ICAN 2001

Inter-Agency Council on Child Abuse and Neglect

Los Angeles County ♦ ICAN Multi-Agency Child Death Review Team
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Report Compiled From 2000 Data

CHILD DEATH REVIEW TEAM REPORT FOR 2001

I C A N

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Photographs were selected from commercially available sources and are not of children in the child protective services system. Children's names in case examples have been changed to ensure confidentiality.

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Names of all children used in case study examples have been changed.

FOREWORD

Three-year-old Ricky died in 1980, hours after his father hit him in the abdomen. His death was recorded as accidental and no legal action was taken. Years later, a Deputy District Attorney involved with ICAN became concerned about past suspicious child deaths and, after reviewing numerous files, initiated criminal actions on several cases. Ricky's father went to prison. The DA's secretary found fire EMT records with a notation of five siblings left in Ricky's house. There was no record of any action to evaluate or intervene with them. No one ever did.

Today our system would manage this case very differently. We have more competent first scene responders, death scene investigations, a better understanding of autopsy findings in young children, and interagency teamwork. Law enforcement and health professionals are more sophisticated in the evaluation of injuries to young children. The Coroner now sends the names of children with suspicious deaths to law enforcement and DCFS. The SIDS program refers suspicious deaths to the Child Death Review Team for review. Public and private health professionals have become more involved with previous health records and non-intentional injuries. The County Office of Education, Mental Health, Probation and other agencies have begun a team effort to evaluate youth suicides. The DA has released the first LA County study on fatal domestic violence. Our ICAN data report, protocols and cross training are national models.

Overall, we have significantly improved investigations, prosecutions and case management. Our findings have inspired prevention programs and actions addressing vulnerable children. However, we still lose information between agencies and records retrieved may be late and incomplete. We have recognized the profound grief suffered by children who lose siblings to unexpected and violent deaths, and we have developed a countywide referral system for grief and mourning counseling for these children. But we cannot serve children if we do not know they exist.

The Child Death Review process needs additional participation from city attorneys and fire EMTs. Automated systems are needed to share information regarding multi-agency interventions and find previous medical records, multi-county case records and case managers. Our retrieval of case information for team review of child deaths needs to be more comprehensive and timely.

We have arrived at a level of competence not unlike the discomfort of adolescence. We are more aware of our progress, our limitations and our potential.

We dedicate this report to the children who died in 1999, to their brothers and sisters whom we seek to protect and comfort, and to all children whose lives we work to spare from pain and loss.

Michael Durfee, M.D.

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ICAN ORGANIZATIONAL SUMMARY

The Inter-Agency Council on Child Abuse and Neglect (ICAN) was established in 1977 by the Los Angeles County Board of Supervisors. ICAN serves as the official County agent to coordinate development of services for the prevention, identification and treatment of child abuse and neglect. It is the largest county-based child abuse and neglect network in the nation.

Twenty-seven County, City, State and Federal agency heads are members of the ICAN Policy Committee, along with UCLA, five private sector members appointed by the Board of Supervisors and the Children's Planning Council. ICAN's Policy Committee is comprised of the heads of each of the member agencies. ICAN's activities are carried out through a variety of committees comprised of both public and private sector professionals with expertise in child abuse. These committees address critical issues affecting the well-being of the most vulnerable children including prenatally substance affected infants, pregnant and parenting adolescents, children exposed to family violence, abducted children, and siblings of children who are victims of fatal abuse. Fifteen community based inter-disciplinary child abuse councils interface with ICAN and provide valuable information to ICAN regarding many child abuse related issues. ICAN provides advice and guidance on public policy development and program implementation to improve the community's collective ability to meet the needs of abused and at-risk children with the limited resources available. ICAN Associates is a private non-profit corporation of volunteer business and community members who raise funds and public awareness for programs and issues identified by ICAN.

In 1996, ICAN was designated as the National Center on Child Fatality Review. ICAN has also received national recognition as a model for inter-agency coordination for the protection of children.

All ICAN Policy and Operations Committee meetings are open to the public. All interested professionals and community volunteers are encouraged to attend and participate.

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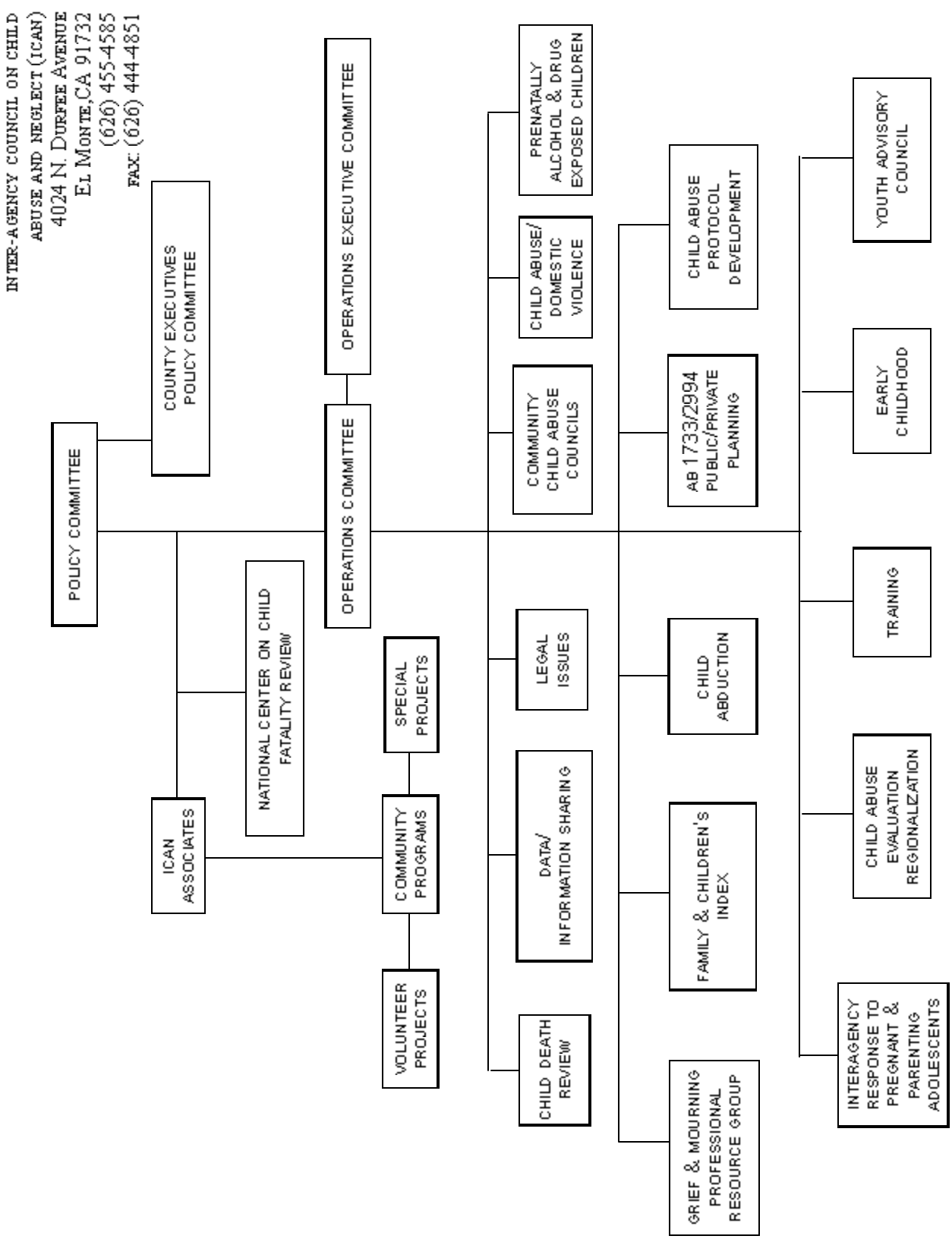
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ICAN ASSOCIATES
NATIONAL CENTER ON CHILD FATALITY REVIEW
COMMUNITY PROGRAMS
SPECIAL PROJECTS
VOLUNTEER PROJECTS
COMMUNITY CHILD ABUSE COUNCILS
CHILD ABUSE/ DOMESTIC VIOLENCE
PRENATALLY ALCOHOL & DRUG EXPOSED CHILDREN
LEGAL ISSUES
DATA/ INFORMATION SHARING
CHILD DEATH REVIEW
AB 1733/2994 PUBLIC/PRIVATE PLANNING
CHILD ABUSE PROTOCOL DEVELOPMENT
CHILD ABDUCTION
FAMILY & CHILDREN'S INDEX
GRIEF & MOURNING PROFESSIONAL RESOURCE GROUP
YOUTH ADVISORY COUNCIL
EARLY CHILDHOOD
TRAINING
CHILD ABUSE EVALUATION REGIONALIZATION
INTERAGENCY RESPONSE TO PREGNANT & PARENTING ADOLESCENTS

POLICY COMMITTEE

Twenty-seven department heads, UCLA, five Board appointees and the Children's Planning Council. Gives direction and forms policy, reviews the work of subcommittees and votes on major issues. (Meets in April & November, no set dates)

COUNTY EXECUTIVES POLICY COMMITTEE

Nine County department heads. Identifies and discusses key issues related to County policy as it affects the safety of children. (Meets as needed)

OPERATIONS COMMITTEE

Member agency and community council representatives in a working body. Reviews activities of subcommittees, discusses emerging issues and current events, recommends specific follow-up actions. (Meets every 2nd Wed., 1:30 p.m., Room 830, Hall of Administration, Los Angeles)

OPERATIONS EXECUTIVE COMMITTEE

Leadership for Operations Committee and liaison to Policy Committee. Helps set agenda for Operations and Policy meetings. (Meets as needed)

ICAN ASSOCIATES

Private incorporated fundraising arm and support organization for ICAN. Sponsors special events, hosts ICAN Policy meetings and receptions, promotes public awareness and raises funds for specific ICAN projects. Maintains volunteer program; conducts media campaigns; issues newsletters and provides support and in-kind donations to community programs; supports special projects such as Roxie Roker Memorial Fund, L.A. City Marathon fundraiser, MacLaren Children's Center Holiday Party and countywide Children's Poster Art Contest. Promotes projects developed by ICAN. (Meets as needed)

CHILD DEATH REVIEW TEAM

Provides multi-agency review of intentional and preventable child deaths for better case management and system improvement. Issues annual report. (Meets every 1st Wed., Dept. of Coroner, 1:00 p.m.) Note: This is a closed meeting.

DATA/INFORMATION SHARING

Focuses on intra and inter agency systems of information sharing and accountability. Produces annual ICAN Data Analysis Report which highlights data on ICAN agencies' services. (Meets as needed)

LEGAL ISSUES

Analyzes relevant legal issues and legislation. Develops recommendations for ICAN Policy Committee and Los Angeles County regarding positions on pending legislation; identifies issues needing legislative remedy. (Meets as needed)

CHILD ABUSE COUNCILS

Provides interface of membership of 14 community child abuse councils involving hundreds of organizations and professionals with ICAN. Councils are interdisciplinary with open membership and organized geographically, culturally, and ethnically. Coordinates public awareness campaigns, provides networking and training for professionals, identifies public policy issues and opportunities for public/private, community based projects. (Meets monthly, no set day)

CHILD ABUSE/DOMESTIC VIOLENCE

Examines the relationship between child abuse and domestic violence; develops interdisciplinary protocols and training for professionals. Provides training regarding issues of family violence, including mandatory reporting. Sponsors annual conference "NEXUS." (Meets as needed for planning of NEXUS Conference.)

PRENATALLY ALCOHOL/DRUG EXPOSED CHILDREN

Works to improve the system rendering services to drug/alcohol exposed children and their families. Provides training on evaluating needs of prenatally substance exposed infants and their families; assists in developing and identifying resources to serve drug impacted families. (Meets every 2nd Tues., 10:00 a.m., White Memorial Medical Center, L.A.)

GRIEF AND MOURNING PROFESSIONAL RESOURCE GROUP

A professional peer group which serves as a resource pool of experts in grief and loss therapy to those providing mental health interventions to surviving family members of fatal family violence. The Group is developing specialized training in grief issues in instances of fatal family violence and a resource directory of services. (Meets every 2nd Tuesday, 9:30 a.m.)

FAMILY AND CHILDREN'S INDEX

Develops implementation of an interagency database to allow agencies access to information on whether other agencies had relevant previous contact with a child or family in order to form multidisciplinary personnel teams to assure service needs are met and/or intervene before a child is seriously or fatally injured. (Meets as needed)

CHILD ABDUCTION/REUNIFICATION

Public/private partnership to respond to needs of children who have experienced abduction. Provides coordinated multi-agency response to recovery and reunification of abducted children, including crisis intervention and mental health services. (Meets every 3rd Wed. at 12:30 p.m., Find the Children, Santa Monica) Note: This is a closed meeting.

AB 1733/AB 2994 PLANNING

Conducts needs assessment and develops funding guidelines and priorities for child abuse services; participates in RFP process and develops recommendations for funding of agencies. (Meets as needed)

CHILD ABUSE PROTOCOL DEVELOPMENT

Develops a countywide protocol for inter-agency response to suspected child abuse and neglect. (Meets monthly, no set day)

INTERAGENCY RESPONSE TO PREGNANT AND PARENTING ADOLESCENTS

Focuses on review of ICAN agencies' policies, guidelines and protocols that relate to pregnant and parenting adolescents and develops strategies which provide for more effective prevention and intervention programs with this high-risk population. Includes focus on child abuse issues related to pregnant teens, prevention of teen pregnancies, placement options for teen mothers and babies, data collection, legal issues and public policy development. (Meets every last Wed. of the month, 12:15 p.m., Edmund Edelman Children's Court)

CHILD ABUSE EVALUATION REGIONALIZATION

Coordinates efforts to facilitate and expand availability of quality medical exams for child abuse victims throughout the County. (Meets as needed)

TRAINING

Provides and facilitates intra and inter agency training. (Meets as needed)

EARLY CHILDHOOD COMMITTEE

Focuses on early childhood issues and issues of prenatal health. (Meets monthly)

YOUTH ADVISORY COUNCIL

Committee comprised of youth ages 15-24 dedicated to working on projects aimed at reducing family violence. Committee also helps to advise the work of other ICAN committees to ensure that a youth viewpoint is considered. (Meets monthly)

CHILD AND ADOLESCENT SUICIDE STUDY GROUP

Multi-disciplinary sub-group of the ICAN Child Death Review Team. Reviews child and adolescent suicides. Analyzes trends and makes recommendations aimed at the recognition and prevention of suicide and suicidal behaviors. (Meets monthly)

CHILD DEATH REVIEW TEAM TRAINING & THE NATIONAL CENTER ON CHILD FATALITY REVIEW

For more than 20 years, ICAN has been in the forefront of efforts to identify, evaluate and prevent child abuse and neglect-related fatalities. The ICAN Child Death Review Team, established in 1978, has become a model of inter-agency collaboration around the issue of analysis of child death resulting from abuse or neglect. ICAN's efforts in this area have garnered attention and support both at the state and national levels, resulting in grants to develop statewide Child Death Review Team Training and to establish ICAN as the National Center on Child Fatality Review (NCFR).

Facilitated by grants from the California Governor's Office of Criminal Justice Planning and the California Department of Social Services (CDSS) Office of Child Abuse Prevention, ICAN and NCFR developed and implemented Child Death Review Team Training during 1998, 1999 and 2000. The two-day training curricula, presented in Los Angeles, Fresno, Emeryville, Redding, Palm Springs, San Diego, and Sacramento used multi-disciplinary presentations, mock case reviews, database development information and technological presentations to further develop and enhance the skills of the hundreds of professional attendees. The training format modeled the inter-agency collaboration necessary to conduct effective and useful reviews of child abuse-related fatalities.

In 1996, ICAN was designated by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, and the U.S. Department of Health and Human Services as the National Center on Child Fatality Review. ICAN Associates subsequently received a private foundation grant to carry out the expanding mission of NCFR.

NCFR provides a source of information exchange and development of services for professionals involved in the field of child fatality review throughout the United States. Further, the NCFR web site, located at ICAN-NCFR.org, provides a central point of information-sharing among national and international professionals in the field. NCFR, with the invaluable assistance of principal consultant Michael Durfee, M.D., has developed a database of child fatality review professional liaisons in all fifty states, international contacts, and national and federal agency contacts. These contacts may be accessed through a searchable directory on the ICAN-NCFR web site. In addition, the NCFR web site has expanded its links to other child death review and child welfare web sites on the Internet, posts national and state data sets regarding child deaths, and offers training videos and "How To" guides to assist local teams. NCFR is committed to the development and improvement of the process of child fatality review in all fifty states.

Child Death Review Team Training and the National Center on Child Fatality Review are two examples of ICAN's work to develop and improve critically important multi-disciplinary review of the intentional and preventable deaths of children. ICAN's efforts in this area continue to evolve and grow as more is learned through the sharing of information among child death review teams locally, nationally and internationally.

INTRODUCTION

Children aren't supposed to die. Healthy newborns start life intimately connected to and dependent upon their environment and caregivers. Thankfully, a child born in Los Angeles County has a very good chance for health, safety and survival until adulthood. Sadly, though, hundreds of children die in the County each year from child abuse, accidental injuries, suicides, or undetermined causes. Most tragically, many of these deaths could have been prevented.

The Los Angeles County ICAN Child Death Review Team meets monthly to review the deaths of children in our county. Often the Team reviews extremely tragic and violent deaths of young children, most of whom were under five years of age. Paradoxically, those entrusted with the child's care and welfare - parents or caregivers - are frequently the perpetrators of the severe physical abuse or neglect which caused the child's death. Other tragic cases reviewed by the Team highlight the need for child safety efforts, product safety and public health campaigns. The circumstances of child death reviewed by the Team often evoke feelings of sadness, anger, confusion and frustration. The lessons learned and the feelings that emerge in Team reviews provoke action, and therein lies the value of the systematic review of child death.

Monthly meetings of the Team are held at the Office of the Coroner. The Team is comprised of professionals from health services, law enforcement, child protective services, District Attorney's office, Coroner's office, Juvenile Dependency Court, schools, mental health and other associated fields. The Team reviews each case in detail, with input from the agencies, which may have known of the child and family before, during or after the death. In this way, a story of the child's life and death emerges, often illuminating problems in communication between agencies, in policies or procedures within and between agencies, or in dissemination of critical child safety information among high-risk populations or the public at-large. The Team is committed to follow-up action; when a problem potentially related to a child's death is identified, the involved agency representatives provide feedback to, or seek clarification from, their own agencies. The information is then provided back to the Team. This feedback process has resulted in more effective child safety practices, improved inter- and intra-agency communication, more effective prosecution of perpetrators of child homicide, and more successful child death and injury prevention programs. Prevention of child death is the ultimate goal of the Team.

This eleventh 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 1999 and were referred to ICAN by the Office of the Coroner. It provides a detailed analysis of children killed by caregivers, accidental deaths, undetermined deaths, fetal deaths or youth suicides. This report also contains recommendations for action, which, if implemented, should improve child safety, enhance our understanding of child death and ultimately, save lives. Psychiatrist Viktor Frankel once said that the task in life is to find meaning in our existence, even in suffering. Finding meaning in the suffering and deaths of these young and innocent children will always guide our work.

CHILD HOMICIDES BY PARENTS/ CARETAKERS/FAMILY MEMBERS

- 35 child homicides committed by parents/caretakers/family members in 2000 were identified by the Team. This is a decrease if 20% from the 44 child homicides by parents/caretakers/family members in 1999 and the lowest number of such deaths over the past 13 years.

- 57% (n=20) of the victims were female; 43% (n=15) were male. Over the past 12 years, there have been a total of 289 male victims (53%) and 261 female victims (47%).

- 28.5% (n=10) of the victims were under the age of 6 months. 40% (n=15) were under age 1 year. Over the past 12 years, 43% (n=238) of the victims have been under the age of 1 year and 85% (n=465) have been under the age of 5 years.

- 37% (n=13) of the victims were African American; 37 % (n=13) of the victims were Hispanic; 20% (n=7) of the victims were White and 6% (n=2) of the victims were Asian.

- Deaths due to multiple trauma (n=11) represented the leading cause of child homicide by parent/caretaker/family member, accounting for 31% of the victims in 2000.

- Deaths due to head injuries caused by blunt force cerebral trauma, shaken baby syndrome or a combination thereof, represented the second leading cause of child homicide by parent/caretaker/family member, accounting for 14% (n=5) of the 2000 victims.

- Gunshot wounds, asphyxiation/suffocation and drowning accounted for 3 homicides each in 2000. Deaths due to gunshots have consistently been the third or fourth leading cause of child homicides by parents/caretakers/family members since ICAN began tracking these data.

- 42.8% (n=15) of the families had a record of contact with the Department of Children and Family Services prior to the child's death. Eight of the children were on open referrals/cases at the time of their deaths.

- Siblings were identified in 57% (n=20) of the child homicide cases. Domestic violence and substance abuse were each identified in the histories of 23% (n=8 each) of the families.

- 71 % (n=25) of child homicide investigations resulted in presentation to the District Attorney's Office by the law enforcement jurisdictions. The average percentage of cases presented to the District Attorney's Office by law enforcement over the past 12 years is 71.5%.

- 42 perpetrators were identified by law enforcement. 52% (n=22) of the perpetrators were female, most frequently the child's mother (n=15), and one mother killed 2 of her children in 2000. Additional female perpetrators in 2000 included a cousin (responsible for 3 child deaths), aunt, grandmother and day care provider.

- 48% (n=20) of the perpetrators were men, most frequently the child's natural father (n=11), stepfather (n=2) or mother's boyfriend (n=2). The other male perpetrators in 2000 were a brother, uncle and cousin's boyfriend (responsible for 2 child deaths).

- In 2000, two relative caregivers with whom the child was placed were identified as perpetrators, including a maternal aunt and maternal grandmother. In addition to these children in placement with relative caregivers 6 other children were victims of extended family members in 2000, including a brother, uncle, grandmother and cousin (3 children killed by a cousin and her boyfriend).

- The District Attorney filed criminal charges on 88% (n=22) of the cases presented by law enforcement. Over the past 12 years, the per-

centage of case presentations resulting in the filing of criminal charges has ranged from 66% to 97%.

- Eight mothers, 1 female cousin (responsible for 3 child deaths), 1 aunt and 1 grandmother were criminally charged in relation to the 2000 child deaths. One mother committed suicide after killing her two children, and one mother of an abandoned newborn could not be identified. The District Attorney rejected the filing of criminal charges against a mother, grandmother and female day care provider.

- Seven fathers, 2 stepfathers, 2 mothers' boyfriends, 1 uncle and 1 cousin's boyfriend (responsible for 3 child deaths) were criminally charged in relation to the 2000 child deaths. Three fathers committed suicide after killing their children, and one brother was too young to be charged in his sister's death. Finally, law enforcement continues to investigate one father in the killing of his daughter and a presentation to the District Attorney for the filing of criminal charges remains possible.

- There were multiple suspects in 32% (n=7) of the cases in which criminal charges were filed. In one case, charges were filed against a 16-year old suspect and her boyfriend in the killing of the suspect's three cousins.

- District Attorney disposition of criminal filings for 2000 child homicides were:

8% (n=3) 25 years to life
2% (n=1) 15 years to life
2% (n=1) between 11 and 13 years of imprisonment
19% (n=7) between 1 and 10 years of imprisonment
2% (n=1) less than 3 months jail
2% (n=1) 3 years of probation (plus time served)
19% (n=7) still pending trial
2% (n=1) dismissed
2% (n=1) warrant pending
No perpetrators found not guilty

- 34% (n=12) of the victims of child homicide by parents/caretakers/family members had medical records at Los Angeles County Department of Health Services Facilities. Five of these children died in these County facilities; 16 child victims died at other medical facilities.

ACCIDENTAL CHILD DEATHS

- 137 accidental child deaths were reported to the ICAN Team for 2000, a 2% increase over the 134 cases reported in 1999. It should be noted that children 0-14 were included in this year's data rather than 0 - 12, as in 1999 (with the exception of age 0-17 for drowning deaths which were previously included); 15 of the 137 accidental child deaths in 2000 were represented by 13 and 14-year olds who would not have been included in last year's analysis. Without this inclusion, a total of 122 accidental child deaths would be reported for 2000--a decrease of 8% from 1999.

- Autopedestrian deaths, deaths resulting from children hit by vehicles, were the leading cause of accidental child death in 2000. This includes children struck not only while standing or walking but also while riding bicycles and scooters. There were 30 autopedestrian deaths, representing 22% of the total accidental child deaths in 2000.

- Non-pedestrian deaths associated with automobiles (automobile v. automobile and solo automobile accidents) comprised 17.5% (n=24) of the accidental child deaths in 2000.

- For the fourth time since ICAN began collecting this data, drowning was not the leading cause of accidental child death. Deaths due to drowning were the third leading cause of accidental child death in 2000. There were 23 accidental child deaths due to drowning in 2000, an 8% decrease from the 25 deaths due to drowning in 1999.

- Deaths associated with maternal substance

abuse were the fourth leading cause of accidental child death in 2000 and represented 16% (n=22) of the total number of accidental child deaths. Deaths associated with maternal substance abuse were the leading cause of accidental child death in 1996 and 1998, the only other years when drowning was not the leading cause.

- 59% (n=81) of the accidental child death victims were male; 41% (n=56) were female.

- 25% (n=34) of the accidental child deaths occurred in victims under the age of one year; 23% (n=31) occurred in children under six months of age.

- 51% (n=70) of the accidental child death victims were Hispanic. Hispanic children comprise 57.5% of the County child population.

- 25% (n=35) of the fatal accident victims were African American. African American children comprise 9.9% of the County child population.

- White children represented 18% (n=24) of the accidental child death victims. White children comprise 19.8% of the County child population.

- 5% (n=7) of the fatal accident victims were Asian. Asian children comprise 9% of the County child population.

- One accidental fetal death was of unknown ethnicity.

- 17% (n=24) of the families had a record of receiving child protective services prior to the death of the child. 33% (n=8) of these cases involved deaths the Coroner indicated were associated with maternal substance abuse.

- The deceased child was known to have siblings in 33% (n=45) of the cases.

- 26 cases were presented by law enforcement to the District Attorney. 17 resulted in the filing of criminal charges and all 17 resulted in successful prosecution.

- 33% (n=45) of the victims were known to have had medical records at Los Angeles County Department of Health facilities.

UNDETERMINED CHILD DEATHS

- 59 undetermined child deaths were reported to the Team by the Coroner for 2000. This number represents the highest number of undetermined deaths since ICAN began collecting this information.

- 80% (n=47) of the undetermined child deaths involved those under 1 year of age. During the period 1989 through 2000, an average of 71% of the undetermined child death victims have been under the age of 1 year.

- 16 of the families were known to the Department of Children and Family Services. 5 cases were open to the Department of Children and Family Services at the time of the death.

- Two cases were presented by law enforcement to the District Attorney for the filing of criminal charges. Both cases were rejected for prosecution due to insufficient evidence.

- 14 of the victims were known to have had medical records at Los Angeles County Department of Health Services facilities.

SUICIDES

- 23 adolescent suicides, ages 10 through 17 years, that occurred in 2000 were reported to ICAN's Child Death Review Team by the Coroner, a decrease of 15% from 1999. The average number of adolescent suicides for the past 13 years (since 1988) is 26.7 per year.

- 70% (n=16) of the suicide victims were male and 30% (n=7) were female. Over the past 13 years

the number of male suicide victims has ranged from 12 to 37 per year, and the number of female victims has ranged from 2 to 11 per year.

- 91% (n=21) of the suicide victims were either 16 or 17 years old. The youngest victims were age 13 (n=1) and 14 (n=1).

- 57% (n=13) of the adolescent suicides were committed by Hispanics. 30% (n=7) of the adolescent suicides were committed by Whites. There were 3 suicide deaths by Asian adolescents and none by African American adolescents in 2000.

- In 48% (n=11) of the 2000 cases, the method of adolescent suicide was hanging. In another 43% (n=10), the method involved firearms. Other methods included carbon monoxide poisoning and suicide by drowning.

- 17% (n=4) of the families with adolescent suicide victims had prior involvement with the Department of Children and Family Services. One case was open at the time of the child's death.

- Siblings were known to survive the suicide victim in 4 of the cases.

- 30% (n=7) of the suicide victims had records of involvement with Los Angeles County Department of Health facilities including 3 victims who died at these facilities.

FETAL DEATHS

- 30 fetal deaths were reported to the ICAN Child Death Review Team for 2000, an 8% decrease from the 39 fetal deaths reported in 1999.

- Hispanic families suffered 40% (n=12) of the fetal deaths identified by the Team and 5 of these 12 fetal deaths involved maternal drug use. The number of fetal deaths in African American families dropped by one from 11 in 1999 to 10 in 2000. Nine of these 10 fetal deaths involved maternal substance abuse. There were 6 fetal deaths in White families in 2000 and 4 of these 6 fetal deaths involved maternal drug use. No fetal deaths in Asian families were reported in 2000. Ethnicity was unknown for 2 additional fetal deaths, and one of these cases involved maternal substance abuse.

- In 71% (n=17) of the fetal accidental deaths, there was a history of maternal drug use.

- There were no fetal homicides reported to the Team in 2000.

- 6 of the families who suffered fetal deaths had a record of prior involvement with the Department of Children and Family Services and 3 cases were open for siblings at the time of the fetal death.

- Law enforcement presented one case to the District Attorney for the filing of criminal charges. However, charges of misdemeanor vehicular manslaughter were rejected by the District Attorney who indicated that the suspect's actions, while negligent, did not rise to the level of criminal negligence.

- 8 of the families with fetal deaths had known medical records at Los Angeles County Department of Health Services facilities.

CHILD AND ADOLESCENT SUICIDE REVIEW TEAM

RECOMMENDATION: SUICIDE PREVENTION PROTOCOL

The Los Angeles County Office of Education (LACOE) should convene an ad hoc committee including representatives from Los Angeles County Departments of Mental Health (DMH), Coroner, Children and Family Services (DCFS), Health Services (DHS), Sheriffs Department (LASD), Probation and Public Social Services; County Counsel; Dependency Court Legal Services; Los Angeles Unified School District (LAUSD); other representative school districts; and representatives of suicide prevention and intervention programs to develop and implement a protocol for child and adolescent suicide prevention, intervention and recovery. The protocol should be guided by the goals and objectives contained in the Department of Health and Human Services National Strategy for Suicide Prevention: Goals and Objectives for Action.

