Santa Clara County Child Death Review Team

Five Year Report

2001-2005

Prepared by:

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April 2007

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 improve their responses to the needs of our children. Activities of the CDRT are intended to enhance interagency collaboration.

THE SANTA CLARA COUNTY CHILD DEATH REVIEW TEAM MEMBERS

Dolores Alvarado Division Director	Santa Clara County Public Health Department
Michelle Avila Lieutenant	Santa Clara County District Attorney's Office Homicide/Sexual Assault Division
Nancy Bain, M.A. LMFT	Santa Clara County Dept. of Alcohol and Drugs Services
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Sunny Burgan, LCSW Social Work Supervisor	Social Services Agency, DFCS
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Curtis Church Clergy	Seventh Day Adventist Church
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Donna Conom, M.D. Neonatologist	Good Samaritan Hospital
Margit David, LCSW Social Work Supervisor Emergency Response	Social Services Agency, DFCS
JR Gamez Lieutenant	San Jose Police Department, Homicide Unit
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Christopher Happy, M.D. Assistant Medical Examiner	Santa Clara County Medical Examiner/Coroner's Office

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Lieutenant

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Clerical Support

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Quality Improvement Coordinator

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CDRT Coordinator & Co-Chair

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Psychiatric Social Worker

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Senior Mediator

Saul Wasserman, M.D. Child Psychiatry
Child Psychiatrist

BACKGROUND

California enacted legislation in 1988 which allowed the development of interagency child death review teams. These teams are intended to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication involved in the investigation of such cases. In response to this legislation, the Santa Clara County Child Death Review Team (CDRT) was formed to provide professional review of deaths of persons under the age of 18 who lived in Santa Clara County.

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.

State law mandates that no less than once each year, each child death review team shall make available to the public; findings, conclusions and recommendations, including aggregate statistical data on the incidences and causes of child deaths (SB 1668 (e) (1)). Due to the sensitivity of the material discussed, confidentiality is maintained pursuant to California Penal Code Section 11167.5. The Santa Clara County CDRT is a professional multidisciplinary collaborative body guided by agreed upon goals and objectives.

The Santa Clara County Child Death Review Team (CDRT), reviews and evaluates the deaths of children <18 years of age reported to the Medical Examiner/Coroner's Office.[1] The hope is that, through a comprehensive and multidisciplinary review of child deaths, we will better understand how and why children die and use our findings to take actions to prevent other deaths, and to improve the health and safety of our children. This process is strongly supported by the Public Health Department-Maternal Child & Adolescent Health Program, with a Public Health Nurse who serves as Coordinator and Co-Chair.

The team is composed of designated representatives from the Santa Clara County Public Health Department, Valley Medical Center-Pediatrics, Office of the Sheriff Medical Examiner/Coroner's Office, California Children's Services, Social Services Agency, Child Protective Services, Family & Children's Services, District Attorney's Office, Juvenile Probation, Children's Shelter, Family Court Services, San Jose Police Department--Homicide Unit , Sunnyvale Department of Public Safety--Persons Crimes Unit and DADS/Children Family & Community Services. Additional members represent State of California Child Community Care Licensing, Child Psychiatry, Good Samaritan Hospital, Emergency Medical Services, and Office of Education.

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

Prior to each meeting, selected CDRT members receive record check information of each child death. The members research their own agency's files for additional information on the child and his or her family. All of the related information is then brought to the monthly meeting for disclosure, compilation, discussion, review and classification.[2] A course of action is determined once the review is complete. Options include keeping the case open for further review, referring the affected parties for additional services, closing the case, or formulating prevention based recommendations.

EXECUTIVE SUMMARY

Two hundred and thirty one cases are included in this report for deaths reviewed from January 2001 until December 2005. Data reflected in this report derived from the Coroner's reports as well as the supplemental information provided by CDRT members agencies' child and/or family contacts.

There were seven hundred and thirty-five child deaths from 2001 to 2005; two hundred and thirty-one of these met the criteria for referral and review by the CDRT. There were eight fetal deaths, and eighty (36%) of the children were under one year of age. The remaining one hundred and forty-three (64%) were between the ages of 1 and 17. Causes of death, race/ethnicity, zip code, circumstances and extenuating circumstances are included in the attached graphs and charts.

Included in this five year report are key findings and recommendations made by the CDRT, that focus on the reduction of the most identified factors associated with these preventable deaths. This Five year report will incorporate information from January 2001 through December 2005.

