



Child Deaths From Abuse and Neglect: Accurate Data, Public Disclosure Needed

By Bill Grimm

The death of 8-year-old Raijon Daniels last October was front page news in the San Francisco Bay Area. Over the next few days, headlines drew repeated attention to his death: “Dead Boy, 8, Was Abused, Police Say”¹; “Mom Held on Suspicion of Torturing, Killing 8-Year-Old Son”²; “No One Took Notice of Boy’s Life of Torture Until It Was Too Late.”³

News reports indicated that when police responded to the mother’s 911 call that her son had stopped breathing, they discovered that the family’s Richmond apartment reeked of household cleaner. Duct tape on the sheets and blanket in Raijon’s bedroom, and rope marks on his hands suggested that he was held hostage, bound and locked in his room. His mother told police that she poured household cleaner on his genitals to discourage him from urinating on himself.

The coroner concluded that Raijon’s death was a homicide, the result of years of physical trauma. Raijon’s body was covered with burns, scars, and bruises consistent with cord or strap injuries. Blood tests revealed dangerously high levels of acids, which the coroner believed was the result of starvation.

Media interviews with police, neighbors, and relatives revealed that there had been prior concerns about Raijon’s safety, and police had voiced their concerns to the county’s child protective services agency several times since May 2005. In fact, the agency had received a total of six referrals about Raijon in the years leading up to his death. An agency spokeswoman, however, refused comment to reporters citing confidentiality laws.⁴

The agency did, however, pledge “a thorough investigation” and the state’s Department of Social Services promised to “review this case.”⁵

Reporters tracked down Raijon’s father, who had met his mother, Teresa, while they were both in high school. He claimed he had not had any contact with his son for years because the mother and her family did not want him around.

Shortly after the release of the coroner’s report on January 8th, the county child protective services agency released the results of its internal investigation. The county agency concluded that its workers had “followed all policies and procedures in handling reports of abuse or neglect involving Raijon.”⁶

Early calls for an independent investigation of the child protective services agency’s responses to reports of prior abuse were ignored.

When 12-year-old Daelynn Foreman was found starved to death in her home in July 2006, she weighed only 23 pounds – the average weight of a one-year-old. Her bedsores were so severe that parts of her pelvic bone were exposed. It wasn’t until the girl’s mother was arrested and charged with homicide and methamphetamine sales in February 2007⁷ that a reporter from the *Sacramento Bee* began to investigate the child protective service agency’s role in the case. When Sacramento officials refused to discuss whether they had received any prior reports about Daelynn, the *Sacramento Bee* filed a Public Records Act request.

Using police reports, court and agency records, and interviews with relatives, the *Bee* pieced together parts of Daelynn’s life. The reporter learned that county child protective services “had received seven reports warning that [Daelynn] was either severely or generally neglected.”⁸ The first was when she was 7-years-old.

1 Karl Fischer, *Dead Boy, 8, Was Abused, Police Say*, *Contra Costa Times*, October 31, 2006, at A1.

2 Karl Fischer, *Mom Held on Suspicion of Torturing, Killing 8-Year-Old Son*, *Oakland Tribune*, October 30, 2006.

3 Patty Fisher, *No One Took Notice of Boy’s Life of Torture Until It Was Too Late*, *San Jose Mercury News*, November 1, 2006.

4 Fischer, *supra*, note 1.

5 *County to Probe Its Handling of Fatal Abuse Case*, *Oakland Tribune*, November 1, 2006.

6 *Report Clears Child Welfare Employees*, *Oakland Tribune*, January 13, 2007.

7 Christina Jewett, *Death Puts Focus on CPS; Child Protective Services Had Warnings Before Girl, 12, Starved to Death*, *Sacramento Bee*, March 20, 2007.

8 Christina Jewett, *CPS Knew of Girl’s Neglect, Records Show*, *Sacramento Bee*, March 20, 2007. The brief excerpts from agency records used by the reporter were obtained under a new state policy discussed *infra*.

At age 9, Daelynn, who had cerebral palsy, weighed 60 pounds. By age 10, she had dropped to 46 pounds, and then to half that weight by the time of her death. In April 2005, apparently under threat of Daelynn's removal from her home by child protective services, the mother took her to a doctor. The mother ignored the doctor's direction that she bring the child to a pediatrician and other specialists for follow-up. The pediatrician called the mother six times over the next six months to try and get her to bring Daelynn in, but the mother ignored the doctor's requests. During this same time, child protective services appears to have dropped the case, satisfied that the mother took Daelynn to one medical appointment, but not checking to see if she followed through with the doctor's recommendations.

During the fall of 2005, Daelynn's mother withdrew her from school. The school sent an in-home teacher to the home twice a week. That teacher noticed Daelynn was losing weight. When the mother refused to take the teacher's advice and bring Daelynn back to the doctor, the teacher reported it to child protective services. On April 7, 2006, child protective services confirmed the teacher's report of neglect.

Little is known about what action, if any, child protective services took after learning about the neglect. An agency worker visited the home on May 19, 2006, just 10 weeks before Daelynn died, but there is no information as to whether the worker had contact with Daelynn. Comments from the director of the child protective services agency suggest that workers found the mother "very believable" and failed to verify what the mother told them.

Sadly, the stories of Raijon Daniels and Daelynn Foreman are not isolated incidents. Every year, hundreds of children die from abuse and

neglect all across the country. Often, child protective services agencies have had contact with the child and family prior to the death. However, efforts to institute programs and policies to help reduce child abuse deaths are hampered by lack of accurate and detailed data, and access to information.

This article discusses the ongoing efforts to record child abuse and neglect fatality data and other information, and highlights recent efforts in California to enact changes that would make this information available to the public.

Number of Child Abuse Fatalities Unknown/ Underreported in California

The accounts of Raijon's and Daelynn's deaths published in the *Sacramento Bee* and *Contra Costa Times* provide a rare glimpse into the circumstances surrounding the deaths of children in California from abuse or neglect. But the public cannot rely upon news stories to document the incidence of child abuse deaths. Such accounts often provide little information about the families' involvement with child protective services. In addition, agency claims of confidentiality often stymie reporters' investigations.

