



Sutter County Child Death Review Team

2001-2005 Five Year Report

By
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Foreword

The very qualities that make children such special beings are also the qualities that can put them at risk of injury or death. Babies are vulnerable and totally dependent upon the adults around them for care and nurturing. Young children are insatiably curious and incredibly quick to explore the world around them, but are not able to foresee that they may be putting themselves in harm's way. Adolescents have a fierce sense of independence and invincibility, yet all too often lack the maturity to temper those feelings with caution. The risks to children change as the child grows and evolves. Parents and caregivers must be aware of these risks and shoulder responsibility for their children's safety. Some risks are just learning experiences. But some end in tragedy for both the child and for the family and friends who must feel the grief and loss.

These are not just theoretical musings. The injuries and deaths with which we as law enforcement, first responders, medical providers, social services, the Child Death Review Team, and other professionals must deal are all too real. Not every illness, injury, or death can be prevented. But we do a terrible disservice to the children and families in our community if we fail to do our best to prevent those that we can. Prevention is far preferable to having to live with the heartbreak of, "If only..."

*Judy Mikesell, RN, BSN, PHN
Coordinator; Co-Chair*

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Sutter Co. Child Death Review Team: Meeting Participants
2001-2005

- *Carl Adams, Sutter County District Attorney*
- *Lou Binninger, Trauma Intervention Program (TIP)*
- *Steve Brock, Bi-County Ambulance*
- *Dave Brockman, Yuba City Fire Department*
- *George Carey, Yuba City Police Department*
- *Art Cheney, Sutter County Fire Department*
- *Rick Cummings, Sutter County Probation*
- *Jim Denney, Sutter County Sheriff*
- *Sharen Dowdall, Child Development Behavioral Specialist*
- *Dick Empy, Sutter County Office of Education*
- *Ed Fischer, Sutter County Human Services- Welfare*
- *Tom Fisher, Rideout Hospital Emergency Department*
- *Frank Gaither, Sutter County Highway Patrol*
- *Shawn Greathouse, Sutter County Sheriff's Department*
- *Deborah Grove, Sutter County District Attorney's Office*
- *Darla Hadrick, Sutter County Sheriff's Department*
- *Lori Harrah, Sutter County Human Services- Welfare*
- *Joan Hoss, Yuba-Sutter Mental Health*
- *Craig Hungrige, Sutter County Sheriff's Department*
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- *Paula Kerns, Sutter County Human Services-CPS*
- *Michael Kinnison, M.D., Sutter County Health Officer*
- *Rob Koopman, Yuba City Police Department*
- *Bob Kruse, Yuba City Unified School District*
- *Jeff Larson, California Highway Patrol*
- *Allan Leavitt, Sutter County Human Services- Public Health*
- *David Marshall, Yuba City Police Department*
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- *Judy Mikesell, Sutter County Human Services- Public Health*
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- *Christine Odom, Sutter County Probation*
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- *Bill Ramsaur, Sutter County Human Services- CPS*
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- *Terry Short, Sutter County Sheriff's Department*
- *Scott Silsbee, California Highway Patrol*
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- *Edmund Smith, Sutter County Human Services*
- *William Smith, Sutter County Public Health Epidemiologist*
- *Jeff Tatro, California Highway Patrol*
- *Jim Ullrey, Sutter County Office of Education*
- *Kerry Vickner, Yuba City Police Department*
- *Joe Walker, Sutter County District Attorney's Office*
- *Katherine Willing, Rideout Hospital Emergency Department*
- *Jana Woodard, Sutter County Human Services-CPS*

EXECUTIVE SUMMARY

The Sutter County Child Death Review Team (CDRT) reviews all deaths of children and adolescents from birth through age 17 that occur within the county, other than natural deaths of newborns in the hospital, if that family resides in another county. The team also reviews deaths of children who are Sutter County residents, even if the death occurs outside the county, since often the dynamics that contribute to the death begin in the home environment, or it is a critically ill or injured child transported to an out-of-county hospital prior to dying.

This report describes the results of CDRT reviews of children aged birth through 17 who died during the first five years since the CDRT was reactivated in 2001. Data breakdowns on these 56 deaths are detailed in this report. This included 22 deaths (39% of the total) due to unintentional (accidental) injuries, 20 (36%) due to natural causes, 8 (14%) due to homicides, and 2 (4%) due to suicides. The exact cause of 4 of the deaths (7%) could not be definitively determined, although 3 were most likely due to unintentional asphyxiation by parent overlay while co-sleeping in an adult bed and 1 was most likely due to natural causes.

At the team's first meeting in 2001, five child deaths from the last half of 2000 were also reviewed. They are not included in graphs in this report, since they were not a full representation of deaths occurring in the year 2000, but are included in the narrative section.

Since a major focus of child death review teams is to try to prevent future child and adolescent deaths, teams attempt to determine if each death was potentially preventable. Of the deaths from 2001-2005, 57% were considered definitely preventable, 13% were possibly preventable, and 30% deemed not preventable. In 4% of the deaths, it was undetermined if it was preventable. The significance is that 70%, did not, or probably did not, need to die.

Five (9%) of the deaths were directly due to child abuse, with three occurring in one incident. Review of the backgrounds of children who died found a history of some form of family violence or neglect in 17(49%) of the 35 cases excluding the "natural" deaths, even though it was not the cause of the death. *The team will continue to look at family dynamics that may put children at higher risk of premature death.*

Recommendations resulting from child death cases included continuing agency and community involvement in prevention events such as the "Every 15 Minutes" drunk driving prevention program for high school students; parenting classes; public and professional education regarding injury prevention issues such as safe driving, child car seat safety; water safety, fire prevention, Shaken Baby Syndrome, and safe sleeping practices for infants; as well as increased awareness regarding the presence of gangs in the community.

Smaller jurisdictions such as ours deal with a statistically small sample of numbers, and variances of just a few cases appear to show major changes. This does not lessen the importance of each case. But it does make it more difficult to draw accurate conclusions from the available data. Some patterns have emerged, however. Motor vehicle crashes comprise the largest segment of unintentional deaths, and in these, certain issues are consistent. Excessive speed was a major factor in 76% of the deaths. The person who died was the passenger rather than the driver in 71%. Additionally, it may take a number of years to show the meaningful results from prevention interventions. As the team continues to review cases in the coming years, it will better be able to identify trends, risks, and successful prevention strategies.

BACKGROUND

Child death review teams (CDRT's) originally formed as a response to the need to better identify child abuse and neglect deaths. While this remains an extremely important component of CDRT's, most teams have expanded their protocols to incorporate the review of all child deaths, with an emphasis on understanding the causes of all avoidable child deaths, whether intentional or unintentional. Since at least ten times as many children die of unintentional injuries as do of intentional injuries, the only way to have a significant impact on reducing child fatalities is to also address unintentional deaths. It has also been learned that even some natural deaths can be prevented (for example, SIDS death rates have been cut in half simply by placing young infants on their backs, rather than on their stomachs, while sleeping).

Analyzing the circumstances surrounding all of these deaths leads to recommendations for possible interventions that can lower the incidence of future similar fatalities. Thorough reviews also allow identification of system changes that may be needed for more effective interagency communication and handling of child deaths.

California passed legislation in 1988 that allowed counties to establish official interagency CDRT's with the legal authority to exchange confidential information relating to child death cases. Penal Code sections 11166.7 – 11166.9, 11167.5, and Welfare and Institutions Code 18951 subdivision (d) cover interagency child death teams and multidisciplinary personnel teams. Core team membership includes representatives from law enforcement, public health, child protective and social services, district attorney's office, schools, first responders, emergency rooms, probation, and mental health. (See Appendix C: Sutter County Child Death Review Team Member Roster.)

Counties are required to submit Fatal Child Abuse and Neglect Surveillance (FCANS) forms to the state if a child's death was due to child abuse or neglect, or if there was any history or suspicion of child abuse or neglect in the child's life. A primary purpose of these forms is to compile a database to help determine how much this type of history increases a child's risk of premature death, even if the death was not directly attributable to abuse or neglect.

In addition to local CDRT's, California enacted legislation to establish the State Child Death Review Council (SCDRC) under the Office of the Attorney General. The state council provides support, technical assistance, and training to local teams. Designated council members represent specific state agencies and professional associations that deal with child fatalities. (See Appendix D: California State Child Death Review Council Member Roster.)

Some valuable resources aid both local CDRT's and the SCDRC. One is the Epidemiology and Prevention for Injury Control Branch (EPIC) of the California Department of Health Services. EPIC provides epidemiological surveillance, professional education and training, data collection, and public information. Others are the National Child Fatality Center (NCFR), established through a grant at the L.A. Interagency Council on Child Abuse & Neglect (ICAN), and the National Center on Child Fatality Review.

SUTTER COUNTY CHILD DEATH REVIEW TEAM

Sutter County reactivated the county Child Death Review Team (CDRT) in 2001. Prior to this time the team had met infrequently because CDRT's historically only reviewed child abuse and neglect deaths, and fortunately these had been rare. An impetus for reactivation was the national emphasis to review child deaths due to all causes, not just abuse and neglect.

The Sutter County CDRT meets quarterly, and consists of representatives from a wide range of agencies that can provide valuable information into the circumstances surrounding each death. Meetings adhere to confidentiality guidelines of multi-disciplinary teams as regulated in the California Penal Code and the Welfare and Institutions Code.

The Public Health Nurse who is the Maternal, Child and Adolescent Health (MCAH) Director from Sutter County Human Services-Public Health is the Coordinator and Co-Chair. A detective from the Sheriff's Department serves as the other Co-Chair. The MCAH Director currently serves as a member of the California State Child Death Review Council at the California Attorney General's Office, as the state MCAH Directors association representative. She also will be serving as 2006 –2007 Co-Chair of the California State Council.

The team reviews deaths of all infants and children from birth through 17 years of age that occur in Sutter County. Excluded are natural deaths of newborns occurring at Fremont Medical Center if the family resides in another county. The team also reviews deaths of children who are residents of the county, even if death occurs elsewhere. It is important to review these cases, since often circumstances contributing to the death begin in the home environment, or the child was injured in Sutter County but is transported to an out-of-county medical facility prior to death. Fetal deaths are not reviewed unless there are extenuating circumstances contributing to the death, such as intentional or unintentional injury to the mother during the pregnancy.

The primary objectives of the review process are to better identify deaths caused by, or related to, child abuse and neglect; to increase knowledge surrounding unintentional deaths and formulate prevention strategies; to analyze trends in county child mortality; and to strengthen interagency communication regarding responses to child deaths.

The team continues to look at strategies that can help prevent future deaths from circumstances similar to those causing deaths that were reviewed. Commonalities of cases and preventability issues are primary areas of focus. Discussions are held regarding "close calls"; situations in which the child averted death, but which could easily have been fatal.

Meetings also serve as a forum where members can share information on any issue pertaining to child deaths, injury and death prevention, or agency functions in regards to child deaths and investigations. This increases the knowledge base of the team and helps all participants better understand the operation of other agencies, as well as any systems issues that may occur.

SUTTER COUNTY CHILD DEATHS 2001-2005

Sutter County Child Death Review Team (CDRT) examined the circumstances of 56 fatalities of children and adolescents from birth through the age of 17 who died from 2001-2005. It must be noted that in smaller counties, where there are statistically small numbers of deaths each year, changes of just a few numbers of cases can appear as dramatic changes in trends, even though those differences may not be statistically significant. The cases reviewed included 22 deaths (39% of the total) due to unintentional (accidental) injuries, 20 (36%) due to natural causes, 8 (14%) due to homicides, and 2 (4%) due to suicides. The exact cause of 4 of the deaths (7%) could not be definitively determined, although 3 were most likely due to unintentional asphyxiation by parent overlay while co-sleeping in an adult bed, and 1 was most likely due to natural causes. There were no deaths due to some of the common causes of childhood and adolescent fatalities, including falls, fire and burns, choking on objects, or young childhood unintentional poisoning.

At the team's first meeting in 2001, five child deaths from the last half of 2000 were also reviewed. These do not appear in the data in this report, since they were not a full representation of deaths occurring in 2000. These included the drowning death of a four year old boy in a pond at an out-of-county golf course; the strangulation murder of a twelve year old Sacramento girl who was abducted there, brought to Sutter County, sexually assaulted and murdered; an unintentional self-inflicted gunshot death of an eleven year old boy; the death of a three month old boy due to birth defects; and the death of a two month old girl due to overwhelming infection complicated by birth defects.

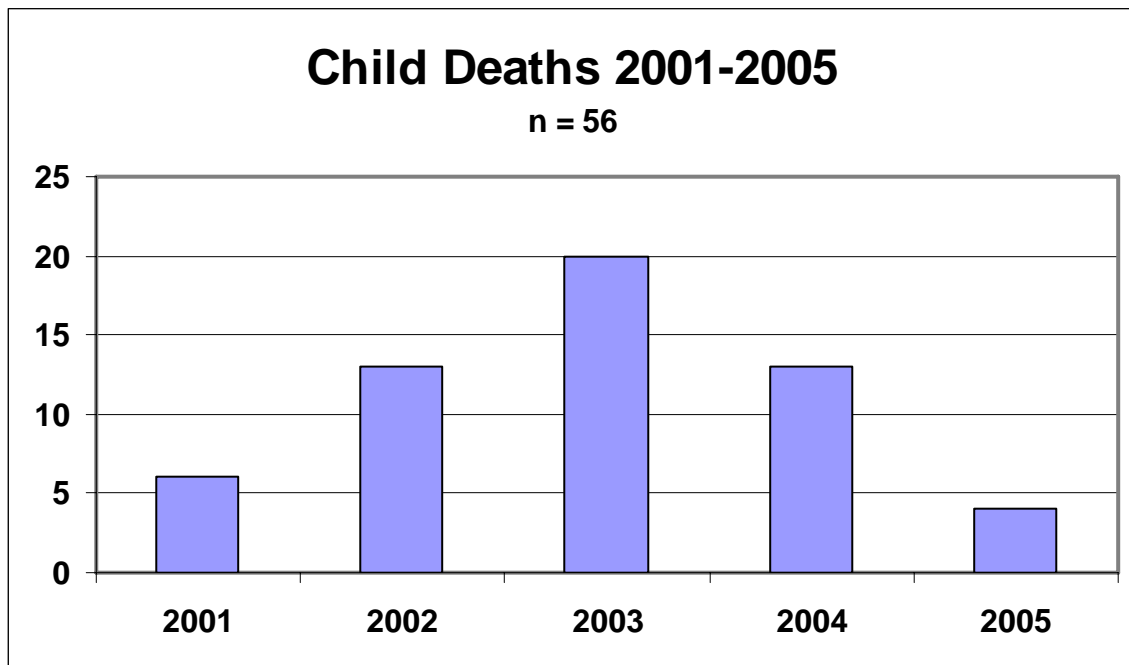
Groupings used in this report are somewhat different than those on the California death certificate. The terms "category" and "mechanism" are used as follows. "Category" refers to the intent or lack of intent of the death, whether intentional (homicide or suicide), unintentional, natural, or undetermined ("could not be determined"). This correlates to the "manner of death" section on the death certificate. "Mechanism" gives more information within each category, and refers to the event leading to the death. For example, the "category" of a death may be "unintentional" but the "mechanism" may be motor vehicle crash, drowning, etc. This report will not go into specific legal "cause" of death as shown on death certificates, since that section delves further into the specific physical condition, such as "asphyxia due to drowning" or "cardiac arrest due organic brain dysfunction". The importance for child death review is to determine what occurrence laid the groundwork for the death.

When looking at categories of death, "natural" includes diseases, birth defects, and other biological conditions. "Unintentional" is replacing the terminology "accidental" in the injury prevention community, meaning that there was no intent to cause the injury or death, but that it was not just a random act over which no potential preventive action could have been taken to keep the injury or death from occurring. However, on California death certificates, the term "Accidental" still serves as the term for that manner of death category.

"Undetermined" and "Could Not be Determined" describe the cause of death and the manner of death, respectively. These terms mean that there was not sufficient physical evidence for the coroner to determine with certainty whether the death was caused intentionally, unintentionally, or was a natural death. In some cases even the cause of death may be undetermined, meaning that even the physical cause of death cannot be definitively determined. The great majority of undetermined deaths are infants under 1 year of age.

