# 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

# Table of Contents

Mission, History, & Team Membership 7

Case Review Process & Fatal Child Abuse and Neglect Surveillance Program (FCANS) 8

**2015 Child Death Review Team Data 9**

Manner of Death 11

Cause of Death 12

Accidental/Unintentional Injuries 13

Deaths by Age Grouping 14

Child Deaths Reviewed by Age and Cause 15

- Children Ages <1 Year 15
- Children Ages 1-4 Years 16
- Children Ages 5-9 Years 17
- Children Ages 10-14 Years 18
- Children Ages 15-17 Years 19

SUID/SIDS Deaths Reviewed 20

Child Deaths Reviewed Geographically 21

Recommendations 23

**Kern County CDRT Five-Year Comparison 2010-2014 25**

Child Deaths Reviewed by Overall Manner of Death 26

Child Deaths Reviewed by Race/Ethnicity 27

# 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)

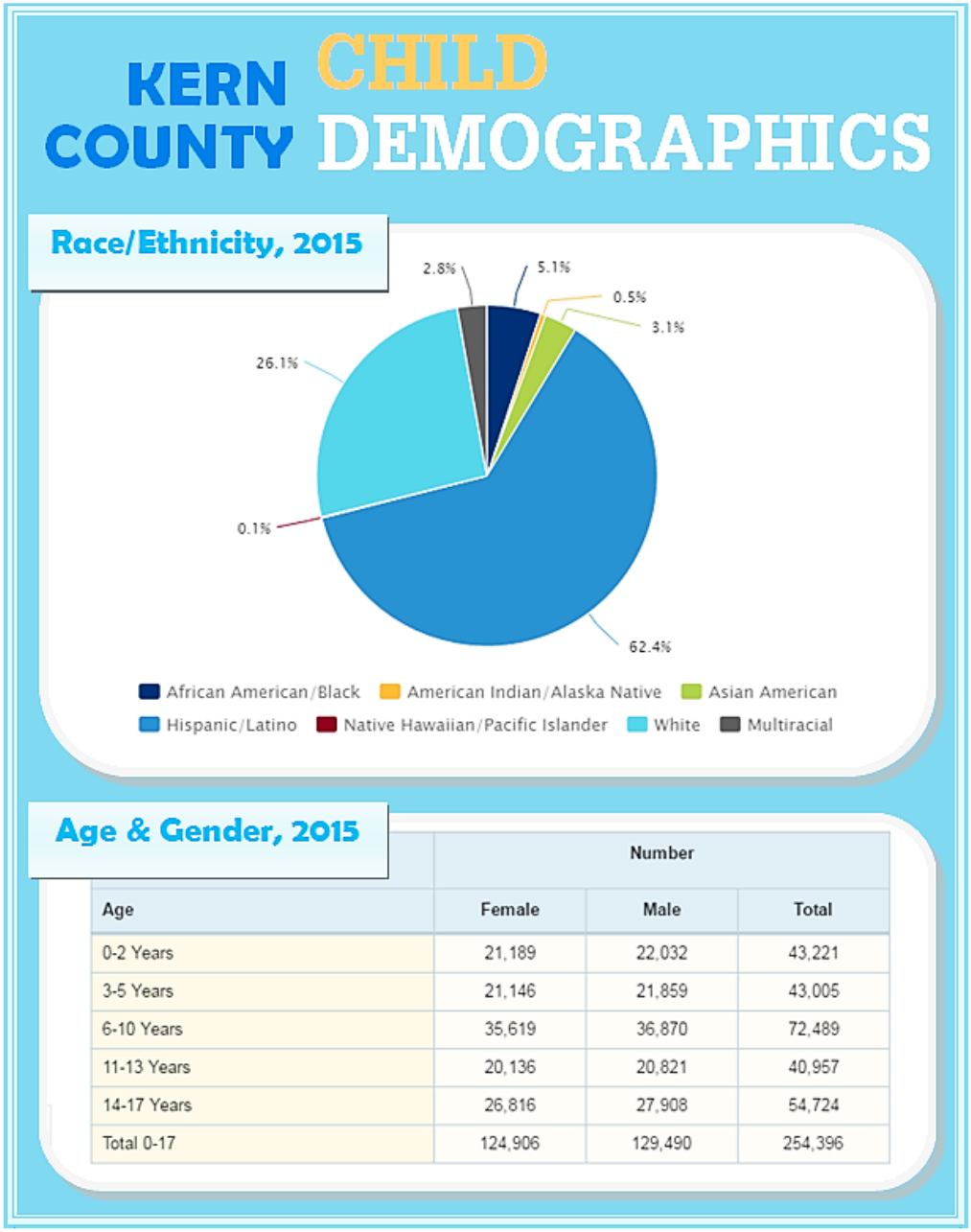
The Kern County CDRT is involved with FCANS through the Safe and Active Communities Branch at the California Department of Public Health. The FCANS program started in 1997 and was designed as an active surveillance system for child maltreatment deaths based on local CDRTs completion and submission of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

