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ORIGINAL ARTICLE

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'Almost everything else goes to the wayside': Experiences of caseworkers, middle managers and leaders responding to child fatality and near fatality cases

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Abstract

While child welfare scholars and caseworkers have acquired a better understanding of risk factors associated with occurrences of child fatalities due to maltreatment over the past 20 years, little is known about the organisational and system-level characteristics that impact efforts to prevent or intervene in these cases. As part of a collaborative agreement between a university-affiliated centre and a state child welfare agency, we conducted interviews by phone with 19 case managers, middle managers and regional leaders who were assigned to manage or oversee a near fatality or fatality case. They illuminated five major themes: 1) their perceived stressors and sources of support; 2) client and perpetrator risk factors; 3) system-level risk and protective factors; 4) case descriptions; and 5) lessons learned. Relying upon their lived experiences, we offer practice and policy recommendations to *Child Abuse Review* to support their efforts to prevent and respond to child fatality cases. Efforts should be devoted to evaluating strategies to reduce risk for all families before the child welfare system is involved, supporting workers when they are assigned to fatality cases by reducing caseloads and preparing them for the fatality review process, and embracing a culture of collaboration across and within child-serving systems.

Key Practitioner Messages

- To respond effectively to child fatality and near fatality cases, child welfare caseworkers and leaders should be assigned fewer cases in the interim, and receive guidance, consultation, and time to prepare for the fatality review process.
- Embracing a culture of collaboration across and within child-serving systems may also prevent fatalities and facilitate an efficient investigative process if/when they do occur.

KEYWORDS
child abuse, child death, child maltreatment, child protection, fatal abuse

INTRODUCTION

According to the Children's Bureau's annual child maltreatment reports, the number of child fatality cases has risen slightly each year over the last five years of reporting. The total number of reported maltreatment fatalities in 2014 was 1546. By 2018, the number of fatalities rose to 1770 (UDHHS, 2016, 2017, 2018, 2019, 2020). While prior studies illuminate the case characteristics and victim profiles of youth who die from child maltreatment, we still do not have a clear understanding of organisational and system-level characteristics (inter-organisational collaboration and capacity to effectively respond to fatality cases and support workers assigned to them). To address this gap, a Mid-Atlantic state

child welfare system (CWS) teamed up with a university-affiliated research centre (referred to herein as 'The Centre'). The state's policy stipulates child welfare agencies must investigate all child deaths or near deaths when child abuse is suspected, and to prepare a report of key findings. As part of a joint agreement with the state, The Centre conducted semi-structured interviews with case managers, middle managers (supervisors and agency directors) and regional leaders who were assigned to a fatality or NF case. Findings are used to propose practice and policy recommendations to support their efforts to prevent and respond to child fatality and near fatality (NF) cases. What follows is a brief overview of the state of the science, outlining what we already know about the characteristics or profiles of child fatality cases, to give context to the responses provided by interview participants in this study.

CHILD CHARACTERISTICS

Several studies, dated from the early 2000s to now, conclude that younger children, male children and children of colour are more likely to die because of maltreatment (Douglas & Finkelhor, 2005). Indeed, Douglas and Mohn's (2014) review of the 1262 child fatalities from the 2010 National Data Archive on Child Abuse and Neglect file unveiled that children who died were more likely to be younger than those who did not die (albeit experienced maltreatment), more likely to be male and more likely to be African American or Black. In their earlier nationally representative analyses, Klevens and Leeb (2010) reviewed 600 deaths of children under five years old reported to the National Violent Death Reporting System. They found that half of the victims of child maltreatment resulting in death were under one year old, 59 per cent were male, 42 per cent were non-Hispanic Whites and 38 per cent were non-Hispanic Blacks. In a dated review of 32 substantiated cases of fatal child abuse in the United States Air Force, Lucas et al. (2002) also validated that males and African Americans were over-represented among the victims, and further concluded that younger victims were more likely to have been previously physically abused by the perpetrator. A review of 22 years of child fatality data spanning the years 1987–2008 in Oklahoma where the fatality was solely attributed to neglect found that males represented 58.1 per cent of the fatalities and that African American and Native American children were overrepresented in the sample when compared to the state population (Welch & Bonner, 2013). While these studies are notable, some samples did not include a difference in risk of experiencing a fatality based on demographics. A 2002 exploratory retrospective study compared 38 child fatality cases to a matched control group of non-fatality cases in a large Southwestern US city and found that neither the demographic characteristics of parents nor the gender of the victim was significantly different between the two groups (Chance & Scannapieco, 2002).

PERPETRATOR CHARACTERISTICS

Most perpetrators of child maltreatment are the biological parents. National statistics from 2018 indicate that 80.3 per cent of child fatalities involved parents acting alone, together or with other individuals. Of these, a mother acting alone accounted for 26.8 per cent of the annual fatalities, a father alone was responsible for 16.4 per cent of the fatalities and mother and father together accounted for 22.1 per cent of fatalities. The perpetrator was unknown in 5.1 per cent of fatality cases (UDHHS, 2020).

RISK FACTORS FOR CHILD FATALITIES

Several studies pinpoint risk factors that may place a child at more increased risk for fatal maltreatment. As noted above, as confirmed by decades of research, a child's age is one of the most significant predictors of fatal abuse or neglect (Klevens & Leeb, 2010; Welch & Bonner, 2013). Children under one year of age are at the highest risk of dying from maltreatment (Douglas & Mohn, 2014). Household risks include: 1) high stress levels in the home (Brewster et al., 1998; Yampolskaya et al., 2009); 2) substance abuse history, parental mental health concerns, domestic violence and criminal justice involvement (Douglas, 2013a; Douglas & Mohn, 2014; UDHHS, 2020); and 3) bed-sharing between children and parents, particularly for infants (Byard, 2012). Prior history of abuse is another indicator of risk, with Jonson-Reid et al. (2007) concluding that children who survived an incident of reported maltreatment were twice as likely to die before age 18 than a comparison group of children without reports of maltreatment. Finally, system involvement, as defined by foster care history, having court-appointed representatives and utilisation of case management services increases risk for fatal incidents (Douglas & Mohn, 2014).

While the current study will inquire about the occurrences of these risk factors during the interviews, we will contribute to existing child welfare scholarship by illuminating how caseworkers and leaders describe fatality and NF cases, the challenges they encounter, and elicit their thoughts on what practices, procedures or policies might support them in their efforts to manage, reduce or prevent cases involving a child fatality.

LOCAL CONTEXT

The Mid-Atlantic state holds one of the largest CWS in the country, with over 16,000 children in out-of-home care each year since 2015 (Kids Count Data, 2020), and it is not immune to grappling with child fatality cases. The most recent Child Maltreatment Report from 2018 provides an historical account of the number of child fatality cases over time. There were 34 fatalities in 2014, 31 fatalities in 2015, 47 fatalities in 2016, 42 fatalities in 2017 and 45 fatalities in 2018 (UDHHS, 2020). The report also looks at the type of maltreatment that resulted in death. Neglect was a factor in 72.8 per cent of cases nationally, with specifically medical neglect being present in 8.1 per cent of cases. Physical abuse contributed to the causing of 46.1 per cent of fatalities, psychological abuse was present in 1.1 per cent of national cases and sexual abuse was seen in 0.6 per cent of fatalities. Other types of maltreatment were noted in 7.8 per cent of fatality cases.

RESEARCH AIMS AND OBJECTIVES

Acknowledging the upward trend in fatality cases, researchers from The Centre relied upon interviews to: 1) inform how to improve outcomes in these highest risk cases; 2) understand the caseworker and supervisory perspectives on factors that may lead to child fatalities and NF; and 3) understand the supports they need to manage, and hopefully prevent, occurrences. The objective herein is to rely on these data to illuminate risk and protective factors related to fatality and NF cases, and utilise the findings to propose specific recommendations to inform policy and practice to prevent child fatalities.

METHODS

Procedures

The Centre recruited participants across the state via email, inviting them to participate in a 45–60-minute semi-structured interview to address study aims. Inclusion criteria included: 1) employed for at least three months in a child welfare agency; and 2) managed, supervised and/or reviewed fatality and NF cases. Results reflect the experiences of participants from four counties across the state of Pennsylvania. The University Institutional Review Board approved all recruitment, data collection procedures and analyses.

Sample

While 29 participants initially expressed interest, 19 (seven case managers, eight supervisors or agency directors – herein referred to as 'middle managers' – and four regional leaders) completed interviews by phone. On average, participants were 42 years old (range 27–59). Most of the participants (n = 17) identified as female and Caucasian (n = 14), while others identified as male (n = 2), African American (n = 4) and mixed race (n = 1). The participants acquired higher education (one had some college, nine had bachelor's degrees, eight had master's degrees, and one had a PhD). Nearly half (n = 9) reported they are trained social workers, while other participants received training in related child/family disciplines (criminal justice, applied behavioural science, elementary education).

Procedures

The lead researcher and The Centre staff developed semi-structured interview guides for each respective role (See Appendix – 'Interview Guides'). After expressing interest, the lead researcher emailed the potential participant a copy of the Consent Form for review. After obtaining verbal consent, the lead researcher recorded the 1:1 semi-structured interview by using 'Recordator'. A professional transcriptionist then transcribed the recordings.

Analyses

Grounded theory methods (Strauss & Corbin, 1990) were used to generate themes using Excel spreadsheets. The lead researcher and Centre staff engaged in a quick read of the text, line by line, and identified and labelled emerging phenomena (open coding). The next step involved convening as a team to agree upon the most significant and/or

frequent codes (axial codes). Afterwards, connections between focused codes were established, thereby generating overarching themes. Finally, The Centre selected quotes that best reflected each of the open codes.

To increase rigour, we engaged in analyst triangulation, which involved each author analysing the data and approving themes and categories reported herein. Each author kept memos, tracking personal insights and biases, and discussed how those thoughts did not interfere with their coding process. The Centre also held several team meetings to discuss when saturation occurred and to reach consensus on the selection of final categories and quotes to support them. Lastly, we engaged in member checking, which involved asking participants to review the findings reported herein for accuracy.

RESULTS

Major themes, codes and relevant quotes to support them are highlighted in Table 1. While we documented all codes in the table, we primarily elaborated on codes reported by at least three participants. The major themes include: 1) experiences of workers and leaders; 2) client and perpetrator risk factors; 3) system-level risk and protective factors; 4) case descriptions; and 5) lessons learned.

Theme 1: experiences of workers and leaders

Initially, participants reflected upon their daily job responsibilities – namely, perceived stressors and sources of support about their job responsibilities – as well as how their overarching attitudes shape how they think about and respond to fatality and NF cases.

