



ICAN

Deanne Tilton Durfee, Executive Director

Los Angeles County ♦ ICAN Multi-Agency Child Death Review Team

(626) 455-4585 Fax (626) 444-4851 Email tiltod@dcfs.lacounty.gov



Report Compiled from 2008 Data

Child Death Review Team Report for 2009

Table of Contents

Table of Contents.....	1
Forward.....	2
Introduction	3
Los Angeles County Child Death Review Team Members.....	5
Los Angeles County Child and Adolescent Suicide Team Members.....	7
Recommendations	9
Child Death Review Team Issues Identified/Lessons Learned	15
Child and Adolescent Suicide Review Team Issues Identified/Lessons Learned.....	21
Selected Findings.....	22
Team Accomplishments	27
Selection of Cases for Team Review	29
Child Deaths In Los Angeles County 2004 – 2008.....	31
Child Homicides by Parent, Caregiver or Other Family Member 1994 – 2008	33
Child and Adolescent Suicides 1994 – 2008	51
Accidental Child Deaths 1994 – 2008	61
Undetermined Child Deaths 1994 – 2008.....	71
Third Party Homicides 2007– 2008.....	80
Third Party Homicides Findings.....	84
Appendix A On-line Resources.....	95

Forward

In 1978, the ICAN Multi-Agency Child Death Review Team was formed to review child deaths in which a caregiver was suspected of causing the death. The Team reviews these deaths to better understand the dynamics of the systems involved with families in order to help them intervene more effectively to prevent child deaths.

This thirty-first annual report of the ICAN Multi-Agency Child Death Review Team provides information on children's deaths that occurred in Los Angeles County during calendar year 2008. The purpose of the report is to provide a detailed analysis of children's deaths in Los Angeles County, their relationship to maltreatment and ICAN agencies' involvement with these children and families prior to and following the death.

The process of the Team has evolved and matured over the past thirty years. Initially, most cases reviewed by the Team were child homicides by a parent, caregiver or family member. Today, the Team reviews these cases along with selected undetermined or accidental child deaths. A separate team was formed in 2001 to review child and adolescent suicide in Los Angeles County.

This 2009 report reflects the continuing commitment to report on all child deaths which have met Team protocol. For the second year, however, the report includes a special supplement to provide data on youth who are victims of a third party homicide.

The purpose of this information is to provide a broader analysis of children and youth deaths in Los Angeles County. Although the number of third party homicides declined in 2008 (n=82) from 2007 (n=100), the rate of these deaths continues to be significant. Thus it is still relevant to provide an analysis of these third party homicide deaths in the hope of gaining a better understanding of child death in Los Angeles County. Ultimately, it is hoped that the study of these deaths will help us intervene more effectively to prevent them.

Introduction

The ICAN Multi-Agency Child Death Review Team is comprised of representatives of the Department of Coroner, Los Angeles Police and Sheriff's Departments, District Attorney's Office, Los Angeles City Attorney's Office, Office of County Counsel, Department of Children and Family Services, Department of Health Services, County Office of Education, Department of Mental Health, California Department of Social Services and representatives from the medical community.

California law requires that all suspicious or violent deaths and those deaths in which a physician did not see the decedent in the 20 days prior to the death be reported to the Department of Coroner. The Coroner is responsible for determining the cause of death to be listed on the death certificate as either: homicide, suicide, accident, natural, or undetermined.

The Department of Coroner refers all cases it has received for children age seventeen (17) and under to ICAN, including fetal deaths, and ICAN staff reviews these cases to determine which cases meet Team protocol. This process first involves the exclusion of all natural deaths. Thereafter, cases that meet at least one of the following criteria are selected for review:

- Homicide by caregiver, parent or other family member
- Suicide
- Accidental death
- Undetermined death

Specific cases are identified for in-depth review by the Team in the Team meeting setting; such cases are most often high profile in nature and/or cases for which a Team member has requested the Team's multi-disciplinary perspective. Generally, three to five cases are reviewed at each month's Team meeting. Due to the high volume of cases that meet Team protocol, not all deaths receive this detailed review by the entire Team, which often requires several hours of Team time per case.

This annual report of the ICAN Child Death Review Team provides information on *all* children's deaths that meet Team protocol and occurred in Los Angeles County during 2008. It provides a detailed analysis of children killed by caregivers, youth suicides, accidental deaths and undetermined deaths. The report also includes information on 3rd party homicides of youth 17 years and younger for the second year.

This report also contains recommendations for action, which, if implemented, should improve child safety and save lives.

Pam Booth
Los Angeles County
Office of the District Attorney

Child Death Review Team
Co-Chair

Dr. Michael Pines
Los Angeles County
Office of Education

Child and Adolescent
Suicide Review Team
Co-Chair

Carol Berkowitz, M.D.
Harbor/UCLA
Medical Center

Child Death Review Team
Co-Chair

Rosemary Rubin
Los Angeles Unified
School District

Child and Adolescent
Suicide Review Team
Co-Chair

Los Angeles County Child Death Review Team Members

Victoria Adams
Office of the District Attorney

Doug Harvey
California Department of Social Services

Fimy Aghoian
Office of County Counsel

Nancy Hayes, LCSW
Mattel Children's Hospital

Denise Bertone
Coroner

Mary Healy
Office of County Counsel

Patti Culross, MD
Public Health

Lt. Pete Hetterma
Pasadena Police Department

Det. Paul Delhauer
Sheriff's Department

Angel Hopson, RN, MSN/MPH, CNS
Public Health

Sandra DeVos
ICAN

Angela Hudson, Ph.D., FNP-C
Public Health

Michael Durfee, MD
ICAN/NCFR

Ruby Jeffery
Children & Family Services

Melissa Egge, MD
Harbor/UCLA Medical Center

Marilyn Kading Martinez
Edelman Children's Court

Kerry English, MD
King Foster Hub

Diane Kochones
Children & Family Services

Lidia Escobar
ICAN

Maria Lieras
Children & Family Services

Paula Gamboa
Children & Family Services

Lt. Art Lucas
Sheriff's Department

Taryn Goff
Public Health

Sharon Marino
Children & Family Services

Shirelle Gordon-Thompson
Probation

Det. Maria Martinez
Los Angeles Police Department

Allison Hanson
Children & Family Services

Monika McCoy, Ph.D
Director, Child Abuse Councils

Linda Medvene
Office of County Counsel

Lt. Vincent Neglia
Los Angeles Police Department

Det. Nancy Nelson
Los Angeles Police Department

Michael Pines, Ph.D
Pines Institute

Franklin Pratt, MD
Fire Department

Gary Puckett, Ph.D
Mental Health

Karen Rodgers, RN MICN
Health Services

Lakshmanan Sathyavagiswaran, MD
Chief Medical Examiner-Coroner

Edie Schulman
ICAN

Maureen Siegel
Office of City Attorney, Los Angeles

Amy Suehiro
Office of the District Attorney

Miyoshi Taylor
Children & Family Services

Sara Thompson, MD
Harbor/UCLA Medical Center

Deanne Tilton-Durfee
Executive Director, ICAN

Ray Vincent
Office of Education

Cathy Walsh
ICAN

Paula Whiteman, MD
Cedars-Sinai Medical Center

David Whiteman, MD
Coroner

Janice Woods, MD
High Desert Health System

Captain to Zuniga
Sheriff's Department

Los Angeles County Child and Adolescent Suicide Review Team Members

Tony Beliz, Ph.D
Mental Health

Sandra Guine
Public Health

Linda Boyd
Mental Health

Wendy Hammond
Gateways Hospital

Officer R. Rub
Los Angeles Police Department

Keith Harris, Ph.D
University of Queensland

Rev. Rick Byrum
Holy Trinity & St. Benedict Parish

Lynda Herrera
Almanson Center

Greg Carlsson
Community Development Commission

Monika McCoy, Ph.D
Director, Child Abuse Councils

Sandra DeVos
ICAN

Lyn Morris
Didi Hirsch Mental Health Suicide Prevention

Elizabeth Koo Edwards, Ph.D
Children & Family Services

Stephanie Murray
California High School

Lidia Escobar
ICAN

Nicole Perras
Health Services

Suzie Ferrell
Sheriff's Department

Irene Pines
Pacific Clinics

Thomas Gallagher
Loyola High School

Michael Pines, Ph.D
Pines Institute

Jessica Gamma
Probation

Martha Reza, Ph.D
Office of Education

Al Garcia
United American Indian Movement

Patricia Rodriguez-Holguin
UCLA Student Psychological Services

Marissa Gehley-Rosoff
School Law Enforcement Partnership

Mike Rogel
El Monte School District

Rene Gilbertson
County Counsel

Rosemary Rubin
Los Angeles USD

Leticia Gomez
Children & Family Services

Lakshmannan Sathyavagiswaran, M.D.
Chief Medical Examiner-Coroner

Emily Sears Vaughn
Marlboro School

Rabbi Danny Tyiftach
Chabad Jewish Community Center

Sara Sherer, Ph.D
Children's Hospital Los Angeles

Ray Vincent
Office of Education

Monique Smith
United American Indian Movement

Tracy Webb
Office of City Attorney Los Angeles

Charles Sophy, MD
Children & Family Services

Linda Weinberger, Ph.D
USC School of Medicine

Tom Sopp
Long Beach USD

Patricia Wilkinson
Office of the District Attorney

Deanne Tilton
Executive Director, ICAN

*For additional information about this report, you may contact Sandra DeVos,
Program Administrator, ICAN, at (626) 258-2058, devoss@dcfs.lacounty.gov*

Recommendations

All child deaths are tragic because most can be prevented. A preventable death is one in which an individual, community or system could have reasonably done something that would have changed the circumstances that led to the death.

The Team considers all accidents and homicides preventable through active intervention such as improved parenting skills, improved parent/caregiver supervision, parent education, legislation, improved and coordinated investigations by Department of Children and Family Services (DCFS) and Law Enforcement. Suicides may be prevented through timely and appropriate interventions to combat bullying, depression, and other mental illness. SIDS and Sudden Unexpected Infant Death (SUID) may be prevented by improving education for parents, caregivers and the public about the risk factors identified by the Team for these types of deaths. Reducing prenatal smoking, second hand smoke exposure, alcohol and illicit drug use, and safe sleeping practices is likely to reduce the number of these undetermined deaths.

The primary goal of the Team is to reduce the number of child deaths in Los Angeles County through multi-disciplinary case review, education of professionals and the public, and by making recommendations for public policy and legislation. To this end, based on the child death case reviews and trends seen in the 2008 data, the Team is making the following recommendations:

Recommendations:

- 1. Law Enforcement agencies should explore the feasibility of including in their protocols immediate drug and alcohol screens on parents, caregivers and any adult having access to a child just prior to the child's death. Protocols for such testing should stress the importance of these screens for all cases of severe or fatal harm to children and should particularly emphasize the importance of testing in cases of deaths related to co-sleeping, unsafe sleep practices and traffic incidents.**

Rationale: Alcohol and drugs frequently play a major role whenever a death or serious injury to a child occurs. In order to assess the extent of involvement the use of substances contributed to the death of a child, immediate testing at the death scene on all care providers present when the child dies should be done. Otherwise, deaths may be inaccurately coded as to cause; perpetrators may go unidentified or unpunished and the involvement of substances in child deaths goes unreported and therefore is not addressed by social service or legislative action.

Note: This recommendation relates to the Safe Sleeping and Cross Reporting to Law Enforcement and/or DCFS sections in the Lessons Learned portion of the report.

- 2. The Family and Children's Index (FCI) be expanded to include LA County Health Services Hospitals, Children's Hospital, the Coroner and Los Angeles Police Department. Further expansion to include other law enforcement agencies and hospitals should be explored once the above agencies are successfully utilizing the index.**

Rationale: The TEAM has observed that many families in which a child dies due to abuse or neglect had received services from other agencies without each other's knowledge. FCI is a pointer system which alerts agencies of a family's involvement or history with other agencies. Encouraging communication, information sharing and collaboration among human, health and law enforcement agencies will assist in better identification and the provision of support to families at risk for abuse/neglect.

Note: This recommendation relates to the Cycle of Abuse, Collateral Contacts and Improved Communication among Agencies sections in the Lessons Learned portion of the report.

- 3. Centers of Excellence and the countywide Child Abuse and Neglect Protocol should be utilized for expanded and ongoing training to healthcare professionals.**

Rationale: A doctor's opinion is powerful and influential and can impact the manner in which DCFS responds to an allegation of abuse or neglect. DCFS workers rely on medical experts' opinion in their decision-making process regarding the nature of a child's injury. Children who die are sometimes injured and treated in emergency rooms weeks or months prior to their deaths. These warning signs that a child may not be safe can be deferred when an injury is labeled as accidental in nature by a physician when the parents brought the child in for treatment. To ensure that when a child is brought into an ER, clinic or physician by a family member or other person, the staff at these facilities should be trained to refer a family to a Center of Excellence when they have a reasonable suspicion that child abuse/neglect may be involved.

Note: This recommendation relates to the Mandated Reporting and Medical Information and Examinations sections in the Lessons Learned portion of the report.

- 4. Healthcare providers should call both DCFS and law enforcement when there is a strong suspicion of inflicted injury to a child.**
- 5. Additionally, when Child Protection Hotline intake evaluators receive a report of suspicious physical injuries from healthcare providers, they should code the allegations as possible severe neglect and/or physical abuse in order to trigger a mandatory cross-report through E-SCARS to law enforcement.**

Rationale: Infants one year of age and under continue to be the most vulnerable victims of homicide by a parent/caregiver or other family member and represent 53% of all child homicides (in Los Angeles County in 2008). Although infant fatalities are most often related to traumatic injuries of the head and abdomen, such injuries can appear on occasion alongside other medical conditions that can complicate the assessment of child abuse by medical professionals which, in turn, can negatively impact the reporting and investigation of child abuse by both DCFS and law enforcement. This will ensure that law enforcement is able to begin an investigation as promptly as possible. The development of the Electronic Suspected cross-reporting system (E-SCARS) is a tremendous asset to cross-reporting and should ensure more timely responses. However, in cases where there is strong suspicion of inflicted injury, notifying both agencies directly will help ensure the prompt response needed to conduct a thorough and appropriate investigation.

The Team further observed that when medical professionals reported suspicious injuries occurring with complicated medical circumstances to the Child Protection Hotline, the reporter's discussion of the circumstances is often misconstrued as an indication that no physical abuse was suspected and thus no cross report was made to law enforcement by the hotline. Dual reporting to law enforcement and DCFS would ensure independent and thorough investigations and assessments are conducted by both law enforcement and DCFS.

Note: These recommendations relates to the Mandated Reporting, Cross Reporting and Medical Information and Examinations sections in the Lessons Learned portion of the report.

- 6. It is recommended that universal neonatal home visitation by a public health nurse be made available to first time parents. At a minimum, home visitation should be provided to teen parents, high risk families in which children have special needs, families in which there are three or more children under the age of 5 years, and when either parent has a history of substance abuse or domestic violence. Families should have the opportunity to accept voluntary services from programs such as the Nurse-Family Partnership, Prenatal Care Guidance, Comprehensive Perinatal Services Program, Black Infant Health Program and Best Start LA.**

Rationale: The Team has observed various high risk factors in child deaths such as lack of biological relationship, lack of attachment to the child, lack of parenting skills, unrealistic developmental expectations, history of child abuse and neglect as a child, substance abuse, domestic violence and parental mental illness. Home visitation has been found to be a highly effective preventive measure to child safety. Home visitation allows for an observation of the home environment, the parent-child interaction, parental attitudes and expectations. Home visitors are trained in identifying post-partum signs of depression or other psychiatric illness and can seek assistance for a family. Additionally, they can observe the physical home for safe sleeping practices, sanitary conditions, the presence of unsafe situations such as an unfenced pool, signs of alcohol

or drug abuse and domestic violence. Services include pre-natal support, parenting skills, household management, resource referrals and coping skills.

Note: This recommendation relates to the following sections of the Lessons Learned portion of the report: Safe Sleeping, Cycle of Abuse, Domestic Violence, Lack of Bonding or Poor Attachment and Medical Information and Examinations.

- 7. First 5 LA, the Department of Public Health (DPH) and the Department of Children and Family Services (DCFS) should provide information on safe sleeping practices to hospitals, community health departments, local clinics, child development networks and child care resource centers for dissemination to parents. The Safe Sleep Tips for Your Baby brochure should be provided to expecting and parents of newborns. DPH, DCFS and First 5 LA should continue to work with ICAN to promote and distribute this brochure to the public to encourage safe sleeping practices.**
- 8. All birth hospitals in Los Angeles County should ensure that new parents receive the Safe Sleep Tips for Your baby brochure. Additionally, a face to face conversation with the new parents on safe sleeping practices and environments take place prior to the discharge of the newborn.**
- 9. The Perinatal Advisory Council/Los Angeles County (PAC/LAC) and other perinatal Councils should continue to survey birthing hospitals in an effort to better determine what these hospitals can do to provide accurate information about the possible dangers of co-sleeping and to encourage safe sleeping practices. Additionally, the Councils can encourage hospitals to inquire about the sleeping environment the newborn is going home to and promote safe sleeping practices.**
- 10. The Consumer Product Safety Commission (Commission) should include information on safe sleeping in products used for infants. In addition, the Commission should encourage the development of new products that facilitate safe sleeping, e.g. infant beds that can be used in or next to the parents' bed to allow a parent to place the infant in a safe place after feeding.**
- 11. When a Children's Social Worker assesses a family with a child under the age of one year, information about safe sleeping practices should be emphasized with the parent or caregiver. The worker should inquire and assess the sleeping environment and practices for the child and provide the family with a Safe Sleep Tips for Your Baby brochure if they have not already received one.**

Rationale: The number of child deaths associated with co-sleeping or "overlay" continues at an alarming rate. Thirty-eight percent of undetermined child deaths were associated with co-sleeping in 2008. Families with infants under the age of one year

need to be aware of the risk of co-sleeping to ensure the infant's safety and survival. Co-sleeping, particularly with a caregiver under the influence of drugs or alcohol increases the chance of overlay or suffocation resulting in Sudden Unexpected Infant Death (SUID). In Los Angeles County, an additional 15% of infants died due to unsafe sleeping environments. Unsafe sleep environments includes sleep surfaces not intended for an infant (adult bed, sofa, couch, chair or futon), excessive bedding, pillows, bumper guards or toys, excessive swaddling, sleeping with face or head covered, sleeping on side or prone. According to a study by the American Academy of Pediatrics and reported by the Centers for Disease Control, 40% of infant deaths nationwide were associated with co-sleeping or unsafe sleep practices.

Note: These recommendations are based on the Safe Sleeping section in the Lessons Learned portion of the report.

12. Whenever there are allegations of physical abuse, severe neglect, or suspected medical problems, DCFS should collaborate closely with PHNs co-located in the office.

Rationale: Public health Nurses have a medical background and knowledge of medical terms which permits them to better interpret medical records, diagnosis and more effectively interface with other medical professionals. PHNs are trained to observe the overall health of a child and developmental growth. Jointly, whether through a review of medical records or joint home call, a CSW and PHN can better respond to a child's medical needs or the identification of physical abuse.

Note: This recommendation relates to sections on Collateral Contacts, Improved Communication among Agencies, Medical Information and Examinations and Lack of Bonding or Poor Attachment in the Lessons Learned portion of the report.

13. Both law Enforcement and DCFS should follow agency protocol on disrobing children and not assume this was done by the other agency. In addition, all agencies should review and follow the ICAN Countywide interagency Protocol¹ when responding to reports of suspected child abuse and neglect. This would include DCFS requesting criminal record checks from law enforcement on all adults known to have access to a child reported for suspected abuse or neglect.

Rationale: The TEAM observed in one case in which a child died of malnourishment, a physical abuse referral was cross reported to law enforcement and DCFS two months prior to the death. Both agencies responded separately and did not communicate with each other. Law enforcement did not disrobe the child when they responded believing DCFS would in their investigation. The parents denied the allegation to DCFS and it

¹ The ICAN Los Angeles County Child Abuse and Neglect Protocol can be downloaded from the websites ican4kids.org or ican_ncfr.org.

was closed as unfounded. Had either disrobed this child and/or referred her for a medical exam, the signs of failure to thrive would have been evident.

Note: This recommendation relates to sections pertaining to Following Agency Protocols for Disrobing Children, Collateral Contacts, Medical Information and Examinations, Lack of Bonding or Poor Attachment, Multiple Referrals and Improved Communication among Agencies in the Lessons Learned portion of the report.

Child Death Review Team

Issues Identified/Lessons Learned

1. Safe Sleeping

The Team has spent a great deal of energy focusing on deaths associated with co-sleeping. These deaths are tragic and are clearly preventable. In the past, the issue of co-sleeping with an infant was considered controversial and tied into cultural values and bonding issues. However, the Team continues to notice a significant increase in the number of deaths associated with co-sleeping and has made recommendations to help prevent these deaths. In addition, the American Academy of Pediatrics and Centers for Disease Control have released research confirming the risk of co-sleeping with infants. The Team has determined that it is important to focus on safe sleeping practices in an effort to minimize the risk to an infant co-sleeping with a caregiver.

One lesson the Team has learned is that these infants are often surrounded by bedding and pillows and are often bundled in clothing in an effort to keep the infant warm. However, statistics indicate overheating contributes to infant mortality and that infants should not be surrounded by pillows, blankets and layered clothing when put to sleep.

The Team has also discussed the role that drugs and alcohol can play in a co-sleeping related death and has discussed the possibility of seeking legislation requiring that parents of infants who die after co-sleeping be required to be tested for any form of substance abuse. Often these parents are unaware that they are overlaying and smothering the child as they are under the influence of drugs and/or alcohol.

