

**Sacramento County Child Death Review Team  
2005 Annual Report**

The following report includes brief descriptions on some of the cases that were reviewed by the Child Death Review Team throughout the 2005 calendar year. These cases were selected to illustrate the range of circumstances and situations that have placed children at risk. In cases where no criminal intent or negligence was found, the names have been changed in order to protect the identity of the victim and any family members who were not responsible for the death of the child.



## **To the People of Sacramento County:**

*This report was completed thanks to a major commitment of time and expertise from a team of dedicated professionals. This group of devoted individuals, and the agencies they represent, comprises the membership of the Sacramento County Child Death Review Team (CDRT) and the Prevention Advisory Committee (PAC). We gratefully acknowledge the entire membership for their input and dedication. The following members were part of the 2005 CDRT and PAC:*

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## Executive Summary



## EXECUTIVE SUMMARY

The death of a child is a tragedy. Even more tragic is the death of a child due to child abuse and neglect. While some deaths are natural and unavoidable, such as a baby born too early or a child's life lost as a result of cancer, many innocent children's lives are lost every year that could have been saved. Many of these unnatural and avoidable deaths are the direct result of child abuse and preventable injuries.

The following report provides an in-depth review of child fatalities in Sacramento County for 2005. Included are descriptions of all deaths whether they were the result of child abuse and neglect, injuries, homicides or natural causes.

2005 marks the sixteenth year that the Sacramento County Child Death Review Team (CDRT) has been working to investigate, analyze, and document the circumstances that have led to all child deaths in Sacramento County. Together, CDRT members review each case as well as any pertinent case information and/or history and come to a mutual consensus on the manner and cause of each death. The goal of the Child Death Review Team is to identify how and why children die in order to facilitate the creation and implementation of strategies to prevent child deaths.

In 2005, 167 children died at a rate of 45.4 per 100,000 children in Sacramento County. Nine less lives were lost in 2005 than 2004 (176 total deaths), while fourteen more lives were lost in 2005 than 2003 (153 total deaths). The three causes of child deaths in 2005 were natural causes (121), injuries (42), and undetermined manner (4).

This year there were 121 child deaths resulting from natural causes such as perinatal conditions, congenital anomalies, SIDS, cancer, infections, and respiratory problems. Deaths resulting from natural causes continue to constitute the majority of deaths in the County, resulting in 72% of all deaths for this year.

Injury-related deaths resulted in 42 child fatalities, accounting for 25% of the total child deaths for this year. The most disturbing detail is the consistent finding that injury-related deaths could have been prevented. This category includes deaths resulting from child abuse and neglect (CAN) homicides, third-party homicides, motor vehicle accidents, drowning, suffocation, burning, suicide and other injuries. Eight of the 42 injury-related deaths were the direct result of a CAN homicide, up from four CAN homicides in 2004.

There were four child fatalities that resulted from an undetermined manner, accounting for 2% of the total child deaths. All four of these deaths were due to sleep-related issues.

Child fatalities tell us a great deal about the well being of children in our community. Supported by a solid statistical foundation, the prevention strategies recommended herein were developed not only for the purpose of preventing child deaths, but also to protect Sacramento County's children from disease, disfigurement, disability, emotional damage, and other long-ranging effects of child abuse, accidental injuries and poor health.

The CDRT 2005 Annual Report findings and recommendations that follow were developed with a sincere awareness of the complexity of problems facing Sacramento County's children and their families. The major findings and recommendations reported highlight the core of child fatalities and recommends strategies to reduce such numbers and improve the health and lives of children in Sacramento County. Additionally, such recommendations recognize the County's existing commitment to early intervention and prevention and advocate strongly for continued support of these efforts.

## Major Findings

This year, there were 167 child deaths in Sacramento County at a child death rate of 45.4 per 100,000 children. In 2004, there were 176 child deaths in Sacramento County at a child death rate of 48.9 per 100,000 children. In 2003, there were 153 child deaths with a rate of 43.3 per 100,000 children. Major findings of the types of deaths that occurred in Sacramento County this year follows.

➤ **One-quarter of all deaths were preventable.**

Forty-four (26%) of the 167 child deaths in 2005 were preventable. Forty-two (42) of these deaths were injury-related, such as motor vehicle accidents, homicides, suicides or drownings. Eight of the 42 deaths were attributed to child abuse and neglect (CAN) homicides. Two of the 42 deaths were due to infections for which there are medical interventions.

Forty-six (26%) of the 176 child deaths in 2004 were preventable. Forty-three (43) of these deaths were injury-related, such as motor vehicle accidents, homicides, suicides or drownings. Four deaths were due to child abuse and neglect (CAN) homicide. Two deaths were due to infections for which there are medical interventions and one death was due to cerebral palsy caused by intrauterine drug exposure.

➤ **Injury-related deaths comprised the vast majority of all preventable deaths.**

In 2005, there were 42 (25%) injury-related deaths. This is a decrease of 1 death when compared to last year's total of 43 injury-related child deaths. These deaths include motor vehicle accidents, homicides, drownings, suicides and other injuries.

➤ **Child abuse and neglect (CAN) homicides increased.**

This year there were eight child abuse and neglect (CAN) homicides, 5% of the 167 child deaths. All eight CAN homicides were separate incidents. Five of the CAN homicides occurred in infants and three were children between one and four years of age. All eight deaths (100%) occurred at the hands of one or both parents. Two victims had involvement with Child Protective Services prior to their death.

In 2004, there were four CAN homicides, which comprised 2% of the 176 child deaths. Two victims were infants, one victim was between the ages of one and four and one victim was between the ages of five and nine. Three victims died at the hands of either one or both parents and one child died at the hand of a family friend. Three victims had involvement with Child Protective Services prior to their death.

Since 1990, there have been 131 CAN homicides, 4% of the total child deaths. Ninety-seven of those 131 CAN homicides occurred in children under five years of age.

➤ **The majority of perpetrators of child abuse and neglect homicides are parents of the decedent.**

Between 1990 and 2005 it has been found that the majority of perpetrators (60%) of child abuse and neglect (CAN) homicides are the parents of the decedent. This includes the mother or father acting alone, or both parents acting together. Including stepparents and the boyfriend or the girlfriend of a biological parent, this figure jumps to 76% of all perpetrators of CAN homicides.

➤ **Alcohol and drug use was present in more than one-half of all injury-related deaths.**

This year, alcohol or drug use was present in 25 of the 42 injury-related child deaths (60%). Substance use or history of substance use occurred with the decedent and/or the caregiver. The causes of death with this risk factor present include seven child abuse and neglect (CAN) homicides, six third-party homicides, four motor vehicle accidents, and three suicides.

➤ **Thirty-nine percent (39%) of all teen deaths occurred by use of a firearm.**

This year, 39% of all deaths of teens 13 to 17 years of age occurred by use of a firearm. Eleven (11) out of the 21 injury-related deaths were a result of the use of a firearm (6 were third-party homicides and 5 were suicides), comprising the majority of injury-related deaths (52%).

In 2004, 10% of all teen deaths occurred by use of a firearm. Six (6) of the 22 injury-related deaths were a result of the use of a firearm comprising more than one-quarter (27%) of the injury-related deaths. In 2003, 27% of all teen deaths occurred by use of a firearm. Seven (7) of the 22 injury-related deaths were occurred by use of a firearm comprising less than one-third (31%) of injury-related deaths.

➤ **Third-party homicides and suicides comprise the majority of teen deaths.**

In 2005, sixteen (57%) of the 28 deaths of teens 13 to 17 years of age, were third-party homicides or suicides. Eight of the deaths were third-party homicides and eight were suicides, comprising the majority of deaths (57%) between 13 and 17 years of age. Of the eight third-party homicides, five (63%) involved the use of a firearm, and five (63%) of the eight suicides involved the use of a firearm.

In 2004, twelve (40%) of the 30 deaths of teens 13 to 17 years of age, were third-party homicides or suicides. Eight of the deaths were third-party homicides and four were suicide, comprising 40% of deaths between 13 and 17 years of age. Of the eight third-party homicides six (75%) involved the use of a firearm, and one (25%) of the four suicides involved the use of a firearm.

➤ **Sleep-related infant deaths, including SIDS and unexpected infant deaths of an undetermined manner, have declined.**

In 2005, there were five SIDS, two sleep-related suffocations, and four sleep-related unexpected deaths of an undetermined manner, resulting in 11 sleep-related deaths, or 7% of all child deaths under 18 years of age in Sacramento County. In 2004, there were 3 SIDS and 10 sleep-related unexpected deaths of an undetermined manner, resulting in 13 sleep-related deaths or 7% of all child deaths. From 1999 through 2003, there were seventy-nine (79) SIDS, and 28 unexpected deaths due to suffocation or undetermined manner resulted in 107 sleep-related deaths, representing 12% of all deaths of children up to 18 years of age in Sacramento County.

➤ **Children under one year of age continue to represent the majority of all child deaths.**

In 2005, children under one year of age comprised 6% of the population under 18 years in Sacramento County and 65% of child deaths (109 out of 167). The major causes of child deaths under one year of age were: perinatal conditions, 68 (62%); congenital anomalies, 20 (19%); and sleep-related, including 5 SIDS deaths, 11 (10%).

In 2004, children under one year of age comprised 6% of the population under 18 years in Sacramento County and 58% of child deaths (102 out of 176). The major causes of child deaths under one year of age were: perinatal conditions, 54 (52% of all infant deaths); congenital anomalies, 22 (22%); and sleep-related, including 3 SIDS cases, 13 (13%).

➤ **African American and Multiracial infants die in disproportionate numbers compared to other ethnic groups.**

African American and Multiracial infants continue to be at a higher level of risk of death amongst all ethnic groups in Sacramento County. In 2005, African American infants comprised 12% of Sacramento County's infant population and 28% of all infant deaths. The rate of death per 1,000 African American infants was 12.2 in 2005 and 11.6 per 1,000 in 2004.

In 2005, multiracial infants comprised 3% of Sacramento County's infant population and 11% of the infant deaths. In 2005, infants of a multi-ethnic background had a death rate of 15.1 per 1,000 infants in Sacramento County. In 2004, infants of a multi-ethnic background had a death rate of 16.9 per 1,000 infants in Sacramento County.

The 2005 infant death rates for Hispanic and Asian children were under the county average of 4.9. The death rates were 1.7 for Hispanic infants and 2.8 for Asian infants, per 1,000 infants, respectively.

The 2004 infant death rates for Hispanic and Asian children were under the county average of 4.8. The death rates were 2.1 for Hispanic infants and 4.4 for Asian infants, per 1,000 infants, respectively.



## Recommendations

- **Support the implementation, continuation and expansion of public education and awareness campaigns aimed at modifiable adult behaviors to educate parents and caregivers on preventable deaths through home visitation programs, hospitals, child care providers, and family resource centers.**

Twenty-six percent of all child deaths in 2005 were preventable. They were the result of poor judgment and/or behaviors by adults. The Child Death Review Team (CDRT) recommends the continuation and expansion of public education campaigns, such as the Shaken Baby Syndrome prevention campaign and SAFE Beginnings, as well as targeted education to hospitals, schools, child care providers, foster families, and through programs such as the Nurse Family Partnership, Black Infant Health, Birth & Beyond, Family Resource Centers, and Child Welfare Services Redesign. The CDRT understands that these adults are either in direct contact with infants and children by caring for them (parents, grandparents, and caregivers), by providing advice (grandparents and hospital staff), or by visiting families with infants and children (home visitors). These educational campaigns, demonstrated to be effective in the Sacramento County community, target specific modifiable adult behaviors in order to reduce the number of preventable child deaths. The SAFE Beginnings campaign, for example, utilizes the approaches derived from the “Spectrum of Prevention” model recognized by the U.S. Centers for Disease Control and Prevention. This includes a social marketing approach which applies commercial marketing strategies to influence the behavior of the target population. Funding for SAFE Beginnings will end on June 30, 2007. Therefore, the CDRT recommends that funding be secured to continue these campaigns to ensure progress towards reducing preventable deaths.

- **Sustain public education campaigns aimed at reducing Sudden Infant Death Syndrome (SIDS) and other sleep-related infant deaths.**

SIDS and other sleep-related infant deaths have decreased since 1999. Since 2003, the number of sleep-related deaths has notably decreased by nearly half. Concurrently, during 2003 through 2005 there was a marked increase in public education campaigns focusing on the importance of infant safe sleeping. The CDRT acknowledges the positive impact of these types of educational outreach programs and encourages continued funding of such programs to help ensure a continued decrease in sleep-related infant deaths.

- **Mobilize a broad-based community group comprised of health providers, policy makers, parents and local leaders in the African American community to assess needs and services to the African American community and to develop a strategic plan for improving the African American community’s utilization of such services.**

The CDRT recommends that Sacramento County and the health community partner with prenatal and new parents, faith-based and community-based organizations, and leaders in the

African American community to find increased solutions and funding for the reduction of the disproportionate number of African American infants that are dying in this community. This community-wide partnership would be most effective with organizational leadership and would include existing programs which target the health and well-being of women and children during pregnancy and beyond, such as the Black Infant Health program, the Perinatal Periods of Risk Committee, Child Welfare Services Redesign, and other similar programs.

➤ **Continue to support and provide funding for prevention and early intervention programs.**

The CDRT applauds the Sacramento County Board of Supervisors for their consistent support of prevention programs and for their leadership in directing the formation of a broad-based effort to engage the community in planning for a comprehensive approach to prevention. Home visitation and early intervention programs targeted to the most at-risk communities, the key strategies selected by public and private stakeholders, have shown success in improving the health, social circumstances, and outcomes of mothers and children including reductions in the incidents of child abuse and neglect. A key component of these prevention programs is service accessibility through neighborhood-based family resource center services. The CDRT recognizes and supports the efforts of the Family Support Collaborative, Child Welfare Services Redesign, Family Resource Centers, and the more than twenty home visitation programs for their efforts to improve the health and safety of children and families. The CDRT recommends improving avenues of collaboration and communication among the different prevention and early intervention programs in Sacramento County, in order to prevent and address system gaps, and that the County Board of Supervisors maintain the infrastructure of the family resource centers and the neighborhood-based services they provide in these at-risk communities.

➤ **Expand the development of public and private substance abuse prevention and treatment programs.**

A history of substance use by the child and/or the child's family existed in twenty-three percent of all child deaths in 2005. In eight percent of the child deaths, drug and/or alcohol use was involved at the time of death. Furthermore, statistical analyses have shown that children who live with a substance abusing parent and/or caregiver are at greater risk of being a victim of a child abuse homicide or sleep-related infant death.

The CDRT recognizes the threat to children resulting from substance abuse by parents, caregivers, and/or the youth themselves. The CDRT further recognizes that many preventable deaths could be reduced if parents, caregivers, and youth were provided with and utilized substance abuse education, treatment and/or intervention and that there is currently a lack of access to and/or utilization of such services. Therefore, the CDRT recommends: 1) a collaborative primary prevention substance abuse approach that includes education and prevention strategies targeted to children and families where early intervention can be most effective; 2) the continuation and expansion of public and private substance abuse programs' efforts to assist parent, caregivers, and youth in eliminating substance abuse; and 3) expanded outreach to parents, caregivers, and youth to increase their utilization of substance abuse intervention services.

➤ **Support efforts to enforce pool safety in order to decrease residential drownings.**

The CDRT recognizes and supports the efforts of the Safe Kids Coalition, which is targeting residential drownings by working with code enforcement officials to mandate pool safety requirements (fence requirements, warning signs, etc.) among new residential pool owners. The Sacramento CDRT continues to recommend that this policy be extended to include pools installed prior to the implementation of this policy.

