SANTA CLARA COUNTY

CHILD DEATH REVIEW

A TEAM DEDICATED TO PRESERVING THE LIVES AND SAFETY OF OUR CHILDREN

TWO-YEAR REPORT

2016-2017
Santa Clara County
Child Death Review Team

REPORT
Case Reports for Calendar Years 2016-2017
Published October 2018

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The cover design reflects our responsibility in providing safety, guidance and trust for our children whether we are a parent, sibling, teacher, mentor, neighbor, friend or distant observer.

Our children deserve to trust us in providing them health, happiness, and safety.

Michelle A. Jorden, MD
Chair, CDRT

In memory of Jim Gaderlund, dedicated member of CDRT
Los Altos, CA
Santa Clara County Board of Supervisors

Mike Wasserman          District 1
Cindy Chavez            District 2
Dave Cortese, President District 3
Ken Yeager, Jr.         District 4
Joe Simitian            District 5

Jeffrey V. Smith, MD, JD
County Executive

Sara H. Cody, MD
Santa Clara County Health Officer and Public Health Director
CONTENTS

Mission Statement......................................................................................................................... 6
Santa Clara County (SCC) Child Death Review Team (CDRT) 2016-2017 and current members* .......... 7
Background ........................................................................................................................................ 10
Executive Summary .......................................................................................................................... 11
   Team Membership ........................................................................................................................ 11
   Case Selection ............................................................................................................................... 12
Key Findings ...................................................................................................................................... 13
   Sleeping .......................................................................................................................................... 13
   Suicides ......................................................................................................................................... 15
   Homicide by a Parent/Relative ...................................................................................................... 16
   Homicide by a Non-Relative ........................................................................................................... 16
   Accidental Deaths ........................................................................................................................ 16
   Drowning ...................................................................................................................................... 16
Child Abuse Prevention Council (CAPC): ......................................................................................... 17
   Child Death Review Team Recommendations .............................................................................. 18
      Safe Sleeping ............................................................................................................................ 18
      Suicides .................................................................................................................................... 18
      Drug Abuse ............................................................................................................................... 19
   Accomplishments for 2016-2017: .............................................................................................. 20
Statistics ............................................................................................................................................. 22
Safe Sleep Initiative .......................................................................................................................... 25
Acknowledgements ......................................................................................................................... 26
Appendix ........................................................................................................................................... 27
   Deaths Reportable to the Medical Examiner-Coroner ................................................................. 27
   Classification of Death, Santa Clara County Child Death Review-REVISED FEBRUARY 2014 ........... 29
   Santa Clara County Demographics, 2016-2017 ....................................................................... 31
   Safe Sleep Education Materials .................................................................................................. 32
   Child Abuse Indicators and Guidelines ....................................................................................... 56
   Retrospective Study of Juvenile Motor Vehicle Deaths ................................................................. 72
   Undetermined Risk Factors for Suicide Among Youth ages 10-24 .............................................. 89
“The death of a child is the single most traumatic event in medicine. To lose a child is to lose a piece of yourself.”

Dr. Burton Grebin

“Safety and security don’t just happen; they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear.”

Nelson Mandela, former president of South Africa
MISSION STATEMENT

It is the mission of the Santa Clara County Child Death Review Team (CDRT) to review and investigate the circumstances surrounding the deaths of children that occur in Santa Clara County. The review is conducted through a process of interagency collaboration and discussion. The objectives of this inquiry are to discover ways to improve children’s lives, and to prevent serious childhood injury and deaths in the future. The CDRT’s review is not intended to assess fault by any particular agency or child care professional.
# SANTA CLARA COUNTY (SCC) CHILD DEATH REVIEW TEAM (CDRT)
## 2016-2017 AND CURRENT MEMBERS*

<table>
<thead>
<tr>
<th>Name</th>
<th>Role/Position</th>
<th>Organization</th>
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<tbody>
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<td>Michelle A. Jorden, MD*</td>
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<td>John Mills</td>
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<tr>
<td>John Sum, MD*</td>
<td>CCS Medical Director</td>
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<td>Medical Director</td>
<td>Santa Clara Valley Medical Center</td>
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<td>Christopher Duncan*</td>
<td>EMS Specialist</td>
<td>SCC Emergency Medical Services</td>
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<td>Senior Mediator</td>
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<td>SCC Dept. of Family &amp; Children’s Services</td>
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<td>Mini Luna</td>
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<tr>
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<tr>
<td>Guests*</td>
<td></td>
<td>Community, county agencies, rotating Resident physicians from Valley Medical Center and Stanford University Medical Center</td>
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*current members
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 (birth up to teenagers under the age of 18) reported to the Medical Examiner/Coroner’s Office. Due to the sensitivity of the material discussed, confidentiality is maintained pursuant to Penal Code Section 11167.5 and reinforced with a signed confidentiality agreement which is signed by every new member as well as any guests attending the meeting. Case material is prepared for each member prior to the meeting and given to each member in the form of a packet at the start of the meeting. To preserve confidentiality of sensitive case material, the packets are secured and accounted for by the CDRT coordinator at the end of each monthly meeting. A sign in and sign out sheet is presented at the start and end of each meeting to further track the packets to prevent the potential for inadvertent dissemination.

Legislation enacted in 1997 required the State Department of Social Services to collect data related to the investigations conducted in child deaths. This data, provided by child death review teams and child protective agencies, is 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. Our team continues to strategize educational forums collaboratively within the team and with major stakeholders in the county to help educate the community in making more informed choices regarding the health and safety of our children in Santa Clara County.

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1 Refer to end of this report for “Deaths Reportable to the Coroner”.
Team Membership

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

- Santa Clara County Department of Public Health
- Medical Examiner’s Office
- Child abuse experts
- 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

Our team is comprised of dedicated members who volunteer their time each month discussing the death of children in our county. Their dedication and resilience to discuss these cases and make a difference cannot be over emphasized. Each month, the CDRT meetings continue to be well attended and nearly full to capacity.

The Medical Examiner-Coroner prepares a Power Point presentation of all the child deaths for each month and each case is presented in detail to allow for questions and discussion among the members with the Medical Examiner prior to the record checks (see below) and state classification.
Case Selection

We review the circumstances of the deaths of children (birth up to teenagers age 17 years) investigated by the Santa Clara County Medical Examiner/Coroner’s Office. In certain cases, the Medical Examiner has the discretion of accepting the cause and manner of death proposed by the reporting source and as such, 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 or a child dying from a long history of battling leukemia. Natural medical deaths may be brought before the team if the case falls under the jurisdiction of the Medical Examiner (e.g. sudden unexpected child death) and when deemed a Medical Examiner case, the Medical Examiner-Coroner Office performs an investigation. This report only includes cases reviewed by the CDRT who were residents of Santa Clara County and those cases which fell under the jurisdiction of the Medical Examiner-Coroner’s Office. The Medical Examiner-Coroner’s Office only examines children who died in Santa Clara County but when a child died in Santa Clara County but lived in another county, death review of the child will occur in the county of residence. 4 cases met these criteria in 2016 and 5 cases met criteria in 2017. These cases are not reviewed by the Santa Clara County Child Death Review Team because record checks do not cross county lines, and thus referred back to the respective CDRT for complete analysis and classification. As a courtesy to the other counties, the Santa Clara County Child Death Review Team will provide the autopsy report and other documentation deemed necessary so the outside CDRT can perform a comprehensive review.

Prior to each meeting, selected CDRT members collect record check information for each child’s 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. At the conclusion of the review, each case is classified for the state providing meaningful statistics which can be tracked at the county or state levels. 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.

In 2016, 37 child deaths met criteria for review by the Child Death Review Team. We reviewed 34 child deaths in 2017. In the past two years, the team has reviewed an average of 35 cases per year. The CDRT reviewed approximately 29% of the deaths of all children in Santa Clara during the 2016-2017 period. For the remaining 71% of child deaths in the county that do not fall under the jurisdiction of the Medical Examiner, Dr. Michelle Jorden continues to review all pediatric death certificates for ages 0-17 years, to determine whether or not an element of child abuse or neglect contributed to the death.

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2 Refer to end of this report for “Classifications of Death”.

12
Annual Report 2016-2017
KEY FINDINGS

Sleeping

Sudden infant death syndrome (SIDS) is rare in Santa Clara County and continues to remain almost non-existent since the last two annual reports (2010-2012 and 2013-2015)! The majority of the sudden unexpected infant deaths continue to be attributed to an unsafe sleep environment to include overlay and accidental suffocation.

Of the 24 infant deaths (age <1 year old/<12 months old) occurring during the 2016-2017 period that were reviewed, there were 17 infant deaths that occurred directly due to either unsafe sleep practice (overlay, etc.) (n=8) or in an unsafe sleep environment (n=9), in which other factors for sudden death were also present (undetermined cases). This number does not include stillborn deaths.

Of the 24 infant deaths, three (3) infants died of natural causes. In one case, a 15-month-old died of suffocation due to entrapment in between a toddler bed and baby gate. One (1) infant died in the setting of a nuchal cord and maternal methamphetamine intoxication. One (1) infant who was a resident of Santa Clara County died in another county; the team classified the death as undetermined as a scene investigation was not conducted by the out of county investigative agency.

A safe sleeping environment for an infant is to be routinely placed on his or her 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 with an adult puts the child at risk and is not recommended. As of October 2011, bed sharing is defined as an adult sleeping on the same sleeping surface as the infant, whereas co-sleeping is defined as the adult and baby sleeping in the same room and not necessarily sharing the same sleeping surface. **In 8 cases, the conclusion of the team was that the infant most likely died from an adult unintentionally rolling on the infant while asleep or the infant suffocated either due to wedging or suffocation within soft bedding within the sleep environment**. The term overlay encompasses situations in which parents/caretakers roll on top of the baby but also encompasses any adult body part (e.g. arm, leg) that may make contact with the infant in such a way as to prevent effective breathing. 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 his or her back after feeding. Also available are the cribs which can attach to the adult bed to ensure the baby has his/her own sleep surface. With further investigation into these deaths and interviewing the parents, sleep deprivation of the parent/caregiver may pose a risk for parents being unaware that they have rolled onto the baby while asleep.

Unsafe sleep environment means 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 (face

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1 This data is based on the CDRT conclusion and does not reflect Medical Examiner’s assigned manner of death for these cases.
(down) with the face pressed into the couch or bed pillows. A safe sleeping environment should be used each time an infant is placed down for a nap or for night’s sleep.

The diagnosis of Sudden Infant Death Syndrome (SIDS) has traditionally been applied to unexpected infant deaths of previously healthy infants with no findings of injury or disease on autopsy, and no recognizable cause of death revealed by scene investigation. 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 American Academy of Pediatrics' Back to Sleep campaign, arising from epidemiologic research relating sudden infant death to sleeping position, emphasized supine sleep position (i.e. putting infants to sleep on their backs) along with the use of a crib or bassinette. Since this recommendation, the overall rate of SIDS in the United States has declined by more than 50% since 1990 (US data). In 2013-2015 Santa Clara County had one (1) case meeting the criteria for SIDS. This is far below the national average. The reason for this low number in comparison to the national data is attributed to our recognition of sleep position as a risk factor and to the detailed death investigation performed by the Medical Examiner. Since 2008, the Medical Examiner-Coroner (MEC) Office has instituted conducting baby doll re-enactments on sudden unexpected infant deaths wherever possible. It is explained to the parents/caregivers that this portion of the investigation allows the Medical Examiner to obtain a better understanding of the infant’s body position when last seen alive, and to compare it to the position of the infant when found unresponsive. In a bed sharing situation where an infant dies, the baby doll re-enactment also allows the Medical Examiner to not only assess the infant’s last body positions, but also the parent’s or caregiver’s body positions as they relate to the infant.