We invite interested parties to use this report's data for research or policy development purposes, and that we are contacted if further information is required.

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

STATISTICS

Santa Clara County Population

	2001	2002	2003	2004	2005
Population					
Total	1,712,156	1,717,009	1,723,819	1,739,380	1,751,330
Male	867,998	870,566	875,682	883,312	892,141
Female	844,158	846,443	848,137	856,068	865,189
<18					
*Male	217,453	218,035	224,502	225,706	226,973
*Female	206,273	206,930	213,569	214,949	216,197
Births					
	27,074	27,047	26,997	26,537	26,553

Table1. Source: Santa Clara County Public Health Dept.

* Percentage of Males <18 was 51% for 2001-2005. Percentage of Females <18 was 49% for 2001-2005. (Santa Clara County 2005 population: 39% Caucasian, 33% Hispanic, 25% Asian, and 2% African American Source; California Department of Finance Population Estimates).

All Santa Clara County Child Deaths
(Child deaths are defined as deaths age < 18 years)

	Total Child Deaths Reviewed by CDRT	Total Santa Clara County Child Deaths	% Reviewed
2001	42	193	22%
2002	42	166	25%
2003	41	189	22%
2004	55	187	29%
2005	51	n/a	n/a
Total	231		

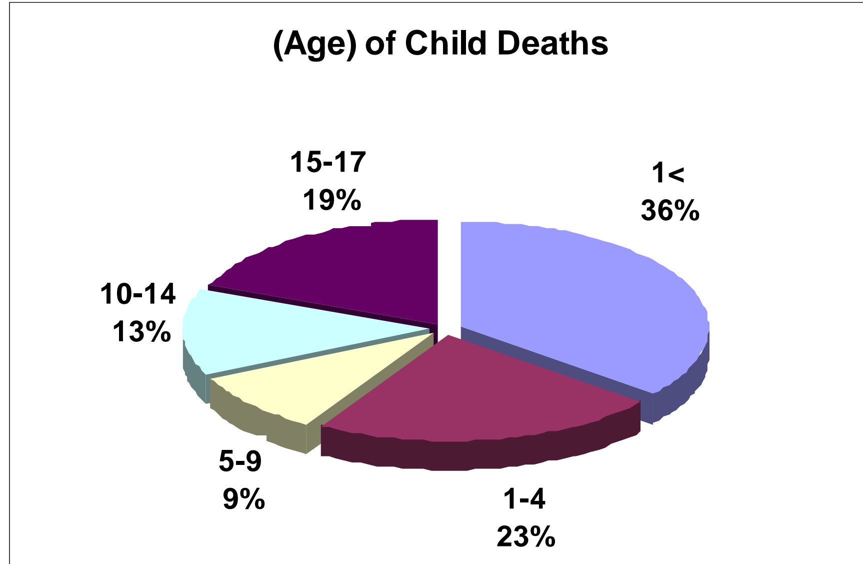
Table 2.

There were a total of 8 fetal deaths reviewed, of these, 3 were abandoned fetus, 2 were associated with methamphetamine use, and 2 due to domestic violence. Not all fetal deaths are reviewed.

Age of Reviewed Child Deaths

Age	Deaths	%
<1	80	36%
1-4	51	23%
5-9	21	9%
10-14	29	13%
15-17	42	19%

Table 3.



Race/Ethnicity of Reviewed Child Deaths

	Deaths	%
White	75	34%
Hispanic	70	31%
Asian/P.I.	54	24%
African-Amer	15	7%
Other/Unknown	9	4%
Total	223	

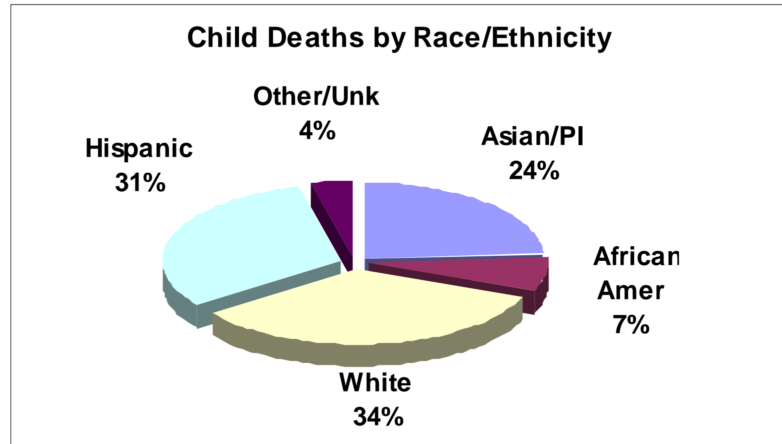


Table 4.
Asian/Asian subgroups include: Vietnamese, East Indian, Filipino, Chinese, Japanese & Korean.

