KERN COUNTY
2016 Child Death Review Team Report

About this report

This report highlights the trends in child deaths that occurred in Kern County during 2016 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.

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

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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 2016 reviews.

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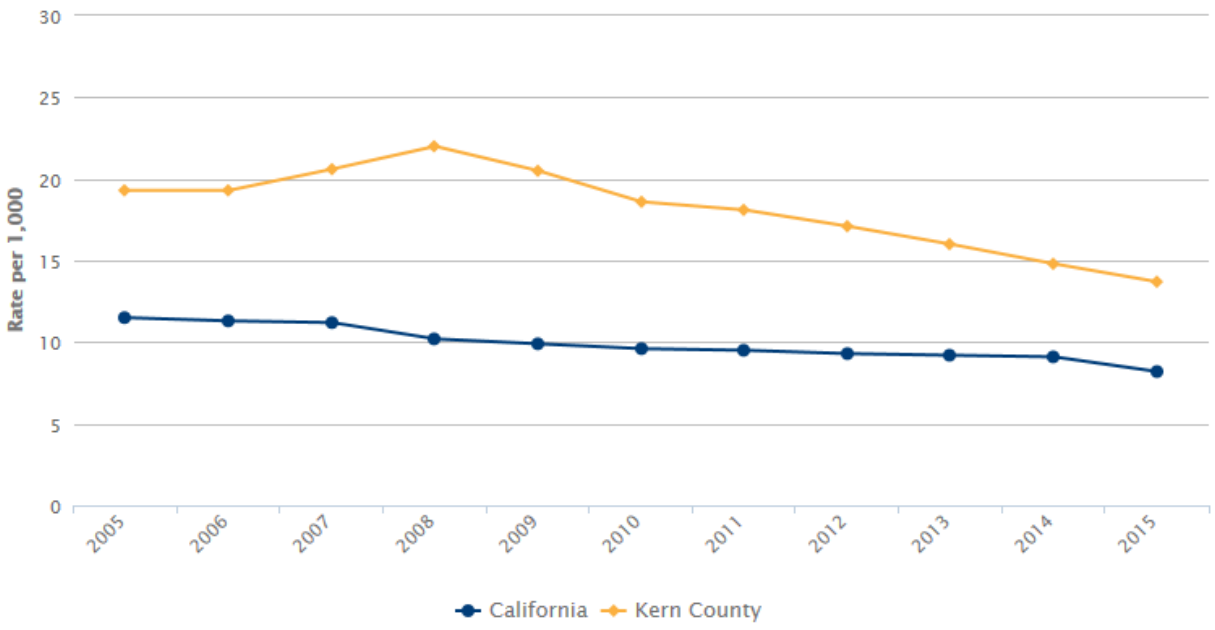
Mission

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. While rates of child abuse and neglect in Kern County are trending downward, county rates are nearly double that of California state rates.

Substantiated Cases of Child Abuse and Neglect: 2005 to 2015



Definition: Number of substantiated cases of abuse and neglect per 1,000 children under age 18 (e.g., in 2015, there were 8.2 substantiated cases of abuse and neglect per 1,000 California children).

Data Source: As cited on kidsdata.org, Webster, D., et al. Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research (Jun. 2016); Annie E. Casey Foundation, KIDS COUNT (Jul. 2016).

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. 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
Kern County Mental Health Services
District Attorney's Office
Probation
Sheriff's Office
Kern County Network for Children
Bakersfield Police Department
Human Services/Child Protective Services

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 child deaths 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.

In 2016, 117 deaths occurred in Kern County in children under the age of 18 years. Forty-two (42) cases were referred to the CDRT and are included in this report, which covers deaths that occurred from January 2016 through December 2016. 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)

