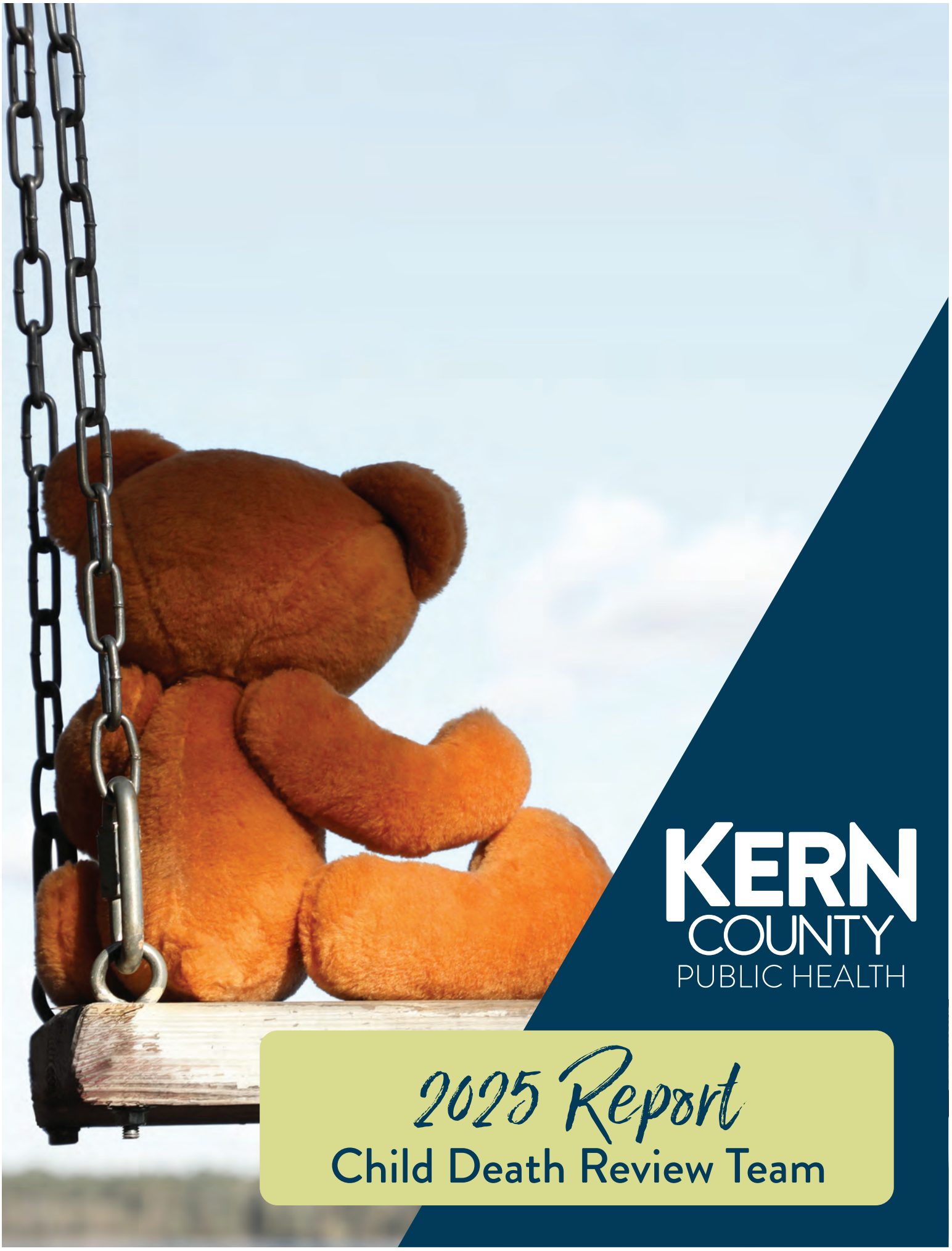


KERN COUNTY
PUBLIC HEALTH

2025 Report
Child Death Review Team

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This report is to highlight the 2025 Child Death Review Team case reviews, including infant and child deaths that occurred in Kern County during the 2025 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
- Outlines recommendations made by CDRT for addressing the data trends

Acknowledgements

CDRT is made possible by the commitment of its members and agencies that are involved. Sincere appreciation and gratitude go to the agencies who participated in the 2025 reviews.

Kern County Public Health

Kern County Coroner's Office

Kern County Department of Human Services

Kern Behavioral Health and Recovery Services

Kern County Counsel

Kern County District Attorney's Office

Kern County Network for Children

Kern County Probation Department

Kern County Sheriff's Office

Kern County Superior Court

Bakersfield Police Department

Adventist Health Delano

California Highway Patrol

First 5 Kern

Valley Children's Hospital

Ridgecrest Regional Hospital

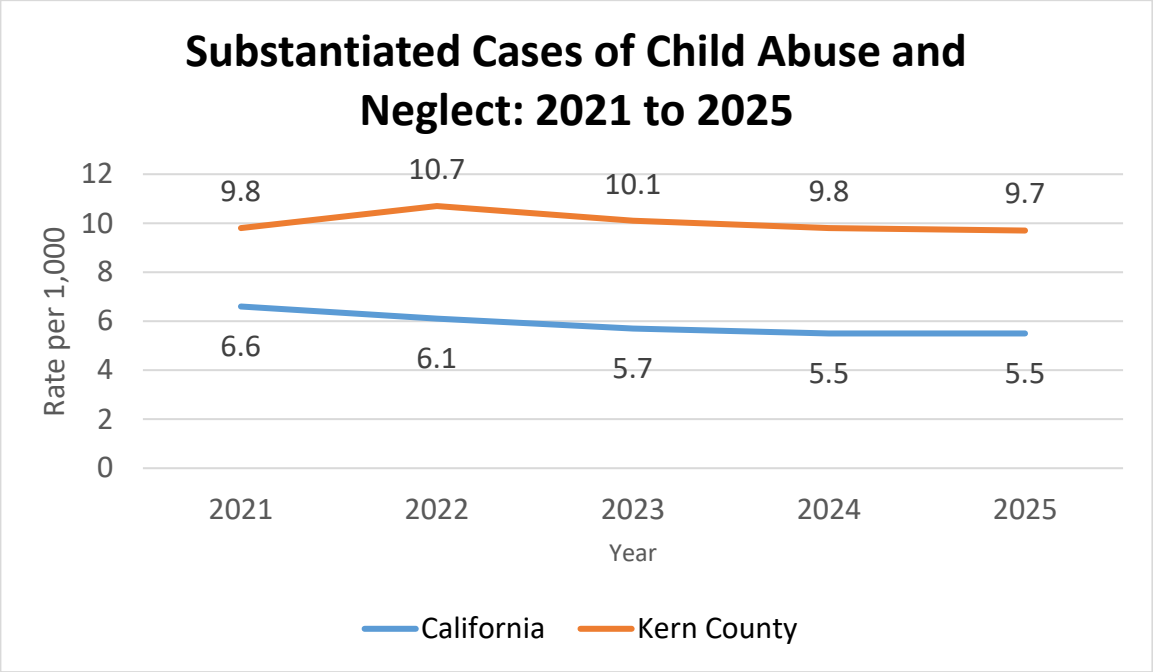
The members of CDRT would also like to thank the Kern County Board of Supervisors for their unwavering commitment to protecting our children.

Mission

The mission of CDRT is to prevent child deaths resulting from abuse, neglect; unsafe conditions; and other avoidable causes.

CDRT uses a multi-disciplinary team at the local level that assists 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 deaths in Kern. Development of these strategies raises knowledge and awareness and leads to systematic changes, thereby preventing further child deaths.

Rates of substantiated child abuse and neglect in Kern County are trending downward and, in 2025, was the lowest we have seen in Kern County over the last five years. However, it is important to note that Kern County's 5-year average was 70% above statewide rates.



Definition: Number of substantiated cases of abuse and neglect per 1,000 children under age 18.

Data Source: As cited on Child Maltreatment Substantiation Rates Report - California Child Welfare Indicators Project (CCWIP) (berkeley.edu), Webster, D., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., Wiegmann, W., Saika, G., Courtney, M., Eastman, A.L., Hammond, I., Gomez, A., Prakash, A., Sunaryo, E., Guo, S., Berwick, H., Hoerl, C., Yee, H., Flamson, T., Gonzalez, A., Ensele, P., Nevin, J., & Guinan, B. (2026).*CCWIP reports*.

History

In 1988, the California legislature authorized each county to establish CDRTs 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 case review meetings.

Case Review Process

CDRT receives and reviews Kern County Coroner's reports on deaths in children aged birth through 17 years. Receiving cases in advance allows time to search respective agency case files for additional information on the child and family. Discussions at the meetings determine if the death was preventable and what services, education, or intervention were provided and/or could have affected the outcome of the case.

At times, CDRT will review cases where a child dies in another county, but is a resident of Kern County; however, Kern County may not always have jurisdiction in these cases. The data in this report only included deaths that Kern County has jurisdiction.

In 2025, 39 cases out of 113 deaths in children under 18 years of age were reviewed and included in this report. All 39 cases were deemed likely preventable by the Kern County Coroner's Office. This is a decrease in cases reviewed by CDRT (47) and total deaths in children under 18 years of age (128) from 2024.

Data reflected in this report comes from Kern County Coroner's reports and supplemental information provided by CDRT team members. To protect the confidentiality of children and families, CDRT presents only aggregate data.

California Child Fatality Surveillance System (CCFSS)

CDRT is involved with CCFSS through the Injury and Violence Prevention Branch at the California Department of Public Health. The CCFSS 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. Kern County CDRT uses these monies to fund community projects such as the Safe Sleep Project.

Risk Factors for Preventable Childhood Death

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

- Child—Vulnerability
  - Less than 4 years old, male, prematurity/low birth weight, illness/disability, colic, challenging behaviors, has 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]

- 1–4-year-olds have the highest drowning rates.
- Drowning happens quickly and quietly, so a lack of close supervision increases risk.
- Highest risk drowning locations varies by age. For those under 1 year of age, two-thirds of all drownings happen in bathtubs. For children aged 1 to 4 years of age, most drownings occur in home swimming pools. For children aged 5 to 18, most drownings occur in natural bodies of water.

Risk factors for Motor Vehicle Accident Deaths[3]

- 4–7-year-olds have a higher incidence of being 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 are often used incorrectly.

[1] Hughes, K. & Pence-Wilson, D., 2012. Child Maltreatment Fatalities—Risk Factors and Lessons Learned. doi:10.1.1.688.6439
[2] Centers for Disease Control and Prevention, 2022. Drowning Facts. Retrieved December 25, 2022 from https://www.cdc.gov/drowning/facts/index.html
[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.
- 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.
- Infants placed to sleep in unsafe environments: Such as bedsharing with adults, sleeping on soft bedding, or being placed in a prone (on stomach) or side position are at significantly increased risk for Sudden Unexpected Infant Death (SUID).

