Child Death Review: The State of the States in 2010

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In 1994, when the first *APSAC Advisor* special issue on child fatalities was published, the process of child death review (CDR) was a fledgling movement in most parts of the United States. Sixteen years later, CDR is a well-established, institutionalized process in all but a few states. Review teams meet regularly at either the state or community level to share information on the circumstances of child deaths in order to improve investigations, services, and agency systems and to prevent other child deaths. However, despite many efforts to standardize the review process, beginning with the Missouri National Symposium in 1994 and continuing through today's federally funded National Center for Child Death Review,[1] there remains quite a bit of variation among states in the review process, much of it to meet state and local needs. Each year the National Center for Child Death Review conducts a survey of CDR to track the status of state and local review processes. This article provides an update using data from the December 2009 survey.

The Purpose

Following the landmark study in the journal *Pediatrics*, which documented the significant under-ascertainment of child abuse and neglect fatalities (Ewigman, Kivlahan, & Land, 1993), child death review gained momentum as a methodology to better investigate and identify child deaths from abuse and neglect (Durfee, Gellert, & Tilton-Durfee, 1992; Ewigman et al., 1993). Many states were able to generate support for legislation and funding by basing their reason for existence on this sole purpose. Subsequent CAPTA legislation helped by making reviews of abuse and neglect a requirement for federal funding. As states organized their reviews, it became apparent to most that focusing reviews only on suspicious deaths would, in fact, limit their ability to identify all maltreatment-related deaths, especially neglect. Some states opted for an expanded purpose when CDR was first organized, using it as a process to focus on all child deaths resulting from SIDS, accidents, homicides, and suicides. This expansion was furthered when the U.S. Maternal and Child Health Bureau issued a report encouraging CDR as a public health approach for all preventable deaths. The U.S. Healthy People 2010 objective was expanded in 2001 to encourage all states to conduct reviews for 100% of all accidents, homicides, and suicides. By 2010, every state except Idaho had a CDR process in place, and all states cited their primary purpose as the prevention of child deaths.

Types of Deaths Reviewed

Every state reviews deaths in children up to age 18, and most review deaths from accidents, homicides, and suicides. Twelve states reported that they met the Healthy People 2010 objective by reviewing 100% of all the above. Eighteen states reported that they also review a large percentage of deaths from natural causes. A few states reported that they review all child deaths. Ohio is the most notable example, in that state legislation requires county-based teams to review 100% of deaths of children through age 17.

Many states reported that by reviewing more deaths, they were actually identifying more deaths from child abuse and neglect. For example, Michigan's state level review team matched caregivers of children in all accidental deaths to caregivers on the state's CPS central registry over a 3-year period, and then it reviewed deaths that matched. This led the team to more than double the number of reported deaths due to maltreatment (Schnitzer, Covington, & Wirtz, 2008). Today, only a few states limit the types of deaths they review to suspected abuse and neglect, or to cases in which the child had a history with the state's child welfare system. Florida's state statute is the most restrictive, limiting reviews to only those children whose deaths were substantiated as abuse or neglect. Several states have formal protocols in place to include near deaths and serious injuries from maltreatment as a part of their review process, but only Wyoming requires these reviews through statute (see article by Gardner in this issue).

State Leadership for CDR

In the 1990s, most CDR programs were coordinated by the state department of social services or the state attorney general's offices. With an expanded focus on prevention, there has been a shift toward moving administrative leadership to public health departments, and currently, 27 state programs are based in state health departments, 11 in social services, 3 in the attorney general's office, and the remainder in an assortment of agencies, including the state child advocate's office (2), the courts (2), a state university (2), and others. However, even as the shift occurs to public health, in most states, social services and other agencies collaborate closely with public health. In every state, at least one person has been designated to be the state CDR program manager. Such persons typically

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manage the state CDR teams and advisory boards, provide training and consultation to local teams, and coordinate the state's CDR reporting requirements.

Funding

CDR continues to be poorly funded at the state level. No states reported funding increases in 2010, and a number of states reported their funds were significantly reduced. The mean level of funding is $125,000, but there is a wide gap in funding levels between states. At the top tier, 10 states have annual budgets of $200,000–$800,000, and at the bottom tier, 16 states have budgets of less than $30,000. There is no dedicated source of federal funds for CDR to the states: Most use their CAPTA, CJA, or Title V MCH block grants to support their programs.

Legislation

Thirty-nine states have laws mandating CDR, and four states have statutes permitting CDR. Statutes generally include requirements related to state and/or local team meetings and team member composition, and the production of annual reports to legislators. Most important for team functioning is that they include provisions allowing teams to access case information and hold confidential discussions. Even in states such as Wisconsin, which requires CDR meetings to be open to the public, the teams can convene a closed session when discussing an individual case.

