An Attempt to Save Lives:

Recommendations by the Santa Clara County Children's Death Review Team

July 2001

Acknowledgements

This report is dedicated to the Children.

Special thanks to all members of the Santa Clara County Death Review Team for their professional contributions and commitment to the team and for their assistance with this report.

A very special thank you to Dr. Saul Wasserman, Child Psychiatrist, for writing this report and for his tireless dedication to the Santa Clara County Death Review Team.

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Background

The death of a child is a profoundly painful and distressing event. More than 15 years ago, members of the Santa Clara County Multidisciplinary Child Abuse Team resolved to carefully examine the circumstances leading up to the death of a child (age 18 and under) within the county that did not appear to be from a clearly medical, non-preventable reason. The team developed a protocol closely modeled on pioneering work by Michael Durfee, M.D. in Los Angeles. The goals were to learn and discuss details that would be useful in the prevention of future deaths, to assure that the family members and especially the siblings in a family that had lost a child were supported and protected, and to identify situations where crimes had been committed.

Since that time, Children's Death Review Teams (CDRTs) have been developed throughout California and the United States. Although the teams differ from locale to locale, all adhere to a similar philosophy and goals. Team discussions alternate between dull bureaucratic rambles and gripping intensity. People from a wide variety of agencies and professions share their records in an honest and straightforward way. Under these circumstances, the team is often able to construct at least a partial picture of the circumstances leading to a child's death. We are able to identify where procedures broke down or were inadequate to the task of preserving life. Many recommendations for improvements in the way we do things have come out of this process.

The multi-disciplinary nature of the team provokes a great deal of discussion and education among members. Each participant, in effect, becomes trained to see more of the ways in which the wellbeing of children is a shared responsibility of many different groups. Our hope is that the members incorporate this knowledge and help expand the perspective of their fellow workers.

Sometimes a child's death becomes a very newsworthy event in the community, and agencies and individuals may be concerned about personal or legal liability. By keeping a low profile, the team can better secure and maintain the cooperation of the involved groups.

Sometimes people that work with children themselves feel great sadness and guilt when a child dies. At times an important part of our task is providing support to workers who had a child die while in their care, when we believe that their work was reasonable and appropriate and that the child's death was not realistically avoidable.

In the discussions, team members have learned a great deal about the way people, who share a common concern for children but who have very different functions, do their work. The struggle to improve the coordination and cooperation between agencies is an ongoing task. Members of the team have been able to take information back to their primary group to help in this process of collaboration. This is important because for each child who dies there are perhaps one hundred children who will be at risk but are fortunate and lucky enough to survive.

In the past few years, several groups have put forth a much more serious effort into preventive education. We salute these efforts, although we think much more can be done. In the past few years, team members have become involved in many prevention-oriented activities, including:

- Conferences addressing teens and alcohol use
- A major conference regarding preventing and responding to teen suicide
- The establishment of a Fetal Infant Mortality Review (FIMR) team
- A perinatal substance abuse program
- The educational program for childhood safety, "Troo the Traumeroo"

We thank the various chiefs, administrators and judges who have allowed us to do our work. We recognize the contributions of the volunteers on the team, who receive no public recognition

but are integral to the team's functioning. We thank the Coroner and his support staff for their vital help. Following are the six priority areas as chosen by the Santa Clara County CDRT.

Recommendations—Six priority areas

In reviewing each death, the team discusses what might be done to prevent a similar death in the future. Over the course of its meetings, the team has made and communicated many specific recommendations to a wide variety of individuals and agencies in the county. Members have found that most people are willing to accept and implement relatively simple and pragmatically achievable incremental improvements in the ways in which children receive care. The following themes tend to appear repeatedly in our analyses. (In effect these themes define larger governmental and community priorities for the future improvement of care.)

Priority One—Prenatal, perinatal and postnatal care education

This grouping includes several important areas. Among them:

- The 1994 "Back to Sleep" campaign has led to a marked decline in the number of Sudden Infant Death Syndrome cases (commonly called SIDS or crib deaths) in the county. However, we find that some parent educators such as clinic and hospital nurses are neither implementing nor demonstrating this approach. Since "Back to Sleep" is demonstrably the single most effective, and easiest to implement, strategy in reducing incidences of SIDS cases, we believe it should receive a stronger focus. Infants should sleep on their back, with proper bedding. We formally recommend that this be emphasized in educational materials for parents, and that personnel at newborn nurseries move away from side propping of newborns. This educational training is important for

foster parents as well, since drug-exposed and other foster children have a higher rate of SIDS than the general population.

