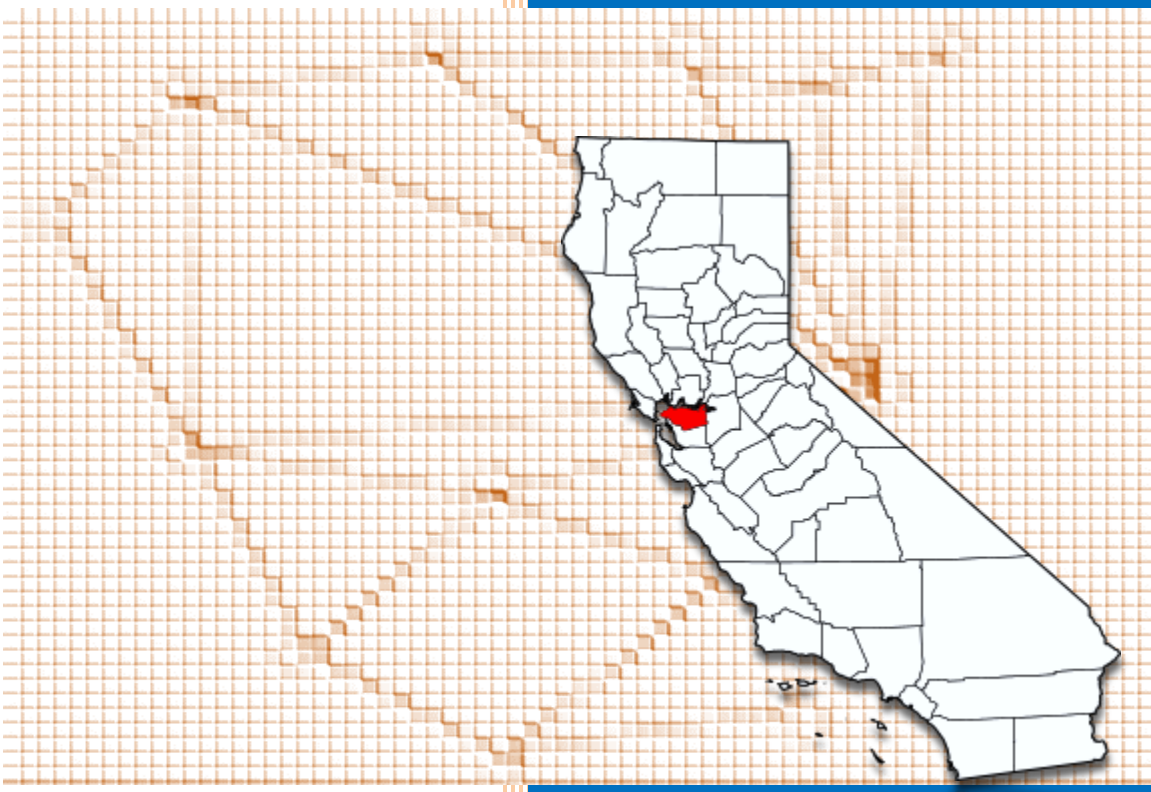
2013

Contra Costa County Child Death Report



Prepared by:
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CONTRA COSTA COUNTY DEPARTMENT OF HEALTH SERVICES In Collaboration With CHILD ABUSE PREVENTION COUNCIL OF CONTRA COSTA COUNTY
Child Death Review Team 1 Year Report
January 1, 2017

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PART I

Overview of Child Death Review Teams and Child Deaths

2013

EXECUTIVE SUMMARY

This report is based upon the multi-disciplinary reviews of 21 child deaths by the Contra Costa County (CCC) Child Death Review Team (CDRT) covering the year 2013.

The review is limited to CCC Coroner cases of children less than 18 years of age. It does not include many natural deaths where the child had been under medical care for, say, cancer or other known health conditions. Coroner cases are classified as accidents, homicides, suicides, natural or undetermined. Reviewed deaths represent about one quarter (27%) of all child deaths in CCC over the study period. The total number of child deaths in CCC in 2013 was 78. Of these 78 total deaths, 43 (55%) occurred in neonates in the first month of life and 7 (9%) occurred in infants after the first month of life.

The primary goal of Child Death Review is to understand why children die and to take action to prevent other death or injury. The main conclusions from this review are below.

1. ***Preventability***: The Contra Costa County CDRT determined that 18 of 21 (86%) of the deaths reviewed were probably preventable by a variety of interventions. Interventions such as active supervision, safe sleeping practices, safer driving and more limited access to firearms would have prevented many of these deaths. Over the 2008-2013 period 118 of 176 deaths or 67% were deemed preventable.

2. ***Ethnicity***: We identified ethnic disproportion regarding deaths with, for example, higher death rates of African-Americans compared to whites and Hispanics with Asian-Pacific Islanders having the lowest death rates.

3. ***Age***: The age distribution of deaths was highest in infants and the older teens aged 15 to17. Infants tended to die in unsafe sleeping environments whereas teens died in accidents, homicide or suicides.

4. ***Gender***: Females represented 17 of 21 or (81%) of the reviewed deaths which was aberrant compared to our previous experience where there has been a preponderance of males.

5. ***Classification of Death***: Accidents or preventable injuries represented the largest percentage, 11 of 21 (52%) of deaths reviewed and were all considered preventable. Suicides and Undetermined deaths accounted for 3 of 21 or (14%) of the deaths reviewed. Homicides and Natural deaths accounted for 2 of 21 or (10%) of the deaths reviewed.

6. ***Accidental Deaths***: were primarily from Motor Vehicle Collision (7 of 11 or 64%), followed by accidental asphyxia (2 of 11 or 18%), followed by a drug overdose and a drowning (1 of 11 or 9%). Teens, males and African Americans were overrepresented in these deaths. All of these deaths were considered preventable:

    a. Motor vehicle-related deaths could have been prevented by safer driving and appropriate use of restraints.

    b. The two sleep-related asphyxias could have been prevented by following safe sleeping practices.

    c. Drownings can be prevented by active supervision, use of personal flotation devices, working barriers or alarms for pools and less adolescent risk-taking behaviors.

    d. Drug overdose deaths can be prevented by a number of modalities including safety caps, addiction treatment, access to Narcan, CUREs registry and others.

7. ***Homicides***: were both male and involved the use of a firearm. Unlike all other years reviewed, there were no African American child homicides in 2013. The CDRT considers gun-related deaths as ultimately preventable.

8. ***Suicides***: occurred in 3 teens in 2013 which is comparable to other years studied. All were male with death in 2 by hanging and 1 by BART train. All 3 had histories of depression with one on medication. Two left posting's on social media. Suicide is deemed probably preventable by the CDRT and The Crisis Center.

9. ***Natural Cause of Death***: includes medical conditions and SIDS. Most of these deaths are not reviewed by the CDRT because they are not Coroners cases. In 2013, we reviewed 2 deaths where the autopsy identified infections: croup and viral myocarditis. Preventability was considered "unable to tell" due to lack of information regarding whether more timely medical contact might have made a difference.

10. ***Undetermined Cause of Death***: included 2 sleep-related deaths and one probable infection. Sleep-related deaths or SUIDS are called Undetermined when the autopsy cannot discriminate between accidental asphyxia and SIDS. Both of these deaths were African American infants in unsafe sleeping environments and deemed preventable.

11. ***Child Abuse or Neglect-related Deaths***: There were no deaths in 2013 directly attributed to child abuse but there were 4 deaths identified with children abuse/ neglect as a potential contributor. Child abuse is a preventable trauma with lifelong and generational consequences if not addressed.

12. ***Sleep-related Deaths***: occurred in 3 infants in 2013 with all in unsafe sleep environments and hence all preventable. Two of three of these deaths were in African Americans, consistent with our and national finding of disproportionate sleep-related deaths in African Americans associated with unsafe sleep practices. Since 2008, there have been 40 sleep-related infant deaths with all but two in unsafe sleep environments. During the 6 year period 2008-2013, 85% of these deaths could have been prevented with adoption of safe sleeping practices.

13. ***Firearm-related Deaths***: occurred in 2 teen homicides. Prevention of firearm-related death is multimodal, beginning with limiting easy access to firearms.

14. ***Recommendations*** for Prevention of Childhood Death and Injury in CCC:

    a. Safe to Sleep Campaign for CC targeting all birthing hospitals, medical providers, home visitors, childcare providers and the public.

    b. Promotion of active supervision.

    c. Promotion of safe storage of firearms, buyback programs, assault weapon ban, research in the public health aspects of firearm injury, trigger lock giveaways.

    d. Promotion of Child Abuse Prevention in all forms including home visitation, parenting classes, and mandated reporter trainings.

    e. School drop-out prevention programs, after-school programs, alternative education, bullying prevention, teen recreation programs, mentor programs and others.

    f. Promote access to healthcare including mental healthcare and substance abuse treatment.

Jim Carpenter MD, MPH, FAAP

Chair, CCC Child Death Review Team

Acknowledgements

We would like to thank the Contra Costa Health Services department: Epidemiology, Planning, and Evaluations (EPE) and specifically Epidemiologist, Lisa G. Diemoz, MPH. Also, we would like to thank the Contra Costa Heath Services department: Family, Maternal, Child, and Health (FMCH) and specifically the Program Manager, Natalie Berbick, MSW. In addition, we would like to extend our appreciation to the Child Abuse Prevention Council of Contra Costa County (CAPC) as administrative support for the Child Death Review Team (CDRT) and their CDRT Coordinator, Kara Vance. We would like to give a large thank you to all CDRT members, both past and present for attending the meetings and contributing their time and energy to this cause. We hope that each and every individual involved understands that their contribution will help make a difference in ensuring that children do not die from a preventable death. Without their efforts this report would not have been possible. Lastly, a great thank you to Dr. Jim Carpenter who established the Contra Costa CDRT and has chaired it since its inception.

Introduction

Child Death Review Teams (CDRTs) or Child Fatality Review Teams (CFRTs) were originally created by pediatricians to look closely at suspicious child deaths and not miss cases of child abuse or neglect. However, with time the process moved towards a comprehensive review of all child deaths to assess their preventability. The approach moved away from a strictly medical evaluation and towards a public health model of interpretation. Regional CDRTs each conduct themselves differently, due to the lack of unifying protocol. Therefore, while some regions utilize the terminology CDRT, others utilize CFRT. Contra Costa began its Child Death Review Team in 1988. Legislation passed at the time made it possible for members of the CDRT to discuss the deaths without violating HIPAA (please see the California penal code in the appendix for reference) and other confidentiality guidelines.

The Contra Costa CDRT reviews coroner's cases of individuals under the age of eighteen who have died within the county. On occasion cases are reviewed of individuals who are residents of the county but died within another county; this is based on the availability on the information of the death presented to the Contra Costa coroner's office when the death occurs elsewhere or from the sharing from another team. The CDRT of Contra Costa County was created and is currently chaired by Dr. Jim Carpenter, a child abuse pediatrician who is affiliated with Contra Costa Health Services (CCHS). Child Abuse Prevention Council of Contra Costa County (CAPC) serves as the administrative support for the CDRT and works in conjunction with Dr. Carpenter. The multidisciplinary team is comprised of select individuals from the coroner's office, law enforcement, public health department, district attorney's office, child protective services, Emergency Medical Services (EMS), SIDS programs, CRISIS, and others. There is a complete of the current team roster below. Meetings occur bi-monthly where a procedural review of old and new cases, as presented by the coroner's office, is performed. This review begins when the coroner's office submits its cases ready for review to CAPC who then sends those cases to members of the CDRT. Each member then review's their own agency's records for information regarding the involved individuals and families. On the meeting days those results are shared and discussed. The review works to determine concurrence with coroner's classifications of death and whether the death was preventable. The goals of the CDRT are as follows:

1. ***To Promote*** improved investigation of all child deaths
2. ***To Ensure*** all child abuse related deaths are identified
3. ***To Enhance*** cooperation, collaboration, and communication between county agencies
4. ***To Increase*** the thoroughness and effectiveness of the child protective interventions process
5. ***To Identify*** leading risk factors resulting in deaths, recommend system and policy changes to prevent child fatalities
6. ***To Develop*** guidelines for coordinating investigations and interventions on child death cases
7. ***To Maintain*** statistical data of child fatalities
8. ***To Recognize*** and protect siblings at risk
9. ***To Provide*** optimal support and resources for survivors

Once the cases are reviewed they are input into a state-wide database. Periodic reports are produced. The primary goals of the report are to raise public awareness, review trends, and provide recommendations for preventability. This report is a comprehensive one-year report covering the 21 coroner's cases of deaths in individuals under the age of eighteen within the Contra Costa County in 2013.

