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Reducing Child Fatalities Through a Team Approach

By Susan Broderick, J.D.¹

Scope of the Problem

An estimated 2,000 children die from abuse and neglect each year. Approximately 40% of those children are under one year old, and the majority are under five years old.² It has been estimated that in the 42 years since Dr. C. Henry Kempe first described the Battered Child Syndrome, more children have died from abuse and neglect than from urban gang wars, AIDS or measles.³ Our society has made great strides in improving other health and safety conditions that in many instances cause untimely deaths, e.g., through immunization efforts and DWI campaigns. However, the public attention and commitment given to the deaths of children due to abuse and neglect by caregivers remain inadequate.

The aforementioned numbers are conservative estimates, and even those statistics do not fully explain the true extent of the problem. Many child fatalities have been systematically misidentified due to inadequate training, insufficient resources, poor inter-agency communication and lack of cooperation among the parties involved in responding to these cases. As a result, agencies that gather and collect information on child deaths find it difficult to obtain an accurate view as to how, why and which children are dying.⁴ The prevention of child fatalities requires not only a commitment to understanding the facts and circumstances surrounding child deaths, but a

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unified approach as well. This realization has led to the development of child fatality review teams.

The Fatality Review Team Approach

Child fatality review teams are multidisciplinary panels that review the medical, social, legal and agency factors surrounding the death of a child. By evaluating circumstances and events, teams are better able to identify gaps or breakdowns in agency services, review existing protocols and recommend revisions in agency investigation procedures. The ultimate goal is to identify effective intervention and preventive measures to decrease the number of preventable deaths.

Historically, the investigation and review of infant fatalities was handled by various agencies working in isolation. The first child death review teams began in the late 1970s and early 1980s in California, Oregon and South Carolina. In 1978, under the direction of Dr. Michael Durfee, a child psychiatrist, a team in Los Angeles developed the first large-scale program reviewing all child fatalities. The hope was that the combined effort of different perspectives might help identify child abuse cases that would otherwise fall through the cracks by establishing a uniform set of criteria for labeling child deaths as homicides. The success of this idea was apparent early on. Within the first five years of operation, the cause of death in seven child fatalities was reclassified from “natural or accidental” to “death at the hands of another,” and another case was changed from “homicide” to “natural death.”⁵

By the late 1980s, grassroots efforts across the country led to a rapid increase in the number of review teams in states and communities. A landmark study of Missouri child deaths, published in the *Journal of Pediatrics*, highlighted the extent of underreporting of maltreatment fatalities and the success of retrospective reviews in identifying these deaths.⁶ As child fatality

review programs expanded across the country, the American Bar Association's Center on Children and the Law provided training and support materials to teams. The American Academy of Pediatrics encouraged national implementation of fatality review programs as well.⁷ This year, the Department of Defense issued a policy that requires the review of all child deaths of active military personnel.⁸ Today, there are review programs in 49 states, Australia, New Zealand, Canada and England, all with the same common goal—to understand and prevent child deaths.

Although the composition of individual teams varies from state to state, most fatality review teams include certain core members, including a medical examiner/coroner, law enforcement officers, social services and/or child protective services representatives, public health officials, and prosecutors. Some teams have very broad membership bases, which include representatives from the medical community, emergency medical services, fire departments, community mental health, hospitals, local schools, and the child and victim advocate communities. Other teams invite ad hoc members when it appears that additional expertise is required based upon the nature of the case they are reviewing.

Throughout the country, teams operate on both the state and local level. Most state teams are organized to review local review team findings and to better identify systemic problems, promote state level communication and coordination and examine state child death trends. Often, state level teams make recommendations for policy and legislative changes. Local teams are usually more investigatory in nature and normally review cases on a regular basis pursuant to a standard protocol. Their purpose is to improve the investigation of child deaths, delivery of services and interagency communication, and to recommend local policies and practices that may prevent other deaths.

Reviews of cases are normally conducted in

one of two ways: The first and most common type is a periodic or retrospective review, conducted at least a month after the death and usually after the entire investigation has been completed. The second type is a parallel and more investigatory review, which occurs as soon as possible after death. This type of review allows for more timely and informed input into collection of data, determination of cause of death, protection of other siblings who may be at risk and provision of other appropriate services.

Current Challenges

Today, there is much consistency among the review programs in terms of purpose, goals and objectives. The basic tenet of these teams is a philosophy that through a comprehensive, multidisciplinary review of deaths, states and communities will better understand how and why children die and use these findings towards the prevention of future deaths. Despite the common goals and aims of these programs, however, there are a number of variations in how the process is implemented in different states and jurisdictions.

One of the biggest variables is the use and definition of operational terms involved in the process. Significant variations exist in the use and definition of terms such as “preventable” and “unexpected” and in the various death categories used. Similar variations also exist in the age ranges reviewed.⁹ Several states have expanded the review to include all child deaths (including accidental); others have created a standardized checklist to be used for all death scene investigations.¹⁰ While a certain amount of flexibility is necessary and expected among the different teams, these variations have led to the biggest challenge facing the programs nationwide—a lack of uniformity.

