Santa Barbara County

Child Death Review Team (CDRT)

January 2015 – December 2016

Acknowledgements

The Santa Barbara Child Death Review Team (CDRT) is made possible by the members themselves and the agencies that commit their time to this endeavor. Sincere appreciation and gratitude goes to the members who participated in the 2015-2016 reviews. This report was compiled, organized and prepared by Ellen Willis-Conger. The data was prepared by Michelle Wehmer. The dedicated efforts of all past and current team members are sincerely appreciated.

Active Members 2015-2016 include:

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Abernathy, Amelia	Marian Regional Medical Center
Barragan, Kelley	SB County PHD/ MCAH and SIDS Coordinator
Cabaungan, Lachelle	Marian Regional Medical Center
Copley, Sandra	SB County PHD/MCAH Program Director
Dudley, Joyce	SB County District Attorney
Finch, Barbara	DSS, Children and Adult Network Director
Grossini, Jason	Sheriff Coroner, Coroner's Bureau
Holmes, Deborah	CALM, Associate Director
Jakowchik, Christopher	Marian Regional Medical Center, NICU Manager
Lord, Susan	Santa Barbara County Victim Witness Program
Lossing, Noel	DSS Division Chief Child Welfare Services
Montez, Manny	SB County Sheriff Coroner Medical Pathologist
Orgeala, Olga	Marian Regional Medical Center
Penzes, Kathleen	Marian Regional Medical Center
Richard, Mary	Marian Regional Medical Center
Robledo, Sal	Cottage Health System, MSW, LCSW
Sewell, Christine	Marian Regional Medical Center
Simon, Jennie	SB County RN, PHD Emergency Medical Services
Stone, Michelle	Marian Regional Medical Center
Torres, Christine	SB County PHN- Child Welfare Services
Tran, Ed	SB County PHD/MCAH Program Director
Wehmer, Michelle	SB County PHD Epidemiologist
Willis-Conger, Ellen	SBC PHD Assistant Deputy Director, Community Health, CDRT Coordinator

CDRT Purpose and Goals

The Child Death Review Team (CDRT) is a county-wide interagency taskforce with the purpose of preventing childhood fatalities through comprehensive and multidisciplinary assessment of child deaths. The local CDRT goals are:

- To identify and review preventable deaths of children under the age of 18 years old with contributing factors that may be the result of child abuse or neglect and require further investigation
- To identify public health related factors and make recommendations to prevent future deaths
- To share data and other information necessary that establish accurate information on the nature and extent of child abuse and neglect fatalities in California

Team Membership

The Santa Barbara CDRT reviews and evaluates selected deaths of children, under the age of 18 years old that are reported via the Santa Barbara County Vital Statistics Office and the Sheriff-Coroner's office. A multi-disciplinary review of child deaths is intended to produce a comprehensive review of each child's death to identify factors that might prevent future deaths. Our local CDRT consists of members from the Public Health Department, Maternal, Child & Adolescent Health (MCAH), and Emergency Medical Services (EMS). Other members include representatives from the Sheriff-Coroner's office, Law Enforcement, Child Welfare Services, Hospital Social Services, District Attorney, Child Abuse Listening & Mediation (CALM) and Child Abuse Prevention Counsel, Marian Reginal Medical Center Trauma, and SB County Dignity Health.

Case Selection

The CDRT Coordinator receives information about child deaths from two sources, the Coroner's Office and the Vital Statistics Office. Immediate consultation is initiated and referrals are made to Child Welfare Services if there are other children who are at risk or if there is a need for supportive services for the family. The coordinator receives information from the Vital Statistics Office quarterly or as needed on all children who have died in Santa Barbara County. A limited number of cases are chosen for review. Cases are selected for review that may provide insights into how similar deaths can be prevented in the future. Cases chosen for review can include deaths where the cause is homicide, Sudden Infant Death Syndrome (SIDS), undetermined causes, and accidents. The CDRT Coordinator obtains the Sheriff-Coroner's reports when these reports are available. A list of cases for review is sent, in advance, to key team members (Child Welfare, MCAH nursing staff, Trauma System Coordinator, Sheriff) to allow time to search case files for additional information on the child and his/her family so that all relevant notes on family interactions with the family may be included in CDRT discussion.

If a case is still under investigation by Law Enforcement, the CDRT does not review the case.

