




Inter-Agency Council on Child Abuse and Neglect

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Child Death Review Team Report 2010

Report Compiled from 2009 Data

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Forward

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

This is the thirty-second annual report of the ICAN CDRT on children's deaths that occurred in Los Angeles County during calendar year 2009. The purpose of the report has been to provide a detailed analysis of children's deaths in Los Angeles County, their relationship to maltreatment and ICAN agencies' involvement with these children and families prior to and following the death.

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

For the third year, ICAN is including child deaths by a third party to provide an analysis of these deaths in the hope of gaining a better overall understanding of child death in Los Angeles County. Ultimately, studying these deaths will help us intervene more effectively to prevent them.

Introduction

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

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

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

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

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

This annual report of the ICAN Child Death Review Team provides information on *all* children's deaths that meet Team protocol and occurred in Los Angeles County during *2009.* It provides a detailed analysis of children killed by caregivers, youth suicides, accidental deaths and undetermined deaths.

The report also includes information on 3rd party homicides of youth 17 years and younger for the third year. These homicides are where the perpetrator was not a family member or caregiver.

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

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Recommendations

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

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

The primary goal of the Team is to reduce the number of child deaths in Los Angeles County through multi-disciplinary case review, education of professionals and the public, and by making recommendations for public policy and legislation. To this end, based on the child death case reviews and trends seen in the 2009 data, the Team is making the following recommendations:

Recommendations:

1. **The Family and Children's Index (FCI) be expanded to include hospitals not under the Health Services Department along with the other independent law enforcement agencies located throughout Los Angeles County.**

2. **FCI should be used throughout the life of a case and not just with the initial referral or contact with a family.**

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

Note: This recommendation relates to the Cycle of Abuse, Domestic Violence, Multiple Referrals and Improved Communication among Agencies sections in the Lessons Learned portion of the report.

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

4. **DCFS should develop a protocol for screening and assessment of substance abuse by parents or caregivers to include illicit drugs, alcohol and prescription medications for use in investigations of families in which a child has died.**

Rationale: Alcohol and drugs frequently play a major role whenever a death or serious injury to a child occurs. It is estimated that approximately 60% of the substantiated DCFS cases involve some degree of substance abuse by the child's parents.

In order to assess the extent of involvement the use of substances contributed to the death of a child, immediate screening for indicators of substance abuse and, when possible, testing on all care providers present at the death scene when the child dies should be conducted. Otherwise, deaths may be inaccurately moded as to cause; perpetrators may go unidentified or unpunished, and the involvement of substances in child deaths goes unreported and therefore not addressed by social service or legislative action. Further, the opportunity to intervene and engage a family into treatment for this high risk behavior is missed, placing surviving siblings at risk for harm.

Note: This recommendation relates to the Safe Sleeping and Fetal Death Associated with Maternal Substance Abuse sections in the Lessons Learned portion of the report.

5. **Centers of Excellence and the HUBs along with the countywide Child Abuse and Neglect Protocol should be utilized for expanded and ongoing training to healthcare professionals.**

Rationale: A doctor's opinion is powerful and influential and can impact the manner in which DCFS responds to an allegation of abuse or neglect. DCFS workers rely on medical experts' opinion in their decision-making process regarding the nature of a child's injury. Children who die are sometimes injured and treated in emergency rooms weeks or months prior to their deaths. These warning signs that a child may not be safe can be deferred when an injury is labeled as accidental in nature by a physician when the parents brought the child in for treatment.

When a child is brought into an ER, clinic or physician by a family member or other person, the staff at these facilities should be trained to refer a family to a Center of Excellence if they have a reasonable suspicion that child abuse/neglect may be involved. The Child Abuse and Neglect Protocol provides a road map for various agencies involved in child abuse/neglect and child death investigations promoting

consistency, communication and a coordinated response among agencies. The protocol should be utilized as a training tool.

Note: This recommendation relates to the Mandated Reporting and Lack of Bonding or Poor Attachment section in the Lessons Learned portion of the report.

6. **Healthcare providers should call both DCFS and law enforcement when there is a strong suspicion of inflicted injury to a child.**

7. **Additionally, when Child Protection Hotline intake evaluators receive a report of suspicious physical injuries from healthcare providers, they should code the allegations as possible severe neglect and/or physical abuse in order to trigger a mandatory cross-report through E-SCARS to law enforcement.**

Rationale: Children age five years and younger continue to be the most vulnerable victims of homicide by a parent/caregiver or other family member, representing 80% of all child homicides (in Los Angeles County in 2009). Although infant fatalities are most often related to traumatic injuries of the head and abdomen, such injuries can appear on occasion alongside other medical conditions that can complicate the assessment of child abuse by medical professionals. This, in turn, can negatively impact the reporting and investigation of child abuse by both DCFS and law enforcement. In cases where there is strong suspicion of inflicted injury, notifying both agencies directly will help ensure the prompt response needed to conduct a thorough and appropriate investigation.

Further, when the hotline receives suspected abuse referrals with complicated medical circumstances, best practice would dictate the referral be coded as physical abuse or severe neglect to generate a cross report to law enforcement. The development of the Electronic Suspected Child Abuse reporting system (E-SCARS) is a tremendous asset to cross-reporting and should ensure more timely responses by both agencies.

Note: These recommendations relate to the Mandated Reporting, Multiple Referrals and Improved Communication Among Agencies sections in the Lessons Learned portion of the report.

8. **It is recommended that universal neonatal home visitation by a public health nurse be made available to first time parents and at risk families. Families should have the opportunity to accept voluntary services from programs such as the Nurse-Family Partnership, Prenatal Care Guidance, Black Infant Health Program and Best Start LA.**

Rationale: The Team has observed various high risk factors in child deaths such as lack of biological relationship, lack of attachment to the child, lack of parenting skills, unrealistic developmental expectations, history of child abuse and neglect as a child, substance abuse, domestic violence and parental mental illness. Home visitation has

been found to be a highly effective preventive measure to child safety. Home visitation allows for an observation of the home environment, the parent-child interaction, parental attitudes and expectations. Home visitors are trained in identifying post-partum signs of depression or other psychiatric illness and can seek assistance for a family. Additionally, they can observe the physical home for safe sleeping practices, sanitary conditions, and the presence of unsafe situations such as an unfenced pool, signs of alcohol or drug abuse and domestic violence. Services include pre-natal support, parenting skills, household management, resource referrals and coping skills.

Note: This recommendation relates to the following sections of the Lessons Learned portion of the report: Safe Sleeping, Cycle of Abuse, Domestic Violence, Verifying the Identity and Relationship of the Caregiver to the Child and Lack of Bonding or Poor Attachment.

9. **First 5 LA, the Department of Public Health (DPH) and the Department of Children and Family Services (DCFS) continue to provide information on safe sleeping practices to hospitals, community health departments, local clinics, child development networks, community partners and child care resource centers for dissemination to parents.**

10. **When a Children's Social Worker assesses a family with a child under the age of one year, information about safe sleeping practices should be emphasized with the parent or caregiver. The worker should inquire and assess the sleeping environment and practices for the child and provide the family with a Safe Sleep Tips for Your Baby brochure if they have not already received one. DCFS should ensure that workers are trained to include assessment for safe sleeping and have the knowledge to inform caregivers during their home visits.**

Rationale: According to the Centers for Disease Control (CDC), Sudden Infant Death Syndrome (SIDS) is the leading cause of death among infants aged 1–12 months, and is the third leading cause overall of infant mortality in the United States. With the back to sleep campaigns from the 1990's, the rate of deaths due to prone positioning has decreased by 50%. However, both the CDC and American Academy of Pediatrics report there has been a significant increase in the rates of other causes of Sudden Unexpected Infant Death (SUID) aside from prone positioning involving the side positioning and the sleep environment.

In Los Angeles County, the number of child deaths associated with co-sleeping or "overlay" continues at an alarming rate. Thirty-three percent of undetermined child deaths were associated with co-sleeping in 2009. Families with infants under the age of one year need to be aware of the risk of co-sleeping to ensure the infant's safety and survival. Co-sleeping, particularly with a caregiver under the influence of drugs or alcohol increases the chance of overlay or suffocation resulting in Sudden Unexpected Infant Death. In Los Angeles County, an additional 26% of infants died due to unsafe sleeping environments. Unsafe sleep environments includes sleep surfaces not

intended for an infant (adult bed, sofa, couch, chair or futon), excessive bedding, pillows, bumper guards or toys, excessive swaddling, sleeping with face or head covered, sleeping on side or prone.

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

Child Death Review Team

Issues Identified/Lessons Learned

1. Cycle of Abuse

A common factor seen in many of the child death cases is that the child's mother, father or other family member had a prior juvenile case themselves in either the Dependency Court or the Delinquency Court, or their family had contact with these agencies when they were a child. Many of them parent as they were parented, thus continuing the cycle of abuse and neglect. The year 2009 was no exception in which five of the homicides involved a parent with a CPS history as a child.

2. Domestic Violence

Over the years, the Team has recognized the connection between domestic violence and child death. When there is violence between adults in the home, children often become the target of violence, either intentionally or unintentionally. ICAN continues to sponsor the annual Nexus conference which includes a focus on the connection between domestic violence and child abuse.

3. Substance Abuse

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

4. Mental Illness

In 2009, several children were the killed by a parent with mental illness. Not all individuals with mental illness place their children at risk. However, those with chronic mental disorders who are non-compliant or uncooperative with medication, treatment, family members or other supports have the potential to place children at risk including death. Community service and treatment providers must be able to identify when a parent's mental condition puts children at risk and report it to DCFS. DCFS in turn needs to accurately assess for risk and develop appropriate case plans to address a caregiver's mental health needs.

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

The identity and relationship of the caregiver to the child needs to be verified by DCFS and law enforcement. Verifying and assessing the relationship should include criminal record checks. If a child is not with a biological parent, the reason for the living arrangement needs to be assessed and verified. Every effort should be conducted to locate biological parents. Additionally, the quality of the relationship of any adult to the child named or observed to be in the home should be assessed ongoing.

6. Lack of Bonding or Poor Attachment

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

In the DCFS Academy and ongoing training provided by DCFS, workers need to be given information on the connection between lack of bonding or poor attachment of the parent/caregiver with a child as a risk factor for child abuse/neglect. Workers need to be aware of how malnourishment or failure to thrive is an indication of poor attachment. The relationship between lack of parenting skills, knowledge of child development and the ability to cope with stressors related to parenting and poor attachment with a child are risk factors for abuse and neglect.

7. Safe Sleeping

The Team has spent a great deal of energy focusing on deaths associated with unsafe sleeping practices involving the sleep position (prone or side) of the infant and/or the sleeping environment. These deaths are tragic and are clearly preventable. Infants should be placed alone, on their back, and with no soft bedding.

Although the issue of co-sleeping with an infant has sometimes been tied to cultural values and bonding issues, the Team continues to note a disturbing number of deaths associated with co-sleeping and has made recommendations to help prevent these deaths. In addition, the American Academy of Pediatrics and Centers for Disease Control have released research confirming the risk of co-sleeping with infants.

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

The Team has observed that infants are often surrounded by soft bedding and pillows and/or are bundled in blankets in an effort to keep the infant warm. However, statistics indicate overheating contributes to infant mortality. Infants should not be placed on soft bedding or pillows and should not be covered with blankets or dressed in layered clothing when put to sleep.

The Team (ICAN) has joined with the Department of Public Health and the Department of Children and Family Services and other public and community agencies to conduct a safe sleeping campaign. A Safe Sleep Tips for Your Baby brochure has been distributed to local clinics, hospitals, county departments and agencies, and child development networks. The office of Supervisor Mark Ridley-Thomas has provided leadership and First 5 LA is assuming a major role in sponsoring the safe sleeping campaign.

8. Drowning/Accidental Death

Drowning has long been a leading cause of accidental child death and some homicides where there is a clear lack of supervision. Through the examination of drowning in pools, ponds and buckets, the Team has learned that it is very easy for a young child to drown without anyone being aware of it. The child's head is heavy and pulls the child under the water before he or she is able to make any sound. Drowning is a silent killer. Contrary to popular belief, there is no splashing, waving, screaming or calling for help. The process of drowning is undramatic and quiet. The Team has learned that a drowning child's natural instinct is to breath and speech is secondary. Voluntary movements such as waving are not possible as the natural response is to extend one's arms laterally and press down on the waters' surface to leverage the body in order to lift one's mouth out of the water to breathe.

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

9. Fetal Death Associated with Maternal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appears to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a large number of fetal deaths with a contributing factor of maternal substance abuse. The Team believes that these cases should be better tracked and that a death report should be taken by law enforcement on all fetal death cases so that a record of these deaths is maintained should there be future contact with the family.

10. Grief and Loss

The Team has worked hard to educate those who work with families and children about the issues of grief and loss and has recommended that surviving family

members be referred for grief counseling when a sibling or other family member dies. The Team, in conjunction with the Child and Adolescent Suicide Review Team, has also worked to ensure that schools are notified when a student has died and that supportive services are provided to the other students at the school the deceased child attended.

11. Mandated Reporting

The issue of mandated reporters failing to report suspected child abuse and neglect is a common theme in many of the cases reviewed. It is clear that more training is needed regarding mandated reporting and that such training should attempt to help clarify how one defines a "reasonable" suspicion of abuse or neglect. The Team has reviewed many cases where a child's life may have been saved had a report to the Department of Children and Family Services (DCFS) and/or law enforcement been made when the child was seen for a prior injury or exhibited signs of abuse at school, at a community agency or at doctor visit. Additionally, when a community based agency is providing in- home services to at-risk families, the Team has observed a failure to report a parent whose behavior or mental health has deteriorated. In some of these cases, the community agency representatives working with families have acted more as friends than a professionals. This relationship has inhibited their reporting a parent for suspected abuse or neglect. As a best practice, mandated reporters should make a report to both DCFS and law enforcement to facilitate a coordinated response by both entities.

12. Multiple Referrals

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

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

13. Improved Communication Among Agencies

DCFS, schools, Department of Health, Department of Public Health, Department of Mental Health, Department of Probation, law enforcement agencies, the District Attorney and City Attorneys, and community based agencies should have ongoing forums to facilitate communication and connections between agencies. These forums would foster better collaboration and understanding of each other's role in child abuse cases. When a family is involved with multiple systems, it is imperative that the agencies servicing the family have ongoing communication with one another for child safety, investigation, and case management purposes.

14. Role of Emergency Medical Responders

The Team has focused on the role of the paramedics and emergency medical responders in child death cases. Often, the tendency is for the responding personnel to rush the child to the hospital, despite the fact that the child is already deceased. The Team has recognized that it is often easier to transport the child as it makes the family feel better and emergency responders want to feel there is something they can do to help. However, in many of these cases, the removal of the already deceased child impedes death scene investigation and may provide time to alter the scene where the death occurred.

The Team also believes that first responders play a very important role in providing initial information concerning a child's death. Those reviewing the death of a child should obtain this information as part of their review.

15. Poverty/Insurance/Medi-Cal

There have been several cases where a family has been unable to obtain appropriate medical care or medication for a sick child due to a problem with medical coverage – either a lack of coverage, problem with a medi-cal card, or co-payment. In addition, clinics that do require insurance should be educated on how to ensure that a family is referred to an appropriate medical care setting should they present with an ill child and no insurance coverage.

16. Regional Centers

Several cases were reviewed where the deceased child or parent had been receiving care through one of the County's Regional Centers. Despite the presence of red flags, the Team has observed reluctance on reporting suspected child abuse or neglect by the Regional Center. It is hoped that the DCFS Regional Center liaison can do much to ensure collaboration between DCFS and Regional Centers to ensure better continuity of care to those children in need of more specialized services, and to foster a better understanding of each agency's role.

17. Community Care Licensing (CCL)

CCL is the state entity responsible for the licensing and oversight of foster care homes and child care facilities. There have been several cases in which CCL had informed a provider not to allow certain individuals to be present at the home or day

care site as they do not meet licensing standards. This is particularly true of individuals with criminal backgrounds. In many cases, these individuals were actually responsible for the child's death. When CCL bars someone from a site, they need to follow-up to assure there is compliance with their determination. It is recommended they make unannounced visits to the site to verify compliance.

18. Criminal Justice System

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

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

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

Lastly, the Coroner will at times mode a suspicious death as undetermined as a signal to law enforcement that further investigation is required to determine whether or not a death was a homicide. However, with a final mode of undetermined, law enforcement will typically end their investigation. This defeats the purpose of such a determination by the coroner to spur additional investigation by law enforcement. Better collaboration between law enforcement and the Coroner to foster an understanding as to why a case is moded undetermined when the initial mode was homicide is needed in these cases.

Child and Adolescent Suicide Review Team

Issues Identified/Lessons Learned

Suicide Rate

The suicide rate among individuals under the age of 18 decreased from 17 suicides in 2008 to 14 in 2009. With the exception of 2008, we have seen a downward trend in suicides over the last five years. The overall five year downward trend may have been due to the increased prevention efforts on the part of public and private schools effectively identifying young people at risk and initiating contact with youth who may be contemplating suicide.

Law Enforcement Response

Through the review of cases, the Team has seen an increase in the impulsive behavior of youth. In 2009 only three of the youth left suicide notes. The investigative practices among law enforcement agencies vary considerably in cases when suicide is suspected. When there is no suspicion of foul play, some investigations are limited because criminal activity is not present. In such cases additional information available to investigators has value to those concerned with prevention including the Team. Potent sources of prevention information include the youth's computer, records of the youth's Internet activities, cell phone records and interviews of the youth's friends. Friends may be privy to information that was being kept purposely hidden from parents and family. The team has discovered communications to friends about their mood, feelings, cognitions, behavior and suicidal intent. In addition, the team has discovered Internet communications that indicate risk factors and suicidal thinking to "virtual" friends on social networking sites.

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

Social Networking

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

An important and disturbing trend among suicidal youth is the relationship with Internet "friends." Some youth have been ostracized, bullied or otherwise socially isolated in real life. The Internet provides access to "virtual friends" from which they seek support. While satisfying in many ways, sometimes the relationships are based on "selves" and are often transitory. The internet has become an attractive home for many youth that are deficient in social skills in the actual world. Some youth may have more than one social networking account. For example, parents may have had privileges to access t a Facebook page which they monitored on a regular basis. Unbeknownst to them, however, may be one or more accounts that they were being kept private from them and from which they did not access privileges, resulting in a lost opportunity for parents to recognize and respond to suicidal clues of their children.

Limited access to private Internet sites is also an obstacle to the ability of the team to study these cases. Like many parents, the team is not a user who was pre-authorized to access this information and the team is prevented from collecting important information about chronic and acute risk factors and warning signs. Team members are currently communicating with providers of some of the primary social networking sites in an effort to gain access for suicide prevention purposes.

Youth are encouraged to share their concerns with an adult or friend whenever they are at risk. Members of the team believe that actual friends are more effective in providing the needed support to at risk children and adolescents than "virtual friends." The team recommends that schools increase their efforts to identify students who lack social skills and that they be referred to mental health services or other interventions designed to increase their social skills in the real world.

Transition from In-patient to Community Support

The Child and Adolescent Suicide Review Team (CASRT) reviews a number of cases in which adolescents fail to receive sufficient support as they transition from in-patient mental health treatment programs back to home and school. The lack of ongoing support during this difficult transition period was seen as a factor that contributed to the eventual suicide of one youth. It would be beneficial for professionals in hospitals and schools to communicate with each other about a patient/student's mental health status. After a hospitalization due to suicidal ideation, school officials should receive a copy of the discharge plan with medication information when a child is released to return to school. School personnel are also encouraged to participate in discharge planning whenever possible.

Communication Barriers between Agencies/Professionals

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

Need for Ongoing Training on Suicide Assessment and Treatment

Mental Health and medical professionals are often not adequately prepared to address the needs of children and adolescents at risk for suicide. The number of professionals with current evidence-based training is alarmingly low. Additional training is needed to recognize and respond to the suicidal risk of children and adolescents in all venues including graduate schools and continuing education. It is recommended that professional organizations and regulatory boards offer incentives and opportunities for professionals to increase their competency in evidence-based and state of the art practices.

