



SANTA CLARA COUNTY

# CHILD DEATH REVIEW

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



THREE-YEAR REPORT  
2010-2012



*Dedicated to the residents of Santa Clara County.*



# SANTA CLARA COUNTY CHILD DEATH REVIEW TEAM

## REPORT

Case Reports for Calendar Years 2010-2012

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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

In 2012, the Child Death Review Team reviewed the team's original mission statement and by-laws under the direction of the Chair. The following is our team's final consensus to reflect our role and dedication in serving the children of Santa Clara County (revised March 28, 2012):

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) 2010-2012 AND CURRENT MEMBERS

<b>Michelle Jorden, MD</b>	Assistant Medical Examiner, Neuropathologist - Current Chair	SCC Medical Examiner/Coroner's Office
<b>Louis Girling, MD</b>	Deputy Health Officer/CDRT- Former Chair	CCS/SHDP/MCAH
<b>Patrick Clyne, MD</b>	Pediatrician – Former Chair	
<b>Lynn Chamberlin</b>	CDRT Coordinator	SCC Public Health Dept. MCAH Program
<b>Emily Harrison</b>	Deputy County Executive	SCC County Executive
<b>Lisa Arieta-Hayes</b>	Supervising Social Worker	Legal Advocates for Children and Youth/Law Foundation of Silicon Valley
<b>Michelle Avila, Lt.</b>	Homicide Supervisor-Investigations	SCC Office of the District Attorney
<b>Brenda Carrillo</b>	Health and Safety Coordinator	SCC Office of Education
<b>James Randol</b>	Lieutenant	San Jose Police Department
<b>Alan Cavallo</b>	Lieutenant	San Jose Police Department
<b>Gwen Chiarmonte</b>	LCSW	Dept. of Family & Children's Services
<b>Donna Conom, MD</b>	Neonatologist	Good Samaritan Hospital
<b>Margaret Ledesma</b>	Hospital Liaison for SCC MHD	RAIC Mental Health Clinic
<b>David Lera, Lt.</b>	Office of the Sheriff, Administration	SCC Medical Examiner/Coroner's Office
<b>Linda Melody Alves</b>	LCSW	Kaiser Permanente/Perinatology Dept.
<b>Dan Lloyd</b>	Health Care Program Manager II	Child, Family & Community Services Division/Dept. Of Alcohol & Drug Services
<b>Anne Marcotte, RN, MSN</b>	Specialty Programs Nurse Coordinator	SCC EMS
<b>Sandy Knight</b>	Program Manager	Community Care Licensing-Child Care
<b>Kelly Mason</b>	RN	Valley Medical Center/Main Jail
<b>Robert Masterson</b>	Deputy DA (Retired)	SCC Office of the District Attorney
<b>Paula McAllister</b>	Sergeant	SCC Office of the Sheriff
<b>Michael Cuevas</b>	Detective	SCC Office of the Sheriff
<b>Cindy DeNoyer-Greer</b>	Supervising Probation Officer	SCCO Probation Department
<b>Jim Gaderlund</b>	Clergy	Foothill Covenant Church, Los Altos
<b>Steve Dick</b>	Supervising Deputy District Attorney	Office of the District Attorney
<b>Barbara Mordy</b>	Regional Manager	Dept. of Social Services, Child Care Program