➤ **Expand the investigation and analysis of youth deaths.**

CDRT members have recommended that CDRT expand its investigation and analysis of youth deaths including youth motor vehicle accidents, homicides, and suicides. Therefore, beginning in 2007 on a quarterly basis, the CDRT will conduct an expanded investigation and analysis of youth deaths and include the aggregate data in the Annual CDRT Report.

➤ **Establish a grass-roots multi-disciplinary teen violence task force to reduce youth violence.**

The CDRT recognizes the increase in youth deaths due to violence and that in 2005, more than half of injury-related teen deaths (both third-party homicides and suicides) occurred due to a firearm. The CDRT recommends the following: 1) that Sacramento County convene a grass-roots multi-disciplinary teen violence task force that includes youth from the communities most at risk, representatives from agencies who work directly with the teen populations in those communities, and a lead organization to provide coordination; 2) that focus groups be conducted to inform the task force on the education and intervention strategies that would be effective in the target communities; and 3) that this task force develop a strategic plan for addressing youth violence, in particular youth access to firearms.

➤ **Implement teen suicide prevention recommendations.**

The CDRT applauds the Sacramento County Division of Mental Health for convening an ad hoc Teen Suicide Prevention Task Force in response to the CDRT 2004 recommendation to develop a coordinated community response to teen suicide. The *Teen Suicide Prevention Taskforce Recommendations to the Department of Health and Human Services In Response to the 2004 Child Death Review Team Report* is included in the Appendix of this Report. The CDRT recommends that Sacramento County find the means to implement the eleven Teen Suicide Prevention Task Force recommendations in the following focus areas: 1) awareness that teen suicide is a preventable public health problem; 2) training and education programs for teen suicide prevention; 3) enhance existing local data collection for suicides. The CDRT will enhance its suicide data collection system in coordination with the Teen Suicide Prevention Task Force.



## INTRODUCTION

A simple child  
That lightly draws its breath,  
And feels its life in every limb,  
What should it know of death?

William Wordsworth

*Eleven-month old Allan was born to a 22 year-old father whose fists were itching to feel flesh, and to a 19-year old mother who so desperately desired a man's love that she willingly sacrificed her own physical safety and eventually, her son's life in an attempt to maintain the relationship. The father not only had a penchant for violence, but also for drugs and alcohol, twin risk factors known to be red flags in CDRT case reviews.*

*In addition to beating Allan's mother during her pregnancy, Allan's father had beaten prior girlfriends and was in a court mandated domestic violence treatment program in another county at the time he abused Allan and his mother. At the time of Allan's death, Allan's mother had a black eye and other injuries incurred in abuse from Allan's father. Her co-workers and friends had all urged her to leave Allan's father, not only for her own sake, but also for Allan's. Although they advised her to call W.E.A.V.E. or CPS or law enforcement, she declined to do so and steadfastly refused all offers of help.*

*When Allan's battered body was autopsied, it was found that he had multiple injuries, both old and new, including multiple fresh bruises about his head and face, a torn frenulum and laceration of his tongue, multiple bruises on his chest, abdomen, back and buttocks, injuries to his liver, pancreas, duodenum, and mesentery, and two fractured ribs. The cause of death was blunt force injuries of the head and torso.*

*Allan's family was not known to CPS prior to his death. Although many people shared a concern for Allan's welfare, no one called CPS or law enforcement to report their concerns. Being unable to convince Allan's parents of the toxicity of the home environment they created, the concerned friends and relatives merely lamented the situation. No one called CPS. No one called law enforcement. So while agencies staffed with competent and caring individuals were waiting and available to dispatch help for Allan, no one cared enough to overcome the strong societal edict to 'mind your own business.'*

*Once Allan was at death's door his father finally called 9-1-1. The call was too late to help Allan. The call was not too late, however, to help all the unknown and possibly unborn Allans. Allan's parents were arrested, the case was tried before two juries, and Allan's father was convicted and sentenced to 32 years to life in prison. It will be a lifetime before Allan's father will have the ability to harm another child. Allan's mother was found guilty of misdemeanor child endangerment and granted probation.*

*This tragedy underscores the fact that domestic violence and child abuse are inextricably linked and that children are often direct victims, as well as peripheral casualties, in domestic violence crimes. While we rightfully question how a mother could have left her baby behind with the person who had been abusing them both, we as a community must dig deeper and ask what we can do to protect a child when a parent is unwilling to do so. The problem itself is centuries old. The magnitude of the consequences to children demand that we as a community consider interventions that might change the fate of the helpless victims of domestic violence who have no choice about where they live, or with whom, before they become names on death certificates.*

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## **Chapter I**

### **Deaths Related to Abuse and Neglect**



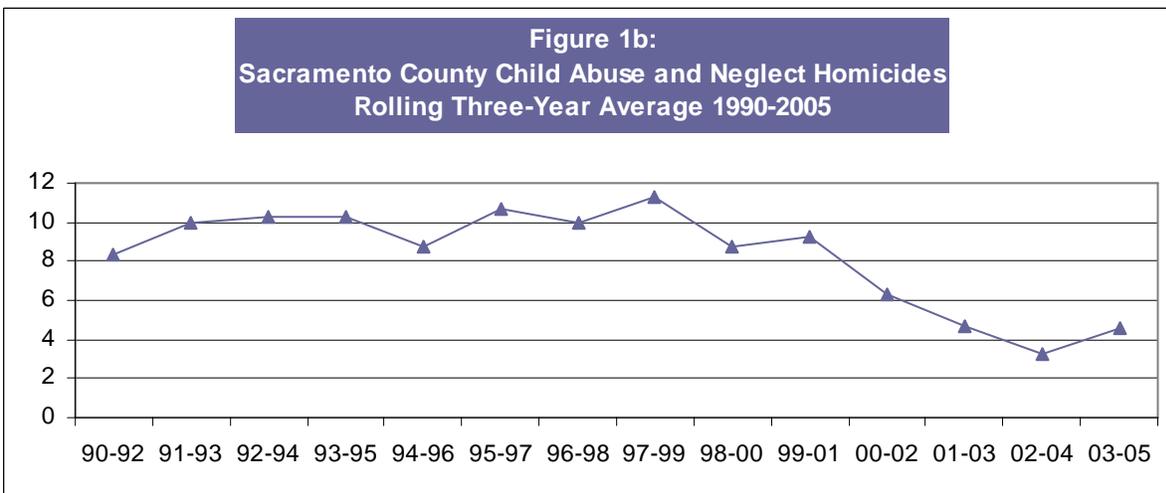
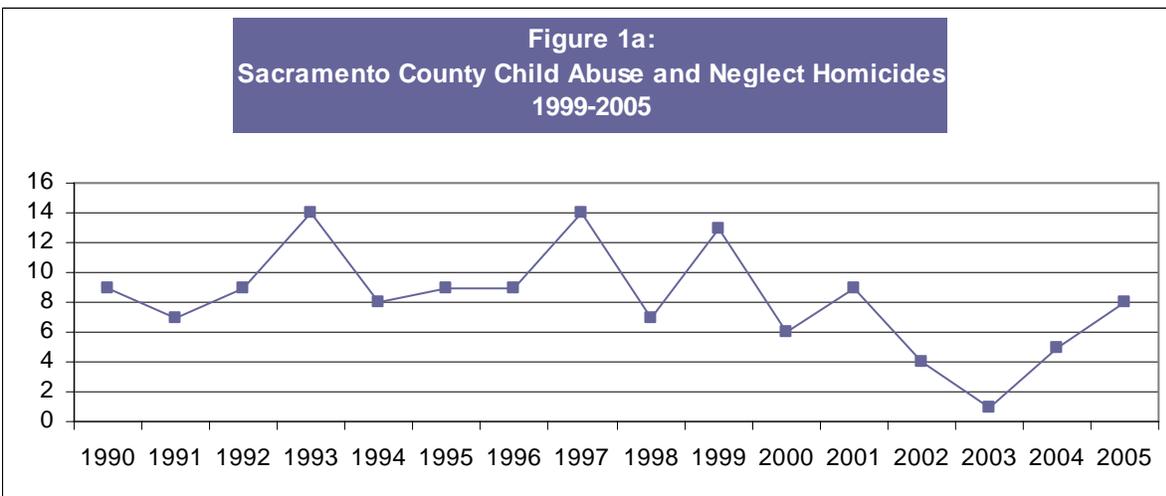
# Chapter One

## Deaths Related to Abuse and Neglect

### Narrative

One of the principal functions of the Sacramento County CDRT is to ensure that all child abuse and neglect-related deaths are identified. Recognizing the risks inherent to children living with a neglectful, violent or substance abusing adult, the CDRT routinely collects information on drug and/or alcohol history, history of prior abuse and/or neglect, and domestic violence during their review process for all deaths, regardless of their cause. This information is derived from criminal histories, social service histories, and crime scene investigations.

In 2005, 167 children died in Sacramento County. Eight deaths were due to child abuse and neglect (CAN) homicides. This is an increase from four CAN homicides in 2004.



Child abuse and neglect was involved in the lives and deaths of 14 of the children who died this year. More specifically, eight children died as a result of a child abuse and neglect homicide, three died indirectly from neglectful behaviors, and three children died where neglect-related behaviors were present. Neglectful behaviors were questionable in two additional deaths. In a case where a

death is not a homicide, but the team concluded that the child experienced some type of abusive or neglectful behavior, the CDRT will classify the deaths as being abuse or neglect related. Elements of neglect include failure by the parent or caretaker to provide for the basic needs of the child, or situations where physical injury occurred. An example of a case involving an element of neglect in 2005 included parents who used a broken crib for their infant. The crib sides were not properly attached causing the child to asphyxiate. A case is defined as neglect-related when the child is left without adequate supervision, food, shelter or medical care and is killed by a suddenly arising danger. An example of neglect-related deaths in 2005 was a young drowning victim who was being supervised near the unfenced family pool by a three-year old sibling.

Through the years that Sacramento's CDRT has met and discussed child deaths, certain risk factors have been identified. These risk factors were present in 13 of the 14 deaths related to abuse and neglect (93%). Examples of risk factors include a family history of alcohol and other drug involvement, or a family history of abuse and neglect, domestic violence or violent crime. The following information was available for the 13 of deaths related to abuse and neglect:

- 11 families had a history of alcohol or drug abuse
- 8 families had a history of abuse or neglect
- 4 families had a history of violent and/or non-violent crime
- 2 families had a history of domestic violence
- 2 family had a history of gang involvement
- 1 family had a history of mental health problems.

### **Child Abuse and Neglect Homicides**

Child homicides fall into two broad categories, those resulting from caregiver abuse or neglect, and those perpetrated by a third-party, such as a friend or stranger. A child abuse and neglect (CAN) homicide is a death that is caused by abuse or neglect through a caregiver, such as a parent, guardian, or babysitter, or other caregivers including family friends. Third-party homicides, defined as those deaths perpetrated by strangers, acquaintances, or friends who were not acting as caregivers, are discussed later in this report.

### **Victims**

This year, eight children residing in Sacramento County were CAN homicide victims. Two victims were female and six victims were male. Five victims were infants under one year of age, and three were in the one through four year old age category. Three victims were Caucasian, three were African American, one was Hispanic and one was of Asian/ Pacific Islander ethnicity.

## **Perpetrators**

In 2005, of the eight CAN homicides, six children died at the hand of their parent(s), and one child died at the hands of another relative. The perpetrator could not be identified in one case, as there were multiple caretakers present.

## **Risk Factors**

In order to detect trends and form prevention strategies at a local level, the CDRT investigates the family environments of all children who die in Sacramento County. Evidence of risk factors or family stressors, such as substance abuse, prior child abuse, domestic or other violence, mental illness, and poverty are collected by CDRT members in preparation for each review.

In 2005, five risk factors were identified in CAN homicides: a family history of abuse or neglect (evident in four of the eight CAN cases), a family history of drugs and/or alcohol abuse (involved in all eight cases), a family history of violent or non-violent crime (in three of the eight cases), a family history domestic violence (in two of the eight cases), and a family history of gang involvement (in two of the eight cases).

## **Prior Agency Involvement**

One of the goals of the CDRT is to identify any gaps in delivery of services, which are identified during the review process. For that purpose, the CDRT records agency involvement with families of CAN homicide victims. Of the eight 2005 CAN homicide victims, four families had involvement with Child Protective Services (CPS) prior to their death. Of those four families, three of the actual victims had involvement with CPS prior to their death. One of the three victims had an open CPS Emergency Response referral at the time of death, one had the case closed 6 months prior to the death, and one had the case closed 9 months prior to the death. In one more CAN homicide cases, CPS involvement was limited to siblings and occurred more than a year prior to the birth of the decedent. The remaining four CAN homicides had no prior involvement with CPS.

## **Investigation and Prosecution**

Nine perpetrators were identified in seven of the 2005 CAN homicides. In the eighth case no charges were filed as there was insufficient evidence to establish the party responsible for the child's death. Of the nine perpetrators:

- One father pleaded no contest to child abuse resulting in death and to another count of child abuse because of old injuries on the child's body. He was sentenced to 18 years and 4 months in prison.
- One father was convicted of second degree murder, child homicide, and domestic violence resulting in a sentence of 32 years to life in prison. The mother was found guilty of misdemeanor child endangerment and was granted probation.
- One mother and her boyfriend are currently pending trial on murder and child homicide charges.
- Three fathers are pending trial.

- A family member's boyfriend is pending trial.

Because cases take time to navigate through the criminal justice system, this annual report attempts to report on the outcomes of all prior identified CAN homicides from prior years. As previously noted, there were four CAN homicides identified in 2004. Five perpetrators were identified in the four 2004 CAN homicides. One mother could not be tried because it was a murder/ suicide. Of the remaining cases, four remaining perpetrators were tried in 2005 and sentenced as follows:

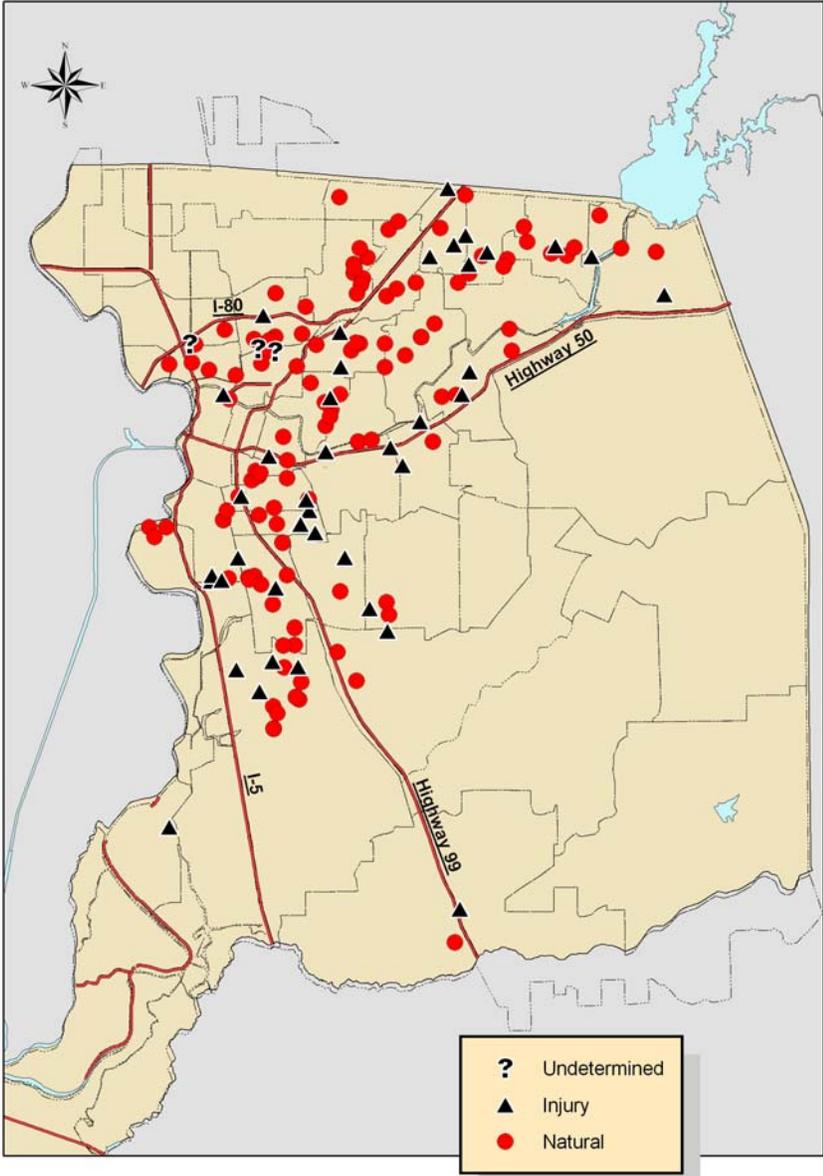
- Godparents were found guilty of murder and child homicide. Both were sentenced to 25 years to life in state prison.
- One mother pleaded no contest to two counts of child abuse/endangerment and two counts of involuntary manslaughter resulting in a sentence of 19 years and 8 months in state prison. The father was found guilty of two counts of felony child endangerment resulting in a sentence of five years and four months in state prison.

