State of California Child Fatality Annual Report – Calendar Year 2014

Prepared by the California Department of Social Services
Children's Services Operations Bureau – August 2017

CDSS
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

State of California Child Fatality Annual Report
Calendar Year 2014

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Executive Summary

Letter from the Director of the California Department of Social Services (CDSS)

This is the sixth edition of the California Child Fatality Annual Report which is prepared pursuant to Senate Bill (SB) 39 (Migden, Chapter 468, Statutes of 2007) and the Welfare and Institutions Code (WIC) section 10850.4(j). The report contains Calendar Year 2014 child fatality incidents which were determined to be the result of abuse or neglect, and were reported by California county child welfare services (CWS) agencies to CDSS. The report reflects a state-level analysis of the aggregate data gathered with respect to these incidents, including information about the child victims and perpetrators involved, major causes and findings associated with these incidents, and the involvement of these families with local CWS agencies prior to and at the time of these incidents.

The findings from 2014 are consistent with those in previous years – blunt force trauma and abusive head trauma remain the leading causes of death, and children under five years of age as well as Black, and Multi-Racial children were over represented when compared to their respective percentages of the statewide child population. The most common perpetrator in a child maltreatment death continues to be the mother.

The report reflects our continued commitment to providing information and data which informs public understanding of these tragic incidents, the children who are victims and the families involved, and systemic issues and trends which can be addressed at a statewide policy level. 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. Through collaborative dialogue and focus at the state and local community level, CDSS continues to develop collective strategies for preventing these deaths.

Additional information, including details regarding the strategies listed above, can be found in the Updates to 2012-2013 Future Plans section of this report.

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

Sincerely,

WILL LIGHTBOURNE
Director

Introduction

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states disclose to the public findings and information about cases of child abuse or neglect that result in fatalities. WIC section 10850.4(j) requires a county welfare department or agency to notify CDSS of every child fatality that is determined to be the result of abuse or neglect that occurs within its jurisdiction. Statute also requires CDSS to annually issue a report identifying the child fatalities and any systemic issues or patterns and other relevant information revealed by the notices submitted to CDSS by the counties.

This report reflects a state-level analysis of the data gathered with respect to fatality incidents that occurred during calendar year 2014 and that were determined by a CWS agency, law enforcement or the medical examiner/coroner to be the result of abuse or neglect. Identifying the types of maltreatment occurring in California provides a basis for the development of strategies and coordination of services among departments within state and local governments, nonprofit agencies, and advocates that aim to protect children and strengthen families.

While the findings from 2014 are consistent with those in previous years, a key finding of this report is that fatalities of young children ages 0-5 are disproportionally caused by physical abuse, specifically blunt force trauma and abusive head trauma (previously referred to as Shaken Baby Syndrome), as compared to other age groups. Additionally, consistent with previous reports, the majority of families with a child abuse or neglect fatality had some form of prior contact with or report to a child welfare agency, and half were known to a child welfare agency within one year of the fatality.

CDSS anticipates releasing an additional report that will provide an expanded analysis on both fatalities and near fatalities that occurred from 2010 through 2014 and additional policy recommendations. The Five-Year Child Fatality and Near Fatality Report will be released later in 2017.

Methodology

Data Collection

Counties are required to report all child fatalities and near fatalities to CDSS, in accordance with WIC 10850.4(j). In order to implement disclosure and reporting requirements, CDSS developed and adopted the County Statement of Findings and Information (SOC 826) form, which is submitted when a county has determined that a child fatality was caused by abuse or neglect. These forms are collected and reviewed by the Children's Services Operations Bureau within CDSS.

In addition to deaths reported via the SOC 826, CDSS seeks to identify child abuse or neglect related fatalities by monitoring the media for stories of child fatalities, and conducting regular reconciliations with the CDSS' Community Care Licensing Division and with data in the Child Welfare Services Case Management System (CWS/CMS) to identify children who are marked as deceased. If a fatality that has not been reported is identified, CDSS contacts the responsible county to request that county staff submit the appropriate documentation to allow the fatality to be reviewed and included in the report.

Analysis

This report contains analysis of 88 child fatalities that occurred during 2014 and were reported to CDSS by county CWS agencies as of March 31, 2016. County CWS agencies reported a total of 120 fatalities of individuals under the age of 18 to CDSS for 2014, of which 32 were excluded as being third party homicides. For purposes of this report, a third party homicide is defined by CDSS as "a child homicide by a perpetrator other than the parent, guardian or a person acting as a caregiver, and in which no contributing abuse or neglect by a parent, guardian or caregiver was found." Often, these deaths are the result of criminal or gang-related activity. Since these deaths are generally not investigated by child welfare, nor would such a death necessarily be grounds for child welfare involvement, these deaths were excluded from the analysis presented in this report.

CDSS staff thoroughly analyzed each fatality using information that was gathered from the CWS/CMS database and the Structured Decision Making (SDM) system, a suite of assessment instruments that promote safety and well-being for those most at risk. For each case review, the following data elements were abstracted and analyzed:

- Demographic information on the child victim, including age, sex and race/ethnicity.
- Demographic information on the perpetrator(s), including age, sex, race/ethnicity and relationship to the victim.
- The documented cause of the fatality.
- CWS history, including any prior investigations, risk and safety assessments and case plans dating from within five years prior to the fatality.

In addition to the case review, CDSS consulted with individual counties on data elements that were initially identified as unknown or undetermined in CWS/CMS, in an effort to gather more specific and current information about the causes and individuals responsible for such incidents.

Researchers at the California Child Welfare Indicators Project (CCWIP) at the University of California, Berkeley provided assistance with the production of tables and figures based upon the data. CDSS analysts produced the final analysis presented in the report. While the report focuses on 2014 fatalities, data for prior years (2009-2013) is presented in the accompanying appendices to provide context and allow for trend analysis. Formal analysis of five-year trends will be presented in the Five-Year Child Fatality and Near Fatality Report.

CDSS makes every effort to identify as many child fatalities and near fatalities as possible in advance of issuing the annual report. However, some deaths are reported only after analysis has been completed for a given report. The most recent data on child fatality and near fatality incidents reported to CDSS can be accessed on the CDSS website at http://www.cdss.ca.gov/inforesources/Child-Fatality-and-Near-Fatality/Data-and-Reports.

Limitations

Statistical Challenges

The number of child abuse and neglect fatality incidents is very small when compared to both the overall child welfare population and the statewide child population. With such small numbers it is possible for even a single event to significantly change reported percentages. Data must therefore be interpreted with caution and percentages should always be examined along with the underlying number of fatalities from which they are derived. In addition to percentages and raw numbers, this report also presents rates to control for fluctuations in the statewide child population and allow for comparisons over time and between groups. While CDSS aims to use the information gleaned from child fatality reviews to identify areas for improvement and to guide policy recommendations, the public is cautioned against generalizing the data contained in this report to child welfare cases overall.

Incidents That Are Not Investigated by Child Welfare

Some child fatality incidents may not be investigated by child welfare, usually in the event of a fatality where there are no other children in the home. These fatalities are usually investigated by law enforcement. As a result, the case files for these incidents may provide less detailed investigatory information within CWS/CMS than might otherwise be available in a fatality investigated by a CWS agency. CDSS uses the information available in CWS/CMS and consultations with counties to gain as much information as possible; however, some information remains unknown.

Underreporting of Deaths

Underreporting of child abuse and neglect fatalities is a challenge recognized nationwide[1] that occurs for a number of reasons – a death that occurs in a household with no siblings may not prompt a call to child welfare, lengthy court trials may delay reporting and decisions as to which incidents meet reporting criteria vary across the state. Additionally, incomplete data-sharing between coroners, law enforcement, and child welfare agencies poses a challenge.

CDSS makes every effort to collect as much available information as is possible about child fatalities and is actively working to improve and increase its data collection efforts with its law enforcement and coroner/medical examiner counterparts.

Additional Information

Population Data

All state-level population data cited in the report and used to calculate rates was retrieved from the California Department of Finance Estimates of Race/Hispanics Population with Age & Sex Detail tables, available from http://dof.ca.gov/Forecasting/Demographics/Projections/.

Rounding

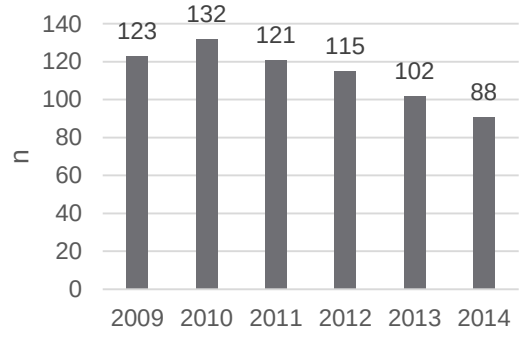
All reported percentages have been rounded to one decimal point. As the result of rounding, some columns may total slightly more or less than 100.0.

Appendix Tables

All data and appendices, with the exception of Figure 1, reflect reviewed child fatality cases. Each year, several cases are received too late to be reviewed. The total number of cases received by CDSS as of March 31, 2016 is reported in Figure 1. All other reported data and appendix tables reflect the number of reviewed cases, which is slightly fewer.

Child Fatalities in 2014

FIGURE 1
2009-2014 Child Abuse & Neglect Fatalities



There were 88 child fatalities* resulting from abuse or neglect in California in 2014, the fourth consecutive year in which the number of such deaths has declined. The statewide child abuse and neglect fatality rate declined slightly from 1.26 per 100,000 children in 2009 to 0.97 per 100,000 children in 2014.[2] This is below the national child fatality rate of 2.13 fatalities per 100,000 children reported in the 2014 Child Maltreatment Report.[3]

The modest decrease in the overall fatality rate is attributable to a concentrated decrease in the fatality rate among infants and a smaller decline among children ages 1-9.† The fatality rate for infants, however, still remained significantly higher than for any other age group at 6.96 per 100,000 in 2014.

Figure 2
2014 Fatalities and California Child Population Demographic Characteristics

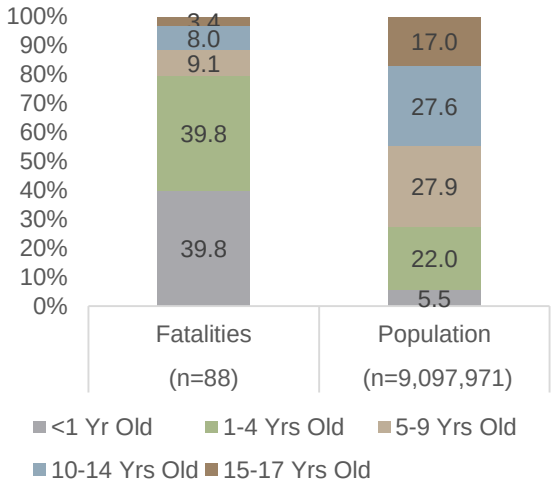
2014 (n=88)	Number	Percent	CA Child Population	Percent of Population	Rate per 100,000
Female	35	39.8	4,451,179	48.9	0.79
Male	53	60.2	4,646,792	51.1	1.14
Total	**88**	**100.0**	**9,097,971**	**100.0**	**--**
Black	14	15.9	487,981	5.4	2.87
Hispanic	29	33.0	4,675,027	51.4	0.62
White	22	25.0	2,465,851	27.1	0.89
Asian/ Pacific Islander	0	0.0	1,017,657	11.2	0.00
Native American	1	1.1	35,119	0.4	2.85
Multi-Racial	14	15.9	416,336	4.6	3.36
Unknown Race	8	9.1	--	--	--
Total	**88**	**100**	**9,097,971**	**100**	**--**
<1 year	35	39.8	502,818	5.5	6.96
1-4 years	35	39.8	1,998,347	22.0	1.75
5-9 years	8	9.1	2,536,409	27.9	0.32
10-14 years	7	8.0	2,514,558	27.6	0.28
15-17 years	3	3.4	1,545,839	17.0	0.19
Total	**88**	**100**	**9,097,971**	**100**	**--**

*All cases received as of March 31, 2016, excluding third party homicides. All other data and appendices reflect reviewed cases.
† The fatality rate among infants declined from 9.22/100,000 in 2009 to 6.96/100,000 in 2014, from 2.39 to 1.75/100,000 for children ages 1-4 and from 0.52 to 0.32/100,000 for children ages 5-9.

