Journal Highlights

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Parents Who Kill Their Children

The authors of this article provide information about *filicide* (homicide of a child by parent) and the physician's role in prevention and in identification of at-risk children. Approximately 60% of child victims of homicide are victims of filicide by a parent or stepparent, and children under age 5 are at most risk.

In filicide cases, the child's death is most commonly an unintended outcome of intentional neglect or abuse, most often after severe head trauma. Other causative factors include birth of an unwanted child, altruistic motives, an acutely psychotic parent, or spousal revenge. "Altruistic" filicide occurs when parents kill their children believing they are doing what is best for the child, as in euthanasia of a severely chronically ill child or a depressed suicidal parent not wanting to leave the child behind. Alternatively, in "acutely psychotic" filicide, a psychotic parent kills the child for no rational reason, as in response to hallucinations. Least frequent is "spousal revenge" filicide, when a parent kills a child to punish the other parent.

Neonaticide is infant homicide by a parent the first day after birth. Mothers usually either have denied or concealed pregnancy and do not deliver in hospitals. Perpetrators are in their late teens to early 20s and unmarried, of lower socioeconomic status, and living with their parents. They may have experienced abuse, family dysfunction, and psychological issues, and the pregnancy may be the result of sexual abuse, incest, or a secret illicit relationship. To minimize family discord or coercion, physicians should meet with a pregnant teen without parents present at some time during the appointment. The physician can give information about prenatal care, Safe Haven laws, and help available from children's services and community programs. Ultrasonography of the developing fetus can help break through denial by providing a convincing visual aid.

Infanticide is child homicide by parents within the first postnatal year. Mothers are likely to be younger than age 19 with more than one child, receive no prenatal care, and experience mental illness or infant anomalies. Postpartum depression occurs in approximately 10% to 25% of mothers, who experience depression and anxiety leading to neglect, difficulty bonding with the baby, or even suicidal thoughts. Postpartum psychosis is more rare and usually occurs in the first weeks after delivery; data show elevated rates of both suicide and infanticide. Pediatricians and protective services personnel play an important role in recognizing postpartum depression or psychosis by evaluating maternal-infant interaction and bonding or having mothers complete the Edinburgh postnatal depression scale. Both postpartum depression and postpartum psychosis are treatable, and most mothers retain custody of their infants.

Mothers who commit filicide often are poor; are primary caregivers and socially isolated; and have experienced sexual abuse or domestic violence, substance abuse, or mental illness. Much less evidence exists regarding fathers who kill; typically, the father's age is mid-30s, and he has history of physical abuse or mental illness. Suicide occurs frequently in cases of both maternal and paternal filicide, but more so with father perpetrators. In addition to parental factors, infant characteristics including colicky infants, autism, and developmental disabilities or chronic illness may elevate risk.

Because child homicide by parents is not common and characteristics of filicidal parents also occur in parents who would never harm their children, identification and prevention is difficult for physicians. Pediatricians ' role includes asking new parents about problems and feelings of being overwhelmed, recognizing stressors, knowing mandatory reporting laws and procedures, and referring patients to psychological treatment, children's services, or specific social programs.

Friedman, S., & Friedman, J. (2010). Parents who kill their children. *Pediatrics in Review, 31*(2), e10–e16. Retrieved from: pedsinreview.aappublications.org/content/vol31/issue2/index.dtl

AAP Policy Statement on Child Fatality Review

The American Academy of Pediatrics (AAP) policy statement highlights the importance of child fatality review to prevent child deaths and advocates improving child fatality reviews through policy development, training, data collection, and data dissemination.

Child fatality review teams (CFRTs) are multidisciplinary committees with representatives from law enforcement, child protective services, coroner's/medical examiner's office, prosecuting attorney's office, the medical community, public health, and other community stakeholders. CFRTs were originally developed to improve identification and prosecution of fatal child maltreatment. The CFRT role has recently evolved toward a public health mode by attempting to prevent child deaths through systematic reviews of deaths in children from birth through adolescence. CFRTs also seek to develop and implement community prevention strategies and use evaluation results to modify and improve interventions.