In 2002, four children died as a result of CAN homicide. For one of those cases, two caretakers were tried during 2005/2006. The stepmother was found guilty of second degree murder and sentenced to 15 years to life in prison. The father was found guilty of first degree murder with two prior "strikes" of child molestation and was sentenced to 75 years to life in prison.

## **Chapter II**

### **All Causes of Child Death**

Map i:  
All Causes of Death  
Sacramento County 2005



## Chapter Two

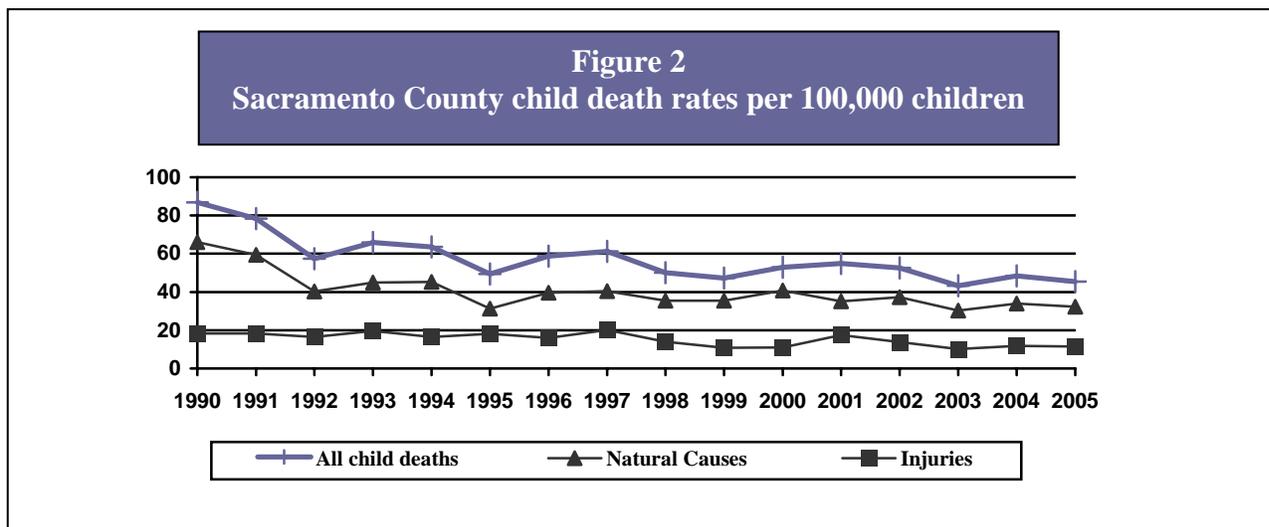
### All Causes of Child Death

Another fundamental mission of the Child Death Review Team (CDRT) is to develop a statistical description of all child fatalities as an overall indicator of the well-being of children. This chapter includes information regarding the overall child death rate, natural and injury-related death rates, a categorical breakdown of the causes and manners of death, and a summary of natural deaths and those caused by accidents, suicides, and undetermined manner. Map i, shown on the previous page, is a graphical representation of all child deaths under 18 years of age that occurred in Sacramento County in 2005.

As noted earlier in this report, the CDRT routinely collects information such as drug and/or alcohol history, prior abuse and/or neglect, domestic violence, and public assistance history for all cases, regardless of any suspected foul play. If needed, additional information is collected that relates to the circumstances surrounding the death. For example, information on adequacy of prenatal care and tobacco exposure to a baby is collected for infant deaths.

### Child Death Rates

In 2005, there were 167 child deaths in children under 18 years of age, who were residents of Sacramento County. The Child Death Rate represents the death rate for Sacramento County residents, under 18 years of age, whose deaths occurred in Sacramento County. Since there are more than 300,000 children in Sacramento County, it is our practice to multiply this quotient by 100,000 in order to detect subtle changes from one year to the next.



The child death rate for 2005 was 45.4 per 100,000 children. This rate is lower than the 2004 rate of 48.9, higher than the 2003 rate of 43.3, and lower than the 2002 rate of 52.6. The raw data and corresponding death rates have been provided in Table A.

Deaths can be classified as natural causes, injury-related or undetermined. The undetermined category is comprised of cases where there was insufficient evidence to determine the exact cause of the death.

In 2005, 72% of all child deaths were due to natural causes. This is two percentage points higher than deaths due to natural causes in 2004. Injury-related fatalities accounted for 25% of all child deaths in 2005. Again, this is one percentage point higher than in 2004. Two percent of child deaths were classified as undetermined in 2005. This is four percentage points lower than in 2004.

## **Cause and Manner of Death**

### **Table A Description**

Table A provides a summary of the conditions and circumstances that resulted in child deaths this year. Deaths in the two main categories, natural causes and injury-related, are broken out into subcategories according to similar conditions. A third category, undetermined, contains cases for which the manner of death could not be identified. Examples of cases in this category include SIDS vs. possible parental overlay, where there was not enough information to categorize this death as natural or due to accidental injury.

Annual rates have been calculated only for categories where there were 15 or more child fatalities. All rates were calculated using the 2005 population demographics provided by the State of California Department of Finance. Rates are based per 100,000 children.

**Table A**  
**2005 Child Deaths by Cause and Manner – Sacramento County**  
**Per 100,000 Children**

Category	Number of Deaths	Rates*
<b>Natural Causes</b>		
Perinatal Conditions	71	19.3
Congenital Anomalies	28	7.6
SIDS	5	--
Cancer	9	--
Infections	5	--
Respiratory	1	--
Other	2	--
Undetermined Natural	0	--
<b>Total Natural Causes</b>	<b>121</b>	<b>32.9</b>
<b>Injury-Related Causes</b>		
CAN Homicide	8	--
Third-Party Homicide	9	--
Arson Homicide	0	--
MVA (Occupant)	3	--
MVA (Pedestrian)	4	--
MVA (Bike)	1	--
Drowning	5	--
Suicide	8	--
Suffocation/Choking	2	--
Fires	1	--
Undetermined Injuries	0	--
Other Injuries	1	--
<b>Total Injury-Related Causes</b>	<b>42</b>	<b>11.4</b>
<b>Undetermined Manner</b>	<b>4</b>	<b>--</b>
<b>TOTAL</b>	<b>167</b>	<b>45.40</b>

\* Rates were not calculated for categories in which there were fewer than 15 deaths.  
 Population Source: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 1970-2040*.

## Cause and Manner of Death

### Natural Causes

*Definition: Death due to complication(s) of disease process, or due immediately to natural cause(s). Examples of natural causes include perinatal conditions, congenital anomalies, Sudden Infant Death Syndrome (SIDS), cancers, and deaths due to infections or respiratory conditions.*

One hundred twenty-one (121) children in Sacramento County died from natural causes in 2005. The two leading natural causes of death were perinatal conditions and congenital anomalies (birth defects).

On the next few pages, you will find information for the two leading natural causes of death: prematurity and other perinatal conditions and birth defects. A third section on SIDS deaths is included in this section, due to the historically high number of SIDS deaths in Sacramento County.

### Perinatal Conditions

Perinatal conditions include prematurity, low birthweight, placental abruption and congenital infections. The perinatal period is defined as the time interval beginning with the completion of the 20<sup>th</sup> to 28<sup>th</sup> week of gestation and ending 7 to 28 days after birth.

In 2005, perinatal conditions accounted for the deaths of 71 children. Prematurity was a contributing factor in 43 (26%) of the 167 child deaths this year. The median gestational age of babies who died from prematurity and other perinatal conditions was 25.0 weeks. The median weight of babies who died from prematurity and other perinatal conditions was 612.2 grams (approximately 1.35 pounds).

The following information was available on the 71 deaths due to perinatal conditions in 2005:

- 14 families had a history of substance abuse
- 10 families had a history of domestic violence
- 5 mothers had positive toxicology reports at birth for alcohol or drugs
- 3 mothers had a history of smoking during their pregnancy

### Congenital Anomalies

*Definition: Congenital - A condition that exists at birth, and usually before birth, regardless of its causation. Anomalies - Marked deviations from the normal standard, especially as a result of congenital defects. These conditions are acquired during the development of the fetus and are generally attributed to heredity/genetics.*

Congenital anomalies include fatal birth defects, such as heart defects and chromosomal abnormalities. The underlying causes of death in this category are generally attributed to

heredity and/or genetics. Birth defects include heart defects, neural tube defects such as anencephaly, and chromosomal abnormalities such as Down Syndrome.

The following information on risk factors was available on the 28 deaths caused by congenital anomalies in 2005:

- 4 families had a criminal history (violent or non-violent)
- 3 families had a history of substance abuse
- 3 families had a history of domestic violence
- 2 children were born to teen mothers

### **Sudden Infant Death Syndrome (SIDS)**

*Definition: A diagnosis of exclusion and unknown etiology, it is the leading cause of death for infants between ages two months to one year in the United States, accounting for about one-third of all such deaths. Section 27491.41 of the California Government Code defines SIDS as “the sudden death of any infant that is unexpected by the history of the infant and where a thorough postmortem examination fails to demonstrate an adequate cause of death.”*

SIDS is classified as a diagnosis of exclusion. This means that the pathologist attributes an infant death to SIDS when an apparently healthy infant dies and a thorough investigation reveals that no other cause of death can be established. Although SIDS deaths tend to be unpredictable, research has demonstrated that certain conditions (sleep position, exposure to tobacco smoke) put some infants at higher risk for SIDS than others. In 2005 there were five SIDS deaths in Sacramento County. Three (60%) of the victims died in environments recognized nationally to increase the risk of SIDS.

The following information was available on the five SIDS deaths in 2005:

- 3 infants were sleeping either facedown or on their side
- 3 infants were in a cluttered or broken crib
- 2 infants had a parent with a history of mental health issues

### **Other Natural Causes**

#### **Cancer, Infections, and Other Natural Causes**

*Definition: Cancer - Death caused by a tumor disease, the natural course of which is fatal. Cancer cells, unlike benign tumor cells, exhibit the properties of invasion and metastasis and are highly anaplastic. Cancers include two broad categories of carcinoma and sarcoma.*

*Infections - Death caused by the invasion and multiplication of microorganisms in body tissues. Examples are meningitis and sepsis.*

*Other Natural Causes - Deaths due to a natural cause not previously mentioned.*

Cancers, mainly those involving the blood and brain, were the most common causes of death in this category.

The following information was available on the 17 deaths due to cancer, infections, and other natural causes in 2005:

- 3 families had a history of domestic violence
- 1 family had a history of violent or non-violent crime
- 1 family had a history of substance abuse
- 1 family had a history of abuse and/or neglect

## **Injury-Related Deaths**

*Definition: Death as a direct result of an injury-related incident. Examples of injury-related deaths include homicide, motor vehicle accident (MVA), suicide, drowning, burns, and suffocation.*

Injury-related deaths can be analyzed in terms of three broad categories: intentional, unintentional and undetermined, which includes all injury-related deaths where there was no sufficient evidence to determine whether the fatal injuries were inflicted on purpose. Motor vehicle deaths, drownings, and suffocations are examples of deaths caused by unintentional injuries. Intentional injuries include homicides and suicides.

## **Unintentional Injuries**

*Four-year old Shenea was walking with her mother and baby sister, Tanya, one evening. Shenea was pushing Tanya's stroller across the street when her mother noticed a car approaching fast. Shenea was able to push the stroller out of the way of the car, but she was run over in the process.*

In 2005 there were 17 unintentional injuries. The two leading causes of unintentional injury-related deaths in 2005 were motor vehicle accidents (8), and drowning (5).

The following information was available for unintentional injuries in 2005:

- 7 victims had a family history that included substance abuse
- 7 of the deaths had a family history of child abuse and/or neglect
- 3 of the deaths were associated with reckless behavior
- 2 victims had a family history that included domestic violence

Motor vehicle accidents accounted for eight of the 17 unintentional injuries for 2005. Three of the victims were either drivers or passengers. Two of the three motor vehicle occupant victims were between the ages of 15 and 17. Of the motor vehicle accidents involving a youth 15-17 years of age, none involved a driver under the influence of either legal or illegal mind-altering substances. Four of the motor vehicle accident victims were pedestrians and one was struck while riding a bicycle.

Drowning victims accounted for five of the 17 unintentional injuries for 2005. Two children died in a residential pool, and one each in a lake, a pond and a bathtub.

## **Intentional Injuries**

### **Homicides**

Homicides represented 17 (10%) of the deaths in 2005. Child homicides for 2005 were comprised of two categories: third-party homicides (i.e., perpetrated by a third-party, such as a friend or stranger), and CAN homicides (i.e., caregiver abuse or neglect). CAN homicides are discussed in a separate section of this report (Chapter One, page 5). Map ii, shown on the following page, is a geographical representation of all CAN homicides and third-party homicides under 18 years of age that occurred in Sacramento County in 2005.

### **Third-Party Homicides**

Of the 17 child homicides in 2005, nine were classified as third-party homicides. Seven of the nine victims were between the ages of 15 and 17 years, one victim was in the 10-14 year old category and one victim was in the 1-4 age category.