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 regarding recent relationship issues)
- Sexual orientation
- Victimization
- Lack of social connection and support
- Bullying

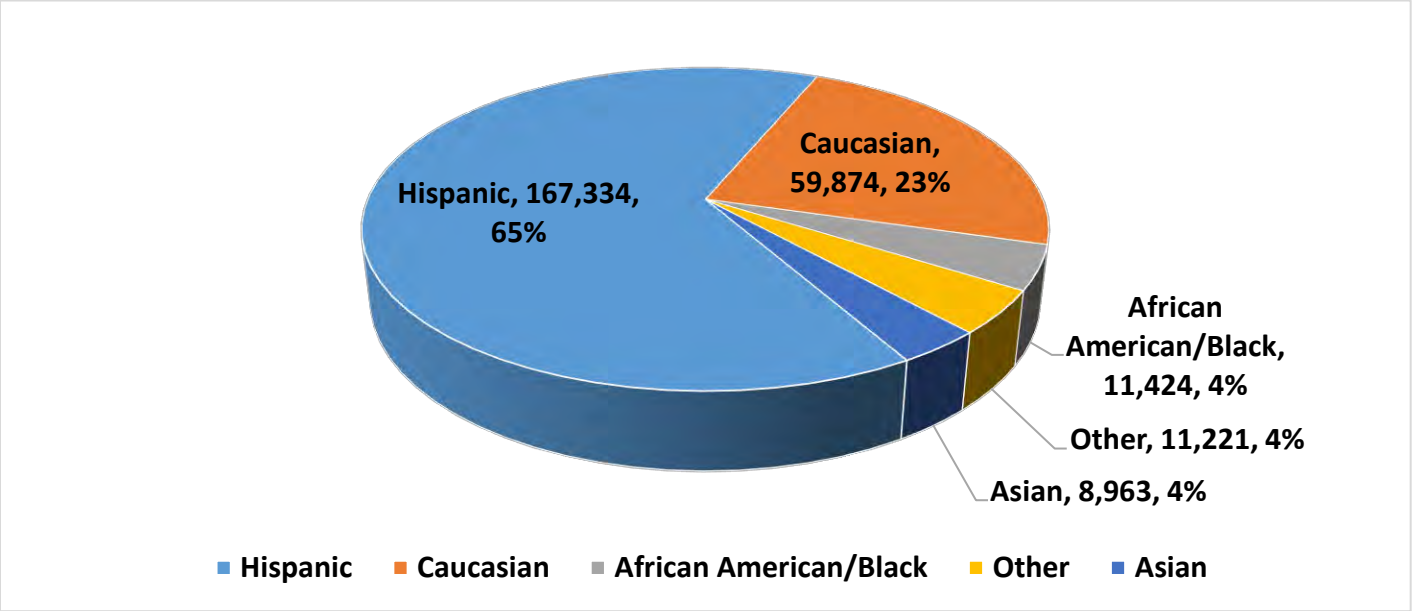
[4] Healthy People 2020, 2018. Maternal, Infant, and Child Health, MICH-1.9 Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed). Retrieved, August 20, 2018 from https://www.healthypeople.gov/2020/data-search/Search-the-Data#objid=4831

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

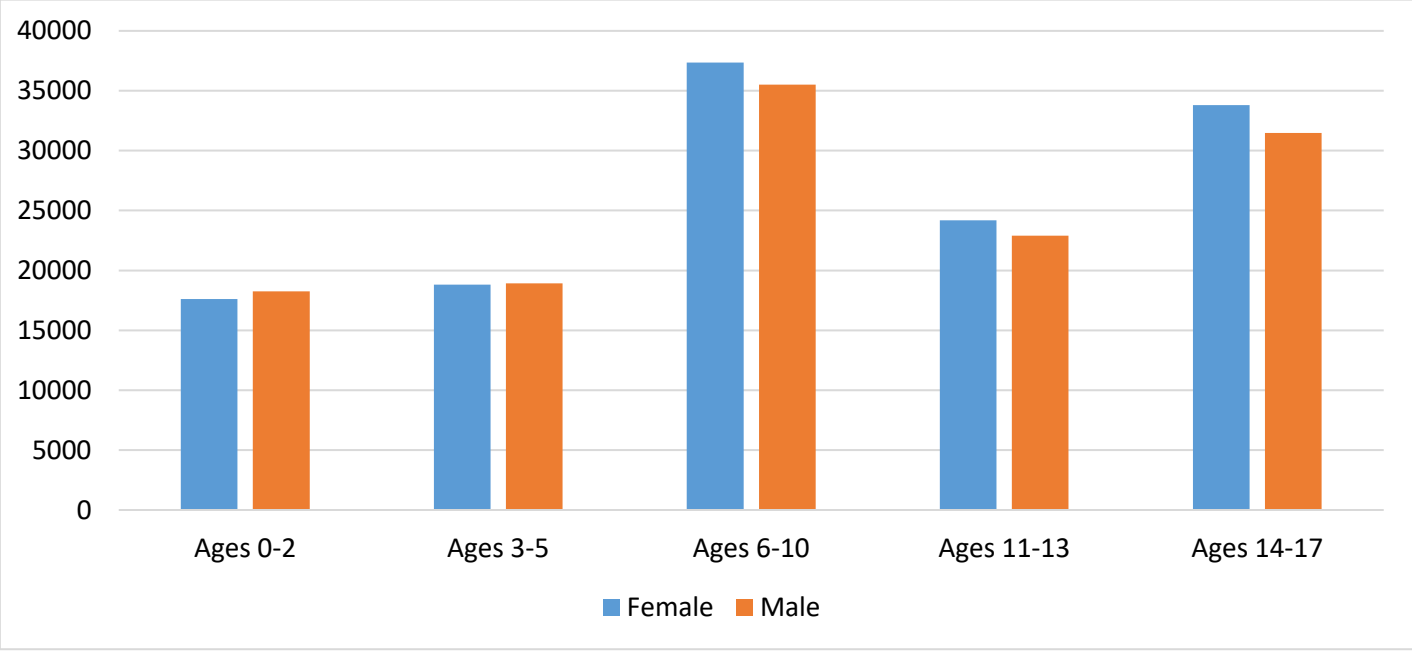
Demographics

Kern County is a large and diverse geographic region of California, comprised largely of agricultural-based communities and regions under urban development. According to the U.S. Census Bureau, 35.3% of Kern County households have child residents.[6] In 2025, there were 258,816 children aged 17 and younger residing in Kern County. During this time frame, most of the child population in Kern County identified as Hispanic/Latino (65%) and Caucasian/White (23%). Compared to California as a whole, the Hispanic/Latino child population was 16% greater in Kern County. The male-to-female ratio among children was approximately equal.

Kern County Children aged 0-17 Population by Race/Ethnicity, 2025



Kern County Children 0-17 Age and Gender, 2025



[6] https://data.census.gov/table/ACSDT1Y2024.B25115?q=households+with+children&t=Families+and+Living+Arrangements&g=050XX00US06029 (July 2025).

CDRT Terminology

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 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 – Death at the hands of another.

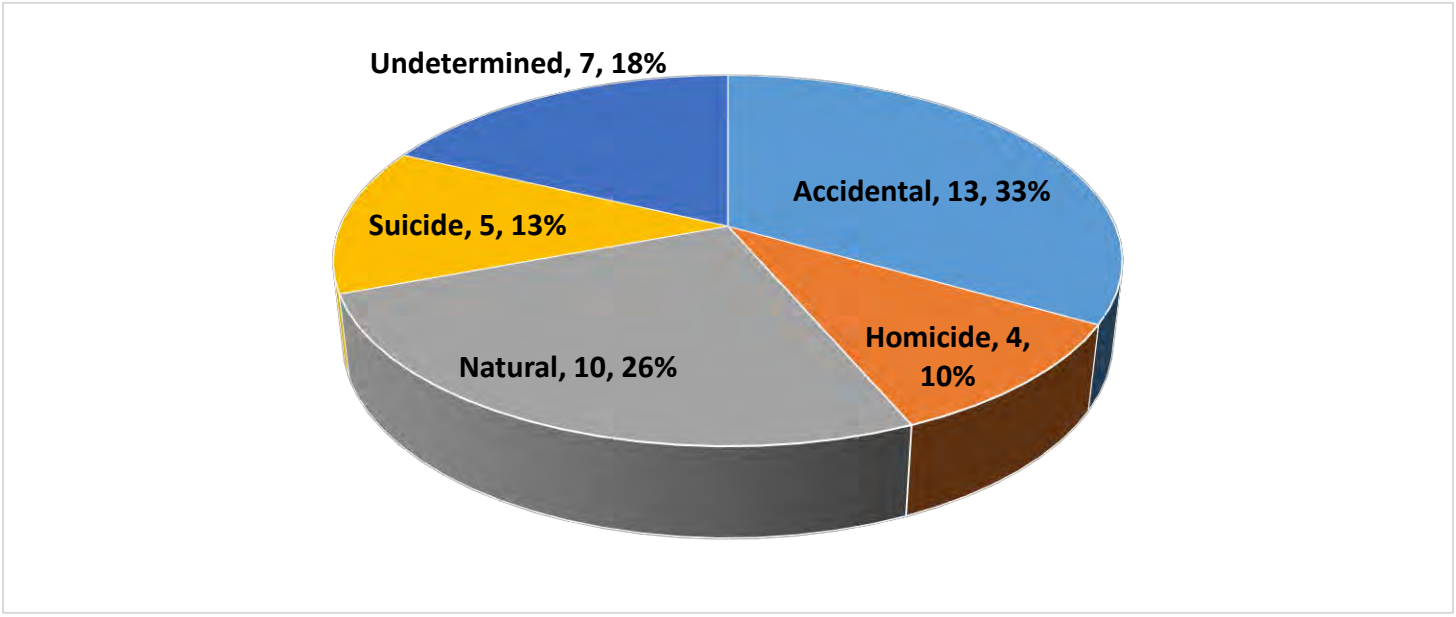
Suicide – Death caused by self-directed injurious behavior with intent of self-harm.

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

Cause of Death – The actual mechanism producing the 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.

Manner of Death

Manner of Preventable Deaths 2025



Key Highlights and Comparisons

In 2025, accidental (13) was the leading manner of childhood deaths reviewed by the team. Homicides decreased in 2025 (4) compared to 2024 (7). Suicide deaths decreased 16.7% from 2024 (6) to 2025 (5).

Cause of Death

Cause of Death 2025

Accidental (13)	
Blunt force trauma, including motor vehicle accidents	6
Inhalation of Products of Combustion	4
Drowning	2
Asphyxia	1
Homicide (4)	
Gunshot wounds	3
Multiple Inflicted Injuries	1

Natural (10)	
Respiratory disease (pneumonia, asthma/influenza)	3
Obstetric/perinatal disease (chorioamnionitis/fetal demise, prematurity)	2
Gastrointestinal disease (bowel infarction, colonic lymphoma)	2
Cardiac Disease (arrhythmia)	2
Metabolic (Diabetic Ketoacidosis)	1
Suicide (5)	
Asphyxia/hanging	2
Gunshot wound	1
Multiple Blunt Force Injuries	1
Diphenhydramine Intoxication	1
Undetermined (7)	
SUID	4
Undetermined	2
SUID w/ Co-Sleeping as a Factor	1

Key Highlights and Comparisons

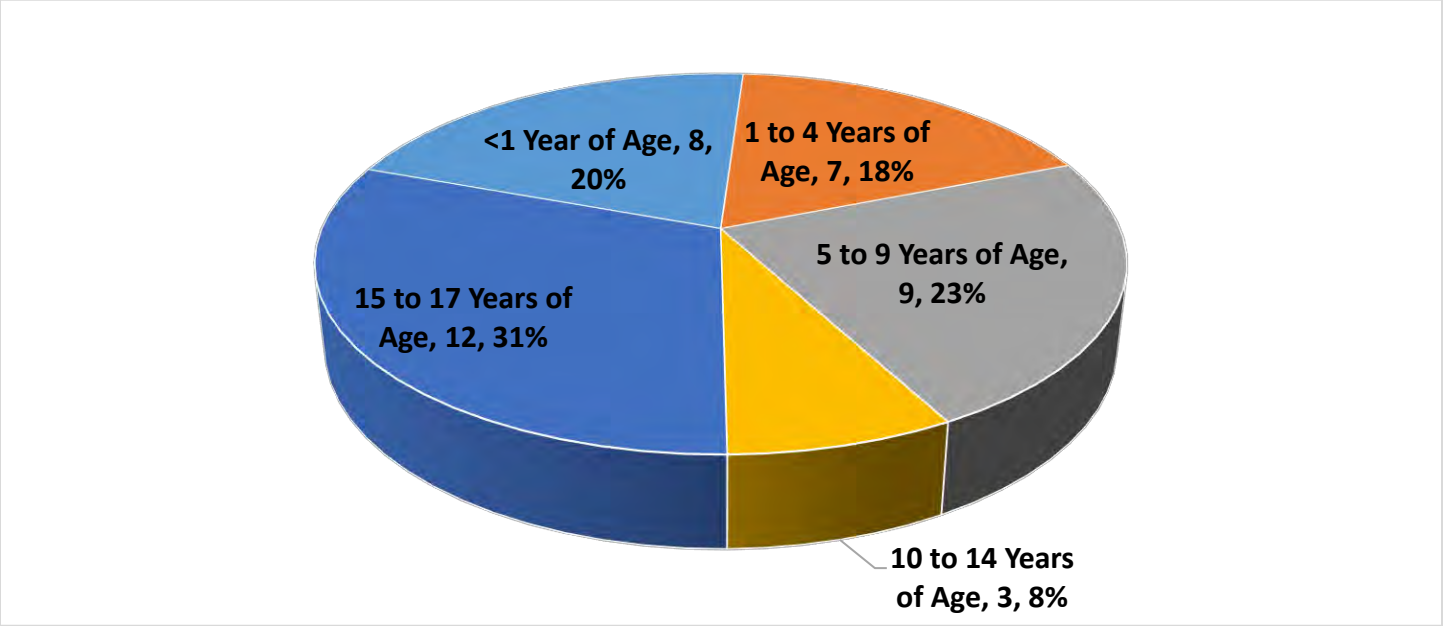
In 2025, motor vehicle accidents accounted for six (6) accidental deaths, representing a 40% decrease from ten (10) deaths in 2024. Drowning deaths also declined from six (6) in 2024 to two (2) in 2025, representing a 67% decrease. Overall, accidental deaths decreased from 17 in 2024 to 13 in 2025, representing a 24% decrease.

