History and Status of Child Death Review Teams

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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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neglect; (3) improve the ability to provide protective services to the siblings of abused or neglected children who may still be living in a dangerous environment; and (4) improve policies, procedures, and practices within the child protection system. The Board currently receives funding from the Children's Justice Act for administrative staff.

The Board is organized at the state level and is a multidisciplinary team comprised of 20 professionals from the district attorney's office; the departments of Health, Human Services, and Mental Health and Substance Abuse Services; the Indian Child Welfare Association; Oklahoma chapters of the ABA, NASW, AAP, APA, CASA, and Association of Osteopathic Physicians; the Office of Child Abuse Prevention; the Children's Hospital Child Protection Committee; the Foster Care Review Board; and the chief child abuse medical examiner, state epidemiologist, and state medical examiner.

The Board meets monthly and conducts retrospective reviews of all deaths of children under 18 years of age with the exception of fetal deaths and children who are born and die having never left the hospital. Board members are divided into four review groups, with each group containing at least one physician. Since its inception in 1992, the Oklahoma Child Death Review Board has (1) written and approved by-laws for its operation; (2) received training from the American Bar Association, Center on Children and the Law; (3) developed a standard data collection form; and (4) reviewed 420 cases of child deaths.

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.

Recommendations have been made on a yearly basis to the Oklahoma legislature, and an annual report has been distributed. Some of the Board's recommendations to the legislature are to (1) require death scene investigations for all suspected SIDS deaths; (2) increase training efforts for all law enforcement agencies and emergency medical teams; (3) increase public awareness regarding gun safety; and (4) target education efforts to teens on motor vehicle/motorcycle safety (Oklahoma Commission on Children & Youth and The Center on Child Abuse and Neglect, 1994).

Colorado

In contrast to Oklahoma's and Missouri's legislatively created Review Boards, Colorado's Child Fatality Review Committee (CFR) was formally established in 1989 by an interagency agreement between the State Department of Health and the Department of Social Services. While the lack of legislative mandate could potentially cause problems in obtaining relevant documents and information, this has not been problematic in Colorado.

Similar to Oklahoma's, the primary goals of the Colorado committee are to (1) describe trends and patterns of child deaths in Colorado; (2) identify and investigate the prevalence of risk factors which existed in the population of deceased children; (3) evaluate service and system responses to children and families who are considered to be at high risk and offer recommendations for improvement in those responses; (4) characterize high-risk groups in terms that are compatible with the development of public policy; and (5) improve sources of data by reviewing autopsies, death investigations, and death certificates.

As in Oklahoma and Missouri, the deaths of all children under 17 years of age receive some form of review at the state level. Children who die of natural causes (neonatal deaths, SIDS, and others) are referred for expert group review, while a CFR Clinical Subcommittee reviews the remaining child deaths. If any case is questioned by either an expert group or the Clinical Subcommittee, the case is submitted to the full CFR Committee for further review.

Membership of the CFR includes professionals from the Colorado Departments of Health, Social Services, Education, Transportation, and Criminal Justice; the Colorado Medical Society, Governor's office, General Assembly, SIDS Program, Domestic Violence Coalition, District Attorney's Council, Coroner's Association, the University Health Sciences Center, Children's Hospital, and Kempe Center; and local health, coroner's, sheriff's, and police departments.

The CFR Committee has developed a standard data form to assist in the collection of specific child fatality information. On the form, the CFR members document (1) if the cause and manner of death are complete and adequate on the death certificate; (2) presence of such conditions as congenital anomalies or other medical problems; (3) quality and access to medical care; (4) prior involvement of the families with social services, public health, law enforcement, and domestic violence; (5) involvement of abuse and/or neglect in the death; (6) adequacy of the death scene investigation; and (7) preventability.

In the annual report, the Colorado CFR Committee describes numerous results associated with the Committee's work (Colorado Department of Health and Colorado Department of Social Services, 1993). Some of the results are (1) the autopsy rates for SIDS deaths have increased; (2) death scene investigation guidelines have been developed for law enforcement, coroners, and social services; (3) the Colorado death certificate has been revised to give more complete information; and (4) legislation has been passed to improve exchange of records among professionals working on child death cases.

