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Child death reviews in the context of child abuse fatalities – learning from international practice

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Violence against children is a pervasive global problem with deaths from child abuse viewed as the most extreme consequence. The World Health Organisation, using limited country data from low- and middle-income countries, estimates that 53 000 children were victims of homicide during 2005.¹ Until recently, very little was known about child deaths in the context of violence in South Africa.

The first national child homicide study established that 1018 children died due to homicide in 2009 at a rate of 5.5 per 100 000 children under 18 years², compared to the global rate of 2.4 per 100 000 children¹. The study also showed for the first time the relationship between child homicide and fatal child abuse in South Africa and estimates that just under half (44.6%) of child homicides were in the context of child abuse and neglect. Almost three quarters (74%) of fatal child abuse occurred in the 0 – 4-year age group, with most of these deaths occurring in the home.

A concern is that this study has underestimated the incidence of fatal abuse as such deaths can be misclassified as natural deaths or accidental injury deaths. In addition this study found that medical practitioners, particularly forensic pathologists, deviated from their legal and ethical obligation to report suspected cases of child abuse and that these cases remain unreported.³

Under-ascertainment of fatal child abuse an international concern

Globally, underestimating the burden from child abuse or child maltreatment has been shown in multiple settings with only a third of these deaths classified as homicide.⁴ It is estimated that 13% of all injury deaths in children under-15 are due to child abuse and neglect.¹ Studies from high-income settings have shown that fatal child abuse is poorly detected in vital statistics and by child protection services and the police, resulting in a huge underestimate of fatal child abuse.⁴ The poor identification rates of child abuse deaths are proposed to be primarily due to difficulties in identifying such deaths, investigating and reporting of the deaths by police to child protection services, and a lack of standard definitions of child maltreatment.⁵ Deaths due to violence or severe physical abuse have been shown to be the most likely recognised child abuse death,⁶ while deaths related to omission of care such as neglect – including abandonment or resulting in drowning, poisoning and fire injury – are more likely to go undetected⁶. In addition, deaths in infancy due to asphyxiation from smothering are easily misclassified as Sudden Infant Death Syndrome (SIDS), with 10% of SIDS deaths shown to be infanticide.⁷ Overall, the most common perpetrators of child abuse are parents, yet in child abuse deaths unrelated perpetrators are more commonly identified.⁶

About this brief

This briefing paper provides a review of published articles and reports on child death review mechanisms internationally. The subject matter and the available literature did not lend itself to a systematic review, although the authors sought to identify the most relevant materials to review. The search revealed child death review processes only in high-income settings, suggesting the need to explore its efficacy in middle- and low-income settings.

The review points to several enabling factors for a child death review mechanism: The use of a public health approach; the need for leadership, resources and a policy and legislative framework; a nationally standardised process to shape policy and practice, and the use of nationally standardised definitions and data collection processes and tools.



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Briefing Paper

Child maltreatment is a global problem

The United Nations *World Report on Violence Against Children* has shown that child maltreatment is a pervasive problem that mainly occurs within the family context and has serious long-term consequences.¹ The family is conceptualised as the natural setting for the optimal growth and development of children and the United Nations Convention on the Rights of the Child requires the state to support the family. However, the nature and construction of families are changing globally due to urbanisation, placing pressure on families as traditional sources of support are no longer available and children are left vulnerable as a result of migration and protracted periods of family separation.⁸

The magnitude of child maltreatment is substantially underestimated and estimates are unreliable as protection services data, self-reports and community surveys are primarily used to determine prevalence and incidence of maltreatment.⁴ Nevertheless, child maltreatment contributes significantly to child mortality and morbidity and has lasting consequences with respect to mental health as well as on the social integration of both males and females.³

Child maltreatment vs child abuse and neglect

Internationally the concept “child maltreatment” is used to define acts of commission or omission by a parent or caregiver resulting in harm, potential harm or threat of harm to the child.⁶

The World Health Organisation defines “child maltreatment” as encompassing physical abuse; sexual abuse; psychological or emotional abuse and neglect.⁸

The concept “child maltreatment” is not widely used in the South African context as legislation does not use this term but defines child abuse and neglect as follows:

The Children’s Act No 38 of 2005 defines:

- abuse in the context of physical injury as “*assaulting a child or inflicting any other form of deliberate injury to a child*”;
- neglect as “*a failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs*” of the child;
- sexual abuse as “*sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted*”.

The Act makes it mandatory to only report deliberate neglect but does not provide a definition for deliberate neglect.

Preventing deaths from child abuse and neglect – child death reviews as an international approach

Child abuse fatalities caught public attention in the United States and United Kingdom in the 1970s through individual case reports and subsequent inquiries into these deaths highlighted failures in their child protection systems.^{9,10,11} In addition, under-reporting of child abuse deaths was a concern as reporting systems were not accurately identifying cause of death in unexplained child deaths. In response, the first child death review team was established in 1978 in Los Angeles County as a multi-disciplinary, multi-agency approach to determine if abuse was associated with the unexpected child death.¹² Child death review teams developed in other states during the 1980s and ’90s in the US with only one state not having a child death review team by 2012.¹³

UNITED STATES

Child death review teams were first established to review suspected child abuse and neglect deaths but have expanded in most US states to a public health model of prevention of child fatalities through the review of all child deaths.¹² In 1991 the US Department of Health and Human Services endorsed the need for child death reviews and recommended its expansion to all states.¹⁴ A National Centre for Child Death Review was established in 2002, funded by the state to support child death review teams through training, the development of best practice models and the promotion of standardised comprehensive reviews.¹⁵

The national centre developed an online data collection tool and reporting tool, but only 37 states use the system, which impacts on the availability of national data and identification of national trends.^{13,15} Challenges remain, with no standardised process to review child deaths although some states mandate child fatality reviews by state or local teams while other statutes may only apply for discretionary formation of teams. The absence of child death reviews in all states and the lack of a national standardised approach affect the ability to collate national comparative data across states to influence national policies.