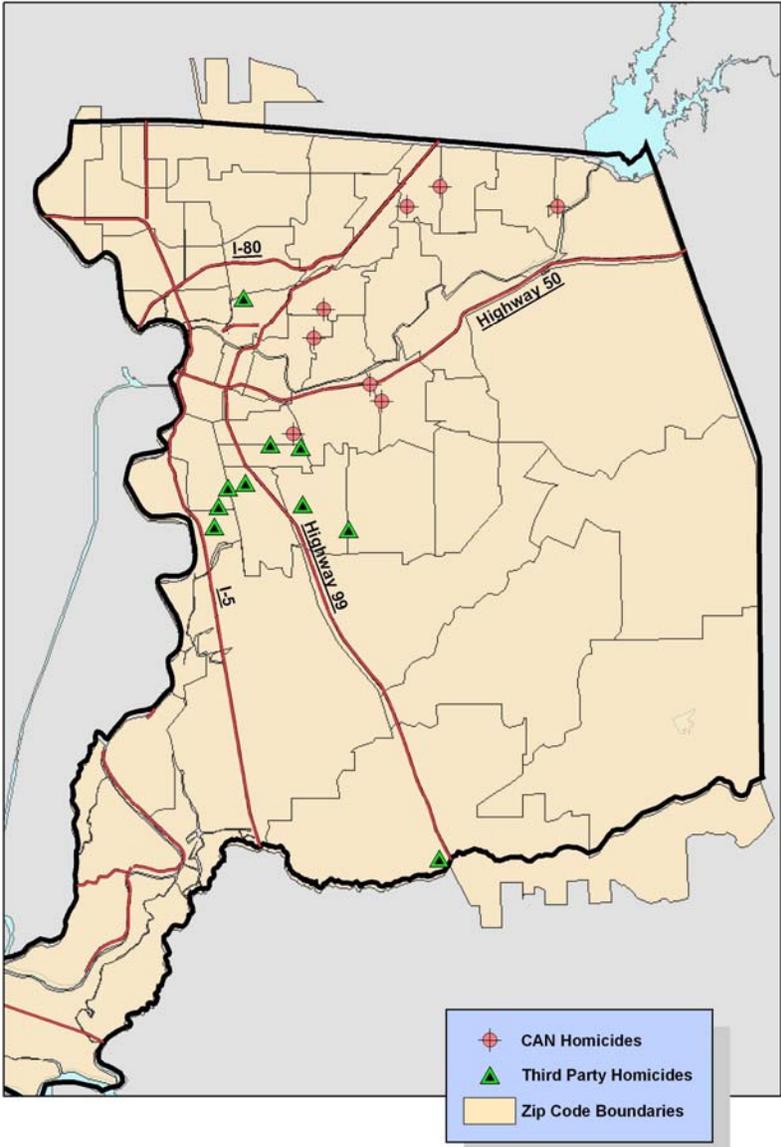
The following information was available for third-party homicides in 2005:

- 4 victims had a family history of criminal activity
- 4 victims had a history of gang involvement
- 3 victims came from families with a history of substance abuse
- 3 victims came from families with a history of domestic violence

### **Suicides**

In 2005, eight child fatalities were identified as suicides. Seven of the eight suicides occurred with children 15 through 17 years of age, and one occurred with a child 10-14 years of age. Five suicides were the result of gun shot wounds, and three suicides resulted from hanging. Of the eight suicides, four victims had a history of mental health issues and two victims had a history of drug and/ or alcohol abuse.

**Map ii:  
Child Abuse and Neglect Homicides and Third-Party Homicides  
Sacramento County 2005**



## Deaths of Undetermined Manner

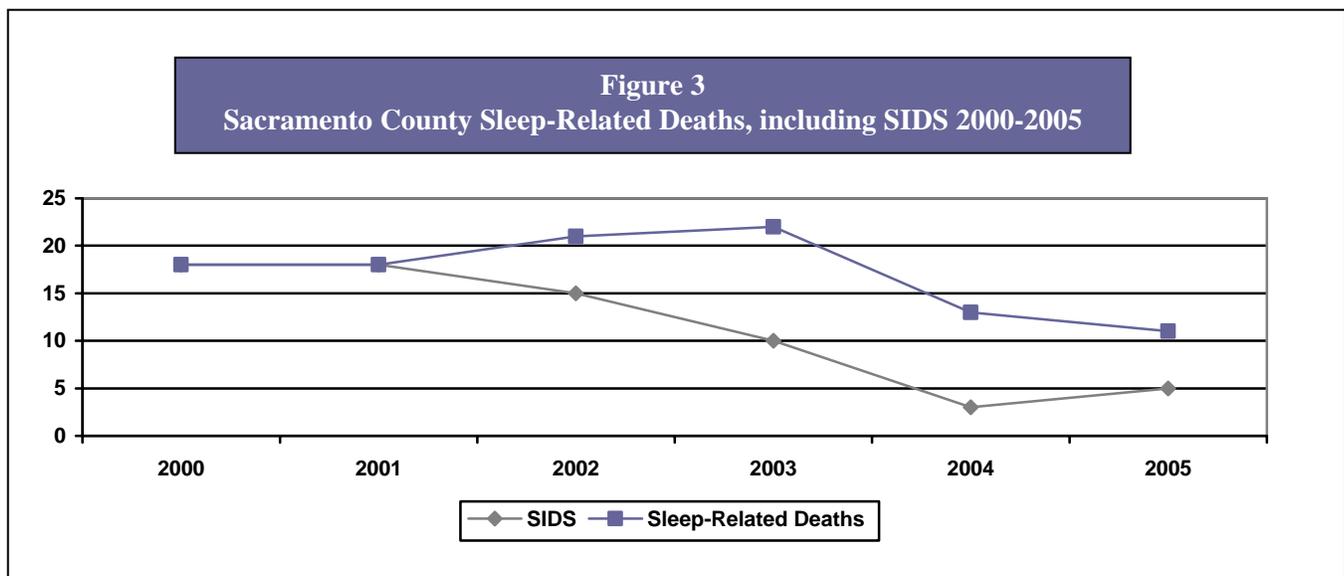
*Definition: Death in which the cause/manner may not be medically identifiable.*

In this category the manner of death may not be determined due to confusion regarding how the fatal condition developed or was inflicted. Deaths that had insufficient information to assign a manner included injury-related fatalities such as the death of a child by gunshot, where the team could not determine if the wound was inflicted on purpose. Also included in this category are unexpected sleep-related infant deaths where there was not enough evidence to determine whether the death was caused by parental overlay or SIDS.

In 2005, all four deaths of an undetermined manner were sleep-related deaths. Risk factors involved in these four deaths include:

- 3 infants were sleeping in either adult or makeshift beds with pillows, comforters and other potential dangers
- 3 infants were co-sleeping with their parents and/or a sibling
- 2 families had a history of substance abuse and/or domestic violence
- 2 infants had a family history of abuse or neglect
- 1 infant was exposed to tobacco smoke

Sleep-related deaths, including SIDS, have been declining since 2003. Figure 3 shows the sleep-related deaths, including SIDS, since 2000.





## **Chapter III**

### **Child Death Demographics**



## Chapter Three

### Child Death Demographics

#### Age

The majority of child deaths occurred in infants, accounting for 65% of all deaths. Children 15 through 17 years of age were the second largest group, accounting for 12% of all deaths in 2005. The third largest group was children one through four years of age, accounting for 11% of all deaths in 2005. The fourth group was children 10 to 14 years of age, accounting for 7% of all deaths. The smallest group in relation to this year's fatalities was children five through nine years of age accounting for 5% of this year's deaths. Table B further illustrates this year's findings.

**Table B**  
**Comparison of Child Deaths by Age and Child Population, 2005**

Age Category	Child deaths (#)	Child deaths (%)	Death rate per 100,000 child population
Infant	109	65%	4.96 (per 1,000)
1-4	18	11%	22.53
5-9	8	5%	8.59
10-14	12	7%	11.25
15-17	20	12%	30.17
Total	167	100%	

Source: State of California, Department Of Finance, *Race/Ethnic Population with Age and Sex Detail, 1970-2040*.

#### Natural Causes

A total of 121 deaths resulted from natural causes, with the majority of these deaths occurring in infants. Infants accounted for 98 (81%) of all deaths due to natural causes. The second largest group was children one through four years of age, accounting for 10 (8%) of all natural deaths. Children 10-14 years of age accounted for six (5%) of all natural deaths, and children five through nine years of age accounted for five (4%) of all natural deaths. Lastly, children 15 through 17 years of age accounted for two (2%) of all natural deaths.

#### Unintentional Injuries

There were a total of 17 deaths resulting from unintentional injuries. Children ages one through four, 10 through 14, and 15 through 17 years of age each accounted for four (24%) of the deaths

due to unintentional injuries. Children five through nine accounted for three (18%) of unintentional deaths and infants accounted for two (12%) of all unintentional injuries.

### Intentional Injuries

There were a total of 25 deaths resulting from intentional injuries. Children 15 through 17 years of age accounted for 14 (56%) of the intentional injury child deaths. Infants accounted for five (20%) of the intentional injuries, and children one through four years of age accounted for four (16%) of deaths due to intentional injuries. Children 10-14 accounted for two (8%) of the intentional injuries. Children five through nine years of age were not represented in the intentional injury category of 2005.

### Undetermined Manner

A total of four deaths were of an undetermined manner. Infants accounted for all four (100%) of these deaths.

### Race and Ethnicity

There are differences in the number and proportions of child fatalities among Sacramento County's various racial and ethnic populations. The most notable difference between the percentage of deaths and the percentage of the child population was found in the African American and multi-racial populations. African American children represent 14% of the children in Sacramento County and 26% of the children who died, and children of more than one race represent six percent (6%) of the child population and nine percent (9%) of the child deaths.

**Table C**  
**Comparison of child deaths by race and child population**

Race/Ethnicity	Child deaths (#)	Child deaths (%)	Death rate per 100,000 child population
Caucasian	70	42%	52.07
African American	44	26%	83.64
Hispanic	14	8%	14.02
Asian	19	11%	38.26
Multiracial	15	9%	70.97
Other	4	2%	39.07
Unknown	1	0.6%	--
<b>Total</b>	<b>167</b>	<b>100%</b>	

Source: State of California, Department Of Finance, *Race/Ethnic Population with Age and Sex Detail, 1970-2040*.

## Risk Factors

### Poverty

In Sacramento County, 18% of children zero to four years of age and 15% of children five to seventeen years of age live in poverty<sup>1</sup>. In 2005 19 (11%) of the 167 children who died had known risk factors related to poverty, such as inadequate living conditions.

### Substance Abuse and Domestic Violence

Substance abuse and domestic violence are major concerns to the Child Death Review Team. As mentioned in previous reports, the overlap between domestic violence and child abuse has been estimated to be between 30 to 50 percent<sup>2</sup>. According to statistics published by the U.S. Department of Health and Human Services in 1999, substance abuse is a “substantial factor” in one-third of all cases of child maltreatment.

In Sacramento County 75 (29%) of the 259 children that died from child abuse and neglect-related deaths from 1990 through 2005 came from a family with a history of substance abuse. Thirty (12%) of the children that died from child abuse and neglect-related deaths from 1990 through 2005 came from a family with a history of domestic violence.

In 2005, 38 of the 167 child deaths (23%) had a history of substance abuse in the child’s family. Eleven of the 38 (29%) were child abuse and neglect-related deaths. The majority of deaths involving a family history of substance abuse included:

- 15 deaths due to perinatal conditions
- 8 deaths due to a CAN homicide
- 3 third-party homicide deaths
- 3 deaths due to congenital anomalies
- 2 deaths of an undetermined nature (sleep-related)

In 2005, there were 24 deaths (14%) that had a history of domestic violence in the child’s family. Two of the 24 (8%) were child abuse and neglect-related deaths. The majority of these deaths included:

- 10 deaths due to perinatal conditions
- 3 deaths due to congenital anomalies
- 3 third-party homicides

<sup>1</sup> U.S. Bureau of the Census, *Census 2000 Long Form*

<sup>2</sup> Jaffe, P.D. Wolf, and S. Wilson. (1990). *Children and Battered Women*. Sage Publications.

- 2 deaths due to an undetermined manner

### **Foster Care**

In 2005, three of the 167 children who died had a family history with foster care (either at the time of death or prior to death). One child died in foster care from an undetermined manner. One adolescent ran away from the foster home and was killed in a third party homicide. The third child, who died from a CAN homicide but who was not personally involved with the foster care system, had a sibling who was previously in foster care.

### **Teen Deaths**

A total of 28 child deaths occurred in youth between 13 and 17 years of age comprising 17% of all child deaths in 2005. Seven (25%) of the 28 deaths were due to natural causes and 21 (75%) were injury-related. Of the 28 teen deaths, 18 were male and 10 were female. Thirteen of the teens were Caucasian, six each were Asian/Pacific Islander and African American, two were Multiracial, and one was Hispanic.

Between 2000 and 2005, a total of 174 child deaths occurred in youth between 13 and 17 years of age, comprising 17% of all child deaths. Fifty-one (29%) of the 174 deaths were due to natural causes and 123 (71%) were injury-related. Of the 174 deaths, 106 were male and 68 were female. Ninety-two of the teens were Caucasian, 34 were Asian/Pacific Islander, 23 were African American, 13 were Hispanic, eight were Multiracial, and two each were American Indian and Other races.

Firearms were involved in 11 (39%) of the 28 teen fatalities, three (11%) involved hangings, two (7%) involved drowning, and one (4%) involved a beating. Between 2000 and 2005, vehicular injuries comprised 44 (25%) of the 174 teen fatalities, 35 (20%) involved firearms, 18 (10%) involved hangings, eight (5%) involved drownings, four each (2%) involved suffocation and knives, two (1%) involved overdoses, and one each involved a burning and a beating.

Known risk factors were present in 15 (54%) of the 28 teen fatalities in 2005. The following is a representation of how the risk factors are broken out across the 15 teen fatalities:

- 9 had a history of non-violent crime
- 5 had a history of violent crime
- 5 had a history of child abuse and neglect
- 5 had a history of alcohol and/or drug use
- 4 had a history of gang involvement
- 2 had a history of domestic violence.

## Natural Causes

Of the teen fatalities due to natural causes in 2005, six (85%) of the seven were due to cancer and one was due to lupus. Six out of seven were female and one was male. Three of the teens were Caucasian, two were Asian/Pacific Islander, and one each was Hispanic and African American.

Of the teen fatalities due to natural causes between 2000 and 2005, 13 (25%) of the 51 were due to congenital anomalies, 15 (29%) were due to cancer, four (8%) were due to infections, two (4%) were due to perinatal conditions, 16 (31%) were due to other natural conditions and one was due to natural causes of an undetermined manner. Thirty-one of the 51 were female and 20 were male. Twenty-seven of the 51 teens were Caucasian, 13 were Asian/Pacific Islander, five were African American, four were Hispanic, and two were Multiracial.

The following information was available on the seven teen fatalities due to natural causes:

- 2 had a history of violent crime
- 2 had a history of non-violent crime

## Injury-Related Deaths

In 2005, there was a total of 21 injury-related teen fatalities comprising 75% of all teen fatalities. Of the 21 injury-related teen fatalities, 18 were male and three were female. Ten victims were Caucasian, four each were Asian/Pacific Islander and African American, two were Multiracial, and one was East Indian.

Between 2000 and 2005 there was a total of 123 injury-related teen fatalities comprising 71% of all teen fatalities. Of the 123 injury-related teen fatalities, 87 were male and 36 were female. Sixty-five victims were Caucasian, 21 were Asian/Pacific Islander, 17 were African American, nine were Hispanic, six were Multiracial, three were another race, and two were American Indian.

In 2005, firearms were involved in 11 (52%) of the 21 injury-related teen fatalities, four involved vehicular injuries, three involved hangings, two involved drownings, and one involved a beating. Between 2000 and 2005, vehicular injuries comprised 48 (36%) of the 123 teen fatalities, 35 (28%) involved firearms, 18 (15%) involved hangings, eight (7%) involved drownings, four (3%) each involved suffocation and knives, two (2%) each involved overdoses, and one each involved a burning and beating.

Known risk factors were present in 12 (57%) of the 21 teen fatalities. The following is a representation of how the risk factors are broken out across the 12 teen fatalities:

- 7 had a history of non-violent crime
- 5 had a history of child abuse and neglect
- 5 had a history of alcohol and/or drug use

- 4 had a history of gang involvement
- 3 had a history of violent crime
- 2 had a history of domestic violence.

