Click Here to Return to Agenda

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

DEPT: HEALTH SERVICES AGENCY **BOARD AGENDA#** B-16

Urgent _____ **Routine** X **AGENDA DATE** October 29, 2002

CEO Concurs with Recommendation YES ~~NO~~ **NO** _____ **4/5 Vote Required YES** _____ **NO** _____
(Information Attached)

SUBJECT:

ACCEPTANCE OF THE FY 2001-2002 THIRD ANNUAL REPORT FROM THE STANISLAUS COUNTY FAMILY VIOLENCE DEATH REVIEW TEAM

STAFF RECOMMENDATIONS:

ACCEPT THE FY 2001-2002 THIRD ANNUAL REPORT FROM THE STANISLAUS COUNTY FAMILY VIOLENCE DEATH REVIEW TEAM.

FISCAL IMPACT:

This report includes recommendations by the members of the Stanislaus County Death Review Team that may result in County agencies shifting funding to respond to areas of concern. No requests for additional funding are associated with the approval of this item.

BOARD ACTION AS FOLLOWS:

No. 2002-835

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

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
MOTION:

1010-08

Christine Ferraro

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk **By: Deputy** **File No.**

Click Here to Return to Agenda

DISCUSSION: For the past three years, the Stanislaus County Family Violence Death Review Team has been meeting to review the circumstances surrounding deaths that were or may have been related to child abuse and neglect, domestic violence, or elder abuse. On behalf of the Stanislaus County Family Violence Death Review Team, the Health Services Agency is presenting this report to the Board.

The report outlines the following areas of community concern with recommendations for community response:

- Adolescent suicide
- Elder abuse
- Infant death due to poor sleeping arrangement
- Toddler drowning
- Abandoned new born
- Domestic violence

POLICY ISSUES: Acceptance of this report addresses the Board's priorities of ensuring a safe, healthy community, delivering excellent community services, and modeling community leadership.

STAFFING IMPACT: There is no staffing impact associated with this request.

Click Here to Return to Agenda

Stanislaus County
FAMILY VIOLENCE DEATH REVIEW TEAM
Third Annual Report
July 1,2001 – June 30, 2002
(Subject to Acceptance by the Board of Supervisors)

The Stanislaus County Family Violence Death Review Team was formed at the recommendation of the Domestic Violence Coordinating Council. The team has met for the last three years under the jurisdiction of State Statutes that allow for interdisciplinary team reviews of child deaths including deaths caused by, related to or suspected of being related to child abuse and neglect, deaths caused by or related to domestic violence or elder abuse and neglect deaths. The review of elder abuse deaths was added in response to SB 333. These statutes require that the reviews be confidential discussions of the cases in question and that case specific information presented not be revealed outside the meetings. The emphasis is on evaluating the need for systems change and identification of gaps in services. The diverse make-up of the team (see attached membership list) provides the members with insight into the approach each discipline takes in addressing these situations and fosters improved understanding of each other's role in the community. The ultimate purpose of these meetings is to be proactive in averting future deaths.

The Stanislaus County Family Violence Death Review Team (DRT) has met monthly through out fiscal year 2001-2002. The goal of these meetings has been to review the circumstances surrounding the untimely deaths of persons who were /or suspected of being the victims of child abuse or neglect, adolescent/child suicide, domestic violence, elder dependent adult abuse or suicide related to one of theses. The purpose of the review was to evaluate these circumstances, the services or interventions available to the victim and or perpetrator and to develop recommendations to the health and supportive services community for changes that might contribute to prevention of future deaths.

This fiscal year the team chose to review clusters of deaths where the cause or circumstances surrounding the death were similar to provide more relevant discussion. Because of this decision not all the deaths took place during fiscal year 2001-2002; some were from previous years.

This year the team reviewed a total of 31 deaths:

14 adults
- 5 Domestic Violence related including suicide
- 8 Elder Dependant Adult Abuse/Neglect related including suicide
- 1 no evidence of abuse or neglect

17 Children
- 5 suicides by hanging
- 1 SIDS
- 4 infant suffocation due to overlay
- 5 drownings due to inadequate supervision

- 2 discarded newborn

CHILD AND ADOLESCENT SUICIDES

The trend most troubling to the DRT, was the number older child/adolescent suicides. The 5 cases reviewed all took place in a 19 month period. During that same period of time there were 46 adolescent deaths from all causes. This makes suicides responsible for 11% of the adolescent deaths in that time period. Although no two cases were identical in circumstances and there did not seem to be a copycat element to any of the cases, there were some trends worth considering for increased prevention efforts.

- Others including family members, friends, health care professionals educators were aware of circumstances, behaviors, physical findings that might have been indications of potential problem, but did not report.

  Possible reasons:
  1. Individuals did not want to get involved,
  2. Those aware of a youth being at risk did not know how or where to report
  3. Family and associates did not understand the significance of warning signs

- In addition there is the concern that young adolescents in particular do not fully comprehend the finality of the act.

