EXAMINING CHILD FATALITY REVIEW TEAMS AND CROSS-SYSTEM FATALITY REVIEWS TO PROMOTE THE SAFETY OF CHILDREN AND YOUTH AT RISK PROJECT

BACKGROUND

The Administration on Children, Youth and Families (ACYF), in the U.S. Department of Health and Human Services, has a primary focus on reducing the risk of child abuse and neglect. To this end, ACYF has long supported the development and continuance of fatality review teams at State and local levels to address the most tragic consequences of maltreatment. The Child Abuse Prevention and Treatment Act (CAPTA), mandates that States establish citizen review panels. These panels review abuse and neglect cases, including those cases involving child fatalities and near fatalities. The Children's Justice Act also requires States to improve their handling of child abuse fatalities. In addition to citizen review panels and child death review (CDR) teams, there are other related fatality review entities—domestic violence fatality reviews (DVFR) and fetal and infant mortality reviews (FIMR). In addition, the Maternal and Child Health Bureau, in the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services, supports the National Center for the Review and Prevention of Child Deaths (NCRPCD). The mission of the Center is to promote, support, and enhance child death review methodology and activities at the State, community, and national levels.

Recognizing the need to further coordinate fatality reviews and establish best practices to support a coordinated and collaborative review process in many jurisdictions, ACYF awarded Walter R. McDonald & Associates, Inc., in partnership with the NCRPCD, a contract to examine recommendations and outcomes of these teams as they work together at the local and State levels. The project was conducted from September 26, 2011 through September 25, 2012. The purpose of the study was to identify promising strategies for fatality review and for furthering collaboration for preventing deaths of children, with a focus on children involved, or who are at risk of involvement, with child protective services (CPS).

STUDY COMPONENTS

The study was comprised of four major components.

- **Literature review**—The literature review focused on documents about best practices (from the past 10 years) for the conduct of fatality reviews; recommendations resulting from these reviews; and changes in policy, practice, or legislation resulting from these reviews.

- **Review of Recommendations and Outcomes**—A review of recommendations and outcomes from CDR, FIMR, and DVFR team reports was conducted. A total of 67 reports were reviewed to identify the prevalence and types of recommendations issued by State and local fatality teams and their reported accomplishments. In addition, an analysis of recommendations from CDR teams in 36 States captured in the National Child Death Review Case Reporting System (NCDR-CRS) from 2008–2011 related to death of children from ages 0–5 years was conducted. The purpose of the analysis was to identify differences in recommendations in which child abuse and neglect (CAN) either caused or contributed to the death of the child and those in which CAN was not a factor.

- **Site Visits**— The project team conducted site visits in 4 jurisdictions with promising strategies for maximizing the impact of their review teams. The goal of the site visits was to learn more about the impact of the recommendations made in the last 3 years that led to changes in

practice, policy, or legislation, and key elements for collaboration. In addition, two States were interviewed by phone.

- **National Meeting**—A national meeting was held August 22–23, 2012. More than 80 representatives from 46 States attended. Members from child death review teams, citizen review panels, fetal and infant mortality review teams, child abuse and neglect agencies, and child welfare agencies attended. In addition to representatives from ACYF, representatives from Indian Health Services, the Maternal and Child Health Bureau of the Health Resources and Services Administration, Centers for Disease Control, and the Department of Defense attended the meeting. Representatives from the National Fetal-Infant Mortality Review (NFIMR) Program, the National Resource Center for Child Protective Services, and the National Center for the Review and Prevention of Child Death also attended. The meeting's goal was to share the project findings and to provide a forum for cross-fertilization of ideas among the attending stakeholders, review teams, resource centers, and Federal agencies.

PRODUCTS

The project resulted in four products that can be used to assist fatality review teams in identifying ways that they could improve their review processes and enhance the impact of their work.

- **Developing Best Practices for Fatality Reviews, Part One: A Tool for Planning and Self-Assessment**—This tool provides questions for fatality review teams to guide them through a discussion to assist them in assessing how well their processes are working, identifying where and how their review processes could be improved, and identifying ways to enhancing collaborative approaches to achieving greater impact in their communities.

- **Developing Best Practices for Fatality Reviews, Part Two: Summary of Findings**—This report summarizes many of the key findings of the study. It also provides background information for each section of the Developing Best Practices for Fatality Reviews, Part One: A Tool for Planning and Self-Assessment.

- **Fatality Review Teams: A Literature Review**—The literature review provides a summary of the articles, reports, book chapters, and other documents published within the last 10 years that provided information about practices for conducting fatality reviews and outcomes resulting from the fatality review processes.

- **A Review of State and Local Fatality Review Team Reports: Recommendations and Achievements**—This report provides a summary of the prevalence and types of recommendations issued by State and local fatality review teams and the reported accomplishments. It is based on a review of reports that included information from reviews within the last 5 years (2007-2011). A total of 67 reports were reviewed—30 CDR team reports, 5 citizen review panel reports, 9 State-level FIMR reports, and 23 DVFR team reports.

FOR FURTHER INFORMATION, PLEASE CONTACT:

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