a manual for the professionals and agencies who respond to child maltreatment deaths

Child Maltreatment Fatalities: Guidelines for Response

North Carolina Child Advocacy Institute

Credit

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The accuracy of the information and opinions expressed by each author is the responsibility of that individual and not of the North Carolina Child Advocacy Institute or the funding agencies.

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IN MEMORY OF

the 366 North Carolina children

known to have been killed

by their caregivers

from 1985 through 1999

and

all the others who have gone

unrecognized or uncounted

A Word About the Dedication

Confronting, seeing, absorbing, and thinking about the hundreds and hundreds of babies and children who have been killed by their caregivers here in North Carolina in the last decade and one-half is overwhelming. The horror and tragedy are beyond comprehension, yet the facts are here and the truth is very real. We must look forward and believe that whatever we do to improve our evaluations of these fatalities is going to help, at least a little, and that we can and must act to affect a societal change. We must work as a community and we must not give up.

To the Children We Are Missing

These little lives barely touch the earth
Before their death rises up and breathes around us
We embrace these children in our hearts
And pray for them
That they not be forgotten.

Then we look forward, as we must
Each child's light shining forth still
And by our living and breathing their light
We will keep our courage
Be unafraid to see and speak the truth
And go forth in gentleness to do our work.

—MEH-G

We have dedicated each page of our book to one of these children. At the end of each section or chapter we give a brief account of cases selected to present the spectrum of child abuse homicides. Information on the cases was obtained, for the most part, from medical examiner files. Because occasional cases contain details not available in public documents, the names of the children in these accounts have been changed to protect the privacy of surviving siblings and family members. All of the homicides took place between 1985 and 1999. Legal outcomes are not available for many of the cases. All other names in the dedication are real.

Dedication

Child Maltreatment Fatalities

Fatalities from child abuse, birth through 10 years of age, North Carolina, 1985 to 2000

North Carolina Child Abuse Fatalities, Ages 0 Through 10, 1985 Through 1999 By Age And Cause Of Death

Cause of Death	Newborn	1-11 months	12-23 months	2-4 years	5-9 years	10 years	11-17** years of age	Total
Beating/battering/ other assault	1	29	18	36	11	0	1	97
Head trauma	1	39	7	18	5	0	0	70
Shaken Baby Syndrome	0	41	10	9	0	0	0	60
Gunshot	0	0	5	5	12	3	8	33
Asphyxiation	3	11	2	8	3	0	0	27
Newborn lack of care/ abandonment	17	na	na	na	na	na	na	17
Drowning	6	3	0	3	1	0	0	13
Burning	0	2	1	2	5	1	0	11
Other*	0	4	3	9	5	1	1	22
Undetermined	2	4	5	4	1	0	0	16
TOTAL	30	133	51	94	43	5	10	366

Source: Office of the Chief Medical Examiner, University of North Carolina, Chapel Hill

* Other includes poisoning (6), car explosion (3), scalding (3), dehydration (2), and (1) each for starvation, hypothermia, alcohol aspiration, motor vehicle injury, restraint, ruptured heart, water intoxication, and decapitation.

** Due to differences in record keeping, children ages 11–17 were only included for the years 1995–99.

This list does not include fatalities from neglect.

Year	First Name	Age	Cause of Death
1985	Phillip	7 years	Asphyxiation
1985	Shaneka	4 years	Asphyxiation
1985	Keith	6 years	Fire
1985	Melika	8 years	Fire
1985	Jermail	5 months	Drowning
1985	Sydney	10 years	Gunshot
1985	Patrice	2 years	Gunshot
1985	Tammy	1 month	Head fracture
1985	Girl Q	8 months	Head injury
1985	Chekeitha	Newborn	Abandoned at birth
1985	Baby F	Newborn	Abandoned at birth
1985	Baby S	Newborn	Abandoned at birth
1985	John	10 years	Car explosion
1985	James	9 years	Car explosion
1985	Kara	5 years	Stabbing
1985	Erin	3 years	Stabbing
1985	Dennis	4 years	Crushed windpipe
1986	Brandon	2 years	Asphyxiation
1986	Hieu	23 months	Suffocation
1986	Dakevia	4 months	Drowning
1986	Adam	8 years	Gunshot
1986	James	8 years	Gunshot
1986	Kelvin	5 years	Head trauma
1986	Ryan	3 months	Head trauma
1986	Anesha	6 months	Head injury
1986	Jeremy	5 months	Head trauma
1986	Victor	11 months	Head trauma
1986	Natasha	1 year	Head trauma
1986	Derrick	Newborn	Abandoned at birth
1986	Lorraine	5 years	Stabbing
1986	Dominique	1 year	Blunt trauma
1986	Wilma	3 years	Stabbing
1986	April	3 years	Trauma
1987	Baby B	Newborn	Suffocation
1987	Lisa	5 years	Suffocation
1987	Donald	8 months	Suffocation
1987	Monique	4 years	Suffocation
1987	Albert	5 years	Gunshot

Note: *Due to restrictions in data review, child abuse fatalities among children over 10 years were not recorded between 1985 and 1993. From 1993 to 2000, 10 children over 10 years of age were killed by caregivers.*

