



# **Child Death Review Team 5 Year Report**

**A Review of Sonoma County Infant and Child Deaths  
2008-2012**

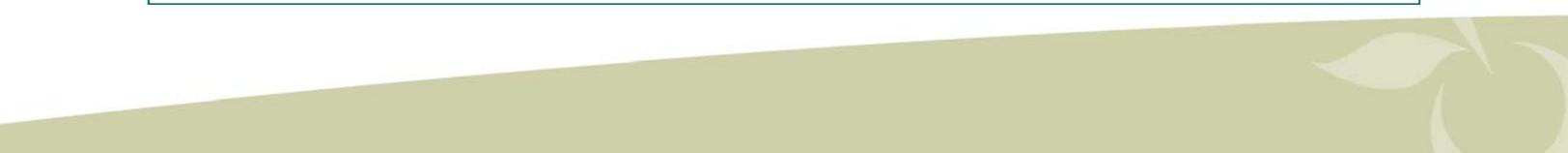
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## Introduction

### Background

The death of a child is an extreme loss not only to the child's parents but to the larger community. In order to reduce death to children, it is important to understand how and why Sonoma County children are dying.

The Child Death Review Team (CDRT) was established in Sonoma County in 1993 to conduct in-depth reviews of infant and child deaths for the following purposes:

- To identify non-accidental deaths.
- To enhance the investigation of deaths through shared information and communication.
- To develop a statistical description of deaths as an overall indicator of the status of children.
- To develop recommendations for the prevention of and response to deaths based on reviews and analysis of statistical information obtained.

Team members include broad representation from community agencies (See Appendix).

### The Child Death Review Process

Infant and child deaths are identified primarily through review of death certificates, local obituaries and in consultation with the Coroner's office. A representative from Sonoma County Public Health compiles a list of cases for review and forwards information from the case death certificates to team members. Each team member is then responsible for reviewing internal agency records to determine what information is available on the child or family. This information is brought by each agency to the team meeting for discussion. From this discussion recommendations for action are determined and appropriate parties are contacted. Information to be entered into the CDR database is collected via record abstraction (see Appendix for information on data elements) by a member of the team and subsequently entered into the database.

### Data Overview

Data presented in this report include deaths of Sonoma County residents and deaths that occurred in Sonoma County to children ages 0 through 17 years.

Two primary sources of data are used in this report. First, vital statistics data are reviewed to determine trends in child death rates. These data are collected from death certificates and represent the official count of infant and child deaths in the county. The second source for data, the Child Death Review database, includes detailed information collected from multiple agencies about each case selected for review by the team. Deaths described in this report are limited to those identified for review at the time of data retrieval from the CDR database. These cases represent 81% of the total infant and child deaths that occurred from 2008 to 2012. When local children die out-of-county—for instance, because they were transported to a hospital offering higher level medical care — a delay may occur in identification and review by the team. For this reason, most, but not all, deaths that occurred during this time period are described in this report. Improved surveillance methods are now in place to reduce the delay between time of identification and review.

In many instances throughout the report, small numbers are presented. To maintain confidentiality and prevent potential identification of the victim and families, limited details on these deaths are provided.

### Use of This Report

The primary purpose of this report is to provide a summary of reviewed cases including actions and recommendations by the CDRT, as well as fulfilling reporting requirements. This report presents information on demographics, cause of death and associated factors, as well as recommendations for prevention by the CDRT. In addition, data in this report may assist agencies in applying for funding to improve the safety and health of children in Sonoma County.

### Definitions

*Child death:* Death to a child who is 1 through 17 years of age.

*Infant death:* Death to a child who is under one year of age.

## Key Findings

Children are not supposed to die. The death of a child is a singularly tragic event, especially when it could have been prevented. Each year, over 40 children up to age 17 die in Sonoma County.

Death rates for infants, children and teens are widely recognized as valuable measures of child well-being. In 1993, the Child Death Review Team was established in Sonoma County to conduct in-depth reviews of infant and child deaths. This review process, which began in Los Angeles in 1978 as a mechanism to identify fatal child abuse and neglect, has grown into a national system to examine child fatalities within the context of prevention. A comprehensive and multidisciplinary approach allows for a better understanding of how and why children die. This information guides prevention efforts and policy development to improve the health and safety of Sonoma County children.

