SOUTHERN AREA CONSORTIUM OF HUMAN SERVICES

Review of the Literature:
Child Maltreatment Fatalities- Risk Factors and Lessons Learned

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Table of Contents

Executive Summary

Executive Summary 1

Introduction

Numbers and Trends 2

How Do These Deaths Occur? 4

Risk Factors

What Groups of Children Are Most Vulnerable? 6
- Age 6
- Gender 7
- Race and Ethnicity 7
- Prior CPS Contact 7
- Additional Child Risk Factors 9

What are the Characteristics of the Perpetrators? 10

Additional Environmental/Family Variables 12

Response/Lessons Learned

Responding to Risk: Reducing Child Fatalities 13
- Scrutiny of High Risk Cases 13
- Safety and Risk Assessment Tools: California SDM 13
- Manageable CWS Caseloads 15
- Staff Support/Reducing Worker Turnover 15
- Involvement of Supervisory Staff 17
- Training 17
- CWS Investigations 18
- Parent Education and Preventative Programs/Services 19
- Reduce Confidentiality Barriers 20
- Multidisciplinary Coordination, Cooperation and Response 21
- Child Fatality Review Teams (CFRTs) 24

Recommendations for Change from Local/State CFRTs

Child Fatality Review Teams: Recommendations.....27
Recommendations about the CFRT Process.....27
Components of Effective CFRT Reviews-Child Abuse and Neglect.....27
What types of additional information should be available to CFRT's?.....28
At each case review, what questions should CFRT members seek to answer?.....29
Use of News Media.....29
Clear and Effective Prevention Strategies 29
Public Awareness Campaigns.....30
State of WY CFRTs-Interagency Recommendations to Reduce Child Fatalities 31
Additional Recommendations from Child Fatality Review Teams: Results of a 2008 US Nationwide Exploratory Study Concerning Maltreatment Fatalities and Social Service Delivery.....32

Conclusion/References

Conclusion 37

References.....38

Appendices

Appendix 1: United States-Child Fatalities, 2006 and 2007.....45

Appendix 2: CDSS-CPS History Fatal Child Abuse/Neglect Victims (7/ 22-9/18/2006).....47

Appendix 3: California Structured Decision-Making (SDM) Overview and Assessment Tools 49

Appendix 4: The California Evidence-Based Clearinghouse for Child Welfare: Reviewed Promising/Supported and Well-Supported Practices.....61

Executive Summary

While the exact number of children affected is uncertain, child fatalities due to abuse and neglect linger as a serious issue in the United States. These tragic consequences of maltreatment are often the focus of media attention, critiquing child welfare systems and communities effectiveness at protecting children. This review summarizes existing research literature to identify common factors/variables related to the type of maltreatment, the child, the parents/caretakers and other circumstances of the case that may contribute to a higher probability of fatal child maltreatment.

Nationally, during FFY 2007:

- *Scope:* An estimated 1,760 children (2.35 deaths per 100,000 children) died due to abuse or neglect at the hands of their caretakers.
- *Type of Maltreatment:* Most child fatalities (35.2%) were caused by multiple forms of maltreatment; 34.1 percent were attributed to neglect only; 26.4 percent to physical abuse only.
- *Age:* More than three-quarters (75.7 percent) of the children who died due to child abuse and neglect were younger than 4 years old; while children younger than one year old accounted for 42.2 percent of these deaths.
- *Gender:* Infant boys (younger than 1 year) had the highest rate of fatalities, at 18.85 deaths per 100,000 boys of the same age in the national population. Infant girls had a rate of 15.39 deaths per 100,000 girls of the same age.
- *Race and Ethnicity:* Nearly one-half (41.1%) of all fatalities were White children. More than one-quarter (26.1%) were African-American children, and nearly one-fifth (16.9%) were Hispanic children.
- *Prior CWS Contact:* Children whose families had received family preservation services in the past five years accounted for only 11.9 percent of child fatalities. However, research indicates a larger percentage of these cases could have been known to CWS through maltreatment referrals or investigations, but may not have received services.
- *Perpetrators:* One or both parents were responsible for 69.9 percent of child abuse or neglect fatalities. Mothers acting alone were the perpetrators in more than one-quarter (27.1 percent) of child abuse and neglect-related fatalities.

(U.S. Department of Health and Human Services, 2009)

Next, lessons learned and practice recommendations to strengthen child fatality investigations and child welfare agencies to minimize the extent to which children are placed at risk of extreme harm are discussed. Although it is impossible for child welfare agencies to "prevent" all child fatalities, strategies supported by research, to improve their intervention efforts and possibly reduce the occurrence include: *scrutiny of high risk cases; utilizing standardized safety and risk assessment tools (Structured Decision-Making); having manageable CWS caseloads; providing a strong support system for lineworkers; maintaining quality supervision; providing basic and advanced training for professionals; integrating evidence-based prevention and intervention programs; addressing barriers to information-sharing among community agencies; adopting an interagency/ multidisciplinary approach; and participating in Child Fatality Review Teams (CFRTs).*

Currently, CFRTs appear to be one of the most promising approaches to improve child death investigations, child death reviews and future prevention efforts. Data gathered in this review includes national recommendations (n=313) from these teams about improving the CFRT process and proposes practices and policies to lessen future child abuse and neglect fatalities. Some of the recommendations by CFRTs have already been implemented in several states as a result.

Introduction

Numbers and Trends[1]

There are two primary sources of national data on child abuse and neglect fatalities: (1) the National Child Abuse and Neglect Data System (NCANDS) operated by the federal Children's Bureau and (2) the surveys conducted by the Child Welfare League of America (CWLA) National Data Analysis System (NDAS). Most data on child fatalities come from State child welfare agencies. However, States may also draw on other data sources, including health departments, vital statistics departments, medical examiners' offices, and fatality review teams. Between 2001 and 2007, the official number of child abuse and neglect fatalities was 10,440[2]. With the exception of Federal Fiscal Year 2005, the number and rate of child fatalities has been increasing over the past 5 years. This can be attributed partly to improved data collection and reporting, but all the causes of the increase are not specifically identifiable.

The National Child Abuse and Neglect Data System (NCANDS) defines *child fatality* as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor.

Nationally, in Federal Fiscal Year 2007:

- Approximately 794,000 children were determined to be victims of maltreatment
- The overall rate of child fatalities was 2.35 deaths per 100,000 children (compared to a rate of 2.05 for FFY 2006)[3]
- An estimated 1,760 children died due to abuse or neglect at the hands of their caretakers[4]
- Approximately four-fifths of deaths were reported based on case-level data from Child Welfare Services (CWS) agencies and one-fifth of child fatality data were reported from agencies other than child welfare
- More than 30 percent (34.1 percent) of child maltreatment deaths were attributed to neglect only; physical abuse also was a major contributor to child fatalities

Collecting accurate data regarding fatalities attributed to child abuse and neglect is challenging and requires multi-disciplinary coordination among agencies, including child welfare services,

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[1] Unless otherwise noted, child fatality statistics are taken from *Child Maltreatment 2007* (U.S. Department of HHS, 2009) and refer to Federal FY 2007. The number of fatalities includes only children who were subjects of reports of abuse or neglect in which the maltreatment allegation was substantiated. Statistics reported are reflective of child deaths resulting from abuse or neglect by parent or primary caregiver. Other child homicides (e.g. those committed by acquaintances & strangers and other causes of death, like unintentional injuries) are not reflected in this report.

[2] Petit (2009) indicates that among the rich democracies, the U.S. child abuse death rate is 3 times higher than Canada's, and 11 times higher than Italy's. Possible explanations: teen pregnancy, violent crime, imprisonment, and poverty rates are much lower in these countries. Also, social policies in support of families are greater and typically include: child care, universal health insurance, paid parental leave, visiting nurses, etc. all which together may reduce abuse/neglect in the first place.

[3] Fatality rates were computed by dividing the number of child fatalities by the population of reporting States and multiplying by 100,000. See **Appendix 1** for details on child fatalities by State.

[4] An FFY 2007 national estimate of 1,760 fatalities was derived by multiplying the national weighted rate of fatalities (2.35 per 100,000) by the national child population (74,904,677) and dividing by 100,000. The estimate was then rounded to the nearest 10.

law enforcement, the medical examiner's office, and the judicial system (U.S. Department of Health and Human Services, 2009). Many researchers and practitioners believe child fatalities due to abuse and neglect are still underreported. Studies in Nevada and Colorado have estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded as such (Department of Health and Human Resources-Division of Child and Family Services, 2005; Crume, et al., 2002).

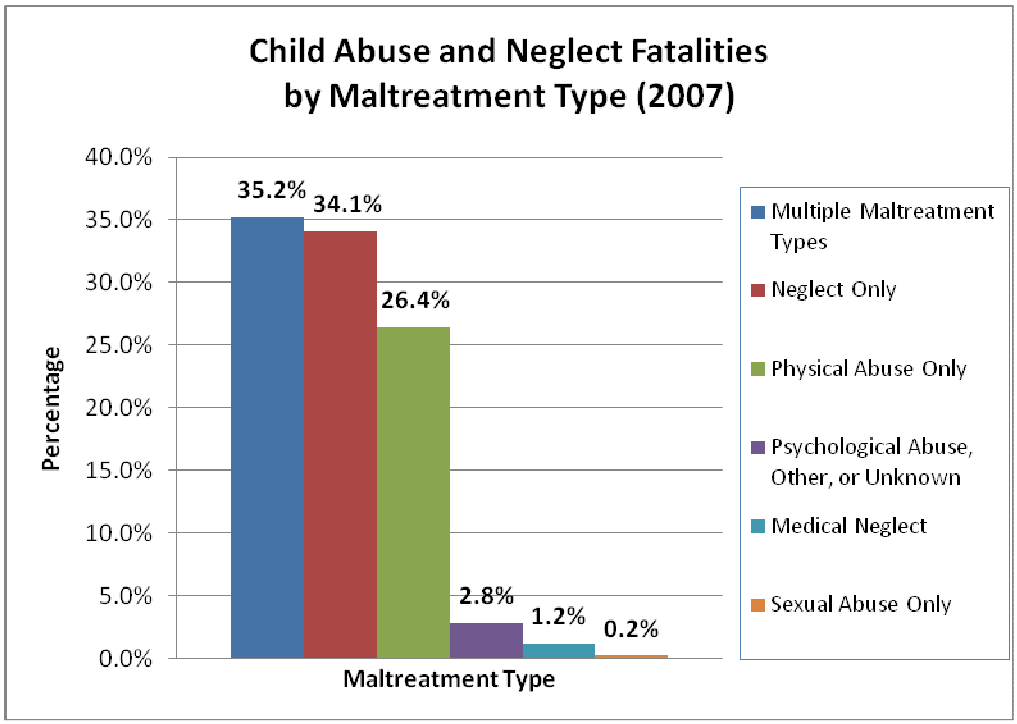
Although the untimely deaths of children due to illness and accidents have been closely monitored, deaths that result from physical assault or severe neglect can be more difficult to track because:

- Many deaths are disguised or misdiagnosed and as a result miscoded on death certificates; this includes deaths labeled as attributable to natural or accidental causes, sudden infant death syndrome (SIDS), or "manner undetermined" that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted
- Many abuse and neglect deaths can only be diagnosed by thorough scene investigations and autopsies. Even then, findings may mimic other unintentional injuries or natural causes.
- There are usually no witnesses to an act that leads to a child abuse homicide
- Neglect deaths in particular are very difficult to identify because the neglect often results in illnesses and infections that can be attributed to natural causes
- There is variation among State reporting requirements due to differing state laws, policies, practices and definitions specific to child deaths
- There are varying roles of CWS agencies in different jurisdictions
- There is a lack of consistent standards for child autopsies or death investigative systems and in training for investigations
- Medical examiners/elected coroners may not have specific child abuse/neglect training
- Uncoordinated, non-multidisciplinary child fatality investigations
- There is variation across Child Fatality Review processes
- Uncoordinated, non-multidisciplinary child fatality investigations
- Of the amount of time (as long as a year, in some cases) it may take to establish abuse or neglect as the cause of death
- There are limited coding options for child deaths, especially those due to neglect or negligence, when using the International Classification of Diseases to code death certificates

(Hargrove & Bowman, 2007; Child Welfare Information Gateway, 2008; Los Angeles County Inter-Agency Council on Child Abuse and Neglect [ICAN], 2009)

How Do These Deaths Occur?

In 2007, slightly more than one-third of fatalities (35.2 percent) were caused by multiple forms of maltreatment. Neglect only accounted for 34.1 percent and physical abuse only for 26.4 percent. Medical neglect accounted for 1.2 percent of fatalities (U.S. Department of Health and Human Services, 2009).



In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's *failure to act*. This includes: failure to provide necessary care; lack of supervision; environmental neglect; medical neglect; drug/alcohol related neglect. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub). Hindley, Ramchandani & Jones' (2007) study has revealed that the risks of recurring abuse are higher with neglect than other types of maltreatment.

Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may involve a single, impulsive incident (e.g., drowning, suffocating, poisoning, or shaking a baby). Non-accidental head trauma is recognized as the leading cause of traumatic death during infancy (Rubin, et al., 2003; Keenan, et al., 2003). Head trauma includes the triad of the so-called shaken baby syndrome, consisting of retinal hemorrhage, subdural, and/or subarachnoid hemorrhage in an infant, with little signs of external trauma (Gerber & Coffman, 2007). Consistent with previous studies, a recent study by Ross, et al. (2009) found that the craniofacial area (47%) was the most frequent fatally injured bodily region.

Ross, et al. (2009) examined high risk criteria, which included rib fractures, multiple fractures, facial injury, or age less than six months, and whether such criteria were found in children with a normal neurological exam. Screening for occult head injury was undertaken using a CT or MRI.

The study found that 37.3% of patients had an occult head injury, including calp swelling, skull fracture and intercranial injury. Skeletal survey alone missed 26% of these cases. The results of their study further underscores the need for more aggressive and combined screening techniques, such as repeat radiology and bone scans, MSCT, MRI scans, autopsy and full skeletal surveys, and serum or cerebrospinal markers in order to accurately determine the etiology of the trauma and detect injuries in cases of suspected abuse (Ross, et al., 2009).

An additional number of infant deaths occur through 'overlying', where parents or caretakers smother their babies while sleeping. Sharing a bed with a baby is not of itself risky behavior, and is commonplace in many countries and cultures. However, the research base demonstrates that there are substantial risks to infants in the following circumstances: if the parent has taken drugs (prescription or illegal) or alcohol, if the parent or caretaker falls asleep with the baby on a sofa or chair rather than in a bed, and if the parent is a smoker (Blair, et al., 2006).

Regardless how fatal abuse occurs, the most disturbing fact is that it occurs at the hands of a caretaker, entrusted with children's protection and safety.

Risk Factors

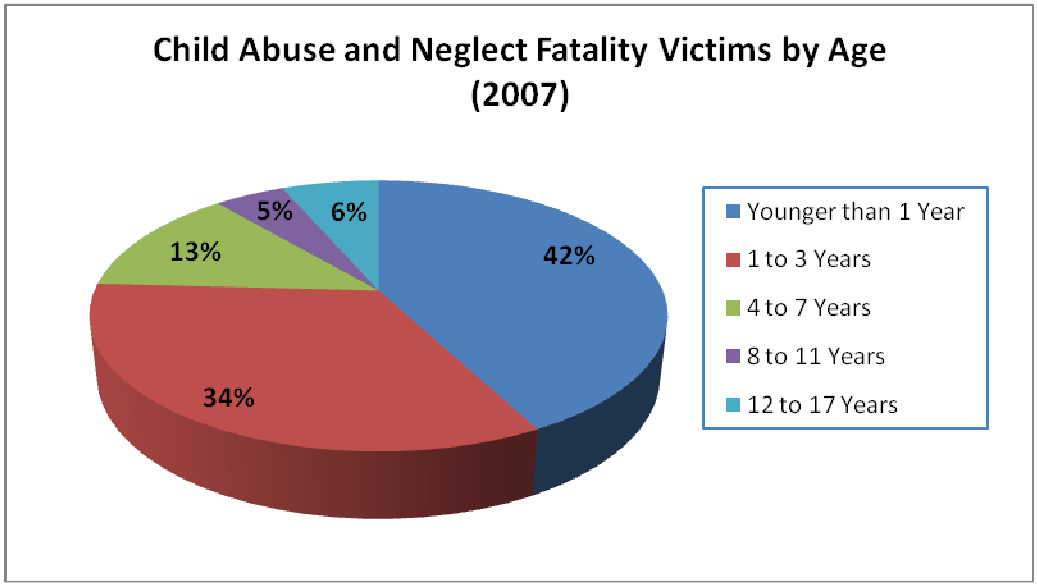
What Groups of Children Are Most Vulnerable?