Victim Age

In 2014, young children (ages 0-4) accounted for 79.6 percent of all child maltreatment fatalities. As Figure 3 illustrates, both infants and children ages 1-4 are disproportionately represented in the fatality population. For instance, infants accounted for approximately six percent of the California child population, but 39.8 percent of all child abuse and neglect fatalities. Similarly, children ages 1-4 accounted for 22 percent of the population but 39.8 percent of fatalities.*

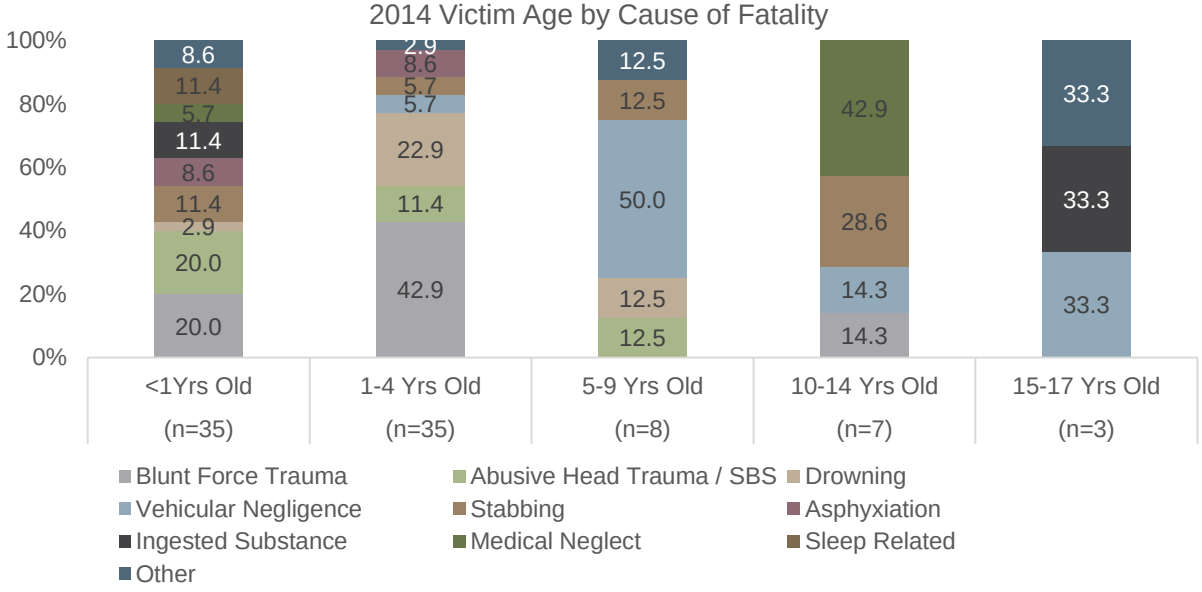
FIGURE 3
2014 Child Fatalities & Population



The disproportionate vulnerability of children under age five, especially infants, is reflected in national data[4] and is attributed to these children's dependency, small size and inability to defend themselves.[5]

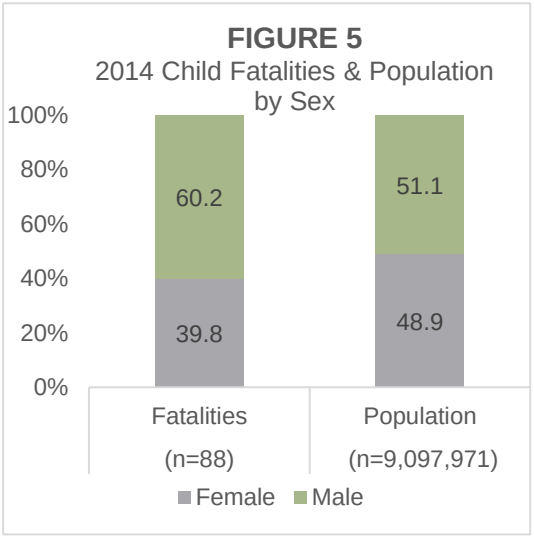
As Figure 4 illustrates, blunt force trauma and abusive head trauma were the leading causes of death among infants. Young children (ages 1-4) experienced proportionally more fatalities from physical abuse (blunt force trauma and abusive head trauma) and drowning than did children in other age groups. More than three quarters (77.2 percent) of fatalities in this age group were attributable to one of these causes. School-aged children ages five and older comprised less than a quarter of all abuse and neglect related deaths. Of the 18 fatalities of children ages five and older, vehicular negligence was the most common cause of death.

FIGURE 4
2014 Victim Age by Cause of Fatality



* For 2014, the fatality rate was 6.96/100,000 for infants and 1.75/100,000 for children ages 1-4.

Victim Sex

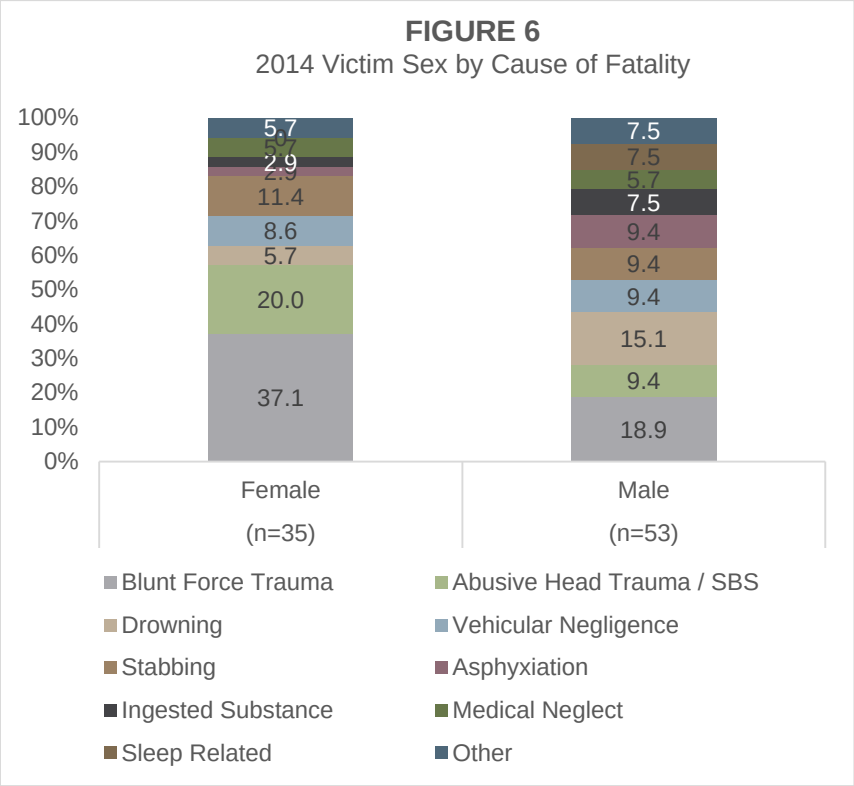


In 2014, boys accounted for 60.2 percent of all child maltreatment fatalities, a trend that has remained consistent over the years and is also reflected in national data (Figure 5).[6]

As Figure 6 indicates, there were some differences in the cause of fatality by the child's sex. In 2014, the majority (57.1 percent) of child fatalities among female children were due to physical abuse (blunt force trauma and abusive head trauma). By contrast, physical abuse accounted for only 28.3 percent of fatalities among male children, with males experiencing a greater proportion of deaths due to other causes. This phenomenon is unusual – overall, since data was first collected in 2009, males have accounted for approximately 55 percent of all fatalities from blunt force trauma and abusive head trauma combined, which roughly matches the gender disparity for all child fatality deaths.[7]

Research has demonstrated that males are more likely than females to suffer death from unnatural causes at every age, beginning in infancy[8] and continuing into adulthood.[9] Reasons for this phenomenon are complex, but one possible answer may lie in how males and females differ in their development, starting in infancy. Nationwide, boys comprise approximately 60 percent of all infant sleep-related deaths.[10] Research demonstrates that mothers report male babies to be fussier, more easily aroused and less likely to stay asleep than female infants.[11] This may lead parents to experiment with unsafe sleep positions, such as placing the baby on his stomach, or co-sleeping.

In the preschool years, boys and girls respond to caregiver supervision in very different ways. As reported by Dr. Barbara Morrongiello, of the University of Guelph in Canada:



…injury rates for boys and girls differed significantly when mothers used the strategy of intermittently going to check on the child, with boys experiencing more injuries than girls. In fact, injury rates for boys when mothers intermittently listened in were as high as when mothers left their sons unsupervised, and rates for girls were as low as when mothers provided direct and close supervision…, anything less than constant supervision was associated with high injury rates among boys. Generally, the research has shown that boys engage in more risk taking than girls and require more frequent and *effortful supervision practices than girls to ensure their safety.*[12]

The trend towards greater risk-taking in males continues into school-age, teen years and beyond into adulthood[13],[14] and may account for the greater rates of accidental neglect-related deaths among males than females.

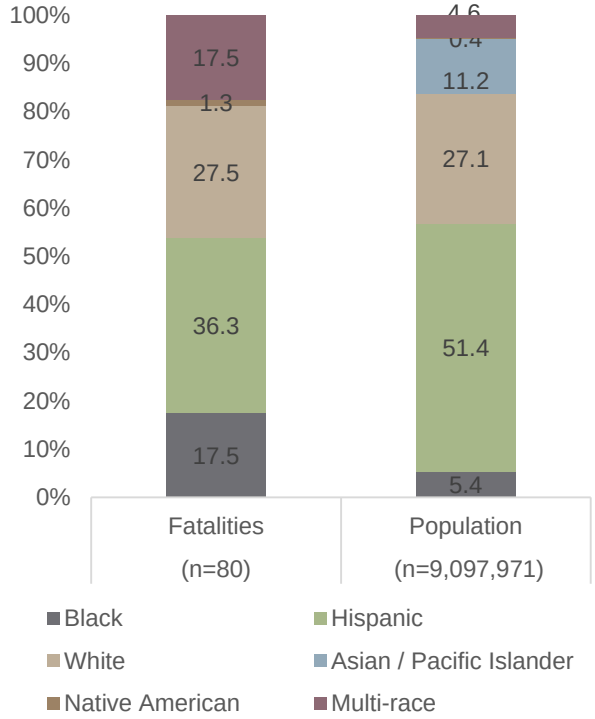
Victim Race/Ethnicity

Compared with their proportions in California's child population, Black and Multi-Racial children were over-represented among victims of fatal child abuse or neglect in 2014. For example, while Black children and those identified as Multi-Racial each accounted for approximately five percent of the statewide child population; they each comprised 17.5 percent of fatalities. In contrast, Hispanic children represented a smaller proportion of fatalities than their proportion of the general population. The trend of Black and Multi-Racial children experiencing proportionally more child abuse and neglect fatalities is consistent with national data.[15]

Overall, the child maltreatment fatality rates for Black and Hispanic children have decreased since 2009. Rates for Black children declined from a high of 5.5 per 100,000 in 2010 to 2.9 per 100,000 in 2014. Rates for Hispanic children also declined from 1.2 per 100,000 to 0.62 per 100,000 over this same period. However, the rate among Multi-Racial children has fluctuated, increasing from 2.5 per 100,000 in 2011 to 3.4 per 100,000 in 2014.[16] It is possible that a portion of the decline in child maltreatment fatality rates among Black and Hispanic children is due to a shift to Multi-Race classification among this population.

As shown in Figure 8, over half of child maltreatment fatalities among Black and Multi-Racial children in 2014 were caused by blunt force trauma and abusive head trauma. The disproportionate incidence of physical abuse in Black children is reflected in state[17] and national[18] research.

