KERN COUNTY
Public Health Services
DEPARTMENT

MATTHEW CONSTANTINE
DIRECTOR

1800 MT. VERNON AVENUE BAKERSFIELD, CALIFORNIA 93306-3302 661-321-3000 WWW.KERNPUBLICHEALTH.COM

October 11, 2016

Board of Supervisors
Kern County Administrative Center
1115 Truxtun Avenue
Bakersfield, CA 93301

PRESENTATION ON THE CHILD DEATH REVIEW TEAM ANNUAL REPORT
(Fiscal Impact: None)

The purpose of this letter is to present to your Board the calendar year 2015 findings of the Kern County Child Death Review Team and highlight the extensive collaboration that takes place within the team.

Pursuant to the California Penal Code, Section 11174.32-11174.35, the County may establish an interagency team to assist in identifying and reviewing suspicious deaths of children and to facilitate communication between those who perform autopsies and the various agencies involved in child abuse and neglect cases.

The Kern County Child Death Review Team is made up of representatives from the following disciplines:

- Experts in the field of forensic pathology.
- Pediatricians with expertise in child abuse.
- Coroners and medical examiners.
- Criminologists.
- District attorneys.
- Child protective service staff.
- Law enforcement personnel.
- Representatives of local agencies involved with child abuse or neglect reporting.
- County Public Health Services Department staff who deal with children's health issues.

The team is charged with reviewing all child deaths that have been brought to the attention of the Coroner's office, including deaths that were accidental or unintentional, homicides or deaths related to child abuse, suicides, or natural with unusual circumstances. The purpose of such reviews is to identify child deaths that may have been avoided and to report on such deaths as they occur in Kern County.

Therefore, IT IS RECOMMENDED that your Board hear the Department's presentation on the Kern County Child Death Review Team's 2015 annual report.

Sincerely,

Matthew Constantine
Director of Public Health Services

MC:bnc:reh
Attachment
CC: County Administrative Office

KERN COUNTY
2015 Child Death Review Team Report

About this report

This report highlights the trends in child deaths that occurred in Kern County during 2015 calendar year. Specifically, it:

- Presents an overview of the purpose and mission of the Kern County Child Death Review Team (CDRT)
- Reports the results of child death cases reviewed by CDRT
- Tracks trends of child deaths using a five-year retrospective
- Outlines recommendations made by CDRT for addressing the data trends

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Special Thanks

The members of the Child Death Review Team wish to thank the Kern County Board of Supervisors for their commitment to protecting our children and addressing Unsafe Infant Sleep practices in Kern County.

Mick Gleason, (District 1)
Zack Scrivner, (District 2)
Mike Maggard, (District 3)
David Couch, (District 4)
Leticia Perez, (District 5)

A special thank you for the commitment and continued support from Kern County Public Health Services Department:

Matt Constantine, Director of Public Health Services
Dr. Claudia Jonah, Public Health Officer
Brynn Carrigan, Deputy Director of Public Health Services

Acknowledgements

The Kern County Child Death Review Team (CDRT) is made possible by the commitment of its members and their agencies. Under the umbrella of the Kern Child Abuse Prevention Council, the CDRT pursues the answers to questions about preventable child deaths. Sincere appreciation and gratitude goes to the members and guests who participated in the 2015 reviews.

Amanda LeBaron	County Counsel
Andrea Kohler	Kern County District Attorney's Office
Carlos Flores, RN	Valley Children's Hospital
Carol Beecroft	Women's Center-High Desert
Chris Knutsen	Bakersfield Police Department
Cristina Castro	Kern County Mental Health
Curt Williams, Co-Chair	Kern County Department of Human Services
Dawn Ratliff	Kern County Coroner's Office
Deanna Cloud	Kern County Mental Health
Dennis Eddy	Bakersfield Police Department
Dr. David Merzel	Bakersfield Memorial Hospital
Dr. Phil Hyden	Valley Children's Hospital
Elaine Anthony, PHN	Kern County Department of Public Health Services
Esther Schlaerth	Kern County District Attorney's Office
Etta Sharp	Kern County Department of Human Services
Gina Pearl	Kern County District Attorney's Office
Jasmine Williams	Kern County Department of Public Health Services
Jeff Burdick	Bakersfield Police Department
Jeffrey Cao	Kern County Department of Public Health Services
Joe Dougherty	Bakersfield Police Department
John Jamison	Bakersfield Police Department
Johnny Agustin, PHN	Kern County Department of Public Health Services
Justin Fleeman	Kern County Sheriff's Office
Karin Stone	Women's Center-High Desert
Kathy Lemon	Kern County Probation Department
Kelley Scott	County Counsel
Kelli Falk	County Counsel
Kristina Pasma	Valley Children's Hospital
Maria Fierros	Kern County Department of Public Health Services
Martin Heredia	Bakersfield Police Department

Mitch Adams	Kern County Sheriff's Office
Rose Cochran	Kern County Department of Public Health Services
Russell Hasting, PHN, Co-Chair	Kern County Department of Public Health Services
Sandra Patterson	Kern County Probation Department
Tom Corson	Kern County Network for Children, Kern County Superintendent of Schools, County Child Abuse Prevention Council
Tom Morgan	County Counsel

Mission

The mission of the Kern County Child Death Review Team (CDRT) is to reduce child deaths associated with child abuse and neglect. Its secondary mission is to reduce other preventable child deaths.

Competent multi-disciplinary case review at the local level serves the primary purpose of assisting in the investigation and management of individual child deaths. Identifying the causes and circumstances of these deaths helps to design strategies aimed at preventing child abuse and neglect. These strategies are developed to raise knowledge and awareness, and produce systematic changes, thereby preventing further child deaths.

History

In 1988, the California legislature authorized each county to establish county Child Death Review Teams to assist in identifying and reviewing suspicious child deaths and facilitate communication among agencies involved in the prevention of, and intervention in, fatal child abuse and neglect. The first Child Death Review Team convened in 1978 in Los Angeles, California.

Since 1988, Kern County has conducted regular monthly meetings with the exception of no more than two months per year.

Team Membership

The Kern CDRT reviews and evaluates the deaths of children, from birth through 17 years of age, reported via the Kern County Sheriff-Coroner's Division. The team is composed of designated representatives from:

Kern County Public Health Services Department
Human Services/Child Protective Services
Kern County Mental Health Services
District Attorney's Office
Probation
Sheriff's Office
Kern County Network for Children
Kern County Superintendent of Schools
Bakersfield Police Department
Kern Regional Center
Kern Medical Hospital
Jamison Children's Center
California Highway Patrol

County and City Fire Department representatives attend as cases warrant. Selected participants may be invited to attend if additional information is needed for a given case.

