



## Comparing types of child fatality review in the U.S.

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### ABSTRACT

Child fatality review programs consist of multidisciplinary teams of professionals, agencies and community members with an interest in caring for and protecting children. While the purpose of all child fatality reviews is to conduct a comprehensive, multidisciplinary review of child fatalities to better understand how and why children die, there are distinct types of reviews in the United States that each use findings to take action to prevent other fatalities and improve the health and safety of children in different ways. Each brings a unique perspective, incorporating different stakeholders and methodologies and playing different roles in identifying patterns, gaps in services, and potential areas for improvement within the broader context of child health and safety. Three major types of review now consistently used across the U.S. include Child Death Review, Fetal Infant Mortality Review, and Citizen Review Panels. These differ in their history of development, statutory authority, financial support, nature of cases reviewed, processes, and reporting to stakeholders. This article is an introduction to the major different types of community-based death review to help practitioners understand and participate more productively in these processes to prevent further fatalities.

### 1. Introduction

Child maltreatment fatalities have increased in the United States during the past 25 years, rising from 935 (1.59 per 100,000 children) in 1997 to 1990 (2.73 per 100,000) in 2022 (U.S. Department of Health and Human Services, 2024). In 2016, U.S. National Commission to Eliminate Child Abuse and Neglect Fatalities found that child abuse deaths are undercounted in the U.S., that we still have not identified the children and families most at risk, and that child fatality reviews are the best way to prevent these deaths, among other things (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016). Child death review, or “CDR” as it came to be called, was first comprised of criminal justice, health, and social service professionals in Los Angeles County, California in 1978 (U.S. Advisory Board, 1995). The number of teams grew, accelerating with the founding of the U.S. National Center for Child Fatality Review and Prevention, first funded by the U.S. Health Resources and Services Administration in 2002 (National Center for Fatality Review and Prevention [NCFRP], n.d.).

The overall purpose of community-based fatality review is to conduct a comprehensive, multidisciplinary review of child fatalities, to better understand how and why children die, and use the findings to take action that can prevent other fatalities and improve the health and safety of

children (NCFRP, n.d.; NCFRP, 2021a). The operating principle is that a child's death is a sentinel event that is a community responsibility. A child's death that should urge communities to identify other children at risk by comprehensively reviewing case information to keep future children healthy, safe and protected. Reviews should be multidisciplinary and focus on prevention which leads to effective actions in the community. Child fatality review has been recommended as a best practice in the United States for understanding and preventing child abuse and neglect fatalities because it improves collection of data about child abuse and neglect fatalities, enhances the ability of national and local systems to share data to save children's lives, and supports research and practice. (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016; Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008).

Three major types of review now used consistently across the U.S. include child death review (CDR), fetal infant mortality review (FIMR), and citizen review panels (CRP). They differ in the history of their development, statutory authority, nature of cases reviewed, processes and desired outcomes (Palusci, 2010). Some look at all child deaths while others focus on a particular cause, such as child abuse and neglect. There are potential overlapping functions that could allow for data sharing, joint staffing and complementary reviews (NCFRP, 2021a). All types of

*Abbreviations:* AAP, American Academy of Pediatrics; CDR, Child death review; CPS, Child Protective Services; CRP, Citizen review panel; FIMR, Fetal infant mortality review; NCFRP, National Center for Fatality Review and Prevention; NFR-CRS, National Fatality Review Case Reporting System.

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review have provisions to keep the process confidential and to share overall findings with stakeholders. Each brings a unique perspective, and [Table 1](#) compares their purposes, review processes, case selection, team member selection, support staffing, and outcomes. While based on these models, they are implemented differently across U.S. states and jurisdictions. This article is an introduction to the major different types of community-based death review used in the U.S. to help practitioners understand and participate more productively in these processes to prevent further fatalities.

