California Child Fatality and Near Fatality Annual Report Calendar Year 2010

Prepared by:

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 (W&IC) 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 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 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 County Statement of Findings and Information (SOC 826) form. This form is the mechanism that a county CWS agency uses to notify 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 condition 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).*

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 that occurred in Calendar Year (CY) 2010 and were determined to be the result of abuse and/or neglect and reported to the CDSS as of December 1, 2011. The CDSS established this cut-off date to enable the timely production of this report. However, despite the cut-off date for inclusion in this annual report, the CDSS continues to accept SOC 826 forms for incidents that occurred in CY 2010 and prior years and will identify any such forms in future years' reports.

The CDSS gathered additional information for each of the reported child fatality and near fatality incidents from the Child Welfare Services/Case Management System (CWS/CMS) and SafeMeasures (a quality-assurance computer application used to analyze CWS/CMS case information) in an effort to gain a broader understanding of the reported incidents and the children and families involved. A glossary (Attachment C) is also included in this report to provide definitions of terminology used throughout this report.

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 2010 report will also be available on the CDSS Website at http://www.childsworld.ca.gov/PG2370.htm.

II. Update of Prior Years' Data

Calendar Year 2008
Since the last update in the CY 2009 annual report, there have been no additional SOC 826 forms submitted for CY 2008.

Calendar Year 2009
The number of fatalities and near fatalities in the CY 2009 annual report, issued in May 2011, represented the total number of SOC 826 forms submitted to the CDSS as of December 3, 2010. At that time, there were 117 reported child fatalities with 111 children residing in the home of a parent or guardian and six children residing in an out-of-home foster care placement and 85 near fatalities where all the children resided in the home of a parent or guardian. Between the date the CY 2009 report was drafted and December 1, 2011, (the cut-off date for this report), the CDSS received an additional six fatality SOC 826 forms and one near fatality SOC 826 form, bringing the total number of reported incidents for CY 2009 to 123 child fatalities and 86 near fatalities. All of the children reported for the six additional child fatalities and one additional child near fatality resided in the home of a parent or guardian at the time of the incident bringing the total number of children who resided in the home of a parent or guardian at the time of the incident to 117 and six out-of-home at the time of incident for fatalities. All 86 near fatality incidents were in the home of a parent or guardian.

These additional child fatality and near fatality incidents represent five percent of all fatalities reported in CY 2009 and one percent of all near fatalities. In the review of these incidents, the information collected was consistent with the data patterns reported for that year; therefore, no further analysis is being provided.

Summary of Prior Years
The table below offers a summary of current totals of reported fatalities and near fatalities.

Table 1. Count of Previous Years' Submitted SOC Forms

Current Totals	2008	2009
Fatalities	120	123
Near Fatalities	91	86

III. Analysis of Calendar Year (CY) 2010 Data

Background

The data included in this report is for all child fatality and near fatality incidents reported to the CDSS via the SOC 826[1] form for CY 2010. The number of fatalities and near fatalities reported represents the total number of SOC 826 forms submitted by a "point-in-time," which was December 1, 2011, for this report. Although the CDSS needed to select a cut-off date to ensure timely production of the annual report, it is recognized that counties may continue to determine causes of incidents that occurred in CY 2010 as well as prior years. As such, any SOC 826 forms submitted after December 1, 2011, will be summarized in future years' reports.

The analysis focuses on providing an understanding of a number of data elements as follows:

- Whether there was prior involvement of these children and their families with the CWS system.
- What was known about CWS involvement at the time of the incident.
- Identification of the age, ethnicity/race and gender groups for the child fatalities and near fatalities resulting from abuse and/or neglect.
- Identification of the number of fatalities and near fatalities that were caused by abuse versus neglect.
- Identification of the relationship of the child to the individual responsible for the fatality and near fatality incidents.
- The causes of the child fatalities and near fatalities as documented by the child welfare agencies.

In addition, the data are further broken out into subsets of children age four and younger. While these subsets are depicted graphically throughout the report, 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 2010,[2] a copy of the SOC 826 form, and a Glossary.

Methodology

The information in this report for child fatalities was gathered pursuant to SB 39 and W&IC 10850.4 which requires that counties notify the CDSS of every child fatality that occurred within its jurisdiction that was the result of abuse and/or neglect. 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 2010.

[1] See Attachment B
[2] See Attachment A

Once a SOC 826 form is submitted to the CDSS, staff reviews the electronic referral or case information available in CWS/CMS regarding the child fatality or near fatality incident. The information is collected in aggregate for further statewide analysis. While there is a process in place to reconcile the SOC 826 forms that were reported by counties and used for analysis, the resulting aggregate data obtained from CWS/CMS is not reconciled with the counties before inclusion in this report, as the data are case information entered by county CWS agencies and is not subject to change after the referral has been closed.

It is also important to note that some fatality and near fatality incidents did not meet the criteria for investigation by the CWS agency and were "evaluated out" to another agency, such as law enforcement, for investigation. As a result, evaluated out referrals provide limited information for the analysis included in this report. The definition of evaluated out as well as other common CWS terminology can be found in the Glossary (Attachment C).

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 initially as a near fatality and subsequently as a fatality, the CDSS accounted for that incident only in the aggregate fatality data information, if both the fatality and near fatality incidents occurred in the same year.

IV. Fatalities

General Information

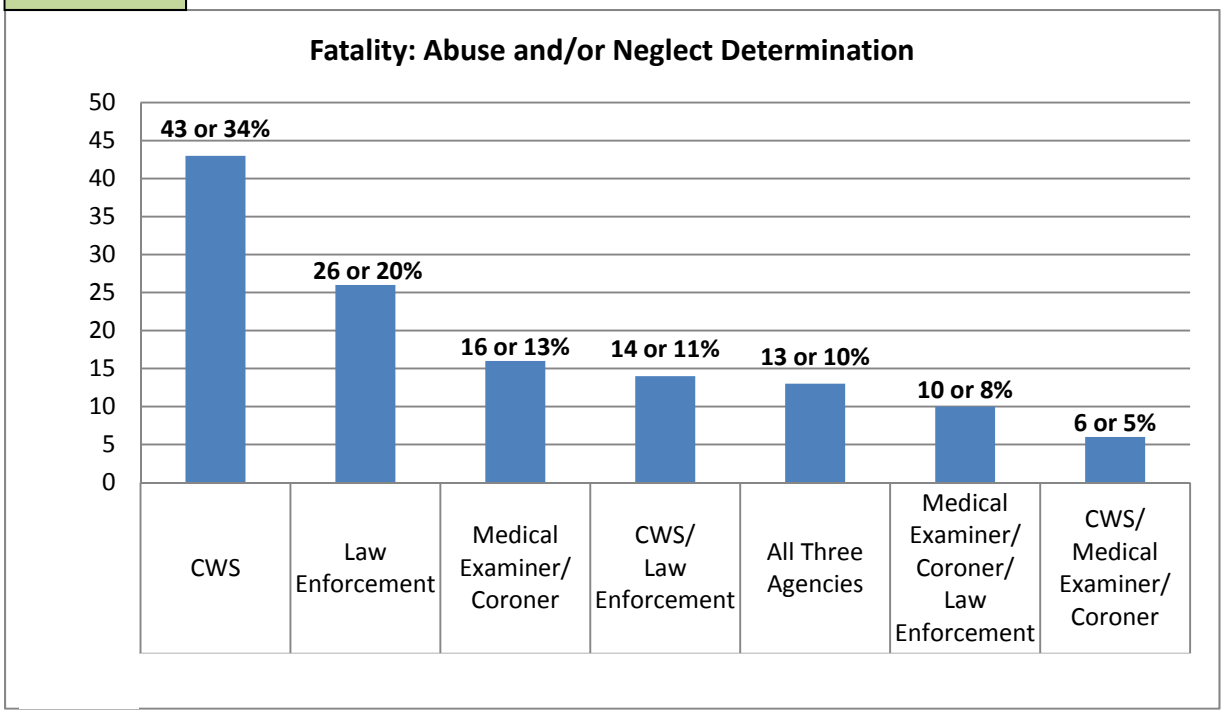
For CY 2010, California CWS agencies reported 128 child fatalities determined to be the result of abuse and/or neglect with 124 children residing in the home of their parent/guardian and four residing in an out-of-home placement or foster care. Thirty-one (24 percent) of the 128 incidents resulted in the referral made to the child abuse emergency response hotline being evaluated out, which means limited documentation is available for those incidents. What follows is information regarding all fatalities regardless of whether the referral was evaluated out or investigated by the CWS agency.

Of the 128 child fatality incidents reported, Chart A depicts which agency (CWS, law enforcement and medical examiner/coroner) made the determination that the child's death was the result of abuse and/or neglect as reported on the SOC 826 form submitted by counties. The determination was made as follows:

- 43 child fatality incidents (34 percent) by the CWS agency.
- 26 child fatality incidents (20 percent) by law enforcement.
- 16 child fatality incidents (13 percent) by the medical examiner/coroner.
- 14 child fatality incidents (11 percent) by the CWS agency and law enforcement.
- 13 child fatality incidents (ten percent) by all three agencies.
- Ten child fatality incidents (eight percent) by the medical examiner/coroner and law enforcement.
- Six child fatality incidents (five percent) by the CWS agency and medical examiner/coroner.

While all three agencies can determine a fatality to be the result of abuse and/or neglect, in CY 2010 over one third of the incidents were determined by CWS alone.

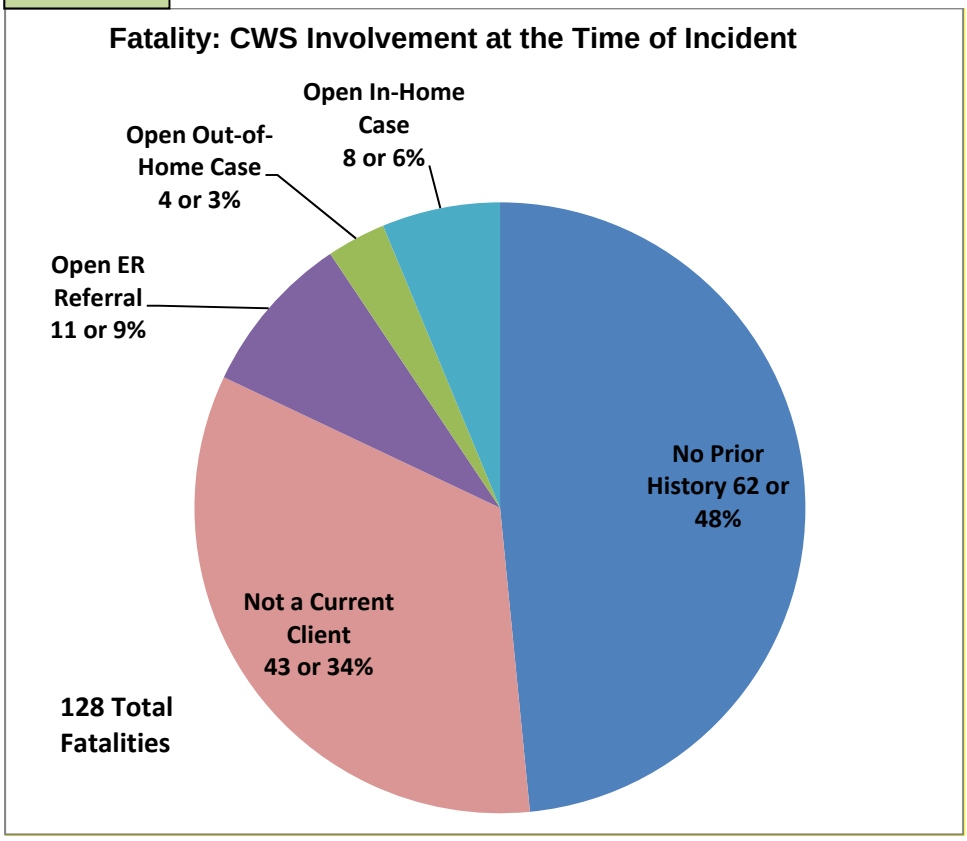
CHART A



Child Welfare Services Involvement/History

In reviewing the total 128 child fatality incidents that were the result of abuse and/or neglect submitted by counties for CY 2010, the data shows that 62 incidents (48 percent) involved children from families who had no prior CWS history in the five years prior to the incident; and 66 incidents (52 percent) involved children from families who were previously known to a CWS agency in the five years prior to the fatality incident, including 23 children (18 percent) whose families were receiving child welfare services at the time of the incident (see Chart B).

CHART B



Families with No CWS Involvement/History in the Five Years Prior to the Incident

As previously stated, of the 128 child fatalities reported, there were 62 incidents that involved children from families that were not known to a CWS agency at the time of the fatality incident, in that the family was not part of an open emergency response investigation nor were the children in an open case. In addition, none of these 62 families had CWS history in the five years prior to the incident. The age group breakdown for these 62 families can be found in the following paragraph.

Of the 62 families that did not have prior CWS history in the five years prior to the incident, 33 children (53 percent) were less than one year of age. In 23 incidents (37 percent), the children were in the one- to four-year-old age group; and lastly, in six incidents (ten percent), the children were in the five- to 17-year-old age group.

Families with CWS Involvement and/or History in the Five Years Prior to the Incident

Sixty-six (52 percent) of the children were from families which had CWS history in the five years prior to the fatality incident.[3] Furthermore, of those that had CWS history, 23 families (35 percent) were involved with a CWS agency at the time of the incident. Table 2 reflects the CWS agency involvement at the time of fatality for the 66 families who had CWS history in the five years prior to the incident.

Table 2. Number of Families with CWS Involvement and/or History in the Five Years Prior to the Incident

43	Not a current client of a CWS agency (but had prior history)
11	Open Emergency Response Referral at the time of incident
8	Open in-home case with a child welfare agency at the time of incident
4	Open out-of-home case with a child welfare agency at the time of incident

CWS Involvement by Age Group

Of the 66 child fatality incidents where the child or family was previously known to a CWS agency, there were 20 incidents for children in the less than one-year-old age group. Of those 20 incidents, 13 families (20 percent) were not current clients of a CWS agency at the time of the fatality incident; in three incidents (five percent), the child was living in the home of his/her parent(s) and receiving CWS services at the time of the fatality incident; in two incidents (three percent), the children were living in an out-of-home foster care placement and receiving services at the time of the fatality incident; and in two incidents (three percent), the families had an open Emergency Response (ER) referral at the time of the fatality incident.

Of the 66 child fatality incidents where the child or family was previously known to a CWS agency, there were 30 incidents for children in the one- to four-year-old age group. Of those 30 incidents, 21 families (32 percent) were not current clients of a CWS agency at the time of the fatality incident; in six incidents (nine percent), the families had an open ER referral at the time of the fatality incident; in two incidents (three percent), the children were living in an out-of-home foster care placement and receiving services at the time of the fatality incident; and in one incident (two percent), the child was living in the home of his/her parent(s) and receiving CWS services at the time of the fatality incident.

Of the 66 child fatality incidents where the child or family was previously known to a CWS agency, there were 16 incidents for children in the five- to 17-year-old age group. Of those 16 incidents, nine families (14 percent) were not current clients of a CWS agency at the time of the fatality incident; in four incidents (six percent), the children were living in the home of his/her parent(s) and receiving CWS services at the time of the fatality incident; and in three incidents (five percent), the families had an open ER referral at the time of the fatality incident.

In summary, the data shows that nearly half of the families in fatality incidents reported for CY 2010 did not have any prior involvement with a CWS agency at the time of the incident or within the five years prior to the fatality incident. Of the fatality incidents involving children from

[3] CWS history/involvement is based on the family of the child whether the parents were the individual(s) responsible for the fatality or not.

families with CWS history, 65 percent were not current clients at the time of the fatality incident, which are the 43 families referenced in Table 2.

Information Regarding the CWS Referral Immediately Preceding the Incident

When reviewing the prior CWS history of those 66 fatality incidents involving children from families which had prior CWS history, it is important for the reader to keep in mind two points. First, when a CWS agency receives a report alleging that a child may be the subject of abuse and/or neglect, the CWS agency is responsible for generating a referral and for processing that referral according to state regulations.[4] As such, it is important to recognize that the existence of a referral does not necessarily mean that the allegations generating that referral were substantiated or found to be true. The referral may not have met the criteria for investigation by the CWS agency and as a result was evaluated out. See Attachment C for a glossary of CWS terminology used in this section and throughout the report. If investigated, the disposition for the referral may have been unfounded, inconclusive or substantiated. Second, the prior CWS history/referrals involving these families may not have included the child who was the subject of the fatality incident, and the household composition may have been different at the time of the fatality. For example, the prior CWS referral may have been for neglect due to unsanitary living conditions before the victim child was even born, while in the current fatality incident, the victim child was the actual subject of the physical abuse. The information that follows offers a look at the families who had CWS history at the time of the fatality incident by examining the referral immediately preceding the incident. These families' histories with the CWS agency may offer some insight into future policy and prevention strategies.

In 40 of these 66 families (61 percent) with prior CWS history, a report of suspected child abuse or neglect had been made and the CWS agency generated a referral in the six months prior to the fatality incident. The remaining 26 families had prior referrals which were spread out over a time period of up to five years. Four families (six percent) had referrals that were reported six to 12 months before the incident occurred; six families (nine percent) had referrals reported in the 12 to 18 months before the incident occurred; two families (three percent) had referrals reported 18 to 24 months before the incident occurred; nine families (14 percent) had referrals reported 24 to 36 months before the incident occurred; and five families (eight percent) had referrals reported 36 to 60 months before the incident occurred.

It was also found that the majority of allegations for the referral immediately preceding the fatality incident were for neglect, 41 (62 percent) of the 66 incidents. Thirteen referrals (20 percent) had an allegation of abuse; nine referrals (14 percent) had combined allegations of abuse and neglect; two referrals (three percent) had allegations of substantial risk; and one referral (two percent) had an allegation of caretaker absence/incapacity.

As previously discussed, the existence of a referral does not necessarily mean that the allegations generating the referral were substantiated. In fact, when looking at the prior referrals of the 66 incidents with CWS history within the five years prior to the fatality incident, in 19 referrals (29 percent), the previous allegations' dispositions were unfounded; in 13 referrals (20 percent), the disposition was inconclusive; in 13 referrals (20 percent), the disposition was substantiated; in 12 referrals (18 percent), there were multiple allegations with multiple

[4] CDSS Manual of Policies and Procedures (MPP) Division 31-101 states, "the county shall respond to all referrals for service which allege that a child is endangered by abuse, neglect, or exploitation." MPP sections 31-105, 31-110, 31-115, 31-120, and 31-125 detail the decision process to respond to the allegations.

dispositions; and in nine referrals (14 percent), the referral was evaluated out; therefore, there was no disposition.

These findings show that of the 66 fatality incidents where families did have prior CWS history, 44 families (67 percent) had some CWS involvement within a year prior to the fatality incident taking place. Of the prior referrals immediately preceding the fatality incident, 62 percent of the allegations were for neglect. Lastly, while these 66 families did have some CWS involvement, 62 percent of the referrals immediately preceding the fatality incident either did not meet the criteria for investigation by the CWS agency or were deemed unfounded or inconclusive upon investigation.

Demographics Information

A comprehensive analysis of the CY 2010 data for age, gender and ethnicity/race for child fatalities determined to be the result of abuse and/or neglect 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 2010[5] was used for analysis. This can be found as Attachment A at the end of this report.