Year	First Name	Age	Cause of Death
1987	Tonya	8 years	Gunshot
1987	Shalonda	4 years	Gunshot
1987	Christopher	2 years	Head trauma
1987	Larry	1 year	Blunt trauma
1987	Omega	2 years	Blunt trauma
1987	April	3 months	Shaken Baby Syndrome
1987	Joshua	4 months	Shaken Baby Syndrome
1987	Erica	4 months	Shaken Baby Syndrome
1987	James	1 year	Shaken Baby Syndrome
1987	Santonio	13 months	Shaken Baby Syndrome
1988	Elizabeth	Newborn	Drowning
1988	Shirley	2 years	Drowning
1988	Falinda	10 years	Gunshot
1988	Wesley	6 years	Gunshot
1988	Nicole	3 years	Gunshot in murder/suicide
1988	Freda	2 months	Head trauma
1988	Elysia	3 years	Head trauma
1988	Christopher	6 years	Water intoxicating
1988	Setaria	11 months	Scalding
1988	Chaketha	2 years	Scalding
1988	Ivy	8 years	Strangling
1988	Jamilya	2 months	Blunt force injuries
1988	Latoya	6 months	Blunt force injury
1988	April	11 months	Blunt force injury
1988	Andrew	1 year	Injury
1988	Equili	18 months	Blunt force injuries
1988	Malik	2 years	Blunt force
1988	William	2 years	Blunt force trauma
1988	Michael	3 years	Strangling
1988	Jamal	4 years	Blunt force trauma
1988	Brandon	2 months	Shaken Baby Syndrome
1988	Mark	14 weeks	Shaken Baby syndrome
1988	Amanda	8 months	Shaken Baby Syndrome
1988	Antwyn	1 year	Shaken Baby Syndrome
1988	Brandin	2 years	Shaken Baby Syndrome
1989	Daniel	8 months	Suffocation
1989	Baby S	Newborn	Drowning
1989	John	17 months	Gunshot
1989	Darren	3 years	Gunshot in murder/suicide
1989	Bianca	Newborn	Stabbing
1989	Quincey	2 months	Strangling
1989	Jake	4 months	Blunt trauma
1989	Heather	13 months	Blunt trauma

Year	First Name	Age	Cause of Death
1989	Child D	1 year	Stabbing
1989	Terrell	1 year	Strangling
1989	Antionette	2 years	Stabbing
1989	Shenika	2 years	Strangling
1989	Jonathan	4 years	Blunt force
1989	Shawn	4 years	Blunt force
1989	Kayla	4 months	Shaken Baby Syndrome
1989	Anthony	2 years	Shaken Baby Syndrome
1989	Joseph	1 month	Undetermined
1989	Keisha	1 year	Undetermined
1990	Jason	7 months	Smothering
1990	Xavier	5 months	Smothering
1990	Tereca	9 years	Gunshot
1990	Brittany	16 months	Gunshot in murder/suicide
1990	Nicholas	2 months	Head trauma
1990	Brittany	3 months	Head trauma
1990	Justin	3 months	Head trauma
1990	Baby H	3 days	Abandoned at birth
1990	Ser	Newborn	Uncared for at birth
1990	Allison	Newborn	Uncared for at birth
1990	Paul	Newborn	Uncared for at birth
1990	Alicia	2 years	Scalding
1990	Laneisha	3 months	Blunt force
1990	Vonisha	3 months	Physical Abuse
1990	Dominique	9 months	Blunt trauma
1990	Crystal	9 months	Physical abuse
1990	Joshua	15 months	Blunt force
1990	Sara	2 years	Blunt trauma
1990	Nathan	2 years	Blunt force
1990	Tyquan	2 years	Blunt trauma
1990	Courtney	1 month	Shaken Baby Syndrome
1990	Chantal	22 days	Shaken Baby Syndrome
1990	Ashley	4 months	Shaken Baby Syndrome
1990	Stephanie	7 months	Shaken Baby Syndrome
1990	Latasha	13 months	Shaken Baby Syndrome
1990	Keion	2 months	Undetermined
1990	Ronald	15 months	Undetermined
1990	Christopher	2 years	Undetermined
1991	Richard	6 years	Suffocation
1991	Nathaniel	1 month	Smothering
1991	Darius	2 months	Smothering
1991	Renee	2 years	Suffocation
1991	Nichole	2 years	Suffocation

Year	First Name	Age	Cause of Death
1991	Blonnie	19 months	Burning
1991	Baby T	Newborn	Drowning
1991	Timothy	11 months	Drowning
1991	Corey	1 month	Head trauma
1991	Timothy	2 years	Dehydration
1991	Shakeral	1 month	Poisoning
1991	Thomas	19 months	Poisoning
1991	Roderick	17 months	Blunt trauma
1991	Jacob	3 years	Blunt trauma
1991	Kimberly	2 months	Shaken Baby Syndrome
1991	Brandel	2 months	Shaken Baby Syndrome
1991	Shane	3 months	Shaken Baby Syndrome
1991	Stephen	3 months	Shaken Baby Syndrome
1991	Tarissa	4 months	Shaken Baby Syndrome
1991	Michael	20 months	Shaken Baby Syndrome
1991	Baby Doe	Newborn	Undetermined
1991	Faith	2 years	Undetermined
1992	Heather	1 month	Suffocation
1992	Kathryn	19 months	Smothering
1992	Devn	2 years	Blunt trauma, shaking, and smothering
1992	Baby O	Newborn	Drowning
1992	Reginald	10 years	Gunshot
1992	Child C	8 years	Gunshot
1992	Tyrren	5 years	Trauma to head, chest and abdomen
1992	Zachery	7 months	Head trauma
1992	Amber	2 years	Head trauma
1992	Baby A	Newborn	Abandoned at birth
1992	Child L	7 years	Strangling
1992	Child C	8 years	Strangling
1992	Jameka	6 months	Abuse
1992	Cynthia	4 months	Persistent child abuse
1992	Michael	19 months	Blunt trauma
1992	Jasmine	20 months	Stabbing
1992	Tashawna	2 years	Blunt trauma
1992	Zakyyah	2 years	Blunt trauma
1992	James	3 years	Blunt trauma
1992	Natalie	4 years	Blunt force
1992	Amanda	4 years	Blunt force
1992	Ashley	1 month	Shaken Baby Syndrome
1992	Keifer	2 months	Shaken Baby Syndrome
1992	Terrance	6 months	Shaken Baby Syndrome

