KERN COUNTY

2018 Child Death Review Team and Fetal and Infant Mortality Review

Annual Report

About this report

This report highlights the trends in fetal, infant, and child deaths that occurred in Kern County during 2018 calendar year. Specifically, it:

- Presents an overview of the purpose and mission of the Kern County Child Death Review Team (CDRT) and the Fetal and Infant Mortality Review (FIMR)
- Reports the results of child death cases reviewed by CDRT and FIMR
- Tracks trends of child deaths using a five-year retrospective
  Outlines recommendations made by CDRT and FIMR 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. Kris Lyon	Public Health Officer
Brynn Carrigan	Assistant Director of Public Health Services

Acknowledgements

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Kern County Department of Public Health Services
- Anthony, Elaine
- Cochran, Rose
- Curioso, Michelle
- Foster, Vicki
- Hasting, Russell—Chair
- Nichols, Erica

Kern County Coroner's Office
- Ratliff, Dawn

Kern County Department of Human Services
- Hawkins, Monique
- Jewett, Wendy
- Rocha, Juan
- Sharp, Etta
- Stevens, Tim
- Williams, Curt

Kern Behavioral Health and Recovery Services
- Bosch, Jeanna
- Castro, Cristina
- Sill, Jennie

County Counsel
- Feige, Jennifer
- LeBaron, Amanda

Kern County District Attorney's Office
- Kohler, Andrea
- Wilson, David

Kern County Network for Children
- Corson, Tom

Kern County Probation Department
- Felix, Ruben
- Gonzalez, Catherine

Kern County Sheriff's Office
- Adams, Mitch
- Bravo, Enrique
- Lackey, Kenzo
- Newell, James
- Nord, Damian
- Swanson, Joel

Bakersfield Police Department
- Burdick, Jeff
- Finney, Josh
- Hilliard, Matt

First 5 Kern
- Maier, Roland

Valley Children's Hospital
- Dr. Burny, Ilyas
- Dr. Hyden, Phil
- Flores, Carlos, RN

Bakersfield Memorial Hospital
- Dr. Bhogal, Madhu
- Dr. Merzel, David
- Dr. Montes, Jorge

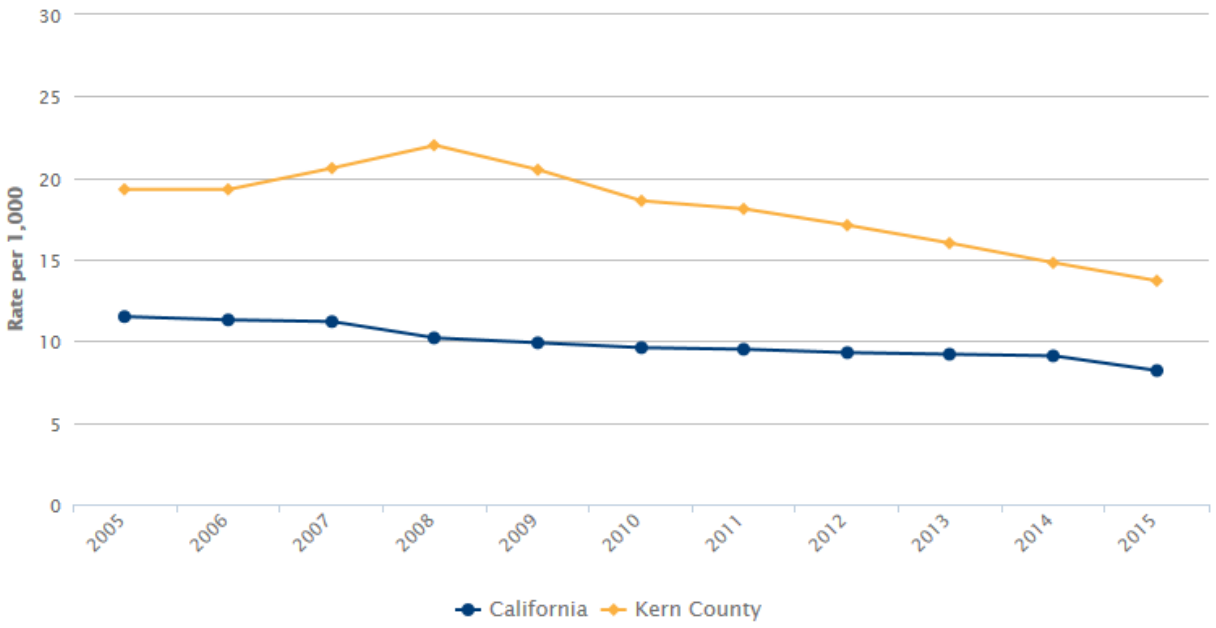
Mission

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. Development of these strategies raise knowledge and awareness, and produce systematic changes, thereby preventing further child deaths.

Rates of substantiated child abuse and neglect in Kern County are trending downward, but as of 2015, county rates were 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. The Kern County 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 many county and community agencies.

Case Review Process

The CDRT receives and reviews Sheriff-Coroner's reports on child deaths in Kern County. Sending a list of cases to team members, in advance, allows time to search case files for additional information on the child and his or her family. Discussions at the meetings determine if the death was preventable, and what services, education, or action could have affected the outcome. The team closes or keeps open cases for further review and/or referral to other services, if needed.

At times, the CDRT will review cases where a child who dies in another county but is a resident of Kern County; however, Kern County may not have jurisdiction. For the following data in this report, only deaths that Kern County received jurisdiction for are analyzed.

In 2018, 46 cases out of 130 child deaths (under 18 years of age), that occurred in Kern County, were referred to the CDRT and have been included in this report, which covers deaths deemed preventable by the county coroner's office, that occurred from January 2018 through December 2018. Data reflected in this report comes from both the Sheriff and the Coroner's reports and the supplemental information provided by team members. To protect the confidentiality of children and families, the CDRT presents only aggregate data.

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. The Kern County CDRT uses these monies to fund community projects such as the Safe Sleep Project through Kern County Public Health Services Department.

KERN COUNTY
2018 Risk Factors and Existing Programs

Preventable Childhood Death—Risk Factors

Common Risk Factors of Fatal Child Abuse or Neglect[1]

- Child—Vulnerability
  - Less than 4 years old, male, prematurity/birth weight, illness/disability, colic, challenging behaviors, other siblings under 3 years of age
- Parental—Parental Capacity
  - Younger age, severe control problems, dependency conflicts, history of abuse/domestic violence, mental illness, jealousy or rejection by child, lack of parenting skills, inability to bond
- Household—Multifaceted Problems
  - Stressful major life event in past year (death, birth, job loss, move, etc.), less education, history of violence, lack of job skills, criminality, mobile/frequently move, current or prior contact with CPS, change in household composition, non-family members present
- Environmental—Confounding Issues
  - Living in poverty, high unemployment, increased crime rates, geographical locality, lack of support systems, multiple service providers involved over time, seen by physician following onset of abuse

Risk factors for Drownings[2]

- 1-2 year olds outside without adequate supervision.
- 1-2 year olds inside but with lapses in supervision, and breaches in barriers.
- 3-4 year olds often in or near the pool, perceived to be safer around water.

Risk factors for Motor Vehicle Accident Deaths[3]

- More 8-12 year olds found not buckled up.
- Driver of vehicle is intoxicated and the child found not buckled up.
- Restraint use among young children often depends on the driver's seat belt use.
- Child restraint systems misused or used incorrectly.

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[1] Hughes, K. & Pence-Wilson, D., 2012. Child Maltreatment Fatalities—Risk Factors and Lessons Learned. doi:10.1.1.688.6439

[2] Agran, P., Winn, D., McDonald, J., 2011. Patterns of Drowning Among Young Children: Implications for Prevention. California Chapter 4, American Academy of Pediatrics. Presentation at the 2011 National Conference & Exhibition, Boston Massachusetts. Retrieved, August 20, 2018 from https://www.aap-oc.org/wp-content/uploads/2015/03/NCE-2011-Drowning-Poster-Presentation.pdf

[3] Centers for Disease Control and Prevention, 2018. Child Passenger Safety: Get the Facts, Risk Factors. Retrieved, August 20, 2018 from https://www.cdc.gov/motorvehiclesafety/child_passenger_safety/cps-factsheet.html

Risk factors for Sudden Unexpected Infant Death[4]

- Maternal age: the infants of 15-19 year old mothers are at highest risk, while the infants of mothers 35 years and older are at the lowest risk for unexpected death
- Marital status of the mother: Infants of unmarried mothers are at highest risk
- Sex of the Child: Males are at an increased risk versus females
- Race/Ethnicity of the Mother: Infants of American Indian/Alaska Native and Black/African American mothers are at higher risk
- Country of Birth Mother: Infants of mothers born in the United States of American are at a higher risk than mothers born elsewhere

Risk factors for Teenage Suicide[5]

- Depression or other psychological illness
- Drug and alcohol use
- Parental separation or divorce
- Economic status
- Race
- Suicidal ideation
- Poor self-esteem
- Distress
- Poor coping mechanisms (particularly in regards to recent relationship issues)
- Sexual orientation
- Victimization
- Lack of social connection and support
- Bullying

[4] Healthy People 2020, 2018. Maternal, Infant, and Child Health, MICH-1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed). Retrieved, August 20, 2018 from https://www.healthypeople.gov/2020/data-search/Search-the-Data#objid=4831

[5] Murphy, K., 2006. What can you do to prevent teen suicide? *Nursing. 35*. 43-5. Doi:10.1097/001521

Current Successful Kern County Programs Aimed at Reducing Preventable Childhood Deaths

Kern County Public Health Services Department offers three perinatal programs to ensure healthy outcomes, and are free and voluntary.

- **Black Infant Health-** A program that aims to improve health among African American mothers and babies and to reduce the Black: White health disparities by empowering pregnant and mothering African American women to make healthy choices for themselves, their families, and their communities. The program includes prenatal and postpartum educational intervention group sessions, culturally sensitive case management, support of early and continuous prenatal care, linkages to related community resources and services, and advocacy of timely immunizations and well-baby check-up exams being up-to-date.
- **Nurse-Family Partnership-** An evidence-based program to help new mothers (with low to moderate income and eligible for Medi-Cal or Emergency Medi-Cal) develop skills to take better care of themselves and their babies. Participants have their own specially trained Public Health Nurse who makes home visits during pregnancy and throughout the first two years of the child's life.
- **Perinatal Outreach Program-** The program aims to promote optimal pregnancy health and birth outcomes by providing brief intervention in-home support and educational services to low-income pregnant women residing in Kern County. The case management services are offered to pregnant women who are low-income, and Medi-Cal eligible. Participants will be assigned a case manager and/or Public Health Nurse to assist gaining access to health coverage and linkage to health providers.

Kern County Public Health Services Department also offers the following:

- **Sudden Infant Death Syndrome (SIDS) Program**- Statute of 1991 (SB362) amended the Health and Safety Code that a designated agent of the Health Officer who is knowledgeable about the incidences of SIDS and the care and support of persons who have experienced death of this nature, and has basic counseling skills provide the bereavement visit. The SIDS Coordinator must contact the parent or guardian within three days after Coroner's notification and thus provide bereavement services and linkage to bereavement resources. Completed Public Health Services Report associated with the case must be submitted to the California SIDS Program within 30 days notification by the

Coroner's Office. This program is funded by the California Department of Public Health, and is under the auspices of Maternal Child Adolescent Health (MCAH).

- **Safer Sleeping Education Project-** The project provides parents and caregivers' one-on-one education on SIDS and Sudden Unexpected Infant Death (SUID) prevention practices and what a safe sleep environment looks like. Public Health Nurses (PHNs) and Public Health Aides (PHAs) provide the safer sleep education and SIDS risk reduction. The staff evaluates the child's current sleep environment and administers a pre-test before educating caregivers, and a post-test to measure understanding of the education program. The staff will make an unannounced follow-up home visit to evaluate appropriate use of the pack-and-play and maintenance of safer sleeping practices. Criteria are followed to determine who is eligible to receive pack-and-plays or gift cards.

