



Child Abuse and Neglect Fatalities 2014: Statistics and Interventions

Despite the efforts of the child protection system, child maltreatment fatalities remain a serious problem.¹ Although the untimely deaths of children due to illness and accidents are 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 involve complicated data collection.

¹ 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 2014, visit the Centers for Disease Control and Prevention website (http://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html). Statistics on child homicide from 1980 to 2011 can be obtained from the U.S. Department of Justice (<http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2221> and <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4863>).

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Unless otherwise noted, statistics in this factsheet are taken from *Child Maltreatment 2014* (see <http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2014>) and refer to the Federal fiscal year (FFY) 2014 (U.S. Department of Health and Human Services, 2015). As all States were able to report unique counts (in which each victim is counted just once) for FFY 2014, the Child Maltreatment report series has transitioned from analyses with duplicate counts (in which a victim is counted each time the child is found to be a victim) to analyses with unique counts. For the *Child Maltreatment 2014* report, basic counts and demographic analyses (age, sex, and race) were conducted with the unique counts. For analyses where events and attributes of the victims were examined—such as disposition type and perpetrator relationship—a duplicate count was used. Statistics were received from all 50 States, the District of Columbia, and Puerto Rico. Statistics refer to the year in which the deaths were determined to be from maltreatment; in some cases, this may have been different from the year in which a child actually died.

How Many Children Die Each Year From Child Abuse or Neglect?

According to data from the National Child Abuse and Neglect Data System (NCANDS), 50 States reported a total of 1,546 fatalities. Based on these data, **a nationally estimated 1,580 children died from abuse and neglect in 2014**. This translates to a rate of 2.13 children per 100,000 children in the general population and an average of four children dying every day from abuse or neglect. This rate increased slightly from FFY 2013 and showed a 1.3 percent increase from 2010. 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 as well as by the U.S. Census Bureau’s child population estimates. Some States that reported an increase in child fatalities between 2010 and 2012 attributed it to improvements in reporting after the passage of the Child and Family Services Improvement and Innovation Act (P.L. 112–34).

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, law enforcement, 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. One report on national child abuse and neglect deaths in the United States estimates that approximately 50 percent of deaths reported as “unintentional injury deaths” are reclassified after further investigation by medical and forensic experts as deaths due to maltreatment (Every Child Matters Education Fund, 2012). It is often more difficult to establish whether a fatality was caused by neglect than it is to establish a physical abuse fatality. The different agencies that come into contact with a case of a possible child neglect fatality may have differing definitions of what constitutes neglect, and these definitions may be influenced by the laws, regulations, and standards of each agency (Schnitzer, Gulino, & Yuan, 2013).

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

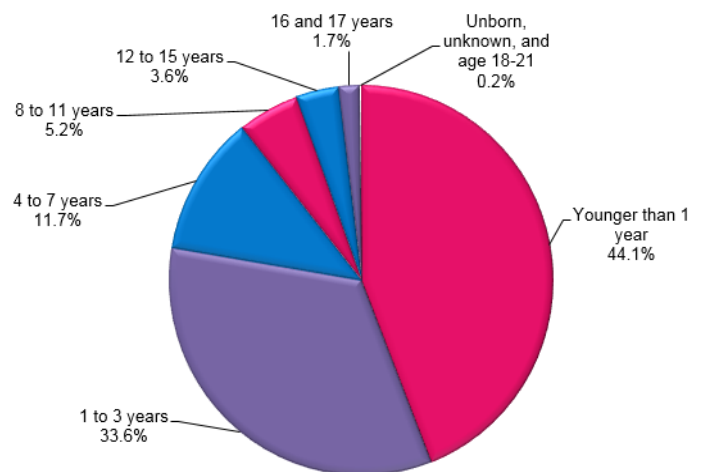
- Inaccurate determination of the manner and cause of death, resulting in the miscoding of death certificates; this includes deaths labeled as accidents, sudden infant death syndrome (SIDS), or “manner undetermined” that would have been attributed to abuse or neglect if more comprehensive investigations 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 report by the U.S. Government Accountability Office that assessed NCANDS data, surveys and interviews with State child welfare administrators and practitioners, and site visit reports to three States suggests that facilitating the sharing of information and increased cooperation among Federal, State, and local agencies would provide a more accurate count of maltreatment deaths (U.S. Government Accountability Office, 2011). 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 2014 demonstrated that children younger than 1 year accounted for 44.2 percent of fatalities; children younger than 3 years accounted for 70.7 percent of fatalities. These children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves.

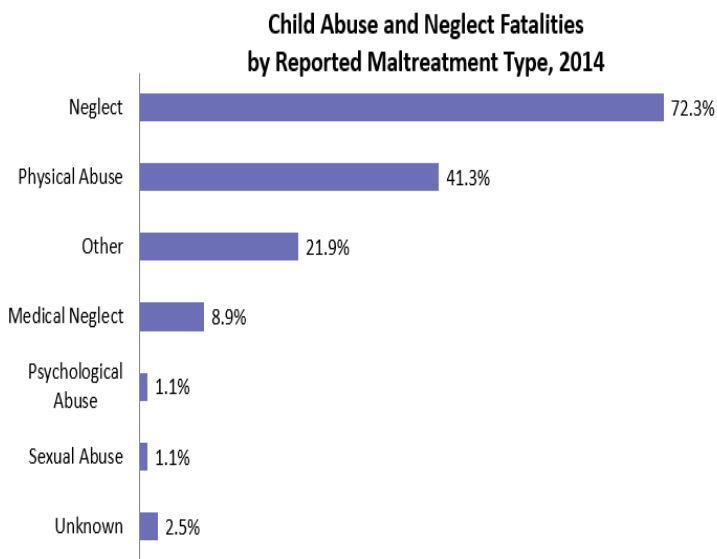
Child Abuse and Neglect Fatality Victims by Age, 2014



