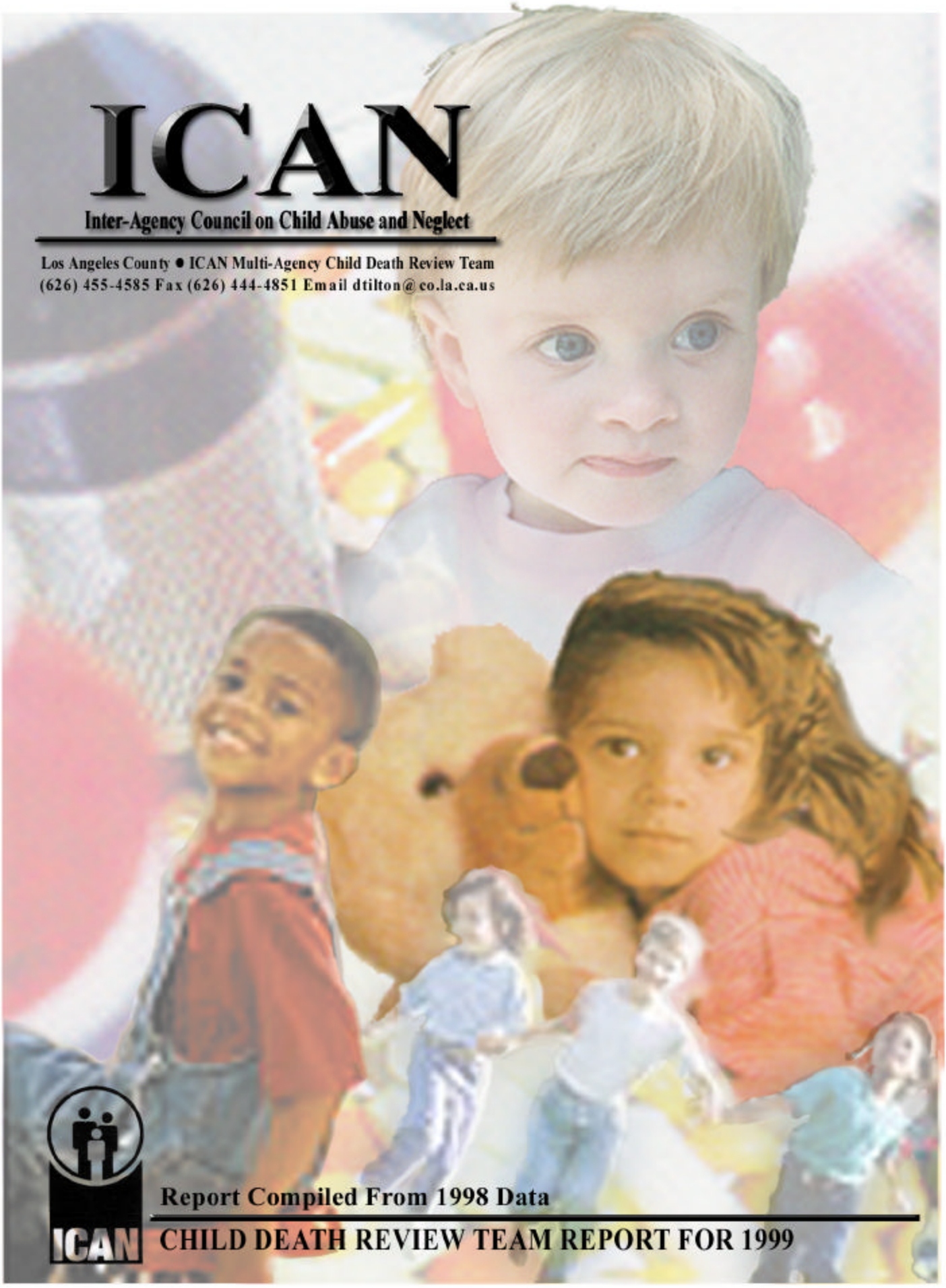

ICAN

Inter-Agency Council on Child Abuse and Neglect

Los Angeles County • ICAN Multi-Agency Child Death Review Team
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Report Compiled From 1998 Data

CHILD DEATH REVIEW TEAM REPORT FOR 1999

ICAN

Deanne Tilton, Executive Director

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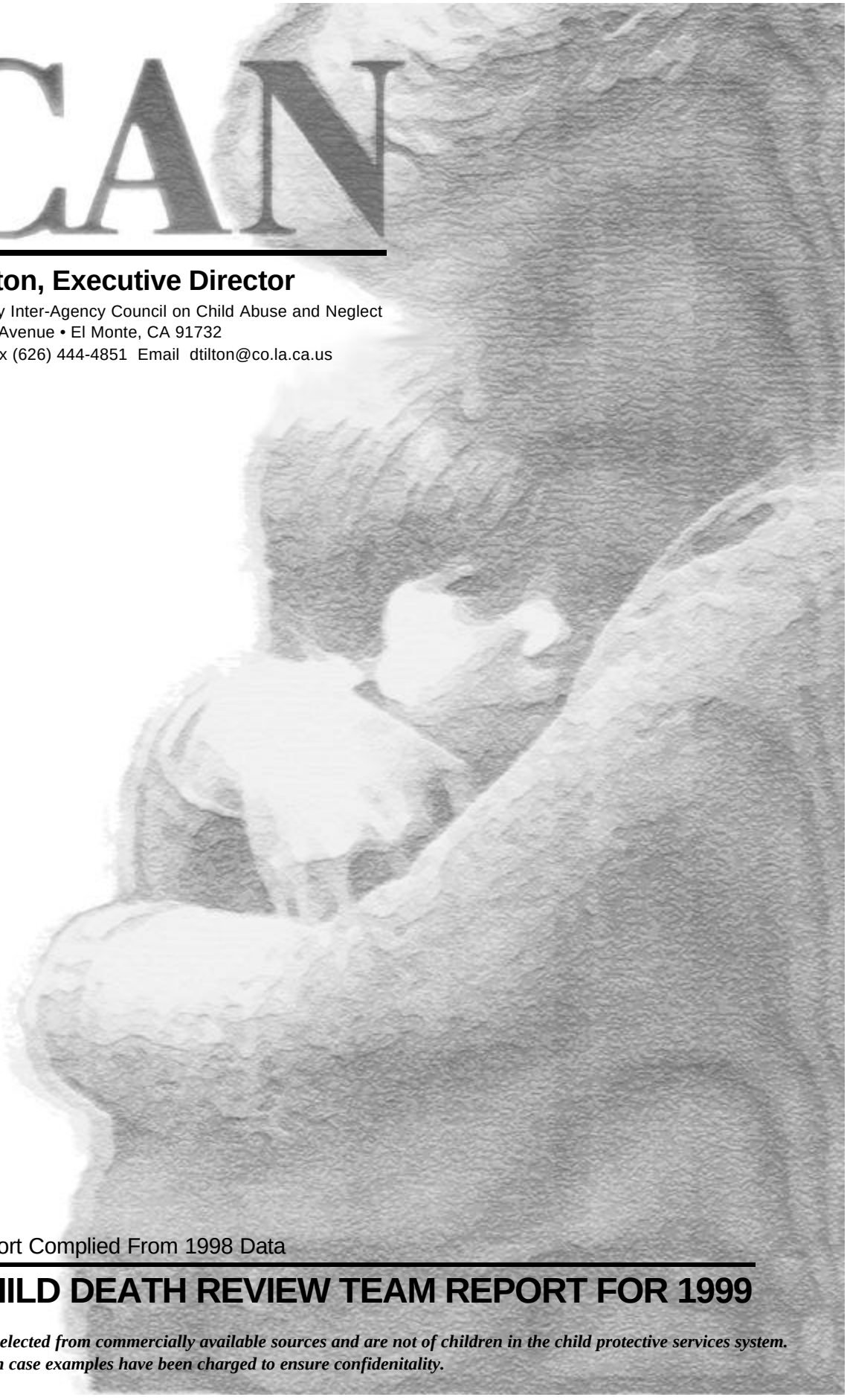

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Photographs were selected from commercially available sources and are not of children in the child protective services system. Children's names in case examples have been charged to ensure confidenitality.

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

FOREWORD

A toddler dies with head trauma after being left with mom's violent boyfriend. An apparent SIDS is found at autopsy to have subdural and retinal hemorrhages. A toddler dies suddenly at childcare from head trauma. These whodunits are well managed by ICAN Child Fatality Review. The ICAN Child Death Review after 600+ reviews of homicide by caretaker has unique competence. Additional resources are necessary to develop competence with all forms of child death including motor vehicle deaths, suicides and coroner's fetal deaths.

About 2,000 children die each year in this county with 200 hundred referred to the ICAN team for consideration. Homicides by caretaker number 40+ in most years, with formal review of 3 to 4 cases a month. Attempts to expand resources by dividing the county into additional teams have failed, but efforts to create special teams and special resources have made progress.

The LA County Office of Education and Department of Mental Health have provided a foundation to address suicide. The Department of Health Services has provided technical resources to develop systems to collect data on all child deaths.

The planned suicide review would consider 20 to 30 cases a year. Previous data on these deaths have included an apparent high rate of previous records for child abuse/neglect and for juvenile delinquency. This unique data defines additional risk factors. Previous professional contacts with children lost to suicide provide a resource for prevention and early intervention for the next child.

Computer and data systems can provide a structure to address all deaths, if only on paper, with demographic data, rates and increased awareness from notices to the agencies with previous contacts. The ICAN Child Death Review needs systematic data collection to participate in an expanding statewide system for standardized data collection on suspicious child death. This same system based on all deaths from all causes will provide a logical structure to expand efforts at prevention and intervention.

Systematic automated collection of case materials will provide material for additional review including child pedestrian and passenger motor vehicle deaths and coroner fetal deaths. All child fatality review provides a focal point to address multiagency intervention and prevention for non-fatal injuries. Responsible case management and learning from success and failure honors the short lives of these children.

Michael Durfee, M.D.

