California Child Fatality and Near Fatality Annual Report Calendar Year 2011

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The California Department of Social Services
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I. Introduction

This report is prepared pursuant to Senate Bill (SB) 39 (Chapter 468, Statutes of 2007). SB 39 and the Welfare and Institutions Code (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) or 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 incidents as well, and while not a requirement of the Child Abuse Prevention and Treatment Act (CAPTA), the CDSS also integrates information from this report into 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 resulting from abuse and/or neglect 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[1]) 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 for Calendar Year (CY) 2011, a near fatality was 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 that were submitted by CWS agencies for child fatalities and near fatalities that occurred in CY 2011 and were determined to be the result of abuse and/or neglect and reported to the CDSS as of March 1, 2014. The CDSS established this cut-off date to enable the timely production of this report. However, the CDSS continues to accept SOC 826 forms for incidents that occurred in CY 2011 and prior years and will identify any such incidents in future years' reports.

The CY 2011 Child Fatality and Near Fatality report, as well as prior years report, are available on the CDSS Website at: http://www.childsworld.ca.gov/PG2370.htm.

[1] See Attachment B

II. Summary of Reported Child Fatality/Near Fatality Incidents by Calendar Year

Calendar Year 2008 and 2009—Update

Since the last update in the CY 2010 annual report, there have been no additional SOC 826 forms submitted for CYs 2008 and 2009. However, as part of a reconciliation process the CDSS has identified a need to identify the change, not just to correct the numbers previously reported for CY 2008 and 2009. Therefore, the total number of child fatalities for CY 2008 increased from 114 to 119, the number of children residing in the home of a parent or guardian increased from 109 to 113, and the number of children residing in an out-of-home foster care placement increased from five to six. For CY 2009, the total number of child fatalities increased from 117 to 122, the number of children residing in the home of a parent or guardian increased from 111 to 117, and the number of children residing in an out-of-home foster care placement decreased from six to five.

Calendar Year 2010—Update

The number of fatalities and near fatalities in the CY 2010 annual report, issued in May 2013, represented the total number of SOC 826 forms submitted to the CDSS as of December 1, 2011. At that time, there were 128 reported child fatalities with 124 children residing in the home of a parent or guardian and four children residing in an out-of-home foster care placement and 121 near fatalities with 118 children residing in the home of a parent or guardian and three children residing in an out-of-home foster care placement. Between the date the CY 2010 report was drafted and March 1, 2014 (the cut-off date for this report), the CDSS received one additional fatality SOC 826 form for CY 2010, bringing the total number of reported fatality incidents to 129 and the total number of children who resided in the home of a parent or guardian to 125.

The additional child fatality incident that was reported after the CY 2010 report was prepared showed that the cause of fatality was due to a combination of blunt force trauma and shaken baby syndrome. All other information collected about this additional fatality was consistent with the data patterns reported for that year.

Current Report Calendar Year 2011

For CY 2011, California CWS agencies reported 119 child fatalities determined to be the result of abuse and/or neglect with 117 children residing in the home of their parent or guardian and two children residing in an out-of-home foster care placement. California CWS agencies also reported 135 child near fatalities determined to be the result of abuse and/or neglect with 129 children residing in the home of their parent or guardian and six children residing in an out-of-home foster care placement. Analysis of these incidents is contained in this report.

Calendar Years 2012 and 2013

Since counties are still reporting incidents for CYs 2012 and 2013, the CDSS has held off conducting an analysis of those incidents to ensure that any final analysis incorporates all of the incidents reported for any given CY. The CDSS believes it is important, though, that the public is made aware of the number of child fatality/near fatality incidents resulting from abuse and/or neglect reported thus far for those years. As such, the CDSS has included that information in the following table. It is important that the reader, in reviewing this information, remember that

counties may continue to determine causes of fatality and near fatality incidents that occurred in these years, and as such, these numbers are subject to change. Updated data will be provided in subsequent years' reports.

Summary of All Years

The table below offers a summary of reported child fatalities and near fatalities resulting from abuse and/or neglect submitted to CDSS as of March 1, 2014.

Table 1. Fatalities and Near Fatalities, by Year

Current Totals	2008	2009	2010	2011	2012*	2013*
Fatalities	119	122	129	119	135	118
	113 In-Home 6 Out-of-Home	117 In-Home 5 Out-of-Home	125 In-Home 4 Out-of-Home	117-In Home 2 Out-of-Home	133 In-Home 2 Out-of Home	115 In-Home 3 Out-of-home
Near Fatalities	91	86	121	135	133	111
	88 In-Home 3 Out-of-Home	86 In-Home	118 In-Home 3 Out-of-Home	129 In-Home 6 Out-of-Home	133 In-Home	106 In-Home 5 Out-of-Home

*Partial data due to timing of the report.

III. Methodology for Analysis of CY 2011 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 form for CY 2011. The number of fatalities and near fatalities reported represents the total number of SOC 826 forms submitted as of March 1, 2014. 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 2011 as well as prior years. As such, any SOC 826 forms submitted after March 1, 2014, will be summarized in future years' reports.

This report provides an understanding of a number of data elements relating to those children who were victims of child fatality and near fatality incidents resulting from abuse or neglect during CY 2011, including:

- Identification of the number of child fatalities and near fatalities that were caused by abuse and neglect.
- 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 fatality or near fatality incident.
- Identification of the age, ethnicity/race, and gender groups for both the individual responsible and the victims of child fatalities and near fatalities resulting from abuse and/or 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 CWS agencies.
- What is known about fatality incidents that were reported to a CWS agency but not investigated.

Methodology

As previously stated, the information in this report for child fatalities and near fatalities was gathered from notices (SOC 826 forms) submitted to CDSS by counties for those child fatality and near fatality incidents that occurred within each counties jurisdiction. The CDSS conducts a periodic reconciliation with each county to ensure that the number of SOC forms in the possession of CDSS accurately reflects the number submitted. 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 those children who died in California during CY 2011 which met the aforementioned criteria.

Based on the SOC 826 forms submitted to the CDSS, staff gathers 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 tool 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. Since case information entered by

county CWS agencies into the CWS/CMS system is generally not subject to change after a referral has been closed, the CDSS does not conduct a reconciliation of the data collected from CWS/CMS for each incident with the counties before inclusion in this report. However, in an effort to improve data quality, the CDSS staff consulted with individual counties on data elements which may have been identified as unknown on CWS/CMS in an effort to gather more accurate data on the causes and individuals responsible for such incidents. In some cases, the CDSS was able to identify more specific data and in some cases the data remained unknown even after additional consultation. All information collected for each incident is compiled in the aggregate and analyzed for statewide patterns and trends.

It is important to note that the Emergency Response (ER) referral for some fatality and near fatality incidents did not meet the criteria[2] for investigation by the CWS agency and were "evaluated out." As a result, evaluated out referrals may sometimes provide less detailed investigatory information than might otherwise be available in a referral which had been investigated by a CWS agency. However, these evaluated out referrals still generally contain key information including, but not limited to, whether the family had CWS history/involvement, the individual(s) responsible for the incident, and/or the cause of the incident which has been incorporated into the analysis included in this report. The definition of "evaluated out," as well as other common CWS terminology used throughout this report, can be found in the Glossary (Attachment C).

In this year's report, the CDSS collected information specific to those individuals who did not commit the act that caused the child fatality or near fatality, but were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the incident. These individuals are referred to in this report as the "secondary individuals responsible" (SIR) for the fatality or near fatality incidents.

Also new to this year's report is the display of ethnicity/race information regarding the victims, the "primary individuals responsible" (PIR), and the SIRs for the fatality/near fatality incidents from CWS/CMS. For this year's report, individuals listed as having two ethnicities/races in CWS/CMS are categorized as Multiracial to capture both ethnicities/races identified. This includes the victim and the primary or secondary adults.

In analyzing the data, the CDSS used a rounding up methodology; therefore, the total percentages cited may not equal to 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 once in the aggregate fatality data information, if both the fatality and near fatality incidents occurred in the reporting year.

[2] http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/cws2.PDF

IV. Fatalities

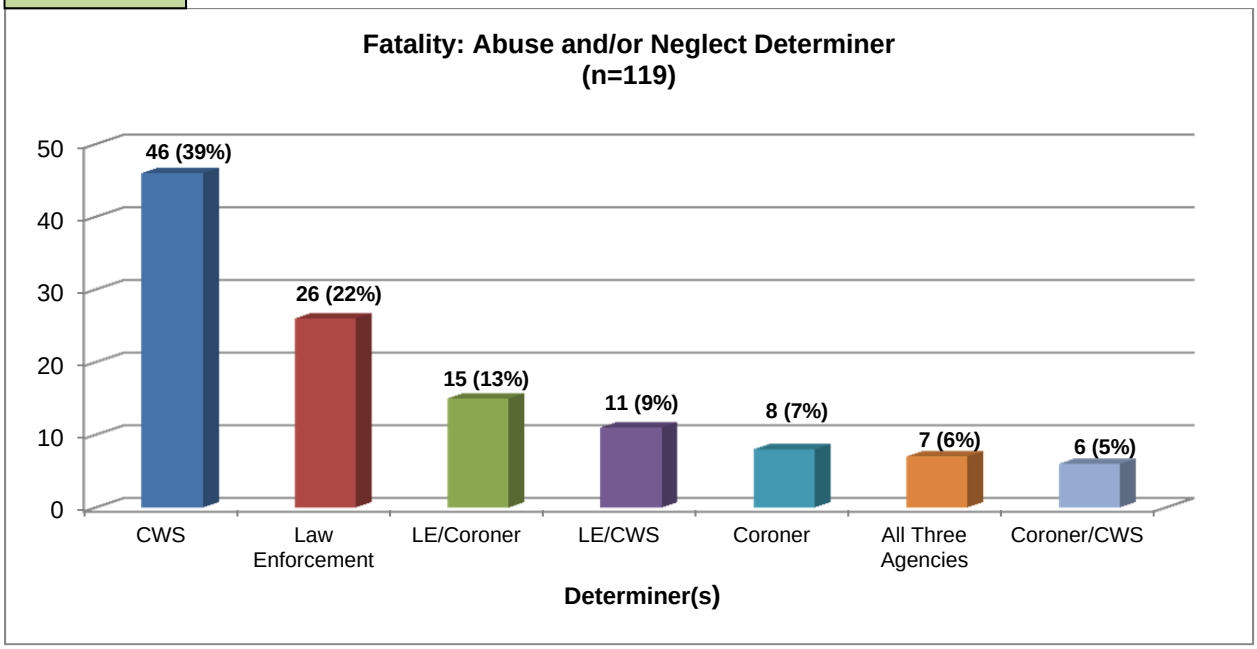
General Information

For CY 2011, California CWS agencies reported via the SOC 826 form 119 child fatalities determined to be the result of abuse and/or neglect with 117 children residing in the home of their parent or guardian and two children residing in an out-of-home foster care placement.

Determiner of Abuse and/or Neglect for Child Fatality

The following chart (Chart A) depicts which agency (CWS, law enforcement, and/or medical examiner/coroner) made the determination that the child's death was the result of abuse and/or neglect. While all three agencies can determine a fatality to be the result of abuse and/or neglect, in CY 2011 over one third of the incidents were determined by CWS alone. Feedback received from counties after the production of the CY 2010 report, which demonstrated similar findings, indicated that one of the reasons CWS agencies may be more likely than other entities to be the determiner in these incidents is their responsibility to conduct immediate investigations to protect the safety of other children who may be in the home of these families.

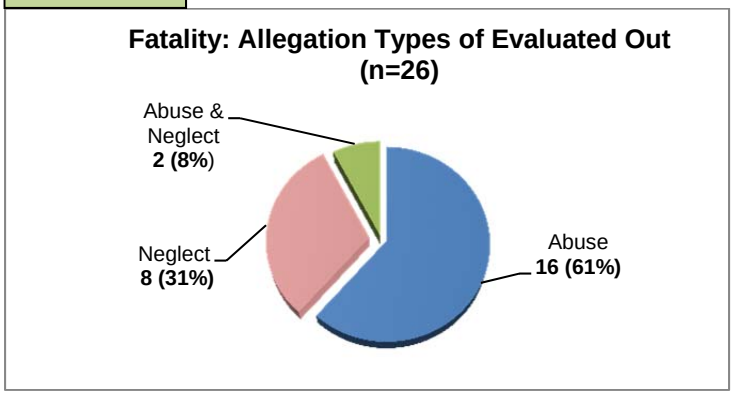
CHART A



Fatality Incidents Evaluated Out by CWS Agency

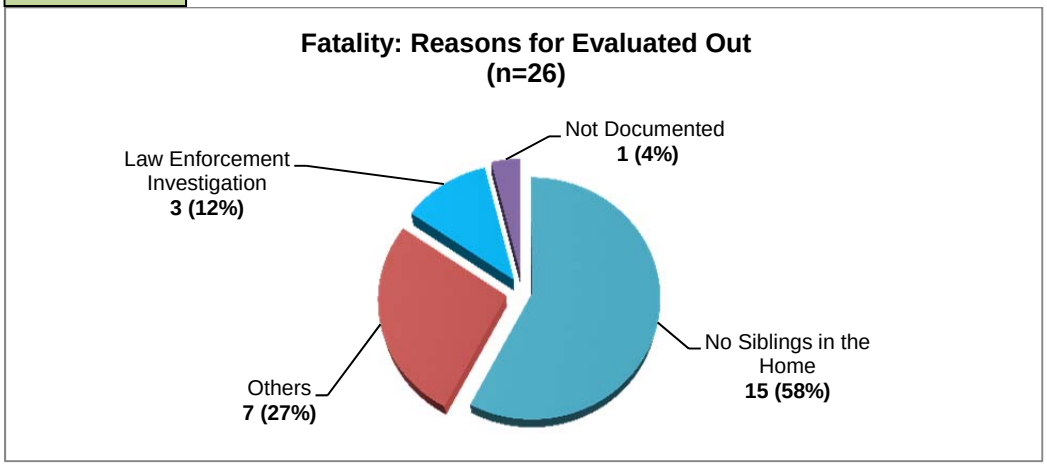
In general, when a CWS agency receives any referral alleging abuse and/or neglect, the agency may evaluate out that referral (see Attachment C for a glossary of CWS terminology used in this report). Evaluated out referrals involve ER referrals that do not meet the criteria for investigation by the CWS agency and can also involve child fatalities resulting from abuse and/or neglect. In reviewing the 119 child fatality incidents reported for CY 2011, 26 of the referrals (22 percent) made to the child abuse ER hotline for these incidents were evaluated out. In 22 of the 26 incidents the determination that the child fatality was the result of abuse and/or neglect was made by law enforcement (11 incidents) or law enforcement and coroner together (11 incidents). Further analysis of the 26 referrals showed that over half of these incidents involved referrals alleging abuse rather than neglect of the victim child (See Chart B).

CHART B



Over half of these 26 referrals were evaluated out by the CWS agency because there were no other siblings in the home in need of protection by the CWS agency. As mentioned above, 11 of the 26 evaluated out referrals were determined by law enforcement alone to be the result of abuse and/or neglect, and all 11 were evaluated out for no other siblings in the home. Besides evaluating the referral out for no siblings in the home, there were seven "Other" reasons for evaluating out the fatality ER referral (see Chart C) which were mainly for either one or both parent(s) being deceased at the time of the fatality incident along with the child(ren).

CHART C



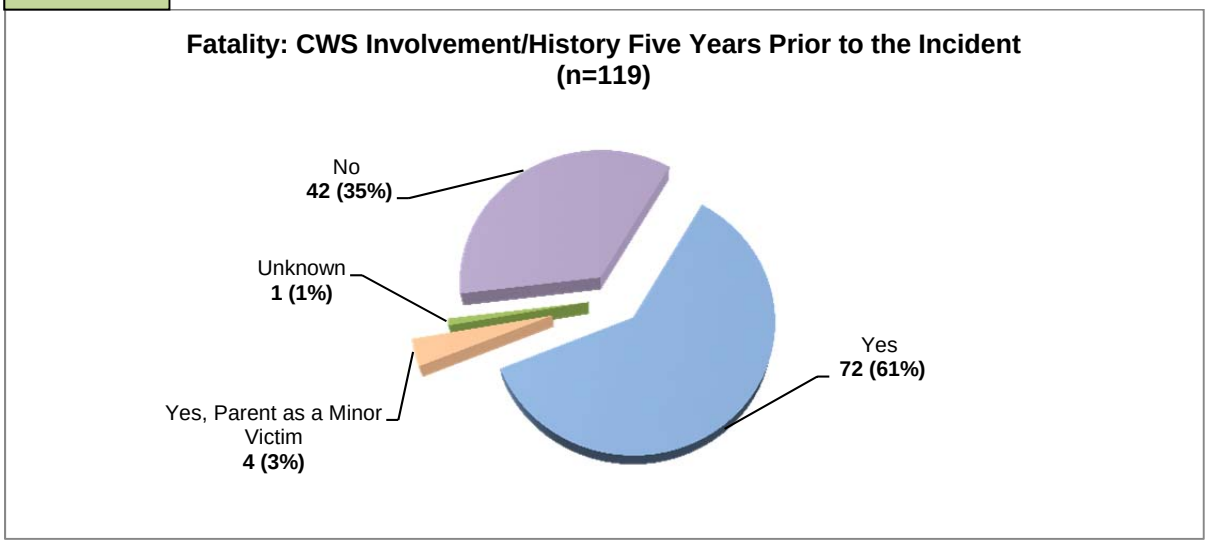
CWS Involvement and/or History

The analysis which follows examines what level of involvement the family of the child fatality victim may have had with the CWS agency. To make this determination, CDSS noted whether there was an open ER referral or case at the time of or within the five years preceding the incident. In gathering this data, the CDSS looks back five years from the date of the fatality incident referral except where otherwise noted.

It is important to note that the prior CWS history 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 over time. 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 physical abuse.

The data shows that of 119 incidents, 42 incidents (35 percent) involved children from families who had no CWS history in the five years prior to the incident; and 76 incidents (64 percent) involved children from families who were previously known to a CWS agency in the five years prior to the fatality incident (see Chart D). There was one incident where it is unknown as to what the CWS involvement of the family was prior to the fatality incident as the child was abandoned and the death remains unsolved by law enforcement and CWS.

CHART D

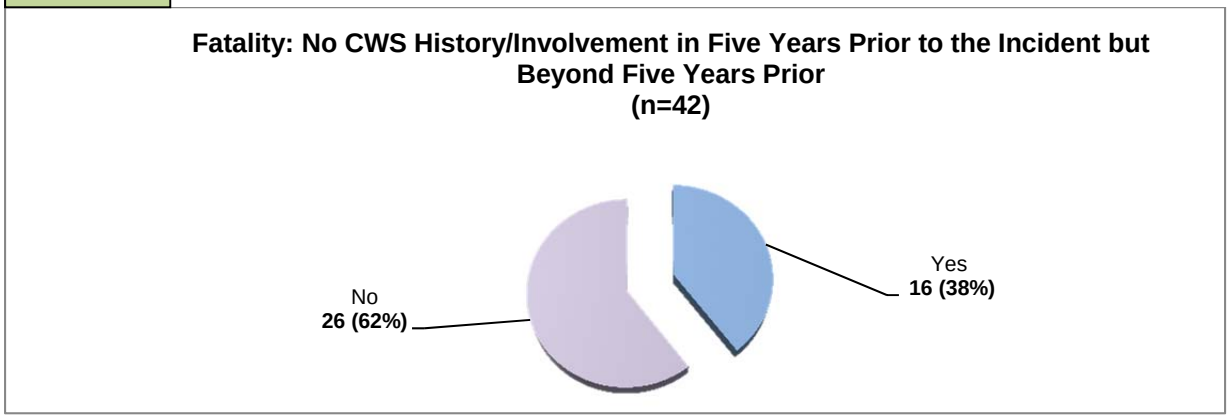


Families with No CWS Involvement and/or History in the Five Years Prior to the Incident

There were 42 incidents that involved children from families that did not have an open ER investigation or open case in the five years prior to the incident. In addition, none of these 42 families had CWS history in the five years prior to the incident. The CDSS conducted further analysis of this subgroup in an attempt to determine whether any of these families had ever been known to a CWS agency at all. This additional analysis of these 42 families revealed that 16 of these families (38 percent) had CWS history beyond the five-year period prior of the fatality (see Chart E). However, these additional families were excluded from the analysis of those families with prior CWS history in this report to permit comparisons of data in this report

with data contained in prior years' reports. Additionally, it should be noted that much of this CWS history did not pertain to the victim of these incidents given that the majority of all fatality incidents involved children four years of age or younger (see Chart N).

CHART E



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

As indicated in Table 2 below, there were 76 fatality incidents involving children from families who were previously known to a CWS agency in the five years prior to the incident. Of these 76 incidents, four incidents involved children from families with parents who were involved with CWS as minors themselves in the five years prior to the fatality incident, but had no CWS history as an adult. Therefore, the CDSS removed these incidents from this analysis as the focus of this analysis is on CWS case and referral history as adult parents. As a result, the total number of fatality incidents involving families known to a CWS agency with the parents as adults is 72. Of these 72 incidents, one incident involved a family who had a case opened during the five-year review period but the referral for that case was received prior to the five-year review period. Therefore, the total number of families who had a CWS referral(s) generated during the five-year review period is 71 (see Table 2).

Table 2. Level of Involvement with CWS

Number of Fatality Incident	Level of Involvement with CWS
76	Had CWS involvement/history in the five years prior to the incident (72 with parents as adults, and four with parents as minors)
72	Had CWS involvement/history in the five years prior to the incident as an adult (excludes four incidents involving parents with history as minors only)
71	Had CWS referrals generated within five years prior to the incident (excludes one incident with a family who had a case opened within the five-year review period but the referral for that case was received prior to the five-year review period)

Table 3 reflects the CWS agency involvement at the time of the fatality incident for the 72 families who had CWS history in the five years prior to the fatality incident.

Table 3. Number of Families with CWS Involvement at the Time of Incident

54	Not a current client of a CWS agency (but had prior history)
10	Open ER referral at the time of incident
4	Open in-home case with a CWS agency at the time of incident
3	Open out-of-home case with a CWS agency at the time of incident
1	Open in-home and out-of-home case with a CWS agency at the time of incident
72	**Total**

Families with CWS Involvement at the Time of the Fatality Incident

Of the 18 child fatality incidents involving families who were involved with a CWS agency at the time of the fatality incident, ten incidents involved families with an **open ER referral** (see Table 3). All of the ER referrals had been opened within six months of the fatality incident.

Of the four incidents involving families who had an open **in-home** case with a CWS agency, all of the cases had been opened within four to 24 months of the fatality incident.

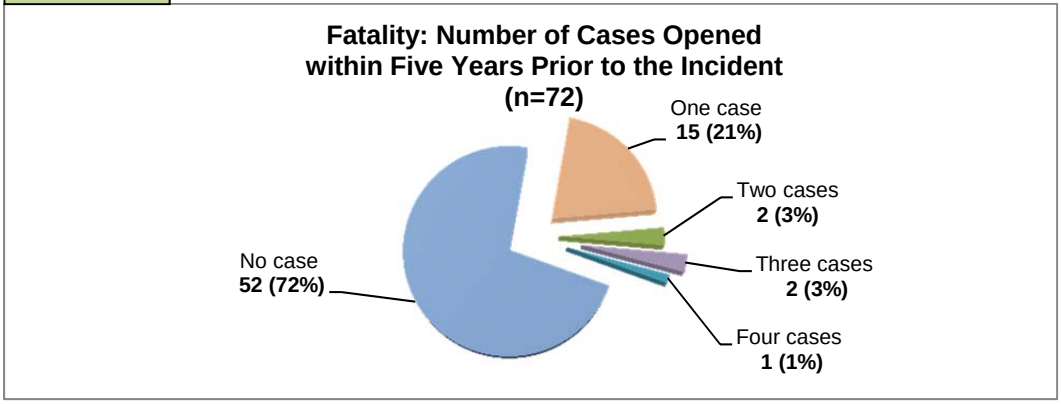
Of the three incidents involving families with an **out-of-home** case with a CWS agency at the time of the incident, two of the out-of-home cases involved the victim children. In one, the out-of-home case had been opened three months prior to the fatality incident. In the other, the out-of-home case had been opened for over five years prior to the incident, however, the child eventually succumbed to the injuries sustained in a near fatality as an infant. In looking at the placement types of these two out-of-home cases involving the victim children, one of the children resided in a foster family home and the other resided in a foster family agency home. The third out-of-home case did not involve the victim child but rather the victim's sibling and the case had been opened 19-36 months prior to the fatality incident.

