

**Sacramento County Child Death Review Team
Two Year Report
2013-2014**

The following report includes brief descriptions on some of the cases of children who died in Sacramento County in the 2013 and 2014 calendar years, 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 identities of the victim and any family members who were not responsible for the death of the child.

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With gratitude,

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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'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 two-year review of child deaths in Sacramento County in 2013-2014. Included are descriptions of all deaths whether they were the result of child abuse and neglect, injuries, homicides or natural causes.

2014 marks the twenty-fifth year the Sacramento County Child Death Review Team (CDRT) has been working to investigate, analyze, and document the circumstances that led to each child death in Sacramento County. CDRT is a multidisciplinary team of professionals from every aspect of a child's and his/her family's life, from medical to academic to law enforcement to child protection. CDRT members share the information and history they have on each case and come to a mutual consensus on the manner and cause of each death. The goal of the CDRT is to identify how and why children die to better facilitate the creation and implementation of strategies to prevent future child deaths.

In 2013-2014, 261 children, birth through 17 years of age, residing in Sacramento County died. The average child death rate decreased to 36.4 per 100,000 children in 2013-2014 from 38.1 per 100,000 children in 2011-2012.

A total of 265 children died in Sacramento County in 2013-2014, including the deaths of four children who died of incidents that occurred in Sacramento County, but were not current Sacramento County residents. Seventy-four percent (196 of 265) of all child deaths in 2013-2014 were natural deaths, 22% (59 of 265) were injury-related deaths, and four percent (10 of 265) were deaths of an undetermined manner.

In 2013-2014, there were 196 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, comprising 74% (196 of 265) of all child deaths in Sacramento County for this two-year period.

In 2013-2014, injuries resulted in 59 child deaths, accounting for 22% (59 of 265) of the total child deaths for this two-year period, including deaths of four out-of-county residents whose injuries occurred in Sacramento County. It is consistently found that almost all 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, suicide and other injuries. Sixteen of the 59 injury-related deaths in 2013-2014 were the result of a CAN homicide, accounting for 27% of all injury-related deaths. The CAN homicide rate among Sacramento County residents nearly doubled, from 1.1 deaths per 100,000 in 2011-2012, to 2.1 deaths per 100,000 in 2013-2014. This is a statistically significant change at the 95% confidence level.

In 2013-2014, there were ten child deaths of an undetermined manner, accounting for four percent (10 of 265) of all deaths during that period. Four of the 10 (40%) undetermined manner deaths were infant sleep-related deaths.

2014 marks the eighth year the Youth Death Review Subcommittee (YDRS) of the CDRT. This subcommittee was convened to conduct in-depth analyses of all injury-related deaths of youth ages 10 through 17 that 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.

In 2013-2014, 51% (30 of 59) of injury-related deaths were in youth between 10 and 17 years of age. Thirty-seven percent of these deaths (11 of 30) were suicides and 33% (10 of 30) were third-party homicides. In addition, there were eight deaths due to Motor Vehicle Collision and one drowning.

Seventy-seven percent (23 of 30) of all youth injury-related deaths were of male decedents, while 23% (7 of 30) were female. Forty percent (12 of 30) of injury-related deaths in youth 10-17 years of age occurred by use of firearm. Seventy-seven percent (23 of 30) of injury-related youth deaths occurred in decedents 15-17 years of age, and 23% (7 of 30) occurred in youths between 10-14 years of age. Twenty-seven percent (8 of 30) of the youth injury-related decedents had a violent or non-violent criminal history. Examples of violent crime include assault and armed robbery, while examples of non-violent crime include drug possession and DUIs.

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 2013-2014 Two-Year CDRT Report findings and recommendations that follow were developed with a sincere awareness of the complexity of problems facing Sacramento County's children and their families. The major findings and recommendations reported highlight the core of child deaths and recommend strategies to reduce such numbers and improve the health and lives of children in Sacramento County.

2013-2014 Major Findings

In 2013-2014, there were 261 child deaths among Sacramento County resident children, birth through 17 years of age, with a child death rate of 36.4 per 100,000 children. There were four additional deaths of children who resided outside of Sacramento County with an incident that occurred in Sacramento County, bringing the total number of child deaths to 265.

Major findings regarding the types of deaths that occurred in Sacramento County in 2013-2014 are as follows:

➤ **There were 16 Child Abuse and Neglect (CAN) homicides, an increase over previous years.**

In 2013-2014, there were 16 CAN homicides of 265 deaths total, 12 of them occurred among Sacramento County residents; all were separate incidents. This is twice as many overall CAN homicides as during the 2011-2012 period, when there were eight in Sacramento County. The rate of CAN homicides among Sacramento County residents increased in 2013-2014 as compared to 2011-2012, from 1.1 deaths per 100,000 children to 2.1 deaths per 100,000 children.

Of the 16 CAN homicides in 2013-2014, eight died due to beatings, of which three died due to abusive head trauma; two died due to riding in a car driven by a parent under the influence; and one each died due to attack by hatchet, shaking with abusive head trauma, drowning, abandonment after concealed pregnancy, infection with chronic neglect, and being rolled on while sleeping with an intoxicated parent. The rate of abusive head trauma cases has increased over past years. Among Sacramento County residents in 2013-2014, there were .42 deaths due to abusive head trauma per 100,000 children, an increase from .32 per 100,000 children from 1990-2012.

Eighty-eight percent (14 of 16) of CAN homicides were in children five years and under, including seven infants. This is consistent with historical trends; since 2004, 79% (52 of 66) of CAN homicide decedents have been five years of age or younger, including 24 infants.

Of the 21¹ perpetrators of CAN homicides in 2013-2014, seventy-six percent (16 of 21) were parents², and 14% (3 of 21) were partners of parents. The remaining two perpetrators were one extended family member and one babysitter.

➤ **There is a statistically significant correlation between Child Abuse and Neglect (CAN) homicides and Child Protective Services (CPS) referrals and/or Temporary Aid to Needy Families (TANF) receipt.**

The CDRT performed an analysis of the statistical correlation between CAN homicides and a past history either of CPS referrals or TANF receipt.

¹ There were 21 perpetrators of 16 CAN homicides because there were two perpetrators in some cases.

² CDRT defines parents as those listed on the child's death certificate, regardless of whether parent is biological or adoptive.

CDRT found a statistically significant correlation between family history of TANF receipt and CAN homicides at a 91% confidence level. CDRT also found a statistically significant correlation between a history of CPS referrals and CAN homicides at a 99% confidence level.

Children receiving TANF are 74% more likely to suffer a CAN homicide than children who do not receive this aid, while children with prior CPS involvement are 2090% more likely to suffer a CAN homicide than children having no prior CPS contact.

Fifty percent (8 of 16) of CAN homicide decedents had known family involvement with Sacramento County CPS. Four decedents had their own involvement with Sacramento County CPS; three of the four had a referral or case open at the time of death and one had a referral or case closed more than six months prior to death. Eight decedents had a sibling who had involvement with Sacramento County CPS; four of the eight had an open case or referral at the time of death. Four decedents had a parent or stepparent with prior Sacramento County CPS involvement as a minor. One decedent had a family CPS referral or case only in another county.

➤ **There were twelve Third-Party Homicides.**

There were 12 Third-Party Homicides in 2013-2014, all among Sacramento County residents. One decedent was an infant, one was between 5-9 years of age, three decedents were between 10-14 years of age, and seven were between 15-17 years old. This is one fewer third-party homicide when compared with the previous two year period of 2011-2012.

Forty-two percent (5 of 12) of third-party homicides involved gang activity and were perpetrated by gang members. Eighty percent of those (4 of 5) involved decedents who were gang members themselves or were otherwise affiliated with gangs.

Fifty percent (6 of 12) of third-party homicide decedents had known family involvement with Sacramento County CPS. No decedents had a parent or stepparent with prior Sacramento County CPS involvement as a minor. Five decedents had their own involvement with Sacramento County CPS; one of the five had a case or referral open at the time of death. Two decedents had a sibling who had involvement with Sacramento County CPS; neither had an open case or referral at the time of death. One decedent had family CPS involvement only in another county.

➤ **Known risk factors are prevalent and increasing among decedents of all child deaths, including government aid, Child Protective Services (CPS) history, criminal history, and substance abuse history in the family.**

Eighty-three percent of all child decedents (221 of 265) had at least one risk factor. Sixty-five percent (172 of 265) of decedents received some form of government aid at the time of death. Fifty-one percent (136 of 265) of decedents had CPS involvement in the family. Forty-five percent (119 of 265) of decedents had a known criminal history in the family. Finally, forty percent (105 of 265) of decedents had a known substance abuse history in the family.

In 2009-2010, seventy-six percent of decedents (208 of 275) had at least one risk factor. Between 2009-2010 and the 2013-2014 time period, the average number of risk factors

increased from 2.0 to 2.5 and the percent of child decedents with at least three risk factors increased from 33 percent (92 of 275) to 45 percent (120 of 265).

➤ **African American children died at a rate more than two times higher than that of all children in Sacramento County.**

In 2013-2014, African American children had a disproportionate death rate of 82.2 per 100,000 children, a decrease from 88.6 in 2011-2012. The death rate for all Sacramento County resident children was 36.4 deaths per 100,000 children, a decrease from 38.1 in 2011-2012. African American children comprised 11% of the Sacramento County child population in 2013-2014 and accounted for 23% (61 of 261) of Sacramento County resident child deaths. In 2011-2012, African American children accounted for 25% (68 of 274) of Sacramento County resident child deaths.

The five causes of child death with the greatest disproportionality among African American children who are Sacramento County residents were as follows: 58% (7 of 12) of CAN homicides were African American children; 43% (3 of 7) of drownings were African American children; 43% (12 of 28) of infant sleep-related deaths were African American infants; 29% (2 of 7) of Motor Vehicle Collision deaths were among African American children; 21% (16 of 77) of perinatal condition deaths were African American children. These account for 66% (40 of 61) of deaths among African American children.

➤ **While the rate of infant sleep-related deaths has decreased, all infant sleep-related deaths had at least one unsafe infant sleep condition.**

The three-year rolling average number of infant sleep-related deaths decreased to 18.0 during the 2012-2014 period from 21.3 during the 2007-2009 period. Of the 28 infant sleep-related deaths in Sacramento County between 2013-2014, 21 were due to Sudden Unexpected Infant Death Syndrome (SUIDS), four were infant sleep-related deaths of an undetermined manner, two were due to Sudden Infant Death Syndrome (SIDS), and one death was due to suffocation.

Unsafe infant sleep conditions are sleep conditions identified by the American Academy of Pediatrics that increase the risk of infant sleep-related deaths.³ In 2013-2014, 100% (28 of 28) of infant sleep-related deaths had known unsafe infant sleep conditions associated with the infant's death. Seventy-one percent (20 of 28) of infant sleep-related deaths were known to occur somewhere other than a crib (18 slept in an adult bed, one each slept on a futon and a chair). Seventy percent (14 of 20) of infants not in a crib were co-sleeping. Of the 8 infant sleep-related deaths that occurred in a crib, 88% (7 of 8) were sleeping in an unsafe position on their side or stomach. A crib was known to be in the home for eighty-two percent (23 of 28) of decedents.

³ "SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment." Task Force on Sudden Infant Death Syndrome. *Pediatrics*. Nov 2011, 128 (5) e1341-e1367; DOI: 10.1542/peds.2011-2285.

➤ **There is a statistically significant correlation between infant sleep-related deaths and Child Protective Services (CPS) referrals.**

The CDRT performed an analysis of the statistical correlation between infant sleep-related deaths and a history of CPS referrals. CDRT found a statistically significant correlation between a history of CPS referrals and infant sleep-related deaths at a 99% confidence level, with infants having a prior CPS referral being 2.4 times more likely to suffer an infant sleep-related death than infants having no prior CPS contact.

➤ **Seventy-three percent (8 of 11) of suicide decedents displayed a known warning sign prior to their death.**

Seventy-three percent (8 of 11) of suicide decedents displayed a known warning sign prior to death, including but not limited to talking about or threatening suicide, past attempts, self-harm, and leaving a note. These warning signs include two decedents who posted concerning messages on social media and two who were known to be withdrawn at school and victims of bullying. In 2010-2012, seventy percent (7 of 10) of suicide decedents displayed warning signs of suicide prior to death.

Recommendations

- **Develop a county-wide protocol for public and private agencies to refer families to support services when they identify, in the family, recognized risk factors for child death.**

Convene a multidisciplinary working group with the task of proposing a comprehensive set of recommendations for a systemic, multidisciplinary, county-wide protocol to recognize and respond to risk factors and make appropriate referrals for services. Workgroup recommendations will be presented to the Board of Supervisors.

Involve and encourage public and private agencies who have contact with children to refer families to support and services, specifically emphasizing follow-through with referrals, including but not limited to school personnel, healthcare providers, criminal justice workers, and government aid points of contact.

Strengthen the system of providing families services once a CPS case is closed, especially focusing on families with children two years of age and under. Ensure families are educated about the services available. The protocol should provide strategies to address language and distance barriers that prevent families from accessing these services.

Ensure co-serving agencies coordinate to support children with known risk factors, including those identified in the Adverse Childhood Experiences Study.⁴ For example, increase public education efforts in waiting rooms for government aid and other resources (Women Infants & Children, Department of Human Assistance, etc.), incorporate child abuse and child fatality prevention in drug and alcohol case management programs, and enhance education provided by law enforcement and probation in routine contacts with families.

- **Continue the effort to reduce the death rate of African American children in Sacramento County, which is disproportionate to the death rate of other children.**

Sacramento County should continue the work of the Reduction of African American Child Deaths Steering Committee to reduce the child death disparity between African American children and other children in Sacramento County. Increase programs and funding for community engagement and education focused on best practices identified to prevent child abuse and neglect homicides, infant sleep-related deaths and deaths due to perinatal conditions.

- **Expand training and education efforts to parents and caregivers of infants and with Child Protective Services (CPS) referrals to reduce the prevalence of infant sleep-related deaths.**

The Safe Sleep Baby Collaborative, funded by First 5 Sacramento, should continue the work of the *Safe Sleep Baby* campaign to educate parents and parent-serving service providers, including CPS, on the importance of safely sleeping babies Alone, on their Back and in a Crib.

Infants with a prior CPS referral are more than two times as likely to be the victim of an infant sleep-related death. The CDRT recommends that the *Safe Sleep Baby* campaign should

⁴ <http://www.cdc.gov/violenceprevention/acestudy/>

be expanded to include specific strategies for targeted awareness, education, and training for parents involved with and referred to CPS.

➤ **Build the capacity for schools and peers to recognize suicide warning signs among youth through suicide prevention education.**

Educate school personnel, families, and students on the warning signs of suicide and how to respond when signs are identified. Implement peer education for teens regarding suicide warning signs and emphasize the importance of reporting distressing social media posts. Expand *Mental Health First Aid* and *Know the Signs* anti-suicide campaigns in Sacramento County.

The CDRT encourages schools and youth serving organizations to ensure all school administration, staff, students, and parents are provided with the number to the nationally accredited Suicide Prevention Crisis Line (916)368-3111 or 1-800-273-8255 and crisis texting service by texting HOPE to 916-668-ICAN. Increase the sharing of records between schools regarding past trauma, changes in behavior and grades, previous referrals and interventions, etc. Move to online, shareable systems that automatically forward data when students transfer to schools so that personnel at new schools can be aware of recognized warning signs. Keep school-based mental health professionals trained in evidence-based suicide intervention skills and how to conduct suicide assessments for students recognized to be at risk.

Chapter I

Deaths Related to Abuse and Neglect

Chapter One

Deaths Related to Abuse and Neglect

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

The umbrella classification of Child Maltreatment deaths refers to deaths involving some element of abuse or neglect. The primary category of Child Maltreatment deaths is Child Abuse and Neglect (CAN) homicide, in which a child was killed, either directly or indirectly, by their caregiver or supervisor. Other deaths, however, might involve an element of maltreatment even though the classification of homicide is not supportable by the coroner's report. Deaths considered to involve child maltreatment 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., an unattended infant who drowns in a bathtub; an unrestrained infant who is killed in a motor vehicle collision)

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 the 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: Death clearly due to prenatal substance abuse as supported by Coroner's reports (e.g., cocaine, intoxication, death from medical complications due to drugs).

Child Abuse and Neglect Homicides

Emily was a three-month old girl who lived with both of her parents. Sometimes Emily would cry because she was hungry, tired, or uncomfortable. One day, her dad became irritated because she would not stop crying. He squeezed her and shook her for about 50 seconds to get her to stop. Doctors later found that her organs were injured, her neck was bruised, and her brain was bleeding. Emily died in the hospital. Her father was convicted of first degree murder and is now serving 25 years to life in prison.

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 perpetrated by 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.

In 2013-2014, there were 16 CAN homicides, twelve of whom were Sacramento County residents. There were 11 CAN homicides in 2013 (including three of out of county residents) and 5 in 2014 (including 1 out of county resident). All 16 CAN homicides in 2013-2014 were separate incidents. This is more than in any three-year period since 2008, when there were 12 CAN homicides in one year.

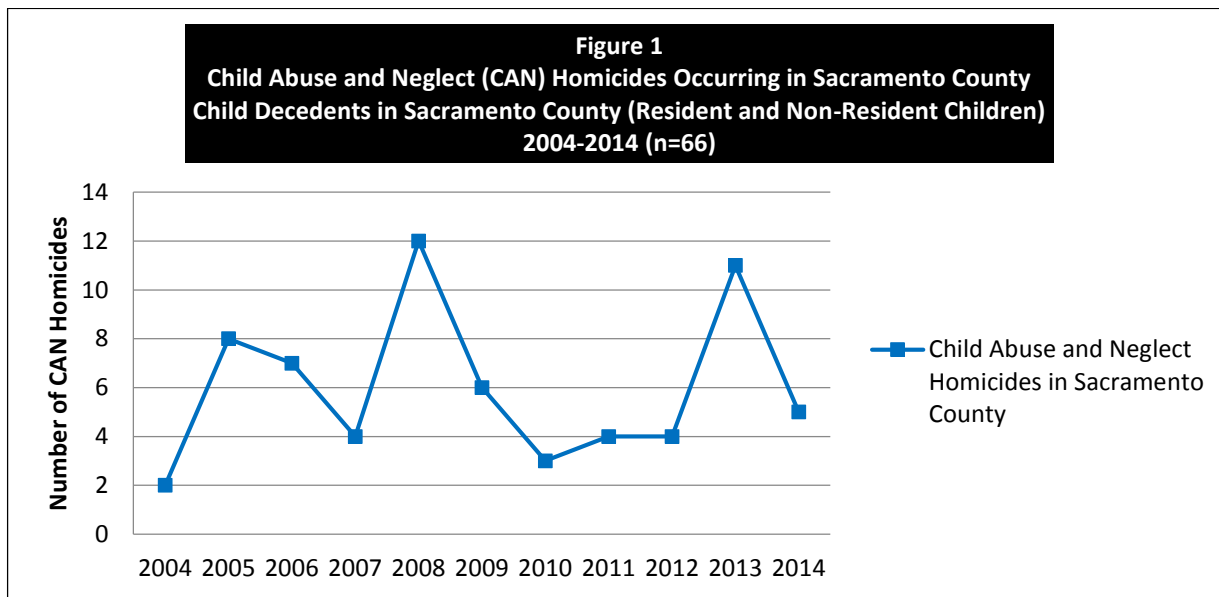


Figure 1 shows the number of CAN homicides occurring in Sacramento County between 2004-2014 and includes both Sacramento County residents and residents of other counties. Figure 2 shows the rate of CAN homicides among Sacramento County residents during the same period. In 2013, there were 2.23 CAN homicides per 100,000 children in Sacramento County; in 2014, this rate was 1.12 per 100,000 children. This is an increase over the prior two-year period. The CAN homicide rate nearly doubled, from 1.1 deaths per 100,000 in 2011-2012, to 2.1 deaths per 100,000 in 2013-2014. This is a statistically significant change at the 95% confidence level.

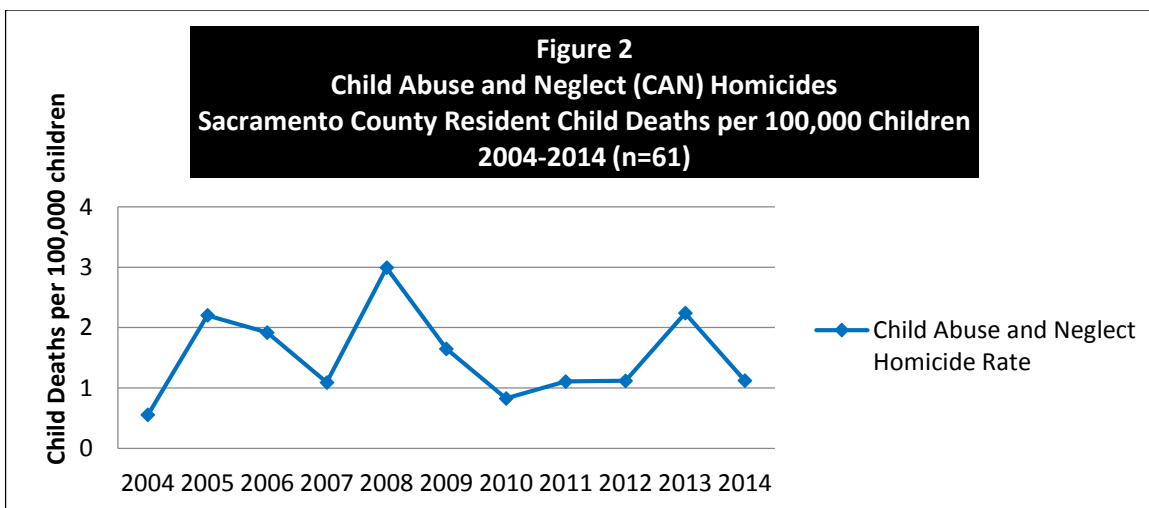
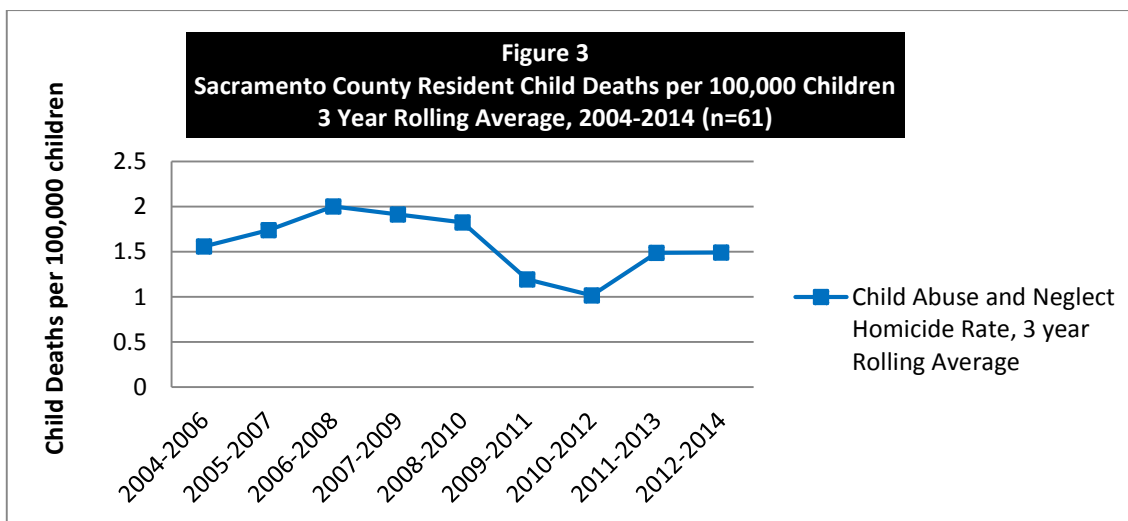


Figure 3 illustrates the rate of CAN homicides as three-year rolling averages from 2004–2014. Using rolling averages of rates makes it easier to depict CAN homicide trends over time. There was a decrease in the rate of CAN homicides from 2.00 deaths per 100,000 children to 1.02 deaths per 100,000 children between the 2006-2008 and 2010-2012 time periods, which was not a statistically significant decrease.⁵ Between 2010-2012 and 2012-2014 there has been a slight increase in the rate of CAN homicides to 1.49 deaths per 100,000 children, though this is also not statistically significant.



Victims

In 2013-2014, there were 16 total victims of CAN homicide, including four out of county residents whose injuries were sustained in Sacramento County. Ten of the 16 total CAN homicide victims were male and six were female. Seven of the victims were infants, six were between 1-4 years of age, two were between 5-9 years of age, and one was between 10-14 years of age. In 2013-2014, eight of the 16 victims were African American, three were Caucasian, two each were Asian/Pacific Islander and Multiracial, and one was Hispanic.

⁵ Based on T-test performed as described in Statistical Primer Number 12, State Center for Health Statistics, North Carolina Public Health.

Table A
CAN Homicides by Age, 2011-2014
Sacramento County Resident Child Deaths (n=20)

Age	# CAN Homicides 2013-2014 (N=12)	% CAN Homicides 2013-2014 (N=12)	# CAN Homicides 2011-2012 (n=8)	% CAN Homicides 2011-2012 (n=8)	% Child Population
Infant	6	50%	4	50%	5%
1-4	5	42%	1	13%	22%
5-9	1	8%	2	25%	28%
10-14	0	0%	0	0%	27%
15-17	0	0%	1	13%	18%

Tables A and B show Sacramento County resident child deaths compared to the Sacramento County child population. Table A shows the percentage of decedents at each age compared to Sacramento County residents in the four year period between 2011-2014. During this period, 50% (10 of 20) of CAN homicide victims were infants, 30% (6 of 20) were ages 1-4, 15% (3 of 20) were ages 5-9, 0% (0 of 20) were ages 10-14, and 5% (1 of 20) were ages 15-17. Table B shows the percentage of decedents of each race compared to Sacramento County child population between 2011-2014. Forty percent (8 of 20) of CAN homicide victims were African American, 30% (6 of 20) were White, 15% (3 of 20) were Asian/Pacific Islander, 10% (2 of 20) were multiracial, and 5% (1 of 20) were Hispanic.

