



Child Abuse and Neglect Fatalities 2009: Statistics and Interventions

Despite the efforts of the child protection system, child maltreatment fatalities remain a serious problem.¹ Although the untimely deaths of children due to illness and accidents have been closely monitored, deaths that result from physical assault or severe neglect can be more difficult to track. The circumstances surrounding a child death, its investigation, and communication across all the disciplines involved make data collection complex.

¹ This factsheet provides information regarding child deaths resulting from abuse or neglect by a *parent* or a *primary caregiver*. Other child homicides, such as those committed by acquaintances and strangers, and other causes of death, such as unintentional injuries, are not discussed here. For information about leading causes of child death, visit the Centers for Disease Control and Prevention website at <http://webapp.cdc.gov/sasweb/ncipc/leadcaus10.html>. Statistics regarding child homicide can be obtained from the U.S. Department of Justice at <http://bjs.ojp.usdoj.gov/content/homicide/children.cfm>.



How Many Children Die Each Year From Child Abuse or Neglect?

Unless otherwise noted, statistics in this factsheet are taken from *Child Maltreatment 2009* and refer to the Federal fiscal year (FFY) 2009 (U.S. Department of Health and Human Services, 2010).

The National Child Abuse and Neglect Data System (NCANDS) reported an **estimated 1,770 child fatalities in 2009**. This translates to a rate of 2.34 children per 100,000 children in the general population. NCANDS defines “child fatality” as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor.

The number and rate of fatalities have been increasing during the past few years. The national estimate is influenced by which States report data. For 2009, several States reported increased fatalities compared to FFY 2008, which resulted in a higher national estimate. The causes of the increases are not specifically identifiable, but several States that reported an increase in the number of child fatalities in 2009 explained in their State commentaries that the increase was the result of new legislation, new procedures, and better reporting.

Most data on child fatalities come from State child welfare agencies. However, States may also draw on other data sources, including health departments, vital statistics departments, medical examiners’ offices, and fatality review teams. This coordination of data collection contributes to better estimates.

Many researchers and practitioners believe that child fatalities due to abuse and neglect are still underreported. Studies in Nevada and Colorado have estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded as such (Child Fatality Analysis [Clark County], 2005; Crume, DiGuseppi, Byers, Sirotnak, & Garrett, 2002).

Issues affecting the accuracy and consistency of child fatality data include:

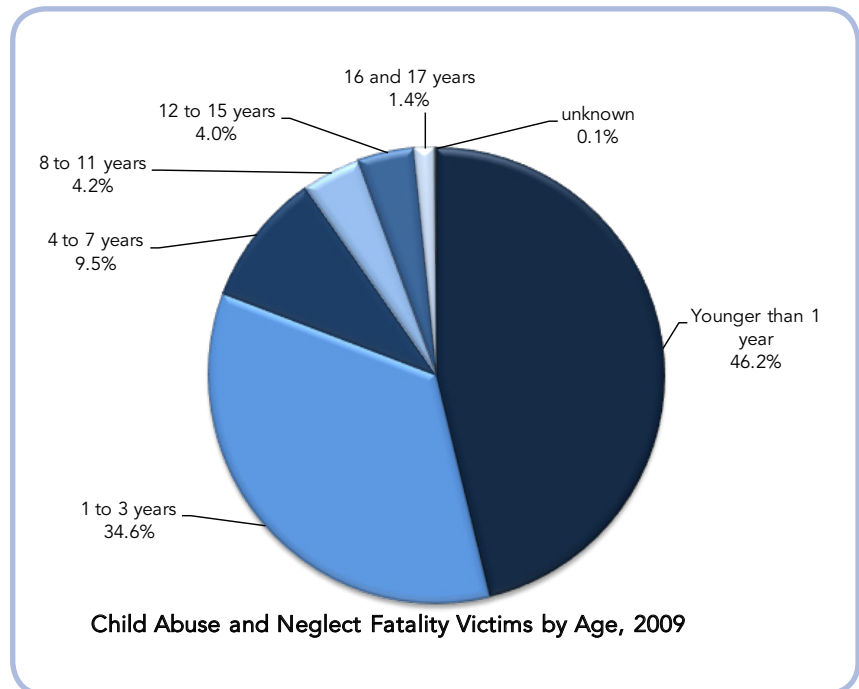
- Variation among reporting requirements and definitions of child abuse and neglect and other terms

