

Sacramento County Child Death Review Team 2004 Annual Report

The following report includes brief descriptions on some of the cases that were reviewed by the Child Death Review Team throughout the 2004 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.

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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 2004. Included are descriptions of all deaths whether they were the result of child abuse and neglect, injuries, homicides or natural causes.

2004 marks the fifteenth 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 2004, 176 children died at a rate of 48.9 per 100,000 children in Sacramento County. Twenty-three more lives were lost in 2004 than in 2003 (153 total deaths) and eight less lives were lost in 2004 than in 2002 (184 deaths). The three causes of child deaths in 2004 were natural causes (123), injuries (43), and undetermined manner (10).

This year there were 123 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 formulate the majority of deaths in the County, resulting in 70% of all deaths for this year.

Injury-related deaths resulted in 43 child fatalities, accounting for 24% of the total child deaths for this year. One of the most disturbing details 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. Four of the 43 injury-related deaths were the direct result of a CAN homicide, up from one CAN homicide in 2003.

There were ten child fatalities that resulted from an undetermined manner, accounting for 6% of the total child deaths. All ten 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 2004 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 176 child deaths in Sacramento County at a child death rate of 48.88 per 100,000 children. In 2003, there were 153 child deaths with a rate of 43.3 per 100,000 children. In 2002, there were 184 child deaths with a death rate of 52.6 per 100,000. Major findings of the types of deaths that occurred in Sacramento County this year follows.

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

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 attributed to Child Abuse and Neglect (CAN) homicides. 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.

Thirty-eight (25%) of the 153 child deaths in 2003 were preventable. Thirty-six (36) of these deaths were injury-related, such as motor vehicle accidents, homicides, suicides or drownings. One death was due to a Child Abuse and Neglect (CAN) homicide. Two deaths were due to intrauterine exposure to communicable diseases (herpes and chicken pox).

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

In 2004, there were 43 (24%) injury-related deaths. This is an increase of 7 deaths when compared to last year's total of 36 injury-related child deaths. These deaths include motor vehicle accidents, homicides, drownings, suicides and other injuries.

➤ **Child Abuse and Neglect (CAN) homicides are on a downward trend.**

An analysis of CAN homicides from 1996-2004 utilizing a rolling three-year approach was done to observe trends in CAN homicide data. There has been a decrease in the CAN homicide three-year average since the 1998/99/2000 three-year period. During this period (1998/99/2000), there was an average of 8.7 deaths, down from 11.3 during the 1997/98/99 three-year period. During the 1999/2000/01 period, there was an average of 9.3 deaths per year, 2000/01/02 6.3 deaths per year, 4.6 deaths per year during the 2001/02/03 period and an average of 3.0 deaths per year during the 2002/03/04 three-year period.

Since 1990, there have been a total of 123 CAN homicides. A t-distribution analysis was used to test the downward trend in CAN homicide deaths. This analysis confirms a significant decrease in the number of CAN homicides.

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 hand of either one or both parents and one child

died at the hands of a family friend. Three victims had involvement with Child Protective Services prior to their death.

➤ **The majority of perpetrators of Child Abuse and Neglect Homicides are parents of the decedent.**

Between 1990 and 2004 it has been found that the majority of perpetrators (58%) 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, the boyfriend or the girlfriend of a biological parent, this figure jumps to 76% of all perpetrators of CAN homicides.

➤ **History of substance abuse is present in one-quarter of all child fatalities.**

Family history of drug or alcohol abuse was present in 46 of the 176 child deaths (26%) in Sacramento County in 2004. The causes of death with this risk factor present include 17 deaths due to perinatal conditions, eight sleep-related deaths (including one SIDS case), four deaths due to congenital anomalies and two Child Abuse and Neglect (CAN) homicides.

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

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 of age were: perinatal conditions, 54 (53% of all infant deaths); congenital anomalies, 22 (22%); and sleep-related, including 3 SIDS cases, 13 (13%).

In 2003, children under one year of age comprised 6% of the population under 18 years in Sacramento County and 59% of child deaths (90 out of 153). The major causes of child deaths under one year of age were: perinatal conditions, 38 (42% of all infant deaths); congenital anomalies, 24 (27%); and sleep-related, including 10 SIDS cases, 22 (24%).

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

As documented in previous years, African American infants continue to be at a higher level of risk of death amongst all ethnic groups in Sacramento County. In 2004, African American infants comprised 11% of Sacramento County's infant population and 28% of all infant deaths. The rate of death per 1,000 African American infants was 11.6 in 2004 and 9.6 per 1,000 in 2003.

The 2004 infant death rates for Caucasian, Hispanic and Asian children were under the county average of 4.79. The death rates were 4.42 for Caucasian infants, 2.05 for Hispanic infants and 4.39 for Asian infants, per 1,000 infants, respectively.

The 2003 infant death rates for Caucasian, Hispanic and Asian children were under the county average of 4.35. The death rates were 3.86 for Caucasian infants, 2.36 for Hispanic infants and 3.83 for Asian infants, per 1,000 infants, respectively.

➤ **Multiracial children have a higher death rate compared to other ethnic groups.**

Children of a multi-ethnic background have a higher rate of death among children in Sacramento County. In 2004, children of a multi-ethnic background had a death rate of 1.0 per 1,000 children under 18 years of age in Sacramento County. The death rate among African American children was 0.9, Caucasian and Asian children each had a death rate of 0.5 per 1,000 children, and children of Hispanic or Latino ethnicity had a death rate of 0.2 per 1,000 children.

In 2003, children of a multi-ethnic background had a death rate of 0.5 per 1,000 children under 18 years of age in Sacramento County. The death rate among African American children was 0.7, Asian children 0.5, Caucasian children 0.4, and children of Hispanic or Latino ethnicity had a death rate of 0.2, per 1,000 children, respectively.

➤ **Reckless driving is a contributing factor in vehicle deaths among teenagers.**

Reckless driving, such as speeding, not wearing a seat belt, going against traffic and not wearing a helmet while on a motorcycle have been identified in nearly half of teenage motor vehicle deaths since 1995 (35 of 71 deaths). In 2004, there were a total of 10 motor vehicle deaths. Five of the 10 were motor vehicle occupant deaths. Of the five occupant deaths, all five involved children 15 through 17 years of age. Reckless behavior was a contributing factor in all five (100%) 15 – 17 year old motor vehicle occupant deaths. The use of mind-altering legal or illegal substances by teenagers was found in three of the five deaths (60%).