1.1. Child death review

CDR focuses on systematically reviewing and analyzing the circumstances surrounding the death of a child, typically under the age of 18 years (NCFRP, n.d.). The formalization of multidisciplinary teams began in the late 20th century as a response to the growing awareness of child abuse as a significant public health issue (Palusci, 2010; Krugman, 2013; U.S. Advisory Board, 1995). All child deaths or near-deaths may be reviewed, although some focus on specific causes such as abuse and

**Table 1**  
Comparison of review types by purpose, team members, Selected cases, process, support staff, outcomes and stakeholder reporting.

	CDR	FIMR	CRP
Purpose of Review	To improve the understanding of how and why children die and to influence policy and services	To identify general community social, economic, cultural and health system issues	To evaluate the effectiveness of agencies charged with child protection responsibility
Team Members	Injury prevention programs; child welfare agencies; public health; law enforcement; medical examiners/coroners; pediatricians	Public health; obstetricians, pediatricians, midwives; other community advocates and professionals	Multidisciplinary professionals and community members
Selected Cases	Children from birth to under the age of 18y who died of any cause, commonly prioritizing sudden, unexpected deaths or deaths due to maltreatment	Stillbirths and infant deaths before age 1 year	Child deaths known to CPS or child welfare systems
Review Process	Team members bring identified records to the review meeting to share and discuss the death and make case findings	Abstracts are created with de-identified summaries of record abstracts and home interview for team review.	Records are collected and may be abstracted for team review. Team summarizes findings with de-identification as needed
Support Staff	Coordinator, scribe	Coordinator, record abstractor, home interviewer, scribe	Coordinator, record abstractor, scribe
Outcomes	Data are entered into NFR-CRS, statistics are calculated, trends are identified, and team makes recommendations	Data are entered into NFR-CRS, trends are identified, team makes recommendations to community action team	Data are recorded, statistics are calculated, trends are identified, and team identifies recommendations, which are reported to CPS/government
Stakeholder Reporting	Governor, Legislators, public at large	Private or public organizations or the public (at large)	State CPS agency or the public at large

CDR: Child death review; CPS: Child Protective Services; CRP: Citizen review panel; FIMR: Fetal infant mortality review; NFR-CRS: National Fatality Review Case Reporting System.

neglect. The primary goal is to identify factors contributing to child fatalities to inform community prevention strategies with an emphasis is on identifying patterns and trends that may indicate systemic issues or gaps in child and family services. CDR often involves case-specific reviews, but aggregated data can also inform broader public health strategies (Batra, Palusci, & Berg, 2022; Palusci & Covington, 2014; Palusci, Schnitzer, & Collier, 2023).

Currently, all 50 U.S. states have established CDR programs, and state laws mandate/support CDR in 39 U.S. states (NCFRP). Twenty-three are based in state health departments and 20 in social services offices (NCFRP, 2021a). Some teams review every child death of any cause, and 10 states review serious injuries or near-fatalities. Thirty-seven states have community teams and state boards. Half review all causes, and all review to age 18 years. Most are funded with federal maternal and child health or child protection dollars, and 44 use the U.S. National Fatality Review Case Reporting System (NFR-CRS), the data system supporting CDR across the country (NCFRP, 2021a; Covington, 2011). Reviews involve a multidisciplinary team including law enforcement, child welfare, medical and mental health, forensic science, education, social services, and other relevant professionals and stakeholders (NCFRP). Review processes vary widely across U.S. states and jurisdictions, with some implementing legislation or policies mandating or permitting their function, and these legal frameworks outline the responsibilities, composition, and procedures.

The American Academy of Pediatrics (AAP) has supported child fatality reviews and pediatrician participation since its 1993 statement from the AAP Committees on Child Abuse and Neglect and Community Health Services (American Academy of Pediatrics, 1993). It first described the problem, the investigation, and the review process, calling for pediatricians and AAP state chapters to advocate for proper death investigation and certification, autopsies for children younger than 6 years with trauma, and comprehensive review systems at the local and state levels. This statement asked pediatricians to take on the responsibility to be involved with the death review process and with training death scene investigators. A 1999 AAP policy statement supported analysis of child fatalities, standards for adequate investigations for individual fatalities, and the importance of pediatrician involvement (Kairys et al., 1999). In 2010, the AAP highlighted the importance of child fatality review in the public health approach to prevention of child fatalities and advocated for improving this process through attention to better training, data collection, and data dissemination (Committee of Child Abuse and Neglect et al., 2010). This was broadened to using CDR as a best practice for pediatricians for identifying child maltreatment fatalities (Palusci et al., 2019). Their recent policy statement highlights the need for supporting pediatricians to participate in the process (Batra et al., 2024).

