Keeping the Public in the Dark

HOW FEDERAL AND STATE LAWS AND POLICIES PREVENT MEANINGFUL DISCLOSURE ABOUT CHILD MALTREATMENT FATALITIES AND NEAR FATALITIES

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Executive Summary

At least 1,800 children die from abuse and neglect every year, and the total is probably considerably greater. Between a third and a half of these deaths may involve families that were already known to Child Protective Services through previous reports of maltreatment. In addition, an unknown number of children are severely injured due to maltreatment every year. Legislators, advocates, and the public need timely information about the circumstances leading to these events so they can identify policy and practice changes necessary to protect children.

Federal law requires every state to have a policy that provides for publicly disclosing findings or information about child fatalities or near fatalities resulting from child abuse or neglect. However, the federal requirement is worded vaguely and has never been interpreted in regulations.

This report found that most states have laws or policies providing for the release of information on child fatalities and near fatalities due to maltreatment, but some of these are vaguely worded, and some have provisions that hinder public access to critical information about these tragic events. Twelve states allow but do not require the release of information about these incidents. Only 17 states have laws or policies that require releasing some information without request, and some of them release only minimal information.

Congress should change federal law to clarify current language and establish parameters for states in interpreting the law. Absent change at the federal level, states should amend their own policies to clarify terms and eliminate exceptions that violate the goal of transparency, require prompt notifications of maltreatment fatalities and near fatalities reported to agencies, and make comprehensive information available on request for all such cases.

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> Abuse and neglect deaths represent child welfare agencies' most tragic failures. Unfortunately, it is often only through such cases that lawmakers and the public learn of systemic inadequacies in child welfare systems. If improvements and reforms are to be achieved, it is vital that the facts about these cases reach the public in a meaningful way.
>
> —Children's Advocacy Institute and First Star[1]

According to states' reports to the federal government, about 1,800 children die from abuse and neglect every year, but this figure is widely considered to be an understatement.[2] Among those deaths, studies suggest that between a third and a half involve families that were already known to Child Protective Services (CPS) through previous reports and may have received child welfare services in the past.[3] In addition, an unknown number of children are severely injured due to maltreatment every year.

Legislators, advocates, and the public must have access to timely information about the circumstances leading to child maltreatment fatalities so they can identify policy and practice changes necessary to protect children. For that reason, Congress added a new section to the Child Abuse Prevention and Treatment Act (CAPTA) in 1996, requiring all states to provide assurances to the US Department of Health and Human Services (HHS) that they have provisions for disclosing findings and information regarding child fatalities and near fatalities from maltreatment.

In 2008 and 2012, the Children's Advocacy Institute (CAI) of the University of San Diego School of Law and First Star published reviews of public disclosure policies in the 50 states and the District of Columbia, giving each state a grade for its policy's transparency.[4] Few states did well based on this analysis. The 2012 report found some states improved but "many states have policies that fail to further the congressional goal of identifying systemic problems in order to implement meaningful reform."[5]

These two reports were published during a surge of interest in child maltreatment fatalities in the early 21st century. In 2010, the National Coalition to End Child Abuse Deaths (NCECAD) was formed by five organizations concerned with child abuse and neglect. In 2011, a report from the US Government Accountability Office commissioned by Congress stoked public concern about these fatalities and states' underreporting these tragedies to the federal government.

Later in 2011, the Protect Our Kids Act was introduced in Congress to establish a national commission on child abuse deaths,[6] and passing the act became the NCECAD's focus. The Protect Our Kids Act passed in January 2013, establishing the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF). CECANF issued its final report, *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities*, in March 2016.[7] Among its numerous recommendations, the report called for changes in federal law and state practices to ensure accountability by requiring that information about child maltreatment fatalities be made publicly available.

After *Within Our Reach* was published, federal and state governments made efforts to advance the commission's recommendations. Some states made changes emphasizing infant safe-haven laws and safe sleep practices.[8] At the federal level, legislation was put forward to reauthorize CAPTA, including a new Title III in CAPTA focused on child maltreatment fatalities and near fatalities and a strengthened disclosure requirement.[9] The CAPTA reauthorization bill was approved by the full House of Representatives and the Senate Health, Education, Labor, and Pensions Committee in 2021, but the legislation was not included in the end-of-year omnibus package.[10]

Child welfare policy has always struggled to balance the need to ensure child safety and well-being with the importance of keeping families together whenever possible. In the years following the passage of the Protect Our Kids Act in 2012, child welfare leaders and advocates began to shift their focus. The increasing attention to stubborn racial disparities throughout society led to a concern about black families' disproportional involvement with child welfare systems.

George Floyd's murder led to a backlash against the police, which soon extended to the child welfare system. Some called it a "family policing system" that should be abolished.[11] Within Our Reach, an office that was established to further the CECANF recommendations, published a "first progress report" on the CECANF recommendations with CAI in January 2018.[12] But no further progress reports have been forthcoming. Instead, the office published a report in 2020 that "highlights the elements of a prevention-aligned, public health approach to child welfare and provides examples of innovative programs from communities and states across the nation that [are] working to shift from a child welfare system to a child and family well-being system."[13] And NCECAD closed in 2022.

But some child advocates have continued to call attention to child maltreatment and its most tragic results.[14] Lives Cut Short, a project of the American Enterprise Institute and the University of North Carolina at Chapel Hill, was formed to document child maltreatment fatalities and reignite interest in learning from these tragic events and promoting child safety.[15] As part of Lives Cut Short's work, I conducted a review of state disclosure policies regarding fatalities and near fatalities to describe the disclosure policy landscape as of 2024.

The current report has two purposes. First, it aims to inform advocates, legislators, the media, and interested citizens about what information can already be released in their jurisdictions. Some jurisdictions already publish extensive information that legislators and advocates could use to inform proposals for change; others have laws and regulations requiring they release information to anyone if there is a fatality or near fatality in which maltreatment is a factor. Second, this report recommends changes at the federal and state level to achieve fuller transparency regarding child maltreatment fatalities and near fatalities. I hope this resource will help advocates and legislators increase the transparency surrounding child fatalities and near fatalities that are due to maltreatment.

The information reported here documents that most states have laws or policies governing access to information about child maltreatment fatalities and near fatalities, but some of these are too vague, and some have provisions that hinder public access to critical information about these incidents. The major findings discussed in this report include the following:

- Federal law requires every state to have a policy that provides for publicly disclosing findings

or information about child fatalities or near fatalities resulting from child abuse or neglect. However, the federal requirement is worded vaguely and has never been interpreted in regulations. Instead, HHS's Child Welfare Policy Manual (CWPM) fails to clarify some issues and confuses some even further. It also adds justifications for withholding, rather than releasing, important information.

- Despite the federal requirement, not every state has a policy for publicly disclosing findings or information about child fatalities and near fatalities. Out of the 50 states and the District of Columbia, four states appear to have no such policy. Another four states have a policy for fatalities but not near fatalities.

- Among the 47 jurisdictions that do contain provisions for disclosing maltreatment fatality and near-fatality information, 35 require the release of findings and information about child maltreatment fatalities, and all but four of those require that of near fatalities as well. Twelve allow but do not require the release of findings and information about these incidents.

- Many state laws and policies are vague, and many contain restrictions that seem to violate the goal of making information about child maltreatment and agency operations publicly available.

- Seventeen states have laws or policies that require releasing some information without request. These releases vary from a few basic facts on each incident to a comprehensive review of the victim's family's history with child welfare. These more comprehensive releases are an excellent resource for child advocates and the media focusing on the state level.

Congress should change federal law to clarify current language and establish parameters for states in interpreting the law. Absent change at the federal level, states should amend their own policies to clarify terms and eliminate exceptions that violate the goal of transparency, require prompt notifications of maltreatment fatalities and near fatalities reported to agencies, and make comprehensive information available on request for all such cases.

What Federal Law Requires

CAPTA, originally enacted in 1974, is the key federal legislation addressing child abuse and neglect. Among other purposes, CAPTA provides federal funding to states for prevention, assessment, investigation, prosecution, and treatment activities.[16]

CAPTA requires each state to submit a plan to the secretary of human services describing how it will use CAPTA funds. A state's plan must include assurances about its laws or policies regarding child maltreatment. One of these requirements is that the state must have "methods to preserve the confidentiality of all records in order to protect the rights of the child and of the child's parents or guardians" by limiting access to only a few specified groups of people.[17]

In 1996, Congress amended CAPTA to add a new item—42 U.S.C. 5106a(b)(2)(A)(x)—to the list of assurances, requiring that every state's plan for spending CAPTA funds must contain

> an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes . . . provisions which allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality.[18]

In adding this assurance, Congress's goal was to ensure information from these tragic events can be used to correct systemic problems and prevent future occurrences.[19] As CAI and First Star put it in their comprehensive 2012 study, *State Secrecy and Child Deaths in the U.S.: An Evaluation of Public Disclosure*

Practices About Child Abuse or Neglect Fatalities or Near Fatalities, with State Rankings:

> This mandate reflects an understanding that the value of maintaining confidentiality of child abuse and neglect reports and records is greatly diminished in cases of fatalities and near fatalities, for in such cases it is of overwhelming importance to examine the performance of the system as a whole and to learn from any mistakes or failings.[20]

CAPTA defines a near fatality as "an act that, as certified by a physician, places the child in serious or critical condition," and most states have adopted similar definitions.[21] Unfortunately, many other terms are not defined by CAPTA, including "findings," "information" and "child abuse or neglect which has resulted in a fatality or near fatality," resulting in a wide variety of interpretations by individual states. HHS has never published regulations governing the implementation of the disclosure provision that would have defined these terms and clarified the disclosure requirement.

HHS did provide some guidance to states in the form of questions and answers in its CWPM.[22] The CWPM clarified some ambiguities in the statutory language. It explained that states must provide findings and information, not "findings or information," as the language suggested. It also clarifies that a state does not have to provide the required information unless it is requested, but once requested, the state must provide it. The CWPM does not have the same force as federal regulations. Nevertheless, some states clearly pay attention to the CWPM text and have mirrored it in their laws and policies, as discussed below.

