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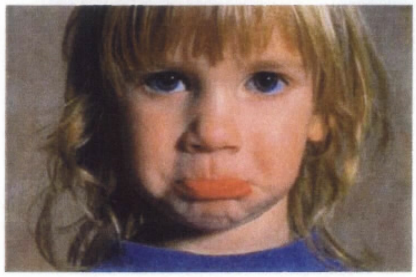
Child Death Review Team Report For 2005




ICAN

Report Compiled From 2004 Data

Table of Contents

Introduction

The ICAN Multi-Agency Child Death Review Team was formed in 1978 to review child deaths in which a caregiver was suspected of causing the death. Over the past 27 years, the activities of the Team have expanded to include review and statistical analysis of child and adolescent suicides, accidental deaths, and undetermined deaths.

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

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

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

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

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

This annual report of the ICAN Child Death Review Team provides information on all children's deaths that meet Team protocol and occurred in Los Angles County during 2004. It provides a detailed analysis of children killed by

caregivers, youth suicides, accidental deaths and undetermined deaths. This report also contains recommendations for action, which, if implemented, should improve child safety and save lives.

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FINDINGS

HOMICIDES

- There were 30 child homicides by parents, caregivers or family members in 2004. This is a 14% decrease from the 35 such child homicides in 2003, and significantly lower than the 15-year average of 43 homicides per year.

- 83% of the children killed by their parents, caregivers or family members were five years of age or younger. This is a decrease from 2003, when 89% of the children were five years of age or younger.

- Five children were over age 5, including one six-year old, one eight-year old, one ten-year old, one eleven-year old and one 15-year old.

- The average age of a child homicide victim in 2004 was 2.63 years (31.60 months). The average age of a child homicide victim in 2003 was 2.51 years (30.06 months).

- Fifteen female children and 15 male children were victims of homicide by parents, caregivers or family members in 2004.

- Seven children died from multiple trauma and seven from head trauma. These include children who were victims of battered child syndrome. Five children died from asphyxiation, three children were victims of gunshot wounds, three children were victims of a stabbing, two children died from malnutrition, one child was left unattended in a bathtub and drowned, one child was poisoned by an overdose of over-the-counter medication, and one abandoned infant's death remains under investigation.

- Seven newborns were abandoned and found deceased and/or killed by their mothers in 2004, the same number of newborns in 2003. Four of these deaths were moded homicide by the Coroner, which represents 13% of the total number of child homicides by a parent, caregiver or other family member. Ten newborns were safely surrendered in 2004.

- Both Hispanic (n=20) and African American (n=7) children were over-represented in child homicides by parents, caregivers or family members. One child was Caucasian, and one was of American Indian descent. One abandoned newborn was of unknown descent.

- Ten children were killed by their mother, nine children by their father or mother's boyfriend, and three children by both parents (these include a mother and her boyfriend). Two children were killed by the babysitter, two children by a relative, one infant was killed by her four-year old brother and one child by his fourteen-year old cousin. Two abandoned deceased infants were included, although no suspect was identified, as it may be assumed that the perpetrators were the infants' mothers.

SUICIDES

- Thirteen children and adolescents committed suicide in 2004. This is a 31.5% decrease from the 19 such suicides in 2003 and significantly lower than the 15-year average of 24.73 suicides per year.

- As in years past, male victims outnumbered female victims by a wide margin. Ten males and three females committed suicide in 2004.

- The leading method in 2004 was death due to hanging, which was the second most common method in 2003. The second most common method in 2004, was death due to gunshot, which was the leading method in 13 of the past 15 years.

- 62% of the children who committed suicide in 2004 were age 15 - 17; five victims were under age 15, and the youngest victims (n=2) were age 12. In comparison, in 2003, four victims were under age 15 and the youngest victim was age 11. The youngest victim reviewed by the Team was age 9 in 2001.

- Caucasian children (n=3) were slightly over-represented in suicide deaths in 2004, while African American children (n=1) were under-represented. Seven children who committed suicide were of Hispanic descent, one was of Asian/Pacific Islander descent and one was of American Indian descent.

ACCIDENTAL CHILD DEATHS

- There were 110 accidental deaths of children age 0 through 14 years in 2004. This is a significant decrease (25%) over the 147 such deaths for this age group reported for 2003.

- For the second year in a row, death due to automobile accidents (n=25) was the leading cause of accidental death for children 14 years of age and under. These data represent both auto v auto and auto solo accidents. Drowning

(n=21) and maternal substance abuse (n=21) tied as the second leading cause in 2004, and autopedestrian accidents (n=18) ranked third.

- ICAN began collecting data on children age 15 - 17 for calendar year 2002. With the inclusion of this older age group, there were 147 accidental deaths (children age 0 through 17) in 2004, and the leading cause of accidental death was automobile accidents (n=43).

- Deaths associated with maternal substance abuse accounted for 14 fetal deaths and 7 deaths of infants up to just under age 6 months. Amphetamine is the drug associated with most of these deaths (n=1 4), followed by cocaine (n=5). Deaths associated with maternal substance abuse accounted for 15% of all accidental deaths in 2004, and fetal deaths associated with maternal substance abuse accounted for approximately 10% of all accidental deaths.

- Accidental drowning claimed the lives of 24 children age 0 - 17 in 2004; these were primarily young children who drowned in residential pools or spas. In addition, one child died in a bathtub, one child fell into a barrel of water and another fell into a bucket of water, one older child died while scuba diving and two children died in a lake and another in a pond.

- Caucasian children (n=36) and African-American children (n=20) both were slightly over-represented in accidental deaths in 2004. Hispanic children were over-represented in autopedestrian deaths (n =16) and automobile accidents (n= 14 auto v auto and n= 8 auto solo).

- In 2004, 90 male children and 57 females died due to accidental death, which is almost a 3:2 ratio. In comparison, in 2003, 120 male children and 62 females died due to accidental death, which was almost a 2:1 ratio.

- In 2004, male children were over-represented in certain types of accidental deaths in comparison to female children. These include autopedestrian accidents in which 16 male children lost their lives as opposed to 5 female children and automobile accidents, in which 27 male children lost their lives due to this type of accident versus 16 female children.

UNDETERMINED CHILD DEATHS

- There were 84 undetermined child deaths in 2004. This is an 18% increase from the 71 such deaths in 2003 and significantly higher than the 15-year average of 37.3 undetermined deaths per year.

- African American (n=28) children were over-represented in undetermined child deaths. Thirty-four children were Hispanic, 15 were Caucasian, and 6 were of Asian/Pacific Islander descent. One fetus, found during autopsy of the mother, was of unknown descent.

- Forty-three percent (n=36) of the undetermined child deaths were associated with co-sleeping. In 50% (n=18) of the undetermined deaths associated with co-sleeping, the infant was sleeping with one adult; eleven of these were sleeping with the mother, six with the father and one with a grandmother. Sixteen infants were sleeping with two adults, and two infants were sleeping with one adult and another child.

- Sixty-one percent (n=22) of the co-sleeping associated deaths were infants between 0 to 3 months of age, 28% (n=1 0) were between 3 to 6 months of age, and 11 % (n=4) were between 6 to 9 months of age.

RECOMMENDATIONS

Recommendation One: Death Reports for Stillborn Deaths

The Independent Police Chief's Association and the Los Angeles Police Department should file death reports for stillborn deaths associated with prenatal drug exposure as an effective case management practice.

Rationale:

The Child Death Review Team reviews cases of child deaths where there is a direct link between placental abruption and premature births with prenatal substance exposure. In 2004, there were 22 child deaths associated with maternal substance abuse, and approximately 64% of these were stillborn fetal deaths. While LASD files reports on these stillborn deaths as current practice, LAPD and many of the Independent Police Agencies do not. LAPD's policy is to take death reports on babies born alive whose deaths are associated with prenatal exposure but not for stillborn deaths linked with such exposure. Given the significant number of stillborn deaths linked to prenatal substance exposure, it would an effective case management practice to take a report. Doing so would initiate a paper trail in these cases and establish a pattern of substance abuse in the event that the mother commits a crime in the future.

Recommendation Two: Public Information Campaign

At the April 2003 Policy Committee meeting, the following recommendation was approved with the acknowledgement that DHS resources were limited and may impact implementation:

> "The Department of Health Services should work with stakeholders, including members of the Child Death Review Team, to address safe sleeping practices and develop a public safety message that can be distributed at labor and delivery hospitals in Los Angeles County and considered for inclusion in the New Parent Kit and other First5 LA projects involving children including the Warmline and Child Abuse Prevention Initiative."

Department of Health Services should provide a status report to the Child Death Review Team regarding progress in implementing this recommendation.

Rationale:
The Team continues to observe an increasing number of infant deaths associated with co-sleeping. In 2004 there were 84 undetermined child deaths, and 43% of these deaths were associated with co-sleeping. A safe sleeping public information campaign would serve to educate parents on the dangers of unsafe sleeping practices for their children.

Child Death in Los Angeles County

Over the past 5 years, an average of 34.4 children each year have been *killed by a parent, caregiver or other family member.*

2000 35
2001 35
2002 37
2003 35
2004 30

Over the past 5 years, an average of 20.2 children and adolescents each year have *committed suicide*. The leading method in 2002 and 2003 was gunshot wounds; in 2000, 2001 and 2004, the leading method was hanging.

