WHO GETS KILLED IN AMERICA?

The National Violent Death Reporting System is Keeping Track

In 2014, over 42,000 US residents killed themselves, and another 16,000 were murdered, making violent death a critical an important public health problem.[1] The National Violent Death Reporting System, or NVDRS, is a one-stop source of information on suicides, homicides, unintentional fatal shootings and law enforcement-related fatalities (excluding executions), including who the victims are and when, where and how they were injured. It was begun by the Centers for Disease Control and Prevention in 2002, with data from just six states. As of 2017, it tracks violent deaths in 40 states, the District of Columbia and Puerto Rico and aims to expand to all 50 states and U.S territories. What makes the NVDRS so valuable to policy-makers, health authorities, law enforcement agencies, researchers and advocacy groups is its status as the only state-based, active surveillance system that merges, standardizes and anonymizes data from multiple sources to provide a rich, detailed picture of violent death in America.

EACH STATE SUBMITS INFORMATION FROM FOUR CORE SOURCES:

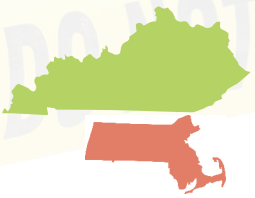
- Death certificates (e.g., victim's sex, age, race, residence, marital status)
- Medical examiner/coroner reports (e.g., cause of death, current health conditions)
- Law enforcement records (e.g., circumstances of death, information on suspected perpetrator)
- Crime laboratories (e.g., toxicology reports)

Some states also report information from child fatality reviews, domestic violence fatality reviews or other records. Altogether, the NVDRS may provide information on more than 270 data elements for each incident, including: the victim's pregnancy status, homeless status and military status; other crimes committed alongside homicide; the relationship of victim to suspect; and whether the death occurred in a single-victim or multiple-victim incident.

Over the years, NVDRS data have been used to inform and evaluate numerous interventions to prevent violent death and its consequences, such as the Alaska Suicide Prevention Plan and a Utah effort to increase referrals to the state Department of Children and Family Services following violent deaths in homes with children.[5]

NVDRS data from 2013, for example, reveal that:[2]

There were 36 incidents of multiple victim violence in Virginia, including 19 homicides followed by suicide.



The rate of homicide in Kentucky (4.21/100,000 population was almost twice that of Massachusetts (2.16/100,000).

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In addition to monitoring where and how often violent deaths happen, the NVDRS provides a closer look at trends surrounding the circumstances of violent death.

Foreclosure-related suicides more than tripled during the US housing crisis from 2005 to 2010

Intimate partner violence extends beyond the couple involved. About 20 percent of homicide victims in cases of intimate partner violence are what are known as corollary victims, such as the primary victim's family members, friends, acquaintances and new intimate partners, as well as police officers and strangers.

Suicide was the leading cause of death among Alaskans ages 15-44 during 2009-2013. Altogether, 21 percent of Alaskans who took their lives during this five-year period were active or discharged US military personnel.

Mental illness and job stress may explain why some physicians die from suicide. This finding helps to explain why the rate of suicide is higher among physicians than the general public.

Fully 78 percent of the 147 Utah children directly exposed to a homicide in 2003-2008 were 5 years old or younger.

About two thirds of child maltreatment fatalities in children under age 5 are due to abusive head trauma, 27.5 percent due to other types of physical abuse and 10 percent due to neglect. More than half of these deaths occur among children younger than 1.

The most common precipitating factors for suicide deaths among youth aged 10-17 are relationship problems, recent crises, mental health problems and school problems. Most of these suicide victims are males, and bullying is a factor in about 12 percent of cases.

LAW ENFORCEMENT AND PUBLIC HEALTH — A CRUCIAL NVDRS PARTNERSHIP

Each state's Violent Death Reporting System, or VDRS, is overseen by a multidisciplinary advisory group, typically including coroners/medical examiners, crime lab scientists, state department of justice personnel, health officials and others. In addition, states work with police departments in various ways to improve the data-sharing that is critical to NVDRS success. Both Oregon and Colorado, for example, engage retired law enforcement officers to help collect police data.[9] The Oklahoma VDRS funds the State Bureau of Investigation to provide a full time officer to collect and enter data from police sources.[9] Other states convene broader stakeholder meetings that include police representation.

At the national level, CDC has central coordinating responsibility for the NVDRS, and maintains relationships with the Federal Bureau of Investigation, US Bureau of Alcohol, Tobacco, Firearms and Explosives, and other national law enforcement authorities. It also reaches out to non-governmental organizations, such as the International Association of Chiefs of Police.

By fostering closer ties between public health and law enforcement, the NVDRS helpfully broadens each community's perspective on violent crime. Public health, for example, treats violence as a contagious disease and works to address the risk factors that can predispose individuals to homicide, suicide or other acts of violence.[10] Public health officials can also mobilize support for violence prevention efforts from groups beyond the typical scope of law enforcement agencies. Law enforcement, on the other hand, recognizes that all crime — even a nonviolent offense — has the potential to increase fear and violence, if only by disrupting healthy community relations and diminishing social capital.[11]

Yet law enforcement officials may not immediately recognize how public health, and NVDRS data in particular, can further their mission. In fact, NVDRS data are being used in several states to do just that.

The Kentucky VDRS has enabled state police, for the first time, to link and cross tabulate violent death data, such as homicide victim characteristics and toxicology test results.[9] New Jersey county prosecutors use the state's VDRS to assess compliance with a mandate requiring the reporting of all suicides and suspicious deaths to their offices.[9] And Massachusetts VDRS data is being used to alert communities near urban cores about changes in patterns of violent death, so they can plan ahead to curb the spread of certain crimes.[9]

A CALL TO ACTION

To assure the most comprehensive picture of violent death in America, greater public health/law enforcement collaboration is necessary. In addition to maintaining strong ties between health and law enforcement authorities, states can foster collaboration by addressing common data-sharing barriers: lack of interoperable information systems with rigorous privacy and security safeguards; use of differing terminology (e.g., public health *surveillance* versus police *surveillance*); and legal strictures that limit the sharing of confidential information.[9] One solution, for example, is the use of memoranda-of-agreement to promote cross-agency partnerships.

Ultimately, the value of the NVDRS stems from the quality and completeness of the data in the system. To maximize that value, stakeholders must be aware of the usefulness of the NVDRS and actively contribute to it.

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