<b>Sarah Scofield, LCSW</b>	Director	Family Court Services, Santa Clara Superior Court
<b>Jennifer Kelleher</b>	Directing Attorney	Legal Advocates for Children and Youth
<b>Nathan Thomas</b>	Supervising Social Worker	Legal Advocates for Children and Youth
<b>John Stirling, MD</b>	Director, Center for Child Protection	Santa Clara Valley Medical Center
<b>Saul Wasserman, MD</b>	Child Psychiatrist	Private Practice-Santa Clara County
<b>Jonathan Weinberg</b>	Social Services Program Manager III	Dept. of Family & Children's Services
<b>Brian Welch</b>	Supervising Deputy District Attorney	Office of the District Attorney
<b>Melody Kinney, LCSW</b>	Director, Medical Social Services	Good Samaritan Hospital
<b>Todd Saretsky</b>	Epidemiologist	SCC Public Health
<b>Nicole Steward, MSW</b>	Vice Chair of Administration	Child Abuse Council of Santa Clara County
<b>Melissa Egge, MD</b>	Pediatrician, Center for Child Protection	Santa Clara Valley Medical Center
<b>Kiersten Wells</b>	CPNP	LPCH/PICU
<b>Guests</b>		Community, county agencies, rotating Resident physicians from Valley Medical Center and Stanford University Medical Center
<b>Theresa Bovey</b>	MDT Coordinator	Santa Clara County Office of Education
<b>Sara Copeland, MD</b>	Assistant Health Officer	Public Health Department
<b>Michael Kihmm, Lt</b>	Lieutenant	San Jose Police Department
<b>Annie Liu</b>	MFT	County Commissioner Child Abuse Council
<b>Mini Luna</b>	VAP Coordinator	YWCA Silicon Valley
<b>Eric Maciel</b>	Detective	Santa Clara County Office of the Sheriff
<b>Carol Marcroft</b>	Regional Manager	Community Care Licensing-Child Care
<b>Paula McAllister</b>	Sgt.	Santa Clara County Office of the Sheriff
<b>Fabian Monge</b>	Detective	Sunnyvale Department of Public Safety
<b>Andrea Flores Shelton</b>	Manager	Injury and Violence Prevention, Public Health Department
<b>Myrna Zendejas</b>	CSH Outreach Specialist	Santa Clara County Office of Education
<b>Mark Eastus, Captain</b>	Office of the Sheriff, Administration, Retired, Past member	Santa Clara Medical Examiner/Coroner Office
<b>Rikki Goede</b>	Past member	Current Piedmont Police Chief and former Assistant Chief for San Jose Police Department

## 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 17 years of age) reported to the Medical Examiner/Coroner's Office<sup>1</sup>. 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 sign-up 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. Over the past couple of years, our team has strategized educational forums in the form of press releases and teaching modules (enclosed) 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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<sup>1</sup> Refer to end of this report for "Deaths Reportable to the Coroner".

# EXECUTIVE SUMMARY

## Team Membership

The Santa Clara County Child Death Review Team (CDRT) reviews selected child deaths, 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
- 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-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 17 years of age) 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 approximately 22% of the deaths of all children during the 2010-2012 period.

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.<sup>2</sup> 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.

The Medical Examiner-Coroner Office suffered the loss of one of their pathologists and created a substantial backlog thus delaying the generation of this report. This report encompasses all CDRT cases who died during 2010 through 2012 period.

In 2010, 28 child deaths met criteria for review by the Child Death Review Team. We reviewed 24 in 2011 and 26 in 2012. For the past three years, the team has reviewed an average of 26 cases per year.

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<sup>2</sup> Refer to end of this report for "Classifications of Death".

## KEY FINDINGS

### Sleeping

#### Sudden unexplained infant death is rare in Santa Clara County!

Of the 33 infant deaths (age <1 year old/<12 months old) occurring during the 2010-2012 period that were reviewed, there were 20 infant deaths<sup>1</sup> that occurred either due to unsafe sleep practice (overlay, etc.) (n=8) or in an unsafe sleep environment (n=12). This number does not include stillborn deaths and one death in which the incident happened in another county but the death was pronounced in Santa Clara. 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 7 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.**<sup>2</sup> 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. 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 down) with the face pressed into the couch or bed pillows. **Two (2) of the suffocation deaths occurred using a "Boppy pillow"™ (a doughnut-shaped nursing pillow) inappropriately despite the warning labels on the product.** 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

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<sup>1</sup> There are two more unsafe sleep related deaths during 2010-2012 period. These were among children 1-2 years of age.

<sup>2</sup> This data is based on the CDRT conclusion and does not reflect Medical Examiner's assigned manner of death for these cases.

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)<sup>3</sup>. In 2010-2012 Santa Clara County had two (2) cases 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 5 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<sup>4</sup>. The team collaborated with First 5 in 2011 to launch a public awareness campaign to educate the community about safe sleep (please refer to appendices for educational materials). Safe Sleep trainings were performed between July 2012 and September 2012 by Dr. Michelle Jorden Assistant Medical Examiner in conjunction with Lynn Chamberlin SIDS Coordinator. The Medical Examiner has educated approximately 300 Social Services workers in July 2012, 65 county professionals in September 2012, presented her data on a national level at the National Association of Medical Examiners meeting in August 2011, and invited as a guest speaker to present her data to the Child Abuse Council in Santa Clara and Grand Rounds at Valley Medical Center and Good Samaritan Hospital.

