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Brief Communication

# Effects of a Citizens Review Panel in preventing child maltreatment fatalities☆,☆☆

Vincent J. Palusci[a,*], Steve Yager[b], Theresa M. Covington[c]

[a] Frances L. Loeb Child Protection and Development Center, New York University School of Medicine, New York, NY, USA
[b] Michigan Department of Human Services, Lansing, MI, USA
[c] Michigan Public Health Institute, National Center on Child Death Review, Okemos, MI, USA

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## Introduction

Though child abuse rates are declining in the United States, there has been no real change in the number of child maltreatment (CM) fatalities (US Department of Health and Human Services, 2008). While year-to-year numbers vary, there were an estimated 1,530 child abuse and neglect deaths reported by the National Child Abuse and Neglect Data System during 2006, representing 2.04 deaths for every 100,000 children. It is widely accepted that this number is underestimated for many reasons, including inconsistencies in investigation, reporting, legal standards and definitions, and medical diagnosis and death certificate coding (Crume, DiGuiseppi, Byers, Sirotnak, & Garrett, 2002; Ewigman, Kivlahan, & Land, 1993; Schnitzer, Covington, Wirtz, Verhoeck-Oftedahl, & Palusci, 2008). There are a number of risk factors associated with maltreatment fatalities, such as residing in homes with unrelated adults, young age of the child, and prior involvement with child protective services, and this information can aid in developing initiatives to prevent further deaths. Fatalities from neglect remain difficult to identify and prevent given the potential overlap with accidental and medical causes (Brewster et al., 1998; Crume et al., 2002; Hicks & Gaughan, 1995; Knight & Collins, 2005). To better identify, understand and respond to the system issues and prevention possibilities in these deaths, we sought to evaluate changes in our state after the implementation of a citizen panel that reviewed child maltreatment fatalities in the child welfare system.

Child fatality review teams (CFRTs) have been instituted in most US states to provide a multidisciplinary, multi-agency review of all or most child fatalities (Durfee, Durfee, & West, 2002; Durfee, Gellert, & Tilton-Durfee, 1992; Hochstadt, 2006;

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* Corresponding author address: Loeb Child Protection and Development Center, 462 First Avenue, Room GC-65, New York, NY, USA.

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National Center for Child Death Review, 2008; Webster, Schnitzer, Jenny, Ewigman, & Alario, 2003). All have reviewed maltreatment fatalities and have identified abuse cases that have been misclassified or misdiagnosed as due to natural causes or unintentional injury (Jenny & Isaac, 2006; Kellogg & Lukefahr, 2005; Levene & Bacon, 2004; National Center for Child Death Review, 2008; Schnitzer et al., 2008). In Philadelphia, most child homicides were found to be preventable, and the review process was thought to provide one source of comprehensive data to allow policymakers to formulate solutions (Onwuachi-Saunders, Forjuoh, West, & Brooks, 1999). In Arizona, the state CFRT was able to identify and correct an incorrect cause of death in 13% of death certificates and suggested that 38% of all child deaths after the first month of life could be prevented (Rimsza, Schackner, Bowen, & Marshall, 2002). This leads some to believe that child death review teams can make significant contributions to the protection of children and the prevention of child deaths and serious injury (Hochstadt, 2006). A recent review identified 11 categories of over 300 recommendations resulting from CFRTs in the US (Douglas & Cunningham, 2008).

There are, however, additional opportunities for improvement and prevention within the child welfare system itself (King, Kiesel, & Simon, 2006). While the death of a child is a rare event and most children known to the child welfare system do not die, there are some who do. In 2006, 13.7% of deaths nationally were in families who had received prior family preservation services and 2.3% had been in foster care during the past 5 years (US Department of Health and Human Services, 2008). This suggests that there may be steps to be taken to improve outcomes in child protective services and foster care agencies. New strategies include using a children's ombudsman (Bearup & Palusci, 1999), a state child advocate (Faith VosWinkle, Connecticut Child Advocate, personal communication), and the establishment of federally mandated Citizen Review Panels (CRPs).