Selected Findings

Homicides

- There were 30 child homicides by parents, caregivers or family members in 2009. This represents a decrease (12%) from 2008 when there were 34 child homicides. The number of child homicides for Los Angeles County in 2008 was lower than the 15 year average of 38 deaths.
- 80% percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is an increase from 2008, when 74% of the children were five years of age or younger. Slightly more than thirty percent (33.3%) of the children were under the age of one year.
- Six children were over age 5, including one six-year old, one eight-year old, one eleven-year old, one twelve-year old, one 16-year old and one seventeen-year old.
- Three of the children over the age of five years died as a result of murder/suicide by a parent or family member. A total of seven children died as a result of murder-suicide.
- The average age of a child homicide victim in 2009 was 3.61 years (43.35 months). The average age of a child homicide victim in 2008 was 3.6 years (42.73 months).
- Sixteen female children and fourteen male children were victims of child homicide by parents, caregivers or family members in 2009.
- Eight children died from head trauma, two died from multiple traumas and one from trauma to the torso/abdomen. These include children who were victims of battered child syndrome. Two children died from asphyxiation/suffocation, eight from gunshot wounds, four children were victims of a stabbing, one died from drowning, one child died from hyperthermia, one child died of dehydration/malnutrition, one died from medical neglect and two were unattended newborns.
- Two newborns were abandoned and found deceased and/or killed by their mothers in 2009. This is the same number as in 2008 except one of the 2008 death's was ruled undetermined by the coroner. The two 2009 abandoned newborns were ruled homicides. Seven newborns were safely surrendered in 2009 which is the same as in 2008.
- African American (n=14) children were greatly over-represented in child homicides by a parent, caregiver or family member accounting for 47% of child homicides. Hispanic (n=13) children were also over-represented and comprised 43% of child homicides by a parent, caregiver or relative. Three children were Caucasian.

- The Department of Children and Family Services (DCFS) or another county's Child Protective Services agency had prior contact with 63% (n=19) of the families in which there was a child homicide and the child died in Los Angeles County. This is an increase from 2008 when 41% of these families had previous contact with DCFS. One homicide had an open referral on the mother with L.A. County DCFS at the time the fatality occurred. Three child homicide victims had an open case with L.A. County DCFS at the time of their death. One homicide was an open case with Riverside County CPS.
- Eleven children were killed by their father, stepfather or mother's boyfriend and Twelve children were killed by their mother (this includes the two newborn abandonments). One child was killed by both parents and two by the mother and her boyfriend. One child was killed by the mother and maternal grandmother. One child was killed by an uncle, one by the aunt's boyfriend and another by their sister.
- The greatest number of child homicides by parents, caregivers or family members occurred in January (n=7). The second greatest number of homicides occurred in the month of October (n=5). The fewest occurred in the month of March (n=1). In the month of October, there were four child homicides. Three child homicides occurred in the months of April, August and November. Two homicides occurred in the months of September and December. Thirty percent of child homicides occurred in the fall of 2009.
- Child homicides occurred throughout all of Los Angeles County in 2009. SPA 8 had the greatest number of child homicides (n=7). Six child homicides occurred in SPA 5 and four child homicides occurred in SPA 2. SPA 1, 3 and 7 each had three child homicides. Two occurred in SPA 6 and one in SPA 4.

Suicides

- Fourteen children and adolescents committed suicide in 2009. This is a decrease from the 17 such suicides in 2008 and lower than the 15-year average of 19.5 suicides per year.
- As in years past, male victims outnumbered female victims by a large margin. Nine males and five females committed suicide in 2009.
- The leading method was death due to hanging, which represents 50% (n=7) of the suicides in 2009. Four of the adolescents committed suicide using firearms and two adolescents overdosed. One adolescent jumped into moving traffic.
- The majority of suicides continue to occur at home. Most of the adolescent suicides were precipitated by interpersonal conflicts.
- Suicides by Hispanic youth represent 50% (n=7) of the total of adolescent suicides and is an increase from 2008 when 46% of suicides were by Hispanics. Twenty-nine percent (n=4) of adolescent suicides in 2009 were by Caucasians

which is one more than the previous year. Suicides by African Americans in 2009 (n=3) remained the same as in 2008. There were no suicides by Asian/Pacific Islander adolescents in 2009.

- Sixty-five percent (n=9) of the children who committed suicide in 2009 were ages 15 – 17; one victim was 13 and one 14 years of age. The youngest victims were age 12 numbering three and representing 21% of the total number of adolescent suicides. In comparison to 2008, eleven victims were age 15 or older and the youngest was 11.
- Eight of the youth had experienced a recent relationship loss or conflict. Three of the youths' families had a prior referral or open case with the Department of Children and Family Services or with the Department of Probation. Four youth had a history of mental illness. One youth had a history of prior self-injury. One youth had previously attempted suicide and three youth exhibited warning signs prior to their suicide. Three of the youth who committed suicide in 2009 left a suicide note. The trend of youth not leaving a suicide note speaks to the impulsivity of the act. One youth were discovered to have a positive toxicology for drugs at autopsy. One youth had experienced academic problems, two youth had received special education services and two had school discipline or truancy problems.
- Child and youth suicides were experienced in most areas of Los Angeles County. The greatest number of incidents occurred in the San Gabriel Valley SPA 3 (n=3) and San Fernando Valley SPA 2 (n=3). Two suicides occurred in SPA one, four, six, and seven.

Accidental Child Deaths

- The rate of accidental deaths among children in Los Angeles County has been declining over the past five years. Accidental child deaths dropped from 147 in 2004 to 101 in 2008. There was an additional decrease of accidental child deaths in 2009 of children ages 0 - 17 which numbered 91.
- The two leading causes of accidental death were automobile accidents (n=28) and auto pedestrian (n=19). A total of 68 accidental child deaths were children ages 0 – 14 years. This is a 7% decrease from 73 such deaths for this age group reported for 2008. Eighty percent of auto pedestrian deaths were children ages 0 to 14 years. There were 23 accidental deaths of youth's ages 15 to 17 years. Youth ages 15 to 17 years accounted for 32 % (n=9) of automobile related deaths in 2009.
- Deaths due to automobile accidents (n=17) was the leading cause of accidental death for children 14 years of age and under. Auto pedestrian (n=15) was the second leading cause. Drowning and maternal substance use (n=10 each) ranked third as the leading cause of accidental death, and an overdose (n=7) ranked forth.
- Deaths associated with maternal substance abuse accounted for 8 fetal deaths, the death of an infant one day of age and one three month old infant.

Methamphetamine is the most associated drug with these deaths (n=5) accounting for 50%. Deaths associated with maternal substance abuse accounted for 11% of all accidental deaths in 2009, and fetal deaths associated with maternal substance abuse accounted for 9% of all accidental deaths.

- Accidental drowning claimed the lives of 10 children ages 0 – 17 years which is an increase from 2008 when there were 7 such deaths. A majority of these drowning deaths were young children who drowned in residential pools. Drowning continues to be one of the leading causes of accidental deaths of children for the past fifteen years in Los Angeles County.
- Hispanic children represented 52% (n=47) of all accidental child deaths in 2009. Sixty-one percent of the auto pedestrian deaths were Hispanic children. Caucasian children represented 25 % (n=23) of the accidental deaths. They were over-represented in automobile deaths (n=6) and under-represented in drowning and auto pedestrian deaths having one each. African-American children (n=10) were slightly over-represented in accidental deaths in 2009. Thirty percent of the African-American child deaths were due to automobile accidents and another 30% due to maternal substance use. Asian/Pacific Islander children in 2009 were over-represented in accidental child deaths with 50% occurring in auto accidents and 40% due to drowning.
- In 2009, 53 male children and 38 females died due to accidental death which is a 3:1 ratio. In comparison, in 2008, 68 male children and 32 females died due to accidental death, which is a 2:1 ratio.
- In 2009, male children tend to over-represent female children in comparison in nearly all types of deaths. Females out-numbered males by four in automobile deaths and by two deaths being crushed by an object. In deaths associated with total automobile accidents, 12 male children lost their lives due to this type of accident in comparison to 16 females and 14 male children died as a result of an auto pedestrian accident versus 5 females.

Undetermined Child Deaths

- There were 121 undetermined child deaths in 2009. This is 8% decrease from the 131 such deaths in 2008 and significantly higher than the 15-year average of 73.4 undetermined deaths per year. Eighty-six percent of the undetermined child deaths were age one year and under (this includes stillborn deaths). Ninety-four percent of undetermined child deaths were age five years and younger.
- African American (n=34) children were over-represented in undetermined child deaths. Sixty-three children were Hispanic, 19 Caucasian and 5 Asian/Pacific Islander descents.
- Thirty-three percent (n=39) of the undetermined child deaths had a noted status of post co-sleeping. This is a decrease from 2008 in which 38% of undetermined child deaths was associated with co-sleeping.

- Forty-one percent (n=16) of the co-sleeping related deaths were infants between 0 to 3 months of age, 39% (n=15) were infants between 3 to 6 months of age, 10% (n=4) were over 6 months to 9 months of age, and, 10% (n=4) were 9 months to 1 year.
- Of the undetermined child deaths associated with co-sleeping, the infant was sleeping with one adult in forty-eight percent of the incidents, 15 of these infants were sleeping with the mother, two with the father, one with a grandmother, and one with a caregiver. Eight infants were sleeping with two adults, 3 were sleeping with one or more other children, 3 were sleeping with one adult and one or more other children and 6 were sleeping with two adults and one or more children.
- Twenty-six percent (n=31) of undetermined child deaths were associated with unsafe sleep practices. Eleven infants were put to sleep prone or on their side, nine placed on soft bedding or a pillow, seven were put to sleep on an adult bed, 3 were excessively swaddled, and one was placed in a car seat.
- Co-sleeping and unsafe sleeping practices accounted for 58% percent of all undetermined child deaths.
- African American infants are over represented in the percentage of both co-sleeping and unsafe sleep practice child deaths. Thirty-one percent of the co-sleeping deaths and 23% of the unsafe child deaths were African American.

Team Accomplishments

In 2009 – 10, the ICAN **Multi-Agency Child Death Review Team (CDRT):**

- Improved case outcomes resulting from Team sharing of information. The Team venue has assisted law enforcement by bringing together legal, medical and other professionals who are able to provide expertise on suspicious child death case investigations.
- Worked with First 5, ICAN Associates, the Los Angeles County Department of Public Health, and the Los Angeles County Department of Children and Family Services to Disseminated the Safe Sleep Tips for Your Baby brochure on safe sleeping practices with infants.
- Devoted several Team meetings to an on-going focused review of child deaths moded as undetermined with a cause of Sudden Unexpected Infant Death (SUID) by the Coroner in an effort to understand the increase in these deaths and to develop prevention efforts. This effort resulted in the formation of a countywide task force on Safe Sleeping to address these deaths through a prevention campaign
- Presented a workshop on lessons learned by the Team and how these lessons can help identify at risk children and families at the 15th Annual Nexus Conference.
- Assisted the Los Angeles Community Child Abuse Councils with the distribution of a child fatality prevention kit that includes materials on safe sleeping, drowning prevention, safety tips in and around cars, and shaken baby syndrome.

In 2009 – 10, the ICAN **Child and Adolescent Suicide Review Team (CASRT):**

- Improved case outcomes resulting from Team sharing information. The Team has provided support to numerous school personnel, providing emotional support and procedural assistance in the aftermath of student suicides. Posthumous activities have included providing suggested guidelines for memorials, mental health interventions and interactions with the suicide victims' family and friends as well as any needed cultural advisement.
- Continued to disseminate two wallet sized cards in English, Spanish and Korean regarding suicide. One post-vention for Dealing with Grief and the second aimed at prevention listing Some Common Signs of Depression. Both cards list resources for families and friends after a suicide, a suicide attempt or threat on the back of the cards.
- Operated a speaker's bureau that conducted presentations at various conferences and employee groups both locally and throughout the United States.

- Participated with the LA County Suicide Prevention Network. The network developed a website with Department of Mental Health, Los Angeles County Office of Education and LAUSD to provide guidance and support to schools. The site is: www.preventsuicide.lacoe.edu
- Participated, as requested on the State Child Death Review Council to provide guidance on issues such as the requirement that all California Child Death Review Teams develop a system to review child and adolescent suicides and to include school representatives in their Team review process.

- Coordinated activities of the Educator's Suicide Prevention Network (ESPN), a unique partnership of secondary and university counselors and psychologists formed for the purpose of collecting data and developing joint data-driven suicide outreach and prevention activities. Focused on the importance of thorough suicide investigation protocols for the purposes of collecting prevention data.

Selection of Cases for Team Review

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

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

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

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

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

Undetermined deaths reflect situations in which the Coroner is unable to fix a final mode of death. For 2009, this mode of death represents the largest category of deaths reported to the Team by the Coroner. These cases often involve insufficient or conflicting information which impacts the Coroner's ability to make a final determination. Usually, there is no clear indicator in these cases whether the death was intentionally caused by another or was accidental. These cases remain suspicious in nature and are of interest to the Team because a final determination cannot be made by the Coroner. Undetermined death cases include perinatal demise of an undetermined cause, which may be child maltreatment related if the infant was left exposed or unattended as is the case with abandoned deceased infants. However, the Coroner may be unable to determine if the exposure caused the death or if the death was due to some other cause. Additionally, a significant portion of the undetermined deaths have a noted status of "post co-sleeping." In these cases, the Coroner is unable to determine the role co-sleeping may have played in the death, e.g., suffocation by accidental layover or some other cause.

Child Deaths in Los Angeles County 2005 – 2009

Over the past 5 years, a parent, caregiver or other family member has killed an average of 31.6 children each year.

2005	33
2006	35[1]
2007	26
2008	34
2009	30

An average of 14 children and adolescents each year has *committed suicide* over the past five years. The leading method from 2005 through 2009 was hanging.

2005	15
2006	14
2007	10
2008	17
2009	14

Over the past five years, an average of 119.2 children have died from preventable accidents. The most common accidental Deaths involve auto pedestrian, automobile accidents, drowning and deaths due to maternal substance abuse.

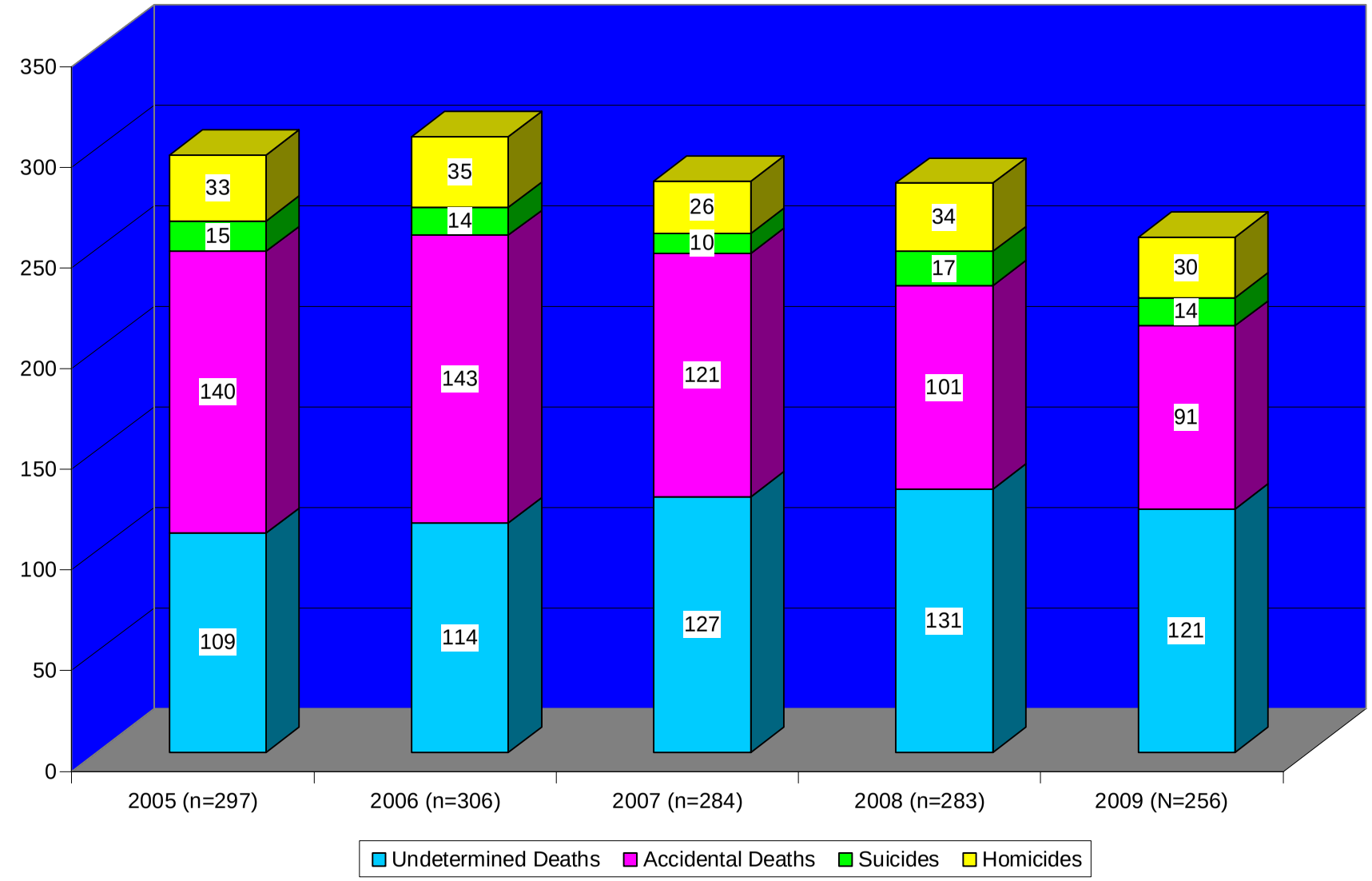
2005	140
2006	143
2007	121
2008	101
2009	91

The number of undetermined deaths has averaged 120.4 per year over the past five years.

2005	109
2006	114[2]
2007	127
2008	131
2009	121

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

Child Death in Los Angeles County 2005 - 2009



Child Homicides by Parent, Caregiver, or Other Family Members 1995 – 2009

Case Summary
Child Homicide by Parent/Caregiver/Family Member

Law enforcement responded to a “CPR call” concerning a one-year old female child named Grace. Upon arrival at the scene, law enforcement officers went into the home from where the call was made and found a number of family members standing in a bedroom pointing to the floor where Grace was lying. CPR was not in progress by any of the family members. Grace appeared to be “lifeless” and her hips and knees were flexed and her arms were “up, but not stiff.” Some redness was noted on her cheek. When law enforcement officers assessed Grace she was found to be pulse-less with her eyes rolled up in her head. Approximately one minute later paramedics arrived and death was determined at the scene. Neither law enforcement nor fire personnel began CPR as Grace was obviously dead.

Law enforcement learned that Grace lived in the home with her mother and five siblings ranging in age from 5-months to 8 years of age. The family reported that Grace had been placed on the lower mattress of a bunk bed to sleep. Approximately thirty minutes later Grace was discovered unresponsive and 911 was called. The dispatch operator instructed the family members to move Grace from the bed to the floor of the room. At the time of law enforcement’s arrival the temperature of the home was very warm and humid. There was a concern that the home had been cleaned prior to the 911 call because the home smelled of cleaning products and a wet mop was found. Reportedly, Grace was found by her sister while lying on the bed and was moved to the floor by her mother.

Law enforcement learned during the course of their investigation into Grace’s death that the family had a history with the Department of Children and Family Services (DCFS). There was an initial referral in 2004 for General Neglect that was unfounded. A second referral to DCFS in 2005 for General Neglect was substantiated and DCFS opened a Voluntary Family Maintenance case with the mother. Reportedly, the father had been using methamphetamines and had attacked the mother. The mother obtained a Protective Order from the father. However, despite DCFS efforts to work with the family, the parents were non-compliant and all of the children were removed from the care of the parents in 2006, including Grace who was a newborn at the time. Mother indicated to both DCFS (while services were being provided) and law enforcement (at the time of Grace’s death) that she had difficulty bonding with Grace because she had been removed from her care as an infant. It was also learned that Grace’s father had been arrested on a drug charge eighteen days before her death.

