Santa Barbara County

Child Death Review Team (CDRT)

January 2019 – December 2020

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 2019-2020 reviews. This report was compiled, organized and prepared by Kelley Barragan. The data was prepared by Michelle Wehmer. The dedicated efforts of all past and current team members are sincerely appreciated.

Active Members 2019-2020 include:

Name	Agency
Abeloe, Lisa	Marian Regional Medical Center
Baldwin, Polly	SBC PHD Primary Care
Barragan, Kelley	CDRT Coordinator/SBC PHD MCAH
Batson, Paige	SBC PHD - Deputy Director
Combs, Michele	SBC PHD Emergency Medical Services
DeHoyos, Melinda	Lompoc Valley Medical Center
Grossman, Eric	Cottage Hospital, MD
Haro, Laurie	CWS
Hawkins, Molly	Cottage Hospital/Safe Kids Coalition
Hanson-Lopez, Gabriela	CALM
Holmes, Deborah	CALM
Jakowchik, Christopher	Marian Reginal Medical Center
Lemus, Carmen	CDRT Admin/SBC PHD MCAH
Modglin, Gabriela	SBC PHD EMS
Morris, Jarret	SBC Sheriff Coroner
Peterson, Stacy	Cottage Hospital LCSW
Race, Heather	CWS
Rico, Joshua	Cottage Hospital LCSW
Smith, Libby	Cottage Hospital
Sodergren, Tom	Casa Pacifica
Sutherlin, Lauren	Cottage Hospital/Safe Kids Coalition
Topping, Gena	Cottage Hospital/Safe Kids Coalition
Tran, Ed	SBC PHD - Assistant Deputy Director
Vang, Zoua	SBC PHD MCAH/SIDS Coordinator

Valenzuela, Kimberly	Casa Pacifica
Wehmer, Michelle	SBC PHD Epidemiologist

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's Maternal, Child & Adolescent Health (MCAH), Epidemiology, Emergency Medical Services (EMS), and Health Care Centers. Other members include representatives from the Sheriff-Coroner's office, Law Enforcement, Child Welfare Services, Cottage Hospital, Lompoc Hospital, Marian Regional Medical Center, District Attorney, Casa Pacifica, Safe Kids Coalition, Child Abuse Listening & Mediation (CALM) and Child Abuse Prevention Counsel.

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, Hospitals, 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.

