# NOBODY KNOWS HOW MANY CHILDREN DIE FROM CHILDHOOD ABUSE or NEGLECT

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## Table 4–3 Child Fatalities by Age, 2020

| Age | Child Population | Child Fatalities | Child Fatalities Percent | Child Fatalities Rate per 100,000 Children |
|---|---|---|---|---|
| <1 | 2,982,424 | 687 | 46.4 | 23.03 |
| 1 | 3,018,680 | 196 | 13.2 | 6.49 |
| 2 | 3,081,767 | 120 | 8.1 | 3.89 |
| 3 | 3,126,811 | 101 | 6.8 | 3.23 |
| 4 | 3,210,326 | 64 | 4.3 | 1.99 |
| 5 | 3,236,417 | 61 | 4.1 | 1.88 |
| 6 | 3,225,797 | 27 | 1.8 | 0.84 |
| 7 | 3,215,877 | 25 | 1.7 | 0.78 |
| 8 | 3,222,471 | 10 | 0.7 | 0.31 |
| 9 | 3,251,797 | 24 | 1.6 | 0.74 |
| 10 | 3,259,859 | 21 | 1.4 | 0.64 |
| 11 | 3,259,890 | 24 | 1.6 | 0.74 |
| 12 | 3,359,300 | 21 | 1.4 | 0.63 |
| 13 | 3,377,805 | 13 | 0.9 | 0.38 |
| 14 | 3,353,562 | 26 | 1.8 | 0.78 |
| 15 | 3,346,596 | 21 | 1.4 | 0.63 |
| 16 | 3,357,944 | 19 | 1.3 | 0.57 |
| 17 | 3,336,411 | 14 | 0.9 | 0.42 |
| Unborn, Unknown, and 18–21 | N/A | 6 | 0.4 | N/A |
| **National** | **58,223,734** | **1,480** | **100.0** | **N/A** |

*Based on data from 46 states.*

**"The national estimate of victims who died from abuse and neglect decreased from 1,830 for FFY 2019 to 1,750 for FFY 2020. The rate of child fatalities also decreased from 2.48 per 100,000 chldren in the population to 2.38 per 100,000 children in the population."**

## Exhibit 4–A Child Fatality Rates per 100,000 Children, 2016–2020

| Year | Reporting States | Child Population of Reporting States | Child Fatalities from Reporting States | National Fatality Rate Per 100,000 Children | Child Population of all 52 States | National Estimate/ Rounded Number of Child Fatalities |
|---|---|---|---|---|---|---|
| 2016 | 50 | 73,444,585 | 1,708 | 2.33 | 74,392,850 | 1,730 |
| 2017 | 51 | 74,031,013 | 1,691 | 2.28 | 74,283,872 | 1,690 |
| 2018 | 52 | 73,977,376 | 1,765 | 2.39 | 73,977,376 | 1,770 |
| 2019 | 52 | 73,661,476 | 1,825 | 2.48 | 73,661,476 | 1,830 |
| 2020 | 51 | 72,026,671 | 1,713 | 2.38 | 73,368,194 | 1,750 |

*Data are from the Child File and Agency File. National fatality rates per 100,000 children are calculated by dividing the number of child fatalities by the population of reporting states and multiplying the result by 100,000.*

*If fewer than 52 states reported data, the national estimate of child fatalities is calculated by multiplying the national fatality rate by the child population of all 52 states and dividing by 100,000. The estimate is rounded to the nearest 10. If 52 states reported data, the national estimate of child fatalities is the number of reported child fatalities rounded to the nearest 10.*

# The Price of America's Inability to Track Child Deaths from Abuse and Neglect? Sometimes, More Lives.

Reliable statistics on deaths and near-deaths from abuse and neglect can help shape better policies to protect children. A new report shows the breadth of government failures to collect and report this information.

