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Brief Communication

Effects of a Citizens Review Panel in preventing child maltreatment fatalities☆,☆☆

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Introduction

Though child abuse rates are declining in the United States, there has been no real change in the number of child maltreatment (CM) fatalities (US Department of Health and Human Services, 2008). While year-to-year numbers vary, there were an estimated 1,530 child abuse and neglect deaths reported by the National Child Abuse and Neglect Data System during 2006, representing 2.04 deaths for every 100,000 children. It is widely accepted that this number is underestimated for many reasons, including inconsistencies in investigation, reporting, legal standards and definitions, and medical diagnosis and death certificate coding (Crume, DiGuiseppi, Byers, Sirotnak, & Garrett, 2002; Ewigman, Kivlahan, & Land, 1993; Schnitzer, Covington, Wirtz, Verhoeck-Oftedahl, & Palusci, 2008). There are a number of risk factors associated with maltreatment fatalities, such as residing in homes with unrelated adults, young age of the child, and prior involvement with child protective services, and this information can aid in developing initiatives to prevent further deaths. Fatalities from neglect remain difficult to identify and prevent given the potential overlap with accidental and medical causes (Brewster et al., 1998; Crume et al., 2002; Hicks & Gaughan, 1995; Knight & Collins, 2005). To better identify, understand and respond to the system issues and prevention possibilities in these deaths, we sought to evaluate changes in our state after the implementation of a citizen panel that reviewed child maltreatment fatalities in the child welfare system.

Child fatality review teams (CFRTs) have been instituted in most US states to provide a multidisciplinary, multi-agency review of all or most child fatalities (Durfee, Durfee, & West, 2002; Durfee, Gellert, & Tilton-Durfee, 1992; Hochstadt, 2006;

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National Center for Child Death Review, 2008; Webster, Schnitzer, Jenny, Ewigman, & Alario, 2003). All have reviewed maltreatment fatalities and have identified abuse cases that have been misclassified or misdiagnosed as due to natural causes or unintentional injury (Jenny & Isaac, 2006; Kellogg & Lukefahr, 2005; Levene & Bacon, 2004; National Center for Child Death Review, 2008; Schnitzer et al., 2008). In Philadelphia, most child homicides were found to be preventable, and the review process was thought to provide one source of comprehensive data to allow policymakers to formulate solutions (Onwuachi-Saunders, Forjuoh, West, & Brooks, 1999). In Arizona, the state CFRT was able to identify and correct an incorrect cause of death in 13% of death certificates and suggested that 38% of all child deaths after the first month of life could be prevented (Rimsza, Schackner, Bowen, & Marshall, 2002). This leads some to believe that child death review teams can make significant contributions to the protection of children and the prevention of child deaths and serious injury (Hochstadt, 2006). A recent review identified 11 categories of over 300 recommendations resulting from CFRTs in the US (Douglas & Cunningham, 2008).

There are, however, additional opportunities for improvement and prevention within the child welfare system itself (King, Kiesel, & Simon, 2006). While the death of a child is a rare event and most children known to the child welfare system do not die, there are some who do. In 2006, 13.7% of deaths nationally were in families who had received prior family preservation services and 2.3% had been in foster care during the past 5 years (US Department of Health and Human Services, 2008). This suggests that there may be steps to be taken to improve outcomes in child protective services and foster care agencies. New strategies include using a children's ombudsman (Bearup & Palusci, 1999), a state child advocate (Faith VosWinkle, Connecticut Child Advocate, personal communication), and the establishment of federally mandated Citizen Review Panels (CRPs).

CRPs were first required in 1996 for US states as part of re-authorization of the Child Abuse Prevention and Treatment Act (CAPTA), and many states have instituted CRPs specifically to review child maltreatment fatalities (Child Abuse Prevention and Treatment Act, 1998; US Department of Health and Human Services, 1998). While both CFRTs and fatality CRPs review child deaths, CRPs are constituted expressly for the purpose of reviewing deaths of children known to the governmental child protective services agency and are charged with making recommendations primarily to that agency within the child welfare system. CRPs are ideally made up of a representative sample of the community, are required to meet at least quarterly, and fulfill a broad mandate which includes ensuring that the state is in compliance with CAPTA, Title IV-E programs, and other requirements (Jones, Litzelfelner, & Ford, 2003). CRPs have been constituted variably across the US, and their effectiveness has been evaluated only to the extent that there was citizen participation or implementation of their recommendations (Jones, 2004). For this study, we were specifically interested in identifying the number of child deaths and problem areas in the state child welfare system during 6 years of review and any specific changes in child welfare law, policy, and practice that could be associated with fewer child maltreatment deaths.

Methods

Team composition

Michigan instituted three CRPs in 1999, each with emphasis on a different area: foster care and adoption, prevention, and child fatalities. For the Fatality CRP, a committee of volunteer members was self-selected from the state's Child Death Review Board, and membership included a broad spectrum of experts in forensic medicine, pediatrics, law enforcement, child law, child protective services, public health, mental health, education and child advocacy similar to other child fatality review efforts (Durfee & Tilton-Durfee, 1995; Durfee et al., 1992; Webster et al., 2003). The state department of social services funded a staff person working at an independent, non-profit agency to assist the team in collecting case information for the reviews. Nine team members participated during the entire study period and received annual multi-day training on both the case review and CRP process. While additional members, support staff, and state agency members were added in later years, there were neither substantial change in the disciplinary composition nor qualitative aspects of the team case review process during the study period.

Case identification and selection

Potential maltreatment deaths were initially identified for children 0–18 years of age by cross-matching death certificate information collected by state vital statistics, county-based child death review team reports, and our state department of human services death abstracts. Published news reports and obituaries were also consulted. Cases were selected for Fatality CRP review when the death was reported to the National Child Abuse and Neglect Data System, was deemed to be from abuse or neglect using state criminal and civil definitions of maltreatment, or when the panel determined that there were serious acts of omission leading to a death, independent of legal determinations. With the cooperation of state social services, public health, law enforcement and local district attorneys, the Fatality CRP had a comprehensive case file on each death for their review that was compiled from state child protective services agency records and the state CFRT.