There was one incident in which the fatality victim's siblings had both an **out-of-home case and an open in-home case** at the time of the fatality incident which were opened within 19-36 months of the fatality incident.

Families with CWS Case History Prior to the Fatality Incident

Of the 72 families with prior CWS involvement/history, 20 families (28 percent) had an open CWS case within five years prior to the fatality incident. Most of these 20 families had only one case opened prior to the fatality incident.

CHART F



Families with CWS Referral History Prior to the Fatality Incident - Information Regarding the Most Recent Referral Preceding the Incident

The following sections provide an analysis of the most recent referrals for those 71 families (see Table 2) who had ER referrals generated during the five years prior to the fatality incident. When reviewing this referral 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.[3] 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 page 10). If investigated, the disposition for the referral may have been unfounded, inconclusive, or substantiated.

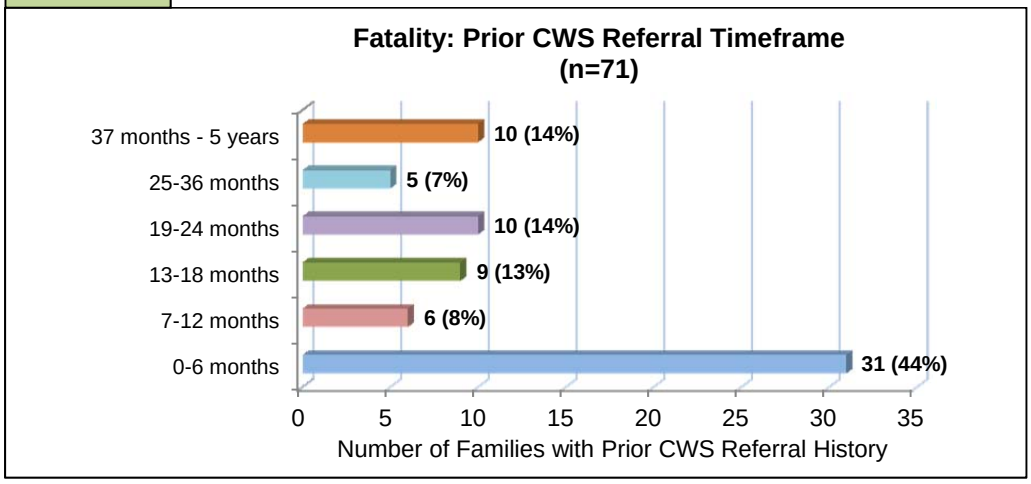
Second, as previously stated, the prior CWS referrals involving these families may not have included the child who was the subject of the fatality incident and the household composition may have been different at the time of the fatality. The information that follows offers a look at the families who had CWS history at the time of the fatality incident by examining the most recent referral preceding the incident. These families' histories with the CWS agency may offer some insight into future policy and prevention strategies.

[3] 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.

Prior CWS Referral Timeframe

In the six months prior to the fatality, 31 of these 71 families (44 percent) with prior CWS referral history had an ER referral generated for suspected child abuse or neglect. The remaining 40 families had prior ER referrals generated which were spread out over a time period of up to five years.

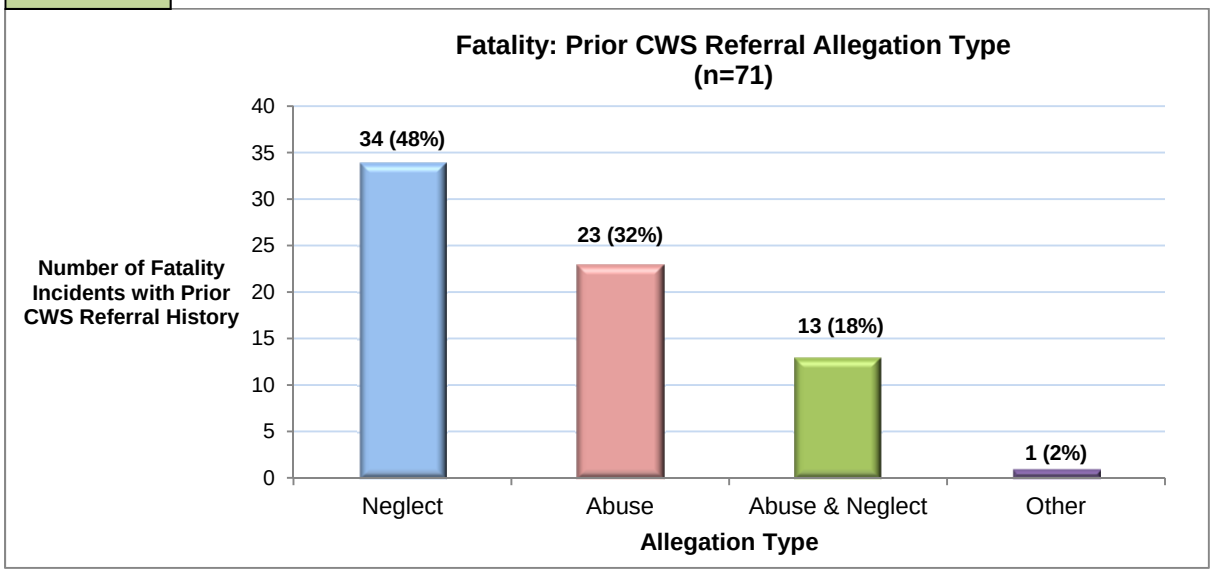
CHART G



Prior CWS Referral Allegation Type

In the 71 incidents with prior CWS referral history, almost half of the most recent referrals preceding the fatality incident had been generated for neglect allegations (48 percent), followed by abuse allegations (32 percent), and lastly combined abuse and neglect allegations (18 percent). There was one prior referral that was for Caretaker Absence/Incapacity (two percent).

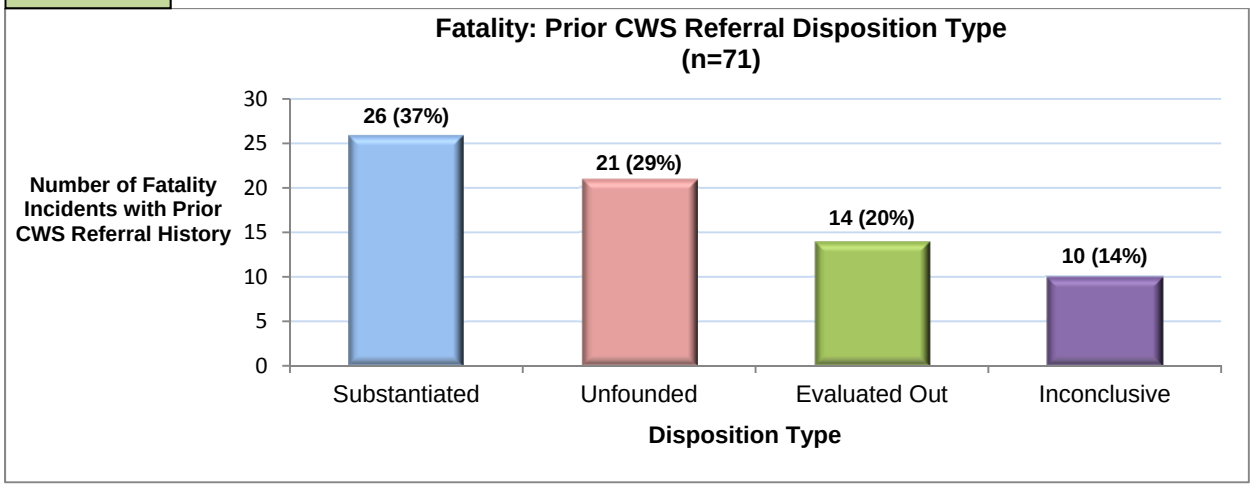
CHART H



Prior CWS Referral Disposition Type

As previously discussed, the existence of a referral does not necessarily mean that the allegations generating the referral were substantiated. However, when looking at the 71 incidents with CWS referral history, over a third of the most recent referrals preceding the fatality incident had allegations that were substantiated (37 percent). This is followed by allegations that were unfounded at 29 percent, evaluated out at 20 percent, and inconclusive at 14 percent.

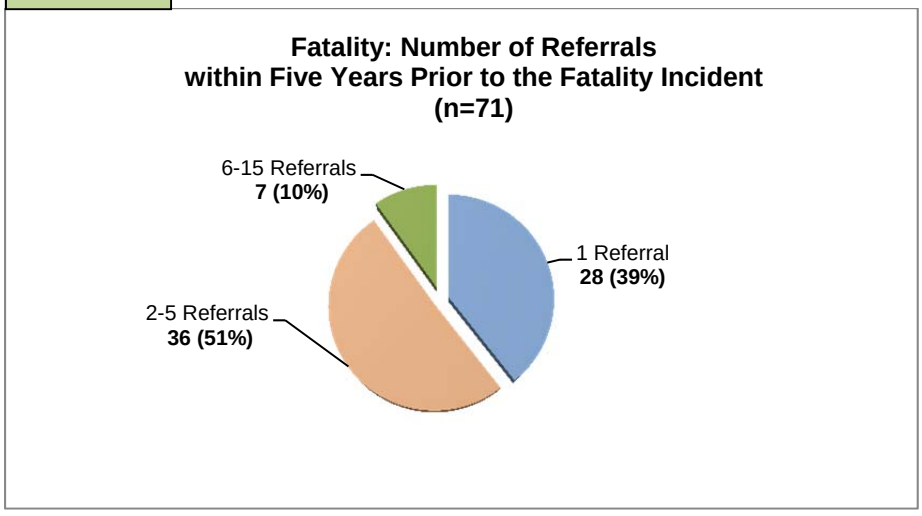
CHART I



Number of CWS Referrals Generated within Five Years of the Incident

Of the 71 incidents involving families with prior CWS referral history, a number of the families had more than one referral generated within the five years prior to the fatality incident. Slightly over half of these families (51 percent) had at least two to five referrals generated within the five years prior to the fatality incident and over a third of these families (39 percent) had only one referral generated within five years prior to the fatality incident.

CHART J



Seven of these 71 families (ten percent) had been the subject of more than six referrals per family prior to the fatality incident (See Chart J). These seven families generated a total of 70 referrals, many of which had been evaluated out or unfounded (see Table 4).

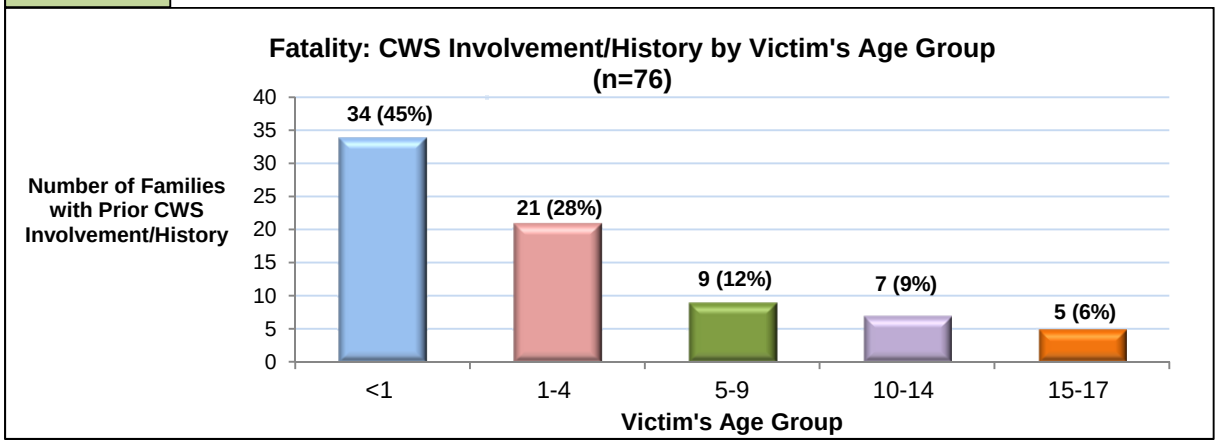
Table 4. Total Number of Referrals Generated in the Five Years Prior to the Incident for Families with More than Six Prior Referrals

Referral Disposition	Number	Percent
Evaluated Out	27	39%
Unfounded	22	31%
Inconclusive	7	10%
Substantiated	14	20%
Total	**70**	**100%**

CWS Involvement and/or History by Age Group

In analyzing the correlation between the child fatality victim's age and whether the child was part of a family known to a CWS agency, victims under the age of one belonged to almost half (45 percent) of the 76 child fatality incidents (see Table 2) where the family was known to a CWS agency. This was followed by victims between the age of one to four years old (28 percent) and five to 17 years old (27 percent).

CHART K



Of the 34 child fatality victims who were one year of age or younger whose families were known to a CWS agency as identified in Chart K, 14 of these victims (32 percent) were between two to five months old (see Table 5).

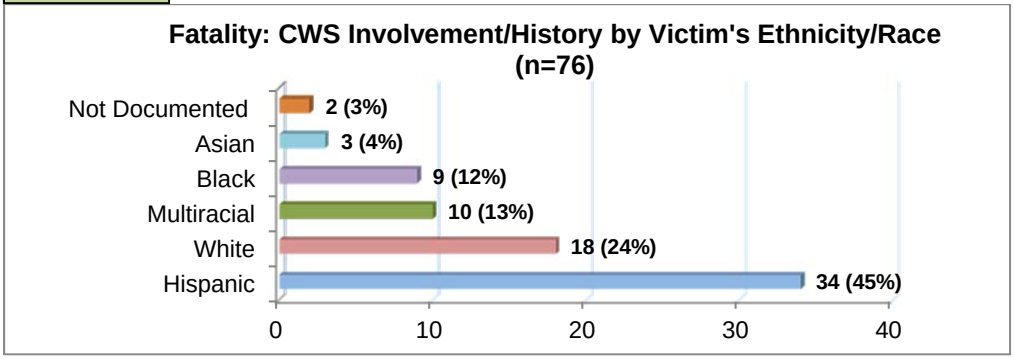
Table 5. Breakdown of CWS Involvement by Age—Under One Year of Age

Age of Victim's <1	Number
1 Month and Under	11
2 - 5 Months	14
6 - 11 Months	9
Total	**34**

CWS Involvement and/or History by Ethnicity Group

In analyzing the correlation between the child fatality victim's ethnicity and whether the child was from a family with CWS history, in almost half (45 percent) of the 76 child fatality incidents with prior CWS history (see Table 2), the victims belonging to these families were Hispanic, which coincides with their general representation in the overall California population. Families who were known to a CWS agency where the fatality victims were White was 24 percent and where the victims were Multiracial[4] was 13 percent. However, Black children represented six percent of the general child population and 12 percent of fatality victims whose families were known to a CWS agency, which indicates a disproportionate number of fatalities for Black children from families known to a CWS agency.

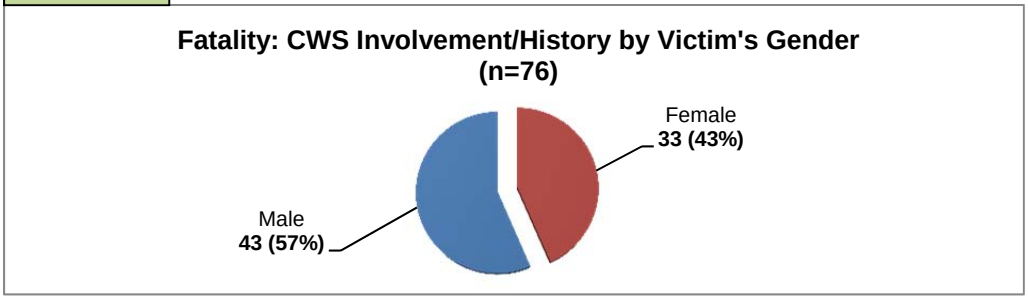
CHART L



CWS Involvement and/or History by Victim's Gender

In analyzing the correlation between the child fatality victim's gender and whether the child was from a family with CWS history, over half (57 percent) of the 76 child fatality incidents involving families that were known to a CWS agency (see Table 2) involved child fatality victims who were males.

CHART M



Summary of CWS Involvement and/or History

In summary, there were 72 incidents involving families with prior CWS history with the parents as adults in which 18 of these incidents involved families who were involved with a CWS agency at the time of the fatality incident. There were 54 incidents where the families were not a current

[4] See Demographics Information section for further information regarding Multiracial ethnicity/race category.

client of a CWS agency at the time of the incident but had CWS history in the five years prior to the fatality incident (see Table 3). Additionally, 20 of these 72 incidents (28 percent) involved families that had an open CWS case within five years prior to the fatality incident. The total number of fatality incidents involving families who had referrals generated during the five-year period under review is 71 (see Table 2). Of these 71 incidents, 37 families (52 percent) had some CWS involvement within a year prior to the fatality incident taking place. Of the most recent prior referrals preceding the fatality incidents, 48 percent of these prior referrals were for neglect. Lastly, while these 71 families did have some CWS involvement, 63 percent of the most recent referrals preceding the fatality incidents either did not meet the criteria for investigation by the CWS agency and were evaluated out or were deemed unfounded or inconclusive upon investigation. Further analysis of the incidents with prior CWS referral history found that a little over a half of the children's families had at least two to five referrals generated within the five years prior to the incident. Additionally, of the ten percent of families which had been the subject of more than six referrals per family prior to the fatality incident, a majority of those prior referrals had been either evaluated out or unfounded. The data demonstrates that many of the families involved in the reported child fatalities had prior CWS history with the most recent prior referral being either evaluated out or unfounded. As a result, additional examination of the process and tools used by CWS agencies when receiving an ER referral and investigating the allegations may be warranted.

Child Demographic Information

The following section is a comprehensive analysis of the CY 2011 data for age, gender, and ethnicity/race of the children who were victims of child fatalities determined to be the result of abuse and/or neglect compared to the general child population. For this report, the age, gender, and ethnicity/race of California's child population during 2011[5] was used for this analysis (See Attachment A).

Demographics of California's Children

An analysis of Attachment A shows that there was not a great difference in the total number of California's general child population between the below-five age group (27 percent), the five- to nine-year-old age group (27 percent), and the ten- to 14-year-old age group (28 percent). Children between the ages of 15- to 17-years-old comprised of 18 percent of the total child population.

With respect to ethnicity/race, the Hispanic population represented 51 percent of the total child population. In the under-five age group, Hispanic children represented 53 percent of the child population, while White children represented 26 percent and Black children represented five percent.

With respect to gender, in the overall population of all California children under age 18, 51 percent were male and 49 percent were female. Of the 4,719,773 male children in California, 1,292,330 (27 percent) were under the age of five. Similarly, of the 4,494,652 female children in California, 1,222,138 (27 percent) were under the age of five.

Demographic Characteristics of Child Fatalities

The data gathered for the 119 child fatality incidents indicates the most vulnerable population were children ages four and younger. Chart N, which depicts the gender of children by age group, shows 93 of the 119 child fatality incidents (78 percent) were children four years of age and younger. Of those, 58 children (49 percent) were less than one year old, and 35 children (29 percent) were between the ages of one and four. The remaining 26 child fatality incidents (22 percent) involved children in the five- to 17-year-old age group. The finding with respect to higher numbers of fatalities for children four years of age and younger is consistent with national data presented by Sheldon-Sherman, Smith, and Wilson (2013)[6] and the Child Maltreatment 2011 report[7] which similarly found that for CY 2011, more child fatalities resulting from abuse and/or neglect involved children under the age of one and between the ages of one and four than other age groups.

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[5] The 2011 population estimate from the Department of Finance (DOF) website was used for the data in this report.

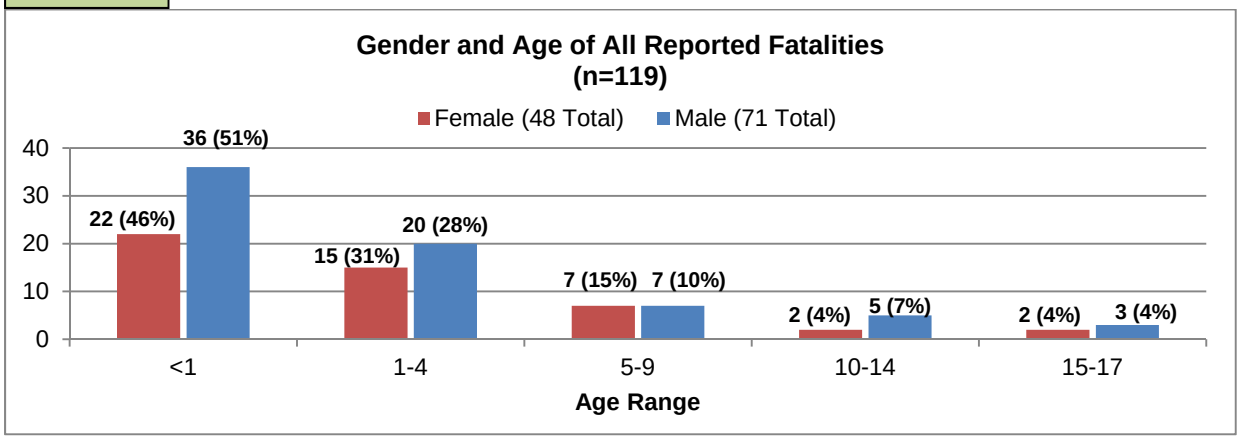
[6] Sheldon-Sherman, Jennifer, Susan Smith, and Dee Wilson. "Extent and Nature of Child Maltreatment-Related Fatalities: Implications for Policy and Practice." *Child Welfare.* Ed. Mallon, Gerald P., Gary R. Anderson, and Rachel Adams. Washington D.C.: Child Welfare League of America, 2013. Vol.92 No 2. 41-58. Print.

[7] U.S. Department of Health and Human Services, Administrations for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011.* Washington, D.C.

Gender and Age

Overall, the number of male child fatality incidents reported was higher than the number of female child fatality incidents; there were 71 incidents compared to 48 incidents, respectively, for all children under 18 in the fatality group (see Chart N).

CHART N



The breakdown for gender in the less than one year old child fatality age group was 22 females and 36 males. The one- to four-year-old child fatality age group had 20 males and 15 females. Chart N, which depicts the gender of children by age group, shows that the less than one year old age group reflects the greatest difference between males and females. The higher number of male children in the less than one year old age group contributed to the greater representation of males overall for child fatality incidents. The general finding with respect to males having a higher rate of child fatality incidents is consistent with national data presented by Sheldon-Sherman, Smith, and Wilson (2013)[8] and the 2011 federal Child Maltreatment report[9] which similarly found that for CY 2011, more child fatalities resulting from abuse and/or neglect involved male children.

Further analysis of victims under the age of one showed that the most vulnerable population is children between the ages of newborn to age three months (53 percent).

Table 6. Fatality by Age and Gender of Victims Under One Year of Age

Victim <1 Age Group	Female	Male	Total
Newborn to 3 months	13	18	**31**
4 months to 6 months	3	7	**10**
7 months to 11 months	6	11	**17**
Total	**22**	**36**	**58**

[8] Sheldon-Sherman, Jennifer, Susan Smith, and Dee Wilson. "Extent and Nature of Child Maltreatment-Related Fatalities: Implications for Policy and Practice." *Child Welfare.* Ed. Mallon, Gerald P., Gary R. Anderson, and Rachel Adams. Washington D.C.: Child Welfare League of America, 2013. Vol.92 No 2. 41-58. Print.

