HISTORY AND STATUS OF CHILD DEATH REVIEW TEAMS: Not Mending Walls

—by Michael Durfee

Multi-agency, multidisciplinary, child death review teams have expanded rapidly in the last five years, essentially without money or mandate. The success or failure of team formation seems generally independent of laws and finance, in a way that reminds me of the Robert Frost poem, "Mending Walls." In "Mending Walls," Frost speaks about the propensity of nature to destroy the walls that separate us. In the poem, a man rebuilds the wall on his property line, following his father's adage that "walls make better neighbors." Multi-agency child death review teams are not begun so much as they already exist, and only need walls to be removed in order to function.

Multi-agency staff who are on or near the line seem naturally to know the value of working together. The death of a child creates pain that drives them to seek resources to temper the pain that comes from feeling alone with a tragedy. The impulse to create multi-agency teams is natural, sometimes concealed by agency "fathers" who have built walls to keep agencies "safe."

Among the lessons from these teams is that success seems to require a systematic multi-agency focus on the child deaths rather than a focus on monitoring the problems of a single agency.

To my knowledge, the first contemporary multi-agency team began in Los Angeles County in 1975 with the author of this paper. I realized that I may have seen children that had been suicide or homicide victims without my knowing it, and I set up a system to retrieve these cases from coroners' records. Eventually, a public health nurse with a background in child abuse joined me to review cases and to establish protocols for the review of potentially suspicious child deaths.

The nation's first multi-agency child death review team began in 1978, housed in the Los Angeles County Interagency Council on Child Abuse and Neglect (ICAN). ICAN has the unusual history of a strong county-wide multi-agency collaboration on child abuse since 1977. The team was initially chaired by representatives from mental health and child protective services, with members from the sheriff's office, the Los Angeles police, the district attorney's office, the coroner/medical examiner's office, the Department of Health, and ICAN.

Most deaths reviewed as possible child abuse/neglect were infants or young toddlers. The major cause of death was head trauma without weapons. Impoverished African-American families were overrepresented. Little has changed in the case profiles and member agency profiles since that first meeting. The major problem in case management was the failure of agencies to communicate or to follow their own protocols. Our first evidence that the system could change case outcome was in 1984, when a Los Angeles Deputy District Attorney reviewed cases from 1981 to 1983, helped change the designation of some cases from accidental and natural deaths to homicide, and sent people to prison.

To my knowledge, the second team was formed in San Diego County in 1982, chaired by child protective services and the District Attorney. By 1989, when the legislature passed a law making such teams permissive, California had about a dozen county-based teams. In the meantime, local child fatality review teams had mushroomed nationwide.

In 1985-86, teams formed in Oregon, South Carolina, and Boone County, Missouri. Oregon's team focused systematically on deaths of children and progressed to publication of the first multi-agency state report. South Carolina's team, formed by legislative mandate, focused more as a monitor of social services and has struggled some with interagency conflict. Boone County had a small, heroic "swat team" that would respond to assist agencies with deaths—the precursor of the first complete systematic state/local system in the nation. Among the lessons from these teams is that success seems to require a systematic multi-agency focus on the child deaths rather than a focus on monitoring the problems of a single agency.

Minnesota, Ohio (Franklin County), Colorado, Florida, Illinois (Cook County), Vermont, Georgia, and Iowa brought the total to 12 states with state and/or local teams in 1990. This rose to 29 states in 1992 and to 40 states, Washington, D.C., and the Department of Defense in December 1994. Teams are learning from each other through publications. Small, informal team reports were published in the early and mid-1980s. Los Angeles County, Colorado, and Oregon shared studies nationally between 1989 and 1994. About a dozen more state and local teams have joined to share their informally published work.

In addition, information about child fatalities is being shared in professional journals and at professional conferences. The National Center on Child Abuse and Neglect (NCCAN) and the National Committee to Prevent Child Abuse (NCPCA) sponsored the first national conference on fatal child abuse and neglect in 1985. Pennsylvania and the American Prosecutors Research Institute sponsored a National Conference on Child Homicide in 1987, bringing together different arms of the criminal justice system. Washington National Medical Center included a forum on fatalities at the National Child Abuse and Neglect Conference in 1988. The American Academy of Pediatrics, the National Association of Medical Examiners, the American Professional Society on the Abuse of Children (APSAC), the State of Missouri and others have made child abuse and neglect fatalities a topic at national conferences.