As can be seen from Attachment A, 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 as each group comprised 27 percent of the total population. Children between the ages of 15 to 17 years comprised 19 percent of the total child population.

With respect to ethnicity/race, the Hispanic population represented 49 percent of the total child population. In the under-five age group, Hispanic children represented 51 percent of the child population, while White children represented 29 percent and Black children represented six 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 5,101,687 male children in California, 1,400,730 (27 percent) were under the age of five. Similarly, of the 4,889,841 female children in California, 1,345,126 (28 percent) were under the age of five.

Demographic Characteristics of Fatalities

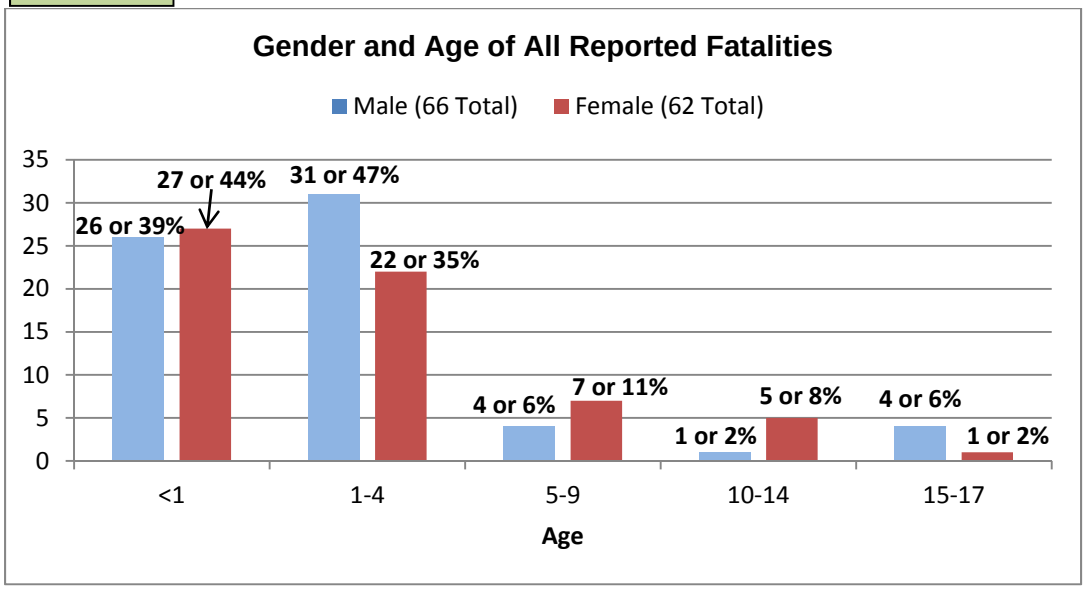
The data gathered for the 128 child fatality incidents indicates the most vulnerable population were children ages four and younger. Chart C on the following page, which depicts the gender of children by age group, shows 106 of the 128 child fatality incidents (83 percent) were children four years of age and younger. Of those, 53 children (41 percent) were less than one year old, and 53 children (41 percent) were between the ages of one and four. The remaining 22 child fatality incidents (17 percent) were in the five- to 17-year-old age group.

[5] The 2010 population estimate from the Department of Finance (DOF) website was used for the data in this report.

Gender and Age

The breakdown for gender in the less than one-year-old age group was 27 females and 26 males. The one- to four-year-old age group had 31 males and 22 females. Chart C, which depicts the gender of children by age group, shows that the one- to four-year-old age group reflects the greatest difference between males and females.

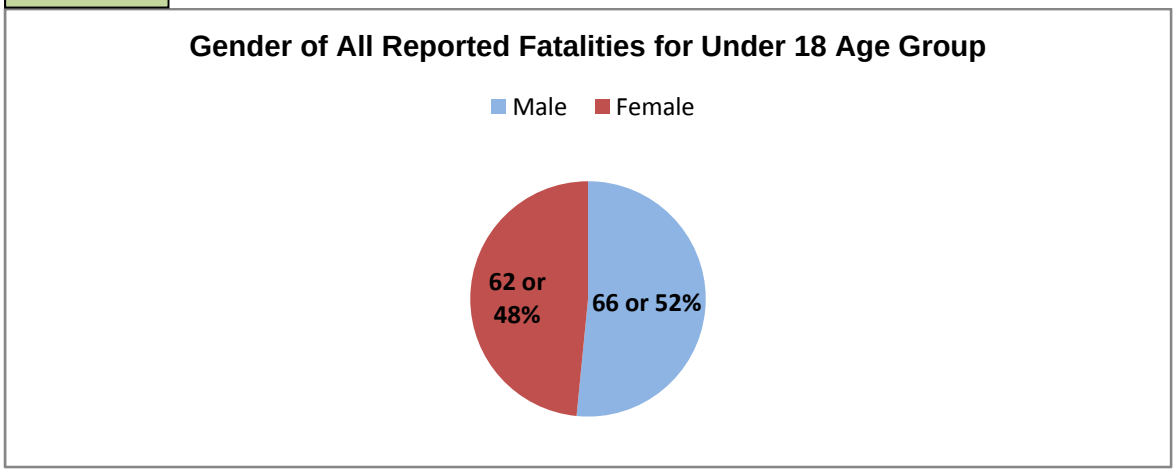
CHART C



Gender

Overall, the number of male child fatality incidents reported was higher than the number of female child fatality incidents; there were 66 incidents compared to 62 incidents, respectively, for all children under 18 in the fatality group (see chart D). The higher number of male children in the one- to four- and 15- to 17-year-old age groups contributed to the greater representation of males for child fatality incidents.

CHART D

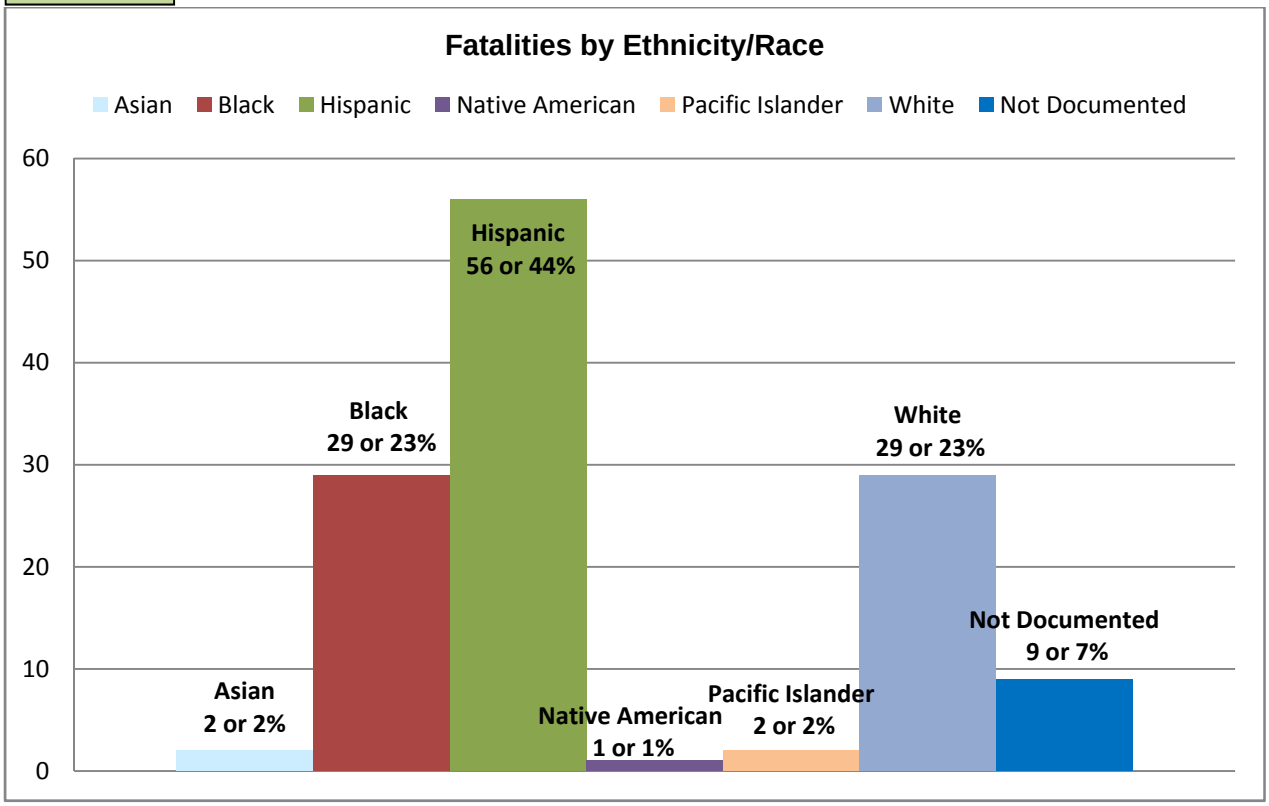


Child Fatalities: Ethnicity/Race

With respect to ethnicity/race for the 128 child fatality incidents reviewed that were determined to be the result of abuse and/or neglect, the data shows that Hispanic children had more reports of fatalities than any other single category of ethnicity/race. It should also be noted that overall, the Hispanic population of children was higher in the general child population in California for 2010 at 49 percent of the total population (see Attachment A).

The data gathered for the 128 child fatality incidents shows 56 of the children (44 percent) were Hispanic, 29 of the children (23 percent) were Black, 29 of the children (23 percent) were White, two children (two percent) were Pacific Islanders, two children (two percent) were Asian and one child (one percent) was Native American. For nine of the children (seven percent) the ethnicity/race of the child was not documented. Chart E depicts the ethnicity/race of all of the fatality incidents reported for CY 2010.

CHART E



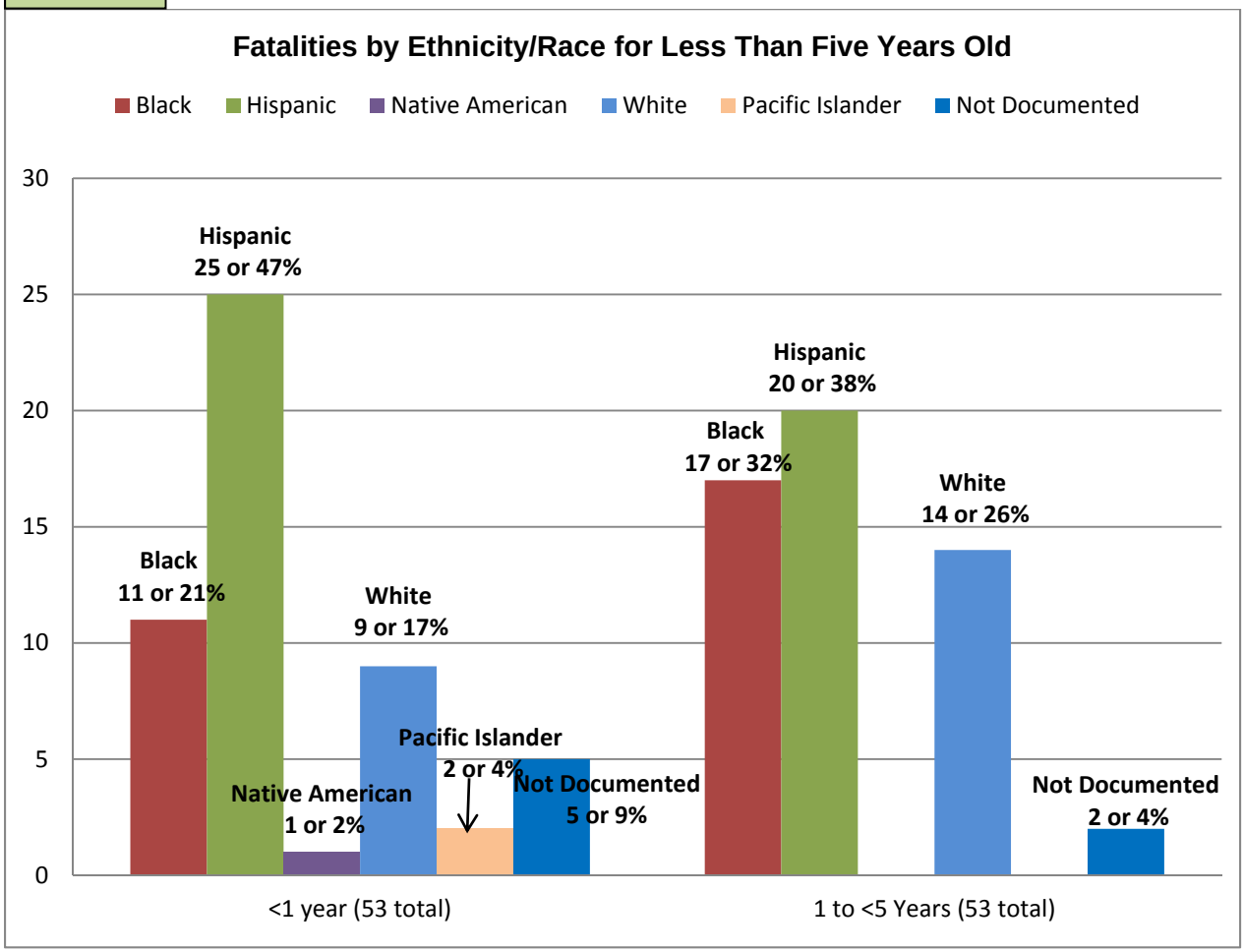
For child fatality incidents reported in CY 2010, Hispanic children were more frequently victims of such incidents based upon the reports submitted to the CDSS, which coincides with their general representation in the overall child population. White children represented 31 percent of the general child population and 23 percent of child fatalities reported. However, Black children represented only six percent of the general child population and 23 percent of child fatalities reported, which indicates a disproportionate number of fatalities for Black children compared to Hispanic or White children.

Of the 128 child fatalities reported, there were 53 child fatality incidents in the less than one-year-old age group. Their ethnicity/race breakdown is as follows: 25 children (47 percent) were Hispanic, 11 children (21 percent) were Black, nine children (17 percent) were White, two children (four percent) were Pacific Islanders and one child (two percent) was Native American. For five children (nine percent) the ethnicity/race was not documented. Chart F depicts the age and ethnicity/race of child fatality incidents for children less than five years old.

Of the 128 child fatalities reported, there were 53 child fatality incidents in the one- to four-year-old age group. Their ethnicity/race breakdown is as follows: 20 children (38 percent) were Hispanic, 17 children (32 percent) were Black, 14 children (26 percent) were White and for two children (four percent) the ethnicity/race was not documented.

Of the 128 child fatalities reported, there were 22 child fatality incidents in the five- to 17-year-old age group. Their ethnicity/race breakdown is as follows: 11 children (50 percent) were Hispanic, six children (27 percent) were White, two children (nine percent) were documented as Asian and one child (five percent) was Black. For two children (nine percent) the ethnicity/race was not documented.

CHART F



Child Abuse Versus Neglect – What is Known

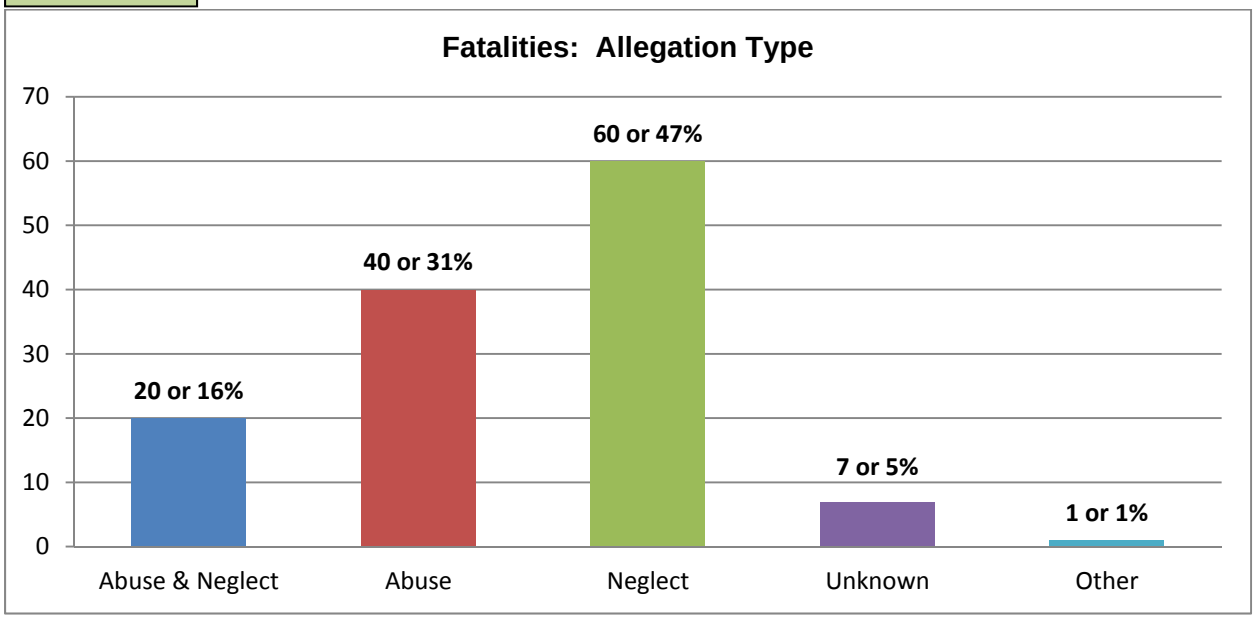
The following data depicts the types of allegations associated with the referrals generated by the CWS agencies for the child fatality incidents that were reported for CY 2010.

It should be noted that a combined allegation of abuse and neglect may occur when there are two individuals responsible for the fatality. These allegation types described below represent the allegations documented for the referrals associated with the SOC 826 form.

The data shows that allegations of neglect were documented in CWS/CMS more often than any other single allegation category in the fatality incidents reported to the CDSS for CY 2010. This is similar to what was found in those incidents with CWS history for the referral immediately preceding the fatality. Chart G depicts the allegation types for all child fatality incidents reviewed for CY 2010.

The data shows that 60 of the 128 child fatality incidents (47 percent) for CY 2010 had allegations of child neglect. The allegation types for the remaining 68 incidents were as follows: 40 incidents (31 percent) were reports of abuse, 20 incidents (16 percent) were reports of abuse and neglect, in seven incidents (five percent) the allegation type was unknown[6] and one incident (one percent) was a combination of abuse and caretaker absence/incapacity listed as "Other."

CHART G



[6] Individuals who were responsible for the fatality incident and whose identity was known to the CWS agency but not given an allegation or disposition in the investigation referral were classified as "unknown."

