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Reporting of fatal neglect in NSW

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A report by the Australian Institute of Family Studies

Executive Summary

This report is provided to the NSW Ombudsman in response to a request for a literature review with a focus on fatal neglect definitions and reporting, and advice relating to the NSW Ombudsman's defining and reporting of fatal child neglect in NSW.

Child death reviews are conducted with the aim of preventing child deaths. The NSW Ombudsman conducts two such reviews relating to the deaths of children, a review of all child deaths in NSW and a more targeted review of a subset of deaths of 'certain' children where abuse or neglect may have contributed to the death.

Despite considerable academic debate there is no universal definition of fatal neglect, rather definitions are operationalized according to the context in which they will be applied. Fatal neglect in a legal context must be specific and enable the prosecution of a perpetrator; those associated with child protection systems can be broader but must enable intervention by child protection authorities. Finally, the broadest of definitions are those utilised in a public health context. They enable identification of risk and prevention factors for development and implementation prevention strategies, polices and procedures.

The NSW Ombudsman and Child Death Review Team (CDRT) reports are among the most comprehensive in the world. This includes their consideration of fatal neglect related deaths. There is some room for improvement in the reporting of fatal neglect, however, particularly in relation to CDRT reporting. Specific identification of neglect related or preventable deaths under subcategories of medical, sleep related, external causes, and supervision related could facilitate an ecological public health response to preventing these deaths.

Providing the additional context for neglect related deaths will allow for improved understanding of the impact of fatal neglect across all child deaths and therefore, improved potential to implement preventive programs, policies and procedures.

1. Background

AIFS was contracted by the NSW Ombudsman to conduct a review of the definition and reporting practices of fatal neglect. The research project has three components:

i) a literature review and analysis of fatal neglect with a focus on definitions of fatal neglect and approaches of reporting fatal neglect in child death review reports, in Australia, and internationally;

ii) a review and analysis of the Ombudsman's reporting of neglect-related reviewable child deaths since 2002; and

iii) advice regarding strengths and weaknesses of current approaches to defining and reporting neglect related deaths and issues for consideration in the reporting of neglect-related deaths in the context of optimising strategies to prevent reviewable child deaths.

2. Methods

A comprehensive review of the literature relating to defining fatal neglect was performed. This included peer review papers, grey literature and reports from child death review teams (CDRT) in Australia, Canada, the United Kingdom (UK) and the United States (US).

A literature search was conducted across the EBSCO, Pubmed and Google Scholar databases. Initially the search terms '*fatal child neglect definition*' were used but this yielded few references so the search terms were broadened to '*fatal neglect*'. There were 148 titles identified that were narrowed to 54 after the abstract was reviewed. After reviewing the papers, another 14 were excluded because they did not include a definition of neglect and were epidemiologic studies or were considering characteristics of families and children where fatal neglect had occurred. Ultimately, this literature review included 40 papers that provided a definition of neglect or fatal neglect and/or debated that definition in some way. (See Appendix A for a summary table of papers included and excluded in the review) Table 1 presents an overview of the results of the literature search.

Table 1: Results of literature search

Database	Number of papers title reviewed	Number of papers abstract reviewed
Google Scholar	74	35
PubMed	55	8
EBSCO Host	10	3
Snowball techniques	9	8
Total	**148**	**54**

A search for Child Death Review Team identified a total of 80 separate jurisdictions across Australia, New Zealand, Canada, United States (USA) and the United Kingdom (UK). In some jurisdictions multiple death review teams relating to child deaths were operating. There was significant variation in the terms of reference for these teams. Reviews ranged from comprehensive – all child deaths to selective; for example deaths associated with maternal and premature birth deaths, only those known to child protection services, those where maltreatment was likely to be associated with the death and deaths where the coroner or medical examiner identified that the death warranted additional review. There was also variation in the criteria applied in relation to the age of the child at death. Some jurisdictions included all deaths from 20 weeks gestation, some from post-natal hospital discharge and this ranged through to children up to 14 years, 18 years or 25 years. In some jurisdictions there was 'more intense' review of children up to 2 years or if there was suggestion that the death was associated with maltreatment.

Table 2: Summary of identified child death reviews and reports

	Total CDRT jurisdictions identified	Report identified	Review all deaths	Review of select deaths
Australia	8	8	5	3
New Zealand	1	1	1	-
Canada	14	4	7	7
USA	50	48	42	8
UK	7	5	5	2
Total	**80**	**66**	**60**	**20**

3. Neglect – setting the scene

There is a common understanding that neglect is the failure of a parent or caregiver to provide basic requirements required for a child to thrive. However, there is no standard, universal definition of neglect. Neglect is further divided into subtypes, generally classified by what is not provided, for example educational, physical, medical, emotional or abandonment (Scott, 2014).

In Australia in the financial year 2013-2014, child neglect was the second most commonly substantiated type of child maltreatment and 28% of all substantiations were neglect related. The neglect substantiation rate in NSW was slightly higher than nationally, with 31.4% of all substantiations related to neglect (Australian Institute of Health and Welfare, 2015). Although neglect is common, it remains one of the most difficult forms of maltreatment to substantiate because it is closely connected to issues of poverty, family structure, gender (it is frequently seen to be associated with mothers rather than fathers), single parenthood, ethnicity and access to resources (Scott, 2014).

The impact and outcome of neglectful behaviour on the part of a parent or caregiver will vary according to the developmental age of the child, the length of time the child is exposed to neglect, what that neglect fails to provide for the child and the degree to which the child is resilient. For example, children who are neglected may suffer more frequent injuries (supervisory neglect), have lower educational outcomes because they do not attend school regularly (educational neglect) or, on the extreme end of the continuum may starve to death (physical neglect).

There is strong evidence to suggest that the number of children who die from maltreatment-related causes is underestimated in official data (Covington & Petit, 2013; Schnitzer, Covington, & Kruse, 2011). Despite the possibility that the parent/caregiver may have meant to harm the child, the child's death per se may not have been their intention, and few parents are prosecuted for the death of a child (Inter-agency Council on Child Abuse and Neglect, 2014).

Deaths from some form of neglect, including supervisory neglect, are more common than abuse-related deaths (Victorian Government, 2011). Many child neglect deaths resemble 'accidental' deaths (Margolin, 1990) and would not meet the threshold for substantiation by child protection authorities (Schnitzer & Ewigman, 2008). Like other forms of neglect, any identification of fatal neglect must take parental competence and caregiver capability, cultural context, child personality and development and environmental factors into account (Executive Committee to Review the Death of Children, 2013).

A failure to provide for a child may occur, not because the family doesn't want to do the best possible for the child, but because they lack the means to do so, due to a number of systemic or underlying issues. Children who are most at risk of any maltreatment-related deaths are often from families struggling with poverty, mental health issues, family violence, previous involvement with the child protection system, and/or involvement with the justice/criminal system (Covington & Petit, 2013). For many neglect-related deaths, the parent or caregiver was simply not present at a time and in a manner that could have prevented the death (Idaho Child Fatality Review Team, 2015).

Neglect is a complex issue and identification relies on a subjective assessment of 'good enough' parenting. The standard for reasonableness relies on cultural and social factors and so can vary from context to context (Scott, 2014). In some circumstances the label of neglect may not describe the true situation, particularly in circumstances of poverty, lack of education, cultural differences or lack of access to services.

Consider the following scenarios in relation to the death of a child. Could, or should, any of these be considered fatal neglect? If prevention is the intent of reviewing the deaths, would there be a difference in how prevention would be approached if any/all/none were deemed fatal neglect?

CASE STUDY

A 9-month old child has been ill for 48 hours with nausea, vomiting and a high fever. Initially she was fussy and difficult to settle, particularly throughout the night. She has not kept any fluid down since 8pm the night before. By 11am she has further deteriorated and is now lethargic and quiet.

Scenario 1:
Her mother has cared for her during the night as the father was out with friends. At 7am the mother checked the sleeping baby, warned the father that she was concerned about how unwell the baby was and left her with the baby's father to go to work. The father had a late night drinking with friends and was feeling hung-over. After checking the sleeping child he returns to bed. He wakes at 11am, checks on the baby and notes she is still asleep, and so returns to bed. At 1pm he wakes, and sees the baby is not breathing and calls an ambulance.

Scenario 2:
Both parents recognise the child is very unwell and call on their local Pastor and members of their church. The parents belong to a church that believes only in the power of prayer and disagree with medical intervention. The congregation pray over the child during the morning. When she stops breathing at 12:30 an ambulance is called.

Scenario 3:
The parents live in a remote town with no access to a car or transport. The nearest hospital is 3 hours away. At 9am the parents borrow a neighbour's car, and drive to the hospital. She is admitted to the emergency department at noon and is pronounced dead at 1pm.

4. Context for operationalisation

Definitions of fatal neglect range from very specific and narrow to much broader and more inclusive, depending on the context for which they are needed, or operationalized (Biron & Reynald, 2015). In a legal context, definitions are quite specific in terms of actions leading to the death and to the person/or persons to whom those actions are attributed in determining criminal or civil liability in a legal framework. For example:

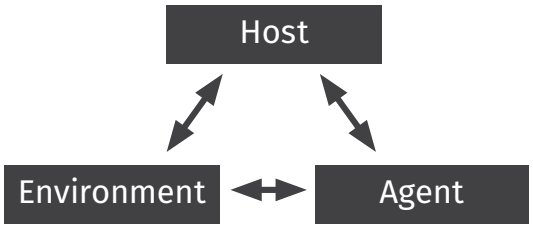
> *'the failure of a caregiver to adequately provide safety, food, clothing, shelter, education, protection, medical/dental care and supervision for a child in his/her care'* (Knight & Collins, 2005). Legal definitions are typically from a 'perpetrator-focused' rather than 'child-focused' perspective. This specificity is necessary and required within the parts of the legal system that are concerned with criminal or civil liability.

Child protection definitions of neglect (including fatal neglect) are somewhat broader; more child focused, and identify a threshold whereby statutory child protection authorities can intervene where a child is deemed to be unsafe. For example, the Victorian Government defines neglect as '*the failure to provide the child with the basic necessities of life such as food, clothing, shelter, medical attention or supervision, to the extent that the child's health and development is, or is likely to be, significantly harmed'* (Victorian Government, 2011).

Determinations of neglect in this context focus on the *level of harm experienced by the child* rather than the *actions of the parent/caregiver.* As in other forms of maltreatment, a threshold of serious harm determines whether or not the maltreatment (i.e., either neglect or abuse) is substantiated and the statutory authority has legislative grounds for intervention (Child Family Community Australia, 2014). In most jurisdictions, the threshold of harm is modified by the presence of a parent or caregiver who is able and willing to protect the child. For example, where a child lives in a home with a parent who has a drug addiction and is neglectful and unable to provide appropriate care for the child, if the other parent (or another caregiver in the home) provides appropriate care then the child is deemed to have a protective parent/caregiver and so child protection authorities may respond by offering support services as required, but not substantiating the neglect.

The broadest definitions of fatal neglect occur in the public health context. Public health responses are based on the presence of risk factors that occur in one of three areas: host, agent, or environment. The condition/disease (in this case fatal neglect) can only occur where there is interaction between the three areas. Public health strategies are based on interfering in some way so that there cannot be interaction to cause the condition/disease in the host (prevention).

Figure 1: Public Health Triangle[1]

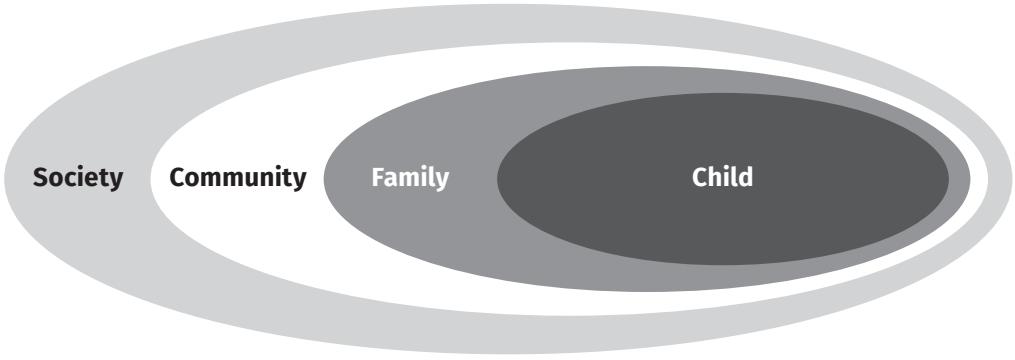


A public health definition of fatal neglect does not specify actions/intent or perpetrator and does not restrict the environment where fatal neglect occurs and so results in a very broad definition. For example: '*neglect is a condition in which a caretaker responsible for a child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide one or more the ingredients deemed essential for developing a person's physical, intellectual and emotional capacities. A caretaker may be i) non-parental (social agency or even community), not limited to consciously motivated behaviour iii) failure to alleviate avoidable suffering is neglectful even if it leaves no certain, long-term damage iv) state of knowledge will change and so concept is ambiguous v) may prove lethal* (Polansky, Hally, & Polansky, 1975, pg 19). Under a public health definition of neglect, it is possible for a government or system to be identified as responsible for neglect, not just a parent or caregiver.

4.1. An ecological approach to understanding fatal neglect in a public health context

An ecological model of child well-being situates child maltreatment across four related domains: child, family, community and societal. Risk and protective characteristics may arise from each of these domains (LaPosata & Verhoek-Oftedahl, 2005). Krug et al (2002) adapted this in their model to explain risk factors for interpersonal violence. Research has recommended that any assessment of fatal neglect in children necessarily must include contributory factors at the parental, community and societal levels (Bonner, Crow, & Logue, 1999) and this framework accommodates these elements.

Figure 2: Ecological model for risk and protective factors for child maltreatment



Source: (Krug, Dahlberg, Mercy, Zwi, & Lorenzo, 2002, pg 12.

As this model suggests, it is impossible to isolate the impact of risks or protective factors for neglect in child characteristics from those in the family, community or the society in which the child lives. For example: The death of a child in a house fire while his/her mother is at work may be influenced by factors at each of the ecological levels:

- Child – age, developmental stage that allows ability to recognise danger, knowledge and competence to know how to respond effectively to the fire;

1. Host – person in which disease occurs
   Agent – organism or force that causes disease e.g.) bacteria to cause malaria, cigarettes cause lung cancer
   Environment – the environment that allows for the interaction of the host and agent e.g.) wetlands where mosquitos breed and people work, pubs and clubs where smokers smoke and wait staff are exposed to second-hand smoke

- Family – more than one parent/caregiver so child is not left unsupervised, education of parents to earn sufficient money to pay for appropriate supervision if parent/caregiver unavailable, parental capacity to teach child to recognise and respond appropriately to danger;
- Community – availability of fire department, safe housing with appropriate fire exits, access to affordable, effective childcare; and
- Society – enforced building codes to maximise fire safety and use of smoke detectors, funding for fire department to enable effective and timely response to fire.

The developmental stage, personality, resilience of the child will be influenced by the structure, size, parental education and income of the family. These in turn will influence and be influenced by the safety, culture, and connectedness of the community where the family lives and all of these will be affected by the laws, expectations and support systems of the society they form part of. While neglect is most commonly thought of as a parent or caregiver failure, the role of community and society cannot be overlooked in preventing it.

5. Definitions of Fatal Neglect

The concept of fatal neglect is complex, evolving and, lacks a universal definition. At a very simplistic level, fatal neglect is a death where a child was deprived of something that was necessary to sustain a healthy life. Neglect definitions, for the most part, do not specify a difference between fatal neglect and other forms.

Child protection experts such as Howard Dubowitz (2007) (Child Family Community Australia, 2014) have noted that seeking a universal definition for neglect may not be achievable or warranted given its heterogeneous nature and the need to take context into account. The advantage of recognition that variance is required allows for context to be applied to each definition and operationalize it for each context in a meaningful manner. The disadvantage to this approach is that, where different definitions for fatal neglect exist different patterns will be seen in reporting, understanding and in approaches to prevention. Given that the aim of child death review is prevention, not to attribute blame, it sits most appropriately in a public health framework.

Definitions for neglect vary from very focused and specific to broad and inclusive. Ultimately, different definitions will identify different patterns of deaths within different populations and different causes/risk and protective factors depending on what is included or excluded. The research literature relating to fatal neglect primarily originates from three different disciplines/paradigms: law, child protection and health/public health. While there is some variance within these, the specificity and reach of the definitions range from most specific in the legal literature to the broadest and most inclusive in the public health literature – with child protection related definitions falling, for the most part in the middle somewhere. This fits with the context where these definitions will be operationalized (Scott, Higgins, Walker, Franklin, & Commission for Children and Young People and Child Guardian QLD, 2012).

