

Child Abuse and Neglect Fatalities 2019: Statistics and Interventions

Despite the efforts of the child protection system, child maltreatment fatalities remain a serious problem.¹ Although the untimely deaths of children due to illness and accidents are closely monitored, deaths that result from physical abuse or severe neglect can be more difficult to track. This factsheet describes data on child fatalities and how communities can respond to this critical issue and, ultimately, prevent these deaths.

¹ This factsheet provides information regarding child deaths resulting from abuse or neglect by a parent or a primary caregiver. Other child homicides, such as those committed by acquaintances and strangers, and other causes of death, such as unintentional injuries, are not discussed here. For information about leading causes of child deaths nationally from 1999 to 2019, visit the [Centers for Disease Control and Prevention website](#). Statistics on child homicide from 1980 to 2011 can be obtained from the [U.S. Department of Justice](#).

WHAT'S INSIDE

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Unless otherwise noted, statistics in this factsheet are taken from the Children’s Bureau’s [Child Maltreatment 2019](#) report and refer to Federal fiscal year (FFY) 2019. Statistics refer to the year in which the deaths were determined to be from maltreatment; in some cases, this may have been different from the year in which a child actually died.

HOW MANY CHILDREN DIE EACH YEAR FROM CHILD ABUSE OR NEGLECT?

According to data from the National Child Abuse and Neglect Data System (NCANDS), 51 States² reported a total of 1,809 fatalities.³ Based on these data, a nationally estimated 1,840 children died from abuse or neglect in FFY 2019, a slight increase from the FFY 2018 number of 1,780. However, it is a 10.8-percent increase over the FFY 2015 number of 1,660.

1,840 children

An estimated 1,840 children died due to abuse or neglect in FFY 2019.

The FFY 2019 data translate to a rate of 2.5 children per 100,000 children in the general population and an average of more than

5 children dying every day from abuse or neglect. NCANDS defines “child fatality” as the death of a child caused by an injury resulting from abuse or neglect or where abuse or neglect was a contributing factor.

The number and rate of fatalities reported by States have fluctuated during the past 5 years. The national estimate is influenced by which States report data as well as by the U.S. Census Bureau’s child population estimates. Some States that reported an increase in child fatalities from 2012 to 2013 attributed it to improvements in reporting after the passage of the Child and Family Services Improvement and Innovation Act (P.L. 112–34), which passed in 2010.

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|------|-------|
| 2015 | 1,660 |
| 2016 | 1,730 |
| 2017 | 1,710 |
| 2018 | 1,780 |
| 2019 | 1,840 |

² In the context of NCANDS, the term “States” includes the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

³ The Children’s Bureau received data from 51 States. Of those States, 45 reported case-level data on 1,515 fatalities, and 34 States reported aggregate data on 294 fatalities.

Most data on child fatalities come from State child welfare agencies. However, States may also draw on other data sources, including health departments, vital statistics departments, medical examiners' offices, law enforcement, and fatality review teams. This coordination of data collection contributes to better estimates.

Many researchers and practitioners believe that child fatalities due to abuse and neglect are underreported (Schnitzer et al., 2013). The following issues affect the accuracy and consistency of child fatality data:

- Variation among reporting requirements and definitions of child abuse and neglect and other terms
- Variation in death investigation systems and training
- Variation in State child fatality review and reporting processes
- The length of time (up to a year in some cases) it may take to establish abuse or neglect as the cause of death
- Inaccurate determination of the manner and cause of death, which results in the miscoding of death certificates and includes deaths labeled as accidents, sudden infant death syndrome, or undetermined that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted

- Limited coding options for child deaths, especially those due to neglect or negligence, when using the International Classification of Diseases to code death certificates
- The ease with which the circumstances surrounding many child maltreatment deaths can be concealed or rendered unclear
- Lack of coordination or cooperation among different agencies and jurisdictions

Several organizations have suggested practices at the Federal, State, and local levels that could improve data reporting and result in a more accurate count of maltreatment deaths. A [report](#) by the Federal Commission to Eliminate Child Abuse and Neglect Fatalities (2016) suggests enhancing the ability of national and local systems to share child fatality data so that agencies can use lessons learned to prevent future deaths. In a May 2019 [report](#), the National Center for Fatality Review and Prevention (NCFRP) suggests that standard protocols and minimum data sets be established for child death review (CDR) and fetal and infant mortality review teams. NCFRP also provides suggestions for improving child welfare reviews in a September 2018 [report](#).