Perceived stressors

Nearly all case managers, seven middle managers and one of the regional leaders underscored that the workload related to the daily responsibilities of managing cases and promoting safety, permanency and wellbeing is taxing. Meeting deadlines for submitting required paperwork and responding to cases and/or home visits in a timely manner were also reported as stressors among 10 of the participants. Four case managers and three middle managers added that the number of cases interferes with their ability to effectively engage with clients. Other stressors included: no management or administrative support (n = 5), lack of worker input (defined as feeling like one's solutions, suggestions or input are/is ignored; n = 3), child removals (n = 3), grappling with inconsistent accounts of responses to child maltreatment allegations (n = 3) and distressing reactions to empathetic understanding of clients' lived experiences (n = 4).

Perceived support

Although stressors were highlighted, participants also reported circumstances that alleviate them. These contexts include support from co-workers (n = 7), support from supervisors (n = 15), job flexibility (defined as the ability to schedule one's own hours and prioritise the work as needed, n = 3), interacting and engaging with youth and families (n = 9), and an inherent feeling that the work is rewarding and that they are helping families (n = 8).

Caseworker attitudes

During interviews, participants called attention to their inherent duty to recognise the right and dignity of individuals and families (n = 1), while two participants conveyed that it is the client's responsibility to locate services to mitigate risk factors.

Theme 2: client and perpetrator risk factors

During interviews, participants illuminated risk factors they observed while managing cases and/or reviewing fatality and NF case files. Namely, risk factors were coded in the following categories: child and family, perpetrator, community, and system factors. For most participants, risk factors between fatalities and near fatalities are indistinguishable.

TABLE 1 Interview themes and categories

Theme 1: Experiences of Workers and Leaders			
Perceived Stressors among Workers and Leaders	workload	**6 CMs, 7 MMs, 1 R**	"There was a period of time where I would get up over 30 cases, which is obviously a lot because then you're talking easily 50, 60, 70 kiddos. That can be stressful because then not only are you just talking about the kids, but you're talking parents. Some cases have multiple parents, and you're talking grandparents usually get involved. If children are moved, you're talking about foster parents, foster care agencies. So you can be upwards of interacting with hundreds of people just on your caseload, which that can be a struggle to maintain who's who, what's what, how to prioritize. And then just continuing obviously to make sure that the safety of everybody is maintained and that the risk is constantly being assessed." (CM) "You never know what the day will bring but you can be fairly certain you're gonna be challenged to get anything done. It feels, to be honest, like you're organizing chaos." (MM)
	paperwork deadlines - timeframes difficult to meet	**4 CMs, 3 MMs, 3 Rs**	"And there's a lot of paperwork. Everything that you do has to be in writing or it doesn't count so there's a lot of that as well." (CM)
	decision-making	**1CM**	"I think a lot of the stressors are the decision-making itself. You don't know what the right or wrong answer is. Or if the services are accurate for—Like they're the right services for the family. " (CM)
	number of cases - engaging clients	**4CMs, 3 MMs**	"And then we are right now having a lot of turnover in our county, so caseload sizes are high. I'm sitting here potentially with 15 vacancies at the caseworker level, so that's 15 caseloads that are distributed amongst the rest of my staff right now." (MM); "There was a period of time where I would get up over 30 cases, which is obviously a lot because then you're talking easily 50, 60, 70 kiddos. That can be stressful because then not only are you just talking about the kids, but you're talking parents. Some cases have multiple parents, and you're talking grandparents usually get involved. If children are moved, you're talking about foster parents, foster care agencies. So you can be upwards of interacting with hundreds of people just on your caseload, which that can be a struggle to maintain who's who, what's what, how to prioritize. And then just continuing obviously to make sure that the safety of everybody is maintained and that the risk is constantly being assessed." (CM)
	No management/ administrative support	**1 CM, 3 MMs, 1 R**	"I have folks below me that are like 'why can't I do it this way and what do you mean I need this to be done today'; but then I have upper management pushing down saying 'your numbers aren't looking so good this week and I need this done right now and HR needs this documentation, etc.' I feel that squishing effect very much so on certain days." (MM)
	child mental health	**1 CM**	"The main stresses and conflicts in the family comes from the child's mental health. And the parents are doing what they can to meet that child's mental health; they're getting them to appointments, getting them to therapy, getting them to counseling, doing all the things that we would have them do, but there's still a lot of conflict, which is resulting in us continually receiving phone calls. But there's no real role for Child Protective Services in that fashion because of this mental health issue, and not a neglect or abuse concern." (CM)
	worker input	**2 CMs, 1 R**	"When we come up with solutions … please take that seriously, because it is affecting the jobs that we may do and potentially putting children's lives at risk." (CM)

(Continues)

TABLE 1 (Continued)

Theme 1: Experiences of Workers and Leaders			
	fear	**1 CM**	"We're not sure what we're walking into when we go out to a family's home. Are they gonna be violent? Am I in danger, are the kids in danger, that kind of thing. And then if the kids are injured, it's kind of stressful if we have to remove from their families. It's stressful for us, it's stressful for the kids." (CM)
	child removals	**3 CM**	"And then if the kids are injured, it's kind of stressful if we have to remove from their families." (CM)
	inconsistent accounts of what happened	**1 CM, 1 MM, 1 R**	I think one of the biggest things is getting an accurate timeline, making sure that we have as much information as possible. (MM)
	trying to get it right	**1 R**	"So I guess the stress of that is always wanting to get it right and something that's constant like that is a bit of stress, I suppose" (R)
	stress related to empathy	**1 CM, 2 MM, 1 R**	"The cases themselves are extremely challenging. It's not direct trauma anymore, it's definitely the vicarious trauma as you read through the stuff." (MM)
	court	**1 CM**	"I would say the court is challenging and just seeing—I mean I really struggle with clients with drug and alcohol, seeing them do really well and then relapse. That's tough to see." (CM)
Perceived Sources of Support among Workers and Leaders	co-worker support	**5 CMs, 1 MM, 1 R**	"I like my coworkers. We're kind of all in it together so we support each other a lot." (CM)
	job flexibility	**2 CMs, 1MM**	"I like the flexibility. It's not a 9 to 5 job, so to speak, so I do like that." (CM)
	interaction with families/engaging clients	**3 CMs, 5 MMs, 1 R**	"And then since I've been here for quite some time now, you're seeing children grow up and come in now as parents but they also, whether it's positive or negative, or just retaliation, the children now parents, they are grateful for the help that you gave them in the past." (CM)
	supervisor support	**7 CMs, 5 MMs, 3 Rs**	I think my management, the accessibility to talk to them. And just to speak openly, to bounce things off them as needed, whether it be during the regular supervision, or hey, I got something going on, like this is my decision or this is what I'm feeling, and I just want to make sure that I'm not missing anything. I think that support goes a long, long way. (MM)
	work is rewarding/ helping families	**5 CMs,3 MM**	"I like when we can help families. I like when we can think outside the box to provide better services." (MM)
	coaching others	**2 MMs**	"What I find fulfilling about the job is the idea that you can coach other folks, younger folks, people who aren't in a position of coming up through the agency to practice in such a way that you can appreciate, in such a way that you feel that even though you're not doing direct practice anymore, you have an influence on those who are doing direct practice. I enjoyed doing direct practice a great deal. I was really fulfilled by it and I thought I helped a lot of folks as much as I could've, and it's really interesting to watch fresh faces come in and they're learning how to do the same thing that you learned how to do. So it's kind of a passing of the torch and basically having some sort of influence on not just what you did at work, what also five other workers will also do. So it's still being able to have an influence and an impact on people's lives in a positive frame." (MM)

(Continues)

TABLE 1 (Continued)

Theme 1: Experiences of Workers and Leaders			
Caseworker Attitudes	individual responsibility of families to locate services	**1 CM, 1 R**	"I think that the way that families look at Child Welfare, they're happy to have a worker. I don't know, is it laziness or what. I don't know what it is. Like go find the resources yourself." (CM).
	value/worth of social workers	**1 CM**	"Workers are so underpaid, we're under-valued." (CM)
	recognition of individual and family Rights	**1 CM**	"Mom's rights were terminated to her three other children for drug use and then inability to care for them."…"We also have to respect her rights. Like she has the right to not receive mental health."…"just because mom's rights were terminated to her three other children doesn't mean she can't successfully parent. Because when I've talked to a few people about this, they're like, `Oh, those three kids were taken, we should've just taken this baby at birth.' No, that's not how this goes. We assess the situation. People change, people change day-to-day, they certainly year-to- -year. People make improvements." (CM)
Theme 2: Client and Perpetrator Risk Factors			
Act 33 Client Risk Factors	level of education	**2 CMs**	"And I don't think that's something people would—That wouldn't be an assumption that would be made, but I would say more of my cases than not they were educated people." (CM) "Yeah. I mean not completing high school." (CM)
	parental age - young	**4 CMs, 3 MMs**	"I would be concerned if I had a parent that was ID (Intellectual Disability). Are they even able to intellectualize what it means to be a parent and what needs to be done."…"Age. Sometimes if we have a kid who's a parent, that puts the child at high risk because if you're 12 and having a baby, you're not mature enough to raise yourself let alone an infant." (CM)
	child under one years of age	**3 CMs, 2 MMs, 1 R**	"Under six months for a child and for a parent, the majority of the parents I've worked with, they've been under 21." (CM)
	child under five years of age	**2 CMs, 5 MMs, 2 Rs**	"The ones that I have had, and this is just my own personal experience, have been under 5 and mostly African-American." (CM)
	adolescence	**1 CM, 1 R**	"We've seen some really unfortunate deaths with older adolescents because they can also put themselves in really risky situations". (R)
	disability	**1 MM**	Well I think sort of age and ability goes hand-in-hand, but then I think maybe you do need to take into the consideration the abilities of an individual with maybe intellectual or physical disabilities right? (MM)
	past history of DHS involvement	**5 CMs, 4 MMs, 2 Rs**	"If we had any previous involvement with the families, we always do a hindsight, what could we have done different file review"…" I would say probably half the cases were known to the agency or another local CYF agency, so had prior CYF involvement. I would say a small handful, we had about three cases where the case was actually opened to us. We had a few cases where the parents came here to get away from—Because we're pretty close to New Jersey, and pretty close to New York City, so we've had a couple where the parents had recently moved here from another state or another county that had prior involvement in other places as well." (MM)

(Continues)

TABLE 1 (Continued)

