Santa Clara County
Child Death Review Team

REPORT
Case Reports for Calendar Years 2013-2015
Published October 2016

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We owe our children health, happiness, and safety.

When we, as adults, provide our love, trust, guidance and protection wholeheartedly, the outcome for that child can only be positive. To be a positive influence on the life of a child does not depend on our marital status, income level, sexual preference or identity, race, age or health, but instead on our resilience to make the world a better place for our children.

Michelle A. Jorden, MD
Chair, CDRT
This report is dedicated to Bob Masterson:

A committed member of CDRT, a skilled attorney and an important pioneer for the safety and well-being of children.

Your presence and guidance are missed.
Santa Clara County Board of Supervisors:

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County Executive

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Santa Clara County Health Officer and Public Health Director
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“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) 2013-2015 MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
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<td>Lt. Michelle Avila</td>
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<td>County Commissioner Child Abuse Council</td>
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<tr>
<td>Mini Luna</td>
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<td>YWCA Silicon Valley</td>
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<tr>
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<td>Community Care Licensing-Child Care</td>
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<td>Mary Segura</td>
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<tr>
<td>Guests</td>
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<td>Community, county agencies, rotating Resident physicians from Valley Medical Center and Stanford University Medical Center</td>
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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 Medical Examiner.”
EXECUTIVE SUMMARY

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. Every month, the CDRT meetings are well attended and nearly full to capacity.

The Medical Examiner 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. The team does not review stillborn deaths.
Case Selection

We review the circumstances of the deaths of children (birth up to teenagers under the age of 18) 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. The CDRT reviewed 28% of the deaths of all children during the 2013-2015 period.

Dr. Michelle Jorden reviews all pediatric death certificates for ages 0-17 years issued in Santa Clara County, whether or not the death falls under the jurisdiction of the medical examiner, to ensure an element of child abuse or neglect has not contributed to the death.

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 of the death. 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 2013, 47 child deaths met criteria for review by the Child Death Review Team. We reviewed 28 child deaths in 2014 and 26 child deaths in 2015. For the past three years, the team has reviewed an average of 34 cases per year.

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

Sleeping

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

Of the 40 infant deaths (age <1 year old/<12 months old) occurring during the 2013-2015 period that were reviewed, there were 17 infant deaths that occurred due to either unsafe sleep practice (overlay, etc.) (n=4) or in an unsafe sleep environment (n=13). There were an additional 12 cases in which the infant died in an unsafe sleep environment but also in which other factors for sudden death was present (undetermined cases). If these cases are included, a total of 29 infants died in Santa Clara County who were found deceased in an unsafe sleep environment upon a thorough scene investigation by the medical examiner.

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 4 cases, the conclusion of the team was that the infant most likely died from an adult unintentionally rolling on the infant while asleep or that possible overlay could not be ruled out. 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 (side carts) 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 either died alone on an adult bed, couch, or pillow or in an unsafe sleep environment shared with a parent. The babies either rolled and became wedged between the bed and wall, or rolled to a prone position (face down) with the face pressed into the couch, bed pillows or linens. In one (1) case, an 8-month-old infant was swaddle and laid on top of pillow on an adult bed and was found unresponsive in another position. The scene investigation revealed the baby most likely turned over and became entrapped in soft bedding, suggestive of suffocation. 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)\(^1\).

The diagnosis of SIDS is far below the national average in Santa Clara County. 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 8 years, the team has acknowledged 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\(^2\). 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).

Since the publication of the prior report, Assistant Medical Examiner, Michelle Jorden, MD, Medical Examiner-Coroner Investigators Christina Pantoja and Rosa Vega and Sara Copeland, MD Deputy Health Officer continue to educate numerous stakeholders in the county and at the state level.

Since the last report, continued education on this topic has commenced in a variety of venues:

The Medical Examiner (Dr. Jorden) continues to devote time to educate the many stakeholders within the county and state on this very important topic and include:

- Presentation to the San Jose Fire Department on response to sudden unexpected infant deaths with an emphasis on the critical review of the sleep environment as a first responder.
- In November 2013, a presentation was given to the Mid-Coastal California Perinatal Quality Improvement Council on sudden unexpected infant deaths and observations made in Santa Clara County on unsafe sleep practices as well as her observations of methamphetamine related

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\(^1\) Centers for Disease Control and Prevention, August 9, 2013.
stillborn deaths. Both topics were adopted as action plan items by the Council to improve outcomes in infant morbidity and mortality.

- In June 2014, October 2014 and January 2015 sudden infant deaths and unsafe sleep environment presentations were performed in Northern California to include Santa Clara, Santa Cruz and Monterey counties.

- Safe sleep presentations continued in November 2014 by Drs. Michelle Jorden and Sara Copeland targeting the Breast Feeding Task Force and the Nursing Mothers Council.

- In 2015, a toolkit was created that compiled all available educational resources into one tool. This toolkit was placed on customized USB drives for the purpose of educating the state coroners and medical examiners about the best practice approach of investigating sudden unexpected infant deaths in order to correctly identify deaths due to unsafe sleep practices with an emphasis on scene investigation and baby doll re-enactments. The USB drives were dispersed at the state coroners meeting in Lake Tahoe in September 2015 (approximately 85 attendees) and presented by Christina Pantoja, Medical Examiner-Coronor investigator.

- 175 perinatal nurses were educated at the Continuing Education Consortium Perinatal Hot Topics Nursing Conference in Sacramento October 2015 on the importance of safe sleep for infants to reduce sudden unexpected infant death.

Dr. Sara Copeland and Medical Examiner-Coronor investigators Christina Pantoja and Rosa Vega educated approximately 71 public health nurses, public health assistants, community health workers and students in two separate trainings in October 2015.

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)
- the Eunice Kennedy Shriver National Institute of Child Health and Human Development
  NICHD Link: http://www.nichd.nih.gov/sts/materials/Pages/default.aspx

In late 2015, First 5 Santa Clara continues to support the Child Death Review Team in providing printing services for educational materials. First 5 has printed an additional 10,150 safe sleep postcards which have been disseminated to the major stakeholders and agencies in Santa Clara County in English, Spanish and Vietnamese languages.