- **Safe Sleep Coalition-** Formed in March 2017, the coalition of organizations and hospitals from around Kern County, working together to create a universal safe sleep message and provide education and opportunities to prevent the number one preventable killer of infants in Kern County. On April 12, 2019, the Safe Sleep Coalition worked with the Kern Literacy Council, for the second year in a row, to provide educational books to hospitals and other groups that serve parents of newborns. Many organizations involved in the coalition work to provide safe sleep spaces (i.e., pack-n-plays) to families in need. The Safe Sleep Coalition meets monthly at First 5 Kern.
- **Cribs for Kids designated Bakersfield Memorial Hospital as Safe Sleep Certified, Gold Status.** The hospital is only one of three hospitals in California with that honor. To qualify for this distinction, the hospital must develop and maintain a Safe Sleep Policy that adheres to the American Academy of Pediatrics; provide staff infant safe sleep training: and provide safe sleep education to the parents prior to discharge. Through the Safer Sleeping Education Project (SSEP), the hospital staff received safe sleep education training from the SSEP Coordinator.

Kern County Public Health Services Department has also worked with community partners to reduce preventable childhood deaths:

- **Safe Kids—**Kern County participates in the Safe Kids Worldwide campaign. Safe Kids hosts car seat inspection events across the country where certified technicians can help parents and caregivers learn to install a car seat properly.
- **Child Passenger Safety Education Program (AKA Car Seat Program) -** Started in 2011, this program stresses the importance of having a car seat for your baby because road injuries are the leading cause of unintentional deaths in the United States. Correctly used child safety seats reduce the risk of death by as much as 71

percent. The goal is to keep families safe. After parents/guardian have completed the education program online or in person and based on the child's age, weight and height, one of the following passenger seats may be provided: a 5-Point Harness booster or a convertible safety seat. A nationally certified car seat safety technician would be available to show how to properly install the child's car seat and answer any questions.

- **Water Watchers-** A Water Watcher is a responsible adult who agrees to watch the kids in the water without distractions and wear a Water Watcher card. After a certain amount of time (i.e. 15 minutes), the Water Watcher card is passed to another adult, who is responsible for the active supervision. Cards are available to the public at the Public Health Department.

Kern Behavioral Health and Recovery Services (Kern BHRS) offers several programs in suicide prevention. Kern BHRS recognizes that the key to prevention is to ensure that those who care for our youth, parents, teachers, probation officers and neighbors are aware of signs and know how to help:

- **Zero Suicide-** Evidence-based zero suicide model that specializes in training and implementing screenings. The goal is to increase awareness of warning signs of suicidal risk and increase intervention to eliminate suicide in Kern County. Program began internally within Kern BHRS and will be expanded to local hospitals, primary care providers, Federally Qualified Health Centers, law enforcement, schools and community partners.
- **Mental Health First Aid-** Aims to reduce stigma and teaches that individuals experiencing mental health challenges can and do get better, and that community members' willingness to step forward and help can be lifesaving to someone in distress. This evidence-based model is provided to teachers, social workers, juvenile justice probation staff and any other community member who has a desire to learn how to identify, understand and respond to signs of mental illness and substance use disorders.
- **Access to Care-Hotline-Outreach and Education Team-** Outreaches to Kern County High Schools and other Community partners to provide suicide prevention and awareness with health classes, to increase awareness of depression and anxiety, suicide warning signs, asking the "suicide" questions and where to get help.
- **Community and School-Base Services-** Every School in Kern County has a Behavioral Health Provider assigned to provide services to youth when needed and be a resource to the educational system. In addition, frequent in-services are provided to schools, probation, DHS and other community partners to ensure they have the knowledge to access help for a family, when needed.

- **Access to Care- Hotline-** Crisis Hotline receives approximately 2900 Transitional Age Youth (TAY) calls a year and 550 calls from youth under the age of 14 a year. Callers are assisted through crisis and many are struggling with suicide thoughts and behaviors. Hotline staff collaborate with callers on safety plans to keep them safe. Law enforcement are called only if there is imminent risk.
- **Youth Brief Treatment – Same Day Access-** This program was established to be responsive to youth at risk of repeated incarceration, school failure/dropout and to reduce/eliminate instances of suicide, suicidal ideation and self-harm. It is available across the Children's System of Care in geographic locations throughout Kern County.
- **Transitional Age Self Sufficiency Project-** Kern BHRS partners with Kern County Superintendent of Schools, Dream Center to serve foster care and homeless TAY youth. This program works closely with the TAY team to link youth that are experiencing behavioral health episodes to intensive specialty mental health services.
- **Juvenile Justice Engagement-** This program provides screening and intervention to the juvenile justice population and their families with the intent of identifying suicide ideation, self-harming and other mental health issues that may lead to prolonged suffering.

Kern BHRS offers programs for those in crisis:

- **Mobile Evaluation Team-** The Mobile Evaluation Team (MET) is dispatched by law enforcement when a mental health crisis is identified in the community. MET provides crisis intervention, voluntary and involuntary assessment for psychiatric hospitalization, and follow-up in the community.
- **Psychiatric Evaluation Center-** The Psychiatric Evaluation Center/Crisis Stabilization Unit (PEC/CSU) is an urgent care psychiatric unit with the goal of providing psychiatric care in the least restrictive environment possible, while still maintaining a safe, locked facility. The PEC/CSU is the designated facility for non-EMS (Emergency Medical Services) involuntary psychiatric evaluation in Kern County for minors and adults. The goal of the PEC/CSU is to resolve the immediate crisis within a few hours, and to provide linkage to appropriate follow-up resources.
- **Mental Health Services Act Full-Service Partnerships**
    - **Youth Wraparound-** Wraparound services are located throughout the Children's System of Care. This is a strength-based approach that strives to intervene with children that have complex behavioral health needs. The youth served by this program have had high risk behavioral health episodes that have led to provisions of crisis services including the PEC.
    - **Transitional Age Youth (TAY) Team-** The TAY Program serves some of our highest risk youth between the ages of 16-25 emancipating from foster care. The goal of these services is to identify early onset behavioral health issues and intervene quickly to help navigate a successful transition into independent adulthood, supporting youth in a variety of life-functioning domains. The Evidence Supported model of Transitions to Independence Process (TIP) is utilized to address issues that are unique to this population. This team is stationed

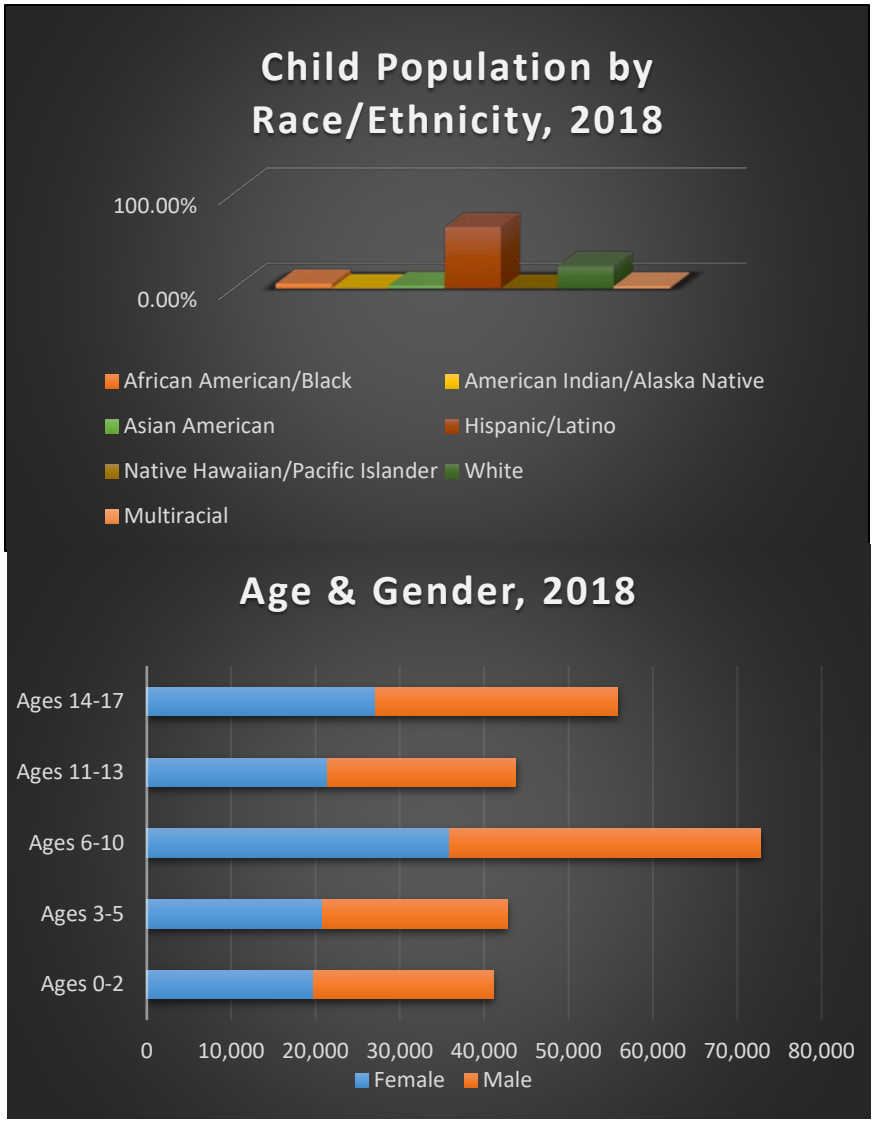
at the Dream Center and works collaboratively with other youth serving agencies to provide cross-system referrals and treatment.

- **Post-Intervention Response**- Kern BHRS is available to respond to schools, DHS, Probation, community members to help facilitate healing, and mitigate negative effects of exposure to suicide.

KERN COUNTY 2018 Child Death Review Team Data

Demographics

Figure 1. Child Demographics in Kern County



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, it estimates that Kern's population in 2018 was 896,764[6]. Of that population, 28.9% were persons under 18 years of age. The vast majority of the child population in Kern identifies as Hispanic/Latino (64.8%) and Caucasian/White (24%)[7]. Compared to California as a whole, the Hispanic/Latino child population is 12.7% greater in Kern County. The largest child age group across both genders is the 6-10 year-old age group (28.4%)[8], most likely due to the broader age category. The male-to-female ratio among children is approximately equal. Refer to the infographic above for further demographic information.

[6] U.S. Census Bureau Quickfacts: Kern County, CA https://www.census.gov/quickfacts/fact/table/kerncountycalifornia,US/PST045218 (2019).
[7] Lucile Packard Foundation for Children's Health, Child Population by Race and Ethnicity (2019).
[8] Lucile Packard Foundation for Children's Health, Child Population by Age Group and Gender (2019).