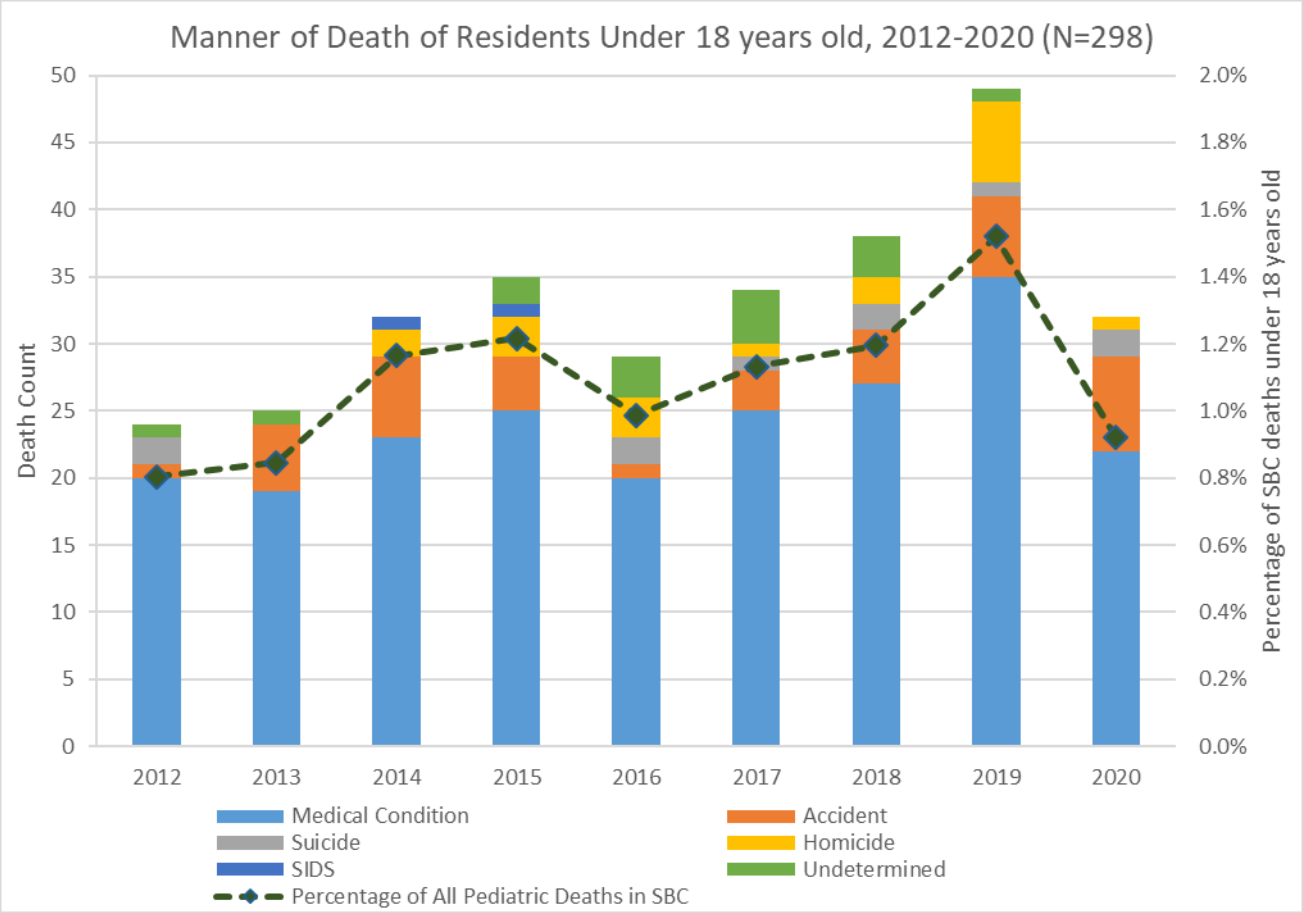
If the team is unable to answer the three conditions for child abuse and neglect due to insufficient information and child abuse is suspected, the team may choose to recommend further law enforcement investigation. The multi-disciplinary team discussion may result in new information which can prompt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

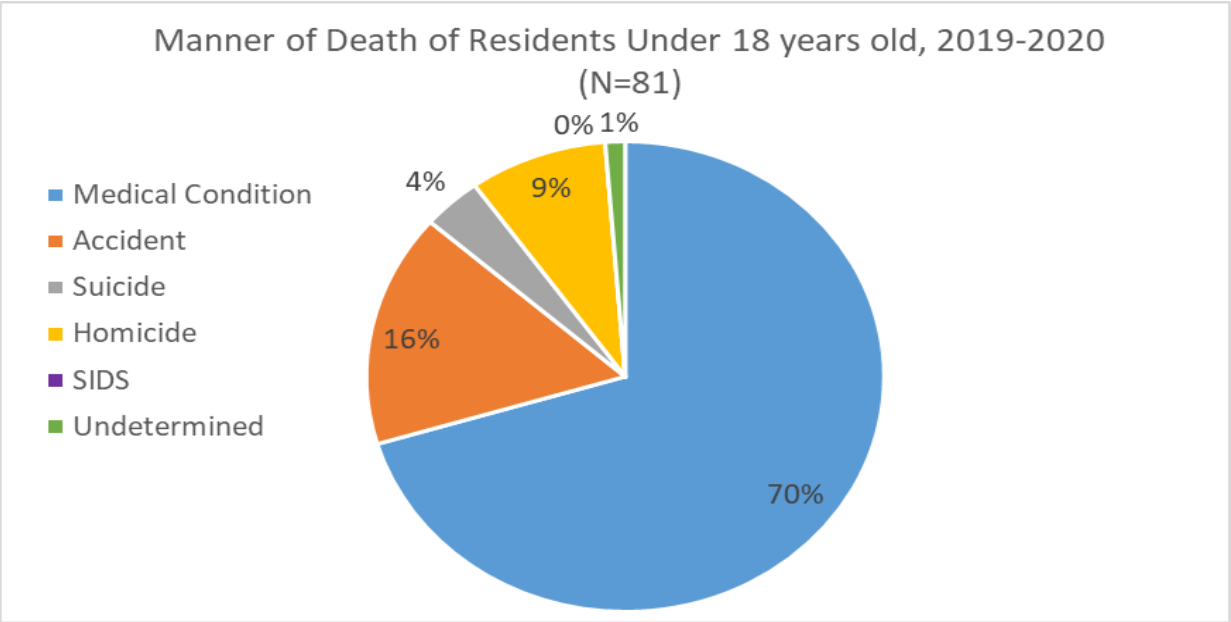
The Santa Barbara County CDRT participates in FCANS though the Epidemiology and Prevention for Injury Control (EPIC) Branch at the California Department of Health Services (DHS). FCANS provides a comprehensive picture of child abuse deaths across the state of California. The FCANS program was designed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

