Sacramento County Child Death Review Team
2007 Annual Report

The following report includes brief descriptions on some of the cases that were reviewed by the Child Death Review Team throughout the 2007 calendar year. These cases were selected to illustrate the range of circumstances and situations that have placed children at risk. 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), the Sacramento County Youth Death Review Subcommittee (YDRS) and the CDRT Prevention Advisory Committee (PAC). We gratefully acknowledge the entire membership for their input and dedication. The following members were part of the 2007 CDRT, YDRS and/or PAC:

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Based upon the direction and feedback of the CDRT, YDRS and PAC, Nazia Ali, CDRT Project Manager was responsible for data analysis, demographic descriptions, and the production of the document as it is presented here. Patrick Brosnan, Child Abuse Prevention Council of Sacramento, was responsible for the geographical maps presented herein. Stephanie Biegler and Gina Roberson, M.S. of the Child Abuse Prevention Council of Sacramento provided overall supervision of staff and the production of this document.

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EXECUTIVE SUMMARY

The death of a child is a tragedy. Even more tragic is the preventable death of a child due to abuse and neglect. While some deaths are natural and unavoidable, such as a child suffering from congenital anomalies 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 deaths in Sacramento County for 2007. Included are descriptions of all deaths whether they were the result of child abuse and neglect, injuries, homicides or natural causes.

2007 marks the eighteenth 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 2007, 192 children residing in Sacramento County died. This includes the death of one child who resided in Sacramento County but died in a surrounding California County. Therefore, the 2007 child death rate of Sacramento County, birth through 17 years of age is 50.6 per 100,000 children. In 2006, 181 children residing in Sacramento County died in Sacramento County. Therefore, the 2006 child death rate of Sacramento County, birth through 17 years of age was 47.7 per 100,000 children.

In 2007, 197 children birth through 17 years of age died. This includes the death of five children who died in Sacramento County, but were not current residents. The three classifications of child deaths were natural causes (139), injury-related (50), and undetermined manner (8). In 2006, 184 children birth through 17 years of age died in Sacramento County. This includes the death of three children who died in Sacramento County, and were not current residents of Sacramento County. This year marks the second year in which deaths of out-of-county residents who die as a result of an injury that occurred within Sacramento County are included in the report.

While the deaths of out-of-county residents are not 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 139 child deaths resulting from natural causes such as perinatal conditions, congenital anomalies, Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome (SUIDS), cancer, infections, and respiratory problems. Deaths resulting from natural causes continue to constitute the majority of child deaths in the County, resulting in 71% of all child deaths for this year.

Injury-related deaths resulted in 50 child deaths, accounting for 25% of the total child deaths for this year. The most disturbing detail is the consistent finding that injury-related deaths could have

been prevented. This category includes deaths resulting from child abuse and neglect (CAN) homicides, third-party homicides, motor vehicle collisions, drowning, suffocation, burning, suicide and other injuries. Three of the 50 injury-related deaths in 2007 were the direct result of a CAN homicide. There were seven CAN homicides in 2006.

There were eight child deaths that resulted from an undetermined manner, accounting for 4% of the total child deaths. Seven of the eight deaths (88%) were infant sleep-related.

2007 also marks the first year the Youth Death Review Subcommittee (YDRS) of the CDRT convened to conduct in-depth analysis of all injury-related deaths of youth ages 10 through 17, which occurred in Sacramento County. The intent of the YDRS is to understand the causes of injury-related youth deaths, identify trends and risk factors, and develop recommendations to reduce preventable youth deaths.

The YDRS findings indicate that the majority (33) of the 50 injury-related deaths (66%) are in youth between 10 and 17 years of age. Eighty-two percent (27 of 33) of the injury-related youth deaths occurred in youth 15 to 17 years of age. Eight of the 27 (30%) injury-related deaths in youth 15 to 17 years of age in 2007 occurred by use of a firearm. YDRS and CDRT findings also conclude that 82% (9 of 11) of motor vehicle collisions that occurred in youth 14 to 17 years of age involved reckless behavior, including the decedent acting recklessly or the decedent being a victim of reckless behavior. Elements of reckless behavior include misuse of a provisional license, street racing, and alcohol and/or drug use.

Child deaths tell us a great deal about the well being of children in our community. 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 2007 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 deaths 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.

2007 Major Findings

In 2007, there were 192 child deaths at a child death rate of 50.6 per 100,000 children, birth through 17 years of age, of children who resided in Sacramento County. There were five additional injury-related deaths of children who resided outside of Sacramento County, and whose death occurred in Sacramento County, bringing the total number of child deaths to 197.

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 resided in Sacramento County. There were three additional injury-related deaths of children who resided outside of Sacramento County and whose death occurred in Sacramento County, bringing the total number of child deaths to 184.

Major findings of the types of deaths that occurred in Sacramento County in 2007 are as follows.

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

  Fifty (25%) of the 197 child deaths in 2007 were preventable. Forty-nine (98%) of these child deaths were injury-related, such as child abuse and neglect homicides, drowning, motor vehicle collisions, suicides and third-party homicides. One of the 50 preventable child deaths was due to lack of early medical treatment for a congenital anomaly.

  Fifty-three (29%) of the 184 child deaths in 2006 were preventable. All fifty-three preventable child deaths (100%) were injury-related, such as child abuse or neglect (CAN) homicides, drowning, motor vehicle collisions, and third party homicides.

- **Injury-related deaths comprised nearly all of the preventable deaths.**

  In 2007, there were 50 injury-related deaths in Sacramento County, five of which were out-of-county residents. The 45 injury-related deaths of Sacramento County residents included 13 motor vehicle collisions, nine third-party homicides, seven drowning, five burn/fire deaths, four suicides, three CAN homicides, two poisoning/overdoses, one suffocation and one other-injury. All five injury-related deaths of out-of-county residents were motor vehicle collisions. One of the 50 injury-related deaths was a drowning for which the CDRT concluded there was no foreseeable preventative measure. In 2006, there was a total of 53 injury-related deaths, which included three out-of-county residents. All 53 injury-related deaths in 2006 were determined to be preventable.

- **Three children died from Child Abuse and Neglect (CAN) homicides.**

  In 2007 there were three Child Abuse and Neglect (CAN) homicides, one percent of the 197 child deaths. All three CAN homicides were separate incidents and all three CAN homicide victims were Sacramento County residents. Two CAN homicide victims were one year of age and under and one CAN homicide victim was between 5 and 9 years of age. All three CAN homicide victims died at the hands of a parent or caregiver. One of the three decedents had no

Child Protective Services (CPS) involvement with any California County including Sacramento County. Two of the three decedents had Child Protective Services (CPS) involvement with Sacramento County CPS. One of the three decedents also had prior involvement with at least one other California County CPS. One of the two decedents that had involvement with Sacramento County CPS also had an open case at the time of death.

In 2006, there were seven CAN homicides, four percent of the 184 child deaths. All seven CAN homicides were separate incidents and all seven victims were Sacramento County residents. Five victims were between 1 and 4 years of age, one victim was between 5 and 9 years of age and one victim was between 10 and 14 years of age.

From 2005 to 2007 there were 18 CAN homicides compared to 9 CAN homicides during the 2002 through 2004 period. Between 1990 and 2007 the majority of perpetrators (60% or 85 of 141) of CAN homicides were the biological parents of the decedent. This includes the mother or father acting alone, or both parents acting together. Including stepparents and the boyfriend and girlfriend of a biological parent, this figure jumps to 76% (108 of 141) are the perpetrators of CAN homicides.

- **Two of the three CAN homicide decedents had prior Sacramento County Child Protective Services (CPS) involvement.**

In 2007, two (67%) of the three CAN homicide decedents were open or reported to Sacramento County CPS. One of the decedents was open or reported to Sacramento County CPS within six months prior to their death. One of the three decedents also had prior involvement with at least one other California County CPS.

In 2006, four (57%) of the seven CAN homicide decedents were open or reported to Sacramento County CPS. Two (50%) of the four decedents were open or reported to Sacramento County CPS within six months prior to their death. Two (50%) of the seven decedents also had prior involvement with at least one other California County CPS.

- **Nine children died from third-party homicides.**

There were nine third-party homicides in 2007, five percent of the 197 child deaths. All nine third-party homicides were separate incidents and all nine third-party homicide victims were Sacramento County residents. Seven (78%) of the nine third-party homicide victims were 15-17 years of age. Two victims (22%) of the nine third party homicides were four years of age and under. Of the seven third-party homicide victims between 15 and 17 years of age, two were female and five were male. Six (86%) of the seven had a crime history within the immediate family (in three cases the decedent had a crime history and in four cases the parents of the decedent had a crime history). Three (43%) of the seven victims between 15 and 17 years of age had a history of gang involvement within their immediate family. Three (43%) of the seven victims had prior CPS involvement in any California County, including Sacramento County.

In 2006, there were nine third-party homicides, five percent of the 184 child deaths. All nine third-party homicides were separate incidents and all nine third-party homicides were Sacramento County residents. Eight (89%) of the nine third-party homicides were youth

victims between 15 and 17 years of age. One of the eight third-party homicide victims was a child between 1 and 4 years of age. Of the eight youth victims 15 to 17 years of age, all were male. Five (63%) of the eight had a crime history within the immediate family (in three cases the decedent had a crime history and in two 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 two of the parents were involved in a gang). Four (50%) of the eight decedents were prior victims of child abuse or neglect.

- **A firearm was used in more than twenty-five percent of injury-related deaths in youth 15-17 years of age.**

  In 2007, nine of the 33 (27%) injury-related youth deaths involved a firearm. Six of the deaths that occurred by use of a firearm were third-party homicides and three were suicides. Eight of the nine injury-related youth deaths that involved a firearm were of youth 15 to 17 years of age. These eight deaths of youth 15 to 17 years of age account for 88% of the child deaths in 2007 that occurred by use of a firearm.

  In 2006, seven of the 18 (39%) injury-related deaths in youth 15 to 17 years of age occurred by use of a firearm. These seven deaths account for 100% of the total child deaths in 2006 that occurred by use of a firearm. Five of the deaths that occurred by use of a firearm were third-party homicides and two were other-injury deaths.

- **One-tenth of all child deaths had an element of child maltreatment.**

  In 2007, 21 child deaths, ten percent of the 197 child deaths, were found to have elements of child maltreatment. Of those 21 deaths, five (24%) were natural deaths, four (19%) were motor vehicle collisions, four (19%) were undetermined manner, three (14%) were CAN homicides, three (14%) were drownings and two (9%) were poisoning/overdose. Three of the four deaths of an undetermined manner were infant sleep-related.

  Of the 21 child deaths with an element of child maltreatment, eight (38%) decedents were open or reported to any California County CPS, including Sacramento County. Five of the eight (62%) had Sacramento County CPS involvement only. Three of the eight (37%) had Sacramento County CPS involvement within six months prior to their death. Thirteen decedents had no Child Protective Services involvement with any California County CPS, including Sacramento County.

  In 2006, 25 (14%) of the 184 total child deaths were found to have elements of child maltreatment. Of those 25, seven were child abuse and neglect (CAN) homicides, seven were drowning, four were undetermined manner, three were motor vehicle collisions, and one each was perinatal, poisoning/overdose, other injury, and a third-party homicide. All four deaths of an undetermined manner were sleep-related.

  Of the 25 child deaths with an element of child maltreatment in 2006, eight were open or reported to Sacramento County CPS. Ten decedents had prior involvement with at least one California County CPS. Six decedents had involvement with Sacramento County CPS within

six months prior to their death. Fifteen decedents had no involvement with any California County Child Protective System, including Sacramento County.

- **Three-fourths 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 15 of the 21 (75%) child maltreatment deaths. Of the 15 child maltreatment deaths of children under five years of age, ten were infants and five were children between 1 and 4 years of age. Of the ten infant deaths with an element of maltreatment, three were infant sleep-related undetermined manner, three were perinatal and one each was a CAN homicide, motor vehicle collision, Sudden Unexpected Infant Death Syndrome (SUIDS) and undetermined-undetermined manner. Of the five deaths of children between 1 and 4 years of age with an element of maltreatment, three were drowning, one was a CAN homicide, and one was a motor vehicle driver/occupant collision.

  In 2006, 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, three were infants and 14 were children between 1 and 4 years of age. Of the three infant deaths with an element of maltreatment, two were infant sleep-related undetermined manner deaths and one was a perinatal death. Of the 14 deaths of children between 1 and 4years of age with an element of maltreatment, seven were drowning, five were CAN homicides, one was a third-party homicide and one was an undetermined-undetermined manner death.