NUMBER OF CHILD DEATHS

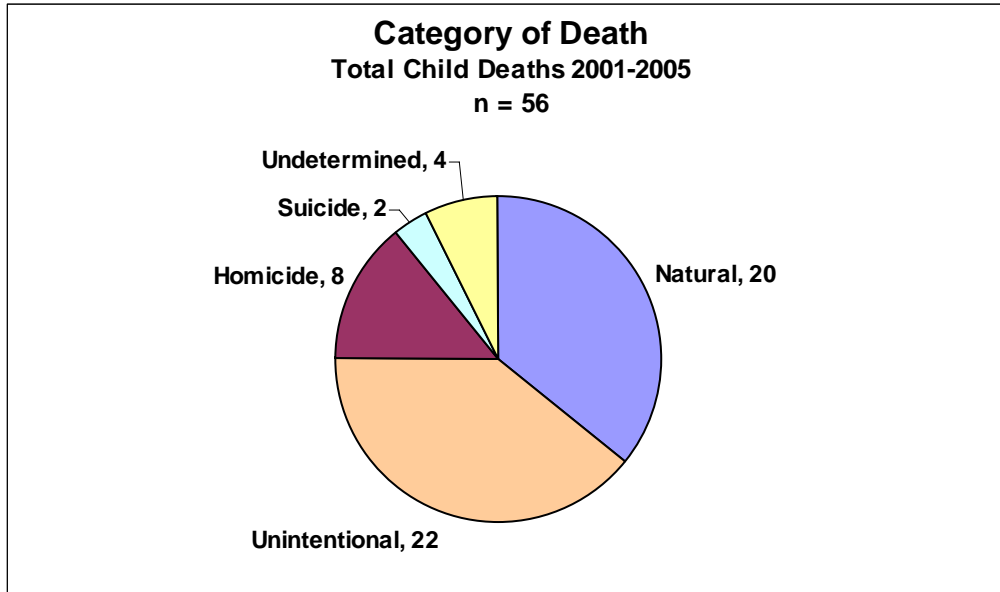
Ages Birth – 17 years
2001-2005



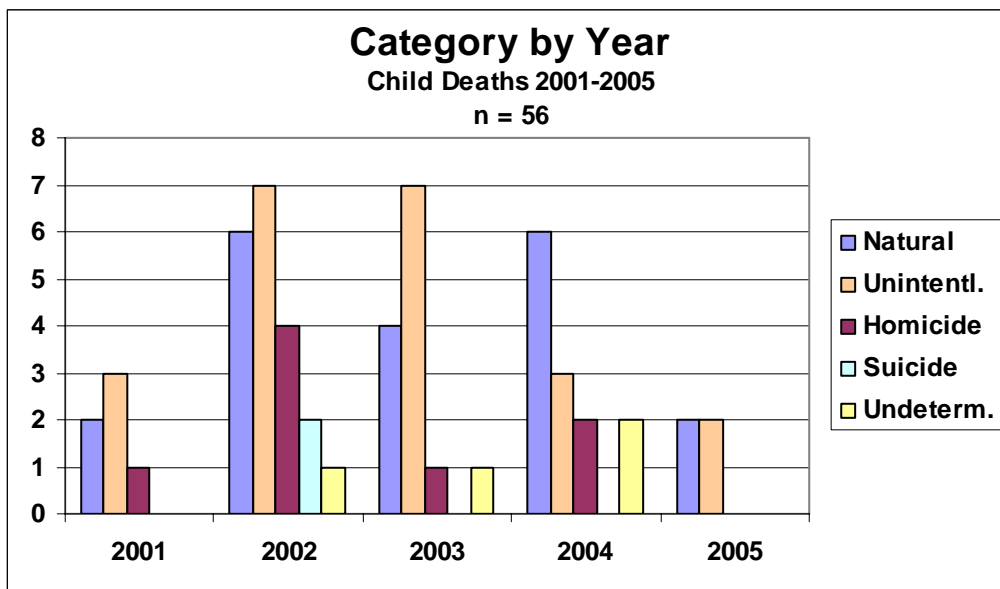
In smaller jurisdictions, such as ours, with statistically small numbers of events, fluctuations of just a few cases can seem as though there is a significant change occurring. Since the CDRT was reactivated in 2001, the team has had as few as four cases, and as many as 20 cases to review in a year. Although it looks as though numbers are dropping considerably, this must be viewed with caution, since as of November 28, 2006 when this report was being completed; there had already been 14 child and adolescent deaths in 2006. Additionally, there was one death in 2006 of a 15 year old that had major birth defects due to intrauterine drug exposure, and had lived in Sutter County until 2 weeks before his death due to these problems. Due to this history, the CDRT reviewed the case, but it was not included in the 14 cases, since he was not living in-county at the time he died.

The following sections give more specific information regarding the types of deaths reviewed.

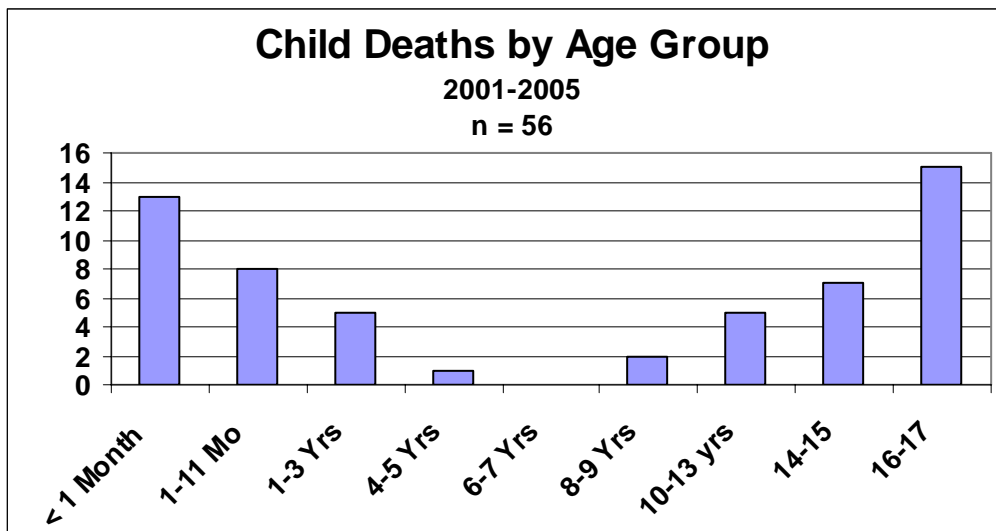
DEATHS BY CATEGORY



CATEGORY OF DEATH BY YEAR

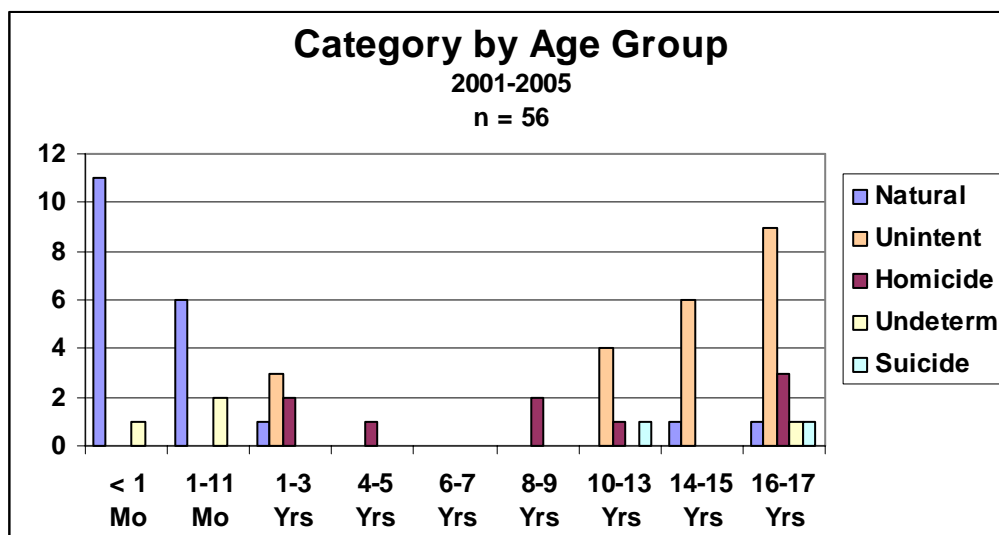


DEATHS BY AGE GROUP



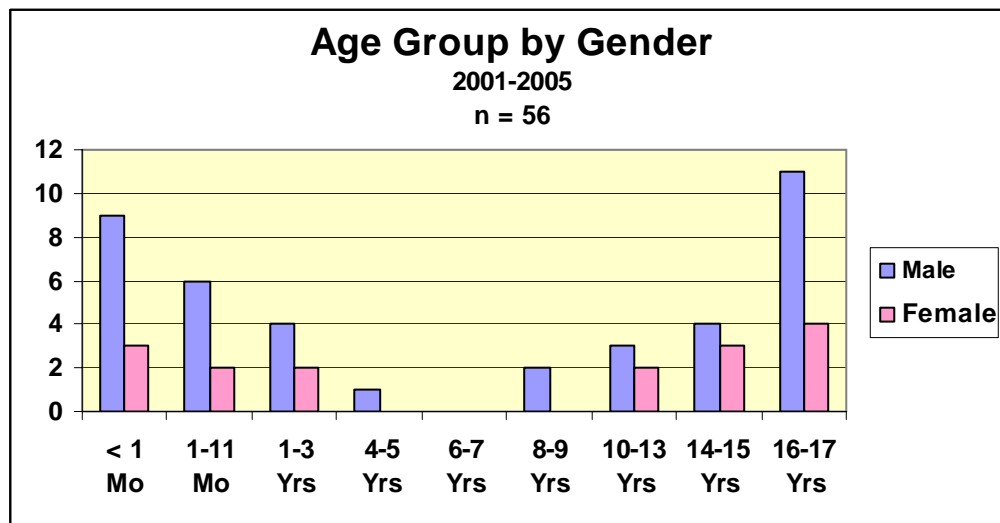
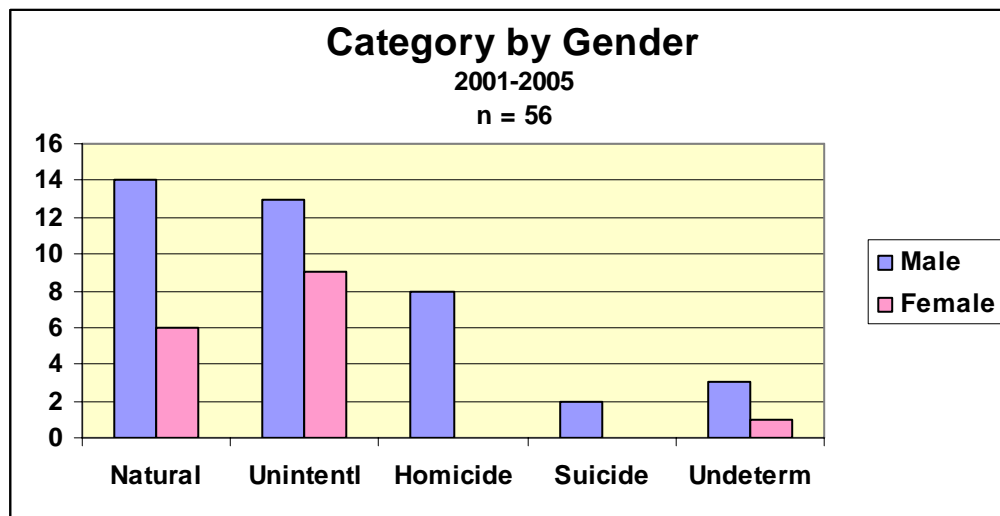
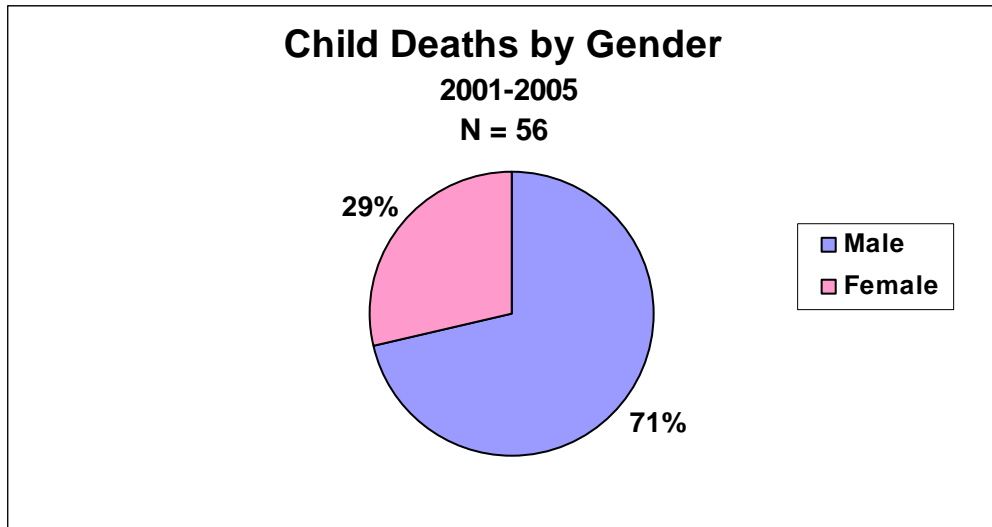
Deaths for children and adolescents do follow some age-related patterns. Generally, the middle years of childhood have the lower numbers of deaths. In fact, in the 5 years of reviews covered by this report, the only deaths between four and 9 years of age were the homicide deaths of three brothers, all committed in the same incident by a parent who came from out of the state the night before the murders. More details are contained in the “Homicide” section of the report.

CATEGORY BY AGE GROUP



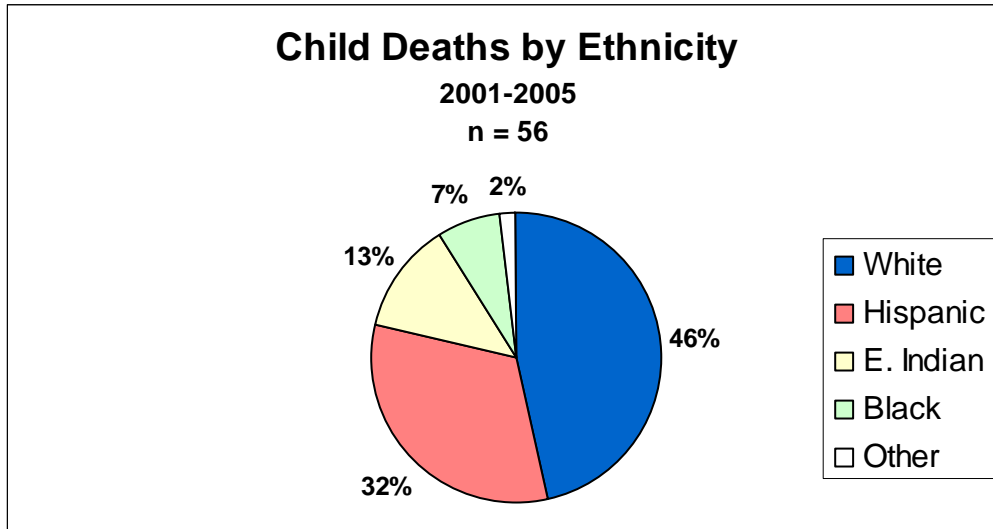
Due to infant, child and adolescent development and behavior, reasons for deaths vary by age group in a fairly predictable fashion. The most common causes of death for infants are prematurity, birth defects and SIDS. At the other end of the spectrum, by far the most common cause of death for adolescents is unintentional injuries, followed by homicide.

DEATHS BY GENDER

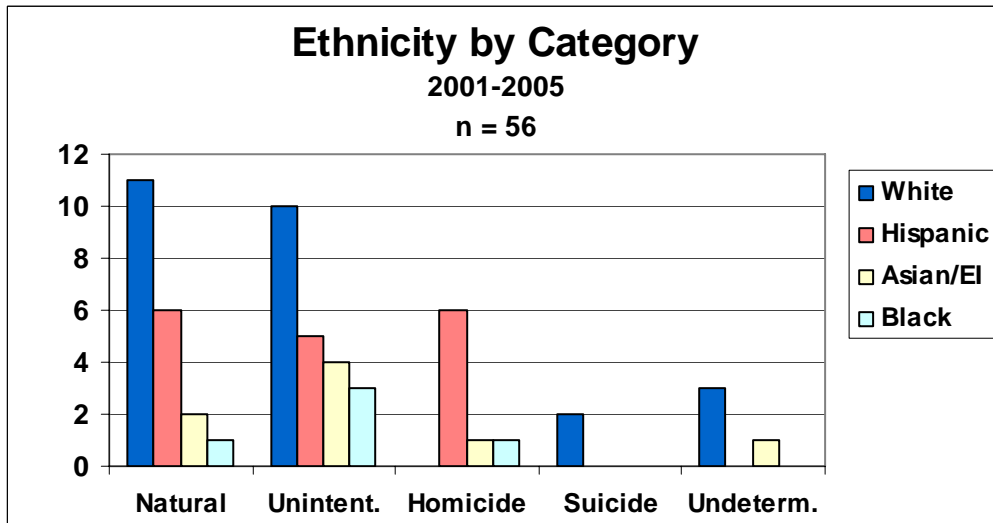


Boys are over-represented in deaths in every age group and category. This pattern holds true on both a local and a national level. Boys have a higher incidence of premature birth, birth defects, and deaths due to homicide, suicide, Shaken Baby Syndrome and unintentional injuries.

