SANTA CLARA COUNTY
DEATH REVIEW COMMITTEE REPORT

JULY 14, 1987

Bob Carroll
County Coordinator of Child Abuse Services
Chairperson, Death Review Committee
Office of the County Executive
In September of 1985, the county Multi-Disciplinary Child Abuse Team (MDT) (Appendix A) initiated a child Death Review.\(^1\) Our focus was on cases where the death may have been abuse or neglect related. The purpose of the review effort is to gather information which may be of use in developing public agency policy to prevent future deaths, and to improve the provision of services for children at risk. We have received good cooperation in this effort from the Department Chiefs and Juvenile Court Judge, and we thank them for their support.

**Procedure**

All coroner's cases\(^2\) involving children and adolescents were briefly reviewed by the Public Health Nurse. Cases that appeared to meet specifically defined criteria (Appendix B) were then reviewed by the team; if there was significant suspicion that the death was abuse/neglect related, a detailed review was done\(^3,4\). This was accomplished by checking records and gathering all available information from agencies and individuals that had contact with the child or family.\(^5\) After reviewing the information, members of the team discussed the case and asked themselves, "Was there any way in which this type of death could be prevented in the future?" We also attempted to make sure that siblings at risk were identified and appropriate steps were taken to secure their safety. Further, we were concerned about the emotional impact of a death on those involved; at times we were able to support those who had worked with the child through intelligent discussion and awareness of the issues involved. Records were kept of each discussion, those records serve as the basis of this report.

Many of our observations and recommendations were informally fed back to various agency personnel during the year and several have already led to

\(^1\)In 1987 a coroner's investigator and a representative from law enforcement was added to the group.

\(^2\)No attempt was made to evaluate child deaths which had not been referred to the coroner, or deaths that did not come to the attention of any medical or governmental authority.

\(^3\)Late in the year we added adolescent suicide (age 14 to 18) to the criteria because of indications that a significant number of suicides had previous histories of physical or sexual abuse.

\(^4\)We also looked at a small group of SIDS deaths because of questions we had about the use of the diagnosis.

\(^5\)Public Health Nursing, Medical, Social Services and Juvenile Probation records were searched. In several cases police records were also reviewed.
Improvements in identification and protection services. Given extremely limited resources, an important focus is on defining priorities both at a system and case level; our focus was on attempting to develop specific and relatively low cost areas of improvement. Decisions about whether a child should be removed from home or returned home inevitably involves a balancing of multiple risks and benefits, both for the child and the system.

We emphasize that Death Review is only one source of information and great care must be used in factoring such information into an overall child welfare policy. Only a small number of children actually die from mistreatment, but the information learned from review of those cases can be of use in helping improve the response to all children at risk.

Data
In 1985 there were about 130 child coroner's cases, about 1/2 of the 267 child deaths reported in the county. Of these, 36 were examined in detail. One case from the last week of 1984 was included because of its high concern; one case was suspicious but we were not able to do a review because we were unable to locate the DSS file, although the name was on the computer. Three cases involved children residing out of county who died in the County, those cases were referred to Death Review Teams or Social Services in the child's county of residence.

The first group of cases are mistreatment related deaths where the child had some form of system involvement prior to the death.

Case 1. This was an overtly mistreated child, who died directly from mistreatment. The child was beaten and force fed as a punishment until he vomited and then choked on his vomit.

This child had previously been removed from the parental home in another county because of neglect, and had been returned to the parent by Social Services, according to governmental (SB 14) guidelines. In reviewing the case many recommendations were made.

Recommendations
1. The school had known that the child had at times stolen food. In retrospect, it is clear that this behavior was related to the parent's use of food deprivation as a method of discipline. School and law enforcement personnel would be wise to consider the possibility that food larceny is a possible sign of neglect and hunger, rather than simply a conduct problem.
2. There is no procedure or mechanism to continue monitoring the status of children returned home whose Court Dependency status has been dismissed. Some of these children are at risk or will be at risk again, and we have no way of knowing how serious a problem this is. The State Department of Social Services would do well to assemble data on the question of how many children "at risk" being returned home under the provisions of SB 14 experience subsequent injury or death.

3. A neighbor alleges that the case was reported to the Department of Social Services Child Abuse and Neglect Reporting and Referral (CAN) Center, but no record was found. Every case contact should be logged; it might well be worthwhile to record the incoming phone calls, as is done by law enforcement. We understand that the procedure was indeed changed; now every call is logged and an appropriate data sheet filled out.

4. At that time, the staff of the CAN Center had no way of reviewing either DSS or JPD files, and thus had no way of knowing that this family was at high risk based on the previous removal. Fragmentary and divided record keeping between JPD and DSS, and the fact that DSS does not have access to the Criminal Justice Information System (CJIS) makes it more difficult for emergency response personnel to get background information, which makes it more likely that they will make decisions based solely on the very limited information immediately available to them. We recommend that appropriate DSS staff have some method of access to CJIS.