Examples of narrow definitions of neglect are:

- *'failure to provide shelter, safety, supervision, and nutritional needs by caretaker' (Kansas State Child Death Review Board, 2015)*
- *'the failure of a caregiver to adequately provide safety, clothing, shelter, education, protection, medical/ dental care, and supervision for a child in his/her care'* (Knight & Collins, 2005)
- *'when a caretaker knowingly does something that places the child's life in danger or does not remove the child from a dangerous situation but does not clearly intend to injure the child'* (Nebraska Child and Maternal Death Review Team, 2015)

Each of the above definitions relates to failure to act or provide specific requirements for identified child needs by a parent or caregiver. The first is limited by the needs specified in the definition and the reference to the actor – the "caretaker". The second is also limited by the reference to caregiver, and potentially by the use the use of the term "adequate": this raises the question of what will be considered inadequate within a spectrum of behaviour that may be based on omission and limited by circumstances including poverty. The third places a cognitive state, "knowingly" at the centre of the definition, which does not refer to children's needs, but applies more generally to placing a child in danger or failing to remove them from danger. The definition further provides that fatal injury need not "be clearly intended", although knowledge that the actions or lack of action involve danger to the child is required. The third definition is distinguished from the other two by this emphasis on the caregiver's cognitive state, and by not specifying children's needs. All three refer to an actor: a caregiver or caretaker.

Broader, more inclusive definitions are less likely to specify a cognitive or mental state such as intent or knowledge, or the person who is to provide for the child or what is to be provided, although because the definition relates to fatal neglect, the behaviour must be of such severity that it results in or makes a significant contribution to the death of a child.

- *'failure to provide resources needed so that a child can grow and be healthy. Neglect can be deliberate, due to oversight or lack of knowledge. Must be chronic, long-standing problem that permeates several aspects of a child's life or so severe that a child's life is endangered'* (Idaho Child Fatality Review Team, 2015)
- *'persistent failure to meet a child's basic and/or psychological needs likely to result in the serious impairment of the child's health or development. It may involve a parent or caretaker failing to protect a child from physical abuse or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of or unresponsiveness to a child's basic needs'* (Ward, Holmes, Moyers, Munro, & Poursanidou, 2004)
- *'any human act of omission or commission that causes or contributes to death'* (Colorado Child Fatality Review Team, 2015)

In the first two of the above definitions, the needs are somewhat broader than those seen in the narrow definitions discussed earlier, however in the second, the 'actor' responsible for providing for the child includes the parent or caregiver, but the use of 'may' suggests that others may be included. These two definitions also require that the behaviour is persistent/chronic, and as such, this rules out short-term, one-off or momentary behaviours. In the first definition, there is specific mention of the severity of the potential outcome of the neglect as a threat to life for the child. Prolonged neglect that does not endanger life (for example, educational neglect) would therefore not fit within this definition. The final definition is the broadest and moves the focus from caregiver/parent to an act of 'any human'. The actions also do not have to cause the death, but contribute to the death of a child. In this definition, there is also no requirement that knowledge/intent plays a role or that the behaviours must occur over a significant period of time, therefore momentary lapses or one-off behaviours could fall within the definition.

5.1. Elements of fatal neglect definitions

Definitions of neglect vary according to five elements. These elements are:

- Actors in the death – ultimately, identification of the party responsible for providing the child with necessities for a healthy life;
- Nature of the action or lack of action that lead to the death – the need that was unfulfilled and lead to death;
- Chronicity – the length of time or magnitude of the failure to provide. Some children are exposed to neglect for lengthy periods of time and survive and in other circumstances, a very short period of neglect may result in a fatality;
- Causation - the role that acts of omission (failure to provide) or commission (actively withholding) played in depriving a child of necessities for a healthy life; and
- Cognitive/mental state (of the actors) – whether the actors knowingly failed to provide for or failed to provide a safe environment for the child or if circumstances meant that, through lack of knowledge, resources or capacity the child was not provided for.

5.1.1. Actors or locus of responsibility

The majority of definitions of fatal neglect are specific to the actions of the parent or caretaker of the child. The act of neglect is seen as a failure by the parent or caregiver to provide for the child. Some definitions approach fatal neglect more broadly, identifying anyone who has responsibility for the well-being of a child as responsible, though there is no more specific mention or definition of how 'responsibility' is determined. The broadest definitions of fatal neglect consider the action of 'any human' and do not specify any direct or indirect relationship with the child or do not stipulate whom the action/inaction relates to.

Definitions where the locus of responsibility is narrow enable attribution of 'blame' for the fatal neglect and those where no relationship to the child is identified or where no individual specified enable a broader focus that may include actors other than a child's parents, for instance, other bystanders who fail to intervene when they notice a child's risk-taking behaviour, like a toddler about to step out onto a busy street.

5.1.2. Nature of the action or inaction that led to the death: Sub-forms of neglect

Fatal neglect may be due to different sub-forms of neglect, categorised by what is not provided for the child and ultimately contributes to the death. These may include basic necessities of life such as food, shelter, warmth (physical neglect), supervision, or less obvious phenomena like a lack of emotional support and nurturing that leads to suicide of a child (emotional neglect). Narrow definitions specify the 'necessities', for instance food, shelter, appropriate medical care. There is variance in definitions with what is considered a necessity – some include only the above, others, while specifying what is considered necessary for child well-being focus on concepts such as '*failure to provide for a child's basic physical, emotional or educational needs or to protect a child from harm or potential harm*' (Alaska Division of Public Health, 2014) or, even more broadly, '*one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities*'(Polansky et al., 1975).

5.1.3. Chronicity

In non-fatal neglect a number of factors may contribute to the impact of neglect on a child. A resilient child with support and care that comes from a source other than a parent or caregiver may not be as severely impacted by neglect as a less resilient child. However, in fatal neglect a single, momentary act of neglect can result in the death of a child and prolonged neglect over many years, may not result in death. Conversely, the same action (or lack of action) by a parent may have a different outcome depending on circumstances. For example, failing to strap a child into a car restraint may not result in the death of a child and go unnoticed by authorities over a number of journeys, however, a single short journey that results in a crash may cause a death.

Some definitions specify that neglect must occur over a lengthy period of time '*chronic, long-standing problem that permeates several aspects of the child's life or so severe that the child's life is endangered*' (Grayson, 2001) and others specify that while neglect may be chronic, acute actions can also be neglectful '*neglect may be chronic (extended malnourishment) or acute (infant who drowns after being left alone in the bathtub)*' (Benincasa, 2014).

5.1.4. Causation

There is a fundamental understanding that fatal neglect is the death of a child that is characterised by an egregious failure to provide the necessities of life for that child and that failure to provide occurs due to an act of omission, compared to abuse which is due to an act of commission (for example, hitting a child). Acts of omission are those where a person responsible for the wellbeing of child fails to provide for that child through a failure to act rather than a specific action directed at the child.

Laws, regulations, standards and the agency perception of societal norms (Indiana Department of Child Services) are changing that understanding, however, with some noting that acts of commission also play an important role in fatal neglect (Biron & Reynald, 2015). For example, a parent or caregiver who chooses not to strap a child into a child restraint in a car is making a conscious decision not to use that safety device and so a traffic crash that results in the death of that child could be considered fatal neglect. The failure to strap the child into the restraint is a deliberate action and a failure to provide a safe environment for the child, therefore meets a definition of neglect.

5.1.5. Cognitive or mental state

In some circumstances parents may want to do the best by their child but not have the means to do so. Parents may be unaware of a child's needs through lack of education or experience, they may recognise the need but be unable to provide for the child due to inadequate financial resources, cognitive impairment or lack of access to resources in a timely manner, or their personal situation/health/mental health makes them unavailable to provide those resources. In some circumstances parents may even believe they are acting in their child's best interest. For example, a woman in a violent relationship may be struggling just to survive, making her emotionally unavailable to her child, and she may not realise this. Similarly, a family struggling to make ends meet financially may want to provide a safe cot but simply be unable to purchase one. In these circumstances, there is intent to do the best possible for a child but the means are not there to do so.

6. The role of Child Death Review Teams

Child death review teams are responsible for reviewing the deaths of children to improve understanding of the circumstances of the death and what might contribute to avoiding similar circumstances in the future. The aim of these reviews is to prevent future deaths and serious incidents, not to determine culpability, or to comment on the performance of individual workers. For the most part these reviews are conducted using document and case note analyses; occasionally interviews may be conducted to gain additional information where required. Child death reviews are conducted because a child's death is seen as a sentinel event that is a community responsibility (The National Center for Child Death Review, 2005).

Death reviews primarily take two forms. The first, and most common, is a review of the child deaths related to maltreatment. These reviews involve multi-disciplinary teams who review maltreatment related deaths. The terms of reference for each team vary and are restricted by whether or not the child has had prior involvement, the type of involvement and how long ago the child was involved with the local child protection authority (McKenzie, Scott, Waller, & Walker, 2011). Reporting practices for these reviews also vary. In some jurisdictions, there is no publicly available reporting on deaths of 'known children', and in others summary reports are available or individual reports on each death or incident. These reviews aim to assess and improve the efficacy of the actions of the child protection authority and other agencies involved in provision of services to the deceased child and his/her family and thereby prevent future child deaths.

The other form of review has evolved from recognition that child deaths due to maltreatment are likely to be under-represented in official statistics and so there is a need to take broader overview of the deaths of all children in a jurisdiction, utilising a public health approach to prevention (Christian, Sege, The Committee on Child Abuse and Neglect, The Committee on Injury and Poison Prevention, & The Council on Community Pediatrics, 2010; Rimsza, Schackner, Bowen, & Marshall, 2002; Webster, Schnitzer, Jenny, Weigman, & A, 2003). These broad-ranging reviews may look at systemic issues, but use a public health-focused response and may include deaths from natural causes, external causes, including assaults and may also include information on child maltreatment-related deaths. Often reports are published and publicly available and include recommendations to prevent future deaths and a summary of actions taken in response to previous recommendations. Some reports include a summary of additional activities undertaken by the review team, for example, submissions to inquiries, involvement in advisory committees, and/or contribution to prevention initiatives (for example developing a safe sleeping information sheet for circulation to new parents).

6.1. Reporting Fatal Neglect

Reports generated by CDRTs address the terms of reference of the team and the associated aims, therefore there is considerable variance in these reports.

6.1.1. Reports based on deaths of children who are known to the child protection system

These reviews relate to children or families who have current or recent historical involvement with the formal child protection system and take on two broad forms:

- specific case reviews that describe a single event; or
- reviews of the deaths of all children within a jurisdiction who are associated with the child protection system.

Case reviews are the narrowest form of reporting. These reports describe single events, and though some case reports may be related to multiple child fatalities associated with a single event, however these are rare and usually relate to siblings within the same family. Case reviews provide a detailed report of all circumstances preceding a child death and make recommendations for systemic change with a view to preventing future deaths.

Alternatively, deaths of children who have had any involvement with the statutory child protection system within a specified time-frame may be reviewed at a case level, but reported at the jurisdiction level. In these reports, individual cases are reviewed but reports aggregate data and identified patterns, and risk factors and recommendations are made according to the analysis of the aggregate data. The reports that take a jurisdiction-wide perspective are very similar in structure to child death review team reports on all child deaths within a jurisdiction and make recommendations specific to system change and review.

6.1.2. Reports of fatal neglect based on deaths of all children in a jurisdiction

For those teams that review all child deaths there is wide variation. A number of jurisdictions make no specific mention of neglect or abuse related deaths. In some, abuse-related deaths are included in reporting of homicides. Reports often include detail on the perpetrator of the homicide, and include information on parents or familial homicides. Neglect may or may not be included in these discussions.

Some jurisdiction reports rely on the identification of neglect in the child protection system. These are often reported in conjunction with abuse related deaths and specifically mention the involvement of the child protection system. The focus of reporting these deaths appears to relate to the level of involvement of the child protection system. Neglect is categorised as reported, substantiated, or child 'in care' when the death occurred. In reports where abuse and neglect definitions rely on involvement of the child protection system, homicides are generally reported separately and relate to deaths where the perpetrator is someone other than a parent or caretaker. There is also variation as to whether or not the intimate partner of a parent (in US reports, referred to as a paramour) is considered in homicide or abuse-related deaths.

A number of reports, but not all, provide a definition for fatal neglect. In some reports additional detail elaborates on more specific causes of death and the associated specifics for those causes of death. For example, a definition that identifies a lack of supervision as a neglect-related death may go on to report the details of child drowning where there was no supervision and say these are neglect fatalities. In other reports, the definition of fatal neglect is provided but there is no further categorisation of deaths associated with fatal neglect, though the association is implicit because the reported statistics include failure to supervise, but there is no specific mention that deaths due to failure to supervise are due to fatal neglect.

In other reports there is no formal definition of neglect that appears in the documentation, but the report identifies and discusses that some causes of death are likely to be associated with neglect and then provides additional detail on those deaths. Finally, some reports do not mention neglect either in definition or as associated with neglect, however, the causes of death are reported in a manner that is very similar to those where explicit connection to neglect is made. Typically, these include unintentional injury-related deaths (such as drowning), a failure to provide a safe-sleeping environment, malnutrition, failure to thrive, improper or absent medical care, failure to thrive and exposure.

Reporting of causes of death associated with fatal neglect

Few reports specifically categorise deaths as being attributed to fatal neglect. In reports where only children who are known to the child protection system are included, there were a number where deaths substantiated as due to a direct result of parental maltreatment or neglect were discussed and, for some, underlying or attributed cause of death discussed in greater detail.

For the most part, where fatal neglect is addressed in the report, the concept is considered in a broad sense with a discussion that centres on the underlying cause of death and association with supervision, a failure to provide or comply with appropriate medical care or where known risk factors were apparent in the child's environment may have contributed to the death. A few reports provide detailed tables where risk factors, including a lack of supervision, were present in the child's environment at the time of death. In most of these reports the deaths included in this discussion were those where child protection authorities had been involved with the family prior to the child's death, included deaths due to abuse as well as neglect and reporting was based on child protection data supplemented with additional information from the formal child death review process.

For the majority of reports, deaths were discussed according to cause of death rather than specific association with neglect. In many reports there was no specific mention of fatal neglect but the way that deaths were reported and the associated recommendations implied that neglect was a contributing factor to the death.

Natural causes and medical neglect

Deaths due to natural causes that could be associated with fatal neglect included failure to thrive, malnutrition, asthma and other chronic disease management. The specific association of neglect to these deaths was rare, but some jurisdictions considered a failure to comply with medical treatment (particularly diabetic diets/ glucose monitoring/injection of insulin, and administration of preventive asthma medications) or failure to seek timely medical attention in the event of a serious infection. Failure to thrive and malnutrition were most often reported as a single cause of death and a possible association with neglect presented in only one or two jurisdictions. For most reports the cause of death was reported in a table and then in the discussion about abuse and neglect related deaths there would be mention of a child who died as a result of malnutrition. There

were seldom any associated recommendations with these deaths; the exception was asthma and compliance with the use of preventive medications. For the most part recommendations centred on parental/caregiver education about the importance of the use of these medications and there was no mention of associated medical neglect in relation to failure to comply.

External Causes

Deaths as a result of external causes were discussed at length in most reports, with the majority of these deaths deemed 'preventable'. Most reports included detailed discussions about childhood drowning, exposure in relation to children who died of hyperthermia when left in hot cars or children who absconded in winter and died of hypothermia, home fires, and safe-sleeping practices. Deaths due to external causes, particularly in toddlers, were more likely to include a discussion of failure to supervise adequately. In a number of reports there were significant discussions about children who drove cars, motorbikes and quad-bikes (or All Terrain Vehicles (ATV)) and the role of parents in educating and supervising children in safely managing the use of these forms of transport.

Drowning

Drowning in young children was always considered in a context of a failure to supervise, regardless of whether or not the death was specifically attributed to fatal neglect. Reports discussed drowning in relation to the place where drowning occurred and made recommendations accordingly. For example a need for parent education about the importance of not leaving a child alone or in the care of an older sibling in a bathtub, securing pool environments, teaching older children the importance of not swimming in open waterways where there was no adult supervision, providing a safe and fenced play area with no access to dams or animal drinking troughs on rural properties, and in the case of teens, not mixing alcohol and/or substance use with swimming.

Deaths due to exposure

Deaths of children due to hypothermia or hyperthermia were generally discussed in the context of the failure of the parent to be aware of where the child was. Deaths of children who were left in hot cars were more common than for children who died of hypothermia and the context of the deaths differed, despite being grouped together under cause of death.

Children who were left in hot cars were typically 'forgotten' in circumstances that had knocked parents or caregivers out of routine. Reports suggested they were seldom prosecuted, with the great majority of these deaths deemed 'accidental'. Recommendations for prevention included double checking the child was not in the car by walking round the car and looking in windows as the driver left the vehicle or leaving an object (like a handbag or briefcase) that would be required at their destination in the back of the car near the child so that when they went to retrieve the object they also noticed the child.

Deaths of children due to hypothermia were more likely to be associated with a toddler absconding from a home while parents slept, or very occasionally, had gone out and left the child unattended. Recommendations for prevention focused on not leaving children unsupervised in the home, ensuring that external doors were secure and unable to be opened by very young children or fitted with an alarm that would alert parents/caregivers if a child opened the door.

Home fires

The death of children in home fires was one of the more frequent causes of death. Fatalities were associated with either children playing with matches/lighters/candles or cigarettes or with parents leaving children in the home alone for a period of time. A number of reports also noted the absence of working smoke detectors in the home for various reasons, including being disabled because of nuisance alarms, faulty batteries or not being installed in the first place. In some deaths, particularly where children were left alone, the alarm had sounded but children were too young or untrained in how to appropriately respond.

For the most part, recommendations related to keeping matches/lighters/candles etc. out of the reach of children and the importance of supervision. All reports noted the importance of working smoke detectors and teaching children an escape plan. The recommendations in a number of reports pointed to associations with over-crowding in the home or accommodation that was not compliant with building codes in areas of in their recommendations.