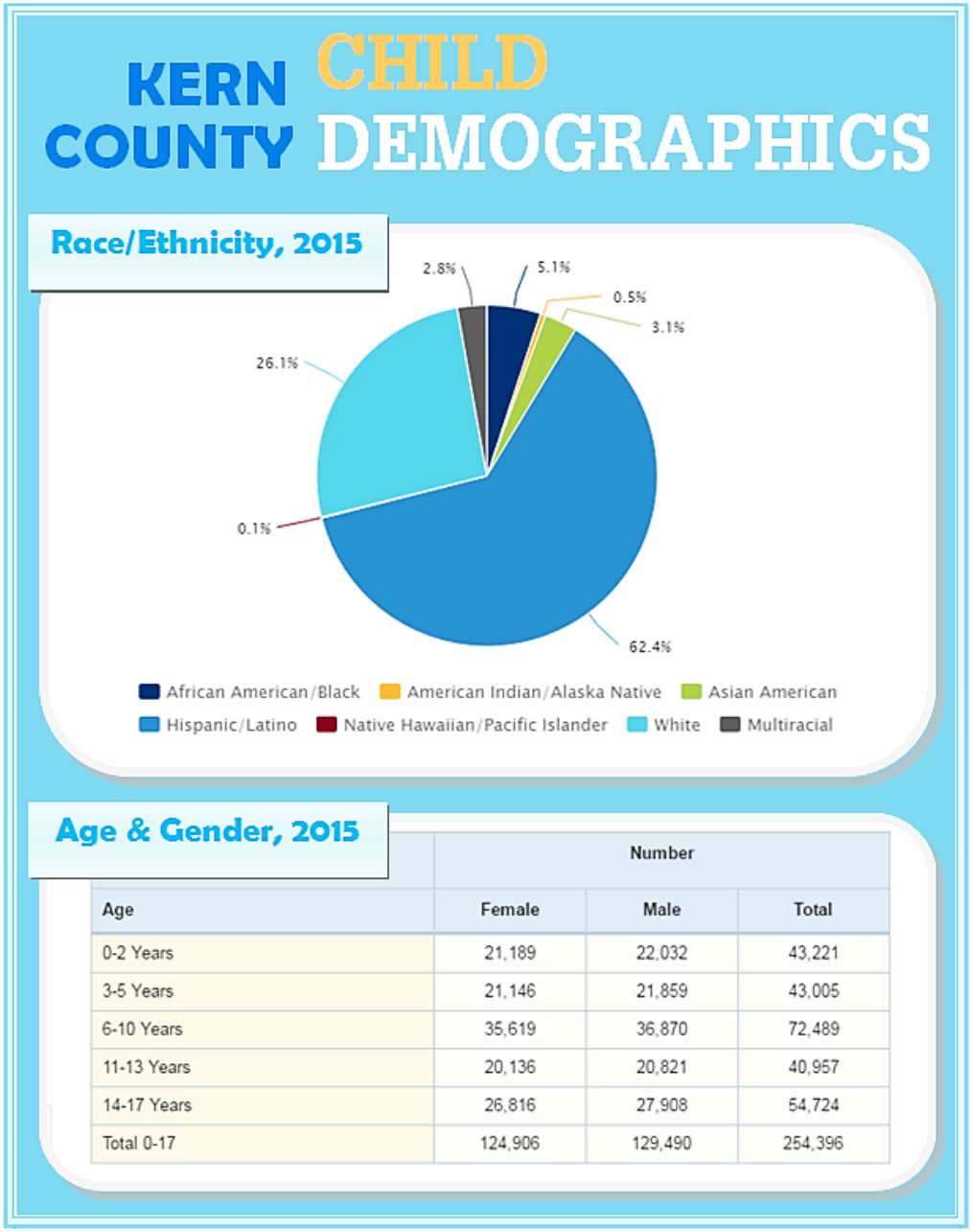
The Kern County CDRT is involved with FCANS through the Safe and Active Communities Branch at the California Department of Public Health. The FCANS program started in 1997 and was designed as an active surveillance system for child maltreatment deaths based on completion and submission of standard data collection by local CDRTs. 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 through Kern County Public Health Services Department.

The National Center for the REVIEW & PREVENTION OF CHILD DEATHS

KERN COUNTY 2016 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 (62.4%) and Caucasian/White (26.1%).[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 (July 2017).
[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.

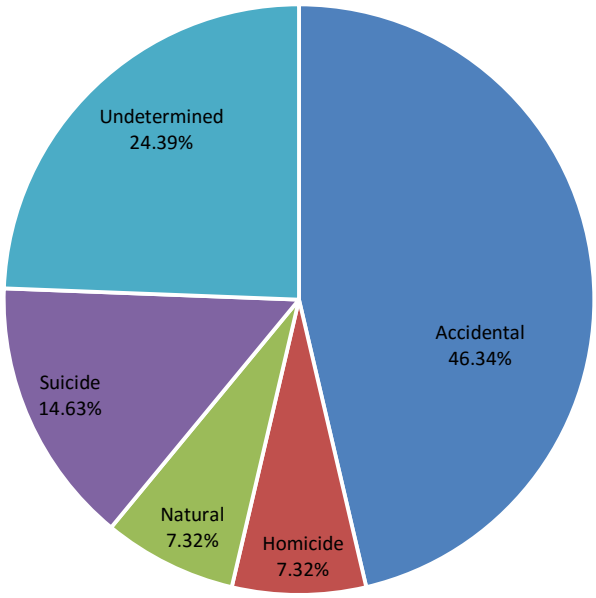
Accidental/Unintentional – These deaths are the result of unintentional injury. Examining these cases allows CDRT to identify prevention strategies to deter future injuries.

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	19
Homicide	3
Natural	3
Suicide	6
Undetermined	10
Pending (Manner of death unavailable at time of report)	1
Total	**42**

