

# California Fatality and Near Fatality Annual Report Calendar Year 2009

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The California Department of Social Services  
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## I. Introduction

This report is prepared pursuant to Senate Bill (SB) 39 (Chapter 468, Statutes of 2007). SB 39 and the Welfare and Institutions Code section 10850.4(j), require a county welfare department or agency to notify the California Department of Social Services (CDSS) of every child fatality that occurred within its jurisdiction that was the result of child abuse and/or neglect. The determination that abuse and/or neglect resulted in the child's death can be made by the coroner/ medical examiner, law enforcement, and/or the Child Welfare Services (CWS)/Probation agency. SB 39 also requires the CDSS to annually issue a report identifying the child fatalities and any systemic issues or patterns revealed by the notices submitted by the counties and any other relevant information in the Department's possession.

In addition, the CDSS has also incorporated near fatality information into this report to enable a thorough understanding of those children as well, and while not a requirement of the Child Abuse Prevention and Treatment Act (CAPTA), the CDSS also integrates information from this report as part of the state's Title IV-B Annual Progress and Services Report. This is an additional source of information that is available to the public regarding fatalities and near fatalities that occur in California.

In implementing the disclosure and reporting mandates of SB 39 and CAPTA, the CDSS developed and adopted the SOC 826 County Statement of Findings and Information form. This form is the mechanism that a county CWS agency uses for notifying the CDSS of a fatality or near fatality that was determined to be the result of abuse and/or neglect. For purposes of reporting near fatalities, a near fatality is defined as a severe childhood injury or conditions caused by abuse or neglect which results in the child receiving critical care for at least 24 hours following the child's admission to a critical care unit(s).

During Calendar Year (CY) 2009, the CDSS adopted both emergency and final regulations that incorporated the SOC 826 form and provided instruction to counties as to their reporting and disclosure mandates under SB 39 for fatality incidents and applied them to near fatality incidents to ensure CAPTA compliance. Together these new mandates have greatly improved child fatality and near fatality reporting by CWS agencies.

The report that follows provides an analysis of the data compiled from those SOC 826 forms submitted by CWS agencies for child fatalities and near fatalities which occurred in CY 2009 and were determined to be the result of abuse and/or neglect, as of December 3, 2010. Despite having a cut-off date for inclusion in this annual report, the CDSS continues to accept SOC 826 forms for incidents that occurred in CY 2009 and the identification of those forms will be included in the subsequent year's report.

The CDSS gathered additional information for each of the reported incidents from the Child Welfare Services/Case Management System (CWS/CMS) and Safe Measures (a quality-assurance computer application that provides CWS case information) in an effort to gain a broader understanding of the reported incidents and the children and families involved.

While rich in additional information, this report does not alter the fact that the SOC 826 submission is the federally approved manner of meeting the public disclosure requirements of CAPTA (42 U.S.C. § 5106). The CY 2009 report will be available on the CDSS Website.

## **II. Update of Calendar Year 2008 Data**

The number of fatalities and near fatalities in the 2008 Annual Report, issued in May 2010, represented the total number of SOC 826 forms submitted to the CDSS as of November 30, 2009. At that time, there were 114 reported child fatalities and 91 near fatalities. Between the date the 2008 report was issued and December 3, 2010 (the cut-off date for this report), the CDSS identified an additional six SOC 826 forms, bringing the total for CY 2008 to 120 child fatalities. Of the six additional child fatalities, one child resided in an out-of-home placement/foster care at the time of the fatality, bringing the total children residing in out-of-home placements/foster care to six cases for CY 2008, from five as previously reported (see page 19 of 2008 Annual Report). The number of near fatalities remains at 91.

These additional cases represent five percent of all fatalities reported in CY 2008. In the review of these cases, the information collected was consistent with the data patterns reported for that year; therefore no further analysis is being provided.

### III. Analysis of Calendar Year 2009 Data

#### Background

The data included in this report, is for all child fatalities and near fatalities reported to the CDSS via the SOC 826 form for CY 2009. The number of fatalities and near fatalities reported represents the total number of SOC 826 forms submitted by a “point-in-time,” which, for this year was December 3, 2010. Although the CDSS needed to select a cut-off date to ensure timely distribution of the annual data in this report, it is recognized that counties may continue to determine causes of fatalities/near fatalities that occurred in CY 2009. As such, any SOC 826 forms submitted after December 3, 2010 will be summarized in the next year’s report.

The analysis that follows for child fatalities and near fatalities that occurred in CY 2009 focuses on providing an understanding of a number of data elements. The data elements are as follows: whether there was prior involvement of these children and their families with the CWS system, what age, ethnicity/race, and gender groups were most vulnerable to child fatalities and near fatalities resulting from abuse and/or neglect, the number of fatalities and near fatalities that were caused by abuse versus neglect, the cause of such child fatalities and near fatalities, and what factors contributed to the findings or cause of the child fatalities and near fatalities, which were reported. In addition, the data is further broken out into subsets of children age four and younger. While these subsets are depicted graphically, data for all age groups can be found throughout the narrative of this report. Attached to this report is the total population of children in the State of California for 2008, a copy of the SOC 826 form and a Glossary.

#### **Methodology:**

It is important to note that the data compiled for this report only represents those child fatalities and near fatalities for which all of the following occurred: 1) the CWS agency became aware of the fatality or near fatality, 2) the fatality or near fatality was determined to be the result of abuse and/or neglect, and 3) the fatality or near fatality was reported to the CDSS via the SOC 826 form. As a result, the data only represents a subset of a larger population of children who died in California during CY 2009.

Once the SOC 826 form is submitted to the CDSS, staff reviews information in CWS/CMS regarding the incident. The information is then collected and entered in aggregate for further analysis. While there is a reconciliation process in place to ensure the SOC 826 forms that will be used for analysis meet the criteria for submission, the resulting aggregate data obtained from CWS/CMS is not reconciled with the counties before this report is generated.

It is important to note, in analyzing the data, the CDSS used a rounding up methodology and as such, the total percentages cited may not equal 100 percent. Additionally, if an incident was reported by a county as both a near fatality and a fatality, the CDSS accounted for that incident in the aggregate fatality data information, to avoid any misrepresentation of the actual number of fatality and near fatality incidents that were the result of abuse and/or neglect. This type of incident was not reflected in the numbers for near fatalities. Similarly, if a single fatality incident was reported more than once, the incident was only accounted for once in the fatality data information.

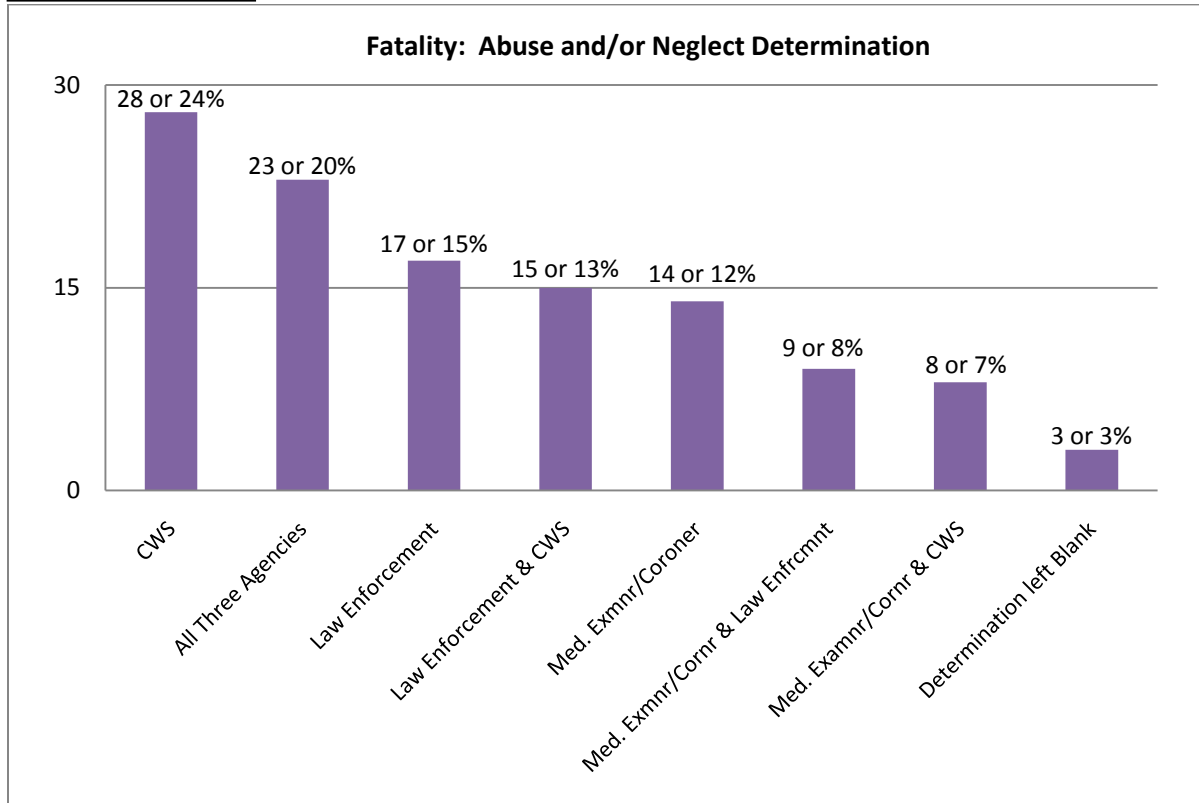
## General Information

For CY 2009, California CWS agencies reported 117 child fatalities determined to be the result of abuse and/or neglect, of which, 111 children were reported to have resided in the home of the parent/guardian and six were reported to have resided in an out-of-home placement or foster care. These numbers do not vary greatly from the CY 2008 report where 114 fatalities were reported and 109 children resided in the home of the parent/guardian and five resided in out-of-home placement or foster care.

Of these incidents reported, Chart A depicts which agency made the determination that the child's death was the result of abuse and/or neglect. In 28 of the 117 child fatality cases (24 percent), the determination was made by the CWS agency; in 23 cases (20 percent) the determination was made by all three agencies; in 17 cases (15 percent) the determination was made by law enforcement; in 15 cases (13 percent) the determination was made by law enforcement and the CWS agency; in 14 cases (12 percent) the determination was made by the medical examiner/coroner; in nine cases (eight percent) the determination was made by law enforcement and the medical examiner/coroner; in eight cases (seven percent) the determination was made by the medical examiner/coroner and the CWS agency and in three cases (three percent) the determining agency was left blank on the SOC 826.

While all three agencies, CWS, Law Enforcement, and Medical Examiner/Coroner, can determine a fatality to be the result of abuse and/or neglect, in CY 2009 about a quarter of the incidents were determined by CWS alone.