From 2008 to 2012, CDRT reviewed 147 deaths, approximately 81% of all infant and child deaths of Sonoma County residents or occurring within Sonoma County during this time period. Key findings from data summarization are described below.

- The Sonoma County infant mortality rate (IMR) has not changed significantly since 2000-2002 and remains relatively low compared to state and national rates during the same time periods. However, both state and national rates have continued to decline which has narrowed the gap.
- From 2000-2002 to 2010-2012 the child death rate decreased significantly from 19.1/100,000 to 12.0/100,000.
- The number of infants who died in the sleep environment increased from 9 deaths (2003-2007) to 12 deaths (2008-2012). While no cases were deemed SIDS deaths during the 5 year period, the number of asphyxia deaths and deaths where cause was undetermined more than doubled (See page 6 for SIDS and undetermined death definitions).
- One in three deaths in the sleep environment occurred among infants between 1 and 3 months of age. Ten out of 12 of all infant deaths in the sleep environment were among male infants.
- A leading cause of preventable death among children 1-17 years continues to be motor vehicle collisions. Unintentional motor vehicle collisions were responsible for 24% of deaths in this age range.
- Seven deaths due to homicide or suicide were reviewed from 2008-2012. Of the three homicide deaths, all of the decedents were female.
- Fatal child abuse and neglect was determined to be a direct or contributing cause in 33 reviewed deaths to children 0-17 years (22% of reviewed deaths- annual average 7 deaths per year). This is less than the proportion of fatal child abuse and neglect deaths from 2006-2007 (35% of reviewed deaths- annual average 12 deaths per year) - the first two years in which the current CDRT database was in use.

## Summary of Childhood Mortality Data

From 2008-2012 there were 180 infant and child death cases eligible for review from CDRT (Table 1). These cases were among Sonoma County residents who died in or out of Sonoma County or a non-resident who died in Sonoma County. Over the 5 year period 146 deaths to children 17 years and under were reviewed, representing approximately 81% of total deaths. When a child dies out of Sonoma County, the death certificate is generated by the county where the death occurred, often making it challenging to learn of the death and gather information surrounding the circumstances of the death.

The infant mortality rate is a measure of all deaths occurring to Sonoma County residents less than 1 year of age. Approximately 60% of all deaths to Sonoma County residents 17 years and under (51% of reviewed deaths) were among infants under 1 year of age (Table 1). While the infant mortality rate has decreased in California overall, the rate in Sonoma County has not changed significantly in the past 12 years. The gap between the California and Sonoma County infant mortality rates has narrowed significantly over the time period and where once Sonoma County had a significantly lower rate than the state, in 2010-2012 the rates were statistically similar (Figure 1).

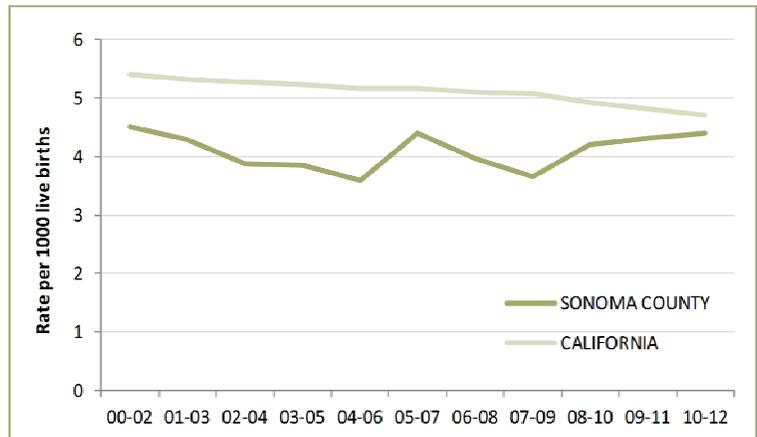
The child death rate is a measure of all deaths occurring to Sonoma County residents ages 1-17 years. The rate decreased significantly from 2000-2002 to 2010-2012 (Figure 2). The average annual number of deaths decreased from 21 in 2000-2002 to 17 in 2004-2006 and decreased again to 12 in 2010-2012 (Figure 2).