Child death review teams have a strong focus on primary and secondary prevention, evolving over time to include identifying and responding to systemic issues using continuous quality improvement, training, and advances in technology such as electronic medical records, case management systems with data analytics (NCFRP, 2021a). The NFR-CRS has been used for studies of child maltreatment fatality (Palusci & Covington, 2014; Batra et al., 2022; Palusci et al., 2023). Examples of community interventions include Tennessee's Child Fatality Review system making key prevention recommendations in 2020 focusing on prevention of suicide deaths, motor vehicle crash fatalities, infant deaths due to premature birth, birth defects, unsafe sleep, and drowning. Ohio focused on preventing child abuse and neglect fatalities based on reviews of 152 child abuse and neglect fatalities between 2015 and 2019 by promoting the use of 24-h parenting hotlines as a safe and confidential source for parents in crisis, supporting educational programs that assist parents and guardians in understanding age appropriate behaviors, and implementing public service announcements educating lay people on signs of child abuse and neglect and how to report it.

Despite progress, challenges persist, including issues related to information sharing, communication of findings to stakeholders, high staff

turnover, the need for cultural competence, and financial support (McCarroll, Fisher, Cozza, & Whalen, 2021). Given their wide variability, it is not surprising that their findings have been thought to be inconsistent over jurisdictions (Mantell, Scharlach, Iyer, & Chergou, 2020; Parry et al., 2017) and they sometimes struggle in terms of leadership, focus, standardization, and funding (Douglas, Ahola, & Proulx, 2017). CDRs may do a better job of assessing the problem than in proposing solutions as indicated by their written recommendations, which often do not address follow-up (Wirtz, Foster, & Lenart, 2011). CDR teams can be improved by giving them injury prevention training, collaborative process improvement coaching, and access to web-based prevention resources, with better identification of evidence based best practices and the development of clear, actionable written recommendations (Johnston, Bennett, Pilkey, Wirtz, & Quan, 2011). In the U.K., teams noted professionals need to continue to actively pursue and create opportunities to collect and collate comprehensive data and promote collaborative multi-agency arrangements to be responsive to all partners involved in the safeguarding process, which includes parents (Sanders, Fisher-Smith, Neill, & Jones, 2020).

### 1.2. Fetal and infant mortality review

Fetal and infant mortality review (FIMR) began as a collaborative effort between the American College of Obstetricians and Gynecologists and U.S. Health Resources and Services Administration Maternal and Child Health Bureau (NCFRP, 2021b). FIMR projects have been conducted since 1988, but the majority of existing FIMRs were formed after 1990. In 2020, 162 FIMR programs were actively reviewing cases with health departments leading the majority (NCFRP, 2021b). Most FIMR programs exist at the local level and are funded with Title V MCH block grant funds. In 2018, the NFR-CRS began including FIMR reviews, and as of 2020, 18 states were using the NFR-CRS (NCFRP, 2021c). FIMR has been used to identify general community, social, economic, cultural, and health systems factors that represent problems in service delivery systems or resources for mothers and infants that require change and to develop recommendations for interventions and policies that can improve both maternal and infant health outcomes.