FIGURE 7
2014 Child Fatalities & Population by Race / Ethnicity*



Causes of death of Hispanic and White children were more disparate. Overall, deaths from drowning and vehicular negligence were more common among Hispanic children compared to other races. Causes of death were relatively evenly distributed among White children, though they experienced proportionally more deaths from ingested substances (accidental or purposeful exposure to prescription or recreational drugs or other toxic substance).

Racial disproportionality has long been observed at each level of the child welfare system. Black and Native American children have consistently higher child maltreatment allegation rates than their counterparts from other race groups, and this disparity persists when one examines rates of substantiation and entry to foster care. Since a majority of child abuse and neglect fatalities occur

* *Percentage calculations displayed in Figure 7 exclude 8 children with missing race/ethnicity

among families with some previous or current child welfare history, it is consistent that this disproportionality among Black children is also reflected in child abuse and neglect fatalities. Due to small number size, trend analysis on California's child fatality data cannot be conducted to determine disproportionality among Native American children. However, national literature has demonstrated this trend.[19]

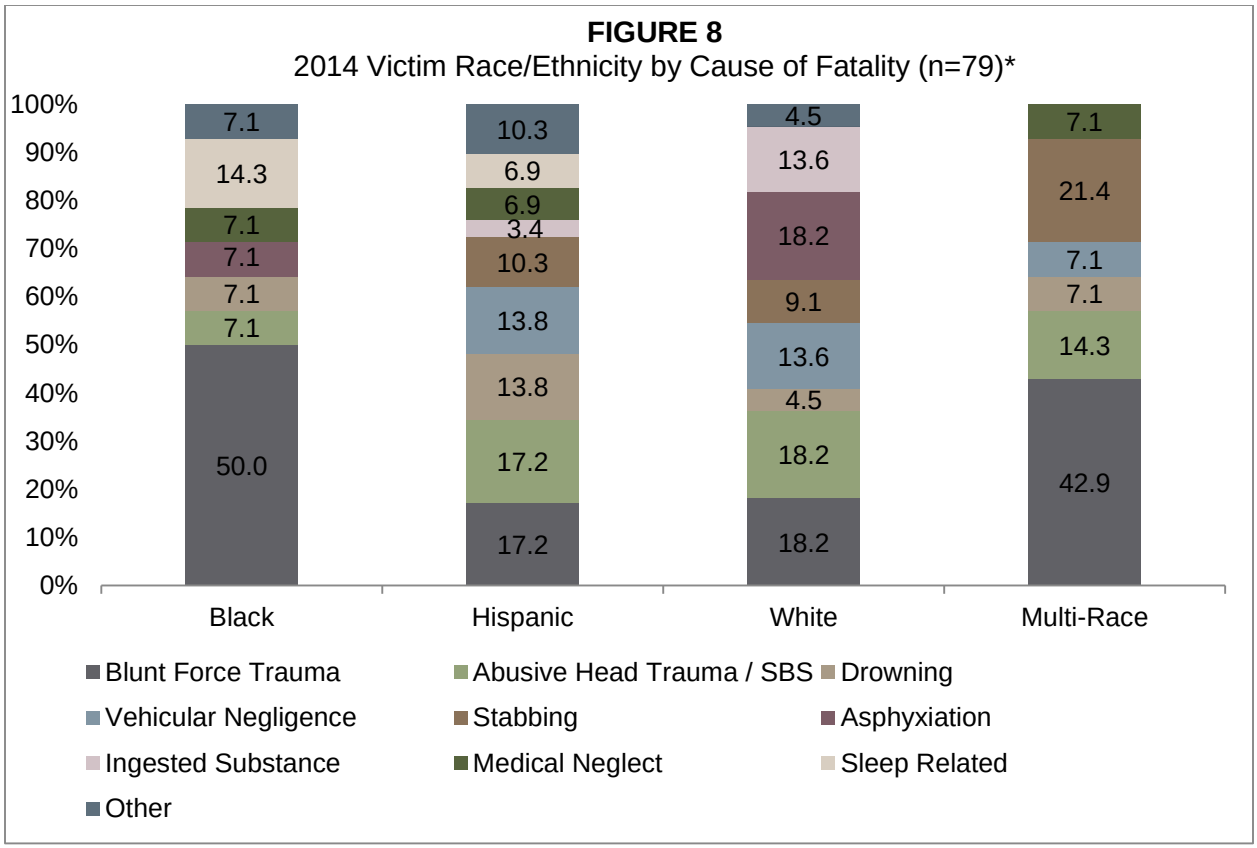
Recent work on racial disparities has illustrated that racial differences in levels of child welfare contact observed greatly changed (either reduced to no difference between groups, or in some cases showing an opposite trend) when the population reviewed is restricted to children in poverty. It may be that higher concentrations of poverty or other risk factors present for some racial groups could contribute to difference observed in child fatality rates among them.[20], [21]

Examining racial disproportionality among child abuse and neglect fatalities allows for evaluation of whether systemic disparities impact specific racial and ethnic groups. The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) issued a report to Congress, dedicating specific sections of the report to Black and Native American children due to their disproportionate representation in child maltreatment fatalities nationwide.[22]

CECANF recognized the impact that implicit bias and disproportionality have on Black children in the child welfare system and recommended including an indicator of disproportionality in the federal Children and Family Service Review system, prioritizing the training of CWS workers and mandated reporters on historical context of racism and in cultural humility and recognizing biases, and increasing use of evidence-based tools such as SDM to reduce individual worker bias. CECANF also called out the work of Sacramento's Blue Ribbon Commission for using a place-based strategy and high amounts of stakeholder engagement to develop strategies to reduce child fatalities in the Black community.

In California, programs such as the Department of Public Health's Black Infant Health Program were created to reduce racial disparities in health outcomes by providing culturally affirming services after years of data consistently showed that Black infant mortality far exceeded that of White infants, and could not be explained by maternal medical or environmental factors alone.[23] The Black Infant Health Program combines weekly group meetings with one-on-one case management to help Black mothers connect with the appropriate community and social services to meet their needs and to develop an individual Life Plan to guide her continued progress.

* Excludes cases with missing race/ethnicity



Populations with Numbers Too Small to Analyze

When a rate is computed for a small population, large fluctuations and margins of error are common. Additionally, when dealing with rare events, such as child fatalities, reporting rates for a single year presents a misleading picture, as even a single fatality produces a seemingly high rate for a given year. Due to the small number of Native American and Asian/Pacific Islander fatalities for the period 2009-2014, rates are analyzed below in aggregate over a six-year period.

Native American Children

Between 2009 and 2014, two Native American children suffered from child abuse and neglect fatalities. This represents an overall rate of approximately 0.91 deaths per 100,000 children. In keeping with trends seen in other child fatalities, both children were under age five and one or both biological parents were responsible for both fatalities.

Asian American/Pacific Islander Children

There were no child maltreatment fatalities among Asian/Pacific Islander (API) children in 2014. Between 2009 and 2014, 19 child maltreatment fatalities occurred among the Asian/Pacific Islander population. The six-year average for API fatalities was 0.32 per 100,000 children.

Comparable to child maltreatment fatalities overall in that time period, 74 percent of all API child maltreatment fatalities were perpetrated by the biological parents. Compared to the general

population, API children experienced fewer fatalities among infants (29 percent of fatalities compared to 42 percent of fatalities over the five-year period) and more fatalities among children ages 10-14 (16 percent of fatalities compared to six percent of fatalities in the total child maltreatment fatality population). However, the very small sample size makes it impossible to determine if this is a trend.

Cause of Death

As discussed earlier in this report and indicated in Figure 10, the most frequent causes of death in 2014 are blunt force trauma and abusive head trauma, which includes cases previously referred to as Shaken Baby Syndrome. These two causes of death, which occur largely in children under age five, accounted for 39.7 percent of all child abuse and neglect fatalities. Drowning, stabbing, and vehicular negligence were the next most common causes of death in 2014. Drowning and vehicular negligence are regularly among the leading causes of preventable death for California children.[24],[25] In 2014, vehicular negligence was the leading cause of abuse or neglect-related death for children ages five or older, while drowning is the second greatest cause of preventable deaths among young children (ages 1-4).

There were nine fatalities due to stabbing in 2014. The number of stabbing incidents was an outlier – in previous years, the number of deaths by stabbing has ranged from one to three. The nine stabbing deaths in 2014 were the result of six incidents, two of which were sibling sets.

Of the 88 fatalities in 2014, 28 resulted in allegations of abuse alone, 37 resulted in allegations of neglect alone and 23 resulted in allegations of both abuse and neglect (allegations of both abuse and neglect may occur, for example, when one parent or caregiver abuses a child, while the other fails to stop or report the abuse or when both physical abuse and unsafe living conditions are both present in the home).

Figure 9

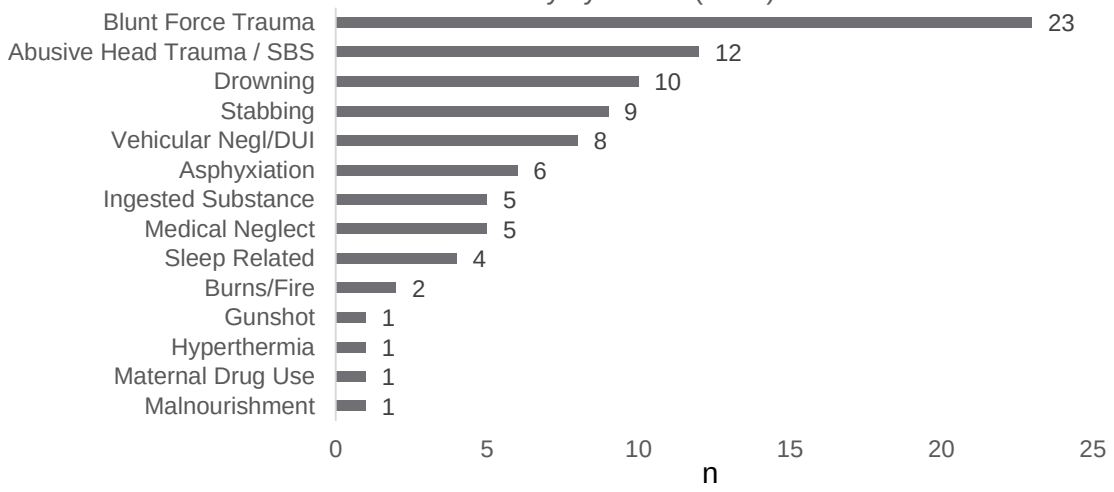
2014 Allegation Associated with Fatality Incident

	Physical Abuse (n=28)	Neglect (n=37)	glect
<1 year	32.1	37.8	52.2
1-4 years	53.6	35.1	30.4
5-9 years	3.6	10.8	13.0
10-14 years	7.1	10.8	4.3
15-17 years	3.6	5.4	0.0

Young children (ages 1-4) were disproportionately represented among fatalities with a physical abuse allegation (Figure 9). Infants were overrepresented in the groups of fatalities associated with both abuse and neglect. The very high proportion of young children among fatalities with

abuse allegations highlights the importance of screening, investigating and providing services for children and families with physical abuse allegations in this age group.

FIGURE 10
2014 Child Fatality by Cause (n=88)



Data Highlight: Differences in Male and Female Perpetrators

Analysis of data from 2012-2014 revealed that while biological mothers were the most frequent individuals responsible when all child fatalities were considered, male caregivers (biological fathers or the mother's significant other) were responsible for the majority of physical abuse-related deaths. Overall, blunt force trauma was the most common cause of death, and male caregivers were the most common perpetrator of the trauma leading to the death in 2014.

Most child abuse prevention and outreach is directed to the child's primary caregiver, usually the mother. [26] [27] *The identified trend indicates that physical abuse prevention efforts should be further targeted to male caregivers. CDSS will investigate ways to reach out to and educate fathers and other male caregivers of young children on child abuse prevention.*

Perpetrators

Figure 11 indicates that as in previous years, biological mothers were the most frequent perpetrator of fatal abuse or neglect in 2014, followed by both parents together and the biological father alone. (The category of both parents together describes situations where both parents were found to have been a primary individual responsible for the child's death). Overall, biological parents were responsible for 71.6 percent of fatalities, slightly lower than the national average of 79.3 percent of deaths being caused by a biological parent.[28] Figure 12 shows that, while responsible for less than half of deaths overall, male perpetrators were responsible for over 60 percent of all physical abuse related deaths. (See Data Highlight, page 14).