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 bassinet. 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.

The Santa Clara County Medical Examiner and Public Health Department along with CDRT conducted a survey of all 10 birthing hospitals in Santa Clara County to assess current policies in place, if any, regarding training to new parents as they relate to safe sleep and proper infant sleep position as well as continued efforts to educate health professionals regarding the dangers of unsafe sleep. Although the majority of the hospitals speak to parents about safe sleep, there is currently no hospital policy in place in any of the area hospitals on this topic.

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.

In 2014, one case of a newborn baby born by a midwife/doula and alive for less than 24 hours before being found unresponsive in his mother’s arms was reviewed. The autopsy and review of the medical records indicated multiple factors at play to include complications arising from the home birth procedure.

**Suicides**

Unfortunately, we continue to have adolescents who take their own lives. **Eleven (11) youths died by suicide in 2013-2015. Five (5) youth completed suicide in 2013, three (3) in 2014, and three (3) in 2015. The most common method used was hanging (6) over this three-year period.** In the remaining cases, we observed other methods of suicide among youth. In one (1) case, a seventeen year old male committed suicide by inhalation of hydrogen sulfide by mixing common household cleaning agents together and inhaling the gas. Unfortunately, in this particular case, the decedent’s father also died as a result of trying to save his son and succumbed to the fumes in a matter of seconds. Two (2) cases in 2014-2015 involved teenagers intentionally jumping from a large structure such as a building and succumbing to multiple fatal traumatic injuries. One (1) case involved a 16-year-old male in 2014 who intentionally was struck by a train resulting in fatal traumatic injuries.
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.

In 2013, after the review of two suicide cases, the Child Death Review Team discussed the topic of bullying with presentations given to the team by the Santa Clara County Probation Department and Sunnyvale Department of Public Safety. These departments discussed their role and provided educational materials used in educating students and parents as well as police officers regarding the harmful effects of cyber-bullying and bridging the disconnect of technology parents encounter when trying to monitor youth behavior on social media.

The team decided to adopt a subcategory under the Suicide classification to capture those cases connected with bullying based on medical examiner/law enforcement investigations.

Not included in the above statistics is the review of a 25-year-old case of a suicide involving a young adolescent who hanged himself at his father’s residence. Dr. Michelle Jorden was asked to review this case and completed a review of the autopsy report, autopsy photographs, and investigative reports. She also returned to the scene and conducted a scene investigation and re-enactment using the investigative reports. Remarkably, the scene was minimally disturbed years later and allowed for a thorough re-investigation. An entire CDRT meeting was devoted to the review of this case, and the CDRT concluded the case was a suicidal death but the team also concluded the young boy was a victim of child abuse.

**Homicide by a Parent/Relative**

**In the 2013-2015 reporting period, 1 infant was murdered by a family member who suffered from mental illness.** The 1-year-old infant was stabbed multiple times and found deceased along his deceased grandmother who also suffered from multiple stab wounds.

**Homicide by a Non-Relative**

**A total of nine (9) teenage boys were murdered in the 2013-2015 reporting period.** Seven (7) teenage boys ages 15, 16 and 17 years were killed by firearms by non-family members in 2013 through 2015. Two (2) teenagers, aged 16 and 17 years, were stabbed.
Accidental Deaths

Twenty-four (24) children and teenagers were fatally involved in motor vehicle, bicyclist, or pedestrian accidents in the 2013-2015 reporting period. Of these, one (1) case involved a 5-year-old girl who was accidentally struck by a sports utility vehicle after darting out in front of a motor vehicle within a crosswalk. One (1) case in 2013, involved a 17-year-old male in a motor vehicle accident which resulted in the explosion of the vehicle producing extensive and deforming thermal injuries.

In contrast to the prior CDRT report of 2010-2012, the number of children and teenagers succumbing to motor vehicle accidents has increased. The team has also identified that of the fatalities, three (3) teenagers were residents of group homes.

In this reporting period, one (1) child aged 7-years-old died accidentally of thermal and inhalational injuries in a house fire due to the use of unsupervised lit candles. The team attributed the death as neglect related due to inadequate adult supervision.

In this reporting period, one (1) child aged 7-years-old accidentally died of head injuries after falling out of a window unsupervised.

Also included in this reporting cycle is the death of a 9-month-old male who was accidentally left in an enclosed motor vehicle in elevated environmental temperatures and succumbed to hyperthermia. This case underscores the importance of never leaving children or pets in enclosed vehicles. In hot weather, the inner vehicle temperature can rapidly rise to danger levels with recorded temperatures of >120°F, exceeding the outside temperature, within a matter of minutes and causing an infant or child to die.

The numbers reported under this category do not include accidental infant suffocations observed as unsafe sleep during 2013-2015.

Drowning

We reviewed the drowning deaths of four (4) children in the 2013-2015 period. A 2-year-old, 4-year-old and 13-year-old died in 2013 and a one-year-old died in 2014. Of the four (4) cases, three (3) of the deaths were classified as neglect and involved lack of parental/caregiver supervision. These numbers do not encompass two (2) other children who died in Santa Clara County but whose cases fell under the jurisdiction of San Mateo and Monterey counties; the details were discussed in those respective county’s CDRT. 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. 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 promotes the importance of constant parental/caregiver supervision of babies and children in and around water.

As the CDRT continues to review child drowning fatalities each year, the CDRT with help from member Andrea Flores-Shelton agreed to review all jurisdictions within Santa Clara County in June 2014 to determine whether adoption of the State’s Swimming Pool Safety Act as specified within the California
Residential Code is present in every city. It is this team’s understanding the State’s Code indicates Appendix G (a specific section addressing the safety standards of swimming pools, spas and hot tubs).

