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

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Multidisciplinary child fatality review teams (CFRT) have existed in the United States (US) for almost 30 years; the products of the review process, however, remain unexamined. This study reviewed reports from CFRT throughout the US to compile and evaluate the identification of problems and recommendations by professionals concerning child maltreatment fatalities. Team- and state-level data were also used for analysis to better understand the context in which recommendations are made. Over 300 recommendations for change from CFRT were grouped into 11 macro categories. The frequency of each type of recommendation and examples from each category are provided. The authors provide recommendations of their own for improvements in CFRT outputs. Copyright © 2008 John Wiley & Sons, Ltd.

KEY WORDS: child fatality review; child welfare; child fatality; improvements in practice

'Multidisciplinary child fatality review teams have existed in the United States for almost 30 years'

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'Reports of child maltreatment fatalities have climbed over the past 30 years'

Since the 1970s, child maltreatment fatalities have gained the concern and attention of our governments, professionals within the child welfare profession and the general public. Defined as the 'death of a child as a result of abuse or neglect, because either an injury resulting from the abuse or neglect was the cause of death; or abuse or neglect were contributing factors to the cause of death' (United States Administration for Children & Families, 2008, p. 123), in the United States (US) in 2006, 2.04 of every 100,000 children were the victim of fatal treatment by a caregiver (United States Administration for Children & Families, 2008). Reports of child maltreatment fatalities have climbed over the past 30 years (McCurdy and Daro, 1994), however, this may be the result of better identification and examination by professionals (McClain *et al.*, 1993). Many of the improved responses to child maltreatment fatalities have been attributed to child fatality review teams (CFRT) (Durfee *et al.*, 1992; Durfee *et al.*, 2002; Durfee and Durfee, 1995; Kellermann *et al.*, 1999; Luallen *et al.*, 1998; Peddle *et al.*, 2002), which are workgroups consisting of professionals from several different fields that review cases of maltreatment-related deaths. While these teams have been in existence for several decades, there is no comprehensive understanding of the outcomes of the review process. CFRT and the work that they complete regarding maltreatment fatalities are the focus of this study.

CFRT

When child maltreatment fatalities first caught public attention in the US, one of the earliest organised efforts in response to these events was the development of review teams. The first child fatality review team was established in 1978 in Los Angeles County, California (Gellert *et al.*, 1995). CFRT perform multidisciplinary, multi-agency reviews of child fatalities in a given county, urban district, or state. According to the National Center on Child Fatality Review (http://ican-ncfr.org/), as of September 2008, all states in the US, plus the nation's capital of the District of Columbia, have a CFRT. Most teams state that their primary mission is to prevent child death or serious injury (Webster *et al.*, 2003). In the US there is great variation concerning the focus of child fatality reviews. For example, some states, such as Arizona (Rimsza *et al.*, 2002), focus on all types of child deaths (i.e. such as natural, accident, suicide, etc.), where as other states, such as Maine, focus primarily on maltreatment-related fatalities. The current study focuses on the aggregate outcomes of *child maltreatment fatality reviews only*. Reviews were considered to focus on maltreatment if identified as such by each individual state.

'The current study focuses on the aggregate outcomes of *child maltreatment fatality reviews*'

As multidisciplinary teams, it is common for US CFRT to be comprised of representation from the legal, child welfare, medical,

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public health and psychology professions. Thus, a comprehensive team might consist of one or several state police officers, assistant district attorneys or attorneys general, child welfare supervisors, medical examiners, paediatricians, coroners, public health nurse supervisors, school officials and psychologists with specialisation in maltreating families. On the less comprehensive side, a CFRT might comprise a state police officer, an assistant attorney general, a child welfare supervisor and a medical examiner. Depending on state population and frequency of child deaths, review teams in the US often exist at the county, region and state levels. Some states implemented review teams before they were officially recognised by their state legislatures, but by 2001, 67 per cent of states had enabling legislation for CFRT. Financial support for the expenses of teams across the country is inconsistent. In 2001, only 67 per cent of teams nationwide were funded through federal dollars, state funds or foundations (Webster *et al.*, 2003).