- ***Age***

The examination of age of non-accidental child fatalities reveals that such occurrences disproportionately affect young children. Studies indicate that infants are at greatest risk of child maltreatment homicide in their first week of life, with the first day of their life being the day of highest risk. The homicide rate on the first day of life is more than ten times greater than the rate during any other time of life. The second highest peak in risk for infant homicide occurs during the eighth week of life and may be due to a caregiver's reaction to an infant's persistent crying. Infant crying duration peaks at six to eight weeks of age (Centers for Disease Control and Prevention, 2002).

NCANDS data for 2007 demonstrated that children younger than one year accounted for 42.2 percent of non-accidental fatalities. In general, child abuse and neglect fatality rates decrease with age: 16.5 percent were children age one year, 10.7 percent were children age two years, and 6.3 percent were children age three years (see Chart 2). When combined, children younger than four years old accounted for more than three-quarters (75.7 percent) of fatalities (U.S. Department of Health and Human Services, 2009).

Chart 2



Children under the age of four are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves. Infants and young children are especially vulnerable to death from massive internal injuries and bleeding (e.g. resulting from punching or kicking) because at this age vital organs are in very close proximity to each other and young children's ribs are often unable to protect them.

In addition, heightened fatality rates for children under the age of four could coincide developmentally with independent stages. Toddlers are particularly vulnerable to evoking hostile care from their parents during this developmental phase when they show defiance and self-assertiveness in their attempts to seek autonomy (Belskey, 1993).

Finally, it should be noted that age is not a risk factor unique to maltreated populations as large studies of general population childhood injuries and death also indicate a higher risk among young children because of the heightened vulnerability at this age (National SAFE KIDS Campaign, 2004).

- ***Gender***

A study by Ross, et al. (2009) found that among children of all ages, many more boys (68%) than girls (32%) died from maltreatment. In 2007, NCANDS also found a higher rate of maltreatment deaths for infant boys (younger than one year), indicating a fatality rate of 18.85 per 100,000 boys of the same age while infant girls (younger than 1 year) had a fatality rate of 15.39 per 100,000 girls of the same age (U.S. Department of Health and Human Services, 2009). This coincides with previous conclusions by Sobsey, et al. (1997) who found that more boys were physically abused than girls.

- ***Race and Ethnicity***

In 2007, NCANDS indicated nearly one-half (41.1%) of all fatalities were White children. More than one-quarter (26.1%) were African-American children, and nearly one-fifth (16.9%) were Hispanic children. Children of American Indian or Alaska Native, Asian, Pacific Islander, and multiple race categories collectively accounted for 4.8 percent of fatalities. More than 10 percent (11.1%) of children were of unknown race (U.S. Department of Health and Human Services, 2009).

- ***Prior CWS Contact***

Failure to diagnose child abuse or initial presentation may result in a 30-50% chance of repeated abuse and a 5-10% chance of death (Cramer & Green, 2003). When Child Welfare Services (CWS) have been previously involved with a family where a child death occurs, the media and public become critical of the agencies and CWS worker's role (Child Welfare League of America, 2002).

According to national statistics the overall number of child fatalities in cases where CWS has already been involved with the family is actually relatively low (Graham, 2010). U.S. Department of Health and Human Services Administration on Children Youth and Families (2009) reported that nationally, in 2007, children whose families had received family preservation services in the past five years accounted for only 11.9 percent of child fatalities. Slightly more than 2 percent (2.6%) of the child fatalities had been in foster care and were reunited with their families in the past five years. While these numbers seem low, a larger percentage of these cases could have been known to CWS through maltreatment reports or investigations, but may not have received services. Older research by Monteleone (1994) indicates that more like 25% to 50% of fatal child abuse victims had some prior involvement with CWS.

Beginning in July 2006, the California Department of Social Services (CDSS) required county child protective service agencies to notify CDSS whenever there is a reasonable suspicion that a child died or suffered near death as the result of abuse or neglect.[5] Within 48 hours of the child's death, counties must file a questionnaire that includes the age, race, and gender of the child and a summary of any prior history the family had with child protective services.[6]

The National Center for Youth Law (NCYL) obtained copies of these questionnaires, which covered 38 cases between July 16 and September 17, 2006. Review of these documents indicated that in 76 percent of the cases (n=29), the family had one or more previous referrals to child protective services. The number of previous referrals ranged from one to as many as eight reports of abuse or neglect. In 52 percent of the families (n=20) there was at least one child abuse or neglect report within a year of the child's death. In 18 percent of these cases (n=7) the family had an open case with social services at the time of the child's death (see **Appendix 2** for a full summary of the reviewed reports) (Grimm, 2007).

These findings are consistent with older data from California's Fatal Child Abuse and Neglect Surveillance (FCANS) system. According to FCANS, in the years 2000 and 2001, of the 178 deaths that Child Fatality Review Teams found to be caused by child abuse and neglect, 74 (42 percent) had a prior family history of CWS involvement. Data from Los Angeles County also mimics these findings. Their Child Fatality Review Team report for 2001 found that in 42.8 percent of the 33 deaths, the families involved had a previous or current record of involvement with the CWS. Similarly, in 2006, Sacramento County's Child Fatality Review Team's Five-Year Report (1999-2003) found that of the 89 child deaths related to abuse or neglect, 40 families (45 percent) had a history of child abuse or neglect (Grimm, 2007).

This high incidence of child fatalities among children whose families have a history with child welfare services is not only a California phenomenon – it is found nationwide. The National Center on Child Abuse Prevention Research's Fifty State Survey found that between 1998 and 2000 an average of 36 percent of child abuse fatalities occurred in families with prior or current contact with child protective service (Peddle, et al., 2002). In some states, the number of families known to CWS was much higher than the national average. In 2004, Texas reported 204 fatalities of which more than half had some history with the child welfare agency. Fifty families had an open case at the time of the child's death and another 55 of the children were previously known to the agency (Grimm, 2007).

With slim child protective agency budgets and staff capacity stretched dangerously thin in comparison to the problem, responding to warning signs is challenging and requires careful attention. It is also important to recognize that an unknown number of child fatalities are prevented by the professional actions of CWS workers each year and CWS caseworkers often do recognize risk conditions that could lead to child fatalities and take effective actions accordingly (Graham, et al., 2010; Petit, 2009).

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[5] California Department of Social Services, All County Letter, 06-24 (July 21, 2006). The All County Letter was adopted in response to federal officials' notifying California that the state was out of compliance with the public disclosure provision of CAPTA.

[6] In California, changes to Child Fatality Reporting and Disclosure Requirements occurred in March 2009 following the passage of SB 39

- ***Additional Child Risk Factors include:***
  - Children with medical, behavioral, and developmental problems
    - Ill or handicapped children
    - Children with a history of premature birth
    - Infants with colic: Structured interviews of parents caring for an infant with colic have demonstrated psychological problems, marital difficulties, and disruptions of their social network. Seventy percent reported aggressive fantasies directed at their child, and 26% endorsed transient homicidal ideation (Levitzky & Cooper, 2000).
    - Children displaying hostile/aggressive, fussy, or otherwise disturbed or unusual behaviors
    - Vomiting: A study in New Mexico highlighting characteristics of child-abuse related deaths found that almost one-fifth (17.8%) of victims showed a recent history of vomiting, and in 63% of these cases the cause of death was head injuries, suggesting perhaps that the two may be associated, with vomiting being the presenting symptom suggestive of underlying head injuries (Lee & Lathrop, 2010). Similar numbers of victims exhibited long-term or recurring medical concerns (with respiratory disease being the most frequent complaint) and/or previous hospitalizations. Thus, when present, these case histories should raise suspicions for child abuse.
  - Lack of suitable child care available
  - Having more siblings under the age of three years
  - Poverty: A child living in poverty is 22 times more likely to be abused than those living in families with an annual income of $30,000 or more (Petit, 2009)
  - Coming from families with children from different biological fathers

What are the Characteristics of the Perpetrators?

Nationally, in Federal Fiscal Year 2007:

- One or both parents were responsible for 69.9 percent of child abuse or neglect fatalities[7].
  - More than one-quarter (27.1 percent) of these fatalities were perpetrated by the mother acting alone

Perpetrator Relationships to Child Fatalities, 2007

Relationship to Child	Child Fatalities	
	Number	Percent
PARENT		
Mother	347	27.1
Mother and Other	96	7.5
Father	208	16.3
Father and Other	11	0.9
Mother and Father	232	18.1
NONPARENT		
Daycare Staff	24	1.9
Foster Parent (Female Relative)	0	0.0
Foster Parent (Male Relative)	0	0.0
Foster Parent (Nonrelative)	3	0.2
Foster Parent (Unknown Relationship)	3	0.2
Friend or Neighbor	2	0.2
Legal Guardian (Female)	0	0.0
Legal Guardian (Male)	0	0.0
More than One Nonparental Perpetrator	52	4.1
Other Professional	2	0.2
Partner of Parent (Female)	4	0.3
Partner of Parent (Male)	35	2.7
Relative (Female)	29	2.3
Relative (Male)	20	1.6
Staff Group Home	2	0.2
Unknown or Missing	210	16.4
Total	1,280	
Percent		100.0

(U.S. Department of Health and Human Services, 2009)

Research also indicates the role of household composition as an independent risk factor for fatal child maltreatment:

- Children residing in households with adults unrelated to them (primarily an adult male) had six to eight times the risk of dying of maltreatment than children in households with two biological parents
- Children residing with step or foster parents and those living with other, related adults who are not a biologic parent (e.g. grandparents, aunts, uncles) were also at increased of maltreatment death
- Risk is not elevated for children living with a single parent, *as long as no other adults live in the home*

(Schnitzer & Ewigman, 2008; Stiffman, et al., 2002)

[7] "Parent" includes the following categories: mother, father, mother and father, "mother with other," and "father with other."

There is no single profile of a perpetrator of fatal child abuse, although several factors seem to characterize many of them. Perpetrators are more likely to be under the age of thirty and:

- Live near or below the poverty level
- Have a low education level (no high school diploma)
- Have poor stress coping abilities
- Have history of abuse as a child
- Have had his/her parental rights terminated in the past
- Be a victim or perpetrator of domestic violence
- Have a history of violence/criminality
- Have a problem with substance abuse
- Have a deficit of skills related to parenting (e.g. this includes an inability to communicate effectively with the child and applying inconsistent and inappropriate discipline)
- Have unrealistic expectations about children's behavior and capabilities (developmental incongruence)
- Lack emotional attachment to the child
- Have mental health problems (e.g. depression)
- Be socially isolated, without a healthy support system

(Child Welfare Information Gateway, 2008; Johnson-Reid et al, 2007; National Center for Injury Prevention and Control, 2005; Spinelli, 2003; Festinger, 1996; Chance & Scannapieco, 2002)

In addition, Overpeck, Brenner, Rumble, Trifiletti, & Berendes (1998) found:

- Younger maternal age dramatically increases the risk for filicide, particularly for the second or subsequent child born to a teenage mother
- Compared to the first child born to a mother over the age of 25 years, the second child of a 16-year-old is almost 11 times as likely to be murdered
- Mothers who never pursued prenatal care are 10.4 times as likely to commit filicide as those who began seeing their doctor before the 2nd month of pregnancy
- Single women are 4.3 times more likely to commit filicide than those who are married.

Mothers are most often responsible for deaths resulting from child neglect. Persons who neglect their children are more likely to be single female caregivers in poverty, who are suffering from postpartum depression or psychosis, substance abuse, domestic violence or mental illness (Graham, et al., 2010).

Most fatalities from physical abuse are caused by fathers and other male caregivers. A Colorado study of child maltreatment fatalities found that 80% of deaths from head and body trauma were attributed to a male perpetrator (Levine, 1994). Person's who physically abuse their children are more likely to be rigid and have an excessive need for control, lack empathy, have problems with anger control, have a low tolerance for frustration, have a childhood history of physical abuse, and have substance abuse issues.

Weeks-Schackleford and Schackleford (2004) found that men are eight times more likely to kill stepchildren than their biological children, and stepmothers are almost three times as likely to commit filicide with unrelated children. The gender difference was attributed to the fact that

stepfathers are often part of the family when the victim is very young whereas stepmothers often enter children's lives when they are older, after the highest risk for maternal filicide is past. Practitioners should understand that these factors described above may increase the risk of harm to children but does not *predict* serious injury or death.

Additional Environmental/Family Variables

- Multiple community service providers, law enforcement, juvenile probation and medical providers had been involved with family over time however communication between providers was inconsistent and lacked coordination (Childrens' Administration Executive Child Fatality Review, 2009)
- Previous studies have documented that as many as one-third of children who eventually die from inflicted injuries were seen by a physician following the onset of abuse (Jenny, 1999).
    - It is believed, however, that in these cases the abuse was unrecognized- not that clinicians recognized abuse and failed to intervene.
- Family stressors (e.g. experiencing unemployment, birth of a child, death of a loved one)
- Frequent family moves
- Both severity and history of maltreatment may be important indicators of potential child fatalities (Graham, et al., 2010; Jonson-Reid, et al., 2007)
- Household composition (Schnitzer & Ewigman, 2008; Stiffman, et al., 2002)
- Multiple father figures in and out of the home
- Prior contact with social services
- A study by Ross, et al. (2009) found that child maltreatment death rates were highest in the months of July (13.6%), August (11.7%) and December (13.6%) (based on a sample size of 162 children)

Response/Lessons Learned

Responding to Risk: Reducing Child Fatalities

- ***Scrutiny of High Risk Cases***

Although predicting serious abuse to children is not straightforward, it is crucial for professionals that they and their employing agency do their best possible for the child (Brandon, et al., 2008). A vital step in this process is to utilize existing research examining the relationships between family characteristics and the outcomes of subsequent substantiated abuse and neglect to accurately guide staff in recognizing important interacting risk and protective factors and then prioritizing cases accordingly (Graham, et al., 2010).

- Standard child welfare risk assessment factors include:
  - Child's age/abilities
  - Severity of abuse
  - Severity of neglect
  - Location of injury
  - Parent's abilities and control (protective capacity)
  - Parent's cooperation
  - Parent's parenting skills/knowledge
  - Perpetrator's access to child
  - Presence of paramour/ step-parent
  - Criminal history of caretakers
  - Previous history of abuse
  - Physical condition of the home
  - Strength of supports
  - Stressors/response to stressors

- Initial questions answered by CWS workers as they assess the severity of risk include:
  - Should they respond to a report of abuse and, if so, how quickly should they respond?
  - Is the child in imminent danger?
  - What's the probability that the family will reabuse the child?
  - What are the family`s strengths, and what services does the family need to reduce risk?

(CDSS Child Protection and Family Support Branch, 2007)

The difference between risk levels is substantial. High risk families have significantly higher rates of subsequent referral and substantiation than low risk families, and they are more often involved in serious abuse or neglect incidents. Thinking critically and systematically will also help to avoid over-reaction, which can destroy lives (Graham, et al., 2010).