The outcome associated with the review indicated all sixteen (16) jurisdictions within Santa Clara County (unincorporated, Stanford, San Jose, Gilroy, Morgan Hill, Los Gatos, Saratoga, Monte Soreno, Los Altos, Los Altos Hills, Cupertino, Campbell, Santa Clara, Milpitas, Mountain View, Sunnyvale and Palo Alto) adopted the 2013 California Residential Code. Ten (10) jurisdictions elected to adopt Appendix G and have made the necessary changes to their municipal codes. Six (6) cities did not elect to adopt Appendix G because their cities’ existing regulations on swimming pools and spas have stricter requirements, such as a minimum height of enclosure.

The CDRT applauds all jurisdictions in this important endeavor of preventing child deaths due to drowning; however, the team also identified the lack of a mechanism in place to ensure codes are enforced or maintained years after living in a home, to ensure children are continually protected.

In 2015, a retrospective 5-year study was performed of all drowning deaths in children who died in Santa Clara County from January 1, 2009 through January 31, 2015 by Dr. Michelle Jorden and student intern Allegra Maeso (please refer to the appendix for the entire report). A total of seventeen (17) cases were identified. The files were pulled and analyzed for the following variables: death date (season), gender, race, age, age of the parents, siblings in the home, manner of death, location of death, were safety measures present, residential zip code, been exposed to water/swimming, extent of supervision, cause of death, other significant conditions, how injury occurred.

This retrospective review identified the following important take home messages for parents and caretakers in Santa Clara County and neighboring counties:

1. Children should never be left unattended for any amount of time, even a few minutes.
2. PARENTS: Make sure your children are supervised at all times when around water!
3. Children can drown even in a bucket of water.
4. The majority of drowning cases were observed in the <1 year-2 year age range.
5. In this study, brain damage can occur in as little as 5 min.
6. 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.

Various members of the CDRT will be collaborating with other stakeholders in the community to emphasize these messages in the early spring and summer months.
Child Abuse Council (CAC):

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.

Each month, time is dedicated under the business item category at the start of the meeting for CAC business. A designated CDRT member who is also a member of the Child Abuse Council verbally reports on main agenda items discussed at the prior CAC meeting.

The CDRT presented at the 31st Annual Child Abuse Symposium in April 2013 and the topic discussed was an overview of the Santa Clara County CDRT. Educational materials on safe sleep for infants were dispersed at the meeting.

The CDRT presented at the 32nd Annual Child Abuse Symposium May 2, 2014 and the presentation consisted of a panel discussion led by Dr. Michelle Jorden and a panel of CDRT experts entitled “Finding How and Why Children Die.”

The CDRT presented at the 33rd Annual Child Abuse Symposium April 17, 2015 and consisted of a panel discussion led by Dr. Michelle Jorden and a panel of CDRT experts entitled “Suicide in the Young.” For this particular presentation, the team was most fortunate to have Shashank Joshi, MD share his expertise on this important topic.

The CDRT has participated in various workshops sponsored by the Child Abuse Council to include the topic of “Transforming System Practices for LGBTQQI Youth” among others.

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/bassinette, 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 acquired 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 public health issue. It is a profound and preventable tragedy no matter what the age of the victim or method used. For teens and young adults 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. It can also work to reach out and get help. Crisis text lines as well as phone apps are available to help individuals find help and prepare for tough times (attached). 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 (attachment). It is correct to say that involvement in bullying, along with other risk factors, increases the chance that a young person will engage in suicide-related behaviors (both perpetrator and victim). In addition, we would also encourage the active involvement of schools as it relates to this growing problem. Everyone plays an important role in prevention and early intervention by learning the signs and symptoms of suicidal behavior. There are many resources for people to connect to and receive appropriate care in our County alone. Persons in crisis as well as their friends and acquaintances can contact 1-855-278-4204 or visit reachout.com for guidance and support. The Suicide and Crisis Hotline is available 24/7, and it is confidential and private. The fog of stigma associated with mental illness continues to dissolve as more communities learn to demystify mental illness and learn that treatment works and people recover. Depression and other mental health conditions can lead to suicidal ideation. With proper treatment and care, young children and teens can learn to manage their illness and lead satisfying lives. The role of media cannot be overemphasized as we discuss suicides among the youth. According to research, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking (attached).

### Drug Abuse

**For this reporting cycle, no child died as a result of a drug overdose.**

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 May 2016, the Medical Examiner (Dr. Jorden) reported deaths in adults due to fentanyl-tainted opiates. We would encourage adults to speak openly to youth about the dangers of buying prescription pills off the street which are counterfeit, illegal and linked to deaths in Santa Clara County.

**Goals for 2016:**

**Topic of unsafe sleep:**
Continued education on this topic will be performed by Michelle Jorden, MD in February 2016 at the California Association of Women’s Health, Obstetric, and Neonatal nurses in San Diego. The toolkit containing the educational materials will be dispersed at this meeting.

CDRT team members will continue to educate their departments on the importance of safe sleep and the benefits of breast feeding and keeping babies safe within the sleep environment.

Continued education to Valley Medical Center and Social Services will also commence.

**Topic of suicide:**
In 2016, the Medical Examiner-Coroner’s Office will collaborate with the Centers for Disease Control (CDC) in reviewing suicides from 2003-2015 in ages 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.

**Topic of accidental deaths:**
Since the last tri-annual report, more youth have died in motor vehicle fatalities. As such, a retrospective, in depth study, of motor vehicle collisions affecting our young in this county will be conducted by the Medical Examiner-Coroner Office. We are hopeful this study will identify the scope of the problem in Santa Clara County but most importantly, identify areas in which we, as major stakeholders, can help to address. This study will include analyzing certain variables such as family dynamics (troubled home), family history of criminal activity, substance use/abuse, presence of domestic violence in the home, school performance, time of day incident occurred, lack of sleep, etc.

**Topic of drowning deaths:**
Emergency Medical Services will incorporate the findings of the drowning death review in their annual message about drowning prevention. We will share this information with other counties, if requested.

