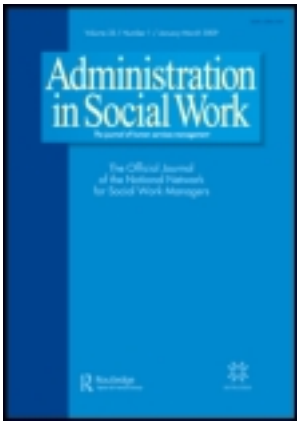

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Child Welfare Workers Who Experience the Death of a Child Client

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Child Welfare Workers Who Experience the Death of a Child Client

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Annually, almost 2,000 children die from maltreatment; 30%–40% are known to child welfare agencies. Critics attribute these deaths to young, inexperienced, untrained workers. This study used a multi-state sample of 123 child welfare workers who had experienced a fatality to address: 1) the characteristics of workers, 2) how workers approached the case, and 3) the fallout after the fatality. Workers were in their late 30s, were well educated, and had several years of experience. They felt confident in handling the case leading up to the fatality, felt supported by coworkers, and did not use formal support. Implications for administrators are discussed.

Keywords: child welfare, fatality, risk assessment, social work administration, training

INTRODUCTION

According to official statistics, in 2009, 1,770 children died from maltreatment (U.S. Department of Health & Human Services, 2010). Many of these victims are previously known to child welfare agencies before their deaths (Anderson, Ambrosino, Valentine, & Lauderdale, 1983; Beveridge, 1994). Significant attention has been paid to child maltreatment fatalities (CMFs) through internal and external reviews to identify agency-level concerns that might be related to the deaths (Douglas & Cunningham, 2008; Durfee & Durfee, 1995; Durfee, Gellert, & Durfee, 1992; Lachman & Bernard, 2006) and through media attention that often places blame for the child's death on individual workers or supervisors. Some argue that the child welfare profession is out of control: workers who experience fatalities are young, inexperienced, and lack professional training, and they miss warning signs leading up to the deaths (Gelles, 2003; National Coalition for Child Protection Reform, 2009). Research has focused on agency-level involvement in deaths (Gustavsson & MacEachron, 2004; Palusci, Yager, & Covington, 2010; Regehr, Chau, Leslie, & Howe, 2002), but little research has focused on child welfare workers (CWWs) who experience a fatality: their demographic and professional experiences, their understanding of events leading up to the death, the personal and

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professional impact of the death on the individual within the agency and the supports that they use, and how these experiences vary by frontline workers and supervisor. These concerns, and the role for social work administrators, are addressed in this paper.

AGENCY AND WORKER INVOLVEMENT IN CHILD MALTREATMENT FATALITIES

Previous research has shown that between 30%–40% of children who die from a maltreatment fatality were previously known to, or received services from, the local child welfare agency before their death (Anderson et al., 1983; Beveridge, 1994). Statistics from 2009 indicate that, in 11.9% of cases of CMFs, families had received family preservation services in the five years before the death, and in 1.9% of CMFs, families had received reunification services in the five years before the death.

CMFs are often reviewed by internal review boards, such as one in Washington state that determined that assigning inexperienced workers to high-risk cases can contribute to CMFs (Washington State Children's Administration, 2008). Deaths are also examined by external review boards, such as multidisciplinary child fatality review teams (Durfee et al., 1992; Webster, Schnitzer, Jenny, Ewigman, & Alario, 2003), the purpose of which is to identify barriers and gaps in services that might have led to CMFs (Durfee et al., 1992; Hochstadt, 2006). Review teams have recommended improvements in inter/intra-agency communication, risk assessments that are conducted on families, and training for child welfare professionals (Douglas & Cunningham, 2008).

Some members of academia have spoken disparagingly about the child welfare system and how it employs workers who are young and lack education and training, and how these factors might place children at higher risk for fatality (Gelles, 2003). Similar conclusions have been drawn by the media (Batty, 2001) and by organizations intended to reform the child welfare system (National Coalition for Child Protection Reform, 2009).

