

Sacramento County Child Death Review Team 2006 Annual Report

The following report includes brief descriptions on some of the cases that were reviewed by the Child Death Review Team throughout the 2006 calendar year. These cases were selected to illustrate the range of circumstances and situations that have placed children at risk. In cases where no criminal intent or negligence was found, the names have been changed in order to protect the identity of the victim and any family members who were not responsible for the death of the child.

To the People of Sacramento County:

This report was completed thanks to a major commitment of time and expertise from a team of dedicated professionals. This group of devoted individuals, and the agencies they represent, comprises the membership of the Sacramento County Child Death Review Team (CDRT) and the Prevention Advisory Committee (PAC). We gratefully acknowledge the entire membership for their input and dedication. The following members were part of the 2006 CDRT and PAC:

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Executive Summary

EXECUTIVE SUMMARY

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

The following report provides an in-depth review of child fatalities in Sacramento County for 2006. Included are descriptions of all deaths whether they were the result of child abuse and neglect, injuries, homicides or natural causes.

2006 marks the seventeenth 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 2006, 181 children residing in Sacramento County died in Sacramento County. Therefore, the 2006 child death rate of Sacramento County, birth through 18 years of age is 47.7 per 100,000 children. In 2005, 167 children residing in Sacramento County died in Sacramento County. Therefore, the 2005 child death rate of Sacramento County, birth through 18 years of age was 45.4 per 100,000 children.

In 2006, 184 children birth through 17 years of age died in Sacramento County. This includes the death of three children who passed away in Sacramento County, but were not current residents of Sacramento County. The three classifications of child deaths in 2006 were natural causes (119), injuries (53), and undetermined manner (12). In 2005, 168 children, birth through 18 years of age died in Sacramento County. This includes the death of one child who passed away in Sacramento County, but was not a current resident. 2006 marks the first year in which deaths of out-of-county residents who perish as a result of an injury that occurred within Sacramento County are included in the body of the report. While the deaths of out-of-county residents will not be included in the death rates or population percentages of Sacramento County residents, information on these deaths will be described within the body of the report.

This year there were 119 child deaths resulting from natural causes such as perinatal conditions, congenital anomalies, SIDS, cancer, infections, and respiratory problems. Deaths resulting from natural causes continue to constitute the majority of deaths in the County, resulting in 65% of all deaths for this year.

Injury-related deaths resulted in 53 child fatalities, accounting for 29% of the total child deaths for this year. The most disturbing detail is the consistent finding that injury-related deaths could have been prevented. This category includes deaths resulting from child abuse and neglect (CAN) homicides, third-party homicides, motor vehicle accidents, drowning, suffocation, burning, suicide and other injuries. Seven of the 53 injury-related deaths were the direct result of a CAN homicide.

There were nine CAN homicides in 2005. The interested reader may refer to the 2006 Supplemental Child Maltreatment report for additional information regarding this topic.

There were 12 child fatalities that resulted from an undetermined manner, accounting for 7% of the total child deaths. Nine of the 12 deaths (75%) were sleep-related.

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 2006 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

The Sacramento County Child Death Review Team (CDRT) reviews deaths of all children under age 18 in Sacramento County. In 2006, there were 181 child deaths in Sacramento County at a child death rate of 47.7 per 100,000 children birth through 17 years of age who reside in Sacramento County. There were three additional injury-related deaths of children who resided outside of Sacramento County, bringing the total number of deaths to 184. In 2005, there were 167 child deaths in Sacramento County at a child death rate of 45.4 per 100,000 children who reside in Sacramento County. There was one additional injury-related death of a child who resided in another county, but whose injury occurred in Sacramento County, bringing the total number of deaths to 168. Major findings of the types of deaths that occurred in Sacramento County in 2006 follows.

Preventable Injury-Related Deaths Findings

➤ **Nearly one-third of all deaths were injury-related and preventable.**

Fifty-three (29%) of the 184 child deaths in 2006 were preventable. All fifty-three (53) preventable deaths were injury-related, such as drownings, motor vehicle accidents, third-party homicides, and child abuse or neglect (CAN) homicides.

Forty-five (27%) of the 168 child deaths in 2005 were preventable. Forty-three (43) of these deaths were injury-related, such as motor vehicle accidents, third-party homicides, child abuse and neglect (CAN) homicides, suicides or drownings. Two of the 43 deaths were due to infections for which there are preventive immunizations.

➤ **Nearly half of all injury-related and preventable deaths were children under five years of age.**

Injury-related and preventable deaths of children under five years of age comprised 47 percent (25 of 53) of injury-related deaths of children under 18 years of age whereas injury-related deaths only comprise 18 percent (25 of 137) of the deaths of children under five years of age. The major causes of injury-related deaths under five years of age were drowning, 11 (44%); and CAN homicides, five (20%).

A disproportionate number of children under five years of age died from injury-related and preventable deaths. Children under five years of age comprised 50 percent (25 of 50) of the injury-related and preventable deaths of Sacramento County residents and only represent 22 percent of the county's child population.

Child Maltreatment Deaths Findings

➤ **There were seven child abuse and neglect (CAN) homicides.**

In 2006, there were seven child abuse and neglect (CAN) homicides, all of which were Sacramento County residents. In 2005, there were nine child abuse and neglect (CAN) homicides, of which eight were Sacramento County residents.

From 2004 to 2006 there were 22 CAN homicides, compared with 14 CAN homicides during the 2001 through 2003 period. Between 1990 and 2006 the majority of perpetrators (60%) of child abuse and neglect (CAN) homicides are the parents of the decedent. This includes the mother or father acting alone, or both parents acting together. Including stepparents and the boyfriend or the girlfriend of a biological parent, this figure jumps to 77 percent of the perpetrators of CAN homicides.

➤ **Nearly two-thirds of the eight homicide decedents (seven CAN homicides and one third-party homicide) had prior Sacramento County Child Protective Services (CPS) involvement.**

Five (63%) of the eight CAN and third-party homicide decedents were open or reported to Sacramento County CPS. Three (38%) of the eight decedents were open or reported to Sacramento County CPS within six months prior to the death. Six (75%) of the eight decedents had prior involvement with at least one California County CPS.

➤ **Nearly half of the injury-related deaths had an element of child maltreatment.**

In 2006, 25 (47%) of the 53 injury-related deaths were found to have elements of maltreatment. Of those 25, seven were child abuse and neglect (CAN) homicides, one was a third-party homicide, and 17 were deaths from other causes that had elements of maltreatment. Other causes include drownings, motor vehicle accidents, poisoning/overdose, medical neglect, and perinatal conditions.

In 2005, 17 (40%) of the 43 injury-related deaths were found to have elements of maltreatment. Of those 17, nine were child abuse and neglect (CAN) homicides, one was a third-party homicide, and seven were deaths from other causes that had elements of maltreatment. Other causes of deaths included strangling/suffocation, drowning, vehicular, and fire.

➤ **Nearly half (8 of 17) of the child maltreatment decedents from other causes were known to any California County Child Protective Service.**

Eight (47%) of the 17 child maltreatment decedents from other causes were known to any California County CPS. Six (75%) of the eight were known to Sacramento County CPS within 6 months of their death.

➤ **Nearly one-third of child maltreatment decedents had special healthcare needs.**

Seven (28%) of the 25 child maltreatment decedents had special healthcare needs, including Cerebral Palsy and Failure to Thrive.

➤ **Nearly three-quarters of child maltreatment decedents with special healthcare needs had Child Protective Service involvement.**

Of seven child maltreatment decedents with special healthcare needs, five (71%) had involvement with any California County CPS. Four (57%) of the seven had Sacramento County CPS involvement. Nearly half (3 of 7) had Sacramento County CPS involvement within six months of their death.

➤ **Abusive head trauma deaths resulting from maltreatment such as beatings and shakings have decreased.**

Child maltreatment deaths due to abusive head trauma decreased from eight cases in 2005 to one case in 2006. In 2005, five (63%) of the eight decedents were infants under one year of age and three (38%) were between one and three years of age. The perpetrator in seven (88%) of the eight deaths from abusive head trauma were one or both of the biological parents. In 2006, the perpetrator of the abuse was a biological parent. Unlike the 2005 cases, in 2006, the child who died from abusive head trauma was between 5 and 9 years of age.

Children Under Five Years of Age Maltreatment Death Finding

➤ **Nearly 70 percent of child maltreatment deaths occurred in children under five years of age.**

Deaths related to child maltreatment of children under five years of age comprised 17 (68%) of the 25 child maltreatment deaths. Of the 17 child maltreatment deaths of children under five years of age, seven (41%) were drowning and five (29%) were CAN homicides.

Perinatal Deaths Finding

➤ **The major cause of child deaths under five years of age was perinatal conditions.**

This year, children under five years of age comprised 76 percent of all Sacramento County resident child deaths (137 of 181) and 27 percent of the Sacramento County population under 18 years of age. The major causes of child deaths under five years of age were perinatal conditions, 65 (47%).

Sleep-Related Infant Deaths, including Sudden Infant Death Syndrome (SIDS) Findings

- **Sleep-related infant deaths, including Sudden Infant Death Syndrome (SIDS), decreased by nearly half.**

A comparison of the three-year time periods (2001 – 2003 and 2004 – 2006) showed that sleep-related infant deaths, including SIDS, decreased 46 percent. From 2004 - 2006, there were 37 sleep-related infant deaths, including SIDS, compared with 68 during 2001 – 2003. Sleep-related infant deaths include deaths from Sudden Infant Death Syndrome (SIDS) and other causes which include accidental suffocation and Sudden Unexpected Deaths (SUDS) in infants.

- **Almost all of sleep-related infant deaths, including Sudden Infant Death Syndrome, occurred in unsafe sleeping environments.**

Twelve (92%) of the 13 sleep-related infant deaths, including SIDS, occurred in unsafe sleeping environments. Seven (54%) of the 13 involved alcohol and/or other drug use by the parent/caregiver at the time of death. Of the thirteen sleep-related infant deaths, 12 infants (92%) were sleeping somewhere other than a crib (9 slept in an adult bed, and 3 slept on a couch). All of the nine undetermined, sleep-related deaths occurred in co-sleeping situations.

Drowning Deaths Findings

- **The number of drowning deaths is the highest in 16 years.**

In 2006, 12 child deaths occurred from drowning – more than any year since 1990. Prior to 2006, nine child deaths from drowning occurred in 1992 and 2002. Four child deaths from drowning occurred in 1995, 1996, and 2003, the lowest number in the 16 years.

- **Over ninety percent of drowning deaths occurred with children three years of age or under.**

There were 12 child deaths from drowning in 2006, of which 11 (92%) occurred with children three years of age or under. Of those 11, seven (64%) involved elements of maltreatment, including lack of supervision and insufficient barriers. In 2005, three (60%) of the five drowning deaths occurred in children three years of age or under. Of those three children three years of age or under, one had an element of maltreatment.

