Santa Clara County
Child Death Review

2006-2007
Report

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Released April 2009

Santa Clara County Board of Supervisors

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MISSION STATEMENT

It is the mission of the Santa Clara County Child Death Review Team (CDRT) to review the causes and circumstances of the deaths of children that occur within Santa Clara County.

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

SANTA CLARA COUNTY
CHILD DEATH REVIEW TEAM MEMBERS

Dolores Alvarado	Division Director	SCC Public Health
Michelle Avila, Lt.	Homicide/Sexual Assault Division	SCC District Attorney's Office
Joaquina Bird	Supervising Probation Officer	SCC Probation Dept. Juvenile Division
Sunny Burgan, LCSW	Social Work Supervisor (Dependency Invest.)	Social Services Agency Dept. of Fam. & Children's Services
Joyce Chung, MPH, PhD	Epidemiologist	SCC Public Health Dept, EMS Agency
Patrick Clyne, MD CDRT Co-Chair	Forensic Pediatrician	Santa Clara Valley Med. Ctr. Dept. of Pediatrics
Michael Cuevas	Deputy Sheriff	SCC Children's Shelter
Margit David, LCSW	Social Work Supervisor (Emergency Response)	Social Services Agency Dept. of Fam. & Children's Services
Mark Eastus, Lt.	Sherriff's Office	SCC Medical Examiner/Coroner's Office
JR Gamez, Lt.	Homicide Unit	San Jose Police Department
Jim Gaderlund	Clergy	Foothill Covenant Church
Louis Girling, Jr., MD	Deputy Health Officer	SCC Public Health Dept. CCS/CHDP/IZ
Rikki Goede, Lt.	Homicide Unit	San Jose Police Department
Michelle Jorden, MD	Asst. Med. Examiner	SCC Medical Examiner/ Coroner's Office
Melody Kinney, LCSW	Social Worker	Good Samaritan Hospital

Carl Lewis	Senior Criminal Investigator	SCC District Attorney's Office
Dan Lloyd	Health Care Program Manager	SCC/DADS Child, Family & Community Services
Anne Marcotte, RN MSN	Quality Improvement	SCC Public Health Dept. EMS Agency
Linda Martinez, RN PHN CDRT Coordinator	Child Abuse Prevention Specialist	SCC Public Health Dept. MCAH Program
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Robert Masterson	Supervising Dep. D.A. (Dependency)	SCC District Attorney's Office
Barbara Mordy	Regional Manager	State Of California Dept. of Social Services, Child Care Community Care Licensing
Daniel Nishigaya	Supervising Dep. D.A. (Criminal)	SCC District Attorney's Office
Ginny Raschella	Psych. Social Worker	SCC Children's Shelter Mental Health
Sarah Scofield	Senior Mediator	SCC Family Court Services
John Stirling, MD	Director	Center for Child Protection
David Walters	Safe & Drug Free Schools	SCC Office of Education
Saul Wasserman	Child Psychiatrist	Child Psychiatry
Jonathan Weinberg, MSW	Social Services Program Manager	Social Services Agency Dept. of Family & Children's Services

BACKGROUND

In 1988 California enacted legislation that allowed the development of interagency child death 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 (CDRT) was formed in response to this legislation.

The CDRT is a professional multidisciplinary collaborative body that is guided by agreed upon goals and objectives. Its primary purpose is to provide professional review of unexpected deaths of children less than 18 years of age that are reported to the Medical Examiner/Coroner's Office[1]. Due to the sensitivity of the material discussed, confidentiality is maintained pursuant to Penal Code Section 11167.5.

Legislation enacted in 1997, required the State Department of Social Services to collect data related to the investigations conducted in child deaths. These data, provided by child death review teams and child protective agencies, are maintained in order to identify deaths occurring in high risk family situations and to 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 this committee are intended to prevent child deaths and the repetition of death in a family. The purpose of the team is to provide prompt, planned, coordinated multidisciplinary response to child fatality reports, and to review previous interventions from information developed by the analysis of data gathered from the reports of such deaths.

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

EXECUTIVE SUMMARY

The CDRT reviews selected child deaths to determine ways to prevent further injuries and deaths, improve responses to the needs of our children, and improve interagency collaboration. The multidisciplinary CDRT members are composed of designated representatives from:

- Santa Clara County Public Health Department's Maternal Child and Adolescent Health Program and California Children's Services
- Santa Clara Valley Medical Center, Department of Pediatrics
- Santa Clara County Medical Examiner/Coroner's Office
- Santa Clara County Social Services Agency, Family and Children's Service Child Protective Services
- Santa Clara County Family Court Services
- Santa Clara County Department of Alcohol and Drug Services Children Family & Community Services
- Santa Clara County District Attorney's Office.

Additional CDRT members include representatives from the State of California Child Care Program, Child Psychiatry, Good Samaritan Hospital, San Jose Police Homicide Unit, and Sunnyvale Department of Public Safety.