ETHNICITY

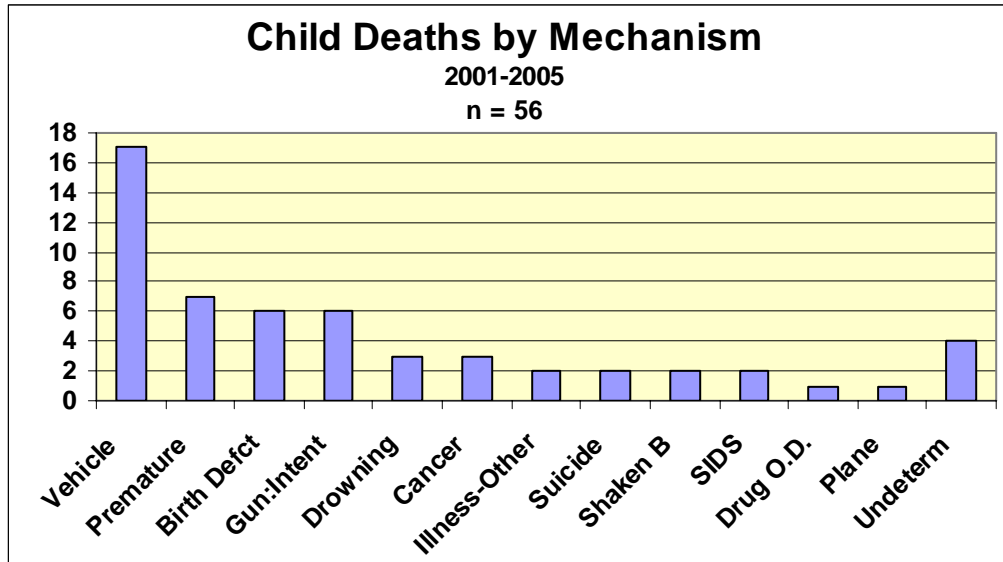


The most recent Department of Finance estimates show that county ethnic composition is approximately 58% White, 25% Hispanic, 12% Asian (including East Indian), 2% Black, 2% American Indian, 2% reporting more than one race, and 1% Other. Therefore, Whites are underrepresented in deaths in this age group during this time period, while Hispanics and Blacks were overrepresented.



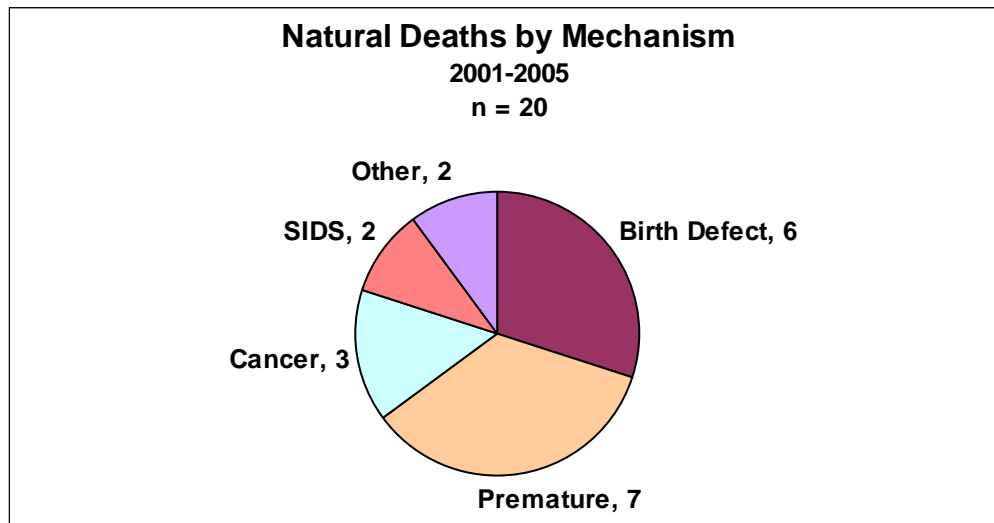
The ethnic proportion in each category runs roughly in accord with the community's ethnic makeup, except in categories of "Homicide", where Hispanics are overrepresented and Whites are underrepresented; "Suicide", where the only two deaths were to White children and "Undetermined", where Whites were overrepresented and Hispanics underrepresented during this time period. It must be noted that the numbers small in some of these categories, making valid statistical conclusions difficult.

DEATHS BY MECHANISM



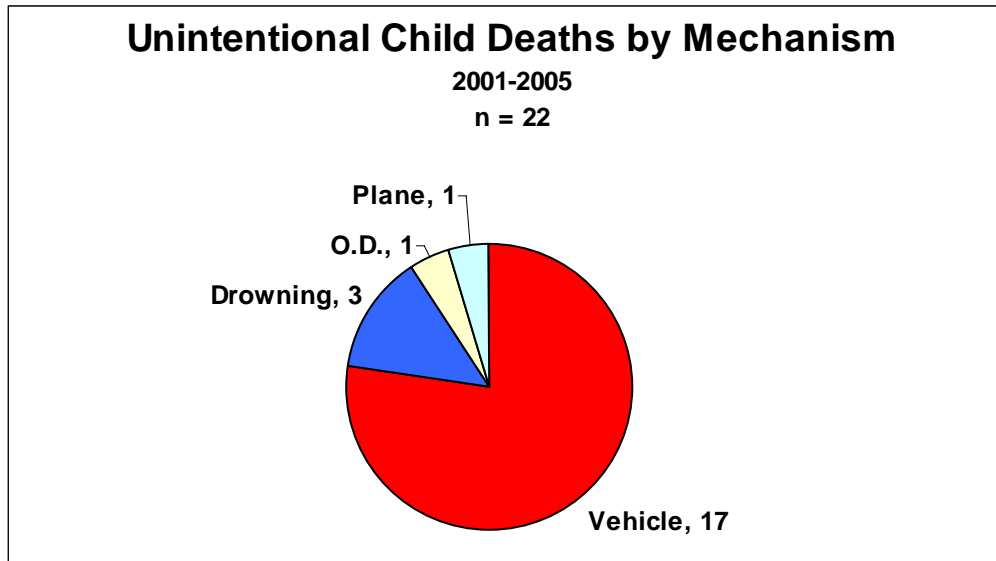
Vehicle deaths account for 30% of all deaths in these age groups. As can be seen, there were no deaths during this time that were due to fire and/or burns, falls, suffocation due to choking on objects, or unintentional poisoning of young children.

NATURAL DEATHS



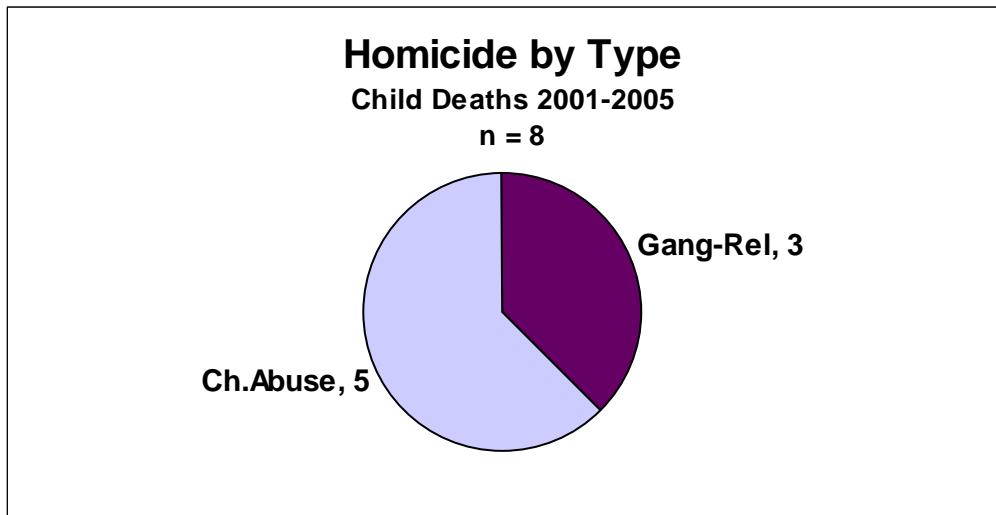
Prematurity and birth defects are statistically the most common causes of death in early infancy. Sudden Infant Death Syndrome (SIDS) is the sudden and unexpected death of a baby, normally under 1 year of age. It is what is called a “diagnosis of exclusion”, meaning that all other potential causes of death have been ruled out. The deaths listed under “Other” were infections that the infants could not survive.

UNINTENTIONAL DEATHS



The term “unintentional” is replacing the term “accidental” in the injury prevention community, although death certificates in California still use “Accident” as the term for Manner of Death. The reason for the change is that although these deaths were certainly not intentional, the large majority of them were preventable. By far, the most common cause of unintentional death (77%) was vehicle-related injury. Three deaths were due to drowning, one to unintentional drug overdose, and one to a private plane crash.

HOMICIDE

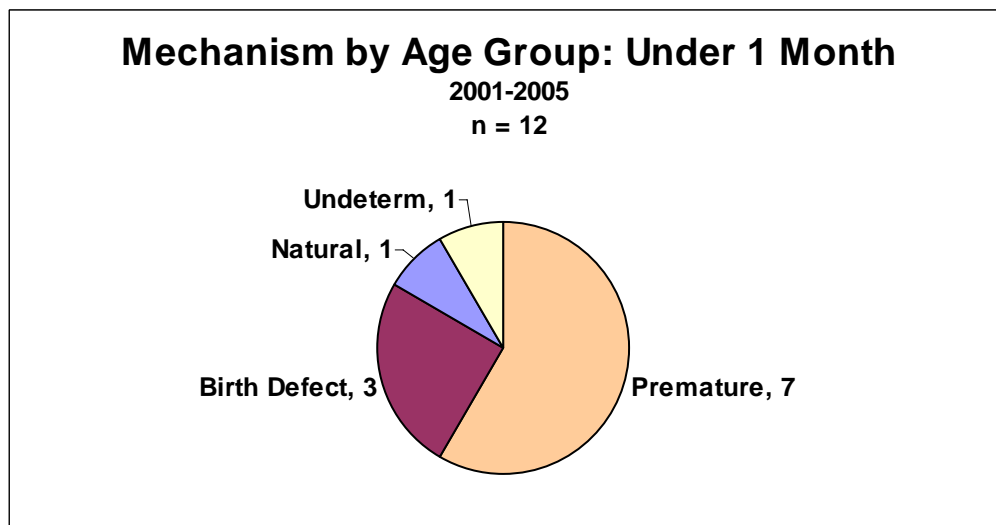
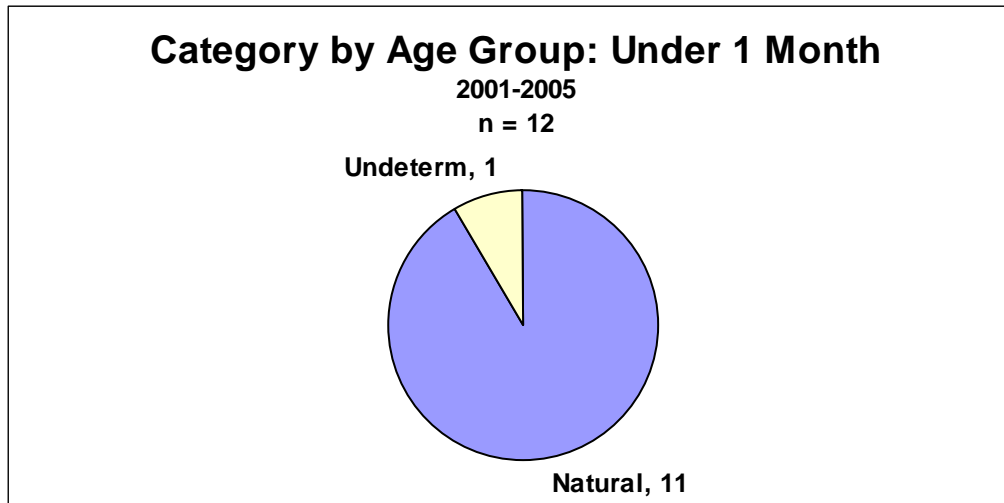


Five of the homicides were child abuse deaths. Two of those children died of late effects of Shaken Baby Syndrome. Three of the homicides occurred during one custody dispute incident, when a father came from out of state the night before the deaths to bring three boys to his estranged wife who had recently come to the area to stay with relatives. During the night he shot and killed the 5 year old boy, his two 9 year old twin brothers, the mother, and himself.

Three of the homicides were teenagers who died in shootings that were apparently gang-related.

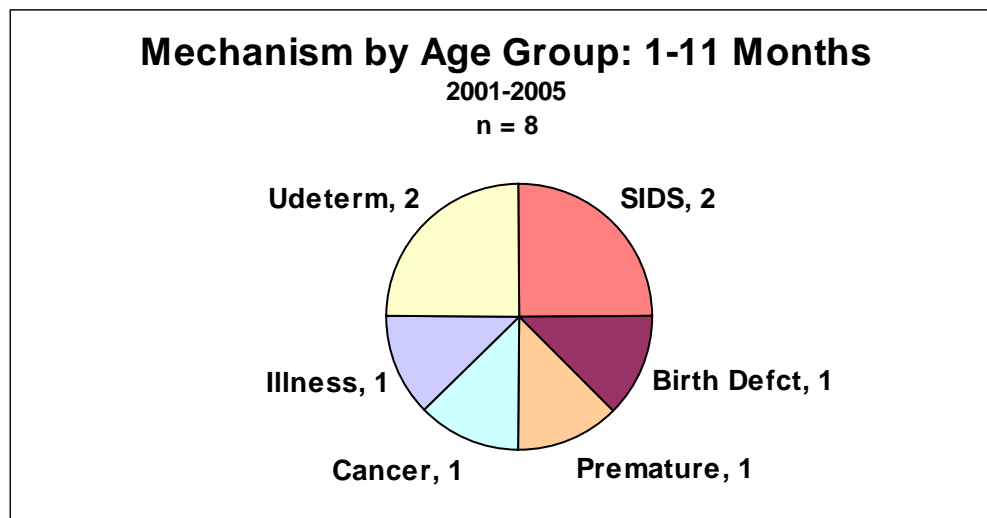
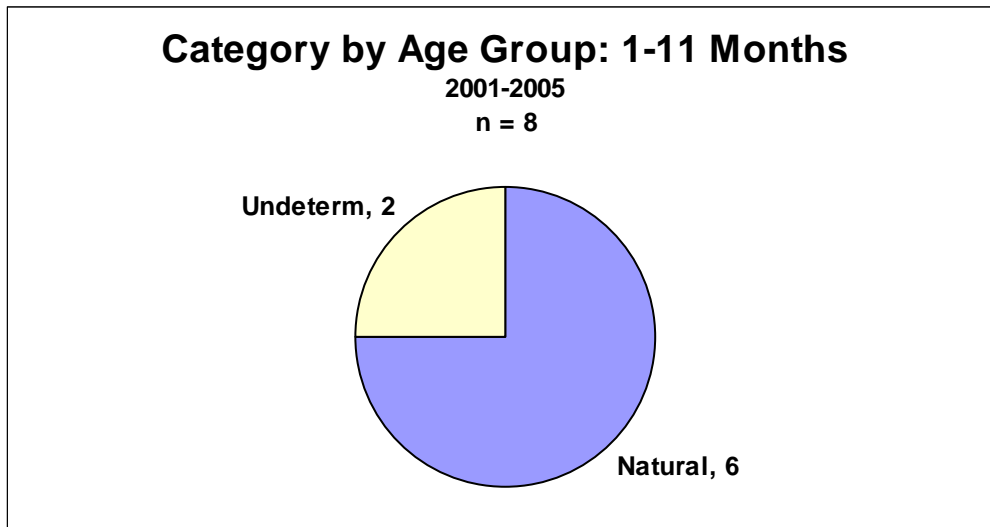
CATEGORY & MECHANISM OF DEATH BY AGE GROUP

UNDER 1 MONTH OF AGE



Prematurity, followed by birth defects, is the most common cause of death of newborns and young infants (Centers for Disease Control). Although the physical examination was inconclusive, the circumstances found in the investigation of the death that fell into the “Undetermined” category indicated that it was probably caused by unintentional suffocation due to a sleeping parent rolling over onto the baby while the infant was in bed with the parent. The natural death was due to an infection that the baby could not survive.

