



KERN COUNTY
2014 Child Death Review
Team Report

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 2014 reviews.

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Mission

The mandate of the Kern County Child Death Review Team (CDRT) is to reduce child deaths associated with child abuse and neglect. The secondary mission is to reduce other preventable 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. Identification of the causes and circumstances of these deaths is utilized to design and improve strategies to prevent fatal child abuse and neglect, work at implementing system changes, and promote education and awareness to prevent other 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 monthly meetings with the exception of the months of August and November. Currently there are fifteen agencies participating in the CDRT.

Team Membership

The Kern CDRT reviews and evaluates the deaths of children, age birth through 17 years, 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 Network for Children
Human Services/Child Protective Services	Kern County Superintendent of Schools
Kern County Mental Health Services	Bakersfield Police Department
District Attorney's Office	Kern Regional Center
Probation	Kern Medical Center
Sheriff's Office	Jamison Children's Center
	California Highway Patrol
	Haven Counseling Center

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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 are 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-three (53) cases are included in this report, which covers deaths that occurred from January 2014 to December 2014. 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)

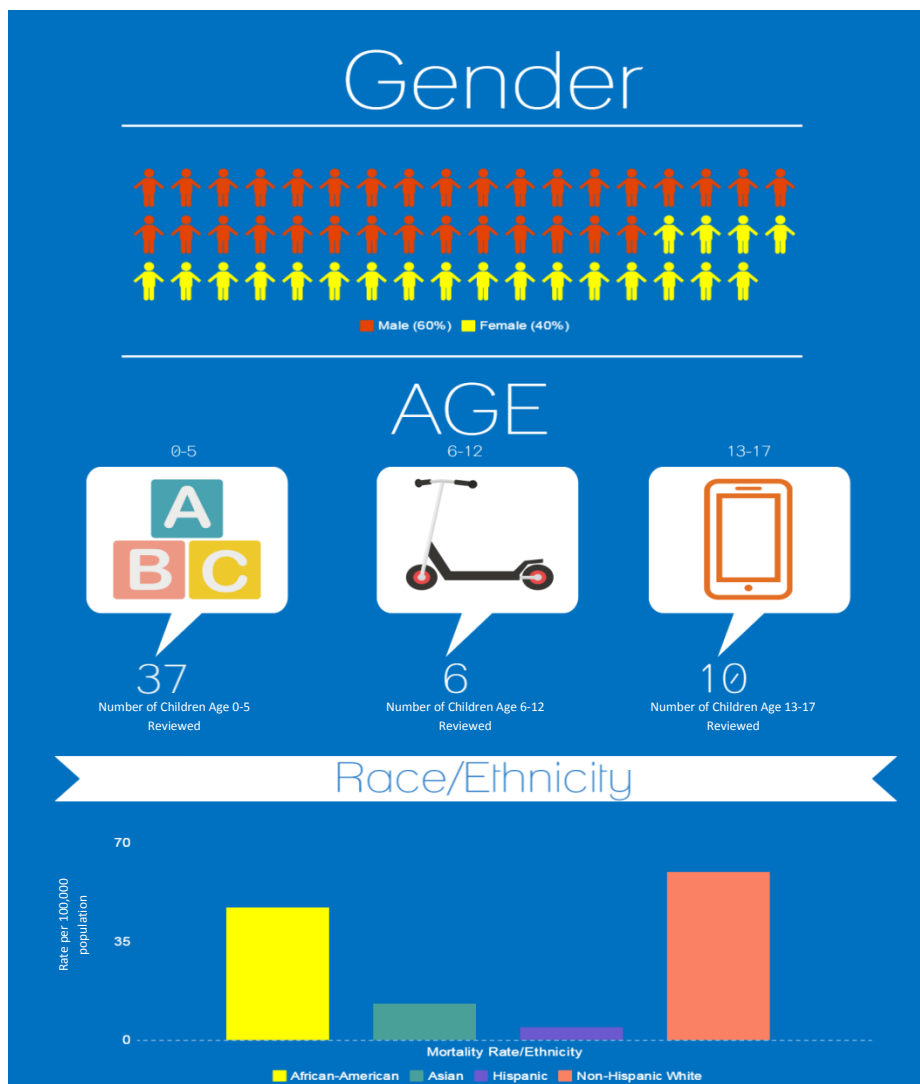
The Kern County CDRT is involved with FCANS through the Safe and Active Communities Branch at the California Department of Public Health. The FCANS program started in 1997 and was designed as an active surveillance system for child maltreatment deaths based on local CDRTs completion and submission of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



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Data Observations

Kern County is a large and diverse geographic area, comprised of agricultural-based communities and regions of 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 children residents.¹ As of 2014, there is an estimate of 256,535 children ages 0-17 residing in Kern County.² Children identified as Hispanic/Latino represent 61.8% of the child population and White children represent 26.9%.³ Compared to California, the Hispanic/Latino child population is 10% greater in Kern County. A total of 53 deaths were reviewed by the review team for this annual report. See infographic below for more demographic information.



¹ U.S. Census Bureau, [American Community Survey](#) (Oct. 2014, Sept 2014).

² California Dept. of Finance, [Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060](#) (Jun. 2014); U.S. Census Bureau, [Current Population Estimates, Vintage 2013](#) (Jun. 2014).

³ California Dept. of Finance, [Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060](#) (Jun. 2014); U.S. Census Bureau, [Current Population Estimates, Vintage 2013](#) (Jun. 2014).

Manner of Death

Manner of death is the classification of categories used to define whether a death is from intentional causes, unintentional causes, natural causes, or undetermined causes. California law requires that all suspicious or violent deaths and those deaths where a physician did not see the decedent in the 20 days prior to the death 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 unintentional, as opposed to intentional. These deaths are of particular interest to the CDRT as the Team is interested in identifying prevention strategies.

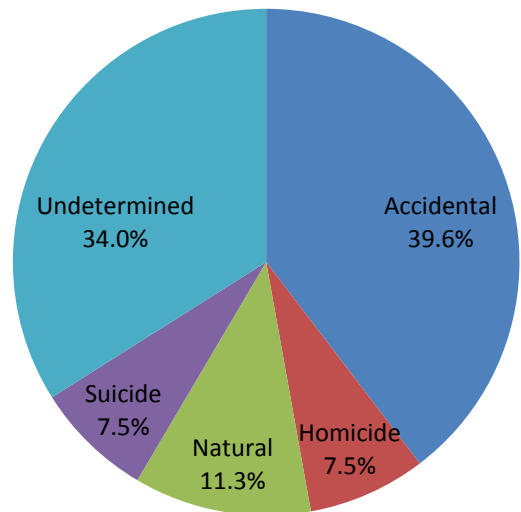
Natural – Natural deaths are from disease or other medical conditions other than injury.

CDRT surveillance of deaths from natural causes is important, as the data may support programs that focus on maternal and prenatal health, well child examinations, 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 any intent to die as a result of the behavior.

Undetermined – Undetermined deaths reflect situations in which the Coroner is unable to fix a final manner of death. These cases often involve insufficient or conflicting information, which affects the Coroner’s ability to make a final determination. Kern CDRT reviews many deaths involving an unsafe sleep environment; the manner in these deaths is undetermined.