Theme 2: Client and Perpetrator Risk Factors		
no past history of DHS involvement - BUT not necessarily protective	**2 CMs, 3 MMs**	"Yeah, the ones I have had, there's been absolutely no prior history." (MM)
physical environment - lack of safety measures in home	**2 MMs**	"We had a couple meetings in a row where somebody either fell out of a window and fractured a skull or was leaning against a screen and the screen gave out. We had two or three kids out of a window in a short period of time. They actually wrote a notice to all of the pediatricians in their hospital network … Please, when you have families with young toddlers remind them that screens don't keep kids in." (MM)
Homelessness	**1 CM, 1 MM**	"When I initially got the phone call on this case, it was a mother who had four children who was essentially homeless from what I can remember." (CM)
change in income	**2 CMs, 1 MM**	" Changes in the home, loss of employment, additional or separation of family members in the home. Changes of income, or a lot of families, unfortunately, move frequently to new residence, so we would look at all of those things." (CM)
loss of job/unemployment	**1 CM**	"I think we would look into all of their past history, any services that were put in place and whether or not they were completed successfully. Changes in the home loss of employment, additional or separation of family members in the home, changes of income, or moving frequently to new residence, we would look at all of those things." (CM).
family separation	**1 CM**	"I think we would look into all of their past history, any services that were put in place and whether or not they were completed successfully. Changes in the home loss of employment, additional or separation of family members in the home, changes of income, or moving frequently to new residence, we would look at all of those things." (CM).
mobility	**1 CM, 1 MM**	"I think we would look into all of their past history, any services that were put in place and whether or not they were completed successfully. Changes in the home loss of employment, additional or separation of family members in the home, changes of income, or moving frequently to new residence, we would look at all of those things." (CM).
co-sleeping/unsafe sleeping	**2 MMs, 2 Rs**	"I'll say trends in the data, there was a time when we were calling them roll-over deaths and that turned into safe sleep aspects. We really did take an active policy approach to what does that look like. It can take the form of you shouldn't sleep with your children if you're under the influence … and making sure the back to sleep, kids are in cribs, just the whole safe sleep aspect."(R)
race- all racial backgrounds impacted	**3 CMs, 5 MMs, 1 R**	"I don't think race sticks out one way or the other, so I can't say they were predominately Hispanic, predominately of color, predominately white." (MM); "And this is just from my office, the demographics for this has been both male and female as well as in terms of their race. It has been both African-American and Caucasian, so it's been down the middle. I'm just really thinking of the most recent ones. And the age can vary." (R)
racial variability	**3 CMs, 2 MMs, 3Rs**	"The majority of my cases have been African-American." (CM); child victims mostly AA (R), African Americans are overrepresented in general (RR); mostly White (MM); more likely to be Black because there are more Black kids in the system (R), case assigned to me was white (CM)

(Continues)

TABLE 1 (Continued)

Theme 2: Client and Perpetrator Risk Factors			
	parenting skills	**2 CMs, 1MM**	"I've run into more than a handful of people who, you know, `well my parents beat me when I was a kid and I turned out okay.' I think there's a lot of that attitude that contributes to it too." (CM)
	unwanted pregnancy	**1 CM**	I mean I really think that it's a lot of the factors that we already look at … Wanted versus unwanted pregnancies. (CM)
	poverty	**1 CM, 3 MMs, 2 Rs**	"One of the things that I learned out of this more than anything else is how much poverty and income has to do with child endangerment. Poverty. And we cannot as caseworkers and child protection improve people's income level, but at the very least, the correlation is something that I think maybe we can use a little bit more education on" (M)
	multiple children	**1 CM**	They had three kiddos under the age of five.…"Dad had other children in another county that he had lost his parental rights to." (CM)
	multiple families/people in home	**1 CM, 1 MM**	"Multiple families living in the same household. I've had a few where kids got into something that one parent didn't realize that another adult in the household had." (CM)
	Significant Other/Paramour in home/caregiver	**2 CM, 6 MMs, 2 Rs**	"While sometimes it is the mother, we see a lot of times it's another caregiver." (R)
	Running away	**1 CM**	"She was released from congregate care and she was back with her mother, who was her adoptive mother, so everything was all good. Closed her case out. Apparently she ran away. She was on insulin…so she ran away and she ran away with her biological family. she was gone for months and months and months and months. mind you the case wasn't open." (CM)
	Medical concerns	**1 R**	"Medical concerns are a red flag." (R)
Act 33 Perpetrator Risk Factors	drugs/Alcohol	**6 CMs, 6 MMs, 3 Rs**	"Drugs and alcohol did play—I mean I'm not saying that they were actively using at the times because we'll never be able to prove that." (CM); "We had two or three where the drug and alcohol provider was aware that the parents relapsed, but one of the things we did here, we actually went out and did some trainings with our local drug and alcohol providers because relapse is part of addiction, and they don't want to call everything in, so the parents keep going to their drug and alcohol addiction counseling but they don't understand or weren't understanding that relapse with an under 12-month-old could this dangerous, so we did some outreach so they would better call us in earlier, for lack of a better term"…". I can't say for mental health that they're using, but either mental health treatment is needed or there are drug and alcohol involved. Those tend to come up on almost every case." (MM)
	untreated mental health	**4 CMs, 7 MMs, 2 Rs**	"A lot of the cases have had either single parent new paramour, some type of relapse either because of the new paramour I wasn't going to my mental health services as regularly, or because of the new paramour I got sucked back into using. "…"It's either lack of being ready to attend them or whatever the other— We don't meet that criteria where we can order them into services yet, it's still voluntary. So if they don't want to go, we can't force that either. "We have been asking the state and I think just recently got unified release information so that whatever release I put in front of them is now good enough for drug and alcohol and mental health, because everybody had different laws and different levels of what the confidentiality is, so that was a barrier". (MM)

(Continues)

TABLE 1 (Continued)

Theme 2: Client and Perpetrator Risk Factors			
	physical or sexual abuse as a child- trauma/prior hx	**3 CMs, 2 MMs**	"Again, going back to an earlier question, I think drug use, mental health, their own childhood history. Depending on their age, we sometimes have access to that history of them as a child. And luckily, in my county we have a lot of workers that have been there for longer than I've been alive and even if the record isn't there, they sometimes remember and can tell us a little bit about their background and what traumas they have experienced." (CM) "Statistically most perpetrators have history of some involvement as children. Statistically most are involved with the criminal justice system. They have history of drug and alcohol. And mental health challenges as well." (MM); "…they sometimes remember and can tell us a little bit about their background and what traumas they have experienced." (CM)
	domestic violence	**4 CMs, 1 MM, 4 Rs**	"IPV services - if we are not aware at the beginning or at the onset, thinking like wow, that could've been a service that we could have put in place. But we have switched our practice in this office in really being intentional in our investigative phase like right at the point where we're reviewing the cases before we assign them and we look for a past history of IPV or a current diagnosis of IPV so we can alert our caseworkers and our supervisor staff." (R); "Mental health, drugs and alcohol, domestic violence. I think those are the three big ones. " (CM) "If they're active with us, it's because they might be homeless, substance abuse, intimate partner violence, just a variety of other challenges" (R) "I think with my case in particular there was a lot of domestic violence behind doors that we weren't aware of. It wasn't just the parents, it was a lot of family members." (CM)
	family support varies	**3 CMs, 4 MMs, 1 R** (1 noted support is present, 2 noted it is absent, and 6 reported it is needed)	"Before the child goes back into the home, we do a family-group decision making. I don't know if you heard that part or if that's right around where we were getting cut off. We have our own family-group decision making rapid response. We try to find the extended family. We've been trying to do more and more family plans versus agency plans and trying to rebuild some of those broken walls if that allows the support to be in place to make sure the children are safe."…"In a lot of the cases, the parent or perpetrator, because of some of their high-risk behaviors, didn't have a lot of the extended family willing to help them, kind of burnt those bridges. "Sometimes its extended family knew about this and didn't want to report, because last time Children and Youth was involved, they almost lost their kids. Sometimes it's a matter of the family didn't know because they already had some estranged relationships". (MM); "Yes, that's right. Lack of family support, too. Sometimes there's no grandparents or aunts and uncles, cousins around that family." (CM)
	probation/criminal history	**4 CMs, 1 MM, 1 R**	"I would say criminal history, extensive criminal history [are among the most pervasive risk factors]" (R)
	parenting skills	**1 CM, 1 MM**	"I've run into more than a handful of people who, you know, `well my parents beat me when I was a kid and I turned out okay.' I think there's a lot of that attitude that contributes to it too." (CM)
	intellectual disability	**1 CM**	"I would be concerned if I had a parent that was ID (Intellectual Disability). Are they even able to intellectualize what it means to be a parent and what needs to be done." (CM)
	gender	**3 MM, 1 R**	"The perpetrator has been the paramour of the parent and there have been female perpetrators and male perpetrators, but predominantly it's the male perpetrator." (R)
	family member	**1 CM, 1 R**	"The perpetrator has been the paramour of the parent … Or the father of the child." (R)

(Continues)

TABLE 1 (Continued)

Theme 2: Client and Perpetrator Risk Factors			
	young parents	**1 CM**	"They were in their mid to late 20s."…"They were a young couple." (CM)
	family Stress (unspecified)	**1 R**	"I'm just thinking on my own, I don't know if the data shows this, but I'm going to talk really generally, and I would say access, stressors. …You could throw that under stressors, so maybe it's not just the relationship with the child, but the relationship with others." (R); "If somebody's a caregiver and they seem to be under an inordinate amount of stress" (R)
Community Risk Factors	resources available	**3CMs, 7 MMs, 2 Rs**	Well the lack thereof depends on what community you're in. There are some communities that are absolutely resource rich (CM)
	resources available, but no awareness	**3 CMs, 6 MMs, 1 R**	"Most of the families that we work with find services through other families that are using those services. Like a [Wesley Spectrum] is not advertising on TV." (MM)
	resources available, but no engagement	**2 CMs, 4 MMs, 3 Rs**	"We have a pretty service-rich area. It's not services are not there. It's either lack of being ready to attend them or whatever. We don't meet that criteria where we can order them into services yet, it's still voluntary. So if they don't want to go, we can't force that either." (MM)
	lack of informal supports	**1 CM, 2 MMs, 1 R**	"And trying to make sure that we are reaching out to those informal supports for the family." (R)
	lack of formal supports (daycare)	**1 MM**	"I find it's an issue all the way across the board with most of the cases where you have any sort of danger, there's a lack of community support. Daycare seems to be a huge issue. People leaving their kids with random folks because you're basically stuck for daycare. you don't have enough money to pay for formal daycare providers and now you're giving the kid to a neighbor that you just met or a friend's friend or the boyfriend's friend. And all sorts of incidents seem to crop up around lack of resources in the community, specifically daycare." (MM)
	community crime (violence/ drugs)	**1 CM**	"Yeah. I find that it's an issue all the way across the board with most of the cases where you have any sort of danger, there's a lack of community support." (MM)
	stigma	**1 CM**	"I think there's a certain stigma with being involved in social services." (CM);
	systemic racism	**1 R**	"I'm interested in how systemic issues affect society too. The way policies, procedures, mandates, legislation to those kinds of factors in my work. So that's a big stressor, knowing that some of the things we do contribute to that same type of systemic racism." (R)
Theme III: System Level Risk and Protective Factors			
(1) Organizational Climate & Capacity	no clear solutions	**1 CM, 1 R**	"I think that both of the incidents that I described were just unfortunate and could not have been prevented. We have more policies than anything." (CM)
	disconnect between supervisors/caseworkers vs. management	**2 CMs, 2 MMs**	"In the 15 years I've been here, I had supportive management maybe for a brief period of that time. I think for the most part management is so concerned about compliance and policies and procedures that the humanistic factor of it sometimes slides to the wayside." (MM)
	caseload not manageable when assigned Act 33 case	**2 CMs, 4 MMs, 1 R**	"Our casework load sizes are high. Not right now due to COVID, and it being summertime, but typically caseloads are very high. Supervisors tend to have 4-6 workers and everybody's carrying a caseload of anywhere from 12-20. It's a lot to keep up on. And then you get assigned a fatality or a near fatality and the amount of paperwork and time that you put in as a caseworker to investigating a near fatality or fatality is pretty in-depth." (MM)