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 and family resource centers.**

Twenty-six percent of all child deaths in 2004 were preventable. They were the result of poor judgment and/or behaviors by adults. The CDRT recommends the continuation and expansion of public education campaigns, such as the Shaken Baby Syndrome prevention campaign, funded by Sutter Medical Center, Sacramento. This grant targets all new mothers in Sacramento County and educates them on infant crying and the risks of shaking your baby. This program garners a promise from the parent that they will not shake their baby, and they will educate other possible caretakers of their children about Shaken Baby Syndrome. The CDRT recommends that campaigns such as this be geared towards parents, grandparents, caregivers, home visitors and hospital staff. 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 and public health nurses). These efforts should be targeted to those Sacramento communities most at risk.

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

Twenty-six percent of all child deaths in 2004 involved a history of substance use in the child's family. Nine percent of the child deaths involved drug or alcohol use. 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 that substance abuse by parents and/or caregivers presents a threat to children. The CDRT further recognizes the complexity of substance abuse issues and recommends 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. The CDRT supports the continuation and expansion of ongoing efforts of public and private substance abuse programs in assisting parents and/or caregivers in eliminating substance abuse. The CDRT acknowledges that many preventable deaths could be reduced if parents and/or caregivers were provided with substance abuse education, treatment and/or intervention.

➤ **Mobilize the African American community to better assess and coordinate services and delivery to African American families.**

The CDRT recommends that African American leaders with faith and community based organizations mobilize to educate the African American community on the disproportionate number of African American children that are dying in Sacramento County. The purpose of this education is to determine better ways of efficient service delivery and coordination. These efforts should be coordinated with existing groups such as the Black Infant Health program, the Perinatal Periods of Risk Committee, Child Welfare Services Redesign and other similar programs.

➤ **Coordinate and expand 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, 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. The CDRT recognizes and supports the efforts of the Family Support Collaborative 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.

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 recommends this policy be extended to include pool owners whose pools were installed prior to the new policy.

➤ **Conduct educational efforts to reduce modifiable reckless and negligent teenage behaviors.**

The CDRT has noticed that since 1995 nearly half of all teenage motor vehicle deaths involved some form of reckless driving. Reckless driving behaviors identified by the CDRT include speeding, street racing, unsafe driving for road conditions, going against traffic, and not wearing a seat restraint. The CDRT recommends that efforts be made to enforce current laws against reckless driving behaviors. Strong enforcement of these laws would prevent unnecessary deaths in teenagers and encourage their safety. The CDRT applauds current programs that target substance abuse among teenage drivers, yet believe more public education needs to be aimed at neglectful and reckless behaviors that do not necessarily include substance abuse.

Suicides among teenagers are preventable. The CDRT recognizes that there is a need to better educate teenagers and communities on the warning signs of teenage suicide and the support that is available. The Sacramento CDRT recommends that Sacramento County follow the example of Placer County and establish a Teenage Suicide Prevention Task Force, to further efforts in teenage suicide prevention within the community as well as within each school district.

INTRODUCTION

Two-month old twins Charlotte and Carrie were living in a one-bedroom apartment with their parents Joe and Molly, and their three-year old brother John. Molly was a young mother with developmental delays, and had been physically and mentally abused as a child.

Molly had been connected to many different services in Sacramento County, and had received adequate prenatal care for her twin girls, who were born healthy. However, the stress of having three children at home was getting to Molly. She was unable to keep appointments with her mental health provider. She was unable to keep appointments at the clinic for Women, Infants and Children. Even though Molly had been connected to several programs that brought services to her home, she was unwilling to keep appointments with these in-home service providers. Around this time, several reports were made to Child Protective Services on Joe and Molly for child neglect. The neglect case was substantiated, and Charlotte and Carrie were removed from their home. During this time, Joe was arrested and sent to jail for an unrelated matter.

Five days after the children were removed from the home, they were reunited with their family, with the understanding that service providers would increase their presence in the home. While the frequency of visits to the home increased after the twins were reunited with their family, there were still missed appointments and refused visits. A month and a half after the children were removed from their home, Charlotte and Carrie were found dead – victims of severe neglect.

While reviewing this case, the Sacramento County Child Death Review Team noted that there was a lack of coordination of care among the different agencies serving this family, and that information may not have been passed between service providers in the most effective manner. The team also noted that there needs to be a more effective process for decision making, and more education to the public about issues related to the failure to thrive among infants and children.

There are many lessons to be learned about child fatality through the Sacramento County CDRT review process each year. Through careful review, hopefully we can improve collaboration and coordination among agencies, as well as improve information sharing in order to prevent families from “falling through the cracks” in the future.

