Child Death Review Team

Issues Identified/Lessons Learned

Each case reviewed by the Team yields valuable lessons or identifies systematic issues in need of attention by one, or various agencies impacting the welfare of children and families. The lessons based upon the 2010 child death cases follow. Unfortunately, most are carryovers from the previous report and have continued to surface for years.

1. Cycle of Abuse

A common factor seen in many of the child death cases is that the child's mother, father or other family member had a prior juvenile case themselves in either the Dependency Court or the Delinquency Court, or their family had contact with these agencies when they were a child. Many of them parent as they were parented, thus continuing the cycle of abuse and neglect. Ten of the 2010 child homicides involved a parent or perpetrator with a Child Protective Service (CPS) history as a child.

2. Domestic Violence

ICAN continues to sponsor the annual Nexus conference which includes a focus on the connection between domestic violence and child abuse. This connection continues to be evident in the 2010 child homicides in which nine of the families had a history of domestic violence. Seven of the nine families also had a history of contact with DCFS or another CPS agency.

3. Substance Abuse

Substance abuse by a parent or caregiver is a well documented high risk factor for child abuse or neglect. Substance abuse often plays a role when there is a child fatality if that parent or caregiver responsible for the child had prior reports or history of substance abuse. In some cases, the individual responsible for the child was under the influence during the incident that led to the child's death. A caregiver's unrealistic developmental expectations and inability to cope with age appropriate behavior, combined with drugs and alcohol, become a lethal situation causing caregivers to lose control and harm the child. In addition, parents under the influence who sleep with their infant increase the risk of overlay or suffocation leading to the death of the child. It would be important to assess for substance abuse in child abuse and neglect referrals, particularly when there has been a past history. Relapse is not an uncommon phenomenon and stress is a common trigger.

4. Mental Illness

In 2010, several children were killed by a parent, caregiver or family member with mental illness. Not all individuals with mental illness place their children at risk. However, those with chronic mental disorders who are non-compliant or uncooperative with medication, treatment, family members or other supports have the potential to place children at risk including death. Community service agencies

and treatment providers must be able to identify when a parent's mental condition puts children at risk and report it to DCFS. DCFS, in turn, needs to accurately assess for risk and develop appropriate case plans to address a caregiver's mental health needs. Additionally, the mental health needs of any family member or significant other residing in the home should be assessed.

5. Presence of Multiple Parental/Caregiver Risk Factors

Risk factors such as mental illness, history of substance use, domestic violence, social isolation, CPS contact, CPS contact as a minor and young parents are usually present when a child dies at the hand of a parent or caregiver. In 2010, only two families of homicide victims had none of these known risk factors present. Lastly, one family with no risk factors was temporarily living with extended family that did exhibit risk factors and the perpetrator was from that family.

6. Lack of Bonding or Poor Attachment

The quality of the relationship of a non-biological adult to the child should be assessed. The level of attachment and the child's responses to the adult should be part of the assessment. This is particularly important when the person assumes a caretaking role for the child. The Team has observed that each year, many of child homicides have been at the hands of the parent's boyfriend, girlfriend, step parent or partner who was not attached or bonded to the child, yet had parenting responsibilities for the child. Lacking a connection with the child may contribute to their inability to manage stress or anger and to cope with parenting the child. This is often seen with children who die as a result of blunt force trauma to the head, chest abdomen, or multiple areas.

7. Multiple Referrals

One of the best predictors of future behavior is past behavior. The Team frequently reviews cases where there have been a significant number of prior referrals to DCFS on a family. These referrals are often closed as either inconclusive or unfounded. In a number of cases, re-examining the prior referrals has determined that the finding of unfounded was an incorrect finding and would have been better determined as at least inconclusive and, in some cases, substantiated. This means the reporting to the Child Abuse Central Index (CACI) will also be inaccurate which could allow someone to obtain a child care or foster care license when there has been an allegation against them. Further, the opportunity to offer services to a family at risk is lost which might have been a preventive factor for the death.

8. Immediate Inter-county Sharing of all Referral and Case Information on the Statewide Child Welfare Services/Case Management System (CWS/CMS) among Child Protective Services (SPS) Agencies

Families are not static and move from one county to another within the state. Although a family may have no child welfare history in Los Angeles County with DCFS, they may have had contact with CPS in another county. The Team has learned that workers do not have access to the services case notes or case documents for other counties in closed referrals or cases from another county.

When there is an open court case from another county, a worker can access the court file, but not the services information located on CWS/CMS. Opening CWS/CMS and finding a previous allegation and/or case but not having immediate access to the detailed services case information seems to defeat the purpose of a statewide system. Valuable information and time is lost in assessing risk and providing services to a family.

9. Safe Infant Sleeping

The Team continues to spend a great deal of energy focusing on deaths associated with unsafe sleeping practices involving the sleep position (prone or side) of the infant and/or the sleeping environment. These deaths are tragic and are clearly preventable.

