Child Safety Forward Indiana

Final Report

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Presented to the Office for Victims of Crime, U.S. Department of Justice

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SCHOOL OF **SOCIAL WORK**

Child Safety Forward Indiana advanced the quality of the child fatality review process, provided evidence for improvements in child fatality review policies, and developed a data-informed, statewide safe sleep campaign, which has started to translate in decreased Sudden Unexpected Infant Death rates so that all children in Indiana can reach their full potential.

July 2023

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> _**Note:** The choice of colors and different font types is intentional. Reading and talking about children's deaths is not easy. We use color and photos to support the reader. We use different font types to reflect the wide variety of voices of parents and youth with lived experiences as well as professionals from a variety of systems and backgrounds._

Improving child fatality review and reducing Sudden Unexpected Infant Deaths (SUIDs) with Child Safety Forward Indiana Project

Translational Science Benefits Model
IMPACT PROFILE

Child Safety Forward Indiana (CSF IN) improved the quality of the child fatality review (CFR) process, provided evidence for child fatality policy changes, and developed a data-informed statewide infant safe sleep campaign, which has already started to translate in decreased SUID rates, so that all children can reach their full potential.

The Impact

The Child Safety Forward Indiana project resulted in practice, community, and policy benefits.

CSF IN conducted a comprehensive needs assessment, providing evidence for policy change, guidelines, & training to improve the CFR process. Indiana Department of Health (IDOH) developed a structure and provides regular trainings, TA, and support to CFR teams and Community Action Teams. Findings also informed policy changes to improve CFR process and data quality. 1.5M video views indicated a positive response to a statewide data-informed campaign. All these factors combined are designed to decrease SUIDs rates in the state, particularly in the target area (Delaware, Grant, Madison, and Clark Counties). While no direct causal inferences can be made, the SUID rates and the rates of deaths due to external injury decreased from 2019 to 2021.

The Challenge

In a five-year retrospective review of 285 child deaths, 27% were sleep-related infant deaths (SUIDs) and Black infants were overrepresented with 38% of these deaths. Child death investigations were inconsistent and only 9% had a complete investigation. Qualitative needs assessment indicated a need for cross-system information sharing, policy changes, improved data, and improved CFR process.

The Approach

Child Safety Forward Indiana improved the quality of the child fatality review (CFR) process in Indiana by:

- Providing structure (e.g., guidelines, forms) & support to teams
- Improving cross-system capacity & collaboration, particularly by tying prevention efforts to maximize results
- Creating Community Action Teams to implement CFR teams recommendations
- Developing data-informed statewide safe sleep campaign materials
- Informing policy changes around CFR teams and SUIDs investigations

HIGHLIGHTS

60% decrease
in SUIDs rates–lower SUID rates than state rates

28% decrease
in deaths due to external injury - lower rates than state rates

1.5M+ views
of statewide infant safe-sleep campaign videos

2 new state laws
regarding child fatalities

Key Benefits

PRACTICE Provided supporting evidence for CFR guidelines and training to improve CFR process .

COMMUNITY Developed data-informed statewide infant safe sleep campaign materials.

COMMUNITY Resulted in lower SUID rates than the state rates and lower external injury rates, comparable to the state rates.

COMMUNITY Increased cross-system collaboration around child fatality review.

POLICY Provided supporting evidence for the modification of existing CFR legislation IC-16-49- 2-2 (2021), regarding CFR team leadership.

POLICY Provided supporting evidence for Indiana House Bill No. 1169 (2022) specifies requirements for consistent SUID investigations.

The Team

Jamie Smith, Indiana Department of Health (IDOH); Susana Mariscal, Indiana University School of Social Work; Bryan G. Victor, Wayne State University School of Social Work; Allie Houston, IDOH; Pam Ashby, IDOH; Mallory Lown, IDOH; Ashley Krumbach, IN Department of Child Services (DCS); Abbigail Hummel, IDOH; County and State Child Fatality Review Teams; Kacie Chase, LifeSpring Health System; Gretchen Martin, Michigan Public Health Institute; Jenna Elliot, IUSSW; Miriam Commodore-Mensah, IUSSW; Hannah Robinson, DCS, Jeffry Wittman, Prevent Child Abuse Indiana, and multiple state and local partners (See Steering Committee, Strengthening Indiana Families & Indiana Parent Group Collaborative).

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Find out more

- Op-ed
- Parent videos

Introduction

This report is the culmination of an in-depth evaluation of the Child Safety Forward – Indiana (CSF) project carried out from October 2019 through June 2023. Here we detail the findings from 127 child fatality reviews conducted during the project period, along with documentation of the multiple ways that the CSF Indiana team has secured improvements to the child fatality review process in the State (See Appendix 2). We also provide a set of recommendations based on the evaluation that is intended to further enhance the capacity of Indiana communities to prevent child fatalities due to external injury (See Overview of findings). We hope that the report is useful to community members, prevention workers, and policymakers who work hard each day to keep children safe.

Fatality Review (FR) is a collaborative public health process that helps explain why child deaths occur and identifies strategies to prevent future deaths. FR teams are multidisciplinary and conduct comprehensive, in-depth reviews of deaths and the circumstances and risk factors involved. Data presented in this report are from the Statewide Child Fatality Review (CFR) Committee and local CFR teams. The Statewide CFR Committee reviews findings of local CFR teams and makes recommendations for prevention and improvements to state policies and practices (See Appendix 3). In 2013, Indiana law IC 16-49 went into effect. This required CFR teams to be implemented in each county, with coordination and support for these teams to be provided by the Indiana Department of Health (IDOH). IC 16-49 also required that a coordinator position be created within IDOH to help support local teams and the Statewide CFR Committee with Governor-appointed members. There are currently 67 CFR teams covering all 92 counties in Indiana.

The local CFR team is responsible for selecting members to serve on the team. They then determine whether to establish a county CFR team or enter into an agreement with another county or counties to form a regional CFR team. Local teams are required to review all deaths of children under the age of 18 that are sudden, unexpected, or unexplained. They also review all deaths assessed by the Indiana Department of Child Services and those determined to be the result of homicide, suicide, accident, or undetermined. In July of each year, local CFR teams submit reports with aggregate data collected from their reviews to the Statewide CFR Committee (See Appendix 4).

This report would not be possible without the hard work and dedication of Child Fatality Review Teams.

Although it is an unfunded mandate and members are not compensated for their participation, local CFR teams are comprised of people who are committed to protecting children and families in their local communities. Collaboration with local teams expanded the impact of this project and opened new opportunities for statewide improvements in the future. We also want to express our gratitude to all our participants and our local and state partners who shared their time, expertise, and knowledge with us. The results of this project include improvements in the CFR process, the development of a prevention campaign, and greater accuracy in data collection (See Appendices 5, 6, 7, 8, 9). Dedicated funding for local CFR teams would increase the effectiveness of reviews and allow for evidence-based strategies for CSF's partnership with the Fetal Infant Mortality Review coordinator. Potential future improvements include increasing diversity in testimonials, representing fathers in materials, prioritizing different materials, allowing more time to film testimonials, and locating space for filming.

What we learned

- Most of this project took place during the COVID-19 global pandemic, which created several data collection and implementation challenges, particularly because the grantee was the Indiana Department of Health (IDOH) and some of the project staff were pulled into COVID-19 efforts. Our cross-system collaboration strategies changed from in-person to virtual meetings, and to build more in-depth relationships, we also held one-on-one meetings with some partners. Because our needs assessment data was collected in the middle of the COVID-19 outbreak in 2020, we had to adjust and quickly make our data collection efforts virtual (or conducting interviews instead of focus groups if necessary). Similarly, CFR teams were reviewing cases and our coordinator had to use creative approaches to make virtual meetings work for CFR. Many of our partners were getting discouraged, finding serious problems with data quality and missing data from the death scene investigation. Our CSF team met weekly and allowed time for problem-solving and brainstorming strategies.
- CSF has been extremely helpful in **legitimizing** Child Fatality Review in Indiana.
  - The needs assessment confirmed that IDOH needed additional staff (See The "secret sauce" of effective child fatality reviews). Now, it is validated by a federal grant.
    - The needs assessment provided data, corroborated needs, and identified inconsistencies (see Overall Summary and Overview of findings).
- **Tying initiatives together with a shared vision** increased success for all initiatives and partners involved. A variety of grants, including Child Safety Forward (DOJ, OVC), Sudden Death in the Young Case Registry (CDC), Safe Sleep (AAP), Strengthening Indiana Families (SIF-CB, ACF), among others, provided legitimacy and power of authority.
  - Sudden Death in the Young (SDY) Case Registry standardized a process to review Sudden Unexpected Infant Deaths (SUID). CFR reviews found inconsistencies.
    - Sudden Unexpected Infant Death Investigation (SUIDI) training with coroners.
- Strengthening Indiana Families improved the quality of needs assessments and implemented primary child maltreatment prevention strategies, such as the macro campaign "Kids don't come with instructions. We're here to help!" They also implemented four Family Resource Centers that provide destigmatized, integrated services that build upon families' protective factors and resilience and mobilize communities to support families. (See Steering Committee)
- CSF allowed for a **systematic assessment of CFR team** functioning in Indiana and identified areas for improvement (See The "secret sauce" of effective child fatality reviews).
- CSF **improved the structure, process, and way IDOH provides support** and technical assistance to CFR and Community Action Teams across Indiana.

  - CSF provided data-informed approaches, increased the capacity of IDOH team and CFR teams (funding for staff, consistent process, increased awareness among teams, statewide trainings), increased structure around CFR, and allowed IDOH to access more opportunities (See Appendix 5).

- **Lessons about CFR teams, process, and technical assistance**
  - While CSF was a *demonstration* project, the data-informed practices and processes used in the target area, such as the CFR toolkit and form, have **expanded to other CFR teams** (See Appendix 6).
  - It is **critical to have a central IDOH CFR coordinator** who provides guidance and TA to the teams. **Who this person is matters**, considering that this individual needs to be approachable, flexible, and creative, and have strong interpersonal skills, solid resources, extensive expertise, and a clear commitment to prevention.
  - **The CFR team leader has a critical role.** Strong leadership will largely determine the fate of a local CFR team. Without a strong, engaged leader with a vision for prevention, teams will drift and cease to continue meeting.
  - **CFR team members are more effective when** cross-systems are represented and members understand their roles and duties, take responsibility, and bring the necessary information.
  - **"It's been a huge struggle to get it going"** – COVID-19 created challenges for teams in getting started, but there are other contributing factors.

> ### *Grant County Data Walk*
>
> *"We have a new prosecutor and sheriff who attend the meetings so that has helped to start the CFR team and do case reviews again."*
>
> *~ CFR Team member (July 2023)*

  - While there was an initial buy-in, the teams in the target area stopped meeting after the review was completed. To date, three of the four teams in the target area are meeting regularly.
  - The legislative change around team leadership enabled teams to meet continuously. Without this change, team members would not have been able to successfully initiate the team and make progress.
  - The team that does not meet regularly has experienced several challenges, including overwhelming responsibilities, and family and health concerns. In addition, the county that is represented by this CFR team struggles with neighborhood divisions and politics, and conflict associated with parent engagement.
  - Local teams are not implementing recommendations and community action teams are not emerging in the target communities. CFR teams are not applying for CSF funds to implement recommendations.

- **Safe sleep campaign:** The skills and knowledge gained from this initiative can be applied in the future to develop successful initiatives (see Appendix 8). These include fostering collaborations with partners, creating culturally appropriate materials for diverse populations, and producing positive testimonials to highlight the benefits of safe sleep practices and other safety measures. We have been collaborating with New York around their safe sleep efforts.

- **Developmental evaluation** helped us to adopt a continuous quality improvement mindset for the fatality review process and all major project activities. CSF evaluators sought special technical assistance around strategies in   the early stages of the project and applied developmental evaluation principles and tools addressing a variety of learnings, including effective legislative changes (see below for a detailed description), statewide safe sleep campaign (before and after), CFR teams and protocols, and others (See Appendices 6, 9, 10, 11, 12).

- We used developmental evaluation tools to identify strategies used by other fatality review teams to successfully implement recommendations. We listed these strategies in the section: *belowThe "secret sauce" of effective child fatality reviews*.
- The **close collaboration** between evaluation and implementation teams contributed to the success of the project as leadership could make data-informed decisions. Dr. Bryan Victor (WSUSW) and Dr. Susana Mariscal (IUSSW) were involved in the project's design and dissemination. Dr. Mariscal also contributed to the grant application. In addition to her extensive experience in prevention and scholarship around resilience, particularly among marginalized groups, Dr. Mariscal's leadership (Strengthening Indiana Families director) and collaboration with multiple initiatives across Indiana facilitated the integration and alignment of prevention efforts, including CSF, in a true spirit of strengths-based prevention.

What we learned about effective legislative changes

- CSF findings informed policy change on regulating who could convene CFR teams and policy requiring coroners to use SUIDI form in manner of death determination (See Appendices 11, 12).
- Legislative changes achieved early in the project have had an ongoing impact on the state of Indiana's capacity to conduct and learn from CFR, including an increase in the number of CFR teams in the state, increased cross-system coordination, and improved SUID data collection. These changes contributed to state shifts towards responding to child deaths from a public health approach.

Step-by-step guide to making effective policy recommendations.

- *Have all resources ready: Conduct studies and have **supporting data/evidence** ready.*
- *Taking advantage of **window of opportunity: Be ready – but you can also CREATE a window of opportunity.***
  - *Infant mortality is a priority for Gov. Holcomb - this contributed to our policy impact.*
- *Prepare for an opportune moment – window opens and closes quickly.*
  - *Identify recommendations for new policy or for policy changes.*
  - *Support your recommendations with data and other research findings.*
  - *Draft rationale for new policy or for changes.*
  - *Draft the language for the new policy or the proposed changes – have documents ready for the time that a window of opportunity emerges.*
- *When the opportunity emerges, **make yourself available** and move fast, respond to requests quickly, get support, information, and engage partners for support.*
- *Circle back to policy changes and implementation.*
- *Conduct an <u>After Action Review</u> to identify strengths, potential challenges, and **next steps.***
- *To CREATE a window of opportunity:*
  - *Garner cross-system support and coordinate work with other agencies.*
    - *CSF opportunity emerged because of the coordinated work of many people (years).*
  - *Engage champions whenever and wherever possible to increase awareness.*
    - *CSF & SIF Champions provided several opportunities for us to increase awareness and support from leaders and policymakers.*

Internal drivers

- *Legitimacy increased due to data collected in Phase I.*
- *Structure that was in place – Fatality Review & Prevention Division intersected well with CSF (building prevention model to CFR, all teams, all this work was synergistic).*
- *Gretchen Martin (MPHI, former CSF director) and Susy Mariscal (IUSSW, CSF lead evaluator) got the grant to drive this work; Jamie Smith (IDOH, Current CSF director) was heavily involved in all aspects of the project-worked with Susy at the beginning of the project. Kacie (former CSF coordinator) works with Susy at IUSSW.*
- *Data-informed recommendations: Data from needs assessment provided clear indicators for both policies.*
- *Passionate commitment among CFR coordinators who continue to push for change.*
- *Common goal: wanting to see child fatality numbers go down.*
- *Having IDOH legislative director (Amy Kent) who came from DCS and understood the work more deeply and is committed to engaging different voices.*
- *CSF evaluators, Susana Mariscal (IUSSW) and Bryan Victor (WSUSW) used developmental evaluation tools, including After Action Reviews to document strategies, processes, and lessons learned to inform future efforts.*
- *Barriers around dissemination related to internal processes.*

External drivers

- *Champions*
- *Cross-system collaboration within and outside CFR– varies by community.*
- *Greater awareness on fatality reviews – more people were talking about it and that it now existed in every single county.*
- *Trifecta: multiple state agency leadership collaborated and worked well together – synergistic – especially DCS and IDOH (leadership at DCS really helped make this possible to get teams moving).*
- *Having Susy Mariscal (IUSSW) was imperative for understanding the funding opportunities available, grant writing and leadership capacity.*
- *Barriers: Red tape – at systems and individual, lack of funding, agencies fear of sharing information due to potential legal consequences.*

Policy changes ripple effects

- *Senate bill and all the work has given community voice to how funding is allocated and utilized.*
- *Helps understand what areas need to be of focus to further move to upstream solutions and preventative recommendations.*
- *The funding that requires the coroners to conduct reviews in a standardized way may open the opportunity for additional funding.*

Key learnings around policy change

- *Change in legislation is possible.*
- *Need to have a **prevention focus**.*
- *After Action Reviews help understand a process that is replicable.*
- *Team dynamics make a difference – seeing how teams were led differently once legislation passed and the ideas and recommendations that were coming through different leaders.*
- *Collective impact –between cross-system coordination, Susy Mariscal (IUSSW, CSF evaluator, SIF director, involved in different prevention workgroups), champions, and grant funding – all this combined **created a momentum** ("started a fire") where we were able to accomplish a lot and is still ongoing.*

Recommendations for others who may want to influence policy changes

- *Gretchen Martin (MPHI, former CSF director, IDOH) and her team established a system and showed the gaps and needs – there needs to be some foundation that demonstrates the hard work that has been done – it's a long game, doesn't happen overnight.*
- *Passionate, persistent, committed, and collaborative individuals and teams that can carry hope throughout the process.*
- *Engaging different/external perspectives allows for seeing barriers and gaps to the work and the potential to be more efficient and effective.*
  - *Using data, disseminating at different levels, and leveraging different channels to communicate it (overcoming barriers) – address at all levels.*
- *Leadership – Having great people on the team who are committed to getting the work done even though its challenging – and by sharing expertise with others – allowed this team to not fall apart despite important leadership transitions.*
- *Using After Action Reviews is helpful to share expertise, identify potential barriers and facilitators, areas to develop next, etc.*
- *Collaborate with community-engaged scholars at universities, like Susana Mariscal (IUSSW), who have the capacity and expertise to lead grant applications and lead large collaborative initiatives.*

Safe sleep today so they are here tomorrow.

Alone, on their Back, in a Crib.

Every nap, every night, every time.

Indiana Department of Health

Indiana SAFE SLEEP PRO

Improving child fatality review and reducing Sudden Unexpected Infant Deaths (SUID) with Child Safety Forward Indiana Project

The Impact

The Impact

The Child Safety Forward Indiana project resulted in community, practice, and policy benefits. Findings from the needs assessment provided evidence to improve child fatality review practice and guidelines, develop and implement training that targets the needs of child fatality review team members, and make data-informed recommendations for policy change concerning child fatality review. CSF also improved cross-system collaboration (see below) and the alignment of prevention initiatives and funding. All these strategies and the multiple prevention initiatives taking place in Indiana contributed to reduced SUIDs rates and external injury death rates in the target area.

Sudden Unexpected Infant Death (SUID) rates decreased in the target area.

COMMUNITY

SUID rates decreased by more than half in the CSF target area, going from 21.6 deaths per 10,000 live births in 2019 to **9.2 deaths per 10,000 live births in 2021**—**lower than the state SUID rate** (10.8 deaths per 10,000 live births) and **matching the national SUID rate** (9.2 deaths per 10,000 live births). In 2019, the target area SUID rate was almost double the state SUID rate (12.2 deaths per 10,000) and more than double the national SUID rate. This represented a **60% decrease in SUIDs in the target area,** going from 10 in 2019 to 4 in 2022 (compared to a 13% decrease in Indiana SUIDs). In the same timeframe, Madison and Clark Counties saw the largest decrease in SUID rates, going from 21.2 deaths per 10,000 live births to **7.0 deaths per 10,000 live births** in Clark County and **0** in Madison County. Delaware County's SUID rate went from 28.5 deaths per 10,000 live births to 17.8 deaths per 10,000 live births. Grant County's SUID rate remained the same. It is important to mention that the state SUID rate decreased from 12.1 deaths to 10.8 deaths per 10,000 live births.

> *SUID rates decreased by more than half in the CSF target area from 2019 to 2021.*
>
> *(21.6 vs. 9.2 deaths per 10,000 live births)*

SUID rates for the target region were lower than those of the State (See Table 1). Figure 2 depicts SUID rates for the target area and the state from 2016 to 2021. Both visuals can be found on the next page.