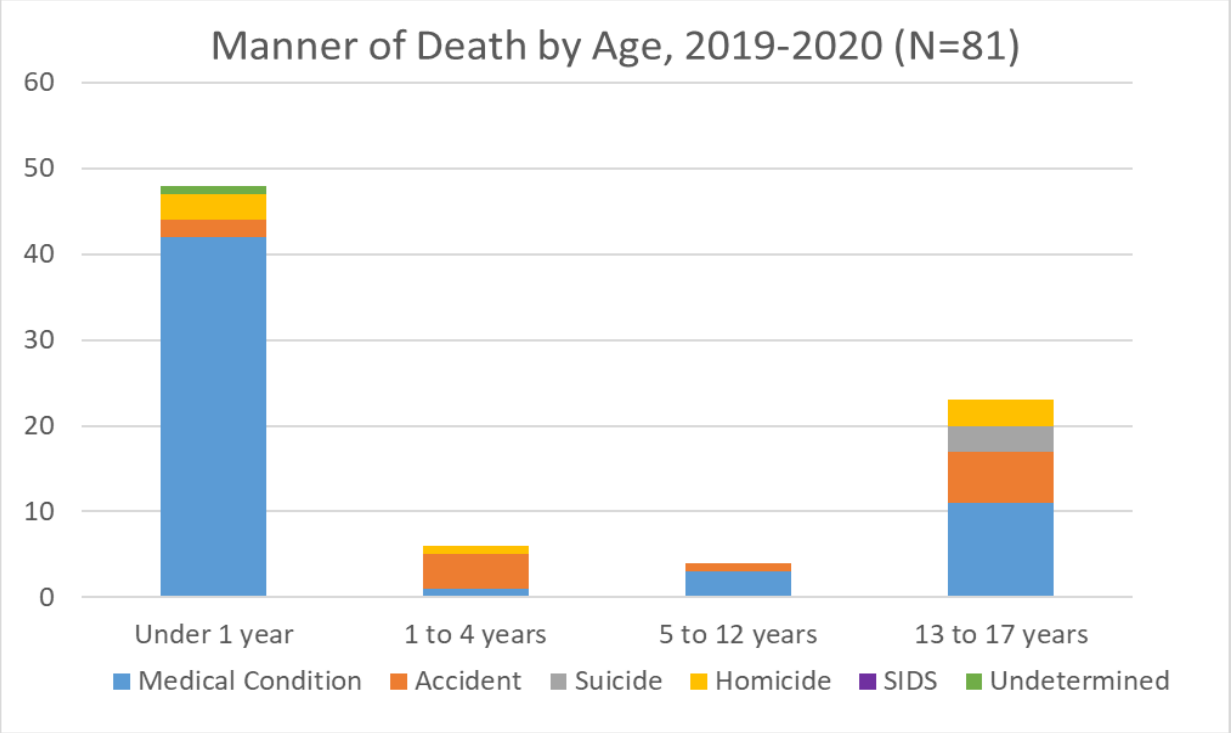
Santa Barbara County Child Resident Deaths
Manner of Death of Children
(Under 18 years old)



