Children's Services
PRACTICE NOTES
For North Carolina's Child Welfare Workers
From the NC Division of Social Services and the Family and Children's Resource Program

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Children's Services Practice Notes is a newsletter for North Carolina's child welfare workers produced four times a year by the North Carolina Division of Social Services and the N.C. Family and Children's Resource Program, part of the Jordan Institute for Families and the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing recent research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!
If you would like to comment about something that appears in this or any other issue of *Children's Services Practice Notes*, please do so! Address your comments to:

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CHILD MALTREATMENT FATALITIES

Workers and agencies must prepare for this possibility.

North Carolina's child welfare workers are engaged in the noble, difficult task of protecting children and supporting families. Each year they receive and investigate more reports of abuse and neglect. In 1999–2000 they investigated reports on 100,682 children; almost a third of these children (31,828) were found to have been maltreated. During this same time period, social workers were responsible for ensuring the safety and well-being of approximately 11,000 children in the state's foster care system.

Every day child welfare workers provide families with services they need, help adults become better parents, and guarantee kids have a nurturing place to live. Every day, unnoticed by the public, they score quiet victories for families and children.

Occasionally, however, things go wrong. In the worst of these cases, children die. In the 1999–2000 fiscal year, the North Carolina Division of Social Services reviewed the deaths of 30 children known to the child welfare system. Seventeen county DSS's were involved in one or more of these tragic deaths.

The public and social workers themselves often see these deaths as social workers' fault. It's a logical conclusion: if their job is to protect children, and a child known to the system dies, they must be to blame.

However, there have been many child fatality cases in which the child welfare workers involved have conducted themselves flawlessly, using sound judgement and following all necessary procedures.

The point is, if you are a child welfare worker, this could happen to you, to a child with whom you work. This fact must be regularly and explicitly acknowledged by everyone working in child protective services, family support, family preservation services, foster care, and adoptions. It is also critical for workers and their agencies to prepare for this possibility.

This issue of *Practice Notes* is a starting point for exploring this grim topic. In it you will find facts about child fatalities, an overview of the agencies and systems who prevent and respond to child deaths in North Carolina, and suggestions of ways to prepare for the possibility of a child fatality in your community. ◆

ANTIONETTE

We present the following true story in an attempt to put a face on the more than 350 children killed by their caregivers in North Carolina between 1985 and 1999.

Antionette, 4 years old, was apparently well cared for, happy, and in excellent health prior to her death. At her death, her mother created a story about unexplained seizures, but later confessed to strangling the child. The medical examiner's report had a considerable amount of background on this case. The autopsy had not revealed a cause of death. The child's father had reported the mother for abuse but the report was not substantiated. Antoinette was survived by two siblings.

Source: Herman-Giddens, M. E. (Ed.). (2001). *Not Invisible, Not in Vain*. Raleigh, NC: North Carolina Child Advocacy Institute.

PREVENTING CHILD FATALITIES

The death of a child from abuse or neglect is a terrible, powerful thing. Upon learning of such a tragedy, people everywhere experience fear, shame, and outrage. They hunger to know how and why this has happened, and resolve that such a thing should never happen again.

Child maltreatment deaths occur in the greatest numbers among infants, followed by toddlers and preschoolers.

Legislators and others in positions of authority have responded to child fatalities and the public outcry that follows by creating a child welfare system charged with keeping children safe and promoting their well being. In many states they have also created a complex system of local and statewide organizations designed to help us understand, respond to, and prevent child deaths. To learn more about NC's child fatality prevention system, see the article beginning on page 6.

Child welfare workers are on the front lines in our efforts to prevent child maltreatment deaths. Every time they respond to a report of abuse or neglect, conduct a child protective services investigation, or assess an adoptive or foster home, child welfare workers are trying to ensure the safety of children. In order to succeed in their efforts, they seek to follow (and refine) protocols and procedures, always keeping in mind that the assessment of risk is an ongoing, continuous process. To help them with this process, we provide the following information about child abuse fatalities.

FACTS ABOUT CHILD FATALITIES

It is not possible to say with complete accuracy how many children in the United States are killed each year by their caretakers. This is due in part to differences in state laws, in the way child deaths are investigated and classified, and in how this information is recorded. Observers also question the accuracy of the available national data on child fatalities because they believe that many child homicides go unclassified or unreported. Official reports probably undercount child abuse homicides by between 20% and 60% (Schlosser, 1992; Herman-Giddens, 2001).

We can speak with some confidence, however, about recent data on child fatalities in North Carolina. From 1985 through 1999, 356 children under 11 years of age are known to have been killed by their parents or caregivers. Children above this age were much less at risk; between 1993 and 1999, only ten children between 11 and 17 years old died in this way (Herman-Giddens, 2001).

We also know that child abuse deaths are increasing in North Carolina: between 1985 and 1994 rates of child abuse homicides rose at about 12.5% a year. Currently, every two weeks or so, a child in North Carolina is killed by his or her caregiver (Herman-Giddens, 2001).

THE CHILDREN

Most of the children killed as a result of maltreatment in North Carolina are unknown to child protective services (CPS). Between 60% and 70% of families experiencing a child maltreatment death have no CPS involvement in the year prior to the death (Herman-Giddens, 2001).

Child maltreatment deaths occur in the greatest numbers among infants, followed by toddlers and preschool children. Children younger than 6 years are most vulnerable because of their small size, incomplete verbal skills, and limited contact with adults other than their primary caregivers (Herman-Giddens, 2001).