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, and 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 2018 Data

Figure 2.1 Manner of Preventable Deaths, 2018

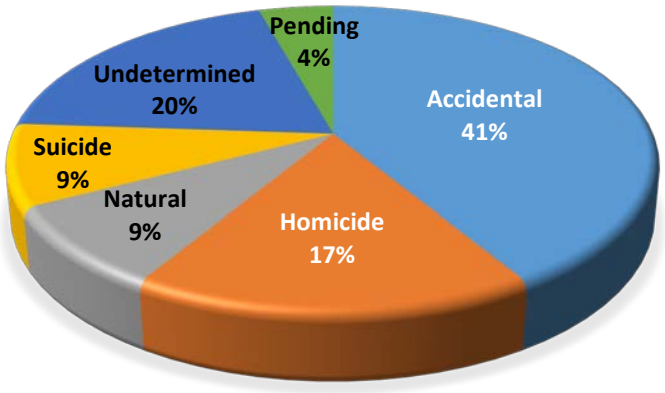


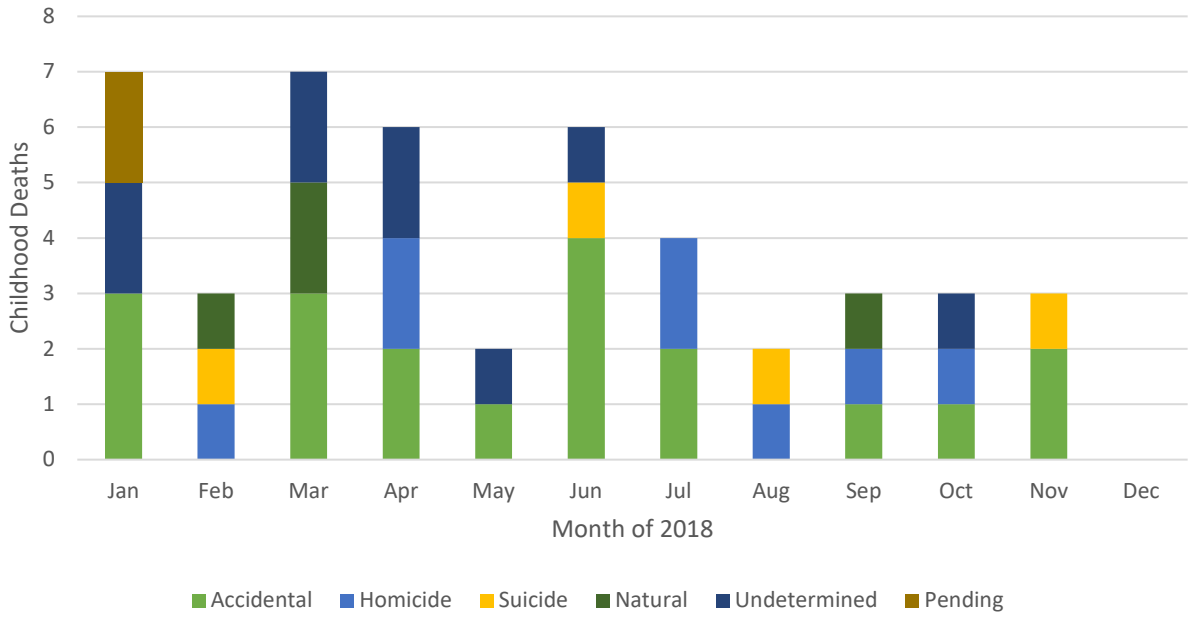
Table 1. Manner of Preventable Deaths, 2018

2018 Manner of Death	*Number of Deaths*
Accidental	19
Homicide	8
Natural	4
Suicide	4
Undetermined	9
Pending (Unavailable at time of report)	2
Total	**46**

Key Takeaways

Accidental and Homicide constituted 58% of all childhood deaths reviewed by the CDRT in Kern County 2018. In June, there was a higher incidence of accidental deaths at four cases; and in the months of February, April, and July through October, there were six homicides. In all but the month of December, there was either an accidental death or a homicide or both.

Figure 2.2 Manner of Preventable Deaths by Months, 2018



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. Each cause of death for cases reviewed in 2018 by CDRT are addressed in Table 2 below.

Table 2. Cause of Preventable Deaths, 2018

Manner of Death	Cause of Death	Number of Deaths
Accidental		**19**
	Asphyxia	2
	Blunt Force Trauma	14
	Choking	1
	Multi Drug Intoxication	1
	Smoke Inhalation and Thermal Burns	1
Homicide		**8**
	Brain Damage related to Loss of Oxygen	1
	Blunt Force Trauma	3
	Drowning	1
	Gunshot wound(s)	2
	Smothering	1
Natural		**4**
	Acute and Chronic pneumonia due to Immaturity	1
	Acute Intussusception of Small Intestine	1
	Asphyxia	1
	Bilateral Acute Pneumonia	1
Suicide		**4**
	Asphyxia (Hanging)	4
Undetermined		**9**
	Stillborn/Multiple Congenital Anomalies[1]	1
	SUID	6
	SUID with contributing factors of Chronic Bronchitis[2]	1
	SUID Co-Sleeping	1
Pending[3]		**2**
Total		**46**

[1] Contributing factor of acute methamphetamine intoxication
[2] Acute Methamphetamine intoxication.
[3] Cause and Manner of death for three cases were not available at the time of this report.

2018 Accidental/Unintentional Injuries

Figure 3.1 Accidental Deaths MVAs, 2018

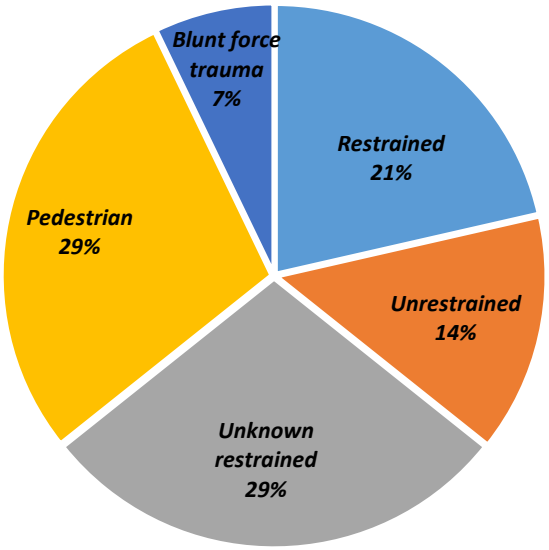


Figure 3.2 Accidental Deaths Various, 2018

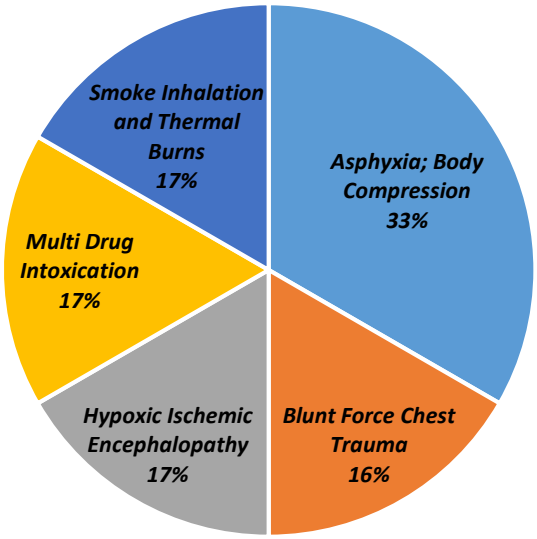


Table 3. Accidental Deaths, 2018

Type of	
Unintentional Injury	**Number of Deaths**
Blunt Force Trauma/ MVAs	14
Asphyxia	2
Choking	1
Multi-drug Intoxication	1
Smoke /Thermal Burns	1
Total	**19**

Key Takeaways

Blunt Force Trauma related to motor vehicle accidents (MVA) were the primary causes of accidental deaths. Three were properly secured in their seats, two were unrestrained, four were categorized as unknown if they were restrained, and the remaining four MVA deaths were pedestrians. There were six accidents that were caused by asphyxia (2), smoke inhalation (1), multidrug intoxication (1), blunt force chest trauma (1), and choking (1).

Reviewed 2018 Child Deaths by Age Group

Figure 4.1 Preventable Deaths by Age, 2018

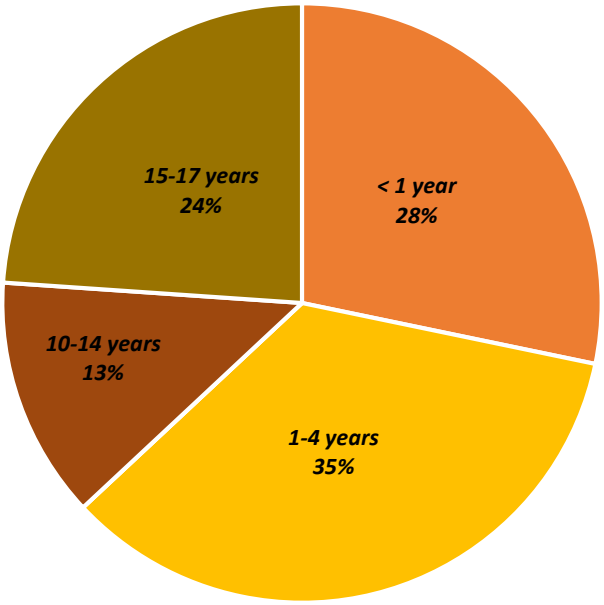


Figure 4.2 Age of Preventable Deaths by Month, 2018

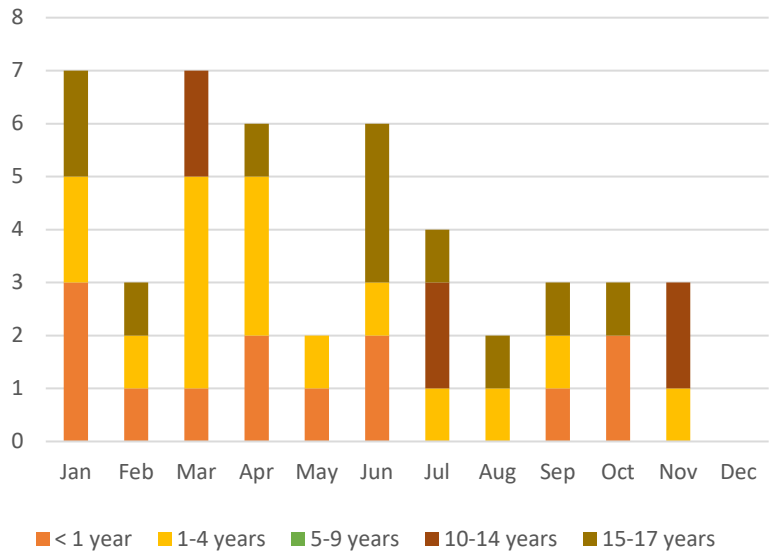


Table 4 Preventable Deaths by Age

2018: Age	Number of Deaths
< 1 year	14
1-4 years	15
5-9 years	0
10-14 years	6
15-17 years	11
Total	**46**

2017: Age	Number of Deaths
< 1 year	24
1-4 years	9
5-9 years	6
10-14 years	3
15-17 years	8
Total	**50**

Key Takeaways

In 2018, the CDRT reviewed 46 cases of preventable childhood deaths, which was an 8% decrease from previous year. The CDRT findings:

- no preventable deaths reported in the 5-9 years age group
- 50% increases in the incidences of preventable deaths in the 10-14 years age group.
- 27% increase in the incidences of preventable deaths in the 15-17 years group compared to the previous year
- Most of the preventable deaths occurred in the months of January through June
- December had no child deaths identified by the Coroner's Office as preventable deaths

Child Deaths Reviewed by Age and Cause

Children Less Than 1 Year of Age

Figure 5. Preventable Deaths: Less than 1 Year of Age, 2018.