In the last decade, California has created two entities to investigate the problem of child abuse deaths – the Child Death Review Teams and the State Child Death Review Council. Unfortunately, neither group has been able to produce accurate and reliable information about the incidence of child abuse and neglect deaths in the state.

Child Death Review Teams

California's county child death review teams (CDRTs) were created by statute in 1997 to investigate child deaths. The CDRTs' goal is to understand how and why children die in order to prevent future deaths and improve the health and safety of children.

However, CDRTs in most California counties do not provide much information about child abuse deaths. Due to lack of funding and staff support, and dependency on volunteers, CDRTs often issue reports that comprise a collection of outdated charts and graphs. Less than half the CDRTs in California's 58 counties publish an annual report. Most contain no details about individual cases. Although the law requires that CDRTs be given access to "prior child abuse or neglect investigation reports maintained involving the same victims, siblings or suspects,"⁹ many teams never receive the information either because they don't ask for it or because their requests are not met.

Child death review team reports in other states appear to be similarly hampered by a lack of resources. For example, Hawaii recently published a report providing limited statistical information about child deaths in 2000 to 2002.¹⁰

Child Death Review Council

Almost a decade ago, the California Child Death Review Council ("the Council")¹¹ set out to determine the number of children who die each year as a result of child abuse and neglect.¹² The Council drew abuse fatality data from three different reporting systems: 1) the Department of Justice Child Abuse Central Index (CACI), 2) the Department of Justice Supplemental Homicide File, and 3) the Department of Health Services Vital Statistics Death Records.

The Council's study concluded that "none of the three databases [could] be considered a definitive source for identifying child abuse and neglect fatalities." Indeed, each system recorded very different numbers documenting child abuse deaths. This may be in part because each of the databases uses a different set of terms and definitions to code child

9 Cal. Pen Code §11170 (b)(5).

10 Hawaii Dep't of Health, *Child Death Review Report 1997-2000* (2007).

11 The State Child Death Review Council was established by statute in 1997 to support county child death review teams. Its membership includes representatives of law enforcement, medical examiners, health care professionals, district attorneys' offices, state department of health and social services, county child welfare agencies, and local child death review teams.

12 California State Child Death Review Council, *Child Deaths in California Related to Abuse and Neglect: 1996-1998*, Introduction (undated).

abuse deaths. A comparison of the three databases in 1998 found that the CACI reported 24 child abuse deaths, the Department of Justice Homicide Files reported 96, and Vital Statistics reported 20.¹³ Further analyses found “that a significant number of cases were recorded in one database, but not included in either one or both of the other systems.”¹⁴ This problem is compounded by inaccurate or incomplete data in each of the individual databases, as discussed in the following sections.

The Child Abuse Central Index

The Child Abuse Central Index (CACI) is maintained by the California DOJ.¹⁵ The law requires that child protective service agencies and law enforcement submit to the CACI all reports for which a complaint is investigated and ruled substantiated or inconclusive.¹⁶ However, a quick glance at the numbers makes clear that many reports are never filed with the CACI. Each year, child protective service agencies find that almost 200,000 (out of 500,000) reports of child abuse or neglect are substantiated or inconclusive.¹⁷ Yet only 38,000 child abuse investigations are reported to the Child Abuse Central Index each year.¹⁸

Department of Justice Homicide File

DOJ’s Homicide File is maintained as part of the FBI Uniform Crime Reporting program. It includes deaths con-

sidered homicides by law enforcement agencies based upon a coroner’s findings. Since the homicide file contains identifying information for the victim, data on perpetrator-victim relationship, and the circumstances preceding death, it can be used to identify some child abuse fatalities. The Homicide File consistently reports substantially more child abuse deaths than other databases.¹⁹

Department of Health Services Vital Statistics Death Records

California’s Vital Statistics system uses death certificate information to record the cause and manner of death. The system designates the underlying cause of death as either “natural” or “injury.” Injuries are subdivided into unintentional injuries, intentional injuries, and undetermined. It classifies the manner of death as either homicide, suicide, accidental, natural, or undetermined.

The Vital Statistics system is a poor source of child abuse deaths for several reasons, including limited information on death certificates, stringent coding guidelines that require a documented history of child abuse, and reluctance on the part of persons completing the death certificate to identify child abuse as the cause of death.²⁰ More than a decade ago, researchers suggested that Vital Statistics records code as few as 15 percent of child abuse fatalities correctly.²¹

Efforts to Improve Knowledge About Child Abuse Fatalities in California

In an effort to improve knowledge about child abuse deaths, the California legislature in 1999 directed that county child welfare agencies “create a record [in the Child Welfare Services/Case Management System (CWS/CMS)] on all cases of child deaths suspected to be related to child abuse or neglect.”²² Unfortunately, the child welfare agencies have not complied with the law.²³ While the CWS/CMS System contains a wide range of statistical information about child abuse victims and foster children, which is publicly available on the Internet, it does not report any data on the victims of fatal child abuse.²⁴

As part of the same 1999 legislation requiring augmentation of the CWS/CMS system, California’s legislature also directed that agencies share information from four databases “to establish accurate information on the nature and extent of child abuse or neglect related fatalities in California.”²⁵ The four databases are: 1) Child Abuse Central Index, 2) DOJ Supplemental Homicide File, 3) Vital Statistics Death Records, and 4) CWS/CMS itself. The State Department of Health Services (DHS) is responsible for designing, testing, and implementing a fatality tracking system.²⁶ As a result, DHS initiated two new programs: (1) Reconciliation Audits, and (2) Fatal Child Abuse and Neglect Surveillance Program.

13 *Id.* at p.8, Table 4.

14 *Id.* at p.8.

15 California’s Child Abuse Central Index is operated by the Department of Justice. Cal. Pen. Code §11170.

16 After child protective services investigates a complaint about child abuse or neglect, it must issue a report stating that the complaint is “substantiated,” “inconclusive,” or “ruled out.” If the report is “substantiated” it means that the investigator found conduct constituting child abuse or neglect. Cal. Pen. Code §11165.12(b).