Homicide deaths decreased from seven (7) in 2024 to four (4) in 2025, representing a 43% decrease. Suicide deaths also declined from six (6) in 2024 to five (5) in 2025, representing a 17% decrease. Undetermined deaths decreased from nine (9) in 2024 to seven (7) in 2025, representing a 22% decrease.

Overall, the decreases across accidental, homicide, suicide, and undetermined deaths reflect an encouraging reduction in several categories of child deaths reviewed by the CDRT in 2025.

Reviewed 2025 Child Deaths by Age Group

Preventable Deaths by Age 2025



Preventable Deaths by Month 2025

Age Group	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
<1 Years of Age	2	1		1	1		1				1	1
1 to 4 Years of Age		1			1		1	1	1	1	1	2
5 to 9 Years of Age			1	1	1		1		1	1		
10 to 14 Years of Age	1				1				1	2	3	
15 to 17 Years of Age	2	3		2		2	2	3	1	1	1	
Total Per Month	**5**	**5**	**1**	**4**	**4**	**2**	**5**	**4**	**4**	**5**	**5**	**3**

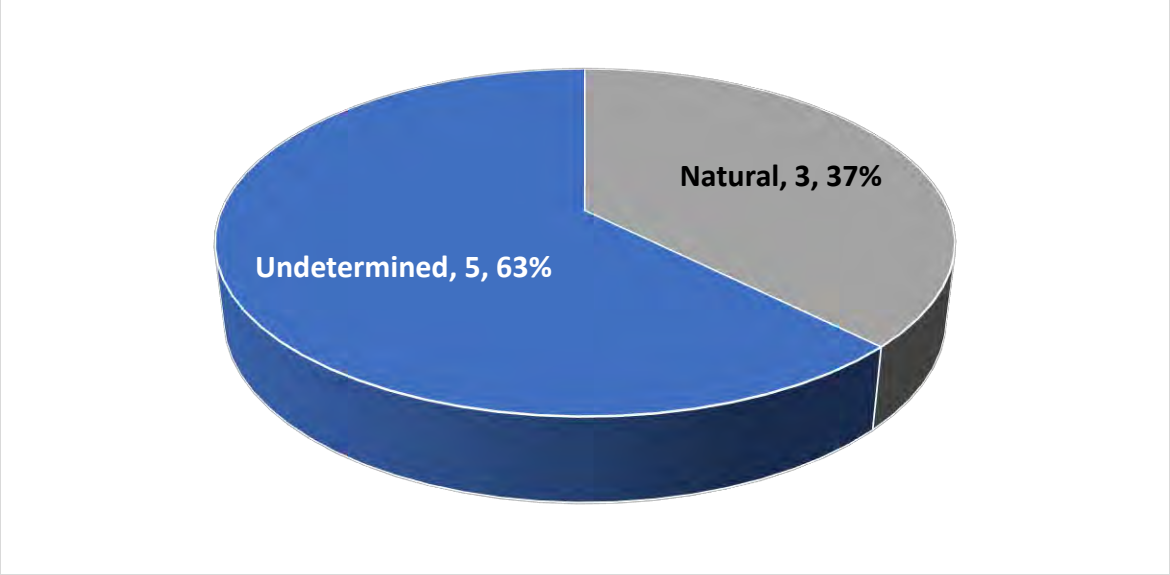
Key Highlights and Comparisons

Among the 39 deaths reviewed by CDRT, slightly less than one-third (31%) occurred in youth ages 15 to 17.

Child Deaths Reviewed by Age and Manner

Children less than a year of Age

Preventable Deaths: <1 year of age 2025



Preventable Deaths per Year: <1 year of age 2025

	<1 Years of Age
Natural	3
Undetermined	5

Key Highlights and Comparisons

In 2025, there were a total of eight (8) deaths among children under one year of age reviewed by the Child Death Review Team (CDRT), representing 21% of all child deaths reviewed.

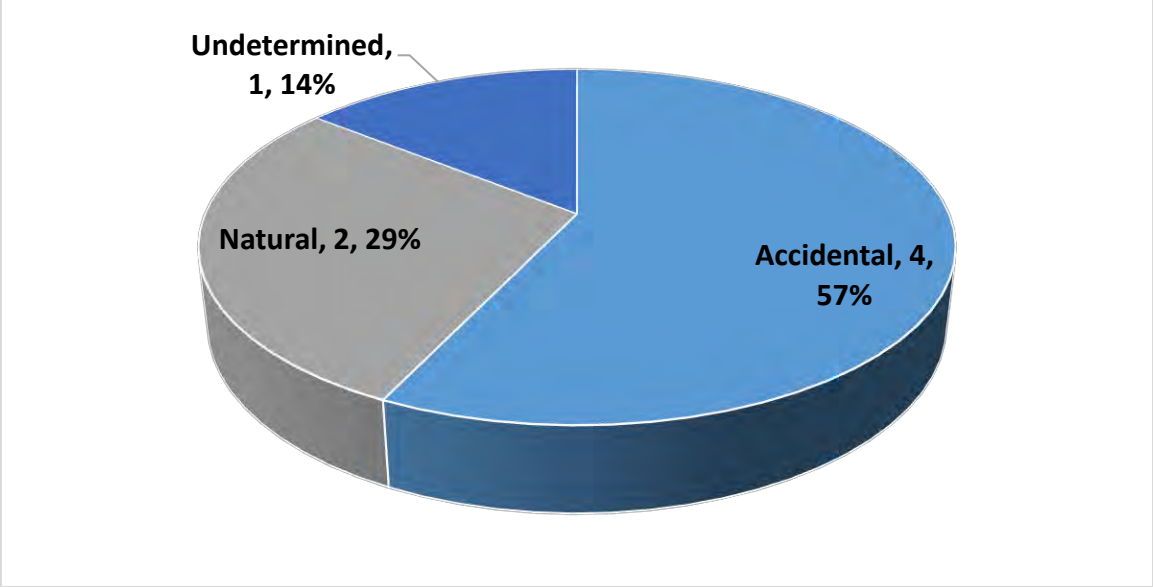
Of these eight deaths:

- Five (5) deaths (62.5%) were an undetermined manner, making it the leading category of death for this age group. Four of the five deaths involved an unsafe sleeping environment.

Child Deaths Reviewed by Age and Manner

Children 1 – 4 Years of Age

Preventable Deaths: 1 – 4 years of age 2025



Preventable Deaths per Year: 1 – 4 years of age 2025

	1 to 4 Years of Age
Accidental	4
Natural	2
Undetermined	1

Key Highlights and Comparisons

In 2025, there were seven (7) preventable deaths among children aged 1 to 4 years, representing a decrease from 9 in 2024 and 13 in 2023.

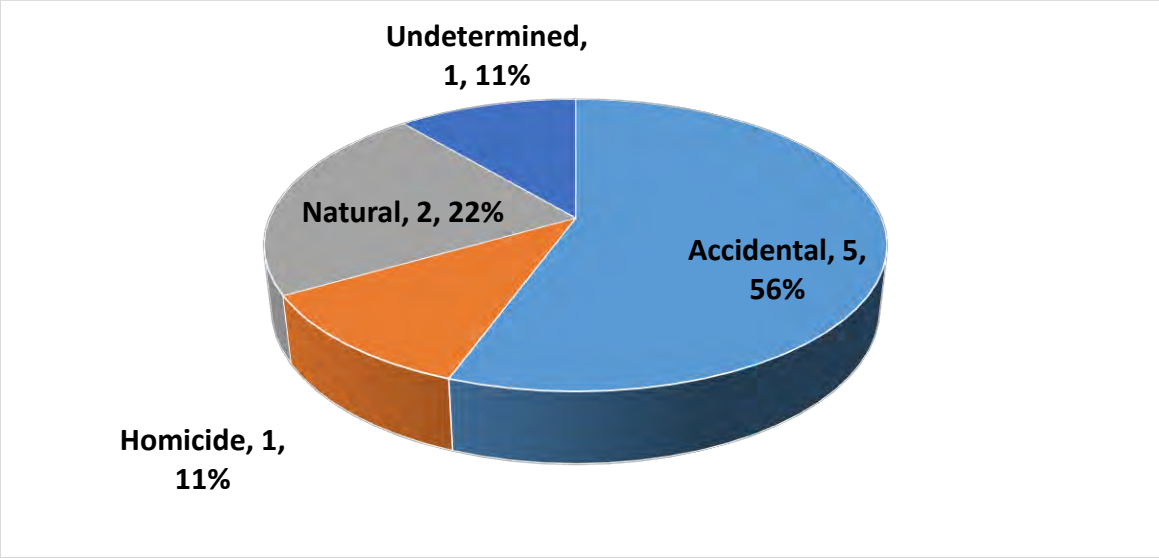
Accidental deaths accounted for four (4) of the seven cases (57%). Of these accidental deaths:

- Two (2) were due to fire, and
- One (1) was due to asphyxia, and
- One (1) was due to drowning

Child Deaths Reviewed by Age and Manner

Children 5 – 9 Years of Age

Preventable Deaths: 5 – 9 years of age 2025



Preventable Deaths per Year: 5 – 9 years of age 2024

	5 to 9 Years of Age
Accidental	5
Homicide	1
Natural	2
Undetermined	1

Key Highlights and Comparisons

Notably, deaths among children aged 5 to 9 years increased by 80%, from five (5) deaths in 2024 to nine (9) deaths in 2025, accounting for 23% of all cases reviewed by the CDRT in 2025.

Of particular concern, accidental deaths among children aged 5 to 9 years increased from two (2) in 2024 to five (5) in 2025, representing a 150% increase. This substantial increase underscores the continued need for focused injury prevention and child safety efforts targeting this age group.

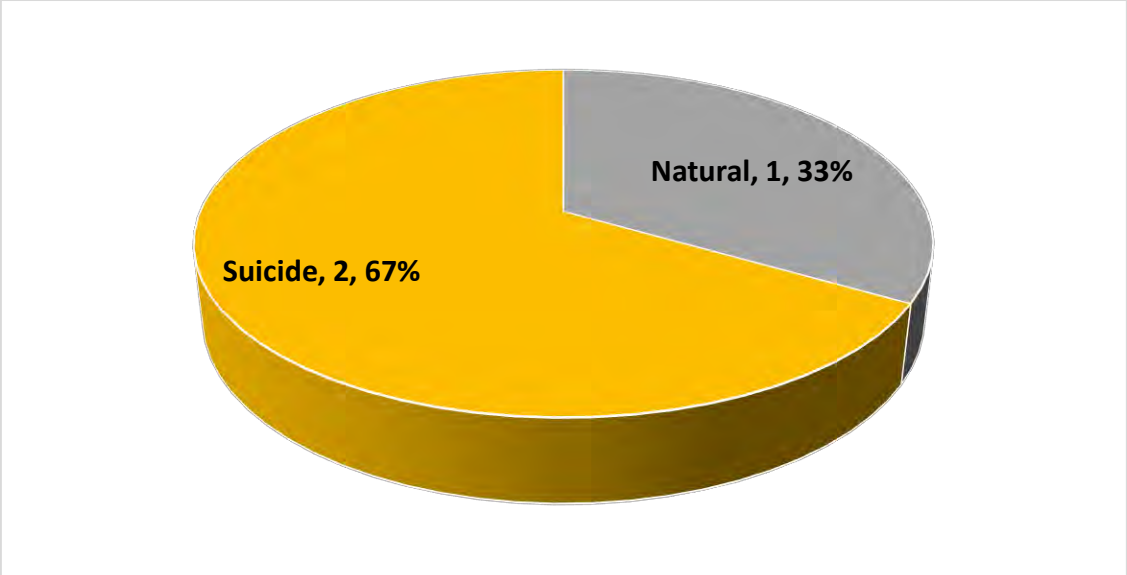
Of the five (5) accidental deaths in this age group:

- Three (3) involved a motor vehicle-related incident, and
- Two (2) were due to fire.