Sheila Anderson
President and CEO
Child Abuse Prevention Center

Chapter I

Deaths Related to Abuse and Neglect

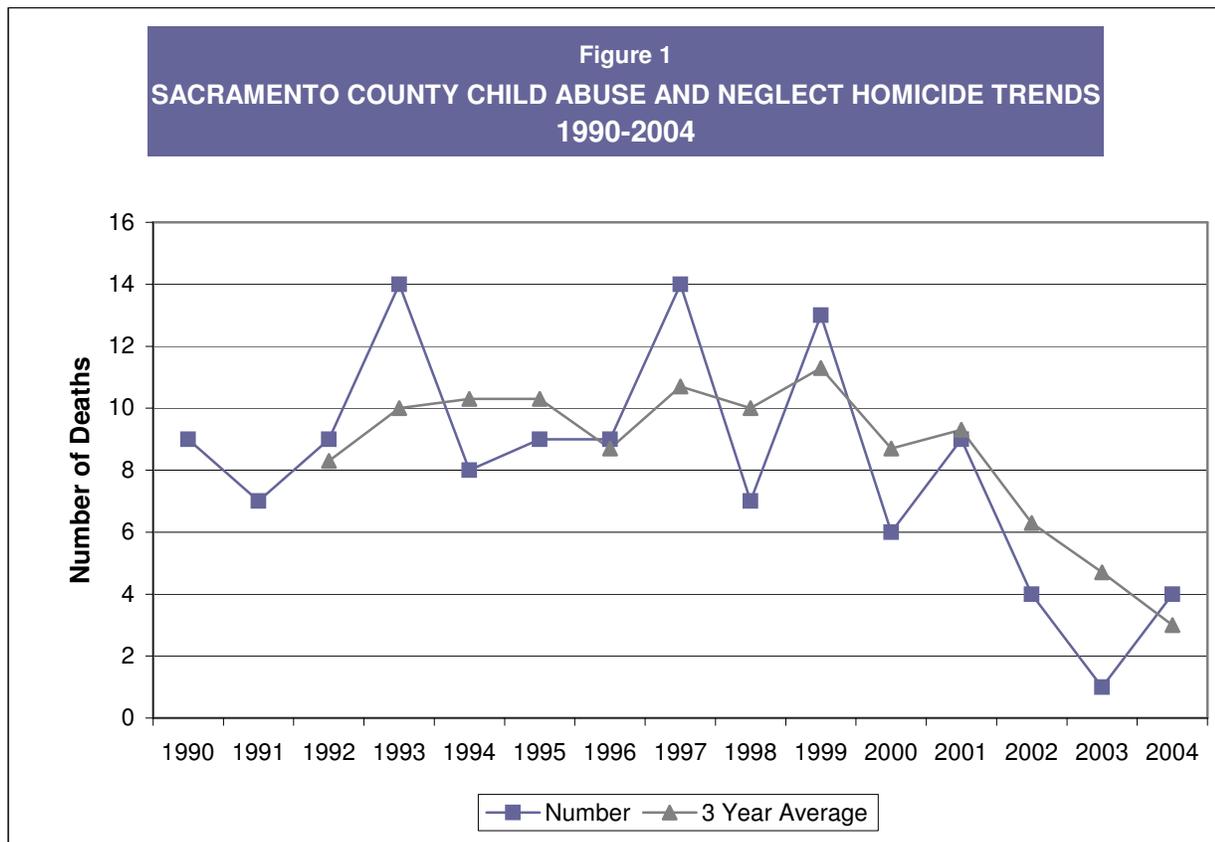
Chapter One

Deaths Related to Abuse and Neglect

Three-year old Joey was full of energy. His mom needed some respite, so she sent Joey and his brother Alex to Joey’s godparent’s house for a week during the summer. Joey’s godparents could not deal with all of Joey’s energy. They slapped him repeatedly, and threw him across the room when he tried to play with them. When Joey’s mom came for a visit during the week, she refused to take him home, even though she saw multiple bruises on his body. Eventually, after multiple injuries, Joey’s brain swelled and Joey died.

One of the principal functions of the Sacramento County CDRT is to ensure that all child maltreatment related deaths are identified. Recognizing the risks inherent to children living with a violent or substance abusing adult, the CDRT routinely collects information on drug and/or alcohol history, 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 2004, 176 children died in Sacramento County. Four deaths were due to child abuse and neglect (CAN) homicides. While this is an increase from 2003, where there was one CAN homicide, there has been a significant downward trend in the number of CAN homicides since 2001, which can be seen in the figure below.



Although a decrease in CAN homicides is welcomed, it is difficult to determine the exact cause. There have been several important changes in our community regarding child abuse prevention that may have contributed to this change. Home visitation programs, proven to reduce the incidence of child abuse and neglect, have expanded in Sacramento County since the late 1990's and are now available to all first-time parents. An increase in public knowledge regarding child abuse as well as intense media coverage of past high-profile cases may have increased early reporting of child abuse and neglect, and prevented homicides. Child Protective Services has developed a program of structured decision-making as well as intensified immediate response to high-risk cases. The Sacramento County Board of Supervisors has supported Child Protective Services in their policy of child safety over family reunification. An increased pool of funding available for prevention programs for young children, especially the population of children under five years of age, which have been seen as the most vulnerable population, has also become available.

Child maltreatment was involved in the lives and deaths of 11 of the children who died this year. More specifically, four children died as a result of a child abuse and neglect homicide, one died indirectly from neglectful behaviors, five children died where neglect-related behaviors were present, and one child died from a cause related to prenatal substance abuse. It is important to note that, aside from the four child abuse and neglect homicides, the remaining seven deaths were caused by something other than a homicidal behavior. In a case where a death is not a homicide, but the child experienced some type of abusive or neglectful behavior, the CDRT will classify the deaths as being abuse or neglect related. A case is further investigated to determine if additional elements of neglect were present, such as a failure by the parent or caretaker to provide for the basic needs of the child, or where physical injury or other injury is either likely (severe neglect) or unlikely (general neglect) to occur. Examples of cases involving an element of neglect in 2004 included parents of a child with cerebral palsy not following with the medical regimen for the child. 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, or when there is a clear medical link between prenatal substance abuse and the child's death. Examples of neglect-related deaths in 2004 included a mother abusing alcohol and drugs while pregnant, complicating her pregnancy and causing her child to be inflicted with cerebral palsy, parents leaving their five year-old child in the care of a thirteen year old who shoots the child with a gun left in an unlocked drawer, parents not fencing in their pool and leaving ample time for their one year-old child to fall into the pool and drown, and a parent leaving a ladder by the pool, allowing a one year-old to climb into the pool and drown.

Risk factors were present in nine of the 11 deaths due to child maltreatment (82%). Examples of risk factors include alcohol and other drug involvement, or a history of abuse and neglect, domestic violence or violent crime. The following is a representation of how the risk factors are broken out across the nine deaths:

- 4 families had a known history of abuse or neglect
- 2 families had a history of drug or alcohol abuse
- 1 family had a history of abuse or neglect and a history of drug or alcohol abuse
- 1 family had a history of abuse or neglect, domestic violence, drug or alcohol abuse and a history of violent crime

- 1 family had a history of drug or alcohol abuse and violent crime

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 (caregivers can include family friends). Third party homicides, those deaths perpetrated by strangers, acquaintances, or friends, are discussed later in this report.

Victims

This year, four children residing in Sacramento County were CAN homicide victims. Three victims were female and one victim was a male. Two victims were infants, one was in the one through four age category, and one victim was between the ages of five and nine. Three victims were multi-racial and one was of African-American ethnicity.

