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Fatal child neglect: Characteristics, causation, and strategies for prevention

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ABSTRACT

Research in child fatalities because of abuse and neglect has continued to increase, yet the mechanisms of the death incident and risk factors for these deaths remain unclear. The purpose of this study was to systematically examine the types of neglect that resulted in children's deaths as determined by child welfare and a child death review board. This case review study reviewed 22 years of data ($n = 372$) of child fatalities attributed solely to neglect taken from a larger sample ($N = 754$) of abuse and neglect death cases spanning the years 1987–2008. The file information reviewed was provided by the Oklahoma Child Death Review Board (CDRB) and the Oklahoma Department of Human Services (DHS) Division of Children and Family Services. Variables of interest were child age, ethnicity, and birth order; parental age and ethnicity; cause of death as determined by child protective services (CPS); and involvement with DHS at the time of the fatal event. Three categories of fatal neglect – supervisory neglect, deprivation of needs, and medical neglect – were identified and analyzed. Results found an overwhelming presence of supervisory neglect in child neglect fatalities and indicated no significant differences between children living in rural and urban settings. Young children and male children comprised the majority of fatalities, and African American and Native American children were over-represented in the sample when compared to the state population. This study underscores the critical need for prevention and educational programming related to appropriate adult supervision and adequate safety measures to prevent a child's death because of neglect.

In fiscal year 2010, an estimated 695,000 unique children were identified as being abused and/or neglected in the United States, translating to 9.2 children per 1,000 (U.S. Department of Health and Human Services [DHHS], 2010). Although the general public perceives physical and sexual abuse as the most common forms of maltreatment, 78.3% of these cases were the result of neglect. In addition, child neglect alone constitutes nearly one-third of all child maltreatment fatalities (DHHS, 2010).

One of the important contributions of neglect research to date has been the classification of neglect as inadequate *care*, such as food or water, and inadequate *supervision*, such as developmentally inappropriate child supervision (Coohey, 2003b; Dubowitz, 2007; Jones, 1987). It is the latter which has proven to be the most problematic to define and categorize. Current research has addressed problems in the measurement, definition, and global classification of child neglect (Coohey, 2003a, 2003b; Dubowitz, 2007; Dubowitz, Pitts, & Black, 2004; Mennen, Kim, Sang, & Trickett, 2010; Slack, Holl, Altenbernd,

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McDaniel, & Stevens, 2003). This research has called attention to the ongoing need to develop and maintain subcategories of neglect for research and clinical purposes. An analysis of 10 subtypes of supervisory neglect revealed that the majority of supervisory neglect cases (29.8%) were attributable to an adult's failure to watch a child closely enough, and leaving a child with inadequate care accounted for 24.5% of cases in the sample (Coohey, 2003a). Although this study examined child neglect and not child neglect fatalities, other research has found that the failure to properly supervise and attend to children tends to be the largest contributor to both child neglect and neglect related deaths (Bonner et al., 1999; Mennen et al., 2009). A number of useful classification systems for neglect have been developed (see Mennen et al., 2009, for a review); however, none has been tailored for child fatalities.

For the purposes of the current study, inadequate care, also termed *deprivation-of-needs neglect*, is defined as the caregiver's failure to provide for the child's basic needs (i.e., food, water, shelter, clothing, education, and medical care) and supervisory neglect is defined as the failure of a parent or caregiver to provide adequate supervision of and/or safety precautions for a child based on the child's age and abilities. Unlike inadequate care, supervisory neglect can be either acute or chronic and needs only to occur once to result in a child's death. Some research studies have used categories other than child neglect for fatal incidents because of lack of momentary supervision, such as "accidents," "homicide," or "maltreatment" (King et al., 2006; Knight & Collins, 2005; Rimsza et al., 2010). For example, Knight and Collins (2005) acknowledged a "gray area" in relation to the classification of some types of child deaths, such as accidental drownings, motor vehicle collisions, and overlaying. This "gray area" exists because these fatal circumstances can be because of either neglect or an accident, and such classifications can vary according to the classification body. A functional system that scrutinizes the cause of child fatalities, however, is key to preventing future child deaths and to understanding the types of supervision problems associated with these deaths. Therefore, all fatal incidents that lacked adequate preventative or appropriate supervision as determined by child welfare and a child death review board are included in this study.

To date, research on child fatalities has been based on information obtained by state child death review boards, death certificates, state child welfare agencies, and/or hospital records. The validity and reliability of each of these sources has been questioned because of large state-to-state variations in the definition and classification of child fatalities (Shanley, Risch, & Bonner, 2010). For example, states using death determinations made by medical examiners as a primary categorization of death in children may underestimate the rates of fatal child maltreatment (Crume, DiGuiseppi, Beyers, Sirotnak, & Garrett, 2002) and could directly impact child fatality research (Herman-Giddens et al., 1999).

If research focused on neglect lags behind the other forms of child maltreatment research in terms of quantity, then by comparison, studies of fatal child neglect are almost nonexistent. Child fatality research has focused on demographic information of the parents, offenders, victims, and situations in which fatal child maltreatment occurred. However, given the low base rate at which child fatalities occur, it can take several years for researchers to accumulate an adequate number of events to allow for meaningful statistical analyses. Thus, the majority of published research examines fatal child maltreatment as a whole and rarely examines this problem by separating abuse and neglect.

The research on child fatalities is in its infancy with regard to addressing possible risk and contextual factors. Several studies have indicated that the presence of certain risk factors can contribute to a child's death. Parent and child characteristics and household composition are examples of such risk factors, and research has shown that at the time of a child's death, living with adults not related to the child increases the risk of maltreatment death by as much as 8% (Schnitzer and Ewigman, 2005; Stiffman, Schnitzer, Adam, Kruse, & Ewigman, 2002). Some baseline data has been collected regarding families' involvement with Child Protective Services (CPS) prior to a child's death; recent estimates place this figure at 13.1% (DHHS, 2007).

Purpose

The purpose of this case review was to examine and categorize child deaths resulting from fatal child neglect by using the five categories of child neglect developed by Mennen et al. (2010) and developing three specific categories related to lethal neglect. These categories are Care Neglect (Deprivation of Needs), Supervisory/Environmental Neglect, and Medical Neglect. Educational and emotional neglect were omitted because they were not direct causes of any child fatalities in this study. Additionally, Environmental Neglect and Supervisory Neglect were combined because data suggested that fatal events were often a combination of a dangerous environment and poor supervision. For instance, it may be both a lack of smoke detectors in a home and the fact that a young child was left in charge of other young children in that home which contributes to a fatal event. Other variables of interest included child and family demographics and family history of CPS involvement.

Method

Participants

Data were collected retrospectively from the files of the Oklahoma Child Death Review Board (CDRB) as part of a larger, ongoing project on child fatalities from abuse and neglect ($N = 754$). From this sample, a total of 372 cases were examined in which the cause of death was determined by the Oklahoma Division of Child and Family Services personnel to result from neglect. This determination included children who died from unintentional shootings, unintentional drownings, medical