Child deaths (birth through <18 years of age) reported through the Santa Clara County Medical Examiner/Coroner's Office are selected for CDRT review based on unexpected and suspicious factors. Natural medical deaths may be brought before the team if compelling reasons are found to further investigate the case. Prior to each meeting, selected CDRT members receive record check information of each child death. Each member researches their own agency's files for additional information on the child and his/her family. All of the information is then brought to the monthly CDRT meeting for disclosure, compilation discussion review and classification[2]. The CDRT classifications may differ from the official manner of death as determined by the medical examiner/coroner. A course of action is determined once the review is complete. Options include keeping the case open for further review, referring the parties for additional services, closing the case, or formulating prevention-based recommendations.

There were 84 child deaths that occurred in 2006 and 2007 that met criteria for review by the Child Death Review Team, and there were 39 cases in 2006 and 45 cases in 2007. Most children were under one year of age (49% of the total). CDRT classifications of death as well as information regarding race, ethnicity, zip code, and extenuating circumstances are included in this report.

Recommendations adopted by the Child Death Review Team are included in this 2006-2007 report. Areas of particular concern continue to be the number of preventable deaths that occur as a result of inadequate supervision and pool safety. Co-sleeping and safe sleep environments emerge as issues in deaths under one (1) year of age.[2]

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

KEY FINDINGS

The Child Death Review Team reviewed 84 cases of child deaths that occurred in 2006-2007 in Santa Clara County. In the past, the child deaths reviewed by the CDRT have constituted about 25% of all child deaths in the County.

Demographics
Among the child death cases reviewed, there were significantly more males (59) than females (25). Nearly 50% (49) of the child death cases reviewed were younger than age one. The racial/ethnic breakdowns of the reviewed cases were Hispanic (42%), White (23%), and Asian/Pacific Islander (21%). Santa Clara County's overall racial/ethnic breakdown[3] consists of 42% White, 26% Hispanic, and 28% Asian/Pacific Islander. The child's parents were first generation immigrants in nine cases. Parent's immigration information was unknown in 67% of the cases. Most deaths occurred at the child's home (50%). A large percent of deaths also occurred on roadways (17%). Throughout the County of Santa Clara, the city of San Jose had the highest number of child deaths (62).

Child Death Review Classifications
In 2006 the common cause of child deaths reviewed were classified as Natural Medical deaths (33%). Fifteen percent of the deaths were classified as accidents and 15% were due to Inadequate Caretaking Skills. However, in 2007 the most common cause of child deaths reviewed were classified as Homicide deaths (22%), followed by Natural Medical (20%) and Inadequate Caretaking Skills (20%). Also, there were more suicides in 2007 than in 2006. [4]

Since 2001, there has been an increase in those deaths classified as due to Inadequate Caretaking skills and Adolescent High Risk Behavior; and there have been declines in deaths classified as Accidents and Natural Medical.

Sleeping
Of the 41 infant deaths (age <1), 25 cases (61%) occurred in an unsafe sleeping environment. In the 17 cases in which information was provided regarding how the child was put to sleep, two were put to sleep on the back, six were on the stomach, and seven were on the side. When the infant deaths were discovered, two were found on their backs, six on their stomachs, and four on the side. In 2006, half the infant sleeping deaths occurred in an adult bed. Objects or persons that were found in the sleeping area when the child was found included: adults (8), pillows (7), mattress (2), blanket (1), and wall (1).

Places where Sleeping Infant Deaths Occurred, 2006-2007

	Frequency	Percent	Frequency	Percent
	2006		2007	
Adult Bed	7	50%		

[3] Refer to end of this report for "Santa Clara County Demographics".
[4] It should be noted that the majority of child deaths due to Natural Medical causes are not Medical Examiner cases, and are therefore not reviewed by the Child Death Review Team.

Crib/Bassinette	3	21%	5	45%
Air Mattress/Futon	3	21%		
Car seat/stroller	1	7%		
Chair			1	9%
Other			2	18%
Unknown			3	27%
Total	14		11	

Motor Vehicle Traffic Incidents

Motor vehicles were involved in fourteen (14) child deaths. These 14 child deaths consisted of five pedestrians, one bicyclist, seven passengers, and one driver. Factors that were involved in these incidents were: reckless driving (5), speeding over the speed limit (4), drug and alcohol use (2), inadequate lighting (2), unsafe speed for conditions (2), poor weather, medical event (1), driver distraction (1), cell phone use while driving (1), poor tires (1), and other (3). In three of the deaths, the lap and shoulder belts were present, but not used.

Drowning

There were five drowning deaths in the two years. In 2006, all three drowning deaths occurred in swimming pools. In 2007, one drowning death occurred in the pool Jacuzzi and the other death at an amusement park wave pool. Three of the children had been in the water before they drowned, and one was poolside. In the pool deaths, none of the children were using a flotation device and in three cases, a fence surrounded all sides of the pool and a gate was present. However the door/gates were left open in two situations.

Drug and Alcohol Use

In the two years, there were seventeen deaths in which the teen (age 15-17) had a history of substance abuse.

In 2006, four (4) intrauterine fetal demises occurred due to maternal drug (methamphetamine) use. Fetal deaths were not included in CDRT review and therefore, not included in the statistics of this report.

Child Maltreatment

In 40% (34) of the child deaths, the Child Death Review Team assented that an act of omission (child neglect/negligence) or act of commission (child abuse) directly caused or contributed to the death. There were five instances of child physical abuse, three instances of child neglect or negligence, four instances of assault (not considered child abuse by the primary caregiver), seven instances of poor/absent supervision, four suicides, one instance of medical misadventure, and two unknown. Of these acts, twelve were considered intentional. In three child deaths, there were two deaths due to Shaken Baby Syndrome, one Chronic Battered Child Syndrome, and another to drug overdose.