CRPs were first required in 1996 for US states as part of re-authorization of the Child Abuse Prevention and Treatment Act (CAPTA), and many states have instituted CRPs specifically to review child maltreatment fatalities (Child Abuse Prevention and Treatment Act, 1998; US Department of Health and Human Services, 1998). While both CFRTs and fatality CRPs review child deaths, CRPs are constituted expressly for the purpose of reviewing deaths of children known to the governmental child protective services agency and are charged with making recommendations primarily to that agency within the child welfare system. CRPs are ideally made up of a representative sample of the community, are required to meet at least quarterly, and fulfill a broad mandate which includes ensuring that the state is in compliance with CAPTA, Title IV-E programs, and other requirements (Jones, Litzelfelner, & Ford, 2003). CRPs have been constituted variably across the US, and their effectiveness has been evaluated only to the extent that there was citizen participation or implementation of their recommendations (Jones, 2004). For this study, we were specifically interested in identifying the number of child deaths and problem areas in the state child welfare system during 6 years of review and any specific changes in child welfare law, policy, and practice that could be associated with fewer child maltreatment deaths.

## Methods

### *Team composition*

Michigan instituted three CRPs in 1999, each with emphasis on a different area: foster care and adoption, prevention, and child fatalities. For the Fatality CRP, a committee of volunteer members was self-selected from the state's Child Death Review Board, and membership included a broad spectrum of experts in forensic medicine, pediatrics, law enforcement, child law, child protective services, public health, mental health, education and child advocacy similar to other child fatality review efforts (Durfee & Tilton-Durfee, 1995; Durfee et al., 1992; Webster et al., 2003). The state department of social services funded a staff person working at an independent, non-profit agency to assist the team in collecting case information for the reviews. Nine team members participated during the entire study period and received annual multi-day training on both the case review and CRP process. While additional members, support staff, and state agency members were added in later years, there were neither substantial change in the disciplinary composition nor qualitative aspects of the team case review process during the study period.

### *Case identification and selection*

Potential maltreatment deaths were initially identified for children 0–18 years of age by cross-matching death certificate information collected by state vital statistics, county-based child death review team reports, and our state department of human services death abstracts. Published news reports and obituaries were also consulted. Cases were selected for Fatality CRP review when the death was reported to the National Child Abuse and Neglect Data System, was deemed to be from abuse or neglect using state criminal and civil definitions of maltreatment, or when the panel determined that there were serious acts of omission leading to a death, independent of legal determinations. With the cooperation of state social services, public health, law enforcement and local district attorneys, the Fatality CRP had a comprehensive case file on each death for their review that was compiled from state child protective services agency records and the state CFRT.

*Case review and reporting*

Depending on the availability of local child death review reports, state records and team members, reviews occurred from 1 to 3 years after the death. Once the file contained CPS, local CFRT and medical examiner reports and death certificate information, team members performed a first review to ensure that the file adequately summarized the case for the full CRP. The chair confirmed the adequacy of the file and scheduled full CRP review which 8–12 CRP members attended. A case summary was presented by staff or the chair, and panel members offered comments, potential findings and recommendations. Case reviews each required 15 to 60 min. The members chose to categorize system failures into timeframes related to (a) before CPS involvement, (b) during CPS investigation and service provision, and (c) during court adjudication. Findings were further categorized under one of four possible mechanisms: (1) non-compliance with existing state law or policy; (2) poor practice and decision-making (which, while not always contrary to existing law, policy or procedure, reflected substandard professional practice); (3) inadequate existing law, policy or procedure; and (4) other system issues outside the child welfare system which may have contributed to CM deaths. The team agreed upon any findings or recommendations as a group, and the chair compiled these into an annual report issued to the director of the state child welfare agency as mandated by CAPTA. State CPS responded to each annual report by identifying specific actions and/or changes they planned to take in response to the findings and recommendations in the report.

*Study procedures*

For the purposes of this study, we compared the annual number of child maltreatment deaths associated with each finding in the annual reports made during two 3-year periods: 1999–2001 (Period I) and 2002–2004 (Period II). These two periods were chosen because they reflected adequate time for recommendations in Period I to be implemented and affect potential future cases in Period II. New findings made after the year 2001 were excluded from the analysis because sufficient time would not have passed. The average annual number of deaths over 3 years was calculated for each specific finding for each period, and death rates were calculated using standard state population estimates. We then reviewed the state CPS agency responses to the panel's annual reports to identify specific changes in law, policy or practice, and we conducted additional post hoc searches for changes by contacting CPS agency directors to confirm that they had occurred. Chi square with Yates correction and Fisher's exact test, as needed, were used to assess the statistical significance of any changes in the frequency of deaths, with alpha set to 0.05 in all analyses.

