

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: HEALTH SERVICES AGENCY
Urgent _____ Routine X *He*
CEO Concurs with Recommendation YES *ght* NO _____
(Information Attached)

BOARD AGENDA # *B-6
AGENDA DATE October 30, 2001
4/5 Vote Required YES _____ NO

SUBJECT:

ACCEPTANCE OF FY 2000-2001 SUMMARY REPORT FROM THE STANISLAUS
COUNTY FAMILY VIOLENCE DEATH REVIEW TEAM.

STAFF
RECOMMEN-
DATIONS:

1. ACCEPT THE FY 2000-2001 SUMMARY REPORT FROM THE STANISLAUS
COUNTY FAMILY VIOLENCE DEATH REVIEW TEAM.

FISCAL
IMPACT: None.

BOARD ACTION

No. 2001-820

On motion of Supervisor Blom, Seconded by Supervisor Mayfield
and approved by the following vote,
Ayes: Supervisors: Mayfield, Blom, Simon, and Chair Paul
Noes: Supervisors: None
Excused or Absent: Supervisors: Caruso
Abstaining: Supervisor: None

- 1) Approved as recommended
- 2) _____ Denied
- 3) _____ Approved as amended

MOTION:

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk

By: Deputy *Christine Ferraro*

File No.

SUBJECT: ACCEPTANCE OF FY 2000-2001 SUMMARY REPORT FROM THE STANISLAUS COUNTY FAMILY VIOLENCE DEATH REVIEW TEAM

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DISCUSSION: The Stanislaus County Family Violence Death Review Team (DRT) was implemented in 1999 at the recommendation of the Domestic Violence Coordinating Council. The interdisciplinary team, which meets monthly, carries out the functions of both a Child Fatality Review Team and a Domestic Violence Death Review Team as allowed by State law. The team reviews deaths caused by or directly related to domestic violence and deaths of children that are or may be caused by child abuse and neglect. As a result of these reviews, the team develops recommendations of actions that could be taken in the future to have an impact on prevention of future fatalities.

The Death Review Team reviewed 13 cases during the FY 2000-2001 session; 5 adult and 8 child deaths. The following circumstances were consistently seen in the lives of the perpetrators:

- Substance abuse
- Mental illness
- Childhood history of experiencing or witnessing violence or abuse

The majority of the child deaths took place at the hands of someone other than the child's biological parent.

As a result of these reviews, the DRT makes the following recommendations for policymakers to consider:

Education and Outreach

1. Outreach to Spanish-speaking parents about supportive services.
2. Outreach to parents about safe, appropriate child care.
3. Education for service providers and parents about child abuse, appropriate infant handling, and vulnerability to head injuries.
4. Educate mandated reporters about cross-reporting child abuse, including cases of child death.
5. Public education with a focus on school employees about domestic violence
6. Education for health care providers and elder caretakers about the potential effect medications may have on behavior and elder abuse

SUBJECT: ACCEPTANCE OF FY 2000-2001 SUMMARY REPORT FROM THE STANISLAUS COUNTY FAMILY VIOLENCE DEATH REVIEW TEAM

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**DISCUSSION
(CONTINUED):**

Agency/InterAgency Policies and Procedures

1. Develop consistent system of communication for cross-checking cases between CPS and law enforcement.
2. CSA to develop an internal system to assure clearance of cases between CPS staff, supervisors and entitlement systems.
3. CSA to evaluate the coordination with, and effectiveness of, the Interstate Compact for Placement of Children (ICP).
4. The Coroner's Office has instituted a policy of full body x-rays on all children who die under suspicious circumstances.
5. Develop a referral system between jurisdictional law enforcement, Coroner, and CPS when there is a death of a parent or sole caregiver to assure appropriate care and placement of minors.
6. The Coroner's Office has implemented a process where DNA is saved on all Coroner's cases to Probation to address substance abuse and mental health issues in domestic violence cases.

Services/Programs

1. Develop a program to provide counseling and follow-up services to siblings or children of victims of violence or suicide.
2. Provide support to adoptive parents, especially those with special needs children.

