

Child Abuse and Neglect Fatalities 2018: 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 are closely monitored, deaths that result from physical abuse or severe neglect can be more difficult to track. This factsheet describes data on child fatalities and how communities can respond to this critical issue and, ultimately, prevent these deaths.

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 deaths nationally from 1999 to 2017, visit the [Centers for Disease Control and Prevention website](#). Statistics on child homicide from 1980 to 2011 can be obtained from the U.S. Department of Justice.

WHAT'S INSIDE

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Unless otherwise noted, statistics in this factsheet are taken from the Children's Bureau's [Child Maltreatment 2018](#) and refer to Federal fiscal year (FFY) 2018. Statistics refer to the year in which the deaths were determined to be from maltreatment; in some cases, this may have been different from the year in which a child actually died.

HOW MANY CHILDREN DIE EACH YEAR FROM CHILD ABUSE OR NEGLECT?

According to data from the National Child Abuse and Neglect Data System (NCANDS), 51 States reported a total of 1,738 fatalities.² Based on these data, a nationally estimated 1,770 children died from abuse or neglect in FFY 2018, a slight increase from the FFY 2017 number of 1,720. However, it is 11.3 percent more than the FFY 2014 number of 1,590. This translates to a rate of 2.39 children per 100,000 children in the general population and an average of nearly 5 children dying every day from abuse or neglect. 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 reported by States have fluctuated during the past 5 years. The national estimate is influenced by which States report data as well as by the U.S. Census Bureau's child population estimates. Some States that reported an increase in child fatalities from 2012 to 2013 attributed it to improvements in reporting after the passage of the Child and Family Services Improvement and Innovation Act (P.L. 112-34), which passed in 2010.

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, law enforcement, 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 underreported (Schnitzer, Gulino, & Yuan, 2013). The following issues affect the accuracy and consistency of child fatality data:

- 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

² The Children's Bureau received data from 51 States. Of those States, 44 reported case-level data on 1,485 fatalities, and 40 States reported aggregate data on 253 fatalities.

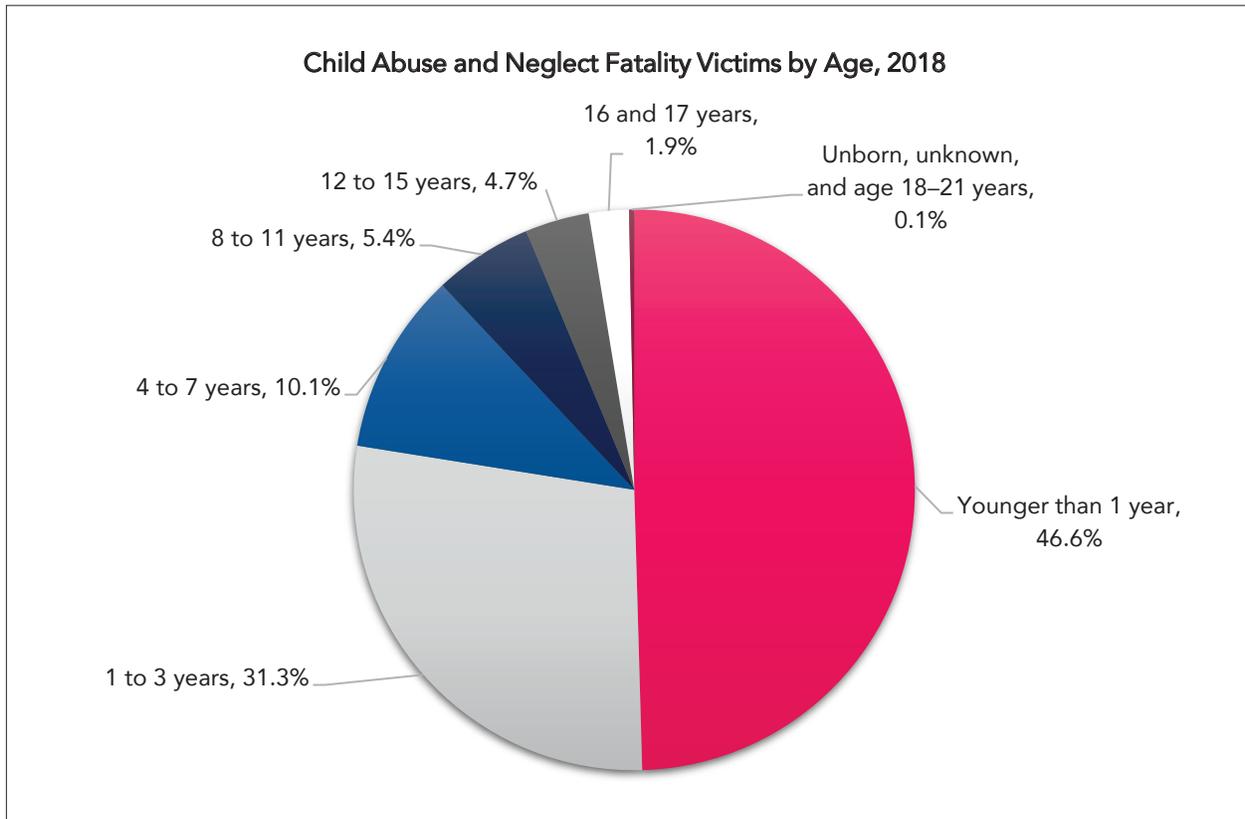
- The length of time (up to a year in some cases) it may take to establish abuse or neglect as the cause of death
- Inaccurate determination of the manner and cause of death, which results in the miscoding of death certificates and includes deaths labeled as accidents, sudden infant death syndrome, or undetermined that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted
- 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 report by the U.S. Government Accountability Office (2011) that assessed NCANDS data, surveys, and interviews with State child welfare administrators and practitioners and site visit reports from three States suggests that facilitating the sharing of information and increased cooperation among Federal, State, and local agencies would provide a more accurate count of maltreatment deaths. 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 being due to child maltreatment (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008).