Preventability Guidelines

Case reviews result in a classification of preventability into one of three categories: "probably preventable, unable to tell, and probably not preventable." It is important to note that all cases are not presented with the same amount of data and many do not fit into clearly cut parameters. Therefore, it is understood that these guidelines are to help the team to make a determination of preventability. Part III of this report has divided the deaths into six categories to look at preventability and intervention models most efficiently. The general guidelines which the CDRT holds on preventability within the six categories are as follows:

1. ***Abuse & Neglect-Related***: CDRT follows the stance of the CAPC and other organizations including the CDC, AAP and AAFP, which believes that all child abuse and neglect is ultimately preventable. Therefore, they are collectively given a "probably preventable" determination by the CDRT. Neglect-related deaths are the most preventable of these deaths since often adequate supervision of the child is all that would be necessary to prevent the death.

2. ***Firearm-Related***: CDRT considers all firearm-related deaths to be "probably preventable." The thought behind this determination is that without the firearm the death would probably not occur.

3. ***Healthcare Access-Related***: This encompasses, prenatal, medical, and mental healthcare. These cases do not follow generalizations and preventability must be accounted for individually for preventability. Each case is assessed for any warning markers beforehand, degree of action that would have to have been taken to treat the illness, and how effective it would have been in avoiding the demise.

4. ***Motor Vehicle Accident-Related***: The CDRT asserts that as a form of an accident, they are probably all preventable.

5. ***Sleep-Related***: The CDRT assesses the quality and quantity of the identified risk factors in the sleeping environment in order to determine preventability. For example, SIDS-Related deaths in a completely safe sleep environment, is considered probably not preventable while asphyxia in an unsafe sleep environment is considered probably preventable.

6. ***Adolescent Risk-Taking -Related***: A stage of adolescence related to peer group pressures, a sense of invulnerability and an immature frontal cortex with attendant deficiencies of impulse control and judgement. The CDRT views these deaths to be probably preventable.

CURRENT CDRT ROSTER

Sergeant William Baker	*Contra Costa County Sheriff-Corner's Division*	Sergeant
Natalie Berbick, MSW	*Public Health*	Program Manager
Krisitin Bianco	*Contra Costa County AMR*	Interim CES Specialist
Jim Carpenter, M.D., MPH	*Contra Costa County, Health Services / Contra Costa Regional Medical Center*	Staff Pediatrician
Carol Carrillo, MSW	*Child Abuse Prevention Council of Contra Costa County*	Executive Director
Malkia Crowder	*Contra Costa County, Probation Dept.*	Probation Supervisor
Mariana Dailey	*Contra Costa Health Services*	Senior Health Education Specialist
Lisa G. Diemoz, MPH	*Contra Costa Health Services, Public Health Division / Epidemiology, Planning & Evaluation*	Epidemiologist
Captain William Duke	*Contra Costa County, Sheriff-Coroner's Division*	Commander
Maria Fairbanks	*Contra Costa EMS*	Trauma Coordinator
Rachel Foster	*Contra Costa County Child and Family Services*	Social Work Supervisor II
Paul Graves	*Contra Costa County District Attorney's Office/Sexual Assault\Family Violence Unit*	Sr. Deputy District Attorney
Elisa Heinrich	*Child Abuse Prevention Council of Contra Costa County*	Accounting Manager
Chad Henry	*Contra Costa County EMS*	Trauma Coordinator
Janet Johnson	*SDMC*	Risk Manager
Arnold Josselson, MD	*Forensic Medical Group, Inc.*	Pathologist
Kimberly Klein, MD	*Kaiser Permanente, Walnut Creek Medical Center*	Pediatrics
Captain John Lowden	*Contra Costa County, Sheriff-Coroner's Division*	Commander
Ted Martell	*Contra Costa County, Probation Dept.*	Probation Manager
Joan Miller, MSW	*Contra Costa County Child and Family Services*	Interim CFS Director
Neely McElroy	*Contra Costa County Child and Family Services*	Division Manager
Susan Nairn PHN	*Public Health*	Program Manager
Becky Nelson	*Contra Costa County, Child Welfare Ombudsman*	Child Welfare
Suzanne Nelson	*Contra Costa County, Probation Dept.*	Probation Supervisor
Colleen Samsing	*Contra Costa County, Probation Dept.*	Probation Supervisor
Det. Krista Sansen	*Concord Police Department*	Detective
Duane Spencer, D.D.S.	*Pediatrics & Forensics Dentistry*	Dentist
Kara Vance	*Child Abuse Prevention Council of Contra Costa County*	DRT Coordinator
Troy Vincent	*Contra Costa County, AMR*	Clinical Coordinator
Michelle Voos	*Contra Costa County, EMR*	Paramedic, Prehospital Care Coordinator

PREVIOUS CDRT MEMBERSHIP

Carol Bokelman	*Children & Family Services*	**Past SWSII**
Barbara Cappa	*Child Abuse Prevention Council of Contra Costa County*	Past DRT Coordinator
James, Rhonda MA, MFT	*Contra Costa Crisis Center*	Past Grief Program Coordinator
Bruce Flynn	*Contra Costa County District Attorney's Office/Sexual Assault\Family Violence Unit*	Past Sr. Deputy District Attorney
Nancy Georgiou	*Contra Costa County District Attorney's Office/Sexual Assault\Family Violence Unit*	Past Sr. Deputy District Attorney
Nicole Gremillion	*Children & Family Services*	Past Social Work Supervisor II
Susie Moore	*Contra Costa Crisis Center*	Past Grief Program Coordinator
Tamra Roberts	*Concord Police Department*	Past Detective
Xavier Shabazz	*Contra Costa County, Sheriff-Coroner's Division*	Past Sargent
Sonia Suri	*Contra Costa Health Services*	Past Assistant
Jordan Walter	*Paramedic*	Past CES Specialist

GLOSSARY

AAP: American Academy of Pediatrics

AAFP: American Academy of Family Practice

Abuse-Related Death: A death that is directly the result of a form of child abuse

Accident: An unintentional and unexpected event; etymology of Old French in the 12c. defines accident as an "act of god" and thus suggests inevitability or fate. However most "accidents" are preventable injuries

Accidental Death: A manner of death indicating non-intentional trauma. See Mode of Death; and Intentional and Non-Intentional Injury

ACP: American College of Physicians

AMA: American Medical Association

APHA: American Public Health Association

Asphyxia: Death caused by being deprived of oxygen. Can be caused by strangulation, suffocation, choking, or smothering

Autopsy: The medical, forensic examination and dissection of a dead body for the purpose of inquiry into the cause of death. An autopsy is required by statute for violent, unexpected, sudden, or unexplained deaths

Bed-Sharing: When an adult (or another child) and an infant sleep together in the same bed

CAPC: Child Abuse Prevention Council of Contra Costa County

CCRMC: Contra Costa Regional Medical Center

CDC: Centers for Disease Control

CDRT: Child Death Review Team can be used interchangeably with CFRT

CFRT: Child Fatality Review Team can be used interchangeably with CDRT

CFS: Child and Family Services, can be used interchangeably with CPS

Child: An individual less than eighteen years of age

CHP: California Highway Patrol

Coroner: A jurisdictional official whose duty it is to investigate sudden, suspicious, or violent death to determine the cause. Contra Costa County has a Sheriff-Coroner.

Coroner's case: A suspicious or sudden death that does not occur as a result of a chronic condition while under medical surveillance

Co-Sleeping: When an adult (or another child) and an infant sleep together in the same room

CPS: Child Protective Services – The social service system design to protect children

CPSC: Consumer Product Safety Commission

CRISIS: Contra Costa Crisis Center

CURES: The Controlled Substance Utilization Review and Evaluation System. A California prescription drug monitoring program, committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

Death: The cessation of life, manifested by loss of heart beat, absence of spontaneous breathing, and the permanent cessation of brain function; loss of life

Death Classification: One of the five categories assigned to all deaths: Accident, Homicide, Natural, Suicide, or Undetermined

Death Scene Investigation: An attempt by a person functioning in an official capacity together information at the site where a fatal illness, injury, or event occurred, for the purpose of determining the cause and circumstances of the death

Emergency Medical Services: (EMS) The complete chain of human physical resources that provide patient care in cases of sudden illness or injury

EPE: CCHS Department of Epidemiology, Planning, and Evaluations

FMCH: CCHS Department of Family, Maternal, Child, and Health

Fatality: Loss of life

Fetal Death: (Common) Death of pregnancy after approximately 20 weeks

Fetus: An unborn baby that is still in its mother's womb

Firearm-Related Death: A death directly involving a firearm

FIMR: Refers to the act that resulted in death being one that was not deliberate, willful, or planned.

Healthcare Access-Related Death: These deaths have directly resulted from a lack of adequate prenatal, medical, or mental healthcare intervention

HIPAA: Health Insurance Portability and Accountability Act. This act was passed in 1996 and regulates the confidentiality of medical information

Homicide: Death at the hands of another (without reference to intent)

IFD: Intrauterine Fetal Demise or stillbirth. It is when the fetus dies after 20 weeks gestation

Infant: Child under one year of age

Injury: Refers to any force whether it be physical, chemical, thermal, or electrical that results in harm or death

MADD: Mothers Against Drunk Driving

Manner of Death: The legal classification of death whether natural, suicide, accidental, homicide or undetermined

MVA: Motor Vehicle Accident

MVC: Motor Vehicle Collision or Crash

MVC-related Deaths: A death that is directly related to a motor vehicle collision, includes trains, trucks, and cars

Natural Cause Death: Death resulting from inherent, existing, conditions; natural causes include congenital anomalies, disease, other medical causes, and SIDS

Negligence: In the law, doing something that a person of ordinary prudence would not do, or the failure to do something that a person of ordinary prudence would do, under given circumstances.

Premature: An infant born before thirty-seven weeks gestation

Preventable Death: A child's death is considered to be preventable if the community (through legislation, education, etc.) or an individual (through reasonable precaution, supervision, or action) could have done that which could have changed the circumstances that led to the death)

Preventability Determination: The determination of either "probably preventable," "unable to tell," or "probably not preventable" that the CDRT assigns to every case it reviews; these determinations assess the degree to which the committee believes the death could have been avoided

Prevention: In public health, the keeping of something (such as an illness or injury) from happening

Reviewable Death: Death which has been reported as having met criteria for review by the Child Death Review Team, whether or not the review has yet been completed and reported

Risk Factors: Refers to a person, thing, event, etc… that put an individual at an increased likelihood of incurring injury, disability, or death

SADD: Students Against Destructive Decisions

SIDS: Sudden infant death is the unexpected death of an infant where after review of the clinical history, death scene investigation, and a thorough postmortem examination including autopsy, fails to demonstrate another cause of death; a diagnosis of exclusion made when there is no underlying cause of death can be identified, it is not caused by abuse or neglect.