Over the past 9 years, the team continues to acknowledge the risk of infants dying due to unsafe sleep environments and support the recommendations set forth by the American Academy of Pediatrics (AAP) position paper generated in October 2011 and most recently 2016. The team collaborated with First 5 in 2011-2013 to launch a public awareness campaign to educate the community about safe sleep as reported in the last 2010-2012 report (please refer to CDRT report 2010-2012).

The Medical Examiner-Coroner’s Office and major stakeholders continue to stress the importance of a safe sleep environment for infants within the first year of life.

The materials about safe sleep currently available to the public in Santa Clara County are as follows (also available in appendix):

- First 5 (www.first5kids.org)
- Santa Clara County Public Health Department (www.sccphd.org)
- Centers for Disease Control and Prevention (www.cdc.gov)

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2 Centers for Disease Control and Prevention, August 9, 2013.
The team continues to recommend and to participate in efforts to increase the public’s awareness of the dangers of placing a child to sleep on any surface other than a crib or bassinette. The back to sleep approach is enforced by the team. Further, bed sharing should be explicitly discouraged. This advice should be disseminated by health educators at pre and postnatal visits, pediatric office visits, daycare provider educational programs, child care/babysitter training in middle and high school and all parent training programs.

Since the last report, the CDRT continues to assist families grieving the loss of a child. With the loss of every child in Santa Clara County who falls under the jurisdiction of the Medical Examiner, grief packets continue to be sent to families, along with a cover letter from the Chair and Coordinator to express our condolences and provide additional grief support resources during a most difficult time.

Some resources researched by CDRT and supplied to the families include:

- First Candle (www.firstcandle.org/grieving-families)
- HAND: Stands for “Helping After Neonatal Death of the Peninsula” (www.handsupport.org)
- Centre for Living With Dying (www.billwilsoncenter.org/services/all/living.html)
- The Compassionate Friends (www.compassionatefriends.org)

The team as well as the Medical Examiner continue to approach the sudden and unexpected death of an infant in this county as Sudden Unexpected Infant Death (SUID) instead of SIDS given the above data emerging from the MEC Office and data which is being collaborated by other Medical Examiner Offices in the country.

## Suicides

Nine (9) youths died by suicide in 2016-2017. Six (6) youth completed suicide in 2016 and three (3) in 2017. The most common method used continues to be hanging (n=5) over this two-year period. In the remaining cases, one (1) teenager intentionally jumped from a roof succumbing to multiple fatal traumatic injuries. One (1) case involved a 17-year-old male who intentionally was struck by a train resulting in fatal traumatic injuries and one (1) case involved a teenager taking his own life with a firearm. Lastly, a 12-year-old died by suicide by partial decapitation with a rotating saw blade after disabling the safety mechanism of the machinery.

As in years past, case review by the CDRT is not inherently designed to determine the complex motivations of the individuals who complete suicide and thus the need to re-visit the CDRT classification system. 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/Relative**

In the 2016-2017 reporting period, 4 children were killed by either their biological parent or someone within their immediate family structure. Two (2) infants died of abusive head injury. One (1) child was intentionally drowned by a parent and one (1) toddler died of homicidal violence.

**Homicide by a Non-Relative**

A total of 4 teenage boys were murdered in the 2016-2017 reporting period and of these, three (3) were considered gang-related. Three (3) teenagers aged 16 and 17 years died of gunshot and shotgun injuries and one (1) 17-year-old died from stabbing.

**Accidental Deaths**

Fifteen (15) cases were classified as accidental in the 2016-2017 reporting period. Motor vehicle collisions, resulting in the death of a driver, passengers, a pedestrian, or a cyclist, accounted for the vast majority of the cases. Eleven (11) children and teenagers were involved in motor vehicle accidents. Of these, one (1) case involved a 3-year-old girl who was accidentally struck while chasing a ball by a motor vehicle when it was backing out of a driveway. One (1) case involved a 6-year-old who was struck while walking with his family in a shopping mall parking lot, and one (1) case in 2016, involved a 17-year-old male involved in a motor vehicle accident after traveling at a high rate of speed which resulted in the explosion of the vehicle producing extensive and deforming thermal injuries.

Please refer to Appendix for the retrospective analysis performed of motor vehicle fatalities in youth.

In this reporting period, three (3) children aged 9, 10 and 14-years-old also died of thermal and inhalational injuries in mobile homes fire. The team attributed two (2) of these incidents as accidental and one (1) as undetermined.

One (1) 9-year-old child who had a chromosomal abnormality accidentally choked on a bolus of food.

The numbers reported under this category do not include accidental infant suffocations observed as unsafe sleep during 2016-2017.

**Drowning**

We reviewed the drowning deaths of four (4) children in the 2016-2017 period. A 1-year-old died in 2016 and a two-year-old, three-year-old, and four-year-old died in 2017. Of the four (4) cases, two (2) of the deaths were classified as neglect to involve lack of parental/caregiver supervision and two (2) were considered non-maltreatment. The CDRT continues to recommend a child-safe fence/barrier with a self-latching gate be installed around the full perimeter of all private home pools. In addition, this team

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4 One of the motor vehicle related deaths was a suicide.
promotes the importance of constant parental/caregiver supervision of babies and children in and around water.

The Child Death Review Team continues to emphasize the following:

1.) **Children should never be left unattended for any amount of time, even a few minutes.**
   - PARENTS: Make sure your children are supervised at all times when around water!

2.) **Children can drown even in a bucket of water.**

3.) **The majority of drowning cases were observed in the <1 year-2 year age range.**

4.) **In our previously published study, brain damage can occur in as little as 5 min.**

5.) Regardless of age, race, or gender of the child, small children remain extremely vulnerable around water, when not being watched carefully by their caregivers. Having fences, locks, and the knowledge of how to act around bodies of water can help to prevent a child from drowning. **Pool safety measures HAVE TO BE IN PLACE at ALL times and need to be working.**

**Child Abuse Prevention Council (CAPC):**

In 2013, the CDRT agreed to closer collaboration with the Child Abuse Council so both entities can work together more cohesively addressing child abuse and neglect issues in Santa Clara County.

The Child Abuse Council (CAC) had changed their name to the Child Abuse Prevention Council (CAPC) and continues to report on their activities monthly at the Child Death Review Team.
Child Death Review Team 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. If parents want to be in close proximity to their infant room-sharing may be indicated with emphasis that the baby is placed in his or her own crib/bassinet, 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 with the remainder of the blanket dangling at the sides and foot of the crib tucked under the mattress.** 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 or pet.** 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, prenatal classes and daycare centers. We strongly discourage the improper use of nursing pillows (such as Boppy pillows™) being used as pillows to place an infant to sleep. We strongly encourage parents to actively read warning labels on products bought for a new baby. We specifically recommend that health care providers ask about the sleeping environment at each infant health care visit.

Based on observations made by the various experts on the team, the team also recommends babies not be placed on their stomachs for sleep until they can fully roll over (front to back AND back to front) to further reduce the risk of possible suffocation or compromising position obstructing the airway within soft bedding.

Suicides

Suicide is a profound and preventable tragedy no matter what the age of the victim or method used. For teens in particular, we encourage educational programs to help peers and adults identify the youth at risk for suicide or who are suicidal. **We also encourage parents to become more engaged in youth activities particularly monitoring the Internet as well as text messages through a cell phone and social media.** The Internet proves to be a resource to individuals, youth and adults alike, of obtaining means to commit the act. We also encourage parents to talk to their children about bullying. By establishing this interaction with their teenagers/children earlier, parents will be educated more about the subtle messages as they relate to bullying. In addition, we would also encourage the active involvement of schools as it relates to this growing problem.
**Drug Abuse**

For this reporting cycle, a 17-year-old died of a heroin overdose. The manner of death was certified as undetermined.

The drug abuse death observed in this county in 2010 allowed the CDRT as well as other county agencies to become more educated on a drug initially thought as “harmless”. *With the increase in the manufacture of designer drugs and the relative ease of acquiring these drugs, the CDRT will continue to monitor drug trends of children/teenagers as they relate to death.*

In June 2017, Mountain View Police Department provided additional training to the CDRT members entitled: Current Drug Trends in the School Age Population. Drug paraphernalia and signs and symptoms of when someone is under the influence was discussed as well as more popular drugs on the street which include marijuana and designer drugs.
Accomplishments for 2016-2017:

Topic of safe sleep for infants:

In 2016, Dr. Jorden and Chief Medical Examiner-Coroner Investigator Rosa Vega provided safe sleep trainings to the nurses at Valley Medical Center.

Dr. Jorden provided training in February 2016 to the District Attorney’s Office on Severe Child Injury and Death highlighting the role of the Medical Examiner in the current county’s investigative protocol.

In 2017, Dr. Jorden along with Chief Medical Examiner-Coroner Investigator Rosa Vega, and Lead Medical Examiner-Coroner Investigator Christina Pantoja, provided training to over 300 social workers on safe sleep for infants.

Topic of well-being:

At the request of the Chair of Child Death Review, a portion of the October 2016 meeting was devoted to learning about radical self-care and vicarious trauma training for the committee members. The review of a child death is not only a time commitment for the committee members but also involves looking deeply into each case with potential development of vicarious trauma which may over time become internalized and affect our members’ well-being.

Topic of suicide:

In 2016, the Medical Examiner-Coroner’s Office worked with the Centers for Disease Control (CDC) in reviewing suicides from 2003-2015 in 10-24 years of age to determine if risk factors specific to Santa Clara County exist, with an emphasis on the Palo Alto suicide clusters observed in past years.

In August 2017, Public Health provided a review of the data collected from the CDC entitled: Epi-Aid 2016-018: Undetermined Risk Factors for Suicide Among Youth, Ages 10-24 and can be found at the following link:


Topic of accidental deaths:

Since the last tri-annual report, The Medical Examiner-Coroner’s Office completed its retrospective review of motor vehicle fatalities affecting youth from years 2006-2015 and is enclosed at the end of this report as Appendix A.

Some take home points were as follows:

1.) Ensure a child is restrained in a seat belt at all times while in a moving motor vehicle.
2.) Be alert for pedestrians when turning left on a green light for on-coming traffic.
3.) Pedestrians and drivers need to be more cognizant of crosswalks to ensure pedestrian safety.
4.) Pedestrians, particularly those under the age of 10, may not be seen depending on vehicle height (i.e. sports utility vehicles or pickup trucks).

This report was received by the Traffic Safe Communities Network (TSCN) lead by Supervisor Wasserman.

**Topic of mandated reporter:**

In September 2016, Jane Smithson, JD presented to the entire committee on the responsibilities of being a mandated reporter. Materials relating to mandated reporting can be found at the end of this report in the Appendix.