17 Needell, B., Webster, D., Armijo, M., Lee, S., Cuccaro-Alamin, S., Shaw, T., Dawson, W., Piccus, W., Magruder, J., Exel, M., Smith, J., Dunn, A., Frerer, K., Putnam Hornstein, E., & Ataie, Y. (2006). *Child Welfare Services Reports for California*. Retrieved March 27, 2007, from University of California at Berkeley Center for Social Services Research website at <http://cssr.berkeley.edu/CWS/CMSreports>.

18 See <http://www.ag.ca.gov/childabuse> (last visited March 27, 2007).

19 California State Child Death Review Council, *Child Deaths in California* (June 2005), at 8.

20 *Id.* at p.7.

21 McClain, Sacks, Froehke & Ewigman, *Estimates of Fatal Child Abuse and Neglect, United States 1979 Through 1988*, 91 PEDIATRICS 338 (1993).

22 SB 525 now codified at Cal. Pen. Code §11174.34 (l). The statute in its entirety reads: County child welfare agencies shall create a record in the CWS/CMS on all cases of child death suspected to be related to child abuse or neglect whether or not the deceased child has any known surviving siblings. Upon notification that the death was determined not to be related to child abuse or neglect, the child welfare agency shall enter that information into the CWS/CMS.

23 ACL No. 14-01: *Process for Recording Child Fatalities Related to Child Abuse and Neglect on the Child Welfare Services/Case Management System* (February 8, 2001). *But see*, ACL No. 06-24: *Public Disclosure of Child Fatalities and Near Fatalities Caused by Abuse or Neglect* (July 21, 2006) at 4 (providing a “request” that counties enter child death information in the CWS/CMS).

24 While CWS/CMS does contain some raw data on child abuse deaths, it is “not easily available because it must be extracted from a complex database.” As explained below, the state Department of Health Services, EPIC branch, has done this but the most recent data is from 2001 (e-mail from Roger Trent, PhD to William Grimm, April 10, 2007).

25 Cal. Pen. Code §11174.34 (a)(2).

26 Cal. Pen. Code §11174.34 (e). Unfortunately, this provision of the legislation “shall be implemented only to the extent that funds are appropriated for its purposes in the Budget Act.” Cal. Pen. Code §11174.34 (e)(6).

Reconciliation Audits

To conduct the reconciliation audits, the DHS's Epidemiology and Prevention for Injury (EPIC) branch, along with the Child Death Review Council ("the Council"), takes the information on child abuse deaths from the state's four databases and reconciles it with the case review information collected by local child death review teams. The most recent results of these audits are contained in the June 2005 report, *Child Deaths in California*, published by the Council. The data in this report documents child deaths between 1999 and 2001. For 2001, EPIC estimated that 133 children were killed by their parents or caregivers.²⁷

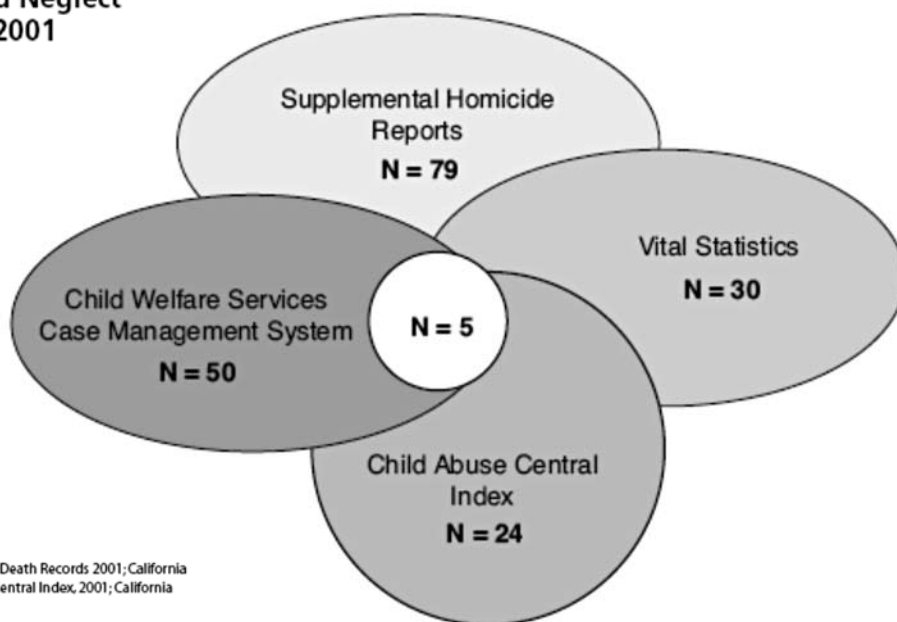
EPIC's review of the 2001 data from the four databases found that discrepancies between the databases continue to be "substantial."²⁸ For example, in 2001, the Homicide Reports recorded 79 deaths while Vital Statistics reported 30 and the Child Abuse Central Index reported only 24. All four of the databases had only five cases in common. *See Figure 3.*

These audits rely largely upon the findings of the local child death review team (CDRT) to reconcile data from the four sources.²⁹ EPIC provides local child death review teams with an unduplicated list of child abuse/neglect deaths in the county along with identifying information drawn from the

four databases. CDRTs are then asked to answer the following questions for each child death:

- Was the team aware of the child's death?
- Did the team review the case?
- Did the team consider the child's death to be a homicide?
- Did the team consider the child's death to be a child abuse or neglect homicide or fatality? If not, why not?
- Did the team identify any other child deaths considered to be a child abuse or neglect homicide or fatality? If so, provide any identifying information.

FIGURE 3: Fatal Child Abuse and Neglect by Data Source, California 2001



Source: California Department of Health Services (DHS), Vital Statistics Death Records 2001; California Department of Justice, Supplemental Homicide File and Child Abuse Central Index, 2001; California Department of Social Services CWS/CMS Extracts, 2001. Prepared by: California DHS, EPIC Branch.

²⁷ State Child Death Review Council, *Child Deaths in California* (2005), at 5.

²⁸ *Id.* at 8.

²⁹ Local CDRT review findings are used "as a relative gold standard." *Id.* at 7.