Figure 2. 2016-2021 SUID rates per 10,000 live births in the target area

SUID RATES (PER 10,000 LIVE BIRTHS)
2016-2021 FOR THE TARGET AREA
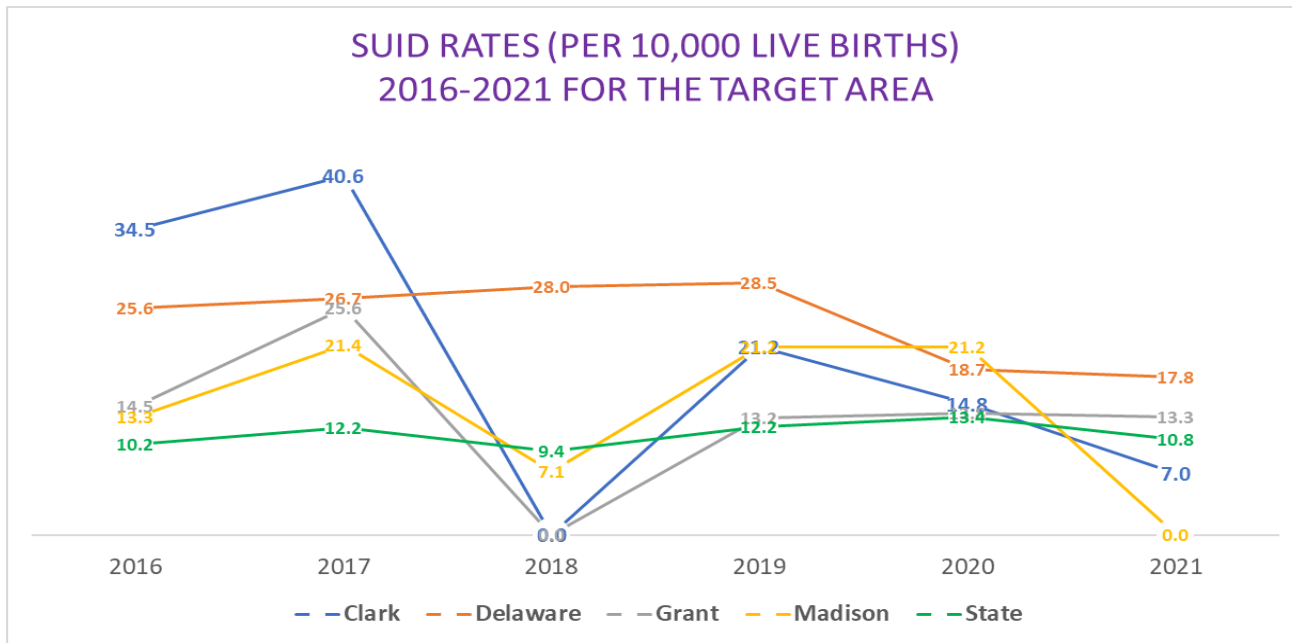
Table 1. SUIDs and External Injury Deaths in Target and Comparison Areas

	SUIDs									Deaths due to external injury								
	2019		2020		2021		Total		Percent change	2019		2020		2021		Total		Percent change
	#	Rate[1]	#	Rate1	#	Rate1	#	Rate1	2021/2019	#	Rate 2	#	Rate[2]	#	Rate[2]	#	Rate[2]	2021/2019
Clark	3	21.2	2	14.8	1	7.0	6	14.3	↓67%	6	23.0	7	26.9	6	22.3	19	24.0	0%
Delaware	3	28.5	2	18.7	2	17.8	7	21.6	↓33%	9	39.2	5	22.2	6	26.7	20	29.5	↓33%
Grant	1	13.2	1	13.8	1	13.3	3	13.4	0%	7	49.2	6	42.1	5	34.1	18	41.7	↓29%
Madison	3	21.2	3	21.2	0	0.0	6	14.2	↓100%	7	25.4	5	18.2	4	14.4	16	19.3	↓43%
Target Area	10	21.6	8	17.5	4	9.2	22		↓60%	29	31.9	23	25.5	21	22.9	73		↓28%
State	99	12.2	105	13.4	86	10.8	290	12.1	↓13%	310	19.8	344	22.0	362	22.8	1016	21.5	↑14%
Howard	3	30.3	3	32.6	0	0.0	6	20.8	↓100%	5	27.2	8	43.2	4	21.1	17	30.4	↓20%
Kosciusko	1	10.5	1	10.9	2	21.2	4	14.2	↑100%	6	32.1	2	10.8	6	31.9	14	25.0	0%
Lake	4	7.0	3	5.5	5	9.2	12	7.3	↑25%	25	22.4	27	24.1	26	22.6	78	23.0	0%
Bartholomew	3	29.0	0	0.0	1	9.8	4	12.9	↓67%	5	25.6	0	0.0	8	40.9	13	22.1	↑60%
St. Joseph	6	17.5	4	12.4	7	21.7	17	17.2	↑17%	16	24.7	16	24.9	18	27.7	50	25.8	↑13%
Comparison	17	14.1	11	9.6	15	13.0	43		↓12%	57	24.2	53	22.5	62	25.9	172		↑9%

Data source: Indiana Department of Health; Stable rates; unstable rates; suppressed rates

> "This is an area the community is very passionate about, so I'm thrilled that we are seeing the impact." *CFR team member-* Data Walk

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[1] Rates per 10,000 live births
[2] Rates per 100,000 children aged 0-17

Rates of death due to external injury decreased in the target area.

In the same timeframe, **the external injury death rate decreased in the target area,** going from 31.9 per 100,000 children to 22.9 per 100,000 children—a little higher than the state's rate (21.5 per 100,000 children). This represents a **28% decrease in the number of deaths due to external injury** (29 vs. 21) in the target area, *whereas the state saw a 14% increase* in external injury rates in the same timeframe. Compared to the other target counties, Madison County had the largest decrease in external injury deaths (43% decrease), followed by Delaware County (33% decrease). Due to small sizes, it cannot be determined whether these decreases are statistically significant (See Table 1). Figure 3 shows the rates of death due to external injury in the target area from 2017 to 2021.

> *External injury death rates decreased in the CSF target area from 2019 to 2021.*
>
> *(31.9 vs. 22.9 deaths per 100,000 children aged 0-17)*

Figure 3. 2017-2021 death due to external injury rates per 100,000 per 100,000 children aged 0-17 in the target area.
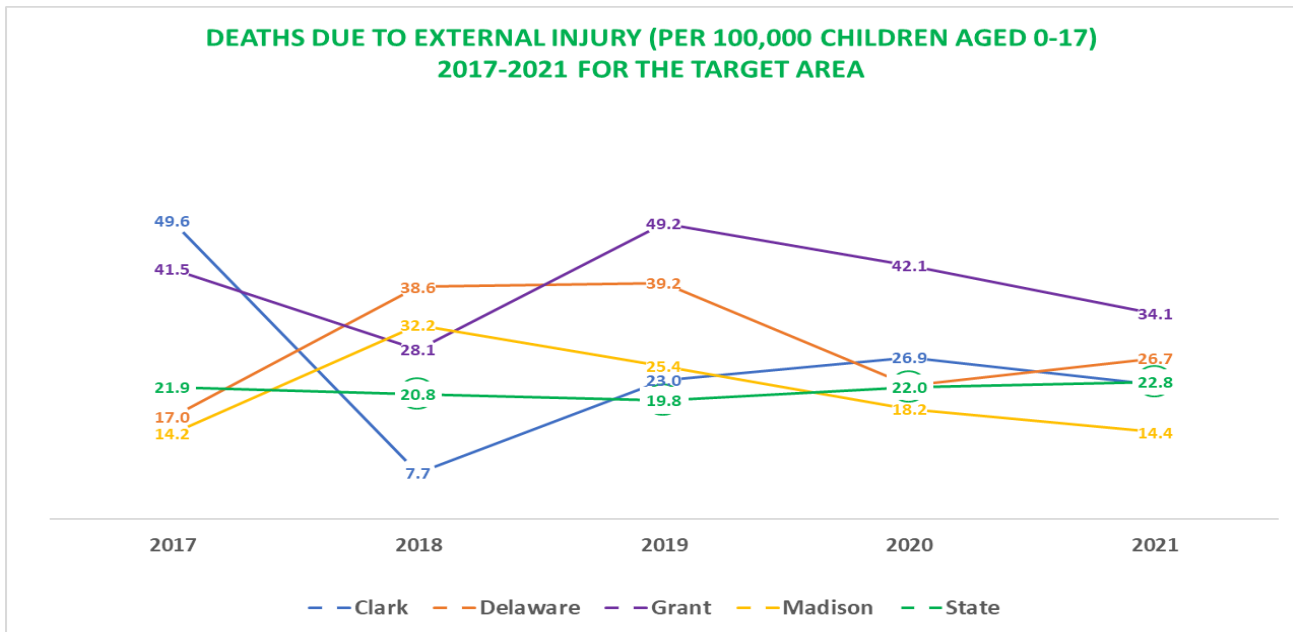
Comparison counties. For comparison purposes, Table 1 includes SUIDs and external injury deaths for the Bartholomew, Howard, Kosciusko, Lake, and St. Joseph Counties, for which selected cases were reviewed by the state child fatality review team during the needs assessment phase. While some cases from these counties were included in the retrospective review, they were not part of the target area where intervention and collaboration efforts were focused. For the same timeframe, **there was a 12% decrease in SUIDs in the comparison area**, and the SUID rate for the area was slightly higher than the state SUID (13 vs. 12.1 deaths per 10,000 live births). However, there was a **9% increase in deaths due to external injury** in this area.

While our evaluation design **precludes direct causal inferences,** CSF-Indiana did facilitate an intensive focus in the target counties on the leading causes of child fatalities, and the urgent need to take corrective action. The CSF team provided considerable support to target counties in completing fatality reviews and considering their implications for prevention. The project also facilitated ongoing cross-system collaboration and coordination around the reduction of child fatalities due to external injury. This support and coordination were not provided in other counties, which collectively saw a smaller decline in SUIDs than the CSF counties. The example below illustrates some of the strategies implemented through collaborative efforts in Madison County.

> *Child Safety Forward Indiana improved the quality of the child fatality review (CFR) process, provided evidence for changes in state-level CFR policies, and developed a data-informed statewide infant safe sleep campaign, which has started to translate in decreased SUID rates so that all children can reach their full potential.*

Community baby showers and "This Side Up" onesies are examples of Safe Sleep related strategies used in Madison County.

In partnership with local agencies, Community Partners for Child Safety (CPCS), a DCS-funded prevention program which is part of Firefly Children and Family Alliance, has implemented a variety of strategies to increase Safe Sleep practices to decrease infant sleep related deaths. Some of these strategies are listed below:

- **Concrete supports:** A yearly **community baby shower** where hundreds of moms-to-be receive "community gifts" and participate in safe sleep education. Among the gifts participants receive, **"This Side Up"** onesies are a favorite. They are "another creative way to remind parents about safe sleep."

  "We have been fortunate enough to receive grant funding in almost all of our counties in Region 11 to do billboards, posters, and other materials that promote safe sleep."

  Aligning different funding sources, this program provides parents of infants with a **portable crib, sleep sack, and a pacifier** as well as a resource packet for baby pantries, local pediatricians, ob-gyns, and information on smoking cessation, and alcohol and substance use programs.

- **In person Safe Sleep education** so that parents can develop connections with other parents and ask questions and engage in conversation. These conversations are possible because the team creates a safe and comfortable environment by building relationships with the participants. In addition, training facilitators have young children, which enhances the personal connection with the participating parents. When parents ask questions, they create a unique learning opportunity and open the possibility for changed behavior toward safe sleep practices. To make it easier for families (and to eliminate other barriers), some safe sleep classes are provided at different agencies, so that facilitators can meet the families where they are comfortable going.

- **Cross-system collaborative partnerships and training:** Strong cross-system collaboration increases the likelihood of everybody's success. "We have a great connection with our community agencies, and they promote our classes as well. That is how the partnership with minority health coalition began." (CPCS leader) CPCS also provides education and training for local first responders and childcare providers.

We have been doing the community baby shower for a long time in Madison County, but this year we got different grants for safe sleep, so we've done the baby shower, we've done some billboards, onesies, educational videos—we have around 45' little videos so that when you have an emergency and you have to give a pack and play, parents can watch a video and you can fit in some of the education too. CPCS has definitely stepped up its primary prevention for sure along with the health department and several other partners.

— CPCS leader- *data walk*

Increased cross-system collaboration around child maltreatment prevention and fatality review in the target area.

To assess CSF and SIF collaboration, cross-system partners completed the Collaboration Assessment Tool (CAT) electronically in 2020 (n=21) and 2023 (n=73). This 69-item tool assesses collaboration factors, including context, members, process, communication, function, resources, and leadership (Marek et al., 2014). It also includes two items corresponding to perceptions of success (current and future). This measure is reliable and valid and allows to assess collaborative efforts comprehensively and effectively. Scores range from 1 to 5, with scores of 4 and above corresponding to areas of strength; scores between 3-3.99 corresponding to borderline areas; and scores below 2.99 are areas of concern. First, the number of partners who completed this assessment tool tripled in 2023. Second, the average score for the overall tool was 3.78 (SD=0.17) in 2020 and 4.10 (SD=0.17) in 2023, which would correspond to a strong collaboration. As Figure 4 shows, CSF & SIF partners considered **all collaboration factors as areas of strength in 2023, except for the "Resources" factor.** Below is a description of each of the CAT areas.

Figure 4. Cross-system collaboration in the target area

CROSS-SYSTEM COLLABORATION IN THE TARGET AREA
(4+ AREA OF STRENGTH; 3-3.99 BORDERLINE; <2.99 AREA OF CONCERN)

	Context	Members	Process	Communication	Function	Resources	Leadership
2020 (n=21)	3.63	3.95	3.55	3.70	3.93	3.36	4.35
2023 (n=73)	4.06	4.3	4.06	4.17	4.18	3.67	4.29

■ 2020 (n=21) ■ 2023 (n=73)
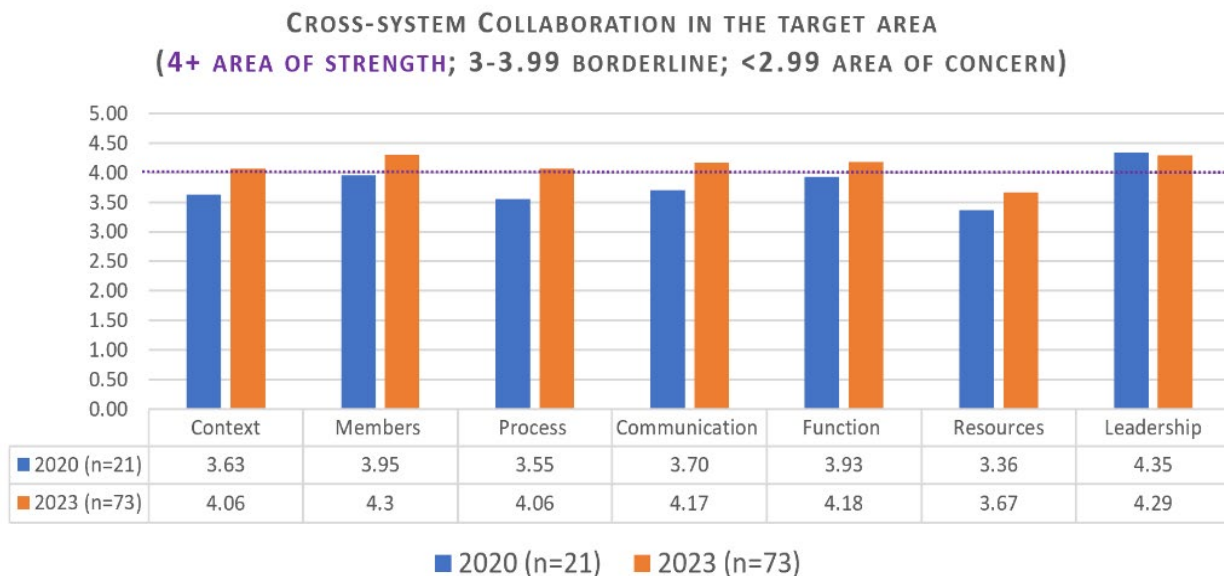
- **Members.** This area had the highest average scores across areas in 2023, including items corresponding to members' shared understanding and respect for the various organizations represented (M=4.59); members' shared understanding and respect for each other (M=4.58); members trust for one another M=4.41); members' unique skills to address this coalition's needs (M=4.45). The item with the lowest score was "Coalition members believe the benefits of the collaboration will offset costs" (M=4.14).
- **Context.** This area's mean scores increased by 11%. The highest rated items corresponded to a history of collaborating with other organizations i" (M=4.75), members' encouragement and support of the activities of this collaborative (M=4.66). The lowest rated item was political leaders; support of the collaborative's mission (M=3.68).

- **Communication.** There was a 12% increase in scores in this area. Highest rated items included a system of communication for coalition members to discuss their efforts (M=4.24); members' frequent informal communication (M=4.24); and formal communication (M=4.21); members' adequate communication is adequate to effectively work towards meeting goals (M=4.13); While "Members of this coalition interact to discuss issues openly." (M=4.1) was the lowest rated item in the area, it was still an area of strength.
- **Leadership.** This area was considered an area of strength since 2019. Highest mean scores included items around coalition leader(s) ' fairness." (M=4.41); team building support and facilitation (M=4.3); strong interpersonal skills" (M=4.38); focus on the goals of the coalition" (M=4.35); The lowest score item was "The coalition leader(s) supports members in carrying out their roles and responsibilities" (M=4.02).
- **Process.** This area showed the most improvement (14% increase) and included items about on how the coalition is as adaptable as necessary in meeting the needs of a changing community (M=4.24); members' frequent informal communication (M=4.24) and marketing efforts and accomplishments to the community to obtain support." (M=4.13).
- **Function.** This area highest rated items included coalition's clear problem definition (M=4.35); goals and objectives based on community needs (M=4.2). In contrast, the lowest rated item was "The goals and objectives of this coalition differ, at least in part, from each of the partner organizations." (M=4.06).
- **Resources.** This was a borderline area at both times, including the lowest rated scores about sufficient funds to sustain coalition operations for the next two years (M=3.26); adequate financial support to maintain coalition operations (M=3.33); plans to secure future funding for coalition operations (M=3.39). One item had a 4.25: mean score "professional expertise, skills, and specialization of coalition members have been identified and are used to advance the goals of the coalition".

Figure 5. Perception of current and future success

This tool also assessed partners' perception of current and future success on a scale from 0-10.

Perceptions of current and future success (1-10)

	Perceptions of Current Success 0-10	Perceptions of Future Success 0-10
2020 (n=21)	3.07	3.64
2023 (n=73)	7.99	8.19
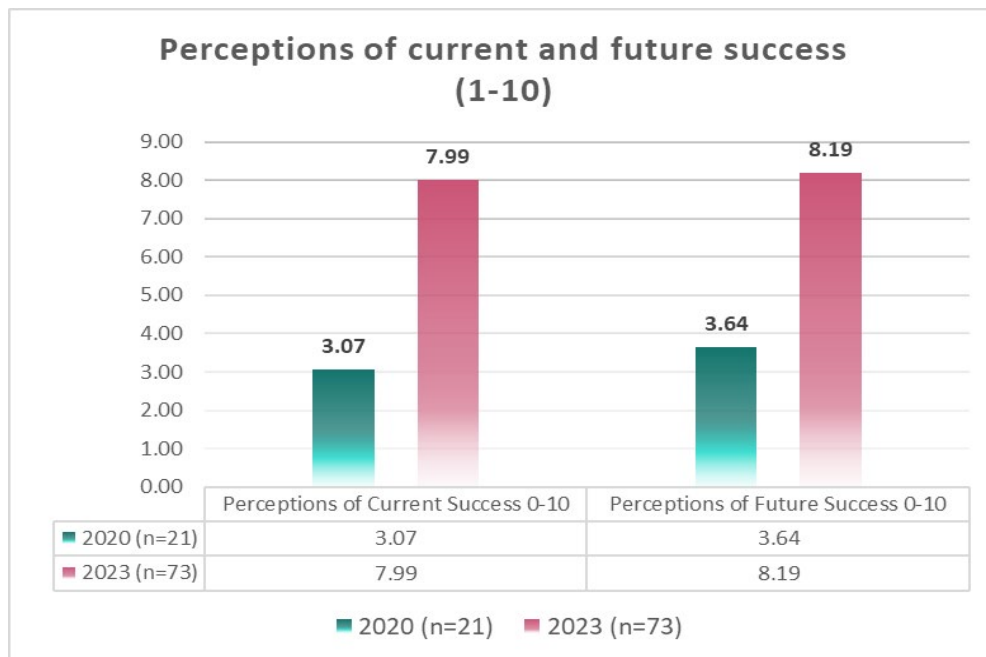
From 2020 to 2023 **partners' perceptions of current success scores increased by 160%** and their **perceptions of future success increased by 125%,** as Figure 5 shows.

Several factors may be associated with this significant increase: Data was collected in the middle of COVID-19 outbreak in 2020, when CFR teams were reviewing cases and finding serious problems with missing information from death scene investigation, and no SIF Family Resource Center had yet opened. All of this may have contributed to the initial low scores. In contrast, by 2023, four Family Resource Centers opened, policies around child fatality review had been enacted, the safe sleep campaign materials had been released, our cross-system collaboration had strengthened, and we were contributing to creating and sustaining a momentum focused on child maltreatment prevention in the state (see below). All of this may be reflected in the significant increase in 2023 scores. CSF's cross-system collaborative partnerships involved multiple organizations and agencies that have collaborated with IDOH before the CSF grant, during the planning year, both during the early work and strategy development.

Data-informed statewide infant safe sleep campaign materials

Safe Sleep Campaign Reach Data

The campaign materials were released in January 2022. Since then, **parent testimonial videos have been viewed over 1.5 million times** across Indiana and beyond. Figure 6 provides a heatmap indicating the areas where the videos had more views in Indiana. About **107,700 printed materials** have been distributed across Indiana. Reach data indicates a positive response of the community towards the data-informed safe sleep campaign materials. Materials will be housed in new locations, including the web page for Strengthening Indiana Families. A new section on the site, Baby Lullaby, will provide useful resources for families and tips for getting infants to sleep safely. This will create a new audience for the materials, increasing both the reach and sustainability.

