SACRAMENTO COUNTY
CHILDREN'S COALITION

Appointed by the Sacramento County Board of Supervisors

**Child Protective Systems Oversight Committee**
Tuesday, October 18, 2016 | 4:00 PM to 6:00 PM
Child Abuse Prevention Center
4700 Roseville Rd, North Highlands, CA 95660

MEMBERS

| Present | | Present | | Present | |
|---|---|---|---|---|---|
| X | Alexander, Roy | X | Green, Rebecca | | Stone, Dimitrius |
| X | Bell, Michelle | | Johnston, Maynard (Chair) | X | Uda, Betsy |
| | Claar, Jane | X | Maulfair, Virginia | X | Zone, Sharon |
| X | Edison, Joni | X | Ore, Chris | | |
| X | Felion, Sister Jeanne | | Saika, Tony | | |
| | | | | | |
| X | Powells-Mays, June (Counsel) | | | | |
| X | Nosce, Abigail (Staff) | | | | |

**Call to Order**
Meeting called to order at 4:10 pm. Quorum was established.

**Review Meeting Minutes**
The August and September 2016 meeting minutes were reviewed. **Motion was made by Gini Maulfair, and seconded, to approve the August 2016 meeting minutes and the revised September 2016 meeting minutes. Motion carried.**

**Child Death Review Team (CDRT) 2013-2014 Report**
Child Abuse Prevention Center Chief Program Officer Stephanie Biegler and CDRT Chair Marian Kubiak provided an overview of the Sacramento County CDRT 2013-2014 Report presented at the October 4, 2016 Board of Supervisors (BOS) meeting. (See Attachment A: CDRT 2013-2014 PowerPoint presentation)

- The mission of the CDRT is to: review all child fatalities of Sacramento County children age 0-17; enhance the investigation of all child deaths through multi-agency review; develop an aggregate description of all child deaths to identify cause of death, including abuse/neglect; and develop recommendations for the prevention and response to child deaths based on the reviews and aggregate information.
    - Participants of the CDRT and related committees include representatives from Sacramento County Departments of Health and Human Services (DHHS) and Human Assistance (DHA), Probation Department, Sheriff's Department, District Attorney's Office, Coroner's Office, Law Enforcement Chaplaincy, First 5 Sacramento, Robla, Sacramento City, Twin Rivers, Natomas, Elk Grove and San Juan Unified School Districts, Elk Grove, Sacramento City and Citrus Heights Police Departments, California Highway Patrol, Sacramento Metropolitan Fire District, Sacramento City Fire Department, UC Davis and Mercy San Juan/Dignity Health Medical Centers, Kaiser Permanente, Sutter Health/Sutter Medical Foundation, WellSpace Health, Center for Community Health and Well-Being and WEAVE.
- In 2013-2014, 261 children age 0-17 residing in Sacramento County died (average death rate of 36.4 per 100,000). This is a decrease from 409 children stated in the 2010-2012 CDRT Report (average death rate of 38.1 per 100,000). The total County and non-County resident child decedents in Sacramento was 265.
    - 196 (75%) were natural; 55 (21%) were injury related; 10 (4%) were of undetermined manner

- The leading causes of death were perinatal conditions (77 or 29%), congenital anomalies (61 or 23%), infant sleep-related (28 or 11%), and homicides (28 or 11%).
- 83% (221 of 265) of all child decedents had at least one risk factor. This is an increase from 76% (208 of 275) in 2009-2010.
  - Risk factors tracked include: family history of alcohol and/or other drug abuse, family history of violent and/or non-violent crime, decedent enrolled in government aid programs, decedent or family history involvement with Sacramento County CPS, family history of domestic violence, and family history of mental health issues.
- Child maltreatment was involved in the deaths of 28 children – 16 of which were Child Abuse and Neglect (CAN) homicide.
  - 76% of CAN homicide perpetrators were the parent
  - Risk factors were known to be present in 94% (15 of 16) of CAN homicides
  - The CDRT found a significant correlation between a family history of receiving TANF and CAN homicides, as well as CPS involvement and CAN homicides.