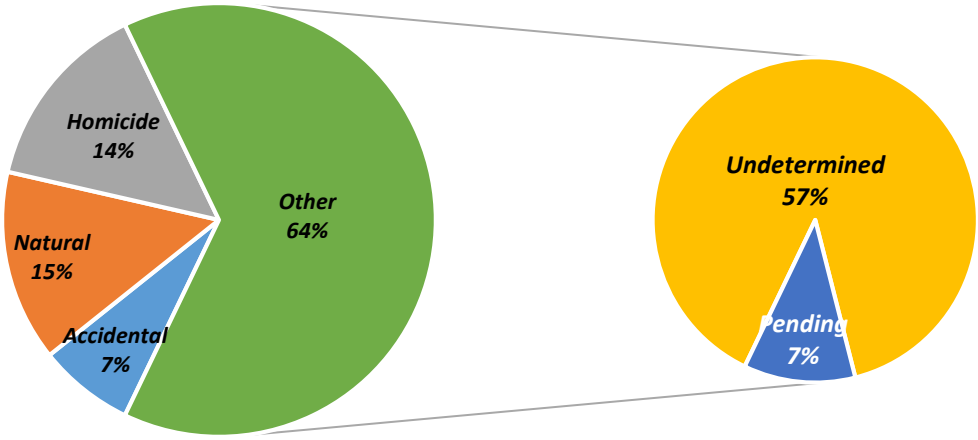


Table 5. Preventable Deaths: Less than 1 Year of Age, 2018

Manner of Death	Cause of Death	Number
Accidental		**1**
	Probable Asphyxia	1
Natural		**2**
	Immaturity	1
	Intussusception of small intestine	1
Homicide		2
	Smothering	1
	Blunt Head Trauma	1
Undetermined		**8**
	SUID	4
	SUID[1]	2
	SUID[2]	1
	Stillborn[3]	1
Pending		**1**
Total		**14**

[1] Contributing: Chronic Bronchitis, Mild: Acute Methamphetamine
[2] Contributing: co-sleeping.
[3] Multiple Congenital Anomalies: contributing factor of Acute Methamphetamine Intoxication

Key Takeaways

There was a significant drop in preventable deaths for those less than 1 year age from the previous year. There were 24 preventable deaths in 2017 compared to 14 in 2018. The most common manner of death continues to be Sudden Unexpected Infant Death as it constituted half of the deaths. In regards to preventable deaths for this age category, the CDRT found that there were two natural, two homicides, one accidental and one pending.

Child Deaths Reviewed by Age and Cause

Children 1-4 Years of Age

Figure 6. Preventable Deaths: 1-4 Years, 2018

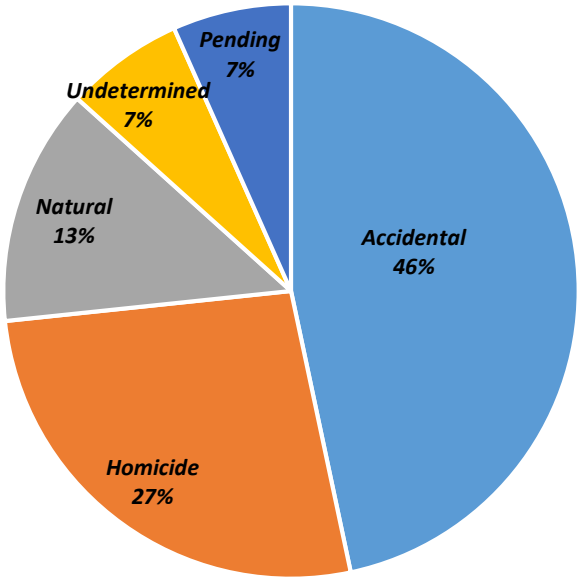


Table 6. Preventable Deaths: 1-4 Years, 2018

Manner of Death	Cause of Death	Number
Accidental		**7**
	Asphyxia; Body Compression	1
	Choking	1
	Blunt Force Trauma	3
	Blunt Force Chest Trauma	1
	Smoke Inhalation/Thermal Burns	1
Homicide		**4**
	Drowning	1
	Brain Damage related to Loss of Oxygen	1
	Blunt Force Trauma	2
Natural		**2**
	Bilateral Acute Pneumonia	1
	Asphyxia	1
Undetermined		**1**
	SUID	1
Pending		**1**
	Pending	1
Total		**15**

Key Takeaways

In 2018, accidents and homicides were the primary causes of preventable deaths for children 1-4 years of age. The data indicates that accidental deaths and homicides constituted 73% of the preventable deaths in this age category. The accidental deaths were largely blunt force trauma due to motor vehicle accidents. Homicides consisted of two incidences of blunt force trauma and one incident of drowning.

Child Deaths Reviewed by Age and Cause

Children 5-9 Years of Age

The CDRT reported no preventable deaths for those children 5-9 years of age. The majority of childhood deaths in this age group in 2017 occurred due to vehicular accidents. Restrained and unrestrained childhood deaths were equally represented. One child was a pedestrian.

Child Deaths Reviewed by Age and Cause

Children 10-14 Years of Age

Figure 8. Preventable Deaths: 10-14 Years, 2018

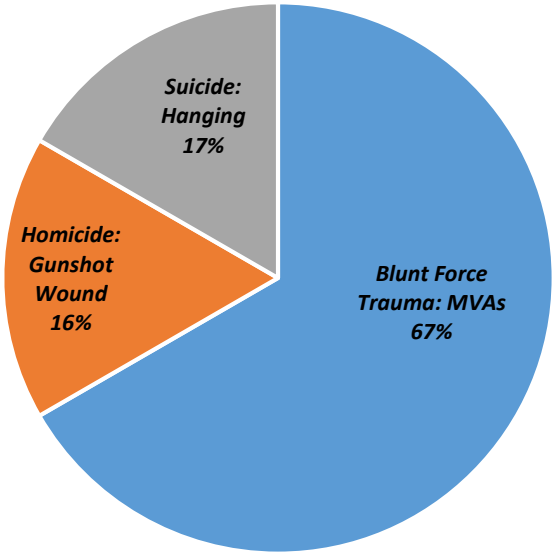


Figure 8.1 Blunt Force Trauma: MVAs, 2018

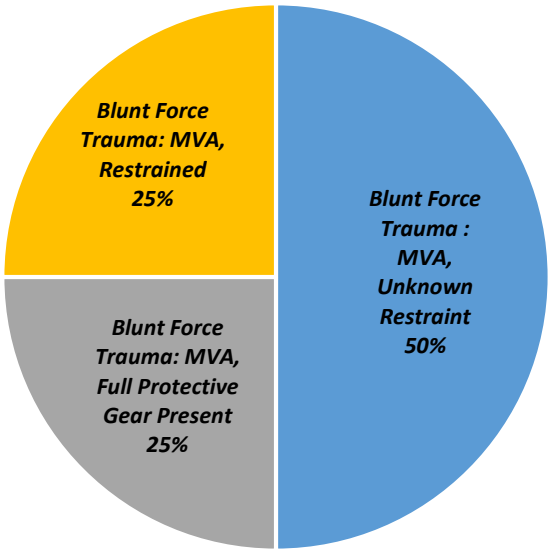


Table 8. Preventable Deaths: 10-14 Years, 2018

Manner of Death	Cause of Death	Number
Accidental		**4**
	Blunt Force Trauma - MVA	4
Homicide		**1**
	Gunshot Wound	1
Suicide		**1**
	Hanging	1
Total		**6**

Key Takeaways

In comparison to 2017, the CDRT reviewed twice the number of preventable deaths for the 10-14 years age group in 2018. The majority of the preventable deaths was due to blunt force trauma related to MVAs. It was unknown if two were restrained, one was restrained and one suffered injuries related to an off-road excursion. There was one suicide by hanging and one homicide by gunshot wound to the chest.

Child Deaths Reviewed by Age and Cause

Children 15-17 Years of Age

Figure 9.1 Preventable Deaths 15-17 Years, 2018

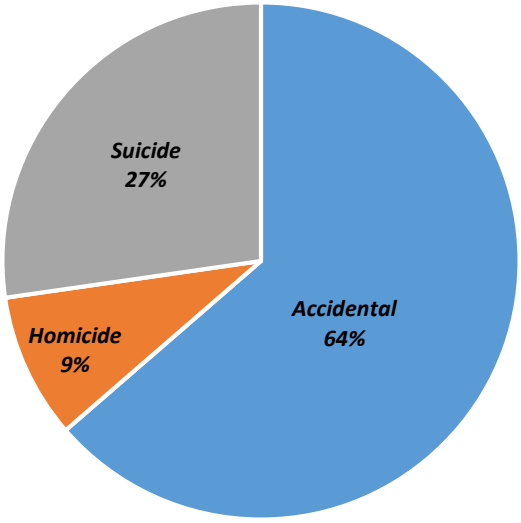


Figure 9.2 Accidental 15- 17 Years, 2018

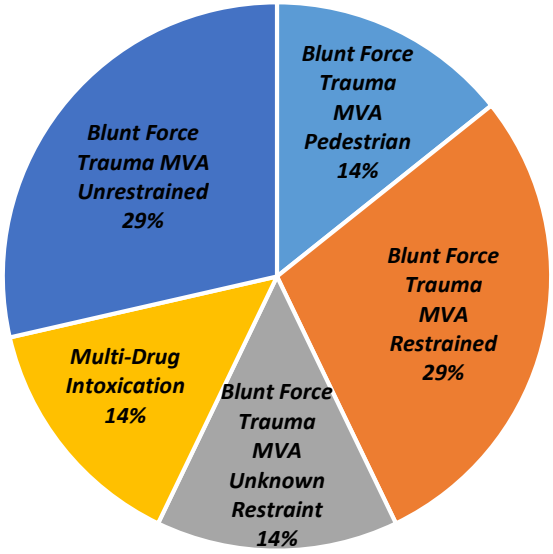


Table 9 Preventable Deaths 15-17 Years, 2018

Manner of Death	Cause of Death	Number
Accidental		**7**
	Blunt Force Trauma MVA	6
	Multi-Drug Intoxication	1
Homicide		**1**
	Multiple Gunshot Wounds	**1**
Suicide		**3**
	Hanging	3
Total		**11**

Key Takeaways

In 2018, accidental incidences and suicides were the primary causes of preventable deaths for those youths aged 15- 17 years. Accidental incidences involved blunt force trauma related to MVAs where two youths were restrained, two were unrestrained, and one with unknown restraint. In addition, one youth was a pedestrian. There was one preventable death related to multidrug intoxication.

KERN COUNTY

2018 CDRT Special Topic: Sudden Unexplained Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS)

Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS)

"Sudden unexpected infant death (SUID) is a term used to describe the sudden and unexpected death of a baby less than one year old in which the cause was not obvious before investigation. These deaths often happen during sleep or in the baby's sleep area… Sudden unexpected deaths include sudden infant death syndrome (SIDS), accidental suffocation in a sleeping environment, and other deaths from unknown causes" (CDC, 2018).

The Kern County SUID rate for 2017 was 126.4 deaths per 100,000 live births. (Note that there were only 12,656 live births in Kern County for the year 2017, which is 12.64 SUID deaths per 10,000.) Kern County's 2017 SUID rate is more than twice that of California's 2013-2015[6] SUID rate and higher than the US 2016[7] rate by a fourth.

Centers for Disease Control and Prevention, National Data

• In 1990, the SUID rate, which includes sudden infant death syndrome, unknown cause, and accidental suffocation and strangulation in bed, was 154.6 deaths per 100,000 live births. The SUID rate declined considerably following the release of the American Academy of Pediatrics safe sleep recommendations in 1992, the initiation of the Back to Sleep campaign in 1994, and the release of the Sudden Unexplained Infant Death Investigation Reporting Form in 1996. Since 1999, declines have slowed. In 2016, the SUID rate was 91.4 deaths per 100,000 live births.

• Sudden infant death syndrome (SIDS) rates declined considerably from 130.3 deaths per 100,000 live births in 1990 to 38.0 deaths per 100,000 live births in 2016.

• Unknown cause infant mortality rates remained unchanged from 1990 until 1998, when rates began to increase. In 2016, the unknown cause mortality rate in infants was 31.6 deaths per 100,000 live births.

• Accidental suffocation and strangulation in bed (ASSB) mortality rates remained unchanged until the late 1990s. Rates started to increase beginning in 1997 and reached the highest rate at 23.1 deaths per 100,000 live births in 2015. In 2016, the rate was 21.8 deaths per 100,000 live

[6] National and State Trends in Sudden Unexpected Infant Death: 1990–2015. Alexa B. Erck Lambert, Sharyn E. Parks, Carrie K. Shapiro-Mendoza. Pediatrics, Feb 2018, e20173519; DOI: 10.1542/peds.2017-3519. August 17, 2018.