FIMR programs differ in their scope and the composition of their teams on the state and local levels, state financial support, administrative leadership, supporting legislation, case selection methods, and reporting systems used (NCFRP, 2021b). This multidisciplinary process brings together a case review team with obstetricians, pediatricians, nurses, and public health officials to review fetal and infant fatalities by a detailed examination of the mother and infant's medical records from the hospital as well as private physicians' offices and clinics. Also included can be autopsy reports, medical examiner reports, and police reports. Case reviews are de-identified before presentation to the review team. Findings are then communicated to a separate community action team to devise and implement community strategies. All infant deaths may be reviewed or reviews may target certain geographic areas or causes. Local teams commonly review deaths from within a specific county; occasionally, they are from a more specific area of the community. In states with several FIMR teams, case review data funnels up to a state program or agency, contributing to a larger, state-level dataset to support broader prevention efforts. Some states have legislation or administrative rules that mandate or permit FIMR. By far, the most important part of the FIMR process is the home interview with the parents that can provide the best insight into our health care system as it gives the perspective of the mother (NCFRP, 2021b).

Fetal and infant case reviews have great potential to stimulate community systems improvement. The process itself is considered continuous quality improvement for systems that impact maternal and infant populations. The impact of teams' prevention work is increased through strategic partnerships with maternal child health programs like home visiting, the federally funded Healthy Start programs, Title V maternal child health programs, and medical care providers (NCFRP, 2021c). A

compilation of team findings from across the U.S. found recommendations running the gamut from increasing prenatal screening services, bereavement services, addiction services and preconception counseling, to promoting safe sleep environments, training, improving access to medical care and informing the public about unsafe toys and bedding in the home. In one U.S. state, for example, the Indiana Governor, informed by FIMR results, set a goal in 2018 to become "Best in the Midwest" for infant mortality by 2024. In 2019, the State General Assembly passed legislation to create an OB Navigator program to connect Medicaid-eligible mothers and others who apply to relevant community-based programs. They also passed legislation removing barriers to allow pregnant teens to access prenatal care without parental consent if the parent or guardians are not supportive of the mother receiving care.

To assess the case in the level of detail required to make meaningful case findings and recommendations, a significant amount of work must be done in preparation for the review itself, and special attention given to the de-identified nature of records and of the review process. Reviews are sometimes limited because of their incomplete access to records, lack of support for the case review team, and inability to conduct parent interviews for various reasons (NCFRP, 2021c). Existing programs have diverse levels of funding and staffing to support state FIMR activities that are significantly impacted by state budgets and competing community priorities. To be successful, FIMRs need community action teams members who have the political will and fiscal resources to implement large-scale systems change and those who can best define a community perspective on how to create the desired change. Some FIMR programs have integrated "consumers" into their CAT who live, work, worship, and play in the FIMR catchment area and use its services and resources.

### 1.3. Citizen review panels

CRPs are community-based entities that involve non-professional community members who review child welfare cases and fatalities of children known to CPS. They were first required for U.S. states in 1996 as part of the amendments to the Child Abuse Prevention and Treatment Act (CAPTA, 1988). CRPs are instituted within state child welfare agencies to review CPS files in adoption, foster care, or investigation, and are required to meet at least quarterly to fulfill a broad mandate which includes ensuring that the state is in compliance with CAPTA, Title IV-E programs, and other requirements (U.S. Department of Health and Human Services [USDHHS], 1998). This differs from CPS multidisciplinary teams formed separately from the CRP fatality process, usually for non-fatal CPS cases. The number of CRPs required in a state depends on the level of funding from the federal government, and many states have instituted CRPs specifically to review child maltreatment fatalities.

Efforts are also made to include nonprofessionals on the review team, such as former clients of the child welfare system and other members of the community. Medical examiners, law enforcement, CPS, and legal professionals can be part of CRPs, as can pediatricians, education professionals, and public health officials (USDHHS, 1998). The CRP process involves the examination of case files, interviews with involved parties, and discussions among panel members. States are required to provide panel members with the support staff and case-level information that the panels deem necessary for them to carry out their mission. As with CDR and FIMR, panel members are bound by confidentiality requirements and cannot disclose identifying information about deaths reviewed. CRPs are required to report to their state child protective services agency and are also expected to prepare an annual report to the public describing their activities (Palusci, 2010).