The Team (ICAN) has joined with the Department of Public Health, First 5 Los Angeles and the Department of Children and Family Services to conduct a safe sleeping campaign. A Safe Sleep Tips for Your Baby brochure has been produced with the goal to provide a safe sleeping brochure to every family with a newborn or infant, local clinics, hospitals, county departments and agencies, and child development networks.

2. Cycle of Abuse

A common factor seen in many of the child death cases is the fact that the child's mother, father or other family member has had a prior juvenile case themselves in either the Dependency Court or the Delinquency Court. The cycle of abuse becomes evident in these cases.

3. Domestic Violence

Over the years, the TEAM has seen the connection between domestic violence and child death. When there is violence between adults in the home, children often become the target of violence, either intentionally or unintentionally.

4. Mandated Reporting

The issue of mandated reporters failing to report suspected child abuse and neglect is a common theme in many of the cases reviewed. It is clear that more training is needed regarding mandated reporting and that such training should attempt to help clarify how one defines a “reasonable” suspicion of abuse or neglect. The Team has reviewed many cases where a child’s life may have been saved had a report to the Department of Children and Family Services (DCFS) and/or law enforcement been made when the child was seen for a prior injury or exhibited signs of abuse in school or at doctor visits. Reporting of injuries and cross-reporting between DCFS and law enforcement are long standing issues addressed by the Team.

The Team has learned that quite often a physician who had previously provided care to a child who has died, is never notified of the fact of that child’s death. The Team has taken action to notify prior providers of care for a child both as a courtesy to that provider and in an effort to help educate physicians as to possible missed red flags or in an effort to provide general education regarding child abuse and neglect.

5. Multiple Referrals

Frequently the Team reviews cases where there have been a significant number of prior referrals on a family; often these referrals are closed as either inconclusive or unfounded. In a number of cases, in re-examining the prior referrals the Team has determined that the finding of unfounded is an incorrect finding and would have been better determined as at least inconclusive and, in some cases, substantiated. The Team has struggled with the issue of how many prior referrals must there be on a case before it becomes clear that the family has some unaddressed needs. It is noted that if a prior referral is determined to be unfounded, this will not trigger the Structured Decision Making (SDM) tool to place a family at higher risk. Thus, it is crucial that only cases that are truly unfounded be determined as such. The Team has questioned whether or not the risk for a family should be assessed upward after a certain number of prior referrals.

The Team has discussed the confusion that appears to exist surrounding the terms “unfounded,” “inconclusive,” and “substantiated” and has asked County Counsel to participate in providing ongoing training to social work staff on how to make such a determination on each referral, including the evidentiary information needed to conclude that a case is “inconclusive” rather than unfounded.”

6. Cross Reporting to Law Enforcement and/or DCFS

When there are allegations of physical or sexual abuse or severe neglect, a cross report should be made to law enforcement and DCFS. The Team has learned that when cross reporting is not done, a thorough investigation is not always conducted which can result in for a time delay. This may give parents time to “create” an explanation for a child’s injuries.

Additionally, when there are multiple addresses for the parent and child, this often requires multiple cross reports to ensure the appropriate law enforcement agency is properly notified to conduct an investigation. The responding CSW needs to follow up with law enforcement rather than letting the hotline intake evaluator's notification stand as the only contact.

When there are children in a vehicle in which the parent is arrested for a DUI, law enforcement should cross report to DCFS even if the child was properly restrained. This will ensure that an assessment of the parents substance use is conducted and appropriate services for the family are provided.

7. Medical Information and Examinations

With allegations of physical or sexual abuse or severe neglect, the child should be seen for a forensic exam at a medical facility whose staff has expertise on child abuse and neglect. Reliance on a community clinic is insufficient. DCFS relies on a doctor's opinion as to findings in these cases. Every effort to ensure the child has been seen by an expert in child abuse should occur in these cases. The Team has reviewed cases in which a child was seen by healthcare providers child who failed to recognize the signs of physical abuse prior to the incident that led to the death of the child.

DCFS should not take the word of a parent or caregiver about medical visits. The visits need to be verified with the treating physician. Collaboration with PHNs to review and interpret the medical information being provided needs to occur in these cases since PHNs are trained in medical terms and are better able to interface with other medical professionals.

When there are concerns for a parent's mental health, DCFS should consult with the co-located mental health staff to assist in obtaining records and/or diagnosis, consult on the risk the parent poses to the child, and assist in obtaining mental health resources for the family.

8. Following Agency Protocols for Disrobing Children

DCFS and law enforcement agencies should not assume in cases of physical abuse or severe neglect, that either party had followed this protocol. Both need to verify with each other that a child was disrobed according to protocol.

It is important to provide ongoing training on disrobing and to develop protocols that build in a requirement to obtain a medical assessment and/or that DCFS respond with a PHN in cases of physical abuse or severe neglect.

9. Lack of Bonding or Poor Attachment

In the DCFS Academy and ongoing training, workers need to be provided information on malnourishment and failure to thrive and the relationship between the lack of bonding or poor attachment of the parent with the child as a risk factor for child abuse/neglect.

When it is known the parent is in a non-biological relationship, the relationship of non-biological adult to the child needs to be assessed. The level of attachment and child's responses to the adult should also be assessed. The Team has observed over the years the majority of child homicides have been at the hands of the parent's boyfriend, girlfriend or partner who was not attached or bonded to the child which apparently contributed to their inability to cope with parenting the child.

10. Verifying the Identity and Relationship of the Caregiver to the Child

The identity and relationship of the caregiver to the child needs to be verified by DCFS and law enforcement. If a child is not with a biological parent, the reason for the living arrangement needs to be assessed and verified. Every effort should be conducted to locate biological parents.

11. Collateral Contacts

When investigating allegations of child abuse or neglect, DCFS should conduct collateral contacts that will assist them in assessing the validity of the allegations and parents explanation in determining the risk to the child before making a finding as to the allegation.

12. Monitored Visits

There have been a number of cases reviewed by the Team where a child was having a "monitored" visit with a family member and killed during such a visit. The Team has worked to strengthen the definition of a "monitored visit" and to ensure that only appropriate individuals are allowed to monitor visits; often the need to protect the child weighs against having a relative caregiver be the monitor for the visits with the abusing parents.

In addition to the concern regarding a relative's ability to appropriately monitor visitation with the child(ren) is the fact that the law states that relatives must first be considered as a resource for an out-of-home placement for a detained child. An assessment as to the relative's ability to provide quality care is often overlooked, resulting in an increased risk of child injuries and child death for children in relative care.

13. Criminal Justice System

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. The Team has held many discussions regarding the fact that juries often do not want to believe that a parent can harm his or her child and this often hinders the prosecutorial process, particularly if there are multiple suspects.

In addition, the District Attorney has an 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 recognizes the frustration that is felt when charges cannot be filed, especially when the medical evidence is clear that the child suffered from some type of inflicted trauma.

The Team has also discussed the potential 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.

14. Improved Communication Among Agencies

There should be more cross training between disciplines and agencies involved in child abuse cases. DCFS, the schools, Department of Health, Department of Public Health, Department of Mental Health, law enforcement agencies, the District Attorney and City Attorney's should have ongoing forums to create and facilitate communication and connections between agencies fostering better collaboration and an understanding of each other's role in child abuse cases.

15. Fetal Death Associated with Maternal Substance Abuse

Over the years, the Child Death Review Team has noted a large number of fetal deaths with a contributing factor of Maternal Substance Abuse. The Team believes that these cases should be better tracked and that a death report should be taken by law enforcement on all fetal death cases so that a record of these deaths is maintained should there be future contact with the family.

16. 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. The Team has researched the laws regarding pool fencing and has learned that these ordinances vary from city to city within Los Angeles County. The Team believes that better efforts should be made to ensure that barriers are placed around both existing and new pools and ponds. Through the examination of drowning in pools, ponds and buckets, the Team has learned that it is very easy for a young child to drown without anyone being aware of it as the child's head is heavy and pulls the child under the water before they are able to make any sound. The Team has learned that the image of someone thrashing around and screaming for help is simply not true in the case of a young child who falls into any body of water.

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(ren) each believe that the other(s) are watching the children; thus, as the responsibility for supervising the child(ren) has been diffused among the various adults, in fact, the child(ren) are actually unsupervised.

17. Grief and Loss

The Team has worked hard to educate those who work with families and children about the issues of grief and loss and has recommended that surviving family members be referred for grief counseling when a sibling or other family member dies. The Team, in conjunction with the Child and Adolescent Suicide Review Team has also worked to ensure that schools are notified when a student has died and that supportive services are provided to the other students at the school the deceased child attended.

18. Role of Emergency Medical Responders

The Team has focused on the role of the paramedics and emergency medical responders in child death cases. Often, the tendency is for the responding personnel to pick up the child and race to the hospital, despite the fact that the child is already deceased. The Team has discussed the fact that is often easier to transport the child as it makes the family feel better and emergency responders want to feel there is something they can do to help. However, in many of these cases, the removal of the already deceased child from the scene impedes further investigation into the child's death and may give family members time to clean up the scene where the death occurred. The Team also believes that first responders play a very important role in providing initial information concerning a child's death and this information should be obtained more regularly by those reviewing the death of a child.

19. Poverty/Insurance/Medi-Cal

There have been numerous cases where a family has been unable to obtain appropriate medical care for a sick child due to a problem with medical coverage – either a lack of coverage or a problem with a medi-cal card. The Team has encouraged the Department of Public Health to follow-up on the policies and procedures in place at clinics that accept patients with no insurance coverage. In addition, clinics that do require insurance should be educated on how to ensure that a family is referred to an appropriate medical care setting should they present with an ill child and no insurance coverage.

20. Regional Centers

Several cases were reviewed where the deceased child had been receiving care through one of the County's Regional Centers. Each of the Regional Centers operates independently and they are often unable to assist the Department of Children and Family Services (DCFS) in locating an appropriate placement for a medically fragile child. The Team has recommended that more training be provided on the role of the Regional Center and what services they can and cannot provide. In addition, it is hoped that the fact that DCFS has a Regional Center liaison can do much to ensure collaboration between DCFS and Regional Centers and, better continuity of care to those children in need of more specialized services.

Child and Adolescent Suicide Review Team

Issues Identified/Lessons Learned

Suicide Rate

Youth suicide continues to be a troubling reality in Los Angeles County. The suicide rate among people under the age of 18 increased from 10 suicides in 2007 to 17 in 2008. This increase occurred even though we have seen a downward trend in suicides over the last five years. The overall five year downward trend may have been due to the increased prevention efforts on the part of public and private schools effectively identifying young people at risk and initiating contact with youth who may be contemplating suicide. Carefully orchestrated school-based post-crisis interventions also appear to have an impact on reducing the risk of suicide among peers at school. It can only be speculated that the increase from 2007 to 2008 may be the result of increased stress on families and adolescents due to the downward trend in the economy beginning in 2008. Additionally, 2008 represents the beginning of budget cuts in mental health personnel and school personnel which may have affected prevention efforts.

Transition from In-patient to Community Support

The Child and Adolescent Suicide Review Team (CASRT) reviews a number of cases in which adolescents fail to receive sufficient support as they transition from in-patient treatment programs back to home and school. The lack of ongoing support during this difficult transition period was seen as a factor that contributed to the eventual suicide of the youth involved.

Communication Barriers between Agencies/Professionals

Perceived barriers to communication among professionals from different agencies continue to result in a significant barrier to timely communication that might have resulted in more timely and effective intervention to prevent suicides among youth.

Need for Ongoing Training on Suicide Assessment and Treatment

Mental Health and medical professionals are in need of additional training to recognize and respond to the suicidal risk of children and adolescents in treatment.

Selected Findings

Homicides

- There were 34 child homicides by parents, caregivers or family members in 2008. This represents a significant increase (24%) from 2007 when there were 26 child homicides. Although an increase of child homicides for Los Angeles County in 2008, it was lower than the 15 year average of 38.6 deaths.
- 74% percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is a decrease from 2007, when 81% of the children were five years of age or younger.
- Nine children were over age 5, including one six-year old, one seven-year old, two eight-year olds, one eleven-year old, one twelve-year old, one 13-year old and one seventeen-year old. Eight of the victims were under age one.
- Six of the children over the age of five years died as a result of murder/suicide by a parent or family member.
- The average age of a child homicide victim in 2008 was 3.6 years (42.73 months). The average age of a child homicide victim in 2007 was 2.9 years (34.86 months).
- Sixteen female children and eighteen male children were victims of child homicide by parents, caregivers or family members in 2008.
- Twelve children died from head trauma, four died from multiple traumas and one from trauma to the torso/abdomen. These include children who were victims of battered child syndrome. Three children died from asphyxiation/suffocation, eight from gunshot wounds, two children were victims of a stabbing, one died from smoke inhalation in a fire, one child died from hyperthermia, one child died of dehydration/malnutrition and one was an unattended newborn.
- Two newborns were abandoned and found deceased and/or killed by their mothers in 2008. This represents a 33% decrease from 2007 in which there were three abandoned deceased newborns. One off the deaths was coded as a homicide and the second as undetermined by the Coroner. Seven newborns were safely surrendered in 2008 which is a 47% decrease from 2007 when 15 newborns were safely surrendered.
- Hispanic (n= 15) children were over-represented in child homicides by a parent, caregiver or family member accounting for 44% of child homicides. African

American (n= 9) children were slightly over-represented in child homicides by a parent, caregiver or family member. Seven children were Caucasian. One child was of Asian/Pacific Islander descent, one child was of Armenian descent and one child was of unknown ethnic origin.

- The Department of Children and Family Services (DCFS) or another county's Child Protective Services agency had prior contact with 41% (n=14) of the families in which there was a child homicide and the child died in Los Angeles County. This is an increase from 2007 when 31% of these families had previous contact with DCFS. One case had an open referral on the mother with L.A. County DCFS at the time the fatality occurred. Four child homicide victims had an open case with L.A. County DCFS at the time of their death.
- Eighteen children were killed by their father, stepfather or mother's boyfriend and seven children were killed by their mother (this includes the one infant abandonment). Three children were killed by both parents and one by the mother and her boyfriend. Two were killed by a relative. One child was killed by the mother's partner and one was killed by the babysitter. One child was killed but the familial relationship has not been established to date.
- The greatest number of child homicides by parents, caregivers or family members occurred in November (n=7). The second greatest number of homicides occurred in the month of September (n=5). The fewest occurred in the month of July (n=1). Three child homicides occurred in the months of February, March and April. Two child homicides occurred each month for January, May and June. Three homicides occurred in the months of October and December. Forty-four percent of child homicides occurred in the fall of 2008.
- Child homicides occurred throughout most of Los Angeles County in 2008. SPA 2 had the greatest number of child homicides (n=6). SPA 3, 4, 6, and 8 each had five child homicides. Four child homicides occurred in SPA 1 and two in SPA 7. Once again, no child homicides occurred in SPA 5 in 2008 as in 2007.

Suicides

- Seventeen children and adolescents committed suicide in 2008. This is a significant increase from the 10 such suicides in 2007 but lower than the 15-year average of 20.4 suicides per year.
- As in years past, male victims outnumbered female victims by a large margin. Eleven males and six females committed suicide in 2008.
- The leading method was death due to hanging, which represents 70% (n=12) of the suicides in 2008. Three of the adolescents committed suicide using firearms

and two adolescents jumped from a height. The majority of suicides occur at home.

- Suicides by Hispanic youth represent 46% (n=8) of the total of adolescent suicides and is a decrease from 2007 when 50% of suicides were by Hispanics. Eighteen percent (n=3) of adolescent suicides in 2008 were by Caucasians and is the same number of suicides as in 2007. Suicides by African Americans in 2008 (n=3) increased by 66% from 2007 (n=1). Suicides by Asian/Pacific Islander also increased from 2007 (n=1) in 2008 (n=3).
- Sixty-six percent (n=11) of the children who committed suicide in 2008 were ages 15 – 17; five victims were 14 years of age, and the youngest was 12. In comparison to 2007, seven victims were age 15 or older and the youngest was 11.
- Twelve of the youth had experienced a recent relationship loss or conflict. Eleven of the youths' families had a prior referral or open case with the Department of Children and Family Services or with the Department of Probation. Four youth had a history of mental illness. Four youth had a history of prior self-injury. Three youth had previously attempted suicide and four youth exhibited warning signs prior to their suicide. Only two of the youth who committed suicide in 2008 left a suicide note. Three youth were discovered to have a positive toxicology for drugs at autopsy. Three youth had experienced academic problems, three youth had received special education services and two had school discipline or truancy problems. Three youth had a criminal and/or juvenile delinquency record.
- Child and youth suicides were experienced in all areas of Los Angeles County. As in 2007, the greatest number of incidents occurred in the San Gabriel Valley SPA 3 (n=6). Four incidents occurred in the northern region of the County with two each in SPA 1 and two. Two suicides occurred in SPA four and six. One suicide occurred in Spa 5, 7 and eight.

Accidental Child Deaths

- There were 101 accidental child deaths of children ages 0 - 17 in 2008. The two leading causes of accidental death were automobile accidents (n=32) and auto pedestrian (n=29). A total of 73 accidental child deaths were children ages 0 – 14 years. This is a 13% decrease from 84 such deaths for this age group reported for 2007. Eighty-six percent of auto pedestrian deaths were children ages 0 to 14 years. There were 28 accidental deaths of youth's ages 15 to 17 years. Youth ages 15 to 17 years accounted for 47 % (n=15) of automobile related deaths in 2008.
- Deaths due to auto pedestrian (n=14) was the leading cause of accidental death for children 14 years of age and under. Automobile accidents (n=17) was the

second leading cause. Maternal substance use (n=9) ranked third as the leading cause of accidental death, and drowning (n=7) ranked fourth.

- Deaths associated with maternal substance abuse accounted for 8 fetal deaths and one death of an infant one day of age and represents a 40% decrease from 2007 in which there were 15 such deaths. Methamphetamine is the most associated drug with these deaths (n=5) accounting for 56%. Cocaine accounts for three of these deaths and heroin one. Deaths associated with maternal substance abuse accounted for 9% of all accidental deaths in 2007, and fetal deaths associated with maternal substance abuse accounted for 8% of all accidental deaths.
- Accidental drowning claimed the lives of 7 children ages 0 – 17 years which is a decrease from 2007 when there were 12 such deaths. A majority of these drowning deaths were young children who drowned in residential pools. Overall, drowning has been one of the leading causes of accidental deaths of children for the past fifteen years in Los Angeles County.
- Hispanic children represented 56% (n=57) of all accidental child deaths in 2008. Sixty-one percent of the auto pedestrian deaths were Hispanic children. Caucasian children represented 12 % (n=12) of the accidental deaths. They were over-represented in automobile deaths (n=6) and under-represented in drowning and maternal substance use deaths having none. African-American children (n=17) were slightly over-represented in accidental deaths in 2008. Forty-seven percent of the African-American child deaths were due to automobile accidents followed by auto pedestrian at 29%. There were 8 accidental deaths of Asian/Pacific Islander children in 2008. Two accidental deaths were children of Middle Eastern descent.
- In 2008, 68 male children and 32 females died due to accidental death which is a 2:1 ratio. In comparison, in 2007, 85 male children and 35 females died due to accidental death, which is a 3:1 ratio.
- In 2008, male children tend to over-represent female children in comparison in nearly all types of deaths. Females out-numbered males by one in drowning and maternal substance use deaths. In deaths associated with total automobile accidents, 23 male children lost their lives due to this type of accident in comparison to 9 females and 22 male children died as a result of an auto pedestrian accident versus 7 females.

Undetermined Child Deaths

- There were 131 undetermined child deaths in 2008. This is 3% increase from the 127 such deaths in 2007 and significantly higher than the 15-year average of 66.73 undetermined deaths per year. Eighty-six percent of the undetermined child deaths were age one year and under (this includes stillborn deaths).

- African American (n=31) children were over-represented in undetermined child deaths. Sixty-six children were Hispanic, 18 Caucasian and 12 Asian/Pacific Islander descents. Four undetermined child deaths were of unknown descent.
- Thirty-eight percent (n=50) of the undetermined child deaths had a noted status of post co-sleeping. This is a slight increase from 2007 in which 33% of undetermined child deaths was associated with co-sleeping.
- Fifty-six percent (n=28) of the co-sleeping related deaths were infants between 0 to 3 months of age, 38% (n=19) were infants between 3 to 6 months of age, 4% (n=2) were over 6 months to 9 months of age, and, 2% (n=1) were 9 months to 1 year.
- Of the undetermined child deaths associated with co-sleeping, the infant was sleeping with one adult in twenty-four of the incidents, 18 of these infants were sleeping with the mother, five with the father and one with a grandmother. Ten infants were sleeping with two adults, 4 were sleeping with one or more other children, 8 were sleeping with one adult and one or more other children and 4 were sleeping with two adults and one or more children.
- Fifteen percent (n= 19) of undetermined child deaths were associated with unsafe sleep practices. Seven infants were put to sleep in an adult bed, three on a couch, four with pillows, 2 were excessively swaddled, two had excessive bedding and one had a plastic bag in the crib.
- Co-sleeping and unsafe sleeping practices accounted for 53% percent of all undetermined child deaths.

Team Accomplishments

In 2008 – 09, the ICAN **Multi-Agency Child Death Review Team (CDRT)**:

- Conducted in-depth monthly reviews of selected cases with continuing follow-up of previously reviewed cases and issues.
- Worked with First 5, ICAN Associates, the Los Angeles County Department of Public Health, and the Los Angeles County Department of Children and Family Services to disseminate the Safe Sleep Tips for Your Baby brochure on safe sleeping practices with infants.
- Improved case outcomes resulting from Team sharing of information. The Team venue has assisted law enforcement by bringing together legal, medical and other professionals who are able to provide expertise on suspicious child death case investigations.
- Devoted several Team meetings to an on-going focused review of child deaths coded as undetermined with a cause of Sudden Unexpected Infant Death (SUID) by the Coroner in an effort to understand the increase in these deaths and to develop prevention efforts.
- Worked with the Los Angeles Community Child Abuse Councils to create a child fatality prevention kit for countywide distribution to include materials on safe sleeping, drowning prevention, safety tips in and around cars, and shaken baby syndrome.
- Presented a workshop on lessons learned by the Team and how these lessons can help identify at risk children and families at the 14th Annual Nexus Conference.