- **There were no abusive head trauma deaths resulting from maltreatment such as beatings and shakings.**

  Child maltreatment deaths due to abusive head trauma decreased from eight cases in 2005 to one case in 2006 to zero in 2007. In 2005 and 2006 there were nine deaths resulting from abusive head trauma. Eight of the nine perpetrators were one or both of the biological parents of the decedent. Five (56%) of the nine decedents were infants under one year of age, three (33%) were between 1 and 3 years of age and one (11%) was between 5 and 9 years of age.

- **The major cause of infant deaths was from perinatal conditions.**

  In 2007, infants comprised 61% of all Sacramento County resident child deaths (118 of 192) and only five percent of the Sacramento County population under 18 years of age. Of the 118 infant deaths, 60 (51%) were from perinatal conditions.

  In 2006, infants comprised 55% of all Sacramento County resident child deaths (101 of 181) and only six percent of the Sacramento County population under 18 years of age. Of the 101 infant deaths, 65 (64%) were from perinatal conditions.

- **Infant sleep-related deaths, including Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death Syndrome (SUIDS) and infant deaths of an undetermined manner increased.**

  Infant sleep-related deaths include deaths from Sudden Infant Death Syndrome (SIDS) and other causes which include accidental suffocation, Sudden Unexpected Infant Death Syndrome (SUIDS) and infant deaths of an undetermined manner.

  A comparison of the three-year time periods (2001 – 2003 and 2004 – 2006) showed that infant sleep-related deaths, including SIDS, decreased 46%. From 2004 - 2006, there were 37 infant sleep-related deaths, comprising seven percent of all resident child deaths. During 2001 – 2003 there were 68 infant sleep-related deaths, comprising 13% of all resident child deaths.

  In 2007, there was an increase in infant sleep-related deaths. There were a total of 21 infant sleep-related infant deaths (nine SIDS, five SUIDS and seven infant sleep-related deaths of an undetermined manner), which represents 11% of all resident child deaths birth through 17 years of age in Sacramento County. This is an increase from 13 infant sleep-related deaths in 2006 and 11 infant sleep-related deaths in 2005. Eighteen (85%) of the 21 infant sleep-related deaths were infants under six months of age.

- **Nearly all infant sleep-related deaths, including Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death Syndrome (SUIDS), occurred in unsafe sleeping environments.**

  Twenty of the 21 (95%) infant sleep-related deaths, including Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome (SUIDS) and deaths of an undetermined manner, occurred in unsafe sleeping environments. Of the 21 infant sleep-related deaths, 16 infants (76%) were sleeping somewhere other than a crib (14 slept in an adult bed, two slept on a couch). Twelve of the 21 (57%) infant sleep-related deaths occurred while co-sleeping with parents and/or siblings. Of the 21 infant sleep-related deaths, 12 (57%) were known to have been put to sleep in an unsafe position (eight were put to sleep on their stomach and four were put to sleep on their side). Five (71%) of the seven undetermined infant sleep-related deaths occurred in co-sleeping situations.

  In 2006, twelve (92%) of the 13 infant sleep-related deaths, including SIDS, occurred in unsafe sleeping environments. Of the 13 infant sleep-related deaths, 12 infants (92%) were sleeping somewhere other than a crib (nine slept in an adult bed, and three slept on a couch). Seven (54%) of the 13 involved alcohol and/or other drug use by the parent/caregiver at the time of death. All of the nine undetermined infant sleep-related deaths occurred in co-sleeping situations.

- **Motor vehicle collision deaths have increased.**

  There were 13 motor vehicle collision deaths of Sacramento County children in 2007. All 13 motor vehicle collision deaths where separate incidents. Seven (54%) of the 13 motor vehicle collision deaths were motor vehicle driver/occupant deaths and six (46%) were motor vehicle pedestrian deaths. All seven motor vehicle collision driver/occupant deaths were of children

between 15 and 17 years of age. Five (71%) decedents of the seven driver/occupant deaths were known to be wearing a seat belt at the time of the collision. Three of the six motor vehicle collision pedestrian deaths were of children between 15 and 17 years of age, two were of children between 12 and 14 years of age and one child was between 1 and 4 years of age. Of the six motor vehicle pedestrian deaths, four occurred in the evening between 6pm and 10pm. Four of the six motor vehicle collision pedestrian deaths were known to not be following pedestrian safety rules.

Three other motor vehicle collision related deaths of Sacramento County residents occurred in 2007. The cause of death in one case was drowning resulting from a motor vehicle collision, and two were third party homicides by a drunk driver. Those deaths were not included in this finding.

In 2007, there were an additional five motor vehicle collision deaths that occurred in Sacramento County of decedents who were out-of-county residents. These five deaths occurred from three incidents. All five deaths were motor vehicle driver/occupant deaths. Of the five motor vehicle driver/occupant deaths, one was an infant, two were between 1 and 4 years of age, one was between 5 and 9 years of age and one was between 10 and 14 years of age. Of the five motor vehicle driver/occupant deaths, it was known that car seats were used improperly in two incidents. It was unknown if seatbelts were used properly in two incidents and if a car seat was used properly in one incident.

In 2006, there were 10 motor vehicle collision deaths of Sacramento County children. Five of the 10 motor vehicle collision deaths (50%) were driver/occupant deaths, three were motor vehicle pedestrian deaths and two were struck while riding a bicycle. There was an additional motor vehicle collision death that occurred in Sacramento County of a decedent who was an out-of-county resident. This incident was a motor vehicle collision driver/occupant death.

- **Eighty-two percent of motor vehicle collision deaths of youth 14-17 years of age involved reckless behavior.**

This year, there were eleven deaths from motor vehicle collisions in youth 14-17 years of age, all of which were Sacramento County residents. Of the eleven, seven were driver/occupants and four were pedestrians. Of the eleven youth deaths from motor vehicle collisions, 82% (9 of 11) had an element of recklessness, including the decedent acting recklessly or the decedent being a victim of reckless behavior. Elements of reckless behavior involved in the seven driver/occupant deaths included misuse of a provisional license, driving without a license, alcohol and/or drug use, speeding, and street racing. Three of the six motor vehicle pedestrian deaths were also known to involve reckless behavior on the part of the decedent.

In 2006, there were six youth deaths from motor vehicle collisions in youth 14 to 17 years of age. Of the six, four were driver/occupants, one was a bicyclist, and one was a pedestrian. Of the six youth deaths from motor vehicle collisions in youth 14 to 17 years of age, four had elements of recklessness, including misuse of a provisional license, street racing, and half were not restrained properly.

- **More than half of all injury-related deaths were youth between 15 and 17 years of age.**

  In 2007, youth between 15 and 17 years of age comprised 54% (27 of 50) of all injury-related deaths of Sacramento County residents and only 18% of the county's child population.

  The causes of the 27 injury-related deaths in youth between 15 and 17 years of age included the following: ten motor vehicle collisions (seven driver/occupants and three pedestrians); seven third-party homicides; three suicides; three drownings; and one each of poisoning/overdose, suffocation, burn/fire, and other-injury.

  Sixteen of the 27 (59%) injury-related deaths in youth between 15 and 17 years of age demonstrated academic challenges before their death. Examples of academic challenges include attendance issues, suspensions, and behavioral problems while in school. Thirty-seven percent (10 of 27) of the decedents of injury-related deaths among youth 15 to 17 years of age had a previous arrest history.

  In 2006, youth between 15 and 17 years of age comprised 36% (18 of 50) of the injury-related deaths and only 18% of the county's child population.

- **The number of burn/fire deaths is the highest in 10 years.**

  In 2007, five burn/fire deaths occurred in three residential fires. This is more than any year since 1997. In all five incidents working smoke detectors were not present. In one fire that accounted for two deaths, a smoke detector was present; however, the battery was removed. In another fire that accounted for two deaths, a smoke detector was not present. In one fire accounting for one death, the smoke detector was removed while the house was being painted. None of the five burn/fire deaths were classified as arson. Four of the five incidents were known to be in rental properties. Three of the five incidents were known to be in homes of English Language Learners. There were zero burn/fire deaths in 2006.

2007 Recommendations

- **Ensure that Child Protective Services, through oversight and accountability, adheres to a social work practice that is aligned with written program policy and that child safety is paramount to preserving the family unit.**

- **The following situations should require that a Child Protective System (CPS) referral or case be investigated in totality, with an increased level of scrutiny and follow-up with collateral agencies, experts, service providers and mandated reporters. This scrutiny should include CPS consultation with each of the child's providers and other agencies serving the family to develop a comprehensive case management plan.**

    - Multiple CPS referrals or reports on a case (even if unfounded or inconclusive), and/or
    - Lengthy history of CPS involvement and services, both in Sacramento County as well as in other California counties or other States
    - Referrals or cases involving children 0-5 years of age
    - Referrals or cases of "severe neglect", medical neglect/failure to thrive, or history of "severe neglect" reports

- **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.

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

  Twenty-five percent of all child deaths in 2007 were preventable. They were the result of poor judgment and/or behaviors by adults. The Child Death Review Team (CDRT) recommends the continuation and expansion of public education campaigns, such as the Shaken Baby Syndrome prevention campaign and an infant safe sleeping campaign. Targeted education to hospitals, schools, child care providers, foster families, and through programs such as the Nurse Family Partnership, Black Infant Health, Birth & Beyond, Family Resource Centers, and Child Welfare Services Redesign should continue to be supported. The CDRT understands these adults are either in direct contact with infants and children by caring for them (parents, grandparents, and caregivers), by providing advice (grandparents and hospital staff), or by visiting families with infants and children (home visitors). Educational campaigns using commercial marketing strategies to influence the behavior of the target population have proved to be effective in

Sacramento County community for reducing the number of preventable child deaths and should be supported. The CDRT recommends funding be allocated for this purpose.

- **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 infant mortality.**

  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 criterion be expanded to include ALL racial and ethnic groups to enable surveillance of all perinatal causes of mortality.

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

  From 2003 to 2005, the number of infant sleep-related deaths in Sacramento County 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. Much of this campaign was targeted to high risk populations in which Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome and other infant sleep-related deaths are more prevalent. By 2007, the funding for some of these infant safe sleeping programs had ended, coincidently with an increase in infant sleep-related deaths. The CDRT acknowledges the positive impact of infant safe sleeping educational outreach programs and encourages continued funding on an ongoing basis of such programs to help ensure a continued decrease in infant sleep-related deaths.

- **Restore and increase funding for programs that prevent abusive head trauma, such as shaken baby syndrome.**

  Evidence based education and prevention programs should be supported and implemented in Sacramento County. From 2004 to 2006, Sacramento County implemented the Diaz model of Shaken Baby Syndrome (SBS) prevention. During implementation, the number of abusive head trauma deaths decreased. Funding and support of this evidence based program should be restored and continue on an ongoing basis.

- **Restore and increase 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.

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

  In 2007, more than 25% of injury-related youth deaths involved a firearm. Most of the youth decedents also had a previous arrest history. Academic challenges and reckless behavior were also prevalent in many of the youth deaths. 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 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.

- **Sacramento County schools should use their access to youth for providing a consistent message regarding youth safety.**

  The majority of youth deaths are injury-related and preventable. Therefore, the CDRT recommends the implementation and expansion of public education and awareness campaigns aimed at modifiable behaviors to educate children, teens, parents and caregivers on making safe decisions. Existing places and services with access to youth, such as after-school programs, family resource centers and community based organizations should be used to reach youth.

- **Encourage schools and youth serving organizations to utilize best practice strategies for motor vehicle collision prevention education targeted to youth and parents.**

  The 2007 CDRT findings conclude that 82% of motor vehicle collisions that occurred in youth 14 to 17 years of age involved reckless behavior, including the decedent acting recklessly or the decedent being a victim of reckless behavior. Elements of reckless behavior include misuse of a provisional license, street racing, and alcohol and/or drug use. Through a prevention education strategy targeted at youth and their parents, these deaths could be prevented.

  The availability of school-based motor vehicle collision and prevention programs through the California Highway Patrol and other local law enforcement agencies such as: *Start Smart, Every 15 Minutes* and *Right Turn* should be promoted. This safety curriculum should be incorporated into schools on a continual basis. The County Board of Supervisors and the County Department of Education, in conjunction with the California Highway Patrol, should conduct an analysis of all motor vehicle collisions involving high school students. After the analysis is conducted, the County Board of Supervisors, County Department of Education and the California Highway Patrol should determine if mandated drivers' education classes in schools would prevent teenage driving collisions or deaths.