## Results

We reviewed 356 child deaths and identified 436 findings in our state's child welfare system using our Fatality CRP over 6 years (Table 1). Overall, deaths reported by our state CPS to the National Child Abuse and Neglect Data System consistently numbered approximately 3% of all child deaths in our state, and our Fatality CRP was able to review most of these deaths as well as additional fatalities. During 1999-2001, there were 186 deaths (2.4 per 100,000 children) with 264 findings, and during 2002–2004 there were 170 deaths (2.2 per 100,000) with 172 findings. This represented a 35% decrease in findings and a 9% decrease in deaths associated with those findings. Most findings were noted in more than one death and decreased over time, with some exceptions (Tables 2–4). Twenty-seven specific finding areas were noted after combining findings from all the cases, and most findings were categorized as occurring because of failures during CPS case investigation, assessment and

**Table 1**
Deaths, cases reviewed and problem areas in reviews.

| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|---|
| All child deaths in State of Michigan | 1,863 | 1,895 | 1,804 | 1,823 | 1,831 | 1,721 |
| Death reports received by DHS | 142 | 146 | 111 | 144 | 155 | 159 |
| CM deaths reported to federal data system | 48 | 49 | 54 | 52 | 55 | 52 |
| Total deaths available for CRP review | 30 | 81[a] | 75[a] | 52 | 60 | 58 |

| | Study period | |
|---|---|---|
| | 1999–2001 | 2002–2004 |
| Deaths reviewed with findings | 186 | 170 |
| Total findings | 264 | 172 |
| Problem areas | | |
| Non-compliance | 171 | 77 |
| Poor Practice | 63 | 63 |
| System issues | 9 | 28 |
| Other issues | 21 | 2 |

CPS = Child Protective Services; CRP = Citizen Review Panel.

[a] Increase attributable to adding in neglect cases that were not previously identified through CPS, law enforcement or local child death review-but were accidental deaths with prior CPS histories that had formal, intensive reviews of the cases at the state level by the CRP and were ascertained as due to neglect.

**Table 2**
Case review findings and changes: identification and reporting.

| Finding | Problem area | Annual # Period I | Cases Period II | % Change (decrease) | System changes |
|---|---|---|---|---|---|
| 1. Failure among medical professionals to diagnose and report suspected abuse or neglect | Non-compliance | 5.7 | 7.3 | +30.4 | Statewide training for physicians |
| 2. Poor medical follow-up by families and medical professionals after hospitalization | Poor practice | 3.3 | 1.3 | (60.6) | |
| 3. Unaddressed mental health needs lead to the death of a child | Inadequate policy | 3.0 | 8.7 | +190* | New protocol for family assessment by foster care agencies |
| 4. Lack of accuracy or consistency by Medical Examiners in categorizing cause or manner of sudden, unexpected deaths in children | Poor practice | 0.7 | 5.0 | +614* | New state protocol to determine cause and manner of sudden child deaths |

CPS = Child Protective Services.
* $P < 0.05$.

services (19 findings), followed by failures in mandated child abuse and neglect reporting (4 findings) and problems during court petition and adjudication (4 findings). Findings associated with non-compliance dropped dramatically in Period II, with no change in findings of poor practice. Statistically significant declines were noted related to screening out complaints, insufficient CPS investigation, inaccurate risk assessment completion and inability of the CPS worker to assess the totality of the case. System issues were identified more frequently but "other" issues less so over time. The number of deaths associated with failure of medical professionals to report suspected child maltreatment actually increased as were those linked to unmet mental health needs in families. There were also increased inaccuracies noted in medical examiner characterization of the manner of child deaths. There were specific changes made in law, policy or practice noted for 24 of these 27 findings areas (Table 5).

