Santa Barbara County

Child Death Review Team (CDRT)

January 2017 – December 2018

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 2017-2018 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 2017-2018 include:

Name	Agency
Abeloe, Lisa	Marian Regional Medical Center
Baldwin, Polly	SBC PHD Primary Care
Barragan, Kelley	SBC PHD MCAH and SIDS Coordinator
Batson, Paige	Deputy Director of Community Health, SBC PHD
Clay, Nicholas	SBC PHD Emergency Medical Services
Combs, Michele	SBC PHD Emergency Medical Services
DeHoyos, Melinda	Lompoc Valley Medical Center
Donati, Vanessa	Pediatric LCSW - Cottage Hospital
Galaviz, Lupita	Student Intern - Cottage Hospital
Grossini, Jason	Sheriff Coroner, Coroner's Bureau
Grover, Amelia	Marian Reginal Medical Center
Haro, Laurie	CWS
Holmes, Deborah	CALM
Jakowchik, Christopher	Marian Reginal Medical Center, NICU Manager
Lemus, Carmen	SBCPHD MCAH
Lord, Susan	Victim Witness Program Advocate
Medina, Regina	Cottage Hospital Social Worker
Minter, Rob	Sheriff Coroner
Peterson, Stacy	Cottage Hospital LCSW
Race, Heather	SBC Social Services
Robledo, Sal	Cottage Hospital, MSW, LCSW
Savage, Judith	SBC PHD MCAH
Simon, Jennie	SBC PHD Emergency Medical Services

Smith, Libby	Cottage Hospital
Sodergren, Tom	Casa Pacifica
Topping, Gena	Safe Kids SBC/Cottage Hospital
Tran, Ed	SBC PHD MCAH Program Director/Assistant Deputy Director of Community Health, SBC PHD
Vicuna, Ana	Behavior Wellness
Wehmer, Michelle	Public Health Epidemiologist
Winckler, John	Behavior Wellness

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, and Emergency Medical Services (EMS). 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.