- Pregnant women and mothers who use alcohol and drugs continue to be of considerable concern. We have seen several child deaths associated with parental substance abuse, especially in the first year of life. The perinatal drug abuse clinic is a good step forward. Many of the women with chemical dependency problems also have psychiatric problems, and the use of psychotropic medication in pregnant women is a complex issue, requiring clinical expertise. For this reason, we would like to see the program have a psychiatrist available at least on a limited basis.

The use of alcohol during pregnancy has been clearly demonstrated to cause serious problems for babies, including low birth-weight, mental retardation and congenital defects. Most people do not realize how much a relatively small amount of alcohol can affect a developing fetus. We would like to see greater effort made to identify pregnant women who are using alcohol, and for agencies to be able to at least offer them services related to detoxification, recovery, and sobriety.

- The county-wide prenatal drug protocol is an effort to identify women who are using illegal drugs, since this population is at high risk for postnatal child abuse and child death. Because obstetricians, hospitals and health care organizations are under intense pressure to move patients through care faster, there is less time to identify high-risk mothers and arrange supportive services. We have reviewed several situations where substance-abusing mothers were not identified as drug users, with tragic consequences.

Priority Two—Interagency cooperation and communication

We see opportunities for improvement in several areas. Most of the time problems in communication represent busy workers who want to work cooperatively but are in effect discouraged either due to governmental policy or problematic circumstance.

- In recent years, the various agencies concerned with children have signed memorandums of understanding (MOU) to share information. For example, Juvenile Court rules provide for exchange of information between Juvenile Dependency, Delinquency, Family and Probate Courts. The rules also provide a protocol for coordination and management of child abuse cases that become active in both DFCS/Juvenile Court and Family Court. Last year, the county DFCS and the State Parole Agency developed an MOU to improve coordination and support for high-risk families. In recent years, more focus has been placed on protecting children who live in families that endure domestic violence. We see both these joint efforts as constructive steps in preventing child deaths. On a day-to-day level, however, the mechanics of interagency cooperation can be much more difficult. It takes time to locate and contact the right people, share file information, and build working relationships. Busy caseworkers may easily let this process slip, especially in the face of court deadlines and heavy caseloads.
- We have seen a few deaths of children associated with long and painful Family Court custody processes in the years prior to their deaths. Allegations of mistreatment arise frequently in Family Court, and assessing validity is far more difficult in this charged environment than in a typical DFCS investigation. While we do not have specific recommendations, we believe that Family Court is unique because it addresses issues that

are of extraordinary importance to parents and children, and we believe it should receive the resources and support needed to do its work in a humane and thoughtful way.

We would like to see those people who work in areas of child advocacy and protection have access to the same high tech tools that corporate America uses for communication. E-mail and cell phones can help people work together more effectively.

Priority Three—Protecting child protection

- The Child Abuse and Neglect (CAN) reporting center is a pivotal point in the process of child protection. This center receives many reports each day, last year they received 20,352 calls. While some require immediate attention, others can be handled in a more paced fashion, and some require no action. This triage process is a vital part of allocating resources to the situations where children are at the greatest risk. In recent years, the process has been streamlined and updated; we continue to see it as a pivotal area deserving ongoing support.
- Current child protection law specifies that when a child is removed from a home because of abuse or neglect, the parent is given a period of time to develop a plan for improved parenting skills. For a substance-abusing parent, this often means going through some form of chemical dependency treatment or rehabilitation. If the parent is judged to have done this successfully by the court, the child is returned to the home. After a period of time the case is closed and the parent is given full custody. Besides allowing the family to be free from an intrusive state process, closing the case frees up resources that can be used for other families.