**Table 1. Total and Reviewed Childhood Deaths by Age, 0-17 years, Sonoma County 2008-2012**

	Sonoma County resident - died in county	Sonoma County resident - died outside of county	Non-resident - died in Sonoma County	Total	Cases Reviewed	Percent of Total Cases Reviewed
< 1 yr	45	58	3	106	75	71%
1-5 yrs	11	16	0	27	27	100%
6-9 yrs	6	4	1	11	10	91%
10-14 yrs	5	9	0	14	12	86%
15-17 yrs	10	8	4	22	22	100%
<b>Total</b>	<b>77</b>	<b>95</b>	<b>8</b>	<b>180</b>	<b>146</b>	<b>81%</b>

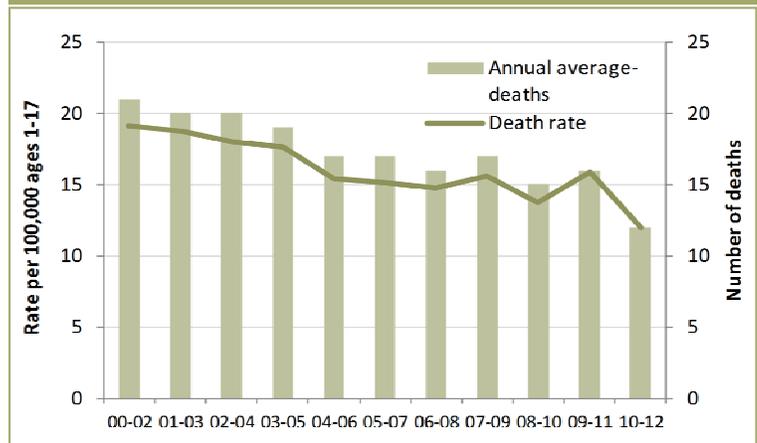
Source: National MCH Center for Child Death Review, www.cdrdata.org; Sonoma County data Accessed 2.2014

**Figure 1. Infant Mortality Rate, 3 Year Moving Average, Sonoma County and California 2000-2012**



Source: CDPH, Death Statistical Master Files 2000-2012; Vital Statistics Query, www.apps.cdph.ca.gov/vsa/Default.asp

**Figure 2. Child Death Rate, 1-17 Years, 3 Year Moving Average, Sonoma County 2000-2012**



Source: CDPH, Death Statistical Master Files 2000-2012

## Infants <1 Year

Seventy-five infant deaths were reviewed from 2008-2012. The majority of these deaths (83%) occurred due to medical causes (Table 2). More than 1 in 6 reviewed infant deaths was due to either asphyxia or an undetermined cause occurring in the sleep environment. No infant deaths were attributed to SIDS. SIDS is defined as the sudden death of an infant that remains unexplained after thorough investigation. If the cause of death remains unknown after the investigation but the death occurred in an unsafe sleep situation, the death must be classified as undetermined.

### Deaths Due to Medical Causes

Deaths from medical causes are those due to complications of a disease process or due immediately to medical causes. There were 62 infant deaths from medical causes reviewed from 2008-2012 (Table 3). Perinatal conditions continues to be the leading cause of deaths from medical causes (42%) followed by congenital anomaly (16%). Perinatal conditions include prematurity, low birth weight, respiratory distress, and congenital infections which arise from 20-28 weeks gestation to 28 days of life. Over 78% of deaths from perinatal conditions were due to prematurity and 85% of deaths from perinatal conditions occurred before 7 days of age. Of the 15 deaths due to congenital anomalies, 67% occurred within the first month of life.

### Deaths in the Sleep Environment

From 2008-2012 there were 12 deaths of infants that occurred in the sleep environment. In most (75%) of these deaths asphyxia was indicated as the primary cause (Table 4). No infant deaths were classified as SIDS. Three in four infant deaths (75%) in the sleep environment occurred when the infant was between 1 month and less than three months of age. Almost 60% of these infant deaths occurred in an adult bed. Sixty-seven percent of infants were sleeping on a surface with another person. Additionally, in half of all deaths soft bedding was indicated in the investigation. Ten out of the 12 deaths were to male infants.