Member Discussion:

- According to the report, there were a total of 11 suicides listed under Injury Related causes of death and 55% (6 of 11) had a history of mental health issues. For the next report, a recommendation is to drill down even further to include the number of children who had a history of psychiatric hospitalization.
- Is there a way to enforce consequences for families with risk factors and who are not utilizing the available resources to decrease these risk factors? A major concern of the Critical Incidents (CI) subcommittee is that there are no consequences for lack of participation.
  - Participation in resource programs is voluntary, however, it can be strongly encouraged and the positive outcomes achieved by participation can be reinforced at various levels and through various points of service.
- What are other community groups doing to address the prevention of child deaths in the Sacramento community?
  - The BOS formed a Blue Ribbon Commission around the disproportionate death rate of African-American children in Sacramento County (23%, or 61 of 261, in 2013-2014). The Reduction of African American Child Deaths (RAACD) project resulted from the Blue Ribbon Commission's recommendations. The project involves multiple County agencies, First 5 Sacramento, the City of Sacramento, large and small community organizations, and seeks to reduce the number of CAN homicides, third party homicides, infant related, and perinatal related deaths in targeted high-risk neighborhoods.
- How do Sacramento County's statistics compare to other county statistics?
  - It is difficult to compare, as other counties do not provide the same level of investigation. There are, however, efforts to provide some standardization across the country, currently.

**Subcommittee Updates**

<u>CI Subcommittee</u>

- The subcommittee is seeing a common theme among cases they review, which are occurrences of children being left in the care of an unsafe or neglectful person while the parent is receiving prolonged treatment or services away from the home. These cases could have been prevented if the service provider would have asked questions about the children in the home and their safety.

<u>Systems Subcommittee</u>

- The subcommittee welcomes its two newest members Rebecca Green and Betsy Uda.

<u>CPS QIC</u>

- No new updates to report.

**Staff Update**

- The December meeting is currently scheduled for December 20, 2016. A proposal was made to reschedule the meeting to December 13, 2016 to accommodate holiday travel plans.
  **A motion was made by Gini Maulfair, and seconded, to approve rescheduling the December meeting to December 13, 2016. Motion carried.**

**2016 Work Plan**

- The committee discussed focus areas and a theme for its 2016 Annual Report to the BOS. The theme will be Sacramento community collaboration on child protection – how it is done now and how it can be improved. This relates to one of the 2015 Annual Report's recommendations to develop a countywide commitment and encourage other agencies to become more aware and responsive to how their decisions impact the safety of children.
- The committee will aim to present its 2016 Annual Report to the BOS prior to the FY 2016-2017 Preliminary Budget hearings in June 2017. Due to the limited amount of meetings available to receive presentations from the various child-serving agencies before the report must be completed, the theme of this year's report will carry into the 2017 Annual Report.
  - The 2016 report will focus on Law Enforcement and County agencies, summarize the project the Oversight Committee is working on, and possibly make preliminary recommendations.
  - The 2017 report will focus on other local government, hospitals and community agencies, provide an overview of the project as a whole, and formulate comprehensive recommendations.
- For the November meeting, representatives from the Sacramento City Police Department and Sacramento County Sheriff's Department will be invited to the meeting to discuss how they respond to instances of child abuse/neglect.
- The Critical Incidents subcommittee will continue to review and report on critical incidents. The Systems subcommittee's work will support the 2016 and 2017 Annual Report Work Plan.

**Announcements**

None.

**Public Comment**

None.

**Meeting adjourned at 6:00pm**

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

Presented to:
Oversight Committee

October 18, 2016

## 25 Years of the Sacramento County Child Death Review Team

**MISSION**

- Review all child fatalities of Sacramento County children birth through 17 years of age.
- Enhance the investigation of all child deaths through multi-agency review.
- Develop an aggregate description of all child deaths to identify cause of death, including abuse/neglect.
- Develop recommendations for the prevention and response to child deaths based on the reviews and aggregate information.