Year	First Name	Age	Cause of Death
1992	Damien	7 months	Shaken Baby Syndrome
1992	Justin	8 months	Shaken Baby Syndrome
1992	Purvis	2 years	Shaken Baby Syndrome
1992	Ashley	6 months	Undetermined
1992	Fernando	2 years	Undetermined
1993	Desmond	6 months	Smothering
1993	Tabitha	1 month	Head trauma
1993	Tony	2 months	Head trauma
1993	Angelica	19 months	Head trauma
1993	Harold	3 years	Head trauma
1993	Ashlie	2 years	Head trauma
1993	Dillon	Newborn	Lack of newborn care
1993	Celeste	Newborn	Lack of newborn care
1993	Ashley	13 days	Blunt force
1993	Stephen	3 months	Blunt trauma
1993	Rebakah	11 months	Brain injury
1993	Blery	4 months	Blunt force
1993	Amber	5 months	Blunt trauma
1993	Lyle	9 months	Blunt trauma
1993	Brandie	2 years	Blunt trauma
1993	Robert	2 years	Blunt trauma
1993	Corey	4 years	Stabbing
1993	Brittinie	24 days	Shaken Baby Syndrome
1993	Joseph	2 months	Shaken Baby Syndrome
1993	Alexandria	2 months	Shaken Baby Syndrome
1993	Tirrell	4 months	Shaken Baby Syndrome
1993	Chelsea	7 months	Shaken Baby Syndrome
1993	Dylan	11 months	Shaken Baby Syndrome
1993	Darian	13 months	Undetermined
1994	Brittany	4 years	Drowning
1994	Krystal	7 years	Gunshot
1994	Sarah	8 years	Gunshot
1994	Patricia	9 years	Gunshot
1994	Marquis	18 months	Gunshot in murder/suicide
1994	Christopher	1 month	Head trauma
1994	DeeShawna	18 months	Head trauma
1994	Tabitha	2 years	Head trauma
1994	Nigel	2 years	Head trauma
1994	Baby Doe	Newborn	Abandoned at birth
1994	Baby L	Newborn	Lack of newborn care
1994	Tavarus	Newborn	Lack of newborn care
1994	Mario	5 years	Trauma
1994	Alissa	3 months	Blunt trauma

Year	First Name	Age	Cause of Death
1994	Shayteia	10 months	Blunt trauma
1994	Maurice	20 months	Blunt force
1994	Ashley	14 months	Blunt trauma
1994	Tra	13 months	Physical abuse
1994	Britnie	2 years	Blunt force
1994	Jodcie	2 years	Blunt trauma
1994	Jennifer	3 years	Blunt trauma
1994	Kiaria	4 years	Blunt force
1994	Kabrell	2 months	Shaken Baby Syndrome
1994	Ryan	2 months	Shaken Baby Syndrome
1994	Tkeyah	5 months	Shaken Baby Syndrome
1994	Heidi	7 months	Shaken Baby Syndrome
1994	Brandon	18 months	Shaken Baby Syndrome
1994	Nelson	2 years	Shaken Baby Syndrome
1994	Amber	2 years	Shaken Baby Syndrome
1994	William	6 years	Undetermined
1995	Jayden	17 months	Asphyxiation
1995	Amber	8 years	Gunshot
1995	Preston	2 years	Gunshot
1995	Jonae	20 days	Head injury
1995	Jillian	6 months	Asphyxiated on couch
1995	William	22 days	Head trauma
1995	Megan	2 months	Head trauma
1995	Angelica	6 months	Head injury
1995	Darius	6 months	Head Injury
1995	Shenika	4 years	Intentional dehydration
1995	Chlaychawanda	4 years	Motor vehicle injury
1995	Cameron	4 years	Blunt force
1995	Darien	18 months	Undetermined
1996	Destiny	3 months	Asphyxiation
1996	Delante	3 years	Suffocation
1996	Chastity	10 years	Fire
1996	Ashley	7 years	Fire
1996	Tia	2 months	Burning
1996	Shatana	3 years	Fire
1996	Rogerick	4 years	Fire
1996	Baby Doe	Newborn	Drowning, left in toilet
1996	Rishea	1 year	Gunshot
1996	David	18 months	Gunshot
1996	Dalton	45 days	Head trauma
1996	Trevor	1 year	Head trauma
1996	Rajah	2 years	Head trauma
1996	Zachary	4 years	Head trauma

Year	First Name	Age	Cause of Death
1996	Crystal	4 years	Head trauma
1996	Rainie	7 years	Starving
1996	Aaliyah	3 months	Ruptured heart
1996	Joshua	17 months	Carbon monoxide poisoning
1996	Timothy	2 years	Hyperthermia
1996	Brittany	6years	Poisoning
1996	Maria	4 years	Poisoning
1996	Kimberly	6 years	Stabbing
1996	Kayla	6 years	Stabbing
1996	Brian	8 years	Bound and choked
1996	Justin	8 years	Strangling
1996	Azzan	2 months	Multiple trauma
1996	Kaitlin	5 months	Fractures
1996	Elija	4 months	Abdominal trauma
1996	Duncan	5 months	Multiple trauma
1996	Leon	10 months	Multiple trauma
1996	Hunter	5 months	Trauma
1996	Debree	1 year	Abdominal trauma
1996	Jameika	2 years	Beating
1996	Devon	2 years	Beating
1996	Charlie	3 years	Decapitation
1996	Lance	2 months	Shaken Baby Syndrome
1996	Yanimiah	2 months	Shaken Baby Syndrome
1996	Olivia	3 months	Shaken Baby Syndrome
1996	Wendy	5 months	Shaken Baby Syndrome
1996	Shane	5 months	Shaken Baby Syndrome
1996	Dustin	5 months	Shaken Baby Syndrome
1996	Amber	2 years	Shaken Baby Syndrome
1997	Jaisen	5 months	Asphyxiation
1997	Erik	7 months	Asphyxiation
1997	Brian	8 years	Fire
1997	Ivan	2 months	Burning
1997	Baby W	1 day	Drowning
1997	Jared	5 years	Head trauma
1997	Amber	6 years	Head trauma
1997	Toby	8 years	Head trauma
1997	Rolando	3 months	Head trauma
1997	Bailey	3 months	Head trauma
1997	Arlynn	4 months	Head trauma
1997	Nikara	7 months	Head trauma
1997	Briana	7 months	Head trauma
1997	DiShawan	8 months	Head trauma
1997	Saquon	8 months	Head trauma