**Table 2. Reviewed Infant Deaths by Cause, Sonoma County 2008-2012**

	Deaths	Percent
Medical causes	62	83%
Asphyxia	9	12%
Undetermined (in sleep environment)	3	5%
Motor vehicle collision	1	1%
SIDS	0	0%
Total	75	100%

Source: National MCH Center for Child Death Review, [www.cdrdata.org](http://www.cdrdata.org); Sonoma County data Accessed 2.2014

**Table 3. Reviewed Infant Deaths Due to Medical Causes, Sonoma County 2008-2012**

	Deaths	Percent
Perinatal conditions	33	42%
Congenital anomaly	15	16%
Cardiovascular	4	6%
Cancer	3	5%
Undetermined medical cause	3	5%
Other medical condition	2	3%
Other infection	1	2%
Unknown	1	2%
Total	62	100%

Source: National MCH Center for Child Death Review, [www.cdrdata.org](http://www.cdrdata.org); Sonoma County data Accessed 2.2014

**Table 4. Reviewed Infant Deaths in the Sleep Environment, Sonoma County 2008-2012**

	Deaths	Percent
Total	12	100%
<i>Cause</i>		
Asphyxia	9	75%
Undetermined	2	17%
Cardiovascular	1	8%
SIDS	0	0%
<i>Infant's age at death</i>		
<1 month	1	8.3%
1 month to < 3 months	9	75.0%
3 month to < 6 months	1	8.3%
≥6 months	1	8.3%
<i>Infant's place of sleep at death</i>		
Adults bed	7	58%
Couch	2	17%
Other	2	17%
Unknown	1	8%

Source: National MCH Center for Child Death Review, [www.cdrdata.org](http://www.cdrdata.org); Sonoma County data Accessed 2.2014

## Children 1-17 Years

Between 2008-2012 the CDRT reviewed 71 deaths to children 1-17 years. The majority of these deaths (59%) were due to medical causes. One in four child deaths was due to unintentional injury. Almost 10% of child deaths were due to intentional causes, either homicide or suicide (Table 5). Four of the seven intentional injury deaths were among females (1 suicide and 3 homicides).

Of the total reviewed child deaths, 56% were male, 48% were White, non-Hispanic, and 35% were Hispanic.

**Table 5. Reviewed Child Deaths by Cause, Sonoma County 2008-2012**

	Deaths	Percent
Total	71	100%
Medical causes	42	59%
Unintentional injury		
Motor vehicle collision	17	24%
Drowning	2	3%
Asphyxia	1	1%
Fall	1	1%
Poisoning	1	1%
Intentional Injury		
Homicide	3	4%
Suicide	4	6%

Source: National MCH Center for Child Death Review, www.cdrdata.org; Sonoma County data Accessed 2.2014

### Deaths Due to Medical Causes

Of the 42 child deaths due to medical causes reviewed from 2008-2012, 29% were due to cancer. Cancer and congenital anomalies continue to be among the leading causes of death from medical causes for children 1-17 years (Table 6). Almost 62% of the deaths from medical causes were among male children, 43% were White, non-Hispanic and 38% were Hispanic.

**Table 6. Reviewed Child Deaths Due to Medical Causes by Cause, Sonoma County 2008-2012**

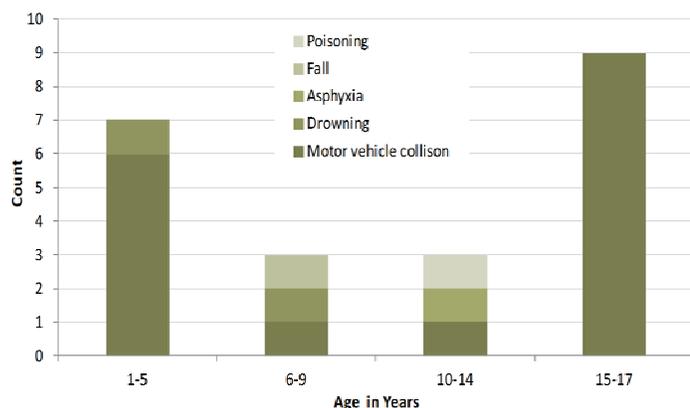
	Deaths	Percent
Cancer	12	29%
Other medical	9	21%
Congenital anomalies	7	17%
Neurological, seizure	5	12%
Cardiovascular	3	7%
Medical, unknown	2	5%
Influenza & pneumonia	2	5%
Other infection	1	2%
Asthma	1	2%
Total	42	100%