[7] Centers for Disease Control and Prevention. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome, Data and Statistics. https://www.cdc.gov/sids/data.htm. August 17, 2018.

Infant Deaths with Unsafe Sleep Environments 2012-2018

Figure 13 Infant Deaths with Unsafe Sleep Environments 2012-2018

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

Key Takeaways

While the Coroner's Office identified only one case of infant death where an unsafe sleep environment contributed to the death of the child in 2018, there were an additional 6 cases of child death where an unsafe sleep environment was present, but not found by the coroner to be contributory to the death of the child. Unsafe sleep environments continue to be a problem in Kern County. Community partners have worked to provide pack and plays and safe sleep education to parents and guardians to prevent future cases. Several programs have been developed and are currently providing pack and plays:

- Public Health – Safer Sleeping Education Project
- Kern Medical - Safe Home, Safe Baby
- Bakersfield Memorial Hospital is Safe Sleep Certified, Gold Status by Cribs for Kids
- Safe Sleep Coalition worked with Kern Literacy Council and First 5 Kern to provide safe sleep books to area hospitals and community partners for distribution to new parents.

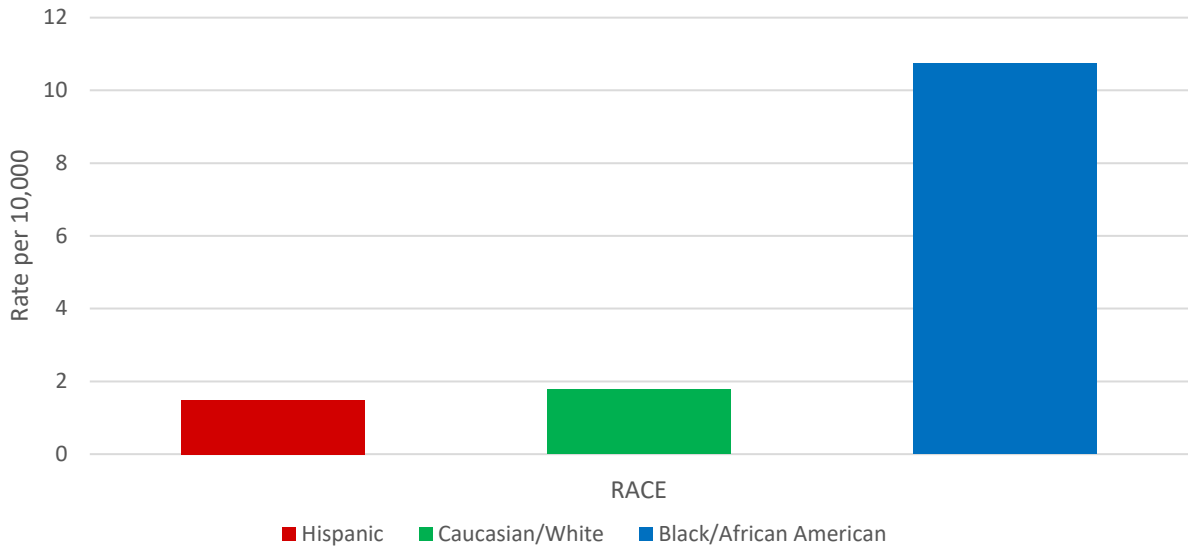
KERN COUNTY

2018 CDRT Special Topic: Health Disparities

Kern County Childhood Health Disparities

According to Healthy People 2020, a *health disparity* is defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage[8]." Health disparities can be organized by various topics such as sex, race/ethnicity, education level, and household income. "Measuring disparities in health status requires three basic components: (1) an indicator of health status, (2) an indicator of social grouping associated with different levels of social advantage or disadvantage, and (3) a method for comparing the health indicator across social groups[9]."

Figure 14. Health Disparities: Kern County Preventable Childhood Death Rates by Race, 2018



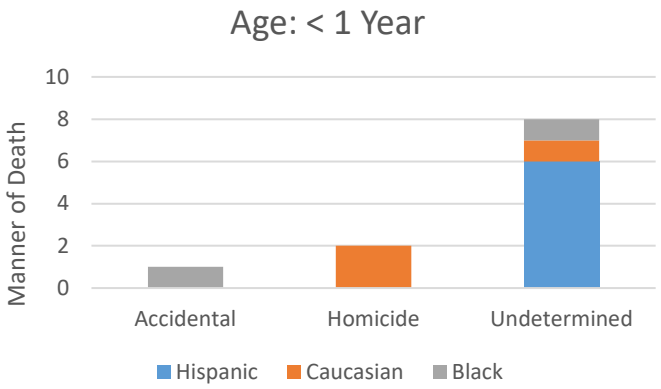
Key Takeaways

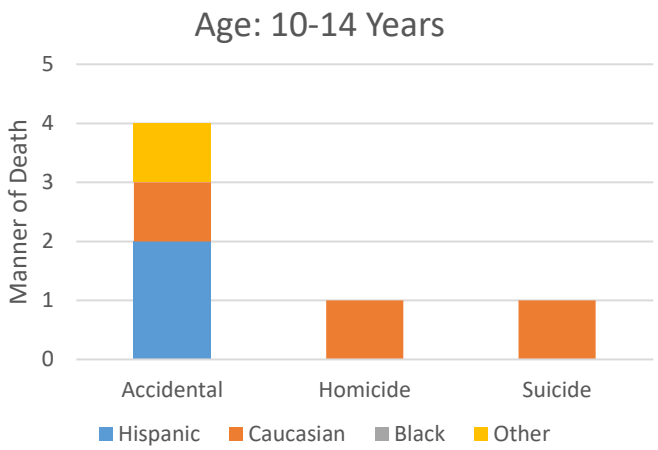
When comparing the race of the CDRT reviewed deaths of Kern County children, we found that the Black/African American children have a preventable death rate more than 10 times the rate of each of the Hispanic and Caucasian/White rates. Half of those preventable deaths in Black/African American children were undetermined (SUID) and occurred before the age of one year.

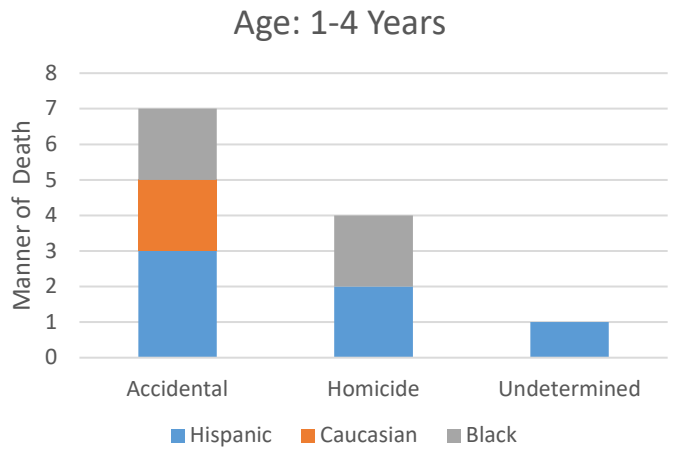
[8] Healthy People 2020, 2018. Disparities*, Foundation Health Measures*. Retrieved Sept. 7, 2018 from https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

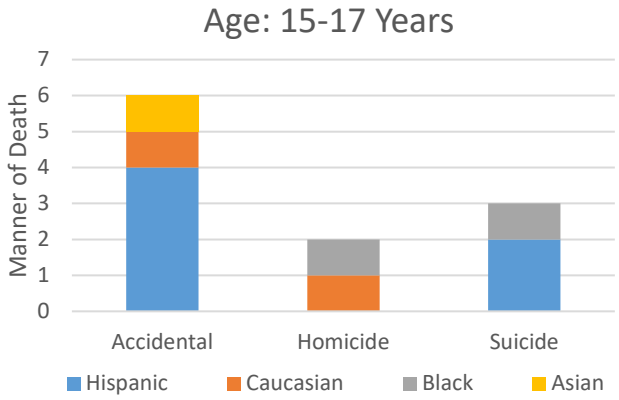
[9] The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 2008. Measuring Health Disparities and Health Equity, *Phase I Report, Recommendations for the Framework and Format of Healthy People 2020*. p.77. https://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf

Figures 15.1-4. Preventable Deaths by Race, 2018









Key Takeaways

Statistical inferences cannot be made from the following notations due to the small numbers available.

- Hispanics had 9 accidental deaths, 7 undetermined, 2 homicides and 2 suicides (Total=20).
- Caucasians had 4 accidental deaths, 4 homicides, and 1 suicide (Total=9).
- Blacks had 3 accidental deaths, 3 homicides, 1 undetermined, and 1 suicide (Total=8).
- Asians had 1 accidental death.
- The other category had 1 accidental death.