Annually, a fair number of workers have experience with fatalities. For example, if 30–40% (Anderson et al., 1983; Beveridge, 1994) of children who die each year are known to child welfare agencies, that means that, in 2009 when 1,770 children died from maltreatment, between 531 and 708 CCWs experienced a fatality on a caseload. If we assume that each open case has a frontline worker and a supervisor, then the number of CWWs involved in fatalities annually is somewhere between 1,062–1,416, which is roughly 3.2%–4.3% of the child welfare workforce (U.S. Department of Health & Human Services, 2010). (This estimate may be slightly inflated because multiple children sometimes die in a single family, who would have had a single worker.) Further, previous research on the dataset that will be utilized for the present paper found that almost one-third of a multi-state sample of child welfare workers reported having a parent disclose a potential intent to kill their children (Douglas, Forthcoming). Nonetheless, no research has been conducted on the characteristics of CWWs who experience fatalities, their professional training, and how they approached the cases that ended in fatality. This gap in the literature will, in part, be addressed in the current paper.

THE AFTERMATH OF CHILD MALTREATMENT FATALITIES

The death of a child who was previously known to child welfare agencies is often accompanied by a high level of media attention, which can create both formal and informal changes in policy and practice. Previous research has shown that media attention to agency-level CMFs often results in new state-level child welfare legislation (Gainsborough, 2009) intended to prevent future fatalities (Douglas, 2009). At the agency-level, children's deaths that occur in birth homes can lead to an increase in the use of foster care, and deaths that occur in foster homes can lead to an increase in

the use of family preservation (Gelles, 1996; Murphy, 1997). Media attention can have an important impact on the climate of child welfare agencies. Cooper (2005) found that in an effort to improve accountability management responded to media coverage by restricting the independence of frontline workers. Others also found that agency-related CMFs resulted in restricted practices and an increase in policing functions within a child welfare agency (Regehr et al., 2002). A British study noted that high profile CMFs resulted in a significant change in oversight procedures, which had a deleterious effect on the overall atmosphere of the agency (Ayre, 2001).

Some in-depth, qualitative research has focused on the experiences of workers who lose a client. Workers often feel distressed by the repeated exposure to traumatic material in the agency's attempts to understand what "went wrong"; the reviews of the events leading up to the death are time consuming and are often critical of the worker(s)'s practice techniques (Regehr et al., 2002). CWWs in an agency that experienced a CMF report being angry and frustrated with the review procedures and "red tape" that accompany a CMF (Cooper, 2005). Such research has been conducted on small samples and/or has been limited to one region. Thus, the field does not know the commonality of these experiences after a death and if these events might differ between states and agencies. Further, the literature has discussed how to support workers who have experienced a CMF through appropriate supervision (Gustavsson & MacEachron, 2002; Gustavsson & MacEachron, 2004) and critical incident debriefing (Horwarth, 1995; Weuste, 2006). We do not know, however, if workers who experience a CMF are even offered such support and, if offered, how many use it and their assessment of these services.

When a child dies who is known to protective services, the public often wants to know that individuals will be held responsible, such as in 2008 when six child welfare workers in D.C. were fired after the death of four siblings who were receiving child welfare services (Associated Press, 2008), or in 2011 when two New York child welfare workers were charged with negligent homicide after the death of a child on their caseload (Secret, 2011). It remains unknown how many workers worry about losing their jobs, being fired, being placed on administrative leave, or who resign from their positions or are reassigned within their agencies. This study will address many of these concerns.

CURRENT PAPER

The background and literature reviewed here describes workers who experience fatalities, the events leading up to the death, the circumstances after the death of the child, and recommendations about how to best support workers who experience a death. This review, however, shows that much of the information that we receive concerning the employees who serve children and their families is anecdotal in nature—or the research that exists has focused on the qualitative, in-depth experiences of workers in specific agencies. This leaves us with an incomplete understanding about the common experiences surrounding the death of a child welfare client. The literature also does not examine how experiences may differ based on one's role in the case, whether a frontline worker or supervisor. This paper will explore some of our gaps in knowledge concerning the events leading up to a child's death, the experiences after a child has died, and will consider the role of the worker in each circumstance. This paper uses data from a multi-state research project of current and former child welfare workers and their experiences and concerns regarding CMFs. Specifically, four questions are addressed:

1. *What are the demographic characteristics and professional experiences of workers at the time of a fatality?* Anecdotal evidence suggests that, at the time of the death, workers would be young, inexperienced, lacking in training that would prepare them for child welfare work, and have high caseloads. One would expect supervisors to have more experience, more relevant education, and higher caseloads.

2. *What are workers' experiences with the events leading up to the CMF?* Critics paint a picture of a child welfare system carrying large caseloads, with workers who are unable to be attentive to clients. The experiences of frontline workers and supervisors will be considered separately.
3. *What happens in the aftermath of the CMF?* The literature suggests that workers will find the death a source of stress for them and that they will look to their colleagues and supervisors for support. The experiences of frontline workers and supervisors will be considered separately.