Source: National MCH Center for Child Death Review, www.cdrdata.org; Sonoma County data Accessed 2.2014

### Fatal Unintentional Injuries

Deaths from unintentional injuries are largely preventable. From 2008-2012 the CDRT reviewed 22 unintentional injury deaths to children 1-17 years. Most of these deaths (77%) were due to motor vehicle collisions (Figure 3). Motor vehicle collision was the leading cause of unintentional injury death for children 1-5 (86%) and 15-17 years (100%). Nationally, male children have higher injury death rates than females but in Sonoma County half of unintentional injury deaths were to male children.<sup>1</sup> More than 63% were to White, non-Hispanic and 23% to Hispanic children.

**Figure 3. Reviewed Child Deaths Due to Unintentional Injury by Cause and Age of Child, Sonoma County 2008-2012**

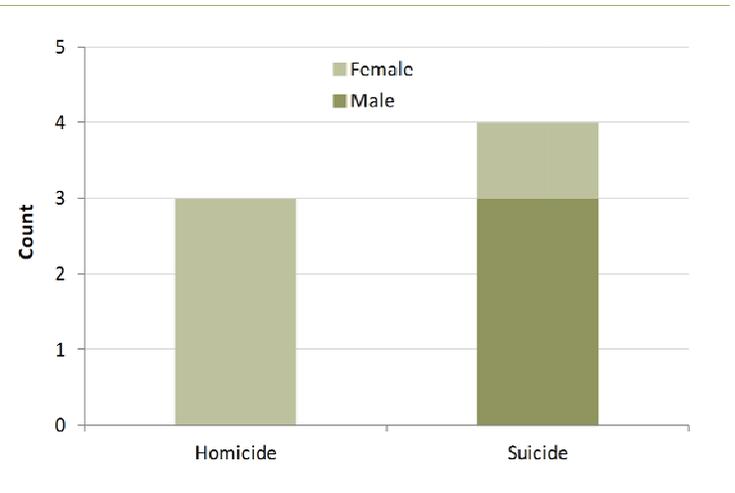


Source: National MCH Center for Child Death Review, www.cdrdata.org; Sonoma County data Accessed 2.2014

<sup>1</sup> CDC Childhood Injury Report, 2000-2006.

## Children 1-17 Years continued

**Figure 4. Reviewed Intentional Injury Deaths by Gender, Sonoma County 2008-2012**



### Fatal Intentional Injuries

Fatal intentional injuries are deaths resulting from suicide or homicide. Suicide is a fatal, self-destructive act with explicit or inferred intent to die. Homicide is a result of a volitional act committed by another person to cause fear, harm or death.

From 2008-2012 seven intentional injury deaths to children 17 years and under were reviewed. Three deaths were due to homicide and 4 deaths were due to suicide. All homicide deaths were to female victims. Three out of four suicide deaths were to male children (Figure 4).

All suicide deaths were among youth 15-17 years. One homicide death occurred to a child 1-5 years, 1 death to a child 6-9 years and 1 death to a teen 15-17 years.

All homicide deaths were among Hispanic children. Among suicides, 2 deaths were White, non-Hispanics, 1 death Hispanic and 1 death Native American.

Among suicides, gunshot (2) and hanging (2) were the two methods used. Among homicides, gunshot was responsible for 1 death, poisoning 1 death and neglect 1 death.