- **Ninety percent of pool drowning deaths had insufficient barriers.**

There were 12 child deaths from drowning, of which nine (75%) occurred in residential or apartment pools. Of the nine drownings of children in residential or apartment pools, 100 percent had insufficient barriers. Eight of the nine pools (89%) either had no fence or an improperly used fence and six of the nine (67%) had unlocked window or doors leading to the outside.

Youth Deaths Findings

- **There is a disproportionate number of injury-related and preventable deaths among youth between 15 and 17 years of age.**

Youth between 15 and 17 years of age comprised 36 percent (18 of 50) of the injury-related and preventable deaths of Sacramento County residents and only 18 percent of the county's child population. In 2005, youth between 15 and 17 years of age comprised 40 percent of the preventable and injury-related deaths of Sacramento County residents and only 18 percent of the county's child population.

- **Seventy-five percent of older youth occupant/driver deaths in Motor Vehicle Accidents involved reckless behavior.**

There were 11 youth deaths from motor vehicle accidents, of which seven (64%) were youth between 13 and 17 years of age. Of the seven, four were occupant/drivers, two were bicyclists, and one was a pedestrian. Of the four occupant/driver deaths of youth in the 15-17 age category, 75% had elements of recklessness, including misuse of a provisional license and street racing, and half were not restrained properly.

- **100 percent of the third-party youth homicides were male.**

In 2006, eight (89%) of the nine third-party homicides were youth victims between 15 and 17 years of age. Of those eight, all were male. Five (63%) of the eight had a crime history within the immediate family (in 3 cases the decedent had a crime history and in 2 cases the parents of the decedent had a crime history). Three-quarters (6 of 8) had a history of gang involvement within the immediate family (3 of the decedents were involved in a gang and 2 of the parents were involved in a gang). Four of the eight were prior victims of child abuse or neglect.

In 2005, seven (78%) of the nine third-party homicides were youth victims between 15 and 17 years of age. Of those seven, 100 percent were male. Three (43%) of the seven had their own crime history and were involved with a gang. One (14%) of the seven was a prior victim of child abuse or neglect.

- **A firearm was used in nearly two-thirds of the third-party youth homicides.**

In 2006, five of the eight (63%) third-party youth homicides of youth between 15 and 17 years of age were the result of the use of a firearm. In 2005, five of the seven (71%) third-party youth homicides between 15 and 17 years of age were a result of the use of a firearm.

Racial and Ethnic Disparity Deaths Finding

- **African American children died in disproportionately higher percentages compared to other ethnic groups.**

In 2006, Sacramento County residents who are African American comprised 17 percent (30 of 181) of all child deaths of Sacramento County residents, and only comprise 11 percent of the

county's child population. The rate of death per 100,000 African American children was 77.59 in 2006. This compares with a death rate of 50.54 per 100,000 White children or 32.98 per 100,000 Hispanic children.

In 2005, African American children comprised 26 percent of all child deaths of Sacramento County residents, and only comprise 14 percent of the county's child population. The rate of death per 100,000 African American children was 83.65 in 2005. This compares with a death rate of 52.82 per 100,000 White children or 14.02 per 100,000 Hispanic children.

2006 Recommendations

Child Maltreatment Recommendations

- **Ensure that Child Protective Services adhere in both written policy and active practice to a course of action based upon what is best for the safety of the child rather than maintenance of the family unit.**
- **The following situations should require that a CPS referral or case be investigated in totality, with an increased level of scrutiny and follow-up with collateral agencies, experts, and providers. This scrutiny should include CPS consultation with each of the child's providers and services agencies to develop a plan for formal case management.**
 - Multiple CPS referrals or reports on a case (even if unfounded or unsubstantiated), and/or
 - Lengthy history of CPS involvement/contact with multiple counties (e.g., family moving from county to county)
 - Cases of “severe neglect”, medical neglect, or history of “severe neglect” reports.
- **DHHS, with leadership of the medical community, should convene a multidisciplinary team to develop a plan on how CPS should respond to reports and cases of suspected child abuse or neglect involving medically fragile children.**

Representatives on the task force should include but not be limited to: Department of Health and Human Services (Division of CPS, Public Health, In-Home Support Services, and California Children's Services), local hospitals, Sierra-Sacramento Valley Medical Society, Alta Regional Center, physicians and others. CDRT strongly recommends that the plan include the following protocol: *When a physician or other medical professional reports suspected child abuse or neglect to CPS – especially current medical neglect, medically fragile, or failure to thrive – the report should result in an immediate response by a CPS social worker and consideration given to forensic medical consultation to review the entire history.*

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

Training should also be provided to other agencies who are assisting parents of children with complex medical needs. Establish respite services for families with a medically fragile child and create a system that allows parents easy access to respite services.

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

- **Require agencies that provide funds to parents/caregivers caring for children with special needs to require proof of care, compliance with treatment plans, attendance at medical appointments, etc.**
- **DHHS should improve training for CPS workers on how to locate families who move from county-to-county and work with other agencies (such as law enforcement) to locate such families.**

The policy regarding cross-county reporting or mechanism for exchange of information between county welfare agencies should be included in this training protocol.
- **Continue to support and provide funding for programs that prevent abusive head trauma, such as shaken baby syndrome.**

Perinatal Recommendation

- **Allocate resources to allow review of all fetal and infant deaths that meet the Fetal Infant Mortality Review (FIMR) criteria, and support ongoing activities in the community to develop best practices to reduce racial disparities in birth outcomes.**

The CDRT recognizes and supports the FIMR committee, which reviews fetal and infant deaths in Sacramento County. After a one-year moratorium, the committee was re-established in 2004 with funding from the State Maternal and Child Health Branch with a mandate to review African American fetal and infant deaths in an effort to find ways of addressing the racial disparities in feto-infant mortality rates. The CDRT recommends that this review criteria be expanded to include all racial and ethnic groups to enable surveillance of all perinatal causes of mortality.

An analysis by the Sacramento County Maternal Child Adolescent Health (MCAH) has shown that there is a racial disparity among perinatal deaths in which African-American infants die at more than twice the rate of any other race or ethnic group. This disparity appears to be related to a disproportionate number of African-American babies born prematurely. The Perinatal, Child and Adolescent Health Committee (PCHAC) in partnership with MCAH has several activities going on to find best practices and make recommendations for reducing disparities in birth outcomes.

Children Under Five Years of Age Recommendations

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

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

continued funding of such programs to help ensure a continued decrease in sleep-related infant deaths.

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

The CDRT recommends the continued support by Sacramento County Board of Supervisors of engaging the community in developing a comprehensive approach to prevention through home visitation and early intervention programs targeted to the most at-risk communities by providing service accessibility through neighborhood-based family resource center services. The CDRT recognizes and supports the efforts of the Family Support Collaborative, Child Welfare Services Redesign, Family Resource Centers, and the more than twenty home visitation programs for their efforts to improve the health and safety of children and families. The CDRT recommends improving avenues of collaboration and communication among the different prevention and early intervention programs in Sacramento County, in order to prevent and address system gaps, and that the Sacramento County Board of Supervisors maintain the infrastructure of the family resource centers and the neighborhood-based services they provide in these at-risk communities.

Drowning Recommendation

➤ **Develop a comprehensive drowning prevention education strategy using best practice methods to prevent drownings.**

The CDRT supports the convening of a committee with representatives from the intentional and unintentional injury fields to develop a drowning prevention education strategy. The committee should include but not be limited to city and county officials; representatives from public health, hospitals, code enforcement, vector control, parks and recreation, universities, American Red Cross, emergency medical services, fire departments, law enforcement, the U.S. Coast Guard, Department of Boating and Waterways, building inspectors, schools, media, swimming pool supply companies, swim instructors, swimming pool builders, parents, caregivers and home visitors. The CDRT recommends developing a prevention education strategy based on best practices to reduce the number of childhood fatalities due to drowning.

Youth Recommendations

➤ **Develop and implement best practice programs that have demonstrated positive outcomes and success in decreasing youth violence.**

The 2006 CDRT findings indicate that youth deaths are largely injury related, preventable, involved a firearm, and in the case of third-party homicides were 100% male. Existing efforts and programs should use these findings to research best practice models to address these factors. The County Executive has been working with county agencies on developing Youth Violence Initiative workshops focused on youth 11-15 years of age and should incorporate innovative collaborative programs and prevention education strategies targeted to male youth violence from firearms. Some examples of promising programs such as mentoring programs, law enforcement and medical education programs, education and

community collaborative programs, and recreational youth programs should be evaluated and supported.

Through the extensive review of youth deaths by the newly formed (2007) Youth Death Review Subcommittee of the CDRT, more comprehensive data will be gathered and reported regarding youth deaths from youth violence and should be used to inform prevention strategies and the development and implementation of future best practice programs.

➤ **Encourage schools and youth serving organizations to utilize best practice strategies for motor vehicle accident (MVA) prevention education targeted to teens and parents.**

The 2006 CDRT findings conclude that seventy-five percent of older youth occupant/driver deaths in MVAs involved reckless behavior. Through a prevention education strategy targeted at youth and their parents, these deaths should be prevented.

Prevention Coordination Recommendation

➤ **County agencies should coordinate county and community services provided to families to address multiple risk factors.**

County agencies from different disciplines, serving the same families for different reasons, should coordinate efforts to share information and serve the family as a whole for the purpose of providing appropriate services, preventing abuse and unintentional injury or death, and holding the family accountable. Additionally, county agencies should develop strong partnerships with community agencies and resources to support families.

INTRODUCTION

Michael was a 6 year-old little boy with cerebral palsy who lived with his mother and her boyfriend. There were multiple CPS reports in another county and a history of domestic violence before they moved to Sacramento. Mother left him briefly alone with the boyfriend, when the child was found unresponsive. He was taken to a local hospital and diagnosed with findings of abusive head trauma, including brain and eye hemorrhages, and old fractures. He was also malnourished.

Andre was a 10 year-old little boy who had survived cancer, but was left with many medical problems following removal of the tumor. He had a complex medical treatment plan to be followed, with life-saving medications to be given when he had colds or other illnesses with fever. His parents brought him to the hospital twice in the past 4 months in critical condition, and he was admitted to intensive care both times. Due to concern about compliance with Andre's medications, his physician made a Sacramento County CPS report of suspected medical neglect. Sacramento County CPS responded, and was not able to locate the family. Three weeks later, Andre was brought to the emergency room and died there from complications of his medical condition.

Two year old Samantha was playing by the apartment complex pool just outside her apartment window with her 4 year-old sister. The two girls regularly jumped out the unlocked first floor window without supervision to play by the pool. The landlord had warned the parents many times to lock the window, but the parents had not heeded the warning. Samantha drowned one day while her 4 year-old sister watched. There were multiple unrelated Sacramento County CPS reports on the family for abuse and neglect.