Journal citations have grown explosively in the last five years. "Shaken Baby Syndrome" and "Munchausen Syndrome by Proxy" have entered our vocabulary; physicians and investigators are more and more aware of the difficulties of distin-

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guishing SIDS from suffocation. In its last annual report, NCPCA published data on fatalities from 1985 to 1993. NCCAN has funded the National Child Abuse and Neglect Data System (NCANDS) that includes data on fatalities since 1990. The American Bar Association and American Academy of Pediatrics received a Robert Wood Johnson Grant in 1989-91 to build model documents for laws, policies, and protocols, and for building and implementing teams.

The popular press is beginning to recognize the phenomenon of abusive child fatalities as well. Mass media coverage on a national scale began with the death of Lisa Steinberg in 1987. The 1987 film "The Unquiet Death of Eli Creekmore" was followed by television news and documentaries, including "Who Killed Adam Mann?" in 1992. Popular books, including *From Cradle to Grave* and *A Death at White Bear Lake* have been joined by numerous publications on murders. The *Atlanta Constitution* was a finalist for the Pulitzer Prize for its coverage of child fatalities, which resulted in the Georgia state law in 1990. The Gannett News Service won the Pulitzer Prize for addressing child autopsies, and the *Chicago Tribune* won the Pulitzer Prize in 1994 (and APSAC's Outstanding Media Coverage Award) for a year-long series on violent child deaths. Many newspapers have done major stories on child abuse and neglect deaths.

What does the future hold? One hopes for a more elaborate system for the sharing of information.

A national system exists today, with a map of active teams and directories of state, national, and federal contacts maintained by ICAN since 1992. More states will start state and local multi-agency, multidisciplinary teams this year. All states may have such teams by the summer of 1995. This national system serves as the national "team" today.

What does the future hold? One hopes for a more elaborate system for the sharing of information. Cases will be managed across county, state, and national boundaries. Support systems for surviving siblings, other family members, and professionals will appear. Professional training will be more predictable and more formal. A national core database will develop. Severe child abuse and fatal domestic violence will be added to cases for review. The team focus will expand from suspicious deaths to all preventable deaths. Intervention following death will be surpassed by early intervention before death. Prevention programs will follow the young age of the victims with a focus on infants, young toddlers, and high risk pregnancies.

Instead of mending the walls that have separated us, we have been busy building bridges to each other. Let us continue our focus on this critical task, for the sake of everyone who is touched by child abuse and neglect fatalities.

Michael Durfee, MD, a child psychiatrist with the Los Angeles County Department of Health Services, helped to found the Los Angeles child death review team and has been instrumental in the creation of such teams around the US and world.

CHILD DEATH REVIEW TEAMS IN ACTION

—by Sheila M. Thigpen and Barbara L. Bonner

The last five years have seen an increasing focus on child deaths due to abuse and neglect. The National Committee to Prevent Child Abuse found a 49% increase in reports of child deaths by state CPS agencies since 1985 (McCurdy and Daro, 1993). Public hearings on child fatalities are currently being conducted throughout the United States by the U.S. Advisory Board on Child Abuse and Neglect. Despite this national attention, the actual incidence of child abuse deaths is poorly documented. It is unknown whether the increase in child deaths is due to a recent escalation in fatal violence against children or is the result of improved detection and documentation. What is known, however, is that approximately three children die each day as a result of abuse or neglect (McCurdy and Daro, 1993).

One response to the problem of abuse-related child fatalities has been the establishment of child death review teams at the state and/or local level. Currently, 39 states have state and/or local child death review boards or teams which investigate child abuse and neglect related deaths. This article will provide a brief overview of various approaches to the organization, structure, and review process currently being used by child death review boards in the U.S. and abroad.

The currently established boards are similar in that they focus on the investigation and prevention of child abuse related deaths; however, the operation of the boards varies across the United States and internationally. The main differences in state and/or local teams include (1) whether the teams are established by an informal agreement among professionals, by formal interagency agreements, or by legislation; (2) whether the teams review all child deaths or only those suspected of being caused by child maltreatment; and (3) the age range for the deaths reviewed. The review process is in the beginning stages in several countries, where the structure and operation of the teams appear to be similar to that of U.S. teams.

For the purpose of providing an overview of models of team functioning, the following sections briefly describe child death review team operations in Oklahoma, Colorado, Missouri, Canada, and Australia.

Oklahoma

The Oklahoma Child Death Review Board was created by legislation in 1991 and held its first state Board meeting in January, 1992. As mandated by law, the Board has the power and duty to (1) conduct case reviews of child deaths in Oklahoma; (2) develop accurate statistical information and identification of child deaths due to abuse and

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