Case Review Process

The CDRT receives and reviews Sheriff-Coroner's reports on each child death in Kern County. A list of cases is sent, in advance, to team members to allow time to search case files for additional information on the child and his/her family. Meeting discussions determine if the death was preventable and what services, education, or action could have affected the outcome. Cases are closed or kept open for further review and/or referred to other services, if needed.

At times, cases where a child who dies in another county but is a resident of Kern County will also be reviewed; however, Kern County may not have jurisdiction. For the data to follow in this report, only deaths that Kern County received jurisdiction for are observed.

Fifty-one (51) cases are included in this report, which covers deaths that occurred from January 2015 to December 2015. Data reflected in this report comes from both the Sheriff- Coroner's reports and the supplemental information provided by CDRT members. To protect the confidentiality of children and families, only aggregate data is presented.

Fatal Child Abuse and Neglect Surveillance Program (FCANS)

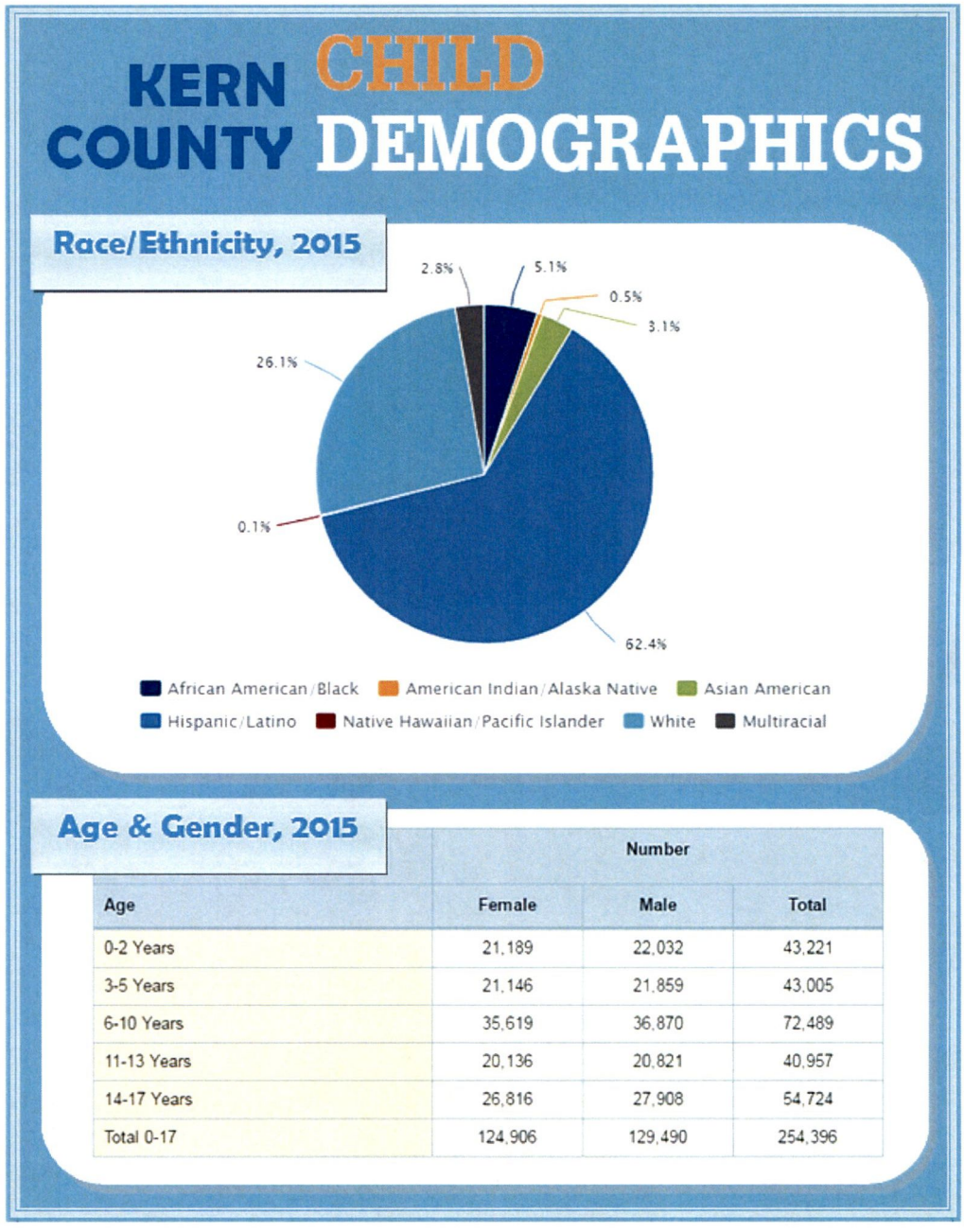
The Kern County CDRT is involved with FCANS through the Safe and Active Communities Branch at the California Department of Public Health. The FCANS program started in 1997 and was designed as an active surveillance system for child maltreatment deaths based on local CDRTs completion and submission of standard data collection. The teams are paid a set amount for each eligible case submitted. These monies are used to fund community projects such as the Safe Sleep Project.

The National Center for the
REVIEW & PREVENTION
OF CHILD DEATHS

KERN COUNTY
2015 Child Death Review Team Data

Demographics

Kern County is a large and diverse geographic region of California, comprised largely of agricultural-based communities and a number of regions under urban development. In addition, there are several rural and frontier communities. According to the U.S. Census Bureau, roughly 45% of Kern County households have child residents.[1] As of 2015, there are an estimated 254,396 children of ages 0-17 residing in Kern County.[2] The vast majority of the child population in Kern County identifies as Hispanic/Latino (61.8%) and Caucasian/White (26.9%).[3] Compared to California as a whole, the Hispanic/Latino child population is 10% greater in Kern County. The largest child age group across both genders is the 6-10 year-old age group (28.5%). The male-to-female ratio among children is approximately equal. Refer to the infographic on the right for further demographic information.



	Number		
Age	Female	Male	Total
0-2 Years	21,189	22,032	43,221
3-5 Years	21,146	21,859	43,005
6-10 Years	35,619	36,870	72,489
11-13 Years	20,136	20,821	40,957
14-17 Years	26,816	27,908	54,724
Total 0-17	124,906	129,490	254,396

[1] U.S. Census Bureau, American Community Survey (May 2016).
[2] California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060 (May 2016)
[3] Lucile Packard Foundation for Children's Health, Child Population Data by Demographic (May 2016)

Manner of Death

Manner of death is a set of categories by which we classify deaths as intentional, unintentional, natural, or undetermined. California law requires that all suspicious, violent, and unexpected (decedent was not seen by a physician 20 days prior to death) deaths be reported to the Coroner's Office. The Coroner is then responsible for determining the circumstances, manner, and cause of these deaths.

