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INTERNATIONAL LEGAL NOTE

Child fatality review teams and the role of social workers

An international perspective

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> New country-by-country data reveals alarmingly slow progress on reducing child deaths . . . While 90 countries are on track to meet the target of reducing child deaths by two-thirds by 2015, 98 countries are considerably off track, and globally the pace of progress is far too slow. (UNICEF, 7 October 2004)

We are living in dangerous and violent times, and our most precious resources, our children, are sometimes its victims. Disease, inadequate health care, violence, a faulty smoke alarm, an unlocked seat belt, a loaded gun, poison or medicine within easy reach, an unprotected electric outlet, a pack of matches: in rich countries and poor countries, all of these things can and have killed children (UNICEF, 2003). When these result in the death of a child, in a growing number of countries and jurisdictions the death is reviewed by a child fatality review team. The purpose is to perform a comprehensive review of child deaths in order to gain a better understanding of these deaths, and to use that knowledge to take preventative actions in similar situations.

A growing global movement

The first child fatality review team was formed in 1978 in Los Angeles, California (Webster et al., 2003). Within five years, there were teams in

21 states 'covering 100 million people, or 40% of the U.S. population' (Durfee et al., 2002: 620). In the USA, child fatality review teams now exist in all 50 states (Hochstadt, 2006), with a dozen states developing a multi-state web-based reporting system.

Review teams also exist in Canada (Taylor, 2006), the UK (Alexander and Case, 2005; Bunting and Reid, 2005), South Africa, the Philippines (ISPCAN, 2004), New Zealand (New Zealand Public Health and Disability Act, 2000) and Australia (Child Death Case Review Committee, 2006; Kovacs and Richardson, 2004). In fact, New Zealand reports that 'A discussion has begun with our Australian equivalents to standardise our reporting categories and exchange information about deaths in either country' (Child and Youth Mortality Review Committee, 2006: v). At the beginning stages of the child fatality review team process are Pakistan, India, Estonia and Portugal.

Composition and responsibilities of child fatality review teams

Child deaths are inherently challenging to investigate. Consequently, the international trend is to acknowledge the value and need for the participation of a number of highly trained specialists. These interdisciplinary teams are composed of representatives of agencies and institutions including but not limited to social workers, coroners, public health and medical professionals, court and law enforcement officials, epidemiologists, educators and lay people. Teams do not review all child deaths. Rather, they review cases based upon established protocols or legislation.

Responsibilities of the team may include conducting specific case reviews; coordinating and integrating efforts to collect, analyze and interpret data on child deaths; suggesting improvements in policies, procedures and practices within the agencies that serve children; reviewing the extent to which the prevention and protection system is coordinated with law enforcement and the court system; and evaluating whether the jurisdiction is efficiently carrying out its prevention and protection responsibilities. See Figure 1 for a schematic depiction of the workflow of a child fatality review team.

Particular attention for many teams is focused on cases that were receiving child protective services.[1] These collaborative, comprehensive reviews are a critical step in accurately identifying risk factors, trends, patterns, and gaining a thorough understanding of the protocols of each key agency that can result in improved information sharing and communication, less duplication of services, and better preservation of