Cause of Death

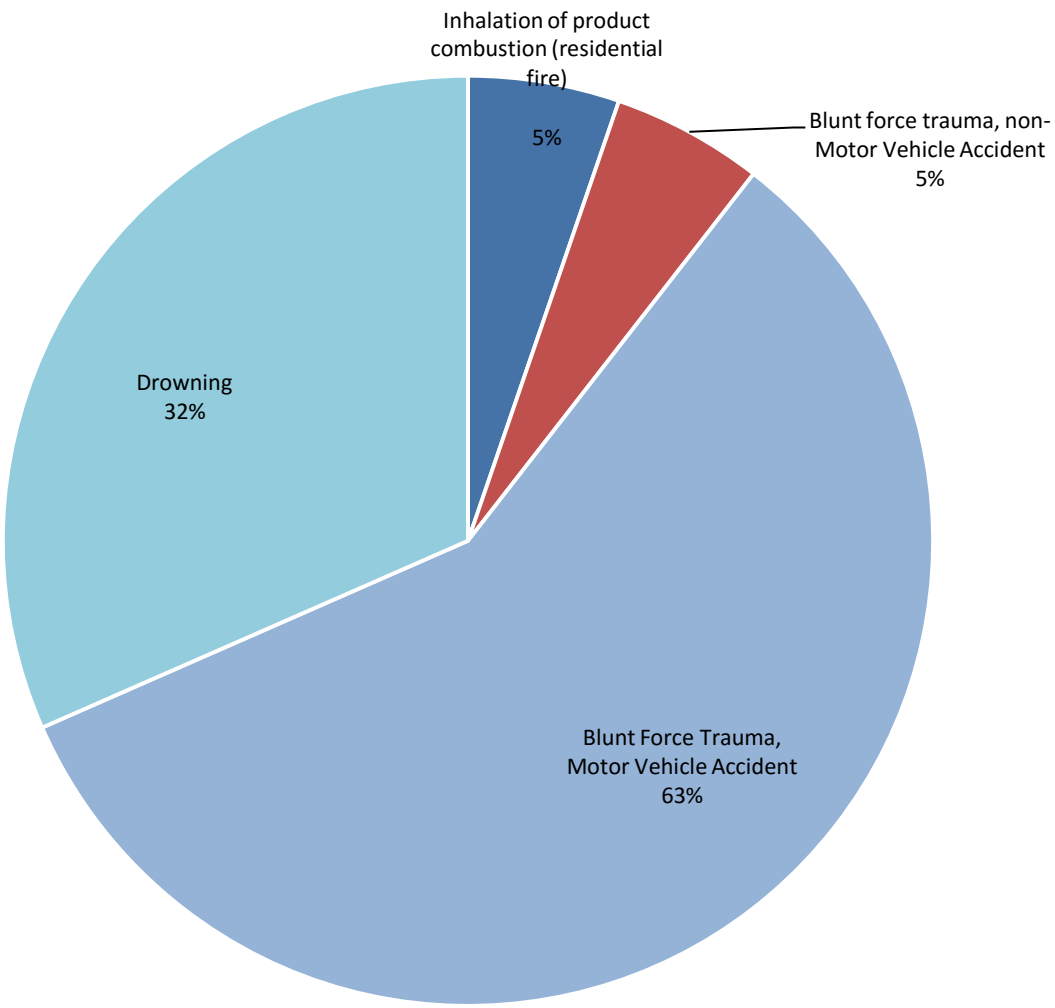
The cause of death is the actual mechanism producing the child's death. It must be distinguished from the manner of death as these terms are often confused. For instance, if homicide is the manner of death, then possible causes of death under homicide may include head trauma, gunshot wound, suffocation, 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		19
	Blunt force trauma	12
	Drowning	6
	Inhalation of product combustion (residential fire)	1
Homicide		3
	Blunt force head trauma and Abdominal Trauma	1
	Gunshot wound to the chest	1
	Acute/Chronic Pneumonia due to blunt force trauma	1
Natural		3
	Various[1]	3
Suicide		6
	Asphyxia/Hanging	4
	Gunshot wound	2
Undetermined		10
	SUID	9
	Smothering	1
Pending[2]		1
Total		42

[1] Includes: Sequelae of Acute Enterocolitis, bronchial asthma, and acute interstitial pneumonia

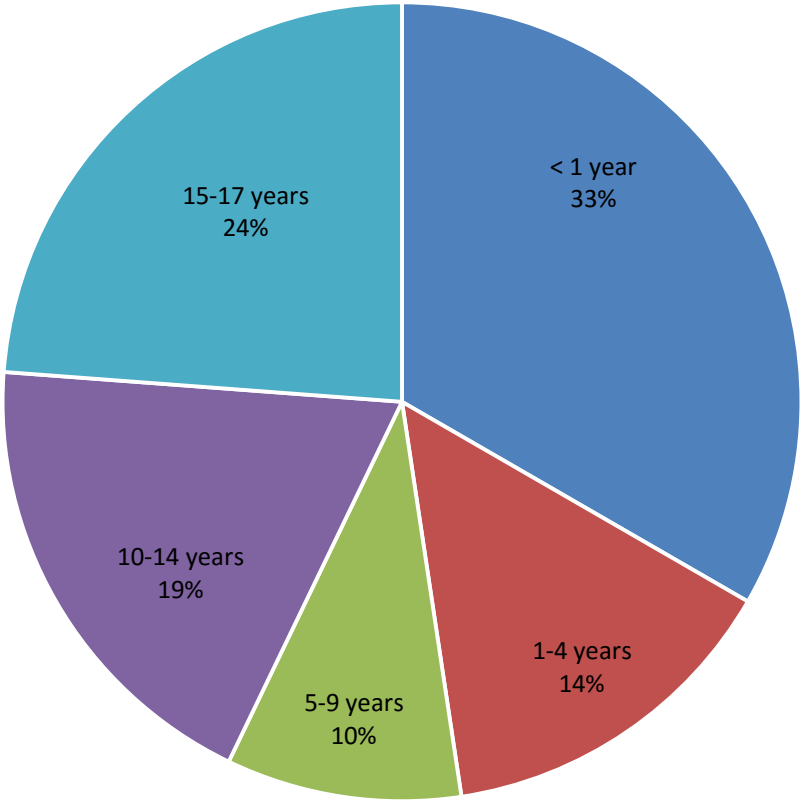
[2] Cause and Manner of death for one case was not available at the time of this report.