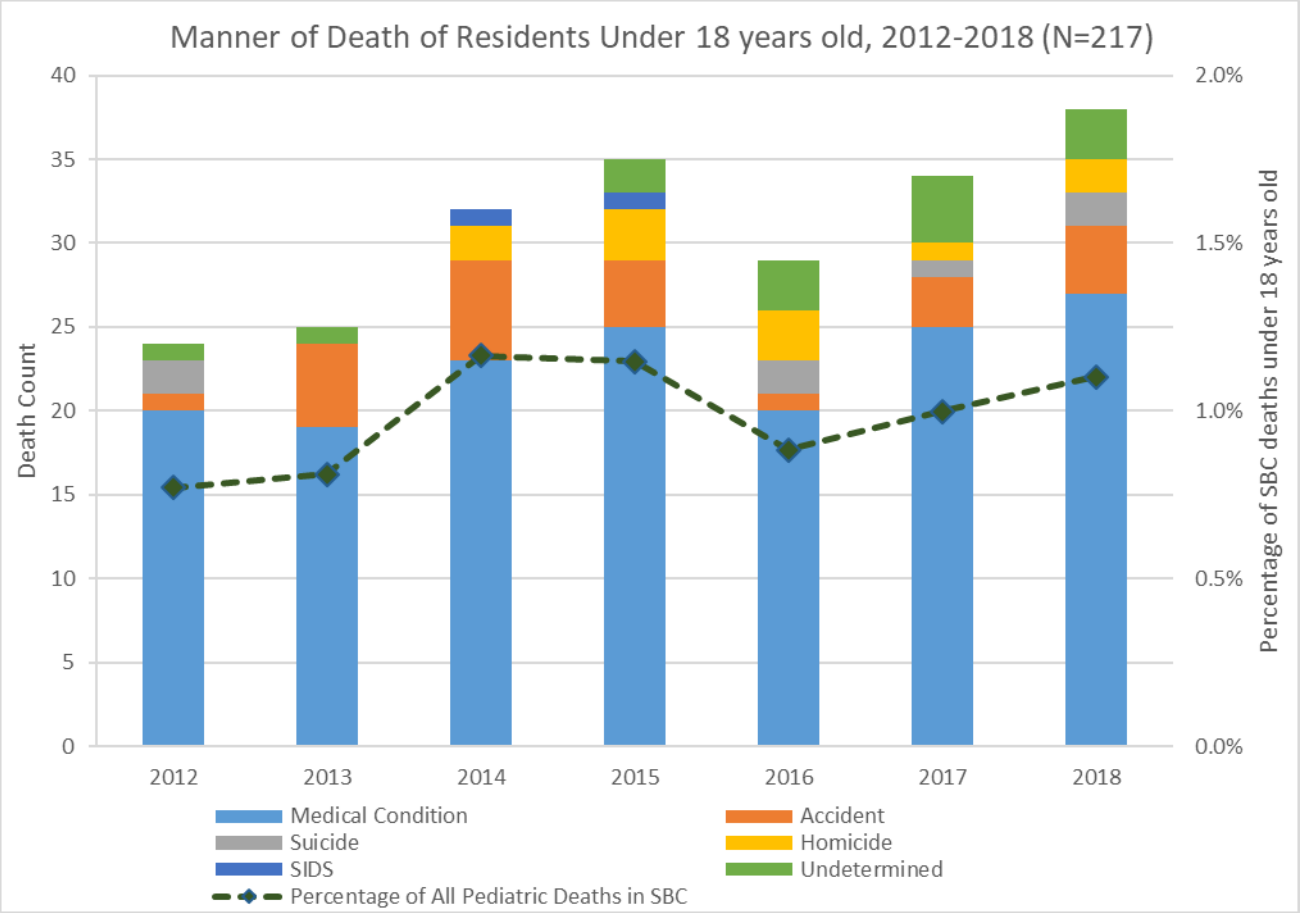
If the team is unable to answer the three conditions for child abuse and neglect due to insufficient information and child abuse is suspected, the team may choose to recommend further law enforcement investigation. The multi-disciplinary team discussion may result in new information which can prompt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

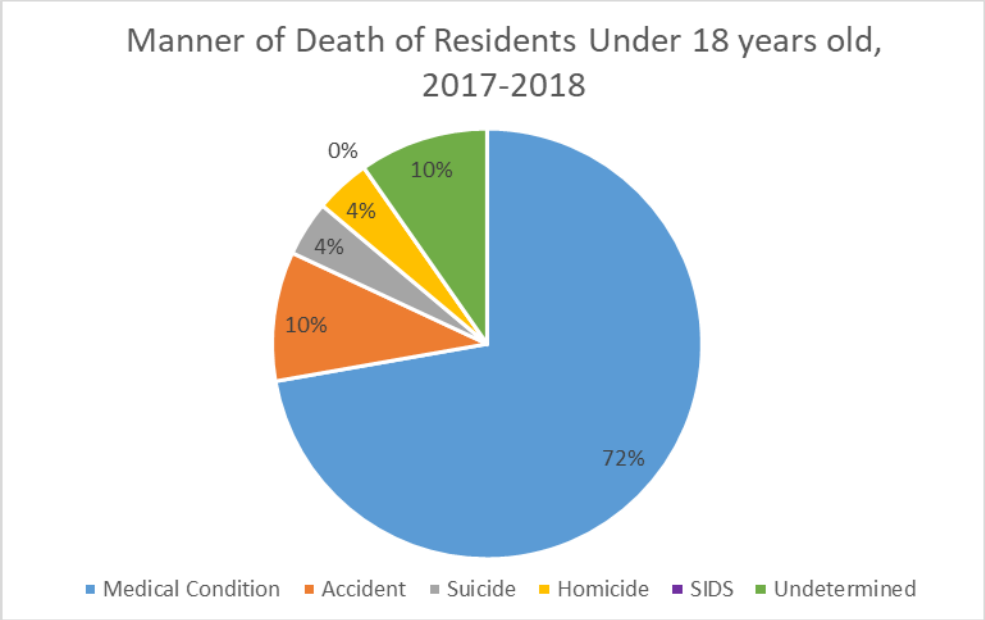


Key points:

- Between 2017 and 2018, the number of children who died ranged from 34-38 decedents per year (January - December).
- Since 2012, the percentage of all pediatric deaths in Santa Barbara County has hovered around 1% of all deaths of residents.
- Over the years, the majority of child deaths were due to medical conditions or unpreventable disease. In 2017, 73.5% (25/34) of all deaths were due to medical conditions; 2018, 71.1% (27/38) of all deaths were due to medical conditions.
- Over the past 2 years, 19 (45.2%) of the 42 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 and undetermined deaths of young children.
- Three undetermined deaths were due to the debris flow event in 2018.

Recurring concerns of the CDRT from previous (2015-2016) reports include:

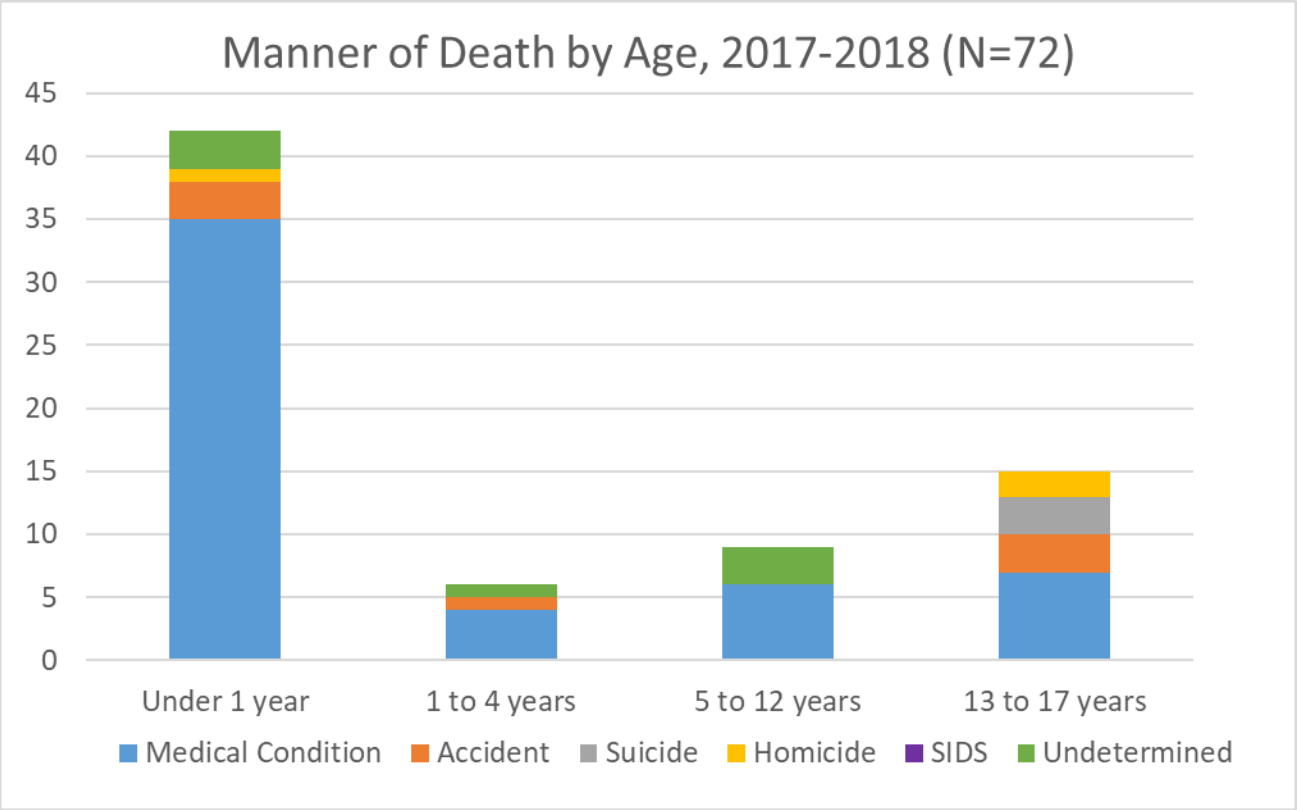
- Parental bed sharing and child death due to possible asphyxiation.
- Parent education for sleeping practices to reduce the risk of SIDS/undetermined infant death.
- Continued education for emergency responders and law enforcement on the collection of evidence in case involving infants-to verify child sleeping positions and possible exposure to toxic drugs.