- **Expand fire safety public education and outreach, by trained public education officers, to underserved and non-English speaking populations.**

  Fire safety education should emphasize the importance of working smoke detectors. A standard smoke detector rental agreement form with fire safety education for all apartment and/or property managers and renters should be provided and translations into different languages should be developed and implemented.

INTRODUCTION

Andre was a 3 month old baby boy who lived with his parents, a 2 year old brother and 3 year old sister. He was a healthy full term newborn, now growing and developing normally. The children all fell asleep in the parent's bed in the evening, while the parents stayed up late. The parents drank a few beers and the father smoked some marijuana before falling asleep in the same bed with the children. The mother breastfed Andre, placed him on his stomach, and fell asleep herself. Early in the morning the mother awoke with the baby lying face down between her and one of the other children. Andre was unresponsive, cold, and blue. His parents called 911. Paramedics responded, but there was nothing they could do. Andre was already gone. The coroner determined the cause of death to be Sudden Unexpected Infant Death Syndrome (SUIDS), which is in the category of sleep-related deaths along with Sudden Infant Death Syndrome (SIDS).

Several important health leaders including the National Institute of Health (NIH) and the American Academy of Pediatrics (AAP) recommend sleeping babies on their back to prevent SIDS and other infant sleep-related deaths. Based on new SIDS prevention research, both organizations extended their recommendations for infant safe sleeping to include avoidance of soft bedding and objects in the baby's sleep environment that can suffocate the baby. The AAP states that accidental suffocation and strangulation in bed is a leading category of injury-related infant deaths in the U.S. In 2005, the AAP and NIH also warned against the hazards of co-sleeping infants with other children and adults, particularly if they are intoxicated or exhausted, because of the risk of overlay and suffocation. According to a recent AAP article, national infant mortality rates attributable to accidental suffocation and strangulation have greatly increased in the last two decades. The AAP recommends that prevention efforts should target families at highest risk and focus on helping parents and caregivers provide safer sleeping environments for their children.

There was a time when pediatricians recommended co-sleeping to promote infant bonding and breastfeeding; however, new research indicates that there is significant risk of infant sleep-related deaths with co-sleeping. Indeed, the safest way to sleep a baby is on his back, alone, and in a plain crib.

The CDRT review of infant sleep-related death cases in Sacramento shows that very few of these babies are slept on their back, alone, and in a plain crib. Of the 21 infant sleep-related deaths in 2007, only one was put to sleep safely. This information about Sacramento County infants is startling, and needs to be shared with pediatric health providers and educators, expectant parents, and child care providers in order to change the way babies are put to sleep. The CDRT has produced the local data that now confirms known national research regarding SIDS/SUIDS risk factors and prevention, but we rely on partnering with local agencies and policy makers to develop and deliver effective prevention. An effective program for SIDS/SUIDS prevention in Sacramento County that changes behavior to sleep babies on their backs, alone and in a plain crib would truly save lives.

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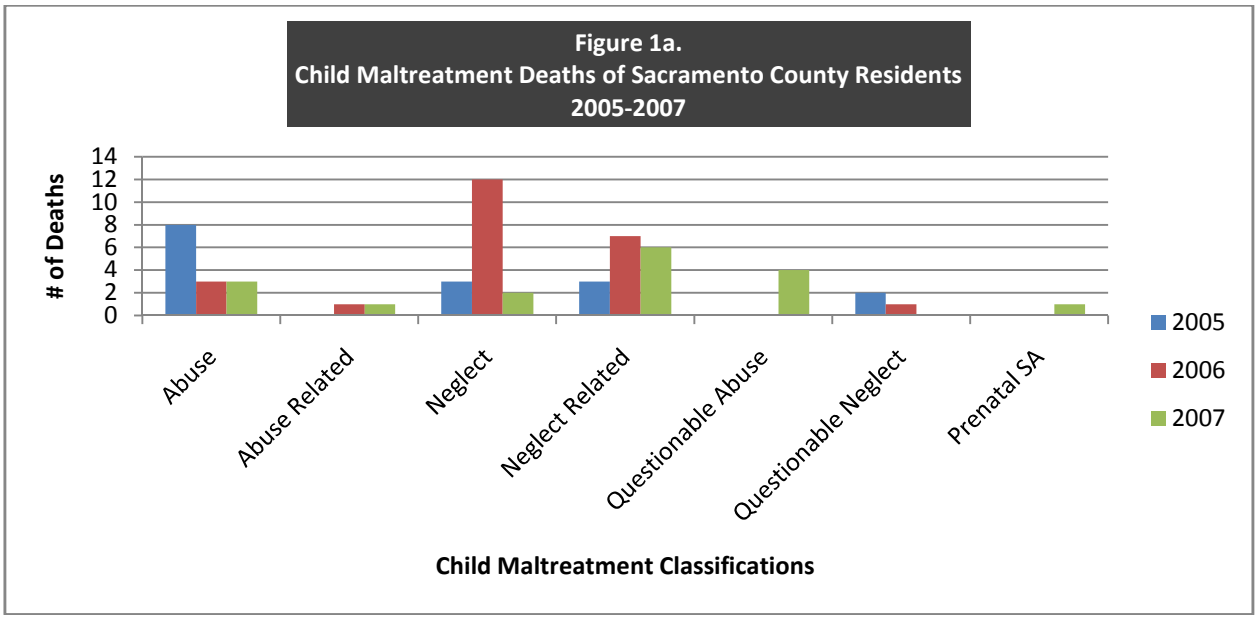
Chapter I

Deaths Related to Abuse and Neglect

Chapter One

Deaths Related to Child Maltreatment

Child Maltreatment Deaths



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.

The umbrella classification of Child Maltreatment deaths is 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. However, 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 or undetermined manner).
Abuse-Related: Death secondary to documented abuse (e.g., suspicious behavior with evidence of prior abuse).
Neglect: Death clearly due to neglect; supported by Coroner's reports or police or criminal investigation (e.g., a parent or caregiver driving recklessly with a suspended license when involved in a motor vehicle collision).
Neglect-Related: Death secondary to documented neglect or any case of poor caretaker skills or judgment (e.g., auto accidents or house fires where caretaker was "under the influence").
Questionable Abuse/Neglect: There are no specific findings of abuse or neglect, but there are 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.
Prenatal Substance Abuse: Clearly due to prenatal substance abuse supported by Coroner's reports (e.g., cocaine, intoxication, death from medical complications due to drugs).

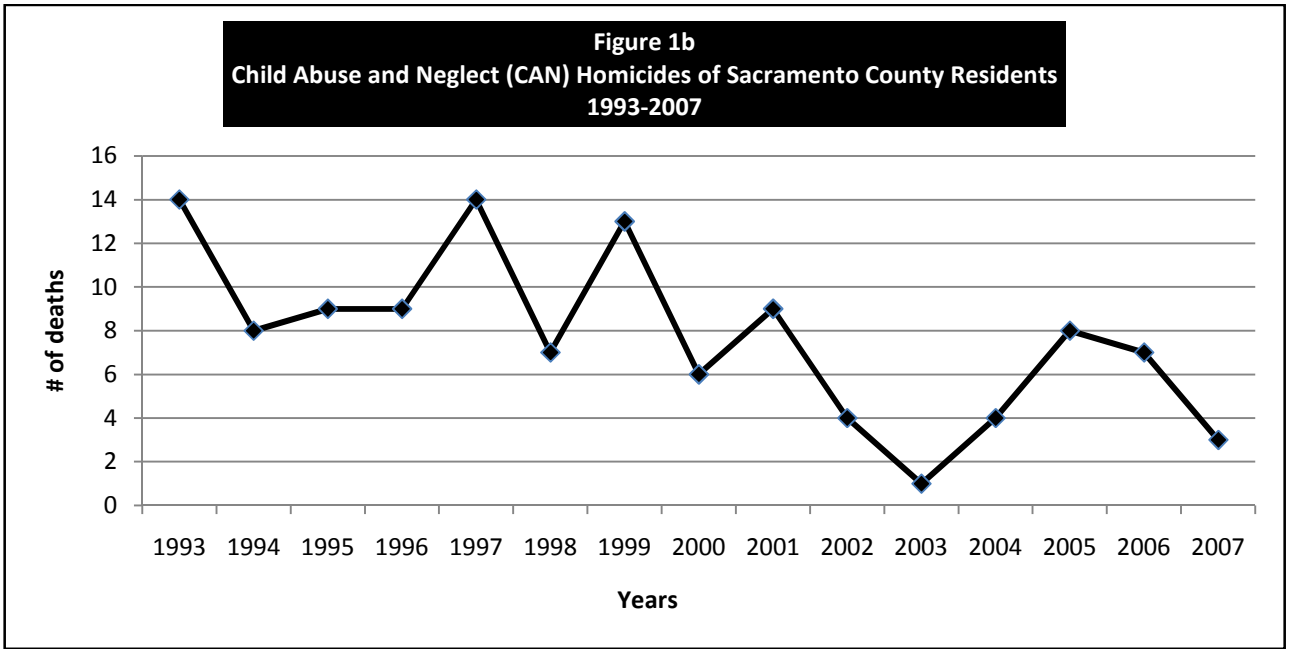
In 2007, child maltreatment was involved in the lives and deaths of 21 children that died in 2007 (see Figure 1a above). Seventeen of the 21 child deaths with an element of maltreatment were Sacramento County residents and four of the 21 decedents were out-of-county residents and whose death occurred in Sacramento County. More specifically, three children died as a result of a child abuse and neglect homicide, three died as a result of drowning where there was an element of maltreatment present, four children died where substance abuse factors were present and 11 children died from neglectful behaviors. Elements of neglect include failure by the parent or caretaker to provide for the basic needs of the child. An example of a case involving an element of neglect is that of a severely malnourished child. The child was not fed a proper diet resulting in his or her weight being far below the average weight of a child the same age, which subsequently resulted in death. A case is defined as neglect-related when the child is left without adequate supervision, food, shelter or medical care and dies from suddenly arising danger. An example of a neglect-related death is a case where a child did not have adequate supervision and was able to get into a pool which resulted in the child's death.

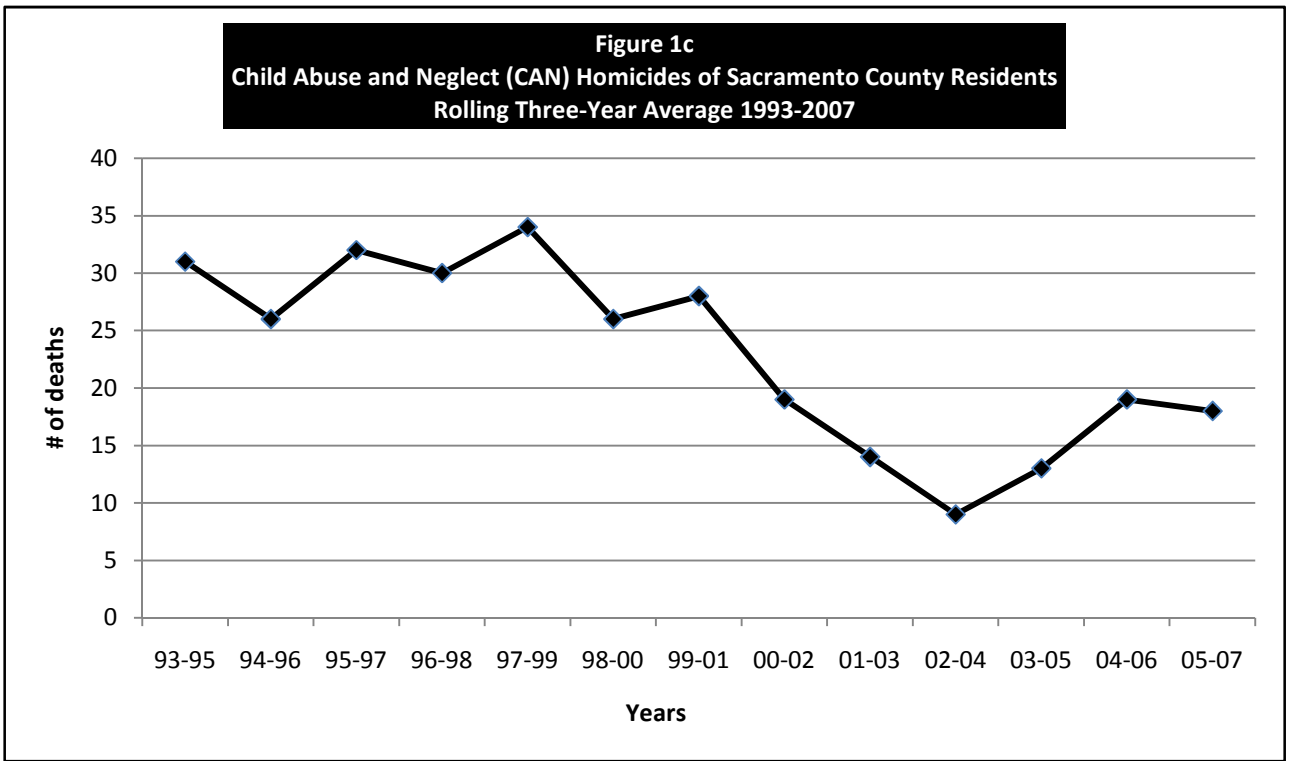
Through the years that Sacramento County's CDRT has met and reviewed child deaths, certain risk factors have been identified. Known risk factors were present in all 21 deaths related to abuse and neglect deaths in 2007. Examples of risk factors include a family history of alcohol and other drug involvement, or a family history of abuse and neglect, domestic violence or violent crime. The following information was available for the 21 deaths with an element of child maltreatment:

- 11 families had either a history of alcohol and/or drug use or alcohol and/or drugs were involved at the time of the decedent's death
- 10 families had a history of violent and/or non-violent crime
- 6 families had a history of domestic violence
- 4 decedents had a history of involvement with any California county CPS
- 3 families had a history of abuse or neglect, either on the decedent, or the decedent's sibling
- 2 decedents had involvement with Sacramento County CPS within 6 months prior to the death

Child Abuse and Neglect Homicides

In 2007, there were three child abuse and neglect (CAN) homicides all of which were Sacramento County residents, out of 192 Sacramento County resident child deaths. All three CAN homicides were separate incidents. In 2006, there were seven CAN homicides, of which all were Sacramento County residents, out of 184 Sacramento County resident child deaths.





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, three children residing in Sacramento County were victims of CAN homicides. Two victims were female and one was male. Two victims were one year of age and under and one was between 5 and 9 years of age. All three victims were African American.

Perpetrators

Of the three CAN homicides in 2007, two died at the hand of their biological parent(s) and one died at the hand of a caregiver.

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 2007, three risk factors were identified in at least one of the CAN homicides: prior child abuse and/or neglect, a family history of violent and/or non-violent crime, a family history of domestic violence, and a family history of drugs and/or alcohol use.

Prior Agency Involvement

One of the goals of the CDRT is to identify gaps in delivery of services, which are identified during the review process. For that purpose, the CDRT records agency involvement with decedents and their families. Of the three 2007 CAN homicide decedents, two decedents had Child Protective Services (CPS) involvement with Sacramento County CPS. One of the two decedents had involvement with Sacramento County CPS at the time of death. One of the two decedents with prior Sacramento County CPS involvement also had prior involvement with at least one other California County CPS.

Investigation and Prosecution

Of the three CAN homicides in 2007, charges were filed in two of the cases. One defendant has been charged with *inflicting corporal injury on a child resulting in death* and is pending trial. One defendant has been charged with *homicide* and is pending trial.

Because cases take time to navigate through the criminal justice system, this annual report attempts to report on the outcomes of prior identified CAN homicides from previous years. Of the eight perpetrators involved in the seven CAN homicides of 2006:

- Four perpetrators were charged with homicide and are currently pending jury trial.
- Two perpetrators were determined to be guilty of misdemeanor child abuse charges. Of those two, one received one year in jail, and one received 12 years and eight months in a state prison.
- One perpetrator was charged with three counts of misdemeanor vehicular manslaughter and has an outstanding warrant for their arrest, but is unable to be located.
- In one case, charges were not filed.

Chapter II

All Causes of Child Death

Chapter Two

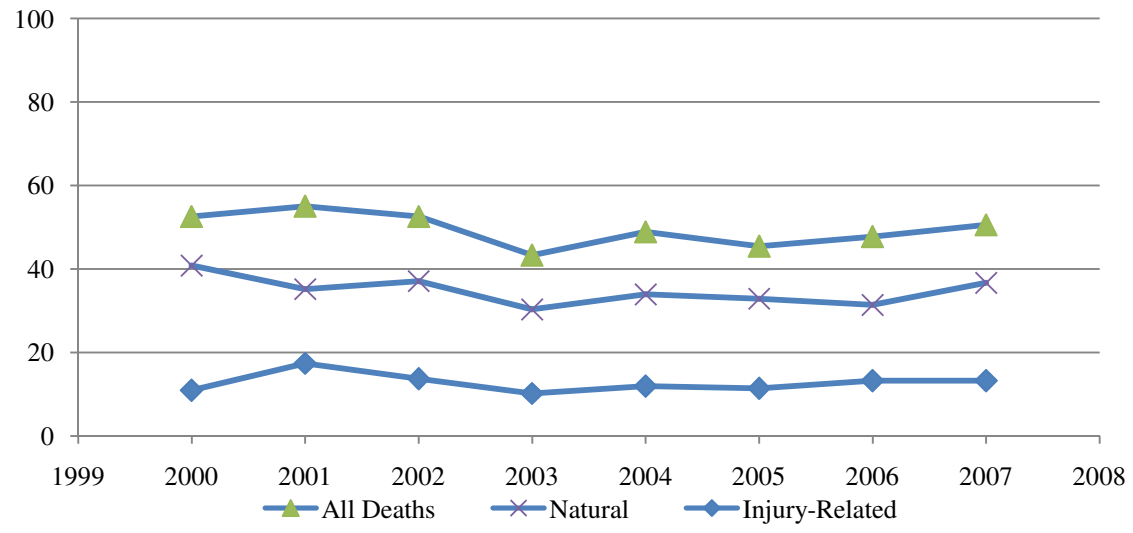
All Causes of Child Death

Another fundamental mission of the Child Death Review Team (CDRT) is to develop a statistical description of all child deaths 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. Figure 3 on the following page shows a breakdown of child deaths by category from 2000 through 2007.

Child Death Rates

In 2007, there were 192 Sacramento County child deaths in children birth through 17 years of age, who were Sacramento County residents. The child death rate represents the death rate for Sacramento County residents, birth through 17 years of age whose death occurred in Sacramento County and in a surrounding 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. Map i, shown on the page 13, is a graphical representation of all Sacramento County child deaths birth through 17 years of age, who were Sacramento County residents.

Figure 2
Sacramento County child death rates per 100,000 children



The child death rate for 2007 was 50.6 per 100,000 children. This rate is higher than the 2006 rate of 47.7, the 2005 rate of 45.4, the 2004 rate of 48.9, and the 2003 rate of 43.3. Figure 2 above illustrates the child death rates of Sacramento County residents from 2000-2007.

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

In 2007, 72% (139 of 192) of all Sacramento County resident child deaths were due to natural causes. This is seven percentage points higher than Sacramento County child deaths than deaths due to natural causes in 2006. Injury-related deaths accounted for 25% (45 of 192) of all Sacramento County children and children who died in Sacramento County in 2007. This is four percentage points lower than in 2006. Four percent of child deaths were classified as undetermined in 2007. This is three percentage points lower than in 2006.

Figure 3 below shows a breakdown of Sacramento County resident child deaths by category from 2000 through 2007.

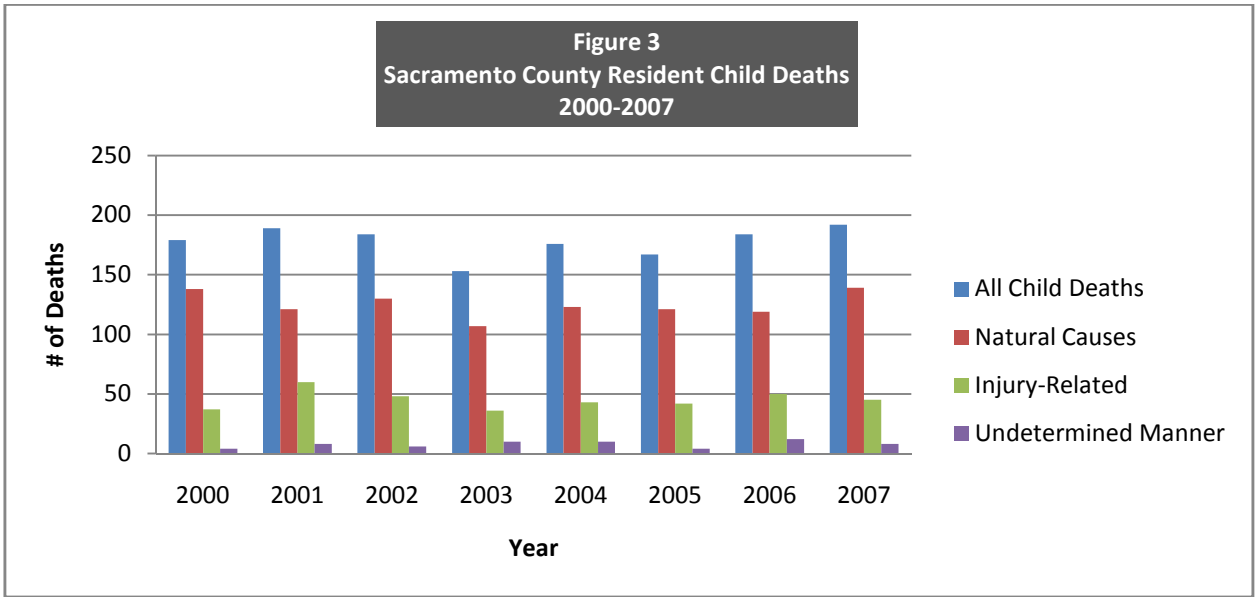


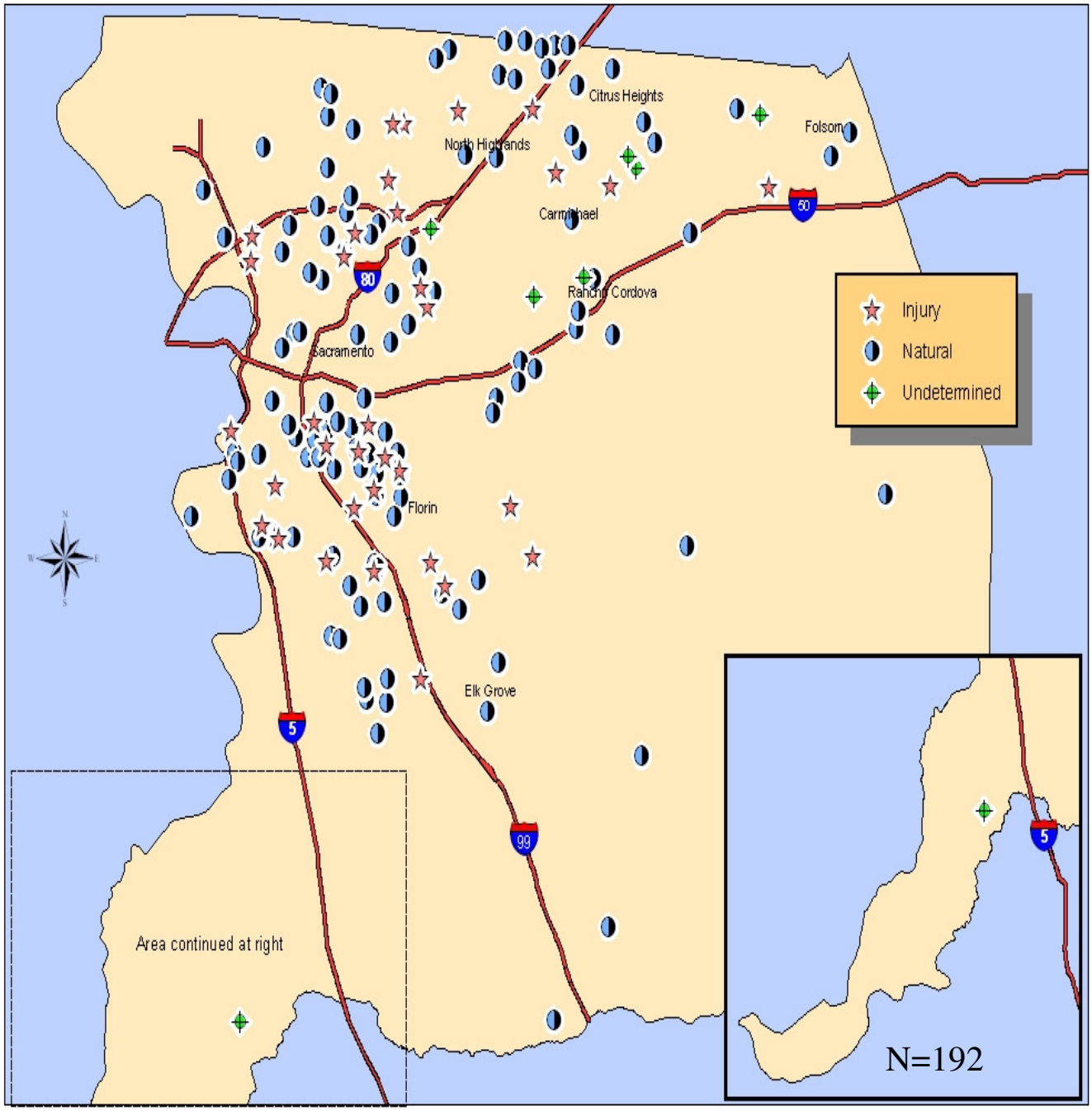
Table A, on the following page, provides a summary of the cause and manner of all 2007 child deaths. Deaths in the two main categories, injury-related and natural causes, are broken out into subcategories according to similar conditions. A third category, undetermined, contains cases for which the manner of death could not be identified. Examples of cases in this category include infant sleep-related deaths, where there was not enough information to categorize the death a natural SIDS or an accidental injury from parental overlay.