All three of these cases showed aspects of child maltreatment. Some were egregious enough to warrant criminal charges and prosecution. Some had previous intervention by Children's Protective Services. All were identified by our CDRT to have elements of child abuse, neglect or endangerment that contributed to the child's death. All were preventable.

During our meticulous case review, the CDRT uncovers when a parent or guardian has abused, neglected or endangered the life of a child. Indeed, with all the details before us, the CDRT also uncovers when an agency has failed to protect a child, when a mandated reporter has failed to report a case of child abuse, or when a home visitor failed to make contact with a high risk family. As a team, we have used these tragic cases to produce a powerful annual report that speaks to our policy makers and our community. All of us together, must use this information to improve our response to children in crisis and build healthier, safer communities and families for our children.

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Chapter I

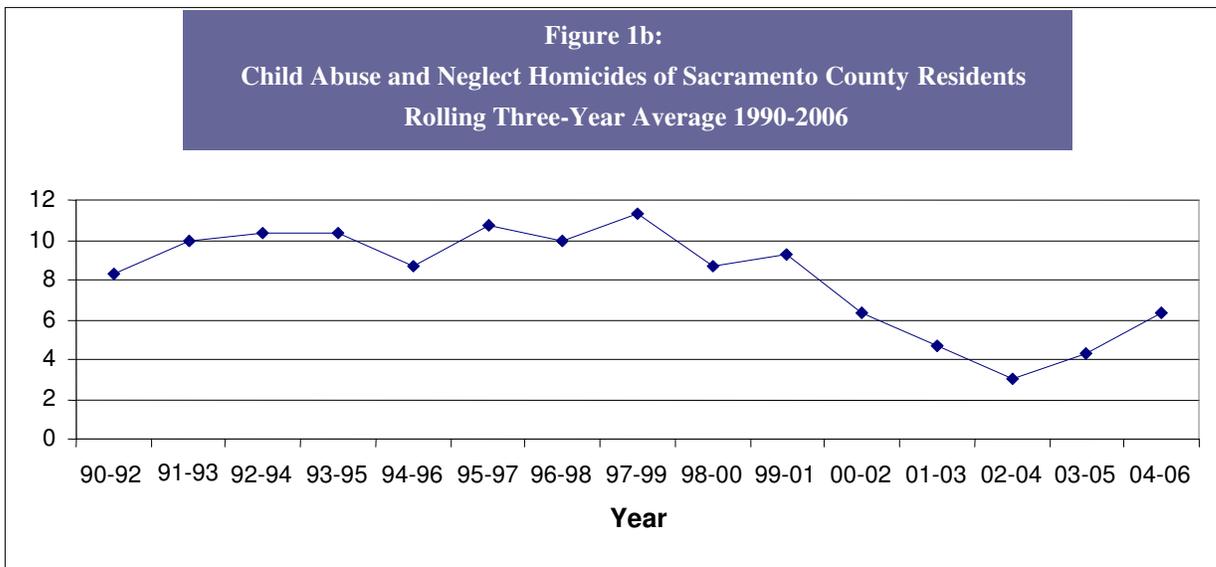
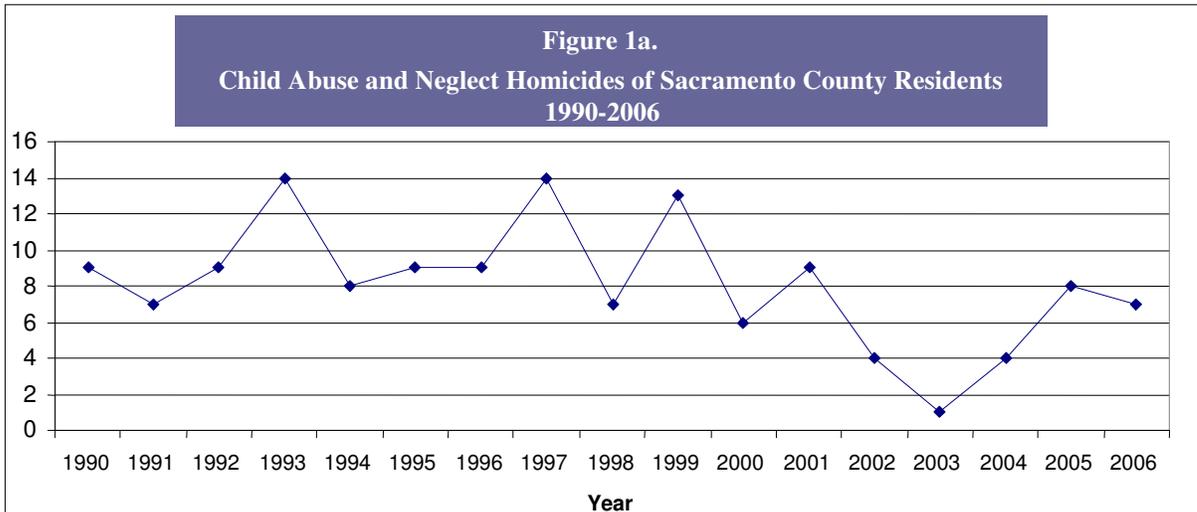
Deaths Related to Abuse and Neglect

Chapter One

Deaths Related to Abuse and Neglect

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

In 2006, there were seven child abuse and neglect (CAN) homicides all of which were Sacramento County residents, out of 181 Sacramento County resident child deaths. In 2005, there were nine CAN homicides, of which eight were Sacramento County residents and one was an out-of-county resident. In 2006, three additional injury deaths of out-of-county residents occurred within Sacramento County (one third-party homicide, one drowning and one motor vehicle accident), raising the total number of deaths of children under 18 years of age to 184.



The umbrella classification of Child Maltreatment deaths are deaths with some element of abuse or neglect involved. The primary category of child maltreatment deaths are child abuse and neglect (CAN) homicides, where a child was killed, either directly, or indirectly, by their caregiver. Deaths not classified as CAN homicides, but considered to have child maltreatment involved fall into one of the following classifications:

Abuse: Death clearly due to abuse; supported by Coroner's reports or police or criminal investigation (e.g., homicide).

Neglect: Death clearly due to neglect; supported by Coroner's reports or police or criminal investigation.

Abuse-Related: Death secondary to documented abuse (e.g., suicide of a previously abused child).

Neglect-Related: Death secondary to documented neglect (e.g., auto accidents or house fires where caretaker was "under the influence"; also includes any case of poor caretaker skills or judgment.

Questionable Neglect: There are no specific findings of abuse or neglect, but there are such factors such as substance use or abuse where substance exposure caused caretaker to experience mental impairment; previously unaccounted for deaths in the same family; or prior abuse/neglect of a child or protective service referral.

Child abuse and neglect was involved in the lives and deaths of 25 of the children who died in Sacramento County this year. More specifically, seven children died as a result of a child abuse and neglect homicide, one child died as a result of third-party homicide with parental involvement, eight children died indirectly from neglectful behaviors, seven children died where neglect-related behaviors were present, and one child died where abuse-related factors were present. Neglectful behaviors were questionable in one additional death. In a case where a death is not a homicide, but the team concluded that the child experienced some type of abusive or neglectful behavior, the CDRT will classify the death as being abuse or neglect related. Elements of neglect include failure by the parent or caretaker to provide for the basic needs of the child, or situations where physical injury occurred. An example of a case involving an element of neglect in 2006 was a case where parents did not recognize their child had a very high fever, which eventually lead to the child's death. The child was suffering from multiple physical ailments, for which additional medication was required. As a result of the parents' failure to administer medications, the child suffered medical complications and subsequent death. A case is defined as neglect-related when the child is left without adequate supervision, food, shelter or medical care and is killed by a suddenly arising danger. An example of a neglect-related death in 2006 was a case where a five year-old was left unsupervised outside with an unfenced pool and he fell into a pool and drowned.

Through the years that Sacramento's CDRT has met and discussed child deaths, certain risk factors have been identified. Known risk factors were present in 17 of the 25 (68%) deaths related to abuse and neglect fatalities in 2006. Examples of risk factors include a family history of alcohol and other drug involvement, or a family history of abuse and neglect, domestic violence or violent crime. The following information was available for 25 of deaths related to abuse and neglect:

- 16 families had a history of abuse or neglect, either on the decedent, or the decedent's sibling
- 11 families had a history of violent and/or non-violent crime
- 8 families had a history of alcohol or drug abuse
- 7 decedents had a history of involvement with any California county CPS

- 7 families had a history of domestic violence
- 6 decedents had involvement with Sacramento County CPS within 6 months prior to the death
- 2 families had a history of mental health problems
- 1 family had a history of gang involvement.

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, babysitter, or family friend. Third-party homicides, defined as those deaths perpetrated by strangers, acquaintances, or friends who were not acting as caregivers, are discussed later in this report.

Victims

This year, seven children residing in Sacramento County were CAN homicide victims. Five victims were female and two victims were male. Five victims were under five years of age, one victim was in the five through nine age category, and one victim was in the ten through fourteen age category. Two victims were Caucasian, two were African American, two were Hispanic and one was of multiracial ethnicity.

Perpetrators

In 2006, of the seven CAN homicides, five children died at the hand of their parent(s), one child died at the hands of the parent's partner and one child died at the hands of another relative.

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 2006, five risk factors were identified in CAN homicides: a family history of abuse or neglect (evident in six of the seven CAN cases), a family history of violent or non-violent crime (in five of the seven cases), a family history of domestic violence (in two of the seven cases), a family history of drugs and/or alcohol abuse (involved in one of the seven cases), and a family history of gang involvement (in one of the seven cases). At least one of these risk factors was present in six of the seven (86%) CAN homicides in 2006.

Prior Agency Involvement

One of the goals of the CDRT is to identify any gaps in delivery of services, which are identified during the review process. For that purpose, the CDRT records agency involvement with families of CAN homicide victims. Of the eight 2006 CAN homicide and third-party homicide decedents, six had involvement with any California County CPS (including Sacramento County CPS) and five decedents had involvement with Sacramento County Child Protective Services (CPS) prior to their death. Three of the five victims had involvement with Sacramento County CPS within six months prior to their death. In one CAN homicide case, CPS involvement was limited to siblings and occurred more than a year prior to the birth of the decedent. The remaining one CAN homicide had no prior involvement with CPS.

Investigation and Prosecution

Of the seven CAN homicides in 2006, charges were not filed in two of the cases. On the remaining five cases, six defendants have been charged with homicide. Three are currently pending jury trial, one is pending preliminary hearing, one has plead guilty to three counts of felony child abuse and is pending sentencing, and one has an outstanding warrant and is unable to be located.