(Continues)

TABLE 1 (Continued)

Theme III: System Level Risk and Protective Factors			
	not a factor or consideration	**1 MM**	"I don't think the [normal run-of-the-mill cases and Act 33 cases] differ in any way." (MM)
	risk present but CPS not appropriate	**1 CM**	There's no additional services that we can provide. I'm thinking of one family, two families that I actually have in particular where the main stresses and conflicts in the family comes from the child's mental health. And the parents are doing what they can to meet that child's mental health; they're getting them to appointments, getting them to therapy, getting them to counseling, doing all the things that we would have them do, but there's still a lot of conflict, which is resulting in us continually receiving phone calls. But there's no real role for Child Protective Services in that fashion because of this mental health issue, and not a neglect or abuse concern (CM)
	reports not made in good faith	**1 CM**	"I had one family that everybody in the family needed glasses terribly and mom was very stressed with money, but they didn't need us. It was a report that was not made in good faith, but because I was able to interact with the family at the time I did, I was able to connect them with an eyeglass clinic that was coming up, so they were all able to get their glasses." (CM)
	immigration/ICE	**1 CM**	"I've had some families in general that were hesitant to engage in those services because they were undocumented or have overstayed, and their concern was that if they engaged in community services, that would put their name on a list somewhere that somebody would have access to"…."But I mean that's even a barrier for us, right, because we knock on the door and they're panicky. We're not ICE, I don't care about your status, I care about child safety." (CM)
	English speaking	**1 CM**	"And if they are in an immigrant family, there's some barriers there as well. Or a non-English-speaking family, there's additional barriers." (CM)
	blaming, accusing, "finger pointing and belittling"	3 CMs, 3 MMs, 3 Rs	"In years past, sometimes people always want to look for who can we blame, and we've had to learn that that's just not helpful for anyone." (R)
	isolation	1 CM, 1 MM	"So then you're feeling like am I the only one feeling this way, am I the only one feeling overwhelmed? And it's just like are you struggling too or am I the only one? So I feel like creating that sense of like okay, you're not alone, like talking it out together would be nice to have that sense of you're not the only one that kind of feels crazy sometimes." (CM)
	suppress feelings	1 CM, 2 MM	"I'm sure caseworkers are trying to give their opinions on solutions, but if no one's doing anything, what you know, yeah, tomorrow's going to be low, you're going to feel helpless, you're going to feel backed in a corner and you're the one who's being blamed and over top of that, something has happened to a child." (CM)
Transformational Leadership	supportive environment	**2 CMs, 4 MMs, 4 Rs**	"I think the folks that manager me trust me and know that I do a pretty consistently good job and so they give me a lot of flexibility and leeway to handle things the way I see fit. So that's super helpful to me." (MM)
	caseworkers do most of the work	**1 R**	"We want them to be involved in policy debate. We want the caseworkers to also be involved because they're the people that actually do the actual work so people get some practical response. Unfortunately, generally they're the people that are the busiest and seem to have the most on their plate and have less time to contribute" (R)

(Continues)

TABLE 1 (Continued)

Theme III: System Level Risk and Protective Factors			
	worker Turnover/Burnout	**2 MM**	"We do get some minor relief from some of the grants, but to actually have somebody on call even if it were for the five local counties and it was like one service that we could bring in that would be helpful to support our own staff so it's not a burnout. I sometimes think that's part of our turnover." AND "When you say caseload sizes and experience, I mean, if I don't have supervisors that have the experience that they used to have, they also are not teaching that experience to my new caseworkers. And then we are right now having a lot of turnover in our county, so caseload sizes are high." (MM)
	laws and regulations change frequently	**1 MM, 1 R**	We have been asking the state and I think just recently got unified releases of information so that whatever release I put in front of them is now good enough for drug and alcohol and mental health, because everybody had different laws and different levels of what the confidentiality is, so that was a barrier. "For every new regulation comes ten more pages of paperwork … the amount of paperwork that goes with the regulations allows less time to actually work with the families" (MM)
Supervision	Cautious of closing cases	**1 CM, 1 MM**	"That's where we brought in anything with medical records we now have the nurses review before we can close a case if there's medical issues, any type of prescriptions involved with anybody in the house, not just the children. If the parents are supposed to be taking things, we're making sure all that compliance piece is there now." (MM)
	collaborative	**1 CM, 1 MM**	"So I called my supervisor and let him know and I said, 'I have to call and get information in the morning.' He immediately lended that hand, lended that branch, like 'Let's do it together. I'm gonna clear my schedule. Let me bring you a coffee. Let's sit down, we'll talk about this as a whole.'" (CM)
	support to process grief provided by supervisors	**5CMs, 4MMs, 3 Rs**	"I think there should be someone else that they should be able to contact and not have to worry about if there was going to be some type of ramification and stuff" (MM)
	support to process grief not provided by administration	**3 CMs, 1 M**	"Why can't caseworkers be seen by a therapist with it really affecting their job?" (CM); "They mad me fill out a form to ask if I wanted any assistance or therapy [because I had a child who attempted to commit suicide in front of me], and then I filled out a form asking that, and then no one has ever followed up. (CM)
	support to process grief/ secondary trauma if offered but not needed	**3 CMs**	"No, and I'm gonna be honest, that kind of makes me nervous sometimes, because I feel like I should need those things but I don't. If that makes sense."…Well I don't feel that I need those things, but I'm a little concerned that I don't feel that I need those things. (chuckles) If that makes sense. Like the typical response to the things that I've seen and the things that I've been through—" (CM)
	calm	**1 CM**	"Maybe just to be calm. You know, when they get all worked up, then that gets caseworkers all worked up, and when everybody's all worked up, nobody hears what's going on, what needs to be done. So I think the best advice would be to just try to be calm, and if you don't know something, just say you don't know and find me the answer while I'm out on the field on the phone with you." (CM)

(Continues)

TABLE 1 (Continued)

Theme III: System Level Risk and Protective Factors			
COVID-19	service disruption	**1 CM**	"I don't think it's a crutch for some people that they're saying, 'I couldn't do it because of Covid.' I that they would've did the services, they just wouldn't have taken out of it what they should of because they both are showing that with the services that they were engaged with." (CM)
	decreased caseload	**1 CM, 1 R**	"Like right now our caseload size is very low. With COVID causing schools closed or people because of remote learning, essentially everything is shutting down for a while, our caseload has plummeted. I'm able to provide a lot more individual attention to my families. Even the families that I know that we're gonna close out, I'm able to provide more individual and more personalized—I shouldn't say more personalized but there's more time in general so I have more time to devote specifically to that family. I try hard to do that when we have higher caseloads, but when your caseloads are 15, 18, and you know there's 4 more coming in, it's hard to be kind of as thorough." (CM)
	decreased personal connection	**1 CM, 2 Rs**	"A lot of people in the office, especially now with COVID, feel very disconnected from each other because we're not seeing each other." (CM). "We were still seeing kids in person and that was with a practice guideline, screening folks ahead of time with questions, have you been in contact with anyone, is anybody in the house sick. We would, if parents said you can't come in, or, yes, somebody's sick, we kind of stay on the front porch. If we went in, we went in with our masks and gloves and our hand sanitizer, because, truthfully, that's pretty much all we have, that's all anyone really has, social distancing." (R)
(2) Inter-agency collaboration	MH system ineffective to address trauma	**1 M**	I would say making sure that we are researching all of the previous cases, all of the referrals that this family may have had with our agency. Trying to have access to other system involvement, which would be like Behavior Health, education, law enforcement, pediatricians, faith-based community organizations, really trying to collaborate with those systems to make sure that we are meeting the best needs of the family. I think when we are able to collaborate with those systems or there is some break somewhere in between, we start to miss thing (R).
	good collaborations with law enforcement	**3 CMs, 6 MMs, 3 Rs**	"And there's more a team approach I've seen as lately going on between not only Children and Youth but the police, the district attorney's office and everyone trying to help-- I don't want to say help. Yeah, I mean figure out what's going on for the family." (CM)
	good collaborations with doctors	**4 CMs, 7 MMs, 2 Rs**	"Now we have like check nurses. They come in the office. They come from [the hospital] but they're placed in each regional office. We went out and did our investigation. We had a nurse there." (CM)
	good collaborations with MH providers	**2 CMs, 2 MMs, 3 Rs**	"We have drug and alcohol assessors right in our office. We have mental health professionals right in our office." (CM)
	collaboration with school/ education	**1 CM, 1 R**	"We also talk to schools and mental health professionals, so all of that's kinda crammed into our day." (CM)
	in-house collaborators/ consultation	**2 CM, 1 R**	"we have nurses in each office, and I grabbed the nurse and asked her to go out with me so that when this mom told me whatever it was she was gonna tell me I could make sure that it was truthful and that it was accurate and that it was appropriate"…"She went with me to the home visit, was able to have conversations with mom and explain to her why different things are important. And then on the flip side, / / eventually returned multiple times and ended in a near fatality, but the nurse was able to help strengthen our case because we had

(Continues)

TABLE 1 (Continued)