Accidental/Unintentional Injuries



Type of Unintentional Injury	Number
Blunt Force Trauma, Motor vehicle accident	11
Drowning	6
Blunt force trauma, non-motor vehicle	1
Total	20

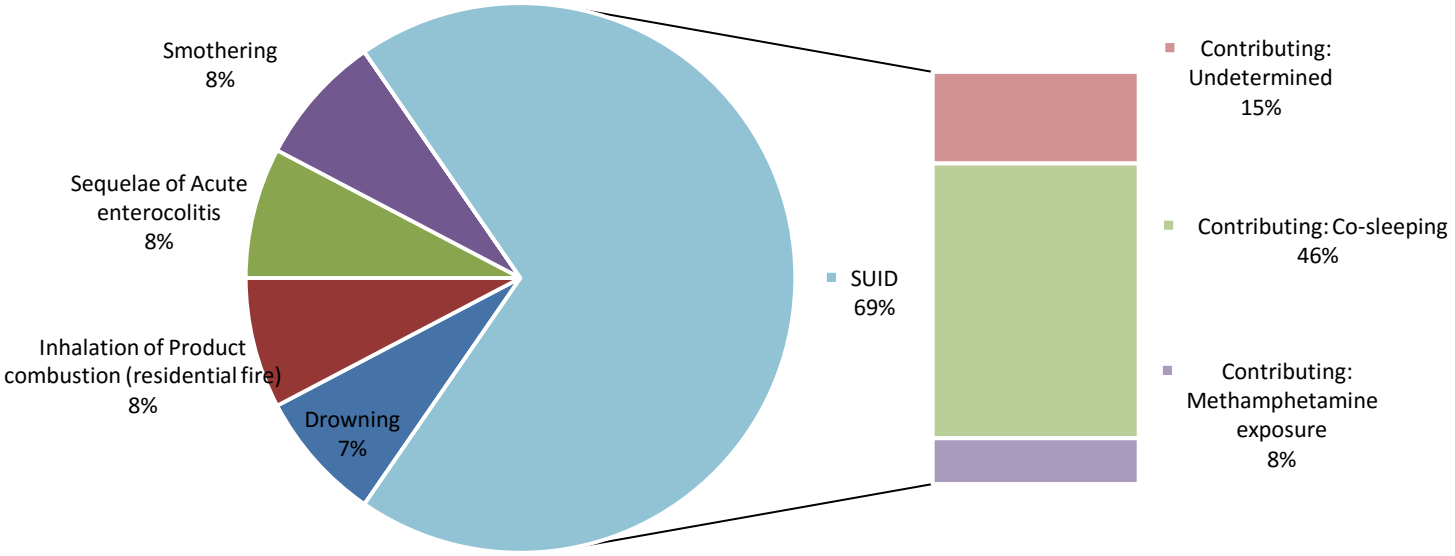
Child Deaths Reviewed by Age Grouping



Age	Number of deaths
< 1 year	14
1-4 years	6
5-9 years	4
10-14 years	8
15-17 years	10
Total	**42**

Child Deaths Reviewed by Age and Cause

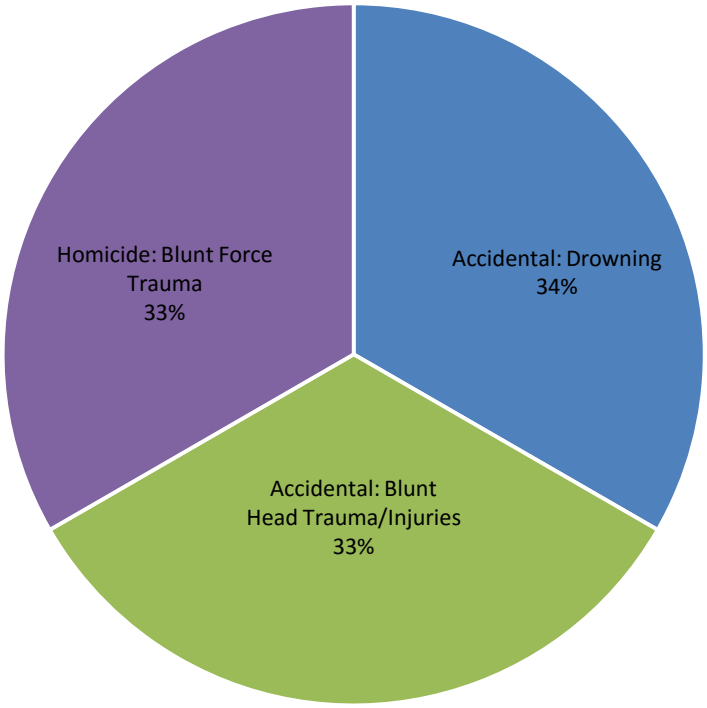
Children <1 Year of Age



Manner of Death	Cause of Death	Number
Accidental		2
	Drowning	1
	Inhalation of product combustion (residential fire)	1
Natural		1
	Sequelae of Acute Enterocolitis	1
Undetermined		10
Sudden Unexpected Infant Death	Smothering	1
	Contributing: Undetermined	2
	Contributing: Co-sleeping	6
	Contributing: Methamphetamine Exposure	1
*Pending		1
Total		**14**

Child Deaths Reviewed by Age and Cause

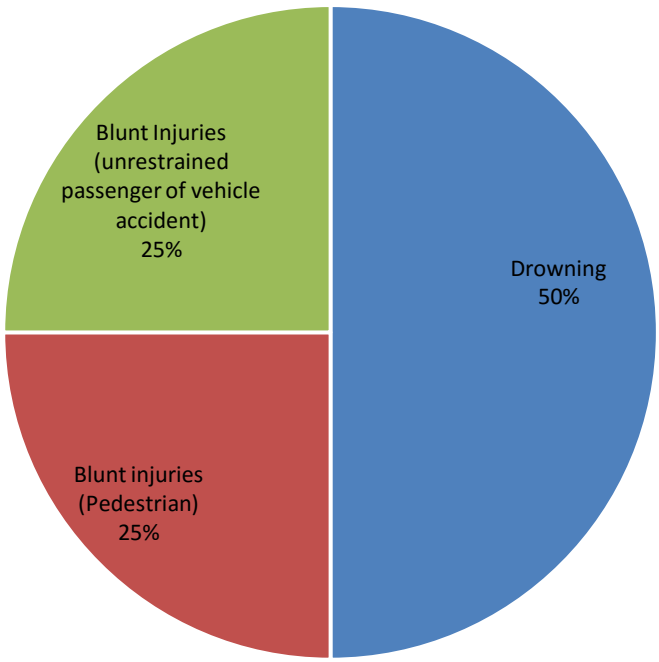
Children 1-4 Years of Age



Manner of Death	Cause of Death	Number
Accidental		4
	Drowning	2
	Blunt Head Trauma	2
Homicide		2
	Blunt Force Trauma	2
Total		**6**