**Legislation:**
The Medical Examiner, County Counsel and the County Executive’s Office, have proposed a legislative initiative that would revise California Penal Code to mirror the language in the elder death review team and domestic violence review team statutes to allow the CDRT to discuss mental health information when conducting its review of unexpected child deaths, to improve its investigation and detection of child abuse and neglect as well as help identify trends to reduce the incidents of child death. The proposed legislative change received support from SCC Mental Health Department and unanimous support from the Board of Supervisors on January 12, 2016.
## STATISTICS

### TABLE 1. CHILD DEATHS REVIEWED BY THE CHILD DEATH REVIEW TEAM COMPARED TO ALL SANTA CLARA COUNTY CHILD DEATHS, 2013-2015

<table>
<thead>
<tr>
<th>Year</th>
<th>Child deaths reviewed</th>
<th>Santa Clara County total child deaths*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>47</td>
<td>132</td>
</tr>
<tr>
<td>2014</td>
<td>28</td>
<td>107</td>
</tr>
<tr>
<td>2015</td>
<td>26</td>
<td>121</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>360</td>
</tr>
</tbody>
</table>


* 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>28</td>
<td>28%</td>
</tr>
<tr>
<td>Male</td>
<td>73</td>
<td>72%</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>40</td>
<td>40%</td>
</tr>
<tr>
<td>1-4</td>
<td>8</td>
<td>8%</td>
</tr>
<tr>
<td>5-11</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>12-17</td>
<td>47</td>
<td>47%</td>
</tr>
<tr>
<td>Total</td>
<td>101</td>
<td>100%</td>
</tr>
</tbody>
</table>

TABLE 3. CHILD DEATHS RESULTING FROM INJURIES, 2013-2015

<table>
<thead>
<tr>
<th>Mode of injury</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motor vehicle and other transport</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Drowning</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Suffocation or strangulation</td>
<td>12</td>
<td>5</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Weapon, including body part</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Fire, burn, or electrocution</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Fall</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>19</td>
<td>19</td>
<td>75</td>
</tr>
</tbody>
</table>


TABLE 4. CHILD DEATHS BY MANNER AND CAUSE OF DEATH, 2013-2015

<table>
<thead>
<tr>
<th>Manner and cause of death</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect Related</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Non-Maltreatment</td>
<td>15</td>
<td>11</td>
<td>13</td>
<td>39</td>
</tr>
<tr>
<td>Undetermined</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Homicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homicide</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Non-Maltreatment</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Natural</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Maltreatment</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Undetermined</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Maltreatment</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Undetermined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect Related</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Non-Maltreatment</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Undetermined</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>


Note: The medical cause of death is a separate classification system and does not match with the classification of manner of death and CDRT cause of death.
<table>
<thead>
<tr>
<th>Medical conditions</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other infection</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>SUID</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Other medical condition</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>9</td>
<td>7</td>
<td>26</td>
</tr>
</tbody>
</table>


Note: The medical cause of death is a separate classification system and does not match with the classification of manner of death and CDRT cause of death.
SAFE SLEEP INITIATIVE

Public Awareness Materials

THIS IS DEADLY!

Learn how to keep your baby SAFE!
ALONE, ON BACK, IN A CRIB.

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.ucphd.org
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.

We also would like to thank First 5 Santa Clara County for their generous financial support in printing the educational postcards currently dispersed throughout the county in English, Spanish and Vietnamese languages.

The author also acknowledges student intern, Stephanie Dong, for her attention and commitment in maintaining the database under study. 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., SBH. 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)
- Fire (related death)
- Disease/Exposure (occupational/contagious)
- No Next-of-Kin (inability to locate)
- In-Custody (Fed. State. County. Criminal. Mental Developmentally disabled)
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
## Santa Clara County Demographics, 2013-2015

<table>
<thead>
<tr>
<th>All Ages</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>926,938</td>
<td>936,728</td>
<td>945,580</td>
</tr>
<tr>
<td>Female</td>
<td>923,657</td>
<td>934,788</td>
<td>944,844</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,850,595</td>
<td>1,871,516</td>
<td>1,890,424</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children 0-17 years of age</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>221,667</td>
<td>222,398</td>
<td>222,994</td>
</tr>
<tr>
<td>Female</td>
<td>212,067</td>
<td>212,982</td>
<td>213,686</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>433,734</td>
<td>435,380</td>
<td>436,680</td>
</tr>
</tbody>
</table>

Source: State of California, Department of Finance, State and County Population Projections by Race/Ethnicity and Age (5-year groups), 2010-2060, Sacramento, California, December 15, 2014

\[1\] Santa Clara County Opioid Overdose Prevention Project, May 12, 2016
ANALYSIS OF DROWNING DEATHS IN CHILDREN IN SANTA CLARA COUNTY
5-YEAR RETROSPECTIVE STUDY (JAN 1, 2009 - JAN 31, 2015)

Michelle A. Jorden, MD and Allegra Maeso, student intern
Project idea: Saul Wasserman, MD
Child Death Review Team, Santa Clara County
DESIGN

A retrospective 5-year study was performed of all drowning deaths in children who died in Santa Clara County from January 1, 2009 through January 31, 2015. A total of seventeen (17) cases were identified. The files were pulled and analyzed for the following variables: death date (season), gender, race, age, age of the parents, siblings in the home, manner of death, location of death, were safety measures present, residential zip code, been exposed to water/swimming, extent of supervision, cause of death, other significant conditions, how injury occurred.