2000 23
2001 27
2002 19
2003 19
2004 13

Over the past 5 years, an average of 131.6 children age 14 and younger have died from preventable accidents. The most common accidental deaths involve automobile accidents, deaths due to maternal substance abuse, autopedestrian accidents and drowning.

2000 137
2001 137
2002 127
2003 147
2004 110

Over the past 5 years, the number of undetermined deaths has averaged 70.8 per year.

2000 59
2001 64
2002 76
2003 71
2004 84

CHILD HOMICIDES BY PARENTS, CAREGIVERS OR OTHER FAMILY MEMBERS

1990 -2004

Case identities are changed

CHILD HOMICIDE BY PARENT/CAREGIVER/FAMILY MEMBER

Five-month old Carmen resided with her mother, father and brother, 17-month old, Ricardo. Her mother worked two jobs while her father stayed at home with the two children. On the day she died, Carmen's mother arrived home from work, changed Ricardo's diaper, fixed some food and got into bed with Carmen. She realized Carmen was cold and stiff, and screamed for the children's father. She called 911 and started CPR, and the father fled the apartment. Paramedics arrived and transported Carmen to the hospital where she was pronounced dead.

Carmen's mother reported that she had planned to take Carmen to the doctor as she'd heard a rattling in her chest. When told of Carmen's injuries, her mother stated that 2 - 3 weeks prior she had noticed that the baby's head was sunken in, she was no longer sucking on her bottle and was acting "retarded like a newborn." She stated that she did not know how to obtain medical care for Carmen although she had given birth to Carmen at a nearby hospital. She initially described the children's father as non-violent with the baby but admitted that he was violent against her and had backhanded Ricardo on occasion.

Initially, law enforcement did not approach Carmen's death as a homicide. However, after the autopsy, the Coroner notified law enforcement that Carmen was found to have three skull fractures and five healing rib fractures, which prompted law enforcement to treat the death as a homicide investigation. When law enforcement returned to the home to conduct the homicide investigation, it was learned that the father had fled with baby Ricardo. With mother's assistance, law enforcement located the father and interviewed him for approximately six hours. He confessed to shaking Carmen and squeezing her abdomen and demonstrated these actions on videotape, but not with the force required to inflict the fatal injuries. When asked how he was handling Carmen's death, he responded that he was fine, but that he could not have handled it if it had been his son who had died.

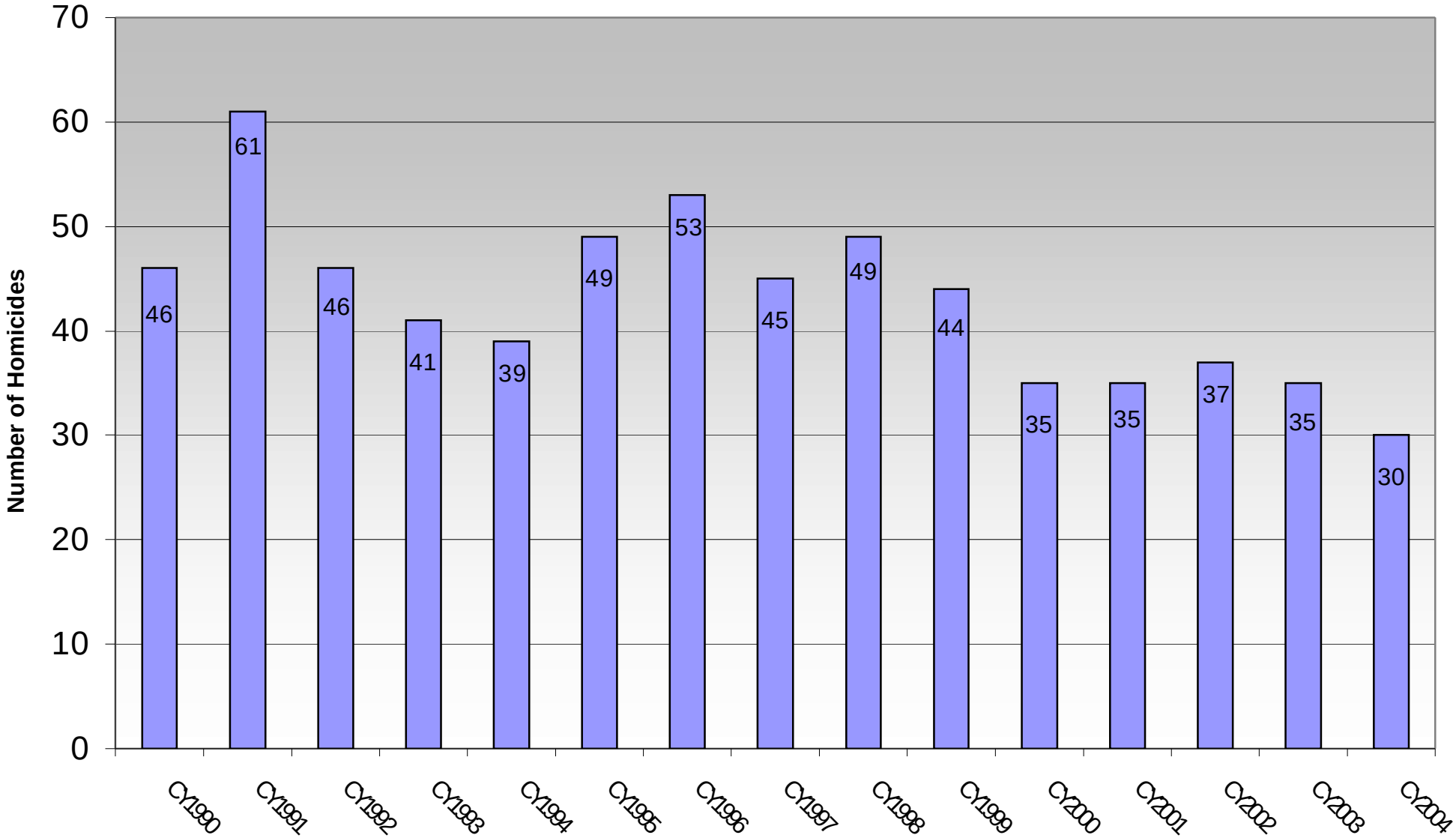
Carmen's mother eventually disclosed a long history of domestic violence perpetrated against her by the children's father. She stated that although he beat her, she didn't think he'd "beat up on his own blood" and that the abuse against Carmen must have happened while she was at work. She stated that she lied to co-workers about her injuries to hide the domestic violence and that when she once attempted to leave the father, he nearly choked her to death.

Although there was no history with the Department of Children and Family Services (DCFS), Carmen's mother resided in foster care from three years of age in another state, and at the time of Carmen's death, she was on probation for aggravated arson charges. She had two older children in permanent placement in another state with her grandmother, the children's great grandmother. As a

result of Carmen's death, both parents were arrested and placed in custody and DCFS recommended no reunification services for the parents.

Charges of assault on a child under age eight leading to death, murder, and child abuse that led to the death of a child were filed against the father by the District Attorney. With the additional information that Carmen's mother ignored the signs of abuse against her infant daughter and continued to go to work, leaving the infant in a dangerous situation in the father's care, she, too, was charged in Carmen's death.

1990 – 2004 Child Homicides by Parent, Caregiver or Family Member



CAUSES OF CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS
1990-2004, Los Angeles County

	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	Total
Head Trauma	18	23	16	14	17	19	15	12	13	15	5	5	2	7	7	**188**
Multiple Trauma	5	7	9	7	7	10	7	10	8	10	11	7	7	10	7	**122**
Gunshot Wounds	11	5	3	2	2	4	4	7	10	4	3	2	1	4	3	**65**
Trauma to torso/abdomen	0	7	3	3	6	2	5	4	2	1	0	0	3	0	0	**36**
Asphyxiation/suffocation	5	1	2	1	0	4	4	4	3	6	3	8	5	6	5	**57**
Drowning	2	5	2	1	1	4	0	2	2	0	3	1	7	1	1	**32**
Fire	0	0	3	1	0	3	8	0	4	0	1	0	0	0	0	**20**
Strangulation	1	4	1	1	1	0	2	2	1	0	0	0	0	0	0	**13**
Poisoning/drug ingestion	0	1	1	6	1	0	2	0	0	0	0	3	6	1	1	**22**
Stabbing	0	2	3	1	0	0	2	0	2	1	4	1	2	0	3	**21**
Unattended newborn	0	3	1	0	1	1	0	1	3	4	2	3	2	3	0	**24**
Undetermined/Unknown	0	2	0	1	2	0	2	1	0	2	1	1	2	0	1	**15**
Dehydration/malnutrition	1	1	1	0	0	1	1	1	1	0	1	1	0	1	2	**12**
Neck compression	1	0	1	1	0	1	1	0	0	0	0	0	0	0	0	**5**
Medical neglect	0	0	0	2	1	0	0	0	0	0	1	2	0	0	0	**6**
Burns	2	0	0	0	0	0	0	1	0	1	0	1	0	0	0	**5**
Hyperthermia	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	**2**
TOTAL	**46**	**61**	**46**	**41**	**39**	**49**	**53**	**45**	**49**	**44**	**35**	**35**	**37**	**35**	**30**	**645**