Allegation Type Compared to Age

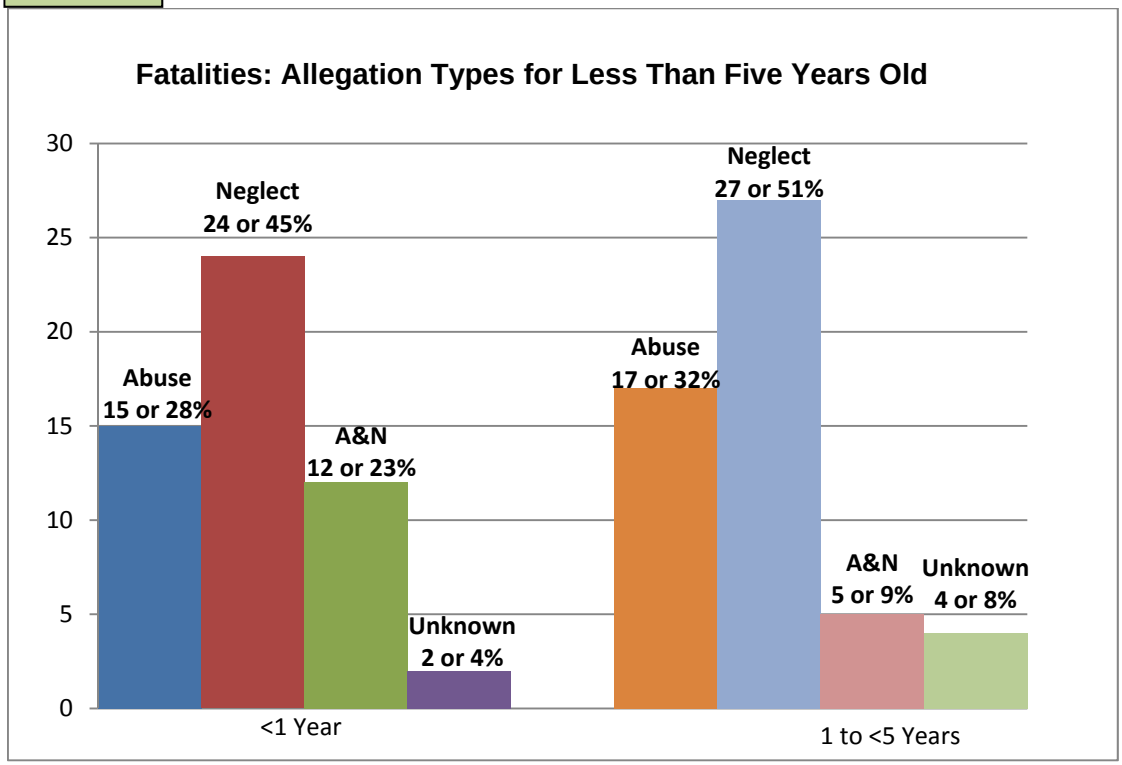
Of the 128 child fatalities reported, the allegation types for the 53 fatality incidents in the less than one-year-old age group were as follows: 24 incidents (45 percent) were neglect allegations, 15 incidents (28 percent) were abuse allegations, 12 incidents (23 percent) were abuse and neglect allegations and two incidents (four percent) were unknown.

Of the 128 child fatalities reported, the allegation types for the 53 fatality incidents in the one- to four-year-old age group were as follows: 27 incidents (51 percent) were neglect allegations, 17 incidents (32 percent) were abuse allegations, five incidents (nine percent) were abuse and neglect allegations and four incidents (eight percent) were unknown.

Of the 128 child fatalities reported, the allegations types for the remaining 22 incidents in the five- to 17-year-old age group were as follows: nine incidents (41 percent) were neglect allegations, eight incidents (36 percent) were abuse allegations, three incidents (14 percent) were abuse and neglect allegations, one incident (five percent) was unknown and one incident (five percent) was a combination of abuse and caretaker absence/incapacity listed as "Other."

For children less than five years of age, neglect was the most reported allegation. Chart H depicts the fatality allegation types for children less than five years old.

CHART H



Who Was Identified as the Individual Responsible for the Fatality Incidents

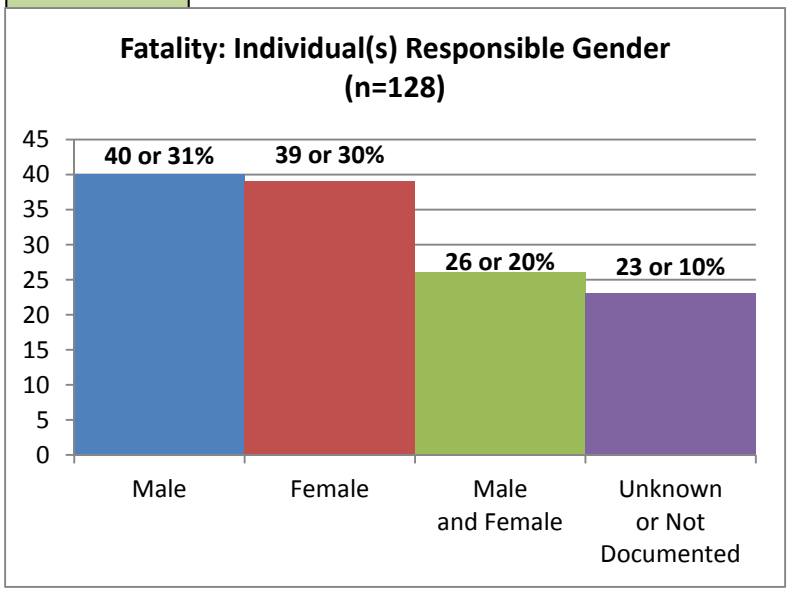
When analyzing child fatalities and addressing the issues surrounding these sensitive incidents, it is important to understand who a CWS agency had identified as being responsible for the abuse and/or neglect that resulted in the child's fatality. It is important to note that the individual responsible for the fatality might not be identified if, at the time of the fatality, more than one individual had access to the child. The following provides information regarding the individual(s) identified by the CWS agency and documented in CWS/CMS as the individual(s) responsible for the fatality incidents. This report also includes additional analysis of incidents in which more than one individual was responsible for the fatality incident. Chart I depicts the gender of the individual(s) responsible for the reported child fatality incidents.

Gender of Responsible Individual(s)

The data shows that in 40 of the 128 child fatality incidents (31 percent), the individual responsible was a male. In 39 of the fatality incidents (30 percent), the individual responsible was a female. In 26 of the fatality incidents (20 percent), there were two individuals identified by the CWS agency as responsible for the fatality which included both a male and a female in each incident. In 23 of the fatality incidents (18 percent), the identity of the individual responsible was unknown or not documented.

Of the 53 child fatality incidents in the less than one-year-old age group, more males than females were identified as the individual responsible for the fatality incident. In 18 of these incidents (34 percent), the individual responsible for the fatality was a male; and in 15 of these incidents (28 percent), both a male and a female were responsible for the fatality. In 12 of these incidents (23 percent), the individual responsible was a female. In eight of these incidents (15 percent), the identity of the individual responsible was unknown or not documented.

CHART I



Of the 53 child fatality incidents in the one- to four-year-old age group, more females than males were identified as the individual responsible for the fatality. In 21 of these incidents (40 percent), the individual responsible was a female; and in 14 of these incidents (26 percent), the individual responsible was a male. In ten of these incidents (19 percent), the identity of the individual responsible was unknown or not documented. In eight of these incidents (15 percent), the individuals responsible included both a male and a female.

Of the remaining 22 child fatality incidents in the five- to 17-year-old age group, more males than females were identified as the individual responsible for the fatality incident. In eight of these incidents (36 percent), the individual responsible was a male; and in six of these incidents

(27 percent), the individual responsible was a female. In five of these incidents (23 percent), the identity of the individual responsible was unknown or not documented. In three of these incidents (14 percent), the individuals responsible included both a male and a female.

Relationship to the Child of Individual(s) Responsible for the Fatality

Table 3 provides greater detail of the individuals identified as being responsible for the fatalities reported. In 87 of the 128 child fatality incidents (68 percent), a biological parent, either individually or in conjunction with another individual, was identified as the individual(s) responsible for the incidents. In 34 of the 128 child fatality incidents (27 percent), the biological mother was exclusively responsible for the fatality; and the biological father was exclusively responsible for 31 of the 128 child fatality incidents (24 percent). In four of the 128 child fatality incidents (three percent), a foster parent, either individually or in conjunction with another individual, was responsible for the incidents.

There were a total of 15 incidents in which the biological parents' significant others were involved in the fatality incidents (12 percent) exclusively or in conjunction with another individual. In 16 of the 128 child fatality incidents (13 percent), the individual responsible for the fatality was unknown.

Table 3. Individual(s) Responsible

Individual(s) Held Responsible for the Fatality	Total Count	Proportion to the Total (n=128)
Bio Mother	34	27%
Bio Father	31	24%
Unknown	16	13%
Biological Parents	15	12%
Not Documented	7	5%
Other[7]	6	5%
Bio Mother's Significant Other (M)	6	5%
Bio Mother & her Significant Other (M)	5	4%
Foster Parents	3	2%
Bio Father & his Significant Other (F)	2	2%
Bio Father's Significant Other (F)	1	1%
Foster Parents & Other	1	1%
Bio Mother's Significant Other (M) & Unknown	1	1%
Total	**128**	**102%**

Seven of the 128 child fatality incidents involved cases in which the individual responsible for the incident which caused the fatality was not documented. It is important to note that in these seven incidents in which the individual responsible for the incident was "not documented," the biological parent(s) were not identified as being responsible for causing the fatality; however, a referral for neglect was substantiated against them for either failing to seek immediate medical care for the injury or illness, failing to provide an explanation of the injury, and/or failing to protect the child.

[7] See Table 4 for a breakdown of "Other" individuals.

Table 4 breaks down the individual(s) held responsible for the fatalities listed as "Other."

Table 4. Other Individual(s) Responsible

Other Individual(s) Held Responsible for the Fatality	Total Count
Other Female Relative	3
Other Male Relative	1
Adoptive Parents	1
Unrelated Adult Male	1
Total	**6**

Individual(s) Responsible for Fatality by the Victim's Age

Table 5 depicts the age of the victim with the individual(s) responsible for the fatality. Biological fathers were most frequently responsible for the fatality incidents of victims under the age of one (32 percent) followed by biological parents together (25 percent), and then by biological mothers (21 percent). Biological mothers were most frequently responsible for the fatality incidents of victims between the ages of one and four years old. Biological parents, either individually or in conjunction with their significant other, were more frequently responsible for the fatality incidents of victims over the age of 10.

Table 5. Individual(s) Responsible and the Age of the Victims

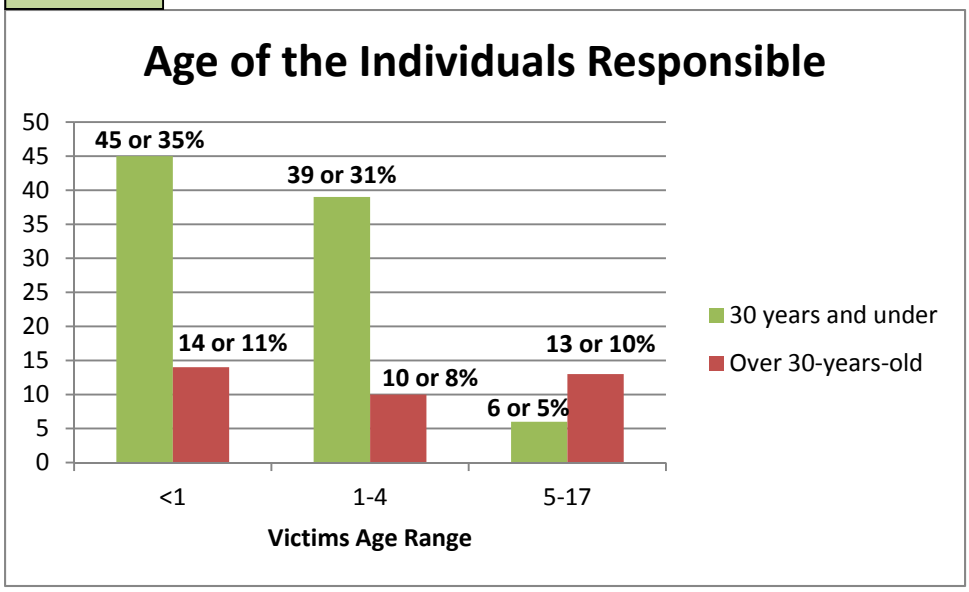
	Age of the Victims					
Individual(s) Responsible	<1	1-4	5-9	10-14	15-18	Total
Bio Father	17	10	1	2	1	**31**
Bio Father & his Significant Other (F)		1		1		**2**
Bio Father's Significant Other (F)				1		**1**
Bio Mother	11	19	2		2	**34**
Bio Mother & her Significant Other (M)	1	3		1		**5**
Bio Mother's Significant Other (M)	1	3	2			**6**
Bio Mother's Significant Other (M) & Unknown			1			**1**
Biological Parents	13	2				**15**
Foster Parents	2	1				**3**
Foster Parents & Other[8]		1				**1**
Not Documented	2	4	1			**7**
Other[8]		3	3			**6**
Unknown	6	6	1	1	2	**16**
Grand Total	**53**	**53**	**11**	**6**	**5**	**128**

[8] Individuals held responsible in Table 5 for the fatality listed as "Other" consists of female relatives, male relatives, a set of adoptive parents, and an unrelated adult male who were responsible for the child fatality.

Age of the Individuals Responsible for Fatality by Victim's Age

Chart J depicts the age of the individuals responsible for the child fatality incidents with the age range of the victim children for those cases in which the age of the individual responsible was known. Of the 128 child fatality incidents, there were a total of 101 incidents in which the age of the individual responsible for the incident was known. Of these 101 incidents, there were a total of 127[9] individuals responsible for the fatalities. For the less than five-year-old age group of victims, the individual responsible was most often 30 years of age or younger (66 percent). However, for the five- to 17-year-old age group of victims, the individual responsible for the fatality was more often over 30 years of age (ten percent). This data pattern seems consistent with common expectations, in that, as children age, so do their parents. As such, fatalities of older children were more likely to involve older parents.

CHART J



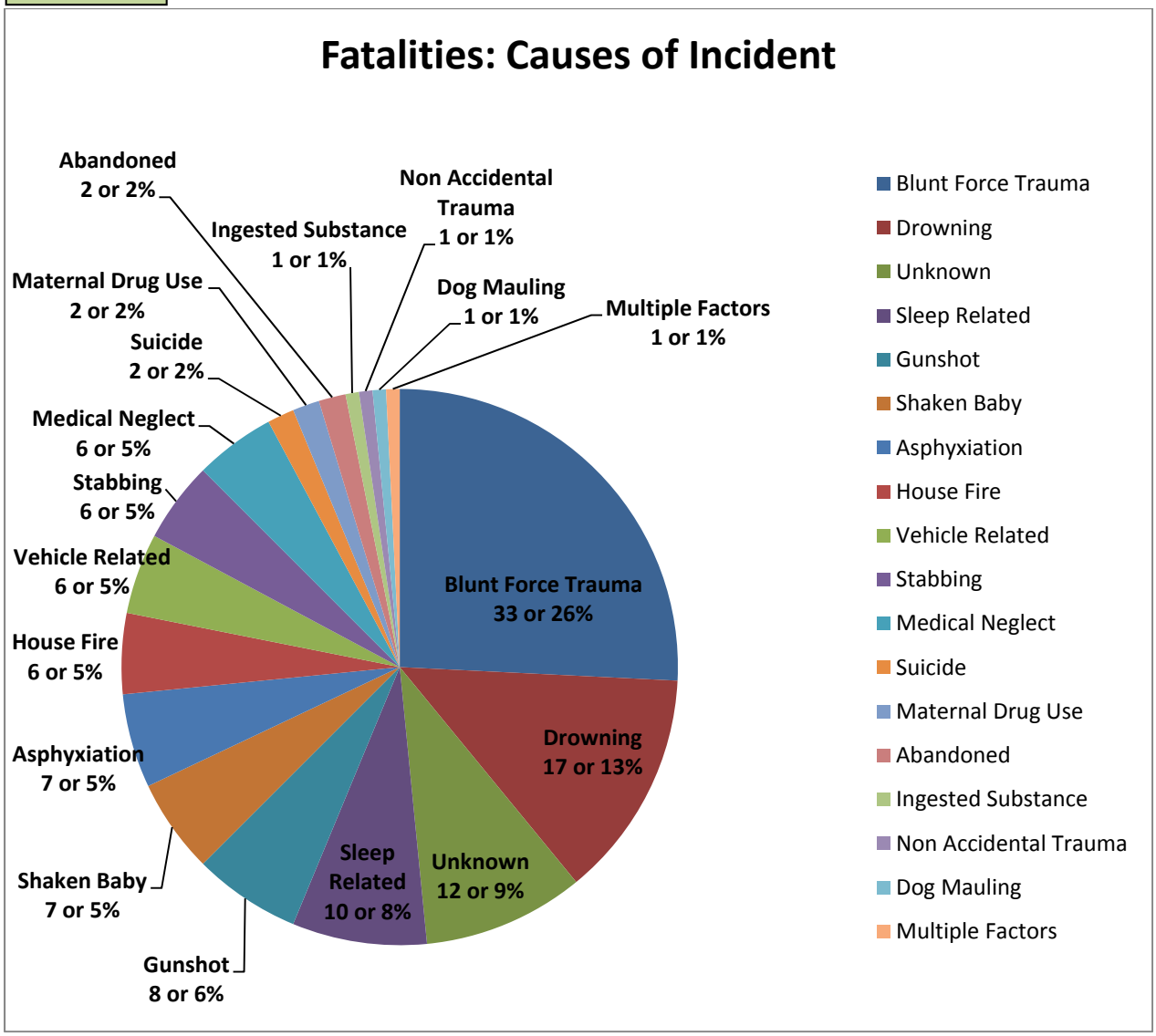
In summary, in reviewing who was identified as the individual responsible for child fatalities reported in CY 2010, more males than females were responsible for the fatality incidents resulting from abuse and/or neglect; however, the margin between the two is very small. For children less than one-year-old and for children between the age of five and 17 years old, more males than females were identified as the individual responsible for the fatality incidents. For children between the age of one and four years old, more females than males were identified as the individual responsible for the fatality incidents. Additionally, there are no significant differences between biological mothers (27 percent) and biological fathers (24 percent) being identified more often as the individual responsible for the fatality. With respect to the age of the individual responsible for the fatality incidents reported, over half of the known individuals responsible for the fatality incidents reported were 30 years of age or younger.

[9] Of the 101 fatality incidents where the age of the individual responsible was known, there were 26 incidents where two individuals were responsible making the total 127 individuals.

Specific Cause/Finding of Incident

The specific causes or findings in the 128 child fatalities reviewed that were determined to be the result of abuse and/or neglect during CY 2010 are categorized below in Chart K. A review of these incidents indicated that the most commonly reported causes of fatalities were blunt force trauma, drowning, unknown and sleep related deaths. The causes listed below are based on the causes identified by counties in the documentation in CWS/CMS. In Chart K, the "multiple factors" category represents those incidents in which two or more causes were identified and documented, such as asphyxiation and blunt force trauma. The "unknown" category represents those incidents in which the cause of the fatality was either undetermined or not documented in CWS/CMS.

CHART K



Causes Compared to Allegation Type

Table 6 is a detailed distribution of the causes of child fatalities and the allegation type that was documented by the CWS agency. Most of the acts of blunt force trauma involved referrals which were substantiated on allegations of abuse or abuse and neglect. Additionally, drownings were primarily substantiated for neglect along with sleep related fatalities.