Key points:

- Between 2019 and 2020, the number of children who died ranged from 49-32 decedents per year (January - December).
- Since 2012, the percentage of all pediatric deaths in Santa Barbara County has hovered just over 1% of all deaths of residents.
- Over the years, the majority of child deaths were due to medical conditions or unpreventable disease. In 2019, 72% (35/49) of all deaths were due to medical conditions; 2020, 69% (22/32) of all deaths were due to medical conditions.
- Over the past 2 years, 24 (50%) of the 48 deaths of children under the age of 1, were due in some part, to prematurity.
- The cases reviewed by the CDRT are a small subset of all pediatric deaths. Accidents encompassed a variety of incident types such as drug overdoses and asphyxiation.
- Unsafe sleeping conditions, such as bed sharing, were factors in several of the accidental deaths of young children.





Key points related to age:

- A child is most at risk of dying during the first 12 months of their life.
- Although in 2016-2020, there was a small number of suicides in children in SBC (8 suicides in 5 years), all of those deaths were in the 13 to 17 year age group. Suicides account for 13% of the deaths in SBC adolescents in 2019-2020 which is lower than the 20% that was observed in the previous two CDRT report for that age group.
- The elementary school age years (5-12 years of age) had the lowest number of child deaths.

CDRT Reviewed Deaths

The CDRT reviewed seventeen cases between January 2019 and December 2020 in Santa Barbara County. The manner of death was determined to be accidental for 11 decedents, and the final cause of death of a subset of those cases, were due to asphyxia, co-sleeping, gunshot, motor vehicle collisions, or drug intoxications. Below are the actions CDRT took to reduce the risk of future preventable child deaths from occurring.

2019

- The Safe Kids Coalition continued their pack-n-play distribution project at Cottage Hospital which is used to promote safe sleeping. Distribution was expanded to include Marian Regional Medical Center.
- Lompoc Valley Medical Center representative joined the CDRT team.
- The Public Health Department developed a media campaign to address cannabis use in youth and pregnant and lactating mothers. Website and fact sheets were distributed to CDRT members to share with their networks.
- The Safe Kids Coalition held car seat safety events in which certified child passage safety technicians conducted checks and distributed car seats as needed.
- Casa Pacifica provided a presentation to CDRT members on call trends and services provided.
- Public Health Department MCAH SIDS Program partnered with Children's Resource and Referral for 1st Annual Safe Sleep Walk to raise awareness of SIDS/Safe sleep recommendations on 9/21/19.
- Public Health Department MCAH SIDS program participated at 5 health fairs throughout the county. A safe sleep game was developed in which 300+ participants demonstrated an increase in knowledge of safe sleep recommendations.

2020

- Need for messaging around both safety and medical aspect of 911 was identified. Partnership with MICOP was established to assist with distribution once messaging is developed.
- June 2020 CDRT Meeting cancelled due to COVID-19 pandemic.
- The Safe Kids Coalition continued their pack-n-play distribution project. Distribution was expanded to include CWS.
- MCAH SIDS Coordinator partnered with Children's Resource and Referral COO to present to the Early Childhood and Family Wellness Coalition on the new laws requiring licensed child care providers to have a written safe sleep plan for every child less than 1 year of age that they care for.
- Coroner's office will provide MCAH program referral line as another resource to families who have a child die due to overlay or other unsafe sleep situation.
- Public Health Department MCAH SIDS program wrote an article for the Health Matters Newsletter which is distributed to 1500+ local providers and community members and shared social media posts in October on SIDS/Safe Sleep recommendations.
- Public Health Department MCAH field nursing unit integrated the evidence-based Period of Purple Crying curriculum which focuses on supporting caregivers in their understanding of early increased infant crying and reducing the incidence of shaken baby syndrome/abusive head trauma.

- Cottage Hospital representatives shared that they provide social work consultation to all pediatric traumas.
- CDRT members researched how other counties are addressing teen substance use and suicides. A presentation by the Fresno County Suicide Prevention Initiative will be provided at February 2021 CDRT meeting.

Further efforts are needed to:

- Increase 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.

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.