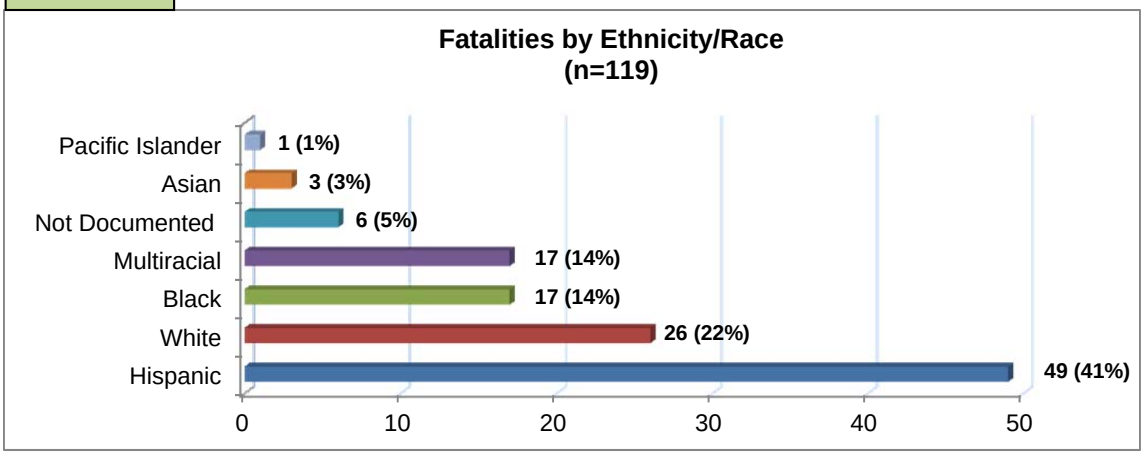
[9] U.S. Department of Health and Human Services, Administrations for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011.* Washington, D.C.

Child Fatalities: Ethnicity/Race

With respect to ethnicity/race of the children for the 119 child fatality incidents that were determined to be the result of abuse and/or neglect, Hispanic children had more reports of fatalities than any other single category of ethnicity/race (see Chart O). For comparison, the Hispanic population of children in the general child population in California in 2011 was 51 percent (see Attachment A).

The data gathered for the 119 child fatality incidents shows that 49 of the children (41 percent) were Hispanic, 26 of the children (22 percent) were White, 17 of the children (14 percent) were Multiracial, 17 of the children (14 percent) were Black, three children (three percent) were Asian, and one child (one percent) was Pacific Islander. For six of the children (five percent) the ethnicity/race of the child was not documented.

CHART O



The most frequently represented primary ethnicities/races in the Multiracial category were Black and White. If the incidents involving Black children were added to the data regarding the number of Black child fatality victims, the number of Black victims would increase from 17 to 24 and the disproportionate percentage of Black children when compared to Hispanic or White children would increase even further.

Table 7. Breakdown of Multiracial Victims

Primary Ethnicity/Race	Secondary Ethnicity/Race	Number of Victims
Black	White	2
Black	Hispanic	3
Black	Asian	2
White	Hispanic	2
White	Black	1
White	Pacific Islander	1
Hispanic	Black	2
Asian	White	2
Native American	Hispanic	1
Native American	White	1
Total		**17**

Summary of Child Demographic Information

In summary, for child fatality incidents reported for CY 2011, the number of male child fatality incidents reported was higher than the number of female child fatality incidents; there were 71 incidents compared to 48 incidents, respectively, for all children under 18 in the fatality group. The higher number of male children in the less than one-year-old age group contributed to the greater representation of males for child fatality incidents.

While Hispanic children comprised the largest category of reported fatalities, they also comprised the largest single ethnicity/race in California's overall child population during CY 2011. However, the data indicates that there are a disproportionate number of Black children who are victims of these incidents when compared to other ethnicities and the general child population numbers.

Child Abuse Versus Neglect—What is Known

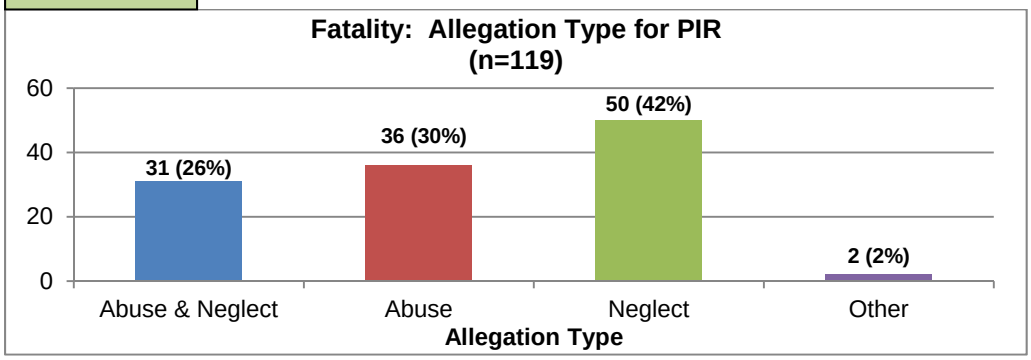
This section discusses the types of allegations associated with the referrals generated by the CWS agencies for the primary individuals responsible (PIRs) for the child fatality incidents that were reported for CY 2011. A summary of the referrals associated with the secondary individuals responsible (SIRs) (the individual(s) who did not commit the act that caused the fatality, however, were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the fatality incident)[10] will also be provided in this section. It should be noted that an allegation of neglect for a child fatality may occur when a determination is made that the fatality was the result of a parent(s)/guardian(s) or caretaker(s) failure to provide the care and protection necessary for the child's healthy growth and development. Additionally, a combined allegation such as abuse and neglect may occur when there are two individuals responsible for the fatality. The allegation types described below represent the allegations documented for the referrals associated with the SOC 826 forms submitted to CDSS.

Child Fatalities: Allegation Type for Primary Individuals Responsible (PIRs)

The data shows when looking at the PIRs for the reported child fatality incidents 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 2011. This data trend is similar to what was found for those incidents with CWS history for the most recent referral preceding the fatality (see Chart H). This is also consistent with data presented by Sheldon-Sherman, Smith, and Wilson (2013)[11] who found that "in 2011, neglect was present in more than two-thirds (71 percent) of child maltreatment deaths and physical abuse was present in approximately half (48 percent)." Chart P depicts the allegation types for all child fatality incidents reviewed for CY 2011.

The data shows that 50 of the 119 child fatality incidents (42 percent) for CY 2011 had a PIR with an allegation of child neglect. The allegation types for the PIRs in the remaining 69 incidents were as follows: 36 incidents (30 percent) were allegations of abuse, 31 incidents (26 percent) were allegations of abuse and neglect, and two incidents (two percent) had allegations listed as "Other," which included one for neglect and caretaker absence/incapacity, and another for abuse, neglect, and caretaker absence/incapacity.

CHART P



[10] A more in-depth definition of the PIRs and SIRs can be found on pages 28 and 33.
[11] Sheldon-Sherman, Jennifer, Susan Smith, and Dee Wilson. "Extent and Nature of Child Maltreatment-Related Fatalities: Implications for Policy and Practice." *Child Welfare.* Ed. Mallon, Gerald P., Gary R. Anderson, and Rachel Adams. Washington D.C.: Child Welfare League of America, 2013. Vol.92 No 2. 41-58. Print.

Allegation Type of PIRs Compared to Victims' Age Range

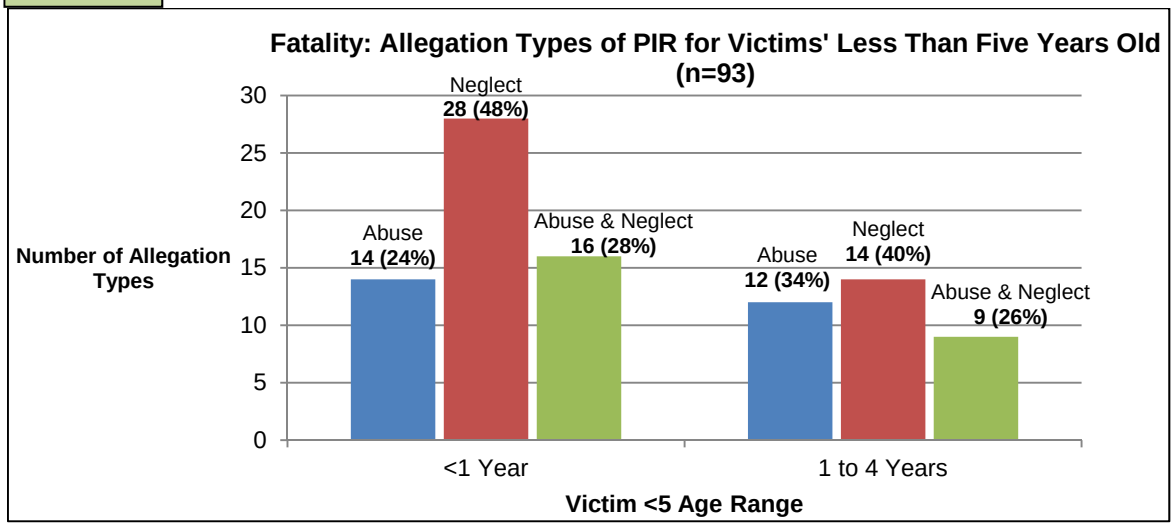
The allegation types for the PIRs in the 58 fatality incidents in the less than one-year-old age group were as follows: 28 incidents (48 percent) were neglect allegations, 16 incidents (28 percent) were abuse and neglect allegations, and 14 incidents (24 percent) were abuse allegations.

The allegation types for the PIRs in the 35 fatality incidents in the one- to four-year-old age group were as follows: 14 incidents (40 percent) were neglect allegations, 12 incidents (34 percent) were abuse allegations, and nine incidents (26 percent) were abuse and neglect allegations.

The allegation types for the remaining PIRs in the 26 incidents in the five- to 17-year-old age group were as follows: ten incidents (38 percent) were abuse allegations, eight incidents (31 percent) were neglect allegations, six incidents (23 percent) were abuse and neglect allegations, and two incidents (eight percent) were listed as "Other," one for abuse, neglect, and caretaker absence/incapacity, and one for neglect and caretaker absence/incapacity.

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

CHART Q



Child Fatalities: Allegation Type for PIRs by Victim's Gender

As previously discussed, neglect was documented in CWS/CMS more often than any other single allegation category for the PIRs in the fatality incidents reported to the CDSS for CY 2011. In comparing the PIRs allegation type by the victim's gender, both male and female victims had almost an equal number of neglect allegations for the fatality incidents. However, abuse allegations doubled for fatality incidents involving male victims (24 male victims compared to 12 female victims).

Table 8. Allegation Type for PIR by the Victim's Gender

Primary Individual Responsible (PIR) Allegation Types	Victim's Gender		Total
	Female	Male	
Neglect	23	27	**50**
Abuse	12	24	**36**
Abuse & Neglect	12	19	**31**
Neglect & Caretaker Absence/Incapacity	1		**1**
Abuse, Neglect, & Caretaker Absence/Incapacity		1	**1**
Total	**48**	**71**	**119**

Child Fatalities: Allegation Type for PIRs by Victim's Ethnicity/Race

The data shows that PIR allegations of abuse alone and combined abuse and neglect were higher for Hispanic victims than any other ethnicity/race. However, neglect allegations alone were slightly higher for White children than Hispanic or Black children.

Table 9. Allegation Type for PIR by the Victim's Ethnicity/Race

Victim's Ethnicity/Race	Allegation Types for PIR				Total
	Neglect	Abuse	Abuse & Neglect	Other[12]	
Hispanic	13	17	19		**49**
White	14	9	2	1	**26**
Black	10	1	6		**17**
Multiracial	7	6	3	1	**17**
Asian	1	2			**3**
Not Documented	4	1	1		**6**
Pacific Islander	1				**1**
Total	**50**	**36**	**31**	**2**	**119**

[12] "Other" allegation types for the PIRs were a combined allegation of neglect and caretaker absence/incapacity; and a combined allegation of abuse, neglect, and caretaker absence/incapacity.

Summary of Child Abuse versus Neglect—What is Known

In summary, when looking at the PIRs for the reported child fatality incidents, allegations of neglect were documented in CWS/CMS more often than any single allegation category. For children less than five years of age, neglect was the most reported allegation for PIRs. In comparing the PIRs allegation type by the victim's gender, both male and female victims had almost an equal number of neglect allegations for the fatality incidents. However, abuse allegations doubled for fatality incidents involving male victims (24 male victims compared to 12 female victims). The number of PIR allegations of abuse alone and combined abuse and neglect were higher for Hispanic victims than any other ethnicity/race. However, neglect allegations alone were slightly higher for White children than Hispanic or Black children.

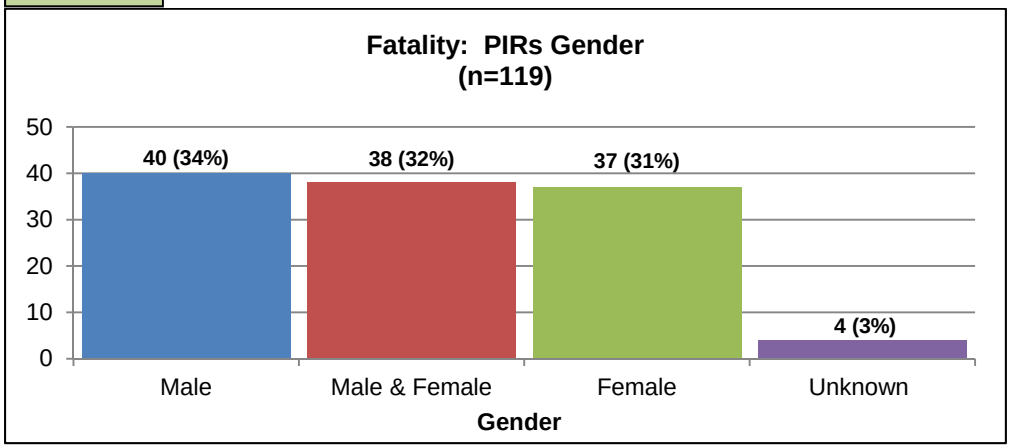
Who Was Identified as the PIRs for the Fatality Incidents

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 PIRs identified by the CWS agency and documented in CWS/CMS as the individual(s) responsible for the fatality incidents. This data also includes additional analysis of incidents in which more than one individual was identified as being responsible for the fatality incident.

Gender of the PIRs

Chart R depicts the gender of the PIRs for the reported child fatality incidents. The data shows that overall the distribution between male and female PIRs for the fatality incidents was not significant. In 40 of the 119 child fatality incidents (34 percent), the PIR was a male. In 38 of the fatality incidents (32 percent), there were two individuals identified by the CWS agency as the PIRs for the fatality which included both a male and a female in each incident. In 37 of the fatality incidents (31 percent), the PIR was a female. In four of the fatality incidents (three percent), the identity of the PIR was unknown.

CHART R



Gender of PIRs by Victim's Age

Of the 58 child fatality incidents in the less than one-year-old age group, more females than males were identified as the PIRs for the fatality incident. In 22 of these incidents (38 percent), the PIR for the fatality was a female; and in 17 of these incidents (29 percent), both a male and a female were responsible for the fatality. In 16 of these incidents (28 percent), the PIR was a male. In three of these incidents (five percent), the identity of the PIR was unknown.

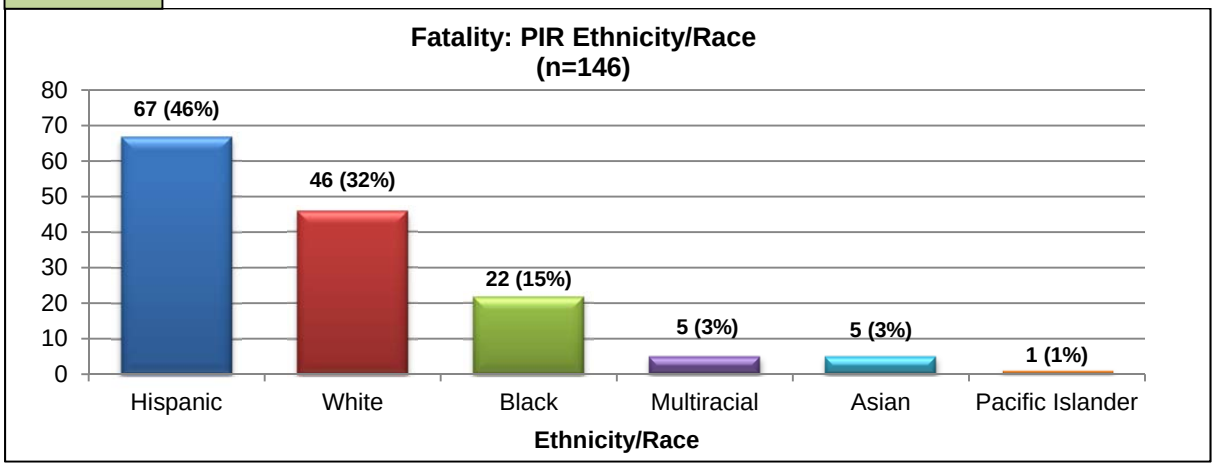
Of the 35 child fatality incidents in the one- to four-year-old age group, males alone almost equaled males and females together as the PIRs for the fatality. In 14 of these incidents (40 percent), the PIR included both a male and a female; and in 13 of these incidents (37 percent), the PIR was a male. In seven of these incidents (20 percent), the identity of the PIR was a female. In one incident (three percent), the identity of the PIR was unknown.

Of the remaining 26 child fatality incidents in the five- to 17-year-old age group, more males than females were identified as the PIR for the fatality incident. In 11 of these incidents (42 percent), the PIR was a male; and in eight of these incidents (31 percent), the PIR was a female. In seven of these incidents (27 percent), the PIR included both a male and a female.

Ethnicity/Race of PIRs

Chart S depicts the ethnicity/race of the PIRs for the 109 incidents in which the ethnicity/race was known. Of these 109 incidents, there were a total of 146[13] PIRs whose ethnicity/race was known for the fatalities. Of these 146 PIRs whose ethnicity/race was known, almost half were Hispanic (46 percent) and almost a third were White (32 percent). This was followed by PIRs who were Black (15 percent), Asian (three percent), and Pacific Islander (one percent). For five of the PIRs (three percent), more than one ethnicity/race was identified in CWS/CMS.

CHART S



Of the PIRs who had more than one ethnicity/race identified in CWS/CMS, Table 10 breaks down the primary and secondary ethnicity/race of the PIRs. This data shows that most of the PIRs in the Multiracial category are a combination of Native American and another ethnicity/racial background or Hispanic and another ethnicity/racial background.

Table 10. Breakdown of Multiracial PIR Ethnicity/Race

Primary Ethnicity/Race	Secondary Ethnicity/Race	Number of PIRs
Native American	White	2
Hispanic	Native American	1
Hispanic	Black	1
Pacific Islander	White	1
Total		**5**

[13] Of the 109 fatality incidents where the ethnicity of the PIRs was known, there were 37 incidents where two individuals were identified as the PIRs for the fatality whose ethnicity/race was known making a total of 146 individuals.

Relationship Between the Child and the PIRs for the Fatality

Table 11 provides greater detail regarding the relationship to the victim of the primary individuals identified as being responsible for the fatalities reported. In 101 of the 119 child fatality incidents (85 percent), a biological parent, either individually or in conjunction with another individual, was identified as the individual(s) responsible for the incidents. In 36 of the 119 child fatality incidents (30 percent), the biological mother was exclusively responsible for the fatality; and the biological father was exclusively responsible for 29 of the 119 child fatality incidents (24 percent). In one of the 119 child fatality incidents (one percent), the foster parents were responsible for the incident.

There were a total of 18 incidents in which the biological mother's significant others were involved in the fatality incidents (15 percent) exclusively or in conjunction with the biological mother. In four of the 119 child fatality incidents (three percent), the individual responsible for the fatality was unknown.

These findings are consistent with the findings from the 2011 federal Child Maltreatment Report[14] which found that "four-fifths (78 percent) of child fatalities were caused by one or more parents. The child's mother acting alone perpetrated more than one-fifth (26 percent) as compared to the father alone (15 percent)."

Table 11. PIRs

Primary Individual(s) Responsible (PIR) for the Fatality	Number	Percent
Bio Mother	36	30%
Bio Father	29	24%
Biological Parents	25	21%
Bio Mother's Significant Other (M)	10	8%
Bio Mother & her Significant Other (M)	8	7%
Unknown	4	3%
Other[15]	3	3%
Bio Mother & Step Parent (M)	1	1%
Bio Mother & Unrelated Adult (M)	1	1%
Bio Mother & Related Adult (M)	1	1%
Foster Parents	1	1%
Total	**119**	**100%**

[14] U.S. Department of Health and Human Services, Administrations for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2012). *Child Maltreatment 2011.* Washington, D.C.
[15] See Table 12 for a breakdown of "Other" PIRs.

Table 12 breaks down the PIRs for the fatalities which are listed as “Other.”

Table 12. Other PIRs

Other Primary Individual(s) Responsible (PIR) for the Fatality	Number
Related Adult (F)	**1**
Unrelated Adult (M)	**1**
Unrelated Adult (M) & Unrelated Adult (F)	**1**
Total	**3**

Primary Individual(s) Responsible for Fatality by the Victim’s Age

Table 13 depicts a breakdown of the age of the victim by the PIRs for the fatality. Biological mothers were most frequently identified as the individual responsible for victims under the age of one (38 percent), followed by biological parents together (26 percent) and then by biological fathers (24 percent). Biological fathers acting alone (25 percent) were slightly more responsible for the fatality incidents of victims between the ages of one and 17 years old than biological mothers acting alone (23 percent). Biological parents, either individually or in conjunction with one another or their significant other, were more frequently responsible for the fatality incidents of victims over the age of ten compared to non-biological individuals. Biological mothers, either individually or in conjunction with their significant other (39 percent), were more frequently responsible for the fatality incidents of victims between the ages of one and four years old. Interestingly, individuals without a parental relationship to the victim, either individually or in conjunction with the biological mother, were more frequently responsible for fatality incidents where the victims were between the ages of one and four years old.

Table 13. Primary Individual(s) Responsible and the Age of the Victims

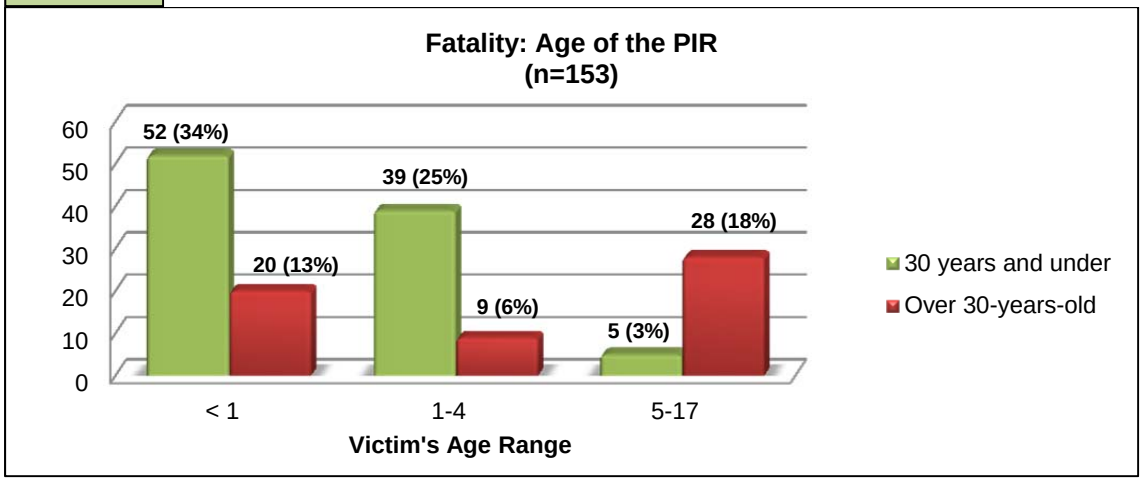
	Victim’s Age Group					
Primary Individual(s) Responsible (PIR)	< 1	1-4	5-9	10-14	15-17	Total
Bio Mother	22	6	6	1	1	**36**
Bio Father	14	6	5	3	1	**29**
Bio Parents	15	4	2	1	3	**25**
Bio Mother's Significant Other (M)	2	6		2		**10**
Bio Mother & her Significant Other (M)	1	7				**8**
Unknown	3	1				**4**
Other		3				**3**
Bio Mother & Step Parent (M)			1			**1**
Bio Mother & Unrelated Adult (M)		1				**1**
Bio Mother & Related Adult (M)		1				**1**
Foster Parents	1					**1**
Total	**58**	**35**	**14**	**7**	**5**	**119**

Age of the PIRs for Fatality by Victim's Age

Chart T depicts the age of the PIRs for the child fatality incidents for the 115 cases in which the age of the PIR was known. Of these 115 incidents, there were a total of 153[16] PIRs for the fatalities.