A survey was performed post training to see if this subject was understood and if participants would incorporate safe sleeping practices into their practice. A total of 92 individuals responded to the survey which broke down into the following percentages; 61 respondents (66%) were social workers, 19 (21%) were Public Health Nurses, 5 (5%) were Registered Nurses, 4 (4%) were Public Health Assistants, 2 (2%) were Health Education Specialists and 1 respondent (1%) was a Santa Clara County Counsel Attorney. Eighty-six respondents (93%) correctly responded that infants should be placed on their backs when being put to sleep. All of the respondents (100%) were aware that pillows were not safe to lay a baby down to sleep on; that bed sharing was not promoted as safe sleeping practice; and that stuffed animals were not alright to have in the crib as they pose an unsafe sleep environment for the child. All of the survey respondents felt that they understood the principles of Safe Sleep after the training and hoped to incorporate these principles into their trainings by sharing information and materials with clients or staff members.

In April 2013, Dr. Michelle Jorden Assistant Medical Examiner and Lynn Chamberlin SIDS Coordinator represented the CDRT at the Child Abuse Council Forum and supplied pins,

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<sup>3</sup> Centers for Disease Control and Prevention, August 9, 2013.

<sup>4</sup> American Academy of Pediatrics Expands Guidelines for Infant Sleep Safety and SIDS Risk Reduction, released 10/18/2011.

magnets and other educational materials to the attendees to keep the issue of safe sleep abreast among county employees working with families as well as the general public.

The Medical Examiner in collaboration with First 5 created a short educational video emphasizing the correct placement of an infant to sleep and can be viewed on the First 5 website.

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](http://www.first5kids.org))
- Santa Clara County Public Health Department ([www.sccphd.org](http://www.sccphd.org))
- Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov))

The team recommends and continues 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 post natal visits, pediatric office visits, daycare provider educational programs, child care/babysitter training in middle and high school and all parent training programs. The Santa Clara County Medical Examiner and Public Health Department along with CDRT are currently conducting outreach studies to the local birthing hospitals 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.

CDRT has recognized the need 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 are currently being sent to families as part of a pilot study, 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](http://www.firstcandle.org/grieving-families))
- HAND: Stands for "Helping After Neonatal Death of the Peninsula" ([www.handsupport.org](http://www.handsupport.org))
- Centre for Living With Dying ([www.billwilsoncenter.org/services/all/living.html](http://www.billwilsoncenter.org/services/all/living.html))
- The Compassionate Friends ([www.compassionatefriends.org](http://www.compassionatefriends.org))

The team as well as the Medical Examiner prefers 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 2010-2012. One (1) youth completed suicide in 2010, four (4) in 2011, and four (4) in 2012. The most common methods used were hanging (4) and firearm (2) over this three-year period.** In the remaining cases, we observed other interesting methods of suicide among youth. In one (1) case, a sixteen year old female committed suicide by inhalation using carbon dioxide with the scene investigation revealing an elaborate setup using a fish tank. In another case, a seventeen year old female committed suicide by thermal and inhalational injuries after setting her bedroom on fire. Lastly, in another case a fifteen year old committed suicide by sustaining multiple blunt force injuries in an intentional motor vehicle accident.

Case review by the CDRT is not inherently designed to determine the 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 2010-2012 reporting period, two (2) children were killed by their parent.** One baby suffered fatal head injuries at the hand of a parent in 2010 and one baby was asphyxiated with a plastic bag being placed over his head at the hand of his biological mother in 2011.

There is one (1) child death due to homicide by a relative. A particularly horrific form of domestic violence is family annihilation. In 2011, one teenager suffered multiple gunshot wounds at the hand of her brother; a veteran suffering from PTSD (posttraumatic stress disorder). The gunman then killed himself. He also killed their biological mother who was found days later with multiple gunshot wounds.

