

## **Sacramento County Child Death Review Team 2008 Annual Report**

The following report includes brief descriptions on some of the cases of children who died in Sacramento County in the 2008 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.



## **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 2008 CDRT, YDRS and/or PAC:*

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## 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 2008. Included are descriptions of all deaths whether they were the result of child abuse and neglect, injuries, homicides or natural causes.

2008 marks the nineteenth year that the Sacramento County Child Death Review Team (CDRT) has been working to investigate, analyze, and document the circumstances that have led to all child deaths in Sacramento County. Together, CDRT members review each case as well as any pertinent case information and/or history and come to a mutual consensus on the manner and cause of each death. The goal of the Child Death Review Team is to identify how and why children die in order to facilitate the creation and implementation of strategies to prevent child deaths.

In 2008, 163 children residing in Sacramento County died. Therefore, the 2008 child death rate of Sacramento County, birth through 17 years of age is 43.07 per 100,000 children. In 2007, 192 children residing in Sacramento County died in Sacramento County. Therefore, the 2007 child death rate of Sacramento County, birth through 17 years of age was 50.6 per 100,000 children.

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, but were not current residents. The three classifications of all child deaths were natural causes (124), injury-related (40), and undetermined manner (2). In 2007, 197 children birth through 17 years of age died in Sacramento County. This includes the death of five children who died in Sacramento County, and were not current residents of Sacramento County. This year marks the third 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 124 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 76% (124 of 163) of all Sacramento County Resident child deaths for this year.

Injury-related deaths resulted in 40 child deaths, accounting for 24% of the total child deaths for this year, including deaths of 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. Twelve of the 40 injury-related deaths in 2008 were the direct result of a CAN homicide. There were three CAN homicides in 2007.

There were two child deaths that resulted from an undetermined manner, accounting for 1% of the total child deaths. Both deaths of an undetermined manner (100%) were infant sleep-related.

2008 marks the second year the Youth Death Review Subcommittee (YDRS) of the CDRT convened to conduct in-depth analysis of all injury-related deaths of youth ages 10 through 17, which occurred in Sacramento County. The intent of the YDRS is to understand the causes of injury-related youth deaths, identify trends and risk factors, and develop recommendations to reduce preventable youth deaths.

The YDRS findings indicate that the majority (21) of the 40 injury-related deaths (53%) are in youth between 10 and 17 years of age. More specifically, six youth died due to Motor Vehicle Collisions (MVC), six suicides, three third-party homicides, two drownings, two other-injuries, one Child Abuse and Neglect homicide (CAN) and one poisoning/overdose. More than two-thirds of all injury-related deaths were of male decedents (17 of 21). 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). Over 70 percent (15 of 21) injury-related youth deaths occurred in youth 15 to 17 years of age. Forty percent (6 of 15) of the injury-related youth deaths in youth 15 to 17 years of age in 2008 occurred by use of a firearm. YDRS and CDRT findings also conclude that Motor Vehicle Collision (MVC) deaths in youth between 10 and 17 years of age decreased from 12 in 2007 to six in 2008.

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

Child deaths tell us a great deal about the well being of children in our community. The prevention strategies recommended herein were developed not only for the purpose of preventing child deaths, but also to protect Sacramento County's children from disease, disfigurement, disability, emotional damage and other long-ranging effects of child abuse, accidental injuries and poor health.

The CDRT 2008 Annual Report findings and recommendations that follow were developed with a sincere awareness of the complexity of problems facing Sacramento County's children and their families. The major findings and recommendations reported highlight the core of child deaths and 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.



## 2008 Major Findings

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 2008 are as follows.

➤ **Nearly one-quarter of all deaths were preventable.**

Forty (24%) of the 166 child deaths in 2008 were preventable. Thirty-nine (98%) of these child deaths were injury-related, such as burn/fire, Child Abuse and Neglect (CAN) homicides, drowning, Motor Vehicle Collisions (MVC), other-injuries, poisoning/overdose, suicides, suffocation/choking, and third-party homicides. One of the 40 preventable deaths was a natural death due to a preventable perinatal condition. All but one injury-related death was preventable.

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

In 2008, there were 40 injury-related deaths in Sacramento County, three of which were in out-of-county residents. Thirty-nine (98%) of the 40 injury-related deaths were preventable. The 39 injury-related preventable deaths in 2008 include 12 Child Abuse and Neglect (CAN) homicides, six suicides, six Motor Vehicle Collisions (MVC), five third-party homicides, four drownings, three other-injuries, and one each of suffocation/choking, poisoning/overdose, and burn/fire.

➤ **Nearly 60% of all injury-related deaths were intentional injuries.**

In 2008, there were 40 injury-related deaths, of which 23 (58%) were intentional injuries and 17 (42%) were unintentional injuries. Of the 23 intentional injury-related deaths, 12 were CAN homicides, six were suicides and five were third-party homicides. Of the 17 unintentional injury-related deaths, six were motor vehicle collisions, four were drownings, four were other injuries, and one each was suffocation, poisoning/overdose and burn/fire.

➤ **There was a four-fold increase of Child Abuse and Neglect (CAN) homicides from 2007 to 2008.**

Child Abuse and Neglect (CAN) homicides have increased from three in 2007 to 12 in 2008, and account for 7% of the 166 child deaths this year. There were eleven separate incidents. Eleven of the 12 CAN homicides were Sacramento County residents and one was an out-of-county resident. Seven were children between 1 and 4 years of age, three were infants, one was between 5 and 9 years of age and one was between 15 and 17 years of age. Six of the decedents died at the hands of a biological parent, one died at the hands of an adoptive parent, four died at the hands of the Mother's boyfriend, and one died at the hands of the Grandmother's boyfriend.

CAN homicide deaths due to abusive head trauma increased from zero in 2007 to two in 2008. One decedent was an infant under 1 year of age, and one decedent, who died as a result of injuries sustained as an infant, was between 5 and 9 years of age.

In 2007, there were three CAN homicides, out of 192 Sacramento County resident child deaths. There were no out-of-county resident CAN homicides in 2007. All three CAN homicides were separate incidents.

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

From 1990 to 2008, 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 152 CAN homicides with 153 perpetrators<sup>1</sup>, of which the majority of perpetrators (60% or 92 of the 153) were the biological parent(s) of the decedent.

Alternate caregivers, such as stepparents and the boyfriend/girlfriend of a biological parent, comprise 18% (27 of 153) of the perpetrators of CAN homicides.

➤ **One-half of the Child Abuse and Neglect (CAN) homicide decedents had prior Sacramento County Child Protective Services (CPS) history.**

Fifty percent (6 of 12) of the CAN homicide decedents had involvement with Sacramento County CPS prior to their deaths. 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 prior involvement with at least one other California County CPS.

In 2007, two (67%) of the three CAN homicide decedents had an open case or referral with Sacramento County CPS. One of the three decedents had an open case or referral with Sacramento County CPS at the time of their death. One of the three decedents also had prior involvement with at least one other California County CPS. One decedent was unknown to any California County CPS prior to their death.

➤ **More than one-tenth of all child deaths had an element of child maltreatment.**

In 2008, 22 (13%) of the 166 child deaths were found to have elements of child maltreatment. Of those 22 deaths, 12 (54%) were Child Abuse and Neglect (CAN) homicides, three (14%) were drownings, two (9%) were perinatal conditions and one each (4%) was Sudden Infant Death Syndrome (SIDS), suffocation, suicide, third party homicide and undetermined manner, where neglectful behaviors were involved. The suffocation and undetermined manner deaths were both infant sleep-related.

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<sup>1</sup> 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.

Of the 22 child deaths with an element of child maltreatment, 10 (45%) decedents were open or reported to any California County CPS. Of the 10 decedents who were open or reported to any California County CPS, nine decedents had Sacramento County CPS involvement of which four decedents had involvement with another California County also. One of the 10 decedents had CPS involvement with another California County only. Four of the 10 decedents had an open case or referral at the time of their death with Sacramento County CPS. One of the 10 decedents had Sacramento County CPS involvement within six months prior to their death. Twelve decedents (55%) had no Child Protective Services involvement with any California County CPS, including Sacramento County.

In 2007, 21 (10%) of the 197 child deaths were found to have elements of child maltreatment. Of those 21 deaths, five (24%) were natural deaths, four (19%) were motor vehicle collisions, four (19%) were undetermined manner, three (14%) were CAN homicides, three (14%) were drownings and two (9%) were poisoning/overdose. Three of the four deaths of an undetermined manner were infant sleep-related.

Of the 21 child deaths in 2007, with an element of child maltreatment, eight (38%) decedents were open or reported to any California County CPS, including Sacramento County. Five of the eight (62%) had Sacramento County CPS involvement only. Three of the eight (37%) had Sacramento County CPS involvement within six months prior to their death. Thirteen decedents had no Child Protective Services involvement with any California County CPS, including Sacramento County.

➤ **More than two-thirds of child maltreatment deaths occurred in children under 5 years of age.**

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 under 5 years of age, 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.

➤ **Infant sleep-related deaths are the highest since 1993.**

Infant sleep-related deaths, including Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death Syndrome (SUIDS), and infant sleep-related deaths of an undetermined manner are at the highest since 1993. In 2008 there was an increase in infant sleep-related deaths, with a total of 27 (15 SUIDS, 6 SIDS, two undetermined manner, and one each of infection, respiratory, suffocation, and undetermined natural). Twenty-six (96%) of the 27 infant sleep-related deaths in 2008 were infants under 6 months of age.

In 2007, there were a total of 21 infant sleep-related deaths (9 SIDS, 5 SUIDS and seven infant sleep-related deaths of an undetermined manner). This is an increase from 13 infant sleep-

related deaths in 2006 and 11 infant sleep-related deaths in 2005. Eighteen (86%) of the 21 infant sleep-related deaths in 2007 were infants under 6 months of age.

➤ **All infant sleep-related deaths occurred in unsafe sleeping environments.**

All 27 (100%) infant sleep-related deaths in 2008, including Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death Syndrome (SUIDS), occurred in unsafe sleeping environments. Of the 27 infant sleep-related deaths, 22 (81%) were sleeping somewhere other than a crib (17 slept in an adult bed, three slept on a couch, 1 slept on a futon, and 1 slept in a car seat/stroller). Seventeen of the 27 (63%) infant sleep-related deaths occurred while co-sleeping with parents and/or siblings. Of the 27 infant sleep-related deaths, 26% (7 of 27) were known to have been put to sleep in an unsafe position. Fourteen of the 27 (52%) infants were in sleep environments cluttered with blankets and/or pillows. Six of the 27 families (22%) had known substance abuse involvement at the time of the infant's death.

➤ **Nearly all of the infant sleep-related deaths were in children under 6 months of age.**

Twenty-six of the 27 (96%) infant sleep-related deaths were in children under 6 months of age. Nineteen of the 27 (70%) infant sleep-related deaths occurred in the Fall or Winter months from September through February.

In 2007, 18 of the 21 (86%) infant sleep-related deaths were in children under 6 months of age. Thirteen of the 21 (62%) infant sleep-related deaths in 2007 occurred in the Fall or Winter months from September through February.

From 2005 through 2008, there were a total of 64 infant sleep-related deaths in children under 6 months of age. Forty-one of the 64 (64%) infant sleep-related deaths occurred in the Fall or Winter months from September through February.

➤ **African American children died at a rate two times higher than Caucasian children in Sacramento County**

In 2008, 30 African American children died at a disproportionate child death rate of 76.82 per 100,000 children compared to Caucasian children who died at a child death 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.

Of the 30 African American children who died in 2008, the causes of death were as follows: nine perinatal conditions, five Child Abuse and Neglect homicides (CAN), five Sudden Unexpected Infant Death Syndrome (SUIDS), three third-party homicides, two congenital anomalies, and one each were respiratory, other-natural, Motor Vehicle Collision (MVC), drowning, suicide and undetermined manner. Eighteen of the 30 children (60%) were under 1 year of age, three were between 1 and 4 years of age, two were between 10 and 14 years of age and seven were between 15 and 17 years of age.

From 2005 to 2008, African American children died at a disproportionate child death rate of 91.03, per 100,000 children compared to Caucasian children who died at a child death rate of 41.54, per 100,000 children during the same time period.

➤ **The number of suicide deaths has increased.**

In 2008, there were six suicide deaths. This is an increase from four suicide deaths in 2007 and one in 2006. All six suicide deaths in 2008 were male decedents. The method of death for four decedents was by a firearm, and two decedents was by hanging. Four of the six decedents had a known mental health history prior to their death. Of the four decedents who had a known mental health history prior to their death, one decedent was receiving mental health services at the time of their death. Three of the six decedents had truancy related issues at school. Two of the six decedents had multiple mid-year transfers in school. Two of the six decedents made prior suicide attempts and threats. Two of the six decedents had a known history of illegal drug use and one of the six had a known history of alcohol abuse.

➤ **More than two-thirds of all youth injury-related deaths were of male decedents**

Youth deaths of children between 10 and 17 years of age, accounted for 21 of the injury-related deaths in 2008. 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.

➤ **Nearly one-half of all youth injury-related decedents had a violent or non-violent crime history**

Of the 21 youth injury-related decedents, 10 youth (48%) had a violent or non-violent crime history. Of those 10 youth, five had a non-violent crime history only and five had both a history of violent and non-violent crime. Five of the 21 (24%) youth injury-related decedents had reported truancy in school.