Perpetrators

In 2004, perpetrators of CAN homicides included the mother of a child, a family friend and in two cases, both parents. This year two children died due to severely neglectful behavior by their caretaker, one child died at the hands of their caretaker, and one death was caused by a method that was undetermined. Data collected since 1990 shows that most CAN homicides are caused by injuries where the perpetrator used his or her bare hands. Deaths caused by battering and shaking are the most common, followed by injuries caused by fatal gunshot wounds.

Certain “triggering events,” such as prolonged fussiness, feeding problems and toileting difficulties often precede fatal child abuse. For the purposes of this report the “triggering event” is the event or situation that prompted the perpetrator’s action that led most directly to the child’s death. In 2004, there were no known triggering factors involved in the CAN homicides.

One CAN homicide involved a child murder/care-taker suicide in 2004. In this particular case, a child died at the hands of her mother, who then proceeded to commit suicide. The method that was employed to kill the child was undetermined. For the purposes of this report, CAN murder/suicides are defined as a fatal child abuse incident after which the offender takes his or her own life. Although CAN murder/suicides are relatively infrequent events in Sacramento County (occurring less than once a year on average), some common denominators separate them from other CAN homicides. As a group, CAN murder/suicides are more likely to involve multiple victims and more likely to involve firearms. Most appear to be triggered by domestic disputes.

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 2004, four risk factors were identified in CAN homicides: a history of abuse or neglect (evident in three of the four CAN cases), a history of drugs and/or alcohol abuse (in two of the four cases), a history of violent crime (in two of the four cases) and a history of mental health issues with regard to the primary caregiver (in two of the four 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.

In 2004, three of the four CAN homicide cases had involvement with Child Protective Services. Two had involvement for severe neglect related to the decedents, and one had involvement in CPS for abuse related to the decedent and their sibling.

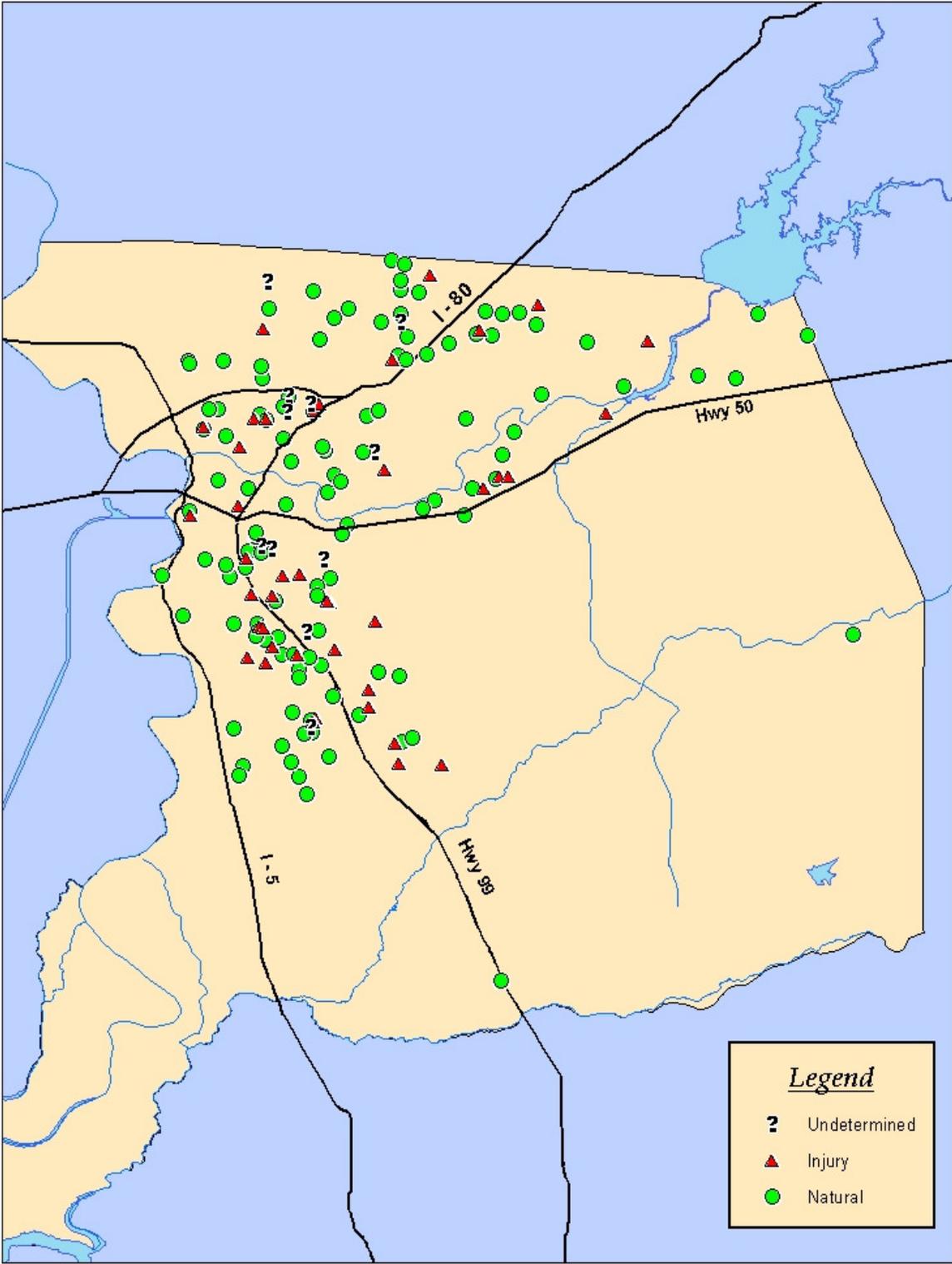
Investigation and Prosecution

Perpetrators involved in the three CAN homicides for which there is a living perpetrator have trial dates set for late 2005.