Rationale:

In 2000, 23 adolescents in Los Angeles County died from suicide. Nationally, suicide is the third leading cause of death among adolescents. More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined. Yet, depression and suicidal feelings are treatable mental disorders. In 1999, the ICAN Child Death Review Team established the Los Angeles County Child and Adolescent Suicide Review Team. This Team has determined that a standardized protocol guided by the goals and objectives of the National Strategy for Suicide Prevention will assure a comprehensive approach to child and adolescent suicide. The stated goals are to:

1. promote awareness that suicide is a public health problem that is preventable;
2. develop broad-based support for suicide prevention;
3. develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services;
4. develop and implement suicide prevention programs;
5. promote efforts to reduce access to lethal means and methods of self-harm;
6. implement training for recognition of at-risk behavior and delivery of effective treatment;
7. develop and promote effective clinical and professional practices;
8. improve access to and community linkages with mental health and substance abuse services;
9. improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media;
10. promote and support research on suicide and suicide prevention;
11. improve and expand surveillance systems

CHILD DEATH REVIEW TEAM

RECOMMENDATION ONE: NOTIFICATION TO SCHOOLS OF STUDENT DEATHS

The Department of Coroner should promptly notify the Los Angeles County Office of Education (LACOE) Division of Student Support Services of all deaths of children age five and above. Following notification of a child's death by the Office of Coroner, the LACOE Division of Student Support Services shall notify the appropriate LACOE district representative who will contact the deceased child's local school administrator.

Rationale:

The death of a student has a profound impact on the school community. In a recent case, school personnel did not learn of the death of one of their students prior to an announcement made in the media. The lack of prior notification to the school further exac-

erbated the traumatic effect that this student's death had on the school community. Timely notification of a student's death will allow administrators at the student's school to assess the impact the student's death may have on other students and staff and organize an effective response. It will permit the district to mobilize mental health resources as needed and assure that other appropriate services are provided to affected students and faculty.

RECOMMENDATION TWO: RELEASE OF HIGH RISK NEWBORNS FROM HOSPITALS

The Los Angeles County Department of Health Services (DHS), in collaboration with the Perinatal Advisory Council (PAC/LAC),and other agencies with expertise in serving high risk newborns and their families should initiate a process to gather information on existing hospital policies and procedures regarding discharge planning for high risk infants. Following the gathering of information, a group should be convened to evaluate the existing policies and procedures and develop a recommended discharge planning protocol to share with all hospitals with labor and delivery services. The protocol should address the needs of the infant for follow-up services, methods to assure that the infant receives recommended services, and the parent or other prospective caregiver's circumstances and abilities to meet the needs of the infant. DHS should encourage hospitals to arrange for periodic training for obstetric, pediatric and social work staff on assessing the needs of high-risk infants and their families.

Rationale:

In the past year, ICAN's Child Death Review Team has reviewed the deaths of several high risk infants. These infants' deaths occurred subsequent to their discharge from hospitals. These were fragile infants who had often been confined to a neonatal intensive care unit following birth. In some instances, the parent's ability to fully understand the medical needs of the infant and provide necessary care was questionable and there was no monitoring in place to assure that the infant's needs were met. To assure their well-being, many high risk infants require specialized follow-up care after discharge from the hospital. Development and distribution of a recommended protocol will assist in assuring that infants' needs are met and families are provided with adequate support systems.

RECOMMENDATION THREE: SUBSTANCE ABUSE AND THE PROTECTION OF CHILDREN

The Los Angeles County Departments of Health Services and Children and Family Services should explore ways to gather accurate countywide data on the number of infants born prenatally exposed to drugs and/or alcohol and the number of children receiving services from the Department of Children and Family Services as a result of a family member's substance abuse.

Rationale:

Children whose parents abuse drugs and alcohol are almost three times more likely to be physically or sexually assaulted, sometimes fatally, and more than four times more likely to be neglected than children whose parents are not substance abusers. In Los Angeles County, twenty-three percent of child homicides committed in 2000 by parent/caregiver/family member involved families with a documented history of substance abuse. According to the Children's Defense Fund, a study conducted in 1995 of 1,576 newborns in foster care in California who were suspected of being involved in substance abuse cases found that 60% already had at least one sibling in foster care. According to the National Center on Addiction and Substance Abuse at Columbia University, parental substance abuse and addiction is the chief "culprit" in at least 70 percent of all child welfare spending. Los Angeles County is faced with many challenges in our efforts to assure the safety and well-being of the county's children. With ever increasing demands for services and limited resources to meet those demands, it is essential to have accurate data in order to determine

how to best allocate available resources. At the present time, there is not a system in place in our county to collect data on either the number of infants born prenatally exposed to drugs and alcohol or the number of children receiving services from the Department of Children and Family Services as a result of a family member's substance abuse. Without this information, it is difficult to determine the most effective allocation of available resources.

RECOMMENDATION FOUR: DOMESTIC VIOLENCE AND THE PROTECTION OF CHILDREN

To establish a better understanding of the nexus between domestic violence and child abuse, it is recommended that: 1) the Sheriff's Department and Los Angeles Police Department evaluate the feasibility and costs involved in collecting and recording information that identifies those cases of domestic violence in which children reside in the home and report back to ICAN within 90 days; and 2) the Department of Children and Family Services evaluate the feasibility and costs involved in collecting and recording information on children who have been exposed to domestic violence in substantiated child abuse and neglect cases and report back to ICAN within 90 days.

Rationale:

Studies indicate that child abuse is 15 times more likely to occur in households where adult domestic violence is also present. In Los Angeles County, twenty-three percent of child homicides committed in 2000 by parent/caregiver/family member involved families with a documented history of domestic violence. Case data on this nexus would help to assess the extent to which children are exposed to family violence and would aid planning efforts among county departments and community agencies that serve these children and families.

RECOMMENDATION FIVE: REVIEW OF PUBLIC HOSPITAL RECORDS

The Los Angeles County Department of Health Services (DHS) should evaluate the feasibility and costs involved in developing a system to assure that County hospital medical staff review previous medical records on potentially suspicious child deaths (e.g., homicide with a caregiver suspect, undetermined child deaths) and report back to ICAN within 90 days. If possible, this system should be expanded to include private hospitals. Information from this review should be made available to the Child Death Review Team.

Rationale:

Previous medical records provide a potential source of significant information in assessing risk factors and understanding the history of child injury. At present, County hospital records are located but not systematically reviewed for Child Death Review Team purposes and private hospital medical records are not systematically located or reviewed. Systematic review of information will assist the Team in identifying measures to prevent similar child deaths. Team findings on case outcomes provided to the hospital will provide valuable feedback.

RECOMMENDATION SIX: SAFE HAVEN FOR NEWBORNS

ICAN agencies should support the efforts of the Children's Planning Council's Safe Haven for Abandoned Babies Task Force by providing available data, assisting with clarification of the Safe Haven law, including contradictions and gaps that may complicate effective implementation of the law; participating in development of a public information campaign and otherwise assuring that information and expertise are shared for the benefit of saving the lives of newborns who might otherwise be abandoned. Following completion of work of the Safe Haven for Abandoned Babies Task Force, ICAN should take an active role in assuring follow-up on findings relevant to the prevention of future deaths of abandoned infants.

Rationale:

From January 1999, through February 2002, 22 cases of abandoned newborn fatalities were reported to ICAN by the Office of Coroner. During 2001, the Department of Children and Family Services identified three abandoned infants who survived their abandonment. It is strongly suspected that other newborns have been abandoned and died but they have not been found and have not come to the attention of authorities. On February 6, 2002, the Los Angeles County Board of Supervisors requested the Children's Planning Council (CPC), in consultation with ICAN, the Commission for Children and Families, the Healthcare Association of Southern California, the Los Angeles County Children and Families First-Proposition 10 Commission, and others develop recommendations on implementation of the Newborn Abandonment Law (SB 1368) and prevention strategies with the goal of assuring that no baby is ever discarded. These recommendations are to include an analysis of what is known about women and girls who have abandoned or are considering abandoning their newborns, and how best to reach them with programs to prevent abandonment and encourage prenatal care and safe delivery.

RECOMMENDATION SEVEN: GRIEF, MOURNING AND TRAUMATIC STRESS SUPPORT FOR CHILDREN, FAMILIES AND PROFESSIONALS INVOLVED IN THE CHILD PROTECTION SYSTEM

The Los Angeles County Departments of Health Services, Children and Family Services, Mental Health, District Attorney, and Education; Los Angeles Unified School District; Los Angeles City Attorney; Dependency Court and County Counsel should evaluate the feasibility and costs involved in assuring that all children who are affected by or survive incidents of fatal or severe family violence, their family members and professionals who work with them are provided with appropriate support and services to assist them in managing their grief, mourning and traumatic stress and report back to ICAN within 90 days.

Rationale:

ICAN's Child Death Review Team frequently reviews cases of fatal child abuse and family violence involving surviving siblings and other family members. In many cases, social workers, teachers, law enforcement officers, prosecutors and other professionals are or were involved in providing services to the deceased family member(s) and survivors. Such violent incidents frequently produce severe trauma and can have long-term debilitating effects. Sometimes the needs of the surviving family members and the professionals are overlooked in the process of addressing issues related to the fatality itself. Surviving children and family members need services to assist in resolving their grief and loss. Professionals need assistance to manage the traumatic stress and compassion fatigue that often results from their responsibilities in serving these traumatized children and families.

RECOMMENDATION EIGHT: NON-INTENTIONAL CHILD INJURY DEATH REVIEW

Members of ICAN's Child Death Review Team, including the Departments of Health Services, Children and Family Services, Coroner, and Sheriff's Department; and Los Angeles Police Department should explore the feasibility of establishing a process to review cases of non-intentional fatal injuries involving children whose families had received prior services from a public agency.

Rationale:

ICAN includes information on accidental deaths each year in the Report of the Child Death Review Team. In 2000, one hundred thirty seven children died from causes moded as "accidental" by the Coroner's office. The leading causes of these deaths were auto-pedestrian accidents, automobile accidents, drowning and circumstances stemming from maternal substance abuse. Most of these deaths were highly preventable and a large number of the families were known to public agencies. Team

review of cases with public agency involvement would lead to a better understanding of the circumstances leading to the child's death, and provide invaluable guidance in developing agency and system-wide responses to prevent these deaths.

RECOMMENDATION NINE: DROWNING PREVENTION

The Los Angeles County Department of Health Services, Forester and Fire Warden and all other ICAN agencies should make efforts to promote public awareness regarding prevention of accidental child drowning.

Rationale:

Drowning deaths of children in Los Angeles County dropped dramatically in 1996 following a comprehensive drowning prevention campaign conducted by the Department of Health Services and the Forester and Fire Warden. However, the number of children who died as a result of accidental drowning in the years since 1996 show an overall increase and indicate a need to reinvigorate prevention efforts, particularly as the summer months approach.

RECOMMENDATION TEN: SYSTEMATIC FOLLOW-UP ON IMPLEMENTATION OF APPROVED RECOMMENDATIONS

ICAN agencies identified in any recommendation of the Child and Adolescent Suicide Review Team or Child Death Review Team should provide written follow-up information on the agency's efforts to implement the recommended actions. This information should be submitted to ICAN for inclusion in the Child Death Review Team's report for the following year.

Rationale:

The Child Death Review Team and the Child and Adolescent Suicide Review Team meet regularly to review deaths of children and adolescents. These multidisciplinary review processes are intended to identify systems improvements that may be needed to assist in prevention of deaths of other children. Recommendations are developed that reflect the findings of these review processes. It is important for impacted agencies to provide feedback on progress in implementing recommendations as a mechanism for the Teams to use in monitoring the effectiveness of the review process.

At age 12, Gilda resided with her father, Gabriel, mother, Hedda, and two older sisters, Lianna and Monika. Her family had immigrated to the United States when she and her sisters were young and remained part of a tight-knit immigrant community. Gabriel was employed full time as a mechanic and supplemented the family's income by working part time as a wedding photographer. Hedda worked full time as a teacher at the private school attended by Gilda and her sisters. Hedda was a much beloved teacher and the family's social life revolved around the school. Students and faculty at the school were all part of the tight-knit immigrant community, and students and teachers knew one another very well.

In December of 1999, Hedda and Gabriel separated. Long-standing financial problems had contributed to marital problems and Hedda told Gabriel that she wanted a divorce. Gabriel moved out of the home but was distraught over the loss of contact with his wife and children. Almost a year later, one afternoon shortly before Christmas, Gilda, then age 13, her sisters, ages 14 and 16, went out shopping with their mother. When they returned home, they found Gabriel waiting outside. Gabriel notified Hedda that his car had broken down and asked her if she would give him a ride back to the car. Hedda agreed and the family got into their minivan and drove towards Gabriel's car. As they approached the car, Gabriel produced a 9mm semi-automatic pistol and began firing. Hedda, who had been driving, was killed instantly. Gilda, who had been seated behind her mother, was also shot; she died at the scene of multiple gunshot wounds to the right ear, left neck and left chest. Both Lianna and Monika were also injured and were taken to the hospital by paramedics in critical condition. Lianna had been shot in the mouth and Monika was pistol-whipped. Following the assault, their father fled on foot and jumped or fell off a nearby freeway overpass where he died of massive trauma.

Investigation into the case indicated that the family had a history of domestic violence. Although law enforcement searched and found no record of calls and child protective services had had no prior contact with the family, Hedda's friends and co-workers indicated that there had been physical violence between Hedda and Gabriel. Law enforcement indicated that, in some immigrant communities such as this family's, there is often a reluctance to call law enforcement, especially on "family issues," such as domestic violence and child abuse. Calls to officials are often considered a breach of the family's or community's confidentiality. Seeking services to address domestic violence is also problematic as members of this family's culture have a heightened concern for confidentiality and "saving face" in their tight knit community. While Gilda's mother was reportedly encouraged to obtain counseling by friends and co-workers, she did not avail herself of such services.

Review of this tragic case by the Child Death Review Team included concern for the well-being of Gilda's siblings. Lianna and Monika both survived their injuries and were referred to the Department of Children and Family Services. They were initially placed into foster care once they left the hospital and then returned to their native country to live with their maternal grandmother. They subsequently moved on to live with family friends in another country, more similar in culture to the United States where they had lived for most of their young lives. Although both girls were understandably and profoundly impacted by the deaths of their mother, father and sister, it is unknown what type of treatment and counseling, if any, the girls received to address their physical and emotional needs.

As the school in this tragic case was severely impacted by the deaths, Team review also focused concern for the family's school and community. By community self-report, the culture of the immigrant students and staff is one in which families do not openly discuss death. As the deaths occurred shortly before Christmas break and the school would be unable to address most student and staff needs until after the two-week break, counselors and grief therapists were especially concerned with how families would address the deaths. A psychologist associated with the school and familiar with the culture of the staff and students sent a notice home with each student, providing parents with recommendations on handling their children's grief. Upon their return to school, teachers and counselors acted as co-therapists, referring those children they were unable to

help for further assistance.

The Team also expressed concern regarding the availability of guns in this immigrant community. It was reported that many of the men in the community maintain guns as they fled their home country due to war and have great concerns about protecting their families. There had been other instances of domestic violence involving guns in this school community, and Team recommendations were made to address these issues.

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

Fifty-four homicides meeting ICAN referral protocol were reported to the Team by the Coroner for 2000. Following a review of law enforcement records, 19 cases were determined not to have been perpetrated buy parents/caretakers/family members. It should be noted as in earlier sections of this report, ICAN's initial referral protocol was raised from age 12 to age 14 in 2000. Of the nineteen cases determined not to have been perpetrated by parents/caretakers/family members, eleven cases involved children age 13 or 14 who would not have been included prior to 2000. These eleven cases reflected eight gang-related homicides (7 gunshot victims and one stabbing victim) and a 14-year old suspect killed during a residential robbery. Also included were two boys, age 13 and 14, beaten by an unrelated peer acquaintance or acquaintances. These victims suffered blunt force trauma and multiple traumatic injuries and were left to die on an elementary school playground on a Saturday evening.

In addition to the eleven homicides of children age 13 and 14 excluded as they were perpetrated by other than parent/caretaker/family member, eight cases of homicide of children under age 13 were determined to have been committed by other than parent/caretaker/family member. These eight cases included 7 gang-related homicides. These gang-related homicides included two fetuses who died when their mothers were killed in drive-by shootings and a 10-month old girl who died in a drive-by shooting while being held by her mother. In addition, a 3-year old girl was shot and killed in a drive-by shooting at Taco Bell, along with one of the 14-year old gunshot victims mentioned above. A 10-year old girl died when hit by stray gunfire while riding her scooter. In this case, assailants reportedly aimed their guns at the intended victim, a 19-year old male who was washing his car four houses away, when the child was hit. Two 12-year olds also died in gang-related incidents, a boy who was fatally wounded in a drive-by shooting and a girl who was killed when she opened the front door of her residence and an assailant showered the home with gunfire. In addition to the 7 gang-related homicides of youth under age 13, an 11-year old boy died as a result of an assault by his peers. A verbal argument reportedly escalated and the peers pushed the boy to the ground. He was struck in the chest, went into convulsions and died.

As discussed in the ICAN Child Death Review Team Report for 1999, the Team revised the intake system established with the Los Angeles County Department of the Coroner for the referral of cases and expanded the Team protocol of cases to be reviewed. This year, as discussed in detail in the Team Protocol section of this report, the Team further expanded its case protocol to include children ages 13 and 14 whose final mode of death was accidental or undetermined, with the exception of drowning deaths that already included children ages 0 through 17. As a result of these changes, the problems in identifying cases that existed in previous years have been significantly reduced.

It should be ntoed that although the Team made the changes mentioned above and discussed more fully in the Team Protocol section of this report, the data regarding the number of homicides by parents, caretakers and family members has always included homicides for age 17 and under and thus, this portion of the protocol could not be expanded. In addition, the Team has previously been able to effectively identify most of these homicides through intensive work with the Coroner's Office by utilizing the case reconciliation process (UCR-SHR, CACI and Vital Statistics) described below. Thus, other than the typical fluctuations that occur from year to year, the number of homicides should not change dramatically.

Traditionally, in an effort to assure that all child homicide cases meeting the protocol were identified, the Team received data from the California Department of Justice Uniform Crime Reports-Supplemental Homicide File (UCR-SHR), the California Department of Justice Child Abuse Central Index (CACI) and the California Department of Health Services Vital Statistics. The child homicide cases listed in these indices were then reconciled with the child homicide cases received from the Coroner's Office. Often through this process, additional cases of child homicide by parent, caretaker or family member were identified. Unfortunately, data from these three state indices

were not received in time to complete this case reconciliation process for this year's analysis. It is possible that if these data had been received, there would be cases of child homicide by parent, caretaker or family member identified that were not discovered through the current intake system established with the Coroner's Office.

Given the above information, the Team determined that there were 35 child homicides perpetrated by parents, caretaker or family members in Los Angeles County in 2000. This is the fewest number of such child homicides over the past 13 years and represents a decrease of 20% from the 44 child homicides by parents, caretaker or family members in 1999. This number is also significantly lower than the 12-year average of 46 per year. Figure 2 displays by year the 550 homicides by parents, caretaker or family members referred to the Team by the Coroner for the period of 1989 through 2000.

GENDER

In 2000, 57% (n=20) of the victims of child homicide by parents, caretaker or family members were female, while 43% (n=15) of the victims were male. Over the past 12 years, there have been a total of 289 male victims (53%) and 261 female victims (47%).

The percentage of female victims has ranged from a low of 29% in 1995 to a high 61% in 1993. The number of female victims varied little until 1994, averaging 24 per year and ranging from 21 to 27. In 1994, there were 12 female victims and in 1995, there were 14. However, this number rose again in 1996 and in both 1996 and 1999, there were 25 female homicide victims. In 1997 there were 17 female victims and in 1998 there were 27; the highest annual number of female homicide victims over the last 12 years.

The number of male victims has had much greater fluctuation over the past 12 years. The average is 24.8 per year and has ranged from a low of 16 in 1993 to a high of 35 in 1991 and 1995.

Figure 3 displays the gender breakdown of the child homicide victims for the past 12 years.

AGE

The ages of victims of homicide by parents, caretaker or family members between 1989 and 2000 are displayed in Figure 4. In 2000, 28.5% of the victims were under the age of six months, 40% under the age of 1 year and 43% were under age 2. 77% of the victims were age 5 or younger. Over the past 12 years, 43% (n=238) of the victims have been under the age of 1 year; 85% (n=465) have been under the age of 5 years. In 2000, three victims of homicide by parents, caretaker or family members were between the ages of 6 and 10. There were 5 victims of homicide by parents/caretakers/family members over the age of 10 years, a significant increase from 1999 when there were no such victims.

Between 1989 and 1993, approximately 60 to 65% of child victims of homicide by parents/caretakers/family members were under the age of 2 years. In 1994, that level rose to 72% and in 1995 to 73%. However, in 1998, that level fell to 51% and rose slightly in 1999 to 52%. Until 1998, 90% or more of the victims were under the age of 5 years, whereas in 1998, only 73% of the victims were under the age of 5. It is believed that the average age of child homicide victims in 1998 increased because of two multiple family killings, one with three children and one with four children, ranging in age between 4 and 13 who were killed by their father and mother respectively. In 1999, the number of child homicide victims under age 5 increased to 91%. In 2000, this percentage decreased to 77% and again this is due, in part, to a siblings set of three children, all over age 9, who were killed in one tragic homicide.

Table 1 displays the relationship between the age and sex of the victims of child homicide by parents, caretaker or family members in 2000. The average age of female victims was 5 years. This is the highest average age of female victims over the past 12 years. The average age of female child victims decreased over the previous years, with the exception of 1996 and 1998. In 1989, the average age was 3.1 years, increasing to 3.8 years in 1990, then decreasing to 2.2 years in 1991, 1.7 years in 1992, 1.6 years in 1993, 1.3 years in 1994, 1.6 years in 1995 and 1.9 years in 1997. In 1998, however, the

FIGURE 2

1989 - 2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

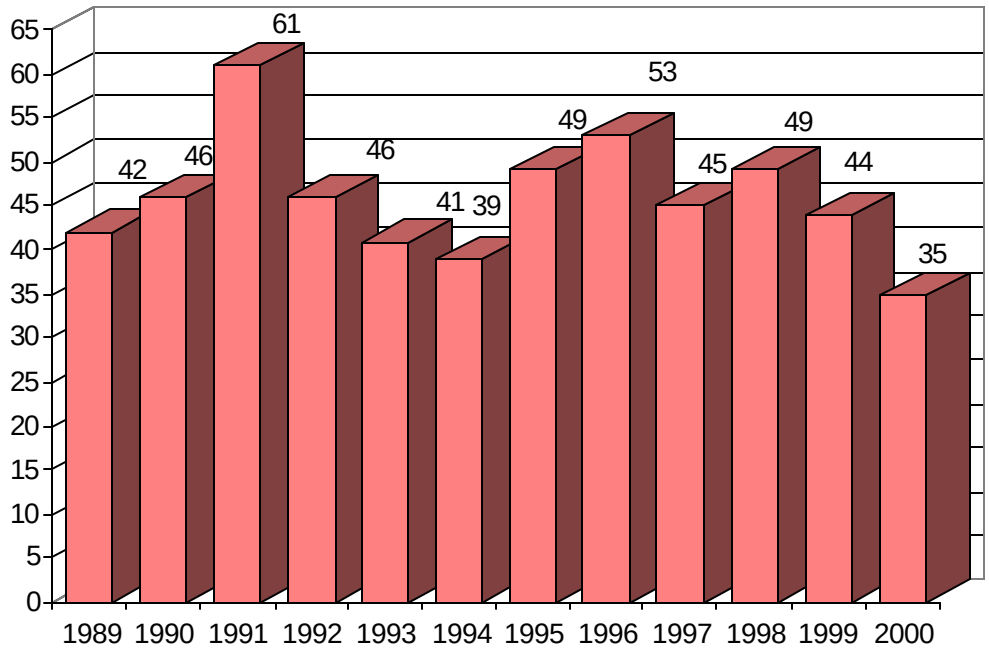
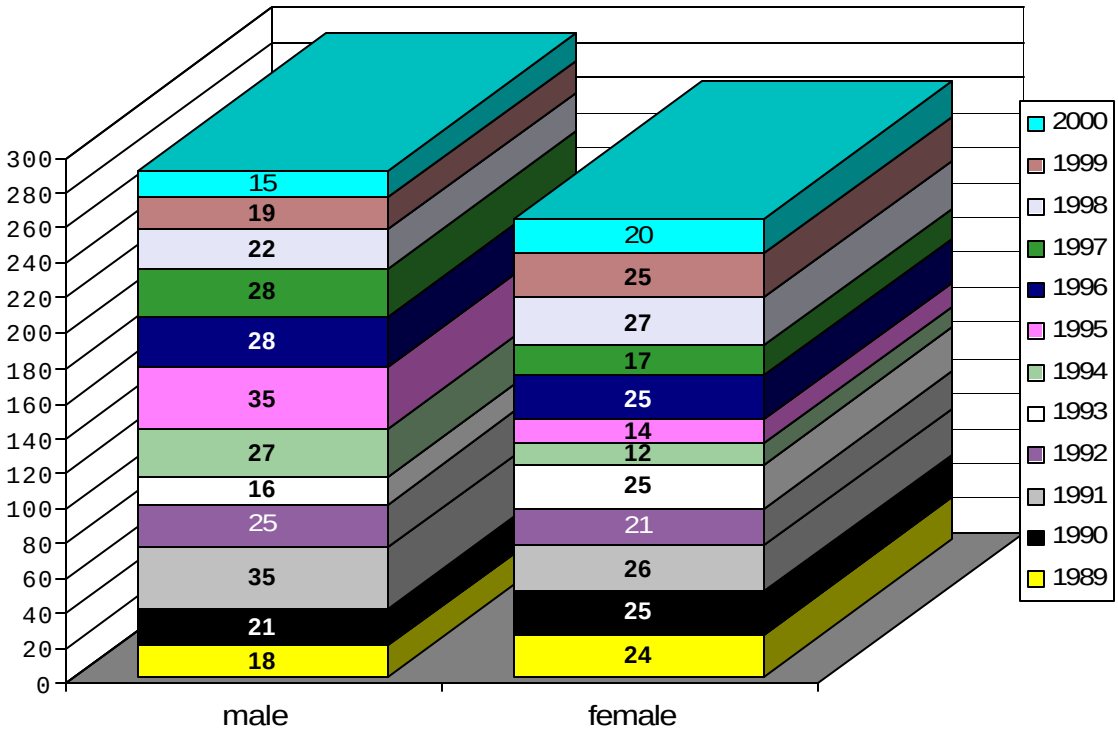


FIGURE 3

1989 - 2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS BY GENDER



average age of female child victims increased to 4.3 years reaching the highest level since 1996 when the average age was 4.8 years, the highest it has ever been until this year. In 1999, the average age of female victims dropped to 2.1 years. In 2000, one of the female victims was killed on the day she was born, found in a trash dumpster, dead of asphyxiation. All three of the 13-year olds and the sole 14-year old were female in 2000.

The average age of male victims in 2000 was 4.1years. As with female victims, this is significantly higher than previous years and may be high due to the inclusion of a 17-year old victim. Prior to 2000, the average age of male victims remained fairly constant with a low of 1.6 years in 1989 and a high of 2.8 years in 1998. One of the male homicide victims in 2000 was killed on the day of his birth, found decapitated in a trash transfer station. The oldest male victim, age 17, was the victim of a multiple homicide along with his 13-year old sister and 10-year old brother.

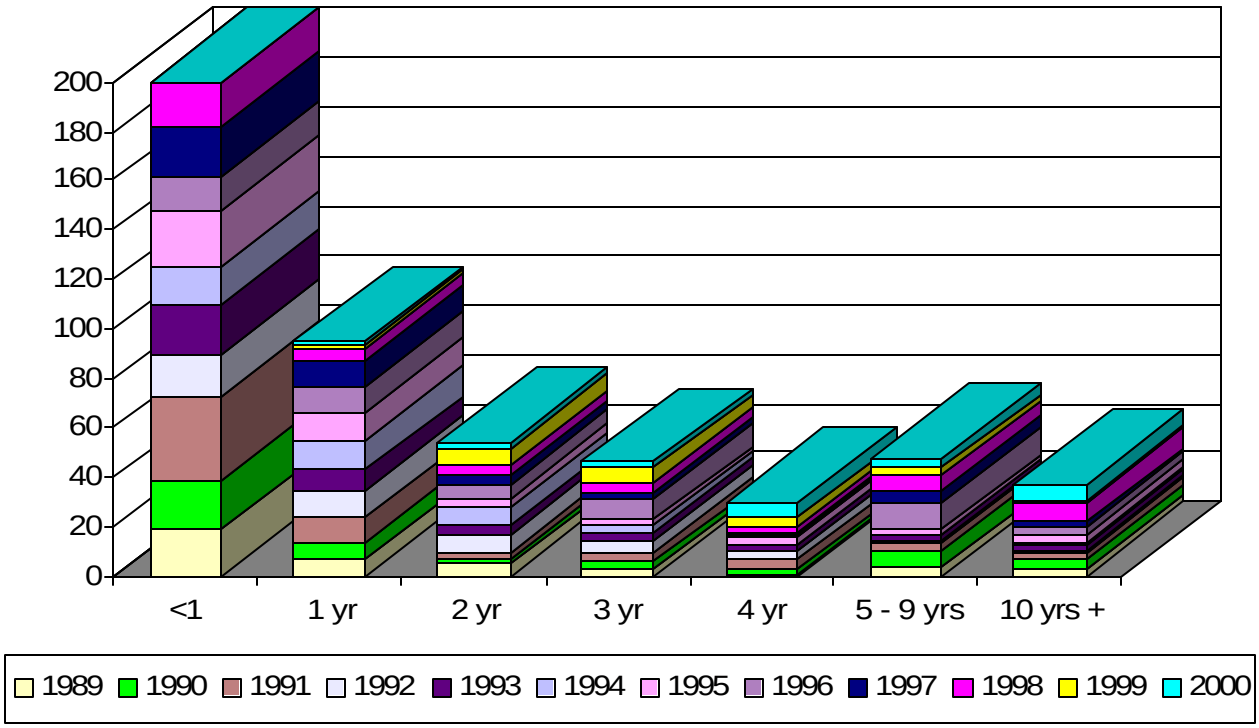
TABLE 4

2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS BY AGE AND SEX

Age	Male	Female
less than 1 year	6	9
1 year	1	0
2 years	2	0
3 years	1	1
4 years	1	5
5 years	1	1
6 years	0	0
7 years	1	1
8 years	0	0
9 years	0	0
10 years	1	0
12 years	0	0
13 years	0	3
14 years	0	1
17 years	1	0

FIGURE 4

1989 - 2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS BY AGE



ETHNICITY

In 2000, 37% of the victims of child homicide by parents/caretakers/family members were African American (n=13). This is a 24% decrease from 1999 (n=17). Hispanics also represented 37% (n=13) of the child homicides, a slight increase over the 12 Hispanic homicides in 1999. There were 7 White victims, representing 10% of the total, a decrease of 42% from 1999 (n=12). There were 2 Asian homicides, representing 6% of the total. In 1999, there were 3 Asian homicides by parents/caretakers/family members.