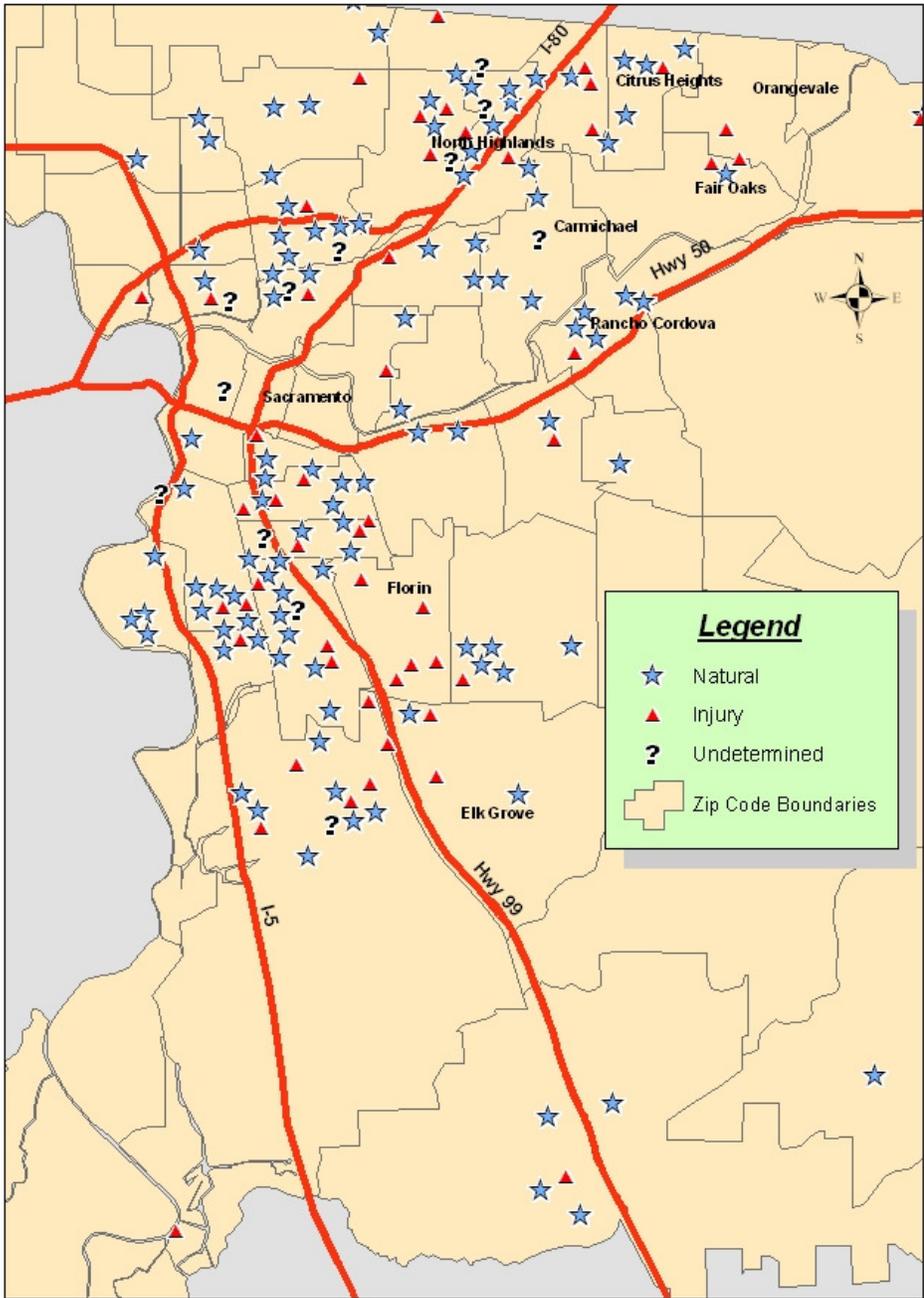
Because cases take time to navigate through the criminal justice system, this annual report attempts to report on the outcomes of all prior identified CAN homicides from prior years. As previously noted, of the ten perpetrators involved in the eight CAN homicides of 2005:

- One was determined to be guilty of first degree torture murder and other related charges and is awaiting sentencing
- Three were determined to be guilty of second degree murder and related charges. Of those three, one received 30 years to life, one received 29 years to life, and one is awaiting sentencing.
- One was determined to be guilty of voluntary manslaughter and was sentenced to 18 years, four months in prison.
- One was determined to be guilty of involuntary manslaughter and is pending trial on felony child abuse causing death charges.
- One was determined to be guilty of involuntary manslaughter and was sentenced to three years state prison.
- One was determined to be guilty of misdemeanor child abuse and was granted probation.
- Two are pending trial on murder and child abuse causing death.

Chapter II

All Causes of Child Death

Map i:
All Causes of Death
Sacramento County 2006



Chapter Two

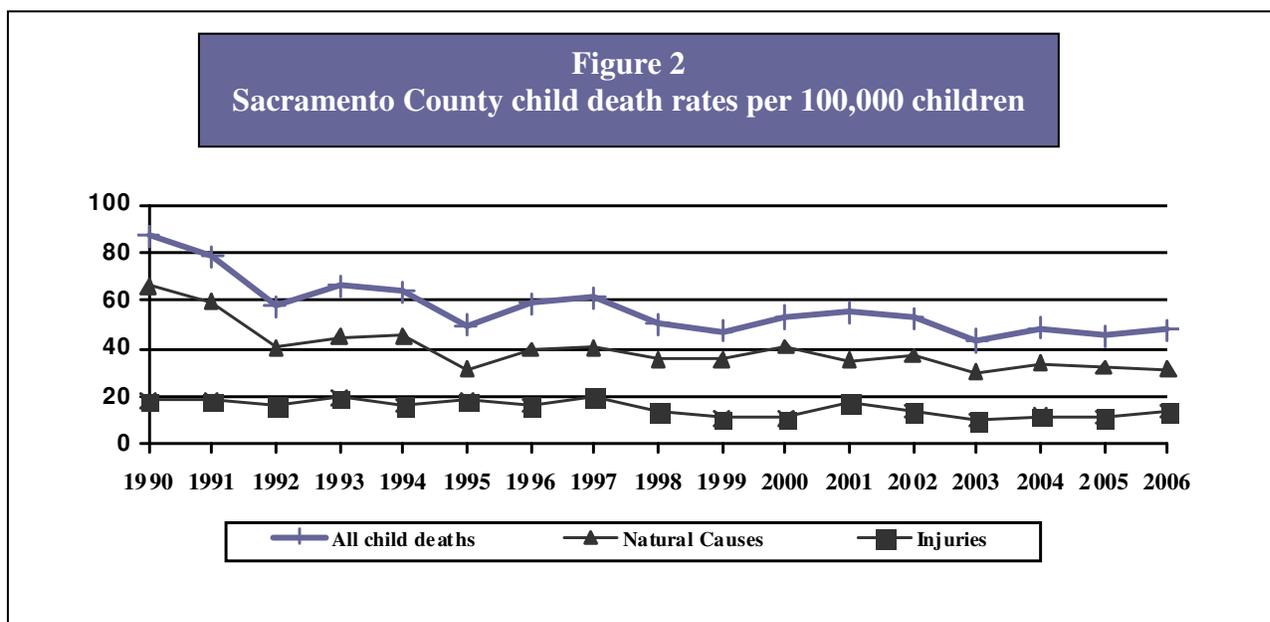
All Causes of Child Death

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 2006.

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 is collected for infant deaths.

Child Death Rates

In 2006, there were 181 child deaths in children under 18 years of age, who were Sacramento residents and died in Sacramento county. The child death rate represents the death rate for Sacramento County residents, under 18 years of age, whose deaths occurred in Sacramento County. Since there are more than 300,000 children in Sacramento County, it is our practice to multiply this quotient by 100,000 in order to detect subtle changes from one year to the next.



The child death rate for 2006 was 47.7 per 100,000 children. This rate is higher than the 2005 rate of 45.4, lower than the 2004 rate of 48.9, higher than the 2003 rate of 43.3, and lower than the 2002 rate of 52.6. The raw data and corresponding death rates have been provided in Table A.

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

In 2006, 65% of all child deaths (including the three deaths of out-of-county residents) were due to natural causes. This is seven percentage points lower than deaths due to natural causes in 2005. Injury-related fatalities accounted for 29% of all child deaths in 2006. This is four percentage points higher than in 2005. Seven percent of child deaths were classified as undetermined in 2006. This is five percentage points higher than in 2005.

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 10 or more child fatalities. All rates were calculated using the 2006 population demographics provided by the State of California Department of Finance. Rates are based per 100,000 children. As these rates are based on the population of Sacramento County residents, the three injury deaths of out-of-county residents that occurred within Sacramento County (one drowning, one third-party homicide and one motor vehicle accident) are not included in these figures.

Table A
2006 Child Deaths by Cause and Manner – Sacramento County
Per 100,000 Children

Category	Number of Deaths	Rates*
Natural Causes		
Perinatal Conditions	65	17.1
Congenital Anomalies	29	7.6
SIDS	3	--
Cancer	9	--
Infections	8	--
Respiratory	2	--
Other	3	--
Undetermined Natural	0	--
Total Natural Causes	119	31.4
Injury-Related Causes		
CAN Homicide	7	--
Third-Party Homicide	9	--
MVA (Occupant)	6	--
MVA (Pedestrian)	3	--
MVA (Bike)	2	--
Drowning	12	2.9**
Suicide	1	--
Suffocation/Choking	3	--
Fires	2	--
Undetermined Injuries	0	--
Poisoning/ Overdose	2	--
Other Injuries	6	--
Total Injury-Related Causes	53	13.2**
Undetermined Manner	12	3.2
TOTAL	184	47.70**

* Rates were not calculated for categories in which there were fewer than 10 deaths.

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

** The death rates included in Table A above represent the Sacramento County deaths of Sacramento County residents. While the three out of county residents who died within Sacramento County are included in the total number of deaths, they are not factored into the death rates.

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 nineteen (119) children in Sacramento County died from natural causes in 2006. The two leading natural causes of death were perinatal conditions and congenital anomalies (birth defects).

On the next few pages, information is provided 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 birth weight, placental abruption and congenital infections. The perinatal period is defined as the time interval beginning with the completion of the 20th to 28th week of gestation and ending 7 to 28 days after birth. In other words, deaths due to perinatal conditions span the time period from the second trimester of pregnancy through one month after birth.

In 2006, perinatal conditions accounted for the deaths of 65 children. Prematurity was a contributing factor in 54 (29%) of the 184 child deaths this year. The median gestational age of babies who died from prematurity and other perinatal conditions was 24.8 weeks. The median weight of babies who died from prematurity and other perinatal conditions was 723.9 grams (approximately 1.60 pounds).