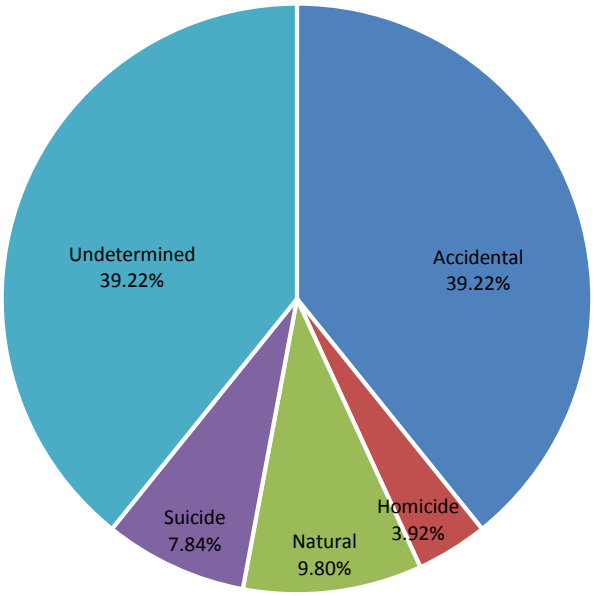
**Accidental/Unintentional** – These deaths are the result of unintentional injury. Examining these cases allows CDRT identify prevention strategies to deter future injuries.

**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** |

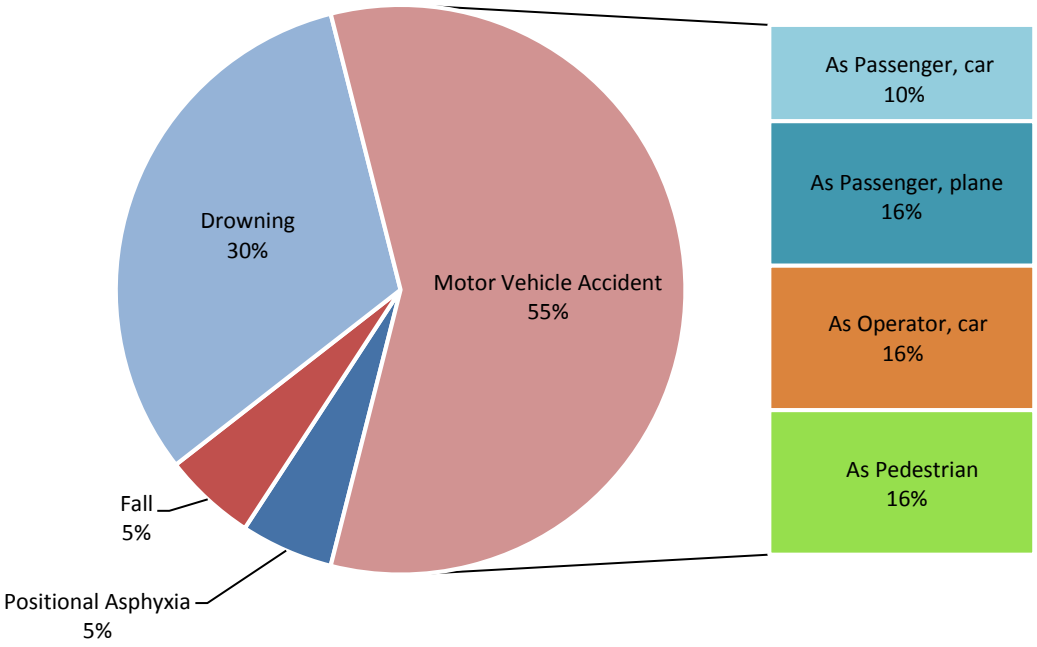
# Cause of Death

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 |

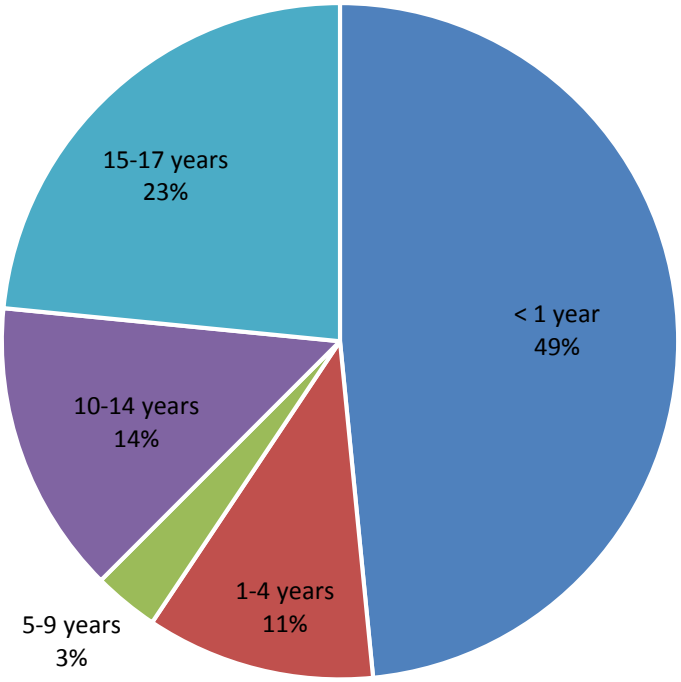
[1] Includes: Acute Bacterial Bronchopneumonia, multiple congenital abnormalities, metastatic hepatocellular carcinoma, probable sepsis