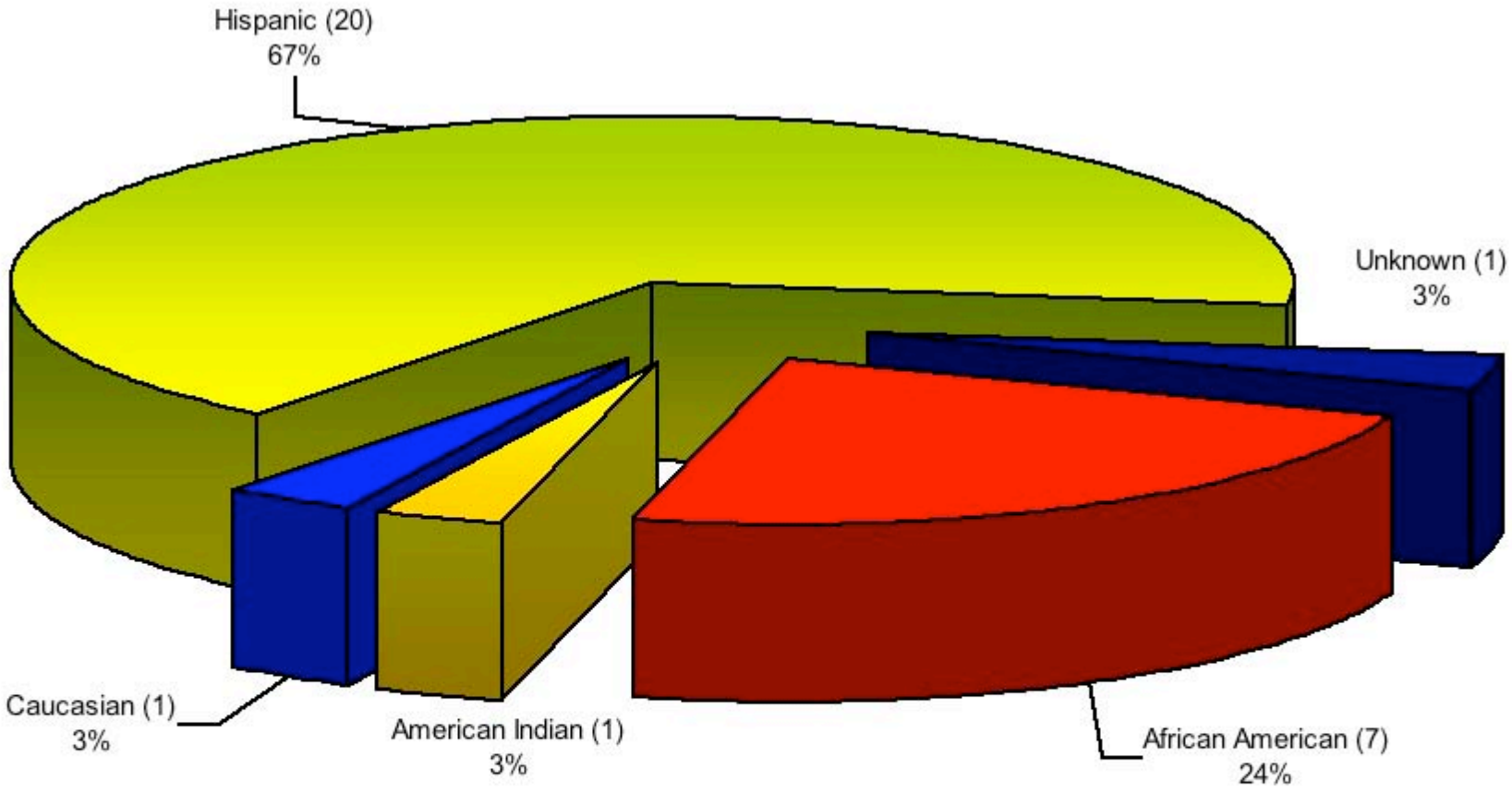
CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS
LOS ANGELES COUNTY - 2004 (N = 30)

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

53 % of the child homicides by parents/caregivers/family members were under one year of age.

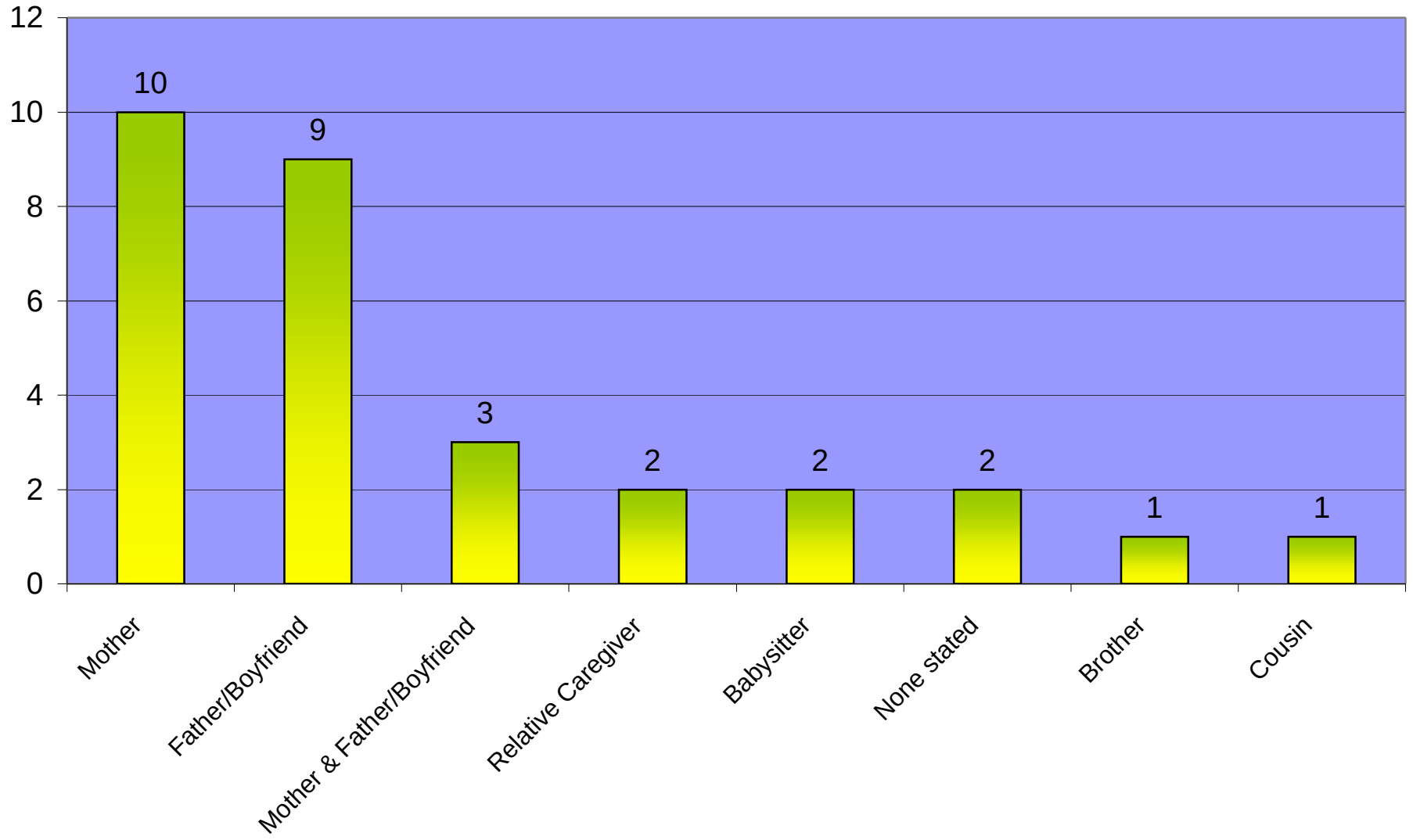
83 % of the child homicides by parents/caregivers/family members were 5 years of age or under.

2004 Child Homicides by Parent, Caregiver or Family Member - Ethnicity



Percentage of Child Population
In Los Angeles County
Hispanics 57.5%
Caucasian 19%
African American 9.9%
Asian/Pacific Islander 9.0%
American Indian 0.3%

2004 Child Homicides by Parents/Caregivers/Family Members
Relationship of Suspect to Victim
Total = 30



CHILD AND ADOLESCENT SUICIDES

1990 -2004

Case identities are changed

SUICIDE CASE SUMMARY

A Metro Link Train struck sixteen-year old Miguel in early spring of 2004. The Train engineer reported seeing Miguel testing the train by allowing it to pass then walking away. This happened on a couple of occasions. On the day of the fatal incident, the Train engineer saw Miguel and applied the emergency brakes. Miguel continued walking westbound until he reached the tracks then stopped in the center and waited for the train to strike him. Miguel traveled 177 feet from the point of impact and landed on the southeast side of the tracks. 9-1-1 was called and once paramedics arrived on the scene, Miguel was confirmed dead. There were papers scattered throughout the area and a backpack and journal were found.