Individuals responsible for child fatalities tended to be in their twenties. In 2014, mothers tended to be younger than fathers involved in child fatalities. Nearly half (46.4 percent) of

mothers responsible were under the age of 23, while only seven percent of biological fathers who were responsible for child fatalities were this young.[29]

FIGURE 11
2014 Child Fatalities by Perpetrator
(n=88)

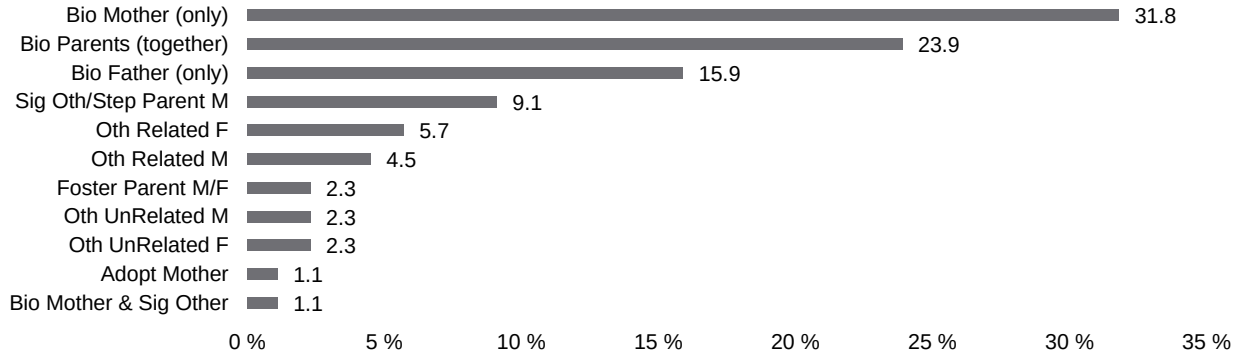
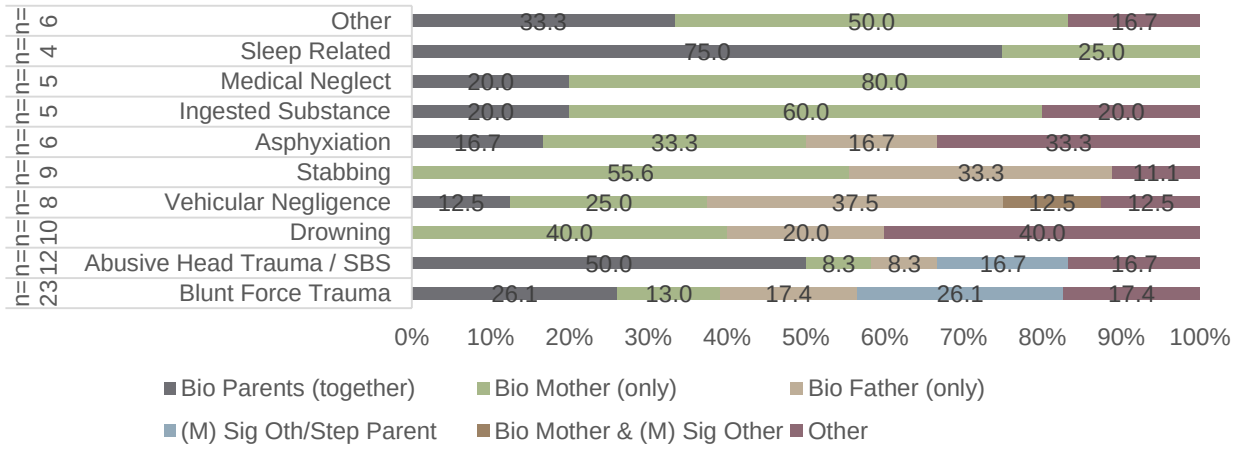
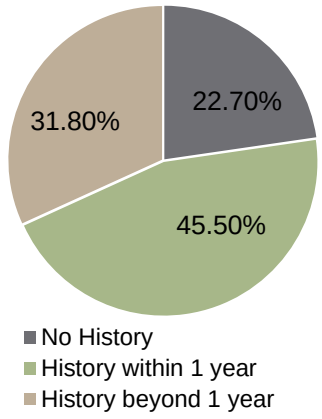


FIGURE 12
2014 Cause of Fatality by Primary Individual Responsible's Relationship to Child



Child Welfare Involvement in Child Fatality Cases

FIGURE 13
2014 Child Fatalities by Child Welfare History Status (n=88)



Of the 88 child maltreatment fatalities, 68 incidents (77.2 percent) involved children from families who previously had some form of contact with a CWS agency. This finding is consistent with data from previous years where approximately three-quarters of families who experience a child abuse or neglect fatality have prior child welfare history. Among those with child welfare history, 51 families (57.9 percent of all families with a fatality incident) had history within five years of the critical incident and 40 families, or 45.5 percent of all families with fatality incidents, had a referral to child welfare within one year of the fatality. The remaining 17 families (19.3 percent of all families) had history that occurred more than five years prior to the critical incident, including involvement of the perpetrator as a child victim.

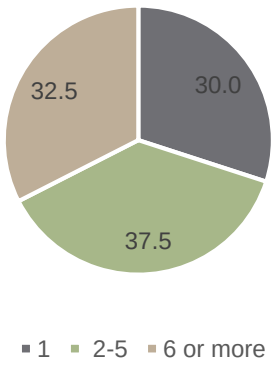
Deaths in Foster Care

Of 88 child maltreatment fatalities that occurred in 2014, 85 occurred while the child was living in his or her home, while three occurred while the child was placed in foster care. Of those three deaths, two were perpetrated by the foster parent and one was perpetrated by a family friend. Two deaths in care were of young children who suffered from abusive head trauma and blunt force trauma. One act was perpetrated by the foster father and the other by an unrelated male in the home. In a third situation, a teenager died as the result of a drug overdose complicated by lack of prompt medical attention.

Families with no Prior CWS History

In 2014, of the 20 families with no prior history, the most common causes of fatality were blunt force trauma (5), drowning (5), vehicular negligence (3) and stabbing (3). Among families with prior child welfare history, the most common causes were blunt force trauma (18), abusive head trauma (11) and stabbing (6).[30] Sleep related deaths also occurred exclusively in families with prior CWS history. Overall, deaths associated with inflicted violence were concentrated among families with former CWS history, while deaths in families with no CWS history were more frequently neglect-related.

FIGURE 14
2014 Number of Prior Referrals Among Families with CWS History within 1 year of the Critical Incident (%)



Families with Recent Child Welfare History

Of the 40 families who had contact with a child welfare agency within one year of the fatality, more than three-quarters of the reports to child welfare had occurred within the previous six months. Approximately two-thirds of households that were referred to child welfare within a year of the fatal incident had multiple referrals (Figure 14).

While the vast majority of parents who are reported to CWS do not go on to fatally injure their children, research indicates that a child who has been the subject of a report to child welfare, even if that report was screened out as not requiring investigation, is at twice the risk of an unintentional fatality and five times the risk of an intentional fatality than a child who has never been the subject of a report to child welfare.[31] To account for this history, the SDM assessment tool increases a family's score on the standardized Risk Assessment tool if the family has been subject of a prior report to CWS.[32] CDSS funds counties to correctly and accurately use the Risk Assessment tool to strengthen identification of families who are in need of support and services.

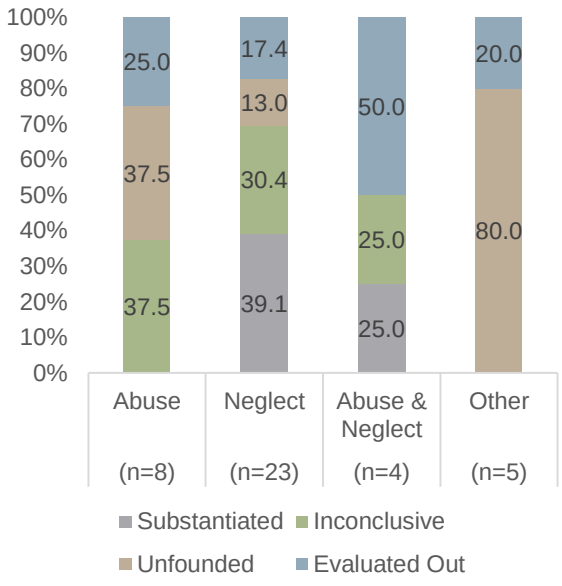
Most Recent Referral

In child welfare, a "referral" refers to the action that brings a child or children to the attention of child welfare services. Usually, this takes the form of a call to the child abuse hotline, a Suspected Child Abuse Report (SCAR) submitted by a mandated reporter, or a cross report from law enforcement or a licensing agency.

CDSS staff analyzed the most recent referral prior to the child fatality for the 40 families in which the most recent prior referral occurred within one year.

As indicated in Figure 15, of the 40 referrals that preceded a fatality by one year or less, eight alleged physical abuse alone, 23 alleged neglect alone and four alleged both physical abuse and neglect. Five referrals preceding a fatality alleged another type of maltreatment (sexual abuse, emotional abuse or exploitation).

FIGURE 15
2014 Most Recent Allegation Type by Disposition



Specifically, of these 40 referrals to CWS:

- Nine (22.5 percent) were evaluated out as not meeting the criteria for investigation, meaning either the allegation did not meet the definition of abuse and neglect, or the allegations reported were already being investigated or addressed in a case plan.

- Ten (25 percent) were investigated and determined to be unfounded, which is defined as the reported actions being false, inherently improbable, accidental, or not constituting child abuse or neglect.
- Eleven (27.5 percent) were investigated and determined to be inconclusive, which is defined as a report that is determined by the investigator not to be unfounded, but for which there is insufficient evidence to conclude that child abuse or neglect occurred.
- Ten (25 percent) were investigated and substantiated, meaning the investigator determined that child abuse and neglect more likely than not had occurred.

Notably, among the prior referrals, 39.1 percent of allegations of neglect alone were substantiated compared to 25 percent of allegations of combined abuse and neglect. None of the eight allegations of physical abuse alone were substantiated.[33] This finding reflects the difficulty in investigating and supporting an allegation of abuse compared to an allegation of neglect. While an unsafe home can be objectively photographed and social workers can request drug testing, physical abuse is far more difficult to confirm as it requires consideration of a number of subjective or variable factors such as: whether the alleged injury is still visible at the time of the investigation, determining that the injury is not accidental or the result of normal childhood activities and whether the child is old enough to make a reliable statement as to the cause of the injury.[34]

One possible avenue to address the difficulty of providing services to families when there is no demonstrable evidence of abuse is to utilize evidence-based and objective risk assessment tools. Rather than focusing on proving whether a child was abused or neglected in the past, the SDM Risk Assessment tool holistically considers the family's circumstances to identify which families are at risk of abuse or neglect in the future. SDM recommends that child welfare workers open cases for service based on the results of a Risk Assessment, rather than solely on whether or not past abuse can be substantiated.

The SDM Combined County Report for 2014 noted that there were nearly 30,000 instances of families with high or very high risk who did not have a case plan opened. Eleven percent of these families also had outstanding safety threats at the time the investigation was closed. This finding is especially striking as families who have a high or a very high risk score are more likely to be the subject of a subsequent referral when no case was opened, as opposed to cases where services were provided.[35] CDSS has actively supported statewide adoption of SDM and advocates for consistent and accurate use of the tool, including the use of the Risk Assessment. It is hoped that increased use of the SDM Risk Assessment tool and subsequent case openings based on risk of future child abuse rather than substantiation of past abuse alone will lead to an increase of services provided to high-risk families, including targeted child abuse prevention services before abuse or neglect even occurs.