Known risk factors were present in 21 of the 65 deaths due to perinatal conditions in 2006 (32%). The following information was available on those deaths:

- 14 families had a history of violent or non-violent crime
- 6 families had a history of substance abuse
- 4 families had a history of domestic violence
- 3 mothers were teenagers
- 2 mothers had a history of smoking during their pregnancy
- 1 mother had a positive toxicology report at birth for alcohol or drugs

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 structural heart defects, neural tube defects such as anencephaly, and chromosomal abnormalities such as down syndrome. 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 29 deaths caused by congenital anomalies in 2006. Known risk factors were present in 10 of the 29 deaths due to this condition (35%).

- 8 families had a history of substance abuse
- 6 families had a criminal history (violent or non-violent)
- 2 families had a history of domestic violence
- 2 mothers were teenagers

Sudden Infant Death Syndrome (SIDS)

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

- SIDS is classified as a diagnosis of exclusion. This means that the pathologist attributes an infant death to SIDS when an apparently healthy infant dies and a thorough investigation reveals that no other cause of death can be established. Although SIDS deaths tend to be unpredictable, research has demonstrated that certain conditions (sleep position, exposure to tobacco smoke) put some infants at higher risk for SIDS than others.

In 2006 there were three SIDS deaths in Sacramento County. Two of the three victims (67%) died in environments recognized to increase the risk of SIDS, such as an adult bed or broken crib. One of the three victims was put to sleep in a position recognized to increase the risk of SIDS, such as face down or on the side.

Risk factors were present in all three deaths related to SIDS in 2006 as follows:

- 3 infants had a parent with a history of substance abuse

- Illegal drug use was involved in the death of one infant

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.

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

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

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

The following information was available on the 22 deaths due to cancer, infections, and other natural causes in 2006. Known risk factors were present in 11 of the 22 deaths (50%) due to these causes.

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

Injury-Related Deaths

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

Injury-related deaths can be analyzed in terms of three broad categories: intentional, unintentional and undetermined, which includes all injury-related deaths where there was no sufficient evidence to determine whether the fatal injuries were inflicted or accidental. Unintentional injuries are those where the forces causing the injuries are accidentally applied or set in motion. Motor vehicle deaths, drownings, and suffocations are examples of deaths commonly caused by unintentional injuries. Intentional injuries include homicides and suicides.

Unintentional Injuries

Four- year-old Brent was at home, waiting patiently for dinner. Seeing his distress with the time he had to wait, Brent's mom placed some snacks on the table. While snacking, Brent picked up a juicy grape. The grape proved to be too big for Brent's throat, and he choked. Brent's family was unable to free the grape, and he asphyxiated.

In 2006 there were 36 unintentional injuries (including the deaths of two out-of-county residents). The two leading causes of unintentional injury-related deaths in 2006 were drowning (12), and motor vehicle accidents (11).

The following information was available for unintentional injuries in 2006. Risk factors were present in 14 of the 36 deaths (39%) due to unintentional injuries in 2006.

- 9 of the deaths had a family history of child abuse and/or neglect
- 8 victims had a family history that included violent or non-violent crime
- 7 victims had a family history that included substance abuse
- 6 victims had a family history that included domestic violence

Drowning victims accounted for 12 of the 36 unintentional injuries for 2006. Nine children died in a residential pool, and one each in a lake, a pond and a hot tub. Nine of the 12 (75%) drowning deaths involved inadequate fencing or locks. Inadequate supervision was a factor in six of the 12 (50%) deaths.

Motor vehicle accidents accounted for 11 of the 36 unintentional injuries for 2006. Six of the 11 victims (55%) were either drivers or occupants. Three of the other motor vehicle accident victims were pedestrians and two were struck while riding a bicycle. Of the six motor vehicle driver/occupant accidents involving a youth 15-17 years of age: four of the six (67%) motor vehicle occupant victims were between the ages of 15 and 17, three of the four were male, two were not licensed properly, one was driving recklessly, and none involved a driver under the influence of drugs or alcohol.

Intentional Injuries

Homicides

Homicides represented 16 (9%) of the deaths in 2006. Child homicides for 2006 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). Map ii, shown on the following page, is a geographical representation of all CAN homicides and third-party homicides under 18 years of age that occurred in Sacramento County in 2006, including the death of one out-of-county resident.

Third-Party Homicides

Of the 16 child homicides in 2006, nine were classified as third-party homicides. Seven of the nine victims were between the ages of 15 and 17, one victim was in the 10-14 age category and one victim was in the 1-4 age category.

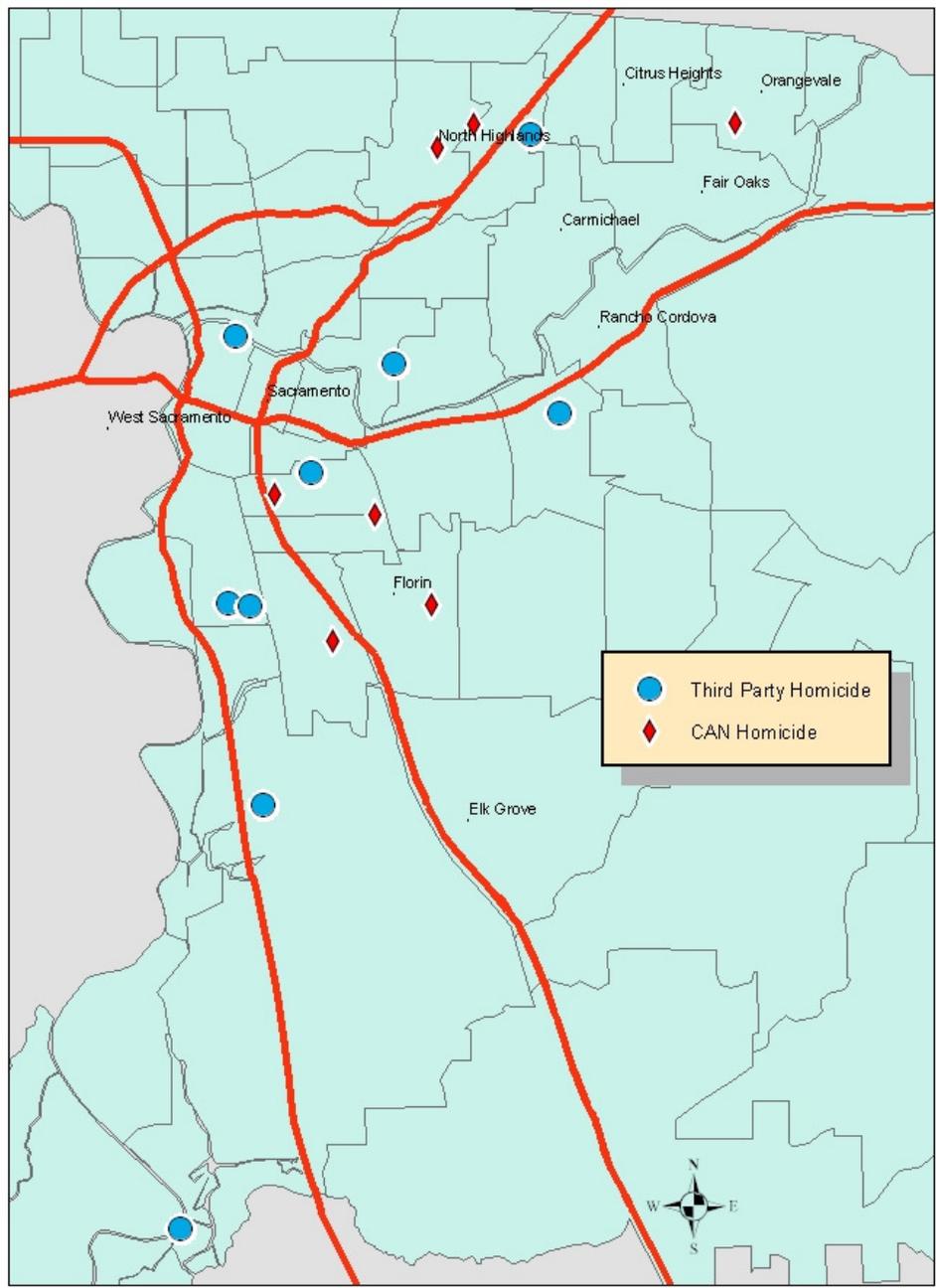
The following information was available for third-party homicides in 2006. At least one risk factor was present in eight of the nine (89%) third party homicides in 2006.

- 6 victims had a history of gang involvement
- 5 victims had a family history of criminal activity
- 4 victims came from families with a history of substance abuse
- 4 victims had drugs or alcohol involved in their death
- 3 victims came from families with a history of domestic violence

Suicides

In 2006, one child fatality was identified as a suicide. The method of suicide was hanging. The decedent was 15 to 17 years of age.

**Map ii:
Child Abuse and Neglect Homicides and Third-Party Homicides
Sacramento County 2006**



Deaths of Undetermined Manner

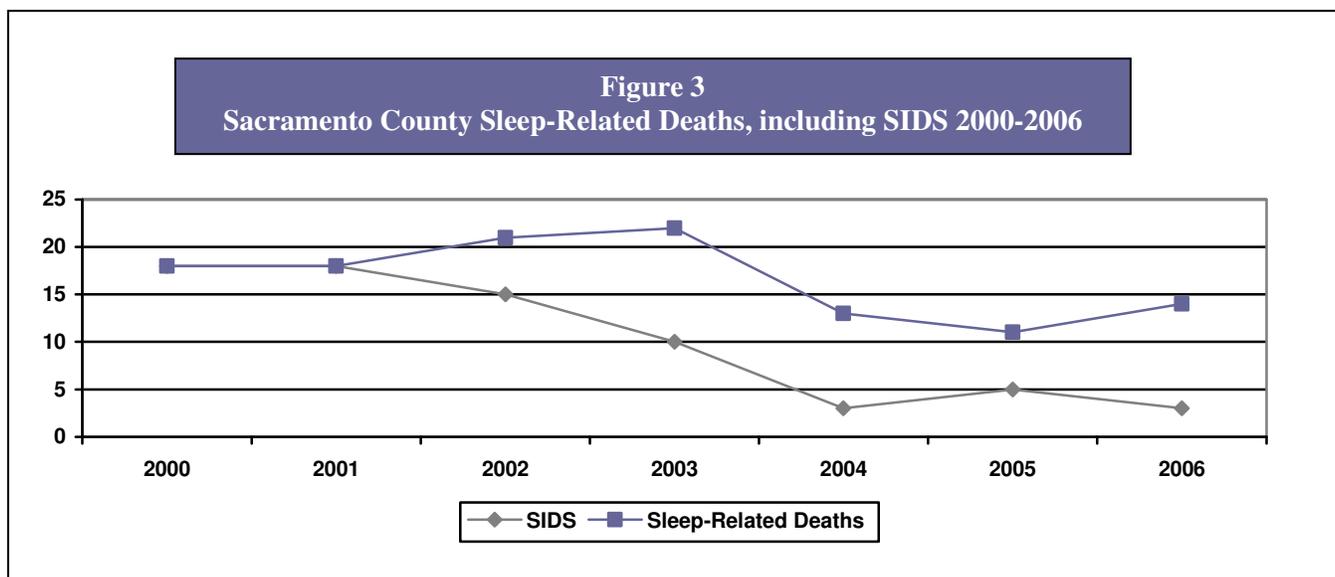
Definition: Death in which the cause/manner may not be medically identifiable.