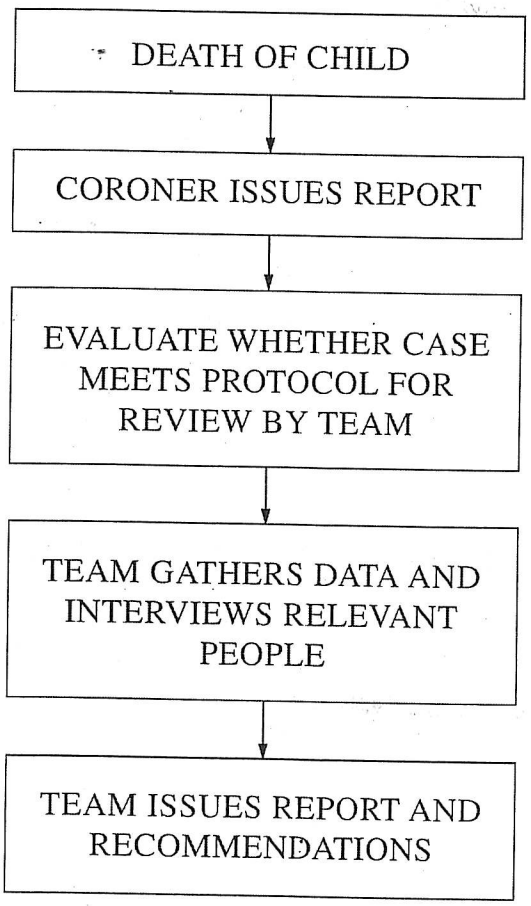

Figure 1 Schematic depiction of the workflow of a child fatality review team

evidence. However, the team is not a substitute for, nor may it infringe upon, the roles and responsibilities of any other agency required to investigate the same incident.

Specific functions of the child fatality review team

Child mortality data give an expansive picture of child deaths in an actuarial manner. Yet it is often from a meticulous study of an individual child's death that we can learn how best to prevent another. When assigned a specific case the team will often review information such as the following:

- the coroner's report;
- court records;
- hospital records;
- school records;
- local, state, provincial and federal law enforcement records;

- medical and dental records;
- department of health records;
- mental health and substance abuse records;
- emergency medical service records; and
- department of social services records.

Many jurisdictions in which review teams operate provide that all otherwise confidential information and records obtained by the team in exercising its duties remain confidential and are not subject to being introduced into evidence in any legal proceedings except pursuant to a court order.

The role of social workers

The role of social workers, especially in child maltreatment cases, may include:

1. Reviewing records to ascertain whether there were previous incidents of domestic violence. The correlation between spouse abuse and child abuse is often quite high (Edleson, 1999; Tajima, 2000).
2. Reviewing files to ascertain whether there was a family history of child abuse and neglect. A number of studies have indicated that a family history of child abuse and neglect increases the chances that a child may be the target of repeated incidents of maltreatment (Gershoff, 2000; Jewell, 2003; Rittner, 2002; Widom and Hiller-Sturmhöfel, 2001).
3. Reviewing records to see if there were previous reports of child abuse or neglect.
4. Assessing the safety of any siblings and other children remaining in the home in which the deceased resided.
5. Interviewing the alleged perpetrator if possible. This may have to wait until after court proceedings have concluded.
6. Interviewing the child's caretakers or parents. This will include assessing the stressors on the caretakers and perpetrator including such things as their social supports, financial situation, marital status, level of education, and number of children. The social worker should also seek other pertinent psychosocial information about the family, including information obtained from relevant collateral sources and professionals involved with the family. Collateral contacts may include childcare personnel, home health professionals, and neighbors (Radhakrishna et al., 2001).
7. Acting as spokesperson on behalf of the team.

Conclusion

Webb writes in his recent book, *Social Work in a Risk Society* (2006: 23), 'The concept of risk is one of the most significant in modern times. We live in a world saturated with and preoccupied by risk. Despite unparalleled degrees of social stability and affluence, we are living through a period of acute personal insecurity, anxiety and change.' Child fatality review teams look at risk simultaneously from the most microscopic and panoramic perspectives. Each death, and any resulting from child abuse and neglect in particular, is viewed in an ecological way. This means we take into account the genesis of all forms of child deaths to be a complex interactive process involving the individual, family, community, and society. Some factors are more closely linked with some causes of child death than others. It is the job of child fatality review teams and the social workers who staff them to discern these subtle differences, to make recommendations accordingly, and to help reduce the incidence of preventable child deaths.

A purposeful look backward is often the wisest way to move forward.

Note

1. The Innocenti Report Card (2003, September) articulates the rates of maltreatment deaths in the 27 member countries of the Organisation for Economic Co-operation and Development (OCED): 'At the top is a small group of countries – Spain, Greece, Italy, and Ireland – where the rate appears extremely low (fewer than 0.2 maltreatment deaths for every 100,000 children). Towards the bottom of the table are two countries – Hungary and New Zealand – where deaths from maltreatment are approximately six times higher. And at the very bottom are two more countries – Mexico and the United States – where the rate of child deaths from maltreatment is more than ten times higher' (p. 5).

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