ICAN

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Report Compiled from 2007 Data

Child Death Review Team Report for 2008

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Forward

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

This thirtieth annual report of the ICAN Multi-Agency Child Death Review Team provides information on children's deaths that occurred in Los Angeles County during calendar year 2007. The purpose of the report is to provide a detailed analysis of children's deaths in Los Angeles County, their relationship to maltreatment and ICAN agencies' involvement with these children and families prior to and following the death.

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

This 2008 report reflects the continuing commitment to report on all child deaths which have met Team protocol. This year, however, the report includes a special supplement to provide data on youth who are victims of a third party homicide.

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 information as well as information on the cause and manner of death. The law enforcement information provides the reader with some insight into which agency conducted the law enforcement investigation, the identity of the suspects, the criminal filings, and the dispositions of filings with the District Attorney's office.

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=100) 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 the first 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 trend analysis.

Introduction

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

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

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

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

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

This annual report of the ICAN Child Death Review Team provides information on *all* children's deaths that meet Team protocol and occurred in Los Angeles County during *2007.* It provides a detailed analysis of children killed by caregivers, youth suicides, accidental deaths and undetermined deaths. For the first time, this report also includes information on 3rd party homicides of youth 17 years and younger. Unlike the child homicides perpetrated by a parent, family member or caregiver, 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

ICAN Child Death Review Team

Data gathered for the 2008 ICAN Death Review Team Report (addressing 2007 data) show that there were 127 undetermined child deaths, and of these, 33% were associated with co-sleeping. ICAN has previously made recommendations regarding the need for public awareness efforts to highlight the dangers of co-sleeping, yet co-sleeping deaths continue to occur in alarming numbers. ICAN recognizes that co-sleeping is a controversial issue tied to cultural values and supported by organizations that believe co-sleeping helps strengthen the bond between parent and child.

However, ICAN believes that steps need to be taken to ensure that families with newborns are enabled to make an informed choice regarding co-sleeping. Such an informed choice can only be made if these families are aware of the risk evidenced by the large number of infant deaths associated with co-sleeping. Options for ensuring a safe environment for infants should be made available and this information should be disseminated on a wide basis. In addition, it should be noted that, anecdotally, many co-sleeping related deaths could be tied to parents who are under the influence of drugs or alcohol. Efforts regarding co-sleeping should also target those parents with a history of substance abuse.

In the 2007 annual report, the following recommendations were made regarding the practice of co-sleeping:

1) The Los Angeles County Office of Education should include information on safe sleeping practices in the curriculum currently in development on the Safely Surrendered Baby Law.

2) The Department of Health Service should provide information on safe sleeping practices to birthing hospitals for dissemination to new parents.

3) The Perinatal Advisory Council/Los Angeles County (PAC/LAC) and other perinatal Councils should survey birthing hospitals in an effort to better determine what these hospitals can do to provide accurate information about the possible dangers in co-sleeping and to encourage safe sleeping practices.

4) The Consumer Product Safety Commission (Commission) should include information on safe sleeping in products used for infants. In addition, the Commission should encourage the development of new products that facilitate safe sleeping, e.g. infant beds that can be used in or next to the parents' bed to allow a parent to place the infant in a safe place after feeding.

5) Law enforcement agencies should send out a training advisory informing officers who respond to “baby not breathing calls” to be cognizant of the role that substance abuse can play in co-sleeping fatalities. The responding officers should take steps to determine if a parent might have been under the influence of drugs or alcohol.

6) The Department Of Health Services and First 5 Los Angeles should develop public service announcements and other public information messages encouraging safe sleeping practices.

ICAN is pleased to report that the first and sixth recommendations have been met. The Los Angeles County Office of Education has included information on safe sleeping practices in their Decisions About a Baby Safely Surrendered Baby brochure for use in school curriculum. ICAN Associates, the Department of Public Health Services and First 5 have developed a brochure on Safe Sleep Tips for Your Baby to be distributed to the public.

While there has been a slight decline in the number of co-sleeping related deaths from 2007, the number remains high and the need for public awareness efforts to highlight the dangers of co-sleeping continues to exist.

It is therefore recommended:

1) The Department of Public Health (DPH) and the Department of Health Service (DHS) should provide information on safe sleeping practices to birthing hospitals for dissemination to new parents. In particular to provide the Safe Sleep Tips for Your Baby brochure to parents of newborns. DPH and First 5 should work with ICAN to promote and distribute this brochure to the public to encourage safe sleeping practices.

2) The Perinatal Advisory Council/Los Angeles County (PAC/LAC) and other perinatal Councils should be encouraged to continue to survey birthing hospitals in an effort to better determine what these hospitals can do to provide accurate information about the possible dangers in co-sleeping and to encourage safe sleeping practices. Additionally, the Councils can encourage hospitals to inquire about the sleeping environment the newborn is going home to and promote safe sleeping practices.

3) The Consumer Product Safety Commission (Commission) should include information on safe sleeping in products used for infants. In addition, the Commission should encourage the development of new products that facilitate safe sleeping, e.g. infant beds that can be used in or next to the parents’ bed to allow a parent to place the infant in a safe place after feeding.

4) Law enforcement agencies should send out a training advisory informing officers who respond to “baby not breathing calls” to be cognizant of the role that substance abuse can play in co-sleeping fatalities. The responding officers should take steps to determine if a parent might have been under the influence of drugs or alcohol.

Infants under one year of age continue to be the most vulnerable victims of homicide by a parent/caregiver or other family member and represent 42% of all child homicides (in Los Angeles County in 2007).

Although infant fatalities are most often related to traumatic injuries of the head and abdomen, such injuries can appear on occasion alongside other medical conditions that can complicate the assessment of child abuse by medical professionals which, in turn, can negatively impact the reporting and investigation of child abuse.

The Team observed that when medical professionals reported suspicious injuries occurring with complicated etiology to the Child Protection Hotline, the reporter’s discussion of the complicated etiology was misconstrued as an indication that no physical abuse was suspected and thus no cross report was made to law enforcement.

In order to ensure that independent and thorough investigations and assessments by law enforcement and DCFS occur, it is therefore recommended:

1) In accordance with best practices, medical personnel should call both DCFS and law enforcement when they first suspect possible inflicted injury to ensure that an investigation is begun promptly in order to provide for optimal multi-disciplinary response.

2) When Child Protection Hotline intake evaluators receive initial reports of suspicious physical injuries (especially head trauma such as subdural hematoma) from medical personnel, they should code the allegations as possible severe neglect and/or physical abuse in order to trigger a mandatory cross-report to law enforcement

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.

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 reposted 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 2007, 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.

Team Accomplishments

In 2007 – 08, the ICAN **Multi-Agency Child Death Review Team (CDRT):**

- Conducted in-death monthly reviews of selected cases with continuing follow-up of previously reviewed cases and issues.

- Worked with the Los Angeles Community Child Abuse Councils to create a child fatality prevention kit for countywide distribution to include materials on safe sleeping, drowning prevention, safety tips in and around cars, and shaken baby syndrome.

- Worked with First 5, ICAN Associates and the Los Angeles County Department of Public Health to develop a brochure on safe sleeping practices with infants.

- Improved case outcomes resulting from Team sharing of information. The Team venue has assisted law enforcement by bringing together legal, medical and other professionals who are able to provide expertise on suspicious child death case investigations.

- Devoted several Team meetings to an on-going focused review of child deaths moded as undetermined by the Coroner in an effort to understand the increase in these deaths and to develop prevention efforts.

In 2007 – 08, the ICAN **Child and Adolescent Suicide Review Team (CASRT):**

- Conducted in-depth monthly review of selected cases with continuing follow-up of previously reviewed cases and issues.

- Coordinated a project with the Los Angeles County Community Child Abuse Councils and the Los Angeles County Department of Coroner to produce condolence cards with grief counseling resources for families of children who have committed suicide.

- Operated a speaker's bureau that conducted presentations at various conferences and employee groups both locally and throughout the United States

- Improved case outcomes resulting from Team sharing information. The Team has provided support to numerous school personnel, providing emotional support and procedural assistance in the aftermath of student suicides. Posthumous activities have included providing suggested guidelines for memorials, mental health interventions and interactions with the suicide victims' family and friends as well as any needed cultural advisement.

- Maintained a Child and Adolescent Suicide Web page on the National Center on Child Fatality Review (NCFR) website –http://ICAN-NCFR.org. Team members provided expertise and information about suggested resources to include on this Web page.

- Participated, as requested on the State Child Death Review Council to provide guidance on issues such as the requirement that all California Child Death Review Teams develop a system to review child and adolescent suicides and to include school representatives in their Team review process.

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

- Provided representation from schools on the Stakeholders committee of the Los Angeles County Mental Health Services Act and in this capacity, provided information to the Team about statewide and countywide planning for prevention and early intervention initiatives.

- Supported legislation to provide suicide prevention training to teachers and to permit Child Death Suicide Review Teams to review suicide deaths of persons up to 24 years of age to capture transitioning youth.

Issues Identified/Lessons Learned

Cycle of Abuse

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

Fetal Death Associated with Maternal Substance Abuse

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

In addition, cases of fetal death with a contributing factor of maternal substance abuse is moded as an accidental death by the Coroner, and the Team recommends that these cases be moded as undetermined, rather than accidental. These cases cannot be moded as homicide as there is no proven intent to kill the baby and no definitive cause and effect between the maternal substance abuse and the infant's death can be made. Many in the law enforcement community would like to be able to press charges in these cases; many in the social services arena believe these cases are better addressed through treatment for the underlying substance abuse and its causes.

Criminal Justice System

The Team often spends a great deal of time examining 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 who is the actual perpetrator of the injuries to the child, particularly when there are a number of people present at the time of the death, or the timeline for the death cannot be determined. The Team has had 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.

In addition, the District Attorney has an ethical duty to only file charges when they believe there is clear and convincing evidence beyond a reasonable doubt that someone has committed a crime. The Team often states the frustration that is felt when charges cannot be filed, especially when the medical evidence is clear that the child suffered from some type of inflicted trauma.

The Team has also focused on the ability of the District Attorney's Office to file charges against a "non-offending" parent for failure to protect the child when they clearly had to be aware of the abuse that the child was suffering.

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 needs to be done regarding mandating 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 and the death prevented had a report to the Department of Children and Family Services (DCFS) and/or law enforcement been made when the child was seen for a prior injury or exhibited signs of abuse in school or at doctor visits. Reporting of injuries and cross-reporting between DCFS and law enforcement are long standing issues addressed by the Team. There has been vast improvement with the implementation of eSCARs.

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

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 now ensured that surviving family members are 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 that the deceased child attended.

Quality of Care in Relative Placements

The Team has reviewed cases where a child is fatally injured while under the care of a relative caretaker who has either failed to comply with the court orders for monitored visitation with the parents or failed to provide adequate supervision of the child(ren) in general. Although California law provides that relatives must first be considered as a resource when looking for an out-of-home placement for a detained child, the Team encourages that there be comprehensive assessment and on-going monitoring of relatives caregivers to provide *quality* of care.

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

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

Poverty/Insurance/Medi-Cal

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

Drowning/Accidental Death

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

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

Regional Center

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

Multiple Referrals

Quite frequently the Team reviews cases where there have been a significant number of prior referrals on a family; often these referrals are disposed as either inconclusive or unfounded. 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. The fact that there are multiple referrals on any child or family, regardless of the previous disposition of those referrals, signals risk and should, therefore, trigger a more in-depth investigation.

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

Safe Sleeping

The Team has spent a great deal of energy focusing on deaths associated with co-sleeping. These deaths are so tragic and are clearly preventable. However, the issue of co-sleeping with an infant is controversial and tied into cultural values and bonding issues. The Team continues to notice a significant increase in the number of deaths associated with co-sleeping and has made recommendations to help prevent these deaths. The Team has determined that it is important to focus on safe sleeping practices in an effort to minimize the risk to an infant co-sleeping with a caregiver.

One lesson the Team has learned is that these infants are often surrounded by a lot of bedding and pillows and are often bundled in too much clothing in an effort to ward off the cold. However, it has been theorized that overheating contributes to infant mortality and that infants should not be bundled in too many blankets or too much clothing when put to sleep. In addition, having items in the bed and/or crib place the infant at risk for suffocation.

The Team has also discussed the role that drugs and alcohol can play in a co-sleeping related death and has discussed the possibility of seeking legislation requiring that parents of infants who die after co-sleeping be required to be tested for any form of

substance abuse. Often these parents are unaware that they are smothering the child as they are passed out due to drugs and/or alcohol.

The Team (ICAN) has joined with the Department of Public Health and First 5 Los Angeles to conduct a safe sleeping campaign. Brochures have been produced and the goal is to provide a safe sleeping brochure to every family with a newborn or infant.

Selected Findings

Homicides

- There were 26 child homicides by parents, caregivers or family members in 2007. This represents a significant decrease (24%) from 2006 when there were 35 child homicides. 2007 represents the lowest number of child homicides for Los Angeles County in the past 15 years.

- Eighty-one percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is an increase from 2006, when 66% of the children were five years of age or younger.

- Five children were over age 5, including one six-year old, one seven-year old, one eight-year old, one nine-year old and one 13-year old. Eleven of the victims were under age one.

- The average age of a child homicide victim in 2007 was 2.9 years (34.86 months). The average age of a child homicide victim in 2006 was 3.55 years (42.55 months).

- Thirteen female children and thirteen male children were victims of child homicide by parents, caregivers or family members in 2007.

- Seven children died from multiple traumas, two from head trauma and one from trauma to the torso/abdomen. These include children who were victims of battered child syndrome. Three children died from asphyxiation/suffocation, five from gunshot wounds, two children were victims of a stabbing, one died from drowning, and one child died of dehydration/malnutrition.

- Three newborns were abandoned and found deceased and/or killed by their mothers in 2007. This represents a fifty percent decrease from 2006 in which there were six abandoned deceased newborns. All of these deaths were moded homicide by the Coroner, which represents 11.5% of the total number of child homicides by a parent, caregiver or other family member. Fifteen newborns were safely surrendered in 2007 which is a 27% increase from 2006 when 11 newborns were safely surrendered.

- Both Hispanic (n= 15) and African American (n=5) children were slightly over-represented in child homicides by a parent, caregiver or family member. Three children were of Asian/Pacific Islander descent, two children were Caucasian and one child was of unknown ethnic origin.

- The Department of Children and Family Services (DCFS) had prior contact with 23% (n=8) of the families in which there was a child homicide. This is a decrease from 2006 when 33% of these families had previous contact with DCFS. One case had an open referral with DCFS at the time the fatality occurred and one death was an open DCFS case. It should be noted that ICAN reports involvement with DCFS based on the Coroner's finding of homicide and does not use the broader definition based on SB 39 Child Fatality Reporting and Disclosure Requirements which DCFS utilizes.

- Thirteen children were killed by their father, stepfather or mother's boyfriend and nine children were killed by their mother (these include the three infant abandonment's). Three children were killed by a relative and one child was killed by a family member but the familial relationship was not identified.

- The greatest number of child homicides by parents, caregivers or family members occurred in August (n=6). The second greatest number of homicides occurred in the month of April (n=5). The fewest occurred in the month of July (n=1). Three child homicides occurred in the months of March and October. Two child homicides occurred each month for February, May, June and September.

- While child homicides occurred throughout Los Angeles County in 2007, there was a clustering of these child deaths in Southern end of the County. There was a clustering of these child deaths in SPAs 6 and 8 (n=5) and SPA 7 (n=4). SPAs 1, 2, 3 and 4 each had one death and no child homicides occurred in SPA 5.

Suicides

- Ten children and adolescents committed suicide in 2007. This is a significant decrease from the 14 such suicides in 2006 and significantly lower than the 15-year average of 22.2 suicides per year.

- As in years past, male victims outnumbered female victims by a large margin. Eight males and two females committed suicide in 2007.