In arriving at its estimate of 133 children killed due to abuse or neglect in 2001, EPIC engaged in the following analysis: It identified 163 unique child maltreatment deaths in 2001 from the four databases. Local child death review teams reviewed 138 of the 163 deaths and confirmed that 109 (79 percent) resulted from child abuse or neglect. Of the 25 cases not reviewed by a child death review team, EPIC determined that 17 would have been confirmed as child abuse if they had been reviewed. In addition, CDRTs identified another seven child abuse deaths not reported in any of the state databases. Using this methodology, EPIC estimated there were 133 child abuse/neglect fatalities in California in 2001.³⁰

The data resulting from the reconciliation audits must be viewed with caution due to its primary reliance on CDRT reviews. The audits provide no explanation for the CDRTs exclusion of 21 percent of cases identified as child abuse/neglect. More importantly, neither the audits nor the CDRTs provide any information upon which the CDRTs based their decisions to find or not find child abuse and neglect. Finally, several local CDRT reports suggest that the teams' access to information was often limited.

EPIC has not conducted reconciliation audits for more recent years. This is due in large part to the Council's decision to join a pilot project initiated by the National Center for Child Death Review and to switch from the paper-based data collection system to a new multi-state, web-

based child death review reporting system.³¹

Fatal Child Abuse and Neglect Surveillance Program (FCANS)

The second method that EPIC designed to gather data about fatal child abuse -- the Fatal Child Abuse and Neglect Surveillance System (FCANS) -- also relies upon the child death review teams.

To assist the child death review teams in gathering accurate and reliable data for FCANS, EPIC created a Matrix for Classifying Child Abuse and Neglect Deaths. The Matrix lists five categories of child abuse or neglect. In order to be counted as a child abuse fatality in FCANS, the case must fall within one of two categories: 1) Definite Child Abuse or Neglect as Primary Cause, or 2) Definite Child Abuse or Neglect Related. In 2000, the child death review teams began receiving training in how to classify child abuse/neglect deaths using the Matrix.

EPIC asked the child death review teams to submit data on standardized data collection forms. To encourage participation, EPIC paid a fee to the teams for each form submitted. Despite this incentive, some child death review teams still failed to submit data.

In 2001, 32 county child death review teams submitted 595 forms to FCANS.³² Of those, the child death review teams found that 374 cases had a history of substantiated or inconclusive child protective services reports prior to the child's death.³³ Out of the 595 deaths reviewed, child death

review teams determined that 116 were "definite child abuse/neglect deaths." The child death teams classified another 191 as "suspicious or questionable child abuse/neglect deaths." Presumably, many of the "suspicious or questionable" deaths were in fact due to child abuse, strongly suggesting that the total number of child abuse fatalities was higher than 116.

As with the reconciliation audits, the child death review teams do not provide any information upon which they based their decisions to find or not find child abuse and neglect. In addition, although the standardized data collection form asks the death review teams to specify what records it reviewed (for example, death certificate, coroner's report, hospital records, police reports, and child protective services records), there is no information as to what documents the child death review teams reviewed, if any.

Child Abuse/Neglect Fatality Data Underreported Nationally

Inaccuracies in the officially reported incidence of child abuse fatalities are not limited to California. More than a decade ago, the U.S. Advisory Board on Child Abuse and Neglect noted that the problem existed nationally.³⁴ A 1999 survey conducted by the Child Welfare League of America found that less than a quarter of child welfare agencies in the country believed that officially reported child abuse fatalities accurately represented the incidence of child abuse deaths.³⁵

We do not have a reliable source to determine accurately why or ex-

30 *Id.* at 12.

31 E-mail communication from Roger Trent to William Grimm, April 10, 2007.

32 *Id.* at 14.

33 It is not clear if 'child abuse history' refers only to prior reports on the child who died or encompasses the family's history of reported abuse, including reports for siblings and other children.

34 U.S. Advisory Board on Child Abuse and Neglect, *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*, xxviii (1995).

35 Child Welfare League of America, *National Working Group to Improve Child Welfare Data Highlights* (July 2001) at 7.

actly how many children die from abuse and neglect. Each national information system is incomplete as a source of comprehensive information on child abuse and neglect deaths. Vital Statistics, the FBI's Uniform Crime Reports, and State child abuse indices each track just one limited part of the picture. U.S. Advisory Board on Child Abuse and Neglect, *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*, xxviii (1995)

Recent analyses of child deaths in Las Vegas, Nevada uncovered a substantial undercounting of deaths related to child abuse and neglect during the last several years.³⁶ An independent panel of experts examined 79 child deaths that occurred between January 2001 and December 2004 in which

child abuse or neglect had not been substantiated.³⁷ The Panel concluded that in 37 (47 percent) of the 79 cases, the death should have been attributed to abuse or neglect.³⁸ In most of the other cases, the Panel had insufficient information to rule out abuse as the cause or contributing factor.

There are two primary sources of national data on child abuse and neglect fatalities: (1) the surveys conducted by the Child Welfare League of America (CWLA), and (2) the National Child Abuse and Neglect Data System (NCANDS) operated by the federal Children's Bureau. NCANDS and CWLA each capture data from a different number of states. In some instances, CWLA data is more complete while in other instances NCANDS has more information. Data for 2000 to 2004 from NCANDS and CWLA are displayed in the chart below.³⁹

The Child Welfare League of America Surveys

The Child Welfare League of America (CWLA) State Child Welfare Agency Survey is part of the CWLA database available on-line. The survey has been conducted since 1993. This survey augments NCANDS with data that is not available from other sources.

