DEPARTMENT OF HUMAN SERVICES

Bulletin

NUMBER
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DATE
October 21, 2022

OF INTEREST TO
County Directors

Social Services Supervisors and Staff

County and Tribal Attorneys

Local Child Mortality Review Coordinators

ACTION/DUE DATE
Information only

EXPIRATION DATE
October 21, 2024

Child Mortality Review Processes

TOPIC

Child fatality and near fatality review processes.

PURPOSE

Provide guidance regarding child fatality and near fatality review processes for local social service agencies.

CONTACT

Child Fatality/Near Fatality Review team**:**

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SIGNED

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TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

I. Background

Understanding the circumstances leading to a child's fatality or near fatal injury and the history of social services provided to their family is helpful in learning about systemic challenges of providing services to families, and developing strategies to improve future outcomes for all children and families.
Minnesota Department of Human Services (department) staff developed three separate processes through which child fatalities and near fatalities are reviewed, including:

- Systemic Critical Incident Review (SCIR) led by the department
- Local child mortality review
- State child mortality review.

Each of these processes involves collaborative efforts by local child welfare agencies, their community partners, department staff, other state agencies, and statewide systems.

II. Notice to the department of child fatality/near fatality

The Child Fatality/Near Fatality Notice provides essential information to the department about child victims, their family, and circumstances leading to a fatality or near fatality. Department policy requires that the local county social services agency submit a completed notice within 24 hours of learning of a fatality or near fatality. A separate notice is required for each child victim of a fatality or near fatality.

A. When is Notice of Child Fatality/Near Fatality required?

The local county social services agency is responsible for sending a completed Notice of Child Fatality/Near Fatality (Attachment A) to the department's Child Safety and Permanency Division when any of the following circumstances are present in a case:

- A fatality or near fatality was due to maltreatment or suspected maltreatment
- A fatality or near fatality was not due to natural causes, (i.e., natural disease process or chronic medical condition), and occurred while a child was in a licensed facility (e.g., child care, foster care, group home, etc.) This also includes:
    - Incidents occurring in a location away from the facility, but licensed provider was responsible for the child's care at the time of fatality or near fatality
- Child fatalities that meet criteria for review by the local and state child mortality review panel, including:
    - The manner of death on the death certificate is classified as accident, homicide, suicide, or cannot determine: or
    - Sleep-related infant death where cause of death on the death certificate or autopsy report states the cause of death diagnosis: Sudden Infant Death Syndrome (SIDS), Sudden Unexplained Infant Death (SUID), or Sudden Death in Infancy (SUDI)**, and**

- Child was a member of a family that was:
  - Receiving social services from a local social service agency at the time of a critical incident, or
  - Received social services during the year before child's death, or
  - The subject of a child protection investigation or assessment.

In addition to notifying the department, if a fatality or near fatality occurred while child was in the care of a licensed facility, notify the local agency licensing supervisor who will notify the department's Licensing Division.

Department staff developed the Near Fatality Tip Sheet (Attachment B), in consultation with Minnesota pediatricians specializing in treating child abuse injuries to guide local agencies in determining whether a child's medical condition is considered serious or critical.

B. Where to find Notice of Child Fatality/Near Fatality

The Notice of Child Fatality/Near Fatality is in the **Chronology** folder of a workgroup in the Social Service Information System (SSIS), Attachment A.

To access the Notice of Child Fatality/Near Fatality in SSIS, follow these steps:

- Log into SSIS
- Open Child/Family's workgroup
- Right click on **Chronology**
- Select **New document template**
- Select **Document** category
- Select **Document name**.

If unable to locate the Notice in SSIS, contact agency's SSIS coordinator/mentor for assistance.

C. Where to send completed Notice of Child Fatality/Near Fatality

Send completed Notice to the department's Child Mortality Review Team via encrypted email to dhs.childfatalityreview@state.mn.us.

III. Child mortality review processes

Child mortality review processes have expanded, and now include the following three complementary components:

- State-led critical incident review
- Local child mortality review panel
- State Child Mortality Review Panel.