Chapter II

All Causes of Child Death

Map i:
All Causes of Death
Sacramento County 2004



Chapter Two

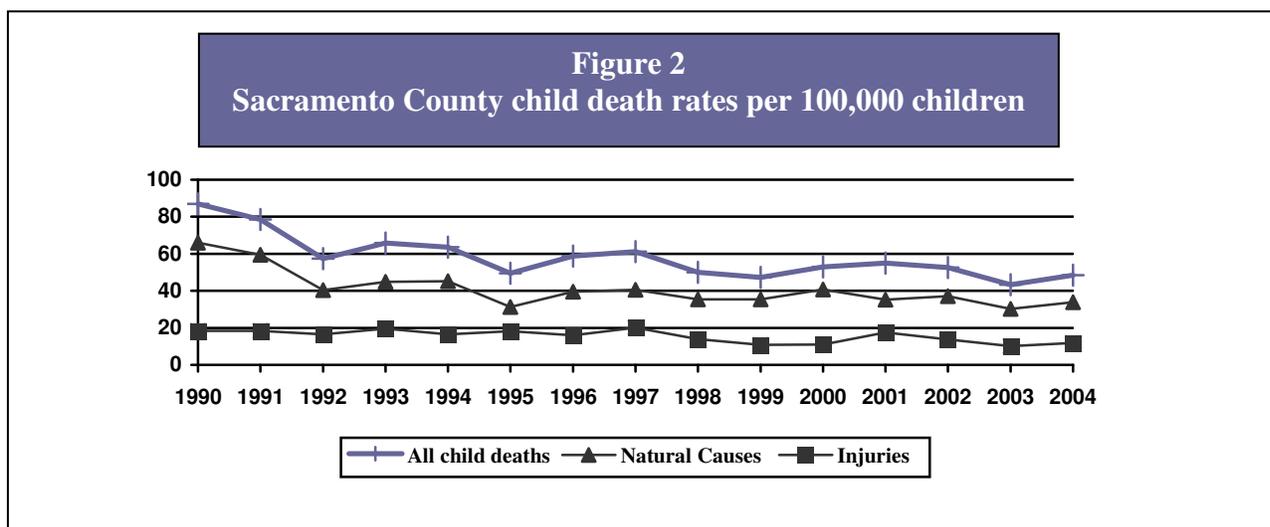
All Causes of Child Death

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 2004.

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 2004, there were 176 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, between ages 0 and 17, 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 2004 was 48.88 per 100,000 children. This rate is higher than the 2003 rate of 43.25, but lower than the 2002 rate of 52.6 and the 2001 rate of 55.0. The raw data and corresponding death rates have been provided in Table A.

Deaths can be classified as Natural, 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 2004, 70% of all child deaths were due to natural causes. This is the same percentage of deaths due to natural causes as found in 2003. Injury-related fatalities accounted for 24% of all child deaths. Again, this is the same percentage as in 2003. The remaining 6% of child deaths were classified as undetermined.

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 current population demographics provided by the State of California Department of Finance. Rates are based per 100,000 children, except for infants whose rates are based per 1,000 live births.

Table A
2004 Child Deaths by Cause and Manner – Sacramento County
Per 100,000 Children

Category	Number of Deaths	Rates*
Natural Causes		
Perinatal Conditions	62	17.2
Congenital Anomalies	31	8.6
SIDS	3	--
Cancer	10	--
Infections	10	--
Respiratory	1	--
Other	6	--
Undetermined Natural	0	--
Total Natural Causes	123	33.9
Injury-Related Causes		
CAN Homicide	4	--
Third Party Homicide	11	--
Arson Homicide	0	--
MVA (Occupant)	5	--
MVA (Pedestrian)	4	--
MVA (Bike)	1	--
Drowning	7	--
Suicide	4	--
Suffocation/Choking	0	--
Fires	0	--
Undetermined Injuries	1	--
Other Injuries	6	--
Total Injury-Related Causes	43	11.9
Undetermined Manner	10	--
TOTAL	176	48.88

* 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 and twenty-three (123) children in Sacramento County died from natural causes in 2004. 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 period shortly before through shortly after birth. This time interval begins with the completion of the 20th to 28th week of gestation and ends 7 to 28 days after birth.

In 2004, perinatal conditions accounted for the deaths of 62 children. Prematurity was a contributing factor in 45 (26%) of the 176 child deaths this year. The median gestational age of babies who died from prematurity and other perinatal conditions was 20.5 weeks. The median weight of babies who died from prematurity and other perinatal conditions was 652.5 grams (approximately 1.44 pounds).

The following information was available on the 62 deaths due to perinatal conditions in 2004:

- 17 families had a case history of substance abuse
- 9 families had a history of domestic violence
- 5 mothers had positive toxicology reports at birth for alcohol or drugs
- 1 child had a positive toxicology report for drugs at birth

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 31 deaths caused by congenital anomalies in 2004:

- 7 families had a criminal history (violent or non-violent)
- 4 families had a case 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 an infant one year of age or younger which is unexpected by the infant’s history 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 2004 there were three SIDS deaths in Sacramento County. All three (100%) of the victims died in environments recognized nationally to increase the risk of SIDS.

The following information was available on the 3 SIDS deaths in 2004:

- 2 infants were sleeping either facedown or on their side
- 2 infants were sleeping in either adult or makeshift beds with pillows, comforters and other potential dangers
- 1 family had a case history of substance abuse and violent crime

- 1 infant was exposed to tobacco smoke

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, sepsis, and goodpastures syndrome.

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 27 deaths due to cancer, infections, and other natural causes in 2004:

- 5 families had a history of domestic violence
- 5 families had a history of violent or non-violent crime
- 4 families had a case history of substance abuse
- 4 families had a case 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

Three-year-old Dennis was playing with his toy lawnmower in the backyard while his father and uncle constructed a fence around the family pool. While Dennis' family members were constructing the area of fencing facing the back-most part of the yard, Dennis pushed his lawnmower into the pool and drowned.

In 2004 there were 24 unintentional injuries. The two leading causes of unintentional injury-related deaths in 2004 were motor vehicle accidents (10), and drowning (7).

The following information was available for unintentional injuries in 2004:

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

Motor vehicle accidents accounted for 10 of the 24 unintentional injuries for 2004. Five of the victims were either drivers or passengers. All five 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, three (60%) 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 seven of the 24 unintentional injuries for 2004. Three children died in a river, three in a residential pool, and one in standing water in the cover of a residential pool.

Intentional Injuries

Homicides

Homicides represented 15 (6%) of the deaths in 2004. Child homicides for 2004 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 3).