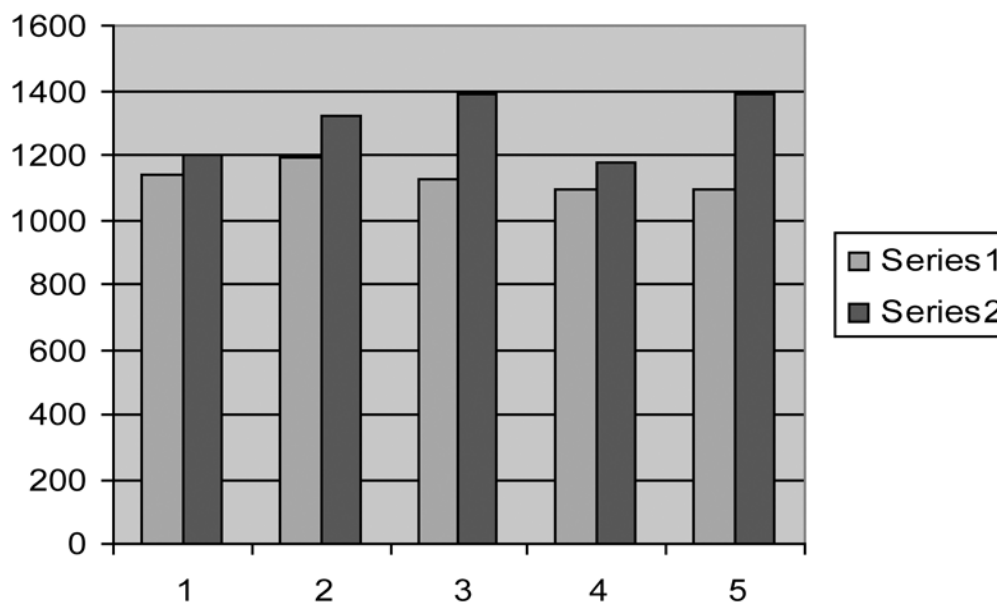
The National Child Abuse and Neglect Data System

NCANDS is a voluntary reporting system established under the Child Abuse Prevention and Treatment Act (CAPTA).⁴⁰ States may, but are not required to, submit data on child abuse and neglect.⁴¹ Most of the data is case specific – for example, the nature of the alleged maltreatment, characteristics of the child and perpetrators, and post-investigative services provided to the child.⁴² For 2004, 44

Child Abuse or Neglect Fatalities 2000-2004

Series 1 = CWLA

Series 2 = NCANDS



36 State of Nevada Department of Health and Human Services Division of Child and Family Services, *Report of the Blue Ribbon Panel for the Review of Child Deaths* (January 2007).

37 Independent Child Death Review Panel for Clark County, *Report of Findings and Recommendations: Child Deaths 2001-2004* (2006).

38 *Id.*, at 27.

39 *Prevent Child Abuse*, a non-profit agency, also has conducted surveys of child welfare agencies to gather data on child fatalities. Their most recent 50 State Survey estimated 1356 fatalities in 48 states.

40 42 U.S.C. 5106a et seq.

41 In 2003 states began submitting data according to the Federal Fiscal Year rather than calendar year. UPDATA at 4.

42 National Data Archive on Child Abuse and Neglect, UPDATA Newsletter (Fall 2006). This data is from what is called the Child File in NCANDS. There is also a Combined Aggregate File/Agency File that collects state-level data that is not covered in the Child File such as screened out referrals. UPDATA at 3.

states and the District of Columbia submitted data to this data system.⁴³

In 1996 Congress amended CAPTA to add a provision requiring states that receive funding under CAPTA to submit an annual State data report.⁴⁴ This report must include information on child deaths resulting from abuse and neglect.⁴⁵ States must identify the number of child deaths that occurred in foster care and the number of deaths among children reunited with their families or receiving family preservation services within five years of the child's death.

The number of states providing data on child fatalities varies from year to year. In 2004, the year for which the most recent data is available, all but three states – Alaska, Michigan, and North Carolina – provided some child fatality data.⁴⁶ States appear to draw upon a variety of sources – not just their child abuse central indices – for this information. In some instances, child deaths identified by coroner's offices or child death review teams are counted in addition to or instead of those reported to child protective services.⁴⁷

Since NCANDS does not attempt to verify the accuracy of the data provided by the states,⁴⁸ it is likely that the national data simply compounds the underreporting of child fatalities in many states. Nevada, for example, reported between three and five child abuse deaths statewide to NCANDS for the same years that an independent panel found at least 37 additional child abuse deaths in Las Vegas alone.⁴⁹

In addition to reporting the number of child abuse fatalities, NCANDS

also calculates the rate of fatalities – i.e. the number of fatalities per 100,000 children in the state. While Texas had the highest number of child abuse fatalities in 2004 with 212, it did not have the highest rate in the country. The highest rates were in Indiana (4.81), the District of Columbia (4.56), Oklahoma (4.54), and Georgia (4.2) (Texas's rate was 3.38).⁵⁰

Estimates of the Child Abuse/Neglect Deaths Nationwide

For 2004, the National Center for Youth Law completed a state-by-state comparison of the number of child fatalities reported to CWLA with those reported to NCANDS. In 17 states, the NCANDS and CWLA numbers matched. In an almost equal number of states, the NCANDS numbers differed from the CWLA statistics.⁵¹ Usually, the numbers differed by just one or two deaths. In a few states, however, the difference was significant. For example, Louisiana reported 18 deaths to NCANDS and 32 to CWLA. Similarly, Tennessee reported 15 fatalities to NCANDS and twice that many (30) to CWLA. Indiana reported 77 deaths to NCANDS and only 57 to CWLA.

For 2004, NCANDS reported 1,387 child abuse and neglect deaths nationally and the CWLA reported 1,098. However, NCANDS included data from 47 states while CWLA obtained data from only 39 states. By using NCANDS data to fill in the blanks for states not included in the CWLA survey, the National Center for Youth Law estimated that 1,441 child abuse/neglect deaths occurred nationwide in 2004.⁵²

Most Child Abuse Fatalities in California Occur in Families with Prior CPS Contact

Because the public cannot get a full and accurate picture of the incidence of child abuse and neglect deaths nationally or statewide, it is difficult to devise effective reforms to reduce child fatalities. The same is true for the lack of detail that the public receives regarding child abuse and neglect deaths. Child welfare advocates need accurate information on whether, and how often, child protective services had contact with a child before his or her death, and what the nature of that contact was. Because the cases in which the child had prior contact with child protective services are numerous, child advocates need more and detailed information in this area in order to address the problem.

Beginning in July 2006, the California Department of Social Services (CDSS) began requiring county child protective services agencies to notify CDSS whenever there is a reasonable suspicion that a child died or suffered near death as the result of abuse or neglect.⁵³ Within 48 hours of the child's death, counties must file a questionnaire that includes the age, race, and gender of the child and a summary of any prior history the family had with child protective services.

