Child Protection Consulting, LLC
Safety, Analysis, Follow-up & Empowerment

Children and Seniors Committee

February 14, 2017

Testimony on:

HB2019 - Establishing the foster care oversight task force/Adrian Jones Act/Kadillak's Bill

Presented by:

Dianne Keech

SAFE Child Protection Consulting, LLC

www.safeconsulting.org

dkeech@safeconsulting.org

913-306-0588

Testimony of:

Dianne Keech
Owner, S.A.F.E. Consulting, LLC
Previous DCF Deputy Director, Prevention and Protection Services
Previous Child in Need of Care Court Services Officer

Testimony on:

HB2019 - Establishing the foster care oversight task force.

Presented To: Chair Alford, Vice Chair Gallagher, Ranking Member Ousley and Members of the Committee:

Introduction

I am Dianne Keech, owner of S.A.F.E. Consulting, LLC. S.A.F.E. stands for Safety, Analysis, Follow-up and Empowerment, which are the keys to making child protection decisions. I am also a former DCF Deputy Director for Prevention and Protection Services. I have 30 years' experience working with or advocating for abused and neglected children, with almost 20 years' experience here in Kansas. I worked at Wyandotte County Juvenile Court for almost 17 years and worked with SRS and the private contractors when foster care was privatized and was active in each of the contract changes thereafter.

First of all, I want to commend the work of DCF to you. The work of child protection is extremely difficult and dangerous. Every day social workers and child protection professionals go into homes where there is criminal activity, drug usage, domestic violence, parental mental health issues, and etc. They must walk the edge of a double edged sword: protect children but keep them in their homes if at all possible. It is my personal opinion that this is the most difficult job in America. If you make the wrong call, children could lose their lives but at the same time the department is always under scrutiny for taking children out of their homes. Child Protection Professionals are my heroes and I believe in them and their work.

Secondly, I would like to point out that Secretary Gilmore has inherited many problems related to foster care, specifically the problems related to privatization. These are issues that have been growing for over twenty years. I commend the Secretary for her commitment and dedication to child safety.

Table of Contents

HB2019 establishes a foster care oversight task force. I would like to outline my testimony regarding the bill as follows:

I. Comments regarding the bill as written
    a. Creation of the task force
        i. History of privatization
        ii. Solutions to privatization (Ending privatization as we currently know it and transition to DCF foster care units with options for foster care contractors to receive cases based on an open market system, which would end the current monopoly and empower DCF social workers and their supervisors to more effectively monitor the contractors)
    b. Evaluate Task Force
    c. Review Duties of Foster Parents
        i. Add additional background searches to include civil (family, domestic, and juvenile) and probate court;
        ii. Change regulations regarding the Child Abuse and Neglect Expungement Process
    d. Collecting Data

II. Recommended bill, "Kaddillak's Bill" in memory of the 10-month old foster child who died in a hot car while the foster parents were using marijuana. This would require a revision of the CINC Code to specifically define risk, safety, and include substance abuse as a definition of abuse/neglect

III. Recommended bill, "Adrian Jones Act", in memory of the child who was murdered by his father and fed to the pigs. This act would require DCF to review child deaths and near deaths in compliance with the Federal Child Abuse and Treatment Act (CAPTA)

IV. Require DCF to respond to all CINC/NAN intakes and not allow the contractors to monitor themselves. The task force may want to be educated about CINC/NAN's in general.

I. **Creation of the Task Force**: **The task force shall review the level of oversight and supervision by DCF over foster care contractors.**

i. History:

1. Please review the history of privatization in Kansas: http://kslegislature.org/li_2016/b2015_16/committees/misc/ctte_spc_2015_special_committee_on_foster_care_adequ_1_20151112_10_other.pdf
2. It is my humble opinion that when Kansas fully privatized foster care, they did not plan a mechanism to provide oversight for the contractors. This has become evident by the fact that all the expertise for foster care has now been completely transferred to the private agencies. **DCF no longer has the institutional knowledge or experience needed to work foster care cases on a day to day basis.** It is impossible to provide oversight without that knowledge.
3. When privatization first started, I believe that SRS did provide excellent oversight. SRS workers remained on the foster care cases to ensure that services were being provided in a timely and sufficient manner. Every foster care child had a DCF worker assigned to the case and that worker attended hearings, case plans, reviewed reports, and kept the cases, "on track" and the children protected.
4. Every four years the contracts change, which makes it difficult to provide oversight and creates chaos for children and families.
5. Sometime around 2004 (ish), SRS stopped the practice of overseeing foster care cases. Once a child was placed in foster care, the child protection case was closed and the "permanency case" was opened. The SRS/DCF social workers no longer provided any oversight over the case. Not only did this create a problem with providing general oversight, it also created a problem in that the work of permanency was separated from the idea of "safety".
6. The overarching goal of each case should be safety. But when DCF closes the "protection case" and the contractors open the "permanency", the overarching goal becomes "permanency". Risk and Safety have become redefined around "family connection" rather than harm and danger. That's because the contractors are under a lot of pressure to get kids out of foster care and back home quickly or to speed up adoption processes. Much compromise has happened (like the Mekhi Boone case) in the name of permanency because safety has been re-defined as "connection".
7. Sometime around 2010 (ish), DCF decided that there needed to be more accountability and they established foster care liaison positions. The problem is that each liaison has been responsible for hundreds of cases and the liaisons do not have a knowledge of the child's history. There is a plan in place by DCF right now to increase the number of liaisons but I believe that this would be less effective than keeping DCF workers on the case. History matters and liaisons don't have time to read all the history for the case and they do not have a relationship with the family The DCF child protection professionals already know this information. They

already have a relationship with the parent and child and they have already spent hours, days and sometimes years investing in the family's wellbeing.

8. 2012 Monopoly: In 2012, only two agencies were awarded the contracts for foster care. This is a problem because DCF is now completely dependent upon these two agencies to provide necessary foster care services. If DCF wanted to do something different, they could not because St. Francis and KVC have all the knowledge and all the power.".

b. **The task force should oversee a privatization transition plan:**
   i. **Require DCF protection workers to remain on the case after children are placed in foster care and provide case by case oversight for each child to ensure continued protection, timely services, and permanency.** The best way to provide case by case accountability for each child's safety and permanency is to maintain the original DCF child protection professional on the case. This worker knows the family and child history. This worker has a relationship with the child and family and is personally invested in keeping the child safe. Every new foster care case has lots of history and documentation to review. When I was a court services officer, it would sometimes take upward of 2-6 hours to review the history of a family. Liaisons don't have time to learn the history but the DCF child protection worker, already knows it.
   ii. **Require each DCF region to create a foster care unit that works foster care cases.** DCF cannot grow in knowledge and expertise if they continue to refer all foster care cases to private organizations. DCF must retain some cases for training and oversight purposes.
   iii. **Open the contracts and end the Monopoly** by allowing many qualifying child placing agencies to obtain foster care contracts, assigned on a case by case basis through provider agreements in the DCF handbook of services.
      1. http://www.dcf.ks.gov/services/PPS/Documents/Contract%20Information/ProviderAgreementServices.pdf Providers would be contracted on a case by case basis, with a recommendation from the social work supervisor (social work supervisors would get to choose what providers they want to use. If a certain contractor is not complying with requirements, they could choose another provider) and this contract would be monitored in the regions by the Provider Agreement Specialists.
      2. Instead of increasing foster care liaison positions to provide oversight on child foster care cases, DCF would increase Provider Agreement Specialist positions to oversee the contracts and the originally assigned DCF child protection workers would provide oversight for each child's case.
      3. This would end the four year RFP process, which would reduce chaos, and increase oversight. All current providers should finish out their current contracts so that children and families do not experience unnecessary changes.

