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

DEPT: HEALTH SERVICES AGENCY **BOARD AGENDA#** *B-10

Urgent ____ **Routine** X **AGENDA DATE** November 4, 2003

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

SUBJECT:

ACCEPTANCE OF THE FY 2002-2003 FOURTH ANNUAL REPORT FROM THE STANISLAUS COUNTY FAMILY VIOLENCE DEATH REVIEW TEAM

STAFF RECOMMENDATIONS:

1. ACCEPT THE FY 2002-2003 FOURTH 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 or community based organizations shifting funding or seeking new revenue sources to respond to areas of concern. No requests for additional funding are associated with the approval of this item. The County Health Services Agency currently has $12,000 in funding in the Fiscal Year 2003-04 in the Public Health legal budget unit specifically for implementation of family violence prevention activities as identified by the community during a strategic planning process. The Community Services Agency also has funding targeted at child abuse prevention through the Children's Trust Fund and Child Abuse Prevention, Intervention and Treatment dollars.

BOARD ACTION AS FOLLOWS:

No. 2003-1027

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

1) X **Approved as recommended**
2) ____ **Denied**
3) ____ **Approved as amended**
4) ____ **Other:**

MOTION:

1010-08

ATTEST: **CHRISTINE FERRARO TALLMAN, Clerk**

File No.

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DISCUSSION: For the past four 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/dependant adult 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:
  -Continued education of adolescents and their families about the signs of adolescent depression and risk of suicide.
  -Focus on education for the faith community, especially churches associated with specific ethnic and racial communities.

- Elder abuse:
  -Increase education of medical office staff, dentists and others who may see vulnerable adults and their caregivers to the signs of depression, being overwhelmed, hopelessness and hints that there is a need for assistance.
  -Educate public and faith community about the role they can play in being supportive of caregivers.
  -Educate the public and faith community about Adult Protective Services (APS) and mandated reporter issues.

- Infant deaths due to poor sleeping arrangement:
  -Community education about choosing safer sleeping environments for infants and the dangers of co-sleeping especially when using drugs or alcohol.
  -Develop a community-wide program to assure that families, especially transient families, have access to appropriate portable cribs and education about proper use.
  -Educate and encourage prenatal providers to refer at-risk women to supportive services during pregnancy.
  -Educate hospital emergency room staff on importance of not labeling infant death cases as SIDS until determination has been made by Coroner's Office. Review protocols for cause of death determination.
  -Improve community access to education about resources for at-risk families.

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DISCUSSION (CONTINUED):

- Infant/toddler deaths due to poor supervision or improper handling:
  -Continuing education for Child Protective Services (CPS) workers and others who make home visits to identify signs of drug use and risk associated with it in the home.
  -Encourage routine CPS referrals to Public Health Nurses when inadequate parenting skills are identified, but abuse not substantiated.
  -Support broad access to parenting education that includes appropriate developmental expectations.
  -Promote continued education of parents concerning age and developmentally appropriate supervision for toddlers and preschoolers.

- Abandoned newborn:
  -Continued and increased community education about availability of prenatal care, coverage sources and support services for families with 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.
  -Educate emergency dispatch and EMS to treat any call reporting a miscarriage or stillbirth as a live birth until the baby is found and viability is determined, regardless of what the caller reports.
  -Continued vigilance to assure that children in the foster care system receive appropriate mental health services.

- Domestic violence:
  -Increase education of medical office staff, dentists and others who may see vulnerable adults and their caregivers to the signs of depression, being overwhelmed, hopelessness and hints that there is a need for assistance.
  -Educate public and faith community about the role they can play in being supportive of caregivers.
  -Educate the public and faith community about APS and mandated reporter issues.

The members of the Death Review Team will assure distribution of this report to County agencies, community service providers and collaboratives.

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POLICY ISSUES: Acceptance of this report supports 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.

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FAMILY VIOLENCE DEATH REVIEW TEAM

Annual Report

(Pending acceptance by the Board of Supervisors)

Fiscal Year 2002-2003

I. Summary

The Stanislaus County Family Violence Death Review Team (DRT) has met monthly through out fiscal year 2002-2003. 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 health and supportive services in the community for changes that might contribute to prevention of future deaths.

In addition to the case review meetings members of the Death Review Team have presented the results form last year's report to a variety of groups including the Stanislaus County Board of Supervisors, Domestic Violence Coordinating Council, Stanislaus Children's Council and the Stanislaus Children and Families Commission.