The National Center for Youth Law (NCYL) obtained copies of these questionnaires for the period from July 16 through September 17, 2006. Our review of these documents revealed that in 29 (76 percent) of the 38 cases, the family had one or more previous referrals to child protective services. The number of previous referrals ranged

43 *Id.*

44 The Child Abuse Prevention and Treatment Act Amendments of 1996 (Public Law 104-235).

45 NCANDS defines 'child fatality' to include the death of a child caused by an injury resulting from abuse or neglect or where abuse or neglect was a contributing factor. U.S. Department of Health and Human Services Children's Bureau Child Welfare Information Gateway, *Child Abuse and Neglect Fatalities: Statistics and Interventions Factsheet* (June 2006) at 2.

46 U.S. Dep't of Health and Human Services Administration for Children and Families, *Child Maltreatment 2004* (2006) at 68.

47 According to the United States Department of Health and Human Services, "in 2004, 18.4 percent of fatalities were reported through the Agency file which includes fatalities reported by health departments and fatality review boards." Child Welfare Information Gateway, U.S. Dep't of Health and Human Services, *Child Abuse and Neglect Fatalities: Statistics and Interventions* (2006) at 2.

48 Unlike AFCARS Assessment Reviews conducted by the Children's Bureau to evaluate the ability of a State's automated information system to gather, extract and submit the correct foster care and adoption data, there are no similar audits of states' submissions to NCANDS. www.acf.hhs.gov/programs/cb/stats_research/index.htm#afcars (last visited April 17, 2007).

49 See n. 47-49 *supra*.

50 *Child Maltreatment 2004*, at 68, Table 4-1.

51 The NCANDS numbers were higher in 10 states and lower in 11 states. The lower numbers reported to NCANDS may be explained by some states not including in their NCANDS submissions any maltreatment fatalities in which there are no other children in the home when the child dies. See, e.g., Arizona Dep't of Health Services, *Arizona Child Fatality Review Program Eleventh Annual Report* (2004) at 11.

52 None of the estimates of child abuse fatalities included data from Michigan.

53 California Department of Social Services, All County Letter, 06-24 (July 21, 2006). The All County Letter was adopted in response to federal officials' notifying California that the state was out of compliance with the public disclosure provision of CAPTA.

from one to as many as eight reports of abuse or neglect. In 20 (52 percent) of the 38 families there was at least one child abuse or neglect report within a year of the child's death.

In seven cases (18 percent) the family had an open case with social services at the time of the child's death. See *Table 1*.

These findings are consistent with data from California's Fatal Child Abuse and Neglect Surveillance (FCANS) system.⁵⁴ According to FCANS, in the years 2000 and 2001, of the 178 deaths that child death review teams found to be caused by child abuse and neglect, 74 (42 percent) had a prior family history of child protective services involvement. Data from Los Angeles also mimics these findings. The child death review team report for 2001 found that in 42.8 percent of the 33 deaths, the families involved had a previous or current record of involvement with the child protective services. Similarly, Sacramento County's child death review team's recent Five-Year Report found that of the 89 child deaths related to abuse or neglect,⁵⁵ 40 families (45 percent) had a history of child abuse or neglect.⁵⁶ Unfortunately, most other child death review teams in California do not collect or report on this type of data.⁵⁷

Nationwide, Many Child Abuse/Neglect Deaths Occur in Families with Prior CPS Contact

This high incidence of child fatalities among children whose families have a history with child protective services is not only a California phenomenon – it is found nationwide. The National Center on Child Abuse Prevention Research's Fifty State Survey found that between 1998 and 2000 an average of 36 percent of child abuse fatalities occurred in families with prior or current contact with child protective services.⁵⁸

Table 1
**Child Protective Services History
Fatal Child Abuse/Neglect Victims In California
July 22, 2006 – Sept. 18, 2006**

Date of Death	Age	No. of Previous Reports on Family	Within 5 Yrs of Death	Within 1Yr. of Death	Open Case at Time of Death
7/22/2006	1 day	7	Yes	No	No
7/22/2006	1 day	6	Yes	Yes	No
7/22/2006	2 yrs.	2	Yes	Yes	Yes
7/28/2006	4.3 yrs	4	Yes	Yes	No
7/30/2006	5 yrs.	5	Yes	No	No
8/2/2006	7 yrs.	1	Yes	Yes	No
8/2/2006	2 mos.	1	Yes	Yes	No
8/7/2006	12 yrs.	0	No	No	No
8/9/2006 NF	1 yr	3	Yes	Yes	No
8/10/2006	4 yrs.	1	No	No	No
8/11/2006	5 yrs.	5	Yes	Yes	Yes
8/14/2006	17 yrs.	2	No	No	No
8/14/2006	7 weeks	1 (2 wks.prior)	Yes	Yes	Yes
8/14/2006 NF	7 yrs.	4	Yes	Yes	yes
8/16/2006 NF	1 yr.	1	Yes	Yes	No
8/17/2006	17 yrs.	1	No	No	No
8/19/2006	1 yr.	4	Yes	No	No
8/21/2006 NF	16 yrs.	8	Yes	Yes	No
8/24/2006 Kin	16 yrs.	2	No	No	No
8/24/2006	5 wks.	3	Yes	Yes	No
8/25/2006	2 mos.	0	No	No	No
8/26/2006 NF	13 yrs.	7	Yes	Yes	No
8/26/2006	1 mo.	1	Yes	Yes	Yes
8/29/2006	2 yrs.	2	Yes	No	No
8/29/2006	12 yrs.	1	No	No	No
9/2/2006	4 yrs.	0	No	No	No
9/6/2006	Stillborn	3	Yes	Yes	Yes
9/8/2006					
Day Care	8 mos.	0	No	No	No
9/8/2006	1 mo.	4	Yes	Yes	No
9/9/2006 NF	3 mos.	0	No	No	No
9/9/2006	1 mo.	0	No	No	No
9/10/2006	4 yrs.	3	Yes	Yes	No
9/11/2006 NF	2 yrs.	0	No	No	No
9/13/2006	6 yrs.	3	Yes	Yes	No
9/13/2006	4 mos.	2	Yes	Yes	Yes
9/18/2006	2 mos.	1	Yes	Yes	No

NF – Near Fatality

Kin – Relative Placement

54 FCANS is discussed in more detail earlier in this article.

55 A case is defined as abuse/neglect related when child abuse or neglect is present and contributes in a concrete way to the child's death. Sacramento child death review team, 1999-2003 *Five Year Report* (2006) at 35.