**POLICY
ISSUES:**

Acceptance of the FY 2000-2001 Summary Report from the Stanislaus County Family Violence Death Review Team will support the Board's priority of a safe and healthy community, multi-jurisdictional cooperation, and community leadership.

**STAFFING
IMPACT:**

None.



HEALTH SERVICES AGENCY
Public Health Services

John A. Walker, M.D.
Public Health Officer

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Death Review Team Summary

FY 2000-2001

The Stanislaus County Family Violence Death Review Team met for its second year, fiscal year 2000-2001. During that year 13 cases were reviewed, 5 adult and 8 child deaths. All deaths were due to one of the following causes: domestic violence, elder abuse, suicide related to domestic violence or child abuse, child abuse or child neglect.

In most cases there is a thread of one or more of the following being a part of the life of the perpetrator; substance abuse, untreated mental illness, childhood history of experiencing or witnessing violence or abuse. In the case of the child deaths, the majority were at the hands of someone other than the child's biological parent.

The proceedings of these meetings have resulted in the following recommendations and accomplishments.

I. Recommendations

The Family Violence Death Review Team makes the following recommendations to our community and the various agencies that serve families.

Education and Outreach

1. Continue to increase and improve outreach to Spanish speaking parents about supportive services. Assure safety in accessing needed services to alleviate concern with regards to INS issues.
2. Outreach to parents under stress to educate about and facilitate use of safe appropriate child care.
3. Education for service providers and parents about child abuse, appropriate infant handling, and vulnerability to head injuries.
4. Educate mandated reporters about cross reporting child abuse including cases of child death.
5. Public education with a focus on school employees, about:
 - Identifying victims of domestic violence and children who may be witnessing it.
 - Appropriate interventions
 - Community resources
6. Education for health care providers and elder caretakers about the potential effect medications may have on behavior. Education for mandated reporters for

elder/dependent adult abuse about the relationship between underlying medical problems and vulnerability to death due to injuries.

II. Agency/Inter-agency Policies and Procedures

1. Develop consistent system of communication for cross checking cases between CPS and law enforcement.
2. CSA to develop an internal system to assure clearance of cases between CPS staff and supervisors and the various entitlement systems to follow up on cases where contradictory information has been reported.
3. Evaluate the coordination with and effectiveness of the Interstate Compact for Placement of Children (ICPC) to assure safety and supportive services to receiving family.
4. The Coroner's Office has instituted a policy of full body x-rays on all children who die under suspicious circumstance
5. Make substance abuse treatment a part of probation plan for Domestic Violence cases where substance use was associated with the offense.
6. Recommend that multiple offenders in Domestic Violence cases obtain a mental health evaluation and facilitate treatment and follow up.
7. Develop a referral system between jurisdictional law enforcement, coroner and CPS when there is a death of a parent or sole care giver to assure appropriate care and placement of minors.
8. The Coroner's Office has implemented a process where DNA is saved on all coroner's cases to facilitate identification of future cases.
9. Probation to address both misdemeanor and felony domestic violence cases more attentively, especially those where there are accompanying substance abuse and mental health issues.

III. Services/Programs

1. Develop a program to provide counseling and follow-up services to siblings or children of victims of violence or suicide.
2. Provide support to adoptive parents, especially those with special needs children.

IV. Accomplishments:

In addition to reviewing cases this year, the DRT has reevaluated its operation and has adopted the following changes to improve effectiveness.

Reorganization

1. Health Officer has taken responsibility of Co-Chair of the DRT.
2. The DRT plans to reinstate a revised screening committee process to facilitate the review of more cases.

