



# Child Abuse and Neglect Fatalities 2010: Statistics and Interventions

Despite the efforts of the child protection system, child maltreatment fatalities remain a serious problem.<sup>1</sup> Although the untimely deaths of children due to illness and accidents have been closely monitored, deaths that result from physical assault or severe neglect can be more difficult to track. The circumstances surrounding a child's death, its investigation, and communication across all the disciplines involved complicate data collection.

<sup>1</sup> This factsheet provides information regarding child deaths resulting from abuse or neglect by a *parent or a primary caregiver*. Other child homicides, such as those committed by acquaintances and strangers, and other causes of death, such as unintentional injuries, are not discussed here. For information about leading causes of child death nationally from 1999 to 2007, visit the Centers for Disease Control and Prevention website at <http://webapp.cdc.gov/sasweb/ncipc/leadcaus10.html>. Statistics regarding child homicide from 1976 to 2005 can be obtained from the U.S. Department of Justice: <http://bjs.ojp.usdoj.gov/content/homicide/children.cfm>



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these numbers and trends online.



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## How many children die each year from child abuse or neglect?

Unless otherwise noted, statistics in this factsheet are taken from *Child Maltreatment 2010* and refer to the Federal fiscal year (FFY) 2010 (U.S. Department of Health and Human Services, 2011).

According to data from the National Child Abuse and Neglect Data System (NCANDS), 51 States reported a total of 1,537 fatalities. Based on these data, **a nationally estimated 1,560 children died from abuse and neglect in 2010**. This translates to a rate of 2.07 children per 100,000 children in the general population and an average of four children dying every day from abuse or neglect. NCANDS defines "child fatality" as the death of a child caused by an injury resulting from abuse or neglect or where abuse or neglect was a contributing factor.

The number and rate of fatalities have fluctuated during the past 5 years. The national estimate is influenced by which States report data. For 2010, several States that reported fewer fatalities compared to previous years provided explanations in their commentaries that included system improvements that reduced case backlogs and the introduction of successful prevention programs.

Most data on child fatalities come from State child welfare agencies. However, States may also draw on other data sources, including health departments, vital statistics departments, medical examiners' offices, and fatality review teams. This coordination of data collection contributes to better estimates.

Many researchers and practitioners believe that child fatalities due to abuse and neglect are still underreported. Studies in Nevada and Colorado have estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded as such (Child Fatality Analysis [Clark County], 2005; Crume, DiGuseppi, Byers, Sirotnak, & Garrett, 2002).

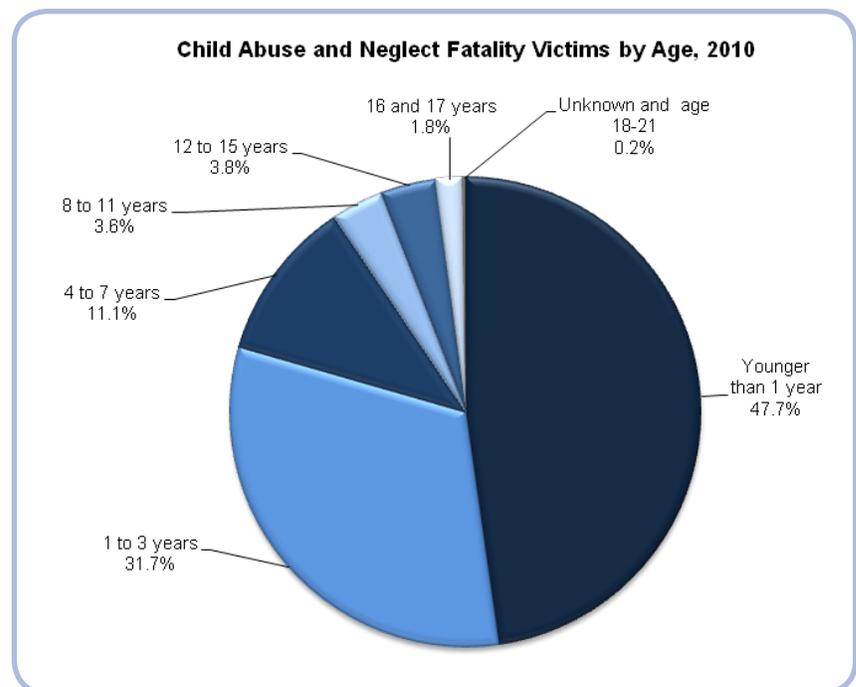
Issues affecting the accuracy and consistency of child fatality data include:

- Variation among reporting requirements and definitions of child abuse and neglect and other terms
- Variation in death investigation systems and training
- Variation in State child fatality review and reporting processes
- The length of time (up to a year in some cases) it may take to establish abuse or neglect as the cause of death
- Inaccurate determination of the manner and cause of death, resulting in the miscoding of death certificates; this includes deaths labeled as accidents, sudden infant death syndrome (SIDS), or “manner undetermined” that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted (Hargrove & Bowman, 2007)
- Limited coding options for child deaths, especially those due to neglect or negligence, when using the *International Classification of Diseases* to code death certificates
- The ease with which the circumstances surrounding many child maltreatment deaths can be concealed or rendered unclear
- Lack of coordination or cooperation among different agencies and jurisdictions