**CHART A**

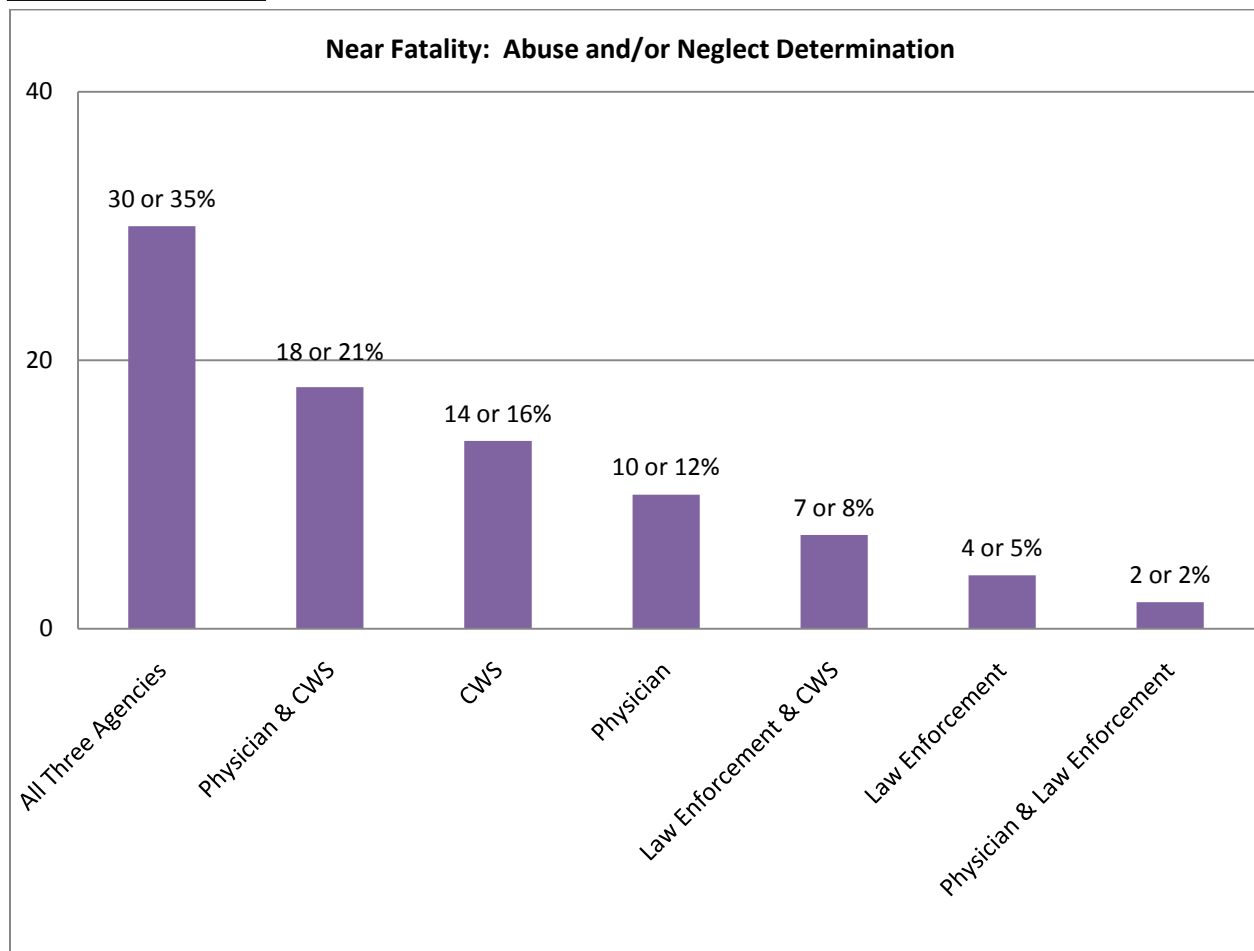


With respect to near fatalities, California CWS agencies reported 85 child near fatalities in CY 2009, determined to be the result of abuse and/or neglect. In all of the 85 near fatalities, the children resided in the home of the parent/guardian. The reported incidents for 2009 reflect a slight decrease from the CY 2008 report when 91 near fatalities were reported, and in 88 of those reports, children resided in the home of the parent/guardian.

Of these incidents reported, Chart B depicts which agency made the determination that the child's near fatality was the result of abuse and/or neglect. In 30 cases (35 percent) the determination was made by all three agencies; in 18 of the near fatality cases (21 percent) the determination was made by a physician and the CWS agency; in 14 cases (16 percent) the determination was made by the CWS agency; in ten cases (12 percent) the determination was made by a physician; in seven cases (eight percent) the determination was made by law enforcement and the CWS agency; in four cases (five percent) the determination was made by law enforcement; and in two cases (two percent) the determination was made by law enforcement and a physician.

Unlike fatalities reported for CY 2009, over a third of the near fatalities reported were determined to be abuse and/or neglect by CWS, Law Enforcement and a Physician.

### CHART B



## What is Known about Child Welfare Services Involvement at the Time of Critical Incident

### Fatalities

In reviewing the 117 notifications for child fatalities that were the result of abuse and/or neglect submitted by counties for CY 2009, the data shows that 56 percent of the families had no prior CWS history in the last five years. For those families that did have prior CWS history, the reader should keep in mind that prior CWS history does not necessarily mean that a child or family had an open CWS case or referral at the time of the incident. In many cases, the prior CWS history included referrals that were determined to be unfounded, inconclusive, or evaluated out. Additionally, the prior CWS history may not have included the child who was the subject of the fatality nor the same household composition at the time of the fatality.

The breakdown for the 117 child fatality cases included 65 families (56 percent) that had no prior CWS history in the last five years and 52 families (44 percent) which were previously known to a CWS agency (see Chart C). CWS agency involvement at the time of fatality in those 52 families can be found below in Table 1.

**Table 1**

36	Not a current client of a CWS agency (but had prior history)
6	Open Emergency Response Referral
5	Children were placed out-of-home with an open case receiving services
4	Children were living in the home of the parent or guardian with an open child welfare case
1	Other <sup>1</sup>

For children less than one year of age, 25 of the 46 cases (56 percent), the family had no prior CWS history in the past five years, at the time of the critical incident. Of the 21 cases where the child or family was previously known to a CWS agency, 13 families (62 percent) were not current clients of a CWS agency, in three cases (14 percent), the child was living in the home of his/her parent(s) and receiving services, three families (14 percent), had an open Emergency Response (ER) referral, and in two cases (ten percent), the children were living in an out-of-home placement and receiving services at the time of fatality.

For children in the one- to four-year-old age group, in 22 of the 49 cases (45 percent), the family had no prior CWS history in the past five years, at the time of the critical incident. Of the 27 cases where the child or family was previously known to a CWS agency, 22 families (81 percent), were not current clients of a CWS agency, three cases (11 percent), the children were living in an out-of-home placement and receiving services, one family (four percent), had an open ER referral, and in one case (four percent), the child was living in the home of his/her parent(s) and receiving services at the time of fatality.

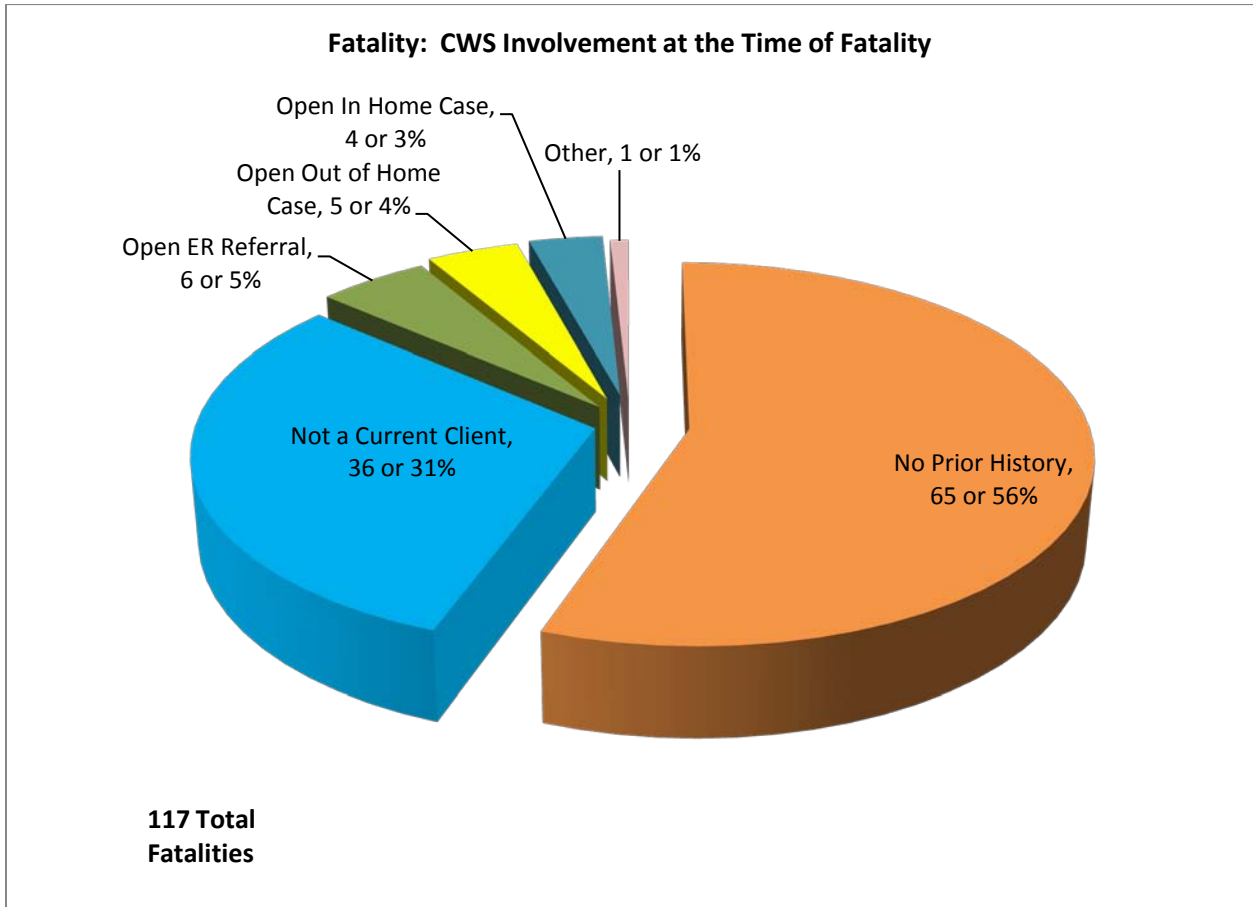
For children in the five- to 17-year-old age group, in 14 of the 22 cases (64 percent), the family had no prior CWS history in the past five years, at the time of the critical incident. Of the eight cases where the child or family was previously known to a CWS agency, five families (63 percent), were not current clients of a CWS agency, two families (25 percent), had an open ER referral, and one case (13 percent), was categorized as "Other" (see footnote).

<sup>1</sup> Cases where more than one category applied was marked "Other."



Families, in over half of the fatality incidents reported for CY 2009, did not have any prior involvement with CWS at the time of the incident. More than a third of the families had previous history with CWS, but were not current clients at the time of the incident.

### CHART C



## Near Fatalities

In reviewing the 85 notifications submitted by counties for child near fatalities that were determined to be the result of abuse and/or neglect, the data shows that 59 percent of the families had no prior CWS history in the past five years. Again, the reader is cautioned to keep in mind that prior CWS history does not necessarily mean that a child or family had an open CWS case or referral at the time of incident. In many cases, the prior CWS history included referrals that were determined to be unfounded, inconclusive, or evaluated out. Additionally, the CWS history may not have included the child who was the subject of the near fatality nor have the same household composition at the time of the near fatality.

The breakdown for the 85 near fatality cases included 50 families (59 percent) that had no prior CWS history in the past five years and 35 families (41 percent) which were previously known to a CWS agency (see Chart D). CWS agency involvement at the time of near fatality in those 35 families can be found below in Table 2.