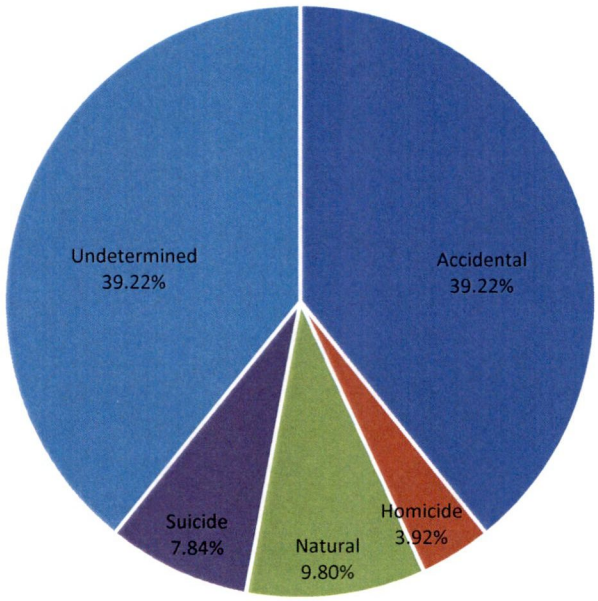
Accidental/Unintentional – These deaths are the result of unintentional injury. Examining these cases allows CDRT identify prevention strategies to deter future injuries.

Natural – Natural deaths are from disease or other medical conditions other than injury.

CDRT surveillance of deaths from natural causes helps inform support programs that focus on maternal and prenatal health, well- child exams, immunizations, and health screenings.

Homicide – Homicide, by Coroner's definition, is death at the hands of another.

Suicide – Death caused by self-directed injurious behavior with intent of self-harm.



Undetermined – Undetermined deaths reflect situations in which the Coroner is unable to determine a conclusive manner of death. This can result from insufficient or conflicting information. In particular, Kern CDRT reviews many deaths that occur in an unsafe sleep environment; often, the manner in these deaths is undetermined.

Pending – Pending cases are still under investigation, awaiting critical information to proceed. These cases are included in the total count, but excluded from data and figures represented in this report.

Manner of Death	Number
Accidental	20
Homicide	2
Natural	5
Suicide	4
Undetermined	20
Total	**51**

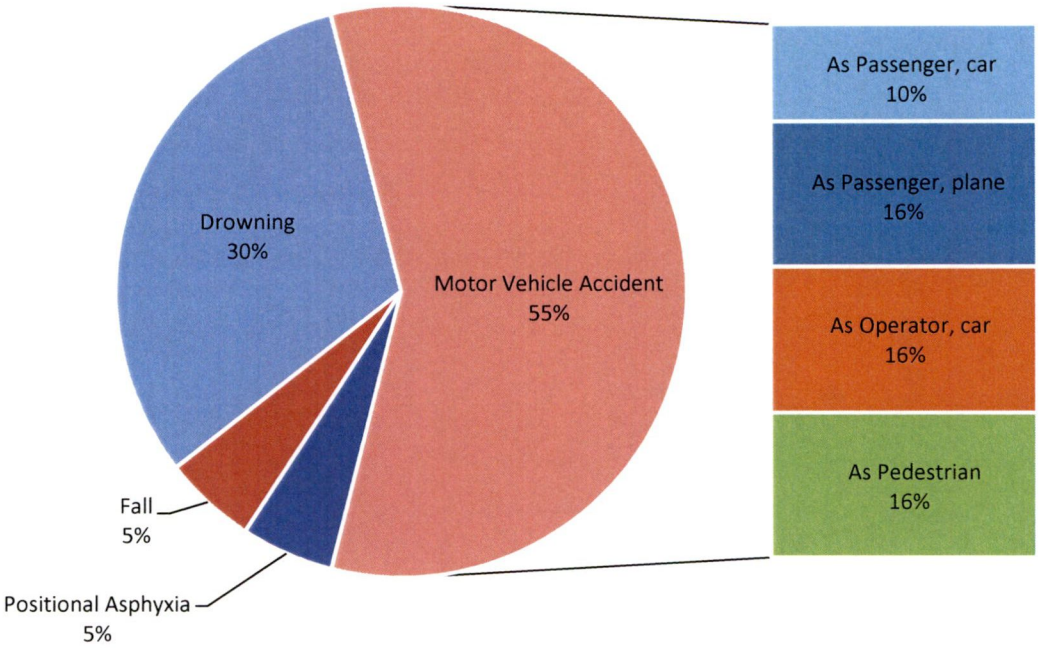
Cause of Death

The cause of death is the actual mechanism producing the child's death. It must be distinguished from the manner of death as these terms are often confused. For instance, if homicide is the manner of death, then possible causes of death under homicide may include head trauma, gunshot wound, suffocation, poisoning, etc. Common causes of death for each of the manners are addressed in the information below.

Manner of Death	Cause of Death	Number
Accidental		20
	Blunt force trauma	12
	Drowning	6
	Seizure Disorder	1
	Positional Asphyxia	1
Homicide		2
	Blunt force trauma	1
	Gunshot wound	1
Natural		5
	Various[1]	5
Suicide		4
	Asphyxia/Hanging	1
	Gunshot wound	2
	Drug Overdose	1
Undetermined		20
	SUID	19
Total		51

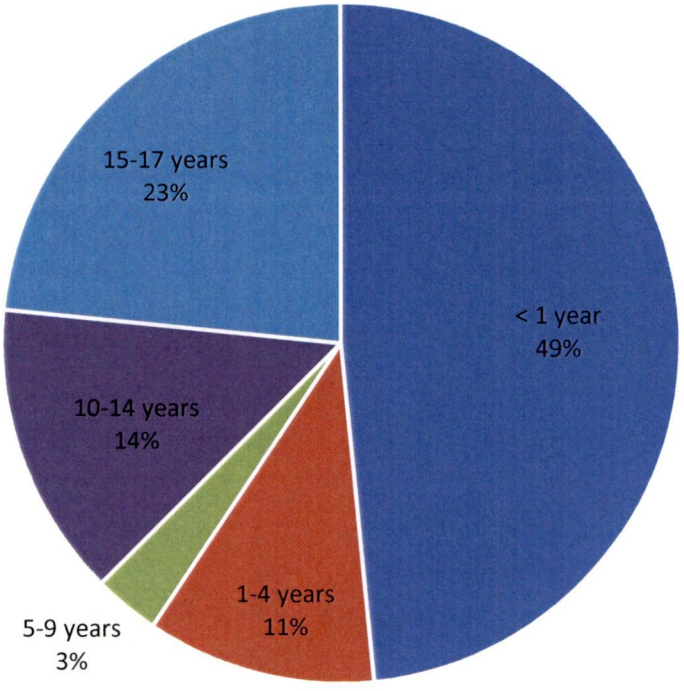
[1] Includes: Acute Bacterial Bronchopneumonia, multiple congenital abnormalities, metastatic hepatocellular carcinoma, probable sepsis