Sleep-Related Death: Deaths occurring in infants that occur during to sleep and are related to sleep environment

Suffocation: Asphyxia caused by a general deprivation of oxygen either from obstruction of external airways or lack of breathable gas in the environment

Suicide: Action of killing oneself intentionally

SUIDS: Sudden unexpected infant death syndrome; after medical history review, complete autopsy and death scene investigation these deaths are attributed to SIDS, accidental asphyxias, a percentage are found to be related to birth defects, metabolic disorders, infections, arrhythmias or seizures, the majority are preventable sleep-related deaths

Inadequate Supervision-Related Death: A death that is the direct result of a lack of adequate supervision, active supervision/surveillance would have prevented these deaths

Undetermined Death: Mode of death is not clear

Unintentional Death: Refers to the act that resulted in death being one that was not deliberate, willful, and/or planned

ABBREVIATIONS

AAP: American Academy of Pediatrics
AAFP: American Academy of Family Practice
ACP: American College of Physicians
AMA: American Medical Association
APHA: American Public Health Association
ASSB: Accidental Suffocation and Strangulation in bed
CAPC: Child Abuse Prevention Council of Contra Costa County
CCHS: Contra Costa Health Services
CCRMC: Contra Costa Regional Medical Center
CDC: Centers for Disease Control
CDR: Child Death Review
CDRT: Child Death Review Team
CDRTs: Child Death Review Teams
CFRT: Child Fatality Review Team can be used interchangeably with CDRT
CFRTs: Child Fatality Review Team can be used interchangeably with CDRTs
CFS: Child and Family Services, can be used interchangeably with CPS
CHP: California Highway Patrol
CPS: Child Protective Services – The social service system design to protect children
CPSC: Consumer Product Safety Commission
CRISIS: Contra Costa Crisis Center
CURES: Controlled Substance Utilization Review and Evaluation System
EKG: Electrocardiogram
EMS: Emergency Medical Services
EPE: CCHS Department of Epidemiology, Planning, and Evaluations
FMCH: CCHS Department of Family, Maternal, Child, and Health
FIMR: Refers to the act that resulted in death being one that was not deliberate, willful, or planned
HIPAA: Health Insurance Portability and Accountability Act.
IFD: Intrauterine Fetal Demise or stillbirth
MADD: Mothers Against Drunk Driving
MVA: Motor Vehicle Accident
MVC: Motor Vehicle Collision or Crash
SADD: Students Against Destructive Decisions
SIDS: Sudden Infant Death Syndrome
SUIDS: Sudden Unexpected Infant Death Syndrome

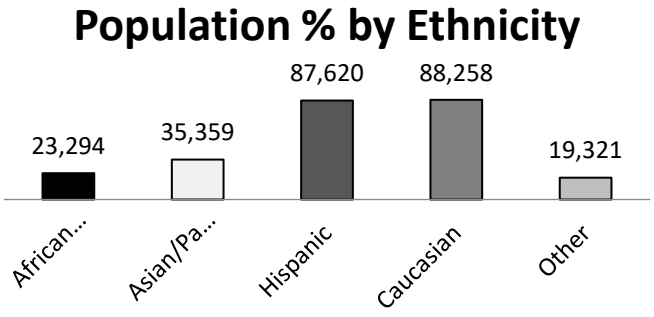
DEMOGRAPHIC BREAKDOWN OF CONTRA COSTA COUNTY 2013

Ethnic variations exist in SES, Access to care and caretaking practices. Rates refer to the likelihood of an event (in this case death) occurring within a group (in this case ethnicity). Consistently, African Americans have the highest rate of death followed by Hispanics. Asians consistently have the lowest rate of death.

Year 2013 *Population and Percent of Children <18 years of age* by *Ethnicity*

Contra Costa County

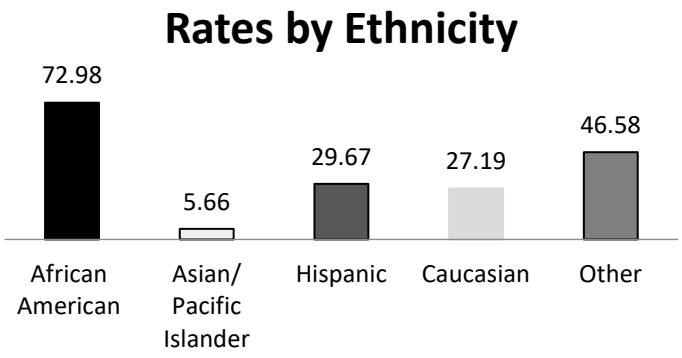
African American	23,294	9.2%
Asian/Pacific Islander	35,359	13.9%
Hispanic	87,620	34.5%
Caucasian	88,258	34.8%
Other	19,321	7.6%
Total	253,852	100%



Years 2013 *Rates of Reviewed Deaths (per 100,000 children) <18 years of age by Ethnicity*

2013

African American	72.98
Asian/ Pacific Islander	5.66
Hispanic	29.67
Caucasian	27.19
Other	46.58



Classification of All 2013 Deaths

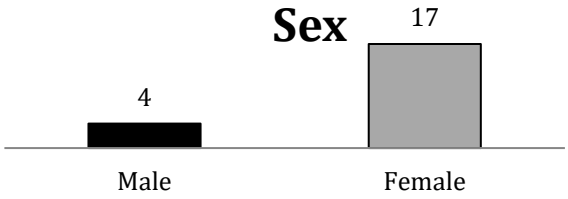
Classifications of Deaths

Accident	11
Homicide	2
Natural	2
Suicide	3
Undetermined	3

Gender Distribution of All 2013 Deaths

Sex

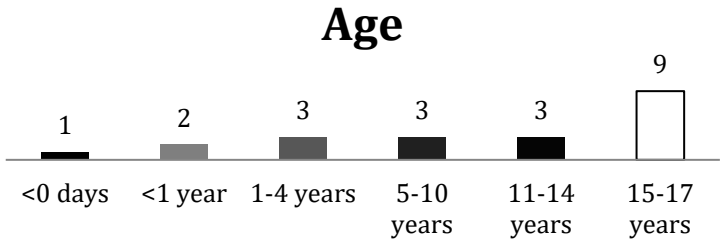
Male	4
Female	17



Age Distribution of All 2013 Deaths

Age

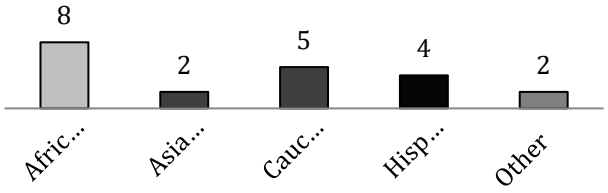
Fetus <0 days	1
<1 year	2
1-4 years	3
5-10 years	3
11-14 years	3
15-17 years	9



Number and Percent of Natural Deaths by Ethnicity of All 2013 Deaths

Ethnicity

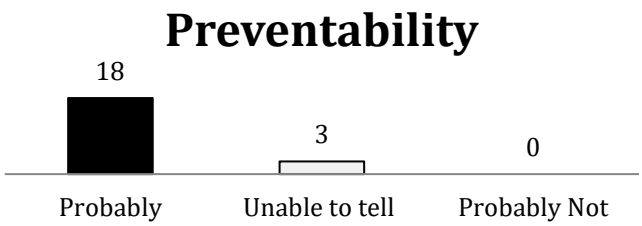
African American	8	38.10%
Asian/Pacific Islander	2	9.52%
Caucasian	5	23.81%
Hispanic	4	19.05%
Other	2	9.52%



Preventability

Preventability

Probably	18
Unable to tell	3
Probably Not	0



PART II

Classifications of Death in Children <18 years in Contra Costa County

2013

ACCIDENTS OR PREVENTABLE INJURIES

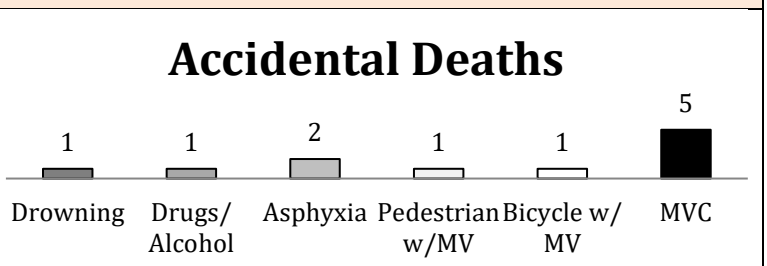
Accidents as a classification of child death represented the largest number of deaths reviewed by the CDRT over the period of 2013. The word "accident" is, form the French for 'act of god' and suggests inevitability or fate. Just the opposite is more accurate. "Accidents" are for the most part, preventable injuries. In fact, 100% of these accidental deaths were determined to be probably preventable by the CDRT.

The specific manners of accidental death included MVA/MVC, bed-sharing overlay, drowning, fire, ingestion and other. Safe sleeping practices would probably have prevented all of the bed sharing deaths. Safer driving and avoidance of adolescent risk-taking behaviors would have probably prevented the motor vehicle crashes. Active supervision would have probably eliminated most of the drowning and fire deaths as well as two children left in cars. Absence of working smoke detectors also contributed to fire deaths.

Manner of Death

Accidental Related Deaths

Drowning	1
Drugs/ Alcohol	1
Asphyxia	2
Pedestrian w/MV	1
Bicycle w/ MV	1
MVC	5



Gender Distribution

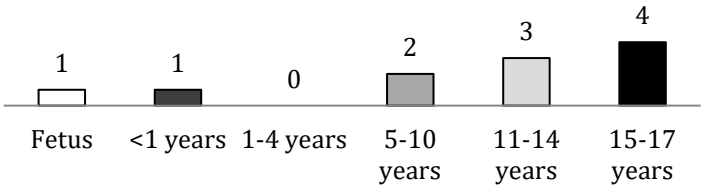
Sex

Male	7
Female	4

Age Distribution

Age

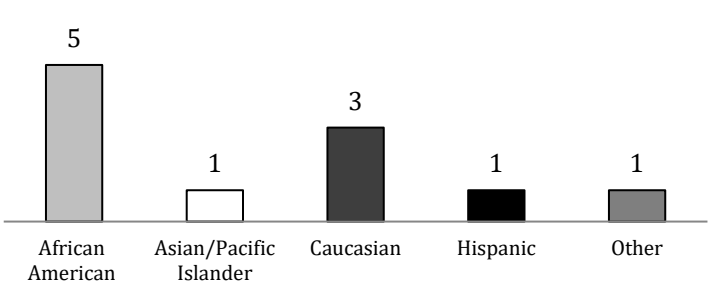
Fetus	1
<1 years	1
1-4 years	0
5-10 years	2
11-14 years	3
15-17 years	4



Number and Percent of Accidental Deaths by Ethnicity

Ethnicity

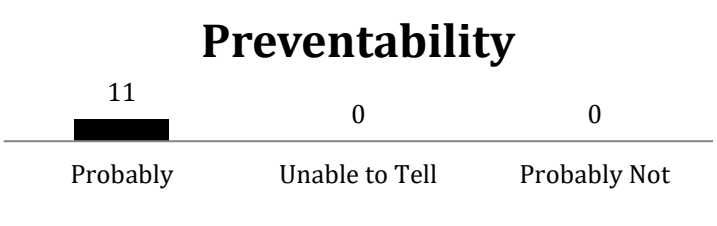
African American	5	45.5%
Asian/Pacific Islander	1	9.1%
Caucasian	3	27.3%
Hispanic	1	9.1%
Other	1	9.1%



Preventability

Preventability

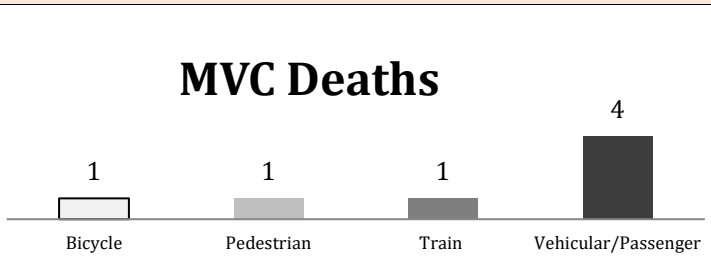
Probably	11
Unable to Tell	0
Probably Not	0