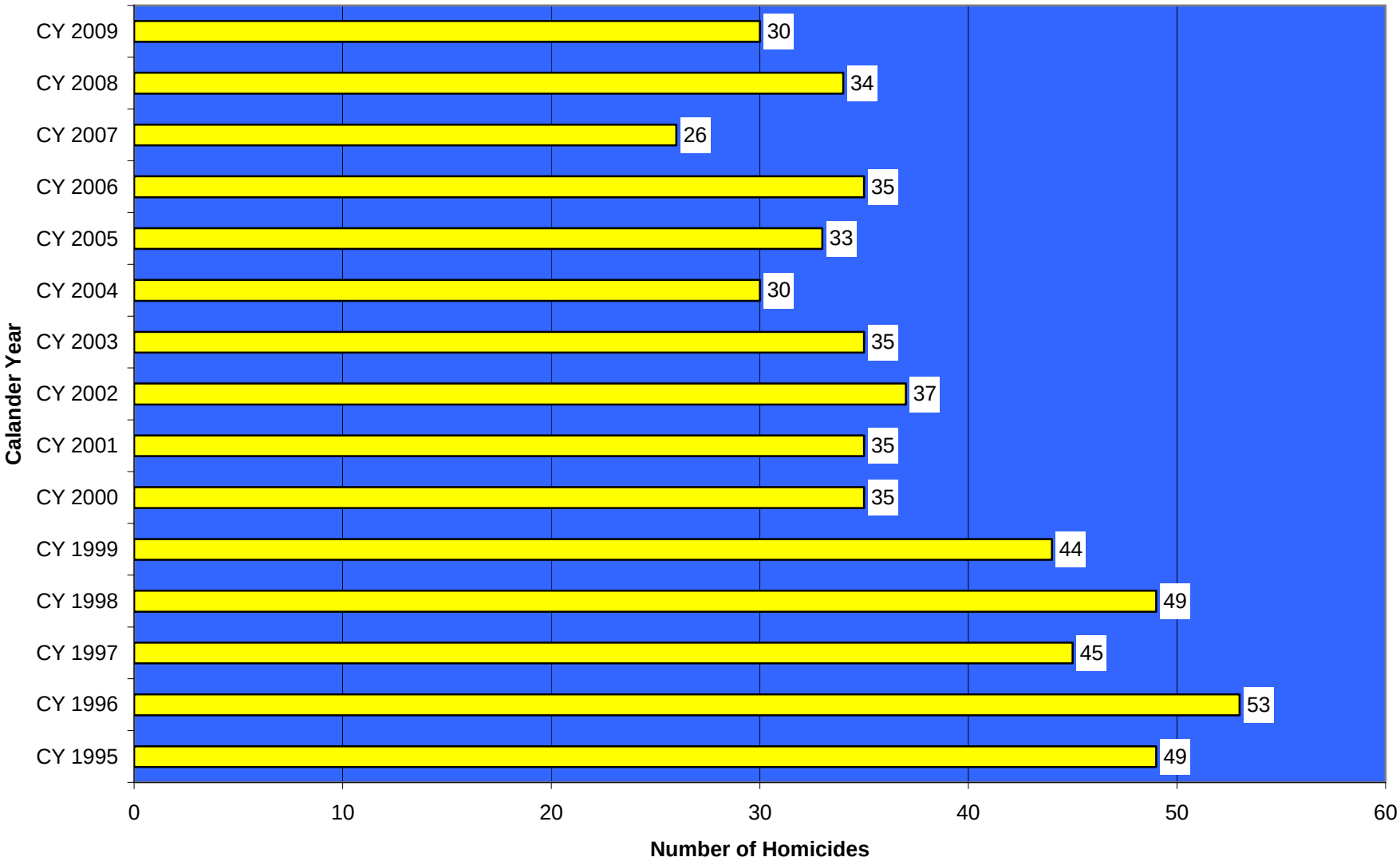
Upon autopsy it was determined that Grace suffered from chronic and progressive malnourishment and that she died as a result of a long, slow starvation process. Grace had nearly no body fat and since her last medical examination while in foster care, she had dropped to the third percentile in height and weight and had lost nearly fifty percent in head circumference. The Coroner determined that Grace’s death was a Homicide. Both parents were arrested and have been held to answer for Grace’s death at the preliminary hearing.

In the review of this case the ICAN Child Death Review Team (CDRT) noted that this case exemplified many of the common red flags seen in child homicide cases. There was a history of substance abuse, domestic violence, lack of bonding with Grace and a lack of compliance with the DCFS case plan. Reportedly, there was nearly an eleven-month gap from Isabel's last medical examination in foster care until her death. Isabel had never been seen by any medical professionals since her return home. In addition, it was learned that Grace was often singled out as being a problem and she was "scapegoated" by her parents, something that is common when there is a lack of attachment or bonding with a child.

The Team review also noted that there had been prior allegations of physical abuse and malnutrition and that law enforcement had responded to a cross-report of physical abuse in March 2008 but did not disrobe any of the children to see if there were signs of abuse and/or malnourishment. It was pointed out during the Team discussion that law enforcement often believes that DCFS social workers are responsible for such disrobing, whereas, social workers often rely upon law enforcement to do so during the course of their investigation. The Team recommended that policies requiring disrobing of children when there are concerns about physical abuse and/or malnourishment be better clarified and that training on the need for disrobing take place. In addition, the Team identified the need for developing stronger protocols that require medical assessments and consultations with Public Health Nurses when working with families where there are allegations of abuse and when it is observed that a child appears to be extremely thin and possibly malnourished. The Team also discussed the fact that in this case the parents' reports regarding medical visits were taken at face value and that it is important to verify whether or not medical appointments took place with the physician.

The Team further recommended that those investigating allegations of abuse and/or neglect be cognizant of attachment and bonding issues between the parent(s) and child(ren). Visitation protocols should emphasize the need to focus on the quality of visitation for each child separately to ensure that none of the children are being treated differently than the other children and that there is no "scapegoating" going on in the family.

1995 - 2009 Child Homicides by Parent, Caregiver, or Family Member



Causes of Child Homicide by Parent/Caregiver/Family Member
1995 – 2009, Los Angeles County

	’95	’96	’97	’98	’99	’00	’01	’02	’03	’04	’05	’06	’07	’08	’09	Total
Head Trauma	19	15	12	13	15	5	5	2	7	7	6	11	11	12	8	148
Multiple Trauma	10	7	10	8	10	11	7	7	10	7	8	7	7	4	2	115
Asphyxiation/suffocation	4	4	4	3	6	3	8	5	6	5	5	6	6	3	2	70
Gunshot Wounds	4	4	7	10	4	3	2	1	4	3	6	1	1	8	8	66
Trauma to torso/abdomen	2	5	4	2	1	0	0	3	0	0	2	1	1	1	1	23
Drowning	4	0	2	2	0	3	1	7	1	1	2	3	3	0	1	30
Fire	3	8	0	4	0	1	0	0	0	0	0	3	3	1	0	23
Stabbing	0	2	0	2	1	4	1	2	0	3	2	2	2	2	4	27
Unattended newborn	1	0	1	3	4	2	3	2	3	0	1	0	0	1	2	23
Poisoning/drug ingestion	0	2	0	0	0	0	3	6	1	1	0	0	0	0	0	13
Dehydration/malnutrition	1	1	1	1	0	1	1	0	1	2	0	0	0	1	1	11
Strangulation	0	2	2	1	0	0	0	0	0	0	0	1	1	0	0	7
Medical neglect	0	0	0	0	0	1	2	0	0	0	0	0	0	0	1	4
Neck compression	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Burns	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	3
Hyperthermia	0	0	0	0	0	0	0	0	2	0	0	0	0	1	0	3
TOTAL	49	51	44	49	42	’00	34	35	35	29	33	35	35	34	30	568

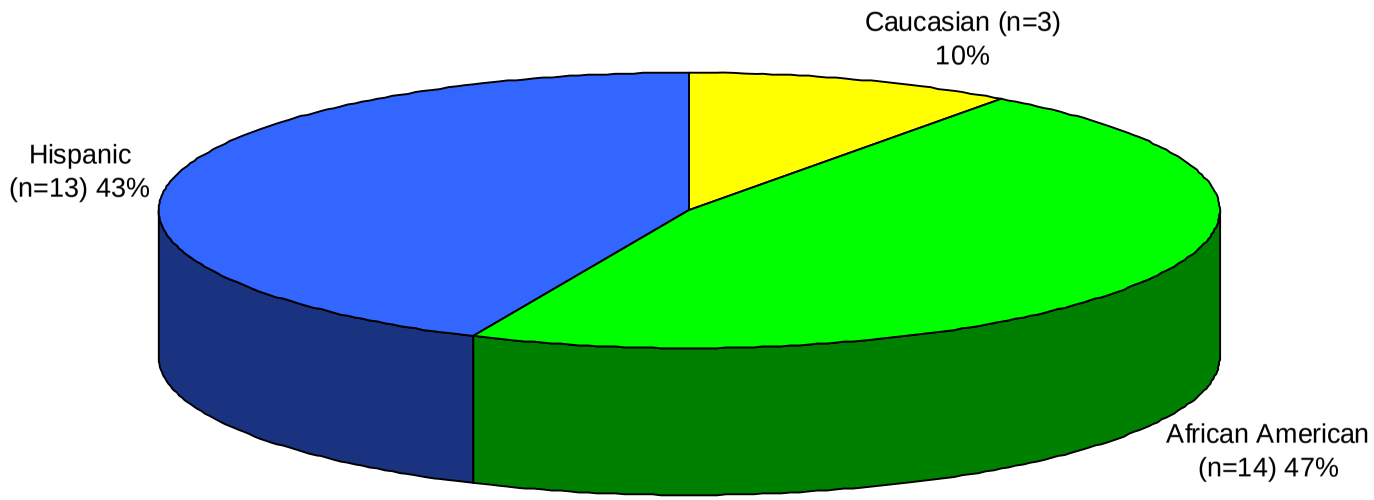
Child Homicide by Parent/Caregiver/Family Member
Los Angeles County – 2009 (N= 30)

Age	Female	Male
Under 1	7	3
1 year	3	3
2 years	0	3
3 years	0	0
4 years	0	2
5 years	2	1
6 years	0	1
7 years	0	0
8 years	1	0
9 years	0	0
10 years	0	0
11 years	1	0
12 years	1	0
13 – 17 years	1	1
TOTAL	**16**	**14**

33% of the child homicides by parents/caregivers/family member were under one year of age.

80% of the child homicides by parents/caregivers/family member were under five years of age or under.

2009 Child Homicides by Parent, Caregiver, or Family member - Race



Los Angeles County child population ages 0 - 18 is 2,758,141. 2010 Children Now Scorecard. 62.3% are Hispanic, 17.5% are Caucasian, 9.2% are Asian American, 8% are African American, 2.7% are Multi-racial and .2% Native American. Kidsdata.org 2009.

Criminal Justice System Involvement

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

Table 1

Law Enforcement Agency Involvement in 2009 ICAN Child Homicide by Parent/Caregiver/Family Member

Agency	n	%
LASD	8	26.7
LAPD	14	46.7
Inglewood P.D.	1	3.33
Long Beach P.D.	1	3.33
Santa Monica P.D.	1	3.33
Pasadena P.D.	1	3.33
Clarement P.D.	1	3.33
Glendale P.D.	1	3.33
Pomona P.D.	1	3.33
Not an LA County Case	1	3.33

The Los Angeles Police Department had investigative responsibility for 46.7% (n= 14) of the 2009 child homicides by parents/caretakers/family member. The Los Angeles Sheriff's Department had investigative responsibility for 26.7% (n=8) of the child homicides by parents/caretakers/family member. Twenty-seven percent (n=8) of the cases were handled by jurisdictions other than LASD and LAPD. Ten different law enforcement agencies were responsible for the investigation of child homicides by parents/caregivers/family member in 2009.

There were a total of thirty–four suspects in the thirty homicide cases. Thirteen of the 2009 cases involving child homicide by parents/caregivers/family member were not presented to the District Attorney. The reasons why those cases were not presented are displayed in Table 2. The most common reason for law enforcement not presenting a case was the perpetrator committed suicide after killing the child. One child homicide occurred outside of Los Angeles County and was covered by another jurisdiction. Two cases remains under investigation. A clear perpetrator or time line could not be established in one case and was closed. Another case involved a parent co-sleeping with an infant while under the influence was not filed on by law enforcement. Lastly, one homicide was an abandoned deceased infant in which law enforcement could not establish the intent and closed the case.

Table 2

Law Enforcement Reasons for Not Presenting 2009 ICAN Child Homicide by Parent/Caregiver/Family Member

	n	%
Murder/suicide	7	54
Under Investigation	2	15
Insufficient Evidence	3	23
Injury did not occur in LA County	1	8
TOTAL	**13**	**100**

Table 3

Criminal Charges Filed on 2004 - 2009 ICAN Child Homicide by Parent/Caregiver/Family Member	2004	2005	2006	2007	2008	2009
Murder (187 (a) P.C.)	27	32	20	21	20	13
Assault on a child under 8 years resulting in death (273ab P.C.)	23	20	15	17	16	11
Child abuse (273a(a) P.C.)	24	34	11	28	19	5
Child endangering (273a(1) P.C.)		1				
Corporal punishment or injury of child (273d P.C.)				1		
Child abuse resulting in death (273a(a) 2 P.C.)						
Voluntary manslaughter (192a P.C.)	2	1	1	5	1	
Involuntary manslaughter (192b P.C.)		5		1	1	
Vehicular manslaughter DUI with gross negligence (191.5(a) P.C.)		1		1		
Vehicular manslaughter (192 (c) P.C.)		5				
Vehicular manslaughter for financial gain (192(c)(3) P.C.)		1				
Attempted voluntary manslaughter (664/192 (a) P.C.)	1					
Attempted murder (664/187 (a) P.C.)	1	1		1	12	
Attempted robbery of person (664/211 P.C.)		1				
Lewd and lascivious acts by force (288(b)(1) P.C.)	1					
Sexual penetration with unconscious victim (289(d)(a) P.C.)	3					
Public exposure of private parts (314(1) P.C.)		1				
Kidnapping (207a P.C.)				2		
Unlawful detention (278 P.C.)	4					
Assault against a peace officer (245 © P.C.)		2				
Battery (242-243(e) 1 P.C.)				1		
Threat of death or great bodily harm to immediate family (422 P.C.)		1				
Spousal abuse (273.5 P.C.)		1				
Torture (206 P.C.)	4	1		1		3
Mayhem (203 P.C)		1				
Vandalism (594 P.C.)				1		
Discharge of firearm inhabited dwelling (246 P.C.)	1					
Assault with semiautomatic weapon (245 (b) P.C.)	2					
Unlawfully causing a fire of any structure (451B)		1				
Aiding and abetting a designated felony (32 P.C.)		3				
Financial gain from prospective adoptive parents (273(d)(a) P.C.)	3					
Possession of marijuana for sale (11359 H&S)		2				
Unlawful to drive while DUI (23153(a) V.C.)		1				
Unlawful to drive with .08% or more DUI (23153(b) V.C.)		1				
Failure to stop @ accident scene resulting in injury/death (20001(a) V.C.)		1				
Flight of peace officer causing serious bodily harm (2800.3 V.C.)		1				
Fleeing pursuing peace officer (2800.2(a) V.C.)		1				

In 2009, seventeen of the twenty-two case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies.

Of the seventeen cases, three were referred back for further investigation by law enforcement. One of the three cases referred back involved two perpetrators, a mother and grandmother. An additional case was referred to Juvenile Division as the mother was 17 years old at the time of the homicide. Manslaughter charges were filed against the mother in the Delinquency Court.

The charges filed by the District Attorney in the past five years are illustrated by Table 3. The District Attorney filed criminal charges on 76% (n=13) of the 17 homicide cases presented to them by law enforcement. Charges were filed against twelve perpetrators. The most frequent charge in 2009 was murder followed by assault on a child. With the exception of one perpetrator, murder charges (187 (a) P.C.) were filed on the cases (n=13) in which charges were filed. In two of the murder cases, the mother was charged twice for the homicide of two children for a total of four counts of murder.

Table 4

Relationship of Perpetrators - 2009 ICAN Child Homicide by Parent/Caregiver/Family Member

Relationship	ID'd by Police	Charged By DA
Mother	10	8
Father	2	1
Stepfather	2	2
Mother's Boyfriend	2	1
Uncle	1	1
Sister	1	1
Maternal Grandmother	1	0

In 2009, there were multiple perpetrators identified by law enforcement and charged by the District Attorney in one case. In the one case in which charges were filed, the mother was implicated along with the mother's boyfriend.

Table 5

Criminal Case Disposition of 2004 - 2009 ICAN Child Homicides by Parent/Caretaker/ Family Member[3]	2004	2005	2006	2007	2008	2009
Life without possibility of parole	1	1	1		1	
50 years to life prison	1	2	1			
40 years to life prison						1
35 years to life prison						
30 years to life prison						
26 years to life prison	2		2			
25 years to life prison	1	1	1	6	8	2
24 years to life prison						
22 years to life prison						
21 years to life prison						
19 years to life prison						1
17 years to life prison						1
16 years to life prison		1				
15 years to life prison	2	1	2	2	1	1
14 years prison						
13 years prison						
12 years prison			1	1	4	1
11 years prison	1			3	1	1
10 years prison	1	1	2	2		1
9 years prison		1	1			
8 years prison	1	1	4			
6 years prison	1	1	1	2	2	1
5 years prison					1	
4 years prison	1	1		2		1
3 years prison						
2 years prison	1	3	1	2	1	
16 months prison			1		1	
1 year jail	1	1				
9 months jail						
6 months jail		1				
Less than 3 months jail	1	1	2			1
6 yrs Probation						
5 yrs Probation	2	1	1		2	
3 yrs Probation	2	3				
Found not guilty	1					
Dismissed		3	3			
Arrest warrant	4					1
Mental competency hearing		1		1		
Sentence pending			2	1	1	
Pending trial	1	1	1	2	2	10
Pending Further Investigation						4
TOTAL	25	26	27	24	25	27
Total C/A Homicides for year	30	33	35	26	34	30

[3] Criminal Disposition is the year a case concluded and includes cases filed in previous years.

Criminal disposition data for the period of 2004 through 2009 is presented in Table 5. In 2009, one perpetrator was sentenced 40 years to life and two were sentenced to 25 years to life in prison. Most perpetrators in 2009 received sentences ranging from ten years to twenty years in prison.

The status of the 2004 cases has change from 2008 and there are now four arrest warrants outstanding and one case pending trial. For 2005, three cases were dismissed and one continues for mental competency. One case is still pending trial and another sentencing. Of the five cases pending trial in 2006, only one case remained pending in 2009. Two cases are still pending trial from 2007. Of the nineteen pending cases from 2008, only two remain pending. The most frequent sentence received in 2007 (n=6) and 2008 (n=8) was 25 years to life in prison. As in 2009, the next most frequent range of sentencing for perpetrators in both 2008 and 2007 was ten to twenty years in prison.

2009 Child Homicides by Parents, Caregivers or Family Member
DCFS Involvement 1994 – 2009*

Year	Total # of homicides by parent/care giver/ family member	Total # of homicides that had previous DCFS contact (prior contact OR open case)	Of total with previous DCFS contact, The # of homicides that had PRIOR DCFS contact only	Of total with previous DCFS contact, the # of homicides in OPEN DCFS Case or referral	# Killed by out-of-home caregiver
1994	39	12	5	7	0 – relative caregivers 1 – foster parent
1995	49	16	5	11	3 – relative caregivers 0 – foster parent
1996	53	13	7	6	2 – relative caregivers 2 –foster parent
1997	45	15	8	7	2– relative caregivers 2 foster parent
1998	49	20	16	4	1 relative caregivers 0– foster parent
1999	44	20	12	8	2– relative caregivers 2 – foster parent
2000	35	15	7	8	2 – relative caregivers 0 – foster parent
2001	35	12	7	5	3 – relative caregivers 2 – foster parent
2002	37	Not Available	Not Available	Not Available	0 – relative caregivers 1 – foster parent
2003	35	18	13	5	2 – relative caregivers 2 – foster parent
2004	30	15	9	6	2 – relative caregivers 0 – foster parent
2005	33	14	11	3	1– relative caregivers 0 – foster parent
2006	35[4]	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3[5]	1 – relative caregivers 0 – foster parent
2008	34	14[6]	6	8	0 – relative caregivers 0 – foster parent
2009	30	19[7]	14	5[8]	1 – relative caregivers 0 – foster parent

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

[4] The CDRT reviewed an undetermined child fatality and changed the manner of death to "homicide". The case was open to DCFS when the fatality occurred. Another open DCFS case with a homicide was autopsied in another county and not reported to ICAN for inclusion in the 2007 report.
[5] One was open to another county.
[6] ICAN counts only deaths in LA County ruled a homicide by the Coroner. Two children died in LA County but were injured in another county and under that county's CPS supervision.
[7] Includes two deaths with a CPS history in another state and one death with history in another county.
[8] One child died in LA County was under the jurisdiction of Riverside CPS.