56 *Id.* at 36.

57 A few CDRT reports do list the number of children who had some contact with CPS, but this data is usually limited to victims with an open CPS case at the time of their death. See, e.g., Alameda County Death Review Team: Five Year Report 1996-2000 (Indicating that 12 of the 49

children who died from abuse or neglect were involved with CPS at the time of their death). Mendocino County's Death Review Team reported that 6 of the 13 children whose deaths were reviewed by the Team had been involved with Children's Services. Mendocino CDR Team 2004 Report.

58 Peddle, Wang, Diaz & Reid, *Current Trends in Child Abuse Prevention and Fatalities: The 2000 Fifty State Survey* (September 2002) at 15.

The Child Welfare League of America's (CWLA) most recent survey includes data on the number of cases in which the family was known to or had an open case with the child protection agency at the time of the child's death.⁵⁹ Almost all of the states reported that some child deaths occurred among families with either an open case or past involvement with the child protection agency. In some states, the number of families known to child protective services was much higher than the national average. Texas reported 204 fatalities in 2004 of which more than half had some history with the child welfare agency. Fifty families had an open case at the time of the child's death and another 55 of the children were previously known to the agency. Of Kentucky's 36 deaths, only 2 had an open case prior to the child's death, but 23 had a prior child protective services history. Nine of the 16 deaths in Mississippi occurred in families with past agency involvement.

Unfortunately, the CWLA survey does not contain further information or data about these statistics. For example, it does not track whether the families had multiple reports or contacts with child protective services. Nor does it state when the family's contact with the agency occurred.

At the recent National Conference on Child Abuse and Neglect in Portland, Oregon, researchers from the Louis de la Parte Mental Health Institute of the University of South Florida presented perhaps the most disturbing data to date on the number of child abuse fatalities that occur in families known to the child welfare agency.⁶⁰ The study included 126 child deaths for which a child death review team determined that abuse or neglect was the cause of death.⁶¹ The deaths occurred between 1999

and 2002. Researchers found that 64 percent of the families were known to the child protection system through previous reports of suspected abuse or neglect. Forty-one percent of the cases involved at least two or more reports of maltreatment prior to the one associated with the child's death.

All of this suggests the need for close scrutiny of the actions, if any, taken by child protective service agencies preceding a child's death. Such scrutiny and accountability, however, depend upon access to information about the factors and circumstances surrounding the child's death.

Congressional Mandate to Release Information on Child Abuse Deaths

A significant roadblock to providing the public with information about child abuse deaths is federal and state confidentiality law that protects against disclosure of child welfare records, including child abuse reports, investigations and findings. In 1996, Congress recognized the importance of public access to more detailed information about the factors and circumstances surrounding a child's death, especially as it relates to child protective services involvement, and eased these confidentiality laws. In doing so, Congress acknowledged that agencies' promises to undertake a serious, comprehensive review of child abuse deaths was not enough to protect children. Instead, Congress made clear that when a child dies from child abuse, the public has a right to examine whether the death was preventable and if so, how other children might be spared a similar fate.

Citing these concerns, Congress amended the federal Child Abuse Prevention and Treatment Act (CAPTA) in 1996 to require the public disclosure of the findings or information about a

case of child abuse or neglect that resulted in a child fatality or near fatality.⁶² In providing clarification of this statutory provision in the Child Welfare Policy Manual, the federal Children's Bureau reiterates that states do not have the discretion to withhold information about child abuse fatalities and that they must provide the public with the available facts in each case. According to the Congress, the new law would "help us answer some very basic questions: what happened, what should have happened to prevent or at least detect such abuse and how can we ensure other children do not suffer a fate similar to these. . . innocent [children]?"⁶³

States, like California, that receive federal funds under CAPTA are required to comply with this provision of the law.

Unfortunately, until recently, the federal Children's Bureau paid little attention to Congress' 1996 mandate and provided little guidance to child welfare agencies about what they must report. Hopefully, that will soon change. In a series of communications with the federal regional Children's Bureau office in San Francisco, attorneys at the National Center for Youth Law (NCYL) have insisted that federal officials begin to hold state agencies accountable for complying with the federal public disclosure provisions. NCYL's insistence, along with extensive media coverage of child abuse deaths in Las Vegas and elsewhere, prompted federal officials to clarify the state's obligations.⁶⁴ In a series of amendments to the Child Welfare Policy Manual last fall, the Children's Bureau stated that: when child abuse or neglect results in the death or near death of a child, the State must provide for the disclosure of the available facts. However, nothing in this provision should be interpreted to require

59 CWLA National Data Archive, *CWLA Survey: Number of Child Abuse & Neglect Fatalities, By History with the Child Welfare System* (2004). Data on child protective service involvement was unavailable from thirteen states.

60 Ilene Berson & Svetlana Yampoiskaya, *Mental Health Risk and Protective Factors Associated with Child Maltreatment Fatalities* (presentation at the 16th National Conference on Child Abuse and Neglect April 18, 2007).

61 Sixty-one percent of the victims were male, 51 percent Caucasian, 37 percent African American, and 10 percent Hispanic. The average age of the victims was four years old. Since the researchers were examining the mental health risk factors possibly associated with child abuse and neglect fatalities, they also collected data on the health of the victims. Twelve percent of the children had behavioral health problems and eighteen percent had medical or physical problems.

62 42 U.S.C. 5106a (b)(2)(A)(vi). A 'near fatality' is defined as "... an act that, as certified by a physician, places a child in serious or critical condition." Hospital records that reflect that the child's condition is 'serious' or 'critical' would be considered a 'near fatality.'

63 This was noted by members of Congress in Congressional hearings in 2003 and 2004 which probed the deaths of several children in Baltimore and New Jersey.