But in terms of one major issue—confidentiality of child welfare records—the CWPM muddied the waters rather than increasing clarity. States doubtless understand that the disclosure requirement for fatalities and near fatalities was intended as an exception to the preexisting requirement that all child welfare records be confidential. Many states place their disclosure requirement in a list of other exceptions to confidentiality. But there are other federal privacy protections, like those included in Title IV-E of the Social Security Act (which governs foster care) and in the regulations governing Temporary Assistance for Needy Families, Medicaid, and other financial assistance programs under Title IV-A of the Social Security Act. States need to know which requirements take precedence, but the guidance in the CWPM does not help.[23]

Instead, different sections of the CWPM seem to contradict each other, as CAI and First Star explain.[24] In the answer to question six of Section 2.1A.1 of the CWPM, which deals with confidentiality, HHS states that the disclosure requirements trump the preexisting confidentiality requirements:

> There may be instances where CPS information is subject both to disclosure requirements under CAPTA and to the confidentiality requirements under title IV-E and 45 CFR 205.50. To the extent that the CAPTA provisions require disclosure (such as . . . in section 106(b)(2)(B)(x) in the case of a child fatality or near fatality), the CAPTA disclosure provision would prevail in the event of a conflict since the CAPTA confidentiality provisions were most recently enacted.[25]

But in Section 2.1A.4, which addresses CAPTA's provisions on public disclosure, the CWPM does not contain the same language, and its answers to five of the eight questions for Section 2.1A.1 repeatedly remind states to ensure they are complying with other federal confidentiality laws.[26]

In 2012, HHS revised the CWPM. But instead of clearing up the confusion on confidentiality, the agency added a provision explicitly allowing states to withhold certain information—or even all information—on fatality or near-fatality cases. Specifically, the revised version provides that

> states may allow exceptions to the release of information in order to ensure the safety and well-being of the 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.[27]

As CAI and First Star explain, the new language pertaining to the child and other family members' safety and well-being completely contradicts the prior language that allowed no exception for such reasons.[28]

The 2012 changes also added a description of the findings and information a state must disclose:

> States must develop procedures for the release of information including, but not limited to: 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.[29]

By fleshing out the meaning of "findings and information," the new language might have helped the cause of transparency if it had not included the word "pertinent," as CAI explains in its 2015 comments to HHS.[30] But by suggesting that a state need disclose only previous reports or investigations that are "pertinent to the child abuse or neglect that led to the fatality or near fatality" without defining "pertinent," the HHS's new language opened the door for states to interpret this term narrowly.

For example, a state could decide a prior incident of neglect was irrelevant if the cause of death was abuse. This would clearly be contrary to the purpose of disclosure, which is to determine whether the outcome might have been different if the state had responded differently to a previous allegation, regardless of the specifics. The same parent often perpetrates multiple types of maltreatment, especially chronically maltreating parents who have had multiple encounters with the child welfare system.[31] And even if a prior incident was markedly different from the fatal or near-fatal incident, it is important to assess how the agency intervened to better understand points at which the child might have been protected.

CAI also reported in its 2015 comments that several states had changed their policies to reflect their increased discretion to withhold information provided by the CWPM's new language.[32] The information I gathered shows that even more states have added language modeled after these provisions to their laws and policies. The CWPM does not have the same force as federal regulations, although the latter's authority is coming under judicial attack, as mentioned earlier. But the changes to law and policy that states adopted following the 2012 CWPM changes show that at least some states attempt to comply with the CWPM.

The next part of this report summarizes state statutes regarding the disclosure of information on child maltreatment fatalities and near fatalities. In conducting this review, I started from *State Secrecy and Child Deaths in the U.S.*, which was based on a comprehensive review of state disclosure laws and policies regarding child maltreatment fatalities and near fatalities in the 50 states and the District of Columbia. I reviewed the statutes and policies cited in the 2012 report and obtained updated versions. In states without legal provisions, or where the law was vague, I searched the internet for policies and contacted state public information officers to ask if they had written policies.

The following findings reflect a good-faith effort to report the information that I found. If anything is misreported or needs to be updated, please contact info@livescutshort.org with any corrections.

State Disclosure Requirements for Child Maltreatment Fatalities and Near Fatalities

For each state and the District of Columbia, Table A1 shows whether it requires, allows, or has no provision for releasing information on child maltreatment fatalities and near fatalities. For those with a provision, the table shows whether the jurisdiction's child welfare agency routinely publishes, without a request,

information including notifications, case summaries, case reviews, and case files.

States That Allow or Require Disclosing Some Information and Findings about Child Maltreatment Fatality or Near-Fatality Cases. I found that 33 states plus the District of Columbia mandate the release of some information to the public when a child fatality occurs and child abuse or neglect is the suspected or confirmed cause.[33] These requirements are included in statutes in all the jurisdictions except Vermont, where the requirement is expressed only in policy. Of these jurisdictions, most also mandate disclosing information about near fatalities.[34] There are four exceptions: Florida, Michigan, and New York allow but do not require the release of information on near fatalities, and New Mexico has no disclosure requirement for near fatalities. In addition, Washington has stringent criteria for disclosing near fatalities, requiring that the perpetrator has been charged, the report or investigation has already been disclosed, or the child is in the department's care or was receiving department services within the previous year.[35]

Thirteen states have provisions that allow but do not require releasing information about child maltreatment fatalities and near fatalities.[36] All these provisions are included in state statutes except in Idaho, where it is addressed in an agency rule. All these jurisdictions include fatalities and near fatalities in their provisions allowing disclosure. One member of this group, Hawaii, allows disclosing information about children who are missing and those who have suffered a fatality or near fatality.[37]

Four states have no provision for disclosing findings and information on child maltreatment fatalities and near fatalities. That group includes one state (Montana) that provides for disclosing information about a child's death due to maltreatment only to specified officials or review teams. North Dakota has no provision for disclosing information on child fatalities or near fatalities in general, but it authorizes the release of information about institutional child abuse, neglect, or death resulting from maltreatment. Two other states (Massachusetts and Wyoming) have no provision at all for releasing case-specific information to the public regarding child maltreatment fatalities or near fatalities.

Cases That Are Subject to Disclosure. Among jurisdictions with disclosure policies, more than half require or allow disclosure of findings and information for fatalities and near fatalities only when maltreatment has been confirmed in some way as a cause or contributing factor. Other jurisdictions require or allow disclosure when there is a suspicion that maltreatment played a role in the fatality or near fatality. Still others require the disclosure of some information in cases where maltreatment is suspected, and additional information or findings when it is confirmed. A few other states have more restrictive or unclear criteria for what cases can or must be disclosed.

Confirmed Maltreatment. Twenty-six states[38] require or allow disclosure only in cases of confirmed maltreatment, reflecting CAPTA's requirement of disclosing the case of maltreatment "which has resulted in a fatality or near fatality."[39] While most of the laws do not define "confirmed maltreatment," there is considerable variation among those that do.

- Iowa and Texas require that the department must have investigated and found that the fatality or near fatality was due to abuse or neglect.[40]

- Arizona requires that "1) the perpetrator is arrested related to the incident; 2) a superior court finds a child dependent based on the allegations of abuse or neglect leading to the death or near death; or 3) [the Department of Children's Services] . . . substantiates findings linking the allegations of abuse or neglect to the death or near death."[41]

- Indiana requires disclosure when a child's death or near fatality "may have been the result of abuse, abandonment or neglect." For that to be the case, either a local office, the Indiana

> Department of Child Services (DCS), or the DCS ombudsman must have found the child's death to be the result of abuse, abandonment, or neglect, or a prosecuting attorney must have filed an indictment or a complaint "alleging the commission of a delinquent act; that, if proven, would cause a reasonable person to believe that the child's death or near fatality may have been the result of abuse, abandonment or neglect," as decided by a judge.[42]

- Minnesota requires disclosure if a person is criminally charged with having caused the fatality or near fatality, the county attorney certifies that an individual would have been charged if they had not died, or a child protection investigation resulted in a determination of maltreatment.[43]

- Louisiana requires a physician to determine whether abuse or neglect was a contributing factor to the fatality or near fatality.[44]

Suspected Maltreatment. Twelve jurisdictions[45] require disclosure of some information for all cases in which maltreatment is suspected, going beyond the CAPTA language, which suggests disclosure is required for confirmed maltreatment. Some of these jurisdictions require disclosure in cases when a report has been made alleging abuse or neglect that resulted in a fatality or near fatality[46] or an incident is being or has been investigated for abuse or neglect.[47] Others require that the fatality or near fatality "is more likely than not to have been caused by abuse or neglect,"[48] there is "reasonable suspicion" or "reason to suspect" that a child fatality or near fatality was caused by abuse or neglect,[49] that neglect or child abuse is suspected[50] in the fatality or near fatality, or that "a child who was part of the [abuse or neglect case] has died."[51] Nevada has the most inclusive range of cases subject to disclosure, requiring a public disclosure

> when a report is received regarding a child fatality or near fatality and that child has been the subject of a report of possible abuse or neglect at any time prior to or including the report of the fatality or near fatality.[52]

Information Disclosed Depends on Whether Maltreatment Is Suspected or Confirmed. Arkansas, California, New Jersey, Oklahoma, Tennessee, and Texas require the release of limited information while the fatality or near fatality is being investigated or if there is a reasonable suspicion of maltreatment. After the incident is substantiated as maltreatment, more extensive information can be released.