Child Deaths Reviewed by Age and Manner

Children 10 – 14 Years of Age

Preventable Deaths: 10 – 14 years of age 2025



Preventable Deaths per Year: 10 – 14 years of age 2025

	10 to 14 Years of Age
Natural	1
Suicide	2

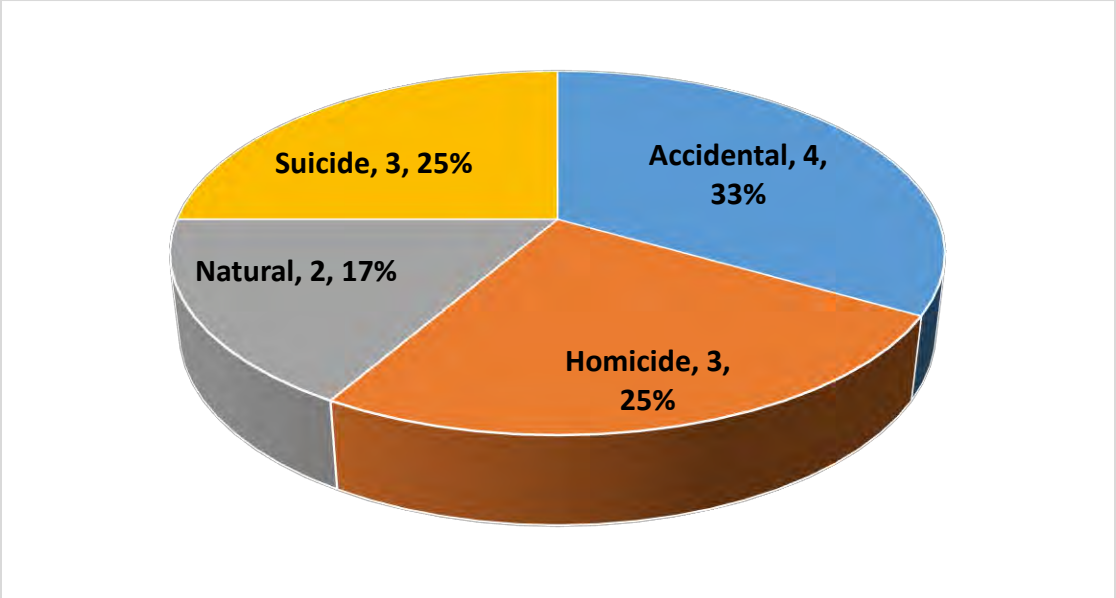
Key Highlights and Comparisons

Notably, there were no accidental deaths among children ages 10–14 in 2025. This marks the first year in the last 10 years with no reported accidental deaths in this age group, representing an encouraging outcome.

There were three (3) suicide deaths among children ages 10–14 in 2024 and two (2) in 2025. Notably, the five (5) suicide deaths reported across 2024 and 2025 exceed the four (4) deaths recorded during the entire 2021–2023 period. This continued occurrence highlights suicide as an important concern among children in this age group.

Child Deaths Reviewed by Age and Manner
Children 15 – 17 Years of Age

Preventable Deaths: 15 – 17 years of age 2025



Preventable Deaths per Year: 15 – 17 years of age 2025

	15 to 17 Years of Age
Accidental	4
Homicide	3
Natural	2
Suicide	3

Key Highlights and Comparisons

In 2025, accidental deaths accounted for four (4) or 33.4% of all preventable deaths in the 15–17-year-old age group. This represents a 43% decrease from the seven (7) accidental deaths reported in 2024.

Of the four accidental deaths:

- Three (3) were related to motor vehicle incidents, and
- One (1) was the result of drowning.

Homicide deaths accounted for three (3) or 25% of deaths in this age group, which is a 50% increase from two (2) in 2024.

Suicide deaths accounted for three (3) deaths, or 25% of deaths in this age group. It is important to note that suicide deaths in the 15-17 age group represented 25% of overall deaths in both 2024 and 2025. This consistency across both years highlights suicide as an ongoing area of concern for this age group.

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[7]." 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[10]."

Figure 8. Health Disparities: Kern County Preventable Childhood Deaths by Race 2024

Asian			Black/African American			Caucasian			Hispanic			Other*		
Count	Population	Rate	Count	Population	Rate	Count	Population	Rate	Count	Population	Rate	Count	Population	Rate
2	8,863	22.57	6	11,497	52.19	8	57,530	13.91	31	172,900	17.93	0	11,343	0.00

Rates are per 100,000

Native American	Pacific Islander	Multiracial	Total
859	297	10,187	11,343

*These are the populations in other

Figure 9. Health Disparities: Kern County Preventable Childhood Deaths by Race 2025

Asian			Black/African American			Caucasian			Hispanic			Other*		
Count	Population	Rate	Count	Population	Rate	Count	Population	Rate	Count	Population	Rate	Count	Population	Rate
1	8,963	11.16	4	11,424	35.01	6	59,874	10.02	25	167,334	14.94	3	11,221	26.74

Rates are per 100,000

852	255	10,114	11,221

*These are the populations in other

Key Highlights and Comparisons

Racial and ethnic disparities in CDRT-reviewed child deaths persisted in Kern County in 2025. Black/African American children had a death rate of 35.01 per 100,000, the highest among the racial and ethnic groups reported. This rate was approximately 3.5 times higher than the rate among Caucasian children (10.02 per 100,000) and more than twice the rate among Hispanic children (14.94 per 100,000). These findings continue to highlight significant racial and ethnic disparities in child mortality and the need for continued efforts to identify and address the underlying factors contributing to these differences.

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

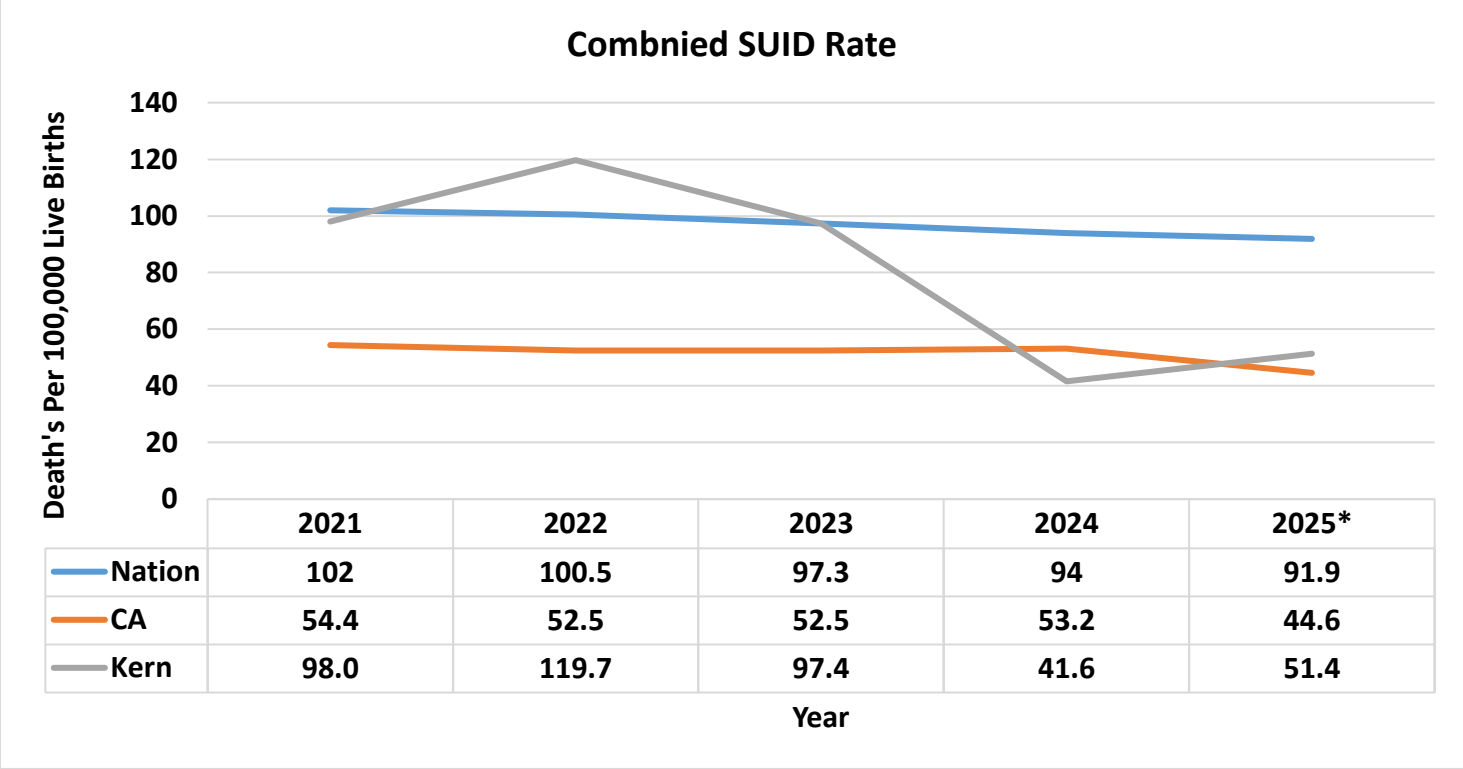
[10] The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020, 2008. Measuring Health Disparities and Health Equity, Phase I Report, Recommendations for the Framework and Format of Healthy People 2020. p.77. https://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf

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, 2022).

In 1990, nationally, the combined 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. From 2019 to 2023 the national average SUID rate was 95 deaths per 100,000 live births.

Kern County's SUID rate for 2021 to 2025 was 81.6 deaths per 100,000 live births. There were 60,795 live births in Kern County between 2021 to 2025. Kern County's SUID rate during that same period is 58.67% higher than California's SUID rate and 15.98% lower than the national rate during the same time frame. Kern's combined SUID rate increased 23.6% from 2024 to 2025.



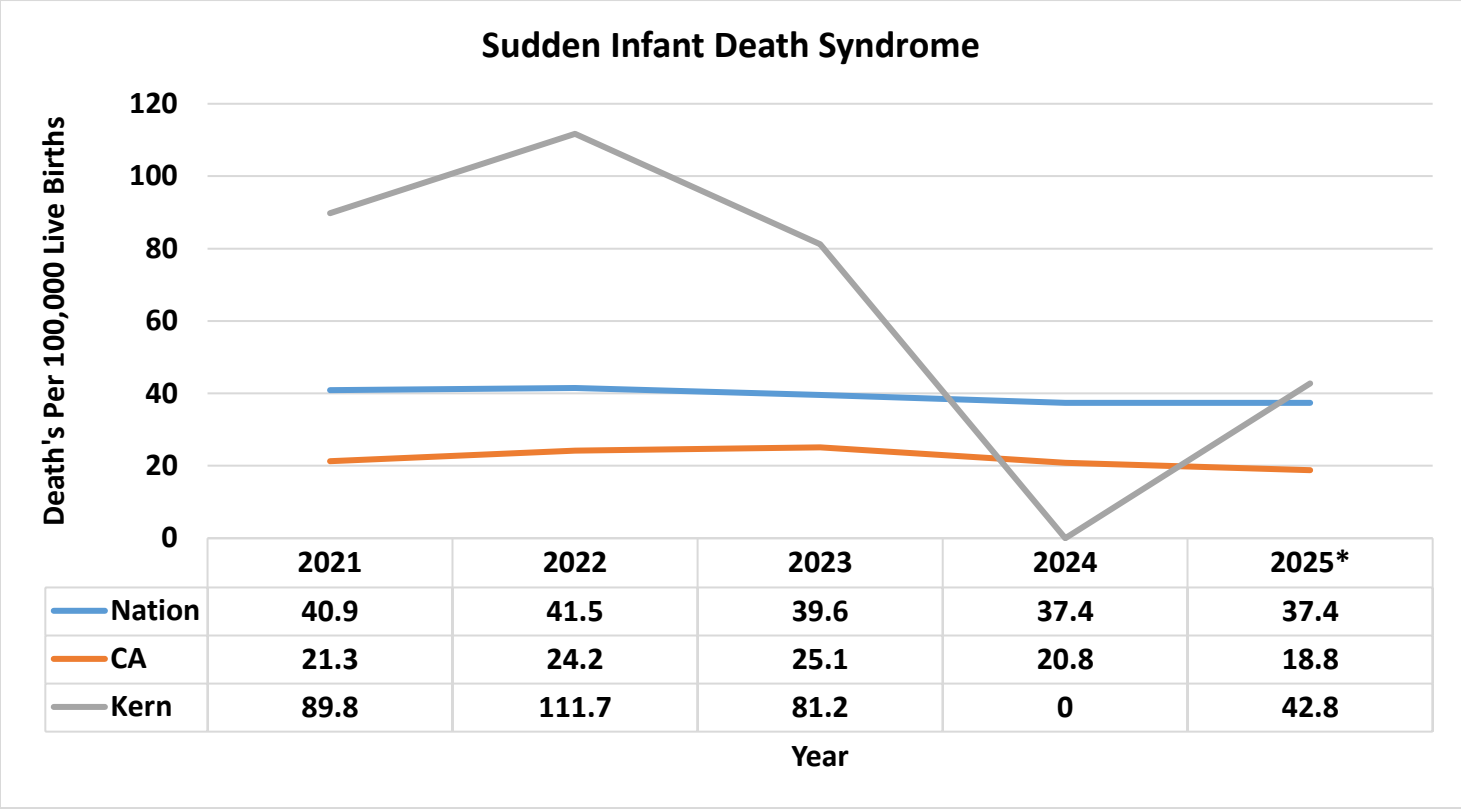
	2021	2022	2023	2024	2025*
Nation	102	100.5	97.3	94	91.9
CA	54.4	52.5	52.5	53.2	44.6
Kern	98.0	119.7	97.4	41.6	51.4

*2025 data is provisional

CDC, 2026 – 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. September 2026.