**Legislation:**

Legislative Bill 2083 was signed by Governor Brown in fall of 2016. This bill authorizes the voluntary disclosure of specified information including mental health records, criminal history information and child abuse reports, by an individual or agency to an interagency child death review team.
# Statistics

## Table 1. Child Deaths Reviewed by the Child Death Review Team Compared to All Santa Clara County Child Deaths, 2016-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Child deaths reviewed</th>
<th>Santa Clara County total child deaths*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>37</td>
<td>126</td>
</tr>
<tr>
<td>2017</td>
<td>34</td>
<td>116</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>242</td>
</tr>
</tbody>
</table>

Source: Santa Clara County Child Death Review, 2016-2017;  
* Only includes deaths to residents of Santa Clara County

## Table 2. Demographics of Child Deaths Reviewed by the Child Death Review Team

<table>
<thead>
<tr>
<th>Sex</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Male</td>
<td>50</td>
<td>70</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>1-4</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>5-11</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>12-17</td>
<td>29</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Santa Clara County Child Death Review, 2016-2017
<table>
<thead>
<tr>
<th>Manner and cause of death</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Homicide</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. By parent or caretaker</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2. Third Party</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3. High risk behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>B. Abuse related (death due to previously documented abuse)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>C. Neglect Related</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. By parent/caretaker</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Third party neglect</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>D. Inadequate Caretaking (bed sharing, unsafe sleep environment)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Bed sharing (overlay)</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. Unsafe sleep environment</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td><strong>E. Non-Maltreatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Natural (non-SIDS)</td>
<td>6</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>2. SIDS</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Accident</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>4. Suicide</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>5. Adolescent High Risk Behavior</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>F. Undetermined</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Suspicious factors</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2. SUID</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>F. Fetal Deaths</strong></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>1. Undetermined</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>2. Known maternal drug use</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Source: Santa Clara County Child Death Review, 2016-2017
### TABLE 4. CHILD DEATHS RESULTING FROM INJURIES, 2016-2017

<table>
<thead>
<tr>
<th>Mode of injury</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle and other transport</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Drowning</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Suffocation/strangulation/hanging</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Weapon, including body part</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Fire, burn, or electrocution</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>18</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: Santa Clara County Child Death Review, 2016-2017

### TABLE 5. CHILD DEATHS FROM A MEDICAL CONDITION, 2016-2017

<table>
<thead>
<tr>
<th>Medical conditions</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Infection</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Other medical condition</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Undetermined/SUID</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10</td>
<td>11</td>
<td>21</td>
</tr>
</tbody>
</table>

Source: Santa Clara County Child Death Review, 2016-2017
SAFE SLEEP INITIATIVE

Public Awareness Materials

THIS IS DEADLY!

Please put me to sleep SAFELY!
Alone, on my back, in my crib.

www.first5kids.org

KEEP ME ALIVE TO THRIVE!

Please put me to sleep safely:
Place me ALONE
On my BACK
In a CRIB or bassinet
NO toys or pillows
NO abundant blankets
I can’t be in an adult bed
I can’t be in bed with my brothers or sisters or pets
I can’t be placed on a couch

For more information on keeping me safe: www.smhpdc.org

Annual Report 2016-2017
ACKNOWLEDGEMENTS

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 Medical Examiner-Coroner’s Office staff for their assistance prior to each CDRT meeting.

The author also acknowledges student intern, Karin Wells, for her detailed report on juvenile motor vehicle fatalities. Finally, the author of this report would like to thank the Public Health Department for their continued support and assisting us with additional resources needed for the completion of this report.
APPENDIX

DEATHS REPORTABLE TO THE MEDICAL EXAMINER-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).
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.
Reportable Deaths to the Medical Examiner

California Health & Safety Code Section 102850
California Government Code Section 27491

- Suicide (or complications from attempt)
- Fetal Deaths with positive drug screening/trauma/accident
- Accident or Injury (recent or remote) Hip Fr, SDH, Vehicle, Industrial, Etc...
- Unattended (by Physician > 20 days)
- Abuse/Neglect Starvation (suspected / alleged)
- Unidentified Decedent
- Poisoning (accidental/intentional)
- Homicide (known or suspected, recent or remote)
- Drowning (complications related to)
- Exposure (environmental)
- Drug or Alcohol (overdose, acute alcoholism, drug addiction)
- Abortion (self induced / illegal)
- Operation/Procedure (During)
- Disease/Exposure (occupational/contagious)
- No Next-of-Kin (inability to locate)
- In-Custody (Fed, State, County, Criminal, Mental, Developmentally disabled)
- Fire (related death)
A. **Homicide:** Death ruled a homicide, either by the Medical Examiner’s report or criminal investigation.

   1. Abuse by parent/caretaker
   2. Third Party
   3. High Risk Behavior (e.g. gang affiliation participant; resulting from verbal and/or physical altercation).

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

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

   1. Neglect by parent/caretaker
      (a) Failure to protect child from safety hazards by parent or caregiver according to recognized community standards (e.g. substance abuse that may have caused the parent/caregiver to use impaired judgment, substance abuse of parent leading to overlay, child drowning in family pool no gate in place etc.)
      (b) Failure to provide for basic needs (i.e., medical neglect)
   2. Third party neglect (not a parent or caregiver)

D. **Non-Maltreatment:**

   1. Natural medical death (e.g. viral infection, pneumonia, etc.)
   2. Sudden Infant Death Syndrome
   3. 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.
      a. Bed sharing leading to possible overlay without evidence of substance abuse by co-sleeper
      b. Provision of unsafe sleep environment: placing infant to sleep prone, inappropriate bedding (pillow, heavy covers, couch, adult bed etc.)
      c. Failure to protect child from other safety hazards not universally recognized by the local community
   4. 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. This would also include unintentional accidental medical mishaps (operating room deaths)
   5. Suicide
a. Current or history of child abuse or neglect

b. Bullying

c. Loss of significant other (loss of boyfriend/girlfriend, family member etc.)

d. History of clinical mental illness. Confirmation required.

6. Adolescent High-Risk Behaviors (Behavior of the Decedent with no direct parental/caregiver contribution of neglect or abuse).
   a. Firearm related
   b. Substance use/abuse
   c. Transportation fatalities

E. Undetermined

1. Suspicious or Questionable Factors: No findings or abuse or neglect but other factors exist such as: previous unaccounted for deaths in the same family: history of prior abuse or neglect of a child.

2. SUID: Used for the undetermined deaths in which multiple factors are at play (e.g. unsafe sleeping practice plus consideration of prematurity).

**FOR ALL CASES:**

*Using the CDC Definition of Child Maltreatment, i.e.* “Any act or series of acts of commission or omission by a parent or other caregiver (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child,” *did this child’s death result from Child Maltreatment? Yes  No*
<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Ages</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>974,589</td>
<td>981,744</td>
<td>1,956,333</td>
</tr>
<tr>
<td>Female</td>
<td>958,238</td>
<td>963,721</td>
<td>1,921,959</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,932,827</td>
<td>1,945,465</td>
<td>3,878,292</td>
</tr>
<tr>
<td><strong>Children 0-17 years of age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>228,952</td>
<td>230,117</td>
<td>459,069</td>
</tr>
<tr>
<td>Female</td>
<td>217,459</td>
<td>217,971</td>
<td>435,430</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>446,411</td>
<td>448,088</td>
<td>894,499</td>
</tr>
</tbody>
</table>

Safe Sleep For Your Baby
Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death

Always place baby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.

Use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet with no other bedding or soft items in the sleep area.

Share your room with baby. Keep baby in your room close to your bed, but on a separate surface designed for infants, ideally for baby’s first year, but at least for the first 6 months.

Do not put soft objects, toys, crib bumpers, or loose bedding under baby, over baby, or anywhere in baby’s sleep area.

To reduce the risk of SIDS, women should:

- Get regular prenatal care during pregnancy.
- Avoid smoking, drinking alcohol, and using marijuana or illegal drugs during pregnancy or after the baby is born.
- Do not smoke during pregnancy, and do not smoke or allow smoking around your baby or in your baby’s environment.
- Think about giving your baby a pacifier for naps and nighttime sleep to reduce the risk of SIDS.
- Do not let your baby get too hot during sleep.

Breastfeed your baby to reduce the risk of SIDS. Breastfeeding has many health benefits for mother and baby. If you fall asleep while feeding or comforting baby in an adult bed, place him or her back in a separate sleep area as soon as you wake up.

Follow guidance from your health care provider on your baby’s vaccines and regular health checkups.

Avoid products that go against safe sleep recommendations, especially those that claim to prevent or reduce the risk for SIDS.

Do not use heart or breathing monitors in the home to reduce the risk of SIDS.

Give your baby plenty of tummy time when he or she is awake and someone is watching.

For more information about the Safe to Sleep® campaign, contact us:

Phone: 1-800-505-Crib (2742) | Fax: 1-866-760-5947
Email: Safetosleep@mail.nih.gov
Website: http://safetosleep.nichd.nih.gov
Mail: 31 Center Drive, B1A12, Building 31, Bethesda, MD 20892-2425
Federal Relay Service: Dial 7-1-1

* A crib, bassinet, portable crib, or play yard that follows the safety standards of the Consumer Product Safety Commission (CPSC) is recommended. For information on crib safety, contact the CPSC at 1-800-638-2772 or http://www.cpsc.gov.

Safe to Sleep® is a registered trademark of the U.S. Department of Health and Human Services.
What Does A **Safe Sleep Environment** Look Like?

The image below shows a safe infant sleep environment.

- Baby’s sleep area is in the same room, next to where parents sleep.
- Use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet.
- Baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else.
- Do not smoke or let anyone else smoke around your baby.

- Do not put pillows, blankets, sheepskins, or crib bumpers anywhere in your baby’s sleep area.
- Keep soft objects, toys, and loose bedding out of your baby’s sleep area. Make sure nothing covers the baby’s head.

Dress your baby in sleep clothing, such as a wearable blanket. Do not use a loose blanket, and do not overbundle.

Always place your baby on his or her back to sleep, for naps and at night.

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*A crib, bassinet, portable crib, or play yard that follows the safety standards of the Consumer Product Safety Commission (CPSC) is recommended. For information on crib safety, contact the CPSC at 1-800-638-2772 or [http://www.cpsc.gov](http://www.cpsc.gov).*
Sueño Seguro Para Su Bebé
Reduzca el riesgo del síndrome de muerte súbita del bebé y de muerte por otras causas relacionadas con el sueño.

Siempre coloque al bebé boca arriba para dormir, durante las siestas y por la noche, para reducir el riesgo del síndrome de muerte súbita del bebé.

Al poner a su bebé a dormir, use una superficie firme y plana, como un colchón en una cuna que cumpla con las normas de seguridad*, cubierta con una sábana ajustable. No incluya ningún otro tipo de ropa de cama ni objetos acolchonados en el lugar de dormir.

Comparta su habitación con el bebé. Mantenga al bebé en su habitación cerca de su cama, pero en un lugar donde duerma solo y que esté diseñado para bebés, idealmente durante el primer año del bebé, pero al menos durante los primeros 6 meses.