## Discussion

We were able to identify decreases in child fatalities associated with findings from death reviews among children known within the child welfare system. We also identified specific changes in law, policy, and practice that could be associated with those findings and potentially linked to those fewer child maltreatment deaths. During the first 3 years of review, there were 1.5 findings per case; this decreased 35% to approximately 1 finding per case in the second 3-year period with a concomitant decline in deaths. Most findings identified in our reviews were similar to "micro" recommendations identified by Douglas and Cunningham (2008) and were related to non-compliance with existing law, policy or procedure by child protective services. These decreased dramatically over time, suggesting that action was taken to improve professional practice. For example, non-compliance with an existing law could occur when mandated reporters failed to report suspected child abuse or neglect as required by the state child protection law. Poor practice could occur when, for example, CPS caseworkers failed to follow internal agency procedures or policy during case investigation, such as completing home visits within a certain timeframe or confirming the safety of children after a report of suspected abuse or neglect. Other poor practices not directly dictated by law, policy and practice remained unchanged. System issues outside the child welfare system such as within medicine became more prominent in Period II, suggesting that as child welfare practices improved, other problem areas worsened or became more identifiable in the courts, law enforcement or medical systems.

The potential problem areas to be addressed by CRP become more apparent when placed in the context of the timeline of reporting, CPS investigation, and adjudication. Deaths associated with three of the four findings in the identification and reporting phase actually rose from Period I to Period II, two with statistical significance. These were the presence of unaddressed mental health needs and the inaccuracy of medical examiner findings. Decreases were noted in deaths associated with 22 findings related to CPS investigation, assessment and services, with only a small increase in the number with a finding that CPS failed to make contact with a family because of failure to locate the family during investigation. Statistically significant declines were noted related to screening out complaints, time lapse between assignment and contact with families, inaccurate risk assessment completion and inability of the CPS worker to assess the totality of the case. After CPS investigation, improvements were noted in the number of deaths associated with court adjudication, although none of the trends reached statistical significance.

However, given the limitations of this study, it is inappropriate at this time to infer that a causal relationship exists between CRP review and decreases in CM fatality. To assess this relationship, it is important to consider whether any changes proposed by the CRP can be reasonably expected to have affected CM fatality. Factors present which suggest some linkage

**Table 3**
Case review findings and changes: CPS investigation, assessment and services.

| Finding | Problem area | Annual # Period I | Cases: Period II | % Change (decrease) | System changes |
|---|---|---|---|---|---|
| 5. Inappropriate screening-out of complaints and delay in acceptance of complaints and case assignment | Non-compliance | 6.7 | 1.0 | (85.1)* | New CPS peer review program |
| 6. Incomplete and insufficient complaint investigation by MDHS staff. ("Incomplete" refers to concluded investigations, but no supervisory sign-off; "insufficient" refers to the apparent omission of required tasks.) | Non-compliance | 9.0 | 6.0 | (33.3) | New training at CPS training institute for new hires |
| 7. Unacceptable time lapses between assignment and contact with families | Non-compliance | 4.0 | 0.7 | (82.5)* | New CPS peer review program |
| 8. Failure of CPS supervisor to sign off on child abuse/neglect assessments and/or properly review the case materials, in accordance with established procedures | Non-compliance | 2.5 | 1.3 | (48.0) | New mandatory CPS supervisor training |
| 9. Poor communication among law enforcement and MDHS and failure to perform joint investigation resulted in the whole picture of the child and family's condition not being properly investigated | Poor practice | 2.7 | 2.3 | (14.8) | New protocol for joint investigation<br>Development of Child Advocacy Centers |
| 10. Inaccurate assessment and improper coding of the five-tiered system | Poor practice | 11.7 | 8.7 | (25.6) | New training at CPS training institute for new hires |
| 11. Failure to perform complete investigations regarding medically fragile children | Poor practice | 1.7 | 0.3 | (82.4) | New protocol and training sessions for medically fragile infants and Munchausen by Proxy |
| 12. Failure to comply with policy requiring that positive drug screens in newborns result in automatic finding of preponderance of evidence of failure to protect | Non-compliance | 1.0 | 0.3 | (66.7) | New birth match system linking birth certificates with CPS records |
| 13. Failure to properly investigate for complaints when otherwise indicated because of inability to contact parents without evidence of due diligence | Non-compliance | 1.7 | 2.0 | +17.6 | New protocol for joint investigation |
| 14. Failure of worker to properly assess well-being of child(ren) in the home or recognize imminent danger and take protective custody | Poor practice | 3.0 | 1.3 | (56.7) | New protocol for joint investigation |
| 15. Failure to recognize and respond to parents' repeated and clear indications that they do not want the child/children | Poor practice | 2.5 | 0.7 | (72.0) | Passage of "Safe Delivery Act" allowing parents to safely leave infants at hospitals and other facilities |
| 16. Safety Assessment completed incorrectly or not at all | Non-compliance | 6.5 | 1.3 | (80.0) | Statewide CPS training on assessment tools<br>Data system upgrades |
| 17. Risk Assessment completed incorrectly or not at all | Non-compliance | 9.5 | 1.3 | (86.3)* | Statewide CPS training on assessment tools<br>Data system upgrades |
| 18. Totality of case inaccessible to the caseworker, including timelines, substantiations and unfounded reports | Other issues | 7.0 | 0.7 | (90.0)* | Data system upgrades |
| 19. Failure to cooperate with and/or coordinate investigations with daycare licensing officials | Poor practice | 3.0 | 1.3 | (56.7) | New mandatory CPS supervisor training |
| 20. Failure to assess the appropriateness of the total number of children in a foster care setting, especially with children with special or complex medical needs | Non-compliance | 1.5 | 0.3 | (80.0) | |
| 21. Failure to remove subsequent children after a finding of preponderance in infants with positive toxicology results | Non-compliance | 1.0 | 0.3 | (66.7) | New mandatory CPS supervisor training |
| 22. Improperly returning a child to a home that had lost its foster care license | Non-compliance | 1.0 | 0.0 | (100) | Data system upgrades |
| 23. Criminal history check was not done; if done, was not complete | Non-compliance | 4.7 | 2.0 | (57.4) | New terminals for criminal history checks placed in CPS offices |