> *Over 1.5 million views of parent testimonial videos*
>
> *Over 107,700 printed materials distributed*

Figure 6. Heatmap of views of safe sleep campaign videos
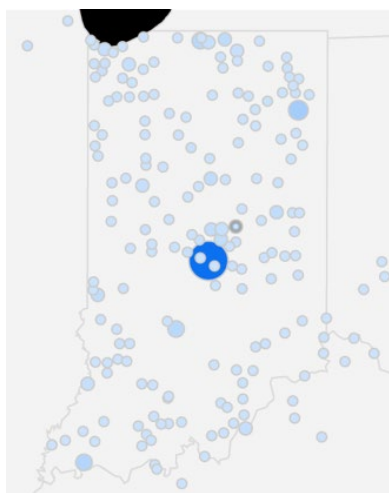
Provided supporting evidence for CFR guidelines and training to improve CFR process

Findings from the needs assessment provided evidence to improve child fatality review practice and guidelines, to develop and implement training targeting the needs of child fatality review team members, and to make data-informed recommendations for policy change concerning child fatality review.

Guidebook and template for child fatality review (CFR)

CSF developed a template and guidelines to conduct a CFR. These guidelines and template describe the most critical information that should be included for each case review, providing guidance around the case discussion, and recommendations generation (Appendix 4). The CFR form has been positively received by new CFR teams and has proven particularly helpful for new CFR teams and/or members. The CFR template enhanced consistency of CFRs and the quality of data entered in the national database. In addition, the template and guidebook developed by CSF improved the structural support for CFR teams around TA, and guidance available to the CFR teams. Using the CFR template as a guide, CFR teams remain focused on the process and generate ideas to reduce future fatalities that go beyond the individual family, targeting communities, systems, and policies. As new team coordinators come on, training will be provided on the templates and guidelines. These tools are also living documents, which will be modified as needed over time.

> *Using the CFR template as a guide, CFR teams remain **focused on the process and generate ideas** to reduce future fatalities that go beyond the individual family, targeting communities, systems, and policies.*

Technical Assistance and Quarterly Community of Practice Calls

About 40 Indiana CFR teams have regular meetings with IDOH team with about 80 percent of members attending. In addition, there have been four Community of Practice calls with over 40 participants each. These calls allow CFR coordinators to address specific questions that local teams may be having, but more importantly, it creates an opportunity for teams to learn from each other. Frequently, newer teams will have questions for teams that have been in existence for years, particularly around problem solving and overcoming barriers. The CFR coordinators at IDOH will continue to host Community of Practice calls and provide TA to teams.

Training tailored to the needs of CFR team members to improve CFR process (See Appendix 7)

Overview of Training Evaluations. Training participants complete a satisfaction survey which also gauges participants' interest in future training topics. Attendance for CSF trainings ranged from 30 to 70 participants from multiple systems (e.g., health, law enforcement, courts, social services, public health, schools, mental health, child welfare, and youth services, among others) across the state. On average, training participants rated their overall experience in the trainings as 4.61 (SD=.59). Table 2 provides an overview of participants' regions, average scores, and whether they found useful information in the training (n=96). SUIDI training participants did not complete evaluation forms.

Table 2. Training evaluation results

Region	% participation	Overall experience 1-5 (5=excellent)	Useful information 0-2 (2=yes)
Northern	30.2%	4.63 (SD=.63)	1.92 (SD=.27)
Central	32.5%	4.63 (SD=.49)	1.90 (SD=.3)
Southern	27%	4.47 (SD=.71)	1.88 (SD=.33)
State	10.3%	4.85 (SD=.38)	1.92 (SD=.3)

The **Death Scene Investigation Training** had the highest levels of participant satisfaction, especially regarding the useful information it provided (M=1.95, SD=.22). Most of the participants reported the training was very effective and helpful as they received the information, procedures, and protocols they were expecting on how to effectively handle a death scene investigation, as the following quote indicates: "insight into more detailed death scene evaluation and multi-agency interaction." Participants provided several examples of what was effective or helpful in the training. More than a third of the participants provided examples related to "knowing the importance of including other professionals and collaboration to complete a thorough investigation." A participant added "reminders of the thorough information that can be provided by EMS and fire was helpful," others referred to the "pathologist speaking." Several participants focused on a compassionate approach to death scene investigation: "I loved how this training wasn't cold but brought in the human aspect of making sure that we are not just following policy and protocol but more about service and compassion." Some participants stated that the resources, documentation, and handouts provided in the training were helpful, including "information on suicide prevention" and a participant stated, "I liked learning about the different forms and things that can help us as well as bereavement packets to help those families."

> *"Hearing first-hand accounts" of "different professionals and their roles and experiences."*
>
> *"Learning that the most effective death scene investigations occur when you have one person as the central authority at the scene."*

The training on **Fatality Reviews and Recommendations** received excellent feedback. Participants stated that it was helpful to receive "information on the why and the what of the review teams." A participant stated, "It was helpful to gain information about the process and the different individuals that work in different capacities regarding fatalities." Another participant added "all of the different death reviews, seems more streamlined than trying to put it all together in my head." The quality of the videos, visuals, and information was also praised by participants, "The combination of the videos and visuals was effective. Great to have the Q&A also." Some participants highlighted the clarity, conciseness, and usefulness of the information presented for fatality review: "The clear, concise information, setting the expectations/goals of the meetings." Other participants stated that having examples of recommendations and prevention efforts was helpful: "Background, facts, prevention strategies, best practice, cultural consideration, and de-stigmatization language." Other participants added, "Examples of concrete recommendations made by Child Fatality Teams that came out of CFR." Participants identified the following as most helpful in **ACEs training:** "Understanding ACES effects on families" and to be able to help families with this information. Other participants focused on "How core protective systems can help," while other participants highlighted learning about the "neurobiology of trauma" while keeping a "focus on communities."

> *"This was great! The overview information, the purposes, the equity statement, the equity/justice description - lots of information and all very useful!"*
>
> *"I was not aware of how all of these programs fit together even though my team and I participate in several of these programs."*

Many participants suggested continuing to offer good quality trainings and resources. Improvement suggestions included having the handouts ahead of time, hosting the trainings in-person, having additional data related to the topics covered, such as drug overdose in minority populations, murder/suicide, improving the audio quality of some of the speakers, making webinars more interactive, providing additional time for Q&A, including more real life stories and examples, "dumb it down a little", and taking time to go more in depth. A participant stated, "the information was really useful, but it was a bit overwhelming." Among additional training topics participants suggested how to improve CFR team collaboration, how to drive improved outcomes, coroner's training for EMS, information on what DCS can do to help/improve CFR process, specifics on taking photos and documenting the scene' specific, and ACEs interventions related to FR implementation.

Provided supporting evidence for the modification of existing CFR legislation [IC-16-49-2-2](#) (2021), regarding CFR team leadership.

POLICY

Data-informed legislative change recommendation. Prosecutors are often overwhelmed with high caseloads and professional duties, and, particularly in counties where many children die from injury, often struggle with the extra work associated with maintaining the child fatality review team. IC 16-49 required the elected county prosecuting attorney to begin the child fatality review process in their county. Findings indicated that, for many years, requiring only the prosecutors to start and convene CFR teams created barriers to initiating and sustaining review teams (see below). Findings suggested that this was a consistent message communicated by CFR teams to IDOH (see below). As a result, the implementation and operation of child fatality review teams varied across counties. Additionally, under the leadership of county prosecutors, some local teams found it difficult to incorporate the review of unintentional child deaths because there is no criminal justice connection. This often excluded the much needed review of deaths due to external injury, such as motor vehicle crashes.

A modification of existing CFR legislation IC-16-49-2-2 was signed into law on April 29, 2021, and took effect on July 1, 2021, making it possible for other agencies (e.g., coroners, prosecutors, law enforcement, and local DCS offices, etc.) to start child fatality review teams in their counties.

CSF devised solutions and provided **recommendations for legislative changes** to amend the child fatality review legislation to shift responsibility of team initiation from the county prosecuting attorney to other CFR team members. This would alleviate the burden on prosecutors and allow leadership and participation from other community partners, enhancing the sustainability of CFR teams. These changes would allow teams to move more quickly and sustainably in the long term by opening the door for other

local partners to initiate and convene local CFR teams. With these legislative changes, the CSF team's goal was to increase CFR in the state.

> *There was a **50% increase** in the number of counties being represented by a CFR team.*

Additionally, this change would also serve as a reminder that child fatality review is not intended to be punitive or investigative in nature. Rather, it is a public health analysis of child injury in an effort to produce evidence-based recommendations for prevention. For more details, see Appendix 11. CSF's successful strategies to impact policy are described in Lessons Learned. These policy changes contributed to a **50% increase** in the number of counties being represented by a CFR team. In 2018, there were 61 counties of 92 being represented by a Child Fatality Review (CFR) team or developing a CFR team in Indiana. In 2023, all 92 counties are being represented by a CFR Local or Regional Team. However, there was an unintended consequence: There was more DCS involvement, which can be challenging because they have limited capacity and more work is being added to their plates.

> *This policy change allowed different perspectives/voices to be included, shifting reviews from legal justice to public health perspective.*
>
> *~ After Action Review*

Provided supporting evidence for Indiana House Bill No. 1169 (2022) specifies requirements for consistent SUID investigations.

Data-informed legislative change recommendation. Findings from the CSF needs assessment indicated that:

- Infants are at a heightened risk for sleep-related deaths (see **Error! Reference source not found.**).
- There were limited policy guidelines around death scene investigations following a sudden unexpected infant death (SUID) in Indiana (see below).
- Retrospective child fatality review identified poor data quality due to inconsistent and incomplete information. Inconsistent and incomplete documentation of SUIDs can limit knowledge of the true SUID rates and risk factors (see below).
- High quality, accurate data are necessary to better understand and address risk factors and implement recommendations.
- CSF devised solutions and provided **recommendations for legislative changes** to reinforce guidelines around death scene investigations following a SUID. Legislation that mandates the types of evidence and data to be collected when a SUID occurs, and that way that evidence and data should be obtained would be extremely useful for better understanding the antecedents of child deaths in Indiana. For more details, see Appendix 12.

> ***[Indiana House Bill 1169](#) was signed into law on March 15, 2022 and took effect on July 1, 2022, providing guidelines for coroner SUID investigations to now include imaging, pathology, and toxicology. This new policy will increase consistency around how SUID is investigated and handled across the state, aligning with the CDC's best practices.***

Ripple effects ("Wave"): Increased support for child maltreatment prevention

As Figure 7 depicts (see page 27), building on existing cross-system collaboration between IDOH and DCS, the collaborative grant writing application with IUSSW tied SIF and CSF grants from the start. The work of these two initiatives together allowed both teams to maximize the resources for a comprehensive needs assessment, increasing our understanding of family, community, system, and structural level factors contributing to foster care entry and child-maltreatment related fatalities in Indiana as well as recommendations for prevention. The needs assessment included parent voices and prioritized relationship-first and strengths-based approach in our work. As both teams established the shared Steering Committee and collaborated with local teams, we were able to strengthen cross-system collaboration at local and state levels. These partnerships, agency leaders, and champions across systems opened opportunities for our teams to disseminate findings, supporting tailored local responses and data-informed

> *"Consider this is more of a potential wave than a ripple effect. By tying these two initiatives together and having the flexibility to do so, you moved fast--fast when others go slow. We can't afford to go slow and this is the future of the work!*
>
> **~ Technical Assistance Team**

decision making. Among these tailored responses, SIF Family Resource Centers offer primary strengths-based child maltreatment prevention supports, which build on family strengths and resilience by increasing community awareness and use of prevention services and supports.

Figure 7. Prevention ripple effects in Indiana

As the community was engaged in different efforts, such as Community Action Teams, community members spread the word about different programs (e.g., the parent testimonial videos). Collaboration with additional prevention efforts, TA, and evaluation efforts increased our local capacity and expertise. Increased community awareness and use of prevention supports was associated with increased awareness and buy-in from leaders and policymakers, which created a momentum, evident in policy changes, funding alignment, and increased financial support for child maltreatment and related fatalities prevention. For instance, prevention funding increased as ripple effects, which was supported by policy benefits.

POLICY Provided supporting evidence for Indiana Senate Bill 2 (2022) that increased funding for child maltreatment prevention

Findings from the needs assessment identified the need for child maltreatment prevention funding, particularly to provide concrete supports for families.

> ***Indiana Senate Bill 2** established the Hoosier Families First Fund, allocating $45 million in 2023 for child maltreatment prevention,* including funding for programs that prevent foster care entry, newborn safety devices, support for families with children under age 4, among others.

Provided subject matter expertise for [Indiana Senate Enrolled Act 4 (2023)](#) to increase funding for local public health departments' prevention efforts

Child fatality review (CFR) is an unfunded mandate in Indiana. **As the needs assessment indicated, CFR is crucial to catalyzing communities to address the risk factors and circumstances involved in child death but was established without any dedicated funding to support local teams.** CFR team members recognize the value and need for the process but are often left without the resources or funding to effectively address the issues identified or implement the needed prevention initiatives.

In August 2021, the Governor's Public Health Commission (GPHC) was established. The GPHC was charged with examining the strengths and weaknesses of Indiana's public health system and making recommendations for improvements. According to Trust for America's Health rankings, Indiana in 2021 ranked 45th in the nation for state government public health funding. The average spending on public health per person statewide is $55, well below the national average of $91. Within the state, local funding per person varies widely from $1.25 to $83, depending on the county. The lack of public health funding contributes to poor health outcomes for Hoosier children and families. The GPHC proposed increasing Indiana's public health spending from $55 per person to closer to $91, the national average. That would bring Indiana's public health investment more in line with other states and lead to improvements in Hoosier health and safety and help ensure the delivery of core public health services in every county. The funding would also help IDOH better support local health departments at the regional and district levels. The bulk of this increased funding would go directly to local health departments to implement programming at the local level that best reflects the needs and priorities of their communities.

Health First Indiana is the state's initiative created by Senate Enrolled Act 4, legislation passed by the 2023 Indiana General Assembly that transforms public health

> *__Health First Indiana__ provides optional funding for local health departments for the implementation of prevention strategies.*

in the state. The legislation provides funding to help local communities prioritize public health and safety. Health First Indiana focuses on providing core services. CFR was included as a core health service in **Senate Enrolled Act 4**, and key performance indicators were established for any county that opts into the additional funding. The indicators include participation in local CFR teams. Participation includes key performance indicators such as providing local teams with birth, stillbirth, and death certificates for case reviews. Although the funding provided by **Health First Indiana** will not be available to directly support local fatality teams, we hope that this initiative increases collaboration between local health departments and local teams. Additional dedicated sources of funding are still needed for the coordination and facilitation of local teams and for comprehensive prevention efforts in local communities.

Final Report Data Walks

To engage in dialogue around research findings about the community, enhancing equity in research, we conducted Data Walks (e.g., interactive presentation of research findings) with the Indiana Parent Group Collaborative and with partners at the state and local levels. Below are some insights:

- **Share this information:** Parents suggested sharing this information with decision-makers and having this information widely available in the community, such as at schools, afterschool programs, and daycares.

> *"Share the data with decision makers in an effort to get more support, but also share the data with families, parents, and communities to show them what they look like in an effort to increase awareness."*
>
> - *Community partner*

> *"Have this information at the schools and after school programs and daycares."*
>
> - *Parent*

- **Increase community informal support:**

> *"We need to show older youth what services are available to them. For example, Safe Place."*
>
> - *Partner*

> **"***We have to figure out how to help people get to know others in their community and be proud of their communities."*
>
> - *Parent*

- **Youth involvement:** Partners stated that we need to start having conversations with youth to identify what they need, what kind of challenges they are facing and how communities can be more supportive of them. A partner suggested connecting with Division of Mental Health (IDOH) youth panel. Parents suggested increasing awareness and connection among older youth about what services are available to them and to realistic career opportunities that motivate them and increase hope.

> *"In my opinion, people need reasons to stay out of trouble and do their best. Young people need to be connected to realistic career opportunities that motivate them. Too many youth see no future."*
>
> - *Parent*

- **Changing community attitudes:** It is vital to shift perspectives on families who need community support and investment for community level solutions.

> *"As for public awareness and engagement, I think the message 'adoption isn't the answer' would be a HUGELY important message to deliver. It will be VERY challenging due to existing strong messaging."*
>
> - *Parent*

> *"To clarify about the messaging around adoption, I think you would find more people willing to invest in community solutions if the attitude of 'getting kids into better homes' was eliminated."*
>
> - *Parent*

- **Increasing optimism and skills**: Recommendations from parents included increasing skills such as problem solving, conflict resolution, communication, and empathy.

> *"We need to create fun ways to teach problem solving, conflict resolution, and how to communicate without getting emotional. We have to figure out how to value one another."*
>
> - *Parent*

> *"I'm stuck on the idea of optimism! I think optimism would be a great asset to our state! How do we increase optimism in our communities?"*
>
> - *Parent*

- **Creating a violence-free space:** The community needs a safe place where people can have discussions and problem-solve.

> *"Find a place where people can have discussions and problem solve without violence."*
>
> - *Parent*

How are you feeling as we close?
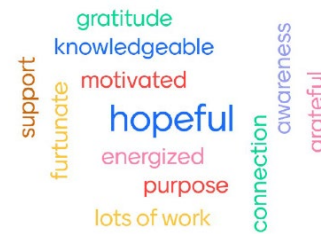
- **Documenting and sharing what was successful:** A partner suggested having a list of things that each of the coordinators, CFR, or CAT did. We included the list of recommendations CFR teams generated (See Appendix 3). We will also include examples in the final report of how some counties moved from a punitive approach toward a supportive approach (See Madison County below).
- **Adding the term "Protective factors:"** Since many community recommendations were related to protective factors, a partner recommended we use the words "protective factors" to increase awareness and consistency. This term is used in several initiatives: "we use this term with PCAA, CPCS, and for the Family Resource Centers." We relabeled the theme in the corresponding section.
- **Parent involvement in prevention:** Partners discussed the need for a training that explains the concrete steps of how to get constructively involved in prevention efforts, as negative involvement can become a significant barrier for any collaborative prevention work. We talked about the technical assistance we received from Kara Georgi who supported us in developing the Indiana Parent Group Collaborative. We mentioned the strategic sharing training from the Children's Trust Fund Alliance. Partners agreed this training would help to overcome barriers created by a parent in the community. Another partner added that the DCS Birth Parent Advisory Board members participated in this training, and it was helpful. However, the parent who is creating barriers to parent participation already

participated in the training. Partners will follow up on this. Another partner mentioned Systems of Care and DCS are working with several families who could be a resource for others in our counties.

- **Track SUID rates longer in the target area:** Considering that rates are unstable, and numbers are small, a partner recommended comparing SUID rates across more years. We agree and IDOH will follow up with this in the coming years.
- **Clarifying misconceptions:** A partner suggested to write about common misconceptions people have about child fatalities, so we can highlight that the data is not supporting them.
- **County data:** A local probation partner stated it would be helpful to know the number and characteristics of suicide and homicide cases in our county.

Dissemination tracking

CSF used several dissemination strategies, products, and materials to reach particular audiences using different channels or spaces and at different timeframes (See Appendix 14 for details). Dissemination strategies and materials included five infographics, one for the overall project and one for each target county; a CSF impact profile, a featured mention in the 2023 Prevention Resource Guide (U.S. Children's Bureau), five media articles (two opinion pieces), and two blogs, 30 presentations (eight refereed conference presentations), among other materials that target the broader community as well as service providers. The statewide safe sleep campaign also targets the broad community. Digital campaign ads direct users to the Baby Lullaby section of the Strengthening Indiana Families website, that includes resources for parents of infants, including Safe Sleep videos with parent testimonials. These three videos have been viewed over 1.5 million times since they were released in 2022.

The CSF Impact Profile, and over 30 community presentations to stakeholders, professionals, and partners across systems seek to increase awareness of child fatality rates and determinants at the state and local level. Community executive presentations, prevention framework discussions, and the CSF Impact Profile seek to increase awareness and buy-in among leaders and policymakers around the challenges and CSF's impact in terms of clinical, community, and policy benefits, so that funding for fatality review and prevention efforts can be increased. Our team, and in particular the lead evaluator, Susy Mariscal, presented and/or discussed findings implications for prevention planning with agency leaders and policymakers over 20 times. Our team had eight peer-reviewed presentations at national or state reputable conferences, such as Prevent Child Abuse America, American Evaluation Association, and the Society for Social Work and Research Conference (also see Appendices 21, 22, 23, 24, 30). The TA team created several opportunities and invited our team to present 5 times at national conferences and meetings, including presentations with TA team members at the Federal Interagency Workgroup on Child Abuse and Neglect and at Social Current's SPARK conference in 2022. In addition, we were also invited to present at Indiana University and Susy Mariscal will be featured as the Translating Research Into Practice (TRIP) Scholar of the Month in October 2023 at Indiana University Indianapolis. Our team has written 11 deliverables (without counting the progress reports) including retrospective review report, recommendations summary, Before and After Action Review reports, plans (see Appendices 10,11, 12), and the like. Finally, our team plans to write five peer-reviewed manuscripts.

