Sacramento County Child Death Review Team
2009 Annual Report

The following report includes brief descriptions on some of the cases of children who died in Sacramento County in the 2009 calendar year, reviewed by the Child Death Review Team. 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.

TABLE OF CONTENTS

Executive Summary		vii
	Major Findings	xi
	Recommendations	xv
Chapter I	**Deaths Related to Abuse and Neglect**	1
	Child Maltreatment Deaths	3
	Child Abuse and Neglect Homicides	5
	Victims	6
	Perpetrators	6
	Mechanism of Death	6
	Risk Factors	6
	Prior Agency Involvement	6
	Investigation and Prosecution	7
Chapter II	**All Causes of Child Death**	9
	Child Death Rates	11
	Table A: All Child Deaths by Cause and Manner 2009	14
	Map i: All Causes of Sacramento County Resident Deaths 2009	15
	Intentional Injuries	16
	Map ii: All Homicides Sacramento County Resident Deaths 2009	18
	Unintentional Injuries	19
	Natural Causes	20
	Infant Sleep-Related Deaths	22
	Map iii: All Infant Sleep-Related Sacramento County Resident Deaths 2009	25
	Deaths of Undetermined Manner	26
Chapter III	**Child Death Demographics**	27
	Age	29
	Table B: Child Deaths by Age Categories of Sacramento County Residents 2005-2009	29
	Race and Ethnicity	31
	Table C: Comparison of Sacramento County Resident Child Deaths by Race and Child Population 2008 and 2009	31
	Risk Factors	31
	Youth Deaths	33

Chapter IV The Sacramento County Child Death Review Team 37

History and Background 39
Mission Statement 40
Membership 41
Review Process 42
Method 43
Report Strengths and Limitations 44

Tables 47

Appendix 59

A. Memorandum of Agreement for the Sacramento County Multidisciplinary Child Death Review Team 61
B. Confidentiality Agreement 67
C. Formation Members 68
D. 2009 Members 69
E. Past Members 70
F. Glossary 75

A Special Thank You 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 2009 CDRT, YDRS and/or PAC:

Christy Adams, R.N., B.S.N., University of California Davis Medical Center
Elizabeth Albers, R.N., M.D., Sacramento County Coroner's Office
Elyssa Anderson, R.N., B.S.N., P.H.N., Mercy San Juan Medical Center
Sonja Atkins, Safe Kids Greater Sacramento
Melinda Avey, Sacramento County Department of Health and Human Services
Jason Baldwin, Citrus Heights Police Department
Keith Bays, Sacramento County Department of Probation
Lisa Bertaccini, Sacramento County Department of Health & Human Services
Joe Blair, Elk Grove Police Department
Mike Blazina, J.D., Sacramento County District Attorney's Office
Cathy Boyle, P.N.P., University of California Davis Medical Center
Kim Burson, Sacramento County Coroner's Office
Kathy Charles, Sacramento County Department of Mental Health
Judy Cooperrider, Sacramento County Department of Health & Human Services
Kevin Coulter, M.D., University of California Davis Medical Center
Margaret Crockett, CNS., Sutter Memorial Hospital
Elizabeth Dutton, California Highway Patrol
Clayton Elledge, Sacramento Metropolitan Fire Department
Pam Gressot, Sacramento County Department of Health and Human Services
Carole Jones, R.N., Kaiser Permanente
Andrew Kincaid, M.D., Kaiser Permanente
Marian Kubiak, Sacramento County Department of Health and Human Services
Diane Lampe, Elk Grove Unified School District
Cassius Lockett, PhD., Sacramento County Department of Health & Human Services
Debra Lyon, R.N., Sacramento City Fire Department
Nancy Marshall, Sacramento County Department of Health & Human Services
Paul Martinson, Sacramento City Police Department
Carol Mims, Sacramento County Sheriff's Department
Joseph Rangel, Citrus Heights Police Department
Jeff Reinl, Sacramento County Sheriff's Department
Yvonne Rodriguez, Sacramento County Department of Health & Human Services
Angela Rosas, M.D., Sutter Memorial Hospital, Children's Specialists Medical Group
Frank B. Russell, Sacramento County Law Enforcement Chaplaincy
Afiya Simpson, SETA Head Start
Andrew Smith, J.D., Sacramento County District Attorney's Office
Ellie Sorkin, Sacramento City Unified School District
Deborah Stewart, M.D., University of California Davis Medical Center
Mark A. Super, M.D., Sacramento County Coroner's Office

Barry Turner, San Juan Unified School District
Carol Tucker, R.N., Sacramento County Department of Health & Human Services
Denice Von Arx, R.N., M.S.N., C.N.S., Mercy San Juan Medical Center
Mary Jess Wilson, M.D., M.P.H., Sacramento County Department of Health & Human Services
Drew Wyant, Sacramento County Sheriff's Department
Julie Zawodny, Sacramento County Department of Health and Human Services

With gratitude,

Sheila Boxley
President and CEO
Child Abuse Prevention Center

The production of this report was made possible through funding secured by the Child Abuse Prevention Council of Sacramento, Inc. (CAPC), sponsor of the CDRT. The printing and staffing were made possible through the Sacramento County Children's Trust Fund, administered by the Sacramento County Children's Coalition.

Based upon the direction and feedback of the CDRT, YDRS, and the 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.

Executive Summary

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 2009. Included are descriptions of all deaths whether they were the result of child abuse and neglect, injuries, homicides or natural causes.

2009 marks the twentieth year 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 2009, 151 children residing in Sacramento County died. Therefore, the 2009 child death rate of Sacramento County, birth through 17 years of age is 40.02 per 100,000 children. In 2008, 163 children residing in Sacramento County died in Sacramento County. Therefore, the 2008 child death rate of Sacramento County, birth through 17 years of age, was 43.07 per 100,000 children.

In 2009, 154 children birth through 17 years of age died in Sacramento County. This includes the death of three children who died in Sacramento County, but were not current residents of Sacramento County. The three classifications of all child deaths were natural causes (122), injury-related (27), and undetermined manner (5). In 2008, 166 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 fourth year in which deaths of out-of-county residents who died 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 122 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 79% (122 of 154) of all Sacramento County resident child deaths for this year.

Injury-related deaths resulted in 27 child deaths, accounting for 18% of the total child deaths for this year, including deaths of three out-of-county residents whose injury occurred in Sacramento County. 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. Six of the 27 injury-related deaths in 2009 were the direct result of a CAN homicide, accounting for 22% of the total injury-related deaths. There were 12 CAN homicides in 2008.

There were five child deaths that resulted from an undetermined manner, accounting for 3% of the total child deaths. Three of the five deaths of an undetermined manner (60%) were infant sleep-related.

2009 marks the third 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 nearly half (13) of the 27 injury-related deaths (48%) are in youth between 10 and 17 years of age. More specifically, five youth died due to Motor Vehicle Collisions (MVC), three third-party homicides, two suicides, two drownings and one poisoning/overdose. Eighty-five percent of all youth injury-related deaths were of male decedents (11 of 13). Eight-five percent (11 of 13) of injury-related deaths occurred in youth 15 to 17 years of age. More than a quarter (3 of the 11) of the injury-related deaths in youth 15 to 17 years of age occurred by use of a firearm. The YDRS also found that 38% (5 of 13) of the youth injury-related decedents had a violent or non-violent crime history. Examples of violent and non-violent crime include assault and possession of illegal drugs.

In 2008, 21 of the 40 injury-related deaths (53%) were in youth between 10 and 17 years of age. Over seventy percent (15 of 21) of the injury-related youth deaths occurred in youth 15 to 17 years of age. Six of the 15 (40%) injury-related deaths in youth 15 to 17 years of age occurred by use of a firearm. The YDRS also found that nearly one-half of all youth injury-related decedents had a violent or non-violent crime history (10 of 21).

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 2009 Annual CDRT 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 recommend strategies to reduce such numbers and improve the health and lives of children in Sacramento County. Additionally, the CDRT recognizes the County's dire fiscal situation and the effect it is having on children's safety net services. Therefore, the recommendations strongly support effective early intervention and prevention programs, and advocate strongly for restored and continued support of these efforts.

2009 Major Findings

In 2009, there were 151 child deaths at a child death rate of 40.02 per 100,000 children, birth through 17 years of age, of children 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 154.

In 2008, there were 163 child deaths at a child death rate of 43.07 per 100,000 children, birth through 17 years of age, of children 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 166.

Major findings of the types of deaths that occurred in Sacramento County in 2009 are as follows

- **Injury-related deaths are the lowest in 20 years.**

  In 2009, there were 27 injury-related deaths, the lowest number of injury-related deaths in 20 years. The lowest number of injury-related deaths, prior to 2009, was 36 in both 1999 and 2003. The highest number of injury-related deaths was 65 in 1997.

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

  Twenty-seven (18%) of the 154 child deaths in 2009 were injury-related and preventable, three of which were out-of-county residents. The 27 preventable injury-related deaths in 2009 include seven drowning deaths, seven Motor Vehicle Collisions (MVC), six Child Abuse and Neglect (CAN) homicides, three third party homicides, and two each of poisoning/overdose and suicide.

- **Nearly half of all injury-related deaths were intentional injuries.**

  In 2009, there were 27 injury-related deaths, of which 11 (41%) were intentional injuries and 16 (59%) were unintentional injuries. Of the 11 intentional injury-related deaths, six were CAN homicides, three were third-party homicides and two were suicides. Of the 16 unintentional injury-related deaths, seven were Motor Vehicle Collisions (MVC), seven were drownings, and two were poisoning/overdoses.

- **There were six Child Abuse and Neglect (CAN) homicides in 2009.**

  In 2009, there were six CAN homicides, out of the total 154 child deaths. There were no out-of-county resident CAN homicides in 2009. All six CAN homicides were separate incidents. All six CAN homicide decedents were 5 years of age and under. Four were children between 1 and 4 years of age, one was an infant, and one was 5 years of age. Five of the six decedents died at the hands of one or both biological parents and one died at the hands of the Mother's boyfriend. The mechanism of death in two of the six CAN homicides was by multiple blunt force injuries,

and one each died due to abusive head trauma *(such as shaken baby syndrome),* severe malnutrition/failure to thrive, drowning and an undetermined mechanism.

In 2008, there were 12 CAN homicides, out of the total 166 child deaths. There were eleven separate incidents. Eleven of the 12 CAN homicides were Sacramento County residents and one was an out-of-county resident.

- **The majority of perpetrators of Child Abuse and Neglect (CAN) homicides in Sacramento County are biological parents.**

In 2009, five of the six CAN homicide perpetrators were one or both biological parents. From 1990 to 2009, the majority of perpetrators of CAN homicides in Sacramento County were the biological parent(s) of the decedent. This includes the mother or father acting alone, or both parents acting together. During this time period, there were 158 CAN homicides with 161 perpetrators[1], of which 60% (97 of the 161) were the biological parent(s) of the decedent.

Alternate caregivers, such as stepparents, foster parents, and boyfriend/girlfriend of a biological parent, comprise 19% (31 of 161) of the perpetrators of CAN homicides, from 1990-2009.

- **Five of the six Child Abuse and Neglect (CAN) homicide decedents had involvement with a Child Protective Services (CPS) agency prior to their death.**

Five of the six (83%) CAN homicide decedents had involvement with a Child Protective Services (CPS) agency prior to their death, in 2009. Of the five, three decedents had involvement with Sacramento County CPS. Two of the three decedents with Sacramento County CPS involvement had cases that were opened and closed prior to 6 months before their deaths. One of these three decedents was reported to Sacramento County CPS within six months prior to the fatal injury. The two decedents who did not have Sacramento County CPS history had CPS history with another State CPS.

In 2008, six (50%) of the 12 CAN homicide decedents had involvement with Sacramento County CPS. Three of the six decedents had an open case or referral with Sacramento County CPS at the time of their death. One of the six decedents had Sacramento County CPS history within six months prior to their death. Two of the six decedents also had history with at least one other California County CPS.

- **Five of the six Child Abuse and Neglect (CAN) homicide decedents had a family history of violent and/or non-violent crime.**

Five of the six (83%) CAN homicide decedents in 2009 had a family history of violent and/or non-violent crime. Two of the six CAN homicides had a family history of violent crime only, one of the six CAN homicides had a family history of non-violent crime only, and two of the six CAN homicides had both a family history of violent and non-violent crime. An example of a

[1] 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.

violent crime would include assault with a deadly weapon and an example of a non-violent crime would include drug possession with the intent to sell.