Accidental/Unintentional Injuries



Type of Unintentional Injury	Number
Positional Asphyxia	1
Blunt force trauma, non-motor vehicle	1
Fall	1
Drowning	6
Motor vehicle accident	11
As Passenger, Car	3
As Passenger, Plane	3
As Operator, Car	2
As Pedestrian	3
Seizure Disorder	1
Total	20

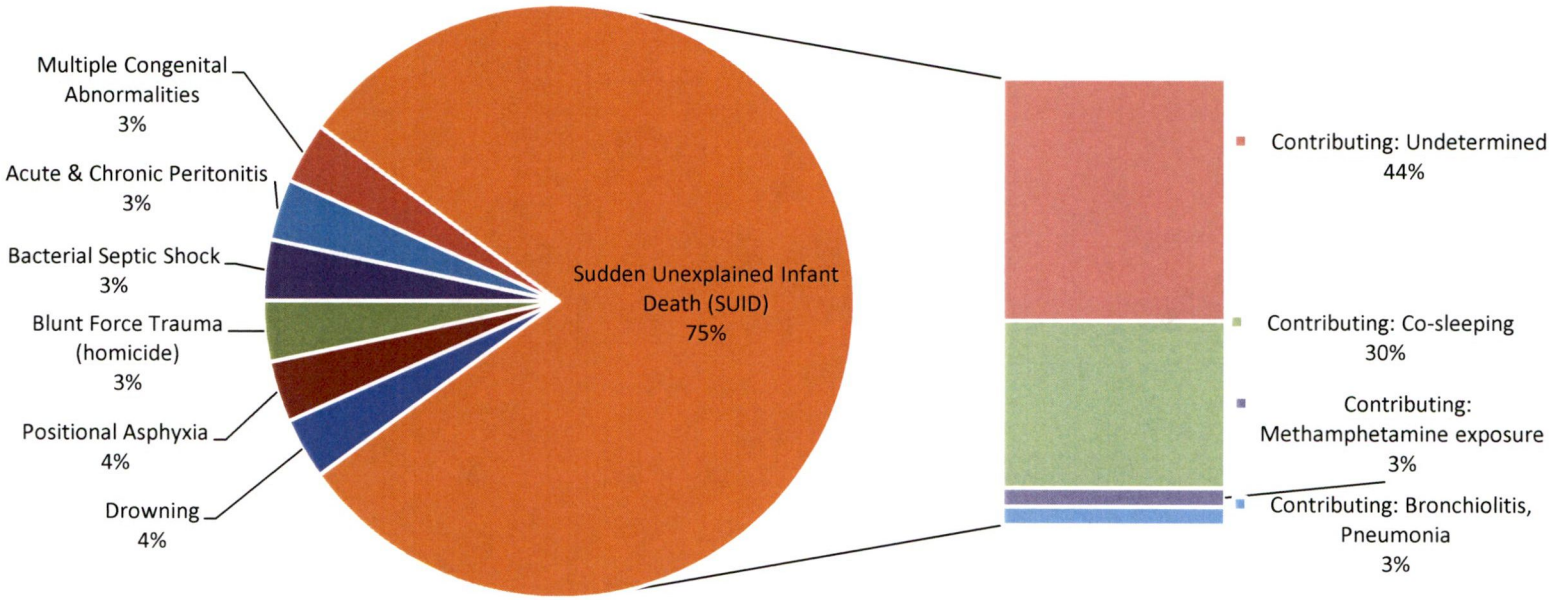
Child Deaths Reviewed by Age Grouping



Age	Number of deaths
< 1 year	24
1-4 years	5
5-9 years	2
10-14 years	7
15-17 years	13
Total	**51**

Child Deaths Reviewed by Age and Cause

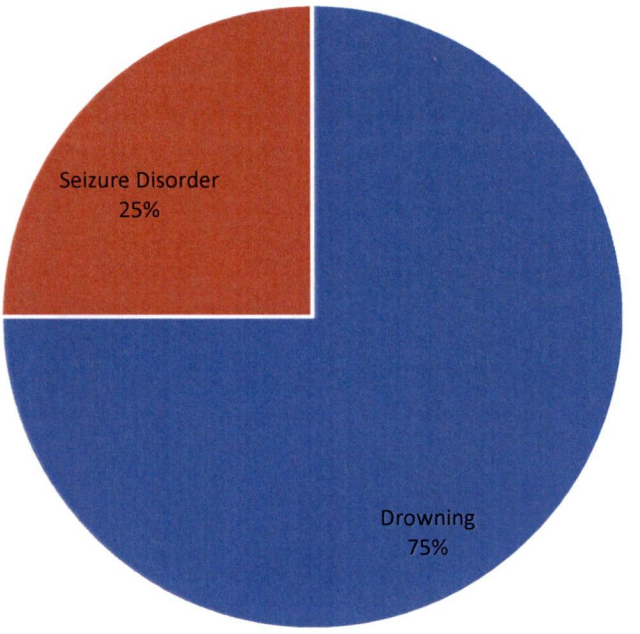
Children <1 Year of Age



Manner of Death	Cause of Death	Number
Accidental		2
	Drowning	1
	Positional Asphyxia	1
Homicide		1
	Blunt Force Trauma	1
Natural		2
	Bacterial Septic Shock	1
	Acute & Chronic Peritonitis	1
Undetermined (SUID)		20
	Contributing: Undetermined	10
	Contributing: Co-sleeping	8
	Contributing: Methamphetamine Exposure	1
	Contributing: Bronchiolitis, Pneumonia	1
Total		**25**

