Child Abuse & Neglect 72 (2017) 433–445

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Research article

A fatal review: Exploring how children's deaths are reported in the United States

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ARTICLE INFO

Keywords:
Child death
Death reporting
Medico-Legal system
Child fatality
Coroner
Medical examiner

ABSTRACT

Child death reports are the leading data source used to orchestrate child fatality prevention policy. Therefore, the way in which child death is reported is crucial to how we sustain life. We sought to assess the systematic ways in which death is reported for children. Based on a qualitative analysis of medico-legal investigation reports collected from a medical examiner's office and a coroner's office, we examined several indicators of data completeness, quality, site organizational structure, and consistency. We found stark differences between the two sites, as well as issues regarding death diagnosis certainty, and a general lack in consistency in the reports' content, as well as procedures performed post-mortem. We conclude that there are some flaws in our death reporting system for child populations, which have the potential to hinder reliability and accuracy of these death reports, as well as thwart their overall usefulness in prevention policies.

1. Introduction

Despite the inevitability of death (Becker, 2007), our society, with the rise of public health and modern medicine, puts a great deal of effort in finding ways to prolong life (Kastenbaum, 2000), notably through the study of death. In recent decades, child death in particular has become of popular interest. Each year, more than 20,000 children and youth under age 20 die unexpectedly in the United States (WHO, 2010). This includes both intentional and unintentional deaths. Despite a dramatic drop in child fatalities throughout the mid- to late-1990s, child death remains a significant concern among the public, policymakers, and researchers. Violent child death is more likely to affect minority youth in inner cities, whereas white youth are at risk for suicide (Balis & Postolache, 2008). Additionally, with the recent string of mass school shootings there has been an increasing interest in violent child death (Alvarez & Bachman, 2016).

Since all deaths in the United States must officially be documented, death reports have been used for a wide variety of prevention efforts. These prevention efforts typically include one of three methods: First, reports of death are used to compile mortality statistics at the local, national (Centers for Disease Control), and international (World Health Organization) levels. Second, these aggregated reports of death are used for theory development and testing in our goal to better understand death in order to prolong life. Such theories tend to focus on identifying factors causally linked to specific types of preventable deaths in populations. Third, based on these theories, the statistics are also used to create public health policies that strive to prevent untimely deaths from occurring.

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http://dx.doi.org/10.1016/j.chiabu.2017.09.005
Received 1 July 2016; Received in revised form 9 August 2017; Accepted 7 September 2017

While the utilization of death reports is a sound approach to prevention efforts, one fundamental issue is that not enough is known about how death is reported. Previous literature has outlined the overall process of death reporting. However, the process itself is complicated by numerous institutional factors pertaining to variations between jurisdictions, as well as individual decedent factors such as gender, race, age, and manner or cause of death. Thus, without more complete knowledge of how child death is reported, previous and current discussions may be lacking crucial insight needed to produce effective death prevention policy.

We propose an in-depth exploration of the characteristics of child death reports in the United States. We do so through a qualitative analysis of the details and components of a small sample of medico-legal child death reports, in order to provide a level of depth and context often missing in the analysis of medico-legal processes. More specifically our analysis focuses on the organizational characteristics, quality, completeness, and consistency of the information presented in deaths reports. We will first provide an overview of the extant literature in order to frame our research, then describe our methodological approach. Finally, after outlining our results, we will discuss their relevance within the field. Furthermore, the strategies and recommendations presented in this article should be viewed as starting points, not solutions. Hopefully, with more knowledge of how child death is reported in the United States, policymakers and the public will begin to think broadly and creatively about how to reduce the death and injury among children and youth.

2. Literature review

2.1. Brief history of death reporting in the United States

Mandated death reporting did not begin in the United States until 1837. Prior to that, following the European tradition, major life events were mainly reported in church records. This was problematic because not all churches maintained such records and not all individuals attended church (Hanzlick, 1997). As many states began to recognize this, the responsibility of death reporting was transferred to the courts. Then in 1844, school teacher and politician Lemuel Shattuck founded of American Vital Records System to house all records of death in this country. This system required all states to submit reports of death annually. These records required a signature either from families, midwives, physicians, or in some jurisdictions, police officers. This was a drastic improvement; however, these records were not standardized (Hanzlick, 2006). It was not until 1910 that a standard death certificate was implemented. The new document included not only the surname, forename, date of birth, sex, place of birth, parent(s)' names, their address, and occupations at the time, but also the immediate, intermediate, and underlying causes of death (Kircher & Anderson, 1987). This new system of death reporting began to play a profound role in death investigations.

Death reporting today has come a long way since 1910. As far as the process for reporting death, states can offer their own variations; however, most comply with the U.S. Standard Death Certificate, which is issued by the Centers for Disease Control's (CDC) National Center for Health Statistics (NCHS). California, Idaho, New York City and State, and Montana were the first to use this form for death reporting. Since then, 27 other states have adopted this same system. The agency last revised its form in 2003 (US Department of Health and Human Services, 2006).

3. Death reporting practices

3.1. Cause of death

One of the most crucial elements of reporting death is listing the cause of death. The cause of death is the disease or injury responsible for the lethal sequence of events (Mokdad, Marks, Stroup, & Gerberding, 2004). These factors are sometimes determined by a specialized dissection procedure known as *autopsy* (Lauer, Blackstone, Young, & Topol, 1999). Additional testing, such as micropathology and toxicology analyses, can be ran, and medical records, psychiatric reports, and statements from next of kin may also be gathered to aid the process (Rao, Lopez, & Hemed, 2006).

3.2. Manner of death

The manner of death differs from the cause of death as it legally classifies the death according to the presence or absence of pathological attributes, as well as the source of a lethal intent (Mokdad et al., 2004). There are four manners of death: natural, homicidal, suicidal, and accidental. *Natural deaths* are characterized by the body ceasing function of its own accord, often because of some form of illness. *Homicide* is described as death which results from one human taking another's life. *Suicide* is the deliberate taking of one's own life. Finally, *accidental death* implies that the death was neither natural, nor intended (either by the decedent or another) (Goodin & Hanzlick, 1997).

Two additional manners of death have been added for legal purposes. In the United States death may be classified as *undetermined*, if there is not enough evidence to determine the type of death (Davis, 1997), or *unclassified*, if the circumstances surrounding the death are too complex to classify (Davis, 1997). This is used in incidents where there is evidence to suggest that multiple events may have contributed to the death.

3.3. What is an autopsy?

In efforts to understand factors that may have contributed to or caused death, an autopsy may be performed. Autopsies