The Case Review Process at the CDRT meeting includes a summary of reports for each child, from the various agencies. The committee determines if there were three conditions that classify the case as child abuse or neglect for purposes of State reporting.

1. Was there causal link? (Was there an act of commission or omission that caused or substantially contributed to the death?)
2. Was the person a caregiver? (At the time of the treatment, was the person in a primary or temporary custodial role?)
3. Was the risk of harm established? (Consider the risk of harm and social context to determine if the death should be called maltreatment.)

The classification of child abuse or neglect for State reporting has different criteria and a different purpose than those of other agencies (e.g. coroner, law enforcement, child welfare), that may use the same terms of abuse and neglect and may not match findings of other agencies.

If the team is unable to answer the three conditions for child abuse and neglect due to insufficient information and child abuse is suspected, the team may choose to recommend further law enforcement investigation. The multi-disciplinary team discussion may result in new information which can prompt this request.

The team will then determine if this child death could be preventable and if anything can be done to prevent future deaths of a similar nature. Specific actions may be recommended to prevent future deaths.

Fatal Child Abuse and Neglect Surveillance Program (FCANS)

The Santa Barbara County CDRT participates in FCANS though the Epidemiology and Prevention for Injury Control (EPIC) Branch at the California Department of Health Services (DHS). FCANS provides a comprehensive picture of child abuse deaths across the state of California. The FCANS program was designed as an active surveillance system for child maltreatment deaths based on local CDRTs completion and submission of standard data collection.

Santa Barbara County Child Resident Deaths Causes of Death of Children (Under the age of 18)

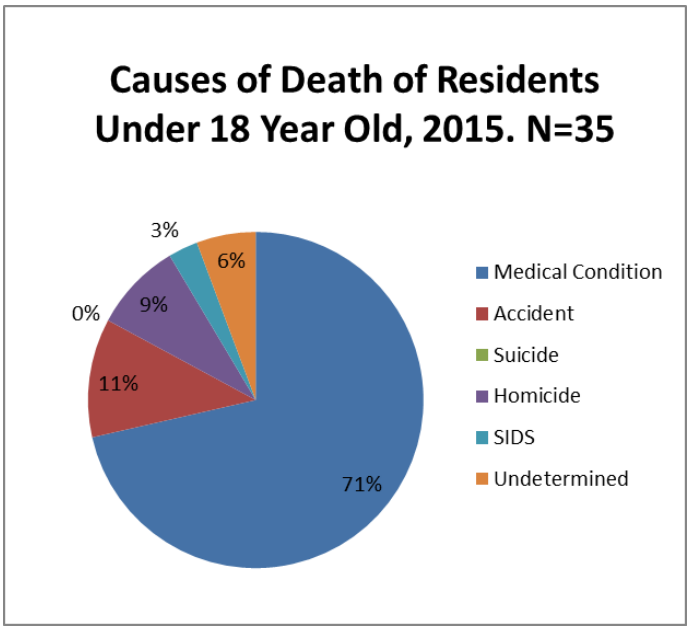
	Medical Condition	Accident	Suicide	Homicide	SIDS	Undetermined	Total Deaths
2015	25	4	0	3	1	2	35
2016	20	1	2	3	0	3	29
Total Deaths by Cause	45	5	2	6	1	5	64

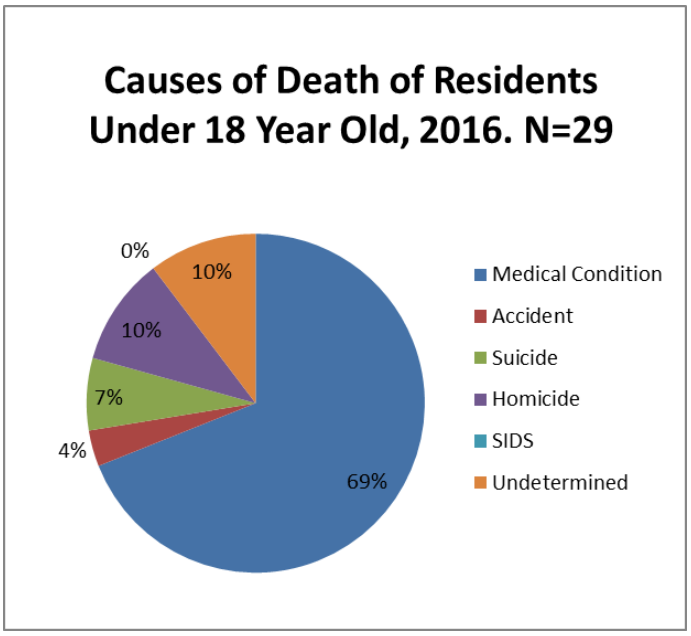
Key points:

- Between 2015 and 2016, the number of children who died ranged from 35-29 per year (January - December).
- The majority of child deaths in both years were due to medical conditions or unpreventable disease. In 2015, 71.4% (25/35) of all deaths were due to medical conditions; 2016, 69.0% (20/29) of all deaths were due to medical conditions.
- Over the past 2 years, 18 (42.9%) of the 42 deaths of children under the age of 1, were due in some part, to prematurity.
- Accidents encompassed a variety of incident types such as motor vehicle accidents and asphyxiation.
- Parents co-sleeping with young children or maternal overlying were factors in 5 of the accidental and undetermined deaths.
- Current data shows that between January 2015 and December 2016, of the cases reviewed, 8 had families that MCAH PHN home visit services after the death of the child. The visits were for presumed Sudden Infant Death Syndrome or Undetermined death of an infant less than one year of age.

Recurring concerns and of the CDRT from previous (2012-2014) reports include:

- Parental co-sleeping and child death due to possible asphyxiation.
- Parent education for sleeping practices to prevent SIDS/undetermined infant death.
- Continued education for Emergency responders and LE on the collection of evidence in case nvolving infants-to verify child sleeping positions and possible exposure to toxic drugs.



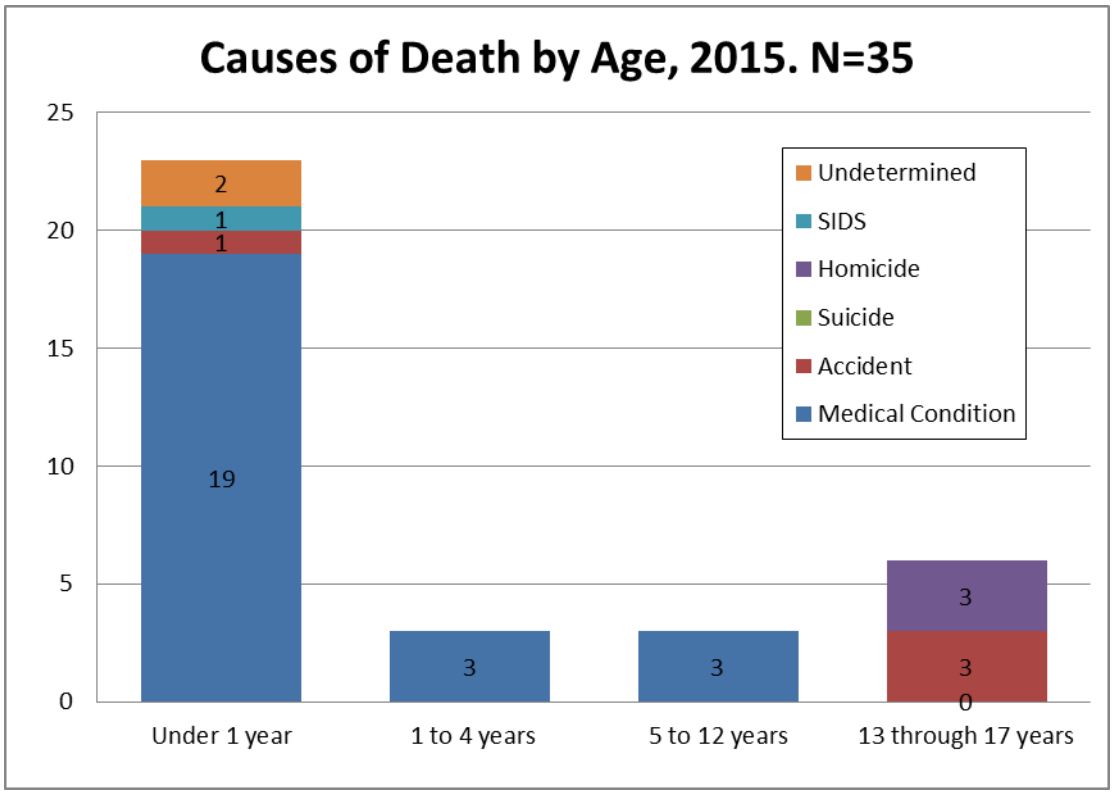


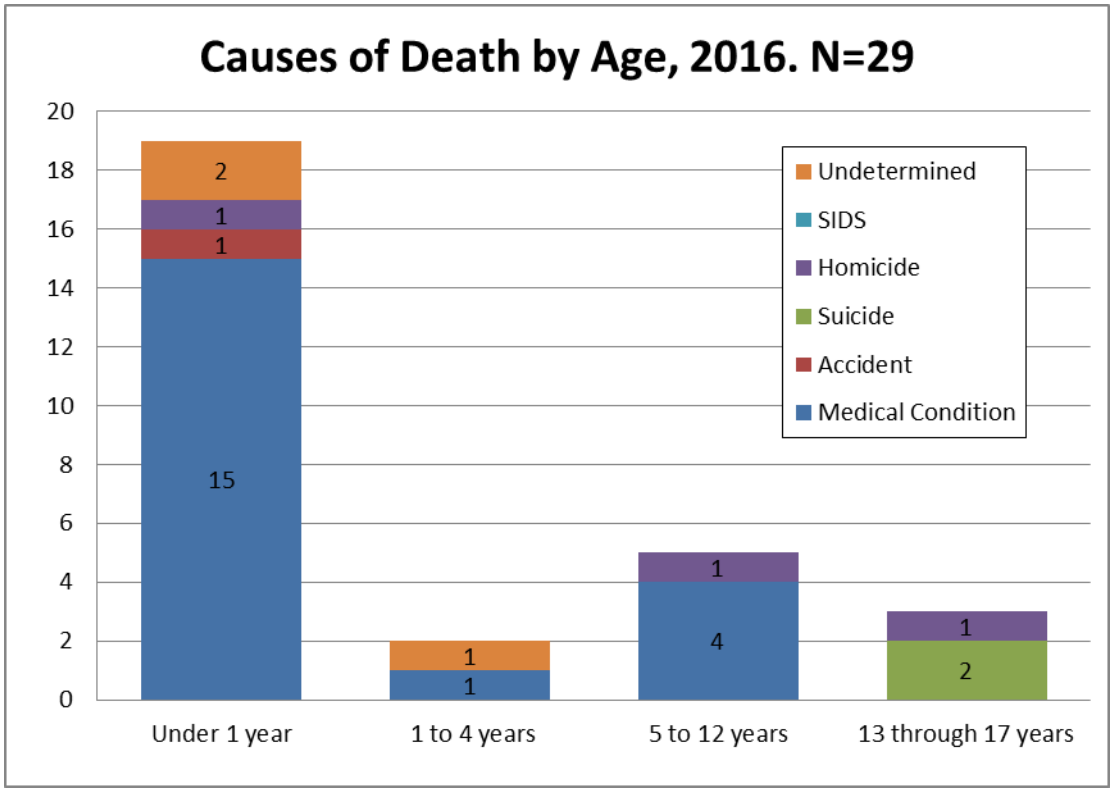
Causes of Death by Age, Santa Barbara County, 2015-2016

	Medical Condition	Accident	Suicide	Homicide	SIDS	Undetermined	Total Deaths
Under 1 year	34	2		1	1	4	**42**
1 to 4 years	4					1	**5**
5 to 12 years	7			1			**8**
13 through 17 years		3	2	4			**9**
Total	**45**	**5**	**2**	**6**	**1**	**5**	**64**

Key points related to age:

- The undetermined deaths are almost exclusive to the first year of life.
- A child is most at risk of dying during the first 12 months of their life.
- There are a small number of suicides among adolescents.
- The pre-school age years (1-4 years of age) had the lowest number of child deaths.