The Approach

Taking action based on current knowledge

Child Safety Forward Indiana improved the quality of the child fatality review (CFR) process in Indiana by:

Improving the quality and sustainability of the child fatality review process in Indiana

Findings from the needs assessment provided evidence to improve the quality and sustainability of the CFR review process in Indiana, by providing templates, guidelines, and technical assistance, tailored training targeting the needs of child fatality review team members, and data-informed recommendations for policy change concerning child fatality review.

Providing statewide structure (e.g., guidelines, forms) & support to teams

Funding from Child Safety Forward Indiana allowed IDOH to develop a statewide structure to provide TA, guidance, support, and resources to child fatality review (CFR) team members. Figure 8 illustrates the counties represented by a CFR and a Community Action Team. Establishing a Central CFR Coordinator at the state level was beneficial in defining and clarifying the vision and direction for all teams across the state. When the Fatality Review and Prevention (FRP) Division was established at the Indiana Department of Health, there was a director who oversaw every kind of fatality review process. Anyone that was hired after that was hired on a short term, contract basis. The FRP program in Indiana was built from the ground up, with support from the Indiana Department of Health management. It is a testament to the strength of the former Division Director, Gretchen Martin, that she was able to establish such a robust division, with teams across the state, and in multiple branches of fatality review. At that point, Gretchen was both Director of the FRP Division as well as the de facto State CFR Coordinator.

As teams developed across the state, and a prevailing belief that teams should be given independence to establish themselves according to their local preferences took hold, over the course of several years, the CFR teams began to fade in effectiveness, consistency, and eventually, many teams were barely meeting at all by the time CSF started. There were many counties that still did not have a team, simply because there was not enough staff at the state level to reach out and help start new teams. It was at this time that the Child Safety Forward Initiative was started.

The CSF project allowed for a specified coordinator to focus on the four local teams that were identified for the project. The coordinator was able to work with identified team leaders, provide one on one technical assistance, identify training needs, and assist the teams with case abstraction and data entry. These teams, some of whom had never met before and others who were rarely met, thrived under this more focused guidance and attention. Through this work, it became clear that a central CFR Coordinator would be essential to the growth and longevity of all teams across the state. It also became clear that having only one coordinator for an entire state that legislatively required every county to have a CFR team was no longer feasible. At that point, FRP was able to hire Northern, Central, and Southern Indiana Coordinators to meet with potential teams, provide technical assistance, attend meetings, help guide teams toward recommendations, and more. Having a State CFR Coordinator for this kind of structured guidance allowed teams to have a point person whom they could consistently reach out to for any questions or concerns. It ensured that best practices were being followed and important information was being communicated effectively. Teams went from being mostly independent and meeting occasionally to having robust

technical assistance and guidance, and meeting very regularly. Many new teams were established, and the importance of collecting fatality data was an added benefit to the new structure. Teams were now instructed on data entry procedures and taught about the importance of the use of the data at the local, state, and federal levels for research and prevention initiatives.

Figure 8. Child Fatality Review and Community Action Teams in Indiana (2023)
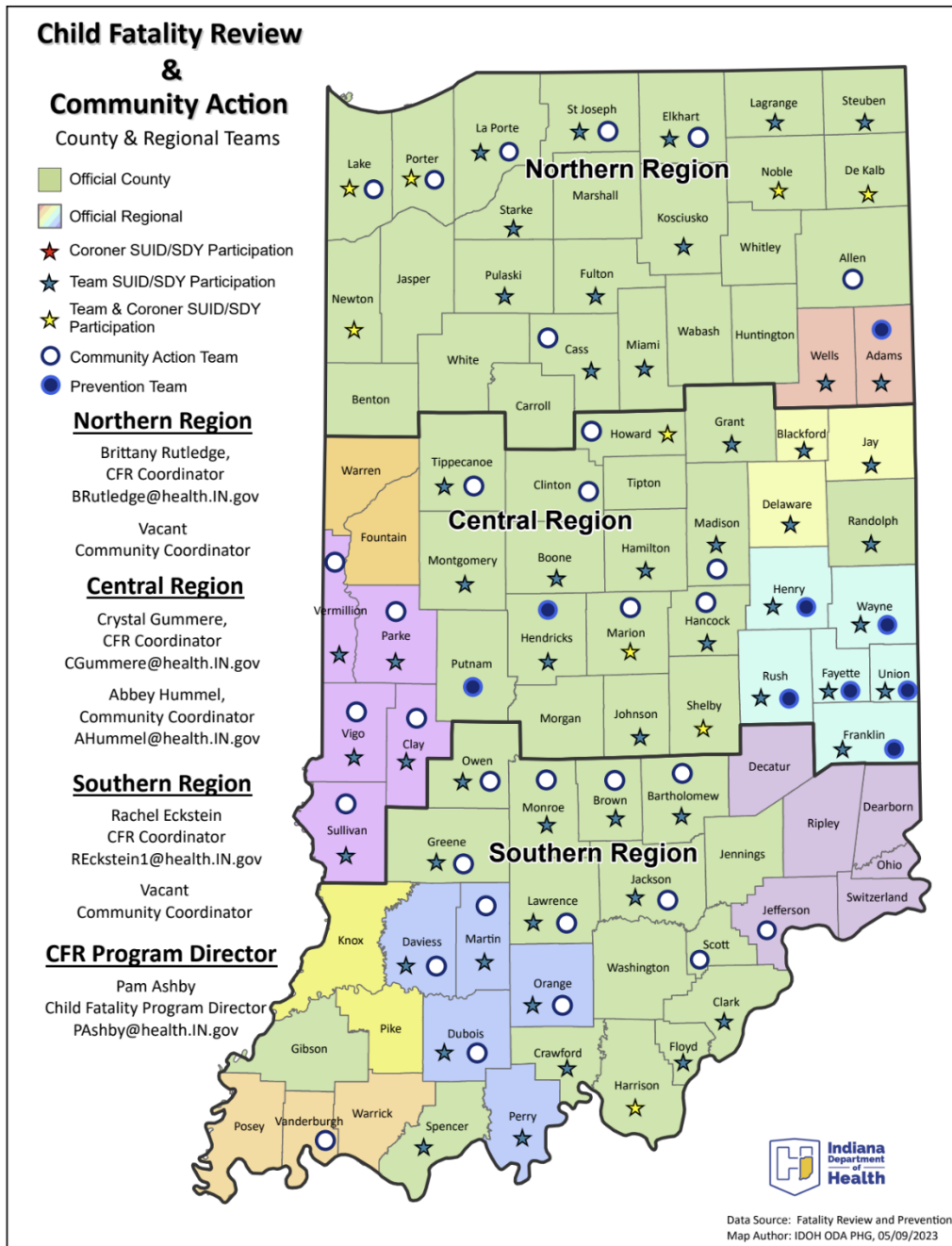
Guidebook and template for child fatality review (CFR)

Having a CFR coordinator who provides expertise and TA to teams, especially to team leaders, has proven to be effective in initiating new CFR teams and supporting existing teams. The role of the CSF Indiana Project Coordinator was instrumental in connecting with team members and community agencies across Indiana. The coordinator was someone who could connect with community leaders, provide a vision for the importance of Child Fatality Review, and give guidance on the technical aspects of starting and maintaining a team. As the CSF team identified CFR teams' needs through the initial stages of the needs assessment, the coordinator developed a template to facilitate CFR. This template includes the minimum information that each case review should have, providing guidance around the case discussion and recommendations generation (Appendix 2). **To be sustainable, dedicated funding is needed to support CFR coordinators.** Teams need the consistent support that coordinators provide in order to maximize the impact of CSF. The CFR template also offers a structured approach for providing TA, support, and guidance to the CFR teams. Using the CFR template as a guide, CFR teams remain focused on the process and generate ideas to reduce future fatalities that go beyond the individual family, targeting communities, systems, and policies. The CFR form was extremely well received by new CFR teams, and while there were some challenges getting some existing teams to adopt the newly developed CFR template, TA, guidance and support was offered to those teams to improve the CFR process, even if the form was not used.

The Child Fatality Review template for the state of Indiana was developed out of a desire to establish a consistent and comprehensive guide for local teams. Prior to having the template, teams were given basic instructions on how to run a CFR team, but it was largely up to the team leader to establish the format of the meetings. The decision to allow teams to function independently (without much oversight from the Indiana Department of Health) was purposeful. The common belief at the time was that local communities would know best what their communities needed; therefore, IDOH gave the teams broad decision-making latitude. As teams became more established, it became clear that they needed stronger guidelines and protocols in order to conduct effective reviews. Although teams required independence in designing their own prevention initiatives, they needed a structure to assist them in creating workable recommendations. The template captured vital data needed for state and federal reporting, while also guiding teams toward generating effective recommendations. Some teams used the template directly, while other teams used it as a guide to help them establish their objectives for each meeting.

Public health outcomes are impacted by inequities, and team reviews create opportunities to better understand the role health equity plays in fatalities. Thus, **health equity is a vital component of fatality review.** Rather than thinking of health equity as a 'lens' that can be easily removed, fatality review uses a constant health equity perspective in the examination of all deaths. As a result of the focus of health equity with the CSF technical assistance providers, as well as the public health emphasis of the Fatality Review and Prevention Division, the necessity of health equity came to the forefront. In addition, the disparities along racial lines in the state of Indiana prompted the CSF team as well as the Fatality Review and Prevention Division to adopt a framework for health equity, which is vital to CFR teams' understanding of why and how deaths in a community occur.

We use the following set of Health Equity statements to set the tone for every meeting:

- *Some families lose infants, children, youth, and adults to the types of deaths reviewed by our teams, not as the result of the actions or behaviors of those who died, or their parents or caregivers.*
- *Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds are also contributing factors in many deaths.*
- *It's important to acknowledge that generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care.*
- *Reducing health disparities through policies, practices and organizational systems can help improve opportunities for all Hoosiers.*

Training and technical assistance tailored to the needs of CFR team members to improve CFR process

IDOH provides regular trainings, TA, and support to CFR teams and Community Action Teams throughout Indiana. Since 2020, a variety of trainings have been implemented (See Appendix 7).

Some teams said they were struggling with the process of using their review data to inform prevention strategies, and the lack of action led to frustration and burnout among team members. Trainings were developed to demonstrate to team members how to address the specific risk factors in their communities. When available, small grants were provided to local teams to facilitate their prevention activities. Resources, including sleep sacks and portable cribs, were also provided to local teams to make prevention activities as easy as possible and to reduce barriers to implementation.

Training also impacted the quality and reliability of the data available to CFR teams. FRP developed and implemented trainings for coroners that focused on the CDC guidelines for complete infant death scene investigations, including deaths due to maltreatment. We discovered during the needs assessment process that only 9% of SUIDs in Indiana between 2015 and 2019 had all the components of a complete investigation. The most commonly missing components of incomplete investigations were scene reenactments with or without a doll and complete X-rays. Autopsies were performed for 98% of total deaths (n=519). Of those, 92% were performed by a Forensic Pathologist or General Pathologist (n=478). For 90% of SUIDs, a death scene investigation was completed (n=475). For 16 deaths, a scene investigation was not completed (3%), and for 37 deaths, scene investigation was blank or unknown to review teams (6%). For 22% of SUIDs, a scene reenactment with a doll was completed as part of the investigation, and for 39% of SUIDs, a scene reenactment without a doll was completed as part of the investigation. Ninety-two percent of investigations included toxicology reports (n=485). For half of the deaths, complete X-rays were included in the death investigation (50%, n=265), and for 57% of the deaths, a SUID Investigation reporting form was completed as part of the investigation (n=301).

To address the incompleteness of investigations and enhance data quality, trainings were provided to coroners, law enforcement, and local DCS staff. These trainings did not just lecture the audience on what we thought they should be doing. We took the time to carefully explain why the components were necessary, and why forensic pathologists, who are typically not present at death scenes, rely on first responders to be their eyes and ears in order to make accurate conclusions during autopsy. FRP will also supply dolls at no cost to coroners to increase use during scene reenactments. The hope is that, over time, there will be an increase in the accuracy of the reported manners of death and an increase in the consistency and completion of death scene investigations and coroners' reports.

Some trainings were provided to local teams virtually to reduce barriers related to transportation and/or the COVID-19 epidemic. Other trainings were recorded and posted on the IDOH website so they could be accessed by local teams when it was most convenient to them. Trainings were also provided in person, given by the local CFR Coordinators and FRP prevention staff. These trainings were provided in tandem with ongoing, one-on-one technical assistance to teams. The result of these activities was an increase in the consistency in the CFR process across local teams, while still embracing the uniqueness of each county and the culture of each team. **This consistency was a result of the development and implementation of CFR protocols, procedures, tools, and templates.** These tools were created after researching options available online, as well as those used by fatality review programs in other states. Tools were tested with teams and modified based on feedback. Finally, the new tools were disseminated statewide, and trainings were provided on how to use each of the tools to improve the quality of the CFR process among all teams. The training and tools that were developed provided structure to local teams, and the CFR Coordinators provided much-needed individual support to teams. The combination of training, tools, and support led to improvements in the quality of the CFR process.

The IDOH Fatality Review and Prevention Division **conducted a survey with CFR teams across the state**. The survey asked questions about what kind of training teams felt they needed, with options ranging from death scene investigation training to Community Action Teams to the importance of collecting fatality data. Team members ranked the options and added their preference for training days and times. Once the Fatality Review Division gathered all of the responses, they decided on four training topics for the year and scheduled them out for each quarter. The invitations were sent to all teams across the state of Indiana for each of the four training sessions, via Microsoft Teams online meeting. The Child Safety Forward Project Coordinator, worked with the other members of the Fatality Review and Prevention Division to develop the four trainings. The first training was an **introduction and overview to the fatality review process.** The training introduced the members of the division and allowed each branch of Fatality Review to give a description of their program: Suicide and Overdose Fatality Review, Fetal and Infant Mortality Review, Child Fatality Review, Maternal Mortality Review, Community Action Teams (Prevention), and data collection. There was an emphasis on the importance of looking at these fatalities as a whole, in order to look at population disparities and social drivers, as well as in their individual specialty areas. The next three trainings looked at specific aspects of fatality review and included various experts and people with lived experience. The first training was about **death scene investigations**, the next was about the **importance of data collection**, and the last was about the connection between **Fatality Review and Community Action Teams.** Considering findings from the needs assessment, we also provided a training on how to **translate CFRs into actionable recommendations** (also see

Table 2. Training evaluation results). All trainings were done live on Microsoft Teams, recorded, and then uploaded to the IDOH website so that teams could access them at any time. While there are materials available for various fatality review subjects that the Fatality Review and Prevention Division could have utilized, we felt that it would be much more effective to establish the leadership of the division, introduce ourselves to the members of the teams across the state, and provide individual feedback and necessary follow-up for the teams.

In addition, IDOH provides regular trainings, technical assistance, and support to Child Fatality Review teams and Community Action Teams throughout Indiana. Informed by CFR process findings, and input from CFR teams, a variety of trainings have been developed (or improved) and implemented. These trainings are offered to all fatality review teams across the state of Indiana on a bi-monthly basis and are recorded and loaded to the Indiana Department of Health website. IDOH covers a variety of topics that are relevant to all fatality review teams (fetal/infant, child, maternal, suicide, and overdose) so that they can reach a broad audience. Also, these fatality review teams often have significant overlap in team membership and community engagement and are working to address the same social/political/structural determinants, as they often play a factor in preventable deaths across the lifespan.

Sudden Unexpected Infant Death Scene Investigation Training (SUIDI)

SUIDI and SUIDI Lite are offered as free trainings to local CFR teams, law enforcement, DCS, prosecutors, first responders, and coroners. The investigators from these agencies learn how to conduct witness interviews and doll reenactments, and to develop a narrative report for the forensic pathologist and local CFR team. This training gives investigators the necessary knowledge and skills to complete the SUIDI Reporting Form (SUIDIRF) during and after the scene investigation. The SUIDI-RF is then used as a resource for data when entering a case in the Case Registry System. During the training, there is also information shared on how to use and relate the SUID algorithm and local child fatality review to improve investigations. SUIDI Lite is Indiana's half-day version of the training with a large focus on doll reenactment. IDOH has offered 10 in-person Sudden Unexpected Infant Death Investigation (SUIDI) Trainings since 2019. These trainings have been successful, with over 60 participants at each training. SUIDI trainings have given law enforcement officers, coroners, and DCS workers, along with other interested professionals, the opportunity to learn effective Sudden Unexpected Death Scene investigation techniques along with doll reenactment techniques and data collection. The trainings encourage team collaboration as well as a trauma-informed approach to death investigations.

Infant Safe Sleep and Family Engagement Training

Infant Safe Sleep and Family Engagement (INSSAFE) is a 'train the trainer' program that can be delivered virtually or in person. This training was originally designed for first responders but has since been provided to in-home care providers and other professionals who work with families. This training teaches the basics of infant safe sleep and shows first responders how they can help prevent Sudden Unexpected Infant Deaths by looking for hazards when they are in people's homes. The focus is on having conversations with families to make sure they understand the importance of safe sleep practices. First responders can also be provided with portable cribs to give to families, along with safe sleep education, if they encounter an infant that does not have a safe place to sleep. These trainings are an ongoing component of the Prevention arm of Fatality Review and Prevention, and Prevention Coordinators regularly provide these trainings upon request throughout the state. FRP will also record one of this training so partners can watch it when it is most convenient to their staff. This recording will be sent to all teams and posted on the IDOH FRP webpage.

Improving cross-system capacity & collaboration

CSF cross-system collaboration built upon long-standing relationships between IDOH and the Indiana Department of Child Services (DCS), which was invigorated by applying for funding opportunities focused on prevention and our collaboration with Indiana University School of Social Work. Starting with the grant application process, Child Safety Forward Indiana and Strengthening Indiana Families (SIF) closely collaborated, tying both initiatives to maximize resources and impact. Considering that both projects required the involvement of the same cross-system partners— DCS Commission on Improving the Status of Children in Indiana, Prevent Child Abuse Indiana, Indiana Family and Social Services Administration, and Courts, among many others— both projects have shared a Steering Committee**, with regular monthly or bimonthly meetings since November 2020.** SIF's **local implementation teams** also meet monthly or bimonthly and provide a venue for CSF to update and engage local partners in Madison, Grant, and Delaware Counties (where SIF implemented Family Resource Centers). These collaborations will continue, and 10 additional Family Resource Centers will be created in other counties throughout the state. DCS, FRP, and the IU School of Social Work will look for additional opportunities to collaborate and seek funding to support efforts to improve the safety and wellbeing of Hoosiers (see Improving cross-system capacity & collaboration).

The impact of the improved cross-system collaboration is particularly evident in the close coordination with DCS Safety Systems Division, which is led by one of our champions, Ashley Krumbach. Ashley provided several opportunities for our team to present our needs assessment findings, participate in task groups, and increase awareness among agency leaders, in addition to providing funding for two additional CFR regional coordinators. The strong collaboration with DCS is also reflected in the new system that DCS developed that feeds data directly, increasing data sharing between DCS and IDOH. Cross-system collaboration is also evident in the CFR report (See Appendix 4). CSF also summarized the TA report integrating recommendations from local and state CFR teams was released in 2022 (See Appendix 3).

In addition, in the true spirit of **strengths-based prevention,** we tied initiatives together toward a common goal of prevention, tailoring the responses to each community and taking into account developmental, cultural, and ethnic characteristics of the target population (Mariscal et al., 2023). CSF partnered with existing prevention initiatives at the state and local levels, including Strengthening Indiana Families, Prevent Child Abuse IN, Healthy Baby, Healthy Families, and the Nurse-Family Partnership, among others, to maximize the impact of the combined efforts and to share resources, creating and sustaining momentum around child maltreatment prevention and promoting a public health approach to child maltreatment prevention in Indiana. It is important to note that there are multiple prevention initiatives happening across Indiana and we were able to engage and collaborate with most if not all of them, directly and indirectly (through partners who were partnering with them). The large majority of initiatives focused on child maltreatment prevention. **Except for the DCS Safety Systems Division, no other initiative or partners specifically focused on reducing child abuse and neglect fatalities or on improving child fatality review process or recommendations.** To build awareness around the way our work intersected with prevention initiatives, our director and evaluator often had to make those connections, describing the prevalence of child fatalities due to external causes, particularly around safe sleep, and the need to increase support for parents. **As we gained support from additional initiatives, the way that our work intersected allowed us to create elevated impact for us all.**

The decision to develop strategic partnerships with existing initiatives in pursuit of a public health approach is one we would recommend based on our experience and observations through CSF Indiana. That is, we think that blending and braiding established initiatives rather than collaborating to launch new projects increases the likelihood of impacting outcomes and has the added benefit of conserving scarce resources. In lieu of investing time on standalone projects, **these organizations opted to intertwine their resources, strategies, and objectives, allowing for a more fluid exchange of knowledge and best practices, and enhanced organizational capacity.** As an example, CSF Indiana was able to quickly and effectively move resources to the Strengthening Indiana Families project, leveraging the established family resource centers to amplify safe sleep messaging and material supports to families in areas with high rates of sleep-related deaths, which will enhance the sustainability of the safe sleep materials.