➤ **Motor Vehicle Collision (MVC) deaths have decreased.**

There were six Motor Vehicle Collision (MVC) deaths of Sacramento County children in 2008. All six MVC deaths were separate incidents. Four (67%) of the six motor vehicle collision deaths were motor vehicle driver/occupant deaths and two (33%) were motor vehicle pedestrian deaths. Of the four motor vehicle collision driver/occupant deaths, three (75%) were of children between 15 and 17 years of age, and one was between 10 and 14 years of age. Three (75%) of the four driver/occupant decedents were known to be wearing a seat belt properly at the time of the collision. Both of the motor vehicle pedestrian deaths were of children between 15 and 17 years of age and were known to not be following pedestrian safety rules. There were no motor vehicle collision deaths of out-of-county residents in 2008.

In 2007, there were 13 motor vehicle collision deaths of Sacramento County children. All 13 motor vehicle collision deaths were separate incidents. Seven (54%) of the 13 motor vehicle



collision deaths were motor vehicle driver/occupant deaths and six (46%) were motor vehicle pedestrian deaths. All 7 motor vehicle collision driver/occupant deaths were of children between 15 and 17 years of age. Five (71%) of the seven driver/occupant deaths were known to be wearing a seat belt at the time of the collision. Three of the six motor vehicle collision pedestrian deaths were of children between 15 and 17 years of age, two were of children between 12 and 14 years of age and one child was between 1 and 4 years of age. Four of the six motor vehicle collision pedestrian deaths were known to not be following pedestrian safety rules. There were an additional five motor vehicle collision deaths that occurred in Sacramento County of decedents who were out-of-county residents. These five deaths occurred from three incidents. All five deaths were motor vehicle driver/occupant deaths.

➤ **There were no Motor Vehicle Collision (MVC) deaths in children birth through 8 years of age.**

In 2008 there were no Motor Vehicle Collision (MVC) deaths in children birth through 8 years of age. In 2007, there were five motor vehicle collision deaths in children birth through 8 years of age and in 2006 there were three.

The current state law (V.C.27360) states “babies and young children must ride in the back seat, properly buckled, in a safety seat or booster until they are least 6 years old or weigh 60 lbs.” However, Sacramento County’s car seat fitting stations promote the National Highway Traffic Safety Administration’s (NHTSA) standards which state children should continue to use booster seats through age 8 or when they reach 4’9” tall.

➤ **Although drowning deaths have decreased, child maltreatment remains a contributing factor.**

In 2008, there were four drowning deaths. Three of the four (75%) had an element of child maltreatment associated with the death, such as lack of appropriate supervision or poor caregiver skills and judgment. Of the four drowning decedents in 2008, one each was under 1 year of age, between 1 and 4 years of age, between 10 and 14 years of age and between 15 and 17 years of age.

In 2007, there were seven drowning deaths of which three (43%) had an element of maltreatment associated with the death. In 2006 there were 12 drowning deaths of which seven (58%) had an element of maltreatment associated with the death. Of the seven drowning deaths in 2007, three decedents were between 1 and 4 years of age, three decedents were between 15 and 17 years of age and one decedent was between 10 and 14 years of age.

## 2008 Recommendations

➤ **The health and safety of Sacramento County's children must remain a priority during county budget cuts.**

The CDRT recognizes Sacramento County's dire fiscal situation. Unfortunately, budget cuts are affecting the safety and lives of children. Sacramento County's Child Protective Services (CPS), Behavioral Health, Human Assistance, and Public Health divisions have been impacted by county budget cuts, eliminating safety net services for vulnerable children. In response to these unprecedented times, the CDRT recommends that county agencies, serving the same families for different reasons, coordinate efforts and share information to support families wholly and more efficiently. County agencies should provide coordinated services to prevent child abuse, and/or death. Additionally, county agencies should develop strong partnerships with community agencies and resources through coordination and communication to address system gaps in serving families. The restoration of funding to children services in Sacramento County during these tough economic times to ensure the health and safety of children must take precedence.

➤ **Restore prevention and early intervention programs implemented and targeted to biological parents aimed at reducing child abuse and neglect in Sacramento County.**

In 2008, there were 12 Child Abuse and Neglect (CAN) homicides, of which six of the perpetrators were the biological parent(s). Of the six, three were the biological mother, one was the biological father and two were both biological parents acting together. The CDRT recommends the Sacramento County Board of Supervisors work with county agencies to restore child abuse and neglect prevention programs, such as the *Birth and Beyond* home visitation program, *Nurse Family Partnership (NFP)*, as well as the Child Protective Services' (CPS) *Family Maintenance* and *Differential Response* programs. These programs target biological parents to reduce child abuse and neglect in this county. 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.

➤ **Develop and support public education and awareness campaigns aimed at modifiable adult behaviors and risk factors contributing to preventable deaths.**

Twenty-four percent of all child deaths in 2008 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 to reduce abusive head trauma deaths and the Safe Beginnings Prevention Program to reduce preventable 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.

- **Sacramento County's Child Protective Services (CPS) should continue to use a standardized risk assessment tool when referrals are made, with an increased level of scrutiny that includes consistent follow-up with collateral agencies, experts, service providers and mandated reporters.**

In 2008, 22 of the 166 (13%) total child deaths had an element of child maltreatment. Of the 22 child deaths with an element of child maltreatment, 10 (45%) decedents were open or reported to any California County CPS, including Sacramento County. Sacramento County CPS' standardized risk assessment tool should continue to consider the following elements: multiple CPS referrals on a family (even if unfounded or inconclusive); lengthy history of CPS involvement and services, both in Sacramento County as well as in other counties or States; referrals or cases involving children 0-5 years of age; and/or referrals or cases of "severe neglect", medical neglect/failure to thrive, or history of "severe neglect" reports. CPS' scrutiny of referrals should include a consultation with each of the child's providers and other agencies serving the family to develop a comprehensive case management plan.

- **Support the implementation of public education campaigns targeted to new parents, aimed at reducing infant sleep-related deaths.**

In 2008, infant sleep-related deaths accounted for 27 of the 166 child deaths, the highest since 1993. This is an increase from 21 infant sleep-related deaths in 2007. From 2003 to 2006, 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. By 2007, the funding for some of these infant safe sleeping programs had ended, coincidentally with an increase in infant sleep-related deaths. The CDRT acknowledges the positive impact of infant safe sleeping educational outreach programs and encourages funding of such programs to prevent infant sleep-related deaths.

- **Develop and implement a countywide strategy to address disproportionality in African American child death rates.**

African American children have died at a rate two times higher than Caucasian children in Sacramento County. In 2008, of the 30 African American children who died, 21 (70%) were children under 5 years of age, and nine (30%) were children between 10 and 17 years of age. Eighteen of the 30 African American children died due to natural causes. Nine of those 18 (50%) died from perinatal conditions. The CDRT recommends the Sacramento County Board of Supervisors work with community leaders, service providers, and residents to develop a comprehensive countywide strategy using data, research, and best practices to understand and address the disparity in child death rates among African American children. The countywide strategy should specifically focus on developing interventions targeted towards African American families with children 0-5 years of age, African American youth between 10 and 17 years of age, as well as pregnant African American women.

➤ **Develop and implement best practice programs that have demonstrated positive outcomes and success in suicide prevention.**

In 2008, the number of suicide deaths increased to six from four in 2007 and one in 2006. The CDRT recommends schools and youth serving organizations develop a comprehensive plan to prevent suicides in youth. The plan should incorporate recommendations from Sacramento County's Suicide Prevention Project funded through the Mental Health Services Act, such as appointing a county liaison, establishing a suicide prevention taskforce and developing specialized training for schools and direct service providers. Additionally, the comprehensive plan should include outreach, resources and training in third party reporting of mental health concerns, signs and symptoms of depression and suicide, and issues around school transfers and external stressors. A mental health counselor should be available and accessible to students who want to address mental health concerns in a confidential and safe place.

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

In 2008, through the extensive review of youth deaths by the Youth Death Review Subcommittee (YDRS) of the CDRT, findings indicate that youth who have a violent crime history, also have a non-violent crime history. It is less commonly found that a youth has only a violent crime history, with no non-violent crime history. Truancy has also been found to be paired with violence in youth. The YDRS found that five of the 21 (24%) injury-related youth deaths had a truancy history at school. This information can be used to target intervention strategies to identify youth at-risk of violent crimes or injury related death.

The YDRS also found that six of the nine suicide and third-party homicide youth deaths in 2008 were by use of a firearm (67%). Existing efforts and programs should use these findings to research best practice models to address the issue of youth violence, access to firearms and empowering youth to speak out when they hear of guns on their school campus or amongst their peers. Sacramento County should incorporate innovative collaborative programs and violence prevention education strategies targeted to youth. Some examples of promising programs such as mentoring programs, youth empowerment programs, education and community collaborative programs, and recreational youth programs should be evaluated and supported.

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

Motor vehicle collision (MVC) deaths decreased in 2008 from 18 in 2007 to six in 2008. MVC deaths in children birth through 8 years of age also decreased to zero in 2008. 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 such as: *Start Smart, Every*

*15 Minutes, Every 37 Minutes, and Right Turn* should be promoted. This safety curriculum should be incorporated into schools on a continual basis. The Sacramento County Board of Supervisors and the Sacramento County Department of Education in conjunction with the California Highway Patrol should conduct an analysis of motor vehicle collisions involving high school students. After the analysis is conducted, the Sacramento County Board of Supervisors, Sacramento County Department of Education and the California Highway Patrol should determine if mandated drivers' education classes in schools would prevent teenage driving collisions or deaths.

➤ **Continue public education campaigns aimed at reducing the number of drowning deaths.**

Drowning deaths decreased to four in 2008, from seven in 2007 and 12 in 2006. The CDRT recommends the continuation of public education to parents and caregivers, educators, healthcare professionals, community organizations, child care providers and law enforcement agencies on drowning safety, including appropriate supervision of children and adolescents in or near water, and required barriers. It is also essential to raise community and personal awareness of child and teen drowning risk factors and prevention/safety strategies.

County agencies should also consider Sacramento County demographics and develop multilingual signage and pictograms as appropriate to be posted near all public pools and open bodies of water. Signage should incorporate proper water safety guidelines, including appropriate supervision, the importance of lifejackets, action to be taken in an emergency, location of the nearest telephone, and other messages aimed at assisting both English and non-English speakers.

## INTRODUCTION

*Four year old Sophia had no idea her life was dramatically and sadly going to end. Living with her mother and brother, she had the cares of most four year olds – playing with her dolls, wearing her pretty pink dress and showing off her sparkly shoes. But life was not so simple. Sophia had nightmares of a monster that would find her in her sleep. A monster that would bruise, beat and hurt her. Her nightmares led to repetitive ‘bed-wetting’ that no one quite understood – not her mother, her brother, her social worker or the ‘monster’ she dreamt of – her mother’s boyfriend. This monster had previously been reported to Sacramento County’s Child Protective Services (CPS) for bruises found on Sophia’s chest during a prior hospital visit, as well as other scrapes and abrasions found on her and her brother’s bodies. Sophia’s ‘monster’ also had an alcohol abuse and illegal drug use history. Although, Sacramento County CPS attempted to contact Sophia’s mother before Sophia’s untimely death, it was too late. On a warm summer day, when most children were playing outside, Sophia was told to stand against a wall for ‘wetting herself’ again, and was punched repeatedly in her abdomen and chest until she died. Her massive internal and external injuries were too extensive for any doctor to stabilize. And another child was lost to child abuse and neglect...*

This year’s CDRT statistics of Sacramento County resident children who died from Child Abuse and Neglect (CAN) homicides show a disturbing rise in the number of children killed by their biological parent and/or a close family friend. In 2008, of the 12 children who died as a result of a CAN homicide, six children died at the hands of a biological parent(s), four children died at the hands of the biological Mother’s boyfriend, one child died at the hands of an Adoptive/Foster Mother and one child died at the hands of Family Friend (Grandmother’s boyfriend). Four of those children were killed by multiple blunt force injuries and two were killed from abusive head trauma. A history of illegal drug use and/or alcohol abuse was involved in nine of the 12 (75%) families as were violent criminal histories and history of interpersonal violence. Half of the children had involvement with Sacramento County CPS prior to their death and one-fourth of the children were considered to be “medically fragile.”

In 2008, The National Child Abuse and Neglect Data System (NCANDS) reported an estimated 1,760 child fatalities resulted from abuse or neglect in the previous year, a rate of 2.35 children per 100,000 children in the general population. NCANDS also reported the number and rate of child fatalities have been increasing over the past five years; and yet most researchers and practitioners believe child fatalities due to abuse and neglect are still underreported.

Most fatalities from physical abuse are caused by fathers and other male caregivers, with multiple stressors. Many of these male caregivers lack emotional bonds with the children. Subsequently, according to a 2005 report by Prevent Child Abuse America, substance abuse, by the abuser, was involved in anywhere from 4% - 65% of all substantiated cases. Additionally 46% of children who died between 2003 and 2005 had prior or recent contact with CPS agencies. Furthermore, in a study of abused victims younger than 24 months, 75% had evidence of previous trauma or history of a previous injury.