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 2014, 72.3 percent of children who died from child maltreatment suffered neglect either alone or in combination with another maltreatment type, and 41.3 percent suffered physical abuse either alone or in combination with other maltreatment. Medical neglect either alone or in combination was reported in 8.9 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 2014, parents, acting alone or with another parent, were responsible for 79.3 percent of child abuse or neglect fatalities. More than one-quarter (28.0 percent) were perpetrated by the mother acting alone, 15.0 percent were perpetrated by the father acting alone, and 21.8 percent were perpetrated by the mother and father acting together. Nonparents (including kin and child care providers, among others) were responsible for 15.7 percent of child fatalities, and child fatalities with unknown perpetrator relationship data accounted for 5.0 percent of the total.

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
- 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 child death review (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 exist at a State, local, or State/local level in the District of Columbia and in every State,² 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.

² For information about child fatality review efforts in specific States, visit the National Center for the Review and Prevention of Child Deaths at <http://www.childdeathreview.org>.

Recent data show that 49 States have a case-reporting tool for CDR; however, there had been little consistency among the types of information compiled. This contributed to gaps in the understanding of infant and child mortality as a national problem. In response, the National Center for the Review and Prevention of Child Deaths, 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 March 2016, 45 States were using the standardized system, and 2 more were considering adopting the system.³ As more States use the system and the numbers of reviews entered into it increase, a more representative and accurate view of how and why children die from abuse and neglect will emerge (Palusci & Covington, 2013). 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 2015, 16 State CDR boards serve additional roles as the citizen review panels for child fatalities.⁴

How Can These Fatalities Be Prevented?

When addressing the issue of child maltreatment, and especially child fatalities, prevention is a recurring theme. The prevention strategies and initiatives discussed below offer a variety of approaches.

³ Kansas and Vermont are considering joining the CDR Case Reporting System. Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming are participating. (Source: National Center for the Review and Prevention of Child Deaths)

⁴ Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Michigan, Missouri, New Jersey, North Dakota, Oklahoma, South Carolina, Texas, Virginia, Wisconsin, and Wyoming

Child fatality review teams. 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).

Data collection and analysis. Some States have begun to integrate other data with CPS data to help identify high-risk families and provide prevention services before maltreatment happens (Putnam-Hornstein, Wood, Fluke, Yoshioka-Maxwell, & Berger, 2013). Integrating data from birth certificates, emergency room visits, and other social services sectors with CPS data and then analyzing those data for trends in risk may also help child welfare professionals make better-informed decisions about prevention (Putnam-Hornstein et al., 2013). Users of the CDR Case Reporting System can record their recommendations for prevention efforts. Examples of recommendations include improved multiagency coordination policies for death investigations; improvements in CPS intake, referral, and case-management procedures; intensive home visiting; worker training; and improved judicial practices (Palusci & Covington, 2013).

A public health approach. A number of experts have championed a public health approach to addressing child maltreatment fatalities, which focuses on improving the health and well-being of individuals and communities before child maltreatment happens (Richmond-Crum, Joyner, Fogerty, Ellis, & Saul, 2013). Specifically, a public health approach involves defining the problem, identifying risk and protective factors, understanding consequences, and developing prevention strategies (Covington, 2013). And, true to its name, a *public health*

approach involves the entire community in preventing child maltreatment and ensuring that parents have the support and services they need before abuse and neglect can occur.

Improved training. Several recent articles have noted the need for better training for child welfare workers in identifying potentially fatal situations. Current child welfare training curricula do not always address child maltreatment fatalities; in fact, a recent study of preservice child welfare training curricula in 20 States found that only 10 States even mentioned child maltreatment fatalities, and only 1 State included a full section on the topic (Douglas, Mohn, & Gushwa, 2014). Given the complex nature of child maltreatment, training needs to go beyond the use of tools and assessments to include good critical thinking and decision-making skills (Pecora, Chahine, & Graham, 2013).

Federal initiatives. The Federal Government has a long history of promoting prevention. The first National Child Abuse Prevention Week, declared by Congress in 1982, was replaced the following year with the first National Child Abuse Prevention Month. Other activities followed, including a 1991 initiative by Louis W. Sullivan, M.D., the Secretary of HHS, designed to raise awareness and promote coordination of prevention and treatment. 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 that included an opportunity for individuals and organizations across the country to work together. This ongoing initiative also includes the publication of an annual resource guide.⁵ 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 and Neglect section of the Child Welfare Information Gateway website at <https://www.childwelfare.gov/preventing>.

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

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.

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Additional Resources

National Center for the Review and Prevention of Child Deaths

<http://www.childdeathreview.org>

The National Center for the Review and Prevention of Child Deaths 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. The State map tool at <https://www.childdeathreview.org/cdr-programs/u-s-cdr-programs/> provides links to CDR reports for each State.

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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