Both the AAP and the American Bar Association (ABA) have endorsed local and state CFRTs. The AAP Division of State Government Affairs offers assistance and guidance to AAP chapters in developing public policy on CFRTs. This collaboration enhances understanding of the epidemiology of child deaths locally, regionally, and nationally; improves the accuracy of vital statistical data; and informs public health and legislative strategies to reduce preventable child fatalities. CFRTs exist at both the state and local levels but vary by state in team membership, relationship between state and local teams, criteria for case review, and policies and procedures for data collection. Currently there is movement to develop standards for child death review, and many states are working to adopt such standards. Despite these advances, however, no federal funding is available for state or local child death review, and not all states have attained the level of funding or leadership commitment necessary to meet national standards.

AAP Recommendations. National leadership and support are critical for expanding child death review to reduce the number of preventable child deaths in the United States. AAP recommends a uniform national approach to improve the child fatality review process, including standardizing child death reviews and data collection, providing training and technical assistance, enabling interstate and cross-jurisdictional data sharing, establishing confidentiality and legal protocols, and publishing reports of CFRT data. The AAP supports the development of federal and state legislation to enhance the child fatality review process and recommends that pediatricians work with state AAP chapters to advocate for death certification legislation and policies to establish funded local and state-level child death review systems. Additional AAP recommendations concern the consultative role of pediatricians and other physicians on the CFRTs and collaboration on local, state, and national policies to reduce preventable child deaths.

Christian, C., & Sege, R., et al. (2010). American Academy of Pediatrics Policy Statement: Child fatality review. *Pediatrics, 126*(3), 592–596.

Child Maltreatment Fatalities in Children Under Age 5

According to the National Center for Injury Prevention and Control, homicide is the fifth leading cause of death for children under 5 years of age, and child maltreatment is the cause for almost half of homicides in young children. Children in this age group consistently account for more than 80% of fatal cases of child maltreatment. This study describes the distribution of child maltreatment fatalities in children under age 5, as recorded in the National Violent Death Reporting System (NVDRS). NVDRS integrates data from multiple other data systems and, consequently, may provide a more comprehensive picture of child maltreatment fatalities than other data systems.

The authors of this article reviewed deaths reported to NVDRS in 16 states from 2003 to 2006. Of 1,374 deaths of children under 5, 600 (44%) were the result of child maltreatment. Over half of these children were under 1 year, and the reported cause of death was abusive head trauma (AHT). In children under age 5, two thirds of child maltreatment fatalities resulted from abusive head trauma (AHT), 27.5% were caused by other types of physical abuse, and 10% resulted from neglect. These data are consistent with the National Child Abuse and Neglect Data System (NCANDS), which identified a child's first year, and particularly first day, of life as a period of heightened risk. Fathers or their substitutes were found to be significantly more likely than mothers to be identified as alleged perpetrators for AHT and other types of physical abuse, while mothers were more likely to be responsible for neglect.

These data demonstrate AHT as a major cause of fatalities in child maltreatment. Educating new parents in maternity wards prior to discharge about dangers of shaking infants and about coping strategies for persistent infant crying could potentially reduce serious injuries from AHT. Additional research would establish whether similar activities during home visits, in pediatricians' offices, or through the media would be effective. However, information and home visitation strategies typically involve mothers and focus on prevention of neglect. The authors stress that to address AHT and other forms of physical abuse, preventive efforts must also focus on fathers and their substitutes.

Klevens, J., & Leeb, R. (2010). Child maltreatment fatalities in children under 5: Findings from the National Violence Death Reporting System. *Child Abuse & Neglect, 34*(4), 262–266.

Sibling Removal After a Child Maltreatment Fatality

Child protective services (CPS) agencies have a responsibility to protect siblings when child fatalities occur. Although researchers have explored factors related to risk of death from child maltreatment, there has been little examination of factors that increase risk of maltreatment or fatality for siblings of child victims.

