EXAMINING CHILD FATALITY REVIEWS AND CROSS-SYSTEM FATALITY REVIEWS TO PROMOTE THE SAFETY OF CHILDREN AND YOUTH AT RISK

Ying-Ying Yuan. Ph.D
Walter R. McDonald & Associates, Inc.

Teri Covington, M.P.H
National Center for the Review and Prevention of Child Deaths

Liz Oppenheim, J.D.
Walter R. McDonald & Associates, Inc.
Overview of Presentation

• What do fatality statistics tell us?
• Study goals
• Study methodology
• Findings
  • The systems of reviews
  • Development of recommendations
  • Implementation of recommendations
  • Accomplishments of fatality review teams
  • Opportunities for collaboration
What do we know?

• For 1-4 year olds, death rates are down
  • But homicide rates are up

• Infant mortality rates are lowest every but still high
  • Disparities of race are seen among infants and 1-4 year olds

• Homicides are among the leading causes of death of 1-4 year olds

• Some causes of death are more likely than others to be related to child abuse and neglect

• Child maltreatment death rates may have peaked in 2007

• States are increasing their prevention and review efforts

• Children younger than 1 year old are among the most high risk
Child Mortality Has Decreased Dramatically for 1-4 Year Olds (Singh, G.K. HRSA, 2010)

- Overall death rate consistently downward trend
  - 1,419 deaths per 100,000 in 1907
  - 28.6 deaths per 100,000 in 2007

- Homicide rate increased between 1970-2007 by 26% (points in time)
  - Homicide percentages increased from 2% to 8%

- Racial/ethnic, socioeconomic and geographic disparities continue
  - Black children 50% higher mortality risk than white counterparts
  - Socioeconomic disparities increasing
Leading Causes of Death for 1-4 Year Olds, 2007 (Singh, 2010)

- Unintentional injuries: 34%
  - 1/3 of these relate to motor vehicle accidents
- Other causes: 27%
- Birth defects: 12%
- Homicides: 8%
- Cancer: 8%
- Heart Disease: 4%
- Pneumonia: 2%
- Septicemia: 2%
- Perinatal conditions: <2%
- Benign Neoplasms: 1%
- COPD: 1%
Most Recent Mortality Data (National Vital Statistics Reports, Final Data for 2009)

• Infant mortality rate is at an all time low:
  • 6.39 infants deaths per 1,000 live births

• Rates:
  • Infants: 619.8 per 100,000
    • 517.9 for White infants
    • 1,170.5 for Black infants
    • 544.5 for AIAN infants
    • 384.4 for API infants
  • 1-4 Year Olds: 26.1 per 100,000
    • 24.1 for White infants
    • 38.8 for Black infants
    • 30.7 for AIAN infants
    • 15.7 for API infants
Background on a Review of NCDR-CRS Selected Records

- 34,000 records of deaths of children between 0-5 years of age were reviewed.
- These records were a subset of the 49,000 records that the database has between 2008-2011.
- Using a very broad definition of CAN related, 13% or 4,500 deaths were CAN-related.
  - Not just if substantiated as a child abuse death.
- The data are from 36 States but with few exceptions are not all deaths in all years from each State.
Causes of Death Related to CAN

- Deaths related to CAN:
  - 78% of deaths from assault (including use of weapons)
  - 53% of deaths from drowning
  - 33% of deaths from fire and burns
  - 25% of deaths from asphyxia
  - 20% of deaths from motor vehicles
  - 11% from SIDS
  - 2% from perinatal causes (prematurity, LBW etc.)
Background on Data from NCANDS

- The National Child Abuse and Neglect Data System:
  - collects data from all States on the CPS investigation or assessment of alleged maltreatment, including deaths
- The majority of the information is provided at the case level, but
  - many States report on additional deaths
- States have been reporting increased attention to such deaths and increased focus on prevention (e.g. safe sleeping campaigns; car seat programs; etc.)
- NCANDS has case level data on 11,600 fatalities. (2002-2011)
CHILD MALTREATMENT FATALITY RATES, 2002–2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate Per 100,000 Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>1.98</td>
</tr>
<tr>
<td>2003</td>
<td>1.93</td>
</tr>
<tr>
<td>2004</td>
<td>2.03</td>
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<tr>
<td>2005</td>
<td>1.94</td>
</tr>
<tr>
<td>2006</td>
<td>2.00</td>
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<tr>
<td>2007</td>
<td>2.28</td>
</tr>
<tr>
<td>2008</td>
<td>2.28</td>
</tr>
<tr>
<td>2009</td>
<td>2.32</td>
</tr>
<tr>
<td>2010</td>
<td>2.07</td>
</tr>
</tbody>
</table>
Number of child fatalities due to maltreatment has fluctuated during the past 5 years; since 2007 on a decrease.