Third Party Homicides

Of the 15 child homicides in 2004, 11 were classified as third-party homicides. Eight of the 11 victims were between the ages of 15 and 17 years, one victim was in the 5-9 year old category, one victim was in the 1-4 age category, and one victim was an infant.

The following information was available for third party homicides in 2004:

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

Suicides

In 2004, four child fatalities were identified as suicides. All four suicides occurred with children 15 through 17 years of age, and all four suicides resulted from hanging. Of the four suicides, one victim had a case history that included physical abuse and substance abuse and one victim had a case history that included substance abuse and non-violent crime. One victim had previously attempted suicide.

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 2004, all 10 deaths of an undetermined manner were sleep-related deaths. There was an abundance of risk factors involved in these 10 deaths including:

- 9 infants were sleeping in either adult or makeshift beds with pillows, comforters and other potential dangers
- 8 infants were co-sleeping with their parents and/or a sibling
- 7 families had a case history of substance abuse and/or domestic violence
- 6 infants were sleeping either facedown or on their side
- 3 infants were exposed to tobacco smoke

Chapter III

Child Death Demographics

Chapter Three

Child Death Demographics

Age

The majority of child deaths occurred in infants accounting for 58% of all deaths. Children 15 through 17 years of age, were the second largest group, accounting for 17% of all deaths in 2004. The third largest group was children one through four years of age, accounting for 15% of all deaths in 2004. The fourth group was children five through nine years of age, accounting for 6% of all deaths. The smallest group in relation to this year's fatalities was children 10 to 14 years of age accounting for 3% of this year's deaths. Table B further illustrates this year's findings.

Table B
Comparison of Child Deaths by Age and Child
Population, 2004

Age Category	Child deaths (#)	Child deaths (%)	Death rate per 1,000 child population
Infant	103	59%	4.8
1-4	27	15%	0.4
5-9	11	6%	0.1
10-14	5	3%	0.1
15-17	30	17%	0.5
Total	176	100%	

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

Natural Causes

A total of 123 deaths resulted from natural causes, with the majority of these deaths occurring in infants. Infants accounted for 85 (69%) of all deaths due to natural causes. The second largest group was children 1 through 4 years of age, accounting for 16 (13%) of all natural deaths. Children five through nine and 15-17 years of age each accounted for 8 (7%) of all natural deaths. Lastly, children 10 through 14 years of age accounted for 4 (3%) of all natural deaths.

Unintentional Injuries

There were a total of 24 deaths resulting from unintentional injuries. Older children accounted for the majority of all unintentional injuries. Children 15 through 17 years of age were the largest group with 10 (42%) of the 24 deaths. The second largest group was children one through four years of age with 9 (38%) of the 24 deaths. The third largest group was infants, with 3 (13%) of the 24

deaths. Children five through nine and ten through fourteen years of age each accounted for 1 (4%) of all unintentional injuries.

Intentional Injuries

There were a total of 19 deaths resulting from intentional injuries. Children 15 through 17 years of age accounted for 12 (63%) of the intentional injury child deaths. Infants accounted for 3 (16%) of the intentional injuries, and children one through four and five through nine years of age each accounted for two (11%) of the intentional injuries. Children 10 through 14 years of age were not represented in the intentional injury category of 2004.

Undetermined Manner

A total of ten deaths were of an undetermined manner. Infants accounted for all ten (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 12% of the child deaths.

Table C
Comparison of child deaths by race and child population

Race/Ethnicity	Child deaths (#)	Child deaths (%)	Death rate per 1,000 child population
Caucasian	65	37%	0.5
African American	45	26%	0.9
Hispanic	20	11%	0.2
Asian	25	14%	0.5
Multiracial	21	12%	1.0
Other	0	0%	
Total	176	100%	

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 poverty¹. In 2004, eight of the 176 children who died (5% of all deaths) had 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 percent². 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 64 (26.1%) of the 245 children that died from child abuse and neglect-related deaths from 1990 through 2004 came from a family with a history of substance abuse. Twenty-eight (11.4%) of the children that died from child abuse and neglect-related deaths from 1990 through 2004 came from a family with a history of domestic violence.

In 2004, 46 of the 176 child deaths (26%) had a history of substance abuse in the child’s family. Five of the 46 (11%) were child abuse and neglect-related deaths. The majority of deaths involving a family history of substance abuse included:

- 17 deaths due to perinatal conditions
- 5 deaths of an undetermined nature (sleep-related)
- 5 third party homicide deaths
- 4 deaths due to congenital anomalies
- 3 deaths due to cancer

In 2004, there were 26 deaths (15%) that had a history of domestic violence in the child’s family. One of the 26 (4%) were child abuse and neglect-related deaths. The majority of these deaths included:

- 9 deaths due to perinatal conditions
- 4 deaths due to an undetermined manner (sleep-related)
- 3 deaths due to congenital anomalies

¹ U.S. Bureau of the Census, *Census 2000 Long Form*

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

- 3 deaths due to cancer
- 3 third-party homicides

Foster Care

In 2004, two of the 176 children who died were in foster care. One child died from an infection and one from natural causes labeled “other.” One child’s death was classified as prenatal substance abuse related.

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 2004 from the following agencies:

Child Abuse Prevention Council of Sacramento, Inc.

Kaiser Permanente

Law Enforcement Chaplaincy of Sacramento

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

Disease Control and Epidemiology

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 2004
Sacramento County

Category	Years													Total		
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002		2003	2004
Perinatal Conditions	79	70	46	46	44	21	42	52	48	40	42	48	56	43	62	739
Congenital	28	33	26	23	24	25	19	30	27	27	33	32	39	32	31	429
SIDS	28	28	21	29	25	18	21	20	19	18	18	18	15	10	3	291
Cancer	11	11	6	9	10	6	9	5	10	10	15	5	10	11	10	138
Infections	8	8	8	3	11	4	7	3	4	6	8	10	6	2	10	98
Respiratory	7	10	3	10	5	7	9	8	4	1	3	0	2	0	1	70
Other	19	10	10	14	21	17	15	12	4	11	16	8	2	7	6	172
Undetermined (Natural)	4	2	0	3	0	0	4	1	1	5	3	0	0	2	0	25
Total Natural Causes	184	172	120	137	140	98	126	131	117	118	138	121	130	107	123	1,962

Table E
Number of injury-related deaths according to category 1990 to 2004
Sacramento County