## Homicide by a Non-Relative

Three (3) teen boys ages 15, 16 and 17 years were killed by firearms by non-family members in 2011 and 2012. A 14-year-old girl was shot while sitting outside on a friend's lawn in 2011. A 15-year-old was stabbed in 2010. A 14-year-old boy was severely beaten in a park by multiple people striking and kicking him sustaining massive blunt force injuries to the head. Finally, one toddler died of asphyxia due to probable forced oral copulation in 2012 and is in the midst of prosecution at the time of this writing.

## Accidental Deaths

**Fourteen (14) cases were classified as accidental in the 2010-2012 reporting period.** Motor vehicle collisions, resulting in the death of a passenger, a pedestrian, or a cyclist, account for the majority of cases. Seven (7) children<sup>5</sup> and teenagers were involved in motor vehicle accidents. Of these, two (2) cases involved children being accidentally struck by a

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<sup>5</sup> One of the motor vehicle related deaths was a suicide.

parent/caregiver driving a motor vehicle. There was one (1) case in 2010 involving a toddler who died of compressional asphyxia when a large tree uprooted and fell onto the cab of the truck trapping the child and his parents for three hours. In one (1) case during 2012, a 4-year-old child died along with her grandparents in an apartment fire. One (1) toddler, aged 3-years-old in 2012, gained access to his father's Glock firearm then shot himself in the head. Upon review of this case by CDRT, it was determined the death was due to parental neglect. The numbers reported under this category do not include accidental infant suffocations observed as unsafe sleep during 2010-2012.

## Drowning

**We reviewed the drowning deaths of three (3) children in the 2010-2012 period.** One child died of complications of persistent vegetative state from a near drowning in 2010. A 21-month-old toddler died in 2011 and a three-year-old toddler died in 2012. These numbers do not encompass one (1) other child who died in Santa Clara County but whose case fell under the jurisdiction of San Mateo County, the details were discussed in that county's CDRT. 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.

## Ecstasy, County Launch of Educational Program in January 2012:

In 2010, the team reviewed a case of a 16-year-old female who died from Ecstasy intoxication. Shortly thereafter, the county observed other deaths in young adults from Ecstasy intoxication and in a few cases, Ecstasy-associated hyponatremia. **In Santa Clara county from 2010-2011, Ecstasy was the third most commonly abused drug next to alcohol and marijuana and ¼ teenagers had at least tried Ecstasy (Data collected by the Department of Alcohol and Drug Services).** Given these alarming statistics and the deaths observed, during 2010-2012, the Medical Examiner, a representative of the DEA and the Department of Alcohol and Drug Services partnered together to educate the county about the dangers of using Ecstasy with the support of the CDRT. We presented to over 1,000 people in the county including various county facilities, Juvenile Hall, Emergency Medical Services, Fire Department, national presentation of data in Chicago, IL in 2011 and the Child Abuse Symposium. Larry Silveria helped produce an educational DVD about the danger of Ecstasy and also composed an original song named "POP". This DVD was then distributed to all the middle and high schools in Santa Clara County. The continued accomplishments of this project include:

- A copy of the DVD was presented to the Obama Administration in Washington D.C.
- The DVD is housed in the State of California Library.
- National recognition for the county's work on addressing the dangers of Ecstasy.
- A similar copy of the video filmed in Canada.
- Widespread attention of the topic by the local area news media.

## CHILD DEATH REVIEW TEAM RECOMMENDATIONS

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

### Safe Sleeping

In the first year of an infant's life, all parents and caregivers should ensure that the infant's sleeping environment is made as safe as possible. 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 from the sides to be 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.

### 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.** 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

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.**

## STATISTICS

**TABLE 1. CHILD DEATHS REVIEWED BY THE CHILD DEATH REVIEW TEAM COMPARED TO ALL SANTA CLARA COUNTY CHILD DEATHS, 2010-2012**

Year	Child deaths reviewed	Santa Clara County total child deaths*
2010	28	103
2011	24	117
2012	26	128
<b>Total</b>	<b>78</b>	<b>348</b>

Source: Santa Clara County Child Death Review, 2010-2012; Santa Clara County Death Statistical Master File 2010-2012