State and Local Reviews

In the very early years of CDR, teams were established at the local level with little state guidance or oversight. For most states, the value of community-based reviews is well accepted. Thirty-eight states now support a network of local CDR teams at the county level (28), city teams (4). and/or regional level (11). In the past couple of years, a number of states have worked diligently to move from state-level to local team reviews, including Wisconsin and Minnesota. New York provides significant funds through a competitive process to encourage local reviews. Even in a few states that support a state-only team, local teams may meet independently, such as in Colorado. Most of the states without local reviews are either primarily rural, or have relatively small numbers of child deaths that can be easily reviewed by one state-level panel, or both. Thirty-five states have state-level advisory boards that either review individual cases, or review local findings to generate recommendations for state level policy, practice, and program improvements, or do both of these.

Coordination With Other Types of Reviews

As child death review has expanded throughout the United States, so too have other review processes—many similar to CDR in methodology but with a different population focus. Today, CDR program coordinators report that the following types of reviews exist in their states:

- Child Welfare Citizens Review Panels....42
- Domestic Violence Review Boards 27
- Maternal Mortality Review....23
- Fetal and Infant Mortality Review....29
- Specialized SIDS Review Boards....6
- Others, including Elder Abuse Reviews....9

CDR sometimes coordinates with these other reviews, and in a number of cases, one panel in a state or community serves multiple functions. For example, 13 states report that their state CDR panel serves as the state's Citizen's Review Panel for Maltreatment Fatalities (see related article in this issue by Palusci). A number of state or local teams will hold a CDR meeting followed on the same day by a domestic violence or elder abuse panel meeting, making only a few changes to team membership. Most of these review processes share common purposes and have only small variations in their protocols and processes.

CDR Reporting

Forty-two states issue annual reports of their child mortality data, their CDR findings, and their recommendations to improve their systems and prevent child deaths. Twenty-three states also issue specialized reports from their findings, such as reports on youth suicides, firearm deaths, or child maltreatment deaths. As states began to build their review programs, most created their own reporting tools while borrowing heavily from other states' tools. Missouri was the first state to develop a comprehensive reporting system, followed by Arizona. In 2001, when the Maternal and Child Health Bureau first funded the National Center for Child Death Review, the Bureau charged the center with exploring the feasibility of a standardized national reporting system. States were so eager for standardization that within 2 years, more than 30 persons from 19 states helped design such a system.

Thirty-four states, soon to be 37, now utilize the National Child Death Review Case Reporting System, a comprehensive web-based tool. The system is housed and managed by the NCCDR. There are over 80,000 reviewed deaths in the database as of October 2010. What makes the system unique is that comprehensive data are being collected in one place, including data on the child, caregivers, supervisors, perpetrators, circumstances of the deaths, findings from the investigation, services provided, and team recommendations for prevention. NCCDR is working with states and national partners to develop a protocol for researchers to access this database. A project is also underway to develop linkages of the system's maltreatment data to the data in CDC's National Violent Death Reporting System. The system is also being used as the core component of the CDC's pilot project to establish a national case registry of sudden and unexpected infant deaths.

Seven states are using an expanded version of the report tool for this effort (CO, GA, MI, MN, NH, NJ, and NM).

Outcomes

Child death review appears to have had a significant impact on improving death investigations and in helping improve the identification and diagnosis of maltreatment deaths. A study conducted by Scripps Howard News Service found that states with both local and state CDR programs had more than twice as many deaths recorded as suffocations instead of unknown or SIDS than a state with no CDR, and a significant increase in homicides (Hargrove & Bowman, 2010).

Type of Review	Accidental Suffocation	Homicide
No CDR	7.1%	7.1%
State only	9.2%	7.5%
Local only	12.4%	8.0%
State and local	15.3%	9.0%

The CDC-funded Child Maltreatment Surveillance Project found child death review to be the best source for identifying child maltreatment, as compared with death certificates, law enforcement reports, and child welfare system reports (Schnitzer et al., 2008).

However, several years ago, a chief prosecutor sitting on a local review team chastened his team by saying, "The review process was wearing on my soul because we aren't using our findings to prevent other deaths." At about the same time, a study conducted in California analyzed over 1,000 CDR recommendations from state reports throughout the United States and found the quality of these to be lacking in specificity, attention to evidence-based approaches, and processes to monitor their implementation (Wirtz, Lob, & Rose, 2008). One state reported that in 10 years of reviews, they could not identify a single result that prevented deaths. There were limited examples of reports in which teams did use their data for prevention, some of them published (Rimsza, Schackner, Bowen, & Marshall, 2002; Azrael, Hemenway, Miller, Barber, & Schackner, 2004). It seemed as if CDR in the U.S. had reached a tipping point: Many teams knew how to conduct reviews but not how to move forward toward translating their reviews into efforts to improve systems and prevent deaths.