5. Parental drug use was a significant factor in this family's deteriorating situation and ultimately contributed to this child's death.

Case 2
A small child died from PCP poisoning after eating a PCP cigarette. The child had previously been removed from the home and then returned home by the Juvenile Court following a similar episode.

Recommendations
1. This type of problem is relatively common in child welfare. In Santa Clara County drug use is the leading cause of removal of children from their parental home. The issue is not simply that the parent is heavily involved with PCP, alcohol, heroin, or cocaine, but that the drug use often goes along with a set of parental attitudes and parenting limitations that places a child in
danger. Given the frequency of these problems, it would be worthwhile to improve procedures used to determine if a parent is abiding by the conditions of a reunification plan and remaining drug free.

Urine testing is one obvious approach. Because the legal issues are delicate, child welfare would benefit from a description of the circumstances under which a social worker or probation officer, acting to protect a child, can request such testing. Although a parent might still have the legal right to refuse to submit a sample to avoid self-incrimination, certainly such a refusal might be significant in terms of assessing compliance with a reunification plan.

The other part of the problem is to have a consistent, simple reliable method to administer and pay for such tests. Although the county has the appropriate equipment, and the cost per test is minimal, the logistic problems of coordinating procedures across county agencies are substantial. On the other hand, once the procedure is established, the information obtained would be of considerable value to those who had to make decisions about the wisdom of returning children back to a home in which drugs had been previously used.

2. This case had been handled by several people within the juvenile probation department and within the court. Our impression is that with each shift of case management responsibility, a great deal of information was lost. Commonly social workers, probation officers and judges know a great deal more about a family and child than appears in the case record. This information is extremely useful in terms of intelligent decision making; the more the case is shifted the less likely that this material will be available to the new worker. In our view, this is a powerful argument for trying to design a system that avoids multiple shifts of responsibility from worker to worker. Heavy staff turnover and frequent shifting of cases lead to a loss of information that reduces the quality of the casework. In medicine this principle is called "continuity of care." Although it was well defined in traditional case work and probation philosophy, this principle seems to have been increasingly lost as a factor in system design.
3. In this case, the first time the child swallowed the PCP, no definitive determination was made as to whether the parents were drug users. The original petition simply focused on the fact that they left the child in a situation where the child could be exposed to drugs. Ultimately, this made it easier for the parents to persuade the court to allow the children to return to their home. We now know that many members of the family, including the parents, were drug users. The evidence and wording of the initial petition and service plan, which became the basis of subsequent legal discussion, were relatively weak. We cannot underestimate the difficulty of the task of the worker during the investigative phase of the Dependency process. The resources at the disposal of the intake worker are very limited, and the time pressure great. The system is not well geared to counter an aggressive defense attorney in court.

4. In this case reliance was placed on parenting classes and brief psychotherapy intervention. In retrospect, compliance with the reunification agreement did not require the change in parental attitude necessary to prevent the death. The reunification contract should have been written with more specific behavioral outcomes, e.g., parents demonstrate that they are capable of remaining drug free as demonstrated by random court ordered urine testing.

5. Parental drug use and parental involvement in the drug using culture was an overwhelming factor in this case.

Case 3
This is a stillborn infant of a heroin addicted mother. This mother was herself a physically and sexually abused child.

Recommendations
1. We found out that the mother had again become pregnant and had a newborn. Steps were taken to assure the safety of that child.
2. Previously we discussed the issue of the drug using parent; the problem of the drug using pregnant woman is even more of concern. About 80% of the women incarcerated at Elmwood are in jail for drug related offenses, about 40% of the women are pregnant; about 30 women at any one time! 6 Our system for

6Observation by public health nurses.
following these women, which involves the cooperation of Valley Medical Center, the Sheriff’s Department, Public Health Nursing, Child Welfare, County Adult Probation, and County Drug Abuse Services, is weak in comparison with the difficulty and urgency of the task. Dr. Puentes, the physician for the County Methadone Program, has been attempting to develop a program for pregnant addicts, but resources are currently quite limited.

These children are at very high risk for starting life damaged, because of the damaging effects of drugs on the fetus and newborn. Alcohol clearly damages the fetus and can cause retardation, cocaine is thought to cause strokes and neurological damage. Heroin and barbiturate addiction leads to severe withdrawal problems in the newborn. Many of these children suffer further because their neurological problems make parenting more difficult so that they are a great burden on their already stressed parent. Thus they are at greater risk for parental frustration leading to abuse. Other such children remain in the child welfare system because they are not adoptable.

The economic and social costs of bearing a neurologically damaged child are so great we would think that a more preventive approach would definitely be worthwhile. A good place to start would be with the pregnant women at Elwood and in the county drug abuse programs. Improved prenatal services, better education, and better followup is at least a place to begin.