More Restrictive Criteria. North Carolina requires disclosure only when criminal charges have been filed or would have been filed had the perpetrator not died—clearly much more restrictive than what CAPTA requires. Idaho is even more restrictive, requiring disclosure only when identifying information related to the case has already been published, all or part of the case information has been disclosed in a court proceeding, or the "disclosure of information clarifies actions taken by the Department on a specific case."[53]

Unclear Criteria. Two states' statutes are unclear on whether they refer to confirmed or alleged maltreatment. In Missouri, disclosure is required in "cases which resulted in a child fatality or near fatality."[54] In Nebraska, the agency director may disclose information "regarding child abuse or neglect and the investigation of and any services related to the child abuse and neglect" if (among other factors) "the information relates to a child fatality or near fatality."[55]

Information That Must Be, May Be, or Cannot Be Disclosed. Disclosure laws or policies in 33 jurisdictions[56] list specific information that must or may be released either in response to a request or routinely for all suspected or confirmed cases. Some of these laws and policies echo the list included in the CWPM, including the child's age and gender, the fatality's causes and circumstances, and the family's previous involvement with the child welfare agency. Some require the release of other information, such as

the nature of the child's injuries, past risk and safety assessments, and criminal charges filed against the offender. Six of these jurisdictions[57] require the release of different information depending on whether the child was residing at home or in foster care. Fourteen states include in their laws only vague language about what can or must be released, such as "findings and information" (copying CAPTA), "findings or information," "available facts and findings," and "summary information."[58] Many states also impose limits on what can be disclosed, as described below.

Names and Identifying Information. Nine states[59] allow or require disclosure of the name of a child who died due to maltreatment or suspected maltreatment. Among these states, Arizona, Arkansas, and Pennsylvania release the name of children who died from maltreatment as part of their routine disclosures. Five states (Georgia, Indiana, Nevada, South Dakota, and Wisconsin) forbid disclosure of the name of a child who died, while Michigan bans the release of "personal identifying information" for any individual identified in a CPS record, other than that of an alleged perpetrator who has been added to the central registry.[60] The same states plus three more[61] prohibit disclosure of the name or identifying information of a child who nearly died. Some states also ban the release of names or identifying information of adult members of the household, including the child's caregivers.[62]

Information "Otherwise Made Confidential by Law." Eight states[63] have provisions preventing the release of information (or sometimes specifically medical or psychological information) that is otherwise made confidential or exempt by federal or state law. These jurisdictions include the four states with the most children and the most foster children (the best proxy we have for the size of their child welfare systems)—California, Florida, Illinois, and Texas. These provisions probably stem from the confusion (discussed above) about whether the requirement to disclose information about maltreatment fatalities and near fatalities supersedes other federal confidentiality requirements.

Disclosures That Might Prejudice Criminal Trials. As described above, HHS added language to the CWPM in 2012 saying that states may allow exceptions to releasing information when "releasing the information would jeopardize a criminal investigation."[64] Laws or policies in 15 jurisdictions[65] have some provision to the following from disclosure requirements: any information that could jeopardize a criminal investigation or trial, an alleged perpetrator's right to a fair trial, or a CPS investigation if released.

Most of these laws or policies allow problematic information to be redacted, but Colorado, Maryland, Pennsylvania, and South Carolina appear to prevent *any* disclosure if it might jeopardize a criminal trial or proceeding or an alleged perpetrator's right to a fair trial.[66] Pennsylvania requires the district attorney to certify that disclosing information might compromise a criminal proceeding (this certification lasts 60 days), but other states lack such a provision to ensure that information is eventually released.[67] One state, Kansas, is hard to classify because the agency can ask a court to prevent disclosing either the record or report or a portion of it.[68]

Disclosures That Might Harm Children or Adult Family Members. As mentioned above, the revised CWPM gave states permission to "allow exceptions to the release of information in order to ensure the safety and well-being of the child, parents and family or when releasing the information would . . . harm the child or the child's family."[69] Seventeen states and the District of Columbia have similar provisions,[70] some of which call for withholding information that might be contrary to the welfare or best interests of or cause mental or physical harm to a child, the child's siblings, or other children in the household. Some states include adults in these prohibitions, prohibiting the release of information which might harm any member of the child's family or any of the child's caregivers. Some of these statutes or policies appear to allow or require redacting the information that, if released, might harm the child or family rather than preventing the disclosure of any information. Others clearly prevent any disclosure on these grounds,[71]

and others are more ambiguous and could be interpreted to allow redaction or prevent disclosure.[72]

New York and Maine, two of the 16 states that prohibit disclosures that might harm other children in the household, specify that the official making this determination "shall consider the interest in privacy of the child and the child's family and the effects which disclosure may have on efforts to reunite and provide services to the family."[73] It is interesting and rather surprising to assume that reunification with the parents or guardians would be in the surviving children's best interests after such a serious incident as a death or life-threatening illness or injury has occurred, regardless of whether the parents or guardians were responsible for the incident.

New York releases reviews of all child fatalities reported to the statewide hotline except in cases where it might harm "the child's siblings or other surviving children in the household."[74] The New York State Office of Children and Family Services (OCFS) must review all local investigations of child fatalities reported to the State Central Register and issue a summary report within six months of the investigation. On its website, OCFS explains that it posts fatality reviews "when it is determined that disclosure would not harm the child's surviving siblings or other children in the household."[75] This is done through a process called a "best interest determination" that OCFS conducts, sometimes assisted by experts from the agency's Statewide Child Fatality Review Team. The process, clearly based on the law mentioned above, considers

> whether publishing a fatality report is contrary to the best interests of a child's siblings or other children in the household, what effects publication may have on the privacy of children and family, and any potentially detrimental effects publication may have on reuniting and providing services to a family.[76]

Based on Lives Cut Short's calculation, it appears that about one-quarter of reports on 2022 fatalities in New York were withheld on these grounds.[77]

Information That Is "Not Pertinent." As discussed previously, the 2012 changes to the CWPM required that states provide only information on reports, investigations, and services that are "pertinent to the child abuse or neglect that led to the fatality or near fatality."[78] Eight states[79] have incorporated this language or a version of it into their statutes or regulations. In addition, California requires redaction of any information that is not relevant to a near fatality.[80] Interestingly, CAI reported that Rhode Island changed its policy to incorporate this language in 2013, but the current policy does not contain this language, suggesting it has since been removed.[81]

Agency Records. A few states by law or practice release actual agency records (rather than or in addition to summaries or cases reviews written by the agency) after a child dies or nearly dies of maltreatment. Florida requires the release of "all records held by the department concerning reports of child abandonment, abuse, or neglect" to "any person in the event of the death of a child determined to be a result of abuse, abandonment, or neglect" except for the reporter's name and "any information otherwise made confidential or exempt by law." (Nevertheless, the state had to be ordered by a court to release case records in the case of Rashid Bryant, who died of abuse in 2021, after the Florida Department of Children and Families refused to release the records for more than a year, falsely claiming their investigation was not concluded).[82]

Arizona requires that on request, the DCS must provide "additional DCS information" after it has released the initial report required in the statute.[83] On its website, DCS explains that it releases records for cases of abuse or neglect that led to a child fatality, with redactions "to protect the privacy of crime victims, sources of DCS reports, and innocent parties in a case," unless the prosecuting agency determines that releasing the records will harm an ongoing investigation or criminal prosecution.[84] Oregon releases "reports and records" regarding a child fatality or near fatality, which the Oregon Department of Human Services defines

as "information specific to the fatality or serious physical injury itself, when founded for abuse. . . . Any other CPS information/history outside of the fatality or serious injury in the CPS Assessment is not disclosed."[85]

Other Limitations. Some states have other substantive limitations on what can be released, which sometimes conflict with the goal of learning from these tragic events. For example, Maryland and Michigan prohibit the disclosure of information not related to the department's actions in responding to reports of abuse or neglect.[86] If taken literally, this provision would allow these states to release little about the family's history of abuse or neglect and the maltreatment that caused the fatality. This information's absence could make it hard for an observer to assess the department's previous interactions with the victim's family.

The District of Columbia bans the release of "personal or private information." While preparing a report on child fatalities in the District, I reached out to DC's Child and Family Services Agency for information on child fatalities due to maltreatment. In their response, the agency used this statute often to justify redacting almost all background information on the parents or caregivers.[87]

Information Released Routinely

As discussed earlier, I identified 17 states that release specific information routinely without a request. The information released routinely appears in the form of notifications, case summaries, case reviews, or, in one state, files of the fatality or near-fatality investigation. Table A2 contains a summary of what information each of these states releases without a request and provides a link to the summaries, reviews, or other information provided.

Notifications. Nine states[88] publicly release notifications of child fatalities or near fatalities that are suspected or have been found to be due to maltreatment. Notifications are generally required to be immediate or "prompt," are issued before a fatality or near fatality is confirmed to be due to maltreatment, and are less detailed than case summaries or reviews issued after an investigation.

- Arkansas, Colorado, Pennsylvania, and Wisconsin require public notification of all child fatalities and near fatalities reported to the hotline.

- Florida and Tennessee[89] require public notification of all fatalities (but not near fatalities) that have been reported to the hotline or investigated for abuse or neglect.[90] Nevada notifies the public about a larger group of cases than do the other states. It discloses information not just about children who are reported to have died or nearly died of maltreatment but any child who has been the subject of a maltreatment report who dies or nearly dies of any cause.[91]

- Oregon publishes notifications only of child fatalities (not near fatalities) where maltreatment is suspected and the child is in the Oregon Department of Human Services' custody or the family has had contact with the department in the past year.[92]

- Unlike the other states, Rhode Island provides notifications only after maltreatment has been confirmed or the child is the subject of an open case.[93]

Notifications vary in level of detail. The most minimal notifications include items like basic demographic characteristics, the incident's date, the type of incident, and whether the child was living at home or in foster care. More comprehensive notifications include information about the alleged or determined cause of the fatality or near fatality, whether the family had a history with the CPS, and sometimes details about the extent of the history. (See Table A2 for details on what each state provides.)

Case Information, Summaries, Reviews, or Files. Fourteen states[94] release specific information, summaries, reviews, or files for certain cases without

waiting for a request. Indiana, New Jersey, Texas, Virginia, and West Virginia publish very brief summaries in their annual child maltreatment fatality and near fatality reports. Arizona, Florida, Pennsylvania, and Wisconsin publish case summaries of varying depths. Colorado, Florida, New York, Oregon, Pennsylvania, and Washington publish detailed case reviews by special review teams for specific groups of cases. And Tennessee releases the entire case file for the fatality or near fatality's investigation. Table A2 provides more information about what these states release.