- ***Safety and Risk Assessment Tools: California Structured Decision-Making (SDM)***

As discussed above, research indicates the importance of focusing CWS workers and supervisors attention to predictive indicators which can identify families at elevated risk of abuse and/or neglect. A formal, comprehensive risk assessment process attempts to assess for the presence of multiple risk factors in families to accurately categorize families with low, moderate, high, or very high probabilities of future abuse or neglect during the before and after phases of

reunification between parents and children. The availability of a standardized risk assessment tool, allows the worker to obtain a more objective appraisal regarding the likelihood that a family will maltreat their child in the next 18 to 24 months.

As other states adopted, most of California counties already have or currently in the process of implementing the use of uniform, researched and evidence-based instruments to structure the process of assessment and response to information related to child safety/risk to assist in the investigation and response of alleged child abuse/neglect. These tools are designed to assist field staff in applying uniform standards as they make important decisions, rather than relying on individual judgment. Referred to as *Structured Decision Making* (SDM), this assessment is performed through not only the completion of forms, but is also an ongoing process that prioritizes the safety of children by gathering and analyzing information that supports sound decision-making.

The four process goals of California's SDM Model include:

1) Improve assessments of family situations to better ascertain the protection needs of children
2) Increase consistency and accuracy in case assessment and case management among child abuse/neglect staff within a county and among counties
3) Increase the efficiency of child protection operations by making the best use of available resources
4) Provide management with needed data for program administration, planning, evaluation, and budgeting

(Children's Research Center, 2009, p. 4)

The SDM process begins with an assessment tool for the hotline workers. California Hotline Tools guide the worker to make every effort to elicit/screen for information from the caller/reporter to make the key hotline decisions on: whether a referral meets the statutory threshold for an in-person CWS response; if not, whether a referral to an alternative community response is appropriate; if so, how quickly to respond and the path of response.

Next, of the referrals identified for an in-person response, CWS workers conduct child protection and child welfare assessments through personal contact with the caregiver in the home, using these uniform tools to assist in identifying factors affecting the child's immediate safety (*California Safety Assessment*-including assessment of Safety Threats; Protective Capacities and Safety Interventions) and future risk of harm (*California Family Risk Assessment*). Using such a model, CWS workers are able to accurately and consistently apply decision-making criteria for screening for investigation, to determine response priority, identify immediate threatened harm, and estimate the risk of future abuse and neglect, therefore classifying families according to the likelihood of subsequent maltreatment (Children's Research Center, 2009).

Additional SDM tools are used by CWS to assess a caregiver or child's strengths and needs (*California Strengths and Needs Assessments*). Combined, all of these SDM tools help to uniformly assess a child's safety and wellbeing, regardless of whether the child is living at home or in an out-of-home placement setting, and are important components in the overall decision-making and handling of the case (Children's Research Center, 2009).

See **Appendix 3** for templates of the following SDM assessment tools: (1) *California Structured Decision-Making Overview*; (2) *California Hotline Tools*-Screening/Response Priority; (3) *California Safety Assessment* (Including Safety Threats; Protective Capacities and Safety Interventions); (4) *California Family Risk Assessme*nt. In addition to outlined policies and procedures for these assessments, additional forms including the *California Family Strengths and Needs Assessment; California Risk Reassessment*; & *California Reunification Reassessment* can be downloaded here: http://www.dss.cahwnet.gov/cfsweb/res/pdf/SDM_Manual.pdf

The contractor for the SDM Project is the Children's Research Center, a division of the National Council on Crime and Delinquency (NCCD). The NCCD is an Oakland-based nonprofit organization dedicated to the improvement of decision-making systems in the field of corrections and, for approximately last 12 years, in the child welfare field. To date the Children's Research Center has assisted or is assisting 16 states to implement the SDM model. These include New York, Michigan, Alaska, Georgia, New Mexico, New Hampshire, Ohio and Rhode Island. In Michigan, a 12-month follow-up evaluation was done to compare the outcomes for cases in SDM counties and non-SDM counties. The study revealed *formerly treated cases in SDM counties had 27 percent fewer new referrals, 54 percent fewer new substantiated allegations, 40 percent fewer children removed to foster care, and 42 percent fewer child injuries that required medical assistance than did formerly treated cases in non-SDM counties. These results indicate that when an agency is able to accurately classify families according to level of risk, they are also able to more selectively focus their resources, resulting in better outcomes for children and families.* CDSS believes SDM will reap many of the same positive outcomes for California's children and families that have been realized around the country (CDSS Child Protection and Family Support Branch, 2007).

- ***Manageable CWS Caseloads***
  - National studies recommend lowering caseloads as a way to reduce child maltreatment fatalities as well as worker burnout and turnover
    - Lowering caseloads to be more in line with The Child Welfare League of America accepted standards can result in more effective decision-making and improved safety to children
      - CWLA calls for a caseload size for family foster care social workers of 12 to 15 children per worker, while the Council on Accreditation recommends that caseloads not exceed 18 children or eight children with special therapeutic needs
      - In order to maintain manageable caseloads, sufficient funding to hire additional caseworkers would need to be available

(Council on Accreditation Standards 7th Edition, Child Protective Services [Section S10.7.06] and Child Welfare Services [Section S21.11])

- ***Staff Support/Reducing CWS Worker Turnover***
  - Caseworker turnover drastically affects the tenure and experience of staff in the agency. Reducing caseworker turnover will increase the experience of staff investigating abuse/ neglect and providing ongoing services to families. Incentives aimed at stabilizing the staffing patterns and encouraging tenured workers to maintain employment with the agency are recommended.

- Results from a 2006 study conducted by the National Council on Crime and Delinquency found that the highest functioning Child Welfare Service agencies were those that had a low turnover rate and whose staff had the highest paying salaries. These agencies had the highest level of practice standards and the lowest rate of child re-abuse (National Council on Crime and Delinquency, 2006).
- Social worker salaries are among the lowest for professionals in general, and in comparison to other professions with a master's degree (Senate Bill 2858), so with a lack of resources available, implementing intrinsic rewards for staff may boost morale.
- As done in the state of Arizona, improvements to CWS staffing can be done by better screening applicants to ensure that the best candidate is hired; and paying incentives to retain CWS workers rather than lose them and have to retrain staff (Kornman, 2008).
- Child welfare is a challenging field-one in which the turnover is already high. Yet, negative media attention that child deaths produce leave workers feeling disheartened and devalued which in turns leads to low organizational commitment. Further front line workers are more likely to be fired as a result of child death (Simms, 2009).
- Social workers are typically the first to respond and repeatedly hear stories of trauma, which in turn produces traumatic thoughts and images themselves resulting in the occurrence of secondary Post-Traumatic Stress Disorder (PTSD). Many social workers are often unaware of their own disorder (Fahmy, 2007). Series injury or death of a child presents significant challenges for practitioners and these events can be difficult both personally and professionally for staff, requiring staff support (Dubowitz, H., & DePanfilis, D., 2000).
    - Without the basic infrastructure needed to undertake this demanding work, mistakes will be made at all levels of intervention. Safe, thoughtful, practice is not possible without proper support for front line staff (Brandon, et al., 2008).
    - If management structures and staff support systems collapse, the result is often paralysis in the workers, or ill health, or absenteeism or other signs of stress (Brandon, et al, 2002).
- In spite of the efforts to move away from the blame culture, serious case reviews do sap morale and leave professionals feeling defeated. A child death from maltreatment is likely to make professionals involved in the case experience feelings of shock, disbelief, guilt, anger and grief. Criticism of professional practice that inevitably follows is likely to exacerbate these feelings and the situation can be worsened by colleagues avoiding those involved in the case, as if they are tainted (Horwarth, 2009).
    - Attention has to be given to the emotional needs of staff as well as building inter-agency relationships in order to deal with overwhelming workloads and cope under pressure.
    - Under such circumstances practitioners need to be encouraged to tend to their own well-being and use available agency supports to deal with their feelings, and to put the entire situation into perspective.
        - Counseling and other Employee Assistance Programs may be offered by a qualified, trained person on staff, or they may be contracted (Dubowitz, H., & DePanfilis, 2000).

- ***Involvement of Supervisory Staff***
  - Effective and accessible supervision is essential if lineworker staff are to integrate into practice the critical thinking required to understand cases holistically, complete analytical assessments, and operate an ecological transactional perspective. Without supervision or accessible professional consultation, practitioners working with children and families with early needs may struggle to cope.
  - In an environment of shrinking resources, supervisors have taken on a number of administrative, maintenance, and support functions that make them less available for case consultation.
    - Due to additional duties and broader-than-recommended spans of control, supervisors are unable to provide the close supervision that is needed within the CWS program
  - Reducing span of control of the supervisor would increase the available time for quality supervision of each caseworker, resulting in more effective decision making, improved safety planning for children, and better overall support to caseworkers.
  - Recommendations indicate CWS supervisors should review every referral, regardless of the decision made after the screening, keeping in mind the history of the entire family. Supervisors may have more experience spotting patterns of recurring and severe abuse that might be happening over time in a family.

  (Lucas, et al., 2002; Chance & Scannapieco, 2002; Jonson-Reid, et al., 2007; Stiffman, et al., 2002)

- ***Training***
  - Improvements to staff training with regard to gathering and recognition of the dynamics of abuse and neglect, the mechanics of injuries and recognizing family risk factors and information indicative of serious abuse and neglect with regard to both future maltreatment and child fatalities can provide workers with tools to guide them in decision-making.
  - Social Services should consider providing photography training to CWS investigators as a means to ensure the quality and preservation of photographs while emphasizing the value of photographs as evidentiary information.
  - To work effectively with complex cases, professionals must be self-aware, flexible and sensitive to the factors underlying their own and the family's behavior and emotions (Cooper, et al., 2003; Glisson & Hemmelgarn, 1998).
  - Mandate and provide refresher training on safety and risk assessment and planning for social work staff on a biennial basis. Offer and include contracted community service partners, public health nurses, and tribal social work staff among others in the training
  - Increase inter-agency training on collaboration and information-sharing between medical providers, law enforcement and CWS with a focus on recognizing the dynamics of child abuse and neglect.
  - It is crucial, when planning and delivering training, to recognize the emotional impact on the workforce of the death of a child from maltreatment (Horwath & Tidbury, 2009)
  - Additionally, increased training for different professional caretakers, such as childcare workers and foster parents; home visitors and domestic violence workers; health providers in the identification of child maltreatment; and mental health providers with regard to maltreating parents and the specific needs of maltreated children is recommended

- To improve communication within the child welfare profession and with other agencies bringing together multi-agency trainings to openly discuss common misunderstandings and the roles and responsibilities of child welfare professionals may be beneficial (Murphy et al., 2006; Packard et al., 2006).
    - All human service practitioners need a holistic understanding of children and families and need training about the way in which separate factors might interact to cause increased stresses in the family and increased risks of harm to the child
- For new CWS Workers and Supervisors, orientation on clear agency policy, consistent standards and procedures for child death prevention and investigations are foundational.

(Childrens' Administration Executive Child Fatality Review, Saranadee Leingag, 2009)

- ***CWS Investigations***
    - Clearly identify the agency-wide roles and responsibilities to respond to child fatalities- from the Director in charge of the agency, to the manager overseeing the day-to-day operations, to the direct supervisor to the worker knocking on the door.
    - Allow the release of information regarding referrals and any findings made within the last year to a mandated reporter or other systems/providers that may serve or be serving identified families.
    - Every referral, regardless of the screening decision, should include a review of the referral history of the family including both screened in and screened out referrals. The consideration of family history supports more accurate screening decisions.
    - Initial CWS investigations conducted should include, but not be limited to the following:
        - Re-contacting referents making reports of child abuse/neglect, particularly mandated reporters to assist in screening decisions
        - Secure photo documentation of the home environment and children (particularly in cases where home conditions are identified issue)
        - Complete multiple collateral contacts and retain supporting documentation and contact information in the case file
        - Complete monthly supervisory reviews, as required by policy, as a means to monitor case intervention and progress
    - The supervisory review of intakes should include a review of the intake history of the family including both assigned and screened out intakes.
    - When multiple agencies and service providers over time have worked or are working with a family or have referred them for intervention, it is recommended to convene a multi-disciplinary or child protection team staffing.
    - The department should facilitate sharing the child's past social history with his/her providers (e.g. medical providers and developmental specialists as well as mental health professionals.)
    - Following the death of a child the first priority is the protection and safety of surviving siblings and other children living in the home or in the placement of the deceased child. In addition, surviving siblings benefit from referrals for grief and mourning counseling and should be allowed to attend the funeral of the deceased child, as appropriate.

- Apply lessons learned from improper assessments of child safety and inappropriate protective service intervention (Freundlich & Bocknek, 2007):

TYPE OF CHILD FATALITY	KEY FINDINGS
Child with family not previously known to the public child welfare agency	Inadequate assessment of safety of surviving siblings
	Inconsistency between safety assessments and subsequent decisions regarding protection of children
	Failures to contact deceased child's physician
Child with family previously known to the public child welfare agency	Inadequate response to patterns of multiple referrals
	Inadequate attention to the interaction of multiple risk factors
	Inadequate monitoring and provision of follow-up services following substantiated reports of maltreatment
	Inadequate assessments of safety of surviving siblings
	Inconsistency between safety assessments and subsequent decisions regarding protection of children
Child in foster care	Failures to contact deceased child's physician
	Inadequate information provided to foster parents regarding children's health conditions and needs
	Inadequate monitoring of the safety of child's placement of home environment when home on trial discharge
	Inadequate efforts to locate and ensure the safety of youth on AWOL status

- Systems' need to develop, implement and hold all employees accountable for adhering to mandates and policies to prevent and respond to child fatalities (Simms, 2009).

(Childrens' Administration Executive Child Fatality Review, Saranadee Leingag Case, 2009; Childrens' Administration Executive Child Fatality Review, R.E. Case, 2009)

- ***Parent Education and Preventative Programs/Services***
  - Preventive services are recommended for parents whose children are at risk of abuse or neglect. These services are designed to increase the understanding of parents and other caregivers of the developmental stages of childhood and to improve their child-rearing competencies. Examples of preventive services include: respite care, parenting education, housing assistance, substance abuse treatment, daycare, and individual and family counseling (U.S. Department of Health and Human Services, 2009).
    - Programs for parents can take many different forms. They may occur in parents' homes, in schools, in medical or mental health clinics, or in other community settings. Programs may involve one-on-one or group sessions.
  - Parent training programs have been found to be effective in preventing the recurrence of physical abuse (Macmillan et al., 2009).
  - Home visitations by trained nurses during pregnancy and/or the first few years of life have been shown to reduce rates of state-verified cases of child abuse and neglect among children of unmarried adolescents of a low socioeconomic status (Overpeck, et al., 1998)
    - In 2001, Prevent Child Abuse America introduced Healthy Families America, a comprehensive home visiting initiative. Such services offer instruction and

support regarding prenatal care, parenting skills, household management, and coping with environmental dangers.
    - A 2006 study on Hawaii's Healthy Start home visitation program found that home visiting produces measurable benefits for participants in the areas of parental attitudes toward children, parent-child interaction patterns, and type and quantity of child maltreatment (National Center on Child Abuse and Neglect, 2006).
- Because most neonaticidal women are young and naive and have little or no family or social support, education about sex and their options regarding pregnancy is imperative. This can be provided by school counselors, healthcare providers, and support services (Vallone & Hoffman, 2003).
- Postpartum psychiatric illness is clearly a treatable risk factor for filicide. New mothers and their families should be educated about postpartum psychiatric illness so that they are able to identify symptoms and are more likely to seek consultation with a healthcare professional without fear of stigma.
    - The unusual presentation of psychosis during the postpartum period results in it often being missed by healthcare professionals. Physicians, nurses, social workers, and others who have contact with at-risk individuals need to be properly trained to identify these illnesses.
        - Because of the high risk of filicide associated with postpartum psychosis, children always should be removed from caregivers with this disorder (Spinelli, 2004).
- There is substantial danger to babies and children from parental volatility and loss of control. Parents need training/education on strategies for managing babies and young children in particular, if they feel they are losing control.
- To reduce the risks of 'over-lying,' public messages should make it clear that it is safer to share a bed with a baby than to fall asleep on a sofa or chair, but bed sharing with babies should never happen if a parent or their partner is a smoker or has been drinking alcohol or taking drugs.
- See **Appendix 4** for additional best/promising interventions and programs to potentially reduce child maltreatment/fatalities, from *The California Evidence-Based Clearinghouse for Child Welfare.*

- ***Reduce Confidentiality Barriers***
    - For years, a significant roadblock to providing the public with information about child abuse deaths were federal and state confidentiality laws that protect against disclosure of child welfare records, including child abuse reports, investigations and findings.
        - Citing these concerns, Congress amended the federal Child Abuse Prevention and Treatment Act (CAPTA) in 1996 to require the public disclosure of the findings or information about a case of child abuse or neglect that resulted in a child fatality or near fatality.
        - In late 2008 State Representative Jonathan Paton wrote a bill geared toward reforming Arizona's CWS stating that transparency was one of the reforms to take place as CWS is one of the most secretive publicly funded operations (Kornman, 2008).
        - California Senate Bill (SB) 39-Child Fatality Reporting and Disclosure Requirements, which went into effect in 2008, provides access and disclosure of

child fatality records which were previously withheld by CWS. SB 39 is a model for balancing privacy interests of children with the public request for information regarding child abuse and neglect deaths:

1. Within five days of a death where there is a reasonable suspicion that the death was caused by abuse or neglect, the county agency must disclose the age, gender, and date of death of the child, and whether a law enforcement or child welfare agency, or both, are conducting an investigation.
2. Once the investigation is completed, the agency, upon request, must disclose specific documents. These documents include information that helps to determine the extent of the child welfare agency's involvement with the family prior to the child's death (e.g. previous referrals, risk and safety assessments, police reports, and medical records other than for diagnosis or treatment of mental health)
3. Members of the public may seek access to portions of a child's actual case file rather than a summary– including investigative narratives, and contact logs - by filing a petition with the juvenile court.
4. CDSS must report aggregate statewide data regarding fatalities/near fatalities as a confirmed result of child abuse/neglect annually. The first report (2008) by CDSS is anticipated to be completed by February 2010 and will be posted online.