In this research, Damashek and Bonner attempted to determine if socio-ecological factors related to child maltreatment deaths also predicted sibling removal. These socio-ecological factors included sibling age, history of CPS involvement, caregiver relationship to the child, gender of child, age of caregiver, family composition, and the type of maltreatment that caused the fatality. To answer this question, they reviewed 250 child fatality cases from a 10-year period in Oklahoma.

Findings from a bivariate analysis suggested that cases in which siblings were younger in age, had younger fathers, had a history of CPS reports, had an unmarried caregiver, or in which the fatality was a result of abuse rather than neglect were more likely to be removed by CPS. Results from logistic regression confirmed that the factors with the greatest capacity to predict the likelihood of sibling removal were sibling age, number of previous CPS reports, and type of maltreatment. In some cases, these findings were not consistent with factors related to risk of child fatality. Victims of child maltreatment fatalities in this sample were less likely to have had a history of child maltreatment and more likely to have died as a result of neglect rather than abuse. The researchers speculated that although more fatalities occur as a result of neglect, workers perceive a greater risk for fatality from abuse.

From this research, one can conclude that worker decision making about the removal of siblings following a child maltreatment fatality is not based solely on empirically supported risk factors. Rather, workers seem to be influenced by their perceptions of events, and they appear to perceive greater risk for siblings when children died as a result of abuse and had a prior CPS history. The authors conclude that when considering other factors, decisions about sibling removal should align with empirically-supported child fatality risk factors. They suggest that more investigation is needed of effective worker decision making about protecting siblings following a child fatality.

Damashek, A., & Bonner, B. L. (2010). Factors related to sibling removal after a child maltreatment fatality. *Child Abuse & Neglect, 34*(8), 563–569.

Effects of Citizens Review Panels in Preventing Child Maltreatment Fatalities

Most U.S. states have instituted child fatality citizens review panels (CRP) to review child maltreatment deaths and to make recommendations to state child protection agencies for changes in child welfare law, policy, and practice. In this study, the authors sought to identify changes in factors associated with child deaths after data from CRP reviews had been communicated to CPS. The study examined the annual number of child maltreatment deaths associated with each problematic finding during two 3-year periods: 1999–2001 (Period I) and 2002–2004 (Period II). These two periods provided adequate time for the recommendations made in Period I to be implemented and to affect future cases in Period II.

With the cooperation of state CPS, public health, law enforcement, and local district attorneys, the CRP created a comprehensive case file on each death to be reviewed. The problematic findings were logged into one of four categories: noncompliance with state law or policy; poor practice and decision making; inadequate existing law, policy, or procedure; or other barriers outside the child welfare system. The state child protective services agency developed action plans in response to the findings and recommendations in the CRP report. This study tracked the actual changes made in law, policy, or practice in accordance with the plan.

From Period I to Period II, there was a 35% decrease in problematic findings and a 9% decrease in child deaths associated with those findings. The CPS agency problem factors that had been statistically significant during the first period included screening out referrals, a time lapse between case assignment and direct family contact, improper completion of risk assessment, and the inability of a CPS worker to thoroughly assess all relevant data in the case. These problems were found to have decreased dramatically in Period II, suggesting that action had been taken to improve professional practice. However, the barriers existing outside the child welfare system had become more prominent during Period II, suggesting that while child welfare practices improved, other problem areas had not. Increases were identified in several areas. Medical professionals continued to fail to report suspected maltreatment to CPS, even after statewide physician training; child deaths were found to be a result of unaddressed mental health conditions; and medical examiner findings were often inaccurate.

As a result of the CRP review, Michigan addressed most of the problem areas associated with child maltreatment fatalities by making changes in law or child protective services agency policy and practice, thereby reducing the number of deaths related to these particular problem areas. The greatest positive effects came from changes in CPS investigation, assessment and service provision, training for workers and supervisors, peer review, and upgrades to the state's data system.