Manner of Death

Motor Vehicle Collision Deaths

Bicycle	1
Pedestrian	1
Train	1
Vehicular Passenger	4
Total	7



Gender Distribution

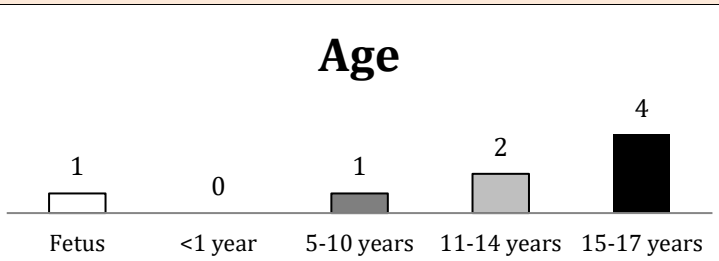
Sex

Male	5
Female	3

Age Distribution

Age

Fetus	1
<1 year	0
1-4 years	1
5-10 years	2
11-14 years	4
15-17 years	1



Number and Percent of MVC Deaths by Ethnicity

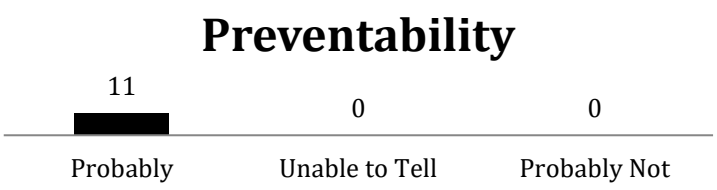
Ethnicity

African American	3	37.5%
Asian/Pacific Islander	1	12.5%
Caucasian	2	25.0%
Hispanic	2	25.0%
Other	0	0.0%

Preventability

Preventability

Probably	11
Unable to Tell	0
Probably Not	0



HOMICIDES

Homicides in common parlance refer to death at the hands of another without reference to intent. Legal definitions include:

1. ***Murder***: Unlawful killing a human being with malice a forethought (requires premeditation plus are element of malice)
2. ***Manslaughter***: An unlawful killing of a human being without malice a forethought
3. ***Voluntary Manslaughter***: An unlawful killing committed under circumstance which, although they do not justify the homicide, mitigate it
4. ***Involuntary Manslaughter***: Criminally negligent homicide, such as a death resulting from the negligent operation of a motor vehicle

In 2013, there were two (2) homicides of teen boys, both by firearm. Unlike most years, neither was African American or Hispanic. Both appeared to be gang-related and one occurred in a teen with prior history of child abuse.

The DRT determined that both deaths were preventable since the CDRT considers gun-related deaths as preventable. Many modalities have to be considered in ultimately preventing these deaths and include:

1. ***Limiting easy access*** to guns and ammunition
2. ***Multi-systemic therapy*** for troubled youth
3. ***Dropout prevention*** programs and alternative education opportunities
4. ***Mentoring***, therapy and bullying prevention support programs
5. ***Parenting programs***
6. ***All forms*** of Child Abuse Prevention
7. ***Other*** preventative measures identified

Manner of Death

Firearms Related Deaths

Homicides	2

Gender Distribution

Sex

Male	5
Female	3

Age Distribution

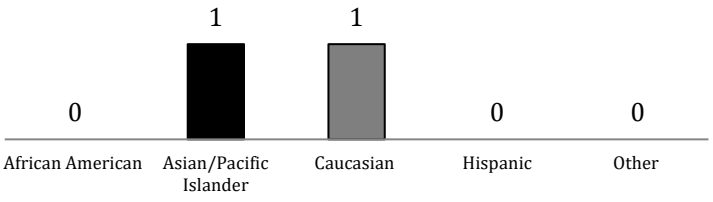
Age

Fetus	0
<1 year	0
1-4 years	0
5-10 years	0
11-14 years	0
15-17 years	2

Number and Percent of Homicide Deaths by Ethnicity

Ethnicity

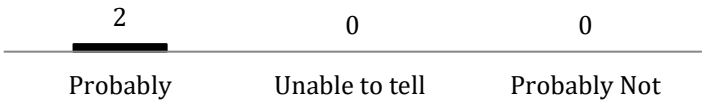
African American	0	0.0%
Asian/Pacific Islander	1	50.0%
Caucasian	1	50.0%
Hispanic	0	0.0%
Other	0	0.0%



Preventability

Preventability

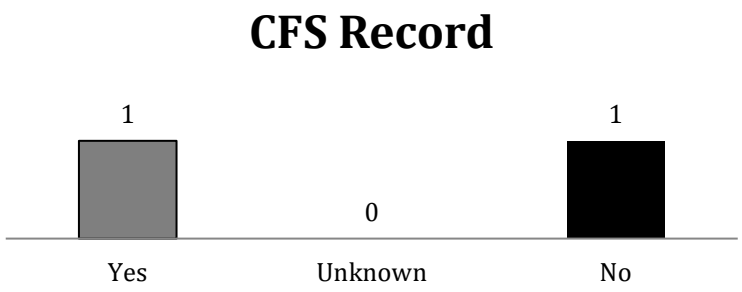
Probably	2
Unable to Tell	0
Probably Not	0



Child Family Services Records

CFS Record

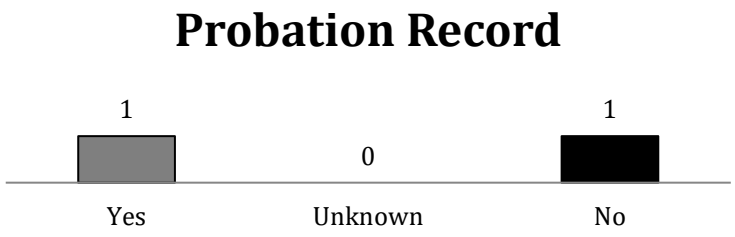
Yes	1
Unknown	0
No	1



Probation Record

Probation Record

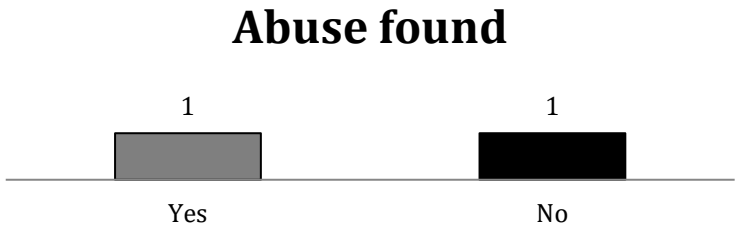
Yes	1
Unknown	0
Yes	1



Abuse Found

Abuse Found

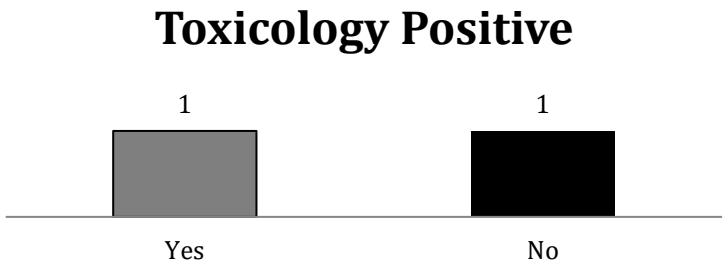
Yes	1
No	1



Toxicology Positive

Toxicology Positive

Yes	1
No	1



NATURAL CAUSE OF DEATHS

Natural Deaths include all medical causes of deaths such as infection, cardiac defects, seizures, intrauterine deaths, and SIDS. Most of these deaths occur in the first year of life with a cluster of cardiac deaths occurring in adolescence. Most natural deaths are not coroner cases and hence are not subject to CDRT review.

In 2013, there were two (2) natural deaths: one infant with acute croup and one child with viral myocarditis. The preventability was considered "unable to tell" due to the lack of information regarding whether more timely access to healthcare night might have made a difference. Known prevention modalities for natural cause of death include:

1. ***Safe sleeping practices***
2. ***Prenatal care***
3. ***Access to healthcare***
4. ***Pre-participation sports examination*** including consideration of electrocardiogram (EKG) or echocardiogram
5. ***AEDs*** - Automatic Electronic Defibrillators in gymnasiums

Manner of Death

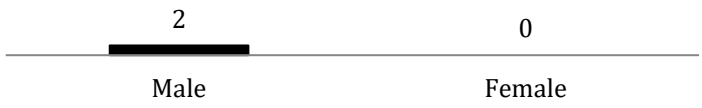
Natural Deaths

Acute Croup	1
Viral Myocarditis	1

Gender Distribution

Sex

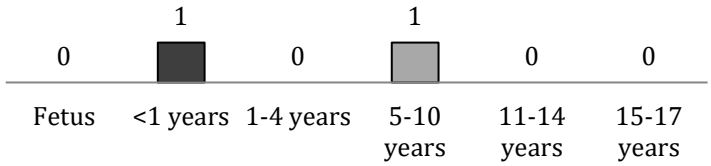
Male	2
Female	0



Age Distribution

Age

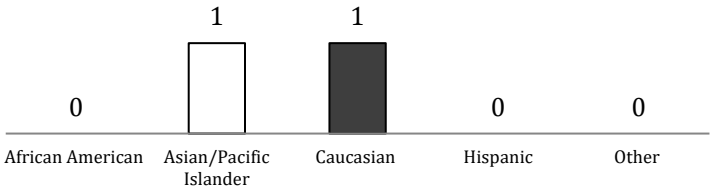
Fetus	0
<1 year	1
1-4 years	0
5-10 years	1
11-14 years	0
15-17 years	0



Number and Percent of Natural Deaths by Ethnicity

Ethnicity

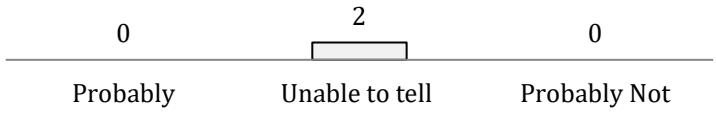
African American	0	0.0%
Asian/Pacific Islander	1	50.0%
Caucasian	1	50.0%
Hispanic	0	0.0%
Other	0	0.0%



Preventability

Preventability

Probably	0
Unable to Tell	2
Probably Not	0



SUICIDES

Adolescent suicide was seen in three (3) cases in 2013: 2 by asphyxia/hanging and 1 by massive trauma from a BART train collision. All 3 were males with histories of depression. One was on medication and all 3 had contact with mental health services. Two victims had left prior postings on social media. Suicide is deemed to be probably preventable by the CDRT and The Crisis Center. Two of these cases had had prior suicidal attempts.

The suicides in 2013 were unlike the findings in 2008 – 2012 where the suicide often had a precipitant of strife at home or school; suicide notes were unusual and the suicide usually impulsive. The ethnic distribution showed an absence of Asian-pacific islanders and African Americans.

Suffocation (hanging or plastic bag) as the manner of suicide has been increasing in national studies as use of firearms or poisoning has been decreasing. The CRISIS Center had contact and provided services for survivors and schools affected by the suicides. (See appendix for description of their program and services). The National Strategy for Suicide Prevention encourages a comprehensive approach to suicide prevention that includes (as cited in Sullivan, Annest, Simon, Luo, 2015)[1]:

1. ***Activities for enhancing social support***, problem-solving skills, and other protective factors to prevent suicidal behavior
2. ***Increasing training*** in recognizing risk factors and taking appropriate referral
3. ***Expanding access*** to social services
4. ***Reducing stigma*** and other barriers to seeking help
5. ***Providing responsible media*** reporting to reduce contagion and to enhance awareness that suicide is preventable

The CDRT suggests a mental health intervention plan that includes both early recognition of mental health distress and appropriate action. Parents, schools, and organizations can make this happen. Parents should be informed on how to tell when their child is mentally not well. Both non-profits and the school systems should hold informational meetings where parents can be educated on the signs and symptoms of emotional distress and resources within the community. Contra Costa schools can hire more counselors to reach all students, teach teenagers the importance of bringing a friend in need to one of those counselors, and enforce that the counselors are there to listen to any student in distress in confidence. Lastly, organizations like the Contra Costa Crisis Center offer wonderful resources for individuals in the community to reach out for help without feeling labeled.