2000 Census figures show the child population in Los Angeles County to be 57.5% Hispanic, 19.8% White, 9.9% African American and 9.0% Asian. When child homicides by parents/caretakers/family members are compared to these child population statistics, African American children continue to be over-represented. Prior to 1999, Hispanic child homicides were fairly consistent with the Hispanic child population rate, with an exception in 1998 when Hispanic children were over-represented. In 1999 and 2000, Hispanics were under-represented. Prior to 1999, White children were under-represented, but in 1999 and 2000, they were slightly over-represented by child population rate. Asian children, as in prior years, are under-represented by population rate. Table 2 displays the ratio between the percentages of child homicides by parents/caretakers/family members by child population.

From a multi-year perspective, as illustrated in Figure 5, the ratio of African American child victims of homicide by parents/caretakers/family members has been greater than their composition within the Los Angeles community every year from 1989. Hispanic child homicides by parents/caretakers/family members increased between 1989 and 1998, not only in real numbers, but also in relationship to the Hispanic percentage of child population. However, in 1999, the number and percentage of Hispanic child homicides decreased dramatically and remain low in 2000. Asian children have consistently been under-represented in child homicides by parents/caretakers/family members, except in 1991. There was a steady decline in White child homicides by parents/caretakers/family members between 1991 and 1995. This figure increased gradually in 1995, 1996 and 1997. There was an increase of 26% in this number in 1998 and an increase of 50% in 1999. In 2000, this number decreased by 42%. Because the number of child homicides by parents/caretakers/family members is extremely small in relationship to Los Angeles County's overall child population, relative increases or decreases in the number of deaths in any one ethnic group may cause the percentage to vary a great deal.

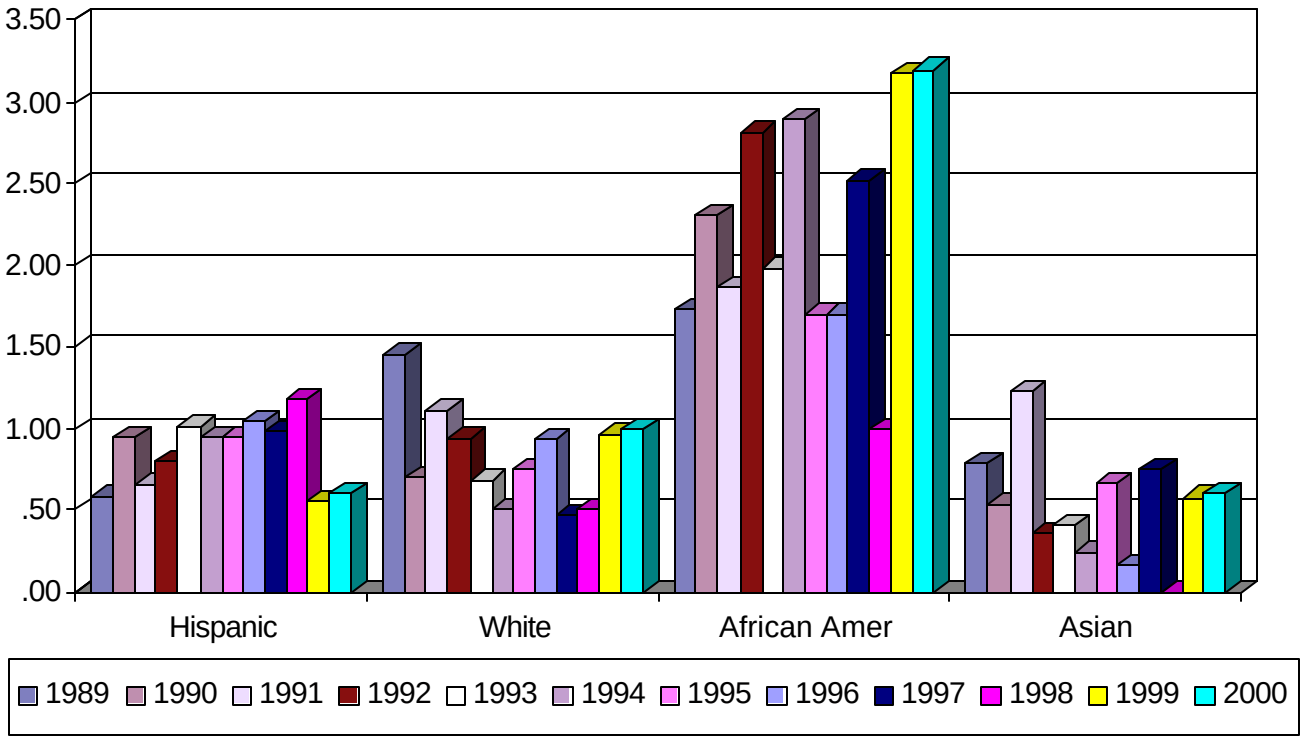
TABLE 2

2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS BY RACE

Race	Number	%	Child Pop	Ratio*
Hispanic	13	37	57.5	0.64
White	7	20	19.8	1.01
African American	13	27	9.9	3.73
Asian	2	6	9.0	0.66

** Ratio = % of deaths by race / % child population by race. A ratio of 1.00 would mean that the % of child abuse homicides is the same as that racial/ethnic groups % of children in Los Angeles County.*

FIGURE 5
1989 - 2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS - ETHNICITY % COMPARED TO POPULATION %



CAUSE OF DEATH

In 2000, the leading cause of death for child homicides by parents/caretakers/family members was multiple trauma, claiming the lives of 31% (n=11) of the victims. Deaths due to head trauma (n=5) were the second leading cause of death, comprising 14% of the cases. Stabbing claimed the lives of 4 children. Gunshot wounds, in most recent years the second leading cause of death, comprised 8% (n=3) of child homicide deaths. Asphyxiation/suffocation, drowning and unattended/neglected newborns each comprised 6% (n=2 each) of child homicides.

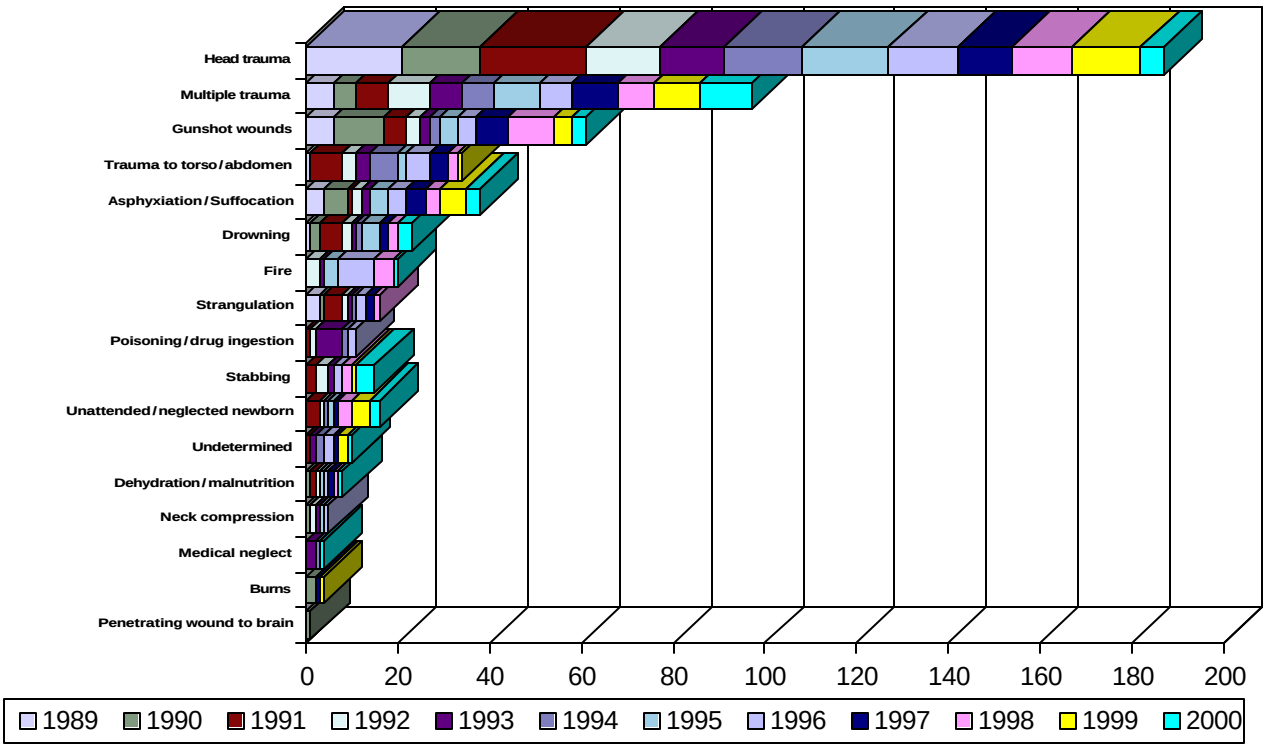
Table 3 and Figure 6 display the different causes of child homicides by parents/caretakers/family members for the 1989 to 2000 period. The most frequent cause of death for all previous 11 years, and comprising 34% of all child homicides by parents/caretakers/family members, was head trauma. Multiple trauma, the leading cause in 2000, was the second most frequent cause of death over the previous 11 years, representing 17.6% of the total deaths. Homicide by guns represented the third or fourth most frequent cause of death over the initial nine-year period, becoming the second leading cause of death in 1998 and dropping again in 1999 and 2000. Deaths due to gunshots represent 11% of the total homicides by parents/caretakers/family members over the past 12 years. All three gunshot victims in 2000 were children killed by their fathers in murder-suicides. In at least two of these cases, child custody issues were known to be a motivating factor. Three of the 4 stabbing deaths involved a set of three siblings killed by their cousin and her boyfriend. The fourth, a 13-year old girl, was reportedly fatally stabbed by her uncle upon rejecting his sexual advances. Drowning homicides included three children who died as the result of caretaker neglect, two young children left alone in bathtubs and a 4-year old who drowned in the family pool after she was left alone while her caretaker went shopping.

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

TABLE 3
CAUSES OF CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS 1989 - 2000

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	TOTAL
Head trauma	21	17	23	16	14	17	19	15	12	13	15	5	**187**
Multiple trauma	6	5	7	9	7	7	10	7	10	8	10	11	**97**
Gunshot wounds	6	11	5	3	2	2	4	4	7	10	4	3	**61**
Trauma to torso/abdomen	1		7	3	3	6	2	5	4	2	1		**34**
Asphyxiation/Suffocation	4	5	1	2	2		4	4	4	3	6	3	**38**
Drowning	1	2	5	2	1	1	4	0	2	2		3	**23**
Fire				3	1		3	8		4		1	**20**
Strangulation	3	1	4	1	1	1		2	2	1			**16**
Poisoning/drug ingestion			1	1	6	1		2					**11**
Stabbing			2	3	1			2		2	1	4	**15**
Unattended/neglected newborn				3	1		1	1	1	3	4	2	**16**
Undetermined			1		1	2		2	1		2	1	**10**
Dehydration/malnutrition		1	1	1			1	1	1	1		1	**8**
Neck compression		1		1	1		1	1					**5**
Medical neglect					2	1						1	**4**
Burns		2							1		1		**4**
Penetrating wound to brain		1											**1**
TOTAL	**42**	**46**	**60**	**46**	**42**	**39**	**49**	**53**	**45**	**49**	**44**		**515**

FIGURE 6
1989 - 2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS- CAUSES OF DEATH



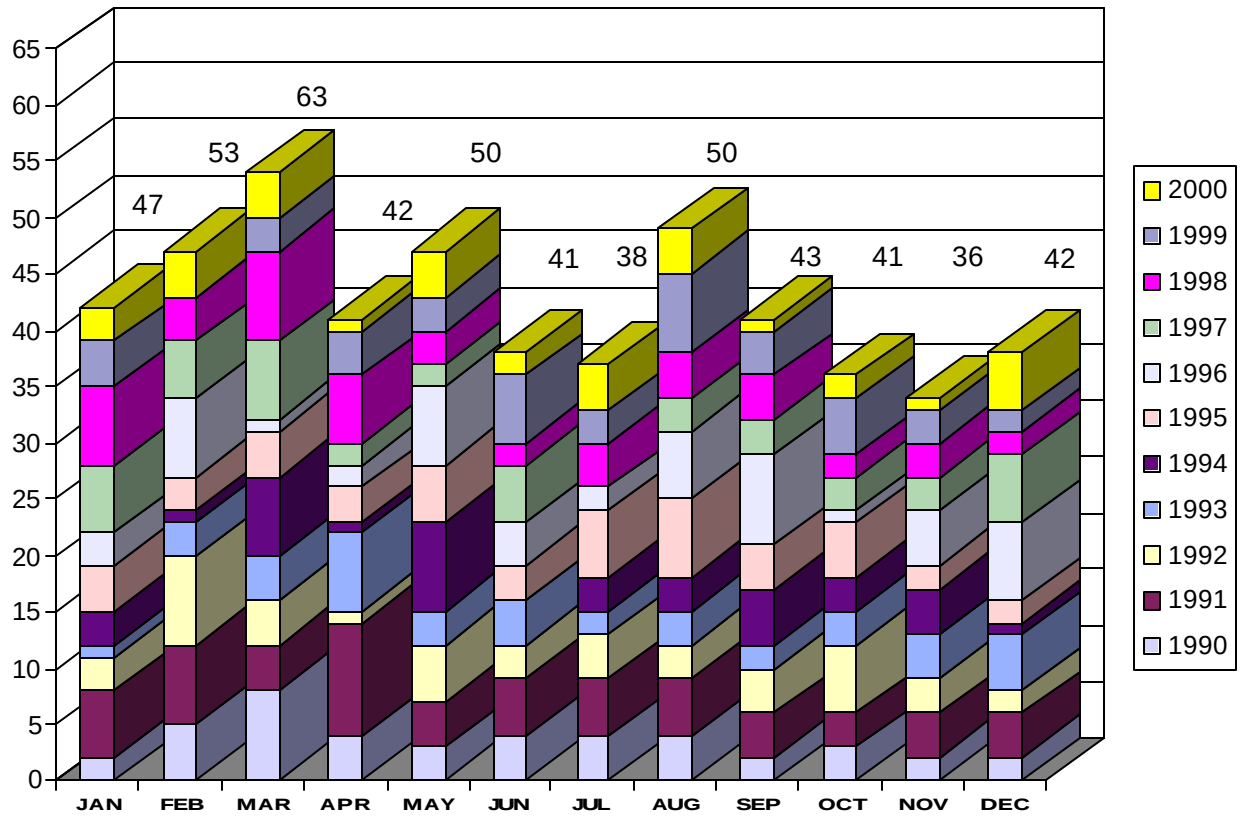
TEMPORAL PATTERN

In 2000, the greatest number of child homicides by parents/caretakers/family members occurred in December (n=5). The second greatest number (n= 4 each) occurred in the months of February, March, May, July and August. Three homicides occurred in January and two each in June and October. The fewest number of homicides occurred in April, September, and November (n=1 each).

Figure 7 displays the child homicides by parents/caretakers/family members by month for the past 12 years. During the period of 1989 through 2000, the greatest number of child homicides by parents/caretakers/family members occurred during the month of March (n=63). The fewest such homicides have occurred during November (n=36) and July (n=38).

The 550 homicides by parents/caretakers/family members during the past 12 years translate to an average of 3.8 homicides per month. While actual deaths in any give month vary, June, 1994 July, 1997 and February, 1999 were the only months in the past 12 years in which no child homicides by parents/caretakers/family members were recorded.

FIGURE 7
1989 - 2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS BY MONTH



CHILD PROTECTIVE SERVICE INVOLVEMENT

Kurt, age 10 months, was brought to the hospital by ambulance after his mother called 911, indicating that her child "wasn't doing well." Kurt and his 15-year old mother, Nina, lived with Nina's boyfriend, age 23. When questioned about Kurt's injuries, Nina initially told hospital staff that two days prior she had discovered Kurt face down on the floor. She related that she didn't know how he had gotten out of his walker or fallen but she had not heard him fall and that he had not cried out. Nina reported that Kurt had seemed fine until that day when she called 911. Upon arrival at the hospital, Kurt's condition was very poor; he was unresponsive with a severe brain injury and placed on life support. He died the following day.

Upon autopsy, Kurt was found to have numerous injuries, including three bruises near his right temple as well as a bruise to the left side of his face and left eyelid. He had numerous retinal hemorrhages and a hemorrhage to the muscle near the neck bone in addition to a fracture of the left radius, approximately three to five weeks old. Kurt's injuries were consistent with shaken impact and the cause of his death was multiple traumatic injuries.

When law enforcement initially questioned Nina about Kurt's injuries, she relayed the story she had shared with medical personnel regarding Kurt's alleged fall from a walker onto a carpeted floor. However, after several hours of interviews, she broke down and confessed that she had been trying to get Kurt to go to sleep at approximately 9:00 pm the night before he was taken to the hospital, but that he wouldn't sleep. She became very frustrated and struck Kurt in the forehead with all her strength. She said that Kurt was fine after she hit him and that it wasn't until the next day that he started "acting mental." She denied ever shaking Kurt or previously hurting him in any way.

Approximately two weeks before his death, Nina had taken Kurt to the same hospital emergency room for a fractured arm. At that time, she reported to hospital staff that she was encouraging Kurt to walk and that he had fallen with his arm extended. The attending physician indicated that while he could not specify that the injury did not occur the way the mother described, he also could not rule out abuse. In addition, he found Nina's story suspicious as she told staff various versions as to when and where the fall had occurred. A skeletal survey of the child was done to check for additional injuries and was negative. Nonetheless, the physician called the Department of Children and Family Services (DCFS) Child Protection Hotline and reported his suspicions. Unfortunately, a hospital hold was not placed on the child and Kurt and his mother left the hospital after his arm was cast and before a social worker arrived at the hospital.

The following morning, the social worker went to the home address provided by the hospital and was met at the door by a young woman who introduced herself as Nina's sister. The woman stated that she did not know where Nina was and that she did not know when she would be home. The social worker made six additional attempts to contact Kurt and Nina without success over the next several days, making diligent efforts to speak to neighbors and other collateral contacts. Unfortunately, she could not make face to face contact with the child or his mother and the case referral was still open at the time of Kurt's death.

DCFS reported that they had history with Nina prior to the call from the hospital reporting suspicions regarding Kurt's broken arm. There had been three prior referrals reporting that Nina herself was a victim of child abuse and neglect. The first referral alleged neglect--that Nina was being left alone without supervision or food, and occurred seven years prior when Nina was age 8. Upon investigation, DCFS found the referral to be inconclusive and the referral was closed. One year later, when Nina was 9 years old, a referral was made alleging physical abuse at the hands of her mother and father; this referral was unfounded. Finally, when Nina was 13 years old, a school counselor contacted the Child Protection Hotline, reporting that Nina had disclosed that her father was sexually molesting her. DCFS investigated the allegation although social workers initially had great difficulty locating the family. When the family was located, they reported that Nina had run away to northern California and

was whereabouts unknown. When Nina was located in northern California and interviewed by child protective services staff in that county, she denied allegations of sexual abuse against her father. At this time, at age 14, Nina was pregnant with Kurt and named someone other than her father as the father of her baby. Two weeks prior to Kevin's birth, she was sent back to Los Angeles by child protective services in northern California and lived with her parents until Kurt was eight months old. At that time, she left her parents' home and went to live with her 23-year old boyfriend with whom she lived at the time of Kurt's death.

Nina's boyfriend was arrested for lewd conduct with a minor, as Nina was just 15 at the time of Kurt's death. Nina was charged with murder, assault resulting in the death of a child under age eight, and willful harm or injury to a child and was tried as an adult. The District Attorney indicated that while it was a difficult decision to try Nina as an adult, Nina was living an emancipated lifestyle at the time of Kurt's death. Prosecutors also took into consideration the extent of Kurt's injuries and the fact that they were not the result of a one-time assault but rather multiple incidents of abuse. Nina pled guilty to willful harm or injury to a child with special allegations that the injury resulted in death. She was sentenced to 6 years in State prison.

Team review of this case involved discussion on how cases are handled when there may be a suspicion of abuse but a physician cannot say with certainty that an injury presented is the result of child abuse. Different hospitals reportedly handle such cases differently. Some hold the parent and child until law enforcement or child protective services arrive to assess the situation while others will not. Some hospitals reportedly make dual reports of suspicious cases to child protective services and law enforcement, as law enforcement can more quickly arrive at the hospital, preventing the parent and child from leaving before a child abuse assessment can be made. Team discussion also involved the necessity for very young mothers, such as Nina, to be provided with interventions to assist them in caring for their infants.

Fifteen of the child victims of homicide by parents/caretakers/family members were members of families that had a record of contact with the Department of Children and Family Services (DCFS) prior to the death of the child. These 15 families represent 42.8% of the total child homicides by parents/caretakers/family members in 2000. This rate is comparable to the national average of 40% reported by Prevent Child Abuse America (1998). Eight referrals/cases were open to DCFS at the time of the child's death.

For the period of 1989 through 1992, there were eleven families each year with DCFS contact prior to the child's death. In 1993, 13 families had received prior DCFS contact; in 1994, 12 families received prior contact; in 1995, 15 families received prior contact; in 1996, 13 families received prior contact; in 1997, 15 families received prior contact; in 1998 and 1999, 20 families per year had a record of DCFS involvement. Figure 8 displays the number of homicides by parents/caretakers/family members with prior child protective services involvement when compared to the total number of cases for the past 12 years.

The 15 cases with prior contact with DCFS in 2000 accounted for a total of 44 prior referrals. Of these 15 cases, 47% (n=7) of the families had one prior referral. Two children came from families that had 3, 4, and 5 referrals each. One family had 7 previous referrals and one family had 9 previous referrals. For the family that had nine previous referrals, 8 referrals were made alleging general neglect and severe neglect, physical abuse and caretaker absence/incapacity for the deceased child's siblings prior to the deceased child's birth. The 9th referral was made at the time of this child's birth as the hospital staff had concerns with the mother's ability to care for the baby's medical needs.

The reasons for prior DCFS services are listed in Table 4. In 2000, 43% (n=19) of the prior referrals were for allegations of general neglect. Allegations of physical abuse (n=8) accounted for 18%, and allegations of severe neglect accounted for 14% (n=6) of the referrals. Caretaker absence/incapacity represented 9% (n=4) of the previous referrals. Sexual abuse and emotional abuse allegations each accounted for 7% (n=3 each) of the referrals. In one case, the reason for the prior referral is unknown. As in 1990, 1991, 1997 and 1998, the most frequent reason for prior referrals to DCFS in 2000 was general neglect. In 1989, 1992, 1993, 1994, 1995, 1996 and 1999, the most frequent reason for prior referral was physical abuse.

Table 5 provides a comparison between the date that DCFS closed the family's most recent prior child protective service case or referral and the date of the child's death. The 8 cases/referrals that were still open at the time of the child's death are not included. In three of the 7 cases with previous contact, the most recent child protective contact was within six months of the child's death. In one such case, 7 previous referrals were investigated for a family with a long history of domestic violence and substance abuse. The 7th referral alleged general neglect and emotional abuse as the father, the sole caretaker in the family, reportedly refused to obtain necessary items for the youngest child, a toddler approximately 1½-years of age. The father was also alleged to have a drug and alcohol problem. DCFS assessed the situation and closed the referral as unfounded for general neglect and inconclusive for emotional abuse. Six days later, the toddler died of asphyxia/imposed suffocation and battered child syndrome at the hands of his father.

In the second case with DCFS contact within six months, a referral of physical and emotional abuse was made concerning a 2-month old child. The referral alleged that the child's father had been observed covering the child's mouth with his hand to stop the child from crying, knocking the baby from his car seat and shaking the child. DCFS investigated the allegations, including interviews with the parents, other relatives and baby's pediatrician; and observed no marks or bruises on the child. The referral was closed as inconclusive. Two and a half weeks later, the baby was brought to the hospital with burns, a swollen eye and multiple traumatic injuries. Upon notification of his baby's death, the father attempted to flee the hospital. He was detained and later arrested in this death.

FIGURE 8
1989 - 2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
CHILD PROTECTIVE SERVICES INVOLVEMENT

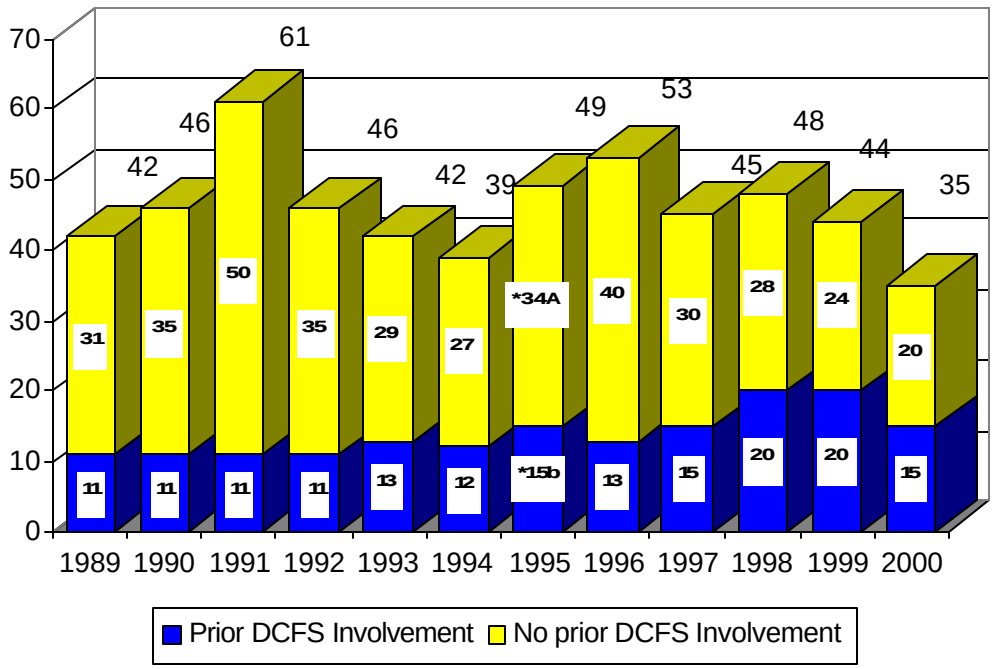


TABLE 4
2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
REASONS FOR PRIOR CHILD PROTECTIVE SERVICES

Reason	n	%
General neglect	19	43
Physical abuse	8	18
Severe neglect	6	14
Caretaker absence/incapacity	4	9
Sexual abuse	3	7
Emotional abuse	3	7
Unknown	1	2

TABLE 5
2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
LENGTH OF TIME BETWEEN PRIOR DCFS CASE REFERAL CLOSURE AND DATE OF DEATH

Time Frame	n	%
1 day to 6 months	3	43
6 to 12 months	2	29
1 to 2 years	1	14
more than 2 years	1	14

CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

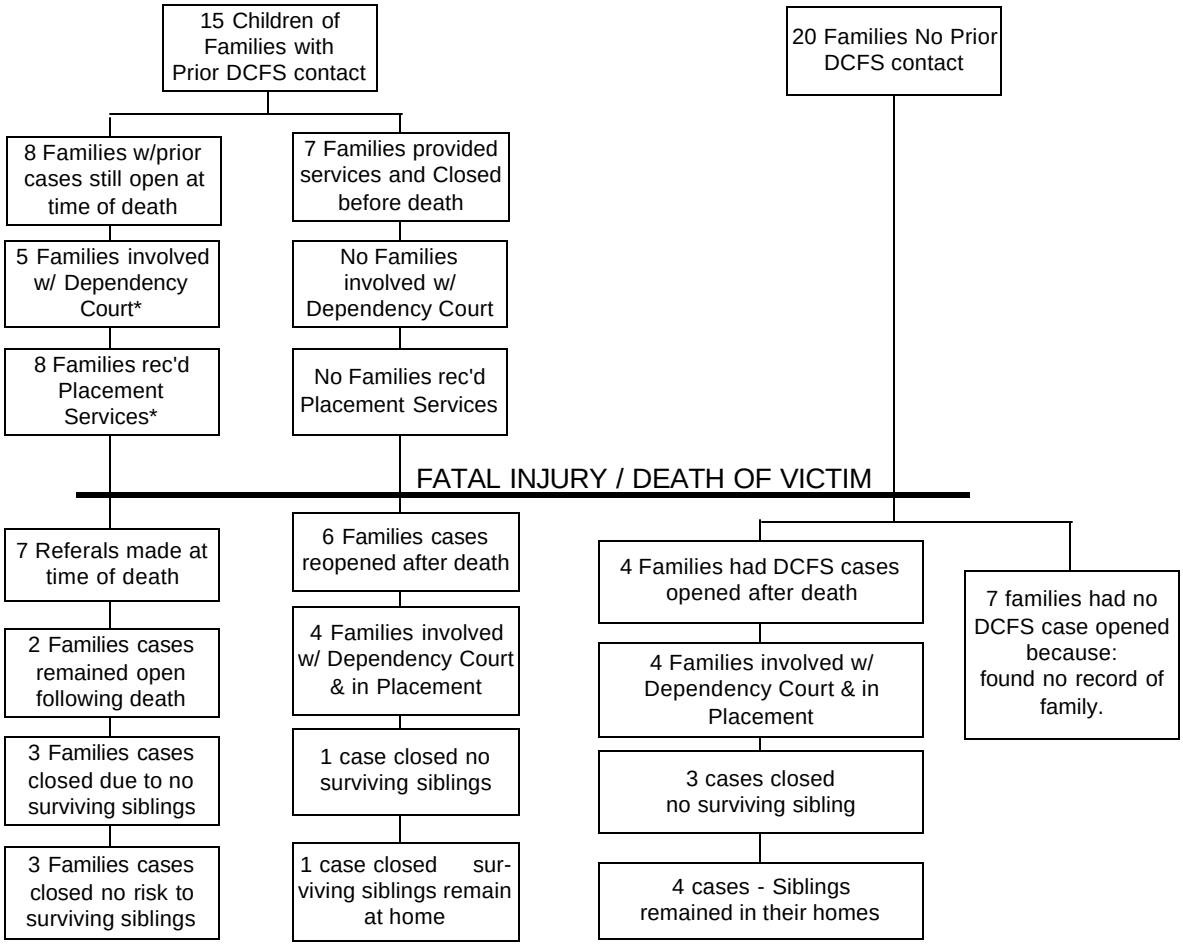
TABLE 6
2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING THE DEATH

Reason	n	%
Physical abuse	17	18
General neglect	6	43
Severe neglect	4	14
Sexual abuse	1	7
Caretaker absence/incapacity	1	9

TABLE 7
2000 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
AGES OF MOTHERS

Ages	n	%
Under 20 years	3	9
20 to 24 years	6	17
25 to 29 years	6	17
30 to 34 years	4	11
35 years and over	6	17
Unknown	10	29

FIGURE 9
CHILD PROTECTIVE SERVICES ACTIVITIES ON 2000 CHILD HOMICIDES
BY PARENTS/CARETAKERS/FAMILY MEMBERS



** In one open case, the deceased child was previously a court dependent and placed in out-of-home care; however, this child was at home and not involved with the court at the time of his death.*

In the final case with DCFS contact within six months, an allegation of sexual abuse was substantiated as a 9-year old boy was determined to have sexually molested his 3-year old brother in their grandmother's home. The 9-year old was sent to live with his mother out of state, the 3-year old remained in his grandmother's care and the referral was closed. Three and a half months later, the 3-year old died of multiple trauma at the hands of his grandmother.