Child Deaths Reviewed by Age and Cause

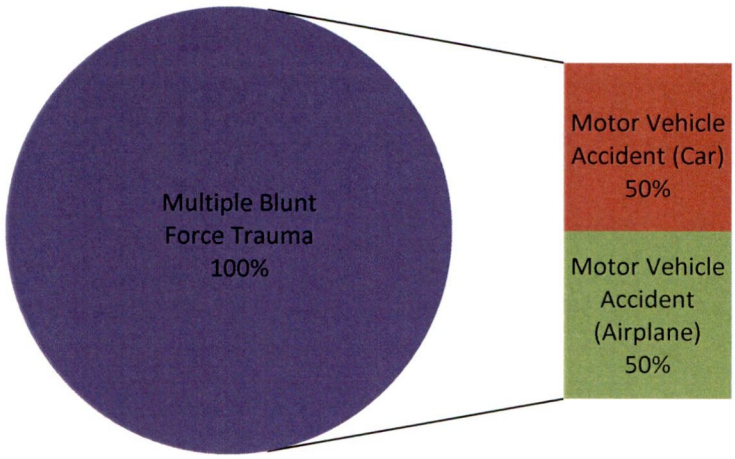
Children 1-4 Years of Age



Manner of Death	Cause of Death	Number
Accidental		4
	Drowning	3
	Seizure disorder	1
Total		**4**

Child Deaths Reviewed by Age and Cause

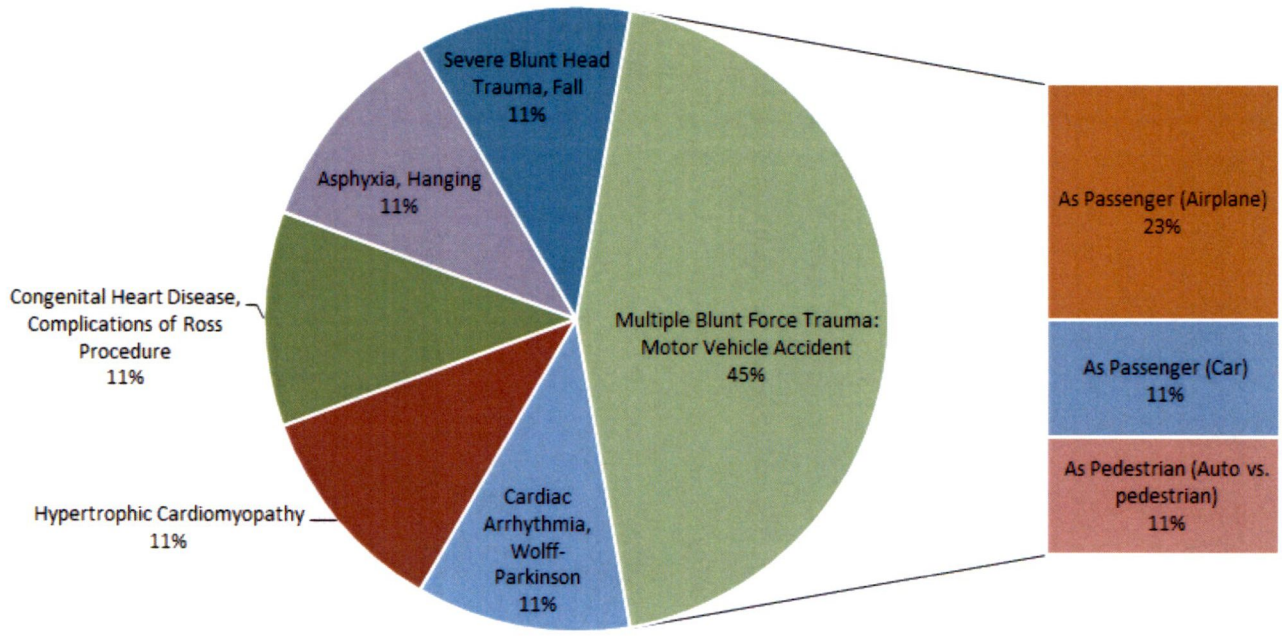
Children 5-9 Years of Age



Manner of Death	Cause of Death	Number
Accidental		2
	Multiple Blunt Force Trauma	2
Total		**2**

Child Deaths Reviewed by Age and Cause

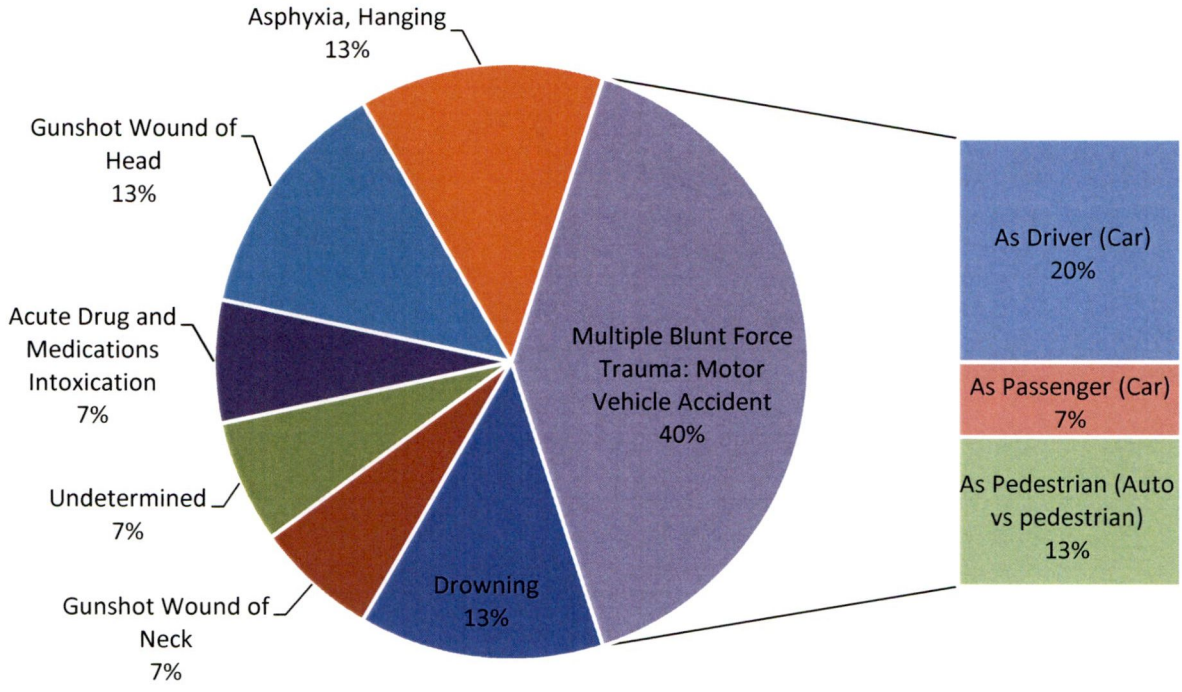
Children 10-14 Years of Age



Manner of Death	Cause of Death	Number
Accidental		4
	Blunt Force Trauma, motor vehicle	3
	Blunt Force Trauma, fall	1
Natural		3
	Cardiac Arrhythmia, Wolff-Parkinson	1
	Hypertrophic Cardiomyopathy	1
	Congenital Heart Disease, Complications of Ross Procedure	1
Total		**7**