No ponga objetos acolchonados, juguetes, protectores para cunas ni cobijas o cobertores de cama sueltos o debajo del bebé, sobre el bebé o en cualquier lugar donde duerme el bebé.

Para reducir el riesgo del síndrome de muerte súbita del bebé, las mujeres deben hacer lo siguiente:

- Recibir atención prenatal regular durante el embarazo.
- No fumar, beber alcohol ni consumir marihuana u otras drogas ilegales durante el embarazo y después del nacimiento del bebé.
- No fume durante el embarazo, y no fume ni permita que se fume cerca de su bebé ni en el lugar donde él duerme.
- Considere darle a su bebé un chupón para las siestas y el sueño nocturno para reducir el riesgo del síndrome de muerte súbita del bebé.
- No deje que su bebé se caliente demasiado mientras duerme.
- Siga la orientación de su proveedor de servicios de salud sobre las vacunas de su bebé y los chequeos médicos regulares.

Para más información sobre la campaña Seguro al Dormir®, comuníquese con nosotros:

Dirección postal: 31 Center Drive, 3124A32, Bethesda, MD 20892-2425
Teléfono: 1-800-505-CRIB (2742)
Correo electrónico: Safetosleep@nichd.nih.gov
Fax: 1-866-760-5947
Web: www.nichd.nih.gov/BebeDormir

* Se recomienda una cuna, un moisés, una cuna portátil o un corralito que cumplan con las normas de seguridad de la Comisión de Seguridad de Productos del Consumidor (CPSC, por sus siglas en inglés). Para obtener información sobre la seguridad de la cuna, póngase en contacto con la CPSC al 1-800-638-2772 (en español e inglés) o ingrese a www.SeguridadConsumidor.gov o www.cpsc.gov.

Sueño Seguro es una marca registrada del Departamento de Salud y Servicios Humanos de los Estados Unidos.
¿Cómo es un ambiente de sueño seguro?
La siguiente imagen muestra un ambiente de sueño seguro para el bebé.

El lugar donde duerme el bebé está en la misma habitación, al lado de donde duermen los padres.

Use una superficie firme y plana para dormir, como un colchón en una cuna que cumpla con las normas de seguridad*, cubierta con una sábana ajustable.

El bebé no debe dormir en una cama para adultos, en un sillón, o en una silla solo, con usted o con cualquier otra persona.

No fume ni permita que otras personas fumen alrededor de su bebé.

No coloque almohadas, cobijas o edredones, pieles de borrego, o protectores de cuna en ninguna parte del lugar de dormir de su bebé.

Mantenga objetos acolchonados, juguetes y ropa de cama suelta lejos del lugar donde duerme su bebé. Asegúrese de que nada cubra la cabeza del bebé.

Vista a su bebé con ropa de dormir, como un saco de dormir. No use cobijas sueltas, y no lo abrigue demasiado.

Siempre coloque a su bebé boca arriba para dormir, durante las siestas y por la noche.

* Se recomienda una cuna, un moisés, una cuna portátil o un corralito que cumplan con las normas de seguridad de la Comisión de Seguridad de Productos del Consumidor (CPSC, por sus siglas en inglés). Para obtener información sobre la seguridad de la cuna, póngase en contacto con la CPSC al 1-800-638-2772 (en español o inglés) o ingrese a www.SeguridadConsumidor.gov o www.cpsc.gov.
SAFE SLEEP FOR YOUR GRANDBABY

Reduce the Risk of Sudden Infant Death Syndrome (SIDS) and Other Sleep-Related Causes of Infant Death
This is what a safe sleep environment looks like. The infant’s sleep area has no bumpers, pillows, blankets, or toys and is in the same room where the parents sleep.
Each year in the United States, thousands of babies die suddenly and unexpectedly. Some of these deaths result from unknown causes, such as Sudden Infant Death Syndrome (SIDS), while others are from known causes, including other sleep-related causes of infant death.

What is SIDS?

SIDS is the sudden, unexpected death—that doesn’t have a known cause even after a full investigation—of a baby between 1 month and 1 year of age. About one half of the sudden, unexpected infant deaths that occur in the United States each year are from SIDS.

What are other sleep-related causes of infant death?

Other sleep-related causes of infant death are those related to how or where a baby slept. These can include accidental:

- **Suffocation**: when something, such as a pillow, or someone covers the baby’s face and nose, blocking the ability to breathe
- **Entrapment**: when the baby gets trapped between two objects, such as a mattress and a wall, and can’t breathe
- **Strangulation**: when something presses on or wraps around the baby’s neck, blocking baby’s airway

**Fast facts about SIDS**

- SIDS is the leading cause of death among babies 1 month to 1 year of age.
- Most SIDS deaths happen when babies are between 1 month and 4 months of age.
What should grandparents and other trusted caregivers know about SIDS and other sleep-related causes of infant death?

We have made great progress in reducing SIDS.

Since the 1990s, when the U.S. back-sleeping recommendations were first released and public awareness efforts began, the overall U.S. SIDS rate has dropped by about 60 percent. This lower rate equals thousands of babies’ lives. Since then, the number of babies placed on their backs to sleep has tripled.

But, as SIDS rates have declined, deaths from other sleep-related causes, such as suffocation, have increased, and certain groups remain at higher risk for SIDS than others. For example, African American and American Indian/Alaska Native babies are at higher risk for SIDS than white, Hispanic, or Asian/Pacific Islander babies. So there is still work to do to save infant lives.
**Babies sleep safest on their backs.**

Babies who sleep on their backs are much less likely to die of SIDS than babies who sleep on their stomachs or sides.

**Every sleep time counts.**

Babies should sleep on their backs for naps and at night. Babies who are used to sleeping on their backs but who are then placed on their stomachs, like for a nap, are at very high risk for SIDS.

**Sleep surface and sleep environment matter.**

Babies who sleep on a soft surface, such as an adult mattress, or under a soft covering, such as a soft blanket or quilt, are more likely to die of SIDS or suffocation. These deaths also are more likely when soft objects, toys, and blankets are in the baby’s sleep area.
What can I do to lower my grandbaby’s risk of SIDS and other sleep-related causes of death?

There is no sure way to prevent SIDS, but grandparents and other trusted caregivers can take steps to reduce the risk of SIDS and other sleep-related causes of infant death:

Always place your grandbaby on his or her back to sleep, for naps and at night, to reduce the risk of SIDS.

The back sleep position is the safest position for all babies until they are 1 year old. Preemies (infants born preterm) should be placed on their backs to sleep as soon as possible after birth. Babies who are used to sleeping on their backs, but who are then placed to sleep on their stomachs, like for a nap, are at very high risk for SIDS.

If baby rolls over on his or her own during sleep from back to stomach or stomach to back, there is no need to reposition the baby. Starting sleep on the back is most important for reducing SIDS risk.
Do not put soft objects, toys, crib bumpers, or loose bedding under grandbaby, over grandbaby, or anywhere in grandbaby's sleep area.

Keeping these items out of the baby's sleep area reduces the risk of SIDS and suffocation, entrapment, and strangulation. Because evidence does not support using them to prevent injury, crib bumpers are not recommended. Crib bumpers are linked to serious injuries and deaths from suffocation, entrapment, and strangulation. Keeping these and other soft objects out of your grandbaby's sleep area is the best way to avoid these dangers.
Use a firm and flat sleep surface, such as a mattress in a safety-approved crib*, covered by a fitted sheet with no other bedding or soft items in the sleep area.

Never place your grandbaby to sleep on soft surfaces, such as on a couch, sofa, waterbed, pillow, quilt, sheepskin, or blanket. These surfaces can be very dangerous for babies. Do not use a car seat, stroller, swing, infant carrier, infant sling, or similar products as baby’s regular sleep area. Following these recommendations reduces the risk of SIDS and death or injury from suffocation, entrapment, and strangulation.

* A crib, bassinet, portable crib, or play yard that follows the safety standards of the Consumer Product Safety Commission (CPSC) is recommended. For information on crib safety, contact the CPSC at 1-800-638-2772 or http://www.cpsc.gov.
Your grandbaby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else. Evidence shows that falling asleep with a baby is especially dangerous when the infant is sharing the bed or other surface with someone who is not a parent.

If you bring your grandbaby into an adult bed for feeding, put him or her back in a separate sleep area when finished. This sleep area should be made for infants, like a crib or bassinet. If you fall asleep while feeding or comforting your grandbaby in an adult bed, place him or her back in a separate sleep area as soon as you wake up. Bed sharing increases the risk of SIDS and other sleep-related causes of infant death, such as suffocation.

Couches and armchairs can also be very dangerous for babies if adults fall asleep as they feed, comfort, or bond with baby while on these surfaces. Grandparents and other caregivers should be mindful of how tired they are during these times. There is also no evidence for or against devices or products that claim to make bed sharing “safer.”
Do not smoke around a pregnant woman, and do not smoke or allow smoking around your grandbaby or in your grandbaby’s environment.

Do not let your grandbaby get too hot during sleep.

Dress your grandbaby in sleep clothing, such as a wearable blanket, designed to keep him or her warm without the need for loose blankets in the sleep area. Dress the baby appropriately for the environment, and do not overbundle. Grandparents and caregivers should watch for signs of overheating, such as sweating or the baby's chest feeling hot to the touch. Keep the baby's face and head uncovered during sleep.

Research links increased SIDS risk with too many layers of clothing or blankets, and with higher room temperature.
Avoid products that go against safe sleep recommendations, especially those that claim to prevent or reduce the risk for SIDS.

Evidence does not support the safety or effectiveness of wedges, positioners, or other products that claim to keep infants in a specific position or to reduce the risk of SIDS, suffocation, or reflux. In fact, many of these products are associated with injury and death, especially when used in baby's sleep area.

Do not use heart or breathing monitors in the home to reduce the risk of SIDS.

Some health care providers recommend these monitors for conditions not related to SIDS or SIDS risk. If you have questions about using these monitors for other health conditions, talk with baby's health care provider, and always follow safe sleep recommendations.
Give your grandbaby plenty of tummy time when he or she is awake and someone is watching.

Supervised tummy time helps strengthen your grandbaby’s neck, shoulder, and arm muscles. It also helps to prevent flat spots on the back of your grandbaby’s head. Limiting the time spent in car seats, once the baby is out of the car, and changing the direction the infant lays in the sleep area from week to week also can help to prevent these flat spots.
What else can parents and caregivers do to reduce the risk of SIDS and other sleep–related causes of infant death?

Other ways to reduce the risk of SIDS and other sleep-related causes of death include the following:

**Breastfeed the baby to reduce the risk of SIDS.**

Breastfeeding has many health benefits for mother and baby. Babies who breastfeed, or are fed breastmilk, are at lower risk for SIDS than babies who were never fed breastmilk. The longer a baby is exclusively breastfed or fed breastmilk, the lower the risk.


**Parents should share their room with baby.**

If parents bring baby into their bed for feeding, they should put him or her back in a separate sleep area when finished. This sleep area should be made for infants, like a crib or bassinet, and close to their bed. If they fall asleep while feeding or comforting baby in their bed, they should place the baby back in a separate sleep area as soon as they wake up. Evidence shows that the longer a parent and infant bed-share, the higher the risk for other sleep-related causes of infant death, such as suffocation.

