Santa Clara County
Child Death Review Team

Cumulative Report
Case Reports For Calendar Years 2005-2009
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Table of Contents

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MISSION STATEMENT

The mission of the Santa Clara County Child Death Review Team (CDRT) is to review the causes and circumstances of the deaths of children that occur within Santa Clara County. An important function of the CDRT is to assist the Coroner or Medical Examiner in determining whether child abuse or neglect was a factor in the death of a child.

The objective of this inquiry is not to assess fault by any particular agency or child care professional, but rather to suggest ways in which caretakers, medical professionals and all organizations and agencies serving children, work together to prevent serious childhood injuries and death. Activities of the CDRT are intended to enhance interagency collaboration.

SANTA CLARA COUNTY CHILD DEATH REVIEW TEAM MEMBERS

Craig Anderson, Lt.	Sunnyvale Dept of Public Safety	Family Violence/Sexual Assault
Lisa Arieta-Hayes	Supervising Social Worker	Legal Advocates for Children and Youth/Law Foundation of Silicon Valley
Michelle Avila, Lt.	Homicide Supervisor	SCC District Attorney's Office
Brenda Carrillo	Health and Safety Coordinator	SCC Office of Education
Alan Cavallo, Lt.	Lieutenant	San Jose Police Department
Lynn Chamberlin PHN	CDRT Coordinator	SCC Public Health Dept. MCAH Program
Gwen Chiaramonte	LCSW	Dept. of Familly & Children's Services
Patrick Clyne, MD	Pediatrician CDRT Co-Chair	Santa Clara Valley Med. Ctr. Dept. Of Pediatrics
Donna Conom, MD	Neonatologist	Good Samaritan Hospital
Margaret Ledesma	Hospital Liaison for SCC MHD	Children's Shelter Mental Health
Dave Lera, Lt.	Office of the Sheriff	SCC Medical Examiner/ Coroner's Office
Dan Lloyd	Health Care Program Manager II	Child, Family & Community Services Division/ Dept. Of Alcohol & Drug Services
Anne Marcotte, RN, MSN	Specialty Programs Nurse Coord.	SCC EMS
Kelly Mason	MICC	Santa Clara Valley Medical Ctr. / SCC Main Jail
Robert Masterson	Deputy D.A. (Retired)	SCC District Attorney's Office
Michael Cuevas	Detective	Office of the Sheriff
Cindy Denoyer-Greer	Supervising Probation Officer	Probation Dept./ Juveline Division
Jim Gaderlund	Clergy	Foothill Covenant Church
James Gibbons-Shapiro	D.A. (Criminal)	SCC District Attorney's Office
Jennifer Kelleher	Directing Attorney	Legal Advocates for Children & Youth
Fabian Monge	Detective	Sunnyvale Dept. of Public Safety/ Family Violence Sexual Assault
Barbara Mordy	Regional Manager	Dept. of Social Services, Child Care Program
Sarah Scofield, MSW	Senior Mediator	SCC Family Court Services
John Stirling, MD	Pediatrician	Director, Center for Child Protection
Saul Wasserman, MD	Child Psychiatrist	Child Psychiatrist
Jonathan Weinberg, MSW	Social Services Program Manager	Social Services Agency
Louis Girling, MD	Deputy Health Officer	CCS/CHDP/MCAH
Michelle Jorden, MD	Medical Examiner	SCC Coroner's office
Melody Kinney, LCSW	Director, Social Services	Good Samaritan Hospital

BACKGROUND

In 1988, California enacted legislation that allowed the development of interagency child death review teams intended to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication involved in the investigation of such cases.

The Santa Clara County Child Death Review Team is a multidisciplinary, collaborative body of professionals guided by agreed upon goals and objectives. Its primary purpose is to provide professional review of unexpected child deaths <18 years of age reported to the Medical Examiner/Coroner's Office[1]. Due to the sensitivity of the material discussed, confidentiality is maintained pursuant to Penal Code Section 11167.5.

Legislation enacted in 1997 required the State Department of Social Services to collect data related to the investigations conducted in child deaths. These data, provided by child death review teams and child protective agencies, are maintained in order to identify deaths occurring in high risk family situations and aid in future identification of children at risk as a preventative measure. Since that time, Santa Clara County Social Services Agency has been reporting data related to cases reviewed.

Actions taken by the Team are intended to prevent child deaths through identification of emerging trends, safety problems and increased public awareness of risks to children in our community. The purpose of the team is to provide prompt, planned, coordinated multidisciplinary response to child fatality reports, and review programs and interventions and compare county data with statistics at the state and national level

[1] Refer to end of this report for "Deaths Reportable to the Coroner".