1 – 11 MONTHS OF AGE

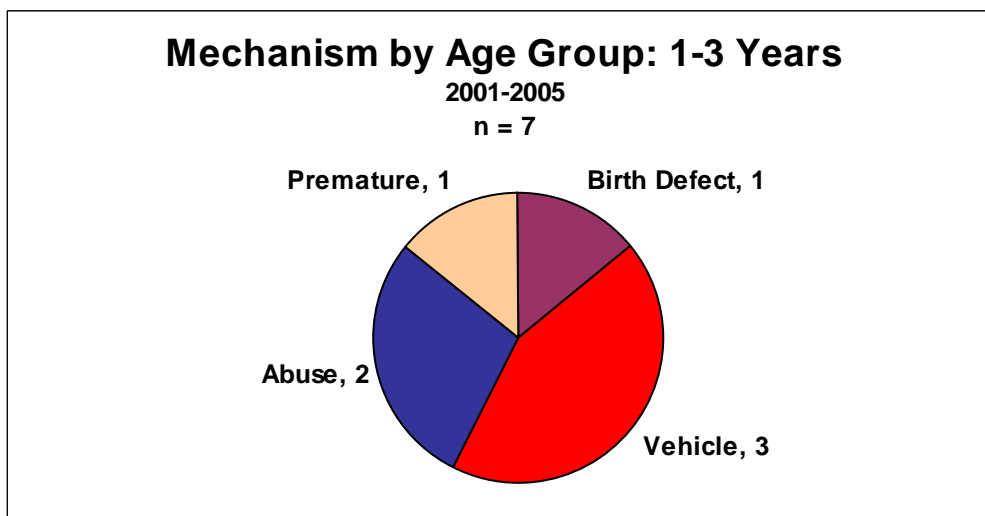
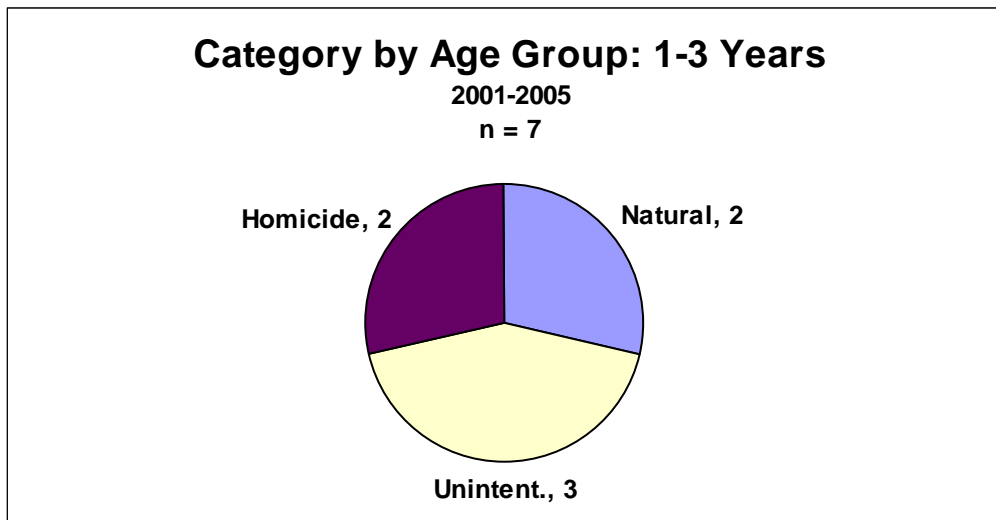


The exact cause of SIDS has not been identified. The majority of SIDS deaths occur between two and four months of age. While it is known that putting infants on their backs, rather than on their stomachs or sides to sleep; not keeping them too warmly covered while sleeping; and putting them on safe bedding prevents about half of potential SIDS cases, it is not known how to prevent the other half at this time.

As with the one “Undetermined” death in the “Under 1 Month of Age” category, investigation indicated that the two “Undetermined” deaths in this age group were probably caused by unintentional suffocation due to a sleeping parent rolling over onto the baby while the infants was in bed with the parent/s. The case of “Illness” was a severe infection that the baby could not survive.

Nationally, birth defects, prematurity and SIDS are the number one, two and three most common causes of death in this age group. (Centers for Disease Control)

1-3 YEARS OF AGE



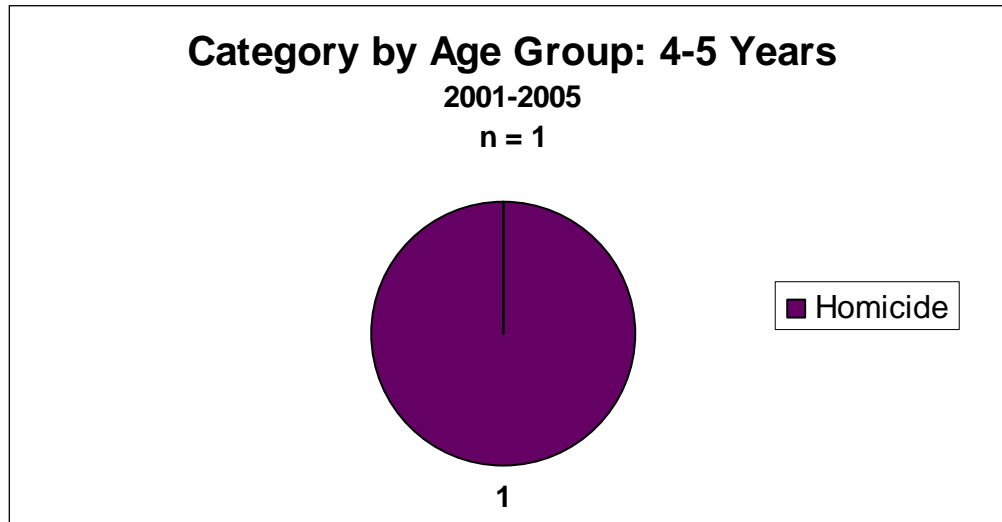
The two abuse homicide deaths were boys who died due to the effects of Shaken Baby Syndrome. Both children finally succumbed to severe neurological injuries inflicted months earlier. Both had been removed from the homes of the perpetrators and were in loving foster and adoptive homes until their deaths.

Two of the vehicle deaths were twin boys who died from complications of near-drowning that occurred when the vehicle in which they were passengers slid off a hail covered road and submerged upside down in a water-filled drainage ditch. The vehicle was not exceeding the posted speed limit, but was apparently traveling too fast for the hazardous road conditions.

The third vehicle death was due to improper placement and installation of a rear-facing infant car seat. It was unfortunate that although it was a low speed crash due to another vehicle making an unsafe turn, the car seat had been loosely strapped into the front seat. Upon impact, the airbag deployed, impacting the car seat which had come up off of the seat due to the crash, resulting in fatal injuries to the 14 month old baby.

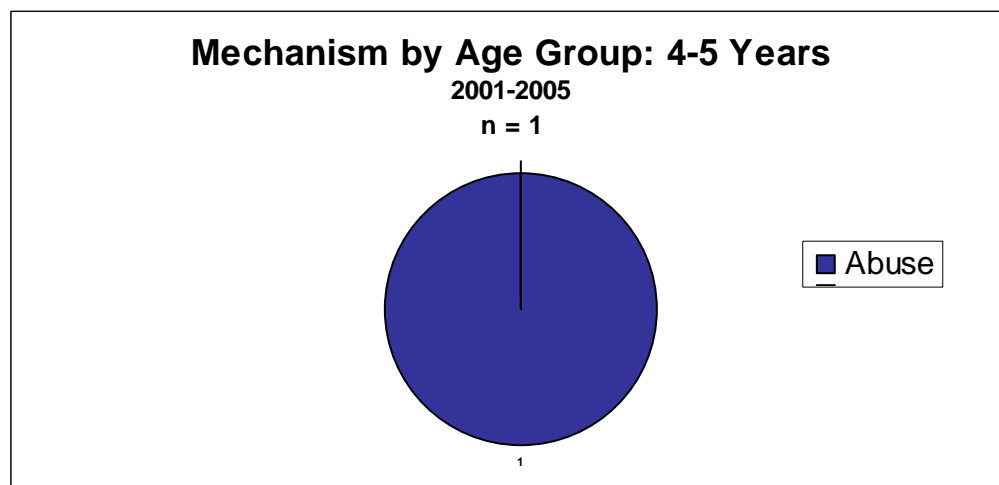
Unintentional injuries are the number one cause of death in this age group, followed by birth defects and homicide. (Centers for Disease Control)

4-5 YEARS OF AGE



The one death in this age group was a 5 year old boy who was shot, along with his mother and 9 year old twin brothers, by his father, who was estranged from the mother. The father then committed suicide. As mentioned earlier in the report, the homicides occurred during one custody dispute incident, when a father came from out of state the night before the deaths to return three boys to his estranged wife who had recently come to the area to stay with relatives. Two sisters in another room and the other relatives were uninjured. Since the perpetrator was a parent, this is categorized as a child abuse death.

Unintentional injuries are the number one cause of death of 5-9 year olds, far outdistancing the following causes of cancer, birth defects, and homicide.



6-7 YEARS OF AGE

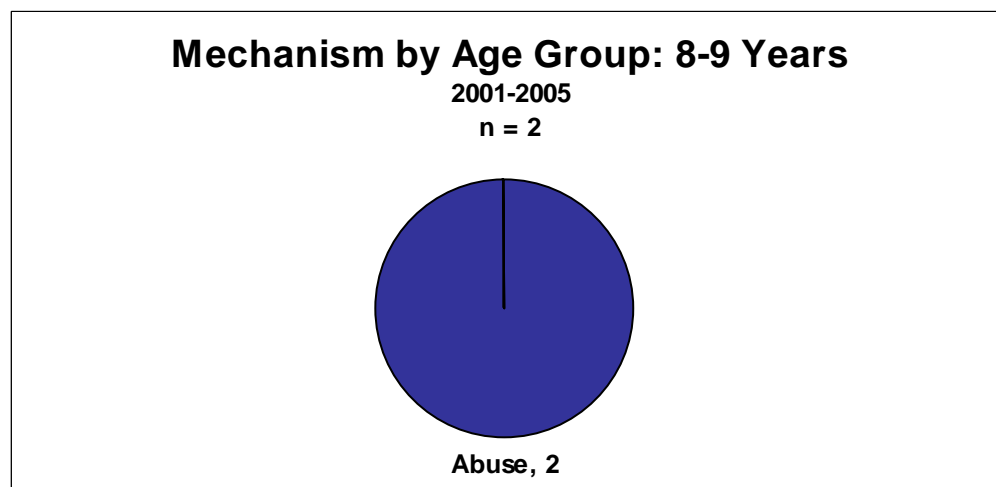
There were no deaths of 6-7 year olds during this time period.

8-9 YEARS OF AGE

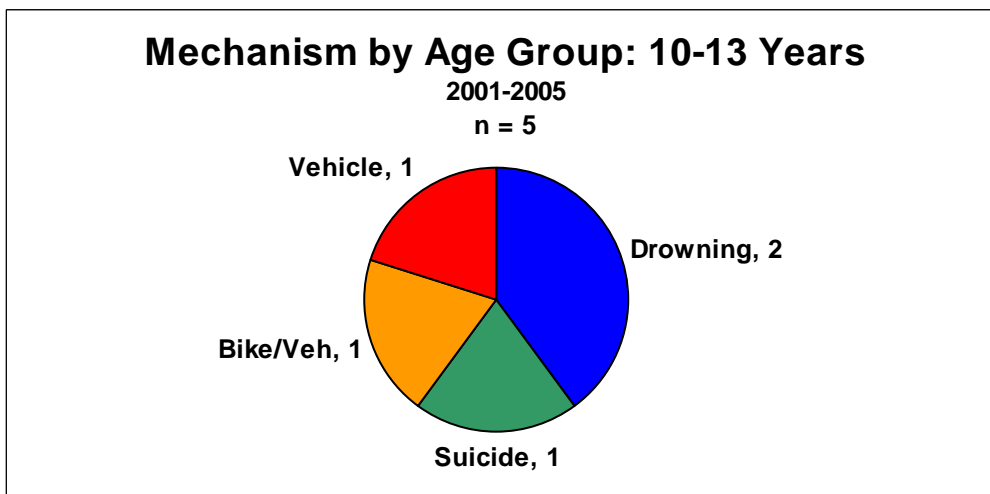
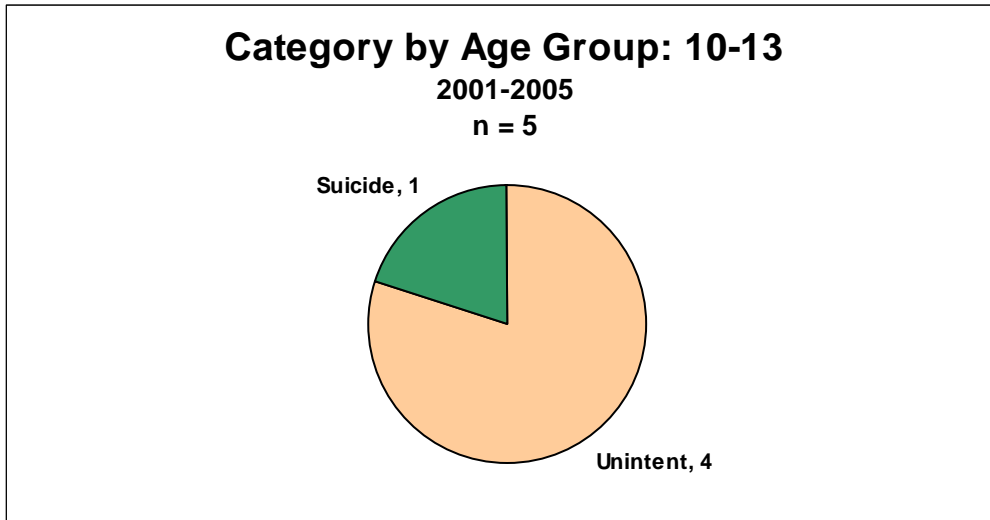


These two deaths were the 9 year old twin brothers of the 5 year old boy described in the previous section, and occurred during the same incident as his death. Since the perpetrator was a parent, these are categorized as child abuse deaths.

As mentioned above, homicide is the fourth leading cause of death of 5-9 year olds, but at approximately 1/9th the rate of unintentional injuries (Centers for Disease Control).



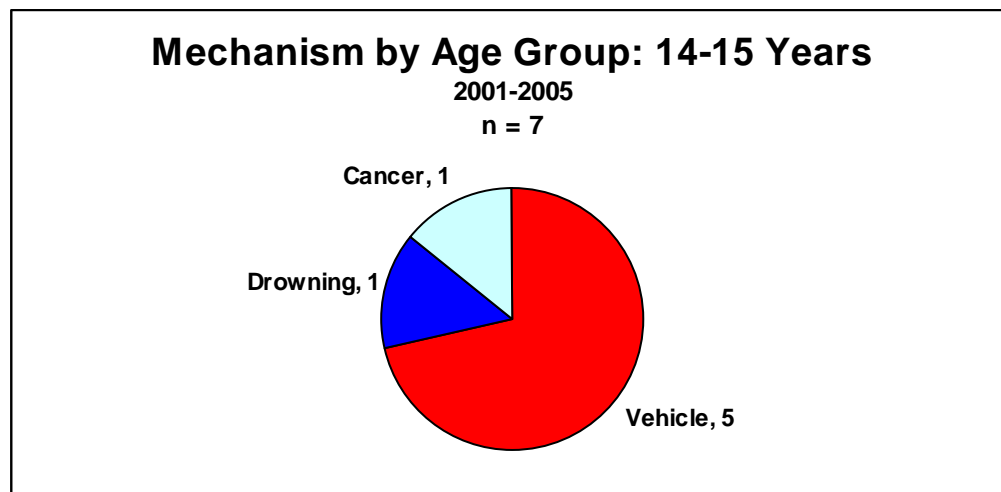
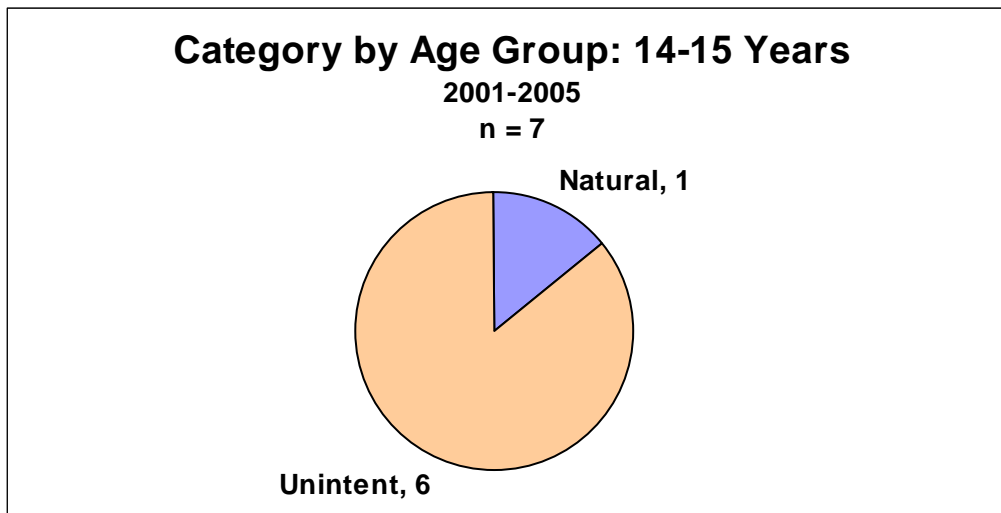
10-13 YEARS OF AGE



One of the two drowning cases, both of whom were ten year olds, occurred in a residential swimming pool, and one was a Sutter County boy who drowned in a lake in Yuba County. In both cases, the adults had temporarily left the immediate vicinity where the child was in the water. The vehicle death was a 10 year old who was not in a seat belt and who was ejected from the family vehicle during a crash. The bicycle vs. vehicle death was of a 10 year old riding a bike, unsupervised on a 2-lane, 55 mph road. He veered into the path of a car, sustaining non-survivable injuries. The suicide was the hanging death of a 10 year old boy.