3. Drug use is a common adult response to the self hatred and despair of the physically mistreated, rejected, or molested child. Although this woman came under court protection as a child, neither our child welfare system nor our juvenile probation system was able to provide her with a sense of value and self-respect; she has now perpetuated that problem with her children. Although the system protects the child, nobody has the goal of restoring the child; the child may move through the system with relatively little focus on meeting the child’s needs. Although a

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7A proposed program in this area was turned down for funding in 1987.
8In 1986 a Santa Clara child severely damaged in utero because of parental drug use died at Agnews after several years of nonfunctioning.
9By the term "restoring" we mean bringing the psychologically damaged child back to a more normal mental state and world view.
The child-centered system is expensive; the costs of not breaking the cycle are far greater.

The next group of cases were cases we thought were likely to have been caused by caretaker mistreatment, but the evidence was not definitive. We considered them suspicious.

Case 4
This is a peculiar case in which a child received very bad thermal burns from lying on a floor furnace heat register. The coroner believed that the child had died prior to the burns; this case was diagnosed as Sudden Infant Death on this basis. Because of the coroner's report, the police stopped their investigation. We believe that a toxicology screen should have been done on the infant because of the history of drug and alcohol use and the peculiar circumstances. We consider this case extremely suspicious but were unable to do anything further.

Recommendation
Better coordination between the police and the coroner might have clarified the circumstances of the burned infant's death. The use of the phrase "sudden infant death" as a catchall phrase discouraged the police from proceeding further with their investigation. SIDS is a diagnosis of exclusion; this case probably should have been diagnosed as, "Infant death, cause unclear, with subsequent burns."

Case 5
This is a child that died of a rapidly progressing infection. The family had previously been considered as possibly neglectful, but had left the area and the case was closed. The child had been ill for at least two days with high fever and vomiting; and had an appointment at a clinic later that day.

1. It is unclear if this was a neglect case, a problem of access to medical care, or a problem of parental ignorance. Contact with a public health nurse might have given the family a resource. No toxicology screen was done on the child.

Case 6
This is a case of a child that died accidentally. The family had previously been reported for neglect, but the matter had been "settled at intake" by DSS.
Comment
These two cases point out the problems we have around the issue of neglect. There are a significant number of children in the community who are put at high risk because of parental limitations. In the face of very limited resources, child protection workers must limit their efforts to the most severe cases. For the less severe situations, tracking, supervision and supportive services are extremely limited. While this is understandable, the sad fact is that these children seem to show up disproportionately in our study. Children who receive poor supervision and care are at higher risk for accidental death or death from failure to seek timely medical care.

Recommendation
As a result of our discussions, the coroner has now developed a procedure to contact DSS on suspicious child deaths to share information. We recommend that this be done on all child coroner's cases (about ten a month).

Case 7,8,9,10,11
Five children were killed when their intoxicated father drove their car into the path of a rapidly traveling train.

Case 12
This is a young child who was killed in a home fire. The mother, who was also killed, was drunk at the time. The circumstances of the fire were unclear.
Recommendation
In situations where a caretaker is under the influence of alcohol or drugs and thus places the child at risk, we should be thinking more about the safety of the child as well as focusing on the offender. Thus in situations were the police stop a driver “under the influence” and there are children in the car, the issue of “child endangerment” should be raised.

Case 13
Although this case was initially suspicious because the child had a head bruise, the ultimate conclusion was that the death was not abuse related. Because of the suspicious circumstance of the death, the police had requested that x-rays and toxicologic studies be done to see if the child had suffered fractures secondary to abuse; these studies were not done.
Recommendations
1. We consider it important that the new coroner's facility have improved capability to do X-Ray studies. We further recommend that toxicologic studies be done on dead children where there is indication of parental drug or alcohol use.
2. Improved coordination between the police, DA, coroner and MDs would improve our diagnosis of head injury deaths. Neurosurgeons are a target group since they are involved in most serious head injuries and should receive training in the recognition of child abuse and non-accidental injuries.

Case 14
This is a case of a child with a head injury and previous bruises. It was suspicious, but there was no overt evidence of mistreatment.

Case 15
This profoundly mentally retarded child died of pneumonia. The cause of her retardation was listed as "Trauma or physical agent at birth...neonatal anoxia." We could not secure her birth records. This case is of interest because the primary issues must be considered to be in the prenatal/natal/neonatal period.

Case 16
This was an adolescent girl who had a history of extensive sexual abuse. She developed emotional disturbance that ultimately led to her death.

The next group are deliberate murders.
Case 17 and 18
This is a case of 2 boys who are thought to have been murdered by a father who then committed suicide. We were unable to find additional information on the case. There were no records of any public agency having prior contact with the family.

Case 19 and 20
These were two children who were murdered and then burned in a housefire, which is believed to have been arson. There is some suggestion that they were killed by their father, who also died in the fire. Nothing is known about the family situation.