Arizona, Florida, New York, Pennsylvania, and Wisconsin routinely disclose the most comprehensive information on the broadest range of cases compared with the other states, with the caveat that New York seems to hold back reviews of about a quarter of fatality cases. The case summaries and reviews from these states provide an excellent source of information for advocates, legislators, and communities. Colorado, Oregon, and Washington publish comprehensive case reviews but only for cases with prior agency involvement within one to three years of the incident, unless the child was in the custody of (or receiving services from, in the case of Washington) the child welfare agency. (See Table A2.)

Needed Changes to Federal and State Legislation

No child should die or be seriously injured due to abuse or neglect. To prevent future tragic events, the public must know about the conditions that may have contributed to past incidents. Unfortunately, few child welfare agencies voluntarily disclose such details to the public. While it does not guarantee transparency about child fatalities and near fatalities, a good disclosure policy is an essential first step.

Federal Legislation. CAPTA's language is vague and has not been clarified by HHS regulations. CAPTA should be amended to clarify the language and establish parameters for states in interpreting the law. The new language should make clear that states must release findings and information about fatalities and near fatalities, and disclosure must be required rather than simply allowed. The law should prescribe the types of information that can be withheld and when disclosure can be postponed, and it should deny states the option of withholding other information or refusing to release information altogether. It should spell out the findings and information that must be released.[95] It should clarify that the CAPTA language overrides other confidentiality provisions in federal law. It should also require that states notify the public of child fatalities and near fatalities that are reported to child abuse hotlines and accepted for investigation. Without such notifications, legislators, advocates, and the public might not know about incidents that they would otherwise want to ask about.

CAPTA has not been reauthorized since 2010, and recent attempts to reauthorize it have failed. Child welfare is one area in which Congress continues to pass bipartisan legislation, but human services legislation tends to leave many definitions and details to the states. CAPTA already uses assurances in state plans to govern state compliance on other issues as well.

These changes would likely be controversial in the current ideological climate surrounding child welfare. Many leaders and advocates view a focus on child fatalities and serious injuries as an invitation to place more children in foster care and disproportionately focus on parents' risks to children rather than their strengths. It may be more realistic to focus on making changes at the state level, where advocates can take advantage of publicity around tragic events to create interest among legislators in changing the laws.

Features of a Good State Disclosure Policy. A disclosure policy, in compliance with CAPTA, should cover fatalities and near fatalities. It should be mandatory and contain no vague terms, conditions, or exceptions.[96] Permitted redactions should be limited to the names of living children in the family and reporters of maltreatment and (temporarily) any information that would cause specific material harm to a criminal investigation. There should be no prohibition on sharing information deemed to be against the best interests of or harmful to the injured child or

any other child in the household. As HHS recognized in its previous interpretation of the CAPTA public disclosure mandate, the public interest in learning from these severe and tragic cases should trump any concerns about harm to surviving children from disclosing details about the incident.

At a minimum, a disclosure policy should require prompt public notification of all fatalities and near fatalities reported to the hotline and accepted for investigation, along with a documented rationale for not investigating others. The notifications should include the name (for a fatality), age, gender, and city or county of residence of the child; the incident's date; the cause of death if known for a fatality; the type and extent of the injuries for a near fatality; the child's living arrangement, whether with family or in foster care; whether the family had involvement with CPS; a detailed summary of prior reports and actions taken by the department during the past five years; and whether the department or law enforcement is conducting an investigation. There should be no requirement that the historical information be "pertinent to the child abuse or neglect that led to the fatality or near fatality."[97] As discussed above, all prior interaction with the family should be deemed pertinent.

Upon completing the investigation, if it is determined that the fatality resulted from abuse or neglect, the department should be required to release a detailed summary of its investigation. The investigation's full case file, with information redacted as appropriate, should be available to any person upon request.

Conclusion

In conclusion, a study of the policies of 50 states and the District of Columbia toward disclosing information regarding child maltreatment fatalities and near fatalities shows that many fall drastically short of embodying Congress's intent in adding Section 106(b)(2)(B)(x) to CAPTA. Most of these difficulties stem from the deficiencies of the CAPTA language itself and the guidance provided in HHS's CWPM.

While changing CAPTA language would be the most efficient way to enable improvement around the country, a more likely reform is for legislators and child advocates on the state level to modify laws to allow full transparency around these deaths. We cannot make progress in preventing severe and life-threatening child maltreatment unless legislators, advocates, and the public can access comprehensive information about what led to these tragic events.

About the Author

Marie Cohen is a senior project associate at Lives Cut Short. After being a policy analyst and researcher for over a decade, Ms. Cohen was a social worker in the District of Columbia's child welfare system for five years. She then created Child Welfare Monitor, a blog analyzing policy and practice in the child welfare system nationally, and a local blog called Child Welfare Monitor DC. She has served on DC's Citizen Review Panel and Child Fatality Review Team. She holds master's degrees in public affairs and social work.

Appendix

Table A1. State Disclosure Requirements for Child Maltreatment Fatalities and Near Fatalities

State	State Requires Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Allows Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Has No Provision for Disclosure of Certain Information on Child Fatalities or Near Fatalities	State Publishes Notifications of Certain Child Maltreatment Fatalities*	State Publishes Individual Case Summaries, Case Reviews, or Case Files*	State Statute or Policy Concerning Disclosure of Information on Maltreatment Fatalities
Alabama		x				Ala. Code § 26-14-8(c)(12) (2022)
Alaska		x				Alaska Stat. § 47.10.093 (2022)
Arizona	x				x	Ariz. Rev. Stat. § 8-807 (2023)
Arkansas	x			x		Ark. Code Ann. § 12-18-1101–08 (2023); and Ark. Code Ann. § 9-28-120 (2023)
California	x					Cal. Welf. & Inst. Code §10850.4; Cal. Gov. Code § 6252.6; "All County Letter No. 15-81"; and "All County Letter No. 16-109"
Colorado	x			x	x	Colo. Rev. Stat. § 26-1-139 (2022)
Connecticut		x				Conn. Gen. Stat. § 17a- 28(h)(16) (2023)
Delaware	x					16 Del. Code Ann. tit. 16, § 932 (2023)
District of Columbia	x					D.C. Code § 4-1303.31–36 (2002)
Florida	x			x	x	Fla. Stat. 39.202(o) (2024); Fla. Stat. 39.2022 (2023); and Fla. Stat. 39.2015 (2018)
Georgia	x					Ga. Code Ann. § 49-5-41 (2023); and "Public Access to Records in Child Fatality and Near Fatality Cases"
Hawaii		x				Haw. Code R. § 17-1601-6(16)(D) (2024)
Idaho		x				Idaho Admin. Code r. 16.05.01 (2024)
Illinois	x					325 Ill. Comp. Stat. Ann. 5/4.2 (2023)
Indiana	x				x	Ind. Code § 31-33-18-1.5 (2024)

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Table A1. State Disclosure Requirements for Child Maltreatment Fatalities and Near Fatalities (Continued)

State	State Requires Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Allows Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Has No Provision for Disclosure of Certain Information on Child Fatalities or Near Fatalities	State Publishes Notifications of Certain Child Maltreatment Fatalities*	State Publishes Individual Case Summaries, Case Reviews, or Case Files*	State Statute or Policy Concerning Disclosure of Information on Maltreatment Fatalities
Iowa	x					Iowa Code § 235A.15(9)–(11) (2024)
Kansas	x					Kan. Stat. Ann. § 38-2212(g) (2023)
Kentucky		x				Ky. Rev. Stat. Ann. § 620.050(12) (2024)
Louisiana		x				La. Rev. Stat. § 46:56(F)(9(a) (2023)
Maine	x					Me. Rev. Stat. tit. 22, § 4008-A (2023)
Maryland	x					Md. Code Ann., Hum. Servs. § 1-203 (2023)
Massachusetts			x			None found
Michigan	x					Mich. Comp. Laws §722.627c (2005); Mich. Comp. Laws § 722.627d (2005); and Mich. Comp. Laws § 722.622(ff) (2005)
Minnesota	x					Minn. Stat. 260E.35 subd. 7 (2023)
Mississippi		x				Miss. Code Ann. § 43-21-261(19) (2023)
Missouri		x				Mo. Rev. Stat. § 210.150(5) (2021)
Montana			x			None found
Nebraska		x				Neb. Rev. Stat. § 81-3126 (2008)
Nevada	x			x		Nev. Rev. Stat. Ann. § 432B.175 (2013); and MTL # 401
New Hampshire	x					N.H. Rev. Stat. § 126-A:5(XII) (2024)
New Jersey		x			x	N.J. Rev. Stat. § 9:6-8.10a (2023); and "Overview: Screening at New Jersey's State Central Registry"

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Table A1. State Disclosure Requirements for Child Maltreatment Fatalities and Near Fatalities (Continued)

State	State Requires Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Allows Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Has No Provision for Disclosure of Certain Information on Child Fatalities or Near Fatalities	State Publishes Notifications of Certain Child Maltreatment Fatalities*	State Publishes Individual Case Summaries, Case Reviews, or Case Files*	State Statute or Policy Concerning Disclosure of Information on Maltreatment Fatalities
New Mexico	x					N.M. Stat. Ann. § 32A-4-33.1 (2024)
New York		x			x	N.Y. Soc. Serv. Law § 20(5) (2023); and N.Y. Soc. Serv. Law § 422-A (2023)
North Carolina	x					N.C. Gen. Stat. § 7B-2902 (2023)
North Dakota			x			None found
Ohio	x					Ohio Rev. Code Ann. § 5153.171 (2000); and Ohio Admin. Code 5101:2-33-21(I)–(J) (2020)
Oklahoma	x					Okla. Stat. tit. 10A, § 1-6-105 (2009)
Oregon	x			x	x	Or. Rev. Stat. § 419B.035 (2022); and Or. Rev. Stat § 418.806–16 (2023)
Pennsylvania	x			x	x	23 Pa., Cons.Stat. § 6343 (2014)
Rhode Island	x			x		72 R.I. Gen. Laws § 42-72-8 (2010); and "Public Disclosure of Child Fatality and Near Fatality Information"
South Carolina		x				S.C. Code Ann. § 63-7-1990(H) (2023)
South Dakota	x					S.D. Codified Laws § 26-8A-13 (2006)
Tennessee	x			x	x	Tenn. Code Ann. § 37-5-107(4) (2023)
Texas	x				x	Tex. Fam. Code Ann. § 261.203 (2021)
Utah	x					Utah Code Ann. § 26B-1-507(6) (2023); and "080.9 Public Disclosure of Information on Fatality and Near Fatalities Related to Abuse/Neglect"