Explanations included system improvements that reduced case backlog and successful prevention programs.

### Child Maltreatment Fatalities

<table>
<thead>
<tr>
<th>Year</th>
<th>States Reporting</th>
<th>Reported Fatalities</th>
<th>Rate per 100,000</th>
<th>Estimated Child Fatalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>49</td>
<td>1,382</td>
<td>2.00</td>
<td>1,500</td>
</tr>
<tr>
<td>2007</td>
<td>50</td>
<td>1,608</td>
<td>2.28</td>
<td>1,720</td>
</tr>
<tr>
<td>2008</td>
<td>51</td>
<td>1,670</td>
<td>2.28</td>
<td>1,720</td>
</tr>
<tr>
<td>2009</td>
<td>50</td>
<td>1,668</td>
<td>2.32</td>
<td>1,750</td>
</tr>
<tr>
<td>2010</td>
<td>51</td>
<td>1,537</td>
<td>2.07</td>
<td>1,560</td>
</tr>
</tbody>
</table>
All Child Fatalities by Age, 2010

- <1–3 Years: 79.4%
- 3 Years: 6.1%
- 2 Years: 11.6%
- 1 Year: 14.0%
- <1 Year: 47.7%
- 4–7 Years: 11.1%
- 8–11 Years: 3.6%
- 12–15 Years: 3.8%
- 16–17 Years: 1.8%
- Unknown and age 18–21: 0.2%

N=44 States (unique count)
Race of 0 and 1-4 Fatality Cohorts

Race of Age, 0

- White, 42%
- African American, 27%
- Hispanic, 15%
- Unknown, 10%
- AIAN, 1%
- Multiple Race, 4%

Race of Age, 1-4

- White, 43%
- Hispanic, 21%
- African American, 26%
- Unknown, 5%
- AIAN, 0.4%
- Multiple Race, 4%
- API, 1%
Maltreatment Types of 0 and 1-4 Fatality Cohorts

- Maltreatment Types of Age, 0
  
  - Neglect
  - Physical Abuse
  - Other
  - Medical Neglect
  - Emotional Maltreatment
  - Sexual Abuse

- Maltreatment Types of Age, 1-4
  
  - Neglect
  - Physical Abuse
  - Other
  - Medical Neglect
  - Emotional Maltreatment
  - Sexual Abuse
Perpetrator Relationship of 0 and 1-4 Fatality Cohorts

Perpetrator Relationship Age, 0

- Mother Only, 29%
- Mother and Father, 26%
- Unknown, 17%
- Parent and Other, 6%
- Male Partner of Parent, 2%
- Other Relative, 2%
- Foster Parent, 0.3%

Perpetrator Relationship Age, 1-4

- Parent and Other, 15%
- Father Only, 15%
- Unknown, 20%
- Other Relative, 5%
- Other, 4%
- Male Partner of Parent, 4%
- Mother and Father, 14%
- Mother Only, 15%
- Foster Parent, 0.2%
Summary

• Child fatalities due to abuse and neglect can be understood within a context of all deaths of young children

• Social and community decisions contribute to the definitions of child abuse and neglect deaths

• We seek to reduce child fatalities through
  • Better identification of causes and factors leading to death
  • More targeted prevention programs
  • Involvement of all sectors of society
Examining Child Fatality Reviews and Cross-System Fatality Reviews to Promote the Safety of Children and Youth at Risk

- Funded by the Administration on Children, Youth and Families, Children’s Bureau
- 9/26/2011 through 9/25/2012
Study Goals

• Identify best practices for improving:
  • Collaboration and increased efficiency within and among fatality reviews
  • Identification and implementation of cross-cutting prevention strategies

• Gain an understanding of the types or recommendations made by fatality reviews

• Gain an understanding of the outcomes and impact of the recommendations
Methodology

- Literature Review
  - 81 articles were selected for full-text review

- Review of Recommendations and Outcomes
  - 67 State and Local Fatality Review Team Reports
  - Analysis of Data from the National Child Death Case Reporting System (NCDR-CRS)

- Site Visits/Telephone Interviews
  - California (Sacramento County), Michigan, Oklahoma, Virginia
  - Delaware, Florida

- National Meeting
**Fatality Reviews Logic Model**

**Purpose:** To increase knowledge about child fatalities and identify promising practices which would reduce preventable child deaths.