Child Deaths Reviewed by Age and Cause

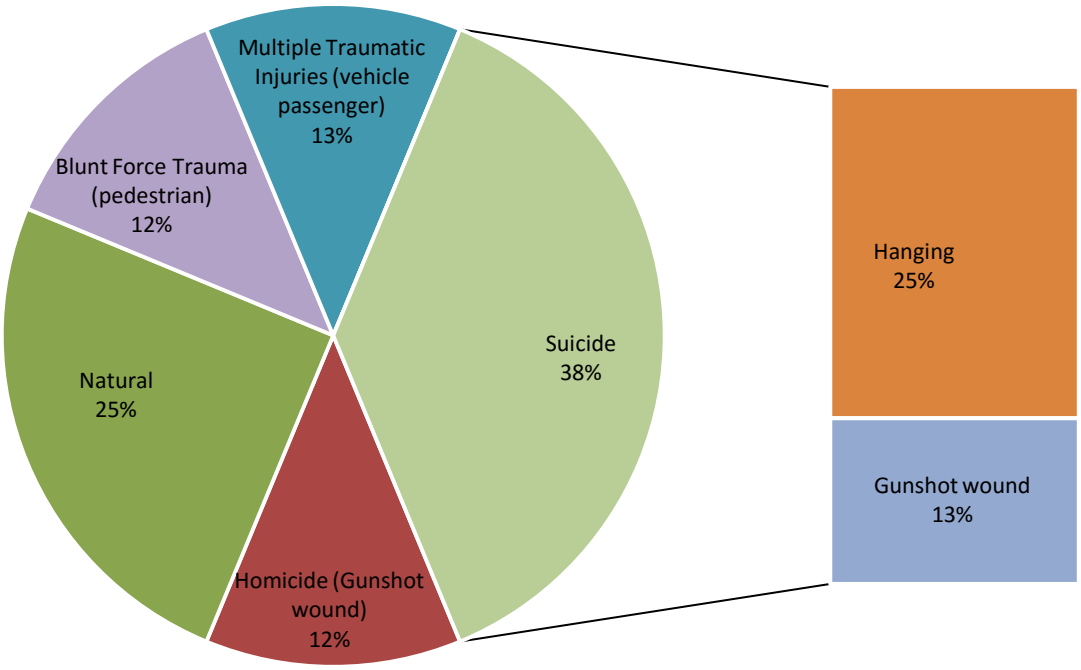
Children 5-9 Years of Age



Manner of Death	Cause of Death	Number
Accidental		
	Drowning (pool)	2
	Blunt Injuries (unrestrained vehicle passenger)	1
	Blunt Injuries (pedestrian)	1
Total		**4**

Child Deaths Reviewed by Age and Cause

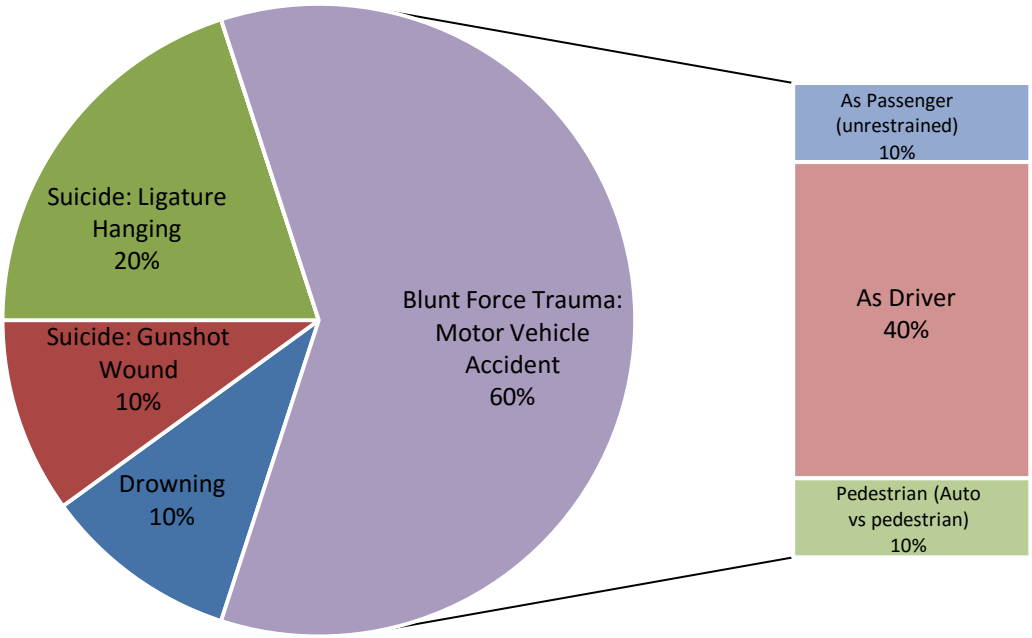
Children 10-14 Years of Age



Manner of Death	Cause of Death	Number
Accidental		2
	Blunt Force Trauma, Pedestrian	1
	Blunt Force Trauma, fall	1
Homicide		1
	Gunshot wound	1
Natural		2
	Bronchial Asthma	1
	Acute Interstitial Pneumonia	1
Suicide		3
	Self-inflicted Ligature Hanging	2
	Self-Inflicted Gunshot Wound	1
Total		**8**