- **<u>Two-thirds of child maltreatment deaths occurred in children 5 years of age or under.</u>**

In 2009, deaths with an element of child maltreatment in children 5 years of age or under comprised nine (75%) of the 12 child maltreatment deaths. Of the nine child maltreatment deaths of children 5 years of age and under, three were infants and six were children 1-5 years of age. Of the three infant deaths with an element of maltreatment, one each was a CAN homicide, infection and undetermined manner death. Of the six deaths of children 1-5 years of age with an element of maltreatment, five were CAN homicides and one was a perinatal death.

In 2008, deaths with an element of child maltreatment in children under 5 years of age comprised 17 (77%) of the 22 child maltreatment deaths. Of the 17 child maltreatment deaths of children 5 years of age and under, nine were infants and eight were children between 1 and 4 years of age. Of the nine infant deaths with an element of maltreatment, three were Child Abuse and Neglect (CAN) homicides, two were perinatal deaths, and one each was a drowning, Sudden Infant Death Syndrome (SIDS), suffocation and undetermined infant sleep-related death. Of the eight deaths of children between 1 and 4 years of age with an element of maltreatment, seven were CAN homicides and one was by drowning.

- **<u>Nearly all infant sleep-related deaths had risk factors associated with the infant's death.</u>**

Seventeen of the 18 (94%) infant sleep-related deaths in 2009, including Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant death Syndrome (SUIDS), had risk factors associated with the infant's death. Fourteen of the 18 (78%) infant sleep-related deaths in 2009 occurred somewhere other than a crib (9 slept in an adult bed, 3 slept in other locations such as an air mattress or futon, and 2 slept on a couch). Nine of the 18 (50%) infant sleep-related deaths occurred while co-sleeping with parents and/or siblings. Of the 18 infant sleep-related deaths, 28% (5 of 18) were known to have been put to sleep in an unsafe position. Three of the 18 infants (17%) were in sleep environments cluttered with blankets or pillows. Two of the 18 families (11%) had known substance abuse involvement at the time of the infant's death.

- **<u>Nearly all of the infant sleep-related deaths were in children 6 months and under.</u>**

Seventeen of the 18 (94%) infant sleep-related deaths were in children 6 months and under. Eleven of the 18 (61%) infant sleep-related deaths occurred in the Fall or Winter months from September through February.

In 2008, 26 of the 27 (96%) infant sleep-related deaths were in children 5 months and under. Nineteen of the 27 (70%) infant sleep-related deaths occurred in the Fall or Winter months from September through February.

- **<u>African American children died at a rate two times higher than Caucasian children in Sacramento County.</u>**

  In 2009, 30 African American children died at a disproportionate rate of 77.71 per 100,000 children compared to Caucasian children who died at a rate of 30.76 per 100,000 children. Sacramento County's population for children birth through 17 years of age in 2009 was 377,245. Of that, African American children comprised 38,607 (10%) of the child population and accounted for 20% of Sacramento County's child deaths.

  Of the 30 African American children who died in 2009, the causes of death were as follows: 19 perinatal conditions, two Sudden Unexpected Infant Death Syndrome (SUIDS), and one each were Motor Vehicle Collision (MVC), respiratory, Sudden Infant Death Syndrome (SIDS), third-party homicide, other-natural, infection, cancer, drowning and Child Abuse and Neglect homicide (CAN). Twenty-four of the 30 children (80%) were under 1 year of age, three were between 15 and 17 years of age, two were between 1 and 4 years of age, and one was between 10 and 14 years of age.

  In 2008, 30 African American children died at a disproportionate rate of 76.82 per 100,000 children compared to Caucasian children who died at a rate of 33.64 per 100,000 children. Sacramento County's population for children birth through 17 years of age in 2008 was 378,375. Of that, African American children comprised 39,049 (10%) of the child population and accounted for 18% of Sacramento County's child deaths.

- **<u>Eight-five percent of all youth injury-related deaths were of male decedents</u>**

  Injury-related youth deaths of children between 10 and 17 years of age, accounted for 13 (48%) of the 27 total injury-related deaths in 2009. Of the 13 youth injury-related deaths, 11 (85%) were male and two (15%) were female. Of the 11 male youth injury-related deaths, four (36%) were 16 years of age, three (27%) were 17 years of age, two (18%) decedents were 14 years of age and two (18%) decedents were 15 years of age. Of the 11 youth injury-related deaths of males, three each were Motor Vehicle Collisions (MVC), and third-party homicides, two each were suicides and drownings, and one was a poisoning/overdose.

  In 2008, injury-related youth deaths of children between 10 and 17 years of age, accounted for 21 (53%) of the 40 total injury-related deaths. Of the 21 youth injury-related deaths, 17 (81%) were male and four (19%) were female. Of the 17 male youth injury-related deaths, three (18%) decedents were between 10 and 14 years of age and 14 (82%) were between 15 and 17 years of age. Of the 17 youth injury-related deaths of males, six were from suicides, five were Motor Vehicle Collisions (MVC), three were from third-party homicides, and one each was from a drowning, other-injury and poisoning/overdose.

2009 Recommendations

- **<u>The protection and safety of Sacramento County's children must remain a priority during county budget cuts.</u>**

  In response to these unprecedented times, the CDRT recommends funding for the protection and safety of children be included as part of the county's priority for public safety. The CDRT recognizes Sacramento County's dire fiscal situation. Unfortunately, budget cuts are affecting the safety and lives of children. Sacramento County's Department of Health and Human Services Divisions of Child Protective Services, Behavioral Health, Public Health, and Department of Human Assistance have been impacted by county budget cuts, reducing safety net services for vulnerable children.

- **<u>Restore prevention and early intervention programs implemented and targeted to new biological parents aimed at reducing child abuse and neglect in Sacramento County.</u>**

  In 2009, there were six Child Abuse and Neglect (CAN) homicides, of which five of the perpetrators were the biological parent(s). Of the five, one was the biological mother, one was the biological father and three were both biological parents acting together. Since 1990 the majority (60%) of perpetrators of CAN homicides in Sacramento County have been the biological parent(s). Prevention efforts must continue to target new biological parents and caregivers to reduce CAN homicides. These prevention efforts must be offered on an ongoing basis for new parents. Sacramento County has developed an infrastructure of family resource centers and neighborhood-based prevention services that engage at-risk families by providing a comprehensive approach to prevent child abuse and neglect deaths through home visitation and early intervention programs. Many of these services have been drastically, if not completely, cut and others are in jeopardy of being eliminated. The CDRT recommends the Sacramento County Board of Supervisors work with county agencies and community based organizations to restore child abuse and neglect prevention programs that target new biological parents to reduce child abuse and neglect in this county.

- **<u>Implement and restore public education and targeted interventions aimed at modifiable adult behaviors and risk factors contributing to preventable deaths.</u>**

  Eighteen percent of all child deaths in 2009 were preventable. They were the result of poor judgment and/or behaviors by adults. The CDRT recommends the continuation and expansion of public education campaigns, such as the *Shaken Baby Syndrome* prevention campaign and the *Safe Beginnings Prevention Program* to reduce the number of preventable abusive head trauma, infant sleep-related and drowning deaths. These educational campaigns and prevention programs have been effective in Sacramento County in reducing the number of preventable child deaths by targeting specific modifiable adult behaviors.

- **<u>Sacramento County's Child Protective Services (CPS) should continue to implement best practices to ensure the safety and well-being of the child remains central.</u>**

  In 2009, of the 12 child deaths with an element of maltreatment, eight (67%) decedents were open or reported to Sacramento County CPS or another State CPS. Of the eight decedents, six (75%) decedents were open or reported to Sacramento County CPS. Three of the six (50%) decedents had an open case or referral at the time of their death with Sacramento County CPS. One of the six (17%) decedents was reported to Sacramento County CPS within six months prior to their fatal injury. Two of the eight decedents had CPS involvement with another State CPS only. Of the 12 decedents with an element of maltreatment, four had no CPS involvement with any CPS agency.

  The CDRT supports the changes made within Sacramento County CPS, such as: utilizing a standardized risk assessment tool when referrals are made; utilizing the Imminent Risk of Removal Team Decision Making (TDM) meetings at the front of end of intervention; utilizing Signs of Safety (SOS) that enhances the Structural Decision Making (SDM) tool and promotes family engagement and deepens critical thinking, while integrating a strength and safety focus; and ensuring children will be assigned one social worker during dependency.

- **<u>Support the implementation and restoration of public education campaigns and intervention programs targeted to new parents, aimed at reducing infant sleep-related deaths.</u>**

  In 2009, infant sleep-related deaths accounted for 18 of the 154 child deaths. This is a decrease from 27 infant sleep-related deaths in 2008. From 2003 to 2007, the number of infant sleep-related deaths decreased by nearly half. Concurrently, during 2003 through 2006 there was a marked increase in public education campaigns focusing on the importance of infant safe sleeping in specific zip codes with the highest rates of infant sleep-related deaths. By 2007, the funding for some of these infant safe sleeping programs had ended, coinciding with an increase in infant sleep-related deaths in the same zip codes. In 2008, with funding from California Kids Plate, a multi-disciplinary collaborative convened to develop a Safe Beginnings prevention program to reduce infant sleep-related deaths. The collaborative conducted focus groups to learn how parents can receive the safe sleeping messages effectively. Through focus groups held in 2009, the Safe Beginnings Collaborative piloted the infant safe sleeping messages and developed targeted educational brochures and videos for parents and caregivers to understand the risks associated with infant sleep-related deaths. The CDRT acknowledges the positive impact of infant safe sleeping educational outreach programs, such as the *Safe Beginnings Prevention Program*, and encourages funding for the implementation of such programs to prevent infant sleep-related deaths.

❖ **Appoint a multi-disciplinary Sacramento County Blue Ribbon Commission to analyze data, explore causes of disproportionality in African American child death rates, and develop a coordinated strategic plan to address it.**

African American children die at a rate two times higher than Caucasian children in Sacramento County. In 2009, of the 30 African American Sacramento County resident children who died, 26 (87%) were children under 5 years of age, and four (13%) were children between 10 and 17 years of age. Twenty-six of the 30 (87%) African American children died due to natural causes. Nineteen of those 26 (73%) died from perinatal conditions. The CDRT recommends the Sacramento County Board of Supervisors appoint a multi-disciplinary Blue Ribbon Commission representative of the target population, including community leaders, service providers, and residents to develop a coordinated comprehensive strategy to understand and address the disparity in child death rates among African American children. The Commission should be lead through a public-private partnership and should use data, research, and best practices to develop interventions targeted towards pregnant African American women, as well as African American families with children 0-5 years of age and African American youth between 10 and 17 years of age.

➢ **Encourage the continuation of comprehensive child passenger safety programs and car safety programs targeted at youth and their parents.**

Motor vehicle collision (MVC) deaths increased in 2009 from six in 2008 to seven in 2009. MVC deaths in children birth through 8 years of age accounted for two of the seven (29%) deaths in 2009. The CDRT encourages Sacramento County to continue to promote the National Highway Traffic Safety Administration's (NHTSA) best practice protocols, which require all children through 8 years of age or 4'9" to remain in a booster seat while being a passenger in a moving motor vehicle.

The CDRT also encourages schools and youth serving organizations to continue comprehensive safety programs through a prevention education strategy targeted at youth and their parents. The availability of school-based motor vehicle collision and prevention programs through the California Highway Patrol and other local law enforcement agencies should focus on addressing reckless and distracted driving, seat belt safety, and drunk driving.

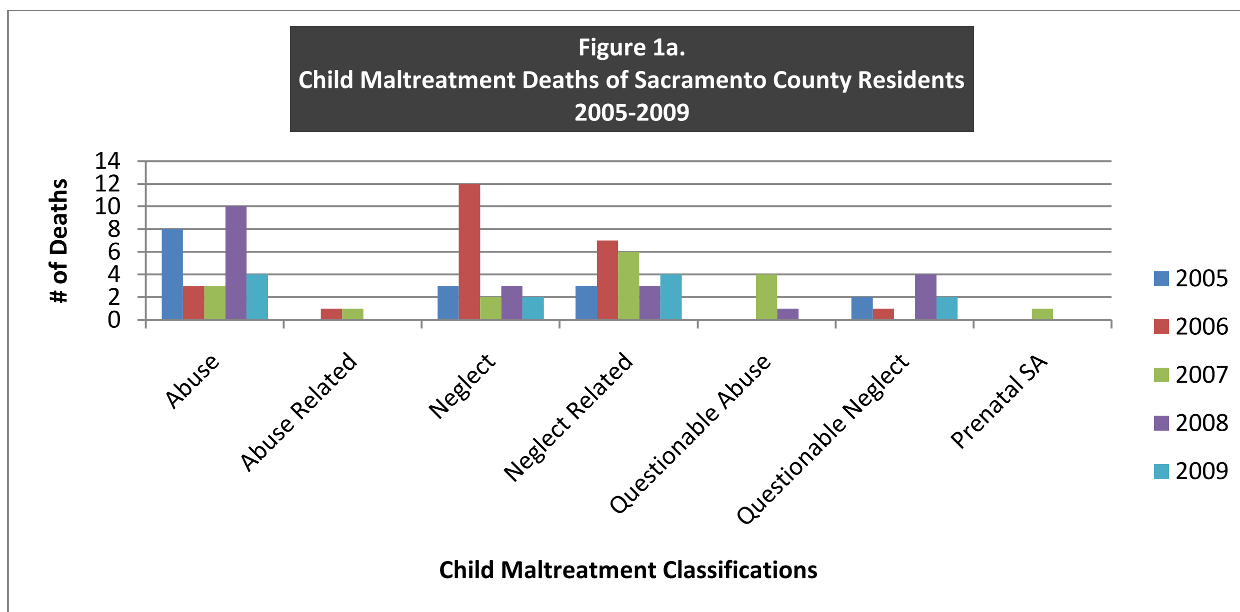
Chapter I

Deaths Related to Abuse and Neglect

Chapter One

Deaths Related to Abuse and Neglect

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 is Child Abuse and Neglect (CAN) homicides where a child was killed, either directly or indirectly, by their caregiver. However, deaths 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).