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INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT (ICAN)

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

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

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

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

For further information contact:

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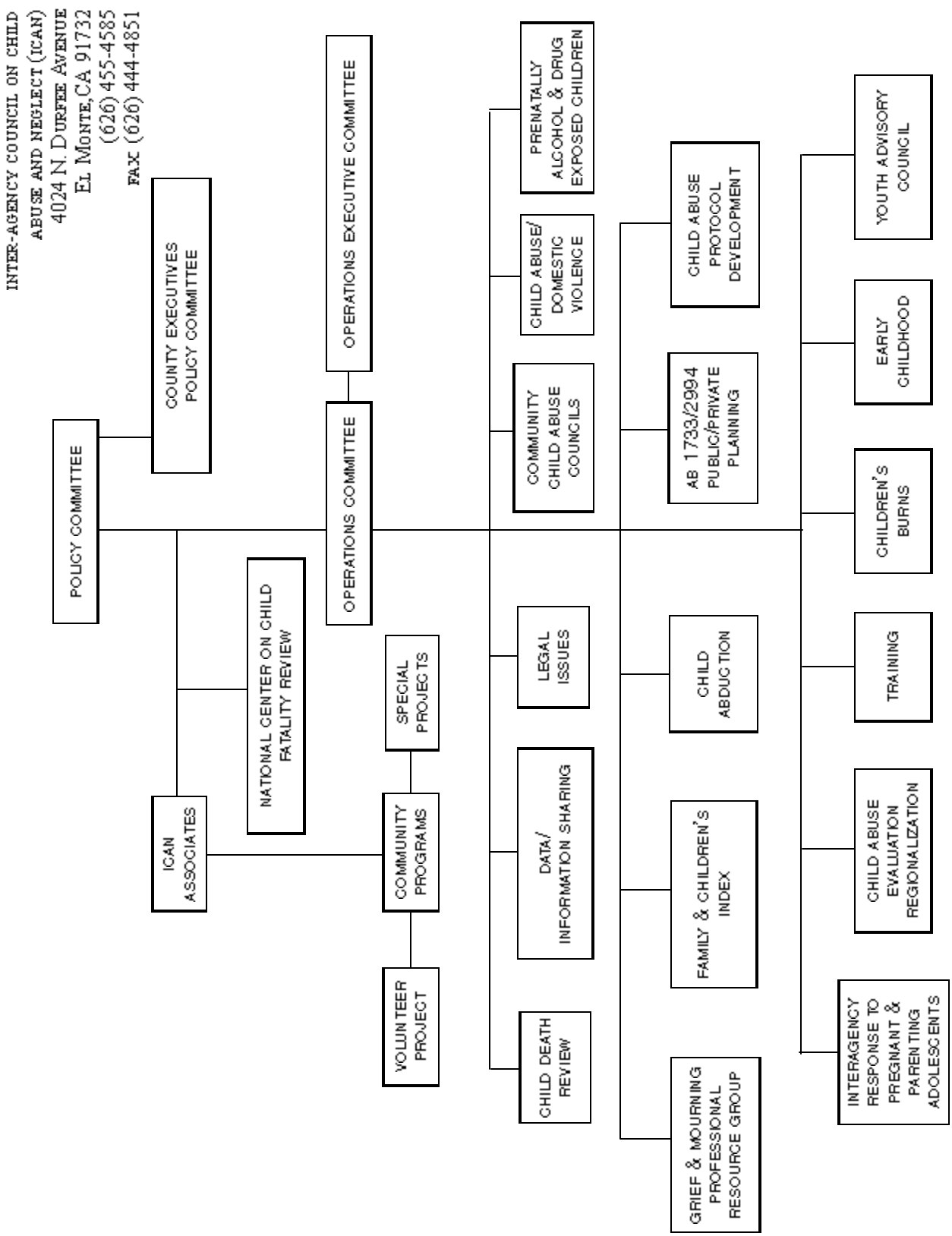
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POLICY COMMITTEE
COUNTY EXECUTIVES POLICY COMMITTEE
OPERATIONS EXECUTIVE COMMITTEE
OPERATIONS COMMITTEE
ICAN ASSOCIATES
NATIONAL CENTER ON CHILD FATALITY REVIEW
COMMUNITY PROGRAMS
SPECIAL PROJECTS
VOLUNTEER PROJECT
CHILD DEATH REVIEW
DATA/ INFORMATION SHARING
LEGAL ISSUES
COMMUNITY CHILD ABUSE COUNCILS
CHILD ABUSE/ DOMESTIC VIOLENCE
PRENATALLY ALCOHOL & DRUG EXPOSED CHILDREN
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CHILD ABDUCTION
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CHILD ABUSE EVALUATION REGIONALIZATION
TRAINING
CHILDREN'S BURNS
EARLY CHILDHOOD
YOUTH ADVISORY COUNCIL

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

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

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

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

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

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

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

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

CHILD ABUSE COUNCILS
Provides interface of membership of 16 community child abuse councils involving hundreds of organizations and professionals with ICAN. Councils are interdisciplinary with open membership and organized geographically, culturally, and ethnically. Coordinates public awareness campaigns, provides networking and training for professionals, identifies public policy issues and opportunities for public/private, community based projects. (Meets monthly, no set day)

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

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

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

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

CHILD ABDUCTION/REUNIFICATION
Public/private partnership to respond to needs of children who have experienced abduction. Provides coordinated multi-agency response to recovery and reunification of abducted children, including crisis intervention and mental health services. (Meets every 3rd Wed. at 12:30 p.m., Find the Children, 3030 Nebraska Avenue, Santa Monica) Note: This is a closed meeting.

AB 1733/AB 2994 PLANNING
Conducts needs assessment and develops funding guidelines and priorities for child abuse services; participates in RFP process and develops recommendations for funding of agencies. (Meets as needed)

CHILD ABUSE PROTOCOL DEVELOPMENT
Develop a countywide protocol for inter-agency response to suspected child abuse and neglect. (Meets monthly, no set day)

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

CHILD ABUSE EVALUATION REGIONALIZATION

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

TRAINING

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

CHILDREN'S BURNS

This committee reviews issues surrounding children's burn injuries that result from parental abuse or neglect. Meets at Grossman Burn Center. (Meets monthly)

EARLY CHILDHOOD COMMITTEE

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

YOUTH ADVISORY COUNCIL

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

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

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

Based upon grants from the California Office of Criminal Justice Planning and the Office of Child Abuse Prevention, ICAN developed and implemented Child Death Review Team Training during 1998 and 1999. The two day training curricula, presented in Los Angeles, Fresno, Emeryville, Sacramento, Redding and San Diego Counties (additional training is planned for Palm Springs and South Lake Tahoe during 2000) used multi-disciplinary presentations, mock case reviews, database development information and a technology presentation to further develop and enhance the skills of the hundreds of professionals who attended the trainings. The training format itself modeled the inter-agency collaboration necessary to conduct effective and useful reviews of child abuse-related fatalities. The San Diego training was unique in the history of child fatality review activities in that more than twenty professionals from various disciplines in Mexico attended, offering a unique, international perspective. Further, the issue of child abduction and international law regarding retrieval of children illegally taken from the U.S. to Mexico was included in the San Diego training, as children have been abducted from the U.S. and subsequently killed while in Mexico.

Beginning in 1996, ICAN was designated by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, and the U.S. Department of Health and Human Services as the National Center on Child Fatality Review (NCFR). The NCFR provides a source of information exchange and development of services for professionals involved in the field of child fatality review throughout the United States. Further, the NCFR web site located at ICAN-NCFR.org provides a central point of information sharing among national and international professionals in the field. The NCFR, with the invaluable assistance of principal consultant Michael Durfee, M.D., has developed a database of child fatality review professional liaisons in all fifty states, international contacts and national and federal agency contacts. These contacts can be accessed through a searchable directory on the ICAN-NCFR web site. In addition, the NCFR web site has expanded its links to other child death review and child welfare web sites on the internet, has posted national and state data sets regarding child deaths, and in March 2000 produced a nationally televised satellite child death

review team training broadcast, reaching thousands of child fatality review professionals throughout the United States and into Canada. The NCFR is committed to the development and improvement of the process of Child Fatality Review in all fifty states.

ICAN has been a leader in the field of Child Fatality Review for over two decades. Child Death Review Team Training and The National Center on Child Fatality Review are two examples of the work ICAN does to further the development and improvement of the critically important work of reviewing the intentional and preventable deaths of children. Prevention of child abuse and neglect related deaths is the ultimate goal of the systematic, multi-disciplinary review of child fatalities, and ICAN's efforts in this area will continue to evolve and grow as more is learned through the sharing of information among child death review teams locally, nationally and internationally.

INTRODUCTION

For most of us, children evoke a sense of hope, optimism, innocence, wonder, and, most of all, love. They represent the chance that we all want to make things right. When children die, the sense of loss is profound, and curiously personal even in those instances where we did not know the child.

ICAN's Child Death Review Team meets monthly to review deaths of children in our county. Usually these children are very young, under the age of three. Often, these infants and toddlers have been intentionally killed by a parent or caretaker or have died as the result of severe abuse or neglect. The circumstances of their deaths are sometimes shocking, often maddening, and always frustrating and poignant.

Through an in-depth review involving professionals from health services, child protective services, law enforcement, district attorney, coroner's office, dependency court, schools, and others, the team attempts to reconstruct events that led up to the child's death, examine the family's life prior to the child's death, and determine whether the death could have been prevented, and, if so, what interventions might have saved the child's life.

This tenth annual report of the ICAN Multi-Agency Child Death Review Team provides information on children's deaths that occurred in 1998. It provides a detailed analysis of child abuse and neglect related fatalities, and data on accidental, natural and fetal deaths, as well as suicides. Importantly, the report also provides recommendations that we hope, when implemented, will save children's lives. Saving those lives is the ultimate goal of our work.

FINDINGS

CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS

- 49 child homicides by parents/caretakers/family members were identified by the Team in 1998. This is an increase of 9% over the 45 child homicides by parents, caretakers or family members identified in 1997, and consistent with the previous 10 year average of 47.
- 55% (n=27) of the victims were female in 1998, 45% (n=22) of the victims were male. Over the past 10 years, there have been a total of 255 male victims (54%) and 216 female victims (46%).
- 33% (n=16) of victims were under the age of 6 months. 43% (n=21) were under the age of 1 year. 59% (n=29) were age 2 or younger. Over the past 10 years, 43% (n=203) of the victims have been under the age of 1 year, 85% (n=400) have been under the age of 5 years.
- 57% (n=28) of victims were Hispanic. 22% (n=11) of the victims were African American. 16% (n=8) of the victims were white and 2% (n=1) of the victims were Asian. The Coroner was unable to determine the ethnicity of 1 of the victims.
- 26.5% (n=13) of the fatal injuries were a result of head injuries caused by blunt force cerebral trauma, shaken baby syndrome or a combination of both.
- 63% (n=31) of the fatal injuries were caused by direct assault, the perpetrator using no weapon other than their own hands.
- Deaths due to gunshots were the second leading cause of child homicide by parents/caretakers/family members, comprising 20.4% (n=10) of the cases. In the past, deaths due to gunshots were the third leading cause of these deaths.
- The deceased child had siblings identified in 53% (n=26) of the cases.
- 53% (n=26) of the families had a history of receiving public assistance from the Department of Public Social Services. Between 1989 and 1997, the percentage of families with prior public assistance ranged from 49.2% to 62.5%.
- 41% (n=20) of the families had a current or prior record of referral of children to child protective services prior to the death of the child.
- 8% (n=4) of the child homicide by parents/caretakers/family members victims had medical records at Los Angeles County Department of Health Services facilities. No comparison with prior years can be made as the method used to obtain these clearances is being updated and clearances could not be obtained for all of the 1998 cases.