In 2008 – 09, the ICAN **Child and Adolescent Suicide Review Team (CASRT)**:

- Conducted in-depth monthly review of selected cases with continuing follow-up of previously reviewed cases and issues.
- Coordinated a project with the Los Angeles County Community Child Abuse Councils and the Los Angeles County Department of Coroner to produce condolence cards with grief counseling resources for families of children who have committed suicide.
- Worked with the Los Angeles County Child Abuse Councils to produce two wallet sized cards in English, Spanish and Korean. One post-vention for Dealing with Grief and the second aimed at prevention listing Some Common Signs of Depression.

Both cards list resources for families and friends after a suicide, a suicide attempt or threat on the back of the cards.

- Operated a speaker's bureau that conducted presentations at various conferences and employee groups both locally and throughout the United States
- Improved case outcomes resulting from Team sharing information. The Team has provided support to numerous school personnel, providing emotional support and procedural assistance in the aftermath of student suicides. Posthumous activities have included providing suggested guidelines for memorials, mental health interventions and interactions with the suicide victims' family and friends as well as any needed cultural advisement.
- Participated, as requested on the State Child Death Review Council to provide guidance on issues such as the requirement that all California Child Death Review Teams develop a system to review child and adolescent suicides and to include school representatives in their Team review process.
- Coordinated activities of the Educator's Suicide Prevention Network (ESPN), a unique partnership of secondary and university counselors and psychologists formed for the purpose of collecting data and developing joint data-driven suicide outreach and prevention activities. Focused on the importance of thorough suicide investigation protocols for the purposes of collecting prevention data.
- Provided representation from schools on the Stakeholders committee of the Los Angeles County Mental Health Services Act and in this capacity, provided information to the Team about statewide and countywide planning for prevention and early intervention initiatives.
- Supported legislation to provide suicide prevention training to teachers and to permit Child Death Suicide Review Teams to review suicide deaths of persons up to 24 years of age to capture transitioning youth.

Selection of Cases for Team Review

The Coroner must designate the manner of death to be listed on the death certificate as either: Homicide, Accident, Natural, Suicide or Undetermined. This report, as have the past Team reports, utilizes the Coroner's classification scheme to group the manners of child death in the County of Los Angeles. Fetal deaths over 20 weeks gestation at the time of death are included in the report as a conservative cut off point for a viable fetus.

Homicides, by the Coroner's definition, are deaths at the hands of another. Child deaths in which the suspected perpetrator is a parent, caregiver or family member, meet the Team protocol for possible review. All such cases are included in the ICAN annual Team report. Homicide by parent/caregiver/family member is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term "homicide" regardless of the criminal intent of the perpetrator or the findings of the criminal justice system. Homicide may describe circumstances ranging from tragedies that involve no clear intent, to vicious, fatal attacks with clear intent.

Accidental deaths continue to be one of the largest categories of deaths reported to the Team by the Coroner. Several types of accidental death, such as auto pedestrian fatalities, drowning, hangings and accidental gunshot wounds, are truly unintentional in nature. However, there may be questions of the caregiver supervision in some of these cases, as well as concern regarding the preventability of these accidents. A significant number of accidental deaths involve newborns who were prenatally exposed to drugs and who subsequently died of prematurely or other related perinatal causes. The relationship between precipitous drug-induced delivery of newborns and child maltreatment fatalities has generated much discussion and concern on part of the Team.

Natural deaths are rarely reported to the Team and are not included in the Team's annual report.

Suicide, by the Coroner's definition, is death of self caused with intent. Suicides of children and adolescents are reported to the Team as a special population. The Team recognizes that suicide, most often in itself, is not a result of child abuse and neglect. However, the ability of the Team to collect information on these deaths from multiple agencies is of benefit in better identifying these high risk youth for prevention purposes. For this reason, a separate Team, the Child and Adolescent Suicide Review Team, was created in 2001 to review these cases.

Undetermined deaths reflect situations in which the Coroner is unable to fix a final mode of death. For 2008, this mode of death represents the largest category of deaths reported to the Team by the Coroner. These cases often involve insufficient or conflicting information which impacts the Coroner's ability to make a final determination. Usually, there is no clear indicator in these cases whether the death was intentionally

caused by another or was accidental. These cases remain suspicious in nature and are of interest to the Team because a final determination cannot be made by the Coroner. Undetermined death cases include perinatal demise of an undetermined cause, which may be child maltreatment related if the infant was left exposed or unattended as is the case with abandoned deceased infants. However, the Coroner may be unable to determine if the exposure caused the death or if the death was due to some other cause. Additionally, a significant portion of the undetermined deaths have a noted status of “post co-sleeping.” In these cases, the Coroner is unable to determine the role co-sleeping may have played in the death, e.g., suffocation by accidental layover or some other cause.

Child Deaths in Los Angeles County 2004 – 2008

Over the past 5 years, a parent, caregiver or other family member has killed an average of 31.8 children each year.

2004	30
2005	33
2006	35 ²
2007	26
2008	34

Over the past five years, an average of 13.8 children and adolescents each year have *committed suicide*. The leading method from 2004 through 2008 was hanging.

2004	13
2005	15
2006	14
2007	10
2008	17

Over the past five years, an average of 130.4 children have died from preventable accidents. The most common accidental Deaths involve auto pedestrian, automobile accidents, drowning and deaths due to maternal substance abuse.

2004	147
2005	140
2006	143
2007	121
2008	101

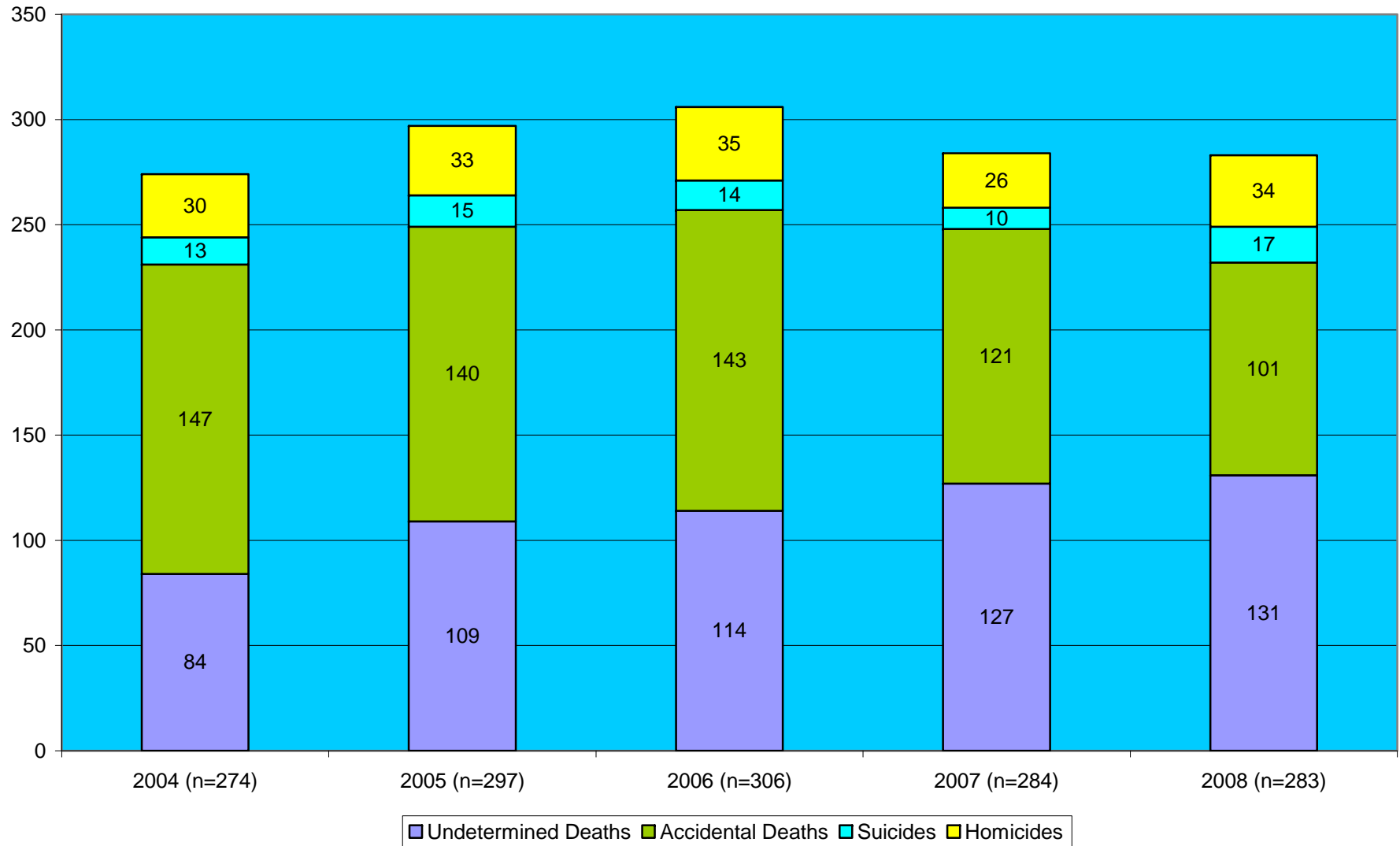
Over the past five years, the number of undetermined deaths has averaged 113 per year.

2004	84
2005	109
2006	114 ³
2007	127
2008	131

² Upon review by the Team in 2008, one case coded as undetermined was reclassified as a homicide and one homicide autopsied in another county was not reported to ICAN for inclusion in the 2007 report.

³ See above.

Child Death in Los Angeles County 2004 - 2008



Child Homicides by Parent, Caregiver, or Other Family
Members 1994 - 2008

Case Summary

Child Homicide by Parent/Caregiver/Family Member

Miguel, age 6 months, presented to the hospital by the mother as being unresponsive and not breathing. The infant was in cardiopulmonary arrest and was dead on arrival. Medical staff attempted to resuscitate the baby but could not and he was pronounced dead.

The hospital called the CAHL suspecting the death was the result of child abuse and/or neglect based on the following: The mother's statement was inconsistent with the statement provided by the neighbor who transported the mother to the hospital; a two hour time delay of the mother noticing the baby not breathing to the time the child was transported to the hospital; and, the baby had dilated fixed pupils which indicated a brain bleed and herniation.

The mother told hospital staff that there were no other children in the home. She told the attending physician she had a history of two pregnancies and one live birth. Miguel was born full term with a birth weight of 14 pounds. The mother described the baby as healthy with no history of illness or trauma. She further reported the baby had not been seen by a physician since birth and had no immunizations.

The neighbor stated there were two other children in the home. The mother then said the two children were her husband's children and they did not reside together. The mother could not provide an address for the father. The neighbor stated both parents asked to be transported to the hospital but he could only take the mother and the baby. He further stated the mother and father lived at the same address next to him.

With respect to the time line, the mother said she fed the baby whole milk with water because she ran out of formula around 3:00 p.m. Between 3:00 and 8:00 p.m., the baby vomited three times. She also reported she changed Miguel's diapers 10 – 12 times due to his having diarrhea. She put the baby to bed at 8:30 p.m. At 9:00 p.m., the mother checked the baby and found him not breathing. She said she called 911 and a taxi to see who would arrive first. When neither came, she asked a next door neighbor for a ride to the hospital. The mother and baby arrived at the hospital at 10:55 p.m.

There was no outward trauma observed on the infant's body. However, he had numerous bald patches all over his head. He appeared dehydrated and his eyes were very sunken. He appeared malnourished as evidenced by thin extremities and prominent ribs.

During the review of the case, it was learned there was DCFS history for the mother as a minor. She was in the foster care system until the age of 18. Further there were two older siblings who were removed from the parents four years earlier due to physical abuse, emotional abuse and domestic violence. The parents never completed the case plan and their parental rights were terminated.

At the hospital the mother gave a false name for the father. When another neighbor arrived to the ER with the Miguel's siblings, the mother admitted to lying. The neighbor said the father left them with her hours ago and took off saying the mother would arrive soon. When she did not, the neighbor came to the hospital to find her. None of the children had been seen by a physician or had medical coverage. The parents deliberately did not seek any public assistance in fear of being reported to DCFS and losing custody of the children.

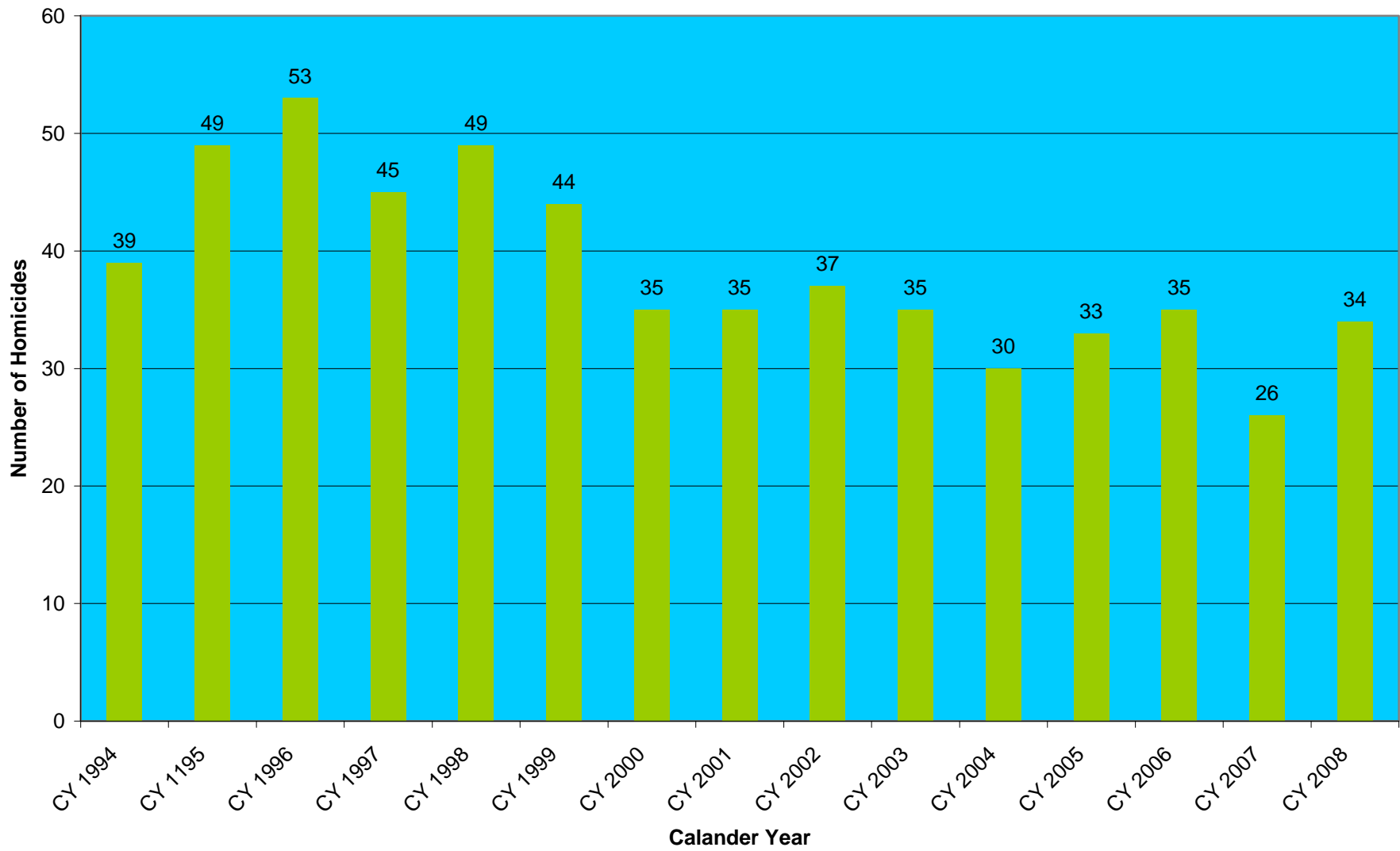
Miguel's siblings were detained. The mother was inconsistent with her statements to hospital staff, the coroner investigator, law enforcement and the DCFS worker. There was a long delay in seeking medical attention for Miguel given his deteriorating condition. The mother went to a domestic violence shelter. While at the shelter, she told her counselor that on the day Miguel died he had been crying. She told the counselor she placed a sock in his mouth. The Coroner ruled the case a homicide due to the effects of asphyxia with acute hypoxic/ischemic encephalopathy. Miguel died as a consequence of obstruction of the airway. Both parents were arrested and were charged with murder.

The Child Death Review Team expressed concern that although all the children were born in hospitals, no risk assessment seems to have been done at the time of their birth. The mother did not receive prenatal care which would normally trigger a hospital to do a risk assessment on the newborn and perhaps refer the family to have a PHN follow-up on the new born. The hospital in Miguel's case accepted the parents' story that they were visiting from another state when Miguel was born.

The Team discussed how the parents did not apply for cash or medical aid to avoid being found and reported to DCFS. This served to isolate the family from services which might have been of assistance to the family. The mother in particular became more isolated already being a victim of domestic violence by the father. The Team discussed how domestic violence may have interfered with the mother's ability to protect the children. There is speculation the mother may have put the sock in Miguel's mouth in an effort to keep him quiet and protect him from the father.

The mother's own childhood experience of being a dependent and removed from her own mother was discussed. A common factor in many child death cases is the fact that one of the parents or other family member had a prior case themselves in either the Dependency or the Delinquency Court. Had permanency been achieved for the mother or a mentor relationship nourished while she was in care, she may have had the opportunity to have better guidance by an adult rather than repeat the cycle of abuse.

1994 - 2008 Child Homicides by Parent, Caregiver, or Family Member



Causes of Child Homicide by Parent/Caregiver/Family Member 1994 – 2008, Los Angeles County

	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	Total
Head Trauma	17	19	15	12	13	15	5	5	2	7	7	6	11	11	12	157
Multiple Trauma	7	10	7	10	8	10	11	7	7	10	7	8	7	7	4	120
Asphyxiation/suffocation	0	4	4	4	3	6	3	8	5	6	5	5	6	6	3	68
Gunshot Wounds	2	4	4	7	10	4	3	2	1	4	3	6	1	1	8	60
Trauma to torso/abdomen	6	2	5	4	2	1	0	0	3	0	0	2	1	1	1	28
Drowning	1	4	0	2	2	0	3	1	7	1	1	2	3	3	0	30
Fire	0	3	8	0	4	0	1	0	0	0	0	0	3	3	1	23
Stabbing	0	0	2	0	2	1	4	1	2	0	3	2	2	2	2	23
Unattended newborn	1	1	0	1	3	4	2	3	2	3	0	1	0	0	1	22
Poisoning/drug ingestion	1	0	2	0	0	0	0	3	6	1	1	0	0	0	0	14
Dehydration/malnutrition	0	1	1	1	1	0	1	1	0	1	2	0	0	0	1	10
Strangulation	1	0	2	2	1	0	0	0	0	0	0	0	1	1	0	8
Medical neglect	1	0	0	0	0	0	1	2	0	0	0	0	0	0	0	4
Neck compression	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Burns	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	3
Hyperthermia	0	0	0	0	0	0	0	0	0	2	0	0	0	0	1	3
TOTAL	37	49	51	44	49	42	34	34	35	35	29	33	35	35	34	576

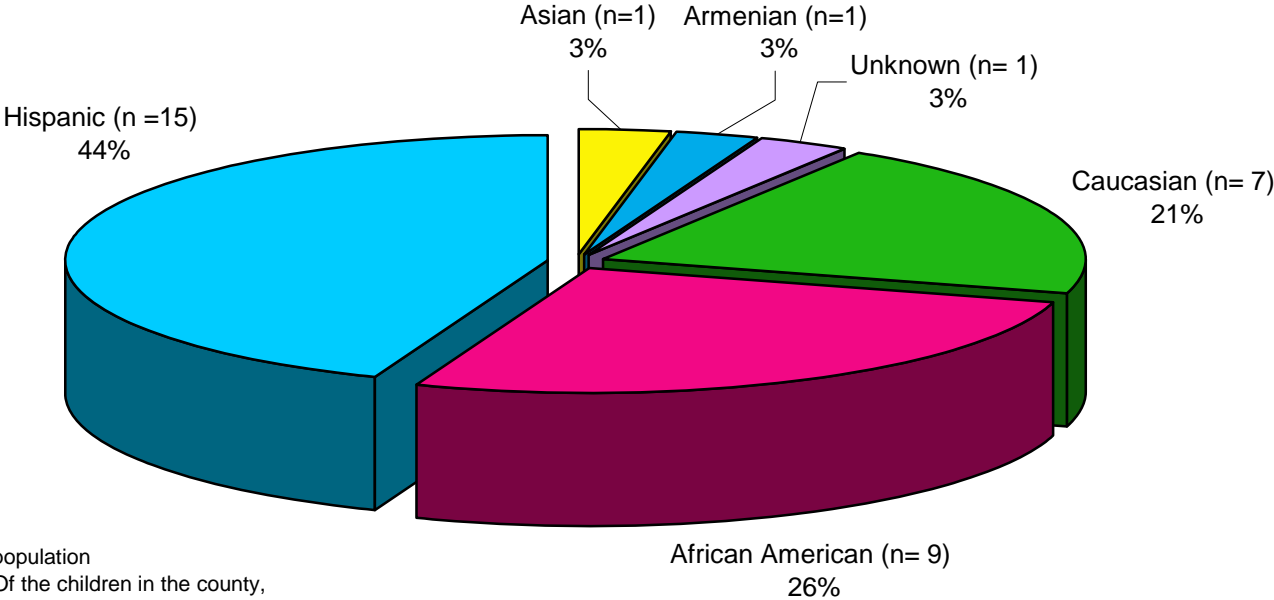
Child Homicide by Parent/Caregiver/Family Member Los Angeles County – 2008 (N= 34)

Age	Female	Male
Under 1	5	3
1 year	4	6
2 years	3	1
3 years	0	0
4 years	0	0
5 years	1	2
6 years	0	1
7 years	1	1
8 years	1	1
9 years	0	1
10 years	0	0
11 years	0	1
12 years	0	1
13 – 17 years	1	1
TOTAL	16	18

54% of the child homicides by parents/caregivers/family member were under one year of age.