\* Only includes deaths to residents of Santa Clara County

**TABLE 2. DEMOGRAPHICS OF CHILD DEATHS REVIEWED BY THE CHILD DEATH REVIEW TEAM**

Sex	Count	Percent
Female	35	45%
Male	43	55%
Age groups		
Less than 1 year	33	42%
1-4	17	22%
5-11	7	9%
12-17	21	27%
<b>Total</b>	<b>78</b>	<b>100%</b>

Source: Santa Clara County Child Death Review, 2010-2012

**TABLE 3. CHILD DEATHS BY MANNER AND CAUSE OF DEATH, 2010-2012**

	Manner and cause of death	2010	2011	2012	Total
A.	Homicide	2	3	5	10
	1. By parent	1	1	0	2
	2. Third Party or caretaker	1	2	5	8
B.	Abuse related	0	0	1	1
C.	Neglect	0	0	1	1
	By parent/caretaker	0	0	1	1
D.	Inadequate Caretaking	10	6	6	22
	1. Co-sleeping	5	2	2	9
	2. Unsafe sleep surface	5	4	4	13
E.	Non-Maltreatment	16	15	14	45
	1. Natural (non-SIDS)	5	9	5	19
	2. SIDS	1	0	1	2
	3. Accident	8	2	4	14
	4. Suicide	1	4	4	9
	5. Adolescent High Risk Behavior	1	0	0	1
F.	Fetal Deaths	2	1	0	3
	1. Undetermined	1	1	0	2
	2. Known maternal drug use	1	0	0	1

Source: Santa Clara County Child Death Review, 2010-2012  
 Note: Numbers do not add up to total death count (n=78).

**TABLE 4. CHILD DEATHS RESULTING FROM INJURIES, 2010-2012**

Mode of injury	2010	2011	2012	Total
Motor vehicle and other transport	4	1	3	8
Drowning	1	1	1	3
Suffocation or strangulation	2	3	2	7
Weapon, including body part	1	4	4	9
Fire, burn, or electrocution	0	0	2	2
Other	1	0	1	2
<b>Total</b>	<b>9</b>	<b>9</b>	<b>13</b>	<b>31</b>

Source: Santa Clara County Child Death Review, 2010-2012

**TABLE 5. CHILD DEATHS FROM A MEDICAL CONDITION, 2010-2012**

Medical conditions	2010	2011	2012	Total
Pneumonia	3	3	2	8
Other infection	0	4	0	4
Cardiovascular	0	1	0	1
SIDS	1	0	1	2
Other perinatal condition	3	1	0	4
Other medical condition	1	0	2	3
Diabetes complications	0	0	1	1
<b>Total</b>	<b>8</b>	<b>9</b>	<b>6</b>	<b>23</b>

Source: Santa Clara County Child Death Review, 2010-2012

# SAFE SLEEP INITIATIVE

**THIS IS DEADLY!**



## Public Awareness Materials



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

[www.first5kids.org](http://www.first5kids.org)



KEEP ME ALIVE TO THRIVE!

Image courtesy of the Back to Sleep Campaign, NCHD, NIH, DHHS

**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.sccphd.org](http://www.sccphd.org)

## Safe Sleep Campaign Press Conference, December 2011



# ECSTASY INITIATIVE



American Academy of Forensic Sciences 63rd Scientific Meeting, February 2011

## SANTA CLARA COUNTY LAUNCHES ECSTASY PREVENTION INITIATIVE

NEWS CONFERENCE    JANUARY 17, 2012, 10:30 A.M.

**SUPERVISOR LIZ KNISS**  
COUNTY OF SANTA CLARA  
BOARD OF SUPERVISORS

**MARTY FENSTERSHEIB, M.D.**  
SANTA CLARA COUNTY HEALTH  
OFFICER

**MICHELLE A. JORDEN, M.D.**  
SANTA CLARA COUNTY  
ASSISTANT MEDICAL EXAMINER

**STEPHEN BETTS**  
DEPARTMENT OF ALCOHOL &  
DRUG SERVICES, PREVENTION  
DIVISION

FEATURING THE DOCUMENTARY FILM:

### ECSTASY: LIVES OUT OF BALANCE

**"E"nough Gazette**

**Issue 1, 09/14/2010**

**Hello to All,**  
Well it has been a month since Bryan and I presented to you on teen use of ecstasy. We will keep this newsletter to a maximum of two pages.