Manner of Death	Number
Accidental	21
Homicide	4
Natural	6
Suicide	4
Undetermined	18
Total	53

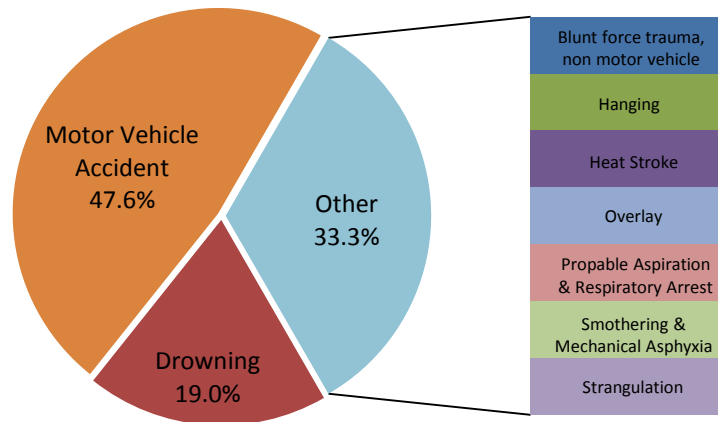
Cause of Death

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		21
	Blunt force trauma	1
	Drowning	4
	Hanging	1
	Heat Stroke	1
	Motor vehicle accident	10
	Overlay	1
	Probable Aspiration & Respiratory Arrest	1
	Smothering	1
	Strangulation	1
Homicide		4
	Blunt Chest Injuries	1
	Gunshot wound	2
	Undetermined	1
Natural		6
	Various ¹	6
Suicide		4
	Asphyxia/Hanging	3
	Self-inflicted ligature	1
Undetermined		18
	SUID/USE ²	17
	Undetermined	1
Total		53

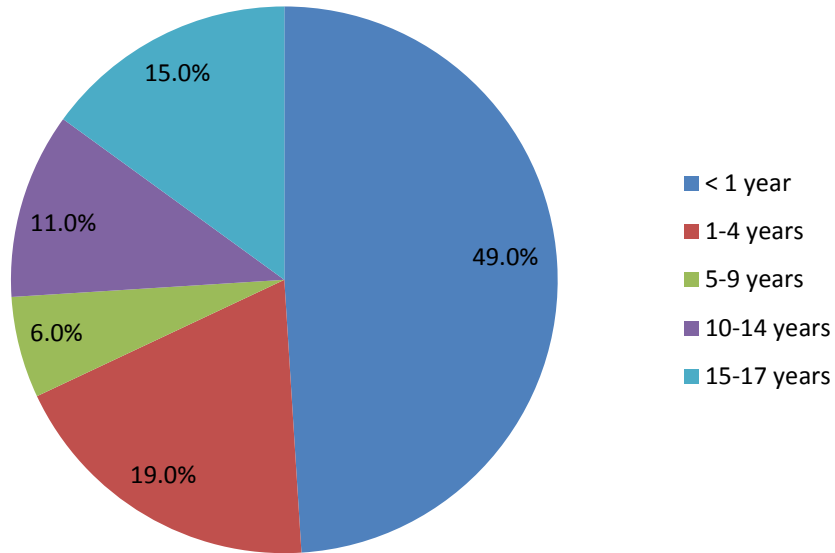
¹ Includes: Acute Bacterial Bronchopneumonia, complications of small bowel strangulation, multiple congenital abnormalities, metastatic hepatocellular carcinoma, probable sepsis ² Sudden Unexplained Infant Death/Unsafe Sleep Environment

Accidental/Unintentional Injuries



Type of Unintentional Injury	Number
Blunt force trauma, non-motor vehicle	1
Drowning	4
Hanging	1
Heat Stroke	1
Motor vehicle accident	10
As Bicyclist	1
As Passenger	6
As Passenger, ejected	1
As Pedestrian	2
Overlay	1
Probable Aspiration & Respiratory Arrest	1
Smothering & Mechanical Asphyxia	1
Strangulation	1
Total	21

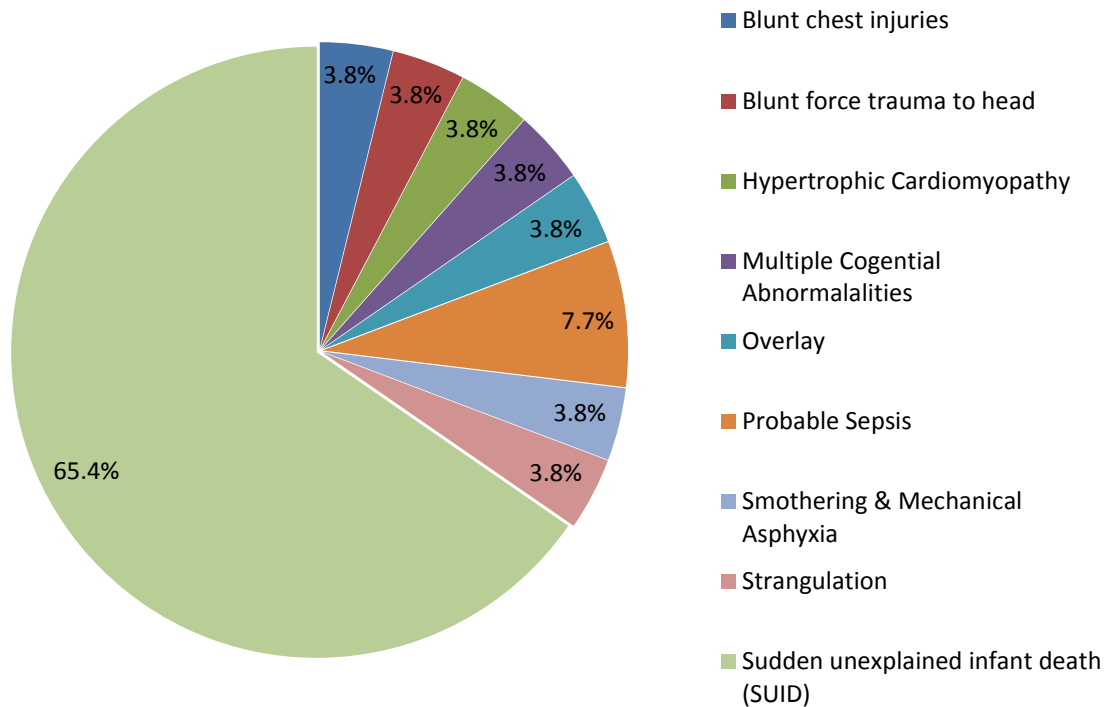
Child Deaths Reviewed by Age Grouping



Age	Number of deaths
< 1 year	26
1-4 years	10
5-9 years	3
10-14 years	6
15-17 years	8
Total	53

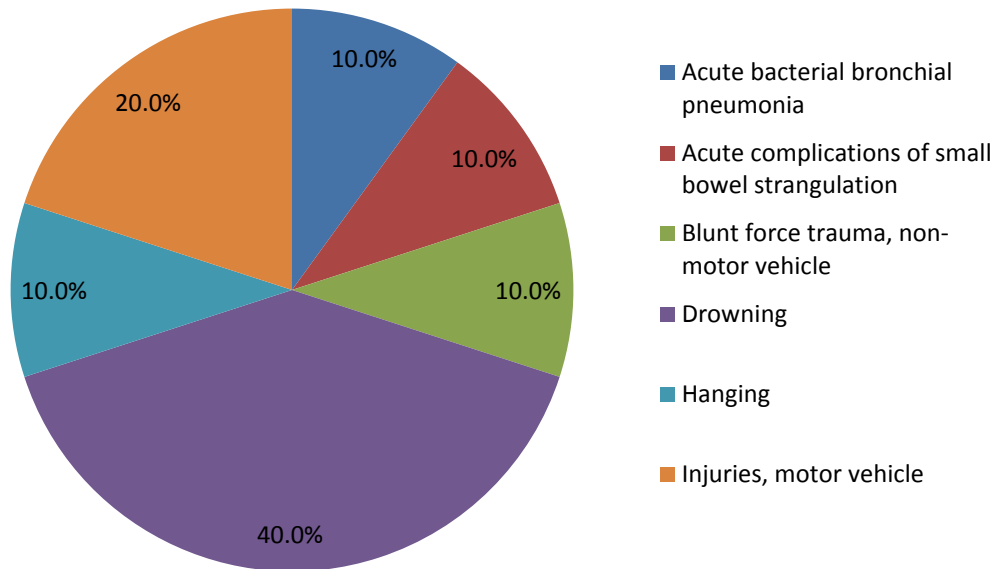
Child Deaths Reviewed by Age and Cause

Children <1 Year of Age



Manner of Death	Cause of Death	Number
Accidental		4
	Blunt force trauma to head	1
	Overlay	1
	Smothering	1
	Strangulation	1
Homicide		1
Natural	Blunt chest injuries	1
	Multiple Congenital Abnormalities	1
	Probable Sepsis	2
	Hypertrophic Cardiomyopathy	1
Undetermined		17
	SUID	17
Total		26