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.

Table A
2007All Child Deaths by Cause and Manner

Category	Number of Deaths
Natural Causes	
Perinatal Conditions	63
Congenital Anomalies	38
SIDS/SUIDS	14
Cancer	15
Infections	3
Respiratory	0
Other	6
Undetermined Natural	0
Total Natural Causes	**139**
Injury-Related Causes	
CAN Homicide	3
Third-Party Homicide	9
MVC (Occupant)	12
MVC (Pedestrian)	6
MVC (Bike)	0
Drowning	7
Suicide	4
Suffocation/Choking	1
Burn/Fires	5
Undetermined Injuries	0
Poisoning/ Overdose	2
Other Injuries	1
Total Injury-Related Causes	**50**
Undetermined Manner	**8**
TOTAL	**197**

Map i:
All Causes of Death
Sacramento County Resident Deaths 2007



Injury-Related Deaths

Definition: Death as a direct result of an injury-related incident. Examples of injury-related deaths include homicide, motor vehicle collisions, suicide, drowning, burns/fires, and suffocation/choking.

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 insufficient 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 collisions and drownings are examples of deaths commonly caused by unintentional injuries. Intentional injuries include homicides and suicides.

Intentional Injuries

Homicides

Homicides represented 12 (6%) of the child deaths in 2007 and 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, on the following page, shows a geographical representation of CAN homicides and third-party homicides of children birth through 17 years of age that occurred in Sacramento County in 2007, including one homicide of an out-of-county resident.

Third-Party Homicides

Of the 12 child homicides in 2007, nine were classified as third-party homicides. Seven of the nine victims were between 15 and 17 years of age, one victim was under one year of age and one victim was between one and four years of age.

The following information was available for the nine third-party homicides in 2007. At least one risk factor was present in seven of the nine (78%) third party homicides in 2007.

- 6 victims had a family history of violent and/or non-violent crime
- 3 victims had a history of gang involvement
- 3 victims had prior CPS involvement in any California County
- 3 victims came from families with a history of substance abuse
- 2 victims had drugs or alcohol involved in their death

Suicides

In 2007, four child deaths were identified as suicides. The method of suicide for three of the four deaths was by a firearm and one was by hanging. One decedent was between 10 and 14 years of age and three decedents were between 15 and 17 years of age.

Map ii:
All Homicides
Sacramento County 2007

Unintentional Injuries

Twelve year old Isaiah was eagerly waiting for his ride home from a school dance. As more time passed, Isaiah decided to find a pay phone and call home. He crossed the street from his school to nearby stores where he was unable to find a phone he could use. As he crossed the street back to school, using an unmarked crosswalk at night, Isaiah was struck by a motor vehicle which subsequently caused his death.

In 2007 there were 34 deaths resulting from unintentional injuries (including the deaths of five out-of-county residents). The two leading causes of unintentional injury-related deaths in 2007 were motor vehicle collisions (18), and drowning (7).

The following information was available for unintentional injury-related deaths in 2007. Risk factors were present in 21 of the 34 deaths (62%) resulting from unintentional injuries in 2007.

- 13 victims had a family history of violent and/or non-violent crime
- 11 victims had a family history that included substance abuse
- 7 victims had a family history that included domestic violence
- 4 victims had a previous history of child abuse and/or neglect

Motor Vehicle Collisions

Motor vehicle collisions accounted for 18 of the 34 unintentional injuries for 2007, including deaths of 13 Sacramento County residents and five out-of-county residents. Twelve of the 18 victims (67%) were either drivers or occupants. Six of the other motor vehicle collision victims were pedestrians. The 18 motor vehicle collisions deaths occurred as a result of 16 separate incidents, where two children died in two of the incidents.

Of the 18 motor vehicle driver/occupant collisions, 11 (61%) involved a youth between 14 and 17 years of age. Seven of the 11 (60%) were male, two (28%) were not licensed properly, nine (82%) had an element of recklessness, including the decedent acting recklessly or the decedent being a victim of reckless behavior, and three (43%) involved a driver under the influence of drugs or alcohol.

Drowning

Drowning victims accounted for seven of the 34 unintentional injuries for 2007. Four children died in a residential pool (including one death in a hot tub), and one each in a bath tub, a slough and in the river. Out of the four residential pool drowning deaths, two (50%) deaths involved inadequate fencing or locks. Inadequate supervision was a factor in three of the seven (43%) deaths. Three of the seven decedents were between 1 and 4 years of age, three were between 15 and 17 years of age and one was between 10 and 14 years of age.

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, cancers, Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Death Syndrome (SUIDS) and deaths due to infections or respiratory conditions.

One hundred thirty nine (139) children who resided in Sacramento County, died from natural causes in 2007. This number includes the deaths of children resulting from Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death Syndrome (SUIDS). The two leading natural causes of death were perinatal conditions and congenital anomalies (birth defects).

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 20^{th} to 28^{th} week of gestation and ending seven 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 2007, perinatal conditions accounted for the deaths of 63 children. Prematurity was a contributing factor in 38 (20%) of the 192 child deaths this year. The median gestational age of babies who died from prematurity and other perinatal conditions was 27 weeks. The median weight of babies who died from prematurity and other perinatal conditions was 1053 grams (approximately 2.32 pounds).

Known risk factors were present in 29 of the 63 deaths due to perinatal conditions in 2007 (46%). The following information was available on those deaths:

- 21 families had a family history of violent and/or non-violent crime
- 16 families had a history of substance abuse
- 8 mothers had inadequate prenatal care
- 3 families had a history of domestic violence
- 3 mothers were teenagers
- 3 mothers had a history of smoking during their pregnancy
- 2 mothers 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 38 deaths caused by congenital anomalies in 2007. Known risk factors were present in 16 of the 38 deaths due to this condition (42%).

- 11 families had a history of violent or non-violent crime
- 6 families had a history of domestic violence
- 4 mothers had inadequate prenatal care
- 2 families had a history of substance abuse
- 2 mothers were teenagers

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.

The following information was available on the 24 deaths due to cancer, infections, and other natural causes in 2007. Known risk factors were present in 13 of the 24 deaths (54%) due to these causes.

- 11 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
- 2 families had a history of abuse and/or neglect

Infant Sleep-Related Deaths

On the next pages, information is provided on infant sleep-related deaths due to the historically high number of infant sleep-related deaths in Sacramento County.

Infant sleep-related deaths represented 21 (11%) of the deaths in 2007 and were comprised of three categories: Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome (SUIDS) and deaths of an undetermined manner. Map iii, on page 22, shows a geographical representation of all infant sleep-related deaths, including SIDS, SUIDS and deaths of an undetermined manner of Sacramento County residents that occurred in Sacramento County in 2007.

Infant sleep-related deaths declined from 20 in 2003 to 13 in 2004 to nine in 2005. However, there has been an increase in 2006 and 2007 (12 in 2006 and 21 in 2007). Figure 4 on page 21, shows all infant sleep-related deaths since 2000. It is important to note that beginning in 2007, SUIDS deaths have been differentiated by the Coroner from SIDS deaths for the first time in any CDRT report. Therefore, a marker for SUIDS is only incorporated for the year 2007.

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."

In 2007 there were nine SIDS deaths in Sacramento County. Five of the nine infants (56%) died in environments recognized to increase the risk of SIDS, such as sleeping in an adult bed or couch. Seven of the nine infants were 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 eight of the nine deaths related to SIDS in 2007, as follows:

- 5 infants slept in unsafe sleeping locations, such as an adult bed or couch.
- 2 infants slept in locations were there was an obstruction of blankets and/or pillows.
- 2 infants were co-sleeping with a parent and/or sibling.
- 1 infant was exposed to second hand smoke.

Sudden Unexpected Infant Death Syndrome (SUIDS)

Definition: Sudden unexpected infant death syndrome (SUIDS) applies to the death of an infant less than one year of age, in which investigation, autopsy, medical history review and appropriate laboratory testing fails to identify a specific cause of death. SUIDS includes cases that meet the definition of Sudden Infant Death Syndrome (SIDS). If there are external or exogenous stressors [risk factors] that a medical examiner would like to incorporate on a death certificate, such as co-sleeping or bed sharing, they may be added to the cause of death, such as in the following way: Sudden unexplained (or unexpected) infant death while bed-sharing.

In 2007 there were five SUIDS deaths in Sacramento County. Risk factors were present in all five deaths related to SUIDS in 2007, as follows:

- All 5 infants were co-sleeping with a parent and/or sibling.
- 4 infants were put to sleep in a position recognized to increase the risk of SUIDS, such as face down or on their side.

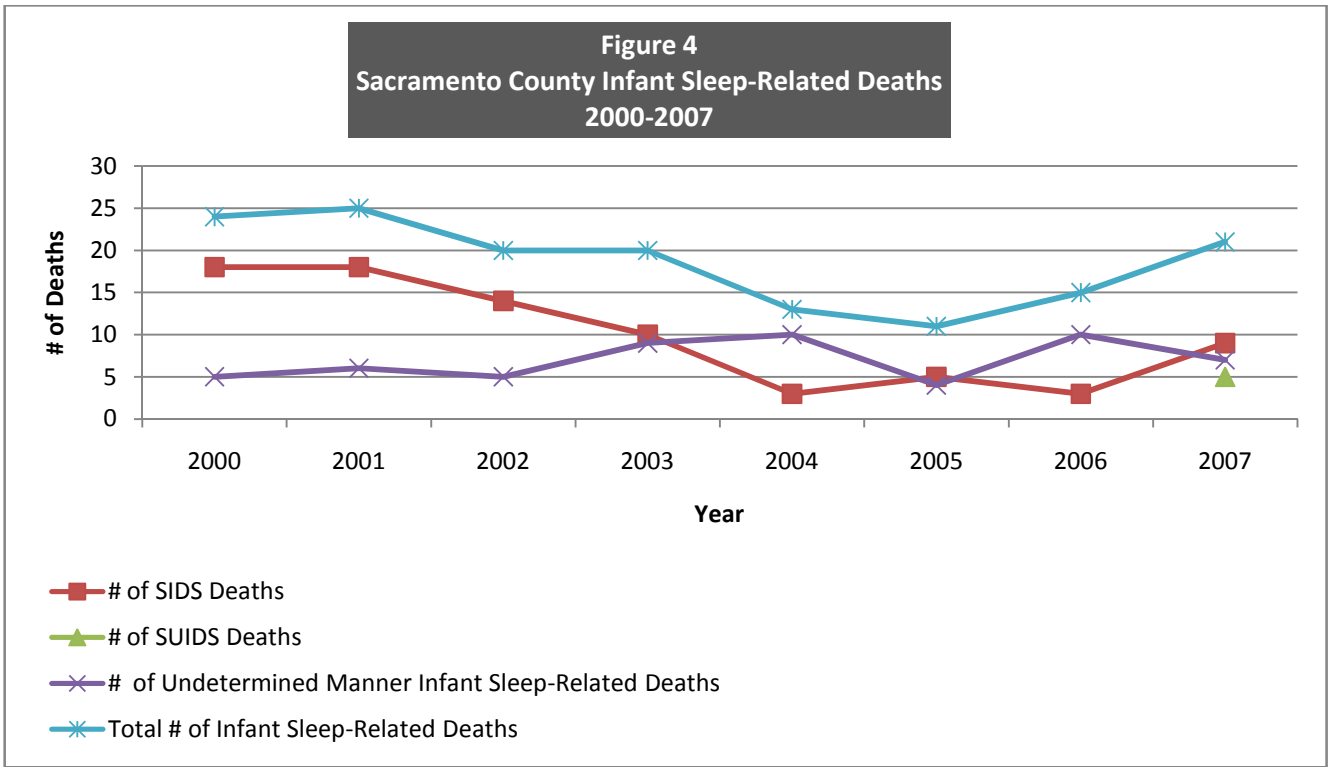
Undetermined Manner Infant Sleep-Related Deaths

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 in this category are infant sleep-related deaths where there was not enough evidence to determine whether the death was caused by parental overlay or SIDS or SUIDS.