> *The mission of the Contra Costa Crisis Center is to keep people alive and safe, help them through crises, and connect them with culturally relevant resources in the community*

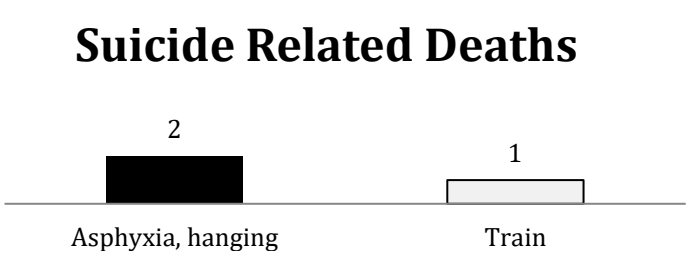
The Crisis Center has a 211 info and referral line, 24 hour crisis lines, and grief counseling programs. The 211 info and referral program is a 24-hour phone line that is available for all categories of emergency referrals within the county. The 24-hour crisis line is a phone line that will directly connect the caller to a crisis trained employee that will discuss any and all issues to try to get that individual to an emotionally safe place where they do not want to hurt themselves or others. In addition, the Crisis Center offers grief counseling following a death or tragedy. This counseling can be offered at schools, in group sessions, or individually. See appendix for more about them.

[1] US Department of Health and Human Services. Office of the Surgeon general and National Action Alliance for Suicide Prevention. *2012 National Strategy for suicide prevention: goals and objectives for action.* Washington, DC: US Department of Health and Human Services; 2012.

Manner of Death

Suicide Related Deaths

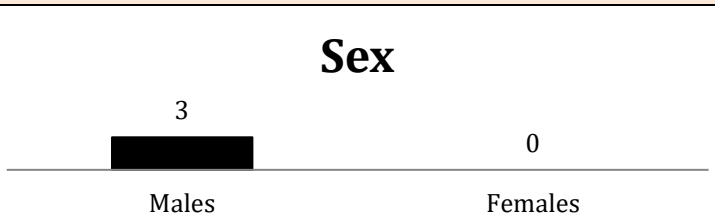
Asphyxia, hanging	2
Train	1



Gender Distribution

Sex

Male	3
Female	0



Age Distribution

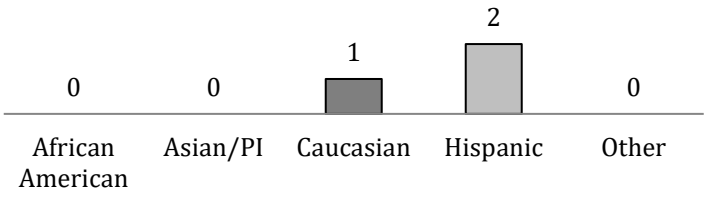
Age

Fetus	0
<1 year	0
1-4 years	0
5-10 years	0
11-14 years	0
15-17 years	3

Number and Percent of Suicide Deaths by Ethnicity

Ethnicity

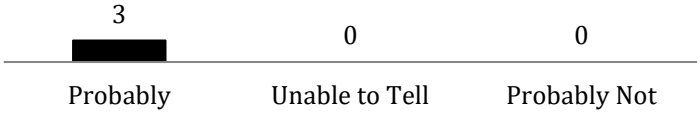
African American	0	0.0%
Asian/Pacific Islander	0	0.0%
Caucasian	1	33.3%
Hispanic	2	66.7%
Other	0	0.0%



Preventability

Preventability

Probably	3
Unable to Tell	0
Probably Not	0



UNDETERMINED CAUSE OF DEATHS

A death is classified as undetermined when after complete autopsy, death scene investigation and review of the medical history; a cause of death cannot be determined. The majority of these were sleep-related deaths where it could not be determined whether the infant succumbed to SIDS or was accidental overlay asphyxia.

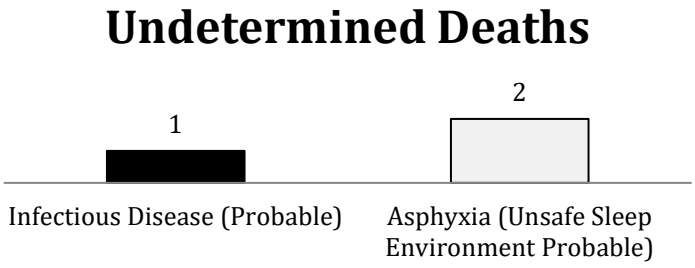
Preventability of undetermined cause of death is difficult to assess except for the SUIDS, which are believed to be 80-90% preventable with safe sleep practices. Medical conditions that may be classified as undetermined include fatal cardiac arrhythmias or unobserved seizures that may leave no evidence at autopsy.

In 2013, there were three (3) undetermined deaths: 2 sleep-related and probably SUIDS and one probable infection. Both SUIDs were African American infants in unsafe sleeping environments and were hence deemed preventable. The infant with findings of dehydration and opacified lungs probably succumbed to a medical malady that since not identified, we could not determine preventability

Manner of Death

Undetermined Deaths

Infectious Disease	1
Asphyxia (Unsafe Sleep Environment Probable)	2



Gender Distribution

Sex

Male	3
Female	0

Age Distribution

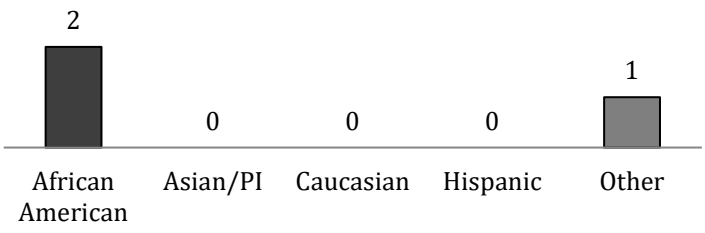
Age

Fetus	0
<1 year	3
1-4 years	0
5-10 years	0
11-14 years	0
15-17 years	0

Number and Percent of Undetermined Deaths by Ethnicity

Ethnicity

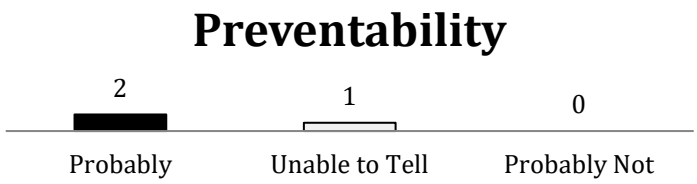
African American	2	66.7%
Asian/Pacific Islander	0	0.0%
Caucasian	0	0.0%
Hispanic	0	0.0%
Other	1	33.3%



Preventability

Preventability

Probably	2
Unable to Tell	1
Probably Not	0



PART III

Selected Topics in Child Death

INTERVENTIONS FOR CHILD ABUSE DEATHS

In 2013, no deaths were directly attributed to child abuse. However, after review there were four (4) deaths where child abuse/neglect was considered contributory to the deaths:

1. A 5-year-old was not restrained and died in a motor-vehicle crash where the mother drove unsafely and was charged with four (4) counts of child abuse/endangerment.
2. A 16-year-old, who died from suicide by BART train, whose parents had prior allegations of child physical abuse and domestic violence.
3. A 14-year-old with MVC death secondary to his jaywalking with history of being in foster-care from San Francisco.
4. A 16-year-old homicide victim whose parents had a report of physical abuse at age 3, although investigation proved inconclusive.

In regards to prevention determinations and intervention models, the CDRT follows the teachings and practices of CAPC. CAPC believes that Child Abuse is 100% preventable, therefore, the many programs that they run not only work to prevent child abuse before it happens but also address abuse as it occurs within the community.

CAPC Mission: To promote the safety of children and prevent child abuse and neglect in Contra Costa County by raising community awareness, influencing public policy, educating our community and providing resources.

The programs that CAPC offers are:

1. ***Baby bag/New parent kit:*** The baby bag/new parent kit is a collection of materials given to parents when they are leaving the clinic or hospital at which their child was born. The materials inside offer support and education surrounding parenting and can be in either English or Spanish. Two of the resources offered within are developmental growth charts and child safety information. The primary goal is to explain normal child-behavior to parents so that they do not have inappropriate expectations of their child that result in parental anger or frustration and possibly abuse. Secondly, to educate the parents on how truly fragile their new child is and how easily it can be to cause them harm. These kits work to fight any chances of possibly shaken baby syndrome from occurring.
2. ***Mandated reporting training:*** Mandated reporting training, which trains individuals who directly work with children on how to identify and report cases of abuse. The training can take either 60 or 90 minutes and are offered free by CAPC. By teaching individuals to report abuses, it stops abuse from occurring for both that individual and any others that may have followed.
3. ***Nurturing Parenting Program (center based and home based):*** Nurturing parenting program are both programs that address cases of abuse before CFS involvement. Individuals can to seek help to stop the cycle of abuse before they are entered into the system. Parents can either be referred to this program or voluntarily enter themselves. There is both a center-based and home-based program available. The center-based program is a 22 week long program and its goals are as follows:
    - Preventing recidivism in families receiving social services
    - Connecting families to community resources
    - Reducing the rate of juvenile delinquency and substance abuse
    - Stopping the intergenerational cycle of child maltreatment by teaching positive parenting behaviors

"Classes highlight replacing abusive behaviors with nurturing intentional habits, promoting healthy physical and emotional development, while teaching appropriate role and developmental expectations. Each week parents and children are provided with dinner and classroom activities entail role plays, videos, worksheets, parent handbooks, and assessment inventories. In addition, parents and children learn how to play games, sing songs and have fun as a family"

The home based program is an evidence based home visitation program that works with families who have children 12 years of age and younger. This program specifically works to assist families that do not qualify for county-based visitation services. This course is only 15 weeks long and its curriculum delivers these measurable outcomes:

- Developing empathy, parent-child bonding and attachment
- Teaching parents appropriate expectations regarding a child's growth and development to foster positive brain development and feelings of self-worth, as well as trust and security
- Administering discipline while promoting dignity for both the adult and child
- Empowering adult and child, so far as how to nurture themselves and each other
- Promoting positive self-worth
- Helping all family members in developing a meaningful level of self-awareness and acceptance

Home based-services are offered to families in both East and Central Contra Costa County and can be in either English or Spanish.

4. ***Speak Up Be Safe:*** Speak up be safe is a program that works with children so that they can understand and recognize abuse. It has been specially designed to be comprehensive and developmentally appropriate. It is implemented with 1st-6th graders and deals with the topics of: child abuse, cyber bullying, bullying, sexual harassment, and technology safety. Each classroom has two safety lessons, followed by activities administered by teachers to enforce the initially presented content. Additional take-home materials are distributed to students to share with their caregivers and encourage conversation. The main purpose is to empower young children, in particular if they are victims of abuse to speak up.

5. ***Surviving Parenthood Guide:*** Surviving parenthood is a comprehensive resource guide given to parents. The pamphlet lists services and resources within Contra Costa County that are available to parents and includes factors to help reduce neglect and abuse. CAPC is currently distributing in 13th edition both in English and Spanish for no charge.