Theme III: System Level Risk and Protective Factors			
			documentation that we had medical prerogatives that we had to provided to the family to connect them with services and they just did not comply. But they're also able to help us connect with something as simply as a family needed transportation to whatever medical appointments because mom's overwhelmed and she has a three-week-old that has significant medical needs. So they're able to get connected. They also help us a lot with the pediatricians, so if we're struggling with a pediatrician or if we need some information prior to confronting a family."…"I will tell you that I think it would be very, very helpful if we had somebody from the mental health field that we could go to in a similar fashion." (CM)
	provider bias	**1 MM**	"The doctors and nurses, in my opinion, were very dismissive of this mother to the point where I had to start talking to them because I was witnessing things that they were dismissing mom. Like I'd witnessed the baby projectile throw up numerous times, and they were saying 'that's not happening' to the mom. And then I had to actually step in at a couple of points to talk to the doctor separately saying 'These are things that I have witnessed' and that's bothersome at times." (MM)
	collaboration between multiple systems	**2 CMs, 1 MM, 1 R**	Interviewer: Thinking back, could you think of any red flags that future caseworkers and leaders should be aware of to determine if a case is at risk of a near fatality or fatality? Regional worker: "Yeah….Trying to have access to other system involvement, which would be like Behavior Health, education, law enforcement, pediatricians, faith-based community organizations, really trying to collaborate with those systems to make sure that we are meeting the best needs of the family. I think when we are able to collaborate with those systems or there is some break somewhere in between, we start to miss things." More data sharing is needed (MM).
	Delayed investigations	**2 CMs, 2 MMs**	This case came in after hours, and when that happens, if there are no other children in the family, we typically do not immediately send a caseworker to respond. We wait, it gets assigned the next day or a few days later, so by the time I got it, the baby had already been transported to the hospital, declared deceased, removed from the hospital, the police had interviewed the parents, the hospital had interviewed the parents, the police had been to the scene. So it was several days so the scene has changed. So when I get it, I'm already behind several days (CM).
Theme 4: Act 33 Case Descriptions			
Types of Injuries Disclosed	stab wounds to chest	**1 CM**	"It was really an awful, awful brutal scene. Mom had stab wounds to the chest. The child had a stab wound to the chest. Her groin was cut deeply with a knife near the femoral artery and to her neck as well near the carotid." (CM)
	liver damage	**1 CM, 1 MM**	"We get a report that the child has bruising all over the face, so our worker goes out to the house, sees the child, the child does have bruising on the face. The child goes to get medically cleared. The child does have liver damage so it becomes a near fatality." (MM).
	bruising on face/physical abuse	**1 CM, 2 MMs, 1 R**	"We get a report that the child has bruising all over the face, so our worker goes out to the house, sees the child, the child does have bruising on the face. The child goes to get medically cleared. The child does have liver damage so it becomes a near fatality." (MM).
	skull fractures – neurological devastation/brain bleeds	**2 CMs**	"The child was found to have bilateral frontal skull fractures and a left skull fracture and multiple brain bleeds." (CM)

(Continues)

TABLE 1 (Continued)

Theme 4: Act 33 Case Descriptions			
	SIDS/safe sleep	**1 CM, 1 MM**	"Actually the autopsy is still pending, but it appears to be either a SIDS death or an unsafe sleep death."…"A lot of the ones that I've seen have been accidental or just SIDS deaths." (CM)
	substance use - in utero or as a young child exposed to a parent's drug use	**2 CMs, 1 MM**	"Mom is on medically assisted treatment for heroin use; dad is on medically assisted treatment for heroin use."…"Baby is born positive for mom's medication, which is completely legal."…"Mom's rights were terminated to her three other children for drug use and then inability to care for them."…". "Both parents are receiving mental health at the drug and alcohol facility, which is another issue if they're not returning our calls and they're not cooperating with us."…"more information about the drug and alcohol system itself, but I think more cooperation would be beneficial."… "Mental health and drug and alcohol are two very critical pieces in child safety. Both the parents' and the child's mental health and drug and alcohol." (CM)
	domestic violence	**1 CM**	"Mental health, drugs and alcohol, domestic violence. I think those are the three big ones."…"there was a history of domestic violence between the parents, past allegations of drug use, and it was investigated and closed"…"There were prior investigations for domestic violence and accusations of drug use."…"If there's allegations of domestic violence, you need to address that." (CM)
	medical neglect	**1 CM, 1 MM**	"Our concern with them was like them actually going to the follow-up appointment because there was a history of the parents not following through with medical appointments and things of that sort." "There wasn't any physical injuries but she was malnourished; she didn't weigh the appropriate weight for her age." (M).
Types of Charges	arson	**1 CM**	We knew that mom had some issues with him. Could we as an agency have done better to protect those boys. That was probably my most recent case with a past history. But the perpetrator did not meet with me, hardly met with law enforcement, but was convicted of arson and murder. (CM)
	murder	**1 CM**	We knew that mom had some issues with him. Could we as an agency have done better to protect those boys. That was probably my most recent case with a past history. But the perpetrator did not meet with me, hardly met with law enforcement, but was convicted of arson and murder. (CM)
	shaking baby	**1 CM**	"It appeared, based on what the parents stated and what the doctors felt was the cause of the injuries that the child was shaken." (CM)
Theme 5: Lessons Learned			
	none	**1 CM, 1 MM, 1 R**	"No. I think both of the incidents that I described were just unfortunate and could not have been prevented. We as an agency, and we joke about it, but I think we have more policies than anything." (CM); AND "I don't think I learned any [lessons]. It's hard to say because I know how to do my job. I don't think we can reduce fatalities. I think it's hard to reduce a near fatality, especially if you're not involved in the case. I think that's impossible. Policies? I can't say that there are any policies because if the staff need help, we get them help. If they feel that they need trauma, we get them in trauma counseling for these cases." (MM).

(Continues)

TABLE 1 (Continued)

Theme 5: Lessons Learned			
	don't know	**1 CM, 1 MM**	"That's difficult. It makes me like second guess everything. Like this is a child that somebody else sent home, but they were also at the house weekly seeing the child. Like the other caseworker, keeping it very rough, like they were at the house weekly. So was the parenting worker. Like there were so many people that were out seeing this baby. I don't know. I don't know." (CM)
	document	**2 CMs, 1 MM**	"I think one of the biggest things is getting an accurate timeline, making sure that we have as much information as possible" (MM)
	self care	**1 M, 3 Rs**	"People respond to near fatalities and fatalities in a different way, and I believe that we3 have to provide them with a specific level of support." - preparing the case is intensive (R)
	modifying conclusions as more information is gathered	**2 MMs, 1 R**	"I also learned that things aren't always what they seem. Like we'll get an investigation that says one thing and it seems like horrific and bad, but then when you go out to interview the people, it's not always what it seems. So just having an open mind and not always taking everything on the paper that's given to you as if that's it and that's final." (MM)
Additional Resources Needed	Families: minimizing stress to prevent fatalities	**1 CM, 1 R**	"I think for best work possible and minimizing stress, to prevent fatalities and in all cases really is good support staff." (CM)
	Families: mental health	**1 CM, 1 MM**	"I had one where there was no criminal justice history, there was no mental health history, there was literally no system interaction, but that's not the typical. Yeah, typically they have criminal justice involvement or mental health involvement or both."…"Both parents are receiving mental health at the drug and alcohol facility, which is another issue if they're not returning our calls and they're not cooperating with us. I don't know that their mental health needs are being addressed appropriately. Which I mean I guess for child welfare isn't—Here's the catch that we have with that. Are their mental health needs being addressed appropriately obviously is a good thing for the person."…"We try to make sure that all that's being done so that we can be supportive to the family because this is a very devastating time in their life and if their mental health needs are already not being met and then they have a child death on top of it, that can be devastating." (CM)
	Families: health and academic education/ engagement for young parents	**1 CM, 2 MMs**	"It's like a frustrated parent or two frustrated parents or paramour, and in a blink of an eye, everybody's life changes, and I don't know that there's a way to educate surrounding that…. (MM)
	Families: availability of "good" or culturally relevant services	**1 CM, 1 MM**	"that depends on what community the family lives in and what information they're provided and how eager they are to seek it out if it's not provided. I've had families where I'm like, 'Oh hey, did you know that there's this down the street from you?' and the family's like, 'No, no clue. That would've been super-helpful.'…"…"some families in general that were hesitant to engage in those services because they were undocumented or have overstayed, and their concern was that if they engaged in community services, that would put their name on a list somewhere that somebody would have access to. They were not aware of like the Latino Family Center (CM)
	Families: more eyes and ears on children	**1 CM, 3 MMs, 1 R**	"A lot of times with newborns and young children under school age, they're not being seen by other people in the community. The parents or even the perpetrator may be the only person having quote/unquote "eyes" on that child, so a lot of times when families in the community are interacting with a church or a community group, have the baby in daycare, it's a little

(Continues)

TABLE 1 (Continued)

Theme 5: Lessons Learned		
		more settling knowing that there are additional, again, eyes on that baby and on the family to see if things are changing." (CM)
Families: need more EBP recourses in community	**2 MMs**	I think that they could have used parenting. I also think Domestic Violence should have had a play in this, because mom did have PFAs against other parties. (MM)
Staff: good support staff, less paperwork in exchange for more time with family	**2 CMs, 1 MM, 1 R**	"We have support workers or case aides that are so helpful in helping us dictate notes, making collateral contacts. The time consuming pieces of case management that isn't necessarily interacting with family." (CM)
Staff: time to process after Act 33 incident is limited	**2 CMs, 3 MMs, 1 R**	"People respond to near fatalities and fatalities in a different way, and I believe that we3 have to provide them with a specific level of support." - preparing the case is intensive (R)
Staff: adjust caseload when assigned Act 33 case	**3 CMs, 5 MMs**	"When you get something so big, so severe, almost everything else goes to the wayside for whatever time frame that needs to happen. How are your other cases impacted by receiving a fatality?" (MM)
Staff: Need to engage in thorough assessment and casework practice	**2 CMs, 4 MMs, 1 R**	"In terms of casework, along with trying to make sure that you're not missing anything in terms of your worker's own cases, sometimes there's little details that maybe you didn't pick up on because you were distracted by your other caseworker's case that was blowing up that day. And you always hope at the end of the day that you didn't miss anything." (MM).
Staff: coaching on how to assess risk and protective factors, & what resources are available to promote resilience	**1 CM, 5 MMs, 3 Rs**	"It would be beneficial to caseworkers to shadow someone who has previously worked on an Act 33 case just to know what to expect. And how to handle the phone calls from criminal lawyers, the family attorneys, just how to put it all together" (CM)
Staff: need centralized information system	**1 CM, 1 MM**	"There's no centralized source of information. We have a resource coordinator and that's great, but if I call her and say, `Hey, I need to talk to somebody at the medical examiner's office, who do I talk to, who's gonna help me,' she has no idea. She's great for resources but not for things like that. Like I'm having issues reaching a doctor at Children's. Oh, okay, we go to each other for that information, but I think having that information in a maybe not centralized is the best word, but in a specific location. An example, there's one doctor, there's one person at Children's that if we need to talk to any emergency room doctor, we go to that one person and she gets us into contact with that emergency room doctor. But you have to know to ask the question to another caseworker who has the information." (CM)
Staff: need to assess for presence of informal supports	**1 CM, 1 R**	"They had very little family support. Mom had a sister who would help out, but that was it. Otherwise very little family support." (CM)
Staff: need to engage fathers	**1 CM, 3 Rs**	"Our family support centers can get almost everything that you need. Especially if there are little kids, they do father engagement. I think family support centers are really critical." (R).
Staff: "specialists"	**1 MM**	"We hand a lot of things off to quote/unquote 'specialists' and that's great because we do need folks who have an inside track on things like domestic violence, things like ages and stages of life, child development. But I don't think caseworkers should be as ignorant to some of these things and dependent on a third party to tell you what's going on with your case. you need to be empowered to see it yourself." (MM)

