

# Child Death Review Teams: A Vital Component of Child Protection

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The alarming number of children killed and seriously injured as a result of child maltreatment and neglect has led to increased calls for action. In response, interdisciplinary and multiagency child death review teams have emerged as an important component of child protection. Paradoxically, child death review teams are among the least visible and understood elements in efforts to protect children. This article examines the role and functions of child death review teams and their contributions to child welfare in practice, prevention, and policy.

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Fatal child abuse and neglect is a nationwide problem. Not only is the number of deaths due to child maltreatment far too high, but an alarming percentage of these deaths occur in children who are known to the child protection system. As a result, the work of child fatality or death review teams (CDRTs) take on added importance. These interdisciplinary and multiagency teams often are little known and their work misunderstood by child welfare and child protection personnel. CDRTs have made important contributions to the protection of children through the identification of case specific interventions for surviving siblings and their families, the formulation of prevention strategies, and the development of public policy designed to prevent child fatalities and serious injuries from maltreatment and other preventable causes.

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### The Scope of the Problem

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The manner in which adults kill children is a testament to the malevolence with which adults treat children. Children are hanged, suffocated, poisoned, drowned, set afire, scalded, starved, shot, strangled, crushed, thrown from windows, and stabbed, among other means. Head trauma is especially devastating to young children. Levitt, Smith, and Alexander (1994) conclude from a review of research that 10%–20% of all physical abuse injuries are caused by head trauma, most in children younger than 2 years. Bruce and Zimmerman (1989) suggest that although 10% of head injuries in children are the result of nonaccidental trauma, 80% of deaths due to head trauma in children under age 2 result from abusive head injury. For example, Hicks and Gaughan (1995), in a review of fatal child abuse and neglect, find that 71% (10 of 14) of cases were the result of blunt head trauma and that two children died of neglect.

Prevalence data on child fatalities caused by abuse and neglect are difficult to evaluate and generally are considered substantially underestimated. Various studies use different base years and data sets and are subject to definitional problems and underreporting,

which all make estimates even more difficult. The ambiguity involved in investigating and determining the cause of a child's death often prevents accurate estimates of death from maltreatment. Many investigations are inconclusive and ultimately closed with the cause of death listed as "undetermined." Herman-Giddens and colleagues (1999) report that of 259 child homicides they reviewed in North Carolina, 220 (84.9%) were caused by child abuse. The state vital records system, however, underrecorded abuse coding of these cases by 58.7%. The authors estimate that between 1985 and 1996, 9,467 homicides occurred among children under 11 in the United States because of abuse rather than the 2,973 reported; the ICD-9 coding system (used by all medical examiners and coroners) underascertained abuse homicides by 6,494, or 61.6% (Herman-Giddens et al.).

Despite the ambiguity about the exact number of child deaths, this country clearly is faced with a tragic problem, estimated at more than 1,000 deaths a year from injuries inflicted by caretakers (Durfee, Gellert, & Tilton-Durfee, 1992). The National Committee for the Prevention of Child Abuse (1993) estimates that 1,383 children died in the United States in 1991 from abuse and neglect—four deaths each day. That is a conservative estimate. Other reports estimate as many as 2,000 deaths a year and a 50% increase in child deaths between 1986 and 1991 (U.S. Advisory Board on Child Abuse and Neglect, 1995). Similarly, the National Committee for the Prevention of Child Abuse reports child fatalities from maltreatment have increased 57% nationwide since 1985.

Other trends continue to be discouraging. Wang (1999) notes that the rate of child maltreatment fatalities confirmed by child protection service agencies have risen steadily during the past 11 years, as have the number of reports of substantiated cases of maltreatment. These estimates do not include the more than 141,000 infants and children who are seriously injured each year because of abuse and neglect, many sustaining injuries that leave them impaired or disabled for life (National Center on Child Abuse

and Neglect, 1991). Finkelhor (1997) reports that the United States has twice the number of child homicides for children of all ages (excluding infants) as the next country.

Underreporting and lack of detection of child fatalities is a significant problem. Ewigman, Kivlahan, and Land (1993) studied 384 children under age 5 to explore the underreporting of fatal child abuse in Missouri. They found that of 121 cases classified as definite maltreatment, only 47.9% had codes reflecting maltreatment on their death certificates. Further, they find that FBI data reported only 38.8% of these cases as homicides. Other studies estimate that up to 85% of childhood deaths from abuse and neglect are misidentified as accidental or caused by disease (McClain, Sacks, & Frohlike, 1993). Misclassification occurs for various reasons: poor investigations, misdiagnosis, poor or absent autopsies, and wide variability in the reporting and recording of deaths by the myriad of public agencies involved (e.g., protective services, public health agencies, law enforcement, justice system). Misclassification also may be the result of socioeconomic and racial bias.

