California Child Fatality Annual Report Calendar Years 2012/2013

Prepared by:
The California Department of Social Services
October 2015

TABLE OF CONTENTS

I. Introduction

Each year the California Department of Social Services (CDSS) analyzes child fatalities to gain a better understanding about the children, families, and circumstances involved in these tragic circumstances and to determine how policy, practice, and prevention efforts may reduce child fatalities.

This report is prepared pursuant to Senate Bill (SB) 39 (Migden, Chapter 468, Statutes of 2007). SB 39 and the Welfare and Institutions Code section 10850.4(j) require a county welfare department or agency to notify the CDSS of every child fatality that occurred within its jurisdiction that was the result of abuse and/or neglect. 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.

This report provides data and analysis of child fatalities which occurred during calendar years (CYs) 2012 and 2013 and were determined by a Child Welfare Services (CWS) agency/probation department, law enforcement, and/or the medical examiner/coroner to be the result of abuse and/or neglect. Detailed analysis adds to an understanding of the types of abuse and neglect cases that are occurring in California, providing a basis for strategies to be developed and services to be coordinated between and among departments within state and local governments, nonprofit agencies, and advocates that will aim to protect children and strengthen families.

Given that over 60 percent of families were known to the CWS system prior to the child fatality, it is clear that intervention practices and supportive services must be evaluated to improve outcomes for children, particularly those under the age of five, who as in years past, are most likely to suffer abuse and neglect. Additional analyses of families who were known to the child welfare system prior to the child fatality is a particular focus of this report.

In implementing the disclosure and reporting mandates of SB 39 and the federal Child Abuse Prevention and Treatment Act, 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. In an effort to analyze and produce more current child fatality data, the CDSS combined its review and analysis of CY 2012 and CY 2013 fatalities.

The CDSS continues to accept SOC 826 forms for incidents that occurred during CYs 2012 and 2013, as well as prior years. While this report is limited to analysis of child fatalities determined to be the result of abuse and/or neglect, the CDSS also reviews and analyzes near fatality incidents and will issue a separate report in early 2016 that provides findings and planned strategies targeted at prevention of near fatal incidents of child abuse and/or neglect.

The CY 2012 and CY 2013 California Annual Child Fatality report, prior years' reports, and child fatality and near fatality current aggregate statewide totals for prior years are available on the CDSS website at: http://www.childsworld.ca.gov/PG2370.htm.

[1] See Attachment B

II. Updates to 2011 Recommendations

Based on the 2011 Child Fatality findings which were published in 2013, the CDSS created goals to target those findings and improve upon current policy, practice, and prevention efforts. An update of the progress that has been made towards each goal is provided below. The CDSS will continue to seek policy, practice, and prevention strategies in order to help reduce child maltreatment that can lead to death or near death.

Risk and Safety Assessment Tools

2011 Goal:

Enhance the Structured Decision Making® System (SDM) (a suite of assessment instruments that promote safety and well-being for those most at risk) tools based upon a recent validity study to improve social workers' estimates of a family's risk of future maltreatment by more effectively targeting service interventions to high risk families. Also, better integrate Child Welfare Services/Case Management Systems (CWS/CMS) and SafeMeasures data into the SDM application which will allow for more accurate safety and risk assessments.

Update:

During the past year, numerous enhancements to SDM have been completed as described on page 41 of this report. Counties are expected to implement the new SDM tools in November 2015.

Best Practices

2011 Goal:

Disseminate data from the Child Fatality/Near Fatality Annual Report to the CDSS network of prevention partners for use in enhancing program delivery efforts and education of community stakeholders.

Update:

The Office of Child Abuse Prevention (OCAP) disseminated the 2011 Child Fatality/Near Fatality Annual Report during April's Child Abuse Prevention Month via a prevention partner listserv that reaches 14,000 child welfare and prevention partners. In addition, by partnering with the California Family Resource Association, the OCAP reached 800 or more family resource centers, child abuse prevention councils, First 5 Commissions and family support organizations.

Case and Practice Review

2011 Goal:

Establish an advisory team to analyze existing child fatality and near fatality data to inform training, policy, practice, and other supportive systems, thereby ensuring continuous quality improvement.

Update:

The CDSS convened a multidisciplinary-interagency Data Advisory Committee, which includes representatives from Children's Data Network, the California Department of Public Health (CDPH), and the California Department of Justice in order to: (1) explore what can inferred from existing data about child fatalities, near fatalities, and maltreatment; (2) what data still is needed to create an accurate picture of the risk factors associated with these incidents, including sources of such; (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 Committee examined how different agencies define maltreatment and what existing data sources may be available to provide a better understanding of risk factors and circumstances of these incidents to provide recommendations for prevention activities.

2011 Goal:

Conduct additional data analysis of child fatality/near fatality incidents involving families with prior CWS agency involvement to assess what additional trends may be evident.

Update:

The CYs 2012 and 2013 California Child Fatality Annual Report contains more in-depth analysis of the level of involvement children and their families had with the CWS system within one year of the fatality incident, including cases and/or referrals that were open to a CWS agency at the time of death. The data primarily focuses on those families who had a prior referral investigated within six months of the fatality. The analysis includes type of CWS involvement; CWS agency contact with families and individuals associated with the family; whether the victim and/or the individual responsible of the subsequent fatality were involved; services provided to families; safety and risk assessment information; and whether the families' involvement was similar to the circumstances which resulted in a child's death.

Partnerships

2011 Goal:

Explore and develop partnerships with hospitals to implement new parent education programs designed to prevent shaken baby syndrome (SBS). This program will be based upon current best practice models.

Update:

The OCAP hosted a hospital focus group meeting in February 2015 to identify current practices in parent education about SBS and to obtain feedback on ways OCAP can support hospitals in providing SBS parent education. From the feedback received, the conclusion was that while some hospitals provide parent education on SBS, the approach varied. Further, some resources being utilized were outdated, and hospitals would welcome information to guide their SBS parent education.

Physical Abuse Prevention

2011 Goal

Continue to provide SBS awareness literature to the general population and to organizations.

Update:

The SBS brochure can be downloaded by the general population, hospitals, and community organizations via the OCAP website at http://www.ccld.ca.gov/PG550.htm. The OCAP is updating existing materials, researching current studies, trends, and programs, and will make the brochure and materials available in additional languages.

2011 Goal:

Explore the feasibility of utilizing existing abuse and parental support crisis hotlines and expanding public education and awareness regarding this resource.

Update:

With feedback from the hospital focus group meeting held in February 2015 and research of Centers for Disease Control and Prevention (CDC)-funded, evidence-based SBS parent education, the OCAP determined it would promote the Childhelp National Child Abuse prevention toll-free hotline 1-800-4-A-CHILD.

III. Summary of Reported Child Fatality Incidents by Calendar Year

Summary of All Years

Table 1 below offers a summary of reported child fatalities resulting from abuse and/or neglect submitted to the CDSS as of May 1, 2015. Preliminary data is also provided for CY 2014 since counties are still making determinations and reporting incidents for fatalities occurring during CY 2014. The CDSS has postponed analyzing the CY 2014 incidents to ensure that the analysis incorporates all of the incidents reported for any given CY. Updated information for CY 2014 data will be provided in subsequent years' reports.

Table 1. Fatalities by Year[2]

	Type of Placement	CY 2008	CY 2009	CY 2010	CY 2011	CY 2012[3]	CY 2013	CY 2014
Fatalities	In-Home	113	118	127	117	109	97	88
	Out-of-Home	6	5	4	2	2[4]	0	0
Total		**119**	**123**	**131**	**119**	**111**	**97**	**88**

[2] SOC 826 forms received from counties as of May 1, 2015.
[3] CY 2012 is the first year following implementation of SB 39 that some counties began reporting third-party homicides as fatalities on the SOC 826 forms. There were 24 such fatalities for CY 2012 with all children residing in the home of their parent or guardian. There were 31 such fatalities for CY 2013 of which three children were in out-of-home foster care placement.
[4] One fatality was not categorized as a third-party homicide as it was determined that there was contributory neglect on the part of the caregiver. The Primary Individual Responsible is unknown.

IV. Methodology for Analysis of CY 2012 and 2013 Data

Background

This report provides an understanding of a number of data elements relating to those child fatalities resulting from abuse and/or neglect during CYs 2012 and 2013. The CDSS conducted a more in-depth analysis of the level of involvement these children and their families had with a CWS agency within one year prior to the fatality incident, including cases and/or referrals that were open to a CWS agency at the time of death. Specifically this report will provide:

- Identification of the number of child fatalities that were caused by abuse and neglect.
- Whether there was prior CWS involvement with these children and their families within five years prior to the fatality and beyond the five-year period.
- What was known about CWS involvement at the time of the fatality incident and at one year prior to the fatality.
- Identification of the age and gender groups for both the individuals responsible and for the victims of child fatalities resulting from abuse and/or neglect.
- Identification of the relationship of the victim to the individuals responsible for the fatality.
- The causes of the child fatalities as documented by the CWS agencies.
- What is known about child fatalities that were reported to a CWS agency but not investigated.

Methodology

The information in this report for child fatalities was gathered from notices (SOC 826 forms) submitted to the CDSS by counties for those child fatality incidents that occurred within each county's jurisdiction.

The CDSS staff gathered additional information for each of the reported child fatality incidents from the CWS/CMS, SafeMeasures (a quality-assurance tool used to analyze CWS/CMS case information), and SDM (a suite of assessment instruments that promote safety and well-being for those most at risk) in an effort to gain a broader understanding of the reported incidents and the children and families involved. The CDSS staff consulted with individual counties on data elements which may have been identified at first as unknown or undetermined in CWS/CMS in an effort to gather more current information on the causes and individuals responsible for such incidents. In some cases, the CDSS was able to identify more specific data, and in others, the data remained unknown or undetermined even after additional consultation. All information collected for each incident is compiled in the aggregate and analyzed for statewide patterns and trends.

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 same reporting year.

Data reported by counties that were determined to be third-party homicides is excluded from this report.

V. Analysis of Fatalities

General Information

For CY 2012, county CWS agencies reported a total of 111 child fatalities determined to be the result of abuse and/or neglect, with 109 children residing in the home of their parent or guardian and two children residing in an out-of-home foster care placement. Both of the foster care placements were relative/nonrelative extended family member (NREFM) homes.

For CY 2013, county CWS agencies reported 97 child fatalities determined to be the result of abuse and/or neglect, with 97 children residing in the home of their parent or guardian. CYs 2012 and 2013 reflect a downward trend in the number of child fatality incidents decreasing from 131 fatalities in CY 2010 to 97 fatalities in CY 2013, which is a 26 percent decrease.

Fatalities Incidents not Investigated by a CWS Agency

A CWS agency may, in some instances, elect not to investigate a report alleging abuse or neglect. When reports are called into the child abuse hotline that do not appear to meet the statutory definition of abuse or neglect to conduct an in-person investigation, the reports are not investigated. In reviewing the 111 child fatality incidents reported for CY 2012, 27 of the referrals were not investigated. For CY 2013, 13 out of the 97 child fatalities were not investigated. More than 60 percent of child fatalities for CYs 2012 and 2013 that were not investigated involved allegations of abuse and were not investigated as there were no other siblings left in the home in need of protection by the CWS agency (Table 2).