- 63% (n=31) of case investigations resulted in presentations to the District Attorney's Office by the law enforcement jurisdictions. This percentage is the lowest since 1990 when 60% of the cases were presented to the District Attorney's Office. The average percentage of cases presented to the District Attorney's Office by law enforcement over the past 10 years is 71%.

- 49 perpetrators were identified by law enforcement. 49% (n=24) of the perpetrators were female, most frequently the child's mother (n=23). One additional female perpetrator in 1998 was a sibling.

- 51% (n=25) of the perpetrators were men, most frequently the child's natural father (n=13) or the mother's boyfriend (n=9). The three other male perpetrators in 1998 were the child's step-father and 2 male siblings.

- In contrast to the 2 sets of foster parents who were identified as perpetrators in 1997, no foster parents or out-of-home caretakers were identified as perpetrators in 1998. Four extended family members were identified as perpetrators in 1998, 1 step-father and 3 siblings.

- The DA filed criminal charges on 90% (n=28) of the cases presented to them. Over the past 10 years, the percentage of case presentations resulting in the filling of criminal charges has ranged from 66% to 97%.

- 9 fathers, 9 mother's boyfriends, 1 step-father and 1 male sibling were criminally charged in 1998. Two fathers (four child death cases - one of the fathers killed three of his children) committed suicide after the murder and the filing of criminal charges against 2 fathers and 1 male sibling were rejected by the DA.

- 15 mothers were criminally charged in 1998. Two mothers (three child death cases - one of the mothers killed two of her children) committed suicide after the murder. Charges against 2 mothers and 1 female sibling were rejected by the DA.

- There were multiple suspects in 18% (n=5) of the cases where criminal charges were filed. In two cases where both the mother and the father were identified as the perpetrators, only the father was ultimately criminally charged.

- District Attorney disposition of criminal filings were:

  90% - (n=28) still pending trial
  (multiple perpetrators were charged in 3 cases)

  3% - (n=1) over 10 years imprisonment

  3% - (n=1) between 2 and 10 years prison

  There have been no dismissals on any of the 1998 child homicides by parents/caretakers/family members cases as of yet.

ACCIDENTAL CHILD DEATHS

- 95 accidental child deaths were reported to the ICAN Team for 1998, a 10% increase over 1997.

- For only the second time since ICAN began collecting this information, drowning was not the leading cause of accidental child death. Deaths associated with maternal substance abuse were the leading cause of accidental child death

in 1998 and represented 40% (n=38) of the total number of accidental child deaths. Deaths associated with maternal substance abuse were also the leading cause of accidental child death in 1996, the only other time when drowning was not the leading cause.

- The number of accidental child deaths due to drowning decreased 33% (n=21) from the 28 deaths due to drowning in 1997. Deaths due to drowning were the second leading cause of accidental child death in 1998.
- Autopedestrian deaths - deaths resulting from children being hit by cars were the third leading cause of accidental child death in 1998. There were 19 autopedestrian deaths, representing 20% of the total accidental child deaths in 1998. This number is a 138% increase over the 8 such deaths in 1997. However, it is unclear if this number represents an actual increase in the numbers of these deaths or rather, better identification of these deaths by the Team.
- 67% (n=64) of accidental child death victims were male, 33% (n=31) were female.
- 41% (n=39) of the accidental child deaths occurred in victims under the age of one year.
- 44% (n=42) of the accidental child death victims were Hispanic children. Hispanic children comprise 48.2% of the county child population.
- White children represented 21% (n=20) of the accidental child death victims. White children comprise 27.9% of the county child population.
- 32% (n=30) of the fatal accident victims were African American, compared to 12.3% of the county child population.
- 48% (n=46) of families had a history of receiving public assistance from the Department of Public Social Services.
- 23% (n=22) of the families had a record of receiving child protective services prior to the death of the child. 50% (n=11) of these cases involved families where the Coroner indicated that the death was associated with maternal substance abuse.
- The deceased child had identified siblings in 29% (n=28) of the cases.
- 16% (n=15) of the victims had medical records at Los Angeles County Department of Health Services facilities.
- 4 cases were presented by law enforcement to the District Attorney. One of these case presentations resulted in criminal charges being filed.

UNDETERMINED CHILD DEATHS

- 28 Undetermined deaths were referred to the Team by the Coroner for 1998. This number represents the highest number of undetermined child deaths since ICAN began collecting this data.
- 71% (n=20) of the undetermined child deaths were of infants under 1 year of age. In the period of 1989 through 1998, an average of 69.7% of the undetermined child death victims have been under the age of 1 year.

- 11 of the families were known to the Department of Children's Services prior to the death.
- 3 of the victims had been seen at Los Angeles County Department of Health Services facilities.
- One case was presented by law enforcement to the District Attorney for the filing of criminal charges.

SUICIDES

- 15 adolescent suicides, ages 12 through 17 years, were reported to ICAN's Child Death Review Team by the Coroner in 1998, a 25% decrease from 1997 and the lowest number of adolescent suicides since ICAN began tracking this information. The average number of adolescent suicides for the past 11 years (since 1988) is 27.5 per year.
- 80% (n=12) of the suicide victims were male. 20% (n=3) of the victims were female. Over the last 10 years the range of male suicide victims has been 12 to 37, the range of female victims, 2 to 11.
- 80% (n=12) of the suicides were committed by Hispanic youths. 20% (n=3) of the suicides were committed by White youths. There were no suicide deaths by African American or Asian youth in 1998.
- 73% (n=11) of the suicide victims were either 15, 16, or 17 years old. The two youngest victims were 12 and 13 years old.
- In 60% (n=9) of the cases, the method of suicide involved the use of firearms. In another 27% (n=4) of the cases the method of suicide was hanging. Other methods included a drug overdose, 6.6% (n=1) and neck compression, 6.6% (n=1). 181 of the 296 (61%) adolescent suicides over the past 11 years involved firearms.
- 33% (n=5) of the families with suicide victims had a history of receiving public assistance from DPSS.
- 40% (n=6) of the families with suicide victims had prior involvement with the Department of Children and Family Services.
- 40% (n=6) of the suicide victims had records of involvement with Los Angeles County Department of Health Services facilities.
- There were siblings identified in 27% (n=4) of the cases.

FETAL DEATHS

- 38 fetal deaths were reported to the ICAN Child Death Review Team for 1998, a 15% increase over 1997. Over the past 10 years, the average number of fetal deaths has been 38.1 per year.
- Hispanic families suffered 16% (n=6) of the fetal deaths identified by the Team. The number of fetal deaths in African American families increased 100% from 10 in 1997 to 20 in 1998. 17 of the 20 fetal deaths involved maternal drug usage. There were 8 fetal deaths in White families in 1998. 7 of the 8 fetal deaths involved maternal substance abuse.

- In 89% (n=34) of the fetal accidental deaths, there was a history of maternal drug abuse present.
- There were two fetal homicides reported to the Team for 1998.
- Six of the families who suffered fetal deaths had a record of prior involvement with the Department of Children and Family Services.
- 26% (n=10) of the fetal death families had a history of receiving public assistance from DPSS.
- Three of the fetal death families had a medical record at Los Angeles County Department of Health Services facilities.
- The District Attorney filed criminal charges on one of the fetal death homicides. On two additional cases, charges are pending.

RECOMMENDATIONS

RECOMMENDATION ONE: TIMELY AND DETAILED REPORTING OF CHILD DEATHS

DCFS and all ICAN agencies should report all known child deaths possibly related to child abuse and/or neglect to ICAN within 24 hours, or as soon as practically possible, of the agencies' awareness of the death. Further, the report to ICAN should include, at a minimum, the child's name, age, date of birth, date of death, and agency investigation/referral number.

Rationale:

Note: Recommendation Ten from the 1997 Child Death Review Team Report requested that DCFS and all ICAN agencies report child abuse/neglect- related deaths to ICAN within 24 hours.

Although there have been improvements in reporting of child deaths to ICAN, information provided is often insufficient to allow for timely review of child abuse-related deaths. In order to conduct timely reviews- which can aid criminal investigation and prosecution, improve case management and agencies' policies and procedures, highlight the need for prevention efforts, and produce additional benefits- DCFS and ICAN agencies must provide the identifying information requested as soon as possible.

RECOMMENDATION TWO: REPORTING AND COLLECTION OF DATA REGARDING CHILD ABUSE DEATHS

It is recommended that the Department of Children and Family Services and Department of Coroner report back at the November 2000 meeting of the Policy Committee: 1) the number of child deaths suspected to have been related to child abuse and/or neglect between January 1, 2000 and June 30, 2000; and 2) the number of child abuse/neglect - related deaths entered into the CWS/CMS system.

Rationale:

A recommendation for the above action for the time period January 1 to March 31, 2000 was a unanimously approved Action Item from the November 1999 meeting of the Policy Committee. The Action Item, requested to assess compliance with a key requirement of SB 525- the entry of child abuse/neglect - related deaths into CWS/CMS- has not yet been implemented. Management changes and integration of new information systems have impacted the agencies' ability to complete the requested action by the April 2000 meeting of the Policy Committee. The proposed review of child death entries in CWS/CMS is necessary and important to identify barriers to accurate and timely entry of child death data in CWS/CMS.

RECOMMENDATION THREE: HEALTH SERVICES DATA COLLECTION

It is requested that the Department of Health Services continue efforts to assist in the development of the total ICAN Child Death data system including deaths caused by other than homicide.

Rationale:

The Department of Health Services Epidemiology and Assessment Unit has assisted with the collection of data including demographic data on cause and manner of all child deaths. Additional assistance is needed to make the case intake more inclusive of cases not retrievable from other databases.

RECOMMENDATION FOUR: CRITICAL INCIDENT DEBRIEFING SERVICES

The Office of Coroner, Department of Children and Family Services, Department of Health Services, and District Attorney's Office should be encouraged to provide services to assist staff in dealing with the stress, grief and mourning which may arise as a result of working with difficult and often tragic cases involving trauma and death of children.

Rationale:

Working closely with the injury and death of children, even when the involvement was indirect or after the death, can cause significant emotional distress for the involved professionals. For many years, law enforcement agencies and fire departments have recognized this reality and have developed specific programs and protocols for helping their staff cope with the acute and cumulative effects of investigating the deaths of children. These agencies have demonstrated willingness to provide training and support for efforts in this area. While county agencies do offer generic Employee Assistance programs for their staff, such services are not sufficient to meet the specific needs of these impacted groups of professionals. For this reason, specific services should be developed to assist staff in the agencies identified above.

RECOMMENDATION FIVE: CHILD SUICIDE DEATH REVIEW

The Los Angeles County Office of Education, LASD, LAPD, Health Services, Office of Coroner, Department of Mental Health, and other agencies as determined by this core group of agencies, should develop a special review team which reviews the suicide deaths of children and adolescents.