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## 2013-2014 Sacramento County Resident Child Deaths

- 265 child deaths
  - includes 4 deaths of out of county residents who died of injuries sustained in Sacramento County

- 261 Sacramento County Resident Child Deaths
  - 196 (75%) Natural Deaths
  - 55 (21%) Injury-Related Deaths
  - 10 (4%) Deaths of Undetermined Manner

- Child Death Rate = **36.4** per 100,000 children

  2011 -2012 Child Death Rate = 38.1 per 100,000 children

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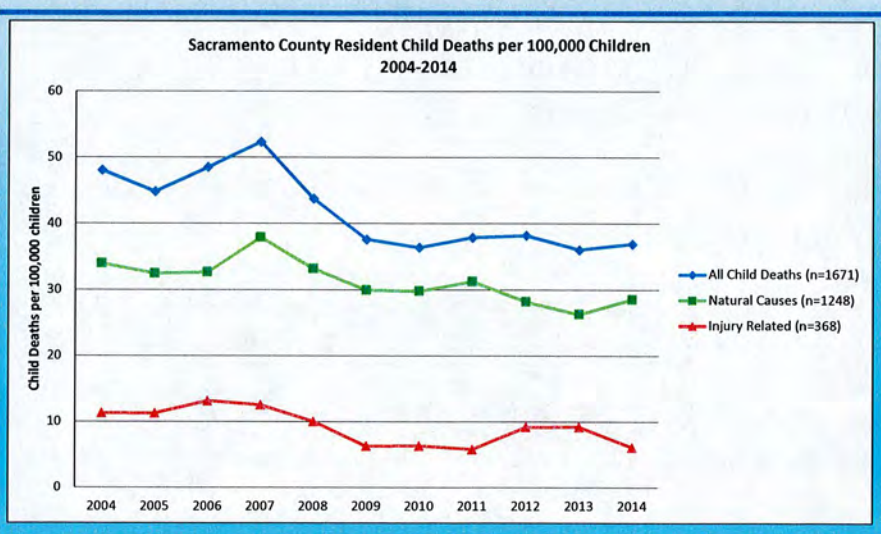
## 2004-2014 Sacramento County Child Death Rates

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## 2013-2014 Leading Causes of All Child Death

- 73% (194 of 265) of child deaths were in four categories:

1. 77 Perinatal Conditions (29%)
2. 61 Congenital Anomalies (23%)
3. 28 Infant Sleep-Related Deaths (11%)
4. 28 Homicides (11%)

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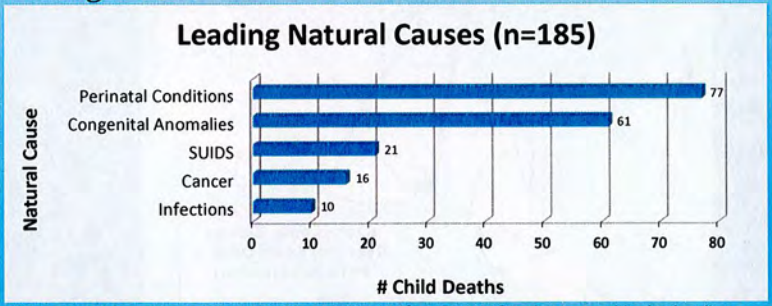
## 2013-2014 Natural Causes

- 74% (196 of 265) of deaths were natural causes
- 8% Decrease from 2011-2012.
- 94% (185 of 196) of natural deaths were in one of five categories.




Note: SUIDS stands for Sudden Unexpected Infant Death Syndrome and is the leading cause of Infant Sleep Related deaths in 2013-2014.

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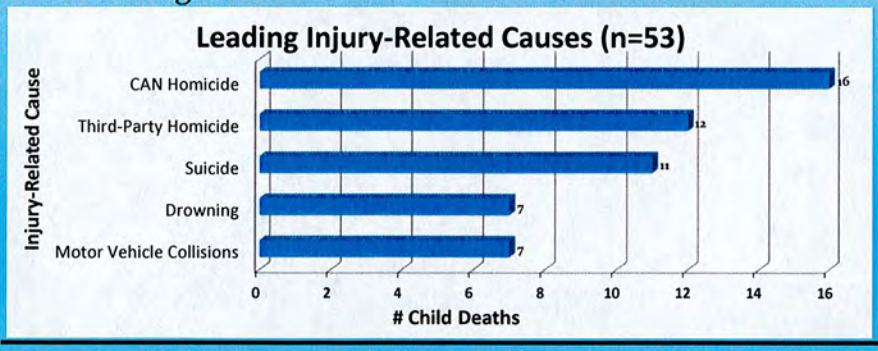
## 2013-2014 Injury-Related Causes

- 22% (59 of 265) of deaths were injury-related
- 7% increase from 2011-2012.
- 90% (53 of 59) of injury-related deaths were in one of five categories.