The aim of CRP is to provide an independent and community perspective on child protection and child welfare cases, ensuring that agencies are following appropriate procedures with an independent perspective on agency efforts, ensuring accountability and transparency. Recommendations can lead to systemic improvements, changes in policy, and increased public awareness regarding child welfare issues. Though

published research regarding their effectiveness is limited, CRP have resulted in improvements in the child welfare system, such as enhanced CPS and mandated reporter training, new CPS data systems and peer review programs, new protocols for investigation and legislative changes regarding CPS reporting and practice. One study of a state's CRP identified 436 findings among 356 deaths in the state's child welfare system over 6 years. Most were categorized as occurring because of failures during case investigation, assessment and service provision. After implementing changes to the child welfare system, the CRP recorded a 35% decrease in findings and a 9% decrease in deaths associated with those findings (Palusci, Yager, & Covington, 2010).

There are several limitations to the CRP process (Jones, Litzelfelner, & Ford, 2003). Early work suggested that the perceived effectiveness of panels in influencing policy was related to increased communication, an awareness of roles and limitations, legitimate collaboration, and realistic goals. Factors that impede effectiveness were thought to include lack of trust, time constraints, unclear roles, and weak communication. More recently, a national survey of panel members revealed that they lack some knowledge related to the federal mandate guiding their work, and panels need to better recruit and retain members representative of the communities in which they are formed (Miller, Collins-Camargo, Jones, & Niu, 2017). Some changes in law, policy, or practice can be implemented only on a county-by-county basis and cannot be implemented effectively by a statewide team. CRPs cannot influence elements in the child welfare system outside the state CPS agency, and an important number of child fatalities cannot be addressed if changes are made only within CPS. CRP generally does not have access to deaths in which there is no CPS involvement but may have greater reach for prevention when given access to files in other review systems such as CDR. Vadapalli (2017) concluded that, while every state complies with a 1996 federal statutory requirement to have CRPs, their functionality and impact have never been assessed. There is immense diversity in the tasks they perform, ways they are organized, resources at their disposal, and impact they have on their respective CPS agencies. Such diversity seems to be a result of inadequate efforts to generate a common understanding of their purpose and role within the child protection enterprise. State CPS agencies stand to benefit from a more instrumental role for CRPs, and the federal Office of Child Abuse and Neglect could help in multiple ways to enhance the effectiveness of CRPs.

#### 1.4. Comparisons to other types of review

Other types of child fatality review have been used to address specific vulnerable populations and services that have special interest for the community. The full range of these processes is beyond the scope of this article, but domestic violence reviews, suicide case reviews, hospital-based critical incident reviews, and disease-specific reviews offer unique opportunities to understand these particular issues and to design specific responses and prevention strategies (National Domestic Violence Fatality Review Initiative, n.d.; NCFRP, 2020; Bates et al., 2023; Rosenman, Hanna, Lyon-Callo, & Wasilevich, 2007). They can have important similarities with and differences from CDR, FIMR and CRP which should be noted, particularly regarding their relationship with community and government services, rules regarding confidentiality, and potential interventions to prevent further deaths.

Community-based child death review began in the USA but has spread across the world (ISPCAN, 2021). Reviews outside the U.S may resemble CDR but also takes different forms internationally. In the U.K., for example, the Serious Case Review System under the Children Act 1989 is used for cases where suspected child abuse or neglect has resulted in serious harm or death (Platt, 2007). In this model, a single person in each agency conducts interviews with the parties, reviews records, and writes a report. The goals are similar to CDR in that they seek to identify lessons to be learned from the death, how these will be acted upon, and what will change as a result, including improved interagency communication. Unlike the U.S., families may be involved in these reviews

(McCarroll et al., 2021). Differences also exist regarding which cases are reviewed and when this review happens. In a comparison of well-resourced countries, Fraser and colleagues (Fraser, Sidebotham, Frederick, Covington, & Mitchell, 2014) found that in England and New Zealand, multiagency rapid-response teams investigated all unexpected deaths; in the U.S. and Australia, only suspicious deaths might undergo rapid response review. In England and New Zealand, all child deaths were scrutinized, whereas in the U.S. and Australia only some deaths were reviewed. Another study adding Canada and Wales concluded that it was not possible to evaluate the effectiveness of different review systems, but it appeared that the structure of review made little difference in terms of determining the extent to which review findings informed prevention efforts (Vincent, 2014).