Missouri

The Missouri Child Fatality Review Program (CFRP) is based on local, county-based teams (Missouri Department of Social Services and State

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Technical Assistance Team, 1994). Missouri has the most immediate review of child deaths of any state at this time

The CFRP was enacted through legislation in 1991 and began its formal operation in January 1992. Missouri law mandates a CFRP panel in all 144 counties and the city of St. Louis. The CFRP panel core membership is mandated by law and includes the county prosecuting attorney, county coroner/medical examiner, and representatives from law enforcement, Family Services, juvenile court, public health, and emergency medical services. Optional members on a case specific or permanent basis may be added at the local panel's discretion.

Like the U.S., Australia has no uniform, nationwide system to collect data on child abuse-related deaths.

Unlike Oklahoma and other teams organized at the state level, the Missouri model is based on concurrent, rather than retrospective, evaluation and review by the panel. The review includes deaths of children from birth through 17 years. Every child death in this age category is evaluated by the county coroner or medical examiner, who determines whether or not the case meets the criteria for detailed review by county-based panels. The coroner or medical examiner prepares and submits a data collection form to the State Technical Assistance Team (STAT). If the case meets the criteria for review, the CFR panel completes and submits a more detailed data form at the conclusion of their review. CFRP data is then merged with selected birth and death certificate data to achieve a comprehensive report

In 1992, 29% of all child deaths in Missouri (N=293) met the CFRP criteria to be reviewed by a panel. In 1993, this number increased to 375 (36%), although the total number of child fatalities was approximately the same (1054 deaths in 1993 compared to 1079 in 1992)

The case review process has resulted in several recommendations: (1) continue investing resources to facilitate community change; (2) improve parental/caregiver supervision through education and better access to child care services; (3) educate all investigators about the importance of accurately recording the level of supervision and circumstances immediately surrounding the death of a child; (4) closely monitor families at risk of a second preventable death or injury and provide them with appropriate services; (5) fund autopsies for the highest risk children; and (6) implement a coordinated strategy aimed at reducing injuries and preventable deaths.

The CRFP's work has resulted in increased coordination and cooperation between the multidisciplinary panel members. In addition, Missouri has seen improved determinations in the cause of child deaths that identify patterns and trends resulting in meaningful deterrent and preventive strategies.

Ontario, Canada

The Coroner's System in the Canadian province of Ontario functions with government-appointed physicians who report to the Solicitor General of Ontario through nine regional coroners acting directly under the Chief Coroner of Ontario. The coroners investigate approximately 30,000 deaths per year which occur under circumstances defined by provincial legislation entitled the Coroner's Act of Ontario.

The Pediatric Review Committee (PRC) began in 1989 to provide assistance with problematic pediatric death cases. Referrals were made following review by one of the supervisory regional coroners or by personnel in the Chief Coroner's Office. Recent expansion in the PRC's role has occurred with a greater number of case reviews. The team is chaired by the Deputy Chief Coroner for Ontario, and is composed of a neonatalogist, an intensivist, a pediatric forensic pathologist, and two community pediatricians, each of whom has special knowledge and interest in the area of child abuse. The PRC has access to assistance from various other knowledgeable professionals, and police and prosecution personnel are present when needed. This team has a predominantly medical focus at this time, as compared with the legislatively established interdisciplinary teams in Oklahoma and Missouri.

Because coroners utilize legislative powers, there is no difficulty in obtaining information required during an investigation. The Coroner's Act states that a coroner may seize anything that he or she has reasonable grounds to believe is material to the purposes of the investigation and can inspect and copy any records or writings relating to the deceased. Data collection occurs centrally, external to the PRC. However, areas of concern that are discovered may be referred to the PRC for comment and further assessment.

In the past year and a half, the PRC has moved from quarterly to monthly meetings. Committee members are funded for attendance at meetings and for pre-meeting preparation. At this time, not all pediatric deaths (age 1 day through 16 years) are reviewed by the PRC, although the vast majority of childhood deaths investigated by the coroner's system undergo an autopsy. Approximately 750-1,000 children die each year in Ontario, and over the past year nearly 70 of these deaths were reviewed by the PRC.