METHODS

Procedure

Data for this paper were collected as part of a larger study, "Child Maltreatment Fatalities: Perceptions and Experiences of Child Welfare Professionals," from September 2010–January 2011. Current CWWs and managers were recruited to participate in an online survey that focused on CWWs' perceptions of and experiences with CMFs, as were former workers who had lost their job as a result of fatality. Potential participants were recruited through 1) online advertisements (e.g., Child Welfare League of America), and 2) postings on the Facebook pages of the National Association for Social Work and of chapter affiliates. Most responses, however, came from 3) announcements that were made to the Child Maltreatment Research Listserv (maintained by the National Data Archive on Child Abuse and Neglect, Cornell University), where members in the field forwarded the recruitment statement to workers and supervisors, and 4) through direct appeals emailed to the most appropriate and easily identified agency administrator in each state.

Individuals who responded to the solicitation were directed to the online survey, which was created using Survey Monkey. Potential participants were informed of their rights as a participant in the study, including that some of the questions may cause them distress. Individuals were assured that they could skip any questions that they liked and cease participation at any time. On the final page of the survey participants were given resources to national hotlines and websites where they could seek assistance for psychological distress should they need it after taking the survey. This study was approved by the Institutional Review Board at Bridgewater State University. Responses for the larger study were received from 493 CWWs; 452 surveys were complete enough to retain for analysis. The subsample for the current set of analyses is comprised of 123, as explained in the following section.

Participants

The overall purpose of this study was to assess workers' knowledge of risk for CMFs and to compare trauma symptomatology and practice orientations between CWWs who experienced a CMF with those who did not, and, of those who did, to describe their experiences related to the CMF. The following steps were taken to identify workers who experienced a CMF. At the start of the survey, participants were introduced to the topic of the study, given the definition that is used by the National Child Abuse and Neglect Data System: "For clarification, a child maltreatment fatality (CMF) is: a child dying from abuse or neglect, because either a) the injury from the abuse or neglect was the cause of death, or b) the abuse and/or neglect was a contributing factor to the cause of death". About one-third through the survey, participants were asked, "Have you ever had a child die who was on your caseload when you were either a frontline worker or supervisor for a county or state child protection/child welfare agency?" For those who answered "Yes," they

were presented with a question concerning the type of maltreatment from which the child died: medical neglect, physical abuse, physical neglect, psychological abuse, sexual abuse, and other. They were also asked a question pertaining to the individual who was responsible for the child's death: mother, father, step-mother/intimate partner of parent, step-father/intimate partner of parent, sister, brother, grandmother, grandfather, foster mother, foster father, child or daycare provider, unknown, and other—with an open field for text. In most instances, the responses concerning the manner of death and the individuals responsible were clear. In 54 instances, additional coding was required, which was performed by the researcher with the assistance of a former state child welfare administrator with 30 years of experience in the child welfare profession. First, 34 deaths were determined to be non-CMF and included instances of deaths due to car accidents, illness, suicide, etc. Second, five cases were coded as CMFs and primarily concerned instances of physical neglect, such as a young child drowning in a bathtub or pool without supervision. Third, 12 cases indicated that a fatality occurred, but did not provide further information. They were considered CMFs and retained for analyses. Fourth, in three instances CWWs provided information about the death, but did not indicate level of responsibility, such as "child drowned." These cases were excluded.

Of the 452 participants in this study, 445 answered the question pertaining to the death of a child client. Specifically, 43.4% (n = 193) had experienced the death of a child; in 7.5% cases (n = 34) the death was a non-CMF; 35.8% (n = 159) had dealt with a death that was a CMF; only 30.5% (n = 135) of the total sample provided enough information about their CMF experience to be retained for analyses. Finally, in 12 of those cases, the CMF was the impetus for opening a new case. Thus, 27.2% of the total sample experienced a CMF on an open, active case, which resulted in n = 123 cases that were retained for the subsample and analyses for this paper. The analyses presented on this subsample range from n = 105–123, due to missing data.