WHAT GROUPS OF CHILDREN ARE MOST VULNERABLE?

Almost three-quarters (70.6 percent) of child fatalities in FFY 2018 involved children younger than 3 years, and children younger than 1 year accounted for 46.6 percent of all fatalities. See exhibit 1 for additional data about the age of fatality victims. Young children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves.

Exhibit 1

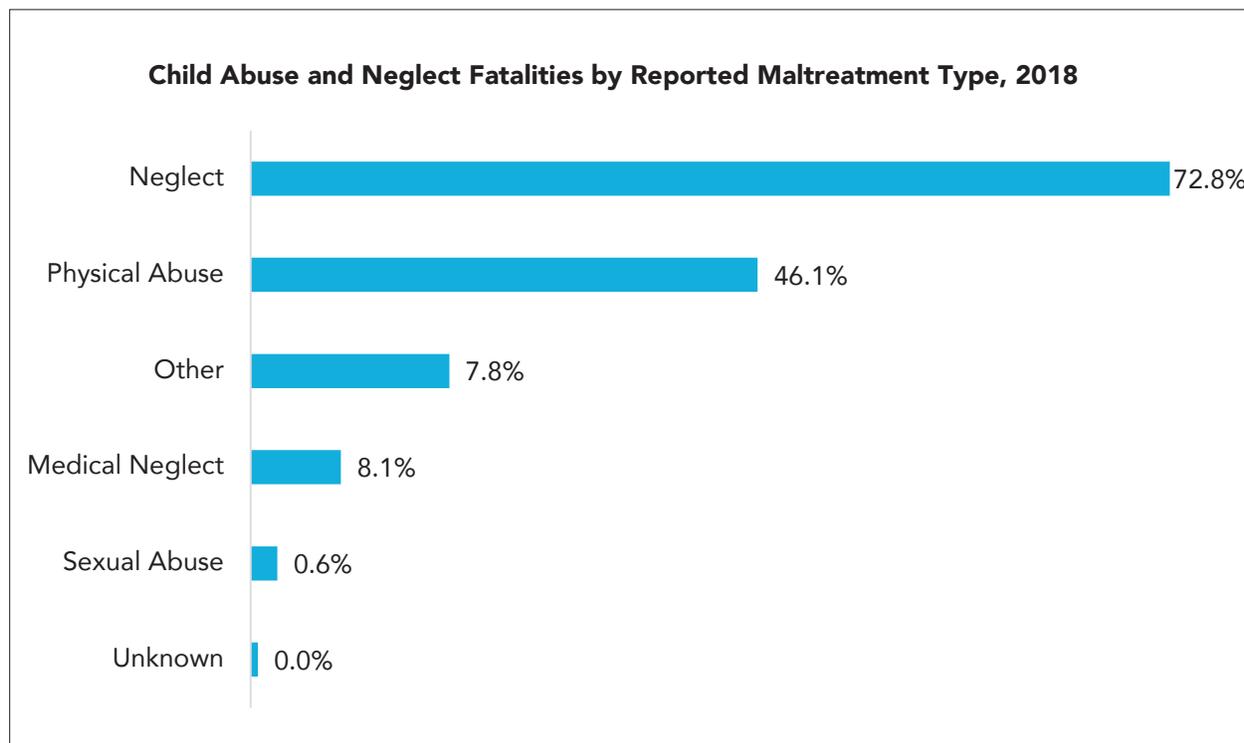


HOW DO THESE DEATHS OCCUR?

Fatal child abuse may involve repeated abuse over a period of time, or it may involve a single, impulsive incident (e.g., drowning, suffocating, shaking a baby). In cases of fatal neglect, the child's death does not result from anything the caregiver does; rather, it results 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 2018, 72.8 percent of children who died from child maltreatment suffered neglect either alone or in combination with another maltreatment type, and 46.1 percent of children who died suffered physical abuse either alone or in combination with other maltreatment. Medical neglect either alone or in combination with another maltreatment type was reported in 8.1 percent of fatalities. See exhibit 2 for additional information about fatalities by maltreatment type.

Exhibit 2



Note: The total of the percentages exceeds 100 percent because fatalities may involve more than one type of maltreatment.

WHO ARE THE PERPETRATORS?

In 2018, parents—acting alone or with another parent or individual—were responsible for 80.3 percent of child abuse or neglect fatalities. More than one-quarter (26.8 percent) of fatalities were perpetrated by the mother acting alone, 16.4 percent were perpetrated by the father acting alone, and 22.1 percent were perpetrated by the mother and father acting together. Nonparents (including kin and child care providers, among others) were responsible for 14.6 percent of child fatalities, and child fatalities with unknown perpetrator relationship data accounted for 5.1 percent of the total.

HOW DO COMMUNITIES RESPOND TO CHILD FATALITIES?

The response to child abuse and neglect fatalities is often hampered by inconsistencies and other issues, including the following:

- Underreporting of the number of children who die each year as a result of abuse or neglect
- Lack of consistent standards for child autopsies or death investigations