INTERVENTIONS FOR NEGLIGENT DEATHS

Additional interventions for negligent-related deaths include:

1. **Active Supervision**
2. **Functioning smoke detectors**
3. **Fire escape plans, extinguishers**
4. **Pool barriers, alarms, gates**
5. **Swim lessons, water safety classes**
6. **Use of personal flotation devices**
7. **Access to healthcare**
8. **Home visitation**
9. **Parenting classes**

INTERVENTIONS FOR FIREARM-RELATED DEATHS

In 2013, we reviewed two (2) firearm-related deaths. Both were homicides in teens and probably gang-related. The prevention of firearm-related deaths begins with two main components; effective storage and control of the family firearm. According to the American Academy of Pediatrics:

> *"Gun avoidance programs are designed to educate children as a way of reducing firearm injury; however, several evaluation studies have demonstrated that such programs do not prevent risk behaviors and may even increase gun handling among children. In contrast results of a large national randomized controlled trial demonstrated that brief physical counseling directed at parents, combined with distribution of gunlocks, may be effective in promoting safer storage of guns in homes with children. A recent randomized controlled trial found that a safe storage campaign with gun safe distribution was both feasible and effective at limiting household exposure to unlocked and loaded guns."*[2]

Children gain access to the firearm in the family home due to its accessibility. If it is properly stored in a locked area, without ammunition, unloaded, safety mechanisms, and trigger locks prevent the likelihood of that child being able to access it and use is severely diminished. It has been proven that keeping a gun locked or unloaded has protective effects of 73% and 70% with regard to risk of both suicide and unintentional injury (as cited in Dowd & Sege et al, 2012).[3] In regards to reducing homicides involving firearms, a combination of safe storage practices and the implementation of community programs that reduce violence within at-risk urban youth can reduce fatalities.

One program that has had success is *Fly* or *Fresh Lifelines for Youth* (See appendix). It is important to note that Fly is not an available program within Contra Costa County, but in looking at its intervention model and strength we can assist in its growth to our county or implement similar models within our own county-wide programs. The detailed intervention model which *fly* utilizes is detailed within the appendix. The program targets youth that are incarcerated or at high risk of incarceration and offers a combination of legal educations, leadership positions, and mentorship opportunities. In an article by Law Center to Prevent Gun Violence it was reported that, "The unsafe storage of firearms is a public health and safety issue in the US […] 73% of children under age 10 living in homes with guns reported knowing the location of their parents' firearms." [4]

Community programs that have been associated with reduction of firearm death and violence in general include:

1. **Buyback programs**
2. **Trigger lock give aways**
3. **School drop-out prevention programs**
4. **After-school programs**
5. **Alternative education**
6. **Bullying prevention**
7. **Teen recreation programs**
8. **Mentor programs**

[2] Dowd, M. Denis MD, MPH, Sege, Robert D. MD, PhD, and Council on Injury, Violence, and Poison Prevention Executive Committee. (2012). Firearm-Related Injuries Affecting the Pediatric Population. *Pediatrics* 130 (2012): e1416. Web.
[3] Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional firearm injuries. JAMA 2005;293(6):707-714. Web.
[4] Frances Baxley & Matthew Miller, parental Misperceptions about children and Firearms, 160 archives of Pediatric & Adolescent Med. 542, 544 (2006). Web.

Health organizations including the APHA, AMA, AAP, AAFP, ACP, and CDC have viewed firearm injuries and death as a public health matter and have encouraged increased research. Presently there are dramatic limitations on research in this area at the national level because of congressional reluctance to counter the gun lobby. In Florida, a law had passed to outlaw a pediatrician from even asking about gun ownership in a home where children reside. This law has since been rescinded. There are 9 other states that have introduced similar legislation limiting physician's ability to query and/or counsel regarding gun ownership and safe storage. This is in spite of research showing that "a gun stored in the house is associated with a threefold increase in the risk of homicide and a fivefold increase in the risk of suicide" (as cited in Dowd & Sege et al, 2012).[5][6][7] There are no restrictions on physician counselling regarding other child safety concerns such as bike helmets, care seats, poisoning prevention, etc. That this law violates the physicians' First Amendment rights and threatens their ability to provide optimal care and help prevent injury demonstrates how ingrained firearms are in the U.S. Mandatory waiting periods, restoration of the assault weapon ban, closure of the gun show loop hole, and mental health restrictions for gun purchases are legal modalities that seem obvious to many but are unlikely to occur in most states or localities let alone nationally.

The firearm is one of few consumer products not subject to regulation by the Consumer Product Safety Commission although it is the most deadly and dangerous consumer product. Technology exists to make firearms both safer and usable by a single user but there is presently little consumer demand for these attributes that could limit injury, death and crime.

Ultimately, firearm-related deaths and injuries are preventable but significant changes in our culture, priorities and legislations will be required before these deaths can be prevented.

[5] Kellermann AL, Rivara FP, Rushforth NB, et al. Gun ownership as a risk factor for homicide in the home. *N Engl J Med*. 1993;329(15):1084-1091

[6] Kellermann AL, Rivara FP, Somes G, et al. Suicide in the home in relation to gun ownership. *N Engl J Med*. 1992;327(7):467-472

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INTERVENTIONS FOR NATURAL CAUSE OF DEATH

In 2013, we reviewed two (2) natural deaths and both were related to infections. For IFDs the proposed prevention plan is adequate prenatal care. The available programs through Contra Costa Health Services are: Black Infant Health, Healthy Families America, and Comprehensive Perinatal Services Program Information for Clients, Prenatal Care Guidance, and Lift Every Voice. These programs are available for low-income Medi-Cal eligible women across the county. Some programs have specific requirements, but each one works towards ensuring that all women have the resources for adequate prenatal care. Early recognition of high-risk pregnancies of any cause increases the likelihood of improved pregnancy outcomes. That 55% of all child deaths (43 of 78) over 2013 occurred in the first month of life, highlights the value of comprehensive preconception, prenatal, and perinatal care. In 2013, of the 78 total deaths, 50 were infant deaths, of those infant deaths 43 were neonatal and 7 were post neonatal. Combining data from 2008-2013 there were 241 neonatal deaths of 574 total child deaths or 42%.

Healthcare interventions are primarily preventative and ongoing medical care. All children participating in sports teams should have an annual pre-participation physical exam with their physician in addition to consideration of EKG or echocardiogram. This procedure will detect an enlarged heart or irregular heartbeat that could be fatal. Any individual with known seizure disorder should remain on anti-seizure medication or have it readily available. Any individual with allergies or asthma should have their epi-pen or inhaler accessible at all times. Parents should have their children vaccinated against disease and get an annual flu shot. Lastly, any child with persistent or worsening symptoms should access healthcare.

Access to healthcare that is comprehensive and prevention-based is the backbone to prevent most natural causes of death. Healthcare education for all of us ought to take place in the schools. Universal healthcare access should be available with a concentration on prevention, disease recognition, and management.

INTERVENTIONS FOR MVA/MVC-RELATED DEATHS

In 2013, the CDRT reviewed seven (7) motor-vehicle accidents (MVA) or motor-vehicle crashes (MVC). Unsafe driving by 4 adults and 1 teen resulted in 5 deaths. Unsafe bicycling by a 12-year-old caused one death and one death was from teen jaywalking. Once of the deaths was determined to be child abuse/endangerment since the child was unrestrained and the driver drove dangerously.

Virtually every MVC death was accompanied by unsafe driving. Adolescent risk-taking behaviors often accompany the fatal collision. Interventions to prevent these deaths include:

1. Continuation of the graduated driver's license.
2. Improvements in car safety including restraints, airbags, crumple zones and collision avoidance.
3. Continuation of use of mandatory child safety restraints through age 8 or 80 pounds.
4. Support for programs such as Mothers Against Drunk Driving (MADD) or Students Against Destructive Decisions (SADD) in the schools.
5. Ongoing and increased enforcement of traffic safety regulations.
6. Limiting access to and better safety crossing at railway tracks.
7. Promotion of bicycle safety fairs and enforcement of the safety helmet law.

INTERVENTIONS FOR SLEEP-RELATED DEATHS

Sleep-related deaths occurred in three (3) infants in 2013. All were in unsafe sleep environments and 67% were African American. One was deemed accidental asphyxia and two were deemed undetermined (could be accidental asphyxia or SIDS). 100% were deemed preventable by safe sleeping practices. Combining 2013 with previous CDRT 2008-2012 data would place 38 of 40 (95%) sleep-related deaths in unsafe sleep environments.

The American Academy of Pediatrics (AAP) released a Policy Statement, SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment and an accompanying Technical Report on October 20, 2016[8]. The AAP in these new guidelines expanded its previous risk reduction recommendations by focusing on a safe sleep environment that can reduce the risk of all sleep-related infant deaths including SIDS. The current AAP guidelines include:

1. *Always place infants on their "back to sleep for every sleep".*
   Parents and caregivers are advised to place infants on their backs for every sleep until they are 12 months old. Once an infant can turn from their back to front (supine to prone) and from front to back (prone to supine), place the infant to sleep on their back, but allow the infant to sleep in the position he or she assumes.

2. *"Use a firm sleep surface" for infants. A firm crib mattress covered by a fitted sheet is the recommended sleeping surface.*
   A crib, bassinet, or portable crib/play yard that meets the current Consumer Product Safety Commission standards is recommended. Do not allow infants to sleep on a couch, chair, cushion, bed, pillow, beanbag, or in a car seat, stroller, swing, infant carrier or bouncy chair. If an infant falls asleep any place that is not a safe sleep environment, move the infant to a firm sleep surface right away. Infant sling carriers are not recommended for babies younger than four months of age because of the risk of suffocation.

3. *"Breastfeeding is recommended" and is protective against SIDS.*
   If possible, mothers should exclusively breastfed or feed their infant expressed human milk, for the first six months. (No formula or non-human milk-based supplements.) Any breastfeeding, however, even for a short time, has been shown to be protective against SIDS.

4. *It is recommended that infants sleep in the parents' room, close to the parents' bed, but on a separate surface designed for infants, ideally for the first year of life, but at least for the first 6 months.*
   Room sharing without bed sharing is recommended. A crib, bassinet, portable crib or play yard should be placed close to the parents' bed. Infants can be brought into bed for feeding or comforting but should be returned to their own crib/bassinet when they fall asleep. Babies should not sleep alone in an adult bed or with adults, other babies or children.

5. *Keep soft objects and loose bedding away from the infant's sleep area to reduce the risk of SIDS, suffocation, entrapment, and strangulation.*

[8] SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. (2016). *Pediatrics,138*(5). doi:10.1542/peds.2016-2938
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No toys, soft objects, stuffed animals, pillows, positioning devices or extra bedding should be in, attached to, or draped over the side of the crib. Bumper pads or similar products that attach to the cribs slats are not recommended. Instead of blankets, a one piece sleeper or wearable blanket can be used to keep a baby warm.

6. *Consider offering a pacifier at nap time and bedtime.*
   Use a pacifier when placing an infant for sleep, unless the baby refuses it. Do not attach a pacifier by a string around the infant's neck or to their clothing or other object. Once the infant is asleep, it is not necessary to reinsert the pacifier. For breastfed babies, wait until the infant is about one month old or is used to breastfeeding, before offering a pacifier.

7. *Avoid smoke exposure during pregnancy and after birth.*
   There should be no smoking near pregnant women or infants. No one should ever smoke around a baby especially in the same room, in a car or in the room where an infant sleeps. Infants who are exposed to smoke have a higher risk of dying from SIDS. Mothers should not smoke during pregnancy or after the baby is born.

8. *Avoid alcohol and illicit drug use during pregnancy and after birth.*
   Mothers should not use alcohol or illicit drugs during pregnancy and after the baby is born. Infants are placed at high risk for SIDS when sharing a bed with adults who are using alcohol and/or illegal drugs.