For the less than five-year-old age group of victims, the PIR was most often 30 years of age or younger (59 percent). However, for the five-to 17-year-old age group of victims, the PIR for the fatality was more often over 30 years of age (18 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. Additionally, the finding with respect to a greater number of child fatalities associated with parents under the age of 30 is supported in a study by Sheldon-Sherman, Smith, and Wilson (2013)[17] which found that "individuals who are responsible for abuse and neglect fatalities are usually under the age of thirty and have remained fairly consistent for the last three decades."

CHART T



[16] Of the 115 fatality incidents where the age of the PIRs was known, there were 38 incidents where two individuals were identified as the PIRs for the fatality making a total of 153 individuals.

[17] Sheldon-Sherman, Jennifer, Susan Smith, and Dee Wilson. "Extent and Nature of Child Maltreatment-Related Fatalities: Implications for Policy and Practice." *Child Welfare.* Ed. Mallon, Gerald P., Gary R. Anderson, and Rachel Adams. Washington D.C.: Child Welfare League of America, 2013. Vol.92 No 2. 41-58. Print.

Primary Individual(s) Responsible for Fatality by the Victim's Gender

Table 14 depicts the gender of the victim by the PIR for the fatality. Biological fathers were more frequently responsible for victims who were males (69 percent). Biological mothers' significant others acting alone were also more frequently responsible for victims who were males (80 percent). Biological mothers alone and biological parents together were almost equally responsible for both female (47 percent and 48 percent respectively) and male (53 percent and 52 percent respectively) victims.

Table 14. Primary Individual(s) Responsible by Victim's Gender

Primary Individual(s) Responsible (PIR)	Victim's Gender		Total
	Female	Male	
Bio Mother	17	19	**36**
Bio Father	9	20	**29**
Bio Parents	12	13	**25**
Bio Mother's Significant Other (M)	2	8	**10**
Bio Mother & her Significant Other (M)	2	6	**8**
Unknown	2	2	**4**
Other	4	3	**7**
Total	**48**	**71**	**119**

Summary of PIRs

In summary, when reviewing who was identified as the PIRs for child fatalities reported for CY 2011, slightly more males than male and females together or females alone were responsible for the fatality incidents resulting from abuse and/or neglect; however, the margin between the three is very small. For children less than one year old, more biological mothers acting alone than biological fathers acting alone were identified as the PIR for the fatality incidents. For children over the age of one, more biological fathers acting alone than biological mothers acting alone were identified as the PIR for the fatality incidents, although the numbers are very close. Additionally, the ethnicity/race of the PIRs was mainly Hispanic, which is consistent with the general fatality victims' demographics. For all age groups combined, biological mothers (30 percent) were identified more often as the PIR for the fatality than biological fathers (24 percent). With respect to the age of the PIRs for the fatality incidents reported, over half of the known PIRs for the fatality incidents reported were 30 years of age or younger.

What is Known About the Secondary Individuals Responsible (SIRs) for the Fatality Incidents

New to this year's report is an analysis about other individual(s) who did not commit the act that caused the child fatality but were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the fatality incident. This SIR may be the person who failed to protect the victim from the PIR. Of the 119 fatality incidents, there were 19 fatality incidents (16 percent) in which there was an individual identified as a SIR. The following summary provides information regarding the 19 SIRs identified by the CWS agencies and documented in CWS/CMS incidents.

The data shows that in ten of the 19 child fatality incidents (53 percent) where a SIR was identified by a CWS agency, the SIR was a male; and in nine of the fatality incidents (47 percent), the SIR was a female.

There were 11 individuals identified as a SIR for the fatality incidents in the less than one-year-old age group and eight individuals identified as a SIR for the fatality incidents in the one- to four-year-old age group. There were no SIRs identified for children over four years old.

The ethnicity/race of the SIR shows that there were slightly more Hispanics (44 percent) identified as the SIR, followed by Whites (38 percent), Blacks (13 percent), and Pacific Islanders (six percent).

In regards to the relationship between the SIR and the victim child, interestingly, both biological mothers and fathers were equally identified as the SIR. An unrelated male adult was also identified as a SIR for one fatality incident for a victim child under the age of one.

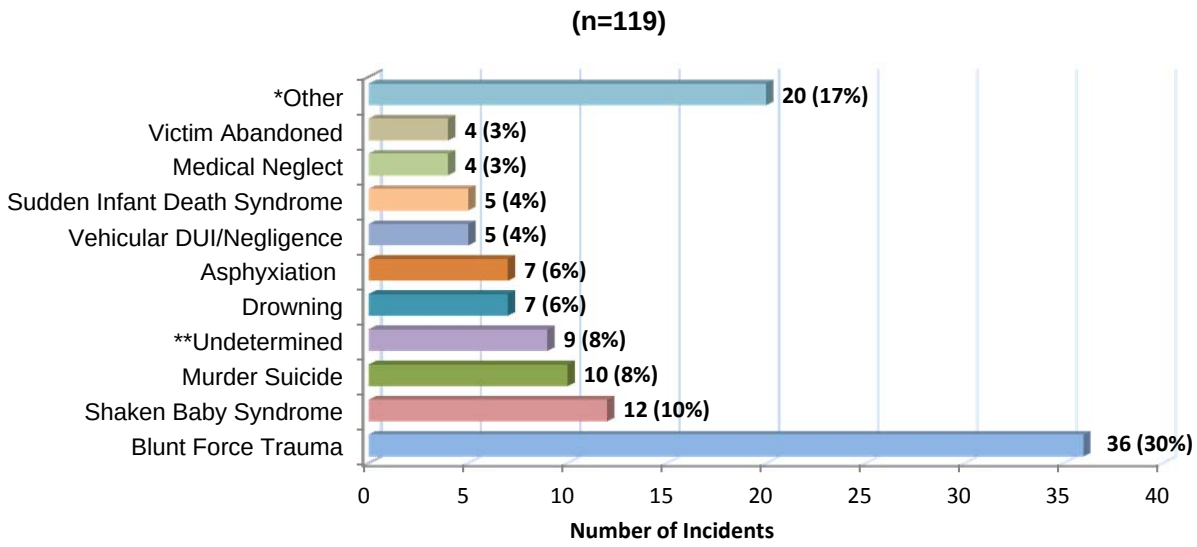
The findings regarding the age of the SIR were similar to what was found for the PIR, in that the SIR was most often 30 years of age or younger for children under the age of five.

The data shows that neglect was documented in CWS/CMS more often than any other allegation type for fatality incidents where a SIR was identified. These findings are consistent with what one might expect given that the SIR is often the person who is identified as failing to protect the children from the PIR, the individual who commited the act that caused the fatality.

Specific Cause/Finding of Incident

The specific causes or findings in the 119 child fatalities that were determined to be the result of abuse and/or neglect during CY 2011 are categorized below in Chart U. A review of these incidents indicated that the most commonly reported cause of fatality was blunt force trauma. The causes listed below are based on the causes identified by counties and documented in CWS/CMS.

CHART U



***** The "Other" category represents those incidents in which there were three or less of the same cause that were identified and documented.
****** The "Undetermined" category represents those incidents in which the cause of the fatality was documented in CWS/CMS as "undetermined."

Table 15 depicts a breakdown of the "Other" category of fatality causes.

Table 15. Breakdown of "Other" Fatality Causes

"Other" Causes	Number
Burns	3
Co-Sleeping	3
Unknown	2
Gunshot	2
House Fire	2
Suicide	2
Ingested Substance	1
Malnourished	1
Stabbing	1
Starvation	1
Asphyxiation and Co-Sleeping	1
Blunt Force Trauma and Neglect	1
Total	**20**

Causes Compared to the Allegation Types of the PIRs

Table 16 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 combined allegations of abuse and neglect. For those blunt force trauma incidents which had neglect allegations (six incidents), it was identified that in many of these incidents the reason this allegation type was associated with this specific cause was that the allegation type was the initial allegation for the fatality referral due to uncertainty regarding the individual responsible at the time the investigation concluded. As such, the neglect allegation was used to conclude the investigation. However, information from associated siblings' cases supported that the fatality was actually due to abuse.

All incidents of shaken baby syndrome were substantiated for abuse or a combined allegation of abuse and neglect and all drowning incidents were substantiated for neglect. Additionally, all incidents involving Sudden Infant Death Syndrome (SIDS) were substantiated for neglect. The factors contributing to the neglect findings for the five SIDS cases were unsafe home environment, lack of supervision, and being under the influence of drugs and/or alcohol which lead to a lack of supervision.

Table 16. Causes Compared to PIR Allegation Type

	Allegation Type of Primary Individual Responsible (PIR)				
Causes	**Neglect**	**Abuse**	**Abuse & Neglect**	**Other**	**Total**
Blunt Force Trauma	6	16	14		**36**
Shaken Baby Syndrome		6	6		**12**
Murder Suicide		8	2		**10**
Undetermined	5		3	1	**9**
Drowning	7				**7**
Asphyxiation	5	1	1		**7**
SIDS	5				**5**
Vehicular DUI/Negligence	4			1	**5**
Medical Neglect	3		1		**4**
Victim Abandoned	2	2			**4**
Other	13	3	4		**20**
Total	**50**	**36**	**31**	**2**	**119**

Causes Compared to Gender of Victim

Table 17 is a detailed distribution of the gender of the victim and the cause of fatality. Male victims accounted for a higher proportion (60 percent) of all fatalities in CY 2011 and were more frequently represented in blunt force trauma (64 percent), shaken baby syndrome (75 percent), and undetermined (78 percent) incidents. Female victims were more frequently represented in fatalities caused by asphyxiation (71 percent).

Table 17. Causes Compared to Gender of Victim

Causes	Victim's Gender			
	Female		Male	
	Number	Percent	Number	Percent
Blunt Force Trauma (36)	**13**	36%	**23**	64%
Shaken Baby Syndrome (12)	**3**	25%	**9**	75%
Murder Suicide (10)	**5**	50%	**5**	50%
Undetermined (9)	**2**	22%	**7**	78%
Drowning (7)	**3**	43%	**4**	57%
Asphyxiation (7)	**5**	71%	**2**	29%
Vehicular DUI/Negligence (5)	**3**	60%	**2**	40%
SIDS (5)	**2**	40%	**3**	60%
Medical Neglect (4)	**1**	25%	**3**	75%
Victim Abandoned (4)	**3**	75%	**1**	25%
Other (20)	**8**	40%	**12**	60%
Total (119)	**48**	40%	**71**	60%

Causes Compared to the Age of the Victim

As previously indicated, 78 percent of all child fatalities in CY 2011 were victims under the age of five (see Chart N). Of the older victims, 14 children (12 percent) were between five to nine years old, seven children (six percent) were between ten to 14 years old, and five children (four percent) 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 fatalities for children under one year of age were blunt force trauma and shaken baby syndrome. Fatalities for children between the ages of one and four years of age were most frequently associated with blunt force trauma. In one incident, a fatality victim between the age of five and nine years old succumbed to injuries caused by shaken baby syndrome in a near fatality as an infant. Older children, ages ten and over, were most frequently associated with fatalities from murder suicide and medical neglect. See Table 18 below for a distribution of the causes of fatalities and the age of victims.

Table 18: Causes Compared to the Age of the Victim

Causes	Age Range of Victims					Total
	Under 1 yr old	1-4 yrs old	5-9 yrs old	10-14 yrs old	15-17 yrs old	
Blunt Force Trauma	15	18	2		1	**36**
Shaken Baby Syndrome	10	1	1			**12**
Murder Suicide		2	3	4	1	**10**
Undetermined	6	2		1		**9**
Drowning	4	3				**7**
Asphyxiation	3	3	1			**7**
Vehicular DUI/Negligence		1	4			**5**
SIDS	5					**5**
Medical Neglect	1		1	2		**4**
Victim Abandoned	3	1				**4**
Others	11	4	2		3	**20**
Total	**58**	**35**	**14**	**7**	**5**	**119**

Causes Compared to the Age of the Victim Under One Year Old

Table 19 is a detailed distribution of the victims under the age of one year old and the cause of fatality. Victims under the age of one (49 percent) comprised almost half of the fatality incidents for CY 2011 (see Chart N). The top two causes of fatalities for victims under the age of one were blunt force trauma (26 percent) and shaken baby syndrome (17 percent).

Table 19: Breakdown of Causes by Victims Under One Year Old

	Age of Victims Under One Year Old											
Causes	**New born**	**1 Month**	**2 Months**	**3 Months**	**4 Months**	**5 Months**	**6 Months**	**7 Months**	**9 Months**	**10 Months**	**11 Months**	**Total**
Blunt Force Trauma		3	2	1	2			**5**	**1**	**1**		**15**
Shaken Baby Syndrome		3	2	1	1	1				2		**10**
Undetermined		1	2	1	1					1		**6**
SIDS		2	1		1	1						**5**
Drowning										1	3	**4**
Asphyxiation			1					1	1			**3**
Victim Abandoned	3											**3**
Co-Sleeping		2		1								**3**
Malnourished		1										**1**
Stabbing						1						**1**
Asphyxiation & Co-Sleeping						1						**1**
BFT & Neglect		1										**1**
Medical Neglect			1									**1**
Burns		1										**1**
Starvation	1											**1**
Unknown							1	1				**2**
Total	**4**	**14**	**9**	**4**	**5**	**4**	**1**	**7**	**2**	**5**	**3**	**58**

Causes Compared to the Ethnicity/Race of the Victim

Table 20 is a detailed distribution of the ethnicity/race of the victim and the cause of fatality. Hispanic victims accounted for a higher proportion (41 percent) of all fatalities in CY 2011 and were more frequently represented in blunt force trauma, shaken baby syndrome, and murder suicide incidents. White victims accounted for 22 percent of all fatalities and were more frequently represented in undetermined causes and blunt force trauma incidents.

Table 20. Causes Compared to the Ethnicity/Race of the Victim

Causes	Ethnicity/Race of the Victim							Total
	Hispanic	White	Black	Asian	Pacific Islander	Multiracial	Not Documented	
Blunt Force Trauma	23	5	3			5		**36**
Shaken Baby Syndrome	7	1	1			2	1	**12**
Murder Suicide	5	2	1	2				**10**
Undetermined	2	5	2					**9**
Drowning	1	1	1			2	2	**7**
Asphyxiation	2	1	2		1	1		**7**
SIDS		3				1	1	**5**
Vehicular DUI/Negligence	2	1				2		**5**
Medical Neglect	1		2			1		**4**
Victim Abandoned	2	1					1	**4**
Other	4	6	5	1		3	1	**20**
Total	**49**	**26**	**17**	**3**	**1**	**17**	**6**	**119**

Causes Compared to Gender of the PIRs

As illustrated in Table 21, male PIRs were more frequently represented in fatalities involving blunt force trauma (42 percent) and murder suicide (80 percent). Female PIRs were more frequently represented in fatalities associated with burns (100 percent), house fires (100 percent), victim abandoned (75 percent), and co-sleeping (67 percent). Males and females together were more frequently represented in fatalities involving blunt force trauma (47 percent).

Table 21. Causes Compared to Gender of the PIRs

Causes	Gender of Primary Individuals Responsible (PIRs)				Total
	Male	Male & Female	Female	Unknown	
Blunt Force Trauma	15	17	4		**36**
Shaken Baby Syndrome	6	5	1		**12**
Murder Suicide	8	2			**10**
Undetermined		4	4	1	**9**
Drowning	1	3	3		**7**
Asphyxiation	3		4		**7**
SIDS	1	1	3		**5**
Vehicular DUI/Negligence	1	1	3		**5**
Medical Neglect	2		2		**4**
Victim Abandoned			3	1	**4**
Co-Sleeping		1	2		**3**
Burns			3		**3**
Gunshot	1	1			**2**
House Fire			2		**2**
Suicide		1	1		**2**
Starvation			1		**1**
Ingested Substance			1		**1**
Malnourished		1			**1**
Stabbing	1				**1**
Asphyxiation & Co-Sleeping				1	**1**
BFT & Neglect		1			**1**
Unknown	1			1	**2**
Total	**40**	**38**	**37**	**4**	**119**

Causes Compared to Age of the PIRs

Table 22 depicts a distribution of the causes of child fatality incidents by the age of the PIRs for the fatality.[18] There are a few noticeable differences in the causes of fatality incidents by the age of the PIRs. Blunt force trauma, undetermined, victim abandoned, unknown, and malnourished incidents were more frequently associated with individuals under the age of 27. On the other hand, murder suicide, drowning, SIDS, vehicular DUI/negligence, medical neglect, suicide/suicide attempt, gunshot, house fire, ingested substance, and a combination of blunt force trauma and neglect incidents were more frequently associated with individuals over the age of 27. The two PIRs (one percent) between the ages of 16 and 17 were exclusively responsible for one of the victim abandoned incidents and one stabbing incident.

Table 22. Causes Compared to the Age of the PIRs

Causes	Age of Primary Individuals Responsible (PIRs)							Total
	16-17	18-20	21-23	24-26	27-30	31-40	Over 40	
Blunt Force Trauma		11	10	16	5	9	2	**53**
Shaken Baby Syndrome			7	2	3	5		**17**
Murder Suicide					1	5	6	**12**
Undetermined		1	3	4	2		2	**12**
Drowning		1		3	3	3		**10**
Asphyxiation			3	1	2		1	**7**
SIDS			1		1	4		**6**
Vehicular DUI/Negligence					1	3	2	**6**
Medical Neglect					1	2	1	**4**
Co-Sleeping			2			2		**4**
Victim Abandoned	1			1	1			**3**
Suicide						1	2	**3**
Gunshot						2	1	**3**
Burns				1	1		1	**3**
House Fire					1	1		**2**
Malnourished			2					**2**
BFT & Neglect						2		**2**
Ingested Substance					1			**1**
Stabbing	1							**1**
Unknown		1						**1**
Starvation			1					**1**
Total	**2**	**14**	**29**	**28**	**23**	**39**	**18**	**153**

[18] Of the 115 fatality incidents where the age of the PIRs was known, there were 38 incidents where two individuals were identified as the PIRs for the fatality making a total of 153 individuals.

Fatalities Summary

In CY 2011, 119 child fatalities that were determined to be the result of abuse and/or neglect were reported to CDSS. Of the 119 incidents, 117 of the children resided with their parent/guardian at the time of the incident and two children resided in an out-of-home foster care placement.

The CWS agency was more often the determiner of abuse and/or neglect. Feedback received from counties after the production of the CY 2010 report, which demonstrated similar findings, indicated that one of the reasons CWS agencies may be more likely than other entities to be the determiner in these incidents is their responsibility to conduct immediate investigations to protect the safety of other children who may be in the home of these families.

The analysis found that 26 of the 119 referrals (22 percent) made to the child abuse ER hotline for these incidents were evaluated out by the CWS agency. Referrals are evaluated out because they do not meet the criteria for investigation by the CWS agency. When reviewing the reasons these referrals were evaluated out, over half were evaluated out because there were no other siblings in the home in need of protection. Some of the other reasons for evaluating out the ER referral in these incidents were due to either one or both parents being deceased at the time of the fatality incident along with the children, and law enforcement currently investigating the incident.

The most vulnerable population of child fatality incidents were children four years of age and younger, which comprised 78 percent of the child fatalities reported. Of those incidents, 49 percent were less than one year old with the most vulnerable subset of that population being newborn to age three months. Overall, the number of male child fatality incidents reported was higher than the number of female child fatality incidents. 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 28 percent of the general child population but were 22 percent of the child fatalities reported. However, Black children represented only six percent of the general child population and 14 percent of child fatalities reported, which indicates a disproportionate number of fatalities for Black children compared to Hispanic or White children. In addition, when looking at the breakdown of incidents of children in the Multiracial category, the most frequently represented primary ethnicities/races of the victims were Black and White, thereby further increasing the disproportionate percentage of Black children when compared with Hispanic or White children.

For CY 2011, 42 of the child fatality incidents (35 percent) reported involved children who were from families who did not have CWS history in the five years prior to the incident. Of the families who did not have CWS history within the five years prior to the fatality incident, the CDSS conducted a sub-analysis of this group which revealed that 38 percent of these families had some CWS history beyond the five-year period, and much of this history did not pertain to the victim of these incidents given that the majority of all fatality incidents involved children four years of age or younger.

Additionally, 76 incidents (64 percent) involved children from families who were previously known to a CWS agency in the five years prior to the fatality incident. Four of these incidents were removed from the analysis because the parents' prior CWS involvement was as a minor, not as an adult. Of these remaining 72 incidents, 18 families (25 percent) were known to a CWS agency at the time of the incident, and 54 families (75 percent) were not current clients at the time of the fatality incident. Of the 72 incidents, 71 families had a CWS referral opened

within five years prior to the fatality incident, of which 20 had an open CWS case (28 percent) within five years prior to the fatality. Of those families with a CWS referral within five years of the child fatality incident, 52 percent had CWS involvement within a year prior to the fatality taking place, although many of the most recent referrals preceding the fatality incident 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 2011 despite neglect being the single most reported allegation overall. Most of the acts of blunt force trauma involved referrals which were substantiated for allegations of abuse or combined allegations of 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 64 percent male and 36 percent female. Male victims were more frequently represented in shaken baby syndrome incidents and female victims were more frequently represented in fatalities caused by asphyxiation. In the analysis of the causes of fatalities by the ages of the children involved, the most frequently occurring cause of fatalities for children under one year of age involved blunt force trauma or shaken baby syndrome.

The PIRs for the child fatality incidents were found to be exclusively male in 34 percent of the fatality incidents reported, exclusively female in 31 percent, both a male and female together in 32 percent, and for three percent of the incidents, the identity of the PIRs was unknown. Eighty-five percent of the PIRs for the fatality incidents for CY 2011 were biological parents who acted either individually or in conjunction with another individual. However, there were more biological mothers (30 percent) acting alone than biological fathers (24 percent) acting alone as the PIR for the fatality. In 15 percent of fatality incidents, the biological mothers' significant others were the PIRs, either exclusively or in conjunction with the biological mother. In one of the 119 child fatality incidents (one percent), a foster parent, either individually or in conjunction with another individual, was responsible for the incident.

Additional analysis revealed that male PIRs were more frequently documented as being the individual responsible for fatality incidents involving blunt force trauma, and murder suicide. Female PIRs were more frequently documented as being responsible for fatalities associated with burns, house fires, abandonment, and co-sleeping.

Additionally, of those incidents where the PIRs were known, for children under the age of five, the PIR was most often 30 years of age or younger (59 percent). However, for the five- to 17-year-old age group of victims, the PIR for the fatality was more often over 30 years of age. 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.

The CDSS also gathered information regarding other individuals who did not commit the acts that caused the child fatality but who were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the fatality incident. These individuals are referred to as "SIR" and may have in some cases been the person identified as the individual who failed to protect the child from the individual who committed the abuse and/or neglect. There were 19 incidents in which there was an individual identified as a SIR. These SIRs were almost equally divided between males (53 percent) and females (47 percent). In addition, there were no SIRs identified in incidents involving children over the age of four. Both biological mothers and fathers were equally identified as SIRs, and SIRs were identified as being most often 30 years of age or younger for children under the age of five.

Comparison with Prior Years' Reports

The number of fatalities reported steadily rose between CYs 2008 and 2010, but declined for CY 2011. While CY 2012 and CY 2013 fatalities are still being reported to CDSS, as of March 2014 the data shows that fatalities increased slightly in CY 2012 and then decreased again for CY 2013. The number of fatalities of children in an out-of-home placement declined since 2008, although it has increased slightly for CY 2013. For CYs 2009 through 2011, fatality incidents have been determined to be the result of abuse and neglect more often by a CWS agency alone.

Consistent with CYs 2008 through 2010, Hispanic children were more frequently victims of such incidents in CY 2011, which coincides with their general representation in the overall child population. However, for Black children, their representation in child fatalities reported throughout the years has been disproportionate to their representation in the general child population. Since CY 2008, the majority of the victims of fatalities have been children less than five years of age. The gender of the majority of victims of child fatality incidents shifted from males in CY 2008 to female victims in CY 2009 and back to male victims in CYs 2010 and 2011.

All the prior CY reports (2008-2010) found that nearly half of the families of 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. However, the CY 2011 report found that just over a third of the families were not known to a CWS agency at the time of the incident nor had history within five years of the incident. Families that were known to a CWS agency at the time of the incident increased from 12 percent in CY 2008 to 14 percent in CY 2009 and 18 percent in CY 2010, but decreased to 15 percent in CY 2011.