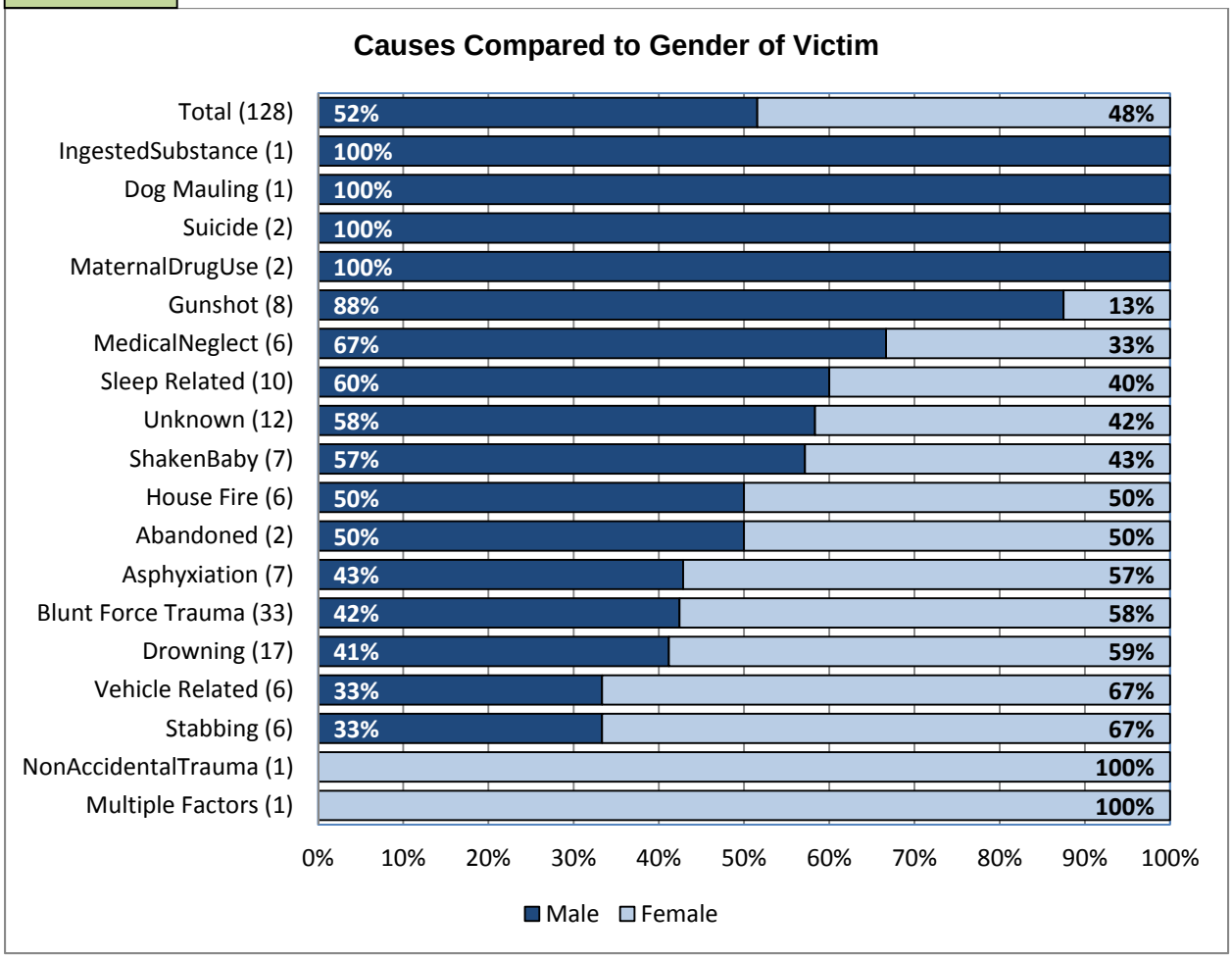
Table 6. Causes and Allegation Type

Causes	Abuse	A&N	Neglect	Other	Unknown	Total
Blunt Force Trauma	16	11	1		5	**33**
Drowning	1	1	15			**17**
Unknown	5	1	5		1	**12**
Sleep Related			10			**10**
Gunshot	3		5			**8**
Shaken Baby	5	2				**7**
Asphyxiation	4	1	2			**7**
Stabbing	4	1	1			**6**
Vehicle Related		2	4			**6**
Medical Neglect			5		1	**6**
House Fire	1		5			**6**
Suicide			1	1		**2**
Maternal Drug Use			2			**2**
Abandoned			2			**2**
Non Accidental Trauma		1				**1**
Multiple Factors	1					**1**
Ingested Substance			1			**1**
Dog Mauling			1			**1**
Grand Total	**40**	**20**	**60**	**1**	**7**	**128**

Causes Compared to Gender of Victim

Chart L is a detailed distribution of the gender of the victim and the cause of fatality. Male victims accounted for a higher proportion (52 percent) of all fatalities in CY 2010 (see Chart D) and were more frequently represented in gunshot (88 percent), medical neglect (67 percent), sleep related (60 percent) and shaken baby (57 percent) incidents. Female victims were more frequently represented in fatalities caused by stabbing (67 percent), vehicle related (67 percent), drowning (59 percent), blunt force trauma (58 percent) and asphyxiation (57 percent) incidents.

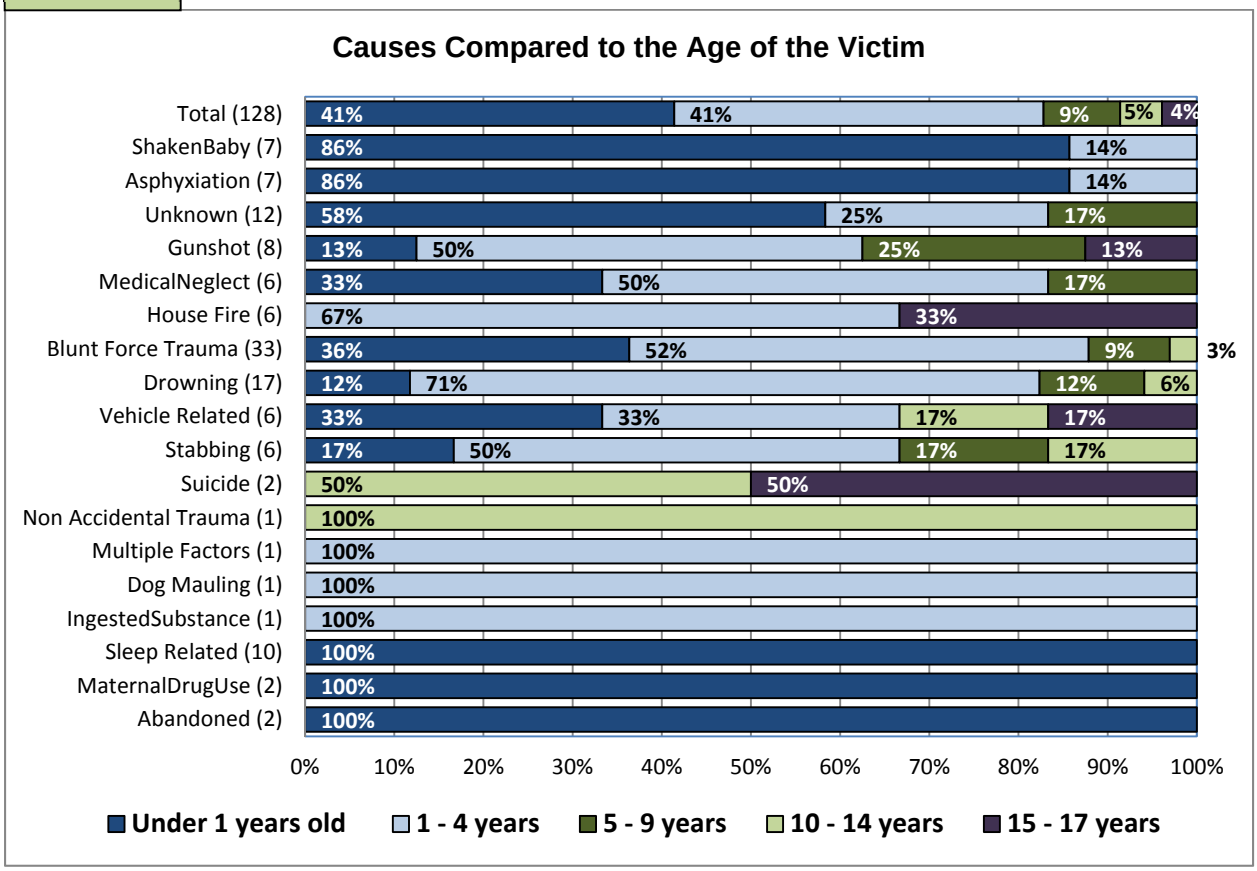
CHART L



Causes Compared to the Age of the Victim

As previously indicated, 83 percent of all child fatalities in CY 2010 were victims under the age of five (see Chart C). Of the older victims, nine percent (n=11) were between five- to nine-years-old, five percent (n=6) were between 10- to 14-years-old and four percent (n=5) were between 15- to 17-years-old. In reviewing the causes of fatalities by the ages of the children involved, the most frequently occurring causes of fatality for children under one year of age were shaken baby (86 percent), asphyxiation (86 percent) and sleep related fatalities (100 percent). Children between the ages of one and four years of age were associated with drownings (71 percent), house fires (67 percent) and blunt force trauma (52 percent). Older children ages ten and over were associated with fatalities from suicide (100 percent), vehicle related incidents (34 percent) and house fires (33 percent). See Chart M below for a distribution of the causes of fatalities and the age of victims.

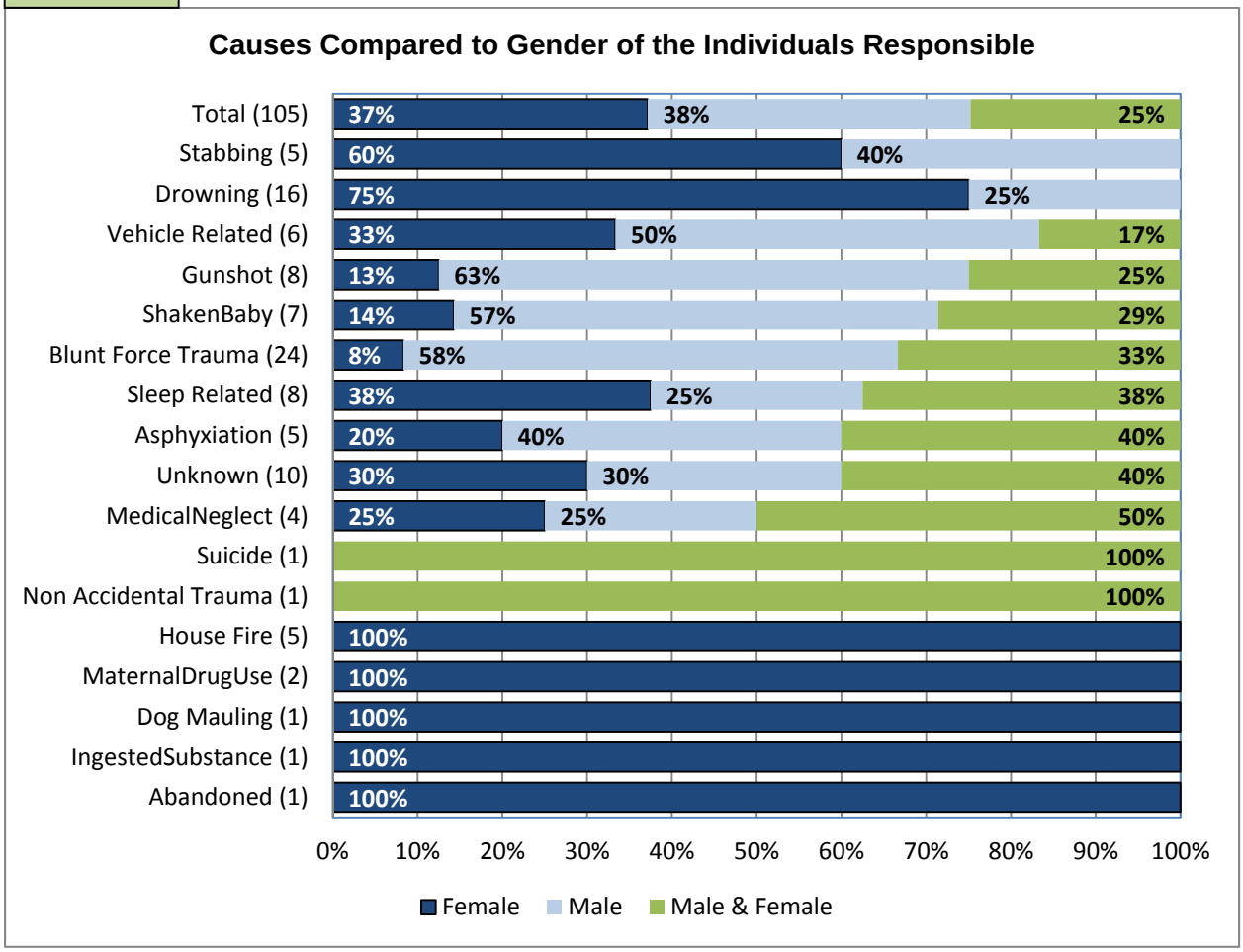
CHART M



Causes Compared to Gender of the Individuals Responsible

As illustrated in Chart N, females were more frequently documented as being responsible for fatalities involving house fire (100 percent), drowning (75 percent), and stabbing (60 percent) incidents. For those cases in which the fatality involved medical neglect of a child, both males and females were responsible (50 percent) exclusively or in conjunction with another individual. Males were more frequently documented as being responsible for fatalities associated with gunshot (63 percent), blunt force trauma (58 percent), shaken baby (57 percent) and vehicle related (50 percent) incidents.

CHART N



Causes Compared to Age of the Individual(s) Responsible

Table 7 depicts a distribution of the causes of child fatality incidents by the age of the individual(s) responsible for the fatality. In 101 of the 128 child fatality incidents where the age of the individual responsible for the fatality was known, there were a total of 127[10] individuals. There are a few noticeable differences of the causes of fatality incidents by the age of the individual responsible. Sleep related fatalities, medical neglect, stabbing, non-accidental trauma, suicide, ingested substance and dog mauling incidents were more frequently associated with individuals over the age of 27. The two individuals between the ages of 16-17 were exclusively responsible for two (two percent) of the 16 drowning fatality incidents.

Table 7. Causes and Age of the Individuals Responsible

	Age of Individuals Responsible							
Causes	**16-17**	**18-20**	**21-23**	**24-26**	**27-30**	**31-40**	**Over 40**	**Total**
Blunt Force Trauma		5	5	7	6	3	5	31
Drowning	2	3	4	2		2	3	16
Unknown		4	2	2	2	2	1	13
Sleep Related				3	6	2		11
Shaken Baby		1	3	1	1	1	2	9
Gunshot				3	2	2	1	8
Asphyxiation		1	3	1	1		1	7
Vehicle Related			2	2	1		2	7
Medical Neglect					1	4	1	6
House Fire				4		1		5
Stabbing		1			3	1		5
Maternal Drug Use				1		1		2
Non Accidental Trauma					1	1		2
Suicide					2			2
Abandoned		1						1
Ingested Substance						1		1
Dog Mauling					1			1
Grand Total	**2**	**16**	**19**	**26**	**27**	**21**	**16**	**127**

[10] Of the 101 fatality incidents where the age of the individual responsible was known, there were 26 incidents where two individuals were responsible, making the total 127 individuals.

Fatality Summary

CY 2010

In summary, it was found that 128 child fatality incidents were reported to the CDSS for CY 2010 that were determined to be the result of abuse and/or neglect. Of the 128 child fatality incidents, four children were living in an out-of-home foster care placement and receiving services at the time of the fatality incident. The CWS agency was more often the determiner of abuse and neglect than other agencies. The most vulnerable population for child fatality incidents were children less than five years old. Overall, the number of male child fatality incidents reported was higher than the number of female child fatality incidents, and Hispanic children were more frequently victims of such incidents based upon the reports submitted to the CDSS, which coincides with their general representation in the overall child population. White children represented 31 percent of the general child population but were 23 percent of the child fatalities reported. However, Black children represented only six percent of the general child population and 23 percent of child fatalities reported, which indicates a disproportionate number of fatalities for Black children compared to Hispanic or White children.

For CY 2010, 48 percent of the child fatality incidents reported involved children who were from families who did not have CWS history in the five years prior to the incident. Of the 66 families who did have prior history, 23 families (35 percent) were also known to a CWS agency at the time of the incident. Sixty-five percent of those 66 families were not clients at the time of the fatality incident; however, 61 percent (40 families) did have some CWS involvement within the six months prior to the incident. Of the 66 families who had prior CWS history, 62 percent of those families' prior referrals immediately preceding the fatality incident either did not meet the criteria for investigation by the CWS agency or were deemed unfounded or inconclusive for abuse or neglect upon investigation.

Blunt force trauma was the most reported cause of fatality incidents for CY 2010 despite neglect being the single most reported allegation. Most of the acts of blunt force trauma involved referrals which were substantiated on allegations of abuse or abuse and neglect. Additional analysis of the causes of incidents by the gender of the victim revealed that the victims of blunt force trauma incidents were 42 percent male and 58 percent female. Males were more frequently represented in gunshot fatality incidents and female victims were more frequently represented in fatalities caused by stabbing and vehicle related incidents. In the analysis of the causes of fatalities by the ages of the children involved, the most frequently occurring causes of fatalities for children under one year of age involved shaken baby (86 percent), asphyxiation (86 percent) and sleep related incidents (100 percent).

The individuals responsible for the child fatality incidents were found to be exclusively male in 31 percent of the fatality incidents reported and female in 30 percent. Additional analysis revealed that females were more frequently documented as being the individual responsible for fatality incidents involving drowning. Sixty-eight percent of the individuals responsible for the fatality incidents for CY 2010 were a biological parent. Additionally, of those cases where the individual responsible was known, 71 percent of those individuals were 30 years of age or younger at the time of the incident.

Of the 128 child fatality incidents reviewed, 31 referrals for the fatality incident (24 percent) were evaluated out, leaving limited documentation in CWS/CMS about those incidents. Due to the

lack of additional documentation in these referrals, the aggregate view of these incidents is limited.

Comparison with Prior Years' Reports

In the CY 2008 report, the coroner or medical examiner determined the fatality incidents to be the result of abuse/neglect more than any other agency. However, in CYs 2009 and 2010, child fatality incidents reported to the CDSS were determined more often by a CWS agency alone. The number of fatalities reported by counties has increased by eight incidents since CY 2008. The percentage of children in an out-of-home placement or foster care has decreased from five percent in CY 2009 to three percent in CY 2010.

Consistent with CYs 2008 and 2009, Hispanic children were more frequently victims of such incidents, which coincides with their general representation in the overall child population. However, for Black children, their representation in child fatalities reported has been disproportionate to their representation in the general population. Since CY 2008, the majority of the victims of fatalities have remained children less than five years of age. The gender of the majority of victims of child fatality incidents has shifted from males in CY 2008 to female victims in CY 2009 back to male victims in CY 2010.

Since the release of the CY 2008 report, the finding that nearly half of the families with reported child fatality incidents were not known to a CWS agency at the time of the incident nor had history within five years of the incident has remained consistent. Of those families that had CWS history, 12 percent in CY 2008, 13 percent in CY 2009 and 18 percent in CY 2010 were known to a CWS agency at the time of the incident.