(Grimm, 2007; Children's Advocacy Institute, 2007)

- A 2008 Children's Advocacy Institute (CAI) and First Star report, titled *State Secrecy and Child Deaths in the U.S.*, evaluates all 50 U.S. states and the District of Columbia state's public disclosure laws and policies regarding cases of child abuse or neglect that resulted in fatalities and near fatalities.
  - Report ranks states from "A" for the best, most transparent policies to "F" for the most secretive or non-existent ones. The results reveal wide variation among the states, with only 6 states earning an "A" or "A-" an alarming 28 states deserving a "C+" or lower, and a staggering 10 states receiving an "F" grade.
    - California earned an A- rating
- Legislation is also being sought in California for a database system which will allow for the easier sharing of information across various public agencies (The Associated Press, 2009).

- ***Multidisciplinary Coordination, Cooperation and Response***

  Safeguarding children is everybody's responsibility, not just the domain of CWS workers. Promoting the building of coordinating and cooperating intra- and inter-agency networks to facilitate the sharing of information and expertise is a best practice in regard to effectively responding to risk and reducing child fatalities, and should include the following professionals:
  - Law Enforcement
    - First Responders
    - Detectives/ Investigators
      - Homicide or Child Abuse Specialists
  - Child Protective Services
    - Emergency or Immediate Responder
    - Child Interview Specialist/ Forensic Interviewer

        - "Alternative Care" Identification
        - On-going, continuing family contact
    - Medical
        - EMT's or First Responders
        - ED Personnel, including hospital SW
        - Medical Specialists (child abuse/ trauma expertise)
        - Medical Examiner
    - Legal
        - Prosecutor- criminal proceedings lead
        - County Counsel- juvenile court proceedings lead
        - Victim Witness Providers
    - Therapeutic
        - Emergency/ Crisis Response for survivors
        - Trauma Informed Therapy for siblings (TF-CBT)
        - Continuing therapy for non-offending parents
        - Support for MDT personnel

The ICAN Multi-Agency Identification and Investigation of Severe Nonfatal and Fatal Child Injury: Guidelines for Networking, Communication and Collaboration Manual (2009) encourages CWS workers to get to know their above counterparts before a worst case scenario comes up. Identifying what other agencies investigative protocol for child death case are (as well as their legal responsibilities) and developing a joint investigative protocol together is key. Seeing each other as sharing a common goal to hold the person who committed maltreatment responsible for their actions/ inactions will allow these entities to assist each other in fact-finding and sharing of information to develop the best approach, which keeps the best interest of the children in focus. Establishing authorization for release of information, medical records, confidentiality and sharing contact information among related professionals allows for more streamlined communications.

Improved specialized cross-training by agencies involved and stronger building of community relationships and networks can lessen the effects or even eliminate some of the following potential obstacles and pitfalls that commonly present themselves during an investigation into suspected child abuse/fatality (ICAN Manual, 2009; Alexander, 2007; Lashley, 2005; National Institute of Corrections, 2004; Ells, 2000):

- *System-wide Obstacles*
    - Not calling law enforcement early enough in a case of child injury/fatality
    - Not being able to get accurate medical and mental health records for children or adults in the case to assess danger adequately
    - Providing evidence or details about the injury or investigation to family members that can be used to contrive an alibi or change the explanation of the injury
    - Bureaucratic red tape that blocks timely access to legal authority for certain emergency medical treatment, search warrants, past medical records, or protective orders
    - Failure to collect and document the interviews by 911 dispatchers, EMS, CWS or other professionals who have had contact with the child or the case

- Doing parallel and separate assessments or investigations without collaborating with the other agencies can undermine the quality of each assessment or investigation
- Competing or conflicting legal time frames in criminal and juvenile court systems
- Lack of systematic notification to all agencies when a child victim or a suspect are concurrently involved with criminal, juvenile and/or family law court proceedings involving the injured child or other children in the care
- Not having agreed upon pathways to resolve disagreements among agencies
- Continual turnover of agency experts or personnel trained in the identification and investigation of child maltreatment
- Insufficient training within the ranks of all agencies about best practices in responding to incidents of child maltreatment or unexplained deaths 24
- Lack of, or limited access to, trained forensic professionals in the community who are experienced in recognizing and responding to cases of child maltreatment
- Not knowing how to make direct contact with other agencies involved in the assessment or investigation or whom to contact or how they are organized
- Not maintaining a "healthy suspicion" after a death/injury
- Allowing personal beliefs and feelings to interfere with doing one's job such as not producing thorough reports, providing only selective biased information, withholding certain facts and/or failing to consult and collaborate with experts in the field

- *Child Welfare Services and Dependency Court System Obstacles*
  - Not finding out about other children (including newborns) under the custody of the suspected abusing parent
  - Giving family members and witnesses specific information from the investigation causing them to contrive an alibi or change their story before law enforcement has interviewed them to lock in a statement
  - Failure to examining scrupulously all in-home or relative placements as to whether or not the parent or relative may still be in denial of the risks posed by the suspect
  - Not having sufficient training in forensic interviewing which leads to leading interviews that can contaminate the evidence and/or cause possible secondary trauma to the child
  - Tipping off the suspect or suspect's family with too many explicit details of the investigation by conducting interviews or family conferences for CWS assessments and/or upcoming Dependency Court hearings
  - Having to provide detailed information about the child's injury or death in Dependency Court while the criminal investigation is still taking place
  - Explaining to family members and witnesses specific medical information on the status and possible mechanism of the child's injury before law enforcement has interviewed them to lock in a statement
  - Failing to turn over case records to prosecutors for review per P.C. 827 or not honoring criminal court subpoenas in a timely manner (ICAN, 2009)

- ***Child Fatality Review Teams***

Federal legislation further supported the development of multi-disciplinary and multi-agency Child Fatality Review Teams (CFRTs), to provide a coordinated approach to assessing and improving the quality of current responses to reports of child deaths. In an amendment to the 1992 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), States were required to include information on Child Death Reviews (CDRs) in their program plans. CFRTs, now exist at a State, local, or State/local level[8] in the District of Columbia and in every State but Idaho. CFRTs are composed of prosecutors, coroners or medical examiners, law enforcement personnel, CWS workers, public health care providers, and others. These CFRTs are not uniform, as there is variation across and within states on a number of case review team program components including leadership, the type of deaths that are reviewed (by age, manner, cause and location), the information made available for review, the time frame from death to review and the process to move from reviews to prevention and case review reporting. (Covington, et al., 2007, p. 436; Child Welfare Information Gateway, 2008)

CFRTs are characterized as one of the most promising approaches to preventing child abuse and neglect deaths, responding to, and accurately accounting for these deaths (Department of Health and Human Services, Administration for Children and Families, 1995). CFRTs are a shared process that brings people together from multiple disciplines to discuss detailed information on the circumstances leading to the deaths of children and the response to these deaths. The structure of CFRTs supports comprehensive case management with coordinated efforts from multiple agencies. The process of CFRTs can improve interagency communication, collaboration and accountability considerably. Interagency, interdisciplinary review team environments are excellent places to identify lessons to be learned, address systematic issues, and grow from tragic events. In fact the diversity of perspectives in CFRTs provides a power for beyond the capacity of any one discipline or agency active alone, to understand the events and learn from them (Wilson & Martinez, 2007, p. 653).

- Child Death Review objectives include:
  - Accurate identification of cause and manner of death
  - Improve communication and linkages among agencies to enhance coordination of efforts
  - Improve agency responses in the investigation of child deaths
  - Improve protection of siblings/other children in the homes of deceased children
  - Improve service delivery to children, families, providers and community members
  - Improve criminal investigations and prosecution of child homicides
  - Identify specific barriers and system issues involved in the deaths of children
  - Identify significant risk factors and trends in child fatalities
  - Identify and advocate for needed changes in legislation, policy and practices
  - Increase public awareness/advocacy for issues affecting the health and safety of children

(Covington, et al., 2007, p. 430-431)

[8] In California every county either has a team or joins with a neighboring county. All counties currently are associated with a team and are under one of the eight regional groups of the State Child Death Review Team (Child Welfare Information Gateway, 2008).

There are different approaches used by teams around the country to conduct CDR. The *National Center for Child Death Review* and the Michigan CDR program developed *Guides to Effective Child Death Reviews* for 12 causes of death to provide guidance for and conducting quality reviews. Whatever the approach the six steps to a quality child death review listed below, will help lead to complete and thorough reviews that address the maximum number of issues involved in children's fatalities:

1. Share, question, and clarify all case information
2. Discuss the investigations
3. Discuss the delivery of services
4. Identify risk factors
5. Recommend system improvements
6. Identify and take action to implement prevention recommendations

(The National MCH Center for Child Death Review, 2005)

When addressing the issue of child maltreatment, and especially child fatalities, prevention is a recurring theme. Well-designed, properly organized CFRTs appear to offer hope for defining the underlying nature and scope of fatalities due to child abuse and neglect. When teams review a cluster of deaths, they are able to identify trends and patterns, which they attempt to translate into recommendations to reduce child fatalities. For the complex task of approaching injury prevention in a systematic way, a model some CFRTs are finding useful is *The Spectrum of Prevention Model* (1999) developed by Larry Cohen of the Prevention Institute and adapted by Rattray, et al. (2002). Starting in 2002, the California Department of Health Services has provided annual trainings to California County's CFRTs on this model.

The Spectrum of Prevention Model describes six levels at which prevention activities can take place:

- Level 1: Strengthening Individual Knowledge and Skills
- Level 2: Promoting Community Education
- Level 3: Educating Providers-Training People Who Can Make A Difference
- Level 4: Fostering Coalitions and Networks
- Level 5: Changing Organizational Policies and Practices
- Level 6: Mobilizing Communities and Influencing Policy and Legislation

In order for recommendations to be effective in getting appropriate responses to prevent child deaths they need to identify the primary outcome of interest for the prevention strategy. And should also clearly describe the particular risk or protective factor that is to be influenced (Alexander, S., 2007, p. 697).

Across the nation, more teams are seeking training and connections with prevention partners and are becoming skilled in using reviews to develop strategies to reduce deaths. A major challenge for the CFRT process is assuring that what is learned from review gets translated into solid and actionable recommendations that are heard by the right people and result in action and changes that lead to prevention (Alexander, S., 2007, p. 693). States continue to evolve their local and state review processes, as a prevention model-using quality child death case reviews to identify risk factors, document findings, develop effective recommendations, and move those recommendations to actions that promote child, adolescent, and family health (Covington, et al.,

2007, p. 433). As of April 2006, 30 states had a model in place in which local CFRTs submit findings to state advisory committees (Covington, et al., 2006). These state committees then review the findings of local teams and make recommendations for improvements to state policies and practices.

To date, the power of this CDR process has led to an increased understanding of the causes of child fatalities; better agency responses to protect children at risk; development of child health and safety services, legislation, policies, and prevention programs; development of product safety actions; and increased public awareness of child and safety issues. CFRT processes helps identify risk factors that may assist prevention professionals, such as those engaged in home visiting and parenting education, to prevent future deaths. In addition, teams are demonstrating effectiveness in translating review findings into action by partnering with child welfare and other child health and safety groups (National MCH Center for Child Death Review, 2007).

Most states whose CFRTs have been operating for several years report having influenced policy changes and prevention activities on both state and local level. For example, Michigan's Fifth Annual Report finds that from 1995 to 2003, local review teams made 1767 recommendations and took local actions to implement 935 of them. A few of the activities and policy changes that have occurred around abuse/neglect related child fatalities as a result of CDRTs in selected states include:

- Advocacy and support for passage of the Child Protection Bill making recklessly and negligently placing a child in danger of harm a felony (Georgia)
- Changes in the length of sentences for criminals who kill a child (Iowa)
- Educational materials on bed sharing were distributed statewide (Iowa)
- The enactment of a statewide Infant Homicide Prevention Act (North Carolina)
- Automatic inclusion of toxicology screens for all unexplained deaths of children (Oklahoma)
- Requiring autopsies in all deaths before the cause of death can be listed as SIDS (Oklahoma)
- Statewide Child Welfare Error Reduction Teams developed to reduce the number of child fatalities in foster care. The agencies in which these teams are housed are mandated by law to use client-level data and other evidence as a basis for decision making (Illinois)

(Alexander, S., 2007, p. 693-695)

A number of states electronically document their review findings and the prevention recommendations and initiatives resulting from their reviews. The virtual library of the ICAN-NCFR Website (http:www.ican-ncrf.org) has 400 team reports from 43 state teams, 50 local teams and Washington, DC. Reports from local teams in: Australia, Canada, and New Zealand are also available. Various data and anecdotal evidence of the vast number of fatality prevention efforts resulting from the reviews are available can be found there (Durfee, 2007, p. 511).

Recommendations for Change from Local/State CFRTs

Child Fatality Review Teams: Recommendations

- ***Recommendations About the CFRT Process***
  - Form national and international CFRTs
  - Teams should review all child deaths
  - Teams should consider all deaths to be on a spectrum of potential preventability
  - Develop and agree on a core national/international database
  - Regionalize death review teams to optimize expertise and case volume
  - Peer review of CFRTs with each other (e.g. joint meetings and teleconferencing)
  - Clarify roles of responsibility, authority and leadership of each representative agency in order to promote a better understanding of their interlocking roles
  - Improve professional coordination/communication systems
  - Develop a list of potential disasters/terrorism/epidemics and plan accordingly
  - Implement general recommendations as specific actions
  - Study recommendations of other teams before formulating your own
  - Extensively research content areas and prevention programs; develop tracking mechanisms to assess the effectiveness of approaches to prevention and modify as needed
  - Issue annual reports
  - Develop a monitoring system for progress on recommendations and publicize this widely

(Alexander, 2007, p.748)

  - To better use the data to advocate for actions to prevent child deaths, improved nationwide coordination and standardization in how State and local CFRTs collect data and analyze and report on their findings is recommended. The use of a web-based Child Death Review Case Reporting System for State and local teams is a promising response to this need. As of April 2008, 22 States were using the standardized system and one more was in the process of implementing it

(Child Information Gateway, 2009)

- ***Components of Effective CFRT Reviews-Child Abuse and Neglect***
  - *Records Needed at Review*
    - Autopsy reports
    - Scene investigation reports and photos
    - Interviews with family members
    - Names, ages and genders of other children in home
    - Child Care Licensing investigative reports
    - EMS run reports
    - Emergency Department reports
    - Prior CWS history on child, caregivers and person supervising child at time of death
    - Child's health history
    - Criminal background checks on person supervising child at time of death
    - Home visits records from public health or other services
    - Any information on prior deaths of children in family
    - Any pertinent out-of-state history

(National MCH Center for Child Death Review, 2005)

- *Services*
  - Involving CWS in assessing the removal of remaining children from the home.
  - Bereavement services for parents and other family members.
  - Burial payments for families needing financial assistance.
  - Critical Incident Stress Debriefing for persons responding to scene.