This year the team reviewed a total of 30 deaths:

11 Adults

- 5 Domestic Violence related including a suicide
- 2 Elder Dependant Adult Abuse/Neglect-related, including a suicide
- 4 Unintentional injuries with no evidence of abuse or neglect

19 Children

- 2 suicides; 1 by hanging , 1 by vehicular accident
- 4 infant suffocation due to overlay or poor choice of sleeping arrangement
- 1 drowning due to inadequate supervision
- 1 child found in a hot car
- 1 adolescent unintended overdose
- 2 discarded/possibly suffocated newborns
- 3 abusive head trauma type injuries, in one case the child died years after the original injury from an unintended injury.
- 2 natural causes 1 infant and 1 Adolescent
- 2 blunt force trauma of unknown intent, 1 child 1 unborn fetus
- 1 fetal death due to domestic violence

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II. CATEGORICAL REVIEW

A. INFANT DEATH DUE TO ASPHXIA

The primary area of concern during this year were infant deaths due to asphyxia as a result of being rolled over on by an adult or because of becoming wedged between bedding, pillows or the bed or chair structure. The deaths were related to inappropriate adult supervision or poor choice of sleeping accommodations for the child's age or development. These deaths seem more likely to take place where the responsible adults are distracted by substance abuse or unstable relationships. In some cases there was no crib available for the infant to sleep in. There were *4 deaths of children age 2-6 months of age in a 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.
- Develop a community wide program to assure that families, especially transient families, have access to appropriate portable cribs and education about proper use.
- Educate and encourage prenatal providers to refer at risk women to supportive services during pregnancy
- Educate hospital emergency room staff on importance of not labeling infant death cases as SIDS until determination has been made by coroner's office. Review protocols for cause of death determination.
- Improve community access to education about resources for at risk families.

Actions taken as a result of review:

- Behavioral Health and Recovery Services Leaps and Bounds Program has added assessment of sleeping arrangements to their intake of infants served and is using some available Prop 10 dollars to provide cribs to their enrolled families in need.
- Health Services Agency has applied for a Prop 10 Grant to address infant mortality. One component of the proposed program will be education about purchasing safe cribs for families that are served.

B. ABANDONED NEWBORNS

There were two deaths to infants who were found dead shortly after their birth. The circumstances surrounding the births were similar in that the mothers had received no prenatal care and the births were unattended, but due to a number of factors the immediate circumstances surrounding their deaths were not clear. In both cases the mothers had other children.

The team has recommended the following actions be taken:

- Continued and increased community education about availability of prenatal care, coverage sources and support services for families with particular outreach to Spanish speaking community through churches and media.

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- Promotion of Safe Arms Act. Particular outreach to Spanish speaking community through churches and media.
- Educate Emergency dispatch and EMS to treat any call reporting a miscarriage or still birth as a live birth until the baby is found and viability is determined regardless of what the caller reports.
- Continued vigilance to assure that children in the foster care system receive appropriate mental health services
- Child Welfare system provide a more vertical format of case management to offer clients the opportunity maintain a relationship with a social worker, facilitating potential intervention at times of stress. The implementation of the Statewide plan for child Welfare Redesign should lead to a more family friendly and supportive system.

C. INFANT/CHILD HEAD TRAUMA/CHILD ABUSE TRAUMA

There were 3 child deaths related to probable shaken baby or inappropriate handling of a baby. In one case the actual cause of death was related to the severe disability the child had suffered due to brain damage as an infant. In all cases the parents or caregivers were, young and/or inexperienced in the appropriate expectations and care of children.

The team has recommended the following actions be taken

- Continuing education for CPS workers and others who make home visits to identify signs of drug use and risk associated with it in the home.
- Encourage routine CPS referrals to PHNs when inadequate parenting skills are identified, but abuse not substantiated.
- Support broad access to parenting education that includes appropriate developmental expectations

Actions taken as a result of review

- Copies of the Stanislaus County Peri-natal Resource Guide and information making public health nursing referrals was sent to the social work departments of the 6 out of county pediatric referral hospitals.
- The Stanislaus Children's Council has facilitated the re-formation of a Child Abuse Prevention Council to address community awareness of child abuse issues and prevention opportunities.

D. ADOLESCENT SUICIDES

This is another trend that has continued to be seen in our county. The numbers are lower than in the last report, but there is still a concern that these adolescents may have been depressed or despondent and there were no indications that were perceived by those around them.

The team has recommended the following actions be taken

- Continued education of adolescents and their families about the signs of adolescent depression and risk of suicide.
- Focus on education for the faith community, especially churches associated with specific ethnic and racial communities

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Actions taken as a result of review of this topic last year

- Behavioral Health and Recovery Services has maintained a consistent schedule of presentations to the education community about adolescent suicide.
- Behavioral Health and Recovery Services have implemented a process where parents of youth seen in emergency services are given an informational brochure describing the risks of teen suicide and recommendations for intervention.

E. DOMESTIC VIOLENCE RELATED DEATHS

There were 5 deaths reviewed that were related to incidents of domestic violence. One of these was a near term fetus and another the suicide of a suspect following a domestic violence murder. One was the death of a disabled adult at the hands of the domestic partner.

