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. 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 years, compared to the global rate of 2.4 per 100 000 children. 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.

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. It is estimated that 13% of all injury deaths in children under-15 are due to child abuse and neglect. 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 underestimation of fatal child abuse. 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. Deaths due to violence or severe physical abuse have been shown to be the most likely recognised child abuse death, 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 undetected. 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. Overall, the most common perpetrators of child abuse are parents, yet in child abuse deaths unrelated perpetrators are more commonly identified.

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.
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. 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.

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. 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.

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. 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. 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.

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. In 1991 the US Department of Health and Human Services endorsed the need for child death reviews and recommended its expansion to all states. 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.

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. 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.
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. 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.

References

[Continued overleaf]
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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**Level, scope and legislative status of child death review processes in different countries**

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


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