# 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 |

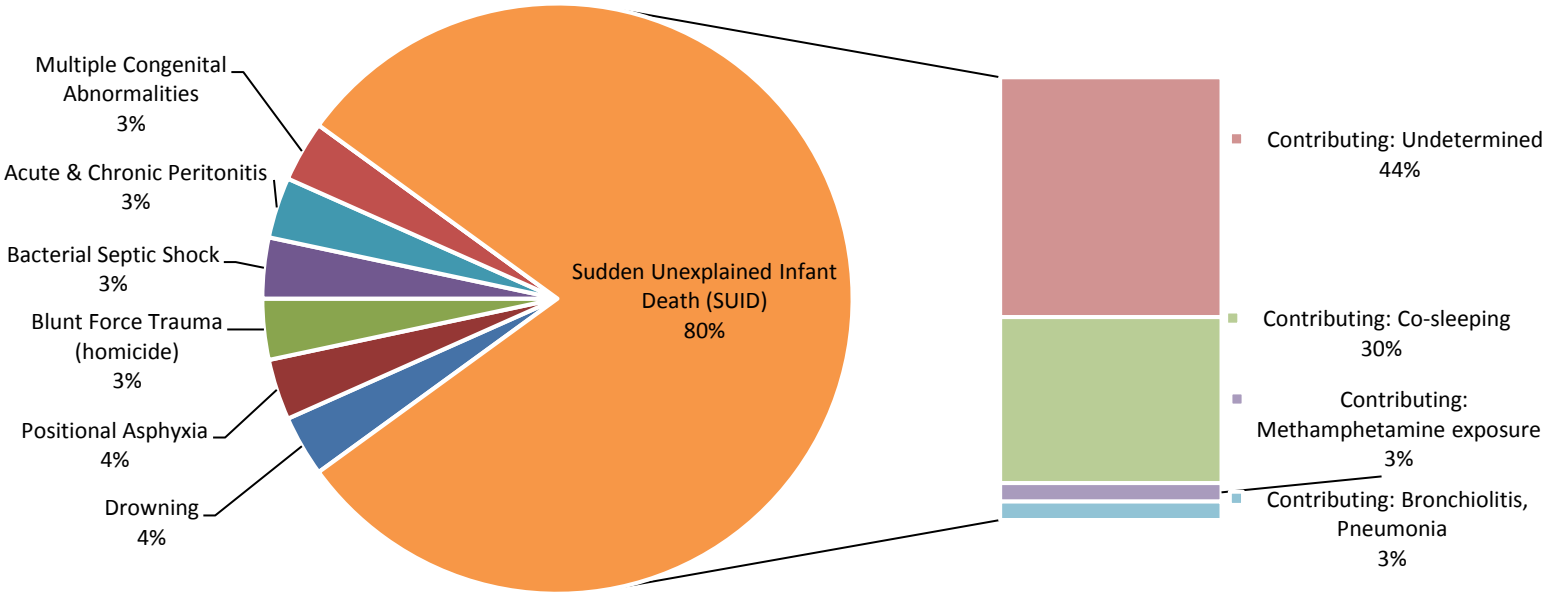
# Child Deaths Reviewed by Age Grouping




| 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

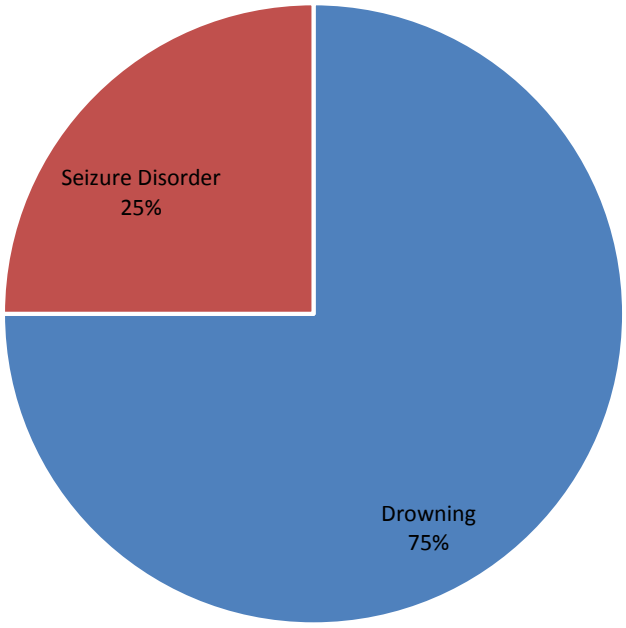
## Children <1 Year of Age




| 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

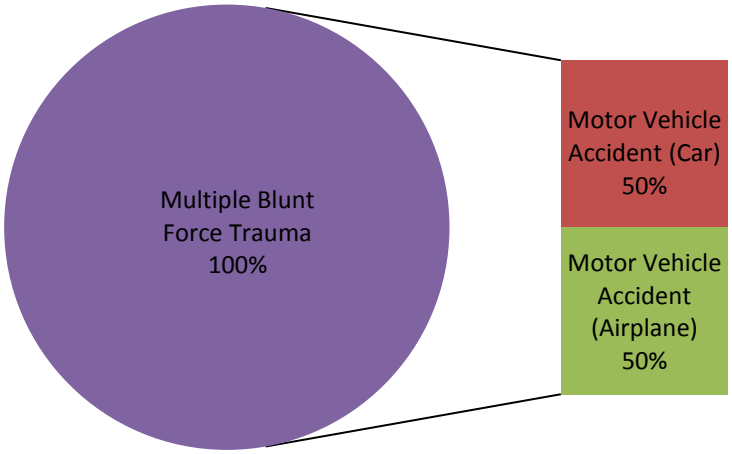
## Children 1-4 Years of Age




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