Risk Factors

Of the 40 families with referrals within one year of the child maltreatment fatality, 34 occurred in counties where SDM is used. SDM assesses families for a variety of risk factors to help workers determine whether or not to open a case for services. Of the documented risk factors for the most recent referral prior to the fatality, drug and alcohol issues were the most common,

present in seven of 34 (20.5 percent) of the assessed families. Housing instability (three referrals), domestic violence (two referrals), and mental health issues (two referrals) were also noted risk factors.[36]

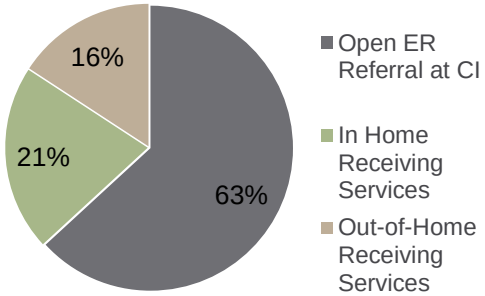
The data regarding risk factors highlights the importance of available and effective community based services to support families experiencing substance use, housing instability, domestic violence and mental health issues. When not addressed, these risk factors may further reduce family functioning and protective capacity to provide a safe and stable home environment.

Child Welfare Involvement at the Time of Critical Incident

When a child fatality occurs in a family with recent child welfare involvement, the natural response is to wonder what CWS could have done differently to save the victim child and better protect his or her siblings. The following section provides additional information about CWS activity in the open referrals and active cases.

Of the 88 child maltreatment fatality victims in 2014, a total of 19 children (21.5 percent) had CWS involvement at the time of the fatality. Seven (7) families had an open CWS case and 11 families (representing 12 fatalities) were in an open referral. Of the seven families in open child welfare cases, three children were living in foster care and four were receiving services in their family home. Of the eleven referrals, one was assessed to not require an in-person investigation (evaluated out) and ten were assigned to an in-person response.

FIGURE 16
2014 CWS Involvement at the Time of the Fatality (n=19)



Children in Open Investigations

CDSS conducted a special review of the 19 cases where children were fatally injured while in an open CWS referral or case plan. CDSS staff reviewed the referral that was under investigation or the referral that led to a case plan being opened to determine if investigatory requirements had been completed. The available documentation was compared to the SDM assessment tools to determine if the tools matched the available narrative or if discrepancies or inaccuracies existed. For children in open case plans, staff additionally analyzed if the child had been regularly visited while in placement and if the circumstances that led to the creation of a case plan were similar to the circumstances that led to the fatality.

Investigatory Requirements

If a referral meets the requirements for an in-person investigation, social workers are generally assigned to respond either “immediately” (within 24 hours) or within 10 days. Eleven referrals were open at the time of the fatality – one referral had been evaluated out (not assigned for investigation) but not yet closed, and ten had been assigned for investigation. Of the ten referrals assigned for investigation, five were determined to require an immediate response and

five were assigned to a ten-day response. Seventy percent of the reviewed referrals that were assigned to an in person investigation were responded to within the assigned time frame and parents were interviewed in 80 percent of the investigations. Collateral contacts with persons who had knowledge of the children were documented as completed in sixty percent of the investigations reviewed.

The allegations in the open referral or case were similar to the child's cause of death in almost one half (45.5 percent) of open investigations, including the allegation that had been evaluated out and not assigned for investigation.

Use of Assessment Tools

Hotline

Review of the standardized hotline assessment tool found the tools were generally accurately completed based on allegations contained in the suspected child abuse report. It is unknown what other conditions or risks may have been present but were not documented because they were not reported by the individual making the maltreatment referral.

Safety Assessment

When a social worker conducts an investigation, the SDM Policy and Procedure Manual indicates that a Safety Assessment should be conducted no later than 48 hours after first contact.[37] The purpose of the Safety Assessment is to determine whether a child can be left in the home during the investigation, or if the threat to the child's safety is so great that either a Safety Plan must be implemented to ensure the child's safety, or the child must be immediately removed to a safer environment. Of the eleven referrals, one referral was evaluated out and not assigned for CWS investigation. Two investigations did not have a Safety Assessment completed, in one case because contact with the family was never made. In total, eight out of ten (80 percent) of Safety Assessments were completed. This is in line with statewide trends, which show that Safety Assessments are completed in approximately 85 percent of investigations.[38]

Of the eight referrals where a Safety Assessment was completed, it was completed in a timely fashion two thirds (63 percent) of the time. All of the children were determined to be "Safe" at home based on the information available at the time. Of the Safety Assessments that were completed, one quarter were completed inaccurately. These inaccuracies consisted of the social worker not selecting a safety threat when one existed, resulting in a false assessment of "Safe." CDSS is in the process of drafting a letter on appropriate and consistent use of the Safety Tool and Safety Plans.

Overall, the majority of child welfare investigations were completed according to prescribed timelines and most investigators made contact with the alleged child victim and parents. Additionally, nearly all hotline tools were filled out accurately when compared with the hotline screener's written documents. However, in two thirds of investigations, the social worker lacked one or more required investigation steps, particularly interviews with collateral contacts, or assessments were incomplete or completed inaccurately.

Children with Open CWS Cases

Of the four children receiving in-home services, the situation addressed in the case plan was similar to the cause of death in one case. The circumstances addressed in the case plan were different than the situation surrounding the death in two cases. The final case did not have a completed case plan at the time of the fatality. Overall, social workers of children with open case plans met their requirements for regular visitation. Out of seven cases, six had complied with the requirement to visit the child every 30 days. Of the three children in foster care, one was placed with a relative and two were placed in non-relative foster homes. One of the non-relative foster homes had no prior CWS history and the other home had a history of prior CWS referrals, although there had been no referrals from during the time the victim child was living with that foster parent. The history of referrals included a number of unfounded and evaluated out referrals – however, a substantiated referral from 2008 did have similar circumstances to the situation that led to the death of the foster youth. It is unknown if action was taken at the time of the substantiated referral, however there had been a five-year period with no referrals prior to the death of the victim child.

Summary of 2014 Findings

In keeping with past trends, 2014 was the fourth year in a row where the number of child maltreatment fatalities decreased overall, particularly among infants. The statewide incident rate also declined slightly from 1.26 child abuse and neglect fatalities per 100,000 children to 0.97 such fatalities per 100,000 children. The year continued many ongoing trends, including the disproportionate representation of infants and young children, male children and Black and Multi-Racial children among child maltreatment fatalities. Blunt force trauma and abusive head trauma remained the leading causes of child maltreatment deaths in 2014, consistent with previous years. The majority of families experiencing a fatality were known to a child welfare agency at some point in the past, and half of these families had a history with child welfare within one year of the fatality.

Additionally, research conducted by CDSS on prior referrals preceding a fatality revealed that inconsistent use of the SDM suite of screening tools and incomplete investigations often preceded a fatality. These findings will drive policy recommendations for preventing child abuse and neglect and reducing the number of child fatalities in the upcoming year.

CDSS is in the process of revising regulations and developing guidance to help counties better meet regulatory requirements for investigating and responding to allegations of abuse and neglect. Additionally, the statewide adoption of SDM, completed in 2016, has provided another avenue whereby the Department can provide consistent guidance and technical support to counties. CDSS will provide an analysis and detailed plans for recommended improvements to child abuse investigations and assessments in its Five Year Child Fatality and Near Fatality Report, to be released later in 2017.

Updates to 2012-2013 Future Plans

Zero to Five

Statewide, approximately four-fifths of all child maltreatment 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 young children (ages 1-4) 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

Minor injuries other than superficial abrasions are uncommon in infants who aren't mobile and, when they occur, should raise a concern for abuse. In a study of 401 infants identified for abuse, 66 percent of sentinel injuries in infants occurred by three months of age and 95 percent occurred by the age of seven months. Medical providers were reportedly aware of the injuries in 42 percent of these cases but did not report them.[39,40] Reasons for not reporting included dismissal of the injury as being minor and insignificant, personal bias (family perceived as low risk), and the provider being unable to imagine that someone would abuse a child.

Action Step:

- CDSS will work closely with the California Department of Public Health (CDPH) to ensure that mandated reporter trainings are interactive, strengthen information provided on sentinel injuries in infants and increase emphasis on the subject of personal biases that could unintentionally prevent reporting of child maltreatment. Updated mandated reporter trainings will be linked to the Office of Child Abuse Prevention (OCAP) website. CDSS will promote the trainings to law enforcement, social workers and healthcare professionals. Further, the OCAP may propose appropriate policy changes if professionals do not have periodic mandated reporter training.

Update:

- *Originally, the CDSS planned to work with CDPH to update mandated reporter trainings. However, the CDSS collaborated with an expert at Rady Children's Hospital to update the Mandated Reporter training to include information regarding Sentinel Injuries. This information was finalized in spring of 2017. Additional information on identifying the signs of child trafficking and exploitation was added to the general mandated reporter training in summer 2016, a training specifically tailored to all school personnel was developed and launched in August 2016, and a new training for child care providers is currently being drafted with an expected launch date of September 2017.*

Action Steps:

- The OCAP will work closely with the CDPH to maximize opportunities to support families with education and services. Specific collaboration will include promotion of Shaken Baby Syndrome (SBS) education programs within hospitals, clinics and doctors' offices. CDSS will partner with hospitals regarding implementing evidence-informed SBS parent education programs through hospitals.

- CDSS is updating existing SBS and Safe to Sleep materials to contain the most current information, inclusive of resources for parents (i.e. the Child help National Child Abuse Prevention Hotline, as well as other hotlines and websites). Brochures will be downloadable and available in multiple languages. CDSS will promote available educational information through its website, social media and partnering agencies including the Essentials for Childhood Initiative, the California Family Resource Association, local Child Abuse Prevention Councils, county First 5 Commissions and the Strategies listserv reaching 14,000 child welfare and prevention partners.

Update:

- *CDSS has finalized an educational brochure and poster for Abusive Head Trauma Prevention and updated the Safely Surrendered Baby outreach and education materials with feedback from a variety of stakeholders including: County Child Welfare liaisons, Family Resource Centers, Child Abuse Prevention Councils, CDSS Healthcare Advisory Group members, CDPH representatives, and a pregnant and parenting teen focus group. All materials have been revised and redesigned to reflect a strength-based approach to prevention and incorporate the feedback of these stakeholder groups, including the addition of QR Codes on brochures to enhance the accessibility of materials through the use of technology. These materials are currently in the process of being printed through the Office of State Publishing, and will be available for dissemination upon request. The materials will also be posted in a downloadable format to the CDSS' website, shared via the OCAP's quarterly newsletter, and shared with social services partners via social media.*

Families with CWS Involvement

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

Action Step:

- CDSS will explore new methodologies and evaluate utilization of predictive risk modeling to aid risk and safety assessments in the years to come.

Update:

- *CDSS is funding the University of Southern California, Children's Data Network (USC/CDN) through a research grant to explore the potential of Predictive Risk Modeling*

within the California Child Welfare System. CDSS finalized the Predictive Analytics Grant with USC/CDN in Summer 2016 and the project will be funded through June 2018. A data sharing Memorandum of Understanding (MOU) between USC/CDN and CDSS has been finalized and will allow for sharing of CWS/CMS data, SDM assessment tool data, and child fatality related data. This project will involve ongoing advisory panel meetings with a variety of stakeholders from across the state to monitor progress and identify any potential issues around disproportionality or racial disparities.

Action Step:

- CDSS will work closely with 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. CDSS will partner with hospitals regarding implementing evidence-informed SBS parent education programs through hospitals.

Update:

- *In an effort to collaborate with the healthcare sector on prevention efforts related to child abuse prevention, CDSS identified key stakeholders and convened the Healthcare Advisory Group (HAG) in September 2016. The agenda for this meeting included discussion of Mandated Reporter Trainings, review of educational materials for Safely Surrendered Baby program and Abusive Head Trauma, and discussion of plans to further address child maltreatment fatalities. The first meeting was well attended and resulted in feedback on our prevention materials, including suggestions to enhance the accessibility of materials through the use of technology, and new partnerships with CDPH on the Text4Baby program, a service that sends out educational messages to expecting and new parents to promote positive health outcomes for families. CDSS will convene this group twice annually to continue collaboration and build partnerships with the healthcare sector. Potential agenda items for upcoming meetings include discussion of the recent Comprehensive Addiction and Recovery Act (CARA) legislation related to substance exposed newborns, and further discussion on safe sleep recommendations.*

Risk and Safety Assessment Tools

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 investigations of child abuse and neglect. 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, CDSS has conducted an extensive research and validation process to improve the performance of the screening and assessment tools.