CPS = Child Protective Services.
* $P < 0.05$.

include: (1) the nature of the actual changes, (2) how they were implemented (CRP findings were incorporated into CPS practices by members of the Fatality CRP, some of whom who were directly engaged in making and/or changing CPS policy and practice at the state and local level), and (3) the time course of change (Fatality CRP reports were available for a year or more, and time had passed to allow changes in Period II). A number of changes made in state law, policy, and procedures had impact in CPS investigation, assessment and service provision, with new training for workers and supervisors, peer review,

**Table 4**
Case review findings and changes: court petition and adjudication.

| Finding | Problem area | Annual # Period I | Cases: Period II | % Change (decrease) | System changes |
|---|---|---|---|---|---|
| 24. CPS failed to file a petition to terminate parental rights for siblings following the death of a child, when the parents are at fault | Non-compliance | 3.0 | 1.0 | (66.7) | New birth match system linking birth certificates with CPS records |
| 25. Courts, investigators and/or Guardian ad Litem did not access complete CPS file, leading to poor decision-making | Poor practice | 1.7 | 0.0 | (100) | Amendment of Juvenile Code requiring L-GAL to complete independent investigation |
| 26. Courts inappropriately returned children to an abusive family, disregarding CPS recommendations | Poor practice | 1.7 | 0.3 | (82.4) | |
| 27. Courts were not provided important information known by DHS, and/or courts failed to share important information with CPS | Poor practice | 1.0 | 0.7 | (66.7) | Data system upgrades |

CPS = Child Protective Services.

and data system upgrades having the greatest positive effects (Table 5). There were also improvements in areas affected by joint investigation protocols, birth match systems, and a "safe delivery act for newborns".

By 2008, 15 states had constituted their fatality CRP as a component of their state's more broadly established Child Death Review Board (National Citizens Review Panels Virtual Community, 2008). While there are several advantages of constituting CRPs in this manner, there are also potential disadvantages, such as the lack of citizen participation from outside "the system" (Lalayants & Epstein, 2005). Participatory decision-making which includes the public can positively influence outcomes when participants are given fair access to the process, power to influence outcomes, access to information, access to adequate analysis and a structure which facilitates constructive interaction (Webler & Tuler, 2000). Reviews by citizens from outside agencies have been used in other settings such as in judicial citizen panels for foster care with limited success (Lindsey & Wodarski, 1986). We theorize that our Fatality CRP may have had some success because the members were familiar with the child welfare system, and there was a formal process to move from reviews to recommendations to state action with monitoring of state actions related to the recommendations.