Table 2. Reason for Fatality Incidents not Investigated by a CWS Agency

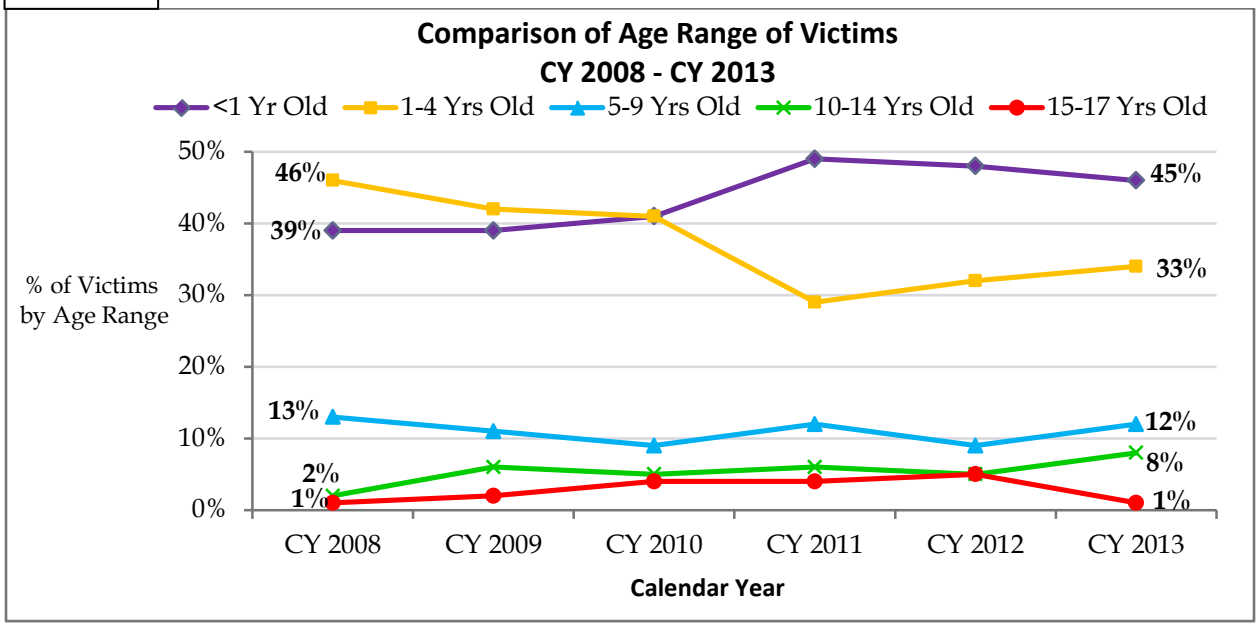
Reason	CY 2011	CY 2012	CY 2013
No siblings in the home	15	20	8
Victim and family deceased	7	3	4
Law Enforcement investigation	3	2	0
Does not meet criteria for CWS Intervention	0	1	1
Identity of victim and family unknown	0	1	0
Not Documented in CWS/CMS	1	0	0
Total	**26**	**27**	**13**

Child Demographic Information

The ethnicity, gender, and age of the victims of child fatalities gathered for CYs 2012 and 2013 is consistent with the data collected in CYs 2008 through 2011. The most vulnerable population for child fatality remains Hispanic male children under the age of five.

This information is consistent with the federal Child Maltreatment 2013 report[5], which includes an analysis of all 50 states' child maltreatment data. The report finds that 73.9 percent of all child fatalities reported involved children younger than three years of age, with male children having a higher fatality rate when compared to female children.

Chart A



As illustrated in Table 3, further analysis of victims under the age of one year shows that since CY 2011, the infant population most at risk is children between the ages of zero to three months. Research[6] refers to this age range as the period of PURPLE[7] crying, where each letter in the word "PURPLE" denotes a characteristic of the crying as typical in a normal developmental stage that starts two to three weeks after birth and lasts for three to four months. Parents frustrated by the crying and a perceived inability to meet the newborns' needs may benefit from early intervention and support services, such as respite care.

[5] U.S. Department of Health and Human Services, Administrations for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). *Child Maltreatment 2013.* Washington, D.C.
[6] Health Day (November 2014), Head Trauma in Abused Babies, Toddlers Can Have Lifelong Impact
[7] PURPLE stands for: peaking in their second month, unexpected, resists soothing, plain-like face, long-lasting and occurring in the evening.

Table 3. Victims under the Age of One

	CY 2011 (n=58)		CY 2012 (n=56)		CY 2013 (n=45)	
Victim <1 Age Group	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Newborn to 3 months	13	18	18	14	8	14
4 months to 6 months	3	7	2	8	2	6
7 months to 11 months	6	11	5	9	9	6
Total	**22**	**36**	**25**	**31**	**19**	**26**

Ethnicity/Race

While Hispanic children comprised the largest number of reported fatalities, they also comprised the largest single ethnicity/race in California's overall child population during CYs 2012 and 2013. The data has shown over the prior years' reports that Black children are disproportionately represented when compared to other ethnicities and their general representation in overall child population (See Attachment A). These are continuing trends for both Hispanic and Black children.

Primary Individual Responsible (PIR) for the Fatality Incidents

When analyzing child fatalities and addressing the issues surrounding these sensitive incidents, it is important to understand who was identified as being responsible for the abuse and/or neglect that resulted in the child's fatality. The CDSS revised its methodology in the CY 2010 report for collecting this data to better distinguish between the PIR for these fatality incidents and secondary individuals (SIR) who did not commit the acts which resulted in the fatality. More information on the SIR is in the following section. If, at the time of the fatality, more than one individual had access to the child, the individual responsible for the fatality might not be identified. This data includes additional analysis of fatality incidents in which more than one individual was identified as being responsible for the fatality.

Relationship between the Child and the PIR for the Fatality

Findings from CY 2010 and forward show that parents are most frequently responsible for inflicting the injury or negligence resulting in the child fatalities. For both CYs 2012 and 2013, biological mothers were more frequently responsible for fatality incidents, followed by biological fathers, and then by biological parents together (See Table 4). These findings are consistent with the findings from the federal Child Maltreatment 2013[8] report which found that "four-fifths (78.9 percent) of child fatalities were caused by one or more parents or with another individual."

When analyzing the role of biological mothers' significant others, in CY 2012 there were six fatality incidents in which the biological mother's significant other was identified as the PIR for the child's death. In CY 2013, there was an increase, with ten fatality incidents which identified the biological mother's significant other as the PIR.

[8] U.S. Department of Health and Human Services, Administrations for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). *Child Maltreatment 2013.* Washington, D.C.

The CDSS consulted with county CWS agencies in order to accurately identify the individual(s) responsible for the child fatality in which the PIR was unknown. For CY 2012 in seven of the 111 child fatality incidents (six percent) and for CY 2013, in two of the 97 child fatality incidents (two percent), the PIR remains unidentified.

Table 4. Primary Individuals Responsible CY 2012 and CY 2013

Primary Individual(s) Responsible for the Fatality	CY 2012		CY 2013	
	Count	Percent	Count	Percent
Bio Mother	41	37	29	30
Bio Father	24	22	24	25
Bio Parents	18	16	12	12
Other[9]	9	8	10	10
Bio Mother's Significant Other (M)	6	5	10	10
Bio Mother & her Significant Other (M)	1	1	6	6
Bio Mother & Bio Father's Significant Other (F)	1	1	-	-
Bio Mother & Step Parent (M)	1	1	-	-
Step Parent (M)	1	1	2	2
Bio Father & his Significant Other (F)	1	1	-	-
Unknown	7	6	2	-
Foster Care Provider	1	1	-	-
Adoptive Mother	-	-	2	2
Total	**111**	**100**	**97**	**100**

[9] See Table 5 and Table 6 for description of PIR listed as Other.

Tables 5 and 6 describe the PIR for the fatalities listed as "Other."

Table 5. Other PIR CY 2012

Other Primary Individual(s) Responsible for the Fatality – CY 2012	Number
Related Adult (F)	1
Related Adult (M)	2
Unrelated Minor (M)	1
Unrelated Adult (F)	4
Unrelated Adult (M)	1
Total	**9**

Table 6. Other PIR CY 2013

Other Primary Individual(s) Responsible for the Fatality – CY 2013	Number
Related Minor	2
Related Adult (M)	1
Related Adult (F)	1
Unrelated Adult (F)	2
Unrelated Adult (M)	4
Total	**10**

Age of the PIRs for Fatality by Victim's Age

For CY 2012 there were 102 incidents involving 124[10] individuals in which the age of the PIR was known. For CY 2013 there were 93 incidents involving 111 individuals in which the age of the PIR was known.[11] The trend of the PIR age by victim's age has remained consistent from CY 2010 forward, with the PIR primarily being 30 years of age or younger. 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)[12] 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."

Allegation Type for PIRs

Since CY 2008, neglect has been the most frequent maltreatment type associated to PIRs for child fatalities in California. This frequency has increased steadily, and peaked (at 55 percent) in CY 2012. This is consistent with data presented in the federal Child Maltreatment 2013[13] report which also found that nationally the highest maltreatment type suffered by the children in child fatalities was neglect. 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)/or guardian(s) failure to provide care and protection. Additionally, a combined allegation such as abuse and neglect may occur when there are two individuals responsible for the fatality.

[10] Of the 102 fatality incidents where the age of the PIR was known, excluding seven unknown PIR and two related adults whose age was not documented, there were 22 incidents where two individuals were identified as the PIR for the fatality making a total of 124 individuals.
[11] Of the 93 fatality incidents where the age of the PIR was known, excluding two unknown PIR and two biological fathers whose age was not documented, there were 18 incidents where two individuals were identified as the PIR for the fatality making a total of 111 individuals.
[12] 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.
[13] USDHHS, 2013.

Summary of PIR

In summary, when reviewing who was identified as the PIR for child fatalities reported for CYs 2012 and 2013, biological parents either individually or together consistently have been the primary individuals responsible for child fatalities. For children less than one year old, more biological mothers acting alone were identified as the PIR for the fatality incidents. The age of the PIR for CYs 2012 and 2013 was primarily 30 years of age or younger.

Secondary Individuals Responsible for the Fatality Incidents

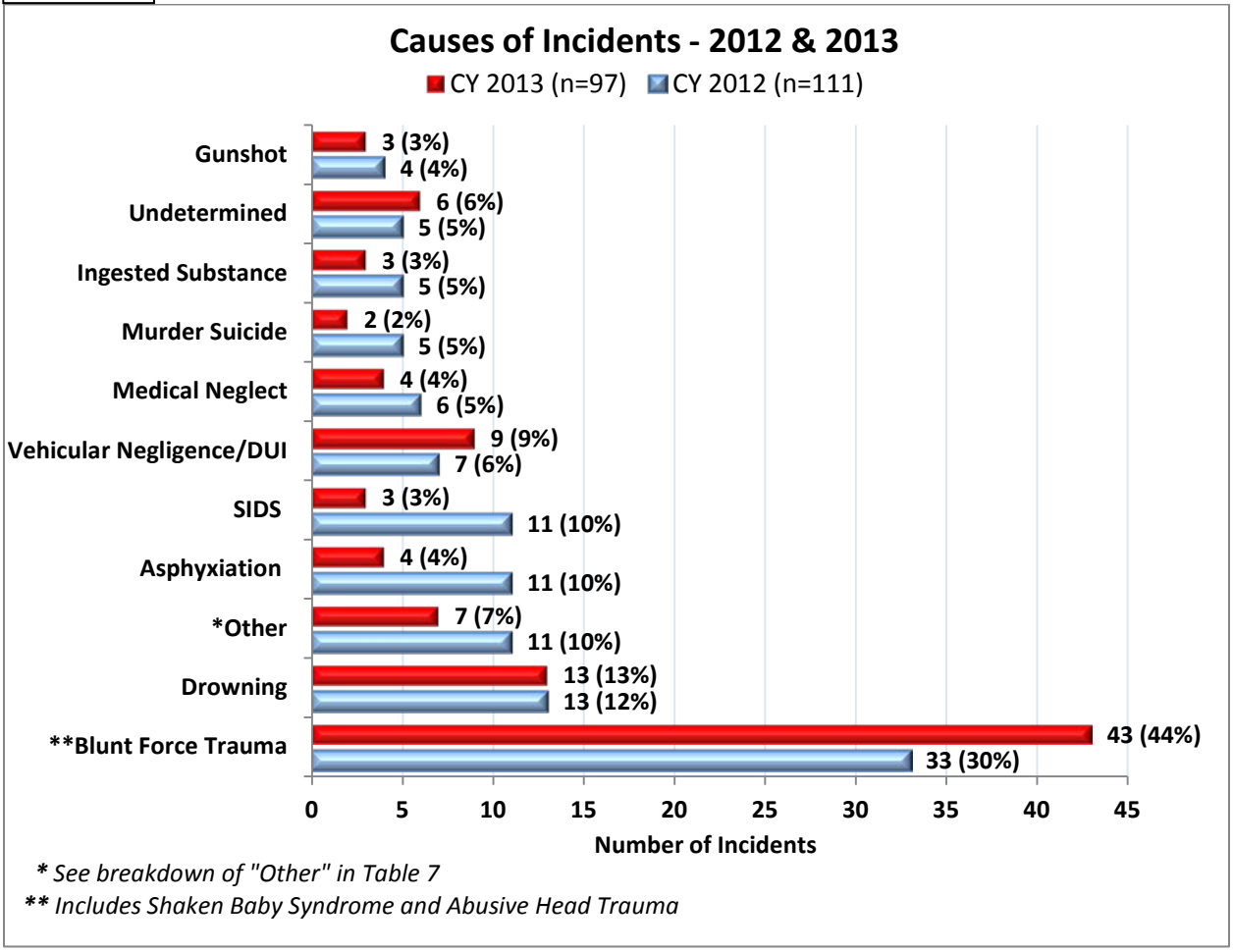
Since CY 2011, the CDSS has been gathering information regarding other individuals who did not commit the act that caused the child fatality but were identified by a CWS agency as a party to the abuse and/or neglect that resulted in the child fatality. These individuals may be the person who failed to protect the victim from the individual who committed the abuse and/or neglect which killed the child. For CYs 2012 and 2013, there were 27 incidents in each CY in which there was an individual identified as a SIR. There were more biological mothers alone identified as the SIR, followed by biological fathers alone. In addition, the SIR was identified as being most often 30 years of age or younger, which is consistent with the PIR group.
The data shows that where a SIR was identified, neglect was associated with the child fatality more often than any other allegation type. 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 child from the PIR, the individual who commited the act that caused the fatality.