- The leading method was death due to hanging, which represents 60% (n=6) of the suicides in 2007. Two of the adolescents committed suicide using firearms, one adolescent overdosed on over-the-counter medicine and one adolescent used a power drill to the head. The majority of suicides occur at home.

- Seventy percent (n=7) of the children who committed suicide in 2007 were ages 15 – 17; two victims were 14 years of age, and the youngest victim was 11. In

comparison to 2006, twelve victims were age 15 or older and the youngest victim was 13.

- Suicides by Hispanic youth represent 50% (n=5) of the total of adolescent suicides and an increase from 2006 when there were four suicides by Hispanics. Thirty percent (n=3) of adolescent suicides in 2007 were by Caucasians and represents a 70% decrease from 2006 (n=10). Suicides by African Americans in 2007 (n=1) decreased by 50% from 2006 (n=2). Suicides by Asian/Pacific Islander also decreased from 2006 (n-3) in 2007 (n=1).

- Family members reported to the Coroner Investigator that seven of the youth had experienced a recent relationship loss or conflict. Five of the youths' families had a prior or open case with the Department of Children and Family Services or the Department of Public Social Services. Three youth had a history of mental illness. One youth had a history of prior self-injury. One youth had previously attempted suicide and one youth exhibited warning signs prior to his suicide. Half of the youth who committed suicide in 2007 left a suicide note. One youth was discovered to have a positive toxicology for drugs at autopsy. Three youth had experienced academic problems, one youth had received special education services and one had school discipline or truancy problems. One youth had a criminal and/or juvenile delinquency record.

- Child and youth suicides were experienced in all areas of Los Angeles County except in SPAS 1, 4, 5 and 7. The greatest number of incidents occurred in the San Gabriel Valley SPA 3 (n=3). Four incidents occurred in the southern region of the County with two each in SPAs 6 and eight. Two suicides occurred in SPA Two.

Accidental Child Deaths

- There were 121 accidental child deaths of children ages 0 - 17 in 2007. The two leading causes of accidental death were auto pedestrian (n=30) and automobile accidents (n=28). A total of 84 accidental child deaths were children ages 0 – 14 years. This is a 22% decrease from 95 such deaths for this age group reported for 2006. Eighty percent of auto pedestrian deaths were children ages 0 to 14 years. There were 41 accidental deaths of youth's ages 15 to 17 years. Youth ages 15 to 17 years accounted for 51 % (n=17) of automobile related deaths in 2007.

- Deaths due to auto pedestrian (n=24) was the leading cause of accidental death for children 14 years of age and under. Maternal substance abuse (n=15) was the second leading cause. Drowning deaths (n=11) and automobile accidents ranked third as the leading cause of accidental death, and medical complications (n=7) ranked forth.

- Deaths associated with maternal substance abuse accounted for 13 fetal deaths and two deaths of infants up to three months of age and represents a 40% decrease from 2006 in which there were 25 such deaths. Methamphetamine is the most associated drug with these deaths (n=10) accounting for 67%. Cocaine accounts for four of these deaths and marijuana one. Deaths associated with maternal substance abuse accounted for 13% of all accidental deaths in 2007, and fetal deaths associated with maternal substance abuse accounted for 11% of all accidental deaths.

- Accidental drowning claimed the lives of 12 children ages 0 – 17 years which remains unchanged from 2006. A majority of these drowning deaths were young children who drowned in residential pools. One death occurred in a bathtub when an infant was left unattended and one toddler drowned in a bucket when left alone. Overall, drowning has been the leading cause of accidental deaths of children for the past fifteen years in Los Angeles County.

- In 2007, 85 male children and 35 females died due to accidental death which is a 3:1 ratio. In comparison, in 2006, 87 male children and 56 females died due to accidental death, which is almost a 3:2 ratio.

- In 2007, male children tend to over-represent female children in comparison in nearly all types of deaths. Females out-numbered males by one in auto v auto and fire deaths. In deaths associated with maternal substance abuse, 9 male children lost their lives as opposed to four female children; and total automobile accidents, in which 20 male children lost their lives due to this type of accident in comparison to 10 females and 23 male children died as a result of an auto pedestrian accident versus 6 females.

Undetermined Child Deaths

- There were 127 undetermined child deaths in 2007. This is almost a 10% increase from the 114 such deaths in 2006 and significantly higher than the 15-year average of 58 undetermined deaths per year.

- African American (n=31) children were over-represented in undetermined child deaths. Sixty-four children were Hispanic, 21 Caucasian and 9 Asian/Pacific Islander descents. One child was of American Indian and one Middle Eastern descent.

- Thirty three percent (n=42) of the undetermined child deaths had a noted status of post co-sleeping. This is a slight decrease from 2006 in which 38% of undetermined child deaths was associated with co-sleeping.

- Fifty-nine percent (n=25) of the co-sleeping related deaths were infants between 0 to 3 months of age, 21% (n=9) 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 twenty- two of the incidents, 16 of these infants were sleeping with the mother, five with the father and one with an adult cousin. Fourteen infants were sleeping with two adults, 3 were sleeping with one or more other children and 3 were sleeping with one adult and one or more other children.

Child Deaths in Los Angeles County 2003 – 2007

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

2003	35
2004	30
2005	33
2006	35[1]
2007	26

Over the past five years, an average of 14.2 children and adolescents each year have *committed suicide*. The leading method 2003 was gunshot wounds; in 2004, 2005, 2006 and 2007 the leading method was hanging.

2003	19
2004	13
2005	15
2006	14
2007	10

Over the past five years, an average of 147 children have died from preventable accidents. The most common accidental Deaths involve auto pedestrian, automobile accidents, drowning and deaths due to maternal substance abuse.

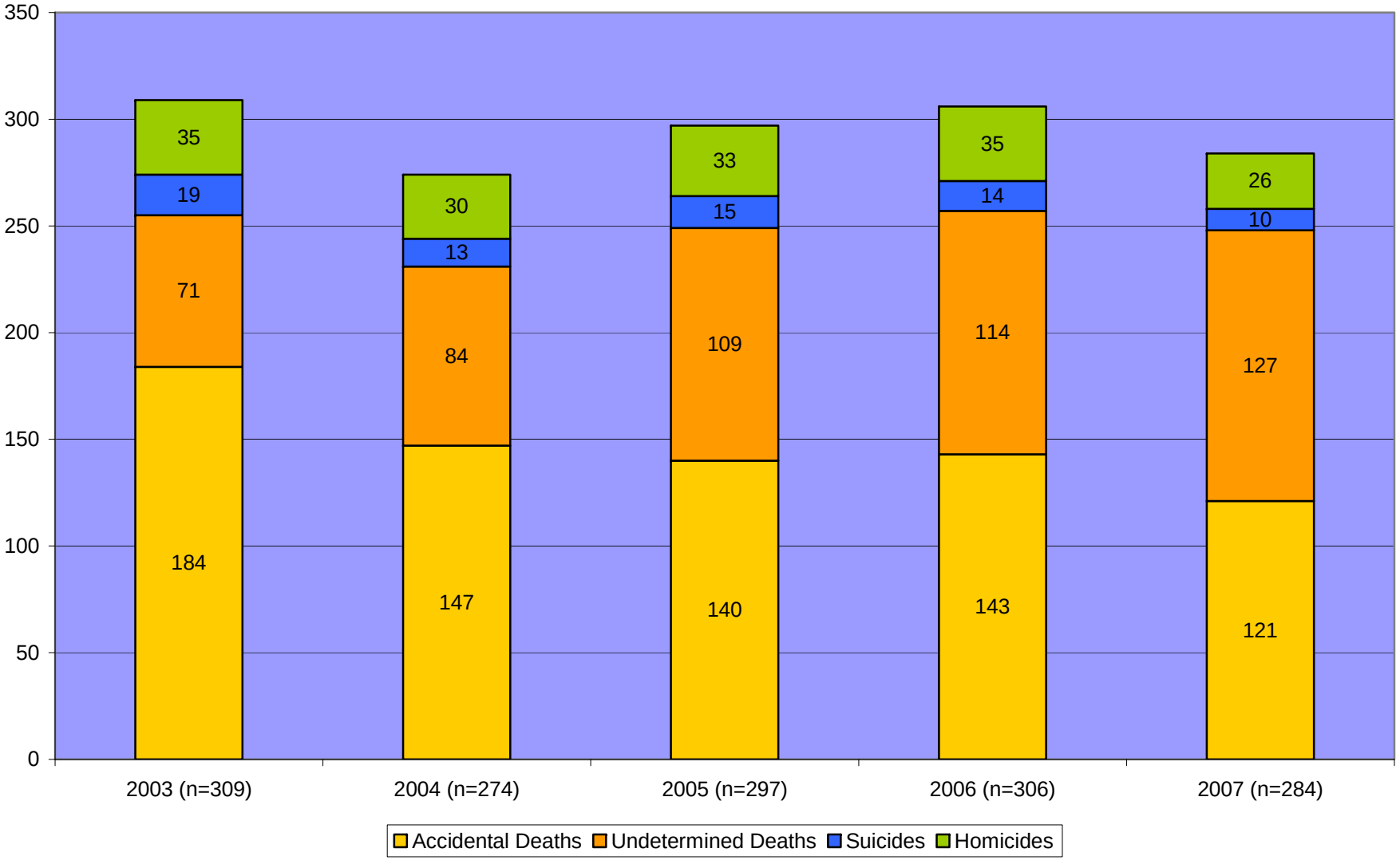
2003	184
2004	147
2005	140
2006	143
2007	121

Over the past five years, the number of undetermined deaths has averaged 101 per year.

2003	71
2004	84
2005	109
2006	114[2]
2007	127

[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 2003 - 2007



Child Homicides by Parent, Caregiver, or Other Family Members 1993 – 2007

Case Summary
Child Homicide by Parent/Caregiver/Family Member

Eva, age 15-months, presented to the hospital with a story that she had choked while eating skittles. When she arrived at the hospital she was found to have anoxic brain injury and after further tests was found to have retinal hemorrhages, optic nerve sheath hemorrhages (that were clearly not from choking), abusive head trauma from shaking and impact, as well as two prior burn injuries. Eva also had burns to her thigh and vaginal area – the family reported that hot soup had fallen on her. The doctors working on Eva's case stated that the burns on top of Eva's body fit with this report but that she had a severe burn on her thigh on her left side and her genitalia were also burned. Reportedly, the family sought medical care for these burns the next day rather than on the night of the incident. The treating physician stated that these burns did not fit with the story provided as no believable scenario for the burns on her genitalia could be surmised.

The Child Death Review Team discussed the fact that the burns were suspicious in nature and that they warranted further questioning and investigation by the treating hospital. The physician treating Eva at the time of the incident causing death obtained the records for Eva's treatment for this burn and reported that there was very poor documentation of any history taken by the staff at the treating hospital; she found inadequate documentation of any investigation or history as to how Eva received her injuries. The physician reported that she contacted the treating hospital and asked about the burns and whether or not they thought the burns matched the story given. Reportedly, they stated that they believed the burns to be accidental.

The Team engaged in an in-depth discussion regarding these burn injuries that included a thorough description of the injuries including the fact that it was a linear burn and that she was wearing a diaper which caused the treating physician to wonder how her genitalia were burned. The physician went on to state that in speaking to the physician at the hospital where Eva was treated for this burn, it was clear that there was no concern regarding abuse and that the physician believed the burn to be accidental. The Team believed that it was clear that the red flags for abuse were never raised or even considered during her treatment for this injury. The physician at this hospital never questioned the family's story and never reported the burns to law enforcement or the Department of Children and Family Services (DCFS). This burn injury occurred approximately three to four weeks prior to the incident that caused Eva's death.

In addition to the burn from the soup, Eva had previously received 2nd degree burns on her feet, reportedly from stepping on a battery operated toy that was stuck in a heating grate. Again, the treating physician at the time of Eva's death thought this story was strange and would have warranted further investigation though Eva was never taken for medical treatment for this burn.

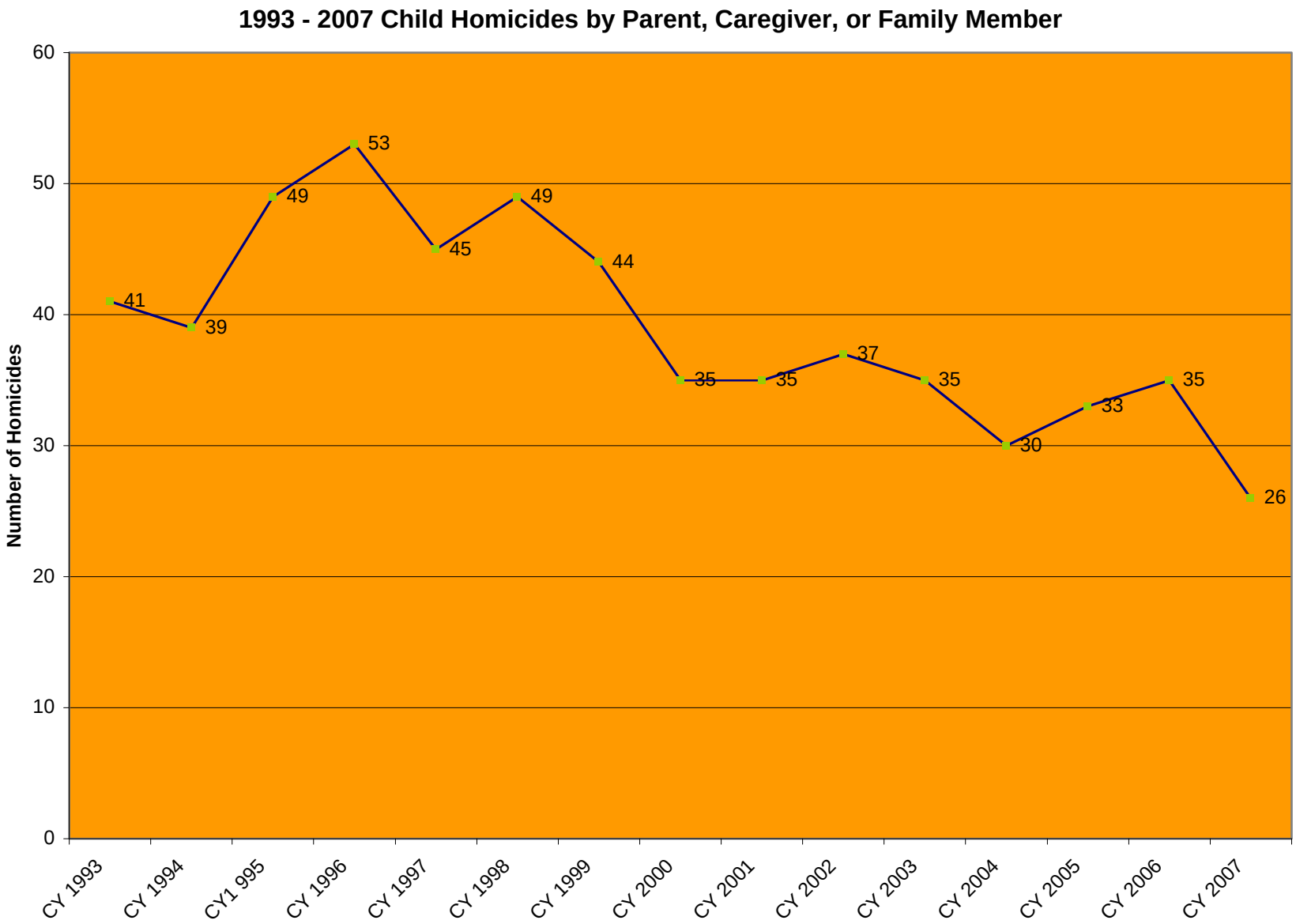
During the review of this case, it was learned that the DCFS Hotline was not notified of Eva's injuries until four hours after she was first admitted to the hospital. It was reported that since Eva had initially come in with a reported choking incident, she was first being worked up for this type of injury. When the burns were discovered later, the Child Protection Hotline was notified, but not law enforcement. In examining why the Hotline did not cross-report the incident to law enforcement, it was theorized that the referral from the treating hospital was first called in as neglect as there was no open case with DCFS. However, the treating hospital contacted the Hotline a second time when retinal and optic nerve sheath hemorrhages were discovered and it became clear that Eva may have been a victim of physical abuse. At this point, the treating hospital also contacted law enforcement.