Suicide
There were four teen suicides; three teens were between age 15-17 and one teen was between age of 10-14. Two of the suicides were conducted by hanging and two involved firearms. In 2007, all the suicides were in male teens; two of the teens had previously known suicide ideations and attempts.

Gang Related
Gang activity took the lives of six teens. Of the gang-related homicides, three were stabbings, one was a random drive by shooting, and another was due to unrestrained falling from a moving vehicle. One suicide mentioned that a gang relation existed which was thought to be getting more violent in nature.

In 2008, the 13th annual list of safe cities based on the crime rates per 1,000 people, CQ Press gave San Jose top honors as the safest big city in America. San Jose has finished on top of the safest big city list for six consecutive years.

CHILD DEATH REVIEW TEAM RECOMMENDATIONS

The focus of Recommendations is the reduction of the most identified factors associated with preventable deaths. Over the past twenty years, the Santa Clara County CDRT has worked diligently to improve the manner in which preventative services can be initiated through early identification of children at risk.

Safe Sleeping

Continue education regarding safe sleep environment to parents and caregivers.

Identify hazards that may result in entrapment or suffocation accidents.

Emphasize Back to Sleep, placement of infants in cribs or bassinets approved by the Consumer Product Safety Commission (CPSC), moving the crib or bassinet closer to the caregiver bed, and discouraging co-sleeping with infants.

Pool Safety

Encourage diligent supervision of children at or near pool sites to reduce accidents or drowning. The lack of adequate supervision and the lack of fencing the pool perimeter were the most frequently identified factors associated with this preventable childhood death.

STATISTICS

Child Deaths Reviewed by the Child Death Review Team Compared to All Santa Clara County Child Deaths, 2001-2007
(Child Deaths are defined as deaths age < 18 years)

Year	Child Deaths Reviewed	Santa Clara County Child Deaths	%
2001	42	193	22%
2002	42	166	25%
2003	41	189	22%
2004	55	187	29%
2005	51	175	29%
2006	39	203	19%
2007	45	n/a	
Total	315		

Figure 1.
Source: Santa Clara County Child Death Review, 2001-2007; Santa Clara County Mortality Records

Santa Clara County Child Death Review Team Classifications, 2006-2007

	Frequency	Percent	Frequency	Percent
	2006		2007	
Natural Medical	13	33%	9	20%
Accident	6	15%	7	16%
Inadequate Caretaking Skills	6	15%	9	20%
Homicide	4	10%	10	22%
Neglect	4	10%	2	4%
Adolescent High-Risk Behavior	3	7%	5	11%
SIDS	1	2%	0	
Suicide	1	2%	3	7%
Undetermined	1	2%	0	
Suspicious/Questionable Factors	0		0	
Total	39	100%	45	100%