Calendar Year 2012 and Calendar Year 2013 - Cause/Finding of Incidents

The causes or findings identified by CWS agencies for the 111 child fatalities reported in CY 2012 and the 97 child fatalities reported in CY 2013 that were determined to be the result of abuse and/or neglect are categorized in Chart B. Review of these incidents reveal that blunt force trauma consistently has been the leading cause of child fatalities. For CY 2012 the next leading causes were drowning, asphyxiation, and SIDS. For CY 2013 the leading causes remained the same with the exception of the third leading cause which was vehicular negligence/DUI. In 2009, the American Academy of Pediatrics reclassified the term “shaken baby syndrome” as abusive head trauma, which allows for consideration of multiple mechanisms of head injury in any child through abuse, including, but not limited to, violent shaking.[14] Fatalities in which the cause was SBS or abusive head trauma have been categorized as blunt force trauma in this report. The murder suicides for both CYs 2012 and 2013 were a result of gunshots.

[14] Christian, Cindy, V Jordan Greenbaum. “Child Abuse: Epidemiology, Mechanism, and Types of Abusive Head Trauma in Infants and Children.” 2015. Print.

Chart B



** See breakdown of "Other" in Table 7*

*** Includes Shaken Baby Syndrome and Abusive Head Trauma*

Table 7. Description of Fatality Causes classified as "Other"

Calendar Year	Other Causes
2012 (n=11)	Stabbing (3), Maternal Drug Use (3), Malnourishment & Ingested Substance (1), Medical Neglect & Blunt Force Trauma (1), Malnourishment (1), Burns (1), Illegal Drug Overdose (1)
2013 (n=7)	Stabbing (1), Co-Sleeping (1), Drug Intoxication (1), Hyperthermia (1), Malnourishment (1), SIDS & Malnourishment (1), Perinatal Asphyxia & Blunt Force Trauma (1)

Causes Compared to the Allegation Types of the PIR

Table 8 provides a detailed distribution of the causes of child fatalities and the allegation type that was associated with the incident. The data continues to show that the allegation type most associated with child fatalities is neglect, a finding that has remained consistent throughout the prior years.

The CWS agencies continue to make the highest number of determinations that the child's death was the result of abuse and/or neglect. The CWS agencies may be more likely than other entities to be the determiner of these incidents due to the agencies' responsibility to protect the safety of surviving siblings and the timeline associated with those investigations.

For CY 2012, of the 111 fatalities incidents, 30 percent were caused by blunt force trauma, with an increase to 40 percent for CY 2013. Research[15] indicates that each year 80 children die from abusive head trauma and are among the 1,500 children who die from abuse or neglect in the U.S. annually. Most of the acts of blunt force trauma involved referrals that were associated with allegations of abuse or combined allegations of abuse and neglect. Blunt force trauma incidents that included neglect allegations may be attributed to: the caretaker(s) denial of causing the injury (no confession at the time of investigation); the explanation of how the injury occurred is inconsistent with the injury itself; failure to provide an explanation of the injury during the CWS investigation; failure to seek immediate medical care for the injury or illness; the autopsy report completed months after the CWS investigation showed abuse was the cause of the fatality; or the PIR is unknown.

For CYs 2012 and 2013, there were 13 fatality incidents caused by drowning per year. The allegation associated with these incidents was neglect. Analysis shows that the drowning incidents were more frequently due to lack of supervision by the caretaker(s). There were three incidents per year that were due to intentional drowning by the caretaker(s).

For CY 2012, the third leading causes, asphyxiation and SIDS, were primarily sleep related. Combining the incidents caused by SIDS and asphyxiation increases the number of fatalities in this category, making sleep related incidents the second leading cause. There were 11 fatality incidents caused by asphyxiation that were primarily associated with neglect due to the caretaker(s) being under the influence of alcohol and/or drugs. Asphyxiation incidents that were associated with abuse allegations were based on the caretaker(s) strangulating and/or physically suffocating the victim.

All 11 fatality incidents caused by SIDS were associated with allegations of neglect. The contributing factors to the neglect findings were: unsafe home environment; the caretaker being under the influence of drugs and/or alcohol; and co-sleeping. The American Academy of Pediatrics[16] has expanded recommendations regarding SIDS with a broader focus on a safe sleeping environment which can reduce the risk of sleep related infant deaths. The safe sleeping environment includes: supine positioning; use of a firm sleep surface; breastfeeding; room-sharing without bed-sharing; routine immunizations; consideration of using a pacifier; avoidance of soft bedding; overheating; and exposure to tobacco smoke, alcohol, and illicit drugs.

[15] Haelle, Tara. "Doctors a Better Way to Diagnose Shaken Baby Syndrome" 2015. Print.
[16] "SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendation for a Safe Infant Sleeping Environment." American Academy of Pediatrics, 2011. Vol. 128 No. 5. 1030-1039. Print.

For CY 2013, the third leading cause was vehicular negligence/DUI. All nine fatalities caused by vehicular negligence/DUI were associated with allegations of neglect. Findings of vehicular negligence were primarily due to failure to use safety restraints, reckless driving, and the child being left in the vehicle for a length of time. For fatalities due to vehicular DUI incidents, the individuals responsible were under the influence of alcohol and/or drugs. Two of the nine incidents involved both negligence and DUI due to not using a car seat and driving under the influence.

Table 8. Causes Compared to Allegation Type of PIR

Causes	Abuse		Neglect		Abuse & Neglect		Other[17]		Total	
	CY 2012	CY 2013	CY 2012	CY 2013	CY 2012	CY 2013	CY 2012	CY 2013	**CY 2012**	**CY 2013**
Blunt Force Trauma	14	26	6	6	12	11	1	-	33	43
Drowning	2	1	10	11	1	1	-	-	13	13
Asphyxiation	4	1	5	3	1	-	1	-	11	4
SIDS	-	-	11	3	-	-	-	-	11	3
Vehicular Negligence/DUI	-	-	6	9	-	-	1	-	7	9
Medical Neglect	-	-	6	4	-	-	-	-	6	4
Murder Suicide	5	-	-	-	-	-	-	-	5	-
Ingested Substance	-	-	5	3	-	-		-	5	3
Undetermined	-	1	3	4	1	-	1	1	5	6
Gunshot	1	5	2	-	1	-	-	-	4	5
Other	3	1	7	4	1	2	-	-	11	7
Total	**29**	**35**	**61**	**47**	**17**	**14**	**4**	**1**	**111**	**97**

[17] For CY 2012, "other" category represents those incidents with a combination of more than one allegations abuse, neglect, caretaker absence/incapacity. For CY 2013, "undetermined" category represents those incidents in which the cause of fatality was documented in CWS/CMS as "undetermined."

As illustrated in Table 9 below, 92 out of 111 child fatalities (83 percent) for CY 2012 and 78 out of 97 child fatalities (80 percent) for CY 2013 involved victims under the age of five and were most frequently caused by blunt force trauma. A study by Haelle (2015)[18] found that more than a half million U.S. children suffer abuse each year, including approximately 30 cases of abusive head trauma among every 100,000 infants. Fatalities for children under the age of one were most frequently associated with blunt force trauma and SIDS, primarily involving newborns to infants three months of age and younger (See Table 10 & 11). Children ten years and older were most frequently associated with fatalities caused by vehicular negligence/DUI, murder suicide and gun shot. Sleep related causes of death, which included SIDS (3 percent) and asphyxiation (4 percent), decreased from CY 2012.

Table 9. 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			
	CY 2012	CY 2013	CY 2012	CY 2013	CY 2012	CY 2013	CY 2012	CY 2013	CY 2012	CY 2013	**CY 2012**	**CY 2013**
Blunt Force Trauma	18	19	14	20	1	3	-	1	-	-	**33**	**43**
Drowning	4	5	5	5	4	3	-	-	-	-	**13**	**13**
Asphyxiation	9	2	2	1	-	-	-	1	-	-	**11**	**4**
SIDS	11	3	-	-	-	-	-	-	-	-	**11**	**3**
Vehicular Negligence/DUI	-	2	3	2	2	2	2	3	-	-	**7**	**9**
Medical Neglect	3	1	2	2	1	-	-	1	-	-	**6**	**4**
Murder Suicide	-	-	2	-	-	-	1	-	2	-	**5**	**-**
Ingested Substance	4	1	1	1	-	1	-	-	-	-	**5**	**4**
Undetermined	3	5	2	1	-	-	-	-	-	-	**5**	**6**
Gunshot	-	-	-	-	1	3	2	1	1	1	**4**	**5**
Other	4	6	5	-	1	-	1	1	-	-	**11**	**7**
Total	**56**	**45**	**36**	**33**	**10**	**12**	**6**	**8**	**3**	**1**	**111**	**97**

[18] Haelle, Tara. "Doctors Devise a Better Way to Diagnose Shaken Baby Syndrome." 2015. Print

Table 10: Causes of Fatality for Victims under One Year Old

Causes CY 2012	Age of Victims Under One Year Old												
	Newborn	1 Month	2 Months	3 Months	4 Months	5 Months	6 Months	7 Months	8 Months	9 Months	10 Months	11 Months	Total
Blunt Force Trauma	1	4	3	2	-	2	2	1	2	-	-	1	**18**
SIDS	2	-	4	2	1	-	-	-	-	1	1	-	**11**
Asphyxiation	1	1	-	2	-	2	-	3	-	-	-	-	**9**
Drowning	-	-	1	-	-	-	-	1	1	-	1	-	**4**
Ingested Substance	-	1	-	-	1	1	-	1	-	-	-	-	**4**
Medical Neglect	1	-	-	1	-	-	-	-	-	-	1	-	**3**
Maternal Drug Use	3	-	-	-	-	-	-	-	-	-	-	-	**3**
Undetermined	2	-	-	-	1	-	-	-	-	-	-	-	**3**
Burns	-	1	-	-	-	-	-	-	-	-	-	-	**1**
Total	**10**	**7**	**8**	**7**	**3**	**5**	**2**	**6**	**3**	**1**	**3**	**1**	**56**

Table 11. Causes of Fatality for Victims under One Year Old

Causes CY 2013	Age of Victims Under One Year Old												
	Newborn	1 Month	2 Months	3 Months	4 Months	5 Months	6 Months	7 Months	8 Months	9 Months	10 Months	11 months	Total
Blunt Force Trauma	1	3	3	1	2	1	3	2	-	1	2	-	**19**
Drowning	-	-	-	-	-	-	-	-	3	1	1	-	**5**
Undetermined	1	1	1	-	-	-	-	-	1	1	-	-	**5**
SIDS	1	-	2	-	-	-	-	-	-	-	-	-	**3**
Vehicular Negligence /DUI	-	-	1	-	-	1	-	-	-	-	-	-	**2**
Asphyxiation	-	1	1	-	-	-	-	-	-	-	-	-	**2**
Medical Neglect	-	1	-	-	-	-	-	-	-	-	-	-	**1**
Ingested Substance	-	-	-	-	-	-	-	-	-	-	1	-	**1**
Other	2	1	-	1	1	-	-	-	-	-	-	1	**6**
Total	**5**	**7**	**8**	**2**	**3**	**2**	**3**	**2**	**4**	**3**	**4**	**1**	**44**

Calendar Year 2012 and Calendar Year 2013 - CWS Involvement within Five Years Prior to Fatality Incident

The analysis which follows examines the level of involvement the family of a child fatality victim had with the CWS agency within five years prior to the incident.