In this category the manner of death may not be determined due to uncertainty 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 or accidental. Also included in this category are sleep-related infant deaths where there was not enough evidence to determine whether the death was caused by parental overlay or SIDS.

In 2006, nine of the twelve deaths (75%) of an undetermined manner were sleep-related infant deaths. Risk factors were present in all nine deaths as follows:

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

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



Chapter III

Child Death Demographics

Chapter Three

Child Death Demographics

Age

The majority of child deaths occurred in infants under one year of age, accounting for 55% of all deaths. Children one through four years of age were the second largest group, accounting for 20% of all deaths in 2006. The third largest group was children 15 through 17 years of age, accounting for 12% of all deaths in 2006. The fourth and fifth group was children five through nine and 10 through 14 years of age, who both accounted for 7% of all deaths. Table B further illustrates this year's findings.

Table B
Comparison of Child Deaths by Age and Child
Population, 2006*

Age Category	Child deaths (#)	Child deaths (%)	Death rate of residents per 100,000 child population
Infant	101	55%	5.12 (per 1,000)
1-4	36	20%	43.59
5-9	12	7%	11.08*
10-14	13	7%	10.85*
15-17	22	12%	31.17*
Total	184	100%	

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

* The death rates included in Table B above represent the Sacramento County deaths of Sacramento County residents. While the three out of county residents who died within Sacramento County are included in the total number of deaths, they are not factored into the death rates

Natural Causes

A total of 119 deaths resulted from natural causes in 2006. Infants accounted for 91 (77%) of all deaths due to natural causes. The second largest group was children one through four years of age, accounting for 10 (8%) of all natural deaths. Children 10 through 14 years of age accounted for eight (7%) of all natural deaths, and children five through nine years of age accounted for six (5%) of all natural deaths. Lastly, children 15 through 17 years of age accounted for four (3%) of all natural deaths.

Unintentional Injuries

There were a total of 36 deaths resulting from unintentional injuries. Children ages one through four, accounted for 18 (50%) of deaths due to unintentional injury. Children 15 through 17 years of age accounted for nine deaths due to unintentional injury (25%), and children five through nine years of age accounted for four (11%) of these deaths. Children 10 through 14 accounted for four (11%) of deaths due to unintentional injury, and infants under one year of age accounted for one death due to an unintentional injury (3%).

Intentional Injuries

There were a total of 17 deaths resulting from intentional injuries. Children 15 through 17 years of age accounted for 9 (53%) of the intentional injury child deaths. Children one through four years of age accounted for six (35%) of intentional injuries. Children in the five through nine and 10 through 14 year-old age categories each accounted for one (6%) death due to intentional injuries. Infants were not represented in the intentional injury category of 2006.

Undetermined Manner

A total of 12 deaths were of an undetermined manner in 2006. Infants accounted for nine (75%) of these deaths. Children one through four years of age accounted for two (17%) of deaths due to an undetermined manner, and children five through nine years of age accounted for one (8%) 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 population. African American children represent 11% of the children in Sacramento County and 17% of the children who died.

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

Race/Ethnicity	Child deaths (#)	Child deaths (%)	% of Sacramento Child Population	Death rate of residents per 100,000 child population
Caucasian	80	43%	42%	49.91
African American	31	17%	11%	75.21*
Hispanic	33	18%	26%	34.00
Asian	19	10%	12%	38.73*
Native American	1	1%	(incl. in other)	--
Multiracial	16	9%	8%	49.43*
Other	4	2%	1%	73.92
Total	184	100%	100%	

Source: State of California, Department Of Finance, *Race/Ethnic Population with Age and Sex Detail, 1970- 2040*. * The death rates included in Table C above represent the Sacramento County deaths of Sacramento County residents. While the three out of county residents who died within Sacramento County are included in the total number of deaths, they are not factored into the death rates.

Risk Factors

Poverty

In Sacramento County, 18% of children under five years of age and 15% of children five to seventeen years of age live in poverty¹ According to the United States Census Bureau,

“To determine a person's poverty status, one compares the person's total family income in the last twelve months with the poverty threshold appropriate for that person's family size and composition (see example below). If the total income of that person's family is less than the threshold appropriate for that family, then the person is considered poor or “below the poverty level,” together with every member of his or her family”.

In 2006 19 (29%) of the 65 children who died due to injury-related causes, or of an undetermined manner had known risk factors related to poverty, such as inadequate living conditions or public assistance.

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 maltreatment³.

In Sacramento County, 81 (29%) of the 284 children that died from child abuse and neglect-related deaths from 1990 through 2006 came from a family with a history of substance abuse. Thirty-seven (13%) of the children that died from child abuse and neglect-related deaths from 1990 through 2006 came from a family with a history of domestic violence.

In 2006, 44 of the 184 child deaths (24%) had a history of substance abuse in the child’s family. Six of the 44 (14%) were deaths that involved an element of child maltreatment. The deaths involving a family history of substance abuse included:

- 8 deaths due to congenital anomalies
- 6 deaths due to perinatal conditions
- 6 deaths of an undetermined nature (5 were sleep-related)
- 4 third-party homicide deaths
- 3 deaths due to Sudden Infant Death Syndrome/ Sudden Unexpected Deaths in infants
- 3 deaths due to cancer

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 U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection*. Washington, DC: U.S. Government Printing Office.

- 3 deaths due to infections

In 2006, there were 26 deaths (14%) that had a history of domestic violence in the child's family. Seven of the 26 (27%) were deaths that involved an element of child maltreatment. These deaths included:

- 3 deaths due to perinatal conditions
- 3 deaths due to third-party homicide
- 3 deaths due to an undetermined manner
- 2 deaths due to congenital anomalies
- 2 deaths due to cancer
- 2 deaths due to drowning

Foster Care

In 2006, 10 (5%) of the 184 children who died had a history with foster care placement. Five children had a history of foster care prior to their death, and five children were in foster care at the time of their death. Of the children who had been placed in foster care previously but were no longer in foster care at the time of circumstances leading to death, two died as a result of a fire, one died as a result of a child abuse and neglect homicide, one died as a result of a third party homicide, and one child died of an undetermined manner (not sleep related). Of the children who were in foster care at the time of their death, three died as a result of congenital anomalies, one died as a result of cancer, and one child died as a result of suffocation (unintentional).

Teen Deaths

A total of 30 child deaths occurred in youth between 13 and 17 years of age comprising 16% of all child deaths in 2006. Ten (33%) of the 30 deaths were due to natural causes and 20 (67%) were injury-related. Of the 30 teen deaths, 22 (73%) were male and 8 (27%) were female. Eight of the teens were Caucasian, eight were Hispanic, six were Asian/Pacific Islander, four African American, and four were multiracial.

Between 2000 and 2006, a total of 204 child deaths occurred in youth between 13 and 17 years of age, comprising 17% of all child deaths. Sixty-one (30%) of the 204 deaths were due to natural causes and 143 (70%) were injury-related. Of the 204 deaths, 128 were male and 76 were female. Ninety-nine of the teens were Caucasian, 44 were Asian/Pacific Islander, 27 were African American, 21 were Hispanic, 12 were multiracial, and two each were American Indian and other races.

Firearms were involved in seven (23%) of the teen fatalities in 2006. One (3%) injury-related death involved a hanging, one (3%) involved drowning, one (3%) involved a stabbing, and one (3%) involved a beating.

Between 2000 and 2006, vehicular injuries comprised 51 (25%) of the 204 teen fatalities, 42 (21%) involved firearms, 19 (9%) involved hangings, nine (4%) involved drownings, five (3%) involved knives, four (2%) involved suffocation, three (2%) involved overdoses, two (1%) involved an assault, and one involved a burning.

Known risk factors were present in 13 (43%) of the 30 teen fatalities in 2006. The following is a representation of the risk factors present in the 13 teen fatalities:

- 8 had a history of non-violent crime
- 7 had a history of violent crime
- 7 had a history of alcohol and/or drug use
- 7 had a history of gang involvement
- 5 had a history of domestic violence within their home
- 3 had a history of child abuse and neglect

Natural Causes

Of the teen fatalities due to natural causes in 2006, four (40%) of the ten were due to congenital anomalies, and 3 (30%) were due to cancer. Seven out of ten were female and three were male. Two of the teens were Caucasian, three were Asian/Pacific Islander, two were Hispanic and three were multiracial.

Of the teen fatalities due to natural causes between 2000 and 2006, 18 (30%) of the 61 were due to cancer, 17 (28%) were due to congenital anomalies, five (8%) were due to infections, two (4%) were due to perinatal conditions, 18 (30%) were due to other natural conditions and one was due to natural causes of an undetermined manner. Thirty-eight of the 61 were female and 23 were male. Twenty-nine of the 61 teens were Caucasian, 16 were Asian/Pacific Islander, five were African American, six were Hispanic, and five were multiracial.

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

- 5 had history of non-violent crime
- 5 had a history of domestic violence in their family
- 5 had a history of alcohol and/or other drug use
- 4 had a history of violent crime

- 1 had a history of smoking during pregnancy
- 1 mother was a teen

Injury-Related Deaths

In 2006, there was a total of 20 injury-related teen fatalities comprising 67% of all teen fatalities. Of the 20 injury-related teen fatalities, 19 were male and one was female. Six victims each were Caucasian and Hispanic, four were African American, three were Asian/Pacific Islander and one was multiracial.

Between 2000 and 2006 there was a total of 143 injury-related teen fatalities comprising 70% of all teen fatalities. Of the 143 injury-related teen fatalities, 106 were male and 37 were female. Seventy-one victims were Caucasian, 24 were Asian/Pacific Islander, 21 were African American, 15 were Hispanic, seven were multiracial, three were another race, and two were American Indian.

In 2006, firearms were involved in seven (35%) of the 20 injury-related teen fatalities, seven involved vehicular injuries, one involved a hanging, one involved a drowning, one involved a stabbing, and one involved a beating. Between 2000 and 2006, vehicular injuries comprised 55 (39%) of the 143 teen fatalities, 42 (29%) involved firearms, 19 (13%) involved hangings, nine (6%) involved drownings, five (4%) involved knives, four (3%) involved suffocation, three (2%) involved an overdose, two (2%) involved a beating, and one involved a burning.