The American Academy of Pediatrics, in its 2007 Statement on Evaluation of Suspected Child Physical Abuse, clearly states that child physical abuse is a common problem of childhood and that the physician must be able to recognize suspicious injuries, conduct comprehensive and careful

examinations, be responsible for reporting suspected abuse, and providing the necessary information and expertise to investigative and legal personnel. It addresses clearly the need for the use of experts in child abuse when injuries are detected, and the need for aggressive, long term, ongoing close follow-up of these families, including child protective services, mental health services, drug and alcohol services, and family violence services. Other prevention programs with at-risk families are also vital to ensuring the health of the children most at risk for CAN homicides. Without ongoing, long term services for families in which abuse and neglect are identified, it is clear that child fatalities due to child abuse and neglect cannot be prevented.

While the exact number of children affected by child abuse and neglect is uncertain, child deaths due to abuse and neglect remain a serious problem in Sacramento County. The CDRT recognizes Sacramento County's dire fiscal situation; however, the health and safety of Sacramento County's children must remain a priority during county budget cuts. Coordinated efforts by county agencies to support families wholly and more efficiently without eliminating safety net services for vulnerable children is crucial. Strong partnerships with community agencies and coordination and communication to address system gaps in serving families during these unprecedented times could save the lives of many of Sacramento County's most vulnerable population.

Deborah Stewart, M.D.  
*University of California Davis Children's Hospital*  
*CAARE Center*





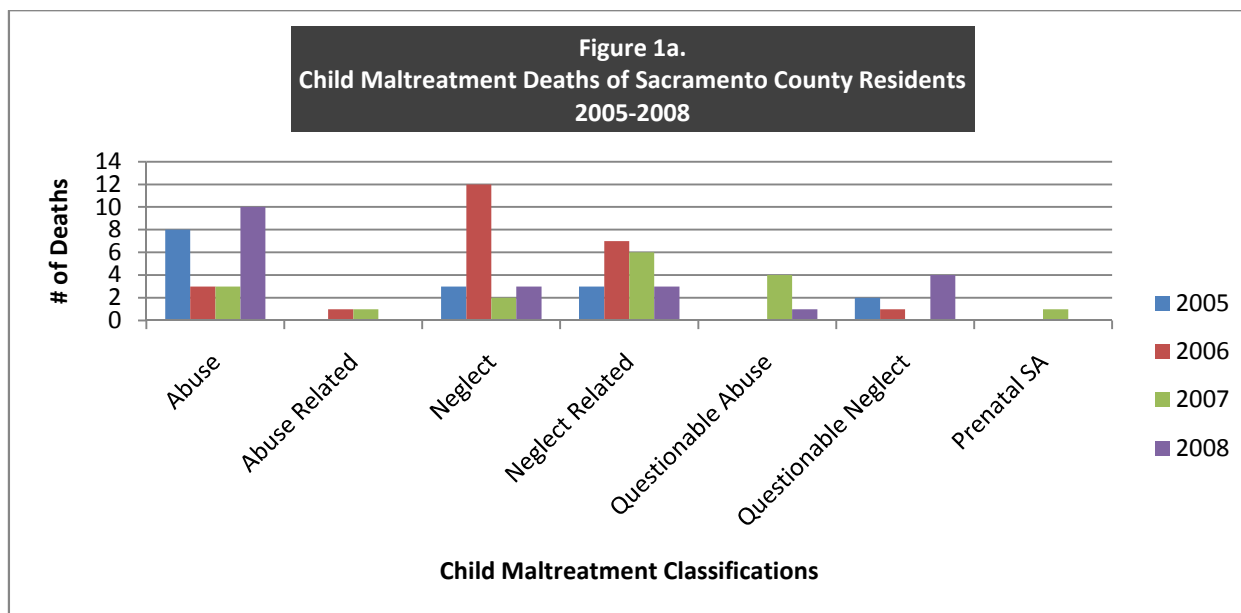
## **Chapter I**

### **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 22 children who died in 2008 (see Figure 1a above). Twenty-one of the 22 child deaths with an element of maltreatment were Sacramento County residents and one of the 22 child deaths was an out-of-county resident whose death occurred in Sacramento County. Of the 22 child deaths with an element of maltreatment, nine decedents were infants, eight decedents were between 1 and 4 years of age, two decedents were between 5 and 9 years of age, two decedents were between 10 and 14 years of age, and one decedent was between 15 and 17 years of age. Of these deaths, 12 children died as a result of a Child Abuse and Neglect (CAN) homicide, three died as a result of drowning where there was an element of maltreatment present, two children died of perinatal conditions and five children died from neglectful behaviors. Elements of neglect include failure by the parent or caretaker to provide for the basic needs of the child. An example of a case involving an element of neglect is of an infant that was being supervised by an intoxicated parent who co-slept with the infant in an adult bed, which subsequently resulted in the infant's accidental asphyxia by overlay. 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 an infant did not have adequate supervision or proper care for several hours because the infant's parents were under the intoxication of drugs.

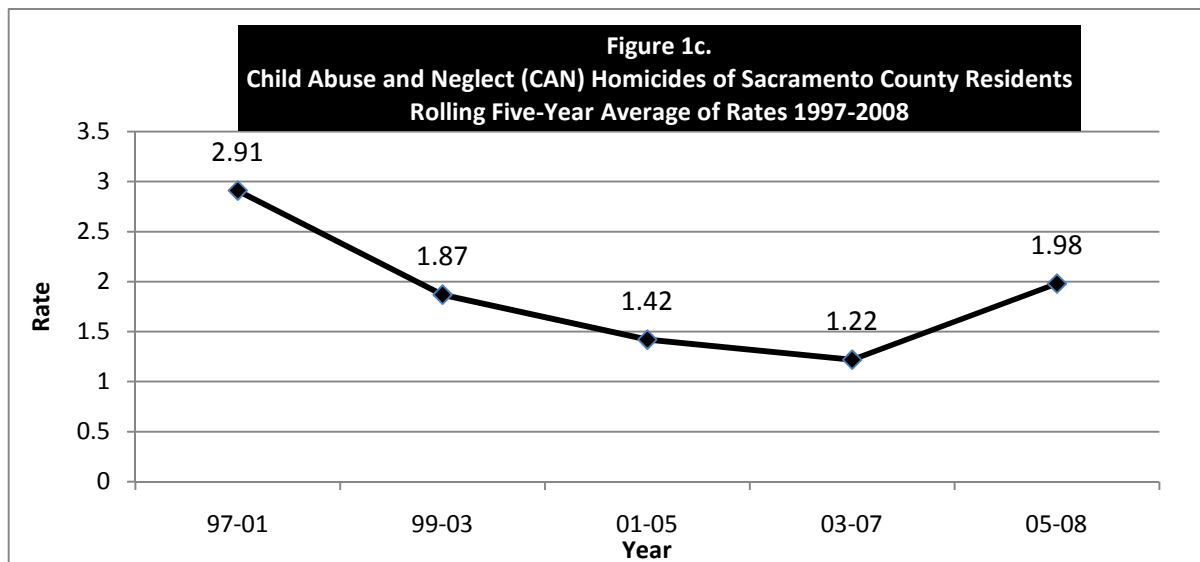
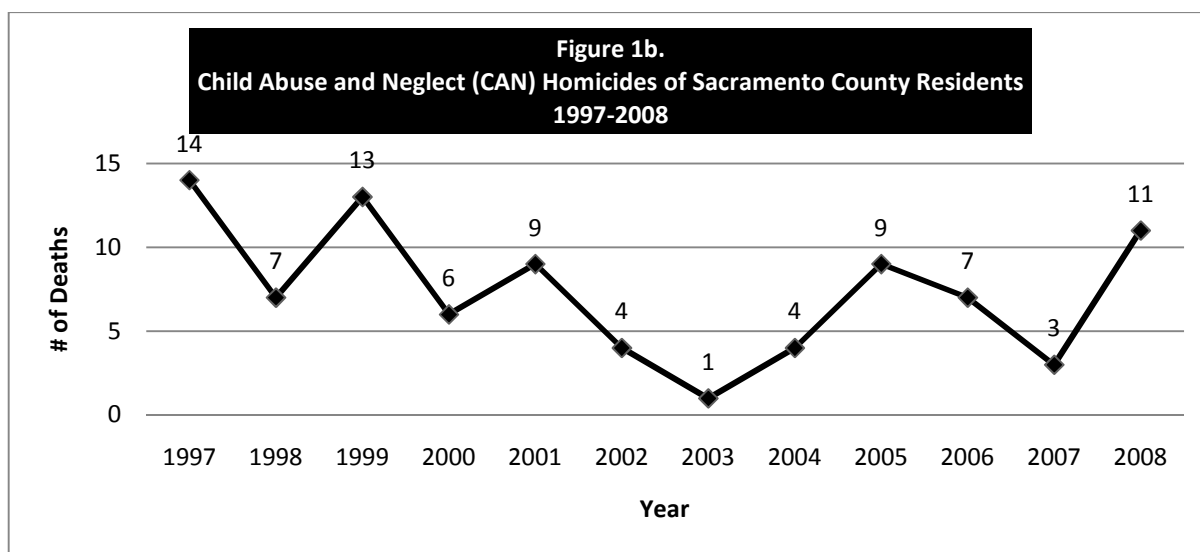
Through the years that Sacramento County's CDRT has met and reviewed child deaths, certain risk factors have been identified. Known risk factors were present in all 22 deaths related to abuse and neglect deaths in 2008. Examples of risk factors include a family history of alcohol and other drug abuse, or a family history of abuse and neglect, domestic violence or violent crime. Known risk factors were present in the 22 deaths with an element of child maltreatment and are as follows:

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

## Child Abuse and Neglect Homicides

In 2008, there were 12 Child Abuse and Neglect (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, there were 11 separate incidents. In 2007, there were three CAN homicides, of which all were Sacramento County residents, out of 192 Sacramento County resident child deaths.

Figure 1b below shows the number of CAN homicides from 1997 – 2008. Figure 1c below illustrates the number of CAN homicides as five-year rolling averages from 1997 – 2008. 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.<sup>2</sup> In the 2003 – 2007 period through 2005 – 2008 period there has been an increase in CAN homicides.



<sup>2</sup> Based on consultation and Poisson regression analyses provided by Dr. Neil Willits, University of California, Davis Statistical Laboratory on 1/14/10 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, of the 12 CAN homicides, 11 children resided in Sacramento County and one victim was an out-of-county resident. Seven victims were female and five victims were male. Three victims were infants, seven victims were between 1 and 4 years of age, one victim was between 5 and 9 years of age and one victim was between 15 and 17 years of age. Five victims were African American, three victims were Asian/Pacific Islanders, and two victims each were Caucasian and Hispanic.

## **Perpetrators**

Of the 12 CAN homicides in 2008, six victims died at the hand of their biological parent(s), four victims died at the hand of the biological Mother's boyfriend, and one victim each died at the hands of the Adoptive/Foster Mother and a Family Friend (Grandmother's boyfriend).

## **Mechanism of Death**

Of the 12 CAN homicides in 2008, four victims died due to blunt force injuries, two victims died due to murder-suicides, two victims died due to abusive head trauma, and one victim each died due to failure to thrive, smothering, drug intoxication and drowning.

## **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 2008, three risk factors were identified in at least one of the 12 CAN homicides: prior child abuse and/or neglect, a family history of violent and/or non-violent crime, medically fragile children 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 12 CAN homicides in 2008, six decedents had Child Protective Services (CPS) involvement with Sacramento County CPS. Three of the six decedents had involvement with Sacramento County CPS at the time of death. One of the six decedents had Sacramento County CPS history within six months prior to their death. Two of the six decedents with prior Sacramento County CPS involvement also had prior involvement with at least one other California County CPS.

## Investigation and Prosecution

Of the 12 CAN homicides in 2008, charges were filed against nine defendants in eight cases. In all cases, defendants were charged for multiple crimes. Seven defendants were charged for *unlawful murder of a human being*; four defendants were charged for *felony child endangerment* and two defendants were charged with *possession of marijuana with the intent to sell*.

Because cases take time to navigate through the criminal justice system, this annual report attempts to report on the outcomes of prior and 2008 identified CAN homicides.