Although the issue of bed-sharing with an infant has sometimes been tied to cultural values and bonding issues, the Team continues to note a disturbing number of deaths associated with bed-sharing and has made recommendations to help prevent these deaths. Infants should be placed in a separate sleep space meant for infants, on their back, and with no soft or loose bedding. In addition, the American Academy of Pediatrics has released research confirming the risk of bed-sharing with infants and recommends against bed-sharing endorsing room-sharing with the infant instead.

The Team has observed that infants are often surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. However, statistics indicate overheating contributes to infant mortality. Infants should not be placed on soft bedding or pillows and should not be covered with blankets or dressed in layered clothing when put to sleep. Infants also should not be placed in cluttered cribs or play pens, car seats, strollers, swings, couches, chairs, futons or adult beds to sleep.

ICAN has partnered with First 5 LA and joined with the Department of Public Health, the Department of Children and Family Services, and other public and community agencies to conduct a safe sleeping campaign. A Safe Sleep Tips for Your Baby brochure has been distributed to local clinics, hospitals, county departments and agencies, and child development networks.

The office of Supervisor Mark Ridley-Thomas has provided leadership and First 5 LA has assumed a major role sponsoring the safe sleeping task force in Los Angeles County. .

10. Drowning/Accidental Death

Drowning has long been a leading cause of accidental child death and some homicides where there is a clear lack of supervision. Through the examination of drowning in various venues, the Team has learned that it is very easy for a young child to drown without anyone being aware of it. A young child's head is heavy and pulls the child under the water before he or she is able to make any sound. Further, drowning is a silent killer. Contrary to popular belief, there is no splashing, waving,

screaming or calling for help. The Team has learned that a drowning child's natural instinct is to breath and speech is secondary. Voluntary movements such as waving are not possible as the natural response is to extend one's arms laterally and press down on the waters' surface to leverage the body in order to lift one's mouth out of the water to breathe. The process of drowning is therefore undramatic and quiet.

In addition, the Team has discussed the concept of diffused responsibility in such cases (and other accidental death cases) where the parties who are supposed to be supervising the child each believe that the other(s) are watching the child; thus, as the responsibility for supervising the child has been diffused among the various adults, in fact, the child is actually unsupervised.

11. Fetal Death Associated with Maternal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appears to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a number of fetal deaths with a contributing factor of maternal substance abuse. Although the number of these deaths has been declining, they remain one of the top four causes of accidental death.

12. Improved Communication Among Agencies

When a family is involved with multiple systems, it is imperative that the agencies servicing the family have ongoing communication with one another for child safety, investigation, and case management purposes. The lack of such communication leaves individual professionals with a one-dimensional view of the case. The Family and Child Index (FCI) is a tool for investigations that alerts an agency of other various agencies having involvement with a family. DCFS, schools, Department of Health, Department of Public Health, Department of Mental Health, Department of Probation, law enforcement agencies, the District Attorney and City Attorneys, and community based agencies should also have ongoing forums to facilitate communication and connections between agencies. These forums would foster better collaboration and understanding of each other's role in child abuse cases. ICAN provides one such forum but others are needed to keep the process going.

13. Poverty/Insurance/Medi-Cal

There have been several cases where a family has been unable to obtain appropriate medical care or medication for a sick child due to a problem with medical coverage – either a lack of coverage, problem with a Medi-cal card, or co-payment. This has also been observed by the Child and Adolescent Suicide Review Team in that a child in need of therapy and/or psychotropic medication did not receive them due to problems with medical coverage or high Medi-Cal co-payments. Medical clinics should ensure that a family is referred to an appropriate medical care setting in the event they present with an ill child and no insurance coverage.

14. Community Care Licensing (CCL)

CCL is the state entity responsible for the licensing and oversight of foster care homes and child care facilities. There have been child death cases in which CCL had informed a provider not to allow certain individuals to be present at the home or day care site as they do not meet licensing standards. This is particularly true of individuals with criminal backgrounds. In many cases, these individuals were actually responsible for the child's death. When CCL bars someone from a site, they need to follow-up to assure there is compliance with their determination. CCL should make unannounced visits to the site to verify compliance.

15. Criminal Justice System

As part of the review process, the Team examines whether or not criminal charges can be filed on any given case. Often these cases are rejected for the filing of charges as there is insufficient evidence to determine the actual perpetrator of the injuries to the child, particularly when there are a number of people present at the time of the death, or the timeline for the death cannot be determined. Team members are often frustrated when charges cannot be filed, especially when the medical evidence is clear that the child suffered inflicted trauma. Despite this frustration, the District Attorney has a strong ethical duty to only file charges when they believe there is clear and convincing evidence beyond a reasonable doubt that someone has committed a crime.