Two child homicides occurred within 6 to 12 months of DCFS' most recent referral/case closure. In the first case, a referral of general neglect was made by hospital staff concerned with a spiral fracture suffered by a 5-year old boy. Unfortunately, the home address provided by the hospital staff was incorrect and, despite diligent efforts, DCFS was unable to locate the family and closed the case without contact. Tragically, 6 1/2 months later, the father shot and killed the boy in a murder - suicide.

In the second case with a child homicide within 6 to 12 months of DCFS case/referral closure, several referrals of general neglect were made against a mother and her boyfriend regarding their care of the woman's 4-month old child. Allegations were determined to be unfounded and the referral was closed. Ten months later, the child died as a result of a beating by the mother and her boyfriend.

In addition to these 5 cases of child homicide that occurred within 12 months of DCFS case/referral closure, one child homicide occurred within one to two years of closure and one child homicide occurred more than two years after case/referral closure.

In the 15 cases (totaling 44 referrals) that had prior DCFS contact, DCFS had proceeded with Dependency Court action on 6. In 8 of the remaining 9 cases, the allegations were either unfounded, unsubstantiated/inconclusive or the situation was stabilized and the case/referral was subsequently closed. Short-term interventions of no more than three months were provided in 5 of these 8 cases. In the 9th case, the child was placed with a relative caregiver by voluntary agreement and Juvenile Court action was not required.

Eight cases, 23% of all 2000 child homicides by parents/caretakers/family members, were open to DCFS at the time of the death. Six of these 8 cases received detailed review by the Team. DCFS had proceeded with Dependency Court action and placed two of these children in out-of-home care. A third child resided with a relative caregiver by voluntary agreement. These three children resided in out-of-home placement at the time of their deaths. The 1st child died while placed in a pediatric care facility; he had been placed in specialized care due to injuries he received when he was shaken by his father as an infant in 1993. He subsequently died from complications resulting from those earlier injuries in placement in 2000. The 2nd and 3rd children in placement at the time of their deaths, were placed with relative caregivers. One child was placed with her maternal aunt as an infant, as her mother was incarcerated at the time of her birth. This child died of head trauma inflicted by the aunt two months later. The other child placed with a relative was a 4-year old girl left home alone for approximately an hour by her grandmother/legal guardian while her grandmother went shopping. The child got into the residence pool and drowned. The Coroner ruled this death a homicide due to caretaker neglect.

In the remaining 5 open referrals/cases, children were in the care of their parents at the times of their deaths. In the 1st case, a referral of general neglect and physical abuse was made by hospital staff concerned with a radial fracture treated in a 10-month old boy. The child's mother, age 15, had provided inconsistent information regarding how the injury had occurred. DCFS staff made several efforts to locate the mother and child without success. Tragically, 15 days after the hospital referral was made, the child died of a blow to head at the hands of his young mother.

In the 2nd open case, a referral for general neglect was made by hospital staff concerned with a mother's ability to locate and maintain medical resources for her newborn's special medical needs. The situation was assessed by the DCFS social worker as requiring additional services and a case was opened. Unfortunately, there is no record of additional services being provided to the family and three months later the infant was fatally injured. She was trans-

ported from her home by paramedics in full arrest and died shortly thereafter of multiple traumatic injuries. The Coroner identified this infant as a battered child.

In the 3rd open referral/case, a referral of general neglect was made by hospital staff. A mother had given birth at home, and she and her newborn has been transported to the facility where both tested positive for methamphetamine. Her newborn son was premature and had problems that required he remain in the hospital. After two months, he was released to the custody of his father under Juvenile Court supervision. The child's mother was allowed to live in the home with the stipulation that she must test clean of drugs. Tragically, within two months of his release from the hospital, this infant died of Shaken Baby Syndrome. His mother reportedly confessed to fatally injuring the child.

The 4th and 5th open cases involved a sibling set of sisters, ages 5 and 7. The girls had previously been removed from their parents' custody after numerous reports of general neglect and physical abuse. Allegations included failing to enroll the older child in school, failing to obtain basic medical and dental care, failing to provide adequate nutrition, the use of physical punishment, and exposing the girls to domestic violence and substance abuse. The girls were initially placed in foster care and then with relatives for over a year. At that time, against DCFS recommendations, the Juvenile Court ordered both girls returned to their father under a "Home of Parent" order. The girls' mother was allowed to reside in the home, but was not to be alone with the children, as she had not complied with Court orders to participate in therapy. Approximately one month later, DCFS notified the Court of concerns as the girls were not enrolled in school/child care and their mother was preventing the social worker from accessing the girls. DCFS recommended the girls be placed into foster care, but the Court ruled that sufficient protective orders were in place and denied DCFS' recommendation. The case remained open and DCFS monitored the home. Five months later, the girls' mother, reportedly distraught over a potential eviction and conflict with her husband, committed murder-suicide. She coerced, pushed or threw both girls off an upper floor of the courthouse and leapt to her death. Both she and the girls died of massive trauma.

Seven of the cases that were open to DCFS at the time of the child homicide by parent/caretaker/family member were referred immediately following the death or fatal injury. Two of these cases remained open to provide services to surviving siblings. Three cases were closed as there were no surviving siblings. Finally, three of these cases were closed as it was determined there was no risk to surviving siblings--in two cases, surviving siblings already resided outside of their parents' care and in one case, the sibling lived with the non-offending parent. Six of the 7 cases that were previously known but closed by DCFS were immediately referred following the death or fatal injury. Four of these referrals resulted in the removal of surviving siblings from parental custody with Juvenile Court supervision. One referral was closed as there were no surviving siblings and in one case, DCFS determined there was no risk to surviving siblings who remained in the home.

Eleven additional families previously unknown to DCFS were referred for services immediately following the death or fatal injury. The allegations for the 24 families for which referrals were made following the death are displayed in Table 6. It should be noted that more than one allegation per referral was made in several instances. The majority of referrals were made for physical abuse (n=17). Referrals were also made for general neglect (n=6), severe neglect (n=4), sexual abuse (n=1) and caretaker absence/incapacity (n=1).

DCFS closed 7 of the 24 cases/referrals shortly after death, as there were no surviving siblings in the home. Another 8 cases were closed shortly after the death as DCFS determined that the surviving siblings would be safe without further DCFS intervention. In these cases, referrals for grief counseling for the surviving family members were provided. Petitions were filed in Juvenile Dependency Court on siblings of the deceased child in 8 cases following the homicide by parent/caretaker/family members. Fourteen siblings in 8 families were removed from the home and placed into out-of-home care.

Figure 9 summarizes the child protective services involvement in the 2000 child homicides by parents/caretakers/family members.

DCFS provides information regarding demographics of families known to them through the Child Welfare Services/Case Management System (CWS/CMS). These data include:

- The mother's age was known in 71% (n=25) of the cases (see Table 7). In 2000, the average age of the mothers was 27.52 years; 26% of the mothers were under the age of 25 years at the time of their child's death. Between 1989 and 1995, the percentage of mothers whose age was below 25 ranged from 42.4% to 84%, but this percentage dropped slightly in 1996 (27.2%), 1997 (39%) and 1998 (40%).
- The father's age at the time of the child's death was known in 46% (n=16) of the cases. The average age of the fathers was 30.6 years.
- The deceased child was known to have had siblings in 57% (n=20) of the families. Six were known not to have any siblings and in 9 of the child homicide, it is unknown if the deceased child had siblings. The percentage of families in which there were known to be siblings has ranged from a low of 38% in 1991 to 1996's high of 72%.
- 23% (n=8) of the families had a known history of domestic violence.
- 23% (n=8) of the families had a known history of substance abuse.

CRIMINAL JUSTICE SYSTEM INVOVLEMENT

Elaina, age three months, lived with her mother, father and two older half-sisters, both teenagers, in an apartment in a working class area of Los Angeles. Her father and mother had been married for just a year. Her father was many years younger than her mother; he was employed as a computer technician and her mother was a full-time homemaker.

One evening Elaina's mother and sisters went out to a family party, leaving Elaina to be cared for by her father. Several hours later, Elaina's mother received a call from her husband, telling her that something was wrong with Elaina and that he was taking her to the hospital. He asked her to meet them at the hospital. Elaina presented at the hospital emergency room in an unresponsive condition and was placed on a ventilator. She never regained consciousness and died two days later.

Elaina's father initially told hospital staff that the baby had "just stopped breathing." However, doctors observed numerous bruises, welts and other evidence of injury on Elaina and confronted Elaina's father about the cause of her injuries, and he eventually admitted to harming the baby. Elaina's father confessed that earlier that evening Elaina would not stop crying when he was changing her diaper and that he sodomized her with his finger. When she cried further, he punched her in the stomach, squeezed her skull, hit her in the buttocks and punched her in the head.

The Coroner reported that Elaina was a severely battered and sexually abused infant. She had suffered numerous traumatic injuries, including: multiple old, new and recurrent rib fractures (posterior and anterior); fractures of varying ages to both femurs and tibias; skull fractures; retinal hemorrhages and anal trauma. Iron cells found in Elaina's tissues indicated that the fatal injuries had occurred between 48 hours and two weeks prior to her death.

Investigation by the Los Angeles Police Department revealed that neighbors had heard Elaina's pained screams but had failed to call law enforcement or child protective services. Elaina's mother denied any knowledge of her daughter's abuse. She stated that Elaina had started crying more in the month before her death, but that she took Elaina to a "healer" rather than a traditional physician and was unaware of her physical injuries. The Team expressed some incredulity that the mother would not have known that something was seriously wrong with her infant.

Elaina's father was charged with Penal Code (PC) 187 murder, with special circumstances due to the torture of his young victim. He was also charged with two counts of PC 273a(a), willful harm or injury to a child, and PC 289, a forcible act of sexual penetration. The District Attorney is seeking the death penalty in this case due to the nature and severity of the attacks. Elaina's father admitted that when he became sweaty during the final assault, he changed his shirt and continued his attack against Elaina. The varying ages of Elaina's injuries indicate that this was a continuously abused child, and whether for sexual gratification or sadistic infliction of pain, the father's sodomy of his daughter constituted torture, and torture qualifies as special circumstances justifying the death penalty.

Elaina's father appeared to have an awareness of his actions and explored the nature of his crimes. Law enforcement found evidence that he had researched and written notes on the law regarding unlawful sex with a minor. His notes indicate that he misread the Penal Code section that designates sex with a minor less than three years younger than the perpetrator as a misdemeanor rather than felony offense. He mistakenly interpreted this section to mean that sex with a minor under age three constitutes a misdemeanor rather than a felony.

The Department of Children and Family Services had no prior contact with this family, but received a referral at the time of Elaina's death and assessed the well-being of Elaina's surviving siblings. Both older half-sisters denied any abuse by their mother or step-father and, in fact, described their step-father as a "nice" man. The Department determined that the girls were not at risk in their mother's care and closed their case. Elaina's mother and sisters moved outside of Los Angeles County soon after Elaina's death.

Information regarding criminal justice system involvement in child homicides by parents/caretakers/family members is gathered from three sources: the Los Angeles County District Attorney's Office (DA), Los Angeles Police Department (LAPD) and Los Angeles Sheriff's Department (LASD). Additional law enforcement agencies were contacted to provide information and participate in Team reviews of cases they have investigated. The number of cases for which each law enforcement agency was responsible is shown in Table 8.

LAPD had investigative responsibility for 36.5% (n=13) of the 2000 child homicides by parents/caretakers/family members, a 23% decrease from the 17 cases investigated in 1999. LASD had investigative responsibility for 36.5% (n=13) of the child homicides by parents/caretakers/family members as well, a 27% decrease from the 18 cases they investigated in 1999. 27% (n=9) of the child homicides committed by parents/caretakers/family members in 2000 were handled by jurisdictions outside LASD and LAPD. The seven additional law enforcement agencies responsible for these investigations in 2000 are identified in Table 8.

71% (n=25) of the law enforcement investigations resulted in presentations to the DA for potential filing of criminal charges. This percentage is consistent with the 12-year average of 71.5%. Law enforcement presentation percentages for the past 12 years are displayed in Figure 10.

Ten of the cases of child homicide by parents/caretakers/family members committed in 2000 were not presented to the DA for the filing of criminal charges. The reasons that these cases were not presented are displayed in Table 9. Five of these cases were not presented as the perpetrator, in each case a parent, committed suicide after killing the child.

In two additional cases, law enforcement indicated that there was insufficient evidence of a crime. In the first such case, a 3-year old girl with a seizure disorder was reportedly left unattended in the bathtub by her mother. The mother stated that when she returned to the bathroom, the child was found floating face down in the tub. While the Coroner noted additional injuries to the child and moded the case a homicide due to caretaker neglect, law enforcement did not believe that the mother's behavior "evidenced a gross departure from the accepted standard of care." In the second case believed to have insufficient evidence of a crime, a 17-day old boy died of pneumonia and anemia. The Coroner moded this case homicide, stating that the child had been neglected by his mother who had not taken him to the doctor. Law enforcement did not present this case to the DA for the filing of criminal charges, stating that "it is not a crime or neglect for a parent not to take a child to the doctor when the child has a cough and runny nose."

An additional case was not presented to the DA as the perpetrator's identity remains unknown. In this case, a full term newborn girl was left in a trash dumpster behind a grocery store and died of probably asphyxiation. Despite fingerprinting and search efforts, law enforcement was unable to identify and locate the baby's mother or father. In an additional case, a law enforcement presentation was not made to the DA due to the age of the suspect. In this case, a 14-year old girl died due to smoke and soot inhalation and body burns in a residential fire. The Coroner moded this case a homicide resulting from a fire following a domestic dispute. However, law enforcement suspects that the girl's young brother started the fire while playing with matches and that there is insufficient evidence of a crime. In the final case of homicide that was not presented to the DA, law enforcement continues to investigate the crime of a 4-year old girl who was pushed or fell off a cliff while walking with her father, a non-custodial parent.

The DA filed criminal charges in 88% (n=22) of the 25 homicide cases presented to them by law enforcement. The percentage of case presentations which have resulted in the DA filing criminal charges has ranged from 66% to 97% over the past 12 years, as represented in Figure 11.

Three of the child homicides committed by parents/caretakers/family members in 2000 that were presented to the DA for the filing of criminal charges were rejected. In the first case, a 5-month old boy died as a battered child of numerous injuries, including a skull fracture that was 2 to 4

FIGURE 10

1990 - 2000 LAW ENFORCEMENT PRESENTATION % OF ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS

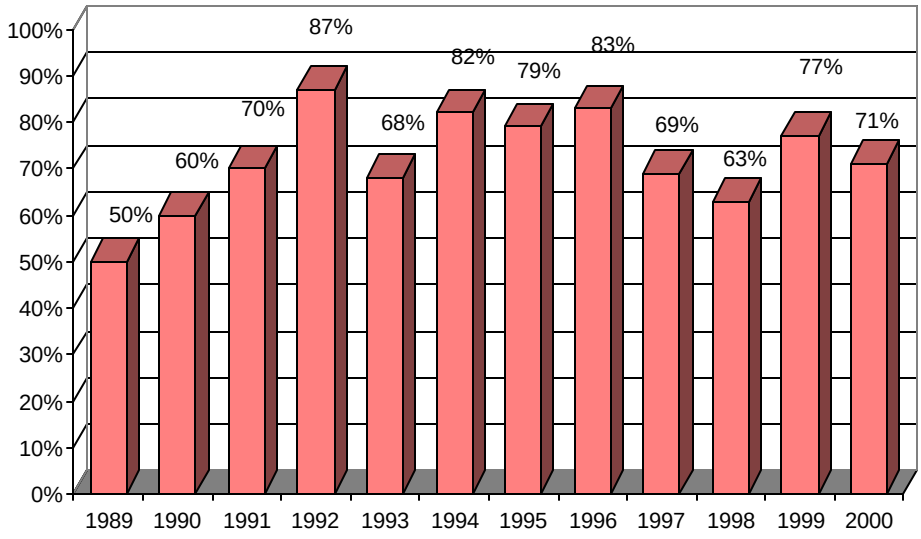


TABLE 8

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/ FAMILY MEMBERS

Agency	n	%
LASD	13	36.5
LAPD	13	36.5
Long Beach P.D.	2	6
Glendale P.D.	2	6
Compton P.D.	1	3
Hawthorne P.D.	1	3
Ontario P.D.	1	3
Pomona P.D.	1	3
Redondo Beach P.D.	1	3

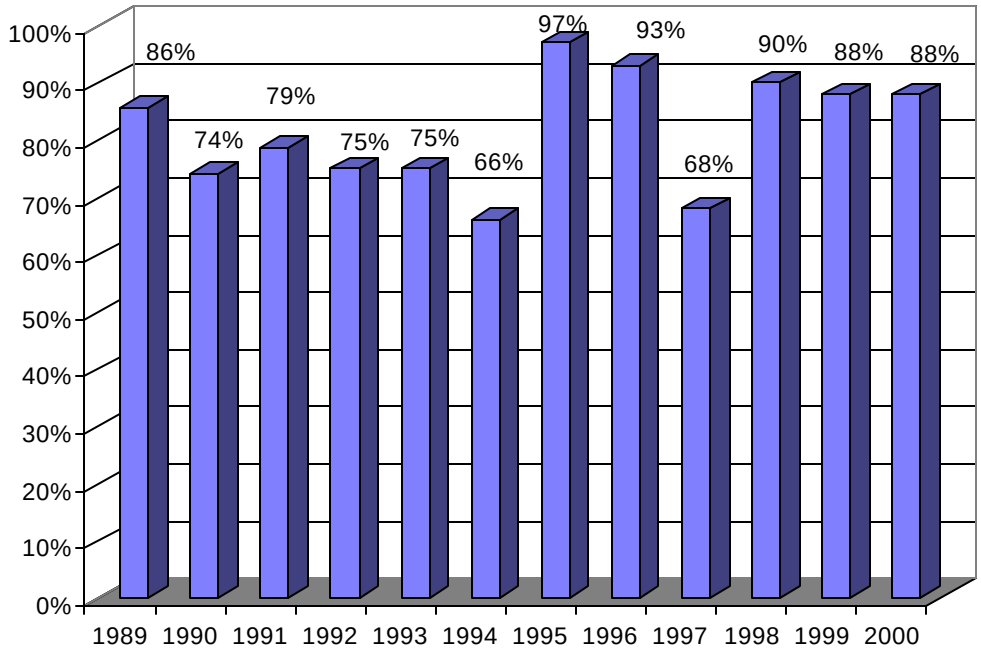
TABLE 9

LAW ENFORCEMENT REASONS FOR NOT PRESENTING 2000 ICAN CHILD HOMICIDES BY PARENT/CARETAKERS/ FAMILY MEMBERS

Reason	n	%
Murder/suicide	5	50
Suspect's identity unknown	4	10
Suspect to young	1	10
Insuffiecient evidence of a crime	1	20
Still under review	1	10

FIGURE 11

1990 - 2000 ICAN CHILD HOMICIDES BY PARENT CARETAKERS FILING RATE
ON CASES PRESENTED TO THE DISTRICT ATTORNEY BY LAW ENFORCEMENT



CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

TABLE 10

CRIMINAL CHARGES FILED ON 1990 - 2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

CRIMINAL CHARGES	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Murder (187 P.C.)	16	28	30	12	21	32	37	19	23	28	20
Child abuse causing death (273ab P.C.)						23	16	12	16	14	13
Child endangerment (273a(a) P.C.)						9	5	6	5	10	1
Child endangering (273a(1) P.C.)	7	13	11	12	9	3	3			4	5
Corporal punishment or injury of child (273d P.C.)			5	3	3	1	3	2	4	4	1
Child abuse resulting in death (273a(a)2 P.C.)					1		13				
Ex-convict in possession of a firearm (12021 P.C.)					1						
Voluntary manslaughter (192a P.C.)						1	1				
Involuntary manslaughter (192b P.C.)	4	6		4			2		2	1	3
Lewd and lascivious acts (288a P.C.)		1				3					
Use of a deadly or dangerous weapon (12022 P.C.)	1									1	
Kidnapping (207a P.C.)	1						1				
Accessory after the fact (37 P.C.)				1				2			
Possession of a controlled substance (11350 H&S)			1								
Mayhem (232 P.C.)											1
Unlawful detention (278 P.C.)	1										
Obstructing or resisting arrest (69 P.C.)		1									
Battery against a peace officer (243b P.C.)		1									
Conspiracy (182a(5) P.C./32 P.C.				1			2				1
Spousal abuse (273.5 P.C.)				1		1					
Penetration of a genital/anal opening (289 P.C)				1		1					1
Sodomy (286 P.C.)						1					
Torture (206 P.C.)						1					
Forgery / uttering a bad check (476aa P.C.)						1					
Under the influence of a controlled substance (11150 H&S)						1					
Unlawfully causing a fire of any structure (451B)											
Poisoning or adulterating food, drink, medicine (347A)							6 1		4		
Criminal storage of firearms (12035 B1)							1		1		
Assault producing great bodily injury (245(A) P.C.)								2			1
Possession of drugs for sale (11378 H&S)										2	
Juvenile Defendant/Murder (602WIC/187P.C.)										2	
Juvenile Defendant/Child Endangerment (602WIC/273a(a)P.C.)										1	

FIGURE 12

MURDER FILINGS FOR CRIMINAL CASES - ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS 1990 - 2000

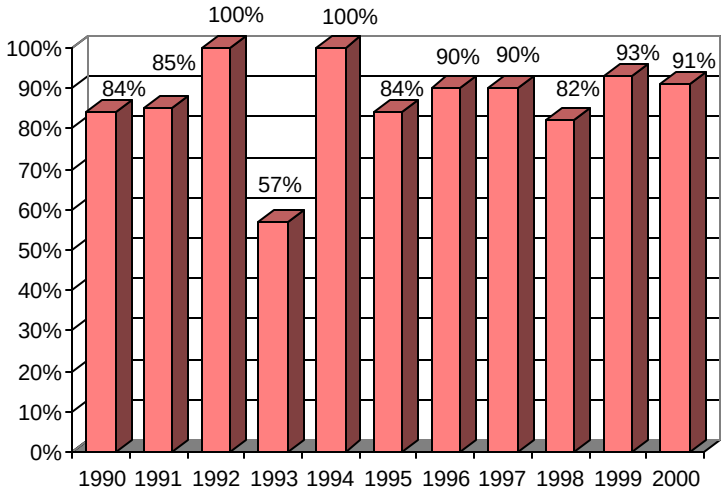


TABLE 11

RELATIONSHIP OF PERPETRATORS BY CHILD 2000 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

Relationship	ID'd by Police	Charged by DA
Mother	15	8
Father	11	7
Mother's boyfriend	2	2
Stepfather	2	2
Sibling (Male)	1	0
Cousin (Female)	3	3
Cousin's Boyfriend	3	3
Aunt	1	1
Uncle	1	1
Grandmother	2	1
DayCare Provider	1	0

TABLE 12

CRIMINAL CASE DISPOSITION OF 1990 - 2000
CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

CRIMINAL CASES	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Life wirhout possibility of parole		1									
49 years to life prison			1				1				
35 years to life prison								1			
30 years to life prison			1		1			1			
29 years to life prison				1							
28 years to life prison						1					
26 years to life prison		1									
25 years to life prison	1		2	1				1	1	4	3
24 years to life prison			1								
22 years to life prison				1							
21 years to life prison			1	1							
19 years to life prison			1								
16 years to life prison						1		1			
15 years to life prison		7	4	3	2	1	1	1		4	1
14 years prison			1								
13 years prison	1									1	
12 years prison						1				1	
11 years prison	3	1	5		2	2		2		2	1
10 years prison			1			2				1	2
9 years prison			2	1	1		1				
8 years prison		1								1	1
7 years prison		5				1				2	
6 years prison		2	1	1	1	2				1	3
5 years prison				1							
4 years prison		1	2	1		2		1	1		
3 years prison			2		1	2	2				
2 years prison		2		3		1					
16 months prison		1	1				1				
1 year jail	3	2	4	3	1	2		1			1
9 months jail				1							
6 months jail			1	1		1					
Less than 3 months jail	2	2									1
CYA commitment	1										
10 yrs Probation		1									
6 yrs Probation		1									
5 yrs Probation	1	1					1			3	
4 yrs Probation										2	
3 yrs Probation		1	1	2			1			3	1
Juvenile probation order	1				1						
Found not guilty		2	1	1						1	
Dismissed	1	2	3		1	3	3	1		1	1
Warrant pending	1				2		2		1		1
Hearings suspended due to insanity plea					1						
Sentence pending	1		1	1	1	1	8			6	7
Pending trial	4	1		1	6	16	23	12	28		
Matter on appeal prior to trial										3	
Unable to locate record	1	2	1	3						1	
TOTAL	**21**	**36**	**38**	**27**	**21**	**39**	**44**	**21**	**31**	**37**	**23**
Total C/A Homicides for year	**46**	**61**	**46**	**41**	**39**	**48**	**53**	**45**	**49**	**44**	**35**

weeks old at the time of his death and other injuries, including abdominal contusions and rib fractures of various ages. The baby's mother and father did not live together, but both spent time with the child in the weeks preceding his death and had unmonitored contact with the baby. In addition, the baby and his mother lived with several other adults who also had contact with the child. The DA rejected the filing of criminal charges in this case, citing an inability to identify who actually inflicted the child's injuries and who was with the child at the time of his death.

In a second case rejected by the DA, a 6-month old girl died in the care of a licensed day care provider. Upon initial investigation, the day care provider denied the child had suffered any injuries in her home. She later stated the child had fallen off a bed onto a carpeted floor, and yet later stated she had lost her footing and dropped the child onto a linoleum floor. The Coroner indicated that the child's injuries were inflicted, most likely by shaking, rather than accidental, and were inconsistent with the story provided by the day care provider. However, the medical examiner stated that while he was confident this was a non-accidental death, some medical literature suggests that such severe injuries could have resulted from a fall, provided the fall was accelerated or involved independent spinning of the head as the baby impacted the floor. The DA stated that they could not file charges as there was insufficient evidence to establish that the day care provider had purposefully injured the child.

In the final case rejected for the filing of criminal charges, a 4-year old girl drowned in her residence pool. She had been left alone for several hours when her grandmother, her primary caregiver, went out shopping. The Coroner moded this a homicide due to caregiver neglect, but the DA rejected the filing of criminal charges due to "lack of evidence that any type of neglect or abuse led directly to the child's death."

The number of cases rejected by the DA has fluctuated over the past 11 years. In 1990, 5 cases were rejected; in 1991, 7 cases were rejected; in 1992 10 cases were rejected; in 1993, 5 cases were rejected, and in 1994, 11 cases were rejected. However, in 1995 no cases were rejected and in 1996 and 1998, only 3 cases were rejected. In 1997, the number had increased and 8 cases were rejected, and in 1999 the number of cases rejected decreased to 4.

The criminal charges filed on the child homicides by parents/caretakers/family members perpetrated from 1990 through 2000 are listed in Table 10. Murder charges (PC 187) were filed on 91% (n=20) of the 22 cases in which charges were filed and 63% of the total number of child homicides perpetrated in 2000. The rate of murder filings for those cases in which criminal charges are filed has ranged from 57% to 100% over the past 11 years. The percentage of cases in which murder charges were filed between 1989 and 2000 is displayed in Figure 12.

Felony child abuse charges [PC 273ab, 273a(a) and 273d] were filed on 77% (n=17) of the 2000 cases in which criminal charges were filed. This is a 17% decrease from 1999 when felony child abuse was charged in 93% of the cases in which charges were filed. As in prior years, several categories of criminal charges were filed by the DA in response to child homicides by parents/caretakers/family members that occurred in 2000. Table 10 illustrates the charges filed for the child homicides that occurred in the past 11 years.

In once case of child homicide in 2000, a father was previously charged and convicted of assault with a deadly weapon and willful harm or injury to a child and was sentenced to three years of formal probation. The father admitted to throwing his 6-month old son off the bed, causing the child severe brain damage and years of debilitation. This tragic event occurred in 1993. Seven years later, in 2000, the boy died of these earlier injuries inflicted by his father and his father was charged with murder and assault resulting in the death of a child under age. He pled guilty to involuntary manslaughter and was sentenced to 6 years in prison for this 2000 child homicide.

The relationship of the perpetrators to the deceased children, as identified by law enforcement, and those perpetrators charged by the DA are listed in Table 11. In 2000, for the ninth straight year with the exception of 1996, mothers have been identified by law enforcement as the relation most frequently involved in the deaths of these children. Fathers

were the second most frequent perpetrators identified in 2000. In both 1999 and 2000 child homicides, more female perpetrators (n=22) than male perpetrators (n=20) were identified by law enforcement. In most prior years, more male perpetrators were identified. While more female perpetrators than male perpetrators were identified in 2000, more male perpetrators were criminally charged by the DA than female perpetrators. With the exception of 1999, this is consistent with prior years, when more male perpetrators have been criminally charged. It should be noted that in 2000, there was a diverse group of perpetrators, including mothers, fathers, stepfathers, mothers' boyfriends, grandmothers, a sibling, a cousin, cousin's boyfriend, aunt, uncle, and day care provider.

Multiple perpetrators were identified by law enforcement in 7 child homicides by parents/caretakers/family members that occurred in 2000. This included three siblings who were killed by their cousin and her boyfriend as well as children killed by their mother and father (2 cases), mother and stepfather (1 case) and mother and her boyfriend (1 case). The DA brought charges against both perpetrators in all seven of these child deaths.

Criminal disposition data for the period of 1989 through 2000 are displayed in Table 12. As in 1999, the percentage of cases still in the pending status remains relatively low at 30%; seven of 23 cases remain in pending status and all 7 are either set for pretrial or trial at the time of this report writing. In addition, it should be noted that 3 of these 7 cases involve one criminal case of multiple homicide in which law enforcement identified that three siblings were killed by their cousin and her boyfriend. In previous years, the percentage of pending status cases has been as high as 90%; the reasons for the tremendous drop in 1999 and 2000 appear to reflect better responses from the DA and investigating law enforcement agencies.

Three perpetrators in the 2000 child deaths were sentenced to 25 years to life. In comparison, 4 perpetrators identified in the 1999 child deaths were sentenced to 25 years to life and none of the perpetrators identified in the 1998 child deaths were sentenced to this extensive a period of time. One perpetrator was sentenced to 15 years to life in the 2000 child deaths while 4 perpetrators were sentenced to this period of time in the 1999 deaths. The number of perpetrators sentenced to possible life in prison in prior years was 8 for 1999 deaths, 1 for 1998 deaths, 5 for 1997 deaths, 2 for 1996 deaths, 3 for 1995 deaths, 3 for 1994 deaths, 7 for 1993 deaths, 11 for 1992 deaths, 9 for 1991 deaths, 1 for 1990 deaths, and 9 for 1989 deaths.