Child Death Classifications by Age (% of Classification)

		<1	1-4	5-9	10-14	15-17	Total
Accident	Deaths	5	22	8	7	8	50
	%	10%	44%	16%	14%	16%	100%
Adolescent High-Risk Behavior	Deaths	0	0	1	2	6	9
	%	0%	0%	11%	22%	67%	100%
Homicide	Deaths	6	10	4	5	13	38
	%	16%	26%	11%	13%	34%	100%
Inadequate Caretaking Skills	Deaths	5	3	1	2	0	11
	%	45%	27%	9%	18%	0%	100%
Natural Medical	Deaths	27	9	5	7	7	55
	%	49%	16%	9%	13%	13%	100%
Neglect	Deaths	7	4	2	0	0	13
	%	54%	31%	15%	0%	0%	100%
SIDS	Deaths	16	0	0	0	0	16
	%	100%	0%	0%	0%	0%	100%
Suicide	Deaths	0	0	0	6	9	15
	%	0%	0%	0%	40%	60%	100%
Suspicious Factors	Deaths	2	1	0	0	0	3
	%	67%	33%	0%	0%	0%	100%
Undetermined	Deaths	12	1	0	0	0	13
	%	92%	8%	0%	0%	0%	100%
Total	Deaths	80	51	21	29	42	223
	%	36%	23%	9%	13%	19%	100%

Table 5a.

Suicides

Firearms		Hanging	
Age	**Gender**	**Age**	**Gender**
14	Male	14	Male
14	Female	14	Male
15	Male	14	Female
17	Male	14	Female
		15	Male
		15	Female
		15	Female
		16	Male
		16	Male
		16	Female
		17	Male

Table 5b.

Gender of Child by Year

	Year											
	2001		2002		2003		2004		2005		Total	
	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Count	%
Female	18	44%	16	38%	18	45%	20	38%	20	43%	92	41%
Male	23	56%	26	62%	22	55%	33	62%	27	57%	131	59%

Table 6.

Age of Child by Year

	Year											
	2001		2002		2003		2004		2005		Total	
	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Count	%
<1	22	54%	15	36%	9	23%	20	38%	14	30%	80	36%
1-4	4	10%	14	33%	10	25%	11	21%	12	26%	51	23%
5-9	5	12%	4	10%	3	8%	6	11%	3	6%	21	9%
10-14	2	5%	6	14%	8	20%	5	9%	8	17%	29	13%
15-17	8	20%	3	7%	10	25%	11	21%	10	21%	42	19%

Table 7.

Child Death Classifications by Gender (% of Classification)

		Female	Male	Total
Accident	Deaths	18	32	50
	%	36%	64%	100%
Adolescent High-Risk Behavior	Deaths	2	7	9
	%	22%	78%	100%
Homicide	Deaths	15	23	38
	%	39%	61%	100%
Inadequate Caretaking Skills	Deaths	5	6	11
	%	45%	55%	100%
Natural Medical	Deaths	26	29	55
	%	47%	53%	100%
Neglect	Deaths	6	7	13
	%	46%	54%	100%
SIDS	Deaths	8	8	16
	%	50%	50%	100%
Suicide	Deaths	7	8	15
	%	47%	53%	100%
Suspicious Factors	Deaths	1	2	3
	%	33%	67%	100%
Undetermined	Deaths	4	9	13
	%	31%	69%	100%
Total	Deaths	92	131	223
	%	41%	59%	100%

Table 8.