Safe sleeping behaviours

All child death reports included extensive discussion and analysis relating to safe-sleeping behaviours. There was no consistent approach to reporting these deaths. In some reports they were discussed with asphyxia/ threat to breathing as the overall category and then further discussion relative to the sub-classifications. Some reports discussed/considered them in two groups – preventable and unexplained; others relied on more formal classifications of Sudden Infant Death Syndrome (SIDS)/ Sudden Unexplained Infant Death (SUID) or Sudden Unexplained Death of an Infant (SUDI), with SUID more common than SUDI, unexplained and Accidental Suffocation/Strangulation (including Overlay). A small number of reports also included statistics and discussions of Sudden Child Death Syndrome (SCDS). Safe sleep was a focus of the prevention activities of many death review teams and most reports included recommendations relating to parent education and child care facility and foster/kinship care compliance with safe sleep practice. A number of reports also included significant recommendations in relation to the investigation and management of the death scene and standard protocols for autopsy and reporting of SUID/SIDS/Unexplained deaths.

Other transport related deaths

There was significant variation in specific types of transport related deaths; however, most child death review team reports included detailed information and discussion in relation to these deaths. For the most part, reports included information on the numbers of children who died as a result of pedestrian, bicycle and motor vehicle injury. Pedestrian deaths were often considered in terms of low-speed run-overs and other pedestrian deaths. Bicycle related fatalities were often included in the discussion of other pedestrian deaths as preventive recommendations were similar and related to age-appropriate independence and, for bicycles competency and use of bicycle helmets. Low-speed run-over prevention recommendations related to parent education about ensuring children were visible when vehicles were moved, the use of technology, such as reversing cameras and separation of driveway and play areas for children. Supervision of children was a key factor in preventive strategies for all these deaths but supervisory neglect was never explicitly identified as a risk factor.

The other significant focus of transport related death review was on children and young people who were operating cars, motorbikes and quad-bikes/ATVs. Motor vehicle crashes with young/inexperienced drivers were a particular focus in most reports. Statistics generally described the time of the crash, where the crash occurred, the position of the young person in the vehicle (passenger, driver) and the potential influence of speed, others in the car, risky driving behaviours and/or alcohol or drugs on the crash. Recommendations related to the implementation of driver education, law enforcement and graduated driver's licenses. Many reports included a discussion of fatalities associated with young children and the use of motorbikes and quad-bikes on private property; this was particularly common in reports from rural USA. Preventive recommendations relied on recognised existing strategies including supervision, training and use of helmets. Recommendations specific to quad-bikes also pointed to never having more than one person on the quad-bike at one time and never allowing a child to operate an adult-sized machine.

Emerging issues – suicide and criminal conduct of children

In both the published literature and in the CDRT reports child suicide and deaths where children are involved in criminal conduct are now being considered, and, in some, linked to fatal neglect. This is particularly evident where parents or caretakers have failed to intervene where concerning behaviours were apparent. In suicide, this may take the form of medical neglect where a child exhibited signs of mental illness or distress and parents did not connect them to appropriate care or failed to comply with treatment regimes identified by practitioners.

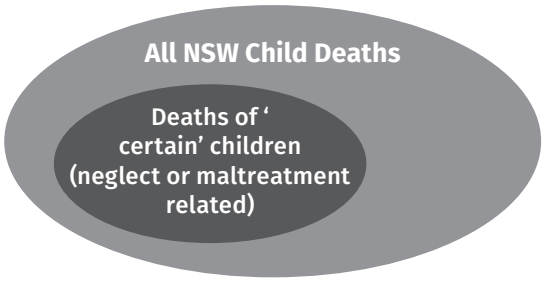
Some reports discussed the potential role of long-term neglect and trauma in childhood as they related to child mental health issues and suicide. Deaths occurring in the context of criminal conduct of children and youth was primarily discussed in terms of failure to supervise.

7. NSW Ombudsman Child Death Review

The NSW Ombudsman has duties related to reviewing and reporting on child deaths in NSW (see Figure 2). This happens as two separate processes:

- deaths of all children, and
- a subset of children, identified as 'certain' children, or reviewable deaths

Figure 3: NSW CDRT reporting



The NSW Ombudsman has responsibility for reviewing the deaths of all NSW children to prevent and reduce the deaths of all NSW children[2]. This CDRT has a broad epidemiological approach to all NSW child deaths, with the aim of reducing and preventing death in all NSW children. CDRT reports are published annually.

The Ombudsman is also tasked with the review of a subset of deaths of 'certain children' (known as reviewable deaths). Fatalities that are included in the reviewable deaths are those where:

a) the death may have been due to abuse or neglect or occurred in suspicious circumstances; or

b) at the time of their death, the child was in care[3] or in detention

The NSW Ombudsman defines neglect as: conduct by a parent or carer that results in the death of a child or young person, and that involves[4]:

- failure to provide for basic needs such as food, liquid, clothing or shelter
- refusal or delay in providing medical care
- intentional or significantly careless failure to supervise: or
- a significantly careless act.

According to the NSW Ombudsman definitions, deaths occur in neglect-related circumstances where these criteria are met. Further applied, the definition also refers to deaths suspicious of neglect where:

i) there is some evidence or information that indicates the death may have been the result of neglect

ii) the autopsy cause of death is undetermined and there is an indication of neglect; or

iii) the autopsy cause of death is a treatable illness and there is an indication that unjustified delay in seeking treatment may have contributed to the death.

The NSW Ombudsman Death Review for Reviewable Deaths is aimed at prevention and reduction of deaths, but specifically those deaths that meet the criteria above. Like the CDRT Report of all child deaths, the Reviewable Deaths Reports also provide an epidemiological perspective for this population; however, these reviews are directed more specifically at recommendations for policy and practice implementation. Reports of Reviewable deaths are published biennially.

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2. During the consultations to inform the drafting of this report, it became apparent that not all prevention activities undertaken by the Ombudsman are included in the reporting processes. The Ombudsman will consult with the State Coroner in relation to matters that he considers may warrant inquest. Under death review and broader powers, the Ombudsman can report to, investigate, and work with agencies and services on issues arising from a review of a child's death..
3. A child under the age of 18 and defined in Section 4 (1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, which includes those in voluntary out-of-home care and disability accommodation services.
4. This report relates only to fatal neglect, therefore any discussion relates specifically to neglect. It is important to acknowledge, however, that it is common for neglect to co-occur with other forms of maltreatment (see (Higgins & McCabe, 2001) and associated risks and outcomes are often entwined.

7.1. Reporting of Child Deaths by NSW Ombudsman and NSW Child Death Review Team

Eight separate reports were reviewed.

NSW Child Death Review Team Reports:

- Annual Report 2014
- Annual Report 2013
- Annual Report 2012
- Annual Report 2011
- Annual Report 2010

Reviewable Deaths Reports:

- Report of Reviewable Deaths in 2012 and 2013 Volume 1: Child Deaths (2015)
- Report of Reviewable Deaths in 2010 and 2011 Volume 1: Child Deaths (2013)
- Report of Reviewable Deaths in 2008 and 2009 Volume 1: Child Deaths (2011)

7.1.1. Overall structure

In both the CDRT reports and the Reviewable Deaths reports, there is detailed information relating to cause of death using the International Statistical Classification of Diseases and Related Health Problems 10th Revision, Australian Modification AM (ICD-10-AM). Deaths are reported according to the underlying cause of death, which has been identified as the most important from a public health or preventive perspective (McKenzie et al., 2011). In both sets of reports the causes of death are described using age, gender, Indigeneity, remoteness, and indicators for disadvantage/socio-economic status.

Reporting this level of detail in relation to child deaths is a strength of the NSW Ombudsman reports. The reports identify trends and patterns within risk factors known to be associated with neglect, particularly those of disadvantage, Indigeneity and to a lesser degree, gender. Detailed reporting on the underlying cause of death also allows for patterns/trends to be identified within causes of death. Both the Reviewable Deaths Reports and the CDRT reports provide detailed analyses of those causes of death where supervision or careless/reckless behaviour on behalf of a parent or caregiver places children at an increased risk of death (for example, drowning, transport related deaths and SUDI). Additionally, the reports take into account the potential role of community and societal systems in considering these deaths, using the ecological public health approach described earlier in this report.

7.1.2. Fatal neglect in Reviewable Deaths

In the 2015 Reviewable Deaths report and the 2013 Reviewable Deaths Report[5], there is a clear statement of purpose for the review of neglect related deaths: *'to understand the factors that contribute to avoidable deaths of children and to identify strategies that may help to prevent them'* (NSW Ombudsman, 2015) page 25 (NSW Ombudsman, 2013) page 33. The reports go on to state that a range of factors are considered in relation to fatal neglect and these include:

- carer's behaviour and factors that may reduce carer capacity;
- interaction between carer knowledge and motivation;
- child developmental stage;
- family background; and
- historical and current family involvement with family support and child protection agencies.

Fatal neglect-related deaths are firstly considered in terms of significantly careless acts, intentional or reckless failure to supervise and, in the 2013 Report, refusal or delay in providing medical care. Deaths of children due to significantly careless acts were due to motor vehicle crashes, downing, house fires, SUDI and/or sudden unexpected death of a child. Those associated with failure to supervise were drowning, house fires and

5. The two most recent reports form the basis of these analyses at the request of the NSW Ombudsman.

pedestrian injury. For each of these underlying causes of death the risk factors and preventable nature of the deaths are described and the developmental stage of the child appears to have been considered in understanding the risks. Further, the report provides details on preventive efforts the CDRT has engaged in relative to each cause of death. These preventive efforts relate to activities beyond simple parental behaviour change, often pointing to assisting child protection workers in risk assessment or systemic changes, for example, those relating to use of car restraints and quad bike use and swimming pool fencing assessment and safety compliance. There is little detail provided in relation to the medical neglect related death except to say that there were long-term concerns relating to the child and, that if untreated the condition could result in the death of the child.

The reports describe family characteristics and relationship of families with support agencies, including Families and Children, police and health services. Where details on the presence of known risk factors, like poverty, young parent age, larger family size, unemployment, carer well-being, substance misuse, mental health conditions, child protection history and family violence (Scott, 2014) are available the report provides information in relation to deaths associated with those risk factors.

A key strength of the structure of this report is the description of failures within community and societal systems to identify and respond to risk and vulnerability within families. These are included under Themes and Issues: neglect-related deaths of children on page 30 (NSW Ombudsman, 2015), for example, *'Issues related to the adequacy of the steps taken by agencies to identify and respond to SUDI risks, including clearly discussing and reinforcing safe sleeping messages with families'* and *'Deficits in interagency work undertaken in relation to some of the families, including action to address chronic neglect'*. Both of these statements note the important role that agency and the family support/child protection sector have in working with parents to enable them to care for their children.

There is also a section on deaths of children in out-of-home care. Children in out-of-home care die with similar underlying causes of death to those who die when under the care of their biological families. Poor or absent supervision and/or use of injury prevention strategies (like pool fencing) also play a role in these deaths. The chapter also provides additional detail into the deaths of children with complex needs and disability. Children who die while in care are a category of reviewable deaths, and the report includes a section on these deaths. Children who enter care may have complex or chronic health problems, and the chapter provides additional detail about the deaths of children with disability and/or complex needs. Poor or absent supervision and/or use of injury prevention strategies (like pool fencing) may also play a role in the deaths of children in care. The report does not identify the deaths of children in care as neglect, although in some cases there are similarities to neglect-related deaths reported elsewhere. While this may be because no deaths in-care met the operational definition of fatal neglect, it would be useful for this to be clarified.

The Reporting of Reviewable Deaths is necessarily specific and targets the potential role of family support and child protection agencies in fatal neglect related deaths. This is slightly different from the CDRT that reviews all child deaths, that requires a broader, population perspective on child death review.

7.1.3. Fatal neglect in CDRT reports

CDRT reports report the deaths of all NSW children. As described above, this report focuses on the underlying cause of death with an aim to prevent child deaths in NSW.

There is no specific mention of fatal neglect in this report. The report describes the proportion of child deaths where the child had a previous child protection history.

The chapters that discuss natural causes of death and SUDI provide information on the trends and patterns of these deaths within the NSW population and, additional detail on the patterns and trends in Aboriginal and Torres Strait Islander children. Deaths due to vaccine-preventable illness and asthma have additional discussion, and for asthma-related deaths, consideration of the development of and adherence to asthma management plans. For SUDI deaths there is significant detail provided in relation to the presence of modifiable risk factors. In the 2015 report the discussion of SUDI deaths includes information on preventive strategies and recommendations on how to improve compliance with these strategies, not just at the parent and family level, but also on a broader systems level, particularly in relation to NSW Health and Families and Communities.

Details of deaths due to external causes are considered in an overview of these deaths and then additional detail for transport related, suffocation and other threats to breathing, drowning, suicide and abuse-related deaths. For each of these deaths there is particular attention paid to the potential behaviours of parent/caregivers that have increased the risk of death. In transport-related injury, risk factors like speed, alcohol or

substance misuse or failing to maintain a safe environment through appropriate vehicle maintenance or the use of appropriately installed restraints are considered and discussed. In drowning, specific mention is made in relation to inadequate or failure to supervise.

Deaths from suicide also include additional consideration in the external causes chapters. Risk factors such as history of childhood trauma, previous history of attempted suicide, association with family or friends with a history of suicide and mental health and substance misuse concerns are all discussed and considered in the context of risk reduction to improve prevention strategies.

The CDRT does not specifically describe fatal neglect in this report; however, through the identification of parental/caregiver behaviours that play a role in the child death, the role of neglect as a risk factor appears to have been considered in these deaths. Failure to supervise adequately and exposing children to risk through high-risk behaviour or failure to provide a safe environment for children meets the definition of neglect, regardless of whether or not neglect is explicitly outlined and reported in the data.

8. Issues to consider in the context of the Ombudsman and CDRT objectives of preventing or reducing child deaths

This report considered 66 child death review reports (See Appendix B). The discussions in the mid-section of this report are based on a comparison of the NSW Deaths of Reviewable Children and CDRT Reports to those reports.

It is a community responsibility to prevent child deaths, and if they do occur, they should be seen as a sentinel event that urges communities to identify other children at risk and to respond, or put in place effective prevention strategies at a whole-of-population level. Effective child death review processes can reduce child deaths by:

- improving delivery of services to children, families, providers and community members; identification of barriers and system issues involved in child deaths;
- identification of significant risk factors and trends in child deaths;
- identification and advocacy for needed changes in policy and practice, legislation and efforts in child health and safety; and
- increasing public awareness and advocacy for issues affecting child health and safety. (The National Center for Child Death Review, 2005).

8.1. Strengths of current methods

Compared to other child death review reports nationally and internationally, the NSW Ombudsman and CDRT reports provide more detailed and comprehensive epidemiological details on all child deaths.

In relation to fatal neglect, the NSW Ombudsman Reviewable Deaths report is among the most detailed reports of all that were reviewed. The information relating to contribution of risk factors using an ecological model provides for an understanding of potentially modifiable risk factors at the child, family, community and systems level, which is in agreement with a public health approach to preventing deaths.

Similarly, in the CDRT report into all child deaths, despite a lack of specific discussion relating to fatal neglect, the consideration of risk associated with fatal neglect was implicit through a discussion of failure to supervise adequately and exposing children to high risk behaviour or failing to provide and maintain a safe environment for children. Medical neglect was also considered in the review of asthma deaths through compliance with asthma plans.

8.2. Potential improvements to reporting methods

There is significant variation in reporting of child deaths, particularly in fatal neglect deaths, across jurisdictions and reports. As described earlier, in some reports there is no mention of fatal neglect or of risk factors associated with fatal neglect, in others there is significant consideration given to the issues, whether they are specifically labelled as due to neglect or classed as preventable.

8.2.1. Observations in relation to Reviewable Deaths and CDRT reports

The NSW Ombudsman and CDRT report child deaths, including those due to fatal neglect, comprehensively and in a manner conducive to effecting change and reducing child deaths. Compared to other CDRT reports, the NSW Ombudsman reports are of high quality and provide enough detail to understand not only the causes of death of children in NSW but also to gain an understanding of the potential risk factors associated with those deaths. There is, however, some potential scope to improve the reporting of fatal neglect.

A strength of the Ombudsman's reporting is its ecological approach, however, the definition of neglect that underpins this is narrow and focused only on parent or carer conduct. It may be useful to expand the focus of the definition of fatal neglect to take a broader, ecological, public health approach, that does not restrict neglect to the actions of parents and/or caretakers and has a strong focus on modifiable risk factors.

8.2.2. Options for reporting Fatal neglect in CDRT reports

A potential benefit in a broad approach to the identification and reporting of fatal neglect is enabling population estimates of numbers of children and families affected by fatal neglect. However, the potential downsides to explicitly identifying fatal neglect is the likely stigmatisation of families where such a death has occurred, the potential perception by some families that the prevention messages do not apply to them because 'they are not neglectful' or that prevention campaigns are the response of a 'nanny state' where all are expected to comply because of a few who can't or won't.