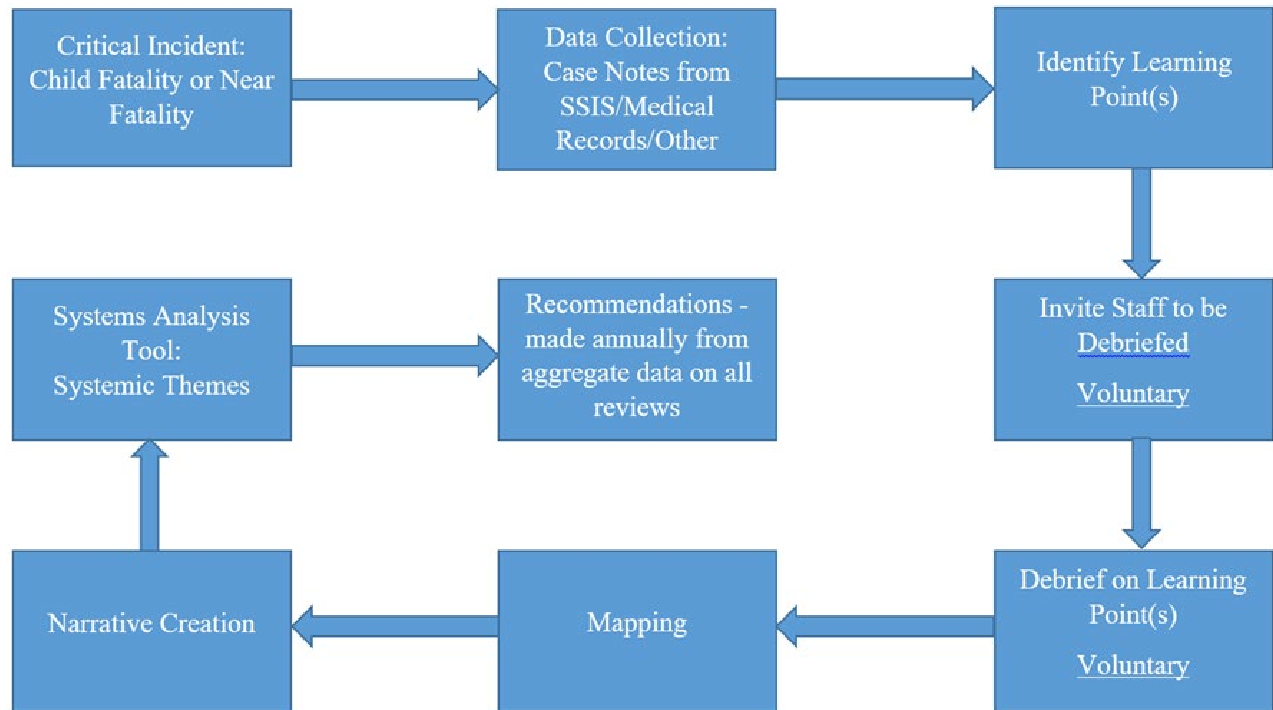
A. Child fatality/near fatality Systemic Critical Incident Review process

Legislation was enacted [Minnesota Statutes, section 256.01, subdivision 12a] in 2015 requiring the department to establish a state team to review child fatalities and near fatalities due to maltreatment, as well as those occurring in licensed facilities not due to natural causes. The statute includes data privacy protections prohibiting members of a Systemic Critical Incident Review Team from disclosing what transpired during review processes, as well as providing protections regarding Minnesota state court proceedings and non-discovery of review team's work.

In consultation with Collaborative Safety, LLC, department staff developed and implemented a Systemic Critical Incident Review (SCIR) process. It uses methods and techniques derived from human factors and system safety science, viewed as learning opportunities to look deeper into environmental features to aid in understanding systemic influences on policy and practice in Minnesota's child welfare system. Reviews are designed to analyze the system to identify opportunities for improvement, as well as barriers to providing the best services to children and families.