(Continues)

TABLE 1 (Continued)

Theme 5: Lessons Learned		
System: Access to counseling through agency for staff	**4 MMs**	"They have a program that workers, sort of a counseling center that you can go to for all the employees. I think there's almost a feeling of you speak to people are connected with the agency and are affiliated with the agency and whether they're telling things to the agency, so I don't know how much people trust to go to an agency affiliated provider is really confidential. I've heard that one so many times so I'm not certain how much of a trust level is there between the workers and this contracted therapeutic agency." (MM).
System: More oversight/ accountability in agency	**1 MM**	"If I could have one wish in child welfare, it would be that there's more oversight and more checks and balances to really look at the patterns where we can build on our strengths and address our deficits so that our families aren't suffering because, I don't know, we are ignorant or we're lazy or we ran out of energy ten years ago. I don't know, but I think that's what would make the biggest difference." (MM)
Staff: need acknowledgement and appreciation	**1 MM**	"And frankly, acknowledge my hard work; that's not something that really happens very much at all. Like I don't need a parade, I don't need a trophy, but like 'Hey, thank you, we appreciate you, you're valued if you left someday we would really miss you. that would be a hard pair of shoes to fill.' Like I don't ever hear that crap." (MM)
System: more involvement or communication with hospitals	**1 CM, 2 MMs, 1 R**	I would say Behavior Health, I would say education and the pediatricians. I think those are three critical collaborations that we should have … I really think system involvement on a deeper level is needed, and I have recommended that in the past. (R)
System: less accusatory language	**2 CMs, 1 MM, 1 R**	"I think I would request less accusatory language being used towards workers. This is a hard job." (CM)
System: use media platforms to create awareness of services	**1 CM, 3 MMs, 1 R**	"A policy recommendation we came up with - we came up with a brochure. The we also did some little radio interviews, 60-second PSAs." (R).
System: address issue of state borders	**1 CM**	The families are constantly coming from (other neighboring states), so you don't know their complete history and getting the records from another state is a nightmare." (CM)
System: training in mandated reporting	**1 CM, 2 MMs**	"I believe that this case actually precipitated a change in the birth hospital's policies about / reporting. Because mom was on a legal substance. The hospital didn't have the information that we had about her history, and we wouldn't expect them to, but I believe thet are now considering changing their reporting."…"If these reports come in after hours or they come in on the weekend, whoever, whatever person that this is gonna be assigned to, and I don't know how this works out in practice, but this is what I think would be best case practice, that we would be notified immediately and be able to respond to the hospital, just like if the Hospital made a report of an infant with a fractured leg, we would go out that day." (CM)
System: More information about MH and D/A systems	**1 CM**	"Mental health and drug and alcohol are two very critical pieces in child safety. Both the parents' and the child's mental health and drug and alcohol. And I think having that information and having that good dialogue would be very helpful because if mom tells me, `Oh, I see Dr. So-and-So and I have bipolar,' well if I'm not familiar with bipolar, okay, well what does that look like? I have to go by with whatever mom tells me unless Dr. So-and-So calls me back. And that kind of puts us at a disadvantage. So I think more information about mental health conditions and how they manifest in people. I understand that they manifest differently in different people, but generalized things, generalized information and kind of more system communication and more system cooperation." (CM)

(Continues)

TABLE 1 (Continued)

Theme 5: Lessons Learned			
	System: Background checks (on people in home)	**1 CM**	"I think that anyone that is involved in any child's life, I'm talking about who may be caring for this child, paramours that live in the home or around the home frequently should have their backgrounds checked." (CM)
	System: Change public perception of DHS	**1 R**	"the public perception is that DHS is punitive - we need that change the perception to one that DHS aims to support and preserve families rather than be punitive." (R)
Previous Efforts to Address Fatalities	safe sleep education	**1 CM, 1MM, 2 Rs**	"In our county we have developed what's called safe sleep, so it's very similar to what new parents go through at the hospital regarding first, not to shake a baby, but secondly and most importantly, is the sleep schedule and what is safe and what is unsafe, such as we inform parents of the dangers of co-sleeping, we inform them of the dangers of drug use." (CM)
	not possible to reduce fatalities	**1 CM, 4 MMs, 1 R**	"I don't really have a good handle on how we can prevent them."…"So being that at this point this was a natural fatality, I don't know that there's anything that would've prevented it, but I think had we known about the child and been able to connect with the family, there is the potential that we could've impacted the family." (CM)
	case not active	**1 CM**	"I really don't know because they had had prior involvement with the agency but when I got assigned to this, they were not active with us."…"I had one, there was a history of domestic violence between the parents, past allegations of drug use, and it was investigated and closed, and then I got called, assigned to this family when the youngest child, who was only a few months old, presented at the emergency room with some pretty severe injuries"…"It wasn't documented clearly so I don't know if anything was tried or not tried and worked or didn't work." (CM)
	information gathering-active cases	**1 MM, 2 Rs**	"So I think one, being diligent and very intentional about how we assess to attempt to gain as much information, historically and present information in regard to the family as a whole and not separating it." (R)
	connecting to support systems	**1 R**	And trying to make sure that we are reaching out to those informal supports for the family, and if we have to provide them with formal support, being intentional with what those formal supports are, not just having a cookie cutter support for the family because you've had a family before that's been involved with IPV or drug and alcohol, but being really intentional on what supports this family needs." (R)
	safety conerns in home	**3 MMs**	"We look at the overall assessment of the home as well. Some of the factors that we look at is where are the children's bedrooms located. We've had a lot of those fatalities last year. Kids falling out of windows. Where are the kids' bedrooms in relation to the parent's bedroom? Are cabinets locked up? Those safety things in the home, those are definitely factors we look at." "Safety proofing their home, or safety proofing a swimming pool, making sure they understand safety with kids." (M).
	technology	**1 CM, 2 MMs**	"We have implemented the COVID guidelines…everybody's Zooming here and Zooming there and we're teaming here and teaming there, so we're Zooming and teaming all around really using technology, FaceTime and there's Google Duo and other things out there that I'm not really familiar with. Using technology a lot more." (R).

Client risk factors

The most-cited child and family risk factors were: 1) prior history of county agency involvement (n = 11); 2) significant other, paramour or other caregiver in the home (n = 10); 3) race, with eight participants reporting incidences of fatality and NF cases are more prominent among certain racial groups. WAmong these eight participants, some noted that fatality and NF cases occur more often among African American children while others indicated White children are endangered more frequently (see Table 1 Theme 2). Nine participants, on the other hand, noted that they occur across all racial/ethnic backgrounds; 4) young parental age (n = 7); and 5) age of the child, with nine reporting children aged five and under are at increased risk, and six specifying that those under one year of age are most at-risk; and 6) poverty (n = 6). One outlier is the fact that five participants (n = 5) noted that while some cases did not involve history of county agency involvement, it did not necessarily serve as a 'protective factor', adding that the circumstances at the time were too dire, and it would have been impossible to prevent or predict the outcome of the case. Finally, while poverty was reported (n = −6), there were other collective indicators of 'SES' that are worth mentioning: homelessness, (n = 2); lack of high school education (n = 2); change in income (n = 3); and loss of job/unemployment (n = 1).

Perpetrator risk factors

The most common perpetrator risk factors reported by participants included substance abuse (n = 15), untreated mental illness (n = 13), domestic violence (n = 9), inconsistent or lack thereof of family support (n = 7) (albeit one participants noted support is indeed present), criminal history (n = 6), and physical or sexual abuse as a child (n = 5). It is worth underscoring that nearly all the participants, regardless of role, agreed that substance abuse and mental illness were indeed 'red flags', and additional efforts must be devoted to ensuring workers and leaders alike are trained and supported to assess for these risk factors, irrespective of whether they are reported or alleged to be issues of concern.

Community risk factors

Twelve participants agreed that while resources to mitigate risk factors are available in their respective communities, 10 reported that lack of awareness of the resources are present among workers and families alike and nine added the issue of concern stems from lack of client engagement. Other community risk factors, such as lack of informal supports (n = 4), formal supports such as day care (n = 1) and systemic racism (n = 1) were not mentioned often during interviews.

Theme 3: system-level risk and protective factors

System-level factors were categorised into the following two prevailing codes: 1) organisation climate and capacity; and 2) inter-agency collaboration. Regarding climate, issues related to climate or psychological safety, supervision and leadership, and the unprecedented COVID-19 pandemic emerged. Nine participants cited a lack of psychological safety, presenting as blaming, finger-pointing and belittling workers who had to grapple with the challenges of managing fatality and NF cases and participating in the case review process. While intended to generate recommendations for improving practice, they interpreted the review process as unsupportive and accusatory. Being assigned additional cases while managing a fatality or NF case added to their perceived level of stress (n = 7). Three participants suppressed their negative feelings to cope with the taxing working environment. A few participants felt COVID-19 perpetuated the toxicity due to decreased personal connections and physical distancing (n = 3) and more reliance on technology (n = 3)

While participants illuminated sub-optimal climate conditions, a few others (two CMs and four middle managers) appreciated working in a 'supportive environment', largely due to transformational leadership displayed by their chain of command. These conditions cultivated an optimal climate to thrive as child protective service employees. Four regional leaders concurred that they cultivated a supportive climate by modelling how to nurture collegial relationships in the context of handling crises. Interestingly, all four regional leaders noted that they cultivate a supportive environment. Also related to climate, case managers (n = 5) and middle managers (n = 4) reflected upon how helpful it was for their supervisors to allot space to process grief while grappling with the death of a child; and three of the regional leaders concurred with them. Four participants (there case managers and one middle manager), however, felt administrators did not create opportunities to grapple with secondary trauma. Three case managers reported that while leaders provided grief support, it was not warranted.