For ten to fourteen year olds, unintentional injuries are the leading cause of death, causing over three times the number of deaths in the next three categories; cancer, suicide and homicide (Centers for Disease Control).

14-15 YEARS OF AGE

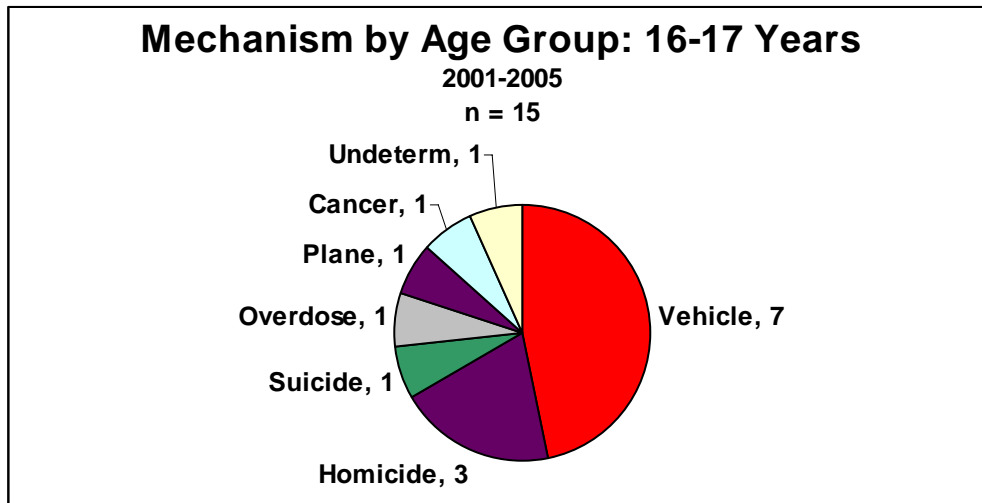
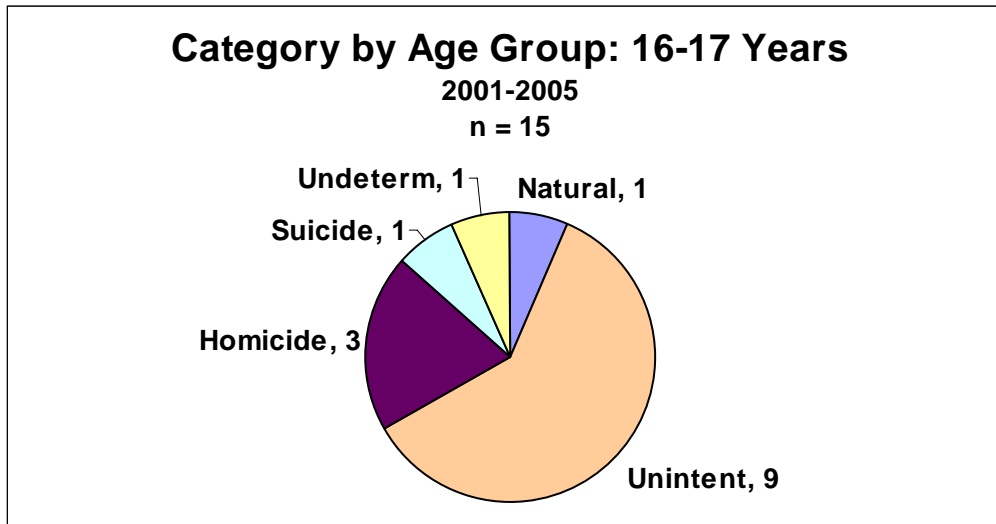


Five of the six unintentional deaths were due to vehicle crashes. All of the victims were passengers. The drivers in four of the crashes were male friends or boyfriends of the victims, and the fifth was an unlicensed female relative. Excessive speed was a factor in four of the crashes. Other factors involved in one or more crashes included alcohol, improper seatbelt (shoulder harness in place, lap belt not fastened), “road rage”, racing, a stolen vehicle, and failure to call for medical aid after a crash occurred.

Those last two factors were involved when three Sacramento County boys stole a car there, were joyriding on levees in Sutter County, and crashed. After the crash, the victim was still alive although he had sustained major injuries. Rather than calling for medical aid, one of the other boys called his father, who told them not to call for help, saying he would come to them. During the nearly three hour wait for his arrival, the uninjured boys turned off vehicle lights and concealed the car from being seen by passing vehicles. During this time, the victim died. The father and a friend then drove the body back to Sacramento County, put the body in water in a drainage ditch and did not report the crash. Arrests did occur in the case.

The drowning was that of a 14 year old boy who was caught in the river current while swimming. The causes of death for 10-14 year olds are listed in the section above. For 15-24 year olds, unintentional injuries remain the number one cause of death, followed by homicide, suicide and cancer (Centers for Disease Control).

16-17 YEARS OF AGE

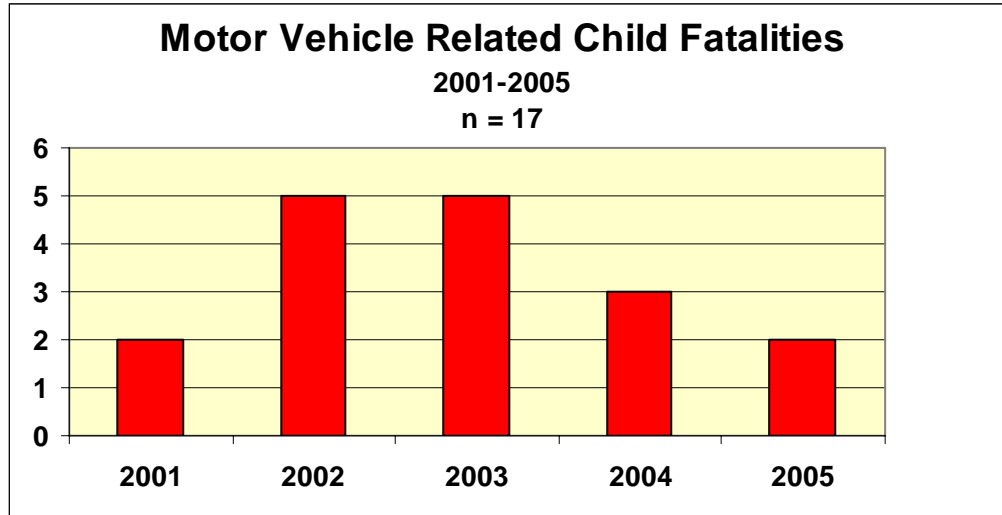


Seven of the deaths in this age group were vehicle-related, and included 5 boys and 2 girls. Three of the victims were passengers, three were drivers and one was a pedestrian. Driving too fast or too fast for road conditions was a factor in loss of control resulting in 6 of the crashes. The seventh victim was a pedestrian wearing dark clothing at night, walking along the road. Other factors included an unlicensed driver, not wearing a seat belt, standing in the bed of a pickup truck as it sped off after an altercation with other youths, and racing another vehicle. One incident, in which a 17 year old and two others were killed was the result of speed, lack of headlights at night, and running a stop sign, resulting in impact with and being run over by a tractor-trailer rig. The other six incidents were single-vehicle crashes. Additional information is included in the section on "Motor Vehicle-Related Deaths".

The three homicides were all shootings which apparently were gang-related. The suicide was that of a 17 year old boy who took his own life with a shotgun. The overdose was a 17 year old girl who unintentionally overdosed on the drug Ecstasy at a party. This incident was particularly sad because apparently others who were present did not summon medical aid in time to save her life. The private plane crash took the life of a 17 year old boy and an adult male pilot. The National Transportation Safety Board (NTSB) report stated that there was marijuana in the systems of both the pilot and the boy. The "Undetermined" death was that of 16 year old boy who collapsed at school, and was apparently due to natural causes.

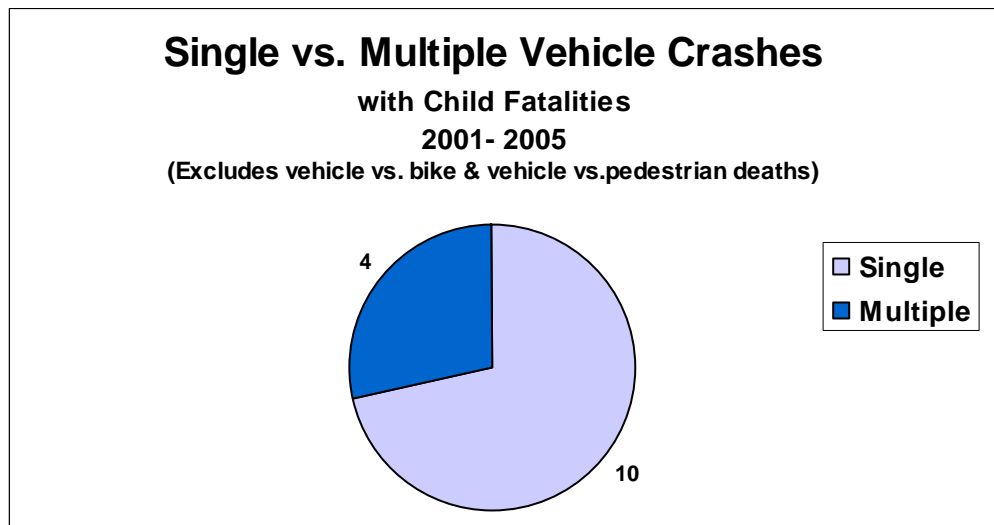
MOTOR VEHICLE-RELATED DEATHS

BY YEAR 2001-2005



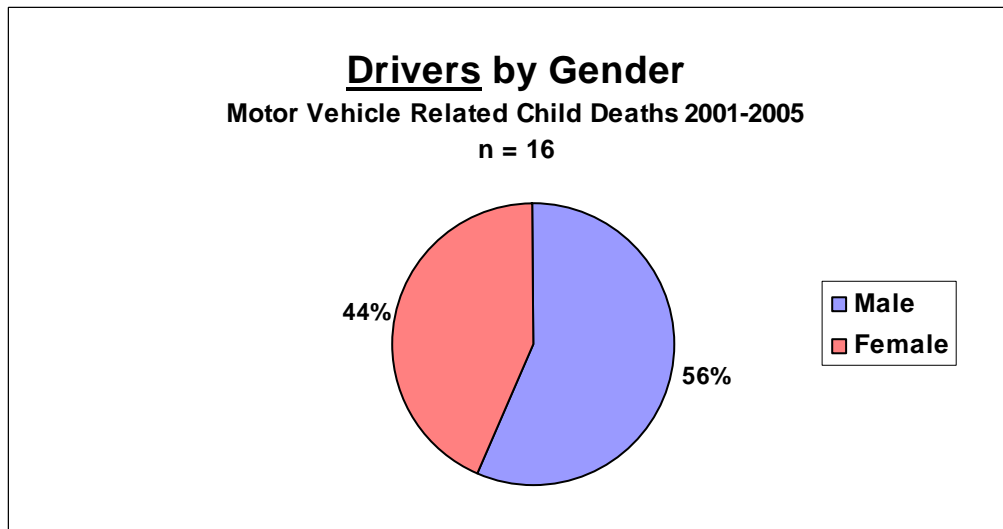
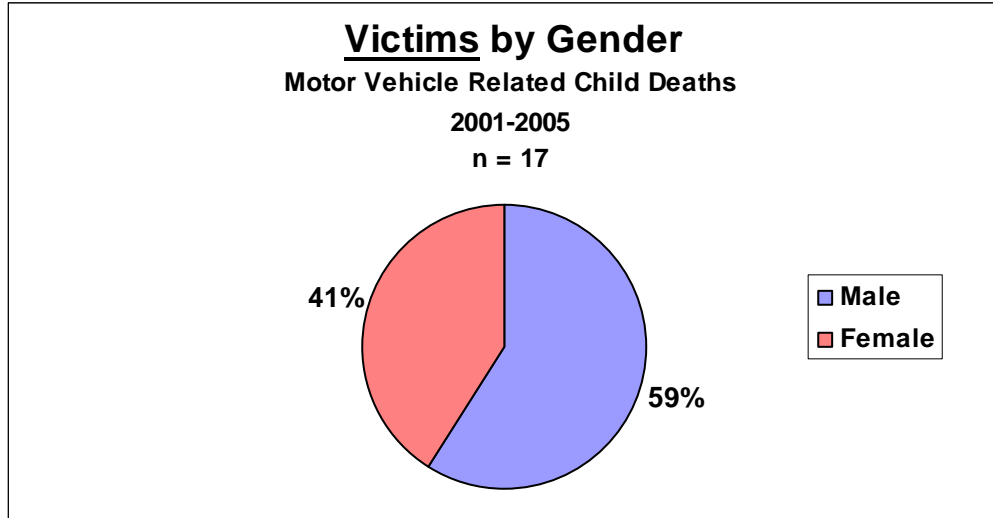
As of October 1, 2006, there had been no vehicle related deaths in the birth to 17 year age group in Sutter County or Sutter County residents for the year 2006.

SINGLE vs. MULTIPLE VEHICLE CRASHES



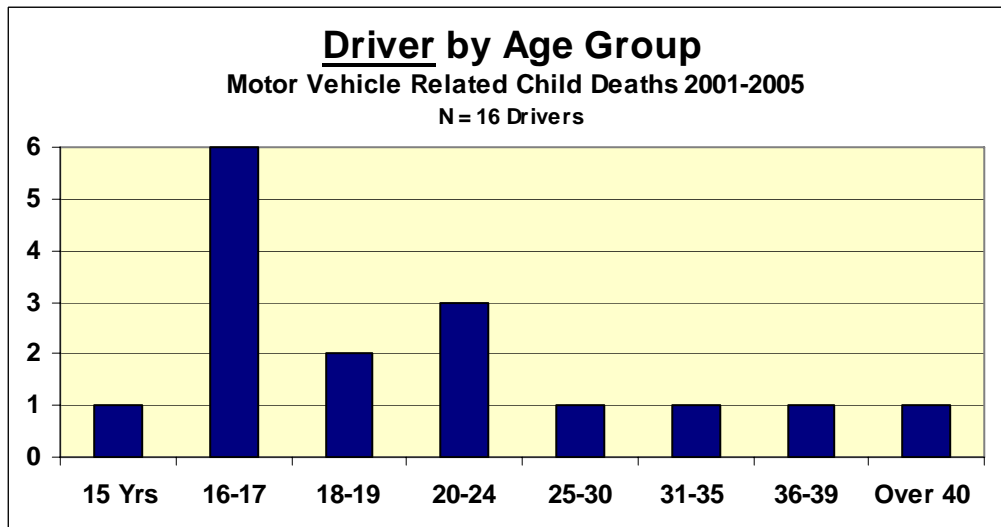
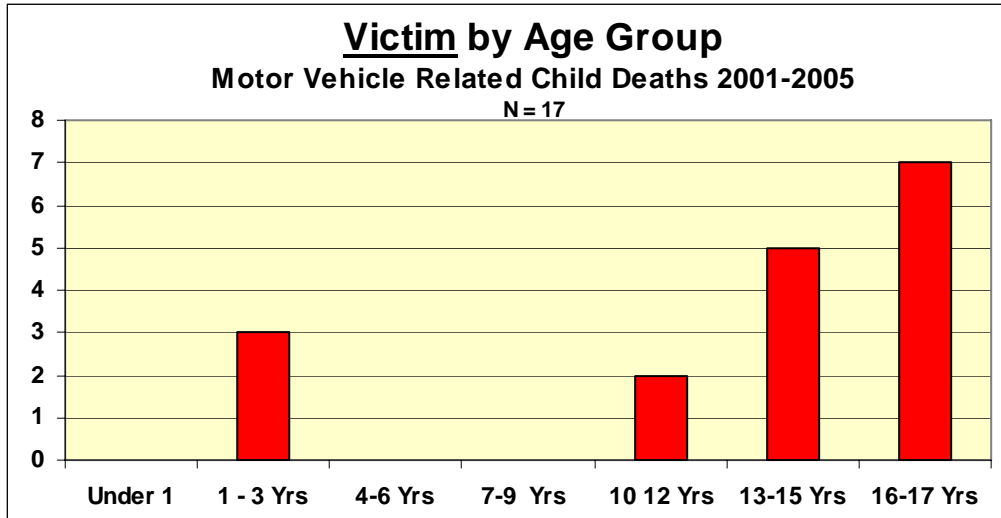
The great majority of these crashes (79%) involved only one vehicle. The most common scenario involved the driver losing control of the vehicle, resulting in it leaving the road and rolling over or impacting an object such as a tree, utility pole, or bridge abutment.