Blunt force trauma has consistently been the most reported cause of child fatalities since CY 2008. While the most reported cause of fatalities has remained the same since 2008, the most reported referral allegation has changed from abuse in CY 2008 to neglect for CYs 2009, CY 2010, and 2011. 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 the CY 2008 and 2009 reports. In an effort to provide a more comprehensive analysis of those individuals responsible for fatality incidents, the CDSS has been revising its methodology over the last couple of years for collecting this data to better distinguish between the PIRs for these incidents and other individuals who did not commit the acts which inflicted the fatalities but who were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the fatality. Therefore, information in this report regarding the individual responsible for the fatality incidents cannot be compared to the data in the CY 2008 and 2009 reports due to the differences in methodology and data collection. However, CY 2011 data can be compared to CY 2010 data as the methodology of gathering the information on the PIRs was the same for both years.

Both the CY 2010 and CY 2011 reports found that males were more frequently documented as the PIRs. Additionally, biological mothers were more frequently responsible for fatality incidents, followed by biological fathers, and then by biological parents together. Interestingly,

the number of biological mothers' significant others who were exclusively responsible for the fatalities rose from six incidents in CY 2010 to ten incidents in CY 2011. Biological mothers' significant others alone continues to be more frequently responsible for fatalities of children between the ages of one and four.

V. Near Fatalities

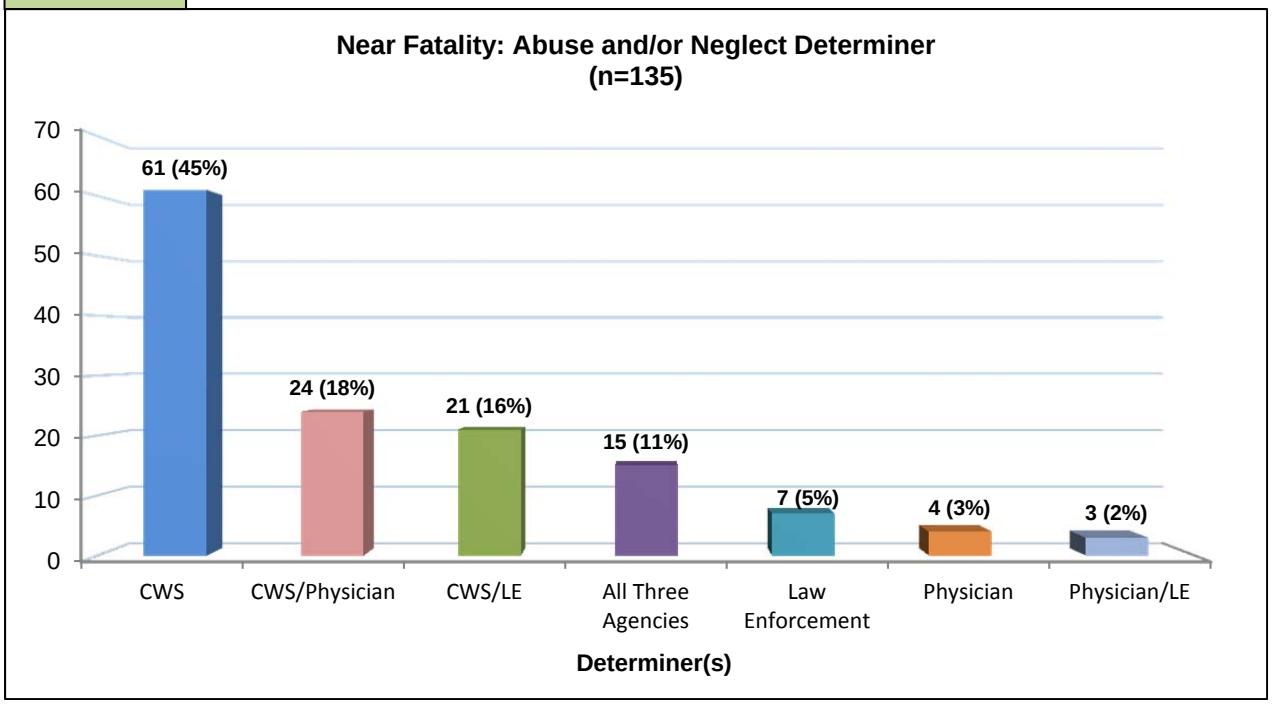
General Information

With respect to near fatalities, California CWS agencies reported via the SOC 826 form 135 child near fatalities determined to be the result of abuse and/or neglect for CY 2011. A near fatality was defined during CY 2011 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 135 child near fatalities reported, 129 children resided in the home of the parent/guardian and six children resided in an out-of-home foster care placement.

Determiner of Abuse and/or Neglect for Child Near Fatality

The following chart (Chart V) 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. While all three agencies can determine a near fatality to be the result of abuse and/or neglect, in CY 2011, almost half of the incidents (45 percent) were determined by CWS alone. Based upon feedback received from counties after the production of the CY 2010 report, one of the reasons CWS agencies may be more likely than other entities to be the determiner in these incidents is their responsibility to conduct immediate investigations to protect the safety of the near fatality victims and other children who may be in the home of these families.

CHART V



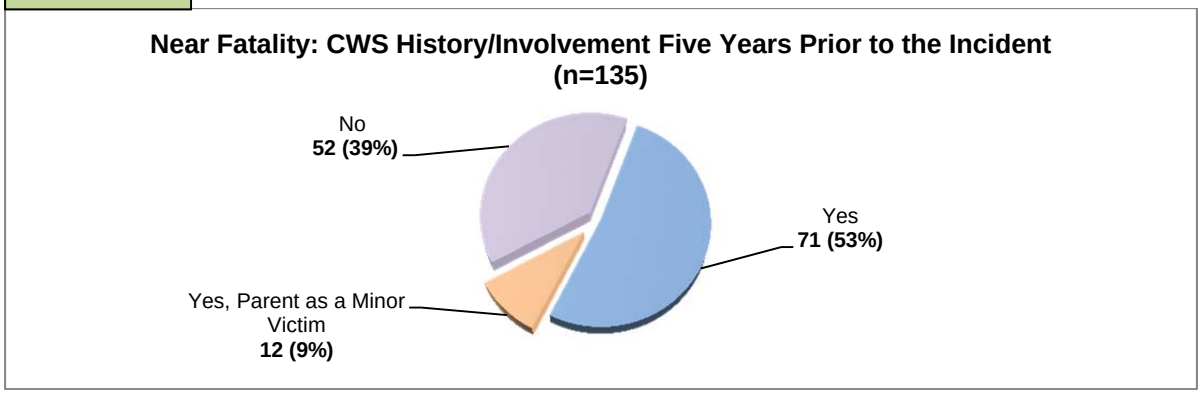
CWS Involvement/History

The analysis which follows examines what level of involvement the family of the child near fatality victim may have had with the CWS agency. To make this determination, CDSS noted whether there was an open ER referral or case at the time of or within the five years preceding the incident. In gathering this data, the CDSS looks back five years from the date of the near fatality incident referral except where otherwise noted.

It is important to note that the prior CWS history 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 over time. 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 data shows that of 135 incidents, 52 incidents (39 percent) involved children from families who had no CWS history in the five years prior to the incident; and 83 incidents (61 percent) involved children from families who were previously known to a CWS agency in the five years prior to the near fatality incident (see Chart W).

CHART W

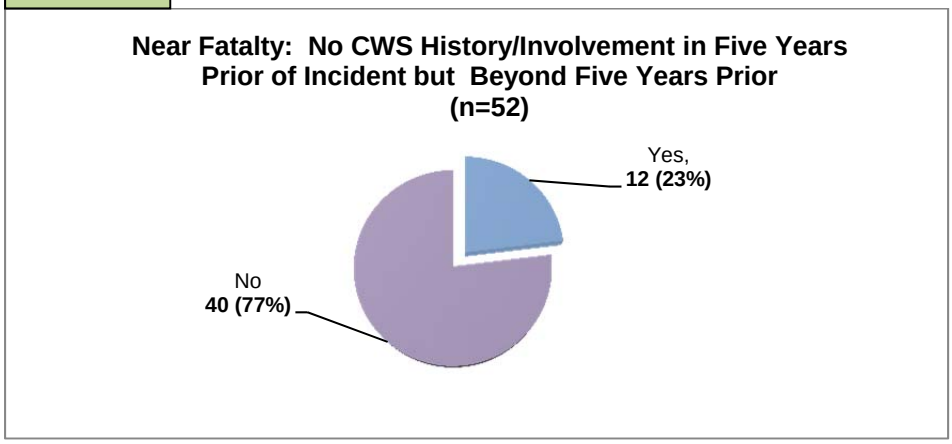


Families with No CWS Involvement and/or History in the Five Years Prior to the Incident

There were 52 incidents that involved children from families that did not have an open ER investigation or open case in the five years prior to the incident. In addition, none of these 52 families had CWS history in the five years prior to the incident. The CDSS conducted further analysis of this subgroup in an attempt to determine whether any of these families had ever been known to a CWS agency at all. The additional analysis of these 52 families revealed that 12 of these families (23 percent) had CWS history beyond the five-year period prior of the near fatality (see Chart X). However, these additional families were excluded from the analysis of those families with prior CWS history in this report to permit comparisons of data in this report

with data contained in prior years' reports. Additionally, it should be noted that much of this CWS history did not pertain to the victim of these incidents given that the majority of all near fatality incidents involved children four years of age or younger (see Chart AG).

CHART X



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

As indicated in Table 23, there were 83 near fatality incidents involving children from families who were previously known to a CWS agency in the five years prior to the incident. Of these 83 incidents, 12 incidents involved children from families with parents who were involved with CWS as minors themselves in the five years prior to the near fatality incident but had no CWS history as an adult. Therefore, the CDSS removed these incidents from this analysis as the focus of this analysis is on CWS case and referral history as adult parents. As a result, the total number of near fatality incidents involving families known to a CWS agency with the parents as adults is 71. Of these 71 incidents, one incident involved a family who had a case opened during the five-year review period but the referral for that case was received prior to the five-year review period. Therefore, the total number of families who had a CWS referral(s) generated during the five-year review period is 70 (see Table 23).

Table 23. Level of Involvement with CWS

Number of Near Fatality Incident	Level of Involvement with CWS
83	Had CWS involvement/history in the five years prior to the incident (71 with parents as adults, and 12 with parents as minors)
71	Had CWS involvement/history in the five years prior to the incident as an adult (excludes 12 incidents involving parents with history as minors only)
70	Had CWS referrals generated within five years prior to the incident (excludes one incident with a family who had a case opened during the five-year review period but the referral for that case was received prior to the five-year review period)

Table 24 reflects the CWS agency involvement at the time of the near fatality incident for the 71 families who had CWS history in the five years prior to the near fatality incident.

Table 24. Number of Families with CWS Involvement at the Time of Incident

46	Not a current client of a CWS agency (but had prior history)
15	Open ER Referral at the time of incident
4	Open out-of-home case with a CWS agency at the time of incident
3	Open in-home case with a CWS agency at the time of incident
2	Open in-home and out-of-home case with a CWS agency at the time of incident
1	Open ER referral and Open in-home case with a CWS agency at the time of incident
71	**Total**

Families with CWS Involvement at the Time of the Near Fatality Incident

Of the 25 child near fatality incidents involving families who were involved with a CWS agency at the time of the near fatality incident, 15 incidents involved families with an **open ER referral** (See Table 24). All of the ER referrals had been opened within six months of the near fatality incident.

Of the four incidents involving families with an **out-of-home** case with a CWS agency, all of the cases involved the near fatality victim and were opened within 12 months prior to the near fatality incident. Additionally, one of the children resided in a foster family home, one resided in a foster family agency home, and two resided with a relative who was approved to provide foster care for the child.

Of the three incidents involving families who had an open **in-home** case with a CWS agency at the time of the near fatality incident, two of the cases had been opened within 18 months of the near fatality incident, and one case had been opened for more than five years prior to the incident. The aforementioned case involved a victim who resided with a legal guardian and the legal guardian had no prior CWS referral history in the five years prior to the incident.

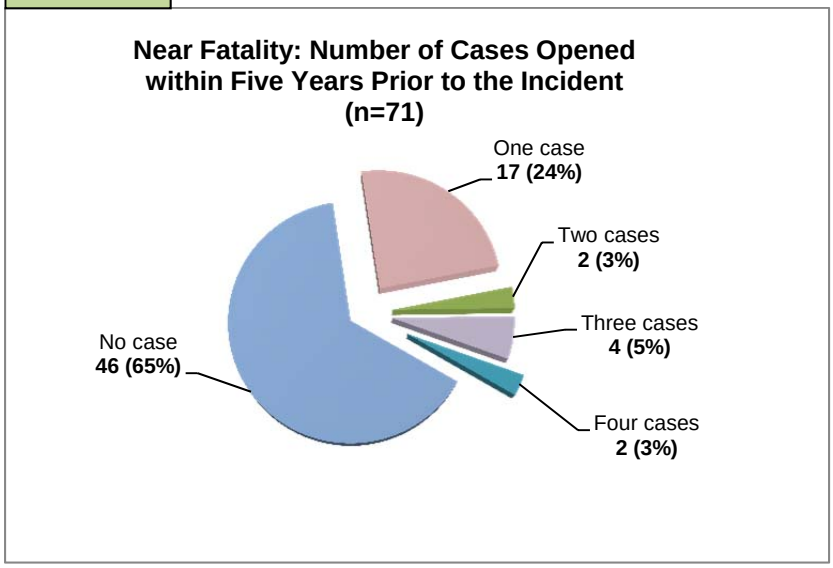
There were two incidents involving families who had an **open in-home and out-of-home** case with a CWS agency at the time of the near fatality incident. In one of these two incidents, the open in-home case involved the near fatality victim and the case was opened within three months of the near fatality. The other incident involved the near fatality victim and their sibling and the case was also opened within three months of the near fatality. Both of the open out-of-home cases involved the near fatality victims' sibling who resided in an out-of-home foster care placement.

Lastly, there was one incident in which the near fatality victim had both an **open in-home case and an open ER referral** at the time of the near fatality incident which were opened within six months of the near fatality incident.

Families with CWS Case History Prior to the Near Fatality Incident

Of the 71 families with prior CWS involvement/history, 25 families (35 percent) had an open CWS case within five years prior to the near fatality incident. Most of these 25 families had only one case opened prior to the near fatality incident.

CHART Y



Families with CWS Referral History Prior to the Near Fatality Incident - Information Regarding the Most Recent Referral Preceding the Incident

The following sections provide an analysis of the most recent referrals for those 70 families (see Table 23) who had ER referrals generated during the five years prior to the near fatality incident. When reviewing this referral 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.[19] As such, 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 page 10). If investigated, the disposition for the referral may have been unfounded, inconclusive, or substantiated.

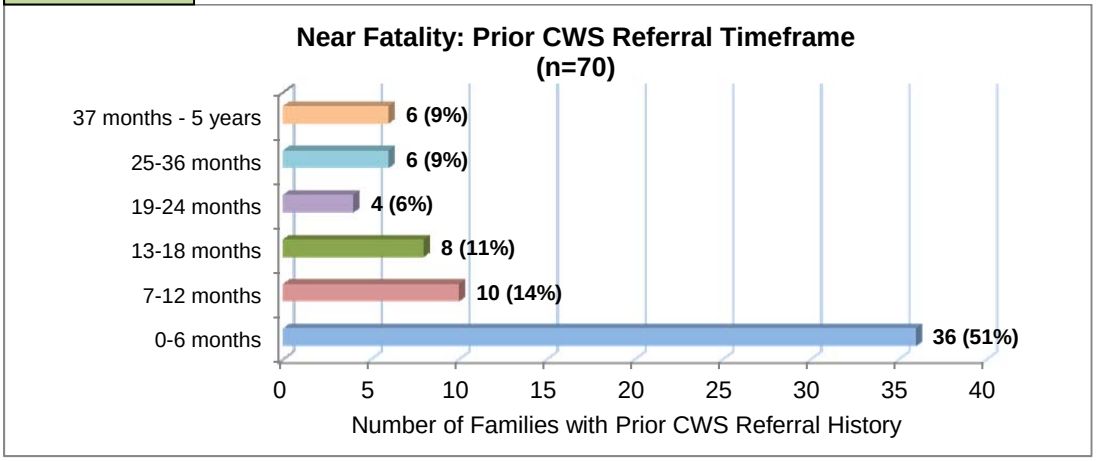
Second, the prior CWS referrals involving these families may not have included the child who was the subject of the near fatality incident and the household composition may have been different at the time of the near fatality. The information that follows offers a look at the families who had CWS history at the time of the near fatality incident by examining the most recent referral preceding the incident.

[19] 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.

Prior CWS Referral Timeframe

In the six months prior to the near fatality, 36 of these 70 families (51 percent) with prior CWS referral history had an ER referral generated for suspected child abuse or neglect. The remaining 34 families had prior ER referrals generated which were spread out over a time period of up to five years.

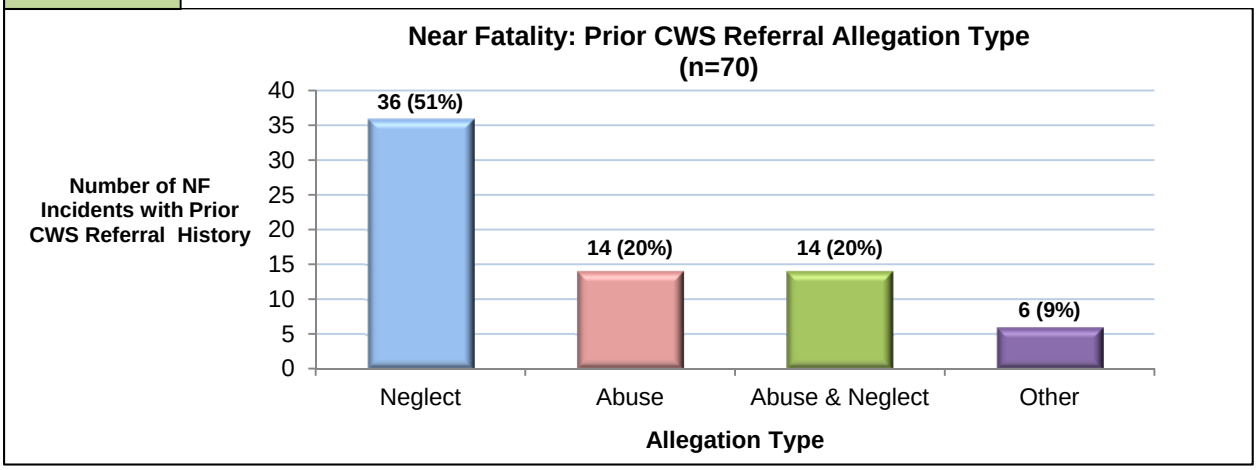
CHART Z



Prior CWS Referral Allegation Type

In the 70 incidents with prior CWS referral history, slightly over half of the most recent referrals preceding the near fatality incidents had been generated for neglect allegations (51 percent), followed by abuse allegations (20 percent), and combined abuse and neglect allegations (20 percent). There were six prior referrals (nine percent) that were categorized as "Other" and included three prior referrals for caretaker absence/incapacity and three prior referrals for a combined allegation of caretaker absence/incapacity and neglect.

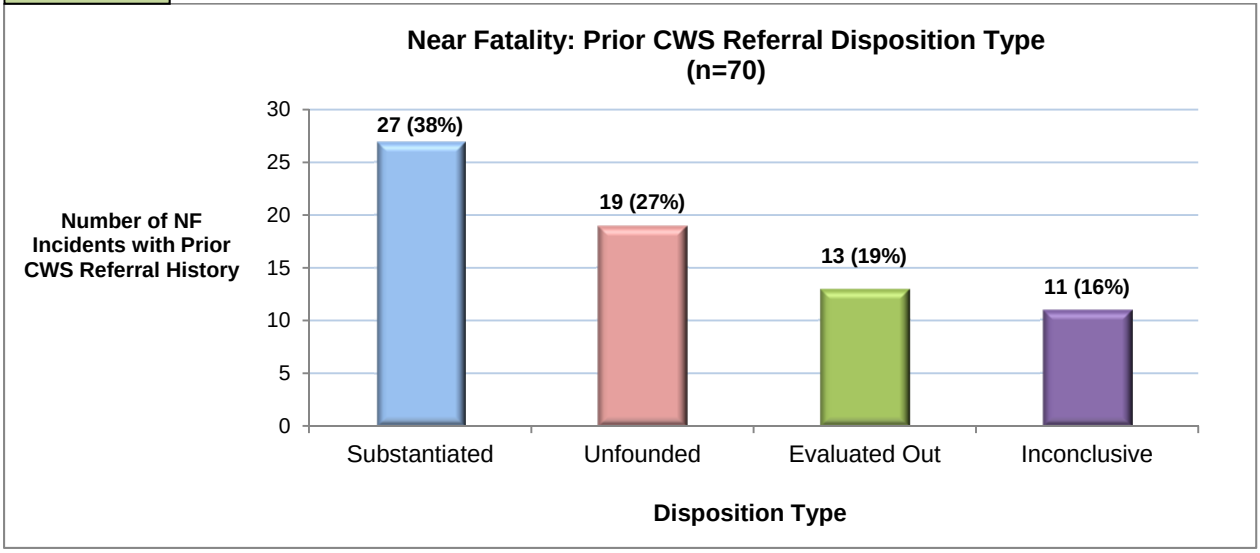
CHART AA



Prior CWS Referral Disposition Type

When looking at the 70 incidents with CWS referral history, over a third of the most recent referrals preceding the near fatality incident had allegations that were substantiated (38 percent). This is followed by allegations that were unfounded at 27 percent, evaluated out at 19 percent, and inconclusive at 16 percent.

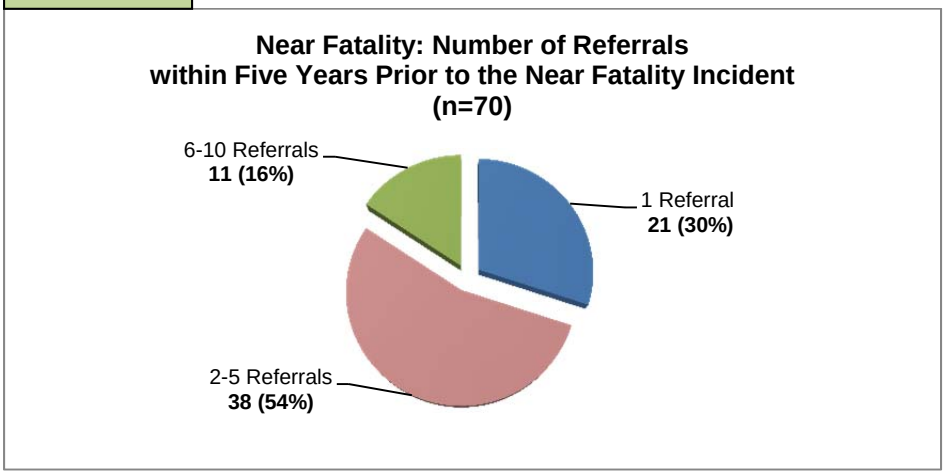
CHART AB



Number of CWS Referrals Generated within Five Years of the Incident

Of the 70 incidents involving families with prior CWS referral history, a number of the families had more than one referral generated within the five years prior to the near fatality incident. Over half of the 70 families (54 percent) had two to five referrals generated within the five years prior to the near fatality incident and almost a third of these families (30 percent) had only one referral generated within five years prior to the near fatality incident.

CHART AC



Eleven of these 70 families (16 percent) had been the subject of more than six referrals per family prior to the near fatality incident (See Chart AC). These eleven families generated a total of 87 referrals, many of which had been evaluated out or unfounded (see Table 25).