**Table 2**

25	Not a current client of the CWS agency
5	Open ER Referrals
5	Children living in the home of the parent/guardian with an open child welfare case

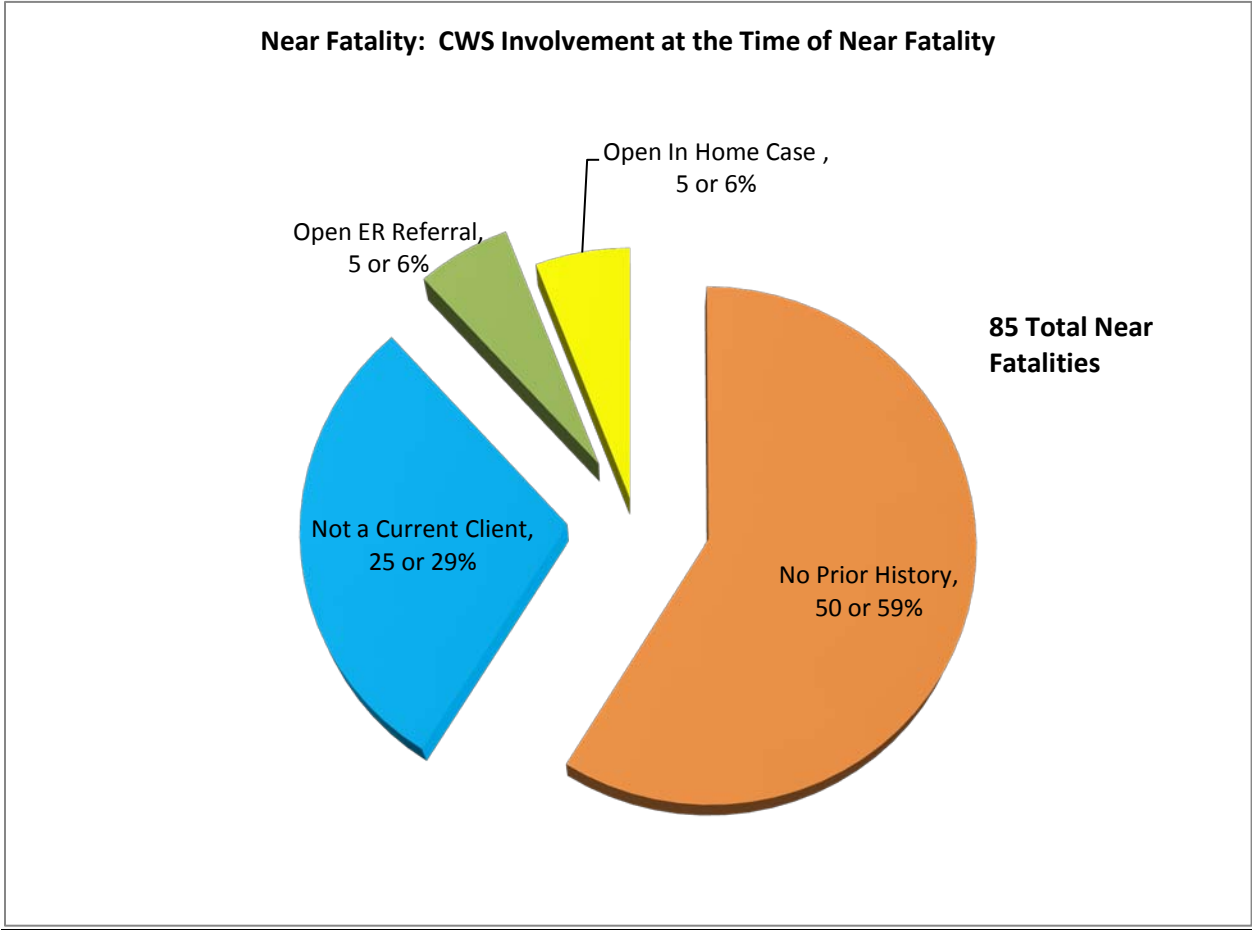
For children in the less than one year-old age group in 35 of the 45 cases (78 percent), the family had no prior CWS history in the past five years at the time of the critical incident. Of the remaining ten near fatality cases, six families (60 percent) were previously known to a CWS agency but not receiving services at the time of the near fatality; three families (30 percent), had an open ER referral, and in one case (ten percent), the child was living at home and receiving services at the time of the near fatality.

For children in the one- to four-year-old age group, in 13 of the 31 cases (42 percent), the family had no prior CWS history in the past five years, at the time of the critical incident. Of the remaining 18 near fatality cases in this age group, 14 families (78 percent), were previously known to a CWS agency but not receiving services at the time of the near fatality, and in four cases (22 percent), the children were living at home and receiving services at the time of the near fatality.

For children in the five- to 17-year-old age group, in two of the nine cases (22 percent), the family had no prior CWS history in the past five years, at the time of the critical incident. Of the remaining seven near fatality cases, five cases (71 percent) included a member of the household that was previously known to a CWS agency but not receiving services at the time of the near fatality, and two families (29 percent), had an open ER referral.

Families, in over half of the near fatality incidents reported for CY 2009, had no prior involvement with CWS at the time of the incident. About one third of the incidents had previous involvement with CWS, but were not current clients at the time of the incident.

**CHART D**



## **What Groups of Children are Victims of Abuse and/or Neglect Related Fatalities and Near Fatalities**

A comprehensive analysis of the data for age, gender and ethnicity/race for child fatalities and near fatalities determined to be the result of abuse and/or neglect that occurred during CY 2009, can only be made in conjunction with a view of the information available for the general child population. For this report, the age, gender and ethnicity/race of California's child population during 2008<sup>2</sup> was used for analysis. This can be found as Attachment A, at the end of this report.

As can be seen from Attachment A, the largest percentage of the child population was under five, at 28 percent. There was not a great margin between the below five age group, the five- to nine-year-old age group and the ten- to 14-year-old age group. The ten- to 14-year-old age group comprised 27 percent of the total child population and the five- to nine-year-old age group comprised 26 percent of the total child population. Children between the ages of 15- to 17-year-old age group comprised 19 percent of the total child population.

With respect to ethnicity/race, the Hispanic population represented 50 percent of the total child population. In the under five age group, Hispanic children represented 52 percent of the child population, while White children represented 27 percent and Black children represented five percent. With respect to gender, in the overall population of all children under age 18, 51 percent were male and 49 percent were female. Of the 5,107,736 male children in California, 1,409,715 (28 percent) were under the age of five. Similarly, of the 4,879,624 female children in California, 1,344,584 (or 28 percent) were under the age of five.

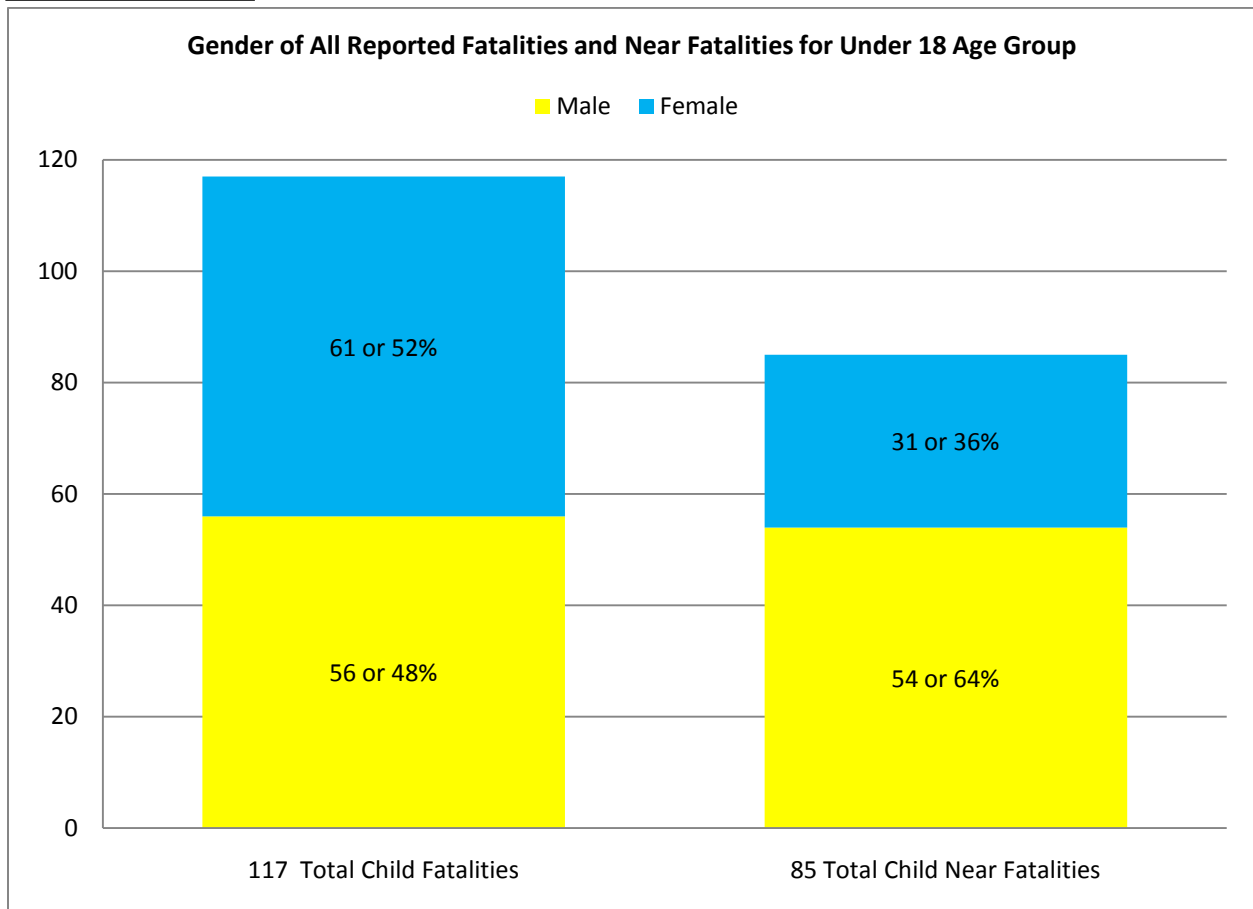
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<sup>2</sup> The 2008 general child population for California was the most recent data available at the time this report was written.

## Child Fatalities/Near Fatalities: Gender

Chart E (below) provides an overall summary of the gender of all of the children under age 18 that were victims of fatalities or near fatalities determined to be the result of abuse and/or neglect in CY 2009. The number of female child fatalities was higher than male child fatalities. For near fatalities, the number of incidents involving males was greater than the number involving females. The following sections offer a more detailed analysis of the age, gender and ethnicity/race for the reported fatality and near fatality incidents.

### CHART E

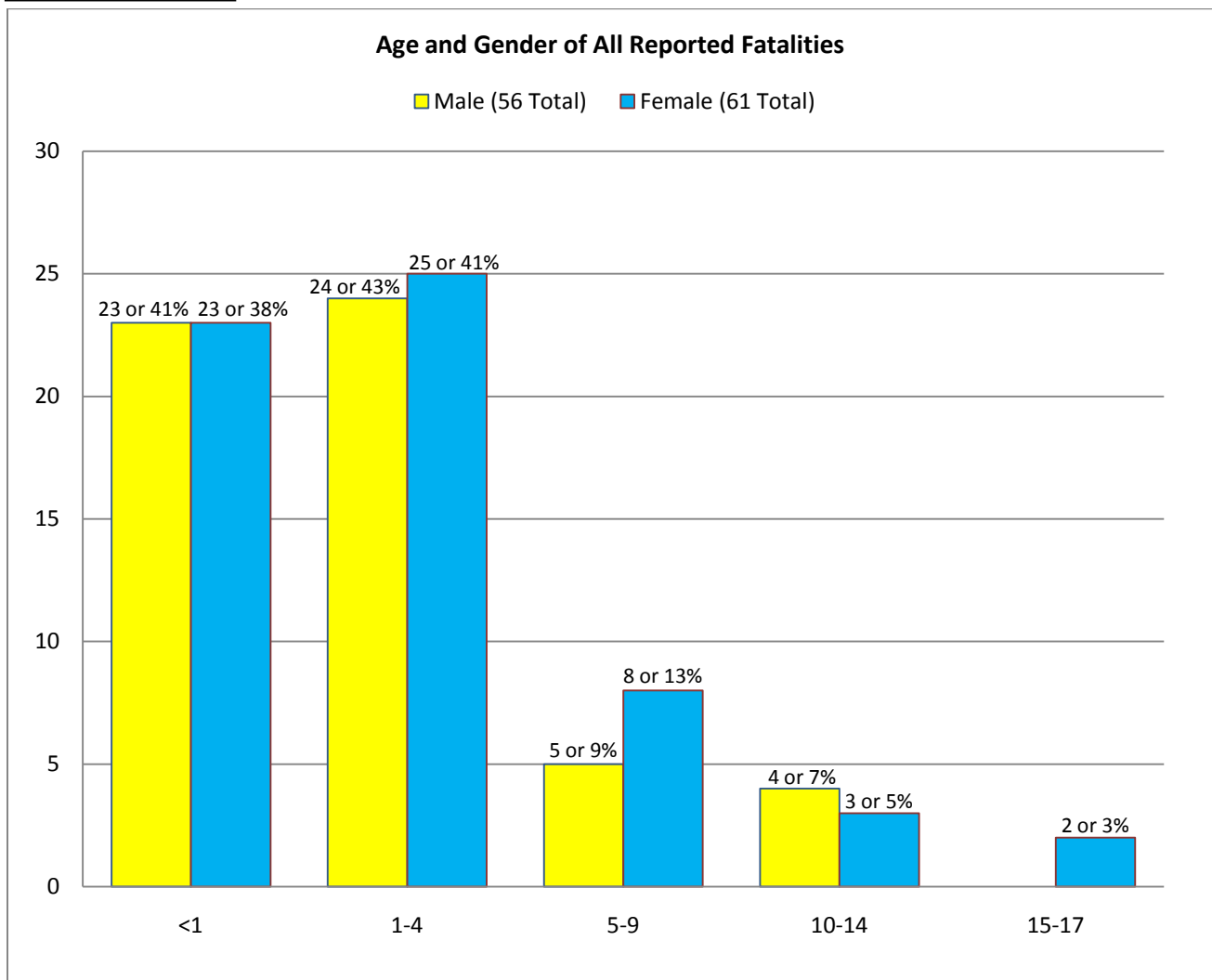


## Child Fatalities: Age and Gender

California CWS agencies reported 117 child fatality cases that were determined to be the result of abuse and/or neglect during CY 2009. The data gathered for these cases indicates the most vulnerable population were children ages four and younger. In fact, 95 of the 117 child fatality cases (81 percent) were children four years of age and younger. Of those, 46 children were less than one year-old and 49 children were between the ages of one and four. The remaining 22 (19 percent) child fatality cases were in the five- to 17-year-old age group. Overall, the number of female child fatalities was slightly higher than the number of male child fatalities, 61 (52 percent) compared to 56 (48 percent) for all age groups.