EXECUTIVE SUMMARY

Team Membership

The Santa Clara County Child Death Review Team (CDRT) reviews selected child deaths to determine ways to prevent further injuries and deaths, improve responses to the needs of our children, and improve interagency collaboration. The CDRT is multidisciplinary, composed of representatives from:

Santa Clara County Department of Public Health
Medical Examiner's Office
District Attorney's Office and Legal Advocates for Children and Youth
Law Enforcement (several jurisdictions)
Valley Medical Center-Pediatrics Department
California Children's Services
Social Services Agency, Dept. of Family and Children's Services
Child Psychiatry and Neonatology
Mental Health Department
Family Court Services
DADS/Children Family & Community Services
Juvenile Probation Department
Faith Community
Santa Clara County Office of Education
Good Samaritan Hospital Social Work Department
Santa Clara County EMS Agency

Case Selection

We review the circumstances of the deaths of children (birth through 17 years of age) investigated by the Santa Clara County Medical Examiner/Coroner's Office. The Medical Examiner has the discretion of accepting the cause and manner of death proposed by the reporter of the death, and that case would receive no further investigation or review by the CDRT. An example would be the death of a premature baby in an NICU who died from complications of prematurity. Natural medical deaths may be brought before the team if the ME does an investigation. The CDRT reviews the deaths of approximately 25% of the deaths of all children.

Prior to each meeting, selected CDRT members receive record check information of each child death. Each member researches their own agency's files for additional information on the child and his/her family. All of the information is then brought to the monthly CDRT meeting for disclosure, compilation, discussion, review and classification.[2] At the conclusion of the review, each case is classified. The team reviews cumulative data annually and creates reports for public review. Case review does not conclude until the Medical Examiner finalizes the report of autopsy.

This report is of all CDRT cases reviewed in the years 2005 through 2009. The years 2008 and 2009 have been highlighted. Cases are analyzed by calendar year of the date of death.

In 2008, 40 child deaths met criteria for review by the Child Death Review Team. We reviewed 39 in 2009. For the past five years, the team has reviewed an average of 45 cases per year.

[2] Refer to end of this report for "Classifications of Death".

KEY FINDINGS

Sleeping

Of the 83 infant deaths (age <1 years) occurring 2005-2009 that were reviewed, there were 31 infant deaths that occurred in an unsafe sleeping environment. A safe sleeping environment for an infant is to be routinely placed on the back in a crib or bassinette. There should be a firm mattress, no toys or stuffed animals, and the clothing should be light to avoid overheating. Bed sharing (or co-sleeping) with an adult puts the child at risk and is not recommended. In 14 cases, the conclusion of the team was that the infant most likely died from an adult unintentionally rolling on the infant while asleep. This tragedy is entirely preventable by using the bassinet or crib for the child's first year. By placing the bassinette next to the bed, breastfeeding can occur without the mother rising from bed. She should be encouraged to return the infant to the bassinette on the back after feeding. The team found that in only three of the 14 cases was there an indication alcohol or drug use by the adult may have contributed to the death. We suspect that most parents of infants are chronically sleep deprived, which increases the risk of being unaware that they have rolled onto the baby while asleep.

In 17 more cases, the infant died alone on an adult bed, couch, or pillow. The babies either rolled and became wedged between the bed and wall, or rolled to a prone position with the face pressed into the couch or bed pillows. These tragedies occurred at home or while visiting relatives and, in some cases, were not in the usual sleeping environment for the infant. A safe sleeping environment should be used each time an infant is placed down for a nap or for night's sleep.

Sudden Infant Death Syndrome (SIDS) had been a leading cause of infant mortality around the world, but has had a dramatic decrease in rate over the past 15 years. In the early 1990's, a public campaign to place infants in a safe sleep environment was instituted. The Back to Sleep campaign emphasized supine sleep position along with use of a crib or bassinette. The rate of SIDS has fallen from 14/10,000 live births in 1988 to 5/10,000 in 2006 (US data). Over the past 5 years in Santa Clara County, there were five cases of SIDS. This is far below the national average. The reason for the low observed local rate of SIDS is not clear.

The team recommends efforts to increase the use of safe sleep environments be made by increasing the public's awareness of the dangers of placing a child to sleep on any surface other than a crib or bassinette. Further, bed sharing should be explicitly discouraged. This advice should be disseminated by health educators at pre and post natal visits, pediatric office visits, daycare provider educational programs, child care/babysitter training in middle and high school and all parent training programs. The Santa Clara County Public Health Department and the CDRT are reviewing informational handouts for general use.