## Deaths from Motor Vehicle Collisions

From 2008-2012 CDRT reviewed 18 deaths due to motor vehicle collisions, slightly less than the 21 deaths reviewed from 2003-2007. Overall the number of motor vehicle deaths occurring in Sonoma County has decreased since 2000. Deaths from motor vehicle collisions to children 17 years and under vary from year to year—from zero deaths in 2012 to a high of 8 deaths in 2003—but a significant decrease has not been observed over the last ten years. Non-fatal hospitalizations from motor vehicle collisions in this age group, however, have decreased dramatically in the past 10 years—from 54 in 2004 to 14 in 2012. This decrease suggests that community prevention efforts have been effective.

**Table 7. Reviewed Motor Vehicle Collision Deaths by Age, Sonoma County 2008-2012**

	Total	Percent Total
<1 yr	1	6%
1-5 yrs	6	33%
6-9 yrs	1	6%
10-14 yrs	1	6%
15-17 yrs	9	50%
Total	18	100%

Source: National MCH Center for Child Death Review, [www.cdrdata.org](http://www.cdrdata.org); Sonoma County data Accessed 2.2014

Among younger children motor vehicle collisions occurred most frequently in those 1-5 years of age. Half of all motor vehicle deaths were to youth ages 15-17 years (Table 7).

**Table 8. Characteristics of Reviewed Motor Vehicle Collision Deaths, Sonoma County 2008-2012**

	Total	Percent Total
Total	18	100%
<i>Gender</i>		
Male	9	50%
Female	9	50%
<i>Race/ethnicity</i>		
White, non-Hispanic	10	56%
Hispanic	5	28%
African American	1	6%
Asian/PI	1	6%
American Indian	0	0%
Unknown	1	6%
<i>Position of child</i>		
Driver	4	22%
Passenger	7	39%
Pedestrian	5	28%
On bicycle	1	6%
No response	1	6%

Source: National MCH Center for Child Death Review, [www.cdrdata.org](http://www.cdrdata.org); Sonoma County data Accessed 2.2014

Of the 18 infant and child deaths reviewed due to motor vehicle collision 50% were among boys, the majority were among White, non-Hispanic children (56%), and most were passengers (39%) or drivers (22%) in a vehicle. Over 1 in 4 motor vehicle deaths involved a child who was a pedestrian (Table 8). Of the five pedestrian deaths, three (60%) occurred in a crosswalk.

## Fatal Child Abuse and Neglect

Fatal child abuse or neglect (CAN) is the fatal physical injury or negligent treatment of a child by a person who is responsible for the child’s welfare. The actual number of abuse and neglect deaths is estimated to be much higher than that reported by death certificate data. There are a number of explanations for this under-reporting including:

- Physical abuse deaths may be coded as homicides.
- Neglect deaths may be coded as deaths from medical causes, for example due to malnutrition or infectious disease.
- Some deaths may be coded as unintentional injuries, even though negligent acts (or failures to act) on the part of the caregivers contributed to the death.
- Deaths may not have been thoroughly investigated, and the child abuse or neglect went undetected.

Reviewing child deaths as a team allows for the collection of detailed information from multiple agencies that could assist in identifying child abuse and neglect fatalities not recorded on a death certificate.

From 2008-2012 more than 22% of the deaths of children 17 years and under reviewed by the Sonoma County CDRT involved child abuse or neglect. Of the 33 deaths reviewed, child abuse and neglect was a direct cause of death in 16 cases and a contributing cause in 17 cases (Table 9). CAN as a direct cause of death refers to an act that was the primary event leading to the death. CAN as a contributing cause of death refers to an act that played a role in but was not necessarily the primary role in a death. The single most

**Table 9. Reviewed CAN Deaths by Direct and Contributing Cause, Sonoma County 2008-2012**

	Direct Cause	Contributing Cause	Total	Percent Total
Poor/absent supervision	2	7	9	27%
Child abuse	1	0	1	3%
Child negligence	0	3	3	9%
Other negligence	1	1	2	6%
Assault, not child abuse	1	0	1	3%
Suicide	4	0	4	12%
Other*	7	6	13	39%
<b>Total</b>	<b>16</b>	<b>17</b>	<b>33</b>	<b>100%</b>

\*Other deaths are generally from unique single causes where description would compromise confidentiality of decedent.