Three of the perpetrators of child deaths by parents/caretakers/family members in 2000 received jail time of one year or less or probation only. This compares to 8 in 1999, 0 in 1998, 1 in 1997, 2 in 1996, 3 in 1995, 2 in 1994, 7 in 1993, 6 in 1992, 8 in 1991, 7 in 1990 and 1 in 1989.

There was one case dismissal for 2000 child deaths by parents/caretakers/family members. In this case, the judge dismissed murder and child assault charges against the mother of a 1-year old boy and her boyfriend as it was difficult for the prosecution to establish who was actually inflicted a beating that killed the child. Charges were re-filed against the mother alone alleging child endangerment leading to death, but these charges were also dismissed as the judge felt that the case could not be proven beyond a reasonable doubt. In prior years there has been an average of 3 acquittals or dismissals with exceptions in 1990, 1993 and 1997 when there was only one dismissal or acquittal per year. In addition, one warrant was issued for a child death in 2000. In this case, a 13-year old girl was stabbed to death by her adult uncle when she refused his sexual advances. Murder and assault charges were brought against the uncle who reportedly fled the country and a warrant remains pending in this child's death.

DEPARTMENT OF HEALTH SERVICES INVOVLEMENT

Officers from the Los Angeles Police Department (LAPD) responded to the scene of a domestic dispute. According to neighbors who called police, a young couple was arguing loudly outside the front of their building. The couple did not live together but were the parents of a seven-month old girl named Teri. Teri's father had not seen Teri for several weeks and was concerned with her well-being. He went looking for the mother and found her on the street. He followed her back to her apartment, questioning her continually about Teri's whereabouts, but the mother was evasive, stating at first that the child was with her relatives and then indicating she was not sure where Teri was. The father became irate and this led to the couple's loud argument.

Teri's mother was known by local authorities to be a dealer and user of narcotics. She had a criminal history dating back to her youth when she was arrested for various offenses including possession of marijuana on school grounds, receiving stolen property, taking a vehicle without the owner's consent, possession of narcotics/controlled substances, and sale and possession of cocaine. When police questioned her, she indicated that she had not seen Teri for three days.

Police entered the apartment and found Teri's body lying on a couch. She had obviously been dead for some time when they discovered her. Scene investigators reported that the apartment was filthy and littered with food and clothing. Teri wore no clothing but was covered with various articles of adult clothing. There were several cans of baby formula, covered with filth in the kitchen. A baby bottle partially filled with water was found on a coffee table near the child, outside of her reach. Also on the coffee table were marijuana cigarettes and razor blades with a white powdery substance, later identified as cocaine.

Teri's mother told police that Teri had appeared not to be breathing; rather than obtaining help, she left the residence without notifying anyone. She was unclear when this had occurred and when she had last seen her daughter. The Coroner indicated that Teri had been dead for several weeks at the time of her discovery and was in a mummified state. There were no signs of trauma, and toxicology results were negative for drugs. Teri's death was ruled a homicide by maternal neglect.

Teri's mother was subsequently arrested for murder, assault resulting in the death of a child under age eight and willful harm or injury to a child. While in custody, she underwent a psychological evaluation; her information processing level tested at age six and her academic skills at the 3rd or 4th grade level. She obviously required a great deal of assistance to properly care for her child and had not received this assistance. Due to her cognitive deficits, the District Attorney reduced the charges against her believing that she may not have fully understood the consequences of her actions. Teri's mother pled guilty to child abuse with a special allegation that the abuse resulted in death and was sentenced to ten years in State prison.

Team discussions in this case revolved around mother's developmental deficits and what services could have been provided to assist her in properly caring for Teri. The Team hypothesized that health care providers who were in contact with Teri and her mother, including those who provided prenatal care, those where Teri was born and those who provided pediatric care, could have referred Teri and her mother for services. However, Team members present who had had contact with the mother indicated that she was very cooperative and that her behavior was misleading in that she did not appear to be developmentally delayed. Notations in medical records made at ten prenatal visits and several pediatric visits, reflected no concern with the mother's ability to parent. Team members recommended that hospitals be provided with mandatory training regarding referrals to the Department of Children and Family Services (DCFS) and/or Public Health Nursing (PHN) programs for such high risk-situations when identified. Team discussion also focused specifically on addressing this woman's needs in prison and thereafter, as she will still be of childbearing age when she is released from prison and could easily give birth and parent another child.

Computer searches for Los Angeles County Department of Health Services (DHS) involved a search of records at four different County facilities: LAC/USC Medical Center, Harbor UCLA Medical Center, King-Drew Medical Center and Olive View Medical Center.

Computer searches for 2000 indicated that 34% (n=12) of the victims of child homicide by parents/caretakers/family members had medical records at these DHS facilities. Five children had records at King-Drew Medical Center, four at LAC/USC Medical Center, two at Olive View Medical Center and one at Harbor UCLA Medical Center.

Over the past 12 years (excluding 1997 when information was available from LAC/USC only), an average of 24.3% of the child victims of homicide by parents/caretakers/family members have had DHS medical records, ranging from last year's low of 9% to this year's high of 34%. Previous medical records are noted in large part for their absence.

Place of death data was provided by the Coroner for the 2000 homicides. Twenty-one of the victims were involved with a total of 11 different medical facilities at the time of the deaths. Eight of the children who were not declared dead in medical facilities died in their own residences. One newborn was killed and dumped in a trash bin and another was found at a trash transfer station, although the Coroner could not determine place of death in this case. Two children died in the ocean and one died on a city street. In addition, one child's body was found encased in concrete and the place of death could not be determined.

Joey, age 5, and his sister, Lindsay, age 3, died in a residential fire in their grandmother's home. Both children had been removed from their parents' care at birth due to substance abuse and placed with their paternal grandmother by the Department of Children and Family Services. Joey was returned to his father's care and his case was closed but his father found that he could not care for Joey and subsequently left Joey with his parental grandmother. While Joey's case was closed, his grandmother had been granted guardianship of Lindsay who remained in an open case with the Department of Children and Family Services at the time of the fire. Social workers visited the children and their grandmother in their home on a regular basis; the children appeared to be well cared for and lovingly attached to their grandmother.

The children's grandmother initially reported that the children were playing in a downstairs bedroom when Joey grabbed a lamp, which fell off the bookcase and onto the couch. The bulb was quite hot and the couch caught fire. The fire spread rapidly and the grandmother yelled to the children to get out of the house, while she ran to the kitchen to get flour or baking soda to douse the flames. Tragically, rather than running out of the home, the children ran upstairs. The fire quickly engulfed the room and their grandmother fled the home. The children's grandmother reported that when she got outside and discovered the children were not there, she reentered the home in an effort to save the children, but flames held her back and she was severely burned. She was hospitalized in critical condition and was initially not notified of the children's deaths as medical staff were concerned that this would negatively impact her will to live and so her survival.

The children's deaths were investigated by detectives from the local law enforcement agency, arson investigators with the Los Angeles County Fire Department, and representatives of the Bureau of Alcohol, Tobacco and Firearms (ATF). As the investigation continued, the children's grandmother recovered and was able to provide clearer information about the circumstances of the fire. It was determined that while there was a lamp located next to the couch where the fire originated, it was most likely not the cause of the fire. Joey reportedly had a history of fire setting, having started at least three previous fires, including one in this same residence. Both grandmother's husband and another adult male who resided in the home smoked, and lighters were accessible to the children. Grandmother clarified that on the evening of the fire, she saw a light by the bed downstairs in their two-story residence. She discovered a quilt on fire next to Joey and told him to get back while she picked up the quilt, causing the fire to flare up and causing grandmother's severe burns. As earlier reported, she yelled at the children to go outside but they tried to escape by running upstairs instead.

The Coroner reported that Joey was identifiable after the fire so a full autopsy was not required. Joey was found to have a high carbon monoxide level. Lindsay was not identifiable and had to be identified through dental records. An autopsy was performed and she, too, was found to have an elevated carbon monoxide level as well as soot in her airways. There were no previous signs of trauma on either child.

The Child Death Review Team reviewed risk factors most associated with house fires, including adult intoxication. Allegations were made that the children's grandmother had a drinking problem and may have been incapacitated at the time of the fire; however, investigators reported that, based on their numerous contacts with the family, it was clear substantial conflict existed between the grandmother and family members who made these allegations. Allegations of alcohol abuse and incapacitation were not substantiated and the deaths were ruled accidental. Other risk factors associated with fire fatalities, including the absence of fire detectors, were also discussed; in this tragic case, the family was almost immediately aware of the fire and detectors would not have resulted in a different outcome. However, fire extinguishers, keeping lighters away from children, and a better understanding of how fires spread may have proved life-saving.

The tragic accidental deaths of these two young children are a good example of the many accidental

deaths reviewed by the Team. Many such deaths may have been prevented with improved vigilance regarding child safety by caregivers or with improved vigilance by systems and agencies charged with the care and safety of children.

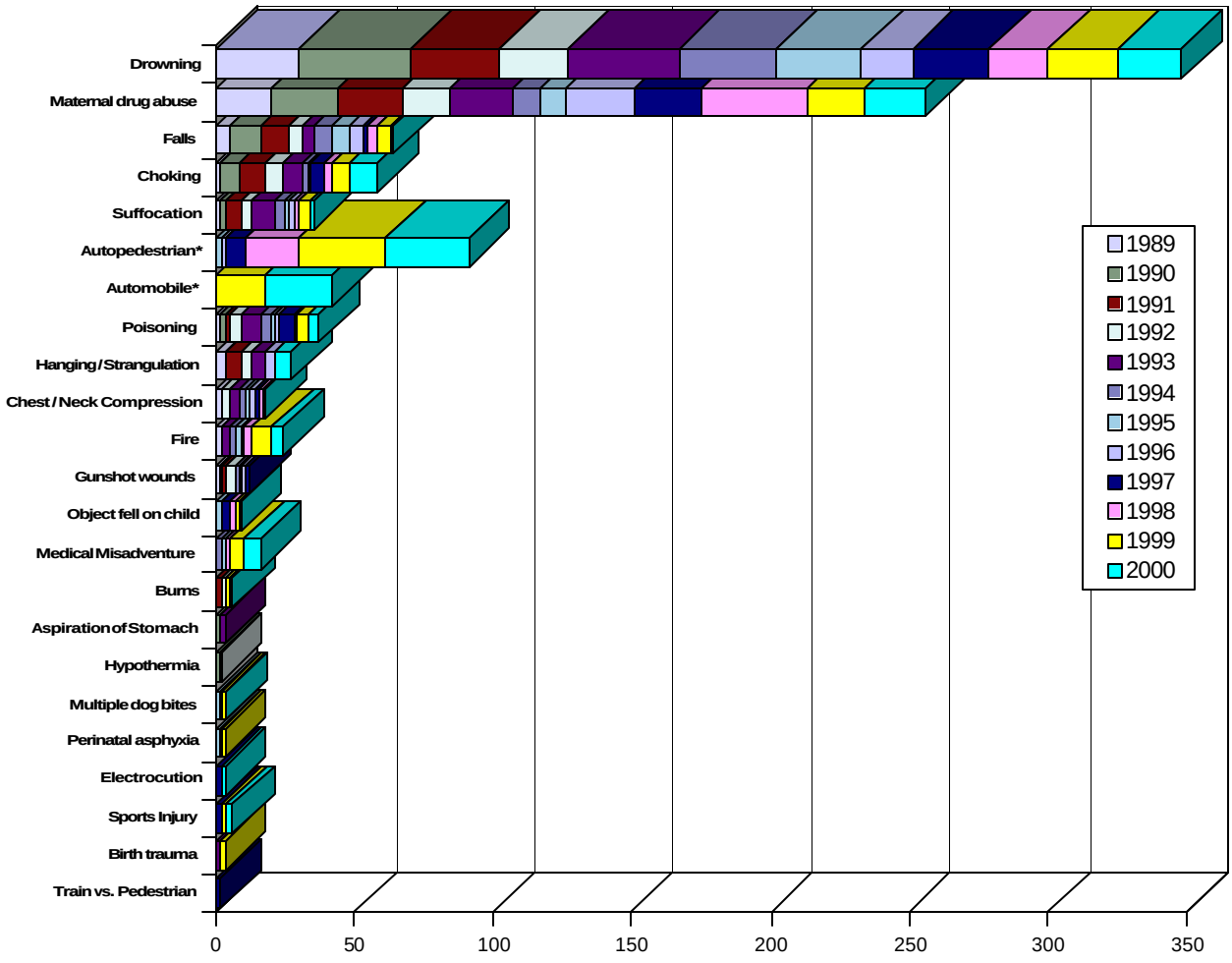
ACCIDENTAL CHILD DEATHS

Accidental deaths are of interest to the Team as one of the Team's primary missions is to identify prevention strategies and the Team is interested in questions of child safety and supervision by care providers at the time of the accident. Accidental deaths have been determined by investigating agencies, law enforcement and the Coroner to be inadvertent and unintended. Many, if not all, of these deaths are preventable.

One hundred thirty-seven accidental child deaths were reported to the Team by the Coroner for 2000. This is a slight (2%) increase over the 134 accidental child deaths reported in 1999. However, as noted in other sections of this report, the Team's protocol was expanded in 2000 to include accidental deaths up through age 14 (with the exception of drowning deaths through age 17) rather than through age 12 as in 1999. Inclusion of accidental deaths for children age 13 and 14 accounts for 15 of the 137 accidental deaths. If 13 and 14-year olds were excluded as they were in 1999, 122 accidental deaths would have been reported for 2000, a decrease of 8% from reported 1999 accidental child deaths. Over the previous eleven-year period (1989 to 1999), the number of accidental deaths reported to the Team ranged from a low of 59 in 1995 to a high of 134 in 1999.

FIGURE 13

1989 - 2000 CAUSES OF ICAN ACCIDENTAL CHILD DEATHS



** Autopedestrian deaths were not reported until 1995; Automobile deaths were not reported until 1999.*

CAUSE OF DEATH

The causes of the accidental deaths between 1989 and 2000 are displayed in Figure 13 and Table 13. As in 1999, the leading cause of accidental death in 2000 was autopedestrian deaths. Thirty children died as a result of autopedestrian deaths, including five children on bicycles and one child riding a scooter. Prior to 1995, accidental deaths due to automobiles v. pedestrians were not reviewed by the Child Death Review Team; however, since that time, the number of autopedestrian deaths has steadily increased until this year, when the number remained fairly constant with last year's number of 31. In 1995, two such deaths were reported to the Team; in 1996, one death; in 1997, eight deaths; in 1998, 19 deaths; and in 1999, 31 deaths. It is possible that the large increase in the number of autopedestrian deaths between 1995 and 1999 does not represent an actual increase in the incidents of these deaths, but instead reflects changes in the Team's data collection which have promoted greater identification of these deaths by the Team.

The second leading cause of accidental death in 2000 was automobile accidents. There were 24 automobile accidents (including automobile v. automobile and solo automobile accidents) for children age zero through 14. The Team first began looking at accidental automobile deaths in 1999; in that year, there were 18 such deaths. As previously noted, accidental deaths of children age 13 and 14 (other than drowning which includes through age 17) are included for the first time in this year's report. Thirteen and 14-year olds represent five of the automobile accident deaths and contribute to the increase in the number of 2000 automobile deaths reviewed by the Team. Without their inclusion, there were 19 automobile accident deaths for children age zero to twelve, a number consistent with the previous year's 18 deaths.

The third leading cause of accidental death in 2000 was drowning. There were 23 accidental drowning deaths in 2000, an 8% decrease from 1999 (n=25). Fifteen of the drowning victims drowned in pools (including one residential spa), three drowned in bathtubs, two in rivers, one in a public pond park, and one in the ocean. Finally, one young toddler died when she fell head first into a bucket of rain water. The lowest number of child drowning deaths was 18 in 1996, followed by 21 in 1998 and 23 this year. The highest number of drowning deaths occurred in 1990 and 1993 (n=40).

Deaths associated with maternal substance abuse were the fourth leading cause of accidental death in 2000. Such deaths are primarily reflected in fetal deaths and very young, prematurely born infants with prenatal exposures. However, in 2000, one ten-year old girl died of a seizure disorder associated with her prenatal drug exposure. In 2000, there were 22 deaths associated with maternal substance abuse, a number which remains fairly constant with the 21 such deaths reported in1999. The 38 deaths associated with maternal substance abuse in 1998 were the highest number of these deaths since ICAN began collecting this data. The second highest number occurred in 1996 (n=25) and the lowest was nine in 1995.

As in prior years, other causes of accidental deaths include choking; hanging/strangulation; fire; suffocation; ingestion of drugs or other poisons, including two brothers who died from oleander poisoning and a teenager who accidentally overdosed on prescription medications; sports injuries; falls; electrocution; multiple dog bites; medical procedure errors; and injuries suffered as a result of objects falling on young children.

GENDER

TABLE 13

CAUSES OF ACCIDENTAL DEATHS 1989 - 2000

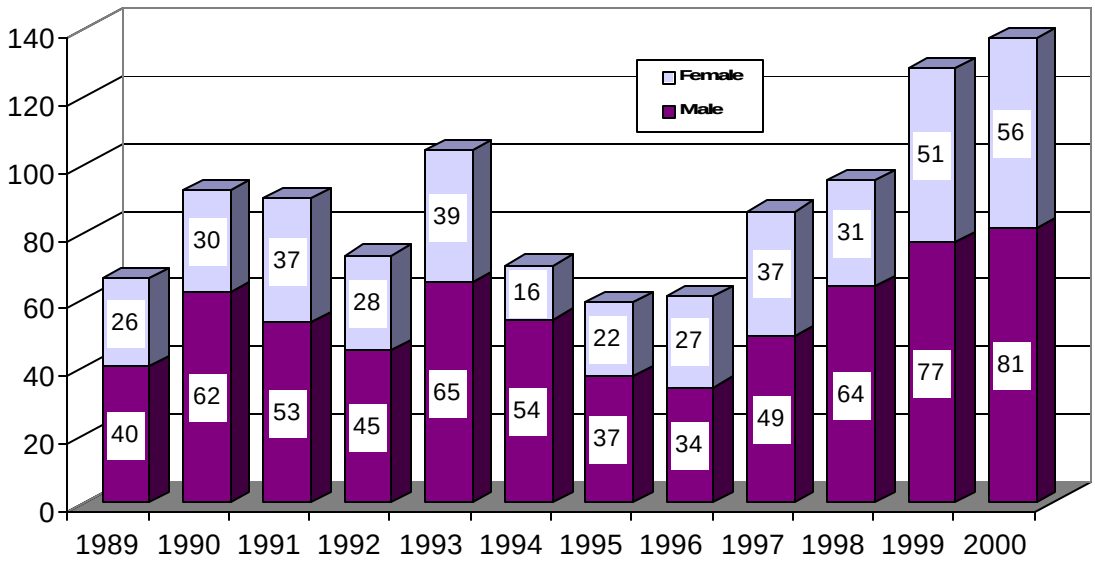
	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Total
Drowning	30	40	32	25	40	35	31	18	28	21	25	23	348
Maternal drug abuse	20	24	23	17	23	10	9	25	24	38	21	22	256
Falls	5	11	10	5	4	7	6	5	2	3	5	1	64
Choking	1	7	10	6	7	2		1	5	3	6	10	58
Suffocation	1	3	5	4	8	4	1	2		2	4	1	35
Autopedestrian**							2	1	8	19	31	30	91
Automobile***											18	24	42
Poisoning	1	3	1	4	7	4	1	1	6	1	4	4	37
Hanging/Strangulation	3	1	5	4	5			3				6	27
Chest/Neck Compression	2			3	3	3	1	2	1	2		1	18
Fire	2				3	2	2		1	3	7	4	24
Gunshot wounds	1	1	2	3		1	1	2	1				12
Object fell on child							2		3	2	1	1	9
Medical Misadventure						2	1	1		1	5	6	16
Burns			2	1	1						1		5
Aspiration of Stomach		1			2								3
Hypothermia		1		1									2
Multiple dog bites							1		1		1	1	4
Perinatal asphyxia							1		1		1		3
Electrocution									2			1	3
Sports Injury									2		2	2	6
Birth trauma					1						2		3
Train vs. Pedestrian									1				1
TOTAL	**66**	**92**	**90**	**73**	**104**	**70**	**59**	**61**	**86**	**95**	**134**	**139**	**1067**

*** Autopedestrian deaths were not referred to the Team prior to 1995.*
****Automobile deaths were not referred to the Team prior to 1999.*

Figure 14 displays the gender breakdown of the accident victims for the past 12 years. In 2000, 59% (n=81) of the 2000 accidental death victims were male and 41% (n=56) were female. Over the past 12 years, the percentage of male victims has ranged from 1996's low of 56% to a high of 77.1% in 1994. Males have outnumbered females since data began being collected in 1989.

FIGURE 14

1989 - 2000 ICAN ACCIDENTAL CHILD DEATHS BY GENDER



AGE

Figure 15 displays the ages of the 2000 accidental death victims. As in past years, the highest number of accidental child deaths occurred in children under one year of age. Twenty-five percent (n=34) were under the age of one year; 23% (n=31) were under the age of six months. Twenty-one of the 31 accidental deaths that occurred in those under age six months involved deaths due to complications of maternal substance abuse. These deaths include 18 fetal deaths, two drug-exposed newborns who died on the day of their birth and one infant who died at age 18 days due to complications associated with in utero drug exposure. The number of accidental deaths decreased for children between age one and four and increased again for children age five to nine (n=28) and age ten years and over (n=27).

The 30 children who died as a result of being hit by an automobile in 2000 ranged in age from one to 13 years of age; ten children were age three or younger. The four oldest autopedestrian accident victims (two age 12, and two age 13) were riding bicycles when they were struck by vehicles.

Drowning victims ranged from one to ten years of age, and the average age of drowning victims was four years old. The average age of drowning victims increased slightly in 1997 when the Team protocol was expanded to include drowning deaths for ages 17 and under. Forty-three percent of the 23 drowning victims in 2000 were two years of age or younger. While in 1999 two drowning victims, aged 15 and 16 died as a result of swimming fatigue, in 2000, the oldest drowning victim was age ten.

The 24 children who died in automobile accidents (auto v. auto and solo automobile accidents) in 2000 ranged in age from zero (fetal deaths when mothers were killed or injured in automobile accidents) to fourteen. The average age of child automobile accident victim was six and half years of age. Again, it should be noted that five of these victims were over age 12 and would not have been included in last year's analysis.

FIGURE 15

2000 ICAN ACCIDENTAL CHILD DEATHS BY AGE

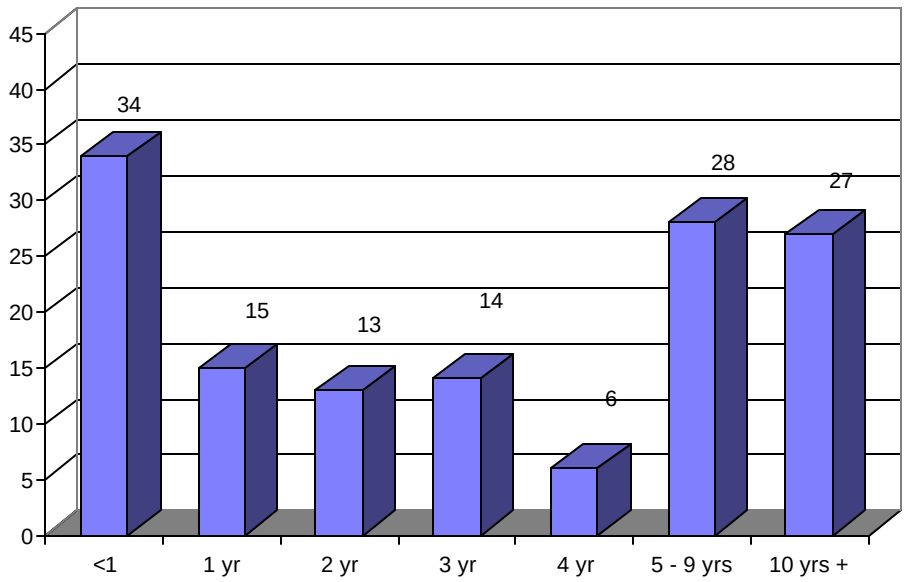


TABLE 14

ETHNICITY OF ICAN ACCIDENTAL DEATHS 2000

	Hispanic	African American	White	Asian	Unknown
Maternal drug abuse	5	11	5	0	1
Drowning	11	6	4	2	0
Autopedestrian	16	6	4	4	0
Automobile	17	3	4	0	0
Choking	7	2	1	0	0
Falls	1	0	0	0	0
Fire	1	3	0	0	0
Suffocation	0	1	0	0	0
Chest/Neck compression	1	0	0	0	0
Object fell on child	0	0	1	0	0
Poisoning	1	0	3	0	0
Medical Misadventure	3	1	2	0	0
Hanging/Strangulation	5	1	0	0	0
Other	2	1	0	1	0
TOTAL	**70**	**35**	**24**	**7**	**1**

ETHNICITY

Table 14 displays the causes of accidental child deaths in 2000 by ethnicity. Hispanic children represented 51% (n=70) of all accidental child deaths in 2000. They suffered in great disproportion the number of automobile and autopedestrian deaths (n=17, n=16) as well as the most drowning (n=11), choking (n=7), hanging/strangulation (n=5) and medical misadventure (n=3) deaths.

African American children represented 25% (n=35) of the 2000 accidental child deaths. As in most previous years, they suffered the most deaths related to maternal substance abuse; in 2000, they suffered 50% (n=11) of all maternal substance abuse deaths, which is 31% of the 35 total accidental deaths suffered by African American children. African American children also suffered 26% (n=6) of the drowning deaths and 20% (n=6) of the auto-pedestrian deaths.

White children represented 18% (n=24) of the accidental child deaths in 2000. Twenty-three percent (n=5) of the deaths related to maternal substance abuse were suffered by White children as were 17% (n=4) of the deaths due to drowning. White children suffered 75%, three of the four, poisoning/drug overdose deaths.

There were seven accidental child deaths of Asian children in 2000, none due to maternal substance abuse, four due to autopedestrian accidents and two due to drowning. In addition, one 2½-month old Asian child died when he was attacked by the family dog and died of multiple dog bites.

Finally, one accidental death was of a fetus of unknown ethnicity.

TEMPORAL PATTERN

Figure 16 and Table 15 display the incidence of accidental death for each month in 2000. The months with the greatest number of accidental child deaths were May and October (n=20 each), followed closely by July with 17 deaths. The fewest accidental child deaths occurred in January (n=4) and February (n=5).

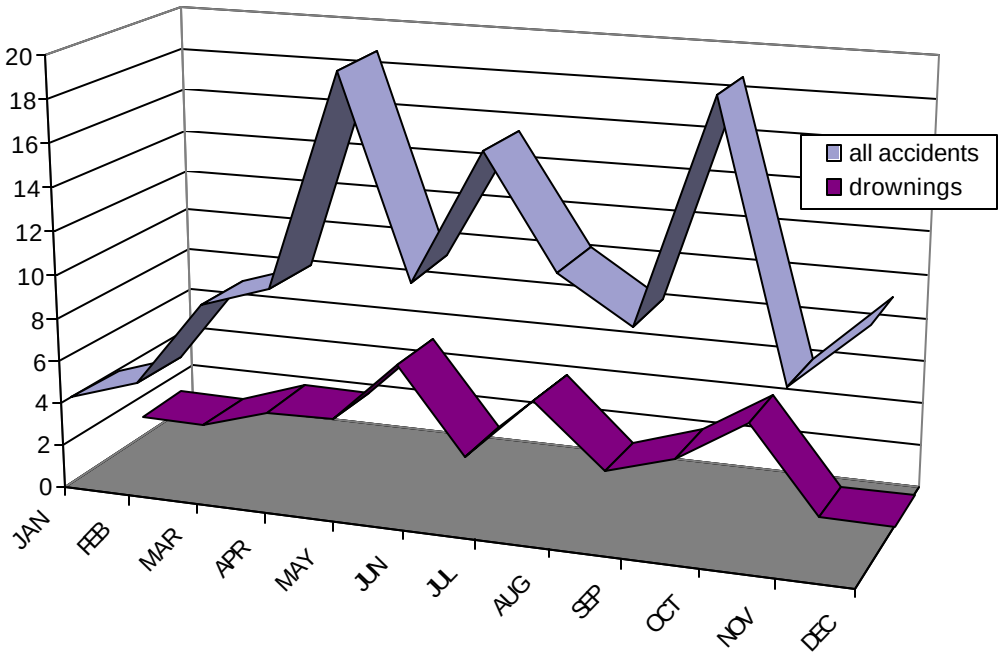
As in past years, the monthly pattern of drowning deaths was compared to all accidental deaths. As might be expected, most drowning deaths occurred in the spring and summer months; 15 of the 23 drowning deaths occurred between April and September. Eleven, nearly half of the 23 drowning deaths, occurred during the four-month period of May through August. As deaths due to drowning are one of the most frequent causes of accidental death and the majority of drowning deaths occur in the spring and summer, they impact the temporal pattern for all accidental child deaths. The months of the most non-drowning accidental deaths were October (n=16) and May (n=15).

TABLE 15
2000 ICAN ACCIDENTAL CHILD DEATHS
MONTHLY PATTERN
ALL ACCIDENTS VS. DROWNINGS

	All Accidents	Drownings
January	4	1
February	5	1
March	9	2
April	10	2
May	20	5
June	11	1
July	17	4
August	12	1
September	10	2
October	20	4
November	8	0
December	11	0

FIGURE 16

2000 ICAN ACCIDENTAL CHILD DEATHS BY MONTH



DEPARTMENT OF CHILDREN & FAMILY SERVICES INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

Figure 17 summarizes the child protection services provided for the accidental child deaths. Seventeen percent (n=24) of the families of accidental child death victims had histories of receiving child protective services prior to the child's death. Thirty-three percent (n=8) of these cases involved a death that the Coroner indicated was associated with maternal substance abuse. This percentage is relatively low in comparison to previous years when 41% to 85% of the accidental death victims whose families had prior child protective services died as a result of maternal substance abuse and when considering that deaths related to maternal substance abuse were the fourth leading cause of accidental death in 2000. Of the cases with prior protective services involvement, 25% (n=6) involved autopedestrian deaths, 12.5% (n=3) involved children who drowned and 8% (n=2) involved siblings who died in a residential fire. Child death cases involving prior child protective services also included an electrocution in which a child grabbed a dangling live wire while seated on a wet pool slide, a fall, a bicycle accident, an adolescent drug overdose, and an infant who choked on a pumpkin seed.

Table 16 provides the reasons the 24 accidental child death cases were known to the Department of Children and Family Services (DCFS) prior to the child's death. Ninety-seven previous referrals were made on these 24 families. Twenty-nine percent (n=7) of the families had one previous DCFS referral, and 21% (n=5) had three previous referrals. Two families each had two, four, five, six and nine previous referrals. One family had ten previous referrals and one family had 13 previous referrals. It should be noted that more than one type of allegation were made simultaneously (e.g., emotional abuse and caretaker absence/incapacity) in several previous referrals.