CDC WONDER – 7 Centers for Disease Control and Prevention. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome, Data and Statistics. https://wonder.cdc.gov/controller/datarequest/D159;jsessionid=BDDD808B13678AD45EDF7822CD5C September 2026.

The combined SUID rate, which includes sudden infant death syndrome, unknown cause, and accidental suffocation and strangulation in bed is further broken down as follows:

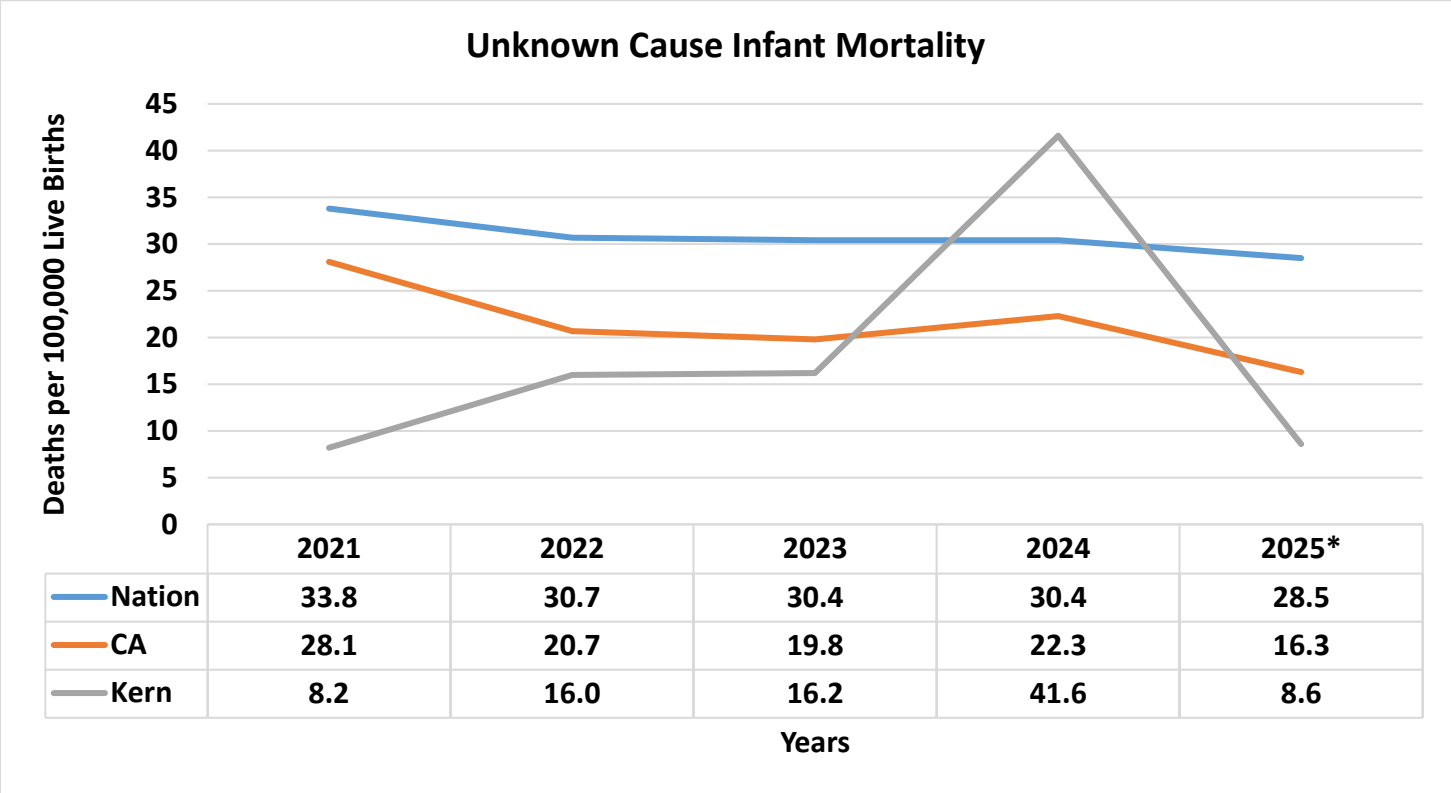


	2021	2022	2023	2024	2025*
Nation	40.9	41.5	39.6	37.4	37.4
CA	21.3	24.2	25.1	20.8	18.8
Kern	89.8	111.7	81.2	0	42.8

*2025 data is provisional

National sudden infant death syndrome (SIDS) rates declined considerably from 130.3 deaths per 100,000 live births in 1990 to an average of 39.4 deaths per 100,000 live births during the period of 2021 to 2025. Kern's SIDS rates averaged 65.1 deaths per 100,000 live births over the last 5 years, which was 195% higher than California and 65% higher than the national rate. While Kern's SIDS rate increased from 0 in 2024 to 42.8 in 2025, the five-year average SIDS rate in Kern County decreased by 18.8%.

CDC, 2026 – Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database http://wonder.cdc.gov/mcd-icd10-provisional.html

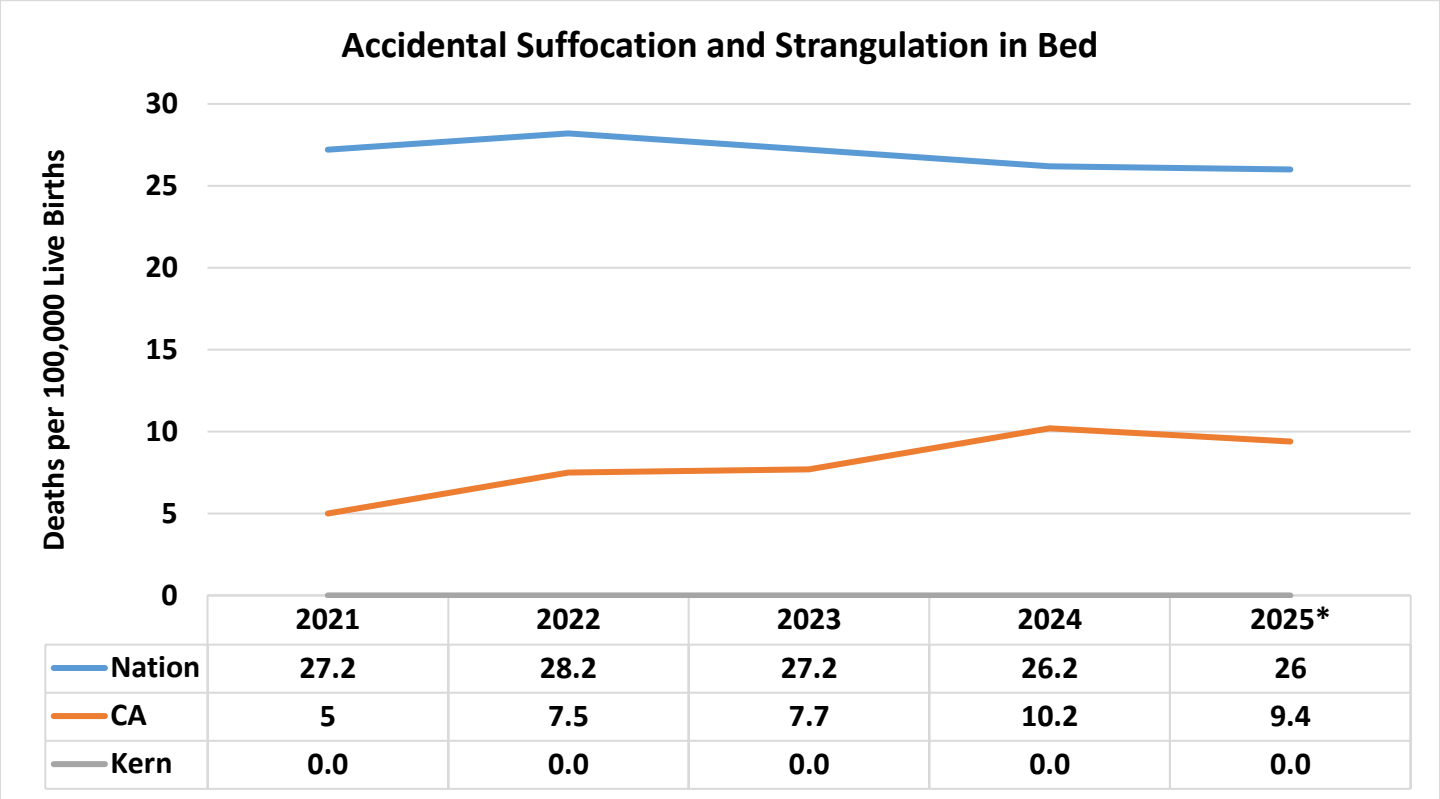


	2021	2022	2023	2024	2025*
Nation	33.8	30.7	30.4	30.4	28.5
CA	28.1	20.7	19.8	22.3	16.3
Kern	8.2	16.0	16.2	41.6	8.6

*2025 data is provisional

Unknown cause infant mortality rates remained unchanged from 1990 until 1998, when rates began to increase. From 2021 to 2025, the national average unknown cause mortality rate in infants was 30.8 deaths per 100,000 live births. Kern's average rate from 2021 to 2025 was 18.12 deaths per 100,000 live births. Kern saw a decrease of 79% from 2024 to 2025. The 5-year trends for Kern County remain lower than the State and national rates. From 2021 to 2025, California's 5-year average was 18% higher than Kern's average and the 5-year national average was 70% higher than Kern's. It is important to note that 2025 data is still provisional.

CDC, 2026 – Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database http://wonder.cdc.gov/mcd-icd10-provisional.html



	2021	2022	2023	2024	2025*
Nation	27.2	28.2	27.2	26.2	26
CA	5	7.5	7.7	10.2	9.4
Kern	0.0	0.0	0.0	0.0	0.0

*2025 data is provisional

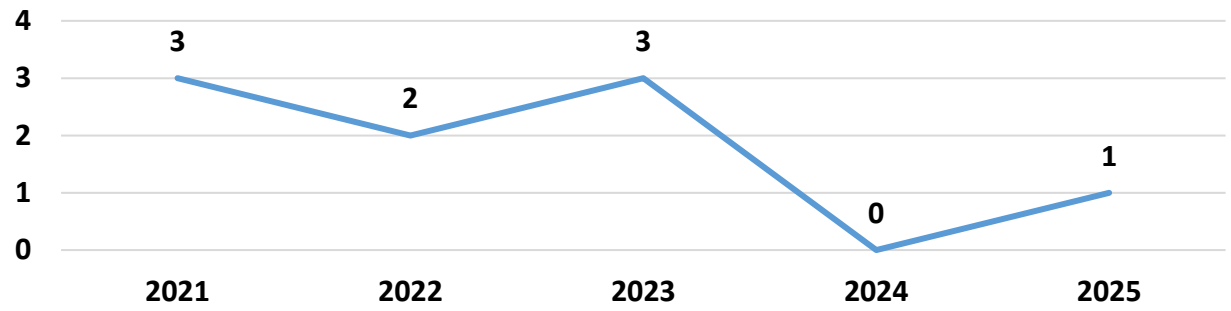
Accidental suffocation and strangulation in bed (ASSB) mortality rates remained unchanged until the late 1990s. Rates started to increase beginning in 1997 and reached the highest rate nationally at 28.2 deaths per 100,000 live births in 2022. From 2021 to 2025, the national average rate was 27 deaths per 100,000 live births. Kern County averaged 0 deaths per 100,000 live births during the same five-year period. 2025 data is provisional.