'Financial support for the expenses of teams across the country is inconsistent'

In conducting a review of a child maltreatment fatality, a team would request and then review past records from agencies or service providers that may have had contact with the victim or family before death (Durfee *et al.*, 2002; Durfee and Durfee, 1995). What a team can request and review, however, may depend on its subpoena power, or its ability to legally command receipt of evidence and information (Webster *et al.*, 2003). For example, a team might request documentation of past records from (1) child welfare services, (2) mental health services, (3) medical providers such as a paediatrician, family physician, medical clinic, or hospital, (4) school systems, (5) public health services, (6) law enforcement agencies, (7) court records and (8) any other agency that worked with or conducted an evaluation of the family. Moreover, records could be requested about the victim, sibling survivors, or any of the caregivers. In addition to a paper review, a team might request that some of the professionals who worked with the family be present at the review (Bunting and Reid, 2005; Durfee *et al.*, 2002; Durfee and Durfee, 1995). Generally, the purpose of such a request is not to place blame, but to better understand the family and the services that it received. Based on problems identified in the review, the team makes a series of'findings' which usually identify how the larger community failed to meet or comprehend the needs of the victim. Most often, each finding is coupled with a recommendation concerning how a professional community, a legislative body, or a specific agency could adapt its practices to better anticipate, understand and meet the needs of its most vulnerable victims. The findings and recommendations of these confidential reviews are deidentified, or edited to remove identifying information (e.g. names, birth dates, etc.), compiled and presented in aggregate in a report made accessible to the public (Douglas, 2005).

'A team might request that some of the professionals who worked with the family be present at the review'

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'The widespread use of the review model indicates a degree of faith in the outcomes of the reviews'

Review teams have gained support and recognition by professionals, advocates and decision-makers—as evidenced by their popularity throughout many parts of the developed world (Brandon *et al.*, 2005; Bunting and Reid, 2005; Reder and Duncan, 1999). The widespread use of the review model indicates a degree of faith in the outcomes of the reviews. There is also reason to believe that positive changes may result from reviews (Durfee *et al.*, 2002). Peddle and colleagues (2002) found that 68 per cent of CFRTs reported that US state agencies and state legislatures have acted on recommendations issued by their teams. Changes may be implemented, yet practitioners and researchers know little about what changes are recommended, and if there are team- or state-level trends that are associated with these recommendations.

Current Study

With the exception of one US state, Georgia (Kellermann *et al.,* 1999), CFRTs have never been subjected to an extensive evaluation and we do not actually know the true usefulness of the reviews. Furthermore, Webster and colleagues (2003) argue that the child fatality review movement lacks official, coordinated, national leadership. All too often the child welfare profession has embraced new techniques without adequate review of practice (Gelles, 2000), and Douglas (2005) has noted that review teams have never undergone a national review in any country to examine the outcomes of the CFRT movement. This study begins that process by conducting an exploratory analysis of the recommendations of US CFRTs (as opposed to reviewing individual cases of fatality). Readers should note that the current study does not examine the effectiveness or usefulness of CFRTs. Instead, we intend to explore and detail the outcomes, or recommendations, of fatality review panels by addressing the following questions:

'To explore and detail the outcomes, or recommendations, of fatality review panels'

1. How many CFRT publish child maltreatment data in their regular reports?
2. How many CFRT make recommendations concerning child maltreatment?
3. What are the recommendations of CFRT?
4. Are there associations between state and/or team characteristics with recommendations?
5. Are there associations between recommendations that are made?

The first three questions are intended to establish basic statistics that are currently unknown about aggregate reports from CFRT. The fourth question will allow us to determine if particular state or team characteristics are related to specific recommendations. The fifth question allows us to assess understand if some recommendations or problems are related to one another.

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Methods

CFRT Reports

Data collection for this study was conducted between September 2006 and February 2007. In order to examine the recommendations of review teams, all recent CFRT reports published in the US between 2000–07 were collected and reviewed. Reports contain a summary of state, aggregate-level data and do not provide data about individual deaths. The collection of reports was aided by the National Center on Fatality Review, which posts reports and contact information for each CFRT on their website: http://www.ican-ncfr.org/. All available reports from this time period, n = 37, were collected and analysed. The states represented are listed, along with data and publication year(s) in Table 1. Only 29 of the state-level reports provided recommendations concerning child maltreatment. The remaining eight reports did not include data on cases involving child maltreatment. The data for this current study are based on these 29 states.