c. **Evaluate whether the oversight task force would aid in addressing foster care concerns**
    i. Foster Care concerns are usually specifically tied to individual children and their circumstances. One of the problems with privatizing is that the contractors hold to their models that may or may not be approved by DCF.
    ii. I am recommending the creation of SAFE Review Teams that review cases in real time using a child protection review model called, S.A.F.E.: Safety, Analysis, Follow-up, and Empowerment. Using these key components, it is possible to review foster case situations (and child protection situations) on a case by case basis to ensure that children are safe, services are in place, and the appropriate entities are held accountable to keep children protected.
    iii. By unifying the department and their contractors through the use of the child protection review model, child protection can be standardized for each child throughout their contact with DCF and their contractors. In addition, this would provide a tool for the community to review cases and keep DCF and their contractors accountable.

d. Review the duties of foster parents
    i. It is my understanding that DCF is in the process of creating an oversight committee that looks at regulations and compliance thereof. I believe that this would fit under that committee and possibly there should be a legislative liaison who could participate in said committee.
    ii. The regulations regarding investigating proposed foster parents should be changed to include the inspection of juvenile, civil and probate court records.
    iii. The regulations that govern the child abuse and neglect expungement process needs to be reviewed. Parents who are placed on the registry should not be removed without intensive investigation and no one should be removed only because they are prohibited from working in a non-regulatory job.

e. Data review
    i. Most of the data listed in this bill is already available through the following means:
        1. http://www.dcf.ks.gov/services/PPS/Pages/PPSreports.aspx
        2. http://www.dcf.ks.gov/services/PPS/Documents/CWHandbookofServices/PlacementServiceStandardsManual.pdf
        3. http://www.dcf.ks.gov/Agency/GC/FCRFL/Pages/default.aspx
        4. https://www.childwelfare.gov/pubPDFs/homestudyreqs.pdf
        5. https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/afcars
        6. https://www.acf.hhs.gov/cb/research-data-technology/reporting-systems/ncands
        7. http://www.dcf.ks.gov/services/PPS/Documents/CFSR/KS_CFSR_Final_Report_2015.pdf
        8. http://www.dcf.ks.gov/services/PPS/Documents/Other/TitleIVBStatePlan.pdf

II. **Change Definitions in the CINC Code to specifically define risk, safety, and abuse/neglect so that children are not harmed while under the watchful eye of the department.**

a. Sometime in 2006 or 2007, the language "imminent risk" was removed from the CINC Code. This language of imminent risk should be added back to 38-2202 (d) (3). Please see the yellow highlights below.

b. Add (4) Use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child; or (5) subjecting a child to domestic violence. Under the definition of Neglect. Please see green highlights below.

c. Add specific definitions for y) "Physical abuse means any non-accidental physical injury to the child or any action that results in the physical harm of the child. Physical abuse shall include drug exposed newborns, the manufacture of a controlled substance in the presence of a child or on the premises occupied by a child, allowing a child to be present where the chemicals or equipment for the manufacture of controlled substances are used or stored. Please see blue highlights below.

d. Define Safety, Risk, Imminent Risk, Investigation and Assessment: (jj) Safety means freedom from the occurrence of injury and danger or risk of harm; (kk) risk means exposure to the chance of injury or danger. Risk assessments inform safety determinations. Risk factors that shall be considered, but shall not be limited to are: caregiver substance use/misuse, domestic violence, parental involvement in criminal activity to include sex trafficking, previous history of child welfare involvement, parental rights termination/unfitness findings, the special needs of children, and parenting capacity; (ll) imminent risk means child is more likely than not to be exposed to danger or injury and/or there is a reasonable belief that the child will be harmed if not immediately removed from the place or residence where the child has been found; **(see 38-2231 (b) (1))**; (mm) investigation means: the gathering of all pertinent information to determine if a child has been harmed as a result of abuse or neglect; and (nn) "Assessment" means to gather all available pertinent information to evaluate risks that could place a child in the way of danger or harm (Please see gray highlights below)

   i. The KAR should also be revised to reflect the recommended changes above.
   ii. Require DCF to screen in all CINC/NAN intakes on open cases for DCF response. Right now, policy 1431 in the manual states that the CINC/NAN intakes may be completed with the decision to "not assign for further assessment and be addressed as part of the open case". DCF sends these reports to the contractors to look into these matters, which is basically allowing the contractor to monitor themselves.