Child Deaths Reviewed by Age and Cause

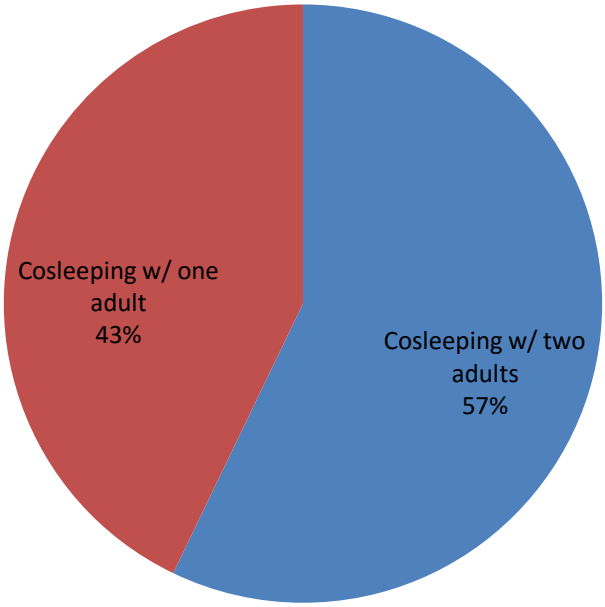
Children 15-17 Years of Age



Manner of Death	Cause of Death	Number
Accidental		7
	Multiple Blunt Force Trauma: Motor Vehicle Accident	6
	Drowning	1
Suicide		3
	Ligature Hanging	2
	Gunshot Wound	1
Total		**10**

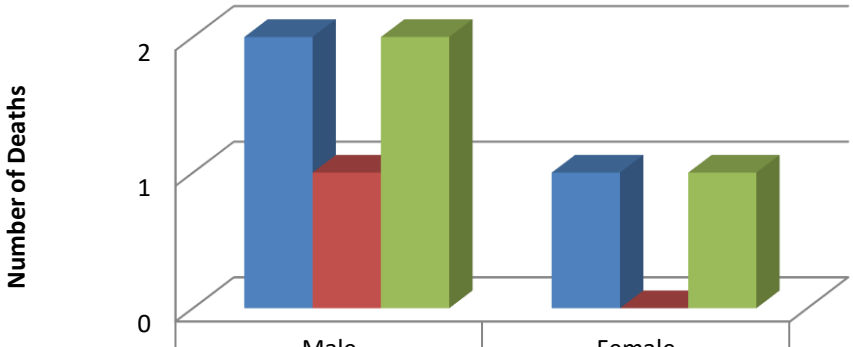
KERN COUNTY
2016 CDRT Special Topic: Unsafe Infant Sleep

Unsafe Infant Sleep Environment Deaths: Contributing Factors



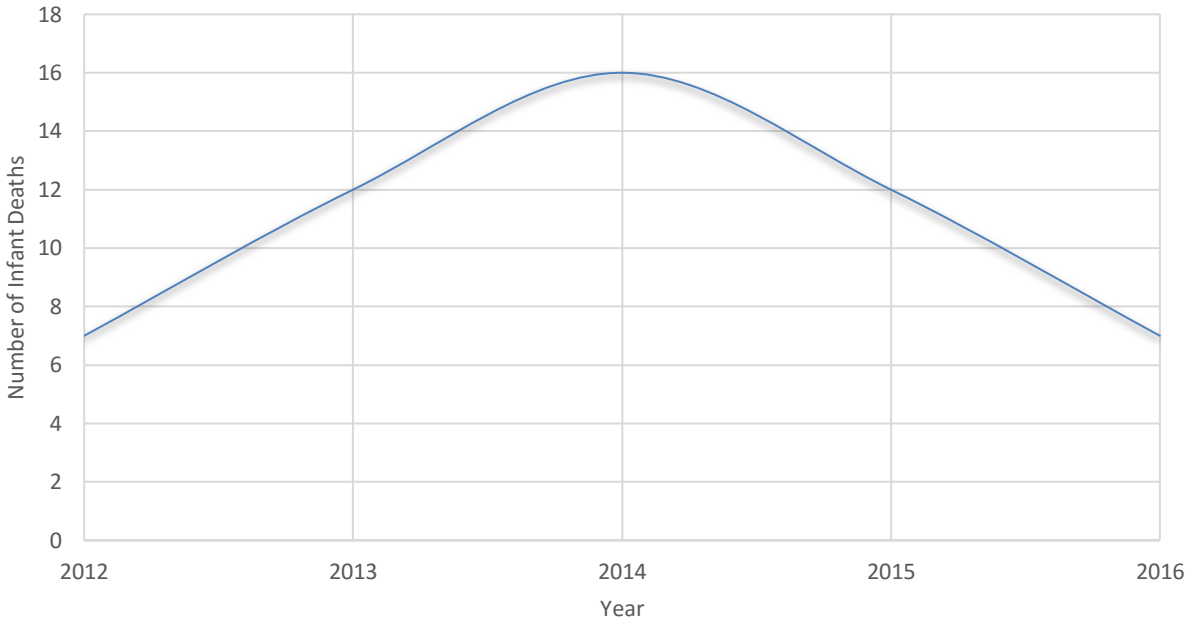
Contributing Factor	
Cosleeping w/ two adults	4
Cosleeping w/ one adult	3