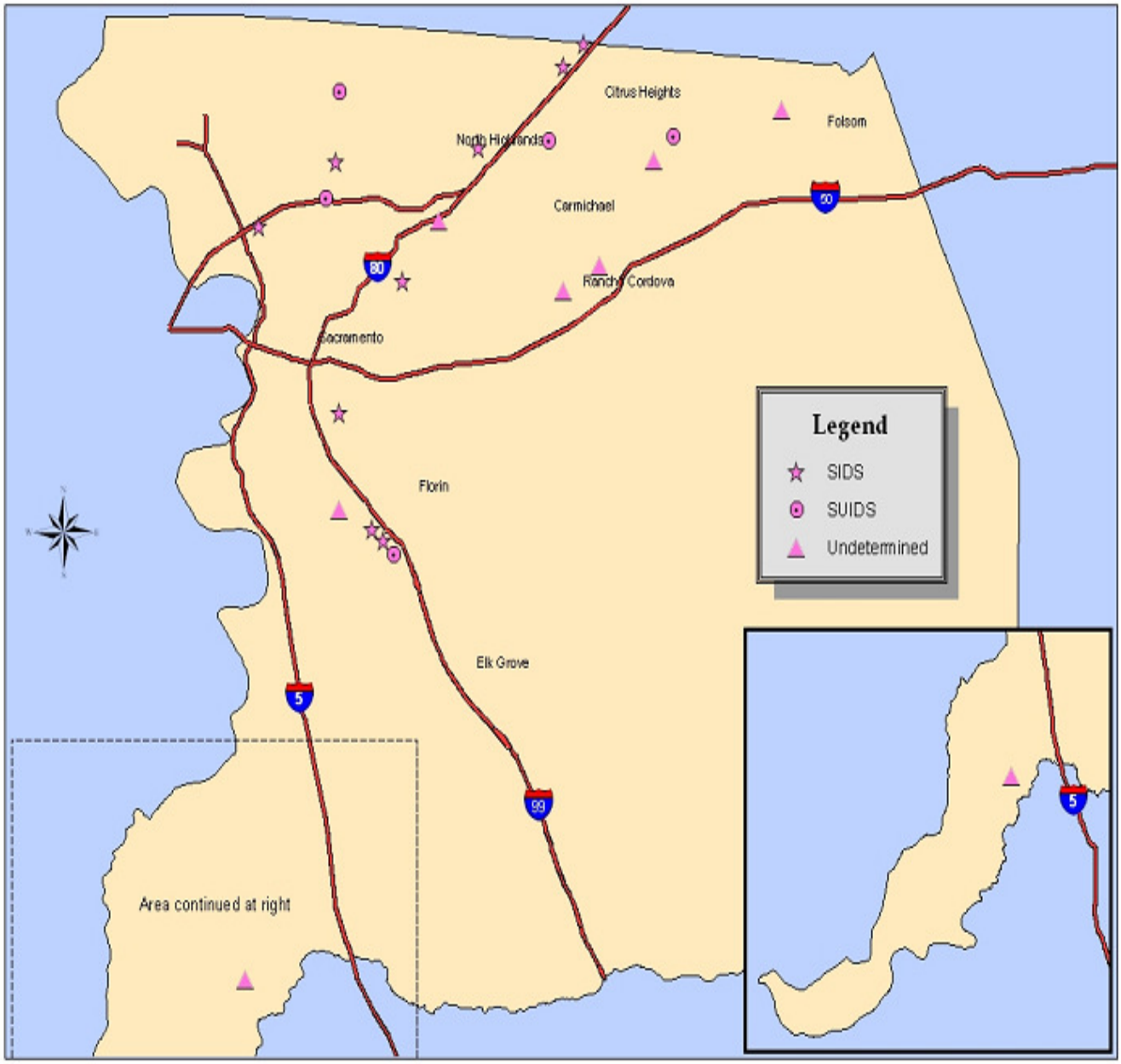
In 2007 there were seven undetermined manner infant sleep-related deaths in Sacramento County. Risk factors were present in all seven deaths and are as follows:

- 6 infants were sleeping in either adult or makeshift beds (i.e. couches) with pillows, comforters and other potential dangers
- 5 infants were co-sleeping with their parents and/or a sibling
- 3 infants were exposed to tobacco smoke
- 2 families had a history of substance abuse
- 1 family had substance abuse involvement at the time of the child's death
- 1 infant had a family history of abuse or neglect
- 1 family had a history of domestic violence



* SUIDS deaths were recorded for the first time in 2007. Previously, SUIDS deaths were incorporated into other infant sleep-related categories, such as SIDS and/or Undetermined Manner.

Map iii:
All Infant Sleep-Related Deaths
Sacramento County 2007



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 whether or not the fatal condition was developed or was inflicted. An example of a death that has insufficient information to assign a manner is a child who was in a questionable situation, where the team could not determine if the death would have occurred naturally, or by an inflicted or accidental injury.
In 2007, seven of the eight (88%) undetermined manner deaths were infant sleep-related. One of the eight deaths (12%) categorized as an undetermined manner death was not considered to be infant sleep-related.

Chapter III

Child Death Demographics

Chapter Three

Child Death Demographics

Age

The majority of Sacramento County resident child deaths occurred in infants under one year of age, accounting for 61% (118 of 192) of all deaths. Children between 15 and 17 years of age were the second largest group, accounting for 18% (35 of 192) of all deaths in 2007. The third largest group was children between 1 and 4 years of age, accounting for 9% (18 of 192) of all deaths in 2007. The fourth group was children between 10 and 14 years of age, accounting for 7% (13 of 192) of all deaths in 2007. Lastly, the fifth group was children between 5 and 9 years of age, accounting for 4% (8 of 192) of all deaths in 2007. Table B below illustrates this year's findings.

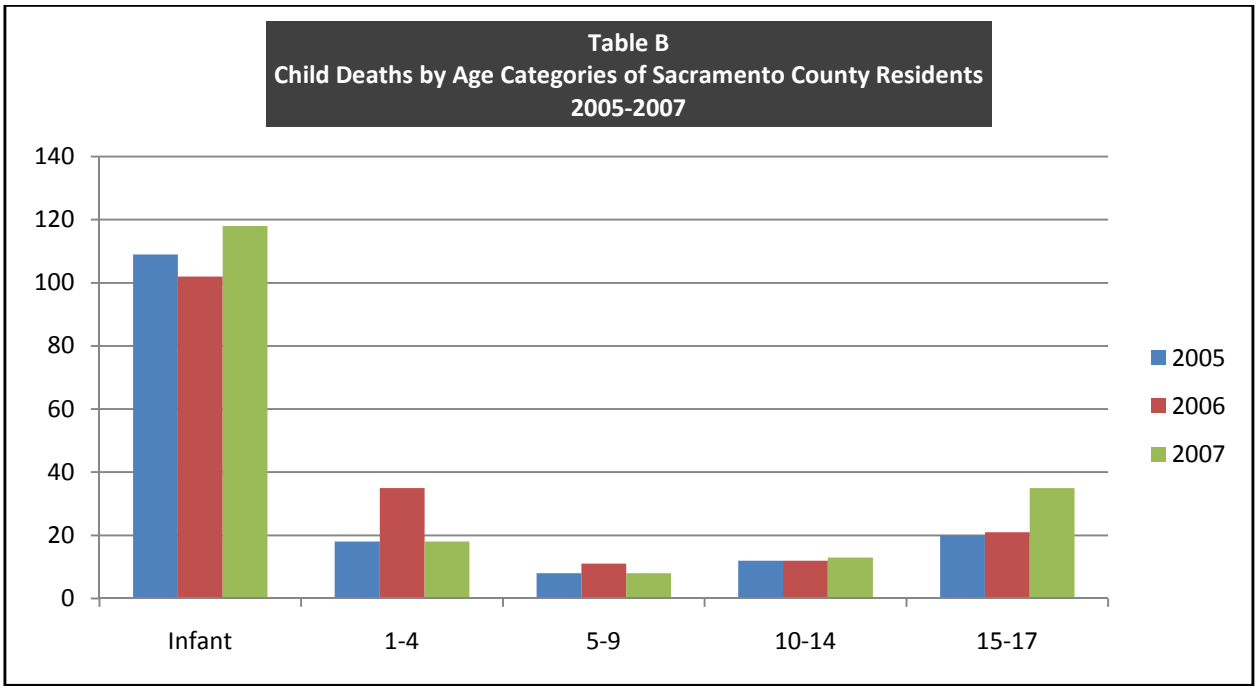


*Table B illustrates child deaths of Sacramento County Residents only; however, the narrative includes information for all child deaths that occurred in Sacramento County.

Intentional Injuries

There were a total of 16 deaths resulting from intentional injuries. Children 15 through 17 years of age accounted for 10 (62%) of the intentional injury child deaths. Infants and children one through four years of age each accounted for two (12%) deaths. Children 10 through 14 years of age accounted for one (6%) of the intentional injury child deaths. Children 5 through 9 years of age also accounted for one (6%) of the intentional injury child deaths.

Unintentional Injuries
There were a total of 34 deaths resulting from unintentional injuries. Children 15 through 17 years of age accounted for 17 (50%) of the deaths due to an unintentional injury. Children 1 through 4 years of age accounted for seven (20%) of the deaths, and children 10 through 14 years of age accounted for five (15%) of these deaths. Children 5 through 9 years of age accounted for three (9%) of the deaths and infants under one year of age accounted for two (6%) of the deaths due to an unintentional injury.

Natural Causes
A total of 139 deaths resulted from natural causes in 2007, SIDS and SUIDS deaths. Infants under one year of age accounted for 108 (78%) of all deaths due to natural causes. The second largest group was children one through four years of age, accounting for 10 (7%) of all natural deaths. Children 10 through 14 years of age and 15 through 17 years of age each accounted for eight (6%) of all natural deaths. Lastly, children five through nine years of age accounted for five (3%) of all natural deaths.

Undetermined Manner
A total of eight deaths were of an undetermined manner in 2007, including infant sleep-related deaths. Infants accounted for seven (87%) of these deaths. Children one through four years of age accounted for one (12%) of the deaths due to an undetermined manner. Children five through nine years of age and 10 through 14 years of age were not represented in the undetermined manner category of 2007.

Race and Ethnicity

There are differences in the number and proportions of child deaths among Sacramento County's various racial and ethnic populations. Table C below represents the Sacramento County child death race and population rates of Sacramento County residents.