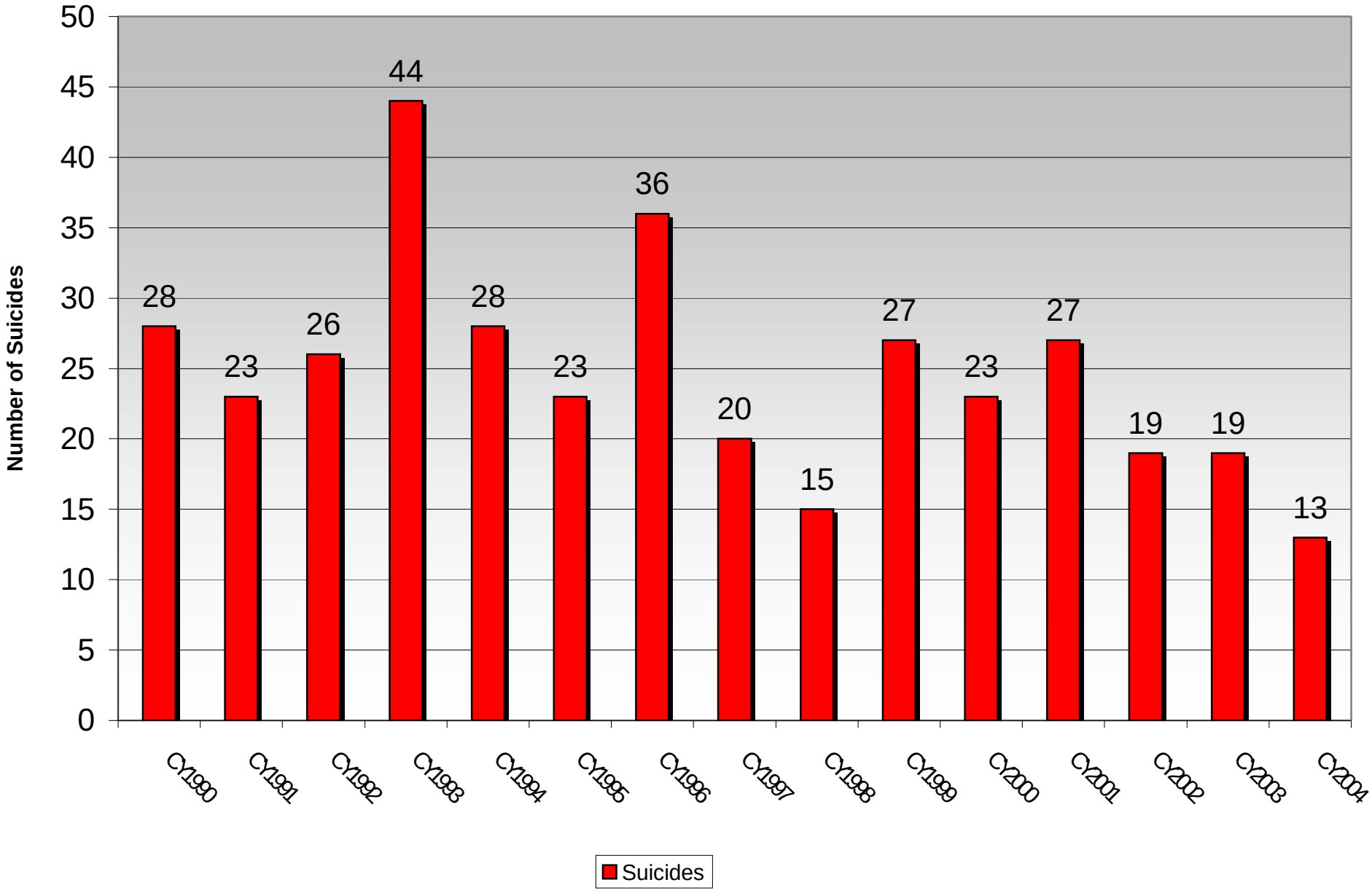
The journal described Miguel's sadness and depression. Miguel was upset over a girl not liking him anymore. He wrote about how he planned to die soon. One entry, written a few days prior to his death, described an incident when Miguel had gone to the train tracks. Reportedly, he arrived at the tracks, waited two minutes and then heard the train approach. However, as the train got closer, Miguel felt something powerful holding him back so he could not go through with his plan.

Miguel's journal contained entries dating back to over a year before his death. In these entries, Miguel wrote that he thought about death and dying for the past six to seven years. He hated life, was recently broken hearted from a girlfriend and experienced constant sadness and depression. Miguel avoided certain activities so he would not develop feelings for another girl. Although broken hearted by his recent breakup, he experienced happiness from his fantasies of intimate moments with girls. Miguel had no interest in trying drugs; he preferred to remain in a constant state of sadness instead of having a temporary escape only to return to feeling sad again. Miguel expressed plans to lose weight because being teased about his weight was the beginning of the end. He also expressed his excitement about using a new video camera. Despite these occasional references to the future, his writings always returned to a focus on death.

The Coroner's report revealed that a toxicology was conducted and Miguel was negative for alcohol and drugs. The Coroner case file contained some of Miguel's recent school reports. Apparently, some of his grades were not very good while others were about average. After Miguel's suicide, school personnel learned that he had been teased about his weight and was called names.

The Child and Adolescent Suicide Review Team pointed out that often, after a completed suicide, that it is discovered that the suicide victim's peers knew something was wrong but did not inform adults because present day culture socializes youth to keep a code of silence. As a result of this review, the Team suggested that school personnel receive training on how to identify high-risk behavior. It was also suggested that information about the warning signs of

suicide, as well as information on how to link any suicide prevention training with bully prevention programs, be provided to school staff.


1990 – 2004 Child and Adolescent Suicides
Number of Suicides
50
45
40
35
30
25
20
15
10
5
0
28
23
26
44
28
23
36
20
15
27
23
27
19
19
13
CY1990
CY1991
CY1992
CY1993
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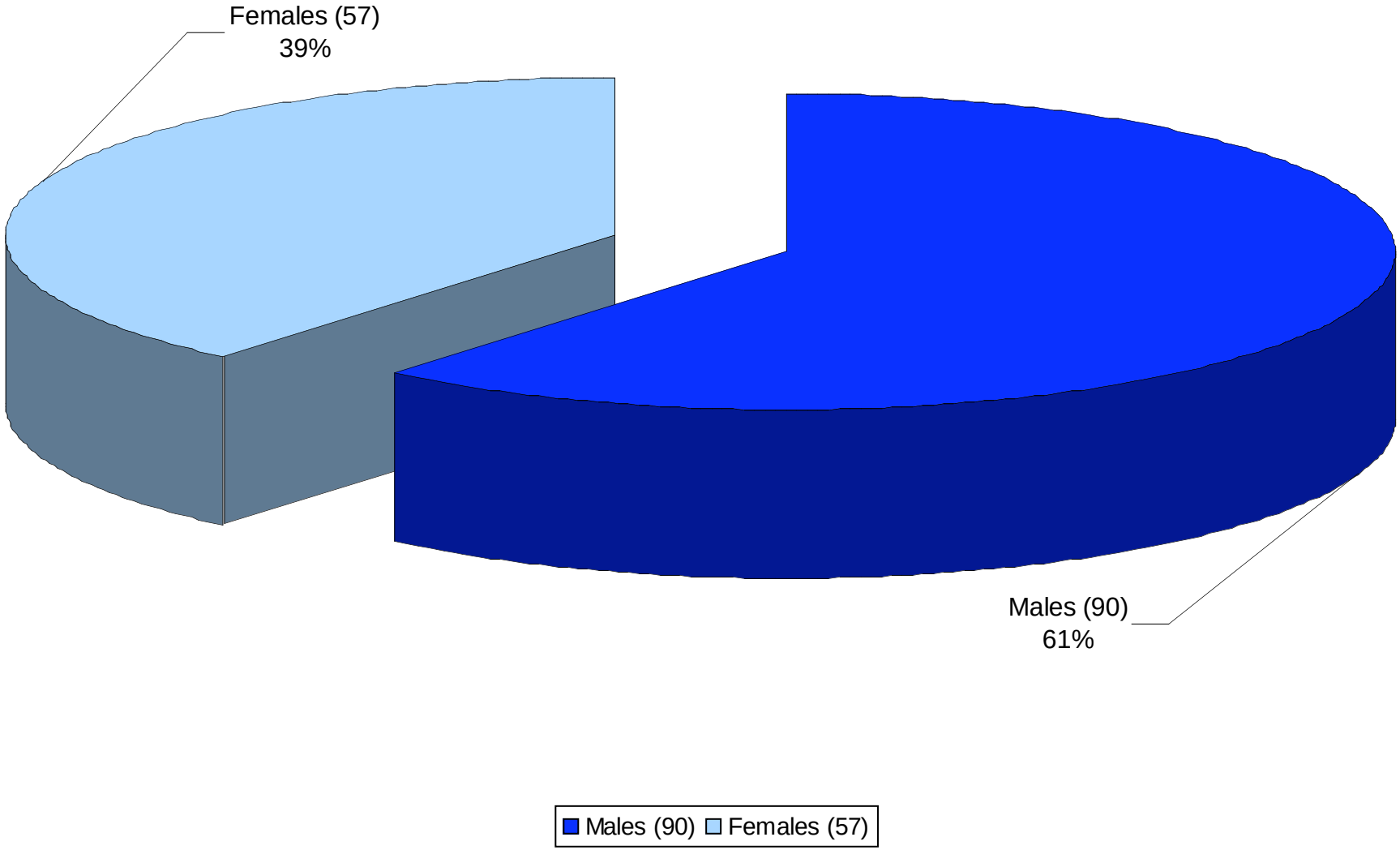
CY2004
Suicides