Table B
CAN Homicides by Race, 2011-2014
Sacramento County Resident Child Deaths (n=20)

Race	# CAN Homicides 2013-2014 (N=12)	% CAN Homicides 2013-2014 (N=12)	# CAN Homicides 2011-2012 (n=8)	% CAN Homicides 2011-2012 (n=8)	% Child Population
White/Caucasian	2	17%	4	50%	35%
Black/African American	7	58%	1	27%	11%
Hispanic	0	0%	1	9%	31%
Asian/Pacific Islander	1	8%	2	27%	15%
Multiracial	2	17%	0	0%	8%
Other	0	0%	0	0%	1%

Perpetrators

There were 21 perpetrators of 16 CAN homicides in Sacramento County in 2013-2014, including both Sacramento County residents and residents of other counties⁶. Of these perpetrators, 76% (16 of 21) were the parent of the decedent (in three cases both parents acted together, in 4 cases the

⁶ In some cases, there were two perpetrators of one incident.

perpetrator was the mother, and in 2 cases the perpetrator was the father); three were romantic partners of the mothers; one was another relative of the decedent; and one was a neighbor in a caregiver's role. CDRT defines parent as the biological or adoptive parent listed on the death certificate. In 25 years of CDRT, a total of 63% (126 of 201) of perpetrators of CAN homicides among Sacramento County residents have been the parent(s) of the decedent.

Mechanism of Death

Of the 16 CAN homicides in 2013-2014, eight died due to beatings including three who died due to abusive head trauma, two due to riding in a car driven by a parent under the influence, and one each died due to attack by hatchet, shaking with abusive head trauma, drowning, abandonment after concealed pregnancy, infection with chronic neglect, and being rolled on while sleeping with an intoxicated parent. The rate of abusive head trauma cases has increased over past years. Among Sacramento County residents in 2013-2014, there were .42 deaths due to abusive head trauma per 100,000 children, an increase from .32 per 100,000 children from 1990-2012.

Risk Factors

Through the years that Sacramento County's CDRT has met and reviewed child deaths, certain risk factors have been identified. Evidence of these risk factors is collected by CDRT members in preparation for each review. "Risk Factor" is the broad term used to describe a variety of social, economic, and/or demographic circumstances or other elements that may be associated with a higher risk of negative health outcomes for children. Risk factors identified in this report represent only those factors known to an agency represented on the CDRT and reported to the CDRT. These risk factors include, but are not limited to, substance abuse, prior child abuse and neglect, family or other violence, poverty, and mental illness.

In 2012, so as to more accurately gauge the impact of poverty on child death, CDRT modified the standards for determining if a family was enrolled in government aid programs at the time of death, including Medi-Cal, Temporary Aid for Needy Families (TANF), and food stamps.

Involvement with Child Protective Services is addressed separately below and is not included in the following list.

In 2013-2014, risk factors were known to be present in 94% (15 of 16) of CAN homicides, and are as follows:

- ❖ 75% (12 of 16) of decedents had a parent with a history of violent or non-violent crime.
- ❖ 69% (11 of 16) of decedents had a family enrolled in government aid programs at the time of death.
- ❖ 69% (11 of 16) of decedents had a family history of alcohol and/or other drug abuse.
- ❖ 63% (10 of 16) of decedents had a family history of domestic violence.
- ❖ 25% (4 of 16) of decedents had a mother who was under 21 years of age at the time of their birth.

Child Protective Services Involvement

One of the goals of the CDRT is to identify service delivery gaps that protect children, which are identified during the review process. For that purpose, the CDRT records Child Protective Service agency involvement with decedents and their families. Of the 16 CAN homicides in 2013-2014, eight (50%) decedents were involved with or had a family involvement with Sacramento County CPS as follows:

- ❖ 50% (8 of 16) of decedents had siblings with involvement with Sacramento County CPS.
 - 4 decedents had a sibling with an open case or referral at the time of death.
- ❖ 25% (4 of 16) of decedents had involvement themselves with Sacramento County Child Protective Services.
 - 3 decedents had an open case or referral at the time of death.
 - 1 decedent had a case or referral open and closed more than six months prior to death.
- ❖ 25% (4 of 16) of decedents had one or more parents or stepparents who had involvement with Sacramento County CPS as children.

Correlations Between CAN Homicide and Select Risk Factors

CDRT found a statistically significant correlation between a family history of receiving TANF and Child Abuse and Neglect (CAN) homicide at a 91% confidence level, as well as a statistically significant correlation between a history of Child Protective Services (CPS) involvement and CAN homicides at a 99% confidence level⁷. Children receiving TANF are 74% more likely to suffer a CAN homicide than children who do not receive this aid, while children with prior CPS involvement are 2090% more likely to suffer a CAN homicide than children having no prior CPS contact.

Investigation and Prosecution

Of the 16 Child Abuse and Neglect (CAN) homicides in 2013-2014, charges were filed against 18 defendants in 13 cases. Of the 3 remaining cases: one perpetrator died in the incident, one evaded arrest, and one was never charged. As of the writing of this report, the outcomes of the 18 defendants charged are as follows:

- ❖ 12 defendants were convicted or plead guilty and are serving time in a state prison.
 - Seven were convicted of first degree murder, three plead guilty to felony child abuse, and two were convicted of child endangerment.
- ❖ At the time of this report, 6 defendants are awaiting judgment and sentencing.
 - Five are on trial for first degree murder and one is on trial for child endangerment.

⁷ This analysis was performed using a chi-square test of independence, which tests the strength of the correlation between two categorical variables. A similar finding using the same test was published in the *International Journal of Sociology and Anthropology* Vol. 2(6), PP. 118-125, June 2010.

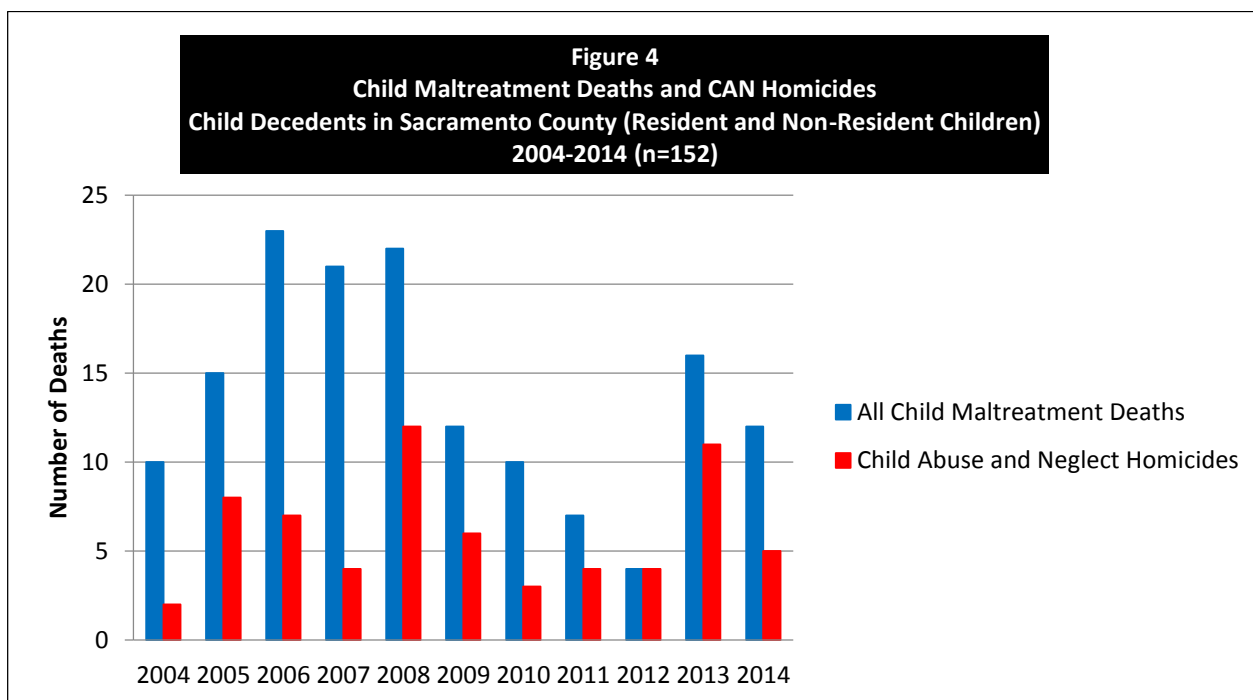
Child Maltreatment Deaths

In 2013-2014, child maltreatment was involved in the deaths of 28 children. Sixteen decedents were infants, nine were between 1-4 years of age, two were between 5-9 years of age, and one was between 10-14 years of age. None were between 15-17 years of age.

Eighty-nine percent (25 of 28) of child maltreatment deaths were children under 5 years of age, which is higher than the historical trend. Between 2004-2012, 76% (95 of 125) of child maltreatment deaths occurred among children under 5 years of age.

Of the 28 child maltreatment deaths in 2013-2014, 16 children died as a result of a Child Abuse and Neglect (CAN) homicide, five died of perinatal conditions with an element of prenatal substance abuse, three experienced neglect related infant sleep-related deaths, two died of neglect related drownings, one died of medical neglect, and one died of both prenatal substance abuse and medical neglect.

Figure 4 shows all child maltreatment deaths between 2004-2014. Child maltreatment deaths among Sacramento County residents decreased from 5.09 deaths per 100,000 children during the 2005-2009 period to 2.67 deaths per 100,000 children during the 2010-2014 period. This decrease is statistically significant at the 99% confidence level. The increase between the 2011-2012 period and the 2013-2014 period from 1.52 deaths per 100,000 children to 3.78 deaths per 100,000 children is also statistically significant at the 99% confidence level.



Risk Factors

Risk factors were known to be present in 27 of 28 deaths involving some element of abuse or neglect in 2013-2014, and are as follows:

- ❖ 82% (23 of 28) of decedents had a family history of alcohol and/or other drug abuse.
- ❖ 71% (20 of 28) of decedents had a family history of violent and/or non-violent crime.
- ❖ 64% (18 of 28) of decedents were enrolled in government aid programs at the time of death.
- ❖ 61% (17 of 28) of decedents had involvement with or a family history of involvement with Sacramento County Child Protective Services:
 - ❖ 54% (15 of 28) of decedents had a sibling with involvement with Sacramento County Child Protective Services.
 - 6 decedents had a sibling with an open case or referral at the time of death.
 - ❖ 32% (9 of 28) of decedents had parents with a history of involvement with Sacramento County Child Protective Services as children.
 - ❖ 29% (8 of 28) of decedents had involvement themselves with Sacramento County Child Protective Services.
 - 7 decedents had an open case or referral at the time of death.
 - 1 decedent had a case or referral closed more than six months prior to the time of death
- ❖ 50% (14 of 28) of decedents had a family history of domestic violence.
- ❖ 29% (8 of 28) of decedents had a family history of mental health issues.

Chapter II

All Causes of Child Death

Chapter Two

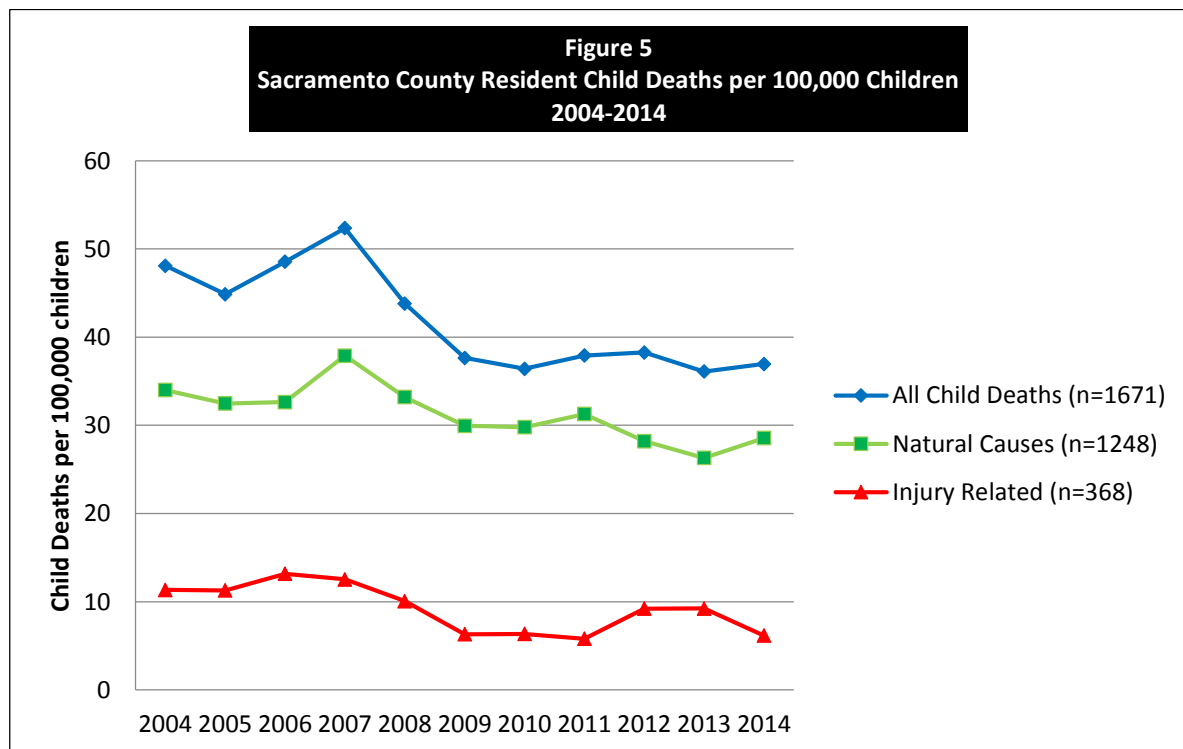
All Causes of Child Death

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 Sacramento County children. This chapter includes information regarding the overall child death rate, natural and injury-related death rates, a categorical breakdown of the causes and manners of death, and a summary of natural deaths and those caused by injuries or undetermined manner.

Child Death Rates

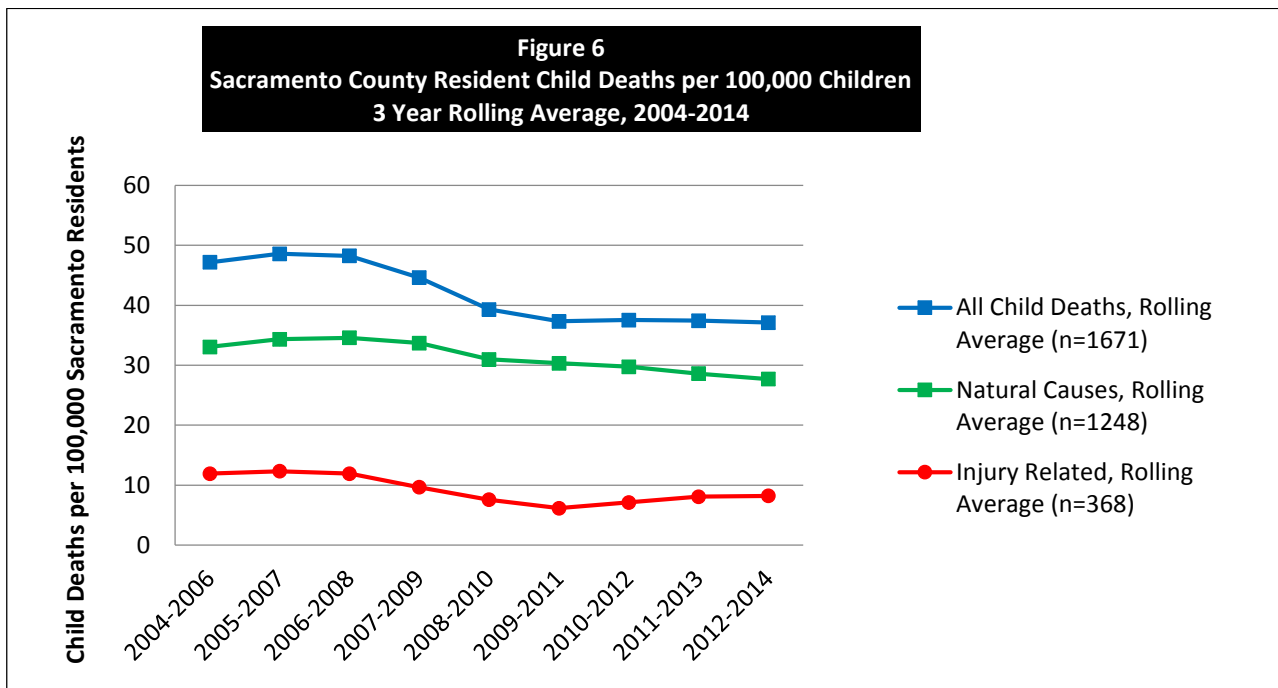
In 2013-2014, there were 261 deaths in children, birth through 17 years of age, who were Sacramento County residents. Given the large number of children living in Sacramento County, and in order to account for the overall child population change, it is useful to look at the child death rate in order to more clearly see subtle variations in the child death data. The child death rate represents the number of child deaths per 100,000 children living in Sacramento County. In Sacramento County, the child death rate in 2013-2014 was 36.4 deaths per 100,000 children. This is a decrease from the death rate for Sacramento County children in the 2011-2012 period of 38.1 deaths per 100,000 children.

Figure 5 illustrates the child death rates of Sacramento County residents from 2004-2014.⁸



⁸ Deaths of undetermined manner are too small and fluctuating to be accurately represented on this chart

Figure 6 illustrates the rolling three-year average child death rate from 2004-2014 in Sacramento County.



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 2013-2014, 75% (196 of 261) of all Sacramento County resident child deaths were due to natural causes. Injury-related deaths accounted for 21% (55 of 261) of all Sacramento County resident child deaths during this period, and deaths of an undetermined manner accounted for four percent (10 of 261) of all Sacramento County child deaths during this period.

Figure 7 shows a breakdown of Sacramento County resident child deaths by category for each year from 2004 through 2014.

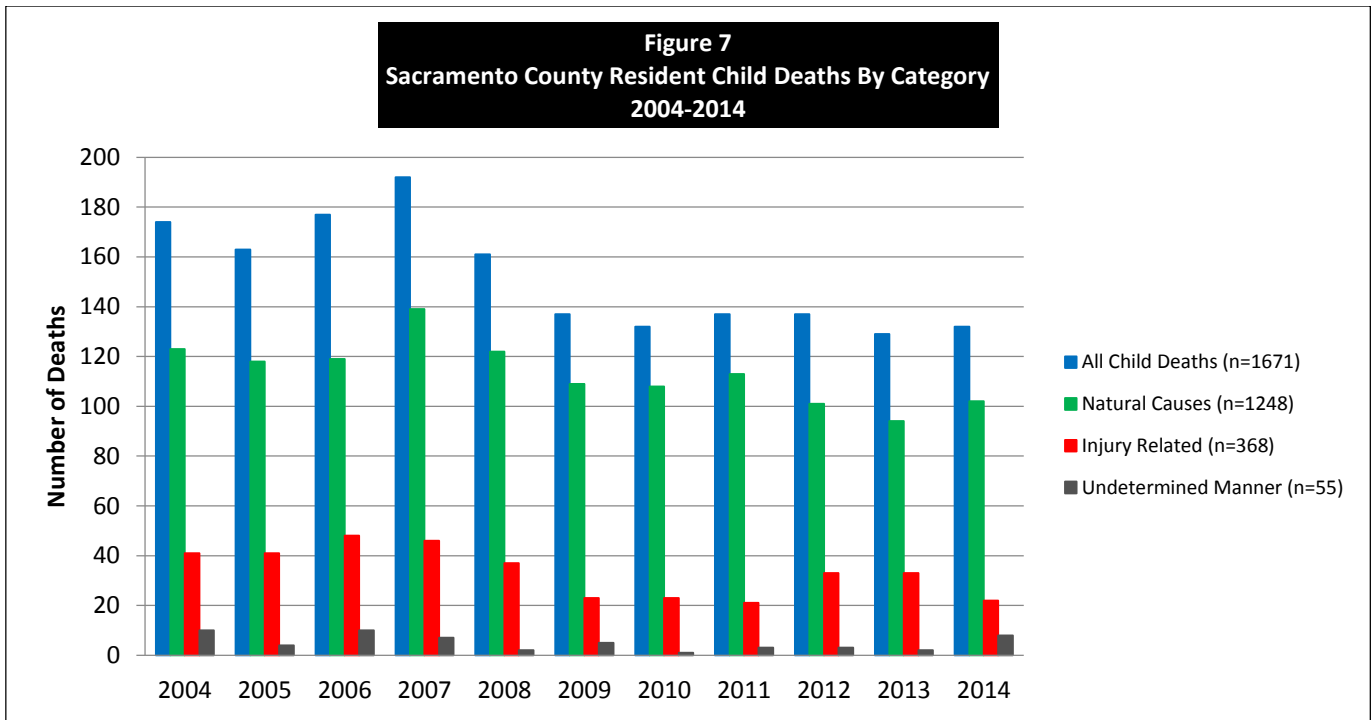


Table C on the page 16 provides a summary of the cause and manner of all child deaths in Sacramento County between 2013-2014. Deaths in the two main categories, injury-related and natural causes, are broken out into subcategories according to similar conditions. A third category, undetermined, contains cases for which the manner of death could not be identified. An example of a case in this category is an infant sleep-related death where there was not enough evidence to determine the manner and/or cause of death, and risk factors present precluded a diagnosis of Sudden Infant Death Syndrome (SIDS).

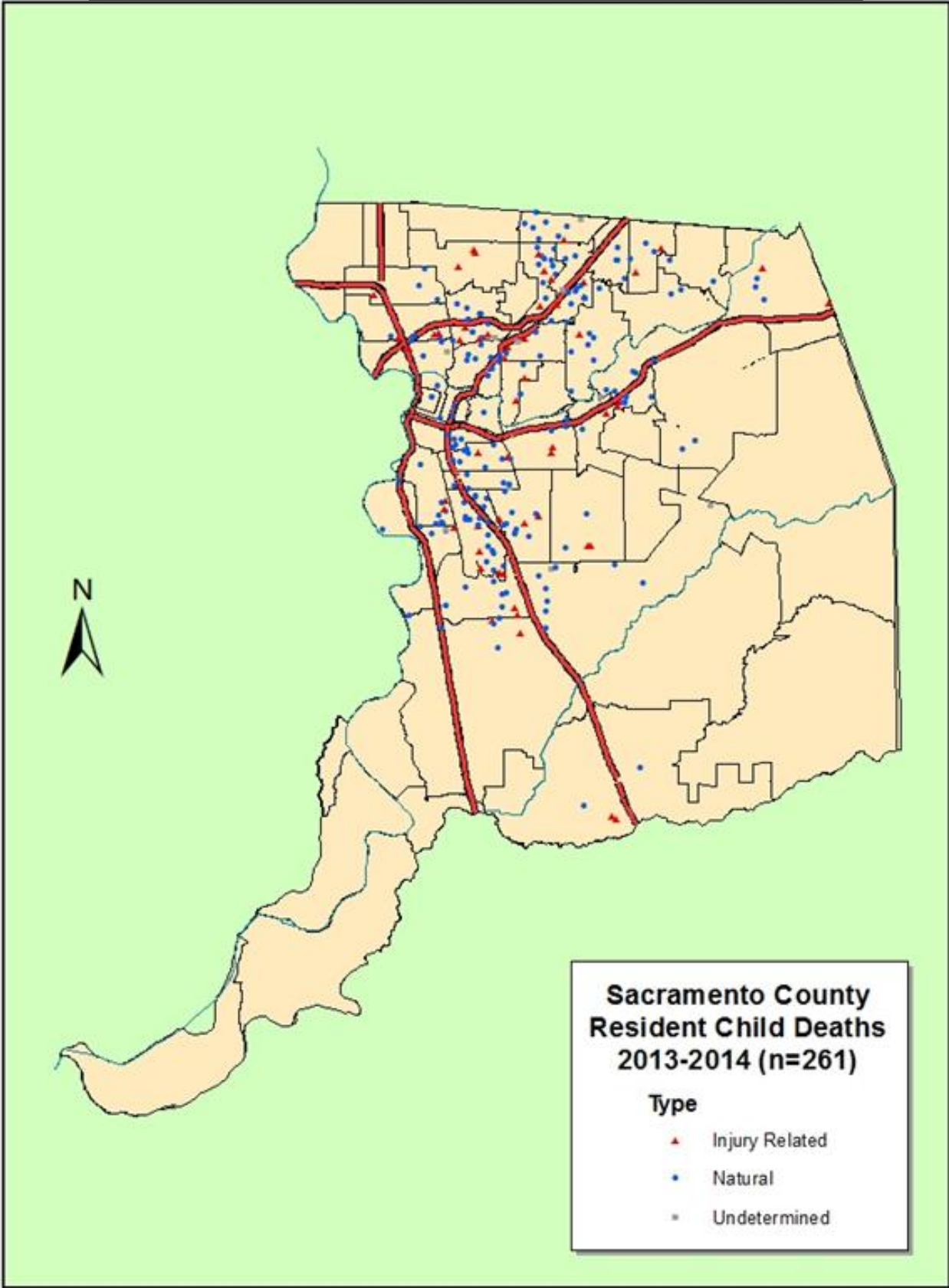
Map i, shown on page 17, illustrates the location of each Sacramento County resident child who died in 2013-2014. Map ii, shown on page 18, depicts the kernel density distribution of the place of residence of all Sacramento County resident children (birth through 17 years of age) who died between 2013-2014, with darker regions indicating a higher concentration of child deaths