Unsafe Sleep Deaths by Race & Sex



	Male	Female
Caucasian	2	1
Hispanic	1	0
Black	2	1

Infant Deaths with Unsafe Sleep Environments: 2012-2016*



*Includes all infant deaths identified by the coroner as having an unsafe sleep environment as a contributing factor to cause of death


Kern County Environmental Health Division
2016 Sudden Unexpected Infant Deaths (SUID)
City of Bakersfield Population Density - Based on 2014 Census Bureau Estimates
Population Density
0 - 1000
1001 - 2000
2001 - 3000
3001 - 4000
4001 - 5000
5001 - 6000
6001 - 7000
7001 - 8000
8001 - 9000
9001 - 20000
Sudden Unexpected Infant Deaths - 2016
0 0.4 0.8 1.6 Miles
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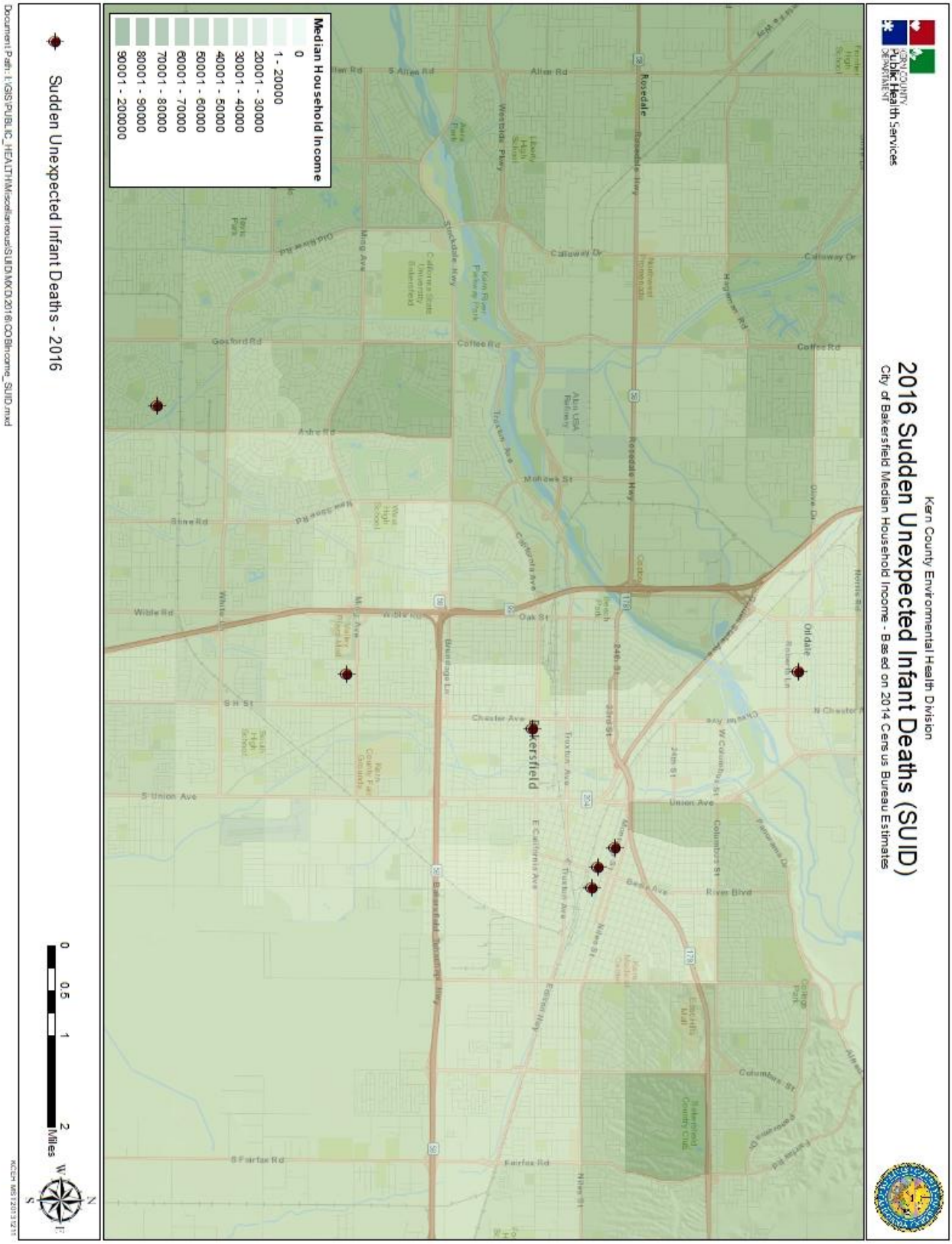
Kern County Environmental Health Division
2016 Sudden Unexpected Infant Deaths (SUID)
City of Bakersfield Median Household Income - Based on 2014 Census Bureau Estimates
Median Household Income
0
1 - 20000
20001 - 30000
30001 - 40000
40001 - 50000
50001 - 60000
60001 - 70000
70001 - 80000
80001 - 90000
90001 - 200000
Sudden Unexpected Infant Deaths - 2016
0 0.5 1 2 Miles
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KERN COUNTY 2016 CDRT Recommendations

Recommendations

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

- With more than two-thirds of child deaths reviewed by CDRT 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.
- All delivering hospitals should develop an infant safe sleep policy statement that incorporates the American Academy of Pediatrics recommendations. The policy should include regular training of staff and education for parents on safe sleep practices, modeling of safe sleep practices, community and media outreach, and periodic audits of infant sleep practices in the facility.
- 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.
- 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.
- 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. CDRT has directly supported this effort by using FCANS stipends to purchase portable crib vouchers for the program.
- Provide support to the Kern County Safe Sleep coalition whose mission is to present universal messaging and education on providing a safe sleep environment for infants.
- Kern County CDRT began facilitating a Safe Sleep Conference for healthcare and daycare providers in Kern County in 2016. It is recommended that this conference be continued and supported to continue needed education regarding safe infant sleep practices.
- Promotion of safe infant sleep practices in all Pediatricians' offices. Promotion can include direct parent/caregiver education, educational materials availability, and referral to resources to obtain a safe sleeping environment such as a portable crib.