### **Third-party Homicides**

Third-party homicides comprised eight (38%) of the 21 injury-related teen fatalities. All eight (100%) of the third-party homicides were male. Three victims were Caucasian, two each were Asian/Pacific Islander and African American, and one was another race. Of the eight third-party teen homicides, four were 17 years of age, three were 15 to 16 years of age, and one was 13 years old. Firearms were involved in six of the cases, one involved a beating, and one involved a drowning.

There were known risk factors in seven of the eight third-party teen homicides:

- 5 had alcohol and/or other drugs involved at the time of the homicide
- 4 had a history of non-violent crime
- 4 had a history of gang involvement
- 2 had a history of child abuse and neglect
- 2 had a history of violent crime
- 2 had a history of domestic violence.

Between 2000 and 2005, third-party homicides comprised 35 (28%) of the 123 injury-related teen fatalities. Twenty-nine (83%) of the victims were male and 6 (17%) were female. Ten victims were Caucasian, eight each were African American and Asian/Pacific Islander, four were Hispanic, two were Multiracial, two were another race, and one was American Indian. Firearms were involved in 25 of the 35 third-party homicides, four involved knives, two involved strangulation/suffocation, and one each involved burns, vehicular injury, beating, and drowning.

### **Suicides**

Suicides comprised eight (38%) of the 21 injury-related teen fatalities. Six of the eight teen suicides were male and two were female. Four of the teens were Caucasian, two were Multiracial, and one each was African American and Asian/Pacific Islander. Of the eight suicides, four were 17 years of age, three were 15 to 16 years of age, and one was 14 years of age. Five teens used firearms and three used hanging as the mechanism of suicide.

In five (63%) of the eight deaths, family members reported that the suicide was not unexpected. A history of known mental health issues was present in four (50%) of the eight teen suicides. There were known risk factors in three of the eight teen suicides:

- 2 had a history of alcohol and/or drug use
- 2 had a history of non-violent crime
- 1 had a history of violent crime
- 1 had a history of child abuse and neglect

Between 2000 and 2005, suicides comprised thirty (24%) of the 123 injury-related teen fatalities. Twenty-three of the 30 suicides were male and 7 were female. Seventeen of the teens were Caucasian, five were African American, four were Multiracial, three were Asian/Pacific Islander, and one was American Indian. Eighteen of the teens used hanging, seven used firearms, two each used suffocation and overdose, and one used vehicular trauma as the mechanism of suicide.

### **Motor Vehicle Accidents**

Motor vehicle accidents comprised four (19%) of the 21 injury-related teen fatalities. Three victims were male and one was female. Of the four motor vehicle accidents, two victims were Caucasian, one was African American, and one was Asian/Pacific Islander. Of the four teen motor vehicle accident fatalities, two were drivers 17 years of age, one was a bicyclist 16 years of age, and one was a pedestrian 14 years of age.

There were known risk-factors that contributed to three of the four teen motor vehicle accident fatalities:

- 2 were behaving recklessly
- 1 was speeding recklessly

Between 2000 and 2005, motor vehicle accidents comprised 46 (37%) of the 123 injury-related teen fatalities. Twenty-three of the victims were female and twenty-three were male. Of the 46 motor vehicle accident fatalities, 30 were Caucasian, seven were Asian/Pacific Islander, and four each were Hispanic and African American, and one was another race. Thirty of the 46 were occupants, ten were pedestrians, and six were bicyclists.



## **Chapter IV**

### **The Sacramento County Child Death Review Team**



## Chapter Four

### The Sacramento County Child Death Review Team

#### History and Background

In November of 1988, a Sacramento County Board of Supervisors resolution directed the Child Abuse Prevention Council of Sacramento, Inc. (CAPC) to develop and coordinate an interagency team to investigate child abuse and neglect fatalities. This action reflected a growing awareness that child abuse and neglect fatalities are often difficult to identify and prosecute without a coordinated multi-agency investigation. The Board of Supervisors' resolution was preceded by specific requests to CAPC from the offices of the District Attorney, the County Sheriff and the Coroner to establish such a team.

The ability to establish confidential Child Death Review Teams was provided in 1988 by revisions to the State Penal Code (Section 11166.7) and the State Welfare and Institution Codes (Sections 830 and 10850.1). These statutes afford the confidentiality necessary to review cases without bias from outside pressures and influences. Under the leadership of Dr. Michael Reinhart, Medical Director of the Child Protection Center at the University of California Davis Medical Center, Formation Committee members worked to establish the precedents for the sharing of confidential information and the written justifications needed to appoint and staff a Sacramento County Child Death Review Team. Dr. Marcia C. Britton, Director of the Child Health and Disability Prevention Program of Sacramento County, obtained all of the County approvals and authorizations necessary to implement the team. After a year of planning, the Sacramento County Child Death Review Team began functioning in November of 1989.

In designing our local team, the Formation Committee had the foresight to broadly define the team's mission, ensuring that all child deaths would be reviewed and investigated. This model was different from most other teams in existence at the time. Typically, other large county teams focused exclusively on suspicious child abuse and neglect homicides or reviewed the deaths of a limited number of children in a narrow range of ages. The Sacramento team remains unique in that it is one of the only large county models that reviews the death of every infant and child under 18 years of age.

## Mission Statement

The mission of the Sacramento County Child Death Review Team is to:

- Ensure that all child abuse related fatalities are identified.
- Enhance the investigation of all child deaths through multi-agency review.
- Develop a statistical description of all child deaths as an overall indicator of the status of children.
- Develop recommendations for the prevention and response to child deaths based on the reviews and statistical information.

## Membership

The Sacramento County Child Death Review Team had consistent representation during 2005 from the following agencies:

Child Abuse Prevention Council of Sacramento, Inc.

Kaiser Permanente

Mercy San Juan Medical Center

Sacramento City Fire Department

Sacramento City Police Department

Sacramento County Coroner's Office

Sacramento County Department of Health and Human Services:

California Children's Services

Child Protective Services

Maternal, Child, and Adolescent Health

Public Health Nursing

Sacramento County District Attorney's Office

Sacramento County Sheriff's Department

Sutter Memorial Hospital

University of California Davis Medical Center

Lists of Sacramento County Child Death Review Team current members, formation members, past members, and the Confidentiality Agreement can be found in the Appendices.

## Review Process

The Child Death Review Team (CDRT) meets monthly to review deaths of all children under age 18 in Sacramento County. The deaths are identified by the Vital Records Unit of the Sacramento County Department of Health and Human Services, and the death certificates are forwarded to the CDRT epidemiologist who then prepares them for review. Team members then compile any pertinent information their agency may have regarding each case. This information is then brought to the monthly meetings in order to identify any potential abuse/neglect issues. The team also identifies trends in other types of child deaths in order to address needs in prevention efforts. The information is stored in a secure centralized database and statistical analyses are performed in order to describe the information and identify any pertinent trends.

Because of the confidential nature of the information discussed, each team member is required to sign a confidentiality agreement, which prohibits dissemination of any information discussed by the team unless otherwise provided by law.

In addition to the review of new cases, the status of any ongoing investigations is reviewed monthly and additional information needs are identified. Non-member agencies may be contacted to provide information related to the team's investigation. All cases remain under review until the team agrees that the underlying cause of death has been determined as accurately as possible.

## Methods

Deaths are categorized by cause and by manner. Both are crucial to the investigation and analysis of fatalities. The following text defines and compares these two often-confused terms.

*Causes* of death, listed on the death certificate, are medical findings coded according to the International Classification of Diseases, tenth edition (ICD-10).

A second finding listed on the death certificate describes the mode or manner of death, which is an investigative finding.

*Manner* of death falls into one of six categories: Natural, Accident, Suicide, Homicide, Pending Investigation, and Could Not Be Determined. In those cases where the cause of death is due to a natural disease process, the manner is listed, usually, as “Natural.” Injury-related deaths generally fall into one of the following three categories: “Accident,” “Suicide,” or “Homicide.”

To illustrate the difference between the manner and cause of death, consider a death certificate where the medical cause of death is “Gunshot wound of the head.” In this case, the wound could have been inflicted in one of four manners: “Accident,” “Suicide,” “Homicide” or “Could Not Be Determined.”

When there is confusion regarding how the fatal condition developed or was inflicted and the manner could not be determined with a satisfactory degree of certainty, the manner is listed as “Could Not Be Determined.” An example of a classification of this type could be found in a situation where a cause of death is listed as “Pulmonary embolism.” A pulmonary embolism can occur as a complication of an injury or it can occur naturally. Due to possible uncertainty regarding the formation of a pulmonary embolism, the manner could be listed as “Could Not Be Determined.”

The manner of death is an important consideration because preventing child deaths, one of the central goals of the Sacramento County Child Death Review Team, relies on the ability to differentiate between intentional and accidental deaths. For example, strategies designed to reduce the number of accidental drownings will differ greatly from those designed to reduce intentional drownings.

## Report Strengths and Limitations

Better identification of child abuse and neglect fatalities is the primary mission of the Child Death Review Team (CDRT). During the review process, the team focuses on any suspicious circumstances surrounding the death of a child. Because of the involvement of multiple agencies, the team is able to generate information that helps to clarify otherwise limited evidence of abuse. Such information can be critical to the death investigation and may ultimately result in a death certificate that more accurately reflects the occurrence of an abuse-related fatality.

As a result of this multi-agency investigation, the cause of death identified by the team, particularly in cases of child abuse and neglect homicide, may be more explicit than the cause of death assigned by the local physician or coroner. Based on the team's findings, a more accurate description of the occurrence of abuse-related deaths in Sacramento County can be provided by a Child Death Review Team report than the information provided by the death certificates filed with the State.

The Sacramento County Child Death Review Team is unique in its approach to investigating child fatalities. By reviewing the circumstances surrounding each child death instead of sampling the childhood fatality population or focusing on suspicious cases only, the CDRT can capture a more detailed and accurate description of child mortality in Sacramento County. This broader understanding of child death and the ongoing identification and investigation of child abuse and neglect fatalities has also provided for the development of effective prevention strategies.

Unfortunately, comparisons between Sacramento and other jurisdictions are difficult. At the present time, there is no uniformity at the state and national levels in reporting, investigating and validating cases of child abuse and neglect and their resulting fatalities. As a result, there is a significant undercount of the annual CAN-related fatalities found in Vital Statistics Death Records.

The criteria for selecting cases to review are established by each county's team and very few teams review all child deaths. In addition, each team defines abuse and neglect-related fatalities differently. Even though the State Child Death Review Council has published a definition of deaths related to abuse and neglect, the final decision is still made at the local level.

All of the children included in this report were Sacramento County residents at the time of their death. Out-of-county cases are reviewed, but are not included in any analysis used to make inferences about Sacramento County children. Similarly, the team does not usually review cases of children who are Sacramento County residents but die in another county. Sacramento County does not receive these death certificates, so these cases have not been included in this report. These factors may account for any discrepancy found when comparing the number of cases in this report to those recorded by the State Registrar for Sacramento County.

The development of the CDRT's Annual Report has been an evolving process. In 1996, the CDRT began following childhood fatality trends on an annual basis, which led to more comprehensive record keeping of all child deaths. For this reason, aggregate data is available for the time period beginning in 1996 through the current year. Other data, such as injury type and demographics,

comes primarily from death certificates and is available for all cases reviewed since 1990. The differences found in the availability and consistency of information is due to the different time periods used to present prior years' data.



# Tables



**Table D**  
**Number of natural deaths according to category 1990 to 2005**  
**Sacramento County**

Category	Years																Total
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	
Perinatal Conditions	79	70	46	46	44	21	42	52	48	40	42	48	56	43	62	71	810
Congenital Anomalies	28	33	26	23	24	25	19	30	27	27	33	32	39	32	31	28	457
SIDS	28	28	21	29	25	18	21	20	19	18	18	18	15	10	3	5	296
Cancer	11	11	6	9	10	6	9	5	10	10	15	5	10	11	10	9	147
Infections	8	8	8	3	11	4	7	3	4	6	8	10	6	2	10	5	103
Respiratory	7	10	3	10	5	7	9	8	4	1	3	0	2	0	1	1	71
Other	19	10	10	14	21	17	15	12	4	11	16	8	2	7	6	2	174
Undetermined (Natural)	4	2	0	3	0	0	4	1	1	5	3	0	0	2	0	0	25
<b>Total Natural Causes</b>	<b>184</b>	<b>172</b>	<b>120</b>	<b>137</b>	<b>140</b>	<b>98</b>	<b>126</b>	<b>131</b>	<b>117</b>	<b>118</b>	<b>138</b>	<b>121</b>	<b>130</b>	<b>107</b>	<b>123</b>	<b>121</b>	<b>2083</b>



**Table E**  
**Number of injury-related deaths according to category 1990 to 2005**  
**Sacramento County**

Category	Year																Total
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	
Homicides	12	18	13	21	15	20	16	23	11	16	10	16	11	9	15	17	243
CAN Homicide	(9)	(7)	(9)	(14)	(8)	(9)	(9)	(14)	(7)	(13)	(6)	(9)	(4)	(1)	(4)	(8)	(131)
Third -Party Homicide	(3)	(11)	(4)	(7)	(7)	(11)	(7)	(9)	(4)	(3)	(4)	(7)	(6)	(8)	(11)	(9)	(111)
Arson Homicide	0	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(1)	(0)	(0)	(0)	(1)
Motor Vehicle Accidents (MVA)	18	15	14	14	15	23	19	17	11	11	14	21	13	14	10	8	237
MVA (Occupant)	(11)	(11)	(8)	(7)	(8)	(12)	(15)	(10)	(7)	(4)	(8)	(10)	(11)	(8)	(5)	(3)	(138)
MVA (Pedestrian)	(6)	(3)	(6)	(6)	(5)	(8)	(2)	(7)	(1)	(5)	(5)	(8)	(1)	(5)	(4)	(4)	(76)
MVA (Bike)	(1)	(1)	(0)	(1)	(2)	(3)	(2)	(0)	(3)	(2)	(1)	(3)	(1)	(1)	(1)	(1)	(23)
Drowning	8	7	9	7	7	4	4	6	7	6	5	5	9	4	7	5	100
Suicide	5	7	3	4	4	3	4	5	8	0	6	5	7	4	4	8	77
Suffocation/ Choking	3	3	0	4	0	0	2	4	2	1	1	3	1	1	0	2	27
Fires	2	2	1	2	1	0	3	5	4	0	0	1	1	1	0	1	24
Other	1	0	0	8	5	3	0	5	1	1	1	8	4	2	6	1	46
Undetermined (Injury)	2	1	9	0	4	4	3	0	2	1	0	1	2	1	1	0	31
Total Injury-Related Causes	51	53	49	60	51	57	51	65	46	36	37	60	48	36	43	42	785
Undetermined Manner	7	2	2	4	6	0	4	2	2	3	4	8	6	10	10	4	74



**Table F**  
**Deaths by category and age 2005**  
**Sacramento County**

<b>Category</b>	<b>Infant</b>	<b>1-4</b>	<b>5-9</b>	<b>10-14</b>	<b>15-17</b>	<b>Total</b>
Perinatal Conditions	68	3				71
Congenital Anomalies	20	5	2	1		28
Sudden Infant Death Syndrome	5					5
Cancer	2	1		4	2	9
Infections	3		2			5
Respiratory			1			1
Other (natural)		1		1		2
CAN Homicide	5	3				8
Third-Party Homicide		1		1	7	9
Arson Homicide						0
Motor Vehicle Deaths (occupant)			1		2	3
Motor Vehicle Deaths (pedestrian)		1		3		4
Motor Vehicle Deaths (bicycle)					1	1
Drowning		3	1		1	5
Suicide				1	7	8
Suffocations	2					2
Burn			1			1
Other Injury				1		1
Legal Intervention						0
Undetermined Injury						0
Undetermined Manner	4					4
<b>Total</b>	<b>109</b>	<b>18</b>	<b>8</b>	<b>12</b>	<b>20</b>	<b>167</b>