# Child Deaths Reviewed by Age and Cause

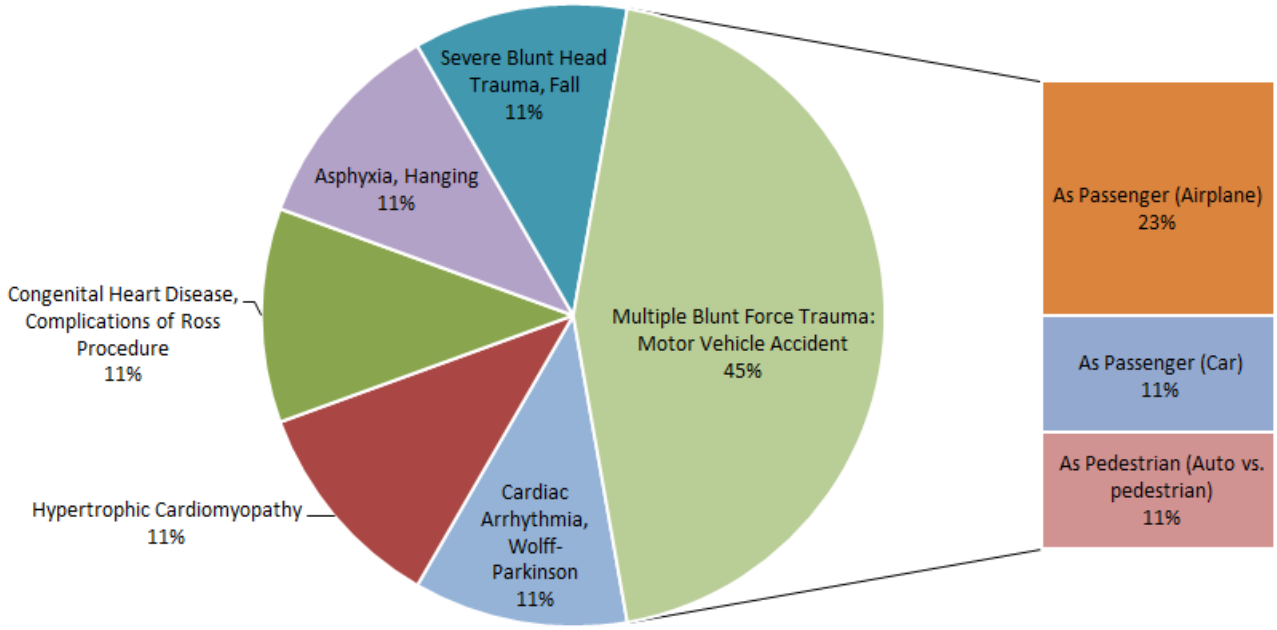
## Children 5-9 Years of Age




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

# Child Deaths Reviewed by Age and Cause

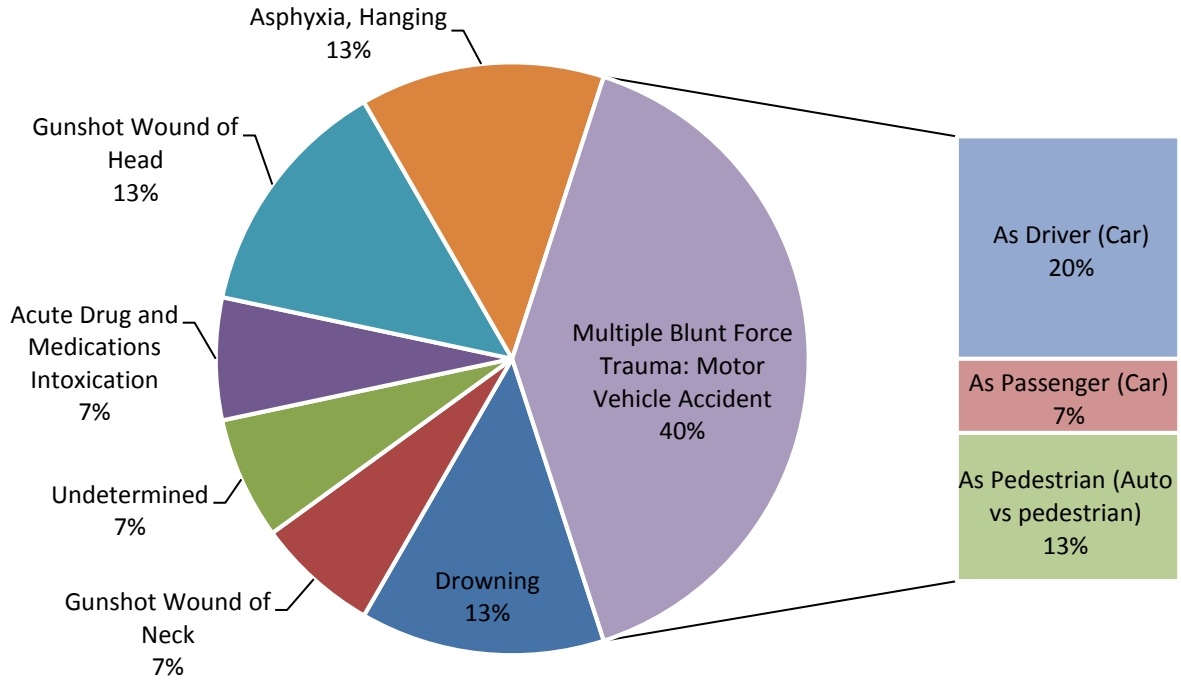
## Children 10-14 Years of Age




| 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** |

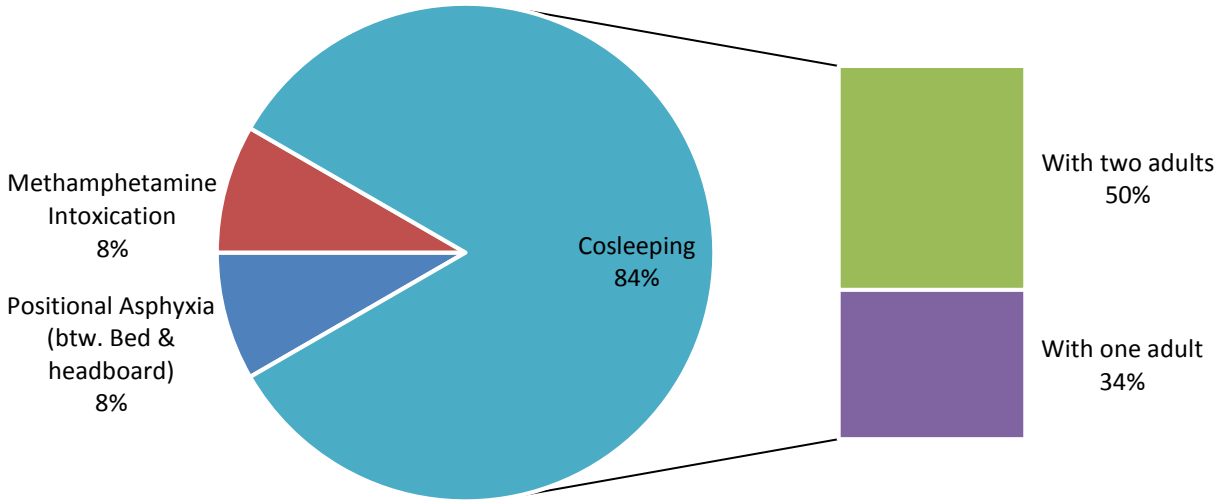
# Child Deaths Reviewed by Age and Cause