Blunt force trauma has consistently been the most reported cause of child fatalities since CY 2008. While the most reported cause of fatality has remained the same since 2008, the most reported referral allegation has changed from abuse in CY 2008, to neglect for CYs 2009 and CY 2010. The increase in neglect allegations may be attributed to either failing to seek immediate medical care for the injury or illness, failing to provide an explanation of the injury and/or failing to protect the child.

With respect to the data in this report regarding the individual responsible for the fatality incidents, the reader is cautioned to not make comparisons between this year's report and prior years' reports. In an effort to provide a more comprehensive analysis of those individuals responsible for these incidents, the CDSS revised its methodology for collecting this data and completed additional analysis of this data element. Therefore, information in this report regarding the individual responsible for the fatality incidents cannot be compared with prior years' reports due to the differences in methodology and data collection.

V. Near Fatalities

General Information

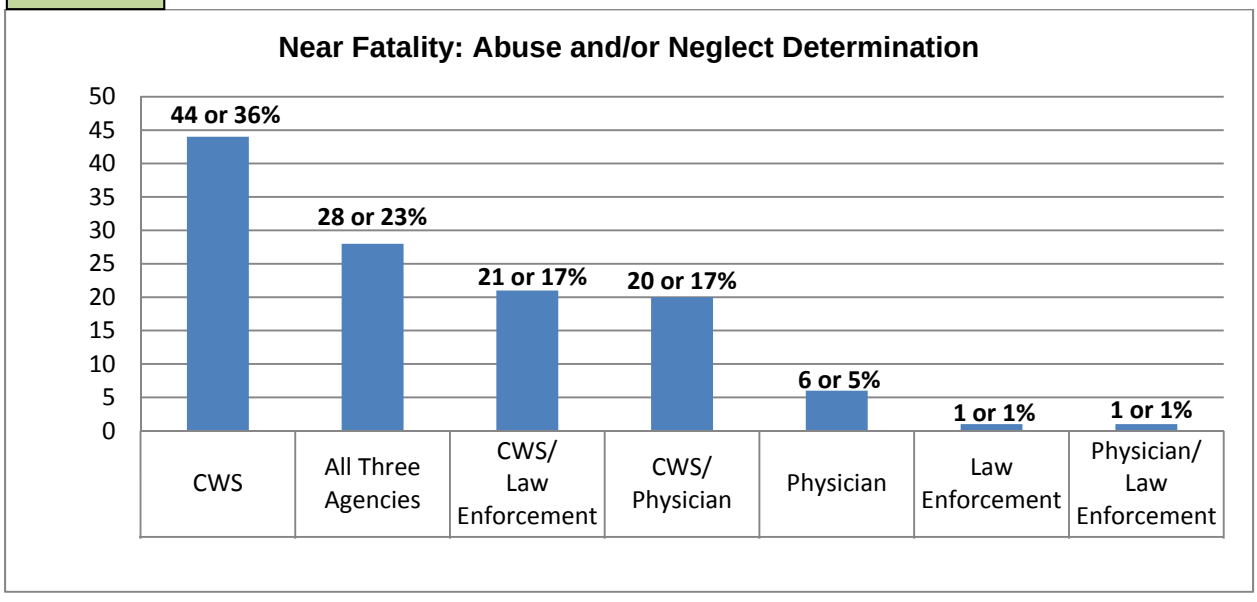
With respect to near fatalities, California Child Welfare Services (CWS) agencies reported 121 child near fatalities determined to be the result of abuse and/or neglect in CY 2010. A near fatality is defined as *a severe childhood injury or condition caused by abuse or neglect which results in the child receiving critical care for at least 24 hours following the child's admission to a critical care unit(s)*. Of the 121 child near fatalities reported, 118 children resided in the home of the parent/guardian and three children resided in an out-of-home placement or foster care.

Of the 121 child near fatality incidents reported, Chart O depicts which agency (CWS, law enforcement and/or a physician) made the determination that the child's near fatality was the result of abuse and/or neglect as reported on the SOC 826 form submitted by counties. The determination was made as follows:

- 44 child near fatality incidents (36 percent) by CWS.
- 28 child near fatality incidents (23 percent) by all three agencies.
- 21 child near fatality incidents (17 percent) by law enforcement and CWS.
- 20 child near fatality incidents (17 percent) by a physician and CWS.
- Six child near fatality incidents (five percent) by a physician.
- One child near fatality incident (one percent) by law enforcement.
- One child near fatality incident (one percent) by a physician and law enforcement.

Similar to child fatalities reported for CY 2010, over one-third of the child near fatality incidents were determined by CWS alone.

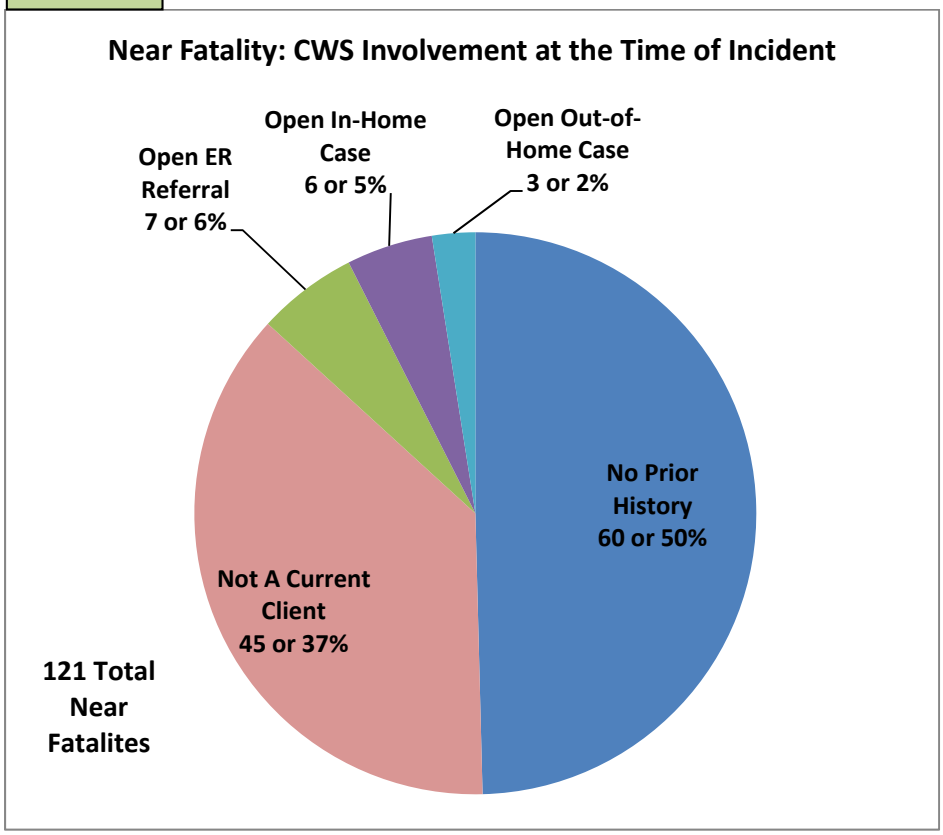
CHART O



Child Welfare Services Involvement/History

In reviewing the total 121 child near fatality incidents that were the result of abuse and/or neglect submitted by counties for CY 2010, the data shows that 60 incidents (50 percent) involved children from families who had no prior CWS history in the five years prior to the incident, and 61 incidents (50 percent) involved children from families who were previously known to a CWS agency in the five years prior to the near fatality incident, including 16 families who were receiving child welfare services at the time of the incident (see Chart P).

CHART P



Families with No CWS Involvement/History in the Five Years Prior to the Incident

As previously stated, of the 121 child near fatality incidents reported, there were 60 incidents that involved children from families that were not involved with a CWS agency at the time of the near fatality incident, in that the family was not part of an open emergency response investigation nor were the children in an open case. In addition, none of these 60 families had CWS history in the five years prior to the incident. The age group breakdown for these 60 families can be found in the following paragraph.

Of the 60 families that did not have prior CWS history in the five years prior to the incident, 33 children (55 percent) were less than one year of age. In 23 incidents (38 percent), the children were in the one- to four-year-old age group; and lastly, in four incidents (seven percent), the children were in the five- to 17-year-old age group.

Families with CWS Involvement and/or History in the Five Years Prior to the Incident

Sixty-one (50 percent) of the children were from families which had CWS history in the five years prior to the near fatality incident.[11] Furthermore, of those that had CWS history, 16 families (26 percent) were involved with a CWS agency at the time of the incident. Table 8 reflects the CWS agency involvement at the time of the near fatality for the 61 families who had CWS history in the five years prior to the incident.

Table 8. Number of Families with CWS Involvement and/or History in the Five Years Prior to the Incident

45	Not a current client of a CWS agency (but had prior history)
7	Open Emergency Response Referral
6	Open in-home case with a child welfare agency
3	Open out-of-home case with a child welfare agency

CWS Involvement by Age Group

Of the 61 child near fatality incidents where the child or family was previously known to a CWS agency, there were 34 incidents for children in the less than one-year-old age group. Of those 34 incidents, 26 families (43 percent) were not current clients of a CWS agency at the time of the near fatality incident; in four incidents (seven percent), the families had an open Emergency Response (ER) referral at the time of the near fatality incident; and in four incidents (seven percent) the child was living in the home of his/her parent(s) and receiving CWS services at the time of the near fatality incident.

Of the 61 child near fatality incidents where the child or family was previously known to a CWS agency, there were 21 incidents for children in the one- to four-year-old age group. Of those 21 incidents, 14 families (23 percent) were not current clients of a CWS agency at the time of the near fatality incident; in three incidents (five percent), the families had an open ER referral at the time of the near fatality incident; in two incidents (three percent), the children were living in the home of his/her parent(s) and receiving CWS services at the time of the near fatality; and in two incidents (three percent) the child was living in an out-of-home foster care placement and receiving services at the time of the near fatality incident.

Of the 61 child near fatality incidents where the child or family was previously known to a CWS agency, there were six incidents for children in the five- to 17-year-old age group. Of those six incidents, five families (eight percent) were not current clients of a CWS agency at the time of the near fatality incident; and in one incident (two percent), the child was living in an out-of-home foster care placement and receiving services at the time of the near fatality incident.

In summary, the data shows that half of the families in near fatality incidents reported for CY 2010 did not have any prior involvement with a CWS agency at the time of the incident or within the five years prior to the near fatality incident. Of the near fatality incidents involving children from families with CWS history, 74 percent were not current clients at the time of the near fatality incident which is the 45 families referenced in Table 8.

[11] CWS history/involvement is based on the family of the child whether the parents were the individual(s) responsible for the near fatality or not.

Information Regarding the CWS Referral Immediately Preceding the Incident

When reviewing the prior CWS history of those 61 near fatality incidents involving children from families which had prior CWS history, it is important for the reader to keep in mind two points. First, when a CWS agency receives a report alleging that a child may be the subject of abuse and/or neglect, the CWS agency is responsible for generating a referral and for processing that referral according to state regulations.[12] As such, it is important to recognize that the existence of a referral does not necessarily mean that the allegations generating that referral were substantiated or found to be true. The referral may have not have met the criteria for investigation by the CWS agency and as a result was evaluated out. See Attachment C for a glossary of CWS terminology used in this section and throughout the report. If investigated, the disposition for the referral may have been unfounded, inconclusive or substantiated. Second, the prior CWS history/referrals involving these families may not have included the child who was the subject of the near fatality incident and the household composition may have been different at the time of the near fatality. For example, the prior CWS referral may have been for neglect due to unsanitary living conditions before the victim child was even born, while in the current near fatality incident, the victim child was the actual subject of physical abuse. The information that follows offers a look at the families who had CWS history at the time of the near fatality incident by examining the referral immediately preceding the incident. These families' histories with the CWS agency may offer some insight into future policy and prevention strategies.

In 36 of these 61 families (59 percent) with prior CWS history, a report of suspected child abuse or neglect had been made and the CWS agency generated a referral in the six months prior to the near fatality incident. The remaining 25 families had prior referrals which were spread out over a time period of up to five years. Six families (ten percent) had referrals that were reported six to 12 months before the incident occurred; six families (ten percent) had referrals reported in the 12 to 18 months before the incident occurred; one family (two percent) had referrals reported 18 to 24 months before the incident occurred; three families (five percent) had referrals reported 24 to 36 months before the incident occurred; and nine families (15 percent) had referrals reported 36 to 60 months before the incident occurred.

It was also found that the majority of allegations for the referral immediately preceding the near fatality incident were for neglect, 36 (59 percent) of the 61 incidents. Fifteen referrals (25 percent) had an allegation of abuse; eight referrals (13 percent) had combined allegations of abuse and neglect; and two referrals (three percent) had an allegation of caretaker absence/incapacity.

As previously discussed, the existence of a referral does not necessarily mean that the allegations generating the referral were substantiated. In fact, when looking at the prior referrals of the 61 families with CWS history within the five years prior to the near fatality incident, in 23 referrals (38 percent) the previous allegations' dispositions were unfounded; in ten referrals (16 percent), the disposition was inconclusive; in ten referrals (16 percent), the disposition was substantiated; in ten referrals (16 percent), there were multiple allegations with multiple dispositions; and in eight referrals (13 percent), the referral was evaluated out; therefore, there was no disposition.

[12] CDSS MPP Division 31-101 states "the county shall respond to all referrals for service which allege that a child is endangered by abuse, neglect, or exploitation." MPP sections 31-105, 31-110, 31-115, 31-120, and 31-125 detail the decision process to respond to the allegations.

These findings show that of the 61 near fatality incidents where families did have prior CWS history, 42 families (69 percent) had some CWS involvement within a year prior to the near fatality incident taking place. Of the prior referrals immediately preceding the near fatality incident, 59 percent of the allegations were for neglect. Lastly, while these 61 families did have some CWS involvement, 67 percent of the referrals immediately preceding the near fatality incident either did not meet the criteria for investigation by the CWS agency or were deemed unfounded or inconclusive upon investigation.

Demographics Information

A comprehensive analysis of the CY 2010 data for age, gender, and ethnicity/race for child near fatalities determined to be the result of abuse and/or neglect 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 2010[13] was used for analysis. This can be found as Attachment A at the end of this report.

As can be seen from Attachment A, 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 as each group comprised 27 percent of the total population. Children between the ages of 15 to 17 years comprised 19 percent of the total child population.

With respect to ethnicity/race, the Hispanic population represented 49 percent of the total child population. In the under-five age group, Hispanic children represented 51 percent of the child population, while White children represented 29 percent and Black children represented six 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 5,101,687 male children in California, 1,400,730 (27 percent) were under the age of five. Similarly, of the 4,889,841 female children in California, 1,345,126 (28 percent) were under the age of five.

Demographic Characteristics of Near Fatalities

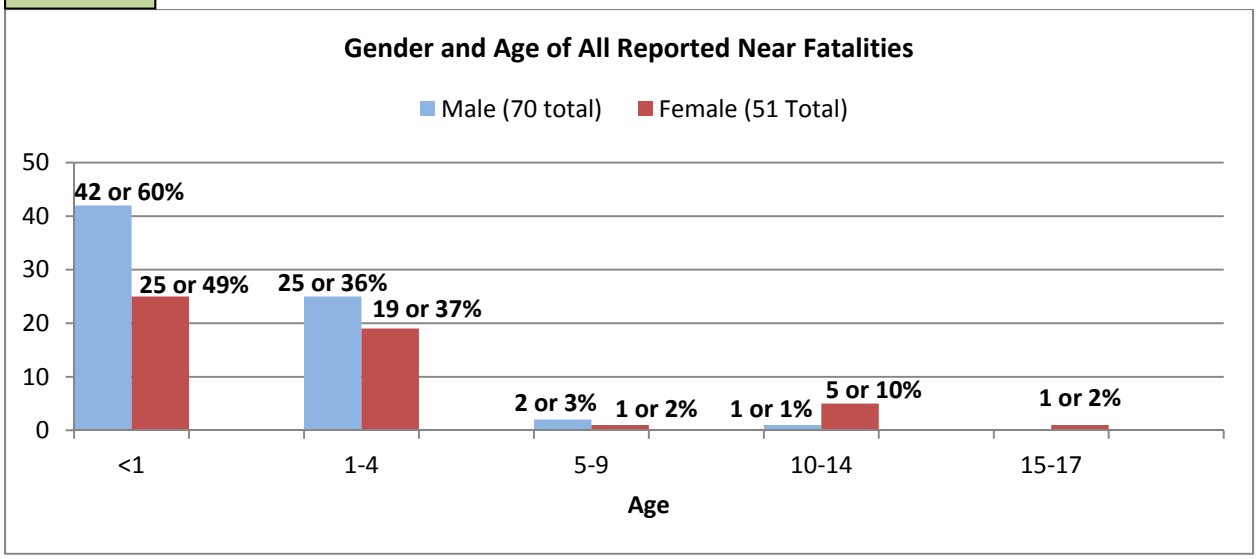
The data gathered for the 121 child near fatality incidents with respect to age was similar to the data for child fatality incidents, with the greater incidences of near fatalities occurring in the youngest populations. Chart Q on the following page, which depicts the gender of children by age group, shows 111 of the 121 child near fatality incidents (92 percent) were children ages four years of age and younger. Of those, 67 children (55 percent) were less than one-year-old and 44 children (36 percent) were between the ages of one and four. The remaining ten child near fatality incidents (eight percent) were in the five- to 17-year-old age group.

[13] The 2010 population estimate from the DOF website was used for the data in this report.

Gender and Age

The breakdown for gender in the less than one-year-old age group was 42 males and 25 females, and in the one- to four-year-old age group it was 25 males and 19 females. Chart Q, which depicts the gender of children by age group, shows that the greatest difference between males and females is for the less than one-year-old age group.

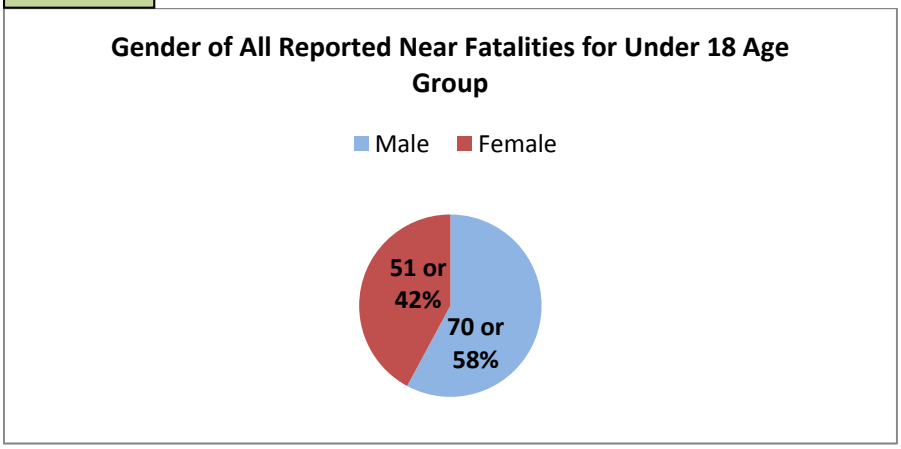
CHART Q



Gender

Overall, the number of male child near fatality incidents reported was higher than the number of female child near fatality incidents; there were 70 incidents compared to 51 incidents, respectively, for all children under 18 in the near fatality group (see Chart R). The higher number of male children in the less than five-year-old age groups contributed to the greater representation of males for child near fatality incidents.

