

A Brief History of Child Death Review in the United States

1978: Local teams spring up in Los Angeles, Oregon and North Carolina to better identify child abuse fatalities.

1980s: Teams expand to other states through grass roots efforts.

1990: Landmark Missouri Child Fatality study validated that child abuse deaths are grossly underreported. This leads to a Missouri state law mandating reviews of all child deaths through age 14.

Child Death Review advocates, especially Michael Durfee of California and Gus Kolilis of Missouri, persistently encourage states to develop programs and begin to track implementation throughout the U.S.

A U. S. Healthy People 2000 Objective in the Violence Section includes, “*improve child death review systems.*”

1991: The American Bar Association Center on Children and the Law receives Robert Wood Johnson Foundation funds for a Child Maltreatment Fatalities Project, and publishes *Child Death Review Teams: a Manual for Design and Implementation* and *Child Fatality Legislation in the United States* as resources to help organize child death review teams.

1992: An article in *JAMA* describes the need to expand national implementation of CDR in response to “*critical need for the systematic evaluation and case management of suspicious child deaths.*”

The Maternal and Child Health Bureau (MCHB) at HRSA convenes an advisory group on CDR, which recommends that the primary purpose of CDR should be prevention and that teams should *implement the most expansive and comprehensive approach for identifying cases.*”

1993: The federal Child Abuse Prevention and Treatment Act (CAPTA) requires states to include information on child death review in their program plans.

1994: The Missing and Exploited Children Comprehensive Action Project holds a two-day national training teleconference on child fatality review teams, with funding from the Department of Justice, Office of Juvenile Justice and Delinquency Prevention (OJJDP),

The American Professional Society on the Abuse of Children forms a Task Force on CDR and publishes a special issue report on Child Fatalities.

Missouri convenes a national symposium on CDR. Forty-three states attend.

- 1995: The U.S. Advisory Board on Child Abuse and Neglect focuses on fatal abuse and in the report, *A Nation's Shame*, find that 45 states have some type of review program and recommends that there be a nationwide system of child death review teams to understand and reduce child abuse and neglect deaths.

The Association of Maternal and Child Health Programs issued a paper recommending that MCHB assume leadership in assisting states in CDR development; and that state Title V Directors develop CDR systems that focus on the prevention of all child deaths.

- 1996: OJJDP funds the Interagency Council on Child Abuse and Neglect (ICAN) in Los Angeles to serve as a resource for CDR teams, with a focus on abuse and neglect. ICAN establishes the ICAN National Center for Child Fatality Review. Funding continues through present day.

In the reauthorization of CAPTA, Congress requires states to establish at least three Citizens Review Panels, and mandates that at least one of them review child maltreatment deaths and near deaths.

- 1997: The ABA Center on Children and the Law's Child Fatality Project, with funding from the National Center on Child Abuse and Neglect in the Administration for Children, Youth and Families, holds a national CDR training in Washington, DC and produces a *Child Fatality Training Curriculum* and *A Selected Annotated Bibliography of Resource Materials for Child Fatality Review Teams*.

A number of states expand CDR reviews to *all* causes of child deaths (e.g. Arizona, Texas, Michigan, Colorado, Missouri, and Oregon.) This trend continues today.

An MCHB survey of state Title V programs finds that 15 of 41 states are funding local CDR efforts.

MCHB convenes a meeting of child death review, fetal infant mortality review and SIDS program experts to develop national recommendations for program coordination.

- 1999: The Midwest Coalition for Child Death Review is organized and holds its first annual meeting; and continues to meet annually each year thereafter.

2000: The U.S. Healthy People 2010 Injury Prevention Objective is changed to state: *Extend state-level child fatality review of deaths to deaths due to external causes for children aged 14 years and under.*

MCHB funds three states to develop review models integrating CDR, fetal infant mortality review, and/or maternal mortality review.

The Southeast Coalition on Child Fatalities is organized and holds its first bi-annual conference. Subsequent conferences are held in 2002 and 2005.

OJJDP's establishes a national training program of several weeklong training sessions on *Child Death Investigation* that include modules on child fatality review teams.

2001: Western states meet for a CDR training session in Lake Tahoe, coordinated by ICAN with funding from OJJDP.

2002: The National Fetal Infant Mortality Review Program publishes a special issue focused on the integration of CDR and FIMR.

MCHB awards a three-year grant to the Michigan Public Health Institute for the National MCH Center for Child Death Review.

2003: State Child Death Review Program Directors from 46 states convene at a meeting in Chicago funded through the National MCH Center for Child Death Review.

The National MCH Center for Child Death Review, with active participation of CDR staff from 25 states, develops a *National CDR Program Manual* and a *Child Death Review Case Reporting System*.

In the reauthorization of CAPTA, Congress recognizes that there may be a duplication of efforts in states with both Child Death Review and Citizens Review Panels, and thus changes from mandatory to permissive the requirement of Citizen Review Panels to study child fatalities and near fatalities. Fourteen states report that their child death review teams serve a dual function as a CAPTA Citizen's Review Panel for Child Fatalities.

Results of a two-year study of the status of child death review teams in the U.S. is published in the American Journal of Preventive Medicine: *Child Death Review, The State of the Nation*.

Results of a review of child death review legislation, conducted by researchers at the University of Louisville School of Medicine, and funded by the U.S. Centers for Disease Control and Prevention and the Association of Teachers of Preventive Medicine, is published in the *Journal of Law, Medicine and Ethics*.

2004: The State of Missouri, the National Child Death Review Resource Center and the Missouri Children's Trust Fund sponsor the Second National Symposium on Child Death Review, attended by 350 persons from 36 states and three countries.

In February, The Association of State and Territorial Health Officers publishes an Issue Brief, *State Efforts to Improve Child Death Review*, describing the status of CDR in the U.S. and stating that *CDR data and recommendations can help state and local public health agencies decide where to best invest their prevention dollars.*

In November, The National Conference of State Legislatures issues a report, *Preventing Child Fatalities*. The report is an overview of CDR and includes a listing of state policy options for child death review.

The Harborview Injury Prevention and Research Center at the University of Washington is awarded a three year grant from MCHB's Emergency Services for Children Program to develop a computer-based decision-support tool for child death review teams to use in identifying evidence based prevention options from their reviews.

2005: Five regional meetings of state teams from the Northeast, Southeast, Midwest and West are held, with funding from MCHB through the National MCH Center for Child Death Review.

The *Child Death Review Case Reporting System* is launched as a pilot in 12 states.

A new U.S. Healthy People 2010 Injury Prevention Objective is being considered as measurable: Objective 15-6: "Extend to 50, the number of states and the District of Columbia, where 100% of deaths to children aged 17 years and younger that are due to external causes, are reviewed by a child fatality review team, and 100% of all sudden and unexpected infant deaths (under one year of age) are reviewed."

MCHB funds the National Center for Child Death Review for three more years, following a competitive review process.

All but one state (Idaho) report that they have state and/or local CDR teams reviewing child fatalities.