Child Fatality Teams

Objectives:

1. Participants will learn what a Child Fatality Team is and how to develop a team within their community and/or CPT.
2. Provide participants with the basic definition, purpose and various structures of a Child Fatality Team.
3. Participants will learn the common problems and answers to addressing child fatality in their community.
4. Participants will better understand why and how Child Fatality Teams are forming and expanding across the United States.
5. Participants will learn strategies to prevention efforts of additional child fatalities in Indian communities.

Activities:

1. Discuss the role of your CPT in child fatalities. Can your CPT also serve as a Child Fatality Team? Why or why not?

Discussion:

1. Discuss the issue of child fatality and how it affects your community.
2. Address the prevention efforts that are in place and what could have helped prevent the fatality of a child.
3. Discuss the awareness of your community to child fatalities and the difficulties in investigation and prosecution.

Training Modules (Power Point Presentation):
Child Fatality Teams

Child Fatality Teams

What are child fatality teams?

Child Fatality Review Teams are multi-agency, multidisciplinary teams that review child deaths from various causes, often with an emphasis on reviewing child death involving caretaker abuse and/or neglect. The scope of cases reviewed is determined by each team, with some reviewing all child deaths from all causes or all Coroner child deaths under the age of 18, while others limit their review to cases fitting into a pre-determined protocol, often based on cause of death or age of the child. Benefits of child fatality review include improved interagency case management, identification of gaps and breakdowns in agencies and systems designed to protect children and the development of data information systems that can guide the formation of protocols and policy for agencies that serve families and children. The common goal for all teams is the prevention of child death and injury.

Why and how teams are forming and expanding

The formation of Child Death Review Teams is generally a natural and simple process whereby agencies and professionals join together to talk about children who have died. In the past, the major block to such interactions has been the tendency of individuals to isolate themselves within their agency or profession. Team intervention is a process that requires the removal of psychological barriers and “turf” issues, thereby allowing the sharing of information and the addressing of each case as a working group.

Multi-Agency Child Fatality Review Teams have now formed throughout the United States and much of Canada and Australia. The energy focus of the team development appears to be fairly consistent. Factors that drive the formation and usefulness of Review Teams include:

- Child deaths, particularly preventable abusive deaths, create great pain for front line professionals who have known the child. This pain creates motivation that pushes individuals to create a larger group of people to share that pain, and to address the facts and follow-up to death.
- Expanding information systems and computer technology help to make the multi-agency team process both familiar and available to professionals and advocates from the line level to the senior management level. The team review model provides a tool for these individual professionals and agencies to work together to be more effective in addressing the many issues involved in child deaths. As a result of team review, agencies may change official protocols and policies, particularly as they relate to multi-agency intervention.
- When professionals and agencies are connected in a collaborative way, they can then build a more open system of multi-agency cooperation and can form alliances that address possible fatal and severe child abuse and/or neglect.
- Child Fatality Review Teams have shown that it is possible to continue past the “child abuse deaths” to address other non-fatal family violence and many other forms of preventable “accidental” and “natural” deaths.

- Teams that are working together on issues pertaining to child death also learn how to develop a multi-agency focus on infants, toddlers and high-risk pregnancies, which can lead to the development of prevention and early intervention programs.
- Team reports that address child deaths and highlight recommendations aimed at prevention can be shared across the local, state and national boundaries and can provide a tool for the sharing of information and resources.
- Neighboring teams can visit each other and share resources. They may also want to join together to form a Regional Team Review process.
- Local teams can provide a forum for sharing information and resources and can support local data collection for use in the development of mandates and reports.
- Over time, teams can expand to engage in a retrospective review of old cases, which will be augmented by the knowledge and experience gained from earlier team reviews.

Basic Team Structure, Philosophy and Process

Almost all active teams have developed a similar structure of membership, philosophy, and case selection.

Core Membership

a. *Coroner/Medical Examiner*: Responsible for providing critical information on the manner and cause of death for all unexpected and/or unexplained child deaths including trauma deaths such as homicides, suicides, and accidents.
b. *Law Enforcement*: Responsible for investigating potential suspicious deaths.
c. *Prosecuting Attorneys*: Responsible for prosecuting provable criminal deaths.
d. *Child Protective Services*: Responsible for intervention with familial child abuse/neglect.
e. *Health* (the most varied of the Core Team Members): Responsible for providing evaluation and treatment to injured children, reporting suspected child abuse/neglect, engaging in outreach to children at risk of abuse/neglect through public health nursing programs, and keeping vital records of births and deaths.