Maltreatment fatality victims are often only children or youngest siblings. Being born with a low birth weight and complications during pregnancy have both been identified as risk factors for infants (Schlosser, 1992).

Depending on the age of the victim, gender appears to be a risk factor for homicide as well. In a 1996 study, Kunz and Bahr examined records of 3,459 children killed by their parents. They found that "in the first week of a child's life, the risk of being killed by a parent was equal for males and females. From 1 week to 15 years, males were the victims in about 55% of all parent-child homicides; the percentage of male victims increased to 77% in the 16–18 year-old group."

It is not clear whether race is a risk factor for child homicide. In their review of the literature, Kunz and Bahr concluded that the research on this topic is inconclusive and in need of further study.

THE PERPETRATORS

Research has found that children are most often killed by their parents or members of their families. Herman-Giddens et al. (1999) found that 63.5% of child maltreatment fatality victims were killed by their biological parents.

Herman-Giddens and colleagues (1999) also found that most of the time (65.5%) the killer was male—usually the father or step-father, although 18.2% of the time it was the mother's boyfriend. Others have found that in neglect-related deaths and homicides of newborns, the mother is usually the perpetrator (Schlosser, 1992; Kunz & Bahr, 1996).

Young children killed by their parents are most often beaten, shaken, or suffocated to death. Older maltreatment fatality victims, especially teenagers, are more likely to be killed with guns or other weapons (Herman-Giddens, 2001).

Parents who kill their children tend to be young, often in their twenties (Schlosser, 1992; Kunz & Bahr, 1996). Mothers who kill their children are often single, gave birth to their first child as a teenager, have low educational attainment, did not receive adequate prenatal care for the child, and experienced complications during pregnancy (Schlosser, 1992). In their study, Overpeck et al. (1998) found a strong association between infant homicide and childbearing at an early age, especially if the mother had given birth previously.

Kunz and Bahr (1996) found that the age of the child had a lot to do with the gender of the murderer. "Among infants in the first week of life," they tell us, "mothers were almost always the ones who committed the homicide. Between the first week of life and the teenage years, mothers and fathers were about equally likely to kill their child. During the 13 to 15 year age group, fathers committed 63% of all homicides, and this increased to 80% among the 16 to 18 year age group" (p. 359).

PRACTICE IMPLICATIONS

The research on child maltreatment fatalities underscores the importance of risk assessment. The risk factors found on North Carolina's risk assessment tool—especially the high risk factors—are based on what we know about the victims of child maltreatment and their families. Social workers should use this assessment tool as a guide as they continuously measure the relative risk and safety of every child they meet.

When there are barriers to providing effective intervention (e.g., families with multiple CPS reports, families that seem resistent to intervention, etc.), social workers should seriously consider requesting a review of the case by their local community child protection team (CCPT). The underlying, unaddressed conditions within these families often contribute to child fatalities. Review by the CCPT can mobilize community resources to prevent a tragic outcome. For more on CCPTs, see page 8.

Social workers should also continue to expand their awareness of the factors that may increase or reduce the risk of a child fatality. A word of caution, however: even if the people they encounter have so-called high risk traits, social workers should be careful not to judge them rashly. Instead, they should bear in mind the fundamental social work belief that every person has innate value and is worthy of respect, regardless of his or her actions or characteristics. ◆

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TWO THINGS YOU CAN DO TO PROTECT INFANTS

1. Preventing Shaken Baby Syndrome. Each year children are shaken to death, often because the person taking care of them is unaware how harmful shaking can be to a child. A study conducted in 1992 found that 25% to 50% of teenagers and adults did not know shaking a baby could be dangerous (Shaken Baby Alliance, 2001).

To prevent fatalities and injuries to infants, tell the parents you know—particularly the men—about the dangers of shaking babies. Explain that babies are vulnerable because their heads are disproportionately large; their neck muscles are weak; and they have watery, gelatinous brains and more space inside the skull. When the baby is forcefully shaken, nerves inside the brain can be damaged or destroyed, resulting in learning or behavioral problems, mental retardation, seizures, hearing loss, paralysis, or death (Herman-Giddens, 2001).

Fussy babies who cannot be easily comforted are at particular risk of being shaken. For information about preventing Shaken Baby Syndrome (SBS) or supporting families and foster parents caring for a child with SBS, visit the Shaken Baby Alliance at <www.shakenbaby.com/>.

2. "Back to Sleep": Preventing SIDS. According to the U.S. Department of Health and Human Services, SIDS is the sudden and unexplained death of an infant under one year of age, which strikes nearly 4,000 babies in the United States every year. Placing a child to sleep on his or her back reduces the risk of death from SIDS. Tell parents and caregivers you know about this, and encourage them to put infants on their backs to sleep.

Sources: The Shaken Baby Alliance. (2001). Prevention. <www.shakenbaby.com/>.

Herman-Giddens, M. E. (Ed.). (2001). *Not invisible, not in vain*. Raleigh, NC: North Carolina Child Advocacy Institute.

INTERVIEW WITH THE N.C. CHILD FATALITY REVIEW TEAM

When a child dies in North Carolina, and that child's family has been involved with a county department of social services within the last twelve months, and there is a suspicion that abuse or neglect was a factor in the death, the North Carolina Division of Social Services State Child Fatality Review Team reviews the case.

The purpose of its review is not to affix blame for the death, but to improve our understanding of why these fatalities occur and to develop recommendations for preventing them in the future. In 1999–2000 the State Child Fatality Review Team reviewed 30 deaths in 17 North Carolina counties.