CHART R

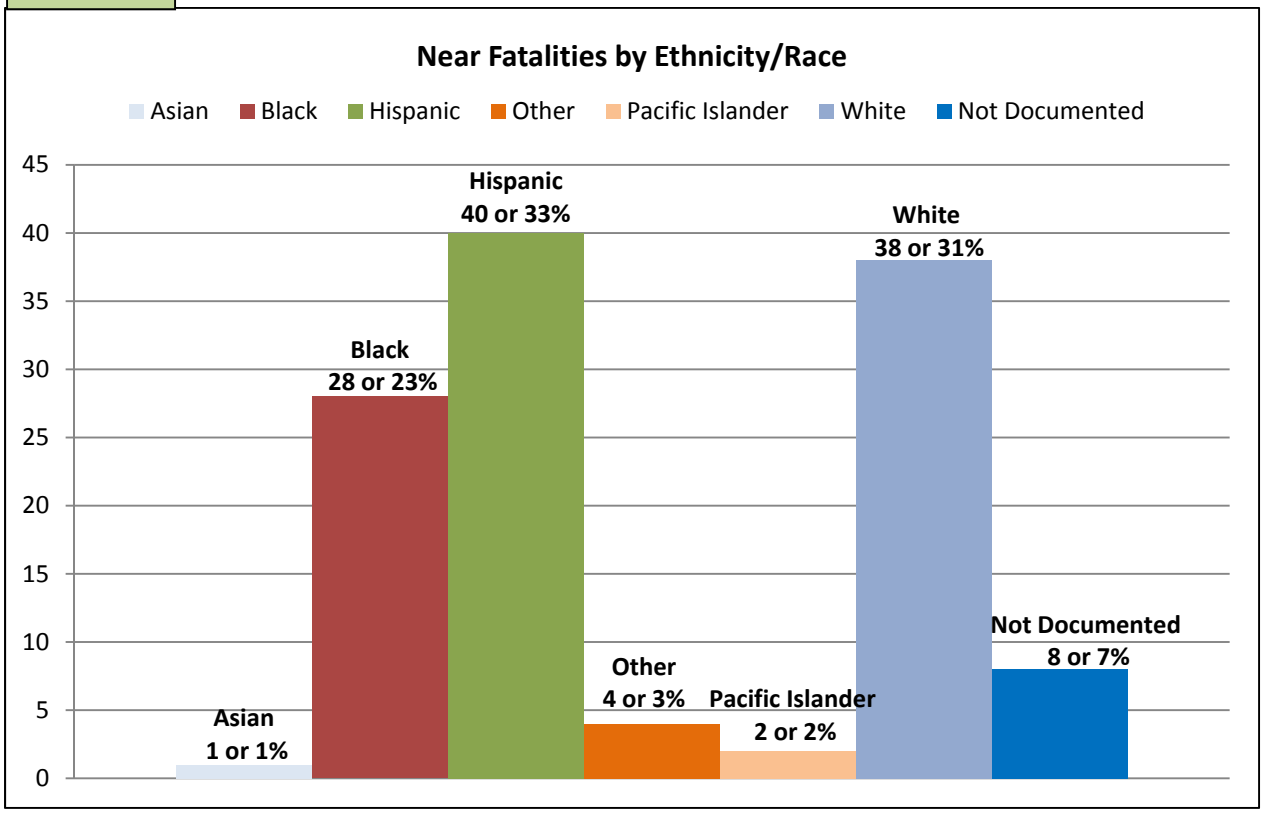


Child Near Fatalities: Ethnicity/Race

With respect to ethnicity/race for the 121 child near fatalities incidents reviewed that were determined to be the result of abuse and/or neglect, the data shows that Hispanic children had more reports of near fatalities than any other single category of ethnicity/race. It should also be noted that overall, the Hispanic population of children was higher in the general child population in California for 2010 at 49 percent of the total population (see Attachment A).

The data gathered for the 121 child near fatality incidents shows 40 of the children (33 percent) were Hispanic, 38 of the children (31 percent) were White, 28 of the children (23 percent) were Black, two children (two percent) were Pacific Islanders and one child (one percent) was Asian. For eight of the children (seven percent) the ethnicity/race of the child was not documented and four children (three percent) were documented as "Other." Chart S depicts the ethnicity/race for all of the near fatality incidents reported for CY 2010.

CHART S



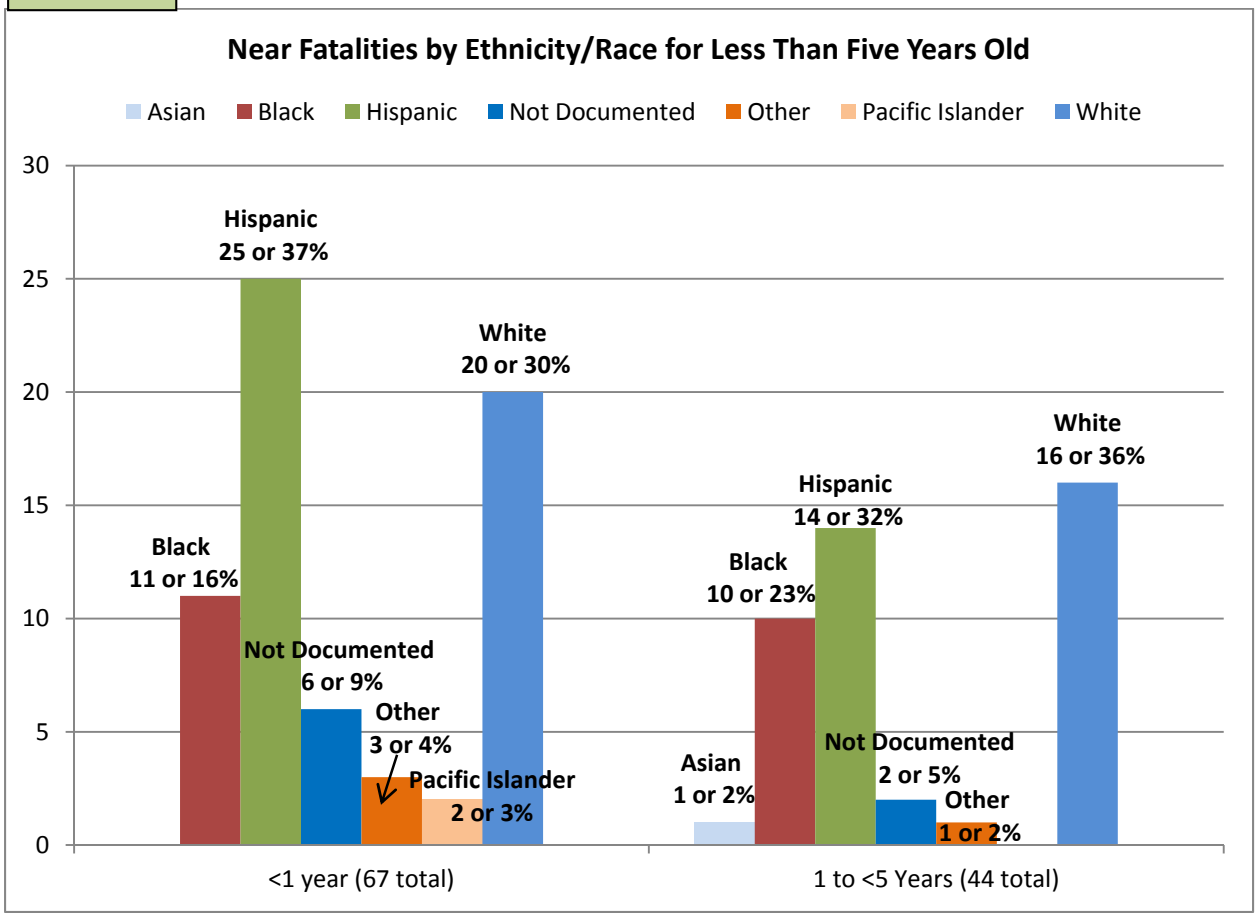
For child near fatality incidents reported in CY 2010, Hispanic children were more frequently victims of such incidents based upon the reports submitted to the CDSS, which coincides with their general representation in the overall child population. White children represented 31 percent of the general child population and were also 31 percent of the child near fatalities reported. However, Black children represented only six percent of the general child population and 23 percent of child near fatalities reported, which indicates a disproportionate number of near fatalities for Black children compared to Hispanic or White children.

Of the 121 child near fatalities reported, there were 67 child near fatality incidents in the less than one-year-old age group. Their ethnicity/race breakdown is as follows: 25 children (37 percent) were Hispanic, 20 children (30 percent) were White, 11 children (16 percent) were Black and two children (three percent) were Pacific Islander. For the remaining incidents, there were six children (nine percent) whose ethnicity/race was not documented; and three children (four percent) were documented as "Other." Chart T depicts the age and ethnicity/race of child near fatality incidents for children less than five years old.

Of the 121 child near fatalities reported, there were 44 child near fatality incidents in the one- to four-year-old age group. Their ethnicity/race breakdown is as follows: 14 children (32 percent) were Hispanic, 16 children (36 percent) were White, ten children (23 percent) were Black and in one incident (two percent) the child was documented as Asian. For the remaining incidents, there were two children (five percent) whose ethnicity/race was not documented; and one child (two percent) was documented as "Other."

Of the 121 child near fatalities reported, there were ten child near fatality incidents in the five- to 17-year-old age group. Their ethnicity/race breakdown is as follows: seven children (70 percent) were Black, two children (20 percent) were White and one child (ten percent) was Hispanic.

CHART T



Child Abuse Versus Neglect – What is Known

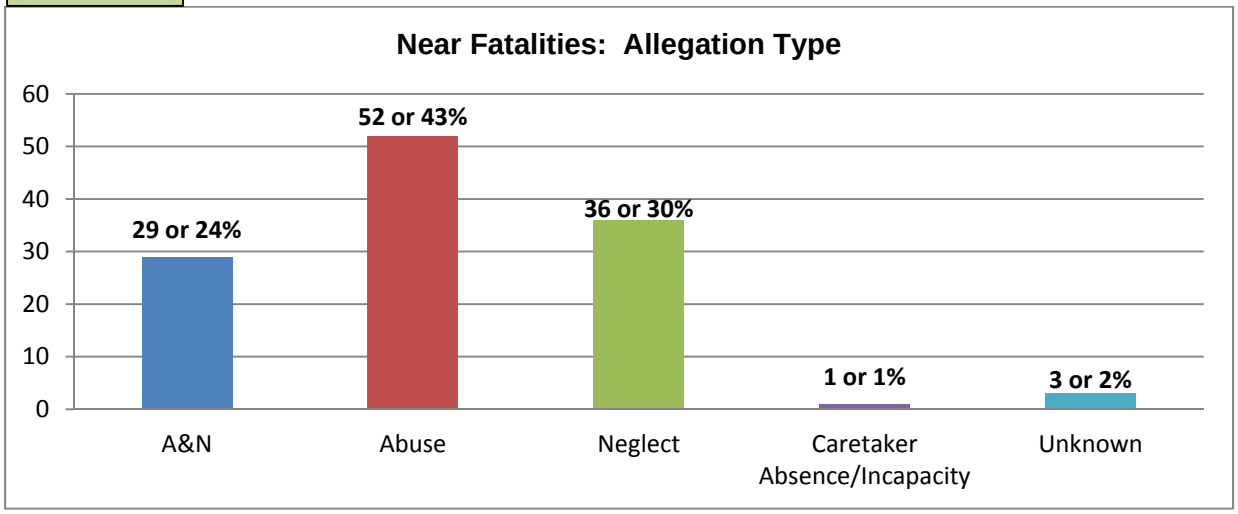
The following data depicts the types of allegations associated with the referrals generated by the CWS agencies for the child near fatality incidents that were reported for CY 2010.

It should be noted that a combined allegation of abuse and neglect may occur when there are two individuals responsible for the near fatality. These allegation types described below represent the allegations documented for the referrals associated with the SOC 826 form.

The data shows that allegations of abuse were documented in CWS/CMS more often than any other single allegation category in the near fatality incidents reported to the CDSS for CY 2010. Chart U depicts the allegation types for all child near fatality incidents reviewed for CY 2010.

The data shows that 52 of the 121 child near fatality incidents (43 percent) for CY 2010 had allegations of child abuse. The allegation types for the remaining 69 incidents were as follows: 36 incidents (30 percent) were reports of neglect, 29 incidents (24 percent) were reports of abuse and neglect, in three incidents (two percent) the allegation type was unknown[14] and one incident (one percent) was a caretaker absence/incapacity in that the biological parent's absence (e.g., incarceration, hospitalization, whereabouts unknown) or inability to provide adequate care for the child (e.g., mental illness, physical illness, substance abuse) resulted in the near fatality.

CHART U



[14] Individuals who were responsible for the near fatality incident and whose identity was known to the CWS agency but not given an allegation or disposition in the investigation referral were classified as "unknown."

Allegation Type Compared to Age

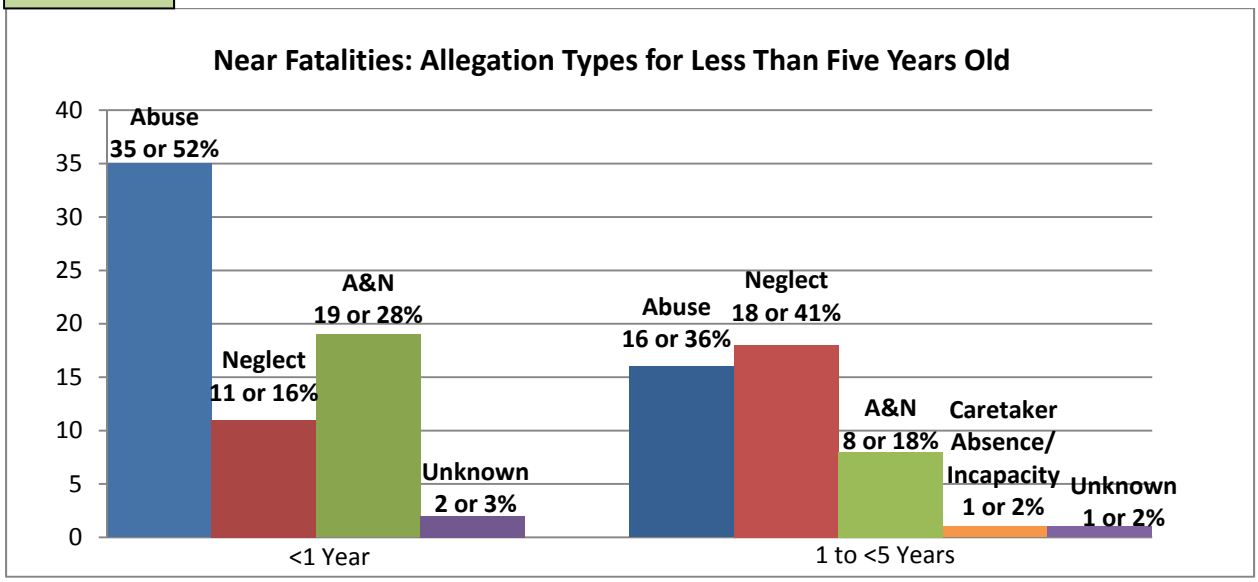
Of the 121 child near fatality incidents reported, the allegation types for the 67 near fatality incidents in the less than one-year-old age group were as follows: 35 incidents (52 percent) were abuse allegations, 19 incidents (28 percent) were abuse and neglect allegations, 11 incidents (16 percent) were neglect allegations and two incidents (three percent) were unknown.

Of the 121 child near fatality incidents reported, the allegation types for the 44 near fatality incidents in the one- to four-year-old age group were as follows: 18 incidents (41 percent) were neglect allegations, 16 incidents (36 percent) were abuse allegations, eight incidents (18 percent) were abuse and neglect allegations, one incident (two percent) was caretaker absence/incapacity and one incident (two percent) was unknown.

Of the 121 child near fatality incidents reported, the allegation types for the remaining ten near fatality incidents in the five- to 17-year-old age group were as follows: seven incidents (70 percent) were neglect allegations, two incidents (20 percent) were abuse and neglect allegations and one incident (ten percent) was an abuse allegation.

For children less than one year of age, abuse was the most reported allegation. For children in the one- to four-year-old age group, neglect was the most reported allegation. Chart V depicts the near fatality allegation types for children less than five years old.

CHART V



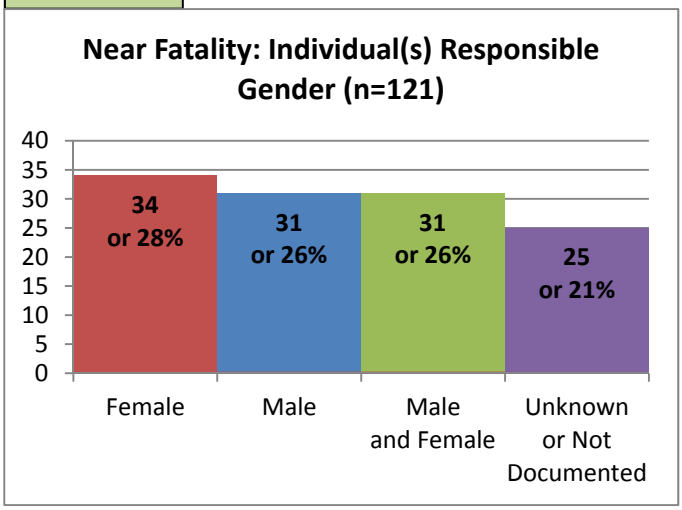
Who Was Identified as the Individual Responsible for the Near Fatality Incidents

When analyzing child near fatalities and addressing the issues surrounding these sensitive incidents, it is important to understand who a CWS agency had identified as being responsible for the abuse and/or neglect that resulted in the child's near fatality. It is important to note that the individual responsible for the near fatality might not be identified if, at the time of the near fatality, more than one individual had access to the child. The following provides information regarding the individual identified by the CWS agency and documented in CWS/CMS as the individual(s) responsible for the near fatality incidents. This report also includes additional analysis of incidents in which more than one individual was responsible for the near fatality incident. Chart W depicts the gender of the individual(s) responsible for the reported child near fatality incidents.

Gender of Responsible Individual(s)

The data shows that in 34 of the 121 child near fatality incidents (28 percent), the individual responsible was a female. In 31 of the near fatality incidents (26 percent), the individual responsible was a male. In 31 of the near fatality incidents (26 percent), there were two individuals identified by the CWS agency as responsible for the near fatality which included both a male and a female in each incident. In 25 of the near fatality incidents (21 percent), the identity of the individual responsible was unknown or not documented.

CHART W



Of the 67 child near fatality incidents in the less than one-year-old age group, more males than females were identified as the individual responsible for the near fatality incident. In 22 of these incidents (33 percent), the individual responsible for the near fatality was a male; and in 17 of these incidents (25 percent), both a male and a female were responsible for the near fatality. In 14 of these incidents (21 percent), the individual responsible was a female. In 14 of these incidents (21 percent), the identity of the individual responsible was unknown or not documented.

Of the 44 child near fatality incidents in the one- to four-year-old age group, more females than males were identified as the individual responsible for the near fatality. In 15 of these incidents (34 percent), the individual responsible was a female. In 11 incidents (25 percent), the individuals responsible included both a male and a female. In 11 incidents (25 percent), the identity of the individual responsible was unknown or not documented; and in seven of these incidents (16 percent), the individual responsible was a male.