Table C
All Child Deaths by Cause and Manner*, 2013-2014

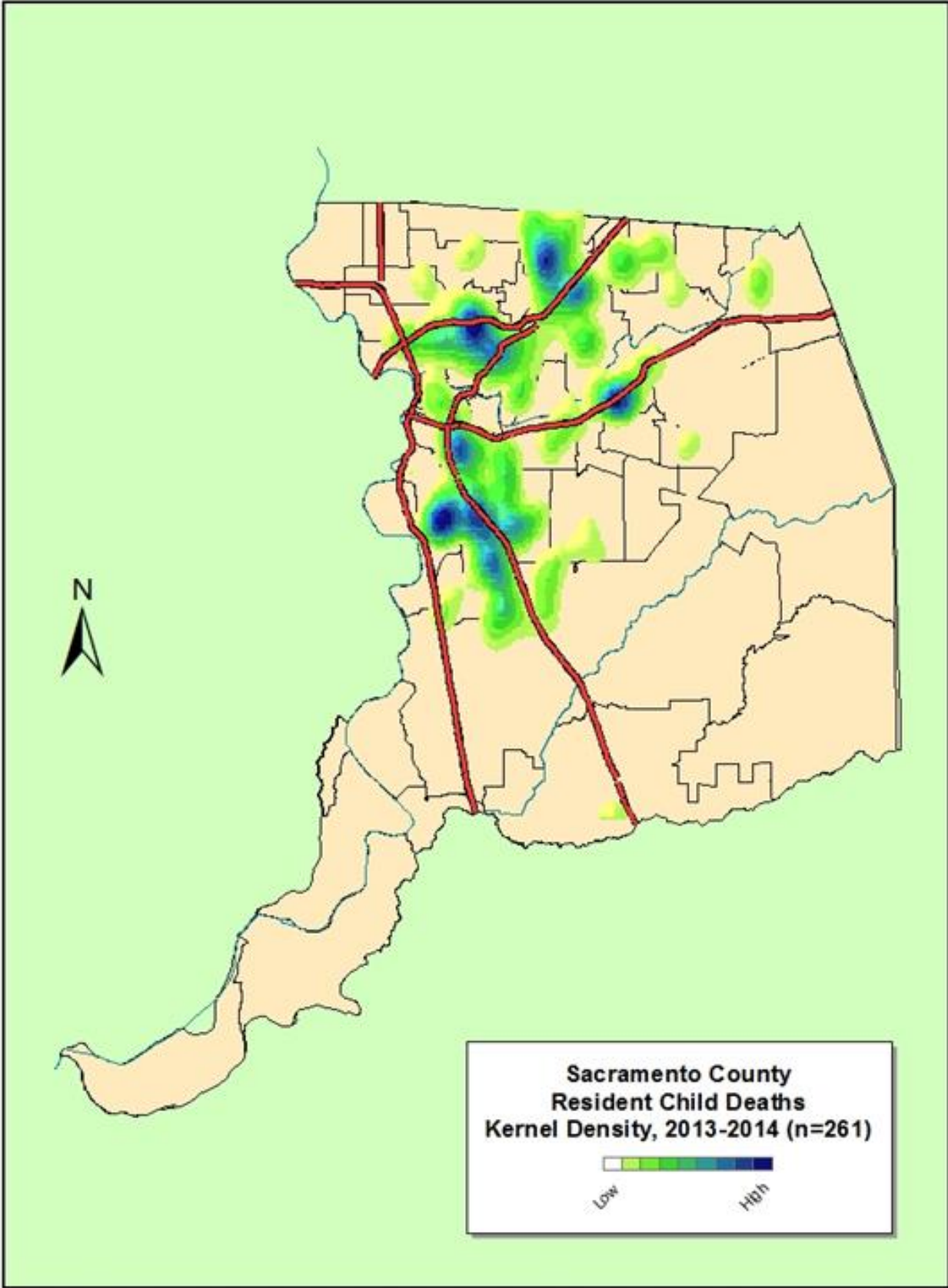
Category	2013	2014	Total
Natural Causes			
Perinatal Conditions	33	44	77
Congenital Anomalies	30	31	61
SIDS	0	2	2
SUIDS	13	8	21
Cancer	7	9	16
Infections	7	3	10
Respiratory	2	1	3
Other -Natural	2	3	5
Undetermined -Natural	0	1	1
Total Natural Causes	94	102	196
Percent Natural Causes	71%	77%	74%
Injury Related Causes			
CAN Homicide	11	5	16
Third-Party Homicide	7	5	12
MVA Occupant/Driver	3	0	3
MVA Pedestrian	2	2	4
MVA Bike	0	0	0
Drowning	2	5	7
Suicide	6	5	11
Suffocation	0	1	1
Poisoning/Overdose	0	0	0
Legal Intervention	0	0	0
Other -Injury	5	0	5
Undetermined Injury	0	0	0
Total Injury Related Causes	36	23	59
Percent Injury Related Causes	27%	17%	22%
Undetermined Manner	2	8	10
Percent Undetermined Manner	2%	6%	4%
Total	132	133	265

**Includes the deaths of four out-of-county residents that died from CAN homicides that occurred in Sacramento County, including three in 2013 and one in 2014.*

Map i
All Causes of Death
Sacramento County Resident Children, 2013-2014



Map ii
All Causes of Death, Kernel Density
Sacramento County Resident Children, 2013-2014



Injury-Related Deaths

Injury-Related Death: 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.

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

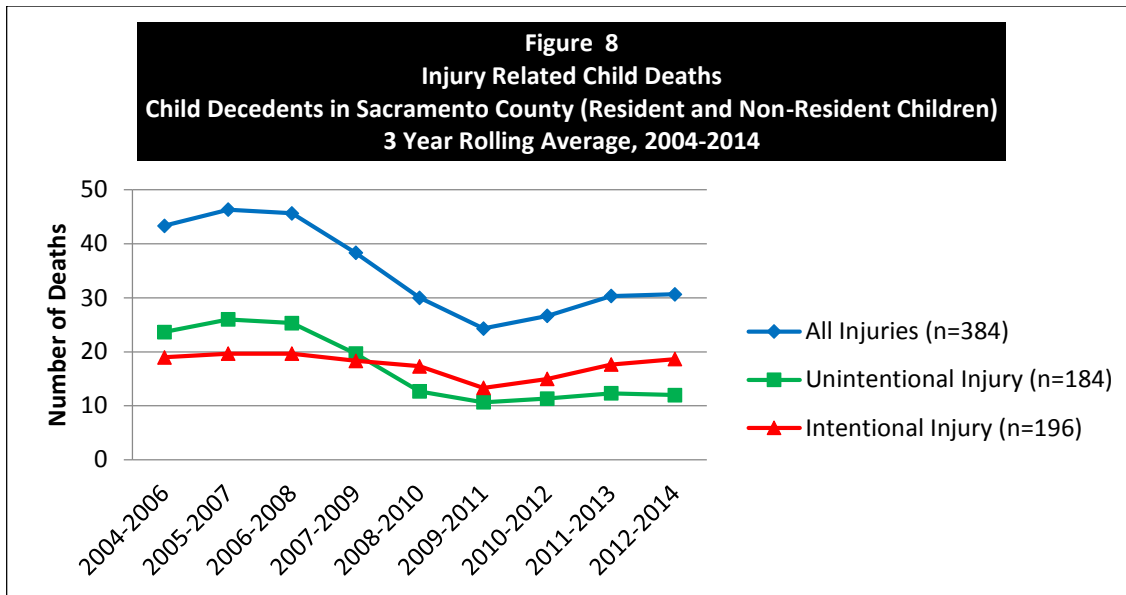
Unintentional Injury-Related Death: An injury that was unplanned and unintended to happen, such as motor vehicle collisions, fires and drownings.

Injury-related deaths can be analyzed in terms of three broad categories: intentional, unintentional, and undetermined. The latter category includes all injury-related deaths in which 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.

In 2013-2014, there were 59 injury-related deaths. This is a small and not statistically significant increase from 55 in 2011-2012. The number of injury-related deaths in Sacramento County decreased between 2007 and 2010, then increased from 2010 to 2014. The majority of this decline is in unintentional injuries. Over the entire ten year period from 2005-2014, this represents a statistically significant decrease in the number of injury-related deaths between the 2005-2009 period and the 2010-2014 period at the 99% confidence level.

The majority of the decrease in injury-related deaths has occurred among *unintentional* injury-related deaths, which have undergone a statistically significant decrease, from 5.86 deaths per 100,000 child residents between 2005-2009 to 3.01 per 100,000 child residents between 2010-2014. *Intentional* injuries did not see a statistically significant decrease, and occurred at a rate of 5.20 deaths per 100,000 child residents between 2005-2009 and of 4.67 deaths per 100,000 child residents between 2010-2014.

Figure 8 shows the three-year rolling average of injury-related deaths in Sacramento County from 2004-2014.



Note: Four injuries from prior reports were sustained in an undetermined manner and it is unknown whether they were intentional.

Intentional Injuries

In 2013-2014, intentional injury-related deaths (homicides and suicides) comprised 66% (39 of 59) of all injury-related deaths. While the three-year rolling average of intentional injury-related deaths has decreased from 19.7 between 2005-2007 to 13.3 in 2010-2012, it has since risen to 18.7 between 2012-2014. After a sharp decline in 2008-2010, intentional injuries now comprise a majority of all injury related deaths.

Homicides

Homicides are comprised of two categories: Child Abuse or Neglect (CAN) homicides, in which the perpetrator is the caregiver or supervisor of the decedent; and third-party homicides, in which the perpetrator is a third-party, such as a friend or stranger. CAN homicides were discussed in Chapter One of this report.

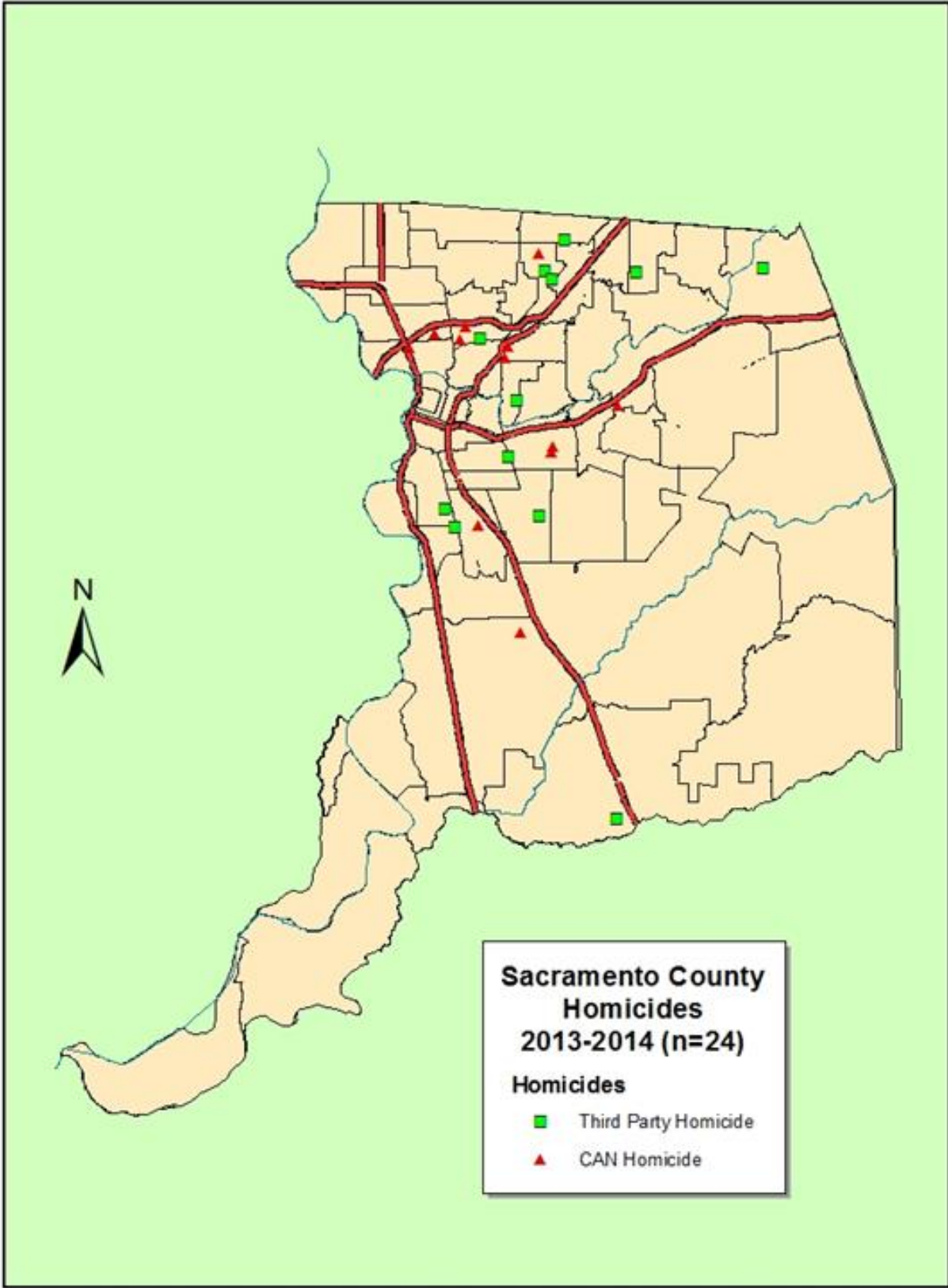
In 2013-2014, homicides represented 72% (28 of 39) of all intentional injury-related child deaths. Twenty-four of these homicides occurred among Sacramento County resident children, while four homicides were out-of-county residents who were in Sacramento County at the time of injury. Sixteen of the 28 homicides were CAN homicides, while twelve were third-party homicides.

Map iii shows the place of residence of each CAN homicide and third-party homicide victim that occurred in Sacramento County among Sacramento County resident children in 2013-2014.

Third-Party Homicides

In 2013-2014, 12 of the 28 child homicides were classified as third-party homicides, all among Sacramento County resident children. Seven of the victims were between 15-17 years of age, three victims were between 10-14 years of age, and one victim each was an infant and between 5-9 years of age. Nine of the victims were male and three were female. Seven of the decedents were Hispanic, two were White, two were African American, and one was Asian/Pacific Islander.

Map iii*
All Homicides
Sacramento County Resident Deaths 2013-2014



In 2013-2014, risk factors were known to be present in 100% (12 of 12) of third-party homicides, and are as follows:

- ❖ 100% (12 of 12) of decedents had families enrolled in government aid programs at the time of death.
- ❖ 83% (10 of 12) of decedents had a family history of violent and/or non-violent crime.
- ❖ 67% (8 of 12) of decedents had a family history of alcohol and/or other drug abuse.
- ❖ 58% (7 of 12) of decedents had illegal drugs or alcohol involved in their death.
- ❖ 50% (6 of 12) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 42% (5 of 12) of decedents had involvement with Sacramento County CPS themselves.
 - One decedent had an open CPS case or referral at the time of death.
 - No decedents had a case or referral within six months of death.
 - ❖ 17% (2 of 12) of decedents had siblings who had involvement with Sacramento County CPS.
 - No decedents had siblings with an open case or referral at the time of death.
 - ❖ No decedents had a parent with a history Sacramento County CPS involvement as a child
- ❖ 50% (6 of 12) of decedents were gang members or were otherwise affiliated with gangs.
- ❖ 42% (5 of 12) of decedents had a family history of domestic violence.

Suicides

In 2013-2014, there were 11 suicide deaths, all among Sacramento County residents. Nine of the decedents were male and two were female. Nine decedents were between 15-17 years of age and two were between 10-14 years of age. Five of the decedents died by hanging, four died from a gunshot wound, one laid on railroad tracks, and one died from walking into traffic.

In 2013-2014, risk factors were known to be present in 73% (8 of 11) of suicides, and are as follows:

- ❖ 64% (7 of 11) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 45% (5 of 11) of decedents had involvement with Sacramento County Child Protective Services.
 - 4 decedents had CPS involvement more than 6 months prior to the time of death.
 - One decedent had a referral opened and closed within 6 months of the time of death.
 - ❖ 45% (5 of 11) of decedents had siblings who had prior involvement with Sacramento County Child Protective Services.
 - No decedents had siblings who had an open referral at the time of death.
 - ❖ 9% (1 of 11) of decedents had a parent with a history of Sacramento County CPS involvement as a child.

- ❖ 55% (6 of 11) of decedents had a family history of alcohol and/or other drug abuse.
- ❖ 55% (6 of 11) of decedents had a history of mental health issues.
- ❖ 45% (5 of 11) of decedents had a family history of violent and/or non-violent crime.
- ❖ 27% (3 of 11) of decedents had families who were receiving government aid at the time of death.

Unintentional Injuries

In 2013-2014, there were 20 deaths resulting from unintentional injuries, all of whom were Sacramento County residents. The causes of death for these 20 decedents were as follows:

- ❖ 7 drownings
- ❖ 7 Motor Vehicle Collisions (MVCs)
- ❖ 5 injury deaths classified as “other”
 - “Other” injuries included one undetermined hanging, one blunt head injury, and three falling objects
- ❖ 1 Suffocation

Risk factors were known to be present in 80% (16 of 20) of deaths resulting from unintentional injuries in 2013-2014 and are as follows:

- ❖ 55% (11 of 20) of decedents had families who were receiving government aid at the time of death.
- ❖ 40% (8 of 20) of decedents had a family history of violent and/or non-violent crime.
- ❖ 40% (8 of 20) of decedents had a family history of alcohol and/or other drug abuse.
- ❖ 35% (7 of 20) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 20% (4 of 20) of decedents had involvement themselves with Sacramento County Child Protective Services.
 - 3 decedents had an open case or referral at the time of death.
 - 1 decedent had CPS involvement more than 6 months prior to the time of death.
 - ❖ 15% (3 of 20) of decedents had parents who had involvement with Sacramento County CPS as children.
 - ❖ 10% (2 of 20) of decedents had siblings who had involvement with Sacramento County CPS.
 - 1 decedent had a sibling who had an open case or referral at the time of death.

- ❖ 15% (3 of 20) of decedents had a family history of mental health issues.
- ❖ 5% (1 of 20) of decedents had a family history of domestic violence.

Drownings

In 2013-2014, drownings accounted for 35% (7 of 20) of unintentional injury-related deaths. Three of the deaths occurred in in-ground pools, two occurred in back yard fish ponds, and one each occurred in a pond and a river. Five decedents were playing near water and two were swimming before their deaths.

Six of the decedents were 1-4 years of age and one was 15-17 years of age.

CDRT records instances of unsafe conditions present in child drowning deaths. Such unsafe conditions were present in 86% (6 of 7) of drowning deaths and are as follows:

- ❖ 6 decedents were playing near or swimming in water with no lifejacket.
- ❖ 1 decedent was playing near a pool with a broken fence.

Motor Vehicle Collisions

In 2013-2014, Motor Vehicle Collision (MVC) deaths accounted for 35% (7 of 20) of unintentional injury-related deaths. Of these seven MVC deaths, four were pedestrians, two were drivers, and one was an occupant. None of the MVC decedents were cyclists.

Six of the decedents were 15-17 years of age, and one was 10-14 years of age. Five of the decedents were male and two were female.

CDRT records instances of unsafe conditions present in MVC deaths. Such conditions include car passengers who were not properly using seatbelts, and cyclists who were not wearing helmets. Such unsafe conditions were present in 100% (7 of 7) of MVC deaths and are as follows:

- ❖ 100% (3 of 3) of driver/occupant deaths involved reckless driving
- ❖ 100% (4 of 4) of pedestrian deaths involved unsafe road crossing

Natural Causes

Natural Causes: Death due to complication(s) of disease process, or due immediately to natural cause(s). Examples of deaths categorized from natural causes include perinatal conditions, congenital anomalies, cancers, Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Death Syndrome (SUIDS) and deaths due to infections or respiratory conditions.

In 2013-2014, 75% (196 of 261) of Sacramento County child deaths resulted from natural causes. This includes those deaths resulting from Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death Syndrome (SUIDS). The two leading causes of natural death were perinatal conditions and congenital anomalies (birth defects). See Table C, on page 16, for a list of all deaths by natural causes.

Perinatal Conditions

Perinatal Conditions: Conditions that include prematurity, low birth weight, placental abruption and congenital infections. The perinatal period is defined as the time interval beginning with the completion of the 20th to 28th week of gestation and ending 28 days after birth. In other words, deaths due to perinatal conditions span the time period from the second trimester of pregnancy through one month after birth.

In 2013-2014, 39% (77 of 196) of all natural deaths in Sacramento County were due to perinatal conditions. Gestational age was known for 86% (66 of 77) of perinatal conditions deaths. Of those, prematurity was a known contributing factor in 88% (58 of 66) of perinatal condition deaths. The median gestational age of babies who died from prematurity and other perinatal conditions was 23 weeks. The median weight of babies who died from prematurity and other perinatal conditions was 479 grams (approximately 1.06 pounds).

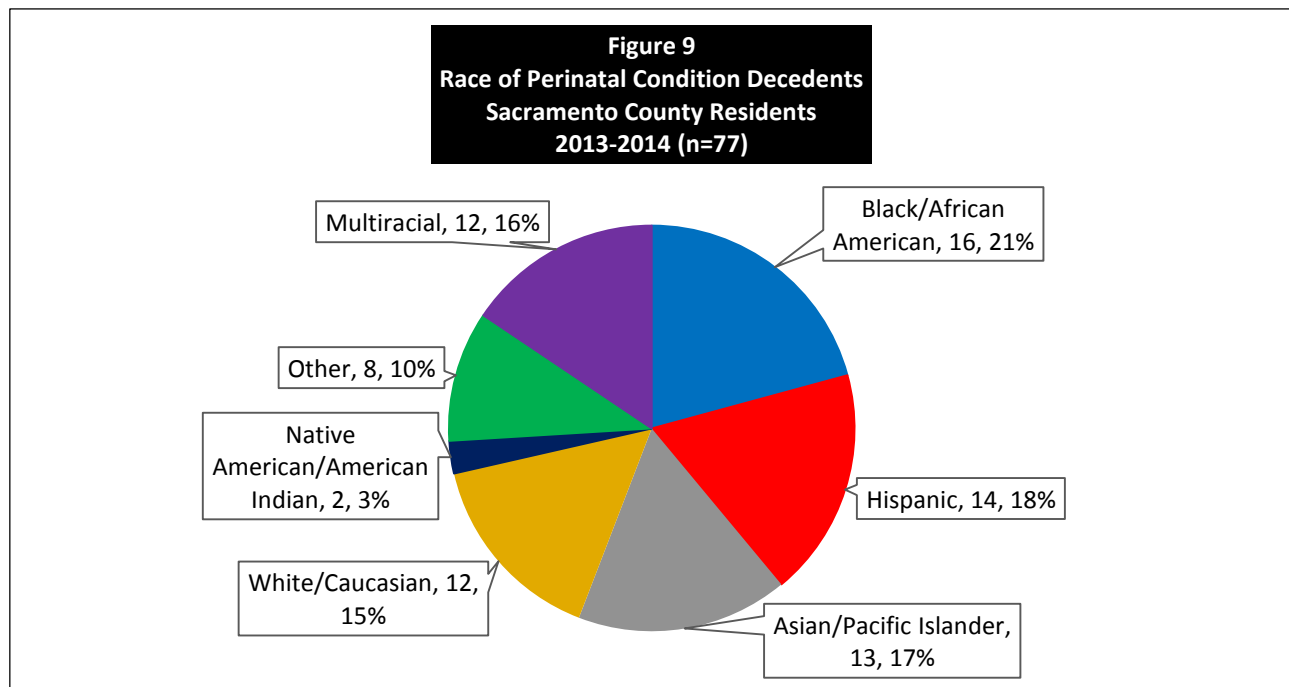


Figure 9 shows the race of perinatal condition decedents. Twenty-one percent (16 of 77) of decedents were African American, 18% (14 of 77) were Hispanic, 17% (13 of 77) were Asian/Pacific Islander (API), 16% (12 of 77) were White, three percent (2 of 77) were Native American, and 10% (8 of 77) were another race. Sixteen percent (12 of 77) were Multiracial; of these, 42% (5 of 12) were White and Hispanic, 25% (3 of 12) were White and African American, and eight percent (1 of 12) were each of White and Native American, Hispanic and Native American, White and API, and Three or More races.

Figure 10 shows the maternal age in perinatal condition deaths. Maternal age is known for 83% (64 of 77) decedents. Of those, 9% (6 of 64) were under 20 years of age, 42% (27 of 64) were 20-29 years of age, 28% (18 of 64) were 30-34 years of age, 17% (11 of 64) were 35-39 years of age, and three percent (2 of 64) were 40 years and older.