DATA

<table>
<thead>
<tr>
<th>Locations</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Jose</td>
<td>7</td>
</tr>
<tr>
<td>Menlo Park (out of county)</td>
<td>1</td>
</tr>
<tr>
<td>Salinas (out of county)</td>
<td>2</td>
</tr>
<tr>
<td>Sunnyvale</td>
<td>1</td>
</tr>
<tr>
<td>Cupertino</td>
<td>1</td>
</tr>
<tr>
<td>Belmont (out of county)</td>
<td>1</td>
</tr>
<tr>
<td>Walnut Creek (out of county)</td>
<td>1</td>
</tr>
<tr>
<td>Saratoga</td>
<td>1</td>
</tr>
<tr>
<td>San Martin</td>
<td>2</td>
</tr>
<tr>
<td>Ages</td>
<td>Deaths</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>1</td>
</tr>
<tr>
<td>1 year</td>
<td>5</td>
</tr>
<tr>
<td>2 years</td>
<td>4</td>
</tr>
<tr>
<td>3 years</td>
<td>1</td>
</tr>
<tr>
<td>4 years</td>
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</tr>
<tr>
<td>5 years</td>
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</tr>
<tr>
<td>6 years</td>
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</tr>
<tr>
<td>7 years</td>
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</tr>
<tr>
<td>8 years</td>
<td>0</td>
</tr>
<tr>
<td>9 years</td>
<td>1</td>
</tr>
<tr>
<td>10-13 years</td>
<td>1</td>
</tr>
<tr>
<td>15 years</td>
<td>1</td>
</tr>
<tr>
<td>Time of the year</td>
<td>Deaths</td>
</tr>
<tr>
<td>------------------</td>
<td>--------</td>
</tr>
<tr>
<td>April</td>
<td>1</td>
</tr>
<tr>
<td>May</td>
<td>2</td>
</tr>
<tr>
<td>June</td>
<td>3</td>
</tr>
<tr>
<td>July</td>
<td>1</td>
</tr>
<tr>
<td>August</td>
<td>6</td>
</tr>
<tr>
<td>October</td>
<td>3</td>
</tr>
<tr>
<td>December</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>4</td>
</tr>
<tr>
<td>White-Hispanic</td>
<td>6</td>
</tr>
<tr>
<td>Asian</td>
<td>4</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>1</td>
</tr>
<tr>
<td>East Indian</td>
<td>1</td>
</tr>
<tr>
<td>Black</td>
<td>1</td>
</tr>
</tbody>
</table>
15 cases rendered accident, 2 undetermined (unwitnessed)

In 7 cases, children were not pronounced dead at the scene but died from complications of being in a persistent vegetative state

8 males, 9 females

1 death in a bucket of water (1-year-old), 7 deaths in swimming pools at own residence, 1 death in a bathtub, 1 death at a beach, 7 deaths in a swimming pool or hot tub at another’s home (relatives, friends)

In 13 cases, safety measures in place

- In 3 cases, the gate attached to the fence around the pool broken or unlocked, 1 case of fence around pool but no safety locks
- Fence separating homes dilapidated so child gained access
- 4 cases sliding glass door open, 1 in which unknown
- 1 case no pool safety measures, but doors locked
- 1 child took off floaters, safety measures in place

In 16 cases, NO supervision for at least 5 min.
CONCLUSION

• Summer months, especially August, appear to be more vulnerable periods for drowning
• Almost half of the cases happened in San Jose
• Ages 1-2 make up majority of cases
  – Active
  – Walking
  – Curious of surroundings
• Males and females almost equally affected
• Children did not know how to swim
• *** Common denominator in almost all cases
  – LACK OF SUPERVISION
• Parents/Babysitters/neighbors knew CPR which was initiated immediately
• All cases – 911 was activated immediately

• Public is greatly lacking in watching their children at all times around water with drowning occurring in as little as 5 minutes
• Kids can drown in a bucket of water
• Although some of the homes had fences, sliding door locks, etc.
  – Useless if they are not locked or used as directed and children can get past the barriers
  – Public needs to be educated on basic pool safety and precautions since some of the cases involved a neighbor’s pool or public pool
TAKE HOME MESSAGES

- **Children should never be left unattended for any amount of time.**
  - PARENTS: 1, 2, 3 - eyes on my children at all times when around water!

- **Children can drown even in a bucket of water.**

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

- **In this study, brain damage can occur in as little as 5 min.**

- 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. **Safety measures HAVE TO BE IN PLACE at ALL times and need to be working.**
The Relationship Between Bullying and Suicide: What We Know and What it Means for Schools

National Center for Injury Prevention and Control
Division of Violence Prevention

CDC
In the past decade, headlines reporting the tragic stories of a young person’s suicide death linked in some way to bullying (physical, verbal, or online) have become regrettably common. There is so much pain and suffering associated with each of these events, affecting individuals, families, communities and our society as a whole and resulting in an increasing national outcry to “do something” about the problem of bullying and suicide.

For this reason, the Centers for Disease Control and Prevention (CDC) and other violence prevention partners and researchers have invested in learning more about the relationship between these two serious public health problems with the goal of using this knowledge to save lives and prevent future bullying.

As school administrators, teachers, and school staff in daily contact with young people, you are uniquely affected by these events and feel enormous pressure to help prevent them in the future. The purpose of this document is to provide concrete, action-oriented information based on the latest science to help you improve your schools’ understanding of and ability to prevent and respond to the problem of bullying and suicide-related behavior.

What We Know about Bullying

• Bullying is unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Bullying includes actions such as making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose. Bullying can occur in-person or through technology.

• Bullying has serious and lasting negative effects on the mental health and overall well-being of youth involved in bullying in any way including: those who bully others, youth who are bullied, as well as those youth who both bully others and are bullied by others, sometimes referred to as bully-victims.

• Even youth who have observed but not participated in bullying behavior report significantly more feelings of helplessness and less sense of connectedness and support from responsible adults (parents/schools) than youth who are have not witnessed bullying behavior.

• Negative outcomes of bullying (for youth who bully others, youth who are bullied, and youth who both are bullied and bully others) may include: depression, anxiety, involvement in interpersonal violence or sexual violence, substance abuse, poor social functioning, and poor school performance, including lower grade point averages, standardized test scores, and poor attendance.

• Youth who report frequently bullying others and youth who report being frequently bullied are at increased risk for suicide-related behavior.

• Youth who report both bullying others and being bullied (bully-victims) have the highest risk for suicide-related behavior of any groups that report involvement in bullying.
What We Know about Suicide

- Suicide-related behaviors include the following:
  - **Suicide**: Death caused by self-directed injurious behavior with any intent to die.
  - **Suicide attempt**: A non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
  - **Suicidal ideation**: Thinking about, considering, or planning for suicide.
- Suicide-related behavior is complicated and rarely the result of a single source of trauma or stress.
- People who engage in suicide-related behavior often experience overwhelming feelings of helplessness and hopelessness.
- ANY involvement with bullying behavior is one stressor which may significantly contribute to feelings of helplessness and hopelessness that raise the risk of suicide.
- Youth who are at increased risk for suicide-related behavior are dealing with a complex interaction of multiple relationship (peer, family, or romantic), mental health, and school stressors.