Case 21
This is a case of a 14 year old boy who had been drinking and rowdy with friends. There was some sort of altercation and he was shot. We considered this a homicide, as did the police.
Suicides

Case 22
This is an adolescent who committed suicide. We found no evidence of abuse or neglect.

Case 23
The child had a prior history of sexual abuse and parental neglect.

SIDS Deaths
Cases 24, 25, 26, 27, 28, 29, 30 These were cases that were signed out as SIDS deaths. Recently in the medical literature the issue of SIDS deaths has been reopened, with the suggestion made that at least some SIDS deaths could be explained by hyperthermia, overlying, or deliberate suffocation.

The issue is further confused by the use of the term SIDS death to describe both a very specific syndrome and the general phenomena of an infant dying with no clearly defined cause.

Recommendations
In the stress of an infant's death, some basic elements of careful observation and history taking are in danger of being lost. Observation of the infant's situation and inquiry as to the circumstances of the child's death, and query as to whether other children in the family have died might be useful in improving assessment of the situation.

Accidental Deaths
Because the circumstances of some of these deaths were peculiar, we looked at them carefully. After scrutiny, we were satisfied that they were indeed accidental deaths.

Case 31
In this case, a child ran out into the street and was hit by a car. The police report did not address the issue of the supervision of the child. This death was probably an accident.

Case 32
This was a child who was brain damaged when hit by a car, who then persisted in a vegetative state for several years.
Case 33
This is an accidental death of an infant who suffocated himself by wedging his head as he fell off a bed.

Case 34
This appears to be an accidental strangulation of an infant on a pacifier tied to a string.

Case 35
An infant suffocated after rolling off of bed and into a plastic bag

Recommendations
Accidents are the major cause of death in young children. Better public education that focused more on "what happened and how it might be prevented" might serve a valuable parent training function.

Medical Deaths
Case 36
This case was originally reported as SIDS but turned out to be an acute varicella pneumonitis. The team recommended that a PHN contact the parents to arrange for an immunologic evaluation of a surviving sibling.

Case 37
This was an infant that was not gaining weight normally, and died suddenly although the infant was receiving pediatric care. This case is still under review.

Case 38
A teenager died of a fulminant bronchopneumonitis while suffering from infectious mononucleosis.

Case 39
In this case an infant died of a fulminant respiratory infection while under pediatric care.

Case 40
This infant died of a fulminant bronchopneumonitis.

These cases were examined because of the suddenness of death. We were satisfied that no foul play occurred.
Appendix A

Ms. Nancy Bent
Juvenile Probation Department

Ms. Fran Bergman
Public Health Nurse

Mr. Robert Carroll
County Child Abuse Services Coordinator

Lieut. Lou Covarrubias
San Jose Police Dept.

Mr. Bruce Hult
Department of Social Services

Mr. Robert Masterson
Deputy District Attorney

Mr. Charles Newman
Coroner's Investigator

Ms. Pat Osborn
Child Advocacy Council

Dr. Saul Wasserman
Child psychiatrist, Director CAPI San Jose Hospital

Dr. Hicks Williams
Chief of Pediatrics, Kaiser Santa Clara
Appendix B

All deaths of children under the age of thirteen in which one or more of the factors listed below were believed to have been present were reviewed.

1. Drug ingestion
2. Cause of death undetermined after coroner's investigation
3. Head trauma (subdural, subarachnoid, subgial)
4. Malnutrition/neglect, including failure to thrive
5. Bathtub drowning
6. Suffocation/asphyxia
7. Fractures
8. SIDS age seven months and over
9. Blunt force trauma
10. Homicide/child abuse/neglect
11. Burns except where cause is clearly not abuse such as house fire
12. Sexual abuse
13. Gunshot wound
14. Suicide 14 and younger10

This list taken from the LA Co ICAN Case Review Subcom
### SANTA CLARA COUNTY
### CHILD DEATH REVIEW TEAM
### SUMMARY OF SUICIDE STATISTICS
### 1988-1996

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* Race/Ethnicity information available only since database computerized
Appendix D

CASE PROCESS FOR DEATH REVIEW

Chairperson and/or Coroner's Representative
1. Approximately monthly fill out initial information on log sheets at coroner's office.

Chairperson
1. Make determination per information in coroner's case records or PHN SIDS logs and according to criteria sheet regarding if case should be reviewed by DRT. Consults with pediatrician if clarification needed regarding medical diagnosis (final diagnosis is often not available for three months after death.)
2. If case needs to be reviewed, arrange to have investigators and autopsy reports photocopied at coroner's office.
3. Review investigators and autopsy reports. Make determination and do follow-up action regarding:
   a. No further review is needed
   b. Mail to another county
   c. Photocopy for team members
4. If case is to be reviewed, write out identifying data for team members so that they may obtain any case information from their agency.
5. Distribute investigators and autopsy reports to DRT members, ahead of time if possible, otherwise at team meeting.