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

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

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

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

Relationship of Suspect to Child Homicide Victim – 2009

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

12 – Father, Stepfather or mother's boyfriend

12 – Mother

1– Both parents

2 – Mother and Boyfriend

1– Sister

1 – Uncle

1 – Mother and Maternal Grandmother

1– Aunt's Boyfriend

Dates[9] of Child Homicides – 2009

7 homicides occurred in January (1/20, 1/26 & five on 1/27/2009)

1 homicide occurred in March (3/19/09)

3 homicides occurred in April (two on 4/2 and 4/19/09)

4 homicide occurred in July (7/08, 7/19, 7/21 & 7/24/08)

3 homicides occurred in August (8/6, 08/08 & 8/18/09)

2 homicides occurred in September (both on 9/02/09)

5 homicides occurred in October (two on 10/17, 10/21, 10/24 & 10/26/09)

3 homicides occurred in November (11/14, 11/16 & 11/22/09)

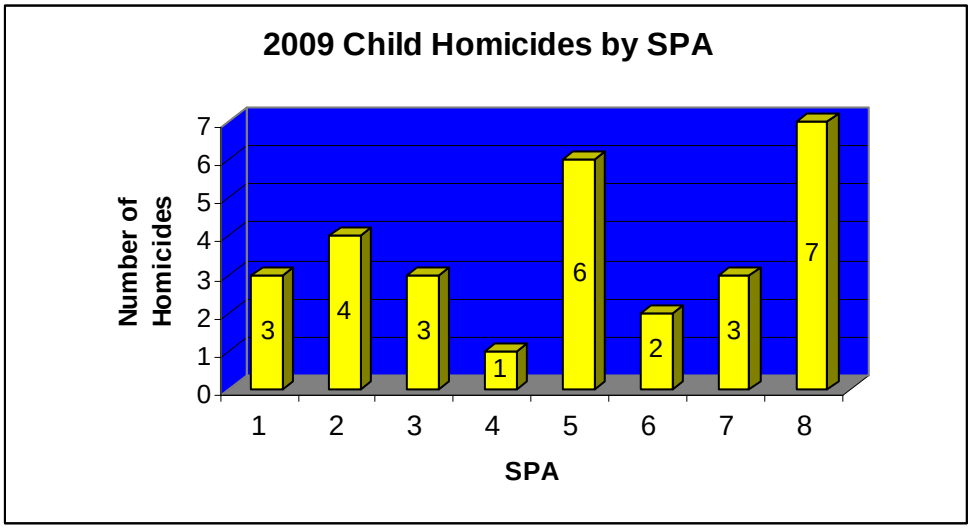
2 homicides occurred in December (12/05 & 12/12/09)

Locations[10] of Child Homicides – Geographic Area – 2009

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

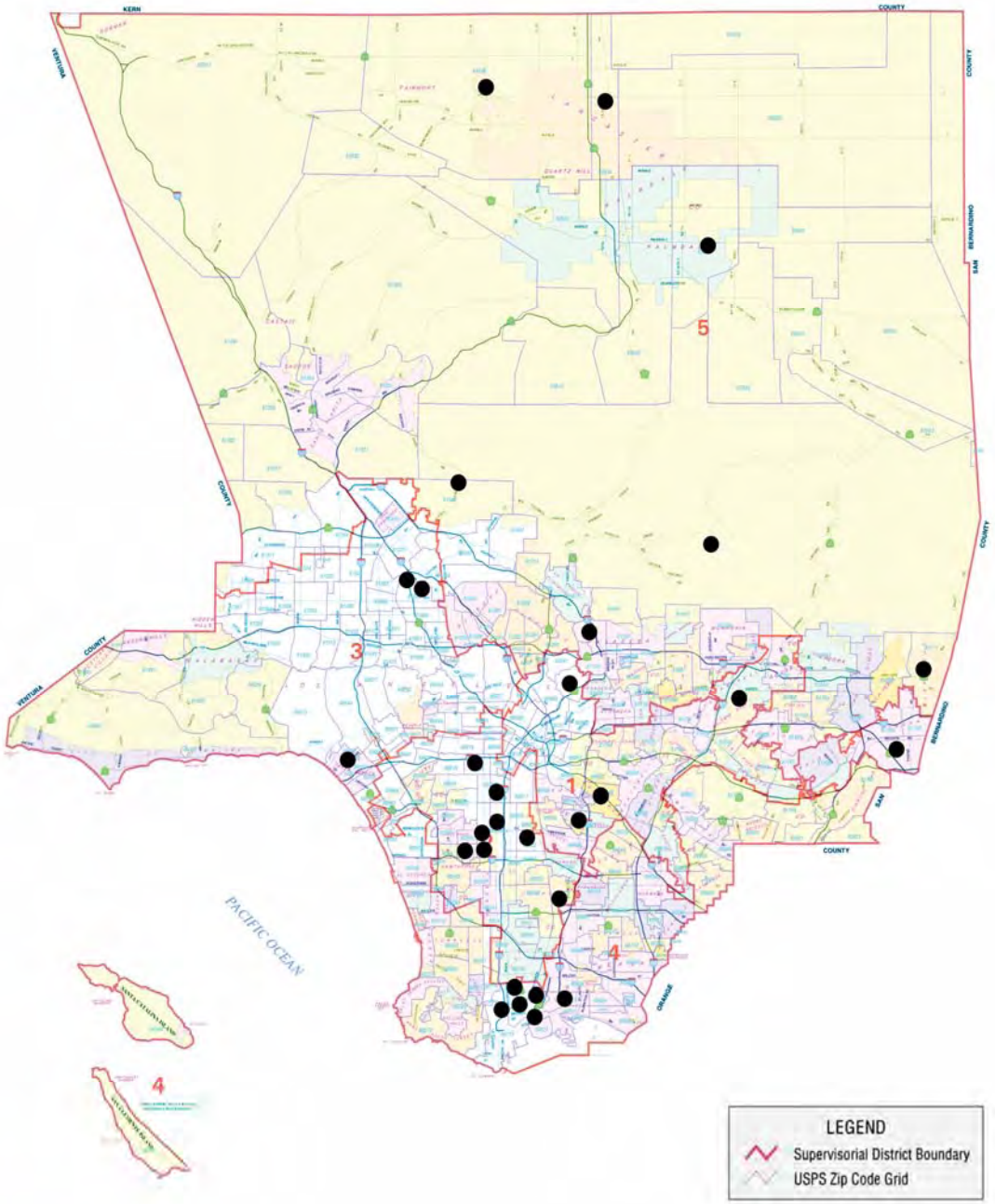
[10] City where the injury/fatality occurred

1 homicide occurred in Bell Gardens (zip code 90201)
1 homicide occurred in Bellflower (zip code 91706)
1 homicide occurred in Claremont (zip code 91711)
1 homicide occurred in Commerce (zip code 90040)
1 homicide occurred in Compton (zip code 90221)
1 homicide occurred in Glendale (zip code 91024)
1 homicide occurred in Indio (zip code 92201)
1 homicide occurred in Inglewood (zip code 90303)
1 homicide occurred in Lancaster (zip code 93534)
1 homicide occurred in Lancaster (zip code 93536)
1 homicide occurred in Los Angeles (zip code 90002)
1 homicide occurred in Los Angeles (zip code 90018)
1 homicide occurred in Los Angeles (zip code 90037)
1 homicide occurred in Los Angeles (zip code 90042)
1 homicide occurred in Los Angeles (zip code 90044)
2 homicides occurred in Los Angeles (zip code 90047)
1 homicide occurred in Long Beach (zip code 90813)
2 homicides occurred in North Hollywood (zip code 91605)
1 homicide occurred in Palmdale (zip code 93552)
1 homicide occurred in Pasadena (zip code 91103)
1 homicide occurred in Pomona (zip code 91766)
1 homicide occurred in Santa Monica (zip code 90403)
1 homicide occurred in Sylmar (zip code 91342)
5 homicides occurred in Wilmington (zip code 90744)



2009 Child Homicides - Location

N = 29*



LEGEND
Supervisorial District Boundary
USPS Zip Code Grid

● = ***Los Angeles County Child Homicide Locations***

* Once child resided in Indeo County but was found in LA

Child and Adolescent Suicides 1995 – 2009

Case Summary
Adolescent Suicide

On her way home from work, Martha called and texted her 13 year old son, Manual but did not get any response. When she arrived home the TV in the living room was on. She called for him, but there was no answer. After searching the home, she discovered Manual in his bedroom closet. The closet door was open and his back was facing her and he appeared to be in a crouching position. When she got closer to the closet, she realized he was not moving. There was a belt around his neck and he was hanging from the clothes rod in the closet. She attempted to get him down but he was too heavy. She ran and called 911. When paramedics arrived, he was pronounced at the scene.

Manual had a history of depression and anxiety. He was participating in therapy. He had been on the antidepressant, Paxil for the past three years. He had seen his therapist two weeks earlier. His father had not been in his life since an early age, but had been spending time with Manual the past year. Family reported the father did not always follow through with plans which upset Manual because he wanted his father in his life.

Family, friends and his teachers were all caught off guard and his death was unexpected. In the prior year, Manual reported he was hearing voices and made suicidal statements. There were no known incidents in which he attempted to harm himself. Over the past six months, he had been doing well. He had just returned from a weekend camping trip the day before and everything appeared to be fine.

Manual was in special education class at school. He was fond of his teachers and despite his feelings of not being liked, he had several close friends. Both his family and school described him as creative and intelligent. There were no known issues at school or with a girl. He had many interests and liked history and reading books. He had been anxious about having made a transition from one middle school to another, but had been working through his concerns in therapy.

According to the mother, on the morning of his death, nothing unusual had happened. She described him as being a pretty predictable kid. There was nothing new in his life or bothering him to her knowledge. He was upset about his relationship with his father and his absence from his life, but was again working this through in therapy. There had been no recent incident of disappointment with his father. A toxicology screen done at autopsy revealed no drugs or alcohol were present. The Paxil found was within normal limits. There were no marks or scars indicating previous attempts on his wrists. No suicide note was found.

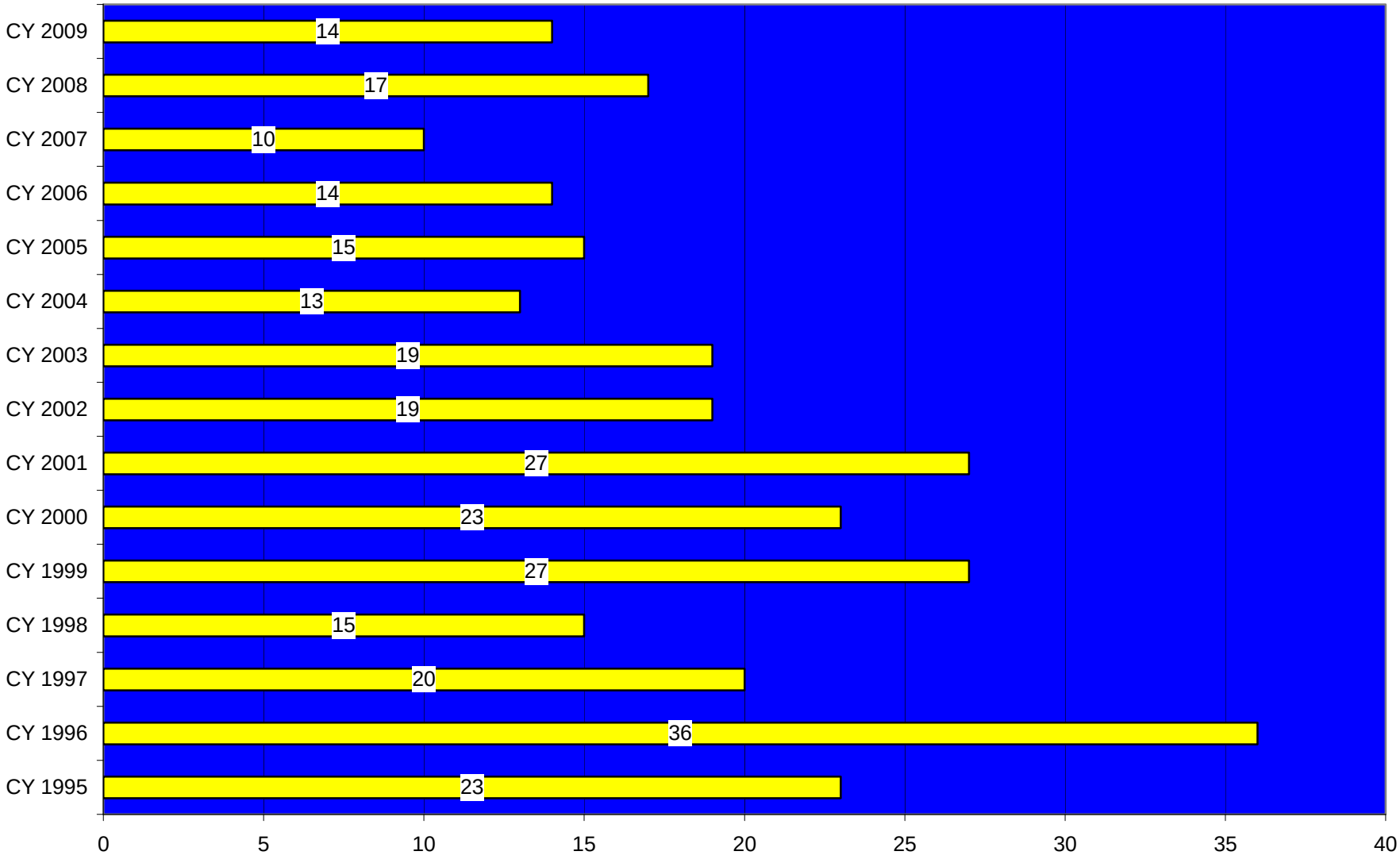
The Department of Children and Family Services (DCFS) had one prior referral in 1999 for emotional abuse and domestic violence involving the father who did not reside in the home. The referral was substantiated but the mother was protective and obtained a restraining order so no case was opened. The mother had moved to Los Angeles two

years prior after her divorce from the father. The father had not been involved with the family since the relocation. After this brief re-entry into Manual's life, the father moved away and did not have any contact until the year prior to Manual's suicide.

The Child and Adolescent Suicide Review Team examined Manual's case. It was learned that although he was never hospitalized in the prior year for suicidal ideation, he was assessed several times for a 72 hour hold. He would make statements of wanting to kill himself but when asked about his plans, they never were realistic ones. One such plan was to drink soda until he exploded. When he first was evaluated for his suicidal ideation and hearing voices, he was placed on Risperdal. His mother was reluctant to have him on anti-psychotic medication and once he stabilized, he was taken off the medication. The team wondered if it were possible he was still experiencing auditory hallucinations and could have benefited from continuing to take Risperdal.

There was much discussion on how youth at this age are very good at covering up their true feelings. Manual was diagnosed with a mental disorder and despite his presenting well, these does not mean he was doing well. The Team discussed the need to openly talk about depression, anxiety and suicide to teens; having prevention posters and material available; training faculty and staff to recognize signs of teens at risk; teaching the teens on how to be more supportive and identify when friends might need some kind of services.

1995 - 2009 Child and Adolescent Suicides



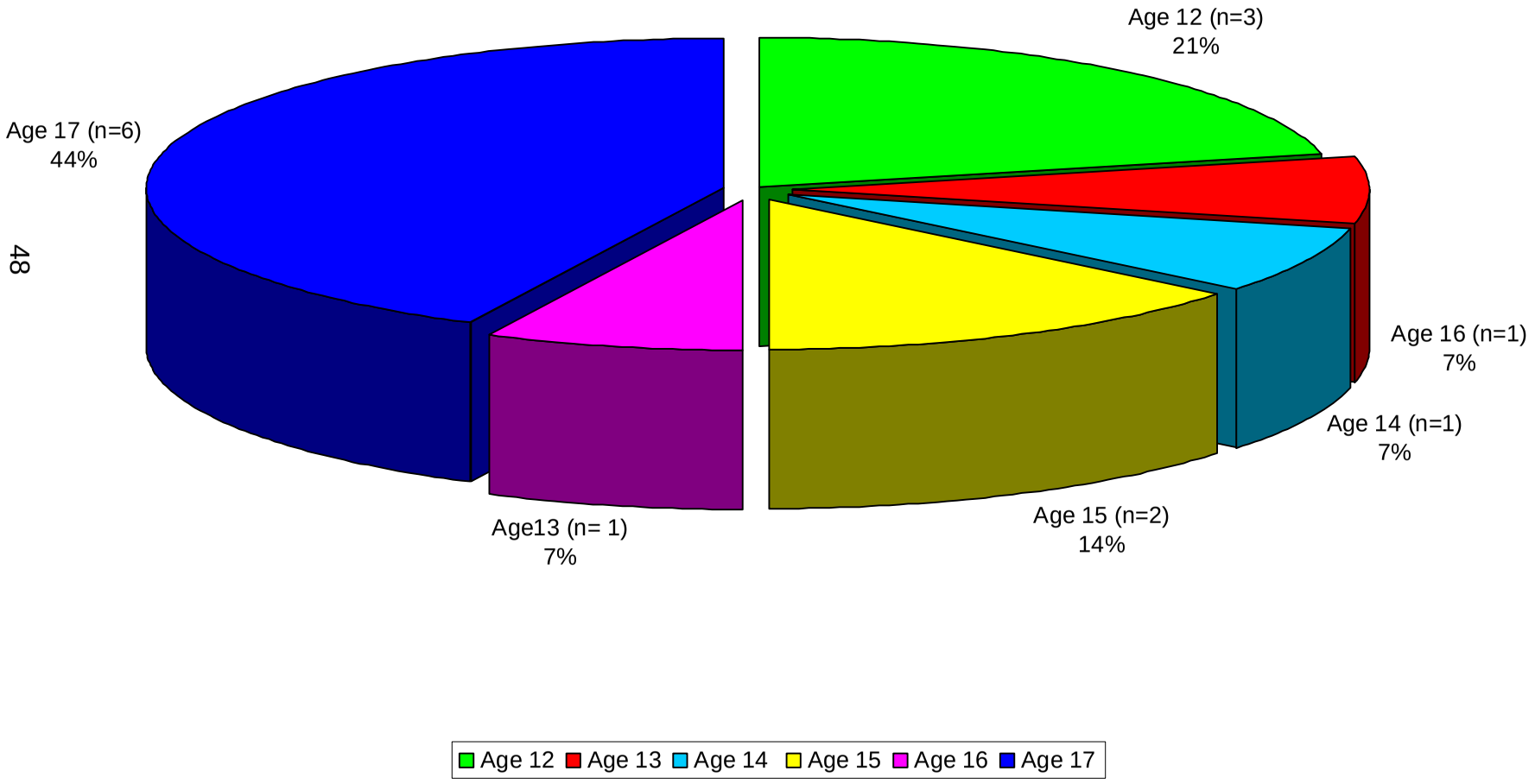
Child and Adolescent Suicides by Method and Gender
Los Angeles County – 2009 (n = 14)

Method	Male	Female
Hanging	5	2
Firearms/Gunshot	4	0
Jump in traffic	0	1
Overdose	0	2
TOTAL	9	5

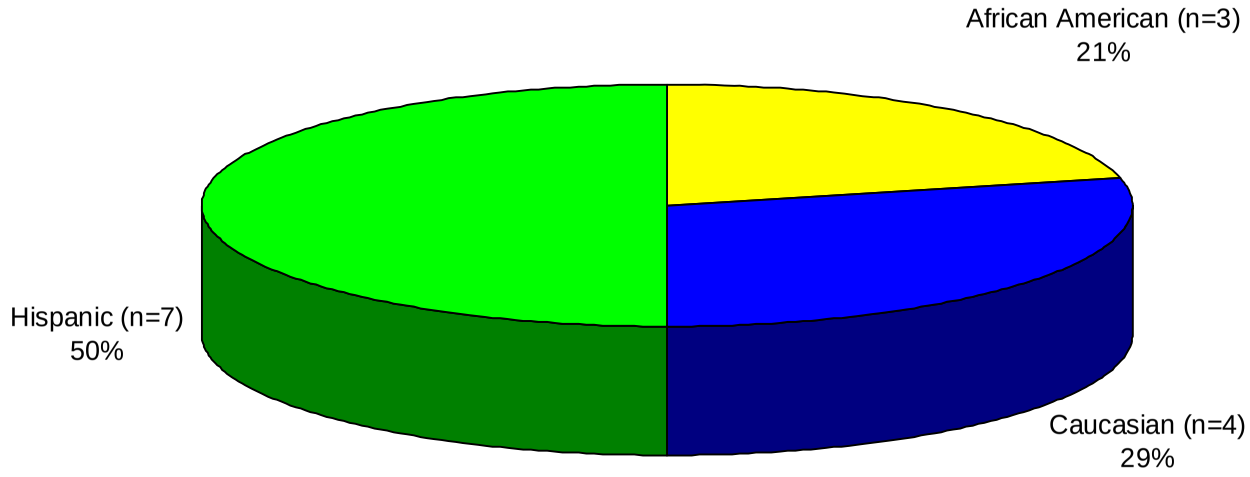
Hanging was the most frequent method of suicide among adolescents and represents 50% of the suicides in 2009. Firearms/gunshot was the second most frequent method of suicide in 2009.