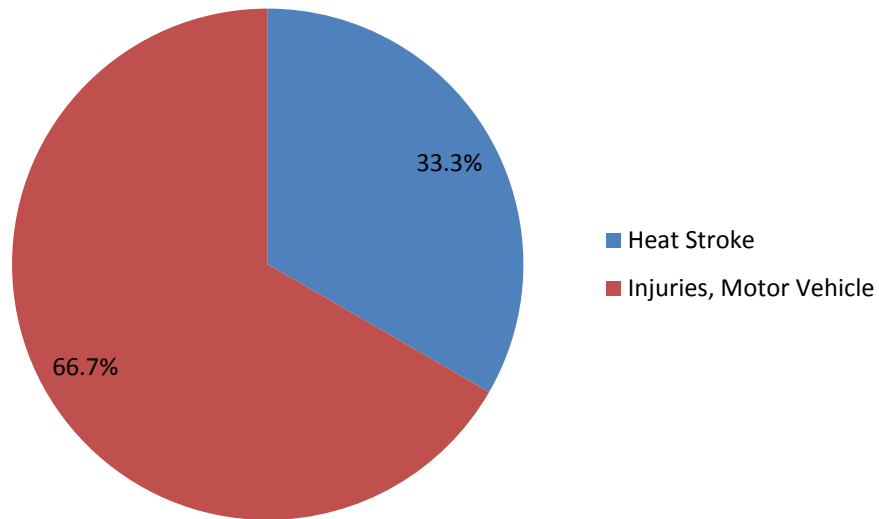
Child Deaths Reviewed by Age and Cause Children 1-4 Years of Age



Manner of Death	Cause of Death	Number
Accidental		8
	Blunt force trauma, non-motor vehicle	1
	Drowning	4
	Hanging	1
	Injuries, motor vehicle	2
Natural		2
	Acute bacterial bronchial pneumonia	1
	Acute complications of small bowel strangulation	1
Total		10

Child Deaths Reviewed by Age and Cause

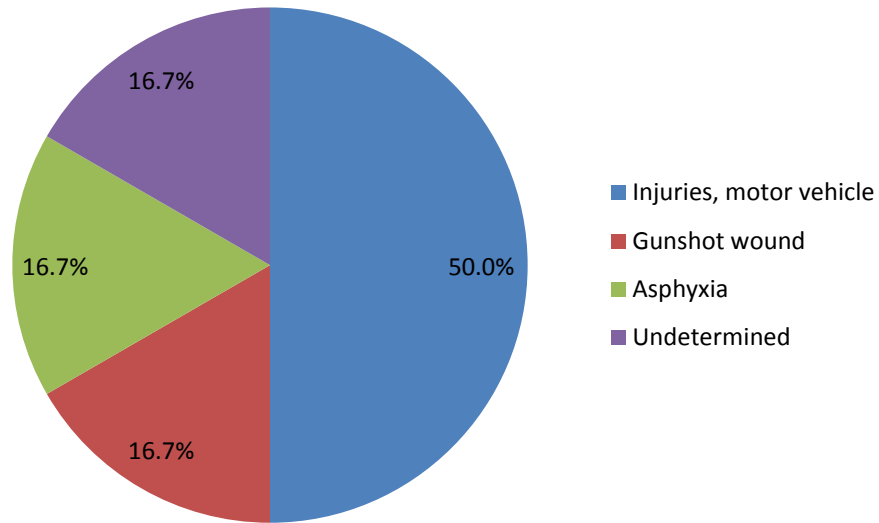
Children 5-9 Years of Age



Manner of Death	Cause of Death	Number
Accidental		3
	Heat stroke	1
	Injuries, motor vehicle	2
Total		3

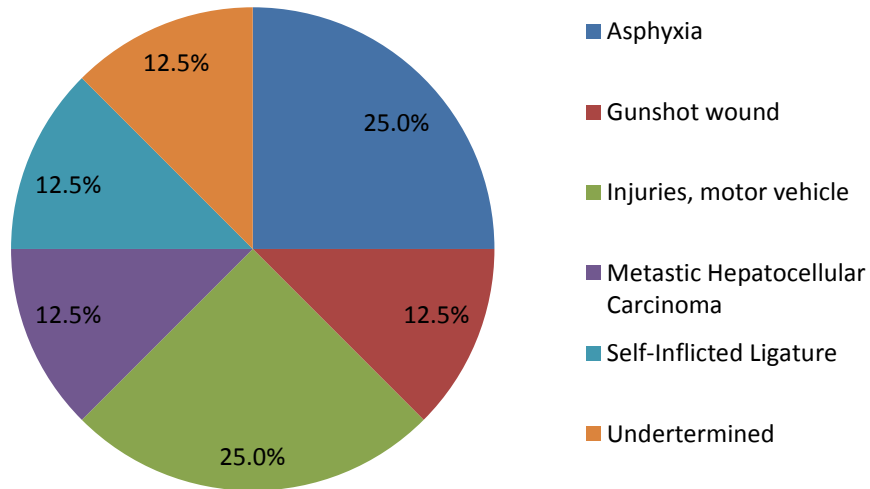
Child Deaths Reviewed by Age and Cause

Children 10-14 Years of Age



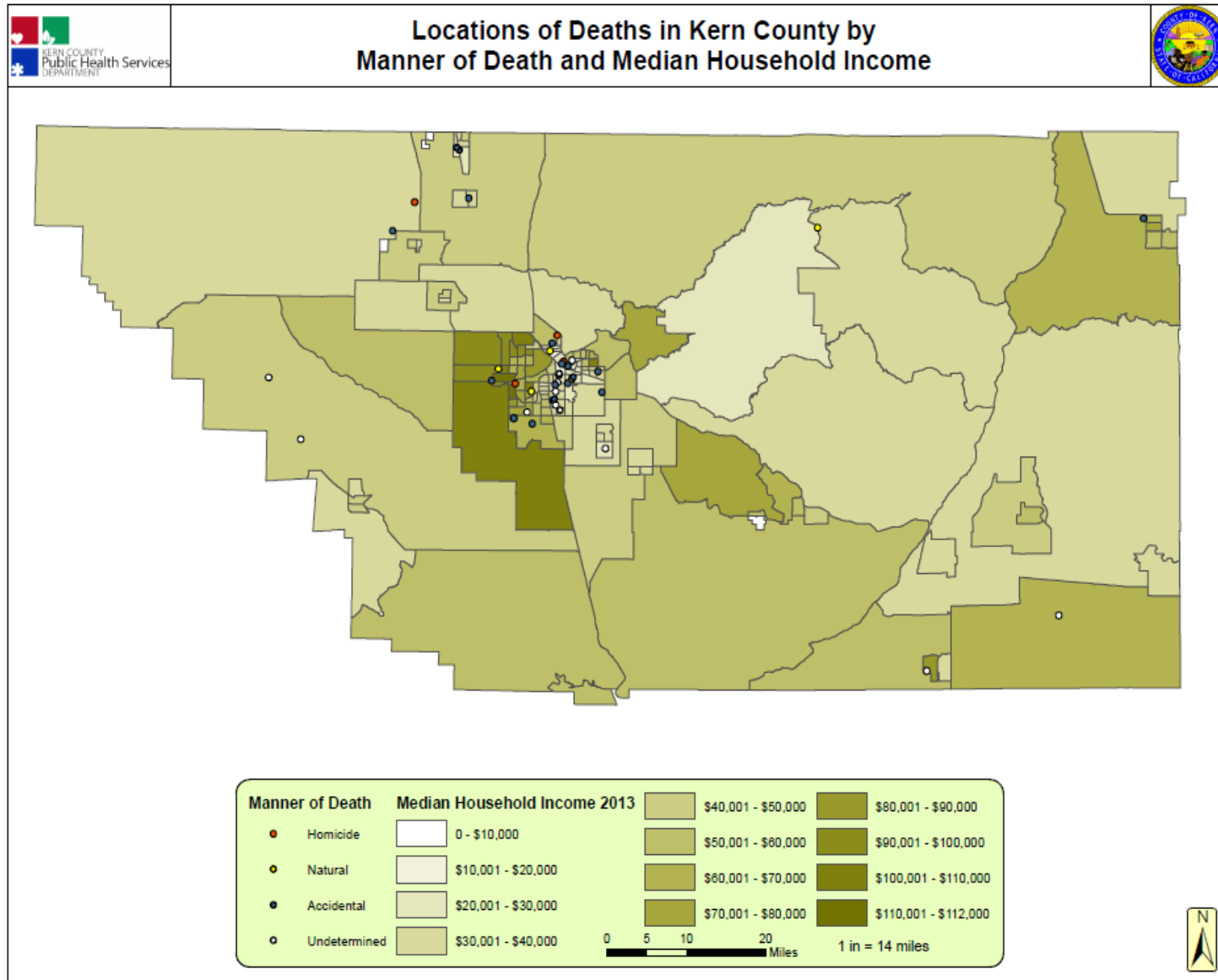
Manner of Death	Cause of Death	Number
Accidental		3
	Injuries, motor vehicle	3
Homicide		1
	Gunshot wound	1
Suicide		1
	Asphyxia	1
Undetermined		1
Total		6