To learn about what this team can tell us about responding to and preventing child deaths, *Practice Notes* spoke with Sara Anderson Mims, head of the Children's Services Section's Program Review Team, and Debra McHenry, a Program Consultant with responsibility for Fatality Reviews within the N.C. Division of Social Services.

CSPN: What would you like to say to child welfare workers and supervisors about child fatalities?

Mims: A child dying for any reason is a tragedy, but a child dying because of abuse or neglect is even more tragic. Child fatalities are hard to even think about, much less discuss. Yet, we must.

Workers tend to think, "This can't happen to the families that I'm working with." When it does, it's devastating. And the response from the media and the community can sometimes make that even more painful and grief-provoking for the worker, their coworkers, supervisors—all the way up to the director.

It is important, we think, for folks in the field to really think about the fact that this could happen to them, and to do some sort of preparation ahead of time for how they will handle communications issues, help staff with the grief process—all the stuff you can't think about in the moment when it has happened.

CSPN: What should workers keep in mind if a fatality happens in their agency?

Mims: When there's a fatality, DSS must immediately determine whether there are other children in the home. If there aren't, DSS is not involved. If there are, DSS must decide whether those children can remain in the home, whether protective services are needed, or whether they should be removed from the home.

McHenry: Workers and supervisors should understand that assessments after a fatality need to be very broad in scope. To ensure the safety of the surviving siblings we [DSS] must understand how the fatality happened.

As the experts in child abuse and neglect, we must look for those factors which may have contributed to the death and decide if they rise to the level of neglect or abuse. We then must share this information with both the police and the medical examiner so they can make a good decision about the incident.

"It's important for folks to think about the fact that this could happen to them, and prepare ahead of time."
—Sara Anderson Mims

CSPN: What do you mean by "broad in scope"?

McHenry: In reviews we often find that school, medical, mental health, and substance abuse information is very important. Often social workers don't request this information because it doesn't seem relevant. Yet it is usually essential to developing the total picture of child safety that workers and their supervisors need to make decisions.

Mims: One of the things we find in almost every fatality that we review is that somebody had a piece of information that somebody else needed and didn't tell them. This is true for most ordinary CPS investigations, too.

McHenry: Sometimes DSS doesn't go looking for all the information, and stops short of asking all the questions necessary to ensure the safety of surviving siblings. You must think about how to use your collaterals in an investigation to help you get the whole picture. Help other professionals and the community understand that when it comes to children's safety, confidentiality is secondary.

CSPN: What about talking with the family?

Mims: There is a real difference in how you approach the family. When a child has died, you've got a family in grief over the loss of a child, and the family may also be blamed for that death. Yet you still have to determine the safety issues for the other children in the home.

McHenry: It's really a balancing act. While you feel badly for someone grieving the loss of their child, you still have an obligation to determine safety. It is a very difficult situation. Most of the time you start investigating even before the funeral has taken place. *continued on page 5*

CSPN: What's the likelihood that the police or others looking into a child death will touch base with DSS while doing their investigations?

McHenry: It's important that DSS, the police, and the medical examiner work together very closely. Too often, I hear from DSS's that they are waiting for the police or the medical examiner to tell them what happened. It is important to remember that DSS has the expertise and the responsibility for determining if there was abuse or neglect involved. Otherwise, how can you make a judgment about the safety of the surviving siblings?

Our reviews show that children are best protected when we combine the unique skill and knowledge of the police, DSS, and the medical examiner. These three professionals should work side by side to determine what happened in a child's death. Each brings part of what is needed to understand the events leading up to the fatality.

We would be glad talk with your county about multidisciplinary responses to child fatalities. Learning more about the unique expertise and the limitations of each of these professions can facilitate good team work and make North Carolina a safer place for children.

CSPN: How should an agency assess safety of the remaining children when there's been a fatality and Sudden Infant Death Syndrome (SIDS) may have been the cause?

Mims: Layovers, where a parent has an infant in the bed with them and rolls over and the infant is smothered, and SIDS are real complicated issues. There may not be enough evidence for anybody to be charged or enough for the medical examiner to put something on the death certificate indicating abuse and neglect, but DSS needs to have their eyes ***wide open.*** They can't just say "Well, the medical examiner said it was SIDS and the police aren't going to charge anybody . . . ." They've got to ask the medical examiner and the police in a very direct way whether they think substance abuse or alcohol was involved and whether the death was in any way suspcious.

McHenry: There's a real misunderstanding sometimes about SIDS. DSS looks at it as some medical reason for a child dying that can be determined, when the reality is that SIDS means that despite the medical examiner's best efforts, they can't tell what killed the baby. A baby could be smothered and you would not necessarily be able to tell. That's where, if there's a good investigation done by the police and DSS has additional information, it might give the medical examiner enough information so they might rule the death something else, or at least undetermined.

LESSONS LEARNED

Based on their reviews of many child fatalities, members of the State Child Fatality Review Team have these suggestions:

- Encourage your agency to put a crisis management plan in place before a tragedy happens. This can make dealing with the media, conducting the CPS investigation, and supporting each other easier.
- Work closely with the police, medical examiner, EMS, and other agencies looking into the fatality. Recognize the role DSS plays and what it has to contribute to efforts to understand the death.
- Conduct your own investigation into safety of the surviving children. Do not rely solely on the conclusions reached by other agencies investigating the event, especially in cases of SIDS or layovers.
- Balance the need to be sensitive to surviving family members with the need to get a full picture of whether there is risk to other children in the home.
- Appreciate the importance of your assessment of risk to other children. Pay special attention to indications of domestic violence or alcohol/substance abuse.
- Gather comprehensive school, medical, mental health, and substance abuse information during your assessment of the safety of surviving siblings.

