THE ROLE OF CHILD PROTECTIVE SERVICES IN RESPONDING TO AND PREVENTING CHILD DEATHS

—by Susan J. Wells

Introduction

The National Center on Child Abuse and Neglect (NCCAN) (U.S. Department of Health and Human Services, 1994) reports that 1,068 child deaths were known to child protective service (CPS) agencies in 1992 (44 states reported fatality data for that year). This number does not include deaths which were recorded by law enforcement agencies as murder, but not reported to CPS; nor does it include many deaths that may have resulted from maltreatment but have gone undetected by the community. Using a combination of law enforcement data and current research on other records of fatalities, e.g., CPS, medical examiner, health services, public safety, McClain et al. (1993) estimated annual child maltreatment death rates based on three different models. The results of their work suggest that anywhere from 949 to 2,022 children die from abuse and neglect each year, depending on the definition and model used, and that the number has been relatively stable over time.

In the Second National Incidence Study of Child Abuse and Neglect (NIS-2), Sedlak (1989) found that, of the children known to the professionals in the community as abused or neglected (N=1,025,200 for the United States), 57% were abused and 49% were neglected (some children were both abused and neglected). Of 1,100 children who were known fatalities in this study, 54% died from physical abuse. The number of actual cases for deaths from neglect were too small to make reliable national estimates. One can conclude, however, that the remaining fatalities, 46%, were from causes other than physical abuse.

Understanding data on child maltreatment deaths

The difficulty in determining the actual number of child maltreatment deaths locally or nationally is at the center of the movement to establish interagency, multidisciplinary, child death review teams. Studies of child deaths have consistently shown that the number of children who die at the hands of their caretakers is not known to any one agency, whether it is the police, child protection, hospitals, or even the coroner or medical examiner (e.g., Shapiro and Lescohier, 1989; Ewigman, Kivlahan, and Land, 1993). This is due not only to lack of cross reporting, but also to lack of initial identification. So many cases may go unidentified due to each agency's or person's having only one part of the story, lack of precision in our current technology and science (e.g., inability to detect some forms of murder such as suffocation of infants), lack of systematic investigations at the time and scene of death, and lack of agreement with respect to what constitutes a death due to abuse or neglect. For example, if a parent leaves a 13-year-old at home alone, in the same house with available liquor and a loaded gun, and that child dies in a scuffle with a friend over the gun, is the death attributable to neglect by that parent? How would and should it be recorded by the various agencies involved? Finally, any professional may be unable, at one time or another, to fully comprehend the meaning of the available evidence. The thought that a parent or caretaker would actually kill a child is so foreign to most people that it is often not considered as a possibility.

CPS definitions

This lack of clarity and precision in identifying the cause of death of children is particularly troubling because lack of accurate information as to cause hinders prevention efforts. The issue is compounded when looking at the role of child protective service agencies in responding to child deaths. Each state defines child abuse and neglect somewhat differently. For example, some states explicitly include infants born with a positive drug toxicology as abused children, while others may specifically exclude them (National Clearinghouse on Child Abuse and Neglect Information, 1992).

The same is true with respect to child deaths. In some states, CPS agencies only investigate reports of a child's death if (1) that child had an open case with the agency or (2) the family was referred to CPS because those responding to the death thought other children in the household might be at risk of abuse or neglect. In other states, CPS would be called to investigate a case if there was any suspicion that the child died due to abuse or neglect. Further, the recording of a child's death as due to abuse or neglect by the CPS agency could depend upon a host of factors. Some of these are: (1) whether the case was open at the time of the child's death, (2) the identity of the suspected perpetrator (the perpetrator must be a caretaker to trigger CPS involvement, and the definition of who is a caretaker varies from state to state), or (3) whether there was a finding of maltreatment in the investigation by the CPS agency. Therefore, the child deaths recorded by a CPS agency in North Carolina are not likely to be the same types of cases recorded as child abuse deaths in Oregon or Georgia.

CPS knowledge of potential risk

When determining which children have died due to child maltreatment, the specific cause of their deaths, and how to prevent future child deaths, it is important to remember that many children who die at the hands of their caretakers have never been reported to a CPS agency. Of children in the U.S. known by community professionals to have been fatally or seriously injured by abuse or neglect in 1986 (N=158,200), only 35% had been investigated by CPS (Sedlak, 1989). The other 65% of these children either were not reported to the CPS agency (Zellman, 1990), or were not investigated by CPS when a report regarding their welfare was made. The decision not to investigate is usually due to a judgment that the case does not fit within the legal definitions which mandate CPS involvement (Wells, Fluke, Downing and Brown, 1989).

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State and local reviews of child deaths have had similar findings. In these studies, the review usually begins with those cases that become known to CPS at the time of the child's death. One of the first state studies of child abuse deaths indicated that of those deaths known to CPS in Texas from 1975-77 (N=267), approximately 75% were unknown to CPS before the report of the death (Region VI Child Abuse and Neglect Resource Center, 1981). In a study of 73 deaths in New York City that were substantiated upon investigation in 1984, 75% were previously unknown to the city's CPS agency (Mayor's Task Force, 1987, Appendix A, Table 77). More recently, of 58 children who were known to have died of abuse or neglect in South Carolina from 1989 through 1991, approximately 60% were not known to child protective services before the report of the death (Christophillis & Riley, 1993).