As promised we are reporting back to you with updates on this evolving issue. Of interest is that with less than 30 days notice for our first workshop on August 12<sup>th</sup>, over 225 people like you attended that workshop. Thank You

All those who requested that I email a copy of my report should have received it by now. If you did not please email me. (See end of newsletter.)

**Post Cards**  
We have just mailed the post cards you completed as a reminder of your commitment to help teens combat their use of Ecstasy.

Bryan and I were amazed at how diverse your responses were. They included your intentions to convince professionals from many disciplines including school principals, youth organizations, the

media, and Hispanic and Vietnamese communities as to the urgent intervention needed to address this issue.

**Further Review of the Literature**  
Bryan and I continue to scour the literature for anything that may help shed light on the growing use of ecstasy, it's effects, and ways to prevent and intervene. Just a few highlights include:

**Pregnancy and Ecstasy**

Some of you wanted to know about the effects of MDMA on women who take Ecstasy during pregnancy.

The U.K. National Teratology Information Service conducted a prospective follow-up study on 78 infants whose mothers had used ecstasy during pregnancy (McElhatton et al. 1999). There was a significantly higher rate of congenital anomalies (15.4% in these women) than expected in the general population (2-3%).

**MDMA & BZP: Synergistic Effect**  
There is evidence to show that these two substances,

"work together" to create physiological problems.

Fatalities with recreation use of BZP with MDMA have been reported in Sweden, Zurich, and sudden death in the United Kingdom. These reports raise further concerns about toxic synergism from these drugs.

**Is MDMA-Related Toxic Dose Dependent?**  
High dose is only one of several risk factors. Serious adverse reaction or death have occurred after modest amounts and in absence of known risk factors

**Exposure:** In one review those interviewed that use more than 11 tablets (lifetime) were 17.4 times more likely to experience psychiatric problems.

**Environmental:** The lethality of MDMA is increased almost five-fold when mice are group housed. Researchers suggest this is due to the stress from a novel physical and social environment. Raves?

Other probable risk factors include: Exercise, dehydration, over hydration, hot or humid settings and other factors  
♦♦♦♦♦♦

