Santa Barbara County

Child Death Review Team (CDRT)

July 2009 – June 2012
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 2009-2012 reviews. This report was compiled, organized and prepared by Sandra Copley. The data was prepared by Michelle Wehmer. The dedicated efforts of all team members are sincerely appreciated.

Members Include:

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Susan Lord Santa Barbara County Victim Witness Program
Megan Riker-Rheinschild Santa Barbara County Victim Witness Program
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, 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. Our local CDRT consists of members from the Public Health Department Maternal, Child & Adolescent Health (MCAH), Emergency Medical Services (EMS) and the County Health Officer. Other members include representatives from the Sheriff-Coroner’s office, Law Enforcement, Child Welfare Services, Hospital Social Services, District Attorney and Child Abuse Listening & Mediation (CALM).

Case Selection

The CDRT Coordinator receives information from the Vital Statistics Office 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 could be prevented in the future. This often includes 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 available. A list of cases for review is sent, in advance, to team members to allow time to search case files for additional information on the child and his/her family.

The Case Review Process at the CDRT meeting includes a summary of reports 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.

**FCANS**
(Fatal Child Abuse and Neglect Surveillance Program)

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 Deaths
### Causes of Death of Children
(Under the age of 18)

<table>
<thead>
<tr>
<th></th>
<th>Medical Condition</th>
<th>Accident</th>
<th>Suicide</th>
<th>Homicide</th>
<th>SIDS</th>
<th>Undetermined</th>
<th>Total Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2009 – June 2010</td>
<td>28</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>37</td>
</tr>
<tr>
<td>July 2010 – June 2011</td>
<td>30</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>44</td>
</tr>
<tr>
<td>July 2011 – June 2012</td>
<td>24</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total Deaths by Cause</strong></td>
<td><strong>82</strong></td>
<td><strong>10</strong></td>
<td><strong>5</strong></td>
<td><strong>5</strong></td>
<td><strong>5</strong></td>
<td><strong>5</strong></td>
<td><strong>112</strong></td>
</tr>
</tbody>
</table>

Key points:
- Between 2009 and 2012, the number of children who died ranged from 31-44 per fiscal year (July-June).
- The majority of child deaths in both years were due to medical conditions or unpreventable disease. In fiscal year 2009 – 2010, 75.7% (28/37) of all deaths were due to medical conditions; fiscal year 2010 – 2011, 68.2% (30/44) of all deaths were due to medical conditions; fiscal year 2011 – 2012, 77.4% (24/31) of all deaths were due to medical conditions.
- Over the three years, 28 of the deaths due to medical conditions for children under the age of 1, were due in some part to prematurity.
- Accidents encompassed a variety of accidents such as motor vehicle accidents, drowning, and accidental drug overdose.
- Parents co-sleeping with young children or maternal overlying are factors in some accidents and undetermined deaths.
Causes of Death by Age across 3 Fiscal Years

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Medical Condition</th>
<th>Accident</th>
<th>Suicide</th>
<th>Homicide</th>
<th>SIDS</th>
<th>Undetermined</th>
<th>Total Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>67</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>78</td>
</tr>
<tr>
<td>1 to 4 years</td>
<td>7</td>
<td>4</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>5 to 12 years</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>13 through 17 years</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>112</td>
</tr>
</tbody>
</table>

Key points related to age:
- A child is most at risk of dying during the first 12 months of their life.
- Accidents appear to occur across all age categories.
- There are a small number of suicides among adolescents.
- The school age years (5 – 12 years of age) had the lowest number of child deaths.
- Homicide is a manner of death with a predominant concentration in adolescents.
Causes of Death by Age
(July 2009-June 2010)

Causes of Death by Age
(July 2010-June 2011)

Causes of Death by Age
(July 2011-June 2012)
CDRT Reviewed Deaths

The CDRT reviewed thirty-three cases that occurred between July of 2009 and June of 2012 including: (8) accidents; (7) SIDS; (5) undetermined/suffocation-co-sleeping; (4) homicide; (3) teen suicide; (2) natural causes; (2) pending investigation; (1) traffic accident; and (1) due to natural causes to determine perinatal prevention efforts.

Recommendations and actions taken as a result of case reviews included:

- Increased efforts to educate pregnant and newly parenting parents on the prevention of SIDS through various community agencies and home visitation programs.
- Presented an in-service to members of the Child Abuse Prevention Counsel regarding current CDRT and SIDS efforts.
- Educated Public Health Department (PHD) Maternal Child and Adolescent Health (MCAH) Field Nursing staff on SIDS, Grief Assessment and Child Abuse Prevention efforts.
- Reviewed current CWS policies regarding how a case is determined substantiated or unsubstantiated and the process for ensuring the child’s future safety. A copy of this policy was distributed to CDRT members.
- Encouraged verbal and written education for all CWS cases regarding appropriate parenting. Public Health can assist with written information if needed to CDRT member organizations.
- Increased the CDRT members understanding of CWS caseload reporting and supervision policies.
- Educated the Children’s System of Care program staff county-wide regarding accidental death from the ‘choking game’ in our teen population. (The ‘choking game’ is defined as self-strangulation or strangulation by another person with the hands or a noose to achieve a brief euphoric state caused by cerebral hypoxia.)
- Attempted to obtain perinatal substance use toxicology data from local hospitals.
- Attempted to find a source for cribs for underprivileged new mothers through the MCAH Field Nursing Program.
- Encouraged Team Decision Meetings occur at critical points in the Child Welfare Case once CWS is involved with the family.

Further efforts are needed to:

- Discuss teen deaths/homicides to determine community-wide preventative efforts.
- Strengthen community education on child death prevention issues, e.g., SIDS, safe sleeping, home safety and child abuse prevention.

There are challenges in increasing the number of child deaths reviewed by the CDRT. Challenges related to barriers preventing further child death reviews included staffing reductions and workload issues affecting participating agencies and cases pending litigation. A more robust review of all child deaths is needed and is planned when more time can be allotted to this process. The CDRT remains committed to addressing these barriers and learning from child deaths to prevent future deaths of children in our community.