74% of the child homicides by parents/caregivers/family member were under five years of age or under.

2008 Child Homicides by Parent, Caregiver, or Family Member - Race



Los Angeles County child population ages 0 - 18 is 2,830,799. Of the children in the county, 9% are African American, 9% are Asian American, 61% Latino, 18% white and 3% are of multiple or other ethnicities. 2008 Children Now County Scorecard

■ Asian
 ■ Armenian
 ■ Unknown
 ■ Caucasian
 ■ Black
 ■ hispanic

Criminal Justice System Involvement

Information on the criminal justice system involvement in child homicides by parent/caregiver/family member is gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). Other police agencies participate in Team review of cases they have investigated. The law enforcement agencies and number of cases for which they are responsible for the investigation are shown in Table 1.

Table 1
Law Enforcement Agency Involvement in 2008 ICAN Child Homicide by Parent/Caregiver/Family Member

Agency	n	%
LASD	9	26
LAPD	14	41
Inglewood P.D.	1	3
Long Beach P.D.	1	3
Montebello P.D.	1	3
Covina P.D.	1	3
Torrance P.D.	1	3
Glendale P.D.	1	3
Pomona P.D.	2	6
Not an LA County Case	2	6
None (fetal death from suicide)	1	3

The Los Angeles Police Department had investigative responsibility for 41% (n= 14) of the 2008 child homicides by parents/caretakers/family member. The Los Angeles Sheriff's Department had investigative responsibility for 26% (n=9) of the child homicides by parents/caretakers/family member. Twenty-four percent (n=10) of the cases were handled by jurisdictions other than LASD and LAPD. Nine different law enforcement agencies were responsible for the investigation of child homicides by parents/caregivers/family member in 2008.

Ten of the 2008 cases involving child homicide by parents/caregivers/family member were not presented to the District Attorney. The reasons for that those cases were not presented are displayed in Table 2. The most common reason for law enforcement not presenting a case was the perpetrator committed suicide after killing the child. Two child homicides occurred outside of Los Angeles County and were covered by other jurisdictions. In one case, the suspect's identity remains unknown and the case remains under investigation. Law enforcement believes this homicide was related to a domestic dispute. Lastly, one homicide was a fetal death as a result of a suicide.

Table 2

Law Enforcement Reasons for Not Presenting 2008 ICAN Child Homicide by Parent/Caregiver/Family Member

	n	%
Murder/suicide	6	60
Suicide	1	10
Suspect's identity unknown	1	10
Injury did not occur in LA County	2	20
TOTAL	10	100

Table 3

Criminal Charges Filed on 2004 - 2008 ICAN Child Homicide by Parent/Caregiver/Family Member	2004	2005	2006	2007	2008
Murder (187 (a) P.C.)	27	32	20	21	20
Assault on a child under 8 years resulting in death (273ab P.C.)	23	20	15	17	16
Child abuse (273a(a) P.C.)	24	34	11	28	19
Child endangering (273a(1) P.C.)		1			
Corporal punishment or injury of child (273d P.C.)				1	
Child abuse resulting in death (273a(a) 2 P.C.)					
Voluntary manslaughter (192a P.C.)	2	1	1	5	1
Involuntary manslaughter (192b P.C.)		5		1	1
Vehicular manslaughter DUI with gross negligence (191.5(a) P.C.)		1		1	
Vehicular manslaughter (192 (c) P.C.)		5			
Vehicular manslaughter for financial gain (192(c)(3) P.C.)		1			
Attempted voluntary manslaughter (664/192 (a) P.C.)	1				
Attempted murder (664/187 (a) P.C.)	1	1		1	12
Attempted robbery of person (664/211 P.C.)		1			
Lewd and lascivious acts by force (288(b)(1) P.C.)	1				
Sexual penetration with unconscious victim (289(d)(a) P.C.)	3				
Public exposure of private parts (314(1) P.C.)		1			
Kidnapping (207a P.C.)				2	
Unlawful detention (278 P.C.)	4				
Assault against a peace officer (245 © P.C.)		2			
Battery (242-243(e) 1 P.C.)				1	
Threat of death or great bodily harm to immediate family (422 P.C.)		1			
Spousal abuse (273.5 P.C.)		1			
Torture (206 P.C.)	4	1		1	
Mayhem (203 P.C.)		1			
Vandalism (594 P.C.)				1	
Discharge of firearm inhabited dwelling (246 P.C.)	1				
Assault with semiautomatic weapon (245 (b) P.C.)	2				
Unlawfully causing a fire of any structure (451B)		1			
Aiding and abetting a designated felony (32 P.C.)		3			
Financial gain from prospective adoptive parents (273(d)(a) P.C.)	3				
Possession of marijuana for sale (11359 H&S)		2			
Unlawful to drive while DUI (23153(a) V.C.)		1			
Unlawful to drive with .08% or more DUI (23153(b) V.C.)		1			
Failure to stop @ accident scene resulting in injury/death (20001(a) V.C.)		1			
Flight of peace officer causing serious bodily harm (2800.3 V.C.)		1			
Fleeing pursuing peace officer (2800.2(a) V.C.)		1			

In 2008, 71% (n=24) of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies.

Of the twenty-four cases, three were declined due to insufficient evidence. In the declined cases, the District Attorney believed there was insufficient evidence to identify who was actually with the child at the time of injury and/or death. One of the three cases received extensive Team review. It involved an 18 month old toddler who was shaken and battered and had both fresh and healing rib fractures. The call came in as a baby not breathing. The mother, mother's boyfriend and mother's roommate were all present at the time paramedics were called. All three gave confusing and vague statements. The law enforcement detectives who investigated the homicide did not believe they had enough information to determine who had inflicted the numerous injuries that the child suffered.

The District Attorney filed criminal charges on 88% (n=21) of the 24 homicide cases presented to them by law enforcement. The charges filed by the District Attorney in the past five years are illustrated by Table 3. The most frequent charge in 2008 was murder followed by child abuse. Murder charges (187 (a) P.C.) were filed on 96% (n=20) of the cases in which charges were filed. There was more than one defendant involved in three of the cases which brought the total number to 24 as shown in Table 4. 68% of the total number of child homicides in 2008 had murder charges filed.

Table 4
Relationship of Perpetrators - 2008 ICAN
Child Homicide by
Parent/Caregiver/Family Member

Relationship	ID'd by Police	Charged By DA
Mother	9	8
Father	5	5
Stepfather	3	3
Mother's Boyfriend	7	6
Mother's Domestic Partner	1	1
Uncle	2	0
Babysitter	1	1
Unknown	1	0

In 2008, there were multiple perpetrators identified by law enforcement and charged by the District Attorney in 3 cases. In all three cases in which charges were filed, the mother was implicated along with either the child's father or mother's boyfriend.

Table 5

Criminal Case Disposition of 2004 - 2008 ICAN Child Homicides by Parent/Caretaker/ Family Member	2004	2005	2006	2007	2008
Life without possibility of parole	1		1		
50 years to life prison	1	2	1		
42 years to life prison					
35 years to life prison					
30 years to life prison					
29 years to life prison					
28 years to life prison					
26 years to life prison	2				
25 years to life prison	2	7	5	1	
24 years to life prison					
22 years to life prison					
21 years to life prison					
19 years to life prison					
16 years to life prison		1			
15 years to life prison	1	1	2	1	1
14 years prison					
13 years prison					
12 years prison				1	1
11 years prison	1			3	1
10 years prison	1	1	1	1	
9 years prison		2			
8 years prison	1	4			
7 years prison					
6 years prison	1	2	2	1	
5 years prison				1	
4 years prison	1	1			1
3 years prison					
2 years prison	1	3			
16 months prison					
1 year jail	2	2			
9 months jail					
6 months jail		1			
Less than 3 months jail	1	1			
10 yrs Probation					
6 yrs Probation					
5 yrs Probation	2	1			
3 yrs Probation	2	3			
Found not guilty	2				
Dismissed		2	3		
Arrest warrant	5				
Mental competency hearing		1		1	
Sentence pending			2	1	1
Pending trial	2	1	5	5	19
TOTAL	29	36	22	16	24
Total C/A Homicides for year	30	33	35	26	34

Criminal disposition data for the period of 2004 through 2008 is presented in Table 5. In 2008, 83% of the cases are still pending trial which is a significant increase from 2007 in which 40% of the cases were still in pending status. The reasons for this increase of cases pending trial are not fully clear and may reflect more aggressive representation on behalf of the perpetrators. One perpetrator was sentenced 15 years to life which is the same as in 2007. Nine percent (n=2) of the perpetrators of child homicide by parents/caregivers/family member received an intermediate term sentence of 11 to 12 years in prison in 2008.

The status of the 2004 cases remains the same - there are five arrest warrants outstanding and two cases pending trial. For 2005, one case was dismissed and one continues for mental competency. Of the five cases pending trial from 2006, one case was dismissed and two remain pending. One perpetrator was sentenced to 25 years to life and one 19 years in state prison. Three cases are still pending trial from 2007. One perpetrator was sentenced 15 years to life; one was sentenced 30 years to life and one perpetrator was sentenced 52 years to life in state prison.

**2008 Child Homicides by Parents, Caregivers or Family Member
DCFS Involvement 1994 – 2008***

Year	Total # of homicides by parent/care giver/ family member	Total # of homicides that had previous DCFS contact (prior contact OR open case)	Of total with previous DCFS contact, The # of homicides that had PRIOR DCFS contact only	Of total with previous DCFS contact, the # of homicides in OPEN DCFS Case or referral	# Killed by out-of-home caregiver
1994	39	12	5	7	0 – relative caregivers 1 – foster parent
1995	49	16	5	11	3 – relative caregivers 0 – foster parent
1996	53	13	7	6	2 – relative caregivers 2 –foster parent
1997	45	15	8	7	2– relative caregivers 2 foster parent
1998	49	20	16	4	1 relative caregivers 0– foster parent
1999	44	20	12	8	2– relative caregivers 2 – foster parent
2000	35	15	7	8	2 – relative caregivers 0 – foster parent
2001	35	12	7	5	3 – relative caregivers 2 – foster parent
2002	37	Not Available	Not Available	Not Available	0 – relative caregivers 1 – foster parent
2003	35	18	13	5	2 – relative caregivers 2 – foster parent
2004	30	15	9	6	2 – relative caregivers 0 – foster parent
2005	33	14	11	3	1– relative caregivers 0 – foster parent
2006	35 ⁴	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3 ⁵	1 – relative caregivers 0 – foster parent
2008	34	14 ⁶	6	8	0 – relative caregivers 0 – foster parent

***Data is based on the Coroner’s findings as Homicide and not the broader definition used by DCFS based on SB 39 Child Fatality Reporting and Disclosure Requirements**

⁴ The CDRT reviewed an undetermined child fatality and changed the manner of death to “homicide”. The case was open to DCFS when the fatality occurred. Another open DCFS case with a homicide was autopsied in another county and not reported to ICAN for inclusion in the 2007 report.

⁵ One was open to another county.

⁶ ICAN counts only deaths in LA County ruled a homicide by the Coroner. Two children died in LA County but were injured in another county and under that county’s CPS supervision.

SENATE BILL 39 (SB 39) IMPACT ON CHILD FATALITY DATA COLLECTION

SB 39 mandates public disclosure of information and findings about children who have died as a result of abuse or neglect under the following circumstances:

It is reasonably suspected that the child fatality is the result of abuse or neglect; the child resided with a parent or guardian or in foster care at the time of the death; and the abuse and neglect was substantiated by the Coroner, law enforcement or DCFS.

This means DCFS can substantiate the child fatality was due to abuse or neglect or law enforcement can determine a crime occurred although the Coroner ruled the death as accidental or undetermined and not a homicide. As a result, the number of child fatalities reported by DCFS under SB 39 differs from ICAN. DCFS reports child fatalities by a parent or guardian with a previous history with LA County DCFS. ICAN reports pertain to only child deaths with a mode of homicide by the Los Angeles County Coroner. DCFS involved homicides that occur outside of Los Angeles County are not included in the ICAN report. Lastly, ICAN includes out-of-county CPS involved child homicides by a parent/caregiver or family member if the child died in Los Angeles County.

CHILD FATALITIES BY PARENT, CAREGIVERS OR FAMILY MEMBERS WITH DCFS INVOLVEMENT 2007 – 2008 COMPARATIVE DATA

Year	ICAN Homicide Data	ICAN Homicide DCFS Involvement Data	DCFS SB 39 Child Fatality Data
2007	26	8	12
2008	34 ⁷	14 ⁸	15

⁷ Includes nineteen homicides not reported as child fatalities due to abuse and/or neglect by DCFS.

⁸ Includes two homicides in which the injury occurred in another county but the child died in Los Angeles County, excludes two homicides with open DCFS cases that occurred in another county and excludes one DCFS case that was ruled as an undetermined death by the Coroner.

Relationship of Suspect to Child Homicide Victim – 2008

The relationship of the suspect to the child was identified by the Coroner Investigator or Law Enforcement as:

- 18 – Father, Stepfather or mother’s boyfriend
- 7 – Mother
- 3 – Both parents
- 1 – Mother and Boyfriend
- 2 – Uncle
- 1 – Mother’s Partner
- 1 – Babysitter
- 1– Undetermined

Dates⁹ of Child Homicides – 2008

- 2 homicides occurred in January (1/03 & 1/19/2008)
- 1 homicide occurred in February (2/24/08)
- 1 homicide occurred in March (3/11/08)
- 1 homicide occurred in April (4/28/08)
- 2 homicides occurred in May (5/11 & 5/19/08)
- 2 homicides occurred in June (both on 6/23/08)
- 4 homicide occurred in July (7/08, 7/19, 7/21 & 7/24/08)
- 5 homicides occurred in September (9/09¹, 9/09, 9/19, 9/20 & 9/29/08)
- 3 homicides occurred in October (two on 10/06 & 10/20/08)
- 7 homicides occurred in November (11/03, 11/04, 11/07, 11/14 & three on 11/21/08)
- 3 homicides occurred in December (12/10, 12/11 & 12/25/08)

⁹ This is the date of death, which, in the majority of cases coincides with the date the injury occurred leading to the child’s death. Two

Locations¹⁰ of Child Homicides – Geographic Area – 2008

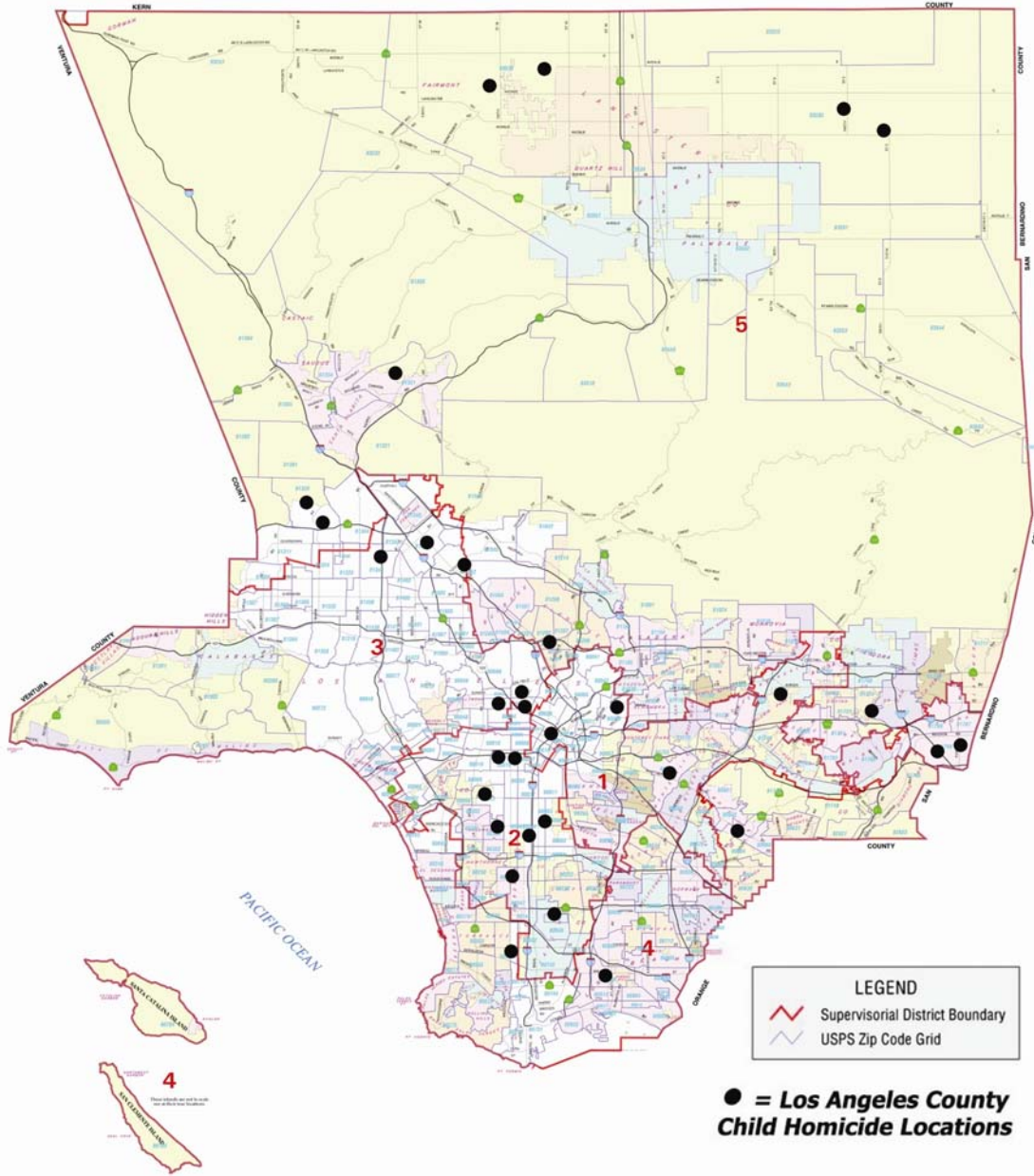
- 1 homicide occurred in Anderson (zip code 96007)
- 1 homicide occurred in Baldwin Park (zip code 91706)
- 1 homicide occurred in Canyon Country (zip code 91351)
- 1 homicide occurred in Carson (zip code 90747)
- 1 homicide occurred in Covina (zip code 91724)
- 1 homicide occurred in Gardena (zip code 90249)
- 1 homicide occurred in Glendale (zip code 91203)
- 1 homicide occurred in Inglewood (zip code 90305)
- 2 homicides occurred in Lancaster (zip code 93535)
- 1 homicide occurred in Lompoc (zip code 93436)
- 2 homicides occurred in Los Angeles (zip code 90003)
- 1 homicide occurred in Los Angeles (zip code 90017)
- 2 homicides occurred in Los Angeles (zip code 90018)
- 2 homicides occurred in Los Angeles (zip code 90029)
- 1 homicide occurred in Los Angeles (zip code 90032)
- 1 homicide occurred in Los Angeles (zip code 90038)
- 1 homicide occurred in Los Angeles (zip code 90043)
- 1 homicide occurred in Long Beach (zip code 90806)
- 1 homicide occurred in Montebello (zip code 90640)
- 1 homicide occurred in North Hills (zip code 91343)
- 1 homicide occurred in Pacoima (zip code 91331)
- 2 homicides occurred in Porter Ranch (zip code 91326)
- 2 homicides occurred in Pomona (zip code 91766)
- 2 homicides occurred in Quartz Hill (zip code 93536)
- 1 homicide occurred in Sun Valley (zip code 91352)
- 1 homicide occurred in Torrance (zip code 90501)
- 1 homicide occurred in Whittier (zip code 90605)

¹⁰ City where the injury/fatality occurred.

2008 Child Homicides

n = 34*

*Two Homicide Locations were outside of Los Angeles County



Child and Adolescent Suicides 1994 – 2008

Case Summary

Adolescent Suicide

Paramedics and law enforcement responded to a call and found 14-year-old Jung suspended from a tree by a ligature made from a belt. His mother arrived home from work and could not find him. After searching the home, she found him hanging from a tree on the hillside behind the home. Paramedics cut him down but found no signs of life, and death was pronounced at the scene.

The coroner investigator described the scene as two story home with a hillside rising up from the backyard in a quite middle class neighborhood. Several flights of stairs run up part of the backyard to various patios. A wooden fence separates the rear of the yard from the hillside beyond. Trees, brush and piles of leaves were on the hillside. The coroner investigator observed the teen suspended from a tree limb approximately twenty feet from the wooden fence with his feet just touching the ground. A small wooden stool was on its side on the hillside near his feet. Jung's body was transported to the Office of the Coroner for autopsy. The Coroner did rule Jung's death as a suicide due to asphyxia.