Rationale:

The Child Death Review Team, by protocol, reviews the child abuse/neglect deaths of children age 12 and younger. Most youth suicides are committed by teens. Prior to many youth suicides, however, there were significant contacts by county agencies. For this reason, it has been ICAN's goal for many years to con-

vene a regular meeting to review youth suicides. The beginnings of such a team, tentatively named the Child and Adolescent Suicide Study Group, is in development, spearheaded by the Los Angeles County Office of Education and Department of Mental Health. The Policy Committee should support the development and growth of this emerging multi-disciplinary team.

RECOMMENDATION SIX: MOTOR VEHICLE CHILD DEATH REVIEW

LASD, LAPD, Health Services, County and City of Los Angeles Fire Departments, Office of Coroner, and other agencies as determined by this core group of agencies, should develop a special review team which looks into the motor vehicle deaths of children.

Rationale:

Given the population of Los Angeles County, the Child Death Review Team must by protocol limit its reviews to child deaths under age twelve, and primarily homicides by caregivers. The Team has become aware of a disturbing number of child deaths related to both passenger and pedestrian related incidents. A significant percentage of those cases appear to be preventable. Further, the annual report of the Child Death Review Team addresses only children hit by vehicles, not those that die in motor vehicle accidents. A separate team, comprised of professionals who deal with such deaths regularly, should be formed to address this group of child-victims.

RECOMMENDATION SEVEN: INTER-COUNTY COORDINATION OF CHILD DEATH REVIEW TEAMS

The California Department of Social Services and Office of the Attorney General should encourage county child death review teams to cooperate in sharing of information when more than one county has had jurisdiction in cases of child death in compliance with SB 644 (Polanco), which became state law in 1997.

Rationale:

Child death review is, by definition, a multi-agency process. Frequently, agencies in counties other than the county where the death occurred had significant contact with the child and family prior to the death. Sharing of information is critical to providing services to the family, assisting in pending prosecution or adjudication of criminal and/or dependency court proceedings, and improved management of inter-county child death cases.

RECOMMENDATION EIGHT: CHILD DEATH REVIEW TEAM PARTICIPATION

It is recommended that the ICAN Policy Committee request that the Independent Police Chiefs' Association commit to assuring that there is regular participation on the Child Death Review Team by officers and detectives of independent police agencies.

Rationale:

The Los Angels County Child Death Review Team reviews cases from all areas of the county. Currently, the Team has standing members from the Los Angeles County Sheriff's Department (LASD) and Los Angeles Police Department (LAPD), who coordinate the attendance of their investigating detectives. The commitment of the Independent Police Chief's Association would facilitate inclusion of detectives from independent police agencies, as well as educate the larger law enforcement community in the county on the work and benefits of child death review. For example, the Team recently had the participation of a police agency that had not previously attended a death review. As a result of the review, the police agency was able to file murder charges against two suspected perpetrators in a case they previously believed to be unfileable.

RECOMMENDATION NINE: PUBLIC HEALTH CAMPAIGNS

The Department of Health Services should review its public health initiatives to ensure that proven effective campaigns such as "Back to Sleep" (SIDS prevention), "Never Shake a Baby" (SBS prevention), and other child abuse/neglect - related campaigns receive adequate funding for continued countywide, bi-lingual distribution.

Rationale:

National data on SIDS has shown that a relatively simple change- putting infants down to sleep on their backs instead on their stomachs- can dramatically reduce the incidence of Sudden Infant Deaths. The "Back to Sleep," "Never Shake a Baby," drowning prevention, and other campaigns are examples of how public health campaigns can reduce preventable child deaths. In Los Angeles County, with our diverse and relatively young population, such efforts to eliminate preventable child injuries and deaths should be fully supported and implemented via multimedia, bilingual campaigns countywide.

RECOMMENDATION TEN: CHILD ABANDONMENT

The ICAN Policy Committee should support SB1368 (Brulte) and AB 1764 (Maddox), which would allow mothers/caregivers to take their newborn children to designated persons/facilities for relinquishment within the newborn's first 30 days of life without fear of prosecution for abandonment.

Rationale:

The tragedy of mothers abandoning newborns to die is a national issue. Legislation offering mothers of newborns the option of leaving the infant at designated facilities within the first 30 days of life without fear of prosecution has passed or is pending in many states. The Los Angeles County Child Death Review Team has reviewed such deaths, and the Coroner's Office reports that numerous formerly healthy newborns are later found dead in landfills, dumpsters, and along roadways in the county each year. Given the high number of couples wishing to adopt infants, active support of this bill and its eventual passage would help to save lives, provide a positive option for unwanted pregnancies, and allow more couples to provide healthy and loving homes for otherwise unwanted children.

TEAM PROTOCOLS FOR CASE REFERRAL

California law requires that all suspicious or violent deaths and those deaths where the decedent was not seen by a physician in the 20 days prior to the death are to be reported to the Department of Coroner. The Coroner is then responsible for determining the circumstances, manner and cause of these deaths.

Every morning, the Coroner's on-duty Supervisor compiles a list of all cases that came to the Coroner's attention during the previous 24 hours. From this compilation, the Coroner has agreed to derive a new list of all children age twelve (12) and under* where one or more of the following factors are present, for review and study by the ICAN Child Death Review Team:

1. Drug ingestion
2. Cause of death undetermined after investigation by Coroner
3. Head trauma (subdurals, subarachnoid, subgaleal)
4. Malnutrition/neglect/failure to thrive
5. Drownings
6. Suffocation/asphyxia
7. Fractures
8. Blunt force trauma
9. Homicide/child abuse/neglect
10. Burns/smoke inhalation
11. Sexual abuse
12. Gunshot wounds
13. Special populations - fetal deaths and suicides are part of separate studies

**Age exceptions are made for apparent suicides, homicides (child abuse) by family member or caregiver and deaths due to drowning.*

Once a case is identified by the Coroner, case specific information is sent to the ICAN offices, where it is routed to Team representatives from the District Attorney's Office, Department of Children and Family Services, Los Angeles Police Department, Los Angeles Sheriff's Department, and Department of Health Services.

Members check each case in their agencies' computers and files for previous contacts with the child or family. Record check findings are then returned to the ICAN office for compilation and analysis.

Selecting cases for comprehensive review by the Team is a process that takes place within the Team itself. Three to five cases that meet the above mentioned criteria are reviewed in depth at each month's meeting. Primarily, high profile cases and cases in which a committee member requests the Team's multidisciplinary perspective, are reviewed by the Team. The Team encourages agency staff involved with the cases to attend the meeting at which that case is discussed to share their observations and findings.

At the end of the year, the Coroner reports summary statistics on all cases reported to the Team to the ICAN Data Information Sharing Committee for its report, The State of Child Abuse in Los Angeles County. This report (ICAN Child Death Review Team Report) expands upon the Coroner's findings by including the results of the record searches of the other member agencies and additional analysis

based upon Team discussion and knowledge.

MANNER OF DEATH

The Coroner has five choices for the manner of death listed on the death certificate: Homicide, Accidental, Natural, Undetermined and Suicide. This report, as have the 9 previous reports by the Team, uses the Coroner's classification scheme to group the manners of child death in the County.

- **Homicides**, by Coroner's definition, are deaths at the hands of another, and if the suspected perpetrator is a parent or caretaker, these cases require evaluation by the Child Death Review Team. Homicide by parent/caretaker is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term regardless of the criminal intent of the perpetrator or the findings of police, the District Attorney, Courts or juries. It describes circumstances ranging from tragedies that involve no clear intent, to vicious, fatal attacks with clear intent.
- **Accidental** deaths are the largest number of deaths reported to the Team by the Coroner. Several of the criteria for reporting, such as drownings, head trauma from falls, suffocations and accidental gunshot wounds, are truly unintentional in nature. There may remain a question of caretaker supervision in some of these cases, as well as concern as to the preventability of these accidents. A portion of the accidental deaths are newborns who were prenatally exposed to drugs and subsequently died of prematurity or other related perinatal causes. The relationship between precipitous drug induced delivery of newborns and child maltreatment fatalities have generated much discussion and concern on the part of the Team.
- **Natural** deaths are rarely reported to the Team. They are reported only when history or condition of the body raises suspicion of child abuse or neglect. SIDS deaths are reviewed at the request of the Department of Health Services SIDS Project. Very few of the estimated 1500 natural child deaths that occur in Los Angeles County are brought to the Team's attention.
- **Undetermined** deaths are situations where the Coroner is unable to fix a final mode of death. Usually, there is no clear indicator in these cases whether the death was 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. These cases include perinatal demise of undetermined cause, which may be child maltreatment related, if the infant was left exposed or unattended. However, the Coroner may not be able to determine if the exposure caused the death or if it was due to some other cause.
- **Suicides** of children and adolescents are reported to the Team as a special population. The Team recognizes that suicide, most often in and of 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 teenagers for prevention purposes.

- **Fetal** deaths are also handled as a special population. They are not reported with other child abuse or suspicious deaths and are reported separately in a special section of the report. They include fetal homicide cases that are a result of violence against the mother.

The gaps between the Coroner's classifications of child deaths and the public's perception of child abuse fatalities create a dilemma with regard to reporting the Team's findings.

The Child Death Review Team's purpose is to work to prevent or minimize child deaths. In order to do so, the Team must work together to confront patterns of preventable child death within the County through coordinated research and analysis of the root causes of these deaths.

It should be noted that the Team is currently working with the Los Angeles County Coroner's office to make changes in the protocol of cases to be reviewed and to overhaul the intake system for determining which cases fit the protocol and should be reviewed and included in this report. Cross checks with law enforcement and other state indices (please see the case conciliation process described in the beginning of the homicide section of this report) indicate that a number of cases were missed. Additionally, the Team became aware of a number of cases with Los Angeles County agency involvement that were not Los Angeles County Coroner cases. Aside from one case where the autopsy was done in Mexico, those cases are not included in this report. A determination as to how to address these non-Los Angeles County Coroner cases will need to be made. The hope is to expand the protocol to include more types of cases, improve the system so that children are not missed and assure the protocol remains manageable given the large population of Los Angeles County. It is clear from the problems that were encountered this year that the planned overhaul of our protocol and intake system is much needed and, when completed, should help to ensure the accuracy of the data presented in this report.

CORONER REFERRALS TO ICAN CHILD DEATH REVIEW TEAM - 1998

197 deaths were reported by the Department of Coroner to the ICAN Child Death Review Team in 1998.