The Team also learned that one month prior to Eva's receiving the "soup burn" injury, her mother had moved out of her parents' home and into her boyfriend's home. It was also reported that Eva had fallen on the concrete a couple of days before she was brought to the hospital for the reported choking incident. All of her injuries occurred while she was in the care of her mother's boyfriend.

The Coroner reported that Eva had burns on her feet that were deep into the muscle and had formed a fungal infection. The burn on her thigh was a 3rd degree burn. She had subdural hemorrhage, retinal hemorrhages and hemorrhages on her optic nerve sheath. The Coroner reported that the optic nerve sheath hemorrhages are a very strong indication of inflicted trauma. Reportedly, this indication of inflicted trauma is stronger with optic nerve sheath hemorrhages than with retinal hemorrhages as there is literature that indicates that retinal hemorrhages could possibly be from causes other than inflicted trauma.

The Child Death Review Team discussed the importance of hospitals having Suspected Child Abuse and Neglect (SCAN) Teams. It was also reported that there used to be 44 SCAN Teams in Los Angeles County and that now there are approximately 20 such Teams. The Team discussed the importance of hospitals having someone on staff that is knowledgeable about and sensitive to child abuse/neglect issues so that this possibility can be explored in all cases and either ruled out or reported to the appropriate parties. Some Team members thought that the benefits of having a SCAN Team could be presented to hospitals in terms of risk management so that the hospital could show due diligence in terms of reporting child abuse/neglect.

The Team expressed concern regarding the lack of investigation into the cause of Eva's burns by the hospital that treated her for these injuries. All Team members indicated that they believed that Eva's death was preventable and most likely could have been prevented had the hospital treating her for the burns she sustained reported her injuries to DCFS, law enforcement or both.


1993 - 2007 Child Homicides by Parent, Caregiver, or Family Member
Number of Homicides
60
50
40
30
20
10
0
41
39
49
53
45
49
44
35
35
37
35
30
33
35
26
CY 1993
CY 1994
CY1 995
CY 1996
CY 1997
CY 1998
CY 1999
CY 2000
CY 2001
CY 2002
CY 2003
CY 2004
CY 2005
CY 2006
CY 2007

Causes of Child Homicide by Parent/Caregiver/Family Member
1992 – 2007, Los Angeles County

	’93	’94	’95	’96	’97	’98	’99	’00	’01	’02	’03	’04	’05	’06	’07	Total
Head Trauma	14	17	19	15	12	13	15	5	5	2	7	7	6	11	2	150
Multiple Trauma	7	7	10	7	10	8	10	11	7	7	10	7	8	7	7	125
Asphyxiation/suffocation	1	0	4	4	4	3	6	3	8	5	6	5	5	6	3	63
Gunshot Wounds	2	2	4	4	7	10	4	3	2	1	4	3	6	1	5	58
Trauma to torso/abdomen	3	6	2	5	4	2	1	0	0	3	0	0	2	1	1	30
Drowning	1	1	4	0	2	2	0	3	1	7	1	1	2	3	1	29
Fire	1	0	3	8	0	4	0	1	0	0	0	0	0	3	0	20
Stabbing	1	0	0	2	0	2	1	4	1	2	0	3	2	2	2	22
Unattended newborn	0	1	1	0	1	3	4	2	3	2	3	0	1	0	3	23
Poisoning/drug ingestion	6	1	0	2	0	0	0	0	3	6	1	1	0	0	0	20
Dehydration/malnutrition	0	0	1	1	1	1	0	1	1	0	1	2	0	0	1	10
Strangulation	1	1	0	2	2	1	0	0	0	0	0	0	0	1	0	8
Medical neglect	2	1	0	0	0	0	0	1	2	0	0	0	0	0	0	6
Neck compression	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	3
Burns	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	3
Hyperthermia	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2
TOTAL	40	37	49	51	44	49	42	34	34	35	35	29	33	35	26	572

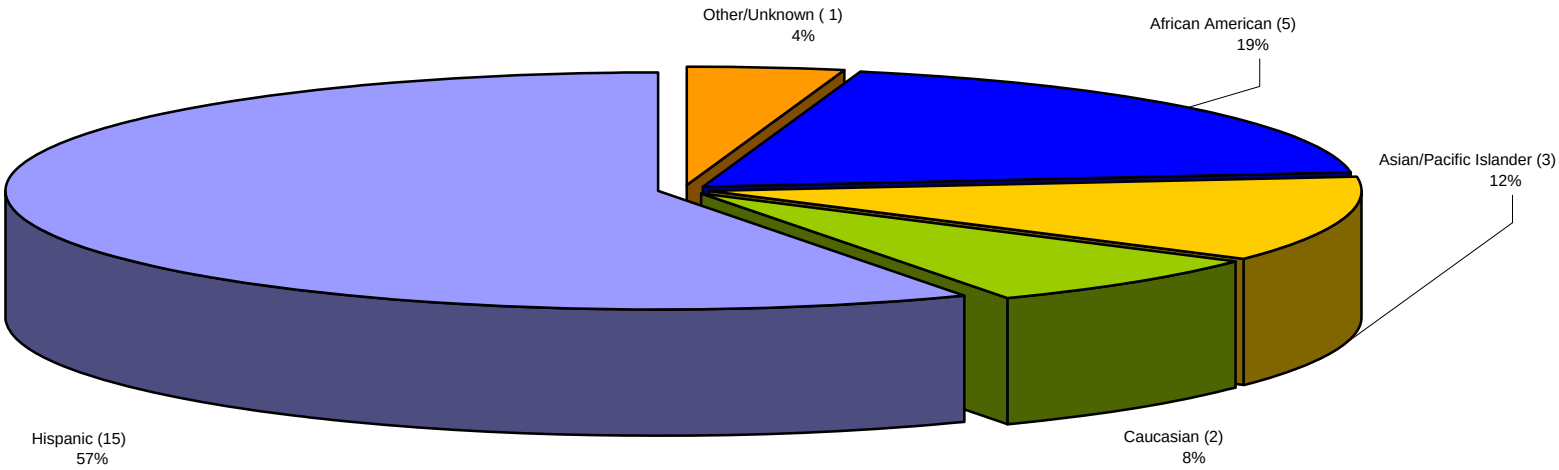
Child Homicide by Parent/Caregiver/Family Member
Los Angeles County – 2007 (N= 26)

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

42% of the child homicides by parents/caregivers/family member were under one year of age.

81% of the child homicides by parents/caregivers/family member were under five years of age or under.

2007 Child Homicides by Parent, Caregiver, or Family Member - Race



Percentage of Child Population
in Los Angeles County[1]
Hispanic 59.5%
Caucasian 20%
African American 9.8%
Asian/Pacific Islander 10.4%
American Indian 0.2%

Other/Unknown | African American | Asian/Pacific Islander | Caucasian | Hispanic

Criminal Justice System Involvement

ICAN is pleased to once again report information on criminal justice system involvement in child homicides by parents/caregivers/family member after several years of not including this information.

Information is gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department and the Los Angeles Sheriff's Department. 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 below.

Table 1

Law Enforcement Agency Involvement in 2007 ICAN Child Homicide by Parent/Caregiver/Family Member

Agency	n	%
LASD	10	38
LAPD	8	31
Inglewood P.D.	1	4
Long Beach P.D.	3	11
Hawthorne P.D.	1	4
CHP Antelope	2	8
None (fetal death from suicide)	1	4

The Los Angeles Sheriff's Department had investigative responsibility for 38% (n=10) of the child homicides by parents/caretakers/family member. The Los Angeles Police Department had investigative responsibility for 31% (n= 8) of the 2007 child homicides by parents/caretakers/family member. Twenty-seven percent (n=7) of the cases were handled by jurisdictions other than LASD and LAPD. Four different law enforcement agencies were responsible for the investigation of child homicides by parents/caregivers/family member in 2007.

Ten of the 2007 cases involving child homicide by parents/caregivers/family member were not presented to the District Attorney. The reasons for that those cases were not presented are displayed in Table 2. The most common reason for not presenting was murder/suicide and the investigation remains open and a decision regarding the filing of charges is pending.

Table 2

Law Enforcement Reasons for Not Presenting 2007 ICAN Child Homicide by Parent/Caregiver/Family Member

	n	%
Murder/suicide	4	40
Suspect's identity unknown	1	10
Insufficient Evidence	1	10
Pending further investigation	4	40

In 2007, there were a variety of charges filed by the District Attorney. Charges filed in the past four years are illustrated by Table 3. The most frequent charge was child abuse followed by murder.

Table 3

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

Table 4

Criminal Case Disposition of 2004 - 2007 ICAN ICAN Child Homocides by Parent/Caretaker/ Family Member

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

Criminal disposition data for the period of 2004 through 2007 is presented in Table 4. In 2007, 40% of the cases are still in pending status. One perpetrator was sentenced to 25 years of life in prison, compared to 5 in 2006, 7 in 2005 and 2 in 2004. One parent is awaiting a mental competency hearing.

Twelve percent (n=3) of the perpetrators of child homicide by parents/caregivers/family member received and intermediate term sentence, 2 to 10 years in prison in 2007. This compares to 9% in 2006, 39% in 2005 and 17% in 2004.

2007 Child Homicides by Parents, Caregivers or Family Member DCFS Involvement 1993 – 2007*

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
1993	41	13	6	7	0 –foster parents unable to determine relative caregivers
1994	39	12	5	7	0 – relative caregivers 1 – foster parent
1995	49	16	5	11	3 – relative caregivers 1 – foster parent
1996	53	13	7	6	2 – relative caregivers 2 –foster parent
1997	45	15	8	7	0 – relative caregivers 1 – foster parent
1998	49	20	12	8	0 – relative caregivers 0 – foster parent
1999	44	20	16	4	1 – 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	9	5	1– relative caregivers 0 – foster parent
2006	35[3]	11	11	2	1– relative caregivers 0 – foster parent
2007	26	8[4]	5	3[5]	1 – relative caregivers 0 – foster parent

*Data is based on the Coroner's findings as Homicide. DCFS reports are based upon the broader definition involving SB 39 Child Fatality Reporting and Disclosure Requirements

[3] 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.

[4] In two cases, the father or stepfather had referrals on other children from a different mother

[5] One was open to another county

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 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 either 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. As a result, the number of child fatalities reported by DCFS differs from ICAN and will be higher in number as can be seen in the table below.

CHILD FATALITIES BY PARENT, CAREGIVERS OR FAMILY MEMBERS WITH DCFS INVOLVEMENT 2006 – 2008 COMPARATIVE DATA

Year	ICAN Data	DCFS Data
2006	11	14
2007	8	12
2008	Pending	14

Relationship of Suspect to Child Homicide Victim – 2007

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

13 – Father, Step father or mother's boyfriend

9 – Mother[6]

1 – Grandfather

1 – Uncle

1 – Cousin

1 – Undetermined[7]

Dates[8] of Child Homicides – 2007

2 homicides occurred in February (2/12 & 2/27/07)

3 homicides occurred in March (3/13 & two on 3/29/07)

5 homicides occurred in April (two on 4/03, 4/16, 4/21 & 4/27/07)

2 homicides occurred in May (5/01 & 5/02/07)

2 homicides occurred in June (6/16 & 6/26/07)

1 homicide occurred in July (7/31/07)

6 homicides occurred in August (8/02, two on 8/08, 8/10, 8/16, 8/19 & 8/27/07)

2 homicides occurred in September (9/09 & 9/10/07)

3 homicides occurred in October (10/09, 10/13 & 10/18/07)

[6] Three of these homicides were cases of infant abandonment.
[7] This case involved multiple relative families living together. The child was killed by a family member but the relationship was not determined.
[8] 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.

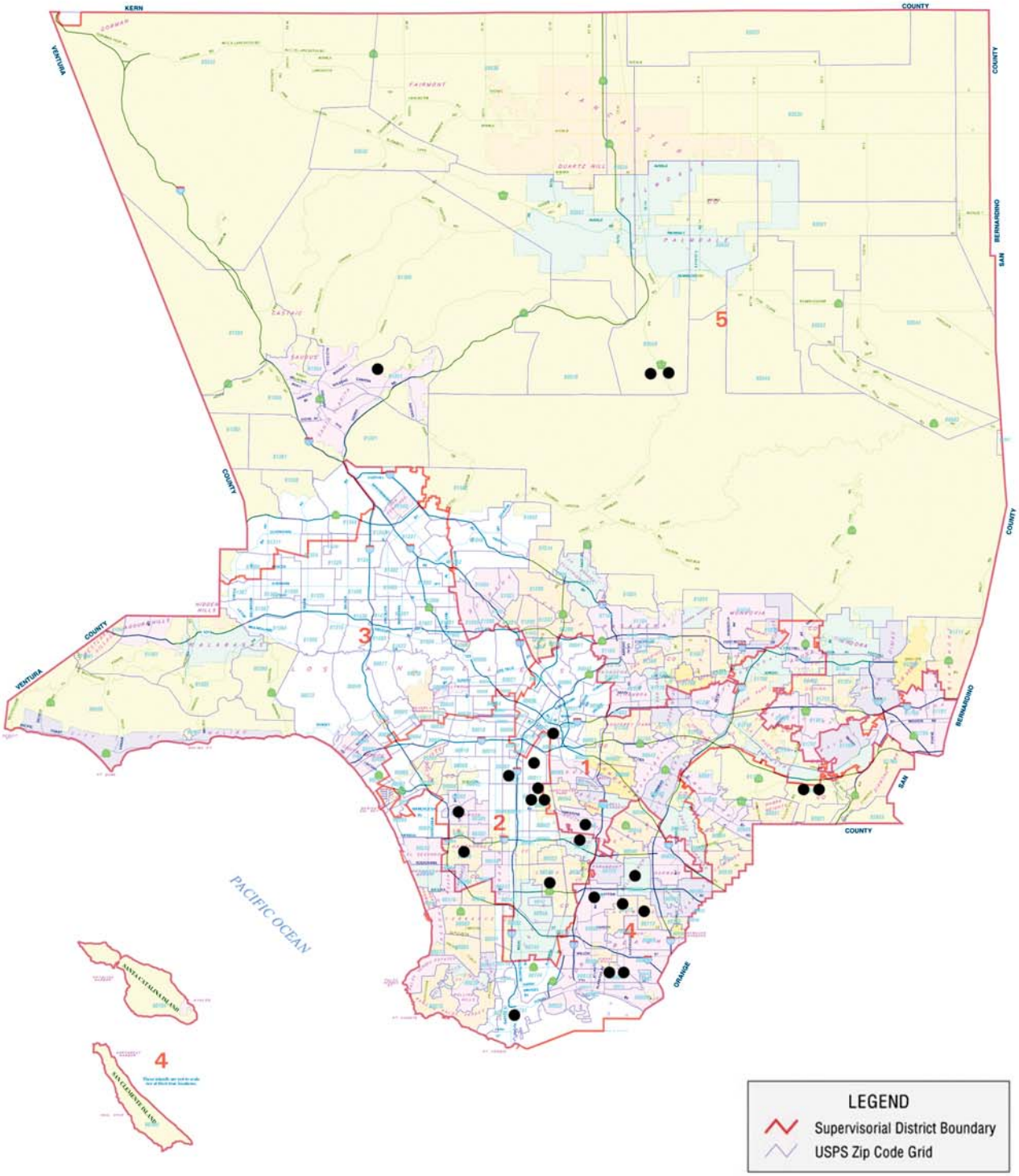
Locations[9] of Child Homicides – Geographic Area – 2007

1 homicide occurred in Bellflower (zip code 90706)
1 homicide occurred in Canyon Country (zip code 91351)
1 homicide occurred in Compton (zip code 90220)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in Inglewood (zip code 90301)
1 homicide occurred in Lakewood (zip code 90712)
1 homicide occurred in Lakewood (zip code 90713)
2 homicides occurred in Long Beach (zip code 90804)
1 homicide occurred in Long Beach (zip code 90805)
3 homicides occurred in Los Angeles (zip code 90001)
1 homicide occurred in Los Angeles (zip code 90011)
1 homicide occurred in Los Angeles (zip code 90013)
1 homicide occurred in Los Angeles (zip code 90037)
1 homicide occurred in Los Angeles (zip code 90262)
2 homicides occurred in Palmdale (zip code 93550)
2 homicides occurred in Rowland Heights (zip code 91748)
1 homicide occurred in San Pedro (zip code 90731)
1 homicide occurred in South Gate (zip code 90280)
1 homicide occurred in unknown area

[9] City where the injury/fatality occurred.