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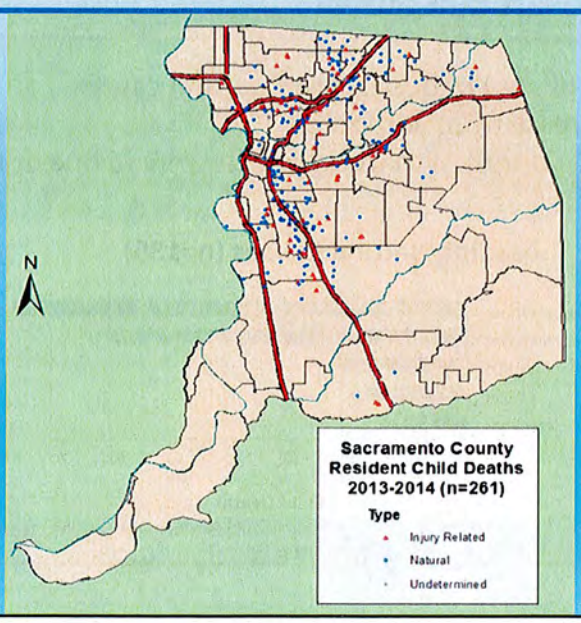
## Geographic Distribution Map 2013-2014 Child Deaths

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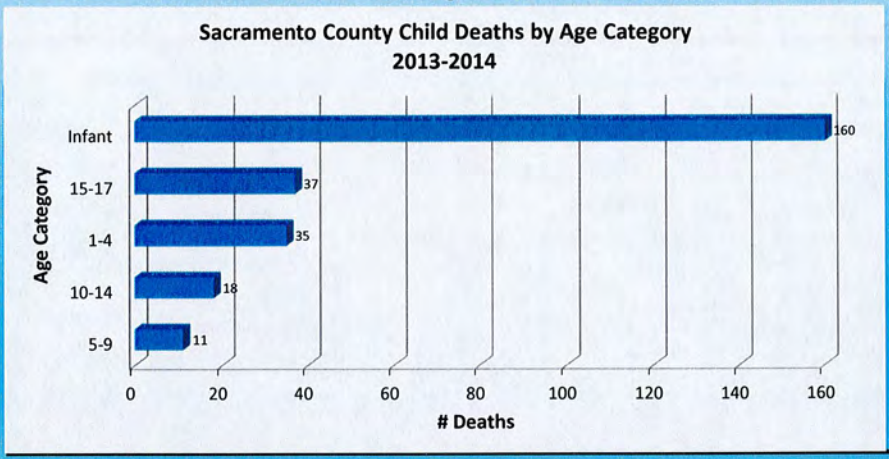
## 2013-2014 Age Demographics

- 261 total Sacramento County resident child deaths.

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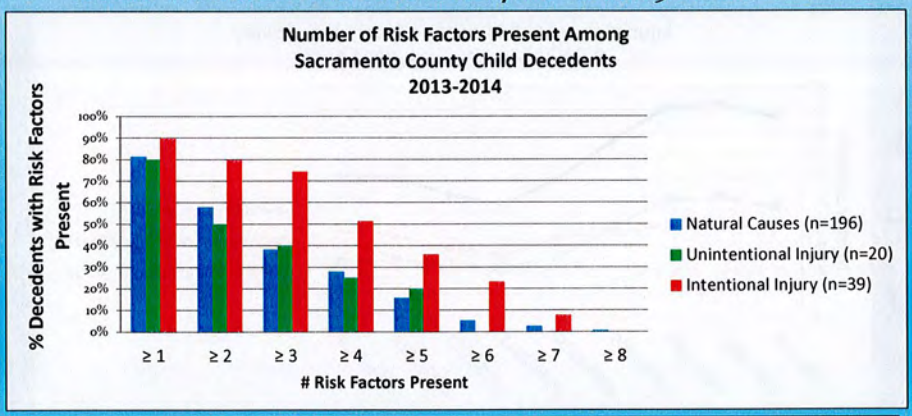
## 2013-2014 Risk Factors

- 83% (221 of 265) of all child decedents had at least one risk factor. This is an increase from 76% in 2009-2010.