GENDER OF VICTIMS AND DRIVERS



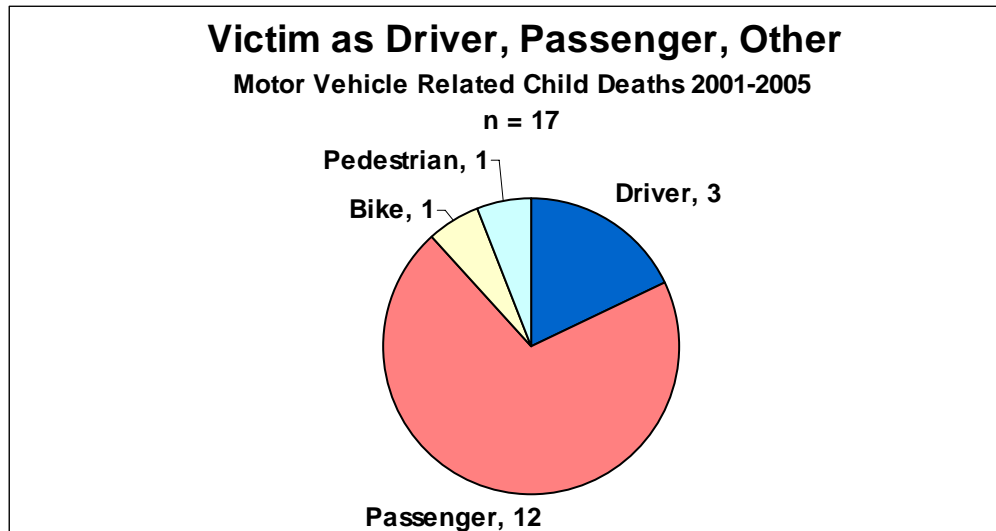
Boys were slightly over-represented as both drivers and victims. The county population is almost evenly divided between males and females. Two of the female drivers were themselves the victims, and three were family members (one mother and two sisters) of the child who died. Two of the female drivers fell into the “Stranger” category, which will be discussed in a following section. All of the drivers who fell into the “friend” of the victim category were boys.

AGE GROUP OF VICTIMS AND DRIVERS

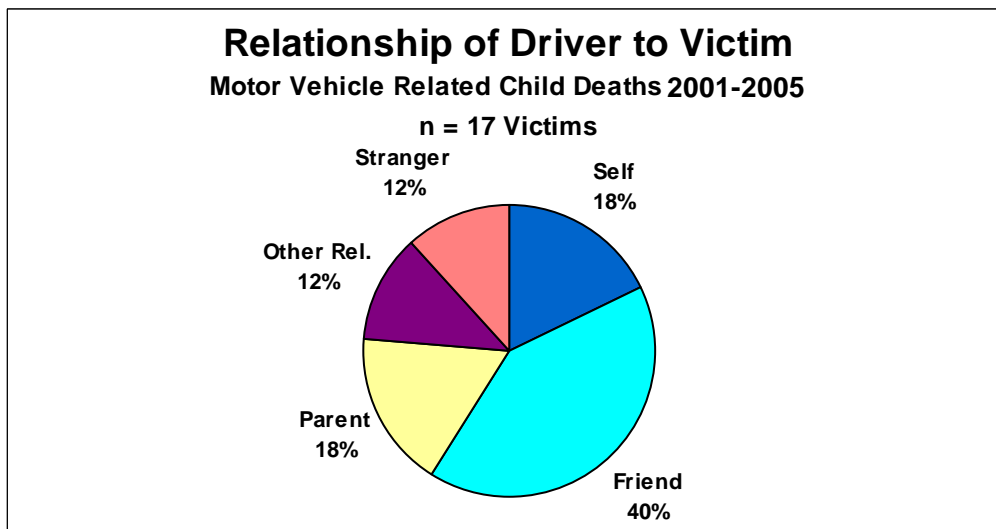


A full 75% of the drivers involved in crashes with fatalities in the birth-17 year age group were themselves under 25 years of age.

VICTIMS, DRIVERS, PASSENGERS

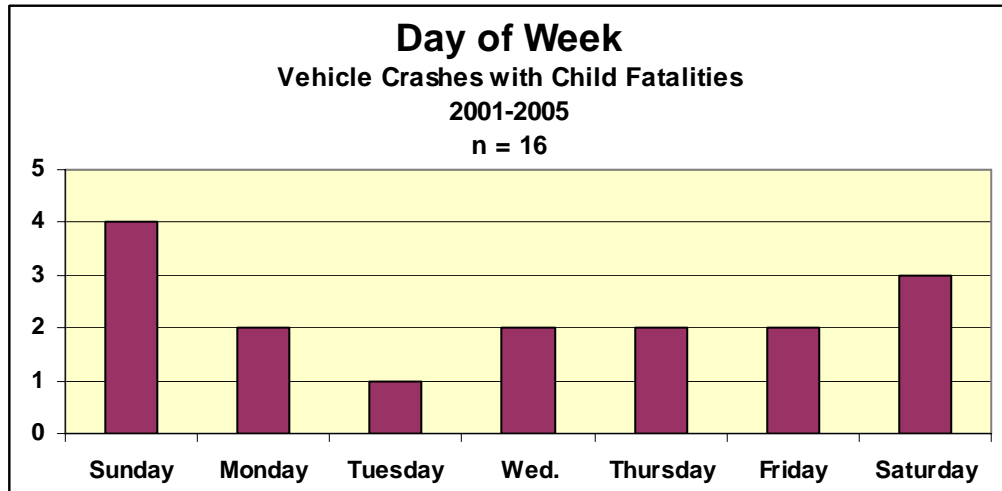


In two of the three incidents where the driver was the victim, the victim was the only occupant in the vehicle. In the third, two other boys were in the car, one of whom received moderate injuries and the other of whom was uninjured. The large majority (71%) of victims were passengers, rather than drivers. This emphasizes the fact that we must not only talk to our teens about the manner in which they themselves drive, but parents must be aware of who their teens are with and discuss with them choices about who they get into a car with, as well as acceptable behaviors of the driver and the passengers.



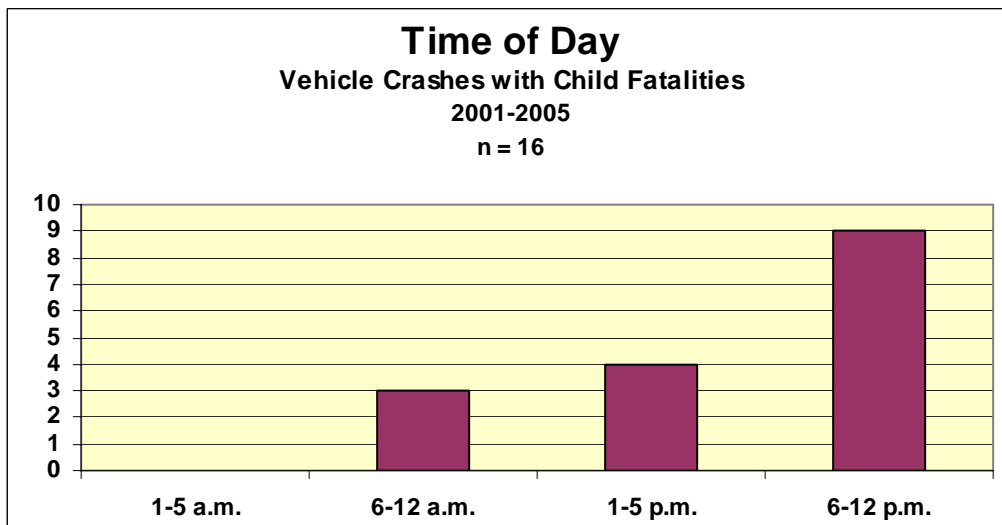
The driver was a friend of the victim in 7 of the cases, and a parent or other relative in 5. The two drivers in the "stranger" category were one who struck a ten year old bicyclist who veered into the path of the car, and the one who struck a pedestrian who was wearing dark clothing and walking along the roadside after dark.

DAY OF WEEK



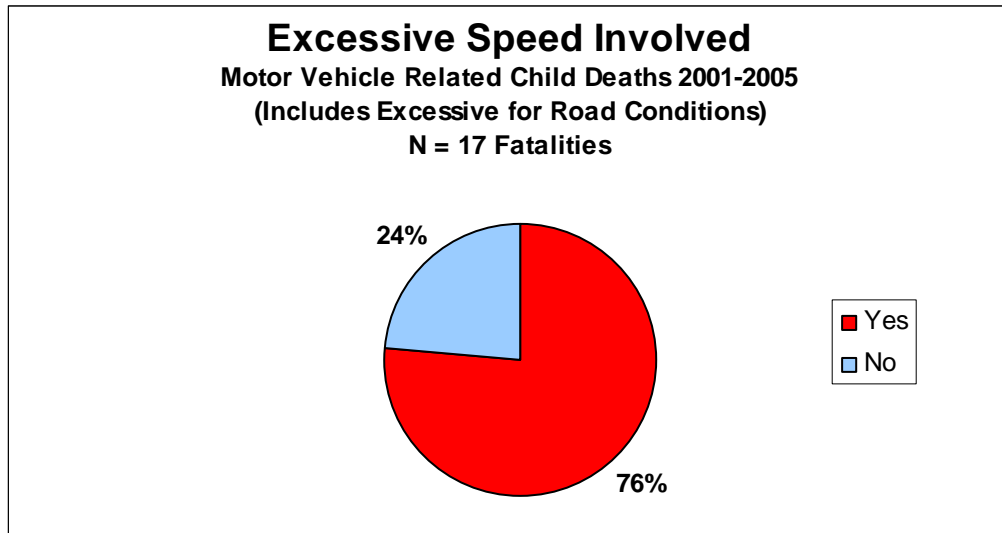
With such small numbers per day, no real conclusion can be drawn from this distribution.

TIME OF DAY

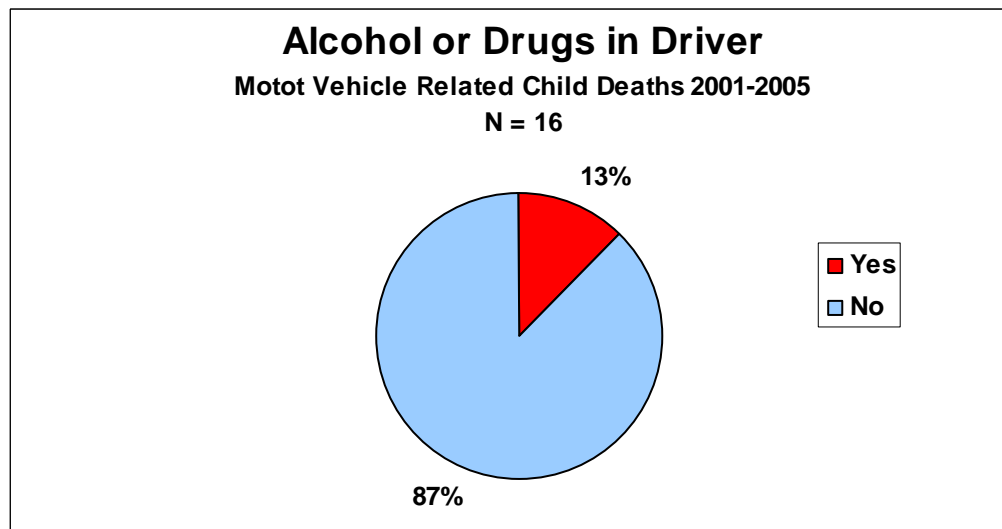


These two charts show the time of day and day of the week for crashes that resulted in child fatalities in the infant to 17 year old age group from 2001-2005. Sixteen crashes are shown, one of which resulted in two deaths, for a total of 17 fatalities. The six-hour period from 6 p.m. to 12 p.m. accounted for 56% of the total fatal crashes.

RISK FACTORS

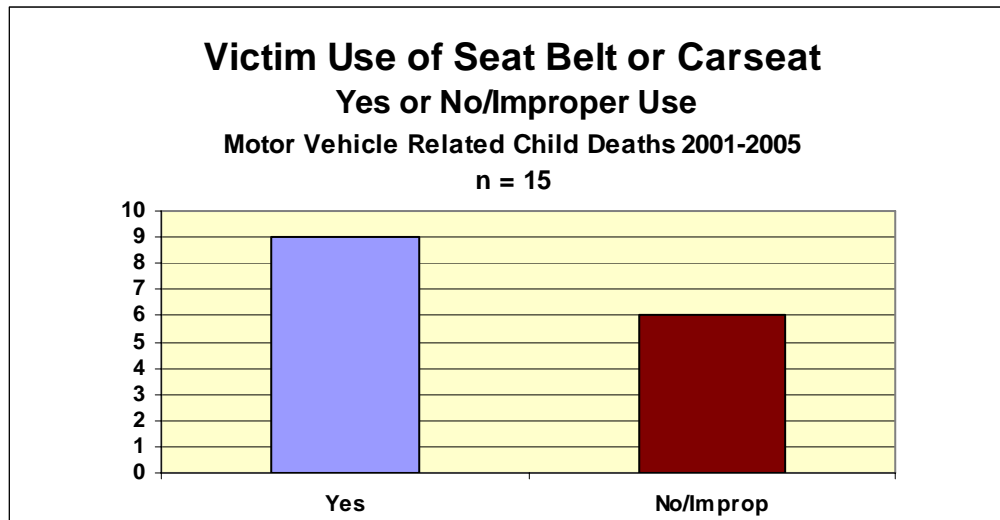


Excessive speed, or speed excessive for road conditions, was a factor in an overwhelming number of these deaths. The result was a loss of control of the vehicle, resulting in it leaving the roadway, usually impacting an object or overturning. In younger driver's inexperience, distraction, and overestimation of their driving ability is often involved in crashes.



One driver was positive for alcohol and one for marijuana at the time of the fatal crashes. Both were boys. Side Note: While investigating the small private plane crash fatality in 2003, the National Transportation Safety Board (NTSB) found marijuana in the systems of both the 17 year old victim and the 50 year old pilot, who also died.

Every year, multiple agencies in the community work together to present the simulated crash "Every 15 Minutes" drunken driving prevention program at two to three high schools. Prevention is always difficult to measure, but the fact that there were not more fatal crashes due to substance use in this age group may demonstrate some measure effectiveness in reaching high school students. However, since teens tend to have a sense of invulnerability, it will take continued efforts on many fronts, including these programs, enforcement of "sales to minors" violations, encouraging positive peer pressure, and effective parental supervision and guidance to effectively prevent both fatal and nonfatal crashes due to drugs or alcohol.

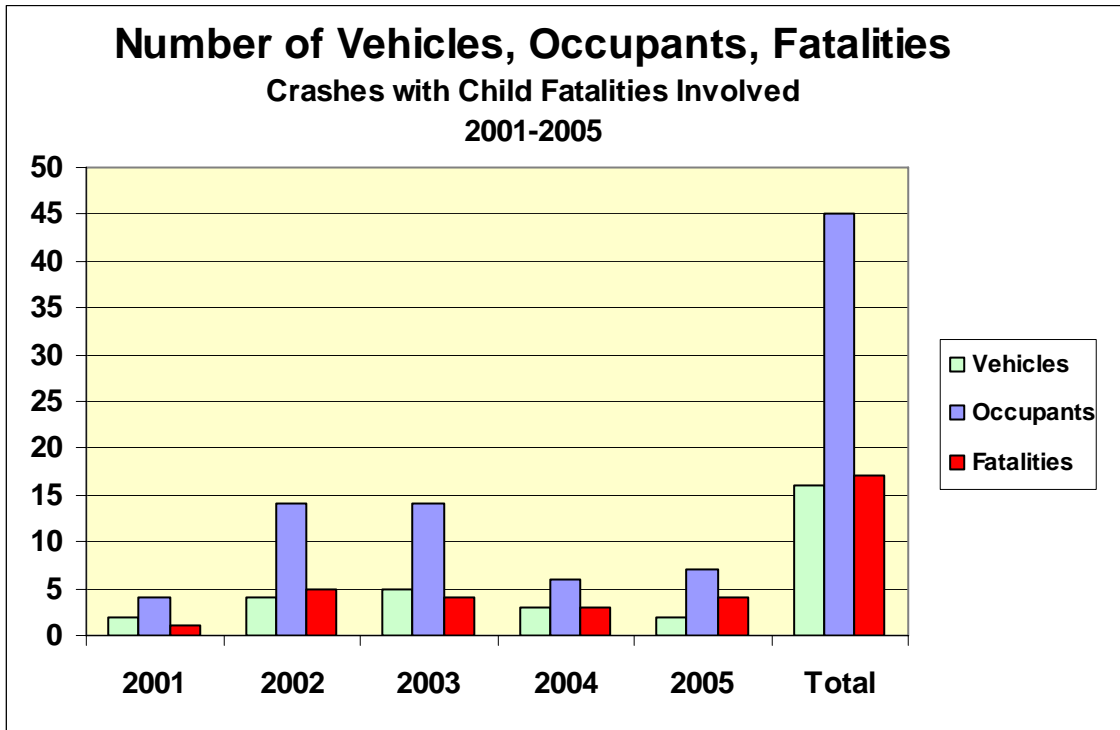


Four of the six “No” cases were the lack of any seatbelt being used. Three of those were ejected from the vehicle during the crash. The fourth apparently had a seat belt on, but the vehicle in which he was a passenger crashed into, and was crushed under a tractor-trailer rig. The injuries were not survivable in any event. Two of the six involved improper use of safety restraints. One of these fatalities was due to an improperly installed infant car seat. The other was a teen front seat passenger, who had the shoulder harness portion of a two-piece seat belt fastened, but not the lap belt portion.