A number of studies, including some funded by the Centers for Disease Control and Prevention, have suggested that more accurate counts of maltreatment deaths are obtained by linking multiple reporting sources, including death certificates, crime reports, child protective services (CPS) reports, and child death review (CDR) records (Mercy, Barker, & Frazier, 2006). A study of child fatalities in three States found that combining at least two data sources resulted in the identification of more than 90 percent of child fatalities ascertained as due to child maltreatment (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008).

## What groups of children are most vulnerable?

Research indicates that very young children (ages 4 and younger) are the most frequent victims of child fatalities. NCANDS data for 2010 demonstrated that children younger than 1 year accounted for 47.7 percent of fatalities; children younger than 4 years accounted for nearly four-fifths (79.4 percent) of fatalities. These children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves.



## How do these deaths occur?

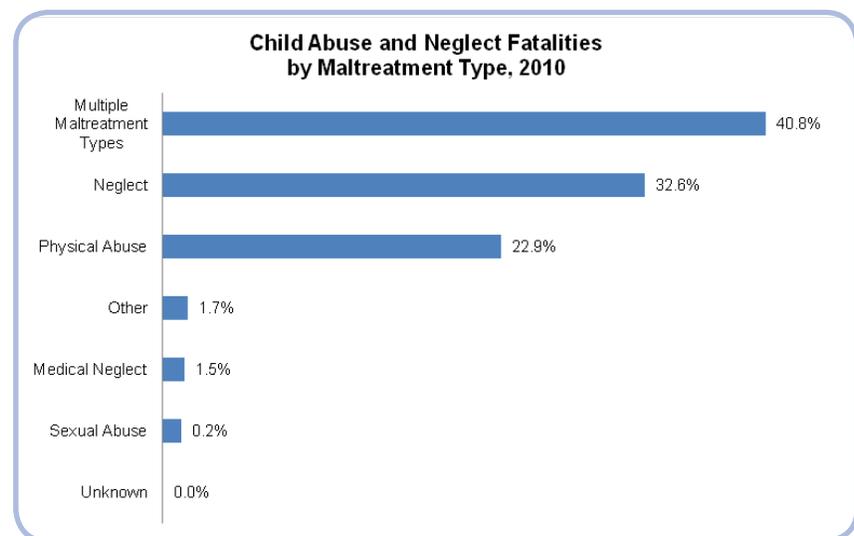
Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may involve a single, impulsive incident (e.g., drowning, suffocating, or shaking a baby). In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub).

In 2010, more than two-fifths of fatalities (40.8 percent) were caused by multiple forms of maltreatment. Neglect alone accounted for 32.6 percent, and physical abuse alone accounted for 22.9 percent. Medical neglect accounted for 1.5 percent of fatalities.

## Who are the perpetrators?

No matter how the fatal abuse occurs, one fact of great concern is that the perpetrators are, by definition, individuals responsible for the care and supervision of their victims. In 2010, parents, acting alone or with another person, were responsible for 79.2 percent of child abuse or neglect fatalities. Almost 30 percent (29.2 percent) were perpetrated by the mother acting alone. Child fatalities with unknown perpetrator relationship data accounted for 8.3 percent of the total.

There is no single profile of a perpetrator of fatal child abuse, although certain characteristics reappear in many studies. Frequently, the perpetrator is a young adult in his or her mid-20s, without a high school diploma, living at or below the poverty level, depressed, and who may have difficulty coping with stressful situations. Fathers and mothers' boyfriends are most often the perpetrators in abuse deaths; mothers are more often at fault in neglect fatalities.<sup>2</sup>



## How do communities respond to child fatalities?

The response to the problem of child abuse and neglect fatalities is often hampered by inconsistencies, including:

- Underreporting of the number of children who die each year as a result of abuse and neglect
- Lack of consistent standards for child autopsies or death investigations

<sup>2</sup> National Center for Child Death Review: <http://www.childdeathreview.org/causesCAN.htm>

- The varying roles of CPS agencies in investigation in different jurisdictions
- Uncoordinated, non-multidisciplinary investigations
- Medical examiners or elected coroners who do not have specific child abuse and neglect training

To address some of these inconsistencies, multidisciplinary and multiagency child fatality review teams have emerged to provide a coordinated approach to understanding child deaths, including deaths caused by religion-based medical neglect. Federal legislation further supported the development of these teams in an amendment to the 1992 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), which required States to include information on CDR in their program plans. Many States received initial funding for these teams through the Children's Justice Act, from grants awarded by the Administration on Children, Youth and Families in the U.S. Department of Health and Human Services (HHS).