Partnering with parents with and without prior child welfare system experiences

The technical assistance provided by Kara Georgi from the Children's Trust Fund Alliance was instrumental in convening a **Parent Advisory Group**, which was established **to emphasize the voices and representation of individuals with lived experiences and advance racial equity and inclusion in shaping prevention programs, strategies and services to achieve better outcomes for children and families.** With Kara's support, parent members named this group and defined its vision, mission, and members' roles and expectations. We had 4 meetings with the **Indiana Parent Collaborative Group** starting in February 2022. Aligned with CSF's vision, the group defined its purpose statement as:

> *The Indiana Parent Group Collaborative strategically partners to provide prevention-minded input and guidance on community needs, resources, and services to inform the work of initiatives across Indiana so all families can thrive.*

This group consists of 10 members (regular attendance/communication 8) who represent a wide variety of parental backgrounds, including parents from minoritized communities (5), foster parents (1), adoptive parents (1), biological parents with experiences in the child welfare system (2), parents with disabilities (1), single mothers (2), parents of children with disabilities (2), fathers (2), grandparents raising grandchildren (1), non-English speaking parents (1), and youth who aged out of foster care (1), and parents of children of different ages. Kara Georgi, TA provider, provided coaching as the group defined roles and expectations, and how to use their influence in their community when meeting with agencies and representing the group. Parents provided feedback on the CSF Impact Profile and Indiana's Sudden Unexpected Infant Death statistics, as well as how to bring more awareness of SUIDs. During the June 2023 meeting, we conducted a CSF final report data walk. The group had the opportunity to give feedback and become involved in safe sleep awareness campaigns. Members are determined to use their voices on behalf of/ for the good of their communities along with those serving children and families. Members are determined to use their voices to inform their communities and those serving children and families. The group hopes to continue meeting after CSF and SIF grant funding ends and has made a commitment to helping their communities thrive. DCS and other partners working on prevention will sustain this group as they share our vision of having strong parent voices shaping prevention programs and services to improve children and families' outcomes. This group will participate in prevention efforts across Indiana.

The names of all our team members and partners, including CSF and SIF Steering Committee members, CFR team members, Indiana Parent Group Collaborative, and IDOH staff, are listed in The Team section.

Creating Community Action Teams to implement CFR team recommendations

Community Action Teams (CATs) are a community-led response for the purpose of education and prevention. The teams have an outcomes-focused approach to building healthy communities. CATs are formed with a group of stakeholders who innovate and adjust based on evidence of what works. Because Fatality Review Teams are formed with individuals from local communities that work and serve in many other capacities, the ability to do the continuing work of prevention and implementation of recommendations was often outside of the scope of possibility. Thus, **the inclusion of Community Action Teams, which also consist of local community partners, directly supported the impact of CFR teams and CSF by extension.**

CATs are led by individuals in the community but are assisted by Community Coordinators from IDOH. A Community Coordinator may begin the process of initiating a CAT, but the community will ultimately drive the team. A CAT will do initial research on the local area, gathering health data, data from historic fatality reviews, population demographics, etc. The team will then identify the community's priorities, identify potential barriers and obstacles, and then formulate a strategy and action plan that fits into those parameters. **CATs are important to public health because they empower communities.** Prevention and education in communities should be conducted *with* a community, rather than *for* or *to* a community. Through an inclusive and fair process, community members can inform and share in the ownership of the work.

Two Community Action Teams were established by the Indiana Department of Health prior to the start of the Child Safety Forward initiative (Clark and Lake Counties). The idea for a local-level, prevention-focused team was based on the Fetal Infant Mortality Review (FIMR) model, which has a Community Action component. Fatality Review and Prevention Division staff felt that this kind of Community Action team was needed on a broader scale, across the state, with the ability to carry out prevention initiatives from any fatality review team (Suicide/Overdose, Child, or Fetal/Infant).

*Indiana **Community Action Teams** increased from **1 team** in 2019 to **27 teams** in 2023.*

The CATs were formed by a Fatality Review and Prevention Division staff person attending a local fatality review meeting, discussing the concept of community action, and then asking for input on the best local people to be involved in such an initiative. The FRP staff person then contacted those individuals, discussed the proposal of a team with them, and started the process of building out a team of 10-15 individuals who would be invested in making a difference in their community. These teams often consisted of local prevention agencies such as youth shelters, child abuse prevention, women's centers, faith-based non-profits, local health departments, and more.

The plan for the CATs was to receive recommendations from the local fatality review teams, discuss a plan of action, and see which items to prioritize and initiate. Often the teams simply met and discussed the work that each of the agencies were doing in the community and developed stronger relationships with one another, thus increasing teamwork and cross collaboration. The fatality review teams and CATs rarely seemed to establish the vital connection that would allow them to take recommendations straight to action in the community. Over time, a few teams across the state did form a base for putting the

recommendations into a hierarchy of need, thus establishing a strong set of actions for the CATs to pull from.

How does Community Action work together with CFR?

Because Community Coordinators (who assist with CATs) and CFR Coordinators (who assist with CFR teams) both correspond to a particular region of Indiana (Northern, Central, or Southern), the two initiatives work very closely together. The main goal is for CFR teams to meet, review child fatalities, provide recommendations for prevention, and then hand those recommendations over to a Community Action Team. The CAT then works to put those recommendations into action within the community.

- Partnering for Prevention
- Writing Recommendations
- Moving from Recommendations to Findings
- Equity and parent engagement increased through the Indiana Parent Group Collaborative. The presence of Community Action Teams is another indicator of cross-system collaboration. In 2019, there was only one Community Action Team in Indiana. In 2023 there are 27 teams, representing 32 counties.

Developing data-informed statewide infant safe sleep campaign materials

Safe Sleep Campaign
Materials, 2022 IDOH

Findings from the needs assessment indicated that basic safe sleep education is necessary but not sufficient. Safe sleep messaging is not getting through to parents. An example of this is that, although nearly all participating parents knew the ABCs of safe sleep, they reported they co-slept with their babies and/or will continue to do so. One of the explanations identified in the needs assessment was that *some parents receive conflicting messages from professionals* and family members (e.g., grandparents), and even conflicting messages from different professionals. **Thus, participants recommended developing a statewide safe sleep campaign and distributing these materials widely across systems in the community, so that the message that families and friends—not just parents—receive is consistent.** Child Safety Forward Indiana developed a statewide safe sleep campaign with video testimonials and evidence-informed printed materials. The messaging, imaging, and videography of this campaign were informed by

parents' lived experiences, findings from focus groups around campaigns, and findings from our needs assessment. Additional recommendations for the safe sleep campaign included first-hand accounts and stories of loss, accurate statistics from trusted sources, access to cribs and safe sleep classes, and avoiding scare tactics, shaming, or shocking, instead showing empathy for parents of infants. This campaign also incorporates findings from our needs assessment (see Overview of findings) and from findings from the IDOH SUID report (see Appendix 28).

The goal was to develop a statewide safe sleep campaign with consistent, evidence-based messages through print materials and video testimonials. CSF used developmental evaluation tools, including before and after-action reviews (See Appendices 7 and 8), to understand and learn about the facilitators, challenges, and lessons associated with developing and implementing a statewide data-informed safe sleep campaign (See Appendix 8). Anticipated challenges included limited funding, differing visions, pushback from bedsharing advocates, and difficulty gaining support from service providers and the public. Potential strategies included using evidence-based messaging, tailoring messaging and disseminating to diverse groups of parents, disseminating information in ways that resonate with parents, and collaborating with agencies across the state to ensure consistent messaging and to gain interagency approval. Once the campaign was developed, we identified challenges the team faced, including recruitment difficulties, lack of diversity, technical challenges in conducting interviews, and the emotional impact of the interviews for parents and the interviewer. We also identified factors contributing to the campaign's success, including the vulnerability and passion of the testimonial participants, input from focus groups and partners, and messaging that explains the reason behind safe sleep rather than simply dictating protocol.
This approach was particularly beneficial for the safe sleep messaging campaign because of its adaptability and real-time feedback. Unlike traditional evaluations that assess performance at the end, **developmental evaluation allowed IDOH and partners to capture learning and make adjustments during the process itself.** Through before- and after-action reviews, CSF-Indiana staff planned their campaign with intention, assessed the effectiveness of their actions, refined their messaging, and promptly implemented changes to maximize impact.

Digital ads campaign and Baby Lullaby

To increase visibility of the campaign materials, CSF is using digital ads on Facebook and Google featuring the Safe Sleep Campaign materials. These ads use geolocation to promote safe sleep in the target counties.

People who click on the digital ads are directed to the Strengthening Indiana Families' website. For this purpose, Child Safety Forward partnered with SIF and Awesurance, **SIF's website** developer. On SIF's website, Awesurance has developed a section called **Baby Lullaby**, which provides resources, information, and supports for parents of infants, including evidence-based strategies to enhance baby sleep, links to lullabies, and the statewide safe sleep campaign materials. In addition, internal links to supports offered at SIF's Family Resource Centers, such as Susy's store (e.g., concrete supports), Community Navigators,

Baby Lullaby (SIF's Website)
*If you have a baby, we're here to help! **Baby Lullaby** helps you figure out what sleep practices work best to keep **your** baby safe so that **you** can get some rest and sleep too! We provide resources and information on baby sleep strategies, including safe sleep, and we connect you with free community programs and supports.*

Community Partners for Child Safety, and Family Fun Events. Clark County's Family Resource Center, set to open in 2023, will be included on SIF's website.

What comes next?

- We will sustain core elements of CSF to the best extent of our capacity so that we can continue *1) improving the quality and sustainability of the CFR process* as well as *2) taking action based on current knowledge* (see our Theory of Change, Appendix 27).

- To increase the quality and reliability of data available to CFR teams, IDOH will:
    - Continue to partner with DCS on data sharing, **monitoring the quality of CFR data**
    - Increase accuracy in the reported manner of death and consistency in completion of investigations and coroners' reports, **there is a need for ongoing training for coroners** so that they are able to accurately classify deaths, thoroughly investigate deaths, and complete all required procedures. **and for death scene investigators** to ensure that death scenes are consistently investigated **and include scene reenactments with dolls**.
    - While policy changes improved the guidelines and specified requirements around SUIDs investigations, funding is needed to offset the high cost of X-rays to local coroners' offices. **One of the most frequently missing components of infant death scene investigations in Indiana is complete X-rays.** Without complete X-rays, it is often impossible to rule out maltreatment as a potential cause of death.

- To enhance CFR process and team functionality, while improving the quality and actionability of CFR recommendations, we will continue to provide tailored training to CFR teams. CSF resulted in improved CFR structure, process, and consistency across teams that were associated to protocols, templates and training that responded to the needs of CFR teams. However, to keep members engaged and CFR teams functioning in an effective and healthy way, there is an **ongoing need for consistency in both the timing and content of training for CFR teams.** IDOH will pursue funding opportunities and/or partner with local public health departments to continue providing training, TA, and support to CFR and CAT teams across the state.
    - Child Fatality Review teams remain unfunded in Indiana. **To truly succeed and prevent future deaths from occurring, teams need funding** to support dedicated staff in coordinating teams, requesting records, abstracting cases, preparing presentations, and facilitating team meetings.

- To increase the capacity to implement CFR recommendations so that we can decrease preventable child deaths, CSF Indiana will:
    - Sustain **cross-system collaboration** both at the state and local levels. Collaboration with other initiatives will be a focus for Child Fatality Review in Indiana. Collaboration reduces duplication of efforts, combines work when applicable, and increases the impact of fatality review. SIF will continue leading the Steering Committee, which will be sustained by DCS and other partners once SIF ends.
    - Promote direct collaboration between a Child Fatality Review Team and a Community Action Team, Local Health Department, or Prevention Group is **essential for implementing sustainable prevention activities and reducing childhood deaths.** Child Fatality Teams need support in the implementation of prevention strategies in local communities.

- o **Sustain and expand our safe sleep campaign materials** to increase diversity and tailored messaging, and to include specific messaging that addresses barriers identified through previous work.
- o Continue to implement innovative solutions through our collaborative partnerships and expand strengths-based primary child maltreatment prevention. Our findings highlight **the urgent need to enhance collaboration and coordination across systems and to develop an integrated and comprehensive service continuum.** The service continuum must be based on a public health approach and provide destigmatized supports, resources, and connection to families to prevent child fatalities, as well as culturally responsive targeted interventions, such as the services and supports provided at the Strengthening Indiana Families (SIF) Family Resource Centers. Preliminary findings from the implementation of SIF suggest that the target area where Family Resource Centers are located is showing a larger decrease in the number of children who enter foster care than that of the state. **Funding and support to expand strengths-based primary child maltreatment prevention programs, including Family Resource Centers, is critical to reducing the number of child fatalities due to external injury.**

- **Prevention requires funding.** Community Action Teams receive no dedicated local, state, or federal funding for prevention. Communities need portable cribs, sleep sacks, affordable swim lessons, car seats, booster seats, firearm locks, trainings on suicide prevention, and much more.

- Finally, **family-strengthening policies and family-supportive attitudes in communities** are also necessary for a paradigm shift in child and family services so that all children realize their potential.

When a baby dies, it affects the whole family. Most sleep-related infant deaths are preventable.

Alone, on their Back, in a Crib.

Every nap, every night, every time.

In honor of Brenton Hittle who lost his life in an unsafe sleep environment.

Indiana Department of Health

Indiana SAFE SLEEP PROGRAM
SafeSleep.isdh.in.gov

The Challenge

The Challenge

Five-year retrospective review of child fatalities due to external injury

Overall Summary

In 2020 and 2021, Indiana Child Fatality Review (CFR) teams in nine counties reviewed 285 child fatality cases that occurred between 2014 and 2019. This section focuses on the 127 cases reviewed by the four target counties, which were identified based on their rate of child deaths due to external injury: **Clark, Delaware, Grant, and Madison counties**. Deaths due to external injury were chosen as an estimate of the burden of child fatality in Indiana during this 5-year period. Causes of death due to external injury include deaths caused by accidental injury, intentional self-harm, intentional assault, and undetermined intention of injury, as well as undetermined causes of death. Clark, Delaware, and Grant counties all had rates of external injury deaths among children that were in the top five counties in the state and were all higher than the state average rate (98.9 external injury or undetermined cause deaths per 100,000 children in Indiana) during that period. All deaths correspond to child fatalities due to external injury. These four counties were chosen using a combination of factors. Their higher than-state rates mean a retrospective review of child deaths in these counties allowed us to identify the risk factors for child injuries and deaths there. Additionally, these counties saw a total of 26 excess injury deaths among children, compared to the state average, so community interventions in these counties have the potential for a large impact.

Table 3 provides a detailed overview of these cases, both overall and by each of the four target counties that participated in Child Safety Forward (CSF) Indiana: Clark, Delaware, Grant, and Madison Counties. The overall numbers also include selected cases from Bartholomew, Howard, Kosciusko, Lake, and St. Joseph Counties, which were reviewed by the state child fatality review team. For more information, see Appendix 2.

The purpose of these analyses was to provide a concise demographic overview of the children involved on these cases, consider geographic trends, note leading causes of death, and highlight associated circumstances that could be useful in devising future prevention strategies. We would like to caution readers that the point estimates provided in this report may exhibit some degree of instability due to the limited number of cases available for analysis. The precision of these estimates could potentially improve as data are collected in the future, hence, they should be interpreted as potentially subject to change in the light of additional information.

Age

The distribution of child fatalities based on age reveals that the largest share of deaths occurred in children less than 1 year old (35%), followed by children ages 1-3 years (23%) and those ages 13-17 years (23%). Within the target area (Clark, Delaware, Grant, and Madison Counties), fatalities of younger children 0-3 years (45%) and youth ages 13-17 years (33%) were the most prevalent. Findings reflect national trends that show heightened risk for child fatalities in infancy and later adolescence.

Race

Most reviewed cases involved White children (54%). About a quarter (24%) of cases involved Black children, while 10% involved Latino children and 7% included Multiracial children. In the target area, most cases involved White children (70%), followed by Black (14%) and Latino children (5%). Black children

and Multiracial children were overrepresented in these cases, as they make up 12% and 4% respectively of the Indiana population under 18 years old (KIDS COUNT, 2023).

Cause of death

Sudden Unexpected Infant Death (SUID) was the leading cause of death, present in 27% of the cases due to external injury and followed closely by bodily force/weapon-related deaths (23%), motor vehicle-related deaths (22%), and drowning (13%). Motor vehicle-related deaths were the leading cause in the target counties and represent a third of the deaths due to external injury.

Supervisor at time of death

Parents were by far the most likely to be responsible for the supervision of a child at the time of death (60%). Information related to supervision was not entered for 28% of cases.

Maltreatment-related fatalities

We also determined the share of fatalities that resulted from either child abuse, child neglect, or poor/absent supervision. A total of 41 cases (32%) included a child fatality attributable to one of these forms of maltreatment.

Manner of death

More than half of the deaths were ruled accidental (56%), while 21% of them were ruled homicides, and 9% of them were ruled suicides. In about 11% of the cases the manner of death was undetermined. Similar trends were found in the target area.

Leading causes of child fatalities statewide:

1. *Sleep-related fatality/SUID: 27%*
2. *Bodily force/weapon: 23%*
3. *Motor vehicle: 22%*
4. *Drowning 13%*

33% of deaths in the target area were related to **motor vehicles**

Table 3 – Overview of Reviewed Cases

Variable	Overall (N = 127)	Clark County (n = 22)	Delaware County (n = 13)	Grant County (n = 12)	Madison County (n = 17)	Overall Target Area (n=64)
Child's age at death						
Less than 1 year old	44 (35%)	9 (41%)	2 (15%)	1 (8%)	4 (24%)	16 (25%)
1-3 years old	29 (23%)	4 (18%)	4 (31%)	3 (25%)	2 (12%)	13 (20%)
4-7 years old	17 (13%)	4 (18%)	2 (15%)	2 (17%)	-	8 (13%)
8-12 years old	8 (6%)	2 (9%)	-	-	4 (24%)	6 (9%)
13-17 years old	29 (23%)	3 (14%)	5 (38%)	6 (50%)	7 (41%)	21 (33%)
Child's race						
White	69 (54%)	18 (82%)	11 (85%)	6 (50%)	10 (59%)	45 (70%)
Black	**31 (24%)**	1 (5%)	1 (8%)	**4 (33%)**	3 (18%)	9 (14%)
Latino	13 (10%)	-	-	1 (8%)	**2 (12%)**	3 5%)
Multi-racial	9 (7%)	1 (5%)	1 (8%)	-	1 (6%)	3 (5%)
Asian	1 (<1%)	-	-	-	-	-
Unknown/not entered	4 (3%)	2 (9%)	-	1 (8%)	1 (6%)	4 (6%)
Cause of death						
Asphyxia: sleep-related	**34 (27%)**	**7 (32%)**	2 (15%)	2 (17%)	3 (18%)	**14 (22%)**
Bodily force or weapon	**29 (23%)**	4 (18%)	1 (8%)	3 (25%)	5 (29%)	**13 (20%)**
Motor vehicle	**28 (22%)**	**7 (32%)**	**4 (31%)**	**4 (33%)**	6 (35%)	**21 (33%)**
Drowning	**13 (10%)**	1 (5%)	3 (23%)	3 (25%)	1 (6%)	**8 (13%)**
Fire, burn or electrocution	8 (6%)	-	1 (8%)	-	-	1 (2%)
Asphyxia: other	7 (6%)	2 (9%)	1 (8%)	-	-	3 (5%)
Fall or crush	4 (3%)	-	1 (8%)	-	-	1 (2%)
Poisoning or overdose	4 (3%)	1 (5%)	-	-	2 (12%)	3 (2%)
Supervisor at time of death						
Childbearing parent	54 (43%)	9 (41%)	5 (38%)	3 (25%)	4 (24%)	21 (33%)
Non-childbearing parent	21 (17%)	7 (32%)	2 (38%)	1 (8%)	3 (18%)	13 (20%)
Babysitter	5 (4%)	1 (5%)	1 (15%)	-	-	2 (3%)
Grandparent	4 (3%)	-	-	1 (8%)	-	1 (2%)
Parent's partner	3 (2%)	-	-	-	-	-
Other relative	2 (2%)	-	-	1 (8%)	-	1 (2%)
Other individual	2 (2%)	-	-	-	1 (6%)	1 (2%)
Not entered	35 (28%)	5 (23%)	5 (38%)	6 (50%)	9 (53%)	25 (39%)
Child previously named on a CPS referral[3]						
Yes	42 (33%)	**9 (41%)**	3 (23%)	4 (33%)	5 (29%)	21 (33%)
No	**85 (67%)**	12 (59%)	10 (77%)	8 (67%)	12 (71%)	**42 (67%)**
Maltreatment-related fatality	41 (32%)	5 (23%)	4 (31%)	**5 (42%)**	5 (29%)	19 (30%)
Yes	86 (68%)	16 (77%)	9 (69%)	7 (58%)	12 (71%)	**44 (70%)**
No						
Manner of death						
Natural	3 (2%)	1 (4.5%)	1 (8%)	1 (8%)	-	3 (5%)
Accident	71 (56%)	11 (50%)	7 (54%)	8 (67%)	9 (53%)	35 (55%)
Suicide	12 (9%)	-	2 (16%)	2 (17%)	1 (6%)	5 (8%)
Homicide	27 (21%)	5 (23%)	3 (23%)	1 (8%)	**5 (30%)**	14 (22%)
Undetermined	14 (11%)	5 (23%)	-	-	2 (12%)	7 (11%)

[3] Variables indicating whether parents had previous child welfare involvement were retired in the most recent version of the data set and were therefore not available for this analysis.