2014 Kansas Statutes 38-2202. Definitions. As used in the revised Kansas code for care of children, unless the context otherwise indicates: (a) "Abandon" or "abandonment" means to forsake, desert or, without making appropriate provision for substitute care, cease providing care for the child. (b) "Adult correction facility" means any public or private facility, secure or nonsecure, which is used for the lawful custody of accused or convicted adult criminal offenders. (c) "Aggravated circumstances" means the abandonment, torture, chronic abuse, sexual abuse or chronic, life threatening neglect of a child. (d) "Child in need of care" means a person less than 18 years of age at the time of filing of the petition or issuance of an ex parte protective custody order

pursuant to K.S.A. 2014 Supp. 38-2242, and amendments thereto, who: (1) Is without adequate parental care, control or subsistence and the condition is not due solely to the lack of financial means of the child's parents or other custodian; (2) is without the care or control necessary for the child's physical, mental or emotional; (3) has been Or is at imminent risk to be physically, mentally or emotionally abused or neglected or sexually abused (4) has been placed for care or adoption in violation of law; (5) has been abandoned or does not have a known living parent; (6) is not attending school as required by K.S.A. 72-977 or 72-1111, and amendments thereto; (7) except in the case of a violation of K.S.A. 41-727, subsection (j) of K.S.A. 74-8810, subsection (m) or (n) of K.S.A. 79-3321, or subsection (a)(14) of K.S.A. 2014 Supp. 21-6301, and amendments thereto, or, except as provided in paragraph (12), does an act which, when committed by a person under 18 years of age, is prohibited by state law, city ordinance or county resolution but which is not prohibited when done by an adult; (8) while less than 10 years of age, commits any act which if done by an adult would constitute the commission of a felony or misdemeanor as defined by K.S.A. 2014 Supp. 21-5102, and amendments thereto; (9) is willfully and voluntarily absent from the child's home without the consent of the child's parent or other custodian; (10) is willfully and voluntarily absent at least a second time from a court ordered or designated placement, or a placement pursuant to court order, if the absence is without the consent of the person with whom the child is placed or, if the child is placed in a facility, without the consent of the person in charge of such facility or such person's designee; (11) has been residing in the same residence with a sibling or another person under 18 years of age, who has been physically, mentally or emotionally abused or neglected, or sexually abused; (12) while less than 10 years of age commits the offense defined in subsection (a)(14) of K.S.A. 2014 Supp. 21-6301, and amendments thereto; or (13) has had a permanent custodian appointed and the permanent custodian is no longer able or willing to serve. (e) "Citizen review board" is a group of community volunteers appointed by the court and whose duties are prescribed by K.S.A. 2014 Supp. 38-2207 and 38-2208, and amendments thereto. (f) "Civil custody case" includes any case filed under chapter 23 of the Kansas Statutes Annotated, and amendments thereto, the Kansas family law code, article 11, of chapter 38 of the Kansas Statutes Annotated, and amendments thereto, determination of parentage, article 21 of chapter 59 of the Kansas Statutes Annotated, and amendments thereto, adoption and relinquishment act, or article 30 of chapter 59 of the Kansas Statutes Annotated, and amendments thereto, guardians and conservators. (g) "Court-appointed special advocate" means a responsible adult other than an attorney guardian ad litem who is appointed by the court to represent the best interests of a child, as provided in K.S.A. 2014 Supp. 38-2206, and amendments thereto, in a proceeding pursuant to this code. (h) "Custody" whether temporary, protective or legal, means the status created by court order or statute which vests in a custodian, whether an individual or an agency, the right to physical possession of the child and the right to determine placement of the child, subject to restrictions placed by the court. (i) "Extended out of home placement" means a child has been in the custody of the secretary and placed with neither parent for 15 of the most recent 22 months beginning 60 days after the date at which a child in the custody of the secretary was removed from the home. (j) "Educational institution" means all schools at the elementary and secondary levels. (k) "Educator" means any administrator, teacher or other professional or paraprofessional employee of an educational institution who has exposure to a pupil specified in subsection (a) of K.S.A. 72-89b03, and amendments thereto. (l) "Harm" means physical or psychological injury or damage. (m) "Interested party" means the grandparent of the child, a person with whom the child has been living for a significant period of time when the child in need of care petition is filed, and any person made an interested party by the court pursuant to K.S.A. 2014 Supp. 38-2241, and amendments thereto, or Indian tribe seeking to intervene that is not a party. (n) "Jail" means: (1) An adult jail or lockup; or (2) a facility in the same building or on the same grounds as an adult jail or lockup, unless the