**REVIEW INPUTS**
- Authorizing legislation
- Multi-agency and multi-disciplinary review teams
- Team member training
- Case data
- Available knowledge about child fatalities, the causes of fatalities, and other research literature
- Guidance, direction, and support
  - National standards
  - Leaders and champions
  - Funding

**REVIEW PROCESSES**
- Collaborate with other review teams
- Identify circumstances leading to or involved with the death
- Identify risk factors: health, social, economic, behavioral, environmental, and systemic
- Identify prevention strategies

**INTENDED RESULTS**

**OUTCOMES**
- Findings
  - Case-specific
  - Aggregate
  - Systemic
- Implementation Plans
- Recommendations
  - Local
  - State
  - National/ Federal

**IMPACT**
- Reduce preventable child death rates

**OUTCOMES**
- Improved collaboration
- Increased funding
- Strengthened organizational capacity
- Improved policies/legislation
- Increased public awareness/education
- Improved service delivery

Data Sources: Literature Review, State Report Reviews, Site Visits, National Meeting
Findings

- The Systems of Reviews
- Development of Recommendations
- Translating Recommendations into Action
- Accomplishments and Outcomes
The Web of Reviews: How They Work

- Purpose
- Types of deaths reviewed
- Administrative homes
- Legislation
- Data collection and reporting
- Scope (state and/or local; internal/external)
- Membership
- Training and technical assistance
- Access and confidentiality
Fatality Reviews in the United States

- All States but one have Child Death Review (CDR) teams
- 17 States use their CDR team as the citizen review panel for review of fatalities
- 200 Fetal and Infant Mortality Review (FIMR) programs in 40 States
- 144 Domestic Violence Fatality Review (DVFR) teams at the State and local level
Shared Guiding Principles

- Deaths and serious injuries are sentinel events: markers for the health and safety of people.

- Environmental, social, economic, health and behavioral factors impact the death or injury.

- These factors are so multidimensional that responsibility for a death or injury doesn’t belong to any one place.

- Reviews focus on what when wrong and how can we fix it, not who is at fault and who should we blame.

- The best reviews are multi-disciplinary.
Keys to Success

- Legislation
- Multidisciplinary membership at leadership
- Local Teams
- State level advisory committees
- Training for members
- Data and reporting
- Deliberate effort to define abuse and neglect.
- Focus on agency improvements as well as prevention.
- Self evaluation
Opportunities for Collaboration

• Administrative home
• Membership
• Case identification
• Data collection
• Joint meetings
• Cross pollination/communication
• Joint training
Commonalities Between Reviews

- Types of cases
- Intense case Review
- Multidisciplinary membership
- State and local focus
- Production of reports
- Goals of improving systems, supporting families and preventing deaths
Differences

- Organizational homes
- Membership
- Citizen/parent involvement
- Focus on “agency performance”
- Only CRP is federally required.
- Near fatal case review
Benefits to Collaboration

- Legislative support
- More cases
- More information
- More knowledge about agencies
- Existing multidisciplinary team
- More resources
- Near fatals
- Access to citizen participation
- Coordinated prevention
What States are Doing to Collaborate
What Can You Do?

• Discourage duplication of efforts in case identification, preparation and review.
• Encourage the sharing of review findings across review processes.
• Maximize possibilities to develop coordinated recommendations and reports.
Writing Effective Recommendations

**Key Ingredients**

- **Assessment**
  - Provide assessment of the problem
  - Describe particular risks or protective factors to be influenced
  - Include information on best and promising practices
  - Discuss current efforts, resources, and capacity

- **Recommendation**
  - Discuss the primary outcome that is sought
  - Identify the agency, persons, or organizations responsible for implementation
  - Identify the target population
  - Include a detailed plan of action
  - Understand the target audience
Writing Effective Recommendations