Death Review Team Members
Bring any records, information, from their agency regarding specific case to the DRT meeting. Carry out any assignments made at the DRT meeting and report back either to the chairperson by phone or at the next DRT meeting.

Chairperson
Complete data sheets as cases are finished, gives completed case information to team recorder for compilation into periodic reports.
APPENDIX B

Letter to the Editor

Adolescent Suicide

To the Editor:

A special team reviews all child deaths potentially related to maltreatment in our county. As part of that work, we examine the child and adolescent suicides.

In the past year, we have seen two teen deaths from overdoses of tricyclic antidepressants. The team has asked me to point out to the medical community the caution necessary in the use of these drugs.

Tricyclics clearly have value in the treatment of some forms of adolescent depression, they are also used to treat enuresis in childhood and at times the ADD/hyperactivity/conduct disorder syndrome. Unfortunately, the drugs can be lethal when taken in overdoses of relatively modest quantities.

Several options are available to the clinician. He can prescribe the drug in small amounts with frequent renewals. He can prescribe the drug in a larger amount and arrange with a pharmacist to only dispense a week's supply at a time. The third alternative is to have the parent control the dispensing of the drug.

This technique may be ineffective unless the parent is specifically informed as to the potentially lethal consequences of an overdose, and the parent is then able to actually keep the drug inaccessible to the teenager. Some parents have difficulty accepting the fact that their teenager might be suicidal because it is so anxiety-provoking. The prescribing physician needs to take this into account in his work with the family.

Sincerely,

Saul Wasserman, MD
Medical Director, CAPI Unit
Clinical Associate Professor
Stanford University School of Medicine

The views expressed in this publication are presented solely to promote thought and dialogue on issues, and do not necessarily reflect the opinion of the Santa Clara County Medical Society.

THE BULLETIN

Santa Clara County Medical Society, 700 Empey Way, San Jose, CA 95128

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teenagers who are often psychologically unable to fully understand and deal with the long term consequences of their behavior. Adolescent denial of pregnancy is a reflection of this lack of maturity. It appears that we have been unable to develop social institutions or traditions that effectively help many teenagers to deal with these problems. New approaches are in order.

Case example--A teenage girl living with a relative knew that she was pregnant but obtained no prenatal care. The baby was born unattended; the mother was later given medical care for post-delivery bleeding. The baby was left at home and died from inattention.

Case example--A teenage girl psychologically denied the fact that she was pregnant. Her baby was born with no medical attention and died. One of the psychological elements contributing to the denial was that the baby was conceived involuntarily.

A few final comments

Abandoning or killing children because of economic or psychological pressures is a very old historical practice. Very good statistical evidence indicates that today's families are subject to great economic and psychological stresses. The death of a child because of maltreatment is the ultimate indication that the child's caretakers have been overwhelmed by those stresses and have failed in their responsibility. The prevention of such deaths is one measure of how truly civilized we are as a society.
Police-Social Services Agency-Juvenile Probation
Department coordination

Although clearly improvements have been made in this area in the past few years, we saw several instances where better coordination between the police, SSA and JPD might have prevented child deaths. This type of coordination is particularly difficult because of the thirteen police jurisdictions in the county, and the extent to which their policies, needs and practices vary. We believe that more could be done in this area to improve the quality of service provided to at risk families.

Case example--an infant was beaten and killed by a father. He had a previous history of violent behavior. Both the SSA and the police had been involved in the case at different times prior to the death. Because the case was not cross-reported, the two agencies were not working cooperatively; and preventive action was not taken.

We particularly are concerned about the very difficult triage process that SSA and police must do when confronting a potentially serious child abuse situation. With little time to gather information, decisions must be made as to whether or not a child is in imminent danger. Often these decisions must be made on evenings or weekends. Accessing the SSA computer records off hours is more difficult. This is a real handicap, since prior behavior is one of the best predictors of future behavior. We would strongly support any steps that would increase the amount of data Emergency Response workers and the police could have to improve their decision making.

Information systems are an important part of governmental infrastructure. Public agencies which must deal with large numbers of families should have systems that provide fast, accessible and reliable information about the families they serve.

Reunification issues

The increase in the number of sexual abuse reports, the increase in problems related to drug usage and the increase in the number of children in foster care caused by the decline in funding for preventive and supportive services has severely
SANTA CLARA COUNTY

CHILD MALTREATMENT

DEATH REVIEW TEAM REPORT

1986-1989
TABLE OF CONTENTS

Introduction 1
Drug and Alcohol use 2
Cranio-cerebral Injuries 4
Sudden Infant Deaths 5
Issues related to post-mortem evaluation 6
Police-Social Services Agency-Juvenile Probation 7
Department coordination
Reunification issues 7
Adolescent denial of pregnancy 8
A few final comments 9
Appendix A - Infection as a cause of child and infant death
Appendix B - Adolescent Suicide
Appendix C - Criteria for Death Review
Appendix D - Case process for Death Review
Appendix E - Death Review Team Member Roster
The numbers are small, and the definition of "abuse" is variable. We would recommend care in drawing conclusions. What is striking is how consistent the numbers are; a fairly constant rate of 10-11 maltreatment deaths of children per 1.25 million people per year (8.4 deaths per million population).

