Child Fatality Review Teams

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• Child abuse • Death • Fatality review

The history of child fatality review (CFR) begins with the work of Ambrose Tardieu in 1860. More than a century later, in 1978, the first team was established in Los Angeles, California. This article reviews the history of CFR, the composition of teams, and its purpose based in preventive public health. The successes of 3 decades and challenges for the future of CFR are discussed.

OVERVIEW

French Physician Ambrose Tardieu described fatal child abuse in detail in 1860.[1] Dr Tardieu wrote in ornate French detailing the injuries of dead children. He added comments about the skepticism of his colleagues, who apparently ignored his work. Child abuse, however, was not widely acknowledged for a century, until the publication of ''The Battered Child Syndrome'' by C. Henry Kempe, MD and colleagues in the *Journal of the American Medical Association* in 1962.[2] This publication led to the development of laws requiring the reporting of child abuse in all 50 states. Child protective services assumed a more substantial role in the early 1970s with the passage of the Child Abuse Prevention and Treatment Act (PL 93-274) by Congress, and increased law enforcement and prosecution followed shortly thereafter. Child abuse was not indexed in the medical literature (Index Medicus) until 1965, and the topic of infanticide was not added until 1970.

Major response to fatal child abuse grew in the late 1980s and the 1990s with expansion of state child death review teams. A diverse group of professionals created the early child death review teams, building on other multiagency programs that were developing in child abuse assessment and prevention programs. Social changes after World War II may be part of the reason that such programs became possible. These changes included the expanding roles for women, which may have been a necessary

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precursor to the increased social status of children, professional and public acceptance that child abuse does occur, and the understanding that child abuse is a public health issue. Team members were exposed to child death, particularly deaths of infants and toddlers. They met counterparts from other professions and learned the value of multiagency team case management. New skills and relationships developed that were helpful in the review of nonfatal cases and in the development of prevention programs. This article discusses the change in the response of professionals to fatal child abuse from Dr. Tardieu's time to the present.

EARLY INFORMAL PEER SUPPORT

In the history CFR, it is clear that the motivation, skills, and leadership of early advocates led to the successful national and international expansion of both the purpose and scope of CFR. Child deaths are painful both to line professionals and to local people who have seen, heard, and touched the child who died. Being close to a child during his life makes the death more of a loss. Team dedication often was driven in part by the pain that accompanies the death of a child. Thus many teams found direction and informal support from members of other teams.

Some teams formed in response to a notorious child abuse fatality. Early case intake and review was expanded beyond abuse to include all injury deaths. Most early, informal teams were local and consisted of members who were on or near the front line of community interaction in their profession. The organizer's task required calling multiple agencies, arranging a room, creating and sharing a list of cases, and being positive. Social skills and tenacity were critical. Maternal mortality review, which measured the death of mothers in childbirth with reports originating in New Jersey in 1938, may have been the first ongoing death review in the United States.

FORMAL TEAMS

The first CFR team began in 1978 in Los Angeles County and was housed in the Interagency Council on Child Abuse and Neglect (ICAN), which had multiagency groups working in other areas.[3] Some questioned the benefits of discussing dead children. A few stated their lack of interest, but those who were invited came to the review. The value of child death review was understood after the first case reviews, as members discovered that each member was lacking information that others could provide. The story of the death became more complete and more real. Case management improved with more complete and more competent information of the events leading to death. A few cases with suspicious injuries were explained reasonably and labeled accidental deaths. Some other reviews uncovered a hidden or incomplete homicide investigation.

San Diego County created the second team in 1982. In contrast to the Los Angeles County cases, which showed a peak for fatal child abuse in the first year of life, the San Diego team initially found a peak for fatal child abuse at age 3 years. The San Diego team increased its focus on infants after consultation with the Los Angeles County team resulted in modifications of their Dan Diego case intake process and yielded an increase in missed suspicious infant deaths. Formal data collection and analysis reaffirmed some early premises, including the fact that infants comprise about 40% of the total cases of fatal child abuse. National data from the US Department of Health and Human Services (USDHHS) confirm these data today.[4]

About a dozen California counties had similar review teams by the mid 1980s, when Oregon, South Carolina, and Missouri initiated teams. Oregon used the California experience to build the first state team with logical structures that provided a model