Suggested Interventions:

- Continue to support and increase mental health outreach and treatment services that are school linked
- Increase physician and community awareness of services available to support families
- Continued education for the general community, with a focus on faith based groups and home schooling organizations about adolescent suicide, depression warning signs and manifestations
- Education for medical providers recommending emotional health screening for adolescents receiving Acutane
- Need to continue to inform teens about importance of reporting when friends share suicidal thoughts
- Increase frequency of presentation to schools and youth groups.
- Coroner Staff include suicide prevention message during presentations to school groups
- Continued education to families of teens, youth and schools about signs of potential teen suicide, appropriate interventions and available services

ELDER ABUSE AND NEGLECT

The next area of concern was victims of elder dependent abuse and neglect. In the majority of these cases death was due to neglect or inadequate supervision rather than outright physical abuse. The causes varied, but the circumstances had some features in common that included:

- Adults who cannot speak adequately for themselves and who do not always have an advocate available to assure their welfare.

- Some vulnerable adults do not have adequate and appropriate supervision or assistance.
- Inter agency/provider/family communication is not always adequate to assure clear transmission of information in the best interest of elder.

The team felt that the following might be important efforts to contribute to prevention of such deaths:

- Increase physician and community awareness of services available to support families.
- Increase community awareness of the danger of certain drug interactions and potential for depression
- Provide information to private medical providers about supportive services available to elderly and disabled
- Continued vigilance on the part of coroner to be aware of "Red Flags" in cases of unexplained or poorly explained elder deaths.
- Hospital to include social workers in all discharge planning for patients unable to advocate for themselves who do not have an advocate present.
- Improve education of residents, other MDs new to area about appropriate inter facility transfer procedures.
- Continued education of care homes about their reporting and supervision requirements.
- Improved system to assure advocacy for people unable to do for them selves.
- Assure continued funding for Adult Protective prevention and intervention services.

TODDLER DROWNINGS:

The next area of concern was deaths to toddlers as a result of drowning. These all relate to inadequate adult supervision of young children around water regardless of whether it was near a large body of water, swimming pool or bathtub. The inattention on the part of the adults was often associated with substance abuse or domestic unrest. Four of these deaths took place in an 18-month period. During that time the number of deaths to children age 1 ½ -3 ½ years of age was 4, making drowning the only reason children in this age group died during this period of time. One death was as a result of injuries caused by a near downing 5 years prior.

The team's recommendations in this area were:

- Outreach and education to community about keeping pools safe from young children.
- Outreach and education about appropriate supervision of and safety measures to protect toddlers around bodies of water
- Increased community education about safety of bath seats and appropriate supervision of children in bath tubs
- Increase education for community about drowning risk, include Spanish and other monolingual communities
- Increase education for community about grief resources, inform law enforcement about resources available to families

INFANT DEATH DUE TO SUFFOCATION

The fourth area of concern were infant deaths due to suffocation as a result of being rolled over on by an adult or older child or because of becoming wedged between bedding pillows or a wall because of inappropriate sleeping accommodations. Again the deaths were related to

inappropriate adult supervision or poor choice of sleeping accommodations. These deaths seem more likely to take place where there is substance abuse occurring among the adults in the home. The four deaths to infants aged 2-8 months took place during a 12-month period when there were a total of 15 infant deaths for all causes. This means 25% of all the deaths to infants in the 2-8 month age group during that 12 month period.

The team has recommended the following actions be taken:

- Community education about choosing safer sleeping environments for infants and the dangers of co-sleeping especially when using drugs and alcohol.

ABANDONED NEWBORNS

There were two deaths to infants who were abandoned at the time of their birth. Although the circumstances surrounding their birth and death were not identical the team's recommendations to contribute to prevention of such situations include

- Continued and increased community education about availability of prenatal care, payer sources and support services for families. Particular outreach to Spanish speaking community through churches and media.
- Promotion of Safe Arms Act. Particular outreach to Spanish speaking community through churches and media.

The team reviewed one infant death that was attributed to Sudden Infant Death syndrome (SIDS). This review led to one recommendation:

- Increase education for child care providers and parents about importance of SIDS risk reduction in all settings

ADULT DOMESTIC VIOLENCE

The team reviewed 5 domestic violence related deaths. These included the suicide deaths of domestic violence perpetrators following the commission of the murder. A clear area of concern is the increased level of lethality just prior to incarceration or shortly after release from custody. The other is the increased level of vulnerability for women who are in the process of leaving a relationship. The team recommendations for domestic violence are:

- Need to decrease the number of convicted domestic violence perpetrators who are given time off to "get affairs in order" before reporting to prison
- Increase community awareness about issues related to relationships between family violence and substance abuse and availability of supportive services.
- Public information/education about domestic violence and risks of escalation.
- Public information about how friends can refer potential victims to resources

One of the adult deaths reviewed was determined to be due to natural causes with no apparent abuse or neglect involved.

In addition to the recommendations the DRT has made in relation to specific causes of death the team makes the following recommendations for improved system response to these situations:

- Education of trauma physicians regarding the needs of the forensic pathologist when there has been a death due to violence

Click Here to Return to Agenda

- Need to institutionalize the system to notify CPS when a child has been orphaned, especially by violence.

TEAM ACCOMPLISHMENTS DURING FISCAL YEAR 2001-2002

- Due to information gained in reviewing cases the Coroner's office has begun to alert Child Protective Services when there has been a death that has left children orphaned or without their legal guardian.
- Reinstated a screening committee to develop list of cases for review
- Initiated initial review of cases concurrent with ongoing investigation- main goal to assure safety of minors and dependant adults
- Clustering of like cases to review
- Initiated review of elder adult abuse cases in compliance with recent legislation