As of the writing of this report, the outcomes of the nine defendants charged in the 12 CAN homicides from previous years and of 2008 are as follows:

- ❖ 4 defendants are pending jury trial
- ❖ 2 defendants are scheduled for preliminary hearings
- ❖ 1 defendant is scheduled for a Supreme Court review
- ❖ 1 defendant was convicted and is serving time in a state prison
- ❖ 1 defendant was tried, found not guilty and acquitted

Of the three CAN homicides in 2007, charges were filed in two cases, in which there were three defendants:

- ❖ 2 defendants were charged with felony child endangerment and received two years each in a state prison
- ❖ 1 defendant was charged with homicide and sentenced to 25 years in a state prison

## **Chapter II**

### **All Causes of Child Death**

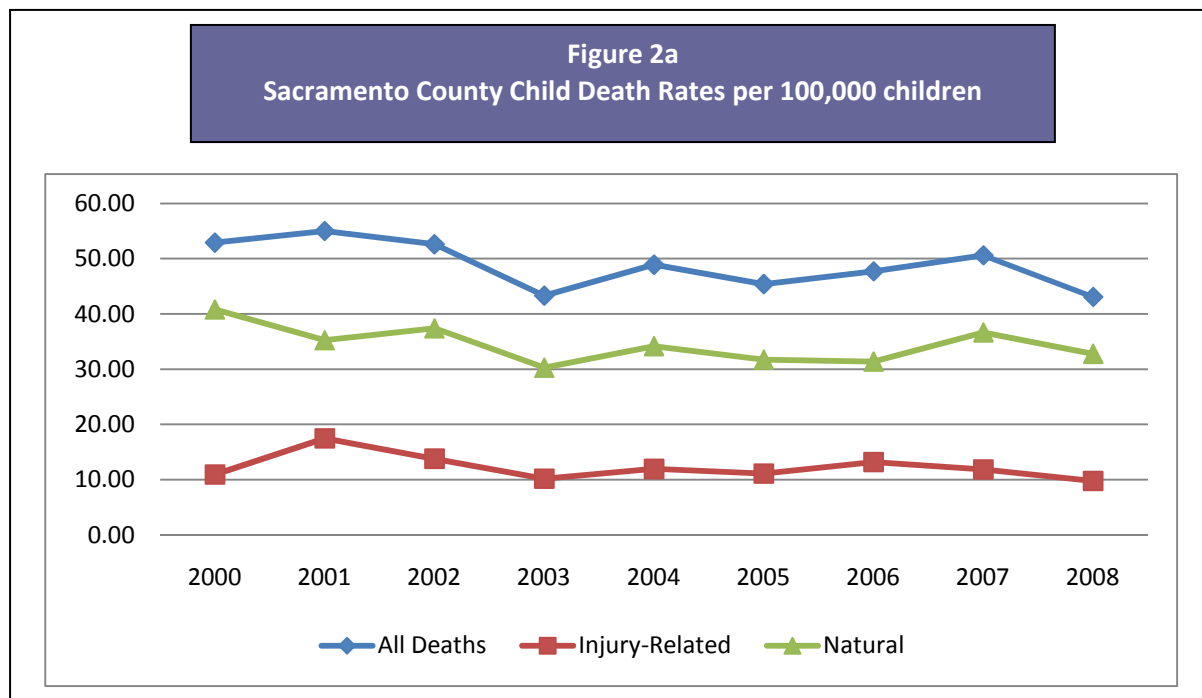
## Chapter Two

### All Causes of Child Death

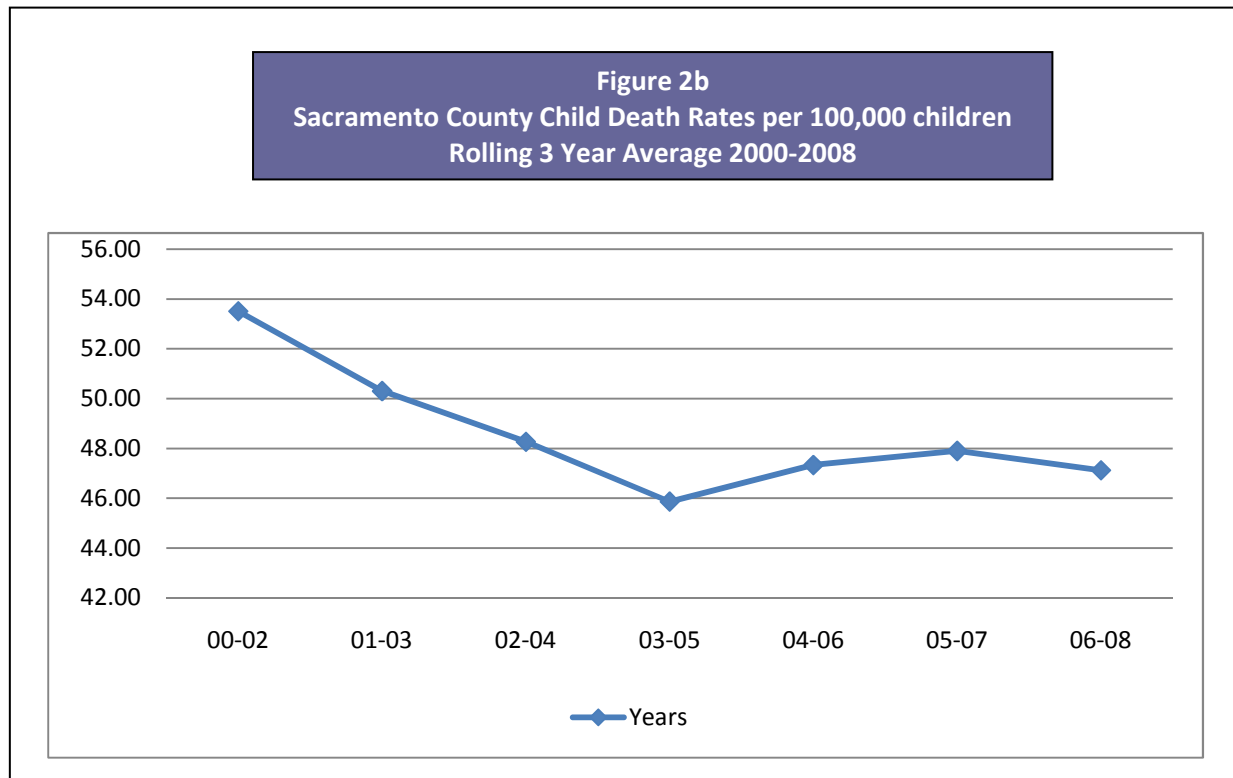
Another fundamental mission of the Child Death Review Team (CDRT) is to develop an aggregate description of all child deaths as an overall indicator of the well-being of children. This chapter includes information regarding the overall child death rate, natural and injury-related death rates, a categorical breakdown of the causes and manners of death, and a summary of natural deaths and those caused by accidents, suicides, and undetermined manner.

### Child Death Rates

In 2008, there were 163 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 2008 was 43.07 per 100,000 children. This rate is lower than the 2007 rate of 50.6, the 2006 rate of 47.7, the 2005 rate of 45.4, and the 2004 rate of 48.9. Figure 2a, on the previous page, illustrates the child death rates of Sacramento County residents from 2000-2008.

Figure 2b above illustrates rolling three year average child death rates from 2000-2008 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 2008, 76% (124 of 163) of all Sacramento County resident child deaths were due to natural causes. This is four percentage points higher than Sacramento County child deaths due to natural causes in 2007. Injury-related deaths accounted for 23% (37 of 163) of all Sacramento County resident children who died in Sacramento County in 2008. This is two percentage points lower than in 2007. One percent of child deaths were classified as undetermined in 2008. This is three percentage points lower than in 2007.

Figure 3 below shows a breakdown of Sacramento County resident child deaths by category from 2000 through 2008.

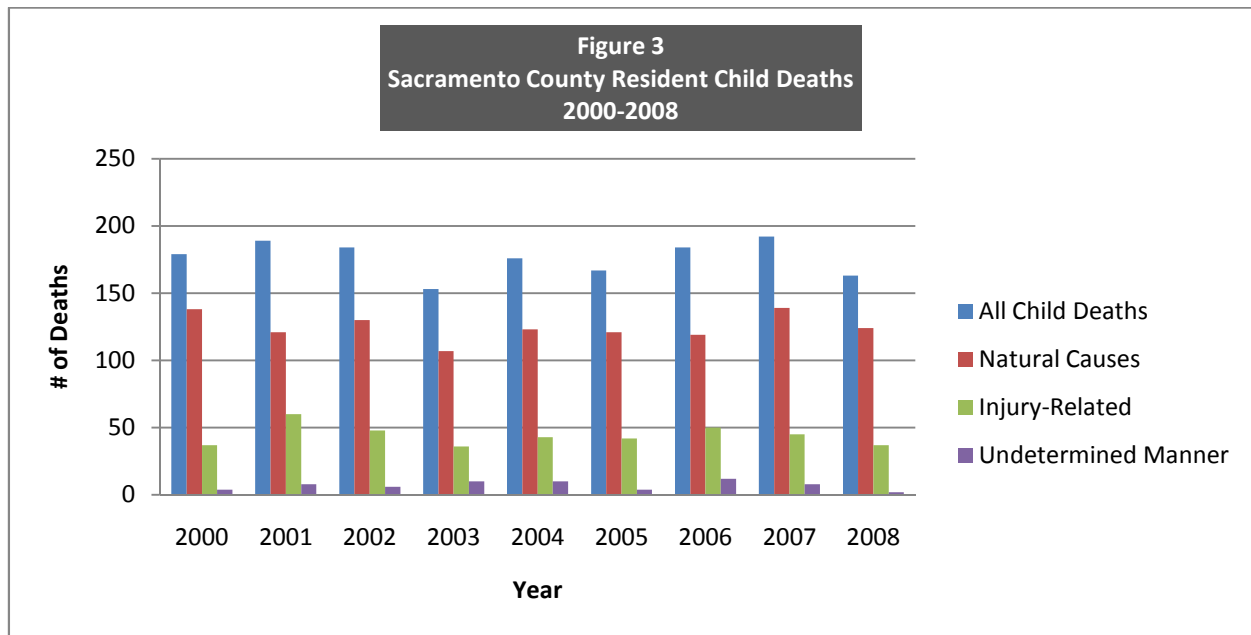


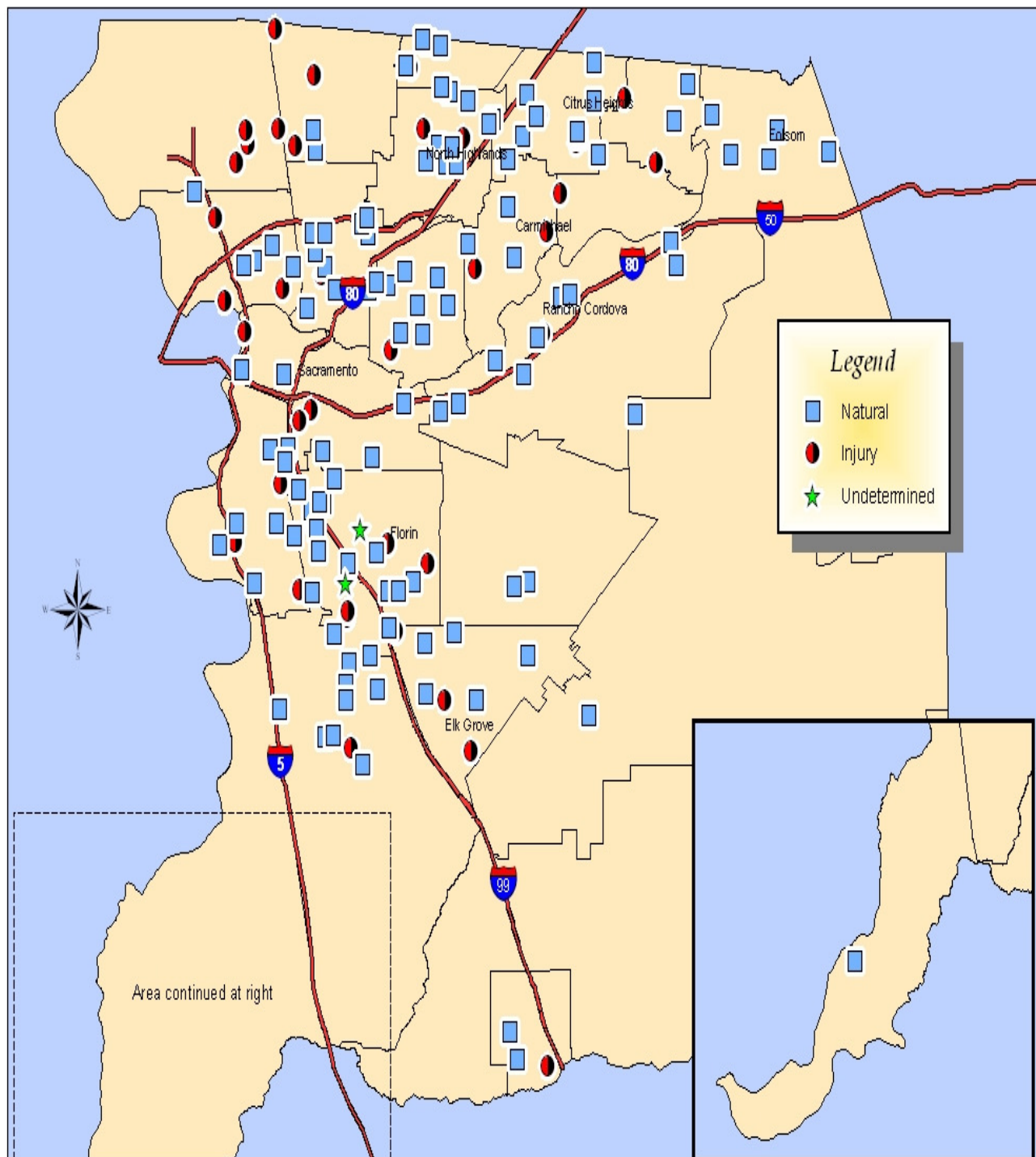
Table A, on the following page, provides a summary of the cause and manner of all 2008 child deaths. Deaths in the two main categories, injury-related and natural causes, are broken out into subcategories according to similar conditions. A third category, undetermined, contains cases for which the manner 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**  
**2008 All Child Deaths by Cause and Manner**

Category	2008
<b>Natural Causes</b>	
Perinatal Conditions	50
Congenital Anomalies	30
SIDS	6
SUIDS	15
Cancer	8
Infections	5
Respiratory	3
Other-Natural	6
Undetermined-Natural	1
<b>Total Natural Causes</b>	<b>124</b>
<b>Injury-Related Causes</b>	
CAN Homicide	12
Third-Party Homicide	5
MVC (Driver/Occupant)	4
MVC (Pedestrian)	2
MVC (Bike)	0
Drowning	4
Suicide	6
Suffocation/Choking	1
Burn/Fires	1
Poisoning/ Overdose	1
Other-Injuries	4
<b>Total Injury-Related Causes</b>	<b>40</b>
<b>Undetermined Manner</b>	<b>2</b>
<b>TOTAL</b>	<b>166</b>

Map i:  
All Causes of Death  
Sacramento County Resident Deaths 2008



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

**n = 163**

## **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 17 (10%) of the child deaths in 2008 and were comprised of two categories: third-party homicides (i.e., perpetrated by a third-party, such as a friend or stranger), and CAN homicides (i.e., caregiver abuse or neglect). CAN homicides are discussed in a separate section of this report (Chapter One). Map ii, on 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 17 child homicides in 2008, five were classified as third-party homicides. Three of the five victims were between 15 and 17 years of age, one victim was between 1 and 4 years of age and one victim was between 5 and 9 years of age.