CSPN: What have you learned about other risk factors in child fatality cases?

McHenry: Last year, out of 22 child deaths* that we intensively reviewed, 17 had both domestic violence and substance abuse as major issues in those families. One had just domestic violence, and one had just substance abuse. So it appears that when you have substance abuse and real violence in a home, the chances for a child fatality seem to be increased. We can't say that for sure, but that's a real high percentage of deaths having both of those factors in them. Also, most of the deaths we review actually come from neglect. We're pretty good about keeping kids safe when there's abuse. ***continued on page 12***

* *Editor's note: Due to when the fatalities occurred, at the time of the interview the NC Child Fatality Review Team had conducted intensive reviews of only 22 of the 30 qualifying child fatalities that occurred last year. All qualifying fatalities are reviewed as soon as possible.*

NORTH CAROLINA'S RESPONSE TO CHILD FATALITIES

What happens when a child dies in North Carolina? As someone working in the child welfare system, you may know that the department of social services (DSS) in the county where the child lived is required to find out immediately whether there are other children in the home. If there are, DSS has 24 hours to initiate a child protective services (CPS) investigation into what happened and whether these remaining children are safe.

To collaborate well, you must know the roles and goals of your collaborators.

Yet DSS is only one of the agencies involved when a child dies in North Carolina. After a child fatality there are many investigations that try to determine why a child died, who as involved, and what can be done to prevent this kind of tragedy from happening in the future.

Perhaps the clearest and most comprehensive description of the different disciplines and agencies that respond to child fatalities in North Carolina can be found in *Not Invisible, Not in Vain*. One of the recurrent themes of the contributors to this unique guidebook, edited by Dr. Marcia Herman-Giddens (North Carolina Child Advocacy Institute, 2001), is the importance of collaboration in our efforts to respond to and prevent child deaths.

To collaborate effectively, you must first have a clear idea of the aims and concerns of those with whom you are supposed collaborate. Therefore, we present you the following brief descriptions of key professionals and organizations that respond to and prevent child fatalities in this state. These descriptions are adapted, with permission, from *Not Invisible, Not in Vain*.

MEDICAL PROFESSIONALS

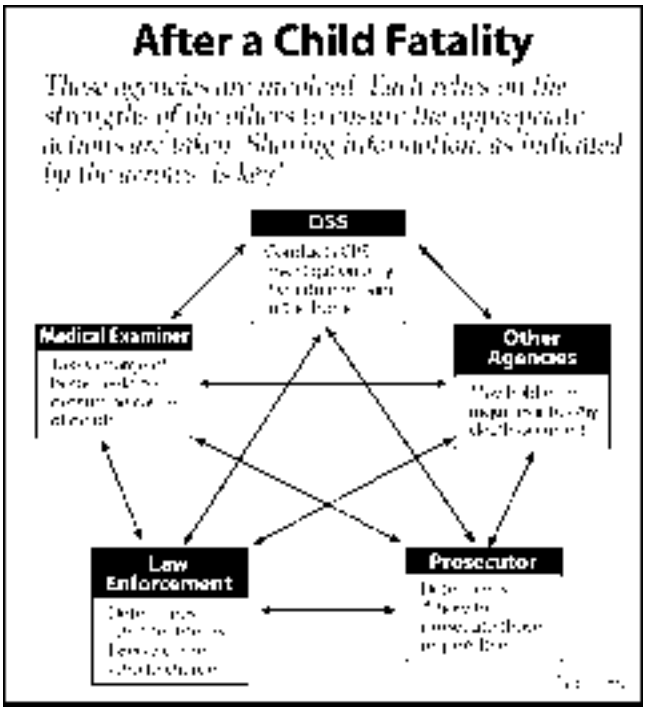
Emergency Medical Services (EMS) and Medical Professionals. EMS personnel and emergency room doctors and nurses are often the first professionals to come in contact with a child who has died. North Carolina reporting laws for suspected abuse and neglect apply to every person. If a child is found dead or near-dead in suspicious circumstances (e.g., the child's injuries do not correspond to the accident parents describe), these professionals are required to make a report to child protective services and law enforcement.

County Medical Examiners (ME). Appointed by the Office of the Chief Medical Examiner (OCME), county MEs are physicians who serve three-year terms. Most counties have more than one ME; a few counties have coroners who also act as county MEs.

Child deaths that are suspicious for violence or trauma must be investigated and certified by the county ME. Sudden and unexplained deaths in neonates, infants, and children also fall under ME jurisdiction. The only child deaths not reported to the ME system are those in which the child had a well-documented medical condition and died of that condition while under the care of a physician.

The ME must take charge of the body and conduct an inquiry to determine cause and manner of death. In investigating the death, the ME must consult with emergency medical services, local law enforcement, and any other relevant parties before finalizing the conclusions. (In most cases where the child has siblings in the home, this would include DSS.) MEs must either visit the scene of death or gather the equivalent information from trained individuals who have knowledge of the scene and circumstances of the death or discovery of the body. If circumstances warrant, the ME will ask the regional pathologist to conduct an autopsy. The ME must file a report about the fatality with OCME within 15 days, although determining cause and manner of death may take longer.

Regional Pathologists. Each county has one or more designated pathology centers. When a child death occurs, the regional pathologist works with law enforcement and the ME to stay properly informed of the case. If *cont. p. 7*



necessary, the pathologist conducts an autopsy to determine, if possible, the cause of death.