OTHER FACTORS INVOLVED

- ❖ Racing another vehicle
- ❖ Road Rage
- ❖ Unsafe passing
- ❖ Unlicensed driver
- ❖ Running stoplight or stop sign
- ❖ No headlights at night
- ❖ Unsafe turn
- ❖ Stolen vehicle
- ❖ Victim in back bed of truck
- ❖ Pedestrian in road, wearing dark clothing at night
- ❖ Did not seek medical aid for injured party
- ❖ Overturned in water-filled ditch > death from near-drowning

VEHICLES, OCCUPANTS, & FATALITIES



As sad as the losses were that occurred in this age group during the five year period, the number of fatalities could have much higher, given the number of total occupants in the vehicles. The average number of occupants per vehicle involved in these fatal child and adolescent crashes was 3.3. The average number of fatalities per vehicle was 1.1.

FAMILY VIOLENCE: CHILD ABUSE OR DOMESTIC VIOLENCE

The effects of all family violence, including domestic violence towards a spouse or co-habitant, must be taken into account when examining risks to children. Frequently, both situations occur within the same household. Studies have shown that 30-50% or more of children in homes where there is domestic violence are also victims of child abuse. In addition, according to the American Medical Association, approximately 25% of domestic violence victims are pregnant, which raises the issue of physical risk to the fetus. Additionally, some perpetrators of domestic violence will injure the children in order to control or “punish” their partner.

Not only does violence in the home raise the immediate risk of injury or death to children, but it has been proven to have long-lasting effects upon the child’s interpersonal relationships. Children who grow up with domestic violence in the home may see this as the “normal” way to resolve problems. In addition, if this is the only parental/caregiver role model that they experience, they do not learn other, more positive coping strategies when it comes to resolving problems in their own lives. These children are significantly more likely to become either abusers or victims of domestic violence as adults. They are also more likely to become substance abusers, have teenage pregnancies, do poorly in school, and have trouble with the law. If we are to make any progress in stopping this inter-generational cycle of violence, the issues of child abuse, child neglect, and domestic violence must be addressed.

The Sutter County Domestic Violence Council was established by ordinance in 1995. Prior to 2002 there was no formal child abuse prevention council in the county. The Domestic Violence Council had become the agent to review local grants and disperse funding allocations received by the county from the state for programs dealing with child abuse and neglect. Due to the recognition of the relationship of the whole spectrum of family violence, in December of 2002 the council was formally changed to the Sutter County Domestic Violence Council and Child Abuse Prevention Council. The mission statement and by-laws were adapted to include the full focus of family violence prevention.

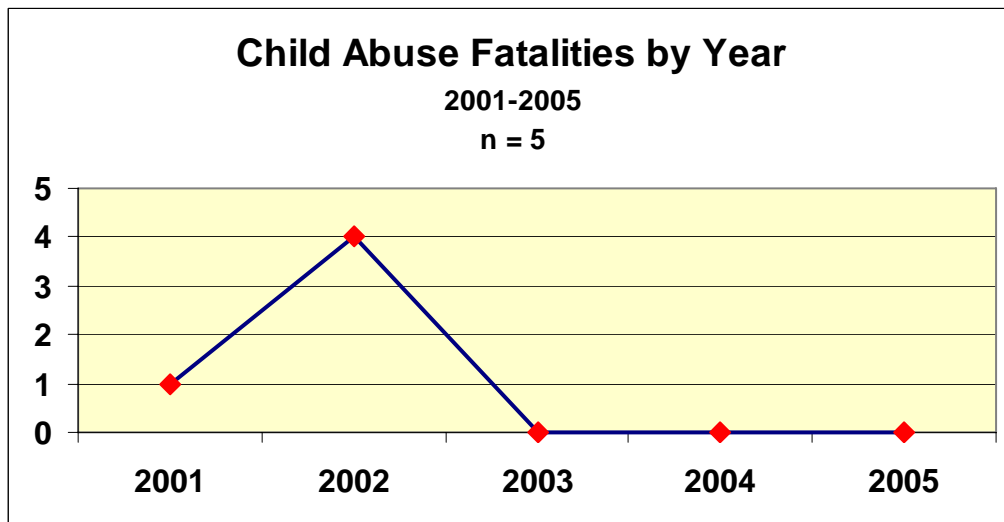
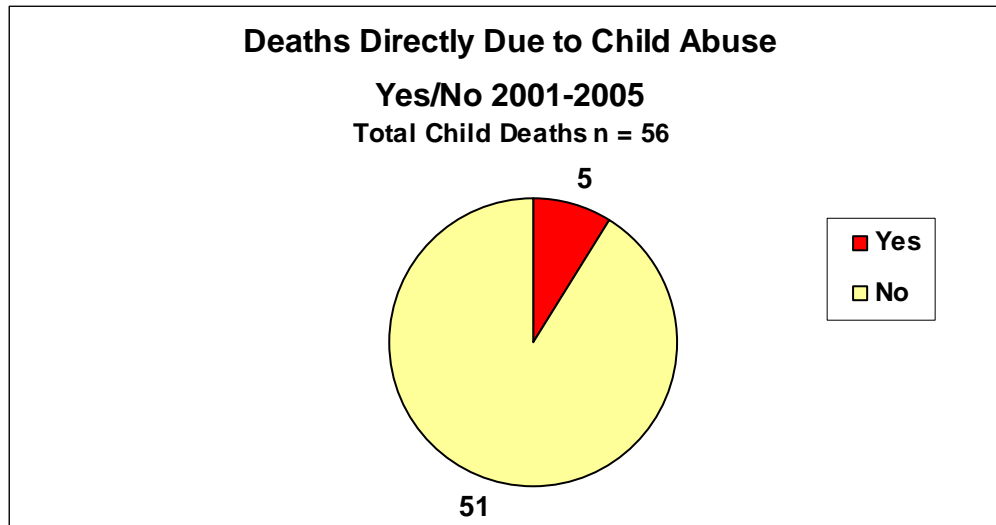
The state of California collects a Fatal Child Abuse and Neglect Surveillance form (FCANS) from child death review teams whenever a child’s death is due to child abuse or neglect or when there has been a history of child abuse or neglect in the child’s life. These reports will be used to build a statistical database to determine if a history of child abuse or neglect in the family increases children’s risk of premature death, even if it is not the direct cause of that death. The results must be tempered with the reality that not all occurrences of child abuse or neglect are reported, and therefore some are sure to be unknown to the agencies reviewing the cases, causing underreporting to the state.

FOSTER/ADOPTIVE CARE

There has been media attention on the national level regarding deaths of children occurring while they were in foster care. During the time period covered in this report, one county child died while in foster care, and one after having been in foster care and then adopted by the foster parents. However, both of these children died due to the effects of severe injuries sustained prior to being placed in foster care. Neither of the deaths was in any way related to the care they received while in the foster or adoptive homes, which provided safe havens for them after the injuries were inflicted.

DEATHS DIRECTLY DUE TO CHILD ABUSE 2001-2005

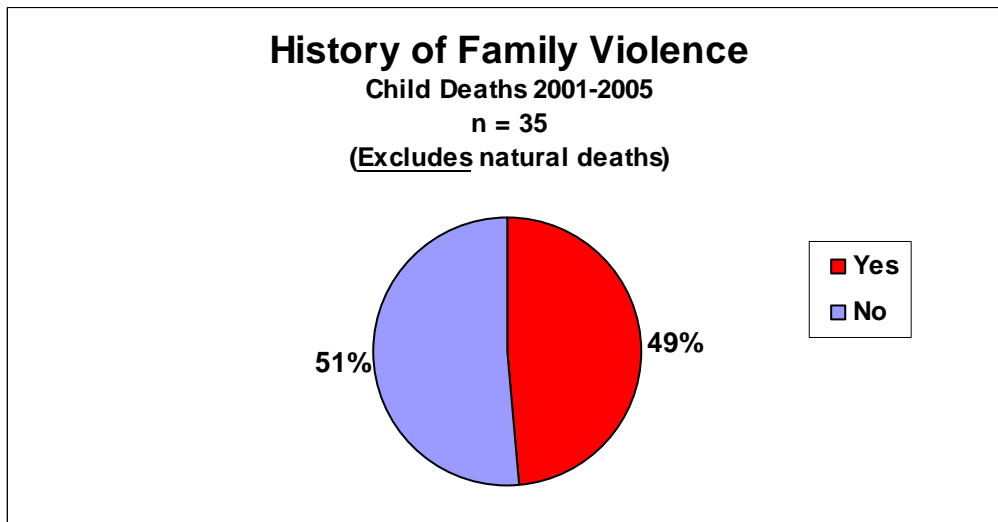
Deaths due to child abuse are especially difficult to review or understand, since they are caused by the very people who are supposed to love, care for and protect these children. From 2001-2005, Sutter County had 5 deaths due to fatal child abuse injuries. Three of these were the brothers killed in the quadruple homicide/suicide by the father. The other two deaths were from the late effects of Shaken Baby Syndrome and Shaken-Impact Syndrome. These two babies had been severely injured as young infants, lived over a year with massive neurological damage, and then died as a result of the original injuries.



**FAMILY VIOLENCE OR NEGLECT HISTORY
IN ALL CHILD DEATHS 2001-2005**



**FAMILY VIOLENCE OR NEGLECT
IN INTENTIONAL, UNINTENTIONAL & UNDETERMINED DEATHS
2001-2005**

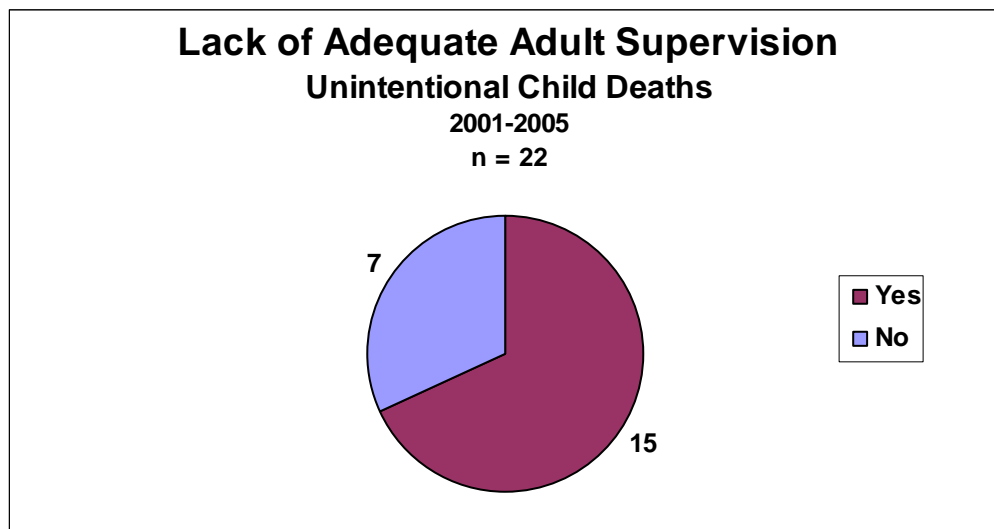


The top graph shows the percentage of all deaths during this time period that had a history of some type of family violence. The second graph excludes the "Natural" deaths, and shows the percentage of the "Intentional", "Unintentional", and "Undetermined" deaths that had a history of some type of family violence. The numbers shown above include the five deaths directly due to child abuse, as discussed earlier in this report. The large percentage in the second graph indicates that having a history of some type of child abuse, neglect or domestic violence in the home, appears to put children at a higher than normal risk of premature death, even though not necessarily directly related to that violence. In some of the cases, this seemed to be a contributory factor in risky behaviors of the child or adolescent that resulted in the fatality. This dynamic will continue to be explored in future reviews.

LACK OF ADEQUATE ADULT SUPERVISION

Depending on a child's age, adequate adult supervision is critical to the child's safety. The predictable "developmental stage" for a child or adolescent is independent of his or her intelligence level. Parents and caregivers frequently overestimate the level of reliability that they can reasonably expect of their child or a child in their care. The result is an inadequate level of supervision or care, given the child's age and activity.

An adult who is rushed, distracted, fatigued, or under the influence of alcohol or other substances is particularly vulnerable to lapses in supervision. Included are both occurrences of lack of direct supervision, and occurrences of failing to ensure that proper safety equipment (including bike helmets, properly installed car seats, etc.) are being used by or for the child. Although this is often falls below the legal level of "neglect", it can easily contribute to injuries or deaths that are completely preventable.



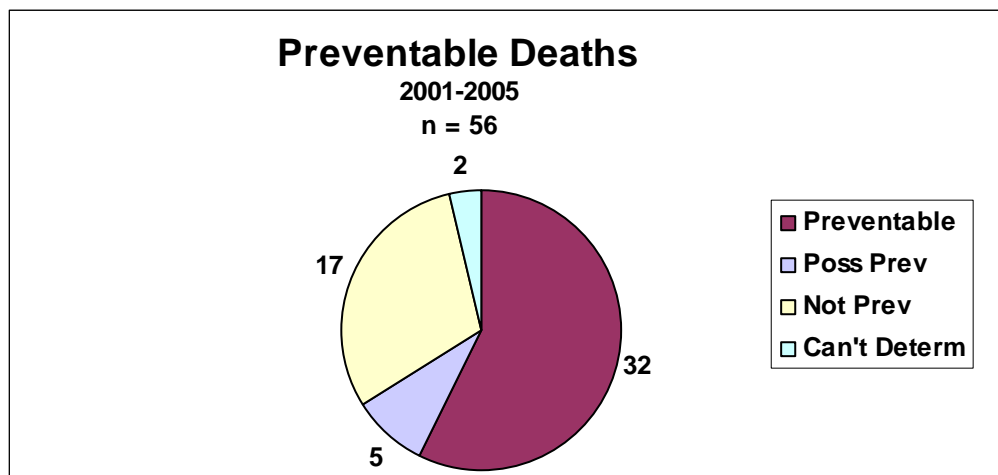
PREVENTABLE & POTENTIALLY PREVENTABLE DEATHS

The main desire of the members of child death review teams is to *prevent* as many child deaths as possible. What then, is considered “preventable”? The widely accepted definition includes “*Preventability refers to the ability of an individual or community to reasonably have done something to alter the conditions that led to the child’s death, thereby preventing the child’s death, or reasonably do something now to reduce the likelihood of future deaths. Examples include, but are not limited to, implementing safety rules, laws, or policies; creating or improving barriers around dangerous areas; educating children or adults in the community; or improving access to health care.*”

The bottom line is that in order to protect our children, we must *learn* from the previous deaths and injuries of other unfortunate children. To continue to see the same types of preventable deaths occur demonstrates that there is much work still to be done in this area.

At the state and national level, it has generally been agreed upon that virtually all unintentional injury deaths and most intentional deaths are preventable or possibly preventable. None of these are unavoidable acts of nature. In addition, at least a percentage of “natural” deaths are potentially preventable. Just a few such examples are babies sleeping on their backs does not eliminate, but lowers their chance of dying of SIDS; early and adequate prenatal care reduces the potential for premature birth, which carries a higher risk of early death; and vitamins with folic acid for all women of childbearing years reduces the risk of some life-threatening neurological birth defects. All child deaths cannot be prevented, but the risk of early death can be reduced in many instances.

It is difficult enough for a family to deal with the heartbreak of their child’s death, regardless of the cause. It is even more heart-wrenching if the death did not have to happen.



Of the fifty-six deaths that occurred during this five year period, 57% (32) were deemed preventable, 9% (5) were possibly preventable and 30% (17) were non-preventable. It could not be determined if 2 of the deaths (4%) were preventable. The significance is that two-thirds of these children did not or probably did not need to die.

CHILD UNINTENTIONAL DEATH & INJURY PREVENTION

Child deaths due to unintentional injuries are merely the tip of the child injury ‘iceberg’. For every one child who dies, there are many more children who are injured. The great majority of these incidents are predictable, and therefore, preventable. In the case of minor injuries, it is often just an inconvenience and a learning experience. Unfortunately, for some, the result is death, or serious and sometimes permanent disability.

There are important reasons that the term “unintentional” is replacing “accidental” when injuries are discussed on local, state, or national levels. Changing to the term, “unintentional” is not simply a matter of semantics. “Accidental” means that the incident happened by chance *without apparent cause*. “Unintentional” simply means that it was *not done on purpose*. The importance of this distinction lies in the fact that if there is an apparent cause, as is true with most injuries, then there are very likely preventive steps that could have been taken to help avoid the injury or death. This distinction also imparts a need for personal responsibility in prevention efforts, rather than individuals simply saying, “it was just an accident”.

A lack of understanding about a child’s expected behavior and self-control at different developmental stages, and lack of adequate adult supervision are the most frequent underlying causes of childhood injuries and deaths, regardless of the specific type of injury. The physical, motor, and behavioral development of children has tremendous impact on their risk for injuries. Parents and other caregivers need to have *realistic* expectations of children’s behavior. If the adults do not understand the developmental stage of their child to the extent that it affects understanding, self-control, and physical coordination, they may fail to adequately protect the child from predictable risks. The most basic aspect of this protection is supervision.