Child death review teams

The main purpose of child death review teams is to conduct a comprehensive review of suspected child abuse deaths, all injury-related child deaths, or all child deaths. Child death reviews aim to better understand how and why children die, and to use those findings to prevent other deaths and improve the health, safety and well-being of all children in the country, state or territory. The child death review team consists of core representatives from law enforcement, child protection/social services, a paediatric nurse/paediatrician, forensic pathologist, and a prosecutor.

UNITED KINGDOM

England and Wales have a long history of reviewing fatal child abuse but followed a model of public inquiry which differed significantly from the multi-disciplinary child death review approach used in the US. This earlier public inquiry model had an explicit focus on suspected child abuse deaths and resulted in the formalisation of interagency child protection procedures, the establishment of area child protection committees and a child protection register.¹⁶ Child death reviews were only formally implemented in England and Wales in 2008 under their Children's Act of 2004 which mandates each local authority to establish a child death overview panel to review all child deaths from birth to 18 years who live in the area.¹⁶ The aim of the reviews is to assess if deaths were preventable and to determine lessons learnt with the aim of preventing future deaths.¹⁶ Drawing on lessons from the US and elsewhere, multi-disciplinary teams are established under the Department of Children, Schools and Families. A framework of the child death review process has been developed nationally and is implemented at local level with a process of feeding recommendations from the local to national level. The establishment of child death overview panels are backed by government funding through health and local authorities.¹¹ Exploring the effectiveness of the current approach, it was recommended that the process should not be entirely based on record reviews but to have practitioners involved in reviews to encourage shared learning.¹¹

Northern Ireland introduced a case management review process in 2009. This process is facilitated by a regional child protection committee comprising senior managers from child protection organisations, health education and police, with a mandate to establish the facts of the case, improve inter-agency collaboration, and to systematically document lessons learnt to work together to safeguard children.¹⁷ Cases reviewed are either known to a child protection service or child abuse is suspected.

CANADA

The first multi-disciplinary child death review team was established in Manitoba in 1992 and has since expanded to all provinces and territories to investigate child deaths where a child was in care or known to a child protection agency.¹¹ The purpose of the review is to identify gaps in the child protection system with the aim of improving services. All reviews are conducted at provincial level located within the coroner's office.¹¹ There is a lack of consistency in the composition of child death review teams and data collected, as well as varying functions across the country. In some provinces they serve as watchdogs of government departments and in others they comprise multi-disciplinary teams either at the conclusion of a case or while a death is being investigated. As reviews are based provincially, without common definitions, they are unable to provide a national picture of child deaths in particular child abuse deaths.

AUSTRALIA

Child death review teams have been established in all states, with the exception of Tasmania and the Australian Capital Territory.¹⁸ There is no uniform national approach to child death reviews as the child protection system is state and territory based with different legislative frameworks that result in variations across the country.¹⁹ The lack of standardised measures results in variability in reporting and a lack of national comparable data for planning and policy development.¹⁸ The National Framework for Protecting Australia's children was introduced in 2009 with the aim of strengthening the child protection system through a national co-ordinated approach. There is however no legislative mandate to govern the establishment of child death review teams and no standardised approach to child death reviews.

NEW ZEALAND

The New Zealand Office of the Commissioner for Children began promoting the idea of a child death review system in 1993, but the Child and Youth Mortality Review Committee (CYMRC) was only established in 2002 after a protracted consultation process.²⁰ The CYMRC is a statutory body and has been established to review and report on all deaths of children and youth aged 28 days to 25 years.¹³ The committee meets quarterly and aims to collect standardised data from district health boards on every child and youth death in New Zealand. The district health board has a local chair and co-ordinator and reviews deaths at the local level and reports to the CYMRC at a national level. The aim is to identify national trends and patterns of child and youth deaths with the purpose of keeping children safe and healthy.

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Level, scope and legislative status of child death review processes in different countries

Country	Review mechanism	Scope of review	Legislated
Australia	Each state/territory differs	Variation across states; some only child abuse deaths and all child deaths	No
New Zealand	National co-ordinated system	All child and youth deaths from 28 days to 25 years	Yes
United States	All but one state have a child death review system, no standardised process	Variation across states; some only child abuse deaths and all child deaths	Variation across states
Canada	Each province/territory differs	Child deaths known to a child protection agency	Variation across provinces
United Kingdom	National co-ordinated system	All child deaths	Yes

Lessons learnt

In considering a child death review approach as a child protection measure, the following are useful to consider:

Public health approach:

Child death reviews use a public health approach in the utilisation of surveillance to identify risk factors and protective factors, and barriers to protection within the family and the community in order to develop interventions that are based on evidence from reviews.¹²

Leadership, policy and resources:

For child death reviews to achieve the aim of preventing child deaths, national leadership is required. This has been shown by models implemented in New Zealand and England, and backed by policy and resources to support the development of a nationally co-ordinated approach to child death reviews.

Policy and legislative framework:

Child death review teams mandated by policy and legislation enable easier data sharing and facilitate a comprehensive review.

Standardised process:

A nationally standardised process for child death reviews is critical to enable national policies and practices to be shaped by recommendations emerging from reviews.

Nationally standardised definitions and data collection processes and tools:

These are critical for national trends and patterns to be documented and to assist in the development of evidence-based prevention interventions.

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