What We Know about Bullying and Suicide Together

- We know that bullying behavior and suicide-related behavior are closely related. This means youth who report any involvement with bullying behavior are more likely to report high levels of suicide-related behavior than youth who do not report any involvement with bullying behavior.
- We know enough about the relationship between bullying and suicide-related behavior to make evidence-based recommendations to improve prevention efforts.

What We DON’T Know about Bullying and Suicide

- We don’t know if bullying directly causes suicide-related behavior. We know that most youth who are involved in bullying do NOT engage in suicide-related behavior. It is correct to say that involvement in bullying, along with other risk factors, increases the chance that a young person will engage in suicide-related behaviors.
The Relationship Between Bullying and Suicide

Recent attention focused on the relationship between bullying and suicide is positive and helpful because it:

1. Raises awareness about the serious harm that bullying does to all youth involved in bullying in any way.
2. Highlights the significant risk for our most vulnerable youth (e.g. youth with disabilities, youth with learning differences, LGBTQ youth).
3. Encourages conversation about the problem of bullying and suicide and promotes collaboration around prevention locally and nationally.

However, framing the discussion of the issue as bullying being a single, direct cause of suicide is not helpful and is potentially harmful because it could:

1. Perpetuate the false notion that suicide is a natural response to being bullied which has the dangerous potential to normalize the response and thus create copycat behavior among youth.
2. Encourage sensationalized reporting and contradicts the Recommendations for Reporting on Suicide (http://reportingonsuicide.org) potentially encouraging copycat behavior that could lead to “suicide contagion.”
3. Focus the response on blame and punishment which misdirects the attention from getting the needed support and treatment to those who are bullied as well as those who bully others.
4. Take attention away from other important risk factors for suicidal behavior that need to be addressed (e.g. substance abuse, mental illnesses, problems coping with disease/disability, family dysfunction, etc.)

Still, a report of a young person who takes his/her own life and leaves a note pointing directly to the suffering and pain they have endured because of bullying is shocking and heartbreaking. While a young person’s death by suicide is a tragedy and both bullying and suicide-related behavior are serious public health problems, our response to such situations must reflect a balanced understanding of the issues informed by the best available research.

It is particularly important to understand the difference between circumstances being related to an event versus being direct causes or effects of the event. To explore this idea, let’s look at a similar but much simpler example:

In the case of drowning deaths among children, those who are not directly supervised by a competent adult while swimming are more likely to die by drowning than those children who are directly supervised. While the lack of adult supervision does not directly cause a child to drown, it is a critical circumstance that can affect the outcome of the situation.

Just as with preventing deaths by drowning, for bullying and suicide prevention, the more we understand about the relationship between circumstances and outcomes the better decisions we can make about what actions to take to prevent bullying and suicide-related behavior.
So, if bullying doesn’t directly cause suicide, what do we know about how bullying and suicide are related?

Bullying and suicide-related behavior are both complex public health problems. Circumstances that can affect a person’s vulnerability to either or both of these behaviors exist at a variety of levels of influence—individual, family, community, and society. These include:

- emotional distress
- exposure to violence
- family conflict
- relationship problems
- lack of connectedness to school/sense of supportive school environment
- alcohol and drug use
- physical disabilities/learning differences
- lack of access to resources/support.

If, however, students experience the opposite of some of the circumstances listed above (e.g. family support rather than family conflict; strong school connectedness rather than lack of connectedness), their risk for suicide-related behavior and/or bullying others—even if they experience bullying behavior—might be reduced. These types of circumstances/situations or behaviors are sometimes referred to as “protective factors.”

In reality, most students have a combination of risk and protective factors for bullying behavior and suicide-related behavior. This is one of the reasons that we emphasize that the relationship between the two behaviors and their health outcomes is not simple. **The ultimate goal of our prevention efforts is to reduce risk factors and increase protective factors as much as possible.**

The bottom-line of the most current research findings is that being involved in bullying in any way—as a person who bullies, a person who is bullied, or a person who both bullies and is bullied (bully-victim)—is ONE of several important risk factors that appears to increase the risk of suicide among youth.

**What Can We Do with What We Know?**

Knowledge is really most helpful if it informs action toward a positive change—in this case, prevention of bullying and suicide-related behavior. In your position—spending several hours a day with youth—you have the opportunity to put some of the best knowledge to work but little time to sift through reams of information. Hopefully, you will find the evidence-based suggestions in this document realistic and actionable in your specific settings.

The following table highlights key research findings about the relationship between bullying and suicide-related behavior, identifies the prevention action you can take based on this information, and suggests places to find supporting resources.
<table>
<thead>
<tr>
<th>What do we know from research?</th>
<th>What can school personnel do?</th>
<th>Where can I find more information?</th>
</tr>
</thead>
</table>
| Youth who feel connected to their school are less likely to engage in suicide-related behaviors. | Help your students feel connected to you and their school. For example, greet them by name every day. Ask them how they are doing, etc. Encourage their extracurricular interests and involvement. A strong sense of connectedness to caring, responsible adults at school can provide invaluable support to youth who may be struggling socially and/or emotionally. | CDC resources for fostering school connectedness:  
• www.cdc.gov/healthyyouth/adolescenthealth/connectedness.htm  
CDC’s Applying Science, Advancing Practice: Preventing Suicide Through Connectedness:  
• www.cdc.gov/ViolencePrevention/pdf/ASAP_Suicide_Issue3-a.pdf |
| Youth who are able to cope with problems in healthy ways and solve problems peacefully are less likely to engage in suicide and bullying related behaviors. | Teach youth coping/life skills. Focus on positive and empowering messages that build resilience and acceptance of differences in themselves and others. Early training (even starting in elementary school) for students to help them develop coping and problem-solving skills, build resilience, and increase their social intelligence and empathy is important to fostering positive mental health and pro-social behavior. | Links to evidence-based, social-emotional learning approaches:  
Good Behavior Game  
• www.air.org/focus-area/education/?type=projects&id=127  
Steps to Respect: Bullying Prevention for Elementary School  
• www.cfchildren.org/steps-to-respect.aspx |
| Youth with disabilities, learning differences, sexual/gender identity differences or cultural differences are often most vulnerable to being bullied. | Provide better training for all school staff who work with youth. Teach personnel about vulnerable populations and appropriate ways to intervene in bullying situations. Understand that acknowledging risk factors is not the same as victim blaming. There are power differences involved in bullying situations. For this reason, general conflict resolution methods are not appropriate or effective. Adopt and implement effective and inclusive anti-bullying policies. | Federal resources on responding to bullying:  
• www.stopbullying.gov/respond/index.html  
• www.stopbullying.gov/prevention/training-center/index.html  
Information on anti-bullying policy:  
### What do we know from research?

