Child Maltreatment Deaths 2004/2005/2006

Presented to:
Sacramento County Board of Supervisors

September 11, 2007

Sacramento County Child Death Review Team

CDRT Mission Statement

- Ensure that all child 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

CDRT Protocol

- Reviews all deaths of children under age 18 in Sacramento County
- 21 representatives from public and private sectors provide case-specific information
- Identifies abuse/neglect and other issues to inform the development of prevention efforts

Report Timeline

March 6, 2007

- CDRT *2005 Annual Report* presented to BOS
- BOS requested analysis of **2006** data earlier than completion of formal *Annual Report*

March – June 2007

- Completed case reviews of 2006 child deaths
- Convened to conduct in-depth analysis of **2006 child maltreatment deaths**
- Identified trends
- Formulated preliminary findings and recommendations for prevention of child maltreatment deaths

July – August 2007

- Completed analysis of 2004/05/06 child maltreatment deaths
- Approved analysis and preliminary findings and recommendations

Report Parameters & Format

Parameters

- Analysis of child maltreatment deaths
- Sacramento County residents under age 18
  (or out-of-county residents whose injuries leading to death occurred in Sacramento County)

Format

- 2006 child maltreatment death data
- 2004/05/06 cumulative data and trends
- Findings and recommendations
- Appendix with tables

Child Maltreatment Deaths - Classifications

- **Abuse:** Clearly due to abuse; supported by Coroner's reports or police or criminal investigation (e.g. homicide)

- **Neglect:** Clearly due to neglect, supported by Coroner's reports or police or criminal investigation

Child Maltreatment Deaths - Classifications

- **Abuse-related:** Death secondary to documented abuse (e.g. suicide of a previously abused child)
- **Neglect-related:** Death secondary to documented neglect (e.g. auto accidents or house fires where caretaker was "under the influence"); also includes any case of poor caretaker skills or judgment

Child Maltreatment Deaths Classifications

- **Questionable neglect:** There are no specific findings of abuse or neglect but there are such factors as:
  - Substance use or abuse where substance exposure caused caretaker to experience mental impairment
  - Previously unaccountable for deaths in the same family
  - Prior abuse/neglect of child or protective service referral

3 Categories of Child Maltreatment Deaths

- **Child Abuse and Neglect (CAN) homicides**
  - Child was killed, either directly, or indirectly, by their caregiver

- **Third-party homicides involving an element of neglect**
  - Child was killed by someone other than their caregiver
  AND
  - There was a failure or unwillingness of parent or caregiver to provide for child's basic needs

- **Deaths from other causes involving classification of abuse-related, neglect, neglect-related, or questionable neglect**

Sacramento County Child Maltreatment Deaths

2004-2006 Summary

- **52 Total Child Maltreatment Deaths**
  10% of 525 total child deaths
  - **20 -** child abuse and neglect (CAN) homicides
  - **3 -** third-party homicides
  - **29 -** maltreatment deaths from other causes

Sacramento County Child Maltreatment Deaths

2006

- **24** of **181** child deaths classified as child maltreatment deaths (13%)
- 7 CAN homicides; 1 third-party homicide; 16 other maltreatment deaths

2005

- **17** of **168** child deaths classified as child maltreatment deaths (10%)
- 9 CAN homicides; 1 third-party homicide; 7 other maltreatment deaths

2004

- **11** of **176** child deaths classified as child maltreatment deaths (6%)
- 4 CAN homicides; 1 third-party homicide; 6 other maltreatment deaths

MECHANISM
2006 CAN & Third-Party Homicides

- Of the **7 CAN homicides**
  - 3 medical neglect
  - 2 battery (1 abusive head injury)
  - 1 vehicular
  - 1 unknown mechanism (neglect involved)
- **1 third-party homicide**
  - Vehicular (parental contribution)