2007 Child Homicides

N = 24*



* One Homicide Location is Unknown

● = ***Child Homicide***

Case Summary
Adolescent Suicide

Law enforcement and paramedics responded to a call and found 15-year-old Sonya lying on the floor of the hall of her apartment after an apparent suicide. Her father had arrived home from work and found her hanging from the hallway ceiling. He cut her down and called 911. Paramedics found no signs of life, and death was pronounced.

The coroner investigator described the scene as a second floor apartment located on a busy street. The home was clean and well furnished. The coroner investigator observed the teen lying on a carpeted floor with a piece of computer cord beneath her head and neck. A wooden stool was upright near her feet. Both a yellow nylon rope and the computer cord seem to have been knotted to the handle of a wooden hatch to the crawl space attic. Sonya's body was transported to the Office of the Coroner for it the autopsy. The Coroner ultimately ruled Sonya's death as a suicide due to asphyxia.

According to her father, the night before her death, Sonya had broken up with her boyfriend. The father said that she was upset and crying. But Sonya had not made any suicidal statements or threats to his knowledge. Law enforcement interviewed her boyfriend who lived across the street. He confirmed that they had been dating for four or five months but had agreed on the night before her death that they would separate. He said that she had been seeing other boys.

Sonya did, however, leave a red spiral notebook with some pictures and numerous letters from her boyfriend on the kitchen table. She also left a 3-page goodbye note written to her boyfriend. Its tone was sad and apologetic. She wrote that the four or five months of their relationship were "the best moment of my life", and she asked for forgiveness for the break up. She also wrote that she was also "suffering" and showed remorse for the loss of the relationship but added "I'm going to miss you very much…who knows what I will do with all this pain…how can I start again?"

Sonya's school records indicated that she was new to the high school. She had, however, a close group of friends from middle school. After her death, her friends revealed that Sonya had been abused by her mother and that Sonya had spoken to them about suicidal thoughts and that she had cutting behaviors.

The Department of Children and Family Services (DCFS) did have a prior history with Sonya's family. Approximately six months prior to her death, there was an incident where Sonya's mother beat her with both a belt with a metal buckle and a cord from an iron. Since Sonya's parents were divorced, she went to live with her father. He obtained full custody of Sonya. Her mother was arrested for the abuse but not convicted. DCFS records also indicated that when Sonya was 13 her mother had sent her to a school for troubled girls in Mexico. After about a year at that school, Sonya's behavior had changed and she returned to Los Angeles. At the time of her death, she was not a behavior problem.

Sonya was a teen who had suffered a string of trauma from being sent away at 13 to another country, to being physically assaulted by her mother and being removed from her care, to the break up of a relationship. The peer reports of suicidal ideation and cutting also reveal a teen under a great deal of emotional stress.

The suicide of a teen has impact on the child's school as well as the family. A local mental health agency came to the school talked to any interested students and faculty. They also met with Sonya's

father and mother, offering them continued grief services. Her father declined; her mother wanted services but had no insurance. The agency was working on a way to provide those services to Sonya's mother.

The Child and Adolescent Suicide Review Team looked at Sonya's case. They discussed ways to develop resources for students struggling with relationship issues, such as peer-to-peer programs on campus that are beginning at a few schools in the county. The team also talked about other ways to reach out to these students, especially when classmates are aware of suicidal talk and cutting. The recommendations included: setting up posters with information about suicide prevention, having access to orientation videos showing age-peers dealing with their own issues; training the faculty and staff on how to recognize signs of teens at risk; and teaching the teens how to be supportive and identify when their friends might need some kind of services.

1993 - 2007 Child and Adolescent Suicides

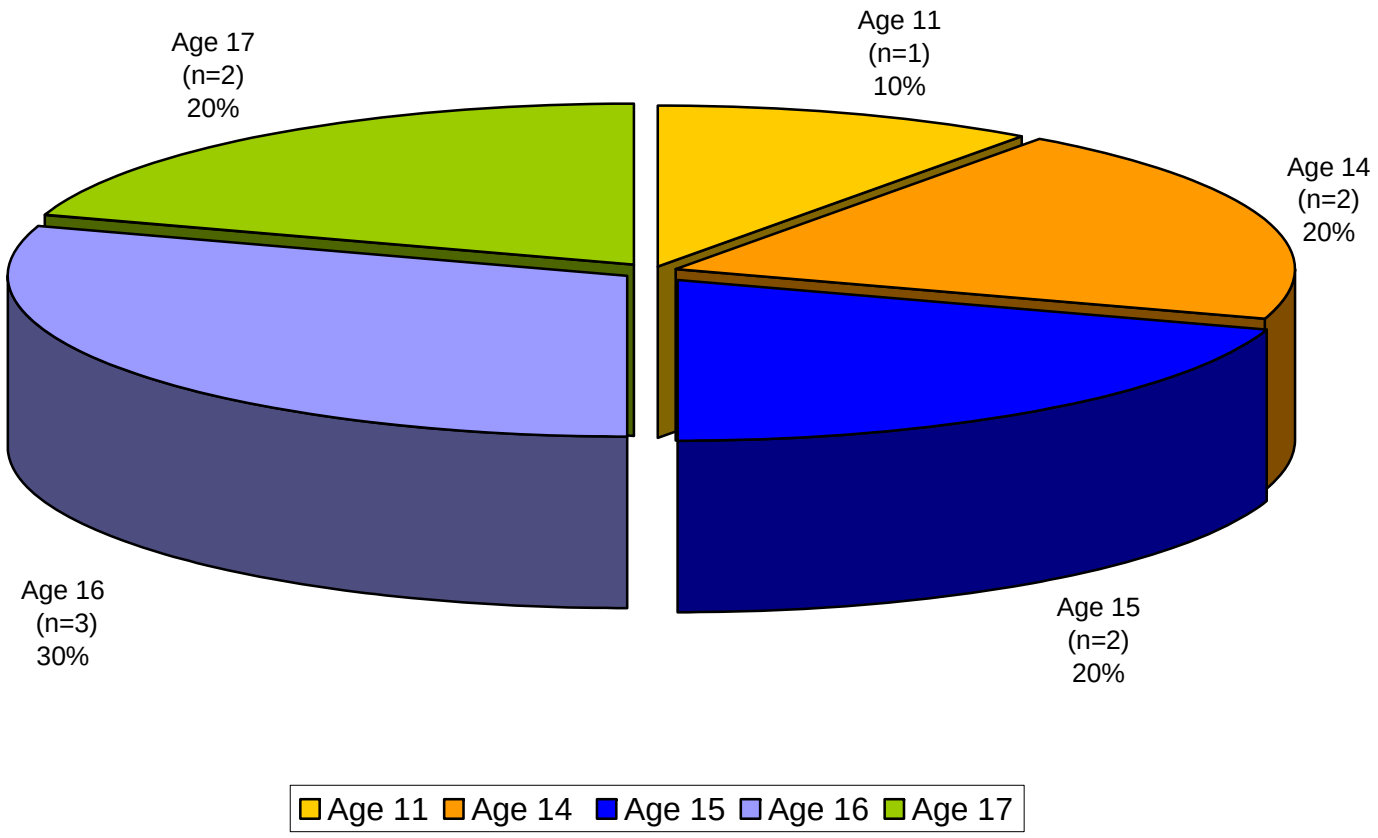
Child and Adolescent Suicides by Method and Gender
Los Angeles County – 2007 (n = 10)

Method	**Male**	**Female**
Hanging	4	2
Firearms/Gunshot	2	0
Overdose	1	0
Power drill	1	0
TOTAL	8	2

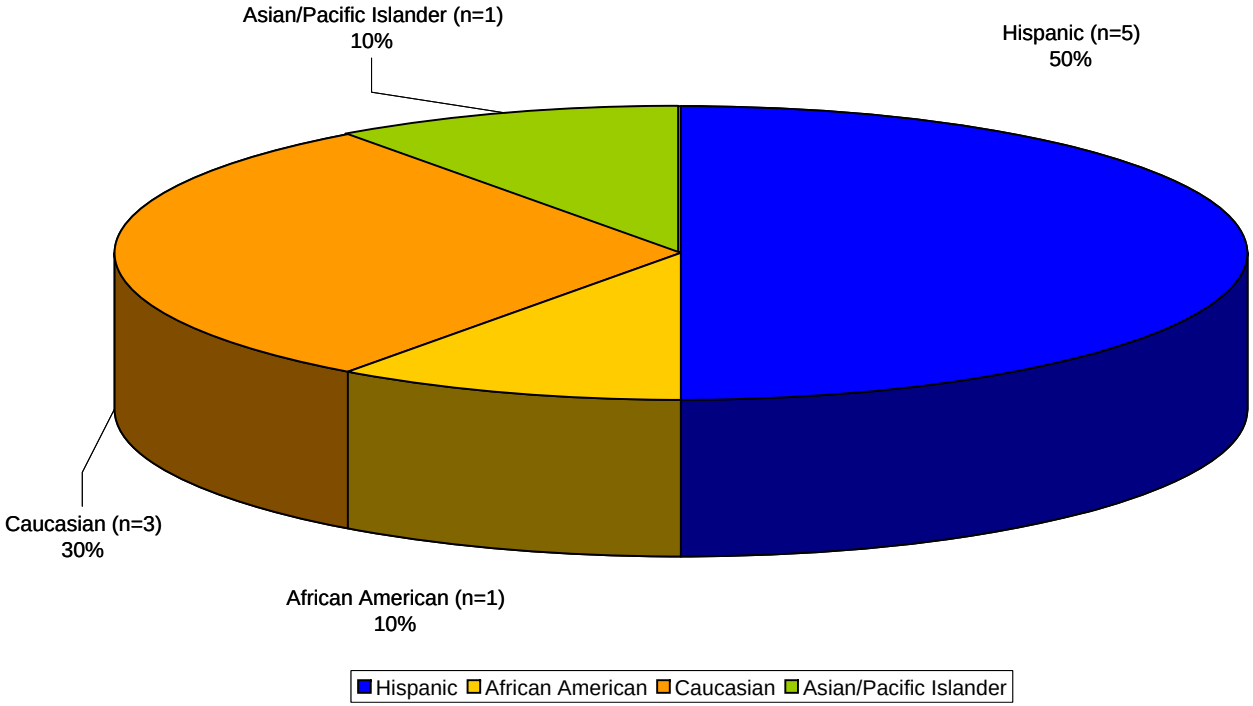
Hanging was the most frequent method of suicide among adolescents and represents 60% of the suicides in 2007. Firearms/gunshot was the second most frequent method of suicide in 2007.

In 2007, 80% (n=8) of the adolescent suicide victims were male. 20% (n=2) of the victims of adolescent suicide in 2007 were female.

2007 Child and Adolescent Suicides - Age



2007 Child and Adolescent Suicides - Race



Child and Adolescent Suicide Victim Characteristics – 2007

Family members reported the following to the Coroner Investigator:

One youth exhibited warning signs prior to their suicide.

Three of the youth had a history of mental illness.

Five of the youth left a suicide note.

One youth had previously attempted suicide

One youth was discovered to have a positive toxicology for drugs at autopsy.

One youth exhibited evidence of drug use prior to their suicide.

Five of the youths' families had a prior or open case with the Department of Children and Family Services or with the Department of Public Social Services.

One youth had a criminal and/or juvenile delinquency record.

Two youth had a history of prior self-injury.

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

One youth had received special education services.

Three of the youth had known academic problems and

One youth had school discipline or truancy problems.

Dates of Child and Adolescent Suicides – 2007

1 suicide occurred in January (01/15/07)
2 suicides occurred in March (03/18 & 03/21/07)
1 suicide occurred in April (04/11/07)
2 suicides occurred in May (05/02 & 05/28/07)
1 suicide occurred in June (06/03/07)
1 suicide occurred in July (07/27/07)
1 suicide occurred in August (08/16/07)
1 suicide occurred in December (12/08/07)

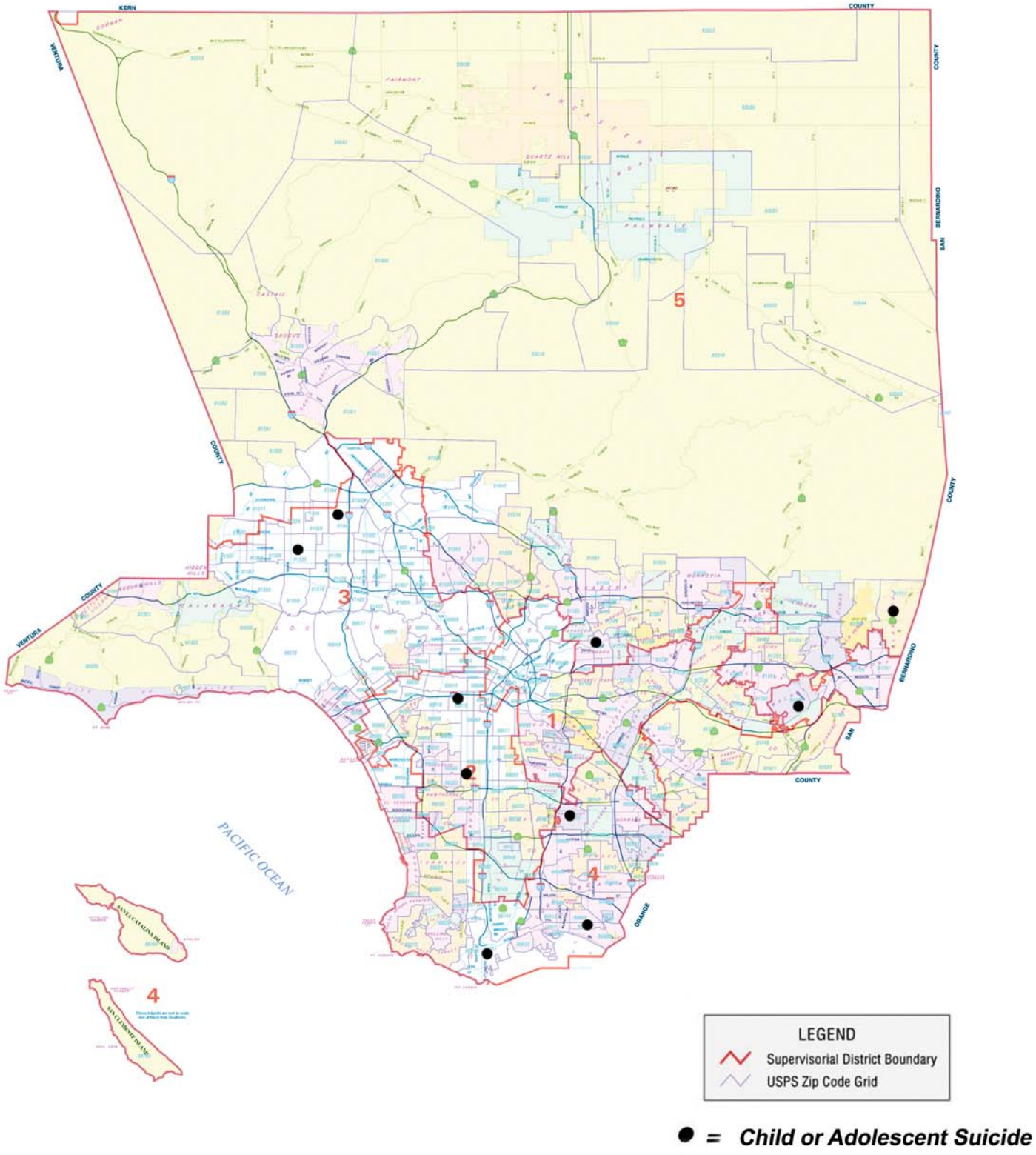
Locations[10] of Child and Adolescent Suicides – Geographic Area – 2007

1 suicide occurred in Los Angeles (zip code 90044)
1 suicide occurred in Walnut (zip code 91789)
1 suicide occurred in San Pedro (zip code 90731)
1 suicide occurred in Los Angeles (zip code 90018)
1 suicide occurred in Alhambra (zip code 91801
1 suicide occurred in Claremont (zip code 91711)
1 suicide occurred in Long Beach (zip code 90814)
1 suicide occurred in North Hills (zip code 91343)
1 suicide occurred in Reseda (zip code 91335)
1 suicide occurred in Paramount (zip code 90723)

[10] City where the suicide occurred.