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Table A1. State Disclosure Requirements for Child Maltreatment Fatalities and Near Fatalities (Continued)

State	State Requires Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Allows Disclosure of Certain Information on Child Maltreatment Fatalities or Near Fatalities	State Has No Provision for Disclosure of Certain Information on Child Fatalities or Near Fatalities	State Publishes Notifications of Certain Child Maltreatment Fatalities*	State Publishes Individual Case Summaries, Case Reviews, or Case Files*	State Statute or Policy Concerning Disclosure of Information on Maltreatment Fatalities
Vermont	x					"303 Fatality and Near Fatality Public Disclosure"
Virginia	x				x	22 Va. Admin. Code § 40-910-100 (2018)
Washington	x				x	Wash. Rev. Code § 74.13.500 (1999)
West Virginia	x				x	W. Va. Code § 49-5-001 (2023)
Wisconsin	x			x	x	Wis. Stat. § 48.981(7)(cr) (2009)
Wyoming			x			None found

Note: * See Table A2 for information about and links to state notifications, case summaries, case reviews, and case files.
Sources other than legislation included in the table: Gregory E. Rose, "All County Letter No. 15-81," November 1, 2015, https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2015/15-81.pdf; Gregory E. Rose, "All County Letter No. 16-109," December 23, 2016, https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-109.pdf; Georgia Division of Family and Children Services Child Welfare Policy Manual, "Public Access to Records in Child Fatality and Near Fatality Cases," June 2021, http://odis.dhs.ga.gov/ViewDocument.aspx?docId=3006726&verId=1; Domonique Rice, "MTL # 0401," email to Timothy Burch, Cindy Pitlock, Betsey Crumrine, Laurie Jackson, and Amber Howell, December 3, 2021, 3, https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Policies/CW/MTL_Policy_0401(1).pdf; New Jersey Department of Children and Families Policy Manual, "Overview: Screening at New Jersey's State Central Registry," July 8, 2005, https://dcfpolicy.nj.gov/api/policy/download/CPP-II-A-1-100.pdf; Rhode Island Department of Children, Youth and Families, "Public Disclosure of Child Fatality and Near Fatality Information," September 1, 2023, https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures; Utah Department of Health & Human Services, Child & Family Services, "080.9 Public Disclosure of Information on Fatality and Near Fatalities Related to Abuse/Neglect," in Administrative Guidelines, September 2024, 128, https://public.powerdms.com/UTAHDHHS/documents/274907; and Vermont Department for Children and Families, "Fatality and Near Fatality Public Disclosure," in Family Services Policy Manual, September 30, 2021, https://outside.vermont.gov/dept/DCF/Shared%20Documents/FSD/Policies/Policy303.pdf.

Table A2. Summary of the Information States Release Without a Request

State	Cases Covered	Information	Where the Information Is Posted
Arizona	Cases include fatalities and near fatalities determined to be caused by abuse or neglect.	**Preliminary reports** include whether the incident was a fatality or near fatality; the name of the victim (if a fatality); relevant dates; the county and general location of the residence; the alleged perpetrator's name, age, and location; the circumstances indicating the incident was caused by abuse or neglect; a detailed synopsis of prior reports or cases of abuse, abandonment, or neglect involving the child or the alleged perpetrator and of the actions taken or determinations made by the department in response to these reports or cases; and the Arizona Department of Child Services' actions in response to the incident. **Summary reports** provide (for children living at home) the victim's age and sex; the dates of the incident, the notification, and the determination that the incident resulted from abuse or neglect; the county and general location of the incident; the alleged perpetrator's name, age, and general location; the circumstances that indicate the fatality or near fatality was caused by abuse or neglect; a brief description of any past reports or cases involving the child or the alleged perpetrator; the Arizona Department of Child Services' actions in response to the alleged fatality; actions taken regarding the child or other children in the home; and whether the agency is providing or intends to provide any direct services or referrals to the family. If the victim was in foster care, the agency will provide the name of the licensing agency, the placement's licensing history, a summary of all violations by the licensee or its employees, and "any other actions by the licensee or an employee of the licensee that constitute a substantial failure to protect and promote the health, safety and welfare of a child." **Source**: Ari. Rev. Stat. § 8-307.01 (2023).	Arizona Department of Child Safety, "Child Fatalities / Near Fatalities Information Releases," https://dcs.az.gov/news-reports/child-fatalities-near-fatalities-information-releases.
Arkansas	Cases include fatalities and near fatalities reported to the hotline.	**Notifications** (which are posted within 72 hours of receiving a report from the hotline) include the date the incident was reported; the name of the child (if a fatality); the child's date of birth, age, gender, and race; the date of the incident; the allegation or preliminary cause; the county where the fatality or near fatality took place; whether the child was living with a relative or nonrelative; whether the alleged offender is a relative or nonrelative; the agency conducting the investigation; and whether the victim had prior history with the Department of Human Services. **Source**: Ark. Code Ann. § 9-28-20 (2023).	Arkansas Department of Human Services, "State Child Fatality List," https://humanservices.arkansas.gov/data-reports/state-child-fatality-list.

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Table A2. Summary of the Information States Release Without a Request (Continued)

State	Cases Covered	Information	Where the Information Is Posted
Colorado	Cases include fatalities, near fatalities, and egregious incidents in which maltreatment is suspected but not confirmed.	**Notifications** (which are posted within 24 hours plus three business days of the county department becoming aware of the incident) contain the child's gender and age, the type of incident (egregious, near fatal, or fatal), whether the child was living at home or in foster care, whether there was past involvement with the Colorado Department of Human Services, the date the county notified the Colorado Department of Human Services, the date the notification was posted, the county investigation's outcome, and whether there will be a review by the Colorado Department of Human Services' Child Fatality Review Team.	Colorado Department of Human Services, "Child Fatality Reviews," https://cdhs.colorado.gov/child-fatality-reviews. See also Colorado Department of Human Services, "Incident of Egregious Child Maltreatment, Near Fatality, and Fatality Review Process Timeline," https://drive.google.com/file/d/0B9eaXW7_92zSaWVkdjdweG1UR1E/view.
	Cases include incidents of egregious abuse or neglect against a child, a near fatality, or a child fatality that involves a suspicion of abuse or neglect, but only when the child or family had previous contact with the agency within three years prior to the incident.	**Case reviews** include an executive summary of an internal report, including the age, race, and sex of the victim and caregivers; risk and contributing factors; a summary of systemic strengths and gaps; a review of agency compliance with statutes and regulations; and recommendations.	
Florida	Cases include all fatalities reported to the hotline.	**Notifications** (which have no time requirement) provide the county, the child's age, and the date of death; causal factors (if known); the family's prior involvement with the Florida Department of Children and Families in the 12 months before the incident; provider involvement (if any); and a brief summary of circumstances and causes, if known. **Case summaries** give a detailed description of circumstances surrounding the death, current and prior involvement with the Florida Department of Children and Families, and the agency's response to the fatality.	On the "Child Fatality Prevention" page, click "Statewide Data." The page will show variables such as year, causal factors, and age range. Select a year and filter the other variables, then click "View Statewide Results." Florida Department of Children and Families, "Child Fatality Prevention," https://myflfamilies.com/childfatality.
	Cases include child deaths reported to the Florida Department of Children and Families if any child in the family was the subject of a verified report of suspected abuse or neglect during the 12 months preceding the event.	**Critical Incident Rapid Response Team reports** include the family's history with the Florida Department of Children and Families, a practice assessment, an organizational assessment, an assessment of the services available, and a response from the private agency involved.	On the "Child Fatality Prevention" page, click on "CIRRT Data," then "View CIRRT Results." Florida Department of Children and Families, "Child Fatality Prevention," https://myflfamilies.com/childfatality.

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Table A2. Summary of the Information States Release Without a Request (Continued)

State	Cases Covered	Information	Where the Information Is Posted
Indiana	Cases include fatalities determined to be caused by abuse or neglect.	**Brief case summaries** include the age and sex of the victim, the Indiana Department of Children and Families' involvement, the number of previous substantiated and unsubstantiated assessments, information about the perpetrator, the perpetrator's history of substantiated assessments, and the circumstances of the incident.	Indiana Department of Child Services, *2022 Annual Report of Child Abuse & Neglect Fatalities in Indiana*, December 2023, https://www.in.gov/dcs/files/2022_Annual_Report_of_Child_Abuse_and_Neglect_Fatalities_in_Indiana.pdf.
Nevada	Cases include any reports "received regarding a child fatality or near fatality and that child has been the subject of a report of possible abuse or neglect at any time prior to or including the report of the fatality or near fatality." **Source**: Domonique Rice, "MTL # 0401," email to Timothy Burch, Cindy Pitlock, Betsey Crumrine, Laurie Jackson, and Amber Howell, December 3, 2021, 3, https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Policies/CW/MTL_Policy_0401(1).pdf.	**Notifications** (which must be submitted by the local child welfare agency to the state agency within five business days of the fatality or near fatality for review and posting) provide information on whether the incident was a fatality or near fatality, the date of the incident and when the agency was notified, the child's location during the incident, a summary of the report of abuse or neglect, the child's date of birth, the cause of the fatality or near fatality (if it has been determined), and a description of past interactions between the agency and the child, family, or household, including whether there was an open case at the time of the incident.	Nevada Department of Health & Human Services, Division of Child & Family Services, "Fatality Disclosures," https://dcfs.nv.gov/Programs/CWS/CPS/ChildFatalities/FatalityDisclosures.
New Jersey	Cases include child fatalities resulting from abuse or neglect.	**Brief case summaries** provide the victim's identifying characteristics; the nature of the incident; the cause of death; information about the perpetrator, including their relationship to the victim; and the family's history with (including last contact with) the Division of Child Protection and Permanency.	New Jersey Department of Children and Families, "Child Fatalities," https://www.nj.gov/dcf/reporting/fatalities.
New York	Cases include child fatalities that are reported to the hotline and investigated when it is determined that disclosure would not harm the child's surviving siblings or other children in the household.	**Case reviews** include a description of the investigation and findings by the local agency, including the adequacy of the local investigation; the local agency's response to the fatality; the family's history with Child Protective Services within three years of the fatality; and recommendations by the New York State Office of Children and Family Services. They must be issued within six months of the local investigation.	New York State Office of Children and Family Services, "Child Fatality Reports," https://ocfs.ny.gov/reports/cfrp.