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# Child Death Review Team
# 2013-2014 Report

## Sacramento County
## Child Death Review Team
## Findings

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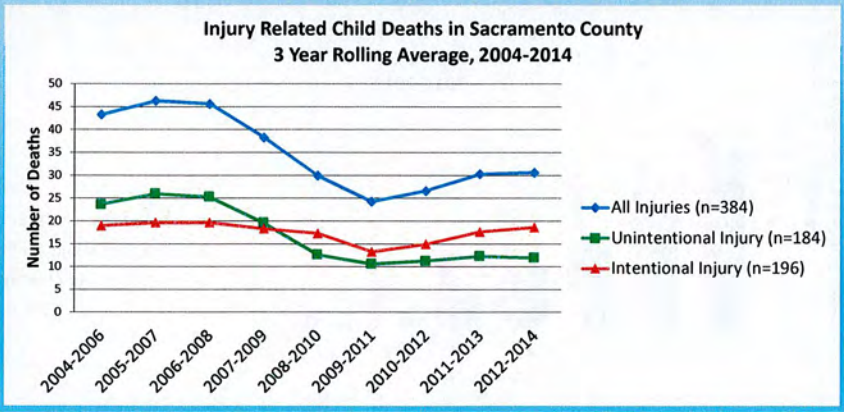
## 2013-2014 Findings
## Injury-Related Deaths

Injury-related deaths increased 7%
from 2011-2012 to 2013-2014

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## 2013-2014 Findings
## Child Abuse and Neglect (CAN) Homicide

- There were 16 CAN homicides
- Rate of CAN homicides increased by 91%
  - 2.1 per 100,000 children between 2013-2014
  - 1.1 per 100,000 children between 2011-2012
- Three-fourths of CAN homicide perpetrators are parents.
  - Thirty-eight percent (6 of 16) of parent perpetrators had a history of CPS referrals or involvement as children.

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## 2013-2014 Findings of all
## Child Abuse and Neglect (CAN) Homicide

Half of the all CAN Homicide decedents (8 of 16) were involved with or had a family involvement with Sacramento County Child Protective Services prior to death.

- 25% (4 of 16) of decedents had history with Sacramento County CPS themselves (referral or case)
- 50% (8 of 16) of decedents had a sibling with Sacramento County CPS history
- 25% (4 of 16) of decedents had a parent with Sacramento County CPS history
- 5 additional decedents had CPS history only in another county

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## 2013-2014 Findings
## Child Abuse and Neglect (CAN) Homicide

- Child Abuse and Neglect (CAN) homicides have statistically significant correlations with the following risk factors:
  - Children with prior Child Protective Services referrals or involvement are 2090% more likely to suffer a CAN homicide than children having no prior Child Protective Services contact, 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, at a 91% confidence level.

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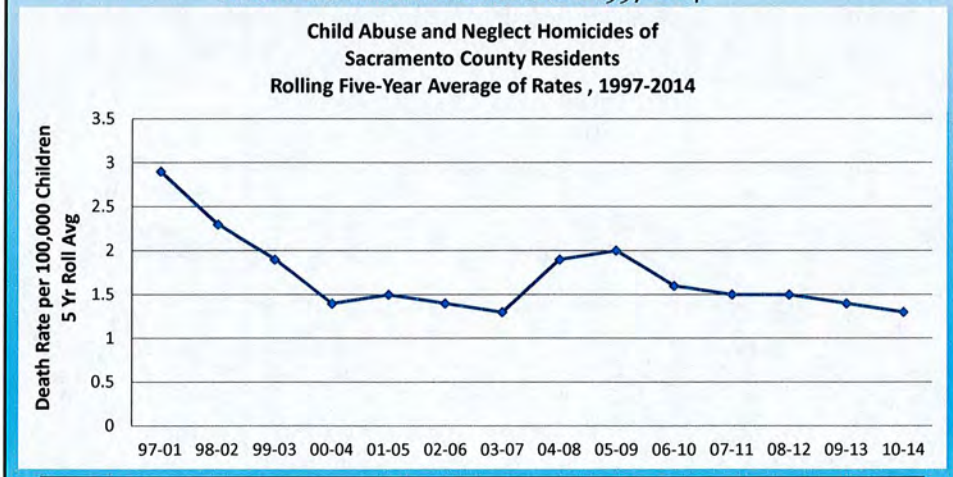
## 2013-2014 Findings
## Child Abuse and Neglect Homicide