In the parents’ room, baby should be close to the bed, but on a separate surface designed for infants, ideally for baby’s first year, but at least for the first 6 months. Room sharing reduces the risk of SIDS. The baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else, including siblings or pets. Having a separate safe sleep surface for the baby reduces the risk of SIDS and the chance of suffocation, strangulation, and entrapment.
Think about giving the baby a pacifier for naps and nighttime sleep to reduce the risk of SIDS.

Do not attach the pacifier to anything—like a string, clothing, stuffed toy, or blanket—that carries a risk for suffocation, choking, or strangulation.

Wait until baby is breastfeeding well before offering a pacifier. Or, if baby is not breastfeeding, offer the pacifier as soon as desired. Don’t force the baby to use it.

If the pacifier falls out of baby’s mouth during sleep, there is no need to put the pacifier back in. Pacifiers reduce the risk of SIDS for all babies, including breastfed babies.
To reduce the risk of SIDS, women should:

- Get regular prenatal care during pregnancy.
- Avoid smoking, drinking alcohol, and using marijuana and illegal drugs during pregnancy and after the baby is born.
- Follow guidance from the baby’s health care provider on his or her vaccines and regular health checkups.

Vaccines not only protect baby’s health, but research shows that vaccinated babies are at lower risk for SIDS.
Q&A Answers to common questions about SIDS and other sleep-related causes of infant death

Q: What is the best way to reduce my grandbaby’s risk for SIDS?
A: The best way to reduce the risk for SIDS is to always place baby on his or her back to sleep in a separate sleep area, designed for a baby, with no soft objects, toys, or loose bedding.

Q: Will my grandbaby choke if placed on the back to sleep?
A: No. Healthy babies naturally swallow or cough up fluids—it’s a reflex all people have. Babies may actually clear such fluids better when sleeping on their backs because of the location of the opening to the lungs in relation to the opening to the stomach. There has been no increase in choking or similar problems for babies who sleep on their backs.
Q: When my children were babies, I put them on their stomachs to sleep. Was that wrong?
A: No. You were following advice based on the evidence available at that time. Since then, research has shown that sleeping on the stomach increases the risk for SIDS. This research also shows that sleeping on the back carries the lowest risk of SIDS, and that’s why the recommendation is “back is best.”

Q: Can I swaddle my grandbaby to reduce the risk of SIDS?
A: There is no evidence that swaddling reduces SIDS risk. In fact, swaddling can increase the risk of SIDS and other sleep-related causes of infant death if swaddled babies are placed on their stomachs for sleep or roll onto their stomachs during sleep. If you decide to swaddle your grandbaby, always place baby fully on his or her back to sleep. Stop swaddling your grandbaby once he or she starts trying to roll over.

Q: Can my grandbaby’s mother practice skin-to-skin care as soon as the baby is born?
A: Experts recommend skin-to-skin care for all moms and newborns for at least an hour after birth, once the mom is stable, awake, and able to respond to her baby. When mom needs to sleep or handle other things, babies should be placed on their backs in a bassinet.
Q: What if I fall asleep while feeding my grandbaby?

A: Any time you fall asleep while holding or feeding your grandbaby, he or she is at risk for SIDS, suffocation, or sleep-related causes of death or injury. Couches and armchairs can be very dangerous for babies when shared with an adult who then falls asleep. Research shows that adult beds are also dangerous in these situations but are less risky than a couch or armchair. Before you start feeding your grandbaby, think about how tired you are. If there’s even a slight chance you might fall asleep, avoid couches or armchairs and remove all soft items and bedding from an adult bed before you start the feeding to reduce the risk of SIDS, suffocation, or other sleep-related causes of death. If you fall asleep while feeding or comforting your grandbaby on any surface, place him or her in a separate sleep area as soon as you wake.
Spread the word!

Make sure everyone who cares for your grandbaby knows the ways to reduce the risk of SIDS and sleep-related infant deaths.

Talk with your health care provider about any questions or challenges related to safe sleep practices for your grandbaby.

Help family members, siblings, grandparents, babysitters, day care workers—EVERYONE—reduce your grandbaby’s risk.

Share these safe sleep messages with those who care for your grandbaby or for any baby younger than 1 year of age.

Remember:
Babies sleep safest on their backs for naps and at night!
For more information, contact the Safe to Sleep® campaign:

Phone: 1-800-505-CRIB (2742)
Email: Safetosleep@mail.nih.gov
Fax: 1-866-760-5947
Web: http://safetosleep.nichd.nih.gov

Safe to Sleep® campaign collaborators include:

Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health
Maternal and Child Health Bureau of the Health Resources and Services Administration
Centers for Disease Control and Prevention, Division of Reproductive Health
Consumer Product Safety Commission
American Academy of Pediatrics
American College of Obstetricians and Gynecologists
Association of SIDS and Infant Mortality Programs
CJ First Candle

NIH Pub No 17-HD-7040
June 2017

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CHILD ABUSE INDICATORS AND GUIDELINES

INDICATORS OF ABUSE

GENERAL SIGNS OF ABUSE

- Running away, not wanting to go home
- Fear of specific person, or type of person or all persons
- Harms animals
- Victimizes other children
- Lack of empathy
- Sets fires
- Poor peer relations
- School problems
- Substance abuse problems
- Suicide attempts
- Depression
- Overly compliant behavior
- Angry, hostile behavior
- “Perfect” child – quiet, shadow child
- Self-mutilation
- Statement by the child he/she is being abused

PARENTAL CLUES

- Unable or unwilling to meet child’s basic needs
- Expresses negative feelings towards child, or harsh disciplinary measures
- Has unrealistic expectations, is unduly harsh and rigid about childrearing
- Humiliates and belittles child
- Impulsive, uses “out of control” discipline
- Indifferent to child, objectifies child
- Social isolation of families
- Poor childhood experiences
- Drug and alcohol use
- Immaturity, youth
- History of being abused as a child
- Domestic violence dynamic
- Chaotic home

PHYSICAL ABUSE: PHYSICAL INDICATORS

- Unexplained or improbably explained fractures, lacerations, bruises, facial injuries
- Burns (cigarette, rope, scalding water, iron, radiator)
- Infected burns, indicating delay in seeking treatment
- Bruises or fractures in different states of healing, indicating repeated trauma over time

PHYSICAL ABUSE: BEHAVIORAL INDICATORS

- Hostile, aggressive, verbally abusive, destructive
- Fearful, withdrawn, self-destructive
- Attempts to hide injuries
- Frequent absence from school
• Difficulty sitting or walking
• Wary of physical contact with adults
• Clingy, forms indiscriminate attachments

PHYSICAL ABUSE: ADDITIONAL INDICATORS
• Knowledge that the child’s injury is unusual for the child’s age
• Knowledge of the child’s history of previous or recurrent injuries
• Parent or caretaker delays seeking or fails to seek medical care for child

SEXUAL ABUSE: PHYSICAL INDICATORS
• Torn, stained, or bloody underclothing
• Physical trauma or irritation to the anal/genital area
• Swelling/discharge from vagina/penis
• Lesions around mouth or genitals
• Abdominal pain, painful urination/defecations, difficulty walking or sitting
• Sexually transmitted diseases
• Psychosomatic symptoms

SEXUAL ABUSE: BEHAVIORAL INDICATORS
• Precociously sexualized behavior
• Compulsive indiscreet masturbation
• Excessive curiosity about sexual matters or genitalia (self and others)
• Excessive concern about homosexuality, especially by boys

NEGLECT: PHYSICAL INDICATORS
• Non-organic, or organic failure to thrive
• Malnutrition or poorly balanced diet
• Inappropriate dress for weather
• Dirty, unkempt, extremely offensive body odor
• Untended medical or dental conditions
• Evidence of poor or inadequate supervision for the child’s age
• Hazardous conditions
• Health risks; presence of rats, feces, no running water, no heat

NEGLECT: BEHAVIORAL INDICATORS
• Depressed, withdrawn, apathetic, low self-esteem
• Antisocial or destructive behavior, hostile, verbally abusive, provocative
• Fearfulness
• Speech, eating, or habit disorders
• Often sleepy or hungry
• Stealing food

EMOTIONAL ABUSE: BEHAVIORAL INDICATORS
• Repetitive, rhythmic movements
• Enuresis, encopresis, regressive behavior
Child Abuse
Reporting Guidelines for Sexual Activity
Between and with Minors

This guide incorporates changes in the Child Abuse Reporting Law, effective January, 1996. For more
detailed information refer to Penal Code Section 11164 & 11165.1 et al.

I. INOLUNTARY SEXUAL ACTIVITY IS ALWAYS REPORTABLE

II. INCEST, even if voluntary is always reportable. Incest is a marriage or act of intercourse between
parents and children; ancestors and descendants of every degree; brothers and sisters of half and
whole blood and uncles and nieces or aunts and nephews. (Family Code, 2200)

III. VOLUNTARY SEXUAL ACTIVITY may or may not be reportable. Even if the behavior is voluntary,
there are circumstances where the behavior is abusive either by Penal Code definition or because
of an exploitative relationship and this behavior must be reported. Review either sections A, B or C
plus section D. In addition, if there is reasonable suspicion of sexual abuse prior to the consensual
activity, the abuse must be reported if previously unreported.

<table>
<thead>
<tr>
<th>&quot;Child&quot; refers to the person that the mandated child abuse reporter is involved with.</th>
<th>Definitions and Comments</th>
<th>Mandatory Report</th>
<th>Not Mandatory Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Child younger than 14 years old</td>
<td>Per 181 Cal App 3d 245 (1986)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Partner is younger than 14 years old and of similar chronological or maturational age. Sexual behavior is voluntary &amp; consensual. There are no indications of intimidation, coercion, bribery or other indications of an exploitive relationship.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Partner is younger than 14 years old, but there is disparity in chronological or maturational age or indications of intimidation, coercion or bribery or other indications of an exploitive relationship.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Partner is 14 years or older.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Lewd and lascivious acts by a partner of any age.</td>
<td>The perpetrator has the intent of &quot;Arouising, appealing to or gratifying the lust, passion or sexual desires of the perpetrator or the child.&quot;</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Partner is alleged spouse and over 14 years of age.</td>
<td>The appropriate authority will determine the legality of the marriage.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
# Child Abuse

## Reporting Guidelines for Sexual Activity Between and with Minors

<table>
<thead>
<tr>
<th>B. Child 14 or 15 years old</th>
<th>Definitions</th>
<th>Mandatory Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Partner is less than 14</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Unlawful sexual intercourse with a partner older than 14 and less than 21 years of age &amp; there is no indication of abuse or evidence of an exploitive relationship</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Unlawful sexual intercourse with a partner older than 21 years of age.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Lewd and lascivious acts by a partner more than 10 years older than the child.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Partner is alleged spouse and over 21 years of age.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

| C. Child 16 or 17 years old |
|-----------------------------|-----------------|
| 1. Partner is less than 14  | X | |
| 2. Unlawful sexual intercourse with a partner older than 14 and there is no indication of an exploitive relationship. | X | |
| 3. Unlawful sexual intercourse with a partner older than 14 & there is evidence of an exploitive relationship. | X | |
| 4. Partner is alleged spouse and there is evidence of an exploitive relationship. | X | |

| D. Child under the age of 18 |
|------------------------------|-----------------|
| 1. Sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, even if consensual, with a partner of any age. | X | |

Mandated child abuse reporters are not mandated under the child abuse reporting law to report Unlawful Sexual Intercourse (Statutory Rapes) that is consensual except in the situations described here. Unlawful sexual intercourse is intercourse with anyone under the age of eighteen.