Given that the aim of death review for the NSW Ombudsman is to prevent child deaths and not to provide population measures of fatalities, it is not necessary to explicitly classify deaths as fatal neglect in any formal manner in CDRT reports. Instead, deaths could be reported based on modifiable risk factors. A system of classification similar to that of LaPosata & Verhoek-Oftedahl (2005) may be more useful:

- Definitely preventable – reasonable intervention would prevent the death
- Probably preventable – preventable but with stronger intervention and less certainty than in the 'definitely' preventable
- Probably not preventable – reasonable intervention may still have resulted in death
- Definitely not preventable – death would not have been preventable regardless of any attempt at intervention

It is important to note that there would be few deaths where preventability would be as clear-cut as this classification suggests. A similar, but less rigid, classification of probably preventable or potentially preventable, based on risk factors and the ability to modify and control for those risks in the child's environment would be more workable within the constraints of accessible information and reporting requirements of the NSW Ombudsman. This system would allow for a very broad, ecological approach and sit within a public health prevention model.

8.2.3. Options for reporting Fatal neglect in Reviewable Death Reports

As discussed earlier in the report, the definition of fatal neglect has evolved over time to include some acts of commission as well as those of omission. These deaths are similar in nature to abuse related deaths. In both abuse and neglect related deaths where there has been a deliberate act, whether it be to perpetrate violence against a child (as in abuse) or to deprive a child of the necessities for life (as in neglect), the risk factors and outcomes are very similar regardless of whether the death is defined as abuse or neglect. For these deaths, a more useful and workable classification may be 'maltreatment related deaths'.

The prevention strategies for deaths where a child was deprived of basic requirements to thrive due to a knowing and wilful act (for example a child who dies from malnutrition or when a drunken or drug affected parent chooses to drive recklessly with their children unrestrained in the car) will be quite different to those where the deprivation is due to a lack of knowledge or access to services. Thus, it would make sense to identify and report deaths separately and include those due to knowing and wilful acts in the Reviewable Death Report rather than the CDRT.

9. Summary

In summary, this report considered the definitional and operational context issues of neglect in published literature. The review then considered these issues in context of the NSW Ombudsman reporting requirements for the deaths of all children (CDRT) and for Reviewable Child Deaths.

There are variations in definitions and operationalization of those definitions according to the context where they will be applied. These range from more specific approaches within the legal system to public health approaches, which offer the broadest context in terms of definition and operationalization. All child death review processes aim to prevent child deaths, including those related to fatal neglect, and so, are consistent with a public health approach.

To that end, this review has found that the NSW Ombudsman approaches to the review of fatal neglect within Reviewable Death Reports, and all child deaths in the CDRT reports are consistent with international best practice in the context of a prevention focused approach. However, in order to support the public health purpose of the reviews further, the following amendments could be implemented:

i) rather than identify deaths in the CDRT as due to neglect, report them in the context of preventability associated with modifiable risk factors

ii) in the CDRT report of all child deaths prevention of deaths could be considered in terms of supervisory neglect and neglect through failure to provide a safe environment for children without explicitly identifying deaths as neglectful

iii) in the Reviewable Deaths report, due to the similarities between abuse and neglect at the severe end of the spectrum, consider all deaths where a wilful and knowing act has contributed to the death of a child as 'maltreatment related' to enable reporting rather than separating abuse from neglect.

The benefit of this public health approach to defining and reporting fatal neglect is that it improves the understanding of the associated risk and protective factors across all causes of death, and potential lethal consequences of child neglect as well as potential to understand the magnitude of the problem. This knowledge can, in turn provide an evidence base to inform system-level change that will result in fewer child deaths.

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Appendices

Contents

Appendix A: Summary table of literature relating to definitional issues

Reference	Inclusions	Definition used	Notes
Benincasa, B. (2014) Protecting our children: A reformation of South Carolina's Homicide by Child Abuse laws. *South Carolina Law Review*, *65*, 735-768		Pg 735 – NCANDS – child fatality = death of a child caused by an injury resulting from abuse or neglect or where abuse or neglect was a contributing factor Fatal neglect – refers to a situation in which the child's death does not result from anything the caregiver does, but whether, the caregivers 'failure to act'. Neglect may be chronic (extended malnourishment) or acute (infant who drowns after being left unsupervised in the bathtub) SC Law child abuse and neglect = an act or omission by any person which causes harm to the child's physical health or welfare. Harm = When a person: a) inflicts or allows to be inflicted upon the child physical injury, including injuries sustained as a result of excessive corporal punishment; b) fails to supply the child with adequate food, clothing, shelter, or health care, and the failure to do so causes a physical injury or condition resulting in death; or c) abandons the child resulting in the child's death.	
Biron, D. & Reynald, D. Developing a revised typology of child homicide. (2015) *Children Australia*. Available on CJO 2015 doi: 10.1017/cha.2015.18.	Inadequate care, poor supervision Likely to include many attributed to natural or accidental causes Rare	Definitions need to be narrow – for legal protection of families and broad – for service provision and risk identification	Difficulties around categorisation of inadequate supervision, infant co-sleeping, child suicide, protection from violent offenders – blurred boundaries. Role of CDRT is to identify effective prevention and intervention processes to decrease preventable deaths. (pg6) Key variable in many deaths, including physical assault

Reference	Inclusions	Definition used	Notes
Bonner, B., Crow, S., & Logue, M. (1999) Fatal Child Neglect. *In: Neglected Children: Research, Practice and Policy*. Sage.	Can occur from inadequacies in physical protection, supervision, nutrition or health care. Less obvious clues as to etiology and responsibility of parents, caregivers or community Most common: • smoke inhalation 30% alcohol significant factor, frequently parental negligent behaviour • drowning – 67% suspicious for abuse or neglect • falls from unprotected windows • baby walkers down stairs • Failure to comply with medical recommendations or to seek appropriate health care.	**Narrowly defined** – death due to parental (or caregiver) failure to provide a reasonable standard of care. Parental responsibility to provide for needs of child, supervise the child adequately and intervene appropriately to prevent harm. **Fatal neglect broadly** – multidimensional problem that requires a focus on all possible determinants of the death: the risk of actual vs. potential harm, the severity of the likely harm to the child, the frequency and chronicity of the situation or the circumstances in which the neglect occurred. **Fatal neglect usually** – death of a child due to parental failure to provide for a child's needs adequately, supervise a child, or intervene to protect a child from harm. The responsibility to meet those needs falls primarily on the parents, although other caregivers, community members and society as a whole share this responsibility. Lac of supervision – clear absence of parental or adult supervision that places a child at significant risk or harm	Pg 158 - "Public health approach includes attention to the assessment of risk that goes beyond the individual child and caregiver and includes other individuals in the community as well as law enforcement, CPS, community groups or agencies, schools and legislative bodies. Community standards of care (housing, pool fences) and tolerance of hazards to children (unsecured guns in home, violence in neighbourhood) are important factors implicated in child neglect and the deaths that may result. Such a broad focus in defining fatal neglect invites an equally broad range of targets for prevention." Limited by: Pg 161 85% of child maltreatment deaths are not recorded as such – may be due to limitations of ICD classification, "failure to recognise maltreatment, definitional inconsistencies, or reluctance to add blame or stigma to grieving parents".
Brandon, M., Bailey, S., Belderson, P & Larsson, B. (2014) The role of neglect in child fatality and serious injury. *Child Abuse Review 23*. 235-245.	• Deprivational neglect – extreme deprivation by withholding food or water • Medical neglect – circumstances where parents failed to comply with medical advice or administer medication • Accidents with some element of forewarning – both fatal and serious harm resulting in a context of chronic, long term neglect and unsafe environment • SUDI – in a context of neglectful care and hazardous home environment • Neglect in combination with physical assault – causing both fatality and very serious injury in context of chronic neglectful care		• No easy answers • Important that practitioners think neglect is harmful but also potentially fatal • Children need to be physically and emotionally healthy and have a safe, healthy living environment – not one or the other. • Practitioners need to be attuned to parent- child relationship • Important that practitioners are aware and alert to harm that arises from 'drift' of neglect cases • Few present with clear signs of catastrophic harm and most appear similar to others without a devastating outcome

continued overleaf

Reference	Inclusions	Definition used	Notes
	• Suicide among young people – with a long-term history of neglect having catastrophic impact on young person's mental well-being		
Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., & Megson, M. (2013) New learning from serious case reviews: a two-year report for 2009-2011. *Department for Education*, Warwick.			Indicators of Fatal neglect: (pg47) • current or past CPS plan • CP have ID-ed neglect as a case characteristic • case features include: – poorly nourished – poor living conditions – drug and/or alcohol in pregnancy – not accessing health care – inappropriate supervision – inadequate clothing/hygiene – school/nursery school attendance concerns – access to firearm or harmful substance concerns due to poor supervision Need to move from a focus on individual cases to underlying similarities for prevention Important to hear child voice in practice and maintain child focus 5%-10% of SIDS/SUDI = homicide Neglect a feature in 60% of deaths and 11/14 suicides
Cicchetti, D & Toth, S. (2005) Child Maltreatment. *Annual Review of Clinical Psychology,* 1, 309-438.		Neglect pertains to both the failure to provide minimum care and the lack of supervision	Definitions – based on actions of perpetrator, the effects on the child or combination?

Reference	Inclusions	Definition used	Notes
Collins, J. (2006) Crime and parenthood: the uneasy case for prosecuting negligent parents. *Northwestern University Law Review. 100*,(2) 807-856.	Some researchers interpret neglect fatalities as extreme consequence of deprivation but others say it more closely resembles 'accidents'. Most often a fatal accident associated with a single, life threatening incident Donna Rosenberg evaluating fatal neglect categories: i) failure to provide, ii) failure to supervise and iii) failure to intervene	Neglect is defined simply as a type of maltreatment that refers to the failure of the caregiver to provide needed, age-appropriate care although financially able to do so or offered financial means to do so NY DSS definition of lack of supervision: leaving a child alone or not completely attended for any period of time to the extent that his or her need for adequate care goes unnoticed or unmet, and the child is harmed or exposed to hazards which would lead to harm. 'neglect – commission – where mothers inadvertently kill their children in an effort to stop them from crying e.g. shaking or smothering	• 'It is relatively simple for parents to kill a young child without criminal consequences' • Recklessness is even more culpable than gross negligence • Neglect proceedings almost exclusive against poor parents –SES influence • Give family privacy and autonomy more weight in child neglect than child abuse • Discussion that failure to provide medical treatment based on religious grounds isn't really negligent as it requires a deliberate choice not to seek treatment so is intentional • Any program to prevent neglect must advocate for a change in cultural norms and public laws that portray family matters as private and children's rights as secondary to parental right to privacy in child rearing matters (Hold and Nabors in The prevention of child neglect in Neglected Children: Research, Practice and Policy • Of interest: In US criminal law more likely to impose affirmative duty on mothers than other classes of people and that courts hold mothers responsible for violence in the family. Compared to UK where women are less likely to be prosecuted than men for a child's death because female child killers are typically viewed as 'mad' and male child killers as 'bad'
Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). Within our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington DC.		Fatal neglect occurs when the child's death results from a caregiver's egregious failure to act. The neglect may be chronic (extended malnourishment) or acute (infant left in bathtub)	

Reference	Inclusions	Definition used	Notes
Connell-Carrick, K. (2003). A critical review of the empirical literature: identifying correlates of child neglect. *Child and Adolescent Social Work Journal, 20* (5), 389-424.	Relates to measurement of an absent behaviour		Harm standard – maltreated only if child has experienced harm Endangerment standard – experience that put child at demonstrable risk of harm Limited by: Studies define neglect differently – often as determined by 'substantiation' by relevant CP authority definition
Covington, T. & Petit, M. Prevention of child maltreatment fatalities. *In: Children's Bureau.*	Infanticide and covert homicide – infants dying from hypothermia when abandoned at birth; infants purposely suffocated; deaths occurring as a result of concealment of pregnancy; deaths resulting from in utero intoxication	Death due to act of omission (p 146) Extreme neglect and deprivation – deaths in which the caregiver did not intend to kill but deliberately neglected the child, including deaths resulting from denial of food or from medical problems for which caretaker refused to seek medical attention Deaths caused or contributed to by caretaker actions or neglect – deaths resulting from accidental injury in which absent or poor supervision put the child in peril, such as drownings, fire deaths, suffocations, in bedding, falls from windows, and accidental poisonings, and deaths in which a child should have been using a safety device but caregiver did not provide one	Purpose of CDRT is to review and make recommendations for improvements in child abuse fatalities. Fatal maltreatment exists on a continuum from persistent torture and battering to one off episodes of neglect that result in death from injury. 5 broad groups – infanticide and covert homicide, severe physical assault, deliberate and overt homicide, neglect and deprivation, and deaths related to but not caused by maltreatment 85% of childhood deaths from abuse and neglect are underreported – can be easily disguised by perpetrators prior allegation of maltreatment = death from intentional injury 5.9x higher than no allegation and 2x more unintentional injury Table 8.2 on pg 147 shows how agencies classify deaths differently Many deaths occur where neglect, not physical abuse was reported Most at risk – poor, young, no high school diploma, mental illness, substance abuse, prison record, prior CPS involvement, DV Information sharing is critical – across agencies, formal, mutual accountability, written cross-system protocols

Reference	Inclusions	Definition used	Notes
Damashek, A., McDiarmid Nelson, M., & Bonner, B. (2013) Fatal child maltreatment: Characteristics of deaths from physical abuse vs neglect. *Child Abuse and Neglect 37*, 735-744.		Oklahoma DHS: a situation in which a person responsible for the child's health, safety or welfare either deliberately or through exceptional lack of attention to the child's basic needs causses the child to suffer emotionally or physically. Neglect involves either a chronic, long-standing problem that impacts several aspects of a child's life or is so severe that it is life threatening.	Unique factors for neglect when compared to physical abuse More frequent to die of neglect than physical abuse. Children from larger families with history of child welfare reports more likely to die from neglect than physical abuse. Fathers more likely to perpetrate physical abuse and mothers neglect.
Finkelhor, D. (1997) The homicides of children and youth: developmental perspective. In: Out of the Darkness: Contemporary perspectives of family violence. Kaufman Kantor, G., Jasinski, J. (ed). Sage Thousand Oaks.		Neglect deaths include situations in which a child dies because parents fail to feed the child or get obviously needed medical attention, and fail to provide such basic supervision or precaution that the child dies in some obviously predictable accident	
Finklehor, D. & Ormrod, R. (2001) Homicides of children and youth. Crimes against children series. *Juvenile Justice Bulletin*. Washington DC. Office of Juvenile Justice and Delinquency Prevention.	Deaths of young children are difficult to distinguish from accidents.	Deaths other than homicides. Neglect deaths are those that a child dies because parents or caretakers failed to provide food or obviously needed medical attention. Deaths caused by negligence, in contrast involve parents or caretakers who fail to provide basic supervision or precaution and a child who dies in a clearly preventable accident, such as falling by being left unattended at an open window.	Homicide is the only major cause of child death that has increased in incidence in the past 30 years. More children in the US 0-4 die from homicide than infectious disease or cancer.
Friedman, E., & Billick, S. (2015) Unintentional child neglect: Literature review and observational study. *Psychiatry Quarterly, 86*, 253-259.	• Acts of parental omission that endanger children • Unintentional neglect is an instance when a parent decides to put a priority of lower value over the ultimate well-being of his or her child. Parents may even believe that they're acting in the child's best interest • May be single incident (shaken baby syndrome) or abuse over several months or years		

Reference	Inclusions	Definition used	Notes
Gardianos. V. (2009-2010) *St John's Journal of Legal Commentary*, 24(1) 201-241)	Duty of child welfare agencies to bring suits against parents who turn a blind eye to their child's needs and behaviour and fail to take action. Schools are held accountable for failing to act on suicidal children, parents should be held 'to higher standard of responsibility'. Not solely failure to provide a safe environment, food and clothes. Parents can neglect their child emotionally – just as damaging as more tangible forms of neglect.	Emotional neglect is the deprivation, by a parent or person in loco parentis, of love, affection, or feelings, with a resulting adverse effect on the ability of the child to develop satisfactory relationships with such parent or person in loco parentis or with other persons generally. Inadequate attention to a child's emotional needs, need for affection, lack of emotional support… and refusing or delaying needed psychological treatment for a child's behaviour or emotional issues. The omission or withholding of words can become emotional neglect.	Children deserve unconditional love, necessarily including protection and support from parents who want them. Health childhood development is crucial for a child to become a well-adapted and productive member of society. Difficult to establish 'objective standards for determining the point at which housekeeping becomes so poor that an ordinary person should know that it poses an unacceptable risk to the mental heath of a child'
Gaudin, J. (1993) Child neglect: A guide for intervention. *US Dept of Health and Human Services Administration for Children and Families*. Washington.		**Generally:** failure of a parent or a caretaker responsible for the child's care to provide minimally adequate food, clothing, shelter, supervision and/or medical care for the child. **Polansky:** a condition in which a caretaker responsible for the child, either deliberately or by extraordinary inattentiveness, permits the child to experience avoidable present suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities. NIS has a number of definitions and operationalisation of subtypes	More recent forms of neglect to consider: • *Withholding medical treatment from infants* – specifically for those children born with serious birth defects • *Prenatal exposure to drugs/alcohol* – courts are still debating this • *Failure to thrive/malnutrition*
Jones, M.J. (1987) Parental lack of supervision: nature and consequence of a major child neglect problem. *Child Welfare League of America*, Washington.		Inattention on the part of, or absence of, the caretaker which results in injury to the child or which leaves the child unable to care for him/herself, or have his (sic) behaviour monitored so that he avoids the possibility of injuring himself or others. NY State – lack of supervision is evident if a child is alone or not competently attended for any period of time to the extent that his or her need for adequate care goes unnoticed or unmet, and the child is harmed or exposed to hazards, which could lead to harm.	Type of supervision problems: 1. Child left unattended 2. Child left in care of unsuitable substitute caretaker 3. Child left in the care of a suitable substitute caretaker, but without proper planning or consent 4. Caretaker inadequately supervising the child 5. Child permitted, encouraged, or forced to engage or not restrained from engaging in harmful, or potentially harmful activity.