Table 1 displays current demographic information for the sample of workers who experienced a CMF. One-fifth (20.7%) of the predominantly female (89.8%) sample identified as a racial or ethnic minority, with the largest percent being African American/Black (12.5%). The sample had a mean age of 41.73; it was also well educated, with 36.6% reporting that they had a bachelor's degree and 61.8% had a master's degree. Only one respondent had an education level lower than this, with an associate's degree. The majority of the sample had a degree in social work (62.3%) or human services (4.9%). About one-quarter of the sample (23.8%) had a degree in another social science discipline; the rest of the sample (9.0%) had a degree in another field. The CWWs came from 27 different states, with large percentages of workers coming from California, North Carolina, Wisconsin, Louisiana, and New York. Almost three-quarters of the deaths occurred between 2000 and 2011. There were only five differences in the results based on whether the CMF occurred prior to 2000; CWWs were: 1) less likely to want to pursue a different treatment plan but were restricted by agency policy; 2) more likely to report having lost their job due to a CMF; 3) less likely to report still being a CWW; 4) younger, by four years when the CMF occurred; 5) and had worked 3.2 fewer years in child welfare.

Instrument and Analyses

The survey asked participants about their knowledge of risk factors for CMF, attitudes about CMFs, training, and practice behaviors concerning CMFs and their experiences with having a child die on their caseload. The survey also included an assessment of their practice behaviors, a measure of their trauma symptomatology, and demographic questions. The survey questions were developed from a review of the literature (see Douglas, 2005; Graham, Stepura, Baumann, & Kern, 2010) and in consultation with a child welfare practitioner with 15 years experience in the field and with expertise in CMFs. The survey was pretested on a small sample of caseworkers and supervisors in Massachusetts and Texas before full implementation.

TABLE 1
Demographic Characteristics of Study Participants and Independent Variable Predicting Fatality on Caseload

Demographic characteristic	*Exp. CMF on active caseload percent/mean (SD)*
Age—Mean (SD)	44.85 (10.40)
Gender—Male (percent)	14.8
Race/ethnicity	
Any Minority	20.7
American Indian	—
Asian	1.0
African American/Black	12.5
Latino/Hispanic	6.7
Pacific Islander	0
White	82.7
Education	
Associate's degree	2.6
Bachelor's degree	36.6
Master's degree	61.8
Area of specialization	
Social work	62.3
Human services	4.9
Other social science field	23.8
Other	9.0
Region of employment	
North (CT, ME, MA, NY, PA)	10.6
Midwest (IL, IN, MI, ND, OH, WI)	20.3
South (AL, DC, GA, LA, MD, NC, OK, TX, VA, WV)	41.5
West (AK, CA, CO, OR, WA, WY)	27.6
Year that CMF occurred	
1970–1989	4.1
1990–1999	18.7
2000–2009	61.8
2010–2011	11.4

This paper concerns the experiences of CWWs who experienced a CMF on their caseload. The workers were asked to report about their age, level of education, and educational specialization at the time of the fatality. Workers were also asked to report on the number of cases they managed when the child died; the length of time that the case was on his/her caseload before the CMF, which was coded in months; and the number of years that they worked in child welfare before this particular child died. Comparisons were made between frontline workers and supervisors using the nonparametric comparison of median test. If workers had experienced more than one CMF, they were asked to report on the most recent fatality to ensure the most accurate recall of data. All of the remaining questions pertaining to experiences with CMFs asked CWWs to rate the extent to which they agreed with each statement on a scale of 1–4, where 1 = strongly disagree and 4 = strongly agree, but were dichotomously grouped for analyses in this paper, into Strong Disagree/Disagree = 0 and Strongly Agree/Agree = 1. There were three areas concerning workers' experiences with CMFs: 1) the approach to handling the case before the fatality, 2) support provided after the fatality, and 3) the aftermath of the fatality. Questions pertaining to the approach before the fatality included statements such as, "I received appropriate guidance on managing the case," "At the time, I felt confident in handling this case," and "I wanted to pursue a different treatment plan with this family,

but our agency policy did not permit it." Questions pertaining to the support provided after the fatality included statements such as "My department/agency offered me support/therapy after this child died," "This support/therapy was helpful," and "My co-workers provided me with emotional support after this child died." Questions pertaining to the aftermath of the CMF included statements such as "I worried about losing my job after this child died," "I asked for a leave of absence after this child died," and "The bureaucratic process that took place after this child died was a source of stress for me." For all of these questions, results are presented for the total sample who experienced a fatality and for frontline workers and supervisors, along with significance testing between the latter two groups. Finally, workers who experienced a CMF were also asked, "Please tell us how else having this child die affected your personal or professional life." These responses were coded by a graduate research assistant under the supervision of the author, using content analysis. We developed codes for similar responses and then consolidated responses into categories.