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.

As shown in Chart C, out of 111 fatality incidents reported for CY 2012, 64 incidents (58 percent) involved children from families who were previously known to a CWS agency in the five years prior to the fatality incident, and the remaining 47 incidents (42 percent) involved children from families who had no CWS history in the five years prior to the incident. The CDSS conducted further analysis of the 47 incidents without CWS involvement in the five years prior to the fatality incident to determine whether any of these families had ever been known to a CWS agency at all. This additional analysis revealed that 16 of the 47 incidents (34 percent) involved children from families with CWS history beyond the five year period prior of the fatality, of which nine incidents involved children from families with parents who were involved with CWS as minors themselves but had no CWS history as adults.

As shown in Chart C, out of 97 fatality incidents reported for CY 2013, 57 incidents (59 percent) involved children from families who were previously known to a CWS agency in the five years prior to the fatality incident, and the remaining 40 incidents (41 percent) involved children from families who had no CWS history in the five years prior to the incident. The CDSS conducted further analysis of the 40 incidents without CWS involvement in the five years prior to the fatality incident to determine whether any of these had ever been known to a CWS agency at all. This additional analysis revealed that 14 of the 40 incidents (35 percent) involved children from families who had CWS history beyond the five year period prior to the fatality, of which five incidents involved children from families with parents who were involved with CWS as minors themselves but had no CWS history as adults. Chart D depicts findings of a family's involvement with a CWS agency since CY 2008.

Chart C

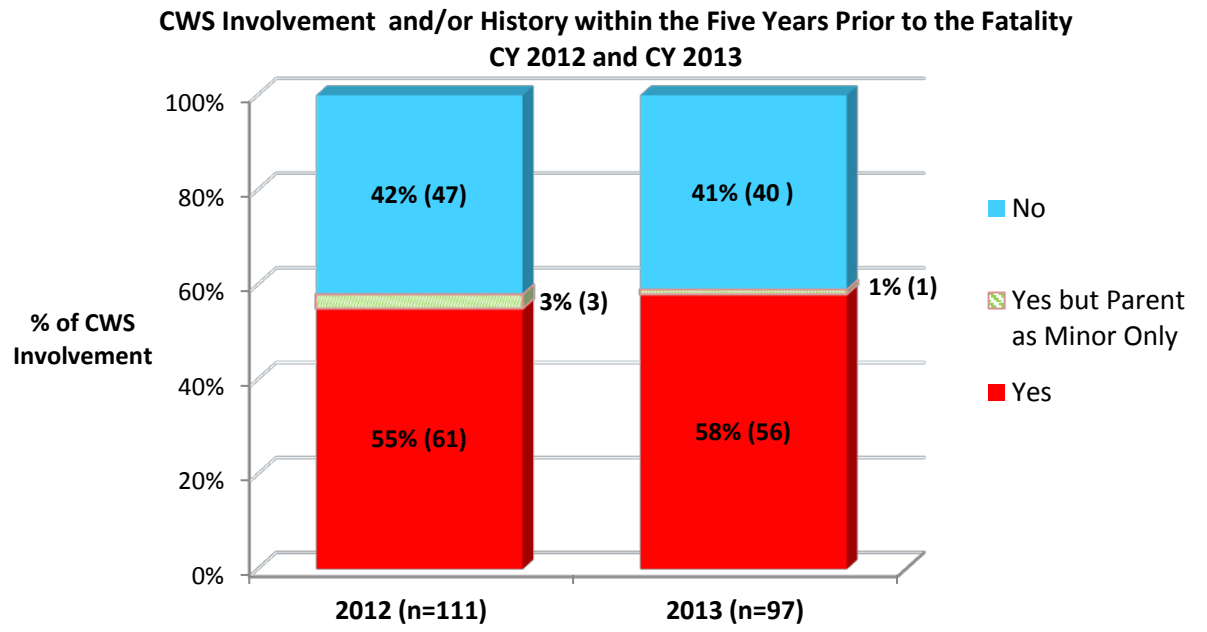
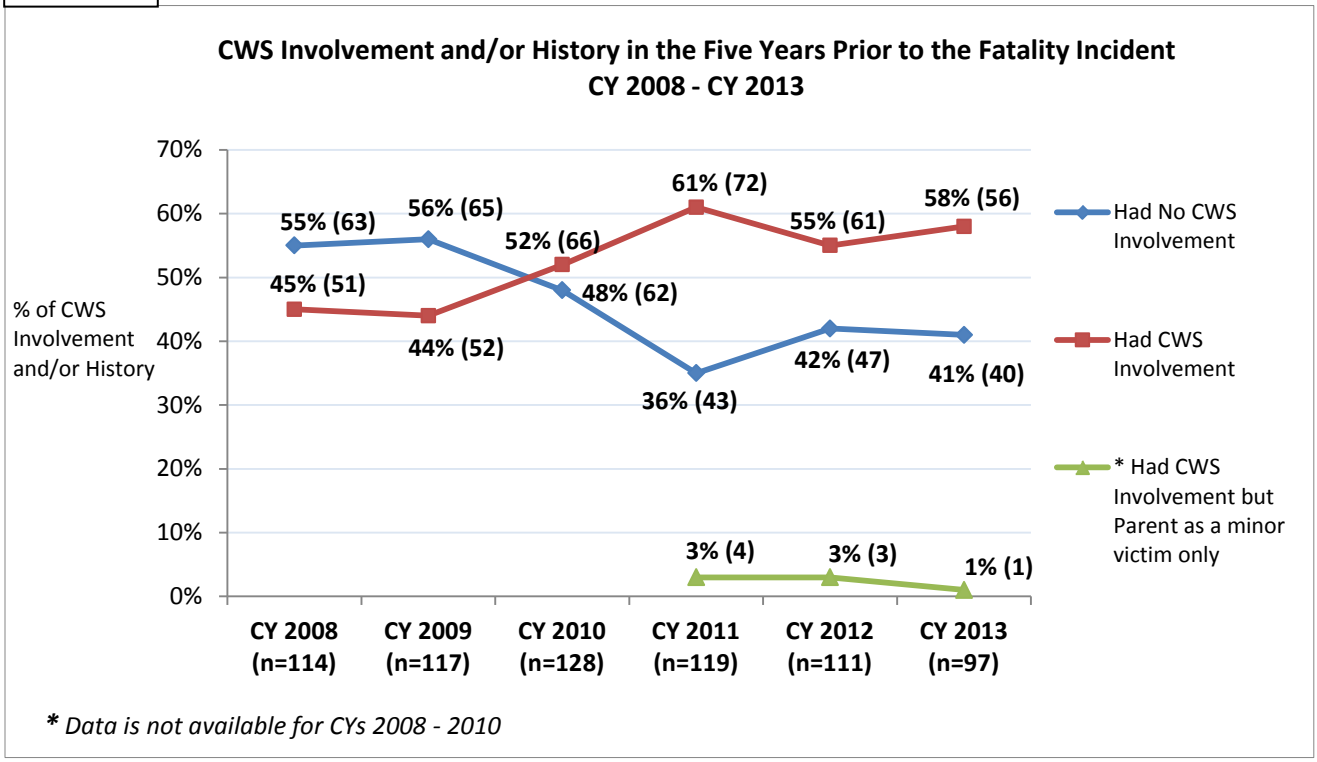


Chart D



** Data is not available for CYs 2008 - 2010*

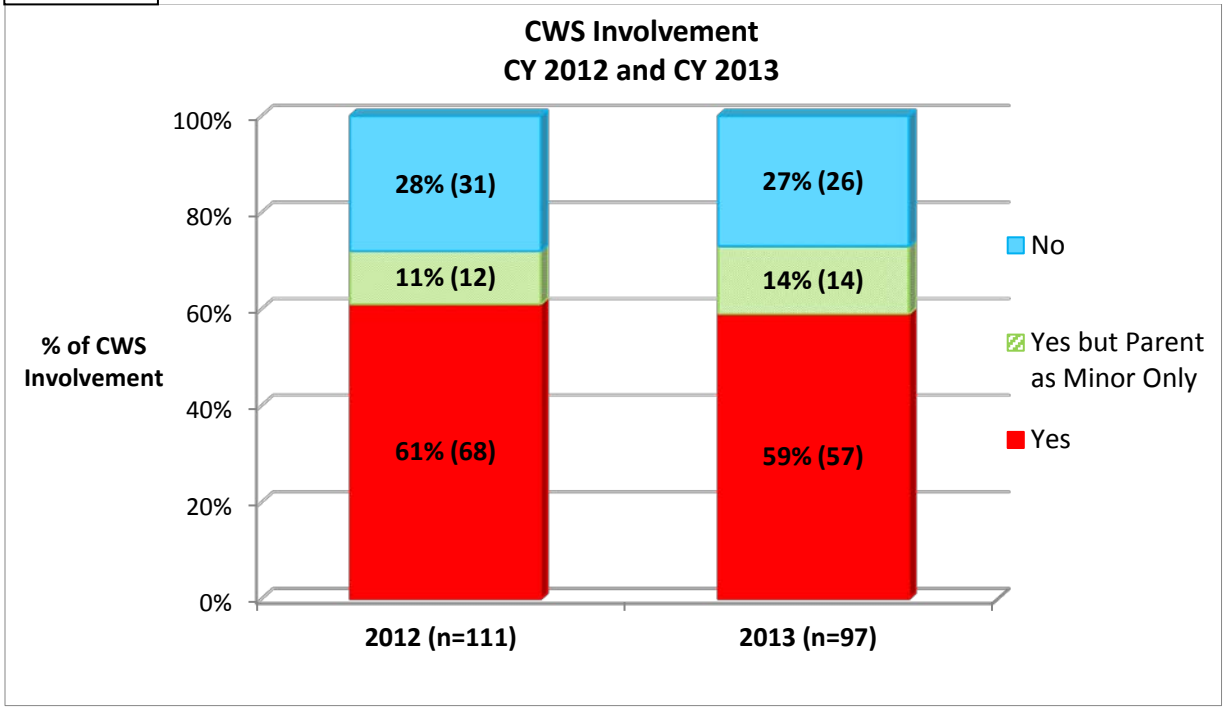
Child Welfare Services Involvement in the Five Years Prior to the Fatality Incident and Beyond Five Years

For CY 2012, there were 64 incidents which involved children from families that had CWS involvement in the five years prior to the fatality incident. This includes three incidents that involved children from families with parents who were involved with CWS as minors themselves but had no CWS history as adults. In addition to a family's involvement within five years, the CDSS conducted further analysis to determine if these families were also known to a CWS agency beyond the five year period and found that 25 of the 64 incidents had history beyond the five year period prior to the fatality. The CDSS data and findings are consistent with the Children's Data Network study which found that "60 percent of infants in California who were reported to CWS for maltreatment were re-reported to CWS for suspected abuse or neglect within five years."[19] Additionally, families involved in 80 of the 111 fatality incidents had some type of CWS involvement regardless of time period, and of these 80 incidents, 12 incidents involved parents who had history with a CWS agency as a minor victim (See Chart E). Various research also indicates that about one-third of child abuse victims go on to become abusers as adults, a finding that supports the need for awareness and support for abuse victims.