Known risk factors were present in 11 (55%) of the 20 teen fatalities. The following is a representation of the risk factors present in the 11 teen fatalities:

- 7 had a history of alcohol and/or drug use
- 7 had a history of gang involvement
- 6 had a history of non-violent crime
- 6 had a history of violent crime
- 4 had a history of domestic violence in their household
- 2 had a history of child abuse and neglect.

Third-party Homicides

Third-party homicides comprised eight (40%) of the 20 injury-related teen fatalities. All eight (100%) of the third-party homicides were male. Four victims were Hispanic, two were African American, and one each were Caucasian and Multiracial. Of the eight third-party teen homicides, four were 17 years of age, three were 16 years of age, and one was 15 years old. Firearms were involved in five of the cases, one involved a beating, one involved a stabbing, and one involved a car accident.

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

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

Between 2000 and 2006, third-party homicides comprised 43 (30%) of the 143 injury-related teen fatalities. Thirty-seven (86%) of the victims were male and 6 (14%) were female. Eleven victims were Caucasian, ten were African American, eight each were Asian/Pacific Islander and Hispanic, three were Multiracial, two were another race, and one was American Indian. Firearms were involved in 30 (69%) of the 43 third-party homicides, five involved knives, two each involved strangulation/suffocation, vehicular injury and beating and one each involved burns, and drowning.

Suicides

Suicides comprised one (5%) of the 20 injury-related teen fatalities in 2006. The teen was male and the method of death was hanging. Due to the small number of suicides in 2006, further details of this suicide will be omitted from this report. Between 2000 and 2006, suicides comprised thirty-one (22%) of the 143 injury-related teen fatalities. Twenty-four of the 31 suicides were male and seven were female. Eighteen of the teens were Caucasian, five were African American, four were multiracial, three were Asian/Pacific Islander, and one was American Indian. Nineteen of the teens used hanging, seven used firearms, two each used suffocation and overdose, and one used vehicular trauma as the mechanism of suicide.

Motor Vehicle Accidents

Motor vehicle accidents comprised seven (35%) of the 20 injury-related teen fatalities. Six victims were male and one was female. Of the seven motor vehicle accidents, four victims were Caucasian, two were Hispanic, and one was Asian/Pacific Islander. Of the seven teen motor vehicle accident fatalities, four were drivers 15-17 years of age, two were bicyclists 13 and 17 years of age, and one was a pedestrian 15 years of age.

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

- 2 were behaving recklessly
- 2 were not properly using a seat belt

- 1 was driving without a license

Between 2000 and 2006, motor vehicle accidents comprised 53 (37%) of the 143 injury-related teen fatalities. Twenty-nine of the victims were male and twenty-four were female. Of the 53 motor vehicle accident fatalities, 34 were Caucasian, eight were Asian/Pacific Islander, six were Hispanic, four were African American, and one was another race. Thirty-four of the 53 were occupants, 11 were pedestrians, and eight were bicyclists.

Chapter IV

The Sacramento County Child Death Review Team

Chapter Four

The Sacramento County Child Death Review Team

History and Background

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

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

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

Mission Statement

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

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

Membership

The Sacramento County Child Death Review Team had consistent representation during 2006 from the following agencies:

California Highway Patrol

Child Abuse Prevention Council of Sacramento, Inc.

Kaiser Permanente

Mercy San Juan Medical Center

Sacramento City Fire Department

Sacramento City Police Department

Sacramento County Coroner's Office

Sacramento County Department of Health and Human Services:

California Children's Services

Child Protective Services

Disease Control and Epidemiology

Public Health Nursing

Sacramento County District Attorney's Office

Sacramento County Probation Department

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 prevention of 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 drug overdose will differ greatly from those designed to reduce intentional drug overdose.

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 or out-of-county residents whose injuries leading to death were sustained in Sacramento County. Other 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 2006
Sacramento County

Category	Years																	Total
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	
Perinatal Conditions	79	70	46	46	44	21	42	52	48	40	42	48	56	43	62	71	65	875
Congenital Anomalies	28	33	26	23	24	25	19	30	27	27	33	32	39	32	31	28	29	486
SIDS	28	28	21	29	25	18	21	20	19	18	18	18	15	10	3	5	3	299
Cancer	11	11	6	9	10	6	9	5	10	10	15	5	10	11	10	9	9	156
Infections	8	8	8	3	11	4	7	3	4	6	8	10	6	2	10	5	8	111
Respiratory	7	10	3	10	5	7	9	8	4	1	3	0	2	0	1	1	2	73
Other	19	10	10	14	21	17	15	12	4	11	16	8	2	7	6	2	3	177
Undetermined (Natural)	4	2	0	3	0	0	4	1	1	5	3	0	0	2	0	0	0	25
Total Natural Causes	184	172	120	137	140	98	126	131	117	118	138	121	130	107	123	121	119	2,202

Table E
Number of injury-related deaths according to category 1990 to 2006
Sacramento County*

Category	Year																	Total
	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	
Homicides	12	18	13	21	15	20	16	23	11	16	10	16	11	9	15	17	16	259
CAN Homicide	(9)	(7)	(9)	(14)	(8)	(9)	(9)	(14)	(7)	(13)	(6)	(9)	(4)	(1)	(4)	(8)	(7)	(138)
Third-Party Homicide	(3)	(11)	(4)	(7)	(7)	(11)	(7)	(9)	(4)	(3)	(4)	(7)	(6)	(8)	(11)	(9)	(9)	(120)
Arson Homicide	0	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(1)	(0)	(0)	(0)	(0)	(1)
Motor vehicle Accidents (MVA)	18	15	14	14	15	23	19	17	11	11	14	21	13	14	10	8	11	248
MVA (Occupant)	(11)	(11)	(8)	(7)	(8)	(12)	(15)	(10)	(7)	(4)	(8)	(10)	(11)	(8)	(5)	(3)	(6)	(144)
MVA (Pedestrian)	(6)	(3)	(6)	(6)	(5)	(8)	(2)	(7)	(1)	(5)	(5)	(8)	(1)	(5)	(4)	(4)	(3)	(79)
MVA (Bike)	(1)	(1)	(0)	(1)	(2)	(3)	(2)	(0)	(3)	(2)	(1)	(3)	(1)	(1)	(1)	(1)	(2)	(25)
Drowning	8	7	9	7	7	4	4	6	7	6	5	5	9	4	7	5	12	112
Suicide	5	7	3	4	4	3	4	5	8	0	6	5	7	4	4	8	1	78
Suffocation/ Choking	3	3	0	4	0	0	2	4	2	1	1	3	1	1	0	2	3	30
Fires	2	2	1	2	1	0	3	5	4	0	0	1	1	1	0	1	2	26
Other	1	0	0	8	5	3	0	5	1	1	1	8	4	2	6	1	6	52
Undetermined (Injury)	2	1	9	0	4	4	3	0	2	1	0	1	2	1	1	0	0	31
Poisoning/ Overdose	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	2	2
Total Injury-Related Causes	51	53	49	60	51	57	51	65	46	36	37	60	48	36	43	42	53	837
Undetermined Manner	7	2	2	4	6	0	4	2	2	3	4	8	6	10	10	4	12	(1)

* Table E above represents the Sacramento County deaths of Sacramento County residents. Not included in this Table are injury-related deaths of out-of-county residents.

Table F
Deaths by category and age 2006
Sacramento County

Category	Infant	1-4	5-9	10-14	15-17	Total
Perinatal Conditions	64	1				65
Congenital Anomalies	18	2	4	5		29
Sudden Infant Death Syndrome	3					3
Cancer		3	2	3	1	9
Infections	6	1			1	8
Respiratory		2				2
Other (natural)		1			2	3
CAN Homicide		5	1	1		7
Third-Party Homicide		1			8	9
Arson Homicide						0
Motor Vehicle Deaths (occupant)			1	1	4	6
Motor Vehicle Deaths (pedestrian)		2			1	3
Motor Vehicle Deaths (bicycle)				1	1	2
Drowning		11		1		12
Suicide					1	1
Suffocations	1	1	1			3
Burn		2				2
Other Injury		2	2		2	2
Legal Intervention						6
Poisoning/ Overdose				1	1	2
Undetermined Injury						0
Undetermined Manner	9	2	1			12
Total	101	36	12	13	22	184

Table G
Deaths by race/ethnicity and age 2006
Sacramento County

Race Classification	Infant	1-4	5-9	10-14	15-17	Total
Caucasian	45	18	7	3	7	80
African American	19	7	0	1	4	31
Asian/ Pacific Islander	11	1	1	4	2	19
Hispanic	15	6	3	2	7	33
Native American	0	1	0	0	0	1
Multiracial	9	2	1	2	2	16
Other	2	1	0	1	0	4
Total	101	36	12	13	22	184

Table H
Child abuse and neglect homicide victims by age 1990 to 2006
Sacramento County*

Period Covered	Infant	1-4	5-9	10-14	15-17	Total
1990-2000	23	51	19	6	6	105
2001	4	5	0	0	0	9
2002	1	1	1	1	0	4
2003	1	0	0	0	0	1
2004	2	1	1	0	0	4
2005	5	3	0	0	0	8
2006	0	5	1	1	0	7
Total	36	66	22	8	6	138

* Table H above represents the Sacramento County deaths of Sacramento County residents. Out-of-county residents are not included in this table.

Table I
Child abuse and neglect homicide victims by race/ethnicity 1990 to 2006
Sacramento County*

Period Covered	White	Hispanic	African American	Asian	Other**	Total
1990-2000	46	18	28	10	3	105
2001	5	0	4	0	0	9
2002	2	0	1	0	1	4
2003	0	0	0	1	0	1
2004	0	0	1	0	3	4
2005	3	1	3	1	0	8
2006	2	2	2	0	1	7
Total	58	21	39	12	8	138

* Table I above represents the Sacramento County deaths of Sacramento County residents. Out-of-county residents are not included in this table.