facility meets all applicable standards and licensure requirements under law and there is: (A) Total separation of the juvenile and adult facility spatial areas such that there could be no haphazard or accidental contact between juvenile and adult residents in the respective facilities; (B) total separation in all juvenile and adult program activities within the facilities, including recreation, education, counseling, health care, dining, sleeping and general living activities; and (C) separate juvenile and adult staff, including management, security staff and direct care staff such as recreational, educational and counseling. (o) "Juvenile detention facility" means any secure public or private facility used for the lawful custody of accused or adjudicated juvenile offenders which must not be a jail. (p) "Juvenile intake and assessment worker" means a responsible adult authorized to perform intake and assessment services as part of the intake and assessment system established pursuant to K.S.A. 75-7023, and amendments thereto. (q) "Kinship care" means the placement of a child in the home of the child's relative or in the home of another adult with whom the child or the child's parent already has a close emotional attachment. (r) "Law enforcement officer" means any person who by virtue of office or public employment is vested by law with a duty to maintain public order or to make arrests for crimes, whether that duty extends to all crimes or is limited to specific crimes. (s) "Multidisciplinary team" means a group of persons, appointed by the court under K.S.A. 2014 Supp. 38-2228, and amendments thereto, which has knowledge of the circumstances of a child in need of care. (t) "Neglect" means acts or omissions by a parent, guardian or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. Neglect may include, but shall not be limited to: (1) Failure to provide the child with food, clothing or shelter necessary to sustain the life or health of the child; (2) failure to provide adequate supervision of a child or to remove a child from a situation which requires judgment or actions beyond the child's level of maturity, physical condition or mental abilities and that results in bodily injury or a likelihood of harm to the child; (3) failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent; however, this exception shall not preclude a court from entering an order pursuant to subsection (a)(2) of K.S.A. 2014 Supp. 38-2217, and amendments thereto; **(4) Use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child; or (5) subjecting a child to domestic violence.**

(u) "Parent" when used in relation to a child or children, includes a guardian and every person who is by law liable to maintain, care for or support the child. (v) "Party" means the state, the petitioner, the child, any parent of the child and an Indian child's tribe intervening pursuant to the Indian child welfare act. (w) "Permanency goal" means the outcome of the permanency planning process which may be reintegration, adoption, appointment of a permanent custodian or another planned permanent living arrangement. (x) "Permanent custodian" means a judicially approved permanent guardian of a child pursuant to K.S.A. 2014 Supp. 38-2272, and amendments thereto. (y) "Physical abuse means any non-accidental physical injury to the child or any action that results in the physical harm of the child. Physical abuse shall include drug exposed newborns, the manufacture of a controlled substance in the presence of a child or on the premises occupied by a child, allowing a child to be present where the chemicals or equipment for the manufacture of controlled substances are used or stored (z) **mental or emotional abuse"** means the infliction of physical, mental or emotional harm or the causing of a deterioration of a child and may include, but shall not be limited to, maltreatment or exploiting a child to the extent that the child's health or emotional