County Overviews

The following paragraphs provide a brief overview of fatality cases specific to the four target counties in CSF-Indiana. Next to each summary is a heat map showing the geographic distribution of cases within the county by zip code. The count of cases reviewed is presented numerically within the zip code. Darker colors indicate higher counts.

Clark

Clark County had the highest number (n=22) of child deaths compared to the other three target counties. There was a higher proportion of cases corresponding to younger children, particularly children under one year (41%) and children between the ages of 4 and 7 years (18%), compared to the other target counties. Like the overall results, the most common cause of child death was sleep-related fatality/SUID (32%), which was about twice as high as that of the rest of the target counties. While Clark County had the highest proportion of cases involving a child with a previous CPS referral (41%), 77% of the cases were not identified as maltreatment-related fatalities. Clark County was the only target county that did not have a case ruled as a suicide; however, this county has the largest proportion of deaths in which the manner of death was not determined.
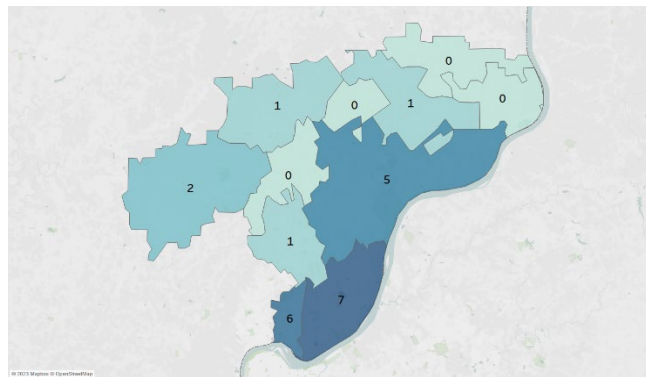
**Figure 8.
Clark County
heatmap**

Delaware

Delaware County had the highest number of child deaths among children ages 1-3 years (31%) and White children (85%) compared to all the overall cases and the rest of the counties. Delaware County had the highest proportion of cases in which the supervisor at the time of death was a parent (74%).
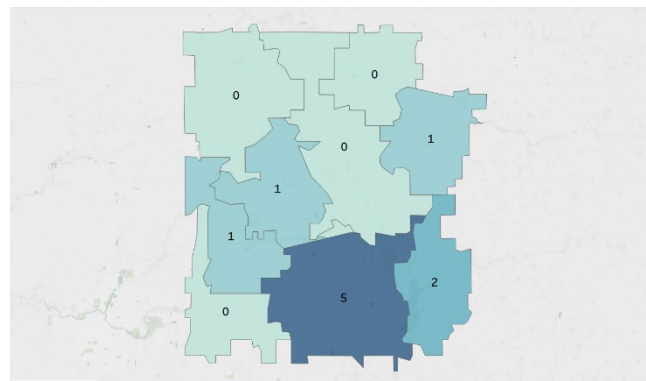
**Figure 9.
Delaware
County heatmap**

Grant

Grant County had the highest proportion of cases involving Black children (33%). Black children were overrepresented on these cases— Black children in Grant County make up only about 1.7% of its children population as of 2021 (KIDS COUNT, 2023). Grant County had the highest proportion of deaths among teenagers, ages 13-17 (50%).
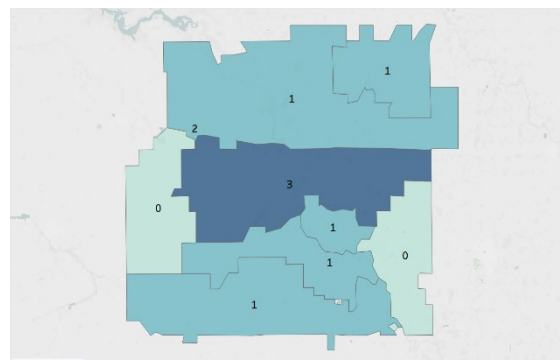
**Figure 10.
Grant County
heatmap**

Madison

The leading cause of child deaths in Madison County involved motor vehicles (35%) compared to that of the overall cases and the three other counties. Most cases involved children ages 8 years and older (65%). Madison County had the highest number of deaths of children between the ages of 8-12 years (n=4, 24%). Madison County had the highest percentage (30%) of homicide cases compared to the overall cases and the other three counties.
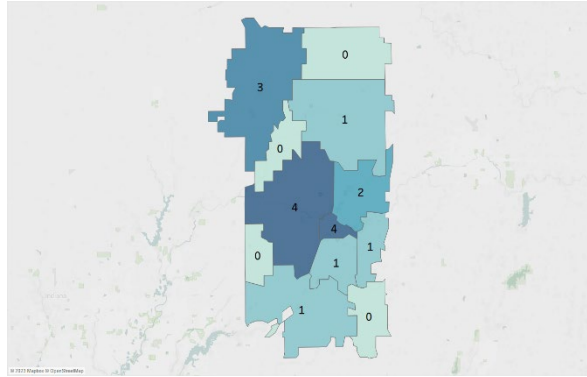
Figure 11.
Madison County heatmap

1. *Clark County: Younger children, 32% asphyxia, CPS referrals BUT maltreatment not identified*
2. *Delaware County: Ages 1-3,White, 31% motor vehicle*
3. *Grant County: Ages 13-17, Black, 33% motor vehicle— Pedestrian*
4. *Madison County: Ages 8+, 35% motor vehicle, 30% homicide*

Sleep-related Fatalities/SUIDs

Overview

There were **34 cases** corresponding to infant sleep-related deaths in the retrospective review data. There were racial/ethnic disproportionalities in sleep-related deaths—over half of the cases corresponded to infants of color: 32% were Black, 15% were Latino and 6% were Multiracial children. Importantly, about two thirds of the cases (67%) occurred during daytime (5am-8pm), particularly in the mornings. Parents were by far the most likely to be

responsible for the supervision of a child at the time of death (89%). Most deaths happened in an adult bed or couch (68%), while 27% of them happened in baby equipment (crib, bassinet, bouncy chair, car seat). In 62% of the cases, the child was not in their usual sleeping space. The child was sharing a bed with an adult in 59% of the cases. In 15% of cases, the person responsible for supervising the infant was impaired by drugs or alcohol at the time of the incident. See Table 4.

White

Most infant deaths during the daytime (5am-8pm) involved White infants (81%). Bed-sharing (75%) and not placing the infant in their usual sleeping space (75%) were most prevalent among White infants, compared to the other groups.

Black

Black infants represented 32% of sleep related deaths included in this retrospective review. Considering that Black children represent 12% of the population under age 4 years, Black infants are dying in unsafe sleep environments at a disproportionate rate (KIDS COUNT, 2023). In about 64% of the cases, Black infants were placed to sleep on an adult bed or on a couch (18%). Importantly, no individual supervising Black or multiracial infants was impaired at the time of the incident (0%).

Latino

Most cases involving Latino infants (60%) happened during daytime, between 12pm to 8pm, which represents a larger proportion of cases compared to other racial groups. Like the Multiracial group, the supervisor was the infant's parent for all cases. About 80% of supervisors were sleeping at the time of the incident, both at night (40%) and during the day (40%), which corresponds to the largest proportion of cases compared to the other groups. The parent supervising the Latino infant was impaired by drugs or alcohol at the time of the incident in 40% of the cases, which is more than twice the proportion of cases involving other races.

Multiracial

All cases involving multiracial infants occurred in the child's usual sleeping space (e.g., crib and bassinette). This means that no incidents were related to adult bed-sharing. Table 4 provides a summary of these cases.

> ***53% infants of color, 38% Black infants***
> ***67% daytime*** *(5am-8pm)*
> *For Black infants**: 64% adult beds***
> *For White infants:* ***75% bed-sharing & unusual sleeping space***
> *For Latino infants:* ***40% supervisors impaired***

Table 4 - Sleep-related Fatalities

Variable	Overall (N = 34)	White (n = 16)	Black (n = 11)	Latino (n = 5)	Multiracial (n = 2)
Incident time of day					
5am-11am	13 (38%)	8 (50%)	4 (36%)	-	1 (50%)
12pm-8pm	10 (29%)	5 (31%)	2 (18%)	3 (60%)	-
9pm-4am	10 (29%)	3 (19%)	4 (36%)	2 (40%)	1 (50%)
Not recorded	1 (3%)	-	1 (9%)	-	-
Supervisor					
Childbearing parent	23 (68%)	10 (62%)	8 (73%)	4 (80%)	1 (50%)
Non-childbearing parent	7 (21%)	4 (25%)	1 (9%)	1 (20%)	1 (50%)
Babysitter	2 (6%)	2 (12%)	-	-	-
Other individual	1 (3%)	-	1 (9%)	-	-
Not entered	1 (3%)	-	1 (9%)	-	-
Sleeping place					
Adult bed	18 (53%)	9 (56%)	7 (64%)	2 (40%)	-
Couch	5 (15%)	2 (12%)	2 (18%)	1 (20%)	-
Crib	5 (15%)	2 (12%)	1 (9%)	1 (20%)	1 (50%)
Car seat	2 (6%)	1 (6%)	1 (9%)	-	-
Bassinet	1 (3%)	-	-	-	1 (50%)
Bouncy chair	1 (3%)	1 (6%)	-	-	-
Other/not recorded	2 (6%)	-	-	1 (20%)	-
Death occurred in usual sleeping space					
Yes	13 (38%)	4 (25%)	5 (45%)	2 (40%)	2 (100%)
No	21 (62%)	12 (75%)	6 (55%)	3 (60%)	-
Objects present in the sleep environment					
Adult	20 (59%)	12 (75%)	5 (45%)	3 (60%)	-
Pillow	17 (50%)	6 (38%)	5 (45%)	4 (80%)	2 (100%)
Mattress	17 (50%)	7 (44%)	7 (63%)	2 (40%)	1 (50%)
Comforter	12 (35%)	5 (31%)	3 (27%)	4 (80%)	-
Blanket	11 (32%)	3 (19%)	4 (36%)	3 (60%)	1 (50%)
Supervisor sleeping at time of incident					
Yes at night	16 (47%)	7 (44%)	6 (54%)	2 (40%)	1 (50%)
Yes during day	8 (24%)	5 (31%)	1 (9%)	2 (40%)	-
No	9 (26%)	3 (19%)	2 (18%)	1 (20%)	1 (50%)
Not entered	1 (3%)	1 (6%)	2 (18%)	-	-
Supervisor impaired by drugs/alcohol					
Yes	5 (15%)	3 (19%)	0	2 (40%)	-
No	24 (70%)	11 (69%)	8 (73%)	3 (60%)	2 (100%)
Unknown/missing	5 (15%)	2 (13%)	3 (27%)	-	-

Bodily Force or Weapon

Overview

The cause of death in 29 cases was related to the use of bodily force or a weapon. A weapon was used in more than half (55%) of the cases, and firearms were the most common weapons (88%). The owners of the weapons were not known to the review teams in half of the cases (50%). Over 86% of the weapon-related fatalities were ruled as either homicide or suicide.

The highest percentage of weapon-related fatalities (50%) was ages 13 to 17 years, whereas younger children had the largest proportion of bodily force-related fatalities, particularly ages 0-3 years (84%). Beating (77%), kicking and/or punching were the most used types of force, followed by shaking (e.g., shaken baby syndrome) and dropping the child.

Table 5 - Bodily Force or Weapon

Variable	Overall (N=29)	White (n=14)	Black (n=7)	Latino (n=3)	Multiracial (n=4)
Cause					
Weapon	16 (55%)	8 (57%)	5 (71%)	1 (33%)	1 (25%)
Bodily force	13 (45%)	6 (43%)	2 (29%)	2 (67%)	3 (75%)

Table 6 - Weapon-related fatalities

Variable	Weapons-related fatalities (n=16)
Age category	
Less than 1 year old	1 (6%)
1-3 years old	2 (12%)
4-7 years old	2 (12%)
8-12 years old	3 (18%)
13-17 years old	8 (50%)
Cause listed on death certificate	
Homicide	9 (56%)
Suicide	5 (30%)
Accident	1 (6%)
Undetermined	1 (6%)
Weapon-type	
Firearm	14 (88%)
Knife	1 (6%)
Other	1 (6%)

Weapon-related fatalities:

- *Teens:* **50%**
- *Black youth:* **71%**

Bodily force-related fatalities:

- *Ages 0-3:* **84%**
- *Multiracial children:* **75%**
- *Latino children:* **67%**

Motor Vehicle

Overview

Overall, there were 28 motor vehicle-related fatalities. In most cases, the child was a passenger (61%), and the child's biological parent or grandparent was the driver in nearly half of the cases. A friend was the driver in 24% of the cases, whereas the child was the driver in 18% of the cases. The child was a pedestrian in 21% of the cases, mostly walking (83%) when they were struck. The child was a passenger in a larger proportion of cases involving White children (68%), compared to Black children. Black children had a higher percentage of cases where the child was a pedestrian (33%) or the driver (22%). Restraints/safety measures were used in 36% of the cases. However, over 55% of the cases were missing this information.

Table 7 – Overview of motor vehicle-related child fatalities

Variable	Motor vehicle related fatalities (n=28)
Position of child	
Driver	5 (18%)
Passenger	17 (61%)
Pedestrian	6 (21%)
Relationship of driver to child	
Biological parent	7 (41%)
Grandparent	1 (6%)
Friend	4 (24%)
Other	1 (6%)
Unknown	1 (6%)
Position of child – Pedestrian	
Walking	5 (83%)
Other	1 (17%)
Causes of incident	
Speeding over limit	6 (21%)
Recklessness	4 (14%)
Poor weather	3 (7%)
Restraint/safety used	
Yes	8 (36%)
No	2(9%)
Missing	12(55%)

Motor vehicle-related fatalities:

- *68% of White children were passengers*
- *33% of Black children were pedestrians*
- *22% of Black children were the driver*

Qualitative data: Factors contributing to child maltreatment-related fatalities and recommendations

Methods

A comprehensive needs assessment focusing on leading determinants of child maltreatment-related fatalities and prevention strategies was conducted between January 2020 and July 2021. We combined efforts with Strengthening Indiana Families, a primary prevention project funded by the U.S. Children's Bureau. We used electronic surveys with open-ended questions (n=548), interviews (n=58), and eight focus groups (n=41), resulting in a total sample of 647 participants. The sample included seven youth with lived experience, 15 parents with lived experience, 566 child welfare practitioners and leaders, 21 legal professionals, 11 public health professionals, eight mental health providers, three health care providers, two school staff, and 15 professionals from a variety of backgrounds (philanthropy, early childhood, housing, library, etc.). Table 8 provides information on interview and focus group participants, who were recruited from a variety of child-serving systems via email invitation through professional networks. Snowball sampling was also used (Patton, 2014). Interview and focus group transcripts were analyzed using constructivist thematic analysis (socioecological framework).

Table 8. Interview and focus group participants

	Youth	Parent	Child Welfare	Mental Health	Health	Public Health	Legal	School	Other	Total Participants
Interviews	7	15	11	4	3	4	9	2	3	58
Focus Groups	0	0	2 (n=12, n=4)	1 (n=4)	0	2 (n=5, n=2)	1 (n=2)	0	2 (n=2, n=10)	8 (n=41)
N (%)	7 (7.1%)	15 (15.2%)	27 (27.3%)	8 (8.1%)	3 (3.0%)	11 (11.1%)	11 (11.1%)	2 (2.0%)	15 (15.2%)	99 (100%)

Sample characteristics

- Most of the participants were female (87.9%, n=87) and identified as white/European American (88.9%, n=88).
- Participants' average age was 42.5 (SD=11.8, range 18-69 years old).
- On average, professionals had 14.2 years of experience in their field (range: 1-40 years) and 6.2 years in their current position (SD=7.7).
- Professionals served children, youth, and families in a variety of roles, including direct services (31.2%), supervision (9.1%), local leadership (29.9%), regional (13%) and state leadership (16.9%).

- Almost 87% of the parents were adoptive and/or foster parents and had between one and five children (median=3).
- Youth spent an average of 6.9 years in foster care (median 4.5. SD=5.8). On average, youth entered foster care at age 11.87 (range: 3-16) and left at age 19 (range: 13-26).

Table 9. Summary of Participant Demographics and Work Experience

Variable	Interview and focus group participants (n = 99)	Child welfare workforce survey participants (n = 548)[4]
Gender		
Woman	87.9%	50.2%
Man	12.1%	9.9%
Nonbinary	-	0.3%
Missing	-	39.6%
Race		
White	88.9%	52.0%
Black/African American	6.1%	5.8%
Latino/Latine	5.1%	1.5%
Multiracial	-	0.9%
A racial group not listed	-	0.6%
Missing	-	39.8%
Position Level		
Direct service	31.2%	61.2%
Supervisor	9.1%	18.1%
Local or Program Director	29.9%	6.8%
Regional or Organization Leader	29.9%	3.1%
Missing	-	10.8%
Service area		
Northern	4.0%	30.7%
Central	61.6%	29.6%
Southern	13.1%	28.5%
Multiple regions	18.2%	6.8%
Missing	-	4.6%
Age	M=41.5, SD=12.6	-
Years in current position	M=6.1, SD=7.7	M=4.3, SD=5.0
Years in child serving agencies	M=14.2, SD=9.6	-

Overview of findings

Several family, community, systems, and structural factors contributing to child maltreatment-related fatalities were identified by youth and parents with lived experience in the child welfare system and child-serving professionals from multiple systems including child welfare, health care, mental and behavioral health, legal, public health, schools, early childhood, housing, and philanthropy. Participants also provided numerous recommendations for preventing child maltreatment-related fatalities.

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[4] 9 survey respondents were legal professionals working in the child welfare system and 539 respondents were child welfare staff, supervisors, and leaders at the local, regional, and state levels.

🏠 FAMILY FACTORS

Intergenerational Trauma + Cycles of Violence

Family factors contributing to child abuse and neglect fatalities include:

- intergenerational trauma
- domestic violence
- parental mental health issues
- lack of parenting skills

> No one sees [adults] as children who have experienced **the same traumatic events** themselves as kids...they're now **putting their children at risk.**
> Public Health Professional

> **>75%**
> of women in my Family Recovery Court have suffered **sexual, physical, or emotional abuse.**
> Judge

> **Depression**...because how can you take care of your kid if you can't get out of bed?
> Youth with lived experience

> Parents struggle with a **lack of parenting skills**, in part due to a **lack of examples of good parenting** as children.
> Child Welfare

Unsafe Infant Sleep Behaviors

are influenced by social norms and a lack of trust in safe sleep messaging by providers.

This leads to continued unsafe sleep practices from parents despite awareness.

> Whoever is providing that safe sleep messaging, [parents] **are not buying it.**
> Public Health

> You think **it wouldn't happen to you.**
> Parent who experienced a loss in an unsafe sleep environment

Suicide Related to Victimization + Lack of Mental Health Support

Factors contributing to youth suicide include:

- lack of mental health services
- suicide ideation/threats not taken seriously
- stigma associated with mental illness

> We're seeing over the last few years, a higher than expected amount of **suicidality** in younger and **younger people.**
> Mental Health

> I full-heartedly believe that **technology** is a huge issue when we are talking about kids and suicide.
>
> Whether it's anxiety [or]...some of the **cyberbullying** that goes on.
> School Principal

🪷 COMMUNITY FACTORS

Barriers to Service Access

Factors such as:

- socioeconomic inequities, poverty, racism
- lack of awareness, stable housing, affordable childcare, and transportation

make it difficult to meet children's needs and engage in services.

> **Transportation** - how do we get families connected?
> Mental Health

> [Resources are] all over the place, and it's hard to know where to go. We have so many families who **had no idea what was out there.**
> Child Welfare Frontline

> I'm going to say the biggest struggle I've had, particularly with my daughter, is **finding resources.**
> Parent

Lack of Material Support

also contributes to child fatalities, in part due to financial stress and a lack of concrete support.

> **Financial stress** increases the emotional load on parents. It makes them more likely maybe to act inappropriately in that stress.
> Early Childhood

> **Low income** and **poverty-related issues**...feed into...crises that families are trying to work through.
> Housing Specialist

Isolation

Factors contributing to a lack of social support and connections include:

- exhaustion from multiple jobs, chaos
- lack of adequate childcare and kinship support
- day-to-day racism

> "**Isolation** is greatest when children are youngest and that's also when they're most vulnerable for **serious injury and fatality.**"
> Child Welfare Supervisor

Reluctance to Report Child Maltreatment

caused by lack of awareness and fear of retribution disallows protective systems from taking necessary action to prevent child fatalities.

> People around us **knew how my mother was treating us** and how it was for us day to day, and **they didn't say anything** out of fear that she wasn't going to be their friend.
> Youth

Limited Community Awareness of Risk

due to denial and lack of understanding prevents members from supporting families.