Child maltreatment was involved in the deaths of 12 children who died in 2009 (see Figure 1a above). All 12 child deaths with an element of maltreatment were Sacramento County residents. Of the 12 child deaths with an element of maltreatment, four decedents were infants, four decedents were between 1 and 4 years of age, three decedents were between 5 and 9 years of age, and one decedent was between 15 and 17 years of age. Of these deaths, six children died as a result of a Child Abuse and Neglect (CAN) homicide, two died as a result of drowning where there was an element of maltreatment present, and one each died from a congenital anomaly, infection, perinatal condition and undetermined manner. 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 a child that was severely malnourished and was not gaining weight while in the care of his or her parents. 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, who did not know how to swim, was left without adequate supervision playing near a swimming pool.

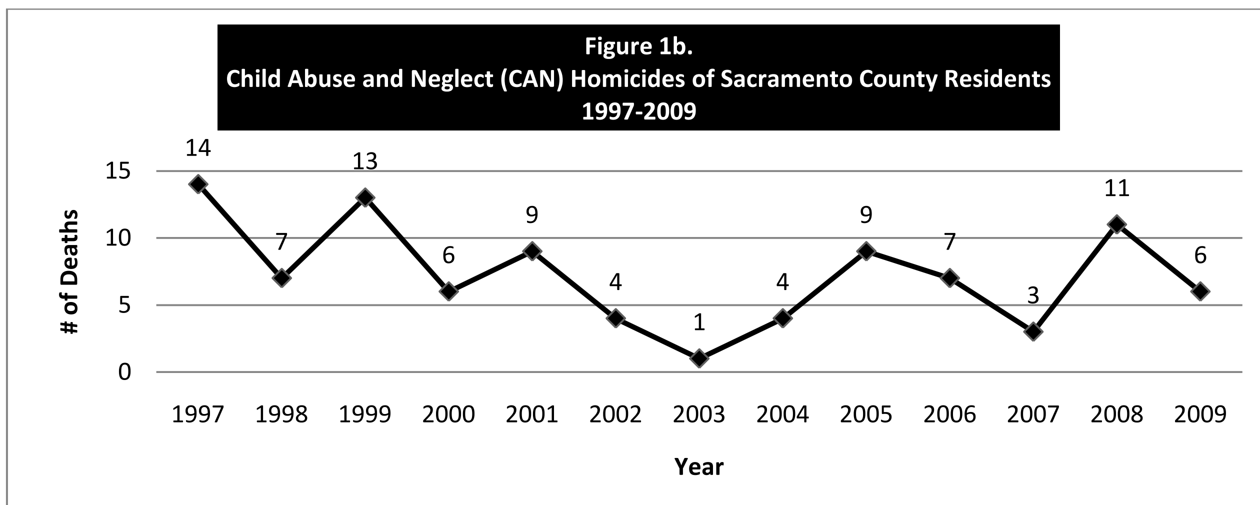
Through the years that Sacramento County's CDRT has met and reviewed child deaths, certain risk factors have been identified. Known risk factors were present in all 12 deaths related to abuse and neglect deaths in 2009. Examples of risk factors include a family history of alcohol and other drug abuse, or a family history of abuse and neglect, domestic violence or violent crime. Known risk factors were present in the 12 deaths with an element of child maltreatment and are as follows:

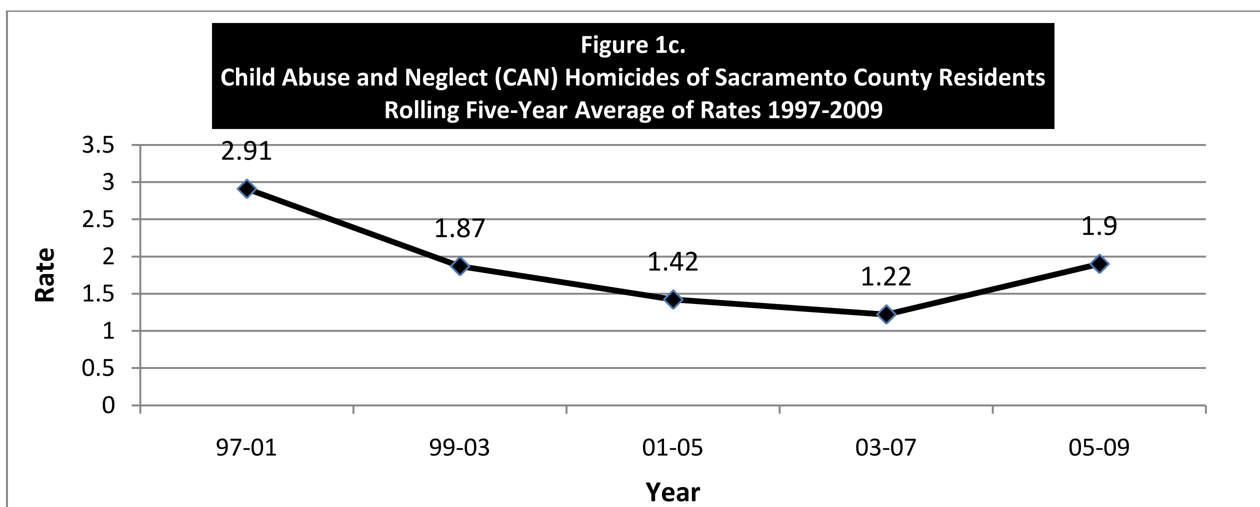
- 8 decedents were open or reported to a CPS agency (6 with Sacramento County CPS and 2 with another State CPS)
- 8 decedents had a family history of violent and/or non-violent crime
- 6 decedents had either a family history of alcohol and/or other drug abuse or alcohol and/or drugs were involved at the time of the decedent's death
- 4 decedents had a family history of domestic violence
- 3 decedents had an open case or referral with Sacramento County CPS at the time of their death
- 1 decedent was reported to Sacramento County CPS within six months prior to their fatal injury

Child Abuse and Neglect Homicides

In 2009, there were six Child Abuse and Neglect (CAN) homicides, all of which were Sacramento County residents, out of 154 total child deaths. All six CAN homicides were separate incidents. In 2008, there were 12 CAN homicides, including deaths of 11 Sacramento County residents and one out-of-county resident, out of 166 total child deaths. Of the 12 CAN homicides in 2008, there were 11 separate incidents.

Figure 1b below shows the number of CAN homicides from 1997 – 2009. Figure 1c below illustrates the number of CAN homicides as five-year rolling averages of rates from 1997 – 2009. Using rolling five year averages of rates makes it easier to depict CAN Homicide trends overtime. There was a statistically significant decrease in CAN homicides from the 1997 – 2001 period through the 2003 – 2007 period.[2] In the 2003 – 2007 period through 2005 – 2009 period there has been an increase in CAN homicides.





[2] Based on consultation and Poisson regression analyses provided by Dr. Neil Willits, University of California, Davis Statistical Laboratory and consultation with Drs. Cassius Lockett (Sacramento County Department of Health and Human Services) and Steve Wirtz (California Department of Public Health).

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, all six CAN homicides were Sacramento County residents. Four victims were male and two victims were female. One victim was an infant, four victims were between 1 and 4 years of age, and one victim was between 5 and 9 years of age. Two victims were Caucasian and one victim each was African American, Hispanic, Multi-racial, and "Other."

Perpetrators

Of the six CAN homicides in 2009, five victims died at the hand of their biological parent(s), and one victim died at the hand of the biological Mother's boyfriend.

Mechanism of Death

Of the six CAN homicides in 2009, two victims died due to multiple blunt force injuries, and one victim each died due to abusive head trauma (such as *shaken baby syndrome*), severe malnutrition/failure to thrive, drowning, and an undetermined mechanism.

Risk Factors

In order to detect trends and develop 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 2009, three risk factors or family stressors were identified in at least one of the 6 CAN homicides: a family history of violent and/or non-violent crime, domestic violence, medically fragile child, and a family history of alcohol and/or other drug abuse.

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 six CAN homicides in 2009, five decedents had involvement with a Child Protective Services (CPS) agency prior to their death. Of the five, three decedents had involvement with Sacramento County CPS. Two of the three decedents with Sacramento County CPS involvement had cases that were opened and closed prior to 6 months before their deaths. One of the three decedents was reported to Sacramento County CPS within six months prior to the fatal injury. The two decedents who did not have Sacramento County CPS history had CPS history with another State CPS.

Investigation and Prosecution

Of the 6 CAN homicides in 2009, charges were filed against seven defendants in five cases. Four of the seven defendants had multiple charges filed against them. Five defendants were charged for *unlawful murder of a human being;* four defendants were charged for *felony child abuse* and one defendant was charged with *felony torture*.

Because cases take time to navigate through the criminal justice system, this annual report attempts to report on the outcomes of prior and 2009 identified CAN homicides.

As of the writing of this report, the outcomes of the seven defendants charged in the 6 CAN homicides from 2009 are as follows:

- 3 defendants are scheduled for preliminary hearings.
- 2 defendants were convicted and are serving time in a state prison.
- 1 defendant is pending jury trial.
- 1 defendant is scheduled for a Supreme Court review.

Of the 12 CAN homicides in 2008, charges were filed against nine defendants in eight cases. As of the writing of this report, the outcomes of the nine defendants charged in the 12 CAN homicides from 2008 are as follows:

- 3 defendants were charged with unlawful murder of a human being and felony child abuse and are pending jury trial.
- 1 defendant was charged for unlawful murder of human being and felony child abuse and was sentenced to 25 years to life in a state prison.
- 1 defendant was charged for unlawful murder of a human being and felony child abuse and was sentenced to 15 years to life in a state prison.
- 1 defendant was charged for felony child abuse and possession of marijuana with the intent to sell and sentenced to 6 years in a state prison.
- 1 defendant was charged with felony child abuse and sentenced to four years in a state prison.
- 1 defendant was charged for unlawful murder of a human being and felony child abuse and is currently in trial.
- 1 defendant was charged for unlawful murder of a human being and felony child abuse and was found not guilty and acquitted.