Of concern is the fact that a significant number of child fatalities occur among children known to the child protection system. Wang (1999), reporting on data from 16 states, notes that 41% of children who died from maltreatment between 1995 and 1997 had prior or current contact with the system. That reflects a consistent trend across the nation. For example, between 1986 and 1993 in Illinois, more than one-third of the 646 children reported as dying from maltreatment had prior substantiated reports of abuse or neglect (Illinois Department of Children and Families, 1994). That likely represents an underreporting because it does not include children who died of abuse but whose prior reports were unfounded.

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### **Demographics of Fatal Child Abuse**

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Younger children are especially vulnerable to fatality and serious injury. The National Committee for the Prevention of Child Abuse

(1993) finds that 79% of the children who died in 1991 were less than 5 years old and 54% were under age 1. These numbers have remained relatively constant. Wang (1999) reports that 78% of children who died of abuse were under 5, while 38% were under 1. McClain, Sacks, Froehlke, and Ewigman (1993) report that 90% of fatal child abuse and neglect occurred in children under age 5 and 41% occurred in infants. According to Herman-Giddens and colleagues (1999), homicide rates for children under age 10 increased from 2.06 per 100,000 in 1985 to 2.43 in 1994. Similarly, rates for infants under age 1 rose from 5.31 per 100,000 to 7.91.

To put fatal child abuse in perspective, more children under age 4 die from maltreatment than from auto accidents, falls, fires, drowning, suffocation, and choking on food (U.S. Advisory Board of Child Abuse and Neglect, 1995).

Looking at the race or ethnicity of child fatality victims, the American Association for Protecting Children (1987) finds that African American children were disproportionately represented among child abuse and neglect fatality victims. Herman-Giddens and colleagues (1999) find that African American children were killed by abuse at three times the rate of Caucasian children (4.3 per 100,000 versus 1.3 per 100,000). Research of the Child Welfare League of America (CWLA) (1999) supports the finding that both African American and Native American children are overrepresented in child abuse fatalities. Similarly, the Colorado Child Fatality Review Committee (1998) finds maltreatment deaths of African American children are six times that of Caucasian children, while Hispanic children are twice as likely to die from maltreatment as Caucasian children. According to CWLA, no reliable data exists on income distribution as it relates to child maltreatment fatalities.

A number of findings about the demographics of fatal abusers seem to contradict some widely held assumptions. Contrary to popular belief, single parents or teenage parents are *not* the primary perpetrators of fatal child abuse and neglect. Alfaro (1988) and Ewigman and colleagues (1993) find that most perpetrators were

not raising their children alone, were in their mid-20s, came from two-adult families (with a male present), and many (50%) were married couples. Herman-Giddens and colleagues (1999) report that biological parents accounted for 63% of the child fatalities in their study. Further, male caretakers, biological parents, and caregivers of children under 1 year old were found to be the most common perpetrators of fatal child abuse.

Concerning the risk posed by fathers or father surrogates, Radhakrishna, Bou-Saada, Hunter, Catellier, and Kotch (2001) find a two-times greater frequency of abuse in children from their birth year through age 8 after a surrogate father moved into the home, as compared to those children with a biological father in the home or no father. This study did not look at fatalities. Levine, Compaan, and Freeman (1994, 1995) find that fathers and other male caretakers caused the preponderance of child abuse fatalities.

Males kill infants and young children by remarkable acts of violence, such as shaking, suffocation, scalding, throwing infants and children from windows, and other violent and homicidal acts. Margolin (1990) reports that mothers and female caretakers tend to inflict fatal child abuse through more neglectful and passive means, such as lack of supervision leading to untoward events (e.g., drowning). The U.S. Department of Justice (2000) reports that in homicides of children under age 5 that occurred between 1976 and 1997, 27% were killed by mothers, 27% by fathers, 24% by acquaintances, 6% by other relatives, 3% by strangers, and 12% by perpetrators whose relationship was unknown.