Action Step:

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

Update:

- *The updated SDM tools were implemented on November 1, 2015. CDSS scheduled trainings for both staff and trainers throughout 2016 to educate staff and promote the new tools. Additionally, CDSS will create one-page briefs on SDM usage to create awareness and improve quality use and disseminate these briefs at the monthly Operations meetings held with the Child Welfare Directors at CDSS.*
- *Some key features of the new tools include:*
    - *Information on prior child deaths was clarified in the Hotline Screening tool*
    - *Information on caregiver complicating factors was added to the Safety Assessment. Caregiver complicating factors, such as substance abuse and mental health, must be considered when making a Safety Plan.*
    - *Use of more neutral language in the Risk Assessment and evaluation of the secondary caregiver's history of abuse and neglect as a child, mental health, drug and alcohol issues and criminal arrest history.*

Case and Practice Review

When reports are called into the child abuse hotline that do not appear to meet the minimum statutory definition of abuse or neglect required 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. This is known as evaluating out a case.

Cases Evaluated out Where There was a Later Child Fatality

An area of particular concern is the event of a child maltreatment fatality where the unsafe home environment was previously reported to a child abuse hotline and the referral was evaluated out and closed either with or without a referral 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. In accordance with Penal Code Section 11174.34(l), county child welfare agencies must create a record in the CWS/CMS on all cases of child death suspected to be related to child abuse or neglect, regardless of whether the deceased child has surviving siblings.

Data Entry and Allegations Regarding Non-Caregivers

As child welfare is specifically tasked with protecting children within their homes, CWS agencies engage in a variety of practices to investigate and record allegations when perpetrators 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 refer the investigation and

prosecution of the perpetrator to law enforcement. This creates a potential issue when the allegation involving the non-parent perpetrator is not documented in CWS/CMS, potentially excluding vital information for future risk and safety assessments from being known.

Action Step:

- CDSS and counties will review selected child fatality cases in order to identify any patterns and practices that may lead to inappropriate response determinations.

Update:

- *CDSS is continuing to review the referrals preceding child fatality and near fatality cases and will provide analysis in the Combined 2014 Child Fatality and Near Fatality Report. CDSS is also partnering with UCB/CCWIP and USC/CDN to develop more advanced analyses of fatality and near fatality cases.*

Action Step:

- CDSS will provide guidance to counties on best practice to ensure that all appropriate persons are entered in the CWS/CMS system when there is an allegation of abuse or neglect.

Update:

- *As a result of the review of 2012 and 2013 incidents with prior child welfare history, CDSS learned that counties differ in their practice of how nonparent perpetrators are entered into the system. Without proper documentation regarding these perpetrators of fatal abuse and neglect, future hotline screeners may not know this crucial piece of information if another allegation of abuse or neglect is made involving that same individual in the future.*

  In response, CDSS is in the process of drafting an All County Letter on the appropriate investigation and documentation practice for documenting child maltreatment fatalities caused by non-parent perpetrators. It is anticipated that this will be released in August 2017.

Partnerships

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

Action Step:

- CDSS is exploring how to build upon the work of 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 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.

Update:

- *CDSS convened the Critical Incident Workgroup (CIW) – a multidisciplinary and interagency group aiming to reduce and prevent child fatalities and near fatalities caused by abuse and neglect. At its fourth quarterly meeting in November 2016, a sub-group specifically addressed the first objective of the CIW: to develop and share standardized and statewide best practices and recommendations for Child Death Review Teams and CWS reviews. The sub-group meeting was attended by participants from Fresno Child Welfare Services, CDPH, The Child Abuse Prevention Center (CAPC) of Sacramento, and the National Center for Child Death Review. The sub-group is consulting with the National Center for Child Death Review for guidance on strengthening use of the Child Death Review Case Reporting System by Child Death Review Teams and developing strategies and best practices for CDRTs and CWS agencies when examining child fatalities to prevent future deaths and ensure child health and safety.*

Glossary

For the purposes of this report, the following definitions are used:

Abuse
The non-accidental commission of injuries against a person. In the case of a child, the term refers specifically to the non-accidental 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.

Abusive Head Trauma
An injury to the skull or intracranial contents of an infant or young child (< 5 years of age) due to inflicted blunt impact or violent shaking. Also includes Shaken Baby Syndrome.

Allegation
A report concerning a specific form of abuse. Examples of allegations include physical abuse, sexual abuse, emotional abuse, general neglect, severe neglect and exploitation. A single referral may contain more than one allegation (for example, physical abuse and general neglect).

Asphyxia
To cause to die or lose consciousness by impairing normal breathing, as by gas or other noxious agents; choke; suffocate; smother.

Blunt Force Trauma
Injuries resulting from an impact with a dull, firm surface or object. Individual injuries may be patterned (e.g., characteristics of the wound suggest a particular type of blunt object) or nonspecific. Includes blunt force trauma to the body or head.

Burn
An incident from injuries to tissues caused by heat, friction, electricity, radiation, or chemicals.

Case
Services provided to families in crisis to prevent or remedy abuse or neglect. Case plans may be voluntary or court ordered.

> Family Maintenance
> Allows social workers to work with the family while keeping the child in the home. Services are provided based on a case plan developed by a child welfare worker and the family services can include, but are not limited to, counseling, emergency shelter care, respite care, emergency in-home caretakers, substance abuse treatment, domestic violence intervention and services, and parenting education.
>
> Family Reunification
> Provides intervention and support services for a limited time period to parents/caregivers and children who have been removed from the home (placed into a foster home, with a relative, or into a group home) to make the family environment safe for the child to return.

Permanent Placement
Provides a permanent home for a child when reunification with a parent is not in the child's best interest. Adoption and legal guardianship are two forms of permanent placement.

Co-Sleeping
The practice of sleeping in the same bed as one's infant or young child.

Determination
A decision by an agency as to whether the child fatality or near fatality was the result of abuse or neglect. Abuse or neglect is determined to have led to a child's death if any one of the following conditions are met:

Child Welfare Services
A county child protective agency determines that the abuse or neglect was substantiated.

Law Enforcement
A law enforcement investigation concludes that abuse or neglect occurred.

Coroner/Medical Examiner
A coroner/medical examiner concludes that the child who died had suffered abuse or neglect.

Drowning/Near-Drowning
A process where a liquid-air interface is present at the entrance to the victim's airway, which prevents the individual from breathing oxygen resulting in respiratory impairment and possible fatality (delayed or rapid).

Evaluated out
A referral alleging child abuse or neglect that does not meet the criteria for investigation. These referrals may be closed with no further action, or a referral to a community agency may be provided, as appropriate.

Gunshot
An incident in which the victim was shot by a firearm intentionally or unintentionally.

Hyperthermia
The dangerous elevation of core body temperature, due to extreme weather conditions, other extremely hot environment or certain medical conditions.

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 has occurred.

Infant
A child between birth and one year old.

Infant Sleep-Related Deaths
Deaths where a child less than one year old dies while sleeping where there is no discernable cause of death.

Ingested Substance
An incident caused by an object or substance that entered a child's body through the mouth.

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.

> General Neglect
> The negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.
>
> Severe Neglect
> The negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Penal Code Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.
>
> Medical Neglect
> The denial or deprivation, by those responsible for the care, custody, and control of the child, of medical or surgical treatment or intervention which is necessary to remedy or ameliorate a medical condition which is life threatening or causes injury. Medical neglect includes not only serious, but mild and moderate medical neglect as well.

Referral
A referral that alleges child abuse, neglect, or exploitation. A referral may be made by a call to the Child Abuse Hotline, a Suspected Child Abuse Report submitted by a mandated reporter, or a cross-report from a law enforcement, licensing or other agency.

Shaken Baby Syndrome
See: Abusive Head Trauma

Stabbing
An incident in which the victim was pierced or wounded by a pointed instrument.

Substance Abuse
Caregiver has abused legal or illegal substances or alcoholic beverages to the extent that control of his/her actions or caregiving abilities is significantly impaired, or information is available that past abuse of legal or illegal substances has impaired the parent's caregiving capabilities in the past.

Substantiated report
A report that is determined by the investigator who conducted the investigation to constitute child abuse or neglect, 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.

Suicide

Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Third Party Homicide

Situations wherein a child was a victim of homicide by a perpetrator other than a parent/guardian or a person acting as a caregiver and there was no contributory abuse or neglect by a parent, guardian or caregiver.

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.

Vehicular DUI/Negligence

DUI

An incident as a result of the caretaker operating a vehicle while under the influence of alcohol or drugs. This includes persons who are operating a vehicle while having .08 alcohol (of their weight) in their system.

Negligence

An incident as a result of the perpetrator operating a vehicle in an unreasonable or unlawful manner (i.e. speeding, not restraining child in carseat etc.)

Appendices

I. 2009-2014 Demographic Characteristics of Child Fatality Victims

	TOTAL	2009	2010	2011	2012	2013	2014
	n	n	n	n	n	n	n
Total	**660**	**117**	**128**	**119**	**111**	**97**	**88**
Gender							
Female	296	61	62	48	51	39	35
Male	364	56	66	71	60	58	53
Race / Ethnicity*							
Black	136	28	29	20	21	24	14
Hispanic	267	49	56	50	46	37	29
White	143	24	29	27	17	24	22
Asian/Pacific Islander	19	3	4	6	4	2	-
Native American	2	-	1	-	-	-	1
Multi-Race*	39	-	-	10	8	7	14
Other	9	6	-	1	2	-	-
Not Documented	45	7	9	5	13	3	8
Age Group							
<1 Yr Old	292	46	53	58	56	44	35
1-4 Yrs Old	240	49	53	35	36	32	35
5-9 Yrs Old	68	13	11	14	10	12	8
10-14 Yrs Old	41	7	6	7	6	8	7
15-17 Yrs Old	19	2	5	5	3	1	3
Age Group (1-4 yr breakout)**							
<1 Yr Old	193			58	56	44	35
1 Yrs Old	57			18	12	13	14
2 Yrs Old	44			8	12	11	13
3 Yrs Old	18			5	5	4	4
4 Yrs Old	19			4	7	4	4
5-9 Yrs Old	44			14	10	12	8
10-14 Yrs Old	28			7	6	8	7
15-17 Yrs Old	12			5	3	1	3
Infant Age Group**							
0 to 3 months	108			31	32	22	23
4 to 6 months	31			10	10	8	3
7 to 11 months	54			17	14	14	9

*Multi-Race category was not available in 2009 and 2010

** Detailed age data not available for 2009 and 2010

II. 2009-2014 Child Fatality Critical Incident Characteristics

	Total	2009	2010	2011	2012	2013	2014
	n	n	n	n	n	n	n
Total Fatalities	**660**	**117**	**128**	**119**	**111**	**97**	**88**
Fatality Location							
Home	643	111	124	117	109	97	85
Foster Care	17	6	4	2	2	-	3
Finding Incident Due to							
Crime	309	62	45	58	52	46	46
Suicide	2	-	-	2	-	-	-
Non-Accidental	182	24	49	29	29	26	25
Undetermined	8	2	2	3	1	-	-
Other	159	29	32	27	29	25	17
Cause of Fatality							
Blunt Force Trauma	214	44	33	37	34	43	23
Abusive Head Trauma / SBS	37	6	7	12	-	-	12
Medical Neglect	29	4	6	4	6	4	5
Ingested Substance	17	-	1	1	6	4	5
Malnourishment	9	3	-	2	2	1	1
Asphyxiation	40	1	7	10	11	5	6
Sleep Related	46	8	10	8	11	5	4
Drowning	68	5	17	10	13	13	10
Maternal Drug Use	7	1	2	-	3	-	1
Gunshot	46	16	8	7	9	5	1
Stabbing	28	8	6	1	3	1	9
Suicide	4	-	2	2	-	-	-
Vehicular Negl/DUI	41	6	6	5	7	9	8
Burns/Fire	14	-	6	5	1	-	2
Victim Abandoned	9	1	2	4	-	1	1
Mauled	1	-	1	-	-	-	-
Other	16	14	2	-	-	-	-
Undetermined	28	-	6	11	5	6	-
Missing	6	-	6	-	-	-	-
Allegation of Critical Incident							
None	7	-	7	-	-	-	-
Abuse	208	33	42	42	28	35	28
Neglect	312	48	61	53	65	48	37
Abuse & Neglect	128	34	18	24	17	12	23
Other	5	2	-	-	1	2	-