For CY 2013, there were 57 incidents which involved children from families that had CWS involvement in the five years prior to the fatality incident, including one incident which involves children from a family with parents who were involved with CWS as minors themselves but had no CWS history as adults. The CDSS conducted further analysis of these incidents that involved children from families with CWS involvement and found that 19 incidents (33 percent) involved children from families that had CWS history in five year as well as beyond the five year period prior to the fatality. Regardless of the time period in 71 out of 97 fatality incidents, the family had some level of involvement with a CWS agency, 14 incidents involving minors (See Chart E).

[19] Palacios, Jania. "Infants in California Remain at High Risk for Maltreatment" (2015) Print.

Chart E



Child Welfare Services Referral History in Five Years Prior to the Fatality Incident

The following sections provide an analysis of the prior Emergency Response (ER) referrals for the 61 incidents for CY 2012 and 56 incidents for CY 2013 depicted in Chart C that involved children from families who had Emergency Room (ER)referrals generated during the five years prior to the 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.[20] As such, it is important to recognize that the existence of a referral does not necessarily mean that the allegation generating a referral was substantiated or found to be true. The referral may have not been investigated by a CWS agency if it did not meet the criteria for investigation by the CWS agency. If investigated, the disposition for the referral may have been unfounded, inconclusive, or substantiated.

Secondly, a prior CWS referral involving these families may not have included the child who died in 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 fatality. These families' histories with the CWS agency may offer some insight into future policy and prevention strategies.

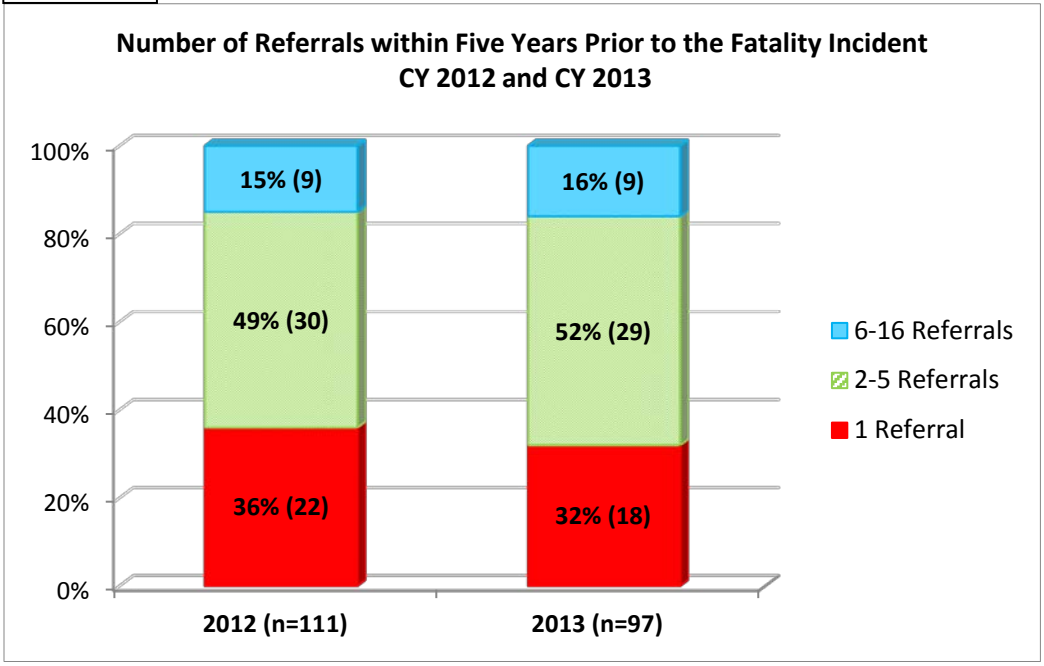
[20] CDSS Manual of Policies and Procedures (MPP) Division 31-101 states, "the county shall respond to all referrals for service which allege that a child is endangered by abuse, neglect, or exploitation." MPP sections 31-105, 31-110, 31-115, 31-120, and 31-125 detail the decision process to respond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

Number of CWS Referrals Generated within Five Years of the Fatality Incident

For CY 2012, 39 incidents involving families with prior CWS referral history had two or more referrals made to a CWS agency prior to the fatality, and over a third of incidents involved families who had only one referral generated within five years prior to the fatality incident.

For CY 2013, 38 incidents involving families with prior CWS referral history had two or more referrals made to a CWS agency prior to the fatality, and over a third of incidents involved families who had only one referral generated. (See Chart F)

Chart F



Prior CWS Referral Timeframe

Chart G depicts the timeframe for the most recent ER referral that was generated for suspected child abuse and/or neglect for the 61 incidents in CY 2012 and the 56 incidents in CY 2013 that involve children from families with prior CWS referral history within five years. The majority of the most recent ER referrals were generated within six months prior to the fatality. The remaining incidents were spread over a time period of up to five years. The timeframe of the most recent ER referral remains consistent since CY 2010 with referrals most frequently being generated between zero to six months. Chart H depicts findings of the timeframe of the prior referrals within five years prior to the fatality since CY 2008.

Chart G

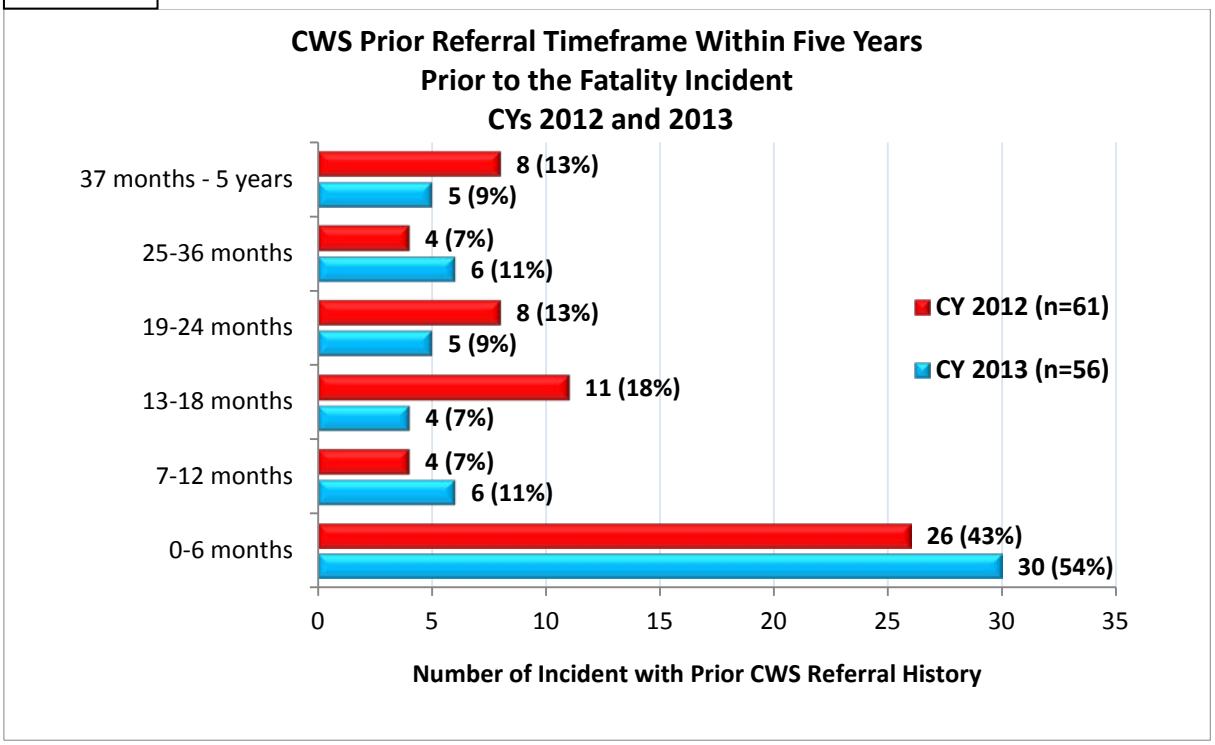
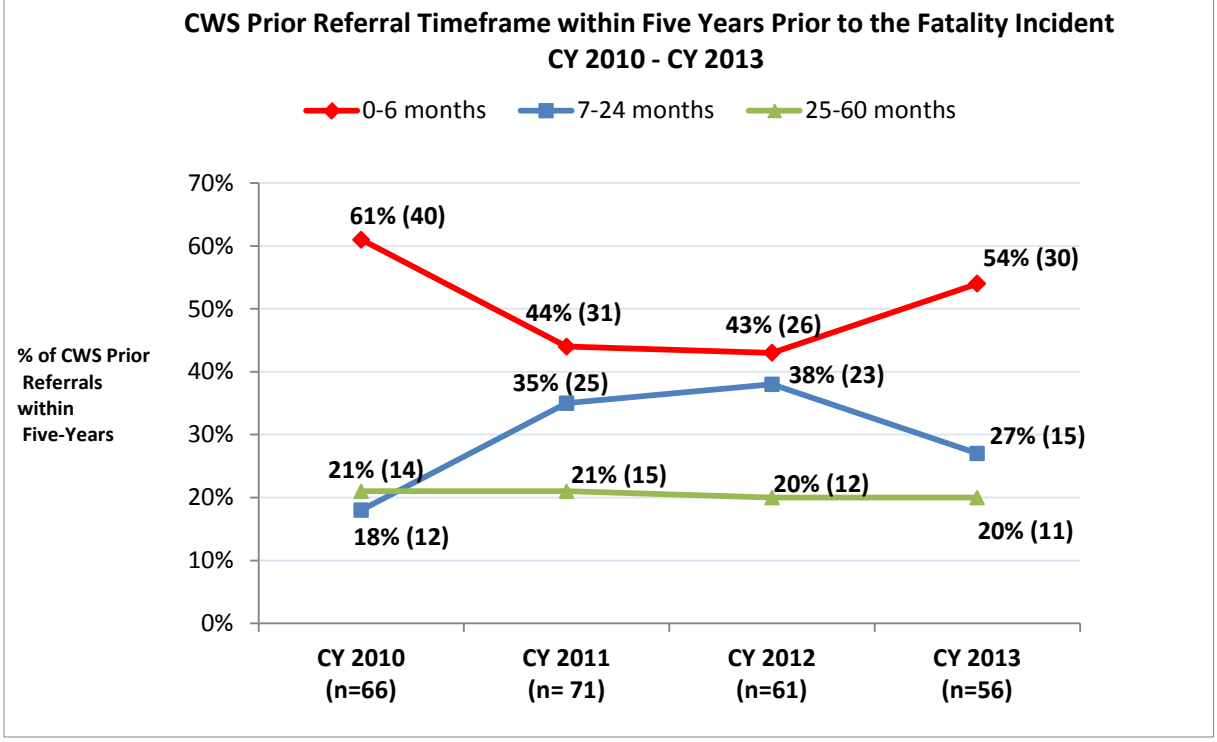