For CY 2009, families with children under five were four times more likely to be a victim of a fatality incident, and female children were victims in more fatality incidents than male children. Chart F depicts the differences found across age groups between male and female reported child fatalities.

**CHART F**

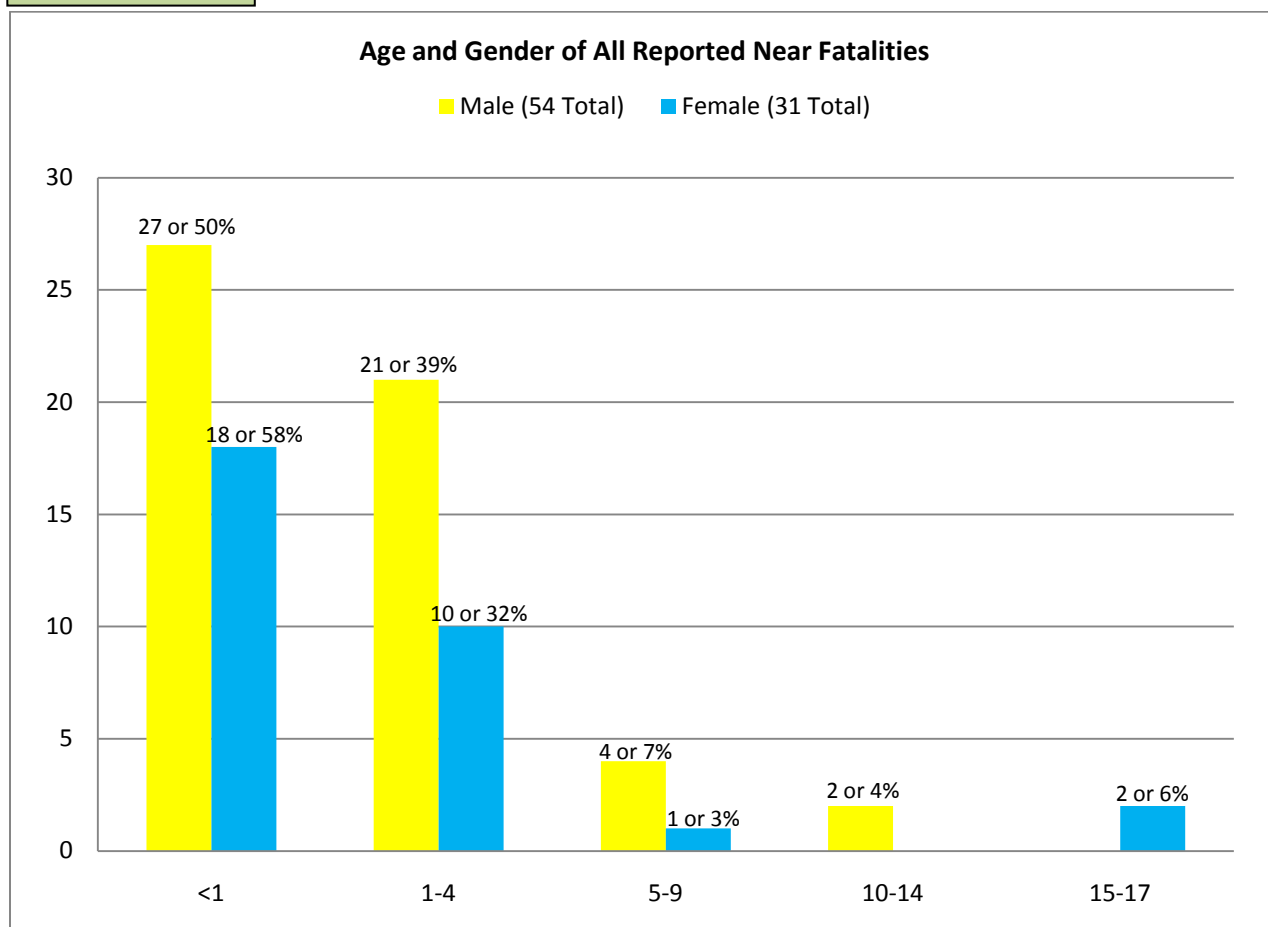


## Child Near Fatalities: Age and Gender

California CWS agencies reported 85 child near fatality cases that were determined to be the result of abuse and/or neglect during CY 2009. The data gathered with respect to age for child near fatality cases reflected the data for child fatality cases. Greater incidences of child near fatalities occurred in the youngest populations. Seventy-six of the 85 child near fatality cases (89 percent) were children four years of age and younger. Forty-five children were less than one year-old and 31 children were between the ages of one and four. The remaining nine cases (11 percent) were in the five- to 17-year-old age group.

The data with respect to gender was different than that found for child fatalities. Overall, the number of male child near fatality cases reported was higher than the number of female near fatality cases, 54 incidents compared to 31 incidents, for all children under 18 in the near fatality group (see Chart G). The breakdown for gender in the less than one year-old age group was 27 males and 18 females. By comparison, the numbers of near fatalities in the one- to four-year-old age group were 21 males and ten females. As Chart G depicts, these two age groups show the greatest difference between males and females.

**CHART G**



## **Child Fatalities and Near Fatalities: Ethnicity/Race**

With respect to ethnicity/race for the total 117 child fatalities reviewed that were determined to be the result of abuse and/or neglect, the data shows that Hispanic children had more fatalities than any other single ethnicity/race. It should also be noted that overall, the Hispanic population of children was higher in the general child population in California for 2008 at 50 percent of the total population (see Attachment A).

The data gathered for the 117 child fatality cases shows 49 of the children (42 percent) were Hispanic, 28 of the children (24 percent) were Black, 24 of the children (21 percent) were White, seven of the child fatality cases (six percent) the ethnicity/race of the child was unknown or not documented, six of the children (five percent) were categorized as "Other," and three children (three percent) were Asian. Chart H depicts the ethnicity/race of all of the child fatality and near fatality cases reported for CY 2009.

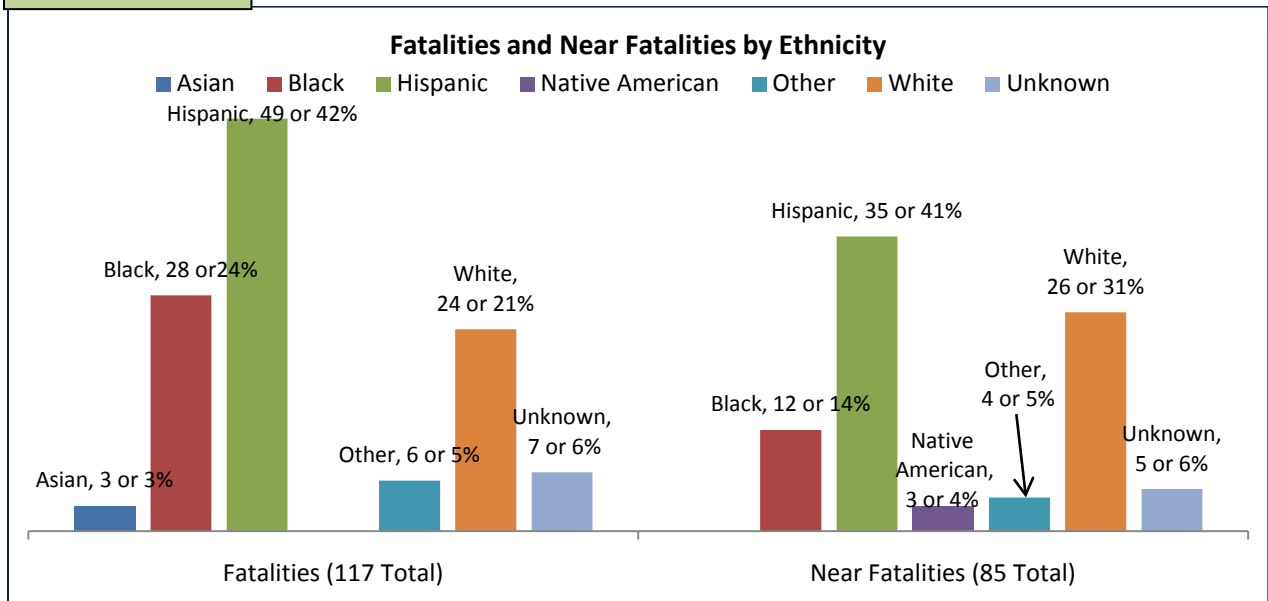
With respect to ethnicity/race in the 85 child near fatalities reviewed that were determined to be the result of abuse and/or neglect, the data shows that Hispanic children had more near fatalities than any other single category of ethnicity/race. Again, it should be noted there was also a higher percentage of Hispanic children in the general population in California.

Of the 85 child near fatality cases, 35 of the children (41 percent) were Hispanic, 26 of the children (31 percent) were White, 12 of the children (14 percent) were Black; five children (six percent) the ethnicity/race of the children was unknown or not documented, four children (five percent) were documented as "Other" and three children (four percent) were Native American (see Chart H for ethnicity/race of the total near fatality cases).



For both fatality and near fatality incidents reported in 2009, Hispanic children were more likely to be victims of a fatality or near fatality, which coincides with their representation of the overall child population. Black children represented only six percent of the child population, but 24 percent of child fatalities and 14 percent of the near fatalities reported. White children represented 29 percent of the child population, but were 21 percent of child fatalities reported and 31 percent of the near fatalities reported.