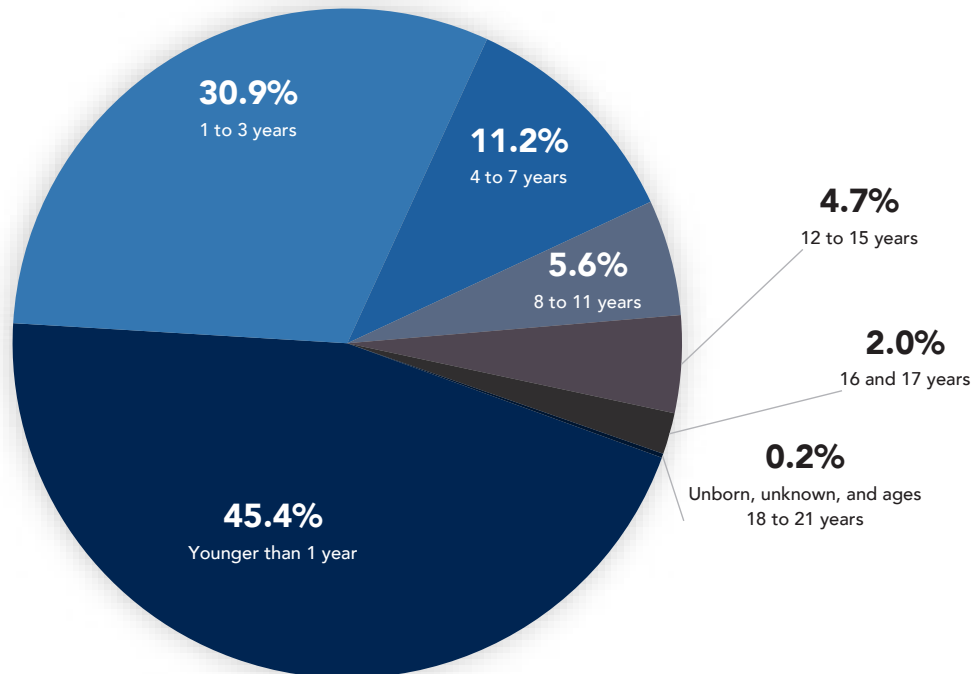
WHAT GROUPS OF CHILDREN ARE MOST VULNERABLE?

Almost three-quarters (70.3 percent) of child fatalities in FFY 2019 involved children younger than 3 years, and children younger than 1 year accounted for 45.4 percent of all fatalities. See figure 1 for additional data about the age of fatality victims. Young children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves.

HOW DO THESE DEATHS OCCUR?

Fatal child abuse may involve repeated abuse over a period of time, or it may involve a single, impulsive incident (e.g., drowning, suffocating, shaking a baby). In cases of fatal neglect, the child's death does not result from anything the caregiver does; rather, it results from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub).

FIGURE 1. CHILD ABUSE AND NEGLECT FATALITY VICTIMS BY AGE, 2019



In 2019, 72.9 percent of children who died from child maltreatment suffered neglect either alone or in combination with another maltreatment type, and 44.4 percent of children who died suffered physical abuse either alone or in combination with other maltreatment.