These studies suggest that of children known by professionals in the community to have died of maltreatment, only a small percentage are ever investigated and recorded by CPS. Further, of those known to CPS as a result of a death, most of these had not had prior contact with the protective service agency.

The conclusions of the Mayor's Task Force report were that (1) fatal and non-fatal CPS cases are more alike than different; and (2) fatalities cannot be predicted. The findings of this study, published seven years ago, remain valid today.

Children with a history of CPS involvement

Even though most children who die from maltreatment are not known to CPS prior to the child's death, cases in which deaths occur after a CPS investigation often become widely known. The public wonders how this case could have been missed, how this child could have been forgotten by society and left to die. Lisa Steinberg of New York City is a name recognized across the country. Every state can readily name fatally abused children who were known to the system, children who should have been protected from their caretakers. For some of these children there was no way to predict the violence they would suffer. Yet for others, systematic intervention by the state and court system could have made a difference.

In just one example, in 1986, the Ft. Lauderdale *News/Sun-Sentinel* reported that 74% of children killed while on CPS caseloads did not receive monthly visits from CPS workers. There was additional concern that the law requires CPS workers to preserve or reunify families even when the child has been seriously or repeatedly injured (Bergal, Bochi, and Schulte, 1986). This latter point is clearly a misreading of the law, but it suggests that workers, supervisors, and lay persons might not have a clear understanding of the goals and procedures to be used in executing general child welfare policies while protecting children.

In an effort to determine whether it is possible to identify which children known to CPS are likely to be fatally injured, the New York City Mayor's Task Force on Child Abuse and Neglect (1987) undertook a study with the support of the National Center on Child Abuse and Neglect to identify possible risk factors. The findings of this study, published seven years ago, remain valid today.

The researchers examined all known maltreatment fatality cases (N=73) from 1984 and a random sample of 114 nonfatal cases that were substantiated during the same time period. Data were gathered from a number of community agencies, e.g., hospitals, public health, drug treatment facilities, schools, and others. The factors most likely to be associated with the fatal were the young age of the child, presence of a father or father substitute in the home, paternal drug use, prior court-ordered removal of the child, absence of a maternal grandmother in the home, ethnicity, and a sibling with medical problems. These factors correctly classified 71% of the fatality cases, but incorrectly identified 17% of the nonfatal cases.

The conclusions of the Mayor's Task Force report were that (1) fatal and nonfatal CPS cases are more alike than different; and (2) fatalities cannot be predicted. They recommended that in order to prevent fatalities, child abuse and neglect in general must be prevented, more research should be done to identify more precise warning signs, workers should focus more on father and father substitute perpetrators, workers should monitor the family closely when only one child is removed [Author's note: or is returned], agencies must enhance cross-agency sharing of information, availability of drug treatment services for caretakers should be increased, the preventive roles of schools should be enhanced, prenatal and postnatal screening should be conducted, and more focus should be given to prevention and treatment efforts with very young children. More recent work by children's services death review teams have echoed several of these findings (see, e.g., Schirner & Griggs, 1993).

Role of CPS in responding to child deaths

The role of CPS in responding to child deaths will vary according to state law. Generally, the agency may be called upon to participate in the immediate investigation, working with law enforcement in determining the cause of death. In addition, CPS may be called upon to review whether they have had past contacts with the child or family. Finally, CPS may be asked to intervene on behalf of the children remaining in the home, to make a safety determination, and to take protective measures if necessary. When a child dies, CPS work in the case is often just beginning. Information on the nature, cause, and circumstances surrounding the child's death may be helpful to CPS planners in reviewing current practices and developing new procedures.

Child death review teams

Most models for child death review teams are currently promoted as multi-agency, interdisciplinary efforts that may be local or statewide in their

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orientation. The local teams generally focus on coordinating investigative work, while the state teams tend to be retrospective, examining the causes of child deaths and determining ways in which community systems can be enhanced to prevent these deaths.

In addition to these interagency efforts, in fact preceding them in many cases, CPS agencies have been undertaking internal reviews of child deaths to examine their own response system and determine how they can improve service delivery. These internal reviews are as critical to the effective functioning of CPS as the interagency teams are to the entire community. The reviews may be conducted by the agency's CPS specialists or may be conducted by an interdisciplinary panel.

In a 1990 national survey of child death review policies, Wells (1991) found that 33 state child protective service agencies had a formal policy or administrative practice of reviewing child abuse deaths. These policies may be concerned with internal agency functioning or be purely investigative in nature. In 1993, 20 states reported state-level teams that meet regularly to review child deaths (Wells, Benedict, West, and Chipman, 1993).

Oregon has proposed the following questions which are useful for internal and interagency reviews (Oregon Department of Human Resources, Children's Division, 1991):

(1) Could the fatality have been prevented?

Review: warning signals, community awareness, state agency response, court system response, community resource availability.