Office of the Chief Medical Examiner (OCME). This organization oversees North Carolina's medical examiner system. All reports of medical investigation, copies of the death certificate, results of the toxicological analyses, and, when performed, reports of autopsies are received at the OCME. If all documents present are in agreement and deemed appropriate, the case is initialled and becomes official public record. If there are inconsistencies or additional evaluations are needed to complete the case, further evaluation is initiated at the OCME in collaboration with the ME and/or regional pathologist. Even after a case has been finalized, it may be reopened upon receipt of pertinent new information.

LAW ENFORCEMENT

The death of a child should always be reported to law enforcement. This includes accidents, apparent natural deaths caused by illness, suicides, unexplained deaths, and all obvious homicides.

The police or sheriff's department involved is then responsible for conducting a thorough, detailed, systematic investigation. Without evidence to the contrary, the "worst case scenario" (homicide) is assumed until it can be eliminated. This investigation will usually involve death/crime scene investigations, examination and collection of physical evidence, and interviews with witnesses and possible suspects. Investigators are also responsible, if necessary, for notifying parents, family members, and others of the death of the child.

Consultation with DSS and other agencies (e.g., medical examiner) is a key component of law enforcement's response to child fatalities. Specifically, police investigators may ask CPS to provide records or reports regarding the family or child in question, and for assistance in conducting initial or follow-up interviews with witnesses. If child abuse is a suspicion, confidentiality should not be an issue between agencies conducting a joint investigation. CPS expertise is often critical in helping law enforcement determine what constitutes child maltreatment. Ultimately, however, it is up to the police to determine whether a crime has been committed and who is responsible.

DISTRICT ATTORNEYS (PROSECUTORS)

Prosecutors take up where law enforcement and the other investigators leave off. Responsible for criminal filing decisions, plea negotiations, and sentencing recommendations, prosecutors have significant power to charge people with crimes. To improve their success in prosecuting child fatality cases, some prosecutors participate in a multidisciplinary response to child fatalities that involves the prosecutor, the medical examiner and other medical professionals, law enforcement, and CPS.

NOT INVISIBLE, NOT IN VAIN

Not Invisible, Not in Vain: Child Maltreatment Fatalities, Guidelines for Response, edited by Dr. Marcia Herman-Giddens, is a remarkable resource for anyone wishing to understand the many agencies and professionals involved in the response to child fatalities. *Not Invisible, Not in Vain* has been distributed to all state and local agencies and professionals responsible for responding to child abuse homicides in North Carolina. **If you work for a county agency, consult your agency's copy, which was sent to the Director**. If for some reason your agency does not have a copy, contact Randi Munns at the NC Child Advocacy Institute, t: 919/834-6623, x. 233; e: randi@intrex.net. *Not Invisible, Not in Vain* is also available on the web at <www.ncchild.org>.

CHILD FATALITY PREVENTION SYSTEM

The purposes of the North Carolina Child Fatality Prevention System (see NCGS § 7B-1406-1413) include: developing a community approach to the prevention of child abuse and neglect, understanding and reporting the causes of child deaths, identifying gaps in services to children and families, and making and carrying out recommendations for changes to laws, rules, and policies to prevent future child deaths, especially those from abuse and neglect. The components of this system are outlined below. Also, see "NC Prevention System Response to a Child Death" on page 8, which describes how different system components interact after the death of child known to DSS.

North Carolina Child Fatality Task Force. The Task Force is the public policy arm created to prevent deaths of children in North Carolina. It meets several times a year, and makes an annual report and recommendations to the General Assembly regarding multidisciplinary child death reviews, confidentiality laws, and rules, laws, and policies promoting the prevention of child deaths.

North Carolina Child Fatality Prevention Team. This team is a multidisciplinary group that reviews all medical examiner deaths of children under the age of 18 ***cont. p. 8***