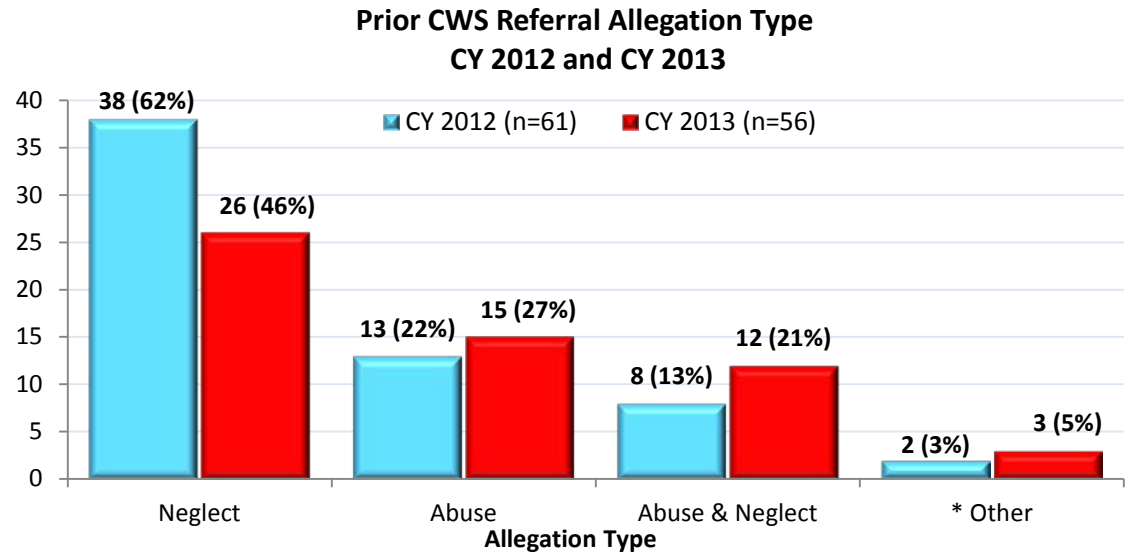
Chart H



Prior CWS Referral Allegation Type

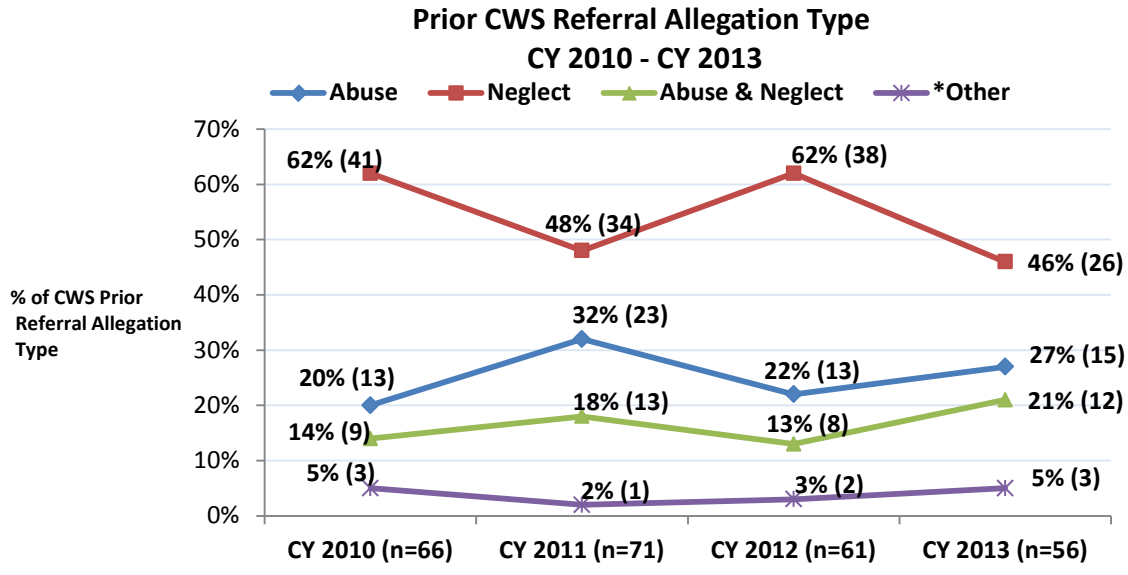
The allegation most associated with the prior referrals in the 61 incidents for CY 2012 and in the 56 incidents for CY 2013 was neglect, followed by abuse (See Chart I). Chart J depicts findings of prior referral allegation type since CY 2008.

Chart I



** 2012: CaretakerAbsence/Incapacity & Neglect (2)*
** 2013: CaretakerAbsence/Incapacity & Neglect (1); Undetermined (2)*

Chart J



**Includes multiple allegation types*

Prior CWS Referral Disposition Type

Chart K provides information on the disposition for those referrals generated by the CWS agency in the five years prior to the fatality. The data shows that the majority of the referrals were either substantiated or unfounded for CY 2012. In CY 2013, a third of the referrals were unfounded, followed by an equal number of dispositions amongst the remaining three categories. Chart L depicts findings of prior referral disposition type since CY 2008.

Chart K

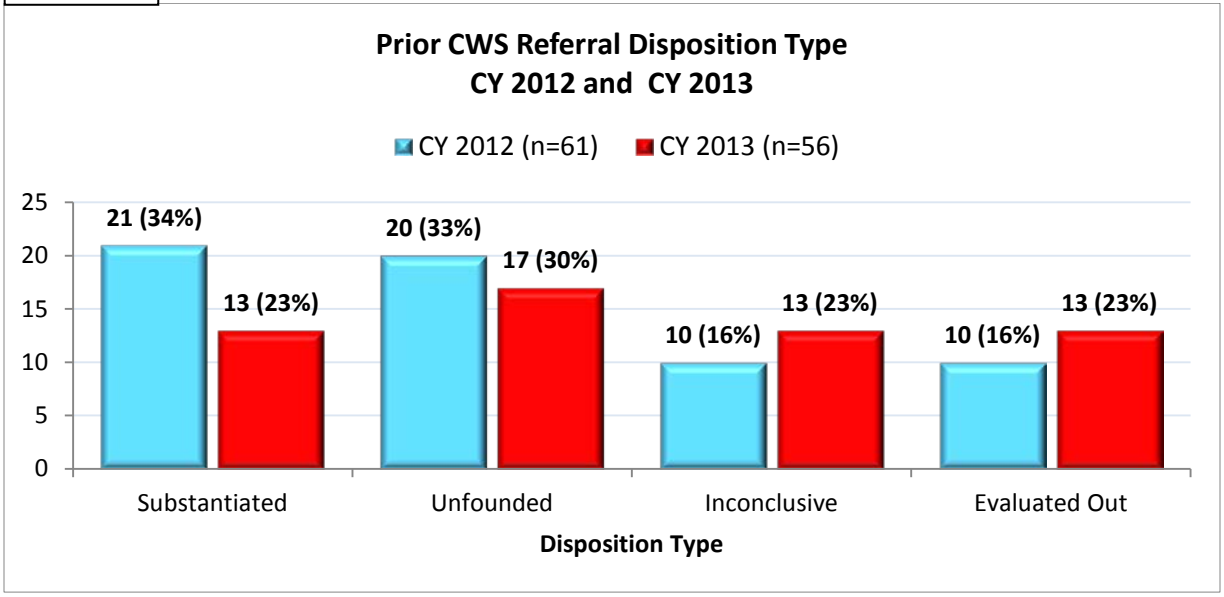
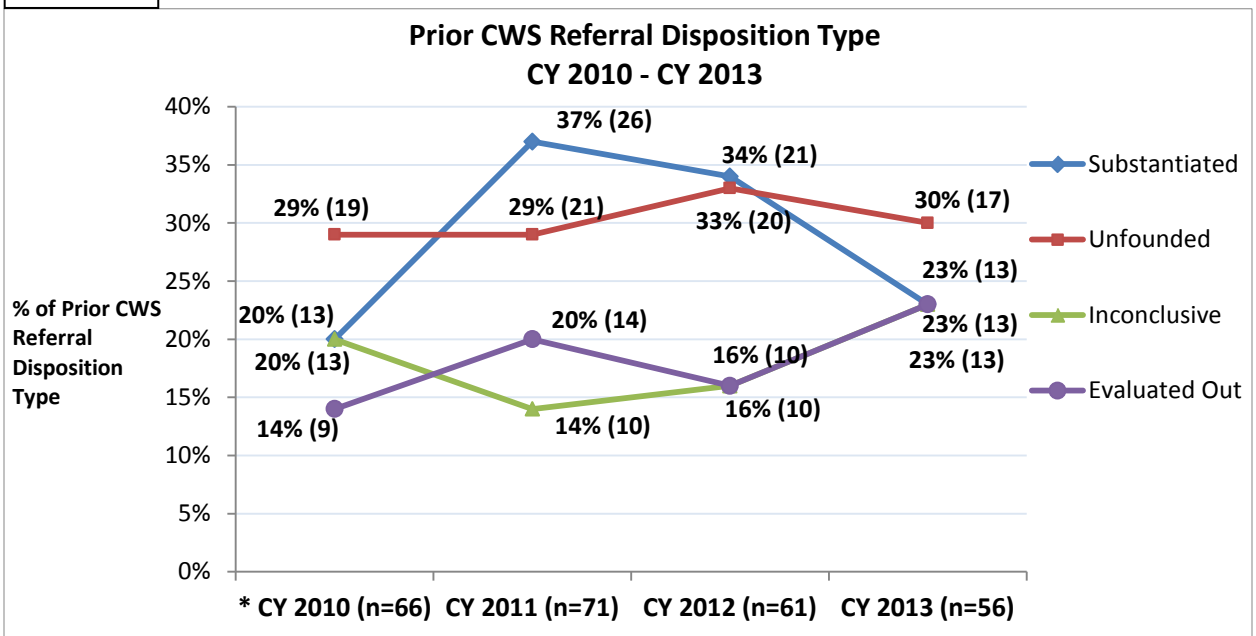


Chart L



***** *Excludes 18% (12 referrals)* **Other** *(multiple allegations with multiple dispositions)*

Child Welfare Services Case History within Five Years Prior to the Fatality Incident

For CY 2012 of the 61 incidents which involved children from families with prior CWS involvement/history, 17 incidents (28 percent) involved families that had an open CWS case within five years prior to the fatality incident. Of these 17 incidents, 11 incidents had only one case with a CWS agency within five years prior to the fatality incident.

For CY 2013 of the 56 incidents which involved children from families with prior CWS involvement/history, 12 incidents (21 percent) had an open CWS case within five years prior to the fatality incident. Of these 12 incidents, seven incidents had only one case with a CWS agency within five years prior to the fatality incident (See Table 12).

Table 12. Number of Cases Opened within Five Years Prior to the Fatality Incident

Number of Prior Case(s)	CY 2012		CY 2013	
	Count	Percent	Count	Percent
One Case	11	18	7	12
Two Cases	3	5	3	5
Three Cases	2	3	1	2
Four Cases	1	2	0	0
Five Cases	0	0	1	2
No Case	44	72	44	79
Total	**61**	**100**	**56**	**100**

In summary, of the 111 child fatalities reported in CY 2012 determined to be the result of abuse and/or neglect, 61 incidents involved families with prior CWS history within five years with the parents as adults. Additionally, 17 of these 61 incidents involved families that had an open CWS case within five years prior to the fatality incident.

Over one-third (21 of 61 incidents) of the allegations generated in the prior referrals were substantiated or unfounded. Of the 61 most recent prior referrals within five years preceding the fatality incidents, 38 involved allegations of neglect. Of the 61 incidents which involved children from families with prior referrals, 26 had a referral generated between zero to six months prior to the fatality incident. Thirty incidents involved families who had between two and five referrals generated within the five years prior to the fatality incident. Lastly, of the 61 incidents, 44 incidents did not have a case within the five years prior to the fatality incident.

In summary, of the 97 child fatalities reported in CY 2013 determined to be result of abuse and/or neglect, 56 incidents involved families with prior CWS history with the parents as adults. Additionally, 12 of these 56 incidents involved families that had an open CWS case within five years prior to the fatality incident.