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State and Team Characteristics

State-level data were collected from federal agencies and from one professional association to provide context against which the CFRT reports could be viewed. State data collected for this purpose were: per capita education and poverty rates for 2003 (United States Census Bureau, 2007), child maltreatment fatality rates per 100,000 children for 2003 (United States Administration for Children & Families, 2005) and states with statutes that make it a criminal act to kill a child, regardless of reason were identified (National Center for Prosecution of Child Abuse, 2006). The year 2003 was selected as a midpoint between the report years of 2000–07. State characteristics such as these are often useful in understanding state decision- or policy-making (Baron and Straus, 1989; Miller *et al.*, 2005; Soule and Real, 2001; Zimmerman, 1988).

'The year 2003 was selected as a midpoint between the report years of 2000–07'

The data for team-level characteristics were taken from Webster *et al.* (2003), the only source for team characteristics. The data document responses to questions concerning a team's primary purposes: (1) to review agency involvement and actions surrounding death, and (2) to assist in the prosecution of child maltreatment fatalities. Team representatives responded on a scale of 1 to 5, where 1 = not important and 5 = very important (reverse coded from the original data). Additional data included in analyses were: (1) whether the team was funded, (2) whether the state had enabling legislation, and (3) the year that the team was formed.

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Table 1. US states and reports included in the analyses

State	Report reviewed	Data year of report	Year report published	CM section in report	Recommendations concerning CM
AL	Yes	2003	2006	No	Yes
AK	No	—	—	—	—
AZ	Yes	2004	2005	Yes	Yes
AR	Yes	2004	2005	Yes	Yes
CA	Yes	2000–01	2005	Yes	Yes
CO	No	—	—	—	—
CT	Yes	—	2000	No	No
DC	No	—	—	—	—
DE	Yes	2000–02	2002	Yes	Yes
FL	Yes	2002	2003	Yes	Yes
GA	Yes	2004	2004	Yes	Yes
HI	Yes	1997–2000	2006	No	No
ID	Yes	2000	2003	No	Yes
IL	Yes	2003	2005	Yes	Yes
IN	Yes	2005	2007	Yes	Yes
IA	Yes	2002	2003	No	Yes
KS	Yes	2002	2004	No	Yes
KY	Yes	2001	2003	Yes	Yes
LA	No	—	—	—	—
ME	Yes	2004	2006	Yes	No
MD	Yes	2005	2006	Yes	No
MA	Yes	2003	2005	Yes	Yes
MI	Yes	2001	2004	Yes	Yes
MN	Yes	2001	2001	Yes	Yes
MS	No	—	—	—	—
MO	Yes	2004	2005	Yes	Yes
MT	Yes	1997–2000	2002	Yes	Yes
NE	Yes	2002–03	2006	Yes	Yes
NV	Yes	2002–03	2003	Yes	Yes
NH	Yes	2003	2005	Yes	Yes
NJ	No	—	—	—	—
NM	Yes	1998–99	2002	Yes	Yes
NY	Yes	2004	2004	Yes	No
NC	Yes	—	2000	No	Yes
ND	No	—	—	—	—
OH	Yes	2002	2004	Yes	Yes
OK	Yes	2002	2004	Yes	Yes
OR	Yes	1999	2001	Yes	Yes
PA	No	—	—	—	—
RI	No	—	—	—	—
SC	Yes	2002	2002	Yes	Yes
SD	No	—	—	—	—
TN	Yes	2003	2005	No	Yes
TX	Yes	2002–03	2005	No	Yes
UT	No	—	—	—	—
VT	Yes	1998	2000	No	No
VA	Yes	2001	2002	No	No
WA	Yes	1999–2000	2003	No	No
WV	No	—	—	—	—
WI	No	—	—	—	—
WY	Yes	2001	2002	No	Yes
Total	37	—	—	24	29

CM = Child maltreatment, about either victims or perpetration of fatal child maltreatment.

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Coding of Team Recommendations

Recommendations from each CFRT report were recorded and grouped into categories according to the content of each recommendation. Categories were not pre-determined and resulted from this first exploratory conceptual content analysis, a method that has been employed in other studies concerning child welfare (Cooper, 2005). Both micro- and macro-level categories were created by a research assistant (second author) in conjunction with a faculty mentor (primary author). In order to create these categories, all of the recommendations were documented in full and listed according to state in a word processing document. We then read and reviewed the recommendations for common themes. Micro-level categories were created out of the common content. Macro-level categories were then created for coding purposes by combining similar micro-level recommendations. For example, 'public education about shaken baby syndrome' and 'public education about motor vehicle-related neglect' were each micro categories on their own, however, they both fit into the larger and more general macro category of 'public education'. Coding of recommendations was completed by the research assistant (second author), under faculty (primary author) supervision and guidance.