The CDRT case reviews have observed that some of these parents ultimately relapse, and the child again becomes at risk. The current law and policy is not oriented toward any sort of long-

term supervision of these families, and a child whose parent has relapsed is again at risk. We have seen some deaths occur under such circumstances. The Santa Clara County CDRT wonders whether the statute can be modified to strike a better balance between the desire not to have cases open indefinitely and the fact that relapse is common in chemical dependency.

- In recent years, DFCS has been accused by parenting groups of being an inappropriate governmental intrusion into family life, and efforts have been made through the court system to limit the investigational search power of social workers. As a society we need to remember that unless we completely recast our child protection system into a voluntary process (and we are not recommending this be done), there inherently will be a tension between the privacy rights of families and the right of a child to grow up safe from grievous harm.

Priority Four—Adolescent needs

Preventable deaths (suicide, homicide and accidental deaths) account for the bulk of adolescent deaths in this county. Parents have the primary prevention responsibility for the children, but the vagaries of the parent-adolescent child relationship may mean that information coming from other sources may be more meaningful. In our opinion, schools are the second best site, since virtually all adolescents are enrolled in some form of formal education.

- We would like to see more “life skills” type of programs in schools, which allow discussion about stress management, drug and alcohol use, and normative social behavior.
- Harassment among children and teenagers is of particular concern. Children can be taunted and attacked because of racial or ethnic identity, sexual identity, social style or physical condition. Over time this can become quite demoralizing and lead to violent

behavior, directed toward the self as suicide or outwardly toward the community. Current research suggests that schools can have some effect on youth culture. Teaching strategies that promote non-violent problem solving, and teaching strategies that promote social acceptance and support rather than harassment and attack, would be helpful.

- A wide range of social/recreational activities and clubs would be useful many students, by focusing energy in positive directions. Keeping busy is one of the main ways that teenagers avoid being depressed, and such activities are more likely to be accepted and used than traditional counseling services.
- For children with identifiable, serious mental health problems, we have few resources between expensive hospitalization and outpatient therapy. It would be helpful to have some better defined transitional or "step-down" services. This is particularly important because hospitalizations today are very short, and there isn't enough time to do more than start treatment.
- We need publicly funded drug treatment for adolescents. Resources are extremely limited.
- In January 2001, a Suicide Prevention Task Force of the CDRT sponsored an educational conference on suicide prevention that brought together the many groups that interface with children. The conference received excellent evaluations and may be repeated in the future.

Priority Five—Training for law enforcement

The police play a crucial role in child protection issues because they are involved in many situations where children are at high risk and because they do the investigation after a child dies. First response officers have a particularly difficult task when responding to a child death. On the

one hand the officer does not wish to add to a family's grief, on the other hand a serious crime may have been committed and the observations and information gathered on the spot may be crucial. All of this occurs in a context where the officer must contend with personal feelings about the death of a child. Without quality training too many decisions are being made based on personal experience and personal views, which wind up being too subjective.

- The law enforcement members of this CDRT believe, and the remaining team members concur, that while some training is currently being done, the team members recommend refining the procedure/ policy for crime scene investigation.

Priority Six—Group home staff training

- The closing down of the large state facilities for the developmentally disabled has led to increased reliance on small board-and-care type facilities. These facilities rely on many people who work for close to minimum wage and may not be trained nor skilled in responding to the children's medical needs. We think that CPR and first aid training should be mandatory for all the staff of group homes as it is for foster parents and others that deal with children.

Trends In Children's Deaths

On the basis of our data, we believe that there has not been a dramatic increase in our county's child death rate in the last 10 years; rather, the rates are stable or declining. Since the numbers are small, fluctuations from year to year can represent big percentage changes, but not have much significance. A statewide data collection tool, California Fatal Child Abuse And Neglect Surveillance (FCANS) Program is being piloted which will contribute to improved data collection, analysis and reporting.

Accidental deaths

The number of accidental deaths has declined from 1993 to 2000. Since the majority of children's accidental deaths are automobile accidents, it is likely that the number of fatal auto accidents has declined. We would suspect that the increasing use of car seats for infants and small children is to be credited with this improvement.

SIDS cases

We see a marked decline in the number of SIDS deaths in the past few years. The most likely cause for this appears to be the increased focus on having infants sleep on their back—the "Back to Sleep" campaign. The results are impressive. Also during this period, the diagnostic criteria for SIDS deaths may have changed because there were major changes in personnel at the coroner's office.