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### **What Are Child Fatality Review Teams?**

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The Los Angeles County Interagency Council on Child Abuse and Neglect/National Center on Child Fatality Review (1999) describe child fatality review teams as

... multiagency, multidisciplinary teams that review child deaths from various causes, often with an emphasis on

reviewing child deaths involving caretaker abuse and/or neglect. The scope of cases reviewed is determined by each team, with some reviewing all child deaths from all causes or all Coroner child death under age 18, while others limit their review to cases fitting into a predetermined protocol, often based on cause of death or age of the child.

The primary goal for all child death review teams, regardless of their composition, is preventing child death and serious injury through an interdisciplinary review of cases. Child death teams attempt to understand cases of preventable death rather than assign blame and to uncover ways that child welfare systems (e.g., child protection, public health, juvenile justice) can be improved to prevent future deaths or injuries.

The first child fatality review team was developed in Los Angeles County, California, in 1978 by Michael Durfee (Durfee, Gellert, & Tilton-Durfee, 1992) in response to rising concern of increasing child deaths from maltreatment. The concept is derived from medical "morbidity and mortality" conferences that review cases of patients who die while hospitalized. These conferences are educational in nature, designed to learn how to prevent such occurrences. Since the inception of the first child death review team in Los Angeles County, almost every state and some foreign countries have instituted some form of child fatality review (Durfee, 1999).

The American Academy of Pediatrics (1999) recommends establishing local or regional child death review teams in each state. This report notes that federal legislation incorporates the establishment of child death review teams into the Child Abuse Prevention and Treatment Act (P.L. 104-235). Nonetheless, no national standards or protocols exist for the form or function of child death review teams. States vary in whether legislation forms these teams; whether the teams are county-based, regional, or statewide; and what type of cases they review. Two organizations provide technical assistance to child death review teams: the Interagency Council on Child Abuse and Neglect (ICAN) National

### Center on Child Fatality Review and the National Center for Child Death Review.

The work of child fatality review teams should be distinguished from the work of internal or administrative review teams of child protective service agencies. These teams generally review cases of child deaths and serious injury with a view toward compliance by child protective investigators with their agency's policies and procedures. In general, these teams are internal, inwardly focused. They generally are not multidisciplinary or multiagency in their scope. Another important distinction is the fact that members of child fatality review teams are typically volunteers and function independently of state-mandated child protective service agencies.

Child death review teams vary in their organization and structure throughout the country; no national standards exist. The ICAN/National Center on Child Fatality Review (1999) has conducted satellite-linked training programs on the formation of child death review teams and developed a guide to build and increase their effectiveness. Similarly, in 2003, the National Center for Child Death Review Teams was established by a federal grant to provide technical assistance to teams throughout the country.

Despite the heterogeneity of teams throughout the country, many teams share some of the following functions:

- Investigation of preventable child deaths and identification of their causes.
- Identification of changes necessary to prevent future deaths.
- The collection of data to identify trends, formulate public policy, develop public health and prevention initiatives, and help allocate public resources for children.
- Networking of professionals and interagency collaboration to understand specific cases and obtain services and desired outcomes for surviving children.

Many teams provide educational and consulting functions. For example, some teams permit trainees (e.g., medical residents, psy-

chology interns, social work students) to attend team meetings as part of their training. Some teams use their remarkable expertise and talent as *de facto* consultants to child protective service teams, law enforcement agencies, prosecutors, coroners or medical examiners, and others.

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### How Child Fatality Review Teams Operate

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Legislation provides the operating charter for child fatality teams in many states. It typically governs the membership of teams, duration of tenure, the cases the team is mandated to review (e.g., age, type of fatality), number of meetings the team hold each year, the organization to whom the teams are administratively responsible (e.g., public health department, child protective services, the governor's office), confidentiality requirements, reporting requirements, and protection offered to the teams' work products and team members.

Operating differently in each state, teams generally are made up of a designated group of experts, usually specified in legislation, who meet regularly to review and discuss cases of child deaths. How teams are organized and perform their reviews varies widely. For example, some states have a child fatality review team in each county; others have regional teams covering several counties or jurisdictions, with each jurisdiction contributing cases to the single regional team. The advantage of regional teams is most obvious in rural areas where child fatalities are rare, as is the expertise to staff the team. Some states have both state and local teams; others have a single team for the entire state.

A state team usually will coordinate the activities of local teams and engage in activities such as data collection, dissemination of findings, development of legislative initiatives, development of prevention campaigns, technical assistance to local or regional teams, and other activities. Smaller or more sparsely populated states may have a single state team that serves to both review individual cases and perform statewide functions. For example,

Iowa has a single statewide child death review team mandated to collect, review, and analyze data; recommend interventions to the governor, general assembly, and other agencies; maintain confidentiality; and develop protocols and committees to review child abuse investigations (Iowa Child Death Review Team, 1999).