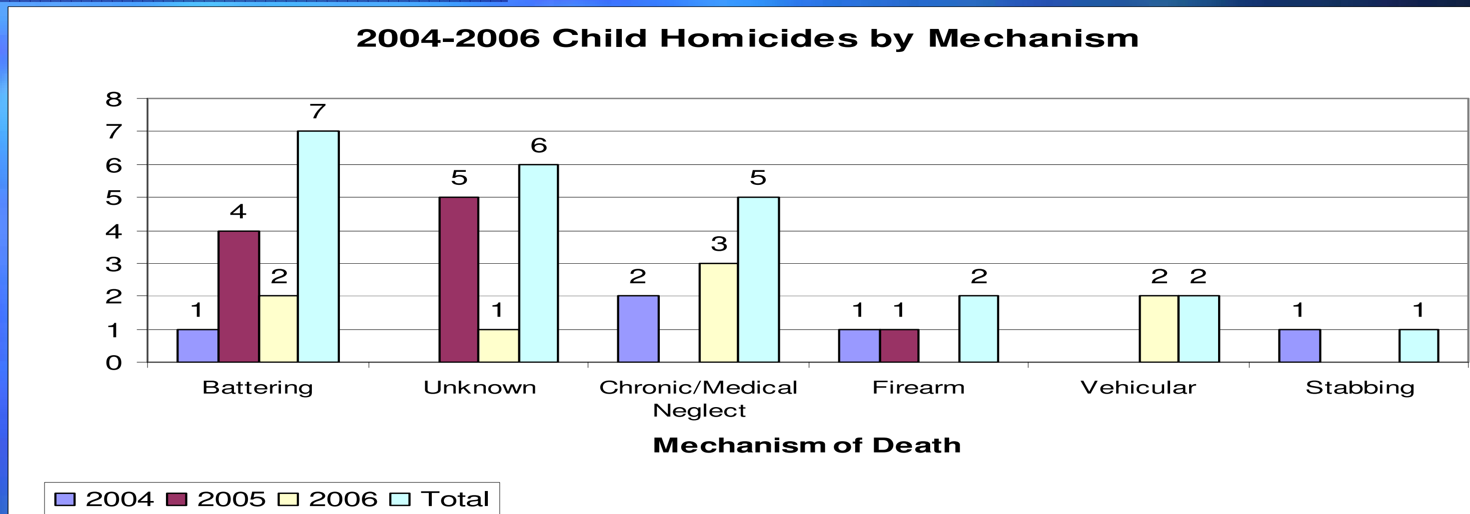
MECHANISM

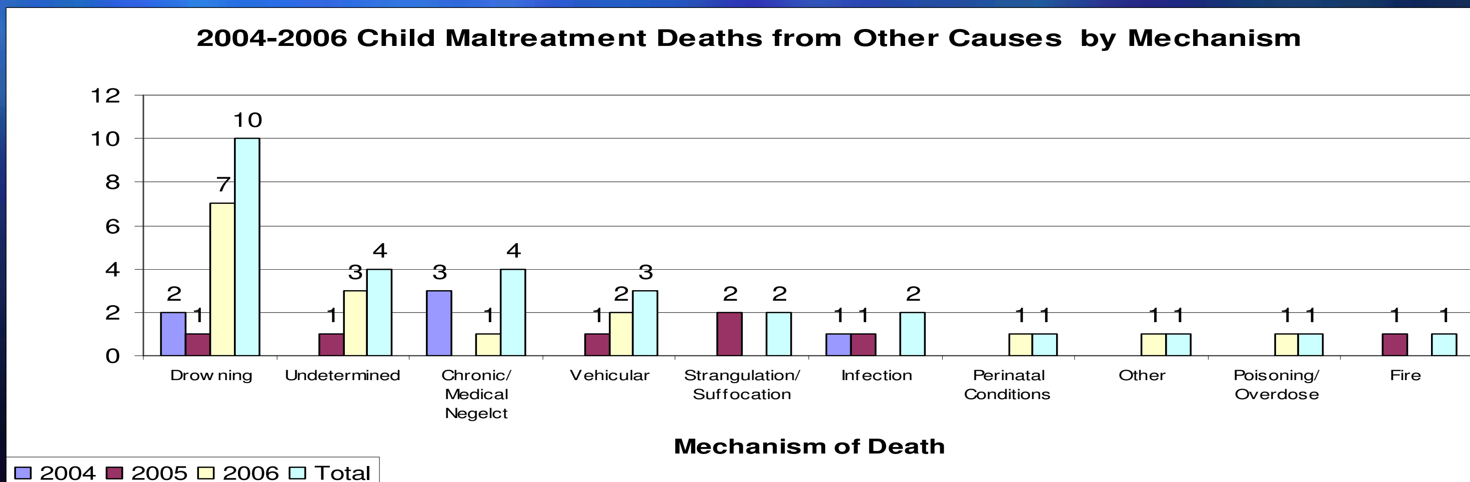
2006 Child Maltreatment Deaths From Other Causes