- *Questions to Improve Agency Practices*
  - Are investigations coordinated with medical examiners, law enforcement and CWS?
  - Are autopsy protocols in place?
  - Are comprehensive scene investigations conducted at place of death, as soon as possible, including scene reenactments and interviews?
  - Are referrals made for bereavement services?
  - Are high-risk families with newborns and young infants provided prevention services?
  - Did mandatory reporters comply with requirement(s) of child protection laws?
  - Were prior inflicted injuries identified and reported?
  - Did CWS conduct a full investigation and make appropriate referrals and recommendations?

- *Effective Preventative Actions*
  - Training hospital emergency room staff to improve their ability to identify child abuse fatalities and improve reporting to the appropriate agencies.
  - Providing an advisory on the mandated reporting of child abuse and neglect to local human service agencies, hospitals and physicians.
  - Re-contacting referents making reports of child abuse/neglect, particularly mandated reporters to assist in screening decisions
  - Completing multiple collateral contacts and retain supporting documentation and contact information in the case file
  - Case management, referral and follow-up of infants sent home with serious health or developmental problems.
  - Media campaigns to enlighten and inform the general public on known fatality-producing behaviors, i.e., violently shaking a child out of frustration.
  - Crisis Nurseries which serve as havens for parents "on the edge" where they can leave their children for a specified period of time
  - Intensive home visiting services to parents of at-risk infants and toddlers.
  - Evidence-based education and intervention programs for parents (see Appendix 4-CEBC)

(The National MCH Center for Child Death Review, 2005)

- ***What types of additional information should be available to CFRTs?***
  - Important information reflecting what was known to the agency about the family and the child before the child's death and how the agency responded to earlier reports of a child at risk may be found in many different parts of the case file.
  - If the death occurred in a foster home, information about the licensing, supervision and support provided to the foster parents is critical.

- The agency whose actions are under scrutiny should not be allowed to determine what documents will be removed from the file and what documents will be disclosed.
    - As long as personally identifying information is removed, the rest of the file should be disclosed.
- Documents necessary to these determinations include such things as the risk and safety assessments, case notes, investigative narratives, emergency protocol/intake referral, police reports, and coroner's reports (documents sought by SB 39)
    - The release of detailed information about child abuse deaths can be the catalyst for real change in the system. For example, in the State of Washington, the release of specific information about the deaths of Justice and Raiden Robinson led to reforms in child abuse investigative practices and the frequency of caseworker visits to families in which children were identified at risk.

(Children's Advocacy Institute, 2007)

- ***At each case review, what questions should CFRT members seek to answer?***
    - Is the investigation complete, or should we recommend further investigation? If so, what more do we need to know? Do we need to discuss it at our next meeting?
    - Are there services we should provide to family members, other children and other persons in the community as a result of this death?
    - Could this death have been prevented and if so, what risk factors were involved in this child's death?
    - What changes in behaviors, technologies, agency systems and/or laws could minimize these risk factors and prevent another death?
    - What are our best recommendations for helping to make these changes?
    - Who should take the lead in implementing our recommendations?
    - Is our review of this case complete or do we need to discuss it at our next meeting?

(National MCH Center for Child Death Review, 2005)

- ***Use of News Media***

News media in particular may be seen as a hazard to teams, and they can be. However, finding or creating opportunities for the recommendations of the team to be heard and acted on are crucial for change. Teams should strive to develop or maintain a positive, ongoing relationship with the media. At the least, a team will do well to have a mechanism for active information sharing with the news media and the community. Remembering that print, radio, television and the Internet are also forums in which to educate the community and advocate for child death review. The release of the CFRT annual report and the follow-up pieces in the media provide opportunities for public education and the spreading of message about prevention programs (Durfee, 2007, p. 521).

- ***Clear and Effective Prevention Strategies***

Some CFRTs recommendations for preventing child death may be more easily understood and endorsed by the community and politicians than others. Prevention strategies for situations perceived by many as "accidents" and not viewed as directly involving parent or caretaker behavior tend to be easier to move to action. Therefore CFRTs have to be persistent and creative to effect change in the more difficult area. For the more difficult prevention goals, identifying multiple strategies with small and measurable steps may be more effective than a broad recommendation such as increasing parent education (Alexander, S., 2007, p. 698). Identifying

the most effective prevention recommendation and learning about the individuals or groups that must be reached to bring about action the recommendation is the first step. The next step in prevention advocacy is determining key messages to be communicated and the most effective way to communicate them. Remember the most effective messages are brief (e.g. "Back to Sleep"). The first impulse is to saturate the audience with all the facts and information available, yet this leads to loss of audience attention before getting to the simple and core message that parents can remember. The solution to the "curse of knowledge" is to think like an outsider (Heath, 2003). CFRTs should ask the question "Why is this important?" until they hit on something simple and concrete (Alexander, S., 2007, p. 702).

For example, recently, most Shaken Baby Syndrome prevention efforts are moving from the longstanding strategy of telling parents "don't shake" to focusing on the main cause of shaking- the inability to cope with infant crying. In a sample of adults who confessed to physically abusing a young child, 67% identified crying as the circumstance that triggered the abuse (Flaherty, 2006). Therefore, prevention programs are successfully working to reach new parents in hospitals after delivery of infants, through pediatrician offices (e.g. Prevent Child Abuse Georgia's "Coping with Crying" Program) and other health care settings to educate parents about infant crying and ways to cope. This message is something that everyone can relate to instead of just the message "Don't Shake" which is something most people feel would never apply to them and thus may limit their openness to the prevention message. Guidelines for writing effective recommendations can be found on the National MCH Center for Child Death Review Website (http://www.childdeathreview.org) (Alexander, S., 2007, p. 698).

- ***Public Awareness Campaigns***

Child maltreatment prevention media campaigns may involve television advertisements, radio advertisements, bulletin boards, educational materials, posters, brochures, and newsletters. These components may occur in different combinations, and may be targeted to specific groups (e.g., parents of newborns) or to a more general population, such as a geographic region. Public awareness campaigns involve focused messages delivered through various forms of media described, with the expressed intent to increase knowledge and awareness of child maltreatment, which in turn may influence behaviors that elevate child maltreatment risk (Douglas, 2009).

Studies that tracked rates of child maltreatment reports attributed increased reporting to improved awareness of maltreatment (Andrews, McLeese, & Curran, 1995; Hoefnagels & Baartman, 1997). The studies reviewed evaluated the effectiveness of public awareness campaigns to increase knowledge about child sexual abuse (Rheingold et al., 2007); shaken baby syndrome (Deyo, Skybo, & Carroll, 2008); safe haven programs (California Department of Social Services, 2005); child abuse (Hoefnagels & Baartman, 1997); the connection between substance abuse and child abuse (Andrews et al., 1995); and positive parenting practices (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009; Calam, Sanders, Miller, Sadhnani, & Carmont, 2008; Waterston et al., 2009).

An experimental study by Prinz and colleagues (2009) *showed a statistically significant decrease in child maltreatment outcomes in counties exposed to the media campaign compared to control counties.* Three studies found an increase in reports of child abuse and neglect after public awareness campaigns had been implemented, suggesting increased awareness of child maltreatment and knowledge of where to report (Andrews et al., 1995; Hoefnagels & Baartman,

1997). Some parents reported learning and retaining new information as a result of a shaken baby campaign (Deyo et al.,2008). Other parents reported improved parenting skills and behaviors (Calam et al., 2008; California Department of Social Services, 2005; Rheingold et al., 2007; Waterston et al., 2009).

- ***State of Wyoming CFRT– Interagency Recommendations to Reduce Child Fatalities (2006)***
  - *Public Policy*
    - Increase the penalty for individuals convicted of child abuse.
    - Establish in statute that an autopsy is to be completed on all "unexpected" deaths of a children, as well as define unexpected.
    - Consent Decrees between the parents and district attorney should not be used in abuse/neglect cases.

  - *Law Enforcement*
    - Law enforcement agencies need to document reported cases of suspected child abuse and/or neglect even if there is not enough evidence for prosecution.
    - Law enforcement should receive in-depth training on how to recognize signs of abuse/neglect on child cases.
    - Law enforcement should receive training on recognition of scene evidence needed in identifying victims of shaken Baby Syndrome.

  - *Health Care/Medical*
    - Emergency room doctors should be better trained in identifying possible child abuse/neglect cases and the steps to report these cases to the proper authorities.
    - Emergency room nurses should receive further training on identification and requirements of reporting child abuse and neglect.
    - Provide clarification to local hospitals concerning reporting of child abuse/neglect and testifying, per HIPPA.
    - Establish ER protocol for identifying Shaken Baby Syndrome signs and symptoms.

  - *Department of Family Services*
    - The Department of Family Services should receive extensive training on identification of Shaken Baby Syndrome and the identification of it.
    - DFS should receive further training on the appropriate information to provide to the local district or county attorney for possible prosecution.
    - Activate monthly child protection teams throughout the state.
    - DFS should train caseworkers in appropriate services for families, as well as how to determine if reunification is appropriate in specific cases.
    - Establish protocol for continued monitoring of a family upon reunification.
    - Cases of severe violence should receive a comprehensive clinical, psychological and substance abuse assessments.
    - The Department of Family Services should become proactive in educating young parents on how to parent appropriately.
    - There is a need for continued training to occur on a variety of issues, to include detection, investigation and prosecution of child abuse cases.

- *Coroner*
  - Establish protocol that states ALL unexpected deaths of a child under the age of four should receive an autopsy.
  - Establish required training for all coroners surrounding abuse/neglect and Shaken Baby Syndrome.
  - Establish continuing education requirement yearly for each coroner that incorporates child abuse/neglect cases including shaken Baby Syndrome.

- *Legal System*
  - Train prosecuting attorneys on evidence based prosecution of child abuse and neglect cases.
  - Consent decrees could be used on those cases identified as low risk for future abuse or neglect.

(*State of Wyoming Child Major Injury/Fatality Review Team Eighth Annual Report,* 2006*,* available at: http://www.childdeathreview.org/reports/WY8thannualreport.pdf)

- **Additional Recommendations from Child Fatality Review Teams: *Results of a 2008 US Nationwide Exploratory Study Concerning Maltreatment Fatalities and Social Service Delivery***

This comprehensive study reviewed and consolidated reports from CFRTs throughout the United States to evaluate the identification of problems and recommendations by professionals concerning child maltreatment fatalities. Formal recommendations from the CFRTs across the nation concerning how to change the service system to better meet the needs of children and the families are summarized below. Over 300 diverse recommendations for change were grouped into 11 macro categories and 51 micro categories. The following table provides a list of these categories, as well as a numerical count (frequency) for each one, while the second table (on pg. 37) provides examples from each of the categories (Douglas & Cunningham, 2008). Many of these micro and macro recommendations parallel what has been previously mentioned in this literature review.

Table Total macro and micro recommendations made by CFRT (N = 313) and number of states making each macro (and micro) recommendation

Macro recommendation — Micro recommendation	Total recommendations[a]	Total states making recommendations
Agency communication:	**29**	**17**
— Communication within agencies	(1)	(1)
— Communication between agencies	(24)	(16)
— Communication between states	(4)	(4)
Child death investigations:	**50**	**15**
— Autopsy protocol	(12)	(5)
— Child death investigation	(29)	(12)
— Child maltreatment investigations	(1)	(1)
— Drug screening at time of death (caretaker)	(5)	(3)
— Funding for child death investigations	(3)	(2)
Child death review teams:	**21**	**8**
— Child death review team membership	(1)	(1)
— Child death review team funding	(3)	(2)
— Child death review team procedure	(2)	(2)
— Child death review team protocol	(15)	(6)
Child welfare system:	**14**	**10**
— Adequate and appropriate treatment	(1)	(1)
— Follow-up for surviving children	(5)	(3)
— Improvements in child welfare system, general	(5)	(5)
— Increase substance abuse treatment for parents	(3)	(2)
— Caseload problems	(1)	(1)
Criminal responsibility:	**8**	**5**
— Penalty for driving with unrestrained child	(4)	(3)
— Sentencing for child maltreatment that results in death	(2)	(1)
— Sentencing for criminal maltreatment	(2)	(2)
Home visiting programmes:	**7**	**6**
— Increase in home visiting programmes	(7)	(6)
Mandated reporting:	**14**	**8**
— Adequate training and enforcement of reporting laws	(14)	(8)
Public education:	**98**	**23**
— Caretaker education	(1)	(1)
— Drowning education and prevention	(14)	(8)
— Fire safety	(5)	(2)
— Motor vehicle-related neglect	(6)	(5)
— Outreach	(1)	(1)
— Outreach, hard to reach parents	(2)	(2)
— Parent education	(18)	(10)
— Public education of reporting for CAN	(4)	(4)
— Public education of CAN	(6)	(5)
— Safe sleeping environment, educating professionals	(1)	(1)
— Safe sleeping environment, educating public	(11)	(8)
— Safety of secondary childcare providers	(6)	(6)
— Shaken baby syndrome prevention/education	(11)	(7)
— Supervision of children	(11)	(9)
— Violence prevention	(1)	(1)
Risk factors/assessment:	**36**	**10**
— Comprehensive risk assessment of families	(1)	(1)
— Psychological evaluation, risk assessment	(2)	(2)
— Risk assessment/risk factors to be monitored	(23)	(6)
— Risk assessment for intimate partner violence	(6)	(3)
— Risk assessment for substance abuse	(4)	(3)
Training for professionals:	**30**	**12**
— Training for caseworkers	(7)	(5)
— Training for caretakers	(10)	(2)
— Training for first responders	(1)	(1)
— Training for judiciary	(1)	(1)
— Training for providers	(7)	(6)
— Training for mental health providers	(4)	(1)
Miscellaneous:	**6**	**5**
— Abandoned infants	(2)	(2)
— Funding for prevention programmes	(1)	(1)
— Hospital protocol	(3)	(3)

[a] Total macro recommendations are given in bold; micro recommendations are given in plain font in parentheses. CRFT = Child Fatality Review Teams. Can = Child abuse and neglect.