RESULTS

Case and Worker Characteristics at Time of Maltreatment Fatality

Table 2 presents descriptive information about workers and case characteristics *at the time that the fatality occurred*, by the total subsample, as well as a comparison between frontline workers and supervisors. CWWs reported that: they had a median of 25 families on their caseload when the child died (range = 1–500); the child had been on their caseload a median of 2 months before the death (range = .25–24.0); and that they worked in the child welfare profession a median of 6 years (range = 0.25–32.0) before the death. CWWs were about 38 years old at the time of the child's death, with supervisors 6 years older than frontline workers. There was a significant difference between frontline workers and supervisors on all of these characteristics. At the time of the child's death, about half of the workers had a college degree (45.9%) and half had a master's degree (52.5%); over one-half (59.4%) had a degree in social work. And only 11.4% had a degree outside the social sciences. There were no educational differences between frontline workers and supervisors.

Child Welfare Workers' Experiences with Maltreatment Fatalities

Table 3 presents the results of workers' experiences with a CMF on one's caseload by topic area for the total subsample as well as for frontline workers and supervisors. The majority reported confidence in their handling of the case: 77.6% reported that they received appropriate guidance on the case, 84.1% reported that they had felt confident in handling the case, and only a minority (10.3%) of the sample reported wanting to pursue a different plan but could not because of agency policy or state/county policy. Supervisors were much more likely to report having received appropriate guidance managing the case leading up to the death (90.0% versus 70.3%). There were no statistically significant differences between frontline workers and supervisors.

Workers reported mixed responses to the support that they received after the CMF. Less than half of the sample (44.6%) reported that their agency offered therapy after the CMF, although this formal support was more likely to be offered to supervisors than frontline workers (57.5% versus 35.0%, $p \leq .05$). Of those who were offered therapy (n = 45), only about half (57.8%) reported using it, but those who did found it to be helpful (91.7%). Only 15.0% reported feeling as though they had to use the therapy even though they did not want to. Four out of five workers (80.2%) reported feeling supported by their coworkers, and more than two-thirds (69.4%) reported feeling supported by their supervisors. There were no other differences between frontline workers and supervisors.

CWWs reported about the circumstances that took place after the death of their client. One-third (30.0%) reported worrying that they would lose their job, and another one-third (30.0%) reported

TABLE 2
Worker and Case Characteristics at Time of Child Maltreatment Fatality by Total, Frontline Workers, and Supervisors (n = 105–123)

	Mean (SD)/Median/Percent			
Variable	*Total CWWs experienced CMF*	*Frontline CWW experienced CMF*	*Supervisor experienced CMF*	*Difference between worker & supervisor t/χ^2*
Case work information				
Number of cases on caseload[1]	25	20	90	25.290***
Number months on caseload[1]	2	2	3	7.488**
Number year in child welfare profession[1]	6	4	13	31.572***
Worker age				
Age at time of death[2]	37.6 (9.24)	34.62 (7.34)	41.40 (9.47)	4.279***
Worker education: Level				1.854[a]
High school degree	0.9	0	0.8	
Associate's degree	0.8	0	0.8	
College degree	45.9	54.5	45.9	
Master's degree	52.5	45.5	52.5	
Worker education: Area of specialization				6.350[a]
Social work	53.7	42.6	53.7	
Human services	5.7	3.7	5.7	
Other social science	29.3	48.1	29.3	
Other area	11.4	5.6	11.4	

[1]Median; [2]Mean; [a]Cell sizes were insufficient to calculate chi[2] significance test; $p \leq .05$; $^{**}p \leq .01$; and $^{***}p \leq .001$.

that they seriously considered leaving their job. A small percent reported that they were placed on administrative leave (4.0%), asked for a leave of absence (3.0%), or were fired (2.2%). Almost three quarters (73.3%) reported that the bureaucratic process that followed the death was a source of stress for them; there was a trend that this was truer for supervisors than frontline workers (82.5% versus 66.7%, $p \leq .10$). Over one-quarter (26.7%) of the workers reported their current belief that the CMF was unavoidable—a belief that may also be more common among supervisors (35.7% versus 21.0%, $p \leq .10$). The CMF did not change the professional status of most workers in that 84.3% said that they still work for the same agency and 79.2% reported still being a child welfare worker. There were no differences between frontline workers and supervisors.