According to the mother, on the morning of his death, she and Jung got into a verbal argument over his not doing chores. His mother said aside from the argument, Jung seemed fine and was acting normally. He has never threatened suicide or made suicidal statements. There had been no major changes in his life and his behavior had been normal the past month. He had no medical history and was not taking any medications. He was a straight A student. His mother believes Jung may have been under stress in trying to maintain his 4.0 grade point average.

Jung did not leave a note or indicate to anyone he was considering suicide. His Facebook page showed no indication he was depressed or contemplating suicide. In the many hours of searching for Jung the night of his death, the mother and her boyfriend found an inquiry on the computer's web browser that read "what's the easiest way to commit suicide with the least amount of pain?"

Jung's school records confirmed he was a straight A student but new to the high school as a freshman. He adopted the name "Daniel" and was called this by his peers. His grades were beginning to suffer and at the time of his death he had one "D" and a couple of "C's". The school reported Jung left his peer group and began to isolate himself in order to focus on his schoolwork. He did not have any attendance or behavior problems. He never discussed suicide and his teachers were shocked to learn of the suicide. After his death, his friends reported they were never allowed into his home. They said his mother was punitive and intense.

Jung was born in Korea and came to this country a few years age with his mother. His biological father remained in his native country. Within a year, his mother became involved with her boyfriend who is Caucasian.

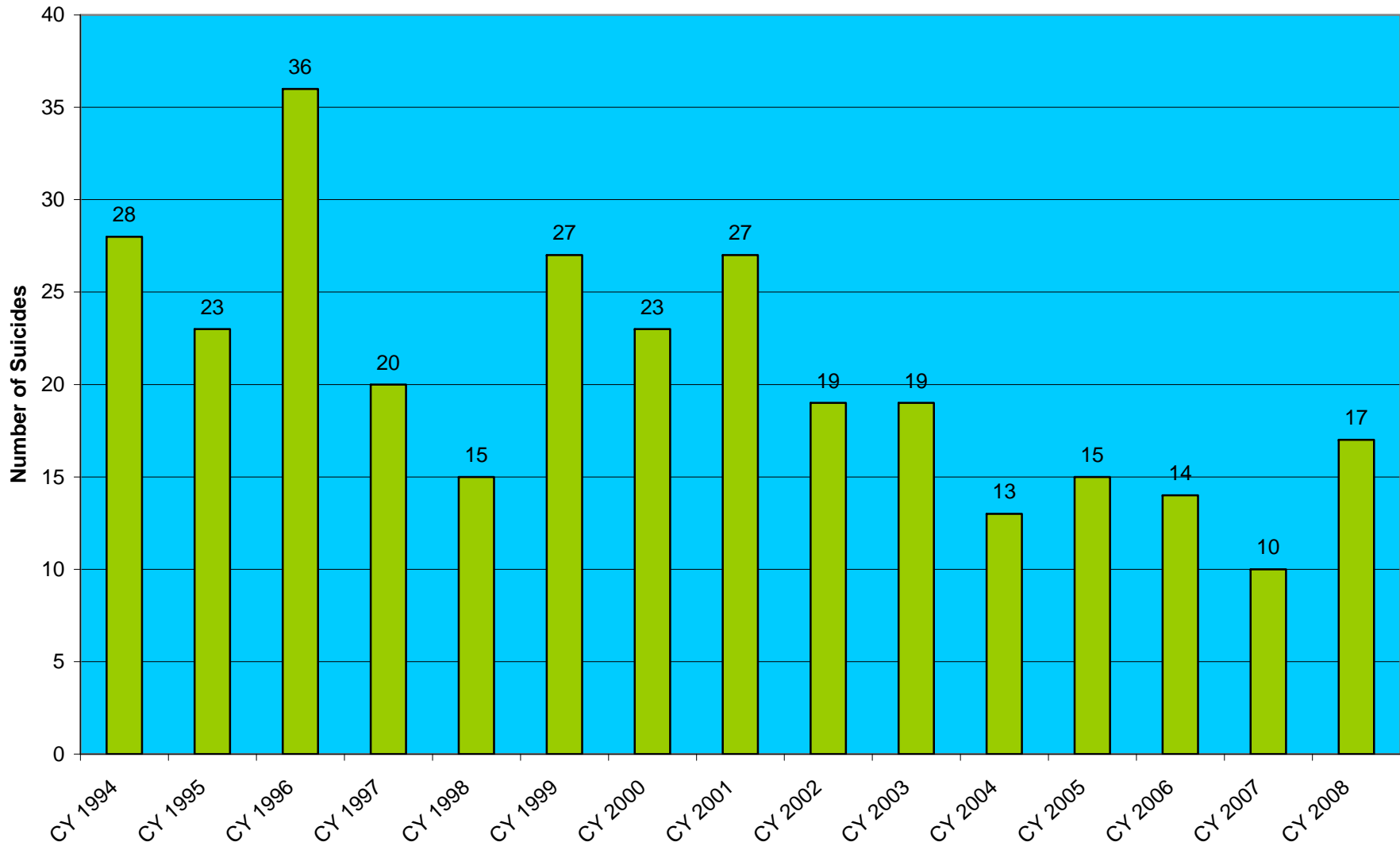
The Department of Children and Family Services (DCFS) did not have any prior history with Jung's family.

The response team from the school district interviewed both the mother and her boyfriend to gather as many facts as possible. They then addressed the student body with the facts in an effort to mitigate rumors from being spread. The staff then focused on the students who were the most affected by the suicide. This was the third suicide in the past three years experienced by the school.

The district psychologists were made available for teachers and other staff. The common denominator in the suicides was they all involved high achievers of Asian descent. The school is 65% Asian.

The Child and Adolescent Suicide Review Team examined Jung's case. They discussed the risk factors or warning signs such as Jung's grades beginning to slip, his isolating himself from his peers, the loss of his father and his recent arrival to the United States. The Team also considered whether due to cultural reasons, Jung was reluctant to seek help. The Team discussed the need to openly talk about depression, anxiety and suicide to teens; having prevention posters and material available; training faculty and staff to recognize signs of teens at risk; teaching the teens on how to be more supportive and identify when friends might need some kind of services.

1994 - 2008 Child and Adolescent Suicides



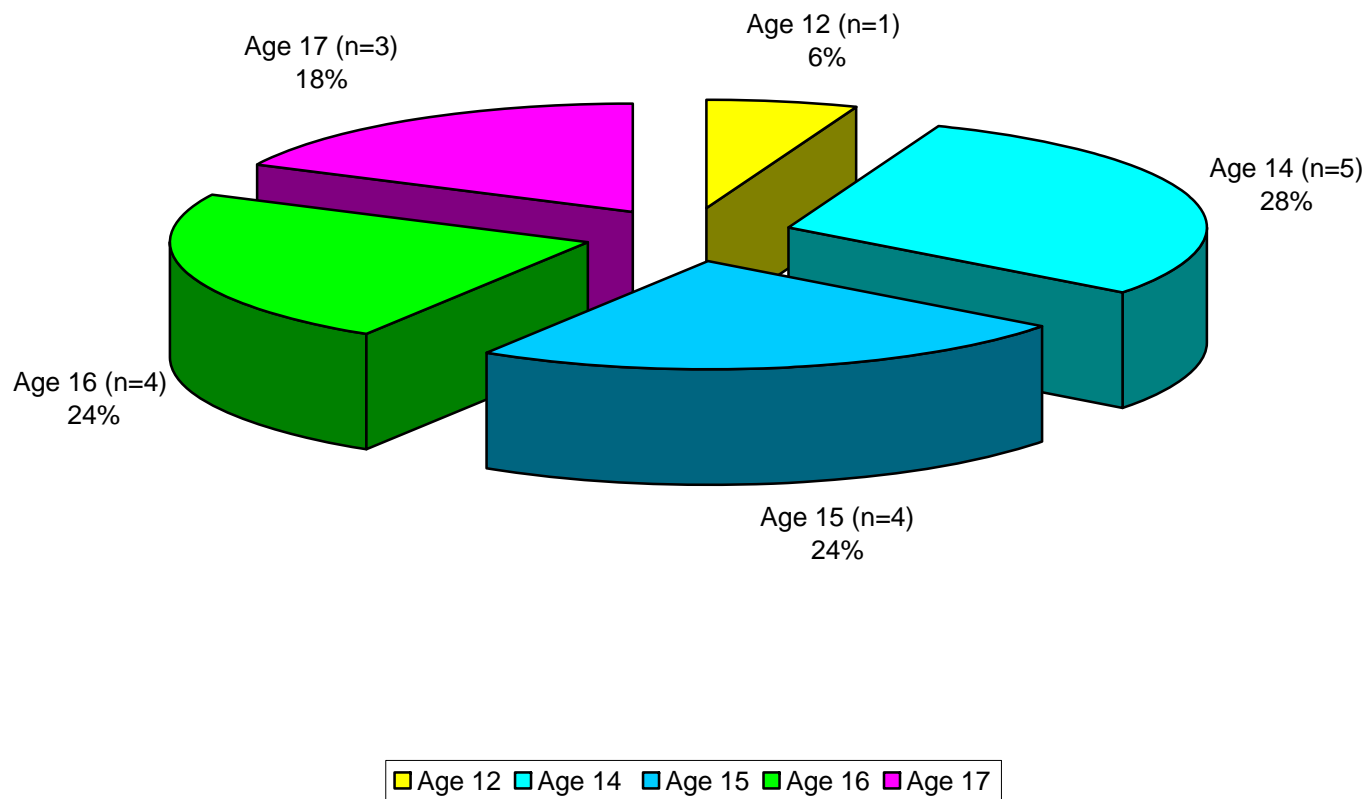
**Child and Adolescent Suicides by Method and Gender
Los Angeles County – 2008 (n = 17)**

Method	Male	Female
Hanging	8	4
Firearms/Gunshot	3	0
Jump from height	0	2
TOTAL	11	6

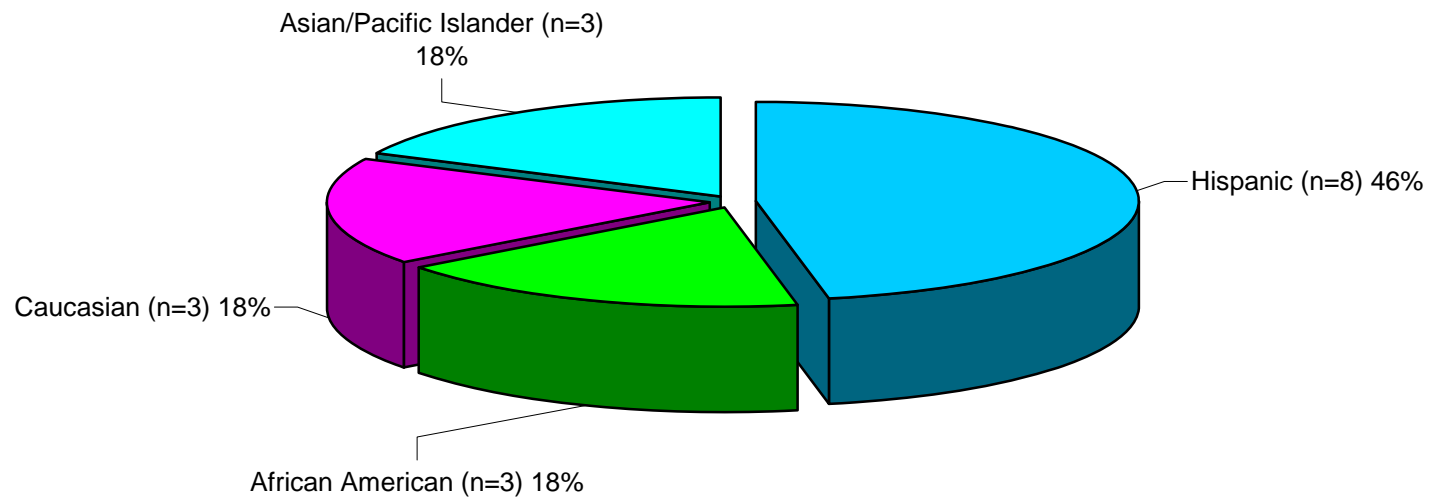
Hanging was the most frequent method of suicide among adolescents and represents 70% of the suicides in 2008. Firearms/gunshot was the second most frequent method of suicide in 2007.

In 2008, 65% (n=11) of the adolescent suicide victims were male. 35% (n=6) of the victims of adolescent suicide in 2008 were female.

2008 Child and Adolescent Suicides - Age



2008 Child and Adolescent Suicides - Race



Los Angeles County child population ages 0 - 18 is 2,830,799. Of the children in the county, 9% are African American, 9% are Asian American, 61% Latino, 18% white and 3% are of multiple or other ethnicities.
2008 Children Now County Scorecard

■ Hispanic ■ African American ■ Caucasian ■ Asian/Pacific Islander

Child and Adolescent Suicide Victim Characteristics – 2008

Four of the youth exhibited warning signs prior to their suicide.

Four of the youth had a history of mental illness.

Two of the youth left a suicide note.

Three of the youth had previously attempted suicide

Three of the youth were discovered to have a positive toxicology for drugs or alcohol at autopsy.

Four of the youth exhibited evidence of drug use prior to their suicide.

Eleven of the youths' families had a prior history and/or an open referral or case with the Department of Children and Family Services or with the Department of Probation.

Three of the youth had a criminal and/or juvenile delinquency record.

Four of the youth had a history of prior self-injury.

Twelve of the youth had experienced a recent relationship loss or conflict.

Three of the youth had received special education services.

Three of the youth had known academic problems and

Two of the youth had school discipline or truancy problems.

Dates of Child and Adolescent Suicides – 2008

1 suicide occurred in January (01/12/08)
1 suicide occurred in February (02/28/08)
1 suicide occurred in March (03/06/08)
1 suicide occurred in April (04/14/08)
4 suicides occurred in May (05/05; 05/08; 05/21 & 05/26/08)
1 suicide occurred in June (06/28/08)
2 suicides occurred in July (07/04 & 07/27/08)
1 suicide occurred in August (08/07/07)
2 suicides occurred in September (09/05 & 09/28/08)
2 suicides occurred in October (10/20 & 10/21/2008)
1 suicide occurred in November (11/10/08)

Locations¹¹ of Child and Adolescent Suicides – Geographic Area – 2008

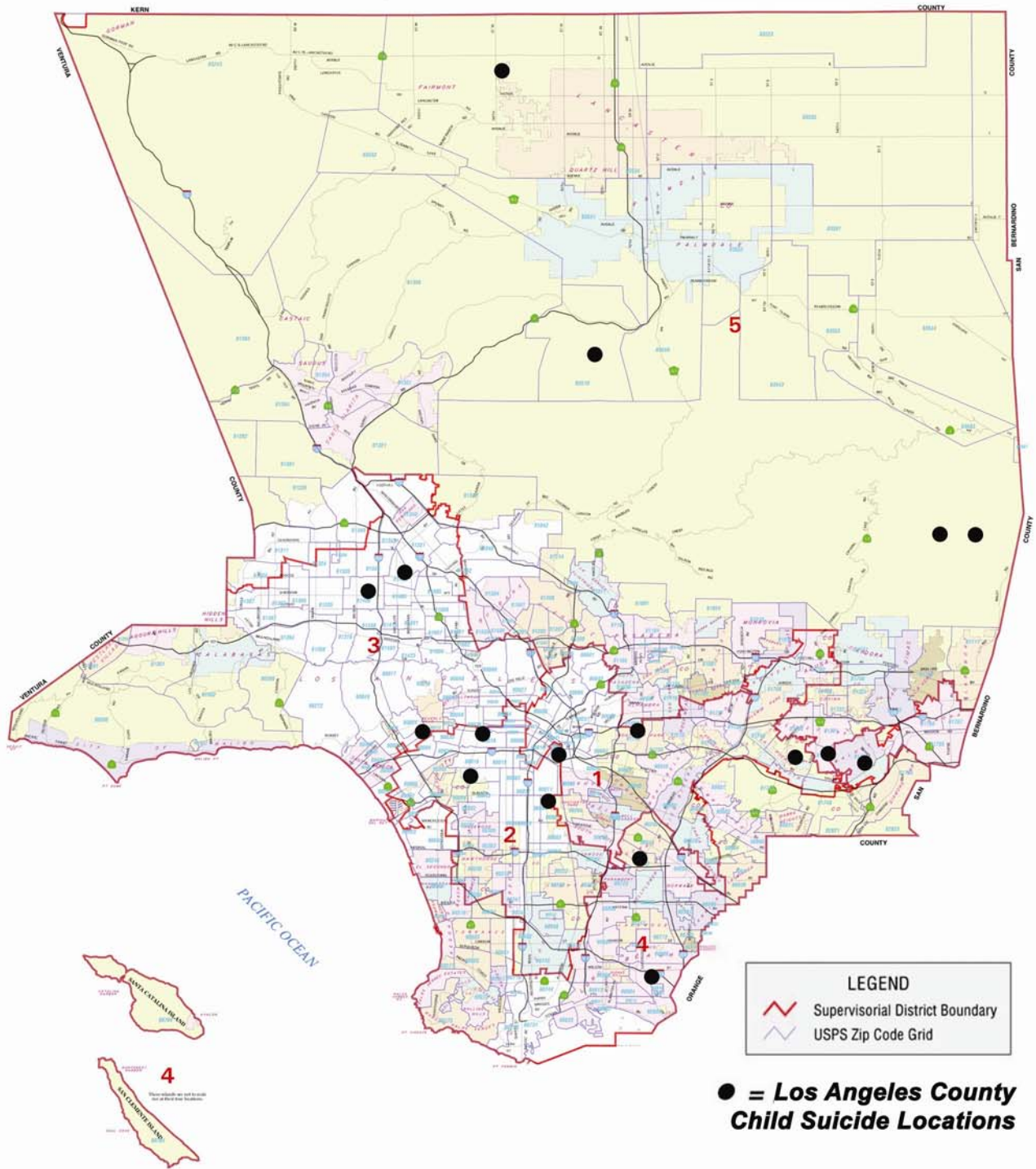
2 suicides occurred in La Verne (zip code 91750)
1 suicide occurred in Los Angeles (zip code 90033)
1 suicide occurred in Walnut (zip code 91789)
1 suicide occurred in Los Angeles (zip code 90001)
1 suicide occurred in Los Angeles (zip code 90019)
1 suicide occurred in Monterey Park (zip code 91754)
1 suicide occurred in Van Nuys (zip code 91402)
1 suicide occurred in Long Beach (zip code 90815)
1 suicide occurred in Los Angeles (zip code 90067)
1 suicide occurred in Downey (zip code 90242)
1 suicide occurred in Van Nuys (zip code 91406)
1 suicide occurred in Los Angeles (zip code 90008)
1 suicide occurred in Lancaster (zip code 93536)
1 suicide occurred in Acton (zip code 93510)
1 suicide occurred in Valinda (zip code 91744)
1 suicide occurred in West Covina (zip code 91792)

¹¹ City where the suicide occurred.

2008 Child and Adolescent Suicides - Location

n = 17*

*City where the suicide occurred



Accidental Child Deaths 1994 - 2008

Case Summary

Accidental Death

Maria, age eight was in the left rear passenger seat of her family's SUV. Her seven month old brother was strapped into a child safety seat next to her. Her father was driving the car and mother was in the passenger's seat in the front.

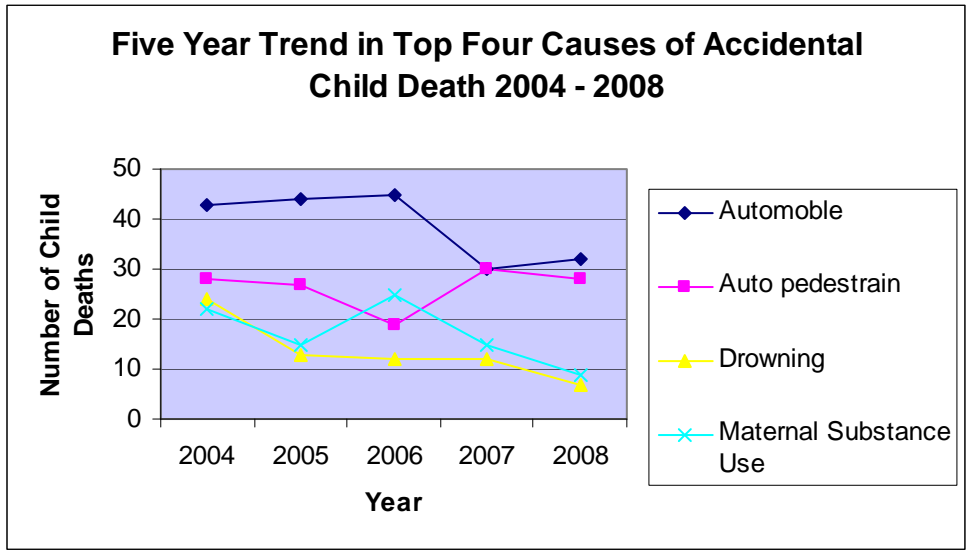
The family car was traveling approximately 70 miles per hour northbound on the freeway when the left rear tire blew. The driver lost control of the car causing it to go off the road and down an embankment over turning several times before striking a pole.

Maria who was not wearing a seat belt was ejected from the car and sustained fatal head injuries and was pronounced at the scene. Her infant brother sustained a lacerated lip and a badly bruised forehead. Although strapped in a car seat, the car seat itself was not properly strapped to the rear seat seatbelt.