**Table G**  
**Deaths by race/ethnicity and age 2005**  
**Sacramento County**

<b>Race Classification</b>	<b>Infant</b>	<b>1-4</b>	<b>5-9</b>	<b>10-14</b>	<b>15-17</b>	<b>Total</b>
Caucasian	42	12	2	4	10	70
African American	31	3	2	4	4	44
Asian/ Pacific Islander	8	3	2	4	2	19
Hispanic	12	0	1	0	1	14
Native American	0	0	0	0	0	0
Multiracial	12	0	1	0	2	15
Other	3	0	0	0	1	4
Unknown*	1	0	0	0	0	1
<b>Total</b>	<b>109</b>	<b>18</b>	<b>8</b>	<b>12</b>	<b>20</b>	<b>167</b>

\* Death Certificate was not available



**Table H**  
**Child abuse and neglect homicide victims by age 1990 to 2005**  
**Sacramento County**

<b>Period Covered</b>	<b>Infant</b>	<b>1-4</b>	<b>5-9</b>	<b>10-14</b>	<b>15-17</b>	<b>Total</b>
1990-2000	23	51	19	6	6	105
2001	4	5	0	0	0	9
2002	1	1	1	1	0	4
2003	1	0	0	0	0	1
2004	2	1	1	0	0	4
2005	5	3	0	0	0	8
<b>Total</b>	<b>36</b>	<b>61</b>	<b>21</b>	<b>7</b>	<b>6</b>	<b>131</b>

**Table I**  
**Child abuse and neglect homicide victims by race/ethnicity 1990 to 2005**  
**Sacramento County**

<b>Period Covered</b>	<b>White</b>	<b>Hispanic</b>	<b>Black</b>	<b>Asian</b>	<b>Other*</b>	<b>Total</b>
1990-2000	46	18	28	10	3	105
2001	5	0	4	0	0	9
2002	2	0	1	0	1	4
2003	0	0	0	1	0	1
2004	0	0	1	0	3	4
2005	3	1	3	1	0	8
<b>Total</b>	<b>56</b>	<b>19</b>	<b>37</b>	<b>12</b>	<b>7</b>	<b>131</b>

\* Including children of mixed racial categories.



**Table J**  
**Perpetrators of CAN homicides 1990 to 2005**  
**Sacramento County**

<b>Perpetrator</b>	<b>1990-2004</b>	<b>2005</b>	<b>Total Cases</b>	<b>%</b>
Father	35	5	40	31%
Mother	28	1	29	22%
Boyfriend of Mother or Guardian	16	0	16	12%
Undetermined	14	0	14	11%
Both Parents	8	1	9	7%
Babysitter	7	0	7	5%
Stepfather	4	0	4	3%
Other Family Member	4	1	5	4%
Foster Parent	3	0	3	2%
Girlfriend of Father or Guardian	2	0	2	2%
Family Friend	2	0	2	2%
<b>Total</b>	<b>123</b>	<b>8</b>	<b>131</b>	<b>100%</b>



**Table K**  
**Deaths caused by intentional injuries by mechanism 1990 to 2005**  
**Sacramento County**

	<b>3<sup>rd</sup> Party Homicide</b>	<b>CAN Homicide</b>	<b>Suicide</b>	<b>Total</b>
Firearm	86	23	33	142
Battering	4	36	0	40
Hanging	0	0	40	40
Shaking	0	19	0	19
Strangulation/Suffocation	1	14	0	15
Poisoning/Overdose	0	8	3	11
Stabbing	10	6	0	16
Fire	2	4	0	6
Undetermined	1	1	0	2
Vehicular	4	0	1	5
Drowning	1	5	0	6
Chronic Neglect	0	7	0	7
Other	1	3	0	4
Unknown	1	5	0	6
<b>Total</b>	<b>111</b>	<b>131</b>	<b>77</b>	<b>319</b>



**Table L**  
**Number of deaths by Sacramento County zip code 1990-2005**

<b>Zip</b>	<b>Neighborhood</b>	<b>2005 Deaths</b>	<b>Deaths 2000-2004</b>	<b>Total</b>
95608	Carmichael	2	23	25
95610	Citrus Heights	5	16	21
95615	Courtland	1	0	1
95621	Citrus Heights	6	16	22
95624	Elk Grove	3	23	26
95626	Elverta	0	5	5
95628	Fair Oaks	1	15	16
95630	Folsom/Clarksville/El Dorado Hills	6	22	28
95632	Twin Cities/Galt/Herald	2	5	7
95638	Herald	0	1	1
95655	Mather	0	1	1
95660	North Highlands	8	32	40
95662	Orangevale	6	11	17
95670	Rancho Cordova	6	34	40
95673	Rio Linda/Robla	0	14	14
95683	Rancho Murieta	1	2	3
95690	Walnut Grove	0	1	1
95693	Wilton	0	1	1
95757	Elk Grove	7	3	10
95758	Bruceville	9	32	41
95763	Folsom	0	1	1
95814	Downtown Sacramento	2	6	8
95815	North Sacramento	4	32	36
95816	Midtown Sacramento	0	5	5
95817	Sacramento/Oak Park	3	16	19
95818	Sacramento/South Land Park	0	8	8
95819	Sacramento/ East Sacramento	2	9	11
95820	Fruitridge	11	46	57
95821	Town and Country Village	8	23	31
95822	Sacramento/Meadowview	6	35	41
95823	Sacramento/Valley Hi	10	81	91
95824	Fruitridge	7	31	38
95825	Arden/Arcade	4	22	26
95826	Perkins/Rosemont	6	19	25
95827	Mills/Walsh Station	3	19	22
95828	Florin	2	39	41
95829	Coffing/Sheldon	4	10	14
95830	Sacramento (Florin & Sunrise)	0	1	1
95831	Greenhaven	3	15	18
95832	Sacramento/Freeport	4	5	9
95833	Arden/ Garden	6	22	28
95834	Sacramento/South Natomas	1	8	9

<b>Zip</b>	<b>Neighborhood</b>	<b>2005 Deaths</b>	<b>Deaths 2000-2004</b>	<b>Total</b>
95835	Sacramento/South Natomas	0	8	8
95837	Sacramento International Airport	0	1	1
95838	Del Paso Heights/Hagginwood	7	32	39
95841	Foothill Farms	3	10	13
95842	Sacramento/Foothill Farms/North Highlands	2	27	29
95843	Sacramento/Antelope	1	23	24
95864	Arden/Arcade	4	1	5
	Unknown*	1	0	1
<b>Total</b>		<b>167</b>	<b>812</b>	<b>979</b>

\* Death Certificate was not available

# Appendix



## APPENDIX A

### Memorandum of Agreement for the Sacramento County Multidisciplinary Child Death Review Team

#### PURPOSE

The purpose of the Multidisciplinary Child Death Review Team is to:

1. Ensure that all child abuse-related fatalities are identified;
2. Enhance the investigation of all child deaths through multi-agency review;
3. Develop a statistical description of all child deaths as an overall indicator of the status of children; and
4. Develop recommendations for the prevention and response to child deaths based on said reviews and statistical information.

#### MEMBERSHIP

The team will be comprised of representatives from the following agencies:

##### **I Sacramento County**

- A. Sacramento County Coroner**
  1. Investigations
  2. Forensic Pathology
- B. Sacramento County Sheriff's Department**
- C. Sacramento City Police Department**
- D. Sacramento City Fire Department**
- E. Law Enforcement Chaplaincy of Sacramento**
- F. California Highway Patrol**

##### **II Department of Health and Human Services**

- A. Child Protective Services**
- B. Epidemiology and Disease Control/ Maternal, Child and Adolescent Health**
- C. California Children's Services**
- D. Public Health Nursing**

##### **III District Attorney's Office**

**IV Local Hospitals**

- A. Kaiser Permanente
- B. Mercy Healthcare Sacramento
- C. Sutter Health - CHS
- D. University of California, Davis Medical Center
  - 1. CAARE Unit
  - 2. Pathology

**V Other Community Service Agencies**

- A. Child Abuse Prevention Council of Sacramento

Said agencies will provide routine representation on an on-going basis. No agency shall withdraw from the Team or suspend their participation without the expressed approval of the appropriate regulatory body. Individual representatives will be expected to consistently attend all meetings for a period of no less than one year.

Each participating agency in the Child Death Review Team shall appoint a lead representative (A) and a single alternate (B) to participate in the death investigation review meetings. The lead person (A) shall provide case specific information on child deaths under review. The agency shall designate a single back-up representative (B) to provide case specific information in the event that person (A) cannot be present. No additional staff person from the agency may replace person A or B. If neither person A nor person B can attend a meeting, the agency will not have a representative at that meeting. The Chair may approve a representative other than A or B to provide case specific information for an upcoming meeting. The request shall be made by the agency in advance to the Chair, if there are extenuating circumstances requiring a person other than A or B to present information from that agency.

New Team representatives will receive an orientation organized by the Child Abuse Prevention Council in conjunction with other experienced Team representatives. This orientation will include information regarding the Team purpose, established protocols and procedures, the role of each Team representative and their agency, current membership, meeting schedule, and data collection requirements.

In addition to the standing representatives, other agencies and individuals may be invited to attend meetings when, after initial review, the Team feels that they may have direct information about a case or that they may have particular subject expertise to contribute to the overall review.

All parties who participate in the child death review process will be required to sign and adhere to a confidentially agreement.

**STATUTORY AUTHORIZATION**

In 1987, Sections 830 and 10850.1 were added to the State Welfare and Institutions Code and provided specific authorization allowing multidisciplinary child abuse teams to receive information related to incidents of child abuse and information which could be relevant to the prevention, identification or treatment of child abuse. In 1988, Section 18961 of the Welfare and Institutions code was amended to allow qualified persons not serving as standing members of

such teams to be deemed a part of the team as necessary, and to receive and disclose information relevant to particular cases as needed.

Also in 1988, Sections 11166.7 and 11166.8 of the State Penal Code authorized the Attorney General and the California Consortium of Child Abuse Providers to develop the protocols necessary for the development and implementation of interagency child death teams for review of suspicious child deaths. Amendments to this legislation in 1992 required that each county establish an interagency child death team and added Section 11166.9, which established the California Child Advisory Board to coordinate and integrate state and local efforts to address fatal abuse and neglect.

In 1999, SB 252 recast several of the provisions of Section 11166.7, including the requirement that local CDRT's participate in the statewide child abuse and neglect monitoring system by meeting minimum standard protocols and submitting information on child abuse and neglect fatalities. It also provided training and technical assistance to CDRT's and professionals involved in case reviews. In 2004, Section 11166.7 was amended and renumbered as Section 11174.32.

## **TARGET POPULATION**

The target population for case review is all children up through 17 years of age that die in Sacramento County. The Team will consider cases for children who are not residents of the county if they die within county limits. The Team will also consider cases for children who die in another county but are residents of Sacramento County.

## **MEETINGS**

Regular meetings of the Team will be held monthly on a set date to be determined annually by the Team representatives. The meetings will occur approximately mid-month and will include all cases from the previous month as well as any cases held over for further review or analysis.

## **GROUND RULES**

Members of the CDRT agree to:

1. Practice timely and regular attendance.
2. Share all relevant information.
3. Stay focused and keep all comments on topic.
4. Listen actively – respect others when they are talking.
5. Be willing to explore others' basis for conclusions if you do not agree with them. However, question members in a respectful manner and refrain from personal attacks.
6. Be prepared for case discussion.
7. Discuss all cases objectively with respect for deceased, their families, and all agencies involved.
8. Respect all confidentiality requests the group has agreed to honor.

## OFFICERS

The officers of the CDRT shall be a Chair and a Vice Chair. Officers will be nominated by CDRT members and approved by consensus of the CDRT.

The duties of the Chair shall be to:

1. Lead the discussion, ensuring all critical case information is shared.
2. Facilitate the meeting, keeping the group in compliance with the established ground rules.
3. Present the annual report to the Board of Supervisors with the President/CEO of the Child Abuse Prevention Council or appoint an alternate presenter.
4. Represent the CDRT at certain functions and events.
5. Approve visitors and emergency alternates on a case-by-case basis.

The duties of the Vice Chair shall be to:

1. Serve as co-facilitator including reinforcing the ground rules as necessary.
2. Provide support to the Chair as necessary.

Nominations will be made by team members at the meeting preceding the ballot. The ballot will be private. The Chair will serve a three-year term. At the conclusion of the three-year term, a person from another discipline shall be elected Chair. A person may serve more than one three-year term but not consecutively. A non-consecutive term will help ensure that the responsibilities of the Chair are rotated among the team's representative disciplines. A Vice-Chair will be appointed at the same time as the Chair. This individual will be eligible, but will not be assured the role of Chair at the end of the three-year term

## PROCEDURES

The representative(s) from the Sacramento County Department of Health and Human Services will acquire death certificates from the Vital Statistics Branch for all children under 18 who have died in the county during the preceding month. These will be collected by the Child Abuse Prevention Council within the first week of the month. Death certificates for children who are Sacramento County residents but who die in other counties will be obtained by the Child Abuse Prevention Council from the child death review teams functioning in the counties where such deaths occur.

The Child Abuse Prevention Council will label the death certificates as to the appropriate agency jurisdiction, whether it is within the county or city limits based upon where in the county the fatal incident has occurred. The certificates will then be copied and mailed, along with a copy of the agency specific data collection forms, to each Team representative in a sealed envelope marked Confidential no later than 2 weeks prior to the next Team meeting. Also included in this mailing will be the agenda for the coming meeting, minutes reflecting general Team process, information for the previous meeting, and any educational or informational items pertinent to the Team.

Each Team representative is then responsible for reviewing his/her internal agency records to determine what information is available on each child and/or family. Relevant information is documented on the data collection forms for those cases where agency information is available. The forms will be completed and brought by the representative to the next meeting. If the standing Lead representative is not available to attend a meeting, the designated Alternate will

bring the data forms to the meeting. In the event that both the Lead and Alternate representatives are not available the data forms will be provided at the next meeting attended by either representative. In addition to data forms, a representative may elect to bring their agency files to the next meeting for reference, but agency files and records are not to be reproduced for central files or distributed to other representatives.

The Team may openly discuss all relevant case data during meetings. No confidential and/or case specific information will be recorded in the minutes. Follow-up cases will be recorded on future agendas by name, date of death, case history, and the CDRT agency responsible for follow-up. Team representatives will destroy all agendas, death certificates and other confidential materials related to case reviews following each meeting. The Child Abuse Prevention Council will complete a Case Summary form for each case reviewed. The Case Summary form will include case information agreed upon by the CDRT. No additional case specific information recorded. Case Summary forms will be kept in a locked file by the Child Abuse Prevention Council. Case Summary information will be entered into a secure database form which aggregate data can be generated.

In the event that a case has yet to progress sufficiently to provide a conclusion at any given meeting, it will be placed on successive agendas until resolved. Meeting agendas will reflect the order in which cases are to be reviewed, with the review of new cases preceding the review of follow-up cases. At any time, a Team representative may request that a particular case be given priority in the order of the reviews. Team representatives may bring up additional cases that have occurred but are not on the agenda and may request that a case be reconsidered at any time.