Suicides

The number of completed suicides does not appear to show any significant pattern of increase or decrease from year to year since 1988 to 2000. Since the numbers are small, it would be easy to be misled by only comparing one year to the next, but the lack of change over a 10-year period is notable.

Teen homicides

We started keeping teen homicide data in 1993. According to our data, there has not been any dramatic change in the number of teen homicides from then to the present.

Maltreatment Deaths

There does not seem to be any significant change in the number of maltreatment deaths from 1990 to 1999. By "maltreatment" deaths, we mean to include all abuse, neglect, and abuse and neglect-related deaths.

Child deaths are just one measure of the well being of the children of Santa Clara County. For each child who dies, many more children are either at risk or suffer injury. Still, a cautionary note on the data: It should be considered just one element of an assessment of our children's wellbeing. While it's interesting to look at some of the data we have collected over a decade, before we review the figures, some cautions are important.

First, the data itself is vulnerable to flaws. The coroner's office went through several changes of personnel and administrative practices during this period. The biggest change as a consequence has been much more caution in attributing deaths to SIDS. Although we believe that there has been a true drop in the incidence of SIDS due to the "Back to Sleep" campaign, we don't believe the results are as good as our small sample would suggest.

Second, the team has changed membership over the years. While we have attempted to be consistent in our classifications, differing viewpoints, evolution in thinking and better or worse understanding no doubt have led us to be vulnerable to changes in classification.

Third, during the decade, we decided to include out-of-home teen homicides with our maltreatment deaths; we have labeled this change in criteria.

Fourth, we added a category for "Adolescent high-risk behavior."

We are presenting our experiences and observations through a process that we have agreed upon through consensus. Although subjective at times, the data does point us toward some

conclusions that are interesting and important. We will need to compare our results with other CDRTs to obtain validation for focusing on the themes and patterns described in our six priority areas.

Appendixes

Santa Clara County
Multidisciplinary Child Abuse Team
Death Review Committee

CRITERA FOR REVIEW:

All deaths of children under the age of 18 in which one or more of the following factors listed below are believed to be present will be reviewed.

1. Substance ingestion or substance exposure in utero
2. Cause of death undetermined after coroner's investigation
3. Head trauma (subdurals, subarachnoid, subglial) (except when caused by auto accident)
4. Malnutrition/Neglect, including failure to thrive
5. Bathtub drowning
6. Suffocation/Asphyxia
7. Fractures
8. SIDS age under one month or over seven months
9. Blunt force trauma
10. Homicide/Child abuse neglect
11. Burns except where cause is clearly not abuse or neglect or caretaker under the influence
12. Sexual abuse
13. Gunshot wound
14. Suicide *
15. Death in day care or foster care (except SIDS 1-7 months)
16. Agnew's deaths (at least cursory review by PHN and pediatrician, and record check)
17. Unexpected medical deaths (where death is not common or is faster than normal – e.g. pneumonia, diarrhea, meningitis). At least cursory review by PHN and pediatrician regarding factors of parental medical neglect and adequacy of medical system
18. Auto accidents if there is suspicion of caretaker substance involvement or no car seats
19. Professional concern (other than above criteria)

- Adolescent suicides through the age of 17 are reviewed

Classifications of Death

A. **Abuse:** Clearly due to abuse, supported by Coroner's reports or police or criminal investigation (e.g. homicide)

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

C. **Neglect:** Clearly due to neglect, supported by Coroner's reports or police or criminal investigation

D. **Neglect Related:** Death secondary to documented neglect (e.g. auto accidents or house fires where caretaker "under the influence"). This category would also include any cases of poor caretaker skills or judgment

E. **Suspicious or Questionable:** There are no specific findings of abuse or neglect, but there are such factors as:

1. Substance use or abuse where substance exposure caused caretaker to have mental impairment.
2. Previous, unaccounted for deaths in the same family.
3. Prior abuse or neglect of child or protective service referral

F. **Maternal Substance Abuse:** Clearly due to prenatal substance abuse supported by Coroner's reports (e.g. cocaine intoxication, death from medical complications due to drugs)