Five-Year Review of Childhood Deaths in Kern County

Figure 16. Preventable Deaths by Manner of Death, 2014-2018

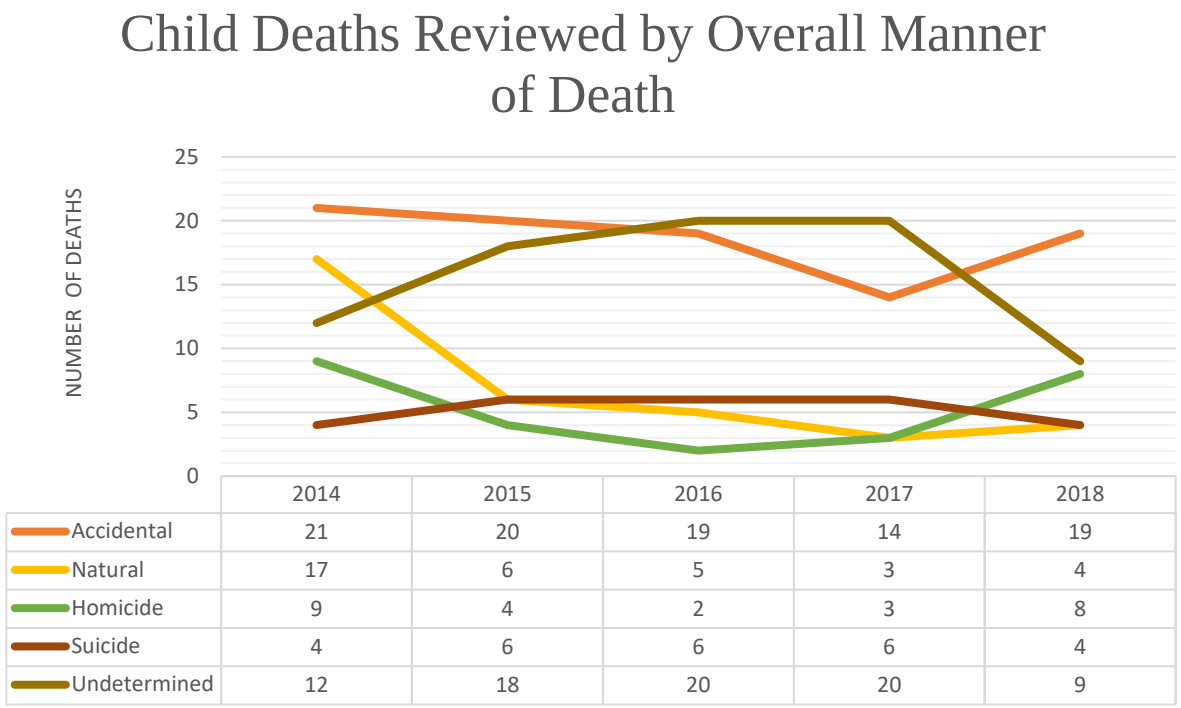
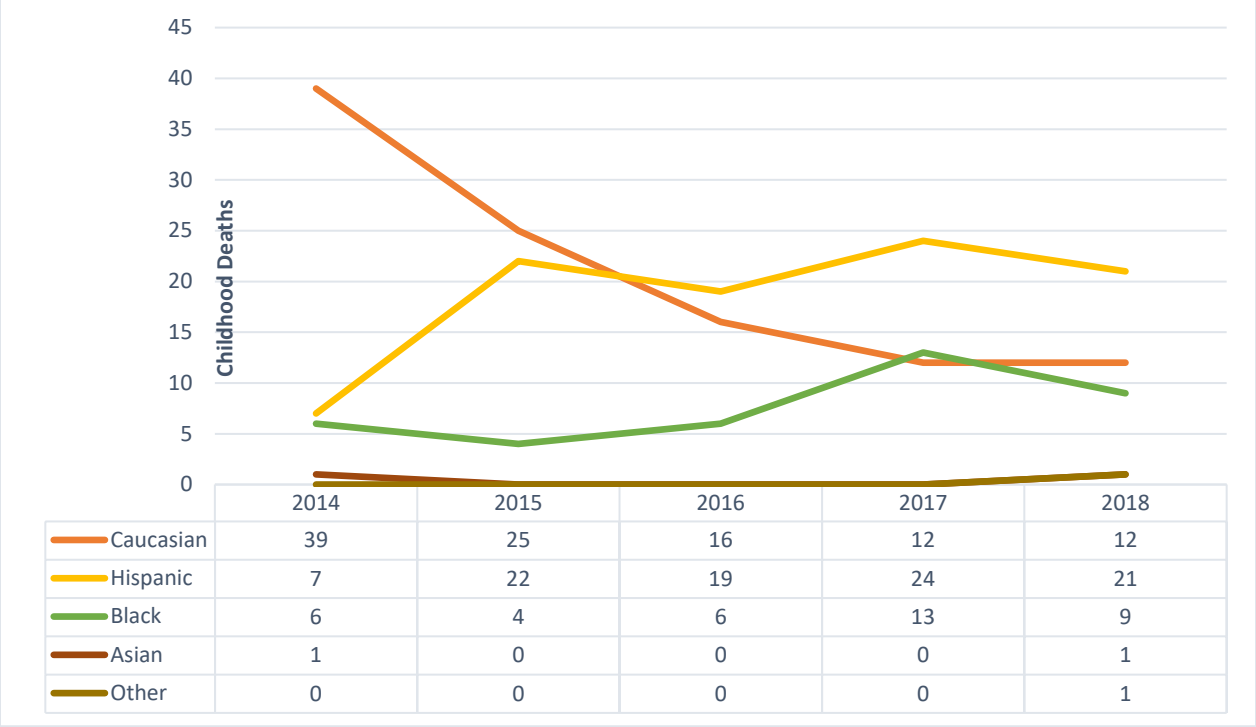


Table 12. Percentage of Preventable Childhood Deaths by Manner of Death, 2014-2018

Manner of Death	2014	2015	2016	2017	2018
Accidental/Unintentional	33%	37%	37%	30%	43%
Natural	27%	11%	10%	7%	9%
Homicide	14%	7%	4%	7%	18%
Suicide	6%	11%	12%	13%	9%
Undetermined	19%	33%	38%	43%	20%
Total	100%	100%	100%	100%	100%

Figure 17.1 Preventable Deaths by Race, 2014-2018

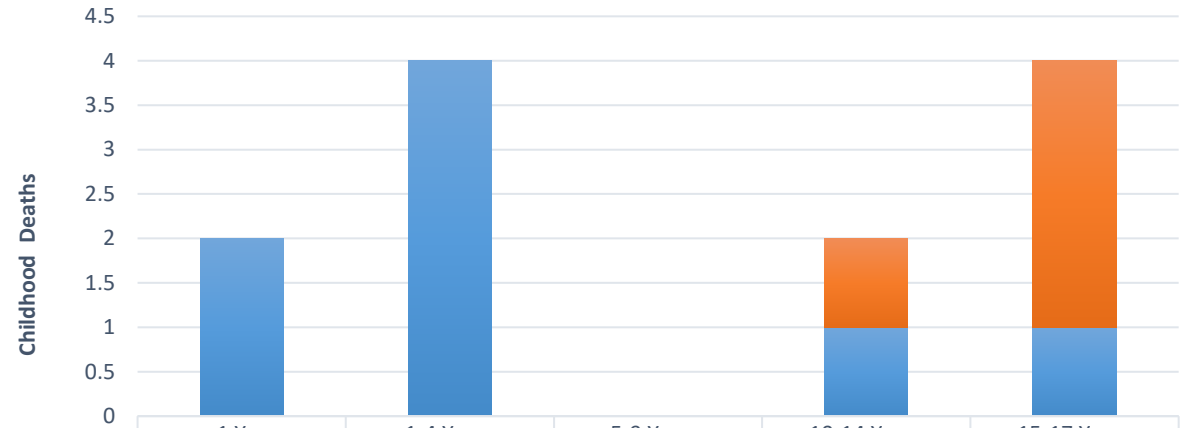


	2014	2015	2016	2017	2018
Caucasian	39	25	16	12	12
Hispanic	7	22	19	24	21
Black	6	4	6	13	9
Asian	1	0	0	0	1
Other	0	0	0	0	1

Key Takeaways

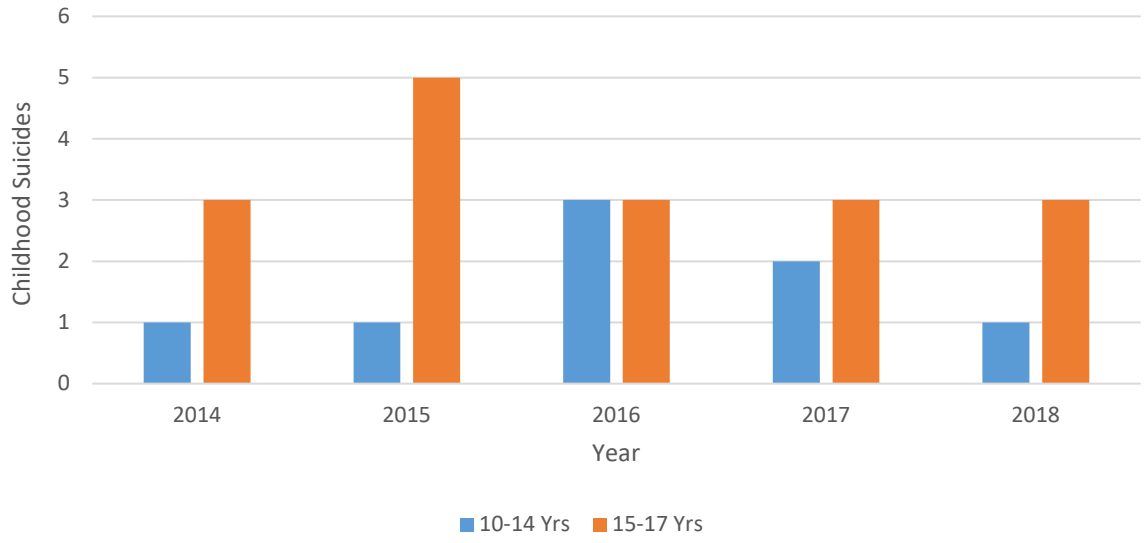
Caucasians have had a marked decline in preventable deaths from 2014 at 39, to 12 in 2018. Since 2015, Hispanics have averaged 21.5 preventable deaths per year. The majority of the suicides are in the 15-17 year olds category. Homicides have been a factor in all age groups except for 5-9 year old category. The 1-4 years old category had four homicides: <1 year old category had two; 10-14 years old and 15-17 years old had one each.

17.2 Preventable Deaths by Homicides and Suicides, 2018



	<1 Year	1-4 Years	5-9 Years	10-14 Years	15-17 Years
Suicides	0	0	0	1	3
Homicides	2	4	0	1	1

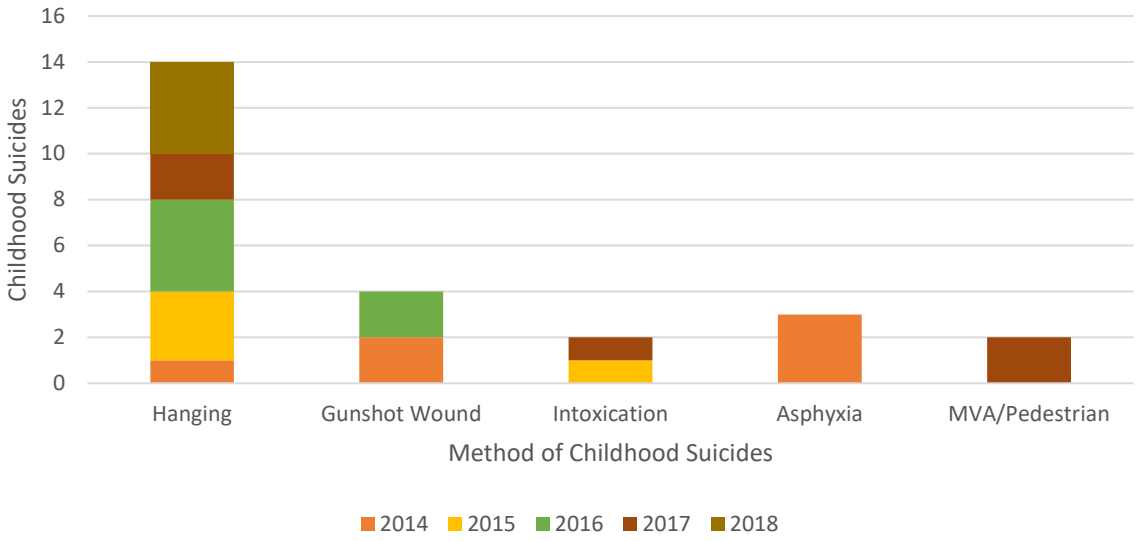
Figure 18.1. Five-Year Childhood Suicide Review by Age in Kern County



Key Takeaways

The average number of suicides over the last five years is five. The majority of the suicides are in the 15-17 year olds category. Hanging continues to be the number one method of suicide for adolescents in Kern County over the last five years.

Figure 18.2. Five-Year Childhood Suicide Review by Method in Kern County



KERN COUNTY 2018 CDRT Recommendations

Recommendations

1. **Significantly increase community awareness, education, and resources regarding the association between unsafe sleep environment and SIDS/SUID deaths with the goal of having every infant born in Kern County having a safe place to sleep upon discharge home from the hospital.**

    a. CDRT advocates that safe sleep concepts, as recommended by the American Academy of Pediatrics, have a continuing need to be reinforced to parents throughout the perinatal period and into infancy. Perinatal care providers and hospital environments need continuous training and education on safe sleep, as well as patient education tools that can be administered easily and effectively, without burdening the healthcare providers.
    b. All delivering Kern County hospitals will 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. Ideally, the policy should also include a mechanism for providing safe sleep environments (pack-n-plays, baby boxes) to every mother/family that is in need of a safe place for their baby to sleep.
    c. 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.
    d. 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.
    e. 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. CDRT has directly supported this effort by using FCANS stipends to purchase portable crib vouchers for the program.
    f. 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.
    g. CDRT began facilitating a Safe Sleep Conference for healthcare and daycare providers in Kern County in 2016. The CDRT recommends that this conference be continued and supported each year, with a 10% increase in capacity, to further needed education regarding safe infant sleep practices.
    h. 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.
    i. Increase outreach efforts that focus on parents of Black children and their communities. Increase Black Infant Health enrollment by 10%, and create programs to gain the trust of this population in order to help reduce the child death rate found in their population.