Key Ingredients

- Recommendations need to be both concrete and visionary
- Recommendations need to be detailed without being too restrictive
- If recommending legislative change, provide suggested legislative language
- Vet recommendations with the targeted agency(ies) to identify and address potential barriers to implementation
Writing Effective Recommendations

Key Ingredients

• Undertake a comprehensive review of the circumstances of a particular cause of death (e.g., SIUDS, motor vehicle)
• Understand the community context
• Establish a separate subcommittee to conduct an analysis of team recommendations and develop final recommendations
• Tie recommendations to specific findings of case reviews in order to make them more persuasive
• Examine recommendations on an annual basis and reissue them until implemented
• Identify the person(s) who will follow-up and track progress on implementation
Fatality Review Team Recommendations

Findings from a Review of Reports

• Most of the recommendations were for:
  • increasing public awareness and education
  • improving policies and legislation
  • strengthening organizational capacity
  • Fewer recommendations for improved collaboration, increased funding, and improved service delivery

• Agency, persons, or organizations for implementation were not often identified

• Many teams made global statements indicating that parents should make specific changes in behavior or that communities should provide particular supports or services
Fatality Review Team Recommendations

Findings from a Review of Reports

- There was no mention about how the different fatality review teams could collaborate in order to enhance injury prevention.
  - Both CDR and FIMR teams made recommendations regarding deaths due to SIDS
  - DVFR teams acknowledged the impact of DV on children and made recommendations for CPS cases involving DV
- All teams acknowledged that collaboration among many agencies and providers was necessary in order to effectively implement recommendations
Fatality Review Team Recommendations

Findings from Selected NCDR-CRS Records

- CAN Related Recommendations
  - 982 records included 1,872 recommendations
  - 28.5% of the recommendations were for parent education
  - 78.8% of the recommendations pertained to some type of educational activity
  - More likely to be directed at local and States entities (child welfare)

- Non-CAN Related Recommendations
  - 2,386 records included 5,010 recommendations
  - 27.5% of the recommendations were for parent education
  - 78.8% of recommendations pertained to some type of educational activity
  - A higher percentage directed at the national level
Development of Recommendations

Opportunities for Collaboration

• Develop an integrated database to track trends and patterns at the State level to better understand child fatalities

• Develop joint training on facilitation of the development of recommendations

• Share information about best and promising practices

• Hold joint meetings to share findings and recommendations to identify areas of mutually identified problems and develop joint recommendations

• Develop joint reports
From Recommendations to Action

Findings

*Even with vastly more specific… recommendations, it is their implementation that actually may reduce the numbers of children who die.*

- **Commitment to prevention**
  - Each team member must be committed to taking what they learn from the reviews and use that information to educate their own agencies and advocate for needed changes in practice and policy
  - Important to highlight problems, but also successes

- **Dissemination strategies**
  - Disseminate reports far and wide (include cover letter)
  - Select the right messenger(s)
  - Work with the media
  - Make in-person presentations
From Recommendations to Action

Findings

- Conditions that Increase Likelihood of Implementation
  - Include people on the team that have the authority to effect changes in their own agencies
  - Conduct advocacy with legislators and elected officials
  - Identify efforts that will change public opinion and public will for change
  - Implement a separate Community Action Teams (CAT) responsible for getting recommendations implemented
  - Develop memoranda of understanding regarding next steps for implementation
  - Conduct research on the consumers of the recommendations
Translating Recommendations into Action

Opportunities for Collaboration

- Identify common ground among the different fatality review teams
  - All have the same purpose of decreasing fatalities
  - “Family violence” is a causal link

- Build strategic partnerships
  - Among fatality review teams
  - With agencies and organizations
Achievements of Fatality Review Teams

Findings

• Results
  • Improved interagency communication
  • Implementation of numerous strategies to promote public awareness and education
  • Implementation of prevention strategies focused on high risk populations
  • Changes in policy and legislation
  • Strengthened organizational capacity
  • Improved service delivery
Achievements of Fatality Review Teams

Findings

- Many of the fatality review team reports did not discuss the accomplishments of the team
- A majority of the reports did not directly link their accomplishments to specific recommendations
Evaluating Fatality Reviews

Findings

“*It is important for teams to assess their processes to ensure that their work continues to be relevant for prevention advocacy*”

- Are there ways to improve the efficiency of the process and functioning?
- Are the reviews leading to changes in policies, services, and programs?
- What is the impact of fatality review teams on reducing fatalities?