| Youth who report frequently bullying others are at high, long-term risk for suicide-related behavior. |
| Youth who report both being bullied and bullying others (sometimes referred to as bully-victims) have the highest rates of negative mental health outcomes, including depression, anxiety, and thinking about suicide. |
| Youth who report being frequently bullied by others are at increased risk of suicide-related behaviors, and negative physical and mental health outcomes. |

### What can school personnel do?

| Provide support and referrals for all youth involved. Include their families. |
| Youth who act out through bullying others may be trying to fit in and/or reacting to stress, abuse, or other issues at home or school. Bullying behavior may be an important signal that they need mental health services and additional support. |
| • While punishment and appropriate consequences are often a necessary part of a school’s response, we must move beyond punishment and blame to set the tone for lasting prevention. |
| • The focus on blame, shame, and criminalization is divisive and can be a roadblock to getting youth and families the professional support that is needed to make a positive change and prevent future suffering. |
| Empower youth by providing concrete, positive, and proactive ways they can influence the social norms of their peer group so that bullying is seen as an uncool behavior. |
| Encourage more work on bystander approaches to violence prevention in general. |

### Where can I find more information?

**Federal resources on supporting youth involved in bullying:**

- [www.stopbullying.gov/respond/support-kids-involved/index.html#address](http://www.stopbullying.gov/respond/support-kids-involved/index.html#address)

**Federal resources for empowering bystanders:**

- [www.stopbullying.gov/respond/be-more-than-a-bystander/index.html](http://www.stopbullying.gov/respond/be-more-than-a-bystander/index.html)

**CDC’s Applying Science, Advancing Practice: The Bully-Sexual Violence Pathway in Early Adolescence**

Looking Ahead

There is a lot of concern, even panic, about the ongoing problem of bullying and suicide-related behavior among school-age youth. Much of the media coverage is focused on blame and criminal justice intervention rather than evidence-based, action-oriented prevention. Public health researchers are continually seeking a better understanding of the relationship between bullying and suicide-related behavior as well as the related risk and protective factors that affect young people. Increased awareness about what we do know, what we don’t know, and what information is most helpful and applicable to prevention is crucial to your schools’ efforts to protect students from harm.

The good news is that we do have evidence-based, actionable information to help prevent bullying and suicide. As teachers, administrators, and school staff you have a vital and rewarding role to play by getting the word out and encouraging colleagues and communities to take action.

Additional Reading


Waasdorp TE, Bradshaw CP, Leaf PJ. The impact of school wide positive behavioral interventions and supports on bullying and peer rejection: A randomized controlled effectiveness trial. *Archives of Pediatric Adolescent Medicine* 2012; 166:149-156.


www.cdc.gov/violenceprevention/suicide/definitions.html
www.stopbullying.gov/what-is-bullying/index.html
MOBILE APPS

**SAMHSA** has just launched a new free mobile app, Suicide Safe, to help health care providers (both physical and mental health) assist patients with suicidal ideation and behaviors. The app uses the SAFE-T model developed by Screening for Mental Health and the Suicide Prevention Resource Center. (SAFE-T stands for “Suicide assessment five-step evaluation and triage” and was designed for mental health professionals). For key App features: [http://store.samhsa.gov/apps/suicidesafe/index.html](http://store.samhsa.gov/apps/suicidesafe/index.html).

**MY3** is a safety planning app developed here in California by the Know the Signs campaign, Santa Clara County and a group of individuals with lived experience in suicidal behaviors and thoughts. It is available in English and in Spanish, and is designed for individuals who may experience suicidal crises to help them avert crises and practice self-care, as well as reach out for help. Included on [www.my3app.org](http://www.my3app.org) are a brief video, fliers and cards that can be downloaded and printed out, and a widget to add to your website.

Both apps are tools for providers to use with their clients but only MY3 is intended to be downloaded onto the patient’s phone. And patients should create their safety plan in partnership with a provider, therapist or counselor.

FACEBOOK

Facebook recently launched a platform for reporting posts from users who may be in suicidal crisis. You can flag a post as troubling, after which a dedicated team at Facebook will review the post and reach out to the individual. As the person who reported the post, you’re also given suggestions on how to best help a person in need or receive support for the emotional distress of encountering a friend or loved one who is suicidal. The process of flagging a post is simple, taking only a few taps or clicks. It's so simple, actually, there's no excuse for not using it when it's warranted:

- You start by flagging a post by clicking or tapping on the arrow in the top-right corner of the post.
- Select "I think it shouldn't be on Facebook."
- Select "It's hurtful, threatening or suicidal."
- Select "I think they might hurt themselves."

Read through the "What You Can Do" screen, which offers advice on how you can help a friend in need. At the bottom of that screen is the option to request Facebook look at the post. Alternatively, you can send a message to the friend, or to a mutual friend in an effort to help the person. When using the
Facebook tool, keep in mind that if you choose the option to have Facebook send the person a message of support, it will NOT be anonymous. The message will read as if it was sent by you.

There's also the option of chatting with a trained helper for advice on how best to move forward. If you are concerned about yourself or someone else, you can ALWAYS call 800-273-8255, from anywhere in the United States, to speak with a trained crisis volunteer.