Some internet resources include:

First Candle
National Institute of Child Health and Human Development (NICHD)
The Center for Disease Control and Prevention

Suicides

Seven youth died by suicide in 2005-2007. Five youth took their own life in 2008 and six in 2009. The most common methods used were hanging (8) and firearm (4) over the five-year period. There was an increase in the number of youth suicides in 2008 and 2009 as compared to 2005-2007. As widely reported in the news media, four teenagers used a train as the means of completing suicide. All were from the same school district.

Although several victims had a history of a mood disorder, most did not. Case review by the CDRT is not designed to elucidate the motivations of the individuals who complete suicide. In some cases, a note and/or interviews with friends and family indicate common themes of feelings of worthlessness, despair after a failed romance, or personal crisis leading to impulsive acts. Yet in many other cases a note was not left and the review did not reveal the motivation of the suicide.

Homicide by a Parent

In the 2005-2009 reporting period, thirteen children were killed by their parent or caretaker. One infant suffered a fatal head injury at the hand of a parent in 2009, another infant succumbed in 2008 from injuries sustained two years before. In separate incidences, a 3 year old and a 6 year old were murdered by their mother's boyfriend.

A particularly horrific form of domestic violence is family annihilation. A father killed his two children and their pregnant mother in 2005. He has been convicted of murder. The tragedy occurred again in 2009 when a father killed his two children, his nephew, and his nephew's parents, and attempted to kill his wife. He then killed himself.

Homicide by a Non-Relative

Five teen boys aged 16 and 17 years were killed by firearms in 2008. All these crimes were suspected to be related to gang activity, perpetrated by non-family members. A 15 year old boy was stabbed at his home in 2009; two classmates were arrested for that crime. This contrasts with statistics from 2005-2007 that included seven deaths by stabbing and one by gunfire attributed to gang violence.

It should be noted that San Jose continues to rank in the top five cities of more than 500,000 people in personal safety and violent crime statistics, see www.morganquitno.com/cit05pop.htm.

Drowning

We reviewed the drowning deaths of 14 children in 2005-2009. Nine drowning deaths occurred in swimming pools at the child's home. In the home pool deaths, none of the children were using a flotation device and in all cases, a fence was present, but the gate was left open. In most cases, entrance to the pool was gained through a house door. While there were no drowning deaths among youth in 2008, four drowning deaths in 2009 occurred when the supervising adult was not aware that the children (all under 3 years old) had gained access to the pool. The CDRT recommends a child-safe fence/ barrier with a self-latching gate be installed around the full perimeter of all private home pools.

Accidental Deaths

Twenty-eight cases were classified as accidental in the 2005-2009 reporting period. Motor vehicle collisions, resulting in the death of a passenger or pedestrian (including cyclist), account for the majority of cases. Two infants accidently suffocated while being carried in a baby-sling device. One toddler drowned in a five gallon bucket, another was strangled when the pull cords of his jacket's hood became tangled in a play structure.

Two young children and one teen died when their tracheostomy tube occluded or became dislodged. All three utilized a mechanical ventilation system and had medical conditions that rendered them completely dependent on the ventilator for life. In all three cases, it had been recommended that a caregiver be at the bedside and awake every night to monitor the ventilation system. Ideally this is done by a trained professional such as a home health nurse. In these cases the funding was not available for home health nursing every night and the families took on the responsibilities for night monitoring.

CHILD DEATH REVIEW TEAM RECOMMENDATIONS

The Santa Clara County Child Death Review Team is committed to reducing the incidence of child and teen death in our community. We make the following recommendations:

Safe Sleeping

In the first year of an infant's life, all parents and caregivers should ensure that the infant's sleeping environment is made as safe as possible. Specifically, we recommend room-sharing with parents, but not bed-sharing. Infants should be placed on their back on a firm mattress in a crib or bassinette and covered with a light sheet to the chest. No pillows, comforters or stuffed animals or toys should be in the crib. Infants should not be placed on an adult bed, couch or pillow to sleep, neither alone nor with another person. These recommendations are in accordance with recommendations by the Center for Disease Control and Prevention (CDC) and the American Academy of Pediatrics. We recommend that parents ensure that other caregivers of their children follow the guidelines as well. We recommend these infant safe sleeping practices be discussed at any forum that includes childcare instruction, including middle and high school health classes and prenatal classes. We specifically recommend that health care providers ask about the sleeping environment at each infant health care visit.