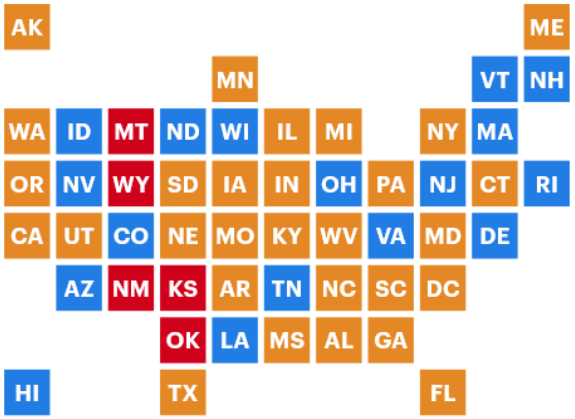
by Jessica Huseman, ProPublica, and Emily Palmer and Heather Schroering, special to ProPublica, Dec. 13, 2019, 9 a.m. EST

"Experts have long suspected that the United States badly undercounts the number of children who die from abuse and neglect. They say **voluntary reporting system** relied on for decades may be off by at least 200%, missing thousands of fatalities. In 2012, Congress moved to make information about the deaths more accessible to the public by **requiring states** to release detailed reports on child fatalities and near-fatalities.

"In 2016, **ProPublica** and **The Boston Globe** requested records for *every child who died from child abuse between 2011 and 2015.* It turned into a frustrating, **three-year slog** through child welfare offices. **41 states handed over data on some 7,000 child fatalities from 2011 to 2015 — slightly more than they had reported over the same period to the voluntary system,** called the **National Child Abuse and Neglect Data System,** or NCANDS, the main source of this data since the 1980s. That's far short of the more than 15,000 child abuse and neglect deaths that many experts estimate for the five years.

"**Reliable statistics on deaths and near-deaths from abuse and neglect can help shape better policies to protect children. Our new report shows the breadth of government failures to collect and report this information.**"

## Here's How Each State and D.C. Responded When We Asked for Records:




**17** provided all required information
**29** provided only some of the required information
**5** provided little or none of the required information

**Note:** Many states provided records of all child fatalities, but only included some of the information required by CAPTA. Most often, states did not include information about previous contact with child welfare services. Other states did not describe the circumstances of the child's death.

**"States decide whether and how much information to submit to NCANDS, and officials frequently do not have access to information on many deaths that should be reported. In most states, for example, police do not report abuse or neglect deaths to child welfare agencies, so state officials may not even know about such fatalities unless they ask. These inconsistencies make it virtually impossible to use NCANDS to compare numbers from different states or even to spot trends or trouble areas within states, experts say."**

“The **ProPublica** and **The Boston Globe** data largely confirm what is known from the voluntary system — that ***male children*** are slightly more likely to die of abuse and neglect and children ***under the age of 3*** are the most common victims of mistreatment — but with new specificity. ***Blunt force trauma was the most common cause of violent death, for example, while neglect deaths were most commonly related to unsafe sleeping conditions.”***

“Just as striking, though, was what was missing. **Wyoming,** for example, released nothing at all, declining to answer questions about why the data was withheld. **Montana** also released no data, acknowledging that that failure was a violation of the Child Abuse Prevention and Treatment Act, the main federal child abuse law for children not in state custody. **Kansas** wanted to charge more than $11,000 for the information and would not answer questions about the cost. (Montana and Kansas have passed laws making their data more accessible, but not retroactively, so they would not provide the years requested.) Other states left out important information, such as the specific cause of death, even though rules set by the U.S. Department of Health and Human Services say that’s among the “minimum” facts that must be released. *Some states insisted that turning over this information would violate laws protecting the privacy of at-risk children and their families.* More than a dozen states provided no information on **near-fatalities** and many said they don’t even track them.”