- Variation in death investigation systems and training
- Variation in State child fatality review and reporting processes
- The amount of time (as long as a year, in some cases) it may take to establish abuse or neglect as the cause of death
- Inaccurate determination of the manner and cause of death, resulting in the miscoding of death certificates; this includes deaths labeled as accidents, sudden infant death syndrome (SIDS), or “manner undetermined” that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted (Hargrove & Bowman, 2007)
- Limited coding options for child deaths, especially those due to neglect or negligence, when using the *International Classification of Diseases* to code death certificates
- The ease with which the circumstances surrounding many child maltreatment deaths can be concealed or rendered unclear
- Lack of coordination or cooperation among different agencies and jurisdictions

A number of studies, including some funded by the Centers for Disease Control and Prevention, have suggested that more accurate counts of maltreatment deaths are obtained by linking multiple reporting sources, including death certificates, crime reports, child protective services (CPS) reports, and child death review (CDR) records (Mercy, Barker, & Frazier, 2006). A study of child fatalities in three States found that combining at least two data sources resulted in the identification of more than 90 percent of child fatalities ascertained as due to child maltreatment (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008).

What Groups of Children Are Most Vulnerable?

Research indicates that very young children (ages 4 and younger) are the most frequent victims of child fatalities. NCANDS data for 2009 demonstrated that children younger than 1 year accounted for 46.2 percent of fatalities; children younger than 4 years accounted for four-fifths (80.8 percent) of fatalities. These children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves.



How Do These Deaths Occur?

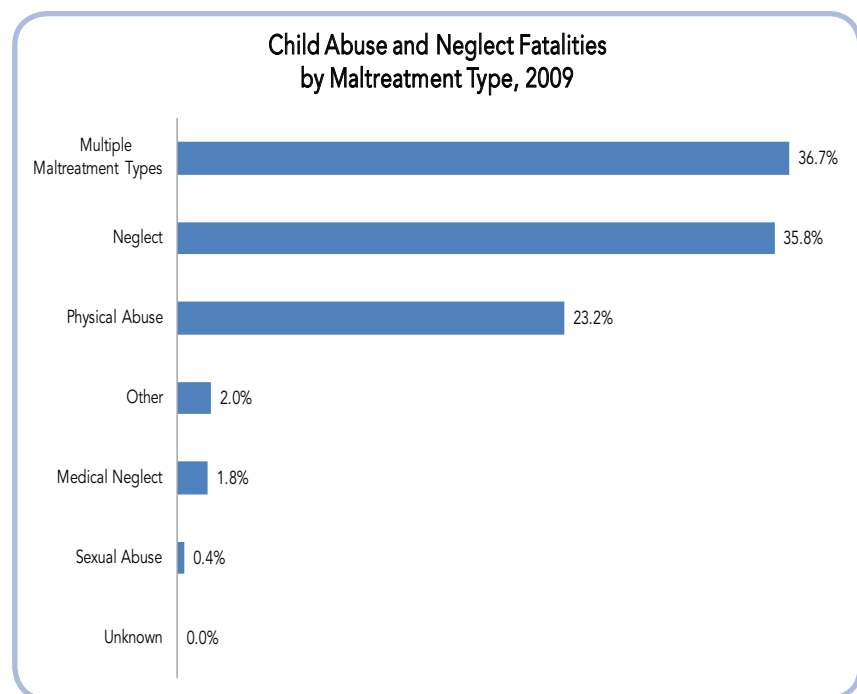
Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may involve a single, impulsive incident (e.g., drowning, suffocating, or shaking a baby). In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub).

In 2009, more than one-third of fatalities (36.7 percent) were caused by multiple forms of maltreatment. Neglect accounted for 35.8 percent and physical abuse for 23.2 percent. Medical neglect accounted for 1.8 percent of fatalities.

Who Are the Perpetrators?

No matter how the fatal abuse occurs, one fact of great concern is that the perpetrators are, by definition, individuals responsible for the care and supervision of their victims. In 2009, parents, acting alone or with another person, were responsible for 75.8 percent of child abuse or neglect fatalities. More than one-quarter (27.3 percent) of these fatalities were perpetrated by the mother acting alone. Child fatalities with unknown perpetrator relationship data accounted for 8.7 percent of the total.