## 2. Conclusions

Child fatality reviews are a useful way for the community to successfully address medical and social issues facing children and families. CDR, FIMR and CRP are distinct approaches in the U.S. that can be used to understand and prevent child fatalities and improve overall child and maternal health. While they share common goals, they differ in their focus, participants, and the specific cases they address. CDR focuses on child deaths, often child abuse and neglect, while FIMR focuses on factors influencing fetal and infant mortality, and CRP focuses on children known to child welfare systems. Deaths may be reviewed by more than one team but these reviews have different objectives and reporting to stakeholders. Furthermore, deaths for review may be chosen from a list of all deaths in vital statistics, only those with injury, or further limited to maltreatment or fetal/infancy issues. Some are mandated by law and others are permitted but not mandated. Each approach has different strengths and weaknesses in their process and ability to implement change, and each is an important part of our toolbox to prevent future deaths. Additional research is needed to better understand how successful they have been in informing policy and practice change and in preventing further fatalities.

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**Vincent J. Palusci:** Writing – review & editing, Writing – original draft, Investigation, Conceptualization.

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## References

- American Academy of Pediatrics, Committee on Child Abuse and Neglect & Committee on Community Health Services. (1993). Investigation and review of unexpected infant and child deaths. *Pediatrics*, 92(5), 734–745.
- Bates, K. E., Freeland, B., Levy, K. L., Lombel, R. M., Mazloom, A., Meerkov, M. S., et al. (2023). Ensuring no death is ignored: Development of a hospital mortality review and notification system. *Pediatrics*, 152(4), Article e2022060555. <https://doi.org/10.1542/peds.2022-060555>
- Batra, E. K., Palusci, V. J., & Berg, A. (2022). Factors associated with child maltreatment fatality among young children with an open Child Protective Services case at death. *Child Abuse Review*, 31, Article e2734. <https://doi.org/10.1002/car.2734>
- Batra, E. K., Quinlan, K., Palusci, V. J., et al. (2024). Child fatality review. *Pediatrics*, 153(3), Article e2023065481. <https://doi.org/10.1542/peds.2023-065481>
- Child Abuse Prevention and Treatment Act, 42 USC 510 1 et seq. (1998).
- Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Washington, DC: US

