Using Citizen Review Panels to Assess Child Maltreatment Fatalities

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During 2007, an estimated 1,760 children died from abuse or neglect at a rate of 2.35 deaths per 100,000 U.S. children (US DHHS, 2009). Although child abuse rates are declining in the United States, there has been no real change in the number of child maltreatment (CM) fatalities. Agencies have their own legal mandates, protocols, and practices, which may lead to differences and inconsistencies in how potential cases are investigated and defined. Associated with maltreatment fatalities are a number of risk factors, such as residing in homes with unrelated adults, young age of the child, and prior involvement with child protective services, and this information can aid in improving child welfare services and developing initiatives to prevent further deaths. It is widely accepted that by conducting child fatality reviews professionals can better identify and respond to child deaths (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008; Christian, Sege, et al., 2010).

Additional opportunities for improvement and prevention within the child welfare system itself are also available (King, Kiesel, & Simon, 2006). Even though the death of a child is a rare event and most children known to the child welfare system do not die, some of them do. In 2007, children whose families had received family preservation services within the child welfare system in the past 5 years accounted for 11.9% of child fatalities. Slightly more than 2% (2.6%) of the child fatalities had been in foster care and were reunited with their families in the past 5 years (US DHHS, 2009). This suggests that all concerned may take steps to improve outcomes in child protective services and foster care agencies. New strategies include using a children's ombudsman (Bearup & Palusci, 1999), a state child advocate (Faith VosWinkle, Connecticut Child Advocate, personal communication, 2009), and the establishment of federally-mandated citizen review panels (CRPs).

Development and Function of CRPs

CRPs were first required for U.S. states in 1996 as part of the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). Many states have instituted CRPs specifically to review child maltreatment fatalities (Child Abuse Prevention and Treatment Act, 1998; U.S. DHHS, 1998). CRPs are ideally made up of a representative sample of community volunteers, are required to meet at least quarterly, and fulfill a broad mandate which includes ensuring that the state is in compliance with CAPTA, Title IV-E programs, and other requirements (Jones, Litzelfelner, & Ford, 2003).

Medical examiners, law enforcement, child protective services, and legal professionals are usually part of the CRP, and many teams add child abuse pediatricians, education professionals, and public health officials to their panels. Efforts are also made to include nonprofessional citizens, such as former clients of the child welfare system and other members of the community at large. States are required to provide panel members with case-level information that the panels deem necessary for them to carry out their mission (US DHHS 1998). Panel members are bound by confidentiality requirements and cannot disclose identifying information about cases reviewed. States are also required to provide staff to enable the panels to carry out their functions.

CRPs have been implemented variably across the United States, and their effectiveness has been evaluated only to determine the extent of citizen participation or implementation of their recommendations (Jones, 2004). At least 15 states have populated fatality CRPs from among members of their state or local child fatality review boards (National Center for Child Death Review, 2008). CRPs are required to report to their state child protective services agency and are also expected to prepare an annual report for the public describing their activities.

CRPs—Similar to or Different From Other Child Death Reviews?

While child fatality review teams (CFRTs), fetal-infant mortality review teams (FIMRs), and fatality citizen review panels (CRPs) all review child deaths, CRPs review deaths only of children known to the governmental child protective services (CPS) agency. These CRPs are charged with making recommendations primarily to the CPS within the child welfare system (Table 1). Child fatality review teams (CFRTs) have been instituted in most U.S. states to provide a multidisciplinary, multiagency review of all or most child fatalities (Durfee, Gellert, & Tilton-Durfee, 1992; Durfee, Durfee, & West, 2002; Webster, Schnitzer, Jenny, Ewigman, & Alario, 2003; National Center for Child Death Review, 2008). All have reviewed fatalities from child maltreatment and have identified abuse cases that had been misdiagnosed or misclassified as being due to natural causes or unintentional injury (Levene & Bacon, 2004; Kellogg & Lukefahr, 2005; Jenny & Isaac, 2006; Schnitzer et al., 2008).

For example, in Philadelphia, most child homicides were found to be preventable, and the review process was thought to provide one source of comprehensive data to allow policymakers to formulate solutions (Onuwuachi-Saunders, Forjuoh, West, & Brooks, 1999). In Arizona, the state CFRT was able to identify and correct an incorrect cause of death in 13% of death certificates, and it suggested that 38% of all child deaths after the first month of life could be prevented (Rimsza, Schackner, Bowen, & Marshall, 2002).