Suicides

Suicide is a profound and preventable tragedy no matter what the age of the victim or method used. We commend the efforts made by the affected schools, Mental Health Department and the county Board of Supervisors in response to the publicized suicides at train crossings. For teens in particular, we encourage educational programs to help peers and adults identify the youth at risk of suicide or who are suicidal.

Ventilator-Dependent Patients

Public and private health plans should provide sufficient funding for home health agencies to be available for care of all people who are dependent on a mechanical ventilation to survive. Families can and do provide most of the care, but they need respite to allow needed sleep for themselves.

STATISTICS

Table 1. Child Deaths Reviewed by the Child Death Review Team Compared to All Santa Clara County Child Deaths, 2005-2009

Year	Child Deaths Reviewed	Santa Clara County Child Deaths
2005	**56**	**175**
2006	**44**	**203**
2007	**45**	**157**
2008	**40**	**149**
2009	**39**	**Not available**
Total	**224**	**N/A**

Source: Santa Clara County Child Death Review, 2005-2009; Santa Clara County Mortality Records

Table 2. Child Deaths by Manner and Cause of Death, 2005-2009

		2005	2006	2007	2008	2009	Total
A	**Homicide**	**6**	**3**	**9**	**6**	**7**	**31**
	1. By parent/caretaker	3	2	4	1	3	13
	2. Third Party	3	1	5	5	4	18
B	**Abuse Related**						
C	**Neglect**	**4**	**2**	**2**	**1**	**1**	**10**
	1. By parent/caretaker	3	2	1	0	0	6
	2. Third party	1	0	1	1	1	4
D	**Inadequate Caretaking**	**6**	**11**	**9**	**4**	**11**	**41**
	1. Co-sleeping	4	2	4	1	3	14
	2. Unsafe sleep surface	1	7	3	2	4	17
	3. Failure to protect/supervise	1	2	2	1	4	10
E	**Suspicious of maltreatment**				**1**		**1**
F	**Non-Maltreatment**	**35**	**23**	**23**	**27**	**19**	**127**
	1. Natural (non-SIDS)	15	12	9	12	7	55
	2. SIDS	3	1	0	1	0	5
	3. Accident	8	6	6	7	1	28
	4. Suicide	4	0	3	5	6	18
	5, Adolescent High Risk Behavior	5	4	5	2	5	21
G	**Undetermined**						
	Fetal Deaths	**5**	**5**	**2**	**1**	**1**	**14**
	1. No known maternal drug use	4	1	1	0	0	6
	2. Known maternal drug use	1	4	1	1	1	8
Total		**56**	**44**	**45**	**40**	**39**	**224**

Table 3. Child Deaths Resulting from Injuries, 2005-2009

	2005	2006	2007	2008	2009
Motor vehicle and other transport	**7**	**9**	**5**	**5**	**1**
Drowning	**4**	**3**	**2**	**0**	**5**
Suffocation or strangulation	**3**	**0**	**3**	**0**	**3**
Weapon, including body part	**6**	**2**	**8**	**8**	**5**
Poisoning	**2**	**1**	**0**	**0**	**2**
Animal bite or attack	**0**	**0**	**1**	**0**	**0**
Fall or crush	**0**	**0**	**1**	**0**	**0**
Fire, burn, or electrocution	**0**	**0**	**1**	**0**	**0**
Undetermined	**0**	**0**	**0**	**0**	**0**
Other	**1**	**2**	**1**	**3**	**0**
Total	**23**	**17**	**22**	**16**	**16**

Source: Santa Clara County Child Death Review, 2005-2009

Table 4. Child Deaths from a Medical Condition, 2005-2009

	2005	2006	2007	2008	2009
Pneumonia	**4**	**2**	**0**	**1**	**0**
Other infection	**2**	**0**	**0**	**0**	**1**
Cardiovascular	**2**	**1**	**0**	**3**	**2**
Congenital anomaly	**2**	**1**	**1**	**3**	**0**
SIDS	**3**	**1**	**0**	**1**	**0**
Prematurity	**1**	**0**	**1**	**0**	**0**
Other perinatal condition	**0**	**1**	**1**	**0**	**0**
Other medical condition	**1**	**6**	**6**	**3**	**3**
Undetermined medical cause	**0**	**0**	**0**	**1**	**0**
Unknown	**0**	**0**	**0**	**0**	**1**
Total	**15**	**12**	**9**	**12**	**7**

Source: Santa Clara County Child Death Review, 2005-2009

ACKNOWLEDGMENTS

We wish to acknowledge the dedication of all those who have contributed in the review of childhood deaths. The members' continued commitment and expertise are valuable to the success of the Child Death Review Team. We would like to thank the Coroner's Office staff for their assistance prior to each CDRT meeting.