Technical support and training for teams, as well as exemplary efforts to systematically focus on translating review findings into action, have catalyzed CDR throughout the United States, leading to renewed emphasis on systems improvements and prevention. Today, NCCDR catalogues initiatives developed by teams throughout the U.S. and has lists of thousands of outcomes being implemented by teams. They range from the simple, such as changing the speed limit in school zones, to the complex, such as implementing home visitation programs for low-income first-time mothers. Many of these can be found by reading state annual CDR reports.[2]

Several of the exemplary efforts to improve the focus on and skills in implementing prevention included the following:

The Harborview Injury Prevention and Research Center in Seattle obtained a special issues grant from the HHS Emergency Services for Children Program. This grant allowed Harborview to work closely with five local CDR teams in Washington state over 3 years to provide technical assistance, peer support, and a web-based decision-making tool on best practices. This support led to significant improvements in those counties' prevention and system improvement outcomes as compared with the nonsupported counties (Johnston, 2009).

The California Health Department developed curricula and then provided training and technical support to local teams to assist them in writing recommendations that would be specific, action oriented, and based on best practices.

Michigan and Nevada developed a systematic approach in their reviews of maltreatment deaths in order to match their findings with specific areas needing improvements, and then developed and implemented recommendations tied to those findings. Nevada counties have been implementing action plans for the past several years, leading to improved interagency coordination, major systems improvements, and additional resources in child welfare. These are continually tracked and monitored by the state.[3] The Michigan experience led to significant decreases in child deaths associated with agency system problems (Palusci, Yager, & Covington, 2010).

CDR in the Next Decade

Budget crises throughout the states have led to decreased funding to support many state and local CDR; yet, all states except Idaho continue to support the process. The hard work underway in states to conduct reviews, report on their findings, and translate those findings into systems improvements and prevention is strong evidence that child death review is a powerful and effective process to keep children safe and healthy.

Improvements and renewed commitments to the process at the national, state, and local level will help ensure that CDR thrives through 2020. Some of these include the following:

2 Reports can be found by state at www.childdeathreview.org/state.htm

3 Retrieved May 20, 2010, from: http://www.dcfs.state.nv.us/DCFS_ChildFatalities_BlueRibbon.htmNevada

At the National Level

- Healthy People 2020 will expand to two objectives, to add that all states should review 100% of sudden and unexplained infant deaths as well as all homicides, suicides, and accidents. Last year, Senator Frank Lautenberg (D, NJ) introduced the Stillbirth and SUID Prevention, Education, and Awareness Act (S 1445). As of June 1, there were 12 senate and 21 house co-sponsors of the bill. This bill includes a section that supports child death review, and if approved, would help allocate dedicated funds to every state specifically to support the review process.
- Numerous federal and national organizations are working with the NCCDR to utilize data from the CDR Case Reporting System for policies and improvements at the national level. For example, the NCCDR recently received funding from HRSA, MCHB to conduct secondary data analysis of the infant sleep-related deaths in the system. However, more work is necessary to ensure that the data on case findings entered at the local and state level are actually used.
- Efforts to better coordinate with other types of reviews and to improve near death reviews are needed at the national level, as well as within states and locally.

At the State and Local Level

- States will continue to struggle with competing budgetary demands to maintain robust CDR programs, and local teams will struggle to engage a wide range of stakeholders as resources diminish. It is imperative that teams continue to keep their eyes on the mission—translating review findings into improved knowledge about how and why children die, and then taking action to prevent more deaths.
- CDR can continue to grow at the local and state level. Teams will expand their reviews to include natural deaths, especially those of infants, to identify and address medical neglect.
- Teams will expand their membership, adding injury prevention expertise, child advocates, and in some cases, bringing the voices of parents to the reviews. We will be able to learn from the innovations in the United Kingdom, as they work to involve parents in the review process by sending out information on the reviews and offering parents the opportunity to share information with a team. Teams will also expand membership to be sure they represent the children most at risk in their communities, by race, gender, income, and other demographics.
- Teams will continue to improve in their ability to translate review discussions and findings into recommendations and actions to improve agency systems and to prevent other children from dying.

In summary, child death review has great potential, metaphorically not to wear on our souls but to heal our souls—collectively as a community, in our own agencies, and within ourselves. It will require renewed commitments and a focus on working together to ensure that what is learned from the deaths of too many children can save lives in the future.

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