CWWs who experienced the death of a child were asked how else the CMF affected their professional or personal lives. Responses were coded into four categories:

1. Negative impact on professional life (n = 28, 22.7%), e.g., feel incompetent, ineffective, burned out. Example: "At first it made me question my abilities as a supervisor and whether I had missed signs that could have prevented the child's death. . . . [T]he agency then used the child's [sic] death as a 'training' on 'what not to do' or at least it felt that way."
2. Positive impact on professional life (n = 17, 13.8%), e.g., feeling motivated, supported by agency co-workers, more cautious about client safety. Example: "You become more cautious . . . It has made me look at assessments as family based instead of incident based."
3. Negative impact on mental health (n = 10, 8.1%), e.g., feeling hopeless, depressed, anxious. Example: "The death of a child and child welfare work in general is stressful and takes a toll on workers. I remember feel[ing] depressed, anxious and in some ways hopeless."
4. Negative impact on personal life (n = 21, 17.1%), e.g., having trouble "leaving work at work," impact on relationships with own family members. Example: "I am very protective

TABLE 3
Child Welfare Workers Experiences with Child Maltreatment Fatality on Caseload, by Total, Frontline Workers, and Supervisors, n = 101–120

	Percent agree or strongly agree/yes			
Question	*Total CWWs experienced CMF*	*Frontline CWW experienced CMF*	*Supervisor experienced CMF*	*Difference between worker and supervisor* χ^2
Approach to handling case before fatality				
Received appropriate guidance on managing case	77.6	70.3	90.0	6.068**
At time, felt confident handling case	84.1	81.3	88.1	.882
Worried about child/family; coworkers disagreed	12.3	11.3	14.3	0.234
Wanted to pursue different treatment plan, but agency policy did not permit it	10.3	12.5	7.1	.783[a]
Wanted to pursue different treatment plan, but state/county law did not permit it	10.3	14.1	4.8	2.359[a]
Support provided after fatality				
Department/agency offered me support/therapy after fatality	44.6	35.0	57.5	4.931*
Used therapy (n = 45)	57.8	71.4	47.8	2.530
Found this therapy to be helpful (n = 26)	91.7	100.00	81.8	2.579[a]
Felt had to use therapy even though did not want to (n = 40)	15.0	27.8	4.5	4.191[a]
Coworkers provided emotional support	80.2	76.7	85.0	1.042
Supervisors provided emotional support	69.4	67.2	74.4	.564
Aftermath of fatality				
Child's death was unavoidable	26.7	21.0	35.7	2.767
Worried about losing my job	30.0	28.3	32.5	.198
Seriously considered leaving my job	30.0	33.3	23.1	1.200
Department placed me on administrative leave	4.0	3.3	5.0	.174[a]
Asked for a leave of absence	3.0	5.0	0.0	2.062[a]
Lost my job	3.0	3.3	2.5	.057[a]
Bureaucratic process of death was source of stress	73.3	66.7	82.5	3.052
Work for the same agency as when child died	84.3	80.3	90.0	1.695
Still a child welfare worker	79.2	75.0	85.0	1.447

[a]Cell sizes were insufficient to calculate chi^2 significance test; ^$p \leq .10$; *$p \leq .05$; and **$p \leq .01$.

of my own children. I can't or don't leave them with anyone else or have a hard time keeping my 1-year-old at a daycare setting."

Supporting Workers in the Aftermath

Participants were also asked for their input on how to support workers who experience a CMF. The responses were coded into four categories, presented here in descending order of prevalence:

1. Provide emotional/legal support for worker (37.4%), e.g., voluntary/mandatory counseling, legal advice, peer/supervisor support. Example: "Openly discuss the death with staff involved, and provide support/counseling as needed."
2. Avoid blaming the CWW (16.0%). Example: "The analysis of what was known and why workers did what they did should be done with a learning focus instead of a blaming focus. Agencies like to take credit for successes, but they're not so eager to accept ownership of part of the problem . . . when a case results in a serious injury or death. The easiest thing is to blame an individual, then when that person is identified and punished by removal or transfer . . ."
3. Training prior to CMF (6.5%), e.g., better preparation, how to deal with secondary trauma. Example: "Prepare for the event prior through training and clinical supervision."
4. Administrative responses (4.1%), e.g., paid leave, reduced workload. Example: "Make sure to give the SW a short 'time out' from new cases and make referral to EAP."