Year	First Name	Age	Cause of Death
1997	Zachariah	2 years	Head trauma
1997	DeMallon	2 years	Head trauma
1997	Cory	4 years	Head trauma
1997	Kelley	4 years	Head trauma
1997	Baby P	1 day	Exposure to cold
1997	Jordon	6 months	Poisoning
1997	Buddy	6 years	Blunt trauma
1997	Marquell	3 months	Blunt trauma
1997	Jessica	7 months	Brain damage
1997	Cheyenne	1 month	Shaken Baby Syndrome
1997	Robert	3 months	Shaken Baby Syndrome
1997	Sage	1 year	Shaken Baby Syndrome
1997	Kiana	1 year	Shaken Baby Syndrome
1997	Christopher	18 months	Shaken Baby Syndrome
1997	Tiaonnia	18 months	Shaken Baby Syndrome
1997	Kenley	2 years	Shaken Baby Syndrome
1997	Erica	6 months	Undetermined
1997	Treshaun	1 year	Undetermined
1997	Tessia	3 years	Undetermined
1998	Baby L	Newborn	Asphyxiation
1998	Keith	8 years	Burning
1998	Brandon	8 years	Drowning
1998	Christiana	4 years	Drowning/head trauma
1998	Hallye	5 weeks	Head trauma
1998	Christian	5 weeks	Head trauma
1998	Marquise	3 months	Head trauma
1998	Miah	3 months	Head trauma
1998	Savanna	5 months	Head trauma
1998	Antoniaysia	1 year	Head trauma
1998	Colton	3 years	Head trauma
1998	Alexander	2 years	Head trauma
1998	Mariana	2 years	Head trauma
1998	Baby J	Newborn	Delivery without proper medical care
1998	Eric	Newborn	Neonaticide
1998	Sarah	1 year	Poisoning
1998	Deshawn	6 months	Shaking
1998	Khaleah	1 year	Abdominal trauma
1998	Channing	2 years	Blunt trauma
1998	Glasya	2 years	Blunt trauma
1998	Alexis	2 months	Shaken Baby Syndrome
1998	Adesha	2 years	Shaken Baby Syndrome
1998	Baby Doe	Newborn	Undetermined

Year	First Name	Age	Cause of Death
1999	Baby L	Newborn	Suffocation
1999	Brianna	6 years	Gunshot
1999	Baby Doe	1 day	Head injury
1999	Shaquellah	1 month	Head trauma
1999	Kayla	1 month	Head trauma
1999	Jazmin	2 months	Head trauma
1999	Azhea	2 months	Head trauma
1999	Johnesone	3 months	Head trauma
1999	Nikolas	3 months	Head trauma
1999	Arcacia	1 year	Head trauma
1999	Kristoff	2 years	Head trauma
1999	Timithy	9 years	Restraining
1999	Adam	2 years	Aspiration of alcohol
1999	Lyian	4 months	Blunt trauma
1999	Jewel	1 year	Abdominal trauma
1999	Christopher	1 year	Abdominal trauma
1999	Alexander	2 years	Blunt trauma
1999	Ciara	3 years	Abdominal trauma
1999	Dustin	5 months	Shaken Baby Syndrome
1999	Trayon	3 years	Shaken Baby Syndrome

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Introduction and Overview

Part I During the Crisis: Involvement and Response

Part II After the Crisis: Community and Family

Part III Long Term Responses to Child Maltreatment Fatalities

Advance Praise from National Experts

Marcia Herman-Giddens and her colleagues have produced a work which will serve as the lead for the country in giving guidance to the multitudes who labor to prevent child deaths. Although it is specific to North Carolina, all of us will find it useful. They have spelled out the complexities of the system. The material is organized in such depth that information can be easily accessed. Roles are well defined and ultimately problem areas can be addressed based on the knowledge available here. But most of all, this work raises a productive voice for the children who are missing. It is a pleasure to contemplate the changes which will occur because of this project.

M. Patricia West, MSSW
Public Health Consultation, Philadephia, PA

That the North Carolina Child Maltreatment Guidelines *begins with a note of respect for 366 child abuse deaths provides lessons for all of us. That respect continues with chapters on the aftermath with community and family including surviving siblings and professionals supported with critical incident debriefing, CID.*

Unique materials address emergency medical services, hospital records as legal documents, law enforcement evidence collection, what to charge, organ and tissue donation, Guardians ad Litem, child care, mental health, mortuaries, clergy, media, judges, and confidentiality.

The appendix includes multiple North Carolina protocols along with materials from other states and national systems. All sections had peer review. This is the most comprehensive statement to date and a model for all states.

Michael Durfee, MD
LA County Department of Health Services, ICAN National Center on Child Fatality Review

"This Manual is just what the emerging panels on Child Fatality need to do their work. It is well-written, comprehensive and sensitive to the needs of the families in whom a child death has occurred. Every child fatality team should have at least one of these, as well as others whose professions bring them into contact with child deaths."