Figure 2.
Source: Santa Clara County Child Death Review, 2006-2007

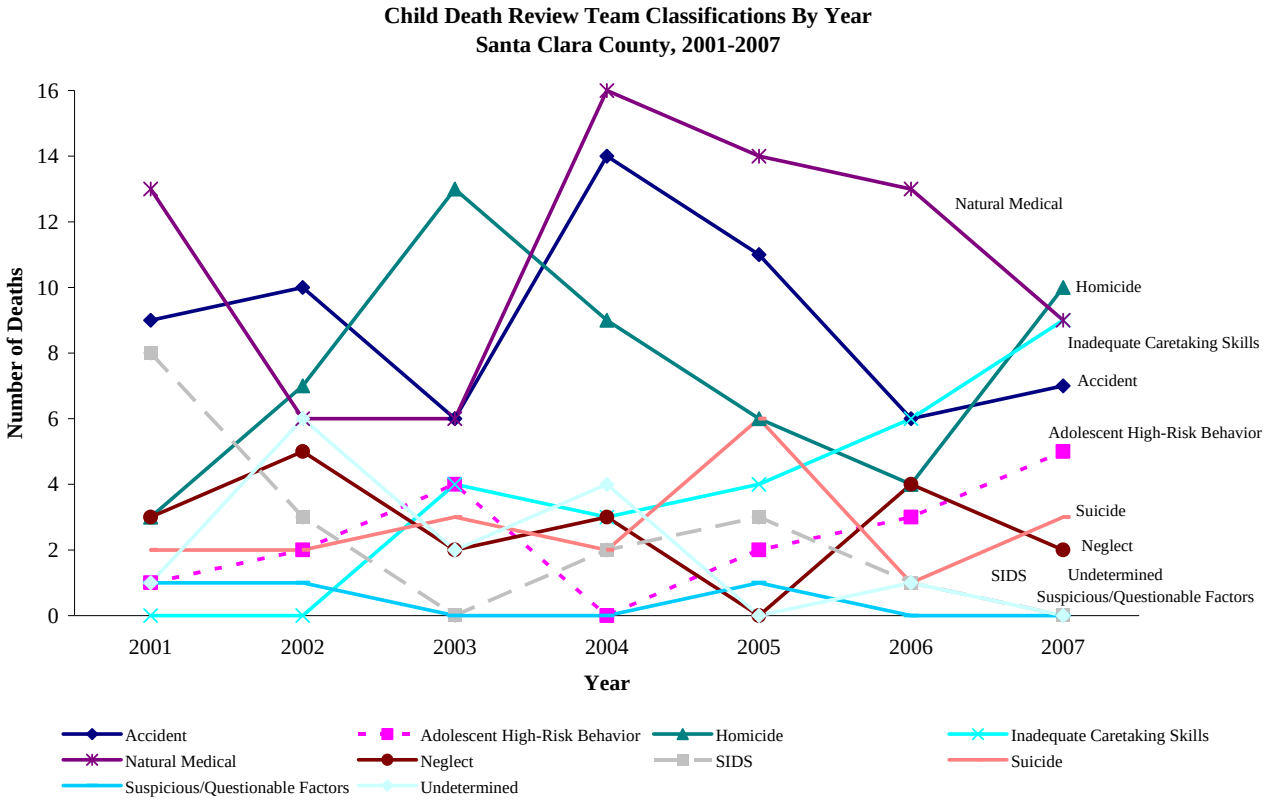

Child Death Review Team Classifications By Year
Santa Clara County, 2001-2007
Number of Deaths
16
14
12
10
8
6
4
2
0
2001
2002
2003
2004
2005
2006
2007
Year
Natural Medical
Homicide
Inadequate Caretaking Skills
Accident
Adolescent High-Risk Behavior
Suicide
Neglect
SIDS
Undetermined
Suspicious/Questionable Factors
Accident
Adolescent High-Risk Behavior
Homicide
Inadequate Caretaking Skills
Natural Medical
Neglect
SIDS
Suicide
Suspicious/Questionable Factors
Undetermined

Figure 3.

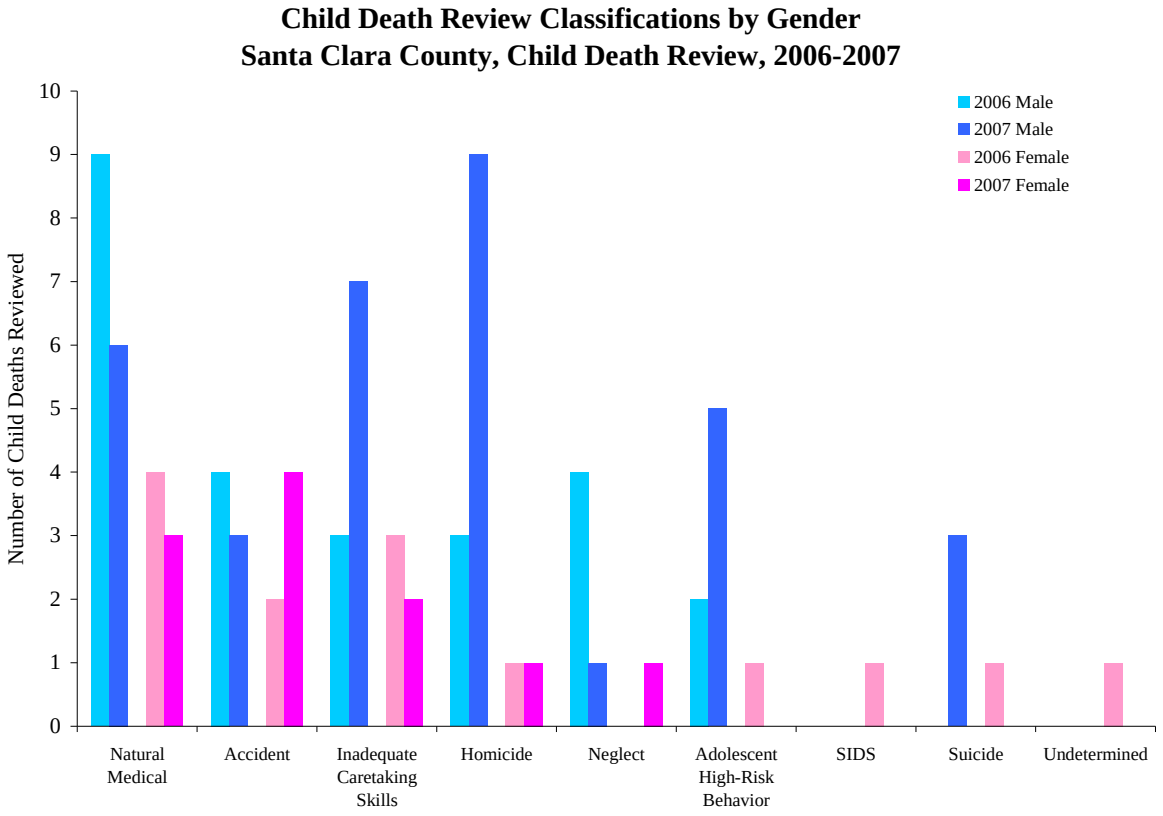


Figure 4a.