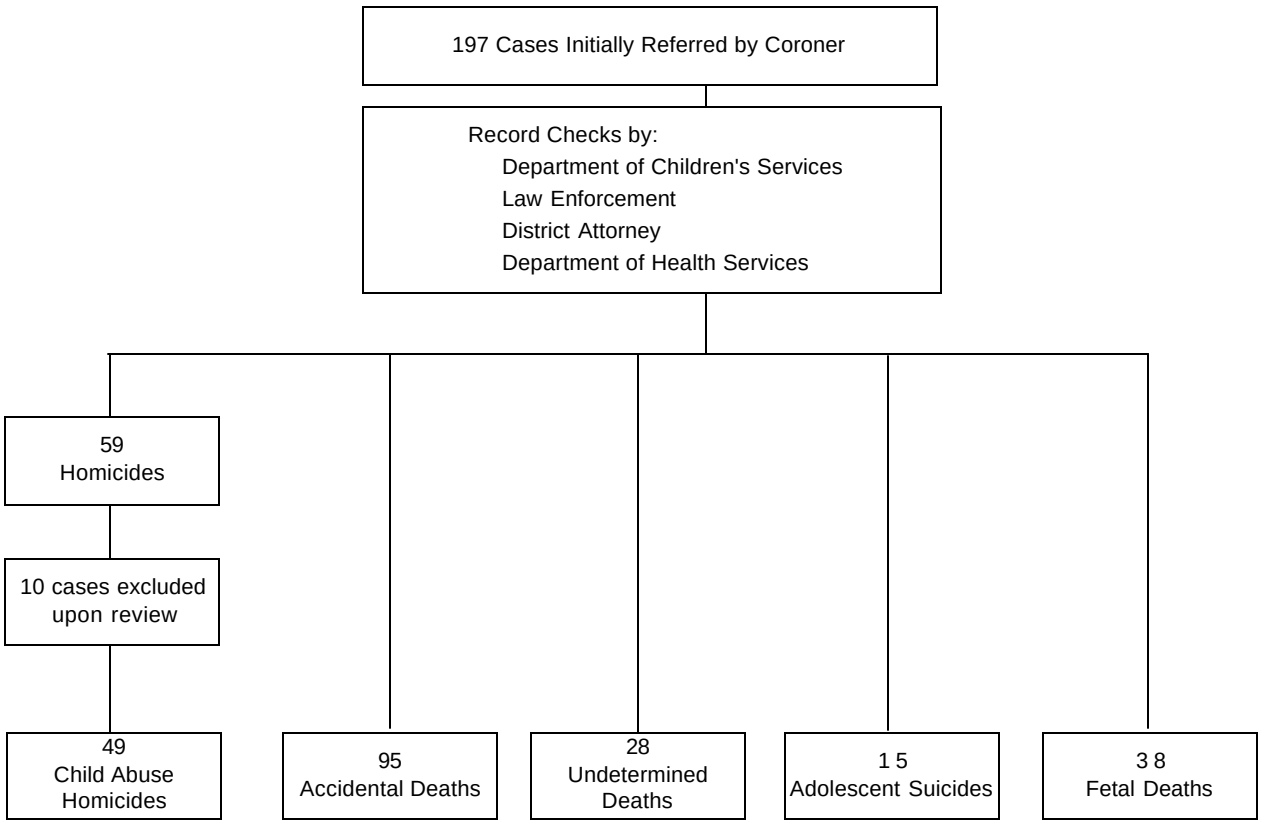
Preliminary review of homicides and reconciliation of the deaths referred by the Coroner to the Team resulted in the removal of 10 out of the 59 homicides that were originally referred to the Team. Of these ten cases, eight involved gunshots, including at least three gang-related shootings, one of which involved a retaliation shooting and one of which involved an exchange of gunfire between 2 rival gangs. In four of the shooting cases, no suspect has been identified. There was also one child killed in an arson fire and one child who was strangled.

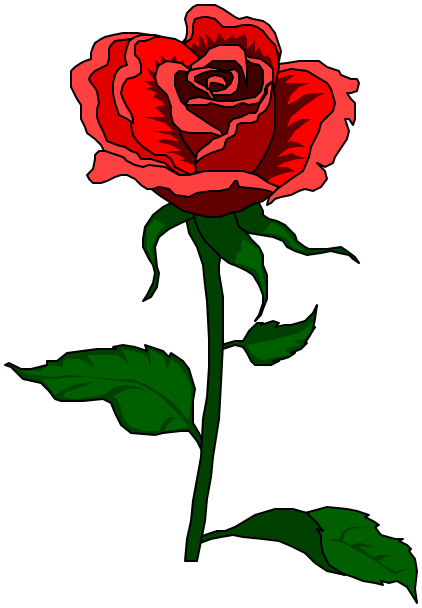
In addition to the 59 homicides (49 by parent/caretaker/family member), 95 accidental deaths, 15 adolescent suicides, and 28 undetermined deaths were referred to the Team. No natural deaths were referred to the Team in 1998.

Figure 1 on the next page summarizes how the 197 deaths referred by the Coroner in 1998 were categorized and where adjustments were made.

Figure 1

FLOW CHART OF CASE DISTRIBUTION FOR ANALYSIS





In the little world in which children have their existence,
Whosoever brings them up,
There is nothing so finely preserved and so finely felt as injustice.

Charles Dickens
Great Expectations

CHILD HOMICIDES BY PARENTS/CARETAKERS/ FAMILY MEMBERS IN LOS ANGELES COUNTY

Deputies of the Los Angeles County Sheriff's Department were conducting a follow-up investigation of an earlier pursuit when they noticed a car parked at the side of the road in a forested area of the county. As they stopped to check on the vehicle, a man and a boy emerged from the forest, the boy's hands covered with mud. Deputies investigated further and found two other children and an adult woman covering a shallow grave with dirt. Deputies dug up the grave and found the body of five year old Enrique. The man (Enrique's father) and woman (Enrique's aunt) were arrested, and the Department of Children and Family Services (DCFS) arrived at the scene and took custody of the three children.

Further investigation by law enforcement and DCFS revealed that the father had been involved with both Enrique's mother and aunt, and had fathered a total of 13 children between them. Previous referrals to DCFS had been received alleging abuse of the children by the father, but allegations had either not been substantiated, or the family could not be located. It was known that Enrique's mother alleged abuse by the father and had left him to seek the safety of shelters on at least two occasions, but had returned to him each time. Each of the surviving children were removed and placed in foster care following Enrique's death.

The Coroner's report stated that Enrique was a five year old boy. He was extremely small (50th percentile in length and 0.5th percentile in weight), and was found buried wearing a diaper. His body was covered with numerous scars. A mark on his abdomen appeared to be from being hit with a wire. He had multiple old and recent rib fractures, and his forearms were deformed and bent from defensive posturing. His brain showed evidence of both old and recent subdural hematomas. The autopsy was clear: Enrique was a malnourished child who had been severely and repetitively physically abused during his life.

The surviving siblings also showed evidence of chronic abuse and neglect. Each sibling was malnourished and undersized, appearing younger than his or her ages. Several children had old and more recent scaring from being hit with objects. Each child also had language delays. They also confirmed the autopsy findings regarding Enrique's life and death: the father had beaten him numerous times throughout his young life, and neither the mother nor the aunt had ever intervened to protect him or any of the siblings.

Shortly after Enrique was found, Sheriff's detectives investigating the gravesite area found the grave of his sibling, Marisela. Marisela was two years old when she was killed. According to the surviving siblings, Marisela was killed about a year before Enrique. The siblings reported that they had all been living with their father and their aunt in a garage when Marisela awoke one night, crying because she had wet herself. The father reportedly beat her with a belt, then hit her against a wall. The aunt cleaned Marisela up and changed her clothes. But, when she continued to cry, the father beat her with the belt some more and threw her against the wall. She subsequently lost consciousness. The father and mother of Marisela apparently took her up to the forest for burial, assisted by some of the siblings. In order to prevent her identification, the father

poured acid over her body. The siblings were instructed to never speak of her.

As the investigation of the deaths and the family history progressed, it was clear that the father of the children had been involved in abusive relationships with both the mother and her sister, had fathered children by both women, and had controlled the women and the children in the family with violence and intimidation. The family lived in extreme poverty and was moved frequently by the father, including back and forth across the U.S.-Mexico border.

The father was charged with murder in the deaths of both Enrique and Marisela. The mother and aunt were initially charged with murder as well, though the murder charges were eventually dropped. They have since been prosecuted for failure to protect the children in their care.

The Team focused on the needs of the surviving siblings in this case, who suffered from their own history of abuse and terror at the hands of the father. They had also witnessed the abuse and murder of their young siblings, and in some cases had been forced to participate in the burial of the bodies. Adoptive placements for two sets of siblings were found in this case, and the oldest sibling, now 18, has gone to live with a relative. All of the siblings were eventually provided with clinically and culturally appropriate counseling, in part due to the advocacy of a Team member who worked with the family from the beginning.

Fifty-nine homicides meeting ICAN referral protocol were reported to the Team by the Coroner for 1998. Following review of law enforcement records, ten cases were determined not to have been perpetrated by parents, caretakers or family members. Of these ten cases, eight involved gunshots, including at least five gang-related shootings. In one of these cases, a 2-year old boy was shot and killed during an exchange of gunfire between two rival gangs. In another case the victim was shot as he stood on the landing of his second story apartment. The suspect, who was standing in the street with a group of males, walked up to the victim and shot him three times. The suspect and his companions then drove away in a van. The victim is the brother of an individual who was involved in a neighborhood brawl prior to his murder. In yet another case, the suspect and several other males were playing cards and drinking in a courtyard area near the victim's home. Earlier in the morning the victim's father had asked the suspect and his companions to be quiet because they were disturbing his family. The group subsequently left and the suspect went to a truck, armed himself with a handgun, walked back to the location and opened fire into the victim's house. The victim's parents were also shot but survived the attack. In addition to the eight deaths due to gunshots, there was also one child killed in an arson fire and one child who was strangled.

It should be noted that two of these excluded cases involved children who had an open case with the Department of Children and Family Services (DCFS). In one of these cases, the 12-year old victim was shot by the owner of a furniture store when the boy attempted to rob the store at gunpoint. Although this child was on informal probation, it was not known that he was involved with gangs and it is believed that this involvement with gangs led to this incident and thus contributed to his death. In the other case, the victim had been placed with a relative due to his mother's substance abuse and her inability to properly supervise him. However, he was abducted from this placement by his mother and at some point became separated from his mother. His body was later found in a trash dumpster and he had been manually strangled to death. He is one of three children in 1998 abducted from their placement through the Department of Children and Family Services who were killed.