## Children 15-17 Years of Age



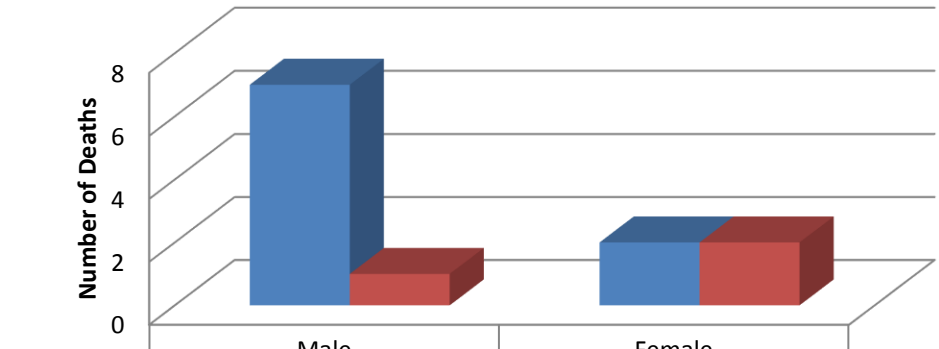

| Manner of Death | Cause of Death | Number |
|---|---|---|
| Accidental | | 8 |
| | Multiple Blunt Force Trauma: Motor Vehicle Accident | 6 |
| | Drowning | 2 |
| Homicide | | 1 |
| | Gunshot wound of Neck | 1 |
| Suicide | | 4 |
| | Acute Drug and Medications Intoxication | 1 |
| | Asphyxia, Hanging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