Chapter II

All Causes of Child Death

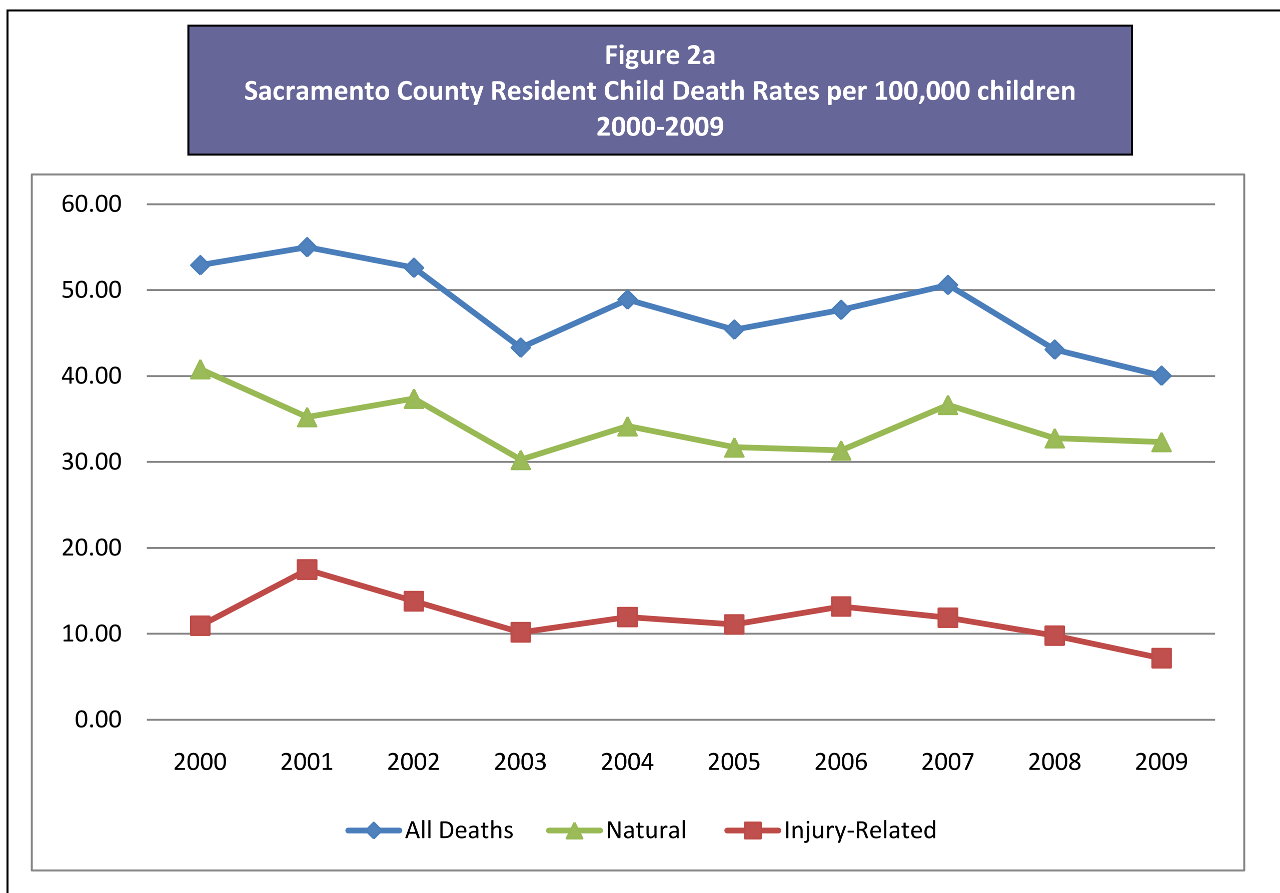
Chapter Two

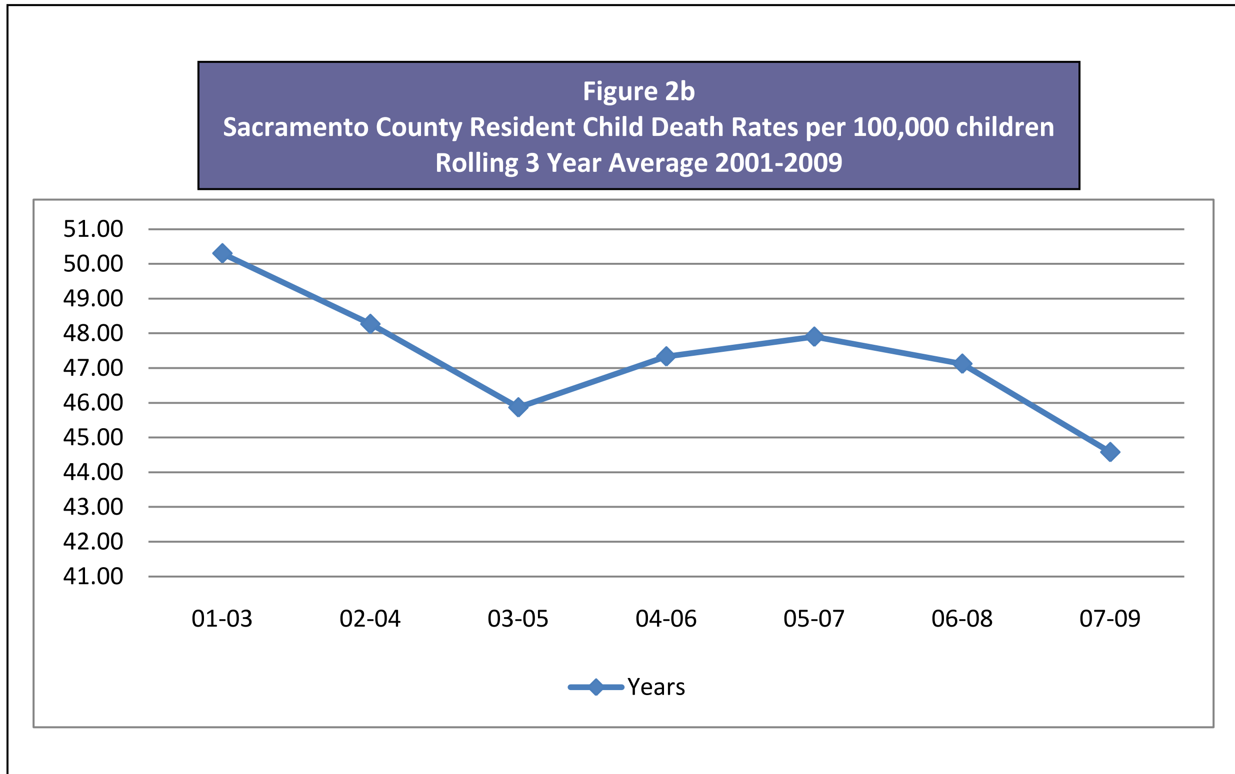
All Causes of Child Death

Another fundamental mission of the Child Death Review Team (CDRT) is to develop an aggregate 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 injuries and undetermined manner.

Child Death Rates

In 2009, there were 151 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. Since there are more than 300,000 children in Sacramento County, it is the CDRT's 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 15, is a geographical representation of all Sacramento County child deaths birth through 17 years of age, who were Sacramento County residents.





The child death rate for 2009 was 40.02 per 100,000 children. This rate is lower than the 2008 rate of 43.07, the 2007 rate of 50.6, the 2006 rate of 47.7, and the 2005 rate of 45.4. Figure 2a, on the previous page, illustrates the child death rates of Sacramento County residents from 2000-2009.

Figure 2b above illustrates rolling three year average child death rates from 2001-2009 in Sacramento County. Death rates were used to account for overall population changes.

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

In 2009, 81% (122 of 151) of all Sacramento County resident child deaths were due to natural causes. This is five percentage points higher than Sacramento County child deaths due to natural causes in 2008. Injury-related deaths accounted for 18% (27 of 151) of all Sacramento County resident children who died in Sacramento County in 2009. This is five percentage points lower than in 2008. Three percent of child deaths were classified as undetermined in 2009. This is two percentage points higher than in 2008.

Figure 3 below shows a breakdown of Sacramento County resident child deaths by category from 2000 through 2009.

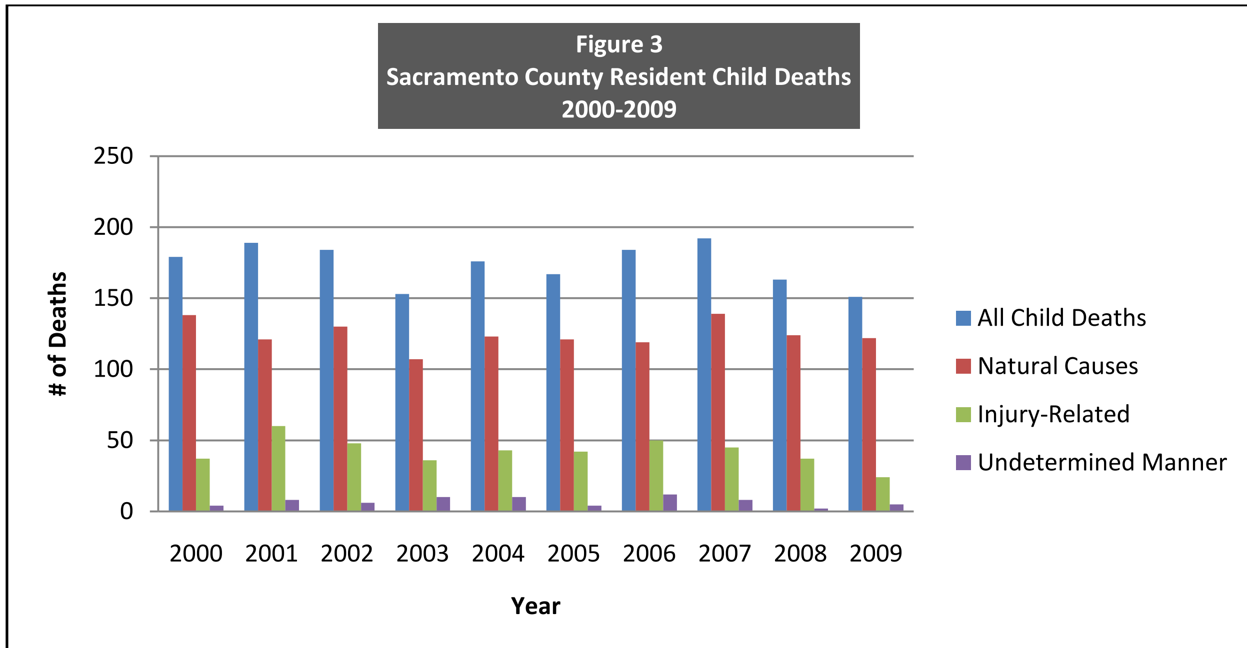


Table A, on the following page, provides a summary of the cause and manner of all 2009 child deaths. Deaths in the two main categories, injury-related and natural causes, are broken out into subcategories according to similar conditions. A third category, undetermined, contains cases for which the manner of death could not be identified. Examples of cases in this category include infant sleep-related deaths, where there was not enough evidence to determine the manner and/or cause of death, and risk factors present precluded a diagnosis of SIDS.

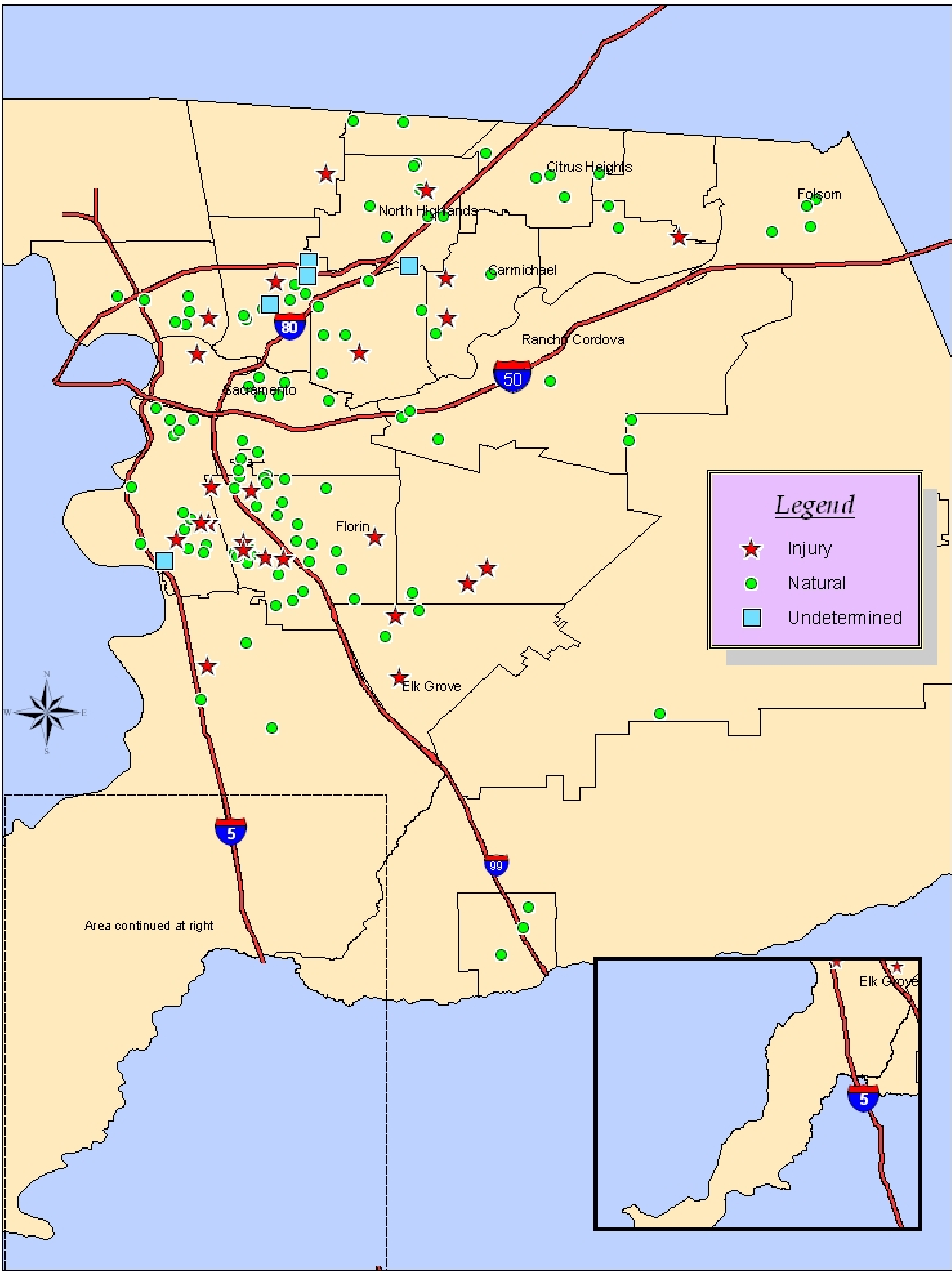
As noted earlier in this report, the CDRT routinely collects information such as alcohol and/or drug abuse history, prior abuse and/or neglect, domestic violence, and public assistance history for all cases, regardless of any suspected abuse. If needed, additional information is collected that relates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