Table C
Comparison of Child Deaths by Race and Child Population
2006 and 2007

Race/Ethnicity	2006 Child deaths (#)	2006 Child deaths (%)	2006 Child death rate of residents per 100,000 child population	2007 Child deaths (#)	2007 Child deaths (%)	2007 Child death rate of residents per 100,000 child population
Caucasian	80	43%	49.91	63	42%	39.61
African American	31	17%	75.21	41	10.4%	103.80
Hispanic	33	18%	34.00	34	25.9%	34.68
Asian	19	10%	38.73	20	12.3%	42.77
Native American	1	1%	--	0	--	--
Multiracial	16	9%	49.43	26	8%	85.34
Other	4	2%	73.92	8	1.4%	147.73
Total	184	100%	47.7	192	100%	50.6

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 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

Substance Abuse and Domestic Violence

Substance abuse and domestic violence are major concerns to the Child Death Review Team. As mentioned previously, the overlap between domestic violence and/or substance abuse is prevalent in child abuse cases. The National Committee to Prevent Child Abuse conducted a survey of public child welfare agencies and found that "as many as 80% of child abuse cases are associated with the use of alcohol and other drugs."[1] Additionally, according to statistics published by the U.S.

[1] McCurdy, K., and Daro, D. (1994) *"Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1993 Annual Fifty State Survey."* Chicago: National Committee to Prevent Child Abuse.

Department of Justice in 2002, "61% of domestic violence offenders also have substance abuse problems."[2]

In 2007, 55 of the 197 child deaths (32%) had a history of substance abuse in the child's family and/or alcohol and drugs were involved at the time of the child's death. The deaths involving substance abuse are as follows:

- 16 deaths due to Perinatal Conditions
- 7 deaths due to Motor Vehicle Collisions
- 5 deaths due to SIDS
- 4 deaths due to Third Party Homicides
- 4 deaths due to Burn/Fire
- 3 deaths due to Other-Natural
- 3 deaths due to Cancer
- 2 deaths each due to Congential Anomalies, Drowning, Infection, SUIDS and Undetermined Manner
- 1 death each due to a CAN Homicide, Poisoning/Overdose and Suffocation

In 2007, 27 of the 197 child deaths (43%) had a history of domestic violence in the child's family. The deaths involving a family history of domestic violence are as follows:

- 6 deaths due to Congential Anomalies
- 4 deaths due to Motor Vehicle Collisions
- 3 deaths due to SIDS
- 3 deaths due to Perinatal Conditions
- 2 deaths each due to Burn/Fire, Cancer and Other-Natural
- 1 death each due to a CAN Homicide, Drowning, Infection, SUIDS and Undetermined Manner

[2] Collins, James J. and Donna L. Spencer. (2002) *"Linkage of Domestic Violence and Substance Abuse Services, Research in Brief, Executive Summary."* U.S. Department of Justice.

Foster Care

In 2007, eight (4%) of the 192 Sacramento County resident children who died were involved with the foster care system. Six of the eight children had a history of foster care prior to their death, and six of the eight children were in foster care at the time of their death. Of the six children who were in foster care at the time of their death, two died as a result of perinatal conditions, and one died each as a result of CAN homicide, drowning, infection, and suffocation. Of the children who had previous foster care history and were no longer in foster care at the time of circumstances leading to death, one died each as a result of perinatal conditions, CAN homicide, congenital anomaly, infection, suffocation and burn/fire. In some cases, children with a current history of foster care also had a previous history of foster care placement.

Youth Deaths

This section of the report summarizes the findings for youth deaths between 10 and 17 years of age that died in Sacramento County in 2007 by the newly formed (2007) Youth Death Review Subcommittee (YDRS) of the CDRT.

Of the total 197 child deaths in Sacramento County in 2007, 49 child deaths occurred in youth between 10 and 17 years of age comprising 25% of all child deaths in 2007. Sixteen (33%) of the 49 deaths were due to natural causes and 33 (67%) were injury-related. Of the 49 youth deaths, 33 (67%) were male and 16 (33%) were female. Fourteen of the youth were Caucasian, 13 were African American, 11 were Hispanic, seven were multiracial, and four were Asian/Pacific Islander.

Through the extensive review of youth deaths by the YDRS, findings indicate that nine of the 33 injury-related youth deaths involved a firearm (27%). Six of the deaths that occurred by use of a firearm were third-party homicides and three were suicides. Eight of the nine injury-related youth deaths that involved a firearm were of youth between 15 and 17 years of age. These eight deaths of youth between 15 and 17 years of age account for 88% of the child deaths in 2007 that occurred by use of a firearm.

Eighty-two percent (27 of 33) of the injury-related youth deaths occurred in youth 15 to 17 years of age. Eight of the 27 (30%) injury-related deaths in youth 15 to 17 years of age in 2007 occurred by use of a firearm. YDRS and CDRT findings also conclude that 82% of motor vehicle collisions that occurred in youth 14 to 17 years of age involved reckless behavior, including the decedent acting recklessly or the decedent being a victim of reckless behavior.

In 2006, a total of 35 child deaths occurred in youth between 10 and 17 years of age comprising 19% of all child deaths. Twelve (34%) of the 35 deaths were due to natural causes and 23 (66%) were injury-related. Of the 35 youth deaths, 26 (74%) were male and nine (26%) were female. Ten of the youth were Caucasian, nine were Hispanic, six were Asian/Pacific Islander, five were African American, and five were multiracial.

Known risk factors were present in 29 (59%) of the total 49 youth deaths in 2007. The following is a representation of the risk factors present in the 29 youth deaths:

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

Injury-Related Youth Deaths

There were a total of 33 injury-related youth deaths comprising 67% of all youth deaths in 2007. Fourteen involved vehicular injuries, four involved a drowning, two involved a hanging, two involved a poisoning/overdose, one involved a suffocation/choking and one death was a result of a fire. Firearms were involved in nine (27%) of the 33 injury-related youth deaths in 2007.

Of the 33 injury-related youth deaths in 2007, 24 were male and nine were female. Ten victims were African American, nine were Caucasian, eight were Hispanic, four were multiracial and two were Asian/Pacific Islander.

In 2006, there were a total of 23 injury-related youth deaths comprising 65% of all youth deaths. Nine involved vehicular injuries, two involved a poisoning/overdose and one each involved a hanging, a drowning, a stabbing, and a beating. Firearms were involved in seven (30%) of the 23 injury-related youth deaths in 2006.

Of the 23 injury-related youth deaths in 2006, 21 were male and two were female. Seven victims were Caucasian, six victims each were Hispanic, five were African American, three were Asian/Pacific Islander and two were multiracial.

Known risk factors were present in 18 (55%) of the 33 youth deaths in 2007. The following is a representation of the risk factors present in the 33 youth deaths:

- 13 had a history of non-violent crime
- 8 had a history of alcohol and/or drug use
- 6 had a history of violent crime
- 4 had a history of gang involvement

- 3 had a history of domestic violence within their home
- 3 had a history of child abuse and neglect

Third-party Youth Homicides

Of the nine total third party homicides in 2007, seven (77%) involved youth between 10 and 17 years of age. Third-party homicides comprised seven (21%) of the 33 injury-related youth deaths. Five victims were male and two were female. Four victims were African American, two were multiracial and one victim was Hispanic. Of the seven third-party youth homicides, four were 17 years of age, two were 15 years of age and one was 16 years of age. Firearms were involved in six of the cases and one case involved a motor vehicle collision.

There were known risk factors in five of the seven third-party youth homicides:

- 4 had a history of non-violent crime
- 3 had a history of gang involvement
- 2 had a history of alcohol and/or drug use.
- 2 had a history of violent crime
- 1 had a history of child abuse and neglect

In 2006, third-party homicides comprised eight (35%) of the 23 injury-related youth deaths. All eight (100%) of the third-party youth homicides were male. Four victims were Hispanic, two were African American, and one each was Caucasian and multiracial. Of the eight third-party youth homicides, four were 17 years of age, three were 16 years of age, and one was 15 years of age. Firearms were involved in five of the deaths, one involved a beating, one involved a stabbing, and one involved a motor vehicle collision.

Suicides in Youth

Suicides comprised four (12%) of the 33 injury-related youth deaths in 2007. Three youths were male and one was a female. The method of death for one case was by hanging and three involved a firearm. Two victims were Caucasian, one victim was Hispanic and one victim was African American.

There were known risk factors in three of the four suicide youth deaths:

- 2 had a mental health history
- 1 each had a history of non-violent crime, violent crime and gang involvement

In 2006, suicides comprised one (4%) of the 23 injury-related youth deaths. Between 2000 and 2007, suicides comprised thirty-five (24%) of the 147 injury-related teen fatalities. Twenty-seven of the 35 suicides were male and eight were female. Twenty of the teens were Caucasian, six were African American, four were multiracial, three were Asian/Pacific Islander, one was American Indian and one was Hispanic. Twenty of the teens used hanging, ten used firearms, two each used suffocation and overdose, and one used vehicular trauma as the mechanism of suicide.

Motor Vehicle Collision Youth Deaths

Motor vehicle collisions comprised 13 (39%) of the 33 injury-related youth deaths. Nine victims were male and four were female. Of the 13 motor vehicle collision youth deaths, five victims were Caucasian, four were African American, two were Hispanic, and two were Asian/Pacific Islander. Of the 13 youth motor vehicle collision youth deaths, eight were driver/occupants and five were pedestrians.

There were known risk-factors that contributed to nine of the 13 (69%) motor vehicle collision youth deaths:

- 3 had alcohol and/or other drugs involved at the time of the collision
- 2 were not properly licensed
- 1 seat belt was not used properly

In 2006, motor vehicle collisions comprised seven (35%) of the 20 injury-related youth deaths. Six victims were male and one was female. Of the seven motor vehicle collisions, four victims were Caucasian, two were Hispanic, and one was Asian/Pacific Islander. Of the seven youth motor vehicle collision deaths, 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.

Natural Youth Deaths

Of the 16 youth deaths due to natural causes in 2007, six (37%) were due to other-natural causes, five (31%) were due to cancer, two (12%) each were due to congenital anomalies and perinatal conditions (12%), and one (6%) was due to an infection. Nine of the 16 were male and seven were female. Five of the youth were Caucasian, three each were African American, Hispanic and multi-racial and two were Asian/Pacific Islander.

Of the youth deaths due to natural causes in 2006, five (42%) of the twelve were due to congenital anomalies, four (33%) were due to cancer, two (17%) were due to other-natural and one (8%) was due to an infection. Seven of the twelve (58%) were female and five (42%) were male. Three each were Asian/Pacific Islander, Hispanic, multi-racial and Caucasian.

The following information was available on the 16 youth deaths in 2007 due to natural causes:

- 9 had history of non-violent crime

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

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 deaths. This action reflected a growing awareness that child abuse and neglect deaths 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 Sacramento County's 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 deaths 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 2007 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 birth through 17 years of age 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 Staff who prepares them for review. Team members compile pertinent information their agency may have regarding each case. This information is brought to the monthly meetings in order to identify 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 data are analyzed in the aggregate 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 deaths. 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 "Undetermined."

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 "Undetermined." 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 "Undetermined."

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 unintentional deaths. For example, strategies designed to reduce the number of unintential drug overdose will differ greatly from those designed to reduce intentional drug overdose.