Mandated reports of sexual activity must be reported to either the Department of Health and Human Services or the appropriate police jurisdiction. This information will then be cross-referenced to the other agency. Reporting does not necessarily mean that a civil or criminal proceeding will be initiated against the suspected abuser.

Failure to report known or reasonable suspicion of child abuse, including sexual abuse, is a misdemeanor. Mandated reporters are provided immunity from civil or criminal liability as a result of making a mandated report of child abuse.
CALIFORNIA

CHILD ABUSE AND NEGLECT

REPORTING LAW

REPRINTED BY THE GREATER BAY AREA CAPC COALITION
WITH PERMISSION FROM THE OFFICE OF THE ATTORNEY GENERAL
The first child abuse reporting law in California was enacted in 1963. That early law mandated only physicians to report physical abuse. Over the years, numerous amendments have expanded the definition of reportable child abuse and the persons required to report it.

It is important for mandated reporters to keep updated on periodic amendments to the law. Your local Child Abuse Prevention Council or county welfare department has current reporting law information. Also visit loginfoca.gov for updated information on the law and any other code section referenced in this material.

The California Child Abuse and Neglect Reporting Law is currently found in Penal Code (P.C.) Sections 11164 - 11174.3. The following is only a partial description of the law. Mandated reporters should become familiar with the detailed requirements as they are set forth in the Penal Code.
WHO ARE MANDATED REPORTERS?
P.C. 11165.7 defines “mandated reporters” as any of the following:

1. A teacher.
2. An instructional aide.
3. A teacher’s aide or a teacher’s assistant employed by any public or private school.
5. An administrative officer or supervisor of child welfare and attendance, or certificated pupil personnel employee of any public or private school.
6. An administrator of a public or private day camp.
7. An administrator or employee of a public or private youth center, youth recreation program, or youth organization.
8. An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.
9. Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis.
10. A licensee, an administrator, or an employee of a licensed community care or child day care facility.
11. A Head Start program teacher.
12. A licensing worker or licensing evaluator employed by a licensing agency as defined in P.C. 11165.11.
14. An employee of a child care institution including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.
15. A social worker, probation officer, or parole officer.
16. An employee of a school district police or security department.
17. Any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school.
18. A district attorney investigator, inspector, or local child support agency caseworker unless the investigator, inspector, or case-worker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.
19. A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code, who is not otherwise described in P.C. 11165.7.
20. A firefighter, except for volunteer firefighters.
21. A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

22. Any emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

23. A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.

24. A marriage, family and child therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.

25. An unlicensed marriage, family, and child therapist intern registered under Section 4980.44 of the Business and Professions Code.

26. A state or county public health employee who treats a minor for venereal disease or any other condition.

27. A coroner.

28. A medical examiner, or any other person who performs autopsies.

29. A commercial film and photographic print processor, as specified in subdivision (e) of P.C. 11166. For purposes of the California Child Abuse Reporting Law, “commercial film and photographic print processor” means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.

30. A child visitation monitor. For purposes of the California Child Abuse Reporting Law, “child visitation monitor” means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.

31. An animal control officer or humane society officer. For purposes of the California Child Abuse Reporting Law, the following terms have the following meanings: (A) “Animal control officer” means any person employed by a city, county, or city and county for the purpose of enforcing animal control laws and regulations. (B) “Humane society officer” means any person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.
32. A clergy member, as specified in subdivision (d) of P.C. 11166. For purposes of the California Child Abuse Reporting Law, “clergy member” means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

33. Any custodian of records of a clergy member, as specified in P.C.11165.7 and subdivision (d) of Section 11166.

34. Any employee of any police department, county sheriff’s department, county probation department, or county welfare department.

35. An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 1424 of the Rules of the Court.

36. A custodial officer as defined in Section 831.5 of the Penal Code.

37. Any person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institutions Code.

38. An “alcohol and drug counselor” is a person providing counseling, therapy, or other clinical services for a licensed or certified drug, alcohol, or drug and alcohol treatment program. However, alcohol or drug abuse, or both alcohol and drug abuse, is not in and of itself a sufficient basis for reporting child abuse or neglect.

39. A clinical counselor trainee, as defined in subsection (g) of Section 4999.12 of the Business and Professions Code.

40. A clinical counselor intern registered under Section 4999.42 of the Business and Professions Code.

41. An employee or administrator of a public or private postsecondary institution, whose duties bring the administrator or employee into contact with children on a regular basis, or who supervises those whose duties bring the administrator or employee into contact with children on a regular basis, as to child abuse or neglect occurring on that institution’s premises or at an official activity of, or program conducted by, the institution. Nothing in this paragraph shall be construed as altering the lawyer-client privilege as set forth in Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code.

42. An athletic coach, athletic administrator, or athletic director employed by any public or private school that provides any combination of instruction for kindergarten, or grades 1 to 12, inclusive.

43. (A) A commercial computer technician as specified in subdivision (e) of Section 11166. As used in the article, “commercial computer technician” means a person who works for a company that is in the
business of repairing, installing, or otherwise servicing a computer or computer component, including, but not limited to, a computer part, device, memory storage or recording mechanism, auxiliary storage recording or memory capacity, or any other material relating to the operation and maintenance of a computer or computer network system, for a fee. An employer who provides an electronic communication service or a remote computing service to the public shall be deemed to comply with this Article if that employer complies with Section 2258A of Title 18 of the United States Code. (B) An employer of a commercial computer technician may implement internal procedures for facilitating reporting consistent with this article. These procedures may direct employees who are mandated reporters under this paragraph to report materials described in subdivision (e) of Section 11166 to an employee who is designated by the employer to receive the reports. An employee who is designated to receive reports under this subparagraph shall be a commercial computer technician for the purposes of this article. A commercial computer technician who makes a report to the designated employee pursuant to this subparagraph shall be deemed to have complied with the requirements of this article and shall be subject to the protections afforded to mandated reporters, including, but not limited to, those protections afforded by Section 11172.

44. Any athletic coach, including but not limited to, an assistant coach or a graduate assistant involved in coaching, at public or private postsecondary institutions.

45. An individual certified by a licensed foster family agency as a certified family home, as defined in Section 1506 of the Health and Safety Code.

46. An individual approved as a resource family, as defined in Section 1517 of the Health and Safety Code and Section 16519.5 of the Welfare and Institutions Code.

NOTE: Unless otherwise stated, volunteers are not mandated reporters.

WHY MUST YOU REPORT?
The primary intent of the reporting law is to protect an abused child from further abuse. Protecting the identified child may also provide the opportunity to protect other children. It is equally important to provide help for the parents. Parents may be unable to ask for help directly, and child abuse may be their way of calling attention to family problems. The report of abuse may be a catalyst for bringing about change in the home environment, which in turn may help to lower the risk of abuse in the home. And lastly, it is the law.
WHAT DO YOU HAVE TO REPORT?

Under the law, when the victim is a child (a person under the age of 18) and the perpetrator is any person (including a child), the following types of abuse must be reported by all legally mandated reporters:

a. A physical injury inflicted by other than accidental means upon a child. (P.C. 11165.6) Note that child abuse does not include a “mutual affray” between minors. It also does not include an injury caused by “reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment.” (P.C. 11165.6)

b. Sexual abuse of a child, including both sexual assault and sexual exploitation. “Sexual assault” includes sex acts with a child, lewd or lascivious acts with a child, and intentional masturbation in the presence of a child. “Sexual exploitation” includes preparing, selling, or distributing pornographic materials involving children; employing a minor to perform in pornography; and employing or coercing a child to engage in prostitution. (P.C. 11165.1)

c. Willful harming or injuring of a child or the endangering of the person or health of a child, including inflicting or permitting unjustifiable physical pain or mental suffering. (P.C. 11165.3)

NOTE: Any mandated reporter may report any child who is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage. (P.C. 11166.05)

d. Willful infliction of cruel or inhuman corporal punishment or injury resulting in a traumatic condition. (P.C. 11165.4)

e. Neglect of a child, whether “severe” or “general,” by a person responsible for the child’s welfare. The term “neglect” includes both acts or omissions harming or threatening to harm the child’s health or welfare. (P.C. 11165.2)

WHEN DO YOU HAVE TO REPORT?

Child abuse must be reported when a mandated reporter, “in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect.” (P.C. 11166 [a])

“Reasonable suspicion” occurs when “it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect.” (P.C. 11166 [a][1]) Although wordy, the intent of this definition is clear: if you suspect that abuse has occurred, make a report.
You must make a report immediately (or as soon as practicably possible) by phone and you must prepare and send, fax or electronically transmit a written report within 36 hours of receiving the information regarding the incident. \(\text{P.C. 11166 (a)}\) Written reports must be submitted on Department of Justice form (SS 8572), which can be downloaded from the California Attorney General’s Website at \(\text{www.ag.ca.gov}\) (click on Find a Form; click on Child Protection Program; click on Suspected Child Abuse Report Form, Form SS 8572 pdf). The mandated reporter may include with the report any non-privileged documentary evidence he or she possesses related to the incident.

**TO WHOM MUST YOU REPORT?**

The report must be made to any police department or sheriff’s department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or county welfare department. \(\text{P.C. 11165.9}\) Any mandated reporter who knows or reasonably suspects that the home or institution in which the child resides is unsuitable for the child because of abuse or neglect shall inform the agency about the unsuitability of the home at the same time he or she reports the abuse or neglect. \(\text{P.C. 11166 (f)}\)

When two or more persons who are required to report jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, a single person from the group may make the report. Any group member who knows that the report was not made, however, shall make the report. \(\text{P.C. 11166 (h)}\)

**IMMUNITY**

Mandated reporters have immunity from criminal and civil liability for any report required or authorized under the Child Abuse Reporting Law. This immunity applies even though the knowledge or reasonable suspicion of abuse was acquired outside his or her professional capacity or outside the scope of his or her employment. \(\text{P.C. 11172 (a)}\) And if a mandated reporter is sued for making a report, he or she may be able to receive compensation for legal fees incurred in defending against the action. \(\text{P.C. 11172 (c)}\)

Any person who makes a report of child abuse, even though he or she is not a mandated reporter, has immunity unless the report is proven to be false and it is proven that the person either knew the report was false or made it with reckless disregard of its truth or falsity. \(\text{P.C. 11172 (d)(1)}\)
ADDITIONAL SAFEGUARDS FOR MANDATED REPORTERS

No supervisor or administrator may impede or inhibit a mandated reporter’s reporting duties or subject the reporting person to any sanction for making a report. (P.C. 11166 (a)(1))

Any supervisor or administrator who violates the above cited code section is guilty of a misdemeanor punishable by a fine not to exceed one thousand dollars ($1,000), by not more than six months in a county jail, or by both a fine and imprisonment. (P.C. 11166.01(a))

If however, death or great bodily injury happens to the child as a result of the abuse, the supervisor or administrator who impeded or inhibited the report is guilty of a misdemeanor punishable by not more than one year in a county jail, by a fine not to exceed five thousand dollars ($5,000), or by both. (P.C. 11166.01(b))

The mandated reporter’s identity is confidential and may only be disclosed to specified persons and agencies. (P.C. 11167 (d)(1))

Mandated reporters and others acting at their direction are not liable civilly or criminally for photographing the victim and including the photograph with their report. (P.C. 11172 (a)) A clergy member who acquires knowledge or a reasonable suspicion of child abuse during a penitential communication is not mandated to report the abuse. For purposes of the Child Abuse Reporting Law, “penitential communication” means communication, intended to be in confidence, including, but not limited to, a sacramental confession made to a clergy member. (P.C. 11166 (d)(1))

LIABILITY FOR FAILURE TO MAKE A REQUIRED REPORT

A mandated reporter who fails to make a required report of child abuse is guilty of a misdemeanor punishable by up to six months in jail or by a $1,000 fine or by both a fine and imprisonment. (P.C. 11166 (c)) If however, death or great bodily injury happens to the child as a result of the abuse, or if the mandated reporter willfully fails to report the abuse the mandated reporter is guilty of a misdemeanor punishable by not more than one year in a county jail, by a fine not to exceed five thousand dollars ($5,000), or by both. (P.C. 11166.01 (b)) He or she may also be found civilly liable for damages, especially if the child-victim or another child is further victimized because of the failure to report. (Landeros v. Flood (1976) 17 Cal.3d 399.)