- Varying investigative roles of child protective services (CPS) agencies in different jurisdictions
- Uncoordinated, nonmultidisciplinary investigations
- Medical examiners or elected coroners who do not have specific child abuse and neglect training

To address some of these issues, 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. The development of these teams was further supported in an amendment to the 1992 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), which required States to include information on child death review (CDR) in their program plans. Many States received initial funding for these teams through Children's Justice Act grants awarded by the Administration on Children, Youth and Families of the U.S. Department of Health and Human Services (HHS).

Child fatality review teams, which exist at the State, local, or combination State/local levels in every State plus the District of Columbia, 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 by improving interagency communication, identifying gaps in community child protection systems, and acquiring 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 to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems.

Recent data show that 48 States have a case-reporting tool for CDR; however, there has been little consistency among the types of information compiled. This contributes to gaps in the understanding of infant and child mortality as a national problem. In response, the National Center for Fatality Review and Prevention, in cooperation with 30 State CDR leaders and advocates, developed a web-based CDR Case Reporting System for State and local teams to use to collect data and analyze and report on their findings. As of February 2019, 45 States were using the standardized system.³ As more States use the system and the number of reviews entered into it increase, a more representative and accurate view of how and why children die from abuse and neglect will emerge (Palusci & Covington, 2013). The ultimate goal is to use the data to advocate for actions to prevent child deaths and to keep children healthy, safe, and protected. (For more information about child fatality review efforts in specific States, visit the National Center for Fatality Review and Prevention at <https://www.ncfrp.org/>).