Although fatality review teams have been endorsed by various organizations across the country, including the American Academy of Pediatrics and the American Bar Association,

there are still no standardized national criteria for child death review, thus frustrating efforts to compare information across state and local lines. To improve coordination of efforts and communication among the various agencies, advocates have called for standardized data collection forms, integrated databases on a national level and the creation of a clearinghouse that would disseminate information about effective practices.¹¹ In fact, establishing national uniform standards and criteria for fatality review teams has been cited as the critical next step in ensuring the effectiveness of this death review process. Finally, child death review teams must always be vigilant in avoiding the 'buck passing' phenomenon that can occur when agencies reviewing a child death are all hoping to avoid responsibility for failing to protect the child in some way.

Additional Resources

Significant strides have been made over the past several years towards establishing a national network to support fatality review teams throughout the country. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) funds the Inter-agency Council on Child Abuse and Neglect (ICAN) in Los Angeles to serve as a resource for teams, with a focus on abuse and neglect deaths. The ICAN National Center on Child Fatality Review (NCFR), located in El Monte, California, under the direction of Dr. Michael Durfee, acts as a national clearinghouse by collecting and disseminating information and resources to review teams across the country.¹²

To expand the review process to include all preventable deaths, and to provide leadership and support to state review programs, the Maternal and Child Health Bureau of the Health Resources and Services Administration, Health and Human Services, founded the National MCH (Maternal and Child Health) Resource Center for Child Death Review in 2002. This Center, based out of the Michigan Public Health Institute, provides

training and technical assistance to help states review all deaths and to translate findings into state and local actions designed to prevent such deaths.¹³

In September 2003, the Center hosted a meeting of child fatality review coordinators from 46 states. These leaders are currently working through the Center to develop a national protocol and training manual, as well as a nationwide reporting system. The reporting system will use a standardized case report tool, a Web-based reporting system, and local, state and national data analysis to provide a more complete understanding of child deaths in America. The pilot for the system will be launched within a few months.

Conclusion

It appears the prevention of child fatalities is finally receiving the attention it deserves. Additionally, there is now broad agreement across the country that the reduction and prevention of child fatalities requires a clearer understanding of why these deaths occur and how they can be avoided in the future. Child fatality review teams have emerged as one of the most effective and promising preventive efforts in this area. A future Update article will discuss specific strategies being developed by the National MCH Resource Center for Child Death Review to improve the capacity of teams to prevent child deaths at the local, state and national levels.

¹ Senior Attorney, National Center for Prosecution of Child Abuse.

² U.S. Advisory Board on Child Abuse and Neglect. *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*. Washington DC: U.S. Department of Health and Human Services, 1995. (Chapter 3—Recommendations).

³ U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, Fact Sheet, April 2001, #12.

⁴ Durfee, M.J., Gellert, G.A., Tilton-Durfee, D., "Origins and Clinical Relevance of Child Death Review Teams,"

JAMA, 267 (1992): 3172–75.

5 Id.

6 Ewigman, B., Kivlahan, C. and Land, G. “The Missouri Child Fatality Study: Underreporting of Maltreatment Fatalities Among Children Younger than Five Years of Age, 1983–1986,” *Journal of Pediatrics*, February 1993: Volume 91, Issue 2: pages 330–37.

7 Policy Statement, *Journal of Pediatrics*, Volume 105, Number 5, Nov. 1999, pages 1158–1160.

8 US Department of Defense, Memorandum for Secretaries of the Military Departments, February 12, 2004.

9 Elster, N. R. and Alcade, M. G., “Child Fatality Review: Recommendations for State Coordination and Cooperation,” *Journal of Law, Medicine and Ethics*, Summer, 2003.

10 For more information regarding a standardized death scene checklist, contact Gus Kolilis, Deputy Director/STAT Chief, State of Missouri Department of Social Services, Division of Legal Services. (573) 751–1608 / http://www.ndaa-apri.org/publications/newsletters/update_volume_17_number_8_2004.html#.

11 Webster, R., Schnitzer, P., Jenny, C., Ewigman, B., Alario, A., “Child Death Review: The State of the Nation,” *American Journal of Preventive Medicine*, Volume 25, Number 1, 2003.

12 To request assistance or additional information from NCFR, call (626) 455-4586 or via the Internet at http://www.ndaa-apri.org/publications/newsletters/update_volume_17_number_8_2004.html#.

13 The National MCH Resource Center for Child Death Review can be reached at (517) 324-7330, or accessed via the Internet at http://www.ndaa-apri.org/publications/newsletters/update_volume_17_number_8_2004.html#.

**American Prosecutors Research
Institute**

99 Canal Center Plaza, Suite 510,
Alexandria, VA 22314

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