In 2009, 64% (n=9) of the adolescent suicide victims were male. 36% (n=5) of the victims of adolescent suicide in 2009 were female.

2009 Child and Adolescent Suicides - Age



2009 Child and Adolescent Suicides - Race



Los Angeles County child population ages 0 - 18 is 2,758,141. 2010 Children Now Scorecard. 62.3% are Hispanic, 17.5% are Caucasian, 9.2% are Asian American, 8% are African American, 2.7% are Multi-racial and .2% Native American. Kidsdata.org 2009.

Child and Adolescent Suicide Victim Characteristics – 2009

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

Four of the youth had a history of mental illness.

Three of the youth left a suicide note.

One of the youth had previously attempted suicide

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

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

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

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

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

Two of the youth had received special education services.

One of the youth had known academic problems and

Two of the youth had school discipline or truancy problems.

Dates of Child and Adolescent Suicides – 2009

1 suicide occurred in January (01/9/09)
1 suicide occurred in February (02/19/09)
1 suicide occurred in March (03/17/09)
1 suicide occurred in April (04/26/09)
2 suicides occurred in May (05/21 & 05/30/09)
1 suicide occurred in July (07/0/09)
1 suicide occurred in August (08/28/09)
1 suicide occurred in September (09/12/09)
2 suicides occurred in October (10/14 & 10/26/2009)
3 suicides occurred in December (12/06, 12/20 & 12/21/09)

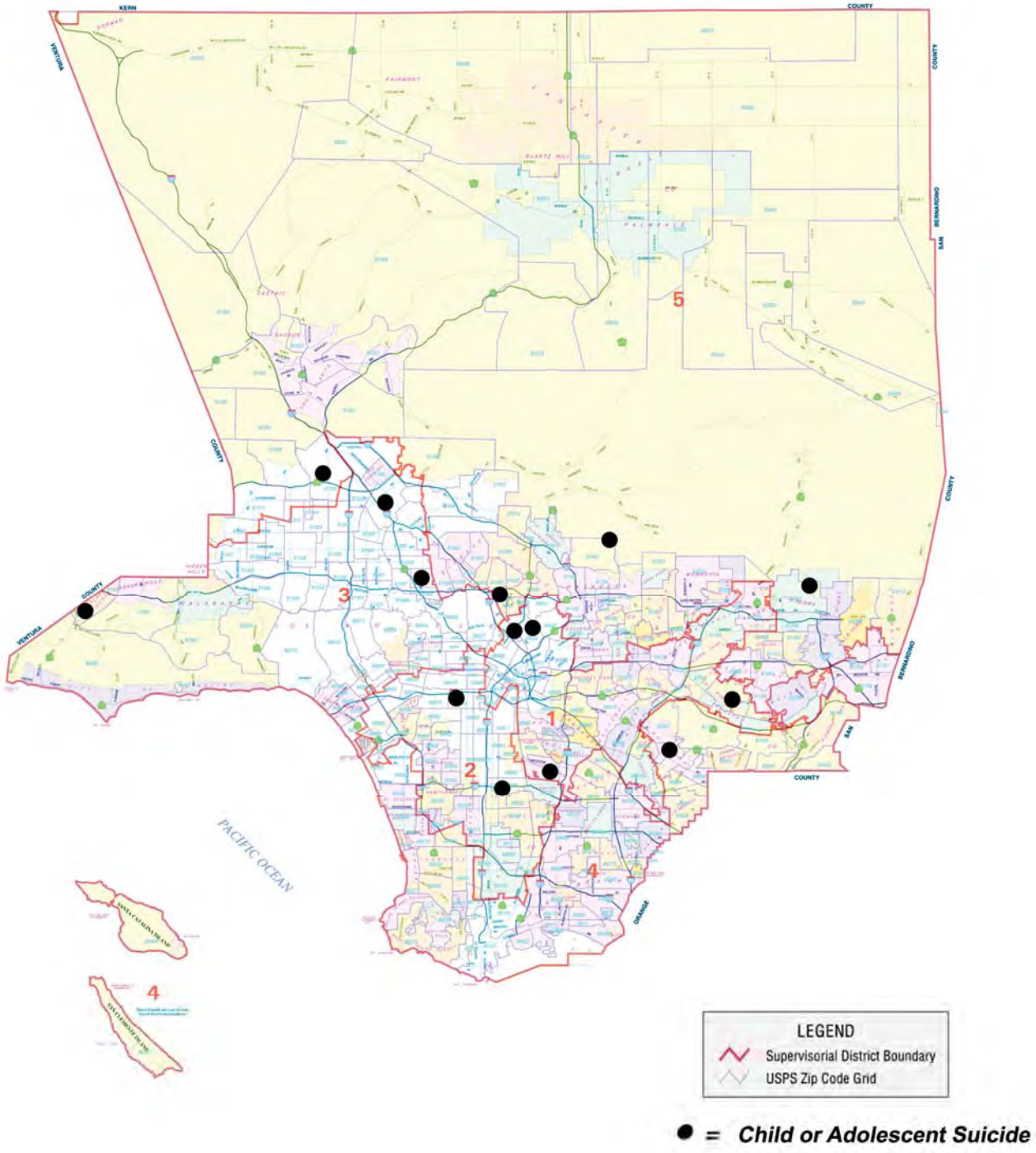
Locations[11] of Child and Adolescent Suicides – Geographic Area – 2009

2 suicides occurred in Los Angeles (zip code 90065)
1 suicide occurred in Los Angeles (zip code 90018)
1 suicide occurred in South Gate (zip code 90280)
1 suicide occurred in Los Angeles (zip code 90059)
1 suicide occurred in Whittier (zip code 90602)
1 suicide occurred in Altadena (zip code 91001)
1 suicide occurred in Sun Valley (zip code 91203)
1 suicide occurred in Pacoima (zip code 91331)
1 suicide occurred in Granada Hills (zip code 91344)
1 suicide occurred in Westlake Village (zip code 91361)
1 suicide occurred in North Hollywood (zip code 91601)
1 suicide occurred in Glendora (zip code 91741)
1 suicide occurred in La Puente (zip code 91744)

[11] City where the suicide occurred.

2009 Adolescent and Child Suicides

N = 14



Accidental Child Deaths 1995 – 2009

Case Summary
Accidental Death

Albert, age two years old lived with his parents, grandmother and three older siblings.

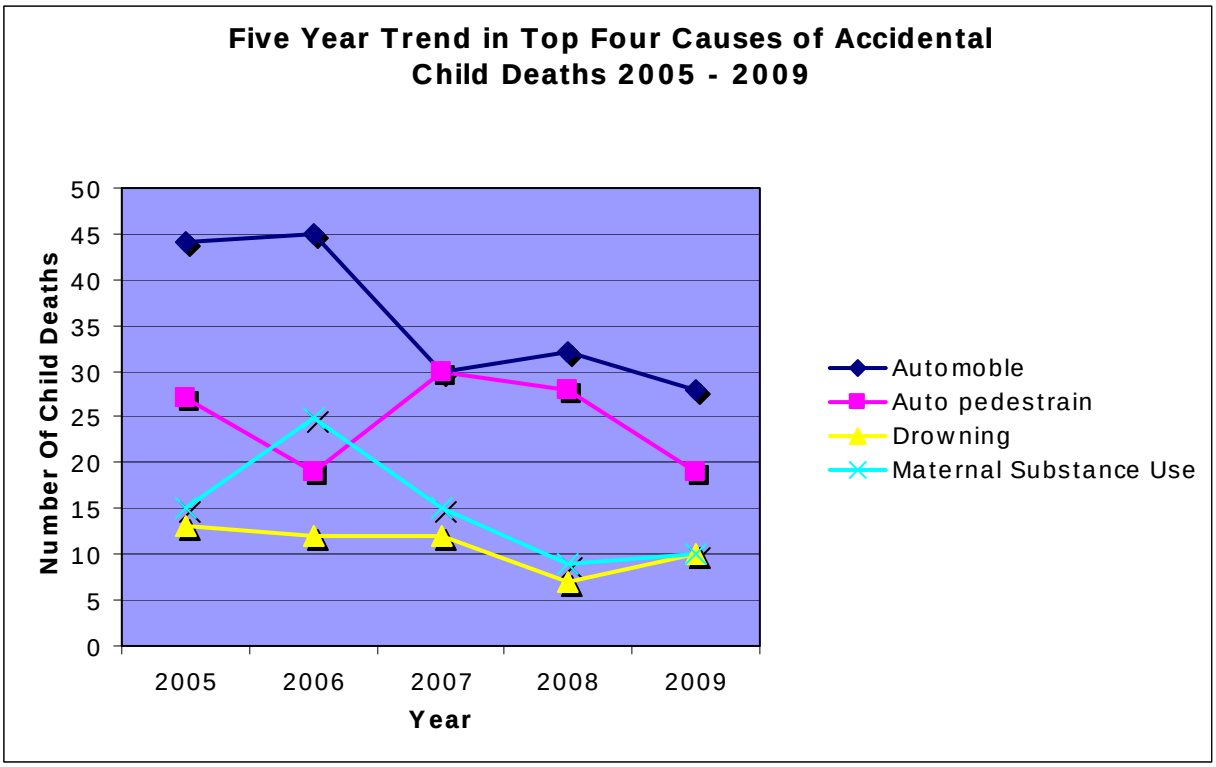
It was late afternoon on a hot summer day and the older children were playing in the front yard. The grandmother was sitting on the front porch supervising the children. The front door was open to cool the home due to the heat. The family was getting ready to leave the residence to go and get ice cream. The father left the home to bring the car from the back to the front of the house.

Albert's father walked the shrub-lined path to his pick up truck parked in the driveway behind the home. After checking his rear view mirrors, he began to slowly back the truck down the driveway. Within moments her felt a bump and heard screams from the front of the house. From the corner of his eye, he saw one of his sons frantically waving at him. He immediately stopped the truck and got out. Albert was lying on the ground pale, moaning and blood coming from his ears and nose.

His father called 911 and Albert was transported to the hospital. Efforts to resuscitate him at the hospital failed and he died shortly upon his arrival. Albert had been inside the home with his parents and no one saw him leave after the father.

The investigation revealed that despite adjusting and checking his rear view mirrors, Albert was too short to be seen by his father in the mirrors. Trucks and SUV's tend to have large blind spots making small children vulnerable to injury from backing up vehicles.

The Team has found that the majority of back up deaths occurs in residential driveways and involves either family members or a neighbor. Young children are small and do not have the cognitive and developmental capacity to comprehend the danger of vehicles. These deaths under score the need for adult supervision of young children at all times including checking vehicles prior to starting and moving.



The chart above depicts the top four causes of accidental child death over a five year period from 2005 to 2009. The trend for all four has for the most part been on a downward trend. The most dramatic decrease has been in the number of child deaths due to maternal substance abuse although there was an increase of one such death in 2009. After a sharp decrease from 2007 in 2008, death by drowning saw the only increase in 2009. The "top four" causes-automobile, auto pedestrian, drowning and maternal substance use accounted for 74% of all accidental child deaths in 2009.

Causes of Accidental Child Deaths, Ages 0 – 17
2009 – Los Angeles County (N = 91)

Automobile – multi-vehicle	19
Automobile – solo vehicle	9
Auto pedestrian	19
Drowning	10
Crushed by an Object	6
Overdose	7
Maternal drug use	10
Fire	1
Medical complications	6
Handgun Discharge	1
Exposure	1
Sports Injury	2
TOTAL	**91**

Causes of Accidental Child Deaths by Age
2009 – Los Angeles County (N = 91)

	Age 0 – 5 years	Age 6 – 14 years	Age 15 – 17 years
Automobile – multi-vehicle	6	11	2
Automobile – solo vehicle	1	1	7
Auto pedestrian	9	6	4
Crushed by Object	0	4	0
Drowning	7	2	1
Overdose	0	0	7
Handgun discharge	0	1	0
Fire	0	0	1
Maternal drug use	10	0	0
Medical complications	5	0	1
Exposure	1	0	0
Sport Injury	0	2	0
TOTAL	**41**	**27**	**23**

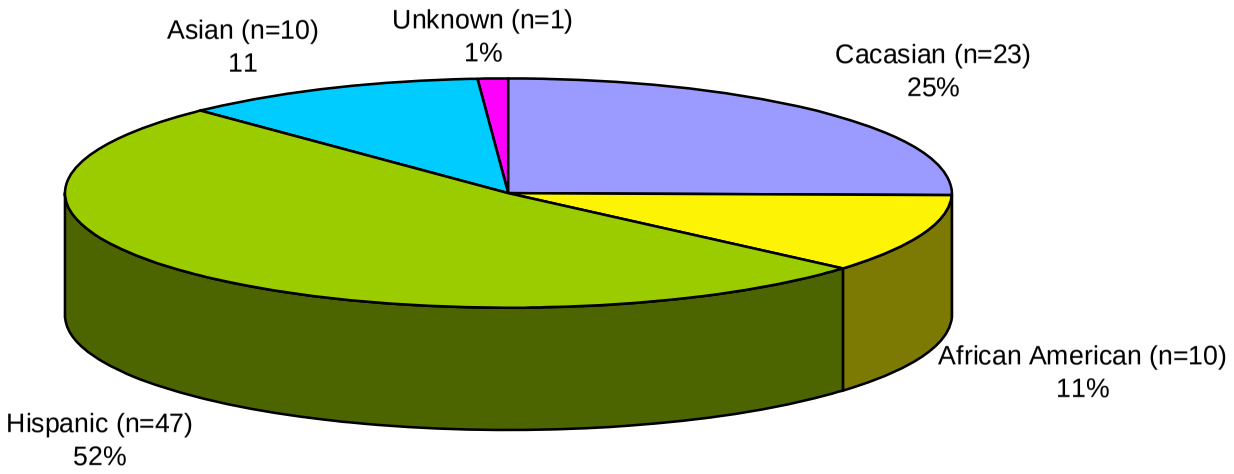
Race of Accidental Child Deaths, Ages 0 – 17
Los Angeles County – 2009 (N = 91)

	Hispanic	African-American	Caucasian	Asian/Pacific Islander	Other/ Unknown
Automobile – multi-vehicle	9	2	6	2	0
Automobile – solo vehicle	5	1	0	3	0
Auto pedestrian	15	3	1	0	0
Choking	0	0	0	0	0
Drowning	4	0	2	4	0
Overdose	2	1	4	0	0
Fire	0	0	1	0	0
Gun Shot Wound	0	0	1	0	0
Exposure	1	0	0	0	0
Sports injury	1	0	1	0	0
Maternal drug use	3	3	2	1	1
Medical complications	2	0	4	0	0
Crushed by object	5	0	1	0	0
TOTAL	**47**	**10**	**23**	**10**	**1**

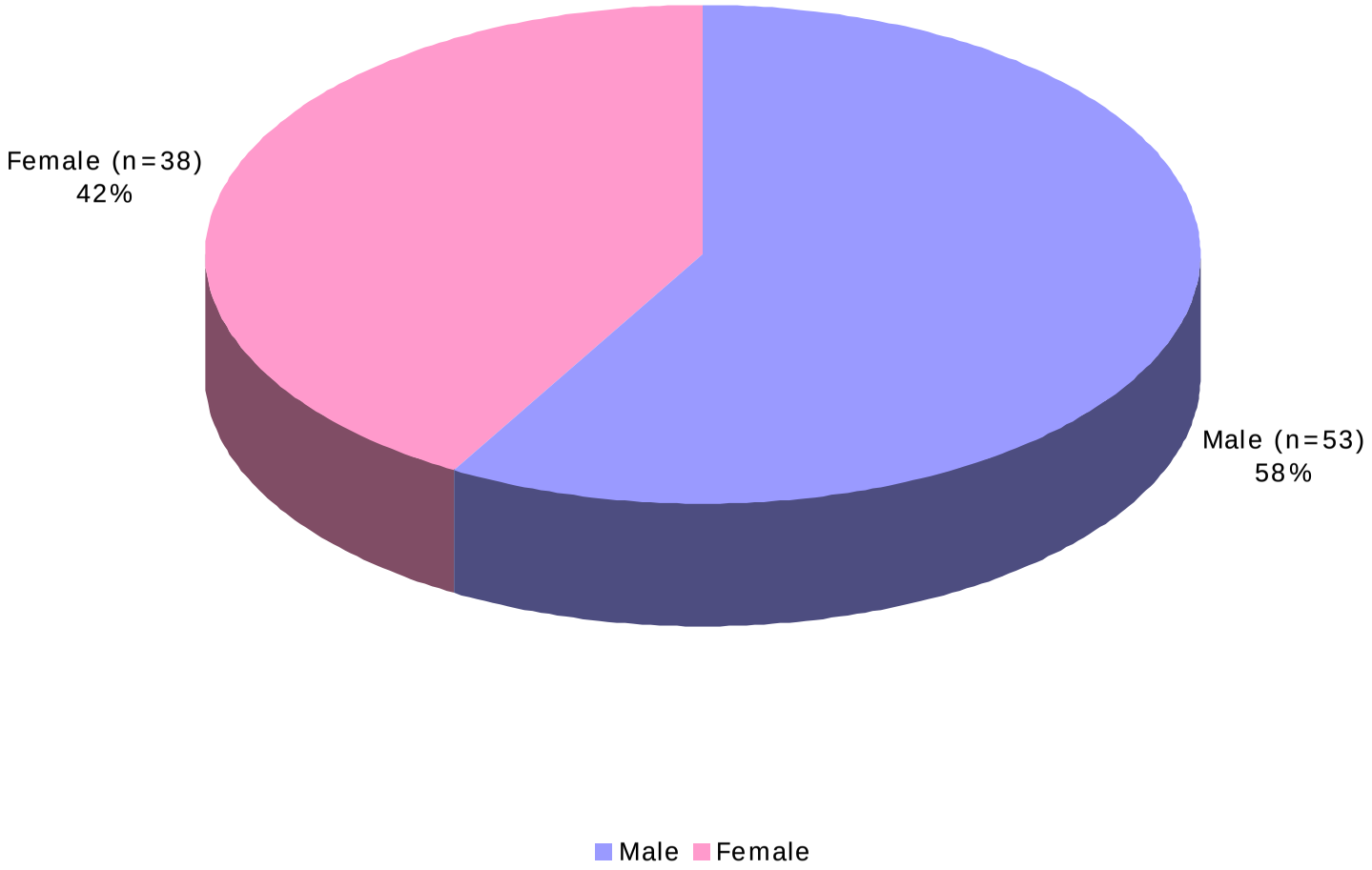
Causes of Accidental Child Deaths, Ages 0 - 14
1995 -- 2009

	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	Total
Drowning	31	18	28	21	25	23	28	16	19	21	12	12	11	7	9	281
Maternal drug abuse	9	25	24	38	21	22	24	25	32	21	15	25	15	9	10	315
Auto pedestrian[1]	2	1	8	19	31	30	41	33	25	21	20	11	25	25	15	307
Automobile[2]	0	0	0	0	18	24	28	20	47	25	21	22	14	17	19	255
Falls	6	5	2	3	5	1	1	3	2	3	1	2	1	1	0	36
Choking	0	1	5	3	6	10	2	8	4	1	3	1	1	2	0	47
Suffocation	1	2	0	2	4	1	3	0	1	1	2	2	0	0	0	19
Poisoning	1	1	6	1	4	4	1	0	2	2	1	2	0	1	0	26
Fire	2	0	1	3	7	4	3	7	0	2	6	7	2	0	0	44
Hanging/strangulation	0	3	0	0	0	6	3	1	2	4	1	3	4	0	0	27
Chest/neck compression	1	2	1	2	0	1	0	0	3	0	0	0	0	1	0	11
Gunshot wounds	1	2	1	0	0	0	0	0	0	0	0	0	0	0	1	5
Crushed by object	2	0	3	2	1	1	0	1	0	1	5	2	2	0	6	26
Sports injury	0	0	2	0	2	2	1	0	0	0	1	0	0	2	2	12
Burns/Thermal Injury	0	0	0	0	1	0	0	1	0	1	0	0	0	0	0	3
Dog bites	1	0	1	0	1	1	0	0	0	0	1	0	0	0	0	5
Medical complications[3]	1	1	0	1	5	6	2	8	7	3	3	2	7	5	5	56
Perinatal asphyxia	1	0	1	0	1	0	0	0	0	0	0	0	0	1	0	4
Electrocution	0	0	2	0	0	1	0	0	1	0	1	0	0	0	0	5
Birth trauma	0	0	0	0	2	0	0	0	0	0	2	0	0	0	0	4
Hypothermia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hyperthermia	0	0	0	0	0	0	0	0	0	0	2	1	0	0	0	3
Airplane related	0	0	0	0	0	0	0	2	2	0	0	0	0	0	0	4
Train v. pedestrian	0	0	1	0	0	0	0	0	0	0	1	0	1	0	0	3
Elective abortion	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Forklift injury	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Drug intake/Overdose	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	2
Motor vehicle (not auto)[4]	0	0	0	0	0	0	0	0	0	4	1	3	0	1	0	9
Impaled	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Gas Leak	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOTAL[5]	**59**	**61**	**86**	**95**	**134**	**137**	**137**	**127**	**147**	**110**	**100**	**95**	**83**	**73**	**67**	**1511**

2009 Accidental Child deaths - Race



2009 Accidental Child Deaths - Gender



Causes of Accidental Child Deaths by Gender
2009 – Los Angeles County (N = 91)

	Female	**Male**
Automobile – multi-vehicle	10	9
Automobile –Single	6	3
Auto pedestrian	5	14
Drowning	3	7
Overdose	5	2
Sports injury	0	2
Maternal drug use	4	6
Medical complications	1	5
Crushed	4	2
Fire	0	1
Gunshot Wound	0	1
Exposure	0	1
TOTAL	**38**	**53**

CASE SUMMARIES
UNDEREMINED DEATHS

CO-SLEEPING

Sammie – Age 21 days

The Coroner's Investigator reported the child was sleeping in a king size bed with the mother when he was found unresponsive with some blood on his face. The mother is a large woman and there is concern that the child's death was due to a layover while the child was sleeping with the mother.