Reference	Inclusions	Definition used	Notes
Knight, L., & Collins, K. (2005). A 25-year retrospective review of deaths due to paediatric neglect. American Journal of Forensic Medicine and Pathology, 26(3), 221-228.		Neglect – the failure of a caregiver to adequately provide safety, food, clothing, shelter, education, protection, medical/dental care and supervision for a child in his/her care	Focus is on identification of homicide death… burden of proof is high. Refers to 'milder' forms of neglect resulting in death – momentary supervision lapses.
Lawrence, R. & Irvine, P. (2004) Redefining Fatal Neglect. Issues Paper, 21. Available at: https://aifs.gov.au/cfca/publications/redefining-fatal-child-neglect	Neglect includes 'socio-cultural values regarding adequate standards of child rearing' Legal – "a person, whether or not the parent of the child or young person, who, without reasonable excuse, neglects to provide adequate and proper food, nursing, clothing, medical aid or lodging for the child or young person in his or her care is guilty of an offence (NSW *Children and Young Persons (Care and Protection) Act 1998*, s.228 Most definitions require information on: • Failure to act • Standard of care • Severity of consequences • Chronicity • Individual or community focus Retrospective – death due to inadequate care – minimum standard of care required for the child to stay alive in the situation was not met in either one-off or ongoing pattern Inadequate supervision common – drowning, transport, fires, suffocation/strangulation, bronchopneumonia, starvation, firearms.		• No universally accepted framework/ definition and so seen individually • Primary focus has been mother and her psych illnesses/state • Table 2 (pg 13) according to 7 domains of neglect. • Table 3 (pg 14) developmental framework for fatal neglect • Inadequate supervision most common in toddler deaths • Abandonment, physical neglect, medical neglect (including on religious grounds), developmental neglect, psychological neglect, failure to provide guidance (in relation to suicide or risk taking), FTT. • Three overarching categories of parental responsibilities – to provide, to supervise and to intervene

Reference	Inclusions	Definition used	Notes
Leeb, R.T., Paulozzi, L., Melanson, C., Simon, T., & Arias, I., (2008). Child Maltreatment Surveillance: Uniform definitions for public health surveillance and recommended data elements Atlanta GA: Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control. Retrieved from http://www.cdc.gov/ncipc/dvp/CM_Surveillance.pdf	Neglect: The failure to provide for a child's basic physical, emotional or educational needs or to protect a child from harm or potential harm. Like acts of commission, harm to a child may or may not be an intended consequence. The following types of maltreatment involve acts of omission: • Failure to provide – Physical neglect – Emotional neglect – Medical/dental neglect – Educational neglect • Failure to supervise – Inadequate supervision – Exposure to violent environments	**Physical neglect –** caregiver fails to provide adequate nutrition, hygiene or shelter; or, caregiver fails to provide clothing that is adequately clean, appropriate size, or adequate for the weather. Examples: • Nutrition: a 9-year-old child makes dinner several times per week because the caregiver(s) are sleeping, away, or otherwise unavailable; a child misses or is denied meals on numerous occasions over time; a child is diagnosed as being severely malnourished. • Hygiene: child is dirty, smells bad, or has unwashed hair. Child's living situation is unsanitary; dirty dishes and spoiled food are left on the kitchen table and counter. • Shelter: living arrangements for the child and family are unstable for two weeks or more; the residence is infested with roaches or vermin; residence is unheated or inadequately heated because caregivers have failed to ensure heat available • Clothing: the child always wears clothing that is too small; the child is not given a warm coat and gloves when the weather is cold.	

Reference	Inclusions	Definition used	Notes
Margolin, L., (1990) Fatal child neglect. *Child Welfare League of America, 4*, (July/August) 309-319.	Neglect fatalities are an extreme consequence of deprivation, primarily stemming from malnutrition and parents' failure to provide adequate health care. Gil (1970) 'Physical abuse of children is the intentional, non-accidental use of physical force, or the intentional, non-accidental acts of omission on the part of a parent or caretaker aimed at hurting, injuring or destroying the child'. Margolin continues 'If the child is harmed inadvertently, although in a manner that could have been avoided if the child were receiving appropriate care, the injury was labelled neglect'.	Neglect fatalities resemble 'accidental deaths'.	'In most cases of fatal neglect a caregiver was not present when needed at a critical moment' Neglect associated with single, life-threatening event rather than chronic forms of neglect (pg 318). Childhood level of living scale responses to 3 items correlated to primary cause of death in 61% of fatalities. Items were: 'Mother uses good judgement about leaving child alone in the house, Mother sometimes leaves child to insufficiently older sibling' and 'Mother will never leave child alone in the house' + 2 other – 'Mother takes precautions in the storage of medicine' and 'Mattresses are in obviously poor condition' – workers may like to assess based on attentiveness to keeping medical appointments, accessibility of guns, matches and lighters, and caregiver awareness of precautions needed at bath time. Prevention – more professionals in the field OR expanded prevention services to provide education and support to all new parents in regard to child safety.
Nixon, J., Pearn, J., Wilkey, I., & Petrie, G. (1981) Social class and violent child death: an analysis of fatal non-accidental injury, murder and fatal child neglect. *Child Abuse and Neglect, 5*, 111-116.	• Non-accidental injury – result of injuries usually sequential and crescendo in nature, inflicted by an adult, usually a parent or guardian • Murder • Neglect	Neglect – where death resulted from an omission on the part of the caretaker to provide adequate nourishment or health care for the child	Part of neonaticid-concealment syndrome

Reference	Inclusions	Definition used	Notes
Parks, S., Kegler, S., Annest, J & Merey, J. (2012) Characteristics of fatal abusive head trauma among children in the USA: 2003-2007: an application of the CDC operational case definition to national vital statistics data. *Injury Prevention, 18* 193-199.	Definite or presumptive abusive head trauma (AHT) Injury/disease code (ICD-10) S02, S02.0-S02.1, S02.7-S02.9, S04.0, S06.0-S06.9, S07.1, S07.8-S07.9, S09.7-S09.8, T90.2, T90.5, T90.8-T90.9 AHT cause code: Y00, Y01, Y04, Y07.0-Y07.3, Yo7.8-Y07.9, Y08, Y09, Y87.1, T74.1, T74.8-T74.9 Probable abusive head trauma disease code (all above) Probable AHT cause code: Y29, Y30, Y33, Y34, Y87.2		
Polansky, N., Hally, C., & Polansky, N. (1975) Profile of Neglect: A survey of the state of knowledge of child neglect. *US Department of Health, Education and Welfare, Social and Rehabilitation Service*. Washington.		Neglect defined as: a condition in which a caretaker responsible for the child either deliberately or by extraordinary inattentiveness permits the child to experience avoidable present suffering and/or fails to provide one or more of the ingredients generally deemed essential for developing a person's physical, intellectual and emotional capacities. i) Caretaker may be non-parental (social agency or even community) ii) not limited to consciously motivated behaviour iii) failure to alleviate avoidable suffering is neglectful even if it leaves no certain, long-term damage iv) state of knowledge will change and so concept is ambiguous v) may prove lethal.	• Neglect may be cruelty but it is more often caused by or exaggerated by poverty or ignorance. • Statement of what constitutes neglect depends on our knowledge of child development in all its facets • Social considers child care a continuum from excellent to adequate, to cause for grave concern to neglect • Represents failure to perform parental duties, including those of supervision, nurture and protection. • Legal conditions that constitute neglect: 1) inadequate physical care; 2) absence of or inadequate medical care; 3) cruel or abusive treatment; 4) improper supervision; 5) exploitation of the child's earning capacity; 6) unlawfully keeping the child out of school; 7) exposing the child to criminal or immoral influences that endangers his morals • Key issue is probably impact on the child

Reference	Inclusions	Definition used	Notes
Putnam-Hornstein, E. (2011) Report of maltreatment as a risk factor for injury death: A prospective birth cohort study. *Child Maltreatment, 16(3)*, 163-174.		Uses CP record for definition	Profile of children at risk of unintentional injury is the same as that of intentional injury fatality: young age, low birth weight, behavioural problems, poor child health, low income, limited maternal education, depression or mental illness, neighbourhood poverty, proximate crisis, weak attachment to community associated with both. Limited by: 50% of fatalities due to maltreatment wrongly coded as due to accident, natural causes or other causes
Putnam-Hornstein, E., Cleves, M., Licht, R., Needell, B. (2013) Risk of fatal injury in young children following abuse allegations: evidence from a prospective, population-based study. American Journal of Public Health, 103(10), e39-e44.		No definition offered… child protection system definition used.	Previous referral for physical abuse = significantly greater risk of intentional fatal injury before 5 than those referred for neglect, but lower risk than for unintentional fatal injury. Attempts to reduce child deaths must focus on neglected children and incorporate strategies to prevent injury.
Scheiderer, J., (1990) When children die as a result of religious practices. Ohio State Law Journal, 51, 1429-1445	Based on US laws – identifies that there is a tension between child protection and murder laws in relation to the right to practice religion. Effectively the difference between non-negligent faith healer and criminal is at the point of the child's death. Modern child protection laws value parental autonomy but purport to protect the child – the state's interest in safety of children outweighs parent's personal rights when the child's life is threatened.		Suggests 2 alternative approaches: 1) prosecute for murder rather than manslaughter to avoid use of endangerment statutes to establish unlawful activity. 2) reject omission analysis, that requires legal duty be established in favour of direct analysis of causal connection between conduct and proscribed harm. Limited by: Exemptions for religious freedom cause unconstitutional entanglement of church and state.

Reference	Inclusions	Definition used	Notes
Schnitzer, P., Covington, T., & Kruse, R. (2011) Assessment of caregiver responsibility in unintentional injury prevention: challenges for injury prevention. Injury Prevention. 17 (Suppl 1) i45-i54.		Use of continuum from not responsible to responsible rather than discrete definition.	Survey to determine what influenced CDR team member decisions to classify a death as neglectful… For prevention purposes it is important to include all deaths – to do otherwise ignores injury prevention work that has reduced unintentional injury in children.
Schnitzer, P., & Ewigman, B. (2008) Household composition and fatal unintentional injuries related to child maltreatment. Journal of Nursing Scholarship, 40(1), 91-97.	Child maltreatment is behaviour directed toward a child that is outside the norms of conduct, and entails a substantial risk of causing physical or emotional harm. Behaviours can include both omission and commission. Definition operationalized to: include deaths that occurred when the adult responsible for the child: a) was not present at the time of the injury event b) was present but not capable of protecting the child (e.g. drunk) c) placed the child in an unsafe sleep environment or d) failed to use legally mandated safety devices.	Child maltreatment is behaviour directed toward a child, which is outside the norms of conduct, and entails a substantial risk of causing physical or emotional harm. Behaviours include both actions and omissions and may be intentional or unintentional. Operationalized to be: deaths that occurred when the adult responsible for supervising the child: a) was not present at the time of the fatal injury event, b) was present but not capable of protecting the child (e.g. intoxicated) c) placed in an unsafe sleep environment, or d) failed to use legally mandated safety devices (e.g. child restraints in a car)	Fatal injuries associated with maltreatment – 1,400-2,000 deaths in US and 31,000 globally. Most fatal injury in children under 5 years of age are attributable to maltreatment. 52% of child maltreatment deaths misclassified on death certificates. Elevated risk in households with step or foster parents and those with adult relatives in residence. Children living with single parents did not have an increased risk if no other parents present in the home. All deaths were preventable, most injuries occurred when adult responsible for them was not present. Note that many of deaths would not meet the criteria for substantiated maltreatment
Schnitzer, P., Gulino, S & Yuan, Y. (2013) Advancing public health surveillance to estimate child maltreatment fatalities: Review and recommendations. Child Welfare, 92 (2), 77-98.	Operational definitions of fatal neglect vary by agency function – influenced by laws, regulations, standards and agency perception of societal norms. Classification of death as neglect related if attributes included: adult supervision, failure to use safety devices, chronicity and intent (knowingly placing child in danger)	CM definition from CAPTA: any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or which presents and imminent risk of serious harm	Defining fatal maltreatment recommendations: • develop a public health focused definition of CM that is unambiguous and lists inclusion/exclusion criteria • consider including categories of presumptive and probable • clear and specific criteria for operationalizing consensus definition that includes attributes identified in literature and a decision tree that contains attributes

Reference	Inclusions	Definition used	Notes
Scott, D., (2014) Understanding child neglect. CFCA. Accessed 25 Feb 2016. AIFS. Melbourne. Available at: https://aifs.gov.au/cfca/publications/understanding-child-neglect		Considered: a failure, on the part of a caretaker, to provide adequate supervision, emotional nurturance, appropriate medical care, food, clothing, and shelter for a child. Types include: Supervisory, physical, medical, educational, abandonment, emotional – always emerging forms with new knowledge.	Risk indicators: child, parent, family, neighbourhood, community, societal Poverty, unemployment, single parent families (usually headed by mother), young children <1 and <3, parents who were neglected/maltreated, family violence, mental illness, substance misuse.
Scott, D., Higgins, D., & Franklin, R. (2012). The role of supervisory neglect in childhood injury. In CFCA (Ed.), CFCA Paper (Vol. 8). Melbourne: AIFS.		A failure on the part of a parent or caregiver, to provide for the physical, psychological, developmental and medical wellbeing of a child. Research definition Behaviour by a caregiver that constitutes a failure to act in ways that are presumed by the culture of a society to be necessary to meet the developmental needs of a child and which are the responsibility of the caregiver to provide.	No 'one size fits all' definition and changes with changing societal norms
Ward, H., Holmes, L., Moyers, S., Munro, S., Poursanidou, D. (2004) Safeguarding children: a scoping study of research in three areas. Centre for Child and Family Research, Loughborough University. Leics.	The following behaviours should be classed as neglectful: • Inadequate nutrition, clothing or hygiene • Inadequate medical, dental or mental health care • Unsafe environments • Inadequate supervision, including the use of inadequate caretakers • Abandonment or expulsion from the home	Neglect is the persistent failure to meet a child's basic and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to protect a child from physical abuse or danger, or failure to ensure access to appropriate medical care or treatment. I may also include neglect of, or unresponsiveness to a child's basic needs.	Cultural perspectives on 'good enough parenting' and identification of children's needs at different ages and stages of development are relevant. 'No single litmus test will reveal the presence of neglect'. Categories include: physical, emotional, supervisory, fatal, prenatal, medical neglect and domestic violence.
Welch, Ginger L. & Bonner, Barbara L. (2013) Fatal child neglect: Characteristics, causation and strategies for prevention. *Child Abuse and Neglect 37*, 745-752	Inadequate care and inadequate supervision. Inadequate supervision primarily adult failure to watch closely enough or to leave a child with inadequate caregiver.	Deprivation-of-needs neglect = caregiver's failure to provide for the child's basic needs (food, water, shelter, clothing, education and medical care) Supervisory neglect = failure of a parent or caregiver to proved adequate supervision of and/or safety precautions for a child based on the child's age and abilities. Can be acute or chronic.	Indicates that '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.' (Pg 746)

Reference	Inclusions	Definition used	Notes
Zuravin, S. (1999) Child neglect: A review of definitions and measurement research. In Neglected Children: Research, Practice and Policy. Sage.	Definitions differ between users – statutory, legal, clinical and research definitions vary between jurisdictions, agencies and even individuals. May be beneficial to have standardised working definitions for different purposes. Need to include dimensions of maltreatment type, frequency, chronicity, severity and perpetrator		Neglect differs clinically because it is an omission rather than commission. Etiology and sequelae of neglect differ by subtype and any definition should include conceptual and operational definitions for each subtype. The definitions should consider chronicity and frequency and must be considered in the context of the needs of the child's developmental stage.

Appendix B: Summary of child death review jurisdictional reports and their consideration of fatal neglect

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
Australia				
ACT Children and Young People Death Review Committee. (2015). Annual Report 2014-2015. Canberra: ACT Children & Young People Death Review Committee.	No description of neglect	Report includes deaths of all ACT children <18 Chapter 5 details deaths of 'in last 5 years who had experienced factors of vulnerability (known to police or CPS) in the lead up to their death'	Not described as neglect related but report includes: children known to CPS or police who died through: accidental drowning, exposure to smoke, fire, flames, SIDS, SUDI, hanging, strangulation, suffocation (undetermined intent), intentional self-harm, transport accidents.	
Child Deaths Review and Prevention Committee. (2015). Annual Report 2014-2015, Northern Territory Child Deaths Review and Prevention Committee. Darwin: Office of the Children's Commissioner.		Assist in the prevention and reduction of child deaths in the NT by maintaining a database on child deaths; conducting research about child deaths, diseases and accidents involving children and contributing to the development of appropriate policy to deal with such deaths, diseases and accidents.	External Causes – intentional self-harm, MVA, drowning.	Menzies conducted literature reviews into bullying of young people using Facebook, Instagram, social media, rising numbers of hospital admissions for females < 18 following self-inflicted or assault related violence, causes and factors of perinatal deaths, parental supervision relating to child deaths. Reports to be presented to parliament but no detail included in the report.

