

NATIONAL RESOURCE CENTER FOR CHILD PROTECTIVE SERVICES

Technical Assistance Report



Prepared for Missouri Department of Social Services
Children's Division

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Analysis of the Missouri Children's Division Critical Incident/Child Fatality Review Process

Overview:

The Missouri Critical Incident/ Fatality Review Process was reviewed utilizing the following documents:

- The current Missouri Critical Incident Review Protocol;
- Missouri Child Welfare Manual Section 2, Chapter 4, Subsection 3: Subsection 8;
- Form CS- 23, Critical Event Report;
- Form CD-47, Fatality/Critical Event Summary;
- Child Welfare Manual sections with references to the roles and responsibilities of the local child fatality review panels and the Missouri Children's Division; and
- Actual case files along with the agency fatality reviews regarding those cases.

The current protocol and Child Welfare Manual sections included three key components commonly part of child fatality/critical incident review protocols or policy:

- Assurance of safety of siblings and child victims in current CPS cases.
- Public accountability and media response.
- Identification and response to systems issues.

A fourth component, which is commonly included in protocols concerning critical incidents/child fatalities, is stress debriefing for staff / local offices involved in the critical incident and/or child fatality. This component was not included in the protocol or the Child Welfare Manual that was provided. This component may be included in another section of the Child Welfare Manual.

For purposes of the NRCCPS review, the focus of the observations and comments will be on the identification and response to systems issues phase of the critical incident/child fatality review process.

Observations:

The current critical incident/fatality review process calls for an initial review by a Circuit Manager and a Regional staff person. The protocol does not indicate whether these are staff persons with particular expertise in safety assessment and in best practices for child protective services. The review is a paper review and does not include any interviews with staff, although the findings of the review are discussed with staff. It is unclear whether changes are made if there is staff input that affects any of the facts or findings in the paper review.

The agency case reviews detailed the actions taken by the agency in previous incidents of involvement with the agency, casework practice strengths and concerns, policy compliance and some discussion of needed casework improvement. Each review followed a different format for providing information. For example, in one review, risk and safety were addressed in a specific category with brief statements about the risk assessments and safety plans that were part of the case record. In the other reviews, risk and safety were minimally discussed in summary observations.

After the reviews are completed and the findings are discussed with staff, the protocol calls for training exercises, using actual scenarios, to be provided at local supervisory meetings. It is not

clear how the findings from the agency reviews are formulated for a training curriculum since the agency case reviews do not go into depth regarding casework practice issues.

Although the Child Welfare Manual included a link to policy related to Child Fatality Panels, it wasn't clear how the agency findings from child fatality reviews were provided to the Child Fatality Panels and how the findings of the Child Fatality Panels and the agency case reviews are combined.

Critical Incident/Fatality Review Enhancements to Consider:

1. In order to accurately identify casework errors in safety decision-making, agency case reviews are best conducted by staff with expertise in safety assessment and management. The focus of the review then remains on safety and prevention of critical events or child fatalities when there has been prior involvement by the Children's Division. In those critical event or child fatality cases where there has been recent or current case involvement with a family, a case review by a team of professionals with safety expertise would be optimal. The perspectives of a team would provide more in-depth analysis and team discussion would provide multiple viewpoints.
2. If staff involved in the case is not interviewed for the review, it would be helpful to provide staff an opportunity, during the discussion of findings, to make any corrections or additions to the findings. Commonly caseworkers have much more information than is available in the case record and it may be very helpful to determine the systemic issues by getting input from staff.
3. Although there is a specific form for documenting the Fatality/Critical Event Summary, each case review documented the information differently. It would be helpful to have common criteria in each review, so that the same information is evaluated in every review. In addition to the information called for in the current event summaries, categories such as safety decision-making, safety assessment, safety planning and ongoing safety management would focus the review and would be helpful in determining if there any barriers to effective safety decision-making.
4. Staff training resulting from findings in the reviews could also be enhanced from the use of common criteria in case reviews. Consistently highlighting issues regarding safety decision-making including safety assessment, safety planning and ongoing safety management in supervisory or staff training would help develop the supervisors' problem solving skills and help them identify potential casework errors.
5. It would be helpful to clarify in the Child Welfare Manual how the agency case review findings and the Child Fatality Panel review findings are utilized together to address systemic issues. If the agency case review findings are not provided to the Child Fatality Panels, it would be helpful to establish a protocol for reviewing both sets of findings to determine if there are differences or if there are recommendations that support the agency review findings.
6. If critical incident stress debriefing is offered to staff, it would be helpful to include a link to the policy or procedure in Critical Incident/Fatality Review Protocol and/or Child Welfare Manual. Critical incident stress debriefing is often a key aspect of addressing the systemic issues that arise in local offices impacted by a critical incident or fatality. Referencing the procedures of critical incident stress debriefing within the review procedures adds the component of staff support during the review process.
7. If a more in-depth systemic critical event/fatality review process is being considered, one approach utilized by some state child fatality review boards is "root cause analysis". In this approach, the review begins with the critical event or fatality and then looks from a systems perspective, rather than individual worker or supervisor failure, at each decision-making point in the series of events that led to the critical incident or fatality. For example, if a child death occurred while there was an active child protective services case then the root cause analysis would begin with the last contact or action made by the staff involved in the case. The analysis

would consider whether there was appropriate decision-making and if not, why? Was the casework error due to lack of policy, barriers to following policy, inexperience of staff or supervisors, insufficient information about present or impending danger, lack of time to make an informed decision, lack of supervisory oversight, or the organizational climate, etc.? The analysis would then continue to look back at each decision-making point in the case to uncover as many systemic issues as possible. Systemic issues can then be addressed from a comprehensive organizational environment standpoint rather than an individual case perspective. More information on root cause analysis can be provided if this is a review process option that Missouri wants to consider.