well-being is endangered. ~~(z)~~ (aa) "Placement" means the designation by the individual or agency having custody of where and with whom the child will live. ~~(aa)~~ (bb) "Relative" means a person related by blood, marriage or adoption but, when referring to a relative of a child's parent, does not include the child's other parent~~.~~ ~~(bb)~~ (cc) "Secretary" means the secretary of the department for children and families or the secretary's designee~~. (cc)~~ dd "Secure facility" means a facility, other than a staff secure facility which is operated or structured so as to ensure that all entrances and exits from the facility are under the exclusive control of the staff of the facility, whether or not the person being detained has freedom of movement within the perimeters of the facility, or which relies on locked rooms and buildings, fences or physical restraint in order to control behavior of its residents. No secure facility shall be in a city or county jail. ~~(dd)~~ (ee)"Sexual abuse" means any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child or another person. Sexual abuse shall include allowing, permitting or encouraging a child to engage in the sale of sexual relations or commercial sexual exploitation of a child, or to be photographed, filmed or depicted in pornographic material. ~~(ee)~~ (ff)"Shelter facility" means any public or private facility or home, other than a juvenile detention facility or staff secure facility, that may be used in accordance with this code for the purpose of providing either temporary placement for children in need of care prior to the issuance of a dispositional order or longer term care under a dispositional order. ~~(ff)~~ (gg) "Staff secure facility" means a facility described in K.S.A. 2014 Supp. 65-535, and amendments thereto: (1) That does not include construction features designed to physically restrict the movements and activities of juvenile residents who are placed therein; (2) that may establish reasonable rules restricting entrance to and egress from the facility; and (3) in which the movements and activities of individual juvenile residents may, for treatment purposes, be restricted or subject to control through the use of intensive staff supervision. No staff secure facility shall be in a city or county jail. ~~(gg)~~ (hh) "Transition plan" means, when used in relation to a youth in the custody of the secretary, an individualized strategy for the provision of medical, mental health, education, employment and housing supports as needed for the adult and, if applicable, for any minor child of the adult, to live independently and specifically provides for the supports and any services for which an adult with a disability is eligible including, but not limited to, funding for home and community based services waivers. ~~(hh)~~ (ii)"Youth residential facility" means any home, foster home or structure which provides 24-hour-a-day care for children and which is licensed pursuant to article 5 of chapter 65 of the Kansas Statutes Annotated, and amendments thereto. History: L. 2006, ch. 200, § 2; L. 2008, ch. 169, § 1; L. 2009, ch. 99, § 1; L. 2010, ch. 75, § 5; L. 2011, ch. 30, § 155; L. 2012, ch. 162, § 60; L. 2013, ch. 120, § 31; July 1. (jj) Safety means freedom from the occurrence of injury and danger or risk of harm; (kk) risk means exposure to the chance of injury or danger. Risk assessments inform safety determinations. Risk factors that shall be considered, but shall not be limited to are: caregiver substance use/misuse, domestic violence, parental involvement in criminal activity to include sex trafficking, previous history of child welfare involvement, parental rights termination/unfitness findings, the special needs of children, and parenting capacity; (ll) imminent risk means child is more likely than not to be exposed to danger or injury and/or there is a reasonable belief that the child will be harmed if not immediately removed from the place or residence where the child has been found; **(see 38-2231 (b) (1))**; (mm) investigation means: the gathering of all pertinent information to determine if a child has been harmed as a result of abuse or neglect; and (nn) “Assessment” means to gather all available pertinent information to evaluate risks that could place a child in the way of danger or harm.

III. Include Adrian Jones Act, which would require DCF to review child deaths and near deaths in compliance with the Federal Child Abuse and Treatment Act (CAPTA)

The Adrian Jones Act:

The Child Abuse and Neglect Fatality and Near Fatality Review Team

According to a report from the Kansas Star, dated 11-14-16, Adrian Jones was,

> "found last year and authorities said it appeared he had been fed to pigs on property rented by Jones and her husband in the 5200 block of North 99th Street year [Kansas City, Kansas]. Heather Jones' husband and Adrian's father, 45-year-old Michael A. Jones, is charged in the case and is awaiting trial. Chief Deputy District Attorney Sheryl Lidtke said that it was the most heinous crime she has seen in her 27-year career as a prosecutor. "He was horribly abused, neglected and ultimately killed," Lidtke said. "I'm sure his suffering was unbearable." She said he was physically and emotionally abused, confined and "essentially starved to death."' [1]

Adrian also had a history with the Kansas Department for Children and Families, but to what extent is unknown to the public.