The following information was known for the five third-party homicides in 2008. At least one risk factor was present in four of the five (80%) third party homicides in 2008 and is as follows:

- ❖ 4 victims had a family history of violent and/or non-violent crime
- ❖ 3 victims had prior CPS involvement in any California County, of which 2 victims had prior Sacramento County CPS involvement
- ❖ 3 victims had a family history of substance abuse
- ❖ 2 victims had a family history of gang involvement
- ❖ 2 victims had illegal drugs or alcohol involved in their death

## **Suicides**

In 2008, there were six suicide deaths, an increase from four suicide deaths in 2007 and one in 2006. All six suicide deaths in 2008 were male decedents. Four decedents were between 15 and 17 years of age and two decedents were between 10 and 14 years of age. The method of death for four decedents was by a firearm, and two decedents were by hanging. Four of the six decedents had a known mental health history prior to their death. Of the four decedents who had a known mental health history prior to their death, one decedent was receiving mental health services at the time of their death. Three of the six decedents had truancy related issues at school. Two of the six decedents had multiple mid-year transfers in school. Two of the six decedents made prior suicide attempts and threats. Two of the six decedents had a known history of illegal drug use and one of the six had a known history of alcohol abuse.

**Map ii:  
All Homicides  
Sacramento County Resident Deaths 2008**



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

**n = 16**

## **Unintentional Injuries**

*Eleven year old Jessica spent the day with her Mom, Aunt and younger siblings at the river. As Jessica walked along the riverbank, her Mom and Aunt lost track of her, and she fell into the water. Jessica did not know how to swim, was not wearing a lifejacket and was not properly supervised, which subsequently led to her death.*

In 2008 there were 17 deaths resulting from unintentional injuries (including the deaths of two out-of-county residents). The unintentional injury-related deaths in 2008 were six Motor Vehicle Collisions (MVC), four other-injuries, four drowning, and one each of burn/fire, poisoning/overdose and suffocation.

The following information was known for the unintentional injury-related deaths in 2008. Risk factors were present in 15 of the 17 deaths (88%) resulting from unintentional injuries in 2008 and are as follows:

- ❖ 13 decedents had prior CPS involvement in any California County, including Sacramento County CPS.
- ❖ 5 decedents had a family history of violent and/or non-violent crime
- ❖ 5 decedents had a family history of alcohol and/or other drug abuse
- ❖ 2 decedents had a family history of domestic violence

### **Motor Vehicle Collisions**

Motor vehicle collisions (MVC) accounted for six of the 17 (35%) unintentional injuries for 2008. Of the six MVC deaths, four (67%) were occupants only and two (33%) were pedestrians. All six MVC deaths were separate incidents.

Of the four MVC occupant only deaths, three (75%) involved a driver under the influence of drugs or alcohol. Three (75%) decedents were known to be wearing their seatbelt properly. Three (75%) collisions involved a youth between 15 and 17 years of age and one (25%) collision involved a youth between 10 and 14 years of age.

### **Drowning**

Drowning accounted for four of the 17 (24%) unintentional injury-related deaths for 2008. Two children died in a river, and one child each died in a residential pool, and bathtub.

The one residential pool drowning death involved inadequate fencing or locks. Three of the four (75%) drowning deaths had an element of child maltreatment associated with the death, such as lack of appropriate supervision or poor caregiver skills and judgment. One decedent each was an infant, between 1 and 4 years of age, between 10 and 14 years of age and 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 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 four (124) children who resided in Sacramento County, died from natural causes in 2008. 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 20<sup>th</sup> to 28<sup>th</sup> 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 2008, perinatal conditions accounted for the deaths of 50 children. Prematurity was a contributing factor in 33 (20%) of the 163 Sacramento County child deaths this year. The median gestational age of babies who died from prematurity and other perinatal conditions was 25 weeks. The median weight of babies who died from prematurity and other perinatal conditions was 777 grams (approximately 1.72 pounds).

Known risk factors were present in 25 of the 50 deaths (50%) due to perinatal conditions in 2008 and are as follows:

- ❖ 19 families had a known family history of violent and/or non-violent crime
- ❖ 11 families had a known history of alcohol and/or other drug abuse
- ❖ 7 mothers were teenagers
- ❖ 6 families had a known history of domestic violence
- ❖ 4 mothers had inadequate prenatal care
- ❖ 4 mothers had a positive toxicology report at birth for alcohol and/or drugs
- ❖ 2 mothers had a known history of smoking during their pregnancy

## **Congenital Anomalies**

*Definition: Congenital - A condition that exists at birth, and usually before birth, regardless of its causation. Anomalies - Marked deviations from the normal standard, especially as a result of congenital defects. These conditions are acquired during the development of the fetus and are generally attributed to heredity/genetics.*

Congenital anomalies include fatal birth defects, such as structural heart defects, neural tube defects such as anencephaly, and chromosomal abnormalities such as down syndrome. The underlying causes of death in this category are generally attributed to heredity and/or genetics. Birth defects include heart defects, neural tube defects such as anencephaly, and chromosomal abnormalities such as Down Syndrome.

In 2008, congenital anomalies accounted for the deaths of 30 children (18%). The following information on risk factors was known for the 30 deaths caused by congenital anomalies in 2008. Known risk factors were present in 12 of the 30 deaths due to this condition (40%) and are as follows:

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

## **Cancer, Infections and Other Natural Causes**

*Definition:*

Cancer - Death caused by a tumor disease, the natural course of which is fatal. Cancer cells, unlike benign tumor cells, exhibit the properties of invasion and metastasis and are highly anaplastic.

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

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

In 2008, cancer, infections, and other natural causes accounted for the deaths of 22 children (13%). The following information was known for the 22 deaths due to cancer, infections, and other natural causes in 2008. Known risk factors were present in 11 of the 22 deaths (50%) due to these causes and are as follows:

- ❖ 10 families had a history of violent or non-violent crime
- ❖ 7 families had a history of alcohol and/or other drug abuse
- ❖ 3 families had a history of domestic violence

## 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 27 (17%) of the 163 Sacramento County resident child deaths in 2008 and were comprised of six categories: Sudden Unexpected Infant Death Syndrome (SUIDS) (15), Sudden Infant Death Syndrome (SIDS) (6), undetermined manner (2), undetermined-natural (1), suffocation (1), respiratory (1), and an infection (1). Known risk factors were present in all 27 infant sleep-related deaths (100%) in 2008. Map iii, on page 25, shows a geographical representation of all infant sleep-related deaths, including SIDS, SUIDS and deaths of an undetermined manner of Sacramento County residents that occurred in Sacramento County in 2008.

Infant sleep-related deaths declined from 20 in 2003 to 13 in 2004 to nine in 2005. However, there has been an increase in 2007 and 2008 (21 in 2007 and 27 in 2008). 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 2008 there were six SIDS deaths in Sacramento County. Known risk factors were present in all six deaths related to SIDS in 2008 and are as follows:

- ❖ 3 infants slept in unsafe sleeping locations, such as an adult bed or couch
- ❖ 3 infants were put to sleep in a position recognized to increase the risk of SIDS, such as face down or on the side
- ❖ 2 infants slept in locations where there was an obstruction of blankets and/or pillows
- ❖ 2 infants were co-sleeping with a parent and/or sibling
- ❖ 2 infants were exposed to second hand smoke
- ❖ 1 infant had intoxicated parent(s) at the time of their death

## **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 2008 there were 15 SUIDS deaths in Sacramento County. Known risk factors were present in all 15 deaths related to SUIDS in 2008 and are as follows:

- ❖ 15 infants slept in unsafe sleeping locations, such as an adult bed or couch
- ❖ 13 infants were co-sleeping with a parent and/or sibling
- ❖ 10 infants slept in locations where there was an obstruction of blankets and/or pillows
- ❖ 4 infants were put to sleep in a position recognized to increase the risk of SUIDS, such as face down or on the side
- ❖ 3 infants had intoxicated parent(s) at the time of their death
- ❖ 1 infant was exposed to second hand smoke

## **Other Infant Sleep-Related Deaths**

In 2008, there were three additional infant sleep-related deaths from other causes. The causes of the three additional infant sleep-related deaths were infection, respiratory, and suffocation. Known risk factors were present in all three deaths and are as follows:

- ❖ 3 families had a history of violent or non-violent crime
- ❖ 2 families had a history of alcohol and/or other drug abuse
- ❖ 2 infants slept in unsafe sleeping locations, such as an adult bed
- ❖ 2 infants were co-sleeping with a parent
- ❖ 1 infant had intoxicated parent(s) at the time of their death

## Undetermined Infant Sleep-Related Deaths

### Definition:

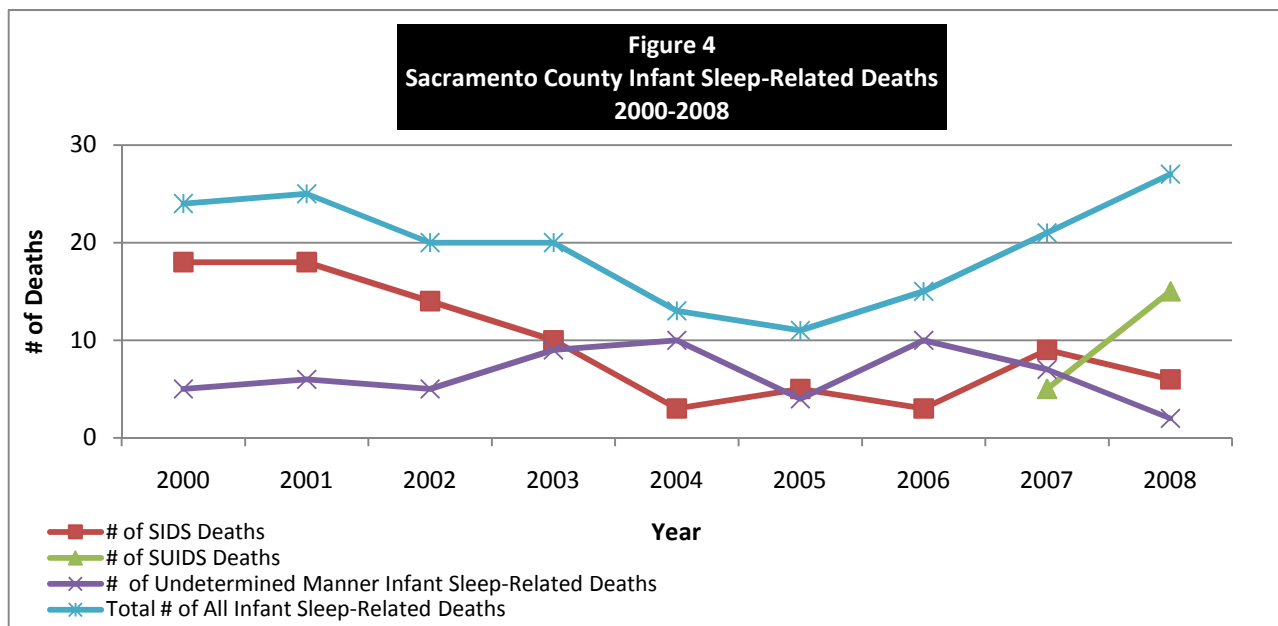
*Undetermined Manner: Death in which the manner or how the death occurred is unknown and the cause of death may or may not be medically identifiable.*

*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.