This year, as discussed in the Team Protocol section of this report, there were difficulties both in determining which cases to include as a part of the protocol and in ensuring that all cases which fit the protocol were identified. In the process of preparing this report, it became clear that the protocol needed to be revised to become clearer. The Team is also interested in expanding the protocol so that it is more inclusive. As discussed in the Team Protocol section of this report, the Team is working with the Los Angeles County Coroner's office to overhaul the intake system used to determine which cases meet the protocol and should be included in this report. It seems clear from the initial phases of this work that cases that should have been reviewed were either not identified as meeting the protocol or were simply missed and thus are not included in this report. Further, the Team has identified a number of cases that had Los Angeles County agency involvement but were not Los Angeles County Coroner cases. Aside from one case where the autopsy was performed in Mexico (another abduction case of a child abducted from his placement with his Maternal Aunt, taken to Mexico and subsequently killed by his parents), those cases are not included in this report. As a part of the changes to be made in the Team Protocol, the Team must determine how to address these non-Los Angeles County Coroner cases and whether or not to include

Figure 2

1989 - 1998 ICAN CHILD HOMICIDES

BY PARENTS/CARETAKERS/FAMILY MEMBERS

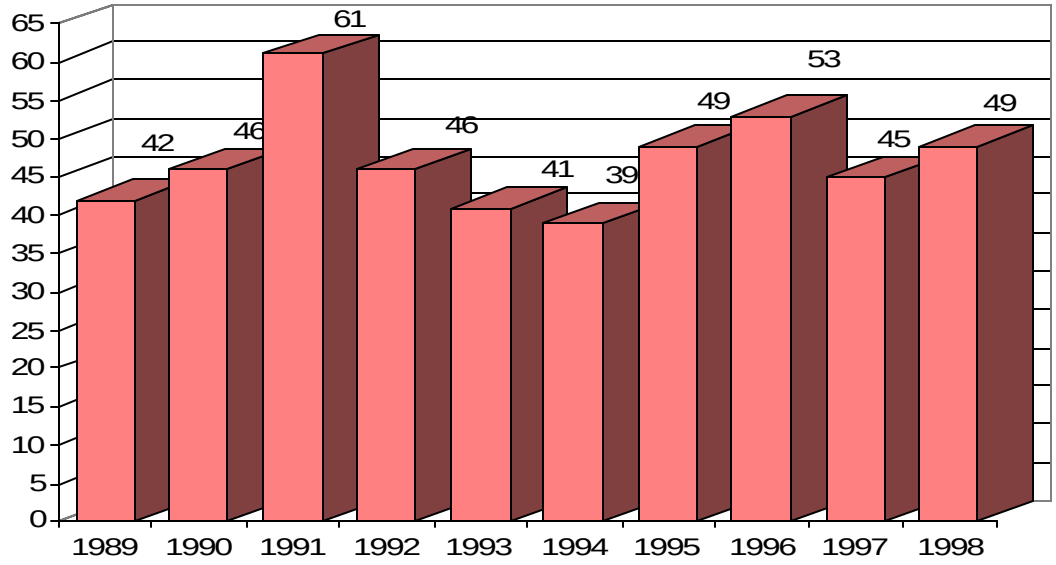
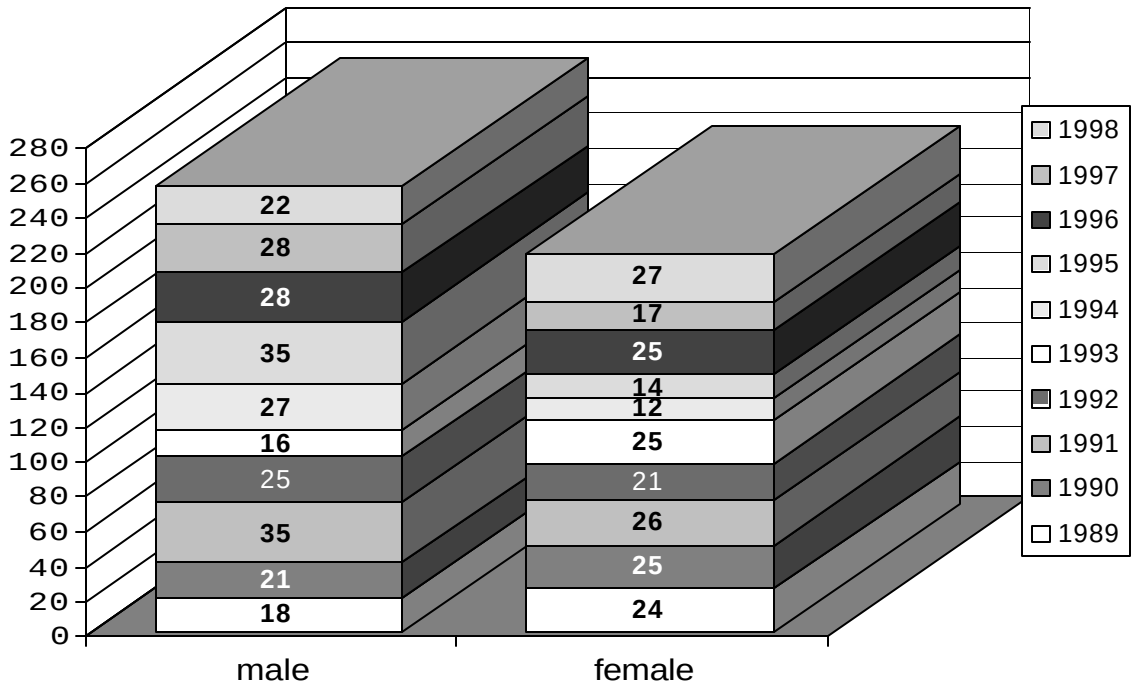


Figure 3

1989 - 1998 ICAN CHILD HOMICIDES

BY PARENTS/CARETAKERS/FAMILY MEMBERS BY GENDER



them as a part of this report.

Additionally, in an effort to assure that all child homicide cases meeting the protocol are identified, the Team receives data from the California Department of Justice Uniform Crime Reports-Supplemental Homicide File, the California Department of Justice Child Abuse Central Index and the California Department of Health Services Vital Statistics. The child homicide cases listed in these indices are then reconciled with the child homicide cases received from the Coroner's office. This year, the data from these three state indices was not received in time to complete the case conciliation process. However, it is clear from an initial review of this data that there are cases that most likely fit the protocol that were not identified in time to be included in this report.

As a result of the above, it is important to note that there are additional cases that have not been identified by the Team and the data reflected below should be viewed with this in mind.

Given these adjustments and the above referenced difficulties with Team protocols and case conciliation, the Team has determined that **there were 49 child homicides perpetrated by parents, caregivers or family members in Los Angeles County in 1998.** This is an increase of 9 % from the 45 child homicides by parents, caregivers or family members in 1997 and is consistent with the previous 10-year average of 47. Figure 2 displays by year the 471 child homicides by parents, caregivers or family members referred to the Team by the Coroner for the period of 1989 through 1998.

GENDER

In 1998, 55% (n=27) of the victims of child homicide by parents, caregivers or family members were female, while 45% (n=22) of the victims were male. Over the past 10 years, there have been a total of 255 male victims (54%) and 216 (46%) female victims.

The percentage of female victims has ranged from the low of 29% in 1995 to a high of 61% in 1993. The number of female victims varied little until 1994, averaging 21 per year and ranging from 21 to 26. Since then, other than 1996's number of 25, the number of female victims had ranged from 12 to 17. However, this year's number of 27 is the highest number of female homicide victims over the last ten years.

The number of male victims has had a much greater fluctuation over the past ten years. The average has been 25.5 per year, and has ranged from a low of 16 in 1993 to a high of 35 in 1991 and 1995.

Figure 3 displays the gender breakdown of the child abuse homicide victims for the past 10 years.

AGE

The ages of the victims of homicide by parents, caretakers or family members between 1989 and 1998 are displayed in Figure 4. In 1998, 33% of the victims were under the age of six months, 43% under the age of 1 year and 59% of the victims were age 2 or younger. 73% of the victims were age 5 or younger and there were five victims of homicide by parents, caretakers or family members who were between the ages 6 and 9. In 1998, eight victims of homicide by parents/caretakers/family members over the age of 10 years were identified.

Over the past 10 years, 43% (n=203) of the victims have been under the age of 1 year, 85% (n=400) have been under the age of 5 years.

The ages of the victims in 1998 have risen as compared to the ages of the victims last year. Between 1989 and 1993, approximately 60% to 65% of child victims of homicide by parents, caretakers or family members were under the age of 2 years. In 1994 that level rose to 72% and in 1995 to 73%. However, in 1998 that level has fallen to

51%. In previous years, 90% or more have been under the age of 5 years, whereas this year, 73% of the victims are under the age of 5. It is believed that the average age of child homicide victims in 1998 increased because there were two different families, one of three children and one of four children, ranging in age between 4 and 13 who were killed by their father and mother respectively.

Table 1 displays the relationship between the age and sex of the victims of child homicide by parents, caretakers or family members in 1998. The average age of female victims was 4.3 years, the median, 907 days or 30 months. The average age of female child victims has decreased over the previous 9 years, with the exception of 1996 where it increased to 4.8 years. In 1989, the average age was 3.1 years, increasing to 3.8 years in 1990, then decreasing to 2.2 years in 1991, 1.7 years in 1992, 1.6 years in 1993, 1.3 years in 1994 and 1.6 years in 1995 and 1.9 in 1997. In 1998, however, the average age of female child victims has gone back up to the highest level since 1996 when the average age was 4.8 years, the highest it has ever been. Four of the 1998 victims who were killed on the day of birth were female as was the oldest victim.

The average age of the male victims in 1998 was 2.8 years, with the median being 270 days. The average age of male victims has remained fairly constant over the last 9 years with a low of 1.6 years in 1989 to this year's high of 2.8 years. Three of the 1998 victims who were killed on the day of their birth were male.

Figure 4

1989 - 1998 ICAN CHILD HOMICIDES
BY PARENTS/CARETAKERS/FAMILY MEMBERS BY AGE

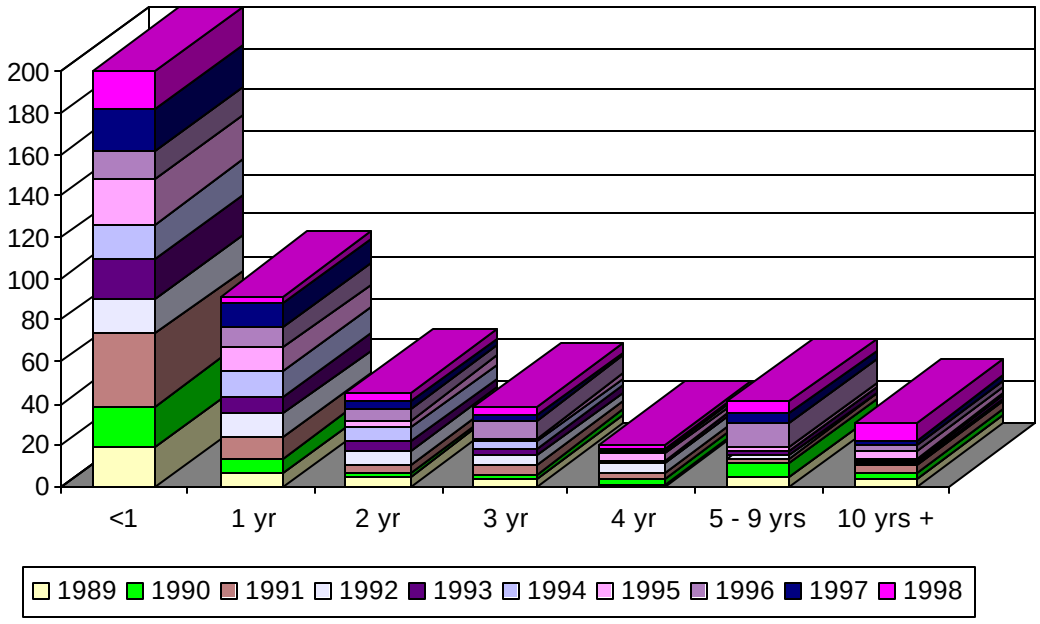


Table 1

1998 ICAN CHILD HOMICIDES
BY PARENTS/CARETAKERS/FAMILY MEMBERS BY AGE AND SEX

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

ETHNICITY

In 1998, 57% of the victims of child homicide by parents, caretakers or family members were Hispanic (n=28). This is a 21% increase from 1997. African Americans represented 22% (n=11) of the child homicides by parents, caretakers or family members, a decrease of 29% from 1997. There were 8 White victims, representing 16% of the total and 1 Asian homicide, representing 2% of the total. The Coroner was unable to determine the race/ethnicity of one of the victims.