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.

Continue efforts to increase community awareness of water safety and the potential drowning dangers of pools, bodies of water, and the Kern River.

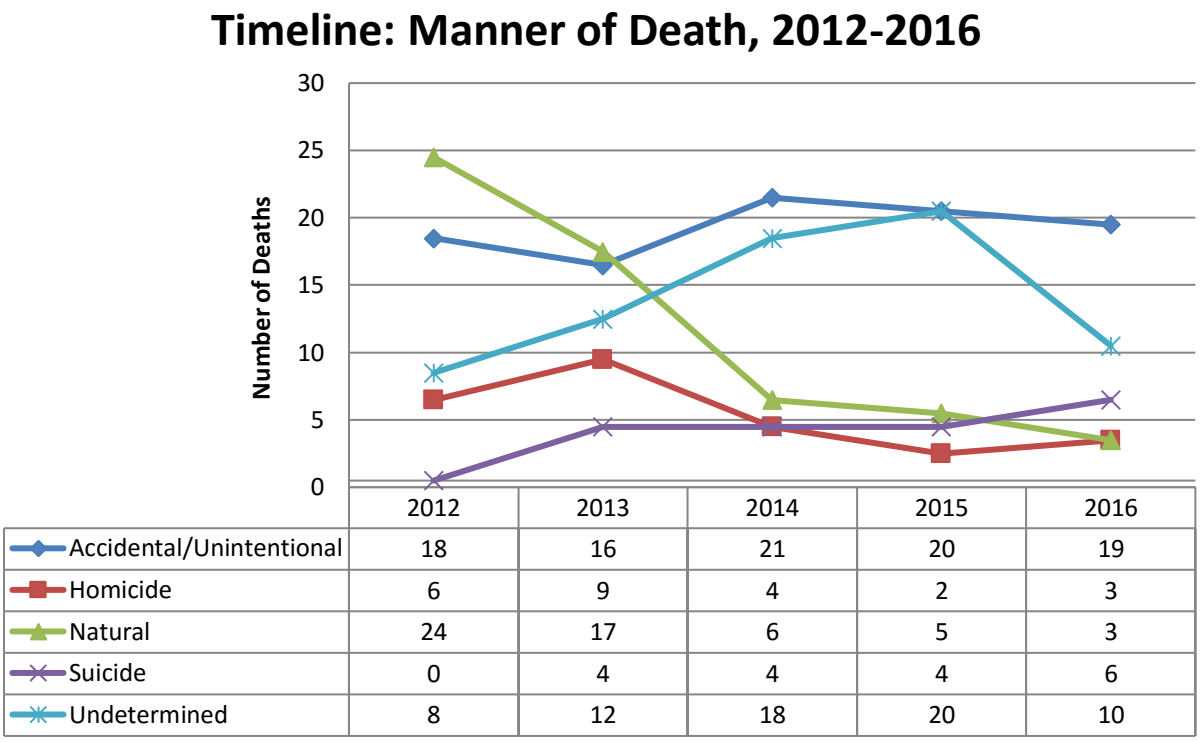
- Community outreach and promotion of the "Water Watchers" campaign through the Kern County Public Health Services Department.
- Promotion of "Water Watchers" in local pediatrician offices along with water safety education for parents of young children.
- All children possess basic swimming skills necessary to recover from falling into a body of water.
- All parents and caregivers of children receive CPR training

Support efforts that address suicide among children to raise community awareness, convey strategies for identifying signs of self-harm, and to develop resources for those at risk of suicide.

- Increase collaboration between schools and mental health services to raise awareness of the issue, provide stress-reduction strategies for children and adolescents, and to connect to needed resources relating to mental health issues.
- Outreach to parents of adolescents and young children to decrease stigma associated with mental illness.
- Increase healthcare provider awareness and knowledge base of strategies to identify early signs of suicidal ideations and early interventions through trainings utilizing depression screenings and education about mental health issues and self-harm.
- Strengthening and support for Bakersfield Police Department and Kern County Sheriff's Department programs addressing social media and bullying.
- Support community efforts that promote and provide training on mental health first aid.

KERN COUNTY 2012 2016 Child Death Review Team Five-Year Comparison Report

Child Deaths Reviewed by Overall Manner of Death



	2012	2013	2014	2015	2016
Accidental/Unintentional	18	16	21	20	19
Homicide	6	9	4	2	3
Natural	24	17	6	5	3
Suicide	0	4	4	4	6
Undetermined	8	12	18	20	10

	Percentage of Deaths reviewed by CDRT according to Manner of Death, by Year					
Manner of Death	**2012**	**2013**	**2014**	**2015**	**2016**	**Total**
Accidental/Unintentional	32	29	39	39	46	37
Homicide	11	16	4	4	7	9
Natural	43	29	10	10	7	21
Suicide	0	7	8	8	15	7
Undetermined	14	20	39	39	24	26
Total (rounded)	**100**	**100**	**100**	**100**	**100**	**100**

Child Deaths Reviewed by Race/Ethnicity