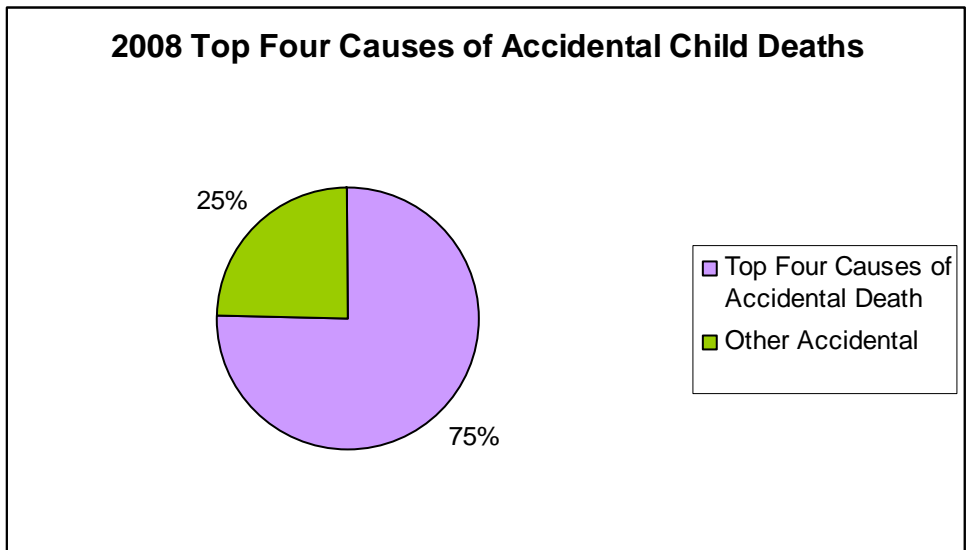
Both parent sustained injuries and were transported along with the infant to the hospital for care.

Maria's tragic death and her brother's injuries were preventable had they been properly restrained. It is not sufficient to have an infant in a car seat without following the manufacture's instruction to tethering the seat with car restraints.

The Team also debated whether drivers in general are automatically tested for alcohol and drugs in fatal accidents involving children. It was pointed out that there is probable cause to do such screenings in accidents such as this but they are not always conducted. The Team also questioned who should be included in the review of accidental deaths. It would have been helpful to have the Highway Patrol present to answer some of the questions. Unfortunately, death due to a car accident such as in this child's case is not uncommon. In the past two years, death due to car accidents was the leading cause of accidental death for children.



The chart above depicts the top four causes of accidental child death over a five year period from 2004 to 2008. The trend for all four has for the most part been on a downward trend. The “top four” causes-automobile, auto pedestrian, drowning and maternal substance use accounted for 75% of all accidental child deaths in 2008.



**Causes of Accidental Child Deaths, Ages 0 – 17
2008 – Los Angeles County (N = 101)**

Automobile – multi-vehicle	23
Automobile – solo vehicle	9
Auto pedestrian	29
Asphyxia	3
Drowning	7
Drug Intake	6
Falls	2
Gas Leak	1
Maternal drug use	9
Medical complications	7
Mother’s ingestion of unpasteurized cheese	1
Motor vehicle other than auto	2
Sports Injury	2
TOTAL	101

Causes of Accidental Child Deaths by Age 2008 – Los Angeles County (N = 101)

	Age 0 – 5 years	Age 6 – 14 years	Age 15 – 17 years
Automobile – multi-vehicle	7	7	9
Automobile – solo vehicle	1	2	6
Auto pedestrian	11	14	5
Choking	1	0	0
Crushed by Object	0	0	0
Drowning	4	3	0
Drug Intake	1	0	5
Falls	1	0	1
Gas Leak	1	0	0
Handgun discharge	0	0	0
Hanging/Strangulation	2	0	0
Hyperthermia	0	1	0
Hypothermia	0	0	0
Maternal drug use	9	0	0
Medical complications	2	3	2
Motor vehicle other than auto ¹²	0	1	1
Mother's ingestion of Unpasteurized cheese	1	0	0
Sport Injury	0	2	0
TOTAL	41	31	29

¹² Category includes mini-bikes, dirt bikes, scooters, go-carts, motorcycles and all-terrain vehicles (ATVs).

**Race of Accidental Child Deaths, Ages 0 – 17
Los Angeles County – 2008 (N = 101)**

	Hispanic	African-American	Caucasian	Asian/Pacific Islander	Other ¹³ / Unknown
Automobile – multi-vehicle	8	6	5	2	2
Automobile – solo vehicle	6	2	1	0	0
Auto pedestrian	17	5	4	1	2
Choking	0	0	0	1	0
Drowning	4	1	0	0	1
Drug Intake	3	0	1	2	0
Falls	1	0	0	0	1
Gas Leak	1	0	0	0	0
Hanging/strangulation	1	1	0	0	0
Sports injury	2	0	0	0	0
Maternal drug use	7	0	0	1	1
Medical complications	5	2	1	1	0
Motor vehicle other than auto ¹⁴	2	0	0	0	0
TOTAL	57	17	12	8	7

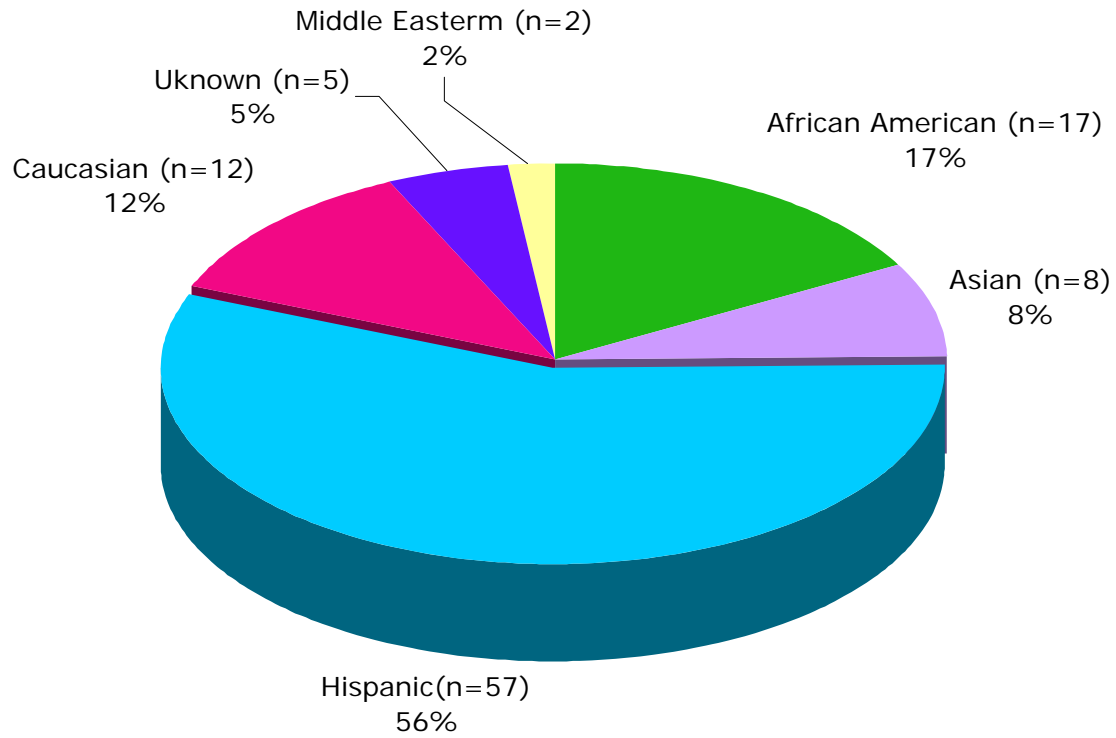
¹³ Includes three children designated as Middle Eastern

¹⁴ Category includes mini-bikes, dirt bikes, scooters, go-carts, and all-terrain vehicles (ATVs).

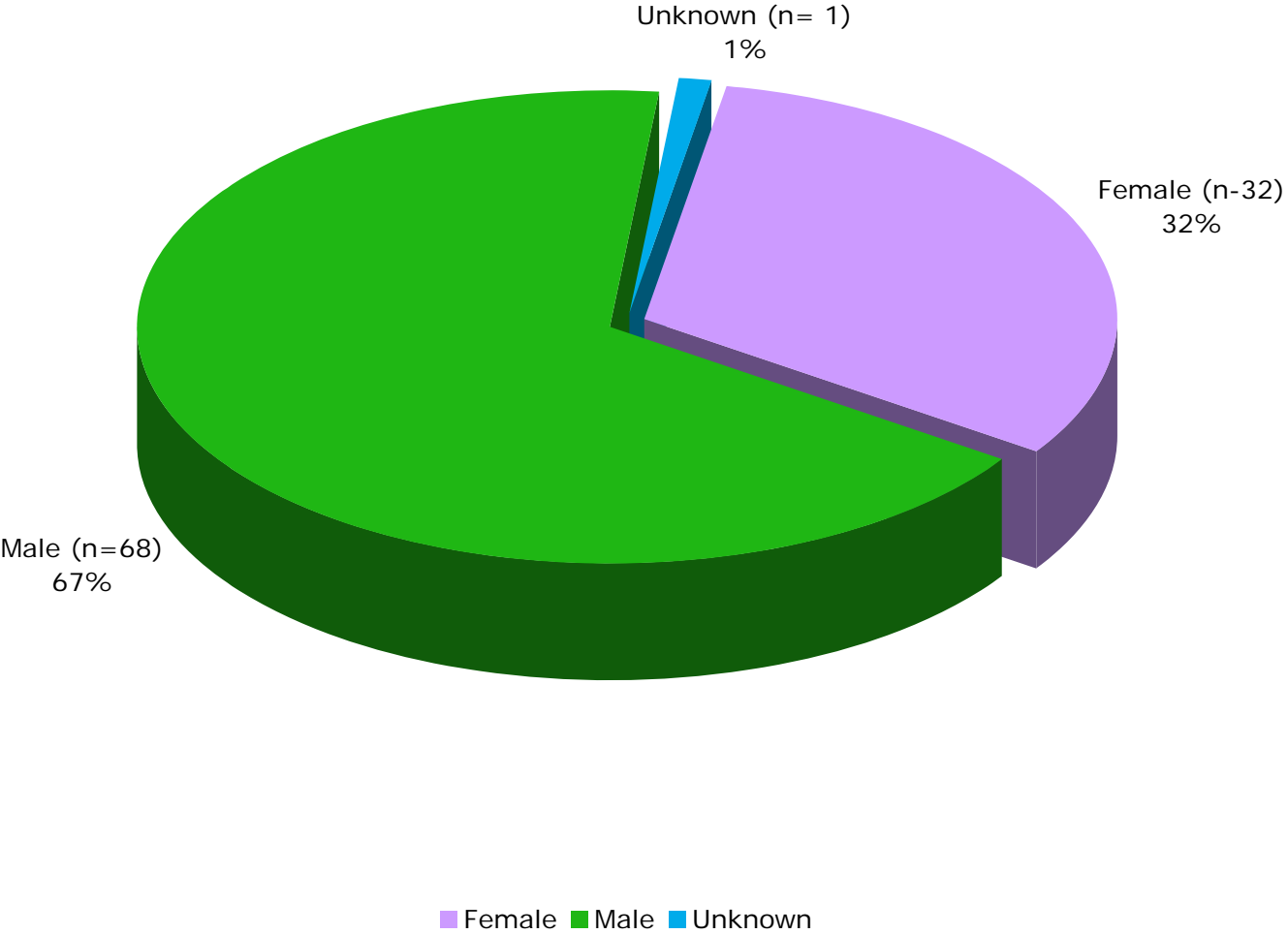
**Causes of Accidental Child Deaths, Ages 0 - 14
1994 -- 2008, Los Angeles County**

	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	Total
Drowning	35	31	18	28	21	25	23	28	16	19	21	12	12	11	7	307
Maternal drug abuse	10	9	25	24	38	21	22	24	25	32	21	15	25	15	9	315
Auto pedestrian ¹	0	2	1	8	19	31	30	41	33	25	21	20	11	25	25	292
Automobile ²	0	0	0	0	0	18	24	28	20	47	25	21	22	14	17	236
Falls	7	6	5	2	3	5	1	1	3	2	3	1	2	1	1	43
Choking	2	0	1	5	3	6	10	2	8	4	1	3	1	1	2	49
Suffocation	4	1	2	0	2	4	1	3	0	1	1	2	2	0	0	23
Poisoning	4	1	1	6	1	4	4	1	0	2	2	1	2	0	1	30
Fire	2	2	0	1	3	7	4	3	7	0	2	6	7	2	0	46
Hanging/strangulation	0	0	3	0	0	0	6	3	1	2	4	1	3	4	0	27
Chest/neck compression	3	1	2	1	2	0	1	0	0	3	0	0	0	0	1	14
Gunshot wounds	1	1	2	1	0	0	0	0	0	0	0	0	0	0	0	5
Crushed by object	0	2	0	3	2	1	1	0	1	0	1	5	2	2	0	20
Sports injury	0	0	0	2	0	2	2	1	0	0	0	1	0	0	2	10
Burns/Thermal Injury	0	0	0	0	0	1	0	0	1	0	1	0	0	0	0	3
Dog bites	0	1	0	1	0	1	1	0	0	0	0	1	0	0	0	5
Medical complications ³	2	1	1	0	1	5	6	2	8	7	3	3	2	7	5	53
Perinatal asphyxia	0	1	0	1	0	1	0	0	0	0	0	0	0	0	1	4
Electrocution	0	0	0	2	0	0	1	0	0	1	0	1	0	0	0	5
Birth trauma	0	0	0	0	0	2	0	0	0	0	0	2	0	0	0	4
Hypothermia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hyperthermia	0	0	0	0	0	0	0	0	0	0	0	2	1	0	0	3
Airplane related	0	0	0	0	0	0	0	0	2	2	0	0	0	0	0	4
Train v. pedestrian	0	0	0	1	0	0	0	0	0	0	0	1	0	1	0	3
Elective abortion	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Forklift injury	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Drug intake/Overdose	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
Motor vehicle (not auto) ⁴	0	0	0	0	0	0	0	0	0	0	4	1	3	0	1	9
Impaled	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Gas Leak	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
TOTAL⁵	70	59	61	86	95	134	137	137	127	147	110	100	95	83	73	1516

2008 Accidental Child Deaths - Race



2008 Accidental Child Deaths - Gender



**Causes of Accidental Child Deaths by Gender
2008 – Los Angeles County (N = 101)**

	Female	Male	Unknown
Automobile – multi-vehicle	6	17	0
Automobile – Single	3	6	0
Auto pedestrian	7	22	0
Choking	0	1	0
Drowning	4	3	0
Drug intake	2	3	0
Falls	1	1	0
Hanging/Strangulation	0	2	0
Sports injury	0	2	0
Maternal drug use	5	4	1
Medical complications	4	4	0
Motor vehicle other than auto	0	2	0
Gas Leak	0	1	0
TOTAL	32	68	1

Undetermined Child Deaths 1994 – 2008

Case Summary

Undetermined Child Death

Denise was a two-month old infant living with her parents and 2 year-old sibling John. After breast-feeding Denise around 11:00 pm, the mother placed her to sleep in her crib. At about 5:00 am, the mother awoke and became concerned because Denise would normally awaken every few hours. She went to the crib that was located in the parents' bedroom and found Denise face down on a pillow. She was purple and not breathing. The mother began CPR while the father called 911. Paramedics responded to the home and found rigor mortis had set in and the infant could not be resituated. Her death was pronounced at the home.

The Coroner Investigator found the home to be clean and well maintained. Denise's crib, however, was not safe for sleeping. It had several blankets and pillows. The mother placed Denise to sleep on her side with her shoulders and head lying on top of a pillow. The mother put a blanket behind Denise to prevent her from rolling on her back. She put a large sofa pillow in front of Denise to prevent her from rolling forward. Denise rolled forward and her face was against the sofa pillow when the mother discovered her. Denise's playpen in the living room also contained numerous soft bedding items and was unsafe.

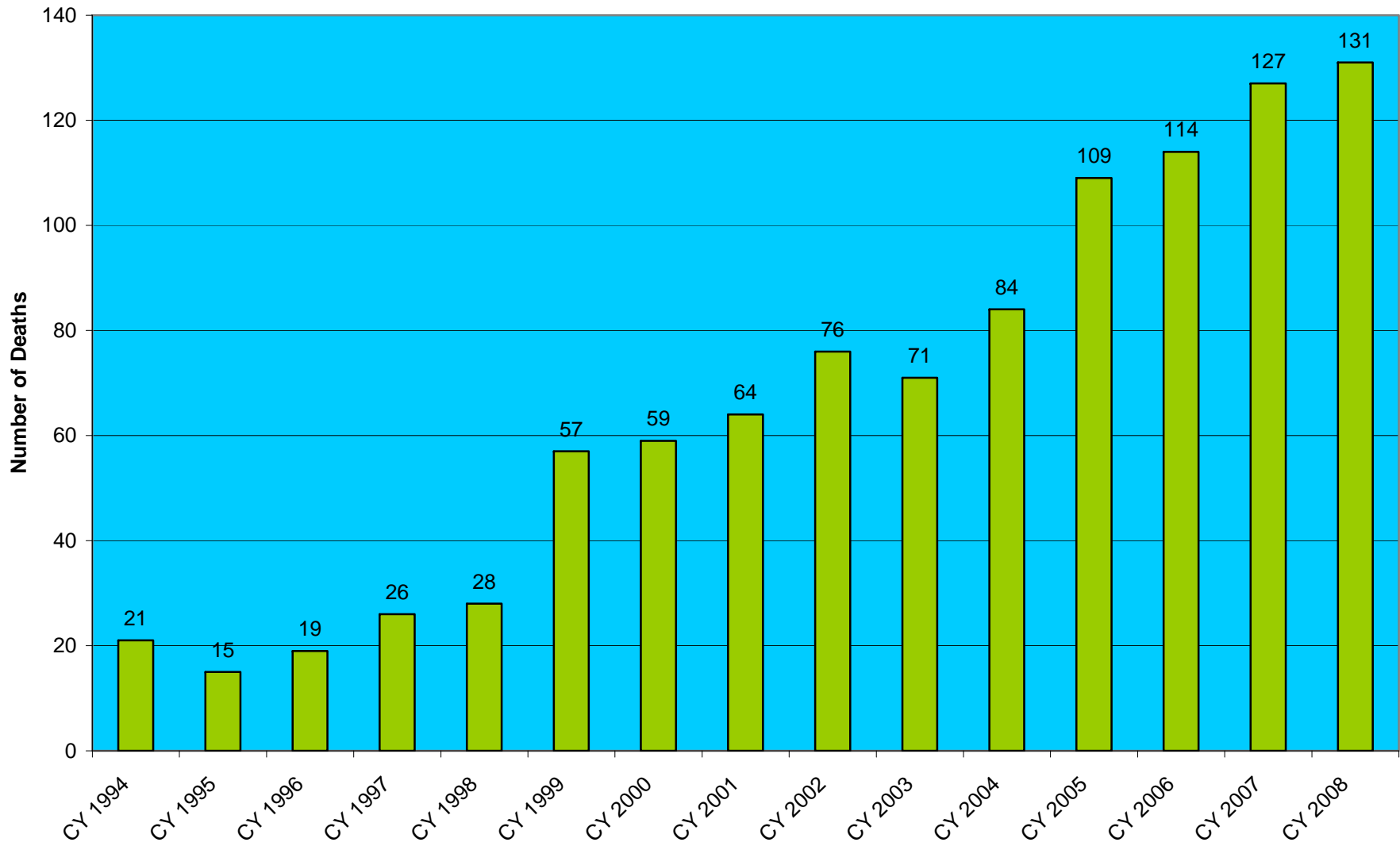
John was sharing the parents' bed on the evening prior to Denise's death. There was no independent bed for John to sleep. John appeared to be clean and well cared for according to the investigator.

Neither parent had a criminal history. There was one previous referral on John to the Department of Children and Family Services (DCFS) a year ago for lack of supervision that was inconclusive. The parents believed a neighbor called it in because they were in a dispute with the neighbor over the loud music they played at night. The parents denied consuming any alcohol or use of drugs the night before Denise's death. The investigator did not see any indication of drug/alcohol use in the home.

DCFS did open a referral on John after Denise's death. The referral was closed when it was confirmed the parents removed all the soft bedding from the crib for John to sleep separately from the parents.

The ICAN Child Death Review Team reviewed this case and identified several concerning issues regarding safe sleeping practices for infants. There have been a large number of deaths related to co-sleeping and/or unsafe sleep environments. For this reason, ICAN has over the years supported efforts to provide information to parents about the risks involved with co-sleeping and safe sleep practices. Denise's tragic death involved the use of soft bedding and pillows that obstructed her ability to breathe when she rolled. Placing her on her side was equivalent to placing her on her stomach which is associated with sudden unexpected infant death.