Classification of Child Deaths

	Deaths	%
Natural Medical	55	25%
Accident	50	22%
Homicide	38	17%
SIDS	16	7%
Suicide	15	7%
Neglect	13	6%
Undetermined	13	6%
Inadequate Caretaking Skills	11	5%
Adolescent High-Risk Behavior	9	4%
Suspicious Factors	3	1%

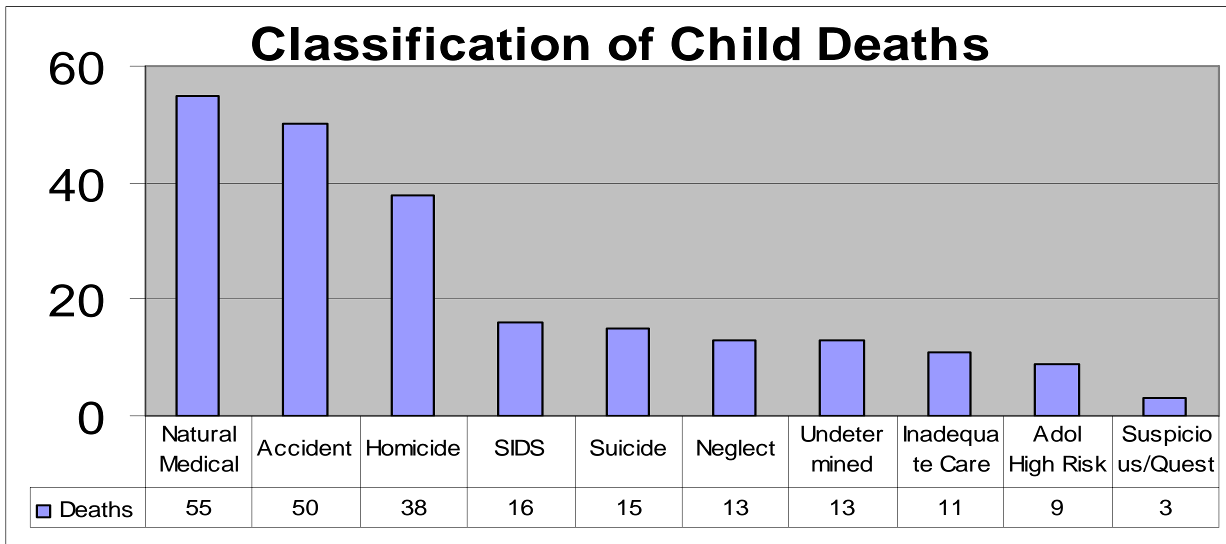


Table 9.

City of Residence by Year

	Year											
	2001		2002		2003		2004		2005		Total	
	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Deaths	%
Campbell	1	2%	1	2%	0	0%	0	0%	1	2%	3	1%
Cupertino	0	0%	0	0%	5	13%	0	0%	1	2%	6	3%
Gilroy	3	7%	1	2%	0	0%	3	6%	1	2%	8	4%
Los Altos	1	2%	0	0%	0	0%	0	0%	0	0%	1	0%
Los Gatos	0	0%	0	0%	0	0%	1	2%	0	0%	1	0%
Milpitas	2	5%	1	2%	1	3%	5	9%	0	0%	9	4%
Monte Sereno	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Morgan Hill	0	0%	1	2%	3	8%	1	2%	1	2%	6	3%
Mountain View	0	0%	1	2%	2	5%	2	4%	1	2%	6	3%
Palo Alto	2	5%	2	5%	2	5%	2	4%	1	2%	9	4%
San Jose	32	78%	31	74%	20	50%	34	64%	35	74%	152	68%
Santa Clara	0	0%	3	7%	7	18%	2	4%	3	6%	15	7%
Saratoga	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Sunnyvale	0	0%	1	2%	0	0%	3	6%	3	6%	7	3%

Table 10 a.