Most teams grow with time to include others including: Juvenile attorneys, representatives from schools, mental health departments, probation departments, fire emergency technicians (EMT), clergy, child life specialists and child advocates.

Team Philosophy

The team philosophy includes a basic respect for the needs of other agencies and disciplines, including necessary rules of confidentiality. This respect also honors the rights of agencies and disciplines to pursue cases and problems within the room during the case review process with no single agency controlling or censuring the process.

Review Process

Cases are chosen by protocol from either the coroner or health records, and most often includes the deaths of all children under age 18. The actual review process addresses one case at a time with each agency, in turn, sharing its knowledge of the child, family,

and the circumstances surrounding the child's death. Teams may begin with a single retrospective review of "closed" cases. With time, however, teams add prospective review of new deaths and cases still under investigation, often with any possible prosecution still pending. The team may continue the collection of information until all aspects of case management are finished, including criminal actions that may take months for completion.

Team Variation

State teams are formed primarily to serve, monitor and work with local teams that provide the basic case management. Local teams often are less public than state teams and more focused on the actual case management of individual cases.

Local teams vary and reflect the interests of the agencies or professionals who have the most interest in the Child Fatality Review Team process and in local resources. Individuals from each of the core agencies have been responsible both for starting a team in some areas and, in other areas for resisting the formation of a team to share information and resources with others.

A major factor in local team functioning is the size of the population. Larger areas may review only coroner's cases. Smaller areas may review child deaths from all causes. These reviews may include more details than larger areas, with the actual case managers from each profession who were involved in the case sharing observations.

Common Problems and Answers

A. One Agency Won't Cooperate

This is a fairly common problem and is often addressed by the rest of the agencies continuing to review cases as well as they can, while noting the absence of the single member. With encouragement, the reluctant agency may return in a month or so, or may continue to avoid participation until there is major pressure from other members. Neighboring experts may assist in the encouragement and motivation of their counterparts. The situation may also be resolved if a new source of data is found or a single person leaves or is replaced.

B. Records Can't be Found

It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. As teams grow, they tend to pursue more information and are able to search with more accuracy. A team might develop a written protocol on how to search for records and may give team members a monthly "report card" noting which files have been found and which remain missing. A monthly team "report card" of found or missing records helps to keep members up to date on themselves and each other.

C. Team Stopped Meeting and Needs to Restart

This is common when the person who started the team and was responsible for keeping it moving retires or otherwise leaves duty. Some other team member then needs to

take the initiative to get the team moving again. It may take a notorious case, a new motivated staff person or an out of town visitor to help get that first new meeting started.

D. Confidentiality

Nationally, teams have a noble record for respecting confidentiality. Information shared in the room seems to stay there. After meetings, members may discuss with other team members the fact that desired data from another member must be obtained through official channels, perhaps including a subpoena for official copies of records.

E. Failure to Write a Report on Team Activity

Writing a report may seem like a mass of trouble for busy people. However, the failure to issue an official report narrows the work to only those who attend team meetings and leaves knowledge lost. A central collection of a year's work also provides a natural forum to add recommendations for system change. Once an initial report has been completed, most teams continue to develop an annual report that contains much of the format and data collection provided by the natural activity of the team. Many teams publish annual reports and recommendations and disseminate to all agencies and individuals within the community.

F. Lack of Staff Resources Necessary to Coordinate Activities When Reviewing Large Numbers of Cases

Teams in large areas may control their caseloads to some degree by reviewing only coroner cases. All teams can expand their resources by sharing duties necessary to maintain the team. Almost all teams function with no official funding for a coordinator.

G. Vulnerability of Line Staff Who Are Involved with a Child who Dies Particularly with Cases that are Notorious in the Press

Very few agencies, and almost no teams, have a process in place to support line staff after a death. The major exception is the support that the Review Team tends to give to it's own members. A few agencies have employee support, critical incident debriefing, or simply talented management staff.

H. Administrators or Tribal Leaders are Bothered by Negative Statements in Reports about Child Death

All systems have failures and successes. It should be possible to write a report that is objective and speaks of the shortcomings and strengths of all members. The fact of continued child death makes it impossible to maintain accurate and consistent data and also write a report that includes improvements and remains only positive.