DISCUSSION

The purpose of this study was to critically assess some of the perceptions that the public holds about child welfare workers and their experiences with CMFs: the characteristics of CWWs who suffered the fatality of a child client, the events leading up to the fatality, and their perceptions and experiences after the death. The results of this multi-state sample of CWWs who experienced a CMF indicated that workers were in their 30s and well trained. They felt confident in their handling of the case leading up to the CMF, felt supported by coworkers after the death, but most did not use formal, agency-based support such as counseling. Previous research has documented how a CMF can change an organization's culture (Cooper, 2005). This study provides new information about the common experiences of workers across states and agencies and how many public perceptions are inaccurate.

Worker Characteristics at Time of Fatality

Despite anecdotal evidence and in contrast to the hypotheses, CWWs were not inexperienced and uneducated about working with families at the time of the death of their client. Workers who had experienced a CMF had a median of 25 cases on their caseload, had carried the case that ended in a fatality on their load for a median two months, and had worked as a CWW for a median of six years. As expected, there were statistically significantly differences between frontline workers and supervisors in all of these areas, with supervisors having more cases and working longer in the profession. The numbers of cases that the workers were carrying are not grossly outside of what is recommended by the Child Welfare League of America, which states that frontline workers should not handle more than 17 cases, and that supervisors should not handle more than 85 cases (Child Welfare League of America, 1999). Frontline workers in this study had a median of three more cases than what is recommended, and supervisors exceeded guidelines by a median number of five. Additionally, with a mean age of 37.6, workers were not young. They were also well educated with

almost half having a college degree and another half with a master's degree. Finally, only 11% had a degree in a field outside of the social sciences, and close to 60% had a degree in social work or human services, indicating a strong educational foundation for doing child welfare work. It is possible that this survey did not reach those who may have been pushed out of the child welfare profession in the wake of a fatality, who might have been younger and less well educated. Outside of that possibility, the findings of this paper do not match many of the concerns that have been expressed about CWWs who have been associated with fatalities (Gelles, 2003; Washington State Children's Administration, 2008).

Handling of Case Prior to Fatality

A strong majority of the sample (78%–84%) felt confident in the handling of the case prior to the CMF. Workers felt that they received appropriate guidance, felt confident, had not worried about the child/family, and only a minority (10%–12%) reported wanting to pursue another course of action before the CMF. Supervisors felt especially confident in having received appropriate guidance on the case. There is little research that addresses worker confidence in practice decisions, and even less which addresses the prevalence of worker confidence. Instead, research has explored what factors are related to higher levels of worker confidence (Regehr, Bogo, Shlonsky, & LeBlanc, 2010; Strand & Bosco-Ruggiero, 2010) and revealed that beginning social workers report feeling at least moderately confident to engage in child welfare practice (Jones & Okamura, 2000). The findings do appear to be consistent with the public perception that the child welfare agencies are unable to recognize when a child is in danger of dying from maltreatment. This finding may speak to agency administrators about the importance of training and the ability to recognize risk factors for CMFs. It also suggests that there is a role for researchers in the need to assess workers' understanding of risk.

Support Provided After Fatality

Less than half of workers reported that their agencies provided them with therapy/support after the fatality, despite many of them voluntarily reporting that they felt distressed, burned out, unable to focus on their work, and insecure about their skills as a worker. This lack of formal support is surprising given the growing attention to "critical incidents" in the workplace (Attridge & VandePol, 2010; Declercq, Meganck, Deheegher, & Van Hoorde, 2011), secondary trauma among child welfare professionals (Bride, Jones, & MacMaster, 2007; Dane, 2000; Horwitz, 2006), and the move to provide grief counseling when the death of a community member is unexpected (Thompson, 1995; Wenckstern & Leenaars, 1993). The lack of support could, in part, be explained by the fact that almost one-quarter of the deaths occurred before the year 2000, when formal supports may have been less likely to be in place. Formal support was offered to supervisors one-and-a-half times as often as it was to frontline workers. This may be because it is assumed that supervisors will provide support for frontline staff and thus supervisors need a different level of support. Of those who reported that therapy was available, just over half used this service. The vast majority of those individuals assessed it as helpful. Between 68%–80% of workers reported that their coworkers and supervisors were a source of support for them, which is consistent with previous research concerning coping with the death of a child client (Regehr et al., 2002).

Workers still noted the desire for additional emotional and legal support from their agencies, an important role for agency administrators, usually in the form of supervision, agency-funded counseling, and guidance regarding being sued and other matters that might arise during a trial that follows a CMF. Future research should explore the extent to which workers are provided with formal assistance, potential resistance to using this support, and its effectiveness in preventing emotional distress.