The systemic review process is a robust, thorough, and time intensive endeavor. It is an in-depth review engaging staff as well as community partners in systemically analyzing child welfare practice and services provided to children and families served through the child welfare system. The process is comprised of a sequence of phases, where professionals' accounts are valued and perspectives gathered to best inform how operations occur in real time. Following systems analysis of multiple systemic reviews, patterns and trends are identified. Data informs the most relevant areas of policy and practice, considered for improvement of the child welfare system.

Department staff, in conjunction with local agency staff specifically trained in the model and review process, and leading the SCIR process. A flow chart outlining the various phases of SCIR is below.



B. Local child mortality review panels

Local child mortality review panels conduct retrospective case reviews to learn about factors that contribute to child fatalities. The review process is intended to help local agencies and community partners strengthen collaboration with local partners offering protection and services to children and families, developing strategies to prevent further harm to children in similar circumstances. Recommendations for improving the state and local child protection system are submitted to the department, reviewed by the state Child Mortality Review Panel. Authority for local reviews is provided in Minnesota Rules, part 9560.0232, subpart 5, and Minnesota Statues, section 56.01, subdivision 12. Local reviews are led by local social services agency (county or tribe), and should be conducted within 60 days of receiving notice of a child fatality, however, delays may be necessary due to criminal proceedings. Within 30 days of review meeting, send a report summarizing the local review meeting to the department. Child welfare Initiative tribes may have local child mortality review panels carry out responsibilities outlined in this bulletin for Initiative-eligible children.

Local child mortality reviews are required in the following situations, child fatalities:

- Due to child maltreatment, or where maltreatment is suspected.
- That occurred while a child resided in a facility licensed by the department (licensed foster care, child care, and residential treatment) not due to a natural disease or chronic medical condition.

- Where the manner of death classification on the death certificate was accident, homicide, suicide, or could not determine (including deaths with a diagnosis of Sudden Infant Death Syndrome or Sudden Unexpected Infant Death), **and child was a member of a family that was:**
    - The subject of a child protection investigation or assessment
    - Receiving social services from a local agency at the time of a fatality or near fatality
    - Received social services during the year before a child fatality or near fatality
    - Child was in the care of a child care provider, foster care home, group home or residential treatment facility, licensed by the department or local social service agency.

Guidance for conducting local child mortality reviews is in the Local Review Format (Attachment)

The review process includes

- Gathering information – Minnesota Statutes, section 256.01, subdivision 12 (c), indicates that state and local social service agencies have access to non-public data regarding a child's death or circumstances surrounding their care, maintained by state agencies, statewide systems, or political subdivisions. Local agencies also have access to records of private hospitals, as necessary, to conduct a local child mortality review. Data a local agency may request for the purpose of a child mortality review is limited to:
    - Law enforcement investigative data, including fatality or near fatality investigations.
    - Centers for Disease Control and Prevention's Sudden Unexplained Infant Death Investigation Reporting form.
    - Reports of prior child maltreatment investigations, prior domestic abuse reports, or pattern of criminal behavior that might affect ability to care for children.
    - Autopsy records and coroner/medical examiner investigative data.
    - Death scene re-enactment documentation from law enforcement or medical examiner.
    - Hospital, public health, or other medical records of child, including medical documentation of their condition following a fatal/near fatal injury, prior injuries, health issues, well-baby care (when relevant), and hospital or other medical records of child's parent regarding prenatal care (when relevant).
    - Records created by social service agencies providing services to child or family within three years preceding child's fatality or near fatality.
- Local review panels – include community professionals with responsibility for serving or protecting children. Panel members include professionals from health care, education, law enforcement, county/tribal attorney, court services, coroner or medical examiner, public health, mental health and social services. Other professionals may be invited (ad hoc) when their expertise is needed, such as licensing supervisor, and chemical health, adult, or

emergency medical services. Invite local agency staff with knowledge of family, including those who provided services to family in another jurisdiction. The local child protection team may also serve as the local child mortality review panel.