2004 Accidental Child Deaths - Gender



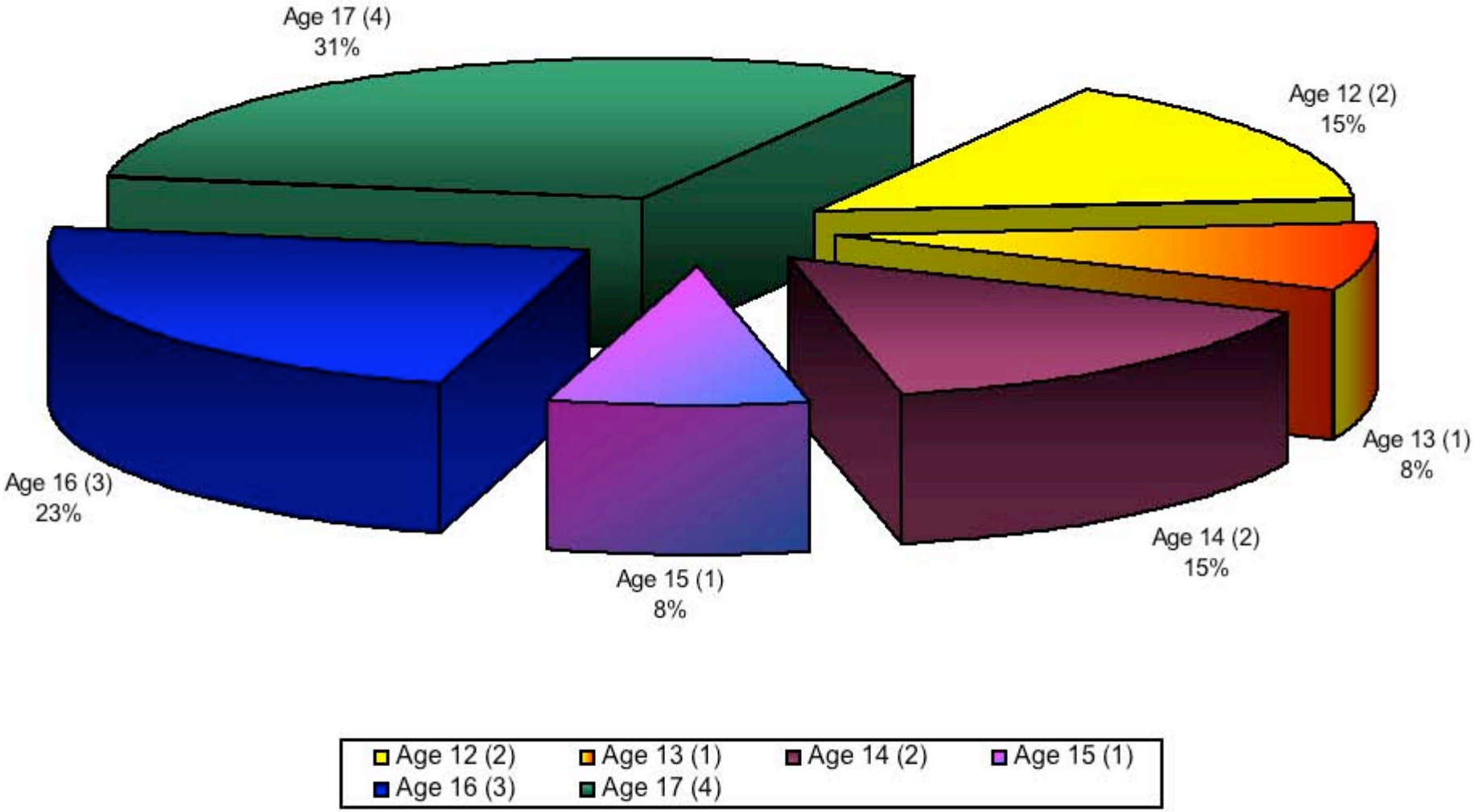
CHILD AND ADOLESCENT SUICIDES
BY METHOD AND GENDER
LOS ANGELES COUNTY - 2004 (N = 13)

Method	Male	Female
Hanging	4	3
Firearms	4	0
Train	2	0
Total	10	3

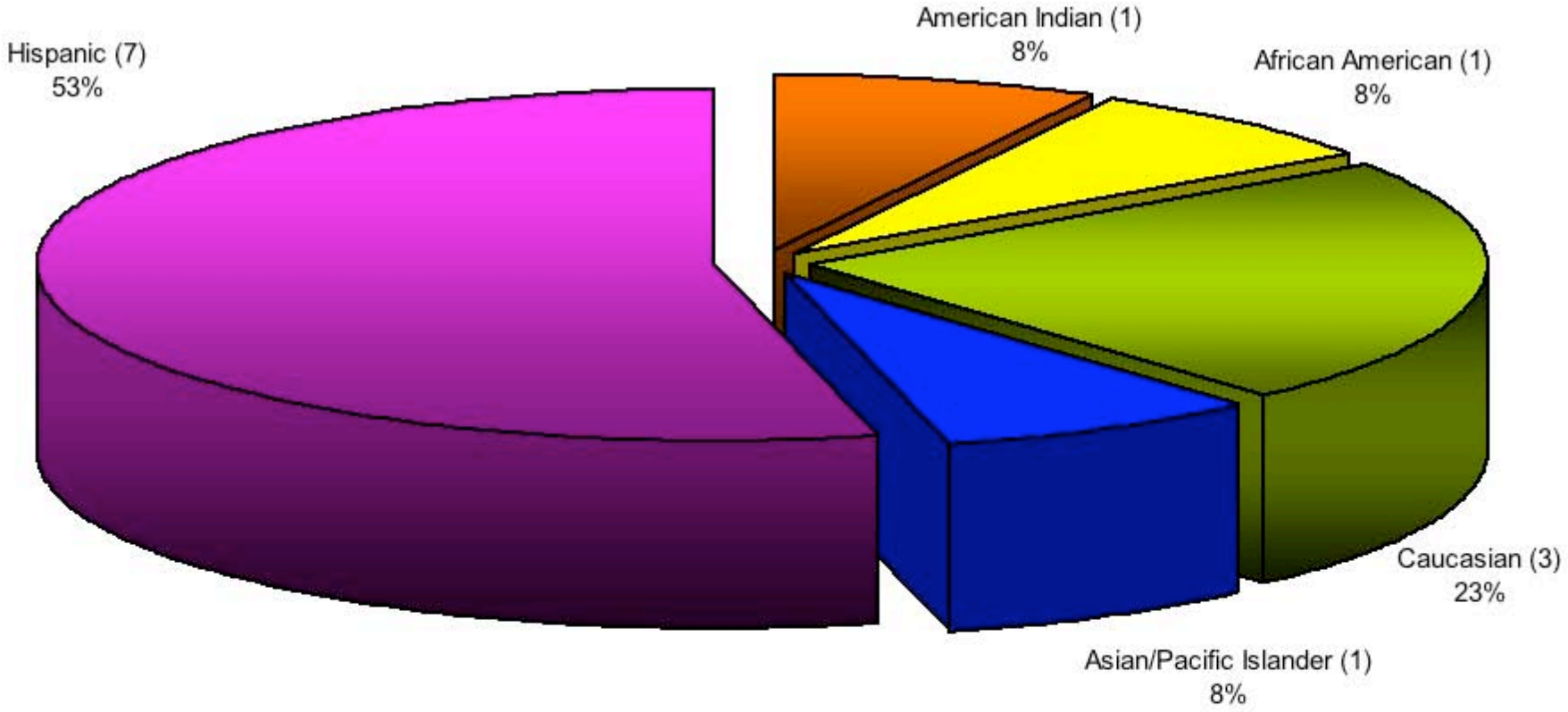
Hanging was the most frequent cause of suicide among adolescents and represents 54% of the suicides in 2004. 40% of the male adolescents used firearms as the preferred method, making this the second most frequent cause of suicide in 2004.

In 2004, 77% (n=10) of the adolescent suicide victims were male. 23% (n=3) of the victims of adolescent suicide in 2004 were female.

2004 Child and Adolescent Suicide – Age



2004 Child and Adolescent Suicides – Ethnicity



Percentage of Child Population
In Los Angeles County
Hispanics 57.5%
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Asian/Pacific Islander 9.0%
American Indian 0.3%

ACCIDENTAL CHILD DEATHS

1990 - 2004

Case identities are changed

CASE SUMMARY

ACCIDENTAL DEATH

Dana, a 9-month old female Hispanic, was in a rear facing infant seat in the front passenger seat of her family's car when her mother, the driver, bent over to pick up her cell phone. Her mother lost control of the car, and the car jumped the curb and hit a pole, which fell on top of the passenger side of the car. The airbag deployed and Dana's mother hit the accelerator rather than the brake. Dana was transported to the hospital and pronounced the next day. The autopsy revealed she had suffered significant head injuries. The Coroner could not determine if the injuries were the result of the airbag without the California Highway Patrol (CHP) investigation report and information from responding paramedics.

Dana's family had no prior contact with the Department of Children and Family Services (DCFS). After Dana's death, the family accepted DCFS Voluntary Family Maintenance (VFM) services. Reportedly, the family had secured counseling services to help them deal with this tragic incident.

The District Attorney filed two counts of PC 273a and one count of vehicular manslaughter against the mother, with a potential sentencing of probation up to 12 years in state prison. Vehicular manslaughter can be filed as a misdemeanor but in this case was not. In vehicular manslaughter cases, the prosecutor looks for a violation of traffic laws that led to the accident that resulted in the death. In this case, the violation of laws involved the mother's inattention and failure to properly secure her children in the car. Prosecutors also consider if others were harmed, and in this case, Dana's 6-year old brother was not wearing a seatbelt and received severe injuries, including a lacerated liver. Prosecutors also look to see if there is a pattern of conduct or repetitive behavior on the part of the defendant, e.g., tickets for failing to properly restrain the children or numerous traffic violations.