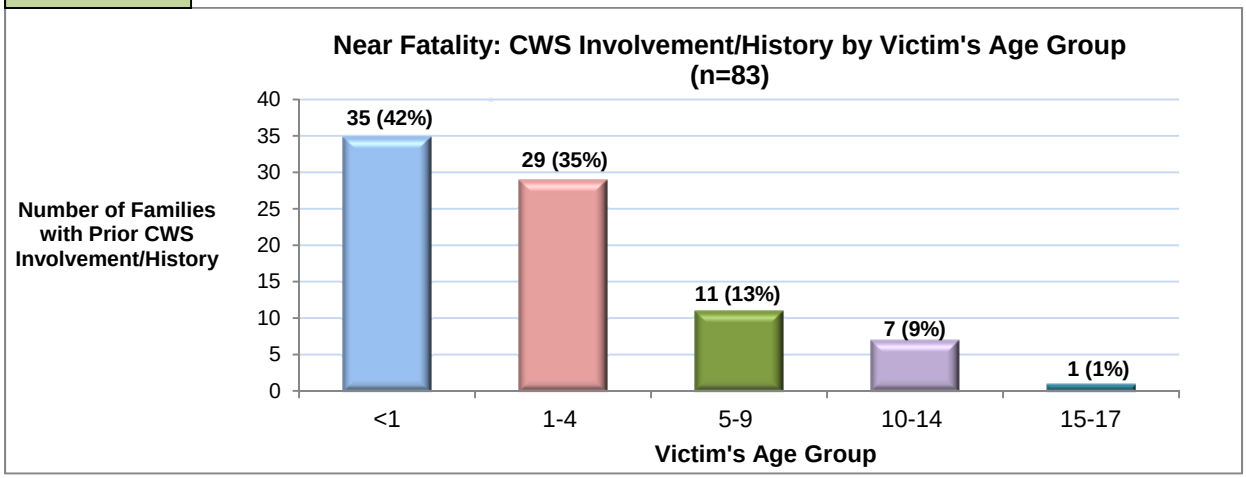
Table 25. Total Number of Referrals Generated in the Five Years Prior to the Incident for Families with More than Six Prior Referrals

Referral Disposition	Number	Percent
Evaluated Out	29	33%
Unfounded	18	21%
Inconclusive	17	20%
Substantiated	23	26%
Total	**87**	**100%**

CWS Involvement and/or History by Age Group

In analyzing the correlation between the near fatality victim's age and whether the child was part of a family known to a CWS agency, victims under the age of one belonged to almost half (42 percent) of the 83 near fatality incidents (see Table 23) where the family was known to a CWS agency. This was followed by victims between the age of one to four years old (35 percent) and five to 17 years old (23 percent).

CHART AD



Of the 35 near fatality victims who were one year of age or younger whose families were known to a CWS agency as identified in Chart AD, 17 of these victims (49 percent) were between two to five months old (see Table 26).

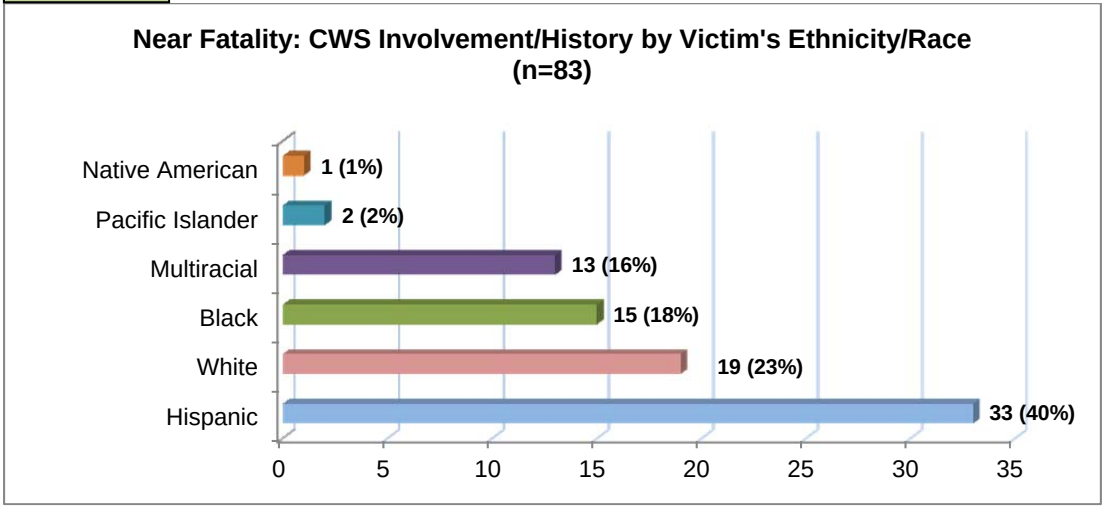
Table 26. Breakdown of CWS Involvement by Age—Under One Year of Age

Age of Victim's <1	Number
1 Month and Under	8
2 - 5 Months	17
6 - 11 Months	10
Total	**35**

CWS Involvement and/or History by Ethnicity Group

In analyzing the correlation between the near fatality victim's ethnicity and whether the child was from a family with CWS history, in almost half (40 percent) of the 83 near fatality incidents with prior CWS history (see Table 23), the victims belonging to these families were Hispanic, which coincides with their general representation in the overall California population. Families who were known to a CWS agency where the near fatality victims were White was 23 percent and where the victims were Multiracial[20] was 16 percent. However, Black children represented six percent of the general child population and 18 percent of near fatality victims whose families were known to a CWS agency, which indicates a disproportionate number of near fatalities for Black children from families known to a CWS agency.

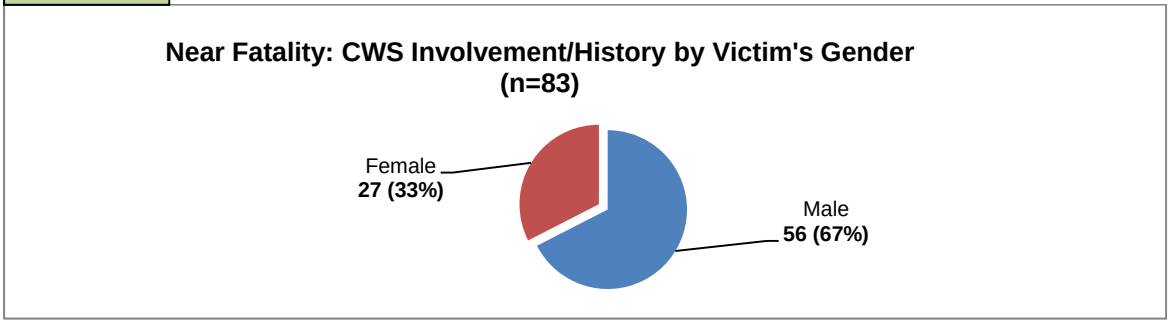
CHART AE



CWS Involvement and/or History by Victim's Gender

In analyzing the correlation between the near fatality victim's gender and whether the child was from a family with CWS history, over two-thirds (67 percent) of the 83 near fatality incidents involving families that were known to a CWS agency (see Table 23) involved near fatality victims who were males.

CHART AF



[20] See Demographics Information section for further information regarding Multiracial ethnicity/race category.

Summary of CWS Involvement and/or History

In summary, there were 71 incidents involving families with prior CWS history with the parents as adults; 25 of these incidents involved families who were involved with a CWS agency at the time of the near fatality incident, and 46 incidents involved families who were not a current client of a CWS agency at the time of the incident but had CWS history in the five years prior to the near fatality incident (see Table 24). Additionally, 25 of these 71 incidents (35 percent) involved families that had an open CWS case within five years prior to the near fatality incident. The total number of near fatality incidents involving families who had referrals generated during the five-year period under review is 70 (see Table 23). Of these 70 incidents, 46 families (66 percent) had some CWS involvement within a year prior to the near fatality incident taking place. Of the most recent prior referrals preceding the near fatality incidents, 51 percent of these prior referrals were for neglect. Lastly, while these 70 families did have some CWS involvement, 61 percent of the most recent referrals preceding the near fatality incidents either did not meet the criteria for investigation by the CWS agency and were evaluated out or were deemed unfounded or inconclusive upon investigation. Further analysis of the incidents with prior CWS referral history found that over half of the children's families had two to five referrals generated within the five years prior to the near fatality incident. Additionally, of the 16 percent of families which had been the subject of more than six referrals per family prior to the near fatality incident, a majority of those prior referrals had either been evaluated out or unfounded. The data demonstrates that many of the families involved in the reported near fatalities had prior CWS history with the most recent prior referral being either evaluated out or unfounded. As a result, additional examination of the process and tools used by CWS agencies when receiving an ER referral and investigating the allegations may be warranted.

Child Demographic Information

The following section is a comprehensive analysis of the CY 2011 data for age, gender, and ethnicity/race of the children who were victims of child near fatalities compared to the general child population. For this report, the age, gender, and ethnicity/race of California's child population during 2011[21] was used for this analysis (See Attachment A).

Demographics of California's Children

An analysis of Attachment A shows that there was not a great difference in the total number of California's general child population between the below-five age group (27 percent), the five- to nine-year-old age group (27 percent), and the ten- to 14-year-old age group (28 percent). Children between the ages of 15- to 17-year-old age group comprised of 18 percent of the total child population. See Attachment A for a more detailed summary of California's general child population.

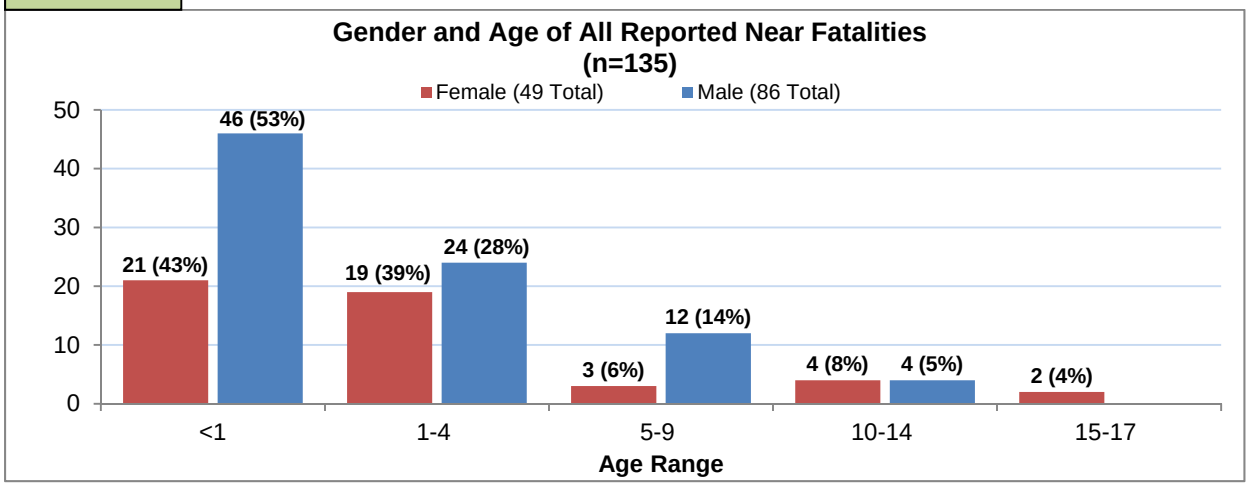
Demographic Characteristics of Child Near Fatalities

The data gathered for the 135 child near fatality incidents indicates the most vulnerable population were children ages four and younger. Chart AG, which depicts the gender of children by age group, shows 110 of the 135 child near fatality incidents (81 percent) were children four years of age and younger. Of those, 67 children (61 percent) were less than one year old, and 43 children (39 percent) were between the ages of one and four. The remaining 25 child near fatality incidents (19 percent) involved children in the five- to 17-year-old age group.

Gender and Age

Overall, the number of male child near fatality incidents reported was higher than the number of female child near fatality incidents; there were 86 incidents compared to 49 incidents, respectively, for all children under 18 in the near fatality group (see Chart AG).

CHART AG



[21] The 2011 population estimate from the Department of Finance (DOF) website was used for the data in this report.

The breakdown for gender in the less than one-year-old child near fatality age group was 46 males and 21 females. The one- to four-year-old child near fatality age group had 24 males and 19 females. Chart AG, which depicts the gender of children by age group, shows that the less than one-year-old age group reflects the greatest difference between males and females. The higher number of male children in the less than one-year-old age group contributed to the greater representation of males overall for child near fatality incidents.

Further analysis of victims under the age of one showed that the most vulnerable population for near fatalities in this age group is children between the ages of newborn to age three months (54 percent).

Table 27. Near Fatality by Age and Gender of Victims Under One Year of Age

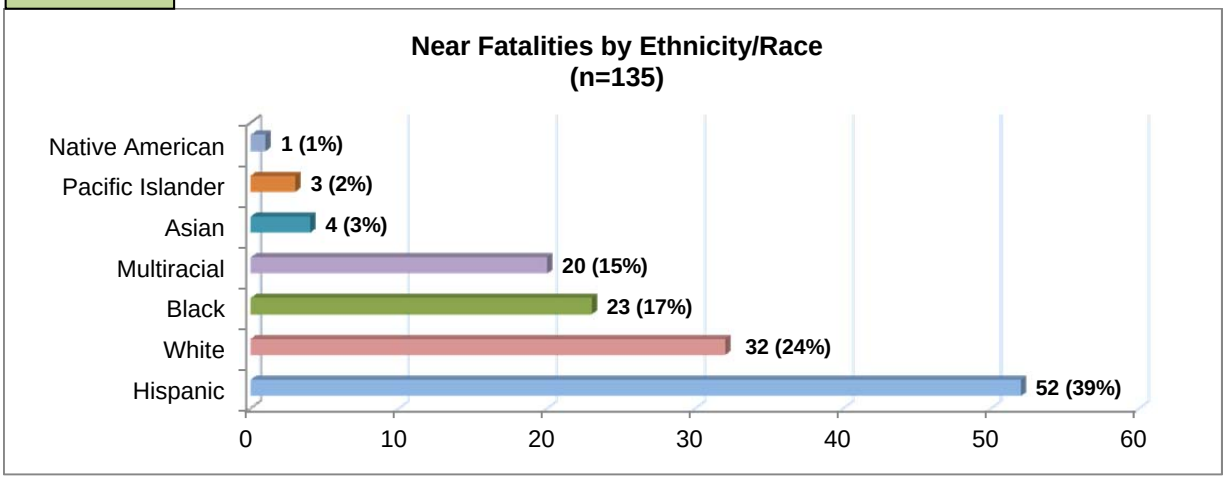
Victim <1 Age Group	Female	Male	Total
Newborn to 3 months	11	25	**36**
4 months to 6 months	5	14	**19**
7 months to 11 months	5	7	**12**
Total	**21**	**46**	**67**

Child Near Fatalities: Ethnicity/Race

With respect to ethnicity/race of the children for the 135 child near fatality incidents that were determined to be the result of abuse and/or neglect, Hispanic children had more reports of near fatalities than any other single category of ethnicity/race (see Chart AH). For comparison, the Hispanic population of children in the general child population in California in 2011 was 51 percent (see Attachment A).

The data gathered for the 135 child near fatality incidents shows that 52 of the children (39 percent) were Hispanic, 32 of the children (24 percent) were White, 23 of the children (17 percent) were Black, 20 of the children (15 percent) were Multiracial, four children (three percent) were Asian, three children (two percent) were Pacific Islander, and one child (one percent) was Native American.

CHART AH



The most frequently represented primary ethnicity/race in the Multiracial category was Hispanic and Black. If these incidents were added to the data regarding the number of Black child near fatality victims, the number of Black victims would increase from 23 to 30 and the disproportionate percentage of Black children when compared to Hispanic or White children would increase even further.

Table 28. Breakdown of Multiracial Victims

Primary Ethnicity/Race	Secondary Ethnicity/Race	Number of Victims
Black	White	3
Black	Hispanic	3
Black	Native American	1
Hispanic	White	3
Hispanic	Black	3
Hispanic	Native American	1
White	Black	1
White	Hispanic	5
Total		**20**

Summary of Child Demographic Information

In summary, the findings associated with child demographic information for child near fatality incidents reported for CY 2011 are consistent with those identified for child fatality incidents. The number of male child near fatality incidents reported was higher than the number of female child near fatality incidents; there were 86 incidents compared to 49 incidents, respectively, for all children under 18 in the near fatality group. The higher number of male children in the less than one-year-old age group contributed to the greater representation of males for child near fatality incidents.

While Hispanic children comprised the largest category of reported near fatalities, they also comprised the largest single ethnicity/race in California's overall child population during CY 2011. However, the data indicates that there are a disproportionate number of Black children who are victims of these incidents when compared to other ethnicities and the general child population numbers.

Child Abuse Versus Neglect—What is Known

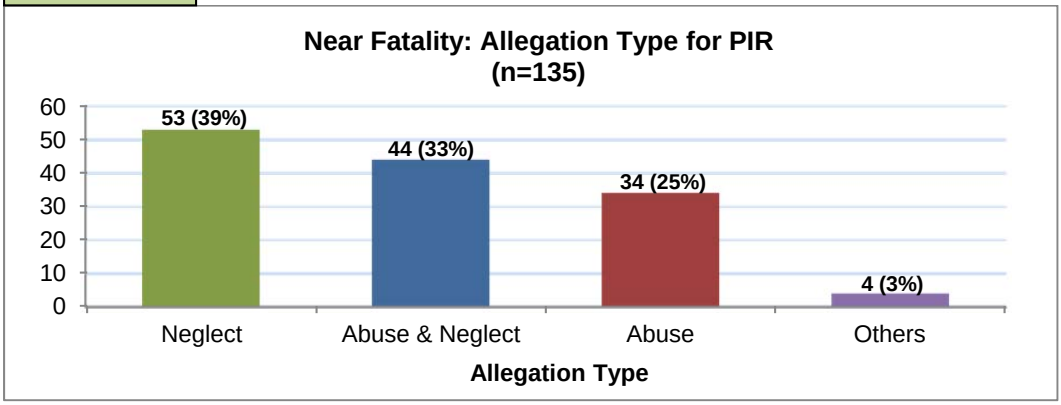
This section discusses the types of allegations associated with the referrals generated by the CWS agencies for the Primary Individuals Responsible (PIRs) for the child near fatality incidents that were reported for CY 2011. A summary of the referrals associated with the Secondary Individuals Responsible (SIRs)[22] will also be provided in this section. It should be noted that an allegation of neglect for a near fatality may occur when a determination is made that the near fatality was the result of a parent(s)/guardian(s) or caretaker(s) failure to provide the care and protection necessary for the child's healthy growth and development. Additionally, a combined allegation such as abuse and neglect may occur when there are two individuals responsible for the near fatality. The allegation types described below represent the allegations documented for the referrals associated with the SOC 826 forms submitted to CDSS.

Child Near Fatalities: Allegation Type for PIRs

The data shows that when looking at the PIRs for the reported child near fatality incidents, allegations of neglect were documented in CWS/CMS more often than any other single allegation category. This data trend is similar to what was found for those incidents with CWS history for the most recent referral preceding the near fatality (see Chart AA). In addition, it is similar to what was found for fatality incidents reported for CY 2011.

The data shows that 53 of the 135 child near fatality incidents (39 percent) for CY 2011 had a PIR with an allegation of child neglect. The allegation types for the PIRs in the remaining 82 incidents were as follows: 34 incidents (25 percent) were allegations of abuse, 44 incidents (33 percent) were allegations of abuse and neglect, and four incidents (three percent) had allegations listed as "Other," which included two for neglect and caretaker absence/incapacity, one for abuse and caretaker absence/incapacity, and one for abuse, neglect, and caretaker absence/incapacity.

CHART AI



[22] A more in-depth definition of the PIRs and SIRs can be found on pages 64 and 70.

Allegation Type of PIRs Compared to Victims' Age Range

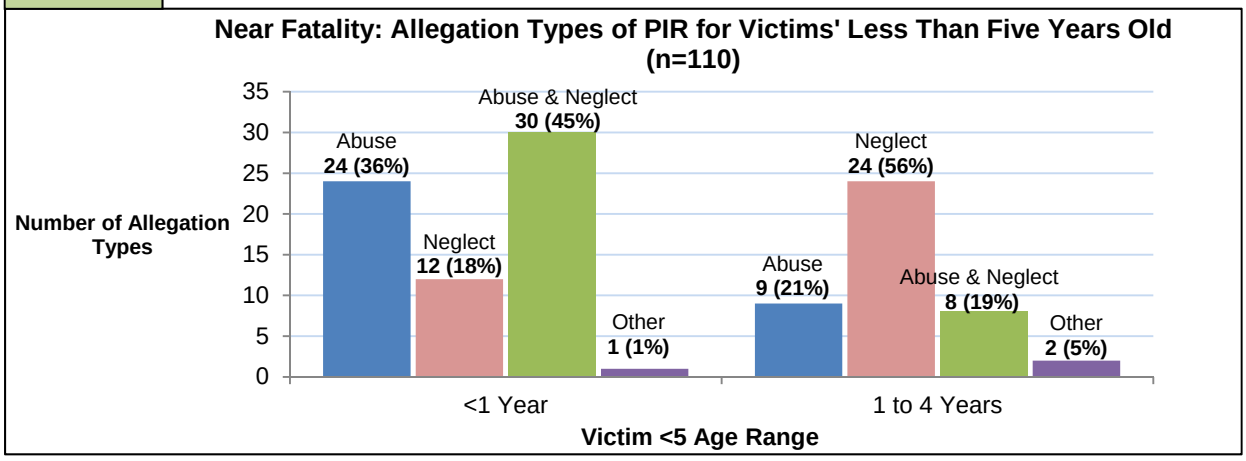
The allegation types for the PIRs in the 67 near fatality incidents in the less than one-year-old age group were as follows: 30 incidents (45 percent) were abuse and neglect allegations, 24 incidents (36 percent) were abuse allegations, and 12 incidents (18 percent) were neglect allegations. There was one incident (one percent) that was listed as "Other" for abuse and caretaker absence/incapacity.

The allegation types for the PIRs in the 43 near fatality incidents in the one- to four-year-old age group were as follows: 24 incidents (56 percent) involved neglect allegations, 9 incidents (21 percent) involved abuse allegations, and eight incidents (19 percent) involved abuse and neglect allegations. There were two incidents (5 percent) that were listed as "Other," one for neglect and caretaker absence/incapacity, and one for abuse, neglect, and caretaker absence/incapacity.

The allegation types for the remaining PIRs in the 25 incidents in the five- to 17-year-old age group were as follows: 17 incidents (68 percent) involved neglect allegations, six incidents (24 percent) involved abuse and neglect allegations, and one incident (4 percent) involved an abuse allegation. There was one incident (four percent) listed as "Other" for neglect and caretaker absence/incapacity.

For children less than five years of age, abuse and neglect (38 incidents) was the most reported allegation type for the PIRs followed closely by neglect allegations (36 incidents). Chart AJ depicts the PIR near fatality allegation types for children less than five years old.

CHART AJ



Child Near Fatalities: Allegation Type for PIRs by Victim's Gender

As previously discussed, neglect was documented in CWS/CMS more often than any other single allegation category for the PIRs in the near fatality incidents reported to the CDSS for CY 2011. In comparing the PIRs allegation type by the victim's gender, both male and female victims had almost an equal number of neglect allegations for the near fatality incidents. However, a combination of abuse and neglect allegations tripled for near fatality incidents involving male victims (33 male victims compared to 11 female victims) and allegations of abuse alone more than doubled for near fatality incidents involving male victims (24 male victims compared to ten female victims).

Table 29. Allegation Type for PIR by the Victim's Gender

Primary Individual Responsible (PIR) Allegation Types	Victim's Gender		Total
	Female	Male	
Neglect	25	28	**53**
Abuse & Neglect	11	33	**44**
Abuse	10	24	**34**
Neglect & Caretaker Absence/Incapacity	1	1	**2**
Abuse & Caretaker Absence/Incapacity	1		**1**
Abuse, Neglect, & Caretaker Absence/Incapacity	1		**1**
Total	**49**	**86**	**135**

Child Near Fatalities: Allegation Type for PIRs by Victim's Ethnicity/Race

The data shows that the number of PIR allegations of neglect alone and combined abuse and neglect were higher for Hispanic victims than any other ethnicity/race. However, Hispanic victims also represented a larger number of victims overall. Combined abuse and neglect allegations and abuse alone almost doubled for White children compared to Black children.

Table 30. Allegation Type for PIR by the Victim's Ethnicity/Race

Victim's Ethnicity/Race	Allegation Types for PIR				Total
	Neglect	Abuse & Neglect	Abuse	Other[23]	
Hispanic	24	16	10	2	**52**
White	10	11	10	1	**32**
Black	12	6	4	1	**23**
Multiracial	4	9	7		**20**
Asian	2		2		**4**
Pacific Islander	1	1	1		**3**
Native American		1			**1**
Total	**53**	**44**	**34**	**4**	**135**

[23] "Other" allegation types for the PIRs were two combined allegation of neglect and caretaker absence/incapacity, one combined allegation of abuse, neglect, and caretaker absence/incapacity, and one combined allegation of abuse and caretaker absence/incapacity.