Category	Year													Total		
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002		2003	2004
Homicides	12	18	13	21	15	20	16	23	11	16	10	16	11	9	15	226
CAN Homicide	(9)	(7)	(9)	(14)	(8)	(9)	(9)	(14)	(7)	(13)	(6)	(9)	(4)	(1)	(4)	(123)
Third Party Homicide	(3)	(11)	(4)	(7)	(7)	(11)	(7)	(9)	(4)	(3)	(4)	(7)	(6)	(8)	(11)	(102)
Arson Homicide	0	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(1)	(0)	(0)	(1)
Motor Vehicle Accidents (MVA)	18	15	14	14	15	23	19	17	11	11	14	21	13	14	10	229
MVA (Occupant)	(11)	(11)	(8)	(7)	(8)	(12)	(15)	(10)	(7)	(4)	(8)	(10)	(11)	(8)	(5)	(135)
MVA (Pedestrian)	(6)	(3)	(6)	(6)	(5)	(8)	(2)	(7)	(1)	(5)	(5)	(8)	(1)	(5)	(4)	(72)
MVA (Bike)	(1)	(1)	(0)	(1)	(2)	(3)	(2)	(0)	(3)	(2)	(1)	(3)	(1)	(1)	(1)	(22)
Drowning	8	7	9	7	7	4	4	6	7	6	5	5	9	4	7	95
Suicide	5	7	3	4	4	3	4	5	8	0	6	5	7	4	4	69
Suffocation/Choking	3	3	0	4	0	0	2	4	2	1	1	3	1	1	0	25
Fires	2	2	1	2	1	0	3	5	4	0	0	1	1	1	0	23
Other	1	0	0	8	5	3	0	5	1	1	1	8	4	2	6	45
Undetermined (Injury)	2	1	9	0	4	4	3	0	2	1	0	1	2	1	1	31
Total Injury-Related Causes	51	53	49	60	51	57	51	65	46	36	37	60	48	36	43	743
Undetermined Manner	7	2	2	4	6	0	4	2	2	3	4	8	6	10	10	70

Table F
Deaths by category and age 2004
Sacramento County

Category	Infant	1-4	5-9	10-14	15-17	Total
Perinatal Conditions	56	2	4			62
Congenital Anomalies	22	4	1	1	3	31
Sudden Infant Death Syndrome	3					3
Cancer	1	4	1	2	2	10
Infections	5	4	1			10
Respiratory			1			1
Other (natural)		2		1	3	6
CAN Homicide	2	1	1			4
Third Party Homicide	1	1	1		8	11
Arson Homicide						0
Motor Vehicle Deaths (occupant)					5	5
Motor Vehicle Deaths (pedestrian)		3			1	4
Motor Vehicle Deaths (bicycle)					1	1
Drowning		3	1	1	2	7
Suicide					4	4
Suffocations						0
Burn						0
Other Injury	2	3			1	6
Legal Intervention						0
Undetermined Injury	1					1
Undetermined Manner	10					10
Total	103	27	11	5	30	176

Table G
Deaths by race/ethnicity and age 2004
Sacramento County

Race Classification	Infant	1-4	5-9	10-14	15-17	Total
Caucasian	36	9	6	1	13	65
African American	28	6	3	3	5	43
Asian/ Pacific Islander	12	5	1	1	6	25
Hispanic	14	3	0	0	3	20
Native American	0	0	0	0	0	0
Multiracial	13	4	1	0	3	21
Other	0	0	0	0	0	0
Total	103	27	11	5	30	176

Table H
Child abuse and neglect homicide victims by age 1990 to 2004
Sacramento County

Period Covered	Infant	1-4	5-9	10-14	15-17	Total
1990-2003	30	56	20	7	6	119
2004	2	1	1			4
Total	32	57	21	7	6	123

Table I
Child abuse and neglect homicide victims by race/ethnicity 1990 to 2004
Sacramento County

Period Covered	White	Hispanic	Black	Asian	Other*	Total
1990-2003	54	18	31	11	5	119
2004			1		3	4
Total	54	18	32	11	8	123

* Including children of mixed racial categories.

Table J
Perpetrators of CAN homicides 1990 to 2004
Sacramento County

Perpetrator	1990-2003	2004	Total Cases	%
Father	35		35	29%
Mother	27	1	28	23%
Boyfriend of Mother or Guardian	16		16	13%
Undetermined	14		14	11%
Both Parents	6	2	8	7%
Babysitter	7		7	6%
Stepfather	4		4	3%
Other Family Member	4		4	3%
Foster Parent	3		3	2%
Girlfriend of Father or Guardian	2		2	2%
Family Friend	1	1	2	2%
Total	119	4	123	100%

Table K
Deaths caused by intentional injuries by mechanism 1990 to 2004
Sacramento County

	3rd Party Homicide	CAN Homicide	Suicide	Total
Firearm	81	23	28	132
Battering	3	33	0	36
Hanging	0	0	37	37
Shaking	0	19	0	19
Strangulation/Suffocation	1	14	0	15
Poisoning/Overdose	0	8	3	11
Stabbing	9	6	0	15
Fire	2	4	0	6
Undetermined	1	1	0	2
Vehicular	4	0	1	5
Drowning	0	5	0	5
Chronic Neglect	0	7	0	7
Other	1	3	0	4
Total	102	123	69	294