The team has recommended the following actions be taken

- Educate prenatal providers about the importance of screening for domestic violence victims at all prenatal visits.
- Investigate deaths and injuries to elder/dependant adults at the hands of their domestic partners or caregivers following the same routines as domestic violence deaths, including the use of a camera to tape scene and interviews, photography of wounds and use of forensic dental experts. In addition victims should be reevaluated after 3 days to photograph wounds where evidence of bruising may be late in developing.
- Educate and encourage inpatient units treating individuals for depression to more closely identify underlying issues
- Community education about domestic violence and elder/dependant adult abuse, how to identify warning signs, where there is help, when to intervene.

Actions taken as a result of review of this topic last year

- Health Services Agency Public Health division has been awarded a Family Violence Prevention Grant to develop, with community input, interventions to prevent or promote early intervention in cases of child abuse domestic violence or elder/dependent adult abuse.

F. ELDER ABUSE AND NEGLECT

The team reviewed 2 deaths of adults that, although they involved domestic partners, involved the death of a severely disabled person and the suicide of the despondent person responsible.

The team has recommended the following actions be taken

- Increase education of medical office staff, dentists and others who may see vulnerable adults and their caregivers to the signs of depression, being over whelmed, hopelessness and hints that there is a need for assistance.
- Educate public and faith community about the role they can play in being supportive of caregivers.
- Educate the public and faith community about APS and Mandated reporter issues.

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Actions taken as a result of review of this topic last year

- Health Services Agency Public Health division has been awarded a Family Violence Prevention Grant to develop, with community input, interventions to prevent or promote early intervention in cases of child abuse, domestic violence or elder abuse.

G. TODDLER DROWNINGS:

One death due to toddler drowning because of inadequate adult supervision.

The team has recommended the following actions be taken:

- Promote continued education of parents concerning age and developmentally appropriate supervision for toddlers and preschoolers

H. UNATTENDED CHILD IN A CAR

One death of a child found in a locked car, circumstances undetermined, potentially inattentive parents.

The team has recommended the following action be taken:

- Continued community education about appropriate supervision of children

I. UNDETERMINED/UNINTENDED INJURY DEATHS

There were 2 child deaths, 2 adolescent and 4 elder or disabled adult deaths where the cause was undetermined or unintended injuries including falls, drowning, train accident, alcohol intoxication and care system breakdown.

The team has recommended the following actions be taken:

- Continued education for middle, Junior high and high School student about the dangers of alcohol use
- Increase awareness by service providers and coroner when there is a death leaving dependant adult children unsupervised. Refer to APS to assure proper care and supervision
- Continue to support fall prevention education for elders and their caregivers
- Educate TANF eligibility staff about developmental disabilities, depression and mental health issues and community resources
- Support development of CPS differential response system

The following action was taken as result of one of the deaths:

- Report to consumer product safety commission about a model of hospital bed and mattress

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III. Next Fiscal Year Plan

The Death Review Team plans to continue its regular meetings in FY2003-2004. This will be accomplished with the continuation of the screening committee process as it was established this year.

The DRT Co-Chairs will work with the Health Service Agency Epidemiology staff to develop a database of reviewed cases to facilitate trend analysis for better future planning based on the reports.

The co-chairs would like to thank and commend the leadership of the many participating agencies for allowing their staff to participate in this important prevention focused process. We would also like to thank those who attend and contribute their time and insight on behalf of their agency or organization

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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 – Michael Zahr, Sergeant, Modesto Police Dept.
Bill Heyne, Sergeant, Sheriff's Office
Detective Priscilla Woods, Sheriff's Office

District Attorney – Chris Dickinson, Criminal Investigator (alternate Fred Antone)

Mental Health
- Madelyn Schlaepfer, Ph.D., Chief, Managed Care Services, Behavioral Health & Recovery Services
- Nancy Millberry, LCSW, Chief, Children's System of Care, Behavioral Health & Recovery Services

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

Child Protective Services – Egon Stammler, M.S.W., Family Services, Community Services Agency

B. Additional team members for cases related to **children:**

Family Court Services – Sandra Lucas, MFCC

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**:

Family Court Services – Sandra Lucas, MFCC

Representative from community agency – Leah Silvestre, Haven Women's Center

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

District Attorney
- Doug Maner, Deputy District Attorney Specialist
- Fred Antone, Criminal Investigator

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Domestic Violence continued

Probation – Sherry Huskey, Supervising Probation Officer
Alternate – Willa Duncan, Deputy Probation Officer

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

Adult Protective Services – Anne Danhoff, Social Worker Supervisor, Community Services Agency

Public Guardian – Kim Mallock

District Attorney Criminal Investigator – Kevin Bertalotto, District Attorney/Community Services Agency

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

Representative from reporting agency
- Kathy Torres, SEPA/Catholic Charities Ombudsman
- Sandy Serna, Ombudsman, Catholic Charities

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
- Insa Duke, 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