**CHART H**

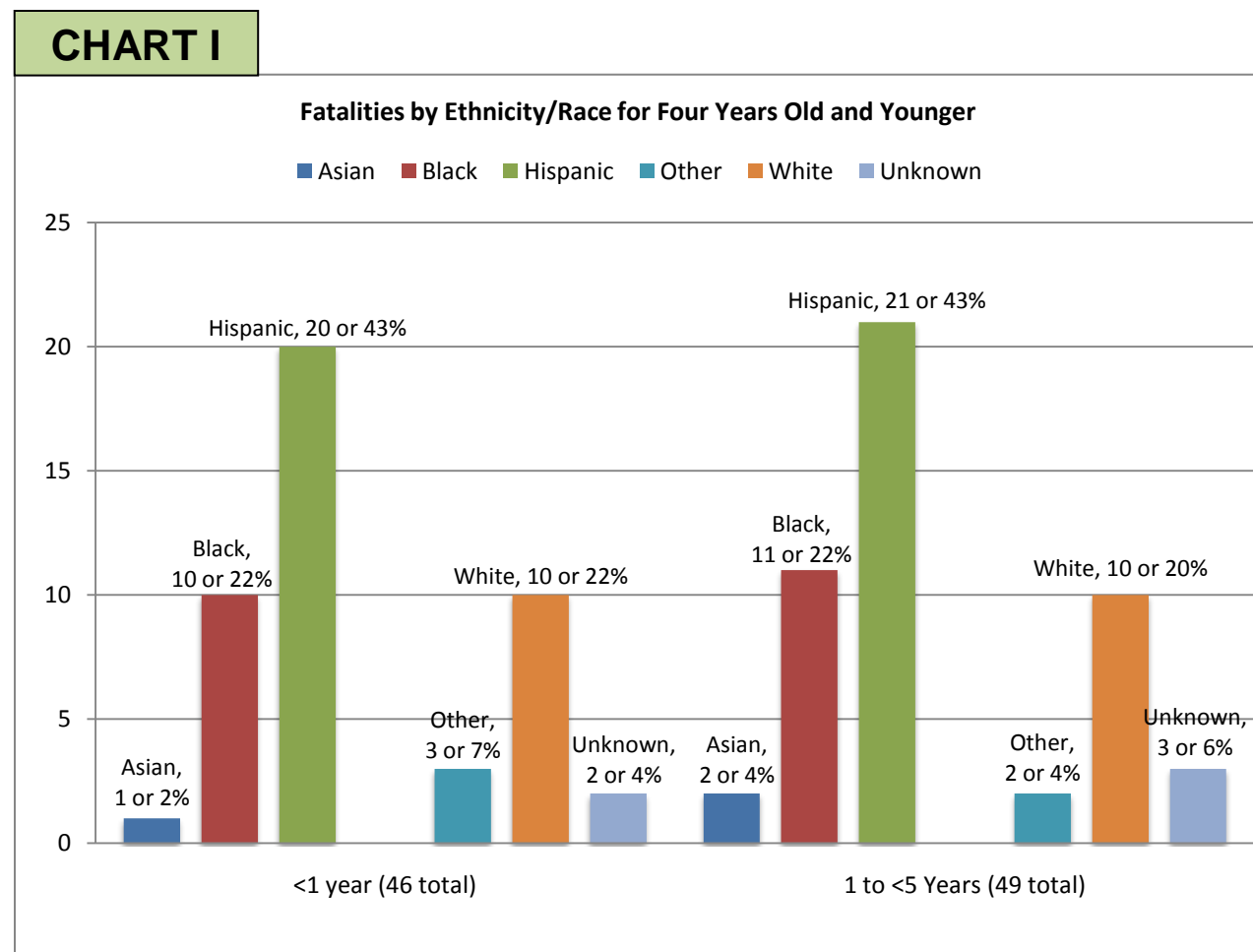


## Child Fatalities: Age Groups & Ethnicity/Race

Of the 46 child fatality cases in the less than one year-old age group, 20 children (43 percent) were Hispanic, ten children (22 percent) were Black, ten children (22 percent) were White, three children (seven percent) were categorized as “Other,” for two children (four percent) the ethnicity/race was unknown or not documented, and one child (two percent) was Asian. Chart I depicts the ethnicity/race of child fatality cases for children four years old and younger.

Of the 49 child fatality cases in the one- to four-year-old age group, 21 children (43 percent) were Hispanic, 11 children (22 percent) were Black, ten children (20 percent) were White, for three cases (six percent) the ethnicity/race of the child was unknown or not documented, two children (four percent) were Asian, and two children (four percent) were categorized as “Other.”

Of the 22 remaining cases for the five- to 17-year-old age group, the cases were categorized as follows: eight children (36 percent) were Hispanic, seven children (32 percent) were Black, four children (18 percent) were White, two children’s (nine percent) ethnicity/race was unknown or not documented, and one child (five percent) was categorized “Other.”



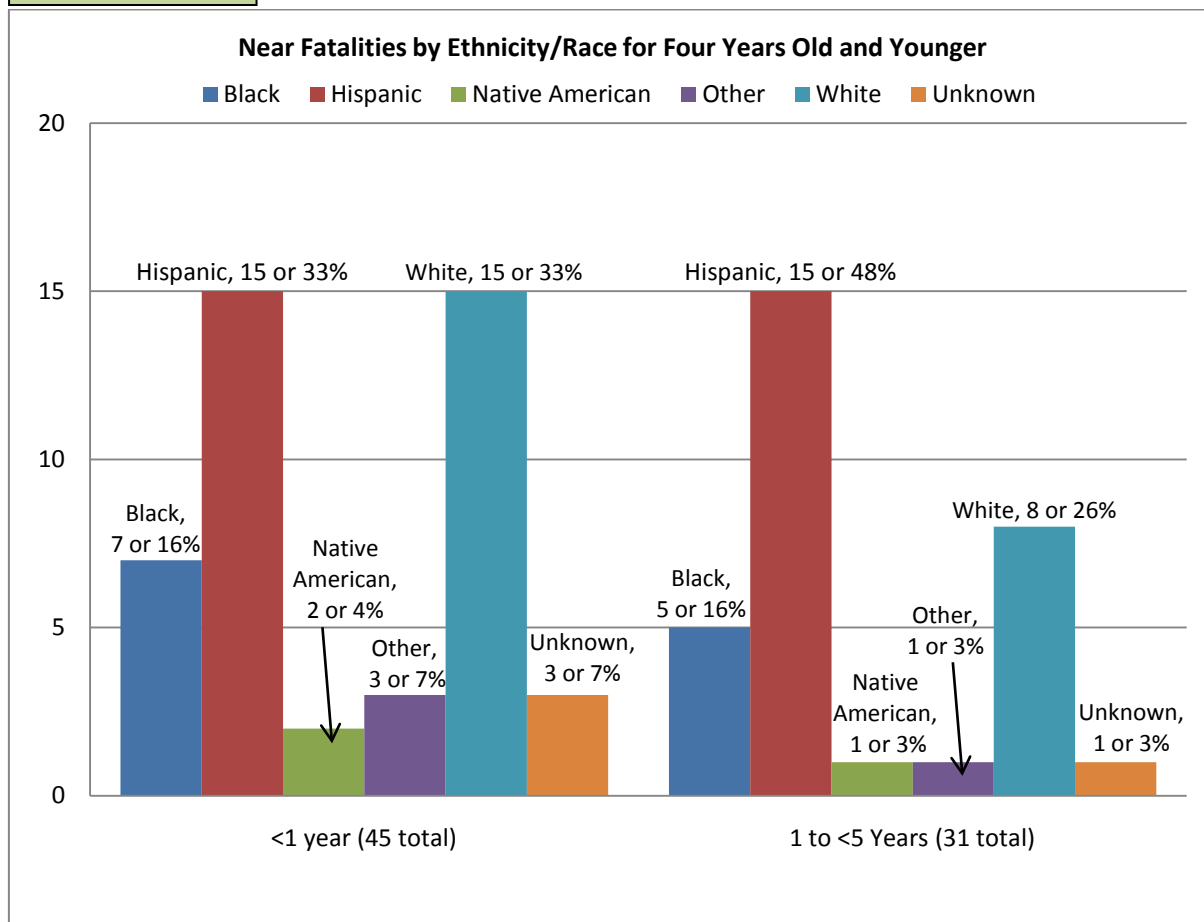
## Child Near Fatalities: Age Group & Ethnicity/Race

Of the 45 near fatality cases in the less than one year-old age group, 15 children (33 percent) were Hispanic, 15 children (33 percent) were White, seven children (16 percent) were Black, for three children (seven percent) the ethnicity/race was unknown or not documented, three children (seven percent) were documented as “Other,” and two children (four percent) were Native American. Chart J depicts the age and ethnicity/race for near fatality cases for children ages four years old and younger.

Of the 31 near fatality cases in the one- to four-year-old age group, 15 children (48 percent) were Hispanic, eight children (26 percent) were White, five children (16 percent) were Black, in one case (three percent) the ethnicity/race of the child was unknown or not documented, in one case (three percent) the child was documented as “Other,” and one child (three percent) was Native American.

Of the remaining nine cases in the five- to 17-year-old age group, five children (56 percent) were Hispanic, three children (33 percent) were White, and one child (11 percent) the ethnicity/race was unknown or not documented.

**CHART J**



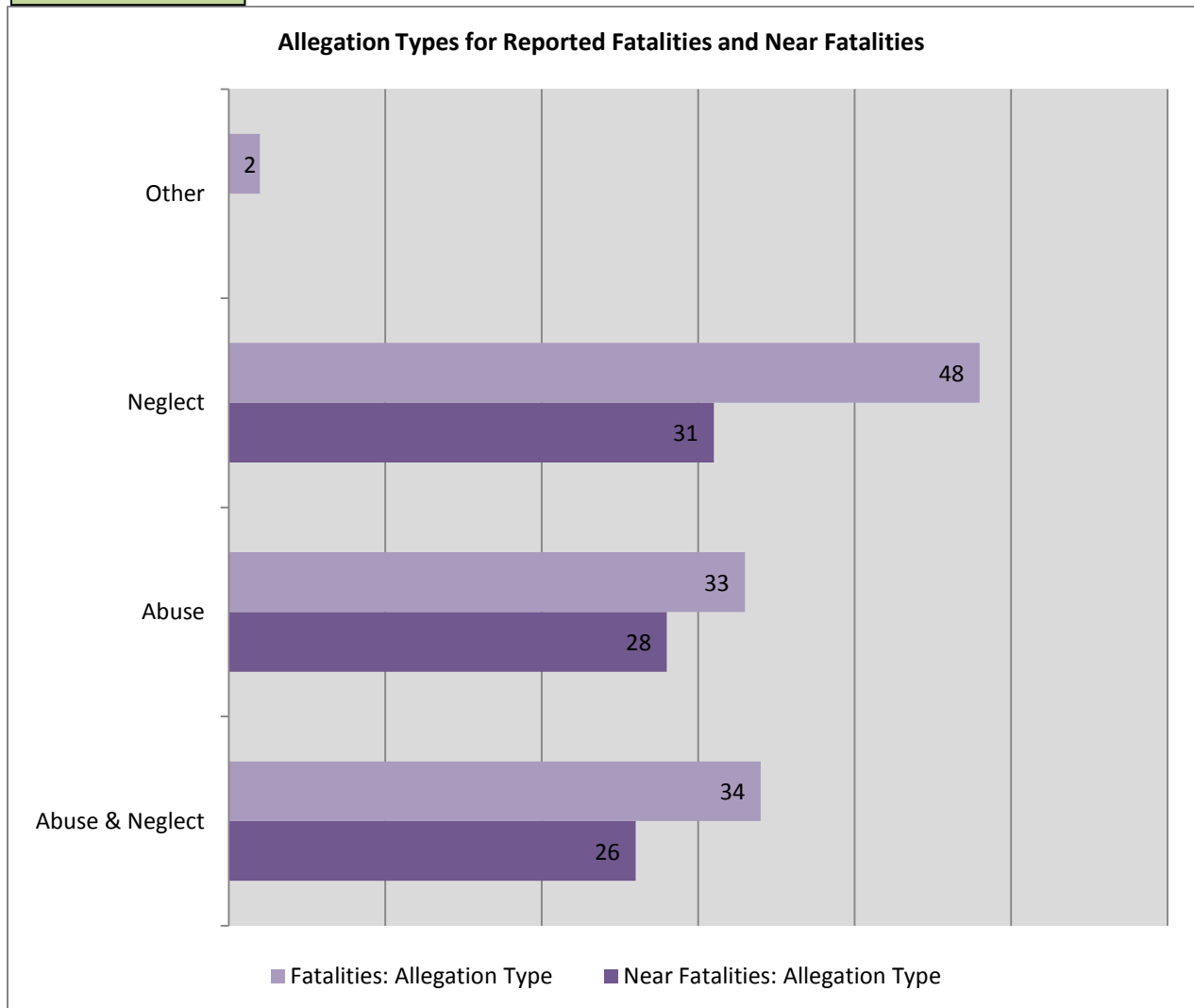
## Child Abuse Versus Neglect – What is Known

The following data depicts the types of allegations that were investigated and substantiated by the CWS agencies for the child fatality and near fatality incidents that were reported for CY 2009.

It should be noted that a combined allegation of abuse and neglect may occur when a caregiver's failure to protect results in the child fatality or near fatality from abuse by another caregiver or individual.

The data shows that neglect<sup>3</sup> played a greater role than abuse or combined allegations in the fatality and near fatality incidents reported to the CDSS in CY 2009. Chart K depicts the allegation types for all child fatality and near fatality incidents reviewed for CY 2009.

**CHART K**



<sup>3</sup> Neglect category includes two cases that were documented as Caretaker Absence/Incapacity.