1994 to 2008 Undetermined Child Deaths



Undetermined Child Deaths – 2008 (N = 131)

Race	Number/Percentage of Undetermined Child Deaths
African American	31 (24%)
Asian/Pacific Islander	12 (9%)
Caucasian	18 (14%)
Hispanic	66 (50%)
Other/Unknown	4 (3%)

Age	Number of Undetermined Child Deaths
------------	--------------------------------------------

Under 1	106
1 year	7
2 years	2
3 years	1
4 years	1
5 years	4
6 years	0
7 years	0
8 years	1
9 years	1
10 years	0
11 years	1
12 years	0
13 – 17 years	7

Gender	Number of Undetermined Child Deaths
---------------	--------------------------------------------

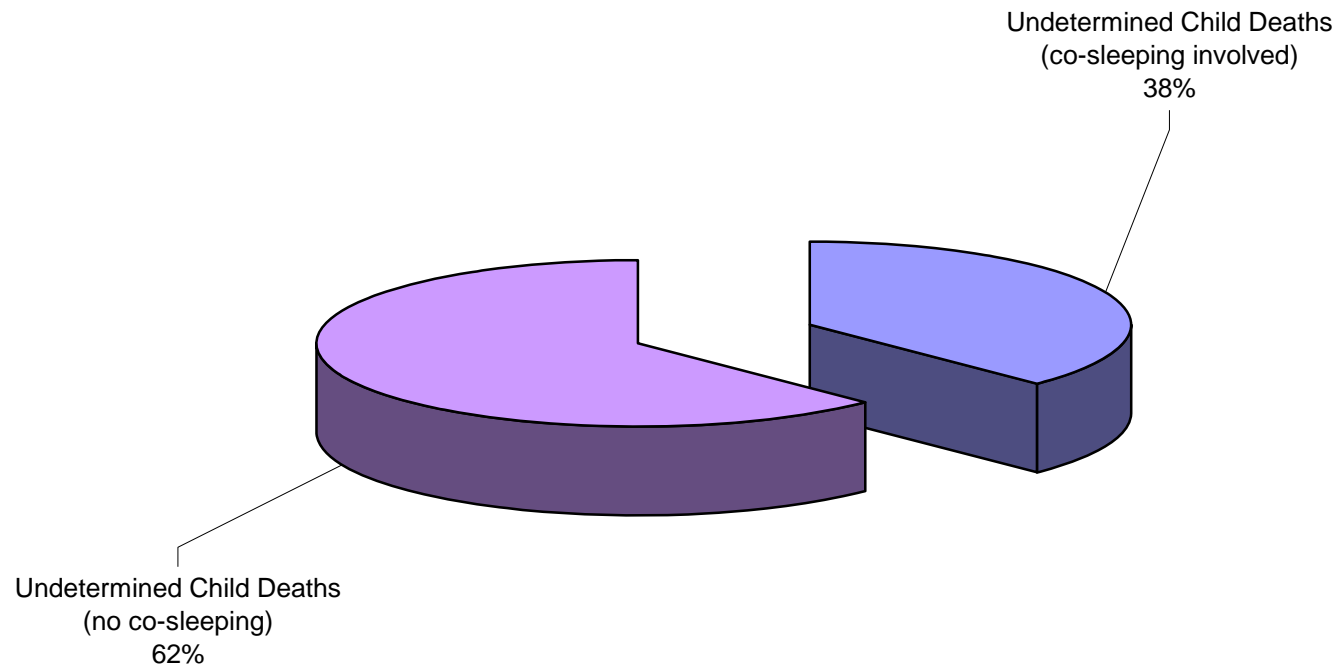
Female	52
Male	78
Unknown	1

African American children were over-represented in undetermined child deaths.

81% of the undetermined child deaths were under one year of age.

92% of the undetermined child deaths were 5 years of age or under.

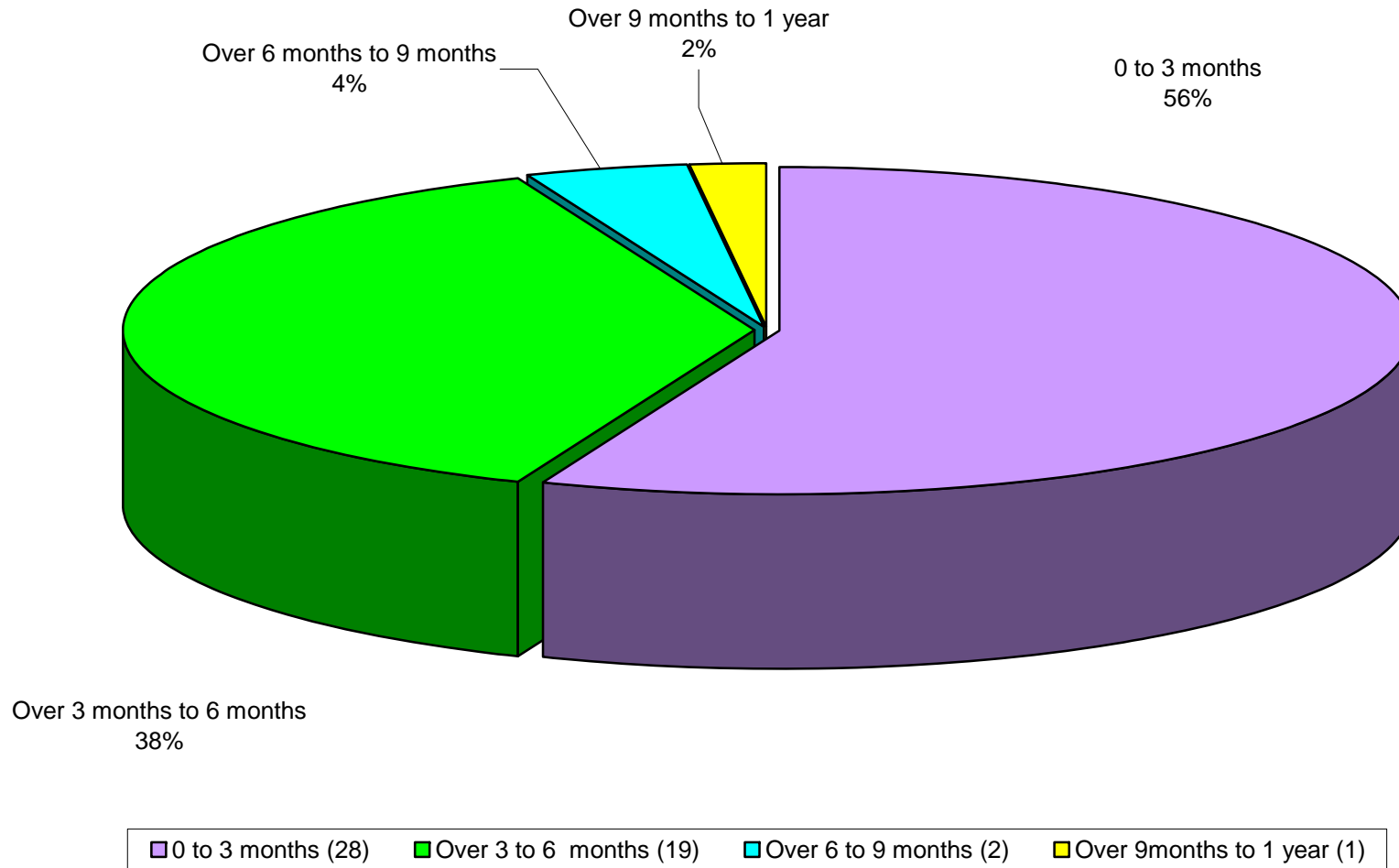
Percentage of Undetermined Child Deaths with a Noted Status Post Co-sleeping 2008



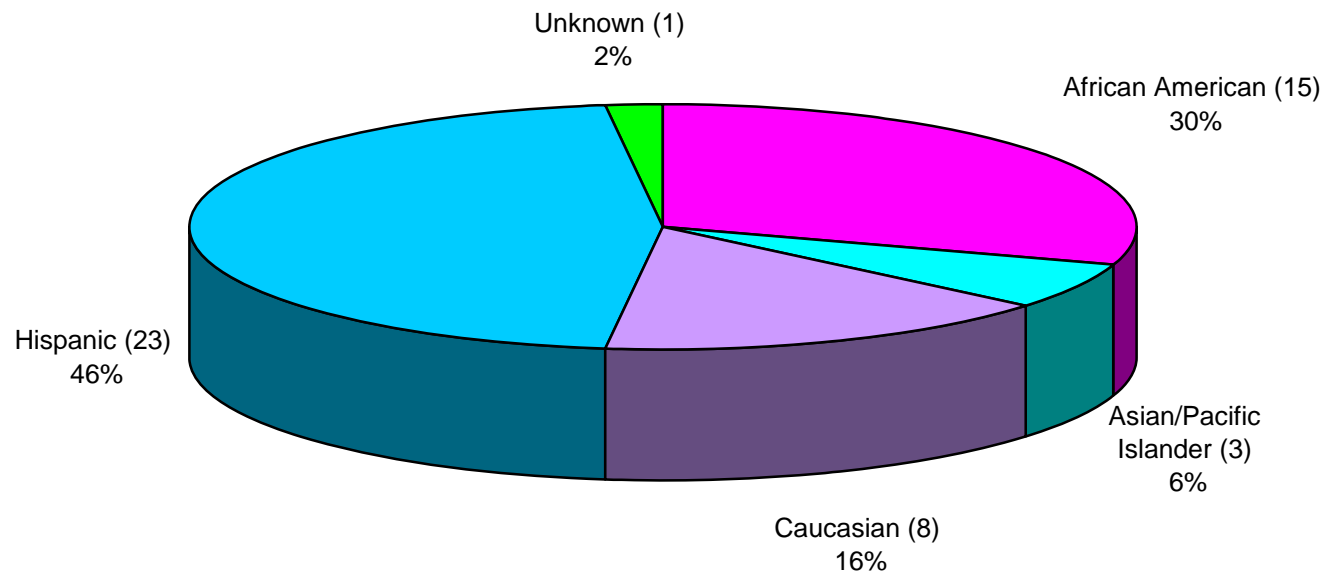
■ Undetermined Child Deaths (co-sleeping involved) 50

■ Undetermined Child Deaths (no co-sleeping involved) 81

2008 Undetermined Child Deaths Associated with Co-sleeping - Age

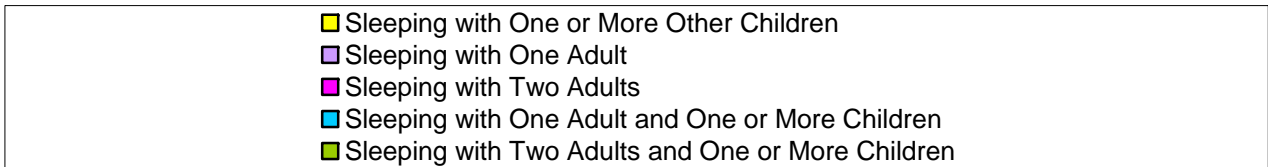
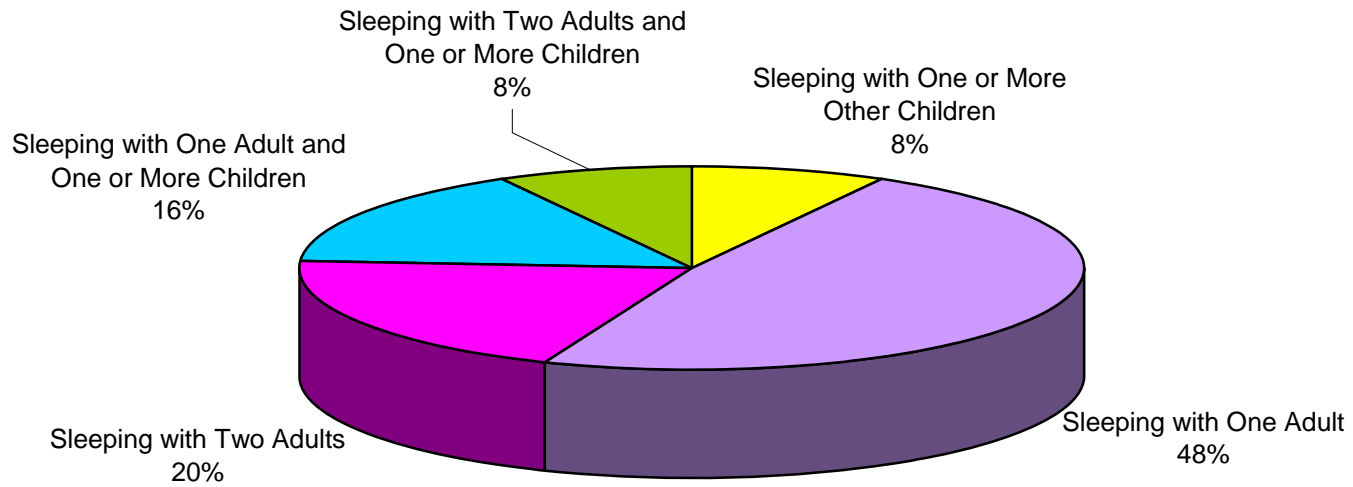


2008 Undetermined Child Deaths Associated with Co-sleeping - Race

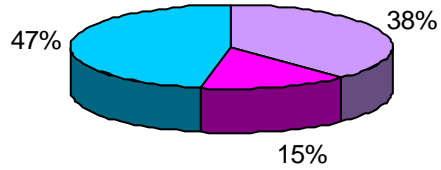


■ African American ■ Asian-Pacific ■ Caucasian ■ Hispanic ■ Unknown

2008 Undetermined Child Deaths Associated with Co-sleeping Number of Persons

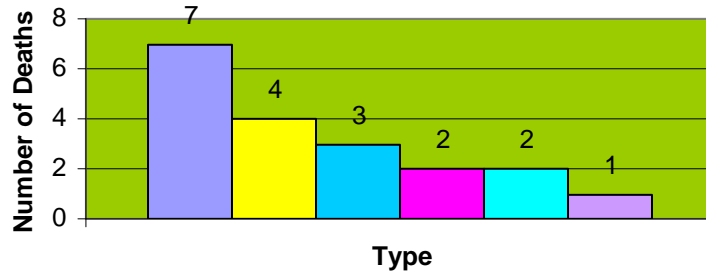


**Percentage of Undetermined Child Deaths
Associated with Co-sleeping and Unsafe Sleeping
Practices - 2008**



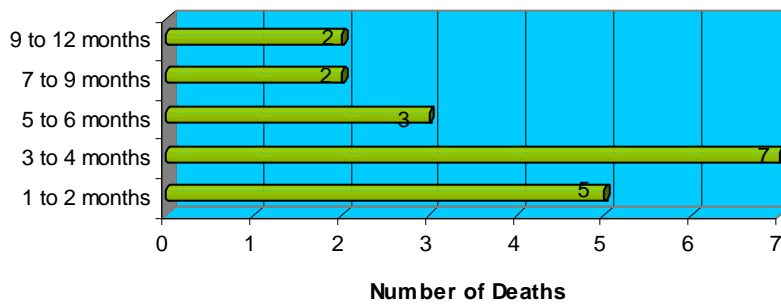
Undetermined Child Deaths Co-Sleeping Involved (50)
Undetermined Child Deaths Unsafe Sleeping Involved (19)
Remaining Undetermined Child Deaths (62)

2008 Unsafe Sleep Environment Type



Adult beds	Pillows
Couch	Excessive swaddling
Excessive bedding	Plastic bag

**2008 Undetermined Child Deaths Associated with
Unsafe Sleep Environments - Age**



Third Party Homicides 2008

Introduction

Historically, the ICAN Child Death Review Team report has included only those cases which have met Team protocol. For the second year, however, the report includes a special supplement to provide data on youth who are victims of a third party homicide. Unlike the child homicides perpetrated by a parent, caregiver, or family member, these homicides are where the perpetrator was not the caregiver or family member.

The information contained in this section is from two primary sources – the Los Angeles County Coroner’s office and the local law enforcement agencies within Los Angeles County. The Coroner’s Office provided demographic data as well as information on the cause and manner of death. Law enforcement provided information as to which agency conducted the criminal investigation, the identity of the suspects, and whether the case was presented to the District Attorney’s office for the filing of criminal charges and, in some cases, the type of charges filed. Also, the Los Angeles Police Department (LAPD) and the Los Angeles Sheriff’s Department (LASD) indicated whether the victim and/or suspect was believed to be gang-involved.

The purpose of this information is to provide a broader analysis of children and youth deaths in Los Angeles County. Since the number is significant (n=82) it seemed relevant to provide an analysis of these third party homicide deaths in hopes to provide a better understanding of child death in Los Angeles County. Ultimately, it is hoped that the study of these deaths will help us intervene more effectively.

Since this is only the second year including these data, there are no charts depicting trends in these deaths. It is anticipated these data shall be included in future Child Death Review Team reports which will enable ICAN to then provide a fuller trend analysis.

Case Summaries*

Third Party Homicides

Adiel, age 15, was riding his bicycle through a residential neighborhood when a car pulled up along side him. An occupant in this car shouted an insult against the area's franchised gang and shot Adiel multiple times before speeding off. Adiel fell from his bike to the asphalt and remained there until paramedics arrived and pronounced his death.

Seventeen-year old Benton was walking on the sidewalk with a friend when an unknown person approached them. This person pulled out a handgun and opened fire. In excess of five rounds were discharged and both Benton and his friend were hit by the gunfire. The perpetrator fled the scene and 911 was called. Benton was taken to the hospital where he was later pronounced. The friend was also taken to the hospital and was expected to survive.

One Saturday morning Victor, age 17, was attending a birthday party at a private residence when he accidentally burned someone with a cigarette. A verbal altercation between Victor and the other person quickly turned into a pushing match. The other person pulled out a gun and shot Victor two times. Victor then collapsed to the ground when he was shot two more times and died quickly thereafter.

Miguel, age 13, was in the front yard of his relative's home picking lemons when family members heard gunshots. The family members looked outside for Miguel but could not see him. A family member then went outside and found Miguel lying on the driveway. He was bleeding and unresponsive. Paramedics transported him to the hospital where Miguel was pronounced dead a short time later.

One early morning a farm worker was driving through a field when he saw what appeared to be trash dumped on a dirt road. As the farm worker got closer, he realized it was not trash but a body wrapped in carpet. When the authorities arrived they discovered the body of a young female with her clothing removed. The authorities later identified the young female victim to be 13 year-old Tasha. According to her mother, Tasha was last seen the day prior when she had left to go swimming with some friends. It was determined that young Tasha had died from strangulation.

Seventeen-year old Cesar was standing on the sidewalk outside a liquor store with his friends when a car drove by and fired multiple shots at the group. Cesar was struck multiple times to his upper torso area. Paramedics arrived on the scene and found Cesar on the sidewalk. He was transported to the hospital, but despite medical intervention he later died. The shooting was suspected to have been gang related.

Gilbert, age 16, was riding his bike when he was approached by a green Camaro and an occupant in this car shot at him multiple times. Law enforcement deputies who were nearby heard the gunfire and immediately went to the scene. Upon arrival, Gilbert was found lying on the sidewalk with his bike still between his legs. The deputies requested medical assistance but Gilbert died before paramedics arrived. Multiple shell casings were recovered at the scene.

Sixteen-year old Daniel was attending a party when a fight ensued between his friend and a known gang member. Daniel attempted to break up the altercation when the gang member pulled out a gun and fired several rounds. A bullet struck Daniel in the chest and he was pronounced dead at the scene.

Raymond, age 16, was talking with a friend when a car with three individuals pulled up and asked Raymond what gang he was in. Once Raymond replied, one person got out of the car, went to the trunk, and retrieved a weapon from a plastic bag and began shooting at Raymond. Raymond attempted to escape and took off running. The perpetrator chased Raymond while continuing to shoot at him. Raymond eventually collapsed to the street and all three perpetrators sped off in their car. All three of these individuals were eventually arrested, but Raymond succumbed to his injuries and died as a result of this incident.

Thirteen-year old Rhianna's charred body was found in a private residence. The fire department was dispatched to a home engulfed in flames and smoke and found young Rhianna's body along with three other bodies including Rhianna's mother and two siblings. The smell of gasoline was noticed throughout the home and blood splatter was found on the walls. It was determined that Rhianna died as a result of multiple stab wounds. The probable suspect later turned himself into the authorities.

Four-year old Courtney was at home with her family when a neighbor broke into the home through a back window. The neighbor kicked in a door to a back bedroom where Courtney and her two siblings were hiding. The neighbor proceeded to fire multiple gunshots striking the three children and their mother. Two of the children were taken to the hospital and received medical attention for their injuries. Courtney and her mother were pronounced dead at the scene.

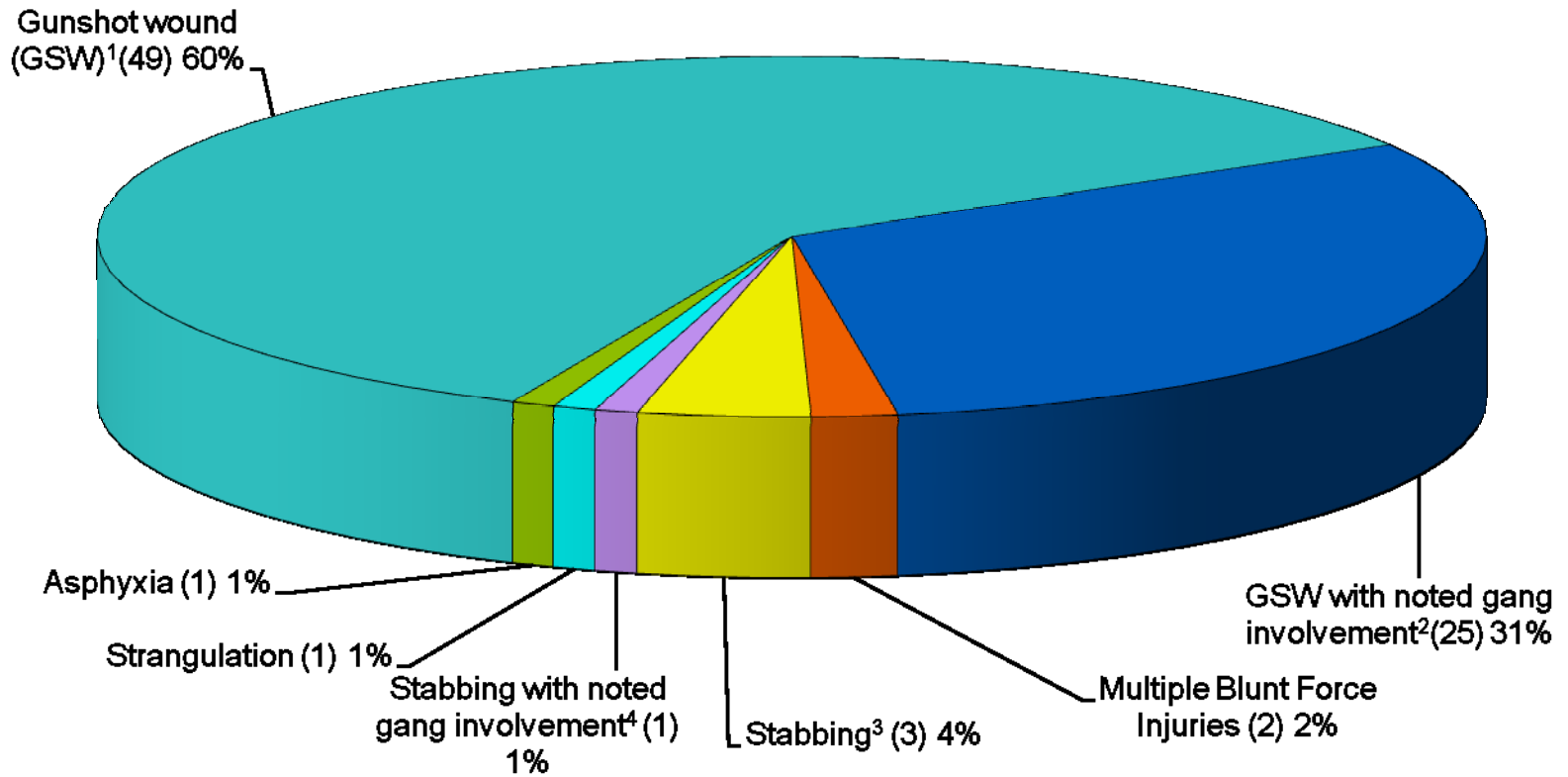
*Case identities were changed.