(2) Was the public agency's intervention provided in accordance with the state statutes and departmental rules, regulations and procedures?

Review: investigation, response time, assessment, services provided.

(3) Are the state statutes and departmental rules, regulations, and procedures adequate?

Review: assessment procedures, gaps in law, guidance to workers, emergency procedures, interface between laws, procedures and practices.

(4) Was the worker adequately prepared to provide protective services?

Review: educational background, agency training, support, ability to assess risk.

(5) Was there adequate communication between social service agencies?

Review: community networking, interagency staffing, training for community agencies, holistic approach to child and family.

(6) Commendable or outstanding work done by workers or supervisors.

Of children known by professionals in the community to have died of maltreatment, only a small percentage are ever investigated and recorded by CPS. Further, of those known to CPS as a result of a death, most had not had prior contact with the protective service agency.

Confidentiality

Confidentiality of case records after a child's death has been the subject of much debate. Some information sharing is essential in the process of promoting interagency cooperation. In addition, reporters and some child advocates believe that the public's right to know about the public agency's functioning supersedes all considerations of confidentiality when a child has died. CPS agencies cite the need to protect their clients and confidentiality provisions in legislation as a reason for not releasing information, while the public accuses CPS of hiding its culpability in child deaths behind the shield of confidentiality. Physicians, schools, and drug treatment programs are under similar constraints in sharing case information in case conferences due to similar legislation and ethical considerations affecting their practice.

The National Center on Child Abuse and Neglect has taken one step toward resolution of this problem by specifically suggesting that for the purposes of multidisciplinary review teams, CPS be allowed to share case information (David Lloyd, personal communication, 1994). The proposed new rules will free states from the threat of loss of federal dollars when participating in multidisciplinary review teams which follow federal standards with respect to confidentiality. This is a major step forward for team building and one that should encourage other disciplines to follow suit.

The issue of releasing information to the public, however, is more difficult. In 1990 Georgia passed legislation allowing the release of case information by the death review team, including names of victims (Georgia Code Ann. section 19-15-1 et seq.). Such a release is highly problematic for the families involved and for the protection of the rights of alleged perpetrators before any arrests have been made. In fact the statute establishing the child fatality review team and permitting the release of such information is subject to another state statute limiting the release of information if such release would result in the loss of federal funds for the state (Ga. L. 1990, section 2) as cited in Editor's notes, Georgia Code Ann. section 19-15-1 et seq.). Because federal law has strict provisions regarding confidentiality, this in effect nullifies such release.

In every state, laws govern the degree to which medical examiners, law enforcement, and prosecutors can release information to the public. These laws were created to protect the rights of the innocent and at the same time give the public full access to information regarding those arrested for, or judged guilty of, crimes against society. Ensuring accountability of public agencies does not arise from holding them to account on individual cases, no matter how vivid or shocking. Rather, it follows from a systematic accumulation of data over time that indicates how agencies are functioning, whom they are serving, and the degree to which they are meeting their mandates. This data informs us only

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in the aggregate, over many cases, and over time

Child protective services is one of the few positions of public responsibility in this country that can rise and fall on the public report of one case, no matter how the agency has functioned for the thousands of other children served. To protect against the politicization of CPS, it is critical to institute mechanisms of quality assurance, to implement mechanisms of accountability and sound management, and to put leadership in the hands of those best trained to do the job.

In lieu of releasing case-specific information, the agency also has an obligation for self study and to release the results of these internal investigations in the aggregate. This enables the public to understand the use of their tax dollars in protecting children and gives the agency a complete structure of accountability which should be the same for all publicly-funded agencies.

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Conclusion

The risk of child homicide has been well studied. Younger children of poorly educated mothers who are unmarried at the time of the child's birth, and children who reside in metropolitan areas are more likely to be killed than other children (Winpisinger et al., 1991). Being African-American appeared to be an independent risk factor but was largely explained by the mother's marital status. Variables associated with pregnancy and congenital malformation have not been consistently associated with child homicide.

These risk factors suggest that society as a whole has an obligation to better provide services and supports to this high-risk population. When coupled with the finding that, among CPS cases, it is not possible to predict child fatalities, the roles of society at large and CPS in particular become more clear.

Agencies must make clear to their workers and to the courts that family preservation and reunification are only desirable ends when the child is judged to be safe in the home.

Only by enhancing services to the entire at-risk population can fatalities be effectively prevented. The role of CPS is to refine their management and supervision of service delivery, to consistently examine their policies and procedures as well as the effect of legislation on practice, and to work with other agencies and organizations in the community to ensure a coordinated investigation and service delivery system. Further, agencies must make clear to their workers and to the courts that family preservation and reunification are only desirable ends when the child is judged to be safe in the home (Administration for Children, Youth, and Families Program Instruction 94-01).

The role of the public, and therefore the legislators, is to understand that for the most part it is impossible to predict which children will die. Whether or not CPS has acted in accordance with all current procedures, the community must also look to itself. Cross agency reporting practices, systematic sharing of case information for the purpose of child protection, the development of ongoing investigation teams, and support of each other in the pursuit of the final goal of child protection are essential and often overlooked.

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