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Table A2. Summary of the Information States Release Without a Request (Continued)

State	Cases Covered	Information	Where the Information Is Posted
Oregon	Cases include child fatalities if the Oregon Department of Human Services reasonably believes the death was the result of child maltreatment and the child was in the Oregon Department of Human Services' custody or the family had contact with the department within the past year.	**Notifications** must be made immediately after the department assigns a Critical Incident Review team, which must occur either 10 days after the department becomes aware of a fatality that it reasonably believes is a result of abuse or neglect or seven days after it initiates an investigation of such a fatality, whichever comes first. Notifications provide the date of the incident, the deceased child's age, whether the child was in the department's custody, whether there was an open investigation at the time of the fatality, the date the Critical Incident Review Team was assigned, and the final report's due date. **Case reviews** have a description of the incident and the investigation, relevant prior reports regarding the child's caregivers and the agency's response, the Critical Incident Review Team's findings regarding action and inaction by child welfare and law enforcement agencies, and recommendations for system improvement. **Source**: Or. Rev. Stat. § 418.806–16 (2023).	Oregon Department of Human Services, "ODHS Child Fatality Review," https://www.oregon.gov/odhs/child-fatality-review/pages/default.aspx.
Pennsylvania	Cases include every fatality or near-fatality report received through the statewide child abuse and neglect hotline.	**Notifications** (which are posted within a week of receiving the report through the hotline) provide the child's age and gender, the date of the report, whether the incident was a fatality or a near fatality, and the county that will be convening a review team. **Case reviews** provide the name of the child (if a fatality) and their date of birth, a summary of the incident, a review of agency involvement before the incident, a summary of the county review team's findings and recommendations, and the Pennsylvania Department of Human Services' findings on the county's strengths and weaknesses, areas of statutory and regulatory noncompliance, and practice recommendations.	Pennsylvania Department of Human Services, "Child Fatality/Near Fatality Reports," https://www.pa.gov/en/agencies/dhs/resources/data-reports/child-fatality-near-fatality-reports.html. For a description of the review process, see Pennsylvania Department of Human Services, "Child Fatality/Near Fatality Reports," https://www.pa.gov/en/agencies/dhs/resources/data-reports/about-child-fatality-near-fatality-reports.html.
	Cases include substantiated child abuse and neglect fatalities.	**Quarterly case summaries** provide the child's age and gender, the date of the fatality, the causes and circumstances of death, the agency's response, information on any criminal investigation, and whether the family was known to the agency.	Pennsylvania Department of Human Services, "Quarterly Summaries of Child Fatalities/Near Fatalities," https://www.pa.gov/en/agencies/dhs/resources/data-reports/quarterly-summaries-child-abuse.html.

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Table A2. Summary of the Information States Release Without a Request (Continued)

State	Cases Covered	Information	Where the Information Is Posted
Rhode Island	Cases include those in which the child is the subject of an open case or child fatalities or near fatalities that are confirmed as being due to maltreatment.	**Notifications** (which are initiated within 48 hours of the department's public information officer receiving "immediate" notice from the division director) include the child's age; the date of the incident; whether the Office of the Child Advocate has been informed, as required by law; and whether the child was involved with the Rhode Island Department of Children Youth and Families at the time of the incident. **Source**: Rhode Island Department of Children, Youth and Families, "Public Disclosure of Child Fatality and Near Fatality Information," https://datadcyf.ri.gov/policyregs/public_disclosure_of_child_fatality_and_near_fatality_information.htm.	Rhode Island Department of Children, Youth and Families, "News and Updates," https://dcyf.ri.gov/about-us/news-and-updates.
Tennessee	Cases include the death of any child in the Tennessee Department of Children's Services' custody at the time of the incident, the death of any child that is being investigated as an allegation of abuse or neglect, and the near fatality of a child (who is in the department's custody or not) if an abuse or neglect allegation is substantiated and a physician determines the child was in a serious or critical condition. **Source**: Tennessee Department of Children's Services, "2024 Deaths," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn/current-year/deaths.html.	**Notifications** (which are posted within two business days of the child's death) detail whether the child was in agency custody, the child's age and gender, and if there was any previous history with the Tennessee Department of Children's Services. **Information released following closure of the investigation** includes the case disposition, whether the case meets criteria for a child death review, and the full case file. **Source**: Tennessee Department of Children's Services, "Methodology and Parameters," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn/methodology-and-parameters.html.	Tennessee Department of Children's Services, "Child Death & Near Death Public Notifications," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn.html; and Tennessee Department of Children's Services, "Current Year," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn/current-year.html.
Texas	Cases include any child fatality that is confirmed to be caused by abuse or neglect and that occurred when the child had an open investigation, in-home case, or foster care case.	**Brief case summaries** are two to three sentences detailing the reasons for the case being open and the date and circumstances of death.	Texas Department of Family and Protective Services, *Fiscal Year 2023: Maltreatment Fatalities and Near Fatalities Annual Report*, March 2024, 50–53, https://www.dfps.texas.gov/About_DFPS/Reports_and_Presentations/PEI/documents/2024/2024-03-20_Child_Maltreatment_Fatalities_and_Near_Fatalities_Annual_Report.pdf.

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Table A2. Summary of the Information States Release Without a Request (Continued)

State	Cases Covered	Information	Where the Information Is Posted
Virginia	Cases include founded and unfounded child death investigations.	**Brief case summaries** are a row in a table that includes locality and date of death; the child's date of birth, age, sex, and race; the abuser's relationship to the child; the abuse type; whether there was previous history with Child Protective Services; and a summary of circumstances.	Virginia Department of Social Services, Child Protective Services Program, *Child Maltreatment Death Investigations: In Virginia During State Fiscal Year 2023*, June 2024, 18–27, https://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2024/Child_Maltreatment_Death__Inv_SFY2023_REPORT_final.pdf.
Washington	Cases include fatalities that are suspected to be caused by child abuse or neglect of any minor who was in the care of or receiving services from the Washington Department of Children, Youth & Families; had been in the department's custody; or had been receiving its services within a year of the death. This also covers near-fatality cases in which the child is in the care of or receiving services from the department or who has been in the care of or received services from the department within three months preceding the near fatality or was the subject of an investigation for possible abuse or neglect. The Washington Department of Children, Youth & Families may conduct a review at its discretion (or at the discretion of the Office of the Family and Children's Ombuds) for near-fatality cases in which the child had been in the care of or received services from the department within three to 12 months preceding the near fatality. **Source**: Wash. Rev. Code § 74.13.640 (2009).	**Executive Child Fatality Reviews** contain a case overview with historical data on the department's interactions with the family, an account of the panel's discussion, and recommendations.	Washington State Department of Children, Youth & Families, Office of Innovation, Alignment and Accountability, "Executive Child Fatality Reviews," https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality/child-welfare.

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Table A2. Summary of the Information States Release Without a Request (Continued)

State	Cases Covered	Information	Where the Information Is Posted
West Virginia	Cases include fatalities and near fatalities of children known to the agency in the previous 12 months.	**Brief case summaries** are one line in an annual table including the child's initials; the county; the date of the incident; the gender, age, race, and ethnicity of the child; the type of maltreatment; a summary of the incident; and the cause of the fatality or near fatality.	West Virginia Department of Health & Human Resources, Bureau for Social Services, Office of Quality Initiatives, *Critical Incident Annual Report: Child Fatalities and Near Fatalities Due to Abuse/Neglect*, December 2022, 18–19, https://dhhr.wv.gov/bss/reports/Documents/FFY 2022 BSS Critical Incident Report.pdf.
Wisconsin	Cases include child deaths, serious injuries, or egregious incidents when maltreatment is suspected.	**Notifications** (which are required within four working days of determining that a qualifying incident has occurred) provide the child's age, the date of the incident, the type of incident (maltreatment-related death, serious injury, or egregious incident), whether the child was residing at home or in foster care, and whether the department is conducting a review of the incident. **Three-month reports** include the following for children living at home: the child's age, gender, race, and any special needs that are relevant to the incident; the date of the incident; a description of the incident, including the suspected cause of the serious injury, death, or egregious abuse or neglect; the agency's findings; whether criminal charges were filed and against whom; the status of the criminal investigation; a description of the family; the services being provided at the time of the incident; the date of the last contact with the family; a summary of all involvement in services by the child's parents or the alleged maltreater in the previous five years; and agency actions since the incident. For children who were living in an out-of-home placement, three-month reports include the child's age, gender, race, and any special needs relevant to the incident; a description of the out-of-home placement, including the basis for the decision to place the child in that placement; a description of all other persons residing in the out-of-home placement; the licensing history of the out-of-home placement, including a summary of all licensing violations and other actions constituting a failure to protect and promote the health, safety, or welfare of a child; the date of the incident and the suspected cause of the serious injury, death, or egregious abuse or neglect; and the agency's findings. **Six-month reports** cover actions taken by the agency in response to the incident, any changes in policy or practice that have been made, and recommendations for any further changes in policy, practice, rules, or statutes if not included in the three-month report. **Source**: Wis. Stat. § 48.981 (2009).	Wisconsin Department of Children and Families, "Public Disclosure of CPS Critical (Egregious) Incidents," https://dcf.wisconsin.gov/cps/incidents.