NORTH CAROLINA'S RESPONSE *continued from page 7*

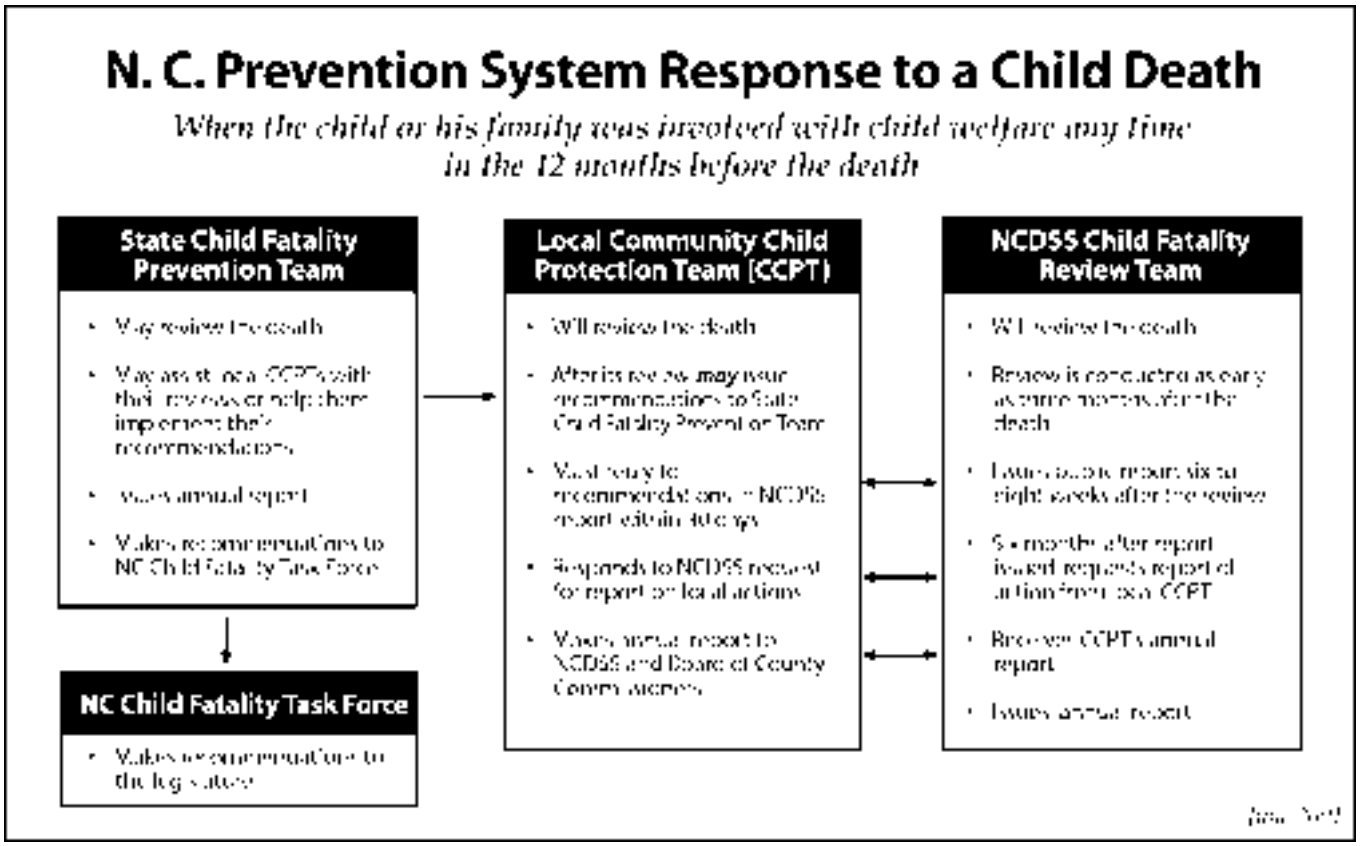
to prevent future deaths by identifying gaps in systems, policies, and laws that may have contributed to child deaths. It meets monthly, and also makes recommendations to the Task Force for improvements and remedies.

Community Child Protection Teams (CCPT). Every county has a CCPT that meets at least quarterly. These groups are comprised of representatives from the community and public and private agencies that provide services to children and their families. Each CCPT promotes a community-wide approach to the problem of child abuse and neglect. They review active CPS cases and child fatalities when the deceased child or the child's family had received child welfare services within twelve months prior to the child's death *and* the death was suspected to have been caused by abuse or neglect.

CCPTs review fatalities to determine whether child abuse, neglect, or dependency were factors in the death. Based on their review, the CCPT recommends actions the community should take to fill in gaps in community services or resources that may prevent other child fatalities. This information is presented in the CCPT's annual report to the board of county commissioners. As illustrated below, during some maltreatment fatality reviews CCPTs sometimes interact with the NCDSS Child Fatality Review Team and the State Team.

Local Child Fatality Prevention Teams (CFPT). Every county has a CFPT which meets at least quarterly. Local CFPTs review all child fatalities that do not meet criteria for review by the local CCPT. (*Note: in many counties CFPTs are combined with CCPTs*). The purpose of the CFPT review is to promote an understanding of the causes of each child's death, to identify deficiencies in the delivery of services to children and families, and to recommend and implement changes that will prevent future child deaths. CFPTs usually review fatalities from the previous year; once a year they make recommendations for preventing future deaths to their county commissioners.

N.C. Division of Social Services State Child Fatality Review Team. Local departments of social services, with the assistance of the state DSS, must review any child fatality where there was suspicion of abuse or neglect involved in the death and where the child had a record with child protective services within the past twelve months. Reviews take between one and two days. For more about the NCDSS child fatality review team, please refer to the interview on page 4. ◆



CHILD FATALITIES AND THE MEDIA

Friction between the child welfare system and the media is often most pronounced when a child involved with the system dies. In the worst cases, the department of social services (DSS), motivated by the desire to aid criminal investigations and prosecutions and restricted by laws about confidentiality, must sit by while newspapers and TV run stories that, from the DSS perspective, focus on the wrong things or distort the facts.

Some observers worry that negative media coverage hurts not only DSS's morale, but social work practice. When they feel besieged and demoralized, social workers may be more likely to make errors, either removing children from their families without sufficient cause or allowing them to remain at home even when there are clear safety concerns (Mendes, 2000).

Understanding the media can help prevent this worst case scenario. Most reporters and journalists are not "out to get" social workers or the child welfare system. Rather, they are motivated by their responsibility to provide the public with information. Indeed, some of the journalists who most persistently cover child welfare issues are driven by a desire to build awareness about issues related to child safety and well being.

Assuming all media coverage will be negative can lock you into an adversarial relationship with the media. Instead:

- **Build a relationship with journalists, editors, and TV and radio producers in your area before a crisis occurs**. Make sure they understand the strengths of your organization, its needs, and the services it provides to families, children, and the whole community.
- **Prepare an agency-wide strategy for dealing with unwelcome press interest**. This should include protocols for who speaks with the media, and for the explanations given if you cannot provide them with the information they seek.
- **Understand North Carolina's Public Records Law** as it applies to your agency in cases of child fatalities or near-fatalities (see sidebar).
- **Create a forum in which staff can discuss negative coverage of your agency in the media** when a crisis does occur. This is an opportunity to support staff and shore up morale. ◆

Sources

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CHILD FATALITIES AND THE NC PUBLIC RECORDS LAW

If DSS or any other state agency was involved with the child's family, recent changes in state law require that the agency disclose to the public, upon request, its findings and information related to the fatality (NCGS § 2902, the North Carolina Public Records Law). The law also applies to near-fatalities.

