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Child Abuse and Neglect Fatalities: 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 because the perpetrators, usually parents, are less likely to be forthcoming about the circumstances. Intervention strategies targeted at solving this problem face complex challenges.

¹ This factsheet provides information regarding child deaths resulting from abuse or neglect by a *parent or 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 www.ojp.usdoj.gov/bjs/homicide/homtrnd.htm

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Unless otherwise noted, statistics in this factsheet are taken from *Child Maltreatment 2007* and refer to Federal fiscal year (FFY) 2007 (U.S. Department of Health and Human Services, 2009).

How Many Children Die Each Year From Abuse or Neglect?

The National Child Abuse and Neglect Data System (NCANDS) reported **an estimated 1,760 child fatalities in 2007**. This translates to a rate of 2.35 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.

With the exception of FFY 2005, the number and rate of fatalities have been increasing over the past 5 years. The national estimate is influenced by which States report data. For 2007, several States reported increased fatalities compared to FFY 2006, which resulted in a higher national estimate. To some degree, this can be attributed to improved data collection and reporting, but all the causes of the increase are not specifically identifiable.

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 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:

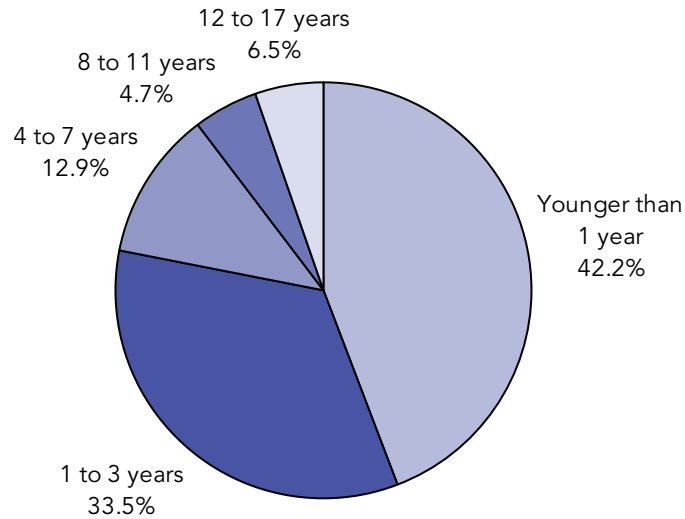
- Variation among reporting requirements and definitions of child abuse and neglect and other terms

- Variation in death investigative systems and in training for investigations
- Variation in State child fatality review 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
- 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).

What Groups of Children Are Most Vulnerable?

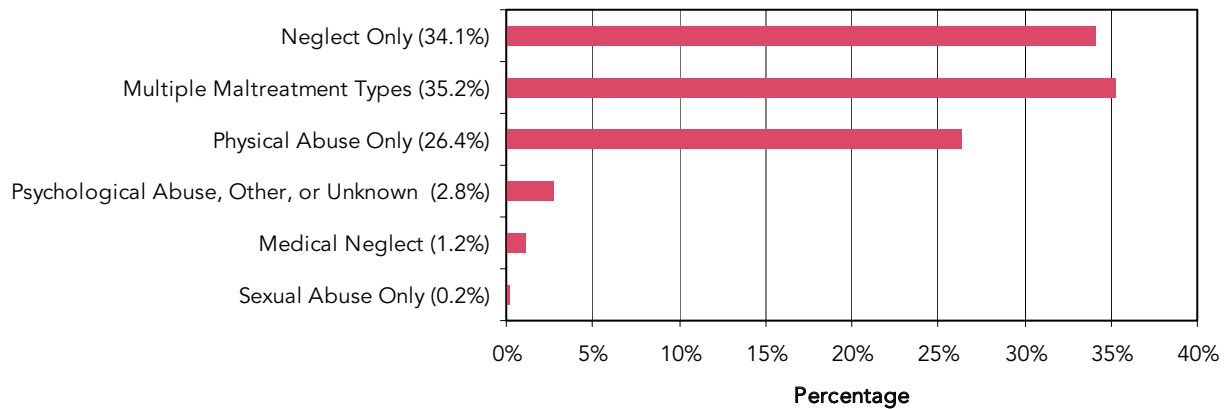
Research indicates that very young children (ages 3 and younger) are the most frequent victims of child fatalities. NCANDS data for 2007 demonstrated that children younger than 1 year accounted for 42.2 percent of fatalities, while children younger than 4 years accounted for more than three-quarters (75.7 percent) of fatalities. These children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves.

Child Abuse and Neglect Fatality Victims by Age, 2007

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 2007, slightly more than one-third of fatalities (35.2 percent) were caused by multiple forms of maltreatment. Neglect accounted for 34.1 percent and physical abuse for 26.4 percent. Medical neglect accounted for 1.2 percent of fatalities.

Child Abuse and Neglect Fatalities by Maltreatment Type, 2007

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 2007, one or both parents were responsible for 69.9 percent of child abuse or neglect fatalities. More than one-quarter (27.1 percent) of these fatalities were perpetrated by the mother acting alone. Child fatalities with unknown perpetrators accounted for 16.4 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. Most fatalities from *physical abuse* are caused by fathers and other male caregivers. Mothers are most often held responsible for deaths resulting from *child neglect* (U.S. Advisory Board on Child Abuse and Neglect, 1995).

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 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 multi-agency 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 one², 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 provided for surviving family members, providing information

² 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

to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems.

As of April 2008, 47 States had a case-reporting tool for CDR; however, there is little consistency among the types of information compiled. This contributes 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 April 2008, 22 States were using the standardized system and one more was in the process of implementing it.³ 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 evaluations of CPS agencies in their State, including the policies and procedures related to child fatalities and investigations. As of April 2008, 11 State CDR boards also serve as 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 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,

³ Minnesota is working to implement the system. Arizona, California, Delaware, Hawaii, Iowa, Massachusetts, Michigan, Nebraska, Nevada, New Mexico, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, West Virginia, Washington, Wisconsin, and Wyoming are participating. (Source: National Center for Child Death Review)

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 groups 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. 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.

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For More Information

National Center for Child Death Review

Phone: 800.656.2434

Email: info@childdeathreview.org

Website: 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

Phone: 626.455.4586

Website: www.ican-n CFR.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

Phone: 859.257.2690

Email: bljone00@uky.edu@uky.edu

Website: 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

Phone: 202.863.2587

Email: nfimr@acog.org

Website: 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.

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Public reporting burden for this collection of information is estimated to be 5 minutes per response to complete this questionnaire. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0970-0303. The control number expires on 09/30/2011.

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- Other organization's website or publication
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