Summary of Child Abuse versus Neglect—What is Known

In summary, when looking at the PIRs for the reported near fatality incidents, allegations of neglect were documented in CWS/CMS more often than any other single allegation category. For children less than five years of age, abuse and neglect (38 incidents) was the most reported allegation type for the PIRs followed closely by neglect allegations (36 incidents). In comparing the PIRs allegation type by the victim's gender, both male and female victims had almost an equal number of neglect allegations for the near fatality incidents. However, a combination of abuse and neglect allegations tripled for near fatality incidents involving male victims (33 male victims compared to 11 female victims) and allegations of abuse alone more than doubled for near fatality incidents involving male victims (24 male victims compared to ten female victims). The number of PIR allegations of neglect alone and combined abuse and neglect were higher for Hispanic victims than any other ethnicity/race. However, combined abuse and neglect allegations and abuse alone almost doubled for White children compared to Black children.

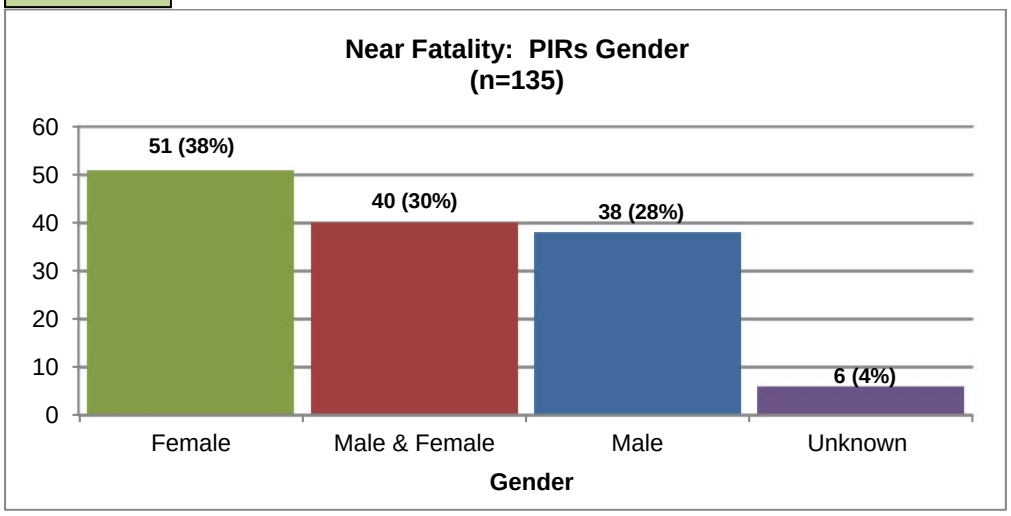
Who Was Identified as the PIRs for the Near Fatality Incidents

The following section provides an analysis of those individuals identified by a CWS agency as being the PIRs for the abuse and/or neglect that resulted in the child's near fatality. Similar to fatality incidents, the PIR 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. This data also includes additional analysis of incidents in which more than one individual was identified as being responsible for the near fatality incident.

Gender of the PIRs

Chart AK depicts the gender of the PIRs for the reported child near fatality incidents. The data shows that there were more females than males responsible for near fatality incidents. In 51 of the 135 near fatality incidents (38 percent), the PIR was a female. In 40 of the near fatality incidents (30 percent), there were two individuals identified by the CWS agency as the PIRs for the near fatality which included both a male and a female in each incident. In 38 of the near fatality incidents (28 percent), the PIR was a male. In six of the near fatality incidents (four percent), the identity of the PIR was unknown.

CHART AK



Gender of PIRs by Victim's Age

Of the 67 child near fatality incidents in the less than one-year-old age group, more males and females together than males or females alone were identified as the PIRs for the near fatality incident. In 24 of these incidents (36 percent), both a male and a female were responsible for the near fatality. In 22 of these incidents (33 percent), the PIR for the near fatality was a male; and in 16 of these incidents (24 percent), the PIR was a female. In five of these incidents (seven percent), the identity of the PIR was unknown.

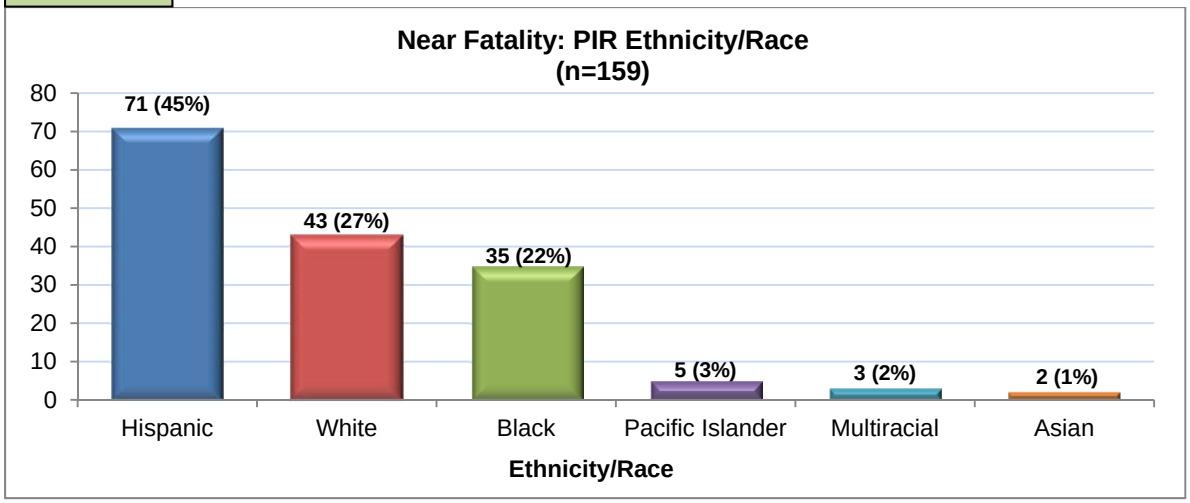
Of the 43 child near fatality incidents in the one- to four-year-old age group, more females than males were identified as the PIRs for the near fatality incident. In 19 of these incidents (44 percent), the PIR was a female; and in 12 of these incidents (28 percent), the PIR was a male. In 11 of these incidents (26 percent), the PIR included both a male and a female. In one incident (two percent), the identity of the PIR was unknown.

Of the remaining 25 child near fatality incidents in the five- to 17-year-old age group, more females than males were identified as the PIR for the near fatality incident. In 16 of these incidents (64 percent), the PIR was a female; and in four of these incidents (16 percent), the PIR was a male. In five of these incidents (20 percent), the PIR included both a male and a female.

Ethnicity/Race of PIRs

Chart AL depicts the ethnicity/race of the PIRs for the 119 incidents in which the ethnicity/race was known. Of these 119 incidents, there were a total of 159[24] PIRs whose ethnicity/race was known for the near fatalities. Of these 159 PIRs whose ethnicity/race was known, almost half were Hispanic (45 percent) and slightly over a quarter were White (27 percent). This was followed by PIRs who were Black (22 percent), Pacific Islander (three percent), and Asian (one percent). For three of the PIRs (two percent), more than one ethnicity/race was identified in CWS/CMS.

CHART AL



Of the PIRs who had more than one ethnicity/race identified in CWS/CMS, Table 31 breaks down the primary and secondary ethnicity/race of the PIRs. This data shows that most of the PIRs in the Multiracial category are a combination of White and another ethnicity/racial background.

Table 31. Breakdown of Multiracial PIR Ethnicity/Race

Primary Ethnicity/Race	Secondary Ethnicity/Race	Number of PIRs
Hispanic	White	1
White	Hispanic	1
White	Native American	1
Total		**3**

[24] Of the 119 near fatality incidents where the ethnicity/race of the PIRs was known, there were 40 incidents where two individuals were identified as the PIRs for the near fatality whose ethnicity/race was known making a total of 159 individuals.

Relationship Between the Child and the PIRs for the Near Fatality

Table 32 provides greater detail regarding the relationship to the victim of the primary individuals identified as being responsible for the near fatalities reported. In 106 of the 135 child near fatality incidents (79 percent), a biological parent, either individually or in conjunction with another individual, was identified as the individual(s) responsible for the incidents. In 41 of the 135 child near fatality incidents (30 percent), the biological mother was exclusively responsible for the near fatality; and the biological father was exclusively responsible for 26 of the child near fatality incidents (19 percent). In four of the 135 child near fatality incidents (three percent), the foster parents, either individually or in conjunction with another individual, were responsible for the incident.

There were a total of 11 incidents in which the biological mothers' significant others were involved in the near fatality incidents (eight percent), either individually or in conjunction with the biological mother. In six of the 135 child near fatality incidents (four percent), the individual responsible for the near fatality was unknown.

Table 32. PIRs

Primary Individual(s) Responsible (PIR) for the Near Fatality	Number	Percent
Bio Mother	41	30%
Bio Parents	32	24%
Bio Father	26	19%
Other[25]	11	8%
Bio Mother's Significant Other (M)	8	6%
Unknown	6	4%
Bio Mother & her Significant Other (M)	3	2%
Foster Parents	3	2%
Foster Parent & Unrelated Adult (M)	1	1%
Bio Father & his Significant Other (F)	1	1%
Bio Father & Unrelated Adult (M)	1	1%
Bio Mother & Step Parent (M)	1	1%
Bio Mother & Unrelated Adult (F)	1	1%
Total	**135**	**100%**

Table 33 breaks down the PIRs for the near fatalities which are listed as "Other."

Table 33. Other PIRs

Other Primary Individual(s) Responsible (PIR) for the Near Fatality	Number
Related Adult (F)	**3**
Adoptive Parents	**3**
Unrelated Adult (F)	**2**
Related Adult (M)	**2**
Related Adult (F) & Cousin	**1**
Total	**11**

[25] See Table 33 for a breakdown of "Other" PIRs.

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

Table 34 depicts a breakdown of the age of the victim by the PIRs for the near fatality. Biological parents together were most frequently identified as the individual responsible for victims under the age of one (34 percent), followed closely by biological fathers (31 percent), and then by biological mothers (19 percent). Biological mothers acting alone (41 percent) were more frequently responsible for near fatality incidents of victims between the ages of one and 17 years old. Biological parents, either individually or in conjunction with one another, were more frequently responsible for the near fatality incidents of victims over the age of ten compared to non-biological individuals.

Table 34. Primary Individual(s) Responsible and the Age of the Victims

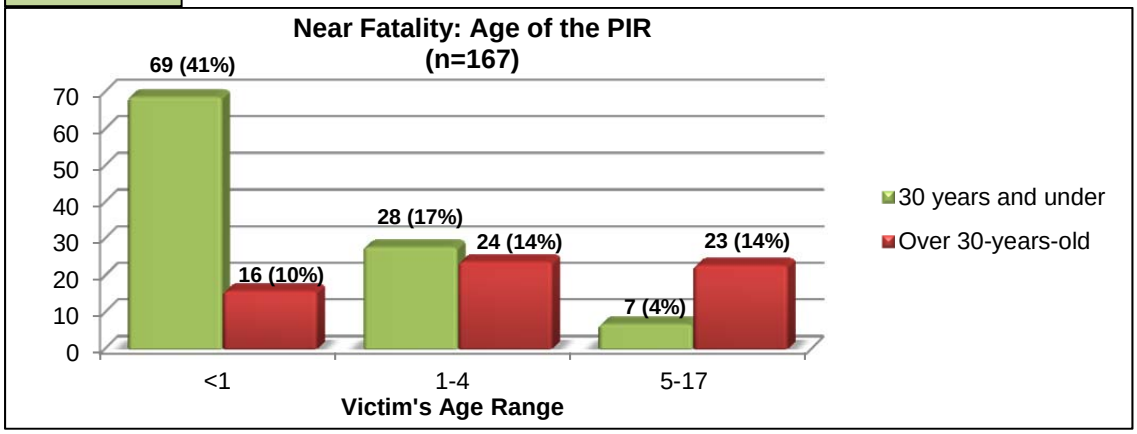
	Victim's Age Group					
Primary Individual(s) Responsible (PIR)	**<1**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Bio Mother	13	14	7	5	2	**41**
Bio Parents	23	6	1	2		**32**
Bio Father	21	4	1			**26**
Bio Mother's Significant Other (M)	1	5	2			**8**
Other	3	3	4	1		**11**
Unknown	5	1				**6**
Bio Mother & her Significant Other (M)	1	2				**3**
Foster Parents		3				**3**
Foster Parent & Unrelated Adult (M)		1				**1**
Bio Mother & Step Parent (M)		1				**1**
Bio Mother & Unrelated Adult (F)		1				**1**
Bio Father & Unrelated Adult (M)		1				**1**
Bio Father & his Significant Other (F)		1				**1**
Total	**67**	**43**	**15**	**8**	**2**	**135**

Age of the PIRs for Near Fatality by Victim's Age

Chart AM depicts the age of the PIRs for the child near fatality incidents for the 124 cases in which the age of the PIR was known. Of these 124 incidents, there were a total of 167[26] PIRs for the near fatalities.

For the less than five-year-old age group of victims, the PIR was most often 30 years of age or younger (58 percent). However, for the five- to 17-year-old age group of victims, the PIR for the near fatality was more often over 30 years of age (14 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 are more likely to involve older parents.

CHART AM



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

Table 35 depicts the gender of the victim by the PIR for the near fatality. Biological fathers were more frequently responsible for victims who were males (81 percent). Biological mothers' significant others acting alone were also more frequently responsible for victims who were males (75 percent). Biological mothers acting alone were more responsible for victims who were females (41 percent).

Table 35. Primary Individual(s) Responsible by Victim's Gender

Primary Individual(s) Responsible (PIR)	Victim's Gender		Total
	Female	Male	
Bio Mother	20	21	**41**
Bio Parents	10	22	**32**
Bio Father	5	21	**26**
Bio Mother's Significant Other (M)	2	6	**8**
Unknown	2	4	**6**
Bio Mother & her Significant Other (M)	1	2	**3**
Related Adult (F)	2	1	**3**
Other	7	9	**16**
Total	**49**	**86**	**135**

[26] Of the 124 near fatality incidents where the age of the PIRs was known, there were 43 incidents where two individuals were identified as the PIRs for the near fatality making a total of 167 individuals.

Summary of PIRs

In summary, when reviewing who was identified as the PIRs for child near fatalities reported for CY 2011, overall, more females alone than males alone or males and females together were responsible for the near fatality incidents resulting from abuse and/or neglect. Furthermore, for all age groups combined, there were more biological mothers (30 percent) than biological parents together (24 percent) or biological fathers alone (19 percent) who were identified as the PIR for the near fatality. For children less than one year old, more biological parents together than biological mothers or fathers acting alone were identified as the PIR for the near fatality incidents, although the numbers between the biological parents and biological fathers acting alone are very close. For children over the age of one, more biological mothers acting alone than biological fathers acting alone or biological parents together were identified as the PIR for the near fatality incidents. Additionally, the ethnicity/race of the PIRs was mainly Hispanic, which is consistent with the general near fatality victim's demographics. With respect to the age of the PIR for the near fatality incidents reported, similar to fatality incidents, over half of the known PIRs for the near fatality incidents reported were 30 years of age or younger.

What is Known About the Secondary Individuals Responsible (SIRs) for the Near Fatality Incidents

Similar to the fatality analysis contained in this report, new to this year's report is an additional analysis about other individual(s) who did not commit the act that caused the child near fatality, but were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the near fatality incident. This SIR may be the person who failed to protect the victim from the PIR. Of the 135 near fatality incidents, there were 43 near fatality incidents (32 percent) in which there was an individual identified as a SIR. For two of these incidents, there were two SIRs identified per incident, therefore bringing the total number of SIRs identified to 45. The following provides information regarding the 45 SIRs identified by the CWS agencies and documented in CWS/CMS.

The data shows that in 32 of the 43 child near fatality incidents (74 percent) where a SIR was identified by a CWS agency, the SIR was a female and in nine of the near fatality incidents (21 percent), the SIR was a male. In two of the 43 near fatality incidents (five percent), there were two individuals identified by the CWS agency as the SIR for the near fatality which included both a male and a female in each incident. In terms of the ethnicity/race of the SIR, there were more Hispanics (41 percent) identified as the SIR, followed by White (27 percent), Black (20 percent), Multiracial (ten percent), and Asian (two percent). The findings regarding the age of the SIRs were similar to what was found for the PIRs, in that the SIRs were most often 30 years of age or younger for children under the age of five.

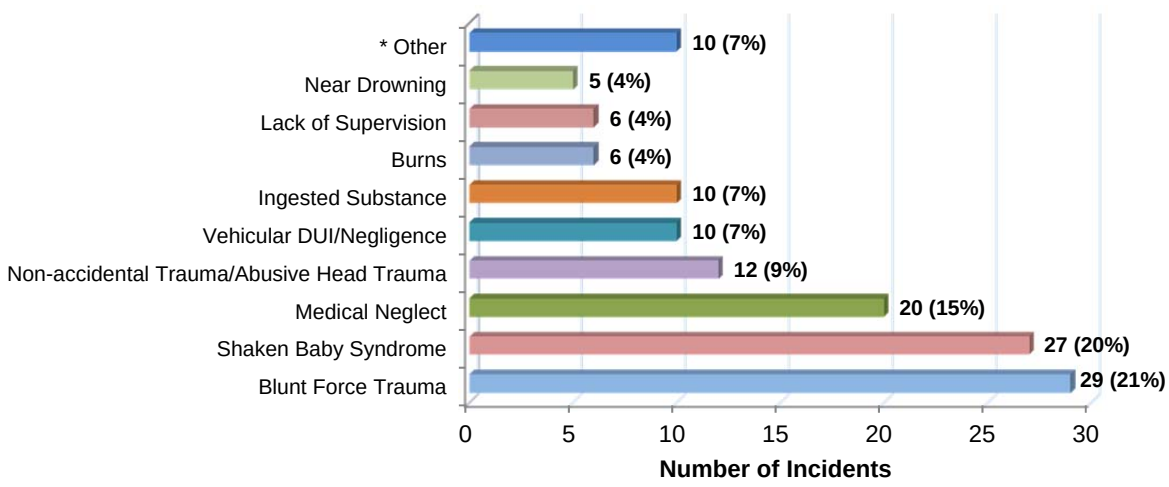
In regards to the victim's age group, there were 25 individuals identified as a SIR for the near fatality incidents in the less than one-year-old age group and 17 individuals for the one- to four-year-old age group. Additionally, biological mothers were more frequently identified as the SIR for children under the age of five. In the five- to nine-year-old age group, there were three individuals identified as a SIR.

The data shows that neglect was documented in CWS/CMS more often than any other allegation type for near fatality incidents where a SIR was identified. These findings are consistent with what one might expect given that the SIR is often the person who is identified as failing to protect the children from the PIR, the individual who commited the act that caused the near fatality.

Specific Cause/Finding of Incident

The specific causes or findings in the 135 child near fatalities are categorized below in Chart AN. The causes listed below are based on the causes identified by counties and documented in CWS/CMS. A review of these incidents indicated that the most commonly reported causes of near fatalities were blunt force trauma, shaken baby syndrome, and medical neglect.

CHART AN



***** The "Other" category represents those incidents in which there were three or less of the same cause that were identified and documented.

Table 36 depicts a breakdown of the "Other" category of near fatality causes.

Table 36. Breakdown of "Other" Near Fatality Causes

"Other" Causes	Number
Abusive Head Trauma	3
Undetermined	2
Blunt Force Trauma and Burns	1
Blunt Force Trauma and Shaken Baby Syndrome	1
Failure to Thrive	1
Ingesting Substance and Slitting the Throat	1
Unknown	1
Total	**10**

Causes Compared to the Allegation Types of the PIRs

Table 37 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 and shaken baby syndrome involved referrals which were substantiated on allegations of abuse or combined allegations of abuse and neglect. For those blunt force trauma and shaken baby syndrome incidents which had neglect allegations (four incidents), it was identified that in many of these incidents the reason this allegation type was utilized by the CWS agency had to do with the failure on the part of the person responsible for the child to protect, seek medical attention, and/or supervise the child.

Table 37. Causes Compared to PIR Allegation Type

Causes	Allegation Type of Primary Individual Responsible (PIR)				Total
	Neglect	Abuse	Abuse & Neglect	Other	
Blunt Force Trauma	2	11	16		**29**
Shaken Baby Syndrome	2	13	11	1	**27**
Medical Neglect	19		1		**20**
Non-accidental Trauma/Abusive Head Trauma		8	4		**12**
Vehicular DUI/Negligence	8			2	**10**
Ingested Substance	9			1	**10**
Burns	3		3		**6**
Lack of Supervision	5		1		**6**
Near Drowning	4		1		**5**
Other	1	2	7		**10**
Total	**53**	**34**	**44**	**4**	**135**

Causes Compared to Gender of Victim

Table 38 is a detailed distribution of the gender of the victim and the cause of the near fatality. Male victims accounted for a higher proportion (64 percent) of all near fatalities in CY 2011 and were more frequently represented in lack of supervision (100 percent), blunt force trauma (86 percent), shaken baby syndrome (67 percent), and non-accidental trauma/abusive head trauma (67 percent) incidents. Female victims were slightly more frequently represented in near fatalities caused by ingested substance (60 percent) and near drowning (60 percent). Male and female victims were equally represented in near fatalities caused by medical neglect and burns.

Table 38. Causes Compared to Gender of Victim

Causes	Victim's Gender			
	Female		Male	
	Number	Percent	Number	Percent
Blunt Force Trauma (29)	**4**	14%	**25**	86%
Shaken Baby Syndrome (27)	**9**	33%	**18**	67%
Medical Neglect (20)	**10**	50%	**10**	50%
Non-accidental Trauma/Abusive Head Trauma (12)	**4**	33%	**8**	67%
Vehicular DUI/Negligence (10)	**4**	40%	**6**	60%
Ingested Substance (10)	**6**	60%	**4**	40%
Burns (6)	**3**	50%	**3**	50%
Lack of Supervision (6)	**0**	0%	**6**	100%
Near Drowning (5)	**3**	60%	**2**	40%
Other (10)	**6**	60%	**4**	40%
Total (135)	**49**	36%	**86**	64%

Causes Compared to the Age of the Victim

As previously indicated, 81 percent of all child near fatalities in CY 2011 were victims under the age of five (see Chart AG). Of the older victims, 15 children (11 percent) were between five to nine years old, eight children (six percent) were between ten to 14 years old and two children (one percent) were 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 syndrome and blunt force trauma. Additionally, all of the non-accidental trauma/abusive head trauma incidents were for children under one year of age. Children between the ages of one and four years of age were most frequently associated with blunt force trauma and ingesting substance. Children between the ages of one and nine years of age were most frequently associated with vehicular DUI/negligence. See Table 39 below for a distribution of the causes of near fatalities and the age of victims.

Table 39: Causes Compared to the Age of the Victim

Causes	Age Range of Victims					Total
	Under 1 yr old	1-4 yrs old	5-9 yrs old	10-14 yrs old	15-17 yrs old	
Blunt Force Trauma	11	13	4	1		**29**
Shaken Baby Syndrome	24	3				**27**
Medical Neglect	5	6	3	4	2	**20**
Non-accidental Trauma/Abusive Head Trauma	12					**12**
Vehicular DUI/Negligence		5	4	1		**10**
Ingested Substance	3	7				**10**
Burns	1	4	1			**6**
Lack of Supervision	1	2	2	1		**6**
Near Drowning	3	1	1			**5**
Other	7	2		1		**10**
Total	**67**	**43**	**15**	**8**	**2**	**135**

Causes Compared to the Age of the Victim Under One Year Old

Table 40 is a detailed distribution of the victims under the age of one year old and the cause of near fatality. Victims under the age of one (50 percent) comprised almost half of the near fatality incidents for CY 2011(see Chart AG). The top three causes of near fatalities for victims under the age of one were shaken baby syndrome (36 percent), non-accidental trauma/abusive head trauma (18 percent), and blunt force trauma (16 percent).