64 See, e.g., Child Welfare Policy Manual at 2.1A.4

disclosure of information which would jeopardize a criminal investigation or proceeding.⁶⁵

The Policy Manual gives states some discretion in the nature and extent of information they are required to provide:

The State is not required to release all of the information in the entire case record. Rather, the State must provide for the disclosure of the “available facts” in such situations. As such, the State may determine its procedures in accordance with these parameters, and can release the full investigation; a summary of the investigation; or a statement of findings or available facts about the incident among other options.⁶⁶

In addition, the Children’s Bureau does not require states to review identifying information. However, states may disclose these facts, with the exception of information about a sibling or another child in the home who was not the victim of fatal or near fatal child abuse.⁶⁷

State Practices Differ on Access to Information about Child Abuse/Neglect Deaths

State practices vary considerably in following the federal mandate to require disclosure of child abuse death information. In many instances, states deny public access to information necessary to conduct an inquiry into the child’s death. NCYL’s recent review of policies and practices around the country confirmed that the public’s access to information concerning child abuse/neglect deaths is often limited. In addition, some states place substantial hurdles in the way of obtaining details about child abuse deaths (like requiring a public records request). For example:

- In Oklahoma, information is available only if criminal charges are filed.⁶⁸
- In South Carolina, the state provides information on children who die while in foster care or who have an open case at the time of death but the state director has discretion to decide what information will be included in the reports released to the public.⁶⁹
- Michigan’s director uses a best interest standard but is specifically barred from denying a request for information “upon a desire to shield a lack of or an inappropriate performance by the department.”⁷⁰
- Florida’s confidentiality laws do not contain any exceptions for child abuse deaths.⁷¹
- New Jersey allows the department to release “findings or information about a case” and allows a person denied information to seek disclosure in the Superior Court.⁷²
- In California, only “tombstone data” may be released for foster children – name, age, gender, date of death and date of birth - and then only upon a formal request under the Public Records Act. The only way to obtain additional information about foster child deaths or any information on child abuse victims who die at home is to initiate an action in juvenile court.⁷³

In practice, states continue to routinely use confidentiality rules to deny the media and the general public information about child abuse deaths – information that should be disclosed under CAPTA.

In part due to NCYL’s recent complaints that California is not complying with federal law, federal officials notified state officials that it is

violating CAPTA by requiring formal court proceedings to obtain information about child abuse and neglect deaths. This prompted the California Department of Social Services to adopt a new policy in July 2006.⁷⁴ The policy requires disclosure of the age, sex, and race of the deceased child, the suspected cause of death, whether the child was in foster care or living with parents, and any previous abuse/neglect referrals for the family. The public may obtain additional information in the case file after petitioning the court and providing notice to interested parties – including the persons who caused the child’s death.

California Bill Balances Privacy with Public Disclosure

In an effort to provide for improved access to information concerning child abuse deaths in California, NCYL and the Children’s Advocacy Institute at the University of San Diego School of Law are sponsoring a bill in the current session of the legislature. The bill, SB 39, is authored by Senator Carole Migden (D-San Francisco). The legislation is a model for balancing privacy interests of children with the public need for information regarding child abuse and neglect deaths. Such information will support an informed public debate about reforms in child protective services. The bill creates a three-tiered system for disclosure:

- 1) Within five days of a death in which there is a reasonable suspicion that the death was caused by abuse or neglect, the agency must disclose the age, gender, and date of death of the child, and whether a law enforcement or child welfare agency, or both, are conducting an investigation.
- 2) Once the investigation is completed,⁷⁵ the agency, upon request,

65 *Id.*

66 *Id.*

67 [D]isclosure of the child’s name, date of birth, date of death or other personal information is not a Federal requirement. However, a State is not prohibited by CAPTA from having procedures or policies that release such information.

68 10 Okla. Stat Ann. 7005-1.4 E. In cases involving the death or near death of a child when a person responsible for the child has been charged by information or indictment with committing a crime resulting in the child’s death or near death, there shall be a presumption that the best interest of the public will be served by public disclosure of certain information concerning the circumstances of the investigation of the death or near death of the child and any other investigations concerning that child, or other children living in the same household.

69 S.C. Code Ann. § 20-7-690.

70 Mich. Comp. Laws §722.627e.

71 Fla. Stat. Ann. §415.51; *State, Dept. of Health and Rehabilitative Services, Dist. 10 v. Miami Herald*, 479 So.2d 158 (Fla. App. 4 Dist.1985) (statute recognizes no exception even when child is deceased and parent is charged with murder).

72 N.J. Stat. Ann. §9:6-8.10a.

73 Cal. Welf. & Inst. Code Ann. §827.

74 Cal. Dep’t of Social Service, *All County Letter 06-24* (July 21, 2006).

75 Investigations of child abuse or neglect reports are to be completed within 30 days of the report.

must disclose specific documents. Those documents include information that helps to determine the extent of the child welfare agency's involvement with the family prior to the child's death. For example, the agency must disclose all previous referrals, risk and safety assessments, police reports, and medical records other than for diagnosis or treatment of mental health. Prior to the release of these documents from the case records, the agency must redact all personally identifying information.

3) Members of the public may seek any other information from the case record – including investigative narratives, and contact logs - by filing a petition with the juvenile court. Interested persons, including the attorney for surviving children, must be given notice and have an opportunity to oppose the release. However, the legislation creates a presumption of disclosure which can be rebutted only by evidence that the release of the additional information from the

case file is detrimental to the safety, protection, or physical or emotional well-being of a child. The privacy interests of persons other than a child and/or sibling are subordinated to the public interest when a child dies from abuse or neglect. The court process is expedited, requiring a decision within 90 days of the request.

Conclusion

Media reports of child abuse deaths like those of Raijon and Daelynn often prompt calls for reform. But efforts at reform are hampered by the difficulty in obtaining specific information about the factors contributing to a child's death. If something more than a call for firing agency administrators or caseworkers is to result from the disclosure of a child's tragic and perhaps preventable death, then the public must have access to information that informs the public debate. California's proposed legislation grants that access while protecting the interests of surviving siblings. Similar legislative reforms are needed in other states.

Bill Grimm is a senior attorney at NCYL, specializing in Child Welfare / Foster Care. He has worked with Assemblywoman Carole Migden (D-San Francisco) and the Children's Advocacy Institute to craft SB 39, legislation that would greatly increase access to the records of children who have died of abuse or neglect. The bill was recently approved by the Senate Judiciary Committee and will now go before the Senate Appropriations Committee.