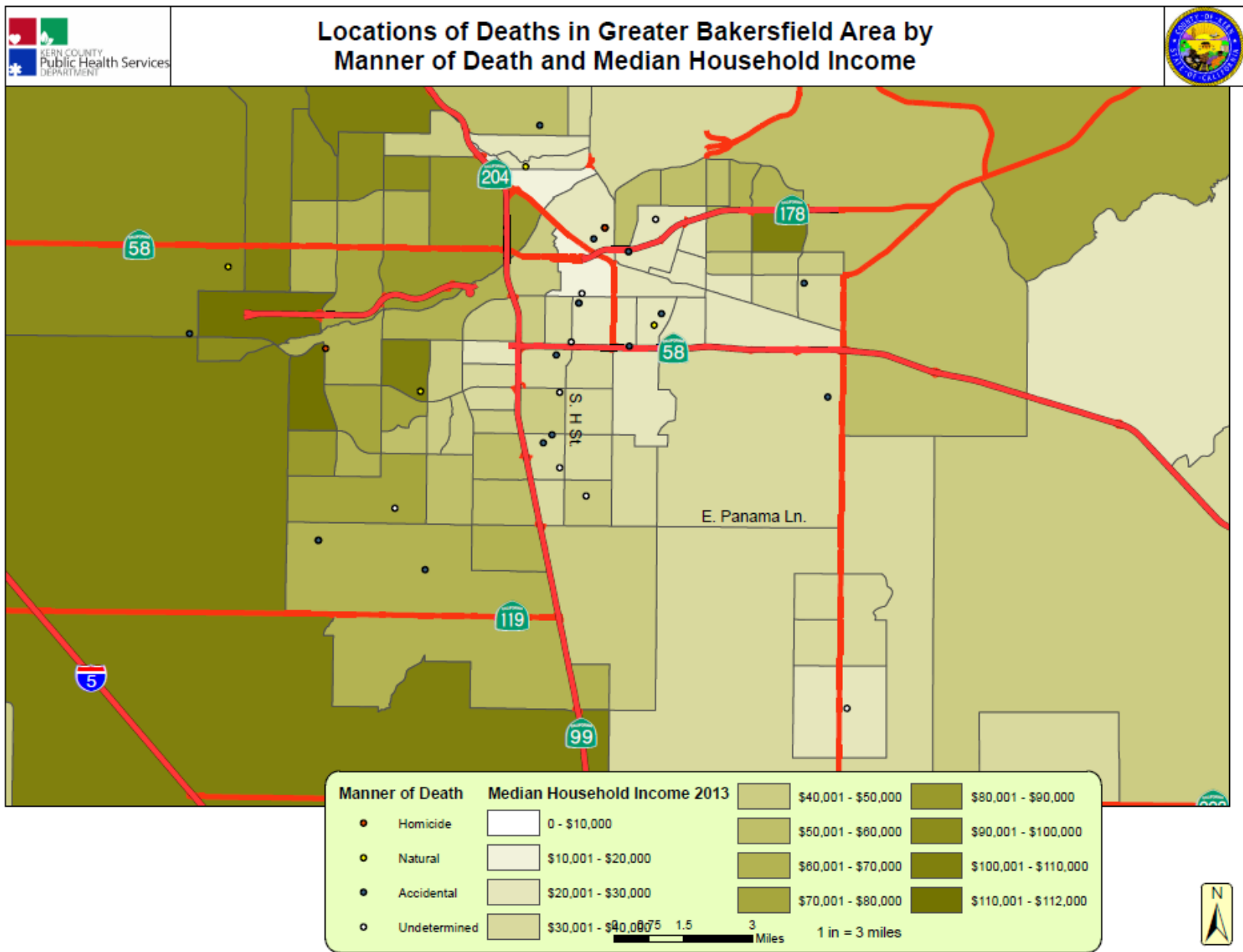
Child Deaths Reviewed by Age and Cause Children 15-17 Years of Age



Manner of Death	Cause of Death	Number
Accidental		2
	Injuries, motor vehicle	2
Homicide		2
	Gunshot wound	1
	Undetermined	1
Natural		1
	Metastatic Hepatocellular Carcinoma	1
Suicide		3
	Self-inflicted ligature	1
	Asphyxia	2
Total		8

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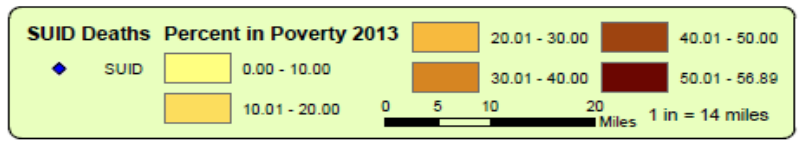
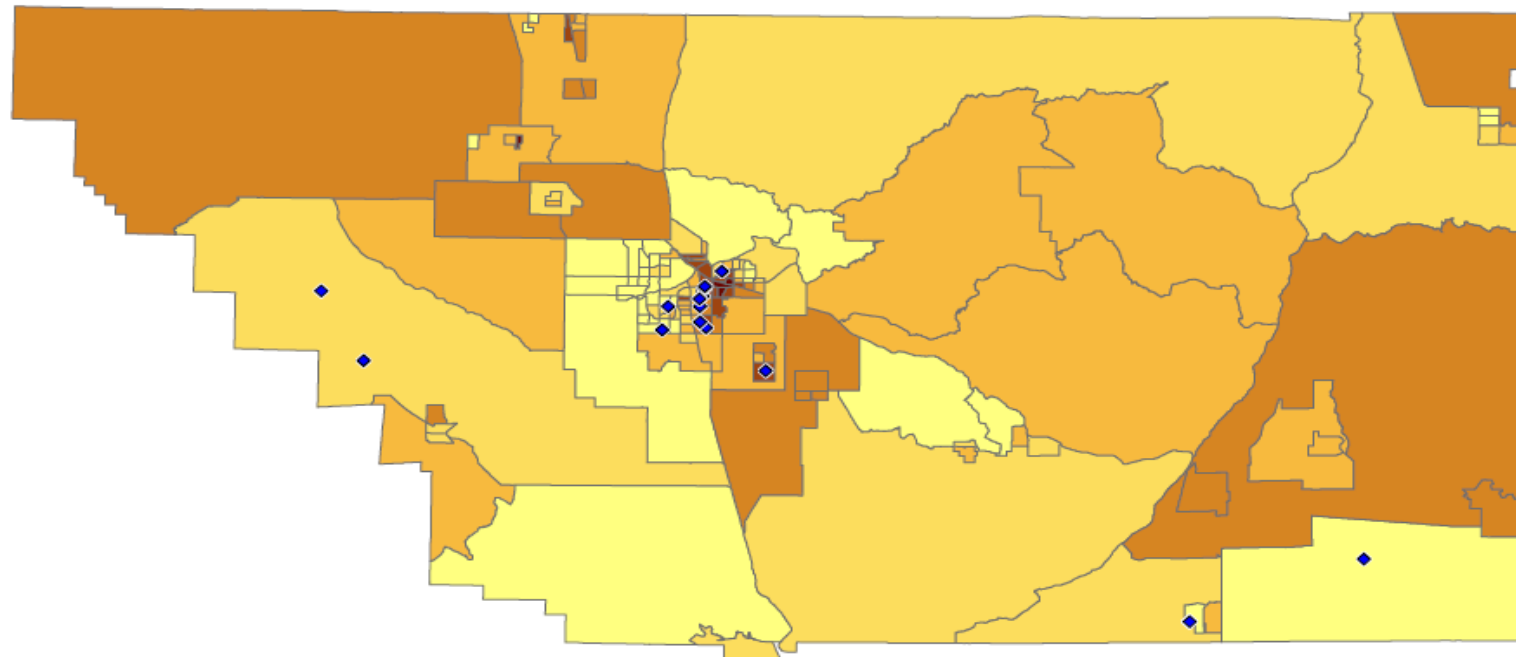