9. *Avoid overheating and head covering in infants.*
   The area where the baby sleeps should be well ventilated and at a temperature that is comfortable for a lightly clothed adult. Bibs and clothing with ties or hoods should be removed and the infant's head should not be covered. An infant is too hot if they are sweaty or their chest is hot to the touch. Infants should be dressed in no more than one layer more than an adult is wearing.

10. *Pregnant women should obtain regular prenatal care.*
    Research studies show that regular medical care during pregnancy is associated with a lower risk of SIDS. Regular medical checkups are the best way to make sure a baby is growing properly and that there are no problems that will affect their health.

11. *Infants should be immunized in accordance with recommendations of the AAP and Centers for Disease Control and Prevention.*
    Recent evidence suggests that immunizations might protect against SIDS. Infants should be immunized as recommended by the American Academy of Pediatrics (AAP) and the Centers for Disease Control and Prevention. It is also important that babies have regular well-child checks as recommended by the AAP.

12. *Avoid the use of commercial devices that are inconsistent with safe sleep recommendations.*
    Home monitors that check a baby's breathing and/or heart rate are not advised as a way to prevent SIDS. Commercial devices such as wedges, positioners, special mattresses or other types of sleeping products should be avoided. There is no evidence that these devices or products protect against SIDS or suffocation or that they are safe.

13. *Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SIDS.*
    The use of cardiorespiratory monitors has not been documented to decrease the incidence of sids. These devices are sometimes prescribed for use at home to detect apnea or bradycardia and, when pulse oximetry is used, decreases in oxyhemoglobin saturation for infants at risk of these conditions. In

addition, routine in-hospital cardiorespiratory monitoring before discharge from the hospital has not been shown to detect infants at risk of SIDS. There are no data that other commercial devices that are designed to monitor infant vital signs reduce the risk of SIDS.

14. ***Supervised, awake tummy time is recommended to facilitate development and to minimize development of positional plagiocephaly.***
Tummy time is important for infant growth and development. It builds muscles and coordination in the head, neck, shoulders, and abdomen and back that are needed to reach important developmental milestones (such as rolling over, sitting up, and crawling). Supervised tummy time when an infant is awake takes pressure off the back of the baby's head so it is less likely to be flat.

15. ***There is no evidence to recommend swaddling as a strategy to reduce the risk of SIDS.***
Swaddling, or wrapping the infant in a light blanket, is often used as a strategy to calm the infant and encourage the use of the supine position. There is a high risk of death if a swaddled infant is placed in or rolls to the prone position. If infants are swaddled, they should always be placed on the back. Swaddling should be snug around the chest but allow for ample room at the hips and knees to avoid exacerbation of hip dysplasia. When an infant exhibits signs of attempting to roll, swaddling should no longer be used. There is no evidence with regard to SIDS risk related to the arms swaddled in or out. These decisions about swaddling should be made on an individual basis, depending on the physiologic needs of the infant.

16. ***Health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk-reduction recommendations from birth***
Hospital NICU/newborn nursery staff should model SIDS risk reduction recommendations and implement these guidelines from the time the baby is born through discharge. Childcare providers should receive education about safe sleep practices and develop written policies to reinforce the guidelines. Health care professionals, physicians and nurses should receive education about infant safe sleep measures.

17. ***Media and manufacturers should follow safe sleep guidelines in their messaging and advertising.***
Be aware of media and advertising messages that provide misinformation about the best and safest ways for a baby to sleep. Educate parents about how they can make their infant's sleep area cozy, cute and comfortable but as safe as possible.

18. ***Continue the "Safe to Sleep" campaign, focusing on ways to reduce the risk of all sleep-related infant deaths, including SIDS, suffocation, and other unintentional deaths. Pediatricians and other primary care providers should actively participate in this campaign.***
Public education should continue for all who care for infants, including parents, child care providers, grandparents, foster parents, and babysitters, and should include strategies for overcoming barriers to behavior change. The campaign should continue to have a special focus on the black and American Indian/Alaskan Native populations because of the higher incidence of SIDS and other sleep-related infant deaths in these groups.

19. ***Continue research and surveillance on the risk factors, causes, and pathophysiologic mechanisms of SIDS and other sleep-related infant deaths, with the ultimate goal of eliminating these deaths altogether.***
Education campaigns need to be evaluated, and innovative intervention methods need to be encouraged and funded. Continued research and improved surveillance on the etiology and pathophysiologic basis of SIDS should be funded.

INTERVENTIONS FOR ADOLECENT RISK-TAKING-RELATED DEATHS

Unlike previous years, we identified adolescent risk-taking as a factor in just four (4) cases:

1. One jaywalking teen
2. One car-racing teen
3. One accidental opiate overdose
4. One canal drowning

Several deaths occurred in children where they were passengers with unsafe adult drivers. All of these deaths were deemed preventable with safer behaviors.

Recommendations from this review team are as follows:

1. We support the graduated driver's license for new drivers
2. Seatbelt laws are essential and need to be enforced
3. MADD and SADD presentations in schools as well as CHP presentations
4. Substance use/abuse programs are to be supported and should be covered by routine health coverage
5. Limiting access to water ways with significant drowning potential
6. The use of "good judgment" as advice from parents, teachers, and other adults to teens

PART IV

Conclusions and Recommendations

INTERVENTIONS & CONCLUSION

The death of a child is a tragedy. A preventable death of a child is an unacceptable tragedy. The majority of the 21 deaths reviewed by the CDRT in 2013 were deemed preventable and often by means no more complicated than the adequate supervision of children or provision of a safe sleep environment.

Some of the findings of this report and prior reports may come as a surprise to the reader but the reasons children die in Contra Costa are for the most part, the same reasons that children die in the rest of the USA.

Teens die from three primary manners of death: 1) accidents (better called preventable injuries) with motor vehicle crashes being the single most common cause of death, 2) homicides with 90% involving firearm, and 3) suicides.

In the first year of life, the most likely cause of death is related to an unsafe sleeping environment resulting in SUIDS, SIDS or accidental asphyxia. This is found by all CDRT's across the country. This has led to a national movement encouraging safe-sleeping practices to be taught, practiced and reinforced from prenatal care, birth and the perinatal period, through the first year of life.

Adequate and active supervision of children can prevent deaths from fire, drowning and being left in a car.

Which brings us to asking who is responsible for preventing unnecessary child fatalities in Contra Costa County? The answer is simple: All of us.

Parents are the first and foremost protectors of children. Active supervision includes noticing someone else's child about to step in the street or the pool. Preventing injury includes using proper restraints in cars on your children and yourself and driving safely and defensively. It includes practicing safe-sleeping in the first year of life, even if you shared a bed with your first child without a problem. It includes checking your smoke detectors annually and having a carbon monoxide detector also. It includes using personal flotation devices on boats even if it is unlikely that you or your children would fall out. It includes always checking the car seat for a sleeping infant even if you have errands and appointments to get to. Prevention of injuries includes checking in with your teen and recognizing distress or risk-taking behaviors. Prevention includes safe storage of a firearm if you have to have a firearm at all.

Teens have a shared responsibility in being aware of their influence on each other and the lack of foresight they may demonstrate in many decisions. Suicides, homicides and MVC's are fatal consequences of the above.

Law enforcement have the responsibility of enforcing laws and also often coming to the rescue when injuries occur. We salute our Emergency Medical Services that have consistently gotten first responders to injuries in a timely fashion. We would like to decrease their calls by the 65% of potentially, preventable fatalities they have to respond to.

The media has a role in injury prevention by provision of child safety public service announcements and stories that educate but do not sensationalize child fatality.

Legislators have a role in child injury prevention and have clear successes in the laws regarding child car restraints and the graduated driver's license. Many extant laws such as regarding smoke detectors in rental units and barriers around pools tend not to be enforced until a tragedy occurs.

It is hoped that this report will elucidate the preventability of childhood injury and fatality so that these 21 children did not die in vain.

NEXT STEPS

It is hoped that the people of Contra Costa County will agree that prevention of child injury and death is a priority and reachable goal.

The following are some steps to consider for our community:

1. ***Safe to Sleep county wide project***. Trainings have already taken place at Contra Costa Regional Medical Center (CCRMC) for perinatal nurses and pediatricians. Nursing protocol is in process to both practice and model safe sleep practices for all newborns at CCRMC. A survey of all delivering hospitals regarding the delivery of the Safe to Sleep message to parents is in process with all hospitals being offered trainings. It has been estimated that 1,000 infants will survive each year in the US if safe-sleeping practices are more universally practiced.

   Los Angeles County did a county-wide Safe to Sleep campaign several years ago, funded by First 5 monies and have already seen a decline in sleep-related deaths in infants. Alameda county has just launched a safe to sleep program with billboards and signage in public transit.

2. ***Treat firearm-related injury and death as a public health problem.*** Blocking research funds for the CDC serves no function other than allowing the continuation of gun-related violence and death. Safe storage of firearms should be part of child safety discussions in the doctor's office and not made illegal, as was in the state of Florida. The firearm is a consumer product and should be made safer and monitored by the Consumer Product Safety Commission (CPSC).

3. ***Suicide prevention can only occur if we look out for each other and provide adequate mental health services.*** The majority of teen suicides occur as impulsive acts in response to the myriad stressors of adolescence colliding with parents, peers and schools. A growing trend is social media induced stress and bullying. Parents need to maintain communication with their teens. Teens need to be aware of their influence on each other. Schools need to serve as both places of education but also providers of counselling and conflict resolution. The Crisis Center is to be applauded for its decades of service to the people in crisis of Contra Costa County (see appendix).

4. ***Homicide prevention requires so much more than dealing with easy access to firearms.*** People in poverty need opportunities other than joining gangs. Mentor programs, teen recreation programs, summer jobs for teens, bullying prevention, after school programs, school drop-out prevention and others should be created, supported and nurtured.

5. ***Child fatality review teams also need to be supported and nurtured.*** All members of the CCC CDRT are volunteers from agencies and programs in CCC and squeeze in their case reviews with their many other duties. The reason there have not been annual reports as suggested by statute has to do with the lack of funding. This report is possible only due to the dedication of staff of CCHS and CAPC.

It is hoped that subsequent reports will be both funded and be more frequent. It is also hoped that agencies that participate in CDRT will continue to support provision of personnel and time to this endeavor.

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APPENDIX

Fly Program

One program that has had success is *Fly* or *Fresh Lifelines for Youth*. It is important to note that Fly is not an available program within Contra Costa County, but in looking at its intervention model and strength we can assist in its growth to our county or implement similar models within our own county-wide programs.

> *FLY is committed to* measurably *working with youth ages 15-18 who are in the juvenile justice system or at-risk of formal system's entry to inspire them to change the trajectory of their lives, build their assets, and ultimately reduce their delinquent behavior. FLY's innovative programs include legal education, leadership training, and one-on-one mentoring.*

Fly's legal program exposes these youth to the criminal justice system, by using role-play, debates, and mock city council hearings. The goals are to allow the children to problem solve, resist peer-pressure, deal with anger management, and develop empathy. The leadership program places youth that have already been in the legal program in leadership placement to contribute to their community. Each individual is assigned a case manager than learns that person's strengths and weaknesses and places them in the appropriate position to grow. In addition, to their placement this program includes a wilderness retreat and community service experiences. The mentor program places these youth with a responsible adult-role model to support and encourage positive decision making. This program encourages youth to have the strength to stay away from violence to move forward in their education and career ambitions. The program has been highly effective and reports the following statistics:

- **More than 80% of youth report that after FLY they are less likely to break the law**, said by one youth: "FLY is a good program because it helps kids change their behavior, their attitudes, and their actions."
- **More than 85% say that knowing about the law gives them more confidence to resist negative peer pressure**. "Now when some friends ask me to hang out I say no because I know they are going to do stuff that's illegal."
- **More than 90% report that FLY gave them access to positive role models.**
- **75% of youth do not offend during the program**
- **60-80% of eligible high school seniors graduate high school or receive their GEDs**
- **80% report they can resist negative peer pressure and are less likely to break the law**
- **Over 90% of mentees report that they have significantly reduced or eliminated their use of drugs and/or alcohol as a result of participating in the Program.**

In conclusion, the recommended intervention plans for firearm-related injury are as follows:
A combination of safe gun storage and violence prevention can reduce firearm-related fatalities. Safe gun storage can be implemented by a combination of education, legislation, and modern engineering. Parents should be educated to keep guns within a locked storage area, unloaded, and without ammunition. Legislation should be passed to support these education efforts and enforce the teachings. Modern engineering can be used to develop personalized safety mechanisms and trigger locks. Lastly, firearms should be sold with a lock and storage box to be expensed by the gun manufacturing companies. Once again, legislature should be passed to enforce this requirement. Secondly, violence prevention initiatives should work with high-risk youth to promote positive lifestyle changes. The model which *fly* implements, that uses legal education, leadership placement, and mentor relationships has proven to be efficient in character development and violence reduction. Contra Costa should extend its hand to *fly* to ask for support in emulating its effective measures within our own already established non-profits and government programs. Specifically in the city of Richmond, that has long struggled with violence amongst youth.

