

# Extent and Nature of Child Maltreatment-Related Fatalities: Implications for Policy and Practice

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This article reviews significant research findings regarding child maltreatment fatalities over the last thirty years. Notably, the article focuses on several important subsets of children who die from maltreatment, including young children, children reported to child protective services, and children who live in families with poor parental attachment, mental illness, substance abuse, and domestic violence. The article then sets forth three proposals for broadening the United States' approach to child protection and reducing child maltreatment fatalities.

Despite the wealth of knowledge regarding child maltreatment deaths in the United States, there are still no proven solutions for addressing the problem. Similarly, despite improvements in child protective service (CPS) agencies' responses to child maltreatment, CPS reforms alone have not significantly reduced child deaths resulting from maltreatment. This article seeks to identify and focus on major findings in child maltreatment research to advance solutions that have clear implications for public policy, public health, and child welfare practice. By concentrating on situations in which children most frequently suffer severe injury or death, the authors propose interventions that have the potential to protect the greatest number of children.

## **Major Research Findings Regarding Child Victims and Perpetrators**

During 2011, child protective service agencies across the country received an estimated 3.4 million referrals involving the alleged maltreatment of approximately 6.2 million children, and agencies confirmed 676,569 children as victims of abuse or neglect (Administration for Children and Families (ACF), 2011). Fifty states, along with the District of Columbia and Puerto Rico, reported a total of 1,545 child maltreatment fatalities in 2011, resulting in a rate of 2.10 deaths per 100,000 children. While the number of reported child abuse and neglect fatalities has fluctuated during the past five years, the number of maltreatment fatalities reported in the National Child Abuse and Neglect Data System (NCANDS) is currently the lowest it has been since 2007. However, much of this decrease may be due to changes in counting and classifying child deaths in a few large states (Miller, 2012).

Child injury rates have similarly fluctuated over the past five years (ACF, 2011). A recent study found a 5% increase in the number of children hospitalized for serious injuries resulting from child abuse over the twelve years from 1997 to 2009 (Leventhal & Gaither, 2012). Notably, children under the age of one accounted for more than half

of the severe cases of hospitalizations resulting from abuse in the twelve year period, and their rate of inflicted injury increased by over 10% during this time (Leventhal & Gaither, 2012). NCANDS data, on the other hand, which does not account for serious injuries resulting from maltreatment, shows a decline in physical abuse over the past five years.

Caretakers, particularly biological parents, are the most common perpetrators of maltreatment leading to fatality (Chance & Scannapieco, 2002). In 2011, biological mothers and fathers accounted for 78% of child deaths from abuse and neglect. This number is consistent with reports of non-fatal maltreatment, which indicate that for more than 81% of victims, a biological parent, either acting alone or with someone else, abused or neglected the child. In 2011, mothers acting alone or with a non-parental individual committed 39% of maltreatment fatalities, biological fathers and mothers acting together committed 22%, and fathers acting alone or with a non-parental individual committed 17%. Individuals without a parental relationship to the child accounted for 13% of maltreatment deaths (ACF, 2011).

These numbers have remained fairly consistent for the last three decades. Individuals who are responsible for abuse and neglect fatalities are usually under the age of thirty, most commonly in their late teenage years or early-to-mid-20s (Chance & Scannapieco, 2002). Males are more likely to cause death through physical force such as shaking, scalding, or battering. Females are more frequently responsible for deaths caused by neglect such as lack of supervision or suffocation roll-over deaths (Hochstadt, 2006). Fortunately, there has been some progress in developing public health strategies to address co-sleeping and suffocation (see Rivara and Johnson in this special issue).

More children die from neglect than any other type of maltreatment. In 2011, neglect was present in more than two-thirds (71.1%) of child maltreatment deaths and physical abuse was present in approximately half (48%). This is consistent with NCANDS substantiation rates that indicate the great majority of children (almost 80%) who suffer non-fatal maltreatment are neglected. Research also indicates that the risk of maltreatment recurrence is higher for neglect than for other

types of maltreatment (Hindley, Ramchandani, & Jones, 2006). Still, the largest percentage of child victims (40.8%) died from a combination of physical abuse and neglect (ACF, 2011; Douglas & Finkelhor, 2005). Thus, many fatally maltreated children are abused and neglected in multiple ways, sometimes chronically.