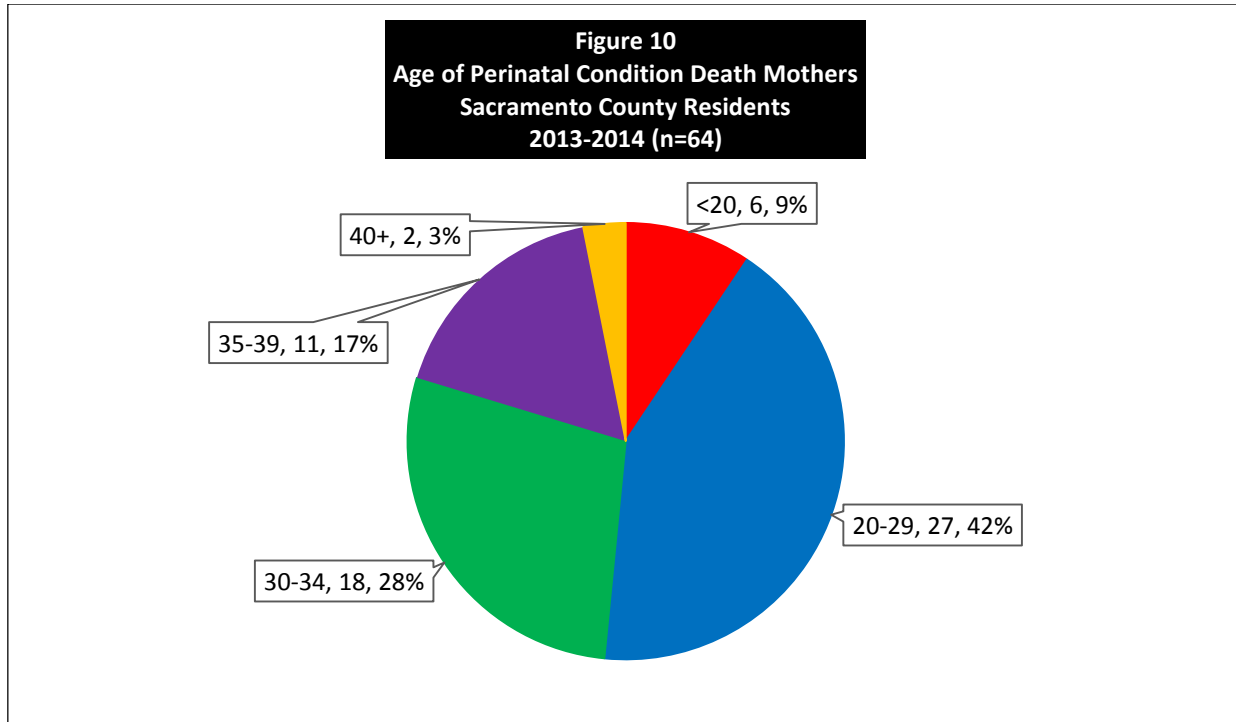
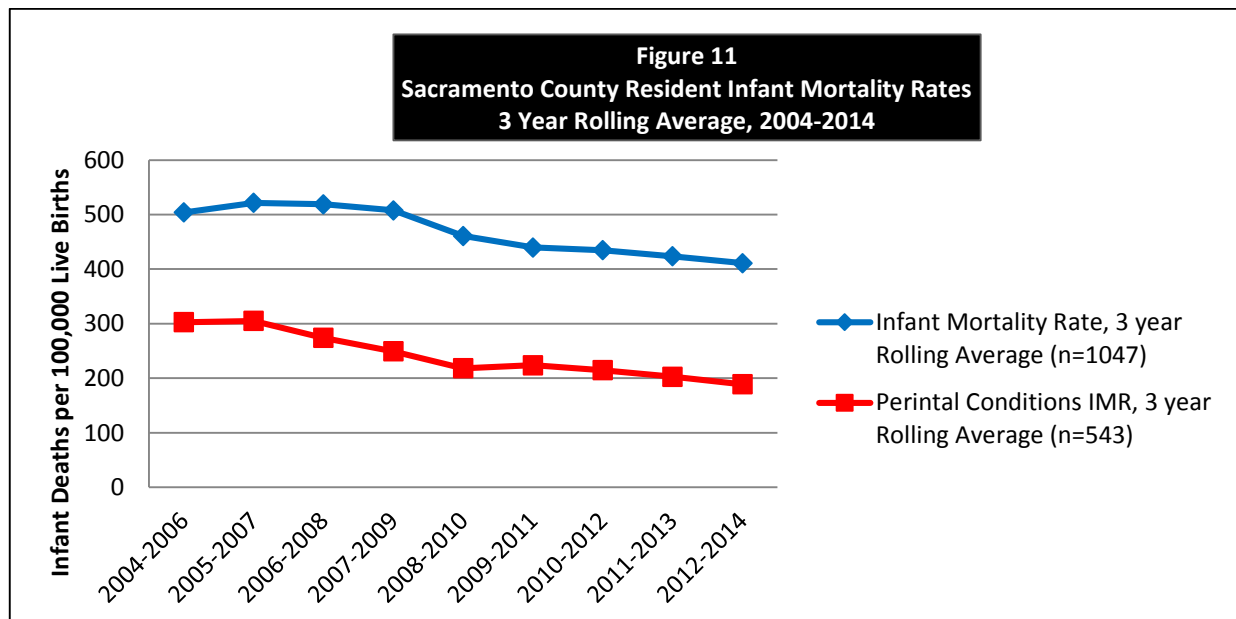


Figure 11 shows the Infant Mortality Rates (IMR) in Sacramento County as well as the three year rolling average rate of infant deaths from perinatal conditions between 2004 and 2014. Deaths from perinatal conditions have decreased from 249 per 100,000 live births to 207 per 100,000 live births between 2011 and 2014, driving the decrease in overall infant mortality in Sacramento County from 448 per 100,000 live births to 410 per 100,000 live births over the same period.



Risk factors were known to be present in 81% (62 of 77) of deaths due to perinatal conditions in 2013-2014 and are as follows:

- ❖ 57% (44 of 77) of decedents had families who were receiving government aid at the time of death.
- ❖ 35% (27 of 77) of decedents had a family history of violent and/or non-violent crime.
- ❖ 31% (24 of 77) decedents had a family history of alcohol and/or other drug abuse.
- ❖ 31% (24 of 77) of decedents had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 21% (16 of 77) of decedents had a parent with a history of prior Sacramento County CPS involvement as a child.
 - ❖ 13% (10 of 77) of decedents had a sibling with a history of prior Sacramento County CPS involvement.
 - 2 decedents had a sibling with a case or referral open at the time of death
 - ❖ 5% (4 of 77) of decedents had a history of prior Sacramento County CPS involvement themselves.
 - 3 decedents had a case or referral open at the time of death
 - No decedents had a case or referral open within six months prior to death
- ❖ 18% (14 of 77) of mothers had inadequate prenatal care.
- ❖ 17% (13 of 77) of decedents had a family history of domestic violence.
- ❖ 13% (10 of 77) of mothers used alcohol/drugs while pregnant.

Congenital Anomalies

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 Trisomy 13 (Patau Syndrome). The underlying causes of death in this category are generally attributed to heredity and/or genetics.

In 2013-2014, 31% (61 of 196) of all natural deaths in Sacramento County were due to congenital anomalies.

Risk factors were known to be present in 79% (48 of 61) of these deaths and are as follows:

- ❖ 69% (42 of 61) of decedents had families who were receiving government aid at the time of death.
- ❖ 34% (21 of 61) of decedents had a family history of violent and/or non-violent crime.

- ❖ 34% (21 of 61) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 18% (11 of 61) of decedents had a sibling who had involvement with Sacramento County CPS:
 - No decedents had a sibling with a CPS case or referral open at the time of death.
 - ❖ 10% (6 of 61) of decedents had involvement with Sacramento County CPS themselves.
 - 3 decedents had a CPS case or referral open at the time of death.
 - 2 decedents had a CPS case or referral open and closed more than 6 months prior to death
 - 1 decedent had a CPS case or referral open and closed within 6 months prior to the time of death.
 - ❖ 11% (7 of 61) of decedents had a parent who had involvement with Sacramento County CPS as a child.
- ❖ 30% (18 of 61) of decedents had a family history of alcohol and/or other drug abuse.
- ❖ 26% (10 of 38 for which prenatal care is known) of mothers had inadequate prenatal care.
- ❖ 18% (11 of 61) of decedents had a family history of domestic violence.
- ❖ 3% (2 of 61) of mothers abused alcohol/drugs while pregnant.

Cancer, Infections, Respiratory and Other Natural Causes

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

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

Respiratory: Death that involves a disease or infection of the lungs or airway passages. Such diagnoses include pneumonia, RSV, asthma, tuberculosis, etc.

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

In 2013-2014, cancer, infections, respiratory, and other natural causes accounted for 17% (34 of 196) of natural deaths in Sacramento County. Risk factors were known to be present in 82% (28 of 34) of these deaths and are as follows:

- ❖ 65% (22 of 34) of decedents had families who were receiving government aid at the time of death.
- ❖ 44% (15 of 34) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 29% (10 of 34) of decedents had a sibling who had involvement with Sacramento County CPS.
 - No decedents had a sibling with a CPS case or referral open at the time of death.

- ❖ 24% (8 of 34) of decedents had involvement themselves with Sacramento County CPS.
 - 6 decedents had a CPS case or referral open and closed more than 6 months prior to death
 - 2 decedents had a CPS case or referral open and closed within 6 months prior to the time of death.
- ❖ 18% (6 of 34) of decedents had a parent who had involvement with Sacramento County CPS as a child.
- ❖ 41% (14 of 34) of decedents had a family history of violent and/or non-violent crime.
- ❖ 29% (10 of 34) of decedents had a family history of alcohol and/or other drug abuse.
- ❖ 21% (7 of 34) of decedents had a family history of domestic violence.

Infant Sleep-Related Deaths

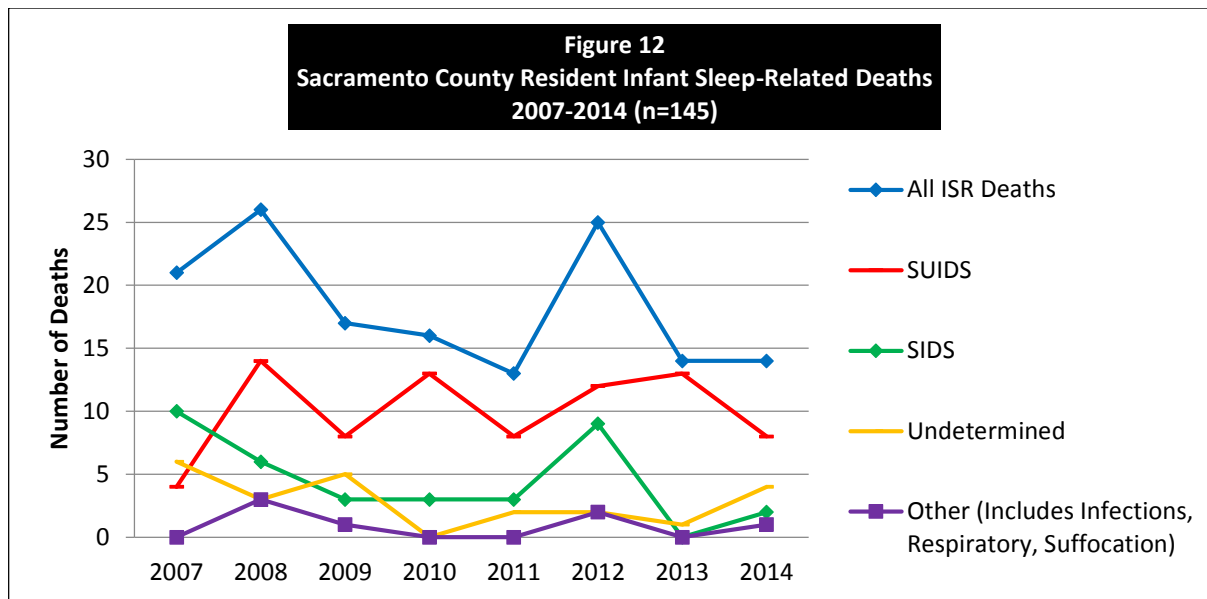
James was a two-month old baby boy who lived with his mom, dad and grandmother. One evening, after a dinner out with family, his mother gave him a bath and breastfed him before bed. After he finished eating, his mom put him to sleep in her queen sized bed as his bassinette was full of clothes. He was propped up on two pillows and placed on his back in the middle of the bed. James' mom checked on him before she and his father fell asleep on either side of him. When they woke up the next morning, they found him on his stomach with fluid around his face. They frantically called 911 and paramedics took him to the hospital. James died later that morning.

Sudden Infant Death Syndrome: 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.”

Sudden Unexpected Infant Death Syndrome: 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 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.

According to the American Academy of Pediatrics, Infant Sleep-Related (ISR) death is an umbrella term used to describe all infant deaths that occur in the sleep environment. Sacramento County CDRT combines all ISR deaths due to variation in the specific categorization of death by the coroner, and to better identify ISR risk factors to help prevent future infant sleep-related deaths.

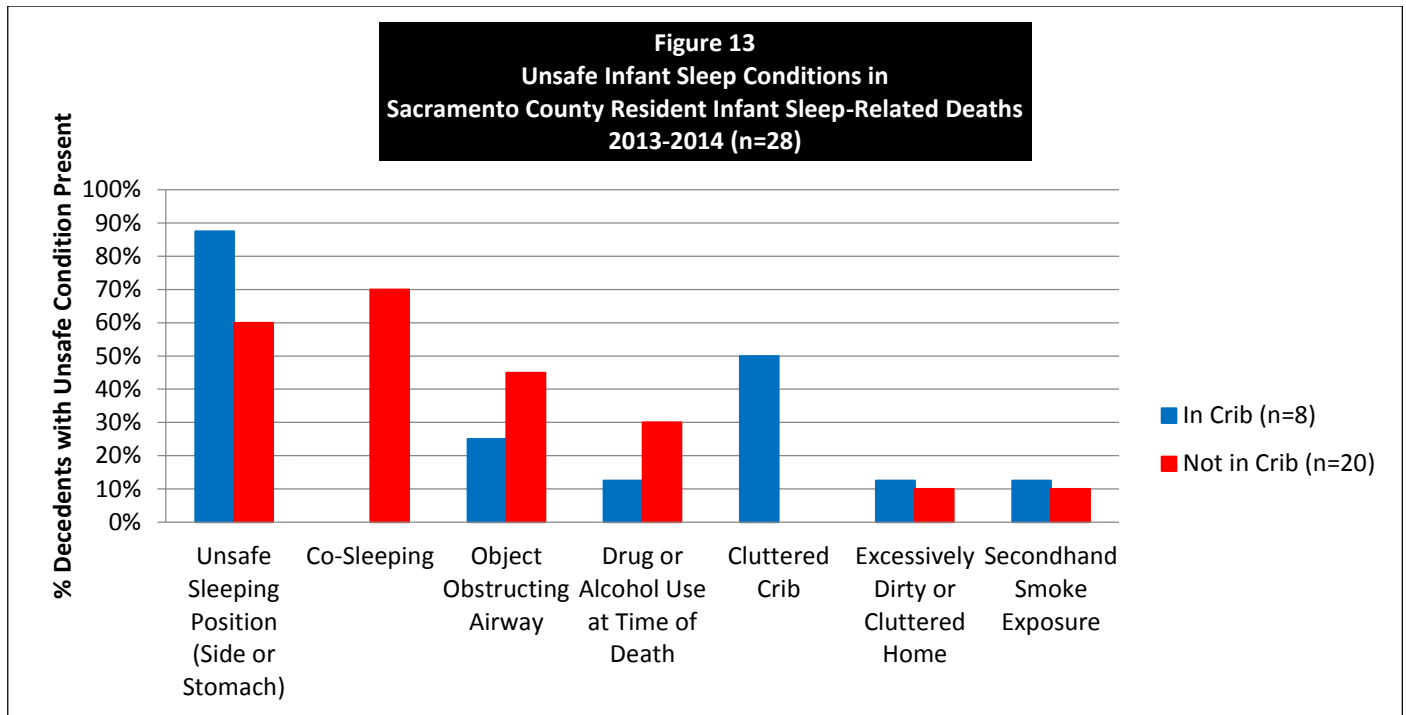
In 2013-2014, there were 28 ISR deaths, representing 11% of all child deaths in Sacramento County. Of these, 21 died of SUIDS, two died of SIDS, one died of suffocation, and four died in an undetermined manner. After declining for three consecutive years between 2009-2011 and rising to 25 in 2012, the number of infant sleep-related deaths fell again to 14 in 2013 and 14 in 2014. Figure 12 shows all infant sleep-related deaths since 2007.



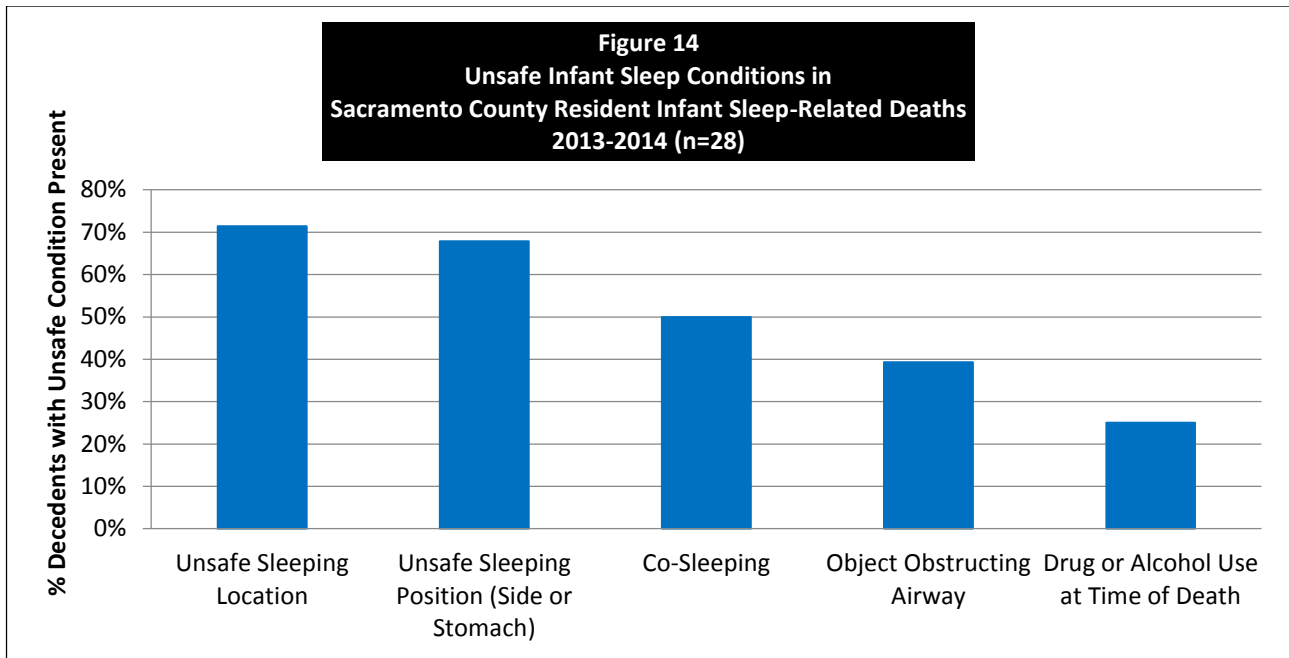
Of the 28 ISR deaths in 2013-2014, unsafe sleep conditions⁹, such as co-sleeping, or the decedent being placed to sleep somewhere other than a crib or bassinette, were known to be present in 100% (28 of 28) of these deaths, and are as follows:

- ❖ 71% (20 of 28 decedents) of decedents were known to have slept in an unsafe sleeping location, such as an adult bed or couch:
 - 64% (18 of 28) of decedents were in an adult bed.
 - 4% (1 of 28) of decedents were on a futon.
 - 4% (1 of 28) of decedents were on a chair.
- ❖ Cribs were known to be present in 23 of 28 homes (82%).
 - 15 cribs were unused
 - 8 cribs were used with unsafe sleeping conditions, including unsafe sleeping positions, second hand smoke, extra blankets in the crib, etc.
 - 7 cribs were used with children in unsafe sleeping positions, either placed or found on their side or stomach.
 - 3 homes did not have cribs.
 - It is unknown whether a crib was present in two homes.

⁹ The American Academy of Pediatrics (AAP) lists several factors related to the sleep environment as being associated with a higher risk of SIDS/SUIDS and other infant sleep-related deaths, such as being placed to sleep in a prone position, a soft sleep surface, co-sleeping, sleeping on an adult bed or mattress, or being put to sleep with items that could cover the head or face.



- ❖ Among decedents not in cribs (20 of 28 decedents):
 - 70% (14 of 20) of decedents were known to be co-sleeping with a parent or sibling at the time of death:
 - 70% (14 of 20) of decedents were co-sleeping with 1 or more adults.
 - 5% (1 of 20) of decedents were also co-sleeping with another child.
 - 60% (12 of 20) of decedents were put to sleep or found in a position recognized to increase the risk of an infant sleep-related death, such as on their stomach or on their side.
 - 45% (9 of 20) of decedents had an object obstructing their airway.
 - 30% (6 of 20) of deaths involved drug or alcohol use by the parent or caregiver.
 - 15% (3 of 20) of decedents went to sleep while feeding; two were breastfed and one was fed by bottle.
 - 10% (2 of 20) of deaths occurred in a dirty/cluttered home.
 - 10% (2 of 20) of decedents were exposed to smoke.
- ❖ Among decedents in cribs (8 of 28 decedents):
 - 88% (7 of 8) of decedents were put to sleep or found in a position recognized to increase the risk of an infant sleep-related death, such as on their stomach or on their side.
 - 50% (4 of 8) of decedents slept in a cluttered crib.
 - 25% (2 of 8) of decedents had airway obstructions.
 - 13% (1 of 8) of decedents slept in an excessively dirty or cluttered home.
 - 13% (1 of 8) of decedents' parents were intoxicated at the time of death.
 - 13% (1 of 8) of decedents were exposed to second hand smoke.



Risk factors were known to be present in 93% (26 of 28) of ISR deaths and are as follows:

- ❖ 82% (23 of 28) of decedents had families who were receiving government aid at the time of death.
- ❖ 71% (20 of 28) of decedents had a family history of violent or non-violent crime.
- ❖ 64% (18 of 28) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 46% (13 of 28) of decedents had a parent who had involvement with Sacramento County CPS as a child.
 - ❖ 25% (7 of 28) of decedents had a sibling who had involvement with Sacramento County CPS:
 - 2 decedents had siblings with an open case or referral at the time of death.
 - 6 decedents had siblings with a CPS case or referral open and closed more than 6 months prior to the time of death.
 - ❖ 21% (6 of 28) of decedents had involvement with Sacramento County Child Protective Services:
 - 3 decedents had a case or referral open and closed within 6 months of the time of death.
 - 2 decedents had a CPS case or referral open and closed more than 6 months prior to the time of death
 - 1 decedent had CPS involvement at the time of death.
- ❖ 57% (16 of 28) of decedents had a family history of drug and/or alcohol abuse.
- ❖ 36% (8 of 22 for whom prenatal care is known) of decedents' mothers received late or inadequate prenatal care.
- ❖ 25% (7 of 28) of decedents had a family history of mental health issues.

- ❖ 25% (7 of 28) of decedents had a family history of domestic violence.
- ❖ 16% (4 of 25 for whom maternal age is known) of decedents were born to mothers under 21 years of age at the time of birth.

In addition to the unsafe sleep conditions and risk factors listed above, the following information was known about the 28 infant sleep-related deaths in 2013-2014:

- ❖ 64% (18 of 28) of decedents were 3 months of age or younger at the time of death.
 - 93% (26 of 28) of decedents were 6 months of age or younger at the time of death.
- ❖ 61% (17 of 28) of decedents were male.
- ❖ 43% (12 of 28) of decedents were African American, 29% (8 of 28) were Multiracial, 25% (7 of 28) were White, and four percent (1 of 28) were Hispanic.

Table D shows the number of infant sleep-related deaths by race between 2010 and 2014 and includes racial background of multiracial decedents. This table also compares the races of decedents to the overall child population.

Table D
Infant Sleep-Related Deaths by Race, 2010-2014
Sacramento County Resident Child Deaths

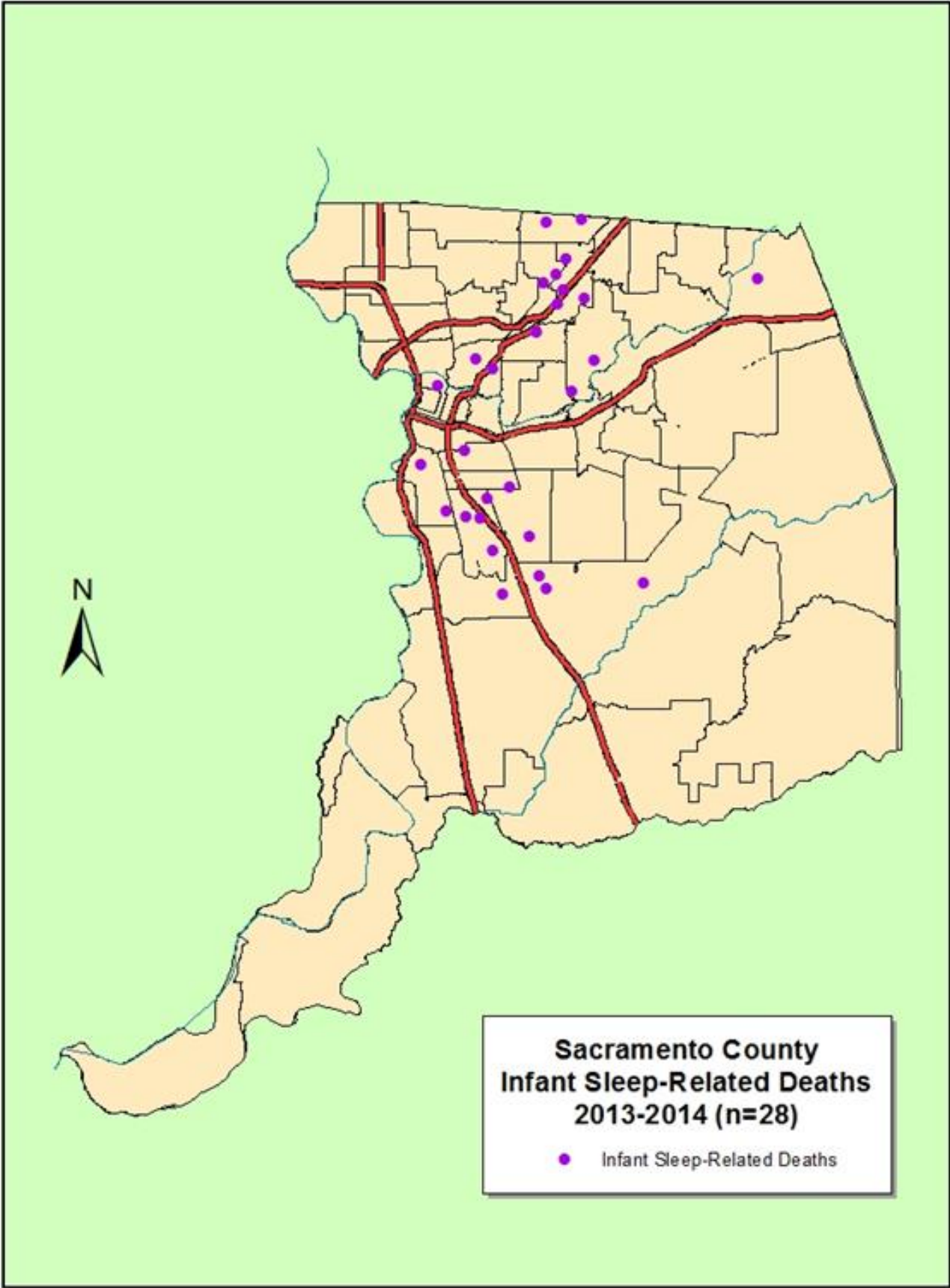
Childs Race	2010	2011	2012	2013	2014	2010-2014		
	# ISR Deaths	# ISR Deaths	# ISR Deaths	# ISR Deaths	# ISR Deaths	# ISR Deaths	% ISR Deaths	% Child Population
Black/African American	5	5	10	7	5	32	39%	11%
White/Caucasian	4	6	5	3	4	22	27%	35%
Hispanic	1	1	2	0	1	5	6%	31%
Asian/Pacific Islander	1	0	1	0	0	2	2%	15%
Native American/American	0	0	1	0	0	1	1%	1%
Multiracial	5	1	6	4	4	20	24%	8%
White/Black	1	0	2	3	1	7	9%	
White/Hispanic	2	0	2	1	0	5	6%	
Black/Hispanic	1	1	1	0	0	3	4%	
3 or More Races	1	0	0	0	1	2	2%	
API/Hispanic	0	0	0	0	1	1	1%	
Native American/API	0	0	0	0	1	1	1%	
Unknown Multiracial	0	0	1	0	0	1	1%	
Total	16	13	25	14	14	82	100%	

In 2013-2014, infant sleep-related deaths in Sacramento County occurred in the zip codes shown in Table E. Residences of these decedents are shown in Map iv.