The National Fetal and Infant Mortality Review Program (FIMR) is a collaborative effort between the American College of Obstetricians and Gynecologists and U.S. Health Resources and Services Administration Maternal and Child Health Bureau (www.acog.org, accessed October 12, 2010). This process brings together key members of the medical community—including obstetricians, pediatricians, nurses, and public health officials—to review information from individual cases of fetal and infant deaths. The purpose of this type of review is to identify general community, social, economic, cultural, and health systems factors that are highlighted by those infant deaths to determine if they represent problems in the service delivery system or resources that require change, and to develop recommendations and assist in the implementation and monitoring of the changes. Case reviews are anonymous and confidential. FIMR projects have been conducted since 1988, but the majority of existing FIMRs were formed after 1990.

In contrast, CRP reviews are limited to child deaths known within the state child welfare agency or to child protective services (CPS). The purpose is to identify issues related to state law, policy, or practices within the state agency that can contribute to fatalities. Specific practices examined can include receiving and responding to reports of suspected child maltreatment, case investigation, outcome determination, and the provision and types of services. While foster care and adoption services are often part of child welfare practice, these are typically examined by CRPs separate from the fatality CRP. CRPs can also assess agency staffing levels, caseworker caseload size and training, the availability and allocation of resources by the state child welfare agency, and compliance with the state CAPTA plan. Although factors outside the CPS system are often reviewed, the focus of recommendations remains within the CPS systems, their contribution to CM fatality, and CPS's ability to influence and improve the lives of children and prevent deaths in other parts of the child welfare system.

Experience Using CRP for Fatality Review

A recent review identified over 300 recommendations in 11 categories from child death reviews in the United States, and some professionals believe that child death review teams can make significant contributions to the overall protection of children and the prevention of child deaths and serious injury (Douglas & Cunningham, 2008; Hochstadt, 2006). Published experience with fatality CRPs is limited. Jones, Litzelfelner, & Ford (2003) surveyed CRP members and CPS staff and found differences in their perceptions of the importance of citizen involvement in the review process. They also differed in their perceptions regarding the need for change and the steps to be taken to improve the child welfare system.

The authors concluded that better communication between CRP and CPS was needed about agency-community partnerships and the value of citizen participation. They recommended a training program to educate lay CRP members about the policies and daily struggles of CPS. Bryan, Jones, Allen, and Collins-Camargo (2007) examined the impact of CRPs in a southern state and found that CRP member perceptions of their own effectiveness were mixed, noting ineffective communication, poor implementation of recommendations by CPS, and lack of CPS responsiveness. State CPS personnel particularly valued CRP's ability to serve as a neutral group that viewed the system with "fresh eyes" and provided additional evidence as the basis for the need for additional support. In addition to recommending steps to improve communication, the authors also cited the need for more systematic reporting and implementation of CRP recommendations as well as improved selection processes and training for CRP members.

We (Palusci, Yager, & Covington, 2010) evaluated changes in the state of Michigan after implementation of a CRP that reviewed CM deaths known to the state child welfare system over a 6-year period. The review specifically identified the number of child deaths, problem areas in the state child welfare system, and any specific changes in child welfare law, policy, and practice that could be associated with fewer child maltreatment deaths. During the first 3 years of the study, a number of findings and recommendations were made that were linked to changes made by CPS in the child welfare system. Those same findings were assessed in a second 3-year period to determine any change on the incidence of fatal CM related to them. In the first period, there were 186 deaths (2.4 per 100,000 children) with 264 findings; in the second period, there were 170 deaths with 172 findings (2.2 per 100,000), which represented a 35% decrease in findings and a 9% decrease in deaths associated with those findings.

Table 2 reviews a selection of findings from Palusci et al. that show significant decreases pertaining to CPS. Most findings were noted in more than one child death and decreased over time, with some exceptions. Twenty-seven specific finding areas were noted after combining findings from all the cases; most findings were categorized as occurring because of failures during CPS case investigation, assessment, and services (19 findings), followed by failures in mandated child abuse and neglect reporting (4 findings) and problems during court petition and adjudication (4 findings). Specific changes were made in law, policy, or practice for 24 of these 27 findings areas. Although causation cannot be inferred, the findings with the greatest degree of change could be directly related to changes in CPS practices that were consistent with recommendations made by the fatality CRP during the first 3 years of the study.