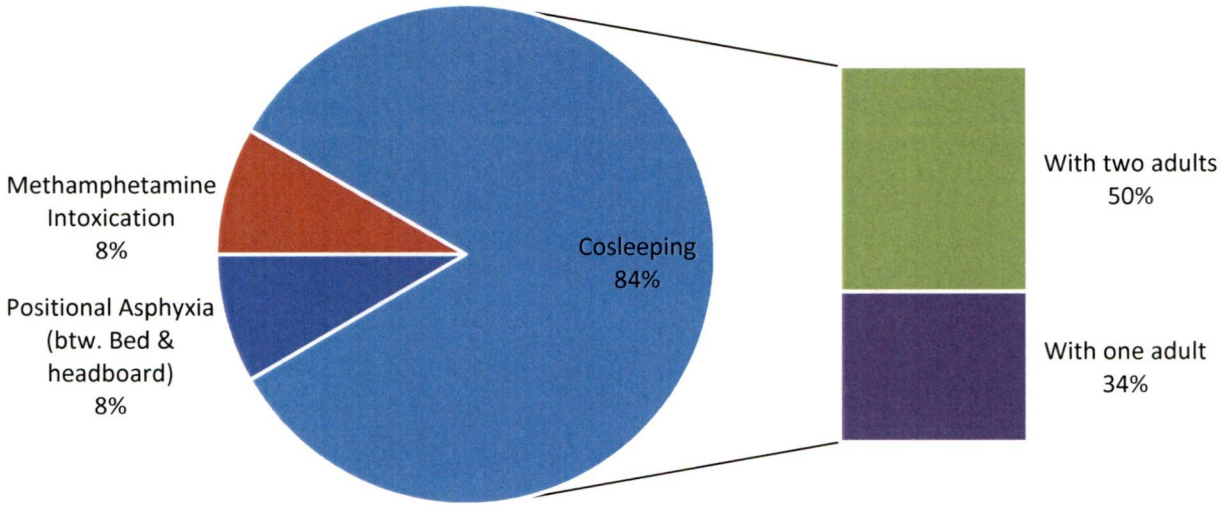
Child Deaths Reviewed by Age and Cause

Children 15-17 Years of Age



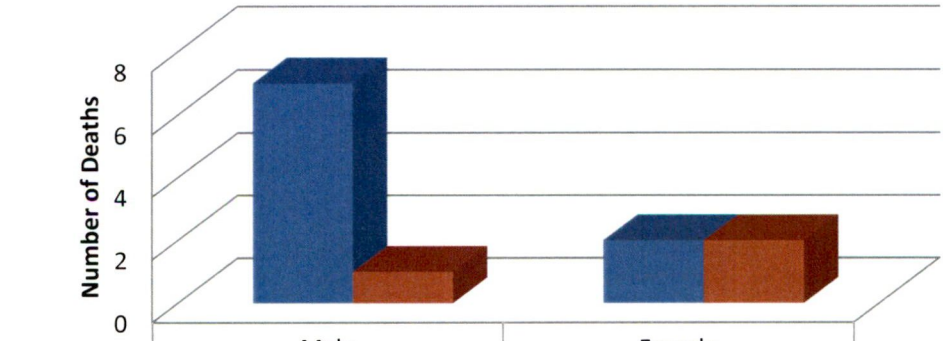
Manner of Death	Cause of Death	Number
Accidental		8
	Multiple Blunt Force Trauma: Motor Vehicle Accident	6
	Drowning	2
Homicide		1
	Gunshot wound of Neck	1
Suicide		4
	Acute Drug and Medications Intoxication	1
	Asphyxia, Hanging	1
	Gunshot Wound of Head	2
Total		**13**