There is a two minute video that explains the Facebook options: https://vimeo.com/120836430

**TEXTING**

Only a few years ago, few crisis centers offered texting options but increasingly, crisis texting options are available. Most are intended for teens. The following list is not comprehensive but covers the major services.

*Crisis Text Line* [text LISTEN to 741741] Offers support for teens 24/7 provided by trained volunteers and employees of crisis center partners. http://www.crisistextline.org/

*The Alex Project* [text ANSWER to 839863 or LISTEN to 741741]
http://www.alexproject.org/
Founded in northern California by a family after losing their teenage son to suicide, the Alex Project publicizes three different crisis text lines. You can order wallet cards that promote the Crisis Text Line and that have a QR code on them. Also on Facebook at https://www.facebook.com/pages/The-Alex-Project/147008955396851.

**839863** also responds to the word **SAFE** as promoted by the *Crisis Support Services* in Alameda County; this service is for teens and is currently offered from 4 – 11 p.m.

*Wellspace* operates the Suicide Prevention Crisis Line that serves 36 counties in northern California. They encourage texting **HOPE** to 1 (916) 668-4226 (iCAN).
http://www.wellspacehealth.org/suicide_prevention.htm

*San Francisco Suicide Prevention* promotes texting **MYLIFE** to 741741 for 24/7 support.

**CHAT**

Until recently, Lifeline chat services were available 12 hours a day, but now their website states 24 hours availability. They offer chat through **CONTACT USA** http://www.crisischat.org/

*San Francisco Suicide Prevention* offers 24 hour chat through their website http://www.sfsuicide.org/

*Other crisis centers* offer crisis chat through their websites although some operate only 12 hours daily. In most instances, phone lines are always available 24 hours, 7 days a week

*Santa Clara County SUICIDE AND CRISIS HOTLINE 24/7: 1 (855) 278-4204*
STAY CONNECTED TO YOUR SUPPORT NETWORK WHEN YOU ARE HAVING THOUGHTS OF SUICIDE.

CREATE YOUR SUPPORT SYSTEM
Simply add the contact information for people who know and care about you and can help when you are experiencing thoughts of suicide.

BUILD YOUR SAFETY PLAN
You can customize a safety plan by identifying your warning signs, coping strategies, distractions and personal networks to help keep yourself safe.

ACCESS IMPORTANT RESOURCES
Personalize MY3 by adding other suicide prevention resources and websites that help you feel better and stay safe. A number of different resources are also already listed in MY3.

If you need to talk to someone about your suicidal thoughts, please contact the National Suicide Prevention Lifeline at 1-800-273-TALK (8255). Trained counselors are available to provide free, confidential help, day or night.

Download MY3 for free on iPhone App Store or Google Play Store. Search for MY3-Support Network.

www.MY3App.org
HELP YOUR CLIENTS STAY CONNECTED TO THEIR SUPPORT NETWORK WHEN THEY ARE HAVING THOUGHTS OF SUICIDE.

CREATE A SUPPORT SYSTEM FOR YOUR CLIENTS
Simply add the contact information for people who can help your clients when they are experiencing thoughts of suicide.

HELP BUILD YOUR CLIENT’S SAFETY PLAN
Help customize their safety plan by identifying their warning signs, coping strategies, distractions and personal networks so they can stay safe.

ACCESS IMPORTANT RESOURCES
Help personalize your client’s MY3 by adding suicide prevention resources that help them feel better and stay safe. Resources are listed in MY3.

Visit www.MY3App.org to download materials and resources for your clients. Download MY3 on iPhone App Store or Google Play Store. Search for MY3-Support Network.
Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking. References and additional information can be found at: www.ReportingOnSuicide.org.

**IMPORTANT POINTS FOR COVERING SUICIDE**

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Suicide Contagion or “Copycat Suicide” occurs when one or more suicides are reported in a way that contributes to another suicide.

References and additional information can be found at: www.ReportingOnSuicide.org.

**INSTEAD OF THIS:**
- Big or sensationalistic headlines, or prominent placement (e.g., “Kurt Cobain Used Shotgun to Commit Suicide”).
- Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.
- Describing recent suicides as an “epidemic,” “skyrocketing,” or other strong terms.
- Describing a suicide as inexplicable or “without warning.”
- “John Doe left a suicide note saying...”.
- Investigating and reporting on suicide similar to reporting on crimes.
- Quoting/interviewing police or first responders about the causes of suicide.
- Referring to suicide as “successful,” “unsuccessful” or a “failed attempt.”

**DO THIS:**
- Inform the audience without sensationalizing the suicide and minimize prominence (e.g., “Kurt Cobain Dead at 27”).
- Use school/work or family photo; include hotline logo or local crisis phone numbers.
- Carefully investigate the most recent CDC data and use non-sensational words like “rise” or “higher.”
- Most, but not all, people who die by suicide exhibit warning signs. Include the “Warning Signs” and “What to Do” sidebar (from p. 2) in your article if possible.
- “A note from the deceased was found and is being reviewed by the medical examiner.”
- Report on suicide as a public health issue.
- Seek advice from suicide prevention experts.
- Describe as “died by suicide” or “completed” or “killed him/herself.”
**AVOID MISINFORMATION AND OFFER HOPE**

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses, that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90% of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information and advice that promotes help-seeking.

**SUGGESTIONS FOR ONLINE MEDIA, MESSAGE BOARDS, BLOGGERS & CITIZEN JOURNALISTS**

- Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies and procedures could support removal of inappropriate and/or insensitive posts.

**MORE INFORMATION AND RESOURCES AT:**

www.ReportingOnSuicide.org or the following local resources:

**HELPFUL SIDE-BAR FOR STORIES**

**WARNING SIGNS OF SUICIDE**

- Talking about wanting to die
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious, agitated or recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide but may not be what causes a suicide.

**WHAT TO DO**

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone
- Remove any firearms, alcohol, drugs or sharp objects that could be used in a suicide attempt
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK (8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

**THE NATIONAL SUICIDE PREVENTION LIFELINE**

800-273-TALK (8255)

A free, 24/7 service that can provide suicidal persons or those around them with support, information and local resources.