CRISIS Intervention

The Contra Costa Crisis Center was founded in 1963 and incorporated as a 501(c)(3) nonprofit organization in 1969. Our mission is to keep people alive and safe, help them through crises, and connect them with culturally relevant resources in the community. We do this by operating the following three countywide programs: 24-hour crisis lines; one of the largest grief counseling programs in California; 2-1-1 information and referral; a large and robust volunteer program.

24-Hour Crisis and Suicide Hotlines: Our 24-hour crisis and suicide hotlines are certified by the National Association of Suicidology and have operated around the clock continuously since 1963. Annually, staff and volunteers answer nearly 30,000 crisis calls. In the last fiscal year this included 5,637 suicide calls, 4,830 child abuse calls, and 1,065 elder abuse calls. Our hotlines also respond to all calls made by Contra Costa County residents to the National Suicide Prevention Lifeline and after-hours calls made to Child and Adult Protective Services. Our callers present a wide and complex range of concerns; they struggle with abuse, depression, grief, mental illness, isolation, and are frequently at risk of suicide. Staff and volunteers receive extensive training to ensure that they are able to provide effective, compassionate interventions to support people experiencing emotional distress and crisis. County records indicate that, there was only one individual who died by suicide who also called for assistance in the past year. While we grieve that loss, we are grateful that our services are working for the large number of county residents who do reach out.

All staff and volunteers are highly trained and supported to perform all aspects of mental health support and crisis intervention. All are ASIST (Applied Suicide Intervention Skills Training) Certified and some staff are also trainers in this internationally recognized best-practice model.

We implement many projects within our Crisis Line program. Examples include:

- Crisis Chat-Online: Crisis Chat-Online was launched on March 1, 2012. The Crisis Center is one of only 10 crisis centers in the U.S. to receive a startup grant from the National Suicide Prevention Lifeline to support the implementation of online crisis chat services. Online crisis support has proven especially effective in reaching young people in crisis who tend not to reach out for help through the phone lines. In the first month of providing this service we responded to over 65 visitors (with minimal advertising). Most were high risk for suicide. Of these, 80% were female and 3% transgender; 60% were aged 13-25. During the first year pilot phase, we are operating on-line Chat services 20 hours per week with plans to extend the service as funding grows.

  Crisis Chat encourages the client's cooperation in keeping safe. As with hotline callers, our first priority is to build rapport and gain trust through non-judgmental, empathic listening. Staff provides a validating, and respectful exchange with the client while also attempting to obtain information about the client's emotional state and surroundings (where they are physically, who else might be nearby, whether they have easy access to lethal means, etc.). We allow ample time for clients to tell their story - the average online exchange is 60 minutes and can be significantly longer – our longest exchange to date was four hours. Ideally, clients receive sufficient support and guidance within one or a series of sessions to address their immediate crisis. We also offer follow-up support through the crisis line once rapport and trust has been gained to ensure help 24/7. We arrange for police intervention in rare cases where there is imminent danger and the client remains highly lethal regardless of the intervention.

- Veteran Crisis Support Line: The Crisis Center is one of six national crisis centers receiving calls from veteran across the country. These calls tend to be longer and more likely lethal than those from the general population.

- Spanish Language Talk line: The Crisis Center responds to this specialized language line in order to support our monolingual Spanish speaking residents as well as participates with surrounding counties to ensure between the seven bay area counties, we have this important second language expertise as well as an understanding of the unique issues some of our monolingual Spanish speakers may be encountering. This service does not depend upon a translation service and is available directly and in real-time.

- Facebook & Tumbler: We maintain social media presence to promote safe and healthy behavior choices and access to support services.

Grief Counseling: Our grief counseling program is one of the oldest, largest, and most diverse bereavement services in California. The goal of Grief counseling is to reduce the risk of suicide and other self-destructive behaviors among youth and adults mourning the death of a loved one. Counseling is conducted by trained staff, interns and volunteers, many of whom were once grief clients themselves. Most of our support groups meet at the Crisis Center in Central County with additional groups in West and East Counties. Individual counseling is available in Central County and can be provided in the client's home when necessary. All counseling is free and services are available in Spanish. We also operate a 24-hour grief counseling phone line, and provide counseling at schools and businesses following the death of a student or adult. We consistently serve an average of 1000 grieving clients per year.

211 Information and Referral: 2-1-1 is the national, toll-free, three-digit phone number to call for information about local health and social services; the Crisis Center is the authorized provider for Contra Costa County. 2-1-1 provides a free and accessible way for individuals and families who are struggling with economic and other crises to access critically needed health and social services. The support callers receive from our trained information and referral specialists empowers them to more easily navigate a confusing and disparate maze of services. Whether the caller is a senior seeking home care, a victim of violence needing help, an unemployed person in need of a job or a single parent facing eviction, 2-1-1 can help. Our staff and volunteers provide a personal touch - people talking to people- instead of an endless web of recorded messages that leave those in need further frustrated.

- We maintain a 2-1-1 database for referrals (www.211database.org) with comprehensive, up-to-date information on 1,500 services available in multiple languages, and we publish specialized resource guides in English and Spanish of essential services. These resources are offered free to everyone in the community including other service providers. Our average call volume per year is nearly 40,000 and 82% of all the 2-1-1 calls we receive are from very low or no income individuals.
- Our 2-1-1 Resource Manager updates the database continually as well as designs specialized guides for target populations by contract engagement.

Outreach Services: Through in-person outreach and presentations, we educate our community about suicide prevention and intervention as well as the services available to assist those in need – both from our agency and from the other service providers in our resource database.

Volunteer Program: The Crisis Center has a long history and core belief in the engagement of highly trained volunteers serving the community in which they live. We are able to operate our 24:7 services because of our combination of staff AND the skilled and dedicated work of nearly 200 volunteers at any given time. Volunteers engage in extensive and specialized training and serve an average of 4-6 hours per week each – some far more. Many of our volunteers remain with the Crisis Center for years – decades even. Most have some personal connection to our mission and have survived from personal loss – quite often served here at the Crisis Center during that loss.

Internship Program: The Grief Counseling program conducts a clinical training program for graduate students who are learning the specialty of grief and loss and are earning hours toward clinical licensure. Interns conduct group and individual grief counseling and are supervised by licensed clinicians.

Administration: The Contra Costa Crisis Center is governed by a 15-member board of trustees. A staff of approximately 20 is assisted by 200+ active volunteers. Our budget is currently$1.8 million with an administrative (including fundraising) overhead rate of 14%. Nearly 60% of our funding comes from individuals, businesses, foundations, civic groups, and proceeds from Leftovers Thrift Shop, an agency auxiliary; 40% of our annual budget is derived from government grants and contracts.

Partner Agencies: *The Crisis Center maintains regular contact with over 1,500 service providers in the County to ensure that when we refer people in need to services, the information we provide is accurate and that the criteria used for determining whether an individual or family is eligible for service is also correct. Additionally, we participate in numerous collaborations – most, meet monthly and include other community based organizations and public service entities. A partial list includes: County Suicide Prevention Collaborative, Bay Area Suicide and Crisis Intervention Alliance, Bay Area 2-1-1 Collaborative, CA 2-1-1 Collaborative, Sudden Infant Death Review Team, Human Services Alliance, Safe & Bright Futures for Children. Other partners include National Suicide Prevention Lifeline, Contra Costa Voluntary Organizations Against Disasters, Living Works, and more.*

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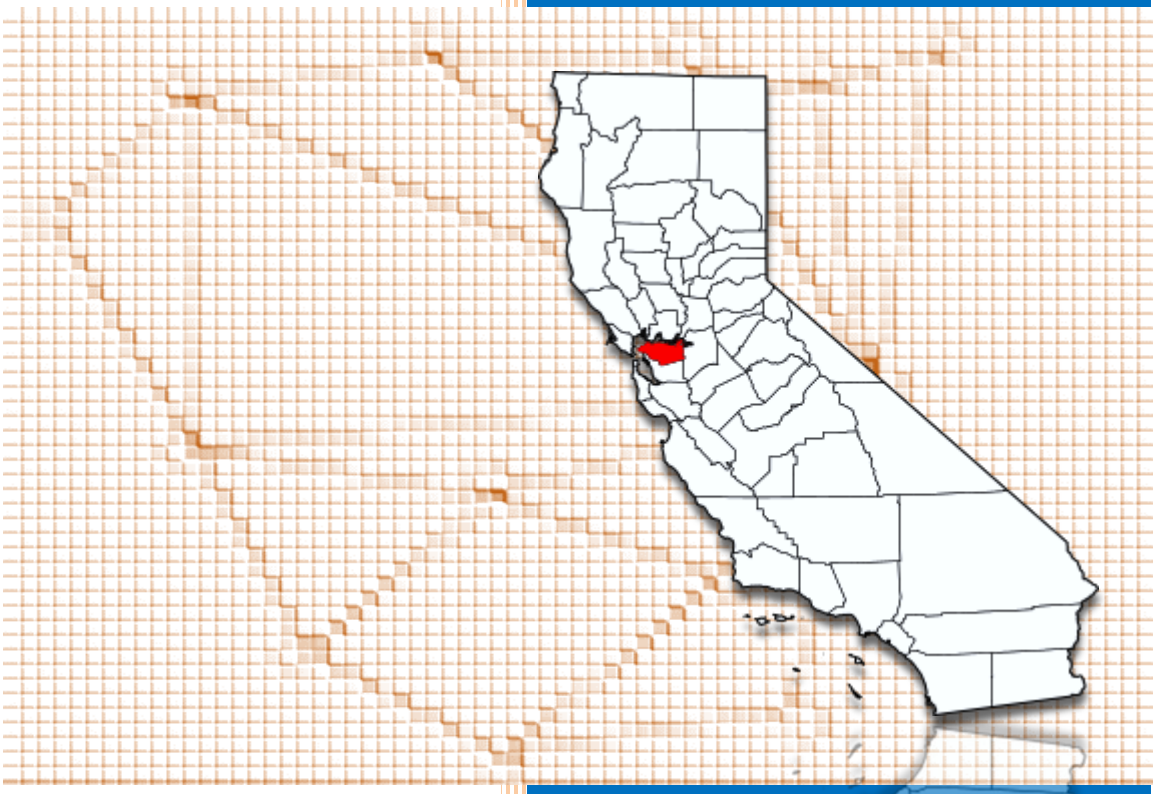
2013

Contra Costa County Child Death Report



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CONTRA COSTA COUNTY DEPARTMENT OF HEALTH SERVICES In Collaboration With CHILD ABUSE PREVENTION COUNCIL OF CONTRA COSTA COUNTY
Child Death Review Team 1 Year Report
January 1, 2017