Child Death Review Classifications by Gender, 2006-2007

	Male 2006	Male 2007	Female 2006	Female 2007	Total
Natural Medical	9	6	4	3	22
Accident	4	3	2	4	13
Inadequate Caretaking Skills	3	7	3	2	15
Homicide	3	9	1	1	14
Neglect	4	1	0	1	6
Adolescent High-Risk Behavior	2	5	1	0	8
SIDS	0		1		1
Suicide	0	3	1	0	4
Undetermined	0		1		1
Total	25	34	14	11	84

Figure 4b.
Source: Santa Clara County Child Death Review, 2006-2007

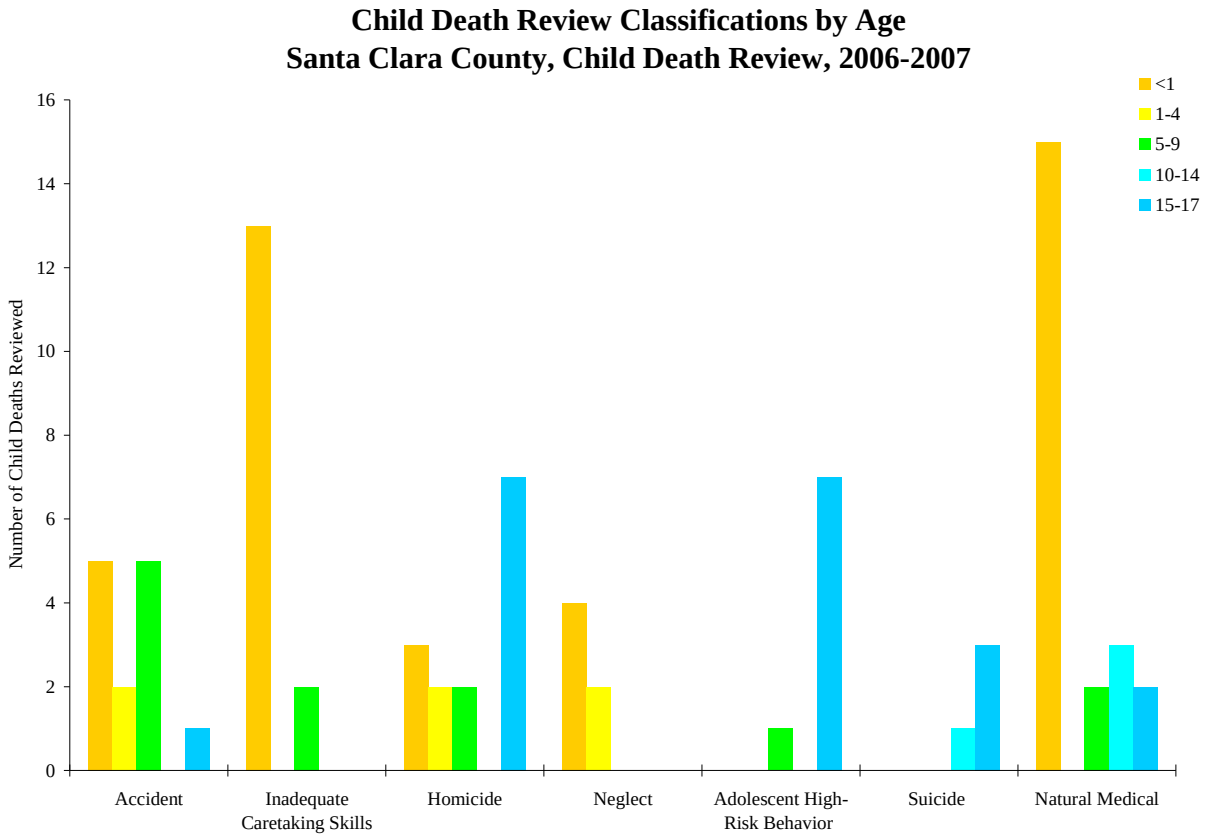


Figure 5a.

Child Death Review Classifications by Age, 2006-2007

	<1	1-4	5-9	10-14	15-17	Total
Natural Medical	15	0	2	3	2	22
Accident	5	2	5	0	1	13
Inadequate Caretaking Skills	13	0	2	0	0	15
Homicide	3	2	2	0	7	14
Neglect	4	2	0	0	0	6
Adolescent High-Risk Behavior	0	0	1	0	7	8
SIDS	1	0	0	0	0	1
Suicide	0	0	0	1	3	4
Undetermined	0	0	0	1	0	1
Total	41	6	12	5	20	84