During its operation, Committee members have become increasingly aware of the differences in knowledge level and investigative methods among the coroners and pathologists in regard to pediatric deaths, especially those of very young children. Because of this recognition, a standardized protocol has been developed and will be released to all coroners province-wide in the near future. This protocol will have stringent guidelines to be fol-

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lowed in death investigations of children under two. The guidelines will include use of radiologic evaluation, toxicologic testing, death scene evaluation, and immediate review of the case with one of the regional coroners. Plans to locate the autopsies in regional centers have been discussed. Following a preliminary investigation, all cases will be reviewed by the PRC. These steps should further centralize the response and greatly improve the investigation of childhood fatalities in Ontario.

New South Wales, Australia

A National Child Protection Council has been established in recent years to provide a national clearinghouse for information and research in child abuse-related deaths in Australia. The Council's main focus is on primary and secondary prevention strategies, but it may have a role in coordinating national data on child abuse deaths.

Despite their differences in scope or operation, child death review teams seek to improve the investigation and disposition of possible child abuse-related fatalities through a standard review process.

Like the U.S., Australia has no uniform, nationwide system to collect data on child abuse-related deaths. The Australian Institute of Criminology is actively establishing a system to assess the extent of the problem. One valuable source of child death data is the National Injury Surveillance Unit, which collects national injury data and focuses on injury prevention. Success has already been demonstrated in areas of prevention, such as increases in the use of seat belts and bicycle helmets and improved playground safety measures.

A Child Death Review Committee was established in late 1993 in New South Wales (NSW), one of Australia's provinces. The goal of the Committee is to identify information related to child abuse-related deaths that might prove helpful in preventing future deaths. The Committee will also establish a database in order to begin defining the extent of the problem at the state and national levels in Australia.

The NSW Committee will review deaths in cases of children 14 years old and under. The categories of child deaths for Committee review include (1) all known deaths attributable to physical abuse, neglect, or failure to thrive; (2) bathtub drownings; and (3) suspicious deaths where no clear explanation is forthcoming from caretakers. After the Committee has developed its review process, additional categories may be included, such as (1) SIDS deaths in children over seven months of age; (2) poisoning deaths; (3) asphyxia deaths; (4) suicides; and (5) homicides. In order to establish a more comprehensive database, the Committee began its review by conducting a retrospective review of child deaths that occurred in 1989. The Committee is working toward the goal of reviewing cases within one month of a child's death.

Conclusion

In summary, despite their differences in scope or operation, child death review teams seek to improve the investigation and disposition of possible child abuse-related fatalities through a standard review process. The long-term goal of developing effective primary prevention programs to reduce the incidence of child abuse-related deaths can be enhanced by the establishment of a standardized review process in each state, increased interdisciplinary education and collaboration, and the implementation of state and national data collection systems.

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Sheila Thigpen is a social worker active with child fatality issues in Oklahoma, and serves on APSAC's Task Force on Child Fatalities.

Barbara Bonner, PhD, is a psychologist, member of Oklahoma's child death review team, past President of APSAC, and co-chair of APSAC's Task Force on Child Fatalities.

Contributors to this article include Jane Beveridge, Director of Child Protection and Early Intervention Child Welfare Services (Colorado); Gus Kolilis, STAT Director (Missouri); Dirk W. Huyer, MD, SCAN Program, Hospital for Sick Children (Toronto, Ontario); James T. Cairns, MD, Deputy Chief Coroner (Ontario, Canada); Paul Tait, MD, Department of Pediatrics, Westmead Hospital (Sydney, Australia).

FIREARMS: A CULTURE OF VIOLENCE

—by Elizabeth C. Powell and Katherine K. Christoffel

Children are being killed at alarming rates. In 1993 in the Chicago area, 61 children under the age of 15 were slain. Half were younger than four years old; they were most often victims of child abuse. The single most common cause of death was from gunshot injuries (30 of 61 victims). Other causes included beating, burns, strangling, and drowning (Chicago Tribune, 1994).

Clinicians and researchers involved with child abuse should be concerned not only about the infant homicide peak due to child abuse, but also about the adolescent homicide peak due to firearms. Members of many of the same families are at risk; survivors of child abuse still face the danger of firearms before they can achieve a long life.

Epidemiology

Deaths. In the United States, firearms are the eighth leading cause of death; they are the second leading cause of death due to traumatic injury. Between 1988 and 1991, the death rate associated with firearms increased 9%, and in 1991 in the states of California, New York, Texas, Maryland, Louisiana, Nevada, and Virginia, and in the District of Columbia, firearm deaths exceeded motor-vehicle related deaths (Fingerhut et al., 1994).

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