Robert M. Reece, M.D.
Clinical Professor of Pediatrics, Tufts University School of Medicine
Director, Institute for Professional Education,
Massachusetts Society for the Prevention of Cruelty to Children, Boston, MA

Child Maltreatment Fatalities: Guidelines for Response, *written by the North Carolina Child Advocacy Institute and the Governor's Crime Commission, is a wonderfully comprehensive and usable text describing the roles and responsibilities of professionals working with abuse related homicides in North Carolina. Though specifically written with North Carolina in mind, this much needed manual can and should be used by all professionals who are tasked with investigating and preventing child maltreatment deaths. Each chapter is efficiently organized around a core outline that includes reporting procedures and responsibilities, agency response, confidentiality and other ethical issues, and most importantly a final summary of best practices. Chapters describe the role of prehospital and medical professionals, law enforcement agents and prosecutors, the courts, child protective services and mental health, child death review teams, public health and data collection agencies and advocacy groups among others. There are even chapters describing the role of mortuary providers and of the media and one on organ and tissue donation issues. Each chapter lists several peer reviewers who evaluated the chapter for accuracy and completion. The end result of all this work is a primer worthy of inclusion in any library and office where professionals face the challenge of child homicides.*

Lawrence R. Ricci, MD
Director, Spurwink Child Abuse Program, Portland Maine
Chair, Maine Child Death and Serious Injury Review Panel
Assistant Professor of Pediatrics, University of Vermont College of Medicine

Preface

Although this document may seem complex and technical, it is the product of a simple belief and an abiding passion. We believe in the value of each and every child's life and in the rightness of honoring the memory of all children who have been robbed of life through abuse or neglect. Our passion is to do whatever is possible to ensure that these tragic deaths are neither invisible nor in vain.

Consequently, this publication was created to make clear that our society's obligations do not end with a child victim's final breath. Behind all the procedures, policies and practices detailed here stand a set of duties that must never be shirked. These include:

- **bringing justice** to those who have inflicted lethal harm upon a child.
- **bringing protection** to those whose lives could be in danger at the hands of someone already responsible for a child's death.
- **bringing comfort** to those who must bear the loss of a child through no fault of their own as well as to those responding to these deaths.

We salute all those individuals, organizations and agencies already recognizing and acting upon these obligations throughout North Carolina. May this volume inspire them to carry on with this difficult and often thankless work — and may it help us all to better understand and appreciate their efforts.

As the awareness of child maltreatment fatalities has grown, so has the need for a coordinated and informed response from the numerous professionals and agencies involved in these tragedies. While many agencies have their own protocols, there has been no single source of guidelines for an effective response to child maltreatment deaths. Initiated and funded by the North Carolina Governor's Crime Commission, this project was conducted by the North Carolina Child Advocacy Institute in Raleigh, North Carolina under the auspices of the NC Department of Health and Human Services. Publication was conducted under the auspices of the NC Department of Administration. *Guidelines for Response* is modeled after the 1997 *Child Sexual Abuse Guidelines: Recommendations for Professionals* published by the North Carolina Department of Justice (available at www.jus.state.nc.us).

Purpose of *Guidelines for Response*

Child Maltreatment Fatalities: Guidelines for Response is a comprehensive manual designed to:

- Provide current information about practice, policies, laws, or protocols for agencies and professionals involved with child maltreatment fatalities
- Provide recommendations for "best practice" to each agency and professional
- Enable a more informed understanding of each discipline's role
- Encourage agencies and professionals within their own communities to use these guidelines to strive for "best practice"

Guidelines for Response provides the reader with knowledge about the roles and responsibilities of each discipline involved when a child is killed or dies from abuse or neglect. They are recommendations, not mandates. Each section is intended to serve as a "best practice" tool for the discipline discussed so that all agencies and professionals involved with a fatality will understand not only what others are supposed to do, but also what they themselves should do.

Although the focus of *Guidelines for Response* is on child maltreatment deaths, much of the information is applicable to other child fatalities, particularly those from non-abuse related trauma such as fatal drive-by shootings. *Guidelines for Response* is not about prevention, although some of the practices and recommendations involve prevention of maltreatment to surviving siblings or other children in the homes where these tragedies have occurred.

Acknowledgements

Child Maltreatment Fatalities: Guidelines for Response could not have come to fruition were it not for the expertise and hard work of more than 100 named and unnamed dedicated professionals whose work and lives are touched by the tragedy of child abuse and neglect deaths. We are deeply grateful for the dedication, time, knowledge, experience, and caring shown by the primary authors, the peer reviewers, and the many others who helped us. Additions and corrections offered by peer reviewers were invaluable for improving the content of the final chapters and assuring accuracy. Additional readers whose names are not reflected reviewed a number of the chapters. The process of editing and writing many of the chapters caused us to struggle with how to express difficult and sometimes controversial issues.

Our work was guided by the 1997 *Child Sexual Abuse Guidelines: Recommendations for Professionals* and without which our task would have been much more difficult. We are particularly grateful for the help and advice of **Kathy Woodcock** and **Maria Myers** whose experience with the *Child Sexual Abuse Guidelines* saved us much time and averted many mistakes.

We thank those who reviewed *Guidelines for Response* in its entirety for all their excellent suggestions: our national reviewers, **Michael Durfee, MD**, **Robert M. Reece, MD**, **Lawrence R. Ricci, MD**, and **M. Patricia West, MSSW**; and our state reviewers, **Jane Harvey**, Consultant, Beaufort, NC; **Sara Anderson Mims**, **MBA,** Division of Social Services, Raleigh; **Bryan A. Queen**, WXII-TV, Winston-Salem; **Jennifer Tolle**, Prevent Child Abuse NC, Raleigh; and **Maria Myers**, Department of Justice, Attorney General's Office, Raleigh. We also thank the **NC Governor's Crime Commission** for underwriting this project, the **NC Division of Women's and Children's Health** (NCDHHS) and the **NC Youth Advocacy and Involvement Office** (NCDOA) for administering the funding. Finally, our appreciation goes to **Carol Majors**, Graphic Designer at Publications Unlimited, for turning this project into a real book.

A word about the Editor-in-Chief and Project Director

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Introduction and Overview

The Scope of the Problem in North Carolina

From 1985 through 1999, 356 children under 11 years of age and 10 children between 11 through 17 (1993 through 1999) — commemorated in the dedication of this manual — were found to have been killed by their parents or other caregivers (Herman-Giddens, et al, 1997; Office of the Chief Medical Examiner, 1992–1996). We know there are more. Currently, every two weeks or so, yet another child in North Carolina is killed at the hands of his or her caregiver.

There are still no accurate counts for neglect deaths, in part because reasonable people may disagree as to what constitutes failure to provide proper care or supervision. Therefore, our numbers do not include such fatalities as children who drown in a bathtub while left unsupervised, children who are killed in a car crash with a drunk parent at the wheel, or children who are left alone in a house that catches fire.