2. **Decrease the incidence of child suicide by 20% within 5 years through supporting efforts that address suicide among children to raise community awareness, convey strategies for identifying signs of self-harm, and develop resources for those at risk of suicide.**

    a. Schools and mental health services will increase their collaboration 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.
    b. Kern Behavioral Health and Recovery Services to outreach to parents of adolescents and young children to decrease stigma associated with mental illness.
    c. Faith-based organizations offering adolescent support services will incorporate education on coping and suicide prevention.
    c. 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.
    d. Increase support for Bakersfield Police Department and Kern County Sheriff's Department programs addressing social media and bullying, by promoting and participating in their efforts and activities.
    e. Support community efforts that promote and provide training on mental health first aid.

3. **Reduce childhood drowning deaths by increasing community awareness of water safety and the potential drowning dangers of pools, bodies of water, and the Kern River.**

    a. Community outreach and promotion of the "Water Watchers" campaign through the Kern County Public Health Services Department.
    b. Every local pediatrician office will promote "Water Watchers" along with water safety education for parents of young children.
    c. All children possess basic swimming skills necessary to recover from falling into a body of water.
    d. All parents and caregivers of children receive CPR training.
    e. Reinforce the need of caregivers to watch small children in and around all sources of water, including bathtubs and buckets.

4. **All Kern County community agencies increase awareness of signs of child abuse and neglect and promote resources that are available when abuse and/or neglect is suspected.**

    a. 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.
    b. 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.

5. **All Kern County community agencies increase awareness of motor vehicle and pedestrian safety among adolescents.**

    a. Support agencies/organizations that provide education to adolescents regarding the use of seat belts, as well as those agencies that distribute car seats. The use of seat belts can reduce the tragic consequences of motor vehicle accidents.
    b. Increase outreach efforts that focus on providing pedestrian safety education to school-age children and their parents regarding the use of cross walks and how to make themselves more visible at night.
    c. Increase car seat technician education training to include speaking with teens regarding motor vehicle and pedestrian safety.
    d. Increase outreach efforts to agencies/organizations that promote safe driving especially to parents and adolescents so that they understand the importance of knowing and following California's graduated driver licensing system https://www.drive-safely.net/californias-graduated-license-system).

KERN COUNTY 2018 Fetal and Infant Mortality Review

Annual Report

Fetal Infant Mortality Review

Acknowledgements

The Kern County Fetal Infant Mortality Review is made possible by the commitment of its members and their agencies, which pursue the answers to questions about preventable fetal and infant deaths. Sincere appreciation and gratitude goes to the members and guests who participated in the 2018 reviews.

Kern County Public Health Services
- Anthony, Elaine
- Cochran, Rose
- Curioso, Michelle
- Harris, Emmetta
- Kaur, Navjot
- Kaur, Sapinder
- Mushonga, Nicole
- Williams, Randy

Kern Family Health Systems
- Ochoa, Bernardo

Health Net
- Moore, Jason

First 5 Kern
- Maier, Roland

Kern Medical
- Hoburn, Monette

Adventist Health Bakersfield
- Blair, Angela

Noel Alexandria Foundation
- Brown, Tammy

FIMR Panel Mission

Fetal Infant Mortality Review (FIMR) is an evidence-based process to examine fetal and infant deaths. It is community based and action oriented with the aim of improving services to women, infants and families and reducing infant mortality. The purpose of FIMR is to look at the losses in the community and examine social, health, economic, and safety issues that affect families and how community resources and local service systems respond to their needs. There are some factors that contribute to fetal and infant deaths cannot be changed with what is currently available; there are still many issues that can be addressed during the reviews. With a comprehensive review of these deaths, we can come to understand how and why our children die and utilize the findings to take action. This will improve the delivery of our health care system, improving the health and safety of our families.

FIMR and Child Death Review are similar in many ways. Both use multidisciplinary review teams to review childhood deaths with the aim of preventing future deaths. Both teams identify gaps in services and look for better ways to deliver those services to women, children and families in our community. The professionals and paraprofessionals that make up the panel represent various agencies and programs from the community that are involved in the delivery of services to our families. There are members on the panel representing Clinica Sierra Vista, Public Health, obstetricians in private practice, Health Net, and Kern Health Systems.

FIMR Background

The California FIMR program was created in 1991 using a Federal Title V block grant. Kern County became one of 11 counties to contract with the California Department of Health Services, Maternal Child Adolescent Health Branch to establish and facilitate a local FIMR program. There are now 16 FIMR programs and 56 Child Death Review Teams (CDRT) in California. In Kern County, the CDRT Chair sits on the FIMR panel and the FIMR Coordinator and Perinatal Investigator sit on the CDRT panel.

Types of Deaths Reviewed

A fetal demise occurs after 20 weeks of pregnancy, the weight is over 500 grams and the child did not draw a breath. Sometimes these types of death are referred to as stillbirths. According to the March of Dimes, “stillbirth affects about 1 in 100 pregnancies each year in the United States” (March of Dimes, 2018. *Stillbirth, What is stillbirth?* https://www.marchofdimes.org/complications/stillbirth.aspx). In most cases, there are no known causes, leaving the families without answers for these deaths.

A neonatal death is a child who was born and lived until the 27th day of life. They can live for a few minutes or up through the entire 27 days of life.

FIMR Process

The Perinatal Investigator receives death certificates on a regular basis. These death certificates are for fetal demises (over 500 grams, over 20 weeks gestational age, and never took a breath), neonatal deaths (birth through 27 days), and post neonatal deaths (28 days up to 1 year of age). The Investigator then decides which cases to present to the panel. The priority cases are Black, teenage parents and Sudden Infant Death Syndrome (SIDS) cases, and includes syphilis cases.

Record reviews come from a variety of sources; these are typically medical records, prenatal records, pediatric records, Death Certificates, Public Health Nursing, social services agencies and the Coroner's office.

The maternal interview is another key to the FIMR process. Observing how the mother/family viewed her care during and after the pregnancy and giving the family a voice in the process can be invaluable.

The Perinatal Investigator prepares a de-identified case for the panel using the information from the record review and maternal interview. When the cases are prepared, the cases are then presented to the panel and problems are identified, recommendations are made, and panel members are assigned interventions that address the problems that were identified.

Issues/Findings of past FIMR years

- Cause of death (wording on death certificates)
- Sudden Unexpected Infant Death (unsafe sleep environments)
- Lack of grief support
- Lack of postpartum depression treatment
- Late or no prenatal care
- Tobacco use
- Perinatal substance abuse
- Mental health issues: depression, suicide attempts, schizophrenia, bi polar, etc.
- Domestic violence
- Homelessness
- 5 or more pregnancies
- Language issues

FIMR 2018 Annual Report Findings

FIMR Findings

The FIMR panel reviewed 17 fetal demises and 7 neonatal deaths during the 2018 calendar year, for 24 total cases. FIMR reports to the state of California on a fiscal year basis (July 1, 2017 through June 30, 2018); 25 cases were reviewed and reported for fiscal year 2018. The CDRT primarily reviews the SIDS/SUID cases, and keeps the FIMR panel updated on the issues that are found with those cases. FIMR reviews the losses in the community and examine social, health, economic, and safety issues that affect families and in these cases how the financial cost is met.

Figure 10. FIMR Maternal Care Payment Sources

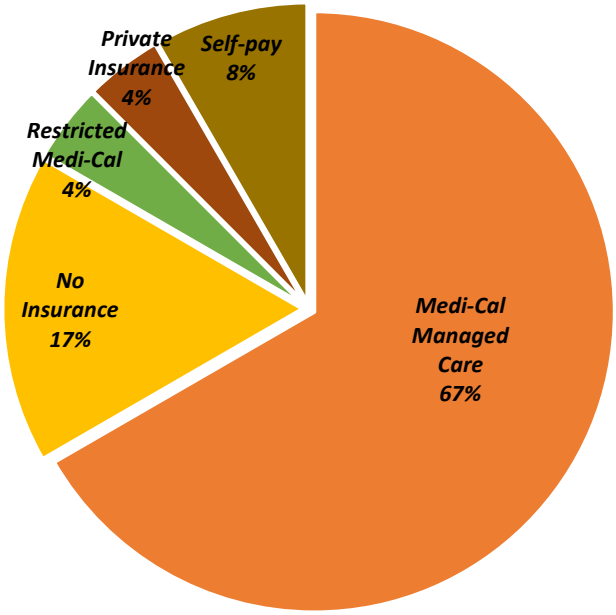


Table 10. Payment Sources

Payment Source	Number
Medi-Cal Managed Care	16
No Insurance	4
Restricted Medi-Cal	1
Private Insurance	1
Self-pay	2
Total	**24**

Key Takeaways

FIMR is an evidence-based process to examine fetal and infant deaths. It is community based and action oriented with the aim of improving services to women, infants and families and reducing infant mortality. Public Health continues to assist the underserved population of Kern County by providing the following

- Deploy nurses to their homes to provide health education and linkage to providers and resources to safeguard health outcomes in Perinatal Outreach Program, Nurse Family Partnership, and Black Infant Health.
- Collaborate with Medi-Cal Managed Care organizations such as Kern Health Systems and Health Net to ensure access to care for pregnant women, mothers and infants.
- Provide pack and plays through the Safer Sleeping Education Project and car seats through the Child Passenger Safety Education Program to ensure the safety of our most vulnerable population.
- Provide opportunities for Public Health Nurses to remain current in clinical assessment of infants and children through the Public Health Nurse Academy.

FIMR 2018 Annual Report Findings

Cases Involving Substance Use and Abuse

Figure 11. FIMR Substance Abuse Cases

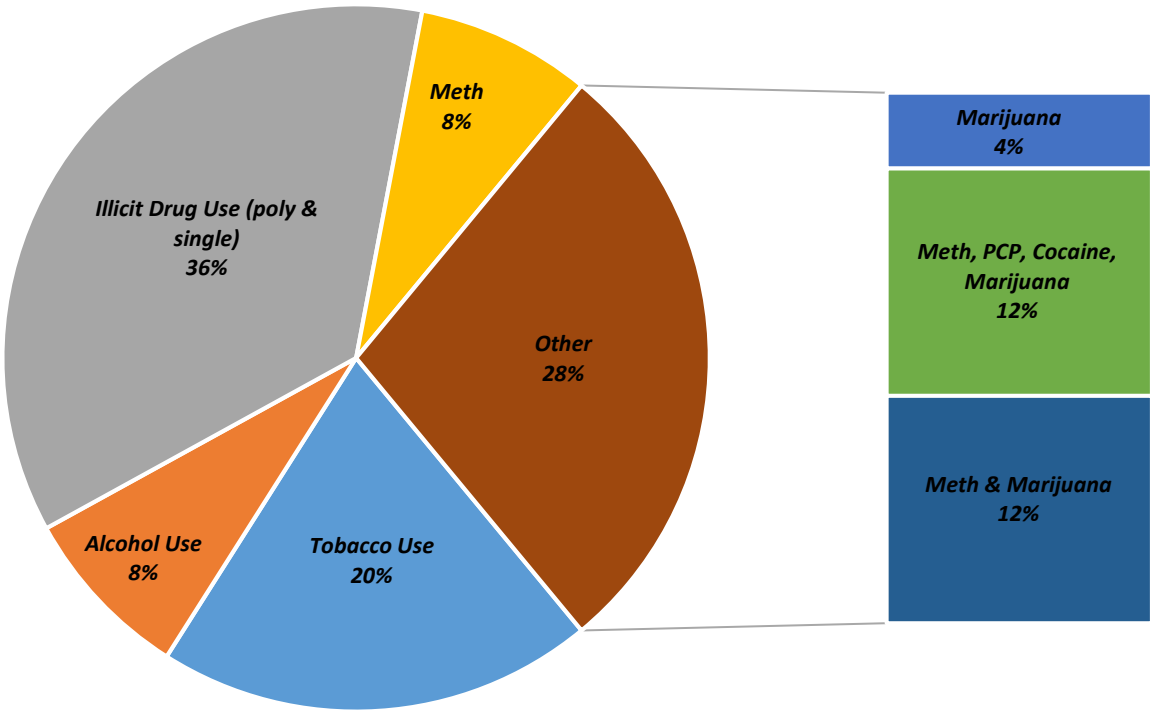


Table 11. FIMR Substance Abuse Cases

Substance Abuse	Number
Tobacco Use	5
Alcohol Use	2
Illicit Drug Use (poly & single)	9
Meth	2
Marijuana	1
Meth, PCP, Cocaine, Marijuana	3
Meth & Marijuana	3
Total	**16**