Unsafe Sleep Environment: Contributing Factors

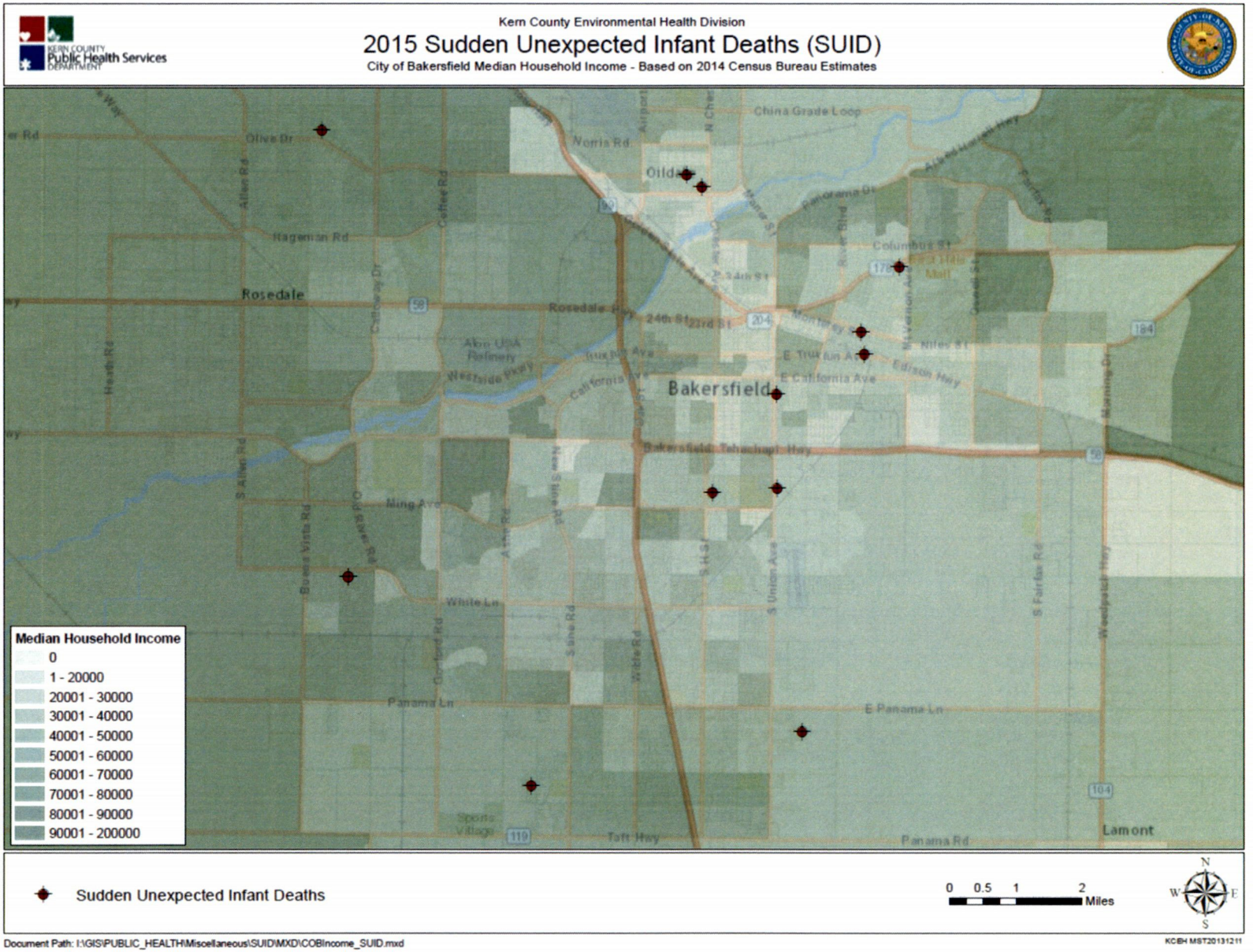


Contributing Factor	
Positional Asphyxia (btw. Bed & headboard)	1
Methamphetamine Intoxication	1
Cosleeping w/ two adults	6
Cosleeping w/ one adult	4

Unsafe Sleep Deaths by Race & Sex, 2015



	Male	Female
Caucasian	7	2
Hispanic	1	2


Kern County Environmental Health Division
2015 Sudden Unexpected Infant Deaths (SUID)
City of Bakersfield Median Household Income - Based on 2014 Census Bureau Estimates
KERN COUNTY Public Health Services DEPARTMENT
Median Household Income
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Bakersfield
Lamont
Olive Dr
Ragsdale Rd
Rosedale Hwy
24th St
23rd St
Westside Pkwy
California Ave
E California Ave
Bakersfield-Tehachapi Hwy
Ming Ave
White Ln
Panama Ln
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Panama Rd
Taft Hwy
Sports Village
Norris Rd
China Grade Loop
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Sudden Unexpected Infant Deaths
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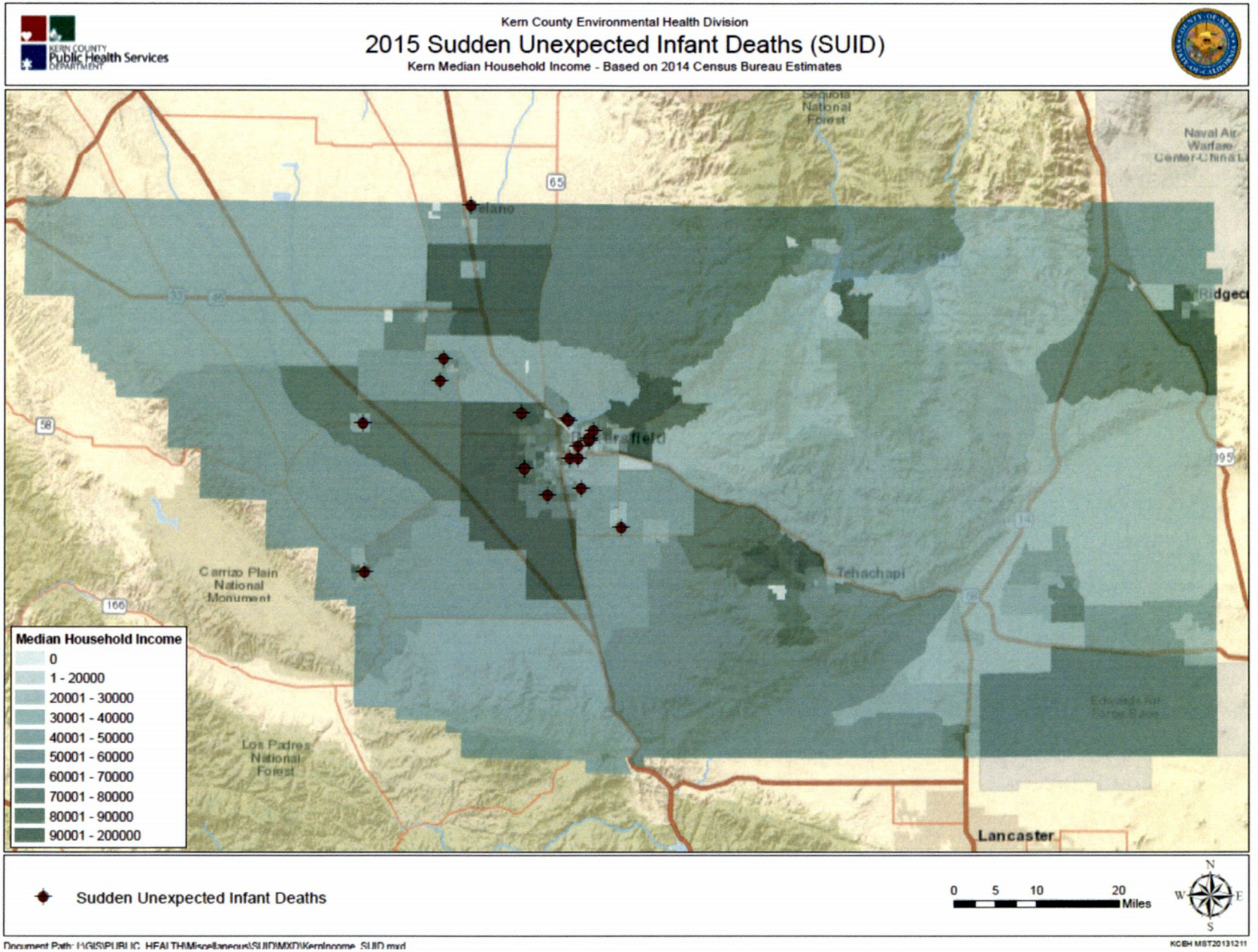
Kern County Environmental Health Division
2015 Sudden Unexpected Infant Deaths (SUID)
Kern Median Household Income - Based on 2014 Census Bureau Estimates
KERN COUNTY Public Health Services DEPARTMENT
Sequoia National Forest
Naval Air Warfare Center China L
Delano
Bakersfield
Ridgecr
Tehachapi
Carrizo Plain National Monument
Los Padres National Forest
Edwards Air Force Base
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Median Household Income
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Recommendations

Continue efforts to increase community awareness and education regarding the association between unsafe sleep environment and SIDS/SUID deaths.