1990 U.S. Census figures show the child population in Los Angeles County to be 48.2% Hispanic, 27.9% White, 12.3% African American and 12.0% Asian. When the child homicides by parents, caretakers and family members are compared to these child population statistics, African American children continue to be over-represented. Hispanics in previous years have been approximately equal to their child population rate, however, in 1998, they are also over-represented. White and Asian children, as in prior years, are under-represented. Table 2 displays the ratio between the percentages of child homicides by parents/caretaker/family member and by child population.

From a multi-year perspective, as illustrated in Figure 5, the ratio of African American children who are victims of homicide by parents/caretakers/family members every year from 1989 has been greater than their composition within the Los Angeles community. Hispanic child homicides by parents/caretakers/family members have increased, not only in real numbers, but also in relationship to the Hispanic percentage of child population. Asian children have been consistently under-represented in child homicides by parents, caretakers and family members, except in 1991. Since 1991, White children had shown a steady decline in child homicides by parents, caretakers and family members until 1995 and 1996. While this number had again declined in 1997, this year, there has been an increase of 26% in these numbers. Because the number of child homicides by parents/caretakers/family members is extremely small in relationship to Los Angeles County's overall child population, relative increases or decreases in the numbers of deaths in any one racial/ethnic group may make the percentage vary a great deal.

Table 2

1998 ICAN CHILD HOMICIDES

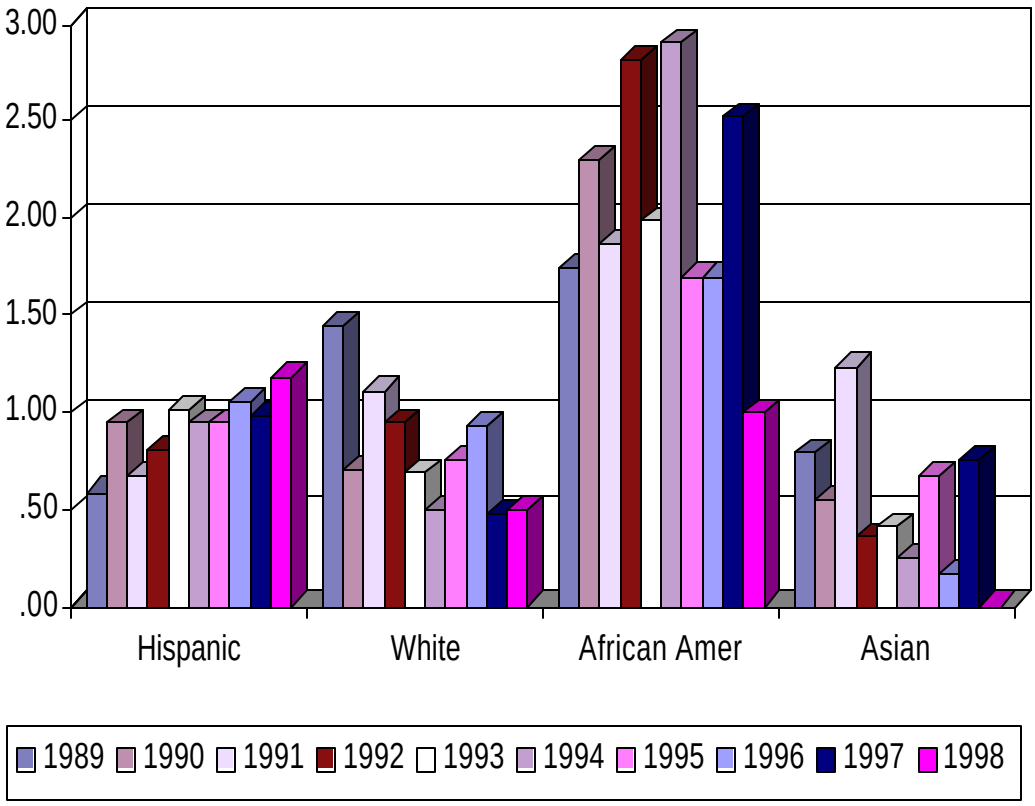
BY PARENTS/CARETAKERS/FAMILY MEMBERS BY RACE

Race	Number	%	Child Pop	Ratio*
Hispanic	28	57	48.2	1.18
White	11	22	27.9	1.79
African American	8	16	12.3	0.57
Asian	1	2	12.0	0.17

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

Figure 5

1989 - 1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
- ETHNICITY % COMPARED TO POPULATION %



CAUSES OF DEATH

In 1998, the leading cause of death in child homicides by parents, caretakers and family members was head trauma, claiming the lives of 26.5% (n=13) of the victims. Deaths due to gunshots was the second leading cause of death comprising 20.4% (n=10) of the cases.

Table 3 and Figure 6 display the different causes of child homicide by parents/caretakers/family members for the period between 1989 and 1998. The most frequent cause of death for all ten years, and comprising 35.4% of all child homicides by parents/caretakers/family members was head trauma. Multiple trauma was the second most frequent cause of death, representing 16.1% of the total deaths. Homicide by guns represented the third most frequent cause of death over the previous nine-year period, but this year became the second leading cause of death. Deaths due to gunshots represent 11.4% of the total homicides by parents/caretakers/family members over the past ten years. Gunshot victims in 1998 included a newborn and her 17 year old mother (maternal assault), a family of three siblings ages 13, 9 and 4 who were shot by their father, another family of two siblings ages 3 and 1 who were shot by their mother and a 1 year old who was shot by her father and then buried in the forest.

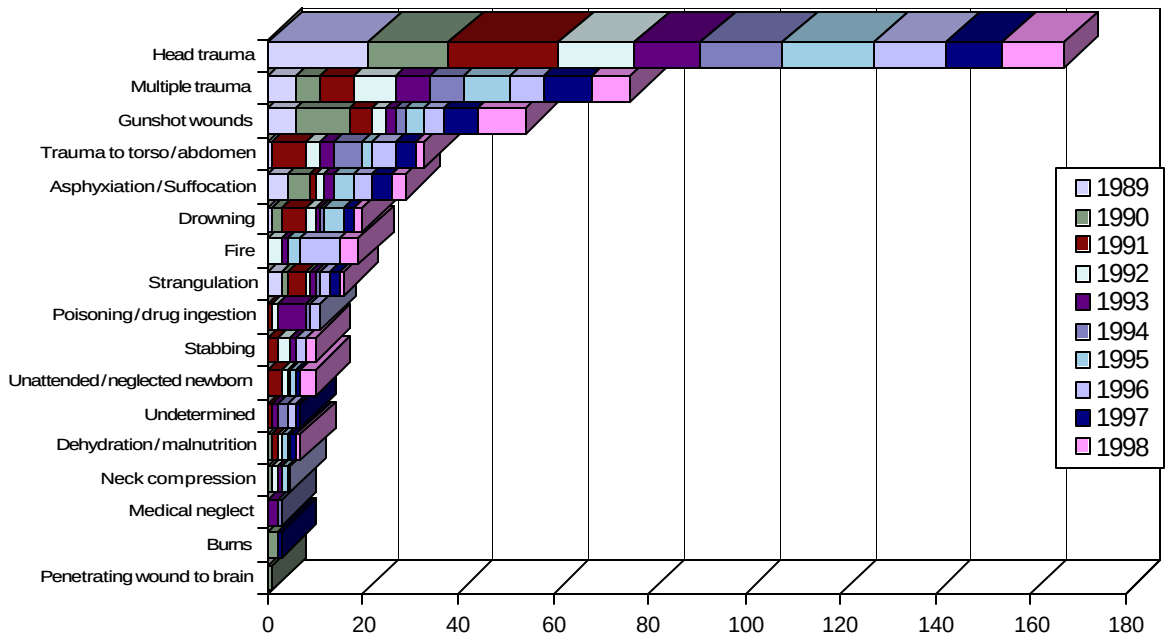
Table 3

CAUSES OF CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS 1989 - 98

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	T0TAL
Head trauma	21	17	23	16	14	17	19	15	12	13	**167**
Multiple trauma	6	5	7	9	7	7	10	7	10	8	**76**
Gunshot wounds	6	11	5	3	2	2	4	4	7	10	**54**
Trauma to torso/abdomen	1		7	3	3	6	2	5	4	2	**33**
Asphyxiation/Suffocation	4	5	1	2	2		4	4	4	3	**29**
Drowning	1	2	5	2	1	1	4	0	2	2	**20**
Fire				3	1		3	8		4	**19**
Strangulation	3	1	4	1	1	1		2	2	1	**16**
Poisoning/drug ingestion			1	1	6	1		2			**11**
Stabbing			2	3	1			2		2	**10**
Unattended/neglected newborn				3	1		1	1	1	3	**10**
Undetermined			1		1	2		2	1		**7**
Dehydration/malnutrition		1	1	1			1	1	1	1	**7**
Neck compression		1		1	1		1	1			**5**
Medical neglect					2	1					**3**
Burns		2							1		**3**
Penetrating wound to brain		1									**1**
TOTAL	**42**	**46**	**60**	**46**	**42**	**39**	**49**	**53**	**45**	**49**	**471**