If a mandated reporter conceals his or her failure to report abuse or “severe” neglect, the failure to report is a continuing offense until the failure is discovered by an agency specified in Section 11165.9. (P.C. 11166(c)) Because it is a continuing offense, the statute of limitations does not start to run until the failure to report is discovered. Statute of limitations is one year.
RESPONSIBILITIES OF AGENCIES EMPLOYING MANDATED REPORTERS

On and after January 1, 1985, with the exception of child visitation monitors, persons entering employment which make them mandated reporters must sign statements, provided and retained by their employers, informing them that they are mandated reporters and advising them of their reporting responsibilities and of their confidentiality rights. (P.C. 11166.5 (a))

On and after January 1, 1993, any person who acts as a child visitation monitor, prior to engaging in monitoring the first visit in a case, shall sign a statement provided and retained by the court which ordered the monitor’s presence to the effect that he or she has knowledge of the provisions of the Child Abuse Reporting Law and will comply with them. (P.C. 11166.5 (a))

Employers are strongly encouraged to provide their employees who are mandated reporters with training in the duties imposed by the Child Abuse Reporting Law. Training in the duties imposed by the reporting law shall include training in child abuse identification and reporting. Whether or not employers provide their employees with training, they shall provide their employees who are mandated reporters with the statement required in subdivision (a) of Section 11166.5. (P.C. 11165.7 (c)) The absence of training shall not excuse a mandated reporter from the duties imposed by the reporting law. (P.C. 11165.7 (e)) Assembly Bill (AB) 1432 requires school districts to provide annual training for employees in their responsibilities as mandated reporters.

EXCEPTION: Any person providing services to a minor child under Section 12300 or 12300.1 of the Welfare and Institution Code shall not be required to make a child abuse report unless that person has received training, or instructional material in the appropriate language, on the duties imposed by the Child Abuse Reporting Law, including identifying and reporting abuse and neglect. (P.C. 11166.5 (e))

FEEDBACK TO MANDATED REPORTERS

Unless otherwise specifically provided, the investigation is completed or the matter reaches a final disposition, the investigating agency is obligated to inform the mandated reporter of the results of the investigation and any action the agency is taking with regards to the child or family. (P.C. 11170 (b)(2))

Please note that the California Child Abuse Reporting Law may have changed since the printing of this material. This material has been reprinted to assist mandated reporters in determining their reporting responsibilities. It is not intended to be and should not be considered legal advice. In the event there are questions about reporting responsibilities in a specific case, the advice of legal counsel should be sought.
PROTECTIVE FACTORS
THAT STRENGTHEN
FAMILIES

Greater Bay Area CAPC Coalition members use the Strengthening Families Framework (incorporating the Five Protective Factors) that protect children and promote their healthy development and well-being—especially during times of stress. Building these strengths at every opportunity is a proven way to make families more resilient and prevent child abuse and neglect. Children need love and respect to encourage their optimal health and development.

THE FIVE PROTECTIVE FACTORS FRAMEWORK
developed by the Center for the Study of Social Policy includes:

1. PARENTAL RESILIENCE
   Strength, flexibility and courage during stress to deal with challenges.

2. SOCIAL CONNECTIONS
   Parents need friends, family and neighbors that care about them and their children.

3. CONCRETE SUPPORT IN TIMES OF NEED
   Everyone needs help sometimes; it’s okay to ask for help, which builds resilience.

4. KNOWLEDGE OF PARENTING & CHILD DEVELOPMENT
   Parenting is part natural and part learned; there’s no such thing as a perfect parent.

5. SOCIAL & EMOTIONAL COMPETENCE
   Through positive interactions with caring adults, children learn to communicate, develop and use their thinking skills appropriately.

For more information on the Protective Factors, go to cssp.org. For more information on the Greater Bay Area CAPC Coalition, go to bayareapreventchildabuse.org.
GREATER BAY AREA CHILD ABUSE PREVENTION COUNCILS
bayareapreventchildabuse.org

ALAMEDA COUNTY
TO REPORT CHILD ABUSE: 510-259-1800
Child Abuse Prevention Council: 510-780-8989
Parent Stress Hotline: 510-893-5444
alamedasocialservices.org

CONTRA COSTA COUNTY
TO REPORT CHILD ABUSE: 877-881-1116
Child Abuse Prevention Council: 925-798-0546
capc-cocc.org

MARIN COUNTY
TO REPORT CHILD ABUSE: 415-473-7153
Child Abuse Prevention Council: 707-585-6108 ext. 1101
or 415-668-0494

MONTEREY COUNTY
TO REPORT CHILD ABUSE: 831-755-4661
Child Abuse Prevention Council: 831-755-4474

NAPA COUNTY
TO REPORT CHILD ABUSE TO CHILDWELFARE SERVICES: 707-253-4261
Child Abuse Prevention Council: 707-252-1123
copefamilycenter.org

SAN FRANCISCO COUNTY
TO REPORT CHILD ABUSE: 415-558-2650
Child Abuse Prevention Council: 415-668-0494
TALK Line: 415-441-KIDS
sfcapc.org

SAN MATEO COUNTY
TO REPORT CHILD ABUSE: 650-802-7922
24 Hour Parent Stress Warmline: 888-220-7575
smcgov.org

SANTA CLARA COUNTY
TO REPORT CHILD ABUSE:
San Jose Area: 408-299-2071
Gilroy/Morgan Hill Area: 408-683-0601
Palo Alto Area: 650-493-1186
Child Abuse Council
cacssc.org

SOLANO COUNTY
TO REPORT CHILD ABUSE: 800-544-8696
Solano Children’s Alliance/Child Abuse Prevention Council: 707-421-7229
childnet.org

SONOMA COUNTY
TO REPORT CHILD ABUSE: 707-565-6304
or 800-870-7064
Prevent Child Abuse Sonoma County: 707-585-6108 ext. 1101
preventchildabuse-sonomacounty.org

bayareapreventchildabuse.org
partnersinprevention.org

71
Annual Report 2016-2017
Retrospective Study of Juvenile Motor Vehicle Deaths

Karin Wells, BA
Michelle A. Jorden, MD

Santa Clara County Medical Examiner-Coroner’s Office
Why this study?

- Dr. Jorden is Chair of the Child Death Review Team and continuously monitors child deaths
  - Increase in number of deaths
- 2013-2015 triannual report recently released
  - Increase in motor vehicle fatalities among youth
  - In 2010-2012 reporting cycle – 14 fatalities
  - In 2013-2015 reporting cycle – 24 fatalities
Research Parameters

- 67 total cases of accidental motor vehicle deaths involving juveniles aged 0 to 17 years during 2006-2015 in Santa Clara County
- 31% were aged 10 years or younger at the time of the accident and/or death
- 21% of decedents were age 15
Classifications

Percentage of Incident Types

- Solo Vehicle 27%
- Multi Vehicle 36%
- Pedestrian 37%
Restraint and Ejection

- 63% of all cases were single or multi vehicle incidents
- 45% of the decedents were restrained and 36% were unrestrained, with 67% of all ejected decedents being unrestrained
- 11 decedents involved in these incidents were 10 years or younger, with 4 of them being unrestrained
Speeding and Racing

• 31% of the cases involved speeding, and 7% involved racing
• The highest concentration of any age group involved in speeding or racing incidents were 15-years-old, 27%
• 10 of the 32 cases involved the use of drugs and/or alcohol
<table>
<thead>
<tr>
<th>Age of Decedent involved in Pedestrian Incident</th>
<th>Number of Decedents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years</td>
<td>1</td>
</tr>
<tr>
<td>8 years</td>
<td>2</td>
</tr>
<tr>
<td>5 years</td>
<td>5</td>
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<tr>
<td>6 years</td>
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<td>8 years</td>
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<td>12 years</td>
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<td>14 years</td>
<td>3</td>
</tr>
<tr>
<td>15 years</td>
<td>5</td>
</tr>
<tr>
<td>16 years</td>
<td>1</td>
</tr>
<tr>
<td>17 years</td>
<td>4</td>
</tr>
</tbody>
</table>

- 10 of the pedestrian decedents were under age 10
- The remaining 15 decedents were between ages 12 and 17
Vehicles Involved in Pedestrian Accidents

• 8 automobiles, 6 trucks, 2 vans, 5 SUVs, 2 light rail trains, and 2 semi-trucks

• 17 of the 25 pedestrian fatalities involved a vehicle larger than an automobile

• These larger vehicles range from 3700-9900 lbs. and 66-76 inches in height

• The decedents range in height from 32-73 inches
Helmet Use

- Of the 11 total decedents riding a bike or scooter, only 2, or 18% were wearing a helmet
- 82% were without a helmet
- Of 15 total instances where a helmet should have been worn, only 3 decedents were found to be wearing a helmet
DUI Cases

• Of the 68 cases, 18, or 26% involved the use of drugs and/or alcohol by a driver, passenger, or pedestrian
DUI Cases

• The majority of decedents involved in DUI cases were 15 and 16 years old
• Marijuana and alcohol were the most common drugs found
• 56% of the incidents occurred after midnight
Distractions

• 13 of the 68 cases, 19%, involved some form of distraction
• Distractions include momentarily taking one’s eyes off the road, blacking out, talking on or looking at a cell phone, emotional distress, loud music, arguing, wearing headphones, reaching into the back seat, and placing a drink into the cup holder (looking down)
Unprotected Left Turns

- A left turn made at a solid green light, or from a center lane, where the driver must yield to oncoming traffic
- 4 of the 68 cases involved an unprotected left, 3 of which were pedestrian incidents
Overall Results

• Using a crosswalk does not automatically mean a pedestrian is safe
• Drivers need to be more cognizant of pedestrians in or near the roadway and vise versa
• Children should be supervised in and around vehicles, crosswalks, and roads at all times
• Our data supports the CDC’s data that you are more likely to be ejected if you are not wearing a seat belt
• The data also shows that children, no matter what they are riding, need to wear a helmet
Summary

• These data can be used to provide important outreach education stressing the importance of vehicle safety and children
• Applying this information would improve youth safety in our county
References


Undetermined risk factors for suicide among youth, ages 10–24 — Santa Clara County, CA, 2016

Amanda Garcia-Williams, MPH, PhD
Julie O’Donnell, PhD, MPH

County Briefing

March 10, 2017

Disclaimer

The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention and the Substance Abuse and Mental Health Services Administration.
May 2009 through January 2010
- Five known suicides
- Incoming, current, alumni
- One high school

In response to community identified\(\dagger\) clusters in the city of Palo Alto, a formal request for epidemiological assistance was made on November 11, 2015


October 2014 through March 2015
- Four known suicides
- Current or alumni
- Two high schools, same district

\(\dagger\)A community identified suicide cluster is a cluster that has been identified by a community but has not been statistically verified.