Rate of CAN Homicides decreased 1997-2014

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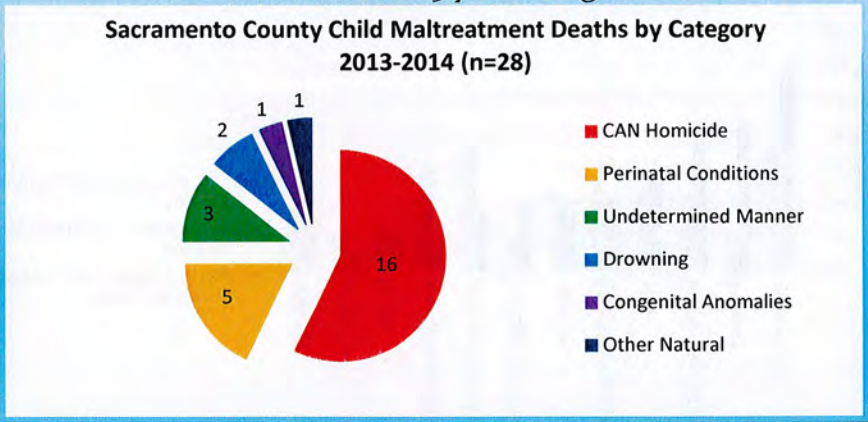
## 2013-2014 Findings
## Child Maltreatment Deaths

89% (25 of 28) of child maltreatment deaths occurred in children 0-5 years of age.

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## 2013-2014 Findings
## African American Child Death Disproportionality

- African American children died at a rate two times higher than that of all children Sacramento County.
  - African American children died at a rate of 82.2 per 100,000 children between 2013-2014, compared to that of all Sacramento County children, who died at a rate of 36.4 per 100,000.
  - African American children comprised 11% of the County child population between 2013-2014, and comprised 23% of all child deaths.

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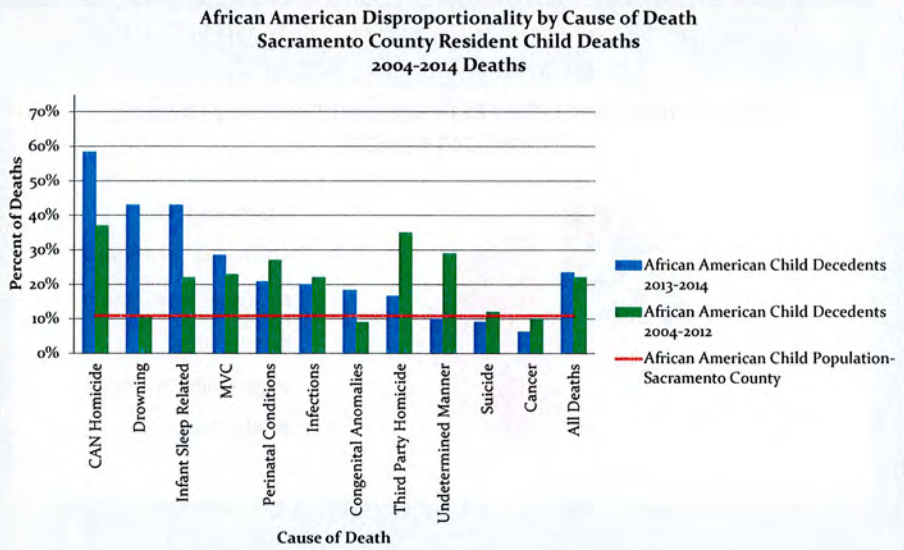
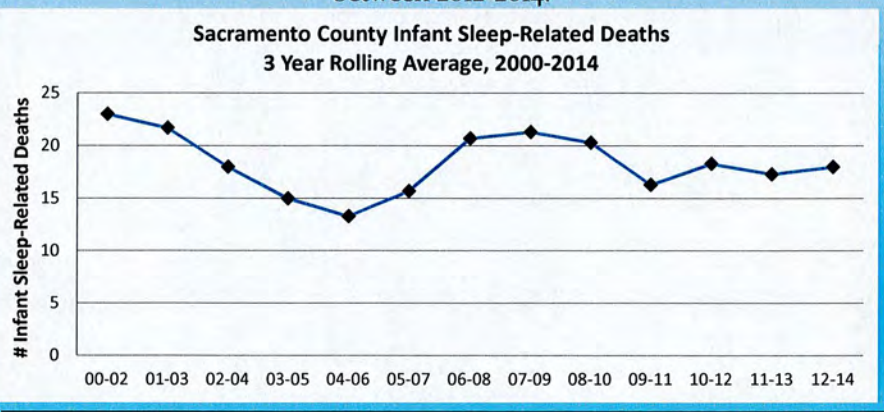
## 2013-2014 Findings
## African American Child Death Disproportionality