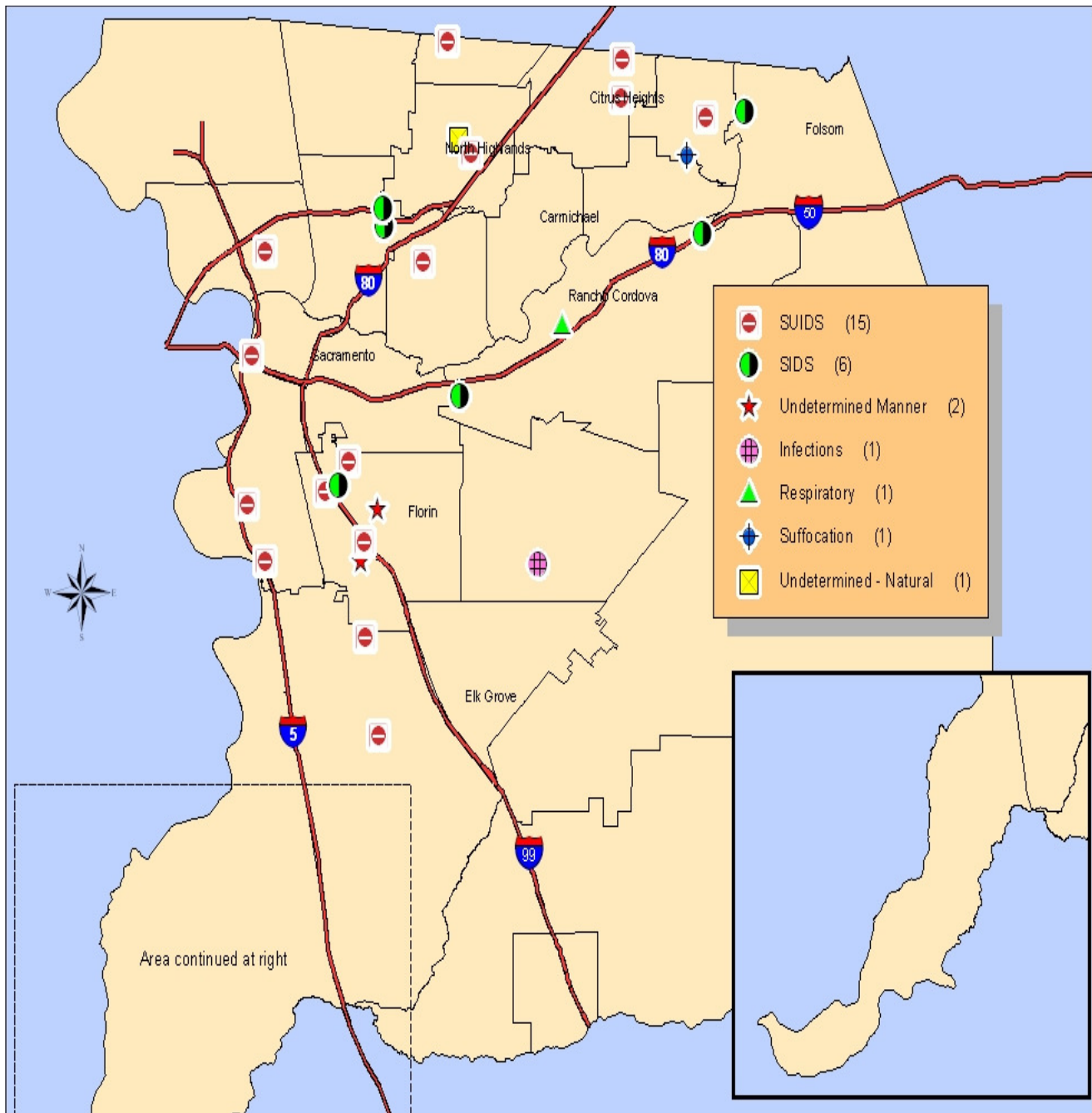
In 2008 there were three undetermined infant sleep-related deaths in Sacramento County, of which two were categorized as an undetermined manner and one was categorized as an undetermined-natural death. Known risk factors were present in all three deaths and are as follows:

- ❖ 3 families had a history of violent or non-violent crime
- ❖ 2 families had a history of alcohol and/or other drug abuse
- ❖ 2 infants slept in unsafe sleeping locations, such as an adult bed or car seat
- ❖ 2 infants had intoxicated parent(s) at the time of their death
- ❖ 2 infants were exposed to second hand smoke
- ❖ 1 infant slept in a location where there was an obstruction of blankets and/or pillows



\* 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 2008**



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

**n = 27**

## **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 team could not determine if the death would have occurred naturally, or by an inflicted or accidental injury. In 2008, both of the two (100%) undetermined manner deaths were infant sleep-related.

## **Chapter III**

### **Child Death Demographics**

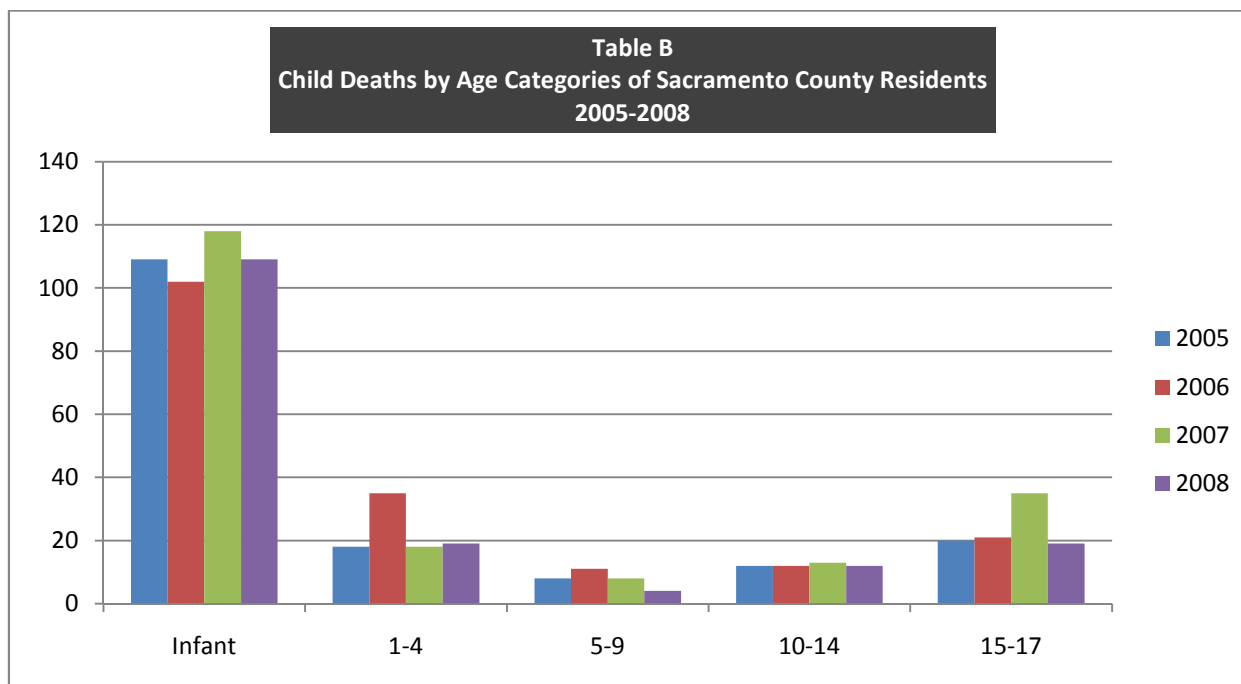


## Chapter Three

### Child Death Demographics

#### Age

The majority of Sacramento County resident child deaths occurred in infants under one year of age, accounting for 67% (109 of 163) of all deaths in 2008. Children between 1 and 4 years of age and 15 and 17 years of age were the second largest groups, accounting for 12% each (19 of 163) of all deaths this year. The third largest group was children between 10 and 14 years of age, accounting for 7% (12 of 163) of all deaths. Lastly, the fourth group was children between 5 and 9 years of age, accounting for 2% (4 of 163) of all deaths in 2008. Table B below illustrates age categories of child deaths from 2005 to 2008.



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

#### Intentional Injuries

In 2008, there were a total of 23 deaths resulting from intentional injuries of the 166 child deaths. Children between 1 and 4 years of age and 15 and 17 years of age each accounted for eight (35%) of the intentional injury child deaths. Infants accounted for three (13%) intentional injury child deaths. Children between 5 and 9 years of age and 10 and 14 years of age each accounted for two (9%) intentional injury child deaths.

#### Unintentional Injuries

There were a total of 17 deaths resulting from unintentional injuries. Children between 15 and 17 years of age accounted for seven (41%) of the deaths due to an unintentional injury. Infants and

children between 10 and 14 years of age each accounted for four (24%) of the unintentional injury deaths. Children between 1 and 4 years of age accounted for two (12%) of these deaths. There were no unintentional injury deaths in children between 5 and 9 years of age.

### Natural Causes

A total of 124 deaths resulted from natural causes in 2008, including SIDS and SUIDS deaths. Infants under 1 year of age accounted for 100 (81%) of all deaths due to natural causes. The second largest group was children between 1 and 4 years of age, accounting for 10 (8%) of all natural deaths. Children between 10 and 14 years of age accounted for seven (6%) and children between 15 and 17 years of age accounted for four (3%) of all natural deaths. Lastly, children between 5 and 9 years of age each accounted for three (2%) of all natural deaths.

### Undetermined Manner

There were two deaths of an undetermined manner in 2008. Both undetermined manner deaths in 2008 were in infants under 1 year of age (100%) and were infant sleep-related.

### Race and Ethnicity

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

**Table C**  
**Comparison of Child Deaths by Race and Child Population**  
**2007 and 2008**

Race/Ethnicity	2007 Child deaths (#)	2007 Child deaths (%)	2007 Child death rate of residents per 100,000 child population	2008 Child deaths (#)	2008 Child deaths (%)	2008 Child death rate of residents per 100,000 child population
Caucasian	63	33%	39.61	52	32%	33.64
African American	41	21%	103.80	30	18%	76.82
Hispanic	34	18%	34.68	37	23%	37.46
Asian	20	10%	42.77	18	11%	38.20
Native American	0	0%	--	1	.06%	52.27
Multiracial	26	14%	85.34	20	12%	65.52
Other	8	4%	147.73	5	3%	143.47
Total	192	100%	50.6	163	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

### Substance Abuse and Domestic Violence

Substance abuse and domestic violence are major concerns to the CDRT. As mentioned previously, the overlap between domestic violence and/or substance abuse 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.”<sup>3</sup> Additionally, according to statistics published by the U.S. Department of Justice in 2002, “61% of domestic violence offenders also have substance abuse problems.”<sup>4</sup>

In 2008, 58 of the 166 child deaths (35%) had a 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:

- ❖ 14 deaths due to perinatal conditions
- ❖ 8 deaths due to SUIDS
- ❖ 7 deaths due to CAN homicides
- ❖ 4 deaths each due to congenital anomalies and third-party homicides
- ❖ 3 deaths each due to MVC’s, SIDS, and suicides
- ❖ 2 deaths each due to drowning, infections, undetermined manner and other-natural deaths
- ❖ 1 death each due to poisoning/overdose, respiratory, suffocation, and undetermined-natural deaths

In 2008, 21 of the 166 child deaths (13%) had a history of domestic violence in the child’s family. The deaths involving a family history of domestic violence are as follows:

- ❖ 6 deaths due to perinatal conditions
- ❖ 3 deaths due to third party homicides
- ❖ 2 deaths each due to CAN homicides, congenital anomalies, and undetermined manner deaths
- ❖ 1 death each due to a drowning, infection, other-natural, suicide, respiratory, and a MVC

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<sup>3</sup> 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.

<sup>4</sup> Collins, James J. and Donna L. Spencer. (2002) “*Linkage of Domestic Violence and Substance Abuse Services, Research in Brief, Executive Summary.*” U.S. Department of Justice.

## **Foster Care**

In 2008, five (3%) of the total 166 child deaths were children involved with the foster care system. One of the five children had a history of foster care prior to their death, and four of the five children were in foster care at the time of their death. Of the four children who were in foster care at the time of their death, one died each as a result of Child Abuse and Neglect (CAN) homicide, third party homicide, suicide and a respiratory condition. The child who had history of foster care prior to their death died as a result of a CAN homicide. In some cases, children with a current history of foster care also had a previous history of foster care placement.

## **Youth Deaths**

This section of the report summarizes the findings 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 2008.

Of the total 166 child deaths in Sacramento County in 2008, 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.

Seventy-one percent (15 of 21) of the injury-related youth deaths occurred in youth 15 to 17 years of age. Forty-eight percent of youth between 10 and 17 years of age had a violent or non-violent crime history and 81% of all youth injury-related deaths were of male decedents.

YDRS findings indicate that six of the 21 (29%) injury-related youth deaths involved a firearm. Four of the deaths that occurred by use of a firearm were suicides and two were third-party homicides. All six injury-related youth deaths that involved a firearm were of youth between 15 and 17 years of age and accounted for 75% of the child deaths in 2008 that occurred by use of a firearm.

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

Known risk factors were present in 17 (53%) of the total 32 youth deaths in 2008 and are as follows:

- ❖ 15 had a history of non-violent crime
- ❖ 11 had a history of alcohol and/or other drug abuse
- ❖ 5 had a history of violent crime

- ❖ 5 had a history of domestic violence within their home
- ❖ 2 had a history of gang involvement

### **Injury-Related Youth Deaths**

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.

In 2007, there were a total of 33 injury-related youth deaths comprising 67% of all youth deaths. The mechanisms of death in the 33 injury-related youth deaths included: 14 vehicular injuries, nine involved firearms, four involved drowning, two involved hanging, two involved poisoning/overdose, one involved suffocation/choking and one death was a result of a fire.