Source: National MCH Center for Child Death Review, www.cdrdata.org; Sonoma County data Accessed 2.2014

common cause of death from CAN was poor or absent supervision of child from a caregiver, indicated in more than 1 in 4 CAN deaths.

**Table 10. Characteristics of Reviewed CAN Deaths, Sonoma County 2008-2012**

	Total	Percent Total
<b>Total</b>	<b>33</b>	<b>100%</b>
<i>Gender</i>		
Male	20	61%
Female	13	39%
<i>Age</i>		
<1 yr	11	33%
1-5 yrs	6	18%
6-9 yrs	3	9%
10-14 yrs	3	9%
15-17 yrs	10	30%
<i>Race/ethnicity</i>		
White, non-Hispanic	18	55%
Hispanic	11	33%
African American	1	3%
Asian/PI	1	3%
American Indian	1	3%
Unknown	1	3%

Source: National MCH Center for Child Death Review, www.cdrdata.org; Sonoma County data Accessed 2.2014

The majority of reviewed CAN deaths were among male children (61%). One in three CAN deaths was to an infant < 1 year (Table 10). Of the 29 CAN deaths with available data on primary person causing the CAN act, 14 (48%) were biological parents. Five of the deaths (17%) were caused by strangers-perpetrators driving recklessly resulting in the death of a child passenger in a vehicle. Most CAN deaths were to White, non-Hispanic children (55%). Eleven of the deaths (33%) were to Hispanic children.

## Actions for Prevention of Child Death

Efforts resulting from recommendations from the Child Death Review Team are described by prevention area.

### Safe Sleep

In 2010 there was an increase in cases of sleep-related deaths reviewed by the team in which the infant was sharing a sleep surface with an adult or another child. That same year the American Academy of Pediatrics released updated safe sleep guidelines and changes to national crib standards for child care providers were released by the U.S. Consumer Product Safety Commission. The team made recommendations to educate the community on these new best practices to ensure safe infant sleep and the association of bed-sharing with local infant deaths. In addition the team supported efforts to help low-income families access safe, affordable cribs. The following activities were implemented:

- Articles were published in local publications & newsletters [Sonoma Seniors, Community Child Care Counsel, La Voz (a bilingual newspaper)]. Presentations were made to a variety of groups – hospital nurses, prenatal staff, foster parents association, alcohol and drug treatment providers.
- The Maternal, Child & Adolescent Health program obtained a small community grant from the CJ Foundation and enlisted the help of Sonoma State University nursing students to develop and execute a social marketing campaign targeting parents, grandparents and others who care for children. Large 24-inch vinyl floor decals were displayed by community businesses and health facilities throughout the county (see illustration below). Participants included K-Mart, local grocery stores (G & G Markets, Lola's, Lucky and Food Maxx), as well as organizations like the YMCA, University of Sports, Redwood Empire Food Bank and the Redwood Gospel Mission Thrift Store. Sonoma Catering displayed the decals on their food trucks.
- In partnership with Safe Kids Sonoma County, a community crib program was established in conjunction with Cribs for Kids, a national organization. To date 239 cribs have been distributed to families needing assistance.
- Safe Kids also reached out to local homeless shelters, transitional housing and perinatal alcohol and drug treatment programs and provided cribs which met the new safety standards. Coalition members delivered the cribs and updated center staff on how to ensure safe infant sleep environment and other safety procedures.



### Pertussis

In the winter of 2007/08, the Sonoma County Department of Health Services (DHS) noted an increase in the number of cases of Pertussis among young children, including the death of an infant. An advisory was issued to local health care providers in early 2008 indicating that new parents were eligible to receive the vaccine with Pertussis (Tdap) through the *Vaccines for Children Program*. In addition, MCAH developed an informational flyer for new and expectant parents: "Protecting Your Baby from Serious Infections" in English and Spanish. Parents were given five specific recommendations including encouraging parents to become immunized, breastfeed, frequent hand washing, keep infant away from others with symptoms of illness, and getting infant immunized.