72.9%

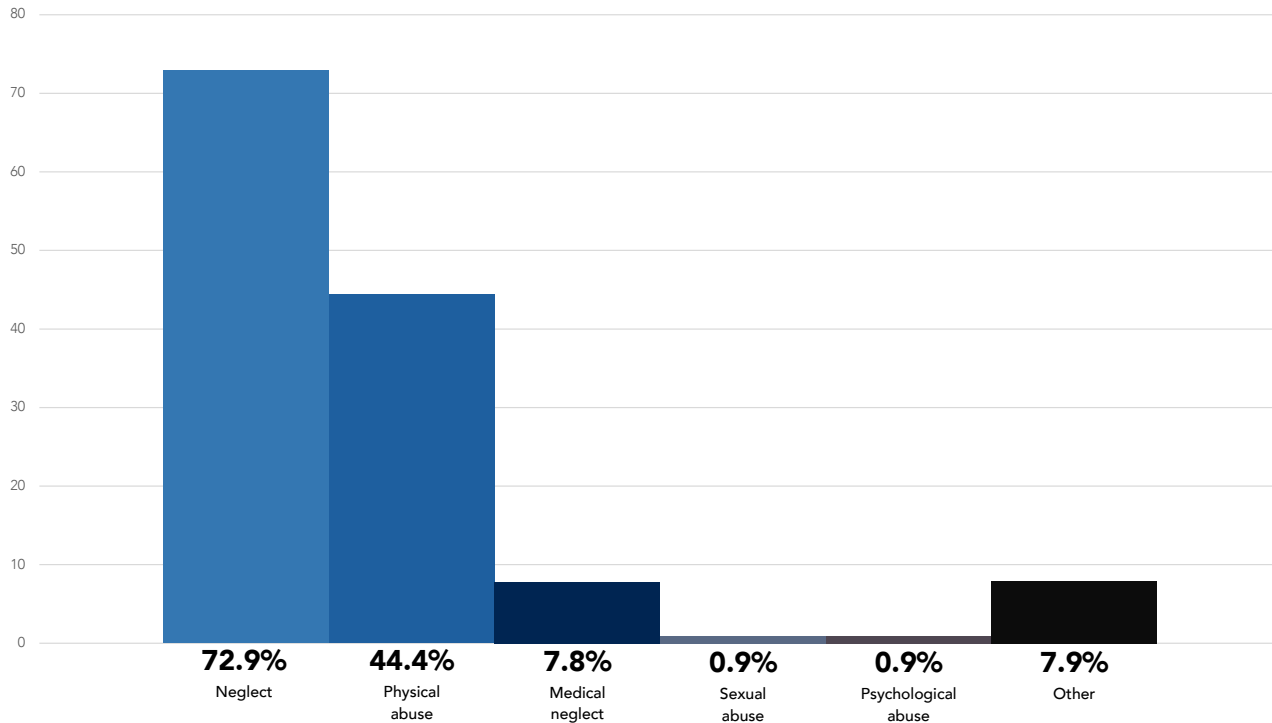
In FFY 2019, 72.9 percent of children who died from child maltreatment suffered neglect either alone or in combination with another maltreatment type.

Medical neglect either alone or in combination with another maltreatment type was reported in 7.8 percent of fatalities. See figure 2 for additional information about fatalities by maltreatment type.

WHO ARE THE PERPETRATORS?

In 2019, parents—acting alone or with another parent or individual—were responsible for 79.7 percent of child abuse or neglect fatalities. More than one-quarter (29.2 percent) of fatalities were perpetrated by the mother acting alone, 14.2 percent were perpetrated by the father acting alone, and 22.6 percent were perpetrated by two parents of known sex⁴ acting together. Nonparents (including kin and child care providers, among others)

FIGURE 2. CHILD ABUSE AND NEGLECT FATALITIES BY REPORTED MALTREATMENT TYPE, 2019



Note: The total of the percentages exceeds 100 percent because fatalities may involve more than one type of maltreatment.

⁴ The “two parents of known sex” category replaces the “mother and father” category and includes mother and father, two mothers, and two fathers.

were responsible for 16.6 percent of child fatalities, and child fatalities with unknown perpetrator relationship data accounted for 3.7 percent of the total. For more information, see figure 3.

HOW DO COMMUNITIES RESPOND TO CHILD FATALITIES?