Jacob – Age 1 month

At approximately 3:00 a.m., the mother fed Jacob and then put him to bed between her and the father. The mother checked on Jacob between 3 a.m. and 7 a.m. and he was sleeping. At approximately 8:40 a.m., the mother checked on Jacob and found him unresponsive, cold to the touch and stiff. There were no obvious signs of external or foul play. The Coroner's Office found that Jacob's death was due to sudden unexpected infant death (SUID).

Katelyn – Age 4 months

Mother reported "she swaddled" Katelyn in blankets and placed her in the bed where her father was sleeping. The bed had an abundance of bedding, five pillows and three blankets. The mother reported she placed Katelyn on her back on a pillow. She fell asleep and later "wakes up to check on the baby". The mother reported she found Katelyn face down on a pillow with the bedding wet underneath her.

Katie – Age 4 months

Katie's parents reported they were sleeping with her on the same bed when they woke up and found she was not breathing. They called 911 and on the way to the hospital, Katie died and efforts to resuscitate her were not successful.

Victor – Age 2 months

Victor and his twin were co-sleeping with the mother when she found Victor unresponsive.

Mark – Age 1 month

Although Mark routinely slept in the crib, the mother took him to bed with her to feed him at 2:00 a.m. The father and sibling were also in the bed. The mother and others in the bed fell asleep and were awakened at 4:30 a.m. when the mother found Mark limp and called 911. The infant never regained consciousness.

UNSAFE SLEEPING

Annette – Age 5 months

The father swaddled Annette in a polyester fleece blanket and placed her in a supine position in the crib. He then covered her with four blankets and put two stuffed animals in the crib with her. The heater in the room was set on the high setting and both the doors and windows of the room were closed. The father went to sleep in his bed. He woke to discover her unresponsive, purple in color and sweaty. The blankets were over her face.

Phillip – Age 4 months

The mother placed Phillip in a crib on his side with a pillow beneath his head and shoulders. Another pillow was in front of him and a rolled blanket along his back. In the morning, Phillip was discovered in a prone position face down in the pillows.

Emily – Age 24 days

The grandmother swaddled Emily with her arms at her sides and placed her to sleep on her side on an adult pillow top mattress. No more than ten minutes later she was found face down with blood from her nose and mouth. She was resuscitated at the hospital with no brain function. Artificial support was withdrawn the following day.

Pedro – Age 4 months

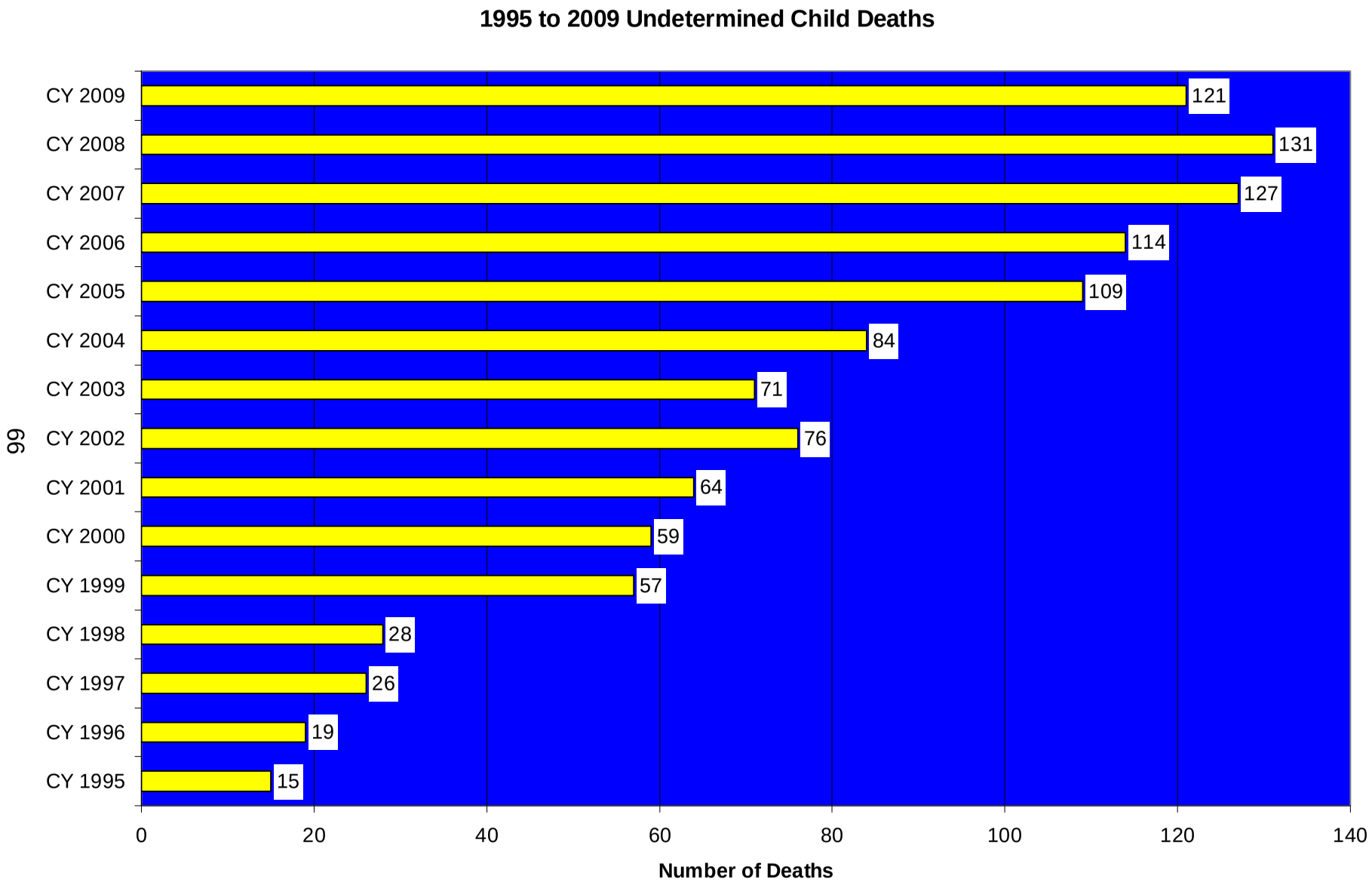
Pedro's mother placed him on the living room couch on his back after he fell asleep from breastfeeding. She went into the kitchen to clean up after the family breakfast. When she returned fifteen minutes later to check on him, she found him on his side with his face in the couch back pillow. He was limp and unresponsive. 911 was called and he was transported to the hospital as paramedics got a heart beat. When he arrived at the hospital, he went into cardiac arrest and further efforts to resuscitate him failed.

James – Age 3 months

The infant was placed on his back on the mother's bed, The bed was a pillow top mattress that was covered with a thick comforter. Pillows were surrounding him, but there was no pillow beneath his head and he was not covered or swaddled in a blanket. No pacifier was in use. The mother went to check on him an hour later and found him on his stomach not breathing and he was limp.

Susan – Age 5 months

Susan slept on the couch and the mother on the floor next to the couch. The mother placed a thin sheet on the couch and placed Susan on her left side on the sheet. She was clad in a pair of socks, a "onesie" type dress and a diaper. The mother covered Susan's legs and abdomen with a thick fleece blanket. At 6:00 am the mother awoke and saw the Susan lying supine on the couch with the bottle at her left side and her legs and abdomen covered with the fleece blanket. There was white mucus in and around the Susan's nose and she was unresponsive.


1995 to 2009 Undetermined Child Deaths
CY 2009
CY 2008
CY 2007
CY 2006
CY 2005
CY 2004
CY 2003
CY 2002
CY 2001
CY 2000
CY 1999
CY 1998
CY 1997
CY 1996
CY 1995
121
131
127
114
109
84
71
76
64
59
57
28
26
19
15
99
0
20
40
60
80
100
120
140
Number of Deaths

Undetermined Child Deaths – 2009 (N = 121)

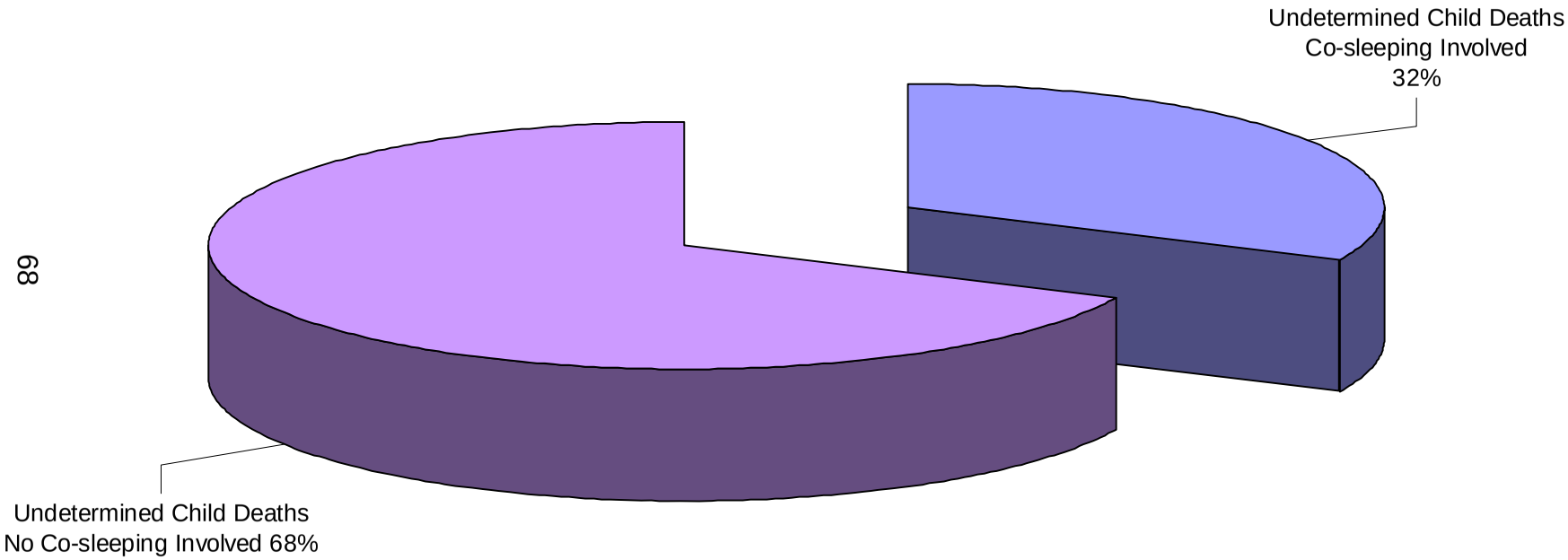
Race	***Number/Percentage of Undetermined Child Deaths***
African American	34 (28%)
Asian/Pacific Islander	5 (4%)
Caucasian	19 (16%)
Hispanic	63 (52%)

Age	***Number of Undetermined Child Deaths***
Under 1	94
1year	10
2 years	4
3 years	2
4 years	2
5 years	2
6 years	1
7years	0
8 years	0
9 years	1
10 years	0
11 years	0
12 years	1
13 – 17 years	4

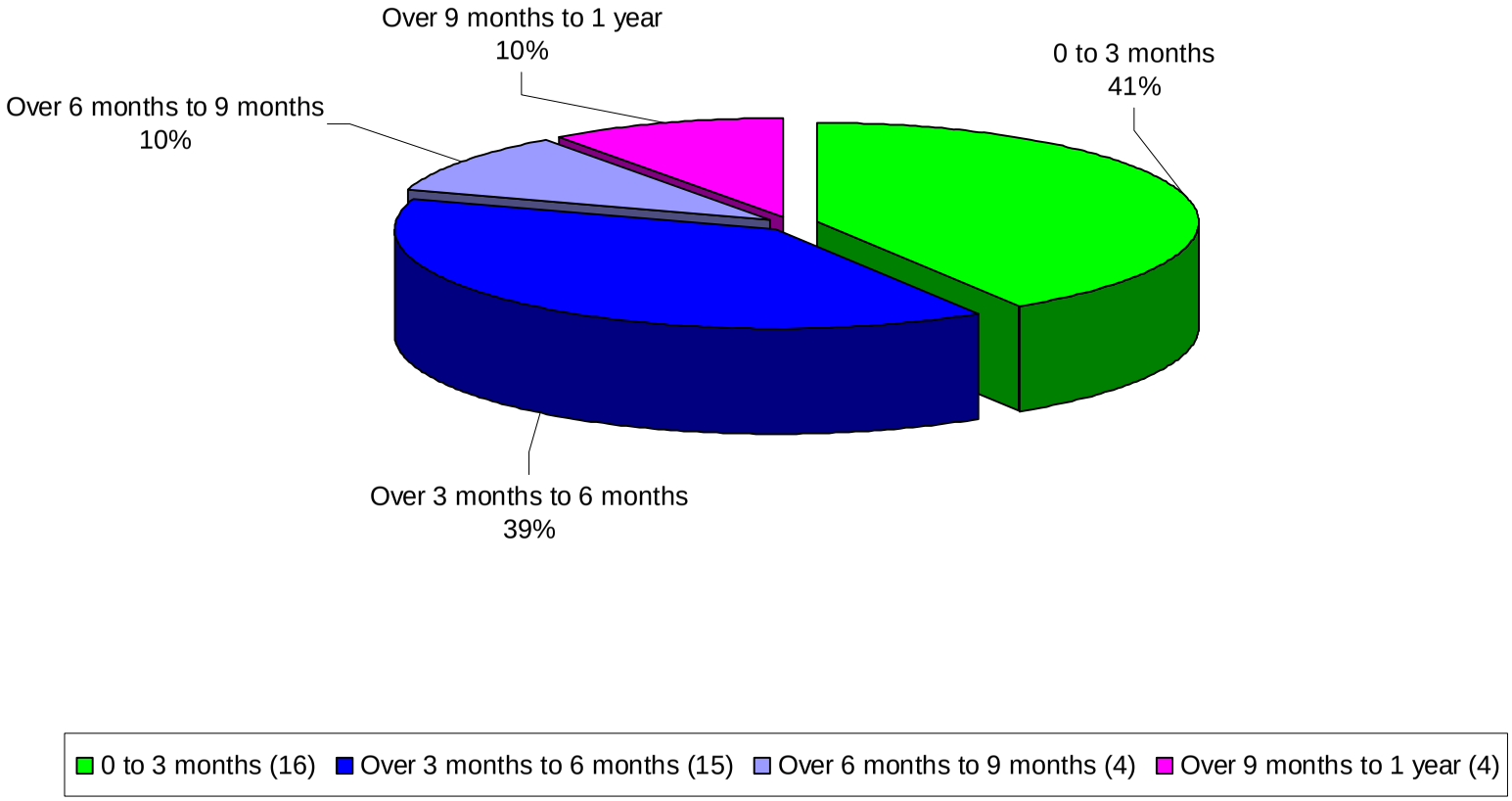
Gender	***Number of Undetermined Child Deaths***
Female	56
Male	65

African American children were over-represented in undetermined child deaths.
86% of the undetermined child deaths were under one year of age.
94% of the undetermined child deaths were 5 years of age or under.