- All **16** child maltreatment deaths from other causes involved parental abuse or neglect:
  - 7 drownings
  - 3 undetermined
  - 2 vehicular
  - 1 chronic/medical neglect
  - 1 perinatal condition
  - 1 poisoning/overdose
  - 1 other mechanism

MECHANISM

2004-2006 Child Maltreatment Deaths





TYPES OF ABUSE & NEGLECT

2004-2006 Child Maltreatment Deaths

- 21 of the 52 maltreatment deaths involved abusive head trauma or medical neglect (40%)

2004 - 2006 Types of Abuse and Neglect

Types of Abuse and Neglect	2004	2005	2006	Total Deaths
Medical Neglect (including Failure to Thrive)	5	0	6	**11**
Abusive Head Trauma	1	8	1	**10**
SUBTOTAL	**6**	**8**	**7**	**21**
2004-2006 TOTAL Child Maltreatment Deaths	**11**	**17**	**24**	**52**

CPS INVOLVEMENT
2006 Child Maltreatment Deaths

13 of 24 child maltreatment decedents had a history of involvement with ANY California county CPS (case open or reported)

- 11 of the 13 had been involved with Sacramento County CPS
  - 9 of the 11 were involved within 6 months prior to their death

CPS Involvement in 2006 Maltreatment Deaths	CAN & Third-Party Homicides	Maltreatment Deaths From Other Causes	Total
Total # Maltreatment Deaths in 2006	**8**	**16**	**24**
1. Decedent had a history of involvement with **ANY CA County CPS** (Case open or reported)	**6**	**7**	**13**
1.1 Decedent had a history of involvement with **Sacramento County CPS** (Case open or reported)	**5**	**6**	**11**
1.1.a Decedent had a history of involvement with **Sacramento County CPS within 6 months prior to death** (Case open or reported)	**3**	**6**	**9**

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

2004-2006 Child Maltreatment Deaths

- **12 of 52 child maltreatment decedents had chronic medical conditions (23%)**
- **Not all children with "medical conditions" were found to have associated "medical neglect"**
- **In 2006, 7 of 24 child maltreatment decedents with Sacramento County CPS involvement, had special health care needs**

2004-2006 Maltreatment Deaths of Children with Special Health Care Needs

Medical Condition	2004	2005	2006	Total
Cerebral Palsy	1		2	3
Diabetes		1		1
Failure to Thrive	2		2	4
Chronic Lung Disease/Asthma			1	1
Seizure Disorder/ Epilepsy			1	1
Other Disorders	1		1	2
SUBTOTAL	4	1	7	12
2004-2006 Maltreatment Deaths	11	17	24	52