2007 Adolescent and Child Suicides

N = 10



Accidental Child Deaths 1993 – 2007

Case Summary
Accidental Death

Jorge, a 5-year old male Hispanic and his brother, Carlos, age 3 were in the care of their paternal grandmother in the front house residence. Their mother was at work and father was napping in the rear residence as he worked nights. The grandmother planned to take the boys to the store and had them playing in the living room. The laundry was going and the washer overflowed. While she cleaned up the water, she realized the living room was quiet. At the same time, she heard her son Oscar screaming for help. The two houses were separated by a non-fenced pool. The father found Carlos floating face down in the murky and leaf filled water. Paramedics were called and took Carlos to the hospital. The father realized his older son was still missing and began searching the pool with a pole because he couldn't see through the dirty water and found Jorge at the bottom. Thirty minutes after the first call, paramedics were again called and Jorge taken to the hospital. Carlos died the next day and Jorge passed six days after the near drowning accident.

The family had moved in five months earlier. The children were not allowed in the backyard because the pool was not fenced. The doors were usually locked to prevent the boys from going outside but they were getting tall enough to unlock the door by themselves. The family had asked the landlord several times to fence, drain or put a cover over the pool. In the meantime, all family members reported the boys were never left unsupervised or allowed to play in the backyard.

The family had no prior contact with the Department of Children and Family Services (DCFS). A referral was made to DCFS for the boys' cousins who resided in the grandmother's front residence as a result of the incident. The parents and extended family were provided grief counseling referrals. The team has learned the importance of surviving family members receiving counseling for their grief and loss. DCFS closed the referral as the landlord filled the pool with clean water and constructed a fence around it.

This was a tragic accident of drowning in a residential pool that had no child barrier.
Drowning has long been a leading cause of accidental death. The Team has researched the laws regarding pool fencing in LA County and has discovered ordinances vary from city to city. The Team believes that better efforts should be made to ensure that barriers are placed around both existing and new pools and ponds.

Causes of Accidental Child Deaths, Ages 0 –14
1992 – 2007, Los Angeles County

	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	Total
Drowning	40	35	31	18	28	21	25	23	28	16	19	21	12	12	11	**340**
Maternal drug abuse	23	10	9	25	24	38	21	22	24	25	32	21	15	25	15	**329**
Auto pedestrian[1]			2	1	8	19	31	30	41	33	25	21	20	11	25	**267**
Automobile[2]							18	24	28	20	47	25	21	22	14	**219**
Falls	4	7	6	5	2	3	5	1	1	3	2	3	1	2	1	**46**
Choking	7	2	0	1	5	3	6	10	2	8	4	1	3	1	1	**54**
Suffocation	8	4	1	2	0	2	4	1	3	0	1	1	2	2	0	**31**
Poisoning	7	4	1	1	6	1	4	4	1	0	2	2	1	2	0	**36**
Fire	3	2	2	0	1	3	7	4	3	7	0	2	6	7	2	**49**
Hanging/strangulation	5	0	0	3	0	0	0	6	3	1	2	4	1	3	4	**32**
Chest/neck compression	3	3	1	2	1	2	0	1	0	0	3	0	0	0	0	**16**
Gunshot wounds	0	1	1	2	1	0	0	0	0	0	0	0	0	0	0	**5**
Crushed by object	0	0	2	0	3	2	1	1	0	1	0	1	5	2	2	**20**
Sports injury	0	0	0	0	2	0	2	2	1	0	0	0	1	0	0	**8**
Burns/Thermal Injury	1	0	0	0	0	0	1	0	0	1	0	1	0	0	0	**4**
Dog bites	0	0	1	0	1	0	1	1	0	0	0	0	1	0	0	**5**
Medical complications[3]	2	2	1	1	0	1	5	6	2	8	7	3	3	2	7	**50**
Perinatal asphyxia	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0	**3**
Electrocution	0	0	0	0	2	0	0	1	0	0	1	0	1	0	0	**5**
Birth trauma	1	0	0	0	0	0	2	0	0	0	0	0	2	0	0	**5**
Hypothermia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Hyperthermia	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0	**3**
Airplane related	0	0	0	0	0	0	0	0	0	2	2	0	0	0	0	**4**
Train v. pedestrian	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1	**3**
Elective abortion	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Forklift injury	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Drug intake/Overdose	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	**2**
Motor vehicle (not auto)[4]	0	0	0	0	0	0	0	0	0	0	0	4	1	3	0	**8**
Impaled	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
TOTAL[5]	**104**	**70**	**59**	**61**	**86**	**95**	**134**	**137**	**137**	**127**	**147**	**110**	**100**	**95**	**83**	**1547**

Causes of Accidental Child Deaths, Ages 0 – 17
2007 – Los Angeles County (N=121)

Airplane related	1
Automobile – multi-vehicle	15
Automobile – solo vehicle	15
Auto pedestrian	30
Choking	1
Crushed by Object	2
Drowning	12
Drug Intake	8
Falls	2
Fire	4
Handgun discharge	1
Hanging/Strangulation	4
Hyperthermia	1
Hypothermia	0
Maternal drug use	15
Medical complications	7
Motor vehicle other than auto	2
Train v pedestrian	1
TOTAL	**121**

Causes of Accidental Child Deaths by Age
2007 – Los Angeles County (N=121)

	Age 0 – 5 years	Age 6 – 14 years	Age 15 – 17 years
Airplane related	0	0	1
Automobile – multi-vehicle	5	2	8
Automobile – solo vehicle	0	4	9
Auto pedestrian	14	10	6
Choking	0	1	0
Crushed by Object	2	0	0
Drowning	10	1	1
Drug Intake	0	0	8
Falls	0	1	1
Fire	0	3	1
Handgun discharge	0	0	1
Hanging/Strangulation	1	3	0
Hyperthermia	0	0	1
Hypothermia	0	0	0
Maternal drug use	15	0	0
Medical complications	6	1	1
Motor vehicle other than auto[11]	0	0	2
Train v pedestrian	0	1	0
Airplane related	0	0	1
TOTAL	**53**	**27**	**41**

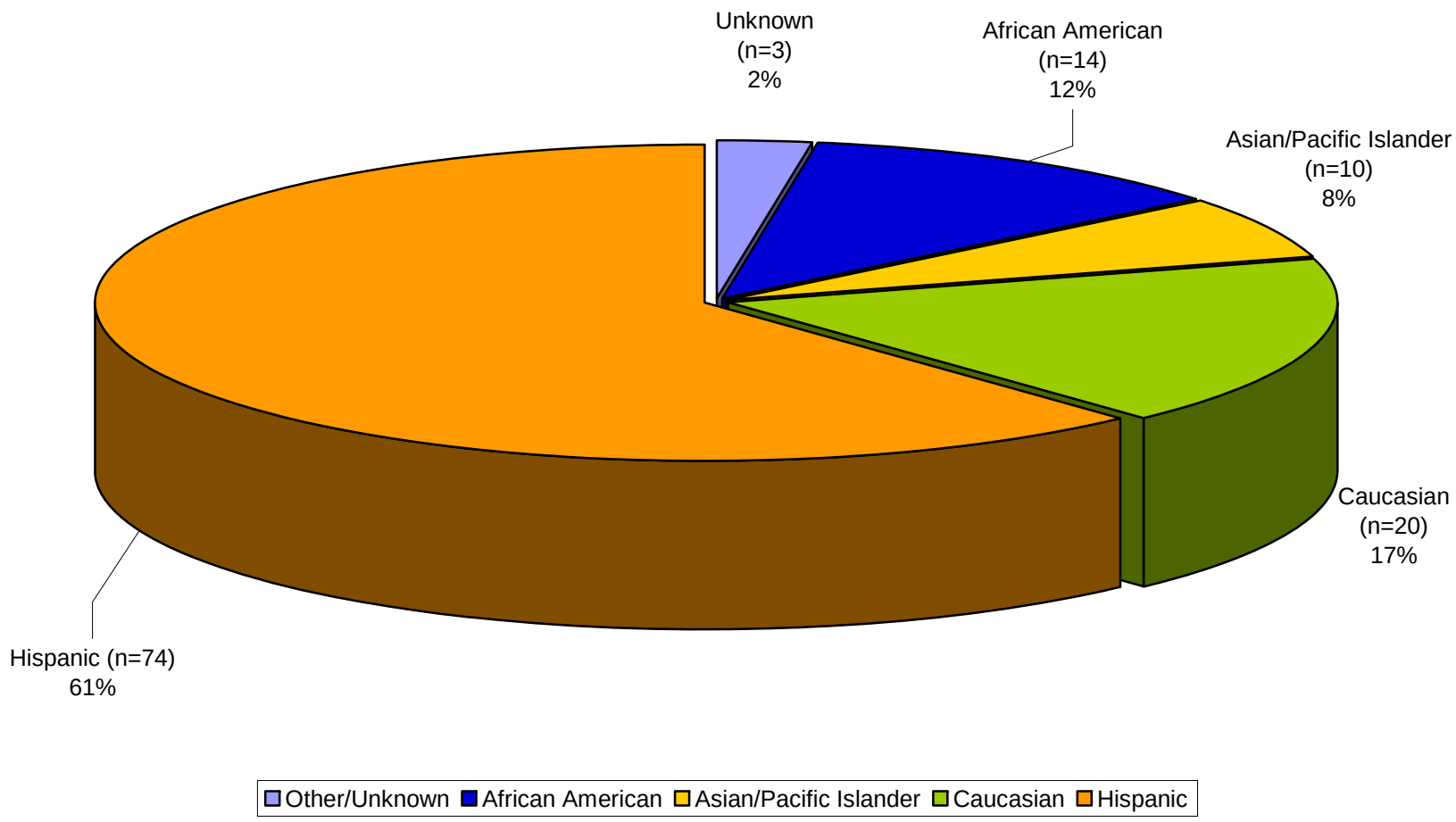
[11] Category includes mini-bikes, dirt bikes, scooters, go-carts, motorcycles and all-terrain vehicles (ATVs).

Race of Accidental Child Deaths, Ages 0 – 17
Los Angeles County – 2007 (N=121)

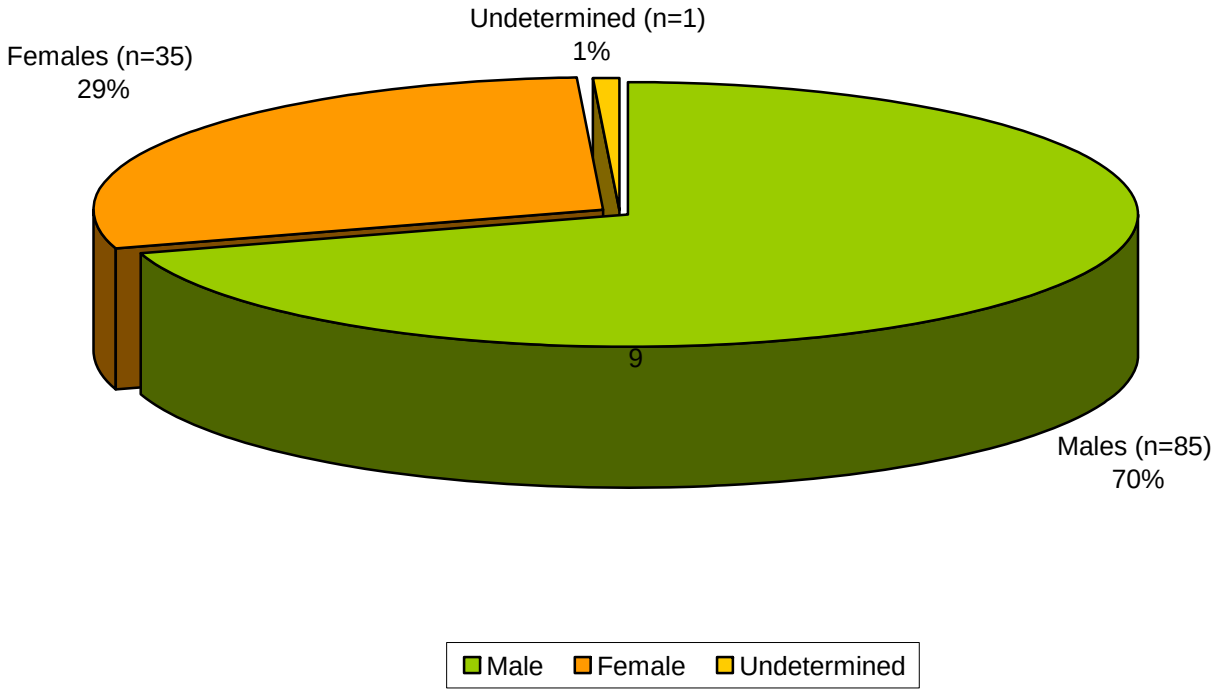
	Hispanic	African-American	Caucasian	Asian/Pacific Islander	Other[12]/ Unknown
Airplane related	0	1	0	0	0
Automobile – multi-vehicle	10	O	4	1	0
Automobile – solo vehicle	7	2	4	2	0
Auto pedestrian	20	3	3	1	3
Choking	0	0	0	1	0
Crushed by Object	1	0	1	0	0
Drowning	8	0	3	1	0
Drug Intake	5	1	2	0	0
Falls	2	0	0	0	0
Fire	4	0	0	0	0
Handgun Discharge	1	0	0	0	0
Hanging/Strangulation	3	0	0	1	0
Hyperthermia	0	1	0	0	0
Maternal drug use	9	2	3	1	0
Medical complications	4	2	0	1	0
Motor vehicle other than auto[13]	0	1	0	1	0
Train v pedestrian	0	1	0	0	0
TOTAL	**74**	**14**	**20**	**10**	**3**

[12] Includes three children designated as Middle Eastern
[13] Category includes mini-bikes, dirt bikes, scooters, go-carts, and all-terrain vehicles (ATVs).