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

Known risk factors were present in 12 of the 21 (57%) youth deaths in 2008 and are as follows:

- ❖ 10 had a history of non-violent crime
- ❖ 10 had a history of alcohol and/or other drug abuse
- ❖ 5 had a history of violent crime
- ❖ 5 had a history of domestic violence within their home
- ❖ 2 had a history of gang involvement

### **Third-party Youth Homicides**

Of the five total third party homicides in 2008, three (43%) involved youth between 10 and 17 years of age. Third-party youth homicides comprised three of the 21 (14%) 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 and one was 16 years of age. Firearms were involved in two of the deaths and one death was a result of vehicular injuries.

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

- ❖ 2 each had a history of non-violent crime, violent crime, a history of alcohol and/or other drug abuse and a history of domestic violence within their home
- ❖ 1 had a history of gang involvement

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

### **Suicides in Youth**

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.

Known risk factors were present in four of the six (67%) suicide youth deaths and are as follows:

- ❖ 4 had a history of non-violent crime
- ❖ 3 had a prior mental health history
- ❖ 3 had a history of alcohol and/or other drug abuse
- ❖ 2 had a history of violent crime
- ❖ 1 had a history of domestic violence within their home
- ❖ 1 each had a history of non-violent crime, violent crime and gang involvement

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

### **Motor Vehicle Collision (MVC) Youth Deaths**

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.

Known risk-factors were present in two of the six (33%) motor vehicle collision youth deaths and are as follows:

- ❖ 2 had alcohol and/or other drugs involved at the time of the collision
- ❖ 2 were not following pedestrian safety laws

In 2007, motor vehicle collisions comprised 13 (39%) of the 33 injury-related youth deaths. Nine victims were male and four were female. Of the 13 motor vehicle collision youth deaths, five victims were Caucasian, four were African American, two were Hispanic, and two were Asian/Pacific Islander. Of the 13 youth motor vehicle collision youth deaths, eight were driver/occupants and five were pedestrians.

### **Natural Youth Deaths**

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.

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

Known risk-factors were present in five of the 11 (45%) youth deaths due to natural causes in 2008 and are as follows:

- ❖ 5 had history of non-violent crime
- ❖ 1 had a history of alcohol and/or other drug abuse

## **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 2008 from the following agencies:

California Highway Patrol

Child Abuse Prevention Council of Sacramento, Inc.

Kaiser Permanente

Mercy San Juan Medical Center

Sacramento City Fire Department

Sacramento City Police Department

Sacramento County Coroner's Office

Sacramento County Department of Health and Human Services:

California Children's Services

Child Protective Services

Disease Control and Epidemiology

Public Health Nursing

Sacramento County District Attorney's Office

Sacramento County Probation Department

Sacramento County Sheriff's Department

Sutter Memorial Hospital

University of California Davis Medical Center

Lists of Sacramento County Child Death Review Team current members, formation members, past members, and the Confidentiality Agreement can be found in the Appendices.

## Review Process

The Child Death Review Team (CDRT) meets monthly to review deaths of all children birth through 17 years of age in Sacramento County. The deaths are identified by the Vital Records Unit of the Sacramento County Department of Health and Human Services, and the death certificates are forwarded to the CDRT Staff who prepares them for review. Team members compile pertinent information their agency may have regarding each case. This information is brought to the monthly meetings in order to identify potential abuse/neglect issues. The team also identifies trends in other types of child deaths in order to address needs in prevention efforts. The information is stored in a secure centralized database and data are analyzed in the aggregate to describe the information and identify any pertinent trends.

Because of the confidential nature of the information discussed, each team member is required to sign a confidentiality agreement, which prohibits dissemination of any information discussed by the team unless otherwise provided by law.

In addition to the review of new cases, the status of any ongoing investigations is reviewed monthly and additional information needs are identified. Non-member agencies may be contacted to provide information related to the team's investigation. All cases remain under review until the team agrees that the underlying cause of death has been determined as accurately as possible.

## Methods

Deaths are categorized by cause and by manner. Both are crucial to the investigation and analysis of deaths. The following text defines and compares these two often-confused terms.

*Causes* of death, listed on the death certificate, are medical findings coded according to the International Classification of Diseases, tenth edition (ICD-10).

A second finding listed on the death certificate describes the mode or manner of death, which is an investigative finding.

*Manner* of death falls into one of six categories: Natural, Accident, Suicide, Homicide, Pending Investigation, and Could Not Be Determined. In those cases where the cause of death is due to a natural disease process, the manner is listed, usually, as “Natural.” Injury-related deaths generally fall into one of the following three categories: “Accident,” “Suicide,” or “Homicide.”

To illustrate the difference between the manner and cause of death, consider a death certificate where the medical cause of death is “Gunshot wound of the head.” In this case, the wound could have been inflicted in one of four manners: “Accident,” “Suicide,” “Homicide” or “Undetermined.”

When there is confusion regarding how the fatal condition developed or was inflicted and the manner could not be determined with a satisfactory degree of certainty, the manner is listed as “Undetermined.” An example of a classification of this type could be found in a situation where a cause of death is listed as “Pulmonary embolism.” A pulmonary embolism can occur as a complication of an injury or it can occur naturally. Due to possible uncertainty regarding the formation of a pulmonary embolism, the manner could be listed as “Undetermined.”

The manner of death is an important consideration because prevention of child deaths, one of the central goals of the Sacramento County Child Death Review Team, relies on the ability to differentiate between intentional and unintentional deaths. For example, strategies designed to reduce the number of unintentional drug overdose will differ greatly from those designed to reduce intentional drug overdose.

## Report Strengths and Limitations

Better identification of child abuse and neglect deaths is the primary mission of the Child Death Review Team (CDRT). During the review process, the team focuses on any suspicious circumstances surrounding the death of a child. Because of the involvement of multiple agencies, the team is able to generate information that helps to clarify otherwise limited evidence of abuse. Such information can be critical to the death investigation and may ultimately result in a death certificate that more accurately reflects the occurrence of an abuse-related fatality.

As a result of this multi-agency investigation, the cause of death identified by the team, particularly in cases of child abuse and neglect homicide, may be more explicit than the cause of death assigned by the local physician or coroner. Based on the team's findings, a more accurate description of the occurrence of abuse-related deaths in Sacramento County can be provided by a Child Death Review Team report than the information provided by the death certificates filed with the State.

The Sacramento County Child Death Review Team is unique in its approach to investigating child deaths. By reviewing the circumstances surrounding each child death instead of sampling the childhood fatality population or focusing on suspicious cases only, the CDRT can capture a more detailed and accurate description of child mortality in Sacramento County. This broader understanding of child death and the ongoing identification and investigation of child abuse and neglect deaths has also provided for the development of effective prevention strategies.

Unfortunately, comparisons between Sacramento and other jurisdictions are difficult. At the present time, there is no uniformity at the state and national levels in reporting, investigating and validating cases of child abuse and neglect and their resulting deaths. As a result, there is a significant undercount of the annual CAN-related deaths found in Vital Statistics Death Records.

The criteria for selecting cases to review are established by each county's team and very few teams review all child deaths. In addition, each team defines abuse and neglect-related deaths differently. Even though the State Child Death Review Council has published a definition of deaths related to abuse and neglect, the final decision is still made at the local level.

All of the children included in this report were Sacramento County residents at the time of their death or out-of-county residents whose injuries leading to death were sustained in Sacramento County. Other out-of-county cases are reviewed, but are not included in any analysis used to make inferences about Sacramento County children. Similarly, the team does not usually review cases of children who are Sacramento County residents but die in another county. Sacramento County does not receive these death certificates consistently, so these cases may or may not be included in this report. These factors may account for any discrepancy found when comparing the number of cases in this report to those recorded by the State Registrar for Sacramento County.

The development of the CDRT's Annual Report has been an evolving process. In 1996, the CDRT began following childhood fatality trends on an annual basis, which led to more comprehensive record keeping of all child deaths. For this reason, aggregate data is available for the time period beginning in 1996 through the current year. Other data, such as injury type and demographics,

comes primarily from death certificates and is available for all cases reviewed since 1990. The differences found in the availability and consistency of information is due to the different time periods used to present prior years' data.

# Tables



**Table D**  
**Number of natural deaths according to category**  
**1991 to 2008**  
**Sacramento County**

Category	Years																		
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
Perinatal Conditions	70	46	46	44	21	42	52	48	40	42	48	56	43	62	71	65	63	50	909
Congenital Anomalies	33	26	23	24	25	19	30	27	27	33	32	39	32	31	28	29	38	30	526
SIDS	28	21	29	25	18	21	20	19	18	18	18	15	10	3	5	3	9	6	286
SUIDS	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	5	15	20
Cancer	11	6	9	10	6	9	5	10	10	15	5	10	11	10	9	9	15	8	168
Infections	8	8	3	11	4	7	3	4	6	8	10	6	2	10	5	8	3	5	111
Respiratory	10	3	10	5	7	9	8	4	1	3	0	2	0	1	1	2	0	3	69
Other	10	10	14	21	17	15	12	4	11	16	8	2	7	6	2	3	6	6	170
Undetermined (Natural)	2	0	3	0	0	4	1	1	5	3	0	0	2	0	0	0	0	1	22
Total Natural Causes	172	120	137	140	98	126	131	117	118	138	121	130	107	123	121	119	139	124	2,281

\* 2008 is the second 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 1991 to 2008**  
**Sacramento County\***

Category	Year																		
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
Homicides	18	13	21	15	20	16	23	11	16	10	16	11	9	15	17	16	12	17	276
CAN Homicide	(7)	(9)	(14)	(8)	(9)	(9)	(14)	(7)	(13)	(6)	(9)	(4)	(1)	(4)	(8)	(7)	(3)	(12)	(144)
Third -Party Homicide	(11)	(4)	(7)	(7)	(11)	(7)	(9)	(4)	(3)	(4)	(7)	(6)	(8)	(11)	(9)	(9)	(9)	(5)	(131)
Motor Vehicle Collisions (MVC)	15	14	14	15	23	19	17	11	11	14	21	13	14	10	8	11	13	6	249
MVC (Driver/ Occupant)	(11)	(8)	(7)	(8)	(12)	(15)	(10)	(7)	(4)	(8)	(10)	(11)	(8)	(5)	(3)	(6)	(7)	(4)	(144)
MVC (Pedestrian)	(3)	(6)	(6)	(5)	(8)	(2)	(7)	(1)	(5)	(5)	(8)	(1)	(5)	(4)	(4)	(3)	(6)	(2)	(81)
MVC (Bike)	(1)	(0)	(1)	(2)	(3)	(2)	(0)	(3)	(2)	(1)	(3)	(1)	(1)	(1)	(1)	(2)	(0)	(0)	(24)
Drowning	7	9	7	7	4	4	6	7	6	5	5	9	4	7	5	12	7	4	115
Suicide	7	3	4	4	3	4	5	8	0	6	5	7	4	4	8	1	4	6	83
Suffocation/ Choking	3	0	4	0	0	2	4	2	1	1	3	1	1	0	2	3	1	1	29
Fires	2	1	2	1	0	3	5	4	0	0	1	1	1	0	1	2	5	1	29
Other	0	0	8	5	3	0	5	1	1	1	8	4	2	6	1	6	1	4	56
Undetermined (Injury)	1	9	0	4	4	3	0	2	1	0	1	2	1	1	0	0	0	0	29
Poisoning/ Overdose	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	2	2	1	5
Total Injury-Related Causes	53	49	60	51	57	51	65	46	36	37	60	48	36	43	42	53	45	40	872
Undetermined Manner	2	2	4	6	0	4	2	2	3	4	8	6	10	10	4	12	8	2	89
* 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 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**  
**2008**

<b>Category</b>	<b>Infant</b>	<b>1-4</b>	<b>5-9</b>	<b>10-14</b>	<b>15-17</b>	<b>Total</b>
Perinatal Conditions	49	0	0	1	0	50
Congenital Anomalies	23	4	1	1	1	30
Sudden Infant Death Syndrome or Sudden Unexpected Infant Death Syndrome (SIDS or SUIDS)	21	0	0	0	0	21
Cancer	1	1	2	3	1	8
Infections	2	3	0	0	0	5
Respiratory	3	0	0	0	0	3
Other (natural)	0	2	0	2	2	6
CAN Homicide	3	7	0	0	1	11
Third-Party Homicide	0	1	1	0	3	5
Arson Homicide						
Motor Vehicle Deaths (driver/occupant)	0	0	0	1	3	4
Motor Vehicle Deaths (pedestrian)	0	0	0	0	2	2
Motor Vehicle Deaths (bicycle)						
Drowning	1	1	0	1	1	4
Suicide	0	0	0	2	4	6
Suffocations	1	0	0	0	0	1
Burn						
Other Injury	2	0	0	0	1	3
Poisoning/ Overdose	0	0	0	1	0	1
Undetermined Manner	2	0	0	0	0	2
Undetermined Natural	1	0	0	0	0	1
<b>Total</b>	<b>109</b>	<b>19</b>	<b>4</b>	<b>12</b>	<b>19</b>	<b>163</b>

**Table G**  
**Deaths by race/ethnicity and age group 2008**  
**Sacramento County Resident Deaths Only**

<b>Race Classification</b>	<b>Infant</b>	<b>1-4</b>	<b>5-9</b>	<b>10-14</b>	<b>15-17</b>	<b>Total</b>
Caucasian	39	2	2	3	6	52
African American	18	3	0	2	7	30
Asian/ Pacific Islander	12	5	0	0	1	18
Hispanic	20	8	1	4	4	37
Multiracial	15	1	1	3	0	20
Native American	0	0	0	0	1	1
Other	5	0	0	0	0	5
<b>Total</b>	<b>109</b>	<b>19</b>	<b>4</b>	<b>12</b>	<b>19</b>	<b>163</b>