Child Abuse Review Vol. 17: 331–351 (2008)
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Table Recommendations by category with examples

Macro category	Example of recommendation from differing micro categories
Public education and outreach	*Drowning*: Emphasis on drowning risk factors in all risk assessments. Incorporate drowning prevention into checklists and educational material used by home visiting programmes [Florida]
	Public education about child abuse and neglect-reporting: DCFS (Department of Children and Family Services) should do a community awareness campaign 'If only one person had called the hotline, this child could be alive today.' [Illinois]
	Safe sleeping environments: Safe-Sleep campaigns can save lives. Community leaders need to . . . make safe-sleep a regular talking point for local parents. Caregivers need to be reminded that Safe-Sleep means placing their baby on their back to sleep, in a crib with no pillows, comforters, bumpers or stuffed animals. [Indiana]
	Shaken Baby Syndrome: Very young children are often the victims of Child Abuse Homicide. Frustrated caregivers, often without any Parental training, combine unrealistic expectations for children's behaviour with a lack of appreciation for their vulnerability. [Kansas]
Child death investigations	*Autopsy protocol*. Expand required autopsies for children from . . . birth through six years. [Iowa]
	Drug screening at time of death (caretaker). In cases of child deaths resulting from firearms, the CDRB (child death review board) . . . recommends the child death scene investigation include mandatory field sobriety testing of all individuals who were present during the shooting. [Oklahoma]
Risk factors/assessment	*Psychological evaluation, risk assessment*. [P]sychological evaluation should be added to . . . risk assessment procedures. Frequency of risk assessment should be increased by clearly defining . . . use in CPS (child protective services) . . . policy. [Florida]
	Risk assessment for intimate partner violence. Require state funded medical insurance providers to . . . screen for domestic violence during well child visits . . . encourage private insurers to [do same]. [Delaware]
	Risk assessment for substance abuse. The department should clarify its policy regarding child endangerment and determinations of child maltreatment to include methamphetamine manufacturing, possession or use as a risk factor . . . [P]ersons mandated to report child protection issues . . . must report when a child is exposed to methamphetamine manufacturing, possession or use [Montana]
Training for professionals	*Training for caseworkers*. Public Health, CPS and other workers providing services for domestic violence families need ongoing training to assess the risk of physical harm to any children in the household. [Washington]
	Training for providers. Educating and supporting the medical community in identifying child abuse/ neglect. [Kentucky]
Agency communication	*Communication between agencies*. Encouraging collaboration among human service agencies and other community resources that can provide support to families at risk for abuse/neglect. [Kentucky]
	Communication within agencies. [P]rocedure in place where . . . Programme Administrators . . . immediately made aware of a death or serious injury. [Maine]
	Communication between states. Improve case coordination across county and state jurisdictions. [Oregon]
Child death review teams	*Child death review panel procedure*. The . . . Legislature should amend the Child Protection Law so that the CDR (child death review) Case Report may be used for research purposes . . . [Michigan]
	Child death review panel protocol. Local teams should be granted discretionary authority to review all child deaths based on local interest and resources. [Florida]
Mandated reporting	*Adequate and appropriate training and enforcement of reporting laws*. Expand training for legally mandated professionals on recognition [of child maltreatment]. [Georgia]
Child welfare system	*Follow-up for surviving children*. When a child dies due to . . . neglect or aggression, efforts be made to visit the surviving children in the home on an on-going basis for a minimum of 3 months to assess their safety and well-being, and enable referrals to appropriate services. [Georgia]
	Improvements in child welfare system, general. Conduct an analysis on the feasibility of providing a 24-hour centralized intake for DCYF (Department of Children, Youth and Families). [New Hampshire]
	Increase substance abuse treatment for parents. Development of SA [substance abuse] treatment programmes for pregnant/parenting women. [Arizona]
Criminal responsibility	*Penalty for driving with unrestrained child*. [I]ncreased fines for drivers transporting unrestrained children. [Oklahoma]
	Sentencing for child . . . death. Increased . . . penalty for child endangerment resulting in . . . death of a child. [Iowa]
Home visiting programmes	*Home visiting*. Home visitation . . . crucial for young parents, particularly those [with] special needs child. [Wyoming]
Miscellaneous	*Abandoned infants*. [L]ocal social services agency should send information about the Safe Place For Newborns to schools . . . and . . . agencies that provide social, educational and recreational activities to youth. [Minnesota]
	Hospital protocol. The commission supports hospitals in developing some type of internal system that alerts physicians when a child's family has a history of violence and/or abuse. [Maine]

- *What are the nationwide themed recommendations of local and state CFRTs?*
    1. *Agency communication.* The majority of recommendations in this category were related to improved communication and collaboration between agencies working with children and families: hospitals, health providers, law enforcement and child welfare services. Four recommendations concerned improved communication and coordination between jurisdictions and states, through legislative action or increased diligence by the child welfare system.

    2. *Child death investigations.* Investigations were mentioned 50 times and in 15 states. The recommendations focused on the need for thorough, timely and standardized investigations and autopsies. The importance of communication between investigating agencies was cited often. Several teams suggested investigating all child deaths regardless of suspicion of crime.

    3. *Child death review teams.* Most of the recommendations in this category (15), addressed the functions of CFRT, including the responsibilities, functioning and training of teams.

    4. *Child welfare system.* Recommendations in this category concerned adequate and appropriate treatment of children in the system, follow-up in services for surviving children, increases in substance abuse treatment for parents, caseload problems and recommendations regarding the child welfare system in general.

    5. *Criminal responsibility.* The recommendations in this category stressed the criminalization of child maltreatment and child maltreatment fatalities. Half of the recommendations made in this category concerned driving with children in a car, a topic that was referenced numerous times in multiple reports.

    6. *Home visiting programs.* Recommendations in this category concerned expanding home visiting programs. Targeted populations included first time or expectant mothers and families, 'high-risk' families, children with special needs and young parents. Recommended services included health, safety and parental assessments, parenting education, instruction and support regarding prenatal care, household management and coping with environmental dangers.

    7. *Mandated reporting.* Fourteen recommendations in eight states concerned the responsibilities of mandated reporters. CFRT reports emphasized the need for individuals to comply with mandated reporting laws.

    8. *Public education and outreach.* Public education was mentioned 96 times by 22 different states. This category covered a broad range of topics including drowning education and prevention, educating the public about safe sleeping environments, educating parents about the importance of adequate supervision and shaken baby syndrome prevention campaigns.

    9. *Risk factors/assessment.* Many recommendations concerned risk factors of child maltreatment and proper assessment of risk for maltreatment. Out of 36

recommendations in this category, ten were related to assessment for substance abuse and intimate partner violence in the family. CFRT reports stressed the importance of proper training in order to increase better identification, treatment and follow-up for risk factors.

10. *Training for professionals.* A total of 30 recommendations in ten states concerned increased training for professionals. Recommendations included training for professional caretakers, caseworkers, mental health providers and other social service providers concerning how to safely care for children and identify maltreatment.

11. *Miscellaneous*. There were six recommendations that did not fit into any of the macro-categories created. These included recommendations about abandoned infants, funding for prevention programs and hospital protocol.

(Douglas & Cunningham, 2008, p. 338-342)

Conclusion

The death of a child due to abuse or neglect is a tragedy that is not only felt by those who knew the child but also by the community at large. Predicting the likelihood that a child will be a victim of serious harm by his/her caretaker is a complex charge. However, knowledge of the various child, perpetrator, family and environmental risk factors to consider can lead to improved assessment and response. For CWS staff, it is best to establish the kinds of responses and working conditions that are more likely to produce safe practice. Committing to a multi-faceted approach to help reduce child abuse and neglect related deaths includes: scrutiny of high risk cases; utilizing standardized safety and risk assessment tools; having manageable CWS caseloads; providing a strong support system for lineworkers; maintaining quality supervision; facilitating basic and advanced training for professionals; integrating evidence-based prevention and intervention programs; promoting information-sharing among community agencies; and working with multidisciplinary teams. Currently Child Fatality Review Teams appear to be among the most promising approaches and based on patterns and trends provide valuable recommendations to accurately count, respond to, and prevent future child abuse and neglect fatalities.

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Appendix 1:
United States-Child Fatalities, 2006 and 2007

(Source: U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. [2009]. *Child Maltreatment 2007*. Washington (DC): Government Printing Office. Available at: www.acf.hhs.gov/programs/cb/pubs/cm07/index.htm)

	2006					2007				
State	Child Population	Child File or SDC Fatalities	Agency File Fatalities	Total Child Fatalities	Fatalities per 100,000 Children	Child Population	Child File or SDC Fatalities	Agency File Fatalities	Total Child Fatalities	Fatalities per 100,000 Children
Alabama	1,119,663	24	0	24	2.14	1,123,537	18	5	23	2.05
Alaska	183,500	0	2	2	1.09	182,218		4	4	2.20
Arizona	1,625,870	16		16	0.98	1,669,866	25	3	28	1.68
Arkansas	696,032	19		19	2.73	700,537	20		20	2.85
California	9,401,360		140	140	1.49	9,383,924		184	184	1.96
Colorado	1,173,753	24		24	2.04	1,192,679	27	1	28	2.35
Connecticut	827,069	3		3	0.36	820,216	4		4	0.49
Delaware	204,023	0	1	1	0.49	205,646	0	0	0	0.00
District of Columbia	114,531	2	0	2	1.75	113,720	2	0	2	1.76
Florida	4,032,726	140	0	140	3.47	4,043,560	153	0	153	3.78
Georgia	2,475,382	63		63	2.55	2,531,609	61		61	2.41
Hawaii	283,576	4		4	1.41	285,694	4		4	1.40
Idaho	399,024	1		1	0.25	407,712	1		1	0.25
Illinois	3,203,178	58	0	58	1.81	3,199,159	74	0	74	2.31
Indiana	1,584,017	31	11	42	2.65	1,586,518	38	15	53	3.34
Iowa	712,097	6	0	6	0.84	711,403	5	0	5	0.70
Kansas	693,395	5	0	5	0.72	696,082	10	0	10	1.44
Kentucky	1,003,483	36	0	36	3.59	1,003,973	41	0	41	4.08
Louisiana	1,066,962	37		37	3.47	1,079,560	26	1	27	2.50
Maine	283,332	0	1	1	0.35	279,467	0	1	1	0.36
Maryland										
Massachusetts										
Michigan										
Minnesota	1,261,017	14	0	14	1.11	1,260,282	17	0	17	1.35
Mississippi	764,275	4	0	4	0.52	768,704	15	4	19	2.47
Missouri	1,425,014	43		43	3.02	1,424,830	50		50	3.51
Montana	218,929	1	0	1	0.46	219,498	1	0	1	0.46
Nebraska	445,094	3	12	15	3.37	446,145	3	13	16	3.59
Nevada	639,645	11	3	14	2.19	660,002	17	4	21	3.18
New Hampshire	302,593	1	1	2	0.66	298,186	2	3	5	1.68
New Jersey	2,079,588	31	1	32	1.54	2,063,789	29	4	33	1.60
New Mexico	497,679	7	7	14	2.81	500,276	4	3	7	1.40
New York	4,467,031	73		73	1.63	4,413,414	96		96	2.18
North Carolina										
North Dakota	143,529	1	1	2	1.39	142,809	1		1	0.70
Ohio	2,774,850	74	0	74	2.67	2,751,874	90		90	3.27
Oklahoma	889,658	26		26	2.92	899,507	29	2	31	3.45
Oregon	857,570		17	17	1.98	862,908	12		12	1.39
Pennsylvania	2,807,284	33	0	33	1.18	2,786,719	47	0	47	1.69
Puerto Rico	1,018,306		5	5	0.49	1,002,944	5	5	10	1.00
Rhode Island	236,719	0	0	0	0.00	233,115	0	0	0	0.00
South Carolina	1,048,614	10	9	19	1.81	1,059,917	12	7	19	1.79
South Dakota	196,231	1		1	0.51	196,890	8		8	4.06
Tennessee	1,462,511	22		22	1.50	1,471,486	44		44	2.99
Texas	6,489,667	257		257	3.96	6,623,366	227	1	228	3.44
Utah	796,877	13	0	13	1.63	816,822	11	0	11	1.35
Vermont	133,878	0	0	0	0.00	131,353	1	2	3	2.28
Virginia	1,821,202	20		20	1.10	1,826,179	31		31	1.70
Washington	1,525,947		21	21	1.38	1,536,368		27	27	1.76
West Virginia	388,451	6	9	15	3.86	387,381	8	4	12	3.10
Wisconsin	1,326,996	13		13	0.98	1,321,279	22		22	1.67
Wyoming	122,974	1		1	0.81	125,365	2	0	2	1.60
Total	**67,225,102**	**1,134**	**241**	**1,375**		**67,448,488**	**1,293**	**293**	**1,586**	
Weighted Rate					**2.05**					**2.35**
Number Reporting	**48**	**44**	**31**	**48**		**48**	**45**	**34**	**48**	

Appendix 2:
CDSS-Child Protective Services History
Fatal Child Abuse/Neglect Victims
(July 22, 2006-Sept. 18, 2006)

(Source: Grimm, B. 2007. Child Deaths From Abuse and Neglect: Accurate Data, Public Disclosure Needed. *Youth Law News, Journal of the National Center for Youth Law, 28* (1): 1-11)

Child Protective Services History
Fatal Child Abuse/Neglect Victims In California
July 22, 2006 – Sept. 18, 2006

Date of Death	Age	No. of Previous Reports on Family	Within 5 Yrs of Death	Within 1Yr. of Death	Open Case at Time of Death
7/22/2006	1 day	7	Yes	No	No
7/22/2006	1 day	6	Yes	Yes	No
7/22/2006	2 yrs.	2	Yes	Yes	Yes
7/28/2006	4.3 yrs	4	Yes	Yes	No
7/30/2006	5 yrs.	5	Yes	No	No
8/2/2006	7 yrs.	1	Yes	Yes	No
8/2/2006	2 mos.	1	Yes	Yes	No
8/7/2006	12 yrs.	0	No	No	No
8/9/2006 NF	1 yr	3	Yes	Yes	No
8/10/2006	4 yrs.	1	No	No	No
8/11/2006	5 yrs.	5	Yes	Yes	Yes
8/14/2006	17 yrs.	2	No	No	No
8/14/206	7 weeks	1 (2 wks.prior)	Yes	Yes	Yes
8/14/2006 NF	7 yrs.	4	Yes	Yes	yes
8/16/2006 NF	1 yr.	1	Yes	Yes	No
8/17/2006	17 yrs.	1	No	No	No
8/19/2006	1 yr.	4	Yes	No	No
8/21/2006 NF	16 yrs.	8	Yes	Yes	No
8/24/2006 Kin	16 yrs.	2	No	No	No
8/24/2006	5 wks.	3	Yes	Yes	No
8/25/2006	2 mos.	0	No	No	No
8/26/2006 NF	13 yrs.	7	Yes	Yes	No
8/26/2006	1 mo.	1	Yes	Yes	Yes
8/29/2006	2 yrs.	2	Yes	No	No
8/29/2006	12 yrs.	1	No	No	No
9/2/2006	4 yrs.	0	No	No	No
9/6/2006	Stillborn	3	Yes	Yes	Yes
9/8/2006 Day Care	8 mos.	0	No	No	No
9/8/2006	1 mo.	4	Yes	Yes	No
9/9/2006 NF	3 mos.	0	No	No	No
9/9/2006	1 mo.	0	No	No	No
9/10/2006	4 yrs.	3	Yes	Yes	No
9/11/2006 NF	2 yrs.	0	No	No	No
9/13/2006	6 yrs.	3	Yes	Yes	No
9/13/2006	4 mos.	2	Yes	Yes	Yes
9/18/2006	2 mos.	1	Yes	Yes	No

NF – Near Fatality

Kin – Relative Placement

Appendix 3:
California Structured Decision-Making (SDM) Overview and Assessment Tools

(Source: Children's Research Center, 2009, *Structured Decision Making: Policy and Procedures Manual;* Available at: http://www.dss.cahwnet.gov/cfsweb/res/pdf/SDM_Manual.pdf)

CALIFORNIA
STRUCTURED DECISION MAKING
OVERVIEW

See policy and procedures sections for each tool for complete details.