> "There's skill kind of this, '**it's none of my business,**' attitude."
> Judge

❀ RECOMMENDATIONS

Community recommendations to reduce child abuse and neglect fatalities include creating more supportive communities that build on family protective factors by increasing availability and awareness of resources and services, such as financial supports for families, affordable and stable housing (with embedded supportive services to reduce unwanted mobility), transportation, "affordable quality childcare," quality employment with benefits, and opportunities for parent educational attainment and workforce development. These supports would improve family well-being and reduce the risk of maltreatment. To decrease isolation and increase family safety and well-being, recommendations focused on promoting community connectedness and inclusion, increasing families' informal supports and opportunities to have fun, and increasing community awareness of trauma and a sense of shared responsibility for child safety.

Barriers to Service Access + Lack of Material Support →

Create More Supportive Communities

by increasing availability and awareness of resources and services, including:

- financial support for families
- affordable and stable housing (with embedded supportive services to reduce mobility)
- transportation + affordable childcare
- employment with benefits + opportunities for parent educational attainment and workforce development

> "
> If there's some place where there's someone that can take their hand and **guide them through some of this** that's not threatening, that's not [the Child Welfare Services], that's not the court ...some place that's completely neutral, I think that's a wonderful idea."
>
> Probation

> If there were ways that we could increase stability, decrease evictions...maybe **housing with embedded supportive services** that help people really...stay put. Then, we could **grow more supportive communities.**
>
> Child Welfare Professional
> "

Limited Community Awareness of Risk + Reluctance to Report Child Maltreatment →

Create Trauma-Informed Communities

through community education to form a sense of shared responsibility for child safety.

> "
> Having community events where people are provided with **education** so that they can understand exactly how to **stop some of those cycles** [of abuse, substance use, and poverty].
>
> Mental Health
> "

60

Isolation →

Create Stronger Connections

To decrease isolation and increase family safety and wellbeing, recommendations focus on promoting community connectedness and inclusion, increasing families' informal supports, and providing opportunities to have fun.

> " For preventing [fatalities], it's really, really, important that we figure out **how to build social connections** for families with very young children who maybe aren't on anybody's radar...How do we connect with those people early...so that **they have someone to call** if the baby's stressing them out?
>
> Child Welfare Professional "

Involve Families in Community Decisions

- increase community partnerships, including businesses
- increase parent engagement by asking them for feedback and including them in decision-making
- keep community needs "on file" to ensure that we are meeting family needs

> " Businesses and schools have to figure out how to **engage different types of parents** and **ask them for feedback** and questions.
>
> Early Childhood

> Every community should keep an updated needs assessment on file, because **the needs of the community and families...will change from time to time.**
>
> School "

✂ SYSTEM FACTORS

Child Welfare System Operations

Several competency factors within the child welfare system contribute to child abuse and neglect fatalities, including:

- high turnover + high caseloads
- lack of training and experience that prevent case managers from connecting with families + conducting thorough investigations

> **High turnover** decreases the ability of caseworkers to provide the level of support that the family needs.
> Public Health

> [There is a] **lack of effective engagement of families**, particularly those in at-risk communities.
> Public Health

> You're plucking people straight out of school to do this job...they don't have experience, and it's an extremely difficult job, so **they're making a lot of these decisions with their own biases.**
> Mental Health

The lack of experience, supervision, and overwhelming caseloads, paired with worker and system bias, likely contribute to racial disparities in the system.

Delayed responses from the Child Welfare System, a "reactive" system, increase risk for child abuse and fatalities, as family issues tend to escalate without adequate support or intervention.

> We've had cases where **we've had to call in to [the hotline] multiple times** before [CPS] would finally open a case... And sometimes even [when it involves physical abuse] **they won't open a case.**
> School Staff

Some participants identified rushed family reunifications as contributors to fatalities. A lack of communication between CWS across states and infrequent check-ins with CWS-involved families were also identified as contributing factors.

> [The CWS is] **not talking to each other across state lines** and having different standards across state lines is a really big problem.
> Judge

> Unfortunately, [children] end up going... back into a home after they've been in the foster care for **18, 20 months**. And then, it goes bad again, and then **they get put back into foster care.**
> Early Childhood Leader

> Some of **[the caseworkers] tend to relax a bit**, and that should not be a thing. [Foster parents] are getting paid to have these youth. [Youth] are coming from broken families, why would they enter into another one? Why, **why are you guys not checking on them?**
> Youth

Legal System Operations

Overwhelming case numbers, capacity limitations, and time restrictions prevent legal professionals from engaging with families and listening to children and youth's voices.

> Now that **[our Family Recovery Court has] hit capacity**, we've had to start having these conversations about **how do we prioritize families to come in**, and what do we do with the folks on the waiting list and all of that.
>
> Judge

> There are kids that are being **sent back home** because **the caseworkers have lied to the judges.** And they don't listen to the foster parents. The foster parents are the ones that the courts need to listen to.
>
> Foster Parent

Judges' and prosecutors' bias, including bias against single mothers, kinship placements, substance use and domestic violence, influence their decisions. The following quotes are examples of this bias:

> I don't think that a lot of these moms had any understanding of **what it means to be a good caregiver.** And probably some of that is [because] **they never saw good parenting growing up.**
>
> Prosecutor

> I've said before, sometimes the crazy apple doesn't fall far from the crazy tree. All you've done is remove the child from one source of chaos and put them into another source of chaos... **Just because the person is family, doesn't make it a fit placement.**
>
> Prosecutor

In addition to secondary trauma, experience with cases involving child abuse and neglect fatalities increases judges' caution around removal and reunification, particularly when there is domestic violence in the family.

> **Domestic violenc**e can be a real significant [reason to remove a child]...Either one parent isn't protecting the children from domestic violence, even if that parent is a victim, or we have both parents perpetrating domestic violence.
>
> Magistrate

Behavioral Health Care Capacity and Operations

The lack or limited availability and the inconsistent or inadequate quality of behavioral health and mental health services are serious factors contributing to child abuse and neglect fatalities.

> The **lack of mental health treatment** in this state is part of what perpetuates [child maltreatment].
>
> Health Care Provider

Contributing factors include:

- high turnover, provider shortage, long waitlists
- overextended providers
- inconsistent, infrequent, and not intense enough services
  - "watered down" services.

> [Mental health] workers are **overworked**, so they're **not consistently seeing their clients**, so the clients are going to fall off.
>
> Child Welfare

✖ SYSTEM FACTORS

Cross System Factors

At the cross-system level, the lack of coordination, collaboration, and communication creates barriers to identifying and responding holistically to families' needs and risk factors. The lack of cross-system coordination is evidenced in the unrealistic expectations that systems impose on parents, which increase their stress and decrease their chances of success. Cross-system services are not integrated, creating serious service navigation challenges for parents.

> In the counties where there seems to be the most incidents of abuse or neglect and fatalities, these are counties or communities where the systems aren't interacting well, collaborating, communicating. **There isn't any coordination**.
>
> Public Health

> People with substance use disorders tend to have fewer supports. They also, from what I am seeing, **don't have a continuous support structure**. And so, you're not eliminating the situation.
>
> Public Health

"Cookie cutter" services, where parents are expected to participate in several predetermined services, without considering the unique characteristics of a family, fail to meet the specific needs of the family as a whole.

> Once families are in the system, it's throwing the **'cookie cutter solution'** at them, and **not talking to the family about, 'What do you need?'**
>
> Judge

Serious limitations around "red-tape" and cross-system information-sharing impedes early identification and intervention, as no single provider has the family's "full picture."

> I think back to this different legislation that I've come across that makes it difficult, like the doctors not being able to give up some information. I think some confidentiality can make it difficult...**They give us red tape that prevents us from easily working with a support system.**
>
> Child Welfare

A lack of trust, respect, and adversarial relationships between systems increase the sense of hopelessness among some professionals around the possibility of cross-system collaboration. All these factors are related to the lack of a public health approach to child maltreatment prevention, considering that services are not proactive, sometimes "not even reactive," and do not consider the holistic needs of a child and their family.

> Supposedly in the court we are all supposed to be on a permanency plan of reunification. I see too many times when, for whatever reasons, the DCS attorney, the case manager, the parent, the PE, **they're just all fighting each other.**
>
> Judge

> We often are not using a public health framework at all. [We're not proactive.] And honestly, I feel like even with child injury and child maltreatment, specifically, **we're not even reactive**. I think there's a complete lack of understanding of public health.
>
> Public Health

Child Welfare System Recommendations

Increase Proactivity

A shift in the child welfare system from a reactive approach to a proactive approach would allow it to detect early needs, respond proactively, helping families identify and/or build support systems and preventing problem escalation and child abuse and neglect fatalities.

> I think if we can just be **more proactive than reactive.** I think we are starting to do some of that. But there are some instances where we are still reactive on some things.
>
> Child Welfare Professional

CWS Practice Improvements

Additional CWS practice recommendations include:

- increasing frequency of visits + child-family team meetings
- following up after closing cases, having peer supports for families involved with CWS
- ensuring emotional needs of children in foster care are met, placing children with trusted adults or in placements that support reunification, improving consistency for children (same schools and doctors)

> We need to **encourage kids to tell us about [abuse] and actually listen to them.** Instead of just saying, 'Oh, you're lying.' We should definitely **investigate everything a kid tells us** is happening.
>
> Youth

Decrease Turnover + Increase Training

Decreasing turnover and decreasing caseloads by increasing staff, pay, staff support from supervisors, mental health providers, and clerical supports.

Improve worker training: soft skills, substance use, effective safety planning, trauma-informed care, adverse childhood experiences, family engagement, identification of risk factors and informal supports, and knowledge of community resources.

> I think that you need **more workers** so that they can **lower caseloads.** I think we need to prioritize funding. I mean, it's really common for social service professionals to be paid less than others.
>
> Public Health Professional

> I think the keys to healthy families, healthy children, are **compassion and empathy.** We have to be compassionate of people, we have to be empathetic people.
>
> Magistrate

Better Engagement of Families

Transparency, consistency, and clear and frequent communication with families are strategies that the CWS can be used to improve family engagement and enhance child safety.

> Just **communicating with families**...and trying to make them feel as if they are somebody that they can be properly communicated with... [otherwise it leads to] families and parents and children not trusting.
>
> Youth

RECOMMENDATIONS

Cross-System Recommendations

Increase Cross-System Collaboration

to provide tailored, integrated, and holistic services to meet families' needs, which would help prevent child maltreatment-related fatalities.

> [We need] everyone around the table really **working together to support families and children.**
>
> School

Increase Availability and Quality of MH Services

by increasing licensed clinical staff and substance use services, services for women and children, and wraparound services. Wait-times would decrease, and timely referrals would increase.

> The ability to just **come in and get help immediately**...would be a game-changer, and really could **add to the overall stability** of the family.
>
> Mental Health

Improve Service Access + Adopt Public Health Approach

Cross-system collaboration would improve by offering all services in a single location (one point of entry), which would be enhanced by providing coordinators to assist families in service navigation. Importantly, adopting a public health approach to prevention is recommended, in which **"prevention is everybody's responsibility."**

Reduce "Red Tape" + Increase Information Sharing

Recommendations included streamlining the processes for receiving records from other agencies and courts, using standardized documents to request children's records, and using an integrated system that allows providers across systems to see the availability of other providers.

> I think it would be great **if the systems can share information**. So, if you have [CWS] involvement, they're reaching out to the school, and the school is able to share information that they have about the family or the child.
>
> Public Health

Cross-System Training

Recommendations include:

- implicit bias, soft skills (empathy), motivational interviewing, substance use
- adverse childhood experiences, compassion fatigue, red flags for maltreatment, mental health first aid training, and the negative impact of removal on children and families

> [Providers] need... **more soft skills training** on how [to] have hard conversations with people, how [to] identify and drive behavior change and sort of understand the foundation and theory behind behavior change.
>
> Early Childhood

> Figuring out how those resources can be combined...and saying we have that resource in the community, but that it's **easily accessed at one location.**
>
> Legal

🔷 STRUCTURAL FACTORS

Stigma Around Receiving Support

The public perception that asking for help is a sign of weakness or inadequacy, as well as taboo around mental health and substance use treatment, deter families from engaging in services.

> We live in a society that values **rugged individualism** where I should be able to handle all my problems on my own. I shouldn't need help from anybody. If I can't handle it myself then **I'm weak and I'm not good enough**.
>
> Public Health Professional

> There's a lot of **shame** surrounding **needing help to know how to parent.**
>
> Youth

Some parents are unable to recognize the need for help and accept help until it it too late.

Insufficient Funding

for prevention efforts inhibits systems from implementing life-saving programs. Lack of funding contributes to:

- inability of providers to meet basic family needs
- limited CWS capacity to provide financial assistance + childcare
- mental health service caps
- competition for funding among smaller communities

These factors all contribute to child abuse and neglect fatalities.

> A lot of the social resources are in the discretionary budget or the discretion part of the government spending, and so of course **one year it can be funded, [but] the next year, it probably won't**, or the funding will likely decrease.
>
> Youth

Distrust of the System

Fear of child removal and termination of parental rights are critical contributing factors to child abuse and neglect fatalities.

> We just wanted to help these two kids because **we didn't want them shuffled around to their fourth family**…They were already in, like, their third placement when we got a call.
>
> Foster Parent

> **Parents are terrified of [the CWS]**… they instantly think that they're going to come in and scoop up their kids and take them away, and they're not going to see them again.
>
> Early Childhood

"Parents are terrified of the child welfare system" and hesitate to ask for assistance in meeting their basic needs even if services are preventive.

Parents' fear and distrust of the CWS are related to frequent removal of children and termination of parental rights, placement instability and separate sibling placement.

> Fear of their children being removed, **parents have a distrust of the CWS.**
> Child Welfare

🔗 RECOMMENDATIONS

Reducing Stigma

Increasing transparency and consistency on how cases are handled would help eliminate stigma around the CWS, so that they are seen as helpful, trustworthy, and supportive instead of "the bad guys." Transparency and consistency are necessary across workers (and even among CWS agencies across the country) and increasing public understanding of CWS processes and decisions, to decrease CWS stigma.

> So I would say the trustworthiness... [of] the case managers, therapists— you name it. So the way that you can **develop their trust,** is just by doing what you say you're going to do and saying what you are going to and **saying what you mean.**
>
> Youth

> If people can **learn that it's okay to have to rely upon others**...that it's okay to ask for help... that doesn't mean that there's anything wrong with me, then that could be something that could lead to some pretty substantial changes.
>
> Public Health

To reduce the stigma associated with asking for and receiving support, family resource centers were recommended as a destigmatized trusted space that could connect families with mental health and substance use services. Those feeling comfortable in this space may be more likely to engage in other services.

Distrust in the system →
Implementing Family-Centered Policies

and preventing foster care entry, such as increasing the minimum wage, parental leave, and child tax credit, was one of the recommendations, along with revising policies and procedures to reduce the red tape across systems, and making some trainings required for child-serving professionals.

> It's up to our government to really just work to **make those jobs available** and to maybe like raise the pay... And maybe that can allow our families to not be in so much poverty.
>
> Youth

Increasing Prevention Funding

would allow for the implementation of local child fatality review action steps and/or targeted interventions to reduce child abuse and neglect fatalities. For instance, a targeted intervention recommended by professionals across systems was implementing a statewide safe sleep campaign with consistent messaging to change parent behaviors around infant sleep.

> **Preventable causes of death are killing our kids.** And yet, **we get no money or support** to help inform the prevention, and that's not just maltreatment. I mean, that's injury overall.
>
> Public Health Professional

# The "secret sauce" of effective child fatality reviews

Overview of findings

Multisystem professionals and two parents who serve(d) on child fatality review (CFR) teams in Indiana identified facilitators, challenges, and value associated with the CFR process. They also provided several recommendations to improve this process. Additionally, multisystem professionals who serve on fetal and infant mortality review teams and/or suicide and overdose fatality review teams in Indiana identified the "secret sauce" for generating effective post-review recommendations and developing action steps for implementation.

There was agreement among CFR team members that the purpose of CFR is to increase cross-system collaboration to review cases, identify risk factors, and prevent child fatalities in the future. Several systems are represented in CFR teams, including law enforcement, child welfare system, prosecutors, mental health, health (pediatricians, family practice physicians, primary care providers, hospitals), public health, schools, prevention agencies, EMS/first responders, and coroners— although some participants noted that coroners "rarely attend" their county/region CFR meetings.

Starting a team

The CFR process begins when the state CFR coordinator reaches out to a local community to assist them with launching a team, as is mandated by Indiana law. Historically, the person to initiate the launch was the elected prosecuting attorney for the county. The prosecutor, with assistance from the CFR coordinator, contacts members of the community that are listed in Indiana statute as being required members of the CFR team. Once those members agree to participate, they are sent a schedule for meetings and information about how to conduct case reviews. From that point on, the designated team leader will send an email each time there is a meeting scheduled, requesting information about specific cases that will be reviewed. Records are also requested from other agencies, including hospitals. The IDOH CFR coordinator or the local CFR team leader compiles all the information,

abstracts each case, and prepares a presentation with all the information. The meeting begins with a case history review, followed by a discussion where everybody adds information on the case and provides recommendations. Meeting notes are distributed, and data are entered into a database for future analyses.
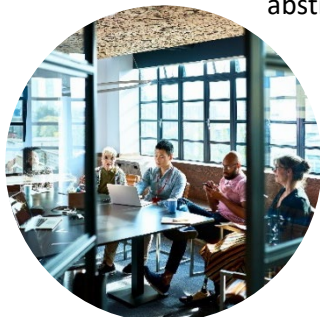
"Everyone should bring any record on the child or the parent." First responder

The CFR coordinator and their staff have been helpful getting us initiated." Local child welfare leader

Facilitators

Mutual respect among team members—even when they disagree, positive relationships, and collaborative partnership emerged as key facilitators of effective CFR teams. "Creating this kind of collaborative, respectful atmosphere from the outset is key," noted a FIMR coordinator. CFR teams are enhanced by consistently having people at the meetings and a motivated leader who seek to improve practice and prevent deaths—instead of "pointing fingers." Having a CFR coordinator at the state level (IDOH), who provides support, technical assistance, guidance, and structure (e.g., forms, standard review guidelines) was identified as a critical factor contributing to successful CFR teams, because it helps team members identify materials and information they are expected to provide. The CFR coordinator can also assist with recommendations, facilitate robust discussion, and provide action steps for moving forward. Team members' participation and investment in the process is a critical factor for CFR process and data quality. See impact above.

Challenges

Interviewees identified challenges impacting the efficacy of CFR teams, including limitations on which individuals are authorized to convene meetings, lack of buy-in from team members, lack of clarity regarding responsibilities, lack of prevention expertise, and absence of recommendations to prevent future fatalities.

- **Prosecutors' team leadership:** Previous state policy required prosecutors to initiate and convene CFR teams, which created several scheduling and continuity challenges due to prosecutors' busy schedules. In some instances, teams had not met for years because prosecutors were unavailable to convene a team. In addition, some participants reported that, when prosecutors convene the teams, there tends to be a punitive bent to the meetings—in which the focus is on whether the cases can be prosecuted rather than on prevention— that can be difficult to overcome (See Impact above).

- **Lack of representation and buy-in:** Some systems, such as schools, are not included, which leaves out important information for understanding a case more comprehensively, and thus, diminishes the quality of the review and the data. This is related to a team's lack of buy-in that manifests in team members not participating even if they attend the meetings, not being allowed to provide information (agencies' red tape), and pointing fingers, particularly to attribute responsibility to the CWS. Some agencies/members are defensive, increasing collaboration challenges. The differences in perspective also contribute to the lack of buy-in. Some people want to punish parents and caregivers, while others seek to create a system in which parents are supported and equipped. See impact above

"The biggest issue we've had is scheduling. Our prosecutor… once he finally got on board, we got things moving… he's pretty busy." *Child welfare leader*

"Our barrier is just getting that buy-in…" Child welfare supervisor

"Our investigations are incomplete…any suicide case, is really poorly investigated …we don't have a lot of those risk factors or case information." *Public health*

- **Lack of structure:** It can be difficult to know whose responsibility it is to get information and the kind of information that is needed, which makes it hard for a team to conduct CFR. Virtual meeting burnout during and after the COVID-19 pandemic also created additional challenges. Some CFR teams require members of the CFR team to specialize in child welfare or other agencies that serve children. But other teams have team members who have very little knowledge of the systems and agencies that engage children. Everyone comes to the meeting with their own set of expertise, yet knowing how to coalesce all of the information into an effective review can be very challenging without a structure to follow. See impact above.

- **Poor data quality and information barriers:** The insufficient and incomplete documentation of sudden unexpected infant deaths (SUIDs) and suicides and the lack of information limit the teams' ability to thoroughly review fatalities, understand risk factors, and discuss recommendations. The lack of information on death scene investigations is related to multiple factors, including inconsistent training of coroners and a lack of interest in completing a full death scene investigation due to overwork, inexperience, and lack of funding. "Red tape" and policies restricting cross-system information sharing—particularly retrieving out-of-state records and getting information if the autopsy was done in a different county or by a different coroner—create serious challenges to CFR. All of these limitations result in poor CFR data quality. See policy impact above.