The Team questioned whether drivers are automatically tested for alcohol and drugs in such cases. It was pointed out that there was probable cause in an accident such as this but that screenings are not always conducted. The Team review also raised the issue of who should be included in the review of unintentional child injury deaths, indicating that in this case, it would have been helpful to have not only participation of CHP and paramedics, but that of engineers who could discuss the design of the pole that fell on top of the car. Unfortunately, death due to an automobile accident such as in this child's case is not uncommon. In the past two of years, death due to automobile accidents was the leading cause of accidental death for children.

CAUSES OF ACCIDENTAL CHILD DEATHS, AGES 0 - 14
1990-2004, Los Angeles County

	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	Total
Drowning	40	32	25	40	35	31	18	28	21	25	23	28	16	19	21	402
Maternal drug abuse	24	23	17	23	10	9	25	24	38	21	22	24	25	32	21	338
Autopedestrian*						2	1	8	19	31	30	41	33	25	18	208
Automobile**										18	24	28	20	47	25	162
Falls	11	10	5	4	7	6	5	2	3	5	1	1	3	2	3	68
Choking	7	10	6	7	2	0	1	5	3	6	10	2	8	4	1	72
Suffocation	3	5	4	8	4	1	2	0	2	4	1	3	0	1	1	39
Poisoning	3	1	4	7	4	1	1	6	1	4	4	1	0	2	0	39
Fire	0	0	0	3	2	2	0	1	3	7	4	3	7	0	2	34
Hanging/strangulation	1	5	4	5	0	0	3	0	0	0	6	3	1	2	4	34
Medical Misadventure	0	0	0	0	2	1	1	0	1	5	6	2	8	7	3	36
Chest/neck compression	0	0	3	3	3	1	2	1	2	0	1	0	0	3	0	19
Gunshot wounds	1	2	3	0	1	1	2	1	0	0	0	0	0	0	0	11
Object fell on child	0	0	0	0	0	2	0	3	2	1	1	0	1	0	1	11
Sports injury	0	0	0	0	0	0	2	0	2	2	1	0	0	0	0	7
Burns/Thermal injury	0	2	1	1	0	0	0	0	0	1	0	0	1	0	1	7
Dog bites	0	0	0	0	0	1	0	1	0	1	1	0	0	0	0	4
Aspiration of stomach	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	3
Perinatal asphyxia	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	3
Electrocution	0	0	0	0	0	0	0	2	0	0	1	0	0	1	0	4
Birth trauma	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0	3
Hypothermia	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2
Airplane related	0	0	0	0	0	0	0	0	0	0	0	0	2	2	0	4
Train v. pedestrian	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Elective abortion	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Forklift injury	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Drug Intake***															2	2
Bicycle v. Vehicle***															3	3
Motor Vehicle (not auto)***															4	4
TOTAL	**92**	**90**	**73**	**104**	**71**	**58**	**64**	**83**	**98**	**133**	**136**	**136**	**127**	**147**	**110**	**1522**

*Autopedestrian deaths were not reported to the Team prior to 1995. **Automobile deaths were not referred to the Team prior to 1999. ***Data in these categories were previously included in other categories, e.g., poisoning, autopedestrian, sports, etc.

CAUSES OF ACCIDENTAL CHILD DEATHS, AGES 0-17
2004 – Los Angeles County

Automobile – multi-vehicle	26
Automobile – solo-vehicle	17
Autopedestrian	21
Bicycle vs. Vehicle	7
Choking	1
Drowning	24
Drug intake	5
Falls	5
Fire	2
Hanging/Strangulation	4
Maternal drug abuse	22
Medical misadventure	4
Motor vehicle other than auto*	6
Object fell on Child	1
Suffocation	1
Thermal injury	1
Total	147

*Category includes minibikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

CAUSES OF ACCIDENTAL CHILD DEATHS, AGE 2004 – Los Angeles County

	Age 0 - 5 years	Age 6 -14 years	Age 15 - 17 years
Automobile - multi-vehicle	7	10	9
Automobile - solo vehicle	4	4	9
Autopedestrian	13	5	3
Bicycle vs. Vehicle	0	3	4
Choking	1	0	0
Drowning	9	12	3
Drug intake	0	2	3
Falls	2	1	2
Fire	0	2	0
Hanging/Strangulation	3	1	0
Maternal drug abuse	21	0	1
Medical misadventure	0	3	1
Motor vehicle other than auto*	0	4	2
Object fell on Child	1	0	0
Suffocation	1	0	0
Thermal injury	1	0	0
Total	**63**	**47**	**37**

*Category includes minibikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

CAUSES OF ACCIDENTAL CHILD DEATHS BY GENDER 2004 – Los Angeles County

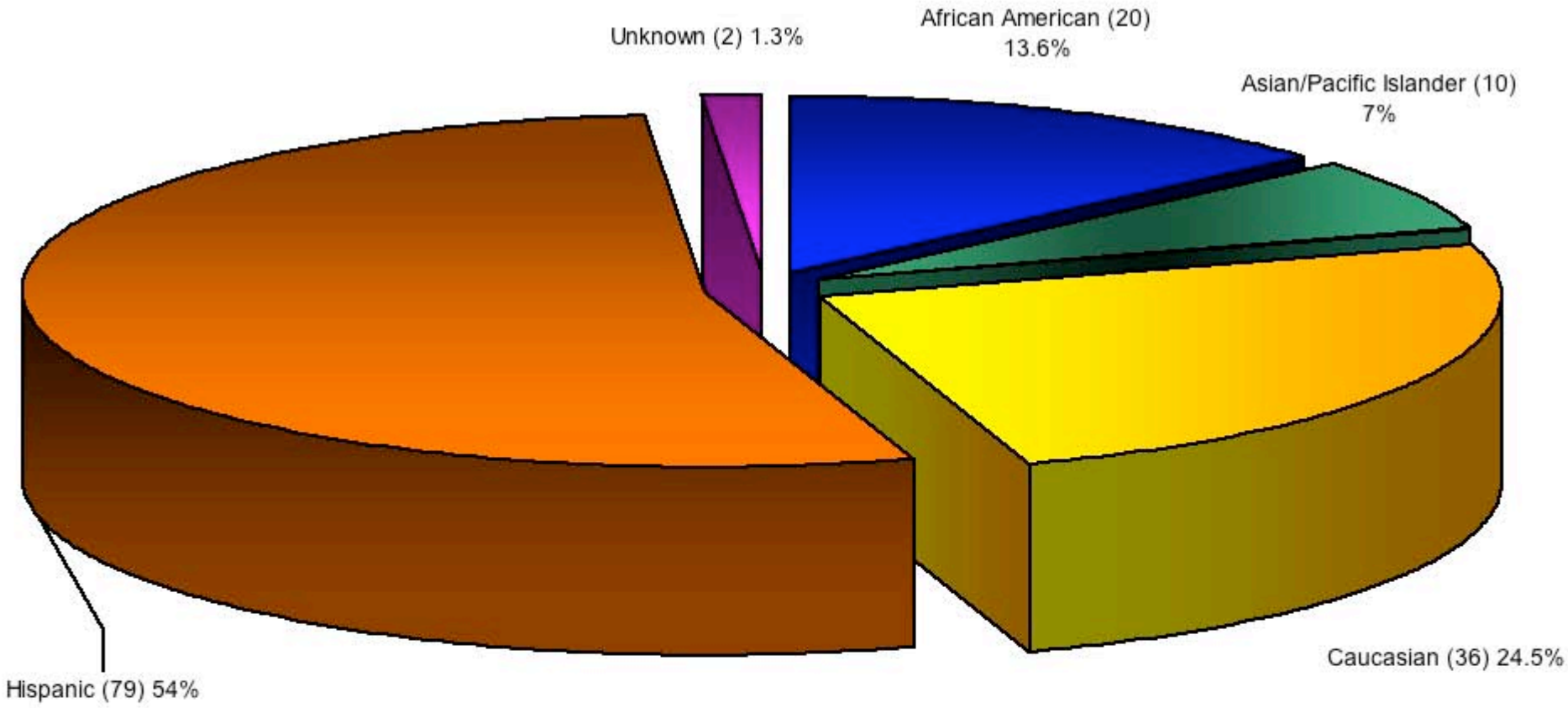
	Male	Female
Automobile – multi-vehicle	14	12
Automobile – solo-vehicle	13	4
Autopedestrian	16	5
Bicycle vs. vehicle	6	1
Choking	1	0
Drowning	15	9
Drug intake	1	4
Falls	1	4
Fire	2	0
Hanging/Strangulation	2	2
Maternal drug abuse	11	11
Medical misadventure	1	3
Motor vehicle other than auto*	6	0
Object fell on Child	0	1
Suffocation	1	0
Thermal injury	0	1
Total	**90**	**57**

*Category includes minibikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

ETHNICITY OF ACCIDENTAL CHILD DEATHS, AGES 0-17
Los Angeles County – 2004

	Hispanic	African-American	Caucasian	Asian/Pacific Islander	Unknown
Automobile – multi-vehicle	14	3	8	1	0
Automobile – solo vehicle	8	3	4	2	0
Autopedestrian	16	0	3	2	0
Bicycle vs. vehicle	4	1	2	0	0
Choking	1	0	0	0	0
Drowning	11	3	6	4	0
Drug intake	3	0	2	0	0
Falls	3	0	1	1	0
Fire	0	1	1	0	0
Hanging/Strangulation	3	0	1	0	0
Maternal drug abuse	8	6	6	0	2
Medical misadventure	2	1	1	0	0
Motor vehicle other than auto*	3	2	1	0	0
Object fell on Child	1	0	0	0	0
Suffocation	1	0	0	0	0
Thermal Injury	1	0	0	0	0
Total	**79**	**20**	**36**	**10**	**2**