There are several issues that have emerged as major themes in our work. These themes define issues relevant to the entire community.

**Drug and Alcohol use**

The chronic use of drugs and alcohol figure heavily in our statistics. About 2/3 to 3/4 of the deaths involve in some way a parent who is either under the influence of a drug or alcohol or is a chronic drug or alcohol user.

Many people who use drugs are dysfunctional in some way before they start, others become dysfunctional as part of and because of their drug use. Alcohol, cocaine, PCP and other drugs have adverse effects on thinking, judgement and the ability to parent.

Case example—a mother was riding in a car with a driver under the influence of PCP. Her child fell from the car when it swerved, was run over, and was killed.

Case example—a father shot and killed his daughter. He was a heavy user of cocaine and alcohol, and had been both physically and verbally abusive to the child before the death. The mother was in jail for drug use.

Case example—a teenager drowned in a bathtub while under the influence of cocaine.
INTRODUCTION

For the past five years, a special team has been reviewing child deaths in Santa Clara County to determine which deaths may have been caused by maltreatment. For each questionable death, we assemble the records of family contact with the main public agencies that provide services for children and do an intensive review. Our question is always, "What could be done to prevent a death like this in the future?"

The models for maltreatment death review developed in Los Angeles and Santa Clara County have been widely used throughout the state as many counties developed their own review teams. Legislation at the state level now supports the development of such teams, and a state task force (with two members from Santa Clara County) is now drawing up a recommended protocol and establishing a statewide data collection system.

Over the years, we have identified many specific issues. When we find a potentially solvable problem we "close the loop" by providing information or suggestions to whomever might benefit in terms of learning better how to protect the lives of children. (Appendix A & B) For every child who dies of maltreatment, perhaps 100 are at risk. Our hope is to not only prevent deaths, but to also serve as one source of information that can improve the identification and response to families that are at risk.

We use a standardized criteria for identifying cases for screening (Appendix C); and have a defined protocol for review (Appendix D). All members of the team are experienced and respected within their field (Appendix E). We express our appreciation to the various Department Chiefs who have been quietly supportive of our efforts. The death of a child is a very emotional event, and we have chosen to be very low key to avoid getting caught up in those emotions.

Dealing with children at risk inevitably involves making decisions that involve judgement and difficult balances about the relative hazard and benefit to the child of various alternatives. We have tried to be sensitive to this fact, as well as to avoid either being a "whitewash" or "hanging" group. We use judgement to evaluate each situation.
Case example--an infant was identified as high risk because of maternal and paternal cocaine use, there were no drugs in the baby's blood at birth. Public health nursing was arranged but support services were ended when the family left the county. A few weeks later the infant died from pneumonia after being grossly neglected by the parents, who continued to use cocaine.

Of particular concern is the negative effects these drugs appear to have on the developing fetus. Heavy alcohol use in pregnancy is associated with irreversible mental retardation; cocaine is heavily implicated in neurological abnormalities and premature birth.

Case example--A mother used cocaine prenatally. The infant was born by C-section with the mother having no prenatal care. The infant had respiratory problems from birth and showed evidence of severe brain damage. Several years later the infant died at the Agnews Center.

Case example--a 3.5 pound infant was born prematurely and without medical care. The baby died at birth. Post-mortem exam showed cocaine in the baby's blood.

Santa Clara County has not had the massive crack epidemics of San Francisco and Oakland, but cocaine use has increased greatly and we reviewed several deaths related to cocaine. In addition to the more obvious drug related deaths, we reviewed deaths occurring soon after birth among babies whose mothers had been using cocaine and PCP prenatally. Since these deaths had no obvious explanation, they were classified as SIDS deaths by the coroner. Some observers believe that cocaine use increases the risk of a SIDS death by a factor of thirty. Studies about this issue are currently in progress.

Case example--an infant was born with a positive toxicology screen for cocaine and heroin. The child was placed in foster care, but died two days after birth with no apparent cause.

Case example--a pair of twins were each found dead. The parents had a history of drug use and PCP was found in the home. Despite extensive analysis, no cause of death could be found, the cases were classified by the coroner as "undetermined cause of death."
We consider integrated, preventive approaches that identify high risk mothers during their pregnancy and provide treatment to stop drug use during this critical period a high priority. Local hospitals vary considerably in their efforts to identify infants who may have been prenatally exposed to drugs. There currently are no well-defined criteria for identifying which infants should have toxicology screens at birth.