Table E
Sacramento County Zip Codes Infant Sleep-Related Deaths
Sacramento County Resident Child Deaths
2013-2014, (n=28)

Neighborhood	Number of Infant Sleep-Related Deaths	Percent of ISR Deaths	Percent of Sacramento Infant Population
North Highlands <i>(95660, 95841, 95842, 95843)</i>	8	29%	10%
Meadowview/Valley Hi <i>(95758, 95823, 95828)</i>	6	21%	16%
Fruitridge/Stockton Blvd. <i>(95820, 95822, 95824)</i>	4	14%	9%
N. Sac/Del Paso Heights <i>(95811, 95815)</i>	3	11%	2%
Elk Grove <i>(95624)</i>	3	11%	3%
Carmichael <i>(95608)</i>	2	7%	3%
Arcade <i>(95821)</i>	1	4%	2%
Folsom <i>(95630)</i>	1	4%	3%
Top 3 Zip Codes <i>(95624, 95823, 95841)</i>	10	36%	12%

Map iv
All Infant Sleep-Related Deaths
Sacramento County Resident Deaths, 2013-2014



Correlation Between Prior Child Protective Services (CPS) Involvement and Infant Sleep-Related Death

In trying to prevent infant sleep-related deaths, the CDRT examines points of contact occurring between the families of infants and various family services. By exploring these prior points of contact, the CDRT can determine where best to allocate additional services and interventions to further reduce the occurrence of infant sleep-related deaths. With that in mind, the CDRT elected to analyze the statistical correlation between ISR death and a prior history of CPS referrals involving the decedent.

Additionally, in 2013, *The Journal of Pediatrics* published a study¹⁰ of California infants to determine such a link between prior CPS involvement by the decedent and increased risk of an ISR death. The study concluded that there was a statistically significant correlation between CPS involvement and increased risk of infant sleep-related death, and that this correlation persisted even when controlled for race and poverty. The findings of the Sacramento County CDRT, detailed below, are consistent with the results of this study.

Between 2007 and 2014, a total of 15,707 infants were referred to Sacramento County CPS, representing an average of 9.8% of all infants each year during that period. During those eight years, 145 Sacramento County resident infants died of sleep-related causes. Of these infant decedents, 21% (31 of 145) had been referred to CPS prior to their deaths. Based on a chi-squared analysis of these numbers, this represents a statistically significant correlation between a history of CPS referral and infant sleep-related death at a 99% confidence level¹¹. Overall, an infant with a history of CPS referrals is 2.4 times more likely to suffer an infant sleep-related death than an infant who has not had a CPS referral.

The correlation between a history of CPS referrals and infant sleep-related death was also explored while controlling for economic risk. To do this, infant sleep-related deaths were divided into one of four economic risk categories based on the poverty level and median income of the decedents' zip code of residence: low, moderate, high, or very high. The percentage of decedents in each category who had been referred to CPS prior to their death was then compared to the total number of infants in those zip codes who had been referred during the period. Based on a chi-squared analysis of the numbers when controlled for economic risk, a statistically significant correlation was found between a history of CPS referrals and infant sleep-related deaths in neighborhoods with very high economic risk at a 98% confidence level.

Lastly, the correlation between a history of CPS referrals and infant sleep-related death was also explored while controlling for race. Based on a chi-squared analysis of the numbers when controlled for race, there is not a statistically significant correlation.

Based on the data, there is a statistically significant correlation between a history of CPS referral and infant sleep-related deaths both overall, and in very poor neighborhoods when controlled for economic risk. While no statistically significant correlation could be determined when controlling for race, it is possible that a larger data set could demonstrate such a correlation.

¹⁰ Putnam-Hornstein, E., Schneiderman, J., Cleves, M., Magruder, J., and Krous, H., A Prospective Study of Sudden Unexpected Infant Death after Reported Maltreatment, *Journal of Pediatrics*, October 17, 2013, [http://www.jpeds.com/article/S0022-3476\(13\)01346-2/abstract](http://www.jpeds.com/article/S0022-3476(13)01346-2/abstract), (Feb. 24, 2014)

¹¹ The Confidence Level represents the percentage chance that the result is statistically significant (i.e., not due to random chance).

Table F shows the risk increases resulting from a history of CPS referrals, as well as the confidence level of each result.

Table F
Increased Risk of Infant Sleep-Related Death Due to
Prior CPS Involvement of the Decedent
Sacramento County Residents, 2007-2014

	ISR Death Rate Overall	ISR Death Rate w/CPS Hx	ISR Death Rate w/No CPS Hx	Risk Increase Due to CPS Hx	Confidence Level
Overall	104.29	216.28	91.71	136%	>99%
By Economic Risk Level					
Low	46.99	88.39	44.23	100%	17%
Moderate	73.71	128.65	67.91	89%	30%
High	128.84	210.67	119.33	77%	47%
Very High	163.55	329.20	136.41	141%	98%
By Race					
White	91.54	128.67	88.22	46%	14%
Black	282.66	348.58	256.76	36%	19%
Hispanic	14.60	34.97	13.31	163%	-
Asian/PI	20.68	159.24	16.98	838%	-
Multiracial/Other	250.91	236.01	254.54	-7%	1%

1. Rate is per 100,000 live births

2. Effect is statistically significant when confidence level is greater than 95%; Confidence level could not be calculated for categories with fewer than 5 decedents

3. Economic Risk Index is calculated by dividing median income in a zip code by child population, then dividing by 100,000.

Economic Risk Level is derived as follows: 1-2.5: Very High; 2.5-6.75: High; 6.75-13.5: Moderate; 13.5-36: Low.

Deaths of Undetermined Manner

Undetermined Manner: 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. For example, the coroner might not be able to determine if the death would have occurred naturally or if it was the result of an inflicted or accidental injury.

In 2013-2014, there were 10 deaths of an undetermined manner, four of which were infant sleep-related. Of the other six undetermined manner deaths: two neglect-related deaths occurred during sleep, two involved physical injury that may have been the result of abuse, one was an older child who died during sleep with no known cause, and one decedent may have used an undetectable designer drug that led to cardiac arrest.

Chapter III

Child Death Demographics

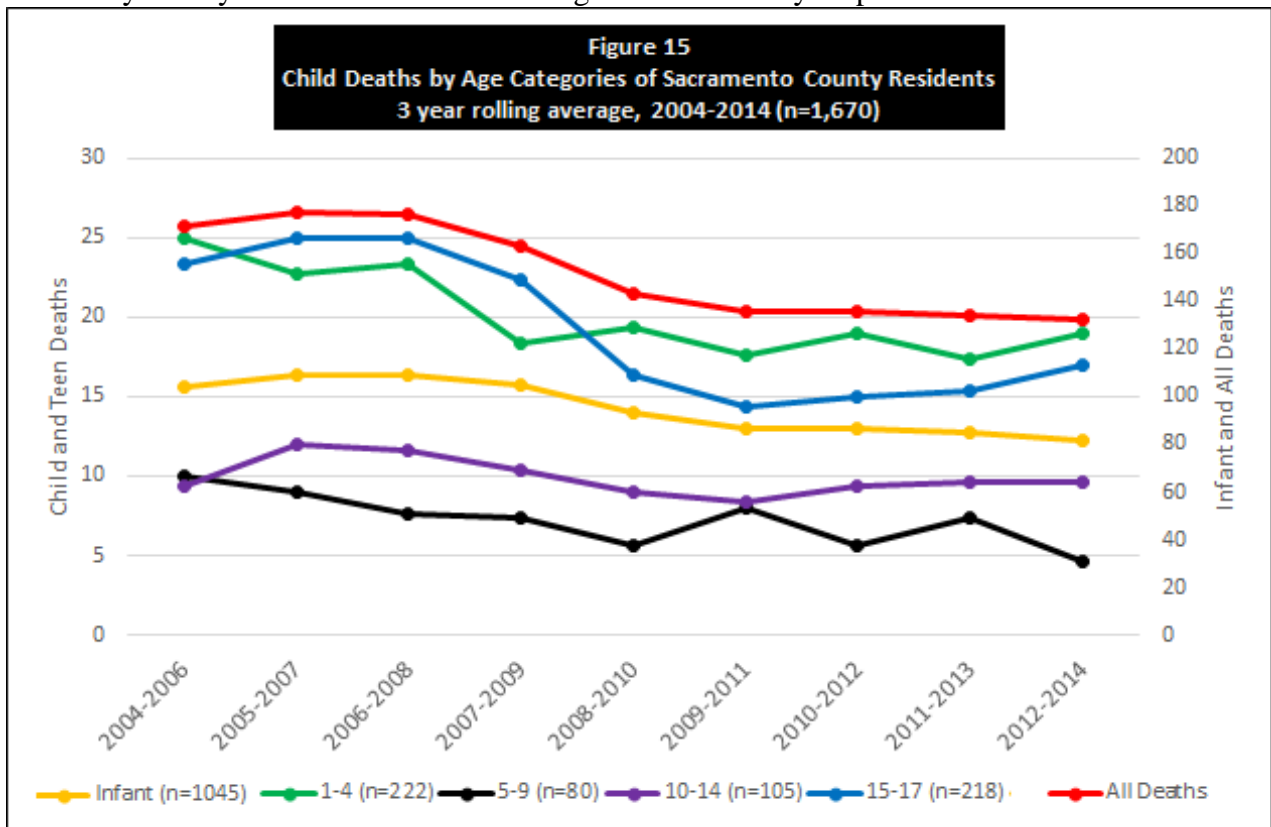
Chapter Three

Child Death Demographics

Age

In 2013-2014, the majority of Sacramento County resident child deaths occurred in infants under one year of age, accounting for 61% (160 of 261) of all deaths. Children between 15-17 years of age were the second largest group, accounting for 14% (37 of 261) of all deaths. Children between 1-4 years of age accounted for 13% (35 of 261) of all deaths, while children between 10-14 years of age comprised seven percent (18 of 261) of child deaths and children between 5-9 years of age accounted for four percent (11 of 261) of child deaths.

Figure 15 shows the number of child deaths by age category between 2004 and 2014. The number of deaths decreased in all age groups except for 10-14 years of age over this time period. The overall number of deaths decreased from an average of 177 per year in 2006-2008 to 135 in 2009-2011 and has remained at similar levels through 2014. The number of infant deaths also decreased during this period, from an average of 109 in 2006-2008 to 82 in 2012-2014. Deaths of teens between the ages of 15-17 decreased from an average of 25 per year between 2005-2008 to a low of 14 in 2009-2011, and increased again to 17 per year by 2014. Deaths of children ages 1-4 and 5-9 show more fluctuation year to year but also declined throughout the eleven year period.



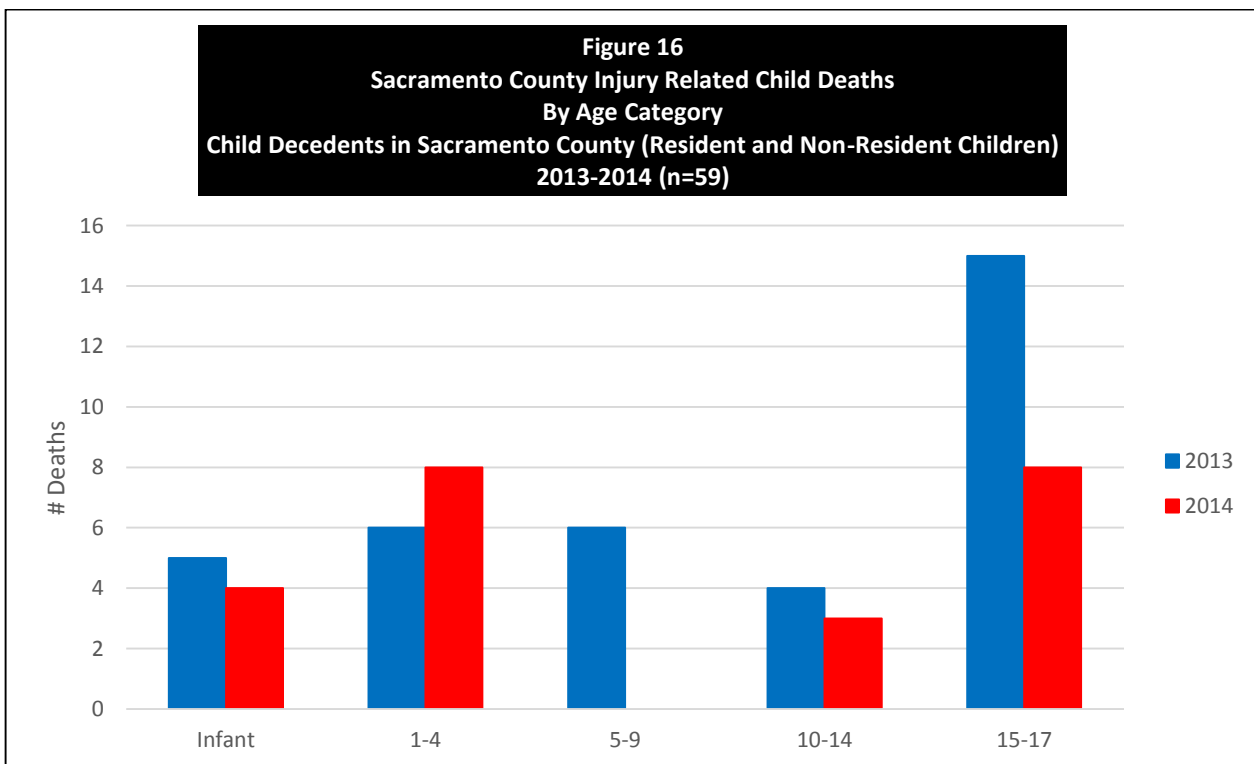
The Sacramento County CDRT categorizes child deaths as either natural, injury-related, or undetermined manner. Injury-related deaths are further broken down into either intentional injury-related, such as a homicide or suicide, or unintentional injury-related, such as a drowning or motor vehicle collision.

In 2013-2014, the largest number of natural deaths among children in Sacramento County occurred among infants, who made up 75% (147 of 196) of all natural deaths. The largest number of intentional injury-related deaths occurred among children 15-17 years of age, making up 41% (16 of 39) of intentional injury-related deaths. The largest number of unintentional injury-related deaths occurred among children 1-4 years of age, making up 40% (8 of 20) of unintentional injury-related deaths.

Infants are at greatest risk for death with a rate of 397.6 deaths per 100,000 infants, followed by youth aged 15-17 with a rate of 30.7 per 100,000 teens, children aged 1-4 with a rate of 21.5 deaths per 100,000 children, and youth age 10-14 with a rate of 9.2 per 100,000 children. Children aged 5-9 have the lowest risk of death, with a rate of 5.4 per 100,000 children. Multiracial/Other children have the highest death rates overall except among teens aged 15-17, at which age African American youth are at the highest risk of death.

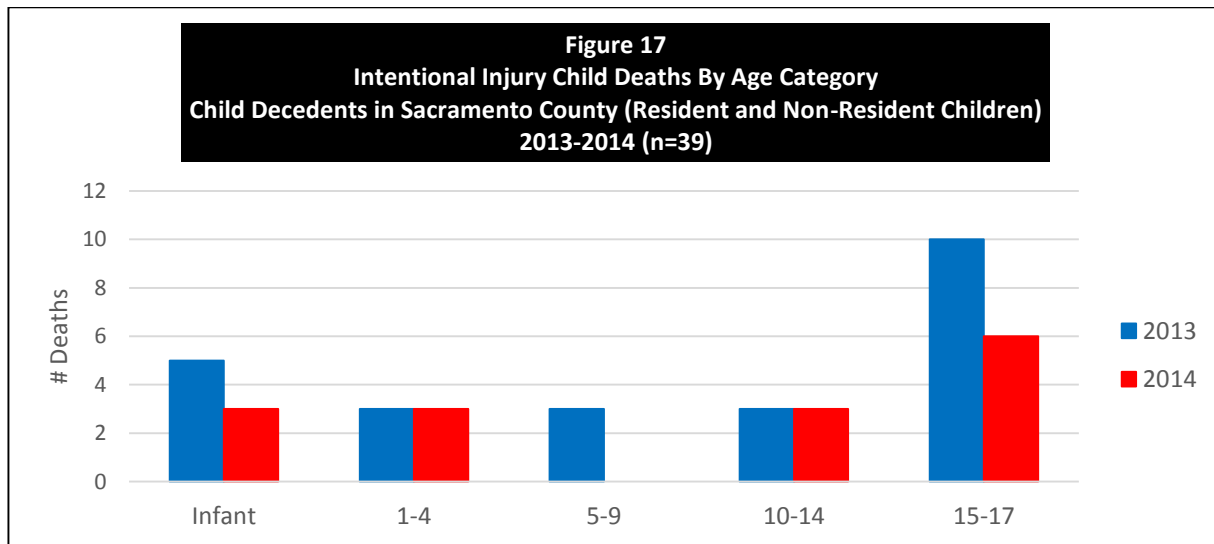
All Injury-Related Deaths

In 2013-2014, there were a total of 59 injury-related child deaths in Sacramento County, including Sacramento County residents and residents of other counties who sustain injuries in Sacramento County. The age group in which the largest number of injury-related deaths occurred was children between 15-17 years of age, with 39% (23 of 59) of all injury-related deaths in 2013-2014. Twenty-four percent (14 of 59) of injury-related deaths occurred among children between 1-4 years of age, 15% (9 of 59) occurred among infants, 12% (7 of 59) occurred among children between 10-14 years of age, and 10% (6 of 59) occurred among children between 5-9 years of age.



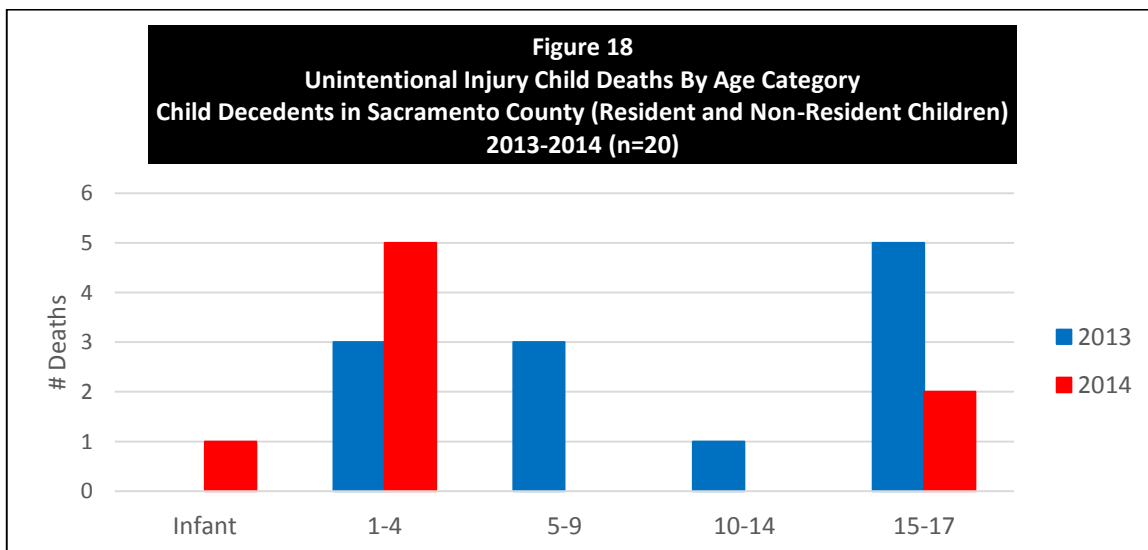
Intentional Injuries

In 2013-2014, there were a total of 39 child deaths resulting from intentional injuries in Sacramento County, including Sacramento County residents and residents of other counties who sustain injuries in Sacramento County. Of these deaths, 41% (16 of 39) occurred in children between 15-17 years of age, 21% (8 of 39) occurred among infants, 15% (6 of 39) occurred among children between 1-4 years of age, 15% (6 of 39) occurred among children between 10-14 years of age, and eight percent (3 of 39) occurred among children between 5-9 years of age.



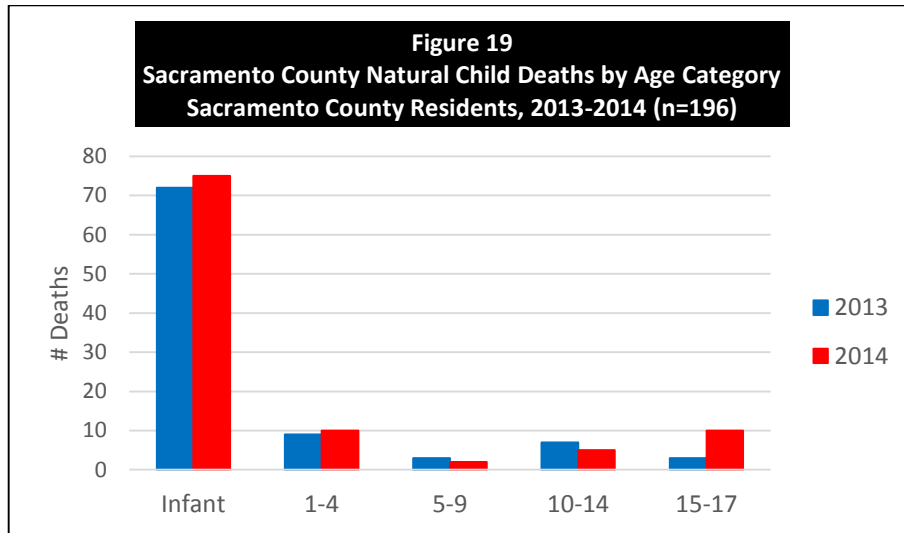
Unintentional Injuries

In 2013-2014, there were a total of 20 child deaths resulting from unintentional injuries in Sacramento County, including Sacramento County residents and residents of other counties who sustain injuries in Sacramento County. Of these deaths, 40% (8 of 20) occurred among children between 1-4 years of age, 35% (7 of 20) occurred in children between 15-17 years of age, 15% (3 of 20) occurred among children between 5-9 years of age, five percent (1 of 20) occurred among each of children between 10-14 years of age and infants.



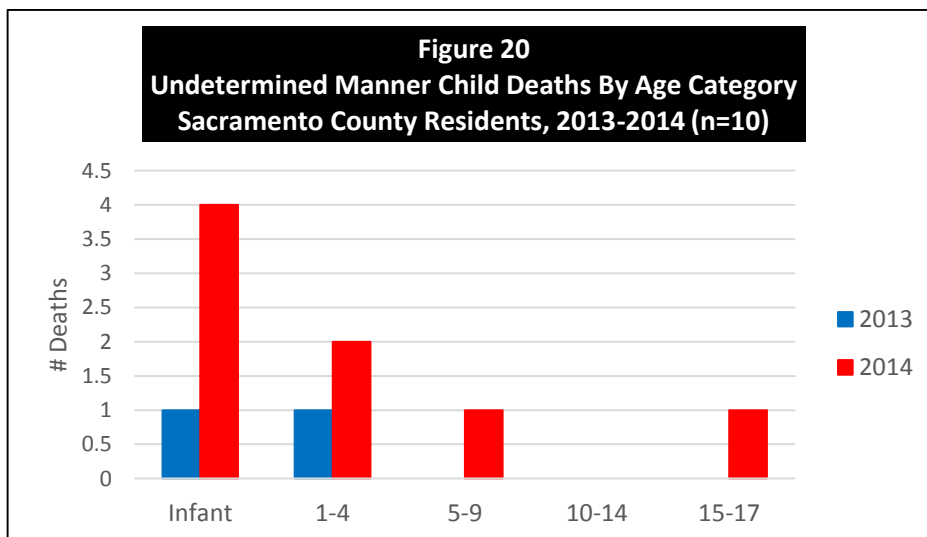
Natural Causes

In 2013-2014, a total of 196 deaths resulted from natural causes, including those deaths due to SIDS and SUIDS. Infants accounted for 75% (147 of 196) of all deaths due to natural causes, while children between 1-4 years of age accounted for 10% (19 of 196) of these deaths, children between 10-14 years of age accounted for six percent (12 of 196), children between 15-17 years of age accounted for seven percent (13 of 196), and children between 5-9 years of age accounted for two percent (5 of 196).



Undetermined Manner

In 2013-2014, there were a total of 10 child deaths of an undetermined manner in Sacramento County. Of these undetermined manner deaths, 50% (5 of 10) were among infants, and 30% (3 of 10) were among children 1-4 years of age, and 10% (1 of 10) occurred in each of children between 5-9 years of age and children between 15-17 years of age. There were no deaths of an undetermined manner among children 10-14 years of age.



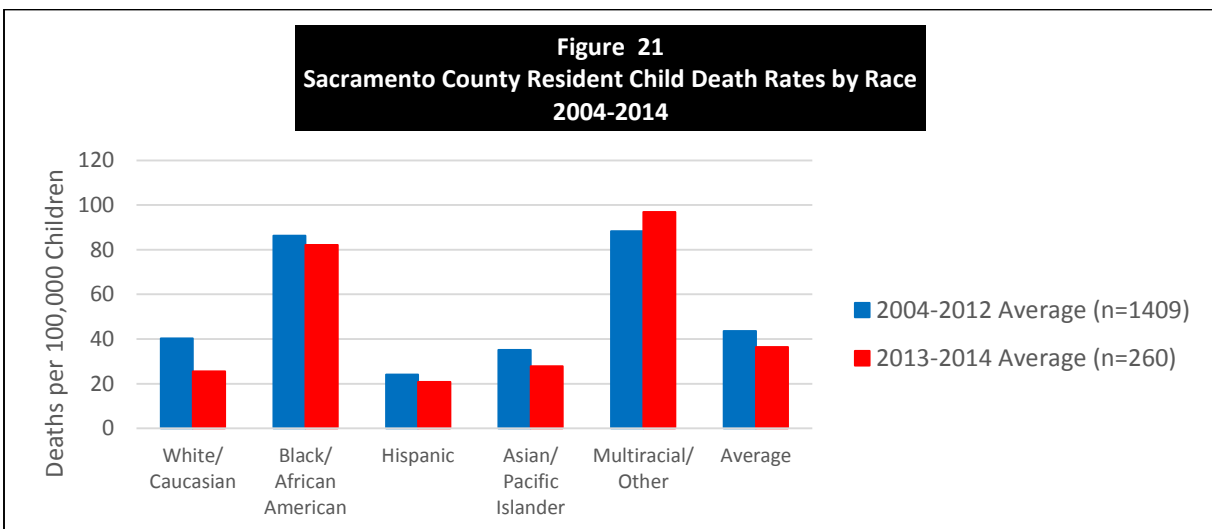
Race and Ethnicity¹²

In 2013-2014, there were 261 deaths among Sacramento County resident children age 0-17. The largest number of child deaths occurred among White children, who comprised 25% (64 of 261) of all child deaths. Twenty-three percent (61 of 261) were African American, 18% (46 of 261) were Hispanic, 16% (43 of 261) were Multiracial, 11% (30 of 261) were Asian/Pacific Islander, one percent (3 of 261) were Native American, and five percent (13 of 261) identified as another race. Race was unknown for one decedent.