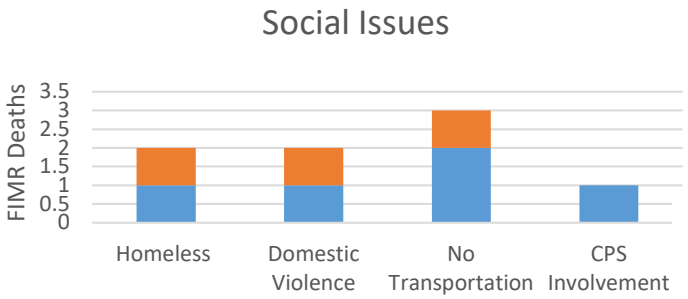
Key Takeaways

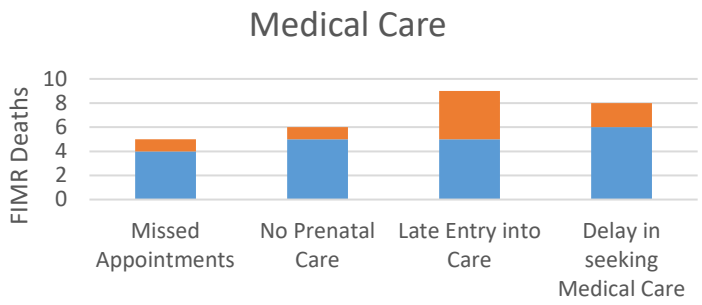
Sixteen cases reviewed had substance abuse identified as issues. There were four cases that involved poly-drug use, two cases with alcohol use, and five cases that involved tobacco use.

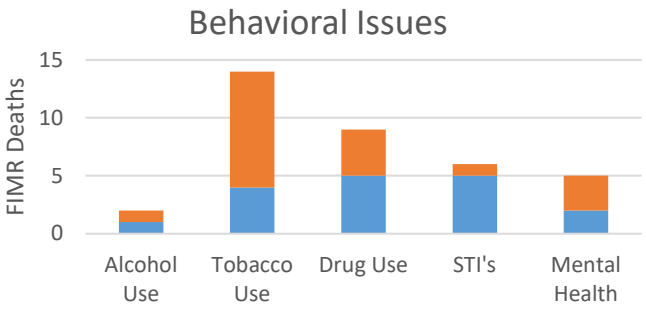
Public Health currently teams with Aegis Treatment Centers to provide comprehensive case management services to the pregnant women in treatment. FIMR also provides information to the Perinatal Substance Use Prevention Partnership and Drug Free Kern.

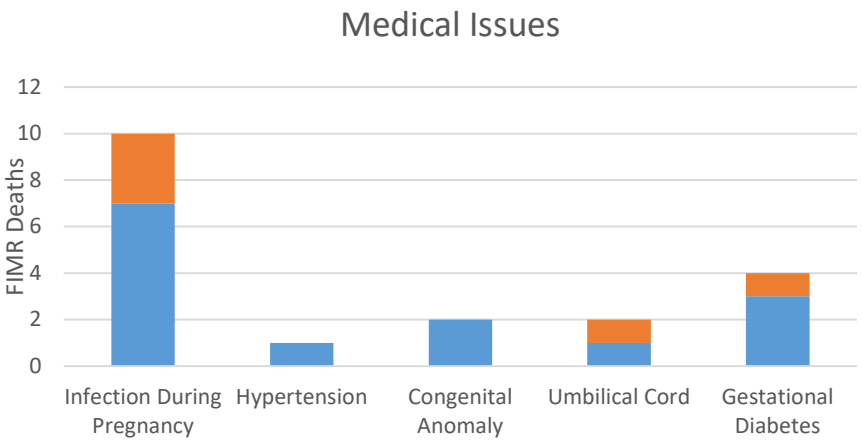
FIMR 2018 Annual Report Findings

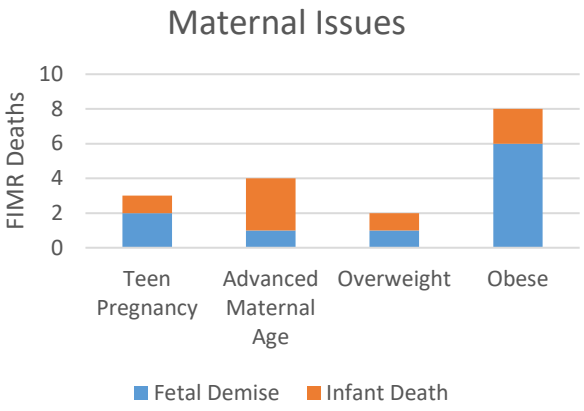
Figures 12.1-12.6. FIMR 2018 Annual Report Findings

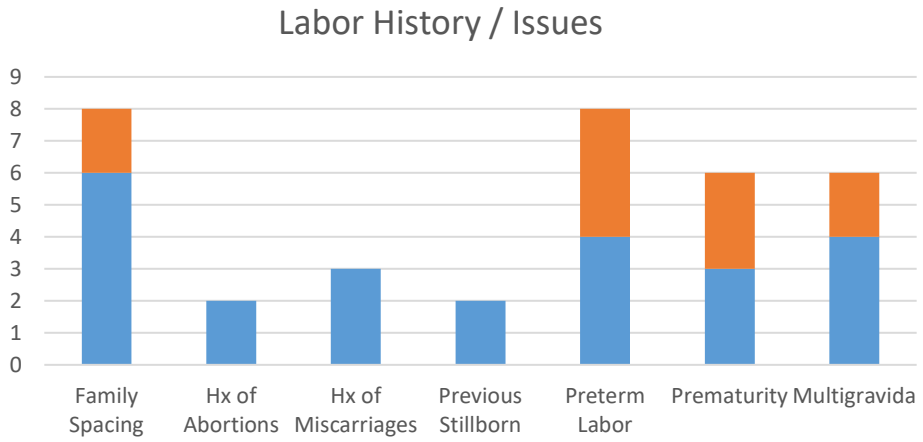












Key Takeaways

In the 2018 calendar year, the FIMR panel reviewed 24 cases. Accessing medical care was the primary issue. Nine cases were late entry into care. Six cases identified as having no prenatal care. Eight delayed seeking medical care. Five cases had propensity for missed appointments. Behavioral issues indicated that drug use (9), mental health (5), and tobacco use (4) were problem areas. Sexually transmitted infections was identified in six cases, two of which involved multiple STIs. Infection during pregnancy (7) and obesity (6) were prevalent in fetal demise.

FIMR 2018 Recommendations

Twenty-four cases were reviewed from January 2018 to December 2018. The panel recommendations relate to the cases before, during and after the birth of the child. Some of the recommendations relate to discussions about the SIDS/SUIDS cases that CDRT reviewed.

Problem: FIMR identified a lack of programs or services for high-risk post-partum mothers who have lost their only child. These cases required follow up that included psychosocial support, and linking and referring to services because they are more likely than not, to keep their post-partum appointments. It was noted that many programs are made for pregnant or parenting women, but none for postpartum women.
Current Practices: Currently there are no formal programs for postpartum women who have suffered the loss of a child.
Recommendation:

- Create a program for high-risk post-partum women who have lost their only child so that hospitals may make referrals prior to discharge. This program would follow the woman through her postpartum period to ensure she keeps her postpartum visit and, provide psychosocial support as needed.
- Enhance Sudden Infant Death Syndrome (SIDS) and Unplanned Pregnancy Prevention Programs (UPPP) to include bereavement and counseling services that include case management through the grieving process and postpartum period.

Problem: FIMR identified fetal demise and infant death cases where substance use and abuse were prevalent. There were six cases that poly-drug use was an issue.

Current Practices: The Public Health Department is currently working with Aegis Treatment Centers to provide comprehensive case management services to the pregnant women in treatment. FIMR also provides information to other panels that deal with substance abuse issues (Perinatal Substance Use Prevention Partnership, and Drug Free Kern).
Recommendation:

- Continue working with Aegis Treatment Centers and refer patients to the Perinatal Outreach Program or Black Infant Health. The goal is that if we provide case management services to perinatal women, they will not be deficient in their access to prenatal/postpartum care.

Problem: FIMR identified the need to reinforce the safe sleeping messaging in the community.
Current Practices: FIMR continues to collaborate with CDRT and the Safe Sleep Coalition, and was instrumental in providing safe sleep education to Bakersfield Memorial Hospital to ensure they receive the Safe Sleep Certification, Gold Status from Cribs for Kids.
Recommendations:

- FIMR should strongly encourage all of the area hospitals so that they may be Safe Sleep Certified by Cribs for Kids. Continue working with Community Connection for Kids, Foster Care Program, First 5 Kern and Community Action Partnership of Kern to ensure that the safe sleep messaging is being disseminated within the community.

Appendix A—Online Resources

Biking Safety

- kernpublichealth.com/road (facts, tips, and safety)
- nhtsa.gov/bicycles (National Highway Traffic Safety Administration)

Child Abuse

- dontshake.org (National Center on Shaken Baby Syndrome, support and education)
- child-abuse.com (Child Abuse Prevention Network for professionals in the field of child abuse and neglect)

Domestic Violence

- kernalliance.org (Alliance Against Family Violence & Sexual Assault)
- kernsheriff.org/crime_prevention.aspx (KCSO brochures-domestic violence)
- mandatedreporterca.com (California Child Abuse Mandated Reporter Training)
- thehotline.org (National Domestic Violence Hotline)
- whengeorgiasmiled.org (Curriculum designed to educate on DV issues)
- Aspire News app (allows victims of abuse to call for help at the touch of a button)

Fire Safety

- smokeybear.com (resources for educators, activities for kids)
- firefacts.org (resources for parents and educators, activities for kids)

Car Safety

- kernpublichealth.com/road (facts, tips, and safety)
- chp.ca.gov/Programs-Services/Services-Information/Bike-and-Ped-Safety (Share the Road)
- nhtsa.gov/road-safety/pedestrian-safety (parent, caregiver, and child safety tips and resources)
- kidsandcars.org (How kids get hurt in and around cars, resources)
- safekids.org (videos and activities for in and around the car)

Safe Infant Sleeping Resources

- safesleepforbaby.com (LA safe sleep website)
- nichd.nih.gov.sts (Safe to Sleep Pub Ed Campaign led by NIH)
- firstcandle.org (First Candle organization, education for caregivers and families)

Suicide-Youth

- suicideispreventable.org (Know the Signs, statewide suicide prevention campaign)
- suicideinfo.ca/youthatrisk (Centre for Suicide Prevention, Youth at Risk Guide)
- kernbhrs.org (Kern Behavioral Health and)
- thetrevorproject.org (crisis intervention/suicide prevention for LGBTQ youth)

Teen Drivers

- ntsa.gov/teen-driving (help to teach kids to be safe, capable drivers)
- kernpublichealth.com/car (facts, tips, and dangerous driving behaviors)

Water Safety

- poolsafely.gov (national public education campaign to reduce child drownings)
- abcpoolsafety.org (swimming safety information for kids 5 and under)
- waterwatcher.org (drowning prevention website, water play supervision)