Of the 56 most recent referrals within five years preceding the fatality incidents, 26 involved allegations of neglect. Out of the 56 incidents, 17 incidents involved allegations that were unfounded. Of the 56 incidents which involved children from families with prior referrals, 30 had a referral generated between zero to six months prior to fatality incident. Twenty-nine incidents involved families who had at least two to five referrals within the five years prior to the fatality

incident. Lastly, of the 56 incidents, 44 involved did not have a case within the five years prior to the fatality incident.

Child Welfare Services Involvement/History within the Year Prior to the Fatality Incident - Information Regarding the Most Recent Prior Referral Preceding the Fatality Incident

The CDSS refined its data collection and analysis to provide a more comprehensive look at the level of involvement these children and their families had with the CWS system within the year prior to the fatality incident. More specifically, this analysis focuses on the most recent prior ER referral preceding the fatality incident, including any CWS involvement at the time the fatality occurred.

In CY 2012, there were 30 families with CWS involvement within the year prior to the fatality incident, representing a total of 64 ER referrals for alleged child abuse and/or neglect. The following analysis will focus on the most recent prior ER referral that precedes the fatality incident for 26 of the 30 families who had a referral investigated within six months prior to the fatality.

Out of the 26 most recent referrals for these families, 14 referrals were closed within 30 calendar days.[21] For the remaining 12 referrals which were open beyond 30 days, additional analysis of these incidents found that these referrals were open for the following reasons: on-going CWS investigations; the ER investigation was completed but the referral was not closed; and/or the assigned social worker was unable to locate the family. The remaining four families who had referrals beyond six months of the death were open beyond 30 days for similar reasons.

In follow up, further analysis was conducted to identify any similarity between the most recent referral and safety plans and services that were in place. Based on analysis of the 26 families, 11 of the incidents involved the same or similar circumstances and allegations to those in the fatality incident. The causes of the fatalities for these 11 families were blunt force trauma, medical neglect, SIDS, asphyxiation, and maternal drug use. Additional analysis revealed that 18 of the 26 referrals within six months prior to the fatality incident involved both the same PIR and fatality victim. For the remaining four families who had referrals beyond six months of the death, three of the incidents involved the same or similar circumstances as the cause of death. The causes of the fatalities for these three deaths were medical neglect and drowning.

In efforts to identify how future maltreatment deaths may be prevented, the CDSS analyzed whether families who had CWS involvement within six months prior to the incident received services or a referral to services from a CWS agency, as well as what type of services were provided to the family. The data found that for 20 families[22] whose referral was investigated by a CWS agency, 11 families were provided services. Services were provided either during the investigation or through a case the family had open at the time of investigation. Types of services included parenting classes, substance abuse treatment, mental health services, public health nurse visits, counseling, and/or domestic violence services. Service referrals to local community resources were provided to five of the 11 families during the investigation. For the remaining four families who had referrals beyond six months of the death, excluding one family

[21] According to Division Regulations 31.101.5, within 30 calendar days of the initial removal of the child or the in-person investigation, or by the date of the dispositional hearing, whichever comes first, the social worker should determine whether child welfare services are needed.
[22] Excludes six referrals that were evaluated out.

who had a referral that was evaluated out, two families were provided services and one family was not provided services.

CWS agency contact is required for all referrals meeting established investigation criteria.[23] Collateral contacts include individuals such as school personnel, therapists, and/or medical staff who may be able to provide additional information pertaining to the family and children's circumstances. The data shows that the CWS agency made contact with families and collaterals in the majority of ER referral investigations. Of the 20 families whose most recent prior referral within six months preceding the fatality incident was investigated by the CWS agency, one family did not have contact with the CWS agency because the social worker was unable to locate the family and collateral contacts were not made for four families. For the remaining four families who had referrals beyond six months of the death, aside from one family whose referral was not investigated by a CWS agency, all three families had CWS and collateral contact.

The SDM is one of two tools utilized in California by CWS agencies to assess the safety and risk of a child. There are three levels for the safety assessment: 1) safe; 2) conditionally safe, which requires a safety plan to be put in place so that the children can remain in the home with their parents; and 3) unsafe, in which intervention is needed, resulting in the placement of children into protective custody.

Of the 26 prior ER referrals within six months of the fatality, six referrals were not investigated by a CWS agency, and four referrals were investigated by counties who did not utilize SDM. Therefore, analysis of these incidents is limited to the 16 referrals that were assessed using SDM. Out of the 16, 11 referrals were determined to be safe. Three referrals were determined to be conditionally safe, and a safety plan was put in place for each referral. The safety plans for these referrals did not have a connection between the safety factors that were present at the time of the investigation for the prior referral and the nature of the fatality incidents. For example, in the prior referral, there were concerns of the mother's ability to provide the basic needs to her children while residing at a women's shelter. The safety plan indicated the mother will continue to follow the shelter's program with assistance from her case worker. The child subsequently died from blunt force trauma by the father. One referral had a safety level of unsafe, and the child was placed into protective custody, and the remaining referral did not have a safety assessment documented. In the remaining four families who had referrals beyond six months of the death, aside from one family whose referral was not investigated by a CWS agency, all three referrals were determined to be safe.

In CY 2013, there were 35[24] families with CWS involvement within the year prior to the fatality incident, representing a total of 75 ER referrals generated for alleged child abuse and/or neglect. The following analysis will focus on the most recent prior ER referral that precedes the fatality incident for 29 of the 35 families who had a referral investigated within six months prior to the fatality.

[23] According to Division 31-125.2 regulations, the social worker investigating the referral shall have in-person contact with all children and parents as well as make necessary collateral contacts with persons having knowledge of the condition of the children.

[24] It should be noted that out of the 36 incidents that involved children from families who had CWS involvement/history within five-years prior (Chart G), there is a sibling set, and the analysis focus is on a family unit. Therefore the analysis to follow will be for 35 families.

Out of the 29 most recent referrals for these families, 18 referrals were closed within 30 days. For the remaining 11 referrals which remained open beyond 30 days, additional analysis of these incidents found that the reasons these ER referrals remained open were due to on-going investigations and investigations completed but not closed. For the remaining six families who had referrals beyond six months of the death, two referrals were closed within 30 days, and four referrals were open beyond 30 days for similar reasons.

In follow up, further analysis was conducted to identify any similarity between the most recent referral and safety plans and services that were in place. Based on analysis of the 29 families, eight of the incidents involved the same or similar circumstances and allegations to those in the fatality incident. The causes of the fatalities for these eight families were blunt force trauma, drowning, SIDS, medical neglect, ingested substance, and undetermined. Additional analysis revealed that 21 of the 29 referrals within six months prior to the fatality involved both the same PIR and fatality victim. For the remaining six families who had referrals beyond six months of the death, one incident involved the same or similar circumstance as the cause of death. The cause of this fatality was drowning.

The data found that of the 20 families[25] whose referral was investigated by a CWS agency within six months prior to the fatality, three families were provided services. Services were provided either during the investigation or through a case the family had open at the time of investigation. Types of services included parenting classes, substance abuse treatment, mental health services, public health nurse visits, counseling, and/or domestic violence services. Services referrals to local community resources were provided to 11 families during the investigation. Six of the 20 families were not provided services or referrals. For the remaining six families who had referrals beyond six months of the death, four families were provided with services, and two families were not provided services.

The CWS agency contact is required for all referrals meeting established investigation criteria.[26] Collateral contacts include individuals such as school personnel, therapists, and/or medical staff who may be able to provide additional information pertaining to the family and children's circumstances. The data shows that the CWS agency made contact with families and collaterals in the majority of ER referral investigations. Of the 20 families whose most recent prior referral within six months preceding the fatality incident was investigated by the CWS agency, one family did not have contact with the CWS agency because the social worker was unable to locate the family and collateral contacts were not made for three families. The remaining six families who had referrals beyond six months of the death, all had contact with CWS agency and collaterals except for one family that did not have contact with a CWS agency.

Of 29 prior ER referrals within six months prior to the fatality, nine referrals were not investigated by a CWS agency, and one referral was investigated by a county who does not utilize SDM. Therefore, a safety assessment analysis of these incidents is limited to the 19 referrals that were assessed using SDM. Out of the 19 referrals, 14 referrals were determined as safe. Two referrals had a conditionally safe level, of which one referral had a safety plan in place and the safety plan had a connection with the nature of the fatality incident. One referral did not have a safety plan since the social worker was unable to locate the family. Two referrals had a safety level of unsafe; one referral the victim's sibling was placed into protective custody

[25] Of the 29 most recent prior ER referrals within six months prior to the fatality, nine were evaluated out.
[26] According to Division 31-125.2 regulations, the social worker investigating the referral shall have in-person contact with all children, parents as well as make necessary collateral contacts with persons having knowledge of the condition of the children.

and in the other referral the family was unable to be located. For the remaining six families who had referrals beyond six months of the death, one referral was investigated by a county who did not utilize SDM; therefore, three referrals were determined safe, and two referrals had a conditionally safe level. Of the two referrals with a conditionally safe level, one referral had a safety plan in place, and one did not have a safety plan documented.

Child Welfare Services Involvement at the Time of the Fatality Incident

Table 13 provides the type of services the families were receiving at the time of the fatality. For CY 2012 there were 16 families who were receiving services with a CWS agency at the time of the fatality; nine families had an open ER referral and the remaining seven families had an open case. Six of the seven cases open at the time of the fatality incident which involved the victim child were opened for reasons including: parents' failed completion of services, caretaker absence/incapacity, drug exposure at birth, parental substance abuse, mental health concerns, lack of supervision, and anger issues. In two families there was a similarity between the case circumstances and the cause of fatality.

For CY 2013 there were 16 families who were receiving services with a CWS agency at the time of the fatality incident, nine families had an open ER referral, and the remaining seven families had an open case. Five of the seven cases open at the time of the fatality incident which involved the victim child were opened for reasons including: physical abuse, medical neglect, parental substance abuse, physical abuse, prior fatality of sibling due to abuse, and non-accidental injury. In four families there was a similarity between the case circumstance and the cause of fatality.

Table 13. Number of Families with CWS Involvement at the Time of Fatality

Type of Service	CY 2012	CY 2013
Not a current client of a CWS agency (but had prior history within 5 years)	45	40
Open ER Referral at time of Fatality	9	9
Open-In Home Receiving Services at time of Fatality	4	6
Open-In Home Receiving Services & Out of Home Receiving Services at time of Fatality	1	-
Out of Home Receiving Services at time of Fatality	2	1
Total	**61**	**56**

Families with Open ER Referral at the Time of Fatality

Analysis of the nine referrals open at the time of the fatality for CY 2012 revealed that four referrals were investigated for circumstances similar to the fatality incident and the allegations associated with those referrals were substantiated due to the death. The causes of the fatalities that were similar to the nature of the open referral were blunt force trauma and medical neglect.

Of the nine open ER referrals, six involved the same victim child and PIR as the fatality incident. In seven of the eight open ER referrals, the CWS agency made contact with the families as well as collateral contacts. Services were provided to three of the families.

Six of the eight open ER referrals had a safety assessment level of safe based on SDM; for one referral, a safety assessment was not documented. The remaining ER referral open at the time of the fatality was not investigated by a CWS agency and referred out to a community agency; therefore, SDM was not available.

For CY 2013 analysis of the nine referrals open at the time of the fatality revealed that four referrals were investigated for circumstances similar to the fatality incident, and the allegations associated with three of the four referrals were substantiated due to the death. The causes of the fatalities that were similar to the nature of the open referral were blunt force trauma and medical neglect.

Of the nine open ER referrals, eight involved the same victim child and PIR as the fatality incident. The CWS agency made contact with eight out of the nine families during the investigation as well as collateral contacts. Services were provided to two families. Three families received referrals to local community resources. In regards to services, four of the nine families were not provided services during the investigation.