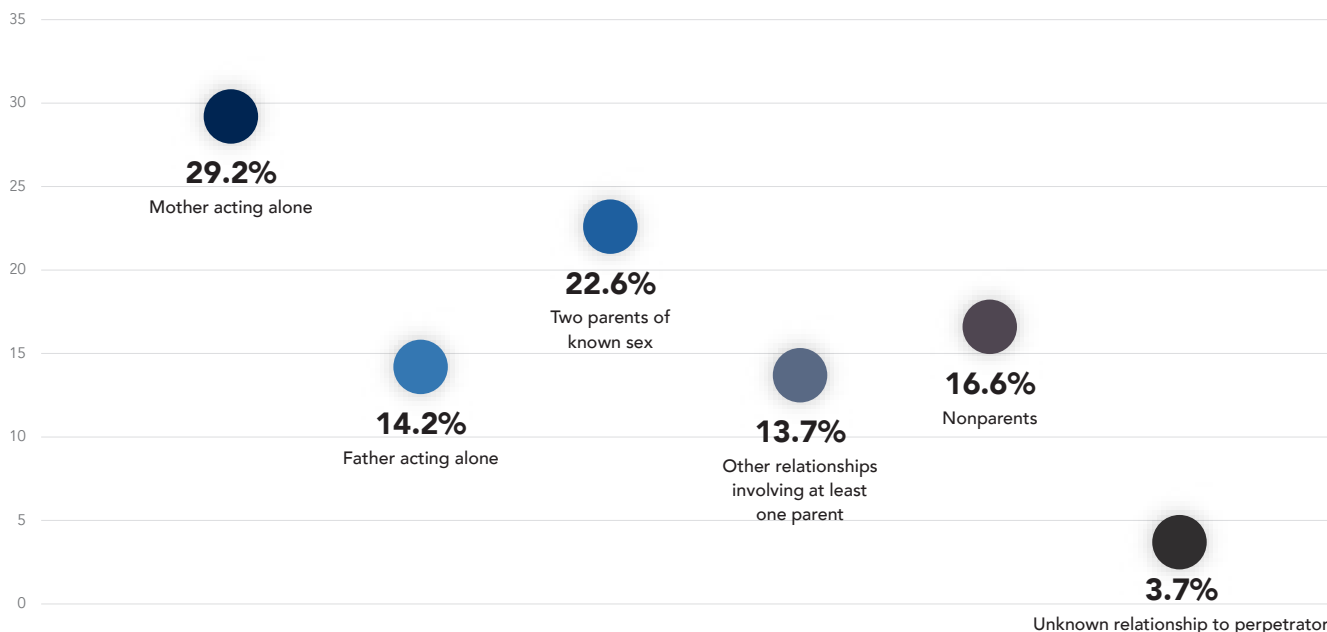
The response to child abuse and neglect fatalities is often hampered by inconsistencies and other issues, including the following:

- Underreporting of the number of children who die each year as a result of abuse or neglect
- Lack of consistent standards for child autopsies or death investigations
- Varying investigative roles of child protective services (CPS) agencies in different jurisdictions
- Uncoordinated, nonmultidisciplinary investigations
- Medical examiners or elected coroners who do not have specific child abuse and neglect training

To address some of these issues, multidisciplinary and multiagency child fatality review teams have emerged to provide a coordinated approach to understanding child deaths, including deaths caused by religion-based medical neglect. The development of these teams was further supported in an amendment to the 1992 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), which required States to include information on CDR in their program plans. Many States received initial funding for these teams through [Children’s Justice Act](#) (CJA) grants awarded by the Administration on Children, Youth and Families of the U.S. Department of Health and Human Services (HHS). Many CJA grantees continue to use a portion of their grant funds to support the ongoing function and enhancement of fatality review teams within their States.

Child fatality review teams, which exist at the State, local, or combination State/local levels in every State plus the District of Columbia, are composed of prosecutors, coroners or medical examiners, law enforcement personnel,

FIGURE 3. FATALITIES BY RELATIONSHIP TO PERPETRATOR, 2019



CPS workers, public health-care providers, and others. Child fatality review teams respond to the issue of child deaths by improving interagency communication, identifying gaps in community child protection systems, and acquiring comprehensive data that can guide agency policy and practice as well as prevention efforts.

The teams review cases of child deaths and facilitate appropriate follow-up. Follow-up may include ensuring that services are provided for surviving family members, providing information to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems.

In 2005, NCFRP, in cooperation with 30 State CDR leaders and advocates, developed a web-based CDR case-reporting system for State and local teams to use to collect data and analyze and report on their findings. As of February 2021, 47 States were using the standardized system.⁵ As more States use the system and the number of reviews entered into it increases, a more representative and accurate view of how and why children die from abuse and neglect will emerge (Palusci & Covington, 2013). The ultimate goal is to use the data to advocate for actions to prevent child deaths and to keep children healthy, safe, and protected. (For more information about child fatality review efforts in specific States, visit the [NCFRP website](#).)