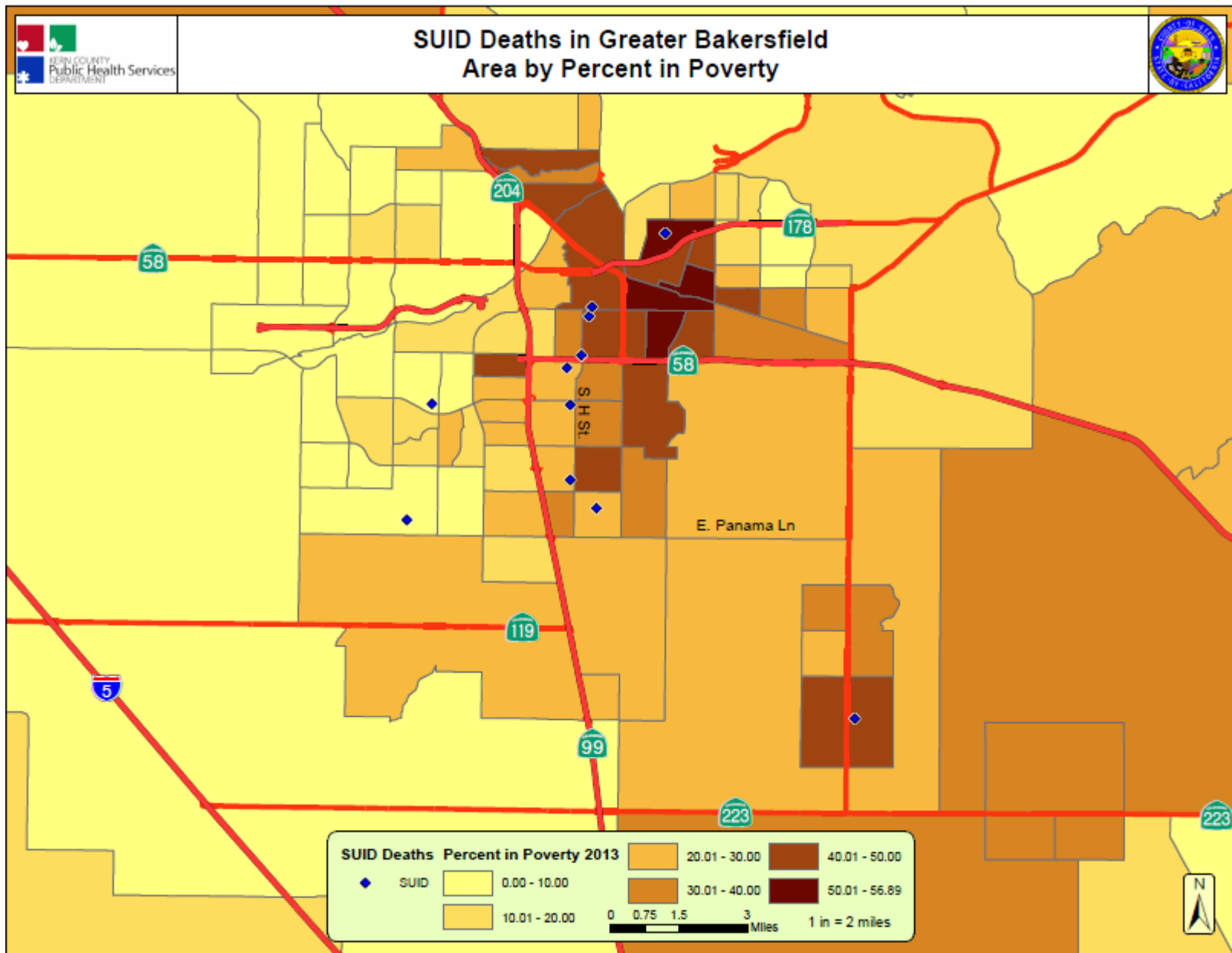


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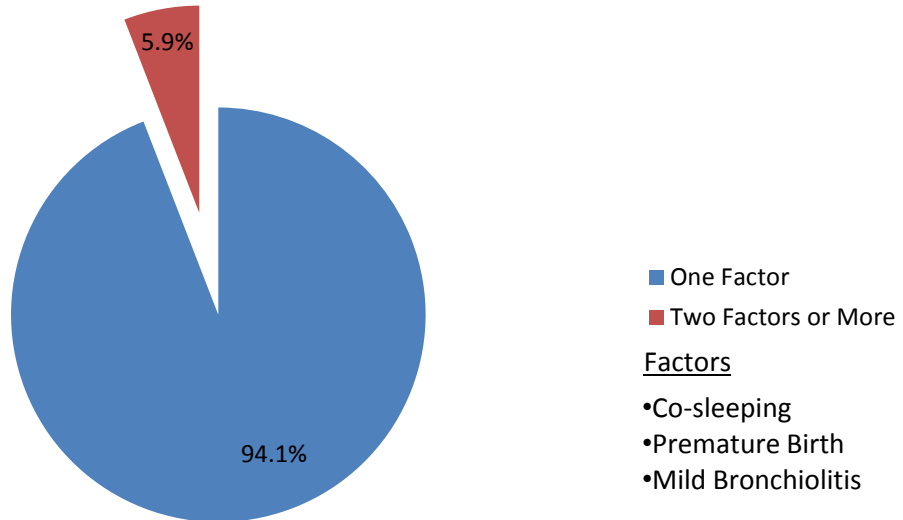
SUID Deaths in Kern County by Percent in Poverty



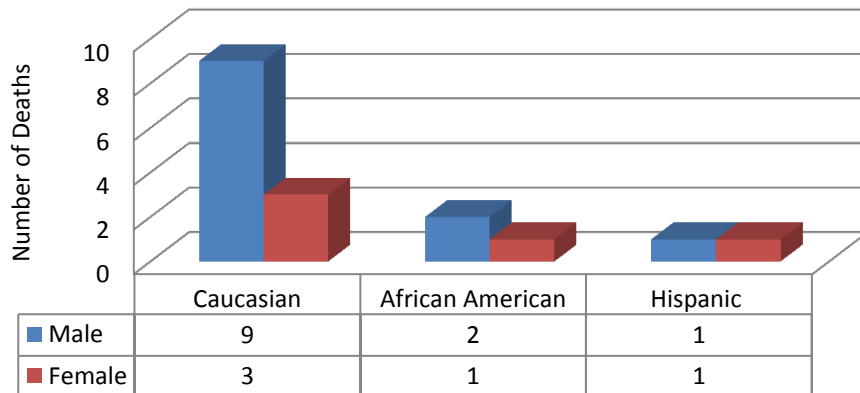


SUID/SIDS Deaths Reviewed

Contributing Factors to SUID/SIDS Deaths



Unsafe Sleep Environment by Race and Sex



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 Safer 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 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.