Figure 5b.
Source: Santa Clara County Child Death Review, 2006-2007

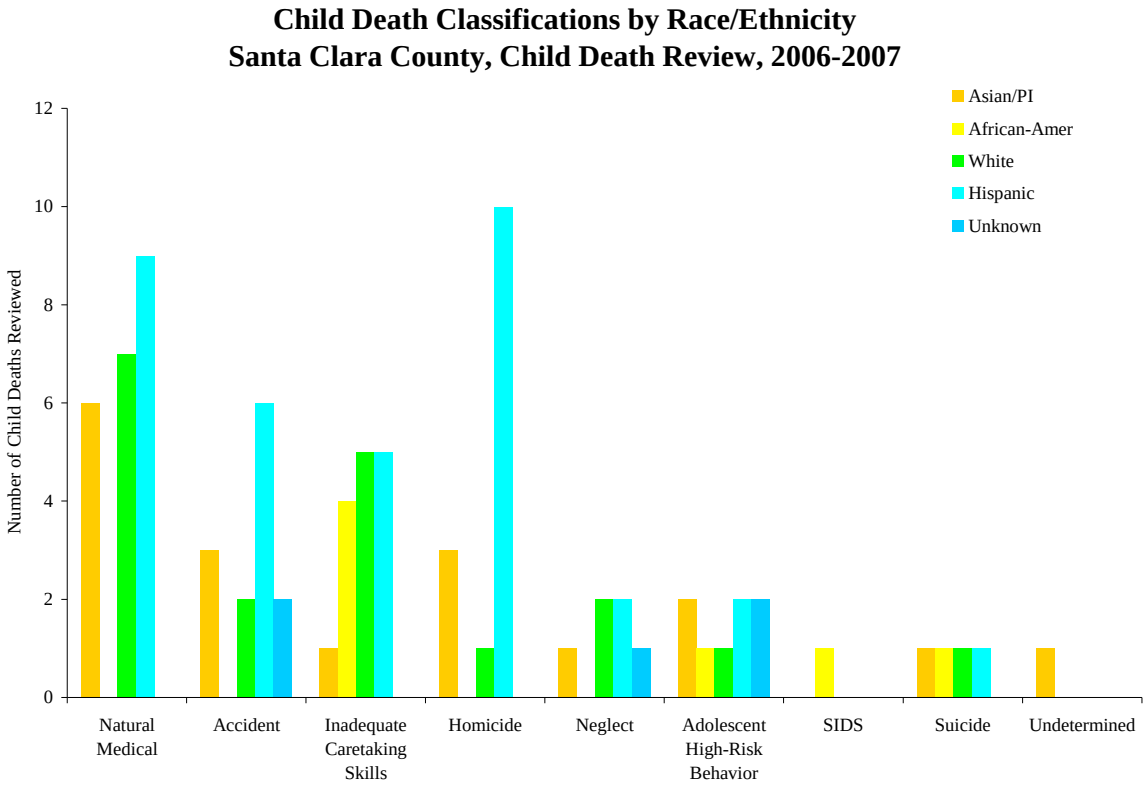


Figure 6a.

Child Death Review Classifications by Race/Ethnicity, 2006-2007

	Asian/PI	African-Amer	White	Hispanic	Unknown	Total
Natural Medical	6	0	7	9	0	22
Accident	3	0	2	6	2	13
Inadequate Caretaking Skills	1	4	5	5	0	15
Homicide	3	0	1	10	0	14
Neglect	1	0	2	2	1	6
Adolescent High-Risk Behavior	2	1	1	2	2	8
SIDS	0	1	0	0	0	1
Suicide	1	1	1	1	0	4
Undetermined	1	0	0	0	0	1
Total	18	7	19	35	5	84

Figure 6b.
Source: Santa Clara County Child Death Review, 2006-2007

Residence City of Child Deaths Reviewed, 2006-2007

	Frequency	Percent	Frequency	Percent
	2006		2007	
San Jose	23	59%	39	87%
Santa Clara	6	15%	4	9%
Palo Alto	3	8%		
Gilroy	3	8%		
Saratoga	2	5%		
Sunnyvale			1	2%
Milpitas	1	3%	1	2%
Morgan Hill	1	3%		
Total	39	100%	45	100%

Figure 7.
Source: Santa Clara County Child Death Review, 2006-2007

Place of Incident, 2006-2007

	Frequency	Percent	Frequency	Percent
	2006		2007	
Child's home	19	48%	23	48%
Roadway	9	23%	5	11%
Relative's home	3	8%	1	2%
Hospital	3	8%	2	4%
Friend's home	3	8%	2	4%
Licensed daycare center/home	1	3%		
Driveway	1	3%	1	2%
Sidewalk			1	2%
Other parking area			1	2%
Other			10	22%