- Government Printing Office. <https://www.acf.hhs.gov/cb/report/within-our-reach-national-strategy-eliminate-child-abuse-and-neglect-fatalities>.
- Committee on Child Abuse and Neglect; Committee on Injury, Violence, and Poison Prevention; & Council on Community Pediatrics. American Academy of Pediatrics. (2010). Policy statement-Child fatality review. *Pediatrics*, 126(3), 592–596. <https://doi.org/10.1542/peds.2010-2006>
- Covington, T. M. (2011). The U.S. National Child Death review case reporting system. *Injury Prevention*, 17(Suppl 1), i34–i37. <https://doi.org/10.1136/ip.2010.031203>
- Douglas, E. M., Ahola, S. B., & Proulx, M. L. (2018). An exploratory analysis of the notable activities of U.S. child death review teams. *Death Studies*, 42(4), 239–246. <https://doi.org/10.1080/07481187.2017.1334015>
- Fraser, J., Sidebotham, P., Frederick, J., Covington, T., & Mitchell, E. A. (2014). Learning from child death review in the USA, England, Australia, and New Zealand. *Lancet (London, England)*, 384(9946), 894–903. [https://doi.org/10.1016/S0140-6736\(13\)61089-2](https://doi.org/10.1016/S0140-6736(13)61089-2)
- International Society for the Prevention of Child Abuse and Neglect [ISPCAN]. (2021). *World perspectives on child abuse* (14th ed.). Aurora, CO: Author.
- Johnston, B. D., Bennett, E., Pilkey, D., Wirtz, S. J., & Quan, L. (2011). Collaborative process improvement to enhance injury prevention in child death review. *Injury Prevention*, 17(Suppl 1), i71–i76. <https://doi.org/10.1136/ip.2010.027334>
- Jones, B., Litzelfelner, P., & Ford, J. (2003). The value and role of citizen review panels in child welfare: Perceptions of citizen review panel members and child protection workers. *Child Abuse & Neglect*, 27(6), 699–704. [https://doi.org/10.1016/S0145-2134\(03\)00107-8](https://doi.org/10.1016/S0145-2134(03)00107-8)
- Kairys, S. W., Alexander, R. C., Block, R. W., Everett, V. D., Hymel, K. P., Johnson, C. F., et al., American Academy of Pediatrics. Committee on Child Abuse and Neglect & Committee on Community Health Services. (1999). Investigation and review of unexpected infant and child deaths. *Pediatrics*, 104(5 Pt 1), 1158–1160. <https://doi.org/10.1542/peds.104.5.1158>
- Krugman, S. D. (2013). Multidisciplinary teams. In R. D. Krugman, J. E. Kobin, & C. Henry Kempe (Eds.), *A 50 Year legacy to the field of child abuse and neglect* (pp. 71–78). Germany: Springer.
- Mantell, D. M., Scharlach, K. M., Iyer, S. K., et al. (2021). State-by-state analysis of child fatality reporting: A 21-year review. *International Journal on Child Maltreatment*, 3, 409–419. <https://doi.org/10.1007/s42448-020-00059-1>
- McCarroll, J. E., Fisher, J. E., Cozza, S. J., & Whalen, R. J. (2021). Child maltreatment fatality review: Purposes, processes, outcomes, and challenges. *Trauma, Violence, & Abuse*, 22(5), 1032–1041. <https://doi.org/10.1177/1524838019900559>
- Miller, J. J., Collins-Camargo, C., Jones, B., & Niu, C. (2017). Exploring member perspectives on participation on child welfare citizen review panels: A national study. *Child Abuse & Neglect*, 72, 352–359. <https://doi.org/10.1016/j.chiabu.2017.08.018>
- National Center for Fatality Review and Prevention [NCFRP]. (n.d.). Child Death Review. Accessed December 1, 2023. <https://ncfrp.org/cdr/>.
- National Center for Fatality Review and Prevention [NCFRP]. (2020). *Best practices in reviewing suicides-national center guidance report*. Michigan Public Health Institute. [https://www.ncfrp.org/wp-content/uploads/Suicide\\_Guidance.pdf](https://www.ncfrp.org/wp-content/uploads/Suicide_Guidance.pdf).
- National Center for Fatality Review and Prevention [NCFRP]. (2021a). *Keeping Kids Alive. Child death review in the United States, 2020*. Michigan Public Health Institute. [https://ncfrp.org/wp-content/uploads/Status\\_CDR\\_in\\_US\\_2020.pdf](https://ncfrp.org/wp-content/uploads/Status_CDR_in_US_2020.pdf).
- National Center for Fatality Review and Prevention [NCFRP]. (2021b). *Fetal & infant mortality review*. Michigan Public Health Institute. <https://ncfrp.org/fimr/>.