- Local social service agencies are responsible for preparing a brief summary of social services provided, law enforcement investigation, medical condition and relevant medical history, and other relevant information.
- The purpose of panel discussions is to learn from a case, not to cast blame. Discussion of facts presented in a local review and input from professionals involved in a case will help to learn how each agency contributed to the investigation or services. As discussions develop, encourage panel members to consider how an issue could be shaped into a recommendation to improve services to families in the future, and how similar incidents may be prevented.
- Local agencies are responsible for preparing reports summarizing cases and recommendations developed during panel meetings. Within 30 days of review meetings, send reports and supporting documents, including law enforcement, medical, autopsy and medical examiner investigation reports to the department, using encrypted email to dhs.childmortalityreview@state.mn.us
- Multiple jurisdictions: Typically, when multiple jurisdictions are involved, the jurisdiction with financial responsibility takes the lead for reviews by preparing cases for review, facilitating meetings, and preparing reports after local child mortality review meetings. In some cases, it may be logical to hold review meetings in the jurisdiction where a death occurred to enable investigators to attend. However, the county with financial responsibility maintains primary responsibility for conducting case reviews held in another jurisdiction. When multiple jurisdictions provided services to family prior to a fatality or near fatality, the agency responsible for conducting reviews must notify those county and tribal agencies that a case requires a child mortality review. When multiple agencies are involved, sometimes those agencies mutually agree that the agency with financial responsibility will not take the lead in conducting a local review; inform the department which agency will be responsible for conducting a review. The agency responsible for conducting a review will request investigative, medical, and other records needed to conduct a review. The agency leading a review will invite a supervisor from each jurisdiction that provided services to participate in review meetings. Collaboration should take place with all jurisdictions in developing recommendations during the review process.
- Conflict of interest: In rare instances, there may be a conflict of interest if reviewing a case at county or tribal agency with jurisdiction for a review. When this occurs, county or tribal agency can request that a neighboring agency host a review meeting using its child mortality review panel. In these situations, the agency with financial responsibility for a case must prepare it for review; gathers records needed to conduct a review, writes child mortality review report, and sends report and supporting documents to the department. Neighboring agency serving as meeting host provides its child mortality review panel and meeting space. A neighboring agency and agency responsible for conducting a local child mortality review

should coordinate to determine who will facilitate review meeting and communicate meeting protocol practiced by neighboring agency. Agency responsible for conducting a review may need to be flexible to provide case information in a format that is typical for neighboring agency's child mortality review panel.

C. Minnesota's state Child Mortality Review Panel

Under authority of Minnesota Statutes, section 256.01, subdivision 12, the department convenes a multi-disciplinary panel to review aggregate data regarding child fatalities and near fatalities. Data gathered from local child mortality review reports and department-led SCIR reviews is collected for each fatal or near fatal incident and reviewed with the state panel. Analysis of de-identified aggregate data provides a broader perspective and helps to identify patterns or emerging trends that can be studied further. Recommendations developed from reviewing aggregate data focus on efforts that may prevent harm to children in similar circumstances.

IV. Data privacy and public disclosure

A. Data privacy pertaining to Systemic Critical Incident Reviews

Minnesota Statutes, section 256.01, subdivision 12a. (b), states: (b) "A member of the child fatality and near fatality review team shall not disclose what transpired during the review, except to carry out the duties of the child fatality and near fatality review team. The proceedings and records of the child fatality and near fatality review team are protected nonpublic data as defined in Minn. Stat. § 13.02, subd. 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state, or a county agency arising out of the matters the team is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were assessed or presented during proceedings of the review team. A person who presented information before the review team or who is a member of the team shall not be prevented from testifying about matters within the person's knowledge. In a civil or criminal proceeding a person shall not be questioned about the person's presentation of information to the review team or opinions formed by the person as a result of the review."

B. Data privacy pertaining to local and state child mortality reviews

Minnesota Statutes, section 256.01, subdivision 12(d), states: "(d) Notwithstanding the data's classification in the possession of any other agency, data acquired by a local or state child mortality review panel in the exercise of its duties is protected nonpublic or confidential data as defined in section 13.02, but may be disclosed as necessary to carry out the purposes of the review panel. The data is not subject to subpoena or discovery. The commissioner may disclose conclusions of the review panel, but shall not disclose data that was classified as confidential or private data on decedents, under Minn.