Of the 43 multiracial decedents in 2013-2014, 74% (32 of 43) of decedents identified as Caucasian, 47% (20 of 43) identified as African American, 44% (19 of 43) identified as Hispanic, 30% (13 of 43) identified as Asian/Pacific Islander, 12% (5 of 43) identified as Native American, and two percent (1 of 43) identified as some other race. (Note that these percentages do not add up to 100%, as each multiracial decedent identified with more than one race.)

Table G shows the death rates by race of Sacramento County child residents in 2013-2014, and illustrates the disproportionality that exists between racial categories. The greatest discrepancy occurs among Multiracial/Other children, who died at a rate of 96.9 per 100,000 in 2013-2014, compared to the average across all races of 36.4 per 100,000. African American children also died at a disproportionate rate of 82.2 per 100,000, while Asian/Pacific Islander children died at a rate of 27.9 per 100,000, Caucasian children died at a rate of 25.5 per 100,000, and Hispanic children died at a rate of 20.0 per 100,000.

Figure 21 shows the comparison of death rates for each race between the 2013-2014 and 2004-2012 periods. Death rates declined across almost all racial categories between 2013-2014 compared to the nine-year period between 2004-2012, with the largest decline occurring among White children, among whom the death rate decreased from 40.2 to 25.5 between the 2004-2012 period and the 2013-2014 period. The death rate among Asian/Pacific Islander children decreased from 35.2 to 27.9, the death rate among African American children decreased from 86.3 to 82.2, and the death rate among Hispanic children decreased from 24.0 to 20.9. The only category for whom the death rate increased was Multiracial/Other children, with the death rate increasing from 88.2 to 96.9 between the two time periods. Race is unknown for one decedent in the 2013-2014 time period.



¹² The race and ethnicity of decedents is determined based on that reported on the decedent's death certificate.

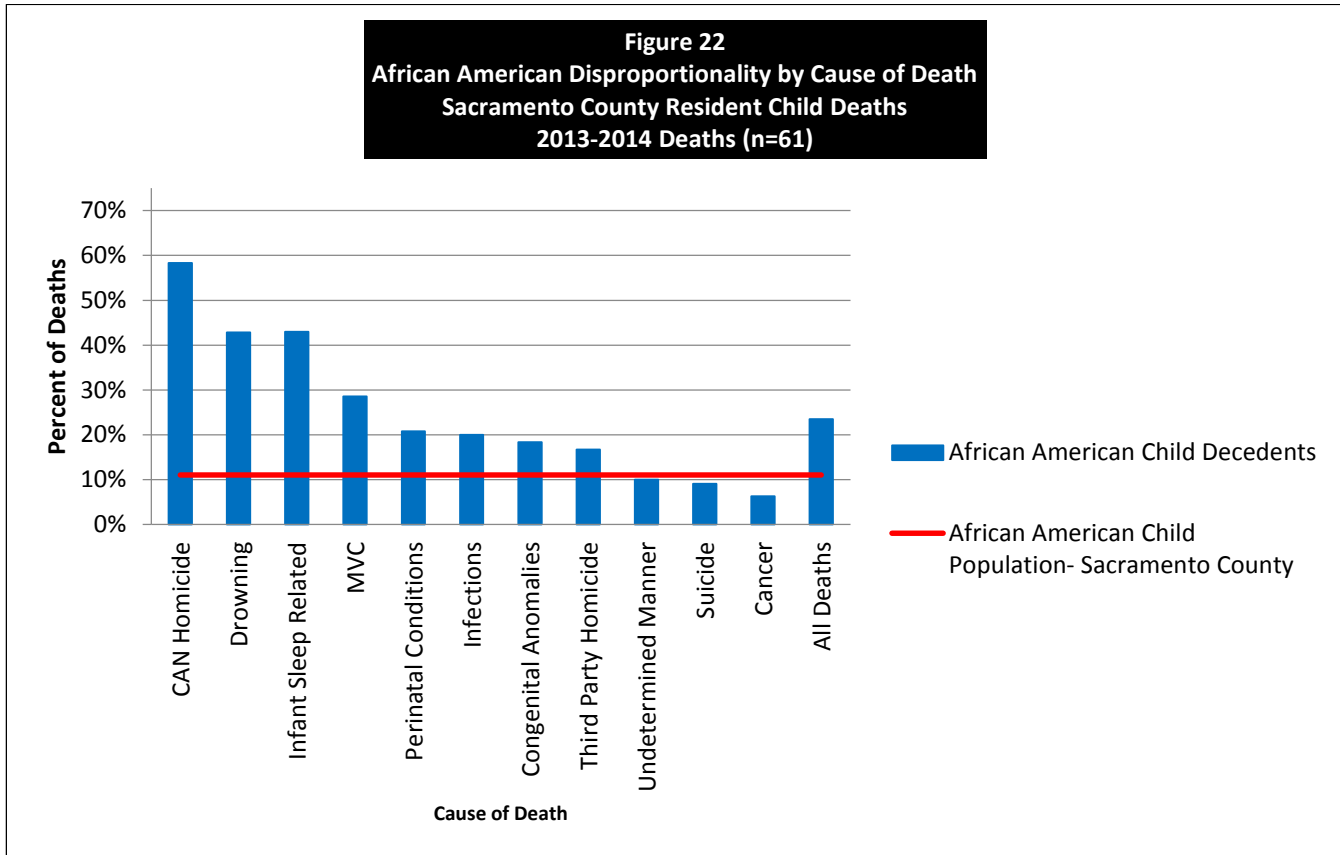
Table G
Sacramento County Resident Child Death Rates by Race
2013-2014

Race	Child Population	% of Child Population	All Child Deaths			Infant Deaths (<1)		Child Deaths (ages 1-4)		Child Deaths (ages 5-9)		Youth Deaths (ages 10-14)		Youth Deaths (ages 15-17)	
			# of Sacramento County Resident Child Deaths	% of Total Deaths	Child Death Rate	# Resident Deaths	Death Rate	# Resident Deaths	Death Rate	# Resident Deaths	Death Rate	# Resident Deaths	Death Rate	# Resident Deaths	Death Rate
White/ Caucasian	125,577	35%	64	24%	25.5	34	240.3	6	10.8	2	2.8	5	7.3	17	40.2
Black/African American	37,127	10%	61	25%	82.2	41	980.2	9	54.8	1	4.7	2	9.9	8	63.9
Hispanic	110,237	31%	46	17%	20.9	28	225.5	6	12.3	2	3.2	4	6.6	6	16.2
Asian/Pacific Islander	53,810	15%	30	12%	27.9	21	346.4	3	12.6	1	3.3	2	6.8	3	16.5
Multiracial/Other	30,452	9%	59	24%	96.9	36	1049.4	10	74.3	5	28.8	5	30.1	3	29.2
TOTAL	357,202	100%	260*		36.4	160	397.6	34*	21.5	11	5.4	18	9.2	37	30.7

* The table above and the chart below do NOT include the deaths of out-of-county residents; the race of one resident aged 1-4 is unknown.

Note: Death rates are per 100,000 Sacramento Resident children in each age group

As African American children have historically experienced the greatest disproportionality among death rates in Sacramento County, CDRT has determined the specific causes of death that exhibit the greatest disproportionality as compared to other races. Figure 22 shows, for each cause of death, the percentage of decedents who were African American children, and compares these rates to the overall African American Child Population in Sacramento County. In 2013-2014, the percentage of child decedents who were African American is greatest in CAN homicides, drowning, infant sleep-related deaths, Motor Vehicle Collisions (MVC) and perinatal conditions.



Note: Includes categories with more than five deaths in 2013-2014

Risk Factors

In order to detect trends and form prevention strategies at a local level, the CDRT investigates the family environments of all children who die in Sacramento County. Risk factors is the broad term used to describe a variety of social, economic, and/or demographic circumstances or other elements that may be associated with a higher risk of negative health outcomes for children. Evidence of risk factors or family stressors such as substance abuse, prior child abuse, domestic or other violence, and mental illness are collected by CDRT members in preparation for each review.

One or more risk factors were known to be present in 83% (221 of 265) of all child deaths in 2013-2014 and are as follows:

Child Protective Services

Decedent CPS History

In 2013-2014, 51% (136 of 265) of all child decedents had past or present family involvement with a CPS agency, of which 80% (109 of 136) had involvement with Sacramento County CPS, and 20% (27 of 136) had involvement with an out-of-county CPS agency only. Of those decedents who had past or present family involvement with a CPS agency, 40% (54 of 136) had involvement with a CPS agency themselves. Of the child decedents who had involvement with a CPS agency themselves, 48% (26 of 54) had a case or referral open and closed more than six months prior to the time of death, 30% (16 of 54) had a CPS case or referral open at the time of death, and 22% (12 of 54) had a CPS case or referral open and closed within six months prior to the time of death.

Sibling CPS History

In 2013-2014, 26% (68 of 265) of child decedents had siblings with CPS involvement, of which 82% (56 of 68) were with Sacramento County CPS, and 18% (12 of 68) were with an out-of-county CPS agency. Of the siblings with CPS involvement, 15% (10 of 68) had a CPS case or referral open at the time of death.

Parental CPS History

In 2013-2014, 24% (63 of 265) of child decedents had a parent (mother or father) with CPS involvement as a child. Of those with previous CPS history, 79% (50 of 63) were with Sacramento County CPS, and 21% (13 of 63) were with an out-of-county CPS agency.

Foster Care History

In 2013-2014, five percent (13 of 265) of child decedents had a history of involvement with the foster care system. Of these, 46% (6 of 13) were in foster care at the time of death. Three percent (9 of 265) of decedents had parents with a history of foster care involvement as children.

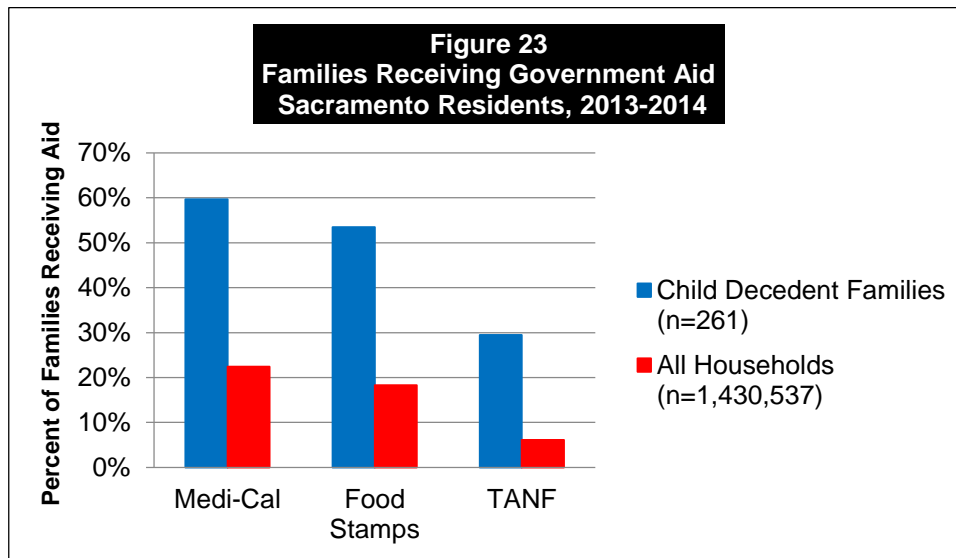
Government Aid Programs

The CDRT recognizes poverty as a factor that can increase the risk of child death. As such, CDRT tracks the number of child decedents whose families are enrolled in various need-based government aid programs. However, enrollment in government aid programs is not a perfect proxy for poverty, as some families in poverty might not be enrolled in such programs for a variety of reasons.

In 2013-2014, 65% (172 of 265) of all child decedents and their families were receiving some form of government aid at the time of death. Fifty-five percent (147 of 265) of decedents' families were receiving Medi-Cal at the time of death, 38% (102 of 265) were receiving CalFresh/food stamps, 23%

(62 of 265) were receiving Temporary Assistance for Needy Families (TANF), and nine percent (24 of 265) were receiving Supplemental Security Income.

Figure 23 shows the percentage of Sacramento County child decedent families receiving government aid at the time of death in 2013-2014, compared to the percentage of all Sacramento County families receiving government aid¹³. The families of child decedents were 2.3 times more likely to be receiving Temporary Work for Needy Families (TANF) benefits at the time of death, with 23% of child decedent families receiving benefits compared to six percent of all Sacramento County families. Decedent families were 2.1 times (38% vs 18%) more likely than the county average to be receiving CalFresh/food stamps at the time of death, and 1.5 times (55% vs 22%) more likely to be enrolled in Medi-Cal.



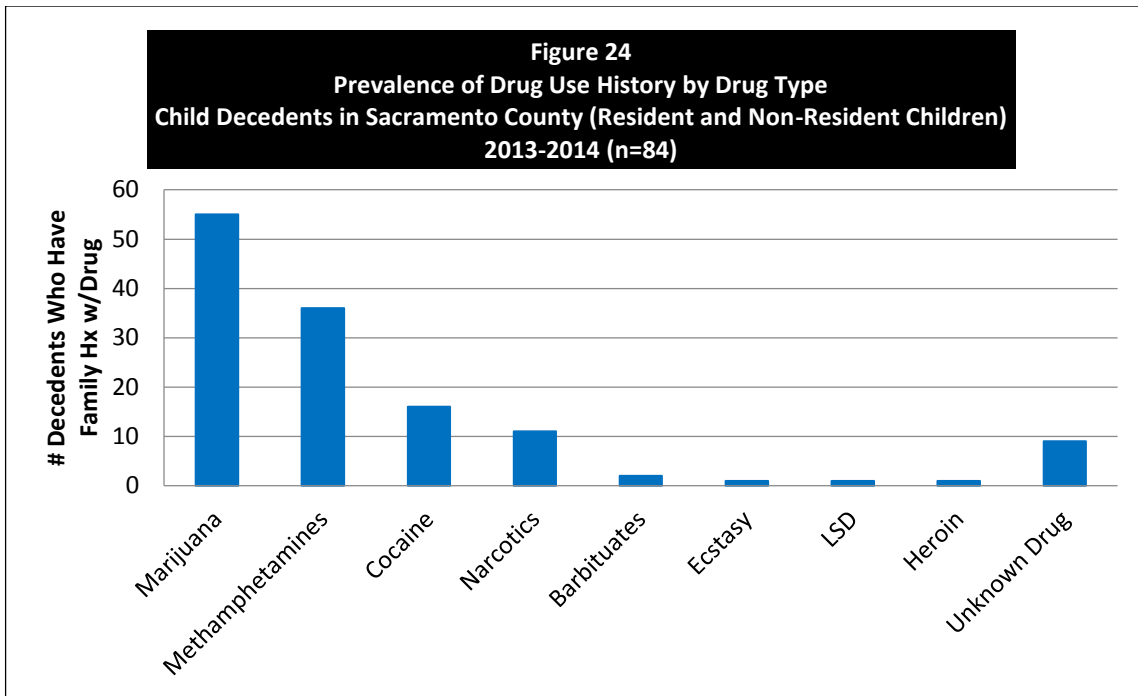
*Population aid data from the California Department of Social Services and the California Department of Health Care Services

Substance Abuse

In 2013-2014, 40% (105 of 265) of all child deaths had a known history of illegal drug use or alcohol abuse in the child's family. Of these deaths, 11% (29 of 265) involved illegal drugs or alcohol at the time of death.

Among Sacramento County child decedents in 2013-2014, 32% (84 of 261) had a family history of illegal drug use. The most commonly used drug was marijuana, which was present in 63% (53 of 84) of families involving illegal drug use. The next most common drug was methamphetamine, present in 43% (36 of 84) of families, followed by cocaine, present in 19% (16 of 84) of families. Note that some families had histories with multiple illicit drugs so total may add up to more than one hundred percent. Figure 24 shows the prevalence of specific illegal drugs present in the family histories of Sacramento County child deaths in 2013-2014.

¹³ California Department of Health Care Services, 2013 data and California Department of Social Services, 2013 data



When looking at both the frequency of drug use and the types of drugs involved, there is variation across different categories of death. The highest frequency of drug use occurs among drowning victims. Of the seven drowning victims in 2013-2014, 57% (4 of 7) of these decedents had a family history of illegal drug use. The most common drugs used by families of drowning victims were marijuana and methamphetamines, which were each used by 29% (2 of 7) of such families.

The next highest frequency of drug use occurred among families of suicide victims. Of the 11 suicide victims in 2013-2014, 55% (6 of 11) of these decedents had a family history of illegal drug use. The most common drugs used by families of suicide victims was marijuana, which was used by 36% (4 of 11) of such families. Methamphetamines were the next most common drug among families of suicide victims, and was used by 18% (2 of 11) of such families. Note that some families had histories with multiple illicit drugs so total may add up to more than one hundred percent.

The third highest frequency of drug use occurs among families of CAN homicide victims, with 50% (8 of 16) of these decedents having a family history of illegal drug use. The most common drugs used by such families were marijuana, used by 63% (5 of 8) of families of CAN homicide victims, methamphetamines, used by 38% (3 of 8) of such families.

Domestic Violence

In 2013-2014, 22% (58 of 265) of all child deaths had a known history of domestic violence in the child's family.

Criminal History

A crime may be categorized as either violent or non-violent. Violent crimes are those in which the offender uses or threatens to use violent force upon the victim, and can be committed with or without

a weapon. Examples of violent crime include robbery, assault, and homicide. Non-violent crimes do not use physical force or cause physical pain. Examples of non-violent crime include prostitution, drug sales, driving under the influence, and burglary. Minor traffic arrests or tickets are not included as non-violent crimes.

In 2013-2014, 45% (119 of 265) of all child deaths involved families with a history of violent and/or non-violent crime. Twenty-four percent (63 of 265) of child deaths had a history of both violent and non-violent crime; 15% (39 of 265) had only a non-violent criminal history; and six percent (17 of 265) had only a violent criminal history.

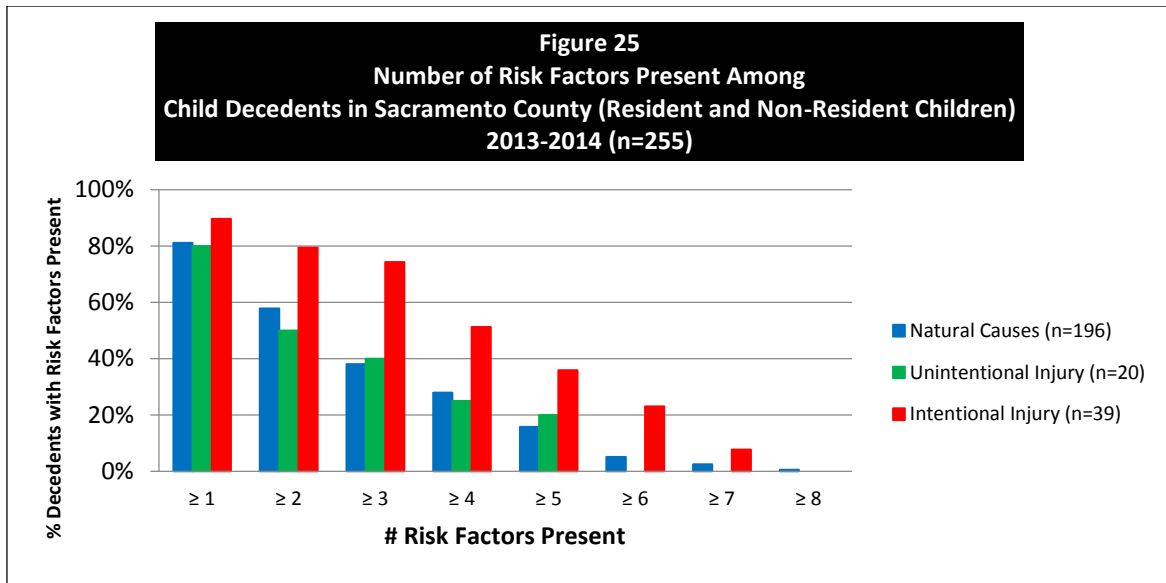
Prevalence of Risk Factors

While it is relevant to note which risk factors are present in the families of child decedents, it's also useful to consider cases in which particularly high-risk families might have multiple risk factors. The data in this report reflects only known risk factor data reported to CDRT; families of decedents may have other risk factors not disclosed and therefore unknown to CDRT.

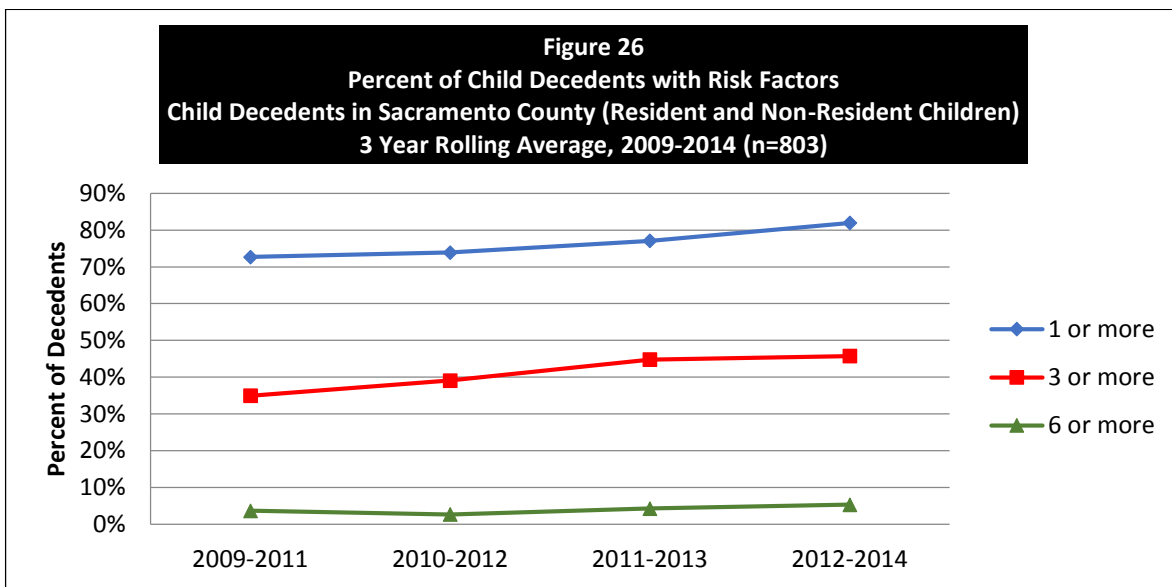
For purposes of assessing the prevalence of multiple risk factors among child decedents, risk factors were combined into categories: family history of CPS involvement; family history of crime; family history of domestic violence; family history of gang involvement; family history of mental health issues; family history of drug or alcohol abuse; family history of foster care; and enrollment in government aid programs at the time of death.

Figure 25 shows the number of risk factors present among child decedents in 2013-2014. Of the 265 child decedents in 2013-2014, 83% (221 of 265) had at least one risk factor present, and 45% (120 of 265) had three or more risk factors present. Among decedents of natural causes, 82% (161 of 196) had at least one risk factor present, while 39% (76 of 196) of decedents had three or more risk factors present. Among decedents of unintentional injury-related deaths, 80% (16 of 20) of decedents had at least one risk factor present, while 40% (8 of 20) had three or more risk factors present. Among decedents of intentional injury-related deaths, 90% (35 of 39) of decedents had at least one risk factor present, while 74% (29 of 39) had three or more risk factors present. Deaths of Undetermined Manner are small in number and are not included in Figure 25.

Among all child decedents in 2013-2014, the mean number of risk factors present was 2.54. Among child decedents of natural causes, the mean number of risk factors present was 2.32. Decedents of unintentional injury-related deaths had a lower mean number of risk factors present, at 2.15, while decedents of intentional injury-related deaths had the highest mean number of risk factors, at 3.62.



Risk Factors are more prevalent in 2013-2014 than in previous years. Figure 26 shows the percentage of decedents with at least one, three and six risk factors between 2009 and 2014. The number of decedents with at least one risk factor has gradually increased over this period from 73% to 82%. The percentage of decedents with at least three risk factors has risen over the period from 35% to 46%, while the percentage of decedents with six or more risk factors has slowly but steadily risen since 2007 from four percent to five percent.



The increase in risk factors appears across various death categories but is concentrated in infant sleep-related deaths. Figure 27 shows the average number of risk factors among decedents overall and for infant sleep-related deaths, other natural deaths and injury related deaths between 2009 and 2014.

While the average number of risk factors for all child deaths increased by .6 from 1.9 in the 2009-2011 period to 2.5 in 2012-2014, the average number of risk factors for infant sleep-related deaths increased by 1.5 from 2.1 to 3.6, the average number of risk factors for other natural deaths

increased by .2 from 2.0 to 2.2, and the average number of risk factors for injury related deaths increased by .3 from 2.7 to 3.0.