Extensions of Process

Domestic Violence Fatality Review

Numerous areas have begun systemic review of fatal domestic violence. This process may be an extension of the local team, especially in smaller areas, or may be a new team of professionals brought together specifically for this purpose.

Review of non-Fatal Severe Child Abuse and/or Neglect
Children should not have to die to merit systematic attention. In some areas, hospitals are beginning to extend their multidisciplinary teams to address a multi-agency review of children hospitalized with severe injuries. Some areas in the country have developed a process of multi-agency review that includes reviews of non-fatal injuries of children hospitalized in intensive care.

Prevention Programs Addressing Perinatal and Infant Toddler Issues
The child fatality review process increases individual agency competence for interventions with infants, toddlers and women with high-risk pregnancies. The multi-agency team learns the value of sharing resources for intervention before any injury or death occurs.

Grief and Mourning
Teams, agencies and individuals are beginning to address the aftermath of fatal family violence. Recognition of the need to develop a system to support the grief and mourning process has developed but siblings and other survivors of child death have not been predictably identified and served. The same is true for other survivors of the child's relationships, such as friends, family, neighbors, and professionals from amongst the large numbers of staff who serve such children and families.

A. Siblings of children who have died from child abuse/neglect, as well as other survivors, may benefit from support for grief and mourning. Even young children or the developmentally delayed may participate in funerals and family gatherings. They may tell their feelings in play or in art. The same needs also exist for children who have experienced loss from a natural death.
B. Mental health professionals may be of assistance with psychopathology but it needs to be recognized that grief and mourning by itself is not a psychopathology.
C. Training, on issues of death for mental health professionals and on issues of psychopathology for non-mental health professionals who address grief and mourning issues, increases the resources available for the provision of these needed support services.
D. Similar needs exist for families who suffer fatal domestic violence, or other family deaths from abuse/neglect, including elder abuse, dependent adult abuse and parricide. In addition, children may mourn the death of professionals with whom they have been involved, including child protective caseworkers.
E. Professionals from all agencies grieving over the death of a child, need similar services and may benefit from Critical Incident Debriefing or informal Critical Incident Defusing. They may also benefit from attending the funeral.
F. Support for sibling, family and professional survivors of child death should be developed and included as part of agency and team protocols.
G. It should be noted that victims of crime funds (State Compensation) might pay for grief and mourning interventions. Other funding sources for the provision of these services should be explored.

H. Intervention and support should be made available for at least one year to meet the significant anniversaries of the death and/or until the end of all legal actions which may impose further stresses on surviving siblings and other family members who may be called on to testify in court.

Prevention and Health

Child Fatality Review helps identify high-risk behaviors and other factors that can assist professionals in preventing future deaths. The findings of the Child Fatality Review Teams may assist prevention-focused programs, such as home visiting and parenting education, in strengthening their programs. Child Fatality Review Teams also function in a preventative way by assuring that surviving siblings are not placed in harm's way, and that adults who are violent towards children are monitored as to their future associations with children. While Child Fatality Review Teams often have a primary goal of working to prevent child abuse fatalities, the larger effect from a team is the potential to develop prevention efforts for all causes of death including accidental, natural and/or non-accidental deaths.

Campaigns and programs addressing child deaths that value prevention include:

- Public education on the potential hazard of accessible 5 gallon buckets to young toddlers resulting in toddler drownings.
- Infant automobile safety seat campaigns that provide donated seats for families who have limited funds.
- Child-proof drug containers, particularly for prescription pills or iron pills that resemble candy.
- Traffic safety campaigns and the provision of speed bumps in neighborhoods with large numbers of young children.
- The enacting of ordinances for swimming pools, spas and river safety programs that utilize warning signs in multiple languages.
- The provision of smoke detectors for homes by child protective services agencies.
- More intensive evaluations for home safety through the use of multi-agency records.
- An increased awareness of the needs of infants and toddlers by both law enforcement and child protective services.
- Multi-agency joint home visits by public health nurses, child protective services and law enforcement.
- Perinatal intervention programs for women in jails and juvenile facilities.
- Parenting programs for incarcerated parents, particularly young fathers.
- Multi-agency integrated data systems to coordinate and monitor services to children and families with multiple problems.