## Child Fatalities: Allegation Type

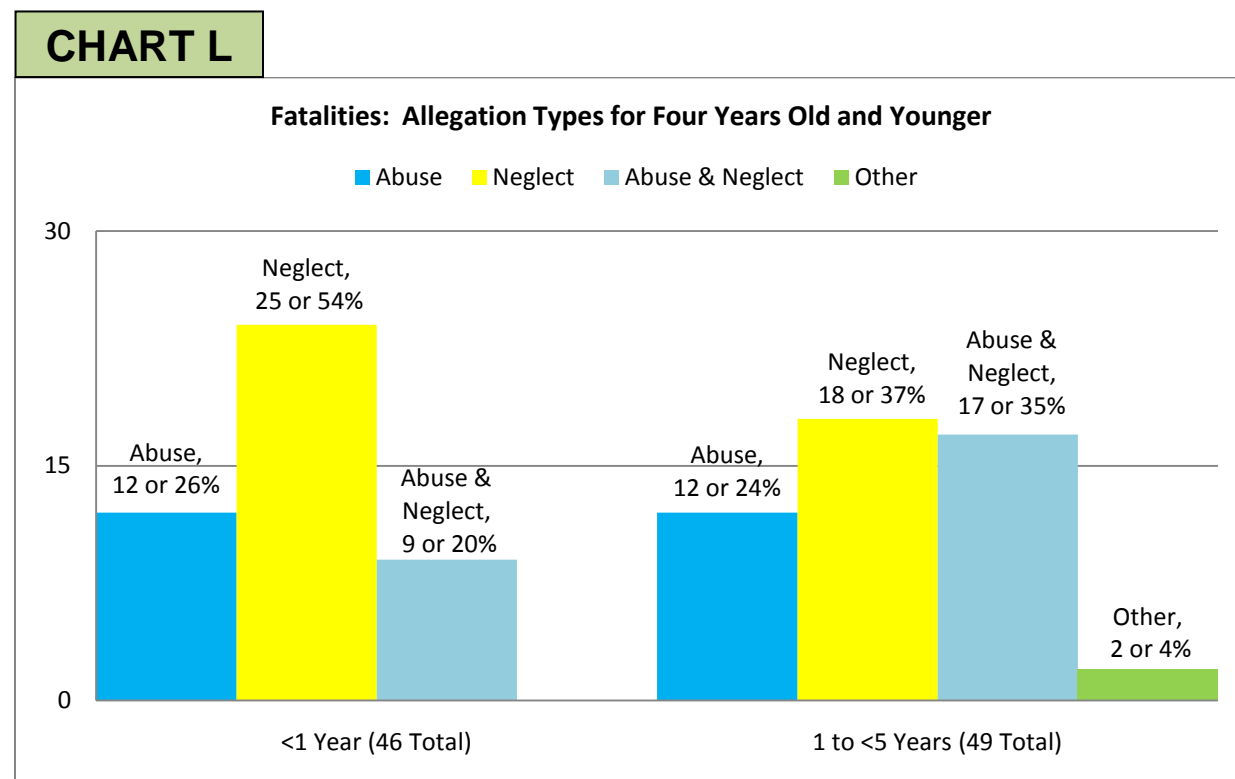
The data shows that 48 of the 117 child fatality cases (41 percent) reported for CY 2009 were neglect allegations (see footnote on pg. 19). The allegation types for the remaining 69 child fatality cases were evenly divided; 33 cases (28 percent) were abuse allegations and 34 cases (29 percent) were abuse and neglect allegations. The remaining two cases fell into the “Other” category (see prior Chart K).

The allegation types for the 46 cases in the less than one year-old age group were as follows: 25 cases (54 percent) were neglect allegations, 12 cases (26 percent) were abuse allegations, and nine cases (20 percent) were abuse and neglect allegations.

The allegation types for the 49 fatality cases in the one- to four-year-old age group were as follows: 18 cases (37 percent) were neglect allegations, 17 cases (35 percent) were abuse and neglect allegations, 12 cases (24 percent) were abuse allegations, and two cases (four percent) were categorized “Other.”

The allegations for the remaining 22 cases in the five- to 17-year-old age group were as follows: nine cases (41 percent) were abuse allegations, eight cases (36 percent) were abuse and neglect allegations, and five cases (23 percent) were neglect allegations.

Children under one were the subject of more neglect allegations than abuse or combined abuse and neglect allegations. Children between one and four were the subject of neglect as well as combined abuse and neglect allegations. Chart L depicts the allegation types for child fatality cases of children ages four years old and younger.



## Child Near Fatalities: Allegation Type

The data for allegation type for child near fatalities was similar to that found for fatalities for the allegation of neglect. The near fatality cases, however, were divided more evenly between categories. Of the allegations investigated, 31 of the 85 near fatality cases (36 percent) were neglect allegations. For the remaining 54 near fatality cases, 28 cases (33 percent) were abuse allegations and 26 cases (31 percent) were abuse and neglect allegations (see Chart K).

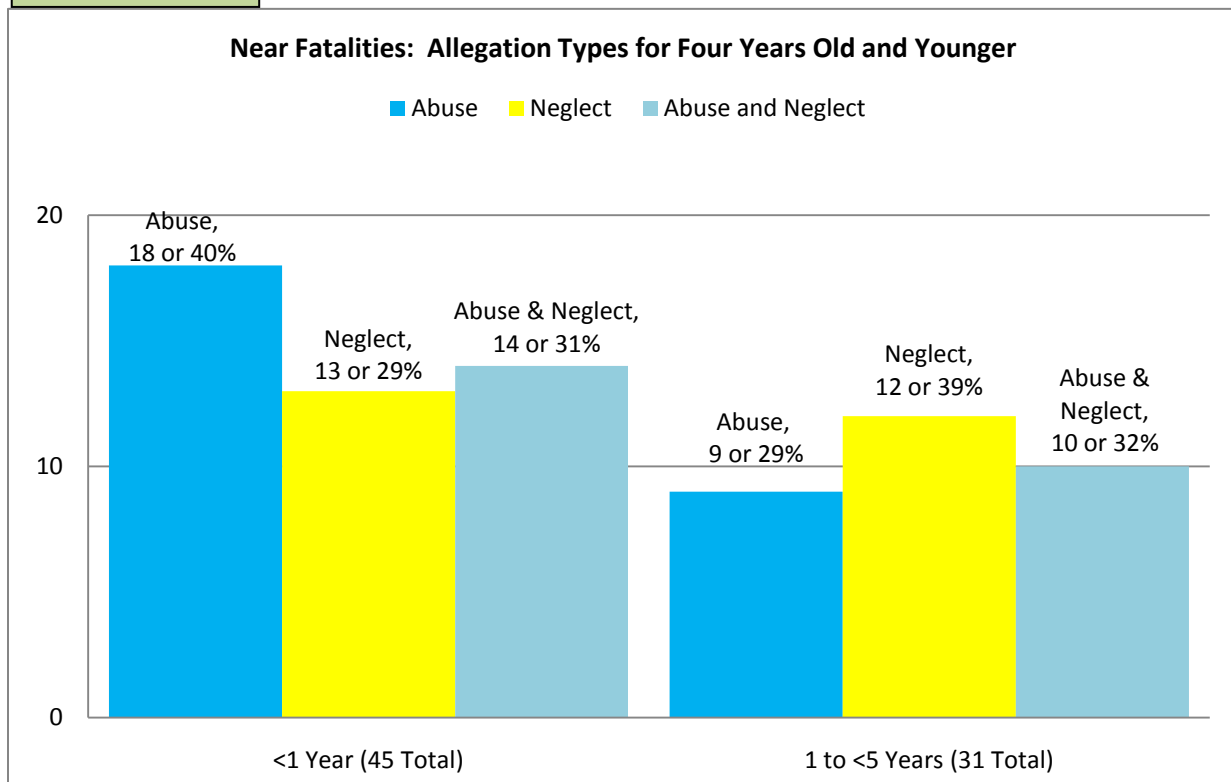
Of the 45 near fatality cases in the less than one year-old age group, 18 cases (40 percent) were abuse allegations, 14 cases (31 percent) were abuse and neglect allegations, and 13 cases (29 percent) were neglect allegations.

Of the 31 near fatality cases in the one- to four-year-old age group, 12 cases (39 percent) were neglect allegations, 10 cases (32 percent) were abuse and neglect allegations, and nine cases (29 percent) were abuse allegations.

Of the remaining nine cases in the five- to 17-year-old age group, six cases (67 percent) were neglect allegations, two cases (22 percent) were abuse and neglect allegations and one case (11 percent) was an abuse allegation.

Near fatalities show a slight difference from fatalities in the reported allegations for children under five. Children between the ages of one and four followed the fatality trend of having more reported neglect and combined abuse and neglect allegations. For children under one, there were more allegations of abuse than neglect reported. Chart M depicts the near fatality allegation types for children four years old and younger.

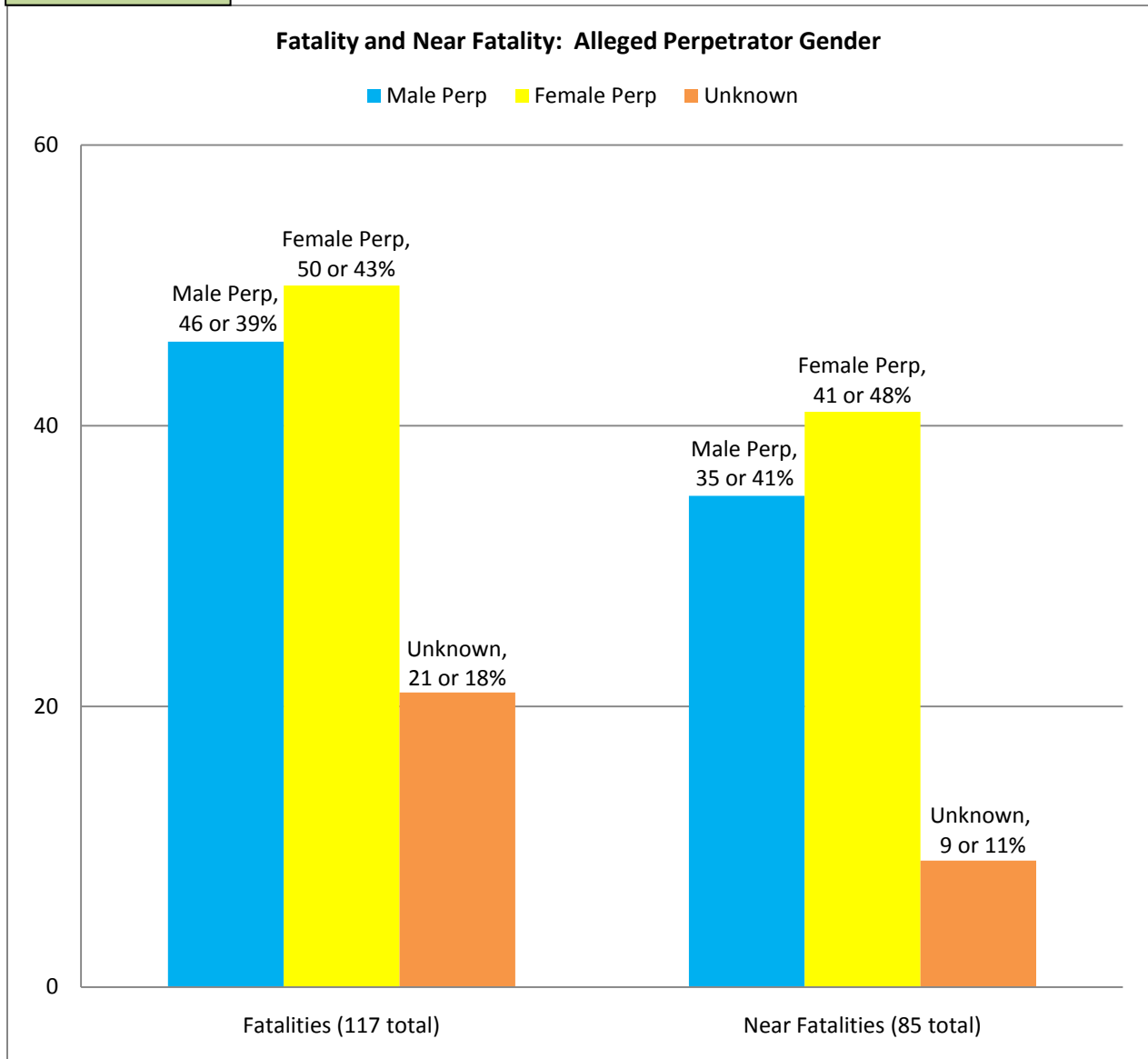
**CHART M**



## Who Was Identified as the Primary Individual Responsible for the Incidents of Abuse and/or Neglect

In analyzing child fatalities and child near fatalities and addressing the issues surrounding these sensitive cases, it is important to understand who was responsible for the incidents of abuse and/or neglect. The following provides information regarding the primary individual responsible (“perpetrator”) for the child fatality or near fatality incidents. It is also important to note that an alleged perpetrator might not be identified if, at the time of the fatality or near fatality, more than one person had access to the child. Chart N depicts the gender of the perpetrators for the reported child fatality and near fatality incidents.