Inter-agency collaboration emerged as the other major 'sub-code' related to system-level factors. Notably, most of the participants appreciated the fruitful collaborations developed with law enforcement (n = 12) and medical professionals (n = 13), adding that they were instrumental in providing reports and/or consultations to aid in fatality and NF investigations. In other cases, they indicated they could rely on them as partners to build a safety net for at-risk youth and families – and ultimately play a role in preventing casualties. Seven of the participants underscored that mental health providers played the same role. Four participants revealed the challenges of 'delayed investigations'. If, for example, a report of abuse is called in after 5 pm, days may pass before a worker is assigned to the case, thereby hindering opportunities to play an active and collaborative role in the investigation process. Finally, four participants noted inability to exchange data and engage in inter-professional or multi-sector case planning.

Theme 4: case descriptions

During interviews, participants were asked to reflect on a case in which they were assigned as one approach to elucidate risk factors related to fatality and NF cases. What emerged in addition to risk factors herein were types of child injuries – and the types of criminal charges the perpetrators had to contend with. Child injuries reported by participants included: 1) bruising on face/physical abuse (n = 4); 2) drug exposure either in utero or as a young child exposed to a parent's drug use (n = 3); 3) liver damage (n = 2); 4) skull fractures (n = 2); and 5) medical neglect (n = 2). Charges included arson, murder and aggravated assault, often precipitated by shaken baby syndrome, all of which were cited by only one participant.

Theme 5: lessons learned

Participants were asked to draw upon their experiences and expertise of managing or overseeing fatality and NF cases to offer recommendations on how to manage and reduce them. Two codes emerged: 1) previous efforts to address fatalities; and 2) resources that are needed to support families, staff and organisational/system capacities. While six participants reported that it is not possible to reduce fatalities (n = 6), a few others took action by implementing safe sleep practices (n = 4). This initiative involved collaborating with medical providers to educate parents and caregivers about safe sleep protocol. Other initiatives involved 'information gathering' or gaining a holistic understanding of family and community-level risk and protective factors (n = 3) and relying on said thorough assessments to inform how best to address safety issues in the home (n = 3).

Participants offered recommendations for how caseworkers could manage and attempt to reduce incidence of fatalities more effectively and efficiently. At the family level, they advised that caseworkers could 1) cultivate child safety nets (i.e. ensure there are more 'eyes and ears' on the child) (n = 5) and 2) engage young parents in health and education resources, acknowledging that they often are not aware of them, or how to access them (n = 3). Regarding the staff level, they highlighted that additional training and coaching is needed to 1) educate workers on how to thoroughly assess risk and protective factors (n = 7) and 2) what resources and system partners/helpers are available to address risks and promote resilience (n = 9). Training and coaching strategies might include more content during orientation and more opportunities to practice skills while shadowing experienced workers. They also believed that caseloads should be adjusted when assigned fatality and NF cases (n = 8), noting it would be helpful if they were not assigned new cases for a couple weeks to focus on the gravity and complexity of child death and serious injury. Allocating time to process grief or secondary trauma following a fatality or NF incident (n = 6), and more emphasis on increasing father engagement (n = 4) in assessment and case planning, were also cited. Finally, at the systems or organisational level, participants suggested the following: 1) use media platforms to increase awareness of services and resources (n = 5); 2) provide agency staff with confidential access to external clinicians to process grief and trauma (n = 4); 3) avoid accusatory language, especially during case reviews (n = 4); 4) cultivate a climate that embraces more communication, information sharing and collaboration with hospitals (n = 4); 5) decrease redundant paperwork to allot case managers more time to engage with children and families (n = 4); and 6) offer training in mandatory reporting to advocates and providers across other child and family-serving systems (n = 3).

DISCUSSION

Our objective was to rely upon interviews with participants to illuminate patterns, risk factors and protective factors related to fatality and NF cases, and utilise the findings from this study to propose specific recommendations to inform policy and practice to prevent child fatalities. Findings from the interviews revealed five major themes: 1) experiences

of workers and leaders; 2) client and perpetrator risk factors; 3) system-level risk and protective factors; 4) case descriptions; and 5) lessons learned. We draw on the limited research to either validate the participants' experiences or to underscore how findings advance knowledge. Like nearly all the participants in the current study, child advocates and scholars report how taxing casework practice is. High caseloads, coupled with insurmountable paperwork and deadlines, interferes with time they can allocate toward thoroughly assessing for risk and protective factors and engaging effectively with children and families (Buckley et al., 2014). Secondly, they echoed many of the child fatality risk factors cited in other studies: prior CWS history (Jonson-Reid et al., 2007) paramour or other caregiver in the home (Yampolskaya et al., 2009), age of the child, lack of family support (Douglas & Mohn, 2014), poverty, parental or perpetrator substance abuse and untreated mental illness (Douglas, 2013a), domestic violence (Yampolskaya et al., 2009) and lack of awareness of services to mitigate risk (Garcia & DeNard, 2017).

While validating, the study also advances our understanding of how child welfare workers and leaders process child fatalities. First, no research to our knowledge delves into an in-depth discussion about the intersection of race and child fatalities. In the current study, nearly half of the participants believed that fatality and NF cases are more prominent among children and families of colour. These perceptions, however, are driven by whether the participants, by chance, were assigned to a fatality or NF case involving an African American or Latinx family. While Douglas and Mohn's (2014) review of over 1200 child fatalities showed that children were indeed more likely to be African American, other scholars suggest otherwise. Examining crude death rates, Barth and Blackwell (1998) found that while Caucasian and Latinx children in foster care had higher rates of death than their counterparts in the general population, African American children in foster care had lower crude death rates in California. In the same state, Putnam-Hornstein et al. (2013) concluded that African American children were no more likely to sustain a fatal injury than Caucasian children, albeit they experienced a higher likelihood of intentional injury deaths. The variability in findings across different contexts underscore the need to integrate a racial equity lens when exploring the underlying causes of child fatalities, especially since youth of colour are overrepresented in the CWS (Gourdine, 2019; Huggins-Hoyt et al., 2019). Indeed, future research should illuminate caseworkers' and leaders' experiences of engaging with parents, caregivers and relatives of different and/or similar backgrounds. In-depth inquiry could entail exploring how their own identity and actions as workers and advocates assigned to these severe cases influence the family's perceptions of them and the CWS. Likewise, the intersectional experiences of identity, race/racism and fatal and non-fatal injuries could be captured by interviewing racially diverse families' experiences of interacting and communicating with workers and leaders who are assigned to these cases.

Secondly, previous research has largely ignored the salience of organisational climate and its potential effects on the occurrence of child fatalities or near fatalities. Nearly half of the participants who managed a fatality and NF case and participated in the review process cited a lack of psychological safety. Blaming for the outcome of these cases while being assigned to manage additional cases during this time, factored into these negative perceptions. In this context, organisational responses to child fatalities and subsequent case reviews are often punitive and perpetuate a taxing culture and climate (Turnell et al., 2013). Six participants, however, appreciated working in a 'supportive environment', largely due to transformational leadership displayed by their chain of command. Transformational leadership is often conveyed by encouraging staff to adhere to mutually agreed upon goals and behaviours (Aarons & Sommerfeld, 2012). These participants suggested that a supportive and collectivistic approach to supervision (Gustavsson & MacEachron, 2002, 2004) exemplifies qualities of transformational leadership during crises.

Thirdly, findings are novel, considering the emphasis on system collaboration. Over half of the participants underscored the salience of inter-professional collaboration and communication with other systems to mitigate risk for youth and families. While not specific to child fatalities, prior research suggests that these types of collaborations promote contextual assessment and case planning (Aarons et al., 2014; Garcia et al., 2020) – and may, in turn, prevent casualties or expedite fair and supportive child fatality investigations and case reviews (Garcia & DeNard, 2017).

Limitations

We must call attention to some limitations. First, findings are applicable to four counties in one large and diverse Mid-Atlantic state. Secondly, observation of body language and cues during an in-person interview was not feasible due to the novel COVID-19 pandemic. Thirdly, only four regional leaders participated in the study; thus, findings are likely more representative of case managers and middle managers. Finally, we must call attention to the expertise of the research team. The first and second authors were former caseworkers; and the third author had held numerous child welfare practice and advocacy roles. To minimise interpreting findings within these confines, we engaged in a reflexive process of verbalising potential biases and validating that the results reflected the experiences of the participants rather than our own experiences.

Implications for research, practice and policy

Despite limitations, findings and in particular 'lessons learned' from the participants shed light on implications for advancing research, informing practice, policy and systems change, and supporting workers. As for practice and systems reform, participants underscored the need to promote more 'eyes and ears' on kids. To achieve its goals of preserving families, the CWS must first ensure that the public and other systems of care do not perceive child welfare involvement as punitive. Assisting providers with developing safe and age-appropriate programming and connecting families to resources expands the network of adults working to keep children safe. Secondly, the CWS must promote a system of reciprocal support with local law enforcement and medical professionals. Child welfare agencies should consider providing inter-professional training to ensure key players are privy to how best to prevent, respond to and investigate child fatality and NF cases. Thirdly, agencies need to develop a policy instructing an immediate response to a fatality or NF. Critical items may be missed in fatality and NF investigations if child welfare workers do not begin working on cases immediately, even if that means they are called in after hours.

To support workers, participants suggested increasing training and coaching opportunities for child welfare staff. After examining over 400 child welfare workers' training and knowledge about child fatalities, Douglas and Gushwa (2020) concluded that while they routinely assessed for risk, they wanted additional training, even though training had minimal impact on knowledge. Considering these findings, as well as our findings, training should be revamped. Agencies should promote a teamwork approach, allowing newer staff to work alongside senior staff. Simulation training for caseworkers, such as Fieldworker Safety Training, provides a realistic experience for trainees to prepare them for real-world interactions (Capacity Building Center for States, 2020).

Moreover, findings underscore the need to provide child welfare staff the time to grapple with secondary trauma. An external trauma specialist should be hired to debrief with workers after every fatality and NF. Staff who were not directly involved in the case may need a safe space, at no cost, to process their reaction to the traumatic event (Pulido & Lacina, 2010). In some cases, it may be advisable to assign a new worker, who is not known to the family, to investigate the fatality or NF. Children and families who were previously being served by caseworkers, who now must focus on a fatality or NF case, are likely to suffer from a decreased level of attention. The notion of a short 'time out' from new cases is echoed by Douglas (2013b).

