

Protect Our Kids Act in 2013, although the overall safety of children has increased in the United States, child fatalities are *not* declining and somewhere between 1,500 and 3,000 U.S. children will die each year from maltreatment. In the report, the chairperson of the commission ironically notes that “Child protection is perhaps the only field where some child deaths are assumed to be inevitable, no matter how hard we work to stop them. This is certainly not true in the airline industry, where safety is paramount and commercial airline crashes are never seen as inevitable” (p. 11).

There are few things more tragic than a child who is killed by a parent or caregiver. Inevitably, we must come to grips with the fact that we—society—failed that child. But where and when did we fail the child? At the very least we must acknowledge that we failed to notice what, presumably, would have been warning signs. Children with prior allegations of child maltreatment died from intentional injuries at a rate 5.9 times greater than children not reported for child maltreatment and the risk was greater for victims of CPA compared to neglect (Putnam-Horenstein, 2011; Putnam-Horenstein, Cleves, Licht, & Needell, 2013). An estimated 30–50 percent of children killed by parents or caretakers were killed after they had been identified by child welfare agencies (Wang & Daro, 1996, 1998). In some cases (12% in 2014), the family had received preservation services from CPS in the previous five years. Most troubling of all, 19 children died in 2014 after spending time in foster care and being reunited with their abusive families (U.S. DHHS, 2016). Not every child death, of course, is evidence of a faulty child protection system. But 1,500 child abuse deaths are too many, and must be addressed.

According to the CECANF (2016), the answer to preventing child fatalities lies not in simply improving the current system of child protection, but in requiring fundamental reform such as a national strategy to create a reinvigorated child welfare system. Such reform would include CPS agencies as leaders in the effort to respond quickly but would also include expanding responsibility for child safety to additional community partners who come into contact with families (e.g., health care and public health agencies and professionals). In addition, the commission recommended greater sharing of CPS data on families, both electronically and in real time, to enhance CPS response, as well as increased identification of children and families at greatest risk for child maltreatment fatality by retrospectively reviewing child fatality cases over the past five years.

What else can be done to help prevent fatalities? One response that has been helpful is the establishment of **child fatality review teams** (Krugman & Lane, 2014; Palusci & Covington, 2014). Such teams are typically composed of community professionals representing multiple agencies who retrospectively review the circumstances under which a child died, including interviewing family members, teachers, neighbors, and others, in order to reconstruct the circumstances and events that may have contributed to the death. Although the functions of these teams vary, typically they identify the prevalence of deaths from abuse and neglect, improve the policies and procedures of CPS to prevent future child deaths and serious injuries, protect siblings of children whose causes of death are unexplained, and increase professional and public awareness of child death due to maltreatment (Block, 2002; Durfee, Durfee, & West, 2002). One study found a 9 percent decrease in the number of child deaths associated with child fatality review team activities (Palusci, Yager, Covington, 2010). Other suggestions for preventing child fatalities include parent education during the newborn period (see Box 3.1); support for new, especially high-risk, parents through home visitation programs (see Chapter 5); and community involvement in promoting healthy families (CECANF, 2016; Krugman & Lane, 2014).