Ideas In-ACTION

Child Welfare Institute

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Learning from Child Fatalities

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In the fall of 1976 I was preparing to move from Ann Arbor, Michigan to a new position in Nashville, Tennessee. During one of my trips to prepare for the move in November of that year, a story broke in the Nashville Tennessean about a young girl named Melissa. Barely three, she was tortured to death by her parents over a period of nearly three days. The details in the newspaper were excruciating and detailed. It was my first in-depth exposure to a high profile child abuse fatality. The Tennessee child welfare system was rocked to its core and the public was outraged. Melissa had once been removed from her parent's custody, and her parents had served time following their conviction on criminal child abuse charges. But after their release, Melissa was returned to them.

Over the years there have been many more names. They are known as Lisa, Elissa, Joseph, Tyrell, Kyshawn and other names. Now their smiles and laughter are known no more. Their deaths, like Melissa's, have led to massive change efforts in child welfare systems. Yet, these tragedies still occur. Today, New York City, whose child welfare system has weathered other storms following the deaths of other children, is now dealing with the tragedy of a child named Nixzmary.

How does a child welfare system learn form such tragedies? On the one hand, they are statistically rare. In 2003, out of approximately 906,000 child maltreatment victims, an estimated 1,500 died. It is not entirely clear how many of these children were known to the public child welfare agency at the time of their death or how many of these fatalities happened on an open case. When a child dies in an open case, many are quick to say that the child protection system failed. In some cases it did. In others there was little actionable information that would have foretold the tragedy.

A prominent public misconception is a belief that, once the child protection agency has substantiated child abuse and neglect, it has the authority to intervene and require changes in family life. This is actually true in far less than half of all substantiated cases. Court intervention requires a much higher standard, often set at imminent danger of serious harm. The Canadian Incidence Study would suggest that only about four percent of cases involve serious harm. It is not clear how many constitute threat of serious harm.

Still, though fatality cases may be an exception, they can reveal much about the risk profile of the CPS agency itself. Simply put, humans and organizations engage in high risk behavior much more often than they experience the serious consequences of these acts. So, a critical question is, "What (agency) high risk behaviors were associated with the fatality?" A second question follows, "What is the prevalence of these high risk elements across the agency caseload as a whole?" Finally, "What does this prevalence suggest about the need for change in agency practices?"

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What constitutes high risk behavior for an agency? High risk behaviors fall into a number of categories. These include: policy, procedure, direct practice, including case decision-making, training and resource allocation. As well, these do not apply to the CPS agency alone. Communities and community partner agencies constitute important elements of the child protection safety net. Any examination of high risk elements should consider the child protection *system*, not just the child protection agency.

Reviews following a child fatality tend to focus most heavily policy and procedural adherence. Primary questions tend to be, "Were policies and procedures followed?" These are critical questions as policies and procedures are put in place for the purpose of ensuring the safety of children. Another question is less frequently asked. "Were the policies and procedures, as they applied to this case, adequate to ensure child safety?" For example, an agency may set contact requirements as an across the board standard, perhaps once or twice a month. Yet, some children may be left at home with an in-home safety plan. Such a child may require much more frequent contact and more intensive service provision. Similarly, agency policy regarding who needs a safety plan and the construction of in-home safety plans may be vague. Unclear decision criteria increase the risk of decision errors. Unclear policies and decision criteria constitute high risk agency behavior.

An examination of the actual decision practices associated with the case is critical to any in-depth review. Questions should include: "Were safety and risk criteria applied validly?" "Was accessible information interpreted correctly?" Were potential sources of relevant information correctly identified?" "Were the actions of service providers fulfilling the needs of the case?" "Was available information actionable?" When one knows the ending, information can take on more significance than it had at the time it was revealed. People will be prone to say that signs of danger were ignored. This is not always the case. A given case event, such as bruises or concerned neighbors, taken without the knowledge of the eventual tragedy, may not have been different from many other cases that did not end in tragedy.

Once the concerning characteristics of the fatality case (or cases where several have occurred in a relatively confined timeframe) are identified, it is possible to develop a risk profile for the agency. This is accomplished by drawing a random sample of cases and testing these cases against the characteristics of concern in the fatality case. It may be helpful or necessary to weight the case characteristics. A flawed in-home safety plan may present more agency risk than failure to document a contact in a particular case. Once this prevalence is established, it is possible to estimate the level of risk across the caseload because one knows the prevalence of agency high risk behavior.

When fatalities occur, it is common for the agency and others to immediately point to high caseloads. Caseload and workload are significant factors influencing caseworkers' ability to maintain contact with families and the service providers involved with them. At the same time, caseloads of service providers may also be a factor. Waiting lists for, or the nonexistence of critical services, also reflect systemic risk factors. Caseloads also may be high across the agency and yet such fatalities are not the norm. Agencies should consider the workload of the caseworker and supervisor as a specific factor when identifying characteristics of the risk profile.

Although fatalities often result in a call for better training, this common response is often not specific and based on the fatality risk profile. Following the death of the Bass twins, Missouri officials reviewed their training curriculum with specific attention to the characteristics of the Bass case. The review revealed several areas in which the curriculum did not develop decision making competencies specific to critical features of the case. As well, the curriculum's tendency to portray all alternative response cases as "inherently" less serious created a mindset in caseworkers that these cases were unlikely to involve safety concerns. The review led to significant changes in the state's training curriculum.

Statistically, fatality cases may appear as an anomaly. However, they may reflect areas of high risk agency policy, procedure and practice. As stated earlier, high risk behavior occurs much more frequently than it results in tragic consequences. Examining fatality cases in the context of their features and what this tells an agency about its overall pattern of high risk practice can be an important way to learn from tragic cases.

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