G. **Maternal Substance Abuse Related:** Death secondary to known or probable prenatal substance abuse (e.g. SIDS or death from medical complications due to drugs)

H. **Non-Maltreatment**:

1. Natural medical death
2. Sudden Infant Death (SID) (No known or suspected prenatal substance exposure)
3. Accident (This category is for accidental deaths for which there are no elements of neglect). The team recognizes that accidents do occur in even the best of families
4. Suicides (No known contributing factors of child abuse or neglect)
5. Non-Maltreatment substance abuse related
6. Adolescent high-risk behavior
    a. Stolen gun
    b. Drug use
    c. Car misuse

Current Death Review Team Members—
April 2001

First and Last Name	Title / Position	Organization Represented
Shelley P. Ash, MPHc	Chapter President	Postpartum Health Alliance of Northern California
Steve Baron	Assistant Director	Santa Clara County Family Court Service
Suzy Baulch, R.N., MHA	Clinical Systems Manager	Santa Clara EMS Agency
Richard L. Bloom	Lieutenant	Sunnyvale D.P.S.
Sunny (Sharon) Burgan, MSSW, LCSW	Social Work Supervisor	Family & Children's Services
Michael Carr	Director, Special Education	San Jose Unified School District
Carmen Castillo, MSW	Social Worker	San Jose Medical Center
Curtis Church	Clergy	Central SDA Church
Patrick Clyne, M.D.	Pediatrician	Santa Clara Valley Medical Center
Joanne Dobrzynski, M.S., MFT	Program Coordinator	Suicide & Crisis Service
Jamie Evans	Detective Sgt. – Sexual Assault	Santa Clara County Sheriff
Betty Garcia	Detective – Child Abuse	Santa Clara County Sheriff
Vicky Garcia, MPH	Health Educator	SCVH & HS, Public Health Maternal Child Health
Susan Kerr, PHN, DRT Chairperson	Child Abuse Prevention Coordinator	SCVH & HS, Public Health Maternal Child Health
Melody Kinney, LCSW	Social Worker	Good Samaritan Hospital
Mylene Madrid Mei	Health Ed. Specialist	SCVH & HS, Refugee & Child
Nina Madrigal	Supervising Probation Officer	Juvenile Probation Dept.
Robert Masterson	Deputy District Attorney	Santa Clara County District Attorney's Office
Glenn McCourtie	Lieutenant-Homicide	San Jose Police Department
Susan McLaughlin, MPH	F.I.M.R. Coordinator	SCVH & HS, Public Health Maternal Child Health
Daniel T. Nishigaya	Deputy District Attorney	Santa Clara County District Attorney's Office
Patricia E. Osborn, M.A.	California Dept. of Justice	Child Death Review Council
Debra Pinck, R.N., PHN Retired DRT Chairperson	Child Abuse Prevention Specialist	SCVH & HS, Public Health Maternal Child Health

Bob Porter	Disaster & Critical Incident Response Coordinator	SCVH & HS, Mental Health Department
Claudine Radcliffe	Chief Investigator	Santa Clara County ME-Coroner
Thomas Schamadan	Marriage Family Therapist II	Dept. of Alcohol & Drug Services
Gregory A. Schmunk, M.D.	Chief Medical Examiner	Santa Clara County ME-Coroner
Sarah Scofield, LCSW	Social Worker	Packard Children's Hospital at Stanford
Saul Wasserman, M.D.	Child Psychiatrist	
Judy Williams	SIDS Coordinator	SCVH & HS, East Valley Public Health

Past Contributing Members of the Death Review Team

First and Last Name	Title / Position	Organization Represented
Terry Bowman	District Attorney's Office – Criminal Div.	Santa Clara County
Lois Hedman, Ph.D.	Social Services Agency	Family & Children's Services
Karen Jensen, MSW	Social Services	Packard's Children's Hospital
Katherine Lucero	Deputy District Attorney	Santa Clara County
Mike O'Conner	Lieutenant	San Jose Police Department
Meg Paris, Ph.D.	Supervisor, Suicide & Crisis Service	SCVH & HS Mental Health Dept.
Chris Powell	Detective	Sunnyvale Dept. of Public Safety
Jane Tanner, SW	Social Worker	San Jose Medical Center