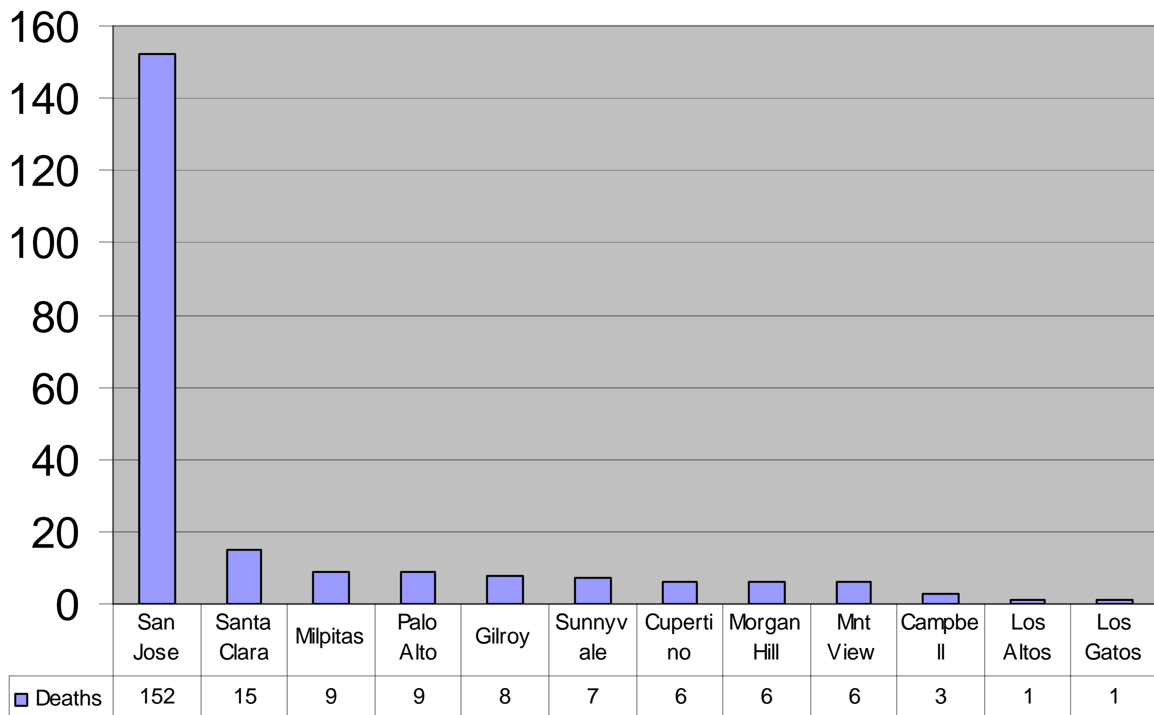


Table 10b.

Zip Codes of Reviewed Child Deaths

	Count	%		Count	%
95112	12	5%	95124	2	1%
UNKNOWN	11	5%	95046	2	1%
95020	9	4%	94304	2	1%
95136	8	4%	94301	2	1%
95050	8	4%	94085	2	1%
95035	8	4%	94040	2	1%
95014	8	4%	95368	1	0%
94086	8	4%	95143	1	0%
95128	7	3%	95118	1	0%
95120	7	3%	95070	1	0%
95132	5	2%	95059	1	0%
95037	5	2%	95054	1	0%
95148	4	2%	95032	1	0%
95133	4	2%	95030	1	0%
95127	4	2%	94806	1	0%
95121	4	2%	94705	1	0%
95119	4	2%	94550	1	0%
95111	4	2%	94305	1	0%
95008	4	2%	94303	1	0%
95129	3	1%	94089	1	0%
95126	3	1%	94043	1	0%
95125	3	1%	94041	1	0%
95123	3	1%	94039	1	0%
95117	3	1%	94037	1	0%
95113	3	1%	94025	1	0%
95110	3	1%	94022	1	0%
95051	3	1%	94020	1	0%
95138	2	1%	93728	1	0%
95135	2	1%	93635	1	0%
95134	2	1%	93291	1	0%
95131	2	1%	91331	1	0%

Table 11.

Child Death Classification by Race/ Ethnicity (% of Race/ Ethnicity)

	Asian/PI		African-Amer		White		Hispanic		Other/Unknown	
	Deaths	% Race/ Ethnicity	Deaths	% Race/ Ethnicity	Deaths	% Race/ Ethnicity	Deaths	% Race/ Ethnicity	Deaths	% Race/Ethnicity
Accident	14	26%	3	20%	15	20%	16	23%	2	22%
Adolescent High-Risk Behavior	1	2%	0	0%	3	4%	5	7%	0	0%
Homicide	9	17%	6	40%	13	17%	10	14%	0	0%
Inadequate Caretaking Skills	0	0%	0	0%	5	7%	6	9%	0	0%
Natural Medical	19	35%	5	33%	9	12%	20	29%	2	22%
Neglect	3	6%	1	7%	6	8%	3	4%	0	0%
SIDS	2	4%	0	0%	7	9%	4	6%	3	33%
Suicide	3	6%	0	0%	9	12%	2	3%	1	11%
Suspicious Factors	0	0%	0	0%	2	3%	1	1%	0	0%
Undetermined	3	6%	0	0%	6	8%	3	4%	1	11%
Total	54	100%	15	100%	75	100%	70	100%	9	100%

Table 12.