If a child has died from suspected abuse, neglect, or maltreatment, and a suspect has been charged, the agency must disclose a written statement of actions taken or services rendered following receipt of information that the child might be in need of protection. The agency may withhold information if the local district attorney believes that release of the information would:

1. Potentially harm a child still residing in the home where a child died,
2. Jeopardize the defendant's right to a fair trial, or
3. Jeopardize an ongoing criminal investigation.

The summary should include the dates, outcomes, and results of any actions taken or services rendered.

It may include results of any review by the State Child Fatality Prevention Team, a local Child Fatality Prevention Team, a local Community Child Protection Team, the Child Fatality Task Force, or any public agency. It can also include confirmation of the receipt of all reports, accepted or not accepted by the county DSS, for investigation of suspected child abuse, neglect, or dependency, including confirmation that investigations were conducted, the results of the investigations, a description of the conduct of the most recent investigation and the services rendered, and a statement of basis for the department's decision.

No information may be released relating to any psychiatric, psychological, or therapeutic evaluations or like materials or information pertaining to the child or the child's family unless directly related to the cause of the child fatality or near fatality. In addition, no information may be released that might reveal the identities of persons who provided information related to the suspected abuse, neglect, or maltreatment of the child (NCGS § 7B-2902).

The agency must provide the report within five working days of when the request was submitted.

All the North Carolina general statutes are available on the Internet (see <http://www.ncga.state.nc.us/statutes/statutes_in_html/chp007b.html>). They can also be found in the appendices of your agency's copy of *Not Invisible, Not in Vain*. Having a copy of N.C.G.S. Chapter 7B in your office is a good idea.

Source: Cook, E. G. & Post, R. (2001). Newspapers. In M. Herman-Giddens and J. H. Haggerty (Eds.), *Nor Invisible, Not in Vain*, pp. 195–202. Raleigh, NC: North Carolina Child Advocacy Institute.

SUPPORTING AGENCY EMPLOYEES TOUCHED BY A CHILD FATALITY

The death of a child can have a profound effect on those who knew and worked with that child. This article describes how agency staff members may be affected by child fatalities and suggests ways to support them.

INCREASED RISK OF PTSD

Child welfare workers who experience a death on their caseload or even in their agency may be at higher risk for **secondary posttraumatic stress disorder**. In this condition, hearing about the pain, suffering, fear, and anxiety of others causes similar feelings in the listener. These feelings have the potential to be as overwhelming for the witness as they are to the person who experiences them first hand. Figley (1995) considers child welfare workers and those who have had unresolved or similar trauma in their own lives to be among the most vulnerable to this kind of "compassionate traumatization." Actually seeing a dead child can further increase an individual's chances of developing full-fledged PTSD (Horwath, 1995).

Untreated, extreme trauma can have a debilitating effect on individuals and the agencies in which they work. Research has found that three out of five police officers involved in a child fatality or similar critical incident leave the department within five years (Woodcock, Morgan, & Greene, 2001).

OTHER REACTIONS

In 1995, Horwath conducted a series of interviews with staff in a British child welfare agency that had experienced a recent child fatality. Immediately after the death, interviewees closely connected with the fatality reported feelings of guilt, uselessness, and worthlessness. These feelings were sometimes made worse by colleagues who avoided them and treated them "as if we were contaminated."

The interviews also revealed the extent to which workers seemingly unconnected with the child fatality experienced stress and confusion. Horwath states, "All staff involved in a child death are affected, including the typist who has typed the family case notes, the receptionist, the support worker, or the nursing assistant who cared for the injured child. A typist described how confused she felt:

> 'I kept thinking if I'd paid attention to what I was typing I might have noticed something which could have saved the child. I know it's stupid but that's how I thought'"(p. 351).

The interviews also revealed that, although people felt more vulnerable and in need of support than ever before, the death somehow became a taboo subject, and an atmosphere of mistrust developed (p. 352).

NEED FOR DEBRIEFING AND DEFUSING

There are several steps agencies can take to reduce the risk of staff turnover and other negative effects following a child death. The first is to offer staff members a chance to debrief this tragic event (Figley, 1995). In this context, debriefing is more than just going over in detail what happened. Rather, it is a structured process designed to help small groups process strong feelings and particularly troubling reactions to an event so that they can continue to serve families and children effectively. Debriefing also gives those facilitating the process the opportunity to identify individuals who need additional aid.

Debriefing is neither psychotherapy nor a critique of the people involved in the fatality. To learn about defusing, a process similar to debriefing, see sidebar, opposite.

Regardless of the specific debriefing technique used, agencies should strongly encourage all staff members to participate. Horwath found that when debrief- *see p. 11*

SUPPORTING FOSTER PARENTS

When a child they once fostered dies, the loss many foster parents experience may be as intense as the loss experienced by the child's birth parents. Yet because they lack the legal standing of family, foster parents seldom get everything they need to come to grips with the child's death, such as prompt, full information about what happened, or a chance to see or touch the child's body.

In the commotion surrounding this tragedy, foster parents may be forgotten altogether. They may no longer be fostering, or they may have cared for this child months or years ago, and so be overlooked by the agency.