We would recommend the development of a more standardized assessment process and criteria for toxicology screens. This criteria then should be adopted by the hospitals as a standard of obstetrical and pediatric care. Substantially improved followup procedures are needed for infants that have been exposed to alcohol or drugs prenataally. We strongly support the efforts of the Santa Clara County's Perinatal Alcohol and Drug Use Coalition, which is addressing the issues we have outlined above. State Senator Presley has convened a statewide task force working in this area.

Cranio-cerebral Injuries

We have reviewed several deaths caused by cranio-cerebral injury that we consider highly suspicious, although abuse was not proven. In several of these, the police or physicians attending to the child were premature in concluding that the injury was accidental; sometimes accepting a questionable description of the events leading to the death. Once the death is called non-maltreatment by the MD or police, the investigation and criminal prosecution process is more likely to be stopped.

The best available data suggests that small children are very unlikely to suffer major head injury from typical household falls. We have shared this information with law enforcement and medical personnel. We favor further education for neurologists, neurosurgeons and ER doctors, as well as the police about this issue.

Case example--A 3.5 month old infant died from a subdural hematoma originally attributed to a fall. The father first said that he slipped going up some steps and the baby fell out of his arms. Physical examination showed bilateral retinal and posterior chamber hemorrhage. The father later admitted to shaking the child and pled guilty to manslaughter.
Case example—An infant died of a closed head injury. The case was originally considered an accident, but no cause for the head injury was apparent. The case was likely a shaken baby syndrome, but several people were caring for the child and it was not possible to identify a perpetrator.

Sudden Infant Deaths

The public awareness and concern for grieving parents of children who die suddenly has at times led to a situation where physicians, police, paramedics and coroner's investigators may overlook doing a careful examination and evaluation of situations in which an infant is found dead with no obvious cause.

Attempting to resuscitate an obviously dead infant accomplishes nothing and makes it more difficult to define a cause of death. We understand that there are legal issues which prevent paramedics from pronouncing a child dead, but we question the wisdom or necessity of attempting to resuscitate obviously dead children.

We recognize that the majority of deaths that are classified as "Sudden Infant Death" are truly deaths for which there are no currently no known cause or prevention. Unfortunately, it is also true that autopsy findings cannot distinguish between Sudden Infant Death and death from suffocation. Careful observation of the death scene and sensitive interviewing of caretakers is crucial to evaluate the situation.

Case example—An infant suffocated from a plastic bag. The autopsy findings were identical with the typical SID case. The diagnosis was made because the baby sitter reported finding the infant with the plastic bag over its face.

Case example—a young infant died with no apparent cause. The mother had previously been reported for physical abuse and another child was a dependent of the court. One neighbor alleged that previously the parent had disciplined a child by placing him face down and hitting it on the back.

Case example—a 4 month old infant presented at death with the typical findings of SID except for a small laceration of the vagina. Ultimately the father was convicted of killing the child.
We recognize the tragic and terrible emotional circumstances a family that has a child who dies for no obvious reason faces. The fact that such deaths are relatively common in infancy is not always known by law enforcement personnel or the public. The State Task Force on Maltreatment Death Review and the State Task Force on SIDS are currently attempting to work together to establish protocols and training for law enforcement and first response teams (e.g. paramedics) to improve skills in this sensitive area.

**Issues related to post-mortem evaluation**

The doctors on the Death Review Team thought that in a percentage of cases, blood cultures should be done either by the physician or the pathologist. We also saw value in saving sera and frozen sections of body organs. The presence of unknown or unidentified infectious agents and metabolic disorders that might cause death in children is of concern, and such samples might be of use in the future from a public health perspective. (Appendix A)

The team is planning on discussing this issue further with the medical community.

We have reviewed cases where a child was described as "well-nourished, well-developed," although this was not the case when we plotted the child's death weight and size on a growth curve. In one case when information about birth weight was included, it was apparent that the child had not thrived. Since failure to thrive can be caused by poor parental care, this is an important issue. We recommend that the coroner plot a growth curve for every young child.

We have reviewed situations where we felt that the pathological and radiological evaluation might have been more comprehensive. When the cause of death can not be adequately determined, the situation leaves a long period of emotional distress, guilt and confusion. Although detailed pathological evaluation can be costly, we see the process as being important for the family and society.
overloaded the child welfare system. The philosophy of SB 14, which was designed to keep caseloads manageable by closing cases quickly, has led to problems responding to families that are chronically or episodically at risk.

We are finding deaths occurring in families subsequent to children having been returned home according to the SB 14 philosophy. We know of no systematic effort on the part of State government to assess the full impact of this law. We think that this data should be assembled.

Case example—a young child was ostensibly under the care of a baby sitter and drowned. Several children had previously been removed from the family because of neglect, but were later returned.

Case example—a teen age girl was placed with a stepfather who had previously molested her. She ultimately killed herself. There is some reason to believe that she had been re-molested.