2007 Accidental Child Deaths - Race



2007 Accidental Child Deaths - Gender



Causes of Accidental Child Deaths by Gender
2007 – Los Angeles County (N=121)

	Female	Male	Unknown
Airplane related	0	1	0
Automobile – multi-vehicle	8	7	0
Automobile – Single	2	13	0
Auto pedestrian	6	23	1
Choking	0	1	0
Crushed by Object	0	2	0
Drowning	3	9	0
Drug intake	3	5	0
Falls	0	2	0
Fire	3	1	0
Gun discharge	0	1	0
Hanging/Strangulation	2	2	0
Hyperthermia	0	1	0
Maternal drug use	6	9	0
Medical complications	4	3	0
Motor vehicle other than auto	0	2	0
Train v pedestrian	0	1	0
TOTAL	**37**	**83**	**1**

Case Summary
Undetermined Child Death

Leslie was a two-month old infant living in the care of her mother and father. Mother had been co-sleeping with Leslie who was nestled in her mother's chest area. When mother awoke, she found that Leslie was not breathing and she called 911. Paramedics transported Leslie to the hospital where she was pronounced dead. Law enforcement was then notified and they initially believed that the death was related to rollover/smothering due to the fact that the mother and Leslie had been co-sleeping. In addition, there were a lot of pillows around the area where they had been sleeping and it did not appear to be a safe sleeping environment.

Mother lived with Leslie in a tent trailer behind a house and during the investigation of Leslie's death, it was learned that mother and Leslie's father both had a long history of substance abuse and manufacture of methamphetamines. During law enforcement's interviews with mother, she described Leslie as whiny and although no drug paraphernalia was found around the house, mother admitted to using methamphetamines and breast-feeding Leslie before going to sleep. Law enforcement also found formula in a bottle that was discovered to have methamphetamines in it (in either the nipple or the bottle). It is unclear if the methamphetamines found in the bottle were added to the bottle or if it was there as a result of left over breast milk and the bottle not having been washed. There was also some information that mother or father may have been mixing methamphetamines in the kitchen area and that some of it may have gotten into the bottle as a result. Law enforcement later discovered that mother had been breast-feeding Leslie, but developed bells palsy and due to the medication that she was taking for this condition, she began to feed Leslie with formula.

At autopsy, Leslie's heart was found to be more than double the normal size. Methamphetamine was found in Leslie's heart blood and there was also cold medication in her stomach. The bottle used to feed Leslie that was found to be positive for methamphetamine was negative for cold medication. There were no specific findings as to the cause of Leslie's death, thus the death was moded as undetermined. Co-sleeping was noted as a contributing factor in Leslie's death, but the ingestion of methamphetamine by the infant made it more difficult to determine the role that co-sleeping may have had with her death. The Coroner noted that the fact that Leslie had methamphetamine in her stomach indicated that she had ingested it –either from the bottle or from breast-feeding.

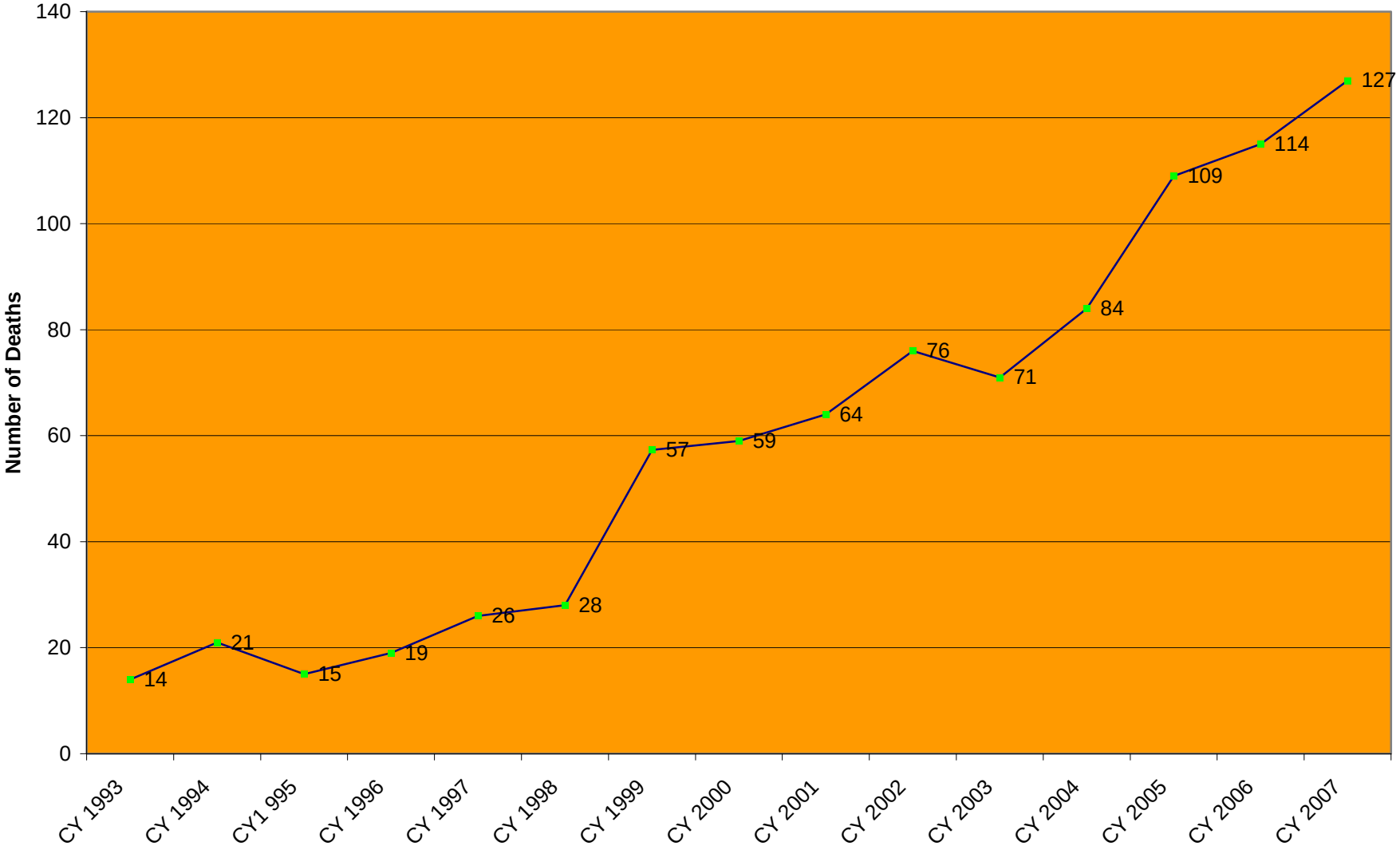
According to law enforcement, the mother is a very heavy methamphetamine user who has been arrested nine times for felony narcotic charges including manufacture of methamphetamines. Reportedly, mother was known in the neighborhood as a "druggie." Leslie's father also has a criminal history for drug manufacture. Law enforcement has expressed interest in filing charges against mother for Leslie's death. They attempted to obtain blood and urine samples from the mother but she refused.

The Department of Children and Family Services (DCFS) did have a prior history for Leslie's family. Reportedly, Leslie's mother has two older children; one now lives with her father as mother lost custody of this child when she abandoned this child with strangers while searching for drugs. There also was a prior referral alleging that the father had physically abused the other sibling, but this allegation was determined to be inconclusive and no services were provided at that time. Mother has refused to disclose the whereabouts of this sibling. As there are no other siblings in the home, there will be no further DCFS involvement with this family.

The ICAN Child Death Review Team identified a number of concerning issues in this case. There have been a large number of deaths related to co-sleeping. Efforts are now underway to provide better information to parents of newborns about the risks inherent in co-sleeping and the need to ensure that the infant has a safe sleeping environment. Leslie's case is further complicated by the drug use of the mother. The Team has reviewed other cases of co-sleeping where the parent was intoxicated or under the influence of drugs and there have been discussions (prompted by a law enforcement detective who is very committed to this issue) to seek legislation to require that parents undergo screening for drugs and/or alcohol in cases of co-sleeping.

Questions were also raised about whether or not a toxicology screen was done by the hospital at the time of Leslie's birth and whether or not the hospital identified Leslie's mother as a drug user and/or identified any risk to Leslie as a result of mother's long history of substance abuse. It was also questioned why the hospital did not complete the mandatory risk assessment form at the time of Leslie's birth and why no report was ever made to DCFS. Should Leslie's mother ever have another child, completion of this risk assessment would be crucial in ensuring that this child is protected from the tragic fate that Leslie suffered.

1993 to 2007 Undetermined Child Deaths



Undetermined Child Deaths – 2007 (N = 127)

Race	***Number/Percentage of Undetermined Child Deaths***
African American	31 (24.4%)
Asian/Pacific Islander	9 (7.1%)
Caucasian	21 (16.5%)
Hispanic	64 (50.4%)
Other/Unknown[14]	2 (1.6%)

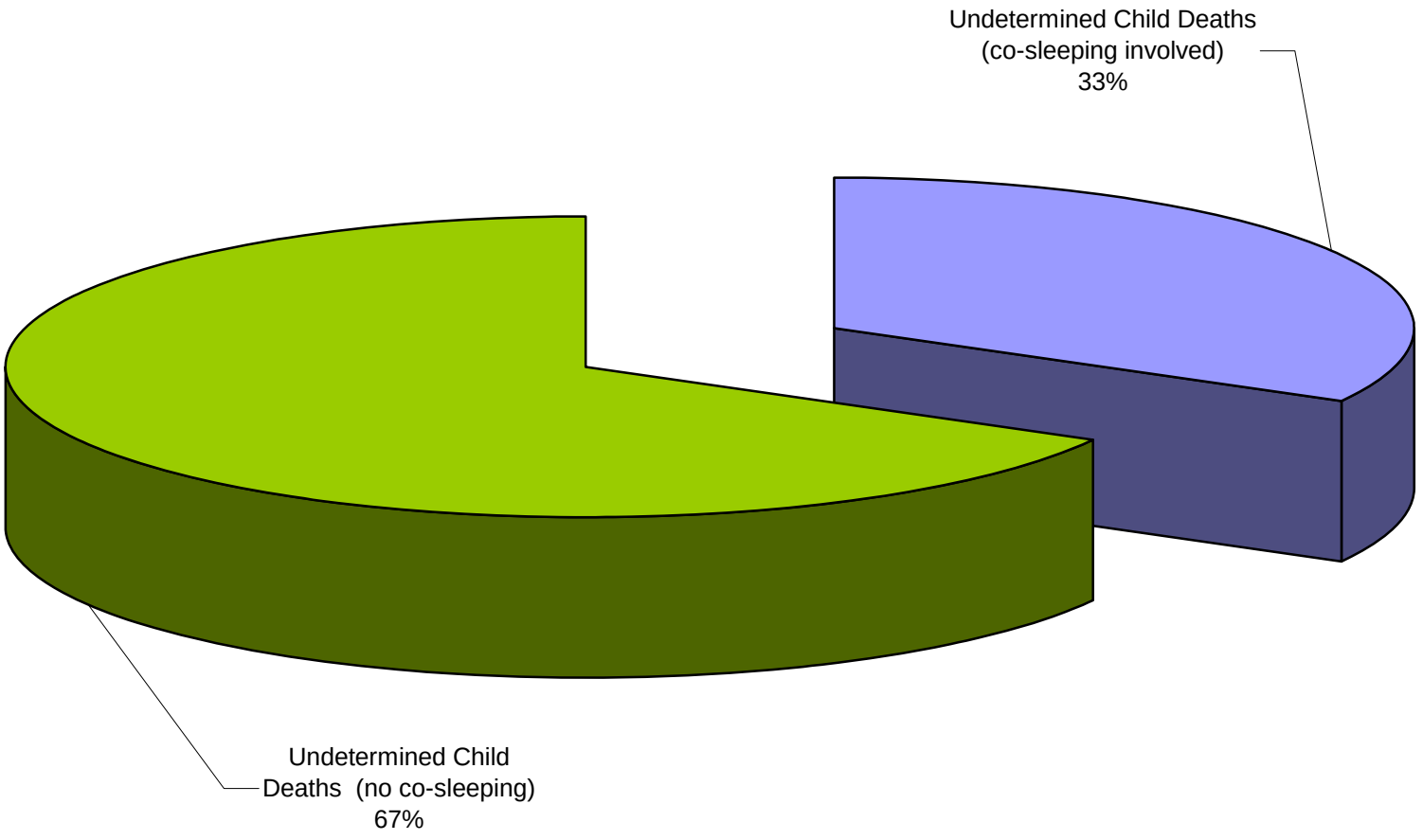
Age	***Number of Undetermined Child Deaths***
Under 1	101
1year	7
2 years	2
3 years	1
4 years	1
5 years	1
6 years	0
7years	0
8 years	1
9 years	1
10 years	1
11 years	0
12 years	1
13 – 17 years	8

Gender	***Number of Undetermined Child Deaths***
Female	56
Male	71

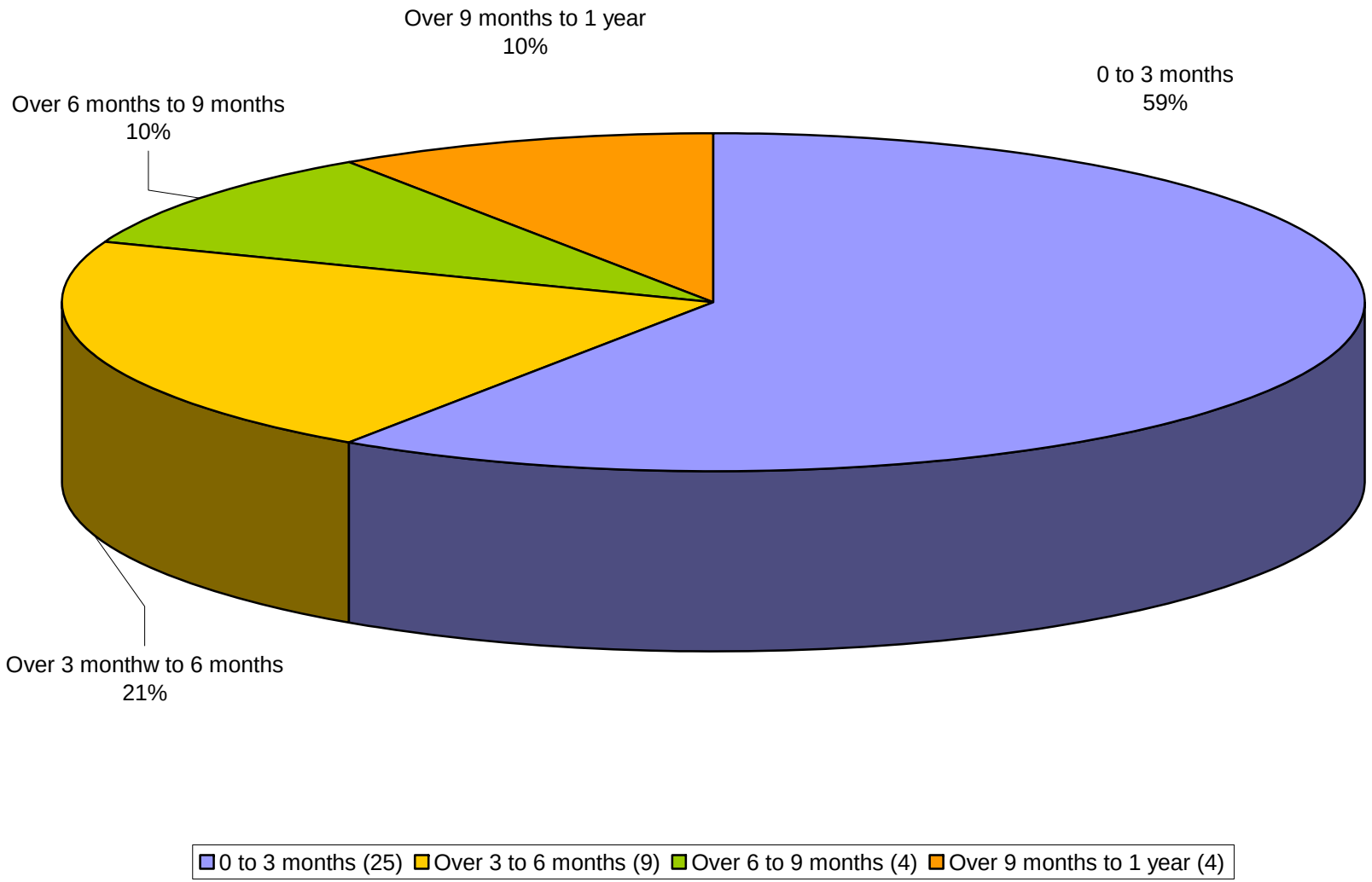
African American children were over-represented in undetermined child deaths.
80% of the undetermined child deaths were under one year of age.
91% of the undetermined child deaths were 5 years of age or under.