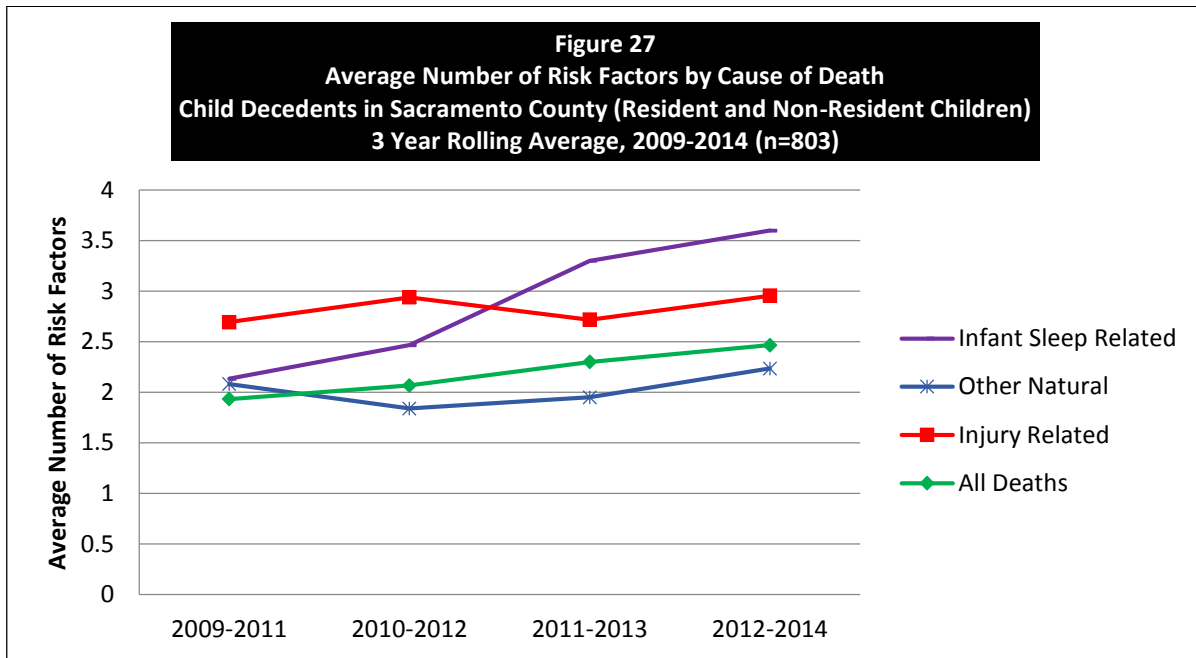
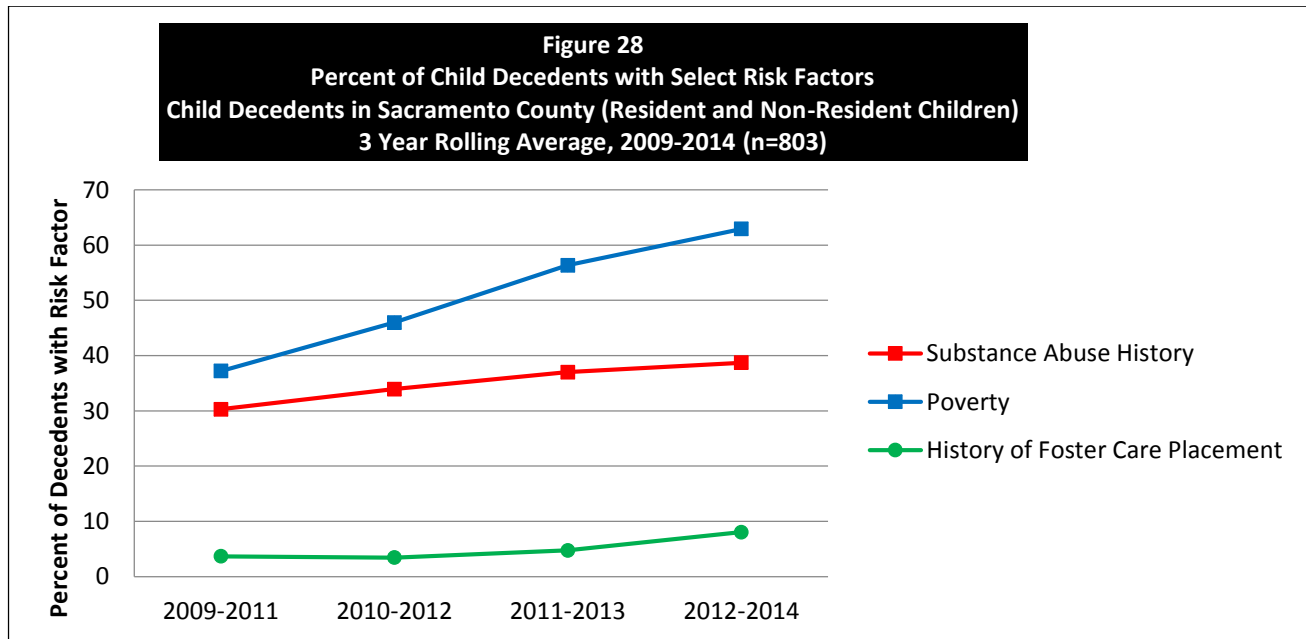


Figure 28 shows the percentage of decedents with specific risk factors over the six year period. Poverty has risen most dramatically over this period from 37% to 63% of decedents, while substance abuse history in the family increased from 30% to 39%. The proportion of decedents with a history of foster care in the family also grew over the period from 3.7% to eight percent.



Youth Deaths

Of the total 265 child deaths in Sacramento County in 2013-2014, 56 child deaths occurred in youth between 10 and 17 years of age comprising 21% of all child deaths. Twenty-five (45%) of the 56 deaths were due to natural causes, 30 (54%) were injury-related, and 1 (2%) was an injury of undetermined manner. Of the 56 youth deaths, 38 (68%) were male and 18 (32%) were female. Twenty-two youth were Caucasian, 11 youth were African American, 10 youth were Hispanic, five were Asian/Pacific Islander, seven were multiracial, and one was another race.

Risk factors were known to be present in 80% (45 of 56) of youth deaths and are as follows:

- ❖ 57% (32 of 56) of decedents had families who were receiving government aid at the time of death.
- ❖ 46% (26 of 56) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 34% (19 of 56) of decedents had involvement with Sacramento County Child Protective Services:
 - 15 decedents had a CPS case or referral open and closed more than 6 months prior to the time of death
 - 3 decedents had CPS involvement at the time of death.
 - 1 decedent had a case or referral open and closed within 6 months of the time of death.
 - ❖ 21% (12 of 56) of decedents had a sibling who had involvement with Sacramento County CPS:
 - 9 decedents had a CPS case or referral closed prior to the time of death
 - 3 decedents had siblings with an open case or referral at the time of death.
 - ❖ 2% (1 of 56) of decedents had a parent who had involvement with Sacramento County CPS as a child.
- ❖ 43% (24 of 56) of decedents had a family history of violent or non-violent crime.
- ❖ 39% (22 of 56) of decedents had a family history of drug and/or alcohol abuse.
- ❖ 18% (10 of 56) of decedents had a family history of domestic violence.
- ❖ 14% (8 of 56) of decedents had a family history of mental health issues.

Natural Youth Deaths

Of the 25 youth deaths due to natural causes in 2013-2014, eleven (44%) were due to cancer, ten (40%) were due to congenital anomalies, three (12%) were due to other natural causes. Fourteen of the 25 were male and eleven were female, and one (4%) was due to perinatal conditions. Eleven of the youth were Caucasian, four each were African American and Hispanic, three were Asian/Pacific Islander, two were multiracial and one was another race.

Known risk factors were present in 21 of the 25 (84%) youth deaths due to natural causes in 2013-2014 and are as follows:

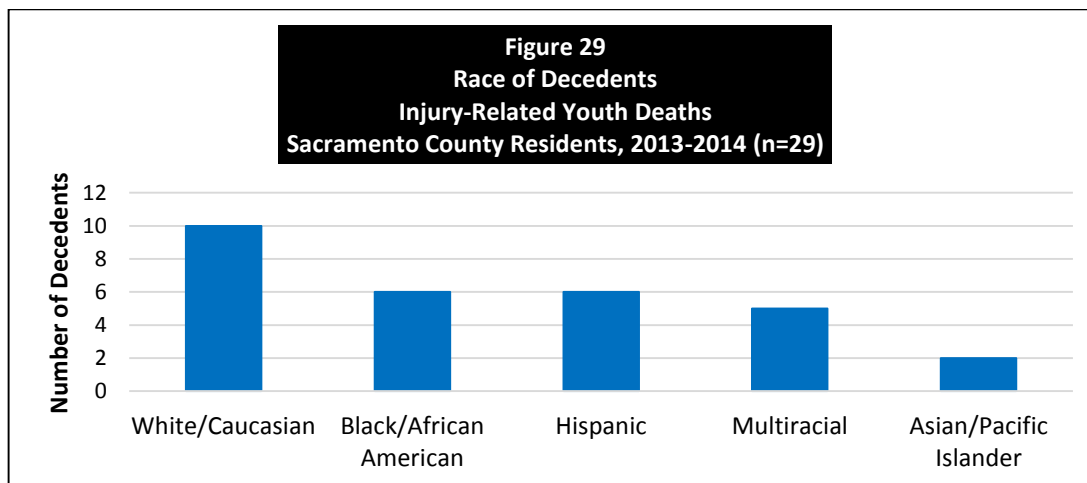
- ❖ 68% (17 of 25) of decedents lived in families who received government aid at the time of death.
- ❖ 48% (12 of 25) of decedents had a history of CPS involvement in the family.
- ❖ 32% (8 of 25) of decedents had parents with a history of violent and/or non-violent crime.
- ❖ 24% (6 of 25) of decedents had parents with a history of alcohol and/or illegal drug abuse.

Injury-Related Youth Deaths

This section of the report summarizes the findings by the Youth Death Review Subcommittee (YDRS) of the CDRT of youth injury-related deaths between 10 and 17 years of age among Sacramento County residents in 2013-2014. The YDRS further explores the death of each Sacramento County resident child between 10 and 17 years of age who died of an injury-related cause. 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.

There were a total of 29 injury-related youth deaths comprising 52% of all youth deaths in 2013-2014. The mechanism of death in the 29 injury-related youth deaths included: twelve involving firearms (eight third-party homicides and four suicides), ten motor vehicle injuries (including two third-party homicides, and one suicide), five hangings (suicides), one suicide on train tracks and one drowning.

Of the 29 injury-related youth deaths in 2013-2014, 22 were male and 7 were female. Ten decedents were Caucasian, six were African American, six were Hispanic, two were Asian, and five were Multiracial. One decedent was 10 years of age, three were 11, one was 12, two were 14, nine were 15, six were 16, and seven decedents were 17 years of age. Figure 29 shows the race of each youth injury-related decedent, while Figure 30 shows their ages.



YDRS findings indicate that 79% (23 of 29) of the injury-related youth deaths occurred in youth 15 to 17 years of age and 76% (22 of 29) of all youth injury-related deaths were of male decedents.

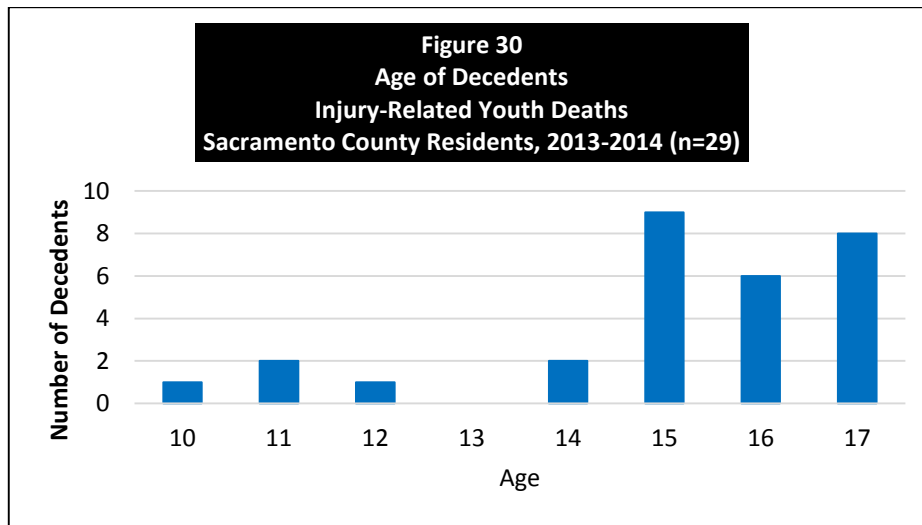


Table H provides a summary of the cause and manner of all injury-related youth deaths from 2007 through 2014. Deaths due to an MVC are further broken down into collisions involving driver/occupants, pedestrians, and bicycles.

Table H
Injury Related Youth Deaths
Sacramento County Residents
2007-2014 (n=136)

Category	2007	2008	2009	2010	2011	2012	2013	2014	Total	Percent
Injury-Related Causes										
Third-Party Homicide	7	3	3	8	4	5	6	4	40	29%
MVC (Total)	13	6	5	1	1	2	5	2	35	26%
<i>MVC (Driver/Occupant)</i>	8	4	2	0	0	0	3	0	17	12%
<i>MVC (Pedestrian)</i>	5	2	1	1	0	0	2	2	13	9%
<i>MVC (Bike)</i>	0	0	2	0	1	2	0	0	5	4%
Suicide	4	6	2	4	3	3	6	5	33	24%
Drowning	4	2	2	0	0	3	1	0	12	9%
Poisoning/ Overdose	2	1	1	1	0	0	0	0	5	4%
Other-Injuries	1	2	0	0	1	0	0	0	4	3%
CAN Homicide	0	1	0	1	1	0	0	0	3	3%
Legal Intervention	0	0	0	0	1	1	0	0	2	1%
Suffocation/Choking	1	0	0	0	0	0	0	0	1	1%
Burn/Fires	1	0	0	0	0	0	0	0	1	1%
Total Injury-Related Causes	33	21	13	15	11	14	18	11	136	

Risk Factors / Family Environment

Risk factors were known to be present in 52% (15 of 29) of injury-related youth deaths in 2013-2014 and are as follows:

- ❖ 69% (20 of 29) of decedents had a known family criminal history. Of these:
 - 100% (20 of 20) of decedents had parents with a criminal history.
 - 90% (18 of 20) of decedents had parents with a non-violent criminal history.
 - 50% (10 of 20) of decedents had parents with a violent criminal history.
 - 40% (8 of 20) of decedents had a criminal history themselves.
 - 35% (7 of 20) of decedents had a non-violent criminal history.
 - 15% (3 of 20) of decedents had a violent criminal history.

- ❖ 58% (14 of 24 for which school history is known) of decedents had known disciplinary concerns at school.

- ❖ 55% (16 of 29) of decedents had a family history of alcohol abuse or illegal drug use. Of these:
 - 50% (8 of 16) of decedents had a history of alcohol abuse or illegal drug use themselves.
 - 75% (12 of 16) of decedents had parents with a history of alcohol abuse or illegal drug use.

- ❖ 55% (16 of 29) of decedents were involved with or had a family history of involvement with Sacramento County Child Protective Services.
 - ❖ 81% (13 of 16) of decedents had involvement with Sacramento County Child Protective Services:
 - 2 decedents had CPS involvement at the time of death.
 - 1 decedents had a case or referral open and closed within 6 months of the time of death.
 - 10 decedents had a CPS case or referral open and closed more than 6 months prior to the time of death
 - ❖ 44% (7 of 16) of decedents had a sibling who had involvement with Sacramento County CPS:
 - No decedents had siblings with an open case or referral at the time of death.
 - 7 decedents had a CPS case or referral closed prior to the time of death
 - ❖ 6% (1 of 16) of decedents had a parent who had involvement with Sacramento County CPS as a child.

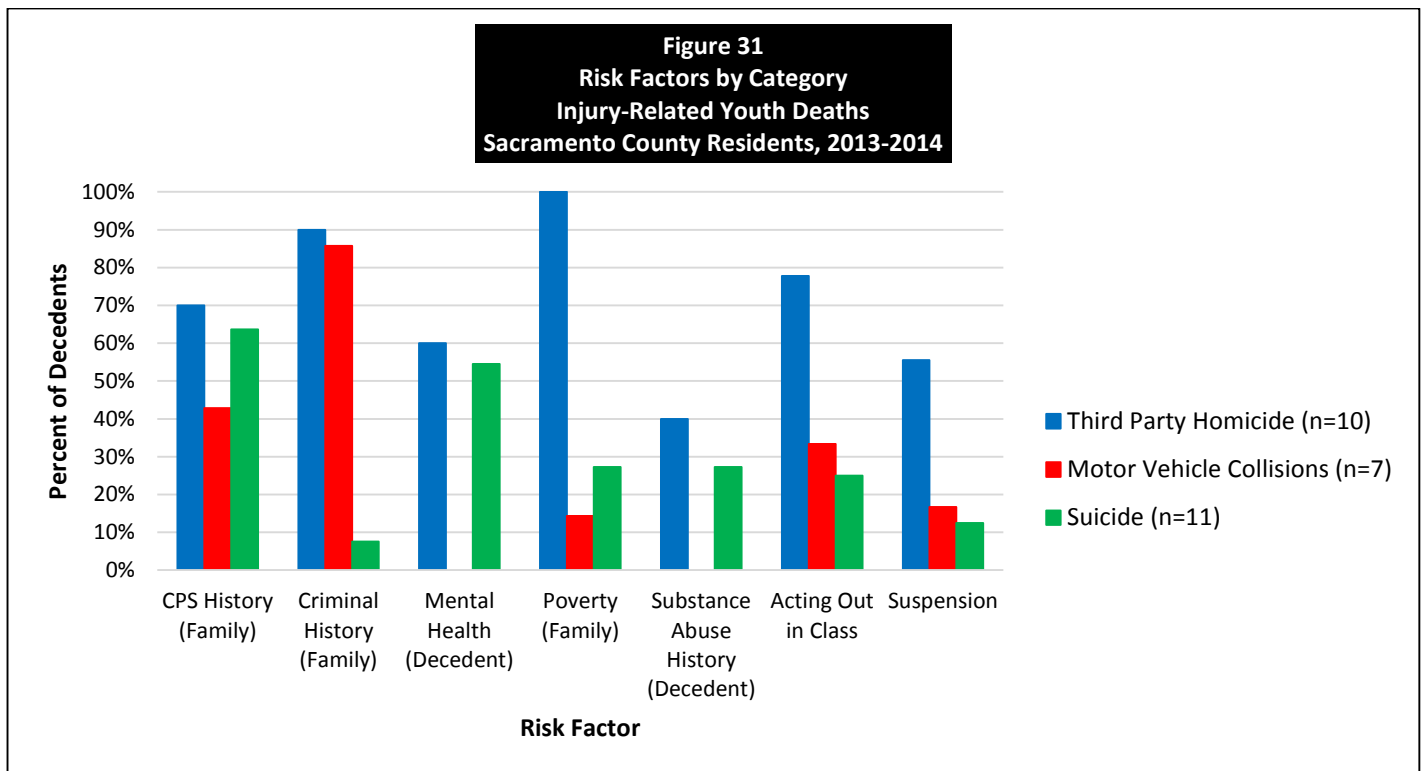
- ❖ 52% (15 of 29) of decedents had families enrolled in government aid programs at the time of death.

- ❖ 45% (13 of 29) of decedents had a family history of mental health issues. Of these:
 - 100% (13 of 13) of decedents had mental health issues themselves.
 - 8% (1 of 13) of decedents had parents with mental health issues.

- ❖ 41% (12 of 29) died of a fatal wound from a firearm.

- ❖ 24% (7 of 29) of decedents had a family history of gang involvement. Of these:
 - 86% (6 of 7) of decedents had a history of gang involvement themselves.
 - 14% (1 of 7) of decedents had parents with a history of gang involvement.
- ❖ 24% (7 of 29) of decedents had a family history of domestic violence.

Figure 31 shows the leading risk factors among injury related youth decedents by type of death. Third-party homicide victims most often receive government aid, have a history of crime in the family, or act out in class. Decedents from Motor Vehicle Collisions are likely to have a criminal record in the family or a history of CPS involvement. Suicide victims most commonly have a history of CPS involvement or mental health issues.



Suicides in Youth

Suicides comprised 11 (38%) of the 29 injury-related youth deaths in 2013-2014. Eight decedents were male and three were female. The method of death for five suicides was hanging, four involved a firearm, one decedent walked into traffic and one laid on railroad tracks. Six decedents were Caucasian, one decedent was African American and one was Asian/Pacific Islander. Three decedents were multiracial.

Known risk factors were present in 10 of the 11 (91%) suicide youth deaths and follows:

- ❖ 73% (8 of 11) decedents displayed known warning signs, including talking about or threatening suicide, self-harm, previous attempts, and notes.

- ❖ 64% (7 of 11) decedents had a history of CPS involvement in the family.
- ❖ 55% (6 of 11) decedents had a history of substance abuse in the family.
- ❖ 55% (6 of 11) decedents had a prior mental health history.
- ❖ 18% (2 of 11) decedents had a history of domestic violence in the home.

Third-Party Youth Homicides

Third-party youth homicides comprised 10 of the 29 (34%) injury-related deaths. Of the 10 third-party homicides in 2013-2014, one youth was 11 years of age (10%), two were 14 years of age (20%), three were 15 years of age (30%), one was 16 years of age (10%), and three were 17 years of age (30%). Seven victims were male and three were female. Five victims were Hispanic, two were African American, two were White, and one was Asian/Pacific Islander. A firearm was involved in 80% (8 of 10) of the deaths.

Known risk factors were present in all 10 (100%) third-party youth homicides and follows:

- ❖ 100% (10 of 10) decedents lived in families who received government aid at the time of death.
- ❖ 90% (9 of 10) decedents had a criminal history in the family.
- ❖ 70% (7 of 10) decedent had a history CPS involvement in the family.
- ❖ 50% (5 of 10) decedent had a history of domestic violence in the home.
- ❖ 50% (5 of 10) of third-party homicides were perpetrated by gang members. Three of these decedents were known to be gang members, one had a sibling in a gang, and one had no gang association.
- ❖ 40% (4 of 10) decedent had a history of illegal drug abuse.

Motor Vehicle Collision (MVC) Youth Deaths

Motor vehicle collisions (MVC's) comprised seven (24%) of the 29 injury-related youth deaths. Four decedents were male and three were female. Of the seven MVC youth deaths, two were White, two were African American, one was Hispanic, and two were multiracial. Of the seven MVC youth deaths, two were drivers, one was an occupant, and four were pedestrians. There were no bicyclists killed in motor vehicle collisions in 2013-2014.

Known risk-factors were present in all seven (100%) motor vehicle collision youth deaths and are as follows:

- ❖ 100% (3 of 3) driver/occupants were in vehicles being driven recklessly.
- ❖ 100% (4 of 4) pedestrians were walking unsafely:
 - 2 were walking on roadways or in front of light rail trains with ear buds in both ears.
 - 2 were dodging or playing traffic with cars or light rail trains.
- ❖ 86% (6 of 7) decedents had a criminal history in the family.
- ❖ 43% (3 of 7) decedents had a personal history of Sacramento CPS involvement.

Other Injury-Related Causes of Youth Death

The remaining youth death was a drowning. The decedent was swimming in the river with no life jacket prior to death.

Chapter IV

The Sacramento County Child Death Review Team

Chapter Five

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 (CAPC) to develop and coordinate an interagency team that would 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, then 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, then 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 differed from that used by most other teams in existence at the time. Typically, other large county teams focused exclusively on suspicious Child Abuse and Neglect homicides or reviewed the deaths of a limited number of children in a narrow range of ages. The Sacramento team remains unique in that it is one of the only large-county models that reviews the deaths of all children from birth through 17 years of age.

Now, the Sacramento County CDRT serves as a model to replicate for other California counties and states. The Sacramento County CDRT has been included in national studies highlighting CDRT best practices. In 2009, the United States Government Accountability Office (GAO) conducted an analysis of national child abuse and neglect data, including the challenges states face in collecting and reporting information on child fatalities from maltreatment to the Department of Health and Human Services. As part of this process, the GAO conducted a visit to Sacramento County's CDRT and other state's child fatality review teams. In 2011, the Children's Bureau Office on Child Abuse and Neglect funded a study on Child Death Review teams to examine recommendations, their implementation, and the impact on reducing child deaths. Sacramento County was visited to gain an understanding of the influence and impact of our CDRT.

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 investigations 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 preventing and responding to child deaths based on the reviews and statistical information.

Membership

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

California Highway Patrol

Child Abuse Prevention Council of Sacramento

Kaiser Permanente

Mercy San Juan Medical Center

Sacramento County Metropolitan Fire Department

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 Health – Sutter Medical Foundation

University of California Davis Medical Center

Lists of Sacramento County Child Death Review Team 2013-2014 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 from 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 child abuse and 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 each ongoing investigation is reviewed monthly and additional informational 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 Undetermined. In those cases where the cause of death is due to a natural disease process, the manner is listed, usually, as “Natural.” Injury-related deaths generally fall into one of the following three categories: “Accident,” “Suicide,” or “Homicide.”

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

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

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

Report Strengths and Limitations

Better identification of child abuse and neglect deaths is the primary mission of the Child Death Review Team (CDRT). During the review process, the team focuses on any suspicious circumstances surrounding the death of a child. Because of the involvement of multiple agencies, the team is able to generate information that helps to clarify otherwise limited evidence of abuse and neglect. 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- and neglect-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- and neglect-related deaths in Sacramento County can be provided by a Child Death Review Team report than the information provided by the death certificates filed with the State.