'Micro-level categories were created out of the common content. Macro-level categories were then created for coding purposes'

Six micro-level recommendations could not easily be combined with other recommendations. These six recommendations were pooled together under a 'Miscellaneous' category. There were times when a single recommendation contained two recommendations. For example, a single recommendation made by Iowa's CFRT addressed monitoring children who had been reunited with their birth families and communication with probation officers. This 'double-barrelled' recommendation was assigned two codes.

In total, 338 recommendations were reviewed for this study, however, 25 recommendations were not coded and were excluded from this study because their recommendations were not clear or lacked sufficient context. For example: 'Appropriate responses within the justice system (i.e. laws and procedures)' (California). A total of 313 recommendations were retained for categorisation and analysis.

'In total, 338 recommendations were reviewed for this study'

Analyses

For each macro-level recommendation, a state was assigned a '1' if the recommendation was made; otherwise '0'. Using Statistical Package for the Social Sciences (SPSS), the frequency of each recommendation was calculated. Second, in order to determine if there were relationships between (a) recommendations and state/team-level characteristics and (b) CFRT recommendations, exploratory analyses were limited to bivariate correlations because

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of the small sample size (n = 29). Bonferroni correction method was not employed because the research is at this stage exploratory.

Results

Questions 1 and 2: Existence of Child Maltreatment Data and Recommendations in Reports

The last two columns of Table 1 report the results for questions 1 and 2. Of the 37 reports reviewed, 24 (65%) contained data on child maltreatment fatalities, such as data on the number of suspected or known maltreatment fatalities, or information about the victim or perpetrator of the fatality. Twenty-nine reports (78%) contained recommendations concerning maltreatment-related fatalities. Eighty-eight per cent of the teams that published information about child maltreatment deaths also published findings and recommendations about fatal maltreatment.

'Eighty-eight per cent of the teams that published information about child maltreatment deaths also published findings and recommendations about fatal maltreatment'

Question 3: What are the Recommendations?

The recommendations made in response to child maltreatment fatalities were organised into 11 macro categories and 51 micro categories. Table 2 provides a list of these categories, as well as a numerical count for each one; Table 3 provides examples from each of the categories.

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 co-ordination between jurisdictions and states, through legislative action or increased diligence by the child welfare system.

Child death investigations. Investigations were mentioned 50 times and in 15 states. The recommendations focused on the need for thorough, timely and standardised 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.

'The importance of communication between investigating agencies was cited often'

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.

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.

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Table 2. 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.

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Table 3. 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]

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Table 3. (*Continued*)

Macro category	Example of recommendation from differing micro categories
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]

Criminal responsibility. The recommendations in this category stressed the criminalisation 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.

Home visiting programmes. Recommendations in this category concerned expanding home visiting programmes. 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.

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

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.

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.

'Many recommendations concerned risk factors of child maltreatment and proper assessment of risk for maltreatment'

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Table 4. Bivariate correlations between team recommendations

Recommendation	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Agency communication	—									
2. Child death investigations	0.03	—								
3. CRFT	0.36*	0.13	—							
4. Child welfare system	0.17	0.27	0.04	—						
5. Criminal responsibility	−0.17	0.26	−0.08	0.05	—					
6. Home visiting programmes	−0.09	0.15	0.26	−0.01	−0.23	—				
7. Mandated reporting	0.21	0.13	−0.04	0.20	−0.08	−0.12	—			
8. Public education	−0.08	0.02	0.12	0.19	0.23	0.05	0.12	—		
9. Risk factors/assessment	0.61***	0.41*	0.53**	0.24	−0.14	0.17	0.20	0.01	—	
10. Training for professionals	0.28	0.25	0.42*	−0.17	−0.20	0.09	0.11	0.08	0.42*	—

* $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$. CFRT = Child Fatality Review Teams.

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.

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 programmes and hospital protocol.