Decision	SDM® Tool		Which Cases	Who	When
Accept referral for in-person response?	Hotline Tools	Screening tool	All referrals created in CWS/CMS	Worker receiving referral	Immediately
How quickly to respond?	Hotline Tools	Response priority	All referrals assigned an in-person response.	Worker receiving referral	Immediately
Path of response*	Hotline Tools	Path decision tool—evaluate out	All referrals that are evaluated out.	Worker receiving referral OR designated differential response worker	Within five days
Path of response*	Hotline Tools	Path decision tool—in-person response	All referrals assigned an in-person response.	Worker receiving referral OR designated differential response worker	Immediately if RP = 24 hours; within 24 hours if RP = ten days
Can the child remain safely at home?	Safety assessment**		All in-person responses	Assigned worker	ALWAYS: prior to completing first face-to-face (record within 48 hours). Additional requirements: see page 43 and 57
Should an ongoing case be opened? At what service level?	Risk assessment		RECOMMENDED: all in-person responses. REQUIRED: all substantiated and inconclusive in-person responses.	Assigned worker	Within 30 calendar days of first face-to-face contact.
Focus of case plan	Family strengths and needs assessment		All open cases	Worker responsible for case plan.	Initial: Prior to initial case plan Review: Voluntary, within 30 days prior to case plan; court, within 65 days prior to case plan
Can case be closed? If not, what level of service?	Risk reassessment		All open cases where ALL children are in the home.	Assigned worker	Division 31 = review every six months. Involuntary cases = No more than 30 calendar days prior to case plan completion or case closure recommendation. Involuntary cases = No more than 65 calendar days prior to case plan completion or case closure recommendation. All cases = sooner if new circumstances or new information that affects risk.
Can child be returned home, or should reunification efforts continue, or should permanency goal be changed?	Reunification reassessment		Cases with at least one child in out-of-home care with goal of return home.	Assigned worker	Division 31 = review every six months. No more than 65 calendar days prior to case plan completion or reunification recommendation or permanency plan change. Sooner if new circumstances or new information that affects risk.

*Differential response counties only
**Standard safety assessment is used for all referrals except substitute care providers. The substitute care provider safety assessment is used when the referral alleges maltreatment by a substitute care provider.

CALIFORNIA
HOTLINE TOOLS

r: 04-09

Referral Name: _____ **Referral #:** _____-_____-_____-_____

Date: ____/____/____ **County:** _____

If review of screening criteria is not required, go directly to B. Screening Decision.

STEP I. APPROPRIATENESS OF A CHILD ABUSE/NEGLECT REPORT FOR RESPONSE

A. Screening Criteria *(Elicit reporter's concerns and mark all that apply.)*

PHYSICAL ABUSE

☐ Non-accidental injury
- ☐ Death of child/another child in home (automatic 24 hour)
- ☐ Severe (automatic 24 hour)
- ☐ Other injury (go to Physical Abuse Tree)

☐ Cruel or excessive corporal punishment (go to Physical Abuse Tree)

☐ Threat of physical abuse (go to Physical Abuse Tree)
- ☐ Threats of physical harm
- ☐ Dangerous behavior toward child or in immediate proximity of child
- ☐ Prior death of a child due to abuse or neglect and new child in the home

EMOTIONAL ABUSE (go to Emotional Abuse Tree):

☐ Caregiver actions have led to child's severe anxiety, depression, withdrawal, or aggressive behavior toward self or others

☐ Threat of emotional abuse
If marked, report is related to:
- ☐ Domestic violence
- ☐ Bizarre or cruel behavior
- ☐ Caregiver's mental health concerns
- ☐ Caregiver's substance abuse concerns

NEGLECT

☐ Severe neglect (automatic 24 hour)
- ☐ Diagnosed malnutrition
- ☐ Non-organic failure to thrive
- ☐ Child's health/safety is endangered
- ☐ Unexplained and/or suspicious death of a child and there are other children in the home.

☐ General neglect (go to Neglect Tree)
- ☐ Inadequate food
- ☐ Inadequate clothing
- ☐ Inadequate/hazardous shelter
- ☐ Inadequate supervision
- ☐ Inadequate medical/mental health care
- ☐ Child has no parent or guardian capable of providing appropriate care
- ☐ Failure to protect

☐ Threat of neglect (go to Neglect Tree)
- ☐ Prior failed reunification or severe neglect, and new child in household
- ☐ Allowing child to use alcohol or other drugs
- ☐ Prenatal substance use
- ☐ Other high risk birth

SEXUAL ABUSE (go to Sexual Abuse Tree)

☐ Any sexual act on a child by an adult caregiver or other adult in the household, or unable to rule out household member as alleged perpetrator
☐ Sexual act(s) among siblings or other children living in the home
☐ Sexual exploitation

☐ Threat of sexual abuse
  ☐ Known or highly suspected sexual abuse perpetrator lives with child
  ☐ Severely inappropriate sexual boundaries

B. Screening Decision

☐ Evaluate out: no criteria are marked
For differential response counties, proceed to Step III, Option A. Path Decision for Evaluate Out.
For counties not implementing differential response, stop: no further SDM assessments required.

☐ In-person response: one or more criteria are marked
Proceed to Step II. Response Priority

☐ Review of criteria not required

OVERRIDES:

☐ In-person response: no criteria are marked, but report will be opened as a referral. No further SDM assessments required. Mark any that apply:
  ☐ Courtesy interview at law enforcement's request
  ☐ Residency verification
  ☐ Response required by court order
  ☐ Local protocol (specify): _____
  ☐ Other (specify): _____

☐ Evaluate out: one or more criteria are marked, but referral will be evaluated out. No further SDM assessments required. Mark all that apply:
  ☐ Insufficient information to locate child/family.
  ☐ Another community agency has jurisdiction
  ☐ Historical information only

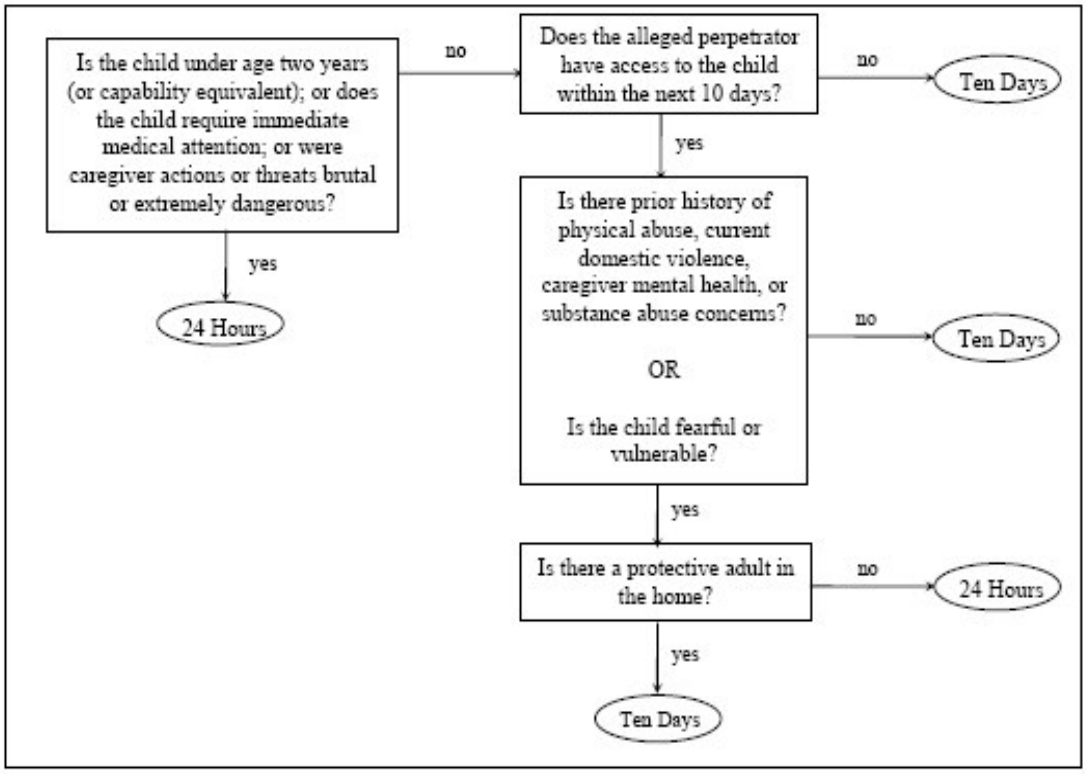
STEP II. RESPONSE PRIORITY r: 10-07

Mark if applicable:
- ☐ Allegation concerns maltreatment by current substitute care provider AND county policy requires response within 24 hours (automatic 24 hour)
- ☐ Child is already in custody (automatic 24 hour)

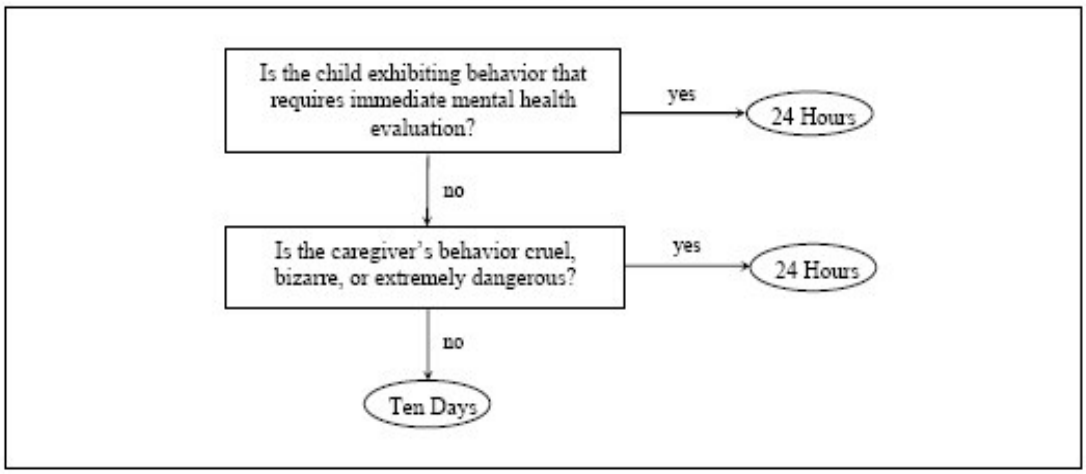
If not applicable, complete the appropriate decision tree(s).

DECISION TREES:

Physical Abuse

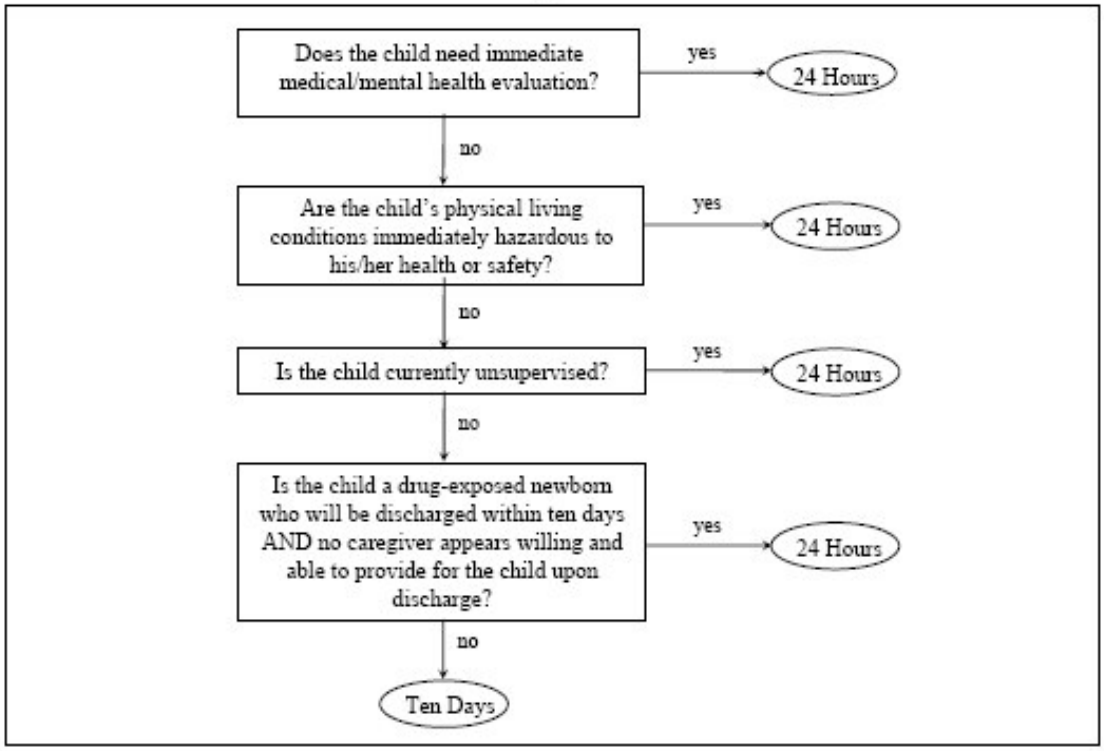


Emotional Abuse

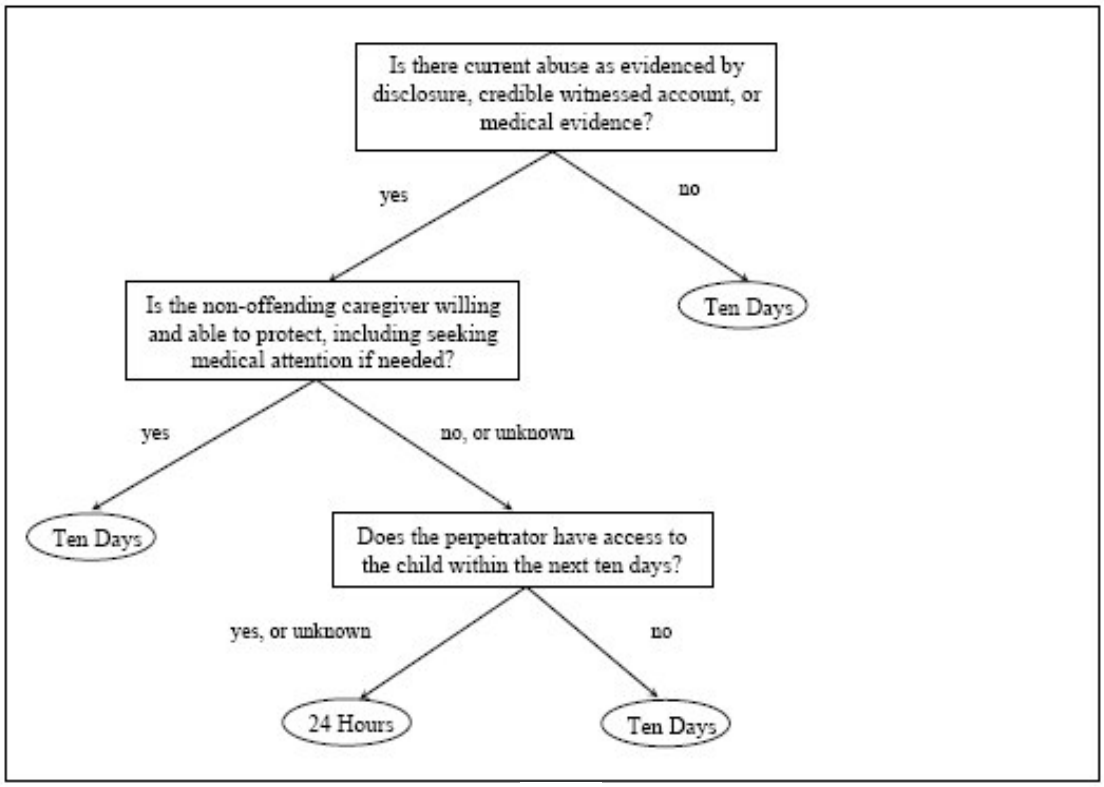


r: 11-05

Neglect



Sexual Abuse



http://sharepoint/nccd/Projects/California/S43/PP_Manual/PP Manual_Part 1.doc

OVERRIDES:

Policy

- Increase to 24 hour whenever:
  - ☐ Law enforcement is requesting immediate response
  - ☐ Forensic considerations would be compromised by slower response
  - ☐ There is reason to believe that the family may flee
- Decrease to ten day whenever:
  - ☐ Child safety requires a strategically slower response
  - ☐ The child is in an alternative safe environment
  - ☐ The alleged incident occurred more than six months ago AND no maltreatment is alleged to have occurred in the intervening time period

Discretionary

☐ Increase OR

☐ Decrease response level (requires supervisory approval)

Reason: _____

Final Response Priority: ☐ 24 hours ☐ Ten days

FIELD UPDATE

To be completed, if needed based on new or additional information, by field supervisor. Mark only decisions that have changed.