III. 2009-2014 Gender by Cause of Fatality

		Total	Blunt Force Trauma	Abusive Head Trauma	Drowning	Vehicular Negligence / DUI	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Sleep Related	Other	Missing
		n	n	n	n	n	n	n	n	n	n	n	n
2009	**Female**	61	23	1	3	3	6	-		2	4	19	
2009	**Male**	56	21	5	2	3	2	1		2	4	16	
2009	**Total**	117	44	6	5	6	8	1		4	8	35	
2010	**Female**	62	19	3	10	4	4	4	-	2	4	7	5
2010	**Male**	66	14	4	7	2	2	3	1	4	6	16	7
2010	**Total**	128	33	7	17	6	6	7	1	6	10	23	12
2011	**Female**	48	13	3	5	3	-	7	-	1	2	11	3
2011	**Male**	71	24	9	5	2	1	3	1	3	6	9	8
2011	**Total**	119	37	12	10	5	1	10	1	4	8	20	11
2012	**Female**	51	16		7	3	2	3	1	3	6	8	2
2012	**Male**	60	18		6	4	1	8	5	3	5	7	3
2012	**Total**	111	34		13	7	3	11	6	6	11	15	5
2013	**Female**	39	15		5	2	-	2	3	2	1	5	4
2013	**Male**	58	28		8	7	1	3	1	2	4	2	2
2013	**Total**	97	43		13	9	1	5	4	4	5	7	6
2014	**Female**	35	13	7	2	3	4	1	1	2	-	2	
2014	**Male**	53	10	5	8	5	5	5	4	3	4	4	
2014	**Total**	88	23	12	10	8	9	6	5	5	4	6	

IV. 2009-2014 Child Fatality by Characteristics of the Primary Individual(s) Responsible

	Total	2009	2010	2011	2012	2013	2014
	n	n	n	n	n	n	n
Total Fatalities	**660**	**117**	**128**	**119**	**111**	**97**	**88**
PIR Relation to Child Victim							
Bio Parents (together)	109	18	15	25	18	12	21
Bio Mother (only)	198	29	34	37	41	29	28
Bio Father (only)	149	26	32	29	24	24	14
Bio Mother & Sig Other	18	5	4	3	2	3	1
F Sig Oth/Step Parent	7	3	2	-	2	-	-
M Sig Oth/Step Parent	66	12	8	16	7	15	8
Oth Related F	11	-	3	1	1	1	5
Oth Related M	9	1	1	-	2	1	4
Oth UnRelated F	9	1	-	-	4	2	2
Oth UnRelated M	11	-	1	3	1	4	2
Adopt Mother	4	1	-	-	-	2	1
Adopt Father	1	-	1	-	-	-	-
Foster Parent M/F	9	1	4	1	1	-	2
Other	59	20	23	4	8	4	-
PIR #2 Relation to Child Victim*							
None	626	107	118	113	109	94	85
Related (F)	1	-	1	-	-	-	-
Related (M)	3	1	-	1	-	-	1
Unrelated (F)	3	-	1	1	-	-	1
Unrelated (M)	19	5	5	3	2	3	1
Other	8	4	3	1	-	-	-
Primary Individual(s) Responsible Age**							
<16 years old	1	-	-	-	-	1	-
16-20 years old	62	5	16	10	15	8	8
21-23 years old	102	14	15	19	20	14	20
24-26 years old	109	17	21	25	19	21	6
27-30 years old	104	14	21	18	13	19	19
31-35 years old	81	11	8	17	18	17	10
36-40 years old	54	15	9	12	8	4	6
41-45 years old	35	9	4	7	4	5	6
46-60 years old	33	6	6	7	5	3	6
60+ years old	3	-	1	-	-	1	1
Missing	76	26	27	4	9	4	6
PIR #1 Race/Ethnicity****							
Black	80	-	-	18	24	22	16
Hispanic	161	-	-	48	42	40	31
White	98	-	-	35	21	20	22
Asian/Pacific Islander	9	-	-	3	4	2	-
Native American	2	-	-	-	-	1	1
Multi-Race	15	-	-	-	4	6	5
Other	8	-	-	5	3	-	-
Missing	42	-	-	10	13	6	13

*Bio Parents Together and Bio Mother with Sig Other are coded as None since they are represented elsewhere.

** When two were listed as PIR, the age of the younger individual was utilized.

V. 2014 Cause of Child Fatality by Demographic and Case Characteristics

	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Sleep Related	Other
	n	n	n	n	n	n	n	n	n	n	n
Total Fatalities	**88**	**23**	**12**	**10**	**8**	**9**	**6**	**5**	**5**	**4**	**6**
Gender											
Female	35	13	7	2	3	4	1	1	2	-	2
Male	53	10	5	8	5	5	5	4	3	4	4
Race / Ethnicity*	88	-	-	-	-	-	-	-	-	-	-
Age Group											
<1 Yr Old	35	7	7	1	-	4	3	4	2	4	3
1-4 Yrs Old	35	15	4	8	2	2	3	-	-	-	1
5-9 Yrs Old	8	-	1	1	4	1	-	-	-	-	1
10-14 Yrs Old	7	1	-	-	1	2	-	-	3	-	-
15-17 Yrs Old	3	-	-	-	1	-	-	1	-	-	1
Age Group (1-4 yr breakout)											
<1 Yr Old	35	7	7	1	-	4	3	4	2	4	3
1 Yrs Old	14	7	-	4	-	1	2	-	-	-	-
2 Yrs Old	13	5	4	1	-	1	1	-	-	-	1
3 Yrs Old	4	2	-	2	-	-	-	-	-	-	-
4 Yrs Old	4	1	-	1	2	-	-	-	-	-	-
Infant Age Group**											
0 to 3 months	23	2	6	-	-	2	2	3	2	4	2
4 to 6 months	3	2	-	-	-	1	-	-	-	-	-
7 to 11 months	9	3	1	1	-	1	1	1	-	-	1

* Due to the requirements of Welfare and Institutions Code 10850.4(e), information on race/ethnicity as it relates to the cause of death has been redacted

2014 Cause of Child Fatality by Demographics and Case Characteristics, cont.	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Sleep Related	Other
Fatality Location											
Home	85	22	11	10	8	9	6	4	5	4	6
Foster Care	3	1	1	-	-	-	-	1	-	-	-
Finding Incident Due to											
Crime	46	15	7	2	6	9	2	3	-	1	1
Suicide	-	-	-	-	-	-	-	-	-	-	-
Non-Accidental	25	6	5	2	2	-	2	-	4	1	3
Undetermined	-	-	-	-	-	-	-	-	-	-	-
Other	17	2	-	6	-	-	2	2	1	2	2
Primary Individual(s) Responsible Relation to Child Victim*											
Bio Parents (together)	21	6	6	-	1	-	1	1	1	3	2
Bio Mother (only)	28	3	1	4	2	5	2	3	4	1	3
Bio Father (only)	14	4	1	2	3	3	1	-	-	-	-
Bio Mother & Sig Other	1	-	-	-	1	-	-	-	-	-	-
F Sig Oth/Step Parent	-	-	-	-	-	-	-	-	-	-	-
M Sig Oth/Step Parent	8	6	2	-	-	-	-	-	-	-	-
Oth Related F	5	1	1	3	-	-	-	-	-	-	-
Oth Related M	4	1	-	-	1	1	-	-	-	-	1
Oth UnRelated F	2	-	-	1	-	-	1	-	-	-	-
Oth UnRelated M	2	-	1	-	-	-	1	-	-	-	-
Adopt Mother	1	1	-	-	-	-	-	-	-	-	-
Adopt Father	-	-	-	-	-	-	-	-	-	-	-
Foster Parent M/F	2	1	-	-	-	-	-	1	-	-	-
Primary Individual Responsible #2 Relation to Child Victim**											
None	85	21	12	10	7	9	6	5	5	4	6
Related (F)	-	-	-	-	-	-	-	-	-	-	-
Related (M)	1	1	-	-	-	-	-	-	-	-	-
Unrelated (F)	1	1	-	-	-	-	-	-	-	-	-
Unrelated (M)	1	-	-	-	1	-	-	-	-	-	-

2014 Cause of Child Fatality by Demographics and Case Characteristics, cont.	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Sleep Related	Other
Primary Individual(s) Responsible Age* **											
<16 years old	-	-	-	-	-	-	-	-	-	-	-
16-20 years old	8	2	1	2	-	2	-	1	-	-	-
21-23 years old	20	8	2	2	1	1	-	2	-	2	2
24-26 years old	6	1	2	1	-	-	1	-	-	-	1
27-30 years old	19	4	5	1	1	3	1	1	1	1	1
31-35 years old	10	1	1	1	4	-	1	-	2	-	-
36-40 years old	6	2	-	1	-	1	2	-	-	-	-
41-45 years old	6	1	-	-	-	2	1	-	2	-	-
46-60 years old	6	1	-	1	2	-	-	-	-	-	2
60+ years old	1	-	-	-	-	-	-	1	-	-	-
Missing	6	3	1	1	-	-	-	-	-	1	-
Primary Individual Responsible #1 Race/Ethnicity	-	-	-	-	-	-	-	-	-	-	-

*Bio Parents Together and Bio Mother with Sig Other are coded as None since they are represented elsewhere.

** When two were listed as PIR, the age of the younger individual was utilized.

* Due to the requirements of Welfare and Institutions Code 10850.4€, information on race/ethnicity as it relates to the cause of death has been redacted

VI. 2014 Allegation of Child Fatality Critical Incident by Demographic and Case Characteristics

	TOTAL	Abuse	Neglect	Abuse & Neglect
	n	n	n	n
Total Fatalities	**88**	**28**	**37**	**23**
Gender				
Female	35	11	11	13
Male	53	17	26	10
Race / Ethnicity				
Black	14	3	7	4
Hispanic	29	6	14	9
White	22	9	7	6
Asian / Pacific Islander	-	-	-	-
Native American	1	-	1	-
Multi-Race	14	8	3	3
Not Documented	8	2	5	1
Age Group				
<1Yrs Old	35	9	14	12
1-4 Yrs Old	35	15	13	7
5-9 Yrs Old	8	1	4	3
10-14 Yrs Old	7	2	4	1
15-17 Yrs Old	3	1	2	-
Age Group (1-4 yr breakout)				
<1 Yr Old	35	9	14	12
1 Yrs Old	14	8	3	3
2 Yrs Old	13	6	4	3
3 Yrs Old	4	1	3	-
4 Yrs Old	4	-	3	1
Infant Age Group				
0 to 3 months	23	5	12	6
4 to 6 months	3	1	-	2
7 to 11 months	9	3	2	4
Fatality Location				
Home	85	26	36	23
Foster Care	3	2	1	-
Finding Incident Due to:				
Crime	46	22	10	14
Suicide	-	-	-	-
Non-Accidental	25	5	12	8
Undetermined	-	-	-	-
Other	17	1	15	1

2014 Allegation of Child Fatality Incident by Demographics and Case Characteristics	TOTAL	Abuse	Neglect	Abuse & Neglect
Primary Individual Responsible Relation to Child Victim*				
Bio Parents (together)	21	2	9	10
Bio Mother (only)	28	6	17	5
Bio Father (only)	14	8	3	3
Bio Mother & (M) Sig Other	1	-	1	-
Bio Father & (F) Sig Other	-	-	-	-
(F) Sig Oth/Step Parent	-	-	-	-
(M) Sig Oth/Step Parent	8	5	-	3
Oth Rel Adult (F)	5	1	3	1
Oth Rel Adult (M)	4	3	1	-
Oth UnRelAdult (F)	2	-	2	-
Oth UnRel Adult (M)	2	2	-	-
Adopt Mother	1	-	-	1
Adopt Father	-	-	-	-
Foster Parent (M/F)	2	1	1	-
Primary Individual Responsible #2 Relation to Child Victim*				
None	85	28	35	22
Related Adult (F)	-	-	-	-
Related Adult (M)	1	-	-	1
Unrelated Adult (F)	1	-	1	-
Unrelated Adult (M)	1	-	1	-
Primary Individual(s)Responsible Age**				
<16 years old	-	-	-	-
16-20 years old	8	3	3	2
21-23 years old	20	6	10	4
24-26 years old	6	3	1	2
27-30 years old	19	7	5	7
31-35 years old	10	1	7	2
36-40 years old	6	2	2	2
41-45 years old	6	2	3	1
46-60 years old	6	-	3	3
60+ years old	1	-	1	-
Missing	6	4	2	-
Primary Individual Responsible #1 Race/Ethnicity				
Black	16	4	8	4
Hispanic	31	9	11	11
White	22	7	10	5
Asian / Pacific Islander	-	-	-	-
Native American	1	-	1	-
Multi-Race	5	1	2	2
Other	-	-	-	-
Not Documented	13	7	5	1

*Bio Parents Together and Bio Mother with Sig Other are coded as None since they are represented elsewhere.