Causes of Death by Age, 2015. N=35
25
20
15
10
5
0
2
1
1
19
3
3
3
3
0
Undetermined
SIDS
Homicide
Suicide
Accident
Medical Condition
Under 1 year
1 to 4 years
5 to 12 years
13 through 17 years


Causes of Death by Age, 2016. N=29
20
18
16
14
12
10
8
6
4
2
0
2
1
1
15
1
1
1
4
1
2
Undetermined
SIDS
Homicide
Suicide
Accident
Medical Condition
Under 1 year
1 to 4 years
5 to 12 years
13 through 17 years

CDRT Reviewed Deaths

The CDRT reviewed twenty-six cases that occurred between January 2015 and December 2016 in Santa Barbara County that including: (8) accidents (included 2 accidental overlays and 2 motor vehicle collisions), (1) SIDS; (3) undetermined; (3) homicide; (2) teen suicide; (9) natural causes.

2015

- Public Health Department (PHD) released a pertussis public service announcement and a Provider Alert and the Child Death Review Team wrote a letter of support for Senate Bill 277.
- PHD Health Officer implemented a system to ensure OB doctors could stock TdaP vaccine at a lower cost to ensure the opportunity for every pregnant woman to be vaccinated.
- Santa Barbara Cottage Hospital received Richie funds to purchase a driving simulator for a safe driving campaign to be implemented in English and Spanish in the next two years as part of becoming a pediatric trauma center.
- The CDRT members expressed concerns about reunification if the parent is continuing high risk behaviors and substance use. The CDRT respects and acknowledges the role of CWS to maintain children with their biological families when it can be done safely and to pursue the least intrusive intervention for the child.
- Due to a SIDS/SUID case of a 3 month old, MCAH initiated an evaluation of hospitals parental education on newborn sleeping practices. All 13 CPSP OB providers have had SIDS presentations. Additional SIDS presentations (10) provided to community organizations that support parents and children.
- The Emergency Medical Services Quality Improvement Coordinator has created and provided additional education and training for paramedic and Emergency Medical responders on mandated reporting of cases on scene.
- Sheriff Coroner initiated use of SIDS dolls for reenactment of the scene as well as new laminated SIDS protocol sheets for detectives
- Sheriff Coroner's office will continue to work with the SBC PHD Public Health Lab to obtain specimens postmortem on potential communicable disease pathogens.
- The CDRT team supported current endeavors for safer pedestrian crossings at Santa Ynez High School.
- A plan was made for the Coroner and Pathologist to provide education to first responders on crime scene investigation and medical service delivery best practices at a future Emergency Medical Services Update (mandatory paramedic education course) Anticipated completion, summer of 2017.
- The CDRT disseminated a letter of support to members of the gang prevention team that is being organized in North County. The letter highlighted a recent training conducted at El Camino School that educated parents on how to assist their children in avoiding gang activity and alcohol use.

2016

- Police Departments were encouraged to collect frozen breast milk at the initial contact for toxicology testing when they are investigating infant deaths.
- Safety measures and messages were promoted related to leaving children in the car; injury prevention coordinators at trauma centers and Safe Kids Coalition.

- Verification was made that Ventura County inpatient psychiatric hospital replaced all shower fixtures that were the type used by patient to hang self.
- Hospitals were urged to contact DSS/PHD when a parent is hospitalized that has younger, high risk children in the home.
- MCAH will review Hospital Labor and Delivery policy to report positive Toxicology screens to CWS and reinforce that pediatricians are to be informed about positive Toxicology screens of birth moms during office visits.
- The "Safe Surrender" program was promoted through media and receiving locations around County.
- EMS will increase education on Tracheotomy tube placement in pediatric patients
- Education is increasing for Mixteco and Spanish speaking parents on use of 911. This education included a review with Community based parent education programs and hospital birth- education programs, and public service announcements in multiple languages on radio.

Further efforts are needed to:

- There is increased collaboration with other County CDRT teams to be aware of children dying in out of County health facilities or other legal jurisdictions that may qualify for review.
- Discussion of teen deaths/homicides will include a focus on community-wide preventative efforts.
- Plans to strengthen community education on child death prevention issues, e.g., SIDS, safe sleeping, home safety and child abuse prevention.
- Initiation of a review of fetal demise cases.

Our goal is to review deaths of children under the age of 18 in order to prevent future deaths and reduce mortality of children in Santa Barbara County. The team has barriers to reviewing all child deaths in depth included staffing levels, workload issues affecting participating agencies, responsibilities for cases pending litigation, and communication across the County when there is a transfer of a child to other regions for specialized care. It is our desire to review all child deaths in a thorough and comprehensive manner. The Child Death review Team remains committed to addressing these barriers and learning from child deaths to prevent future deaths of children in our community.