There is no single profile of a perpetrator of fatal child abuse, although certain characteristics reappear in many studies. Frequently, the perpetrator is a young adult in his or her mid-20s, without a high school diploma, living at or below the poverty level, depressed, and who may have difficulty coping with stressful situations. In many instances, the perpetrator has experienced violence firsthand (Cavanagh, Dobash R. E.; Dobash, R. P.; 2007). Fathers and mothers' boyfriends are most often the perpetrators in abuse deaths; mothers are more often at fault in neglect fatalities.²



² Source: National Center for Child Death Review: www.childdeathreview.org/causesCAN.htm

How Do Communities Respond to Child Fatalities?

The response to the problem of child abuse and neglect fatalities is often hampered by inconsistencies, including:

- Underreporting of the number of children who die each year as a result of abuse and neglect
- Lack of consistent standards for child autopsies or death investigations
- The varying roles of CPS agencies in investigation in different jurisdictions
- Uncoordinated, non-multidisciplinary investigations
- Medical examiners or elected coroners who do not have specific child abuse and neglect training

To address some of these inconsistencies, multidisciplinary and multiagency child fatality review teams have emerged to provide a coordinated approach to understanding child deaths, including deaths caused by religion-based medical neglect. Federal legislation further supported the development of these teams in an amendment to the 1992 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), which required States to include information on CDR in their program plans. Many States received initial funding for these teams through the Children's Justice Act, from grants awarded by the Administration on Children, Youth and Families in the U.S. Department of Health and Human Services.

Child fatality review teams, which now exist at a State, local, or State/local level in the District of Columbia and in every State but one³, are composed of prosecutors, coroners or medical examiners, law enforcement personnel, CPS workers, public health-care providers, and others. Child fatality review teams respond to the issue of child deaths through improved interagency communication, identification of gaps in community child protection systems, and the acquisition of comprehensive data that can guide agency policy and practice as well as prevention efforts.

The teams review cases of child deaths and facilitate appropriate follow-up. Follow-up may include ensuring that services are

³ Idaho currently does not have a child death review program. For information about child fatality review efforts in specific States, visit the National Center for Child Death Review website at www.childdeathreview.org

provided for surviving family members, providing information to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems.

Most recent data show that 48 States have a case-reporting tool for CDR; however, there had been little consistency among the types of information compiled. This contributed to gaps in our understanding of infant and child mortality as a national problem. In response, the National Center for Child Death Review, in cooperation with 30 State CDR leaders and advocates, developed a web-based CDR Case Reporting System for State and local teams to collect data, and analyze and report on their findings. As of December 2010, 35 States were using the standardized system, and 6 more were in the process of joining it.⁴ The ultimate goal is to use the data to advocate for actions to prevent child deaths and to keep children healthy, safe, and protected.

Since its 1996 reauthorization, CAPTA has required States that receive CAPTA funding to set up citizen review panels. These panels of volunteers conduct reviews of CPS agencies in their States, including policies and procedures related to child fatalities and investigations. As of April 2010, 16 State CDR boards serve additional roles as the citizen review panels for child fatalities.

How Can These Fatalities Be Prevented?

When addressing the issue of child maltreatment, and especially child fatalities, prevention is a recurring theme. Well-designed, properly organized child fatality review teams appear to offer hope for defining the underlying nature and scope of fatalities due to child abuse and neglect. The child fatality review process helps identify risk factors that may assist prevention professionals, such as those engaged in home visiting and parenting education, to prevent future deaths. In addition, teams are demonstrating effectiveness in translating review

⁴ Arkansas, Indiana, Kentucky, Louisiana, Montana, and Utah are working to join the system. Alabama, Arizona, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin, and Wyoming are participating. (Source: National Center for Child Death Review)

findings into action by partnering with child welfare and other child health and safety groups. In some States, review team annual reports have led to State legislation, policy changes, or prevention programs (National Center for Child Death Review, 2007).