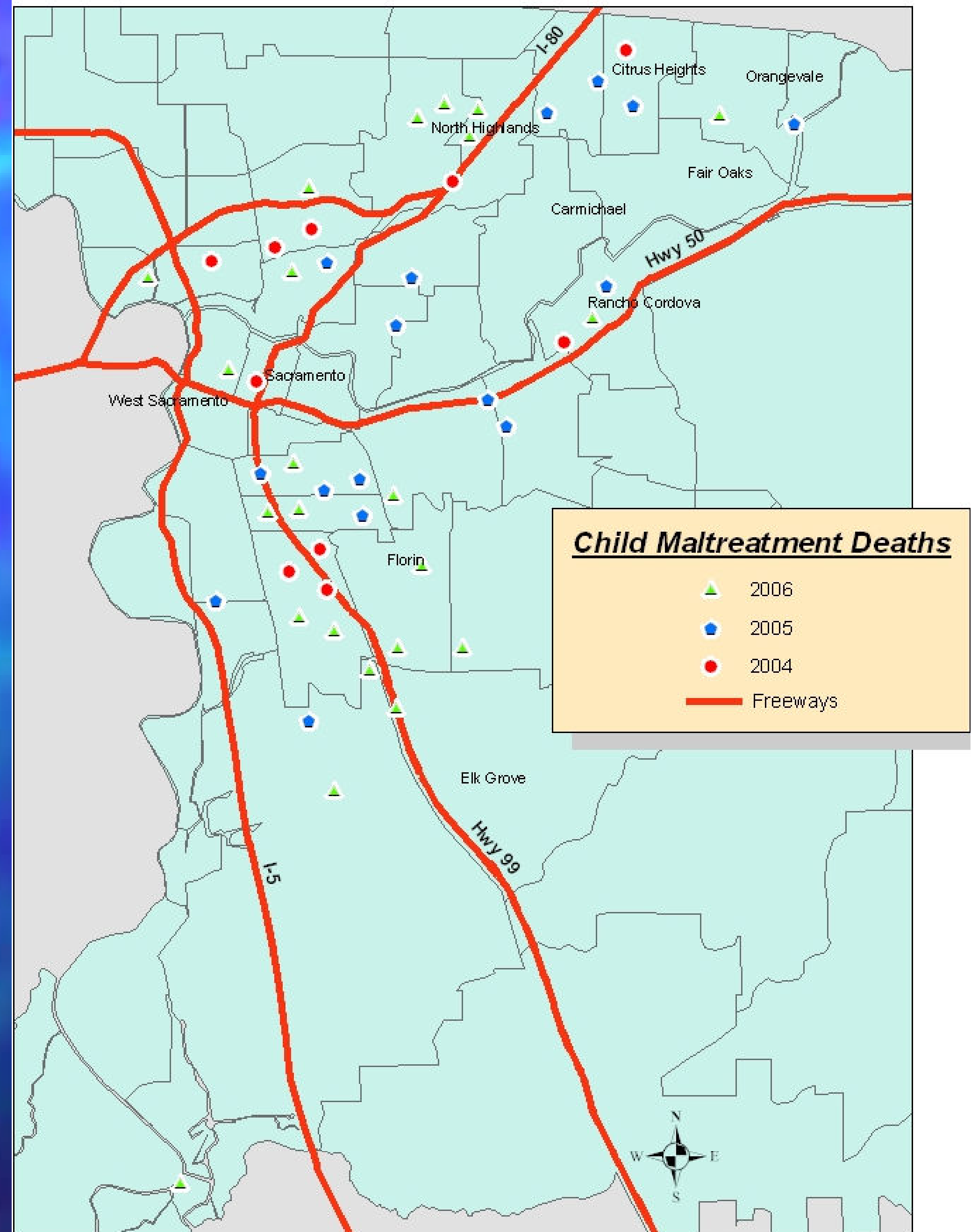
CHILDREN WITH SPECIAL HEALTH CARE NEEDS & CPS INVOLVEMENT
2006 Child Maltreatment Deaths

Of the 7 maltreatment deaths of children with special medical conditions:

- 5 decedents had a history of involvement with ANY California county CPS (case open or reported)
  - 4 of those 5 had been involved with Sacramento County CPS
    - 3 of the 4 were involved with Sacramento County CPS within 6 months prior to their death