2004 Accidental Child Deaths – Ethnicity
(Total = 147)



Percentage of Child Population
In Los Angeles County
Hispanics 57.5%
Caucasian 19%
African American 9.9%
Asian/Pacific Islander 9.0%
American Indian 0.3%

- African American (20) 13.6%
- Asian/Pacific Islander (10) 7%
- Caucasian (36) 24.5%
- Hispanic (79) 54%
- Unknown (2) 1.3%

UNDETERMINED CHILD DEATHS

1990 - 2004

Case identities are changed

CASE SUMMARY

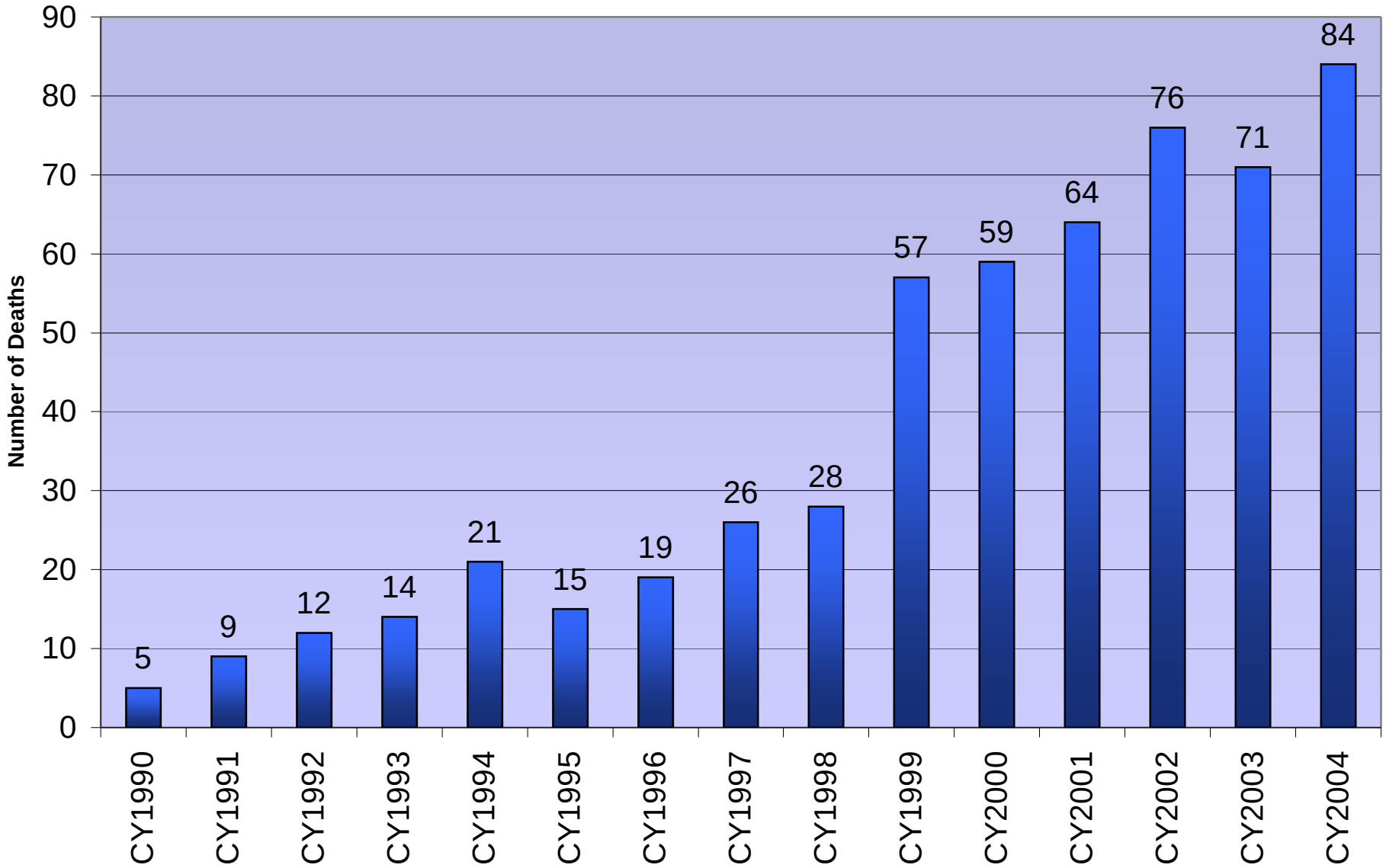
UNDETERMINED DEATH

Max, age 3 months, was found dead in his maternal aunt's home. Max's mother, Rachel Grier, was staying there but it was not her residence. Max was sleeping in bed with his mother and the maternal aunt's daughter, age 17 years. Max had not been sick but when the alarm went off, Max was found dead. He had mucus on his face and no other marks or bruises. Law enforcement arrived and found Max on the bed surrounded by and laying on boric acid - though boric acid was not found in Max's system at autopsy. The family reported that the boric acid was used to kill roaches. The home was found to be very filthy and boric acid was found everywhere. Reportedly, boric acid is commonly used to kill roaches and is not very toxic.

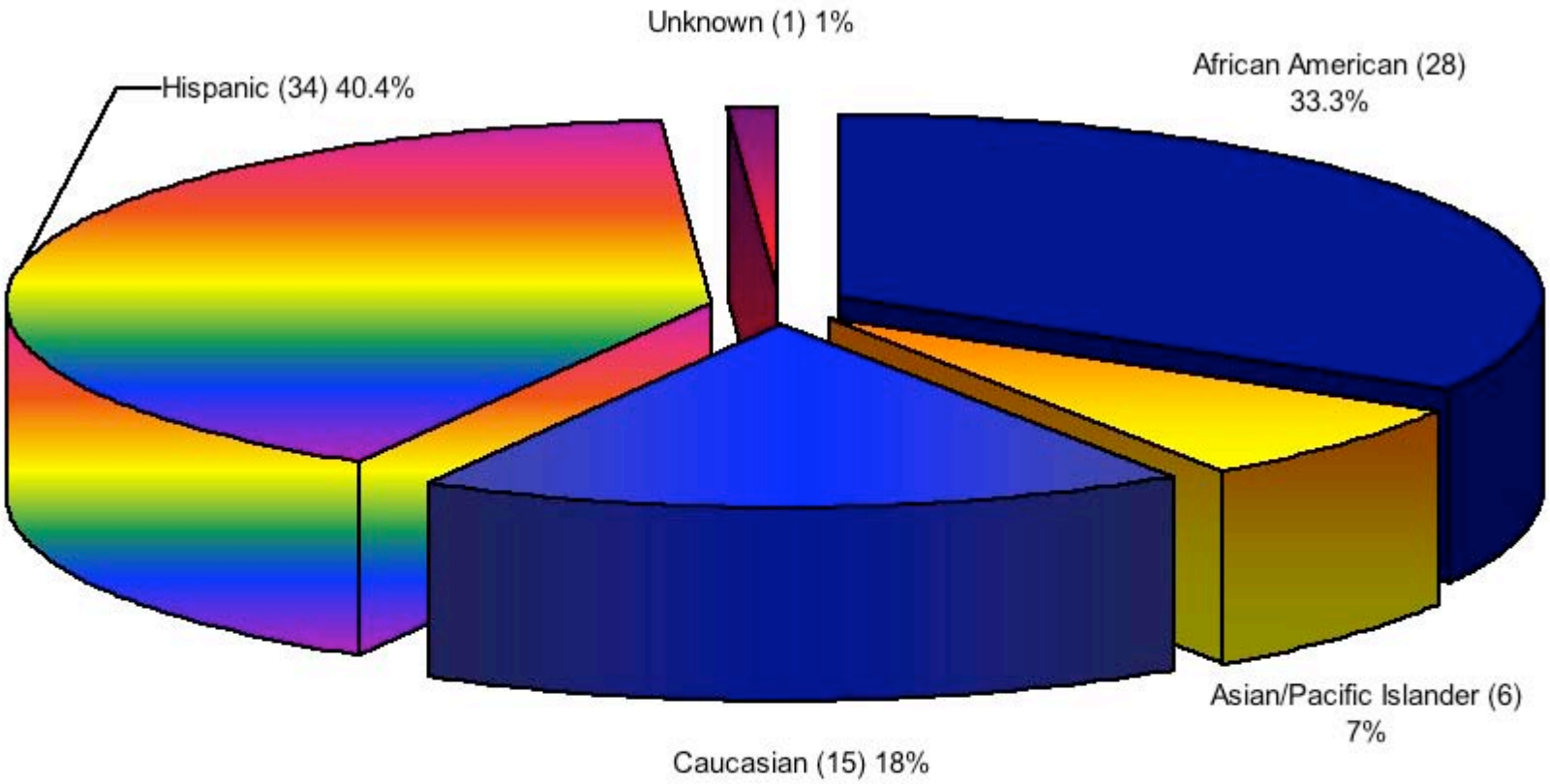
Max's 18-month old sibling, Alexander, was placed with paternal relatives under DCFS supervision. Alexander was neglected and had PKU. Both his mother and father were given training on how to care for him and his condition. The parents were asked to take parenting classes and the mother was asked to partake in individual counseling.