The authors conclude that citizens review panels can potentially reduce child deaths from child maltreatment by improving CPS practices. They further theorize that Michigan's CRP experienced success because its members were familiar with the child welfare system, and it employed a formal process to use data from reviews to

make recommendations for state action. The authors recommend further research to explore the relationship between CRP reviews and decreases in child maltreatment fatalities.

Palusci, V., Yager, S., & Covington, T. (2010). Effects of a citizens review panel in preventing child maltreatment fatalities. *Child Abuse & Neglect, 34*(5), 324–331.

The Seasonality of Child Homicide

Previous data indicate that the overwhelming majority of child homicides are due to child abuse committed by a caregiver. Small-scale research has not supported the anecdotal belief that the incidence of child abuse homicide, particularly abusive head trauma (AHT), increases during the winter months and around the winter holidays due to increased caregiver stress. However, significant seasonal effects are well documented in adult homicides, suicides, and violent crime rates, making parallel seasonality for child abuse homicide at least plausible.

This study examined seasonal and monthly variation in homicides in a large population of young children to determine if a relationship existed. The authors examined death certificates from 1999 through 2006 in Indiana, Ohio, Oklahoma, Missouri, and Washington for all children (N=797) younger than age 5 who were homicide victims.

The total population of children under age 5, and study subsets of children younger than 2 and between ages 2 and 5, indicated no statistically significant variation by either season or calendar month. The researchers conclude that there was no seasonality associated with child homicides. The authors suggest year-round preventive strategies that address caregiver responses to common stressors, including crying, toileting accidents, and normal childhood behaviors such as temper tantrums.

The authors also note that even though AHT is the leading cause of child abuse-related homicides against children younger than 4 years of age, they found no specific AHT code on death certificates reviewed for this study. They speculate that it may be possible that AHT deaths are seasonal or may increase around holidays, but further study would require a larger precise data source or multiple sources, including child fatality review program data.

Laskey, A., Thackeray, J., Grant, S., & Schnitzer, P. (2010). Seasonality of child homicide. *Pediatrics, 157*(1), 144–147.

Predicting Child Fatalities Among Less-Severe CPS Investigations

In an effort to better understand why child maltreatment-related fatalities have increased over the past decade, the researchers in this study attempted to identify variables present in maltreatment cases in which child fatalities occurred. The study sample included both cases that involved child fatality and a control group of nonfatality cases. The researchers considered both the severity and the chronicity of variables for both groups. Initially, the researchers conducted a comparative analysis and found that in the most severe cases, workers had recognized the severity and had responded appropriately.

In cases where these “actionable” variables existed (i.e., easier to identify and typically more acceptable as legal evidence of child maltreatment), these variables tended to be associated with decreased risk of child fatality. In other words, recognition of an immediately dangerous situation increased the likelihood that an effective safety plan would be put in place. Consequently, the most severe cases were not included in the predictive analysis. In cases where a “less actionable” variable was present, such as poor quality of attachment between a caregiver and a child, the risk of a child fatality increased. From the analysis, the researchers concluded that it was possible to identify specific sets of variables with “reasonably good predictive power” (p. 277) in less-severe physical abuse child fatality and nonfatality cases. However, the analysis also revealed that variable sets were considerably different for neglect cases. Therefore, while a model can be used to help identify child fatality risks in less-severe physical abuses cases, a similar model does not have the same predictive power in less-severe neglect cases.

The authors highlight the need for improved risk assessment instruments to better guide staff in recognizing risk factors in these cases. They further conclude that staff training is also needed, specifically around skills in gathering and recognizing information indicative of risk for future maltreatment and child fatality, and on the importance of consistent documentation and providing complete information about family histories of maltreatment.

Graham, J., Stepura, K., Baumann, D., & Kern, H. (2010). Predicting child fatalities among less-severe CPS investigations. *Children and Youth Services Review, 32*(2), 271–280.