**Is it Really an Epidemic?**  
John Murray Last MB, MD, MPH, editor of *The Dictionary of Epidemiology*



Final Santa Clara County Ecstasy Workshop, March 2012

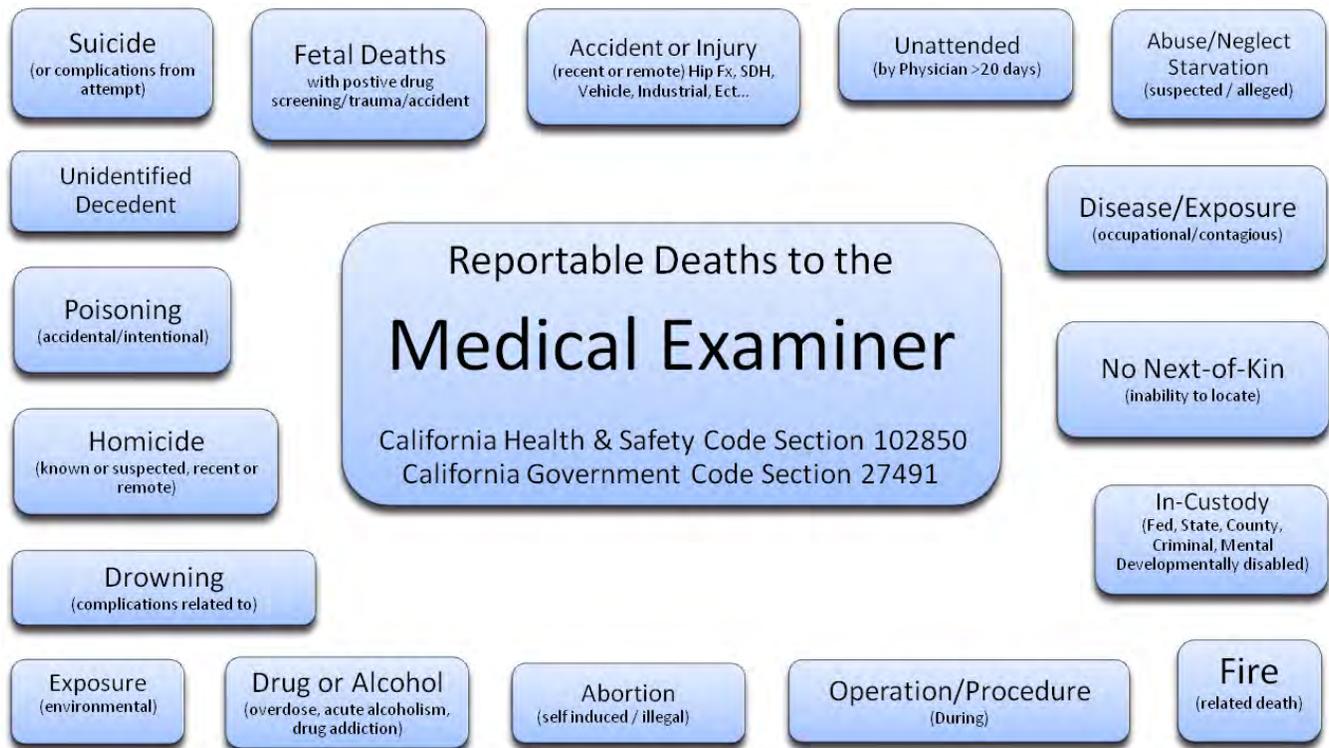
## ACKNOWLEDGEMENTS

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 Christina Pantoja, Medical Examiner-Coroner Investigator for her efforts in creating and maintaining the data of infants succumbing to unsafe sleep practices. We would like to thank the Medical Examiner-Coroner's Office staff for their assistance prior to each CDRT meeting. Finally, we also would like to thank Amy Cornell from the Public Health Department for 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).
9. Poisoning (food, chemical, drug, therapeutic agents).
10. All deaths due to occupational disease or injury.
11. All deaths in operating rooms.
12. All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room, or elsewhere.
13. All solitary deaths (unattended by a physician, family member, or any other responsible person in period preceding death).
14. All deaths in which the patient is comatose throughout the period of a physician's attendance, whether in home or hospital.
15. All death of unidentified persons.
16. All deaths where the suspected cause of death is Sudden Infant Death Syndrome (SIDS).
17. All deaths in prisons, jails, or of persons under the control of law enforcement agency.
18. All deaths of patients in state mental hospitals.
19. All deaths where there is no known next of kin.
20. All deaths caused by a known or suspected contagious disease constituting a public health hazard, including AIDS.
21. All deaths due to acute alcoholism or drug addiction.



## CLASSIFICATION OF DEATH, SANTA CLARA COUNTY CHILD DEATH REVIEW

- A. **Homicide:** Death ruled a homicide, either by the Medical Examiner's report or criminal investigation.
  1. Abuse by parent/caretaker
  2. Third Party
- B. **Abuse Related:** Death secondary to documented abuse (e.g. death occurs several years following brain damage due to abuse; suicide in a previously abused child).
- C. **Neglect Related:** Death clearly due to neglect, supported by the Medical Examiner's report or criminal investigation.
  1. Neglect by parent/caretaker
  2. 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.)
  3. Failure to provide for basic needs (i.e., medical neglect)
  4. 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. No known child abuse or neglect
  - b. Current child abuse or neglect
  - c. History of child abuse or neglect
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. Motor vehicle misuse

#### E. Undetermined

1. Suspicious or Questionable Factors: No findings of 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, 2010-2012**

<b>All Ages</b>			
	<b>2010</b>	<b>2011</b>	<b>2012</b>
<b>Male</b>	895,848	906,488	918,009
<b>Female</b>	890,581	900,393	910,588
<b>Total</b>	1,786,429	1,806,881	1,828,597
<b>Children 0-17 years of age</b>			
<b>Male</b>	220,429	221,988	224,497
<b>Female</b>	209,909	210,616	211,951
<b>Total</b>	430,338	432,604	436,447
<b>Births</b>			
	23,936	23,652	28,819

Source: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013, Santa Clara County Birth Statistical Master Files, 2010-2012.

*Note: The children pictured on the cover of this report are alive and well.  
We are dedicated to preserving the lives and safety of all the children of Santa Clara County.*