Administrators must promote an agency culture that prioritises inter- and intra-departmental support and employee self-care. Child welfare agencies should aspire to cultivate a culture and climate where work is appreciated, input is valued, accusatory language is avoided and ongoing self-care is encouraged. Finally, flexibility in meeting required home visit standards should be allotted. A system that requires a mandatory home visit once per month may lead to a complacent approach where caseworkers seek only to meet this minimum standard. Building off the lessons learned during the COVID-19 pandemic, caseworkers should be encouraged to use virtual visitation when possible.

Additional research is needed to examine how and under what conditions the aforementioned policies and practices prevent or reduce child fatalities and support the CWS workforce. Researchers need to conduct interviews with caregivers and families involved in child fatality cases, as well as with other system providers who are impacted by these cases. Their respective voices could shed light on the impact of strategies to reduce risk (e.g. home visiting, and inter and intra-collaboration and communication). Finally, research is needed to ensure more CWS workers from different backgrounds and experiences are represented.

Concluding remarks

Predicting the occurrence of child fatalities is challenging at best and is often nearly impossible. As described by the participants, because risk factors between fatalities and near fatalities are indistinguishable, workers must be equipped to align service provision or case plans to target specific underlying risks and enhance protective factors. Similar to the argument of Turnell et al. (2013), fatalities cannot be isolated – and to exhaust efforts to identify them and place blame cultivates a climate of toxicity. Rather, efforts should be devoted to implementing and evaluating strategies to reduce risk for all families before CWS is involved, supporting workers when they are assigned to fatality cases, recruiting and training directors to engage in transformational leadership, and embracing a culture of collaboration across and within systems. We have a moral and ethical imperative to ensure all children are protected, families are supported and that workers are equipped to engage effectively with them.

ETHICS STATEMENT

The University Institutional Review Board approved all recruitment, data collection procedures and analyses. All participants consented to participate in the study.

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CONFLICT OF INTEREST

There are no conflict of interests to report.

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APPENDIX

INTERVIEW GUIDES

Interview Guide for Case Managers

Section I: Introduction

1. Tell us about caseworkers' major responsibilities and objectives. Walk us through a typical day for you at your agency.
2. Tell us about the types of stressors caseworkers commonly experience.
3. Tell us about what you like about your current job.
4. Tell us about what factors help you achieve responsibilities and objectives.

Section II: Occurrence and Predictors of Child Fatalities

For many reasons, beyond your control, responsibilities and objectives are not achieved. In rare circumstances, child fatalities or near child fatalities occur through no fault of your actions. We would like to better understand, from your perspective, what case characteristics and other factors increase the likelihood of these incidents occurring while DHS is involved with the family. By doing so, we hope to provide practice and policy recommendations to prevent child fatalities and near child fatalities.

1. From your perspective, what case characteristics should workers and supervisors screen for to assess whether a child fatality or near child fatality will likely occur? Ask participants to reflect upon the following categories:
   - Case descriptives/risk factors
   - Child characteristics/risk factors
   - Family/household characteristics/risk factors
   - Perpetrator characteristics/risk factors
   - Community/inter-agency collaboration factors (e.g. agencies known to CPS, collaboration with other agencies and community resources, availability of relevant and culturally congruent services)

- System-level factors: workforce issues, retention, caseload size, leadership, data sharing, organisational culture (norms, or the way things are done in the agency), organisational climate (or psychological safety/impact of job on wellbeing)
- Other factors: child/family engagement in services, communication and collaboration with colleagues, and utility of screening and assessment protocol and procedures

2. Think back to when a child fatality and/or near child fatality occurred and describe what happened. Ask participants to share details about a couple of incidents.
   - Walk us through what happened prior to the child fatality or NF case? What was going on with the case prior to the incident? Reflect on case descriptives and prior case history, child and family characteristics, perpetrator characteristics, and community/inter-agency collaboration factors, system-level factors and other factors.
   - If applicable, what services were already in place at the time of the fatality or near child fatality?
   - How did you respond to the fatality or near child fatality?
   - What impact did the fatality have on agency norms and morale?
   - How did your supervisor respond to the incident?
   - How did other agencies you collaborate with (e.g. law enforcement, court, health/mental health, etc.) respond to the incident?
   - Thinking back, were there any practices, policies or protocols that might have helped prevent the child fatality or near child fatality and, if so, what might those be?
   - Tell us about what lessons you learned from the incident.

Section III: Final Thoughts and Recommendations

- What additional supports do you need to engage in best practice and prevent child fatalities or near child fatalities?
- What resources do you believe might have helped you process the grief and/or trauma following experience with a fatality/NF?
- If given the chance, what would you tell your supervisor or other DHS leaders about your experience as a case manager as it pertains to child fatality cases or near child fatality cases?
- Do you have any other thoughts, suggestions or recommendations to prevent child fatalities or near child fatalities?
- Do you have any other thoughts, suggestions or recommendations on how best to respond to child fatalities or near child fatalities?

INTERVIEW GUIDE FOR SUPERVISORS

Section I: Introduction

1. Tell us about supervisors' major responsibilities and objectives. Walk us through a typical day for supervisors at your agency.
2. Tell us about the types of stressors supervisors commonly experience.
3. Tell us about what you like about your current job.
4. Tell us about what factors help you achieve responsibilities and objectives.

Section II: Occurrence and Predictors of Child Fatalities

For many reasons, beyond your control and the control of your staff, responsibilities and objectives are not achieved. In rare circumstances, child fatalities or near child fatalities occur through no fault of your actions or the actions of your staff. We would like to better understand, from your perspective, what case characteristics and other factors increase the likelihood of these incidents occurring while DHS is involved with the family. By doing so, we hope to provide practice and policy recommendations to prevent child fatalities and near child fatalities.

1. From your perspective of overseeing cases, what case characteristics should workers and supervisors screen for to assess whether a child fatality or near child fatality will likely occur? Ask participants to reflect upon the following categories:
   - Case descriptives/risk factors
   - Child characteristics/risk factors

- Family/household characteristics/risk factors
- Perpetrator characteristics/risk factors
- Community/inter-agency collaboration factors (e.g. agencies known to CPS, collaboration with other agencies and community resources, availability of relevant and culturally congruent services)
- System-level factors: workforce issues, retention, caseload size, leadership, data sharing, organisational culture (norms, or the way things are done in the agency), organisational climate (or psychological safety/impact of job on wellbeing)
- Other factors: child/family engagement in services, communication and collaboration with colleagues, and utility of screening and assessment protocol and procedures

2. Think back to when the most recent child fatality and/or near child fatality incident(s) occurred in your agency and describe what happened. Ask participants to share details about a couple of incidents.
   - Walk us through what happened prior to the child fatality or near child fatality cases? What was going on with the case prior to the incident? Reflect on case descriptives and prior case history, child and family characteristics, perpetrator characteristics, and community/inter-agency collaboration factors, system-level factors and other factors.
   - If applicable, what services were already in place at the time of the fatality or near child fatality?
   - How did you as an agency leader respond to the child fatality or near child fatality?
   - What impact did the child fatality or near child fatality have on agency norms and morale?
   - How did the assigned caseworker respond to the incident?
   - How did other agencies you collaborate with (e.g. law enforcement, court, health/mental health, etc.) respond to the incident?
   - Thinking back, were there any practices, policies or protocols that might have helped prevent the child fatality or near child fatality and, if so, what might those be?
   - Tell us about what lessons you learned from the incident.
   - What is your agency currently doing to support caseworkers about how work on a fatality/NF case?

Section III: Final Thoughts and Recommendations

- What additional supports do you need to ensure best practices, policies and protocols are implemented in your agency to prevent child fatalities or near child fatalities in the future? What might need to change in your organisation to prevent occurrences of child fatalities or near child fatalities?
- What resources do you believe might have helped you process the grief and/or trauma following experience with a fatality/NF?
- If given the chance, what would you tell DHS leaders/directors about your experience in overseeing child fatality cases or near child fatality cases?
- Do you have any other thoughts, suggestions or recommendations to prevent child fatalities or near child fatalities?
- Do you have any other thoughts, suggestions or recommendations on how best to respond to child fatalities or near child fatalities?

INTERVIEW GUIDE FOR REGIONAL STAFF

Section I: Introduction

1. Tell us about your role specific to child fatalities and near fatalities at DHS.
2. Tell us about your major responsibilities and objectives regarding child fatalities and near fatalities.
3. What is your role specifically in the fatality and near fatality process?

Section II: Occurrence and Predictors of Child Fatalities and Near Fatalities

We would like to better understand, from your perspective, what case characteristics and other factors increase the likelihood of the occurrence of a child fatality or near-fatality. By doing so, we hope to provide practice and policy recommendations to help prevent future child fatalities and near fatalities.

1. From your perspective, what case characteristics should caseworkers and supervisors screen for to assess whether a child fatality/near fatality will likely occur? Ask participants to reflect upon the following categories and the challenges to identifying each:
   - Case descriptives/risk factors
   - Child characteristics/risk factors
   - Family/household characteristics/risk factors
   - Perpetrator characteristics/risk factors
   - Community/inter-agency collaboration factors (e.g. agencies known to CPS, collaboration with other agencies and community resources, availability of relevant and culturally congruent services)
   - System-level factors: workforce issues, retention, caseload size, leadership, data sharing, organisational culture (norms, or the way things are done in the agency), organisational climate (or psychological safety/impact of job on wellbeing)
   - Other factors: child/family engagement in services, communication and collaboration with colleagues, and utility of screening and assessment protocol and procedures

Section III: Policy and Practice Improvement

Your role as regional staff places you in the important position of recommending policy and practice improvement through the lens of child fatality and near fatalities. We would like to learn more about your experiences in this area.

Think back to a child fatality and near fatality that involved active/open cases:

- What policy and/or practice recommendations have you made in response to those reviews?
- What policy and/or practice changes have been made as the result of those reviews?
- What, if any, policy and/or practice recommendations did you make that were not implemented. If implemented, to what extent do you feel it could have prevented a subsequent child fatality or near fatality?
- What barriers do you see in implementing recommendations from child fatality and near fatality case reviews?

Section IV: Final Thoughts and Recommendations

- Do you have any recommendations on how the child fatality and near fatality review process could be improved?
- Please describe any duplication of efforts and/or gaps in the process of reviewing child fatalities and near fatalities.
- Do you have any other thoughts, suggestions or recommendations on how best to respond to child fatalities?
- Do you have any recommendations for preventing child fatality and near fatality incidents?
- Do you have any recommendations on how to support caseworkers and supervisors who are assigned child fatality and near fatality cases?