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 December 2018, 16 State CDR boards serve additional roles as the citizen review panels for child fatalities.³

³ Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. (source: National Center for Fatality Review and Prevention)

⁴ Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Michigan, Missouri, New Jersey, North Dakota, Oklahoma, South Carolina, Texas, Virginia, Wisconsin, and Wyoming (source: National Center for Fatality Review and Prevention)

HOW CAN THESE FATALITIES BE PREVENTED?

The following strategies and initiatives offer a variety of approaches to the prevention of child fatalities as well as child maltreatment in general.

Child fatality review teams. Well-designed child fatality review teams appear to offer hope for defining the underlying nature and scope of fatalities due to child abuse or 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. The information and recommendations generated by the review teams may also help influence policymakers.

Data collection and analysis. Some States have begun to integrate CPS data with other data to help identify high-risk families and provide prevention services before maltreatment happens (Putnam-Hornstein, Wood, Fluke, Yoshioka-Maxwell, & Berger, 2013). Integrating data from birth certificates, emergency room visits, and other social services sectors with CPS data and then analyzing those data for trends in risk may also help child welfare professionals make better informed decisions about prevention (Putnam-Hornstein et al., 2013). Users of the CDR Case Reporting System can record their recommendations to prevent future deaths. Examples of recommendations entered into the system include improved multiagency coordination policies for death investigations; improvements in CPS intake, referral, and case-management procedures; intensive home visiting; worker training; and improved judicial practices (Palusci & Covington, 2013).

Public health approach. A number of experts have championed a public health approach to addressing child maltreatment fatalities, which focuses on improving the health and well-being of individuals and communities before child maltreatment happens (Richmond-Crum, Joyner, Fogerty, Ellis, & Saul, 2013). Specifically, a public health approach involves defining the problem, identifying risk and protective factors, understanding consequences, and developing prevention strategies (Covington, 2013). Additionally, a public health approach engages the entire community in preventing child maltreatment and ensuring that parents have the support and services they need before abuse or neglect occur.

Improved training. Researchers have noted the need for better training for child welfare workers in identifying potentially fatal situations. Current child welfare training curricula do not always address child maltreatment fatalities. A recent study of preservice child welfare training curricula in 20 States found that only 10 States even mentioned child maltreatment fatalities and that only 1 State included a full section on the topic (Douglas, Mohn, & Gushwa, 2014). Given the complex nature of child maltreatment, training should go beyond the use of tools and assessments to include good critical thinking and decision-making skills (Pecora, Chahine, & Graham, 2013).

Federal initiatives. The Federal Government has a long history of promoting prevention. The first National Child Abuse Prevention Week, declared by Congress in 1982, was replaced the following year with the first National Child Abuse Prevention Month. Other activities followed, including a 1991 initiative by Louis W. Sullivan, M.D., the Secretary of HHS, which was designed to raise awareness

and promote coordination of prevention and treatment. In 2003, the Office on Child Abuse and Neglect, which is within the Children's Bureau of the HHS Administration for Children and Families, launched a child abuse prevention initiative that included an opportunity for individuals and organizations across the country to work together. This ongoing initiative also includes the publication of an [annual resource guide](#). 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 about prevention, visit the [Preventing Child Abuse & Neglect](#) section of the Child Welfare Information Gateway website. For more resources and tools to help prevent child abuse and neglect, visit the [National Child Abuse Prevention Month website](#).

SUMMARY

While the exact number of children affected is uncertain, child fatalities due to abuse or neglect remain a serious problem in the United States. Fatalities due to child maltreatment disproportionately affect young children and most often are caused by one or both of the child's parents. One of the most promising approaches to curtailing child fatalities is review teams, which can help communities accurately count, respond to, and prevent these as well as other avoidable deaths.

ADDITIONAL RESOURCES

[National Center for the Review and Prevention of Child Deaths](#)

The National Center for Fatality Review and Prevention is a resource center for State and local CDR programs. The HHS Maternal and Child Health Bureau established the center in 2002 and has funded it ever since. The [State map tool](#) provides links to CDR reports for each State.

[National Center for Fatality Review and Prevention](#)

This 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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SUGGESTED CITATION:

Child Welfare Information Gateway. (2020). *Child abuse and neglect fatalities 2018: Statistics and interventions*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.



U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau



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