#### **CHILD ABUSE PREVENTION COUNCIL RESPONSIBILITIES**

As sponsor of the Sacramento County Child Death Review Team, the Child Abuse Prevention Council of Sacramento, Inc. (CAPC) is responsible for:

1. The identification and maintenance of resources and staff as needed for the continued implementation of the CDRT including but not limited to:
  - a. Coordination and staffing for all CDRT meetings.
  - b. Administrative and technical support necessary for multi-agency death review: timely collection and distribution of death certificates and agency specific data collection forms; distribution of the agenda, prior meeting minutes reflecting general Team process information, and any educational or informational items pertinent to the Team.
  - c. Collection and maintenance of agency specific data collection forms.
  - d. Management of all confidential CDRT data and case files.
2. Participation in and implementation of the Fatal Child Abuse and Neglect Surveillance (FCANS) Program.
3. Provision of technical and administrative support necessary for the development and distribution of the CDRT Annual Report.

#### **EVALUATION**

An annual report will be published each year and presented to the Sacramento County Board of Supervisors. The report will serve as one indicator of the status of children in Sacramento County and will be one base of information for a response to identified problems. The report

shall include data describing the causes of death to provide the information necessary for the development of a full range of prevention efforts.

Data described in the annual report will be based upon those elements collected in the Team's data collection forms. In addition to demographics, the report will include available socioeconomic data.

The annual report will also include recommendations made by the Team based on the data collected. In keeping with the goals of the Team, there may be additional reports or systems recommendations, which emerge as a result of case reviews and data analysis. The Team reserves the option to issue separate reports and policy recommendations in addition to the annual report.

#### **INDEMNIFICATION AND INSURANCE**

Each party shall defend, indemnify and hold harmless the other, its officers, agents, employees and volunteers from and against all demands, claims, actions, liabilities, losses, damages, and costs, without limitation including payment of reasonable attorneys' fees, expert witness or consultant fees and expenses related to the response to, settlement of, or defense of any claims or liability arising out of, or in any way connected with the respective responsibilities and duties hereby undertaken, except that each party shall bear the proportionate cost of any damage attributable to the fault of that party, its officers, agents, employees and volunteers. It is the intention of the parties that, where fault is determined to have been contributory, principles of comparative fault will be followed.

Each party, at its sole cost and expense, shall carry insurance -or self-insure - its activities in connection with this Agreement, and obtain, keep in force and maintain, insurance or equivalent programs of self-insurance, for general liability, professional liability, workers compensation, and business automobile liability adequate to cover its potential liabilities hereunder.

**APPENDIX B****Sacramento County Child Death Review Team  
Confidentiality Agreement**

As a member of the Sacramento County Child Death Review Team (CDRT), I understand all cases discussed, information received, and all documents reviewed pertaining to cases presented to the CDRT, are strictly confidential. As an individual and/or a representative of my agency on the CDRT, I further understand and agree to abide by the current Memorandum of Understanding establishing and maintaining the CDRT.

I agree that I will not discuss, disseminate in any manner, nor otherwise cause dissemination of such information, to any non-member unless otherwise provided by law. I further understand, and agree, that my duty to preserve and protect the confidentiality of all information received as a team member, is a continuing and permanent duty, and is not contingent upon my status as a team member, and is not terminated upon conclusion of my membership.

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

AGENCY/PROFESSIONAL DISCIPLINE REPRESENTED:  
\_\_\_\_\_

DATE: \_\_\_\_\_



**APPENDIX C****Sacramento County Child Death Review Team Members  
Formation Members****California State Attorney General's Office**

Michael Jett  
Senior Field Deputy, Crime Prevention Center

**Child Abuse Prevention Council of Sacramento, Inc.**

Marie Marsh  
Executive Director

Sheila Anderson  
Child Death Review Team Coordinator

**Juvenile Justice Commission**

Alison Kishaba  
Commission Chairperson

**Sacramento City Police Department**

Detective Ernie Barsotti

**Sacramento County Coroner's Office**

Robert Bowers  
Chief Deputy Coroner

**Sacramento County Department of Health and Human Services**

Marcia Britton, M.D.  
Director, Child Health and Disability Prevention

**Sacramento County Department of Social Services**

Sarah Jenkins

**Sacramento County District Attorney's Office**

Janice Hayes  
Deputy District Attorney

**Sacramento County Executive's Office**

Margaret Tomczak  
Children's Commission

**Sacramento County Sheriff's Department**

Sergeant Harry Machen

**University of California Davis Medical Center**

Michael Reinhart, M.D., CDRT Founding Chair  
Medical Director, Child Protection Center



## APPENDIX D

### Sacramento County Child Death Review Team Current Members

**California Children’s Services**

Mary Jess Wilson, M.D., M.P.H.  
Medical Director

**California Highway Patrol**

Elizabeth Dutton

**Child Abuse Prevention Council of Sacramento, Inc.**

Blessilda Canlas  
CDRT Project Manager

Meghann K. Leonard, M.P.P.A.  
CDRT Data Analyst

**Department of Health and Human Services  
Child Protective Services**

Judy Pierini, M.S.W.

Paula Christian, M.S.W.

**Department of Health and Human Services  
Epidemiology and Disease Control**

Cassius Lockett, PhD  
Epidemiologist

**Department of Health and Human Services  
Public Health Nursing**

Jane Wagener, R.N., P.H.N.  
Supervising Public Health Nurse

**District Attorney’s Office**

Robin Shakely, J.D.  
Deputy District Attorney

**Elk Grove Police Department**

Mario Guzman  
Sergeant

**Kaiser Permanente**

Carole Jones, R.N., C.C.R.N.

**Law Enforcement Chaplaincy - Sacramento**

Frank Russell  
Supervising Senior Chaplain

**Mercy San Juan Hospital**

Gale Schmaltz, R.N., M.S.N.

**Sacramento City Fire Department**

Anthony Medina  
Captain

**Sacramento City Police Department**

Fernando Enriquez  
Sergeant

**Sacramento County Coroner’s Office**

Kim Burson  
Assistant Coroner/ Investigation

Mark Super, M.D., CDRT Vice Chair  
Forensic Pathologist

**Sacramento County Metropolitan Fire  
Department**

Clayton Elledge, EMS

**Sacramento County Sheriff’s Department**

Kevin Givens  
Detective

**Sutter Memorial Hospital**

Angela Rosas, M.D., CDRT Chair  
Pediatrician

Margaret Crockett, R.N., CNS  
Neonatal Nurse Specialist

**University of California, Davis Medical Center**

Cathy Boyle R.N.C., P.N.P.  
Pediatric Nurse Practitioner  
Child Protection Center



## APPENDIX E

### Sacramento County Child Death Review Team Past Members

Amelia Baker, P.H.N. Public Health and Promotion/Del Paso Center Department of Health and Human Services	Laura Coulthard Bureau Chief, Emergency Response Department of Health and Human Services
Sandra Baker Executive Director Child and Family Institute	Jacque Cramer, P.H.N. Director of Field Nursing Department of Health and Human Services
Walt Baer Detective, Child Abuse Bureau Sacramento County Sheriff's Department	Mark Curry Deputy District Attorney, Homicide District Attorney's Office
Michael Balash Captain Sacramento Fire Department	Velma Davidson Director Patient Support Services University of California, Davis Medical Center
Will Bayles Sacramento County Sheriff's Department	Nolana Daoust, M.P.H. Epidemiologist Department of Health and Human Services
Ken Bernard Sacramento City Police Department	Joe Dean Sergeant, Homicide Unit Sacramento County Sheriff's Department
Chinayera Black CDRT Coordinator Child Abuse Prevention Council of Sacramento, Inc.	Lynell Diggs Supervisor, FM/FPCP Division Department of Health and Human Services
Bill Brown, M.D. Chief Coroner Sacramento County Coroner's Office	Bob Dimand, M.D. Chief Pediatrician Mercy Healthcare/UC Davis Medical Center
Sue Boucher CDRT Coordinator Child Abuse Prevention Council of Sacramento, Inc.	Paul Durenberger Deputy District Attorney, District Attorney's Office
Sarah Campbell, M.D. Northern California Forensic Pathologists Sacramento County Coroner's Office	Phil Ehlert Sacramento County Coroner's Office
Kim Clark Detective, Sacramento City Police Department	Wendy Ellinger, R.N., P.H.N. Department of Health and Human Services
Rod Chong Division Chief, Sacramento City Fire Department	Norma Ellis, P.H.N. Field Services Nurse Department of Health and Human Services
Linda Copeland, M.D. Foundation Health Medical Group, Inc.	Earl Evans Sacramento County Sheriff's Department
Sherri Cornell, R.N. California Children's Services	Mark Fajardo, M.D.

Stephanie Fiore, M.D.  
Sacramento County Coroner's Office

David Ford  
Sergeant, SACA Unit  
Sacramento City Police Department

Mary Ann Harrison  
Department of Social Services

Rich Gardella  
Sergeant, Homicide Unit  
Sacramento City Police Department

Keith Gault  
ACLS Coordinator  
Sacramento City Fire Department

Jason Gay  
Detective  
Sacramento County Sheriff's Department

James Jay Glass  
Paramedic Captain  
Sacramento City Fire Department

Ethel Hawthorn  
Supervisor, Child Protection/Family Preservation  
Department of Health and Human Services

Max Hartley  
California Highway Patrol

Donald Henrickson, M.D.  
Northern California Forensic Pathology

Richard Ikeda, M.D., M.P.A.  
Executive and Medical Director  
Health For All

Michelle Jay, D.V.M., M.P.V.M.  
Chief Epidemiologist  
Department of Health and Human Services

Pamela Jennings  
Maternal, Child and Adolescent Health  
Department of Health and Human Services

Maynard Johnson, M.D.  
Pediatrician,  
Kaiser Permanente Foundation

Jeff Jones  
Chaplain  
Law Enforcement Chaplaincy

Evelyn Joslin  
Deputy Director  
Department of Social Services

Angela Kirby  
Detective  
Sacramento County Sheriff's Department

Joan Kutschbach, M.D.  
Kaiser Permanente

Melinda Lake, M.S.W.  
Human Services Program Manager  
Child Protective Services  
Department of Health and Human Services

Larry Lieb, M.D.

Tim Maybee  
Sacramento County Fire Department

Rich Maloney, R.N.  
Sacramento Metro Fire District

Debbie Mart  
Sacramento City Fire Department

Arelis Martinez, M.S.  
CDRT Coordinator  
Child Abuse Prevention Council of Sacramento, Inc.

Gary Martinez-Torres, M.D.  
Pathologist, County Coroner's Office

John McCann, M.D.  
Child Protection Center  
University of California Davis Medical Center

John McGinness  
Homicide Unit  
Sacramento County Sheriff's Department

Alan Merritt, M.D.  
Neonatologist  
University of California Davis Medical Center

Bud Meyers  
Children's Protective Services  
Department of Health and Human Services

Richard Miles  
Sacramento County Coroner's Office

John Miller  
Sacramento City Fire Department

Jay Milstein, M.D.  
Neonatologist  
University of California Davis Medical Center

Bobby Mitchell  
Sergeant, Homicide  
Sacramento City Police Department

Ketty Mobed, Ph.D.  
Chief Epidemiologist  
Department of Health and Human Services

Kate Moody  
Sutter Healthcare

Ann Nakamura  
CDRT Coordinator  
Child Abuse Prevention Council of Sacramento, Inc.

Joanne O'Callaghan  
Children's Protective Services  
Department of Health and Human Services

Mark O'Sullivan  
Senior Chaplain  
Law Enforcement Chaplaincy

Christy L. Olezeski, M.S.  
CDRT Project Manager  
Child Abuse Prevention Council of Sacramento, Inc.

Kenneth Ozawa, M.D.  
Mercy Healthcare of Sacramento

Arti Parikh  
Epidemiologist  
Department of Health and Human Services

James Pearson  
Sacramento City Police Department

Cliff Peppers  
Sergeant  
Sacramento County Sheriff's Department

Jan Peter, P.H.N.  
Public Health Nursing  
Department of Health and Human Services

Ronald Potter  
Captain  
Sacramento City Fire Department

Dan Read  
Child Protective Services  
Department of Health and Human Services

Gregory Rieber, M.D.  
Pathologist  
University of California, Davis Medical Center

Steve Roberson  
Detective  
Sacramento County Sheriff's Department

Curtis Rollins, M.D.  
Northern California Forensic Pathology

Sandee Rowlee M.S, R.N, A.C.N.P.-C.S.  
Trauma Nurse Practitioner  
Mercy San Juan Hospital

Mindi Russell  
Deputy Senior Chaplain  
Law Enforcement Chaplaincy

Mike Savage, J.D.  
Deputy District Attorney  
District Attorney's Office

Gregory Schmunk, M.D.  
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Mary Ella Schubert, P.H.N.  
Public Health Promotion  
Department of Health and Human Services

Howard Sihner  
District Attorney's Office – Juvenile Division

Sue Simmons, R.N., M.P.V.  
Field Nurse  
Department of Health and Human Services

Edward E. Smith  
Assistant Coroner/ Investigation  
Sacramento County Coroner's Office

Bev Sprenger  
Department of Health and Human Services

Mark Starr, D.V.M., M.P.V.  
Epidemiologist  
Department of Health and Human Services

Dr. John Stockman  
Stockman and Associates

Grant Stomsvick  
Detective  
Sacramento County Sheriff's Department

Ben Sun, D.V.M., M.P.V.M.  
Epidemiologist  
Department of Health and Human Services

Debbie Yip  
CWLA Supervisor  
Department of Health and Human Services

Jane Tabor-Bane  
Child Protective Services  
Department of Health and Human Services

Ellen Tappero  
Center For Women's Health  
Sutter Memorial Hospital

Cheri Taylor  
CDRT Coordinator  
Child Abuse Prevention Council of Sacramento, Inc.

Jane Thaxter-McCann, M.D.  
Child Protection Center  
University of California Davis Medical Center

Ted Voudouris  
Sacramento County Sheriff's Department

Ken Walker  
Lieutenant  
Sacramento City Police Department

Stephen Wallach  
Child Protective Services  
Department of Health and Human Services

Phil Whitbeck  
Chaplain  
Law Enforcement Chaplaincy

Patty Will  
School Attendance Review Board  
San Juan Unified School District

Victoria Witham  
EMT Liaison  
Sacramento City Fire Department

Stephen Wirtz, Ph.D  
CDRT Coordinator  
Child Abuse Prevention Council of Sacramento, Inc.

Greg Wyatt  
Deputy Coroner  
Sacramento County Coroner's Office

Samuel Yang, M.D.  
Medical Director  
California Children's Services

## APPENDIX F

### GLOSSARY

Abuse Homicide: (A subset of the CAN homicides) Child abuse was the direct cause, or was in the direct chain of causes of the child's death. All deaths caused intentionally or unintentionally by abuse where the perpetrator was a parent or a caregiver fall under this category. Examples:

- A baby who dies from shaken baby syndrome
- A murder/suicide, where a parent kills his/her child and then him or herself

Abuse-Related Death: Child abuse was present and contributed in a concrete way to the child's death.

Cancers: A tumor disease, the natural course of which is fatal.

Cause of Death: Causes of death are coded according to the Tenth Revision of the International Classification of Diseases (ICD - 10). Natural cause and injury (E-Codes) classifications are used.