Younger children are particularly vulnerable to fatality and serious injury from abuse and neglect (Hochstadt, 2006). In 2011, more than four-fifths (82%) of fatally abused children were under the age of four, and 42% were younger than one. The vulnerability of very young children is also demonstrated in rates of child fatalities. Children younger than one died at a rate of approximately 16.8 per 100,000 in 2011, whereas seventeen-year-olds died at a rate of 0.12 per 100,000. As a general trend, maltreatment fatality rates decrease as children become older (ACF, 2011).

Young children also suffer high rates of non-fatal maltreatment. However, children under four comprise a much smaller portion of the total children suffering substantiated maltreatment than they do of children who die from maltreatment. In 2011, for example, children younger than one accounted for 42% of maltreatment deaths but comprised only 11.5% of non-fatal maltreatment victims. Likewise, children younger than four accounted for 82% of maltreatment deaths but comprised only 32% of non-fatal maltreatment victims. Thus, children under four die from maltreatment at rates disproportional to the rates that they experience maltreatment.

There is also a racial difference in fatalities: in 2011 approximately 40.5% of victims were Caucasian, 28.2% were African American, 17.8% were Hispanic, and 2% were American Indian or Asian. These numbers are consistent with percentages of children who suffer non-fatal abuse and neglect (ACF, 2011). While the number and percentage of African American children who die from maltreatment is lower than for Caucasian children, African American children are overrepresented in child maltreatment fatalities as compared to their proportion of the nation's child population. This finding is consistent with African American children's heightened risk for non-fatal injury from abuse and neglect (Hochstadt, 2006).

Gender differences in fatality risk are also noteworthy. In 2011, boys had a higher rate of child fatality than girls, with approximately 2.5 boys per 100,000 dying due to maltreatment versus 1.8 girls per 100,000. However, girls accounted for a slightly higher percentage of victims of non-fatal abuse and neglect (ACF, 2011). In general, most studies find that boys are slightly more likely than girls to die in maltreatment related incidents (Stiffman, Schnitzer, Adam, Kruse, & Ewigman, 2002).

Contact with child protective services is another important dimension of maltreatment fatalities. Approximately one-third of children who die from maltreatment were known to CPS before their deaths (Putnam-Hornstein, 2011; Peddle & Wang, 2001; Levine et al., 1994). According to the 2011 federal child maltreatment report, 1.4% of fatally abused and neglected children had been in foster care, while 8.8% lived in families who received family preservation services during the past five years (ACF, 2011). One study indicated that the median time between a first maltreatment report to CPS and a child's death was nine months (Jonson-Reid, Chance, & Drake, 2007). A large California study also found that a CPS report on a child younger than five was the strongest risk factor for maltreatment or injury related mortality. The same study found that children reported for maltreatment were almost six times more likely to die from intentional injury before age five than children not reported to CPS (Putnam-Hornstein, 2011).

Child victims of maltreatment deaths are disproportionately born into homes with multiple risk factors and limited resources. Mental health problems, domestic violence, substance abuse, and poverty are prevalent in families where fatal maltreatment occurs. An unpublished study by Emily Douglas (2010) examined characteristics of families known to CPS prior to a fatality and found that 56% had mental illness, 43% had domestic violence reports, 36% had drug use or abuse, and 24% abused alcohol (Douglas, 2010). Other research on fatal maltreatment suggests that domestic violence is the single most common precursor to a child maltreatment death (Mills et al., 2000).

These findings underscore research on non-fatal maltreatment which indicates that one-third to two-thirds of child abuse and neglect cases involve substance abuse (Substance Abuse and Mental Health Services Admin., 1999); that parents who are perpetrators of domestic violence are more likely to physically abuse their children (Edleson, 1999); and that parents who have annual incomes under \$15,000 are twenty-two times more likely to abuse or neglect their children than parents who make an annual income of \$30,000 or more (Every Child Matters Education Fund, 2010). Overall, the mortality rate of children born into low-income families is approximately twice that of children who are not born into low-income families (Brooks-Gunn & Duncan, 1997).

Major life stressors, such as moving, unemployment, the birth of a child or the death of a loved one, are also frequently present in families who fatally abuse or neglect their children (Brewster et al., 1998). Douglas's study found that 64% of families involved in maltreatment fatalities were frequently unemployed; 51% had recently experienced a stressful, major life event; and 45% reported being socially isolated. Additionally, research shows that parents who are unable to cope with daily stressors, such as infant crying, are more likely to engage in fatally abusive behavior. A recent study of child homicides in Kansas found that a baby's or child's inconsolable crying was the trigger for abusive incidents leading to fatality in 44.2% of cases in the study sample (Kajese, et al., 2010).