Of the 24 cases with prior child protective services, 14 were closed before the child death; three of these were opened and closed before the birth of the child that died. Several cases had been closed quite recently at the time of the child's death. In one case, allegations of physical abuse were assessed and the referral was closed as inconclusive four days prior to the child's death. This child died when she ran out from between parked cars and was hit by an ice

cream truck. A second case was opened with allegations of general neglect when a newborn girl tested positive for barbituates. The case was closed as inconclusive and less than a month later, this newborn's older brother, age two, died when he ran into traffic and was struck and killed by a pickup truck. A third case with general neglect allegations was closed as unfounded; one month later, the three-year old boy drowned in the family's swimming pool. DCFS proceeded with court action and out-of-home placement before the death in 54% (n=13) of the families that had received prior referrals for services.

Forty-two percent (n=10) of the cases that were known to DCFS were open at the time of the child's accidental death. Six of the deaths in these open cases were the result of maternal substance abuse; in all six cases, the deceased child's siblings had all been removed from the parent(s) and placed in out-of-home care at the time of the death and remained in out-of-home care after the death. Two additional open cases involved autopedestrian deaths. In one case, a nine-year old boy ran away from his group home placement with two other youth. He bolted onto the freeway and was struck and killed by oncoming traffic. In the second case, another nine-year old boy was struck and killed by a vehicle while in placement with his grandmother. In addition to these two autopedestrian deaths, a third nine-year old boy who had been placed with his maternal grandparents was killed in a bicycle accident. He was riding on the handlebars of a friend's bicycle when the friend lost control; his unhelmeted head struck the pavement and he died of massive head trauma. Finally, in the last of the ten open cases, a three-year old girl died in a residential fire reportedly caused by a lamp knocked over by her or her brother, a five-year old boy who had previously received DCFS services and was living voluntarily with his grandmother. The girl had been placed with her grandmother at birth due to prenatal drug exposure and remained in her care at the time of her death.

Of the ten cases that were open to DCFS at the time of the accidental death, nine remained open after the death. Surviving siblings were already in out-of-home placements in these nine cases and required ongoing DCFS services. In the tenth case, the child's only sibling died with her in a residential fire and DCFS services were no longer required as there were no surviving siblings. In addition to these nine cases, 21 additional families received DCFS services after their child's death. Five of these cases previously received DCFS services and were closed and reopened at the time of the death. Referrals were also received for 16 families with whom DCFS had no previous contact. The reasons for referrals on the 21 families who received services after the death are displayed in Table 17. Please note that two families were simultaneously referred

TABLE 16
ICAN ACCIDENTAL CHILD DEATHS

REASONS FOR PRIOR CHILD PROTECTIVE SERVICES

Reason	n	%
General neglect	32	32
Physical abuse	23	23
Caretaker absence/incapacity	19	19
Severe neglect	13	13
Emotional abuse	6	6
Sexual abuse	6	6

TABLE 17
ICAN ACCIDENTAL CHILD DEATHS

REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING DEATHS

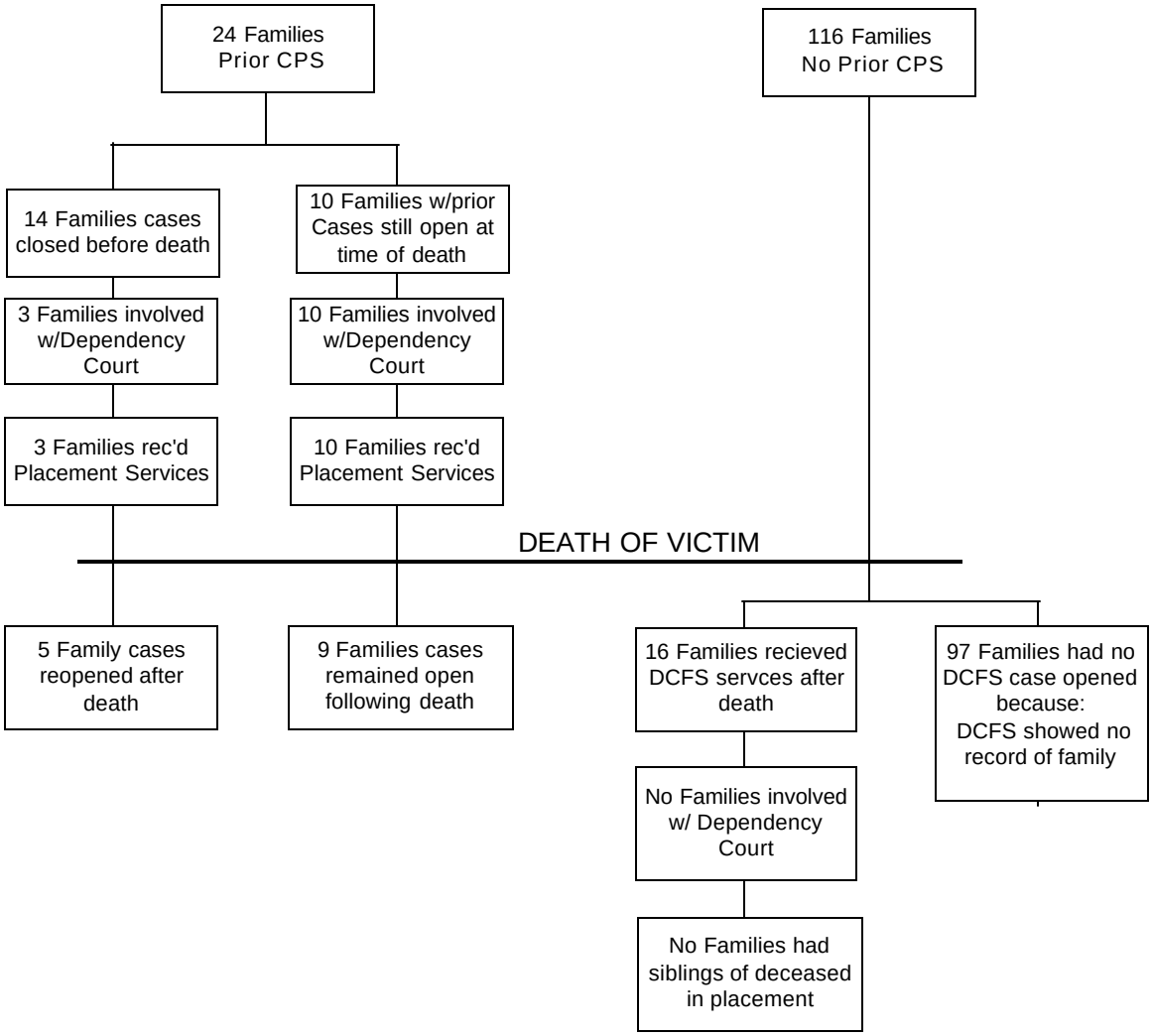
Reason	n	%
Severe neglect	13	57
General neglect	6	26
Caretaker absence/incapacity	2	9
Physical abuse	1	4
Sexual abuse	1	4

TABLE 18
ICAN ACCIDENTAL CHILD DEATHS

AGE OF MOTHERS

Age	n	%
Less than 25 years	6	15
25 to 29 years	12	29
30 to 39 years	21	51
40 years and older	2	5

FIGURE 17
CHILD PROTECTIVE SERVICES ACTIVITIES ON 2000 ACCIDENTAL CHILD DEATHS



for more than one allegation type. None of the referrals made on these 21 cases resulted in removal of surviving siblings from their homes; one surviving sibling was already living with his grandmother and other siblings were found not to be at risk. Families were provided with grief counseling referrals and, in one case, more extensive Family Preservation Services to assist the family with their loss.

The Department of Children and Family Services provided the following information on the families of 2000 accidental child deaths:

- The mother's age at the time of the death was known in 30% (n=41) of the families. Table 18 provides a breakdown of the mothers' ages.
- The deceased child was known to have siblings in 33% (n=45) of the cases. Two of the families were known not to have any children other than the victim. It was unknown if there were siblings in 66% (n=90) of the families.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

Information on criminal justice system activity on accidental child deaths was gathered from the Los Angeles Police Department, Los Angeles Sheriff's Department and Los Angeles District Attorney's Office. The Los Angeles Police Department had investigative responsibility for 30% (n=41) of the accidental deaths, and the Los Angeles Sheriff's Department had responsibility for 24% (n=33) of the cases. Independent law enforcement agencies had responsibility for investigation of 34% (n=46) of the accidental child deaths. Investigative agencies were unidentified for 17 accidental death cases. Table 19 displays the 18 different law enforcement agencies known to have involvement with the 2000 accidental child deaths.

HEALTH SYSTEM INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

Forty-five of the child accident victims had medical records at Los Angeles County Department of Health facilities: 22 at the Los Angeles County/King-Drew Medical Center (LAC/King-Drew), 13 at the Los Angeles County/University of Southern California Medical Center (LAC/USC), seven at the Los Angeles County/Harbor-UCLA Medical Center, and five at Olive View Medical Center. It should be noted that two of the decedents had medical records at both LAC/USC and LAC/King-Drew Medical Center. Place of death data provided by the Coroner indicate that 25 of the child accident victims died in Los Angeles County Department of Health Services facilities and 94 victims died at one of 32 other medical facilities. Place of death for the remaining victims is listed as a private residence or public roadway.

TABLE 19
LAW ENFORCEMENT AGENCY INVOLVEMENT IN 2000 ACCIDENTAL CHILD DEATHS

LAPD	41
LASD	33
Baldwin Park P.D.	2
California Highway Patrol	14
Compton P.D.	1
Culver City P.D.	1
Huntington Park P.D.	1
Inglewood P.D.	5
La Verre P.D.	2
Long Beach P.D.	6
Pasadena P.D.	3
Pomona P.D.	2
Santa Monica P.D.	1
Signal Hill P.D.	1
South Pasadena P.D.	1
Torrance P.D.	1
West Covina P.D.	2
Whittier P.D.	3
Unknown	17

Darla, age 10 months, and her three older half-siblings resided with their maternal grandparents. They had been left by their mother without provisions for their care and their grandmother called the Department of Children and Family Services (DCFS) for assistance. The children's mother had an extensive history as a victim of domestic violence and residing with violent men, including the fathers of Darla and her older siblings. The children were formally placed in the grandparents' care and DCFS began to provide court-ordered services to reunify the children with their mother and fathers. While services were being provided, the children's mother accused Darla's father of domestic violence and physically abusing Darla. She claimed that Darla's father had placed Darla in a cooler and, on separate occasions, placed his hand over Darla's mouth until she turned blue to stop Darla from crying. She later recanted and stated she had fabricated these allegations to retaliate against the father for leaving her and her children. There was insufficient evidence to sustain a Dependency Court petition on these allegations and no criminal charges were ever filed.

Darla's mother and father were initially permitted supervised visits with Darla in the grandparents' home. Later, against DCFS recommendation, the Dependency Court allowed Darla's father to take her from the home and have unmonitored contact. Mother failed to comply with the Court's orders to attend parenting classes and therapy and was allowed monitored contact only.

During one of father's unmonitored visits, he reported that he had discovered Darla unresponsive. He stated that he had picked Darla up from the grandparents' home and attended church with Darla and Darla's mother earlier that day. After church, Darla's mother made breakfast for the family and left for work. Father reported that he diapered Darla and put her down to bed as she had had a "temper tantrum" and he thought she would cry herself to sleep. He reported that when he checked on her approximately 45 minutes later, he discovered that she was not breathing and called 911.

Paramedics responded to the home and were frustrated to discover they were unable to enter the apartment due to a locked security gate. Darla's father came to the gate, leaving Darla unattended, and provided the paramedics with access. When they entered the apartment, they found Darla on the bedroom floor, face up. Her father told paramedics he had attempted to perform CPR as instructed by the 911 operator, but later told police investigators that he had not attempted CPR. Paramedics initiated CPR and transported Darla to the nearest emergency hospital. Darla did not respond to resuscitative measures and death was pronounced shortly after arrival.

After a complete autopsy, Darla's cause of death was ruled Undetermined. She was found to have several small epidural hemorrhages on the right occipital dura but no other trauma to the brain. She had no skull fracture or scalp contusions. She was found to have contusions to the lower left lip and tip of the tongue as well as a small hemorrhage to the right lower gingiva. There were also petechial hemorrhages bilaterally to the lungs and bridge of the nose. In addition to these injuries, Darla had interstitial pneumonitis. The Coroner indicated that none of these findings were sufficient to be the actual cause of Darla's death. At age ten months, Darla's age fell outside the parameters generally accepted for Sudden Infant Deaths Syndrome (SIDS) and the Coroner indicated that suffocation could not be ruled out. The presence of bruising indicated that there was some kind of trauma, but again the injuries identified were insufficient to provide a determination of the cause of the death or to provide a determination that the trauma caused the death. Had there been more evidence to determine the cause of death, the case would likely have been ruled a homicide.

Law enforcement indicated that due to lack of evidence and the fact that the cause of death remained undetermined, the District Attorney would not pursue prosecution of the case. Darla's mother subsequently had another child with Darla's father; tragically, less than two years later, this child was removed from their care based on allegations that the father had immersed the infant in scalding water due to a diaper changing issue. He is currently incarcerated for burning this child. While the couple has a long history of domestic violence, Darla's

mother has stated that she loves the father and plans to marry him when he is released from jail.

This case is an example of the difficulty in determining the mode of death in cases with suspicious, but not diagnostic, findings. The Coroner's Office has stated that many deaths moded as Undetermined may be homicides, but cannot be conclusively ruled as homicides without additional investigation and evidence.

UNDETERMINED CHILD DEATHS

Fifty-nine undetermined child deaths were reported by the Coroner to the Team in 2000. This is a very slight increase over the 57 undetermined child deaths reported in 1999. As noted in other sections of this report, increases in numbers of cases reported to the Team may be due, in part, to improved referral procedures utilized by the Team. The number of undetermined deaths reported to the Team has ranged from 3 in 1989 to this year's high of 59. The average over the past 12-year period (1989 to 2000) is 21.75 per year.

Undetermined deaths are those for which the Coroner is unable to assign a manner of death. Usually, there is no clear indication if the death was caused by another or accidental. As illustrated in the above case, these cases involve either a lack of information or conflicting information, which confounds the Coroner's ability to make a final determination as to the manner of death. An undetermined death often presents unanswered questions or raises suspicions as to the cause of death and there is insufficient concrete evidence to make a determination that the injury causing the death was inflicted rather than accidental. As a result, the Coroner may mode a death as undetermined as a signal to law enforcement that the case warrants a more in-depth investigation to try to answer some of the questions that surround the death.

As undetermined deaths are often suspicious in nature, they are of interest to the Team and often warrant detailed Team review in an attempt to determine what actually occurred. Nine of the 59 undetermined deaths that occurred in 2000 received in-depth review by the Team.

GENDER

In 2000, 37 (63%) of the undetermined deaths were male and 22 (37%) were female. In 10 of the past 12 years, there have been more male than female undetermined deaths.

AGE

In 2000, 80% (n=47) of the undetermined deaths were of infants under one year of age. In addition, three victims were one year of age, three victims were two years old and one victim each was 4, 5, 9, 10, 11 and 13 years of age. Between 1989 and 2000, an average of 71% of the undetermined deaths have occurred in children under the age of one year.

ETHNICITY

37% (n=22) of the undetermined child deaths were Hispanic; 37% (n=22) were African American; 15% (n=9) were White; and 11% (n=6) were Asian. Over the past 11 years, the ethnicity of child victims of undetermined deaths has fluctuated, but has averaged 44.3% Hispanic, 31.3% African American, 23% White and 1.3% Asian.

CAUSE OF DEATH

The diversity of causes of undetermined deaths is consistent with prior year findings. The most frequent cause of undetermined deaths in 2000 was "undetermined after autopsy" (n=23). The second most frequent cause was "undetermined" (n=19), and the third most frequent cause was "intrauterine fetal demise" (n=6).

In 2000, there were several deaths that were of a suspicious nature but lacked the information the Coroner needed to make a final determination of homicide. In one case, the death of a 5-year old boy was initially moded as a possible accident or homicide. The child had reportedly drowned in the bathtub while in the care of his father. His father reported that he left the child along in the bathtub and upon returning moments later, found the child face down in approximately 6 inches of water. The boy had no known adverse medical history consistent with a seizure or other condition that would have led to a drowning. The death was suspicious in light of this and other factors, including the presence of an ongoing custody dispute over the child by his parents and the presence of posterior neck muscle hemorrhages found at autopsy. Although the Coroner indicated the child died of sequelae of hypoxic brain injury/asphyxia, the mechanism was unknown and the death was moded as undetermined.

A second suspicious undetermined death also initially presented as a possible accident or homicide. In this case, a one-month old infant lived with his mother, age 19, father, age 17, and maternal grand-

parents. There is no evidence that this child had any pediatric care after birth, although he had a low birth weight. The parents reported that they found the child stiff and lying on the floor. Rather than calling 911, they locked themselves in their room with the child, stating that they did not wish to part with him. Two days later, the grandparents forced themselves into the room and called 911. By this time, the infant's body was in a state of extensive decomposition. There was concern that the child had not been properly nourished but the Coroner was unable to establish a cause of death at autopsy and the death was ruled an undetermined death.

A third suspicious death that was moded as undetermined involved a 2 ½ month old twin whose cause of death remains unknown after autopsy. This infant was reportedly put down for a nap by her parents and discovered "blue and not breathing" when they went to check on her. At the hospital, a doctor reportedly told law enforcement officials that the baby may have died from an infection. However, upon autopsy it was learned that she had rib fractures approximately 4 to 6 weeks old, as well as several other old healing fractures, including a right arm radial fracture. She also had a subdural neomembrane and interstitial pneumonia. The Coroner indicated that the fractures could not be seen as a direct cause for the baby's death and moded the death as undetermined. The Team discussed the possibility that the rib fractures may have impacted the baby's ability to breathe and law enforcement agreed to review their case investigation.

A fourth suspicious undetermined death involved a four-year old boy who died of malnutrition. Upon autopsy, he was found to be severely emaciated, but with no signs of bruising or trauma. The child had a history of severe medical and developmental problems and did not receive proper feeding to sustain him. He did not receive proper medical care for approximately a year preceding his death and his parents had stopped taking him to services previously provided to address his developmental needs. The Team discussed this case in detail on several occasions as questions were raised regarding the parents' intent in failing to obtain proper nutrition for the child through medical interventions, such as a feeding tube. The parents' level of sophistication and ability to provide for his special needs are unknown, and as such, their intent is unclear. For this reason, the Coroner moded his death undetermined.

One of the undetermined deaths in 2000 involved an abandoned female newborn found in a plastic bag on a set of railroad tracks. The Coroner indicated that the case involved "peripartum demise-cause not established." In addition, a male fetus between 24 - 28 weeks gestation washed ashore with no visible signs of trauma and the Coroner moded this as an undetermined death.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVOLVEMENT

Sixteen (27%) of the undetermined child deaths in 2000 had prior child protective services involvement, and five of these cases were open to the Department of Children and Family Services (DCFS) at the time of the death.

The reasons for DCFS involvement with these families included general neglect, severe neglect, physical abuse, sexual abuse, emotional abuse and caretaker absence/incapacity. For those families in the five open cases, one family each had 1, 2, 6, 7 and 8 referrals to DCFS prior to the child's death. The eleven families with closed cases had prior referrals ranging from one to 6 in number. Three of the five open cases had previously resulted in court action and out-of-home placement for the child and/or his or her siblings prior to the child's death. In one of the additional open cases, the surviving sibling was placed outside of the home at the time of the child's death, and in the fifth case, voluntary services were provided to the surviving siblings without court supervision or placement. In addition to the open cases, one case with prior DCFS involvement resulted in court action and out-of-home placement for the deceased child's siblings at the time of the child's death. In this case, the siblings were placed into foster care as their parents were incarcerated for making methamphetamine in their home. This illegal activity was discovered at the time of the infant's death, a death that was ruled undetermined but for which there was suspicion that

exposure to chemicals used to produce methamphetamine had led to the child's demise.

In one of the cases which was open at the time of the child's death, a toddler died in the care of his great aunt with whom he was placed shortly after birth and who had applied to adopt him. The child had been born in a restroom toilet and rescued by a bystander two years before his death. At age two, he was reportedly found unresponsive by his relative caregiver. Upon autopsy, he was found to have a small amount of methadone and cough medicine in his system. The mechanism of death was unknown and the case was ruled undetermined. This child had no siblings.

In the second open case, a 10-month old girl was removed from her parents' care and placed with her grandparents due to physical abuse. There were allegations that her father had placed his hand over her mouth and placed her into a cooler to silence her crying. Against DCFS recommendation, the Court authorized the child to have unmonitored visits with her father. During one of these unmonitored visits, the child fell into a state of unconsciousness and later expired due to undetermined causes. The child's three surviving siblings remained placed in out-of-home care with their grandparents.

In the third open DCFS case, eight referrals alleging general neglect and severe neglect were made for a family with 11 children. The family received ongoing voluntary services for approximately one year five years prior to the child's death. In June, 2000, a referral of general neglect was made alleging that a school-aged sibling with asthma was being medically neglected. The referral was open when the youngest child, a 1-month old boy, died of undetermined causes. It is possible that the infant was smothered by his 2-year old sibling with whom he was sleeping. The family was provided with voluntary services after the child's death.

In the fourth open case, a 2-month old girl died of possible maternal overlay, as she was found unresponsive after sleeping with her mother. The family had previously had 7 referrals alleging general neglect, severe neglect, physical abuse and sexual abuse. The child's four surviving siblings had already been placed out-of-home and remained outside of the home after the child's death of undetermined causes.

Finally, in the fifth open DCFS case, a referral was made alleging general neglect of a 7-month old girl and her 1-year old brother. The reporting party stated that the children were left alone in the home while the parents went out at night and that the children, especially the infant girl, cried incessantly. The girl had been born over 2 months premature and was sent home from the hospital with an apnea monitor to be used for 9 months. Two months later, the monitor company came to the home and took the monitor. The child's pediatrician was not informed of this and the child died of undetermined causes shortly thereafter. At the time of her death, her brother was placed with the paternal grandparents and the parents were permitted to live in the home.

In addition to the five open cases, 7 of the cases with previous contact were referred to DCFS after the death. In one of these referred cases, a sibling set was removed from the home due to severe neglect, and court action was initiated. In a second referred case, court action was initiated while the family received in-home services and in a third, surviving siblings were already living outside of the parents' care with relatives without court supervision. In the remaining cases with previous contact, surviving siblings were determined not to be at risk. An additional 19 families who had no prior contact with DCFS were referred to the Department at the time of the child's death. It was determined that there were no surviving siblings in 8 of these cases. Ten of the families received services from DCFS, including grief and mourning referrals, but it was determined there was no risk to the surviving siblings and they remained at home without court or DCFS supervision. Finally, one family was referred for services at the time of the child's death, but DCFS was unable to locate the family. It should be noted, that as in the past, deaths related to undetermined causes have not usually resulted in court involvement and/or out-of-home placement for surviving siblings.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

The Los Angeles Police Department was the investigating law enforcement agency for 39% (n=23) of the undetermined deaths and the Los Angeles County Sheriff's Department was responsible for the investigation of 35% (n=21) of the cases. Thirteen cases were handled by independent police agencies, including Hawthorne, Long Beach, Pomona, Torrance, Vernon and the Kern County Sheriff's Department. Law enforcement agencies could not be identified in two of the undetermined cases.

Two undetermined cases were presented to the District Attorney's Office for the filing of criminal charges. In the first case, parents of a one-month old infant were booked on charges of willful cruelty to a child, resulting in injury or death. In this case, the infant had been born to immigrant parents at home. The parents were unmarried and attempted to hide the birth of their child. The child was not taken for medical care during his short life. At age one-month, his father placed him on an adult bed and went to sleep next to him. When the father awoke, approximately 3 to 4 hours later, he found the infant dead. The parents delayed contacting emergency personnel and instead waited until the next morning, approximately 24 hours later, to drive the child's body to a mortuary. Mortuary personnel informed the couple that they could not accept the child and the parents called 911 en route home with the body.

HEALTH SYSTEM INVOLVEMENT

Fourteen of the children with undetermined deaths had records at Los Angeles County Department of Health Services facilities: 6 at Los Angeles County/University of Southern California Medical Center, 5 at Harbor/UCLA Medical Center, 2 at King-Drew Medical Center and 1 at Olive View Medical Center.

Place of death data provided by the Coroner indicated that 24 different medical facilities were involved in the undetermined deaths and six of these victims died in Los Angeles County Department of Health Services facilities. Other victims died in other medical facilities (n=40) or at their residence (n=11). In addition, one newborn who died of undetermined causes was found abandoned along railroad tracks and a fetus was found in the ocean.

At age seventeen, Nancy was attempting to break free from a strict family background. On the night preceding her death, she told her parents she was going to work but instead went to a party at a nearby vacant house. Her parents reported her as a runaway upon discovering she had not shown up for work. Nancy told her friends she was afraid to go home because she had been drinking. She returned home in the middle of the night and slept in a camper outside the family home. When her parents found her, a fight ensued and her mother instructed her father to discipline her with a belt, which he did. Her father then collected several of Nancy's belongings from her room and took them to the back yard to burn them. Nancy retreated to her parents' bedroom where she obtained a gun. While her parents were outside burning her things, they heard a gunshot. When they re-entered the home, Nancy turned the gun on herself, shooting herself in the stomach.

Early one morning, sixteen-year old Clark's mother found him bleeding from a self-inflicted gunshot wound to the head. Clark, a shy, obese boy had obtained the gun from the trunk of a friend's car without her knowledge. He had stopped attending high school, opting to take classes at a local junior college and had few close friends; he spent much of his free time on the computer and communicated regularly via Internet chat rooms. The night before he died, Clark expressed feelings of depression and suicidal thoughts to those in one of his regular chat rooms. Concerned individuals from the chat rooms contacted Clark's home the next day; they learned of Clark's death when their calls were answered by law enforcement investigating the suicide. Clark left several suicide notes on the internet detailing his feels of isolation and desire to escape taunting by peers.

Brian, age seventeen, was diagnosed with Attention Deficit Disorder (ADD) as a child and arrested for sexually assaulting a five-year old neighborhood boy at age fourteen. He spent time in group home care and lived with relatives for approximately a year and a half. Upon returning to the family home, he was enrolled in high school and appeared to be adjusting. However, several months into the school year he was suspended for three days following a peer altercation. On the first morning of his suspension, his parents went off to work, leaving Brian at home to do chores. He was reportedly in good spirits. However, when Brian's mother returned home at mid-day, she found Brian hanging from a garage beam. Brian had made no previous suicide attempts and left no suicide note.

Reggie, age seventeen, committed suicide by carbon monoxide poisoning. Law enforcement responded to report of smoke coming from a residential garage and found Reggie in the family car. The car windows had been sealed shut, and a garden hose ran from the tailpipe through the front driver side window. Reggie was a popular student and excellent athlete with no history of problems at school or home. Several suicide notes were located in Reggie's bedroom, blaming his ex-girlfriend and parents for his actions. Those who knew Reggie denied he had a history of suicidal ideation or attempts, although his letters alluded to several previous attempts.

Juana, age sixteen, resided with her mother, stepfather and younger siblings. She was found dead of a self-inflicted gunshot wound by her mother one evening when her mother returned from work. A note found in her room expressed that Juana was in love with a young man named Francisco and wanted to have his child. She stated that she was heartbroken that Francisco already had two children and did not want to have another child. He did not appear to be as interested in her and she was with him; she stated that she'd rather be dead than live without Francisco. Juana had a history of involvement with law enforcement and was reportedly involved in gang activity. She was found to have amphetamine and alcohol in her system at autopsy.

Paul was reported missing by his father on his sixteenth birthday. Paul had told his estranged girlfriend that he was going to die that night, and when his father discovered his gun missing from under his mattress, he contact the Sheriff's Department. A search was conducted for 48 hours without success. Twelve days later, Paul's body was located in a concrete pipe, with a handgun under his arm. He had died of a self-inflicted gunshot wound to the head. Paul's parents described Paul's older brother as

very attractive and athletic and stated that Paul had not compared in these areas. However, Paul's friends indicated that Paul was quite popular and that Paul's father "rode" him about his grades. No suicide note was found.

ADOLESCENT SUICIDES

Twenty-three suicides of victims 17 years of age or younger were reported to the ICAN Child Death Review Team for 2000. This is a 15% decrease from 1999 when there were 27 adolescent suicides. The average number of youth suicides referred to the Team since tracking this population began in 1988 is 26.7 per year.

While the Child Death Review Team does not primarily focus on this population, clearances from law enforcement, the Department of Children and Family Services and the Department of Health Services provide a picture of these children and families and their interactions with public agencies prior to their deaths. In the year 2001, the Child and Adolescent Suicide Review Team, under the auspices of ICAN and the Los Angeles County Office of Education, began multi-disciplinary team reviews of suicide deaths. Thirteen of the twenty-three child and adolescent suicides were reviewed by this Team in 2001 with additional 2000 suicides to be reviewed in 2002. Valuable insights have been obtained and the work of this Team is hoped to contribute to the understanding and prevention of adolescent suicides. (See recommendations made by this Team in the Findings and Recommendations Section of this report.)

GENDER

Figure 18 displays the gender breakdown of the adolescent suicide victims for the past 13 years. Seventy percent (n=16) of the 2000 adolescent suicide victims were male. Over the past 13 years, the percentage of male victims has ranged from 68 to 90%, and the average number of male victims has been 20.9 with a range of 12 (1998) to 37 (1993) deaths per year. Thirty percent (n=7) of the victims of adolescent suicide in 2000 were female, a slight decrease from the six female suicides reported in 1999. The average number of female victims over the last 13 years is 6.1 per year. The number of female victims between 1998 and 2000 has ranged from two victims in 1995 to 11 victims in 1989.

AGE

The average age of adolescent suicide victims increased slightly from 15.44 years in 1999 to 16.93 in 2000. There was a decrease in the number of suicides for ages 10 - 15 and an increase in the number of suicides for ages 16 and 17. In 1999, the youngest victim was ten year of age and there were 11 suicides for adolescents ages 10 to 15, whereas the youngest victims in 2000 were age 13 and 14 and they were the only two suicides for the age 10 to 15 age group. However, in the older age 16 - 17 group, there were 16 suicides in 1999 and 21 suicides in 2000.