- National Center for Fatality Review and Prevention [NCFRP]. (2021c). *More first birthdays: A report on the Status of fetal and infant mortality review in the United States, 2020*. Michigan Public Health Institute. [https://ncfrp.org/wp-content/uploads/Status\\_FIMR\\_in\\_US\\_2020.pdf](https://ncfrp.org/wp-content/uploads/Status_FIMR_in_US_2020.pdf).
- National Domestic Violence Fatality Review Initiative. (n.d.). <https://ndvfrf.org/>.
- Palusci, V. J. (2010). Using Citizen Review Panels to assess child maltreatment fatalities. *APSAC Advisor*, 22, 9–12 (Fall).
- Palusci, V. J., & Covington, T. M. (2014). Child maltreatment deaths in the U.S. national child death review case reporting system. *Child Abuse & Neglect*, 38(1), 25–36. <https://doi.org/10.1016/j.chiabu.2013.08.014>
- Palusci, V. J.; Council on Child Abuse and Neglect; Kay, A. J., Batra, E.; Section on child death review and prevention; Moon, R. Y.; Task Force on Sudden Infant Death Syndrome; National Association of Medical Examiners; Corey, T. S., Andrew, T., & Graham, M. (2019). Identifying child abuse fatalities during infancy. *Pediatrics*, 144(3), e20192076. <https://doi.org/10.1542/peds.2019-2076>.
- Palusci, V. J., Schnitzer, P. G., & Collier, A. (2023). Social and demographic characteristics of child maltreatment fatalities among children ages 5-17 years. *Child Abuse & Neglect*, 136, Article 106002. <https://doi.org/10.1016/j.chiabu.2022.106002>
- Palusci, V. J., Yager, S., & Covington, T. M. (2010). Effects of a citizens review panel in preventing child maltreatment fatalities. *Child Abuse & Neglect*, 34(5), 324–331. <https://doi.org/10.1016/j.chiabu.2009.09.018>
- Parrish, J. W., Schnitzer, P. G., Lanier, P., Shanahan, M. E., Daniels, J. L., & Marshall, S. W. (2017). Classification of maltreatment-related mortality by Child Death Review teams: How reliable are they? *Child Abuse & Neglect*, 67, 362–370. <https://doi.org/10.1016/j.chiabu.2017.03.003>
- Platt, M. W. (2007). Reviewing child deaths. In P. Sidebotham, & P. Fleming (Eds.), *Unexpected death in childhood: A handbook for practitioners* (pp. 205–231). West Sussex, England: John Wiley & Sons, Ltd.
- Rosenman, K. D., Hanna, E. A., Lyon-Callo, S. K., & Wasilevich, E. A. (2007). Investigating asthma deaths among children and young adults: Michigan asthma mortality review. *Public Health Reports*, 122(3), 373–381. <https://doi.org/10.1177/003335490712200311>
- Sanders, C., Fisher-Smith, D., Neill, S., & Jones, M. (2020). Lessons for the future: Reflections on a review of child death overview panels through a local lens in the United Kingdom. *Journal of Child Health Care*, 24(2), 274–296. <https://doi.org/10.1177/1367493519844101>
- Schnitzer, P. G., Covington, T. M., Wirtz, S. J., Verhoek-Oftedahl, W., & Palusci, V. J. (2008). Public health surveillance of fatal child maltreatment: Analysis of 3 state programs. *American Journal of Public Health*, 98(2), 296–303. <https://doi.org/10.2105/AJPH.2006.087783>
- U.S. Advisory Board on Child Abuse and Neglect. (1995). *A Nation's Shame: Fatal child abuse and neglect in the United States. Fifth report*. U.S. Department of Health and Human Services, Administration for Children and Families. <https://eric.ed.gov/?id=ED393571>. (Accessed 1 May 2024).
- U.S. Department of Health & Human Services. (2024). Administration for children and families, administration on children, Youth and families, children's Bureau. *Child maltreatment 2022*. Available from: <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>.
- U.S. Department of Health and Human Services [USDHHS]. (1998). *Establishment of the citizen review panel requirement under the Child Abuse Prevention and Treatment Act (No. ACYF-PI-CB-98-0 1)*. Washington, DC: Government Printing Office. <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/pi9801.pdf>.
- Vadapalli, D. (2017). Citizen review panels in child protection: Misunderstood, neglected, and underutilized. *Children and Youth Services Review*, 79, 539–546. <https://doi.org/10.1016/j.chilyouth.2017.07.008>
- Vincent, S. (2014). Child death review processes: A six-country comparison. *Child Abuse Review*, 23, 116–129. <https://doi.org/10.1002/car.2276>
- Wirtz, S. J., Foster, V., & Lenart, G. A. (2011). Assessing and improving child death review team recommendations. *Injury Prevention*, 17(Suppl 1), i64–i70. <https://doi.org/10.1136/ip.2010.031252>