The committee will consist of:

Health Officer

Supervising PHN

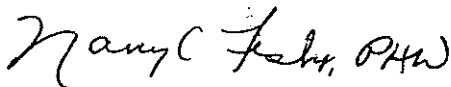
Coroner's representative/Forensic Pathologist

CPS Manager

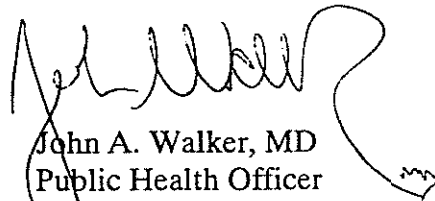
3. Plan to seek participation of a Pediatrician on child death cases.
4. Plan to screen all child deaths

V. Operation

1. Data collection has begun for the State F-CANS (Fatal Child Abuse and Neglect System) system. The first cohort of data will be submitted in July 2001 for fiscal year 2000-2001.
2. Members of the DRT attended an F-CANS training in Sacramento.
3. Child death cases are being reviewed concurrent with judicial process as recommended by State Child Death Review Team.
4. The Team will review the ability to be concurrent with Domestic Violence and Elder/Dependent Adult Abuse Cases.



Nancy Fisher, PHN
Supervising Public Health Nurse
Health Services Agency
Co-Chair, Death Review Team



John A. Walker, MD
Public Health Officer
Stanislaus County
Co-Chair, Death Review Team

June 22, 2001

Attachment: List of DRT participants

Stanislaus County Family Violence Death Review Team Membership Directory

A. Core Team:

Public Health

Nancy Fisher, Supervising Public Health Nurse
John Walker, MD, Public Health Officer

County Coroner – Jennifer Rulon, MD, Pathologist

Law Enforcement – Alan Carter, Sergeant, Modesto Police Dept. (alternate Ray Taylor)
Rick Irwin, Lieutenant, Sheriff's Office

District Attorney – Linda Weidman, Criminal Investigator (alternate Fred Antone)
Linda McFadden, Deputy District Attorney

Mental Health – Madelyn Schlaepfer, Ph.D., Chief, Managed Care Services, Behavioral Health & Recovery Services

Criminologist – Cecil A. Rhodes, J.D., Professor, California State University-Stanislaus

Child Protective Services – Teri Kook, M.S., Manager IV, Section Chief, Child Welfare Services, Community Services Agency (alternate Egon Stammler)

B. Additional team members for cases related to children:

Medical Practitioner –

Family Court Services – Sandra Lucas, MFCC

Deputy District Attorney – Linda McFadden

Representative from community agency – Colleen Garcia, Children's Crisis Center
(alternate Lety Mendoza)

Representative from reporting agency – Patricia Cassinerio, Office of Education

C. Team members for cases involving domestic violence:

Medical Practitioner –

Family Court Services – Sandra Lucas, MFCC

Representative from community agency – Paula Harter, Haven Women's Center
(alternate Irene Westbury)

Representative from reporting agency – Lina Ruppel, Health Services Agency (HSA)

Domestic Violence (continued)

District Attorney

- JaVonne Phillips, Deputy District Attorney Specialist
- Fred Antone, Criminal Investigator

Probation – Lisa Reece, Deputy Probation Officer II (alternate Denise Locke)

D. Team members for cases involving elder and dependent adult abuse:

Medical Practitioner –

Adult Protective Services – Anne Danhoff, Social Worker Supervisor, CSA

Public Guardian – Denise Hunt

Deputy District Attorney – Alan Cassidy

Representative from community agency – Margie Palamino, Area Agency on Aging

Representative from reporting agency – Kathy Torres, SEPA/Catholic Charities Ombudsman

Public Health professional – Phyllis Sarasqueta, PHN, Community Services Agency
Fred Gack, PHN, CSA (alternate)

E. Team members for suicide cases:

Psychiatrist or psychologist – Madelyn Schlaepfer, Ph.D.

Representatives from community agencies

- Nancy Creech, Center for Human Services
- (Judy Kindle, Sierra Vista Family Counseling)

F. Temporary members, as needed:

- Child care or development specialist
- Drug and alcohol counselor
- Educator
- Clergy
- Private legal community with expertise in family law
- Representative of an agency that services youth or adolescents
- First responder or emergency medical technician
- Hospital emergency room staff
- Public health or home health nurse
- Nursing home ombudsman
- Medical ethicist
- Arson or fire investigator
- Representative from law enforcement at CSUS
- Others, as needed