Table L
Number of deaths by Sacramento County zip code-2004

Zip	Neighborhood	2004 Deaths	Deaths 2000-2003	Total
95608	Carmichael	1	22	23
95610	Citrus Heights	4	12	16
95621	Citrus Heights	5	11	16
95624	Elk Grove	8	15	23
95626	Elverta	1	4	5
95628	Fair Oaks	2	13	15
95630	Folsom/Clarksville/El Dorado Hills	4	18	22
95632	Twin Cities/Galt/Herald	1	4	5
95638	Herald	0	1	1
95655	Mather	0	1	1
95660	North Highlands	8	24	32
95662	Orangevale	1	10	11
95670	Rancho Cordova	6	28	34
95673	Rio Linda/Robla	3	11	14
95683	Rancho Murieta	1	1	2
95690	Walnut Grove	0	1	1
95693	Wilton	0	1	1
95757	Elk Grove	3	0	3
95758	Bruceville	13	19	32
95763	Folsom	1	0	1
95814	Downtown Sacramento	1	5	6
95815	North Sacramento	6	26	32
95816	Midtown Sacramento	3	2	5
95817	Sacramento/Oak Park	4	12	16
95818	Sacramento/South Land Park	1	7	8
95819	Sacramento/ East Sacramento	0	9	9
95820	Fruitridge	9	37	46
95821	Town and Country Village	2	21	23
95822	Sacramento/Meadowview	4	31	35
95823	Sacramento/Valley Hi	21	60	81
95824	Fruitridge	8	23	31
95825	Arden/Arcade	8	14	22
95826	Perkins/Rosemont	3	16	19
95827	Mills/Walsh Station	4	15	19
95828	Florin	6	33	39
95829	Coffing/Sheldon	1	9	10
95830	Sacramento (Florin & Sunrise)	0	1	1
95831	Greenhaven	1	14	15
95832	Sacramento/Freeport	1	4	5
95833	Arden/ Garden	5	17	22
95834	Sacramento/South Natomas	1	7	8
95835	Sacramento/North Natomas	3	5	8

TABLES

Zip	Neighborhood	2004 Deaths	Deaths 2002-2003	Total
95837	Sacramento International Airport	0	1	1
95838	Del Paso Heights/Hagginwood	10	22	32
95841	Foothill Farms	2	8	10
95842	Sacramento/Foothill Farms/North Highlands	2	25	27
95843	Sacramento/Antelope	7	16	23
95864	Arden/Arcade	1	0	1
Total		176	636	812

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:

1. To ensure that all child abuse-related fatalities are identified;
2. To enhance the investigation of all child deaths through shared information and communication;
3. To develop a statistical description of all child deaths as an overall indicator of the status of children; and
4. To 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. Medical
 - 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. California Children's Services
 - B. Child Protective Services
 - C. Epidemiology and Disease Control
 - D. Public Health Nursing
- III District Attorney's Office**

IV Local Hospitals

- A. Kaiser Permanente
- B. Mercy San Juan Medical Center
- C. Sutter Memorial Hospital
- 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.

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 may 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. Data forms

will be collected by the Child Abuse Prevention Council for compilation and input into the database. If the standing Team representative is not available to attend a meeting, a designated substitute will bring the data forms; in the event that a substitute representative is not available, the standing representative is responsible for the delivery of the data forms to the Child Abuse Prevention Council no later than 1 day prior to the scheduled meeting. 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. Recommendations for any follow-up actions specific to a given case will be recorded on future agendas and Team representatives will destroy all agendas, death certificates and other confidential materials related to case reviews following each meeting. Data collection forms will be kept in a locked file by the Child Abuse Prevention Council.

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.

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 socioeconomic data as well.

The annual report will also include recommendations made by the Team based on the data collected. Should there be any disagreement with a proposed recommendation agreed upon by a majority of the Team representatives, a minority comment may be included in the appendix of the report. 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.

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
Max Hartley

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

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

**Department of Health and Human Services
Epidemiology and Disease Control**
Nolana Daoust, M.P.H.
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
Mike Savage, J.D.
Supervising Deputy District Attorney

Kaiser Permanente
Joan Kutschbach, M.D

Law Enforcement Chaplaincy - Sacramento
Frank Russell
Supervising Senior Chaplain

**Mercy Healthcare Sacramento
Mercy San Juan Medical Center**
Carole Jones, R.N., C.C.R.N.

Sacramento City Fire Department
Ronald Potter
Captain

Sacramento City Police Department
Fernando Enriquez
Sergeant

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

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

Sacramento County Sheriff's Department
Angela Lauinger
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

Sandra Baker
Executive Director
Child and Family Institute

Walt Baer
Detective, Child Abuse Bureau
Sacramento County Sheriff's Department

Michael Balash
Captain
Sacramento Fire Department

Will Bayles
Sacramento County Sheriff's Department

Ken Bernard
Sacramento City Police Department

Chinayera Black
CDRT Coordinator
Child Abuse Prevention Council of Sacramento, Inc.

Bill Brown, M.D.
Chief Coroner
Sacramento County Coroner's Office

Sue Boucher
CDRT Coordinator
Child Abuse Prevention Council of Sacramento, Inc.

Sarah Campbell, M.D.
Northern California Forensic Pathologists
Sacramento County Coroner's Office

Kim Clark
Detective, Sacramento City Police Department

Rod Chong
Division Chief, Sacramento City Fire Department

Linda Copeland, M.D.
Foundation Health Medical Group, Inc.

Sherri Cornell, R.N.
California Children's Services

Laura Coulthard
Bureau Chief, Emergency Response
Department of Health and Human Services

Jacque Cramer, P.H.N.
Director of Field Nursing
Department of Health and Human Services

Mark Curry
Deputy District Attorney, Homicide
District Attorney's Office

Velma Davidson
Director Patient Support Services
University of California, Davis Medical Center

Joe Dean
Sergeant, Homicide Unit
Sacramento County Sheriff's Department

Lynell Diggs
Supervisor, FM/FPCP Division
Department of Health and Human Services

Bob Dimand, M.D.
Chief Pediatrician
Mercy Healthcare/UC Davis Medical Center

Paul Durenberger
Deputy District Attorney, District Attorney's Office

Phil Ehlert
Sacramento County Coroner's Office

Wendy Ellinger, R.N., P.H.N.
Department of Health and Human Services

Norma Ellis, P.H.N.
Field Services Nurse
Department of Health and Human Services

Earl Evans
Sacramento County Sheriff's Department

Mark Fajardo, M.D.

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

APPENDIX

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

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

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

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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
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Kate Moody
Sutter Healthcare

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

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Department of Health and Human Services

Mark O'Sullivan
Senior Chaplain
Law Enforcement Chaplaincy

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

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

Gregory Schmunk, M.D.
Northern California Forensic Pathology

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

Robin Shakely, J.D.
Deputy District Attorney – Major Crimes Unit
District Attorney's Office

Howard Sihner
District Attorney's Office – Juvenile Division

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

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

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.
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University of California Davis Medical Center

Ted Voudouris
Sacramento County Sheriff's Department

APPENDIX

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

Debbie Yip
CWLA Supervisor
Department of Health and Human 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.

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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.

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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.