# CALIFORNIA CONFUSION

**DEPARTMENT of JUSTICE**

**CHILD DEATH**

- **POLICE**
- **CORONER /MEDICAL EXAMINER**
- **COUNTY CHILD WELFARE AGENCY**

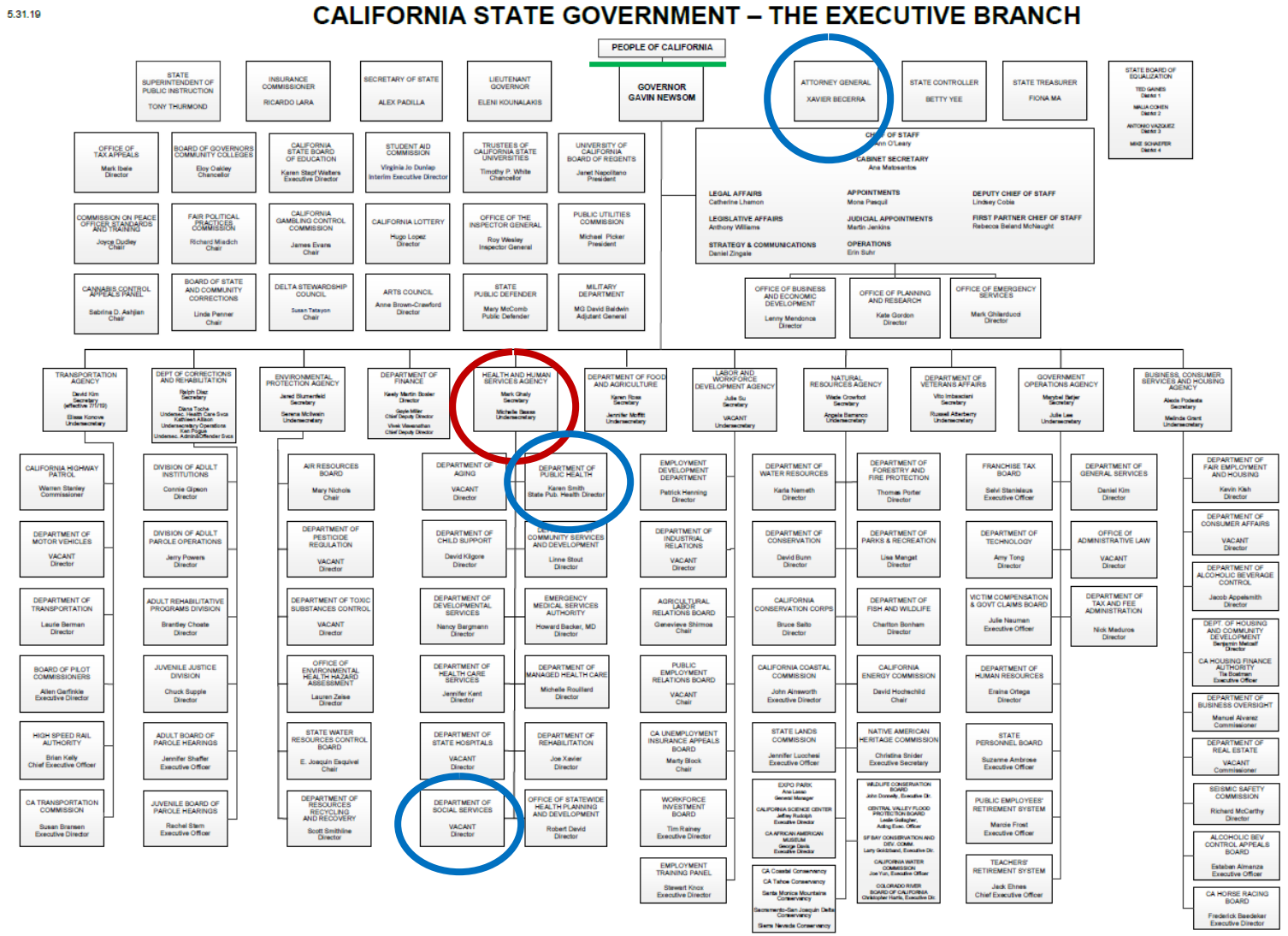
**EVALUATION**

- **COUNTRY DEATH REVIEW TEAM -> CCFSS (FCANS): DPH**
- **DSS; CRITICAL INCIDENT OVERSIGHT and SUPPORT UNIT**

**STATS POLICY PREVENT**

- **DEPARTMENT OF SOCIAL SERVICES**
- **DEPARTMENT OF PUBLIC HEALTH**

# CALIFORNIA CONFUSION




# DEPARTMENT OF PUBLIC HEALTH, INJURY and VIOLENCE PREVENTION BRANCH

## Fatal Child Neglect and Abuse Surveillance (FCANS) System

**Number of Child Death Cases Collected in California from 2003 to 2019 in FCANS and Vital Statistics Data**

| | Child Deaths | |
|---|---|---|
| Case Year | FCANS | Vital Statistics[a] |
| 2003 | <11* | N/A |
| 2004 | 63 | N/A |
| 2005 | 698 | N/A |
| 2006 | 743 | N/A |
| 2007 | 888 | N/A |
| 2008 | 1041 | N/A |
| 2009 | 706 | N/A |
| 2010 | 630 | N/A |
| 2011 | 585 | N/A |
| 2012 | 688 | N/A |
| 2013 | 547 | N/A |
| 2014 | 565 | N/A |
| 2015 | 383 | 3174 |
| 2016 | 371 | 3176 |
| 2017 | 341 | 3241 |
| 2018 | 348 | 3065 |
| 2019 | 629 | 2936 |