Table A
All Child Deaths by Cause and Manner 2009

Category	2009
Natural Causes	
Perinatal Conditions	53
Congenital Anomalies	27
SIDS	5
SUIDS	8
Cancer	13
Infections	9
Respiratory	2
Other-Natural	4
Undetermined-Natural	1
Total Natural Causes	**122**
Injury-Related Causes	
CAN Homicide	6
Third-Party Homicide	3
MVC (Driver/Occupant)	2
MVC (Pedestrian)	3
MVC (Bike)	2
Drowning	7
Suicide	2
Suffocation/Choking	0
Burn/Fires	0
Poisoning/ Overdose	2
Other-Injuries	0
Total Injury-Related Causes	**27**
Undetermined Manner	**5**
TOTAL	**154**

Table A above includes the deaths of three out-of-county residents that died in Sacramento County

Map i
All Causes of Death
Sacramento County Resident Deaths 2009



**Map i above illustrates the deaths of Sacramento County residents only. Not included in this map are deaths of out-of-county residents.*

n = 151

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 nine (6%) of all child deaths in 2009 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). All nine child homicide decedents were Sacramento County residents. CAN homicides are discussed in a separate section of this report (Chapter One). Map ii, on page 18, shows a geographical representation of CAN homicides and third-party homicides of children birth through 17 years of age that occurred in Sacramento County and who were Sacramento County residents.

Third-Party Homicides

Of the nine child homicides in 2009, three were classified as third-party homicides. Two of the three victims were between 15 and 17 years of age and one victim was between 10 and 14 years of age.

The following information was known for the three third-party homicides in 2009. At least one risk factor was present in two of the three (67%) third-party homicides and is as follows:

- 2 decedents had a family history of violent and/or non-violent crime
- 2 decedents had prior Sacramento County CPS involvement
- 1 decedent had a family history of substance abuse
- 1 decedent had illegal drugs or alcohol involved in their death

Suicides

In 2009, there were two suicide deaths, a decrease from six suicide deaths in 2008 and four in 2007. Both suicide deaths in 2009 were male decedents and were between 15 and 17 years of age. The method of death for one decedent was by firearm, and one decedent was due to a fall. One of the two decedents had a known mental health history prior to their death but was not receiving mental health services at the time of their death. Neither was known to have any issues at school, to have made prior suicide attempts and/or threats, or had a history of illegal drug use or alcohol abuse.

Map ii
All Homicides
Sacramento County Resident Deaths 2009

**Map ii above illustrates the deaths of Sacramento County residents.*

n = 9

Unintentional Injuries

Sixteen year old Sarah was a passenger in a motor vehicle that was caravanning to a local teen hang out. The three cars involved in the caravan came to a red light where they all began revving their engines. When the light turned green, all three cars sped off in a high speed race. The car Sarah was in was in the lead when the driver lost control and slammed into a tree. The recklessness that took place during this accident unintentionally took Sarah's life.

In 2009 there were 16 deaths resulting from unintentional injuries (including the deaths of three out-of-county residents). The unintentional injury-related deaths in 2009 were seven Motor Vehicle Collisions (MVC), seven drowning, and two poisoning/overdose.

The following information was known for the unintentional injury-related deaths in 2009. Risk factors were present in nine of the 16 deaths (56%) resulting from unintentional injuries in 2009 and are as follows:

- ❖ 6 decedents had prior CPS involvement in any California County, including Sacramento County CPS
- ❖ 6 decedents had a family history of violent and/or non-violent crime
- ❖ 6 decedents had a family history of alcohol and/or other drug abuse
- ❖ 3 decedents had illegal drugs and/or alcohol involved at the time of their death
- ❖ 1 decedent had a family history of domestic violence
- ❖ 1 decedent had a family history of gang involvement

Motor Vehicle Collisions

Motor Vehicle Collisions (MVC) accounted for seven of the 16 (44%) unintentional injuries for 2009. Of the seven MVC deaths, three (43%) were pedestrians, two (29%) were driver/occupants (one decedent was a driver and one decedent was an occupant) and two (29%) were bike deaths. All seven MVC deaths were separate incidents.

Of the two MVC driver/occupant deaths, none involved a driver under the influence of drugs or alcohol; however both incidents involved reckless driving. One (50%) decedent was known to be wearing their seatbelt properly. Both (100%) driver/occupant collisions involved a youth between 15 and 17 years of age.

Drowning

Drowning accounted for seven of the 16 (44%) unintentional injury-related deaths for 2009. Five children died in a residential pool, one child died in a residential pond and one child died in a lake.

All five residential pool drowning deaths involved inadequate fencing or locks. Two of the five (40%) drowning deaths had an element of child maltreatment associated with the death, such as lack of appropriate supervision or poor caregiver skills and judgment. Two decedents were between

1 and 4 years of age, two decedents were between 5 and 9 years of age and one decedent was between 15 and 17 years of age.

Natural Causes

Definition: Death due to complication(s) of disease process, or due immediately to natural cause(s). Examples of deaths categorized from 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 twenty two (122) children, who resided in Sacramento County, died from natural causes in 2009. 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). See Table A, page 14 for a list of all deaths by natural causes.

Perinatal Conditions

Perinatal conditions include prematurity, low birth weight, placental abruption and congenital infections. The perinatal period is defined as the time interval beginning with the completion of the 20th to 28th week of gestation and ending 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 2009, perinatal conditions accounted for the deaths of 53 children. Prematurity was a known contributing factor in 35 (23%) of the 151 Sacramento County resident child deaths this year. The median gestational age of babies who died from prematurity and other perinatal conditions was 24 weeks. The median weight of babies who died from prematurity and other perinatal conditions was 684 grams (approximately 1.45 pounds).

Known risk factors were present in 26 of the 53 deaths (49%) due to perinatal conditions in 2009 and are as follows:

- 23 decedents had a known family history of violent and/or non-violent crime
- 12 decedents had a known family history of alcohol and/or other drug abuse
- 9 decedents had a known family history of domestic violence
- 6 mothers had inadequate prenatal care
- 3 mothers were teenagers

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.

In 2009, congenital anomalies accounted for the deaths of 27 children (18%). Known risk factors were present in eight of the 27 deaths due to congenital anomalies (30%) in 2009 and are as follows:

- 3 decedents had a family history of violent and/or non-violent crime
- 3 mothers had inadequate prenatal care
- 3 decedents had a family history of alcohol and/or other drug abuse
- 2 decedents had a family history of domestic violence
- 1 mother was a teenager

Cancer, Infections, Respiratory 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.
Respiratory – Death that involves a disease or infection of the lungs or airway passages. Such diagnoses would include pneumonia, RSV, asthma, tuberculosis, etc.
Other Natural Causes - Deaths due to a natural cause not previously mentioned.

In 2009, cancer, infections, respiratory and other natural causes accounted for the deaths of 28 children (18%). The following information was known for the 28 deaths due to cancer, infections, respiratory and other natural causes in 2009. Known risk factors were present in 14 of the 28 deaths (50%) due to these causes and are as follows:

- 9 decedents had a family history of violent or non-violent crime
- 6 decedents had a family history of alcohol and/or other drug abuse
- 3 decedents had a family history of domestic violence
- 3 mothers smoked during their pregnancy

- 1 mother was a teenager
- 1 decedent had illegal drugs and/or alcohol involved at the time of their death

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 18 (12%) of the 151 Sacramento County resident child deaths in 2009 and were comprised of five categories: Sudden Unexpected Infant Death Syndrome (SUIDS) (8), Sudden Infant Death Syndrome (SIDS) (5), undetermined manner (3), undetermined-natural (1), and an infection (1). Known risk factors were present in 17 of the 18 infant sleep-related deaths (94%) in 2009. Map iii, on page 25, shows a geographical representation of all infant sleep-related deaths, including SIDS, SUIDS, deaths of an undetermined manner, and infection of Sacramento County residents that occurred in Sacramento County in 2009.

Infant sleep-related deaths declined from 20 in 2003 to 13 in 2004 to nine in 2005. There was an increase in 2007 and 2008 (21 in 2007 and 27 in 2008) and then a decrease in 2009 (18). Figure 4 on page 24, 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 from 2007 and forward.

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 2009 there were five SIDS deaths in Sacramento County. Known risk factors were present in four of the five (80%) infant deaths related to SIDS in 2009 and are as follows:

- 2 decedents were put to sleep in unsafe infant sleeping locations, such as a couch or changing sling
- 2 decedents were put to sleep in a position recognized to increase the risk of SIDS, such as face down or on the side
- 2 decedents had a family history of violent or non-violent crime
- 1 decedent 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 2009 there were eight SUIDS deaths in Sacramento County. Known risk factors were present in all eight (100%) deaths related to SUIDS in 2009 and are as follows:

- 8 decedents were put to sleep in unsafe infant sleeping locations, such as an adult bed or couch
- 7 decedents were co-sleeping with a parent and/or sibling
- 5 decedents had a family history of violent or non-violent crime
- 4 decedents slept in locations were there was an obstruction of blankets and/or pillows
- 2 decedents were put to sleep in a position recognized to increase the risk of SUIDS, such as face down or on the side
- 2 decedents had parent(s) who were intoxicated at the time of their death

Other Infant Sleep-Related Deaths

In 2009, there was one additional infant sleep-related death from other causes. The cause of the additional infant sleep-related deaths was an infection. One known risk factor was present in that case and is as follows:

- 1 decedent was put to sleep in an unsafe infant sleeping location, such as an adult bed

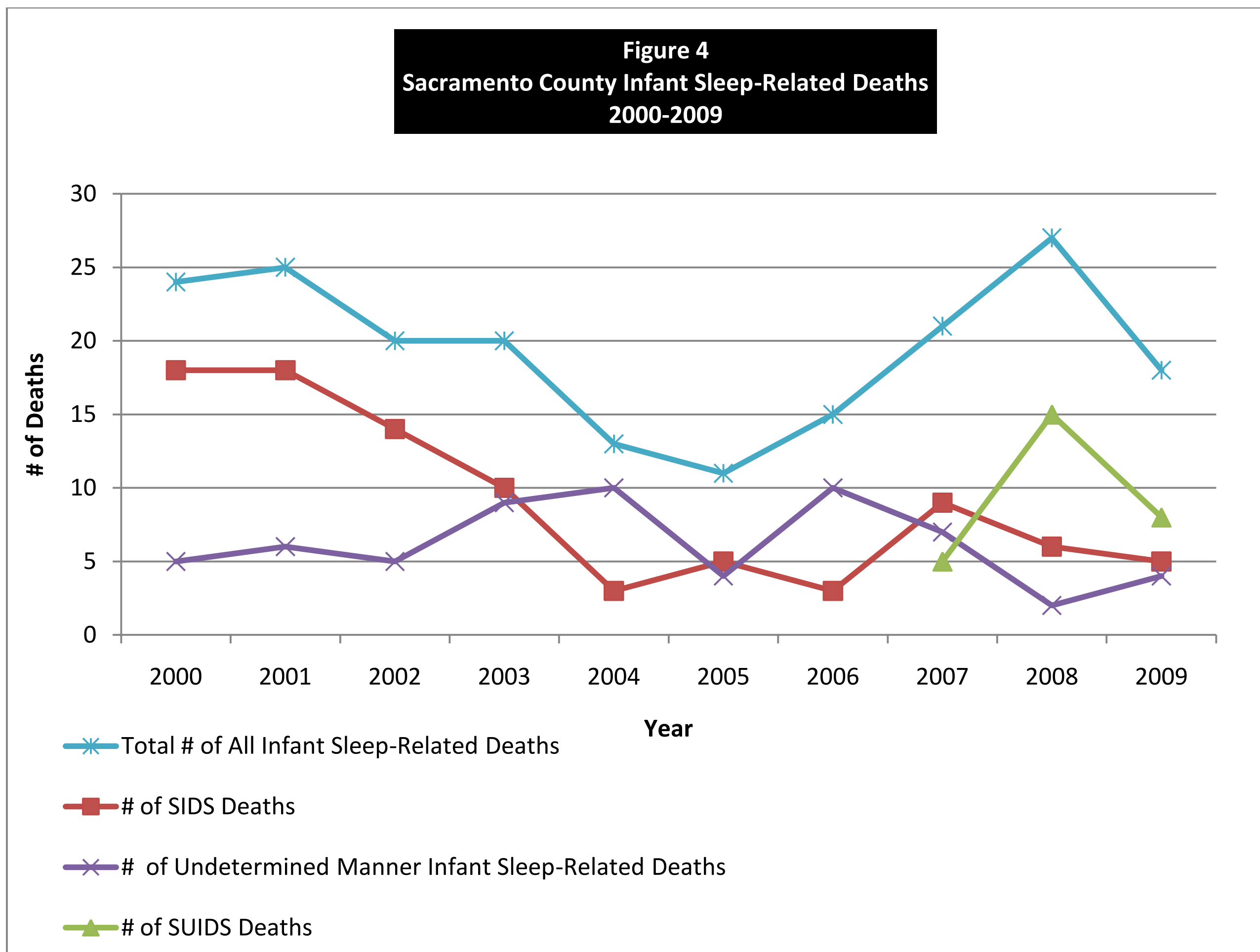
Undetermined Infant Sleep-Related Deaths