Stat. § 13.10, or private, confidential, or protected nonpublic data in the disseminating agency, except that the commissioner may disclose local social service agency data as provided in Minn. Stat. § 260E. 35, subd. 4, on individual cases involving a fatality or near fatality of a person served by the local social service agency prior to the date of death. "

Minnesota Statues, section 256.01, subdivision 12(e), states, "(e) A person attending a child mortality review panel meeting shall not disclose what transpired at the meeting, except to carry out the purposes of the mortality review panel. The proceedings and records of the mortality review panel are protected nonpublic data as defined in Minn. Stat. § 13.02, subd. 13, and are not subject to discovery or introduction into evidence in a civil or criminal action against a professional, the state or a county agency, arising out of the matters the panel is reviewing. Information, documents, and records otherwise available from other sources are not immune from discovery or use in a civil or criminal action solely because they were presented during proceedings of the review panel. A person who presented information before the review panel or who is a member of the panel shall not be prevented from testifying about matters within the person's knowledge. However, in a civil or criminal proceeding a person shall not be questioned about the person's presentation of information to the review panel or opinions formed by the person as a result of the review meetings."

C. Public disclosure of fatality and near fatality information

The Child Abuse Prevention and Treatment Act require states to provide for public disclosure of findings or information about a case of child abuse or neglect resulting in a child fatality or near fatality. Disclosure in child fatalities and near-fatality cases ensures compliance with this federal requirement. Minnesota Statutes, section 260E.35, subdivision 7, outlines circumstances under which information must be disclosed and what information must **not** be disclosed.

The department convened a work group with representatives appointed by the Minnesota Association of County Social Service Administrators in 2017 to develop a standardized format for local agencies to use that complies with obligations for public disclosure. The Findings and Information form was distributed to local agencies, included as Public Disclosure Findings and Information.

Prior to release of any information, a review with county/tribal attorney is encouraged.

Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling (651) 431-3809 (voice) or toll free at (800) 627-3529, or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

DEPARTMENT OF HUMAN SERVICES

Guide for Local Child Mortality Review and Format for Local Review Report

Background

Minnesota Statutes, section 256.01, subdivision 12, authorizes the commissioner of the Minnesota Department of Human Services to require a county agency to establish a local child mortality review panel. This authority is exercised through Minnesota Rules, part 9560.0232, subpart 5, which establishes procedures for the review of child fatalities. Procedures include a requirement that the local review panel examine fatality cases meeting criteria for review and to submit a report of a review to the department.

The purpose of this guide is to:

- Outline the circumstances in which a local review is required
- Suggest an outline for discussion during local review meetings
- Provide a format for the written report of the review.

What is a local review?

A local review is a comprehensive examination of information known about a family before and after a fatal incident for the purpose of developing recommendations to improve services and prevent future harm to children. Documents obtained for the purpose of a local child mortality review are used by local review panels to gain a broader understanding of the facts of a case, the needs of the family, the impact services provided had on family functioning and child safety. The discussion of a case from the multi-disciplinary panel members' perspective will generate the issues, findings, and recommendations to improve practice and policy in the child protection system, as well as for other community agencies. If recommendations are made, they may be directed at both the state and local levels.

What cases require review by the local panel?

[Minnesota Rules part 9560.0232, part 5], requires that a local review be conducted within 60 days of a child's death if:

- The death was caused by maltreatment
- The manner of death was due to sudden infant death syndrome or was other than by natural causes, and the child was a member of a family receiving social services from a local agency, a member of a family that received social services during the year before the child's death, or a member of a family that was the subject of a child protection assessment; or
- The death occurred in a facility licensed by the department if the manner of death was by other than natural causes.

Preparing for the local child mortality review meeting

It is helpful for local review panel members to understand the facts of a case, including:

- Circumstances leading to the fatal incident
- Summary of child protection investigation
- Summary of law enforcement investigations following a fatality and relevant law enforcement history
- Summary of social services that a family received within the preceding three years, including a summary of social services provided to a family by other jurisdictions
- Medical records related to maltreatment
- Autopsy report.