County **child death review teams (CDRTs)** review suspicious child deaths and submit standardized FCANS data to the DPH. FCANS data was analyzed for the first time in 2021 and it was noted that **FCANS is misnamed** because it included many fatalities reviewed by CDRTs that were determined to be from accidental or of natural cause.

** Health and welfare are county responsibilities in California.
** Since the early 1980's county-level ***voluntary*** **Child Death Review Teams** (CDRTs) identify and review suspicious child deaths, coordinate agencies involved in child abuse or neglect cases, promote prevention programs and compile data.
** The **California State Child Death Review Council** was established in 1997 to oversee the coordination and integration of state and local efforts but ***it was discontinued in 2008 when it was defunded by the Department of Justice***.

**** There are two data collection efforts that provide information about child deaths in California:** one in the **California Department of Public Health** (CDPH) and one in the **California Department of Social Services** (CDSS).

(1) Under Penal Code Section§11174.34 the CDPH, Injury and Violence Prevention Branch (CDPH/IVPB) runs the **Fatality Review Case Reporting System** (FCANS, now CCFSS). From 2003 to 2021, only ***39 out of 58 counties*** submitted FCANS data. ***This reporting declined in 2008 after the program was defunded by the Department of Justice.***
** The total cases submitted in FCANS from 2003 to mid 2021, are 9,688 with a ***significant drop in cases per year after 2008 when the FCANS program was defunded***. A total of 1,722 cases from only 21 counties were submitted in FCANS from 2017 to mid 2021. FCANS reports are made on all child deaths reviewed ***and includes children who were determined to have died of natural causes.*** **California's FCANS data is of limited value since reporting is incomplete and not validated. About 60% of the reports the cause of death was determined to be uncertain.**

# CHILD DEATHS and "CRITICAL INCIDENTS" in CALIFORNIA

(2) Senate Bill (SB) 39 (Chapter 468, Statutes of 2007) and the Welfare and Institutions Code (WIC) section 10850.4(j) **requires** all county welfare agencies and departments to notify the California Department of Social Services (CDSS) of **all** child fatalities and near fatalities that occurred within its jurisdiction that were the result of child abuse or neglect, and requires CDSS to establish a procedure for, and **annually report** on those notifications.

**State of California**
**Child Fatality and Near Fatality Annual Report**
**Calendar Year 2016**

**Table 1 – Data Figure 1 – 2009-2016 Number of Child Fatalities Reviewed**

| Critical Incident Year | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|
| TOTAL Fatalities | 117 | 128 | 119 | 111 | 97 | 88 | 104 | 114 |

**Summary of Findings:**

- Overall, the statewide child abuse and neglect fatality rate decreased slightly from 1.26 per 100,000 children in 2009 to 1.24 per 100,000 children in 2016. This rate is below the national average of 2.36 fatalities per 100,000 children as reported in the 2016 Child Maltreatment Report published by the U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau.
- Children age four and under accounted for 82 percent of all child maltreatment fatalities, up slightly from 2014 and 2015.

| 2008-2021 Child Fatality Incidents By Placement and Calendar Year | | | | |
|---|---|---|---|---|
| Type of Placements | In Home | Out-of-Home | 3PHs | Total Fatalities |
| CY 2008 | 114 | 6 | * | 120 |
| CY 2009 | 119 | 5 | * | 124 |
| CY 2010 | 128 | 4 | * | 132 |
| CY 2011 | 120 | 2 | * | 122 |
| CY 2012 | 138 | 1 | 2 | 141 |
| CY 2013 | 101 | 3 | 31 | 135 |
| CY 2014 | 100 | 3 | 24 | 127 |
| CY 2015 | 107 | 6 | 40 | 153 |
| CY 2016 | 110 | 5 | 36 | 151 |
| CY 2017 | 114 | 0 | 32 | 146 |
| CY 2018 | 114 | 4 | 36 | 154 |
| CY 2019 | 117 | 3 | 33 | 153 |
| CY 2020 | 104 | 1 | 30 | 135 |
| CY 2021 | 85 | 3 | 11 | |