Case example—a teen age boy was returned to his mother from whom he had been removed because of maltreatment. Though under court supervision because of delinquent behavior resulting from his failure to adjust in his mother's home, he remained in the home. He ultimately committed suicide.

**Adolescent denial of pregnancy**

Every year we review a few cases in which teenagers denied that they were pregnant, to their families and at times to themselves. Their babies were born without medical care and subsequently died from abandonment, drowning or being ignored.

These young women—fourteen, fifteen and sixteen year olds—are psychologically unready to deal with the results of early adolescent sexual activity. While a full discussion of the issues relating to teen pregnancy is beyond the scope of this report; these deaths serve as a grim reminder that psychological maturity does not automatically parallel the ability to conceive.

In the past, when girls were married at twelve; adolescent sexuality was not an issue. The creation of a long adolescence; and the loosening of sexual restrictions that has come with effective birth control has created major problems for
ADDENDIX A

INFECTION AS A CAUSE OF CHILD AND INFANT DEATH

PROPOSED POLICY STATEMENT DRAFTED BY J.H. WILLIAMS, M.D., FAAP
MEMBER SANTA CLARA COUNTY CHILD DEATH REVIEW COMMITTEE

A child's or infant's death can be considered a failure of the community to protect that child from those factors which caused the death. The cause or causes for each child or infant death should be defined; and further, we should use the information obtained from that death to develop means to prevent similar situations in the future. The common causes of child and infant death such as accidental trauma, homicidal trauma, death due to toxic agents, are usually systematically evaluated by the coroner, social services and the police. Infectious disease as a cause of death often does not receive the same systematic and meticulous evaluation. We often do not collect timely and appropriate cultures and specimens and thereby miss the opportunity to define the true cause of death, as in many cases autopsy findings are equivocal, or no autopsy is done.

All medical centers which receive dead or dying infants and children must be prepared to obtain in a timely fashion appropriate cultures and serum and tissue samples to define the potential bacterial, viral and protozoal cause of death. At the very least a heart blood sample should be saved for appropriate cultures and serologic studies as indicated by the clinical picture. (For example, in situations of high risk for HIV I (AIDS), the serum should be screened for HIV I as, the immune incompetence caused by AIDS can lead to overwhelming sepsis as the initial evidence of AIDS.)

The blood samples should be obtained as soon as possible after death, if they have not been obtained prior to death as part of the work-up of the child's illness. This means that any physicians caring for such a child in the Emergency Room or on the ward or ICU should obtain these cultures, and there should be appropriate laboratory support available to give accurate bacteriologic and viral information to the treating physicians as well as Public Health agencies. Funding of this laboratory support may be a problem for those patients without medical insurance or Medi Cal coverage. In those cases at least the culture should be paid for by a Public Health agency in the county.
Appendix C

CRITERIA FOR DEATH REVIEW

All deaths of children under the age of fourteen in which one or more of the factors listed below were believed to have been present were reviewed.

1. Substance ingestion or substance exposure in utero
2. Cause of death undetermined after coroner's investigation.
3. Head trauma (subdural, subarachnoid, subgial), (except when caused by auto accident).
4. Malnutrition/neglect, including failure to thrive.
5. Bathtub drowning
6. Suffocation/asphyxia
7. Fractures
8. SIDS age under one month or over seven months.
9. Blunt force trauma
10. Homicide/child abuse/neglect
11. Burns except where cause is clearly not abuse.
12. Sexual abuse
13. Gunshot wound
14. Suicide (through 17)
15. Death in foster or day care (except SIDS 1-7 months)
16. Agnew's deaths (at least cursory review by PHN and pediatrician)
17. Certain medical deaths where death is not common or is faster than normal e.g.: pneumonia, diarrhea, meningitis. At least cursory review by PHN and pediatrician regarding parental medical neglect and adequacy of the medical system
18. Auto accidents if there is suspicion of caretaker drug or alcohol use or no car seats
19. Cases brought to our attention by concerned professionals

5-1-85, rev. 6/90
Appendix E

DEATH REVIEW TEAM MEMBER ROSTER

Ms. Nancl Quast Bent (till 1988)
Mr. Ray Colar
Juvenile Probation Department

Ms. Fran Bergman
Public Health Nursing

Mr. Robert Carroll (till 1989)
County Child Abuse Services Coordinator

Sgt. Peter Graves (till 1988)
Lt. Richard Gummow (1988-89)
Lt. Richard T. Arca (1990-)
San Jose Police Department

Mr. J. Bruce Hult
Department of Social Services

Sgt. Joseph Kirby
Santa Clara County Sheriff's Department

Mr. Robert Masterson
District Attorney's Office

Mr. Charles Newman (till 1988)
Mr. Joe Davis (1988-89)
Ms. Marie Robinson
Coroner's Office

Ms. Patricia E. Osborn
Child Advocacy Council

Dr. Saul Wasserman
Child psychiatry

Dr. J. H. Williams
Pediatrics