- With more than half of child deaths under the age of one categorized as SUID, CDRT advocates that Safe Sleeping concepts need to be reinforced to parents throughout the perinatal period and into infancy. Perinatal care providers and hospital environments need training and education on safe sleep, as well as patient education tools that can be administered easily and effectively, without burdening the healthcare providers.
- CDRT identifies the use of health communication measures as an effective route to reaching community residents including collaborating with local news stations who are interested in spreading awareness on health issues that plague the community.
- The Safe Sleeping Education Project is an ongoing program within Public Health Services Department in which high-risk families, as well as home child care providers, receive SIDS prevention education, a voucher for a safe-sleep crib, and are additionally followed up to assess compliance. The program operates yearly. CDRT has directly supported this effort by using FCANS stipends to purchase portable crib vouchers for the program.
- Kern County Network for Children continues to sponsor a robust Safe Sleeping Awareness Month campaign, held annually in October. The campaign includes press releases, social media marketing, training for community outreach workers, and additional creative media presentations.

Provide support to agencies that serve and/or advocate for the wellbeing of children.

- Continue increasing awareness of signs of abuse and resources, which can be used if abuse is suspected, such as the child abuse hotline.
- Support agencies/organizations that provide safety net care to suspected neglected and abused children, as well as those agencies/organizations that provide preventive and treatment services to parents and caregivers at risk for abuse.
- Increase outreach efforts that focus on parents of preschool age children— not just those children already in preschool, but those who are at home with caregivers— where parents/caregivers and their children are isolated and "invisible." These parents and children may have little knowledge of community support and parenting tools that are available to them.

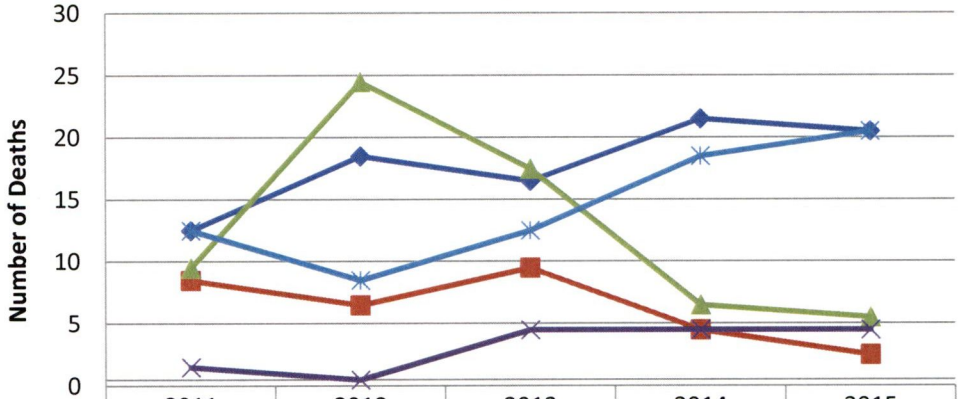
Facilitate the continuing communication between agencies representative on the CDRT as well as coordinate identified trainings during CDRT meetings, which would benefit agency development.

- Public Health Services Department currently meets with two local hospitals to strengthen communication between services providers ensuring pediatric needs are being met. CDRT suggests expanding this coordination with other major hospitals in the area.
- The Coroner's department has a strong relationship with emergency departments within hospitals. CDRT suggest utilizing this relationship to ensure the appropriate persons receive training on documentation from the district attorney's office.

KERN COUNTY 2011 Child Death Review Team Five-Year 2015 Comparison Report

Child Deaths Reviewed by Overall Manner of Death

Timeline: Manner of Death, 2011-2015

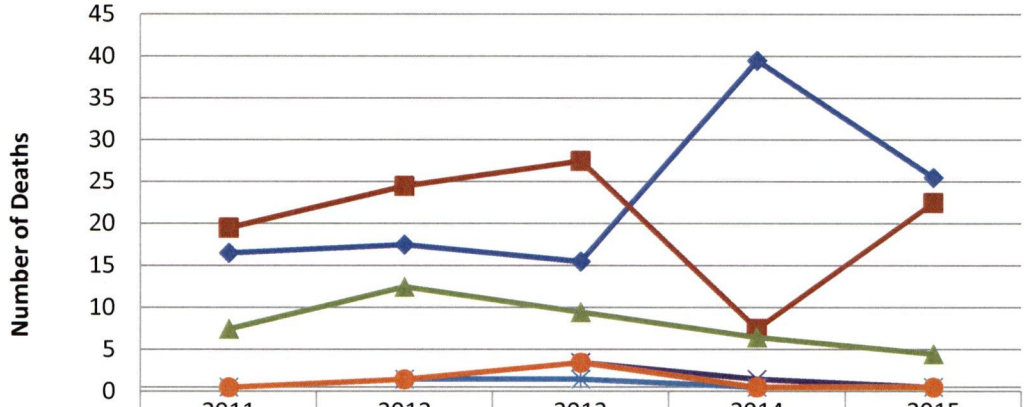


	2011	2012	2013	2014	2015
Accidental/Unintentional	12	18	16	21	20
Homicide	8	6	9	4	2
Natural	9	24	17	6	5
Suicide	1	0	4	4	4
Undetermined	12	8	12	18	20

	Number of Deaths, by Year					
Manner of Death	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
Accidental/Unintentional	12	18	16	21	20	87
Homicide	8	6	9	4	2	29
Natural	9	24	17	6	5	61
Suicide	1	0	4	4	4	13
Undetermined	12	8	12	18	20	70
Total	**42**	**56**	**58**	**53**	**51**	**260**

Child Deaths Reviewed by Race/Ethnicity

Timeline: Death Count by Race, 2011-2015



	2011	2012	2013	2014	2015
White, Non-Hispanic	16	17	15	39	25
Hispanic/Latino	19	24	27	7	22
African-American	7	12	9	6	4
Asian	0	1	3	1	0
Pacific Islander	0	1	1	0	0
East Indian	0	1	3	0	0

	Number of Deaths					
Race/Ethnicity	**2011**	**2012**	**2013**	**2014**	**2015**	**Total**
White, Non-Hispanic	16	17	15	39	25	112
Hispanic/Latino	19	24	27	7	22	99
African-American	7	12	9	6	4	38
Asian	0	1	3	1	0	5
Pacific Islander	0	1	1	0	0	2
East Indian	0	1	3	0	0	4
Total	**42**	**56**	**58**	**53**	**51**	**260**