Of the remaining ten child near fatality incidents in the five- to 17-year-old age group, in five of these incidents (50 percent) the individual responsible for the near fatality was a female. In three of these incidents (30 percent), the individuals responsible included both a male and a female; and in two of these incidents (20 percent), the individual responsible was a male.

Relationship to the Child of Individual(s) Responsible for the Near Fatality

Table 9 provides greater detail of the individuals identified as being responsible for the near fatalities reported. In 84 of the 121 child near fatality incidents (69 percent), a biological parent, either individually or in conjunction with another individual, was identified as the individual(s) responsible for the incidents. In 23 of the 121 child near fatality incidents (19 percent), the biological father was exclusively responsible for the near fatality; and the biological mother was exclusively responsible for 22 of the 121 child near fatality incidents (18 percent). In three of the 121 child near fatality incidents (two percent), the foster parents were responsible for the incidents.

There were a total of eight incidents in which the biological mothers' significant other was involved in the near fatality incident (seven percent) exclusively or in conjunction with the biological mother. In 20 of the 121 child near fatality incidents (17 percent), the individual responsible for the near fatality was unknown.

Table 9. Individual(s) Responsible

Individual(s) Held Responsible for the Near Fatality	Total Count	Proportion to the Total (n=121)
Biological Parents	25	21%
Bio Father	23	19%
Bio Mother	22	18%
Unknown	20	17%
Not Documented	5	4%
Bio Mother & Unknown	5	4%
Other[15]	5	4%
Bio Mother & her Significant Other (M)	4	3%
Bio Mother's Significant Other (M)	4	3%
Foster Parents	3	2%
Bio Father & Unknown	2	2%
Bio Mother & Other	2	2%
Bio Father & Other	1	1%
Total	**121**	**100%**

Five of the 121 child near fatality incidents involved cases in which the individual responsible for the incident which caused the near fatality was not documented. It is important to note that in these five incidents in which the individual responsible for the incident was "not documented," the biological parent(s) were not identified as being responsible for causing the near fatality; however, a referral for neglect was substantiated against them for either failing to seek immediate medical care for the injury or illness, failing to provide an explanation of the injury, and/or failing to protect the child.

[15] See Table 10 for a breakdown of "Other" individuals.

Table 10 breaks down the individual(s) held responsible for the near fatalities listed as "Other."

Table 10. Other Individual(s) Responsible

Other Individual(s) Held Responsible for the Near Fatality	Total Count
Adoptive Parents	1
Day Care Provider	2
Other Female Relative	2
Total	**5**

Individual(s) Responsible for Near Fatality by the Victim's Age

Table 11 depicts the age of the victim with the individual(s) responsible for the near fatality. Biological fathers were most frequently responsible for the near fatality incidents of victims under the age of one (28 percent), followed by biological parents together (22 percent) and biological mothers (13 percent). Biological parents' together and biological mothers alone were most frequently responsible for the near fatality incidents of victims between the ages of one and four years old. Biological parents, either individually or in conjunction with another individual, were more frequently responsible for the near fatality incidents of victims age five and older.

Table 11. Individual(s) Responsible and the Age of the Victims

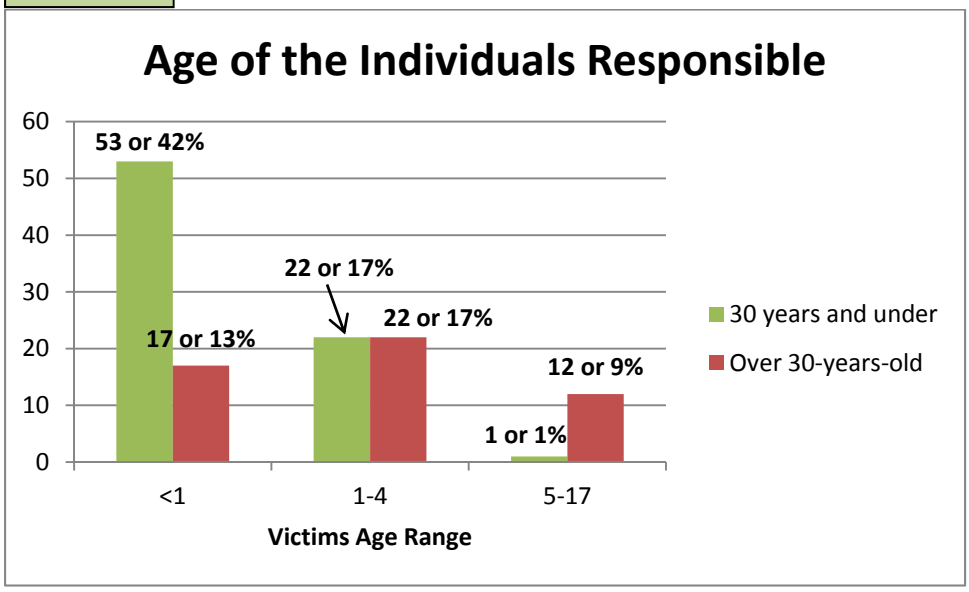
	Age of the Victims					
Individual(s) Responsible	<1	1-4	5-9	10-14	15-17	Total
Bio Father	19	2		2		**23**
Bio Father & Other[16]			1			**1**
Bio Father & Unknown	2					**2**
Bio Mother	9	10	1	2		**22**
Bio Mother & her Significant Other (M)	3	1				**4**
Bio Mother & Other[16]		1		1		**2**
Bio Mother & Unknown	3	1	1			**5**
Bio Mother's Significant Other (M)		4				**4**
Biological Parents	15	10				**25**
Foster Parents		2			1	**3**
Not Documented	2	3				**5**
Other[16]	2	2		1		**5**
Unknown	12	8				**20**
Grand Total	**67**	**44**	**3**	**6**	**1**	**121**

[16] Individuals held responsible in Table 11 for the near fatality listed as "Other" consist of female relatives, day care providers, a set of adoptive parents, and a legal guardian who were responsible for the near fatality.

Age of the Individuals Responsible for Near Fatality by Victim's Age

Chart X depicts the age of the individuals responsible for the child near fatality incidents with the age range of the victim children for those cases in which the age of the individual responsible was known. Of the 121 child near fatality incidents, there were a total of 96 incidents in which the age of the individual responsible for the incident was known. Of these 96 incidents, there were a total of 127[17] individuals responsible for the near fatalities. For the less than one-year-old age group of victims, the individual responsible was most often 30 years of age or younger (42 percent). For the one- to four-year-old age group of victims, there were no differences in the age range of individual responsible. For the five- to 17-year-old age group of victims, the individual responsible for the near fatality was more often over 30 years of age (ten percent). This data pattern seems consistent with common expectations, in that, as children age, so do their parents. As such, near fatalities of older children were more likely to involve older parents.

CHART X



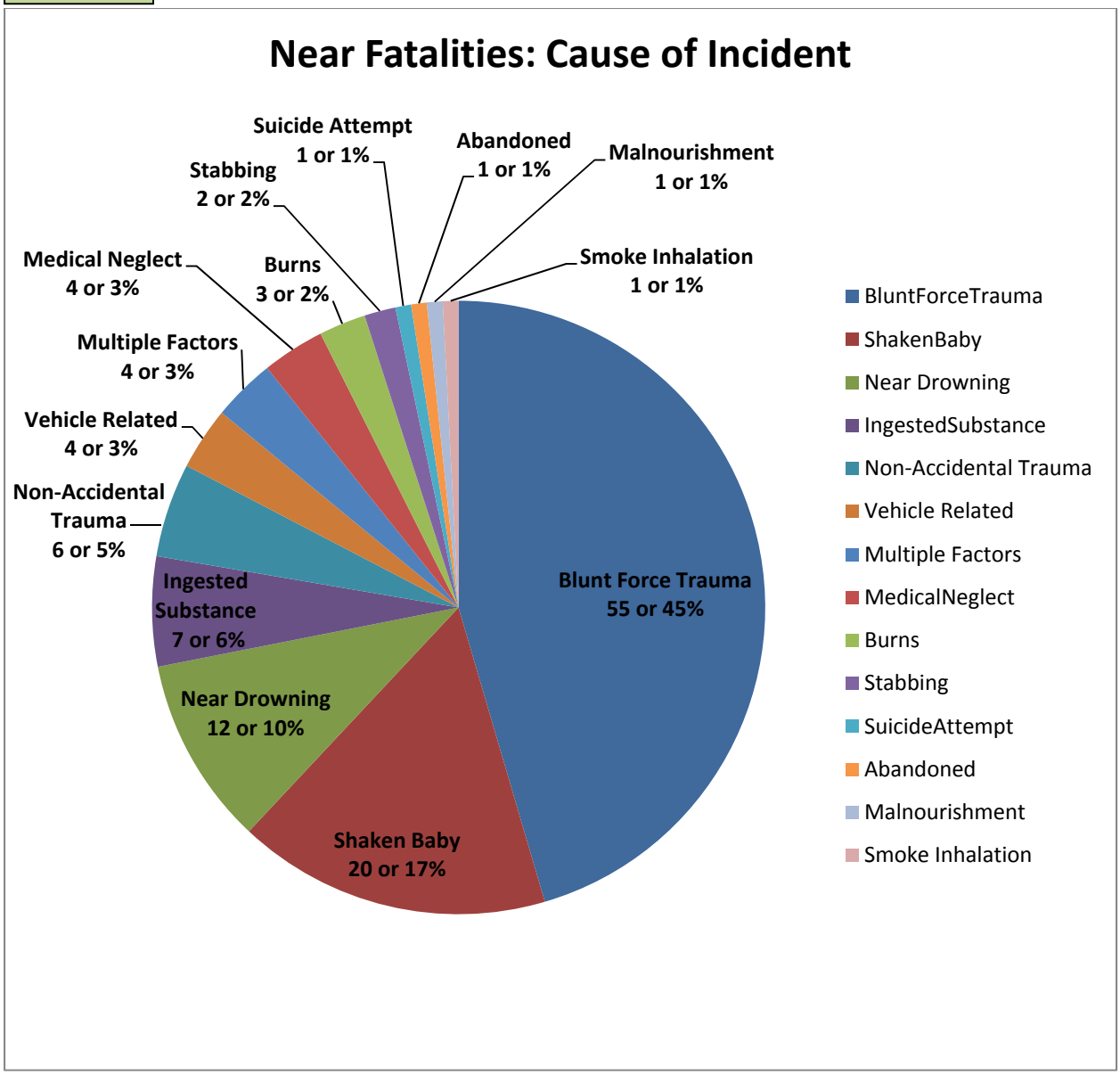
In summary, in reviewing who was identified as the individual responsible for child near fatalities reported in CY 2010, more females than males were responsible for the near fatality incidents resulting from abuse and/or neglect; however, the margin between the two is small. For children less than one-year-old, more males than females were identified as the individual responsible for the near fatality incidents. However, for all other age groups, more females than males were identified as the individual responsible for the near fatality incidents. Additionally, there are no significant differences between biological fathers (19 percent) and biological mothers (18 percent) being identified more often as the individual responsible for the near fatality incidents. With respect to the age of the individual responsible for the near fatality incidents reported, 60 percent of the known individuals responsible for the near fatality incidents were 30 years of age or younger.

[17] Of the 96 near fatality incidents where the age of the individual responsible was known, there were 31 incidents where two individuals were responsible, making the total 127 individuals.

Specific Cause/Finding of Incident

The specific causes or findings of the 121 child near fatalities reviewed that were determined to be the result of abuse and/or neglect during CY 2010 are categorized below in Chart Y. A review of these incidents indicated that the most commonly reported causes of child near fatalities were blunt force trauma, shaken baby and near drowning. The causes listed below are based on the causes identified by counties in the documentation in CWS/CMS. In Chart Y, the "multiple factors" category represents those incidents in which two or more of the causes were identified and documented in CWS/CMS such as medical neglect and blunt force trauma.

CHART Y



Causes Compared to Allegation Type

Table 12 is a detailed distribution of the causes of child near fatalities and the allegation type that was documented by the CWS agency. Most of the acts of blunt force trauma involved referrals which were substantiated on allegations of abuse or abuse and neglect. Additionally, shaken baby incidents were primarily substantiated for abuse; and near drowning incidents were primarily substantiated for neglect.

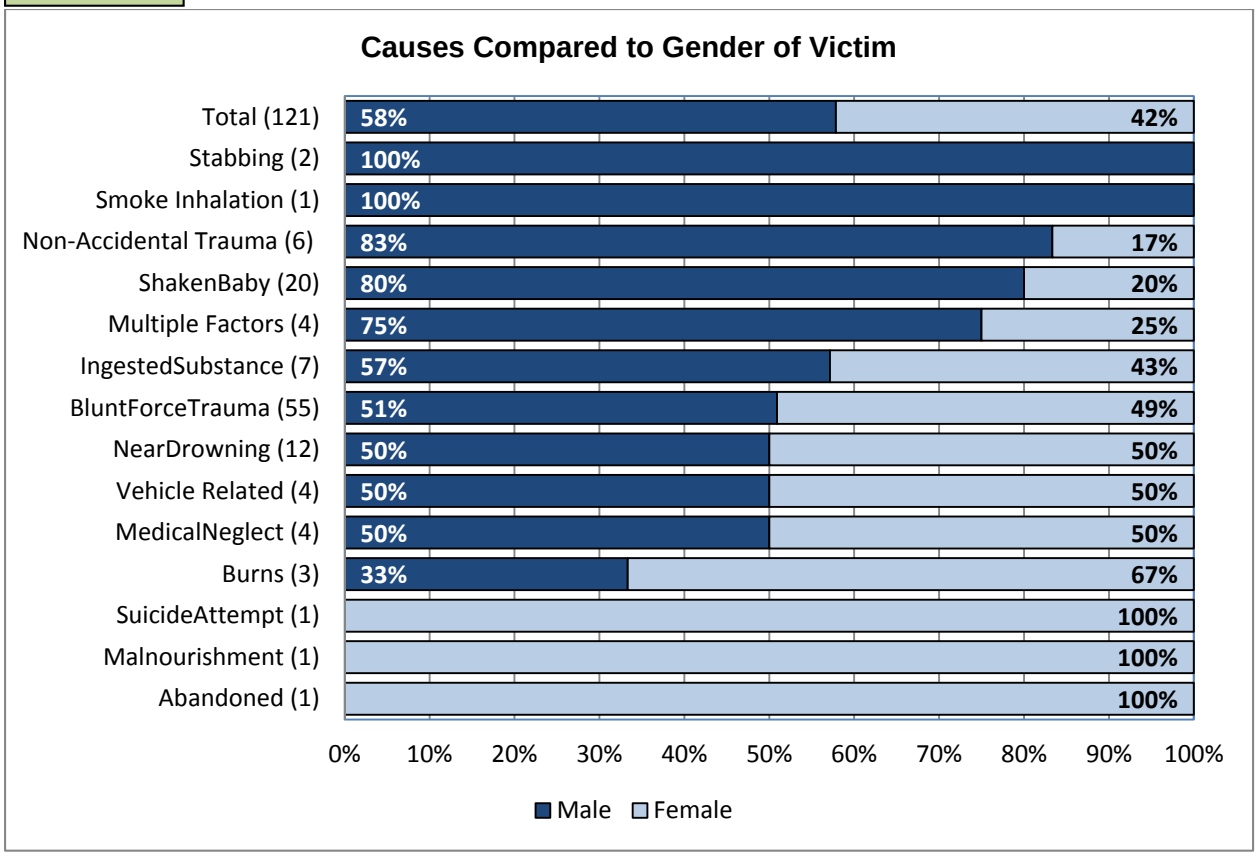
Table 12. Causes and Allegation Type

Causes	Abuse	A&N	Neglect	Caretaker Absence/ Incapacity	Unknown	Total
Blunt Force Trauma	30	20	4		1	**55**
Shaken Baby	13	4	1		2	**20**
Near Drowning	1	1	10			**12**
Ingested Substance			7			**7**
Non-Accidental Trauma	4	2				**6**
Vehicle Related			4			**4**
Multiple Factors	2		2			**4**
Medical Neglect			4			**4**
Burns		1	2			**3**
Stabbing	1	1				**2**
Suicide Attempt	1					**1**
Abandoned			1			**1**
Malnourishment			1			**1**
Smoke Inhalation				1		**1**
Grand Total	**52**	**29**	**36**	**1**	**3**	**121**

Causes Compared to Gender of Victim

Chart Z is a detailed distribution of the gender of the victim and the cause of the child near fatality. Male victims accounted for a higher proportion (58 percent) of all near fatalities in CY 2010 (see Chart R) and were more frequently represented in non-accidental trauma (83 percent), shaken baby (80 percent) and incidents where multiple factors (75 percent) caused the near fatality. Female victims were more frequently represented in near fatalities caused by burn (67 percent) incidents.

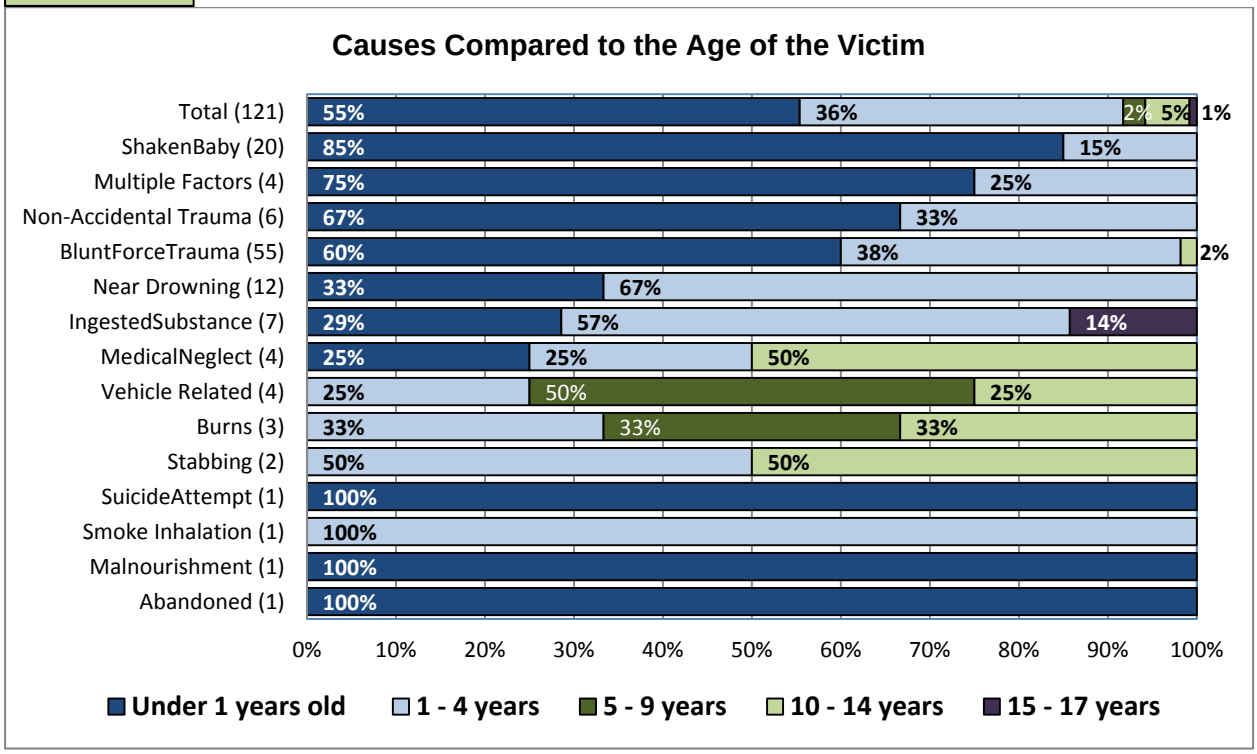
CHART Z



Causes Compared to the Age of the Victim

As previously indicated, 92 percent of all child near fatalities in CY 2010 were victims under the age of five (see Chart Q). Of the older victims, two percent (n=3) were between five- to nine-years-old, five percent (n=6) were between 10- to 14-years-old and one percent (n=1) was between 15- to 17-years-old. In reviewing the causes of near fatalities by the ages of the children involved, the most frequently occurring causes of near fatalities for children under one year of age were shaken baby (85 percent), incidents where multiple causes contributed to the near fatality (75 percent), non-accidental trauma (67 percent) and blunt force trauma (60 percent). See Chart AA below for a distribution of the causes of near fatalities and the age of victims.