GEOGRAPHIC DISTRIBUTION

2004-2006 Child Maltreatment Deaths



GEOGRAPHIC DISTRIBUTION

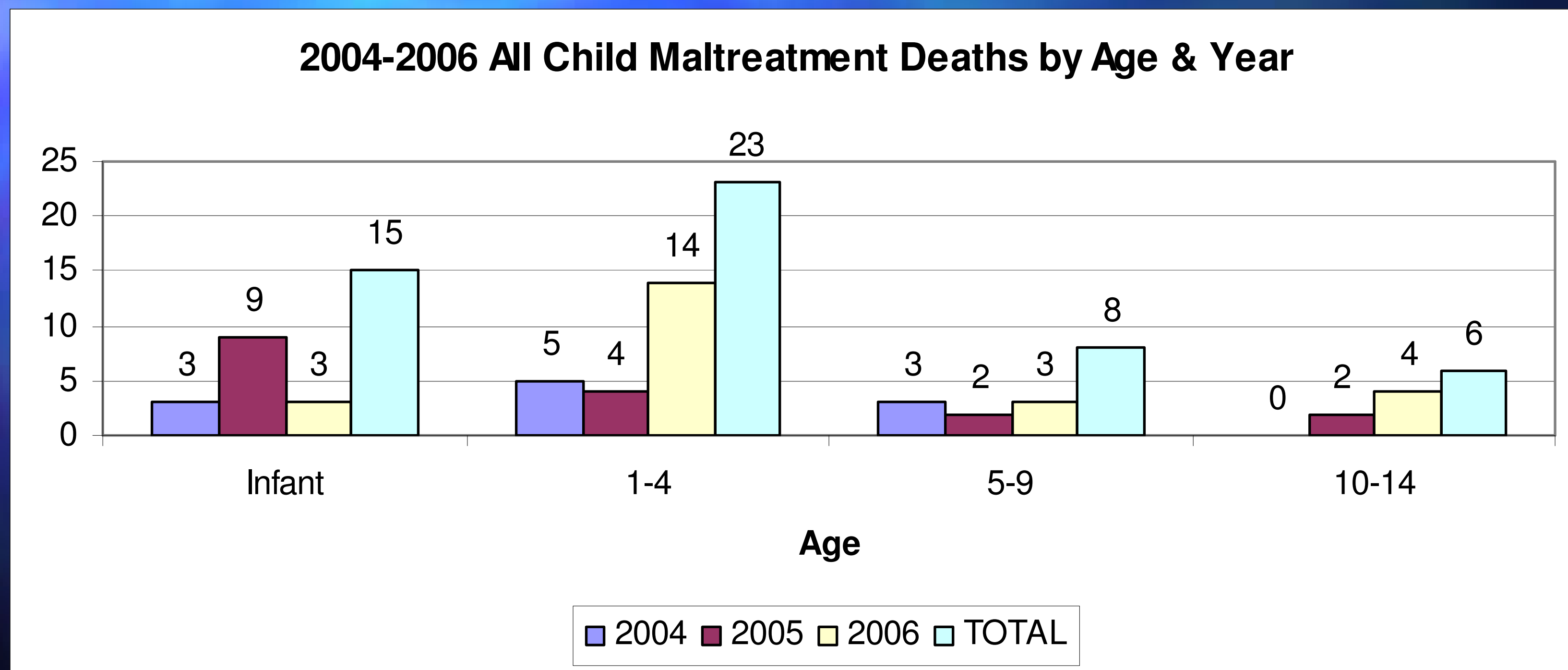
2004-2006 Child Maltreatment Deaths

Zip Code	CAN	Third Party	Other	TOTAL
District 1				16
95838		1	1	2
95833			2	2
95820	1		2	3
95816	1			1
95815			3	3
95814			1	1
95660	1		3	4
District 2				15
95832			1	1
95824	2		2	4
95823	4		3	7
95758		1	2	3
District 3				4
95864	1			1
95842	1			1
95821	1			1
95842	1			1
District 4				6
95662	2			2
95621	2			2
95610			2	2
District 5				11
95829			1	1
95828	1		2	3
95827	1			1
95826	1			1
95757			1	1
95690		1		1
95670			3	3
2004-2006 SACRAMENTO COUNTY TOTAL				52