### *Team Composition*

Generally, state, local, or regional teams are made up of many of the following representatives: a pediatrician or other physician knowledgeable about child abuse and neglect, medical examiner (forensic pathologist) or coroner, prosecuting attorney, social worker (hospital or community-based), mental health professional (psychologist or psychiatrist), child protective service representative, law enforcement personnel (police officer, detective), public health professional (nurse), educator (teacher, administrator), and emergency medical service personnel (paramedic). Many jurisdictions have permissive legislation that mandates a core group of professionals but also permits the appointment of other professionals as deemed necessary, including judges, public guardians, public defenders, consumer product safety representatives, domestic violence representatives, and others. This flexibility enables teams to add to their expertise as the need of given cases or the particular jurisdiction may demand. Professionals generally volunteer their services.

### *Confidentiality*

Confidentiality is an essential element of child fatality review teams. Without the ability to discuss cases and findings with the absolute certainty that identifying information or the nature of the discussion will not leave the team, the child death review will not be useful. Team members and those presenting cases require absolute assurance that their deliberations will not be made public. Meetings generally are closed to the public and exempted from the Open Meetings Act, and their records and information are not subject to legal discovery and exempted from the Freedom of Information

Act. Most teams have confidentiality provisions as part of the legislation establishing the teams; many require members to sign a confidentiality statement. In some states, legislation also indemnifies the work of team members against any potential legal action arising from their work on the team. Some legislation exempts members from testifying in criminal and civil proceedings concerning information presented during team reviews (Illinois Child Death Review Team Act of 1994, P.A. 88-614 & 1.).

### *Reviewable Deaths*

Depending on legislation, teams may review all deaths of children under a specified age or only selected fatalities. For example, Iowa reviews all child deaths under age 6 (Iowa Child Death Review Team, 1999). Illinois' legislation (P.A. 88-614 & 1) specifies that all children through age 17 who have had some current or past involvement with the child protective service system must be reviewed. Teams have the discretion to review any other "sudden, unexpected, or unexplained child death" (p. 5). Alternatively, Missouri's legislation mandates review of every child death through age 17 (Missouri Department of Social Services, 2000).

### *Access to Information*

Legislation establishing child fatality review teams often gives teams the ability to obtain the information needed to conduct case reviews from a wide variety of sources, including the following records: police, medical, protective services, public health, coroner or medical examiner, corrections, and mental health.

### *Outcomes and Benefits of Child Fatality Review Teams*

The overarching purpose of child fatality review is preventing future deaths and improving systems that provide services to children. Durfee, Gellert, and Tilton-Durfee (1992) report on a variety of potential outcomes of child death review teams, including improved interagency communication resulting in better management of

future cases, better intervention for surviving and at-risk siblings, improved criminal and civil prosecution, reduction of misclassifications of child death causes, improved services to high-risk families, improved data collection for the study of child deaths, increased public education about child abuse prevention, and better intercounty and interstate communication about child deaths. Some child fatality review teams identify high-risk behaviors for prevention and health maintenance (Los Angeles County Interagency Council on Child Abuse and Neglect, 1999). For example, prevention campaigns emerging from CDRTs have addressed public education campaigns to reduce toddler drowning in buckets; the use of child proof medicine containers, especially for iron pills; fencing to reduce child drowning in pools; the use of home smoke detectors; traffic safety campaigns; and education of mothers about the potential danger of paramours to their children.

Teams throughout the country report an impressive number of findings and subsequent action plans. Illustrations of recommendations and action plans that have influenced child protection and child welfare practices and policies are noted in Tables 1–3. These examples were nonempirically selected. Action plans and recommendations of child fatality review teams fall into three broad categories:

1. *Case specific*: recommendations requiring actions on a specific case reviewed by a team. For example, following the death of a child, protective services may be directed to obtain medical evaluations of the surviving siblings and provide grief counseling for family members.

2. *Systemic*: recommendations requiring actions having broad implications for the many systems that impinge on the safety and well-being of children. For example, the Cook County, Illinois, Child Death Review Team recommended that the state protective service agency develop specific guidelines for the number of children who can reside in foster homes as a function of the acuity of care required by the children in residence (Illinois, 1999).