Child fatality review teams, which now exist at a State, local, or State/local level in the District of Columbia and in every State but one,<sup>3</sup> are composed of prosecutors, coroners or medical examiners, law enforcement personnel, CPS workers, public health-care providers, and others. Child fatality review teams respond to the issue of child deaths through improved interagency communication, identification of gaps in community child protection systems, and the acquisition of comprehensive data that can guide agency policy and practice as well as prevention efforts.

The teams review cases of child deaths and facilitate appropriate follow-up. Follow-up may include ensuring that services are provided for surviving family members, providing information to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems.

Recent data show that 48 States have a case-reporting tool for CDR; however, there had been little consistency among the types of information compiled. This contributed to

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<sup>3</sup> Idaho currently does not have a child death review program. For information about child fatality review efforts in specific States, visit the National Center for Child Death Review website: <http://www.childdeathreview.org>

gaps in our understanding of infant and child mortality as a national problem. In response, the National Center for Child Death Review, in cooperation with 30 State CDR leaders and advocates, developed a web-based CDR Case Reporting System for State and local teams to use to collect data and analyze and report on their findings. As of December 2011, 37 States were using the standardized system, and 4 more were in the process of joining it.<sup>4</sup> The ultimate goal is to use the data to advocate for actions to prevent child deaths and to keep children healthy, safe, and protected.

Since its 1996 reauthorization, CAPTA has required States that receive CAPTA funding to set up citizen review panels. These panels of volunteers conduct reviews of CPS agencies in their States, including policies and procedures related to child fatalities and investigations. As of December 2011, 17 State CDR boards serve additional roles as the citizen review panels for child fatalities.

## How can these fatalities be prevented?

When addressing the issue of child maltreatment, and especially child fatalities, prevention is a recurring theme. Well-designed, properly organized child fatality review teams appear to offer hope for defining the underlying nature and scope of fatalities due to child abuse and neglect. The child fatality review process helps identify risk factors that may assist prevention professionals, such as those engaged in home visiting and parenting education, to prevent future deaths. In addition, teams are demonstrating effectiveness in translating review findings into action by partnering with child welfare and other child health and safety groups. In some States, review team annual reports have led to State legislation, policy changes, or prevention programs (National Center for Child Death Review, 2007). Findings associated with these reviews have identified decreases in child fatalities (Palusci, Yager, & Covington, 2010).

<sup>4</sup> Arkansas, Florida, Montana, and Utah are working to join the system. Alabama, Arizona, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, Wisconsin, and Wyoming are participating. (Source: National Center for Child Death Review)

In 2003, the Office on Child Abuse and Neglect, within the Children's Bureau, Administration for Children and Families, HHS, launched a Child Abuse Prevention Initiative to raise awareness of the issue in a much more visible and comprehensive way than ever before. The Prevention Initiative is an opportunity for individuals and organizations across the country to work together, and this effort includes the publication of an annual resource guide.<sup>5</sup> Increasingly, this effort focuses on promoting protective factors that enhance the capacity of parents, caregivers, and communities to protect, nurture, and promote the healthy development of children.

For more information, visit the Preventing Child Abuse & Neglect section of the Child Welfare Information Gateway website at <http://www.childwelfare.gov/preventing>

## Summary

While the exact number of children affected is uncertain, child fatalities due to abuse and neglect remain a serious problem in the United States. Fatalities disproportionately affect young children and most often are caused by one or both of the child's parents. Child fatality review teams appear to be among the most promising current approaches to accurately count, respond to, and prevent child abuse and neglect fatalities, as well as other preventable deaths.

### Suggested Citation:

Child Welfare Information Gateway. (2012). *Child abuse and neglect fatalities 2010: Statistics and interventions*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

<sup>5</sup> Access the free guide from Child Welfare Information Gateway: <http://www.childwelfare.gov/preventing/preventionmonth/guide2012>

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## Additional Resources

### **National Center for Child Death Review**

<http://www.childdeathreview.org>

The National Center for Child Death Review is a resource center for State and local CDR programs, established and funded since 2002 by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services.

### **National Center on Child Fatality Review**

<http://www.ican-ncfr.org>

The National Center on Child Fatality Review (NCFR) is a clearinghouse for the collection and dissemination of information and resources related to child deaths. NCFR was established in 1996 with a grant from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, and is dedicated to providing training and technical assistance to CDR teams throughout the world.

### **National Citizens Review Panels**

<http://www.uky.edu/SocialWork/crp>

This website is a virtual community containing information about each State's Citizens Review Panel, including annual reports, training materials, resources, sample review instruments, and other documents, as well as a discussion board.

### **National Fetal and Infant Mortality Review Program**

<http://www.nfimr.org>

This program is a collaborative effort between the American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau. The resource center provides technical assistance on many aspects of developing and carrying out fetal infant mortality review programs.



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