[14] Category includes one American Indian and one Middle Eastern.

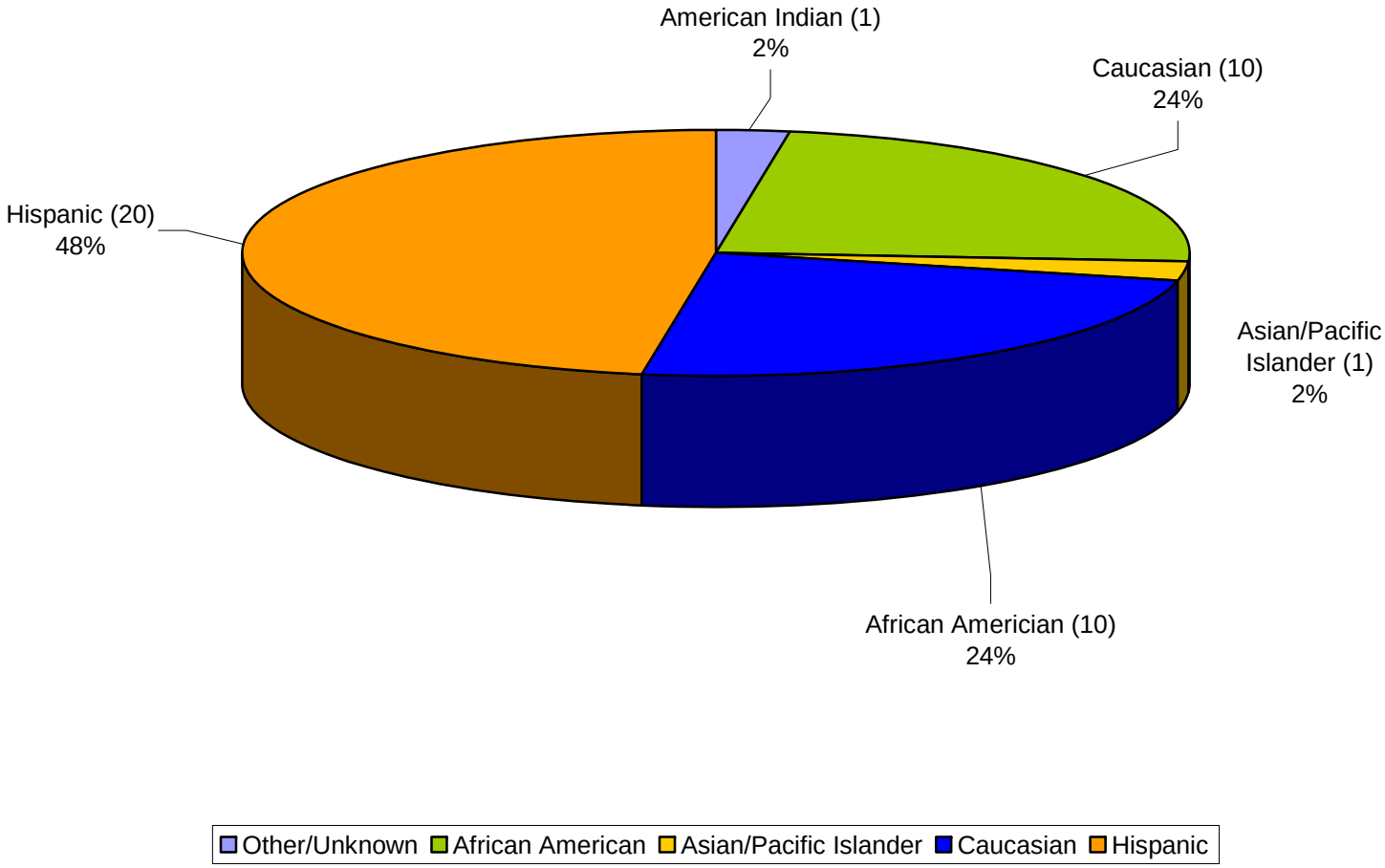
Percentage of Undetermined Child Deaths with a Noted Status Post Co-sleeping - 2007



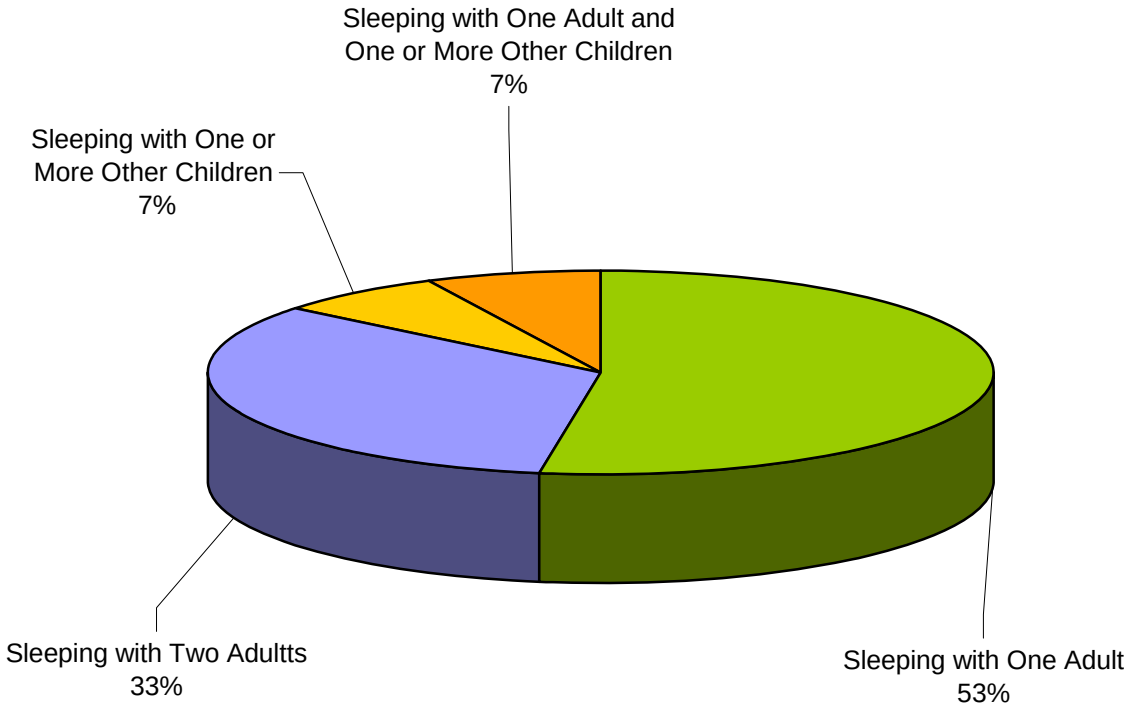
2007 Undetermined Child Deaths Associated with Co-sleeping - Age



2007 Undetermined Child Deaths Associated with Co-sleeping - Race



2007 Undetermined Child Deaths Associated with Co-sleeping Number of Persons



Sleeping with One Adult (22) 53%	Sleeping with Two Adults (14) 33%
Sleeping with One or More Other Children (3) 7%	Sleeping with One Adult and One or More Other Children (3) 7%

Introduction

Historically, the ICAN Child Death Review Team report has included only those cases which have met Team protocol. This 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 perpetrator's relationship to the victim, 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=100) 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 the first 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 trend analysis.

Case Summaries*
Third Party Homicides

Thomas, age 16, was in the front seat of a car when a second car pulled up along side his car. The occupants of this second car began shooting at Thomas and he was struck by their gunfire. The perpetrators sped off in their car. Despite all life saving measures, death was pronounced a short while after Thomas arrived at the hospital.

Randy, age 14, was standing in the front yard of his home when he was approached and shot at multiple times. Randy's parents heard the sound of the gunfire and came running out of the house. Randy's father attempted to chase down the perpetrators only to have them turn around and shoot back at him. Both Randy and his father died as a result of this incident.

Seventeen-year old Raul and some friends were walking home from school when a lone person crossed the street and began to fire at them. Raul was hit by the gunfire and the perpetrator fled the scene. Raul was taken to the hospital and died a short time later.

Sixteen year-old Jennifer was walking with her male gang member friend when a car pulled up and a rival gang member confronted them. The two gang members shot at each other but neither was struck. Jennifer, however, was inflicted with a gun shot wound from the cross fire and she later died.

Miguel, age 17, was on a sidewalk when he was approached and shot one time. Miguel had a through and through gun shot wound to the head and paramedics transported him to the hospital where he was placed on life support. Miguel was pronounced dead a short time later.

Fifteen-year old Albino was standing outside a restaurant waiting for his food. A person pulled up in a car, exited his vehicle, and then began shooting at Albino. Albino attempted to escape by running through the restaurant but the perpetrator followed and continued to shoot at him. Albino managed to run through the restaurant to the rear parking lot where he collapsed on the sidewalk and was found dead by paramedics.

Henry left his home and walked across the street where he was picked off by gunfire from a passing car which then quickly fled. Suffering a single gun shot wound to the head, Henry collapsed to the ground and was pronounced. Three casings were recovered from the scene.

LaTanya, age 17, was at a restaurant for a party when fighting ensued. Someone then pulled out a gun and fired 25 to 30 rounds into the crowd striking LaTanya. It was learned that the perpetrator was suspected to be a fellow gang member who accidentally killed LaTanya.

Charlie, age 16, was standing on the sidewalk by a school when someone walked up on foot and shot at him numerous times. Charlie sustained multiple gun shot wounds to his chest, arms, and back. He was taken to the hospital but they were unable to resuscitate him and he was pronounced dead. Law enforcement found projectiles and casings at the scene.

Pedro, age 17, was walking down a street with several friends when they were confronted by three individuals who asked Pedro and his friends where they were from. Pedro responded by saying he was from nowhere and then one of the individuals pulled out a revolver and shot Pedro numerous times before fleeing. Pedro was found alert and conscious and was taken to the hospital for care. He was later diagnosed with anoxic brain injury and brain death was declared. He was later officially pronounced.

Jonathan, age16, was in a parking lot with his cousin unloading or loading food into a trunk when he was approached and shot once in the head. Paramedics and law enforcement arrived on the scene and Jonathan was taken to the hospital. Death was pronounced the following day.

*Case identities were changed.

Third Party Homicides

- There were 100 third party homicides in 2007. This is the first year collecting these so there are no prior data to compare.

- Ninety-one percent (n=91) of the youth were victims of gunshot wounds. These include 33 youth who were victims of homicides perpetrated by suspects with possible gang involvement. Seven youth were victims of a stabbing, two of whom were cases with possible gang involvement. Finally, one youth died from blunt head trauma after being hit over the head with a beer bottle while attending a party, and one female victim died from strangulation.

- Male victims outnumbered female victims by a broad margin. Eighty-nine males and eleven females were homicide victims in 2007.

- Sixty-seven percent (n=67) of the children who were victims of a third party homicide in 2007 were ages 16 – 17; seventeen victims were 15 years of age, twelve were age 14, two were age 13, and two victims were one year of age or under.

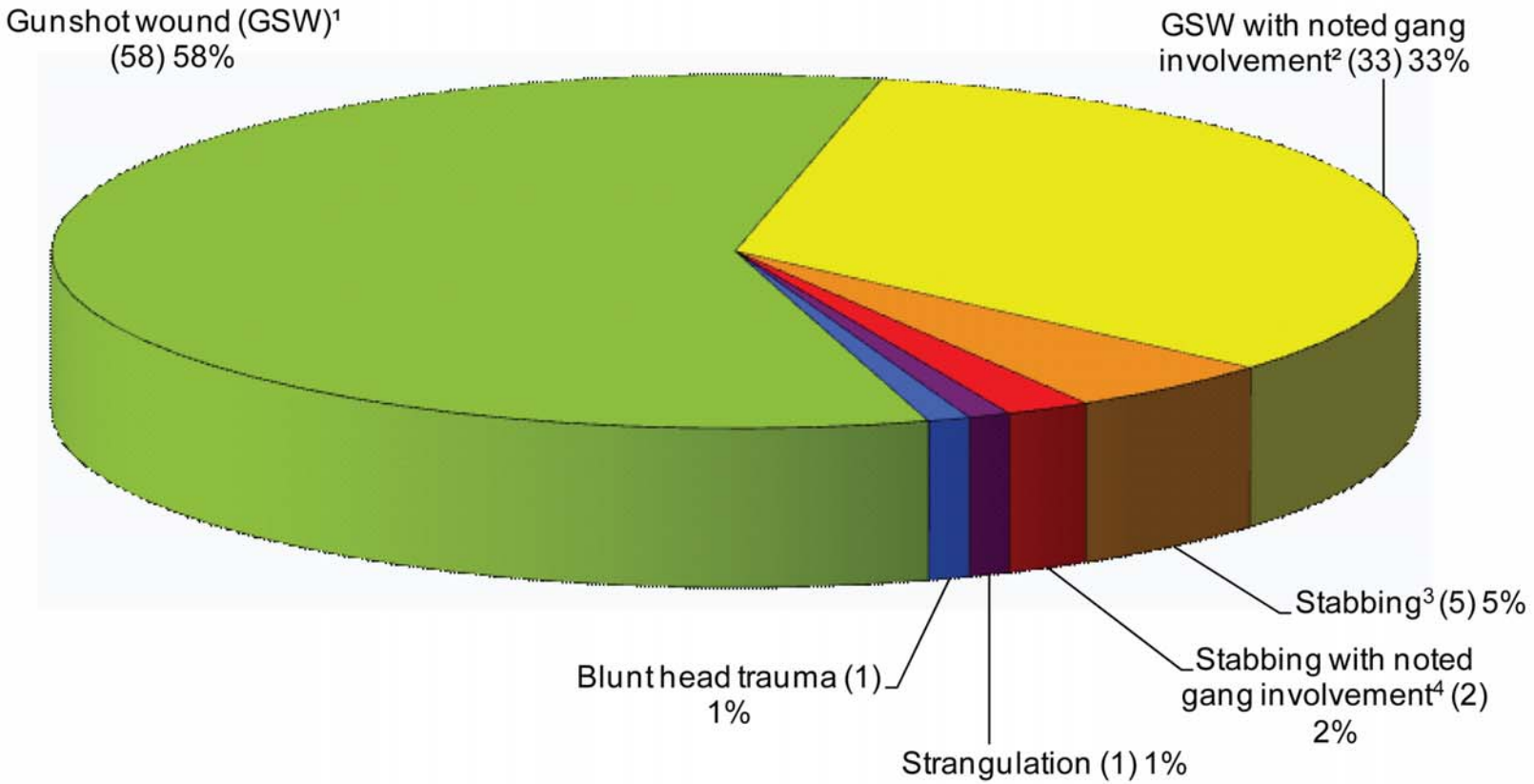
- Both Hispanic (n=65) and African-American (n=32) youth were over-represented in third party homicides. There were three third party homicides of Asian/Pacific Islander youth in 2007, and none of the victims were of Caucasian descent.