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
NSW Ombudsman. (2015). Report of Reviewable Deaths in 2012 and 2013: Volume 1: Child Deaths. In NSW Ombudsman (Ed.), Report of Reviewable Deaths (Vol. June 2015). Sydney: NSW Ombudsman.	Neglect – Conduct by a parent or caregiver that results in the death of a child or young person, and that involves: • failure to provide for basic needs such as food, liquid, clothing or shelter • refusal or delay in providing medical care • intentional or significantly careless failure to supervise, or • a significantly careless act		15/41 deaths 2012-2013 neglect related, 4, 5, 4 <1,1-4 and 5-9 years respectively 12/41 deaths 2012-2013 Aboriginal or Torres Strait Islander, 5, 4, 1 <1, <1,1-4 and 5-9 years respectively----12/15 neglect Aboriginal and Torres Strait Islander 18 children in 2012-2013 neglect related – 12 a significantly careless act of parent (e.g. 6 transport, 6 sleep) 6 intentional or reckless failure to adequately supervise (e.g. 3 drowning, 2 house fire, 1 transport. No neglect related deaths due to lack of basic needs or medical care.	NSW Ombudsman. (2015). Report of Reviewable Deaths in 2012 and 2013: Volume 1: Child Deaths. In NSW Ombudsman (Ed.), Report of Reviewable Deaths (Vol. June 2015). Sydney: NSW Ombudsman.
Queensland Family and Child Commission. (2015). Annual Report: Deaths of children and young people: Queensland 2014-2015. Brisbane: Queensland Family and Child Commission.	Fatal neglect – death where a child that is dependent on a caregiver for the basic necessities of life dies owing to the failure of the caregiver to meet the child's ongoing basic needs. Child focused as perpetrator's intent is not relevant	All deaths registered between 1 July 2014 and 30 June 2015 with a focus on external cause related deaths	Reports on diseases and morbid conditions (include SIDS, SUID), External causes – Suicide, transport, drowning, fatal assault and neglect, other non-intentional injury-related death. Specific mention of supervision in drowning	
Queensland Commission for Children and Young People and Child Guardian. Annual Report: Deaths of children and young people 2013-2014	Death where a child that is dependent on a caregiver for the basic necessities of life dies owing to the failure of the caregiver to meet the child's ongoing basic needs			Child focused so as perpetrator's intent is not relevant. Assault and neglect may not be exclusive categories

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
Child Death and Serious Injury Review Committee. (2015). Child deaths and serious injury review committee: Annual report 2014-2015. Adelaide: Child Death and Serious Injury Review Committee.	A death resulting from an act of omission by the child's carer(s) including: • Failure to provide for the child's basic needs • Abandonment • Inadequate supervision, and • Refusal or delay in provision of medical care. This definition can account for both chronic neglect and single incidents of neglect or a combination of both (Referenced to Lawrence, R. & Irvine, P. Redefining fatal child neglect. Child Abuse and prevention, 21, 1-22).	Review cases in which children die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future and to make, and monitor the implementation of recommendations for avoiding preventable death or serious injury.	Illness and disease, prematurity, unsafe sleeping conditions, accidents and suicide, deliberate acts, fire, neglect, drowning, various accidents (falls, poisoning and suffocation), health system adverse events.	Committee's view that the only way to assess whether neglect is occurring, as a first step is to sight the child in their home environment. Children must be sighted in cases of severe domestic squalor (there is a SA Severe Domestic Squalor Interagency Group).
Victorian Child Death Review Committee. (2013). Annual report of inquiries into the deaths of children known to Child Protection 2013. Melbourne Commission for Children and Young People.	No definition offered	Review each death of children known to CP at time of death or within 3 months (later 12 months) of death Child/Young person characteristics: prematurity, inadequate antenatal care, neonatal abstinence, complex medical needs, multiple disabilities, developmental delay, intellectual disability, educational issues, substance use, challenging/high risk behaviours, mental ill health.	Accidental death – road trauma, drowning, suicide, drug related, fire, SIDS, SUDI, non-accidental trauma.	Responsibility now sits with Commissioner for Children

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
Victorian Child Death Review Committee (2006) Child death group analysis: Effective responses to child neglect. Child Safety Commissioner. Melbourne.	Physical neglect – characterised by poor hygiene, physical abandonment, insufficient food and water and inadequate clothing. Encapsulates other forms: environmental neglect (living in inadequate, unhygienic or unsafe environment), medical neglect (not provided timely/appropriate health care. Supervisory neglect – inadequate supervision for extended periods of time that are considered inappropriate on the basis of the childs age/development. Developmental neglect – lack of attention or interaction resulting in a child not meeting their developmental milestones. Includes Educational neglect (not enrolled in school or truancy not responded to, not following through on educational needs). Emotional neglect – rejection or absence of attachment and relational opportunities by parents. Includes not responding to emotional needs of a child.			Definitions must take account of child development Continuity of experience can be episodic (one-off, occasional, infrequent episodes) or chronic (unremitting low level of care, pervasive, entrenched or ingrained patterns of inaction and hopelessness of the parents. Includes chaos and multiple crises) Cumulative harm – accumulation of risk factors rather than in isolation. Child protection response often minimises 'neglect' but responds to physical or sexual abuse.

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
West Australia http://www.ombudsman.wa.gov.au	No definition of fatal neglect offered	• 2 years before child death: CEO and CDPFS had received information that raised concerns about wellbeing of a child or a relative of the child, • Under S32 (1) of Children and Community Services Act 2004 the CEO had determined action should be taken to safeguard or promote the wellbeing of the child or a relative of the child and • Any of the actions listed in S32 (1) of Children and Community Services Act 2004 was done in respect of a child or a relative of a child • The child or a child relative of the child is in the CEO's care or protection proceedings are pending in respect of the child or a child relative of the child. • Review circumstances of in which and why child deaths occur, identify patterns and trends and seek to approve public administration or prevent and reduce child deaths • Can review other notified deaths • Includes social and environmental factors associated with investigable deaths – F/DV, drug/substance use, alcohol use, parenting, homelessness, parental mental health issues		

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
International Reports				
New Zealand				
NZ Mortality Review Data Group. (2014). NZ Child and Youth Mortality Review Committee: 10th Data Report 2009-2013. Otago: NZ Child and Youth Mortality Review Committee.	Reports proportion of deaths due to assault/suicide but no mention of abuse or neglect	All child and youth deaths reviewed	Includes: medical, unintentional injury, intentional injury, SUDI/SUID. Lists COD by ICD 10 chapters, injury by external cause	Data from BDR, Ministry of Health, Child, Youth and Family, Coroners, Coronial Services, Water Safety NZ, Ministry of Transport, Local Child and Youth Mortality Review Groups, families
Canada				
Paediatric Death Review Committee and Deaths Under Five Committee. (2014). Paediatric Death Review Committee and Deaths Under Five Committee Annual Report 2014. Toronto: Office of the Chief Coroner.	Neglect/Inadequate supervision – it was suspected and/or verified by a CAS on at least one occasion that the child/children in the family were victims of neglect or inadequate supervision	DU5C – all deaths investigated by coroners involving children under the age of 5. PDRC – Child Welfare – review all deaths involving children and youth when the child, the youth or their family were receiving, or had received, the services of a Children's Aid Society within 12 months of the death.	Comparison to Canada, demographics, sleep associated, social risk factor associated, SIDS Top 10 factors identified in PDRC Child Welfare Case Reviews – caregiver capacity, substance abuse, neglect/ inadequate supervision, DV, 3+CAS referral, caregiver cooperation, mental health, high risk subject child, 3+CAS openings, childhood history with a CAS, criminal activity	Includes recommendations
Alberta		No report found	Child Welfare death review if next of kin requests or COD is violent or undetermined. All deaths <18 - – if NOK requests or COD is violent or undetermined. All deaths <18	

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
Child Death Review Unit. (2010). Child Mortality in British Columbia. Victoria: British Columbia Coroners Service.	No specific mention of neglect in the report – only that some children were in receipt of services and/or in care.	All deaths <18 with investigation at various levels of coroner's system Coroners Act (2007) legislated mandate to review, on individual or aggregate basis, the facts and circumstances of child deaths in BC for purposes of discovering and monitoring trends in child deaths with a view to prevent similar deaths in future.	¼ in receipt of services from Ministry of Children and Family Development. 58% natural causes, 35% injury related, 7% undetermined. 14 children in care at time of death. Injury related deaths – MVA, suicide, homicide, other. Injury related include falls, airway obstructions, unintentional poisoning, drowning, fire. Children under 10 not reported as suicide – not able to form intent. Commonly hanging	Includes leading 3 COD by age group. SUDI #3 in <1, Unintentional injury #1 in 1-4 yr. olds, unintentional injury #2 in 5-9 yr. olds, unintentional injury #1 and suicide #2 in 10-14, #1 unintentional injury, #2 suicide and #3 homicide in 15-18 yr old.
Children's Advocate. (2015). Annual Report 2014-2015: Little Voices, Big Echo. Winnipeg: Office of the Children's Advocate.		Reporting is 'unofficial' and may differ from coronial determination. Includes those where the child or child's family, had an open file with a child welfare agency at the time of death or where they had received child welfare services in year preceding child death. Child Welfare Review - where parents, siblings, or deceased child (<18) who was known to CP within 2 years prior to the death All deaths - all 'non-natural' deaths of children <18 are reportable and reviewed by medical examiner investigator/ medical examiner. Intra op and post op deaths med examiner reviews.	Includes all Manitoba deaths, reviewable deaths and child in care deaths. Death details on natural (medically fragile, prematurity, disease, other), Accidental (MVA, drowning, in the home, other), Suicide, Homicide, Undetermined.	

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
New Brunswick		Child Welfare deaths - deceased child (<16 or less than 19 if disabled) was known to CP within 1 year prior to death or was in the legal care of the Department All deaths - All <19 years with inquest process in mind.		No report
Newfoundland		All child deaths (legislation defines child as <16 but wardship extends to 19)		No report
Northwest Territories		Child Welfare deaths - deaths of all children between 8 days and 16 years. All deaths – ad hoc as required		
Nova Scotia		Child Welfare - < 16 yrs. who died as a result of child abuse while receiving CP services. Other - ad hoc as required		No report
Ontario		Child Welfare deaths - all deaths of children <18 receiving service from a Children's Aid Society during the previous year, including natural deaths. All - all child deaths <18 if under agreement for service or <16 where child is receiving CP service at time of death and all deaths of children <2 in addition to complex deaths where police, coroners office or other agencies have concerns		No report
Prince Edward Island		Ad hoc as required		No report
Quebec		All child deaths (<18) from violent or unknown causes including accidents, suicides, homicides and deaths of undetermined cause.		No report

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
The Saskatchewan Children's Advocate. (2005). A summary of child death reviews for the years 2000 and 2001. Regina: Saskatchewan Children's Advocate Office.	No definition of neglect - in care/ foster home	If <18 is unexplained or unnatural, the police investigate on behalf of coroner. A recommendation was made that all children's deaths be reviewed with 'an educated eye' To be completed for all deaths where child was in care of Minister or where youth is receiving services at the time of their death or 6 months prior to death	Leading cause Accident, natural cause, suicide, SIDS, homicide, undetermined/unclassified.	
Yukon		Has a family violence death review team but not child. All child deaths - <18 where prevention issues are reviewed. Also if questions an inquest can answer if there is a need to focus on a type of death or if there is a public outcry for inquest.		
Christianson-Wood, J., & Murray, J. L. (1999). Child death reviews and child mortality data collection in Canada. Ottawa: Health Canada.		No national system (in 1999) – commonalities across systems exist: 'assessment of quality of services provided measured against the applicable legislation and standards and the resulting recommendations are directed toward correcting any identified short-comings'. Cases for review vary by jurisdiction.		Multidisciplinary CDT in British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, Nova Scotia, New Brunswick, Northwest Territories.

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
USA				
Alabama Child Death Review System. Alabama Child Death Review System Annual Report: Report Completed for 2007 Data: Learning from the past to protect the future. Montgomery: Alabama Child Death Review System.	No mention of neglect or abuse	Unexpected and unexplained deaths of children under 18.	Includes: SIDS, MVC, Fire related, Drowning, Suffocation, Firearm/ weapon, suicide, poison, electrocution, assault, undetermined, natural causes Includes recommendations specific to each type of reviewed death.	
Alaska Division of Public Health. (2014). Alaska Maternal-Infant Mortality Review: 2014 Annual Report - Reviews of infant deaths in Alaska from 2008-2012. Juneau: MIMR.	Abuse – deliberate words or overt actions on the part of a caregiver that cause harm, potential harm or threat of harm to a child. May be physical, sexual or psychological. Neglect – includes failure to provide for a child's basic physical, emotional, or educational needs or to protect a child from harm or potential harm. Gross negligence – failure to exercise reasonable care at the level that would be expected of most people in a similar situation. While harm may not have been intended, maltreatment refers to the consequences.	Reviews for foetal, infant, child deaths 0-14 + maternal q10y. Reviews all prosecutable deaths 0-18 focusing on legal issues surrounding the death. Final product is a decision on legal action and decision on cause and manner of death to put on the death certificate.	Calculation of infant mortality rates: SUID/Asphyxia, congenital anomalies, infection, perinatal events and preterm birth, trauma/injury, unknown. Includes substance misuse, child maltreatment, preventability.	

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
Arizona Department of Health Services - Office of Injury Prevention, Dudek, J., & Rupp, S. (2015). Twenty-Second Annual Report. In Arizona Child Fatality Review Program (Ed.). Phoenix: Arizona Department of Health Services - Office of Injury Prevention.	CFR team determines if parents or caregivers failed to arrange for the child's daily necessities including clothing, food, safe shelter, medical care and supervision. Neglect deaths are typically failure to thrive, accidents from unsafe environments, prenatal substance exposure. Some the result of long-term abuse and neglect, unintentional and intentional and some the result of a single incident Classification of death as due to maltreatment must meet 4 conditions: 1. Was there 'an act or failure to act by parent, caregiver, or other person defined under State law which results in physical abuse, neglect, medical neglect, sexual abuse, emotional abuse or an act or failure to act which presents an imminent risk of serious harm to a child' 2. The relationship of the individual accused of committing the maltreatment to the child must be the child's parent, guardian or caretaker 3. A team member, who is a mandated reporter, would be obligated to report a similar incident to the appropriate child protective services agency 4. Was there an act or failure to act during critical moments that caused or contributed to the child's death?	Includes all deaths of children under 18 years	Includes statistical detail on 'disparities' – groups who are overrepresented in the data Specific detail on 'preventable' deaths and recommendations made for 'Arizona Public' Report on deaths due to prematurity; unintentional injury –suffocation, MVC, drowning, other; home-safety related deaths – suffocation, drowning, lack of supervision, unsafe sleep environment, substance use, access to water; SUID; maltreatment – physical such as intentional trauma, suffocation, drowning; neglect – that resulted in unintentional injury, homicides, natural manner – prenatal substance use, failure to obtain medical care; perpetrator, child protective service involvement in case, preventable factors – substance use, lack of supervision, unsafe sleep environment; prevention factors – parent or caregiver, family factors, child factors, environmental factors; MVC; suicide – contributing factors; homicide; drowning, firearm related	

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Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
	Also reports deaths classified as maltreatment in other categories – i.e. AHT if blunt force = homicide and maltreatment death. Accidental deaths may be classed as maltreatment if team identifies caretaker negligence or actions contributed to or caused the fatality.			
Arkansas Infant and Child Death Review Program, & Injury Prevention Centre at Arkansas Children's Hospital. (2015). Arkansas Infant and Child Death Review Program Annual Report: December 2015. Little Rock: Arkansas Infant and Child Death Review Program.	Includes a table with 'Acts of Omission/Commission Listed for reviewed cases by age group'	Unexpected deaths of children 0-17 Inclusion: paediatric deaths Exclusion: under criminal investigation, prosecution or cases adjudicated in a court of law.	Top 3 COD; sleep related; asphyxia, drowning, exposure, fall or crush, fire/ burn or electrocution, MVC/Other transport, Poisoning/Overdose and acute intoxication, SUID, weapon, unknown, other, suicide – other or gun use, omission/commission related acts, Includes recommendations, team activities	
Inter-agency Council on Child Abuse and Neglect. (2014). Child Death Review Team Report 2014: Report compiled from 2013 data. Los Angeles: Inter-agency Council on Child Abuse and Neglect.		ME designates death as homicide, accident, natural, suicide or undetermined. Foetal deaths over 20 weeks are included.	Report provides a number of case reports and statistical tables. Includes: head trauma, multiple trauma, asphyxiation/suffocation, gunshot, trauma torso/abdo, drowning, fire, stabbing, unattended newborn, poisoning/drug ingestion, dehydration/ malnutrition, strangulation, medical neglect, burns, hyperthermia, post-term gestation, suicide, train/pedestrian, golf cart rollover, infant sling, skateboard/ no helmet, fall, scooter vs. car, unsafe sleeping/SUID. Also covers 'third party homicide' – where perpetrator was not the caregiver or family member. Common factors: at least 1 prior child welfare contact and parent had child welfare or probation as a history, substance misuse Also reports on criminal charges filed and case disposition (sentencing)	