**CHART N**



## **Child Fatalities: Alleged Perpetrator's Gender and Relationship to Child**

It was found in the 117 child fatality cases reviewed, slightly more females than males were identified as the person responsible for the abuse and/or neglect that led to a child's death. In 50 of the child fatality cases (43 percent) the alleged perpetrator was a female, and in 46 child fatality cases (39 percent) the alleged perpetrator was a male. In 21 cases (18 percent), the identity of the alleged perpetrator was unknown (see Chart N). Of the 96 cases where the alleged perpetrator is known, 48 cases (or 50 percent) involved alleged perpetrators who were 30 years of age or younger.

It was also found that in 77 of the 117 child fatality cases (66 percent), the parent/guardian was identified as the alleged perpetrator. In 14 of the child fatality cases (12 percent), the parent's significant other was identified as the alleged perpetrator.

Of the 46 child fatalities in the less than one year-old age group, counties reported that in 20 cases (43 percent) the alleged perpetrator was a female, in 13 cases (28 percent), the alleged perpetrator was a male, and in 13 cases (28 percent), the alleged perpetrator was unknown. In 23 cases (50 percent), within this age group when the alleged perpetrator was known, he/she was 30 years of age or younger. The parent/guardian was identified as the alleged perpetrator in 29 of the 46 cases (63 percent).

Of the 49 child fatalities in the one- to four-year-old age group, counties reported that in 23 cases (47 percent), the alleged perpetrator was a female, and in 20 cases (41 percent), the alleged perpetrator was a male. In six of the cases (12 percent), the identity of the alleged perpetrator was unknown. In 26 cases (53 percent), within this age group when the alleged perpetrator was known, he/she was 30 years of age or younger. The parent/guardian was identified as the alleged perpetrator in 30 of the 49 child fatality cases (61 percent).

Of the remaining 22 cases in the five- to 17-year-old age group, counties reported that in 12 cases (55 percent), the alleged perpetrator was a male, in nine cases (41 percent), the alleged perpetrator was a female, and in one case (five percent), the alleged perpetrator was unknown. In four cases (19 percent), within this age group when the alleged perpetrator was known, he/she was 30 years of age or younger. The parent/guardian was identified as the alleged perpetrator in 20 of the 22 cases (91 percent).

For fatalities reported in CY 2009, females were more likely than males to be the primary individual responsible for incidents of abuse and/or neglect. Also, age played a role in the incidents reported, as half of the known perpetrators of the fatality incidents reported were less than 30 years old.



## **Child Near Fatalities: Alleged Perpetrator's Gender and Relationship to Child**

Similar to the data for child fatality cases, it was found that in the 85 near fatality cases, more females than males were identified as the person responsible for the near fatality incident that resulted from abuse and/or neglect. In 41 of these cases (48 percent) the alleged perpetrator was female. In 35 of the near fatality cases (41 percent) the alleged perpetrator was male. In nine of the cases (11 percent) the identity of the alleged perpetrator was unknown (see Chart N). Much like the data provided in the fatality cases, 78 percent of the near fatality cases where the alleged perpetrator was known, he/she was 30 years of age or less.

Further, in 69 of the 85 near fatality cases (81 percent) the parent/guardian was identified as the alleged perpetrator. In five of the 85 near fatality cases (six percent), the parent's significant other was identified as the alleged perpetrator.

Of the 45 near fatality cases for children less than one year of age, the percentage of male versus female perpetrators is different than the percentage for near fatalities for all ages. In 20 of these cases (44 percent) the alleged perpetrator was a male, and in 18 cases (40 percent) the alleged perpetrator was a female. In seven of the cases (16 percent) the identity of the alleged perpetrator was unknown. In 34 cases (76 percent), where the identity of the alleged perpetrator was known, he/she was 30 years of age or younger. For the less than one year-old age group, the parent/guardian was identified as the alleged perpetrator in 37 of the 45 near fatality cases (82 percent).

Of the 31 near fatality cases in the one- to four-year-old age group, fewer males were identified as the person responsible for the near fatality. In 16 of these cases (52 percent) the alleged perpetrator was a female, and in 13 of these cases (42 percent) the alleged perpetrator was a male. In two cases (six percent) the identity of the alleged perpetrator was unknown. In 21 (68 percent) of the cases where the alleged perpetrator was known, he/she was 30 years of age or younger. In 23 of the 31 near fatalities in this age group (74 percent) the parent/guardian was identified as the alleged perpetrator.

Of the remaining nine near fatality cases in the five- to 17-year-old age group, the primary person responsible was very similar to the one- to four-year-old age group. In five of these cases (56 percent), the alleged perpetrator was a female and in two of these cases (22 percent) the alleged perpetrator was a male. In two cases (22 percent) the identity of the alleged perpetrator was unknown. In three cases (43 percent) where the alleged perpetrator was known, he/she was 30 years of age or younger. In seven of the nine near fatalities in this age group (78 percent) the parent/guardian was identified as the alleged perpetrator.

For near fatalities reported in CY 2009, females were more likely than males to be the primary individual responsible for incidents of abuse and/or neglect. Age played a role in the near fatality incidents reported, as over three-quarters of the known perpetrators of the near fatality incidents reported were less than 30 years old.

## Specific Cause/Finding of Incident

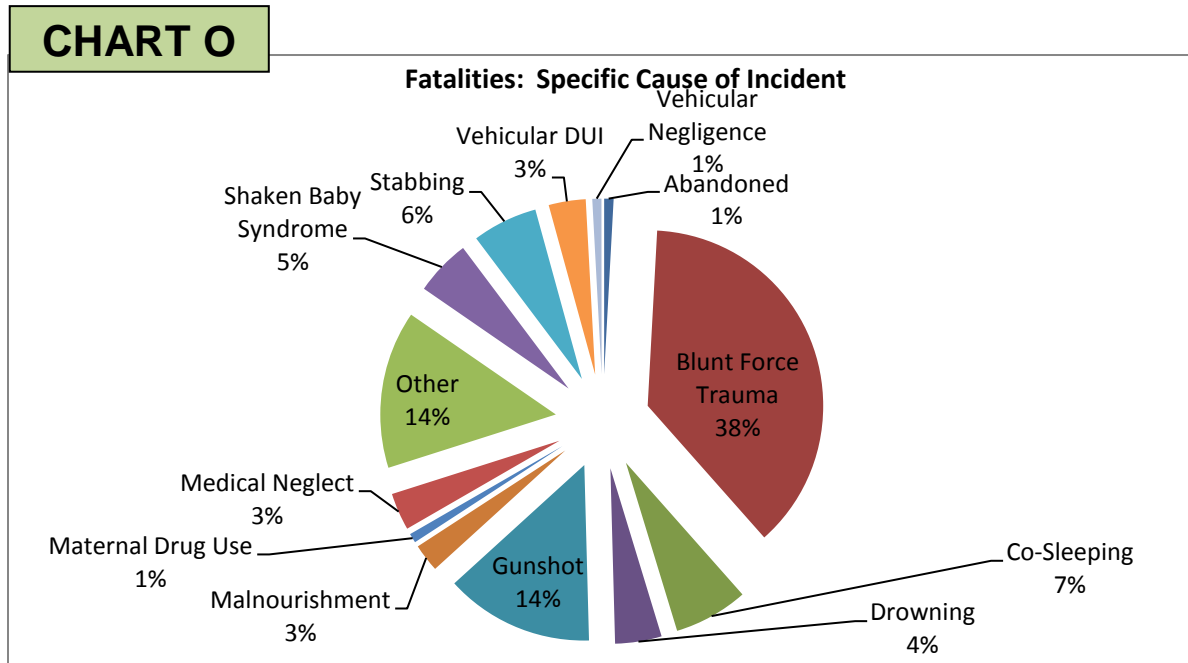
### Child Fatalities:

The specific causes or findings of the 117 child fatalities reviewed that were determined to be the result of abuse and/or neglect during CY 2009, are categorized below in Table 3 and depicted in Chart O. A review of these cases indicates that the number one finding for cause of death is Blunt Force Trauma<sup>4</sup>.

**Table 3**

Abandoned	1	Medical Neglect	4
Blunt Force Trauma	44	Other <sup>5</sup>	17
Co-Sleeping	8	Shaken Baby Syndrome <sup>6</sup>	6
Drowning	5	Stabbing	7
Gunshot	16	Vehicular DUI	4
Malnourishment	3	Vehicular Negligence	1
Maternal Drug Use	1		

For the 95 fatalities in which the children were age four years old and younger, the finding for specific cause of fatality in 41 of the cases (43 percent) was Blunt Force Trauma.



<sup>4</sup> Blunt Force Trauma includes trauma to the head, body or both.

<sup>5</sup> "Other" includes but is not limited to: instances where the cause of death was not documented in CWS/CMS or was a combination of several causes

<sup>6</sup> Shaken Baby Syndrome cases were only counted as such when documentation in CWS/CMS clearly identified the cases as Shaken Baby Syndrome.

## Child Near Fatalities:

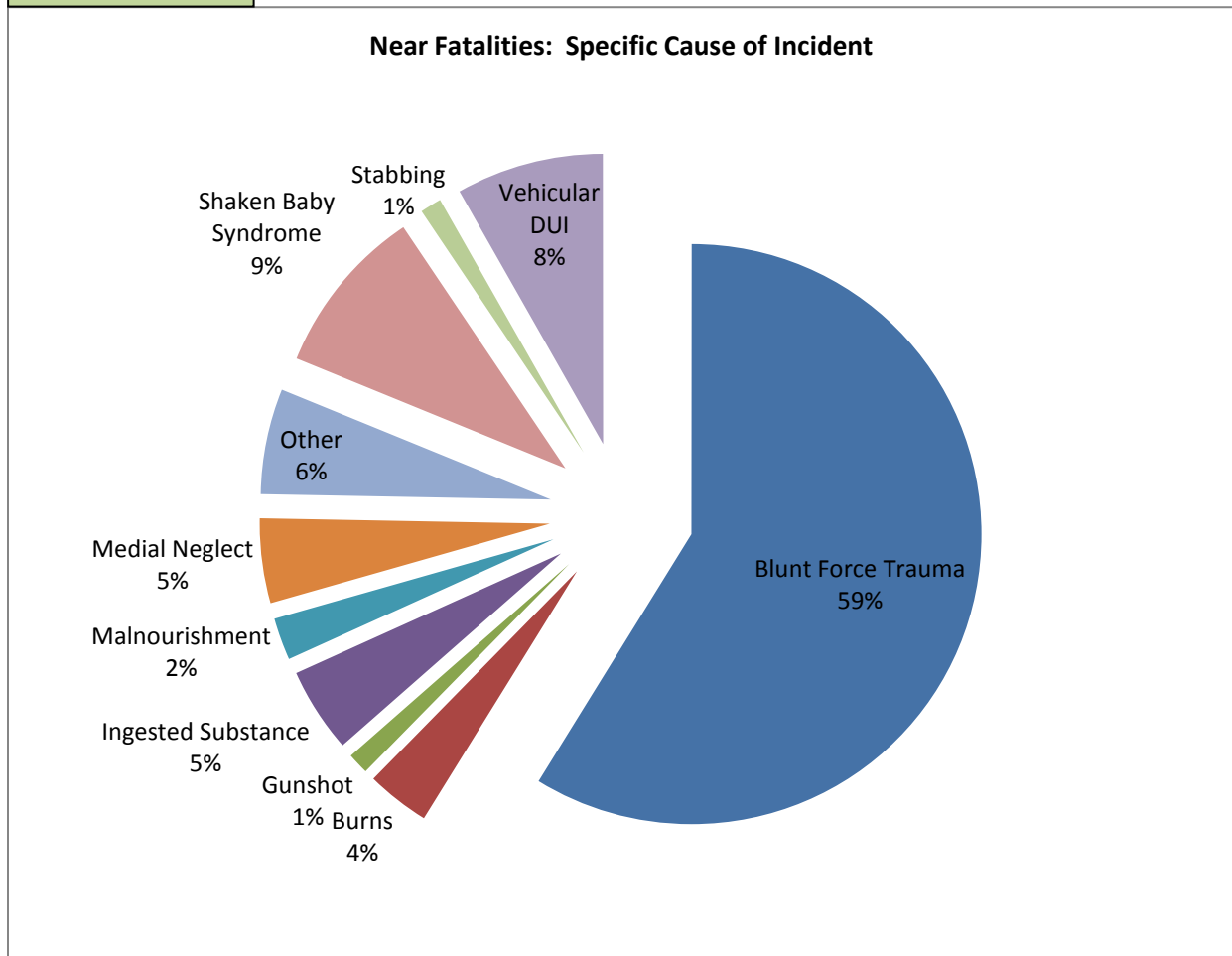
The specific causes or findings of the 85 child near fatalities that were determined to be the result of abuse and/or neglect during CY 2009, are listed below in Table 4 and depicted in Chart P. Similar to the child fatality cases, a review of these near fatality incidents indicates that the number one reported cause of the near fatalities is Blunt Force Trauma.