Prior to 1985, no accurate statistics exist for child abuse homicides. Official reports undercount homicides due to child abuse by as much as 60% (Herman-Giddens et al., 1999). The North Carolina Child Homicide Study found that from 1985 through 1994 the rate of child abuse homicides rose approximately 12.5% a year. (Herman-Giddens et al., 1999). Currently, the State Child Fatality Prevention Team provides the most accurate data on abuse fatalities (Chapter 9, Section 1 and Chapter 13, Section 2). Comparisons of NC rates to other states or the nation cannot be made accurately because there is no consistent system nationally for identifying and counting child maltreatment fatalities.

The majority of child maltreatment fatalities occur in families who are unknown to Child Protective Services (CPS). Approximately 30% to 40% of families experiencing a child maltreatment death do have a history of CPS involvement. These figures demonstrate that the prevention of and response to child maltreatment fatalities is a community problem that needs the cooperation of many professions and agencies. Prevention and response must not and cannot rest solely with CPS.

■ Why *Guidelines for Response* Was Written: The Need for a Coordinated, Multidisciplinary Response

In 1995, studies undertaken in North Carolina to understand responses to child abuse homicides and the criminal justice outcomes found wide variability in response among the many involved disciplines (Herman-Giddens et al., 1997; Herman-Giddens et al., 1999). These findings are further amplified by the ongoing child fatality reviews conducted by or under the direction of the state Division of Social Services whenever a child known to Child Protective Services within the past year dies from suspected maltreatment (Division of Social Services, 2000). Particularly disturbing was the study's finding that almost one-third of the probable perpetrators of the homicides were never charged or penalized. When sentencing was imposed, punishment for similar crimes ranged from probation to life imprisonment. Some of this variability may be influenced by inconsistencies in other practices; for example, failure to notify law enforcement when a child dies unexpectedly at home, lack of death scene investigations, varying autopsy procedures, or policy differences among the District Attorney's offices across NC's 100 counties.

These findings point out the need for informed agencies and professionals, and multidisciplinary efforts in diagnosis, criminal investigation, community response, and the protection and treatment of the people dealing with the aftermath of child maltreatment deaths. *Guidelines for Response* encourages a consistent response to these tragedies and effective multidisciplinary coordination that will lead to greater protection for children as well as more equitable criminal justice outcomes.

■ The Diversity of Cases, Outcomes, and Consequences

The understandable impulse to avoid thinking about the gruesome details of these children's deaths cannot be allowed to divert our minds from the task of thinking carefully and clearly about the remarkably different situations covered by the term "child maltreatment fatalities." The common link is the wrongful death of a child. But what constitutes the best possible response can vary greatly from case to case (and from profession to profession).

The goal is to achieve the right balance between considering the unique circumstances of each case and ensuring a reasonable degree of uniformity in similar cases. It simply is wrong to have two very similar cases result in very different consequences for the responsible "caregivers" (e.g., probation versus a long prison term). However, it is equally wrong to behave as if completely different

kinds of cases (for example, a death resulting from the failure to safely store poisonous household cleaners versus one resulting from torture or deliberate starvation) are identical and should result in identical outcomes for the responsible "caregiver."

The general public may have the luxury of not thinking about child maltreatment fatalities at all — and, indeed, may dismiss the whole subject as "unthinkable." A child dying at the hands of the very person entrusted to care for and to protect that young life is never easy or pleasant to consider. On the one hand, we recoil from, and are sickened by, the monstrous cruelty evident in some cases. We would rather pretend there are not individuals among us capable of such criminal violence against children. On the other hand, some deaths resulting from sins of omission (e.g., being inattentive or distracted for short periods) chill us because we recognize the shadow of our own failures to be ever-vigilant in safeguarding the children in our care. It is the rare caregiver who has **never** acted in a way that potentially could have gone tragically — even fatally — awry in relation to a child.

Turning a blind eye toward child maltreatment deaths is not a luxury available to the professionals and agencies covered by this publication. Mercifully, having to respond to a fatality of this kind may not occur often for most people in most of these professions or agencies. Others have little respite from their daily contact with children dead or dying from maltreatment. However, even if it is only a one-time occurrence in someone's career, it still is crucial that all the people involved carry out their particular roles as well as possible.

The diversity of the cases means that they must be thought about, and acted upon, in something other than a "one size fits all" manner. As a starting point, it might be helpful to view each child maltreatment death along two major lines. The first continuum — from clearly unintentional (accidental) to clearly intentional (non-accidental) — addresses the circumstances surrounding the death itself. Society draws a dramatic distinction between the deaths of a child who drowns in a pool or pond while the caregiver left briefly to use the lavatory versus a child who is held upside down by the caregiver until drowned in a toilet bowl. The first death by drowning would be regarded as a tragic accident that occurred because of some degree of neglect. The second would be regarded as a horrible murder.

The second continuum — from clearly requiring consequences to clearly not — addresses the circumstances surrounding the outcomes for the caregiver(s) involved in a child's death. What

happens to the individual responsible for a child maltreatment fatality is crucial in terms of two of the societal duties articulated in the Preface: 1) bringing justice to those who have inflicted lethal harm upon a child; and, 2) bringing protection to those whose lives could be in danger at the hands of someone already responsible for a child's death. What happens in the larger context of community responsibility is part of the purpose of multidisciplinary child fatality review and prevention teams.

The specific criteria and processes by which the determination is made as to whether a caregiver can, should, and will be criminally sanctioned are spelled out in later chapters. It should be noted that consequences do not always take the form of criminal prosecutions. For instance, the termination of parental rights in relation to surviving siblings is one available non-criminal sanction.

The general point is that many of the professionals and agencies discussed in this volume have (or could have) an important role in answering one or more of the four key questions in each case:

- Was child abuse or neglect a significant factor in this death?
- Is a criminal sentence or other consequence regarding the responsible caregiver(s) a reasonable and appropriate option?
- If so, what sentence or other consequence best fits the situation?
- What else should be done?