The Federal Child Abuse and Protection Treatment Act (CAPTA) Section 106(b)(2)(B)(x) of CAPTA requires states to provide for the public disclosure the following:

> "findings or information about a case of child abuse or neglect which results in a child fatality or near fatality, specifically the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; the result of any such investigations; and the services provided by and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality or near fatality."

In addition to the requirements of CAPTA, the Federal Commission to Eliminate Child Abuse and Neglect Fatalities issued their report in April 2016. According to their fact sheet, too many children are victims of preventable maltreatment fatalities and the first recommendation made by the commission is for State to undertake a "retrospective review of child abuse and neglect fatalities from previous five years to identify family and systemic circumstances that lead to fatalities.[2]

This bill is being recommended in memory of Adrian Jones. By reviewing the past five years of maltreatment fatalities and continuing to do so in the future, hopefully the task force can identify ways in which to prevent future devastating tragedies from occurring.

A. Definitions

1. Child" means a person less than 18 years of age.
2. The term 'child abuse and neglect' means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or

[1] http://www.kansascity.com/news/local/crime/article114641128.html

[2] https://eliminatechildabusefatalities.sites.usa.gov/files/2016/03/CECANF-Report_Fact-Sheet-final-3.17.16.pdf

emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

3. The term "near fatality" means an act that, as certified by a physician, places the child in serious or critical condition.

B. Purpose: A Child Abuse and Neglect Fatality and Near Fatality Review Team, hereafter called the Fatality Review Team, shall be created for the purposes of complying with the CAPTA requirements to provide for the public disclosure of findings or information about a case of child abuse or neglect which results in a child fatality or near fatality, specifically the cause of and circumstances regarding the fatality or near fatality; the age and gender of the child; information describing any previous reports or child abuse or neglect investigations that are pertinent to the child abuse or neglect that led to the fatality or near fatality; the result of any such investigations; and the services provided by and actions of the State on behalf of the child that are pertinent to the child abuse or neglect that led to the fatality or near fatality; and to identify family and systemic circumstances that lead to fatalities. This shall be accomplished by a thorough case review of each child's record from the Kansas Department for Children and Families.

C. Child Abuse Neglect Fatality and Near Fatality Review Team; executive director; development of protocol; annual report; confidentiality of records; rules and regulations.

1. There is hereby established a Child Abuse and Neglect Fatality and Near Fatality Review Team", hereafter called the "Fatality Review Team", which shall be composed of professionals with knowledge and experience relating to the criminal justice system and issues of child physical abuse, child neglect, child sexual abuse and exploitation, and child maltreatment related fatalities. The Fatality Review Team shall include
    i. A member of Law Enforcement with experience in investigating child abuse and neglect
    ii. Child in Need of Care Judge;
    iii. Guardian Ad Litem;
    iv. A District or County Attorney;
    v. Child Advocacy Center professional;
    vi. Pediatric child abuse specialist;
    vii. Mental health professional;
    viii. Representative from DCF Prevention and Protective Services;
    ix. School personnel experienced in working with children with disabilities;
    x. A parent;
    xi. A representative of a parents' groups;
    xii. An adult former victim of child abuse and or neglect; and
    xiii. An individual experienced in working with homeless children and youths (as defined in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a).
2. The chairperson of the Fatality Review Team shall be appointed by the attorney general to represent the office of the attorney general.
3. The Fatality Review Team shall be within the office of the attorney general as a part thereof and can be housed with the State Child Death Review Board and share resources, if deemed appropriate. All budgeting, purchasing and related management functions of the board shall be administered under the direction and supervision of the attorney general. All vouchers for expenditures and all payrolls of the board shall be approved by the chairperson of the board and by the attorney general. The Fatality Review Team shall establish and maintain an office in Topeka.