Figure 8.
Source: Santa Clara County Child Death Review, 2006-2007

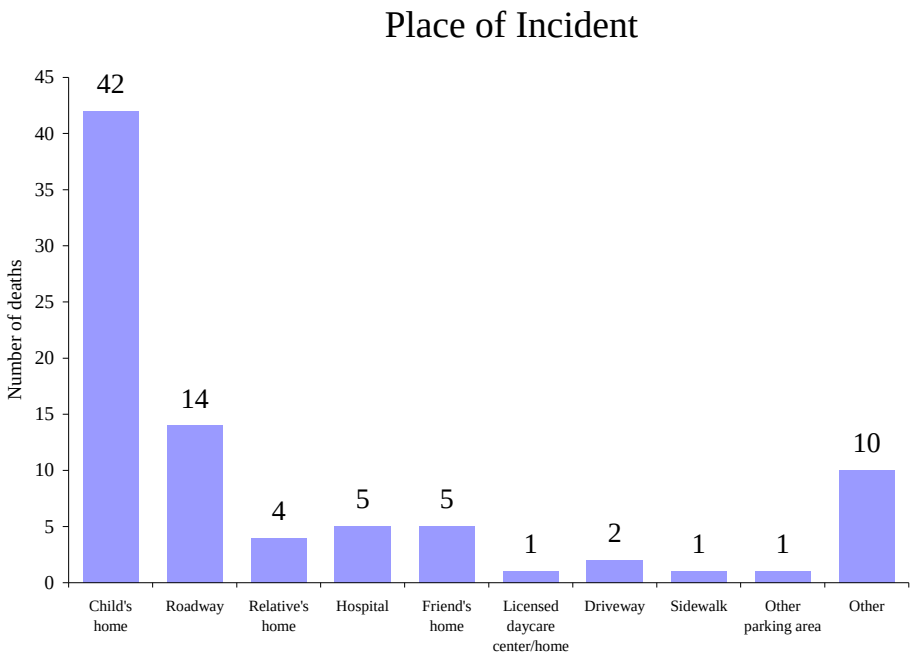
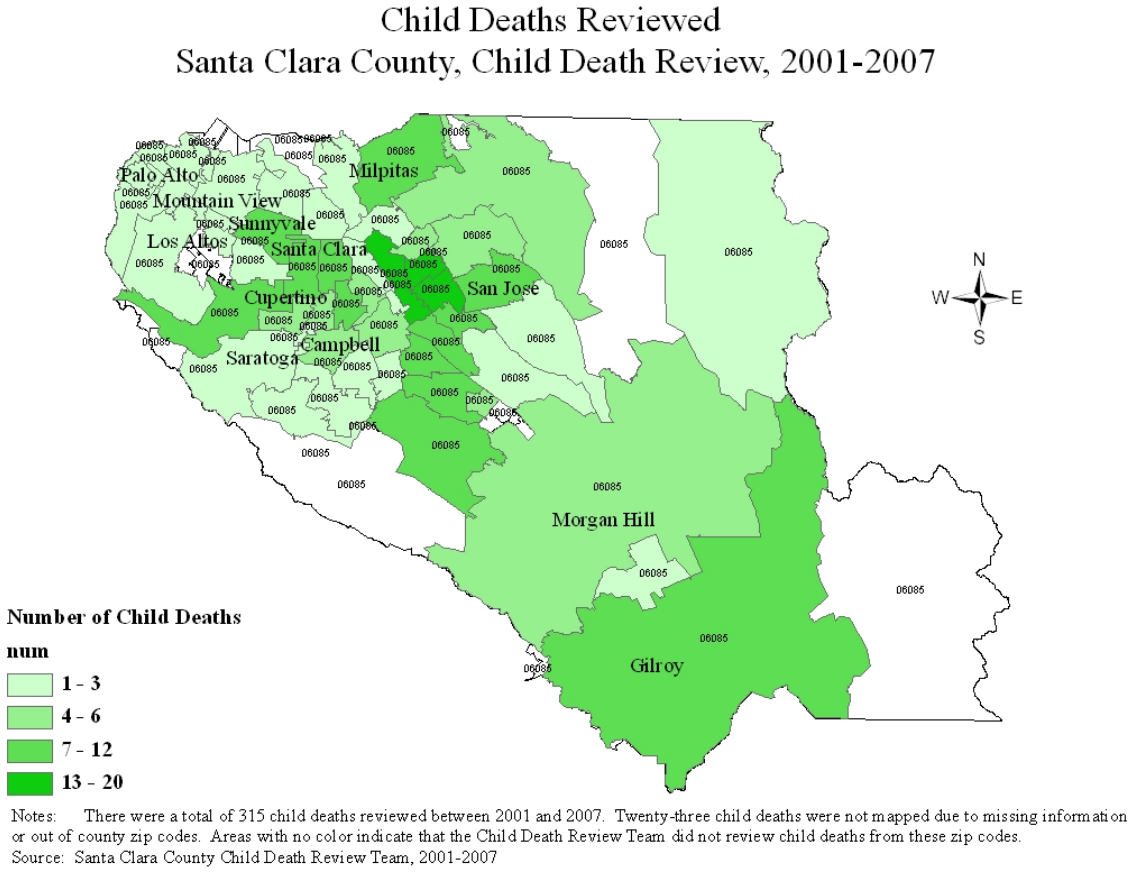


Figure 9.



Notes: There were a total of 315 child deaths reviewed between 2001 and 2007. Twenty-three child deaths were not mapped due to missing information or out of county zip codes. Areas with no color indicate that the Child Death Review Team did not review child deaths from these zip codes.
Source: Santa Clara County Child Death Review Team, 2001-2007

Figure 10.

Medical Examiner/Coroner's Manner of Death of Child Deaths from Autopsy Report, 2006-2007

	Frequency	Percent	Frequency	Percent
	2006		2007	
Natural	12	31%	11	24%
Accident	12	31%	19	42%
Undetermined	11	28%	3	7%
Homicide	3	8%	9	20%
Suicide	1	3%	3	7%
Total	39	100%	45	100%

Figure 11.
Source: Santa Clara County Child Death Review, 2006-2007

Santa Clara County Child Death Review Team (CDRT) Classification as Compared to the Medical Examiner/Coroner's Manner of Death, 2006-2007

	Official Manner of Death					
CDRT Classifications	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Total**
Natural Medical	19	1	0	0	3	23
Accident	0	13	0	0	0	13
Inadequate Caretaking Skills	1	6	0	0	8	15
Homicide	0	2	0	12	0	14
Neglect	2	2	0	0	2	6
Adolescent High-Risk Behavior	0	7	0	0	0	7
SIDS	1	0	0	0	0	1
Suicide	0	0	4	0	0	4
Undetermined	0	0	0	0	1	1
Total	23	31	4	12	14	84