Child Death Classifications by Year

	Year											
	2001		2002		2003		2004		2005		Total	
	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Deaths	%	Deaths	%
Accident	9	22%	10	24%	6	15%	14	26%	11	23%	50	22%
Adolescent High-Risk Behavior	1	2%	2	5%	4	10%	0	0%	2	4%	9	4%
Homicide	3	7%	7	17%	13	33%	9	17%	6	13%	38	17%
Inadequate Caretaking Skills	0	0%	0	0%	4	10%	3	6%	4	9%	11	5%
Natural Medical	13	32%	6	14%	6	15%	16	30%	14	30%	55	25%
Neglect	3	7%	5	12%	2	5%	3	6%	0	0%	13	6%
SIDS	8	20%	3	7%	0	0%	2	4%	3	6%	16	7%
Suicide	2	5%	2	5%	3	8%	2	4%	6	13%	15	7%
Suspicious Factors	1	2%	1	2%	0	0%	0	0%	1	2%	3	1%
Undetermined	1	2%	6	14%	2	5%	4	8%	0	0%	13	6%

Table 13a.

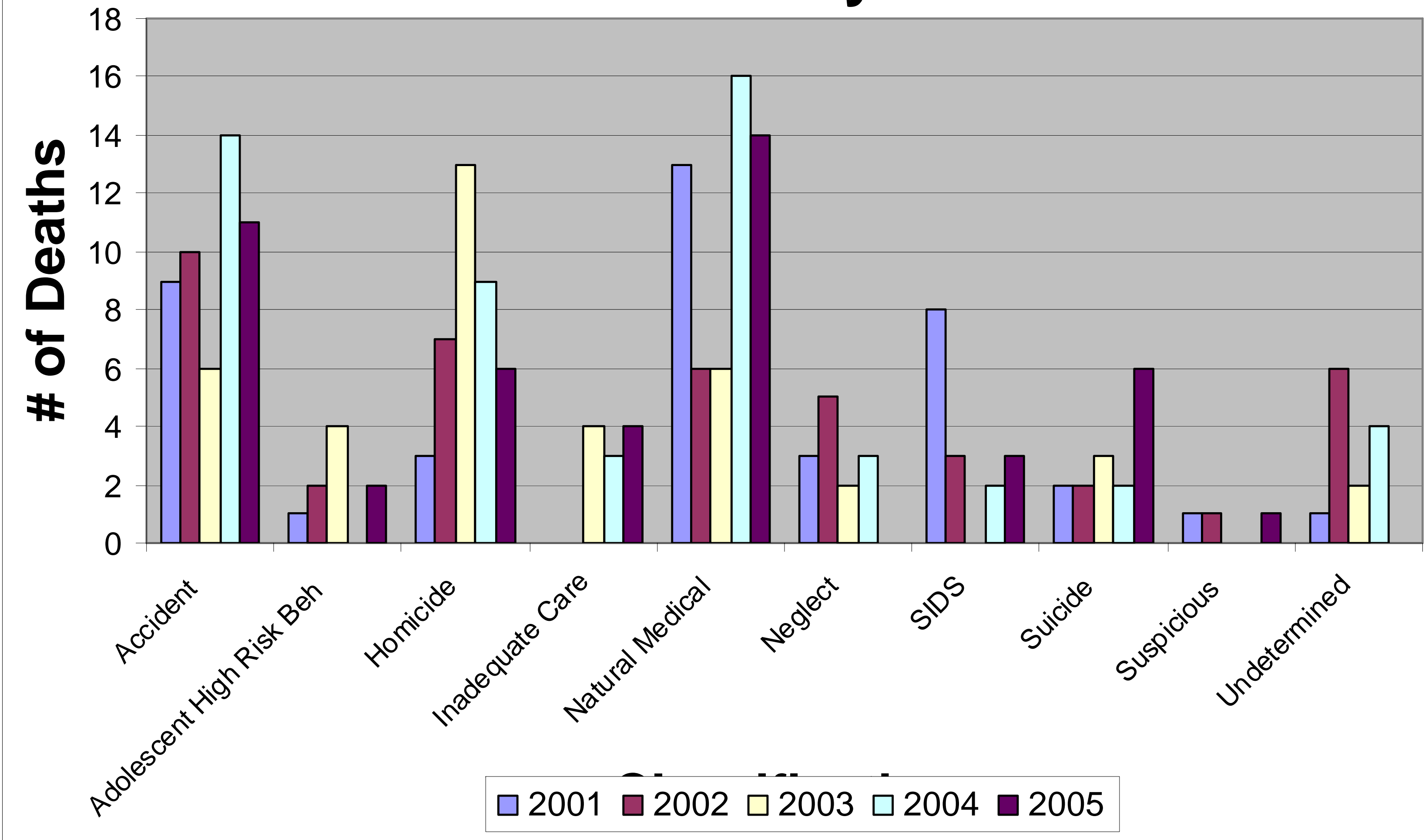


Table 13b.

KEY FINDINGS

For all child death cases reviewed ages 0-17, there were significantly more males (131) than females (92).

There were significantly more deaths of Caucasian children (75), closely followed by Hispanic children (70).

Throughout the County of Santa Clara, the City of San Jose had the highest number of children deaths. There were forty-two (42) child deaths in the East San Jose zip codes, followed by twelve (12) in the Downtown San Jose areas.

There were thirty-eight (38) homicides; --- seventeen (17) Gunshots, eight (8) Stabbings, four (4) Shaken Baby, two (2) Strangulations, one (1) Drowning, one (1) Asphyxia, one (1) Blunt impact to the abdomen, one (1) Motor vehicle, and one (1) Drug overdose. Two (2) intrauterine deaths were due to Domestic Violence. Six (6) adolescent males died in incidences related to gang activity.

Motor vehicle accidents took the lives of twenty-two (22); --- ten (10) of which were unrestrained children with one (1) improperly restrained infant. There were ten (10) teens (driver or occupants) of which six (6) of the deaths included high risk behavior: speeding, alcohol, riding in the back of a pick-up truck, or unrestrained.

Drowning took the lives of fourteen (14); --- ten (10) pools, two (2) hot tubs, one (1) koi pond, and one (1) in a bucket of water.

Twenty-seven (27) infants died in their sleep of those, sixteen (16) were SIDS cases, and eleven (11) undetermined, due to co-sleeping.

Suicide took the lives of fifteen (15); --- nine (9) males, and six (6) females.

Three (3) toddler deaths were the result of vehicle back-over.

Three (3) deaths were the result of house fires—1 of which the smoke alarm was non-operational.

Three (3) fetuses were found abandoned.

One (1) death was a result of a fall from a second story window.

One (1) death a result of an infant left in a vehicle unattended.