** When two were listed as PIR, the age of the younger individual was utilized.

VII. 2014 Cause of Death by CWS History Ever

	Total	Blunt Force Trauma	Abusive Head Trauma / SBS	Drowning	Vehicular Negligence	Stabbing	Asphyxiation	Ingested Substance	Medical Neglect	Sleep Related	Other
Total	88	23	12	10	8	9	6	5	5	4	6
No	20	5	1	5	3	3	1	-	1	-	1
Yes	68	18	11	5	5	6	5	5	4	4	5

*Includes cases where perpetrator had CWS history as a minor only

VIII. 2011-2014 Child Fatalities by Child Welfare History Status

	Total	2011	2012	2013	2014
	n	n	n	n	n
Total	**415**	**119**	**111**	**97**	**88**
Any CW History*					
No	104	27	31	26	20
Yes	311	92	80	71	68
As adult	188	63	45	43	37
As minor	123	29	35	28	31
CW History within 5 years of Critical Incident					
No	167	43	47	40	37
Yes	248	76	64	57	51
As adult	239	72	61	56	50
As minor	9	4	3	1	1
CWS History within 1 year of Critical Incident					
No	272	82	81	61	48
Yes	143	37	30	36	40
As adult	143	37	30	36	40
As minor	-	-	-	-	-

* Includes cases where perpetrator had CWS history as minor only

IX. 2011-2014 Children with Some CWS History within 1 Year of Critical Incident

	Total	2011	2012	2013	2014
	n	n	n	n	n
Total	**143**	**37**	**30**	**36**	**40**
Number of Prior Referrals					
1	42	11	8	11	12
2-5	66	19	15	17	15
6 or more	35	7	7	8	13
Time between Referral and Critical Incident					
0 to <6 Months	118	31	26	30	31
6 to <12 Months	25	6	4	6	9
Most Recent Allegation Type					
Abuse	27	9	3	7	8
Neglect	87	21	24	19	23
Abuse & Neglect	22	7	3	8	4
Other	7	-	-	2	5
Most Recent Allegation Disposition					
Substantiated	46	15	12	9	10
Inconclusive	28	4	6	7	11
Unfounded	36	8	7	11	10
Evaluated Out	33	10	5	9	9

X. 2011-2014 CWS Involvement at the Time of the Fatality

	Total	2011	2012	2013	2014
	n	n	n	n	n
Total Fatalities	**415**	**119**	**111**	**97**	**88**
Fatalities with CWS Case History	**103**	**28**	**26**	**21**	**28**
Case Service Component at Critical Incident					
Not current client (prior CWS history) *	36	10	10	5	11
Open ER Referral at CI	39	10	9	9	11
In Home Receiving Services	18	4	5	6	3
Out-of-Home Receiving Services	9	3	2	1	3
Other	1	1	-	-	-

*Within 5 years of the critical incident

XI. 2014 Child Fatalities with CWS History within 1 year - Most Recent Referral SDM Assessment Information

SDM Assessment Information	n
SDM Data Subtotal (County uses SDM Tool)	34
Most Recent Referral Risk Factors	
Alcohol & Drugs	7
Mental Health	2
Domestic Violence	2
Housing Instability	3
No Risk Factors	21
SDM Hotline Screening Decision for CI Referral	
None	3
In Person	24
Evaluated Out	7
SDM Hotline Response Priority for CI Referral	
None	3
Immediate	9
10-day	15
Priority Not Required	7
SDM Risk Level for CI Referral	
None	12
Low	3
Moderate	5
High	7
Very High	2
Not Documented	5
SDM Safety Decision for CI Referral	
None	11
Safe	18
Conditionally Safe	2
Unsafe	1
Not Documented	2

XII. 2014 Most Recent Allegation Type by Disposition

	Total	Abuse	Neglect	Abuse & Neglect	Other
	n	n	n	n	n
Total	**40**	**8**	**23**	**4**	**5**
Substantiated	10	-	9	1	-
Inconclusive	11	3	7	1	-
Unfounded	10	3	3	-	4
Evaluated Out	9	2	4	2	1

XIII. 2009-2014 Child Fatalities and Rates per 100,000 by Year

	2009	2010	2011	2012	2013	2014
Total CA Child Population (age 0-17) (1)	9,307,822	9,273,754	9,203,420	9,149,419	9,104,860	9,097,971
Total Abuse / Neglect Fatalities	117	128	119	111	97	88
CA Abuse & Neglect Fatality Rate	1.26	1.38	1.29	1.21	1.07	0.97
National Abuse & Neglect Fatality Rate (2)	2.34	2.07	2.10	2.20	2.04	2.13
CA Total Injury Fatality Rate (3)	9.73	8.02	7.83	7.11	7.77	7.22
National Injury Fatality Rate (3)	12.79	12.17	11.99	11.75	11.39	11.36

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XIV. 2009-2014 Child Population, Child Fatalities, and Rate per 100,000

	Child Population (age 0-17)						Child Fatalities						Rate per 100,000					
	2009	2010	2011	2012	2013	2014	2009	2010	2011	2012	2013	2014	2009	2010	2011	2012	2013	2014
Total	**9,307,822**	**9,273,754**	**9,203,420**	**9,149,419**	**9,104,860**	**9,097,971**	**117**	**128**	**119**	**111**	**97**	**88**	**1.26**	**1.38**	**1.29**	**1.21**	**1.07**	**0.97**
Age Group																		
<1 Yr Old	499,032	493,399	506,768	495,240	497,410	502,818	46	53	58	56	44	35	9.22	10.74	11.45	11.31	8.85	6.96
1-4 Yrs Old	2,050,313	2,033,169	2,013,325	2,005,213	1,989,392	1,998,347	49	53	35	36	32	35	2.39	2.61	1.74	1.80	1.61	1.75
5-9 Yrs Old	2,512,471	2,504,035	2,501,508	2,524,358	2,537,336	2,536,409	13	11	14	10	12	8	0.52	0.44	0.56	0.40	0.47	0.32
10-14 Yrs Old	2,594,362	2,583,627	2,553,685	2,529,056	2,515,768	2,514,558	7	6	7	6	8	7	0.27	0.23	0.27	0.24	0.32	0.28
15-17 Yrs Old	1,651,643	1,659,524	1,628,134	1,595,552	1,564,954	1,545,839	2	5	5	3	1	3	0.12	0.30	0.31	0.19	0.06	0.19
Sex																		
Female	4,548,386	4,528,816	4,497,506	4,473,282	4,453,134	4,451,179	61	62	48	51	39	35	1.34	1.37	1.07	1.14	0.88	0.79
Male	4,759,436	4,744,938	4,705,914	4,676,137	4,651,726	4,646,792	56	66	71	60	58	53	1.18	1.39	1.51	1.28	1.25	1.14
Race/Ethnicity*																		
Black	545,047	527,695	516,416	503,885	493,035	487,981	28	29	20	21	24	14	5.14	5.50	3.87	4.17	4.87	2.87
Hispanic	4,718,325	4,747,973	4,722,627	4,697,887	4,669,624	4,675,027	49	56	50	46	37	29	1.04	1.18	1.06	0.98	0.79	0.62
White	2,654,374	2,560,676	2,526,028	2,505,391	2,486,123	2,465,851	24	29	27	17	24	22	0.90	1.13	1.07	0.68	0.97	0.89
Asian/P.I.	965,249	1,006,311	1,001,196	999,957	1,008,249	1,017,657	3	4	6	4	2	-	0.31	0.40	0.60	0.40	0.20	-
Nat American	39,093	37,975	37,148	36,289	35,620	35,119	-	1	-	-	-	1	-	2.63	-	-	-	2.85
Multi-Race	385,734	393,124	400,005	406,010	412,209	416,336	-	-	10	8	7	14	-	-	2.50	1.97	1.70	3.36

XV. Child Fatalities with Open Child Welfare Involvement at time of Critical Incident

	Open Referral	Open Family Maintenance	Open Family Reunification (Foster Care)
Total	12*	4	3
Victim Gender			
Female	5	1	1
Male	7	3	2
Victim Age			
>1 Yr Old	4	2	1
1-4 Yr Old	5	1	1
5-9 Yrs Old	3	0	0
10-14 Yrs Old	0	0	0
15-17 Yrs Old	0	0	1
Victim Race			
Black	3	1	0
Hispanic	1	2	0
White	6	1	1
Asian/PI	0	0	0
Multi-Race	0	0	2
Not Documented	2	0	0

	Open Referral	Open Family Maintenance	Open Family Reunification (Foster Care)
Was First Contact Timely?			
Yes	7	N/A	N/A
No	3	N/A	N/A
No contact	2	N/A	N/A
Were all children interviewed?			
Yes	4	N/A	N/A
No	2	N/A	N/A
Too Young to Interview	4	N/A	N/A
No investigation	2	N/A	N/A
Were all parents interviewed?			
Yes	8	N/A	N/A
No	2	N/A	N/A
No investigation	2	N/A	N/A
Were Collateral Contacts Interviewed			
Yes	5	N/A	N/A
No	5	N/A	N/A
No investigation	2	N/A	N/A

* One referral accounted for two fatalities

	Open Referral	Open Family Maintenance	Open Family Reunification (Foster Care)
Cause of Death			
Blunt Force Trauma	2	1	1
Abusive Head Trauma	1	2	1
Medical Neglect	1	0	0
Ingested Substance	0	0	1
Asphyxiation	2	1	0
Sleep Related	1	0	0
Drowning	3	0	0
Vehicular Negligence	2	0	0
Did Hotline Tool match documents?			
Yes	11	N/A	N/A
No	1	N/A	N/A
Response Time			
Evaluate Out	1	N/A	N/A
Immediate	6	N/A	N/A
10 Day	5	N/A	N/A

	Open Referral	Open Family Maintenance	Open Family Reunification (Foster Care)
Was Safely Assessment Completed Timely?			
Yes	6	N/A	N/A
No	3	N/A	N/A
No Safety Assessment	3	N/A	N/A
Safety Finding			
Safe	9	N/A	N/A
Safe with a Plan	0	N/A	N/A
Unsafe	0	N/A	N/A
No Safety Assessment	3	N/A	N/A
Was Risk Assessment Completed Timely?			
Yes	2	N/A	N/A
No	3	N/A	N/A
Fatality prior to Risk Assessment completion	7	N/A	N/A
Were circumstances of fatality addressed in Case Plan?			
Yes	N/A	2	0
No	N/A	2	3
Had SW visited child within 30 days of fatality?			
Yes	N/A	3	2
No	N/A	1	1

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