Figure 12.
Source: Santa Clara County Child Death Review, 2006-2007

Child Deaths Resulting from Injuries, 2006-2007

	Frequency	Percent	Frequency	Percent
	2006		2007	
Motor vehicle and other transport	9	23%	5	11%
Drowning	3	8%	2	4%
Suffocation or strangulation	1	3%	2	4%
Weapon, including body part	1	3%	6	13%
Poisoning	1	3%		
Animal bite or attack			1	2%
Fall or crush			1	2%
Fire, burn, or electrocution			1	2%
Undetermined	3	8%	1	2%
Other	3	8%	11	24%
Total	21	100%		

Figure 13.
Source: Santa Clara County Child Death Review, 2006-2007

Child Deaths from a Medical Condition, 2006-2007

	Frequency	Percent	Frequency	Percent
	2006		2007	
Other medical condition	7	18%	8	18%
Pneumonia	2	5%		
Prematurity			2	4%
SIDS	1	3%		
Cardiovascular	1	3%		
Congenital anomaly	1	3%	1	2%
Other infection	1	3%		
Other perinatal condition	1	3%	2	4%
Undetermined medical cause	1	3%		
Unknown	2	5%		
Total	17	100%	13	100%

Figure 14.
Source: Santa Clara County Child Death Review, 2006-2007

ACKNOWLEDGMENTS

We wish to acknowledge Sunny Burgan, Margit David, JR Gamez, and Carl Lewis for their years of Service and their contribution in the reviews of childhood deaths. The members' continued commitment and expertise are invaluable to the success of the Child Death Review Team. The team also thanks the Coroner's Office staff for their assistance prior to each CDRT meeting every month.

CONCLUSION

The Santa Clara County Death Review Team has evolved into a productive team that reviews the deaths of children in Santa Clara County. These reviews not only gather mandated data that is provided to the State of California, they also issues related to child deaths. It has been successful in focusing the role of education in several areas that may have contributed in actual reduction in certain types of child deaths and improving the processes related to the investigation and prevention of future child deaths. It is the intention of the CDRT to continue the practice of issuing an annual report in order to provide important information in this vital area to the public.

The team continues to participate in prevention programs and various campaigns that address: Safe Sleeping, Safe Surrender, Suicide, Drowning Prevention, Child Passenger Safety, and Pedestrian Safety around schools, Never Leave Children Alone In or Around Cars and "Don't Shake your Baby". Team products include annual reports, public education, protocols, standards and guidelines all to prevent the injury and death of our children.

Deaths Reportable to the Coroner

1. Known or suspected homicide

2. Known or suspected suicide

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

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

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

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

7. No physician has attended the deceased in the 20 days prior to death

8. 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

Classifications 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 assault

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

C. **Neglect**: Death clearly due to neglect, supported by Medical Examiner's report or criminal investigation.
   1. Neglect by parent/caretaker
   2. Third party neglect
   3. Failure to protect child from safety hazards according to recognized community standards

D. **Inadequate Caretaking Skills**: Death related to poor caretaking skills and/or lack of judgment: includes actions that contributed to the child's death but do not rise to the severity of neglect.
   1. Co-sleeping leading to possible overlay without evidence of substance abuse by co-sleeper
   2. Provision of unsafe sleep environment ie: placing infant to sleep prone, in-appropriate bedding (pillow, heavy covers, couch, adult bed etc.)
   3. Failure to protect child from other safety hazards not universally recognized by the local community

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

F. **Non-Maltreatment**:
   1. Natural medical death (other than SIDS)
   2. Sudden Infant Death Syndrome (SIDS)
      A. maternal smoking during pregnancy
      B. maternal substance use during pregnancy
      C. ETS exposure after birth
   3. Accident/unintentional injury: An unintentional death due to injury that had no elements of neglect and where reasonable precautions were taken to prevent it from occurring.
   4. Suicide (no known contributing factors of child abuse or neglect)
   5. Adolescent High-Risk Behaviors (behavior of the decedent)

A. firearm related
B. substance use/abuse
C. motor vehicle misuse

G. **Undetermined**

Appendix.

Santa Clara County Demographics, 2002-2007

Population						
	2002	2003	2004	2005	2006	2007
Total	1,717,009	1,723,819	1,739,380	1,751,330	1,780,757	1,794,522
Male	870,566	875,682	883,312	892,141	902,178	910,276
Female	846,443	848,137	856,068	865,189	878,579	884,246
Age <18						
*Male	218,035	224,502	225,706	226,973	231,207	228,047
*Female	206,930	213,569	214,949	216,197	220,941	217,537
Births						
	27,047	26,997	26,537	26,553	26,942	27,484

Figure 15.

Source: California Department of Finance Population Estimates; Santa Clara County Public Health Department, Birth Records
Notes: *In 2006-2007, the percentage of males <18 was 51% and females <18 was 49%. Racial and ethnicity distribution in 2006-2007: 42% White, 26% Hispanic, 28% Asian/Pacific Islander, 3% African-American, <0.5% Native-American, 2% Multi-race