Question 4: Associations Between Recommendations

The first set of exploratory correlation analyses confirmed that there are several significant, positive relationships between team recommendations as displayed in Table 4. For example, teams that recommended changes in risk factors and risk assessment were more likely to recommend changes in agency communication ($r = 0.61$, $p = 0.000$), child death investigations ($r = 0.41$, $p = 0.03$), and CFRT protocol and procedures ($r = 0.53$, $p = 0.003$).

'Teams that recommended changes in risk factors and risk assessment were more likely to recommend changes in agency communication'

Question 5: Associations Between Team or State Characteristics and Recommendations

The second set of correlation analyses focused on state/team characteristics and team recommendations; the results are displayed in Table 5. Teams that primarily focus on identifying agency involvement in child maltreatment fatalities were more likely to make recommendations concerning changes in agency communication ($r = 0.46$, $p = 0.02$) and changes in the child welfare system ($r = 0.41$, $p = 0.04$). Teams from states with lower levels of college education were more likely to recommend changes in CFRT procedures ($r = 0.41$, $p = 0.03$). Those from states with lower levels of poverty were more likely to recommend changes in public education ($r = -0.54$, $p = 0.002$).

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Table 5. Correlations between state or team characteristics and CFRT recommendations

	1.[a]	2.	3.	4.	5.	6.	7.	8.	9.	10.
Team: Assist in prosecution	–0.06	–0.24	–0.07	–0.03	–0.26	0.38	–0.33	–0.20	0.03	–0.11
Team: CFRT enabling statute	0.24	0.19	–0.11	0.16	0.31	–0.24	0.35	0.11	–0.06	0.04
Team: CFRT receives funding	–0.13	0.11	–0.12	0.17	0.01	–0.10	0.26	0.19	–0.05	–0.23
Team: Review agency involvement	–0.46*	0.17	–0.32	–0.41*	0.27	0.09	–0.29	0.12	–0.38	–0.20
Team: Year implemented	0.32	–0.06	0.07	–0.12	–0.28	–0.30	–0.10	–0.10	0.25	0.14
State: Child homicide law	0.00	0.03	0.21	0.17	0.20	–0.26	0.05	0.26	0.17	0.14
State: Child fatality rate 2003	–0.11	–0.01	0.24	0.02	–0.15	0.52**	–0.32	–0.35	0.08	–0.09
State: Level of education 2003	0.16	0.14	–0.41*	0.03	–0.20	0.09	0.23	–0.24	0.19	–0.06
State: Poverty level 2003	0.10	0.13	0.25	0.04	–0.21	0.33	–0.04	–0.54**	0.35	–0.05

* $p \leq 0.05$; ** $p \leq 0.01$. [a] Recommendations: 1. = Agency communication; 2. = child death investigation; 3. = CFRT protocol/procedure; 4. = child welfare system; 5. = criminal responsibility; 6. = home visiting; 7. = mandatory reporting; 8. public education; 9. = risk factors/assessment; 10. = training for professionals. CFRT = Child Fatality Review Teams.

Discussion

CFRTs have existed in the US for approximately 30 years with little systematic review of the effectiveness or their findings. It is outside of the scope of this study to examine the effectiveness of CFRT, but this study is the first to explore the findings and recommendations of the US CFRTs nationwide. Furthermore, this paper documents and categorises the recommendations of CFRT reports and, although with a limited methodology, explores some of the conditions under which those recommendations are made.

'This study is the first to explore the findings and recommendations of the US CFRT nationwide'

CFRT are dedicated to examining and documenting the causes of death in their geographic region. Maltreatment fatalities were documented in 65 per cent of the reports reviewed for this study; 78 per cent of state reports included recommendations concerning how to reduce these deaths. Fatal maltreatment is a small percentage of the total child deaths in any region, yet it is our position that the heinous nature of these fatalities warrants that all CFRTs in all states give recognition to this cause of death.