Deaths Reportable to the Coroner

1. Known or suspected homicide.

2. Known or suspected suicide

3. Accident: Whether the primary cause or only contributory; whether the injury occurred immediately or at some remote time.

4. Injury: Whether the primary cause or only contributory; whether the injury occurred immediately or at some remote time.

5. Grounds to suspect that the death occurred in any degree from a criminal act of another.

6. No physician in attendance. (No history of medical attendance)

7. Wherein a physician has not attended the deceased in the 20 days prior to death.

8. Wherein a physician is unable to state the cause of death (must be genuinely unable and not merely unwilling).

9. Poisoning (food, chemical, drug, therapeutic agents).

10. All deaths due to occupational disease or injury.

11. All deaths in operating rooms.

12. All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room, or elsewhere.

13. All solitary deaths (unattended by a physician, family member, or any other responsible person in period preceding death).

14. All deaths in which the patient is comatose throughout the period of a physician's attendance, whether in home or hospital.

15. All death of unidentified persons.

16. All deaths where the suspected cause of death is Sudden Infant Death Syndrome (SIDS).

17. All deaths in prisons, jails, or of persons under the control of law enforcement agency.

18. All deaths of patients in state mental hospitals.

19. All deaths where there is no known next of kin.

20. All deaths caused by a known or suspected contagious disease constituting a public health hazard, including AIDS.

21. All deaths due to acute alcoholism or drug addiction.

Classification of Death
Santa Clara County Child Death Review

A. **Homicide**: Death ruled a homicide, either by the Medical Examiner's report or criminal investigation.

1. Abuse by parent/caretaker
2. Third Party

B. **Abuse Related**: Death secondary to documented abuse (e.g. death occurs several years following brain damage due to abuse; suicide in a previously abused child).

C. **Neglect**: Death clearly due to neglect, supported by the Medical Examiner's report or criminal investigation.

1. Neglect by parent/caretaker
2. Third party neglect
3. Failure to protect child from safety hazards according to recognized community standards

D. **Inadequate Caretaking Skills**: Death related to poor caretaking skills and/or lack of judgment: includes actions that contributed to the child's death but do not rise to the severity of neglect.

1. Co-sleeping leading to possible overlay without evidence of substance abuse by co-sleeper
2. Provision of unsafe sleep environment:
   placing infant to sleep prone, inappropriate bedding (pillow, heavy covers, couch, adult bed etc.)
3. Failure to protect child from other safety hazards not universally recognized by the local community

E. **Suspicious or Questionable Factors**: No findings of abuse or neglect but other factors exist such as: substance use/abuse that may have caused caretaker to have impaired judgment; previous unaccounted for deaths in the same family; history of prior abuse or neglect of child.

F. **Non-Maltreatment**:

1. Natural medical death (other than SIDS)

2. Sudden Infant Death Syndrome (SIDS)
   - **A.** Maternal smoking during pregnancy
   - **B.** Maternal substance use during pregnancy
   - **C.** ETS (Exposure to Tobacco Smoke) after birth

3. Accident/unintentional injury: An unintentional death due to injury that had no elements of neglect and where reasonable precautions were taken to prevent it from occurring.

4. Suicide (no known contributing factors of child abuse or neglect)

5. Adolescent high-Risk Behaviors (Behavior of the Decedent)
   - **A.** Firearm related
   - **B.** Substance use/abuse
   - **C.** Motor vehicle misuse

G. **Undetermined**

Santa Clara County Demographics, Counts by Year, 2005-2009

All Ages					
	2005	**2006**	**2007**	**2008**	**2009**
Male	891,992	902,178	909,627	916,860	923,897
Female	869,090	878,579	885,822	892,914	899,862
Total	1,761,082	1,780,757	1,795,449	1,809,774	1,823,759
Age < 18					
Male	230,100	231,207	231,495	231,089	230,518
Female	220,157	220,941	221,447	221,503	221,093
Total	450,257	452,148	452,942	452,592	451,611
Births					
	26,553	26,942	27,484	26,730	25,200

Source: State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000–2050; State of California, Department of Public Health, Birth Records.*

Racial and ethnicity distribution in 2009: 26% White, 37% Hispanic, 34% Asian/Pacific Islander, 2% African-American, <1% Native-American, 1% Multi-race