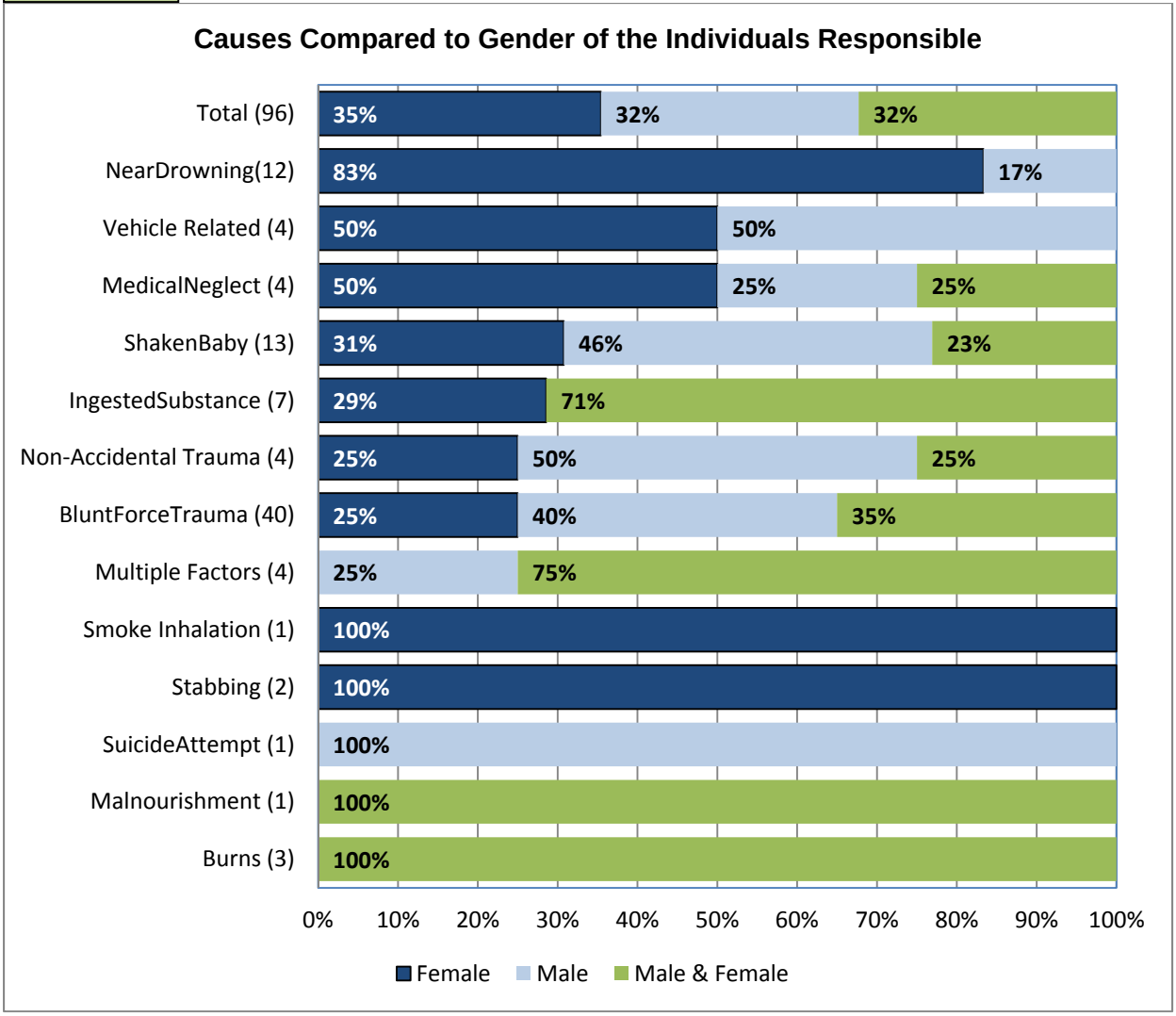
CHART AA



Causes Compared to Gender of the Individual(s) Responsible

As illustrated in Chart AB, females were more frequently documented as being responsible for near fatalities involving near drowning (83 percent). For those cases in which the near fatality involved a child ingesting a substance, both males and females were responsible (71 percent) for those incidents. Males were more frequently documented as being responsible for near fatalities associated with non-accidental trauma (50 percent), shaken baby (46 percent) and blunt force trauma (40 percent) incidents.

CHART AB



Causes Compared to Age of the Individual(s) Responsible

Table 13 depicts a distribution of the causes of child near fatality incidents by the age of the individual(s) responsible for the near fatality. In 96 of the 121 child near fatality incidents where the age of the individual responsible for the near fatality was known, there were a total of 127[18] individuals. There are a few noticeable differences of the causes of near fatality incidents by the age of the individual responsible. Individuals ages 31 and over were more frequently responsible for burns (100 percent) and medical neglect (80 percent). Individuals between the ages of 18-20 were more frequently responsible for near fatalities caused by multiple factors (71 percent). Individual(s) between the ages of 21-23 were more frequently responsible for blunt force trauma incidents (26 percent) than other age groups.

Table 13. Causes and Age of the Individuals Responsible

	Age of Individuals Responsible						
Causes	**18-20**	**21-23**	**24-26**	**27-30**	**31-40**	**Over 40**	**Total**
Blunt Force Trauma	8	14	8	7	11	5	53
Shaken Baby	2	3	2	4	4	1	16
Near Drowning	2	1		2	6	2	13
Ingested Substance	2	2	1	1	5	1	12
Multiple Factors	5		1	1			7
Burns					3	3	6
Medical Neglect		1			2	2	5
Non-Accidental Trauma	1	1	1	1		1	5
Vehicle Related		1			2	1	4
Malnourishment	2						2
Stabbing				1	1		2
Smoke Inhalation					1		1
Suicide Attempt	1						1
Grand Total	**23**	**23**	**13**	**17**	**35**	**16**	**127**

[18] Of the 96 near fatality incidents where the age of the individual responsible was known, there were 31 incidents where two individuals were responsible, making the total 127 individuals.

Near Fatality Summary

CY 2010

In summary, it was found that 121 child near fatality incidents were reported to the CDSS for CY 2010 that were determined to be the result of abuse and/or neglect. Of the 121 child near fatality incidents, three children were living in an out-of home foster care placement and receiving services at the time of the near fatality incident. The CWS agency was more often the determiner of abuse and neglect than other agencies. The greater incidences of near fatality incidents occurred for children less than five years old. Overall, the number of male child near fatality incidents reported was higher than the number of female child near fatality incidents, and Hispanic children were more frequently victims of such incidents based upon the reports submitted to the CDSS, which coincides with their general representation in the overall child population. White children represented 31 percent of the general child population and were also 31 percent of the child near fatalities reported. However, Black children represented only six percent of the general child population and 23 percent of child near fatalities reported, which indicates a disproportionate number of near fatalities for Black children compared to Hispanic or White children.

For CY 2010, half of the child near fatality incidents reported involved children who were from families who did not have CWS history in the five years prior to the incident. Of the 61 families who did have prior history, 16 families (26 percent) were also known to a CWS agency at the time of the incident. Seventy-four percent of those 61 families were not clients at the time of the near fatality incident, however, 36 families (59 percent) did have some CWS involvement within the six months prior to the incident. For the 61 families who had prior CWS history, 67 percent of those families' prior referrals immediately preceding the near fatality incident either did not meet the criteria for investigation by the CWS agency or were deemed unfounded or inconclusive for abuse or neglect upon investigation.

Blunt force trauma was the most reported cause of near fatality incidents for CY 2010 with abuse being the most reported type of allegation associated with these incidents. Additional analysis of the causes of incidents by the gender of the victim revealed that the victims of blunt force trauma incidents were 51 percent male and 49 percent female. Males were more frequently represented in non-accidental trauma and shaken baby incidents. In the analysis of the causes of near fatalities by the ages of the children involved, the most frequently occurring cause of near fatalities for children under one year of age was shaken baby.

The individuals responsible for child near fatality incidents were found to be exclusively female in 28 percent of the near fatality incidents reported and male in 26 percent. Additional analysis revealed that females were more frequently documented as being the individual responsible for near fatality incidents involving near drowning. Over two-thirds of the individuals responsible for the near fatality incidents reported for CY 2010 were a biological parent. Additionally, of those cases where the individual responsible was known, 60 percent of those individuals were 30 years of age or younger at the time of the incident.

Comparison with Prior Years' Reports

From CY 2008 to 2009, there was a decrease of five near fatality incidents reported to the CDSS, however, there was a 40 percent increase in the number of near fatality incidents reported in CY 2010 from 2009. It is unknown at this time whether this fluctuation is a true reflection of a statistical increase/decrease or due to variances in data reporting and collection

between the three years. Further analysis of future years' data will hopefully shed light on whether the increase holds true over time.

In the CY 2008 report, all three agencies together (CWS, law enforcement and a physician) determined the child near fatality incidents to be the result of abuse/neglect more than any other agency. However, in CYs 2009 and 2010, child near fatality incidents reported to the CDSS were determined more often by a CWS agency alone.

Consistent with CYs 2008 and 2009, Hispanic children were more frequently victims of near fatality incidents, which coincides with their general representation in the overall child population. However, for Black children, their representation in child near fatalities reported has been disproportionate to their representation in the general population. Since CY 2008, the majority of the victims of near fatality incidents have remained children less than five years of age and the gender of the majority of victims have remained males.

Since the release of the CY 2008 report, the finding that at least half of the families with reported child near fatality incidents were not known to a CWS agency at the time of the incident nor had history within five years of the incident has remained consistent. Of those families that had CWS history, seven percent in CY 2008, 12 percent in CY 2009 and 13 percent in CY 2010 were known to a CWS agency at the time of the incident.

Blunt force trauma has consistently been the most reported cause of child near fatalities since CY 2008. While the most reported cause of near fatality has remained the same since 2008, the most reported referral allegation changed from abuse in CY 2008, to neglect in CY 2009 and back to abuse in CY 2010.

With respect to the data in this report regarding the individual responsible for the near fatality incidents, the reader is cautioned to not make comparisons between this year's report and prior years' reports. In an effort to provide a more comprehensive analysis of those individuals responsible for these incidents, the CDSS revised its methodology for collecting this data and completed additional analysis of this data element. Therefore, information in this report regarding the individual responsible for the near fatality incidents cannot be compared with prior years' reports due to the differences in methodology and data collection.

VI. Future Plans

CDSS Future Plans

The information gathered from the analysis of child fatality and near fatality incidents can help to inform the CDSS, county child welfare agencies and stakeholders of risk factors impacting safety of children, as well as policies and actions that may mitigate those risks. Specifically, the analysis has identified the most common victims, individuals responsible, allegations and causes of fatality and near fatality incidents, which can each be used to influence the CDSS' direction in child abuse prevention as well as risk and safety management.

The most common victims identified were less than five years old. The report also indicated that the most common individuals responsible for child fatalities and near fatalities were 30 years of age or younger.

California counties have several funding sources available for use with these vulnerable populations such as the Child Abuse Prevention, Intervention and Treatment Act (CAPIT) funds. The CDSS provides oversight and technical assistance to county child welfare agencies to ensure these funds are used in accordance with state statute and to encourage service priority is given to prevention programs provided by nonprofit agencies, including, where appropriate, programs that identify and provide services to isolated families, particularly those with children less than five years old. County consultants who work with child welfare agencies to develop their five year prevention plans can be trained to support counties to consider and address the specific risk factors identified in the report.

The CDSS also provides oversight to county child welfare agencies for use of federal Community Based Child Abuse Prevention Program (CBCAP) funding. CBCAP provides priority funding for effective community-based programs serving low income communities and those serving young parents or parents with young children, including community-based child abuse and neglect prevention programs. The CDSS utilizes a portion of CBCAP funding to fund grants that provide prevention services to the communities. An example of this is a grant that supports the establishment of parent leadership academies. These academies provide parent leadership training to low income parents with culturally diverse backgrounds. The academies incorporate the Strengthening Families' Five Protective Factors and help parents identify leadership strengths and then utilize their strengths to build and sustain multidisciplinary supports for the prevention and treatment of family crises warranting CWS intervention. These skills help equip parents to take on new leadership roles in the systems that serve children and families in their communities. The CDSS can ensure future grant funded programs address the specific issues outlined in the report, when possible.

Data from the report indicated that 31 percent[19] of the families in child fatality incidents had received child welfare services within six months prior to the child's death. It also indicated that 12 percent of child fatality incidents were caused by parents' significant others either exclusively or in conjunction with another individual. Considering these findings, the CDSS will be researching how data from the report may be used to inform existing prevention efforts and safety identification methodologies. In 2009, the CDSS issued All County Letter 09-31 to emphasize the importance of thoroughly assessing the safety and risk factors that may be present in each child abuse and/or neglect referral investigated by a county CWS agency. The safety assessment systems, Structured Decision Making (SDM), used by 54 counties, and Comprehensive Assessment Tool (CAT), used by four counties, are valuable tools for social workers and supervisors in determining safety factors for children and families. Identifying

[19] Of the 128 child fatalities, 40 families (31 percent) had some CWS involvement within six months prior to the child's death.

safety factors during an investigation is a key element in reducing the likelihood of child fatalities and near fatalities when the child/family is known to the CWS agency. In 2012, The Children's Resource Center (CRC) focused efforts on the Safety-Organized Practice (SOP) curriculum, trainings, and development of trainers to enhance worker skills in the use of SDM assessments and related interviews. CRC has worked in conjunction with the CDSS and the Northern Regional Training Academy to develop the SOP curriculum to provide a seamless link between practical skills and the SDM assessments. Throughout 2013, CRC will convene workgroups in conjunction with the CDSS to review all SDM assessments. Informed by data and practice, the workgroups will decide on any revisions that would strengthen the tools, definitions, and their use. Workgroups will consist of 25 to 35 staff and stakeholders who are knowledgeable users of the SDM system and can bring SDM practice experience to the process. This process will continue until final approval in December 2013, after which, changes to the SDM Policy and Procedures Manual and web SDM will occur as necessary.

The CDSS also regularly convenes an internal team whose purpose is to revise regulations and procedures regarding the reporting and disclosure of child fatalities. The CDSS has been utilizing input from county CWS agencies and stakeholders in order to improve the procedures for public access to information regarding child fatalities that were the result abuse and/or neglect. Public access to such information is essential to future child abuse and neglect prevention efforts.

VII. Attachments

California Children Population as of January 1, 2010:

Age	Total Population	Hispanic or Latino	Not Hispanic or Latino					
			White Alone	Asian Alone	Black Alone	Multiracial	American Indian and Alaska Native Alone	Native Hawaiian and Other Pacific Islander Alone
Total Population:								
Under 5 years	**2,745,856**	1,390,826	806,832	294,627	151,675	79,719	10,490	11,687
		51%	29%	11%	6%	3%	<0%	<0%
5 to 9 years	**2,708,138**	1,352,229	791,965	254,123	137,130	157,033	7,558	8,100
10 to 14 years	**2,730,077**	1,321,952	869,541	260,365	167,052	84,232	16,897	10,038
15 to 17 years	**1,850,322**	873,742	611,328	176,614	121,704	48,118	11,722	7,094
Total	**10,034,393**	**4,938,749**	**3,079,666**	**985,729**	**577,561**	**369,102**	**46,667**	**36,919**
		49%	31%	10%	6%	4%	<0%	<0%
Male:								
Under 5 years	**1,400,730**	709,554	411,452	150,407	77,317	40,679	5,377	5,944
		51%	29%	11%	6%	3%	<1%	<1%
5 to 9 years	**1,382,365**	689,857	404,317	130,182	69,803	80,157	3,887	4,162
10 to 14 years	**1,394,236**	671,909	446,601	134,009	85,060	42,866	8,616	5,175
15 to 17 years	**925,161**	436,871	305,664	88,307	60,852	24,059	5,861	3,547
Total	**5,101,687**	**2,508,191**	**1,568,034**	**502,905**	**293,032**	**187,761**	**23,741**	**18,023**
		49%	31%	10%	6%	4%	<1%	<1%
Female:								
Under 5 years	**1,345,126**	681,272	395,380	144,220	74,358	39,040	5,113	5,743
		51%	29%	11%	6%	3%	<1%	<1%
5 to 9 years	**1,325,773**	662,372	387,648	123,941	67,327	76,876	3,671	3,938
10 to 14 years	**1,335,841**	650,043	422,940	126,356	81,992	41,366	8,281	4,863
15 to 17 years	**883,101**	436,871	305,664	88,307	60,852	24,059	5,861	3,547
Total	**4,889,841**	**2,451,174**	**1,385,938**	**476,031**	**279,430**	**248,855**	**21,540**	**16,656**
		50%	28%	10%	6%	5%	<1%	<1%

State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050.* Sacramento, CA, July 2007.http://www.dof.ca.gov/research/demographic/data/race-ethnic/2000-50/)-

SOC 826 Statement of Findings and Information

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CHILDREN'S SERVICES OPERATIONS BUREAU
(916) 651-8100

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.

SOC 826 (8/09)

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
A decision by an agency as to 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, upon receipt of a report alleging that a child may be the subject of abuse and/or neglect, an in-person investigation is required, and is included in the outcome options, which are listed 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)

Inconclusive report
A report that is determined by the investigator who conducted the investigation not to be substantiated or unfounded, but the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect, as defined in Section 11165.6, has occurred. (See Penal Code 11165.12 (c))

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))

Substantiated report
A report that is determined by the investigator who conducted the investigation to constitute child abuse or neglect, as defined in Section 11165.6, based upon evidence that makes it more likely than not that child abuse or neglect, as defined, occurred. A substantiated report shall not include a report where the investigator who conducted the investigation found the report to be false, inherently improbable, to involve an accidental injury, or to not constitute child abuse or neglect as defined in Section 11165.6. (See Penal Code 11165.12 (b))

Unfounded report
A report of child abuse, which is determined by a child protective agency investigator to be false, to be inherently improbable, to involve an accidental injury, or not to constitute child abuse as defined in Penal Code section 11165.6. (See MPP division 31 section 31-002 (u)(1))