- The greatest number of third party homicides occurred in July (n=15). The second greatest number of homicides occurred during the months of March and September (n=11). The fewest number of homicides occurred in the month of May (n=3). At least six third party homicides occurred during the months of January, February, April, June, August, October, November and December.

- While third party homicides occurred throughout Los Angeles County in 2007, the majority of these deaths occurred in SPA 6 (n=40) and in SPA 4 (n=19). Fourteen third party homicides occurred in SPA 8, eight in SPA 7, seven in SPA 3, five each in SPA 1 and SPA 2, and one homicide occurred in SPA 5. The location of one third party homicide is unknown as the youth was strangled in an unknown location, then her body was dumped.

- The Los Angeles Police Department (LAPD) had investigative authority for 52% of the third party homicide cases in 2007. Thirty-eight percent of the cases were under the jurisdiction of the Los Angeles Sheriff's Department, and 10% of the cases were handled by jurisdictions other than LAPD and LASD. Where the relationship of the perpetrator was identified by law enforcement, 66% of the perpetrators were a rival gang member, and 34% of the victims were gang involved. Finally, 39% (n=39) of the case investigations resulted in the filing of criminal charges by the District Attorney's Office. Many of the cases were still under investigation or unsolved and therefore, had not been presented to the District Attorney's Office.

2007 Third Party Homicides - Cause



Blunt head trauma (1) 1%	Gunshot wound (GSW)¹ (58) 58%	GSW with noted gang involvement² (33) 33%
Stabbing³ (5) 5%	Stabbing with noted gang involvement⁴ (2) 2%	Strangulation (1) 1%

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

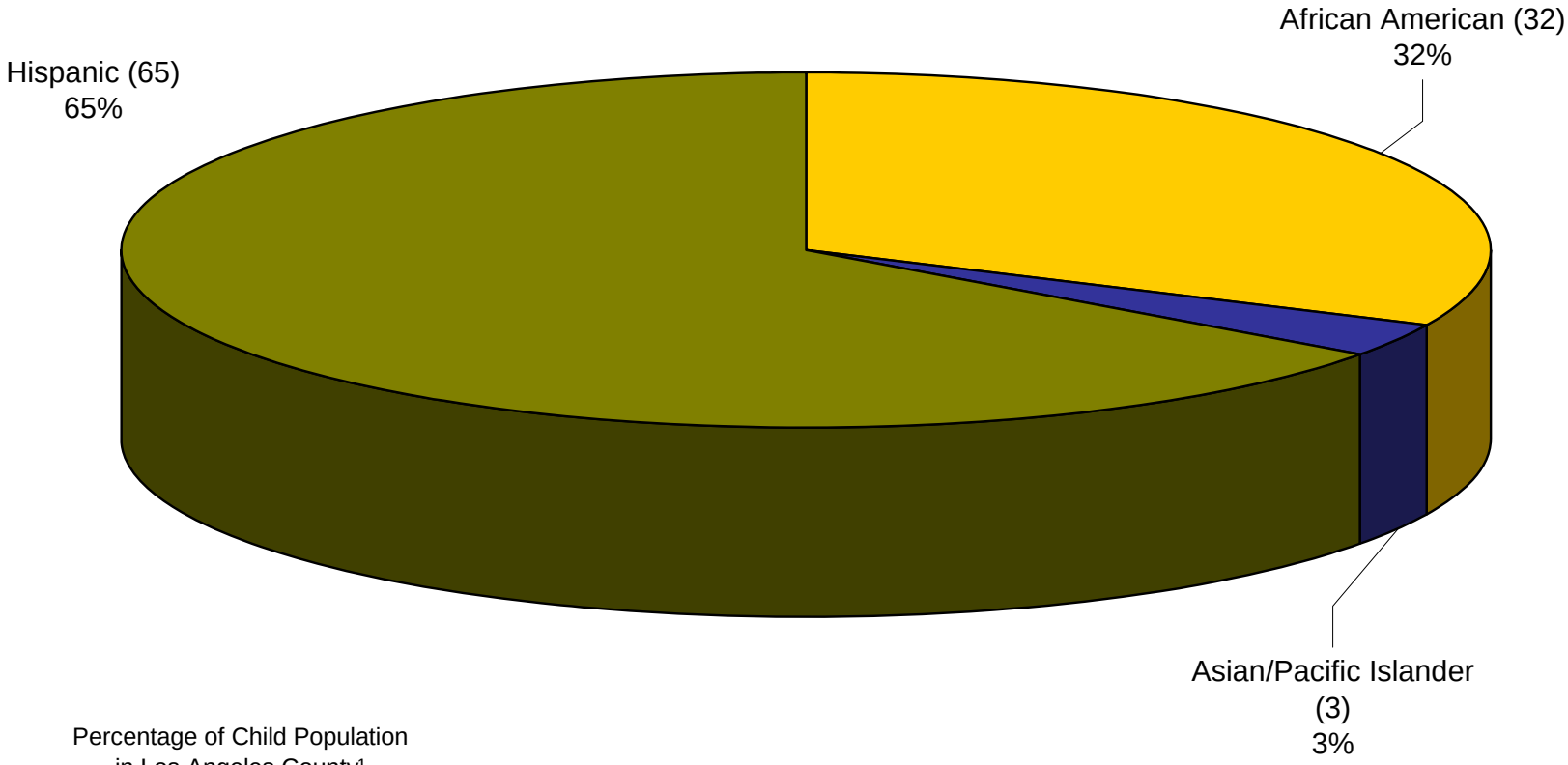
Third Party Homicides
Los Angeles County – 2007 (N = 100)

Age	Female	Male
1 year or under	1	1
2 – 12 years	0	0
13 years	0	2
14 years	1	11
15 years	2	15
16 years	4	23
17 years	3	37
Total	11	89

89% of the third party homicide victims were male.

60% of the third party homicide victims were 16 to 17 years of age.

2007 Child Homicides by Third Party - Race



Percentage of Child Population
in Los Angeles County[1]
Hispanic 59.5%
Caucasian 20%
African American 9.8%
Asian/Pacific Islander 10.4%
American Indian 0.2%

[1]From Los Angeles County Children's
Planning Council Scorecard 2006

Dates[1] of Third Party Homicides - 2007

7 homicides occurred in January (1/06, 1/09, 1/19, 1/21, 1/30 & two on 1/31/07)
7 homicides occurred in February (2/05, 2/06, 2/12, 2/16, 2/18, 2/20 & 2/24/07)
11 homicides occurred in March (3/04, 3/06, 3/10, 3/16, 3/18, 3/19, 3/23, 3/24, 3/26 & two on 3/30/07)
6 homicides occurred in April (4/04, 4/06, 4/09, 4/12, 4/16 & 4/27/07)
3 homicides occurred in May (5/03, 5/20 & 5/26/07)
8 homicides occurred in June (6/01, 6/02, 6/04, 6/10, 6/11, 6/15, 6/20 & 6/25/07)
15 homicides occurred in July (7/04, 7/08, 7/15, 7/16, two on 7/17, 7/19, 7/21, 7/24, two on 7/25, 7/29, 7/30 & two on 7/31/07)
9 homicides occurred in August (8/06, 8/08, 8/15, 8/16, three on 8/18, 8/22 & 8/31/07)
11 homicides occurred in September (9/01, two on 9/02, 9/10, two on 9/15, 9/21, 9/24, 9/26, 9/27 & 9/28/07)
8 homicides occurred in October (10/06, 10/07, 10/08, 10/11, 10/12, 10/23, 10/26 & 10/27/07)
8 homicides occurred in November (11/05, 11/09, 11/11, 11/13, 11/14, 11/20 & two on 11/24/07)
7 homicides occurred in December (12/01, 12/02, 12/06, 12/10 12/15, 12/22 & 12/24/07)

[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 - 2007

1 homicide occurred in Baldwin Park (zip code 91706)

1 homicide occurred in Bellflower (zip code 90706)
5 homicides occurred in Carson (zip codes 90745 & 90746)

6 homicides occurred in Compton (zip codes 90220 & 90221)
2 homicides occurred in Cudahy (zip code 90201)
1 homicide occurred in East Rancho Dominguez (zip code 90222)
1 homicide occurred in El Monte (zip code 91731)
1 homicide occurred in Hollywood (zip code 90038)
1 homicide occurred in Huntington Park (zip code 90255)
2 homicides occurred in Inglewood (zip codes 90302 & 90305)
4 homicides occurred in Lancaster (zip code 93535)
4 homicides occurred in Long Beach (zip codes 90805 & 90813)
49 homicides occurred in Los Angeles (zip codes 90001, 90002, 90004, 90005, 90007, 90011, 90017, 90018, 90019, 90026, 90029, 90033[3], 90034, 90037, 90038, 90044, 90047, 90057, 90059, & 90065)
1 homicide occurred in Lynwood (zip code 90262)
1 homicide occurred in Maywood (zip code 90270)
1 homicide occurred in North Hills (zip code 91343)
2 homicides occurred in North Hollywood (zip codes 91605 & 91606)
1 homicide occurred in Palmdale (zip code 93550)
2 homicides occurred in Paramount (zip code 90723)
1 homicide occurred in Pasadena (zip code 91104)
2 homicides occurred in Pomona (zip code 91766)
1 homicide occurred in San Pedro (zip code 90731)
2 homicides occurred in South Gate (zip code 90280)
1 homicide occurred in Temple City (zip code 91780)
1 homicide occurred in Torrance (zip code 90501)
1 homicide occurred in Valinda (zip code 91744)
2 homicides occurred in Van Nuys (zip codes 91403 & 91406)
1 homicide occurred in Whittier (zip code 90606)
1 homicide occurred in Wilmington (zip code 90744) and
1 homicide occurred in an unknown location[4]

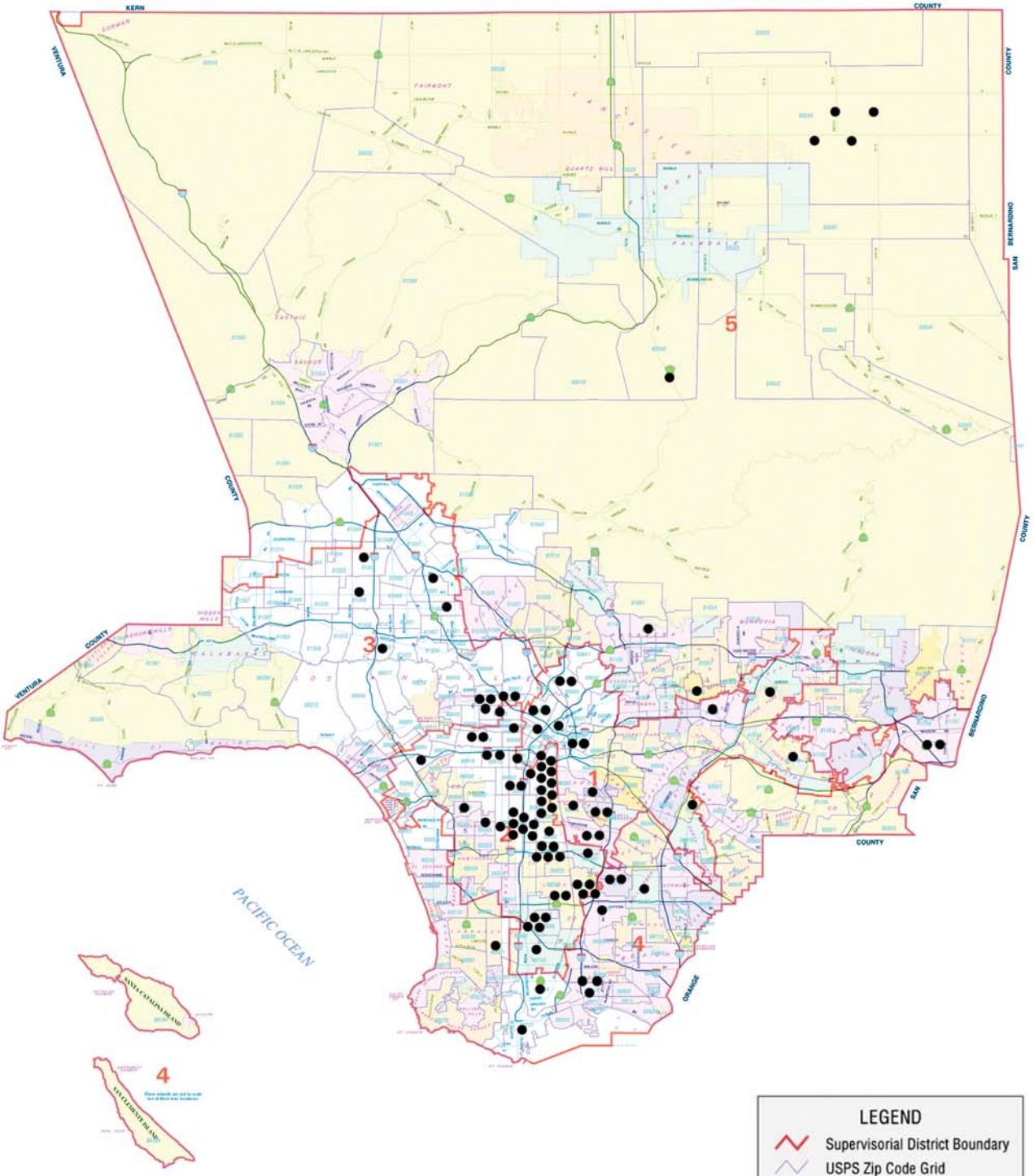
[2] City where the injury/fatality occurred

[3] Decedent was struck in the head with a bottle while attending a party, staggered home, went to bed, then died at home. The city and zip of the party location were not provided.

[4] Decedent found in LA, 90019, but the body was dumped at that location and it is unknown where the fatality occurred.

2007 Third Party Homicides - Location

N = 100*



LEGEND
Supervisorial District Boundary
USPS Zip Code Grid

* One decedent was found in LA, 90019, but the body was dumped at that location and it is unkown where the fatality occurred.

● = ***Los Angeles County Third Party Homicide Locations***

Information on criminal justice system involvement in third party homicide cases was gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). In 2007, there were 100 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 1 below.

Table 1

Agency	Number of Cases	Percentage
LAPD	52	52%
LASD	38	38%
Long Beach P.D.	4	4%
Inglewood P.D.	2	2%
Pomona P.D.	2	2%
Huntington Park P.D.	1	1%
Pasadena P.D.	1	1%

Table 2 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation. These data on the perpetrator's gang involvement vary from those found in the chart on page 69 because law enforcement often obtains information that was not available at the time the Coroner investigation summary was prepared.

Table 2

Perpetrator's Relationship to Victim	Number of Cases
Rival Gang Member	66
Stranger	5
Acquaintance	1
Unknown	20
No Information Provided	8

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

Table 3

Victim Information	Number of Cases
Attacked for No Apparent Reason While Walking	1
Stabbed at School	1
Attempted Carjacking Resulting in Murder	1
Dispute over Drug Transaction	1
Shot While Watching a Fight between Other Gang Members	1
Seen Shot after being Chased on Foot	1
Shot While Burglarizing a Shed used by Suspect to Cultivate Marijuana	1
Had Prior Fights at School with Suspect	1
Shot while in the Company of Adult Male Driving by an Abandoned House used as a Gang Hang-out	1
Gang Member	34
No Information Provided	57

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), 39 of the 100 cases of third party homicides had criminal charges filed by the District Attorney's Office in 2007. It should be pointed out that information provided by LAPD indicated if the case generated a filing, but did not specify the type of criminal charges. Also, of the 38 cases under LASD jurisdiction, 17 remain unsolved and are still under investigation. Finally, of the 10 cases reviewed by the LADA, information was found for only three 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	16
Ex-convict in possession of a firearm	1
Robbery	2
Assault with Deadly Weapon	4
Information not Provided	23