The Team has also discussed the ability of the District Attorney's Office or City Attorney's Office to file charges against a "non-offending" parent for failure to protect the child when they must have been aware of the abuse that the child was suffering. This has been pursued in a limited number of cases.

Child and Adolescent Suicide Review Team

Issues Identified/Lessons Learned

1. Suicide Rate

The suicide rate among individuals under the age of 18 years increased from 14 suicides in 2009 to 16 in 2010. Despite the increase in 2010, we have seen a downward trend in youth suicides over the last ten years. The highest number of youth suicides was in 2001 with 27 which fell to 19 suicides in 2002 and 2003.

2. Law Enforcement Response

Through the review of cases, the Team has seen an increase in the impulsive behavior of youth. In 2010, only four of the youth left suicide notes. The investigative practices among law enforcement agencies vary considerably in cases when suicide is suspected. When there is no suspicion of foul play, some investigations are limited because criminal activity is not present. In such cases additional information available to investigators has value to those concerned with prevention, including the Team. Potent sources of prevention information include the youth's computer, records of the youth's Internet activities, cell phone records and interviews of the youth's friends. Friends may be privy to information that was being kept purposely hidden from parents and family. The team has discovered suicidal teens talk to friends about their mood, feelings, cognitions, behavior and suicidal intent. In addition, the team has discovered Internet communications that indicate risk factors and suicidal thinking to "virtual" friends on social networking sites.

Whenever these sources are not explored, a great opportunity to learn more about suicidal thought and motivation is lost forever. Many law enforcement agencies recognize the prevention value of conducting a thorough investigation in cases of suicidal behavior. The Los Angeles County Department of Coroner has taken the lead in its efforts to expand their investigation and documentation in suspected suicide cases. It is recommended that all law enforcement agencies also develop a protocol for suicide investigations.

3. Social Networking

The role the Internet plays in the lives of youth is an important one. Some youth use social networking to communicate to their peers about their feelings and, in some cases, the intent to end their lives. The Team has developed a social networking template and routinely checks social networking sites and the internet to gain additional information about a youth's mind set and the response to their suicide. The Team has found this to be a great tool to gain a better understanding of a youth.

An important and disturbing trend among suicidal youth is the relationship with Internet "friends." Some youth have been ostracized, bullied or otherwise socially isolated in real life. The Internet provides access to "virtual friends" from which they seek support. While satisfying in many ways, sometimes the relationships are based on "selves" and are often transitory. The internet has become an attractive home for many youth that are deficient in social skills in the actual world. Some youth may have more than one social networking account. For example, parents may have had privileges to access a Facebook page which they monitored on a regular basis. Unbeknownst to them, however, may be one or more accounts being kept private from them and from which they did not access privileges, resulting in a lost opportunity for parents to recognize and respond to suicidal clues of their children. Limited access to private Internet sites is also an obstacle to the ability of the Team to study these cases. Like many parents, the Team is not a user who was pre-authorized to access this information and the Team is prevented from collecting important information about chronic and acute risk factors and warning signs.

4. Communication Barriers between Agencies/Professionals/Parents

Perceived barriers to communication among professionals from schools and/or agencies continue to result in a significant barrier to timely communication that might have resulted in more effective intervention to prevent suicides among youth. Many private practice providers are reluctant to share timely information because they are unaware of important exceptions to legislative requirements to maintain patient confidentiality.

The Team has observed school personnel are often unaware that a students' family is under investigation for suspected child abuse. Schools should always be informed when agencies are working with children. As children spend the majority of their day at schools, they may have crucial information about a child and/or family. Knowing another agency is working with a child may help strengthen the safety net around a child.

Schools are often in a position to provide at risk students with support and they can play a crucial prevention role by monitoring the behavioral effects of medication at school. However, some parents choose to exercise their right to privacy and not disclose to schools that students are at risk and/or receiving services. All agencies providing mental heath services to youth should provide detailed information about the risks and benefits of information exchange and this should be carefully explained to families. The Team has reviewed cases in which the family was not forthcoming to schools, agencies, and social service workers with information about prior suicide attempts with tragic results.

5. Access to Mental Health Services

The Team has observed that parents may have health insurance or Medi-Cal but after the initial intervention, the family's share of cost is a barrier to continue access to mental health intervention for children and youth at risk for suicide. Children at

risk for suicide should have access to culturally competent mental health services without regard to citizenship, immigration status, language or insurance coverage.

6. Need for Monitoring Youth Prescribed Psychotropic Medication

When children at risk for suicide are receiving psychotropic medication for treatment of psychological symptoms, adherence to the medical regimen should be carefully monitored. Health professionals need to consider the financial impact of treatment to reduce non-adherence that occurs when prescriptions are not refilled on a timely basis. The importance of refilling prescriptions needs to be clearly explained to both the child and family.