## 2013-2014 Findings
## Infant Sleep-Related Deaths

The number of infant sleep-related deaths decreased, from 21.3 per year between 2007-2009 to 18.0 per year between 2012-2014.

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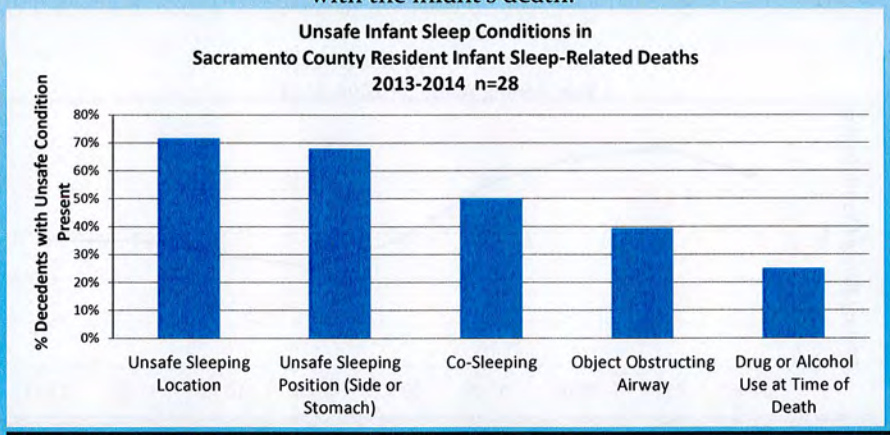
## 2013-2014 Findings
## Infant Sleep-Related Deaths

100% of infant sleep-related deaths had unsafe sleep conditions associated with the infant's death.

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## 2013-2014 Findings
## Infant Sleep-Related Deaths

- Infants with prior Child Protective Services referrals are 2.4 times as likely to suffer an infant sleep-related death.
- A statistically significant correlation at a 99% confidence level based on a chi-squared analysis.
- A statistically significant correlation was found between a history of Child Protective Services referrals and infant sleep-related deaths in neighborhoods with very high economic risk at a 98% confidence level.

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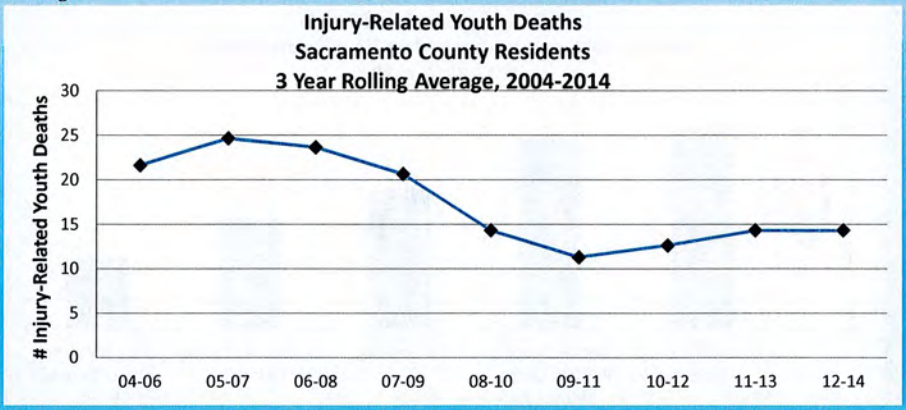
## 2013-2014 Sacramento County Youth Death Findings Ages 10-17

- Injury-related youth deaths among Sacramento County Residents decreased by 42%, from 24.7 per year between 2005-2007 to 14.3 between 2013-2014.
- Three-fourths of injury-related youth deaths occur among children 15-17 years of age.