**Table H**  
**Child abuse and neglect homicide victims by age 1990 to 2008**  
**Sacramento County Resident Deaths Only**

<b>Period Covered</b>	<b>Infant</b>	<b>1-4</b>	<b>5-9</b>	<b>10-14</b>	<b>15-17</b>	<b>Total</b>
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
<b>Total</b>	<b>40</b>	<b>74</b>	<b>23</b>	<b>8</b>	<b>7</b>	<b>152</b>

**Table I**  
**Child abuse and neglect homicide victims by race/ethnicity 1990 to 2008**  
**Sacramento County Resident Deaths Only**

<b>Period Covered</b>	<b>Caucasian</b>	<b>Hispanic</b>	<b>African American</b>	<b>Asian</b>	<b>Other**</b>	<b>Total</b>
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
<b>Total</b>	<b>59</b>	<b>23</b>	<b>47</b>	<b>15</b>	<b>8</b>	<b>152</b>

**\*\* Including children of mixed racial categories.**

**Table J**  
**Perpetrators of CAN homicides 1990 to 2008**  
**Sacramento County\***

<b>Perpetrator</b>	<b>1990-2007</b>	<b>2008</b>	<b>Total number of Perpetrators**</b>
Biological Father	41	1	42
Biological Mother	36	3	39
Both Parents	9	2	11
Boyfriend of Mother or Guardian	17	4	21
Undetermined	14	0	14
Babysitter	7	0	7
Stepfather	4	0	4
Other Family Member	6	0	6
Adoptive/Foster Parent	4	1	4
Girlfriend of Father or Guardian	2	0	2
Family Friend	2	0	3
<b>Total</b>	<b>142</b>	<b>11</b>	<b>153</b>

*\* 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 2008**  
**Sacramento County Residents Only\***

	<b>3<sup>rd</sup> Party Homicide</b>	<b>CAN Homicide</b>	<b>Suicide</b>	<b>Total</b>
Firearm	101	25	40	166
Battering	5	42	0	47
Hanging	0	0	44	44
Shaking	0	20	0	20
Suffocation/Strangulation	1	16	0	17
Poisoning/Overdose	0	8	3	11
Stabbing	11	6	0	17
Fire	3	4	0	7
Undetermined	1	1	0	2
Vehicular	10	2	1	13
Drowning	1	6	0	7
Chronic Neglect	0	13	0	13
Other	1	4	0	5
Unknown	1	5	0	6
<b>Total</b>	<b>135</b>	<b>152</b>	<b>88</b>	<b>375</b>

*\* 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\***  
**2000-2008**

<b>Zip</b>	<b>Neighborhood</b>	<b>2008 Deaths</b>	<b>Deaths 2000-2007</b>	<b>Total</b>
95608	Carmichael	8	33	41
95610	Citrus Heights	7	30	37
95615	Courtland	0	1	1
95621	Citrus Heights	3	36	39
95624	Elk Grove	9	35	44
95626	Elverta	2	7	9
95628	Fair Oaks	1	24	25
95630	Folsom/Clarksville/El Dorado Hills	5	38	43
95632	Twin Cities/Galt/Herald	2	15	17
95638	Herald	0	5	5
95641	Isleton	1	0	1
95655	Mather	0	2	2
95660	North Highlands	5	48	53
95662	Orangevale	3	19	22
95670	Rancho Cordova	6	55	61
95673	Rio Linda/Robla	3	24	27
95683	Rancho Murrieta	0	4	4
95690	Walnut Grove	0	3	3
95693	Wilton	1	1	2
95757	Elk Grove	4	19	23
95758	Bruceville	6	56	62
95763	Folsom	0	1	1
95742	Rancho Cordova	1	0	1
95811	Mather	1	0	1
95814	Downtown Sacramento	0	12	12
95815	North Sacramento	5	43	48
95816	Midtown Sacramento	1	6	7
95817	Sacramento/Oak Park	1	22	23
95818	Sacramento/South Land Park	0	11	11
95819	Sacramento/ East Sacramento	0	13	13
95820	Fruitridge	4	84	88
95821	Town and Country Village	4	38	42
95822	Sacramento/Meadowview	5	59	64
95823	Sacramento/Valley Hi	12	110	122
95824	Fruitridge	4	52	56
95825	Arden/Arcade	4	35	39
95826	Perkins/Rosemont	3	32	34



95827	Mills/Walsh Station	1	27	28
95828	Florin	7	55	62
95829	Coffing/Sheldon	2	23	25
95830	Sacramento (Florin & Sunrise)	0	1	1
95831	Greenhaven	2	25	27
95832	Sacramento/Freeport	2	14	16
95833	Arden/ Garden	5	35	40
95834	Sacramento/South Natomas	2	13	15
95835	Sacramento/North Natomas	3	13	16
95837	Sacramento International Airport	1	1	2
95838	Del Paso Heights/Hagginwood	8	61	69
95841	Foothill Farms	0	17	17
95842	Sacramento/Foothill Farms/North Highlands	10	41	51
95843	Sacramento/Antelope	6	36	42
95864	Arden/Arcade	3	7	10
	Unknown**	0	1	1
<b>Total</b>		<b>163</b>	<b>1,343</b>	<b>1,506</b>

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

*\*\* Death Certificate was not available*

# Appendix



## **APPENDIX A**

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

#### **PURPOSE**

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

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

#### **MEMBERSHIP**

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

##### **I Sacramento County**

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

##### **II Department of Health and Human Services**

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

##### **III District Attorney's Office**

**IV Local Hospitals**

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

**V Other Community Service Agencies**

- A.** Child Abuse Prevention Council of Sacramento

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

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

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

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

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

**STATUTORY AUTHORIZATION**

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

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

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

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

## **TARGET POPULATION**

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

## **MEETINGS**

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

## **GROUND RULES**

Members of the CDRT agree to:

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

## **OFFICERS**

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

The duties of the Chair shall be to:

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

The duties of the Vice Chair shall be to:

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

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

## **PROCEDURES**

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

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

Each Team representative is then responsible for reviewing his/her internal agency records to determine what information is available on each child and/or family. Relevant information is documented on the data collection forms for those cases where agency information is available. The forms will be completed and brought by the representative to the next meeting. If the standing Lead representative is not available to attend a meeting, the designated Alternate will bring the data forms to the meeting. In the event that both the Lead and Alternate representatives are not available the data forms will be provided at the next meeting attended by either representative. In addition to data forms, a representative may elect to bring their agency files to

the next meeting for reference, but agency files and records are not to be reproduced for central files or distributed to other representatives.

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

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

#### **CHILD ABUSE PREVENTION COUNCIL RESPONSIBILITIES**

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

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

#### **EVALUATION**

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



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

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

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

#### **INDEMNIFICATION AND INSURANCE**

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

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

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

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

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

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

AGENCY/PROFESSIONAL DISCIPLINE REPRESENTED:

---

DATE: \_\_\_\_\_

## **APPENDIX C**

### **Sacramento County Child Death Review Team Members Formation Members**

**California State Attorney General's Office**

Michael Jett

Senior Field Deputy, Crime Prevention Center

**Child Abuse Prevention Council of Sacramento, Inc.**

Marie Marsh

Executive Director

Sheila Anderson

Child Death Review Team Coordinator

**Juvenile Justice Commission**

Alison Kishaba

Commission Chairperson

**Sacramento City Police Department**

Detective Ernie Barsotti

**Sacramento County Coroner's Office**

Robert Bowers

Chief Deputy Coroner

**Sacramento County Department of Health and Human Services**

Marcia Britton, M.D.

Director, Child Health and Disability Prevention

**Sacramento County Department of Social Services**

Sarah Jenkins

**Sacramento County District Attorney's Office**

Janice Hayes

Deputy District Attorney

**Sacramento County Executive's Office**

Margaret Tomczak

Children's Commission

**Sacramento County Sheriff's Department**

Sergeant Harry Machen

**University of California Davis Medical Center**

Michael Reinhart, M.D., CDRT Founding Chair

Medical Director, Child Protection Center

## APPENDIX D

### Sacramento County Child Death Review Team Current Members

**Department of Health & Human Services**
**California Children's Services**

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

**California Highway Patrol**

Elizabeth Dutton

**Child Abuse Prevention Council of Sacramento, Inc.**

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

Gina Roberson, M.S.

Associate Director, Coordination & Collaboration

Nazia Ali

CDRT Project Manager

**Citrus Heights Police Department**

Ron Pfleger, Detective

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

Marian Kubiak, M.S.W.

Julie Zawodny

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

Cassius Lockett, PhD, Epidemiologist

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

Carol Tucker R.N.

**District Attorney's Office**

Andrew Smith, J.D.,

Supervising Deputy District Attorney  
of Sexual Assault Child Abuse Unit

**Elk Grove Police Department**

Mario Guzman

Sergeant

**Kaiser Permanente**

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

Andrew Kincaid, M.D., Pediatric Specialty Clinic

**Law Enforcement Chaplaincy - Sacramento**

Frank Russell

Supervising Senior Chaplain

**Mercy San Juan Hospital**

Denise von Arx, CNS

**Sacramento City Fire Department**

Debra Lyon, R.N.

Sacramento City Police Department

Paul Martinson, Sergeant

Sacramento County Coroner's Office

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

Greg Wyatt, Coroner

Kim Burson, Assistant Coroner/ Investigation

**Sacramento County Metropolitan Fire Department**

Clayton Elledge, Captain

**Sacramento County Probation Department**

Robin Wilkins

**Sacramento County Sheriff's Department**

Carol Mims, Detective

Jeff Reinl, Sergeant

**Sutter Memorial Hospital**

Angela Rosas, M.D.

Pediatrician

Margaret Crockett, R.N., CNS

Neonatal Nurse Specialist

**University of California Davis Medical Center**

Cathy Boyle R.N., P.N.P.

Pediatric Nurse Practitioner

Child Protection Center

Deborah Stewart, M.D.

## APPENDIX E

### Sacramento County Child Death Review Team Past Members

Amelia Baker, P.H.N.  
Public Health and Promotion/Del Paso Center  
Department of Health and Human Services

Sandra Baker  
Executive Director  
Child and Family Institute

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

Michael Balash  
Captain  
Sacramento Fire Department

Will Bayles  
Sacramento County Sheriff's Department

Ken Bernard  
Sacramento City Police Department

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

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

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

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

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

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

Kim Clark  
Detective, Sacramento City Police Department

Rod Chong  
Division Chief, Sacramento City Fire Department

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

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

Sherri Cornell, R.N.  
California Children's Services  
Laura Coulthard  
Bureau Chief, Emergency Response  
Department of Health and Human Services

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

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

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

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

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

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

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

Paul Durenberger  
Deputy District Attorney, District Attorney's Office

Phil Ehlert  
Sacramento County Coroner's Office

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

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

Fernando Enriquez  
Sergeant  
Sacramento City Police Department

Earl Evans  
Sacramento County Sheriff's Department

Mark Fajardo, M.D.

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

David Ford  
Sergeant, SACA Unit  
Sacramento City Police Department

Mary Ann Harrison  
Department of Social Services

Rich Gardella  
Sergeant, Homicide Unit  
Sacramento City Police Department

Guy Gates, Detective  
Citrus Heights Police Department

Keith Gault  
ACLS Coordinator  
Sacramento City Fire Department

Jason Gay  
Detective  
Sacramento County Sheriff's Department

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

Kevin Givens, Detective  
Sacramento County Sheriff's Department

James Jay Glass  
Paramedic Captain  
Sacramento City Fire Department

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

Max Hartley  
California Highway Patrol

Donald Henrickson, M.D.  
Northern California Forensic Pathology

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

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

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

Maynard Johnson, M.D.  
Pediatrician  
Kaiser Permanente Foundation

Jeff Jones  
Chaplain  
Law Enforcement Chaplaincy

Evelyn Joslin  
Deputy Director  
Department of Social Services

Angela Kirby  
Detective  
Sacramento County Sheriff's Department

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Kaiser Permanente

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

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Sacramento County Fire Department

Rich Maloney, R.N.  
Sacramento Metro Fire District

Debbie Mart  
Sacramento City Fire Department

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

Bobby Mitchell  
Sergeant, Homicide  
Sacramento City Police Department

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Sacramento City Police Department

Cliff Peppers  
Sergeant  
Sacramento County Sheriff's Department

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Child Protective Services

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Dan Read  
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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.  
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Department of Health and Human Services

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Assistant Coroner/ Investigation  
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Dr. John Stockman  
Stockman and Associates

Grant Stomsvick  
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Lieutenant  
Sacramento City Police Department

Stephen Wallach  
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Department of Health and Human Services

Phil Whitbeck  
Chaplain  
Law Enforcement Chaplaincy

Patty Will  
School Attendance Review Board  
San Juan Unified School District  
Victoria Witham  
EMT Liaison  
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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 to 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:** An death resulting under water or other liquid of suffocation.

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

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

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

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

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

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

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

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

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

**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 (SUDDS) 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.

**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.

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

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

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

**Prenatal Substance Abuse-Related Deaths:** Deaths secondary 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.

**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 what 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 identify 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:** Is 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

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