AGE

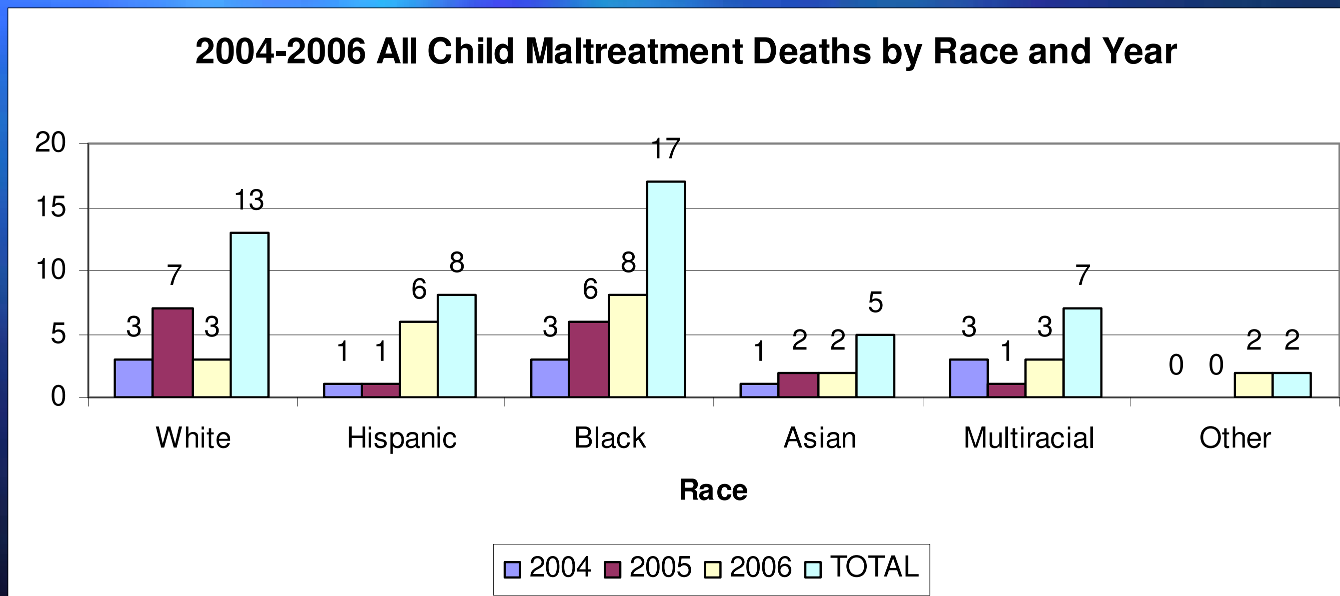
2004-2006 Child Maltreatment Deaths

- Children under the age of 5 are at greatest risk for maltreatment death



RACE/ETHNICITY
2004-2006 Child Maltreatment Deaths

- Race as defined by family member on death certificate
- Increase in number of deaths among Hispanic children
- Increase in number of deaths among Black children



PERPETRATORS

2004-2006 Child Abuse & Neglect (CAN) Deaths

20 **CAN homicides**

- **15** were perpetrated by the biological parents
  - 6 – biological father
  - 6 – biological mother
  - 3 – both parents
- Perpetrators of the remaining 5 were
  - 2 – other family member
  - 2 – boyfriend of mother or guardian
  - 1 – family friend

RISK FACTORS
2004-2006 Maltreatment Deaths

- Limited to data known by CDRT members
- **36 of 52 (69%)** maltreatment deaths involved families with known risk factors
  - 25 families had a history of violent and/or non-violent crime
  - 12 families had a history of alcohol and/or drug use
  - 11 families had a history of domestic violence
  - 3 families had a history of gang involvement

2006 FINDINGS

- Six of the 8 **CAN and third-party homicide decedents** had prior CPS involvement.
  - **63% (5 of 8)** were open or reported to Sacramento County CPS
  - **38% (3 of 8)** were open or reported to Sacramento County CPS <u>within six months prior to the death</u>
- Nearly half (7 of 16) of **child maltreatment decedents from other causes** were known to a California county child protection system.

2006 FINDINGS

- Nearly one-third of all child maltreatment deaths (7 of 24) involved children with **special health care needs.**

- Over half of **child maltreatment decedents with special health care needs** (4 of 7) had Sacramento County CPS involvement.
  - Nearly half (3 of 7) had Sacramento County CPS involvement <u>within six months of their death</u>
  - Nearly three-quarters (5 of 7) had involvement with **any** California county CPS

2006 FINDINGS

- Child maltreatment deaths by abusive head trauma have decreased.
  - 1 case in 2006; 8 cases in 2005
- Nearly 60% of the child maltreatment deaths occurred among children ages 1 through 4
  - Less than 25% in 2005; 45% in 2004