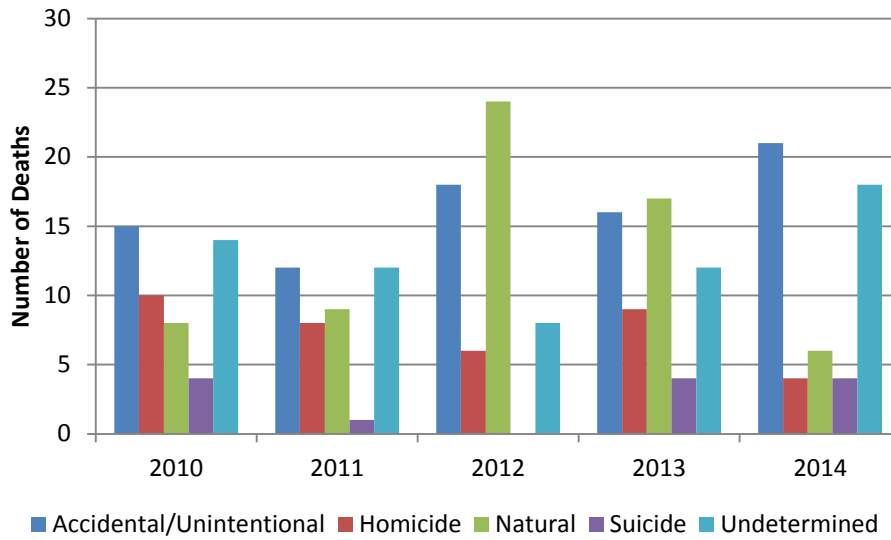
Kern County Child Death Review Team 2014 Report

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 one local hospital 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**
2010 Child Death Review
Team Five-Year
2014 Comparison Report

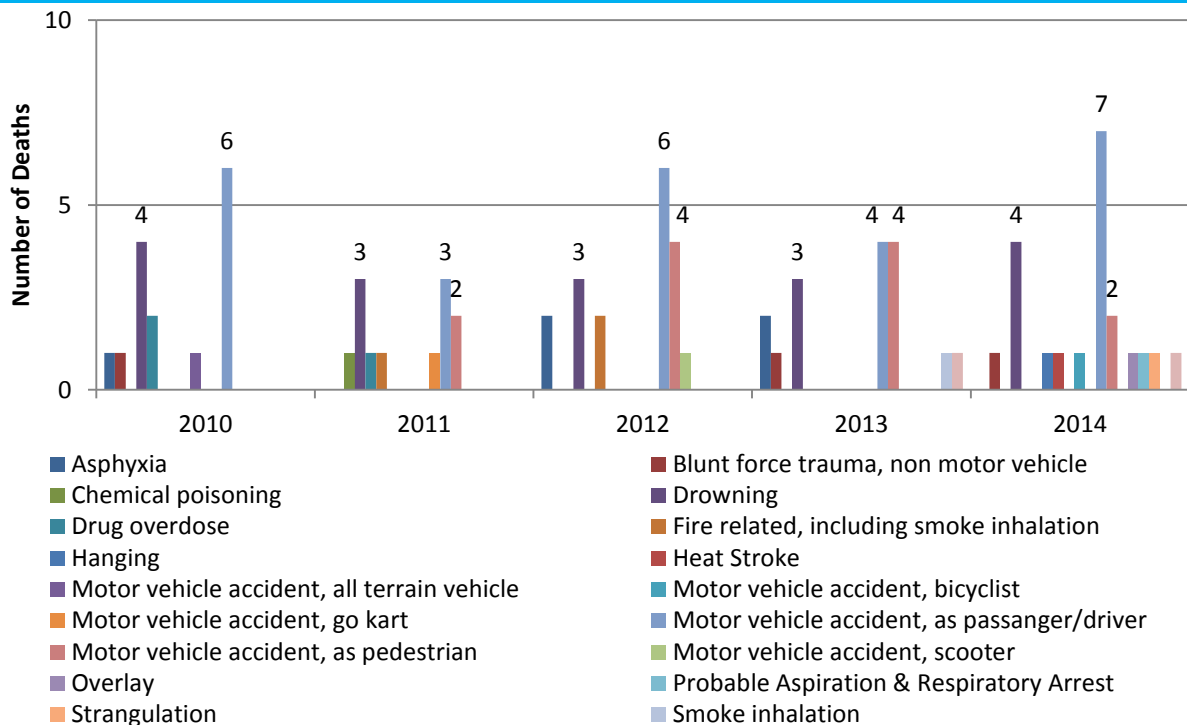
Child Deaths Reviewed by Overall Manner of Death



Manner of Death	Number of Deaths					Total
	2010	2011	2012	2013	2014	
Accidental/Unintentional	15	12	18	16	21	82
Homicide	10	8	6	9	4	37
Natural	8	9	24	17	6	64
Suicide	4	1	0	4	4	13
Undetermined	14	12	8	12	18	64
Total	51	42	56	58	53	260

Child Deaths Reviewed by Accidental/Unintentional Injuries

Cause of Death	Number of Deaths					Total
	2010	2011	2012	2013	2014	
Asphyxia	1		2	2		5
Blunt force trauma, non-motor vehicle	1			1	1	3
Chemical poisoning		1				1
Drowning	4	3	3	3	4	17
Drug overdose	2	1				3
Fire related, including smoke inhalation		1	2			3
Hanging					1	1
Heat Stroke					1	1
Motor vehicle accident, all-terrain vehicle	1					1
Motor vehicle accident, bicyclist					1	1
Motor vehicle accident, go kart		1				1
Motor vehicle accident, as passenger/driver	6	3	6	4	7	26
Motor vehicle accident, as pedestrian		2	4	4	2	12
Motor vehicle accident, scooter			1			1
Overlay					1	1
Probable Aspiration & Respiratory Arrest					1	1
Strangulation					1	1
Smoke Inhalation				1		1
Smothering				1	1	1
Total	15	12	18	16	21	82