Since its 1996 reauthorization, CAPTA has required States that receive CAPTA funding to set up citizen review panels. These panels of volunteers conduct reviews of CPS agencies in their States, which can include assessments of policies and procedures related to child fatalities

and investigations. As of December 2018, 16 State CDR boards serve additional roles as the citizen review panels for child fatalities.⁶

HOW CAN FATALITIES BE PREVENTED?

There are several promising practices and strategies to reduce child fatalities from abuse and neglect. Every year, the Office of Child Abuse and Neglect within the U.S. Department of Health and Human Services' Children's Bureau releases a [resource guide](#) as part of [National Child Abuse Prevention Month](#) with the goal of raising awareness about emerging child abuse prevention concepts.

Promoting [protective factors](#) has been central to the resource guide for several years. Protective factors are conditions or attributes in individuals, families, communities, or the larger society that mitigate or eliminate risk, thereby increasing the health and well-being of children and families. The protective factors include nurturing and attachment, knowledge of parenting and of child and youth development, parental resilience, social connections, concrete supports for parents, and social and emotional competence of children.

The resource guide addresses prevention from the perspective of a social-ecological model, an approach that acknowledges there are factors beyond the individual child and family that affect caregivers' ability to nurture and protect their children. Because of the many factors that play into prevention, the most successful efforts are those that employ various programs, practices, and partnerships over time.

⁵ Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming (Source: NCFRP)

⁶ Florida, Georgia, Illinois, Indiana, Kansas, Maryland, Michigan, Missouri, New Jersey, North Dakota, Oklahoma, South Carolina, Texas, Virginia, Wisconsin, and Wyoming (Source: NCFRP)

The following strategies and initiatives offer a variety of approaches to the prevention of child fatalities as well as child maltreatment in general.

Child fatality review teams. Well-designed child fatality review teams work to identify the underlying nature and scope of fatalities due to child abuse or neglect. The child fatality review process helps identify risk factors that may assist prevention professionals, such as those engaged in home visiting and parenting education, to prevent future deaths.

Data collection and analysis. Some States have begun to integrate CPS data with other data to help identify high-risk families and provide prevention services before maltreatment happens (Putnam-Hornstein, Wood, Fluke, Yoshioka-Maxwell, & Berger, 2013).

Public health approach. A number of experts have championed a public health approach to addressing child maltreatment fatalities, which focuses on the health, safety, and well-being of entire populations rather than individuals. They also may focus on social determinants of health, which are conditions in the places where people live, learn, work, and play that affect health risks and outcomes. Resources that enhance quality of life can significantly impact population health outcomes (Centers for Disease Control and Prevention, 2021).

Improved training. Better training for child welfare workers may help identify potentially fatal situations.

Use the following resources for more information about preventing child fatalities:

- [Preventing Child Abuse & Neglect](#) (Child Welfare Information Gateway)
- [Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities](#) (Commission to Eliminate Child Abuse and Neglect Fatalities)
- [“Better Child Abuse Fatality Reviews Are Key to Overhauling Child Welfare”](#) (Covington & Levinson)
- [“Characteristics, Classification, and Prevention of Child Maltreatment Fatalities”](#) (McCarroll, Fisher, Cozza, Robichaux, & Fullerton)
- [“If I Knew Then What I Know Now: Seven Strategies to Reduce Child Abuse and Neglect Fatalities”](#) (Casey Family Programs)

SUMMARY

While the exact number of children affected is uncertain, child fatalities due to abuse or neglect remain a serious problem in the United States. Fatalities due to child maltreatment disproportionately affect young children and most often are caused by one or both of the child’s parents. One of the most promising approaches to curtailing child fatalities is the implementation of review teams, which can help communities accurately count, respond to, and prevent these as well as other avoidable deaths.

ADDITIONAL RESOURCES

[Citizen Review Panels](#)

This Child Welfare Information Gateway webpage presents resources about citizen review panels, which help ensure States are following child protection requirements.

[National Center for the Review and Prevention of Child Deaths](#)

The NCFRP is a resource center for State and local CDR programs. The HHS Maternal and Child Health Bureau established the center in 2002 and has funded it ever since. The [State map tool](#) provides links to CDR reports for each State.

[National Fetal-Infant Mortality Review Program](#)

This program is a collaborative effort between the American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau. The resource center provides technical assistance on many aspects of developing and carrying out fetal infant mortality review programs.

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Children's Bureau



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