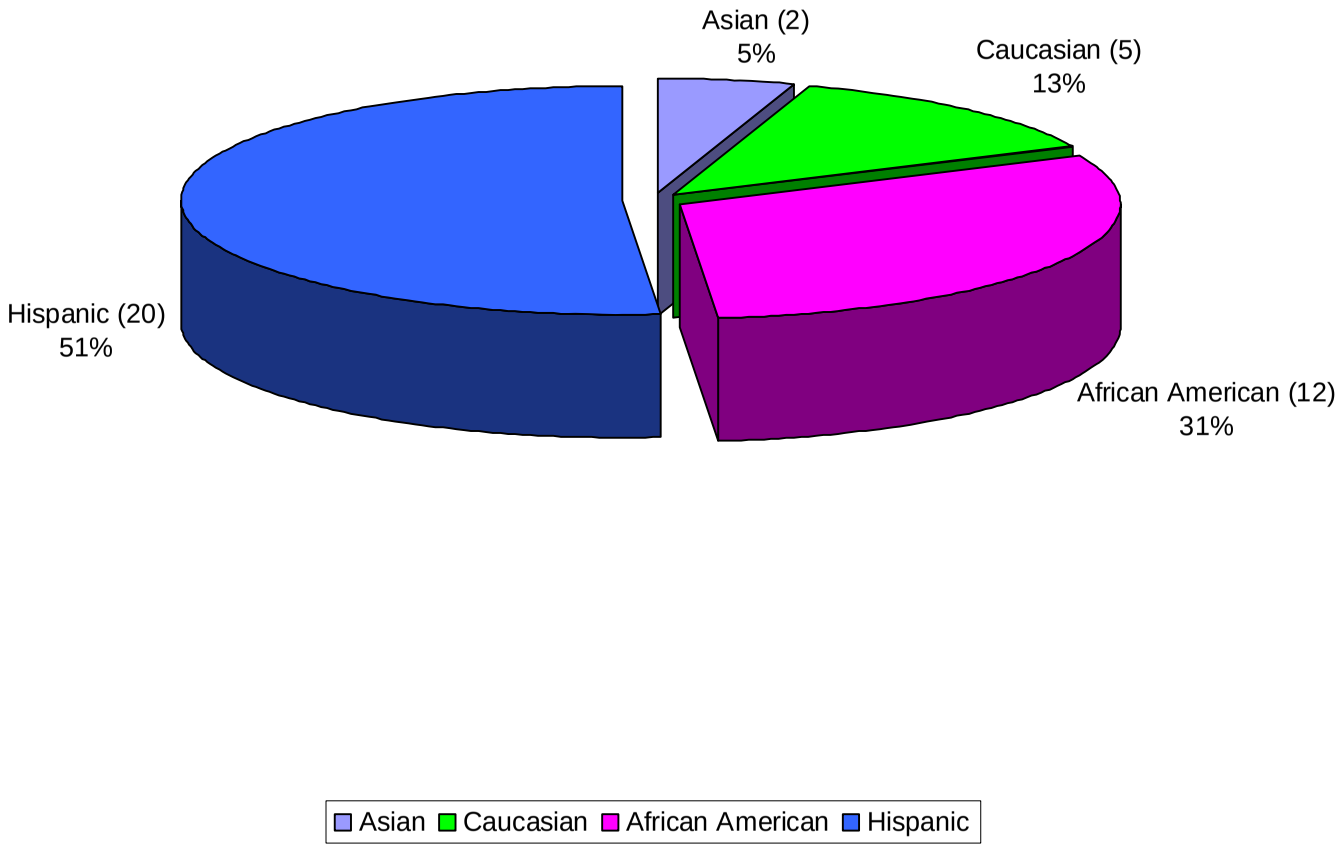
Percentage of Undetermined Child Deaths with a Noted Status Post Co-sleeping 2009



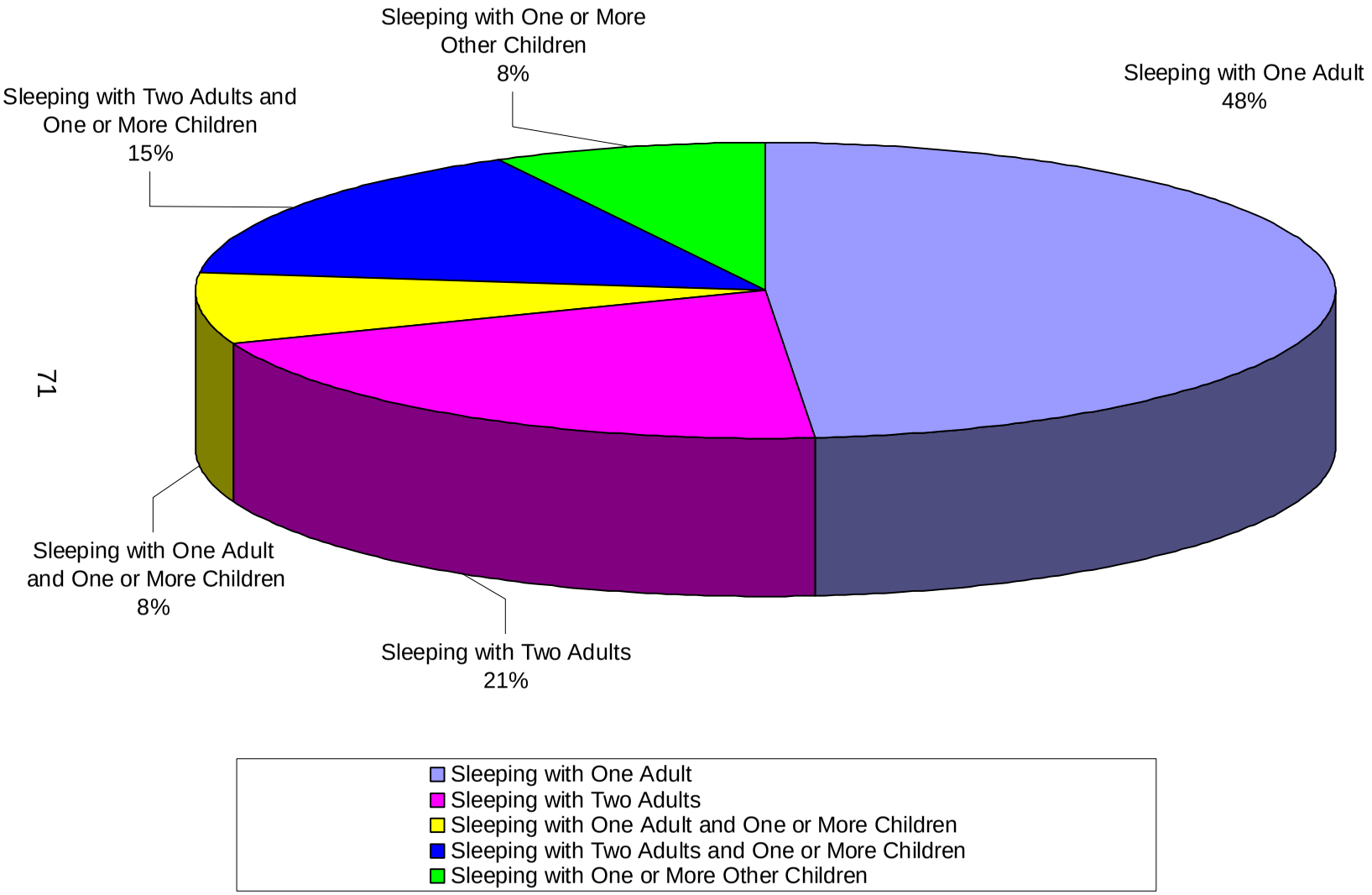
2009 Undetermined Child Deaths Associated with Co-sleeping - Age

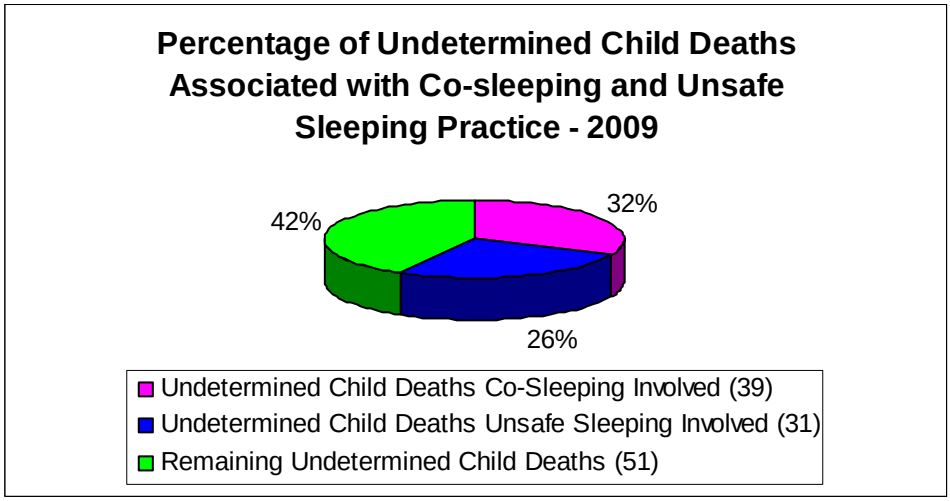


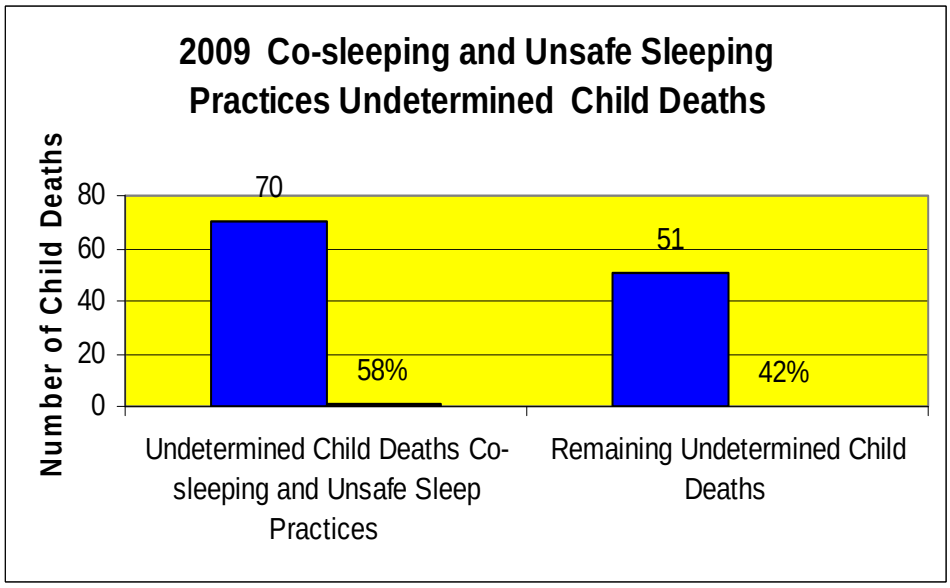
2009 Undetermined Child Deaths Associated with Co-sleeping - Race

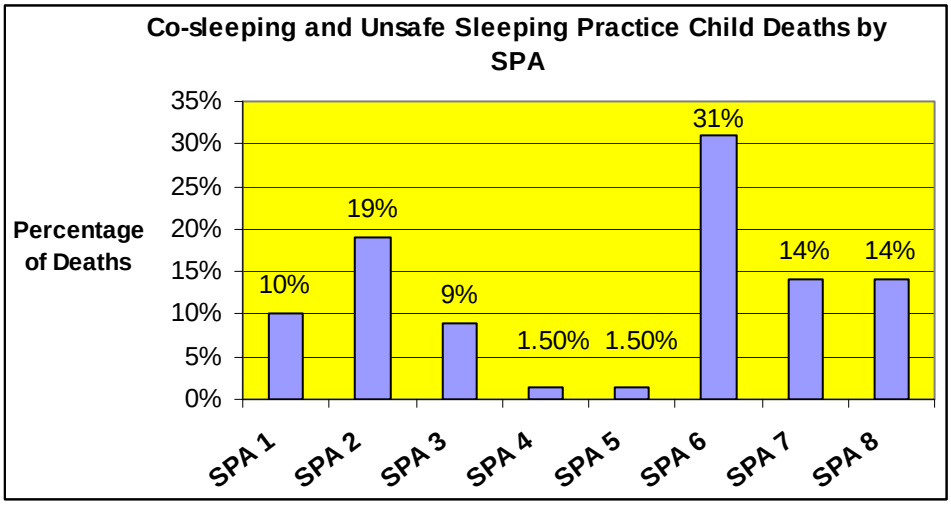


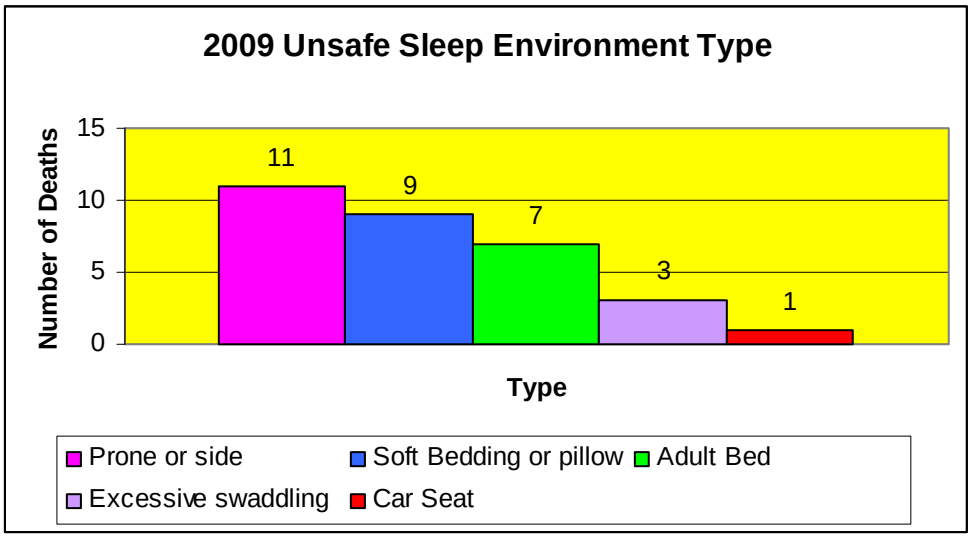
2009 Undetermined Child Deaths Associated with Co-sleeping - Number of Persons

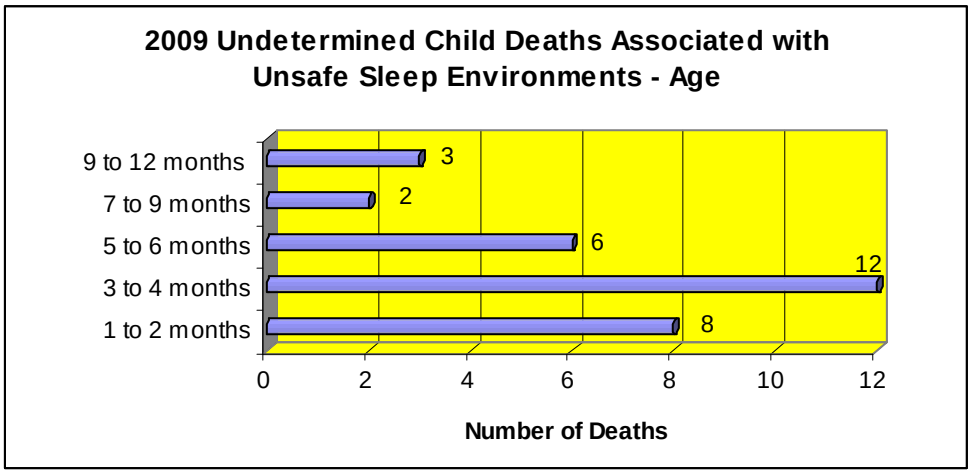


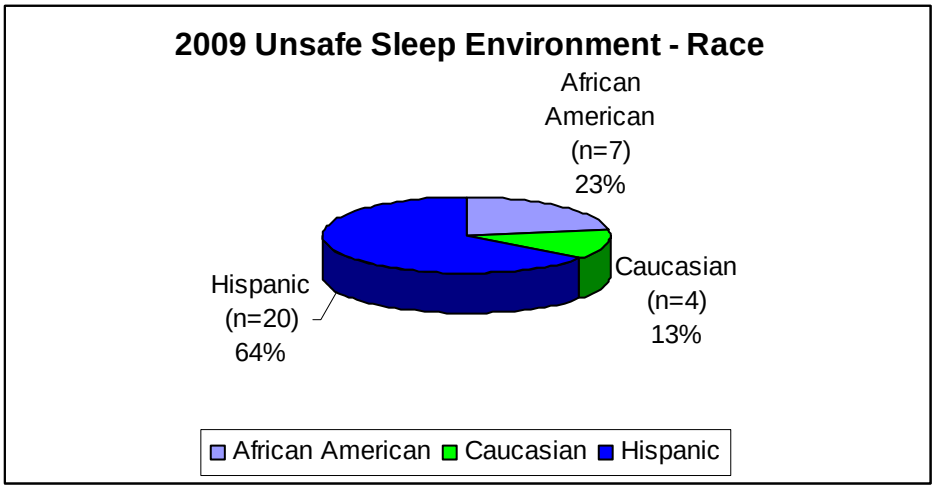

Percentage of Undetermined Child Deaths Associated with Co-sleeping and Unsafe Sleeping Practice - 2009
42%
32%
26%
Undetermined Child Deaths Co-Sleeping Involved (39)
Undetermined Child Deaths Unsafe Sleeping Involved (31)
Remaining Undetermined Child Deaths (51)


2009 Co-sleeping and Unsafe Sleeping Practices Undetermined Child Deaths
Number of Child Deaths
80
60
40
20
0
70
58%
51
42%
Undetermined Child Deaths Co-sleeping and Unsafe Sleep Practices
Remaining Undetermined Child Deaths


Co-sleeping and Unsafe Sleeping Practice Child Deaths by SPA
Percentage of Deaths
35%
30%
25%
20%
15%
10%
5%
0%
10%
19%
9%
1.50%
1.50%
31%
14%
14%
SPA 1
SPA 2
SPA 3
SPA 4
SPA 5
SPA 6
SPA 7
SPA 8


2009 Unsafe Sleep Environment Type
Number of Deaths
15
10
5
0
11
9
7
3
1
Type
Prone or side
Soft Bedding or pillow
Adult Bed
Excessive swaddling
Car Seat


2009 Undetermined Child Deaths Associated with Unsafe Sleep Environments - Age
9 to 12 months
7 to 9 months
5 to 6 months
3 to 4 months
1 to 2 months
3
2
6
12
8
0
2
4
6
8
10
12
Number of Deaths


2009 Unsafe Sleep Environment - Race
African American (n=7) 23%
Caucasian (n=4) 13%
Hispanic (n=20) 64%
African American
Caucasian
Hispanic

Introduction

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

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

The purpose of this information is to provide a broader analysis of children and youth deaths in Los Angeles County. Since the number is significant (n=62) it seemed relevant to provide an analysis of these third party homicide deaths in hopes to provide a better understanding of child death in Los Angeles County. Ultimately, it is hoped that the study of these deaths will help us intervene more effectively.

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

Case Summaries[1]
Third Party Homicides

Fifteen-year old Benjamin was standing on the sidewalk talking with a young woman. A person walked up to them and fired several gunshots, striking both Benjamin and the young woman. The shooter then fled. The young woman suffered only a minor graze wound but Benjamin was pronounced dead after arrival at the hospital.

Roberto, age 15, was at a private residence celebrating a high school football game with approximately 50 to 75 other party goers. An unidentified group of males attempted to crash the party but were turned away. A physical altercation ensued between Roberto and the group of males. A handgun was produced and shots were fired striking Roberto several times. Roberto was pronounced dead at the scene.

Seventeen-year old Victor was at a bus stop with friends when a rival gang member approached them. Words were exchanged and the rival gang member pulled out a handgun and opened fire. Victor was hit by the gunfire. The perpetrator fled the scene and 911 was called. Victor was taken to the hospital where death was determined.

One summer day, an employee at a private business spotted a car that was illegally parked in the loading area. The employee went to advise the occupant that the area was private property and parking was not allowed. The employee then discovered Jennifer, age 17, who appeared unresponsive. Police and paramedics were called. Paramedics observed an incise wound to Jennifer's neck. Jennifer was pronounced dead at the scene. Police observed blood drops leading away from her car. A camera in the loading area showed an unknown male leaving Jennifer's car minutes after arrival. Her parents had filed a missing person report with police when she never returned from the errand sent on by her mother. Prior to her death, Jennifer called her parents asking how to withdraw cash from the ATM. After that call, Jennifer was not heard from again. It was determined that seventeen-year old Jennifer had died from the stab wound to her neck and was the apparent victim of a robbery/assault.

Seventeen-year old Jeremy was standing on the sidewalk when he was confronted by an unknown person who, after a brief exchange and robbery attempt, shot Jeremy in the chest. Jeremy was taken to the hospital where he expired shortly after admission. The shooting was suspected to have been gang related.

Kyle, age 16, was sitting with some friends on a patio outside a private residence when they were approached by a male suspect who produced a hand gun and fired multiple times. Kyle and a friend were pronounced dead at the scene. A third victim was transported to the hospital where he was expected to survive his injuries.

Fourteen-year old Miguel was standing in front of an apartment building with two friends when they were approached by a person on foot. This person asked Miguel where he was from, and after Miguel responded, the person brandished a gun and fired multiple shots hitting Miguel in the head. Witnesses called 911 and paramedics responded and determined Miguel's death at the scene.

Seventeen-year old Monica and her gang-affiliated boyfriend were in the living room at Monica's home when an argument ensued. Monica's two friends were a couple of feet away in the kitchen and were witness to the incident. Reportedly, the argument started when Monica told the boyfriend that she wanted to go to a party and he did not want to go. The argument started off as "playful," but then it got more heated. After a moment of brief silence the friends heard a loud bang. The boyfriend had shot Monica in the head. The boyfriend then made a comment alluding to the fact that he was never going to be able to hide or clean up what he had done. The boyfriend then fled while the friends called 911. Paramedics arrived and Monica was pronounced dead.

Seventeen-year old Daryl and a rival gang member were riding the bus when they got into a verbal confrontation. The confrontation ended when the rival gang member produced a small caliber hand gun and shot Daryl in the forehead from close range. Responding paramedics pronounced death at the scene.

Late one summer morning, two suspects drove up in a van and sat in wait for seventeen-year old Troy. When Troy arrived to the site, he was seen approaching the two suspects when they opened fire and Troy was shot multiple times. Troy was taken to the hospital by ambulance, but despite life saving measures death was pronounced shortly after his arrival.

Four-month old Matthew was on the lap of a passenger seated in the front of a parked car on the street. A group of people were hanging around the parked car. One of Matthew's cousins, who earlier had been in an altercation with a rival gang member, was standing in this group of people. While the group was hanging around the car, two individuals were seen across the street. The cousin and the two individuals exchanged words and hand signals, then one of the individuals pulled out a gun and starting firing into the group. Baby Matthew was shot in the head and died three hours later.