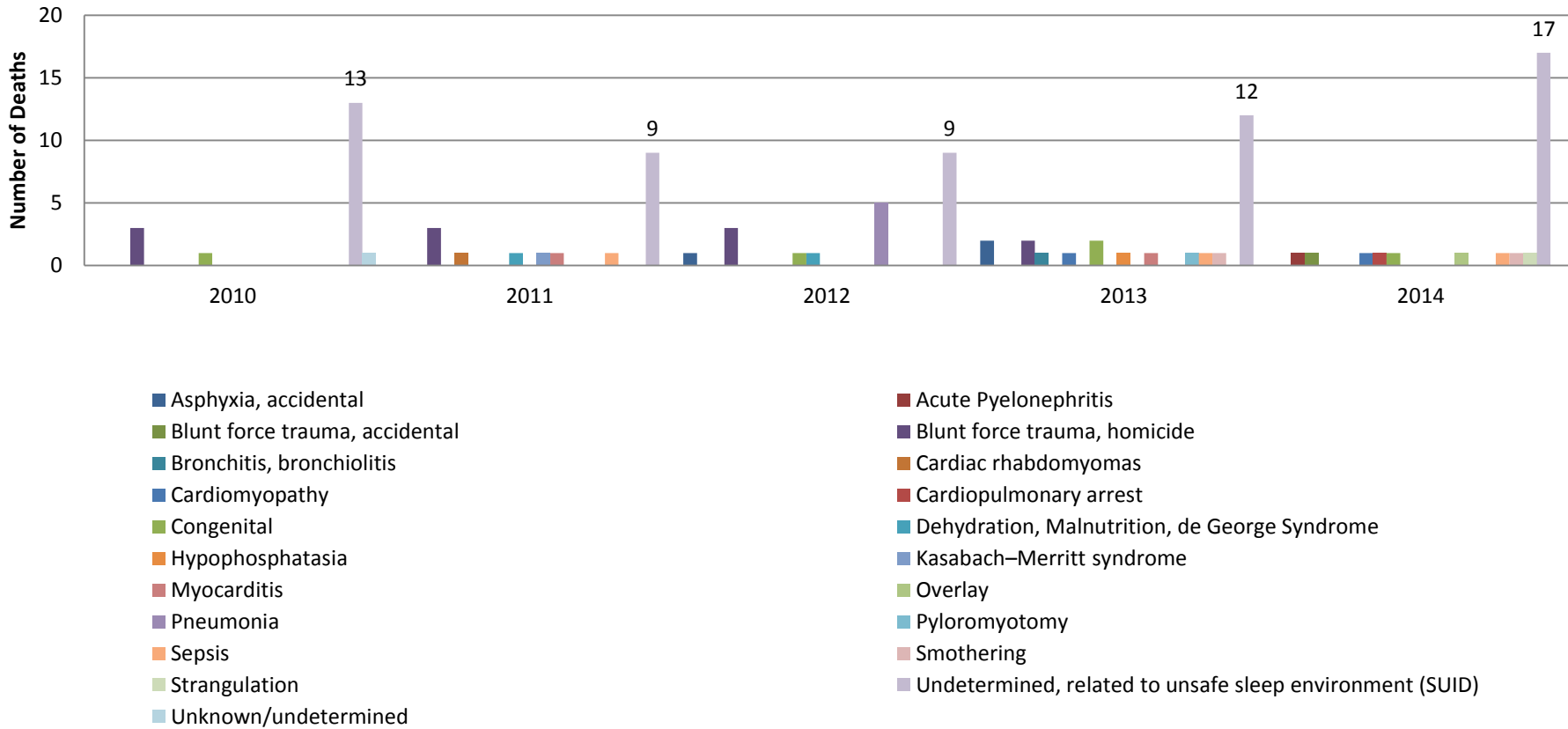


Child Deaths Reviewed by Age and Cause

Children <1 Year of Age

Cause of Death	Number of Deaths					Total
	2010	2011	2012	2013	2014	
Asphyxia, accidental			1	2		3
Blunt force trauma, accidental					1	1
Blunt force trauma, homicide	3	3	3	2	1	12
Bronchitis, bronchiolitis				1		1
Cardiac rhabdomyomas		1				1
Cardiomyopathy				1	1	2
Cardiopulmonary arrest					1	1
Congenital	1		1	2	1	5
Dehydration, Malnutrition, de George Syndrome		1	1			2
Hypophosphatasia				1		1
Kasabach–Merritt syndrome		1				1
Myocarditis		1		1		2
Overlay					1	1
Pneumonia			5			5
Pyloromyotomy				1		1
Sepsis		1		1	1	3
SIDS			1			1
Smothering				1	1	2
Strangulation					1	1
Undetermined, related to unsafe sleep environment (SUID)/ Sudden Infant Death Syndrome (SIDS)	13	9	8	12	17	59
Unknown/undetermined	1					1
Total	18	17	20	25	26	106

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Child Deaths Reviewed by Age and Cause

Children Ages 1-17 Years of Age

Cause of Death	Number of Deaths					Total
	2010	2011	2012	2013	2014	
Acute Bacterial Bronchopneumonia					1	1
Acute peritonitis				2		2
Airway obstruction			1	1		2
Alveolar damage			1			1
Asphyxia, suicide	2	1		3	3	9
Asphyxia, accidental	1		1			2
Blunt force trauma, homicide	4	3	1	4	1	13
Blunt force trauma, non-motor vehicle, accidental				1	1	2
Brain tumor		1		1		2
Cardiomegaly				1		1
Cardiomyopathy		1	2			3
Cerebral palsy	1					1
Complications of small bowel strangulation					1	1
Diabetes			1			1
Drowning	4	3	3	3	4	17
Drug overdose, accidental	2	1				3
Drug overdose, suicide	1					1
Epilepsy			1			1
Fire related, including smoke inhalation		1	2	1		4
Gunshot wound, homicide	2	1	2	2	2	9
Gunshot wound, suicide	1			1		2
Hanging					1	1
Heat Stroke					1	1
Hemophagocytic lymphohistiocytosis			1			1
Heterotaxy syndrome			1			1
Hirschsprungs disease			1			1
Hypertrophic heart disease				1		1
Hyponatremic dehydration			1			1
Intussusception	1					1
Metastatic Hepatocellular Carcinoma					1	1