CY 2012 is the first year CIOS unit started to receive SOC826s for Third Party Homicides of children 17 years of age and under, referred to in these charts as “3PHs”.
https://www.cdss.ca.gov/inforesources/child-fatality-and-near-fatality/data-and-reports
Accessed May 5, 2022

OFFICE OF THE GOVERNOR

SEP 28 2022

To the Members of the California State Assembly:

I am returning Assembly Bill 2660 without my signature.

This bill would require each county, by no later than January 1, 2025, to establish an interagency child death review team, and to develop and adopt a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners in the identification of child abuse or neglect.

While I agree with the intent of this bill, it creates a large mandate, potentially costing the state millions of dollars. With our state facing lower-than-expected revenues over the first few months of this fiscal year, it is important to remain disciplined when it comes to spending, particularly spending that is ongoing. We must prioritize existing obligations and priorities, including education, health care, public safety and safety-net programs.

The Legislature sent measures with potential costs of well over $20 billion in one-time spending commitments and more than $10 billion in ongoing commitments not accounted for in the state budget. Bills with significant fiscal impact, such as this measure, should be considered and accounted for as part of the annual budget process. For these reasons, I cannot sign this bill.

GOVERNOR GAVIN NEWSOM • SACRAMENTO, CA 95814 • (916) 445-2841

Sincerely,

Gavin Newsom

**Section-by-Section of the CAPTA Reauthorization Act of 2022**

*Sponsored by HELP Chair Patty Murray (D-WA) and Ranking Member Richard Burr (R-NC)*

*Bill to reauthorize the Child Abuse Prevention and Treatment Act, the Adoption Opportunities Act, and the Family Violence Prevention and Services Improvement Act.*

## TITLE III—Public Health Approaches to Identify and Prevent Child Fatalities and Near Fatalities Due to Child Abuse and Neglect

Amends CAPTA to add a new Title III.

*Subtitle A. "Public health approaches to identify and prevent child fatalities and near fatalities due to child abuse and neglect"*
*Section 301. Purpose*
Establishes that the purpose of this title is to develop coordinated leadership and shared responsibility at the Federal, State, and local levels to implement data-driven strategies and reforms to prevent child fatalities and near fatalities due to child abuse and neglect from occurring in the future through the use of improved collection, reporting, and analysis of all child fatalities and near fatalities due to child abuse and neglect.

*Section 302. Federal Work Group on Data Collection Related to Child Fatalities and Near Fatalities Due to Child Abuse and Neglect*
Requires the Secretary to establish the Federal Work Group on Public Health Surveillance of Child Fatalities and Near Fatalities Due to Child Abuse and Neglect within 90 days of this Act's enactment. The Secretary is required to appoint representatives to the Work Group from the Administration for Children and Families, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Department of Justice, and other Federal agencies, as the Secretary determines, and to consult with experts on this topic, including individuals with personal experience in the child welfare system.

The Work Group's duties include:

- overseeing the development of uniform public health data standards that are designed to promote consistent terminology and data collection related to child fatalities and near fatalities due to child abuse and neglect, in accordance with all applicable Federal and State privacy laws; and
- examining all Federal data collections related to child fatalities and near fatalities due to child abuse and neglect and make recommendations to improve the accuracy, uniformity, and comparability of such data collected by States, localities, Indian Tribes, and Tribal organizations; ensure that such data collections are informative and can be effectively utilized by local, State, Federal policymakers and the public to make data-driven decisions to prevent such fatalities and near fatalities; and recommendations on roles of existing data systems, and how such data systems or next-generation data systems can be more effective for relevant purposes.

The Work Group is required to submit an annual report of its activities to the Secretary.

*Section 303. Case Registry for Child Fatalities and Near-Fatalities Due to Child Abuse and Neglect*