Definition:
Undetermined Manner: Death in which the manner or how the death occurred is unknown and the cause of death may or may not be medically identifiable.
Undetermined Natural: Natural death in which the cause may not be medically identifiable.

In this category the manner of death could 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 the manner and/or cause of death, and risk factors present precluded a diagnosis of SIDS or SUIDS.

In 2009 there were four undetermined infant sleep-related deaths in Sacramento County, of which three were categorized as an undetermined manner and one was categorized as an undetermined-natural death. Known risk factors were present in all four (100%) deaths and are as follows:

- 3 decedents were put to sleep in unsafe infant sleeping locations, such as an adult bed or car seat
- 2 decedents had a family history of violent or non-violent crime
- 2 decedents had a family history of alcohol and/or other drug abuse



* 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 Resident Deaths 2009

**Map iii above illustrates the deaths of Sacramento County residents.*

n = 18

Deaths of Undetermined Manner

Definition: Death in which the manner or how the death occurred is unknown and the manner of death may or 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 Coroner could not determine if the death would have occurred naturally, or by an inflicted or accidental injury. In 2009, there were five undetermined manner deaths, of which four (80%) were infant sleep-related. The undetermined manner death that was not infant sleep-related was an undetermined death by drowning.

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 66% (100 of 151) of all deaths in 2009. Children between 1 and 4 years of age were the second largest group, accounting for 12% (18 of 151) of all deaths this year. The third largest group was children between 15 and 17 years of age, accounting for 9% (13 of 151) of all deaths. The fourth largest group was children between 5 and 9 years of age, accounting for 8% (12 of 151) of all deaths. Lastly, the fifth group was children between 10 and 14 years of age, accounting for 5% (8 of 151) of all deaths in 2009. Table B below illustrates age categories of child deaths from 2005 to 2009.

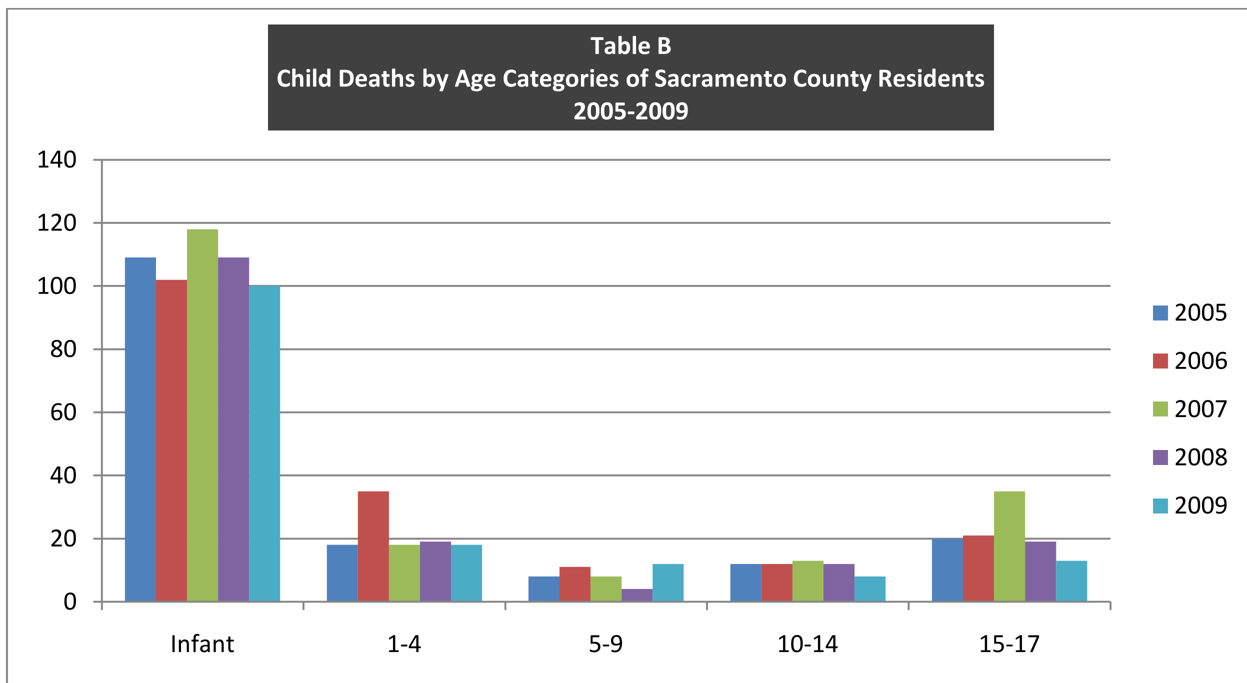


*Table B illustrates child deaths of Sacramento County Residents only; however, the narrative includes information for all child deaths that occurred in Sacramento County.

All Injury-Related Deaths

There were a total of 27 injury related deaths in 2009 of the 154 child deaths. Children between 15 and 17 years of age accounted for 11 (41%) of all injury related child deaths. Children between 1 and 4 years of age accounted for ten (37%) of all injury related child deaths. Children between 5 and 9 years of accounted for three (11%) of all injury related child deaths, followed by children between 10 and 14 years of age, accounting for two (7%) of all injury related child deaths. Lastly, infants accounted for one (4%) of all injury related child deaths.

Intentional Injuries

In 2009, there were a total of 11 deaths resulting from intentional injuries of the 154 child deaths. Infants (27%) and children between 15 and 17 years of age (27%) each accounted for three of the intentional injury child deaths. Children between 1 and 4 years of age (18%) and 5 and 9 years of age each (18%) accounted for two intentional injury child deaths. Lastly, children between 10 and 14 years of age accounted for one (9%) intentional injury child deaths.

Unintentional Injuries

There were a total of 16 deaths resulting from unintentional injuries. Children between 15 and 17 years of age accounted for seven (44%) of the deaths due to an unintentional injury. Children between 1 and 4 years of age accounted for six (38%) of the unintentional injury deaths. Children between 5 and 9 years of age accounted for two (13%) of these deaths. Lastly, children between 10 and 14 years of age accounted for one (6%) of the unintentional injury deaths in 2009.

Natural Causes

A total of 122 deaths resulted from natural causes in 2009, including SIDS and SUIDS deaths. Infants under 1 year of age accounted for 94 (77%) of all deaths due to natural causes. The second largest group was children between 5 and 9 years of age, accounting for nine (7%) of all natural deaths. Children between 1 and 4 years of age accounted for eight (7%) and children between 10 and 14 years of age accounted for six (5%) of all natural deaths. Lastly, children between 15 and 17 years of age each accounted for five (4%) of all natural deaths.

Undetermined Manner

There were five deaths of an undetermined manner in 2009, of which four were in infants under 1 year of age (80%). One of the five deaths of an undetermined manner in 2009 was of a child between 1 and 4 years of age (20%).

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 Sacramento County Resident Child Deaths by Race and Child Population
2008 and 2009

Race/Ethnicity	2008 Child deaths (#)	2008 Child deaths (%)	2008 Child death rate of residents per 100,000 child population	2009 Child deaths (#)	2009 Child deaths (%)	2009 Child death rate of residents per 100,000 child population
Caucasian	52	32%	33.64	48	32%	30.76
African American	30	18%	76.82	30	20%	77.71
Hispanic	37	23%	37.46	27	18%	27.20
Asian/Pacific Islander	18	11%	38.20	20	13%	42.14
Native American	1	.06%	52.27	0	0%	--
Multiracial	20	12%	65.52	21	14%	68.78
Other	5	3%	143.47	5	3%	93.16
Total	163	100%	--	151	100%	--

Source: State of California, Department Of Finance, Race/Ethnic Population with Age and Sex Detail, 1970- 2040. * The death rates included in Table C above represent the Sacramento County deaths of Sacramento County residents. While the 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

As previously stated, one of the goals of the CDRT is to identify gaps in delivery of services, which are indentified during the review process. For that purpose, the CDRT records risk factors and agency involvement of their families.

Child Protective Services (CPS)

Decedent CPS History

In 2009, 33 of the 154 child deaths (21%) had involvement with a CPS agency. Of the 33, 11 (33%) had an open case or referral at the time of their death. Six of the 33 (18%) had CPS involvement within six months prior to their death.

Decedent Foster Care History

In 2009, two (1%) of the total 154 child deaths were children known to be involved with the foster care system. Both children had a history of foster care prior to their death, and neither was in foster care at the time of their death. One child died as a result of Child Abuse and Neglect (CAN) homicide and one child died as a result of a perinatal condition.

Sibling CPS History

In 2009, of the 154 child deaths, 113 (73%) decedents had siblings with CPS involvement that could include Sacramento County, another California County and/or another State CPS.

Parental CPS History

Of the 154 child deaths in 2009, 90 (58%) decedents had a parent (mother or father) with CPS involvement as a child that could include Sacramento County, another California County and/or another State CPS.

Temporary Aid to Needy Families (TANF)

Of the 154 child deaths in 2009, 43 (28%) families were known to be receiving TANF.

Substance Abuse

Substance abuse is a major concern to the CDRT and is prevalent in child abuse and neglect 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."[3]

In 2009, 20 of the 154 child deaths (13%) had a known history of substance abuse in the child's family and/or alcohol and/or drugs were involved at the time of the child's death. The deaths involving substance abuse are as follows:

- 7 deaths due to perinatal conditions
- 2 deaths each due to SUIDS, Cancer and MVC's
- 1 death each due to a CAN homicide, poisoning/overdose, undetermined manner, congenital anomaly, drowning, other-natural and third-party homicide

[3] 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.

Domestic Violence

In 2009, 23 of the 154 child deaths (15%) had a known history of domestic violence in the child's family. The deaths involving a family history of domestic violence are as follows:

- 9 deaths due to perinatal conditions
- 3 deaths due to CAN homicide
- 2 deaths each due to congenital anomalies, SUIDS and undetermined manner
- 1 death each due to a cancer, drowning, other-natural, poisoning/overdose and respiratory

Criminal History

In 2009, 61 of the 154 (40%) child deaths had a violent and/or non-violent crime history (decedent and/or family). Thirty of the 154 (19%) child deaths had both a violent and non-violent crime history. Seventeen of the 154 (11%) had a non-violent crime history only, and 14 of the 154 (9%) child deaths had a violent crime history only. Ninety-three of the 154 (60%) child deaths had neither a violent or non-violent crime history.

Youth Deaths

This section of the report summarizes the findings by the Youth Death Review Subcommittee (YDRS) of the CDRT of youth deaths between 10 and 17 years of age that died in Sacramento County in 2009.

Of the total 154 child deaths in Sacramento County in 2009, 24 child deaths occurred in youth between 10 and 17 years of age comprising 15% of all child deaths. Eleven (46%) of the 24 deaths were due to natural causes and 13 (54%) were injury-related. Of the 24 youth deaths, 17 (71%) were male and seven (29%) were female. Nine youth were Caucasian, five youth were African American, four youth each were Asian and Hispanic and two were Multi-racial.