2001-2005 Child Death Review Team Recommendations

The Recommendations focus on the reduction of factors associated with preventable deaths.

Motor Vehicle Safety

Continue programs educating parents/caregivers on proper use of safety belts for small children. Emphasize proper use of age appropriate equipment, as well as car seat recall information. Continued seat belt enforcement by the proper authorities. Lack of appropriate use of vehicle restraints is an identified factor associated with this preventable childhood death.

Pool Safety

Diligent supervision of children at or near pool sites, reducing accidents or drowning. Lack of adequate supervision, as well as fencing of pool perimeters is the most highly identified factors associated with this preventable childhood death.

Safe Sleeping

Continue education to parents or caregivers regarding safe sleep environments. 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.

ACKNOWLEGMENTS

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. The staff of the Office of Sheriff Medical Examiner/Coroner's Office for all of their support. We would also like to thank the various agencies who facilitate participation of team members.

CONCLUSION

The Santa Clara County Death Review Team has evolved over time into a productive team that reviews the deaths of children that reside in Santa Clara County. These death reviews not only gather mandated data that is provided to the State of California, but make recommendations to prevent future 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 Santa Clara County 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, Pedestrian Safety around Schools 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. 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.

Classifications of Death

A. **Homicide**: Death clearly due to abuse, supported by Coroner's report and police and criminal investigations.
   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 Coroner's report and criminal investigations.
   1. Neglect by parent/caretaker
   2. Third party neglect

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.

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. placing the infant to sleep prone
      B. inappropriate bedding (pillow, heavy covers, adult bed, couch)
      C. maternal smoking during pregnancy
      D. maternal substance use during pregnancy
      E. 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
      A. firearm related
      B. substance use/abuse
      C. motor vehicle misuse

G. **Undetermined**