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Compilation of Listed Sources: Ari. Rev. Stat. § 8-807.01 (2023); Arizona Department of Child Safety, "Child Fatalities / Near Fatalities Information Releases," https://dcs.az.gov/news-reports/child-fatalities-near-fatalities-information-releases; Ark. Code Ann. § 9-28-20 (2023); Arkansas Department of Human Services, "State Child Fatality List," https://humanservices.arkansas.gov/data-reports/state-child-fatality-list; Colorado Department of Human Services, "Child Fatality Reviews," https://cdhs.colorado.gov/child-fatality-reviews; Colorado Department of Human Services, "Incident of Egregious Child Maltreatment, Near Fatality, and Fatality Review Process Timeline," https://drive.google.com/file/d/0B9eaXW7_92zSaWVkdjdweG1UR1E/view; Florida Department of Children and Families, "Child Fatality Prevention," https://myflfamilies.com/childfatality; Domonique Rice, "MTL # 0401," email to Timothy Burch, Cindy Pitlock, Betsey Crumrine, Laurie Jackson, and Amber Howell, December 3, 2021, 3, https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Policies/CW/MTL_Policy_0401(1).pdf; Nevada Department of Health & Human Services, Division of Child & Family Services, "Fatality Disclosures," https://dcfs.nv.gov/Programs/CWS/CPS/ChildFatalities/FatalityDisclosures; New Jersey Department of Children and Families, "Child Fatalities," https://www.nj.gov/dcf/reporting/fatalities; New York Office of Children and Family Services, "Child Fatality Reports," https://ocfs.ny.gov/reports/cfrp; Oregon Department of Human Services, "ODHS Child Fatality Review," https://www.oregon.gov/odhs/child-fatality-review/pages/default.aspx; Or. Rev. Stat. § 418.806–16 (2023); Pennsylvania Department of Human Services, "Child Fatality/Near Fatality Reports," https://www.pa.gov/en/agencies/dhs/resources/data-reports/child-fatality-near-fatality-reports.html; Pennsylvania Department of Human Services, "Quarterly Summaries of Child Fatalities/Near Fatalities," https://www.pa.gov/en/agencies/dhs/resources/data-reports/quarterly-summaries-child-abuse.html; Rhode Island Department of Children, Youth and Families, "Public Disclosure of Child Fatality and Near Fatality Information," https://datadcyf.ri.gov/policyregs/public_disclosure_of_child_fatality_and_near_fatality_information.htm; Rhode Island Department of Children, Youth and Families, "News and Updates," https://dcyf.ri.gov/about-us/news-and-updates; Tennessee Department of Children's Services, "2024 Deaths," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn/current-year/deaths.html; Tennessee Department of Children's Services, "Methodology and Parameters," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn/methodology-and-parameters.html; Tennessee Department of Children's Services, "Child Death & Near Death Public Notifications," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn.html; Tennessee Department of Children's Services, "Current Year," https://www.tn.gov/dcs/program-areas/child-safety/cdnd-pn/current-year.html; Texas Department of Family and Protective Services, *Fiscal Year 2022: Maltreatment Fatalities and Near Fatalities Annual Report*, March 1, 2023, 50–53, https://www.dfps.texas.gov/About_DFPS/Reports_and_Presentations/PEI/documents/2023/2023-03-01_Child_Maltreatment_Fatalities_and_Near_Fatalities_Annual; Virginia Department of Social Services, Child Protective Services Program, *Child Maltreatment Death Investigations: In Virginia During State Fiscal Year 2022*, June 2023, 17–27, https://www.dss.virginia.gov/files/about/reports/children/cps/all_other/2023/Final_Child_Maltreatment_Death_Investigations_ SFY2022 _08222023.pdf; Wash. Rev. Code § 74.13.640 (2009); Washington State Department of Children, Youth & Families, Office of Innovation, Alignment and Accountability, "Executive Child Fatality Reviews," https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality/child-welfare; West Virginia Department of Health & Human Resources, Bureau for Social Services, Office of Quality Initiatives, *Critical Incident Annual Report: Child Fatalities and Near Fatalities Due to Abuse/Neglect*, December 2022, 18–19, https://dhhr.wv.gov/bss/reports/Documents/FFY 2022 BSS Critical Incident Report.pdf; Wis. Stat. § 48.981 (2009); and Wisconsin Department of Children and Families, "Public Disclosure of CPS Critical (Egregious) Incidents," https://dcf.wisconsin.gov/cps/incidents.

Notes

1. Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.: An Evaluation of Public Disclosure Practices About Child Abuse or Neglect Fatalities or Near Fatalities, with State Rankings*, 2012, 14, https://www.firststar.org/wp-content/uploads/2015/02/StateSecrecy2ndEdition_Final.pdf.

2. See Marie Cohen, "A Jumble of Standards: How State and Federal Authorities Have Underestimated Child Maltreatment Fatalities," American Enterprise Institute, May 9, 2024, https://www.aei.org/research-products/report/a-jumble-of-standards-how-state-and-federal-authorities-have-underestimated-child-maltreatment-fatalities. See also Teri Covington and Abby Collier, *Child Maltreatment Fatality Reviews: Learning Together to Improve Systems That Protect Children and Prevent Maltreatment*, National Center for Fatality Review and Prevention and Within Our Reach, September 2018, https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/CAN_Guidance.pdf; US Government Accountability Office, *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention*, July 2011, https://www.gao.gov/products/gao-11-599; Patricia G. Schnitzer et al., "Public Health Surveillance of Fatal Child Maltreatment: Analysis of 3 State Programs," *American Journal of Public Health* 98, no. 2 (February 2008): 296–303, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2376893; M. E. Herman-Giddens et al., "Underascertainment of Child Abuse Mortality in the United States," *JAMA* 282, no. 5 (August 1999): 463–67, https://pubmed.ncbi.nlm.nih.gov/10442662; and Tessa L. Crume et al., "Underascertainment of Child Maltreatment Fatalities by Death Certificates, 1990–1998," *Pediatrics* 110, no. 2 pt. 1 (August 2002): 18, https://pubmed.ncbi.nlm.nih.gov/12165617.

3. Commission to Eliminate Child Abuse and Neglect Fatalities, *Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities*, 2016, 35n14, https://www.acf.hhs.gov/sites/default/files/documents/cb/cecanf_final_report.pdf.

4. For the 2008 report, see Children's Advocacy Institute, *State Secrecy and Child Deaths in the U.S.: An Evaluation of Public Disclosure Practices About Child Abuse or Neglect Fatalities or Near Fatalities, with State Rankings*, April 1, 2008, https://digital.sandiego.edu/law_cai_spec/17. For the 2012 report, see Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S*, 2012.

5. Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.*, 2012, 6.

6. The chronology to this point is based on Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.*, 2012, 19–21.

7. Commission to Eliminate Child Abuse and Neglect Fatalities, *Within Our Reach*.

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10. Futures Without Violence Policy Center, "Child Abuse Prevention and Treatment Act," https://policy.futureswithoutviolence.org/resource_center/child-abuse-prevention-and-treatment-act-capta.

11. upEND Movement, "UpEND: We Can't Reform a Punishment System. We Must Imagine and Invest in Care and Healing.," https://upendmovement.org/wp-content/uploads/2023/02/upEND-one-page-2023.pdf.

12. Harfield et al., *Steps Forward*.

13. Within Our Reach, website, https://www.social-current.org/engage/within-our-reach.

14. Naomi Schaefer Riley et al., "What Child Protection Is For," American Enterprise Institute, September 1, 2021, https://www.aei.org/research-products/report/what-child-protection-is-for.

15. Lives Cut Short, website, https://livescutshort.org.

16. See the US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "Child Abuse Prevention and Treatment Act," February 6, 2019, www.acf.hhs.gov/cb/law-regulation/child-abuse-prevention-and-treatment-act-capta.

17. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "Child Abuse Prevention and Treatment Act."

18. Grants to States for Child Abuse or Neglect Prevention and Treatment Programs, 42 U.S.C. § 5106a (2017).

19. Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.*, 2012, 15.

20. Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.*, 2012.

21. Child Abuse Prevention and Treatment and Adoption Reform, 42 U.S.C. § 51016a(b)(4)(A) (2017).

22. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," in Child Welfare Policy Manual, https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=68.

23. Children's Advocacy Institute, "Comments in Response to ACF's Notice for Public Comment on the Child Abuse Prevention and Treatment Act (CAPTA)," June 26, 2015, 7, http://www.caichildlaw.org/Misc/CAI_Comments_CWPM_CAPTA.pdf.

24. Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.*, 2012.

25. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," answer to question 6.

26. Children's Advocacy Institute, "Comments in Response to ACF's Notice for Public Comment on the Child Abuse Prevention and Treatment Act (CAPTA)," 7.

27. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," answer to question 8.

28. Children's Advocacy Institute, "Comments in Response to ACF's Notice for Public Comment on the Child Abuse Prevention and Treatment Act (CAPTA)," 7.

29. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," answer to question 8.

30. Children's Advocacy Institute, "Comments in Response to ACF's Notice for Public Comment on the Child Abuse Prevention and Treatment Act (CAPTA)," 4–5.

31. For further discussion, see Marie Cohen, "Chronic Maltreatment: A Blind Spot for Child Welfare," Child Welfare Monitor, January 3, 2023, https://childwelfaremonitor.org/2023/01/03/chronic-maltreatment-a-blind-spot-for-child-welfare.

32. Children's Advocacy Institute, "Comments in Response to ACF's Notice for Public Comment on the Child Abuse Prevention and Treatment Act (CAPTA)," 5–7.

33. The jurisdictions are Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

34. Washington's policy regarding the release of information about near fatalities is much more restrictive than its policy regarding the release of information about fatalities.

35. Wash. Rev. Code § 74.13.500 (1999).

36. The 13 states are Alabama, Alaska, Connecticut, Hawaii, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Jersey, New York, and South Carolina.

37. Most states that require or allow disclosing information about child maltreatment fatalities and near fatalities have the same disclosure policy for both. Four states have different policies for the two groups. Among those states, Florida and Michigan allow rather than require disclosing information about near fatalities, Florida makes information on near fatalities more difficult to obtain, and Washington imposes more conditions on releasing information about near fatalities. California has complex requirements for each category of cases based on multiple laws and regulations modifying previous requirements. In the end, the latest guidance from the

California Department of Social Services shows that the requirements for what must be released for a near fatality are ultimately the same as what must be released for a fatality, but the agency is given more time to release the information. See Gregory E. Rose, "All County Letter No. 16-109," December 23, 2016, https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2016/16-109.pdf.