CDC, 2026 – Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database http://wonder.cdc.gov/mcd-icd10-provisional.html

Infant Deaths with Unsafe Sleep Environments 2021-2025

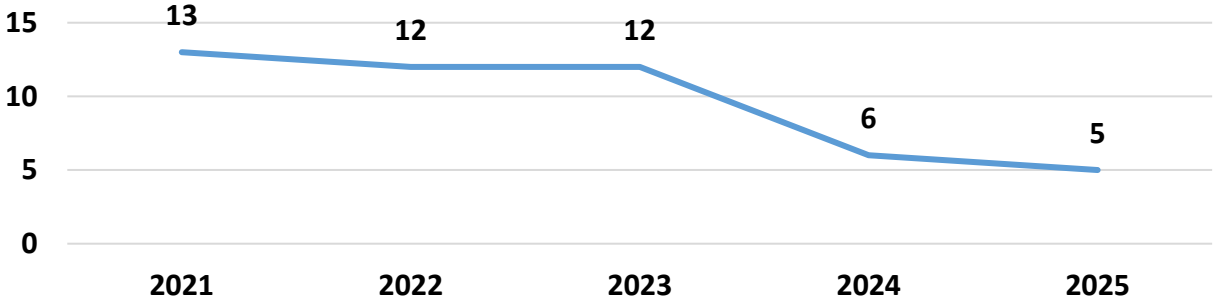
Infant Deaths with Unsafe Sleep Environments Identified by the Coroner* 2021-2025

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



Infant Deaths with Unsafe Sleep Environments Identified by the Coroner or an Unsafe Sleep Environment was Present* 2021-2025

*Includes all infant deaths identified by the Coroner as having an unsafe sleep environment as a contributing factor to cause death or where an unsafe sleep environment was present, but not found by the Coroner to be contributory to the death of the child.



Key Highlights and Comparisons

From 2021 to 2025, infant deaths related to unsafe sleep environments in Kern County averaged 9.2 deaths per year. During this five-year period, Kern County saw a high of 13 deaths in 2021, but has seen a steady decline since. Specifically, 2021 had 13 deaths and 2025 had 5 deaths with an unsafe sleep environment present. One infant death related where unsafe sleep environments was identified by the Coroner as a contributing cause of death in 2025. Unsafe sleep environments still pose risks that require continued awareness and prevention efforts in Kern County.

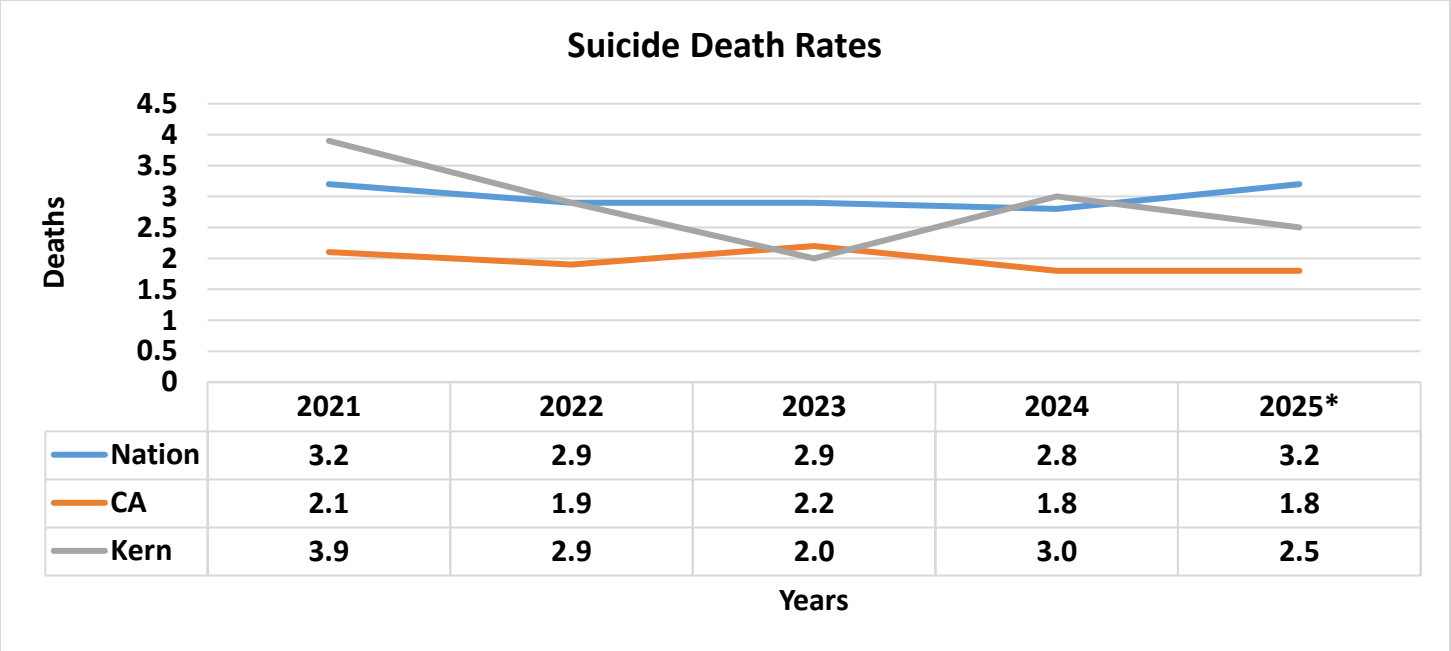
Community partners have worked to provide pack-n-plays and safe sleep education to parents and guardians. Several programs have been developed and are currently providing pack-n-plays:

- Kern County Public Health – Safer Sleeping Education Project
- Safe Sleep Coalition, in collaboration with Kern Literacy Council and First 5 Kern - provide safe sleep books to area hospitals and community partners for new parents.
- Safe Kids Kern

Suicide

Suicide is death caused by injuring oneself with the intent to die. According to the Centers for Disease Control and Prevention, suicide is connected to other forms of injury and violence, as people who have experienced violence, including child abuse, bullying or sexual violence have a higher suicide rate.

Suicide was the second leading cause of death for people ages 10-14 nationwide.



	2021	2022	2023	2024	2025*
Nation	3.2	2.9	2.9	2.8	3.2
CA	2.1	1.9	2.2	1.8	1.8
Kern	3.9	2.9	2.0	3.0	2.5

*2025 data is provisional

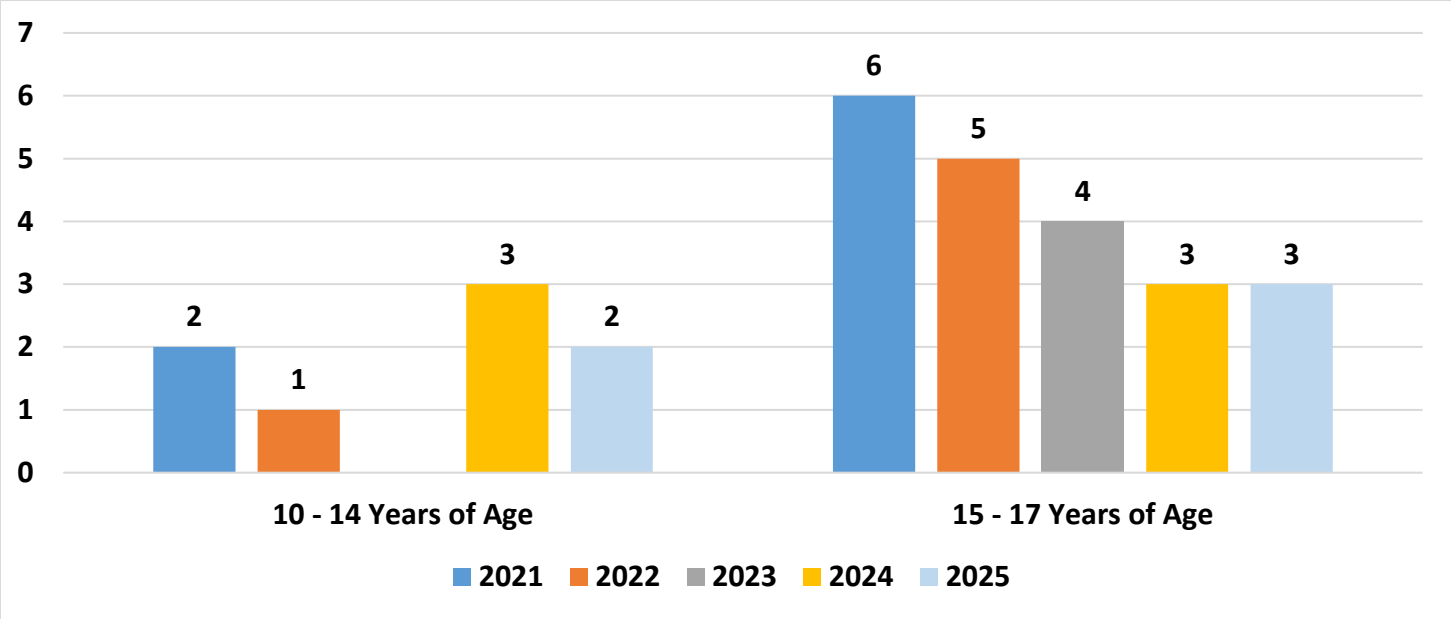
From 2021 to 2025, the average suicide rate among youth aged 5 to 17 years was:

- 3.0 per 100,000 nationwide
- 2.0 per 100,000 in California
- 2.9 per 100,000 in Kern County

Kern County's 5-year average rate was 45% higher than the state average and 3.3% lower than the national average during this five-year period. However, in 2025, Kern County's suicide rate fell below the national average, indicating a positive trend.

CDC, 2026 – Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database http://wonder.cdc.gov/mcd-icd10-provisional.html

Five-Year Childhood Suicide Review by Age in Kern County, 2021 – 2025



For 0-9 years of age there were 0 suicide deaths.

Key Highlights and Comparisons

Between 2021 and 2025, the majority of child suicides in Kern County occurred among youth aged 15 to 17, accounting for twenty-one (21) of the twenty-nine (29) total deaths. Among children aged 10 to 14, there were a total of three (3) suicide deaths from 2021–2023. This increased to three (3) deaths in 2024 and two (2) deaths in 2025. While the number of deaths decreased slightly from 2024 to 2025, the continued occurrence of suicide deaths in this age group represents a concerning pattern and a notable increase compared with the 2021–2023 period.