YDRS findings indicate that 85% (11 of 13) of the injury-related youth deaths occurred in youth 15 to 17 years of age. Thirty-eight percent (5 of 13) of all youth injury-related deaths had a decedent with a history of alcohol and/or illegal drug use and 85% (11 of 13) of all youth injury-related deaths were of male decedents.

In 2008, a total of 32 child deaths occurred in youth between 10 and 17 years of age comprising 19% of all child deaths. Eleven (34%) of the 32 deaths were due to natural causes and 21 (66%) were injury-related. Of the 32 youth deaths, 24 (75%) were male and eight (25%) were female. Nine youths each were Caucasian, Hispanic, and African American, three were multi-racial, one was Asian/Pacific Islander, and one was Native American.

Known risk factors were present in nine (38%) of the total 24 youth deaths in 2009 and are as follows:

- ❖ 7 decedents had a history of alcohol and/or illegal drug abuse
- ❖ 6 decedents had a history of non-violent crime
- ❖ 6 decedents had a history of violent crime
- ❖ 3 decedents had a history of gang involvement
- ❖ 2 decedents had a history of domestic violence within their home

Injury-Related Youth Deaths

There were a total of 13 injury-related youth deaths comprising 54% of all youth deaths in 2009. The mechanism of death in the 13 injury-related youth deaths included: five vehicular injuries, three involved firearms (one suicide and two third-party homicides), two involved drowning, one involved jumping from a structure (suicide), one involved a poisoning/overdose, and one involved a beating (third-party homicide).

Of the 13 injury-related youth deaths in 2009, 11 were male and two were female. Three decedents each were Caucasian, African American, Hispanic, and Asian. One decedent was Multi-racial.

In 2008, there were a total of 21 injury-related youth deaths comprising 66% of all youth deaths in 2008. The mechanism of death in the 21 injury-related youth deaths included: eight vehicular injuries (six MVC, one other-injury, and one third-party homicide), six involved firearms (four suicides, and two third-party homicides), two involved hanging (suicides), two involved drowning, and one each involved poisoning/overdose, failure to thrive (CAN homicide) and an animal-related accident (other-injury).

Of the 21 injury-related youth deaths in 2008, 17 were male and four were female. Six decedents were African American, six were Hispanic, five were Caucasian, three were multi-racial and one was Asian/Pacific Islander.

Known risk factors were present in six of the 13 (46%) injury-related youth deaths in 2009 and are as follows:

- ❖ 5 decedents had a history of alcohol and/or illegal drug abuse
- ❖ 4 decedents had a history of violent crime
- ❖ 3 decedents had a history of non-violent crime
- ❖ 3 decedents had a history of gang involvement

Third-party Youth Homicides

Third-party youth homicides comprised three of the 13 (23%) injury-related deaths. Of the three third party homicides in 2009, one youth each was 14 years of age (33%), 16 years of age (33%) and 17 years of age (33%). All three victims were male. One victim each was African American, Hispanic and Multi-racial. A firearm was involved in two of the deaths and one death was a result of a beating.

Known risk factors were present in two of the three (67%) third-party youth homicides and follows:

- ❖ 2 decedents had a history of violent crime and gang involvement
- ❖ 1 decedent had a history of illegal drug abuse

In 2008, third-party homicides comprised three (14%) of the 21 injury-related youth deaths. All three victims were male. Two victims were African American and one was Hispanic. Of the three third-party youth homicides, two were 17 years of age (66%) and one was 16 years of age (33%). Firearms were involved in two of the deaths and one death was a result of vehicular injuries.

Suicides in Youth

Suicides comprised two (15%) of the 13 injury-related youth deaths in 2009. Both decedents were male. The method of death for one suicide involved a firearm and one involved jumping from a multiple story structure. One decedent was Caucasian and one decedent was an Asian/Pacific Islander.

Known risk factors were present in one of the two (50%) suicide youth deaths and follows:

- ❖ 1 decedent had a prior mental health history

In 2008, suicides comprised six (29%) of the 21 injury-related youth deaths in 2008. All six decedents were male. The method of death for two suicides involved hanging and four involved firearms. Four decedents were Caucasian, one decedent was African American and one decedent was multi-racial.

Motor Vehicle Collision (MVC) Youth Deaths

Motor vehicle collisions (MVC's) comprised five (38%) of the 13 injury-related youth deaths. Three decedents were male and two were female. Of the five MVC youth deaths, two were Hispanic, two were African American, and one was Asian. Of the five MVC youth deaths, two were driver/occupants, two were bike deaths and one was a pedestrian.

Known risk-factors were present in three of the five (60%) motor vehicle collision youth deaths and are as follows:

- ❖ 2 decedents had a history of alcohol and/or illegal drug abuse

- 1 decedent had alcohol and/or illegal drugs involved at the time of the collision
- 1 decedent had a history of violent crime
- 1 decedent of a vehicle was an unlicensed driver

In 2008, motor vehicle collisions (MVC's) comprised six (29%) of the 21 injury-related youth deaths. Five decedents were male and one was female. Of the six MVC youth deaths, three were Hispanic, and one each was African American, Caucasian, and multi-racial. Of the six MVC youth deaths, four were driver/occupants and two were pedestrians.

Other Youth Injury-Related Deaths

There were three other youth injury-related deaths in 2009 out of the 13. Two of the three were due to a drowning and one was due to a poisoning/overdose. All three were male. Two were Caucasian and one was Asian/Pacific Islander.

Known risk-factors were present in two of the three (67%) other injury-related deaths and follows:

- 2 decedents had a history of alcohol and/or illegal drug abuse
- 2 decedents had alcohol and/or illegal drugs involved at the time of their death
- 2 decedents had a history of violent and/or non-violent crime
- 1 decedent had a history of gang involvement

Natural Youth Deaths

Of the 11 youth deaths due to natural causes in 2009, six (55%) were due to cancer, two (18%) each were due to other-natural causes and perinatal conditions, and one (9%) was due to congenital anomalies. Six of the 11 were male and five were female. Six of the youth were Caucasian, two were African American and one each was an Asian/Pacific Islander, Hispanic and Multi-racial.

Of the 11 youth deaths due to natural causes in 2008, four (36%) were due to cancer, four (36%) were due to other-natural causes, two (18%) were due to congenital anomalies and one (9%) was due to a perinatal condition. Seven of the 11 were male and four were female. Four of the youth were Caucasian, three were Hispanic, three were African American and one was Native-American.

Known risk-factors were present in five of the 11 (45%) youth deaths due to natural causes in 2009 and are as follows:

- 4 decedents had history of violent and/or non-violent crime
- 2 decedents had a history of alcohol and/or illegal drug abuse
- 1 decedent had a history of domestic violence within their home

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 review the death of all children birth through 17 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 2009 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 2009 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 unintentional drug overdose deaths from accidental exposure or access to drugs, will differ from strategies designed to reduce intentional drug overdose deaths, such as suicide.

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 County 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
1992 to 2009
Sacramento County*

Category	Years																		
	1992	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Total**
Perinatal Conditions	46	46	44	21	42	52	48	40	42	48	56	43	62	71	65	63	50	53	**892**
Congenital Anomalies	26	23	24	25	19	30	27	27	33	32	39	32	31	28	29	38	30	27	**520**
SIDS	21	29	25	18	21	20	19	18	18	18	15	10	3	5	3	9	6	5	**263**
SUIDS	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	5	15	8	**28**
Cancer	6	9	10	6	9	5	10	10	15	5	10	11	10	9	9	15	8	13	**170**
Infections	8	3	11	4	7	3	4	6	8	10	6	2	10	5	8	3	5	9	**112**
Respiratory	3	10	5	7	9	8	4	1	3	0	2	0	1	1	2	0	3	2	**61**
Other	10	14	21	17	15	12	4	11	16	8	2	7	6	2	3	6	6	4	**164**
Undetermined (Natural)	0	3	0	0	4	1	1	5	3	0	0	2	0	0	0	0	1	1	**21**
Total Natural Causes	**120**	**137**	**140**	**98**	**126**	**131**	**117**	**118**	**138**	**121**	**130**	**107**	**123**	**121**	**119**	**139**	**124**	**122**	**2,231**

** 2009 is the third 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 1992 to 2009
Sacramento County*

Category	Year																		
	1992	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**Total**
Homicides	13	21	15	20	16	23	11	16	10	16	11	9	15	17	16	12	17	9	**267**
CAN Homicide	(9)	(14)	(8)	(9)	(9)	(14)	(7)	(13)	(6)	(9)	(4)	(1)	(4)	(8)	(7)	(3)	(11)	(6)	**143**
Third -Party Homicide	(4)	(7)	(7)	(11)	(7)	(9)	(4)	(3)	(4)	(7)	(6)	(8)	(11)	(9)	(9)	(9)	(5)	(3)	**123**
Motor Vehicle Collisions (MVC)	14	14	15	23	19	17	11	11	14	21	13	14	10	8	11	13	6	5	**241**
MVC (Driver/ Occupant)	(8)	(7)	(8)	(12)	(15)	(10)	(7)	(4)	(8)	(10)	(11)	(8)	(5)	(3)	(6)	(7)	(4)	(1)	**135**
MVC (Pedestrian)	(6)	(6)	(5)	(8)	(2)	(7)	(1)	(5)	(5)	(8)	(1)	(5)	(4)	(4)	(3)	(6)	(2)	(2)	**81**
MVC (Bike)	(0)	(1)	(2)	(3)	(2)	(0)	(3)	(2)	(1)	(3)	(1)	(1)	(1)	(1)	(2)	(0)	(0)	(2)	**25**
Drowning	9	7	7	4	4	6	7	6	5	5	9	4	7	5	12	7	4	6	**115**
Suicide	3	4	4	3	4	5	8	0	6	5	7	4	4	8	1	4	6	2	**78**
Suffocation/ Choking	0	4	0	0	2	4	2	1	1	3	1	1	0	2	3	1	1	0	**26**
Fires	1	2	1	0	3	5	4	0	0	1	1	1	0	1	2	5	0	0	**28**
Other	0	8	5	3	0	5	1	1	1	8	4	2	6	1	6	1	3	0	**56**
Undetermined (Injury)	9	0	4	4	3	0	2	1	0	1	2	1	1	0	0	0	0	0	**28**
Poisoning/ Overdose	--	--	--	--	--	--	--	--	--	--	--	--	--	--	2	2	1	2	**7**
Total Injury-Related Causes	**49**	**60**	**51**	**57**	**51**	**65**	**46**	**36**	**37**	**60**	**48**	**36**	**43**	**42**	**53**	**45**	**37**	**24**	**846**
Undetermined Manner	2	4	6	0	4	2	2	3	4	8	6	10	10	4	12	8	2	5	**92**

** 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
2009

Category	**Infant**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Perinatal Conditions	50	1	0	1	1	53
Congenital Anomalies	23	1	2	1	0	27
Sudden Infant Death Syndrome or Sudden Unexpected Infant Death Syndrome (SIDS or SUIDS)	13	0	0	0	0	13
Cancer	1	2	4	4	2	13
Infections	4	4	1	0	0	9
Respiratory	2	0	0	0	0	2
Other (natural)	0	0	2	0	2	4
CAN Homicide	2	3	1	0	0	6
Third-Party Homicide	0	0	0	1	2	3
Arson Homicide	0	0	0	0	0	0
Motor Vehicle Deaths (driver/occupant)	0	0	0	0	1	1
Motor Vehicle Deaths (pedestrian)	0	2	0	0	0	2
Motor Vehicle Deaths (bicycle)	0	0	0	1	1	2
Drowning	0	3	2	0	1	6
Suicide	0	0	0	0	2	2
Suffocations	0	0	0	0	0	0
Burn	0	0	0	0	0	0
Other Injury	0	0	0	0	0	0
Poisoning/ Overdose	0	1	0	0	1	2
Undetermined Manner	4	1	0	0	0	5
Undetermined Natural	1	0	0	0	0	1
Total	**100**	**18**	**12**	**8**	**13**	**151**

Table G
Deaths by race/ethnicity and age group 2009
Sacramento County Resident Deaths Only

Race Classification	Infant	1-4	5-9	10-14	15-17	Total
Caucasian	30	5	5	5	3	48
African American	24	2	0	1	3	30
Asian/ Pacific Islander	13	1	2	0	4	20
Hispanic	14	6	4	1	2	27
Multiracial	16	2	1	1	1	21
Other	3	2	0	0	0	5
Total	**100**	**18**	**12**	**8**	**13**	**151**