Research also indicates that children who die from maltreatment are likely to live in homes with many people, including non-family members (Schnitzer & Ewigman, 2008; Chance & Scannapieco, 2002; Stiffman et al., 2002). Children residing with unrelated adults, particularly men, are at six-to-eight times the risk of dying from maltreatment than children who live in a home with two biological parents (Schnitzer & Ewigman, 2008; Stiffman et al., 2002).

Finally, a few important studies have found that the quality of the parent-child relationship bears on a child's risk of death from maltreatment. Research indicates that children whose parents or caregivers are emotionally disconnected from them are at elevated risk of

death from maltreatment (Graham, Stepura, Baumann, & Kern, 2010; Goyer, Graham, Baumann, & Kern, 1998).

## Discussion

Numerous studies conducted over several decades have consistently found a common set of risk factors associated with child deaths from abuse and neglect. However, because maltreatment deaths are (fortunately) a low base rate phenomenon, there are limitations to gathering information about victims, abusers, and the circumstances of injuries and deaths. Information is especially difficult to obtain when families are not known to CPS, and even when there are open CPS cases, information may be inaccessible because of confidentiality laws.

Despite these limitations, research has identified a number of factors that have important implications for policy and practice, including: children's age, substance abuse in the home, mental health problems, family violence, emotional disengagement of caregivers, and the presence of unrelated adults living with at-risk families. In addition, most studies have found that while only 20-30% of children who die in abuse and neglect related incidents had contact with CPS prior to death, such contact is an important risk factor.

Substantially reducing the number of fatally abused and neglected children requires broadening the focus of public child welfare agencies to include prevention and early intervention services to children in high-risk families and engaging other service delivery systems such as public health departments to support at-risk families prior to CPS reports. Waiting for babies and other young children in at-risk families to be injured or endangered before reaching out to caregivers with voluntary family support services is not sound public policy.

Applying the research on adverse childhood experiences (ACE) to maltreatment fatalities is one approach to broaden the scope of preventative services for children at risk of abuse and neglect fatality. The effects of ACEs on the health and mortality of adults into their 50s and 60s has led to discussions of public policies and programs that

would reduce children's exposure to child abuse and neglect in its various forms, as well as parental substance abuse, mental health problems, domestic violence, and separation from parents at an early age. Research indicates that ACEs are highly interrelated. A significant percentage of children in families in which even a single ACE is present are likely to be exposed to multiple adversities (Dong, et al, 2004).

The same policies and programs that reduce exposure to ACEs have the potential to reduce maltreatment related deaths of young children. Parents who receive publicly funded substance abuse or mental health services, who have been referred to law enforcement agencies due to domestic violence, or who have been identified by medical personnel due to their lack of emotional responsiveness to babies and other young children should be offered a range of family support services. Thus, practitioners should focus on ACEs, particularly with regard to how these experiences impact the parent-child relationship. The overarching public policy guideline should be: the more troubled the family and the more vulnerable the child, the earlier the intervention.

## Recommendations

This section presents three recommendations to decrease severe child injuries and fatalities.

1. ***Broaden the public policy focus on families who have: children ages 0-3, caretakers with serious substance abuse or mental health problems, domestic violence present during pregnancy or following a child's birth, or impoverished living conditions, regardless of whether these families have had prior contact with CPS.*** Most of the families in which a child dies from maltreatment are afflicted by the same risk factors as high-risk families with open or recently open CPS cases; yet studies find that only 30% or fewer of these families have contact with CPS prior to the child's death. To significantly reduce maltreatment related deaths, service delivery systems must employ a broad variety of support mechanisms and service



providers to reach the most at-risk children, known or unknown to CPS, prior to serious child injury.

Home visiting programs are one means to ensure that families unknown to CPS receive adequate support to cope with the many stressors that lead to maltreatment. Currently there is little or no evidence regarding the efficacy of home visiting programs in reducing fatal maltreatment (Paulsell, Avellar, Sama, Martin, & Del Grosso, 2010). However, this intervention is generally accepted as an effective means of supporting and improving overall child and maternal health (Levine et al., 1994). Additionally, research shows that home visiting can positively impact a variety of outcomes including child development, school readiness, appropriate parenting practices, and family economic self-sufficiency (Paulsell, et al., 2010).