**Table 4**

Blunt Force Trauma	50	Medical Neglect	4
Burns	3	Other	5
Gunshot	1	Shaken Baby Syndrome	8
Ingested Substance	4	Stabbing	1
Malnourishment	2	Vehicular DUI	7

For the 76 near fatalities in which children were age four years old and younger, the reported cause of the near fatality in 48 cases (63 percent) was blunt force trauma.

### CHART P



## IV. Conclusion

The information provided in this report represents a compilation of aggregate data for those child fatalities and near fatalities resulting from abuse and/or neglect that occurred during CY 2009 and were reported by counties via the SOC 826 form. In reviewing the data it is important to remember that the data compiled for this report only represents those child fatalities and near fatalities for which all of the following occurred: 1) the CWS agency became aware of the fatality or near fatality, 2) the fatality or near fatality was determined to be the result of abuse and/or neglect, and 3) the fatality or near fatality was reported to the CDSS via the SOC 826 form.

The data demonstrates that the most vulnerable population subject to child fatalities and near fatalities resulting from abuse and/or neglect remains (from the CY 2008 report) our youngest population, children four years old and younger. Additionally, the data shows that allegations of neglect played a greater contributing factor to these fatalities and near fatalities than did allegations of abuse. With respect to the perpetrators of these incidences, the data shows that in a large percentage of these cases, the perpetrator was known to the child as the child's parent/guardian or parent's significant other and was under the age of 30 at the time of the incident. Lastly, the data highlights that the number one cause of these fatalities and near fatalities was blunt force trauma.

Much of the data for CY 2009 remains consistent with the data in the CY 2008 report. There are areas where there are some distinct differences. It is unknown at this time whether these differences are a true reflection of statistical increases/decreases, or merely fluctuations due to the differences in data reporting and collection between the two years as the CDSS and the counties implemented SB 39. One area is in the age of the children reported in fatalities and near fatalities. While children less than five years old still encompass the majority of reported fatalities and near fatalities, there was a three percent increase in the five- to 17-year-old age group in CY 2009. Another area was the cause/finding of the reported incidents. Again, blunt force trauma was the cause of a great percentage of fatalities and near fatalities, but there was a noticeable increase in the number of reported gunshots and stabbings as the cause of fatality from the CY 2008 report, while the reported near fatalities showed a 14 percent increase of blunt force trauma as the cause. Additionally, for the identified primary perpetrator in both reported fatalities and near fatalities, there was a shift from a higher number of male perpetrators from the CY 2008 report to a higher number of female perpetrators in CY 2009. Further analysis of future years' data will hopefully shed light on whether these variances hold true over time.

As we continue learning about the causes and circumstances of child fatalities and near fatalities resulting from abuse and/or neglect, the CDSS is committed to continuing to collect and compare this data in future years.

California Child Population as of January 1, 2009<sup>7</sup>

Age	Total Population	Hispanic or Latino	Not Hispanic or Latino					
			White Alone	Asian Alone	Black Alone	Multi-race	American Indian and Alaska Native Alone	Native Hawaiian and Other Pacific Islander Alone
<b>Total Population:</b>								
<b>Under 5 years</b>	<b>2,754,299</b>	1,420,288	736,037	261,788	129,698	194,188	4,297	8,003
		52%	27%	10%	5%	7%	<0%	<0%
5 to 9 years	<b>2,635,031</b>	1,310,460	747,627	261,400	143,240	155,402	8,195	8,707
10 to 14 years	<b>2,740,318</b>	1,359,491	802,395	278,699	171,965	99,619	17,518	10,631
15 to 17 years	<b>1,857,712</b>	907,976	566,638	182,490	123,148	58,397	11,725	7,338
<b>Total</b>	<b>9,987,360</b>	<b>4,998,215</b>	<b>2,852,697</b>	<b>984,377</b>	<b>568,051</b>	<b>507,606</b>	<b>41,735</b>	<b>34,679</b>
		50%	29%	10%	6%	5%	<0%	<0%
<b>Male:</b>								
<b>Under 5 years</b>	<b>1,409,715</b>	724,816	377,653	135,299	66,192	99,472	2,197	4,086
		51%	27%	10%	5%	7%	0%	0%
5 to 9 years	<b>1,349,112</b>	668,603	384,489	135,377	72,333	79,506	4,207	4,597
10 to 14 years	<b>1,398,891</b>	690,672	412,818	143,677	87,543	50,510	8,195	5,476
15 to 17 years	<b>950,018</b>	462,950	291,799	93,993	62,553	29,263	5,596	3,864
<b>Total</b>	<b>5,107,736</b>	<b>2,547,041</b>	<b>1,466,759</b>	<b>508,346</b>	<b>288,621</b>	<b>258,751</b>	<b>20,195</b>	<b>18,023</b>
		50%	29%	10%	6%	5%	<0%	<0%
<b>Female:</b>								
<b>Under 5 years</b>	<b>1,344,584</b>	695,472	358,384	126,489	63,506	94,716	2,100	3,917
		52%	27%	9%	5%	7%	0%	0%
5 to 9 years	<b>1,285,919</b>	641,857	363,138	126,023	70,907	75,896	3,988	4,110
10 to 14 years	<b>1,341,427</b>	668,819	389,577	135,022	84,422	49,109	9,323	5,155
15 to 17 years	<b>907,694</b>	445,026	274,839	88,497	60,595	29,134	6,129	3,474
<b>Total</b>	<b>4,879,624</b>	<b>2,451,174</b>	<b>1,385,938</b>	<b>476,031</b>	<b>279,430</b>	<b>248,855</b>	<b>21,540</b>	<b>16,656</b>
		50%	28%	10%	6%	5%	<0%	<0%

<sup>7</sup> State of California, Department of Finance, *E-3 Race / Ethnic Population Estimates with Age and Sex Detail, 2000–2008*. Sacramento, CA, June 2010 (<http://www.dof.ca.gov/research/demographic/data/e-3/>)

**CHILD FATALITY/NEAR FATALITY  
COUNTY STATEMENT OF FINDINGS AND INFORMATION****INSTRUCTIONS:**

Counties shall complete this form for each child fatality/near fatality determined to be a result of abuse and/or neglect. The form shall be submitted to CDSS within ten business days of notification of final determination from the investigating agency.

For a child fatality, complete parts A and B.

For a child near fatality, complete parts A and C.

**PART A - ALWAYS COMPLETE THIS INFORMATION FOR CDSS SUBMISSION**

Date form completed: \_\_\_\_\_  Fatality  Near Fatality

**Note: Redact information in this box prior to the public release of this document.**

CWS/CMS 19 DIGIT REFERRAL # OF CHILD VICTIM:

COUNTY CONTACT AND PHONE NUMBER (INDIVIDUAL THAT CDSS WOULD CONTACT FOR ADDITIONAL INFORMATION):

COUNTY WHERE INCIDENT OCCURRED:

REPORTING COUNTY (IF DIFFERENT):

CHILD'S GENDER:

MALE  FEMALE

CHILD'S AGE:

DATE OF FATALITY/NEAR FATALITY (IF KNOWN):

RESIDENCE OF THE CHILD AT THE TIME OF THE ABUSE/NEGLECT THAT RESULTED IN THE FATALITY/NEAR FATALITY:

Home of parent/  
legal guardian  Foster Care/Out-of-Home Care

INVESTIGATION CONDUCTED BY:

Law Enforcement  CWS/Probation

**PART B - CHILD FATALITY FINDINGS - CONCLUSION OF INVESTIGATING AGENCY**

DETERMINATION MADE BY:

Coroner/  
Medical Examiner  Law Enforcement  CWS/Probation

FINDING OF CHILD FATALITY DUE TO (CHECK ALL THAT APPLY):

Crime  Suicide  Non-Accidental  Undetermined  Other: \_\_\_\_\_

**PART C - CHILD NEAR FATALITY FINDINGS - CONCLUSION OF INVESTIGATING AGENCY**

DETERMINATION MADE BY:

Physician  Law Enforcement  CWS/Probation

FINDINGS OF CHILD NEAR FATALITY DUE TO (CHECK ALL THAT APPLY):

Crime  Attempted  
Suicide  Non-Accidental  Undetermined  Other: \_\_\_\_\_

**DO NOT INCLUDE A NARRATIVE; CHECK THE APPROPRIATE BOXES ABOVE.**

*Please fax this form to:  
Children's Services Operations Bureau,  
Attention: Bureau Chief at (916) 651-8144.*

## Glossary

**For the purposes of this report, the definitions for key terms are defined below.**

### Abuse

The nonaccidental commission of injuries against a person. In the case of a child, the term refers specifically to the nonaccidental commission of injuries against the child by or allowed by a parent(s)/guardian(s) or other person. The term also includes emotional, physical, severe physical and sexual abuse. (See Manual of Policies and Procedures (MPP) Division 31 Section 31-002 (c)(9))

### Determination

The agency that made the determination whether the child fatality or near fatality was or was not the result of abuse/and or neglect (See MPP Division 31 Section 31-502.25):

#### CWS or Probation

A “determination” of abuse or neglect by CWS or Probation is the substantiation of abuse and/or neglect allegations which resulted in the fatality.

#### Law Enforcement

A law enforcement investigation concludes that the child’s death was a result of abuse and/or neglect.

#### Coroner/Medical Examiner

A coroner/medical examiner concludes that the child’s death was a result of abuse and/or neglect.

### Emergency Response Referral

A referral that alleges child abuse, neglect, or exploitation as defined by Penal Code Section 11165 et seq. and the Division 31 regulations. (See MPP Division 31 Section 31-002 (e)(9))

### Evaluated out

Part of the decision making process for determining whether an in-person investigation is required, and is included in the outcome options, which are listed in that section as (a) Evaluate out with no referral to another community agency; (b) Evaluate out, with a referral to an appropriate community agency; or (c) Accept for in-person investigation. (See MPP Division 31 Section 31-105.116)

### Neglect

The failure to provide a person with necessary care and protection. In the case of a child, the term refers to the failure of a parent(s)/guardian(s) or caretaker(s) to provide the care and protection necessary for the child’s healthy growth and development. Neglect occurs when children are physically or psychologically endangered. The term includes both severe and general neglect as defined by Penal Code section 11165.2. (See MPP Division 31 Section 31-002 (n)(1))