Especially for young children, the underlying cause of the great majority of injuries is *lack of adequate adult supervision*, as shown in the graph earlier in the report. This is especially true when the child is in a high risk environment such as in a motor vehicle; in driveways, streets, or unenclosed yards; around swimming or wading pools, rivers, lakes or other water hazards; in shopping carts, at playgrounds, or around fires.

The intent of making this distinction between “accidental” and “unintentional” is not to place blame or guilt, but to look at strategies to *prevent* incidents and lower the rate of unintentional injuries and deaths. Beginning on the following page is a discussion of recommendations specific to the cases reviewed by the CDRT.

RECOMMENDATIONS

An important function of child death review teams is to make recommendations that can reduce the number of child deaths and injuries. To continue to see children being killed and injured due to the same circumstances is both heartbreaking and frustrating. Formulating and implementing these recommendations is one of the most difficult tasks that any child death review team or community faces. Recommendations can come under areas defined by the “4 E’s of Prevention”. These include Education, (of the public, professionals, and legislators), Enforcement, (regarding safety laws and policies), Engineering, (technology such as child-resistant medication containers or flame-retardant children’s sleepwear), and Environmental Modification (such as cement medians between lanes of highways, or pedestrian walkways). When feasible, engineering or environmental modifications are the most effective strategies, impacting the greatest number of people. The reason is that the change is *in place*, regardless of individual’s knowledge or willingness to act in a safer manner.

Recommendations also include system changes, which can help local agencies work together more efficiently and effectively when looking into child injuries and deaths.

Prior to each child death case being closed to review at a CDRT meeting, the team is asked to make any recommendations they may feel could be useful in preventing future deaths or severe injuries from the same or similar circumstances. The attempt is made to formulate practical recommendations that can be actually put into effect and have a real chance of affecting outcomes. In order to do so, one must first look at what services in that area are currently available in the community, information on numbers that can be served, cost, and language, as well as what agencies, organizations or individuals could implement the recommendation. As circumstances change or strategies show effectiveness or lack of effectiveness, recommendations may need to be altered.

Please see specific recommendations beginning on the next page.

RECOMMENDATIONS

FAMILY VIOLENCE

- The Sutter County Domestic Violence Council & Child Abuse Prevention Council will continue to meet quarterly to address issues in the area of family violence.
- The community will continue to hold to a “no tolerance” position towards family violence. Local law enforcement agencies and Child Protective Services utilize protocols specific to family violence situations.
- Events sponsored by Casa de Esperanza and other agencies, such as “Hands Across the Bridge” during Child Abuse Prevention Month in April, and the “Candlelight Vigil” during Domestic Violence Awareness Month in October will involve the community as a whole in the awareness and prevention of family violence.
- Refer at-risk parents to appropriate community resources for parenting classes.
- The Sutter County CDRT’s *Shaken Baby Syndrome Prevention Project* will promote awareness of the dangers of SBS with outreach efforts funded by a mini-grant from the Sutter County Children and Families Commission, and donations from Sutter County Sheriff’s Department, and community organizations. Since young males cause 70-80% of shaken baby and shaken-impact injuries are, the project, started in 2003, developed a billboard showing local young men in various sports and occupations holding babies, with a title, “Real Men Know When to be Gentle.... NEVER SHAKE A BABY”.

This project also includes posters, pamphlets, movie theater on-screen ads; educational presentations at numerous parent, student, professional, and community venues; public access television educational spots; and “Fragile: Never Shake a Baby” window and mirror clings in local businesses and restaurants. The pamphlets were produced in English, Spanish and Punjabi. These can be downloaded at the Sutter County Human Services-Public Health section on the county web page at http://www.co.sutter.ca.us/doc/government/depts/hs/ph/hs_public_health. The posters are available free at Sutter County Health Public Health, as long as supplies remain.

PARENTAL & CAREGIVER SUPERVISION

- The Sutter County Children and Families Commission funded a Child Development Behavioral Specialist who is located at the Public Health building. She will work with parents regarding parenting skills and child behavior. Parenting classes area also available through Friday Night Live and other community organizations.
- Public Health Nurses, Friday Night Live, Children’s Home Society, Head Start and Migrant Head Start, First Steps, Casa de Esperanza, and Child Protective Services, Bright Futures, Parent Network, schools, and others provide assessment and /or parenting education, part of which addresses the need for adequate, consistent adult supervision of children.

.....
MOTOR VEHICLE SAFETY
.....

- Multiple agencies will continue to provide community programs such as “Every 15 Minutes” high school drunk driving prevention program.
- Multiple agencies, with law enforcement as lead, will continue to provide safe driving educational messages and outreach regarding areas such as child safety restraints, seatbelt use, drunk and drugged driving, aggressive driving and unsafe passing, driving safety around schools and school buses, and young drivers.

Note: Unfortunately, Office of Transportation Safety (OTS) funding for the child safety restraint and low cost infant/child car seat and booster seat program previously offered through public health is no longer available. A limited number of child safety restraints are available through law enforcement. California Highway Patrol, Yuba City Police Department, and Sutter County Sheriff’s Department have OTS trained Child Safety Restraint technicians that perform child “Car Seat Checks”.

- DUI check-points will continue to be utilized by the law enforcement agencies in the county, including California Highway Patrol, Sutter County Sheriff’s Department and Yuba City Police Department.
- Cal Trans will continue to widen areas of Highway 99, changing a larger percentage of the road into four lanes. This gives drivers a safer option for passing slower vehicles, without needing to enter a lane of oncoming traffic.

.....
SIDS PREVENTION & SAFE SLEEP ENVIRONMENTS FOR BABIES
.....

“Safe Sleep” for infants encompasses both SIDS prevention, such as the “Back to Sleep” Campaign, and safe sleeping environments to avoid deaths by unintentional suffocation.

- Education will continue with Public Health Nurse presentations to groups such as Cal Works, Teen Health Focus at Friday Night Live, First Steps Perinatal Substance Treatment Program, Casa de Esperanza, prenatal classes, and health fairs; during Public Health Nurse home visits, & hospital new parent discharge instruction.

.....
BICYCLE SAFETY
.....

- Multiple agencies, including law enforcement and public health will promote bicycle safety at health fairs, during educational talks, and at other venues.
- Sutter County Sheriff’s Department and Yuba City Police Department will conduct bicycle safety “rodeos” that help youth learn skills necessary to safe biking, as their staffing and funding permits.
- Parents must be responsible for ensuring that their children have the skills they need and that they wear securely fastened helmets at all times when they are riding. Educational talks given by numerous agencies will emphasize this to parents.

.....
GANGS
.....

- Law enforcement agency efforts, including the Yuba-Sutter Anti-Gang Enforcement units, will continue to identify, assess, and work to prevent gang activity throughout Sutter County, including Yuba City and Live Oak. Those efforts will include public awareness and prevention presentations to students, parents, and other citizens, as staffing and funding permits.

.....
SUBSTANCE ABUSE
.....

- Multiple agencies will participate in “Drug Store”. The event takes 2,500 middle school students through a series of eight performed vignettes depicting events leading up to the “fatal” overdose of a student, and the effects upon the family in the emergency room and at the student’s funeral.

NOTE: The “Drug Store” event was held until 2004, but had to be cancelled as of 2005. Although this was a valuable tool, producing this 4-5 day event required an incredible amount of time and staffing on the parts of the agencies involved. As agency budgets became tightened and personnel became less available, it was no longer feasible to hold the program. The Substance Abuse Steering Committee is looking at other prevention strategies, including bringing guest speakers to the county, and having a youth group make anti-drug presentations to students.

- Law enforcement, Mental Health, Public Health, and other agencies will continue to provide community education efforts regarding substance abuse in any form to professionals, parents, pregnant women, students, and other adults regarding the dangers of substance abuse in any form.
- Agencies will work to link substance abusing individuals with treatment programs and/or support groups, to increase their potential for abuse cessation.

.....
WATER SAFETY
.....

- Water safety awareness and education regarding all types of water safety risks (river, swimming pools, large buckets, swimming lessons, adequate adult supervision, etc.) will continue to be addressed by Sutter County Sheriff’s Boat Patrol, other law enforcement and fire personnel, Public Health staff, American Red Cross, Yuba City Parks and Recreation Department, the YMCA, and Yuba City Unified School District, among others.

Note: The team was unable to enact a recommendation made for water safety prevention in 2002 and followed up in 2003. The suggestion had been made to put cautionary signage at various points near the river, regarding the dangers of swimming in the river. Due to some legal concerns, that was not deemed possible at that time. The team plans to revisit this due to continued drownings.

SYSTEM RECOMMENDATIONS

- Child protective services will notify the Sheriff-Coroner’s office of name changes, as happens when a child is adopted, if the child had sustained but survived severe child abuse injuries. This will facilitate linkage of facts regarding the original injuries if the child later dies of the effects of those injuries, such as can occur with Shaken Baby Syndrome. In these types of cases, without the name change information, the true underlying cause of the death would be more difficult to determine, or the adoptive parents might inadvertently be suspected of causing the injuries.
- Continue to work with the State Child Death Review Council, the regional Child Death Review Council and other county child death review teams to facilitate cross-jurisdictional information exchange for child death cases when county of residence, and/or death differ, and to share information for interventions that can lower the incidence of child deaths.

CONCLUSIONS

Although 56 deaths were reviewed from 2001-2005, there are limitations to the conclusions that can be drawn. As was mentioned early in the report, within different categories these are still small numbers, and small fluctuations can seem to show changes in trends that may not actually be statistically significant. The numbers of deaths in a year varied from 4 at the lowest to 20 at the highest, which averages 11 deaths per year. As of October 1, 2006, when this report was being completed, there had been 10 deaths in 2006.

Because some types of child fatalities, such as suicide, SIDS, and child abuse deaths, occur relatively rarely in Sutter County, a pattern cannot really be identified. A spike in child abuse deaths showed up in 2002, but was mainly due to 3 deaths in one incident in which the perpetrator came from an out-of-state residence the night prior to the incident. So although this was horrifying and dramatic, it does not portend a trend.

There have been no suicides or child abuse deaths in the age group covered by the CDRT since 2002. However, fatalities represent only the tip of the intentional or unintentional injury "iceberg". For each fatality, there are many more injuries, from mild to severe. Even some "natural" deaths may be preventable. Therefore, to ignore prevention aspects would be doing a major disservice to our children.

There are some consistencies to be seen throughout the years. Boys die more frequently than girls, at all ages, and of all causes. Newborns die most often from prematurity, followed by birth defects. In the "Unintentional" category, vehicle-related deaths far outnumber deaths by all other causes. The passenger, rather than the driver was the victim almost three-quarters of the time. The driver was a friend of the victim in 40% of the deaths. In the vehicle-related incidents, excessive speed was by far the most common factor. When looking at all of the unintentional deaths, inadequate adult supervision was the underlying cause in 55% of the cases; and in even a larger proportion of the unintentional deaths under the age of thirteen. All of the homicide victims during this time period were boys. These findings are all fairly consistent with state and national statistics.

A child's home should be their haven, and be the primary place in their world where they can depend on being loved, cared for, and protected. Although deaths directly attributable to child abuse accounted for "only" 9% of the deaths, there was a history of some type of family violence or neglect in 30% of the total deaths. Excluding "natural" deaths, there was a history of some type of known family violence or neglect in 49% of the homes in which children died due to intentional, unintentional, or undetermined causes. The community needs to continue to look at the dynamics of families where family violence or neglect occurs. For not only do these children face a higher risk of premature death from causes other than violence and neglect, but they often grow up to repeat the patterns of abuser or victim in relationships in their own adult lives.

We as parents, relatives, friends, caregivers, educators, professionals, and the community at large need to continue to look at prevention strategies that will help keep our children safe and healthy. No child should die an early death if that death was preventable.

APPENDIX A

ON-LINE RESOURCES

There are countless resources available, many on-line. The following is just a sampling of reputable web sites with information on some of the topics covered in this report. Please use caution when going to web sites in general. Many exist that purport to be experts in a particular area, but may not have objective or legitimate information, especially concerning sensitive areas such as child injuries and deaths.

CHILD DEATH REVIEW

National MCH Center for Child Death Review <http://www.childdeathreview.org/>

National Center on Child Fatality Review <http://ican-ncfr.org/>

CHILDREN & CANCER

National Cancer Institute: Childhood Cancers

<http://www.nci.nih.gov/cancertopics/types/childhoodcancers>

CHILD SAFETY: GENERAL INFORMATION

Center for Injury Prevention Policy & Practice <http://www.cipp.org/>

Harborview Injury Prevention & Research Center <http://depts.washington.edu/hiprc/>

Safe Kids <http://www.safekids.org/>

Sutter County Children & Families Commission

<http://www.co.sutter.ca.us/doc/government/depts/hs/cfc/cfchome>

Sutter County Human Services: Public Health

http://www.co.sutter.ca.us/doc/government/depts/hs/ph/hs_public_health

Sutter County Human Services: Welfare & Social Services

http://co.sutter.ca.us/doc/government/depts/hs/wss/hs_welfare_social_services

Sutter County Sheriff's Department Boat Patrol

http://sheriff.co.sutter.ca.us/patrol_division/boat_patrol.htm

Sutter County Fire Services

http://www.co.sutter.ca.us/doc/government/depts/cs/cs_fire_services

U.S. Army Corps of Engineers: Water Safety <http://www.spk.usace.army.mil/cespk-de/kidssite/watersafety/>

U.S. Consumer Product Safety Commission http://www.cpsc.gov/cpscpub/pubs/chld_sfy.html

Yuba City Fire Department <http://www.yubacityfire.org/>

Yuba City Police Department: Crime Prevention <http://www.ycpd.org/index.cfm?navID=1037>

DATA

California Highway Patrol <http://www.chp.ca.gov/html/publications.html>

California County Health Status Profile

<http://www.dhs.ca.gov/hisp/chs/OHIR/reports/healthstatusprofiles/2006/profiles.pdf#search=%22california%20county%20profile%202006%22>

California Department of Health Services, Epidemiology & Prevention

<http://www.applications.dhs.ca.gov/epicdata/default.htm>

Centers for Disease Control (CDC) Statistics <http://www.cdc.gov/ncipc/wisqars/> and

<http://www.cdc.gov/search.do?action=search&page=2&queryText=10+leading+causes+of+death+chart>

Child Trends <http://www.childtrends.org/>

Children Now <http://www.childrennow.org/>

Office of the California Attorney General: *Child Deaths in California 2005*:

http://safestate.org/documents/Child_Death_in_California_report.pdf

U.S. Census: Sutter County <http://quickfacts.census.gov/qfd/states/06/06101.html>

U.S. Dept. of Health & Human Services <http://www.os.dhhs.gov/>

U.S. Dept. of Justice <http://www.ojp.usdoj.gov/bjs/welcome.html>

GRIEF & MOURNING

Compassionate Friends <http://www.compassionatefriends.org/>

Trauma Intervention Program (TIP) of Yuba-Sutter Counties <http://tipnational.org/node/192>

MOTOR VEHICLE INJURY INFORMATION & PREVENTION

California Highway Patrol <http://www.chp.ca.gov/>

Kids and Cars <http://www.kidsandcars.org/>

National Highway Transportation Safety Administration

<http://www.nhtsa.dot.gov/portal/site/nhtsa/menuitem.9f8c7d6359e0e9bbb30811060008a0c/>

PREMATURITY & BIRTH DEFECTS

March of Dimes <http://www.marchofdimes.com/>

SHAKEN BABY SYNDROME

National Center on Shaken Baby Syndrome <http://www.dontshake.com/>

National Institute on Neurological Disorders

<http://www.ninds.nih.gov/disorders/shakenbaby/shakenbaby.htm>

SUDDEN INFANT DEATH SYNDROME (SIDS)

California SIDS Program: <http://californiasids.com/Universal/MainPage.cfm?p=10>

U.S. Consumer Product Safety Commission: Crib Safety & SIDS Prevention

<http://www.cpsc.gov/cpsc/pub/pubs/cribsafe.html>

SUICIDE-YOUTH

Bi-County Mental Health

http://www.co.sutter.ca.us/doc/government/depts/hs/mh/hs_mental_health

Center for Suicide Prevention <http://www.suicideinfo.ca/youthatrisk/>

VIOLENCE & CHILDREN/YOUTH

California Attorney General: *Sate from the Start* <http://www.safefromthestart.org/>

California Attorney General: *Sate State* <http://safestate.org/index.cfm?navid=110>

Centers for Disease Control (CDC) *Best Practices for Youth Violence Prevention*

<http://www.cdc.gov/ncipc/dvp/bestpractices.htm>

National Council on Child Abuse and Family Violence <http://nccafv.org/>

Prevent Child Abuse America <http://www.preventchildabuse.org/index.shtml>

Yuba City Police Department: Gang Prevention for Parents

<http://www.ycpd.org/ycpd/news/index.cfm?navID=1019&id=5098&action=detail>

APPENDIX B

SUTTER COUNTY CHILD DEATH REVIEW TEAM
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CHIEF RICHARD DOSCHER
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APPENDIX C

CALIFORNIA STATE CHILD DEATH REVIEW COUNCIL
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