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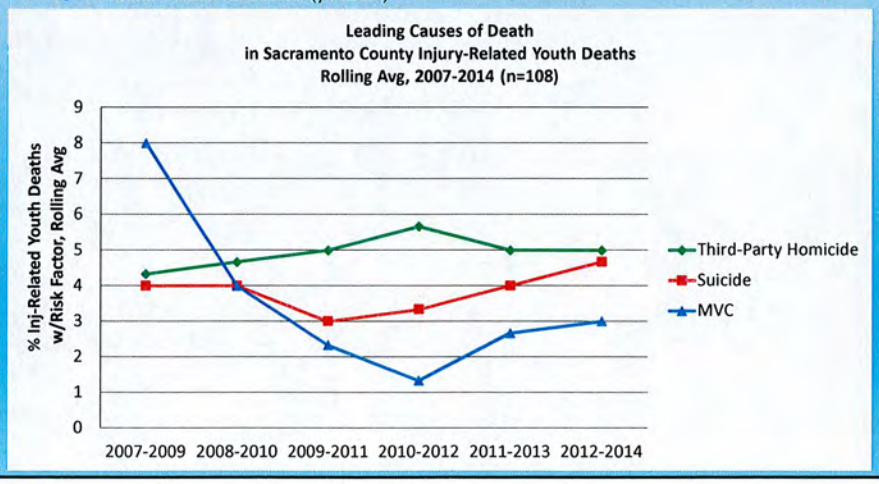
## 2013-2014 Sacramento County Youth Death Findings Ages 10-17

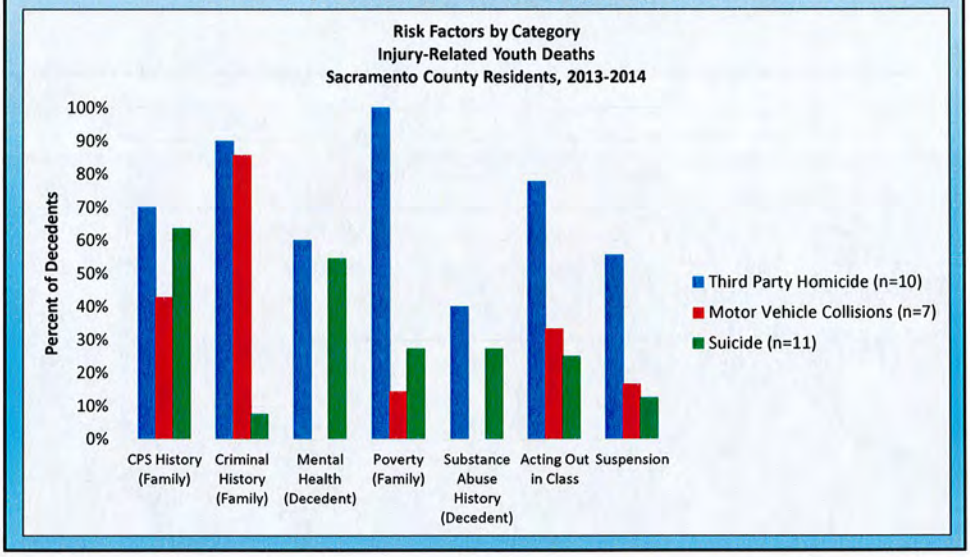
The three leading causes of injury related death among Sacramento County resident youths in 2013-2014 were:

- Suicide (11 deaths)
- Third-party homicide (10 deaths)
- Motor Vehicle Collisions (7 deaths)



## 2013-2014 Sacramento County Youth Death Findings Ages 10-17

Risk factors present in families differ by category of death.




## 2013-2014 Sacramento County Youth Death Findings Ages 10-17

- One-half of all third-party homicide perpetrators in youth deaths were known gang members.
- Firearms were used in more than half of third-party homicides and youth suicides.
- Nearly three-quarters of suicide decedents displayed known warning sign prior to their death.

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Child Death Review Team
2013-2014 Report

Sacramento County
Child Death Review Team
Recommendations

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Recommendations
Coordinating Support and Prevention Services

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.

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## Recommendations
## African American Child Death Disproportionality

Continue the work of the Blue Ribbon Commission, Sacramento County First 5, and the Reduction of African American Child Deaths Steering Committee to implement and monitor targeted, coordinated efforts to reduce the disproportionate African American death rates.

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## Recommendations

### Infant Safe Sleeping

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

### Suicide Prevention Education

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

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## Comments & Questions

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