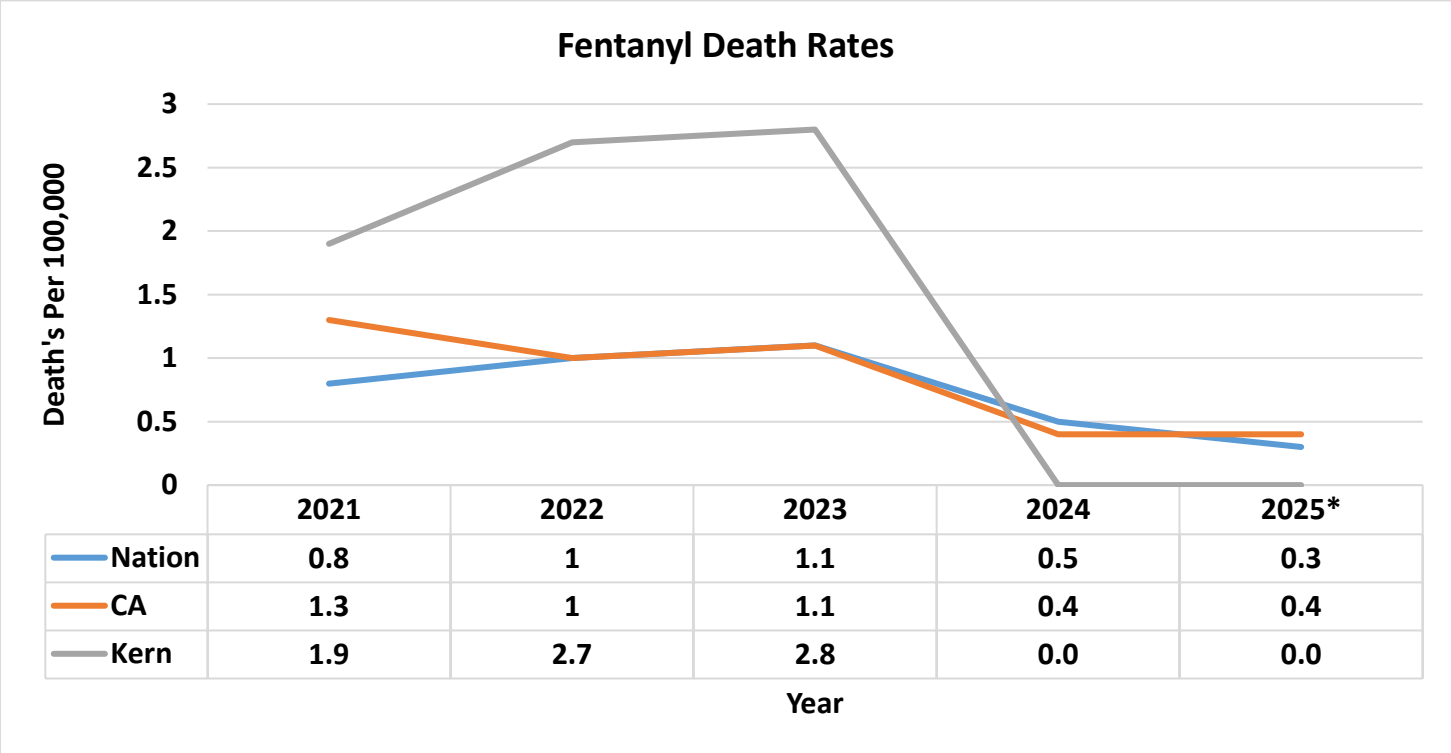
Five-Year Childhood Suicide Review by Method in Kern County 2021– 2025

10 - 14 Years of Age	2021	2022	2023	2024	2025
Asphyxia	2			2	2
Overdose		1		1	
15 - 17 Years of Age					
Asphyxia	4	4	3	1	
Gunshot Wound of Head	2		1	1	1
Thermal Burns		1			1
Blunt Force Trauma				1	
Overdose					1

Key Highlights and Comparisons

Asphyxia, which includes hanging and smothering, is the most used method of suicide for adolescents in Kern County. Over the past 5 years, asphyxia accounted for 18 or 62% of the 29 total suicide deaths.

Fentanyl



	2021	2022	2023	2024	2025*
Nation	0.8	1	1.1	0.5	0.3
CA	1.3	1	1.1	0.4	0.4
Kern	1.9	2.7	2.8	0.0	0.0

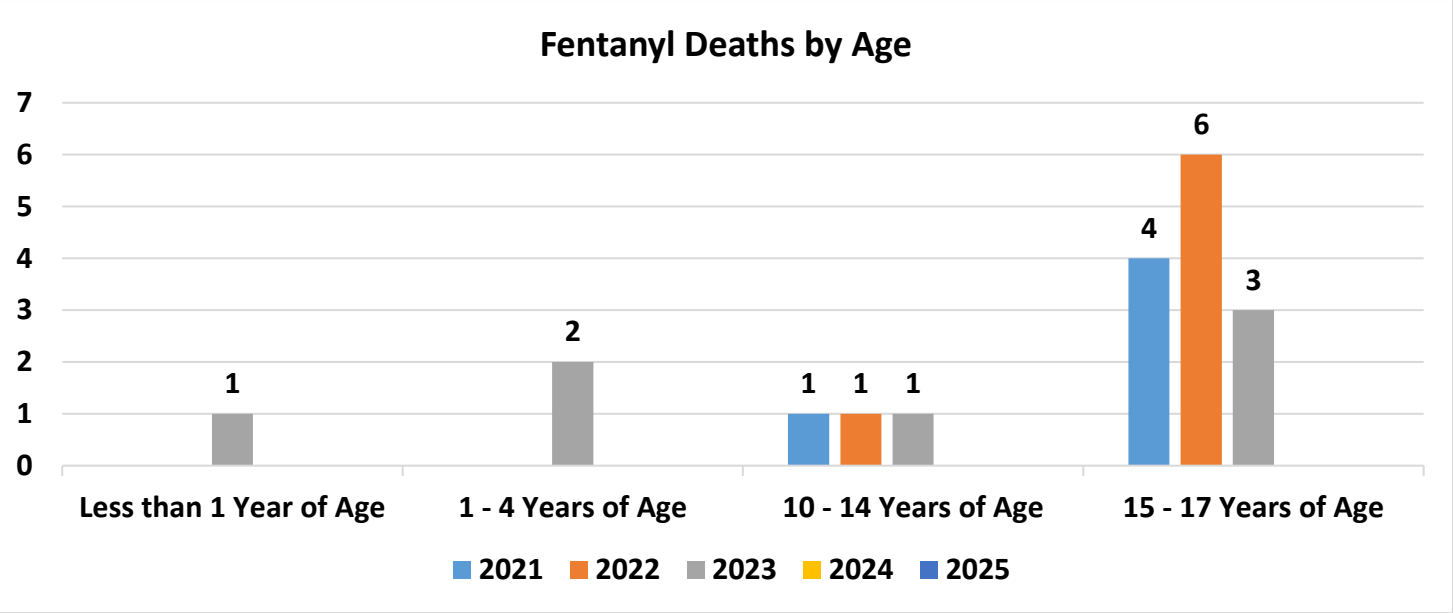
*2025 data is provisional

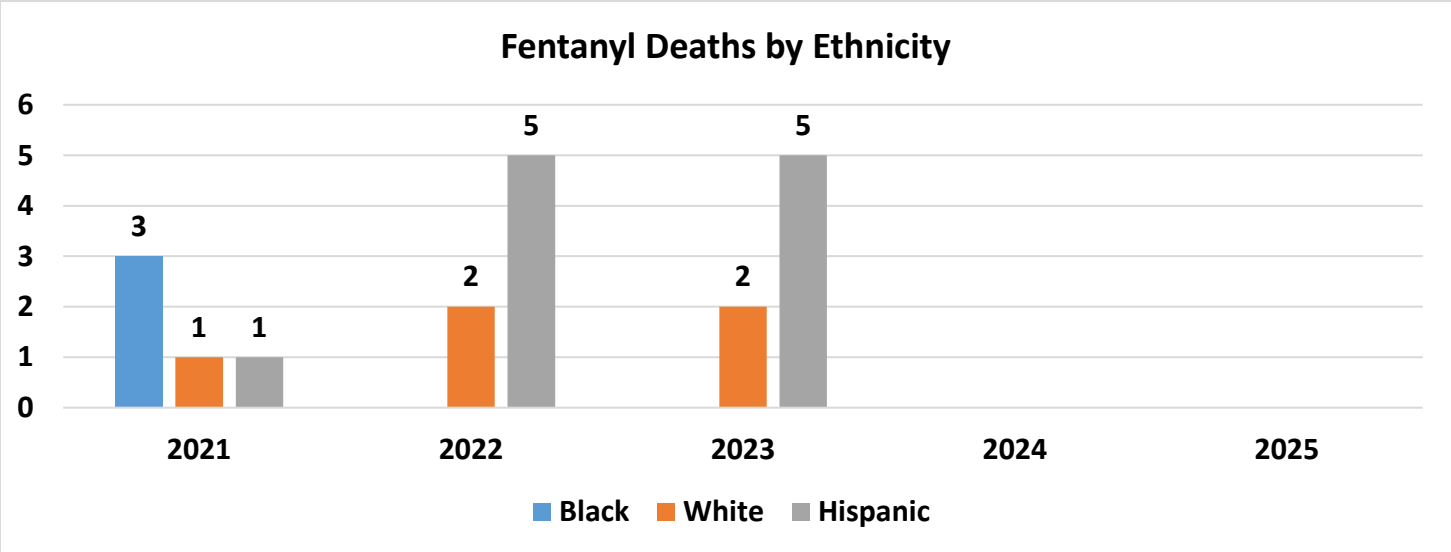
From 2021 to 2025, the average fentanyl-related death rate nationwide was 0.74 deaths per 100,000 population. During the same period, California's average rate was slightly higher at 0.84 deaths per 100,000.

Kern County experienced a notably higher fentanyl-related death rate of 1.48 deaths per 100,000 population. Kern's rate was consistently higher than both California and the nation from 2021–2023. However, the rate dropped to 0.0 in both 2024 and 2025, marking no fentanyl-related deaths among children in 2024 and 2025.

CDC, 2026 – Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Provisional Mortality on CDC WONDER Online Database Provisional Mortality Statistics, 2018 through Last Week Results Form (cdc.gov)

Five-Year Childhood Fentanyl Review by Age and Ethnicity in Kern County, 2021 – 2025





Key Highlights and Comparisons

Fentanyl-related deaths among children in Kern County increased by 40% from 2021 to 2022 and remained at seven (7) deaths in 2023. A notable improvement was observed in 2024, when no child fentanyl-related deaths were reported. This improvement continued in 2025, with no child fentanyl-related deaths reported for the second consecutive year. The continued absence of reported child fentanyl-related deaths in 2024 and 2025 is an encouraging public health outcome.

The 15-to-17-year age group accounted for the highest number of fentanyl-related deaths during this five-year period, totaling sixteen (16) deaths. Among demographic groups, Hispanic individuals were most affected, experiencing a 400% increase in fentanyl-related deaths from 2021 to 2022, with rates stabilizing in 2023 and diminishing in 2024 and 2025.

Current Successful Kern County Programs Aimed at Reducing Preventable Childhood Deaths

Black Infant Maternal Health Initiative – Formed in February of 2021 from a Kern County Public Health and First 5 Kern collaboration, this initiative was created to address disparities in health outcomes in Kern County Black women, babies and children. Local government organizations, community-based groups, faith-based organizations, non-profits and community members come together to conduct focus groups and education healthcare providers to improve the health of Kern County's Black mothers and children.

Black Infant Health – A free, voluntary, evidence-based program aimed to improve health among African American mothers and babies 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 – A voluntary, 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.

Sudden Infant Death Syndrome (SIDS) Program – The SIDS Coordinator must contact the parent or guardian within three days after Coroner's notification of a SIDS-related death and provide bereavement services and linkage to bereavement resources. A completed report associated with the case is 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 under 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 and support staff provide 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-n-play and maintenance of safer sleeping practices.



Safe Sleep Coalition – Formed in March 2017, the coalition of organizations and hospitals from around Kern County work together to create a universal safe sleep message and provide education and prevention opportunities. Many organizations involved in the coalition work to provide safe sleep environments to families in need. The Safe Sleep Coalition meets bi-monthly.

Cribs for Kids designated Bakersfield Memorial Hospital as Safe Sleep Certified, Gold Status – The hospital is only one of three hospitals in California with Gold Status Safe Sleep Certified. 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.

Safe Kids Kern – This coalition started in August 2023 with the partnership of Safe Kids Worldwide campaign. The primary purpose is to keep kids safe from preventable injuries, including motor vehicle injuries, pedestrian safety, drownings, poisonings, and suffocations, by collaborating with community partners to educate children, parents, and caregivers through a multifaceted approach to childhood injury prevention. Injury topics will be addressed through the following:

- **Child Passenger Safety Education Program (AKA Car Seat Program)** – This program stresses the importance of having a car seat for your child 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 will be available to show how to properly install the child's car seat and answer any questions.
- **Water Watchers –** The program designates a Water Watcher which 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 Kern County Public Health.

Kern County Child Abuse Prevention Council – Kern County Network for Children (KCNC) was designated by the Kern County Board of Supervisors as Kern's Child Abuse Prevention Council on October 27, 2009. KCNC fulfills the following required roles and activities for Child Abuse Prevention Councils (CAPC) by:

- Providing a forum for interagency cooperation and coordination in the prevention, detection, treatment, and legal processing of child abuse cases;
- Promoting public awareness of the abuse and neglect of children and the resources available for intervention and treatment;
- Encouraging and facilitating training of professionals in the detection, treatment, and prevention of child abuse and neglect;
- Recommending improvements in services to families and victims; and
- Encouraging and facilitating community support for child abuse and neglect programs.