4. The Fatality Review Team shall meet at least quarterly to review all reports submitted to the Fatality Review Team. The chairperson of the Fatality Review Team may schedule monthly meetings or call a special meeting of the board at any time to review any report of a child abuse and neglect fatality or near fatality.
5. Within the limits of appropriations therefor, the Fatality Review Team shall appoint an executive director who shall be in the unclassified service of the Kansas civil service act and shall receive an annual salary fixed by the Fatality Review Team and paid through Child Abuse and Treatment Act grant money.
6. Within the limits of appropriations therefor, the Fatality Review Team may employ other persons who shall be in the classified service of the Kansas civil service act.
7. Members of the Fatality Review Team shall not receive compensation, subsistence allowances, mileage and expenses as provided by K.S.A. 75-3223, and amendments thereto, for attending meetings or subcommittee meetings of the board.
8. Fatality Review Team shall develop a protocol to be used by the task force. The protocol shall include written guidelines for coordination and cooperation among the Fatality Review Team, the Kansas State Child Death Review Board, and the Kansas Department for Children and Family Services. The protocol shall be adopted by the Fatality Review Team by rules and regulations.
9. The Fatality Review Team shall initially review the previous 5 years of fatalities and near fatalities and submit a report on or before October 1 2018. Afterwards, annual reports shall be due on or before October of each subsequent year. Such reports shall include:
    i. the number of child abuse and neglect fatalities and near fatalities reviewed;
    ii. the cause of and circumstances regarding each fatality or near fatality;
    iii. the age and gender of the children;
    iv. any and all safety concerns
    v. all previous reports made to the Kansas Protection Report Center, investigations, assessments, and etc.
    vi. the result of all intakes, assessments and /or investigations
    vii. services provided by and actions of the State on behalf of the child
    viii. the identification of family and systemic circumstances that led to fatalities
    ix. Review of policies on screening reports of abuse and neglect to ensure that the children most at risk for fatality—those under age 3—receive the appropriate response, and they and their family are prioritized for services, with heightened urgency for those under the age of 1.

D. Same; activation of board to investigate; access to records; subpoena power; report issued; disclosure of conclusions.
1. DCF shall immediately, upon receipt, forward to the Fatality Review Team all current Child Abuse and Neglect Fatality and Near Fatality Critical Incidents. In addition, DCF shall provide the Fatality Review Team a list of Child Abuse and Neglect Fatality and Near Fatality Critical Incidents from January 1, 2012 to the present. The Kansas Department for Children and Family Services shall provide associated case files, contained both electronically and on paper, to the Fatality Review Team upon request.
2. The Kansas State Child Death Review Board shall forward to the Fatality Review Team any and all current child death cases that have had any DCF contact in the last 2 years. In addition, the SCDRB shall send to the Fatality Review Team a list of child death cases with a history of DCF that were reviewed from January 1, 2012 to the present.

3. Information acquired by, and records of, the Fatality Review Team shall be confidential, shall not be disclosed and shall not be subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding, except that such information and records may be disclosed to any member of the legislature or any legislative committee which has legislative responsibility of the enabling or appropriating legislation, carrying out such member's or committee's official functions. The legislative committee, in accordance with K.S.A. 75-4319, and amendments thereto, shall recess for a closed or executive meeting to receive and discuss information received by the committee pursuant to this subsection. The Fatality Review Team shall comply with all other relevant federal confidentiality laws, including the confidentiality requirements applicable to titles IV-B and IV-E of the Social Security Act.
4. The Fatality Review Team, DCF and the SCDRB shall have a free flow of information regarding child fatalities and near fatality cases. DCF and the SCDRB shall not withhold information from the Fatality Review Team but the Fatality Review Team may make an exception to release information in the yearly report in order to ensure the safety and well-being of a child, parents and family or when releasing the information would jeopardize a criminal investigation, interfere with the protection of those who report child abuse or neglect or harm the child or the child's family.
5. The Fatality Review Team may apply to the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any records relevant to the cause of any death being investigated by the task force. Any records received by the task force pursuant to the subpoena shall be regarded as confidential and privileged information and not subject to disclosure
6. The Fatality Review Team shall maintain permanent records of all written reports concerning child deaths.
7. Information, documents and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of a Fatality Review Team. A person who presented information before the board or who is a member of the board shall not be prevented from testifying about matters within the person's knowledge.