Third Party Homicides Findings

- There were 82 third party homicides in 2008. This is an 18% decrease from 2007 when there were 100 such deaths.
- Ninety percent (n=74) of the youth were victims of gunshot wounds. These include 25 youth who were victims of homicides perpetrated by suspects with possible gang involvement. Four youth were victims of a stabbing, one of whom was a case with possible gang involvement. Finally, two youth died as a result of multiple blunt force injuries, one youth died from asphyxia after someone broke into her family's home and set it on fire, and one female victim died from strangulation after being sexually assaulted.
- Male victims outnumbered female victims by a broad margin. Sixty-four males and eighteen females were homicide victims in 2008.
- Sixty-five percent (n=53) of the children who were victims of a third party homicide in 2008 were ages 16 – 17; eleven victims were 15 years of age, seven were age 14, three were age 13, and eight victims were 12 years of age or under.
- Both Hispanic (n=55) and African-American (n=24) youth were over-represented in third party homicides. There were three third party homicides of Caucasian youth in 2008, and none of the victims were of Asian/Pacific Islander descent.
- The greatest number of third party homicides occurred in January, May, and October (n=9). The second greatest number of homicides occurred during the months of March and September (n=8). The fewest number of homicides occurred in the month of December (n=3). At least four or more third party homicides occurred during the months of February, April, June, July, August, and November.
- While third party homicides occurred throughout Los Angeles County in 2008, the majority of these deaths occurred in SPA 6 (n=24) and in SPA 7 (n=16). Ten third party homicides occurred in SPA 8, eight each in SPA 2 and SPA 4, seven in SPA 3, five in SPA 1 and three homicides occurred in SPA 5. The location of one third party homicide is unknown as the youth was strangled in an unknown location, then her body was wrapped in carpet and dumped.
- The Los Angeles Police Department (LAPD) had investigative authority for 49% of the third party homicide cases in 2008. Thirty-eight percent of the cases were under the jurisdiction of the Los Angeles Sheriff's Department, and 13% of the cases were handled by jurisdictions other than LAPD and LASD. Where the relationship of the perpetrator was identified by law enforcement, 66% of the perpetrators were a gang member, and 30% of the victims were gang involved. Finally, 41% (n=34) of the

case investigations resulted in the filing of criminal charges by the District Attorney's Office. Many of the cases were still under investigation or unsolved and therefore, had not been presented to the District Attorney's Office.

2008 Third Party Homicides - Cause



■ Asphyxia (1) 1%	■ Gunshotwound (GSW) (49) 60%	■ GSW with noted gang involvement (25) 31%
■ Multiple Blunt Force Injuries (2) 2%	■ Stabbing (3) 4%	■ Stabbing with noted gang involvement (1) 1%
■ Strangulation (1) 1%		

1.3 Gang involvement unknown
 2.4 Noted from the Coroner Investigative Narrative

THIRD PARTY HOMICIDES
LOS ANGELES COUNTY – 2008 (N = 82)

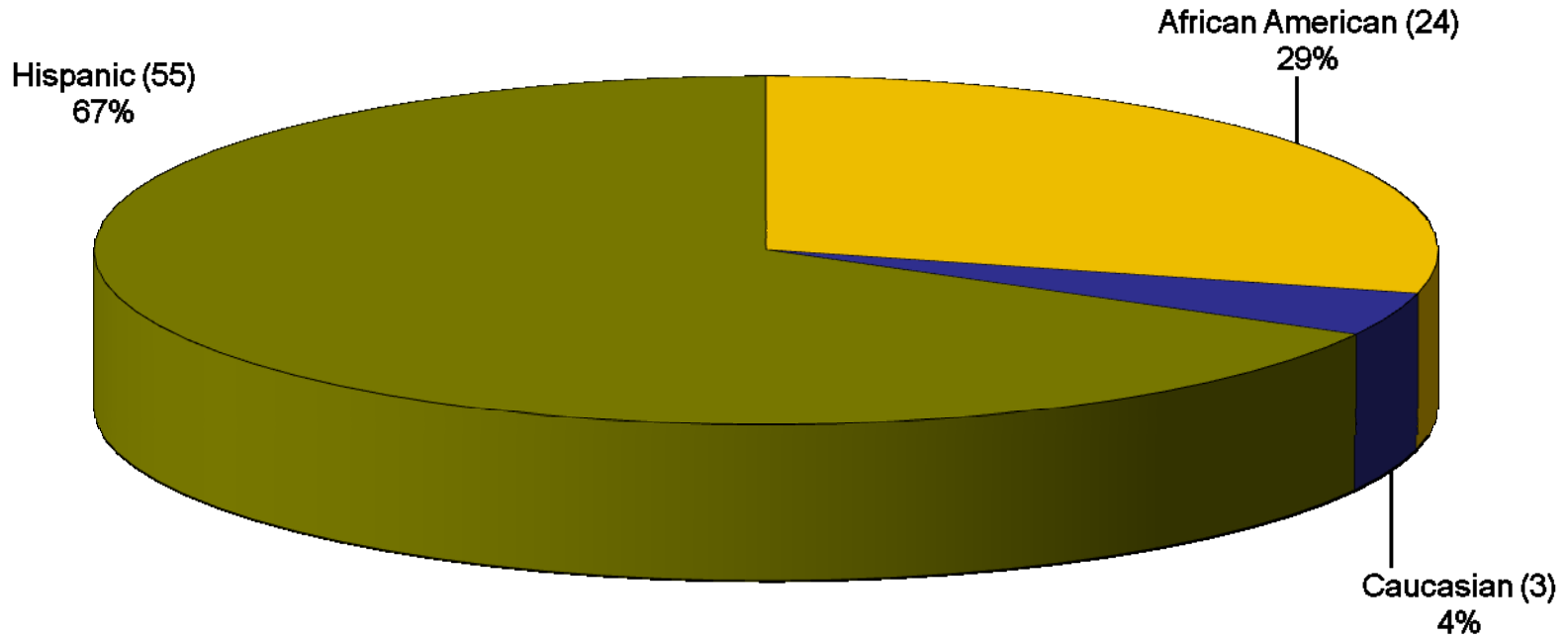
Age	Female	Male
1 year or under	1	0
2 – 12 years	4	3
13 years	1	2
14 years	2	5
15 years	3	8
16 years	4	19
17 years	3	27
<i>Total</i>	18	64

78% of the third party homicide victims were male.

28% of the third party homicide female victims were 12 years of age or younger. In contrast, only 5% of the male victims were in this age category.

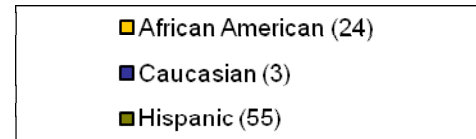
65% of the third party homicide victims were 16 to 17 years of age.

2008 Third Party Homicides - Race



Los Angeles County child population¹
Ages 0 - 18: 2,830,799
Latino 61%
Caucasian 18%
African American 9%
Asian/Pacific Islander 9%
Multiple or Other Ethnicities 3%

¹From 2008 Children Now
County Scorecard



Dates¹ of Third Party Homicides - 2008

9 homicides occurred in January (1/03, 1/06, 1/09, two on 1/20, 1/25, 1/26, 1/28, & 1/29/08)
4 homicides occurred in February (2/08, 2/09, 2/18, & 2/25/08)
8 homicides occurred in March (3/02, 3/06, 3/09, 3/10, 3/16, 3/17, 3/25, & 3/26/08)
6 homicides occurred in April (two on 4/08, 4/12, 4/18, 4/23, & 4/27/08)
9 homicides occurred in May (5/03, 5/05, 5/09, three on 5/12, 5/17, 5/27, & 5/31/08)
6 homicides occurred in June (6/07, 6/17, 6/19, 6/22, 6/26, & 6/27/08)
7 homicides occurred in July (7/03, 7/15, 7/22, 7/23, 7/25, 7/26, & 7/30/08)
7 homicides occurred in August (8/02, 8/08, 8/09, 8/11, 8/12, 8/20, & 8/27/08)
8 homicides occurred in September (9/03, 9/07, 9/08, four on 9/09, & 9/23/08)
9 homicides occurred in October (10/02, 10/06, two on 10/12, 10/13, 10/17, 10/18, 10/19, & 10/20/08)
6 homicides occurred in November (11/03, 11/08, 11/15, 11/24, 11/25, & 11/29/08)
3 homicides occurred in December (12/13, 12/17, & 12/30/08)

¹ This is the date of death, which, in a majority of the cases coincides with the date the injury occurred leading to the youth's death.

Locations² of Third Party Homicides – Geographic Area - 2008

1 homicide occurred in Artesia (zip code 90701)
3 homicides occurred in Baldwin Park (zip code 91706)
1 homicide occurred in Bell Gardens (zip code 90201)
2 homicides occurred in Compton (zip codes 90220 & 90221)
2 homicides occurred in Cudahy (zip code 90201)
2 homicides occurred in East Los Angeles (zip code 90063)
1 homicide occurred in Gardena (zip code 90260)
1 homicide occurred in Hawaiian Gardens (zip code 90716)
1 homicide occurred in Hawthorne (zip code 90250)
2 homicides occurred in Huntington Park (zip code 90255)
1 homicide occurred in Inglewood (zip codes 90301)
1 homicide occurred in La Puente (zip code 91744)
3 homicides occurred in Lancaster (zip code 93535)
5 homicides occurred in Long Beach (zip codes 90804, 90806, 90808, & 90813)
35 homicides occurred in Los Angeles (zip codes 90001, 90002, 90003, 90007, 90015, 90018, 90019, 90023, 90026, 90033,

90037, 90042, 90043, 90044, 90047, 90057, 90059, 90061, 90062, 90065, 90222, & 90501)

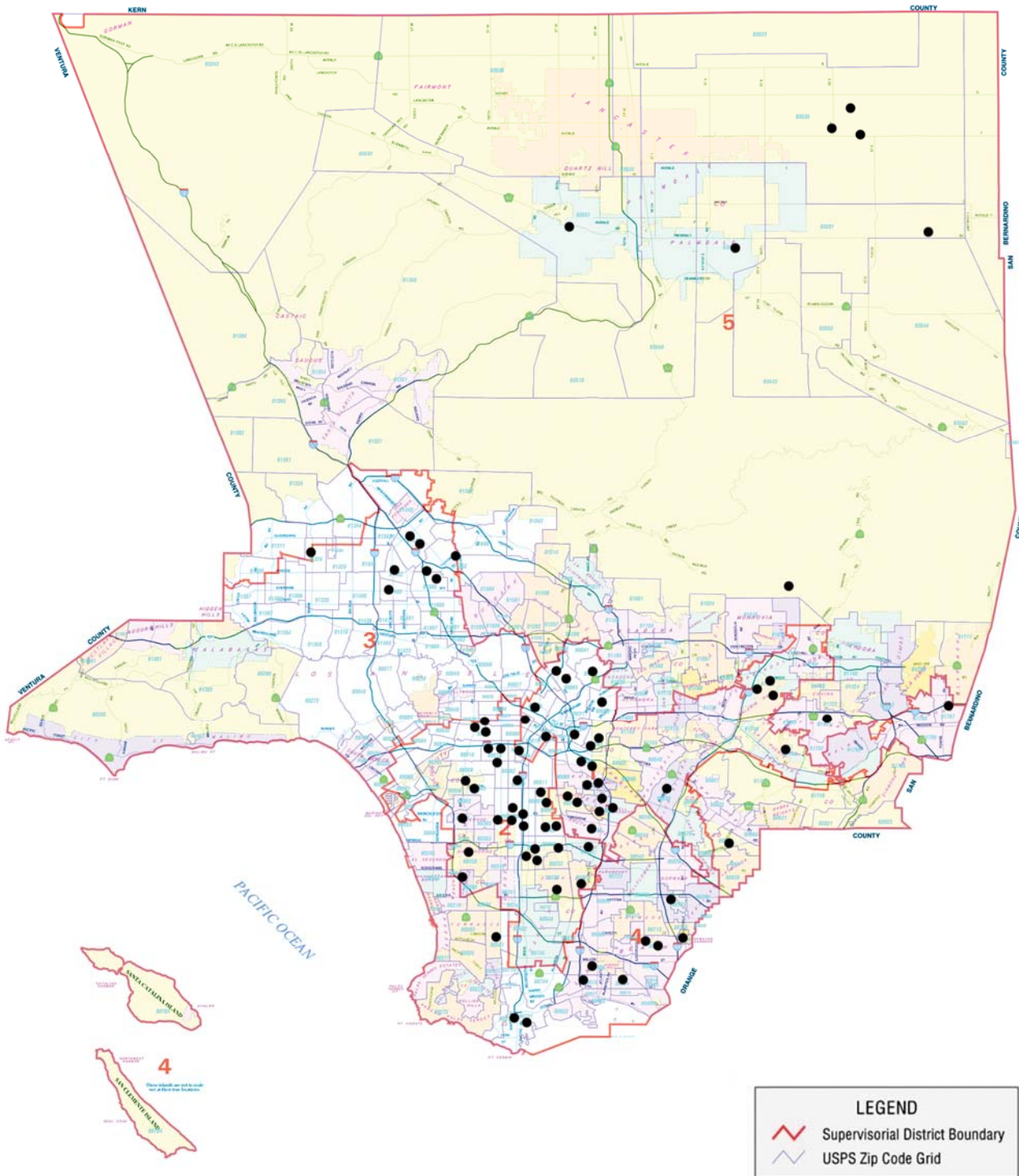
- 1 homicide occurred in Lynwood (zip code 90262)
- 2 homicides occurred in Maywood (zip code 90270)
- 1 homicide occurred in Monrovia (zip code 91016)
- 1 homicide occurred in Montebello (zip code 90640)
- 2 homicides occurred in North Hollywood (zip code 91605)
- 1 homicide occurred in Northridge (91324)
- 2 homicides occurred in Pacoima (zip code 91331)
- 2 homicides occurred in Palmdale (zip code 93551 & 93352³)
- 1 homicide occurred in Panorama City (zip code 91402)
- 1 homicide occurred in Pico Rivera (zip code 90660)
- 1 homicide occurred in Pomona (zip code 91767)
- 2 homicides occurred in San Pedro (zip code 90731)
- 1 homicide occurred in South Gate (zip code 90280)
- 1 homicide occurred in Sun Valley (zip code 91352)
- 1 homicide occurred in Van Nuys (zip code 91405)
- 1 homicide occurred in West Covina (zip code 91791)

² City where the injury/fatality occurred

³ Body of a female discovered in an onion field at this location wrapped inside a roll of carpet. It is unknown where the fatality occurred.

2008 Third Party Homicides - Location

N = 82*



* One decedent was found in Palmdale, 93552, but the body was dumped at that location and it is unknown where the fatality occurred.

● = Los Angeles County
Third Party Homicide Locations

Information on criminal justice system involvement in third party homicide cases was gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). In 2008, there were 82 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 1 below.

Table 1

Agency	Number of Cases	Percentage
LAPD	40	49%
LASD	31	38%
Long Beach P.D.	5	6%
Huntington Park P.D.	2	3%
Hawthorne P.D.	1	1%
Inglewood P.D.	1	1%
Montebello P.D.	1	1%
West Covina P.D.	1	1%

Table 2 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation. These data on the perpetrator's gang involvement vary from those found in the chart on page 86 because law enforcement often obtains information that was not available at the time the Coroner investigation summary was prepared.

Table 2

Perpetrator's Relationship to Victim	Number of Cases
Gang Member	54
Acquaintance	4
Stranger	3
Neighbor	1
Unknown	1
No Information Provided	19

Table 3 provides information about the victim's circumstances or activities prior to being murdered and whether the victim was known to be gang-involved.

Table 3

Victim Information	Number of Cases
Killed in their own Home after their Mother rejected the Sexual Advance of a Male Acquaintance	3
Killed while at Home after a Neighbor entered the House and Murdered the Family	1
Stabbed during a Fight that Ensued after a Failed Attempt to Crash a Party	1
Shot During an Assault on a Police Officer	1
Killed after Getting Involved in a Shoot-out Encounter	1
Shot by a Stray Round of Gunfire from an Unknown Source	1
Killed as a Result of Possible Revenge	1
Murder after Being Sexually Assaulted	1
Gang Member	25
No Information Provided	47

According to the information provided by the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD), 34 of the 82 cases of third party homicides had criminal charges filed by the District Attorney's Office in 2008. It should be pointed out that information provided by LAPD indicated if the case generated a filing, but did not specify the type of criminal charges. Also, of the 31 cases under LASD jurisdiction, 16 remain unsolved and are still under investigation. Finally, of the 11 cases reviewed by the LADA, information was found for only five cases. This may mean that law enforcement has not identified the assailants, not submitted the case for review or some other reason. Table 4 displays the number of filings by the type of criminal charge.

Table 4

Type of Criminal Charges Filed	Number of Cases
Murder/Multiple Murder	18
Arson	3
Assault with Deadly Weapon	2
Participation in a Criminal Street Gang	2
Rape	1
Sex with a Minor	1
Concealed Firearm	1
Information not Provided	16

APPENDIX A ON-LINE RESOURCES

Safe Sleeping Resources

<http://www.first5la.org/articles/safe-sleep-brochure>
<http://lacdcfs.org/news/documents/Safety%20Precautions.pdf>
<http://www.cpsc.gov/cpsc/pub/pubs/5049.html>
<http://www.cpsc.gov/cpsc/pub/pubs/5030.html>
<http://www.cpsc.gov/cpsc/pub/pubs/5091.html>
<http://www.californiasids.com/Universal/MainPage.cfm?p=10>
<http://www.firstcandle.org/>

Water Safety

<http://www.cpsc.gov/cpsc/pub/pubs/drown.html>
<http://www.cpsc.gov/cpsc/pub/pubs/5097.html>
<http://www.cpsc.gov/cpsc/pub/pubs/359.pdf>
<http://www.redcross.org/www-files/Documents/pdf/Preparedness/SummerSafety/ItOnlyTakesaMoment.pdf>
<http://www.redcross.org/www-files/Documents/pdf/Preparedness/SummerSafety/IsYourPoolSafe.pdf>
http://fire.lacounty.gov/SafetyPreparedness/SafetyPrep_Pool_safety.asp

Biking Safety

<http://www.cpsc.gov/cpsc/pub/pubs/343.html>
<http://www.chp.ca.gov/html/bicycleriding.html>
<http://lasd.org/bear/index.html>

Child Abuse

<http://www.dontshake.org/>
<http://www.endabuse.org/>
<http://www.child-abuse.com/>
<http://safestate.org/index.cfm?navID=6>

Fire Safety

<http://www.redcross.org/portal/site/en/menuitem.1a019a978f421296e81ec89e43181aa0/?vgnextoid=f8676768b6280210VgnVCM10000089f0870aRCRD&vgnnextfnt=default>
<http://fire.lacounty.gov/FirePrevention/FirePrevFirePreventionTips.asp>

In and Around Cars

<http://www.usa.safekids.org/skbu/cars/spotthetot.html>
<http://www.nhtsa.dot.gov/people/injury/pedbimot/ped/BackoversTry2/index.htm>
<http://www.kidsandcars.org/>
<http://www.chp.ca.gov/community/safeseat.html>
<http://www.aap.org/family/carseatguide.htm>

Pedestrian

<http://www.kidsandcars.org/>
<http://www.chp.ca.gov/html/walkwithcare.html>
<http://www.chp.ca.gov/html/skateboard.html>

Teen Drivers

<http://www.nhtsa.dot.gov>
<http://www.youtube.com/watch?v=vqDgcWNBcl&feature=related>
<http://coroner.co.la.ca.us/html/yddvp1.htm>

Grief and Mourning

<http://www.californiasids.com/Universal/MainPage.cfm?p=10>
<http://www.compassionatefriends.org>
<http://griefcenterforchildren.org>

Suicide-Youth

<http://www.suicideinfo.ca/youthatrisk>
<http://suicidehotlines.com/california.html>
<http://www.spyc.sanpedro.com/suicide.htm>
http://www.uaii.org/uaiiinc_007.htm
<http://www.youtube.com/watch?v=iCaMpd2L2kQ>
<http://www.youtube.com/watch?v=CHynDpYv1Gw&NR=1>