Kern Behavioral Health and Recovery Services (KernBHRS) offers several programs in suicide prevention. KernBHRS recognizes that the key to prevention is to ensure that those who care for our youth, parents, teachers, probation officers, social workers, 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.
- **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** – Provides support through community resource fairs and suicide prevention/awareness presentations for our local college campuses, high/middle schools, and other community partners.
- **Community and School-Based 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, Kern County Probation, Kern County Department of Human Services (DHS) and other community partners to ensure they have the knowledge to access help for a family, when needed.
- **Access to Care Hotline** – In 2025, Crisis Hotline/988 received 1,486calls/chats/texts from youth 15 years and under and 3,431 calls/chats/texts from 16-25-year-olds (Transitional Age Youth TAY). Help seekers are supported through emotional crises and suicidal thoughts/behaviors with coping skills, follow up contacts, and linkage to behavior health treatment when appropriate. Hotline crisis counselors collaborate with callers in creating safety plans that include identifying warning signs, coping strategies, and community resources.
- **Future Focused** – This program provides screening and linkage to the juvenile justice population and their families as they are returning to community.

KernBHRS offers programs for those in acute crisis:

- **Mobile Evaluation Team** – KernBHRS provides 24/7 Mobile Crisis Response services to the community, accessible through our 988 Hotline. In addition, the Mobile Evaluation Team (MET) is dispatched by law enforcement when a behavioral health crisis is identified in the community through a 911 call. MET and Mobile Crisis Response provides crisis intervention, voluntary and involuntary assessment for psychiatric hospitalization, and follow-up in the community. In addition, the team has several specialized sub-

programs aimed at enhancing various collaborations to support behavioral health crises in collaboration with local law enforcement.

- **Crisis Stabilization Units** – The Psychiatric Evaluation Center/Crisis Stabilization Unit (PEC/CSU) and Telecare Ridgecrest CSU operate around the clock, offering vital Behavioral Health Crisis services. Their primary mission is to deliver assessment, crisis intervention, and treatment in the least restrictive environment while ensuring the individuals safety through secure, locked units. As LPS designated facilities, both CSUs cater to involuntary psychiatric evaluations for non-emergency medical services in Kern County, serving both minors and adults. These units strive to address acute crises within a few hours, facilitating connections to appropriate behavioral health care levels and ensuring follow-up care and necessary community resources.

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

Kern County CDRT 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 with a safe place to sleep upon discharge home from the hospital.**
    a. Perinatal care providers and hospitals will provide continuous training and education on safe sleep, as well as patient education tools that can be administered easily and effectively, without overburdening the healthcare providers.
    b. All delivering Kern County hospitals will develop an infant safe sleep policy that incorporates the American Academy of Pediatrics recommendations. The policy should include regular training of staff, 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 family that needs a safe place for their baby to sleep upon discharge.
    c. Use communication measures as an effective route to reach community residents including collaborating with local news stations who are interested in spreading awareness.
    d. Kern County Network for Children will continue to sponsor a robust Safe Sleeping Awareness Month campaign held annually in October. The campaign shall include 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 Kern County Public Health in which high-risk families, as well as home childcare providers, receive SIDS prevention education and a voucher for a safe-sleep crib and are followed up to assess compliance. CDRT has directly supported this effort by using CCFSS 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. Annually facilitate the Safe Baby, Safe Child Conference for healthcare and daycare providers in Kern County, ensuring awareness and invitations be distributed widely throughout the county. A main topic of the conference every year should focus on safe sleep information and training.
    h. Promotion of safe infant sleep practices in 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. Create programs to gain the trust of this population to help reduce the child death rate found in the population.
    j. Promote consistent safe sleep messaging across healthcare, public health, childcare, and community settings to help reduce sleep-related infant deaths.
        i. Develop a standardized countywide safe sleep education package.
        ii. Distribute consistent educational materials to healthcare providers and community partners.
        iii. Identify and address conflicting safe sleep practices or messaging across settings.
    k. Provide safe sleep education during pregnancy and reinforce key practices after birth to help families establish safe sleep environments from the start.

i. Collaborate with healthcare providers and community partners to expand safe sleep education during pregnancy.
ii. Integrate safe sleep education into prenatal classes and existing maternal and child health programs.
iii. Reinforce safe sleep practices through home visits, newborn follow-up appointments, and other early postnatal contacts.

2. **Decrease the incidence of child suicide through supporting efforts that raise community awareness, convey strategies for identifying signs of self-harm, and develop resources for those at risk of suicide.**
    a. Kern Behavioral Health and Recovery Services will continue to provide outreach to schools, DHS, Probation, and other child serving partners 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 will continue to offer crisis care and follow the Zero Suicide model.
    c. Kern County Public Health will refer instances of self-harm identified through emergency medical intervention to KernBHRS for trauma informed crisis care to family and youth including connection to ongoing treatment and support.
    d. Faith-based organizations offering adolescent support services will incorporate education on coping and suicide prevention.
    e. Increase healthcare provider awareness and knowledge 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.
    f. 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.
    g. Support community efforts that promote and provide training on mental health first aid.
    h. Develop a youth- and family-focused mental health and suicide prevention campaign that reduces stigma, normalizes conversations about emotional distress and suicide, and promotes help-seeking through youth-friendly messaging and communication channels, including social media and other platforms commonly used by young people. Engage parents and caregivers, frame behavioral health as a community and public health priority, and address cultural and religious stigma that may prevent families from seeking support.

3. **Reduce childhood drowning deaths by increasing community awareness of water safety and the potential drowning dangers of pools, the Kern River, and other bodies of water.**
    a. Continue community outreach and promotion of the "Water Watchers" campaign through Kern County Public Health.
    b. Increase efforts for pediatrician offices to promote "Water Watchers" along with water safety education for parents of young children.
    c. Educate parents and caregivers of children about the importance of children possessing basic swimming skills necessary to recover from falling into a body of water.
    d. Educate parents and caregivers of children about the importance of receiving hands-only CPR training.
    e. Reinforce the need of caregivers to watch small children in and around all sources of water, including bathtubs and buckets.

f. Dedicate more outreach and education to zip codes with more prevalent drowning incidences.

4. **Increase all Kern County community agencies' 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.
    c. Provide child abuse and neglect awareness and prevention information, training announcements, and community resource information emails sent at least monthly to more than 2,000 community members and service providers throughout Kern County.
    d. Hold monthly collaborative meetings with local service providers and community meetings providing presentations targeted at child abuse and neglect awareness and prevention.
    e. Hold monthly training for service providers and community members related to issues that children and families at risk of experiencing child abuse and neglect struggle with, mandated reporter training, and strategies available to help strengthen families.
    f. Continue to provide Kern County Network for Children's Differential Response (DR) countywide. DR is an effective research-based approach that allows Child Protective Services to respond differently to accepted reports of child abuse and neglect, based on such factors as the type and severity of the alleged maltreatment, number and sources of previous reports, and willingness of the family to participate in services. DR expands the ability of Child Protective Services by assisting families at the first signs of trouble.
    g. Kern County Public Health will enhance the County pre-hospital emergency medical services electronic patient care reporting system to include questions leading to the identification of suspected child abuse and or neglect. Training and ongoing usage of this form will help emergency response personnel to identify safety concerns for at-risk children.

5. **The Safe Kids Kern Coalition will help agencies increase awareness of motor vehicle and pedestrian safety among adolescents.**
    a. 1. Strengthen enforcement and accountability for unsafe driving by collaborating with law enforcement agencies to reduce speeding, reckless, impaired, and distracted driving to help prevent fatal crashes.
        i. Establish annual collaboration with law enforcement agencies to address traffic safety concerns.
        ii. Prioritize enforcement in school zones during drop-off and pick-up times, focusing on speeding and failure to yield or stop for pedestrians.
        iii. Conduct walk audits with law enforcement in locations with documented speeding or other traffic safety concerns.
        iv. Strengthen partnerships with law enforcement to refer families with child passenger safety violations to Kern County Public Health's Car Seat Check Program for education and assistance.

b. Identify areas with high rates of pedestrian injuries and fatalities and collaborate with relevant agencies and community partners to address infrastructure concerns and identify solutions to improve pedestrian safety.
c. Increase car seat technician education training to include car seat check-up events, providing the community with resources.
d. Provide education for community members to be educated on the importance of passenger safety and demonstrate the correct way to install car seats. Provide and promote information on the locations of certified car seat technicians who can educate parents and caregivers on how to properly install car seats.
e. Provide education on California driving laws to all families that obtain car seat education/check-ups.

6. **Significantly increase community awareness and education regarding the dangers of fentanyl and the importance of the usage and availability of Narcan.**
    a. Ensure that Narcan is universally available, especially in situations where individuals know they or others will be using substances.
    b. Promote awareness of community sites that offer Narcan.
    c. Increase community Narcan training to reduce overdose deaths.
    d. Increase awareness on the Good Samaritan law for bystanders to call 911, even if individuals were using substances themselves.
    e. Promote awareness to properly dispose of expired and unused medications.
    f. Equip staff who provide services in the field and/or interact with the public with Narcan.
    g. Implement a multi-disciplinary fentanyl taskforce in Kern County.

Online Resources

Website	Description
Bicycle Safety	
Bicycle Safety: Bike Safety Tips for Kids and Adults | NHTSA	National Highway Traffic Safety Administration Bike Safety
Bike | Safe Kids Worldwide	Safe Kids Bicycle Safety
Child Abuse	
National Center on Shaken Baby Syndrome - Home (dontshake.org)	National Center on Shaken Baby Syndrome, support and education
Child Abuse Prevention | Kern County Network for Children	Kern County Child Abuse Prevention Council Community Resources
Domestic Violence	
Domestic Violence Resources | Kern County, CA - Department of Human Services (kcdhs.org)	Kern County Department of Human Services Domestic Violence Resources
Child Abuse Mandated Reporter Training (mandatedreporterca.com)	California Child Abuse Mandated Reporter Training
Domestic Violence Support | The National Domestic Violence Hotline (thehotline.org)	National Domestic Violence Hotline
Family Justice Center | Kern County, CA	Kern County District Attorney's Family Justice Center
Car / Pedestrian Safety	
Car Seat Safety - Kern County Public Health (kernpublichealth.com)	Car Seat facts, tips, and safety
Child Safety Seats (ca.gov)	California Highway Patrol - Child Safety Seats
Youth Programs and Services (ca.gov)	California Highway Patrol - Youth Programs and Services
Pedestrian Safety: Prevent Pedestrian Crashes | NHTSA	National Highway Traffic Safety Administration Pedestrian Safety
Home | KidsandCars.org	How kids get hurt in and around cars, resources
https://www.safekids.org	Videos and activities for in and around the car
Fentanyl Education / Narcan Resources	
NARCAN-2023.pdf (kerncountylibrary.org)	Kern County Library Narcan Flier
Naloxone Distribution Project | Behavioral Health & Recovery Services (kernbhrs.org)	Narcan FAQs, How to Obtain Narcan and Narcan training
Narcan - Kern County Public Health (kernpublichealth.com)	Narcan Resources
OPI Landing Page (ca.gov)	CDPH Overdose Prevention Initiative

Safe Infant Sleeping Resources	
Sleep Safety and Suffocation | Safe Kids Worldwide	Videos and activities for sleep safety
Safe to Sleep® - Publications | NICHD - Eunice Kennedy Shriver National Institute of Child Health and Human Development (nih.gov)	Safe to Sleep Pub Ed Campaign led by NIH
First Candle: Committed to ending Sudden Infant Death Syndrome (SIDS)	First Candle organization, education for caregivers and families

Suicide-Youth	
Youth at Risk - Centre for Suicide Prevention (suicideinfo.ca)	Centre for Suicide Prevention, Youth at Risk Guide
Kern Behavioral Health & Recovery Services (kernbhrs.org)	Crisis intervention/suicide prevention
The Trevor Project | For Young LGBTQ Lives	Support for LGBTQ young people
Water Safety	
Pool Safely	National public education campaign to reduce child drownings
Water Watchers - Kern County Public Health (kernpublichealth.com)	Drowning prevention website, water play supervision