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
Colorado Child Fatality Review Team. (2015). Colorado Child Fatality Prevention System 2015 Annual Legislative Report. Denver: Colorado Child Fatality Review Team.	Review whether any act of omission or commission caused or contributed to the death, including child abuse and/or neglect. Team members consider if any human action or inaction caused and/or substantially contributed to the death of a child.	Comprehensive reviews of deaths <18 yo – natural, accident, homicide, suicide, undetermined as classified by coroner. Accidental deaths include – MVA, transport, asphyxia, drowning, falls, crushes and poisoning. Other COD include – suicide, homicide. (Of the homicide – (2009-2013) 59.5% deems abuse or neglect)	Includes SUID deaths – (mandates use of CDC Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) for law enforcement agencies and coronial investigations for infant death scene investigation) Recommend primary enforcement of seating restraint use in vehicles.	
Connecticut Child Fatality Review Panel. (2011). An examination of Connecticut Child Fatalities: A Ten Year Review - Jan 1 2001 to January 1 2011. Hartford: Child Fatality Review Panel.	No detail on neglect/abuse	Deaths of children under 18 as determined by medical examiner. Particular emphasis on children in OOHC. Reviews all unexplained and unexpected child deaths, but typically conducts a full fatality investigation of deaths where state agencies or state-supported services either were or should have been involved in the child's life.	Includes: SIDS, Accidental – MVA, Drowning, Asphyxia, Fire, Overdose, Homicide, Suicide Includes recommendations.	
Child Death Near Death and Stillbirth Commission. (2015). Annual Report for Calendar Year 2013. Wilmington: CDNDSC.	No specific definition of neglect. Stats show 69.9% died from neglect – either alone or with another maltreatment type, 44.3% physical abuse either alone or with another maltreatment type. Medical neglect 8.9% 2 infant abstinence syndrome, 4 cases mother +-ve for substance abuse at birth Neglect deaths and type of death by drowning, asphyxia, weapon, other and verified or not verified	Three panels: Child Death Review, Child Abuse and Neglect Review, F oetal and Infant Mortality Review as well as a linked multi-disciplinary Maternal Mortality review	Includes MVA (passenger, driver, pedestrian, bicyclist or ATV), suicide, unsafe sleeping environments, neonatal abstinence syndrome, homicide not related to abuse or neglect. Table of stats includes: Natural – injury, asthma, cancer, cardiovascular, neuro/seizure, other. Accident – MVA, drowning, asphyxia. Suicide – Asphyxia, poisoning/OD/ Acute Intoxication. Undetermined – medical, weapon, unknown.	Report included injury as a natural COD, identified paramour as a perpetrator in 4 deaths and when discussing SUDI deaths included 'sleeping with obese adult' as well as co-sleeping, caregiver relationship to child at time of death, historical maltreatment for child and type of maltreatment.

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
District of Columbia Child Fatality Review Committee. (2008). 2007 Annual Report. Washington: District of Columbia Child Fatality Review Committee.	Reports on fatal abuse and neglect fatalities but no definition.	Deaths of children birth to 18 but can include children to 25 if death is known to Juvenile Justice, Child Welfare, Mental Retardation and Developmental Disabilities System.	Includes: natural causes, violent deaths – homicides, fatal abuse, youth violence, other, unintentional injury, undetermined deaths, suicide, unintentional injury – Transport, house fire/smoke, asphyxia, electrocution, SUDI/undetermined, juvenile justice fatality data, Child welfare fatality data.	
Child Abuse Death Review Committee. (2015). Annual Report: 2015 Working to eliminate preventable child abuse and neglect deaths in Florida. Florida: Child Abuse Death Review Committee.		It appears that in 2015 - Widened scope to include all fatalities reported to Florida Abuse Hotline. In 2014 only those verified as abuse were included in reviews.	Incudes: drowning, asphyxia (primarily unsafe sleep practices, trauma/ wounds caused by a weapon, Deaths are classed as: verified, not substantiated, and, no indicators present. Report includes table of COD (natural, accident, suicide, homicide, undetermined, pending, unknown) by verified or non-verified maltreatment and further breakdown by E-code and medical COD (i.e. Cancer, malnutrition/ dehydration, premature, SIDS) and verified/non-verified	Extensive data provided on historical abuse of caregivers, criminal history, substance misuse, historical death of another child, partner violence, receipt of social services, military service, NESB, education caregivers, employment status caregivers, disability of caregiver.
Georgia Child Fatality Review Panel. (2016). Annual Report - Calendar Year 2014. Atlanta: Georgia Child Fatality Review Panel.	Neglect – Failure to provide basic needs, such as food, shelter, and medical care. Reported as cause – direct cause or contributing factor; decedent history – child had a history of maltreatment but was not primary cause of death, caregiver history – child caregiver had maltreatment history as perpetrator but decedent had no Hx as victim, poor supervision – decedent had no reported history of maltreatment but committee believed death was related to poor supervision	Review child deaths that are sudden, unexpected, and/or unexplained in children <18.	Maltreatment direct or contributing factor in 99 deaths (includes abuse, neglect, and poor supervision) Includes medical, sleep related, MVA, unknown (include SUID), drown, homicide, suicide, asphyxia, other injury, fire, unknown intent, firearm, poison Reports specifically on 'preventable death' – 78% of the 402 were definitely or possibly preventable and undetermined due to missing information for 101 deaths.	Report specifically on preventability by no probably not yes probably, team could not determine and % preventable by COD – i.e. Unintentional 94.9% preventable, suicide 76.2% preventable. Reports on delinquent history, child in receipt of special health care need services, agency service involvement in 12 months prior to death.

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Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
	In relation to homicide: Hindering the youth's physical and mental health and development – neglect is the principal cause of childhood fatalities.			
Idaho Child Fatality Review Team. (2015). Child Deaths in Idaho 2012. Boise: Idaho Child Fatality Review Team.	Noted that supervision played a role in drowning and ATV deaths. No mention of abuse or neglect. 1 homicide that was not reported because the death was pending criminal investigation	Review deaths of children under the age of 18, using a comprehensive and multidisciplinary process. Identify common links or circumstances in deaths that may be addressed to prevent similar tragedies in the future.	Due to an external cause or was unexplained or was due to a cause with identified risk factors: SUID (includes SUDI, SIDS), MVA, strangulation, drowning, suicide, natural manner where medical intervention was refused by parents. Report provides statistics on MVA, drowning, suffocation, strangulation, machinery, firearm, crush injuries.	
Illinois Child Death Review Teams. (2016). Annual Report on child deaths that occurred in calendar year 2014. Chicago: Illinois Child Death Review Teams.	No definition of neglect.	9 regional teams - Review the circumstances of child death fatalities in order to gain a better understanding of their causes and recommend changes in practice and policy that will prevent future injuries and deaths. Statistics on gunshot wounds, injury (appears to be physical abuse related), other (includes malnutrition/starvation/neglect, poisoning/overdose, with history of abuse and neglect), MVA (includes motorcycles, ATV, sleds trains), fires and burns, suffocation/asphyxia, SUID, prematurity, scald, SUCD	Report includes mandatory and discretionary reviews – investigation in year preceding death, indicated investigations, DCS wards, open DCS cases or investigations.	

Reference	Definition used for fatal neglect	Terms of reference	Reporting of fatal neglect	Notes
Indiana Department of Child Services. Child Abuse and Neglect: Annual Report of Child Fatalities 2013. Indianapolis: Indiana Department of Child Services.	Abuse: an act in which a child's physical or mental health is seriously endangered due to injury by the act or omission of the child's parent, guardian or custodian. Neglect: an act in which a child's physical or mental condition is seriously impaired or seriously endangered as a result of the inability, refusal or neglect of the child's parent, guardian or custodian to supply the child with necessary food, clothing, shelter, medial care, education or supervision.	DCS completes a review of all child fatalities if the child is under 1 and the circumstances are reported to be sudden, unexpected or unexplained, or if there are allegations of abuse or neglect: for children 1 and over if the circumstances involve allegations of abuse or neglect. Aim is to identify risk factors that are common elements related to abuse and/or neglect fatalities and use that information to develop prevention education and service programs.	Report focuses on deaths substantiated as a direct result of caregiver maltreatment or neglect. 29% abuse and 71% neglect Unemployment in 98% in combined Substance misuse in 43% of both dv in 47% abuse and 23% neglect 50% abuse and 60% neglect by biological parent ad 45% abuse and 21% neglect by parents intimate partner or another relative Report gives case summaries and then tables of statistics – no published recommendations Pattern of insufficient income.	
Clabough, G., & Goodin, J. Iowa's Child Death Review Team Report to the Governer and General Assembly: 2011 Annual Report. Des Moines: Iowa Child Death Review Team.	No specific mention of neglect or neglect related deaths. Malnutrition is listed as COD under 'Natural causes'.	Deaths of children 17 and under Recommendations used to identify trends that require systemic solutions.	Goal to identify risks or factors in childhood that result in fatal outcomes through retrospective review of child death cases. Includes: natural deaths; accidents – MVC, teen drivers, quad bikes, bicycles, drowning, poisoning, fire/flames: suicide, homicide; undetermined; sleep related	
Kansas State Child Death Review Board. (2015). State Child Death Review Board 2015 Annual Report (2013 Data). Topeka: Kansas State Child Death Review Board.	Neglect – failure to provide shelter, safety supervision and nutritional needs by caretaker.	Deaths of all Kansas children birth to 17 years.	Includes "prevention points" 6 categories: Natural except SIDS, Natural SIDS, Unintentional injury - MVA, Suffocation/strangulation, drowning, fire; Homicide – abuse/ neglect, Suicide, Undetermined.	

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Child Fatality and Injury Prevention Program Division of Maternal and Child Health. (2015). Public Health Child Fatality Review Program: 2015 Annual Report. Frankfort: Kentucky Department for Public Health.	Reports on abuse and neglect but no definition	Deaths by special request only and SUID not covered at local level. Local teams review coroner deaths up to 18 years of age	Includes: Prematurity, SUID, Natural, Injury: MVC, maltreatment, homicide, suicide drowning, fires Includes prevention effort summary	
Bergo, C. (ND). Louisiana Child Death Review Report 2010-2012. Baton Rouge: Louisiana Child Death Review Team.	No detail or definition on maltreatment related	All children <15 in Louisiana obtained and selected unexpected/unexplained deaths reviewed.	Includes recommendations Includes: infant death, SUID, injury, neglect or abuse, suicide, homicide, undetermined.	
Maine Child Death and Serious Injury Review Panel. (2014). Report of the Maine Child Death and Serious Injury Review Panel. Augusta: Maine Child Death and Serious Injury Review Panel.	Fatal neglect – death that results not from anything the caregiver does, but from a caregiver's failure to act. The neglect may be chronic or acute. Jeopardy to health or welfare or jeopardy means serious abuse or neglect as evidenced by: • Deprivation of adequate food, clothing, shelter, supervision, care, or education when the child is at least age 7 and has not completed grade 6 • Deprivation of necessary health care when the deprivation places the child in danger of serious harm • Abandonment of the child or absence of any person responsible for the child that creates a threat of serious harm • The end of voluntary placement, when the imminent return of the child to his or her custodian causes a threat of serious harm.	Review cases of children up to 18 years who were suspected to have suffered fatal child abuse and/or neglect or to have suffered serious injury resulting from child abuse/neglect	Report provides some stats on abuse and neglect, case studies on substance abuse/abstinence syndrome, safe sleeping and summarises activities of panel over previous 12 months.	

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	Abuse or neglect means a threat to a child's health or welfare by physical, mental or emotional injury or impairment, sexual abuse or exploitation, deprivation of essential needs or lack of protection from these or failure to ensure compliance with school attendance requirements.			
Maryland State Child Fatality Review Team. (2011). Maryland State Child Fatality Review Team 2010 Annual Legislative Report. Baltimore: Maryland State Child Fatality Review Team.	No mention neglect or abuse.	Deaths of 0-17 but local may review up to 21. All causes of deaths received from medical examiner (unusual and unexpected deaths).	Includes table with top 5 COD, injury related – MVC, homicide, suicide, fire, drowning, non-transport, undetermined, other transport, falls, poisoning, legal interventions Includes team activities.	
Massachusetts Child Fatality Review Program. (2015). A multi-disciplinary approach to the prevention of child deaths. Boston: Massachusetts Child Fatality Review Program.	No mention neglect/abuse	All deaths under 18 years and some include premature infants.	Includes recommendations Includes: tables with top 10 COD by age group, SUID, Suicide drowning injury deaths by age group Report focuses on team activity rather than statistics and recommendations.	
Michigan Child Death State Advisory Team. Eleventh Annual Executive Report: A report on reviews conducted in 2012. Lansing: Michigan Public Health Institute & Michigan Department of Human Services.	Report includes abuse and neglect but no definition	Deaths of children 0-17 – varies by local team from all to only those under ME responsibility.	Includes: preventability, sleep related COD and Recommendations, suicides, MVC, abuse and neglect.	

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Mississippi Child Death Review Panel. (2013). 2013 Report of Mississippi Child Deaths. Jackson: Mississippi State Department of Health.		Reviews data related to infant and child mortality (unexpected or unexplained) about residents of Mississippi	Includes recommendations Includes: COD, infant, drowning/ watercraft, motor vehicle, weapon, poisoning/overdose/acute intoxication, fire/burn related, abuse/ neglect	
Minnesota Department of Human Services. (2015). Review of Minnesota Child Deaths and Near Fatalities Related to Child Maltreatment 2012-2014. St Paul: Minnesota Department of Human Services.	Deaths due to omission or commission	Review child deaths and near fatal injuries attributed to maltreatment, or where maltreatment is a contributing cause.	Report on drowning – usually lack of supervision component. SUID – usually unsafe sleep position or environment. Suicide – mental health and conflict with family/friends. Most inflicted injury was AHT, MVA, falls, canine attack, ingestion of prescription medications	Fatal inflicted injury, 20 near fatal inflicted injury, 71 SUID, 14 fatal accidents, 8 near fatal accidents, 2 suicides
State Technical Assistance Team. (2015). Preventing Child Deaths in Missouri: Missouri Child Fatality Review Program Annual Report for 2014. Jefferson City: Missouri Department of Social Services.	Neglect – an act of omission, often fatal when due to grossly inadequate physical protection, withholding nutrition or health care necessary to preserve life. These deaths are often difficult to identify because neglect results in illnesses and infections that can be attributed to natural causes, exposure to hostile environments or circumstances that result in fatal accidents. Definitions vary depending on legal, medical, psychological, social or lay perspective. Widely recognised areas of neglect include: physical, emotional, medical, neglect of mental health, educational neglect. Definitions within that include subsets of nearly fatal and fatal. Neglect may not be intentional – but the end result is the same for the child whether due to ignorance, depression, overwhelming stress, inadequate support.	All child deaths that are unclear, unexplained, or of a suspicious circumstance (which includes all injury events, homicides, suicides, medical nonfeasance and SUID (1 week – 1 yr.) are reviewed.	Stats on all COD more detailed stats on reviewable. Report included on: natural fatalities, SIDS, SUID, unintentional injury fatalities – vehicular, suffocation, drowning, fire/burn, firearm, poisoning, fall, exposure, other inflicted, electrocution, crush, homicide – abuse and neglect and other where perpetrator was not in charge of child (AHT, neglect Provides a table that describes death circumstances, number of similar deaths, COD, column with poor/ absent supervision, child neglect, other negligence, other (e.g. drowning in ponds on property, hyperthermia from being left in a hot car, mauled by a dog, shot by intruder seeking revenge against father, unsafe sleep arrangements).	