The situational examples as characterized by cases 1 through 4 below illustrate consequences specific to the offending caregiver where a maltreatment death has occurred and do not address wider consequences that may be appropriate such as changes in agency, community, corporate, or social practices and protocols. There can be changes as to the group into which a specific case properly is placed. For instance, new evidence can cause a particular death to be understood in a new light and, consequently, to warrant reclassification.

> An example of a Group 1 case (unintentional; offender consequences) is when young children are left alone in a home for a long period and die in a fire at that home.
>
> An example of a Group 2 case (unintentional; no offender consequences) is when a child dies in a car accident after being thrown from a child safety seat that was defective, but the caregiver had no prior knowledge that it was unsafe. Consequences may be appropriate for the manufacturer.

An example of a Group 3 case (intentional; offender consequences) is when a child repeatedly is kicked in the head until dead.

An example of a Group 4 case (intentional; no offender consequences) is when a caregiver kills her child and then herself.

All of these groups include a wrongful, tragic ending of a young life. And yet, each group represents a significantly different kind of child maltreatment fatality. This diversity poses a challenge to the ways in which society — and especially a professional or agency covered by this publication — thinks about, and acts in relation to, events we all wish never happened in the first place. When the death of a child cannot be prevented, the best we can hope for is that the response will be multilevel, serious, honorable, and just. That is, the least we owe these unfortunate victims across our state.

■ How to Use *Guidelines for Response* Most Effectively

Guidelines for Response organizes chapters about agencies and professionals that become involved in child maltreatment deaths into *three parts* divided by the time periods of response to the death.

Within each part, each chapter or section is organized into five subsections:

- The **Introduction** gives an overview of the agency or discipline under discussion.
- **Fatality Reporting Procedures and Responsibilities** details the legal requirements regarding reporting as well as the authorities to whom each particular agency or profession must report.
- **Agency Response** includes the duties and responsibilities of each agency or profession regarding a child maltreatment fatality, their processes, and case follow-up as appropriate.
- **Confidentiality and Other Ethical Issues** presents the legal requirements for confidentiality in each field and discusses related ethical dilemmas which may arise in some situations.
- The **Best Practice** section discusses, from each agency or professional's point of view, those practices and procedures that need to be accomplished for effective handling of child maltreatment fatalities.

- **Resources and References** are listed at the end of the chapter. Certain additional material referenced in the chapters is included in the Appendices.

Part I, "***During the Crisis: Involvement and Response***," addresses the disciplines which must have *direct involvement and responses* during the crises period following an abuse or neglect fatality.

Chapter 1, "**The Medical Community**," includes emergency medical services response, and appropriate procedures for medical providers and medical examiners when handling a maltreatment fatality. The chapter identifies the importance of distinguishing abuse from unintentional injury or natural illnesses. The section on organ procurement describes the organ donor protocol and the circumstances under which a child homicide victim might be a possible donor.

Chapter 2, "**Law Enforcement and Prosecution**," includes three sections. The first describes the law enforcement response to child homicides, including both local law enforcement and the State Bureau of Investigation. The second provides an extensive discussion on prosecution procedures and strategies with pertinent legal citations. The third section provides information on the juvenile justice system in the rare event that a suspected perpetrator of a maltreatment fatality is under 16 years of age. These chapters will help those involved in the legal system investigate and build a case carefully. In addition, they will help those who must intersect with the legal system to understand the legal terms, protocols, and necessary procedures.

Chapter 3 presents further **legal areas**. The judges' section addresses the responsibility of judges in the varied legal settings that intersect with child maltreatment fatalities as well as some of the dilemmas in their work. The Guardian ad Litem section describes their legally mandated service that interfaces with Child Protective Services.

Chapter 4 includes sections on **Child Protective Services** and the Division of Child Development's roles in the investigation of child fatalities. Child Protective Services is involved only if there are other children in the household. The Division of Child Development must investigate if a child dies while in certain child care arrangements.

Chapters 5 through 8 address the other disciplines that are necessarily involved in the immediate response to a child

maltreatment fatality: **mental heath**, **mortuary providers**, the **clergy**, and the **media**. The mental health chapter not only explains the mental health system and the appropriate response of therapist to these tragedies, but also offers suggestions for all persons who must respond to the fatality. Chapters for mortuary professionals and clergy describe their special roles and services, and their interaction with the investigation, the bereaved family, and the community. The media chapter delineates responsible approaches for coverage of the event for television and newsprint reporters, and gives suggestions for others who must interact with the media.

Part II, "***After the Crisis: Community and Family***," describes agencies and programs, that may become involved *after the crisis*.

Chapter 9 outlines the **North Carolina Child Fatality Review and Prevention System** using a helpful graphic that illustrates the interconnections of programs within this system. Functions and processes of the NC Child Fatality Task Force and the State Child Fatality Prevention Team are discussed along with their interface with the Local Child Fatality Prevention Teams and the Community Child Protection Teams. The section on the State Child Fatality Review Team (not to be confused with the teams above) delineates that team's role in their legally mandated review of cases where suspicious deaths occurred to children known within the past 12 months to Child Protective Services.

Chapters 10 and 11 detail **programs** and **systems** that may have been involved with child victims and may continue to be involved with any surviving siblings, such as the Child Medical Evaluation Program, Early Intervention Programs, public and private schools, and public health. While often viewed as preventive services, these programs may become involved in the direct response to a child maltreatment fatality, in subsequent investigations, or providing services to affected family and community members, as well as in the longer term community response.

Part III, "***Long Term Responses to Child Maltreatment Fatalities***," addresses agencies that provide *statistical support and advocacy*.

Chapter 12 includes sections on the **Governor's Youth Advocacy and Involvement Office** and non-governmental child advocacy groups. The advocacy response, which focuses on the prevention of future fatalities, enforcing public agency mandates, generating community awareness and changing

public policy is delineated. The final section on domestic violence discusses the interrelationship between general family violence and child fatalities, and describes the interventions and resources domestic violence agencies can provide.