The Coroner's report revealed that Max was a 3-month old black male who was found unresponsive in bed, co-sleeping with two adults. Nothing remarkable was found at autopsy and all tests were negative. Petechiae were found in the thymus, but it is common to see petechiae on the thymus in cases of unexplained death. The cause of death was undetermined and the case was moded as undetermined due to the co-sleeping.

The Department of Children and Family Services (DCFS) records revealed one prior referral for this family alleging neglect. The referral was substantiated and a Voluntary Family Maintenance (VFM) case was opened to allow the mother to receive assistance, childcare, bus tokens, in-home services and parenting. The case was closed, however, as the mother did not cooperate - she was a teen mother and could not be located. The father was not allowed in the home. The District Attorney's records found that mother had a juvenile case from 1996 in Delinquency Court. Unfortunately, Max's case is merely 1 out of the 36 undetermined child deaths associated with co-sleeping in 2004.


1990 to 2004 Undetermined Child Deaths
Number of Deaths
0
10
20
30
40
50
60
70
80
90
5
9
12
14
21
15
19
26
28
57
59
64
76
71
84
CY1990
CY1991
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
CY2003
CY2004

2004 Undetermined Child Deaths – Ethnicity



Percentage of Child Population
In Los Angeles County
Hispanics 57.5%
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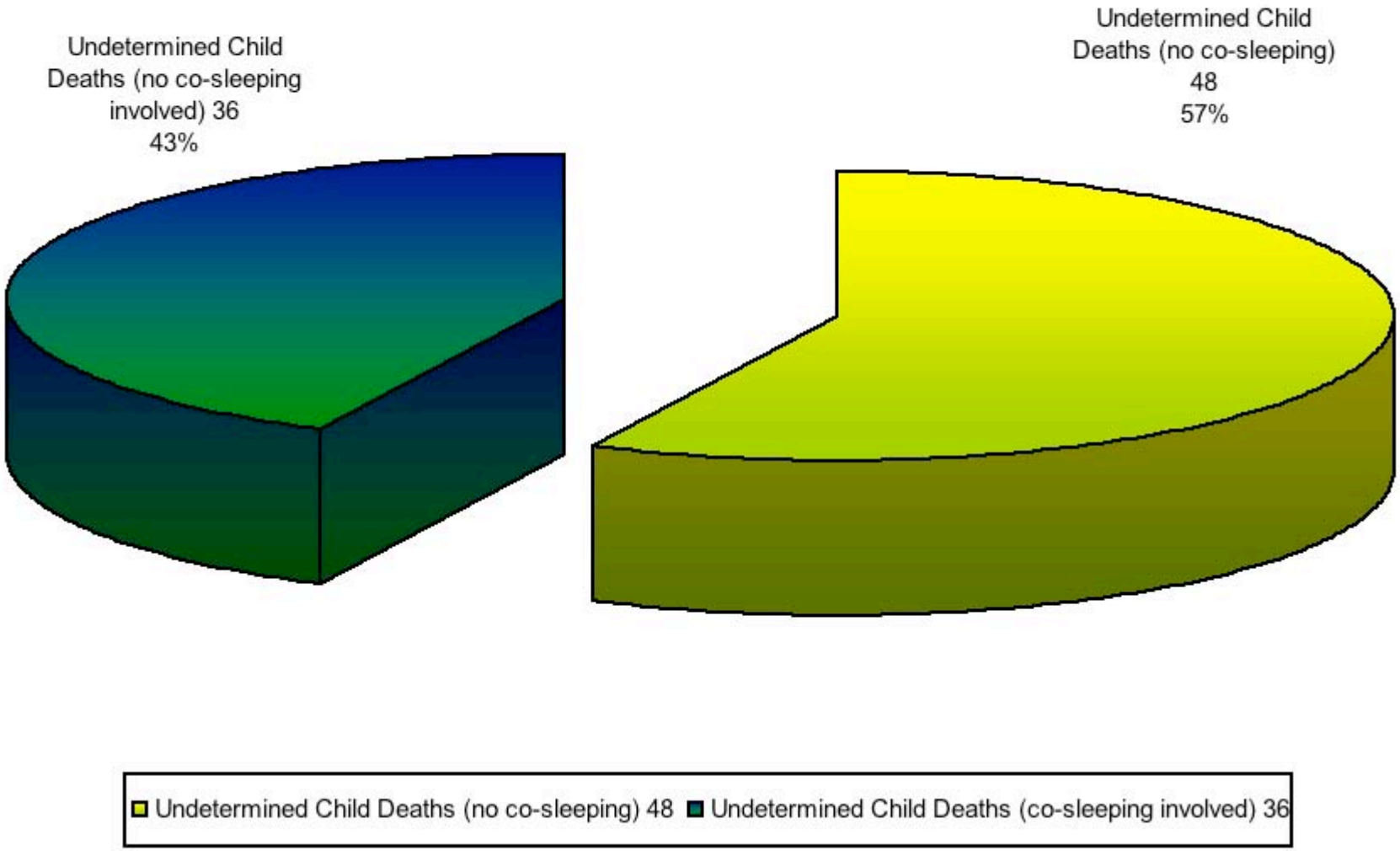
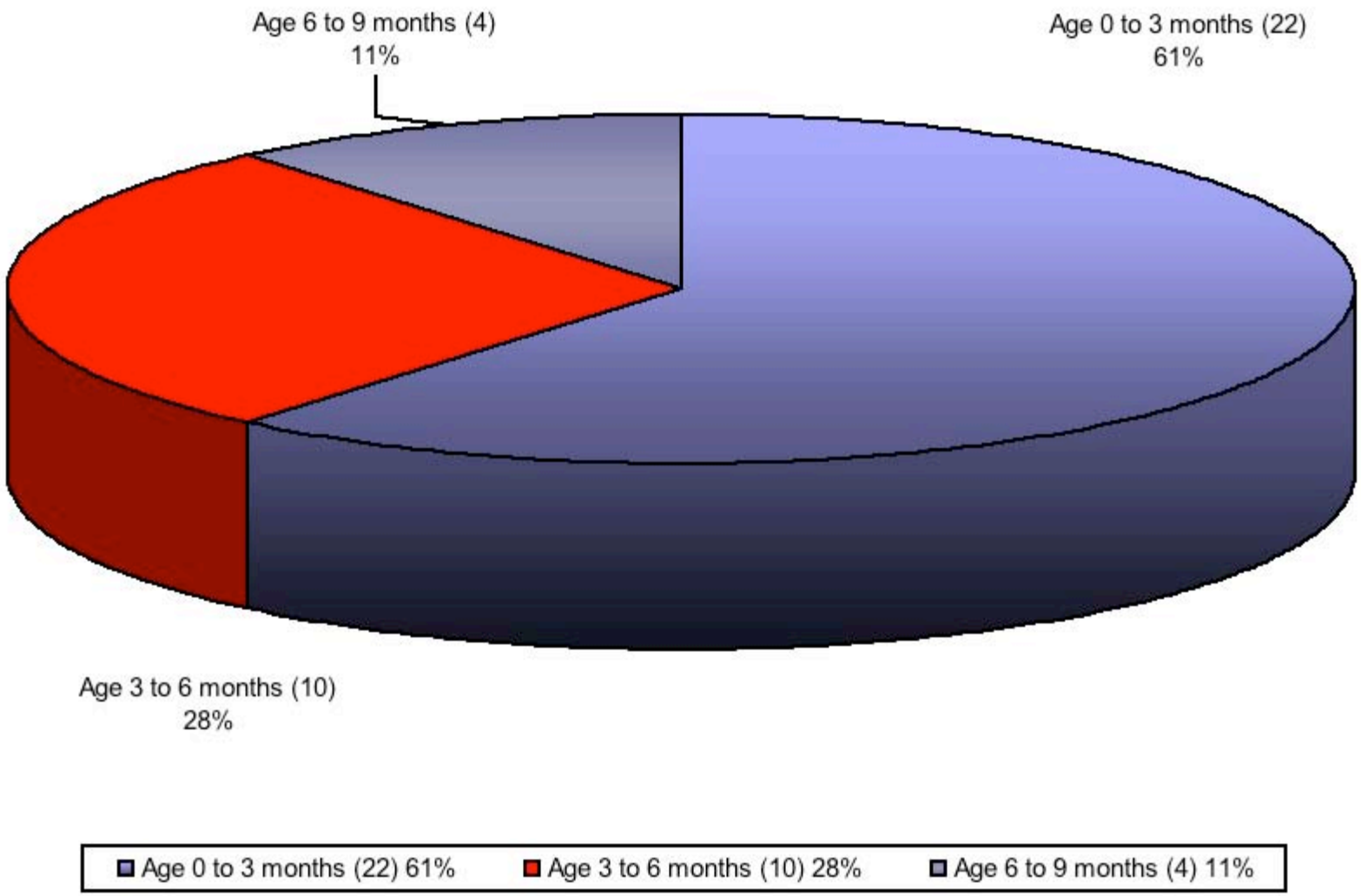
African American 9.9%
Asian/Pacific Islander 9.0%
American Indian 0.3%

2004 Co-sleeping Deaths as a Percentage of Undetermined Child Deaths



2004 Undetermined Child Deaths Associated With Co-sleeping – Age



2004 Undetermined Child Deaths Associated With Co-sleeping
Number of Adults