- **Limited discussion and lack of funding for recommendations and action steps.** CFR teams do not spend enough time, if any, discussing recommendations and action steps, in part due to time limitations, lack of prevention expertise, secondary trauma, numbness, frustration, or hopelessness due to the lack of action, as they see similar preventable cases over and over. Conflicting viewpoints regarding whether to "prosecute and put in jail or set up systems to assist families" contribute to the standstill/ lack of prevention efforts. Insufficient funding for action steps also prevents CFR teams from implementing prevention strategies. The lack of funding further limits team members' engagement since CFR teams are an unfunded mandate, and members have time constraints due to many other responsibilities. See training above.

CFR Value

Most participants recognized the value of CFR in conducting more in-depth reviews of fatalities, bringing forth different perspectives and pieces of information that together provide a more comprehensive understanding of the circumstances surrounding fatalities, improving communication and collaboration among team members that expand beyond CFR, increasing members' motivation and focus on risk factors through regular meetings, allowing for the identification of prosecutor and system bias, helping identify trends, and proposing potential solutions. Some participants noted that CFR is valuable as long as the team or community takes action based on the information; simply talking is not enough. A couple of participants expressed their dissatisfaction with the lack of support from the state CFR team because they felt that their

"Frustration, lack of movement… not knowing what to do or how to do it" *Child welfare leader*

"Why are we reviewing the deaths if we're not going to put our money where our mouth is and put money into prevention." Probation

"more extensive TA including prevention." *Local public health*

"It's definitely valuable if we do something with it… what are we doing with that afterwards?" Health care

recommendations were ignored or not included in the state recommendations and action steps.

Recommendations to Improve Child Fatality Review

To improve CFR data quality, interviewees recommended improving team structure and data sharing, including through using a standard template that guides members and helps them remember critical information elements that need to be provided, as well as recommendations and action steps (See impact above). Having the CFR coordinators guide and provide technical assistance to new teams (See impact above) and walk them through the process were common recommendations for helping team members understand expectations and responsibilities (See impact above). Other recommendations focused on providing improved, consistent coroner training and revising policies to require consistent and complete SUID investigations (See impact above). Improving data systems for data entry was also recommended. Additional recommendations were provided to improve the CFR team process, including increasing the consistency of team meetings (See impact above), introducing co-chairs or having members other than prosecutors leading the teams (See impact above), and providing trainings to CFR team members on several topics (See impact above), including strategies for developing recommendations and action steps. Embedding recommendation discussions into the process would ensure that CFR teams produce recommendations and plans for implementing them and assessing their impact. At the same time, increasing the connection between CFR teams and Community Action Teams (CATs) would allow members to implement their recommendations to prevent future fatalities. Additionally, funding is essential to maintain the structure and technical assistance for local teams and to implement targeted prevention strategies and interventions.

Recommendations' "Secret Sauce"

To improve the CFR recommendations and action steps, additional interviews were conducted in 2022 with leaders of Fetal and Infant Fatality Review (FIMR) and Suicide and Overdose Fatality Review (SOFR) teams that have been effective in implementing recommendations and action steps to prevent deaths. **The recipe for their "secret sauce" for effective recommendations calls for:**

- **A two-tiered system of multidisciplinary teams:** The case review team and the CAT are collaborating in real time, allowing for recommendations to be immediately put into action. This kind of immediate action allows both the CFR team and the broader community to understand the value of the review process. It also sets up the teams to do more extensive, long-term prevention strategies in the future.

"Funding would probably be great for those who actually want to kick off some improvement opportunities." Child welfare leader

"The team decides how— what they want to say, what they want to focus on and things like that. But she helps to just find the words." Health care- SOFR

"They take it back what they have learned to their own agencies…and have made change… that also helped us be successful …The people that are at the table, are the people that can make the change." Behavioral health – SOFR

- **One IDOH team coordinator:** This coordinator provides TA, guidance, support, and resources through ongoing communication and regular meetings with the teams, facilitating the initiation and continuity of teams. Guidance includes information on who should be involved in the team, how case reviews work, what records to gather, and how to make recommendations, and how to collaborate with a local CAT or prevention agency. This guidance adheres to state and federal requirements as IDOH coordinators receive federal information, synthesize and share it with the team leaders. IDOH coordinators participate in/facilitate team meetings, and they were perceived as helpful—to "bring back the focus … and help write [their] goals out."

- **One or two effective team leaders, one data abstractor, and representation from multiple systems and disciplines that have the power to make changes:** Representation from hospitals and community health centers is critical, as they bring different perspectives from individuals with medical training who can understand medical records and abstract case information. Some of the more successful teams have a nurse or a social worker as their leader. The inclusion of a data abstractor is crucial due to the time required for the essential task of collecting and parsing out pertinent information. Having members at the table who are empowered to make protocol and practice changes, or at the very minimum, bring the recommendations to the right venues, is key to creating the short- and long-term changes the teams want to see.

- **Clearly designated responsibilities for members:**
  - The FIMR coordinator gathers medical records, abstracts and deidentifies cases, and sends out cases securely to all members a week before the meeting, giving the team time to review the cases before the meeting.
  - The FIMR coordinator also creates a slide deck with a summary for each case. The slide deck is used during the meeting to help prompt conversation and information sharing.
  - All members gather information on each case and bring it to share it in the meeting.
  - Members read the case summary before the meeting, ask questions, and engage in in-depth conversations.
  - Members generate actionable recommendations, which are given to the CAT or are assigned to members of the FIMR team.
  - FIMR also conducts maternal interviews to try to further understand the context around which the family experienced a loss. This interview allows data points to be clarified and often allows for the social determinants of health to be identified.

"We have an end of the year case review team meeting. Where …we strictly talk about the recommendations that have come up throughout the year."
FIMR coordinator

"I put the recommendation that the team came up with, a rough timeline for when we think it should be done, and if we have any specific things that we think could potentially help that happen … then I take that document and I bring it to our first Community Action Team meeting … Then we have action steps underneath those, that we tried to assign to a specific individual and put a timeframe on it."
FIMR coordinator

Generating meaningful recommendations

Teams who are successful in implementing recommendations:

- Track recommendations. IDOH coordinator tracks recommendations by date, reviews list periodically, and highlights keywords that come up repeatedly. Brings these keywords to the team and asks them to consider one overarching recommendation.
- Have a dedicated meeting at the end of the year to review recommendations.
- Share recommendations and documentation with CATs.
- Assign action steps to specific individuals.
- Place a timeline on action steps.
- Document recommendations using two important strategies:
    - Share previous recommendations at each meeting.
    - Record recommendations monthly to analyze and share for funding and community education.
- Prioritize recommendations. Tie recommendations from CFR and FIMR to propel action. Review and analyze (code) top themes emerging on recommendations. Identify which goals are achievable and relevant to the county. Identify which goals can be achieved without much funding.
- Track action steps implementation through IDOH coordinator tracking sheet, state reporting, and the National Center for Fatality Review and Prevention for policy advocacy.

Don't forget!

- **Equity focus:** From a public health approach, the IDOH FIMR coordinator examines cases, collects, and tracks data outside the case reporting system on social determinants of health.
- **Collaborative partnerships:** Fluid communication with community agencies and team leaders. Communities of practice allow teams to learn from one another.
- **Policy and funding to support case review and implementation of action steps.**

The Team

The Team

Child Safety Forward Indiana's impact could not have been possible without the dedicated work and consistent support from cross-system partners, particularly CFR team members, parent advocates, and CSF and IDOH Fatality Review and Prevention Division team members. It is important to acknowledge that all this work was done during the COVID-19 pandemic and related challenges, through important leadership and key personnel transitions, and important health and other challenges that team members faced. Trust, support, collaboration, and coordination were critical strengths that enhanced the resilience of this coalition and its members. Following are listed the team members. Any omission is unintended.

Child Safety Forward Indiana Team (also part of Steering Committee)

- Jamie Smith, IDOH, Fatality Review & Prevention, Director, CSF Director
- Susana Mariscal, Indiana University School of Social Work, CSF Lead Evaluator, Strengthening Indiana Families Director
- Bryan Victor, Wayne State University School of Social Work, CSF Evaluator, SIF Lead Evaluator
- Kacie Chase, IUSSW Research assistant, Former CSF Coordinator
- Jenny Elliot, IUSSW, Graduate Research Assistant
- Pamela Ashby, Child Fatality Review (CFR) Program Director
- Allie Houston IDOH Fatality Review & Prevention, Prevention Programs Director
- Miriam Commodore Mensah, IUSSW Graduate Research Assistant
- Abigail Hummel, Central Community Action Team/Child Safety Forward Coordinator
- Brittany Rutledge, Northern Coordinator (CFR)
- Crystal Gummere, Central Coordinator (CFR)
- Rachel Eckstein, Southern Coordinator (CFR)
- Gretchen Martin, Former CSF Director
- Sophia Liang, IUSSW, Research Assistant
- Gifty Ashirifi, IUSSW, Graduate Research Assistant
- Zohra Asad, IUSSW Doctoral Student

Child Fatality Review Teams

Clark County 2019 Fatality Review Team

- Camille Anderson-Trauma and Injury Prevention, IDOH
- Jeremy Mull-Prosecutor
- Beth Kenney-Mental Health-LifeSprings
- Vicki Yazel-Doctor
- Eric Yazel-ER Doctor/EMS
- Caitlin Short-Suicide and Overdose Fatality Review Program Manager, IDOH
- Caitlin Busick- DCS
- Rachel Eckstein- CFR, IDOH
- Misty Rainey- Sheriff's Office
- Mike Ross- EMS

Grant County 2019 Fatality Review Team

- Team Chairs: Kelly Scott/Kim Whitehurst
- Department of Child Services: Kelly Scott
- Law Enforcement: Jay Mitchener MPD and Jason Ewer Sheriff Dept
- Pediatrician/Family Physician: Dr. Paul Wolfe/Dr. Kyle Speakman
- Other Members
- Hospital Representative: Pam Leslie
- Probation: Kim Whitehurst
- DNR: John Neargardner

Delaware County 2019 Fatality Review Team

- Linda Cook, MPD
- Kris Swanson, MPD
- Bill Curtis, DCSD
- Michael Burt, Pediatrician
- Jolene Clouse, Forensic Pathologist
- Heidi Monroe, Mental Health, Meridian
- Ken Mace, Juvenile Court
- Jan Kornilow, Hospital
- Dana Fluhler, Hospital
- Ashley Hunter, Hospital
- Donna Wilkins, Health Department
- Rob Meade, Fire Department
- Kiely Culberson, EMS
- Jason Rees, Schools
- Rick Howell, Coroner
- Chris Butche, Coroner
- Tim Crawford, Coroner
- Michael Brewster, Coroner
- Tod Waters, Coroner
- Ashley Soldaat, CASA
- Kelly Broyles, DCS
- Krista Garrett, DCS
- Jeremy Soultz, DCS
- Amanda Hartman, DCS
- Jessica Maxwell, DCS
- Eric Hoffman, Courts Delaware Co.
- Shelley Moore, Courts Delaware Co.

Madison County 2019 Fatality Review Team

- Ashley Krumbach, DCS
- Amy Waltermire, DCS
- Laura Houston, DCS
- Courtney Rusk, DCS
- Jay Kay, DCS
- Nick Oldam, DCS
- Rachel Parrett, DCS
- Peter Beyel, Madison County Prosecutor's Office
- Steve Koester, Madison County Prosecutor's Office
- Betsy Baxter, Victim's Advocate, Prosecutor's Office
- Joanne Ray, MD
- Elaine Smith, Community Health Anderson
- Joni Brickman, Community Hospital Anderson
- Sharine Todd, Ascension Health
- Darren Isaacs, St. Vincent Anderson
- Ellison Cameron, St Vincent Police
- Joey Cole, Sheriff's Department
- Darrell Hunter, EMS
- Freddie Tevis, APD
- Bryce Gibbons, Alternatives Inc.
- Laura Taylor, Alternatives Inc.
- Megan Wills, Children's Bureau
- Kim Bales, Juvenile Probation
- Adam Matson - Alexandria Fire Dept. / Madison County Chief Deputy Coroner
- Kacie Chase, Indiana Department of Health - Child Safety Forward
- Denise Valdez, Kids Talk Child Advocacy Center
- Caitlin Morency, Madison County Sheriff's Department
- Ben Gosnell, Elwood PD
- Pam Ashby, IDOH
- Donna Barker, Aspire
- Allie Houston, IDOH
- Traci Barber, CASA
- Annette Craycraft, CASA

Indiana 2019 Fatality Review Team

Chairwoman and Pediatrician
Roberta A. Hibbard, MD
Professor Emeritus of Pediatrics Chief, Division of Child Protection Programs. Indiana University School of Medicine

Indiana State Child Fatality Review Program Coordinator
Gretchen Martin, MSW Director, Division of Fatality Review and Prevention, Indiana Department of Health (IDOH)

Mental Health Provider Representative
Angela Comsa, LCSW Clinical Director
Children and Family Services Regional Mental Health

Law Enforcement Representative
Capt. Robert Herr, Protective Services Coordinator
IU Health Bedford Hospital

Representative of the Department of Child Services Ombudsman
Alfreda Singleton-Smith & Shoshanna Everhart
Director, DCS Ombudsman Bureau

Coroner Representative
Alfarena Ballew, Chief Deputy Coroner, Marion County Coroner's Office

Prosecuting Attorney Representative
Eric Hoffman, Delaware County Prosecuting Attorney

Forensic Pathologist Representative
Roland Kohr, MD, Forensic Pathology Specialist, Terre Haute Regional Hospital

Local Health Department Representative
Craig Moorman, MD, Local Health Officer Johnson County

Department of Child Services Representative
Ashley Krumbach, Safe Systems Director, Indiana DCS

Emergency Medical Services Provider Representative
Paul Miller, Division Chief of EMS, Crawfordsville Fire Department

Child Abuse Prevention Representative
Nick Miller, Admin. General Manager, Ireland Home-Based Services

Department of Education Specialist
Jason Marer, School Safety & Wellness Specialist, Indiana Department of Education

Epidemiologist
Jenny Durica, Epidemiologist, Division of Maternal and Child Health IDOH

Ad Hoc Fatality Specialists
Kelly Cunningham, MPH
Lauren Savitskas, MPH
Division of Fatality Review and Prevention, IDOH

Ad Hoc Department of Child Services Fatality Team
Melissa Haywood, Indiana DCS
Susan Grider, Indiana DCS

Ad Hoc Child Abuse Prevention Representative
Sandy Runkle, MSW Director of Programs, Prevent Child Abuse Indiana

Ad Hoc Community Member Representative
Ashley Bruggenschmidt Principal, Sharon Elementary Warrick County Schools Founder, Play for Kate

Child Safety Forward Project
Kacie Chase, MBA
Courtney Gwin, MSW
Division of Fatality Review and Prevention, IDOH

SUID/SDY Case Registry Program Coordinator
Olyvia Hoff, MSW
Division of Fatality Review and Prevention, IDOH

Child Fatality Review Program Manager
Pamela Ashby
Division of Fatality Review and Prevention, IDOH

Indiana Parent Group Collaborative

Alex Oleson	Marion
Angela Villasana	Tipton
Ashley Saldana	Madison
Jarrod Hummer	Delaware
Jhovana Lopez	Madison
Lisa Johnson	Madison
Mandy Hummer	Delaware
Tatyana Bonner	Delaware
Teresa "Terri" Berg	Vanderburgh

Additional Staff at Indiana Department of Health, Fatality Review and Prevention Division

Caitlyn Short, Suicide Overdose Fatality Review (SOFR) Program Director

Rebekah Mason, Project Coordinator (SOFR

Janean Gross, Project Coordinator (SOFR)

Chelsie Irwin, Trauma Informed Communities Project Manager

Linzi Horsley, Fetal-Infant Mortality Review (FIMR) Program Manager

Melanie Pote, Program Coordinator (FIMR)

Alexis Builta, Sudden Unexpected Infant Death (SUID)/Sudden Death in Young (SDY) Case Registry Program Manager

Cameron Willett, Maternal Mortality Review (MMR) Program Director

Maria Bukowska, Epidemiologist (MMR)

Angelica Guzman, Records Abstractor

Steering Committee

- Sarah Sailors, DCS leadership
- Kelly Broyles (Region 7 DCS Regional Office Director)
- Joanie Crum (Region 11 DCS Regional Office Director)
- Jeff Wittman (PCAIN, Director)
- Harmony Gist (DCS- Deputy Director of Strategic Solutions and Agency Transformation)
- Ashley Krumbach (DCS- Safety Systems Director)
- Hannah Robinson (DCS- Prevention Director)
- Valerie Morales (DCS- CBCAP Manager)
- Willie Taylor (DCS – Prevention Coordinator)
- Stacey Morgan (DCS LOD- Tipton County),
- Brad Fortner (DCS, LOD Clark County)
- Krista Garret (DCS LOD- Delaware County)
- Andrea Wilson (DCS LOD- Grant County),
- Jessica Maxwell (DCS LOD – Madison County)
- Jill Kelly (Firefly Children and Family Alliance VP Prevention Services)
- Tashia Weaver (Firefly Region 7 Prevention Director)
- Megan Wills (Firefly Region 11 Prevention Director)
- Christina Chandler (Firefly, Grant County Family Resource Center Coordinator – Local implementation team -LIT)
- Loryn Craig (Firefly, Delaware County Family Resource Center Coordinator – LIT)
- Brittany Shryrock (Firefly, Madison County Family Resource Center Coordinator – LIT)
- Alisha Armes (Firefly, Tipton County Family Resource Center Coordinator – LIT)
- Ann Carruthers, SOC, Clark County
- Ashley Bruggenschmidt, parent

- Mark Fairchild (Commission - Executive Director)
- Peggy Welch (FSSA- Chief Advocacy Officer)
- Laura Berry. Indiana Coalition against Domestic Violence
- Jim Oliver, IPAC
- Rachel Parrett, DCS Safe System
- Kelly Scott, DCS, Grant County
- Ellen Sheets, Indiana Criminal Justice Institute
- Jake Sipe, Indiana Housing and Community Development
- Eric Yazel, EMS Clark County, Indiana EMS Director
- Lauren Zylla-Whetstone, Safe Systems Review
- Tonia Corriger, FSSA Indiana Head start Collaboration Director
- Angel Crone, Foster Success
- Bernice Corley, Indiana Public Defender Commission
- Jeff Heck, Indiana Legal Services, Pro bono
- Eden Bezu, IDOH, Maternal and Child Health
- Rene Withers, FSSA Early Childhood
- Kim Whitehurst, Juvenile probation officer
- Lisa Connors, Alternatives (DV), Advocate
- Linda S. Wilk, Hands of Hope, director
- Amanda Mendenhall (Tipton Co, Boys & Girls Club
- Eric Hoffman, Courts Delaware Co.
- Christine Blessinger, IDOC
- Michael Moore, Indiana Public Defender Council
- Brandon George, Mental Health America
- Leslie Dunn, Courts
- Jessica Hale, FSSA, Office of Early Childhood and out of school learning
- Kim Lambert, CJI
- Jeremey Mull, Courts, Clark County
- Nicole Novell, FSSA, Early Childhood and Out-of-school programs

Former Steering Committee Members

- Terry Stigdon, DCS, Former Director
- Heather Kestian, DCS, Former Deputy Director of Strategic Solutions and Agency Transformation
- Julie Whitman, Former Executive Director, Commission on Improving the Status of Children in Indiana
- Sandy Runkle, Prevent Child Abuse Indiana, Former Director of Education
- Amy Waltermire, DCS, Former LOD Madison County
- Jeremy Soultz, DCS Former LOD Grant County
- Amy Akins, DCS, Former LOD Tipton County
- Kelly Cunningham, IDOH, Former Fetal-Infant Mortality Review
- Cassondra Kinderman, IDOH. Former Child Fatality Review Coordinator
- Olyvia Hoff, IDOH, Former Child Fatality Review Coordinator
- Courtney Goddard< former CSF Data Abstractor
- Angel Crone, Foster Success, former SIF Coordinator
- Matthew Walsh. Former SIF Coordinator
- Jessica Deyoe, IDOH, Nurse Family Partnership Administrator
- Karen McKeown, FSSA OB Navigator Program, Director
- Jerad Marks & Rodney Faulk A, Yonally (Grant County Prosecutors)
- Stephen Koester (Madison Co. Prosecutor)
- George Pancol (Madison Co Judge)
- Courtney Curtis (IPAC)
- Annette Craycraft (East Central CASA)
- Leah Rhea (Corporation for supportive housing)
- Lori Phillips-Steele (Corporation for supportive housing)
- Sarah Wiehe, Karen Amstutz, Nicole Cerman (Indiana University health)
- Beth Tharp (Community, Meridian)
- Cary Jamison & Angela Sutton (IDOC), Department of Corrections
- Lucinda Nord, Indiana Library Federation, Former Director
- Sarah Later (Anderson Public Library)
- Jama Donovan (Madison Co.) YMCA
- W. Barnes Griffin (Delaware Co) Parks and Recreation
- B. Scott Aspire Mental Health
- A. Fullenkamp, Grant Blackford Mental health center
- Johna Y. Lee, Alternatives (DV), Former Director
- Teresa Clemmons, A Better Way, Director
- Denisse Lovelace, Firefly, Former Region 7 Director
- Matthew Peiffer, Youth with lived experience
- Margo Ramaker, Riley Hospital
- Lauren Savitskas, IDOH, Former Suicide and Overdose Fatality Review Coordinator
- Holly Wood, IDOH, former, Safe sleep coordinator