[1]Case identities were changed.

THIRD PARTY HOMICIDES

- There were 62 third party homicides in 2009. This is a 24% decrease from 2008 when there were 82 such deaths and a 38% decrease from 2007.

- Eighty-seven percent (n=54) of the youth were victims of gunshot wounds. These include 23 youth who were victims of homicides perpetrated by suspects with possible gang involvement and one youth who was a domestic violence victim. Seven youth were victims of a stabbing, one of whom was a young man stabbed in the stomach during an argument with his girlfriend. Finally, one victim, a pregnant woman's unborn infant, died as a result of blunt force head trauma after the pregnant mother was intentionally run over by a vehicle.

- As in the previous two years, male victims outnumbered female victims by a broad margin. Fifty-five males and seven females were homicide victims in 2009.

- Sixty-six percent (n=41) of the children who were victims of a third party homicide in 2009 were ages 16 – 17; eleven victims were 15 years of age, two were age 14, five were age 13, and three victims were 12 years of age or under.

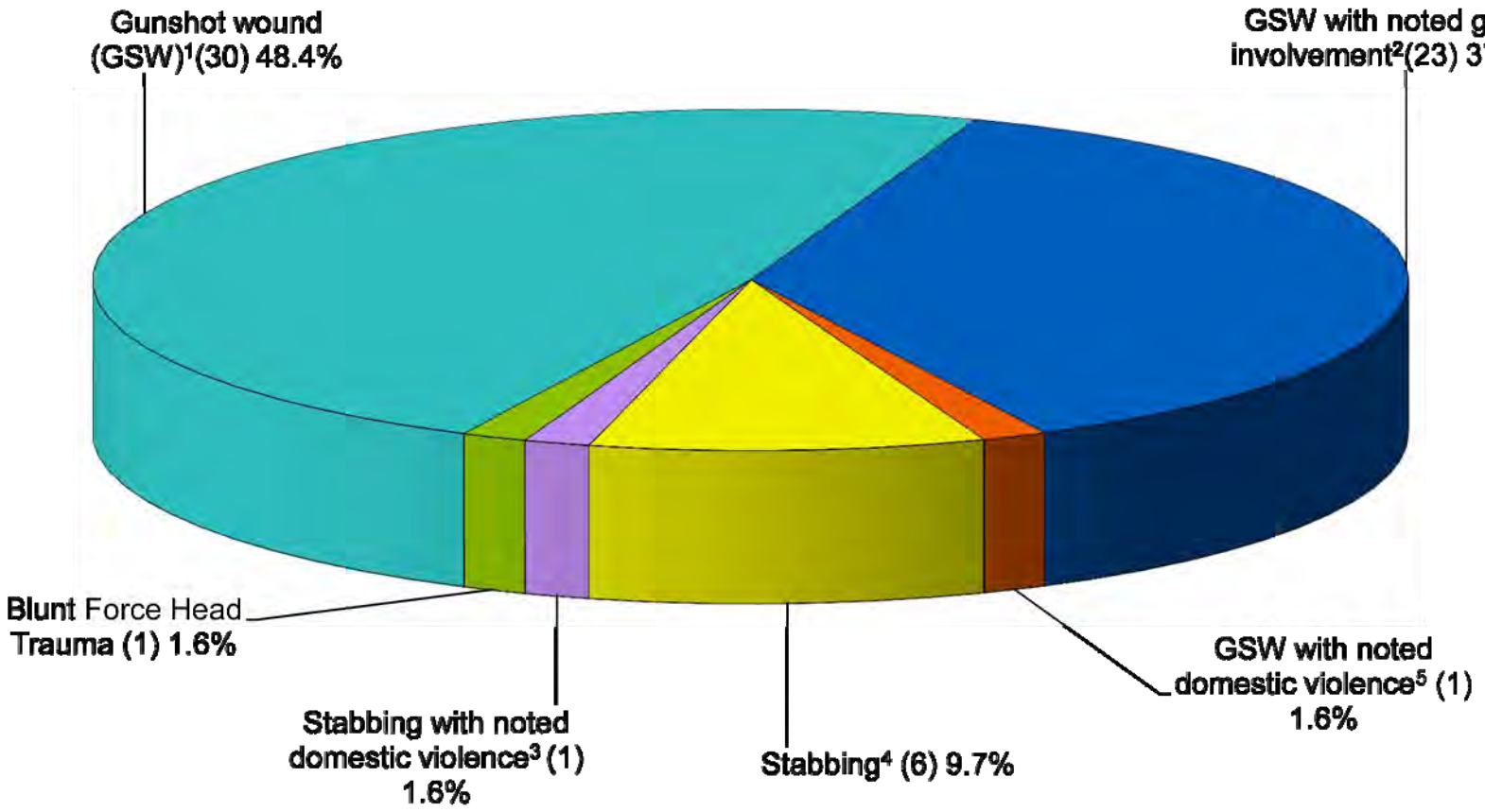
- African-American (n=24) youth were over-represented in third party homicides in 2009. There were 33 third party homicides of Hispanic youth, three third party homicides of Caucasian youth, and two of the victims were of Asian/Pacific Islander descent.

- The greatest number of third party homicides occurred in August (n=8). The second greatest number of homicides occurred in June (n=7) and the third greatest number occurred during the months of January, April, May, and July (n=6). The fewest number of homicides occurred in the month of December (n=2). Finally, while four third party homicides occurred during the months of February, March, September, and October, five third party homicides occurred in November.

- While third party homicides occurred throughout Los Angeles County in 2009, the majority of these deaths occurred in SPA 6 (n=23). Ten third party homicides occurred in SPA 3, nine in SPA 8, seven each in SPA 2 and SPA 7, five in SPA 4, one in SPA 1, and there were no homicides in SPA 5.

- The Los Angeles Police Department (LAPD) had investigative authority for 45% of the third party homicide cases in 2009. Forty-two percent of the cases were under the jurisdiction of the Los Angeles Sheriff's Department, and 13% of the cases were handled by jurisdictions other than LAPD and LASD. Where the relationship of the perpetrator was identified by law enforcement, 29% of the perpetrators were a gang member, and 23% of the victims were gang involved. Finally, 50% (n=31) of the case investigations resulted in the filing of criminal charges by the District Attorney's Office. Some of the cases were still under investigation or unsolved and therefore, had not been presented to the District Attorney's Office.

2009 Third Party Homicides - Cause



Blunt Force Head Trauma (1) 1.6%	Gunshot wound (GSW) (30) 48.4%	GSW with noted gang involvement (23) 37.1%
GSW with noted domestic violence (1) 1.6%	Stabbing (6) 9.7%	Stabbing with noted domestic violence (1) 1.6%

1,4 Gang involvement unknown
2,3,5 Noted from the Coroner Investigative Narrative

THIRD PARTY HOMICIDES

LOS ANGELES COUNTY – 2009 (N = 62)

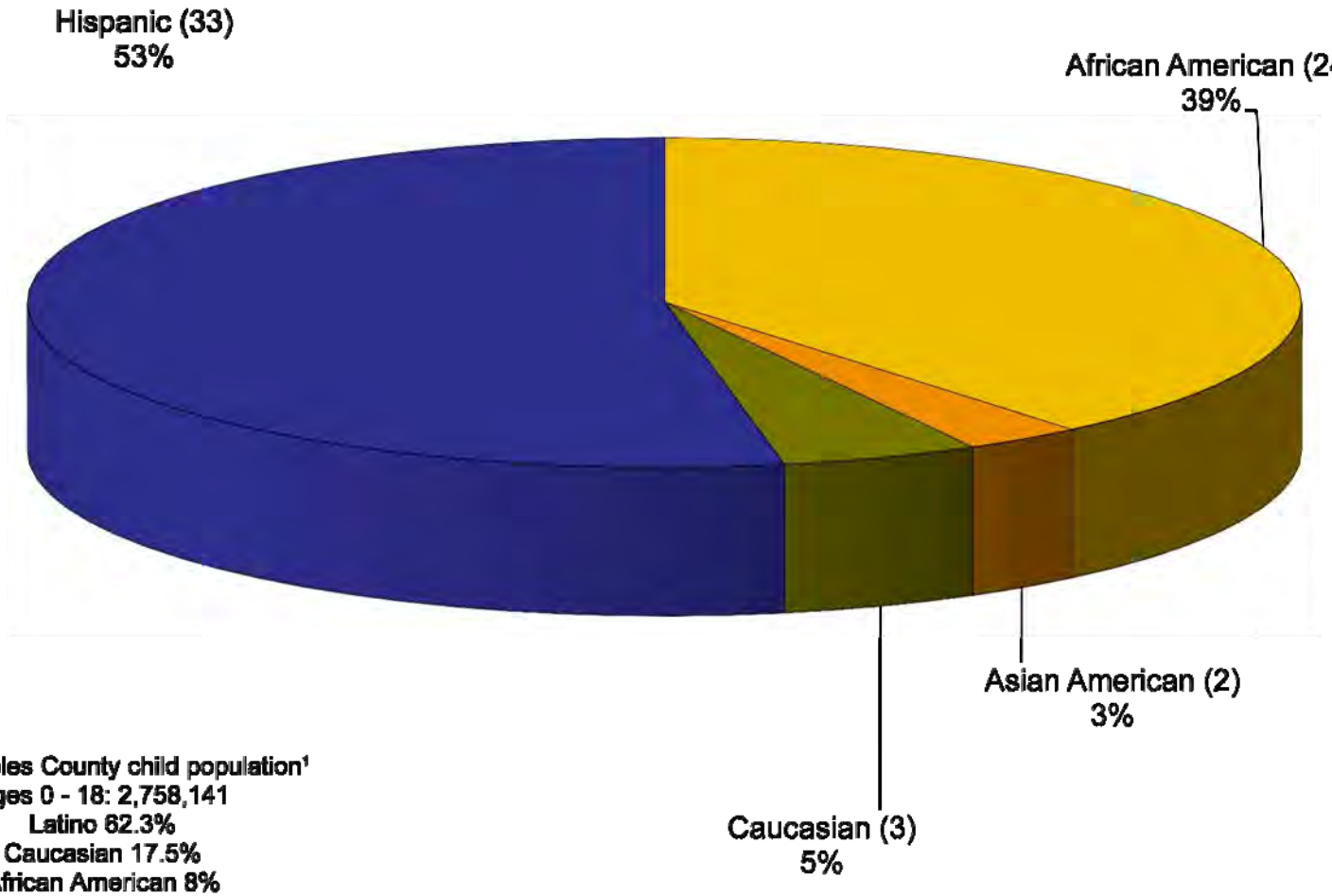
Age	Female	Male
1 year or under	1	1
2 – 12 years	0	1
13 years	1	4
14 years	0	2
15 years	0	11
16 years	2	11
17 years	3	25
Total	7	55

89% of the third party homicide victims were male.

Less than 5% of the third party homicide victims were 12 years of age or younger.

66% of the third party homicide victims were 16 to 17 years of age.

2009 Third Party Homicides - Race



Los Angeles County child population[1]
Ages 0 - 18: 2,758,141
Latino 62.3%
Caucasian 17.5%
African American 8%
Asian American 9.2%
Multi-racial 2.7%
Native American .2%

[1]From 2010 Children Now County Scorecard

Dates[1] of Third Party Homicides - 2009

6 homicides occurred in January (two on 1/10, 1/13, 1/21, 1/30, & 1/31/09)
4 homicides occurred in February (2/01, 2/20, 2/21, & 2/23/09)
4 homicides occurred in March (3/07, two on 3/13, & 3/31/09)
6 homicides occurred in April (4/05, 4/09, two on 4/11, 4/15, & 4/27/09)
6 homicides occurred in May (5/02, 5/05, two on 5/06, 5/10, & 5/23/09)
7 homicides occurred in June (6/01, 6/02, 6/06, 6/08, 6/19, 6/26, & 6/27/09)
6 homicides occurred in July (7/03, 7/05, 7/17, 7/24, 7/25, & 7/29/09)
8 homicides occurred in August (8/03, 8/07, 8/13, 8/16, 8/18, 8/20, 8/23, & 8/25/09)
4 homicides occurred in September (9/19, 9/20, 9/27, & 9/30/09)
4 homicides occurred in October (10/12, 10/23, 10/30, & 10/31/09)
5 homicides occurred in November (two on 11/06, 11/08, 11/19, & 11/22/09)
2 homicides occurred in December (12/7, & 12/19/09)

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

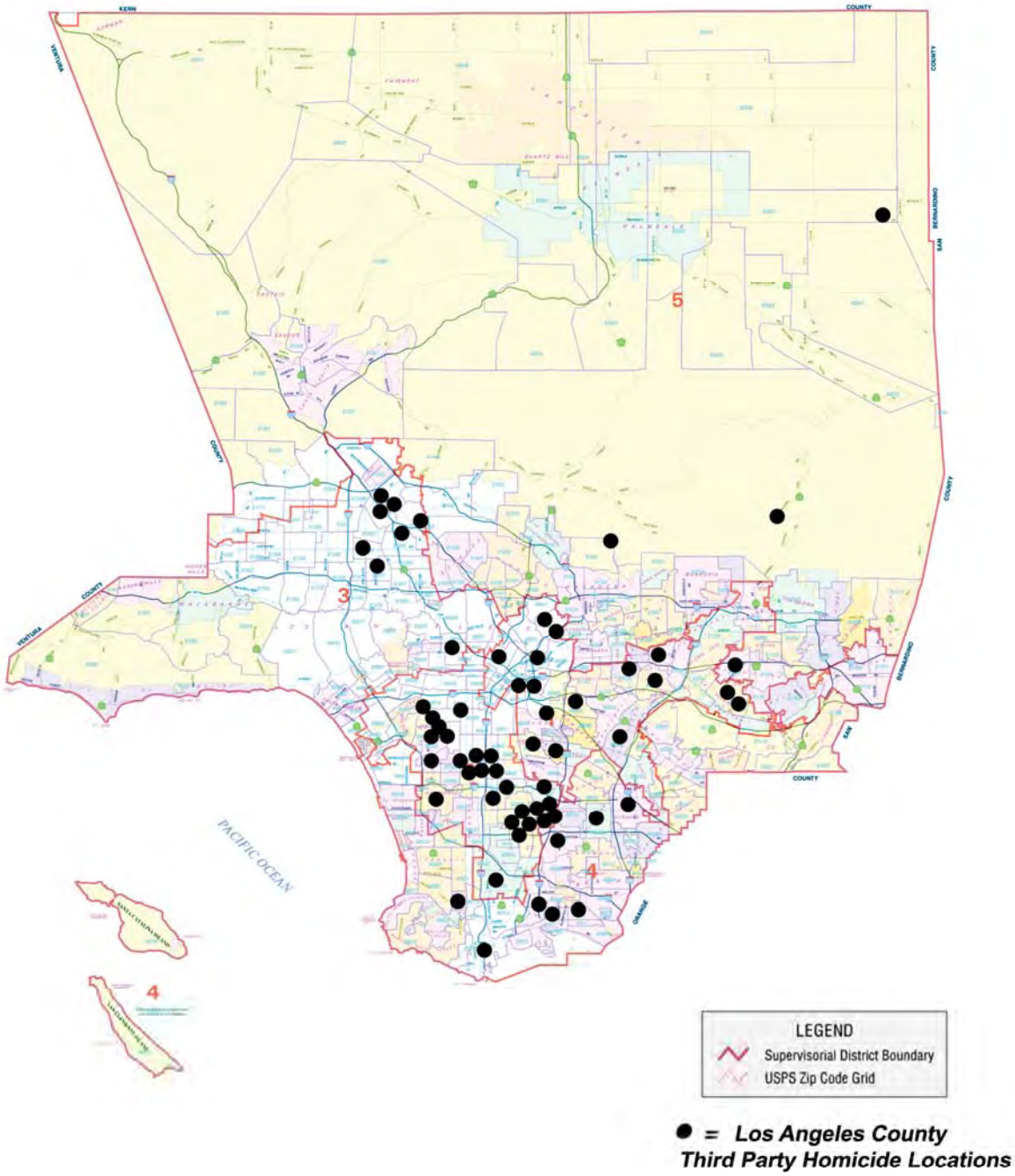
Locations[2] of Third Party Homicides – Geographic Area - 2009

1 homicide occurred in Altadena (zip code 91001)
1 homicide occurred in Athens (zip code 90061)
1 homicide occurred in Azusa (zip code 91702)
1 homicide occurred in Bell Gardens (zip code 90201)
1 homicide occurred in Bellflower (zip code 90706)
1 homicide occurred in Carson (zip code 90745)
8 homicides occurred in Compton (zip codes 90220 & 90221)
2 homicides occurred in East Los Angeles (zip codes 90022 & 90023)
2 homicides occurred in El Monte (zip codes 91731 &91733)
1 homicide occurred in Harbor City (zip code 90717)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in Hollywood (zip code 90038)
1 homicide occurred in Huntington Park (zip code 90255)
1 homicide occurred in Inglewood (zip code 90301)
2 homicides occurred in La Puente (zip code 91744)
1 homicide occurred in Lake Los Angeles (zip code 93591)
4 homicides occurred in Long Beach (zip codes 90804, 90805, & 90813)
14 homicides occurred in Los Angeles (zip codes 90003, 90008, 90013, 90026, 90031, 90033, 90042, 90043, 90047, 90059, & 90062)
1 homicide occurred in Lynwood (zip code 90262)
2 homicides occurred in North Hollywood (zip codes 91352 & 91605)
1 homicide occurred in Norwalk (zip code 90650)
3 homicides occurred in Pacoima (zip code 91331)
1 homicide occurred in Pico Rivera (zip code 90660)
1 homicide occurred in Rosemead (zip code 91770)
1 homicide occurred in San Pedro (zip code 90731)
2 homicides occurred in Van Nuys (zip codes 91401 & 91405)
1 homicide occurred in West Covina (zip code 91790)

[2] City where the injury/fatality occurred

2009 Third Party Homicides - Location

N = 62



Information on criminal justice system involvement in third party homicide cases was gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). In 2009, there were 62 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 1 below.

Table 1

Agency	Number of Cases	Percentage[1]
LAPD	28	45%
LASD	26	42%
Long Beach P.D.	4	6%
Azusa P.D.	1	2%
Huntington Park P.D.	1	2%
Inglewood P.D.	1	2%
West Covina P.D.	1	2%

Table 2 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation. It should be pointed out that only LASD provided this information which explains the excessive number of cases in the "no information provided" category and why these data on the perpetrator's gang involvement vary from those found in the chart on page 79.

Table 2

Perpetrator's Relationship to Victim	Number of Cases
Gang Member	18
Friend	3
Law Enforcement Officer	3
Acquaintance	1
No Information Provided	37

Table 3 provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved. As above, only LASD provided the information needed for this Table.

Table 3

Victim Information	Number of Cases

Shot during an assault on a police officer	3
Shot accidentally by a friend who was playing with a gun	2
Stabbed after attempting to force sex on a girlfriend	1
Stabbed during a fight that ensued after drinking alcohol	1
Shot after getting robbed by gang members	1
Shot during a drive-by shooting	1
Killed when hanging out with a group of friends and a gang member fired several shots into the group	1
Gang member	14
No information provided	38

According to the information provided by the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD), 31 of the 62 cases of third party homicides had criminal charges filed by the District Attorney's Office in 2009. It should be pointed out that of the 28 cases under LAPD jurisdiction, two remain unsolved and are still under investigation. Also, of the 26 cases under LASD jurisdiction, three were presented to the District Attorney but not filed on because a determination of justifiable homicide was made. Finally, of the 8 cases reviewed by the LADA, information was found for only four cases. This may mean that law enforcement has not identified the assailants, not submitted the case for review or some other reason. Table 4 displays the number of filings by the type of criminal charge.

Table 4

Type of Criminal Charges Filed	Number of Cases
Murder/Attempted Murder	**31**
Assault with Deadly Weapon	**6**
Participation in a Criminal Street Gang	**8**
Concealed Firearm/Possession by a Minor	**1**

[1] Percentages were rounded to the nearest whole number explaining the reason the total slightly exceeds 100%.

APPENDIX A
ON-LINE RESOURCES

Safe Sleeping Resources

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

Water Safety

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

Biking Safety

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

Child Abuse

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

Fire Safety

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

In and Around Cars

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

Pedestrian

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

Teen Drivers

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

Grief and Mourning

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

Suicide-Youth

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