At the meeting, provide panel members with a summary of the incident description, social service history, law enforcement investigation findings, relevant medical history, and autopsy report/medical examiner investigation.

Outline for case summary

A child mortality review case summary informs panel members of the information known about a family prior to a fatality and can be used for the local review report that will be submitted to the department. This summary is the basis for discussion with the local review panel members.

Include in the case summary:

- Information about the review:
  - Name of local agency that conducted the child mortality review
  - Date of review meeting
  - Names of review team participants, including their profession and agency.
- Background information:
  - Child's name, date of birth and date of death. (If multiple children suffered a fatality, include

each child's name and date of birth/death in this section).
    - Names of siblings or other children residing in the household and dates of birth.
    - Mother's name, father's name, and dates of birth.
    - Names and dates of birth of other adults residing (full-time or part-time) in child's home
    - Name and relationship of extended family members who had a significant role in the case.
    - Employment status of adults residing in the household.
    - Childcare arrangements while parent is at work.
    - Brief description if any household members have physical or mental health issues that may impact ability to care for children, such as mental health, developmental disability, chemical dependency, history of anger issues, violent behavior or criminal history.
- Circumstances surrounding the fatality; describe the circumstances preceding a fatality, including:
    - Explain who was caring for the child/children, and that individual's relationship to the child.
    - Describe how the injury occurred or symptoms developed.
    - Describe how the caregiver responded (for example, did caregiver immediately call 911, drive the child to the hospital, or wait several hours before seeking help?)
    - What action was taken to assess the safety and protect the surviving children?
    - Describe any significant issues identified from law enforcement or medical reports about the caregiver's behavior or response to the crisis.
- Supporting Documentation
    - Any information from the Systemic Critical Incident Review (SCIR) completed by the Department of Human Services' Child Mortality Review team, if a review was completed and information is available.
    - Include a summary of documentation from other agencies (e.g., law enforcement; autopsy report; investigation reports from coroner or medical examiner; medical/hospital records; court action, including CHIPS proceedings, criminal history/probation, etc.) These may include:
        - Social services – include a concise summary of information needed to provide an understanding of the social services case history. Relevant social services history includes child protection, Parent Support Outreach Program, child welfare, minor parent, licensing, services for individuals with developmental disabilities and adult/children's mental health case management. Include information from county and/or tribal agencies that provided social services to the family prior to the fatality. The summary often includes:
        - Summary of prior maltreatment reports, screening decisions, findings and determinations that are relevant to a review.
        - Summary of services provided, and progress made by the family.
        - Summary of CHIPS and/or TPR petition status.
        - Indicate whether the death occurred in a licensed or non-licensed childcare facility. Indicate the ages and number of children present in a licensed facility when the fatality occurred (might be found in law enforcement investigation). Provide history about the provider's childcare, foster care or facility license, including brief summary of licensing complaints, correction orders, suspension or revocation.
        - Law enforcement – summarize investigation findings regarding the fatality. Were criminal charges filed? What was the outcome of criminal proceedings (conviction, acquittal, or dismissal)?
        - Medical history – include brief information about the child's health or injuries

prior to a fatality and after the incident that resulted in a fatality. If a medical provider documented an injury or health condition that was due to maltreatment or suspected maltreatment, provide a brief summary of the medical findings and treatment. If public health services were provided, include a summary of relevant issues and services. If the fatality involves an infant, indicate if the parent(s) were provided safe infant sleep information by the hospital, clinic and public health.

- Medical examiner/coroner findings– include a brief summary of the medical examiner investigator's report and cause of death diagnosis from the autopsy report. If the medical examiner and/or law enforcement investigators conducted an infant death scene re-enactment using a doll, provide a summary of the death scene re-enactment findings. During an infant death scene re-enactment, photos are often taken of a doll placed in the sleep environment and in the position that the infant was placed, in when last seen alive. Photos are also taken of a doll in the sleep environment and in the position where the infant was found. During a review meeting, it may be helpful for panel members to understand how an infant's sleep environment or position contributed to the death by viewing some of the photos. Some panel members may prefer not to see doll re-enactment photos, so offer the photos in a manner that allows a panel member to decline to view a photo. For example, place the photos inside of a folder before passing the folder to panel members in a meeting room.
- Other relevant information – some cases may have unique circumstances that involve investigation information from other sources. When relevant, request information from the state Fire Marshall investigator, licensed residential treatment facility internal review, or motor vehicle accident reconstruction from the Minnesota State Patrol, etc.