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	Grossly negligent behaviour involves failure to protect from harm and withholding or otherwise failing to provide food, shelter or medical care necessary to meet the child's basic needs that is egregious and surpasses momentary inattention.			
Montana Department of Public Health and Human Services. (2009). Foetal, Infant, and Child Death in Montana: A summary of mortality reviews conducted in 2005 and 2006. Helena: Montana Department of Public Health and Human Services.	Inadequate supervision mentioned as risk factor in preventable deaths (88%). Homicide deaths include abuse and neglect	All COD of children <18 and maternal deaths.	Includes recommendations Includes: Motor vehicle, poisoning, suffocation, accidental firearm, drowning, electrocution, fall, fire and burn, poisoning, other unintentional, medical, undetermined, SID, Homicide, suicide, foetal deaths, reviewed deaths	
Nebraska Child and Maternal Death Review Team. (2015). Nebraska Child Death Review Report for Child Deaths Occurring in 2010 and 2011. Lincoln: Nebraska Child and Maternal Death Review Team.	Physical abuse – any intentional physical injury to a child. Neglect – when a caretaker knowingly does something that places the child's life in danger or does not remove the child from a dangerous situation but does not clearly intend to injury the child. There are 5 forms of supervisory neglect: failure to protect from hazard, failure to provide necessities (food, shelter, other), failure to seek medical care/follow treatment, emotional neglect, abandonment.	Deaths of children under 18.	Includes recommendations Includes: COD, preventability, SIDS/SUID, cancer, general medical, MVA, unintentional, suicide, homicide, child maltreatment, medical error, substance misuse during pregnancy, undetermined	

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Executive Committee to Review the Death of Children. (2013). 2013 Statewide Child Death Report. Carson City: State of Nevada, Division of Child and Family Services.		State mandated reviews include: those requested from adults related to the child within one year of the date of death, children who were in custody of a child welfare agency or whose family received services from such an agency, children who died from alleged abuse or neglect, children whose siblings, household members or day care providers were subject to an abuse or neglect investigation within the previous 12 months, children adopted through a child welfare agency, children who died from SIDS	Report covers: non-motor vehicle accidents – asphyxia, SUID, drowning, drug exposed, other, fall, overdose, poisoning, fire, GSW, weapon, homicide, MVA, suicide (by GSW, asphyxia, overdose, fall), Homicide divided by abuse, neglect, GSW, other weapon. Reporting of abuse and neglect by type of abuse (physical, emotional, sexual, AHT, chronic battered child syndrome, beating/kicking, scalding/ burning, Munchausen syndrome by proxy, other physical abuse, unknown physical abuse. Suicide reporting includes contributing factors – mental health, substance misuse, CAN Hx, Hx crim behaviour, sexual identity issues, school issues, bullying, arguments	
New Hampshire Child Fatality Review Committee. (2016). 2015 Committee Report. Concord: New Hampshire Child Fatality Review Committee.	No specific mention of abuse/ neglect/ homicide		Provides broad breakdown of all deaths based on ICD10 3 character codes, Cause of injury – MVA, other land transport, suffocation, drowning, poisoning, smoke/fire/flames, pedestrian, struck by or against, water transport, not stated, pedal cyclist, exposure, falls, firearms, machinery, SUID	'Cross-fatality' recommendation that access to lethal means be shared across all fatality review committees – e.g. DV, Suicide.

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Child Fatality and Near Fatality Review Board. (2015). 2014 Child Fatality and Near Fatality Review Board Annual Report. Trenton: Child Fatality and Near Fatality Review Board.	No specific mention of neglect	Review if: the COD is undetermined, deaths where substance abuse may have been a contributing factor, homicide due to abuse or neglect, death where child abuse or neglect may have been a contributing factor, malnutrition, dehydration or medical neglect or FTT, sexual abuse, head trauma, fractures or blunt force trauma without obvious innocent reason, such as auto accidents, suffocation or asphyxia, burns without obvious innocent reason such as auto accident or house fire, suicide. All deaths where families are under the supervision of child protection within the previous 12 months, near fatalities (perm neuro or physical impairment, life-threatening injury or that creates the probability of death in the near future), all drowning, MVAs where driver was <18 and toxicology +ve, under supervision of CP, all SUID and SIDS	Provides statistics and risk factors for various deaths – natural deaths, drowning (supervision), blunt force trauma, asphyxia, substance/ alcohol abuse, homicide, suicide, undetermined intent, child protection related cases- fatalities and near fatalities by cause	
New Mexico Department of Health. (2015). New Mexico Child Fatality Review - Annual Report 2014. Santa Fe: New Mexico Department of Health.		Reports deaths of all children	Summary table with 5 most common COD/ age group + stats on Homicide, Child abuse and neglect panel review recommendations, Suicide, unintentional injury – MVA, drowning, poisoning, SUID.	

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New York State Office of Children and Family Services. (20). 2008/2009 Office of Children and Family Services Report on Child Fatalities. In New York State Office of Children and Family Services (Ed.). New York: New York State Office of Children and Family Services,	No mention abuse/neglect	All children 17 or younger – due to SIDS, homicides, suicides, abuse and neglect + cases with CP involvement and/or in foster care.	Includes recommendations Specific table with detail on lack of supervision, inadequate food, clothing/shelter, inappropriate custodial conduct, emotional neglect, malnutrition/FTT, educational neglect.	
Child Fatality Task Force. (2012). Annual Report of the North Carolina Child Fatality Task Force to the Governor and General Assembly. Raleigh: Child Fatality Task Force.	No mention of abuse or neglect	Fatalities of all under 18	Includes recommendations and activities. Includes: deaths as reported by state centre for statistics, Birth defects, SIDS, illnesses, unintentional injury – MVA, bicycle, fire, drowning, falls, poisoning, suicide, other.	
Tenamoc, M. (2014). North Dakota Child Fatality Review Panel (CFRP) Annual Report: 2010 & 2011. Bismark: North Dakota Department of Human Services,	No specific mention of neglect but discussion of reports to CPS due to physical neglect, physical abuse, lack of supervision and psychological maltreatment as risk factors associated with CPS deaths.	All child deaths but with different intensity. In-depth review of all sudden, unexplained and unexpected deaths and all abuse and neglect near deaths. Includes recommendations	Unintentional child fatalities: vehicular, ATV, pedestrian, cyclist, snowmobile; asphyxia, blunt head injury, drowning, drug overdose, shotgun wound; homicide, suicide, SIDS.	

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Ohio Department of Health. (2015). Ohio Child Fatality Review: Fifteenth Annual Report. Columbus: Ohio Department of Health.	Abuse and neglect is any act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation, or that presents an imminent risk of serious harm. Neglect is the failure of parents or caregivers to provide for the basic needs of their children including food, clothing, shelter, supervision and medical care. Deaths from neglect are attributed to malnutrition, FTT, infections and accidents resulting from unsafe environments and lack of supervision.	All <18 retrospectively or concurrently.	Includes recommendations and preventable deaths Includes: demographics, poisoning, homicide, suicide, child abuse and neglect, deaths by age groups, preventable deaths, injury – asphyxia, vehicular, weapons, drowning, fire/ burn/electrocution, SIDS/Sleep related.	
Oklahoma Child Death Review Board. (2011). Oklahoma Child Death Review Board Recommendations Submitted to the Oklahoma Commission on Children and Youth. Oklahoma City: Oklahoma Child Death Review Board.	No definition	Unattended deaths of children <18, serious injury/near fatalities included.	Report focuses on recommendations based on the number of deaths in that category – MVA, sleep related deaths, drowning, fire, child abuse and neglect.	
Oregon Child Fatality Review Team. (1999). Keeping Kids Alive: Oregon Child Fatality Review Team Report. Salem: Oregon Child Fatality Review Team.	Abuse – SBS, strangulation, suffocation, water intoxication Neglect – MVC, suffocation, fire, drowning, SUID, gunshot, natural causes, strangulation suicide.	Unexpected deaths including homicide, suicide, accidents, unexpected natural deaths and undetermined to children less than 18.	Includes recommendations, activities Includes: MVC, Suffocation, Drowning, Firearm, Fire, SUID< suicide, CAN, Lack of adequate supervision, deaths in disabled, History of alcohol /drug, DV.	

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Pennsylvania Department of Health. (2013). Pennsylvania Child Death Review Annual Report. Harrisburg: Bureau of Family Health, Division of Child and Adult Health Services.	Homicide reviewed to determine if an act of omission or commission caused the death.	All deaths of children from birth to 21 years of age.	Includes recommendations and actions Includes: demographics, COD (top 5 by age), SUID/SIDS/Safe sleep, Injury related deaths – MVA, Smoke/ fire/flames, other non-transport, drowning/submersion, accidental poisoning and exposure to noxious substances, other transport, falls: Transport related deaths, homicides, suicides, Includes information on CPS involvement for homicide and suicide.	
LaPosata E, & Verhoek-Oftedahl, E. (2005). Rhode Island's Child Death Review Team. Medicine and Health/Rhode Island, 88(9), 232-324.	Neglect/abuse not mentioned	Retrospective review of deaths to children to 17 years. Review SUID, injuries, homicides, suicides, neglect/abuse and deaths of natural causes that are potentially preventable (e.g. asthma)	Includes Preventability: Definitely preventable, probably preventable, probably not preventable, definitely not preventable. Details on: MVA, co-sleeping, homicide.	Doesn't appear to be any yearly report
South Carolina		Any death of a child under 18 investigated if death is unexpected and unexplained including SIDS, violence, unattended by physician or if occurring in unusual or suspicious manner.		No report found
Randall, B., & Wilson, A. (2011). Regional Infant and Child Mortality Review Committee 2010 Final Report. Pierre: South Dakota Regional Infant and Child Mortality Review Committee.	No mention of neglect	All infant and child deaths from post delivery hospital discharge to 18.	Includes some recommendation Includes: SIDS; MVC; bicycle; suicide; homicide – inflicted head injury	

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Tennessee Department of Children's Services. (2015). Child Death Review: Annual Report 2014. Nashville: Tennessee Department of Children's Services.	Neglect – inadequate care	Department of Health reviews all child deaths (<18). DCS review death or near death of any child in state custody at the time of their death or near death, and deaths or near deaths of any child where there is an allegation of abuse or neglect (this report).	Medical (not SIDS, premie, neglect), AHT, motorised vehicles, weapon/ firearm, drowning, blunt force trauma, poisoning/OD, fire/burn, inadequate care/ neglect (environmental, medical, nutritional), non-accidental trauma, SIDS, suffocation/strangulation/ asphyxiation due to unsafe sleeping environment, suffocation/ strangulation/asphyxiation, fall injury, unable to determine, other.	
Texas Child Fatality Review Team. (2013). Annual Report - 2013. Austin: Texas Child Fatality Review Team.	Abuse and neglect described as proportion of homicide No definition	Death certificate is basis for review of all children under 18. If child is <2 birth abstracts and medical information is included.	Includes recommendations, activities Includes: MVC, Drowning, Homicide, Sleep-related, suicide.	
Utah Department of Health Violence and Injury Prevention Program. (2011). Child Injury deaths in Utah, 2005-2007. Salt Lake City: Utah Department of Health Violence and Injury Prevention.	• Abuse as part of homicide. • No definition of abuse or neglect • Drowning discussed in context of lack of supervision • Where a homicide and parental suicide occurred it wasn't classed as abuse • Suicide – includes a number of children 9-11 • Under 'Other/Undetermined' specific mention is made of 'Supervision deaths'	All suspicious, unexplained, unexpected deaths based on death certificate data for all children <18.	Includes: Homicide, suicides, drowning, other unintentional, ATV, MVC, Sleep-related, poisoning, Other/ Undetermined.	
Vermont Child Fatality Review Team. (2007). Vermont Child Fatality Review Team Ten-Year Report 1996-2006. Montpelier: Vermont Child Fatality Review Team.	No definition or mention of neglect	Review deaths of all children 0-17	Tables of stats detailing COD by natural (e.g. congenital, neoplasia, infection), maternal conditions, SIDS, undetermined, unnatural (MVC, drowning, fire, asphyxia, substances) Report focuses on activities of team rather than recommendations or interpretation of data	

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Virginia Department of Social Services. (2015). Virginia Department of Social Services Child Fatality Review Teams Annual Report: Deaths reviewed in 2013. Richmond: Virginia Department of Social Services.	No definition of neglect	Review child deaths that were investigated by local departments of social services. Deaths cannot be reviewed until all criminal proceedings are complete.	Includes stats on caregivers (demographics, employment, public assistance, role, high risk indicators), stats on persons responsible for death, COD (external cause/asphyxia, weapon, drowning) medical condition/ SIDS.	
Washington		Retrospective review unexpected deaths age 17 and under except extreme prematurity		Specialised data reports for a range of stakeholders but no annual report
West Virginia Child Fatality Review Team. (2007). Child Deaths in West Virginia 1999-2004. Charleston: Department of Health and Human Resources.	Fatal abuse – fatal physical injury of a child by a caregiver of the child.	Basic review on all deaths and full review on avoidable deaths – homicide, suicide, SIDS/SUIDS, accidents and undetermined for children <18.		Last report 2004 data in 2007
Children's Health Alliance in Wisconsin. (ND). Keeping kids alive in Wisconsin: Death Review Team guidelines. Milwaukee: Children's Health Alliance in Wisconsin.	No definition of neglect	Review deaths for those younger than 19 (but may review up to 21 or 25) in all categories but at a minimum: homicide, unintentional injury, suicide, undetermined causes, SUID/ SIDS, all cases from ME/ coroner, all cases with previous CP involvement/under law enforcement investigation. Important to focus on ALL cases not just abuse, neglect, injury or homicide. Team includes Foetal Infant Mortality Review.	Report is a process and description of CDR rather than statistical, facts presentation.	

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Wyoming Child Death Review and Prevention Team. (2015). 2013-2014 Annual Report. Cheyenne: Wyoming Child Death Review and Prevention Team.	No definition of neglect		Some stats and percentages, recommendations and future directions. Reviewed 14 deaths and 64 major injury cases between 1/1/13 and 31/12/14. Covered MVA – all fatalities, child maltreatment – (overheating, drowning, co-sleeping, malnourishment, shaken baby/AHT, endangerment, physical and sexual abuse) Infant sleep-related deaths, SBS/AHT, sexual assault, suicide	
UK				
Department for Education. (2015). Child Death Reviews - Year ending March 2015. London: Department for Education.	No definition of neglect	Review deaths of all children from birth (including stillborn babies) up to 18 years of age who are normally resident in their area.	Stats on Medical, SUDI, SUID, Trauma/ External cause, suicide or self-inflicted harm, deliberately inflicted injury/abuse/neglect	Summary data from 148 different CDRT No recommendations
Booth, J. (2014). Manchester Safeguarding Children Board - Annual Report 2013-2014. Manchester: Manchester Safeguarding Children Board.		CDOP – all deaths of Manchester children <18.		Specific mention of neglect – effective response to early signs of neglect is important, multi-agency implementation plan, multi-agency response, connectivity across themes of alcohol, domestic abuse, mental health, parental behaviour, child sexual exploitation. Report covers population demographics, activities of board, risk factors (unhealthy diet, high-risk sex, alcohol and drugs, tobacco use, social care, education)

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Manchester Child Death Overview Panel. (ND). Manchester Child Death Overview Panel: Annual Report 2014-2015.			Stats on SES, general demographics, prematurity, deliberate/inflicted/ abuse/neglect, suicide, trauma and other external factors, malignancy, acute med/surg, chronic medical, chromosomal/genetic/congenital, perinatal/neonatal event, SUDI. Modifiable factors: deprivation, house/living conditions, smoking, antenatal care, domestic abuse, suicide	Speaks of deaths with modifiable factor identification and expected deaths. Includes recommendations
Sharkey, P. (2010). Serious Case Review: Executive Summary in Respect of Child A, Child B and Child C. City of York: City of York Safeguarding Children Board.	Speaks specifically of dental neglect in all three children but no definition of 'neglect' provided	Carry out a Serious Case Review when a child has died or has been seriously harmed and there is cause for concern as to the way the local authority, their Board partners or other relevant persons have worked together to safeguard children.		
Blackpool Safeguarding Children Board. (2014). Pan-Lancashire Child Death Overview Panel: Annual Report 2013-2014. Blackpool: Blackpool Safeguarding Children Board.	No neglect definition	Review all deaths of children up to age of 18 (excluding infants live-born following planned, legal terminations of pregnancy) resident within the 3 Local Authority areas.	Details board activities and compliance with previous recommendations, stats on SUID, infection, perinatal/neonatal event, chromosomal/genetic/congenital abnormalities, chronic medical condition, acute med/surg condition, malignancy, trauma/other external factors, deliberate/inflicted injury/ abuse/neglect, Modifiable factors: deprivation, house/living conditions, smoking, antenatal care, domestic abuse, suicide	Includes recommendations Discusses modifiable factors Includes concern for disability due to consanguinity

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Humphreys, C., Price, L., & Heatman, B. (2013). Child Death Review Programme Annual Report. Swansea: Safeguarding Children Board.	No neglect definition	Review all live born children after 1 Oct 2009 and before child's 18 birthday normally resident in Wales or dies in Wales	Reports demographics, deprivation, reported by ICD10 chapter, Additional detail on External Cause codes – transport (Pedestrian, pedal cyclist, motorcycle, car passenger, car driver, other/unsp), Falls, exposure inanimate mechanical forces, animate mechanical forces, accidental drowning and submersion, other accidental threats to breathing (strangulation/hanging), exposure to smoke, fire and flames, exposure to forces of nature, poisoning, intentional self-harm, assault, undetermined intent, complications of medical surgical care.	Includes recommendations Thematic reviews – teenagers in motor vehicles, suicide, SUID with overlay/co-sleeping, asthma, quad bike deaths/ minimotos, firearms
Shannon, G., & Gibbons, N. (2012). Report of the Independent Child Death Review Group. Dublin: Children and Youth Affairs.	No neglect definition	Deaths of children in care, in receipt of aftercare (leaving care), known to child protection services.	COD – Natural - Asthma, cancer, complications from development delay, SCDS, complications from CF, complications from diabetes, heart problems, genetic neurological condition, stillborn, undetermined, misc. Non-natural – asphyxia (accidental), drowning (accidental), drug related, suicide, RTA, unlawful killing, accidental fall, head injuries (unknown cause), house fire, unknown. Report on emerging factors – alcohol in home, drugs in home, physical or sexual abuse, neglect, bereavement, DV, mental illness in parent/guardian, children experiencing severe behavioural problems, problematic alcohol use by young person, problematic drug use by young person, criminal activity, non-school attendance, homelessness	Includes recommendations