NEW DECISIONS

SCREENING: ☐ Evaluate out

RESPONSE PRIORITY: ☐ 24 hour ☐ Ten day

PATH: ☐ No response ☐ Path 1 ☐ Path 2 ☐ Path 3

BASIS: (State reason for change based on SDM criteria and new or additional information):

_____

CALIFORNIA
SAFETY ASSESSMENT

r: 10-07

Referral Name: _____ **Referral #:** _____

County: _____ **Worker:** _____

Date of Assessment: ____/____/____

Assessment Type: ☐ Initial ☐ Subsequent (mark one): ☐ review/update ☐ referral/case closing

Names of Children Assessed: (If more than six children are assessed, add additional names and numbers on reverse side.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are there additional names on reverse? ☐ 1. Yes ☐ 2. No

Household Name: _____ **Were there allegations in this household?** ☐ 1. Yes ☐ 2. No

Factors Influencing Child Vulnerability (conditions resulting in child's inability to protect self; mark all that apply to any child):

☐ Age 0-5 years
☐ Significant diagnosed medical or mental disorder
☐ School age, but not attending school
☐ Diminished mental capacity (e.g., developmental delay, non-verbal)
☐ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs)

SECTION 1A: SAFETY THREATS

Assess household for each of the following safety threats. Indicate whether currently available information results in reason to believe safety threat is present. Mark all that apply.

Yes	No		
☐	☐	1.	Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: ☐ Serious injury or abuse to the child other than accidental. ☐ Caregiver fears he/she will maltreat the child. ☐ Threat to cause harm or retaliate against the child. ☐ Excessive discipline or physical force. ☐ Drug-exposed infant.
☐	☐	2.	Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.
☐	☐	3.	Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern.
☐	☐	4.	Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.
☐	☐	5.	Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.
☐	☐	6.	The family refuses access to the child, or there is reason to believe that the family is about to flee.
☐	☐	7.	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
☐	☐	8.	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
☐	☐	9.	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
☐	☐	10.	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
☐	☐	11.	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
☐	☐	12.	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
☐	☐	13.	Other (specify): _____

SECTION 1B: PROTECTIVE CAPACITIES
(If no safety threats are present, skip to Section 3.)
Mark all that apply.

Child

☐ 1. Child has the cognitive, physical, and emotional capacity to participate in safety interventions.

Caregiver

☐ 2. Caregiver has the cognitive, physical, and emotional capacity to participate in safety interventions.

☐ 3. Caregiver has a willingness to recognize problems and threats placing the child in imminent danger.

☐ 4. Caregiver has the ability to access resources to provide necessary safety interventions.

☐ 5. Caregiver has supportive relationships with one or more persons who may be willing to participate in safety planning, AND caregiver is willing and able to accept their assistance.

☐ 6. At least one caregiver in the home is willing and able to take action to protect the child, including asking offending caregiver to leave.

☐ 7. Caregiver is willing to accept temporary interventions offered by worker and/or other community agencies, including cooperation with continuing investigation/assessment.

☐ 8. There is evidence of a healthy relationship between caregiver and child.

☐ 9. Caregiver is aware of and committed to meeting the needs of the child.

☐ 10. Caregiver has history of effective problem solving.

Other:

☐ 11. _____

SECTION 2: SAFETY INTERVENTIONS

(If no safety threats are present, skip to Section 3.) For each identified safety threat, review available protective capacities. With these protective capacities in place, can the following interventions control the threat to safety? Consider whether the threat to safety appears to be related to caregiver's knowledge, skill, or motivational issue.

Consider whether safety interventions 1-8 will allow the child to remain in the home for the present time. If protective capacities 2, 3, and/or 7 are not marked, carefully consider whether *any* safety interventions 1-8 are appropriate to immediately protect the child. Mark the item number for all safety interventions that will be implemented. If there are no available safety interventions that would allow the child to remain in the home, indicate by marking item 9 or 10, and follow procedures for initiating a voluntary agreement for taking the child into protective custody. A safety plan is required to systematically describe interventions and facilitate follow-through.

Mark all that apply:

☐ 1. Intervention or direct services by worker. (DO NOT include the investigation itself.)

☐ 2. Use of family, neighbors, or other individuals in the community as safety resources.

☐ 3. Use of community agencies or services as safety resources.

☐ 4. Have the caregiver appropriately protect the victim from the alleged perpetrator.

☐ 5. Have the alleged perpetrator leave the home, either voluntarily or in response to legal action.

☐ 6. Have the non-offending caregiver move to a safe environment with the child.

☐ 7. Legal action planned or initiated—child remains in the home.

☐ 8. Other (specify): _____

☐ 9. Have the caregiver voluntarily place the child outside the home.

☐ 10. Child placed in protective custody because interventions 1-9 do not adequately ensure the child's safety.

SECTION 3: SAFETY DECISION

Identify the safety decision by marking the appropriate line below. This decision should be based on the assessment of all safety threats, safety interventions, and any other information known about the case. Check one response only.

☐ 1. No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.

☐ 2. One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care (e.g., foster family, group home). Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger. SAFETY PLAN REQUIRED.

☐ 3. One or more safety threats are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.

- ☐ All children placed.
- ☐ The following children were placed: *(enter number from page 1)*

_____ _____ _____ _____ _____ _____

CALIFORNIA
FAMILY RISK ASSESSMENT

r: 05-08

Referral Name: _____ **Referral #:** _____ **Date:** ___/___/___

County Name: _____ **Worker Name:** _____ **Worker ID#:** _____

NEGLECT		Score
N1.	Current Report Is for Neglect a. No ..... 0 b. Yes 1	_____
N2.	Prior Investigations (*assign highest score that applies*) a. None ..... -1 b. One or more, abuse only ..... 1 c. One or two for neglect ..... 2 d. Three or more for neglect 3	_____
N3.	Household Has Previously Received CPS (*voluntary/court ordered*) a. No ..... 0 b. Yes 1	_____
N4.	Number of Children Involved in the Child Abuse/Neglect Incident a. One, two, or three ..... 0 b. Four or more 1	_____
N5.	Age of Youngest Child in the Home a. Two or older ..... 0 b. Under two 1	_____
N6.	Characteristics of Children in Household *(add for score)* a. Not applicable ..... 0 b. One or more present (*mark all applicable and add*) ☐ Developmental, learning, or physical disability ..... 1 ☐ Developmental ☐ Learning ☐ Physical ☐ Medically fragile or failure to thrive ..... 1 ☐ Mental health or behavioral problem 1	_____
N7.	Primary Caregiver Provides Physical Care Inconsistent with Child Needs a. No ..... 0 b. Yes 1	_____
N8.	Primary Caregiver Has a History of Abuse or Neglect as a Child a. No ..... 0 b. Yes 1	_____
N9.	Primary Caregiver Has/Had a Mental Health Problem a. None/not applicable ..... 0 b. One or more apply 1	_____
N10.	Primary Caregiver Has/Had an Alcohol and/or Drug Problem a. None/not applicable ..... 0 b. One or more apply (*mark all applicable*) ..... 2 ☐ Alcohol (☐ Last 12 months and/or ☐ Prior 12 months) ☐ Drugs (☐ Last 12 months and/or ☐ Prior 12 months) ☐ Marijuana ☐ Methamphetamine ☐ Heroin ☐ Cocaine ☐ Other: _____	_____
N11.	Primary Caregiver Has Criminal Arrest History a. No ..... 0 b. Yes 1	_____
N12.	Current Housing a. Not applicable ..... 0 b. One or more apply ..... 1 ☐ Physically unsafe, AND/OR ☐ Family homeless	_____
TOTAL NEGLECT RISK SCORE		_____

ABUSE		Score
A1.	Current Report Is for Physical Abuse a. No ..... 0 b. Yes 1	_____
A2.	Number of Prior Investigations a. None ..... -1 b. One or more, neglect only ..... 0 c. One for abuse ..... 1 d. Two or more for abuse 2	_____
A3.	Household Has Previously Received CPS (*voluntary/court ordered*) a. No ..... 0 b. Yes 1	_____
A4.	Prior Physical Injury to a Child Resulting from Child Abuse/Neglect or Prior Substantiated Physical Abuse to a Child a. None/not applicable ..... 0 b. One or more apply ..... 1 ☐ Prior physical injury to a child resulting from CA/N ☐ Prior substantiated physical abuse of a child	_____
A5.	Number of Children Involved in the Child Abuse/Neglect Incident a. One, two, or three ..... 0 b. Four or more 1	_____
A6.	Characteristics of Children in Household (*score 1 if any present*) a. Not applicable ..... 0 b. One or more present (*mark all applicable*) ..... 1 ☐ Delinquency history ☐ Developmental disability ☐ Learning disability ☐ Mental health or behavioral problem	_____
A7.	Two or More Incidents of Domestic Violence in the Household in the Past Year a. No ..... 0 b. Yes 1	_____
A8.	Primary Caregiver Employs Excessive/Inappropriate Discipline a. No ..... 0 b. Yes 1	_____
A9.	Primary Caregiver Is Domineering a. No ..... 0 b. Yes 1	_____
A10.	Primary Caregiver Has a History of Abuse or Neglect as a Child a. No ..... 0 b. Yes 1	_____
A11.	Primary Caregiver Has/Had a Mental Health Problem a. No ..... 0 b. One or more apply ..... 1 ☐ During the last 12 months ☐ Prior to the last 12 months	_____
TOTAL ABUSE RISK SCORE		_____

SCORED RISK LEVEL. Assign the family's scored risk level based on the highest score on either the neglect or abuse indices, using the following chart:

Neglect Score	Abuse Score	Scored Risk Level
☐ -1–1	☐ -1–0	☐ Low
☐ 2–5	☐ 1–3	☐ Moderate
☐ 6–8	☐ 4–6	☐ High
☐ 9 +	☐ 7 +	☐ Very High

POLICY OVERRIDES. Mark yes if a condition shown below is applicable in this case. If any condition is applicable, override the final risk level to very high.

☐ Yes ☐ No 1. Sexual abuse case AND the perpetrator is likely to have access to the child.
☐ Yes ☐ No 2. Non-accidental injury to a child under age two years.
☐ Yes ☐ No 3. Severe non-accidental injury.
☐ Yes ☐ No 4. Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. If a discretionary override is made, mark yes, increase risk by one level, and indicate reason.

☐ Yes ☐ No 5. If yes, override risk level (mark one): ☐ Moderate ☐ High ☐ Very High
Discretionary override reason: _____

Supervisor's Review/Approval of Discretionary Override: _____ Date: ___/___/___

FINAL RISK LEVEL (mark final level assigned): ☐ Low ☐ Moderate ☐ High ☐ Very High

Http://sharepoint/nccd/Projects/California/543/FP_Manual/FP Manual_Part 1.doc

RECOMMENDED DECISION

Final Risk Level	Recommendation
Low	Do Not Promote*
Moderate	Do Not Promote*
High	Promote
Very High	Promote

*Unless there are unresolved safety threats.

PLANNED ACTION:
☐ Promote
☐ Do Not Promote

If recommended decision and planned action do not match, explain why:

_____

SUPPLEMENTAL ITEMS

Note: These items should be recorded, but are not scored.

1. Primary caregiver characteristics:
   Yes No
   a. ☐ ☐ Blames child
   b. ☐ ☐ Provides insufficient emotional/psychological support

2. Secondary caregiver characteristics:

   ☐ No secondary caregiver

   Yes No
   a. ☐ ☐ Has history of abuse/neglect as a child
   b. ☐ ☐ Has/had mental health problem
      ☐ During the last 12 months ☐ Prior to the last 12 months
   c. ☐ ☐ Has/had an alcohol and/or drug problem (*mark all applicable*)
      ☐ Alcohol (☐ Last 12 months and/or ☐ Prior 12 months)
      ☐ Drugs (☐ Last 12 months and/or ☐ Prior 12 months)
         ☐ Marijuana ☐ Methamphetamine ☐ Heroin ☐ Cocaine
         ☐ Other: _____
   d. ☐ ☐ Employs excessive/inappropriate discipline
   e. ☐ ☐ Domineering
   f. ☐ ☐ Secondary caregiver has criminal arrest history

Appendix 4:
The California Evidence-Based Clearinghouse for Child Welfare (CEBC) Reviewed Promising/Supported and Well-Supported Practices[9][10]

(Source: The California Evidence-Based Clearinghouse for Child Welfare, 2007; Available at: http://www.cebc4cw.org/)

[9] The California Evidence-Based Clearinghouse for Child Welfare (CEBC) provides child welfare professionals with easy access to vital information about selected child welfare related programs. The primary task of the CEBC is to inform the child welfare community about the research evidence for programs being used or marketed in California.* The CEBC also lists programs that may be less well-known in California, but were recommended

[10] Additional reviews of promising practices/interventions that may prevent child deaths and injuries are available at http://www.childinjuryprevention.org/approach.aspx?id=118 (Child Death Review: Child Injury Prevention Tools, 2007)

Interventions for Neglect

Programs with a Scientific Rating of 2 - Supported by Research Evidence

1. Childhaven Therapeutic Child Care (reviewed August 2009)
2. HOMEBUILDERS (reviewed February 2009)

Programs with a Scientific Rating of 3 - Promising Research Evidence

1. Family Connections (FC) (reviewed May 2008)
2. Safe Care (reviewed September 2009)

Prevention of Child Abuse and Neglect (Secondary)

Programs with a Scientific Rating of 1 - Well-Supported by Research Evidence

1. The Incredible Years (reviewed February 2008)
2. Triple P-Positive Parenting Program (reviewed February 2008)

Programs with a Scientific Rating of 3 - Promising Research Evidence

1. Effective Black Parenting Program (EBPP) (reviewed December 2007)
2. Family Connections (FC) (reviewed May 2008)
3. Nurturing Parenting Programs (reviewed December 2007)
4. Period of Purple Crying (reviewed April 2009)
5. Safe Care (reviewed September 2009))
6. The Upstate New York Shaken Baby Syndrome Education Program (reviewed January 2008)

Programs with a Scientific Rating of NR - Not able to be Rated

1. Confident Parenting: Survival Skill Training Program (reviewed January 2008)
2. Los Ninos Bien Educados (LNBE) (reviewed January 2008)
3. Love and Logic (reviewed December 2007)
4. Strengthening Families through Early Care and Education (reviewed December 2007)
5. The Happiest Baby (THB) (reviewed February 2008)

Parent Training

Programs with a Scientific Rating of 1 - Well-Supported by Research Evidence

1. Parent-Child Interaction Therapy (PCIT) (reviewed December 2009)
2. The Incredible Years (reviewed February 2008)
3. Triple P - Positive Parenting Program (reviewed February 2008)

Programs with a Scientific Rating of 2 - Supported by Research Evidence

1. 1-2-3 Magic: Effective Discipline for Children 2-12 (reviewed June 2008)

Programs with a Scientific Rating of 3 - Promising Research Evidence

1. Attachment and Biobehavioral Catch-up (ABC) (reviewed December 2009)
2. Nurturing Parenting Programs (reviewed December 2007)
3. Parenting Wisely (reviewed June 2008)
4. Safe Care (reviewed September 2009)
5. STEP: Systematic Training for Effective Parenting (reviewed June 2009)
6. Teaching-Family Model (reviewed June 2008)

Programs with a Scientific Rating of NR - Not able to be Rated

1. Circle of Security (COS) (reviewed November 2009)

Home Visiting

Programs with a Scientific Rating of 1 - Well-Supported by Research Evidence

1. Nurse-Family Partnership (NFP) (reviewed April 2008)

Programs with a Scientific Rating of 2 - Supported by Research Evidence

1. Home Instruction for Parents of Preschool Youngsters (HIPPY) (reviewed October 2009)

Programs with a Scientific Rating of 3 - Promising Research Evidence

1. Parents as Teachers - Born to Learn (reviewed May 2008)
2. Safe Care (reviewed September 2009)
3. The Parent-Child Home Program (reviewed April 2008)

PLEASE NOTE: Following the most recent review by CEBC (as indicated) for each of the above interventions, additional research evidence may now exist. Please review the most current research available for the particular program/intervention of interest.