FIGURE 18

1988 - 2000 ICAN ADOLESCENT SUICIDES BY GENDER

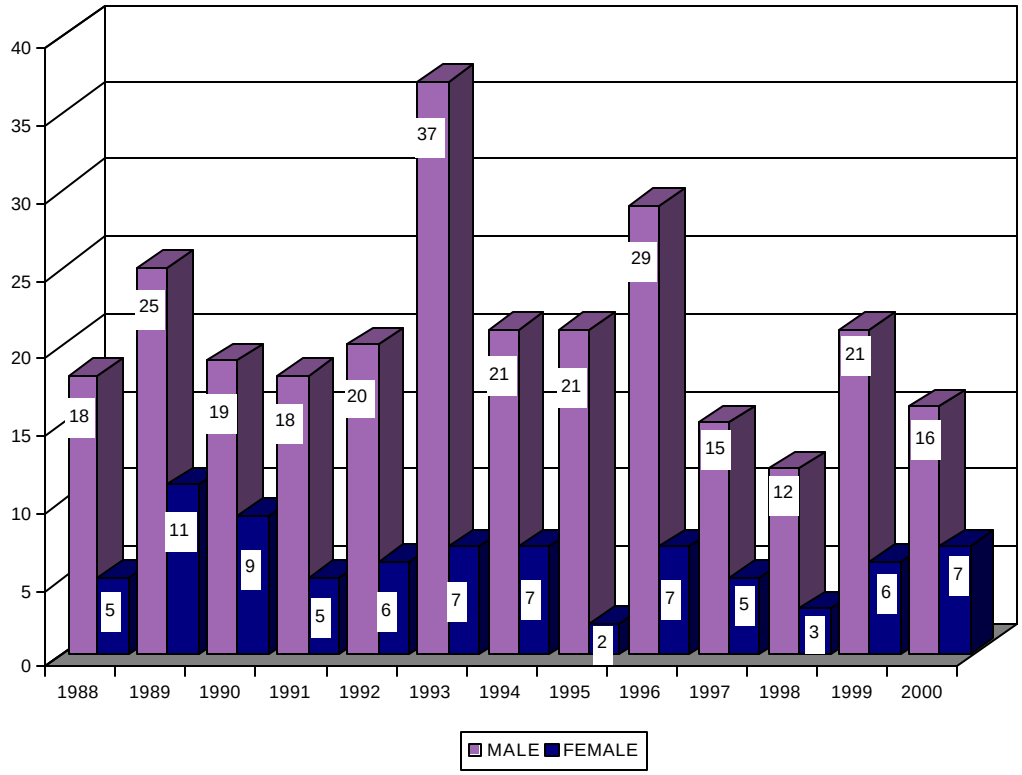


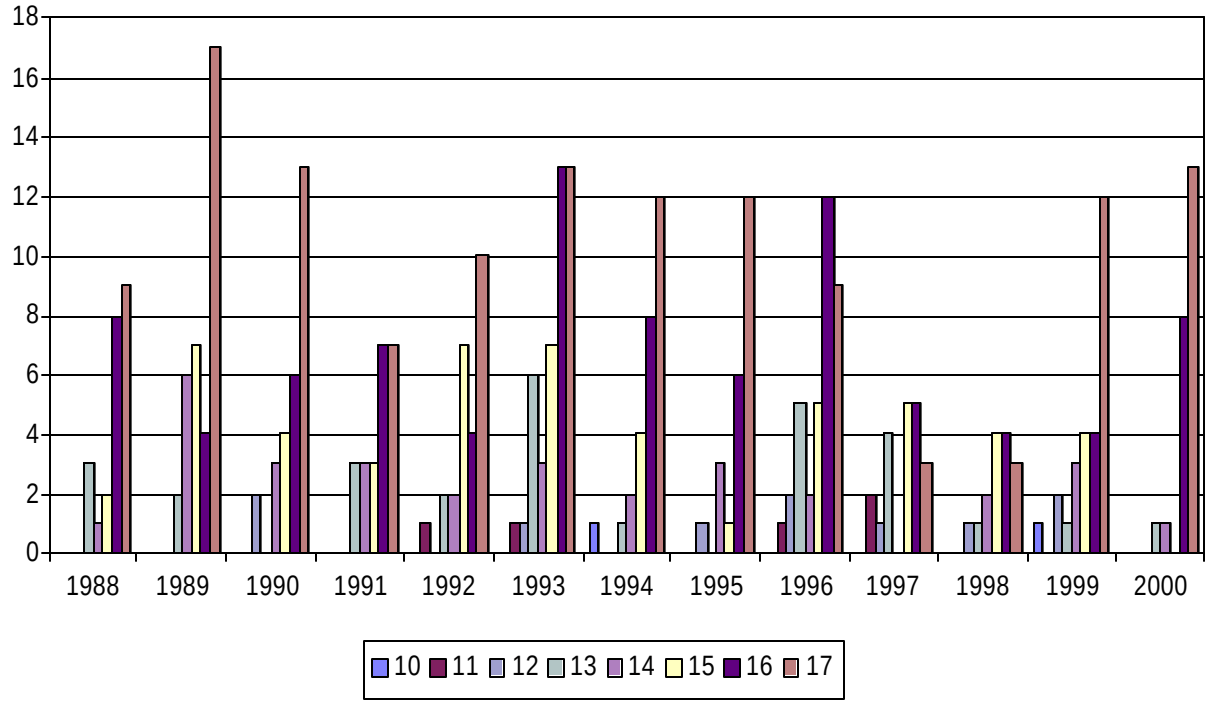
TABLE 20

AGE BREAKDOWN OF ADOLESCENT SUICIDES 1988 - 2000

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Total
10	0	0	0	0	0	0	1	0	0	0	0	1	0	2
11	0	0	0	0	1	1	0	0	1	2	0	0	0	5
12	0	0	2	0	0	1	0	1	2	1	1	2	0	10
13	3	2	0	3	2	6	1	0	5	4	1	1	1	29
14	1	6	3	3	2	3	2	3	2	0	2	3	1	31
15	2	7	4	3	7	7	4	1	5	5	4	4	0	53
16	8	4	6	7	4	13	8	6	12	5	4	4	8	89
17	9	17	13	7	10	13	12	12	9	3	3	12	13	133
TOTAL	23	36	28	23	26	44	28	23	36	20	15	27	23	352

FIGURE 19

1988 - 2000 ICAN ADOLESCENT SUICIDES BY AGE



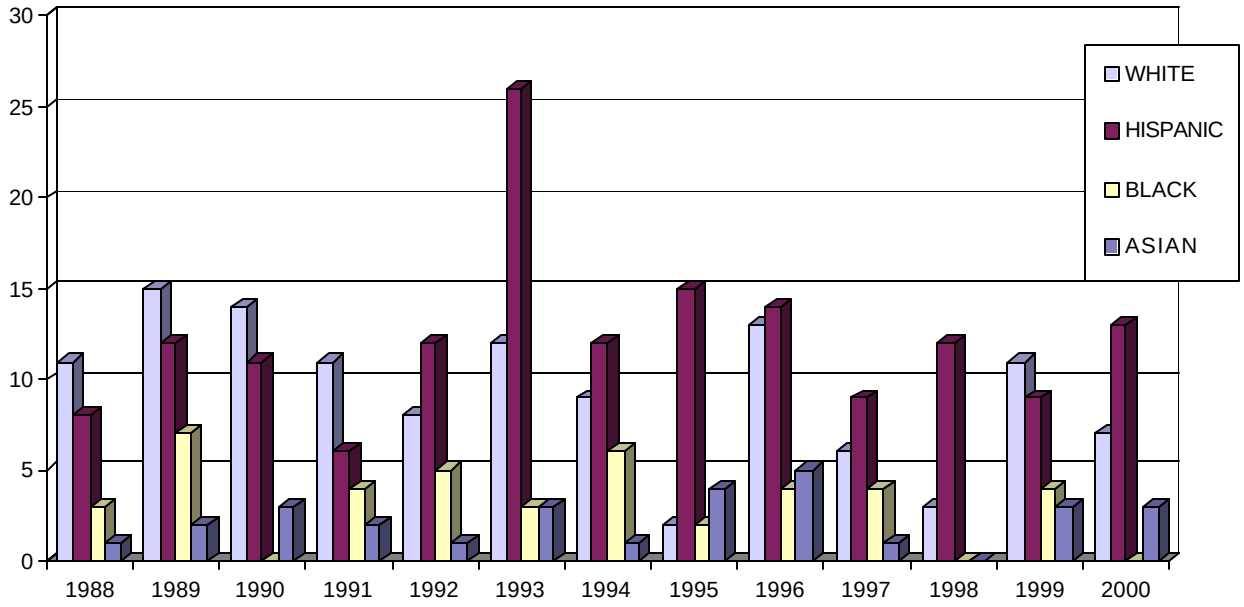
ETHNICITY

Hispanic suicides represent 57% of the total number of adolescent suicides in 2000 and the number of such suicides increased by 44% from nine in 1999 to 13 in 2000. Thirty percent (n=7) of adolescent suicides were committed by Whites which represents a 36% decrease from 1999 (n=11). The number of Asian adolescents who committed suicide remained constant, as there were three victims in both 1999 and 2000. The number of African American adolescent suicides decreased from four in 1999 to none in 2000. There were no African American adolescent suicides in 1998 as well.

From a multi-year perspective, as illustrated in Figure 20, Hispanic adolescents average the greatest number of suicides (x=11.76), with White adolescents following (x=9.61). The percentage of Hispanic adolescents who committed suicide rose as the number of Hispanic youth in the population increased with the exception of a one-year decrease in 1999. The number of White adolescents who committed suicide increased in 1999 after a decrease in both 1997 and 1998. With the exception of 1995 (n=2), the number of White adolescent suicides in 2000 is relatively low but consistent with years 1988 to 1999. The number of African American adolescents who have committed suicide over the past 13 years has averaged 3.3 per year, with a range of zero to eight. The number of Asian adolescents who have committed suicide has averaged two per year, with a range of zero in 1998 to 1996's high of five.

FIGURE 20

1988 - 2000 ICAN ADOLESCENT SUICIDES BY ETHNICITY



CAUSE OF DEATH

Figure 21 graphically display the different methods of suicide over the past 13 years. Hanging was the most frequent cause of suicide among adolescents in 2000. Eleven hanging suicides were reported, including the deaths of a 13-year old boy who hung himself with two belts in his bedroom closet and a 14-year old boy who hung himself from the family's backyard swing set. Both boys had reported psychiatric histories, including medication for depression and Attention Deficit Disorder (ADD). There have been 103 adolescent suicides by hanging over the past 13 years.

Firearms were the second most frequent method of suicide in 2000; 43% percent (n=10) of the adolescents committed suicide by using firearms in 2000. This is the first year since this data has been tracked that firearms were not the leading method. Firearms have been the predominant method of adolescent suicide over the past 13 years; 207 of the 346 adolescent suicides (60%) during this period have involved firearms. The percentage of total suicides involving firearms has ranged from 1996's low of 40% to a high of 73% in 1992.

In addition to hanging and firearm suicides in 2000, one adolescent, age 17, died of carbon monoxide poisoning when he sealed off the family garage and channeled automobile exhaust into his vehicle. Finally, a 16-year old girl tied dumbbells around her ankles and jumped into the family pool where she drowned. Although there are most often one or two suicides attributed to drug overdose per year, there were no drug overdose suicides in 1999 or 2000.

TEMPORAL PATTERN

Figure 22 displays the temporal pattern of adolescent suicides from 1988 through 2000. In 2000, there were four adolescent suicides each in June, September and October. In other words, these three months (25% of the year) accounted for 52% of the suicides. In one month, March, there were three suicides and in two months, May and December, there were two adolescent suicides per month. In four months, February, July, August and November, there was one suicide per month, and in the months of January and April there were no adolescent suicides. Over the period 1988 - 2000, the months having the greatest number of adolescent suicides are March and October.

FIGURE 21

1988 - 2000 ICAN ADOLESCENT SUICIDES BY CAUSE

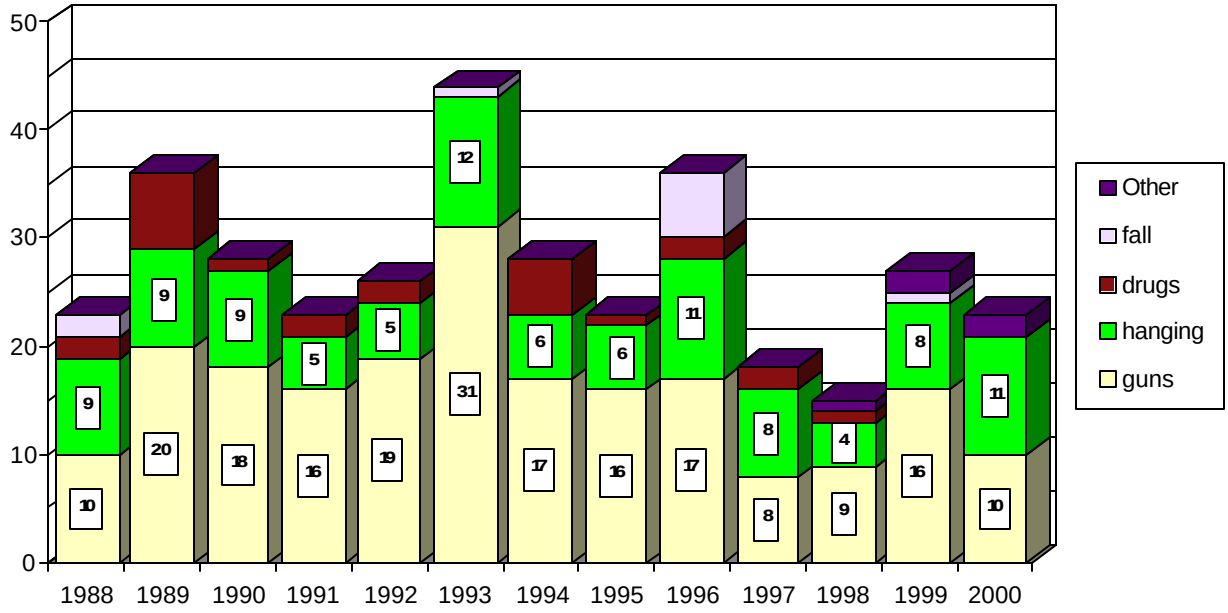
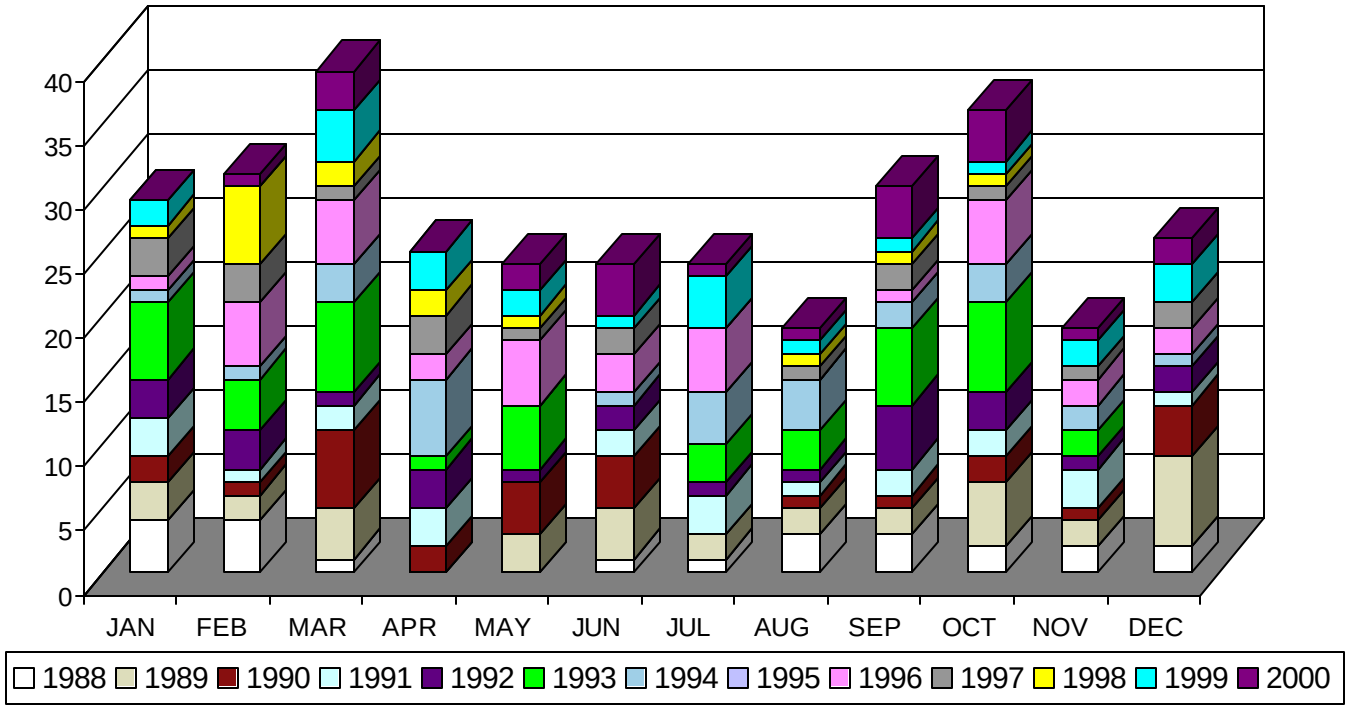


FIGURE 22

1988 - 2000 ICAN ADOLESCENT SUICIDES BY MONTH



DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVOLVEMENT

In 2000, the Department of Children and Family Services (DCFS) had prior contact with 17% (n=4) of the families of adolescent suicide victims. During the past 13 years, the percentage of such families with DCFS involvement has ranged from a low of 4% (one of 23 cases) in 1995 to a high of 40% in 1997 (eight of 20 cases) and 1998 (six of 15 cases). The average length of time between the period when DCFS was involved with the families and the 2000 suicide was seven months and ranged from three days to one year and ten months.

One of the four families with whom DCFS had prior contact was open for DCFS services at the time of the child's suicide. In this case, a 17-year old girl hung herself with a window blind cord at the residential facility where she had been placed three months prior. This female had been removed from her father's care following substantiated allegations of physical abuse, sexual abuse, emotional abuse and caretaker absence/incapacity. She had originally been placed in regular foster homes, but due to depression and suicidal ideology, was placed into the residential facility three months prior to her suicide.

The second case with prior DCFS contact involved another 17-year old girl who hung herself by her pajama strings in a residential psychiatric facility. She had been placed at the facility by her adult cousin caregiver, and the facility had contacted DCFS with concerns that the cousin appeared unable to care for her upon her release. An allegation of caretaker absence/incapacity was made; the social worker assessed that the cousin and his wife had made suitable plans for the girl's care and closed the case. Unfortunately, the girl committed suicide within the facility three days later.

In the third case, a 16-year old boy with two previous DCFS referrals hung himself in his bedroom. Five years prior to his death, DCFS has substantiated allegations of physical abuse and domestic violence against the boy's step-father, and he and his siblings were placed out of the home and into foster care. They were returned to the home in their mother's care a year later when the step-father was gone. Two years later, DCFS substantiated an allegation of sexual abuse in the home when the boy was arrested for sexually assaulting his seven-year old sister. The boy was placed in a probationary setting and his mother and siblings were provided with voluntary in-home services by DCFS. The boy was released to the home of his father where he subsequently committed suicide. One month after his death, DCFS assessed allegations of sexual abuse as a referral was made by a school counselor that the boy had previously disclosed that he was being sexually abused by his mother. The well-being of the siblings was checked and the allegations were found to be inconclusive.

In the fourth suicide case with previous DCFS contact, a 17-year old boy hung himself from a garage beam. Two years prior, DCFS had had two contacts with the family investigating allegations of sexual abuse, as the boy had allegedly molested a younger neighbor boy on two occasions. He was arrested and placed in a group home for approximately 13 months. He had returned to the family home and was reportedly having difficulties at school at the time of his death.

The reasons for DCFS involvement in the adolescent suicide cases included sexual abuse (five referrals), physical abuse (three referrals), emotional abuse (one referral), caretaker absence/incapacity (one referral) and severe neglect (one referral). Table 21 displays the reasons for prior DCFS services on suicide cases between 1989 and 2000.

It was known that there were sibling survivors on four suicide cases. For the remaining 19 cases, it is unknown if there were siblings. No reports were made to the DCFS Child Protection Hotline and no cases were opened to assess siblings directly as a result of these adolescent suicides.

TABLE 21

REASONS FOR PRIOR DCFS SERVICES FOR ADOLESCENT SUICIDES 1989 - 2000

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	Total
Sexual Abuse	1		3		3	1		3	3	4	4	5	**27**
Physical Abuse	1	1	1		2	2		2	5	5	4	3	**26**
Severe Neglect	3			1	1			1			1	1	**8**
General Neglect	1			1	3	1		1	1	8	1		**17**
Emotional Abuse					3		1					1	**5**
Caretaker absence									1	2	2	1	**6**
Info. unavailable	6	2	1	2	2	1		2	1	1			**18**
TOTAL	**12**	**3**	**5**	**4**	**14**	**5**	**1**	**9**	**11**	**20**	**12**	**11**	**107**

** Some families had more than one prior referral to DCFS*

LAW ENFORCEMENT INVOLVEMENT

Eight different law enforcement agencies were involved in the investigations of the 23 adolescent suicides in 2000. The Los Angeles Sheriff's Department was responsible for the investigation of nine of the suicides and the Los Angeles Police Department was responsible for the investigation of eight cases. Six additional law enforcement agencies (Compton, Glendale, LaVerne, Santa Monica, Torrance and Whittier) were responsible for the investigation of the remaining six suicides.

Table 22 shows the law enforcement agencies involved in all adolescent suicides reported to the Team for 2000. Division area detail is provided for the Los Angeles Police Department.

PUBLIC HEALTH SYSTEM INVOLVEMENT

Searches for Department of Health Services records determined that 30% (n=7) of the 2000 adolescent suicide victims had records at County medical facilities: four at LAC/USC Medical Center, one at LAC/Harbor-UCLA Medical Center and one at LAC/King-Drew Medical Center. In addition, one suicide victim had records at both LAC/USC and LAC/King-Drew Medical Centers.

Place of death data provided by the Coroner indicates that three of the 2000 suicide victims died at Los Angeles County Department of Health Services facilities. In addition, Antelope Valley Hospital, Arcadia Methodist Hospital, Garfield Medical Center, Granada Hills Community Hospital, Providence/Holy Cross Medical Center and Santa Monica/UCLA Medical Center were each listed as place of death for one suicide victim. Ten of the suicide victims died at their place of residence and one each died in an automobile, alley, field and vacant lot.

TABLE 22
LAW ENFORCEMENT AGENCY INVOLVEMENT IN 2000 ADOLESCENT SUICIDES

LAsd hOMICIDE	**9**
LAPD	
77th Street Division	1
Devonshire Division	2
Foothill Division	1
Newton Division	1
Southwest Division	1
Wilshire Division	2
Compton P.D.	1
Glendale P.D.	1
Laverne P.D.	1
Santa Monica P.D.	1
Torrance P.D.	1
Whittier P.D.	1

Leslie, age 32, was found face down in the middle of a residential street. Paramedics transported her to the hospital where she was declared dead. At autopsy, it was discovered that Leslie had been 23 weeks pregnant at the time of her death. According to her mother, Leslie had a 15-year history of substance abuse. Leslie had three older children, all of whom had been removed from her care and placed with her mother by the Department of Children and Family Services. She reportedly struggled with her addiction and attempted to "get clean" while living with her mother several times, only to relapse and return to the streets.

Sylvia, age 19, tested positive for marijuana at each prenatal visit. When she was 28 weeks pregnant, her obstetrician detected no sign of fetal life. Sylvia was admitted to the hospital where labor was induced and she delivered a stillborn male fetus. This was Sylvia's first pregnancy and she had never been referred to the Department of Children and Family Services as a perpetrator of child abuse or neglect. However, records from the Department indicate that several referrals of physical abuse and neglect were substantiated against Sylvia's parents when Sylvia and her siblings were minors.

Cynthia, age 23, was 8 months pregnant with her first child when she fell asleep at the wheel of her SUV. Cynthia was not wearing a seatbelt when her SUV plummeted over a freeway overpass. She was rushed to the hospital but died from multiple blunt force trauma. The hospital attempted to deliver her fetus by Cesarean section without success. The fetus had perished of asphyxia as a result of her mother's death.

Vanessa, age 34, was pregnant with her fourth child, all of whom were healthy, full-term babies. She went into labor and rapidly at 23 weeks gestation and delivered a male fetus in the family's van on the way to the hospital. The baby's father indicated that the fetus showed no signs of life - no sound or movement - and called 911. Paramedics transported the mother and fetus to the hospital where the fetus was reported dead on arrival. The mother was receiving regular prenatal care and reported no history of trauma or tobacco, alcohol or drug use. The fetal death was moded "Undetermined" with a cause of "interauterine fetal demise, cause not established."

Marlene, age 40, called the paramedics when she went into labor and delivered a set of triplets at approximately 30 weeks gestation. The heaviest triplet survived, while two fetuses of lesser weight were stillborn. Mother tested positive for cocaine and methamphetamine and indicated that she had no prenatal care. She also tested positive for hepatitis C and was found to be HIV positive. The surviving infant remained in the Intensive Care Unit for over two months and was then placed into foster care.

These cases are typical of the fetal death reported by the Coroner to ICAN during 2000, the majority of which involved fetal deaths due to maternal drug and/or alcohol abuse. Many of these cases continue to provide evidence of the great risk to fetal health posed by the abuse of drugs and alcohol by expectant mothers.

Thirty fetal deaths determined to warrant ICAN review were reported to the Team by the Coroner in 2000, an 8% decrease from the 39 fetal deaths reported in 1999. The number of fetal deaths reported to the Team in the past 12 years has ranged from a low of 11 in 1995 to a high of 66 in 1989.

For the purposes of Coroner records, fetal deaths are those in which an unborn child is over 20 weeks gestation. The number of fetal deaths reported to the Coroner, and therefore the Team, fluctuates greatly from year to year. Very few fetal death cases come to the Coroner's attention. It is unclear what criteria physicians use to determine whether to refer a fetal death to the Coroner or sign the fetal death certificate themselves. One fact that may encourage the referral of a fetal death to the Coroner is a history of maternal substance abuse.

The Corner is not required to report a manner of death to the State Department of Health Services for fetal death certificates. However, the Coroner provided this information to the Team for the purpose of this analysis.

MANNER AND CAUSE OF DEATH

The most frequent manner of fetal death in 2000 was accidental (n=24), followed by undetermined (n=6). As in 1999, no fetal homicides were reported to the Coroner in 2000.

The most frequent cause of death listed for accidental fetal deaths continues to be "intrauterine fetal demise" or "intrauterine fetal death" (n=12). The additional accidental fetal deaths were attributed to placental abruption, maternal drug intake, extreme maturity, blunt trauma, automobile accident and head trauma during delivery. The Coroner reported that there was a history of maternal drug use present in 18 of the 24 accidental fetal deaths (75%), consistent with the 75% of accidental fetal deaths that were attributed to maternal drug use in 1999. In 2000, 6 accidental fetal deaths were associated with automobile mishaps (4 auto v. auto accidents and 2 fetuses killed in solo automobile accidents).

The causes of the undetermined fetal deaths were similar to the accidental fetal deaths. In 5 of the undetermined fetal deaths, the cause was listed as "intrauterine fetal demise" and in one case, the cause was listed as "stillbirth and immaturity." Maternal drug abuse was noted in 1 of the 6 undetermined fetal deaths.

ETHNICITY

Table 23 lists the manner of death for the fetal deaths broken down by the ethnicity of the victims. Hispanic families represented 40% of the fetal deaths in 2000. The number of fetal deaths to Hispanic women (n=12) was slightly lower than the 13 reported in 1999. Three of the undetermined fetal deaths and 9 of the accidental fetal deaths were in Hispanic families. Five of the 12 deaths involved maternal drug use. The number of fetal deaths in African American families decreased by one, from 11 in 1999 to 10 in 2000. One of the undetermined fetal deaths and 9 of the accidental fetal deaths occurred in African American families. Nine of the 10 fetal deaths involved maternal drug use. The number of fetal deaths in White families decreased by 40% from 10 in 1999 to 6 in 2000. Four of these 6 fetal deaths involved maternal substance abuse. One undetermined fetal death occurred in a White family. No fetal deaths occurring in Asian families were reported to the Coroner in 2000. Finally, ethnicity was unknown in 2 additional fetal death cases, and one of these cases involved maternal substance abuse. Figure 23 shows the comparative rates of fetal deaths by ethnicity.

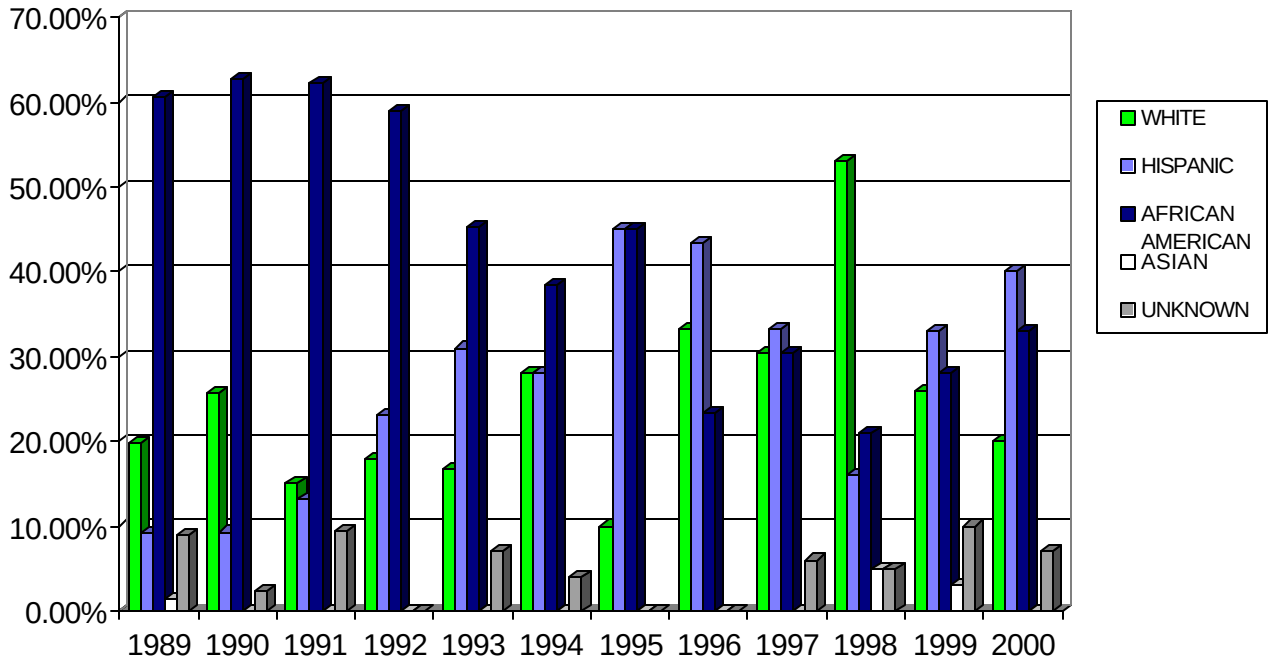
TABLE 23

ICAN 1999 FETAL DEATHS BY ETHNICITY AND MANNER OF DEATH

	AFRICAN-AMER	HISPANIC	WHITE	ASIAN	UNKNOWN	**TOTAL**
Accident	9	9	5	0	1	**24**
Undetermined	1	3	1	0	1	**6**
Homicide	0	0	0	0	0	**0**
TOTAL	**10**	**12**	**6**	**0**	**2**	**30**

FIGURE 23

1988 - 2000 FETAL DEATH PERCENTAGES BY ETHNICITY



TEMPORAL PATTERN

The number of fetal deaths per month is displayed in Figure 24. The number of deaths ranged from 0 to 5 in any given month. There were no fetal deaths in January, and April (n=5) and August (n=5) had the most fetal deaths. The greatest number of fetal deaths for one month reported to ICAN involved 10 fetal deaths reported in June, 1994, followed by 7 fetal deaths in April, 1996 and September, 1999.