Report Strengths and Limitations

Better identification of child abuse and neglect deaths 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 deaths. 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 deaths 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 deaths. As a result, there is a significant undercount of the annual CAN-related deaths 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 deaths 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 consistently, so these cases may or may not be 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 2007
Sacramento County

Category	Years																		
	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**Total**
Perinatal Conditions	79	70	46	46	44	21	42	52	48	40	42	48	56	43	62	71	65	63	**938**
Congenital Anomalies	28	33	26	23	24	25	19	30	27	27	33	32	39	32	31	28	29	38	**524**
SIDS	28	28	21	29	25	18	21	20	19	18	18	18	15	10	3	5	3	9	**308**
SUIDS	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	5	**5**
Cancer	11	11	6	9	10	6	9	5	10	10	15	5	10	11	10	9	9	15	**171**
Infections	8	8	8	3	11	4	7	3	4	6	8	10	6	2	10	5	8	3	**114**
Respiratory	7	10	3	10	5	7	9	8	4	1	3	0	2	0	1	1	2	0	**73**
Other	19	10	10	14	21	17	15	12	4	11	16	8	2	7	6	2	3	6	**183**
Undetermined (Natural)	4	2	0	3	0	0	4	1	1	5	3	0	0	2	0	0	0	0	**25**
Total Natural Causes	**184**	**172**	**120**	**137**	**140**	**98**	**126**	**131**	**117**	**118**	**138**	**121**	**130**	**107**	**123**	**121**	**119**	**139**	**2,341**

** 2007 is the first year where SUIDS (Sudden Unexpected Infant Death Syndrome) deaths were differentiated from SIDS (Sudden Infant Death Syndrome) deaths for the Annual CDRT Report.*

Table E
Number of Injury-Related Deaths According to Category for 1990 to 2007
Sacramento County*

Category	Year																		
	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**Total**
Homicides	12	18	13	21	15	20	16	23	11	16	10	16	11	9	15	17	16	12	**271**
CAN Homicide	(9)	(7)	(9)	(14)	(8)	(9)	(9)	(14)	(7)	(13)	(6)	(9)	(4)	(1)	(4)	(8)	(7)	(3)	**(141)**
Third -Party Homicide	(3)	(11)	(4)	(7)	(7)	(11)	(7)	(9)	(4)	(3)	(4)	(7)	(6)	(8)	(11)	(9)	(9)	(9)	**(129)**
Arson Homicide	0	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	**(1)**
Motor Vehicle Collisions (MVC)	18	15	14	14	15	23	19	17	11	11	14	21	13	14	10	8	11	13	**261**
MVC (Driver/ Occupant)	(11)	(11)	(8)	(7)	(8)	(12)	(15)	(10)	(7)	(4)	(8)	(10)	(11)	(8)	(5)	(3)	(6)	(7)	**(151)**
MVC (Pedestrian)	(6)	(3)	(6)	(6)	(5)	(8)	(2)	(7)	(1)	(5)	(5)	(8)	(1)	(5)	(4)	(4)	(3)	(6)	**(85)**
MVC (Bike)	(1)	(1)	(0)	(1)	(2)	(3)	(2)	(0)	(3)	(2)	(1)	(3)	(1)	(1)	(1)	(1)	(2)	(0)	**(25)**
Drowning	8	7	9	7	7	4	4	6	7	6	5	5	9	4	7	5	12	7	**119**
Suicide	5	7	3	4	4	3	4	5	8	0	6	5	7	4	4	8	1	4	**82**
Suffocation/ Choking	3	3	0	4	0	0	2	4	2	1	1	3	1	1	0	2	3	1	**31**
Fires	2	2	1	2	1	0	3	5	4	0	0	1	1	1	0	1	2	5	**31**
Other	1	0	0	8	5	3	0	5	1	1	1	8	4	2	6	1	6	1	**53**
Undetermined (Injury)	2	1	9	0	4	4	3	0	2	1	0	1	2	1	1	0	0	0	**31**
Poisoning/ Overdose	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	2	2	**4**
Total Injury-Related Causes	**51**	**53**	**49**	**60**	**51**	**57**	**51**	**65**	**46**	**36**	**37**	**60**	**48**	**36**	**43**	**42**	**53**	**45**	**883**
Undetermined Manner	7	2	2	4	6	0	4	2	2	3	4	8	6	10	10	4	12	8	**(104)**

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

Table F
Sacramento County Resident Deaths Only

Category	Infant	1-4	5-9	10-14	15-17	Total
Perinatal Conditions	60	1	0	1	1	63
Congenital Anomalies	32	2	2	1	1	38
Sudden Infant Death Syndrome or Sudden Unexpected Infant Death Syndrome (SIDS or SUIDS)	14	0	0	0	0	14
Cancer	2	5	3	3	2	15
Infections	0	2	0	0	0	2
Respiratory	0	0	0	0	1	1
Other (natural)	0	0	0	3	3	6
CAN Homicide	1	1	1	0	0	3
Third-Party Homicide	1	1	0	0	7	9
Arson Homicide	0	0	0	0	0	0
Motor Vehicle Deaths (occupant)	0	0	0	0	7	7
Motor Vehicle Deaths (pedestrian)	0	1	0	2	3	6
Motor Vehicle Deaths (bicycle)	0	0	0	0	0	0
Drowning	0	3	0	1	3	7
Suicide	0	0	0	1	3	4
Suffocations	0	0	0	0	1	1
Burn	1	1	2	0	1	5
Other Injury	0	0	0	0	1	1
Legal Intervention	0	0	0	0	0	0
Poisoning/ Overdose	0	0	0	1	1	2
Undetermined Injury	0	0	0	0	0	0
Undetermined Manner	7	1	0	0	0	8
Total	**118**	**18**	**8**	**13**	**35**	**192**

Table G
Deaths by race/ethnicity and age group 2007
Sacramento County Resident Deaths Only

Race Classification	Infant	1-4	5-9	10-14	15-17	Total
Caucasian	42	4	3	4	10	63
African American	22	5	1	4	9	41
Asian/ Pacific Islander	11	4	2	1	2	20
Hispanic	18	4	1	3	8	34
Multiracial	19	0	0	1	6	26
Other	6	1	1	0	0	8
Total	**118**	**18**	**8**	**13**	**35**	**192**

Table H
Child abuse and neglect homicide victims by age 1990 to 2007
Sacramento County Resident Deaths Only

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
2007	1	1	1	0	0	3
Total	**37**	**67**	**23**	**8**	**6**	**141**

Table I
Child abuse and neglect homicide victims by race/ethnicity 1990 to 2007
Sacramento County Resident Deaths Only

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
2007	0	0	3	0	0	3
Total	**58**	**21**	**42**	**12**	**8**	**141**

** *Including children of mixed racial categories.*

Table J
Perpetrators of CAN homicides 1990 to 2007
Sacramento County*

Perpetrator	1990-2006	2007	Total number of Perpetrators**
Father	40	1	41
Mother	34	2	36
Boyfriend of Mother or Guardian	17	0	17
Undetermined	14	0	14
Both Parents	9	0	9
Babysitter	7	0	7
Stepfather	4	0	4
Other Family Member	6	0	6
Foster Parent	3	1	4
Girlfriend of Father or Guardian	2	0	2
Family Friend	2	0	2
Total	**138**	**4**	**142**

** 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.*

*** The total number of perpetrators exceeds the total number of CAN homicides, because in some cases more than one perpetrator was involved in the death of a child.*

Table K
Deaths caused by intentional injuries by mechanism 1990 to 2007
Sacramento County*

	3rd Party Homicide	CAN Homicide	Suicide	Total
Firearm	99	23	36	158
Battering	5	37	0	42
Hanging	0	0	42	42
Shaking	0	19	0	19
Suffocation/Strangulation	1	16	0	16
Poisoning/Overdose	0	8	3	11
Stabbing	11	6	0	17
Fire	2	4	0	6
Undetermined	1	1	0	2
Vehicular	8	2	1	11
Drowning	1	5	0	6
Chronic Neglect	0	12	0	12
Other	1	3	0	4
Unknown	1	5	0	6
Total	**130**	**141**	**82**	**353**

** 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*
2000-2007

Zip	Neighborhood	2007 Deaths	Deaths 2000-2006	Total
95608	Carmichael	4	29	33
95610	Citrus Heights	2	28	30
95615	Courtland	0	1	1
95621	Citrus Heights	8	28	36
95624	Elk Grove	5	30	35
95626	Elverta	0	7	7
95628	Fair Oaks	5	19	24
95630	Folsom/Clarksville/El Dorado Hills	6	32	38
95632	Twin Cities/Galt/Herald	3	12	15
95638	Herald	1	4	5
95655	Mather	0	2	2
95660	North Highlands	2	46	48
95662	Orangevale	1	18	19
95670	Rancho Cordova	9	46	55
95673	Rio Linda/Robla	7	17	24
95683	Rancho Murieta	1	3	4
95690	Walnut Grove	1	2	3
95693	Wilton	0	1	1
95757	Elk Grove	5	14	19
95758	Bruceville	5	51	56
95763	Folsom	0	1	1
95814	Downtown Sacramento	3	9	12
95815	North Sacramento	2	41	43
95816	Midtown Sacramento	1	5	6
95817	Sacramento/Oak Park	2	20	22
95818	Sacramento/South Land Park	2	9	11
95819	Sacramento/ East Sacramento	1	12	13
95820	Fruitridge	16	68	84
95821	Town and Country Village	3	35	38
95822	Sacramento/Meadowview	8	51	59
95823	Sacramento/Valley Hi	13	107	120
95824	Fruitridge	10	42	52
95825	Arden/Arcade	7	28	35
95826	Perkins/Rosemont	3	29	32
95827	Mills/Walsh Station	3	24	27
95828	Florin	8	47	55
95829	Coffing/Sheldon	3	20	23

95830	Sacramento (Florin & Sunrise)	0	1	1
95831	Greenhaven	3	22	25
95832	Sacramento/Freeport	2	12	14
95833	Arden/ Garden	3	32	35
95834	Sacramento/South Natomas	3	10	13
95835	Sacramento/North Natomas	2	11	13
95837	Sacramento International Airport	0	1	1
95838	Del Paso Heights/Hagginwood	13	48	61
95841	Foothill Farms	2	15	17
95842	Sacramento/Foothill Farms/North Highlands	3	38	41
95843	Sacramento/Antelope	11	25	36
95864	Arden/Arcade	0	7	7
	Unknown**	0	1	1
Total		**192**	**1,161**	**1,353**

** 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 deaths 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 deaths. 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 from 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.
Stephanie Biegler
Director, Child Abuse Prevention Council of Sacramento, Inc.

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

Nazia Ali
CDRT Project Manager

Citrus Heights Police Department
Ron Pfleger, Detective

Department of Health and Human Services
Child Protective Services
Marian Kubiak, M.S.W.
Julie Zawodny

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
Andrew Smith, J.D.,
Supervising Deputy District Attorney
of Sexual Assault Child Abuse Unit

Elk Grove Police Department
Mario Guzman
Sergeant

Kaiser Permanente
Carole Jones, R.N., C.C.R.N.

Andrew Kincaid, M.D., Pediatric Specialty Clinic

Law Enforcement Chaplaincy - Sacramento
Frank Russell
Supervising Senior Chaplain

Mercy San Juan Hospital
Denise von Arx, CNS

Sacramento City Fire Department
Debra Lyon, R.N.

Sacramento City Police Department
Paul Martinson, Sergeant

Sacramento County Coroner's Office
Mark Super, M.D., CDRT Vice-Chair, Forensic Pathologist
Greg Wyatt, Coroner
Kim Burson, Assistant Coroner/ Investigation

Sacramento County Metropolitan Fire Department
Clayton Elledge, Captain

Sacramento County Probation Department
Robin Wilkins

Sacramento County Sheriff's Department
Carol Mims, Detective
Jeff Reinl, Sergeant

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

Paula Christian, M.S.W.
Department of Health and Human Services
Child Protective Services

Kim Clark
Detective, Sacramento City Police Department

Rod Chong
Division Chief, Sacramento City Fire Department

Judy Cooperider, M.S.W.
Department of Health and Human Services
Child Protective Services

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

Guy Gates, Detective
Citrus Heights Police Department

Keith Gault
ACLS Coordinator
Sacramento City Fire Department

Jason Gay
Detective
Sacramento County Sheriff's Department

Lori Greene, J.D., Deputy District Attorney
District Attorney's Office

Kevin Givens, 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

Meghann K. Leonard, M.P.P.A.
Child Abuse Prevention Council of Sacramento, Inc.
CDRT Project Manager/Data Analyst

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

Anthony Medina, Captain
Sacramento City Fire 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

Judy Pierini, M.S.W.
Department of Health and Human Services
Child Protective 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

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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, fiancee, 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 injuried (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 nomal metabolism, appetite, and activity. Causes include illness, chomosomal 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 judgment 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.

Prenatal Substance Abuse Deaths: Clearly due to prenatal substance abuse supported by Coroner's reports (e.g., cocaine, intoxication, death from medical complications due to drugs).

Prenatal Substance Abuse-Related Deaths: Deaths secondarty to known or probable substance abuse (e.g., SIDS/SUIDS with known perinatal exposure to drugs).

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.

Questionable Abuse/Neglect Deaths: There are no specific findings of abuse orneglect, but there are factors such as substance abuse 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.

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 whe 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.

Sudden Unexpected Infant Death Syndrome (SUIDS): The sudden unexpected/unexplained infant death (SUID) applies to the death of an infant less than one year of age, in which investigation, autopsy, medical history review, and appropriate laboratory testing fails to idenify a specific cause of death. SUIDS includes cases that meet the definition of Sudden Infant Death Syndrome (SID). If there are external or exogenous stressors [risk factors] that a medical examiner would like to incorporate on a death certificate, such as co-sleeping or bed sharing, they may be added to the cause of death, such as in the following way: *Sudden unexplained (or unexpected) infant death while bed-sharing.*

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.