Aftermath of a Child Maltreatment Fatality

Finally, over a quarter of the sample (27%) reported currently feeling that the CMF that occurred on their caseload was unavoidable. I conducted a follow-up set of analyses to examine if this response varied by the manner in which the child died (e.g., physical abuse versus physical neglect). Respondents were equally likely to say that the death could/could not have been avoided regardless of the how the child died. Believing that a child's death could not have been avoided may carry into practice techniques as a CWW and also may indicate a lack of confidence in the services that the system provides. This finding is likely related to the workers' reports that overall they felt confident in their assessment of the case prior to the CMF. It raises important questions about training for risk factors and the extent to which CWWs see themselves as agents of prevention.

High media attention to CMFs can leave workers who are involved with a CMF feeling uncertain about their job security (Cooper, 2005; Regehr et al., 2002). One-third of the CWWs in this sample reported either worrying about losing their jobs or seriously considered leaving their jobs, but only 3%–5% of respondents reported being placed on administrative leave after the death, asking for a leave of absence, or being fired. Readers should note that since this survey was most widely distributed by child welfare agency contacts, it may not have reached many individuals who have left the child welfare profession because of a child's death. Recruitment efforts were made to reach individuals who were still social workers, but working outside of child welfare. There was some success in reaching those outside of the profession: one-fifth of the sample that experienced a fatality reported that they were no longer child welfare workers. Finally, almost two-thirds of the respondents indicated that the bureaucratic process that followed the death of the child was a source of stress for them, but the majority of those who experienced a CMF on their caseload continue to work for the same agency as when the child died. Since another one-fifth of respondents indicated that they no longer work in child welfare, these individuals have likely been reassigned to other responsibilities within that same agency, such as adoptions or licensing.

Limitations

This study is not without limitations. First, it is based on a convenience sample of CWWs and is not representative of all workers nationwide or workers in their respective states. The sample is, however, similar to a national study of CWWs (Barth, Lloyd, Christ, Chapman, & Dickinson, 2008). Second, the workers who were recruited by agency directors or the workers themselves could have a special interest in CMFs, which may influence the findings. Third, this survey reached many more current than former child welfare workers. Thus, it could have reached individuals who were better prepared to handle fatalities and received better support from colleagues and their agencies, and did not reach those who were driven out or who resigned after a fatality. Fourth, the sample size is relatively small, which further limits the generalizability of the findings. Finally, the study required workers to recall events that in some instances may have happened years ago, potentially compromising their ability to accurately report information. Retrospective data collection is a well-accepted method in social sciences, especially involving a major, and potentially traumatic, life event (Arias, 2004; Derevensky & Deschamps, 1997; Finkelhor, Moore, Hamby, & Straus, 1997; Stevens & Higgins, 2002). Despite these limitations, this is the first study to address a sample of workers who experienced a CMF and provides new information to the literature and social work field about their common experiences and concerns.

Summary

In closing, this study calls into question some of the anecdotal evidence about child welfare professionals who experience the death of a child. Workers who experienced a CMF were not

overwhelming young, inexperienced, and uneducated about social work. In fact, workers who experienced a CMF on their caseloads had several years of child welfare experience. At the same time, workers did not perceive the cases where a fatality was suffered to be high risk cases and a quarter believed the death to be unavoidable. These findings, supported by additional research on this sample concerning worker knowledge of risk factors for CMFs (Douglas, forthcoming) suggests that child welfare administrators may want to increase training regarding the risk factors for CMFs. CWW professionals are the most likely group of service providers to come into contact with children and families at risk of suffering a CMF, which means that they are also the group of professionals most able to prevent fatalities. Providing CWWs with adequate training and knowledge of risk factors should be a part of our effort to prevent maltreatment-related fatalities.

In the aftermath of a fatality, workers reported using more informal than formal sources of support, which is likely related to the fact that formal supports were only offered about half of the time. At the same time, when asked, workers reported desiring more formal sources of support, usually funded by agencies: mandatory or voluntary counseling, paid time off, temporary reduction in caseload, and legal guidance when workers are being sued or involved in a criminal case following a CMF. In closing, this study raises many important areas that can be addressed by administrators and researchers, including workers' conceptualization of risk for a fatality, workers' desire for emotional and legal support following a death, and a more comprehensive understanding of the availability of and workers' use of such supports when a child dies.

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