Child Abuse: Any act of omission or commission that endangers a child's physical or emotional health and development. (PC 11164-11174.3)

Child Neglect:

General Neglect: The unwillingness of the parent or caregiver to provide for adequate basic needs, where there is no physical injury or injury is not likely to occur. The failure of a person responsible for a child to supply necessary food, clothing, shelter, or medical, dental or psychiatric care when that person is able to do so or failure to protect the child from imminent and serious danger to his or her physical or mental health. Examples:

- Children not being fed or lacking adequate shelter. Examples include hazardous conditions (exposed wiring, broken glass), unsanitary conditions (garbage, spoiled food, excrement), food unavailable or intentionally withheld.

Severe neglect: The unwillingness of the parent or caregiver to provide for adequate basic needs where there is physical injury or injury is likely to occur, such as: malnutrition, chronic neglect, abandonment, willful endangerment, refusal to seek medical care.

Child Abuse and Neglect (CAN) Homicide: A death in which a child is killed, either directly, or indirectly, by their caregiver.

Child Death: A death occurring from age one year up to, but not including, eighteen years of age.

Child Protective Services (CPS): A part of the County Department of Health and Human Services. CPS works with families where there are concerns of abuse and neglect and with children in foster care.

Congenital Anomalies: Abnormal intrauterine development of an organ or structure; commonly referred to as "birth defects".

Death Certificate: Certifies the occurrence of a death and provides the basis for the identification of cases to be reviewed by the Child Death Review Team.

Death Rate: The number of deaths within a population divided by the total number of members in that population. Death rates are used to make comparisons between groups of varying size and composition. In this document, since we are working with small numbers, the death rates were multiplied by 100,000 so that subtle deviations could be more easily detected.

Domestic Abuse: Also called domestic violence, domestic abuse is violence against a spouse, cohabitant, fiancée, or other person with whom the abuser has a dating relationship, or someone formerly in any of these relationships. Types of violence includes: sexual assault; placing a person in reasonable apprehension of being seriously injured (threats); intentionally or recklessly causing or attempting physical injury.

Epidemiology: The study of distribution and determinants of disease, disability, injury, and death.

Emotional Abuse: When a person causes or permits a child to suffer unjustifiable or significant mental suffering.

Fetal Alcohol Syndrome (FAS): A group of birth defects seen among babies whose mothers consumed alcohol during pregnancy, which includes mental retardation, developmental disabilities, and physical deformities.

Fetal Death: A death occurring in a fetus over 20 weeks gestational age; not a live birth.

Failure To Thrive: The abnormal retardation of growth and development of an infant resulting from conditions that interfere with normal metabolism, appetite, and activity. Causes include illness, chromosomal abnormalities, major organ system defects, and malnutrition.

Infant Death: A death occurring during the first year of life; includes both neonates and post neonates.

Infant Mortality Rate: The number of infants who die within the first year of birth per 1,000 live births.

Infection: The invasion and multiplication of microorganisms in body tissues.

Injury-Related Death: A death that is a direct result of an injury-related incident. Examples include homicides, motor vehicle accidents (MVA), suicides, drownings, burns and suffocations.

International Classification of Diseases: A guide for the classification of morbidity and mortality information for statistical purposes published by the World Health Organization.

Low Birth Weight: Birth weight below 2500 grams.

Manner of Death: Cause of death as indicated on the death certificate, which includes the following six categories: Natural; Accident; Suicide; Homicide; Pending Investigation; Could Not Be Determined.

Mandated Reporter: A person, who (1) in their professional capacity or within the scope of their employment, has a special relationship or contact with children and (2) is legally required to report known or has "Reasonable Suspicion" (see definition) of child abuse and neglect, obtained in the scope of their employment.

Methamphetamine: A synthetic drug, which affects the central nervous system. Street methamphetamine is sometimes called "speed," "meth," "crank," "chalk," and "zip".

Medically Fragile: A term used to describe children at risk for abnormal growth and development and/or serious medical problems.

Neglect Homicide: (A subset of the CAN homicides) Neglect was the direct cause, or was in the direct chain of causes, of the child's death. Deaths caused by the negligent failure of a parent/guardian or caregiver to provide adequate food, clothing, shelter, or medical care. Examples:

- An abandoned newborn that dies of exposure.
- A child who dies from an untreated life threatening infection.

Neglect-Related Deaths:

Supervision and Situational Neglect: Deaths that involve critical moments in which the child, left without adequate supervision, food, shelter, or medical care is killed by a suddenly arising danger. Deaths where poor caregiver skills and/or judgement endangered the life of a child are also included in this category.

- An unattended infant who drowns in a bathtub.
- Unrestrained child killed in a motor vehicle accident.

Prenatal Substance Abuse: Prenatal substance abuse where there is a clear medical link to infant death or death is secondary or known to probable prenatal substance abuse. Examples:

- Maternal methamphetamine use that causes a premature birth and subsequent death.
- An infant exposed prenatal to cocaine and alcohol that dies from multiple birth defects.

Neonatal Death: A death occurring during the first 27 days of life.

Pathology: The study of disease, its essential nature, cause, and development; and the structural and functional changes it produces.

Perinatal: The period shortly before through shortly after birth, variously defined as beginning with the completion of the twentieth to twenty-eighth week of gestation and ending 7 to 28 days after birth.

Physical Abuse: (California Law – PC 11165.6) Any physical injury inflicted on a child by other than accidental means. Any physical injury that is unexplainable by the child's medical history. Physical abuse also includes discipline or control by any means not authorized by law to manage persons who are mentally challenged or impaired.

Physical Neglect: (PC 11165.2) – Negligent or maltreatment of a child by a caregiver – including both acts and omission of care.

Postneonatal Death: A death occurring between age 28 days up to, but not including, age one year.

Postmortem: An examination of the body after death, usually with such dissection as will expose the vital organs for determining the cause of death or the character and extent of changes produced by disease; an autopsy.

Public Health Nursing (PHN): A part of the County Department of Health and Human Services. PHN provides a broad array of services to families with small children, from working with pregnant women to helping families with high-risk infants, to providing grief counseling.

Prenatal: The period beginning with conception and ending at birth.

Prematurity: Birth prior to 37 weeks gestation.

Preterm Labor: Onset of labor before 37 weeks gestation.

Positive Toxicology Profile: For the purpose of this report, a positive toxicology profile refers to a child born with drugs in his or her system at birth.

Reasonable Suspicion: (PC 11166[a]) When it is objectively reasonable for a person to entertain such a suspicion, when based upon the facts that could cause a reasonable person in a like position, drawing what is appropriate on his or her training and experience, to suspect child abuse.

Sexual Abuse and Exploitation: (PC 11165.1) Sexual assault on or sexual exploitation of a minor. Specifically, sexual abuse includes: rape, gang rape (or rape in concert), incest, sodomy, oral copulation, and lewd and lascivious acts.

Sudden Infant Death Syndrome (SIDS): The sudden death of an infant under one year of age, which remains unexplained following an investigation of the case, including the performance of a complete autopsy and review of the clinical history.

Syndrome: A set of signs or symptoms that occur together often enough to constitute a specific condition or entity.

Third-Party Homicide: A homicide where the perpetrator was not a caregiver.

Toxicology Screening: For the purpose of this report, toxicology screening refers to blood analysis used to detect prenatal drug exposure.

Deaths Classified as Child Abuse and Neglect Fatalities  
Definitions

**I. Abuse**

- (A) Abuse Homicides: (A subset of the CAN homicides) Child Abuse was the direct cause, or was in the direct chain of causes of the child's death. All deaths caused intentionally or unintentionally by abuse where the perpetrator was a parent or a caregiver fall under this category. Examples:
- A baby who dies from shaken baby syndrome
  - A murder/suicide, where a parent kills his/her child and then him or herself
- (B) Abuse-Related Deaths: Child abuse was present and contributed in a concrete way to the child's death.

**II. Neglect**

- (A) Neglect Homicides: (A subset of the CAN homicides) Neglect was the direct cause, or was in the direct chain of causes, of the child's death. Deaths caused by the negligent failure of a parent/guardian or caregiver to provide adequate food, clothing, shelter, or medical care. Examples:
- An abandoned newborn that dies of exposure.
  - A child who dies from an untreated life threatening infection.
- (B) Neglect-Related Deaths:
- a. *Supervisional and Situational Neglect*: Deaths that involve critical moments in which the child, left without adequate supervision, food, shelter, or medical care is killed by a suddenly arising danger. Deaths where poor caregiver skills and/or judgement endangered the life of a child are also included in this category.
    - An unattended infant who drowns in a bathtub.
    - Unrestrained child killed in a motor vehicle accident.
  - b. *Prenatal Substance Abuse*: Prenatal substance abuse where there is a clear medical link to infant death or death is secondary or known to probable prenatal substance abuse. Examples:
    - Maternal methamphetamine use that causes a premature birth and subsequent death.
    - An infant exposed prenatally to cocaine and alcohol that dies from multiple birth defects.

In addition to the deaths that meet the above definitions, there are tragic deaths involving neglect and/or abuse that do not fall neatly into either of the above categories. A positional asphyxiation of an infant sleeping in an overcrowded, filthy home is one example. The accidental death of a child with multiple unsubstantiated referrals for neglect and/or abuse is another. Since 1996, these deaths have been classified as **“questionable” and/or “suspicious”** due to elements of possible existence of abuse and/or neglect. Deaths in this category generally have a combination of behavioral risk factors, such as substance abuse and family violence.

## APPENDIX G

### **Teen Suicide Prevention Taskforce Recommendations to the Department of Health and Human Services In Response to the 2004 Child Death Review Team Report September 6, 2006**

The 2004 Child Death Review Team (CDRT) Report issued earlier this year identified four child fatalities as suicides. Recognizing a need to better educate teenagers and communities on the warning signs of teenage suicide and the support that is available, the CDRT recommended that Sacramento County establish a Teenage Suicide Prevention Taskforce to further efforts in teenage suicide prevention within the community and each school district.

In response to that recommendation, Jim Hunt, Deputy Agency Administrator for the Countywide Services Agency, requested that a Teen Suicide Prevention Taskforce be formed. The taskforce was convened by the Division of Mental Health with the charge of developing a coordinated community response to teen suicide.

The taskforce included participation from:

- Sacramento County Department of Health and Human Services:
  - Division of Mental Health
  - Child Protection Services
  - Alcohol and Drug Services
- Sacramento County Department of Human Assistance
- San Juan Unified School District
- Elk Grove Unified School District
- Sacramento City Unified School District
- Child Abuse Prevention Council
- UC Davis Medical Center
- Youth and Family Advocates
- Community Youth
- Friends for Survival
- Law Enforcement Chaplaincy
- California State Department of Education
- Nevada County Department of Public Health
- Sacramento County Independent Living Program
- The Effort, Inc.
- Southeast Asian Assistance Center
- Healthy Start Programs
- Mental Health Association
- Turning Point
- Sutter Counseling
- Terkensha Associates
- La Familia
- SETA

- Hmong Women's Heritage Association
- Child Abuse Prevention Council
- Another Choice Another Chance
- Asian Pacific Counseling Center
- Sacramento Children's Home

The members of the taskforce used the National Strategy for Suicide Prevention framework developed by the Surgeon General, Centers for Disease Control (CDC), National Institutes of Health, Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Resources and Services Administration. The taskforce has met weekly since May 10, 2006 with the goal of developing a coordinated community response regarding teen suicide. In so doing, it has identified three priority focus areas for Sacramento County. The three selected areas of focus are Public Awareness, Training and Education, and Data Collection.

Within each area of focus, the taskforce has made specific recommendations important to increasing efforts to educate communities regarding suicide prevention. In some instances, the taskforce has begun implementing recommendations. This information is included in this report under the Community Response section. Where the taskforce has not developed specific action steps to the recommendations due to a lack of resources or other variables, no Community Responses are included.

The taskforce strongly recommends that the Department of Health and Human Services allocate funds specifically for suicide awareness and to assist in the implementation of the following recommendations.

<p><b>Focus Area #1:</b>  <b>Awareness that Teen Suicide is a Preventable Public Health Problem</b></p>
---

The taskforce's first priority area focuses on the development of strategies that will increase awareness in Sacramento County that teen suicide is a public health problem that is preventable.

**Recommendation 1:** Develop training programs on suicide prevention geared towards the general public, faith based organizations, professionals, educators and community-based agencies.

**Community Response 1:** A collaboration between community based service providers, volunteer agencies, and DHHS was formed to submit a grant proposal to develop a speaker's bureau and suicide awareness training teams. The training teams would be available to the Sacramento County community to provide education and awareness regarding the prevention of teen suicide.

**Recommendation 2:** Develop and disseminate informational packets directed toward youth that highlight suicide risk factors, and how to ask for help.

**Community Response 2a:** The taskforce developed, assembled and distributed over 200 suicide prevention packets which included posters, pocket cards, brochures and ribbons to school and youth counselor's within Sacramento County for Suicide Prevention Week.

**Community Response 2b:** Public service announcements are being developed for use on popular teenage radio stations.

**Recommendation 3:** Develop flyers and brochures in Sacramento County Division of Mental Health threshold languages that promote suicide awareness and reduces the stigma associated with suicide. These threshold languages include Spanish, Russian, Cantonese, Vietnamese, and Hmong. These flyers, brochures, and other suicide awareness packets can be distributed at health and cultural fairs held throughout the year.

**Community Response 3:** Sacramento County Division of Mental Health, Department of Health and Human Services is currently reviewing existing flyers and brochures for use in programs throughout the county.

**Recommendation 4:** Develop countywide school-based suicide awareness educational programs.

**Community Response 4:** The taskforce has reviewed suicide awareness curricula and recommends two curricula for consideration of implementation by school districts:

- Signs of Suicide copyrighted 2006 by Screening for Mental Health, Inc.
- The Jason Foundation, Inc. suicide prevention curricula.
- School district taskforce members are bringing this information back to their administrations.

**Recommendation 5:** The taskforce supports the funding of a community based provider to establish and facilitate an ongoing Sacramento County Suicide Awareness Committee that oversees countywide suicide prevention activities including the annual promotion of Suicide Prevention Month.

**Focus Area #2:  
Training and Education Programs for Teen Suicide Prevention**

The taskforce's second priority area focuses on the improvement of training and educational programs for professionals and paraprofessionals.

**Recommendation 1:** Create standards for clinical practices in community-based organizations by 2008.

**Recommendation 2:** Develop core competencies for assessment, intervention, and pre/postvention services. This includes the development of job qualifications and descriptions that integrate the provision of mental health and alcohol/drug treatment for individuals who have co-occurring disorders.

**Recommendation 3:** Train professionals and para-professionals working with youth on standardized assessment, intervention, and pre/postvention techniques.

**Recommendation 4:** Educate parent and caregivers including foster parents on how to recognize risk factors for suicide and how to seek mental health help. Toward this end, the Department of Health and Human Services may consider the integration of suicide awareness into parenting classes, advocate support groups, and foster parent education.

<p style="text-align: center;"><b>Focus Area #3:</b> <b>Enhance Existing Local Data Collection for Suicides</b></p>
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The taskforce's third priority area focuses on the enhancement of current data collection to better understand local trends. This would, in turn, assist with the development of strategies to better address local area risks and concerns regarding teen suicide.

**Recommendation 1:** Create a tracking system for suspected suicide attempts at the Mental Health Treatment Center children's crisis unit -Minor Emergency Response Team (MERT).

**Community Response 1:** Sacramento County Division of Mental Health is exploring the development of this database for use by MERT.

**Recommendation 2:** Include sexual orientation, history of use of alcohol and other drugs, and previous suicide attempts in the data collected regarding completed suicides.

**Community Response 2:** A subcommittee of the taskforce is exploring current data collection activities, with recommendations to improve local data collection standards.