38. The 26 states are Alabama, Alaska, Arizona, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Minnesota, Mississippi, New Hampshire, New York, Ohio, Oregon, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Washington, and West Virginia. Ohio requires disclosure in cases of suspected maltreatment, but agency policy requires confirmed maltreatment for disclosure.

39. Grants to States for Child Abuse or Neglect Prevention and Treatment Programs, 42 U.S.C. § 5106a (2017).

40. Iowa Code § 235A.15.9 (2023); and Tex. Fam. Code § 261.203(b) (2023).

41. Arizona Department of Child Safety, "Child Fatalities / Near Fatalities Information Releases," https://dcs.az.gov/news-reports/child-fatalities-near-fatalities-information-releases.

42. Ind. Code § 31-33-18-1.5 (2024).

43. Minn. Stat. § 260E.35 (2023).

44. La. Rev. Stat. § 46:56 (2023).

45. The 12 jurisdictions are Colorado, the District of Columbia, Florida, Hawaii, Maryland, Michigan, Nebraska, Nevada, New Mexico, Pennsylvania, Virginia, and Wisconsin.

46. Fla. Stat. § 39.2022 (2023); Haw. Code R. § 17-1601-6 (2024); Md. Code Ann., Hum. Servs. § 1-203 (2023); and 22 Va. Admin. Code § 40-910-100 (2024).

47. The District of Columbia requires the disclosure of "findings and information related to a child fatality or near fatality," which suggests that any event that was investigated would be open for disclosure. D.C. Code § 4-1303.32 (2002).

48. Colo. Rev. Stat. § 26-1-139 (2022).

49. N.M. Stat. Ann. § 32A:4-33.1 (2023); and Wis. Stat. § 48.981 (2009).

50. Pa. Cons. Stat. § 6340(c) (2023).

51. Mich. Comp. Laws § 722.627c (2005).

52. Domonique Rice, "MTL # 0401," email to Timothy Burch, Cindy Pitlock, Betsey Crumrine, Laurie Jackson, and Amber Howell, December 3, 2021, 3, https://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Policies/CW/MTL_Policy_0401(1).pdf.

53. Idaho Admin. Code r. 16.05.01.210 (2024).

54. Mo. Rev. Stat. § 201.150 (2021).

55. Neb. Rev. Stat. § 81-3126 (2008).

56. These jurisdictions are Arizona, Arkansas, California, the District of Columbia, Georgia, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.

57. The six jurisdictions are Arizona, California, Kansas, Oklahoma, Texas, and Wisconsin.

58. The 14 states are Alabama, Alaska, Colorado, Connecticut, Florida, Hawaii, Kentucky, Louisiana, Michigan, Missouri, New, Oregon, South Dakota, Washington, and West Virginia. Colorado requires releasing "findings or information" and specifies that the child's age, gender, and race or ethnicity should be released. Colo. Rev. Stat. § 26-1-139 (2022).

59. The nine states are Arizona, Arkansas, Colorado, Maryland, New Hampshire, New York, Ohio, Oklahoma, and Pennsylvania.

60. Mich. Comp. Laws § 722.622(ff)(i) (2005).

61. The three additional states are Alaska (if the disclosure would harm the child), Maryland, and New Hampshire.

62. Georgia bans releasing the name of "any parent or other person legally responsible" for the victim or any member of the household of the alleged victim, provided that such person is not under investigation for the reported child abuse or neglect. See Ga. Code Ann. § 49-5-41 (2022). Colorado, Maine, Maryland, Nevada, New York, and Wisconsin exclude from disclosure any member of the victim's family or household. Maine, Maryland, and New York exclude disclosure of the parent or other person legally responsible for the child. Wisconsin bars disclosure of the name of the victim's caregiver. See Wis. Stat. § 48.981 (2009). Maryland and Wisconsin

explicitly shield the alleged perpetrator from disclosure and do not provide for disclosure of the name or identifying information for an individual who is confirmed by Child Protective Services as the maltreatment perpetrator or is found guilty in court. See Md. Code Ann., Hum. Servs. § 1-203 (2023); and Wis. Stat. § 48.981 (2009). Michigan forbids the release of identifying information for any individual in the agency record. See Mich. Comp. Laws § 722.622 (2005).

63. The eight states are California, Florida, Georgia, Iowa, New Jersey, New Mexico, Oklahoma, and Texas.

64. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," answer to question 8.

65. The 15 jurisdictions are Arizona, Arkansas, California, Connecticut, the District of Columbia, Georgia, Illinois, Iowa, New Mexico, Nebraska, Nevada, North Carolina, Ohio, Rhode Island, and Virginia.

66. Colo. Rev. Stat § 26-1-139 (2022); Md. Code Ann., Hum. Servs. § 1-203 (2023); 12 Pa., Cons. Stat. § 6343c. (2014); and S.C. Code Ann. § 63-7-940 (2023).

67. 12 Pa., Cons. Stat. § 6343c(4) (2014).

68. In Kansas, when a person requests records of a child who died or nearly died of abuse or neglect, "the secretary . . . may file a motion requesting the court to prevent disclosure of such record or report, or any select proportion thereof. . . . If such motion is filed, the court shall consider the effect such disclosure may have upon an ongoing criminal investigation, a pending prosecution, or the privacy of the child, if living, or the child's siblings, parents or guardians, and the public's interest in the disclosure of such records or reports." Kan. Stat. Ann. § 38-2212 (2023).

69. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," answer to question 8.

70. The 18 jurisdictions are Colorado, the District of Columbia, Georgia, Illinois, Iowa, Maine, Michigan, Nebraska, New Hampshire, New Jersey, New York, North Carolina, Ohio, Rhode Island, South Carolina, Vermont, Virginia, and Washington.

71. These states are New York, North Carolina, Ohio, and South Carolina.

72. For example, Nebraska's language reads, "The chief executive officer . . . may disclose information regarding child abuse or neglect and the investigation of and any services related to the child abuse and neglect if the chief executive officer or director determines that such disclosure is not contrary to the best interests of the child, the child's siblings, or other children in the household." Neb. Rev. Stat. § 81-3126 (2008).

73. N.Y. Soc. Serv Law § 422-A (2023); and Me. Rev. Stat. tit. 22, § 4032 (2023).

74. N.Y. Soc. Serv Law § 422-A (2023).

75. New York State Office of Children and Family Services, "Child Fatality Reports," https://ocfs.ny.gov/reports/cfrp.

76. New York State Office of Children and Family Services, "Child Fatality Reports."

77. A member of our team obtained this percentage by dividing the number of 2022 fatalities that New York released reports for by the total number of deaths that were assigned an identification number when they were reported to the State Central Register. The total deaths reported to the State Central Register was imputed based on missing values in the sequence of identification numbers.

78. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," answer to question 8.

79. The eight states are Georgia, Kansas, Minnesota, Mississippi, South Carolina, South Dakota, Utah, and Vermont.

80. Cal. Welf. & Inst. Code § 10850.4 (j) (2023).

81. Children's Advocacy Institute, "Comments in Response to ACF's Notice for Public Comment on the Child Abuse Prevention and Treatment Act (CAPTA)," 6.

82. Fla. Stat. § 39.202 (2024); and Carol Marbin Miller, "Florida Claimed It Couldn't Say Whether Child Was Abused to Death. Here's What Evidence Said," *Miami Herald*, March 20, 2022, https://www.miamiherald.com/news/politics-government/state-politics/article259552949.html.

83. Ariz. Rev. Stat. § 8-807 (2023).

84. Arizona Department of Child Safety, "How Soon Will the DCS Records Be Released?," https://dcs.az.gov/resources/faq/question-how-soon-will-dcs-records-be-released.

85. Jake Sunderland (Press Secretary, Oregon Department of Human Services), email to author, August 6, 2024.

86. Md. Code Ann., Hum. Servs. § 1-203 (2023); and Mich. Comp. Laws § 722.627 (2005).

87. Marie Cohen, "*We Are Not Here to Save Children*": *Deaths from Abuse and Neglect After Contact with the District of Columbia Child and Family Services Agency, 2019–2021*, Child Welfare Monitor, https://drive.google.com/file/d/1NPMBVz5R3r_EjMMGp-R-PIzPK2_iHjjt/view.

88. The nine states are Arkansas, Colorado, Florida, Nevada, Oregon, Pennsylvania, Rhode Island, Tennessee, and Wisconsin.

89. In Tennessee, near fatalities must be substantiated as abuse or neglect to require a notification, and in Florida, no notifications are issued for near fatalities.

90. It is not clear whether the states that require public notification of all cases reported to the hotline include those screened out by the hotline because they do not involve an allegation of child abuse or neglect.

91. Rice, "MTL # 0401."

92. Oregon Department of Human Services, "ODHS Child Fatality Review," https://www.oregon.gov/odhs/child-fatality-review/pages/default.aspx.

93. Rhode Island Department of Children, Youth and Families, "Public Disclosure of Child Fatality and Near Fatality Information," https://datadcyf.ri.gov/policyregs/public_disclosure_of_child_fatality_and_near_fatality_information.htm.

94. The 14 states are Arizona, Colorado, Florida, Indiana, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas, Virginia, Washington, West Virginia, and Wisconsin.

95. These suggestions are based on recommendations that the Children's Advocacy Institute, First Star, and other child advocacy organizations made to the House Education and the Workforce Committee before the Child Abuse Prevention and Treatment Act reauthorization in 2010, as summarized in Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.*, 2012, 18–19. Unfortunately, none of these recommendations were incorporated into the reauthorization bill that passed.

96. Children's Advocacy Institute and First Star, *State Secrecy and Child Deaths in the U.S.*, 2012, 15.

97. US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, "2.1A.4 CAPTA, Assurances and Requirements, Access to Child Abuse and Neglect Information, Public Disclosure," answer to question 8.