Child Homicide Review- Perspectives for Team Success

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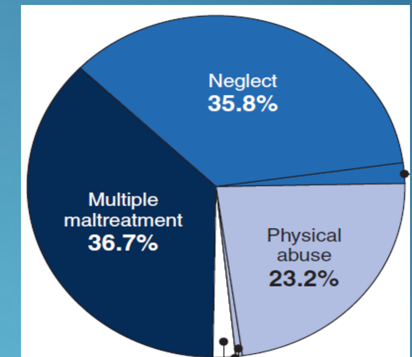
Background

- Homicide- what it means and what types of deaths does it include?
- Child maltreatment deaths
  - Often the most emotionally-charged deaths to review
  - Usually involve multiple systems
  - Maltreatment prevention opportunities may be difficult to frame
- Why review these deaths?
  - U.S. People 2020
  - Significant public health problem

What do we know about child maltreatment deaths?



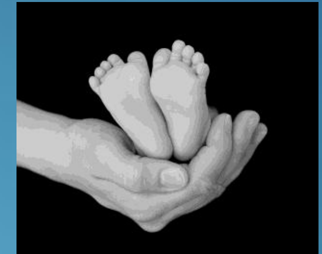
- 1770-2500/year- every 5 hours!
- Causes
  - Neglect
  - Abusive Head Trauma (shaken baby syndrome)
  - Abdominal trauma
- Reasons that infancy is the highest risk time
- Who abuses?
- Why- what are the triggers and risk factors?
- Do we know how many maltreatment deaths occur per year?

Data from HHS *Child Maltreatment 2009* report

Who reviews child maltreatment deaths?

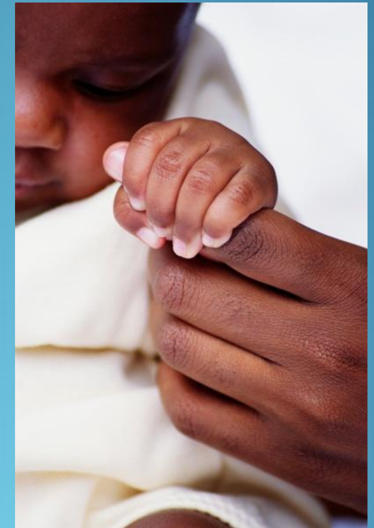
- Child Welfare
  - Wisconsin Department of Children and Families reviews all deaths and egregious incidents
  - Reporting on reviewed cases is through the Disclosure Act
- Law Enforcement
- Other
  - City/county reviews such as the Milwaukee Homicide Review Commission
  - Independent child death reviews
  - **County Child Death Review teams**

CDR basics- Reviews



- Regardless of the team size, make sure everyone in the room is introduced – name and role
- Try to maintain a consistent core team so that trust and communication grow over time
- Provide an overview including purpose and confidentiality at each meeting
- Facilitator- should make the meeting safe for all members to improve teamwork and communication

Six steps to an effective review



- Share information, seek solutions and avoid blame
- Discuss the investigation
- Discuss the delivery of services
- Identify risk factors
- Recommend systems improvements
- Identify and be a catalyst for action to implement prevention recommendations
- However, these are more difficult in an abuse case. . .

Crucial Conversations!

- Stakes are high, opinions vary and emotions run strong
- If they feel unsafe, child maltreatment death review team members are at risk of silence and violence:

Silence	Violence
Masking	Controlling
Avoiding	Labeling
Withdrawing	Attacking

- Make it safe- Keep prevention as the central focus, phrase questions tentatively, treat fellow team members with respect and kindness

Patterson, K., et al (2002). CrucialConversations

Questions to discuss:

- Review information and decide what additional information is needed?
- What aspects of the case might suggest prevention opportunities?
- Are there ways for the various disciplines who improve child/family safety to work better in the future?
- Is there a pattern of risk that might indicate a prevention opportunity?
- Were there confounders that allowed the case to occur "under the radar" of professionals?

Where are the land mines?

- Agency blaming- such as questions "Why did you. . .?"
- Critiques of an agency's policies or procedures
- Disparaging remarks about the family or professionals involved with the family
- HIPAA- medical confidentiality –AAP Policy http://aappolicy.aappublications.org/cgi/reprint/pediatrics;125/1/197.pdf

"Disclosure of a child's protected health information during child fatality reviews is a permissible HIPAA exception that relates to public health matters and surveillance. It is also permissible to disclose such information to multidisciplinary teams and organizations that review child abuse cases."

Lessons Learned

- See handout
- Keep meeting safe for all of the disciplines to share information/perspectives
- Get to know each other; consistent attendance by core team members will help (so does food!)
- Focus on prevention and creative ways to work together to improve the safety of children in your community
- Celebrate successes

Prevention

- Was there good coordination during the investigation?
- Were there effective protocols in place such as medical protocols for identifying abuse and mandated reporting? Are autopsy protocols in place? Were there scene investigations/re-enactments?
- Are there trends based upon our accumulated data?
- Are at risk families receiving home visits after birth?
- Are there respite and parenting resources in the community and do medical providers know about them?
- Other

Discussion- Lessons learned and other thoughts?

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