Table H
Child abuse and neglect homicide victims by age 1990 to 2009
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
2008	3	7	0	0	1	11
2009	1	4	1	0	0	6
Total	**41**	**78**	**24**	**8**	**7**	**158**

Table I
Child abuse and neglect homicide victims by race/ethnicity 1990 to 2009
Sacramento County Resident Deaths Only

Period Covered	Caucasian	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
2008	1	2	5	3	0	11
2009	2	1	1	0	2	6
Total	**61**	**24**	**48**	**15**	**10**	**158**

*** Including children of mixed/multi racial categories.*

Table J
Perpetrators of CAN homicides 1990 to 2009
Sacramento County*

Perpetrator	1990-2008	2009	Total number of Perpetrators**
Biological Father	41	3	44
Biological Mother	42	2	44
Both Parents	9	0	9
Boyfriend of Mother or Guardian	19	1	20
Undetermined	15	0	15
Babysitter	5	0	5
Stepfather	4	0	4
Other Family Member	9	0	9
Adoptive/Foster Parent	5	0	5
Girlfriend of Father or Guardian	2	0	2
Family Friend	4	0	4
Total	**155**	**6**	**161**

** 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 2009
Sacramento County Residents Only*

	3rd Party Homicide	CAN Homicide	Suicide	Total
Firearm	103	25	41	166
Battering/Beating	6	44	0	47
Hanging	0	0	44	44
Shaking/Abusive Head Trauma	0	21	0	20
Suffocation/Strangulation	1	16	0	17
Poisoning/Overdose	0	8	3	11
Stabbing	11	6	0	17
Fire	3	4	0	7
Fall/Jump	0	0	1	1
Undetermined	1	1	0	2
Vehicular	10	2	1	13
Drowning	1	7	0	7
Chronic Neglect	0	14	0	13
Other	1	4	0	5
Undetermined Mechanism	0	1	0	1
Unknown	1	5	0	6
Total	**138**	**158**	**90**	**386**

** 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*
2000-2009

Zip	Neighborhood	2009 Deaths	Deaths 2000-2008	Total
95608	Carmichael	3	41	44
95610	Citrus Heights	3	37	40
95615	Courtland	0	1	1
95621	Citrus Heights	2	39	41
95624	Elk Grove	4	44	48
95626	Elverta	0	9	9
95628	Fair Oaks	3	25	28
95630	Folsom/Clarksville/El Dorado Hills	5	43	48
95632	Twin Cities/Galt/Herald	4	17	21
95638	Herald	0	5	5
95641	Isleton	0	1	1
95655	Mather	0	2	2
95660	North Highlands	3	53	56
95662	Orangevale	0	22	22
95670	Rancho Cordova	2	61	63
95673	Rio Linda/Robla	0	27	27
95683	Rancho Murrieta	0	4	4
95690	Walnut Grove	0	3	3
95693	Wilton	1	2	3
95757	Elk Grove	2	23	25
95758	Bruceville	3	62	65
95763	Folsom	0	1	1
95742	Rancho Cordova	2	1	3
95811	Mather	0	1	1
95814	Downtown Sacramento	1	12	13
95815	North Sacramento	7	48	55
95816	Midtown Sacramento	1	7	8
95817	Sacramento/Oak Park	1	23	24
95818	Sacramento/South Land Park	4	11	15
95819	Sacramento/ East Sacramento	3	13	16
95820	Fruitridge	3	88	91
95821	Town and Country Village	6	42	48
95822	Sacramento/Meadowview	10	64	74
95823	Sacramento/Valley Hi	23	122	145
95824	Fruitridge	9	56	65
95825	Arden/Arcade	6	39	45
95826	Perkins/Rosemont	2	34	36
95827	Mills/Walsh Station	1	28	29

95828	Florin	7	62	69
95829	Coffing/Sheldon	4	25	29
95830	Sacramento (Florin & Sunrise)	0	1	1
95831	Greenhaven	1	27	28
95832	Sacramento/Freeport	2	16	18
95833	Arden/ Garden	9	40	49
95834	Sacramento/South Natomas	0	15	15
95835	Sacramento/North Natomas	1	16	17
95837	Sacramento International Airport	0	2	2
95838	Del Paso Heights/Hagginwood	4	69	73
95841	Foothill Farms	2	17	19
95842	Sacramento/Foothill Farms/North Highlands	4	51	55
95843	Sacramento/Antelope	2	42	44
95864	Arden/Arcade	1	10	11
	Unknown**	0	1	1
Total		**151**	**1,505**	**1656**

** 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.** Sacramento County Probation Department
- **F.** Law Enforcement Chaplaincy of Sacramento
- **G.** 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 Sacramento/San Juan Catholic Healthcare West
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:
Practice timely and regular attendance.
Share all relevant information.
Stay focused and keep all comments on topic.
Listen actively – respect others when they are talking.
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.
Be prepared for case discussion.
Discuss all cases objectively with respect for deceased, their families, and all agencies involved.
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 Boxley
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
2009 Members

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

Gina Roberson, M.S.
Associate Director

Nazia Ali
CDRT Project Manager

Department of Health & Human Services
California Children's Services
Mary Jess Wilson, M.D., M.P.H., CDRT Chair
Medical Director

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

Sutter Memorial Hospital
Angela Rosas, M.D., CDRT Chair
Pediatrician

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

California Highway Patrol
Elizabeth Dutton

Citrus Heights Police Department
Ron Pfleger, Detective

Department of Health and Human Services
Epidemiology and Disease Control
Cassius Lockett, PhD, Epidemiologist

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

Elk Grove Police Department
Joe Blair, 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/CHW
Wendy Edwards, RN.
Judi Marschel, BSN, RNC-NIC

Sacramento City Fire Department
Keith Gault, Capt.
Trent Waechter

Sacramento City Police Department
Paul Martinson, Sergeant

Sacramento County Metropolitan Fire Department
Clayton Elledge, Captain

Sacramento County Probation Department
Keith Bays

Sacramento County Sheriff's Department
Jeff Reinl, Sergeant
Brian Shortz, Detective

University of California Davis Medical Center
Kevin Coulter, 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.

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

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

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

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

Margaret Crockett, R.N., CNS
Neonatal Nurse Specialist
Sutter Memorial Hospital

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

Mario Guzman
Sergeant
Elk Grove Police 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 Johnston, 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., 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.

Debra Lyon, R.N.
Sacramento City Fire Department

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
Child 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

Carol Mims, Detective
Sacramento County Sheriff's Department

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
Child 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

Curtis Rollins, M.D.
Northern California Forensic Pathology

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

Mindi Russell
Deputy Senior Chaplain
Law Enforcement Chaplaincy

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

Ernest Sawtelle, J.D., Deputy District Attorney
District Attorney's Office

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

Gregory Schmunk, M.D.
Northern California Forensic Pathology

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

Robin Shakely, J.D., Deputy District Attorney
District Attorney's Office

Brian Shortz, Detective
Sacramento County Sheriff's Department

Howard Sihner
District Attorney's Office – Juvenile Division

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

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

Bev Sprenger
Department of Health and Human Services

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

Deborah Stewart, M.D.
University of California Davis Medical Center

Dr. John Stockman
Stockman and Associates

Grant Stomsvick
Detective
Sacramento County Sheriff's Department

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

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

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

Ellen Tappero
Center For Women's Health
Sutter Memorial Hospital

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

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

Carol Tucker R.N.
Public Health Nursing
Department of Health and Human Services

Denise von Arx, CNS
Mercy San Juan Hospital/CHW

Ted Voudouris
Sacramento County Sheriff's Department

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

Ken Walker
Lieutenant
Sacramento City Police Department

Stephen Wallach
Child Protective Services
Department of Health and Human Services

Phil Whitbeck, Chaplain
Law Enforcement Chaplaincy

Robin Wilkins
Sacramento County Probation Department

Patty Will
School Attendance Review Board
San Juan Unified School District

Victoria Witham
EMT Liaison
Sacramento City Fire Department

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

Greg Wyatt
Deputy Coroner
Sacramento County Coroner's Office

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

Debbie Yip
CWLA Supervisor
Department of Health and Human Services

APPENDIX F

GLOSSARY

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

Abuse-Related Death: Child abuse was present and contributed in a concrete way to the child's death. Child death secondary to documented abuse (e.g., suspicious behavior with evidence of prior abuse).

Burn/Fire: Death caused by fire through a rapid combustion or consumption in such a way as to cause detrimental harm to one's health.

Cancers: 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.

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 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 in a child birth through 17 years of age.

Child Death Review Team (CDRT): An interagency team that investigates child abuse and neglect deaths of children birth through 17 years of age. 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).

Child Maltreatment: Child Maltreatment deaths are deaths with some element of abuse or neglect involved *(abuse, abuse-related, neglect, neglect-related, questionable abuse/neglect, prenatal substance abuse).*

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 Protective Services (CPS): An agency within the Sacramento County's Department of Health and Human Services. CPS investigates child abuse and neglect and provides services to keep children safe while strengthening families. CPS also trains foster parents, acts as an adoption agency, and licenses family daycare homes.

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

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

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.

Drowning: A death resulting under water or other liquid of suffocation.

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.

Family Criminal History: The violent or non-violent criminal history for the decedent and/or parent(s)/guardian(s). *See violent or non-violent criminal history for definitions*.

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 (12 months) 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. Examples are meningitis and sepsis.

Injury-Related Death: A death that is a direct result of an injury-related incident. Examples include homicides, Motor Vehicle Collisions (MVC), suicides, drownings, burn/fires and suffocations.

Intentional Injury: An injury that is purposely inflicted, by either oneself or another person.

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 five categories: Natural; Accident; Suicide; Homicide; and Undetermined.

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.

Mechanism of Death: The means by which the death of a child occurred or is accomplished.

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.

Motor Vehicle Collision (MVC): A traffic collision (motor vehicle collision, motor vehicle accident, car accident, or car crash) is when a road vehicle collides with another vehicle, pedestrian, animal, road debris, or other geographical or architectural obstacle.

Natural Deaths (Causes): 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.

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. Deaths clearly due to neglect, supported by a Coroner’s reports or police or criminal investigation. Examples:

- An abandoned newborn that dies of exposure.
- A child who dies from an untreated life threatening infection.
- A parent or caregiver driving recklessly with a suspended license when involved in a motor vehicle collision.

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. Death secondary to documented neglect or any case of poor caretaker skills or judgment. Examples:

- An unattended infant who drowns in a bathtub.
- Unrestrained child killed in a motor vehicle accident.
- Motor Vehicle Collisions (MVC's) or house fires where caretaker was "under the influence.

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.

Non-violent Criminal History: Non-violent crime does not use physical force and cause physical pain. Non-violent crime includes, but is not limited to, prostitution, drug sales/trafficking, DUI, burglary, theft, etc. It does not include minor traffic arrests/tickets.

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.

Perinatal conditions: Conditions that include prematurity, low birth weight, placental abruption and congenital infections. Deaths due to perinatal conditions span the time period from the second trimester of pregnancy through one month after birth.

Poisoning/Overdose: Death caused by a substance with an inherent property that tends to destroy life or impair health with the possibility of death.

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.

Prevention Advisory Committee (PAC): An advisory committee to the CDRT consisting of public and private agency service providers that meet to review aggregate data and draft major findings and recommendations for CDRT consideration, pertaining to the annual CDRT report.

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.

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.

Respiratory: Pertaining to or serving for respiration: *respiratory disease.*

Questionable Abuse/Neglect Deaths: There are no specific findings of abuse or neglect, 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 when 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.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."

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.*

Suicide: The intentional taking of one's own life.

Suffocation/Choking: A death caused by the prevention of access of air to the blood through the lungs or analogous organs; to impede respiration.

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 the primary caregiver. Commonly referred to as "third-degree murder," third-party homicide is a killing that resulted from indifference or negligence. Usually there must be a legal duty (parent - child), but can also include crimes like driving drunk and causing a fatal accident.

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

Undetermined Manner: The manner or how a death occurred is unknown and the cause of death may or may not be medically identifiable.

Undetermined Natural: Natural death in which the cause of death may not be medically identifiable

Unintentional Injury: An injury that was unplanned, and unintended to happen, such as motor vehicle crashes, fires and drownings.

Violent Criminal History: Violent crime is a crime in which the offender uses or threatens to use violent force upon the victim. This entails both crimes in which the violent act is the objective, such as a murder, as well as crimes which violence is the means to an end. Violent crimes include crimes committed with and without weapons. Violent crime includes, but is not limited to, robbery, assault, and homicide.

Youth Death Review Subcommittee (YDRS): A subcommittee of the CDRT that investigates Sacramento County resident youth deaths from 10 through 17 years of age.