2004-2006 FINDINGS

- Child abuse and neglect (CAN) homicides increased.
  - 20 CAN homicides in the last 3 years
  - 14 CAN homicides in previous 3-year period of 2001-2003
- Three-fourths of the perpetrators of CAN homicides (15 of 20) were the biological parents of the decedents.
  - Mother or father acting alone or both parents acting together

2004-2006 FINDINGS

- Child maltreatment deaths occurred throughout the county, without geographic concentration.
- Child maltreatment deaths occurred among all ethnic groups. Of 52 maltreatment deaths:
  - One-third were African-American children
  - One-fourth were White children
  - Number of deaths increased among Hispanic and African-American children

2004-2006 FINDINGS

- Nearly three-fourths of child maltreatment deaths (38 of 52) were among children ages 0-4.
- Drownings accounted for one-third (10) of all child maltreatment deaths from other causes.

RECOMMENDATIONS

- Ensure that Child Protective Services adhere in both written policy and active practice to a course of action based upon what is best for the safety of the child rather than maintenance of the family unit.

RECOMMENDATIONS

- The following situations should require that a CPS referral or case be investigated in totality, with an increased level of scrutiny and follow-up with collateral agencies, experts, and providers. This scrutiny should include CPS consultation with each of the child's providers and service agencies to develop a plan for formal case management.
  - Multiple CPS referrals or reports on a case (even if unfounded or unsubstantiated), and/or
  - Lengthy history of CPS involvement/contact with multiple counties (e.g. family moving from county to county)
  - Cases of "severe neglect", medical neglect, or history of "severe neglect" reports

RECOMMENDATIONS

- DHHS, with leadership of the medical community, should convene a multidisciplinary team to develop a plan on how CPS should respond to reports and cases of suspected child abuse or neglect involving medically fragile children.

  Representatives on the task force should include but not be limited to: Department of Health and Human Services (Divisions of CPS, Public Health, In-Home Supportive Services and California Children's Services), local hospitals, Sierra-Sacramento Valley Medical Society, Alta Regional Center, physicians and others.

  CDRT strongly recommends that the plan include the following protocol:

  > "When a physician or other medical professional, reports suspected child abuse or neglect to CPS— especially current medical neglect, medically fragile, or failure to thrive— the report should result in an immediate response by a CPS social worker and consideration given to forensic medical consultation to review the entire history."

RECOMMENDATIONS

- Agencies whose primary mission is to serve children with special health care and developmental needs and their families, need to provide training for families on how to access services and support.

  Training should also be provided to the other agencies who are assisting parents of children with complex medical needs.

  - Establish respite services for families with a medically fragile child and create a system that allows parents easy access to respite services

RECOMMENDATIONS

- DHHS should provide CPS access to information, such as from In-Home Supportive Services (IHSS), for collateral consultation regarding the service plan for the child.

- Require agencies that provide funds to parents/caregivers caring for children with special needs to require proof of care, compliance with treatment plans, attendance at medical appointments, etc.

RECOMMENDATIONS

- DHHS should improve training for CPS workers on how to locate families who move from county-to-county and work with other agencies (such as law enforcement) to locate such families.
  - The policy regarding cross-county reporting or mechanism for exchange of information between county welfare agencies should be included in this training protocol.

RECOMMENDATIONS

- Continue to support and provide funding for programs that prevent abusive head trauma, such as shaken baby syndrome.
- Support multi-agency public education, outreach programs, and public service announcements in a continuing effort to reduce deaths by drowning.

COMMENTS & QUESTIONS

APPENDIX

Table A Categories of Maltreatment Deaths 2004-2006

Table B Geographic Distribution 2004-2006 Maltreatment Deaths

Map B Child Maltreatment Deaths 2004-2006

Table C 2004-2006 Child Maltreatment Deaths by Age and Category

Table D 2004-2006 Child Maltreatment Deaths by Age and Year

Table E 2004-2006 Child Maltreatment Deaths by Race and Category

Table F 2004-2006 Child Maltreatment Deaths by Race and Year

Table G 2004-2006 Child Homicides by Perpetrator

Table H 2004-2006 Maltreatment Deaths of Children with Special Health Care Needs

Table I 2006 Maltreatment Deaths of Children with Special Health Care Needs and CPS Involvement