

MANDATING MULTIDISCIPLINARY REVIEW OF SERIOUS CHILD MALTREATMENT CASES

An Overview of Law and Policy Issues

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In 1996 amendments to the federal Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. '5106a(b)(2)(A), the CAPTA provisions on confidentiality of child protection case information were altered to permit public disclosure (by CPS agencies) of:

*the findings or information about the case of child abuse or neglect which has resulted in a child fatality or **near fatality**.*

Near fatality is later defined in that law as an act that, as certified by a physician, places the child in serious or critical condition.

One purpose of this exemption from **strict child protection record confidentiality requirements** was to encourage (or at least permit) public dissemination of information about the CPS agency's past involvement with and investigative actions and findings related to a child and family **in the most severe of cases**.

Or in other words: What did the CPS agency know, and when did it know it?

Although it's the news media that's most interested in reporting on and making sense of these most sensational of child tragedies, the sharing of CPS information *among professionals* on such cases has, of course, another potential purpose:

To examine the circumstances of a child tragedy and inquire how not only this, but also other potential tragedies, might be prevented.

The prevention of child maltreatment deaths is of course one of the most important purposes of the formal child fatality review team (CFRT) process. But what about examining and preventing not merely child deaths, but also child maltreatment related serious injuries?

How Many Cases of Child Maltreatment Near Fatalities or Serious Injuries Are There?

Although 2001 data from the Children's Bureau National Child Abuse and Neglect Data System (NCANDS) listed a total of 1,225 child maltreatment fatalities that year, **the number of near fatalities is not collected** by NCANDS, nor is the number of children who are severely injured by child maltreatment. It is a reasonable *assumption* that **far more children are hospitalized in serious or critical condition, than die, as a result of parental maltreatment**.

There were 168,278 substantiated child victims of physical abuse in 2001, according to NCANDS. Some unknown (and likely small) percentage of these cases involved victim children

who were hospitalized and listed in serious or critical condition as a consequence of their maltreatment.

The most recent National Incidence Study of Child Abuse and Neglect (NIS-3), based on data collected about ten years ago, reported that the *estimated* number of **_seriously injured_** abused and neglected children essentially quadrupled from 141,700 to **565,000 per year** in the intervening 7 years between the NIS-2 and the NIS-3 (a 299% increase!). These figures represent cases not necessarily known to CPS agencies, but rather actual cases known to professionals in various disciplines.

It may therefore be reasonably suggested that **at least several hundred thousand children a year are seriously injured as a result of child maltreatment**. That is certainly an intimidating number when one considers a need for new interdisciplinary case reviews, **as it represents 100 times the number of child maltreatment deaths reported by CPS agencies**. Clearly, existing child fatality review teams and their members **lack the time and resources** to review all those cases.

However, **the number of children hospitalized as a result of their injuries, and then labeled in serious or critical condition is, I would guess, a much lesser number**. It is those cases -- **situations that necessitate a child's hospitalization and major medical treatment** -- that I contend are **most worthy of identification and special retrospective multidisciplinary inquiry**.

I believe that looking at these non-fatality cases will add an important level of independent and impartial child maltreatment case review that could both:

- a) **Prevent** repeat maltreatment of that specific child, including prevention of a later fatality, and
- b) **Educate** professionals on steps that can be taken to prevent both serious injuries *and* fatalities of other children.

Legal Issues

According to information on state child fatality review teams collected by M. Gabriela Alcalde and Nanette R. Elster in their 2002 report funded by the Centers for Disease Control and Prevention, *Child Fatality Review in the United States: A National Overview*, there were, at that time, at least 8 states where CFRTs already had an authorization, or a mandate, to review cases *other than fatalities*.

These states are:

Maine: Team is called the State Fatality and Serious Injury Panel

Maryland: Team also reviews near fatalities

New Jersey: Team is called the Child Fatality and Near Fatality Review Board

New York: Team also reviews near fatalities resulting from child abuse and neglect

Oklahoma: Team reviews near fatalities and has a process for review of near death cases

Rhode Island: Child Death and Injury Review Teams review cases involving critical injuries

South Dakota: Team reviews near fatality cases

Wyoming: Child Major Injury/Fatality Review Team reviews near fatalities and major injuries to children who at time of injury were in child welfare agency custody

Some states that review near fatality or serious injury cases may do so even though the legislation or regulations establishing the review process make no mention of reviews in other than death cases. However, as can be seen above, **half (4) the states that claim to review these non-fatality cases have these larger functions designated in the title of their team.**

If it is deemed important for a state or local CFRT to review non-fatality cases, then it is **very important for state law to clearly empower the team to review near fatality or serious injury cases.** The primary reason: **HIPPA.** The HIPPA privacy regulations affect the ability of teams to collect and share information needed for case reviews from hospitals and other providers covered by HIPAA. Covered entities under HIPAA may not use or disclose protected health information except as specifically required or permitted by the HIPAA regulations. A key permitted disclosure provision of HIPAA applicable to the CFRT process says that covered entities may disclose protected health information without authorization from the individual (whose records are being sought) to:

*a public health authority that is **authorized by law** to collect or receive such information for the purpose of preventing or controlling injury including but not limited to the reporting of injury and the conduct of public health surveillance, public health investigations, and public health interventions.*

The key words here are authorized by law. If a state or local CFRT, established by or operating under the provisions of a state statute, wishes to expand into looking at non-fatality cases, it may run into HIPAA-related health record access problems unless it is specifically authorized by law to examine these non-fatality situations.

It is also important to note that few states have clearly defined the term near fatality or serious injury in their child maltreatment legislation, or in procedures and protocols that local teams and the state use to review such cases.

Another legal issue affecting team review of non-fatality cases is that these cases are, possibly more than with fatality case review, likely to involve situations where there is **on-going consideration of both criminal and civil intervention** within the family of the seriously injured child. Also, rather than a review process involving (and sometimes led by) coroners or medical examiners, the non-fatality case review may not even involve those individuals. **Their legal ability to conduct a forensic review of a case may be limited to situations where a person has died.** To the extent that it would be helpful for these forensic experts to be involved in child maltreatment near fatality case review, it may be important to consider amending the law to empower such individuals to assist in these cases.

Final Thoughts

It is hoped that there will be interest among funding sources and state legislatures, in expanding the process of comprehensive examination of child maltreatment cases from fatalities to non-fatal severe harm inflicted on children. Such a coordinated, multidisciplinary inquiry into such situations (**case surveillance**) is critical so that a group of incredibly vulnerable children, who may now not get such attention unless they die, will have their cases effectively studied. There is, in fact, one federal program to support such expanded efforts. The National Center for Injury Prevention and Control of the U.S. Centers for Disease Control and Prevention funded five state health departments to implement mortality **and morbidity** (i.e., non-fatal) **child maltreatment case surveillance**. California, Michigan, Minnesota, Missouri, and Rhode Island are comparing alternative approaches to state-level case data collection and review for fatal and non-fatal child maltreatment. According to CDC, these programs will address a pressing need for a practical surveillance system in child maltreatment cases that can be implemented at the state level.

Data that could be used for such case surveillance include: **hospital data, child protective services data, FBI/police data, child fatality review data, and medical examiner or coroner data**. As such demonstrations of new data collection and analysis continue, much can be learned from the experiences of states that systematically examine non-fatality child maltreatment cases in a multidisciplinary manner.

The author welcomes comments on this, at davidsonha@staff.abanet.org