# Unsafe Sleep Environment: Contributing Factors

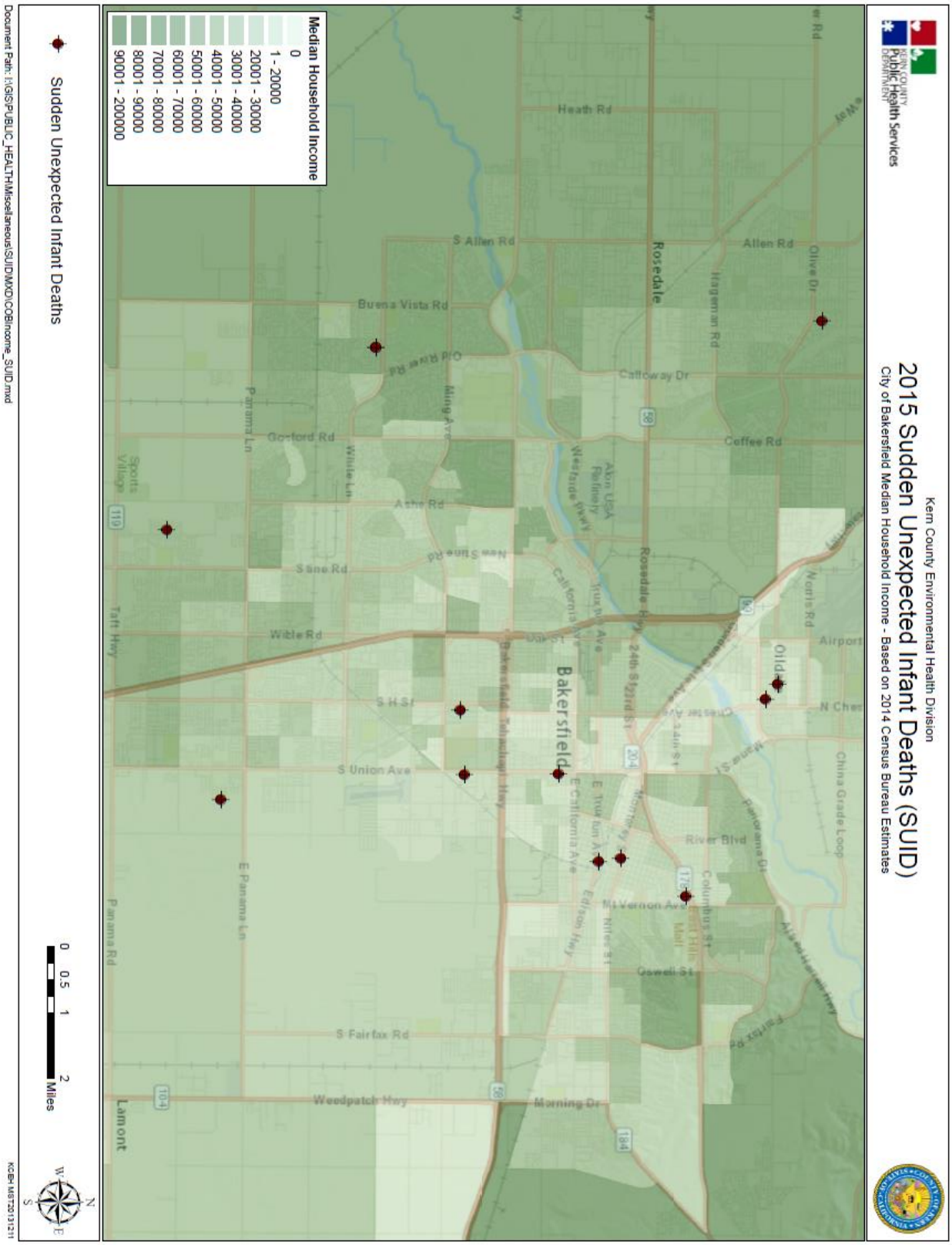


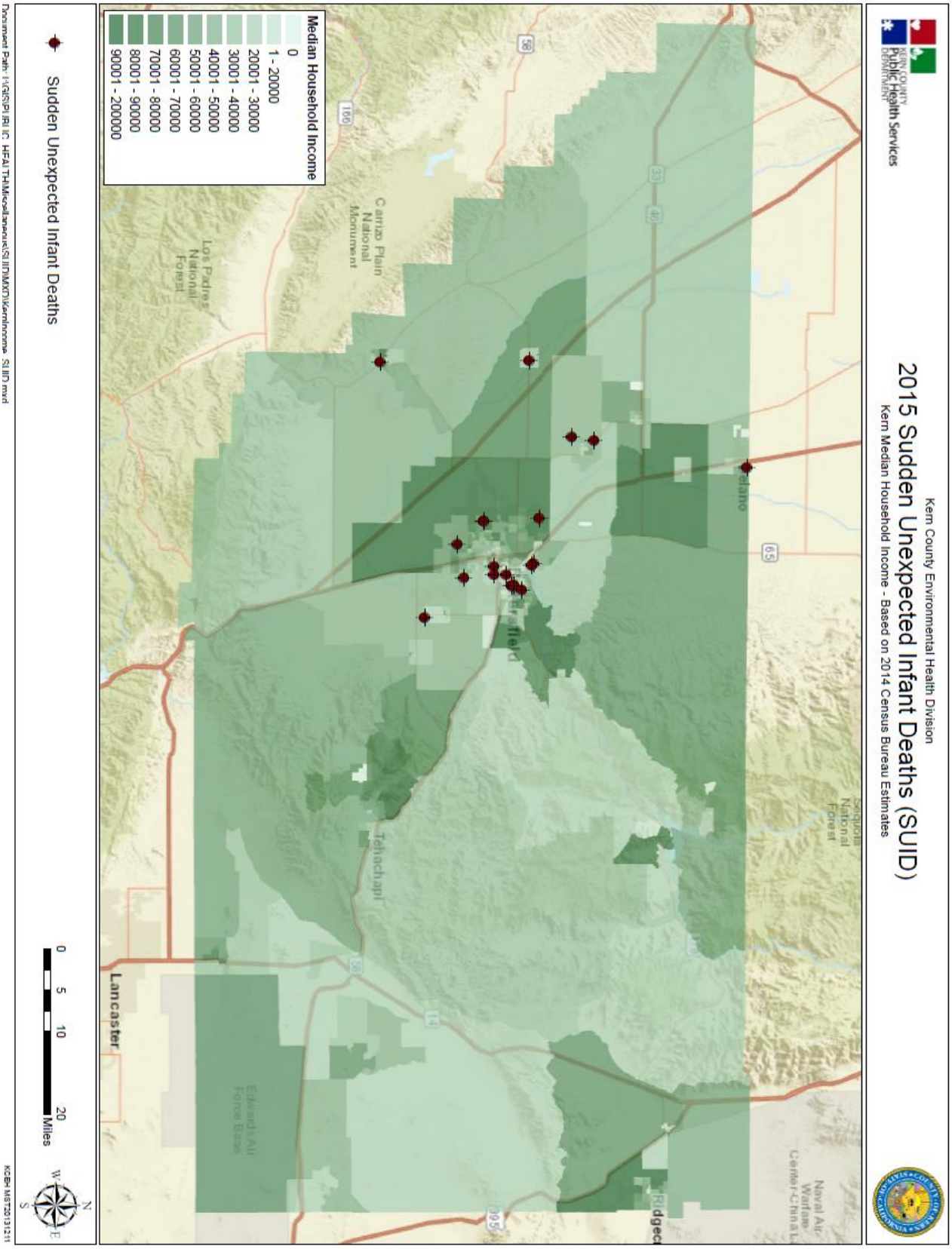

| Contributing Factor | |
|---|---|
| Positional Asphyxia (btw. Bed & headboard) | 1 |
| Methamphetamine Intoxication | 1 |
| Cosleeping w/ two adults | 6 |
| Cosleeping w/ one adult | 4 |

# 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
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
0 0.5 1 2 Miles
Bakersfield
Lamont
Document Path: H:\GIS\PUBLIC_HEALTH\Miscellaneous\SUID\MXD\COBIncome_SUID.mxd
KCEH M6T20131211


Kern County Public Health Services Department
Kern County Environmental Health Division
2015 Sudden Unexpected Infant Deaths (SUID)
Kern 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
Carrizo Plain National Monument
Los Padres National Forest
Sequoia National Forest
Naval Air Warfare Center-China L
Edwards Air Force Base
Lancaster
Tehachapi
Delano
Ridgec
0 5 10 20 Miles
N
W
E
S
Document Path: H:\GIS\PIR\C HEALTH\Miscellaneous\SUID\MXD\Kernlncome SUID.mxd
KCEH MST20131211