Recommendations Made by CFRT

Every month, in nearly every state in the union, members of the social service and 'helping professions' gather to examine and discuss breakdowns in the social welfare system. They document the aspects of service delivery that potentially failed and may have aided in the death of a child. The end products of these meetings are formal recommendations concerning how to change the service system to better meet the needs of children and the families to whom the children belong. The recommendations are many and diverse; but there are themes among them. The most commonly cited recommendation was an increase in public education including general parent education, safe sleeping environments, fire safety,

'The most commonly cited recommendation was an increase in public education'

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motor vehicle-related neglect and shaken baby syndrome. Public education is believed to be an important prevention tool and has contributed to the decline of a number of social problems including sexual abuse (Jones *et al.*, 2001, 2006), diagnoses of HIV positive (Crepaz *et al.*, 2006; Herbst *et al.*, 2005) and smoking (Chen *et al.*, 2003; Hwang *et al.*, 2004; Levy *et al.*, 2004; Younoszai *et al.*, 1999). Parenting education has been noted to change some parenting behaviours, but comprehensive programmes are necessary to effectively change high-risk or maltreating behaviours (Barth *et al.*, 2005; Lundahl *et al.*, 2006).

Changes to and improvements in child death investigations were often cited by US CFRT reports. Most often recommendations concerned increased training and changes in protocol relating to child death investigations and autopsy procedure. A number of US agencies sponsor such training. The US Centers for Disease Control and Prevention offer training in the proper investigation and identification of unexplained infant deaths; the US National District Attorneys Association provides training concerning the investigation and prosecution of child fatality and physical abuse; and the US Institute of Police Technology and Management offers a course in child fatality investigations.

'CFRTs have called for more attention to risk factors and more comprehensive risk assessments'

Another often-cited recommendation was a call for attention to and improvements in risk factors and assessments. An often-noted failure of the child welfare system (Gelles, 1996; Munro, 2005b; Murphy, 1997; Rushton and Dance, 2005; Shlonsky and Wagner, 2005), CFRTs have called for more attention to risk factors and more comprehensive risk assessments—to examine more family members, to examine cases with more depth, and to adequately assess families during the before and after phases of reunification between parents and children. Because of concerns regarding human error in judging the severity of child welfare cases, the profession has recently experimented with computerised means of assessing the capacity of caregivers to parent their children. Such experimentation has had limited success (Schwalbe, 2004; Schwartz, 1987; Shlonsky and Wagner, 2005); but the profession continues to explore decision-making models as a way to potentially reduce the number of false negatives in the child welfare profession. In fact, Munro (2005a, 2005b) argues that the child welfare profession should model itself after other potentially high-risk professions, such as engineering, that also deal with the causes and consequences of human error.

Another often-noted recommendation concerned increased training for different professional caretakers, such as childcare workers and foster parents; child welfare workers with regard to supervision; 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

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of maltreated children. Historically, the child welfare profession has made repeated calls to train professionals to more adequately identify and meet the needs of children and families (Kenny, 2001, 2004; Lawrence and Brannen, 2000; Weinstein *et al.*, 2001). This continues today with calls to better train human service workers in the relationship between intimate partner violence and child maltreatment (Magen *et al.*, 2000) concerning changes in policy and practice implementation (Horwath, 2001), for foster and adoptive parents and for public health home visiting workers concerning child maltreatment (LeCroy and Whitaker, 2005).

An often-cited recommendation concerned improving communication within the child welfare profession and with other agencies. These concerns are not new and have been expressed elsewhere (Darlington *et al.*, 2005; Firestone, 2004). Problems include inadequate tracking systems, overloaded caseworkers and systems, inadequate decision-making protocols, high turn-over rates and dissatisfaction, confidentiality, barriers across state and county lines, conflict over clients and different approaches based on ideology (Bruns *et al.*, 2006; Curry *et al.*, 2005; Gelles, 2003; Lachman and Bernard, 2006; Lawrence-Webb and Cornelius, 2006; Michàlle *et al.*, 2006; Reder and Duncan, 2003; Stoesz, 2006; Zell, 2006). The child welfare system has grappled with such problems since its inception (Murphy, 1997) and continues to do so today. Some helping professionals suggest bringing together multi-agency trainings to openly discuss common misunderstandings and the roles and responsibilities of child welfare professionals (Murphy *et al.*, 2006; Packard *et al.*, 2006).

Finally, the remaining areas of recommendations with frequent citations concerned protocols and procedures for the activities of CFRT, mandatory reporting and changes in the child welfare system. These recommendations point to important trends within the larger child welfare system. CFRT have been in existence in the US in one form or another since the early 1970s, but at this point, they are not standardised, are relatively unorganised and remain unevaluated as to their effectiveness (Douglas, 2005; Webster *et al.*, 2003). Organising efforts, such as those by the US National Center on Fatality Review (http://www.ican-ncfr.org/) and more serious examination to determine the effectiveness of CFRT, such as in the case of Georgia (Kellermann *et al.*, 1999), will likely improve this social service initiative.