** Including children of mixed racial categories.

Table J
Perpetrators of CAN homicides 1990 to 2006
Sacramento County*

Perpetrator	1990-2005	2006	Total Cases	%
Father	40	0	40	29%
Mother	29	5	34	25%
Boyfriend of Mother or Guardian	16	1	17	12%
Undetermined	14	0	14	10%
Both Parents	9	0	9	7%
Babysitter	7	0	7	5%
Stepfather	4	0	4	3%
Other Family Member	5	1	6	4%
Foster Parent	3	0	3	2%
Girlfriend of Father or Guardian	2	0	2	1%
Family Friend	2	0	2	1%
Total	131	7	138	100%

** Table J above represents the perpetrators of Sacramento County CAN Homicides of Sacramento County residents. Out-of-county residents are not included in this table.*

Table K
Deaths caused by intentional injuries by mechanism 1990 to 2006
Sacramento County*

	3rd Party Homicide	CAN Homicide	Suicide	Total
Firearm	92	23	33	148
Battering	5	37	0	42
Hanging	0	0	41	41
Shaking	0	19	0	19
Strangulation/Suffocation	1	15	0	16
Poisoning/Overdose	0	8	3	11
Stabbing	11	6	0	17
Fire	2	4	0	6
Undetermined	1	1	0	2
Vehicular	6	1	1	8
Drowning	1	5	0	6
Chronic Neglect	0	11	0	11
Other	1	3	0	4
Unknown	1	5	0	6
Total	121	138	78	337

** Table K above represents the Sacramento County deaths of Sacramento County residents. Out-of-county residents are not included in this table.*

Table L
Number of deaths by Sacramento County zip code*
1990-2006

Zip	Neighborhood	2006 Deaths	Deaths 2000-2005	Total
95608	Carmichael	4	25	29
95610	Citrus Heights	7	21	28
95615	Courtland	0	1	1
95621	Citrus Heights	5	22	28
95624	Elk Grove	4	26	30
95626	Elverta	2	5	7
95628	Fair Oaks	3	16	19
95630	Folsom/Clarksville/El Dorado Hills	4	28	32
95632	Twin Cities/Galt/Herald	5	7	12
95638	Herald	3	1	4
95655	Mather	1	1	2
95660	North Highlands	6	40	46
95662	Orangevale	1	17	18
95670	Rancho Cordova	6	40	46
95673	Rio Linda/Robla	3	14	17
95683	Rancho Murieta	0	3	3
95690	Walnut Grove	1	1	2
95693	Wilton	0	1	1
95757	Elk Grove	4	10	14
95758	Bruceville	10	41	51
95763	Folsom	0	1	1
95814	Downtown Sacramento	1	8	9
95815	North Sacramento	5	36	41
95816	Midtown Sacramento	0	5	5
95817	Sacramento/Oak Park	1	19	20
95818	Sacramento/South Land Park	1	8	9
95819	Sacramento/ East Sacramento	1	11	12
95820	Fruitridge	11	57	68
95821	Town and Country Village	4	31	35
95822	Sacramento/Meadowview	10	41	51
95823	Sacramento/Valley Hi	16	91	107
95824	Fruitridge	4	38	42
95825	Arden/Arcade	2	26	28
95826	Perkins/Rosemont	4	25	29
95827	Mills/Walsh Station	2	22	24
95828	Florin	6	41	47
95829	Coffing/Sheldon	6	14	20
95830	Sacramento (Florin & Sunrise)	0	1	1
95831	Greenhaven	4	18	22
95832	Sacramento/Freeport	3	9	12
95833	Arden/ Garden	4	28	32

95834	Sacramento/South Natomas	1	9	10
95835	Sacramento/North Natomas	3	8	11
95837	Sacramento International Airport	0	1	1
95838	Del Paso Heights/Hagginwood	9	39	48
95841	Foothill Farms	2	13	15
95842	Sacramento/Foothill Farms/North Highlands	9	29	38
95843	Sacramento/Antelope	1	24	25
95864	Arden/Arcade	2	5	7
	Unknown**	0	1	1
Total		181	979	1,160

* Table L above represents the Sacramento County deaths of Sacramento County residents. Out-of-county residents are not included in this table.

** Death Certificate was not available

Appendix

APPENDIX A

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

PURPOSE

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

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

MEMBERSHIP

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

I Sacramento County

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

II Department of Health and Human Services

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

III District Attorney's Office

IV Local Hospitals

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

V Other Community Service Agencies

- A. Child Abuse Prevention Council of Sacramento

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

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

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

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

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

STATUTORY AUTHORIZATION

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

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

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

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

TARGET POPULATION

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

MEETINGS

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

GROUND RULES

Members of the CDRT agree to:

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

OFFICERS

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

The duties of the Chair shall be to:

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

The duties of the Vice Chair shall be to:

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

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

PROCEDURES

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

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

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

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

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

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

CHILD ABUSE PREVENTION COUNCIL RESPONSIBILITIES

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

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

EVALUATION

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

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

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

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

INDEMNIFICATION AND INSURANCE

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

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

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

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

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

NAME: _____

SIGNATURE: _____

AGENCY/PROFESSIONAL DISCIPLINE REPRESENTED:

DATE: _____

APPENDIX C

Sacramento County Child Death Review Team Members Formation Members

California State Attorney General's Office

Michael Jett
Senior Field Deputy, Crime Prevention Center

Child Abuse Prevention Council of Sacramento, Inc.

Marie Marsh
Executive Director

Sheila Anderson
Child Death Review Team Coordinator

Juvenile Justice Commission

Alison Kishaba
Commission Chairperson

Sacramento City Police Department

Detective Ernie Barsotti

Sacramento County Coroner's Office

Robert Bowers
Chief Deputy Coroner

Sacramento County Department of Health and Human Services

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

Sacramento County Department of Social Services

Sarah Jenkins

Sacramento County District Attorney's Office

Janice Hayes
Deputy District Attorney

Sacramento County Executive's Office

Margaret Tomczak
Children's Commission

Sacramento County Sheriff's Department

Sergeant Harry Machen

University of California Davis Medical Center

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

APPENDIX D

Sacramento County Child Death Review Team Current Members

Department of Health & Human Services

California Children's Services

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

California Highway Patrol

Elizabeth Dutton

Child Abuse Prevention Council of Sacramento, Inc.

Gina Roberson, M.A.
Associate Director, Coordination & Collaboration

Meghann K. Leonard, M.P.P.A.

CDRT Project Manager

Citrus Heights Police Department

Guy Gates, Detective

Department of Health and Human Services

Child Protective Services

Judy Pierini, M.S.W.
Paula Christian, M.S.W.
Judy Cooperider, M.S.W.

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

Cassius Lockett, PhD, Epidemiologist

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

Carol Tucker R.N.

District Attorney's Office

Lori Greene, J.D., Deputy District Attorney
Robin Shakely, J.D., Deputy District Attorney

Elk Grove Police Department

Mario Guzman
Sergeant

Kaiser Permanente

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

Law Enforcement Chaplaincy - Sacramento

Frank Russell
Supervising Senior Chaplain

Mercy San Juan Hospital

Denise von Arx, CNS

Sacramento City Fire Department

Anthony Medina, Captain

Sacramento City Police Department

Paul Martinson, Sergeant

Sacramento County Coroner's Office

Mark Super, M.D., CDRT Vice Chair
Forensic Pathologist
Greg Wyatt, Deputy Coroner
Kim Burson, Assistant Coroner/ Investigation

**Sacramento County Metropolitan Fire
Department**

Clayton Elledge, EMS

Sacramento County Probations Department

Robin Wilkins

Sacramento County Sheriff's Department

Kevin Givens, Detective
Brian Shortz, Detective

Sutter Memorial Hospital

Angela Rosas, M.D.
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

Deborah Stewart, M.D.

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

Blessilda Canlas
Child Abuse Prevention Council of Sacramento, Inc.
CDRT Project Manager

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

Nolana Daoust, M.P.H.
Epidemiologist
Department of Health and Human Services

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

Fernando Enriquez
Sergeant
Sacramento City Police Department

Earl Evans
Sacramento County Sheriff's Department

Mark Fajardo, M.D.
Stephanie Fiore, M.D.
Forensic Pathologist
Sacramento County Coroner's Office

David Ford
Sergeant, SACA Unit
Sacramento City Police Department

Mary Ann Harrison
Department of Social Services

Rich Gardella
Sergeant, Homicide Unit
Sacramento City Police Department

Keith Gault
ACLS Coordinator
Sacramento City Fire Department

Jason Gay
Detective
Sacramento County Sheriff's Department

James Jay Glass
Paramedic Captain
Sacramento City Fire Department

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

Max Hartley
California Highway Patrol

Donald Henrickson, M.D.
Northern California Forensic Pathology

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

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

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

Maynard Johnson, M.D.
Pediatrician
Kaiser Permanente Foundation

Jeff Jones
Chaplain
Law Enforcement Chaplaincy

Evelyn Joslin
Deputy Director
Department of Social Services

Angela Kirby
Detective
Sacramento County Sheriff's Department

Joan Kutschbach, M.D.
Pediatrician
Kaiser Permanente

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

Larry Lieb, M.D.

Tim Maybee
Sacramento County Fire Department

Rich Maloney, R.N.
Sacramento Metro Fire District

Debbie Mart
Sacramento City Fire Department

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

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

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

John McGinness
Homicide Unit
Sacramento County Sheriff's Department

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

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

Richard Miles
Sacramento County Coroner's Office

John Miller
Sacramento City Fire Department

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

Bobby Mitchell
Sergeant, Homicide
Sacramento City Police Department

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

Kate Moody
Sutter Healthcare

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

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

Mark O'Sullivan
Senior Chaplain
Law Enforcement Chaplaincy

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

Kenneth Ozawa, M.D.
Mercy Healthcare of Sacramento

Arti Parikh
Epidemiologist
Department of Health and Human Services

James Pearson
Sacramento City Police Department

Cliff Peppers
Sergeant
Sacramento County Sheriff's Department

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

Ronald Potter
Captain
Sacramento City Fire Department

Dan Read
Child Protective Services
Department of Health and Human Services

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

Steve Roberson
Detective
Sacramento County Sheriff's Department

Curtis Rollins, M.D.
Northern California Forensic Pathology

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

Mindi Russell
Deputy Senior Chaplain
Law Enforcement Chaplaincy

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

Gale Schmaltz, R.N., M.S.N.
Mercy San Juan Hospital

Gregory Schmunk, M.D.
Northern California Forensic Pathology

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

Howard Sihner
District Attorney's Office – Juvenile Division

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

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

Bev Sprenger
Department of Health and Human Services

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

Dr. John Stockman
Stockman and Associates

Grant Stomsvick
Detective
Sacramento County Sheriff's Department

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

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

Ellen Tappero
Center For Women's Health
Sutter Memorial Hospital

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

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

Ted Voudouris
Sacramento County Sheriff's Department

Jane Wagener, R.N., P.H.N.
Supervising Public Health Nurse
Department of Health and Human Services
Public Health Nursing

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.

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

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

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

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

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

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

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

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

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

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

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

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

Low Birth Weight: Birth weight below 2500 grams.

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

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

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

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

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

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

Neglect-Related Deaths:

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

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

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

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

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

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

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

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

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

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

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

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

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

Prematurity: Birth prior to 37 weeks gestation.

Preterm Labor: Onset of labor before 37 weeks gestation.

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

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

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

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

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

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

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

Deaths Classified as Child Abuse and Neglect Fatalities
Definitions

I. Abuse

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

II. Neglect

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

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