Four of the eight open ER referrals had a safety assessment level of safe. Two referrals had a conditionally safe level, of which one did not have a safety plan documented. Two referrals had a safety level of unsafe; In one referral the victim's sibling was placed into protective custody and in the other referral the family was unable to be located.

VI. Future Plans

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

Zero to Five

Statewide, approximately four-fifths of all child fatalities occur in children under the age of five, with the greatest percentage of deaths occurring prior to age one. Very young babies, particularly those with prolonged unexplained crying that can last for hours each day for a period of weeks or months, are vulnerable to physical abuse from frustrated and exhausted caregivers. Older infants and toddlers are also vulnerable to physical abuse, as they lack the intellectual development to protect themselves in potentially dangerous situations and are often more socially isolated than their older peers, limiting their exposure to mandated reporters.

Injuries in infants

The 29th Annual San Diego Conference on Child and Family Maltreatment held in January 2015 presented the findings from a hospital study on child fatalities and near fatalities. Minor abusive injuries, also known as sentinel injuries, can precede severe physical abuse in infants, but are often not reported to CWS agencies. Minor injuries other than superficial abrasions are uncommon in infants who aren't mobile and, when they occur, should raise a concern for abuse. Within a study of 401 infants identified for abuse, injuries in infants occurred 66 percent at three months of age and 95 percent at or before the age of seven months. Medical providers were reportedly aware of the injuries in 41.9 percent of cases but did not report them. Reasons for not reporting included thoughts of the injury being minor and insignificant, personal biases (family perceived as low risk), or the provider could not imagine that someone would abuse a child.

Action Step:

- The OCAP will work closely with the CDPH to ensure that mandated reported trainings are interactive and strengthen information o sentinel injuries in infants and emphasize the subject of personal biases that could prevent reporting. Updated mandated reporter trainings will be linked to the OCAP website. The OCAP will promote the trainings to law enforcement, social workers and healthcare professionals. Further, the OCAP will make appropriate policy changes if professionals do not have periodic mandated reporter training.

Abusive Head Trauma/SBS

The hospital study on child fatalities and near fatalities referenced above further discovered that abusive head trauma including SBS are common causes of infant deaths.[27] The hospital study

[27] Abusive Head Trauma and SBS are categorized by CDSS as Blunt Force Trauma as explained on page 16.

identified that parents/caregivers get overwhelmed and frustrated by the infant's crying, as it can occur for up to seven to nine hours a day, but this is normal for an infant. Infant crying typically peaks at six weeks of age. Abusive head trauma typically begins at two to three weeks and peaks at nine to thirteen weeks. Infant distress is more common when a child is abused. The primary prevention techniques noted include: educating parents on the normalcy of infant crying, implementing evidence informed curriculums for parent education such as The Period of PURPLE Crying®, and supporting caregivers with respite. California hospitals are required by law to provide informational materials to parents or guardians of newborns to help prevent SBS. California is among the 34 percent of states requiring SBS materials be provided to parents. New York (NY) reports the implementation of the NY/Dias parent education program has reduced the incidence of abusive head injuries by 47 percent. New York also has legislation surrounding the NY/Dias program implementation which requires hospitals and birth centers to request parents to view a video on the dangers of shaking infants and small children.

Action Step:

- The OCAP will work closely with the CDPH to maximize opportunities to support families with education and services. Specific collaboration will include promotion of SBS education programs within hospitals, clinics and doctors' offices. The CDSS will partner with hospitals regarding implementing evidence-informed SBS parent education programs through hospitals.
- The OCAP is updating existing SBS and Safe to Sleep materials to contain the most current information, 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 OCAP will promote available educational information through its website, social media and partnering agencies including the Essentials for Childhood Initiative, the California Family Resource Association - reaching 800 family resource centers, Child Abuse Prevention Councils, First 5 Commissions, and the Strategies listserv reaching 14,000 child welfare and prevention partners.

Families with CWS Involvement

In coordination with the Department's county partners, a variety of efforts are underway to aid improvement in services and supports to troubled families. The CDSS is continuously reviewing other state's practices and national research for best practices and innovative policies to reduce child injuries and deaths.

Action Step:

- The CDSS will explore new methodologies and evaluate utilization of predictive risk modeling to aid risk and safety assessments in the years to come.
- The OCAP will work closely with the CDPH to maximize opportunities to support families with education and services. Specific collaboration will include promotion of SBS education programs within hospitals, clinics and doctors' offices. The CDSS will partner with hospitals regarding implementing evidence-informed SBS parent education programs through hospitals.

Risk and Safety Assessment Tools

The SDM is a series of assessment tools used to screen calls to the child abuse hotline and assess the risk and safety of families during investigation for child abuse and neglect. It is currently used in 54 of California's 58 counties. The accuracy of the tools is crucial to determining when to investigate and whether to provide services to a family or remove a child from his or her home. Using research from the Children's Research Center and feedback from a multiagency workgroup, the CDSS has conducted an extensive research and validation process to improve the performance of the screening and assessment tools.

Hotline Assessment

The child abuse reporting hotline tool is the first assessment of a family's risk. The updated hotline tool was revised in 2014 to clarify information on prior child deaths – hotline screeners are asked to assess whether a child in the home previously died of suspected abuse or neglect (as opposed to only cases where abuse or neglect was substantiated or determined by law enforcement) and previous child death from abuse has been separated from previous child death due to neglect. The tool was also modified to focus more on caregiver actions than caregiver characteristics – mental health issues, substance abuse, and presence of domestic violence alone are no longer risk factors; the tool focuses on caregiver actions stemming from those conditions to assess risk.

In-home Investigation – Risk and Safety Assessments

When families are investigated by an emergency response social worker for abuse and neglect, the social worker completes a risk assessment and safety assessment to determine if services are required and if the child is safe to remain in the home.

The risk assessment is the key determinant of what level of action is taken when a family comes into contact with Child Protective Services (CPS). In 2013, the risk assessment tool underwent a validation study, the chief objective of which was to assess how well the current risk assessment tools estimated future maltreatment. A second objective was to explore opportunities to improve the classification abilities of the assessment tools.[28] The validation study concluded that the current risk assessment tools classified the risk level of families reasonably accurately overall, but that performance could be improved and subsequent enhancements were recommended. Among other changes, the new risk assessment tool now evaluates the secondary caregiver in addition to the primary caregiver and distinguishes between families that received CWS services in the past versus receiving them currently.

The updated safety assessment tool adds a more specific domestic violence screening component and added caregiver complicating behaviors that are not an immediate threat but may contribute to the child's safety. The family strengths and needs assessment was updated to include "prior adverse experiences/trauma" and "cognitive/developmental abilities" to the caregiver domains.

The new tool will also incorporate data from CWS/CMS and SafeMeasures to create more accurate risk and safety assessments. These revisions will allow CPS to more effectively focus its efforts on the families who are at the highest risk of seriously injuring their children.

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

Investigation Findings of "Safe" or "Conditionally Safe with a Safety Plan."

In some instances, CPS had investigated a home within months of a fatality and using SDM to assess the safety of the children, either found the children to be safe or conditionally safe with a safety plan. CDSS will review these cases to identify any patterns, particularly examining the use and components of safety plans. If appropriate, CDSS may issue an ACL or ACIN to counties to encourage best practices in regards to development and use of safety plans.

Action Step:

- It is anticipated that county CWS agencies will begin implementing the new SDM tools in November 2015.

Case and Practice Review

When reports are called into the child abuse hotline that do not appear to meet the statutory definition of abuse or neglect minimum to conduct an in-person investigation, the reports are not investigated by a CWS agency. A report that is not investigated by a CWS agency may be closed with no further action, or the reporter or family may be referred to another agency or community organization that better meets their needs, if appropriate.

Cases Evaluated out Where There was a Later Child Fatality

An area of particular concern is the event of a child fatality where the unsafe home environment was previously reported to a child abuse hotline and the referral was referred to another agency.

Child Fatalities Referred to Law Enforcement

In instances in which a CWS agency receives a report following a child fatality, the report may not be investigated by the CWS agency if there are no other children present in the home. Since there are no living children in need of protection, the CWS agency will instead refer the case to law enforcement for investigation and prosecution, if necessary. However, this has the potential to create no record of a child death within the statewide CWS/CMS case tracking system, which may exclude vital information for future risk and safety assessments from being known.

Data Entry and Allegations Regarding Non-Caregivers

As child welfare is specifically tasked with protecting children within their homes, there can be a variety of practices as to how a CWS agency may investigate and record allegations for perpetrators who are not a parent, guardian, caregiver or household member of the child victim. In some referrals, if a household visitor fatally injures a child, the CWS agency might substantiate neglect against the parent (for allowing an unsafe person access to the child), and defer the investigation and prosecution of the perpetrator to law enforcement. This poses an issue where the perpetrator is not tracked in CWS/CMS, again potentially excluding vital information for future risk and safety assessments from being known.

Action Step:

- The CDSS and counties will review selected child fatality cases in order to identify any patterns and practices that may lead to inappropriate response determinations.
- The CDSS will work with counties to clarify best practice and ensure that all appropriate persons are entered in the child welfare services/case management system when there is an allegation of abuse or neglect.

Partnerships

Explore and develop partnerships with various sources for continual quality improvement and greater prevention effectiveness throughout the State.

Action Step:

- The CDSS 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.

VII. Attachments

Attachment A

2013 California Children Population Projections by Age, Race & Gender (as of December 2014)

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	**2,486,802**	1,261,821	681,052	272,945	125,280	128,330	8,737	8,637
	100%	*51%*	*27%*	*11%*	*5%*	*5%*	*<1%*	*<1%*
5 to 9 years	**2,537,336**	1,339,288	662,127	266,685	132,374	118,367	9,792	8,703
10 to 14 years	**2,515,768**	1,287,445	694,845	267,729	141,477	104,876	10,293	9,053
15 to 17 years	**1,564,954**	781,070	448,049	168,601	93,904	60,636	6,798	5,896
Total	**9,104,860**	**4,669,624**	**2,486,123**	**975,960**	**493,035**	**412,209**	**35,620**	**32,289**
	100%	*51%*	*27%*	*11%*	*5%*	*5%*	*<1%*	*<1%*
Male								
Under 5 years	**1,268,769**	643,436	347,870	139,566	63,593	65,455	4,467	4,382
	100%	*52%*	*27%*	*11%*	*5%*	*5%*	*<1%*	*<1%*
5 to 9 years	**1,297,146**	683,741	340,101	136,173	67,339	60,451	4,951	4,390
10 to 14 years	**1,285,772**	656,215	356,787	137,195	72,067	53,453	5,303	4,752
15 to 17 years	**800,039**	397,751	230,331	86,937	47,853	30,647	3,493	3,027
Total	**4,651,726**	**2,381,143**	**1,275,089**	**499,871**	**250,852**	**210,006**	**18,214**	**16,551**
	100%	*51%*	*27%*	*11%*	*5%*	*5%*	*<1%*	*<1%*
Female								
Under 5 years	**1,218,033**	**618,385**	**333,185**	**133,379**	**61,687**	**62,875**	**4,270**	**4,255**
	100%	*51%*	*27%*	*11%*	*5%*	*5%*	*<1%*	*<1%*
5 to 9 years	**1,240,8190**	655,547	322,026	130,512	65,035	57,916	4,841	4,313
10 to 14 years	**1,229,996**	631,230	338,108	130,534	69,410	51,423	4,990	4,301
15 to 17 years	**764,915**	383,319	217,718	81,664	46,051	29,989	3,305	2,869
Total	**4,453,134**	**2,288,481**	**1,211,034**	**476,089**	**242,183**	**202,203**	**17,406**	**15,738**
	100%	*51%*	*27%*	*11%*	*5%*	*5%*	*<1%*	*<1%*

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

Attachment B

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))

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 Penal Code 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 Penal Code 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 Penal Code 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))