Table 1. Comparison of Reviews by Different Child Death Review Systems

	Child Fatality Review Teams (CFRT)	**Fetal-Infant Mortality Reviews (FIMR)**	**Fatality Citizen Review Panels (CRP)**
Composition	Multidisciplinary professionals and community members (medical examiner, law enforcement, CPS, public health, prosecutors, others)	Medical and public health professionals (obstetricians, perinatologists, geneticists, nurses, pediatricians, public health workers, others)	Multidisciplinary professionals and community members (medical examiner, law enforcement, CPS, public health, prosecutors, pediatricians, former clients, others)
Source of cases	All or selected child deaths (often homicides, accidents, suicides)	All infant deaths (<1 year), maternal deaths, and fetal demise	All child deaths among children known within the CPS or child welfare systems
Purpose of Review	To improve our understanding of how and why children die; to demonstrate the need for and to influence policies and programs to improve child health, safety, and protection; and to prevent other child deaths	To identify general community, social, economic, cultural and health systems factors highlighted by those infant deaths, to determine if they represent service delivery system or resource problems that require change, and to develop recommendations	To evaluate the effectiveness of the agencies charged with child protection responsibility and examining the policies, procedures, and where appropriate, specific child deaths handled by state and local agencies providing child protective services. Also to evaluate compliance with state CAPTA plans, standards, and other criteria as determined
Reporting and Implementation of Recommendations	Variable. CFRTs may report to specific agencies, the governor and/or legislators, and/or the public at large. There is no legal mandate for implementation.	Variable. FIMRs report to private and public organizations and the community. There is no legal mandate for implementation.	Federally mandated response by the state child protective services agency. CRPs are required to monitor the impact and implementation of their recommendations.

Table 2. Fatality CRP Findings Related to CPS and Significant Changes in CM Deaths

CRP Finding	**Problem Area**	**Change in CM Deaths**	**CPS System Change**
Inappropriate screening out of reports and delays in assignment	Non-compliance	- 85.1%	Systemwide peer review
Unacceptable delays between assignment and contact with families	Non-compliance	- 82.5%	Systemwide peer review
Risk assessment completed incorrectly or not at all	Non-compliance	- 86.3%	Statewide training and data system upgrades
Totality of case inaccessible to caseworker	Other issues	- 90.0%	Data system upgrades

Source: Palusci et al., 2010.

Limitations of CRPs in Identifying Deficiencies in the CPS System

While CRP fatality review leads to potentially promising outcomes, there are several limitations to the CRP process. Some changes in law, policy, or practice can be implemented only on a county-by-county basis and cannot be implemented effectively by a statewide team. CRPs cannot influence elements in the child welfare system outside the state CPS agency, and an important number of CM deaths cannot be addressed if changes are made only within CPS. Effectiveness is enhanced when CRP and CFRT work together to address needs across systems, but the fatality CRP generally does not have access to cases in which there is no CPS involvement, or the case does not become known to the state's CFRT, or both.

It is difficult to measure the number of CM fatalities and the effectiveness of CRPs in reducing those deaths given the small numbers of deaths in any one jurisdiction and the difficulty in constructing an experimental model with a control group to measure improvements in a statistically sound way. Our study (Palusci et al., 2010) had wide variations and small numbers that precluded statistical significance for many of the changes in the frequencies of deaths. Any trends in deaths are also affected by changing community practices and policies plus other factors unrelated to the CRP, such as trends in overall child death.

Conclusions

Child maltreatment (CM) fatalities are often preventable, and reviewing these cases often highlights problems in law, policy, or practice that can be addressed to prevent future deaths. Citizen review panels (CRPs) comprising medical and child welfare professionals were first established in 1996 by the federal government to review Child Protective Services (CPS) practices as a requirement of the federal Child Abuse Prevention and Treatment Act.

While these panels have traditionally been used to review cases with living children in the child welfare, foster care, and adoption systems, there is growing use of CRPs in CM fatality cases. CRPs are different from and complementary to reviews by child fatality and infant mortality review teams and are able to specifically address deficiencies in CPS professional practice during case identification and reporting, investigation, and in other child welfare services. Though published research regarding their effectiveness is limited, CRP recommendations are federally required to be reported to and answered by the state's department of social services and can result in significant improvements in the child welfare system.

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