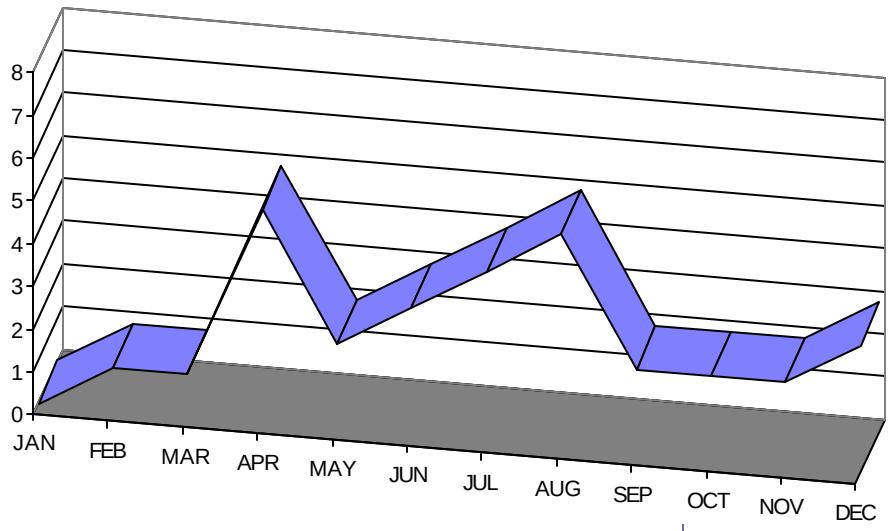
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The Department of Children and Family Services had a record of prior involvement with 6 of the families in which a fetal death occurred. Three of these cases were open for services to siblings at the time of the fetal death. All 3 were open due to allegations of substance abuse, and the siblings were already placed in out-of-home care where they remained after the fetal death. In addition to the 3 open cases, three fetal death cases had prior DCFS involvement and were closed prior to the fetal death. In one case with prior DCFS involvement, the family was referred to DCFS on three occasions for neglect and siblings were removed from the home under court supervision. Family reunification services were provided and the children were returned to the home 11 months before this fetal death due to maternal substance abuse. No referral was made to DCFS at the time of this fetal death. In the second case with previous referrals, the fetus' mother and mother's siblings had been reported to be victims of caretaker absence/incapacity when they were minors. No referral was made to DCFS at the time of this fetal death. In the 3rd case with prior contact, one previous referral was made when the mother had a stillborn child due to substance abuse in 1998. At that time, the reporting party at the hospital indicated that mother previously had a stillborn child due to substance abuse in 1994. At the time of the 1998 referral, an older surviving sibling was determined not to be at risk as he was placed in probate guardianship with his grandmother. At the time of the 2000 fetal death, DCFS again assessed that this older, surviving sibling remained safe in his grandmother's care.

Finally, two fetal deaths resulted in neglect referrals for families that had no prior DCFS involvement. In both cases, referrals were made at the time of the fetal death due to drug exposure and in both cases, surviving siblings were determined not to be at risk. In one case, the surviving siblings already lived with their grandmother and in the second, the surviving sibling lived with his mother and grandmother and was assessed as safe in this home.

TABLE 23

2000 ICAN FETAL DEATHS BY MONTH



CRIMINAL JUSTICE SYSTEM INVOLVEMENT

Seven law enforcement agencies were known to be involved in the investigations of fetal deaths in 2000. Eleven of the case investigations involved the Los Angeles Police Department and 7 of the case investigations involved the Los Angeles Sheriff's Department. Five independent police agencies were involved in 6 of the additional fetal deaths. Finally, in the remaining 6 fetal deaths, the investigating law enforcement agency is unknown. Table 24 displays the law enforcement agencies involved in all fetal deaths reported to the Team for 2000. Division area detail is reported for the Los Angeles Police Department.

One fetal death case resulted in criminal charges. In this case, an 8-month old fetus and his mother died of blunt force trauma following a solo car accident. The driver of the vehicle, the mother's sister, was charged with misdemeanor vehicular manslaughter after she ran into a brick wall. However, the District Attorney rejected these charges, indicating that "the actions of the suspect, while negligent, did not rise to the level of criminal negligence necessary for a manslaughter charge."

HEALTH SYSTEM INVOLVEMENT

Eight of the 30 fetal death cases reported to ICAN in 2000 had records at a Los Angeles County Department of Health Services facility. Five of these records were found at King-Drew Medical Center, two were found at Harbor/UCLA Medical Center and one was found at Los Angeles County/University of Southern California (LAC/USC) Medical Center. Place of death data provided by the Coroner indicated that 8 different hospitals were involved in the fetal deaths. In addition, one fetus was abandoned in the ocean and found in a plastic bag washed ashore.

TABLE 24
LAW ENFORCEMENT AGENCY INVOLVEMENT IN 2000 FETAL DEATHS

LASD		7
LAPD		11
Child Abuse Unit	1	
Central	2	
Harbor Division	1	
Northeast Division	1	
South Traffic	2	
Southeast Division	3	
Baldwin Park P.D.		1
Baldwin Park		1
Hawthorne P.D.		1
Long Beach P.D.		2
Unknown		6

Child Fatality Review Teams play a critical role in defining the underlying nature and scope of fatalities from child abuse and neglect. Many benefits result from the work of Child Fatality Review Teams, including identifying gaps and breakdowns in agencies and systems designed to protect children, more effective determination of the cause of suspicious deaths, and accurate identification of deaths due to maltreatment. The Teams also provide an opportunity to identify factors that increase the likelihood of serious and fatal child abuse as well as preventable deaths from accidents, disease and suicide.

California formed the nation's first Child Fatality Review Team in 1978. There are now Child Fatality Review Teams in all 50 states, as well as in Canada and Australia. The following "How To" Guide for Child Fatality Review Teams was developed as a part of the curriculum for the ICAN California Child Fatality Review Team Training Project. This Training Project, conducted under the auspices of the Office of Criminal Justice Planning and the California Department of Social Services, Office of Child Abuse Prevention, is designed to provide a core training program for professionals interested in the Child Fatality Review Process. To date, 6 on-site Regional Training Sessions and a National Satellite Training Broadcast have been completed and more on-site Regional Training Sessions are anticipated for the coming year.

The "How To" Guide is presented here to provide guidance on the basic structure and functioning of a Child Death Review Team and to provide the reader with a basic understanding of the Child Fatality Review Process.

This "how to" guide includes the basic lessons for building, rebuilding, maintaining, and increasing the effectiveness of the multi-agency system commonly known as the "Child Fatality Review Team." This manual is based on the experience and publications of hundreds of teams in the United States, Canada and Australia. The preventable death of any child is a tragedy. It may also be an opportunity for a community to grow together, learn together and thereby grow stronger.

Case One

A three year old is beaten to death by his father. Three years later, after a review of old cases, the original mode of accidental death listed in this case is changed to homicide and the father is sent to prison. Five siblings, who were seen by Fire Department Emergency Medical Technicians at the death scene, were not noted in any other agency record. These sibling survivors of fatal child abuse apparently were never interviewed and a very delayed attempt to find them determined only that they had moved and could not be found.

Case Two

An emaciated infant dies after a series of beatings while in the care of her mother and her mother's male companion. The District Attorney does not file charges because there is not enough evidence to prove "beyond a reasonable doubt" that one or the other parent caused the death. There are also no misdemeanor charges filed and none of the agencies involved with the family reports the case to the state Child Abuse Index. Agencies who may have future contact with these adults will probably find no record of this cruel infanticide.

Case Three

A single family has had multiple agency contacts: a public health nurse has been following a "failure to thrive infant;" a child protective services worker has evaluated a toddler who may have been molested; two separate hospitals had seen both these children who had been brought in by their mother in the early AM with vague complaints about possible injuries; the police and fire EMT have been called to the family's home several times for domestic violence; several years ago another child in the family died from "undetermined" causes. None of the professionals involved in any one of these events knew of the actions of the professionals involved in any of the other events.

Case Four

A teenager with a history of having been sexually abused as a child is found dead from a self-inflicted gun shot wound. This teenager had been having school problems and had a history of acting out in class. The teenager had also been to the hospital several times for treatment of various injuries, including an overdose of drugs. Previous interventions may have been sufficient enough to stop the molestation but did not address other factors and were not adequate enough to provide the child with a healthy environment.

Case Five

A young woman is able to hide her pregnancy from others and eventually gives birth in her bathroom at home. She does not seek help and eventually places a dead baby in the trash. It is not clear if the child was born alive or was stillborn. This woman had previously dropped out of school, had received treatment for substance abuse and had an active probation status. No one knew about or questioned her about the pregnancy.

Responses

The responses to these case examples, all of which involved child fatalities, were compromised by the failure to record and communicate information. However, important communications, such as those needed in the above examples, can and do occur within the multi-agency Child Fatality Review Process. Additionally, multi-agency team review of old cases can often result in the filing of criminal charges and convictions of the offenders, months or years later, because of the sharing of essential information.

I. What are Child Fatality Review Teams?

Child Fatality Review Teams are multi-agency, multi-disciplinary teams that review child deaths

from various causes, often with an emphasis on reviewing child deaths involving caretaker abuse and/or neglect. The scope of cases reviewed is determined by each team, with some reviewing all child deaths from all causes or all Coroner child deaths under age 18, while others limit their review to cases fitting into a pre-determined protocol, often based on cause of death or age of the child. Benefits of child fatality review include improved inter-agency case management, identification of gaps and breakdowns in agencies and systems designed to protect children and the development of data information systems that can guide the formation of protocols and policy for agencies that serve families and children. The common goal for all teams is the prevention of child death and injury.

II. Why and How Teams are Forming and Expanding

The formation of state and local Child Fatality Review Teams is generally a natural and simple process whereby agencies and professionals join together to talk about children who have died. In the past, the major block to such interactions has been the tendency of individuals to isolate themselves within their agency or profession. Team intervention is a process that requires the removal of psychological barriers and "turf" issues, thereby allowing the sharing of information and the addressing of each case as a working group.

Multi-agency Child Fatality Review Teams have now formed throughout the United States and much of Canada and Australia. The energy and focus of team development appears to be fairly consistent. Factors that drive the formation and usefulness of Review Teams include:

1. Child deaths, particularly preventable abusive deaths, create great pain for line professionals who have known the child. This pain creates motivation that pushes individuals to create a larger group of people to share that pain, and to address the facts and follow-up to the death.

2. Expanding information systems and computer technology help to make the multi-agency team process both familiar and available to professionals and advocates from the line level to the senior management level. The team review model provides a tool for these individual professionals and agencies to work together to be more effective in addressing the many issues involved in child deaths. As a result of team review, agencies may change official protocols and policies, particularly as they relate to multi-agency intervention.

3. When professionals and agencies are connected in a collaborative way, they can then build a more open system of multi-agency cooperation and can form alliances that address possible fatal and severe child abuse/neglect.

4. Child Fatality Review Teams have shown that it is possible to continue past the "child abuse deaths" to address other non-fatal family violence and many other forms of preventable "accidental" and "natural" deaths.

5. Teams that are working together on issues pertaining to child death also learn how to develop a multi-agency focus on infants, toddlers and high-risk pregnancies, which can lead to the development of prevention and early intervention programs.

6. Team reports that address child deaths and highlight recommendations aimed at prevention can be shared across state and national boundaries and can provide a tool for the sharing of information and resources.

7. Neighboring Teams can visit each other and share resources. They may also want to join together to form a Regional Team Review process.

8. State Teams can provide a forum for the sharing of resources and can support local data collection for use in the development of state mandates and state reports.

9. Over time, Teams can expand to engage in a retrospective review of old cases, which will be augmented by the knowledge and experience gained from earlier team reviews.

10. The national interaction of State Teams, National Associations and Federal Agencies can provide a forum for the development of a national system for the Child Fatality Review Process. International contacts can provide the resources to coordinate this process on an international basis.

III. Basic Team Structure, Philosophy and Process

Almost all active teams have developed a similar structure of membership, philosophy, and case selection.

A. Core Membership

1. Coroner/Medical Examiner: Responsible for providing critical information on the manner and cause of death for all unexpected and/or unexplained child deaths including trauma deaths such as homicides, suicides, and accidents.

2. Law Enforcement: Responsible for investigating potential suspicious deaths.

3. Prosecuting Attorneys: Responsible for prosecuting provable criminal deaths.

4. Child Protective Services: Responsible for intervention with familial child abuse/neglect.

5. Health (the most varied of the Core Team Members): Responsible for providing evaluation and treatment to injured children, reporting suspected child abuse/neglect, engaging in outreach to children at risk of abuse/neglect through public health nursing programs, and keeping vital records of births and deaths.

Most teams grow with time to include others including: Juvenile or Civil Court attorneys, representatives from schools, mental health departments, probation departments, fire emergency technicians (EMT), clergy, child life specialists and child advocates.

B. Team Philosophy

The Teams' philosophy includes a basic respect for the needs of other agencies and disciplines, including necessary rules of confidentiality. This respect also honors the rights of agencies and disciplines to pursue cases and problems within the room during the case review process with no single agency controlling or censuring the process.

C. Review Process

Cases are chosen by protocol from either coroner or health records, and most often include the deaths of all children under age 18. The actual review process proceeds one case at a time with each agency, in turn, sharing its knowledge of the child, family, and the circumstances surrounding the child's death. Teams may begin with a single retrospective review of "closed" cases. With time, however, Teams add prospective review of new deaths and cases still under investigation, often with any possible prosecution still pending. The Team may continue the collection of information until all aspects of case management are finished, including criminal actions which may take months for completion.

IV. Team Variation

State teams are formed primarily to serve, monitor and work with the local teams which provide the basic case management. Local teams often are less public than state teams and more focused on the actual case management of individual cases.

Local teams vary and reflect the interests of the agencies or professionals who have the most interest in the Child Fatality Review Team process and in local resources. Individuals from each of the core agencies have been responsible both for starting a team in some counties and, in other counties, for resisting the formation of a team to share information and resources with others.

A major factor in local team functioning is the size of the county's population. Larger counties may review only coroner's cases. Smaller counties may review child deaths from all causes. These reviews may include more details than larger county team reviews, with the actual case managers from each profession who were involved in the case sharing observations. In some counties, case data may be collected on standardized sheets before team review.

V. Central Log or Data Systems

A. Minimum Log/Data System

A minimal central confidential log should be kept which includes case identifiers, the cause and manner of death and the relationship to any possible suspect(s). This log may also include agency contacts and details of the case review, noting information that each core member has provided. With time, this log can become more systematic, more sophisticated, and can even be computerized.

B. Demographic Data/Team Reports

With time, the data collected can be expanded to include more demographic data including the age, gender and race of the child victim. Factors including the date and location of the injury, previous

records or agency contacts with the family, including any prior child protective services and risk factors including domestic violence, violent criminal records and substance abuse can be tracked and recorded. This information can then be compiled into team reports which provide data analysis and recommendations based on the case data collected and examined.

C. Computerized Data

Teams can eventually keep data by computer making data queries and data analysis both easier to do and more complex in scope. For instance, death data may be mixed with other population data to analyze the rates and distinctions between the prevalence and the incidence of death.

D. Systematic County Level Demographic Data Set

A third level of data collection includes a systematic collection of demographic data, that looks for patterns and problems which can be addressed by changes in programs, policies or laws. This data collection level is visible in the growing number of states and/or counties that issue written reports on various types of child deaths within that county.

E. County/State/National Triple Data Set

A further layer of data collection involves the integration of state data bases with local case data. This "triple data base" model involves reconciling local case data with data from the following three state/national level data sets:

1. Law enforcement child homicides recorded in the Federal Bureau of Investigation - Uniform Crime Reports - Supplemental Homicide Reports (FBI-UCR-SHR). These are "child homicides" as determined by law enforcement.

2. Vital statistics child homicides as recorded in vital statistics kept by public health agencies, typically through death certificates. These are those child deaths that a Coroner determines fits the "homicide" mode of death.

3. "Fatal child abuse/neglect" as noted in state Child Abuse Central Indices. These are deaths due to child abuse or neglect which are reported to the state index by law enforcement and/or child protective services.

Through this reconciliation process lost cases and case information can be identified. In California, local and state efforts to reconcile these various data sets has resulted in the discovery of cases and case information that had been lost due to the failure to properly complete forms or input collected data. In addition, this reconciliation process can help to find cases that have been lost to multi-agency intervention because information was not shared across agency lines. Multi-county cases also may be identified through this reconciliation process, thereby assisting case managers in finding their counterparts in other counties. Finally, the reconciliation process provides for a method of quality control and a common language. This is necessary to build a foundation for a statewide data information system that will be able to methodically and predictably examine fatal child abuse/neglect.

VI. Common Problems/Answers

A. One Agency Won't Cooperate

This is a fairly common problem and is often addressed by the rest of the agencies continuing to review cases as well as they can, while noting the absence of the single member. With encouragement, the reluctant agency may return in a month or so, or may continue to avoid participation until there is major pressure from other members. Neighboring experts may assist in the encouragement and motivation of their counterparts. The situation may also be resolved if a new source of data is found or a single person leaves or is replaced.

B. Records Can't Be Found

It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. It is also hard to find records from multiple counties and to connect state and county record systems. As teams grow, they tend to pursue more information and are able to search with more accuracy. A team might develop a written protocol on how to search for records and may give team members a monthly "report card" noting which files have been found and which remain missing. A monthly team "report card" of found or missing records helps to keep members up to date on themselves and each other.

C. Team Stopped Meeting and Needs To Restart

This is common when the person who started the

team and was responsible for keeping it moving retires or otherwise leaves duty. Some other team member then needs to take the initiative to get the team moving again. It may take a notorious case, a new motivated staff person or an out of town visitor to help get that first new meeting started.

D. Confidentiality

Nationally, teams have a noble record for respecting confidentiality. Information shared in the room seems to stay there. After meetings, members may discuss with other team members the fact that desired data from another member must be obtained through official channels, perhaps including a subpoena for official copies of records.

E. Failure To Write a Report On Team Activity

Writing a report may seem like a mass of trouble for busy agency people. However, the failure to issue an official report narrows the work to only those who attend team meetings and leaves knowledge lost. A central collection of a year's work also provides a natural forum to add recommendations for system change. Once an initial report has been completed, most teams continue to develop an annual report that contains much of the format and data collection provided by the natural activity of the team. Many teams publish annual reports and recommendations and often post them on the internet.

F. Lack of Staff Resources Necessary to Coordinate Activities in Counties Reviewing Large Numbers of Cases

Teams in larger counties may control their caseload to some degree by reviewing only coroner cases. All teams can expand their resources by sharing duties necessary to maintain the team. Almost all teams function with no official funding for a coordinator. However, local teams in counties with total populations over one million generally need one-half or more of a full time equivalent staff to maintain lists of names, keep some form of minutes and central records, arrange rooms, send notices, prepare agendas, etc. With time, larger counties and states are finding funding resources. Teams may share resources with neighbors and benefit from visiting neighboring teams.

G. Increased Sophistication Requiring Training

The professional literature is expanding and is available by computer and the internet. Many major conferences now include materials on child death. Teams from different counties and states may share resources. In addition, the ICAN National Center on Child Fatality Review (ICAN/NCFR) has materials and can assist in locating experts by topic.

H. Vulnerability of Line Staff Who Are Involved With A Child Who Dies Particularly With Cases That Are Notorious in the Press

Very few agencies, and almost no teams, have a process in place to support line staff after a death. The major exception is the support that the Review Team tends to give to it's own members. A few agencies have employee support, critical incident debriefing (C.I.D.), or simply talented management staff.

I. Senior Administrators or Political Leaders Are Bothered By Negative Statements in Reports about Child Death

All systems have failures and successes. It should be possible to write a report that is objective and speaks of the shortcomings and strengths of all members. The fact of continued child death makes it impossible to maintain accurate and consistent data and also write a report that includes improvements and remains only positive.

VII. Extensions of Process

A. Domestic Violence Fatality Review

Numerous counties and states have begun a systematic review of fatal domestic violence. This review process may be an extension of the local team, particularly in smaller counties, or may be a new team of professionals brought together specifically for this purpose. A national network is beginning to form and coordinate with child fatality review and there should be a national presence for domestic violence fatality review in a few years.

B. Review of Non-Fatal Severe Child Abuse/Neglect

Children should not have to die to merit systematic attention. In some states or counties, hospitals are beginning to extend their multi-disciplinary teams to address a multi-agency review of children hospitalized with severe injuries.

C. FIMR and SIDS Programs

The United States Department of Health and Human Services (USDHHS) sponsored a meeting in November 1997, with professionals involved in Child Fatality Review (CFR), Fetal Infant Mortality Review (FIMR) and Sudden Infant Death Syndrome (SIDS). This group recommended that CFR and FIMR should work together on data collection, noting that CFR and FIMR have a parallel process for gathering data. In addition, SIDS programs have a service component that we can all learn from in our treatment of surviving siblings and other family members.

D. Multi-County and Multi-State Case Review

This pattern of review is already underway as counties find components of their cases in other counties, often because of injured children being brought to neighboring medical facilities or families traveling to other counties or states. The national directories of teams compiled by ICAN/NCFR facilitates referrals to distant states. The fact that some family problems naturally cross state lines will force us to learn how to share information and resources across these state lines.

E. Computers, E-mail and the World Wide Web/ A National System for Child Fatality Review

The rapid growth in the use of computers and the Internet is also driving changes in child fatality review. More teams are using computers for word processing and, with time, will use them for data collection, data analysis, and composition of reports. The Internet and E-mail are also making it possible to find others in different Regions and to search for information on multiple topics. ICAN/NCFR sponsors a web site (ican-ncfr.org) and ListServ. Multiple states are now posting team reports on their web sites. A national data system has been proposed matching national data sets on child death.

F. Prevention Program Addressing Perinatal and Infant Toddler Issues

The child fatality review process increases individual agency competence for interventions with infants, toddlers and women with high risk pregnancies. The multi-agency team learns the value of sharing resources for intervention before any injury or death occurs.

VIII. Grief and Mourning

Teams, agencies and individuals are beginning to address the aftermath of fatal family violence. Recognition of the need to develop a system to support the grief and mourning process has developed but siblings and other survivors of child death have not been predictably identified and served. The same is true for other of the child's relationships, such as friends, family, neighbors, and professionals from amongst the large numbers of staff who serve such children and families.

A. Siblings of children who have died from child abuse/neglect, as well as other survivors, may benefit from support for grief and mourning. Even young children or the developmentally delayed may participate in funerals, grave visitation and family gatherings. They may tell their feelings in play or in art. The same needs also exist for children who have experienced loss from a natural death.

B. Mental health professionals may be of assistance with psychopathology but it needs to be recognized that grief and mourning by itself is not a psychopathology.

C. Training, on issues of death for mental health professionals and on issues of psychopathology for non-mental health professionals who address grief and mourning issues, increases the resources available for the provision of these support services.

D. Similar needs exist for families who suffer fatal domestic violence, or other family deaths from abuse/neglect, including elder abuse, dependent adult abuse and parracide. In addition, children may mourn the death of professionals with whom they have been involved, including child protective services caseworkers.

E. Professionals from all agencies, grieving over the death of a child, need similar services and may benefit from Critical Incident Debriefing or informal Critical Incident Defusing. They may also benefit from attending the funeral or visiting the grave.

F. Support for sibling, family and professional survivors of child death should be developed and included as a part of agency and team protocols.

G. It should be noted that victims of crime funds may pay for grief and mourning interventions. Other funding sources for the provision of these services should be explored.

H. Mental health professionals may be joined by Child Life Specialists, hospital social workers and hospice workers who can add specific understanding and expertise to the management of children and families after death.

I. Intervention and support should be made available for at least one year to meet the significant anniversaries of the death and/or until the end of all legal actions which may impose further stressors on surviving siblings and other family members who may be called upon to testify in court.

J. Based upon studies showing a link between social deviance and a history of being a victim of child abuse and neglect, violent criminals, substance abusers, people who self mutilate and others with significant psychological problems may benefit from addressing issues of grief and mourning in their lives.

IX. Prevention / Health

Child Fatality Review helps identify high risk behaviors and other factors that can assist professionals in preventing future deaths. The findings of Child Fatality Review Teams may assist prevention focused programs, such as home visiting and parenting education, in strengthening their programs. Child Fatality Review also functions in a preventive way by assuring that surviving siblings are not placed in harm's way, and that adults who are violent towards children are monitored as to their future associations with children. While Child Fatality Review Teams often have a primary goal of working to prevent child abuse fatalities, the larger effect from a county team is the potential to develop prevention efforts for all causes of deaths including accidental, natural and/or non-intentional deaths.

Campaigns and programs addressing child deaths which value prevention include:

1. Public education on the potential hazard of accessible 5 gallon buckets to young toddlers resulting in toddler drownings.

2. Infant automobile safety seat campaigns that provide donated seats for families who have limited funds.

3. Child-proof drug containers, particularly for presciption pills or iron pills that resemble candy.

4. Traffic safety campaigns and the provision of speed bumps in neighborhoods with large numbers of young children.

5. The enacting of ordinances for four-sided fencing to help prevent pool and spa drownings and river safety programs that utilize warning signs in multiple languages.

6. The provision of smoke detectors for substandard homes (particularly homes where infants and toddlers reside) by child protective service agencies.

7. More intensive evaluations for home safety through the use of multi-agency records.

8. An increased awareness of the needs of infants and toddlers by both law enforcement and child protective services.

9. Multi-agency joint home visits by public health nurses, child protective services and law enforcement.

10. Perinatal intervention programs for women in jails and juvenile facilities.

11. Parenting programs for incarcerated parents, particularly young fathers.

12. Multi-agency integrated data systems to coordinate and monitor services to children and families with multiple problems.

Glossary of Terms

Accidental death - a mode of death indicating non-intentional trauma (see mode of death and intentional and non-intentional injury)

Baby gram - (slang) one or two x-rays taken in order to see all of a baby's body at one or two angles (often inadequate)

Blunt force trauma - injury caused by force from a blunt object (such objects may include hands and feet)

Board certified - a physician who has completed residency training and has passed an official examination to be listed as an official specialist

C.A.T. Scan (computerized axial tomography) - a radiological study using x-rays translated by com-

puter to show body cross sections (see M.R.I.)

Cause of death - the effect or condition which brought about the cessation of life (e.g. trauma, asphyxia, cancer)

Child Abuse - (common, legal) intentional injury to a child

Child Abuse Central Index (CACI) - the state central index of reports of child abuse/neglect; it generally includes acts or omissions by caretakers that are held to be true and of significance after an investigation by law enforcement or child protective services (CPS)

Child Neglect - (common, legal) an injury to a child caused by the omission of necessary acts including failure to provide food, healthcare, shelter or safety

Child Protective Services - (common) the welfare department/social service system designed to protect children

Competent intent - the desire to cause an event to happen by someone with the ability to form that intent (some say a child under the age of 8 does not have the ability to form competent intent)

Coroner's Investigator - an official investigator for the coroner (note these investigators may have varied backgrounds and levels of education)

Crime Scene - the physical site where a crime may have occurred (see death scene)

Criminal Court - a court designated to hear matters relating to criminal law (see dependency court, see family court)

Death - loss of life (see fatality)

Death Scene - physical site where death occurred (see crime scene)

Death Certificate - official document noting the cause and mode of death (see cause, mode, and fetal death certificate)

Dependency Court - specialized civil court designated to hear matters pertaining to child abuse/neglect (see criminal court, see family court)

Expert Witness - someone the court determines to have expertise on a subject (does not necessarily require any graduate degree)

Family Court - court designated to hear matters pertaining to family law (e g. divorce and child custody)

Fatality - loss of life (see death)

Fetal Death - (common) death of pregnancy after approximately 20 weeks

Fetal Death Certificate - official document noting the death of a fetus (note - does not include a space for mode of death, see mode of death)

Fetal Homicide - (law) the death of a viable fetus caused by competent intent (see viable fetus)

Forensic - having to do with the study of criminal acts

Forensic Pathologist - a pathologist with training in criminal pathology (see board certified)

Foster Care - placement for children under dependency court jurisdiction (note- this includes single family homes, group homes with no more than six children, or institutions with many children -see dependency court)

Homicide- (official) death caused by another with the intent to kill or severely injure
Homicide -(common but not official) death at the hands of another (without reference to intent)

Homicide Detective/Investigator - a police department or sheriff department investigator with an expertise in homicide investigations

Injury - caused by physical trauma

Infant - child under one year of age (see neonate)

Intentional Injury Death- public health term used to define death caused by another with the intent to cause harm (see competent intent)

Intern - post student trainee (e.g. a physician's first year of work after medical school)

Intent -desire to cause to happen (see competent intent)

ListServ - computerized newsletter that allows individuals to share information with a group

Mechanism of Death - the physical reason for a death (e.g. head trauma caused brain swelling which caused decreased brain function which caused the heart and/or lungs to stop functioning)

Mode or Manner of Death - official category for a death certificate (homicide, suicide, undetermined, accidental, natural)

Neonate - infant under one month of age

Non-Intentional Injury Death - public health term to replace accidental death

Pathologist - physician with residency training in pathology (see forensic pathologist, pediatric pathologist and forensic pediatric pathologist)

Pediatrician - physician who has completed residency training in pediatrics

Pediatric Pathologist - physician with special training in pediatrics and pathology (see board certified)

Resident - in medicine, a post-intern trainee in an official training program (e.g. pediatrics)

Retinal hemmorhage - bleeding in the retina of the eye

Shaken Baby Syndrome - characterization of head injuries to a young child caused by shaking without impact (see blunt force trauma)

Shaken Impact Syndrome - characterization of head injuries to a young child with shaking and impact

Skeletal series of x-rays - defined series of x-rays designed to find most fractures (see baby gram)

Stillborn - potentially viable fetus born dead

Subdural hematoma - bleeding between the internal lining of the skull and the brain

Suicide - death of self caused with intent (see intent)

Undetermined Death - death where the mode of death is not clear (see mode of death)

Viable Fetus - a fetus that would be able to live outside the uterus, if born (as defined by experts)

Victims of Crime Fund - money available to serve crime victims through a federal and/or state program with local officials having responsibility for distribution of funds

World Wide Web - hardware and software network that supports the connection of computers internationally