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Epi-Aid investigations
- Short, rapid investigation
- Public health authorities must make a formal request
- Not research studies
- Make practical recommendations for public health action

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Annual Report 2016-2017
Objectives

1. Characterize the epidemiology of, and trends in, fatal and nonfatal suicidal behaviors among youth occurring from 2003 through 2015 in Santa Clara County, California; and data permitting, compare characteristics at multiple levels, such as school districts and cities.

2. Examine the degree to which media coverage of youth suicides occurring from 2008 through 2015 in Santa Clara County, California, met safe suicide reporting guidelines.

3. Inventory and compare youth suicide prevention policies, activities, and protocols used in the community to evidence-based and national recommendations.

4. Synthesize information from objectives 1-3 to make recommendations on youth suicide prevention strategies that can be used at the school-, community-, and county- levels.

Data sources

- CDC WONDER
- Vital statistics
- Medical examiner reports
- National Violent Death Reporting System
- Emergency Department (ED) data
- Patient Discharge data
- Developmental Assets Survey
- California Healthy Kids Survey
- Project Safety Net Community Survey
- Media scan
- Inventory of programs and policies
Crude suicide rate for youth residents of California (5.3/100,000) was similar to the crude suicide rate for youth residents of Santa Clara County (5.4/100,000) for combined years of 2003–2014.

Data Source: CDC WONDER
Case Definition: Youth suicide decedent, age 10-24, 2003-2014

Crude youth suicide rate by two year periods

Crude suicide rate in Santa Clara County is similar to the suicide rate in California.

Data Source: CDC WONDER Case Definition: Youth suicide decedent, age 10-24, that died in the United States 2003-2014
229 suicides among youth residents of Santa Clara County that died in California

For combined years of 2003–2015

Data Source: Vital statistics, combined years 2003–2015
Case Definition: (1) County of residence listed as Santa Clara County, (2) Death occurred in state of California, (3) Decedent 10 to 24 years of age, (4) Manner of death listed as suicide.

Biological sex of youth suicide decedents, 2003–2015

Male: 75.1%
Female: 24.9%

Data Source: Vital statistics, combined years 2003–2015
Case Definition: (1) County of residence listed as Santa Clara County, (2) Death occurred in state of California, (3) Decedent 10 to 24 years of age, (4) Manner of death listed as suicide.
Age category of youth suicide decedents, 2003–2015

- 20 to 24 years old: 66.4%
- 10 to 19 years old: 33.6%

Data Source: Vital statistics, combined years 2003-2015
Case Definition: (1) County of residence listed as Santa Clara County, (2) Death occurred in state of California, (3) Decedent 10 to 24 years of age, (4) Manner of death listed as suicide.


- White, Non-Hispanic: 38.9%
- Hispanic, any race: 27.1%
- Asian or Pacific Islander, Non-Hispanic: 27.1%
- Black, Non-Hispanic: 4.4%

Data Source: Vital statistics, combined years 2003-2015
Case Definition: (1) County of residence listed as Santa Clara County, (2) Death occurred in state of California, (3) Decedent 10 to 24 years of age, (4) Manner of death listed as suicide.
Location of youth suicides, 2003–2015

- House, apartment, garage: 65.2%
- Railroad tracks: 10.5%
- Other: 10%
- Roadway or parking area: 7.1%
- Outdoor area: 7.1%

Data Source: Medical examiner reports (2003-2015)
Population: (1) County of residence listed as Santa Clara County, (2) Death occurred in Santa Clara County, (3) Decedent 10 to 14 years of age, (4) Manner of death listed as suicide.

81% of youth suicide decedents had two or more known precipitating circumstances

Data Source: Medical examiner reports (2003-2015)
Population: (1) County of residence listed as Santa Clara County, (2) Death occurred in Santa Clara County, (3) Decedent 10 to 14 years of age, (4) Manner of death listed as suicide.
Known precipitating circumstances for youth suicide, 2003–2015

<table>
<thead>
<tr>
<th>Condition</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent crisis</td>
<td>52.6</td>
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<tr>
<td>Current mental health problem</td>
<td>47.4</td>
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<tr>
<td>Ever treated for mental health problem</td>
<td>42.8</td>
</tr>
<tr>
<td>Suicide note</td>
<td>42.3</td>
</tr>
<tr>
<td>Suicide thought history</td>
<td>37.1</td>
</tr>
<tr>
<td>Current depressed mood</td>
<td>32.5</td>
</tr>
<tr>
<td>Current treatment for mental illness</td>
<td>30.4</td>
</tr>
<tr>
<td>Suicide intent disclosed</td>
<td>29.4</td>
</tr>
<tr>
<td>Suicide attempt history</td>
<td>29.9</td>
</tr>
</tbody>
</table>

Data Source: Medical examiner reports (2003-2015)
Population: (1) County of residence listed as Santa Clara County, (2) Death occurred in Santa Clara County, (3) Decedent 10 to 24 years of age, (4) Manner of death listed as suicide.

3,915 emergency department visits for suicide attempt†
among youth residents of Santa Clara County, and seen in California
For combined years of 2005–2014

1,787 hospitalizations for suicide attempt‡
among youth residents of Santa Clara County, and hospitalized in California
For combined years of 2003–2014

† Suicide attempt without suicidal ideation
Data Source: Emergency Department Data (2003–2014)
Population: (1) Patient was 10 to 24 years of age, (2) Patient was a resident of Santa Clara County, and (3) Visit was for suicide attempt/self-injury. Suicide attempt/self-injury was defined based on the principal or any other diagnosis coded with ICD-9 external cause of injury codes (E-codes) in the range 950.0–959.9, corresponding to suicide attempt and self-inflicted injury.

‡ Suicide attempt without suicidal ideation
Data Source: Patient Discharge Data (2003-2014)
Population: (1) Patient was 10 to 24 years of age, (2) Patient was a resident of Santa Clara County, and (3) Hospitalization was for suicide attempt/self-injury. Suicide attempt/self-injury was defined based on ICD-9 external cause of injury codes (E-codes) in the range 950.0–959.9, corresponding to suicide attempt and self-inflicted injury.
Emergency Department visits for suicide attempt by Santa Clara County youth residents

Data source: Emergency department data (2005-2014). Population: (1) Patient was 10 to 24 years of age, (2) Patient was a resident of Santa Clara County, and (3) Visit was for suicide attempt/attempted injury. Suicide attempt/attempted injury was defined based on the principal or any other diagnosis coded with ICD-9 external cause of injury codes (E-codes) in the range 950.0-959.9, corresponding to suicide attempt and self-inflicted injury.

Hospitalization for suicide attempt by Santa Clara County youth residents

Data source: Patient Discharge Data (2004-2014). Population: (1) Patient was 10 to 24 years of age, (2) Patient was a resident of Santa Clara County, and (3) Hospitalization was for suicide attempt/attempted injury. Suicide attempt/attempted injury was defined based on ICD-9 external cause of injury codes (E-codes) in the range 950.0-959.9, corresponding to suicide attempt and self-inflicted injury.
### Individual level risk and protective factors for nonfatal suicidal behavior among public high school students

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug, alcohol, pain medication, cigarette use</td>
<td>Positive perceptions of self</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Positive outlook on future</td>
</tr>
<tr>
<td>Sexual orientation (Lesbian, Gay, Bisexual)</td>
<td>Problem solving</td>
</tr>
<tr>
<td>Delinquent behavior</td>
<td>Emotional self-awareness</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>Self-efficacy for help-seeking</td>
</tr>
<tr>
<td>Female gender</td>
<td></td>
</tr>
<tr>
<td>Lack of purpose and control over life</td>
<td></td>
</tr>
<tr>
<td>Sensation seeking</td>
<td></td>
</tr>
<tr>
<td>Sexual intercourse</td>
<td></td>
</tr>
</tbody>
</table>

Data Sources: Developmental Assets Survey (2010), California Healthy Kids Survey (2003-2016)
Population: Public high school students from Santa Clara County

### Interpersonal level risk and protective factors for nonfatal suicidal behavior among public high school students

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence perpetration/victimization</td>
<td>Close and positive relationship with parents and family</td>
</tr>
<tr>
<td>Family violence</td>
<td>Parent involvement in youth’s life</td>
</tr>
<tr>
<td>Physical, emotional, cyber bullying</td>
<td>Being encouraged by family to do one’s best</td>
</tr>
<tr>
<td></td>
<td>Open communication with parents</td>
</tr>
<tr>
<td></td>
<td>Engagement in outside activities</td>
</tr>
<tr>
<td></td>
<td>Close and positive relationship with adults outside of school/family</td>
</tr>
<tr>
<td></td>
<td>Caring relationships with fellow students</td>
</tr>
</tbody>
</table>

Data Sources: Developmental Assets Survey (2010), California Healthy Kids Survey (2003-2016)
Population: Public high school students from Santa Clara County
Community level risk and protective factors for nonfatal suicidal behavior among public high school students

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Feeling unsafe at school</td>
<td>• Caring relationships with teachers and adults at school</td>
</tr>
<tr>
<td>• Feeling unsafe in neighborhood</td>
<td>• School culture</td>
</tr>
<tr>
<td></td>
<td>• Connection to and encouragement from school</td>
</tr>
<tr>
<td></td>
<td>• Being pushed by teachers to be best can be</td>
</tr>
<tr>
<td></td>
<td>• Positive relationship with neighborhood/community</td>
</tr>
<tr>
<td></td>
<td>• High level of school expectations</td>
</tr>
</tbody>
</table>

Data Source: Developmental Assets Survey (2010), California Healthy Kids Survey (2003-2016)
Population: Public high school students from Santa Clara County

Recommended suicide prevention strategies

1. Multiple prevention approaches to address multiple risk factors
2. Access to evidence-based mental health care
3. Family relationships and family-based programs
4. Connection to school and school-based programs
5. Identify and support people at risk
6. Crisis intervention
7. Suicide postvention
8. Prevention of other forms of violence
9. Reducing access to lethal means for youth at risk
10. Safe messaging and reporting about suicide
11. Strategic planning for suicide prevention
12. Selection and implementation of evidence-based programs
13. Continuous program evaluation