Since the implementation of the US mandatory reporting laws, there have been regular calls to train mandated reporters. There are repeated requests to train physicians, teachers, mental health professionals, members of the clergy and in some states—the public at large (Ewigman *et al.*, 1993; Besharov, 1990; Johnson, 1993; McDaniel, 2006; Waugh and Bonner, 2002; Webster *et al.*, 2005). Professionals who sit on CFRTs are also concerned about the

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degree to which mandated reporters are able to identify maltreatment and the extent to which they are willing to report known or suspected maltreatment. At the same time, recent research indicates that there is no bivariate relationship between legislation that mandates professional groups to report maltreatment and actual reporting rates by those professional groups (Douglas and Cunningham, 2008). Thus, it is difficult to determine what prompts professionals to report suspected or known maltreatment.

Factors Associated with Recommendations

The bivariate correlations indicated that many factors are associated with risk assessment. Teams that made recommendations concerning risk assessment were more likely to make recommendations concerning agency communication, child death investigations, and CFRT protocol and procedures. It is possible that concern regarding risk factors and assessment serve as an important marker for larger problems within the team's child welfare system. Gelles (1996) has suggested that attention to risk factors and risk assessment are not only key, but necessary first steps to improve the child welfare system.

The results of the bivariate correlations between team or state characteristics and recommendations are often self-evident. For example, teams primarily concerned with agency involvement in children's deaths were more likely to make recommendations concerning agency communication and the child welfare system.

'The results of the bivariate correlations between team or state characteristics and recommendations are often self-evident'

Limitations

There are several limitations of this study. First, this study is exploratory with few controls in place. This makes it more difficult to draw firm conclusions from the data. Second, this study has a small sample size, thus limiting the complexity of the statistical analyses that could be performed. Third, we intended to perform a nationwide study of CFRT; data from only 37 of the 50 US states were available. Fourth, we conducted 140 bivariate correlations which increases the risk of committing a Type I error. We did not take steps to control for this using a more stringent method, such as the Bonferroni correction, because our research at this stage is exploratory and we are reporting potential trends and areas that may deserve closer attention in future research. Should we have used the Bonferroni correction, no relationships would have been statistically significant. Finally, this study examined reports which summarised individual death reviews; we have no assurance that CFRT practised reliable methodology with their data, which is a potential threat to the validity of this study.

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Conclusion

One of the factors that made this research arduous was the lack of uniformity between the team reports. A number of steps could be taken to make future studies less difficult.

1. Child maltreatment fatalities are not always identified in reports, either because a state did not identify any maltreatment fatalities or because maltreatment fatalities are not a priority of that state's CFRT. We recommend that all teams identify maltreatment fatalities (or the lack thereof) that occurred in their state, and that the summary demographic information for victims and perpetrators be presented.
2. CFRT reports cover different time periods; this is due to the differing number of children who die in each state in a given year. We recommend that reports should cover standardised periods of time, but nothing longer than three year periods. Otherwise, it is difficult to follow trends within a given timeframe.
3. We excluded 25 recommendations from our analyses because they lacked context. All CFRT recommendations for improvement should be paired with an identified problem.
4. Recommendations often lack specificity. For example, some teams recommended increased training for 'caregivers', which could include both family and professionals. To avoid confusion, CFRT should target specific populations in their recommendations.
5. Reports from CFRT should document when previously identified problems have been addressed or remedied. Progress, as much as 'failure' is worthy of note.

'We recommend that reports should cover standardised periods of time, but nothing longer than three year periods'

There is evidence that the recommendations of US CFRT have influenced state-level policy and protocol (Peddle *et al.*, 2002) but they have not been subjected to a rigorous examination at a national or international level. When combined, the recommendations paint a picture of problems that plague the professions that respond to child maltreatment in the US. The recommendations that were summarised in this paper deserve serious attention, as they reflect the failures of the nation's social service system, as identified by those working 'in the trenches' with fatal maltreatment. Most important, we still do not know the effectiveness of CFRT to implement new practice and policy procedures and to prevent future maltreatment fatalities—an area that deserves concentrated attention in future studies.

'The recommendations that were summarised in this paper deserve serious attention'

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