WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

Dear Reader:

This is the fifth edition of the California Child Fatality Annual Report which is prepared pursuant to Senate Bill 39 (Migden, Chapter 468, Statutes of 2007) and the Welfare and Institutions Code section 10850.4(j). The report is based on Calendar Years (CYs) 2012 and 2013 child fatality incidents which were determined to be the result of abuse and/or neglect and reported by California county child welfare services (CWS) agencies to the California Department of Social Services (CDSS). The report reflects a state-level analysis of the aggregate data gathered with respect to these incidents, including information about the children and perpetrators involved, major causes and findings associated with these incidents, and the involvement of these families with local CWS agencies at the time of and prior to these incidents.

The following major findings are presented in the report:

- There were 111 child fatalities for CY 2012 and 97 child fatalities for CY 2013 resulting from abuse and/or neglect reported to the Department.
- In addition, in CY 2012 the Department began receiving reports of fatalities that were the result of a third-party homicide. These are not included in the aggregate child fatalities data. There were 24 such reports for CY 2012 and 31 such reports for CY 2013.
- The common victims of child fatalities were children younger than five years old, with the number of male victims being greater than female victims.
- 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 2013. Black children continue to be disproportionately represented as victims of child fatality incidents when compared to other ethnicities and their general representation in the overall child population.
- The primary individuals responsible for these incidents were most often the biological parents, with biological mothers being found responsible more often than biological fathers, and both parents being 30 years of age or younger.
- Over half of the incidents involved children who were from families with prior CWS history within five years of the incidents.
- Neglect was found to be the single most reported allegation type associated with these incidents.
- Blunt force trauma continues to be the leading cause of fatality incidents for both years. In CY 2012 the second leading cause was drowning followed by asphyxiation and Sudden Infant Death Syndrome. For CY 2013 the third leading cause was vehicular negligence/DUI.

The report reflects our continued commitment to providing information and data which will inform our understanding of these tragic incidents and the children and families involved, and the systemic issues and trends which can be addressed at a statewide policy level. It is our hope that through continued dialogue and focus at the state and local community levels, we will be able to develop collective strategies for reducing incidences of child maltreatment deaths and near deaths in the future. Our hope is that members of the public, researchers, policy makers, and others find the information in this report useful in developing solutions aimed at mitigating the incidence of future maltreatment and fatalities. To that end, the report identifies future steps which the CDSS will undertake, which include:

- The Office of Child Abuse Prevention (OCAP) will work closely with the Department of Public Health to ensure that mandated reporter trainings are interactive and strengthen information on sentinel injuries in infants and emphasize the subject of personal biases that could prevent reporting. Updated mandated reporter trainings will be linked on the OCAP website. The OCAP will explore avenues to promote the trainings to law enforcement, social workers and healthcare professionals. Further, the OCAP will obtain an understanding of the requirements for mandated reporter trainings by various professionals and discuss possible policy changes if professionals do not have required periodic mandated reporter training.
- The OCAP will work closely with the Department of Public Health to identify and maximize opportunities to support families with education and services. Specific collaboration will include promotion of one of the two shaken baby syndrome (SBS) programs, The Period of PURPLE Crying or the NY/Dias programs, within hospitals, clinics and doctors' offices. The OCAP and the Department will partner with hospitals regarding dissemination of SBS materials through hospitals. The OCAP will explore implementation science models to assist hospitals implementing evidence-informed SBS parent education programs.
- The OCAP will review and update its existing SBS and Safe to Sleep materials, ensuring materials contain the most current information that is inclusive of resources for parents (i.e. the Childhelp National Child Abuse Prevention Hotline, as well as other hotlines and websites). Brochures will be downloadable and available in multiple languages. The Department will promote educational information available through its website, social media and partnering agencies (i.e. The Essentials for Childhood Initiative, The California Family Resource Association - reaching 800 family resource centers, Child Abuse Prevention Councils, First 5 Commissions and Strategies listserv reaching 14,000 child welfare and prevention partners).
- The OCAP will explore best practice models on leveraging community resources for respite care and develop a toolkit to be shared with county CWS agencies.
- The Department will explore new methodologies and evaluate utilization of predictive risk modeling to aid risk and safety assessments in the years to come.
- The Department will review selected child fatality cases in order to identify any patterns and practices that may lead to inappropriate response determinations.

- The Department will work with counties to clarify best practice, so that all perpetrators are entered in the child welfare services/case management system with an appropriate allegation of abuse or neglect.
- The OCAP will stay abreast of current and emerging practices toward preventing child abuse and neglect fatalities, monitoring a variety of resources including the Centers for Disease Control (CDC), the Commission to Eliminate Child Abuse and Neglect Fatalities, and the California SIDS Advisory Council.
- The OCAP will present the findings of the California Child Fatality Annual Report with the First 5 Commission, The Essentials for Childhood Initiative, and the CDC to discuss how this information affects our respective organizations.
- The Department is exploring how to build upon the work of the CDSS Data Advisory Committee by reviewing aggregate data and case information for victims of child fatalities and near fatalities determined to be the result of abuse and/or neglect. The team will evaluate case data from multiple vantage points to identify antecedent risk factors, recommend practice and policy changes, and discover new opportunities for improved assessment, intervention and prevention of child maltreatment that can lead to death or near death.

This report, as well as prior years' California Annual Child Fatality and Near Fatality Reports, can be found at http://www.childsworld.ca.gov/PG2370.htm. Questions regarding the report should be directed to CSOB@dss.ca.gov or (916) 651-8100.

Sincerely,

WILL LIGHTBOURNE
Director

Enclosure