Conducting a local review meeting

The local review of a child fatality is intended to be a way to better understand the risk factors and services provided to a family to learn how to prevent similar harm to other children. In reviewing the case, it is helpful for the review panel to consider the case history from the perspective that decisions made on a case were based on the information that was available to the worker at the time that services were being provided. The meeting facilitator must guide the discussion in a manner that helps panel members to understand the case, recognize the challenges that workers face in providing services and discourages and discontinues discussion that appears to blame staff who were involved with the case. Recognize that panel members know the outcome of the case and have much more information than the staff had when they provided services to the family.

A local review meeting should include a thorough discussion of the information provided in the summary, as well as additional information presented by professionals with experience working with the family. The discussion is intended to learn from the incident, identify issues and identify preventative measures to address those issues in other families. Some questions to help the panel to explore the issues could include the following:

- Did the family have barriers in obtaining services to address identified child safety issues in the household?
- Were there community resources available to provide necessary services to the family? If relevant, how can availability of local resources be enhanced?
- Review the background studies and home studies of licensed or relative caregivers. If concerns were noted, how were they addressed?
- What changes in state or local agency policies, interagency collaboration and/or laws, practice or technology might improve safety or minimize risk factors for other families?

Developing recommendations

A child mortality review is a process to learn from cases and identify areas where systemic change can prevent future harm. If developed, recommendations can be directed toward changes in local/state policies, local collaboration, and practice.

Discussion during a local review meeting of a case summary, may identify issues related to local or state policies. Explore issues identified, to develop ideas to improve state and local policies that may help to prevent future fatalities from similar conditions. Risk factors that contributed to a fatality that are identified during the review process may generate considerations or recommendations to help prevent future harm for other families. Identify which local agency will take the lead in developing a way to promote prevention efforts and moving that effort to a local, regional or statewide system as a prevention recommendation.

Report of local child mortality review panel meeting

A local review report is a summary of a local child mortality review meeting, issues noted during a review meeting, and recommendations to address issues that will improve service delivery and prevent harm to children in the future.

When writing a local child mortality review report, recognize that reports will be read by department staff who are not familiar with local staff and agencies. Avoid using abbreviations or acronyms because they may not be understood or have a much different meaning outside a local jurisdiction. When referring to people, programs or places by name, specify the person's or agency's role in the case (for example, mental health practitioner, county attorney or chemical health treatment agency) to ensure accurate understanding by the reader.

A summary report prepared to inform the local review panel about a case can be used as the foundation of the report of a local child mortality review meeting. Include relevant information about the case that was obtained during the review meeting to the case summary. Clearly explain the issues identified from the local review panel's discussion, and the ideas or recommendations developed by the panel to address prevention efforts or system improvements. Recommendations should be clear and specific enough to explain the recommended change and who is responsible locally for carrying recommendation forward. Recommendations may address improvements in the areas of local agency-level practice, policy, training; coordination with other agencies;

public awareness and/or prevention efforts that may be necessary; or Minnesota statutes, rule, statewide training and resources.

Within 30 days of completing a local review, send the report of local child mortality review to the department's Child Mortality Review staff. Include with the report, copies of all the supporting documents used to prepare the case summary for the local review meeting. Send the report by encrypted email to: dhs.childfatalityreview@state.mn.us

Department Use of Local Child Mortality Review Reports

Reports of local child mortality reviews are used to prepare cases for the state child mortality review and to identify patterns and trends in cases throughout the state. Data elements from cases are collected, and aggregate data is analyzed to identify patterns or trends that may help inform professionals to better serve families and prevent or reduce the severity of maltreatment. The aggregate data may also be used to support considerations or recommendations for policy improvements or to support legislative changes.