Manner of Death by Age, Santa Barbara County, 2017-2018

	Medical Condition	Accident	Suicide	Homicide	SIDS	Undetermined	Total Deaths
Under 1 year	35	*	0	*	0	*	**42**
1 to 4 years	*	*	0	0	0	*	**6**
5 to 12 years	6	0	0	0	0	*	**9**
13 to 17 years	7	*	*	*	0	*	**15**
Total	**52**	**7**	*	*	**0**	**7**	**72**

The * signifies a value less than 5 and therefore not displayed to protect decedent HIPAA laws.



Key points related to age:

- A child is most at risk of dying during the first 12 months of their life.
- Although in 2015-2018, there was a small number of suicides in children in SBC (5 suicides in 4 years), all of those deaths were in the 13 to 17 year age group. Suicides account for 20% of the deaths in SBC adolescents in 2017-2018 which was similarly observed in the previous CDRT report.
- The pre-school age years (1-4 years of age) had the lowest number of child deaths.

CDRT Reviewed Deaths

The CDRT reviewed eighteen cases that occurred between January 2017 and December 2018 in Santa Barbara County. The manner of death was determined to be accidental for 9 decedents, and the final cause of death of a subset of those cases, were due to accidental positional asphyxiations or motor vehicle collisions. The manner of death of the remaining 9 cases reviewed were either undetermined, due to teen suicide, or due to natural causes.

2017

- A press release was created for heat injury prevention day in collaboration with County Emergency Medical Services, the Public Health Department and the Safe Kids Coalition.
- First 5 and Family Resource Centers informed about the YMCA's low-cost/no-cost programs for swim classes.
- The hospital work flow processes between bereavement services and hospice linkages were shared across the group in order to learn of best practices.
- A Behavioral Wellness representative and hospital social workers from Cottage Hospital and Marian Regional Medical Center joined the CDRT team.
- Release of Information forms between Behavioral Wellness and the Hospitals have been streamlined for quicker access to mental health records when caring for a patient in the hospital.

2018

- At the April 17th SBCH grand rounds, ACES and how to incorporate screening in pediatric offices was discussed. The presentation was led by Dr. Nadine Burke.
- The Safe Kids Coalition began a pack-n-play distribution project used to promote safe sleeping. Waivers, agreements, referrals forms and guidelines were created for the program and pack-n-plays have been distributed across the county.
- The need for education on the use of 911 amongst Mixteco and Spanish-speaking parents was identified. Multiple agencies have been working to develop a plan for messaging.
- The County Education Office and CALM have been working together to increase suicide screening in schools and mitigate the increasing number of suicides in adolescents.
- The Youth Well Coalition opened a drop-in center on State Street for youth counseling.
- The Public Health Department created a Chill Zone connected to the Carpinteria Health Care Center for community-based drop-in counseling
- The Board of Supervisors approved funding for a cannabis program at the Public Health Department. Three-fourths of the funding is focused on youth prevention and 25% is focused on pregnant/breastfeeding women.
- The CDRT was informed that referrals can be made to CWS following discussion of a case if in that instance one was not made.
- Educational materials was distributed by MCAH to delivery hospitals and CDRT members on how to find a quality childcare provider.
- MCAH, hospital, and CHP staff participated in a 40 hour national child passenger safety certification program.

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.