# 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.

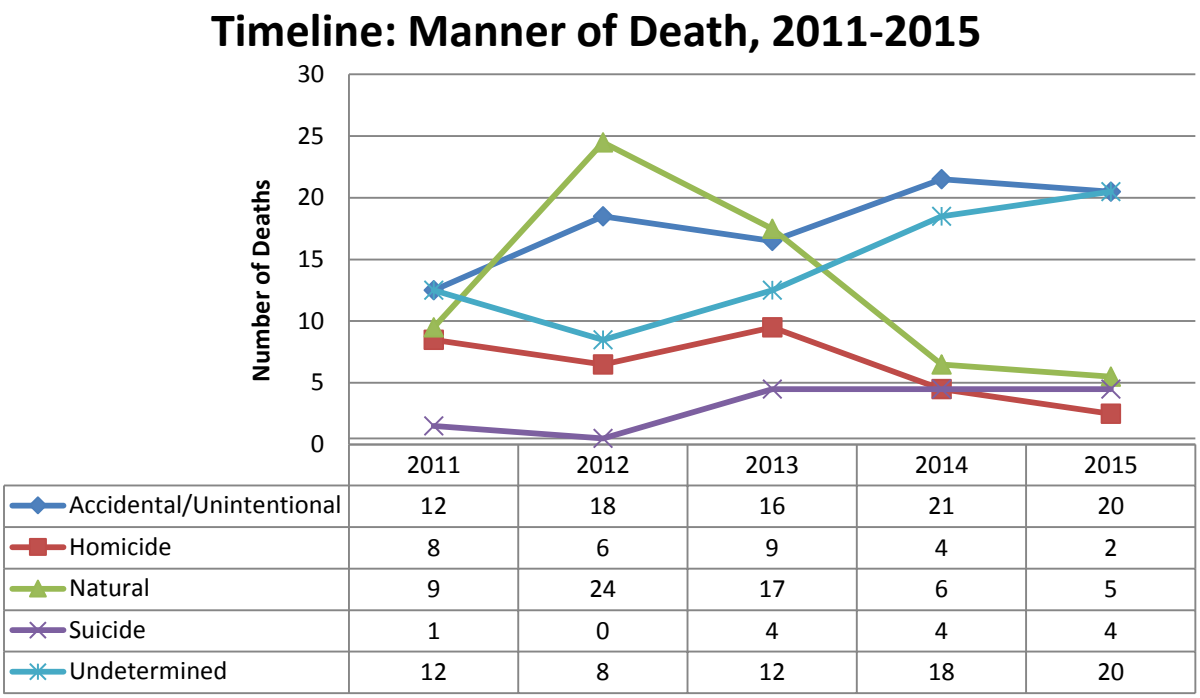
**Facilitate the continuing communication between agencies representative on the CDRT as well as coordinate identified trainings during CDRT meetings, which would benefit agency development.**

- 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 2015 Child Death Review Team Five-Year Comparison Report

# Child Deaths Reviewed by Overall Manner of Death

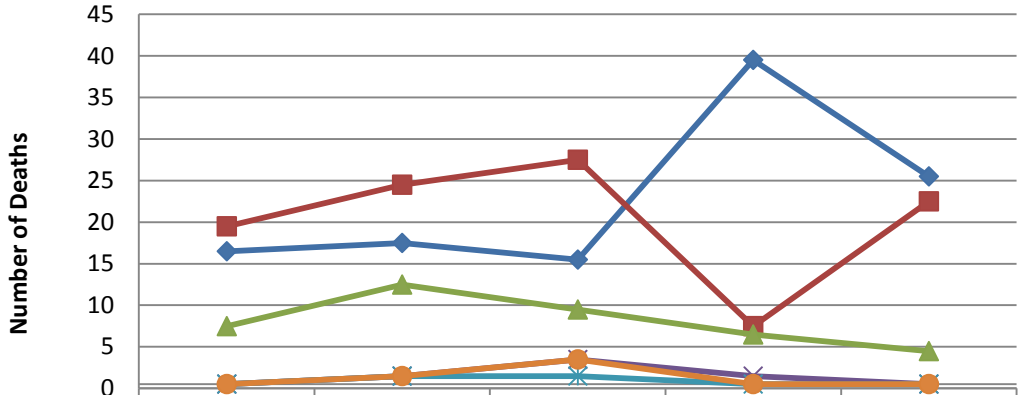



| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Accidental/Unintentional | 12 | 18 | 16 | 21 | 20 |
| Homicide | 8 | 6 | 9 | 4 | 2 |
| Natural | 9 | 24 | 17 | 6 | 5 |
| Suicide | 1 | 0 | 4 | 4 | 4 |
| Undetermined | 12 | 8 | 12 | 18 | 20 |

| | 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** |