Table 40: Breakdown of Causes by Victims Under One Year Old

Causes	Age of Victims Under One Year Old												Total
	New born	1 Month	2 Months	3 Months	4 Months	5 Months	6 Months	7 Months	8 Months	9 Months	10 Months	11 Months	
Shaken Baby Syndrome	1	3	4	7	2	5		1	1				**24**
Non-accidental Trauma/ Abusive Head Trauma	1	1	1	3	2	1	1		1	1			**12**
Blunt Force Trauma	1	3	1	2	1	1	1				1		**11**
Medical Neglect	1	1	1	1	1								**5**
Ingested Substance		1					1					1	**3**
Near Drowning									1		1	1	**3**
Abusive Head Trauma					1		1						**2**
Undetermined	1		1										**2**
Burns												1	**1**
Lack of Supervision									1				**1**
Blunt Force Trauma/Shaken Baby Syndrome								1					**1**
Failure to Thrive		1											**1**
Unknown						1							1
Total	**5**	**10**	**8**	**13**	**7**	**8**	**4**	**2**	**4**	**1**	**2**	**3**	**67**

Causes Compared to the Ethnicity/Race of the Victim

Table 41 is a detailed distribution of the ethnicity/race of the victim and the cause of near fatality. Hispanic victims accounted for a higher proportion (39 percent) of all near fatalities in CY 2011 and were more frequently represented in shaken baby syndrome, blunt force trauma, and medical neglect incidents. White victims accounted for 24 percent of all near fatalities and were more frequently represented in blunt force trauma, shaken baby syndrome, and medical neglect incidents.

Table 41. Causes Compared to the Ethnicity/Race of the Victim

Causes	Ethnicity/Race of the Victim							Total
	Hispanic	White	Black	Multiracial	Asian	Pacific Islander	Native American	
Blunt Force Trauma	8	9	6	4		1	1	**29**
Shaken Baby Syndrome	10	6	2	8		1		**27**
Medical Neglect	8	6	4	2				**20**
Non-accidental Trauma/ Abusive Head Trauma	4	2	2	2	2			**12**
Vehicular DUI/Negligence	6		4					**10**
Ingested Substance	5	2	2		1			**10**
Burns	3	1	1	1				**6**
Lack of Supervision	3	1	1	1				**6**
Near Drowning	1	3			1			**5**
Other	4	2	1	2		1		**10**
Total	**52**	**32**	**23**	**20**	**4**	**3**	**1**	**135**

Causes Compared to Gender of the PIRs

As illustrated in Table 42, male PIRs were more frequently represented in near fatalities involving blunt force trauma (41 percent) and non-accidental trauma/abusive head trauma (42 percent). Female PIRs were more frequently represented in near fatalities associated with medical neglect (60 percent), vehicular DUI/Negligence (80 percent), near drowning (80 percent), and lack of supervision (67 percent). For near fatalities that involved both males and females together, shaken baby syndrome (48 percent), and blunt force trauma (34 percent) were more frequently represented.

Table 42. Causes Compared to Gender of the PIRs

Causes	Gender of Primary Individuals Responsible (PIRs)				Total
	Male	Male & Female	Female	Unknown	
Blunt Force Trauma	12	10	7		**29**
Shaken Baby Syndrome	7	13	4	3	**27**
Medical Neglect	2	6	12		**20**
Non-accidental Trauma/Abusive Head Trauma	5	3	1	3	**12**
Vehicular DUI/Negligence	2		8		**10**
Ingested Substance	4	1	5		**10**
Burns	2	2	2		**6**
Lack of Supervision		2	4		**6**
Near Drowning	1		4		**5**
Abusive Head Trauma	1		2		**3**
Blunt Force Trauma & Burns	1				**1**
Blunt Force Trauma/Shaken Baby Syndrome	1				**1**
Failure to Thrive		1			**1**
Ingesting Substance & Slitting the Throat			1		**1**
Undetermined		1	1		**2**
Unknown		1			**1**
Total	**38**	**40**	**51**	**6**	**135**

Causes Compared to Age of the PIRs

Table 43 depicts a distribution of the causes of child near fatality incidents by the age of the PIRs for the near fatality.[27] There are a few noticeable differences in the causes of near fatality incidents by the age of the PIRs. Blunt force trauma, shaken baby syndrome, and non-accidental trauma/abusive head trauma incidents were more frequently associated with individuals under the age of 27. On the other hand, medical neglect, ingested substance, vehicular DUI/negligence, lack of supervision, and abusive head trauma incidents were more frequently associated with individuals over the age of 27.

Two PIRs under the age of 16 (one percent) were exclusively responsible for one of the incidents involving blunt force trauma and one involving shaken baby syndrome. There were three individuals (two percent) between the ages of 16-17 that were exclusively responsible for four of the shaken baby syndrome incidents.

Table 43. Causes Compared to the Age of the PIRs

	Age of Primary Individuals Responsible (PIRs)								
Causes	**< 16**	**16-17**	**18-20**	**21-23**	**24-26**	**27-30**	**31-40**	**Over 40**	**Total**
Blunt Force Trauma	1		8	4	8	5	9	2	**37**
Shaken Baby Syndrome	1	4	10	7	2	2	10	1	**37**
Medical Neglect			2	3	4	3	8	5	**25**
Non-accidental Trauma/ Abusive Head Trauma			6	3	1	2			**12**
Ingested Substance			1		2	2	3	4	**12**
Vehicular DUI/Negligence					2	1	4	3	**10**
Burns			1	2	2		1	3	**9**
Lack of Supervision					2	1	4	1	**8**
Near Drowning				1	2		1	1	**5**
Abusive Head Trauma						1	1		**2**
Failure to Thrive					1	1			**2**
Blunt Force Trauma & Burns					1				**1**
Blunt Force Trauma/Shaken Baby Syndrome					1				**1**
Ingesting Substance & Slitting the Throat							1		**1**
Undetermined		1	2						**3**
Unknown						1	1		**2**
Total	**2**	**5**	**30**	**20**	**28**	**19**	**43**	**20**	**167**

[27] Of the 124 near fatality incidents where the age of the PIRs was known, there were 43 incidents where two individuals were identified as the PIRs for the near fatality making a total of 167 individuals.

Near Fatalities Summary

In CY 2011, 135 near fatalities were determined to be the result of abuse and/or neglect and reported to CDSS, of which 129 children resided with their parent/guardian at the time of the incident, and six children resided in an out-of-home foster care placement. A near fatality was defined during CY 2011 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 135 child near fatality incidents reported to the CDSS, the CWS agency was more often the determiner of abuse and/or neglect than law enforcement and/or a physician, which is what one might expect given that the CWS is actively investigating cases involving near fatalities. The greater incidences of near fatality incidents occurred in children four years of age and younger, with 67 incidents (50 percent) being under the age of one. Further analysis of victims under the age of one showed that the most vulnerable population in this age group were children between the ages of newborn to three months (36 incidents). 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, which coincides with their general representation in the overall child population. White children represented 28 percent of the general child population and were 24 percent of the child near fatalities reported. However, Black children represented only six percent of the general child population and 17 percent of child near fatalities reported, which indicates a disproportionate number of near fatalities for Black children compared to Hispanic or White children. In addition, when looking at the breakdown of incidents of children in the Multiracial category, the most frequently represented primary ethnicity/race of the victims was Hispanic and Black, thereby further increasing the disproportionate percentage of Black children when compared with Hispanic or White children.

For CY 2011, 52 of the child near fatality incidents (39 percent) reported involved children who were from families who did not have CWS history in the five years prior to the incident. Additionally, 83 incidents (61 percent) involved children from families who were previously known to a CWS agency in the five years prior to the near fatality incident. Of those incidents involving families with history, 12 incidents involved families where the parents had history as minors but had no CWS history as an adult. Of the remaining 71 incidents involving children from families with CWS history in the five years prior to the near fatality incident, there were 25 families (35 percent) who were involved with a CWS agency at the time of the incident and 46 families (65 percent) who were not clients at the time of the near fatality incident but had history with the parents as adults in the five years prior to the near fatality incident. Of the incidents involving families who had a referral generated within the prior five years, 66 percent of the families had a referral generated within a year of the near fatality incident with slightly over half of those referrals being generated for neglect allegations. Upon investigation of those referrals by the CWS agency, over a third had allegations with dispositions being made that were substantiated, followed by allegations that were deemed inconclusive or unfounded at 43 percent.

Blunt force trauma, shaken baby syndrome, and medical neglect were the most reported causes of near fatality incidents for CY 2011. Most of the acts of blunt force trauma and shaken baby syndrome involved referrals which were substantiated for allegations of abuse or combined allegations of 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 86 percent male and

14 percent female, and shaken baby syndrome were 67 percent male and 35 percent female. Those incidents involving medical neglect were evenly distributed between male and female victims. 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 involved shaken baby syndrome.

The PIRs for child near fatality incidents were found to be exclusively female in 38 percent of the near fatality incidents, exclusively male in 28 percent, and both a male and a female in 30 percent of the incidents. Seventy-nine percent of the child near fatality incidents involved a biological parent either individually or in conjunction with another individual as the PIR for the incident. However, there were more biological mothers acting alone (30 percent) than biological fathers acting alone (19 percent) who were identified as the PIRs for the near fatality incidents. In eight percent of the near fatality incidents, the biological mothers' significant others were the PIR, either exclusively or in conjunction with the biological mother. In four of the 135 child near fatality incidents (three percent), the foster parents, either exclusively or in conjunction with another individual, were responsible for the near fatality incidents. Additionally, of those cases where the PIR was known, over half of those individuals were 30 years of age or younger at the time of the incident.

Additional analysis revealed that male PIRs were more frequently documented as being the individual responsible for near fatality incidents involving blunt force trauma (41 percent) and non-accidental trauma/abusive head trauma (42 percent). Female PIRs were more frequently documented as being responsible for near fatalities associated with medical neglect (60 percent), vehicular DUI/negligence (80 percent), near drowning (80 percent), and lack of supervision (67 percent).

There were 43 near fatality incidents in which there was an individual identified as a SIR. In 74 percent of these incidents the SIR was a female and in 21 percent the SIR was a male. With respect to ethnicity, 41 percent of the SIRs were Hispanic. There were 25 individuals identified as a SIR for incidents in the less than one year age group, 17 individuals in the one to four age group, and three SIRs in the five to nine age group. Biological mothers were more frequently identified as the SIR for children under the age of five. The findings with respect to the age of the SIR were similar to what was identified for the PIR in that the SIRs were most often 30 years of age or younger for children under the age of five. With respect to allegation types for the SIRs, the data shows that neglect was documented most often, which is consistent with what one might expect given that the SIR is often the person who is identified as failing to protect the children from the PIR.

Comparison with Prior Years' Reports

For CYs 2010 and 2011 there was an increase in the number of near fatality incidents reported to the CDSS. However, for CYs 2012 and 2013 to date there has been a decrease in the numbers. Since county CWS agencies may still be reporting near fatalities for these years it is unknown at this time whether the downward trend for CYs 2012 and 2013 will continue. In the CYs 2008 and 2009 reports, all three agencies together (CWS, law enforcement, and a physician) determined the near fatality incidents to be the result of abuse/neglect. However, in CYs 2010 and 2011, near fatality incidents reported to the CDSS were determined more often by a CWS agency alone.

Consistent with CYs 2008 through 2010, Hispanic children were more frequently victims of near fatality incidents in CY 2011, which coincides with their general representation in the overall

child population. However, for Black children, their representation in child near fatalities reported throughout the years has been disproportionate to their representation in the general child population. Additionally, from CY 2008 through 2011, the majority of the victims of near fatality incidents have been children less than five years of age. With respect to the gender of near fatality victims, from CY 2008 through CY 2011 the majority of the victims were male.

Since the release of the CY 2008 report, families with reported child near fatality incidents who were not known to a CWS agency at the time of the incident nor had history within five years of the incident has declined from 59 percent in CY 2009 to 50 percent in CY 2010 to 47 percent in CY 2011. Families that were known to a CWS agency at the time of the incident has increased over the years from eight percent in CY 2008 to 12 percent in CY 2009, 13 percent in CY 2010, and 19 percent in CY 2011.

Blunt force trauma and shaken baby syndrome have consistently been the most reported causes of child near fatalities since CY 2008, and that trend continues for CY 2011. While the most reported cause of near fatalities has remained the same since 2008, the most reported referral allegation for near fatalities has changed over the years from abuse in CY 2008 to neglect in CY 2009 to abuse in CY 2010 and to neglect for CY 2011.

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 CY 2008 and 2009 reports. In an effort to provide a more comprehensive analysis of those individuals responsible for near fatality incidents, the CDSS has been revising its methodology over the last couple of years for collecting this data to better distinguish between the PIRs for these incidents and other individuals who did not commit the acts which inflicted the near fatalities but who were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the near fatality. Therefore, information in this report regarding the individuals responsible for the near fatality incidents cannot be compared to the data in the CY 2008 and 2009 reports due to the differences in methodology and data collection. However, CY 2011 data can be compared to CY 2010 data as the methodology of gathering the information on the PIRs was the same for both reports.

Both CY 2010 and CY 2011 reports found that females were more frequently documented as the PIRs. The relationship between the PIRs and the victim changed between CY 2010 and CY 2011. In CY 2010, biological parents were more frequently documented as the PIR followed by biological fathers, and then by biological mothers. In CY 2011, there were more biological mothers alone than biological parents together followed by biological fathers documented as the PIRs. Interestingly, the number of biological mothers' significant others who were exclusively responsible for the near fatality doubled between these two reports from four biological mothers' significant other (CY 2010) to eight biological mothers' significant other (CY 2011). Biological fathers alone and biological parents together continue to be more frequently responsible for children under the age of one while biological mothers continue to be evenly more frequently responsible for children between the ages of one and four. Biological mothers' significant others alone continues to be more frequently responsible for children between the ages of one and four.

VI. Future Plans

Continued Enhancement to Risk and Safety Assessment Tools

California currently employs two safety assessment systems which are valuable tools for social workers and supervisors in determining safety factors for children and families. Structured Decision Making (SDM®) is used by 54 of 58 counties and the remaining counties use the Comprehensive Assessment Tool (CAT). Identifying 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 2013, the Children's Resource Center (CRC) and CDSS convened workgroups to review all SDM® assessments. Informed by data and practice, the workgroup recommended revisions to strengthen the tools, definitions, and their use, scheduled for release by January 1, 2015.

The CRC also initiated a validation of the initial risk assessment tool. After review of the study results, it was determined that although the current risk assessment tool classified families reasonably accurately overall, results suggested that performance could be improved. This led to modification of the training curriculum that was implemented by developing a web-based program for trainers. The results of the validation study can be found in CRC's October 2013 publication "Risk Assessment Validation: A Prospective Study."[28] Additionally, CRC developed a case plan field tool that was designed to help social workers and parents communicate up front about how they will partner to increase safety for children. The tool incorporates all elements of Safety Organized Practice (SOP) and the SDM® system.

It is anticipated that in 2015/16 there will be identified enhancements made to the SDM®. These are to include enhancing the assessment tools, based upon the validity study, to provide for the improvement of a workers' estimate of a family's risk of future maltreatment. This, in turn, would permit the CWS agencies to reduce subsequent maltreatment by more effectively targeting service interventions to high risk families. Enhancements will also be made to better integrate CWS/CMS and SafeMeasures data into the SDM® application which will allow for more accurate safety and risk assessments.

Prevention Activities

In response to recent data regarding child fatalities in California, the CDSS Office of Child Abuse Prevention (OCAP) will work to execute a comprehensive multi-prong data-driven strategy to reduce the number of child deaths in California, particularly those that are the result of shaken baby syndrome and blunt force trauma. The OCAP will employ evidence-based strategies and collaborate with partners and stakeholders to accomplish its objectives.

The OCAP's primary focus over the next year will be on the youngest children, newborn to one year old, two to five years old secondarily, and all other children thirdly. These groups represent in order the children respectively most at risk of being victims of shaken baby syndrome or blunt force trauma.

The OCAP will utilize its extensive network, including Public Health, private hospitals systems, Department of Healthcare Services, and nonprofit organizations currently operating effective programs and strategies, to accomplish the goals of the program. We will leverage resources to maximize the impact of the selected activities. The OCAP is a key participant in several

[28] http://nccdglobal.org/sites/default/files/publication_pdf/risk-assessment-validation.pdf

statewide initiatives, including Safe, Stable, Nurturing Relationships, and Environments program (SSNR-E), which is led by the California Department of Public Health, Early Childhood Comprehensive Systems (ECCS), and Strengthening Families Roundtable (OCAP), through which statewide policy and systems changes can occur.

As part of both the SSNR-E and the ECCS, the OCAP is working with key partners to develop through different approaches, statewide common agendas to address child maltreatment. The OCAP will bring the goals of its shaken baby syndrome program to each collaborative to include as part of that common agenda, establishing it as a priority.

The OCAP program, to reduce child deaths as a result of shaken baby syndrome and blunt force trauma, will tie in to other OCAP initiatives including the Family Support Initiative and Strengthening Families. The objectives and strategies are as follows.

Objective 1: Assist parents and caregivers in dealing with emotional crisis before it causes the loss of control that result in shaking or beating young children.

> **Strategy 1:** The OCAP will address the feasibility of utilizing existing national child abuse crisis hotlines and expanding public education and awareness regarding this resource. The OCAP will educate parents about using the child abuse crisis hotline for support, encouragement, and information.
>
> There are multiple existing child abuse and parental support hotlines staffed with professional crisis counselors. The OCAP will examine these existing hotlines to determine which one best meets the needs for California families and promote it in a state-wide public awareness and education campaign.
>
> **Strategy 2:** The OCAP will update the CDSS's shaken baby syndrome awareness media materials, based upon data-driven research currently being conducted, to make the message more effective. The OCAP will continue to provide shaken baby syndrome awareness literature on demand to the general population and to organizations as part of a statewide dissemination plan.

Objective 2: Decrease child fatalities and near fatalities through early education of new parents about the dangers of shaken baby syndrome and what steps they can take to prevent shaking their babies.

> **Strategy 1:** The OCAP will explore and develop partnerships with hospitals to implement a new parent education program to increase new parents knowledge about the dangers of shaking their babies and teach them steps they can take instead when they are in an emotional crisis and in danger of shaking their babies. The OCAP will base its new parent education program on evidence-based best practice models such as the Dias New York Program model.[29]
>
> **Strategy 2**: The OCAP will partner with the California Home Visiting Program through California Public Health and Maternal Child and Adolescent Health to connect with parents of children newborn to five in their homes to provide targeted and repeated awareness and training information on shaken baby syndrome since current data shows that 49 percent of the victims are under age one and 29 percent are from one to four years old.

[29] http://pediatrics.aappublications.org/content/115/4/e470.full

Objective 3: The CDSS will leverage its current network of partners for dissemination of information. The CDSS will continually reassess and modify its strategies based upon the most current data-driven knowledge regarding child abuse and neglect.

> **Strategy 1:** The OCAP will disseminate the Child Fatality/Near Fatality Annual Report to its network of partners providing highlights of key data and strategies for using the data to enhance their program delivery and to educate and inform their community stakeholders.

Objective 4: The CDSS will examine data regarding child fatalities, near fatalities, and child maltreatment to inform training, policy, practice, and other supportive systems thereby ensuring continuous quality improvement.

> **Strategy 1:** The CDSS will form an advisory team to review and analyze child fatality, near fatality, and maltreatment data and make findings and recommendations based upon these analyses. The advisory team will report to the CDSS on the following: (1) what can be inferred from existing data about child fatalities, near fatalities, and maltreatment; (2) what data is still needed to create an accurate picture of the risk factors associated with child fatalities, near fatalities, and maltreatment; (3) what trends or commonalities does the data reveal about child fatalities, near fatalities, and maltreatment; and (4) what issues/gaps exist with current data and practices.
>
> The CDSS plans to form the advisory team as a multidisciplinary-interagency group which will include, but not be limited to, representatives from the CDSS, Children's Data Network, Rady's Children's Hospital, UC Berkeley School of Social Welfare, and the California Department of Public Health. This advisory team will meet quarterly to biannually, depending on the needs of the CDSS and availability of the advisory team members. The CDSS' goal with forming this advisory team is to keep children healthy, safe, and protected through a better understanding of risk factors and a focus on data-driven recommendations for prevention activities.

Objective 5: Measure the impact of these aforementioned activities by evaluating future California Child Fatality and Near Fatality data to see if the new steps taken by the OCAP resulted in a decrease in the numbers of child fatalities and near fatalities, and if they did, try to establish which strategies were most effective and why so that those strategies can be enhanced or expanded going forward. The OCAP will measure the impact starting with raised awareness (short-term) and changes in child fatality and near fatality statistics (long-term).

> **Strategy 1:** The OCAP will work with the CDSS internal partners and the CWS/CMS system to establish an evaluation for these proposed activities. New data fields or processes may be necessary.

Future Data Analysis of Child Fatality and Near Fatality Incidents Involving Families with Prior Child Welfare Services (CWS) Agency Involvement

The CDSS plans to conduct further analysis on child fatality and near fatality incidents involving families with a history of prior CWS. In 2011, over half of child fatality and near fatality victims and/or their families, which had CWS history within five years of the incident, had a referral generated within a year prior to the incident that caused each fatality or near fatality. In order to better determine whether this data pattern illustrates areas for improved State policy, the CDSS

will be conducting a more in-depth analysis of incidents with this type of CWS history in the future to determine what additional trends may be evident. The Department's goal is to utilize this data to inform the analysis which will be provided in the next release of this report and provide any subsequent conclusions therein.

VII. Attachments

Attachment A

2011 California Children Population Projections by Age, Race & Gender
(as of January 2013)

Age	Total Population	Hispanic or Latino	*Not Hispanic or Latino*					
			White Alone	Asian Alone	Black Alone	Multiracial	American Indian & Alaska Native Alone	Native Hawaiian & Other Pacific Islander Alone
Total Population								
Under 5 years	**2,514,468**	1,324,183	660,595	254,824	133,074	124,488	9,260	8,044
		53%	*26%*	*10%*	*5%*	*5%*	*< 0%*	*< 0%*
5 to 9 years	**2,496,676**	1,297,911	671,168	264,997	132,467	111,609	10,052	8,472
10 to 14 years	**2,556,893**	1,296,616	719,657	270,054	147,860	103,054	10,524	9,129
15 to 17 years	**1,646,388**	809,084	482,987	176,219	103,964	60,815	7,023	6,296
Total	**9,214,425**	**4,727,794**	**2,534,407**	**966,094**	**517,365**	**399,966**	**36,859**	**31,941**
		51%	*28%*	*10%*	*6%*	*4%*	*<1%*	*<1%*
Male								
Under 5 years	**1,292,330**	679,051	341,072	132,109	67,556	63,760	4,707	4,076
		53%	*26%*	*10%*	*5%*	*5%*	*<1%*	*<1%*
5 to 9 years	**1,274,935**	661,184	344,864	135,134	67,599	56,758	5,081	4,315
10 to 14 years	**1,307,647**	661,707	369,296	138,583	75,388	52,437	5,440	4,796
15 to 17 years	**844,861**	414,239	248,558	91,398	53,143	30,774	3,581	3,167
Total	**4,719,773**	**2,416,181**	**1,303,790**	**497,224**	**263,686**	**203,729**	**18,809**	**16,354**
		51%	*28%*	*11%*	*6%*	*4%*	*<1%*	*<1%*
Female								
Under 5 years	**1,222,138**	**645,132**	**319,522**	**122,715**	**65,518**	**60,728**	**4,553**	**3,968**
		53%	*26%*	*10%*	*5%*	*5%*	*<1%*	*<1%*
5 to 9 years	**1,221,741**	636,727	326,303	129,863	64,868	54,851	4,971	4,157
10 to 14 years	**1,249,246**	634,908	350,361	131,470	72,473	50,617	5,084	4,333
15 to 17 years	**801,527**	394,845	234,428	84,820	50,821	30,041	3,443	3,129
Total	**4,494,652**	**2,311,612**	**1,230,614**	**468,868**	**253,680**	**196,237**	**18,051**	**15,587**
		51%	*27%*	*10%*	*6%*	*4%*	*<1%*	*<1%*

Source: State of California Department of Finance, *Report P-3: Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060*

http://www.dof.ca.gov/research/demographic/reports/projections/P-3/

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 (ER) 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))