In 2003, the Office on Child Abuse and Neglect, within the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, launched a Child Abuse Prevention Initiative to raise awareness of the issue in a much more visible and comprehensive way than ever before. The Prevention Initiative is an opportunity for individuals and organizations across the country to work together to strengthen families and communities. Increasingly, this effort focuses on promoting protective factors that enhance the capacity of parents, caregivers, and communities to protect, nurture, and promote the healthy development of children.⁵

For more information, visit the Preventing Child Abuse & Neglect section of the Child Welfare Information Gateway website at www.childwelfare.gov/preventing

Summary

While the exact number of children affected is uncertain, child fatalities due to abuse and neglect remain a serious problem in the United States. Fatalities disproportionately affect young children and most often are caused by one or both of the child's parents. Child fatality review teams appear to be among the most promising current approaches to accurately count, respond to, and prevent child abuse and neglect fatalities, as well as other preventable deaths.

References

Child Fatality Analysis (Clark County). (2005). Retrieved January 31, 2011, from http://dhhs.nv.gov/DO_CD/PR_2005-12-01.pdf

Crume, T., DiGuseppi, C., Byers, T., Sirotnak, A., & Garrett, C. (2002). Underascertainment of child maltreatment fatalities by death certificates, 1990–1998. *Pediatrics*, *110*(2). Retrieved

⁵ The initiative's report, *Emerging Practices in the Prevention of Child Abuse and Neglect*, is available at www.childwelfare.gov/preventing/programs/whatworks/report

- January 31, 2011, from <http://pediatrics.aappublications.org/cgi/reprint/110/2/e18.pdf>
- Hargrove, T., & Bowman, L. (2007). Saving babies: Exposing sudden infant death in America. Scripps Howard News Service. Retrieved January 31, 2011, from www.scrippsnews.com/node/27463
- Mercy, J. A., Barker, L., & Frazier, L. (2006). The secrets of the National Violent Death Reporting System. *Injury Prevention*, 12(Suppl. 2), ii1–ii2. Retrieved January 31, 2011, from <http://dx.doi.org/10.1136/ip.2006.012542>
- National Center for Child Death Review. (2007). *Child death review findings: A road map for MCH injury and violence prevention; Part I* [PowerPoint presentation]. Retrieved January 31, 2011, from www.childrensafetynetwork.org/presentation/webinar.asp
- Schnitzer, P. G., Covington, T. M., Wirtz, S. J., Verhoek-Oftedahl, W., & Palusci, V. J. (2008). Public health surveillance of fatal child maltreatment: Analysis of 3 State programs. *American Journal of Public Health*, 98(2), 296-303. Retrieved January 31, 2011, from www.ncbi.nlm.nih.gov/pmc/articles/PMC2376893/pdf/0980296.pdf
- Thomas, D., Leicht, C., Hughes, C., Madigan, A., & Dowell, K. (2003). *Emerging practices in the prevention of child abuse and neglect*. Retrieved January 31, 2011, from www.childwelfare.gov/preventing/programs/whatworks/report
- U.S. Department of Health and Human Services, Children's Bureau. (2010). *Child maltreatment 2009*. Retrieved January 31, 2011, from www.acf.hhs.gov/programs/cb/pubs/cm09/index.htm

For More Information

National Center for Child Death Review

www.childdeathreview.org

The National Center for Child Death Review is a national resource center for State and local CDR programs, established and funded since 2002 by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services.

National Center on Child Fatality Review

www.ican-ncfr.org

The National Center on Child Fatality Review (NCFR) is a clearinghouse for the collection and dissemination of information and resources related to child deaths. NCFR is dedicated to providing training and technical assistance to CDR teams throughout the world.

National Citizens Review Panels

www.uky.edu/SocialWork/crp

The National Citizens Review Panels website is a virtual community containing information about each State's Citizens Review Panel, including annual reports, training materials, resources, sample review instruments, and other documents, as well as a discussion board.

National Fetal and Infant Mortality Review Program

www.acog.org/goto/nfimr

The National Fetal and Infant Mortality Review Program is a collaborative effort between the American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau. The resource center provides technical assistance on many aspects of developing and carrying out fetal infant mortality review programs.

Suggested Citation

Child Welfare Information Gateway. (2011). *Child abuse and neglect fatalities 2009: Statistics and interventions*. Washington DC: U.S. Department of Health and Human Services, Children's Bureau.