Chapter 13 on **data** outlines the responsibilities and limitations of vital records in recording data on child maltreatment fatalities and the interface and differences between data gathered by vital records, the State Child Fatality Prevention Team, and the Department of Social Services. This chapter explains the necessity of all reporters using accurate terms and providing timely reports as this can assist the prevention system in their work.

The **Appendices** offer additional resources and further reading. Resources are listed for the most part without names since personnel changes quickly render such lists obsolete. In some cases, forms are provided for use by a particular discipline. In other cases, due to space limitations, directions are provided to obtain necessary material.

Appendix A provides definitions of terms and abbreviations used in the book.

Appendix B offers agency and service contact information beginning with how to reach the agencies cited in this manual and ending with national child advocacy resources.

Appendix C includes protocols referenced in the various chapters as models for practice. The Cook County (IL) Autopsy Protocol and the CDC Death Scene Investigation Report Form are frequently cited for best practice in conducting medical examiner and legal investigations. Emergency medical services and prehospital advanced life support protocols and procedures are included to assist other facilities in developing appropriate responses to such medical crises.

Appendix D provides the key North Carolina General Statutes relevant to the topics in this book such as the child abuse reporting laws, the statutes on the Child Fatality Prevention System, and the medical examiner system.

Appendix E offers further reading including ways to access free services relevant to many chapters. Two articles are printed intact because of their succinct, state-of-the-art information regarding investigating child fatalities and evaluating children for sexual abuse. The last appendix offers a suggested reading list that includes key references from the

chapters in this book as well as further readings covering child maltreatment fatalities, child abuse, and child fatality review teams.

How Child Maltreatment Fatalities Are Defined for the Purposes of Guidelines for Response.

Child maltreatment is usually thought of as a term encompassing all forms of abuse and neglect by a parent or caretaker whose relationship to the child victim is defined by law (Appendix D). The limitation of requiring this specific relationship of the perpetrator to the victim provides the necessary parameter for the involvement by Child Protective Services Units (CPS) within each county's Department of Social Services. While a child may be abused and killed by caregiving babysitters, neighbors, relatives, or others outside the home, these situations would usually be under the sole purview of law enforcement and would not require a CPS report unless an element of neglect by the parent was suspected. However, making too strict a distinction would defeat the usefulness of this book. For example, if a child is killed by someone responsible for the child who is not a parent or legal caretaker, the roles and responses of the various disciplines to the fatality would still be much the same. In addition, it is always best to report a situation of suspected maltreatment to CPS whether or not the suspected perpetrator seems to fit the legal definition of "caretaker." It is the job of CPS to make this determination, not that of other professionals responding to the fatality. ***Therefore, this book refers to anyone who, at a given time, is responsible for the care of a child, whether a parent, caretaker, or other person, as a* caregiver.**

Fatal physical abuse occurs when a child is lethally injured by beating, burning, shaking, stabbing, shooting, poisoning, or other methods of physically harming the child. Munchausen Syndrome by Proxy is another form of physical abuse which may kill children by torture, poisoning, smothering, or other forms the syndrome takes. Although some children are deliberately murdered by their parents or other caregivers, in most cases of fatal physical abuse, the perpetrator does not intend to kill the child.

Fatal child neglect may occur when basic needs have not been met for reasons other than ignorance or poverty. These include abandonment, inadequate supervision, refusal or delay in seeking health care, failure to intervene to protect, or failure to provide adequate food or liquids. It is important to distinguish between causal or co-incidental effects of poverty in neglect situations.

In conclusion, each chapter is designed to be helpful to a particular professional or agency as well as to inform those in other disciplines. *Guidelines for Response* is unique in that it offers a comprehensive view of all necessary responses to a child maltreatment fatality. Readers are urged to review sections beyond their own profession or agency. When viewed as a whole, this book offers the opportunity to understand not only the importance of each discipline's duties and response to these tragedies, but how each fits into the entire constellation of necessary community action.

Suggested Portions for Everyone to Read.

General information and cross-cutting sections and which will be of special help or interest to all readers include:

It does take a village to raise a child. When a child is killed by a caregiver, it is especially imperative that everyone in the village work together. Thus, it may be equally accurate to say that it also "takes a village" to rightly deal with the wrongful death of a child. May fewer of North Carolina's children — and fewer of its villages — experience such tragedies in the years ahead.

For more information or questions or comments contact:

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References

Citizens' Rights Division. Child sexual abuse guidelines: recommendations for professionals. Raleigh (NC): NC Department of Justice, Attorney General's Office, 1997 [Available online at *http://www.jus.state.nc.us*].

Herman Giddens ME, Brown G, Verbiest S, Carlson PG, Hooten EG, Howell E. North Carolina child homicide study, 1985–1999: Report to State Child Fatality Prevention Team. Raleigh (NC): NC Department of Health and Human Services, Office of the Chief Medical Examiner, 1997.

Herman Giddens ME, Brown G, Verbiest S, Carlson PG, Hooten EG, Howell E, Butts JD. Under-ascertainment of child abuse mortality in the United States. *JAMA* 1999;282:463–467.

Herman-Giddens M, Eizember F. Childhood fatalities in North Carolina: 1994. North Carolina Child Fatality Prevention Team report to the North Carolina Child Fatality Task Force. Raleigh (NC): NC Department of Environment, Health, and Natural Resources, 1996, p 54. [Available from 919-733-9461].

Herman-Giddens M, Zolotar A. Childhood fatalities in North Carolina: 1995. North Carolina Child Fatality Prevention Team report to the North Carolina Child Fatality Task Force. Raleigh (NC): NC Department of Environment, Health, and Natural Resources, 1997, p 34. [Available from 919-733-9461].

Program Review Team. State child fatality review report: SFY 1998–99. Raleigh, (NC): NC Department of Health and Human Services, Division of Social Services, 2000 Feb 14. [Available from 919-733-9461].