Research also shows that home visiting programs can decrease physical injury. Studies have demonstrated that programs such as “Healthy Families America” (see <http://www.healthyfamiliesamerica.org/home/index.shtml>) and the “Nurse Family Partnership” (see <http://www.nurse-familypartnership.org/>) reduce physical abuse (DuMont et al., 2009; Olds, 2006). Additionally, research indicates that some home visiting programs targeted at disadvantaged mothers—including teenagers, unmarried mothers, and those of low socioeconomic status—can reduce child injury rates (Dawley, Loch, & Bindrich, 2007). Given the link between injury and subsequent fatal maltreatment and the capacity of home visiting programs to reach low-income, single-parent families (Howard & Brooks-Dunn, 2009), home visiting may provide an important means of supporting currently underserved families with services whose benefits extend throughout childhood.

Information and public awareness campaigns are also an easily administered and effective way of broadly and inexpensively assisting families with and without CPS contact. For example, programs that help parents skillfully cope with daily

stressors, such as a baby's crying, have the potential to reduce the large percentage of abuse related deaths triggered by inconsolable infants (Dong, et al, 2004). Research shows that informational/awareness campaigns like the National Center on Shaken Baby Syndrome's "Period of PURPLE Crying Program" increase parental awareness and change parental behavior around inconsolable infant crying (Barr, et al., 2009).

Finally, programs that utilize a variety of intervention techniques, including education seminars, self-help books, DVDs, group classes, and individual counseling sessions, provide a feasible means of supporting families with young children. The "Triple-P Positive Parent Partnership," designed to be delivered as a public health initiative, promotes itself as one such system that reaches a large number of parents with a wide-ranging variety of services (see [www.triplep.net](http://www.triplep.net)). With its broad, multi-tiered approach, the Triple-P Program attempts to destigmatize the receipt of parenting support by offering diverse programming implemented through multiple service delivery mechanisms to meet varying levels of need. Studies demonstrate that the Triple-P Program reduces child maltreatment injuries requiring hospitalization (Prinz, Sanders, Whitaker, Shapiro, & Lutzker, 2009), improves parents' well-being and parenting skills (Nowak & Heinrichs, 2008; Sanders, et al., 2008), decreases foster care placements (Prinz, et al., 2009), and enhances children's general behavioral and emotional health (Sanders et al., 2008).

The broad availability of programming like that discussed above, provided through multiple delivery mechanisms by a variety of service providers, can reach the greatest number of children at risk for maltreatment prior to or concurrent with their involvement with CPS. Public health departments may be uniquely positioned to facilitate this process, engaging service providers and coordinating interventions on a systemic basis. Once supportive programming is made widely available on a cost-free or reduced-cost basis to all parents of

young children, the United States could reduce the risk of fatal maltreatment dramatically.

2. ***In responding to CPS referrals, child welfare agencies must focus on non-serious allegations of abuse and neglect for children 0-5, as well as cases with clear safety threats, and intervene early in families in which multiple risk factors are present.*** A significant percentage of fatally maltreated babies and young children who have prior contact with CPS have been the subject of more than one, sometimes several, CPS reports. Additionally, research shows that a significant amount of time, typically about nine months, passes between a child's first maltreatment report and subsequent death. Research has also identified a set of factors in CPS cases with non-severe allegations that increase a child's risk of death from abuse and neglect.

Given these findings and the feasibility of providing interventions between an initial maltreatment report and child death, CPS agencies should not wait for identified, actionable safety threats to engage parents in voluntary family support services, including child and respite care. Waiting for very young children who are known to CPS to be harmed, or to be at risk of imminent harm, before taking steps to mitigate risks to child safety through services and safety plans is a dangerous approach to child protection. The physical vulnerability of young children requires a major child welfare investment in early intervention services, especially for families with chronic referral histories, even when no immediate, actionable safety threats are present.

Children age 0-5 reported to CPS for alleged physical abuse are at highly elevated risk of death from inflicted injury. In a subsequent analysis of her large California study, Putnam-Hornstein found that young children reported to CPS for physical abuse were nine times more likely to die of an injury resulting from abuse than children reported for neglect (Putnam-Hornstein, personal communication, December 24, 2011). In these cases, even minor inflicted injuries to young

children should be viewed as indicators of safety threats requiring coercive CPS intervention, if necessary.

Furthermore, there is a population of families with young children chronically referred to CPS for both abuse and neglect (English, Graham, & Viyasilpa, 2011). In many of these families, parenting standards have collapsed or eroded to an alarming degree, and very young children are at highly elevated risk of serious physical and emotional harm. It is important that CPS programs recognize the significance of allegations of multiple forms of chronic maltreatment in families with babies and preschool-aged children. These families have distinctive dynamics, especially the combination of harsh and non-nurturing parenting, which warrant special CPS attention.