There are several recommendations that have been made to improve the perceived effectiveness of CRPs with regard to citizen participation and communication with child welfare agencies. After using a variety of methods to assess the value of CRPs, Bryan, Jones, Allen, and Collins-Camargo (2007) noted that CRP members' perceptions of their effectiveness were mixed, and there were concerns about their ability to affect state CPS policy and practice, having limited communication with state-level CPS, and receiving a poor response from CPS regarding their reports. They recommended strengthening the CRP process by strengthening the legislative basis for CRPs, better formalizing and improving communication between the CRPs and state-level CPS agencies, assisting CRP members to better understand CPS practices, and enhancing state responses to CRP reports. While we did not look specifically at these issues, these potentially problematic areas affecting CRP function could also have affected our Fatality CRP's ability to further reduce CM deaths.

While the limitations of this study preclude inferring causation, the results suggest promising outcomes after CRP review. Some changes in law, policy or practice, such as new protocols for joint investigation, which were implemented on a county-

**Table 5**
Changes made and case findings addressed during Period I.

- Enhanced training for physicians (1)
- New protocol for family assessment by foster care agencies (3)
- New protocol to determine the cause and manner of sudden infant deaths (4)
- New CPS peer review programs (5 and 7)
- New training topics at the CPS training institute for new hires (6 and 10)
- New mandatory CPS supervisor training (8, 19, and 21)
- New protocols for joint CPS and law enforcement investigation (9 and 14)
- New protocol and training for assessment of medically fragile infants and Munchausen by Proxy (11)
- New birth match system linking birth certificates with CPS records (12 and 24)
- New "safe delivery act for newborns" allowing parents to turn over newborns to CPS at hospitals, police stations and fire houses (15)
- New training for workers on assessment tools (16)
- Upgrades to CPS data systems and new access to criminal record systems (16–18, 22, 23, and 27)
- Amendment of Juvenile Code requiring legal representative to complete independent investigation (25)

Figures in ( ) refer to findings in Tables 2–4.

by-county basis, were not associated with changes in the numbers of deaths. Medical professionals continued to fail to report suspected CM even after implementation of statewide physician training, and there were more inaccurate death determinations even after a new statewide protocol for medical examiners and investigators. There were also wide variations and small numbers that precluded statistical significance for many of the changes in the frequencies of deaths, with the non-significant results having less than 0.5 power to detect true differences because of the small numbers of deaths with those findings. Any changes in death trends could also have been affected by changing community practices, policies, and other factors unrelated to the CRP, such as trends in overall child death. The Fatality CRP generally does not have access where there is no CPS involvement and/or the case does not become known to the state's child fatality review teams. While the CRP composition was stable over the study period, there were potentially changes in their knowledge and training that could have affected the panel's findings and recommendations over time. These data can only reflect one state's experience, and, while consistent risk factors for CM fatality have been noted across the US, child welfare policies vary widely from state to state, and this affects our ability to generalize the effects of the CRP process. Lastly, our process for identifying changes in law, policy and practice relied on reports and surveys of state CPS directors rather than a more systematic line-by-line review of state law and agency policy. This could have resulted in our incorrectly identifying any changes or misattributing their implementation.

Our understanding of CRPs and their potential role in improving the child welfare system deserves further research, especially given their mandated role by CAPTA and their ability to make recommendations that must be responded to by state CPS. Specific studies are needed comparing CRP and CFRT processes, team composition, and the role they can play in preventing child abuse and neglect deaths.

## Conclusions

We identified a number of problem areas in our state's child welfare system by reviewing child maltreatment fatalities using a citizen review panel. Most of these problem areas identified were addressed by the state child protective services agency with changes in law, policy, or practice, and there was a later reduction in the number of findings and in the number of deaths associated with those findings over time. While further research is needed to assess the impact of CRPs on child welfare practices, child fatality reviews by federally mandated citizen review panels offer the potential to reduce CM deaths by improving child protective service practices.

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