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

Unfortunately, comparisons between Sacramento County and other jurisdictions are difficult. At the present time, there is no uniformity across 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 Child Abuse and Neglect-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 I
Number of natural child deaths according to category
1995 to 2014
Sacramento County*

Category	Year																	Total			
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011		2012	2013	2014
Perinatal Conditions	21	42	52	48	40	42	48	56	43	62	71	65	63	50	53	39	54	42	33	44	968
Congenital Anomalies	25	19	30	27	27	33	32	39	32	31	28	29	38	30	27	37	35	25	30	31	605
SIDS	18	21	20	19	18	18	18	15	10	3	5	3	9	6	5	3	3	9	0	2	205
SUIDS	--	--	--	--	--	--	--	--	--	--	--	--	5	15	8	13	8	12	13	8	82
Cancer	6	9	5	10	10	15	5	10	11	10	9	9	15	8	13	11	9	8	7	9	189
Infections	4	7	3	4	6	8	10	6	2	10	5	8	3	5	9	0	1	1	7	3	102
Respiratory	7	9	8	4	1	3	0	2	0	1	1	2	0	3	2	2	1	0	2	1	49
Other	17	15	12	4	11	16	8	2	7	6	2	3	6	6	4	6	1	2	2	3	133
Undetermined (Natural)	0	4	1	1	5	3	0	0	2	0	0	0	0	1	1	0	1	2	0	1	22
Total Natural Causes	98	126	131	117	118	138	121	130	107	123	121	119	139	124	122	111	113	101	94	102	2346

* 2014 is the eighth year during which SUIDS (Sudden Unexpected Infant Death Syndrome) deaths were differentiated from SIDS (Sudden Infant Death Syndrome) deaths for the Annual CDRT

Table J
Number of injury-related child deaths according to category
1995 to 2014
Sacramento County Residents

Category	Year														Total						
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008		2009	2010	2011	2012	2013	2014
Homicides	20	16	23	11	16	10	16	11	9	15	17	16	12	16	9	11	8	13	15	9	264
CAN Homicide	(9)	(9)	(14)	(7)	(13)	(6)	(9)	(4)	(1)	(4)	(8)	(7)	(3)	(11)	(6)	(3)	(4)	(4)	(8)	(4)	(134)
Third -Party Homicide	(11)	(7)	(9)	(4)	(3)	(4)	(7)	(7)	(8)	(11)	(9)	(9)	(9)	(5)	(3)	(8)	(4)	(9)	(7)	(5)	(138)
Motor Vehicle Collisions	23	19	17	11	11	14	21	13	14	10	8	11	13	6	5	3	4	3	5	2	213
MVC (Driver/ Occupant)	(12)	(15)	(10)	(7)	(4)	(8)	(10)	(11)	(8)	(5)	(3)	(6)	(7)	(4)	(1)	(1)	(0)	(0)	(3)	(0)	(113)
MVC (Pedestrian)	(8)	(2)	(7)	(1)	(5)	(5)	(8)	(1)	(5)	(4)	(4)	(3)	(6)	(2)	(2)	(2)	(3)	(1)	(2)	(2)	(73)
MVC (Bike)	(3)	(2)	(0)	(3)	(2)	(1)	(3)	(1)	(1)	(1)	(1)	(2)	(0)	(0)	(2)	(0)	(1)	(2)	(0)	(0)	(25)
Drowning	4	4	6	7	6	5	5	9	4	7	5	12	7	4	6	4	4	8	2	5	114
Suicide	3	4	5	8	0	6	5	7	4	4	8	1	4	6	2	4	3	3	6	5	88
Suffocation/ Choking	0	2	4	2	1	1	3	1	1	0	2	3	1	1	0	1	0	4	0	1	28
Fires	0	3	5	4	0	0	1	1	1	0	1	2	5	0	0	0	0	0	0	0	23
Other	3	0	5	1	1	1	8	4	2	6	1	6	1	3	0	1	1	1	5	0	50
Undetermined (Injury)	4	3	0	2	1	0	1	2	1	1	0	0	0	0	0	0	1	0	0	0	16
Poisoning/ Overdose	--	--	--	--	--	--	--	--	--	--	--	2	2	1	2	1	0	0	0	0	8
Legal Intervention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	2
Total Injury-Related Causes	57	51	65	46	36	37	60	48	36	43	42	53	45	37	24	25	22	33	33	22	811
Undetermined Manner	0	4	2	2	3	4	8	6	10	10	4	12	8	2	5	2	3	3	2	8	103

Table K
Child Deaths by Age Group, 2013-2014
Sacramento County Resident Child Deaths Only
2013-2014

Category	Infant	1-4	5-9	10-14	15-17	Total
Perinatal Conditions	74	1	1	0	1	77
Congenital Anomalies	41	10	0	5	5	61
SUIDS	21	0	0	0	0	21
SIDS	2	0	0	0	0	2
Cancer	2	1	2	6	5	16
Infections	5	5	0	0	0	10
Respiratory	1	1	1	0	0	3
Other -Natural	0	1	1	1	2	5
Undetermined -Natural	1	0	0	0	0	1
CAN Homicide	6	5	1	0	0	12
Third-Party Homicide	1	0	1	3	7	12
MVA Occupant/Driver	0	0	0	0	3	3
MVA Pedestrian	0	0	0	1	3	4
Drowning	0	6	0	0	1	7
Suicide	0	0	0	2	9	11
Suffocation	1	0	0	0	0	1
Other –Injury	0	2	3	0	0	5
Undetermined Manner	5	3	1	0	1	10
TOTAL	160	35	11	18	37	261

Table L
Child Deaths by Race/Ethnicity and Age Group, 2013-2014
Sacramento County Resident Child Deaths Only

Race Classification	Infant	1-4	5-9	10-14	15-17	Total
Caucasian	34	6	2	5	17	64
African American	41	9	1	2	8	61
Hispanic	28	6	2	4	6	46
Multiracial	24	8	4	5	2	43
Asian/ Pacific Islander	21	3	1	2	3	30
Other	12	2	1	0	1	16
Total	160	34	11	18	37	260

**Note: Race for one decedent age 1-4 is unknown.*

Table M
Child Abuse and Neglect Homicide victims by age 1990 to 2014
Sacramento County Resident Child Deaths Only

Period Covered	Infant	1-4	5-9	10-14	15-17	Total
1990-2000	23	51	19	6	6	105
2001	4	5	0	0	0	9
2002	1	1	1	1	0	4
2003	1	0	0	0	0	1
2004	2	1	1	0	0	4
2005	5	3	0	0	0	8
2006	0	5	1	1	0	7
2007	1	1	1	0	0	3
2008	3	7	0	0	1	11
2009	1	4	1	0	0	6
2010	1	1	0	1	0	3
2011	1	1	1	0	1	4
2012	3	0	1	0	0	4
2013	4	3	1	0	0	8
2014	2	2	0	0	0	4
Total	52	85	27	9	8	181

Table N
Child Abuse and Neglect Homicide victims by race/ethnicity 1990 to 2014
Sacramento County Resident Child Deaths Only

Period Covered	Caucasian	Hispanic	African American	Asian	Other*	Total
1990-2000	46	18	28	10	3	105
2001	5	0	4	0	0	9
2002	2	0	1	0	1	4
2003	0	0	0	1	0	1
2004	0	0	1	0	3	4
2005	3	1	3	1	0	8
2006	2	2	2	0	1	7
2007	0	0	3	0	0	3
2008	1	2	5	3	0	11
2009	2	1	1	0	2	6
2010	0	0	2	1	0	3
2011	2	1	0	1	0	4
2012	2	0	1	1	0	4
2013	1	0	5	1	1	8
2014	1	0	2	0	1	4
Total	67	25	58	19	12	181

* Including children of mixed/multiracial categories.

Table O
Perpetrators of Child Abuse and Neglect (CAN) Homicides 1990 to 2014
Sacramento County Residents*

Perpetrator	1990-2012	2013	2014	Total # of Perpetrators**
Father	48	1	1	50
Mother	48	4	0	52
Both Parents	9	1	2	24
Boyfriend of Mother or Guardian	21	2	1	24
Undetermined	15	0	0	15
Babysitter	5	1	0	6
Stepfather	4	0	0	4
Other Family Member	12	1	0	13
Adoptive/Foster Parent	5	0	0	5
Girlfriend of Father or Guardian	2	0	0	2
Family Friend	4	0	0	4
Total	182	11	6	201

* Table Q 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 P
Child deaths caused by intentional injuries, by mechanism, 1990 to 2014
Sacramento County Child Residents Only*

	Third-Party Homicide	CAN Homicide	Suicide	Total
Firearm	123	26	48	197
Battering/Beating	7	52	0	59
Hanging	0	0	55	55
Shaking/Abusive Head Trauma	0	26	0	26
Suffocation/Strangulation	1	17	1	19
Poisoning/Overdose	0	9	3	12
Stabbing	15	7	0	22
Fire	3	5	0	8
Fall/Jump	0	0	1	1
Undetermined	1	1	0	2
Vehicular	17	4	2	23
Drowning	1	7	0	8
Chronic Neglect	0	15	0	15
Other	1	5	1	7
Undetermined Mechanism	0	1	0	1
Unknown	1	6	0	7
Total	170	181	111	462

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

Table Q
Number of child deaths by Sacramento County zip code*
2000-2014

Zip	Neighborhood	Child Deaths						
		2000-2009	2010	2011	2012	2013	2014	Total
95608	Carmichael	44	3	4	3	5	3	62
95610	Citrus Heights	40	8	1	3	3	2	57
95615	Courtland	1	0	0	0	0	0	1
95621	Citrus Heights	41	1	3	0	3	1	49
95624	Elk Grove	48	4	5	4	1	9	71
95626	Elverta	9	0	2	1	0	0	12
95628	Fair Oaks	28	2	1	0	1	1	33
95630	Folsom	48	1	8	7	1	4	69
95632	Twin Cities/Galt/Herald	21	5	0	3	2	1	32
95638	Herald/Clay	5	1	1	0	0	0	7
95641	Isleton	1	0	0	0	0	0	1
95655	Mather	2	0	1	0	0	0	3
95660	North Highlands	56	4	2	5	4	8	79
95662	Orangevale	22	2	1	0	2	0	27
95670	Rancho Cordova	63	4	4	2	6	9	88
95673	Rio Linda/Robla	27	1	2	0	2	1	33
95683	Rancho Murrieta	4	1	1	0	0	0	6
95690	Walnut Grove	3	0	0	0	0	0	3
95693	Wilton	3	0	1	0	0	0	4
95742	Rancho Cordova	3	3	2	1	1	3	13
95757	Elk Grove	25	4	2	3	3	3	40
95758	Bruceville	65	7	6	4	6	3	91
95763	Folsom	1	0	0	0	0	0	1
95811	Midtown/Dos Rios/ Southern Pacific-Richards	1	0	0	0	0	1	2
95814	Downtown Sacramento	13	0	0	1	0	2	16
95815	North Sacramento	55	4	0	5	5	3	72
95816	Midtown	8	0	1	0	0	1	10
95817	Oak Park/Elmhurst	24	3	2	0	2	4	35
95818	Land Park/ Curtis Park	15	1	3	1	0	0	20
95819	East Sacramento/River Park	16	1	0	1	1	0	19
95820	Fruitridge	91	6	6	5	4	7	119
95821	Town and Country Village	48	2	4	6	8	2	70

Zip	Neighborhood	2000-2009	2010	2011	2012	2013	2014	Total
95822	Meadowview	74	5	5	4	5	2	95
95823	Valley Hi	145	11	12	16	14	13	211
95824	Parkway- South Sacramento	65	7	6	4	4	1	87
95825	Arden-Arcade	45	2	3	3	5	1	59
95826	Perkins/Rosemont	36	1	1	5	3	3	49
95827	Mills/Walsh Station	29	1	2	7	0	2	41
95828	Florin	69	10	7	1	2	7	96
95829	Elder Creek/Vineyard	29	0	3	1	3	1	37
95830	Sacramento (Florin & Sunrise)	1	0	0	0	0	0	1
95831	Pocket/Greenhaven	28	4	8	4	2	0	46
95832	Freeport/Meadowview	18	1	0	4	3	5	31
95833	Arden/Garden	49	8	5	3	4	1	70
95834	Natomas	15	1	3	8	4	2	33
95835	North Natomas	17	3	2	4	2	2	30
95837	Sacramento International Airport	2	0	0	0		0	2
95838	Del Paso Heights/Hagginwood/Robla	73	3	11	4	7	9	107
95841	Foothill Farms	19	2	3	2	6	4	36
95842	Foothill Farms	55	2	3	7	0	2	69
95843	Sacramento/Antelope	44	5	0	2	5	5	61
95864	Arden/Arcade	11	1	0	2	0	0	14
	Unknown**	1	0	0	1	0	1	3
Total	Sacramento County	1656	135	137	137	129	132	2326

* Table S 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 or CDRT was otherwise not able to determine address of decedent.

Table R
Cause of Child Death by Race and Age, Sacramento County Resident Child Deaths
2013-2014

	<i>Infant</i>						<i>1-4</i>						<i>5-9</i>					
	White	Black	Hisp.	Asian	Multi	Other	White	Black	Hisp.	Asian	Multi	Other	White	Black	Hisp.	Asian	Multi	Other
Peri. Cond.	10	16	14	13	12	9						1	1					
Cong. Anom.	13	6	11	7	2	2	1	3	2		3							
SIDS	1	1																
SUIDS	4	11			6													
Cancer	2										1				1		1	
Infections		2	1	1	1		1		2		2							
Respiratory						1				1				1				
Other -Nat.								1								1		
Undet. -Nat.					1													
CAN Hom.	1	5					1	2		1	1							1
Third-Party Hom.			1												1			
MVA Occ/Driver																		
MVA Ped.																		
MVA Bike																		
Drowning							3	2		1								
Suicide																		
Suffocation	1																	
Other -Inj.									1		1		1				1	1
Undet. Inj.																		
Pois/OD																		
Legal Intervention																		
Undet. Manner	2		1		2			1	1			1					1	
TOTAL	34	41	28	21	24	12	6	9	6	3	8	2	2	1	2	1	4	1

Table R (cont.)
Cause of Child Death by Race and Age, Sacramento County Resident Child Deaths
2013-2014

	10-14						15-17						All Children 0-17					
	White	Black	Hisp.	Asian	Multi	Other	White	Black	Hisp.	Asian	Multi	Other	White	Black	Hisp.	Asian	Multi	Other
Peri. Cond.							1						12	16	14	13	12	10
Cong. Anom.	2	1	1	1			3	1				1	19	11	14	8	5	3
SIDS													1	1				
SUIDS													4	11			6	
Cancer	2	1	1		2		2	1	2	1			6	1	4	1	4	
Infections													1	2	3	1	3	
Respiratory													0	1		1		1
Other -Nat.				1			1	1					1	2		2		
Undet. - Nat.																	1	
CAN Hom.													2	7		1	2	
Third-party Hom.	1		2				1	2	3	1			2	2	7	1	0	
MVA Occ/Driver							2				1		2				1	
MVA Ped.					1			2	1					2	1		1	
MVA Bike																		
Drowning								1					3	3		1		
Suicide					2		6	1		1	1		6	1		1	3	
Suffocation													1					
Other - Injury													1		1		2	1
Undet. Injury																		
Pois/OD																		
Legal Intervention																		
Undet. Manner							1						3	1	2		3	1
TOTAL	5	2	4	2	5	0	17	8	6	3	2	1	64	61	46	30	43	16

Appendices

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 investigations 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 preventing and responding to child deaths based on said reviews and statistical information.

MEMBERSHIP

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

I Sacramento County

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

II Department of Health and Human Services

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

III District Attorney's Office

IV Local Hospitals

- A. Kaiser Permanente
- B. Mercy Sacramento/San Juan Dignity Health
- C. Sutter Health – Sutter Medical Foundation
- D. University of California, Davis Medical Center
 - 1. CAARE Unit
 - 2. Pathology

V Other Community Service Agencies

- A. Child Abuse Prevention Council of Sacramento

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

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

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

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

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

STATUTORY AUTHORIZATION

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

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

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

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

TARGET POPULATION

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

MEETINGS

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

GROUND RULES

Members of the CDRT agree to:

Practice timely and regular attendance.

Share all relevant information.

Stay focused and keep all comments on topic.

Listen actively – respect others when they are talking.

Be willing to explore others' basis for conclusions if you do not agree with them. However, question members in a respectful manner and refrain from personal attacks.

Be prepared for case discussion.

Discuss all cases objectively with respect for the deceased, their families, and all agencies involved.

Respect all confidentiality requests the group has agreed to honor.

OFFICERS

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

The duties of the Chair shall be to:

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

The duties of the Vice Chair shall be to:

1. Serve as co-facilitator, and reinforce 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 with 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 will be 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

will 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 that 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 Formation Members

California State Attorney General's Office

Michael Jett
Senior Field Deputy, Crime Prevention Center

Child Abuse Prevention Council of Sacramento, Inc.

Marie Marsh
Executive Director

Sheila Boxley
Child Death Review Team Coordinator

Juvenile Justice Commission

Alison Kishaba
Commission Chairperson

Sacramento City Police Department

Detective Ernie Barsotti

Sacramento County Coroner's Office

Robert Bowers
Chief Deputy Coroner

Sacramento County Department of Health and Human Services

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

Sacramento County Department of Social Services

Sarah Jenkins

Sacramento County District Attorney's Office

Janice Hayes
Deputy District Attorney

Sacramento County Executive's Office

Margaret Tomczak
Children's Commission

Sacramento County Sheriff's Department

Sergeant Harry Machen

University of California Davis Medical Center

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

APPENDIX D

Sacramento County Child Death Review Team 2013-2014 Members

Child Abuse Prevention Council of Sacramento

Stephanie Biegler, Chief Program Officer
Sara Fung, M.S., Director
Gina Roberson, M.S., Associate Director
Susan Richardson, Evaluation Project Manager
Jeff Hemenway, CDRT Project Manager

Department of Health & Human Services

California Children's Services
Mary Jess Wilson, M.D., M.P.H.
Medical Director

Sacramento County Coroner's Office

Kim Gin, Supervising Deputy Coroner
Stephany Fiore, MD, Coroner
Greg Wyatt, Coroner
Jason Tovar, MD

Sutter Health – Sutter Medical Foundation

Angela Vickers, M.D., CDRT Chair, Pediatrician

Department of Health and Human Services

Child Protective Services
Marian Kubiak, M.S.W., CDRT Chair
Julie Zawodny, M.S.W
Susan Anderson, M.S.W
Judy Cooperrider, M.S.W

California Highway Patrol

Elizabeth Dutton
Chad Hertzell

Department of Health and Human Services

Epidemiology and Disease Control
Cassius Lockett, PhD, Epidemiologist
Jamie White, Epidemiology Program Manager
Sheila Villegas

Department of Health and Human Services

Public Health Nursing
Quinn Wells

District Attorney's Office

Anne Marie Schubert., J.D., Supervising Deputy
District Attorney
Mike Blazina, J.D.
Chris Ore, JD

Kaiser Permanente

Carole Jones, R.N., C.C.R.N.
Rebekah Pearson, R.N.
Michele Evans, MD

Law Enforcement Chaplaincy - Sacramento

Frank Russell, Supervising Senior Chaplain
Mindi Russell

Mercy San Juan Hospital/Dignity Health

Wendy Edwards, R.N.
Judi Marschel, BSN, RNC-NIC
Megan Cornwell, RN
Diane Galati, RN
Patti Gale, RN

Sacramento City Fire Department

Keith Gault, Capt.
Trent Waechter

Sacramento City Police Department

Paul Martinson, Sergeant
Rudy Chan, Sergeant

Sacramento County Metropolitan Fire Department

Clayton Elledge, Captain
Jim Johnson

Sacramento County Probation Department

Keith Bays
Karen Dodrill
Pamala Gilyard
Pam Moore
Jill Noble

Sacramento County Sheriff's Department

Jeff Reinl, Sergeant
Brian Shortz, Detective
Janae Galovich, Detective
Todd Hengel, Detective
Drew Wyant, Detective
Aaron Marino, Sergeant

University of California Davis Medical Center

Kevin Coulter, M.D.

APPENDIX E

Sacramento County Child Death Review Team Past Members

Nazia Ali-Prasad
CDRT Coordinator
Child Abuse Prevention Council of Sacramento, Inc.

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
Coroner
Sacramento County Coroner's Office

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

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

Kim Burson
Assistant Coroner/ Investigation
Sacramento County Coroner's Office

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

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

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

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

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

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

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

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

Paul Durenberger
Deputy District Attorney, District Attorney's Office

Phil Ehlert
Sacramento County Coroner's Office

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

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

Fernando Enriquez
Sergeant
Sacramento City Police Department

Earl Evans
Sacramento County Sheriff's Department

Mark Fajardo, M.D.

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

David Ford
Sergeant, SACA Unit
Sacramento City Police Department

Mary Ann Harrison
Department of Social Services

Rich Gardella
Sergeant, Homicide Unit
Sacramento City Police Department

Guy Gates, Detective
Citrus Heights Police Department

Keith Gault
ACLS Coordinator
Sacramento City Fire Department

Jason Gay
Detective
Sacramento County Sheriff's Department

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

Kevin Givens, Detective
Sacramento County Sheriff's Department

James Jay Glass
Paramedic Captain
Sacramento City Fire Department

Mario Guzman
Sergeant
Elk Grove Police Department

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

Max Hartley
California Highway Patrol

Jeff Hemenway
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Child Abuse Prevention Council of Sacramento, Inc.

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Northern California Forensic Pathology

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

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

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

Maynard Johnston, M.D.
Pediatrician
Kaiser Permanente Foundation

Jeff Jones
Chaplain
Law Enforcement Chaplaincy

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Pediatric Specialty Clinic

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Tim Maybee
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Rich Maloney, R.N.
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Debbie Mart
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John McCann, M.D.
Child Protection Center
University of California Davis Medical Center

John McGinness
Homicide Unit
Sacramento County Sheriff's Department

Anthony Medina, Captain
Sacramento City Fire Department

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

Bud Meyers
Child Protective Services
Department of Health and Human Services

Richard Miles
Sacramento County Coroner's Office

John Miller
Sacramento City Fire Department

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

Carol Mims, Detective
Sacramento County Sheriff's Department

Bobby Mitchell
Sergeant, Homicide
Sacramento City Police Department

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

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Sutter Healthcare

Ann Nakamura
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Trauma Nurse Practitioner
Mercy San Juan Hospital

Mindi Russell
Deputy Senior Chaplain
Law Enforcement Chaplaincy

Mike Savage, J.D.
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Robin Shakely, J.D., Deputy District Attorney
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Brian Shortz, Detective
Sacramento County Sheriff's Department

Howard Sihner
District Attorney's Office – Juvenile Division

Sue Simmons, R.N., M.P.V.
Field Nurse
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Andrew Smith, J.D.
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Deborah Stewart, M.D.
University of California Davis Medical Center

Dr. John Stockman
Stockman and Associates

Grant Stomsvick
Detective
Sacramento County Sheriff's Department

Ben Sun, D.V.M., M.P.V.M.
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Mark Super, M.D., CDRT Vice-Chair,
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Ted Voudouris
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Public Health Nursing

Ken Walker
Lieutenant
Sacramento City Police Department

Stephen Wallach
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Phil Whitbeck
Chaplain
Law Enforcement Chaplaincy

Robin Wilkins
Sacramento County Probation Department

Patty Will
School Attendance Review Board
San Juan Unified School District

Victoria Witham
EMT Liaison
Sacramento City Fire Department

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

Greg Wyatt
Deputy Coroner
Sacramento County Coroner's Office

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

Debbie Yip
CWLA Supervisor
Department of Health and Human Services

APPENDIX F

GLOSSARY

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

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

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

Cancers: A tumor disease, the natural course of which is fatal. Cancer cells, unlike benign tumor cells, exhibit the properties of invasion and metastasis and are highly anaplastic.

Cause of Death: Causes of death are coded according to the Tenth Revision of the International Classification of Diseases (ICD - 10). Natural cause and injury (E-Codes) classifications are used.

Child Abuse: Any act of omission or commission that endangers a child's physical or emotional health and development. (PC 11164-11174.3)

Child Abuse and Neglect (CAN) Homicide: A death in which a child is killed, either directly, or indirectly, by their caregiver.

Child Death: A death occurring in a child birth through 17 years of age.

Child Death Review Team (CDRT): An interagency team that investigates child abuse and neglect deaths of children birth through 17 years of age. The ability to establish confidential Child Death Review Teams was provided in 1988 by revisions to the State Penal Code (Section 11166.7) and the State Welfare and Institution Codes (Sections 830 and 10850.1).

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

Child Neglect:

General Neglect: The unwillingness of the parent or caregiver to provide for adequate basic needs, where there is no physical injury or injury is not likely to occur. The failure of a person responsible for a child to supply necessary food, clothing, shelter, or medical, dental or psychiatric care when that person is able to do so or failure to protect the child from imminent and serious danger to his or her physical or mental health. Examples:

- Children not being fed or lacking adequate shelter. Examples include hazardous conditions (exposed wiring, broken glass), unsanitary conditions (garbage, spoiled food, excrement), food unavailable or intentionally withheld.

Severe neglect: The unwillingness of the parent or caregiver to provide for adequate basic needs where there is physical injury or injury is likely to occur, such as: malnutrition, chronic neglect, abandonment, willful endangerment, refusal to seek medical care.

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

Congenital Anomalies: Abnormal intrauterine development of an organ or structure; commonly referred to as "birth defects". Congenital - A condition that exists at birth, and usually before birth, regardless of its causation. Anomalies - Marked deviations from the normal standard, especially as a result of congenital defects. These conditions are acquired during the development of the fetus and are generally attributed to heredity/genetics.

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

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

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

Domestic Abuse: Also called domestic violence, domestic abuse is violence against a spouse, cohabitant, 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.

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

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

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

Failure To Thrive: The abnormal retardation of growth and development of an infant resulting from conditions that interfere with 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 (12 months) of life; includes both neonates and post neonates.

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

Infection: The invasion and multiplication of microorganisms in body tissues. Examples are meningitis and sepsis.

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

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

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

Legal Intervention Death: Death due to injuries inflicted by the police or other law-enforcing agents in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order, and other legal action.

Low Birth Weight: Birth weight below 2500 grams.

Manner of Death: Cause of death as indicated on the death certificate, which includes the following five categories: Natural; Accident; Suicide; Homicide; and Undetermined.

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

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

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

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

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

Natural Deaths (Causes): Death due to complication(s) of disease process, or due immediately to natural cause(s). Examples of natural causes include perinatal conditions, congenital anomalies, cancers, Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Death Syndrome (SUIDS) and deaths due to infections or respiratory conditions.

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

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

- A parent or caregiver driving recklessly with a suspended license when involved in a motor vehicle collision.

Neglect-Related Deaths:

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

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

Prenatal Substance Abuse: Prenatal substance abuse where there is a clear medical link to infant death or death is secondary or known to probable prenatal substance abuse. Examples: Maternal methamphetamine use that causes a premature birth and subsequent death.

- An infant exposed prenatal to cocaine and alcohol that dies from multiple birth defects.

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

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

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

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

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

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

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

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

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

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

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

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

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

Prenatal Substance Abuse-Related Deaths: Deaths 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.

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

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

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

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

Risk Factor: The broad term used to describe a variety of social, economic, and/or demographic circumstances or other elements that may be associated with a higher risk of negative health outcomes for children.

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: A homicide where the perpetrator was not the primary caregiver. Commonly referred to as "third-degree murder," third-party homicide is a killing that resulted from indifference or negligence. Usually there must be a legal duty (parent - child), but can also include crimes like driving drunk and causing a fatal accident.

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

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

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

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

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

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