Finally, there is a significant population of children who have been referred to CPS for non-severe allegations that do not generally warrant coercive CPS intervention, yet are still at risk of death from maltreatment. In 2010, Graham, Stepura, Baumann, and Kern found that variables related to the “the quality of the connection between the caregiver and the child, caregiver abilities and skills, and child vulnerability” (including fragility, emotionally detached parenting, and child behaviors) were indicative of future fatality in families reported to CPS for non-severe allegations of maltreatment. The study also showed that when CPS agencies receive non-severe allegations of abuse and neglect in families with a vulnerable child (due to disability or special needs) and a caregiver lacking in capacity, caseworkers should consider the possibility of future child fatality. Additionally, the authors found that violence indicators not directly related to children, and therefore not immediately actionable by CPS, increase children’s risk of death from maltreatment (Graham et al., 2010).

CPS agencies should provide immediate support services to families when non-severe allegations of abuse and neglect

occur with one or more of the following: (1) caregivers demonstrate weak emotional connections to babies and other young children; (2) young children are physically abused even in minor ways; (3) young children are chronically referred to CPS for abuse and/or neglect; or (4) violence or violent individuals are present in the home. In these families, CPS agencies should also involve other community service providers to help assess family functioning and promote protective factors that may decrease the potential of abuse and neglect (see *Strengthening Families*, <http://www.cssp.org/reform/strengthening-families>).

3. ***Pay more attention to emotionally detached or disengaged parenting.*** Within both groups of families—those who are referred to CPS and those who are not—practitioners should focus on the quality of the parent/child relationship. Risk assessment instruments do not generally include factors related to the quality of parent-child interactions—a serious deficiency—and caseworkers may not be trained to assess the quality of the nurturing environment in which children live. But a parent’s emotional disconnection from infants and toddlers elevates the risk of a maltreatment death.

According to St. James-Roberts (2012), an expert on infant crying, “some parental psychological characteristics such as a low-frustration threshold, poor parent-infant attachments, low self-confidence or inability to tolerate stress, may make some parents particularly susceptible to infant crying or unsettled night-time behavior.” St. James-Roberts also comments that “recent research has identified a much smaller group of infants who have multiple crying, sleeping and other problems after 3 months of age and has shown that these cases often involve persistent child psychological and family disturbances.” While most parents are distressed by their baby’s inconsolable crying, it may be situations in which caregivers have weak emotional connections to a baby, are unable to tolerate stress, and have no

easily accessible support system that a baby's crying has the potential to lead to assault.

Additionally, a number of studies have found that the presence of unrelated males living in the home greatly increases the risk of a child's maltreatment related death. Some scholars (Herring, 2013) have speculated that biological causes account for elevated risk of male violence directed at unrelated young children. However, it is at least equally plausible that the lack of an emotional connection between a child and a caregiver accounts for the elevated risk of maltreatment death in families where unrelated males have a major caretaking role. The same dynamic may increase the risk of child death from maltreatment in families where attachment processes between infants and mothers are poorly developed due to maternal depression, incarceration, or other reasons.

Public health nurses, caseworkers, and other service providers serving families with young children should be trained to recognize indicators of emotionally unresponsive parenting and the signs of insecure or disorganized attachment in young children. In addition, any event that separates children and parents—e.g., an out-of-home placement or any lengthy separation that interferes with the capacity of parents to form strong positive emotional connections to infants and toddlers—should lead to services designed to strengthen emotional connections before children are returned to the home. In addition, both public health nurses and CPS caseworkers should be trained to utilize brief screening tools for depression, given the well-documented negative effects of maternal depression on parenting.

## **Conclusion**

It remains uncertain what specific family support services and skills-based programs will prove most effective in reducing child

maltreatment deaths. But programs that provide emotional support, respite care, and concrete services to a broad segment of at-risk parents are a reasonable place to start given the inadequate support systems and poverty of many vulnerable families. Initially, supportive programming must be made widely available to families with young children, regardless of whether they have prior CPS contact. Additionally, caseworkers, public health nurses, and other professionals who work with at-risk families must be trained to recognize non-severe forms of abuse that still indicate risk of future fatal maltreatment along with signs of parent-infant relationships in which early attachment processes have been compromised. Particularly, the inconsolable crying of infants in troubled families with multiple vulnerabilities should be targeted as a high risk factor by both public health and child welfare agencies. Finally, interventions should focus on fostering and supporting emotionally responsive parenting in families struggling with multiple adversities to offer the best protection for infants and toddlers.

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