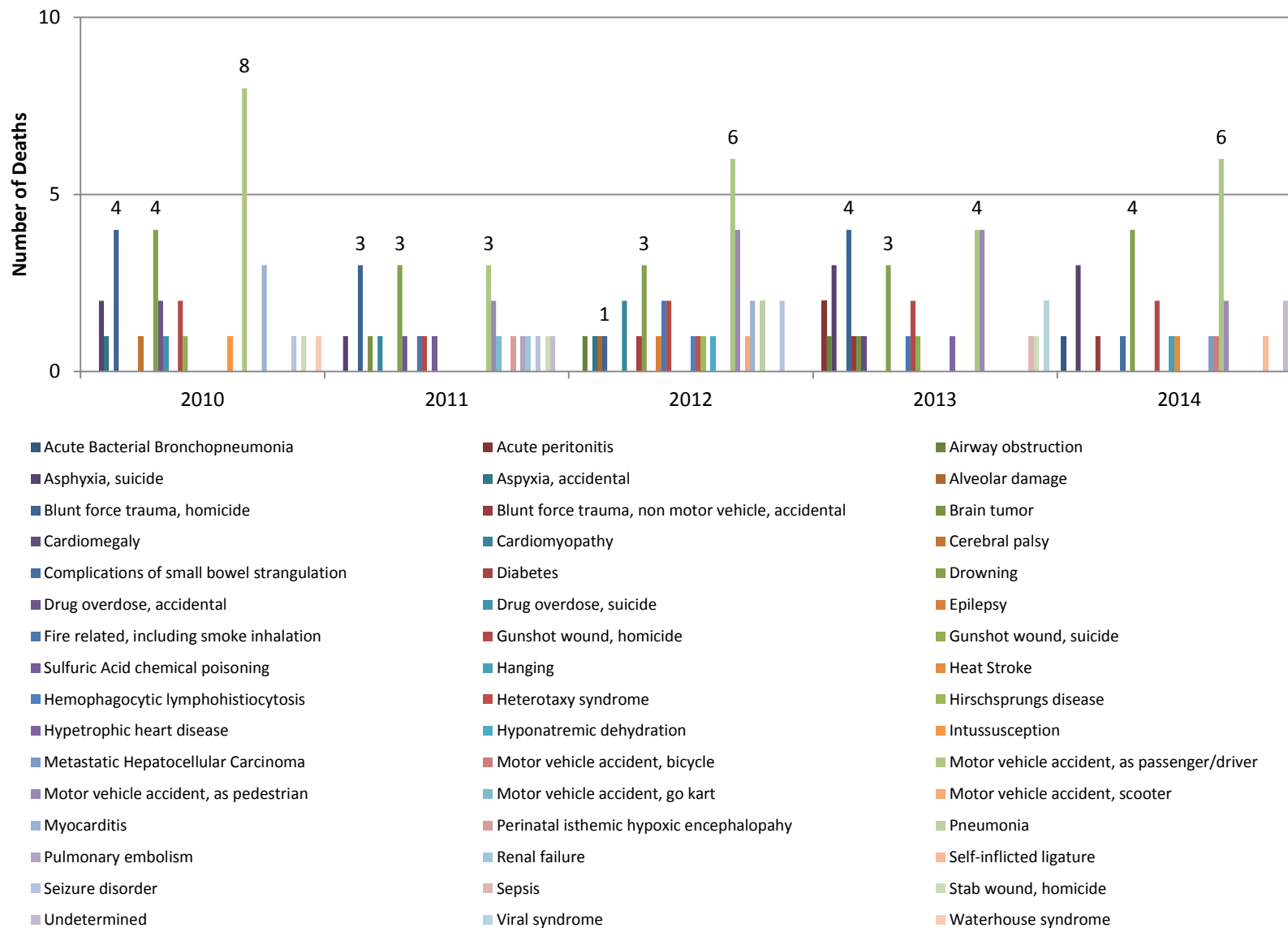
Child Deaths Reviewed by Age and Cause

Children Ages 1-17 Years of Age

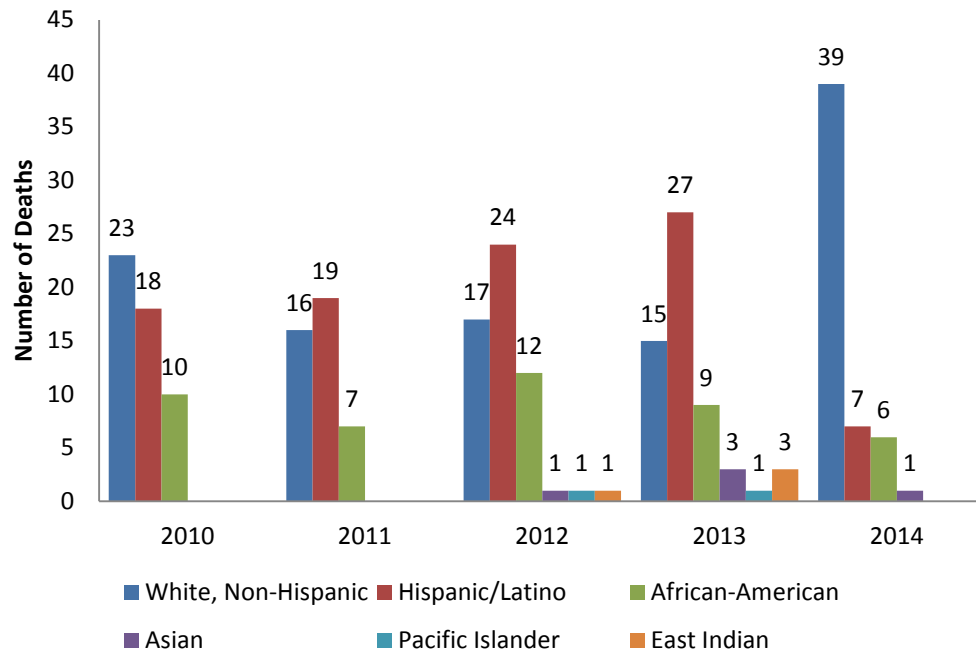
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Cause of Death	Number of Deaths					Total
	2010	2011	2012	2013	2014	
Motor vehicle accident, as passenger/driver	8	3	6	4	6	27
Motor vehicle accident, as pedestrian		2	4	4	2	12
Motor vehicle accident, bicycle					1	1
Motor vehicle accident, go kart		1				1
Motor vehicle accident, scooter			1			1
Myocarditis	3		2			5
Perinatal isthemic hypoxic encephalopathy		1				1
Pneumonia			2			2
Pulmonary embolism		1				1
Renal failure		1				1
Seizure disorder	1	1	2			4
Self-inflicted ligature					1	1
Sepsis				1		1
Stab wound, homicide	1	1		1		3
Sulfuric Acid chemical poisoning		1				1
Undetermined		1			2	3
Viral syndrome				2		2
Waterhouse syndrome	1					1
Total	33	25	36	33	28	155

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Child Deaths Reviewed by Race/Ethnicity

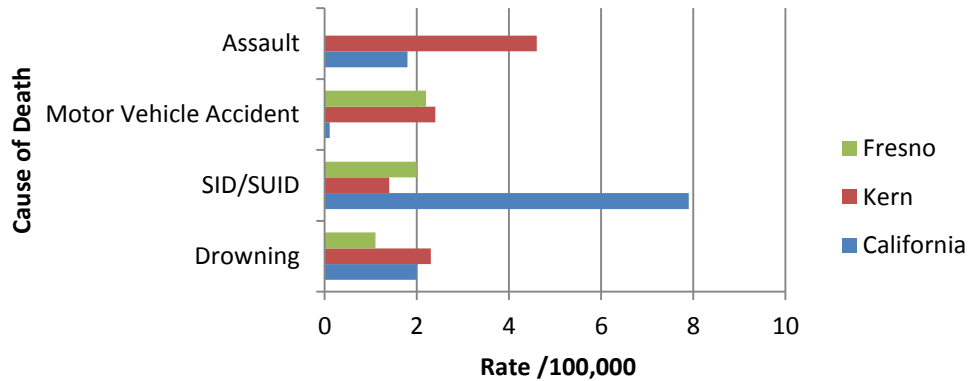


Race/Ethnicity	Number of Deaths					Total
	2010	2011	2012	2013	2014	
White, Non-Hispanic	23	16	17	15	39	110
Hispanic/Latino	18	19	24	27	7	95
African-American	10	7	12	9	6	44
Asian			1	3	1	5
Pacific Islander			1	1		2
East Indian			1	3		4
Total	51	42	56	58	53	260

 **KERN COUNTY**
2013^{*} **County Comparison**
on Special Topics

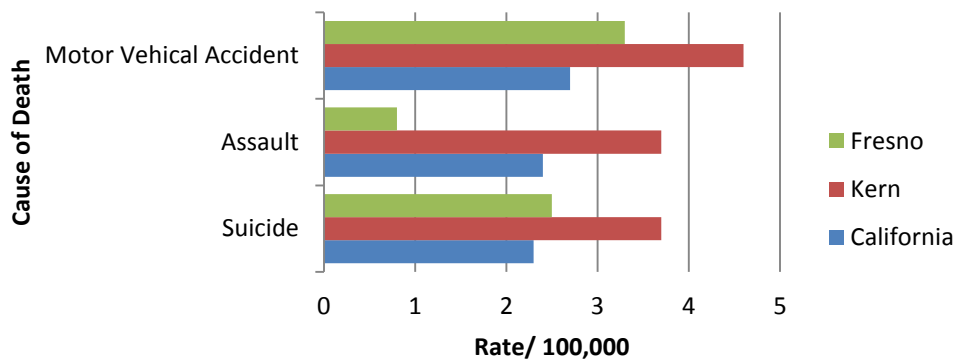
*State and County comparison data acquired from external sources with most recent data dated 2013

Rate of Leading Causes of Death among 0-5 year olds in Kern County, Fresno County & California



Sources:
 CDPH Vital Statistics Death Statistical Master Files. Prepared by: California Department of Public Health, Safe and Active Communities Branch. Report generated from <http://epicenter.cdph.ca.gov> on: June 30, 2015.
 State of California, Department of Public Health, Death Records. Dec 9 2014. Accessed July 2, 2015.
 2013 Kern County Child Death Review Team Report & Five Year Comparison 2009-2013.

Rate of Leading Causes of Death among 10-17 year olds in Kern County, Fresno County, & California



Sources:
 CDPH Vital Statistics Death Statistical Master Files. Prepared by: California Department of Public Health, Safe and Active Communities Branch. Report generated from <http://epicenter.cdph.ca.gov> on: June 30, 2015.
 2013 Kern County Child Death Review Team Report & Five Year Comparison 2009-2013.