In April 2010 MCAH updated the flyer which was disseminated through prenatal care providers, pediatricians, home visiting staff, Fetal Infant Mortality Review Team members, the Vital Statistics office, summer camp programs, and student health centers at SRJC & SSU. In August 2010 CDPH released materials to address this statewide issue.

### Systems Improvements

The need for better service system coordination was identified by the team and led to systems improvements in the following areas:

#### *Substance use*

- An education workshop on methadone treatment programs for prenatal and postpartum women was provided to social workers and public health nurses who work in the Family Youth & Children's (FY&C) services and MCAH Home Visiting programs. This effort resulted in improved case coordination for clients served by both programs.
- A local hospital revised its policy to include a more comprehensive assessment of mothers prior to discharge from the hospital after delivery who are participating in methadone treatment programs.
- The MCAH Home Visiting programs revised their referral status notification system to ensure all providers (inclusive of medical and FY & C) are informed in a timely manner when services are declined by referred families.
- In partnership with the Safe Kid Crib program, the MCAH Home Visiting program established a Safe Sleep assessment tool and an educational protocol for all families enrolled in home visiting services. In addition, over 80 cribs were distributed to families in need.
- Recommendations to prevent prescription drug misuse by local youth, emphasizing the importance of proper storage and disposal of prescription medications were developed by the Safe Kids Coalition, published in local media, and distributed to health care providers.
- Over 100 local health care providers attended two Work-

## Actions for Prevention of Child Death continued

shops related to substance abuse and misuse including the overprescribing of opioid medications.

### *Drowning*

- Worked with YMCA to add ocean safety curriculum to Vamos A Nadar, an annual bilingual swim instruction program for young children.
- Worked with the Parks Department to increase bilingual beach signage warnings of sleeper waves and raise awareness of the dangers of tidal shifting of sand contours.

### *Sudden Unexpected Deaths (SUDs)*

- Strengthened coordination and collaboration between the Coroner's Office and DHS resulting in improved assistance to families facing the loss of an infant by providing more immediate connections to grief support systems and other practical needed resources.

### *Homicide/Suicide*

- Provided information to the School Attendance Review Board to clarify that local law enforcement may be utilized for welfare checks when a possible abuse or neglect situation (including unexplained absence) has been identified. A number of school districts have since updated their policy with this clarification.
- A California Children's Services (CCS) protocol was expanded to include referrals to MCAH Home Visiting when the mother of a child on their caseload has a history of mental illness and/or is homeless.
- CDRT has identified teen suicide as an area of concern and is currently meeting with key informants to determine what more can be done to prevent these tragic deaths.

### *Vehicle accidents*

- A number of fatal accidents related to youth drivers were reviewed and the team supported continued education around safe driving and existing restrictions on first time drivers. Connections were made with CHP on school youth outreach and with SRJC's "Alive @25" to strengthen linkages. Following one of these deaths the team connected with the local jurisdiction to seek signage for a particular crossing which it was believed had contributed to the death of an adolescent passenger. This was supported by law enforcement and Cal Trans agreed to make those changes.

### *Preventable medical deaths*

- The team connected with the Asthma Coalition to address the importance of caregivers being educated on how to use asthma medications with minors. The Coalition agreed to add this to their educational work with provider offices i.e. emphasize to parents the importance of ensuring caregivers know and follow individual care plans.

## Appendix

### Team Members

*Co-chair* Sonoma County Dept of Health Services  
*Co-chair* Sonoma County District Attorney's Office

Sonoma County Coroner  
Sutter Medical Center  
California Parenting Institute  
Coastal Valley EMS  
Healdsburg Police Department  
Sonoma County Sheriff's Department  
Petaluma Police Department  
Rohnert Park Police Department  
Sonoma County Human Services Department  
California Highway Patrol  
Kaiser Permanente  
Santa Rosa Memorial Hospital  
Santa Rosa Police Department

### Data Collection Tool

The web-based Child Death Review Case Reporting System from National Center for Child Death Review was adopted for use in Sonoma County in 2006. This case reporting tool can be viewed at

<http://www.childdeathreview.org/Reports/PrintCaseVersion3.pdf>

For more information, contact:

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