**TABLE 1****Examples of Systemic Recommendations of Child Fatality Review Teams**

RECOMMENDATIONS	STATE
Increase the number of autopsies performed on children whose deaths were suspicious.	Kansas (1999)
Provide services sooner to children involved with CPS and increase the number CPS staff.	Oklahoma (1998)
Legislature should create a special study panel to improve the state's coroner system (e.g., standardize manner and cause of death).	Louisiana (1999)
Develop guidelines for the number of children in foster homes as a function of the amount of care they require.	Illinois (1998)
Have interagency discussions on improving the child welfare and justice system within counties.	Michigan (1999)
Create closer collaboration between wraparound services and high-risk families.	Michigan (1999)
Collaborate with the Office of the Medical Examiner to review SIDS program and expand to include services to families and communities impacted by SIDS.	New Hampshire (2002)
Death investigation and autopsies should be done on all suspected SIDS deaths or unexplained deaths. A thorough death scene investigation is essential.	Oregon (1999)
Develop bereavement packets to be given to families in which a child has died suddenly and unexpectedly.	New Hampshire (2002)
Improve the sharing of information among investigative agencies (e.g., law enforcement, SCF, medical examiner), as occurs on Child Fatality Review Teams, which will help promote thorough investigation of child deaths.	Oregon (1999)

*3. Prevention and public health:* action plans about primary prevention efforts, which may involve changes in public policy and legislation. For example, Iowa's child death review team recommended that the Community Empowerment Initiative be expanded throughout Iowa so that 60% of their funding is devoted to home visits for all families having newborn children (Iowa, 1999).

**TABLE 2****Examples of Systemic Plans and Actions from Child Fatality Review Teams**

RECOMMENDATIONS	STATE
Public education campaign directed at male caregivers	Michigan (1999)
Establish an early identification and comprehensive intervention approach to reduce child suicides.	Texas (1998–1999)
Enhance training on mandatory child abuse reporting for health, education, and human services providers.	Michigan (1999)
Consider ways to provide trigger locks for all firearms sold in Michigan.	Michigan (1999)
A county child fatality review team identified a dangerous intersection and worked to install a traffic signal.	Oregon (1999)
Promote back-to-sleep campaign to reduce SIDS.	Oregon (1999)
Promoted a variety of initiatives to encourage usage and proper maintenance of smoke alarms.	Oregon (1999)
Increase interagency communications about domestic violence in cases of child abuse and neglect.	Illinois (2001)
Developed shaken baby awareness campaign; purchased and placed videos in physicians' offices and social services agencies showing seriousness of this type of injury.	Virginia (2002)
Develop interagency collaboration for drowning prevention awareness campaign.	Illinois (2001)
Develop a public awareness campaign on the risks of cosleeping/bed-sharing (adults with children).	Illinois (2001)

**TABLE 3****Systemic Recommendations for Agencies**

RECOMMENDATIONS	STATE
Protective service agency should request a psychological evaluation to determine mother's cognitive level prior to returning other children to her care.	Illinois (2001)
Protective service agency must review this case to determine why the deceased child's mother was not referred to the teen parenting network and ascertain if there are other teens in workers' caseloads that require a similar referral.	Illinois (2001)
Protective service agency will contact the States Attorney's Office to ensure that the father not be permitted any contact with the surviving child.	Illinois (2001)

Illinois' CDRT-enabling legislation provides a unique feedback loop enabling teams to have more clout to ensure that recommendations and action plans are implemented (Illinois Department of Children and Family Services, 1994). This legislation mandates that recommendations made by any of the nine regional child death review teams concerning the child protective service system be sent to the director of the Department of Children and Family Services, and that the director responds within 90 days. This feedback loop ensures action plans are monitored and implemented as part of an interactive process with the teams.

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## Conclusion

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Still in their infancy, child fatality review teams have made significant contributions to the protection of children and the prevention of child deaths and serious injury. Through an interdisciplinary and inter-agency approach, CDRTs—now in virtually all states—review preventable deaths of children. Their goal is to assist surviving siblings and families, assist the protective service system, develop prevention strategies and influence public policy for the betterment of children. The work of child fatality review teams must become integrated into local, regional, and statewide efforts to reduce child deaths and serious injury. This change must be done judiciously so as not to compromise the independence and confidentiality of these teams. Current efforts by CDRTs around the country are focused on improving data collection, improving collaboration between CDRTs in contiguous states, and making the data and recommendations a more viable resource for legislators and public policymakers.

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