Agencies have a responsibility to support foster parents who knew the murdered child, regardless of their current relationship with the agency. Soon after the child's death, they should reach out to the child's former foster parents to offer debriefing, counseling, and other support services. Agencies should also seek ways to support foster parents over the long term, for it takes a long time to grieve the loss of a loved one.

In addition to it being the right thing to do, agencies have a practical incentive for providing this level of support to foster parents. The way they treat foster parents has a lot to do with people's willingness to step forward to provide this invaluable service to children, the community, and the agency.

ing was "available on a casual basis, workers felt it was perceived as a weakness to take up the offer." Too, although most child welfare workers are comfortable identifying others who need help, they may have a difficult time asking for assistance themselves (Rosenfeld & Caye, 1999). For these reasons, agencies should emphasize the importance and normality of debriefing after traumatic situations.

It is often helpful to have support for staff members provided by someone from outside the agency. The death of a child can provoke overwhelming feelings, and child welfare workers need a safe place to talk about their emotions. Especially if they have feelings, rightly or wrongly, of personal responsibility for the death, workers may need the kind of confidentiality only an independent counselor can provide.

CRISIS PLAN

Because child fatalities, violence against staff, and other traumatic events have the ability to severely affect individuals and the staff as a whole, agencies should develop a policy for follow-up to serious events. "There needs to be an agency-wide response that gives staff the comfort they need to hold on and move forward. As negative news unfolds, a sense of direction is the one advantage the agency can control" (Griffin, 1997).

As a first step, agencies may wish to develop a crisis response committee to assess what the organization might need during a crisis and to identify potential resources for meeting those needs. One way to develop such a plan is through consultation with a local mental health center or with a crisis response group involved with a local hospital or the police.

CONCLUSION

Child fatalities can have serious mental and emotional consequences for those working in the child welfare system. To minimize the negative effect this type of tragedy can have on individual workers, foster parents, and the organizations in which they work, agencies should develop a crisis management plan before the need arises. This can make supporting each other, conducting the investigation, and moving on much easier. ◆

References

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THE GROUP DEFUSING PROCESS

This is just one of several therapeutic interventions that may help child welfare workers and other DSS staff members come to grips with a child fatality or other traumatic event. The following is a brief description of this process. To learn more, consult the materials listed under "Resources" below, or contact your local mental health center.

Purpose: To help small groups process strong feelings and particularly troubling reactions to an event so they can continue to serve families and children effectively.

Duration: 30–45 minutes

Group size: Maximum of 8 people. Advantages of using a group process include: providing an environment in which members listen to others and describe what was difficult and what they were proud of during the crisis; normalizing the stressors and the symptoms (e.g., irritability, intrusive thoughts, emotional numbing, jumpiness, guilt) that may accompany the traumatic incident; and encouraging members to share coping strategies.

Trained Facilitators: Usually two

GENERAL STRUCTURE

Phase 1: Introduction and Orientation

Invites group to decompress, get support, get ready to return to their tasks.

Phase 2: Ventilation and Validation

Provides opportunity to express reactions to their experiences related to the fatality.

Phase 3: Prediction and Preparation

Groups consider whether they will be troubled by their experience and explores possible coping strategies.

Phase 4: Summary and Conclusion

Acknowledges participants' competence and the value of their work for families and children. Reassures them of continuing support.

RESOURCES

National Organization for Victim Assistance. (1997). *The community crisis team training manual* [On-line]. Washington, DC: Author. Available <www.try-nova.org/index.html>

Armstrong, K. R., Lund, P. E., McWright, L. T., & Tichenor, V. (1995). Multiple stressor debriefing and the American Red Cross: The East Bay Hills fire experience. *Social Work, 40*, 83–90.

Sidebar Source: Rosenfeld, L. & Caye, J. (1999). *When their world comes apart: Managing the effects of disasters on families and children*. Chapel Hill, NC: University of North Carolina School of Social Work.

N.C. CHILD FATALITY REVIEW TEAM INTERVIEW *from page 5*

What all this means for practice is that you need to do a comprehensive assessment in all of your CPS investigations. Often times workers—I think because of feeling pressed for time—are just dealing with the issue at hand. So therefore they may not get all the information they need to assess safety for children.

CSPN: If there's been a fatality in their community and your team will be coming to review the case, what can a county DSS do to prepare?

McHenry: We understand that some agencies are apprehensive before a review. The whole review process will be easier if, when you assessed the safety of surviving siblings, you gathered comprehensive information from schools, doctors, and every agency that knew members of this family, including the dead child. If this is not the case, there will be more work leading up to the review as we try to gather any missing information.

As far as the review process itself, we know it will be difficult for you. You'll have to relive an awful situation, and a lot of people will be looking at your work. Please know that we understand how this process may feel to you. As we conduct the review, we must perform a delicate balancing act that mirrors the one that you must perform after a fatality. To learn what we can to prevent future child deaths, we must conduct a thorough, objective review. Yet at the same time, we care about and are there to support the people most involved with this tragedy.

"We'd be glad to talk about multidisciplinary approaches to fatality investigations with your county."

—Debra McHenry

MORE INFORMATION

If you have questions about child fatalities in North Carolina or about the State Child Fatality Review Team, please contact Sara Anderson Mims, Debra McHenry, or Carlotta Dixon at the N.C. Division of Social Services, Children's Services Section, Program Review Team, 325 N. Salisbury Street, Suite 772, 2407 Mail Service Center, Raleigh, NC, 27699-2407. Tel: 919/733-9461. You can also find the child fatality review protocols and the most recent annual report from the State Child Fatality Review Team by visiting <childrensservices.dhhs.state.nc.us/programreview/fatality_protocol.htm>. ◆

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