Figure 6

1989 - 1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS - CAUSES OF DEATH



TEMPORAL PATTERN

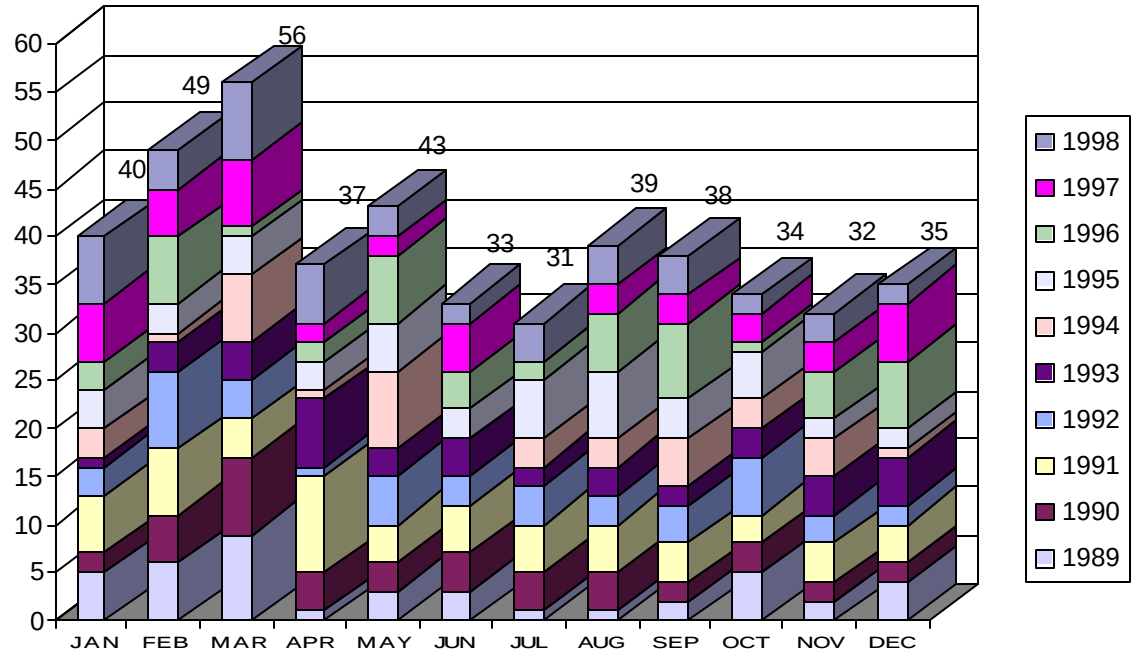
In 1998, the greatest number of child homicides by parents/caretakers/family members occurred in March (n=8). The second greatest number of homicides occurred during January (n=7). The fewest number of homicides occurred in June, October and December (n=2). At least 2 child homicides by parents/caretakers/family members occurred in every month of 1998.

Figure 7 displays the child homicides by parents/caretakers/family members by month for the past ten years. During the period of 1989 through 1998, the greatest number of child abuse homicides occurred during the month of March. The least number of child homicides by parents/caretakers/family members have occurred during July and November.

The 471 homicides by parents/caretakers/family members during the past ten years translates to an average of 3.9 per month. While actual deaths in any given month vary, June 1994 and July 1997 were the only months in the past ten years in which no child homicides by parents/caretakers/family members were recorded.

Figure 7

1989 - 1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS BY MONTH



CHILD PROTECTIVE SERVICE INVOLVEMENT

At 5:00 a.m. paramedics were called to an apartment complex due to a report of a non-responsive 11 month old. When paramedics arrived, the mother and a babysitter, who reported that Cassie was dead, met them. Paramedics attempted to resuscitate Cassie, but she never regained a heartbeat. The mother, who lived in an apartment unit at the other end of the complex, reported to police who responded that she had dropped off Cassie with the sitter at 7:00 p.m. the previous night, and that the sitter had ran to get her before she called paramedics. The mother, who lived in an apartment with her children and numerous other people, was reported by other residents to be a poor mother, one who had frequently left her children for extended periods with unrelated caregivers, and who had been observed shaking Cassie on at least one occasion previously.

The mother had previously had a two year old child removed by the Department of Children and Family Services (DCFS) after she had abandoned her with a babysitter. Her parental rights were eventually terminated in that case, and the child was placed in the Adoptions Division of DCFS. She subsequently had another child, Omar, who was four years old at the time of Cassie's death. Omar was removed from the home by Children and Family Services on the morning of Cassie's death and placed in a foster home.

On the morning of Cassie's death, the mother was arrested. She was released, however, pending completion of the autopsy report. The autopsy report revealed that the cause of death was blunt force trauma, not Sudden Infant Death Syndrome (SIDS) as originally suspected at the hospital. The autopsy showed that the infant had been spanked, and that there had been a blow to the head. The injuries were acute, or recently inflicted. The death was determined to be a homicide.

Law enforcement, following a detailed investigation, determined that the babysitter had sole care of Cassie for at least 48 hours prior to the paramedics being called, not approximately eleven hours as reported previously by the sitter and the mother. In addition, the mother and the babysitter each gave different stories to the DCFS social worker than they had given to law enforcement. The sitter claimed that the mother had actually dropped the baby off with her several days before the death and had not returned for her. Given the acute nature of the injuries and the apparent length of time that Cassie was with the sitter, the babysitter appeared to be the primary suspect. As the law enforcement investigation progressed, however, several witnesses retracted their statements, and neither the mother nor the babysitter has yet been charged in Cassie's death.

At the time of review by the Team, County Counsel and DCFS were seeking a no-reunification order regarding the mother's four year old child, Omar. However, if the babysitter were to be charged with Cassie's death, a plan for family reunification between Omar and his mother would be developed, despite the earlier removal of a child from her custody and her own documented history of substance abuse. Omar's father has not been located. The court ordered grief and morning therapy for Omar, who had been asking about his baby sister while in placement. DCFS social workers arranged for the therapy for Omar, and they continue to monitor the criminal investigation of Cassie's death.

Twenty of the families in which there was a child homicide by parent/caretaker/family member had a record of contact with the Department of Children and Family Services (DCFS) prior to the death of the child. These 20 families represent 40.8% of the total child homicides by parents/caretakers/family members. This rate is comparable to the national average of 41% reported by the National Committee to Prevent Child Abuse (1997). Four cases were open at the time of the child's death.

For the period of 1989 through 1992, there were eleven families each year with DCFS contact prior to the child's death. In 1993, 13 families had received prior DCFS contact, in 1994, 12 families received prior DCFS contact, in 1995, 15 families received prior DCFS contact, in 1996, 13 families had received prior DCFS contact and in 1997 15 families had a record of prior DCFS contact. Figure 8 displays the number of homicides by parents/caretakers/family members with prior child protective services when compared to the total number of cases for the past 10 years.

The twenty cases with prior referrals to DCFS accounted for a total of 32 prior referrals. Of these twenty cases 75% (n=15) of the families had one prior referral and 10% (n=2) had two prior referrals. There were also two families that had four prior referrals and one family that had five prior referrals to DCFS.

The reasons for prior DCFS services are listed in Table 4. In 1998, 37.5% (n=12) of the prior case openings were for allegations of neglect. Allegations of physical abuse (n=10) accounted for 31% and allegations for caretaker absence/incapacity (n=6) accounted for 18.7% of the referrals. There were also allegations for sexual abuse (n=1), pre-natal drug exposure (n=1), and one allegation of child endangerment related to domestic violence. In one case the reason for the prior referral was unknown.

Compared to prior years, 1998 was only the second time in six years that physical abuse was not the most frequent reason for prior DCFS services. In 1989, 1992, 1994, 1995 and 1996 the most frequent reason was physical abuse. In 1990, 1991 and 1997, the most frequent reason was for neglect. In 1993, the most frequent reason was prenatal substance abuse.

Table 5 provides a comparison between the date that DCFS opened the prior child protective services case and the date of the children's deaths. Fifteen of the 32 prior referrals had been opened in the 6 months prior to the child's death. In fact, in one of these cases four referrals for general neglect were made to DCFS over the three month time period before the child's death, including one referral seven days prior to the child's death from starvation and malnutrition. In three other cases, DCFS had received referrals for physical abuse within two to five months of the child's death and after investigation had closed the cases based on medical opinions indicating minimal concerns for child abuse. All three children were subsequently beaten to death by their caregivers. Of the other prior referrals, one had been opened between 6 months and 1 year prior to the child's death and five of the referrals had been opened over 1 year prior to the death. This pattern is similar to prior years.

In the twenty cases (totaling 32 referrals) that had prior DCFS contact, DCFS had proceeded with Dependency Court action on six of them. In the fourteen other cases, the allegations were either unfounded or unsubstantiated or the situation was stabilized and the case was subsequently closed. Short-term interventions of no more than 3 months were provided in seven of these fourteen cases.

Figure 8

1989 - 1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS

CHILD PROTECTIVE SERVICES INVOLVEMENT

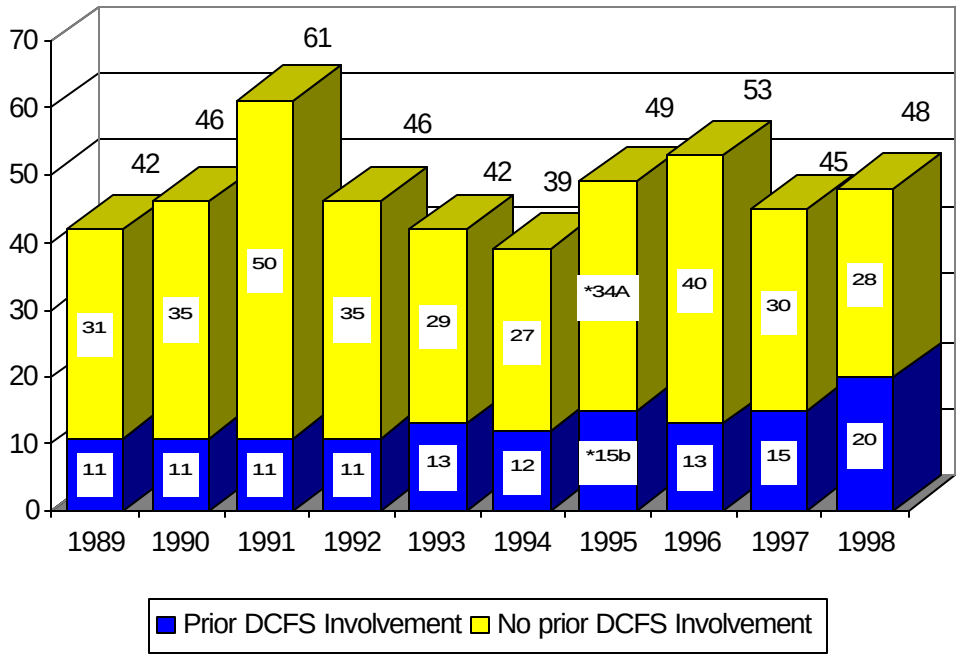


Table 4

1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS

REASONS FOR PRIOR CHILD PROTECTIVE SERVICES

Reason	n	%
General and/or medical neglect	12	37.5
Physical abuse	10	31
Caretaker Absense/incapacity	6	18.7
Sexual abuse	1	3.2
Prenatal substance abuse	1	3.2
Domestic Violence/Child Endangerment	1	3.2
Unknown	1	3.2

Table 5

1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS

LENGTH OF TIME BETWEEN PRIOR DCFS CASE OPENING AND DATE OF DEATH

Time Frame	n	%
1 to 6 months	15	46.8
6 to 12 months	1	3.3
1 to 2 years	5	15.6
2 years or more	11	34.3

** a) Two additional families had prior CPS contact but cases were closed prior to the birth of the deceased child.*
b) The whereabouts of one mother and child were unknown to DCFS at the time of the child's death.

Table 6

1998 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS

REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING THE DEATH

Reason	n	%
Physical abuse	26	96
Severe neglect	1	4

Table 7

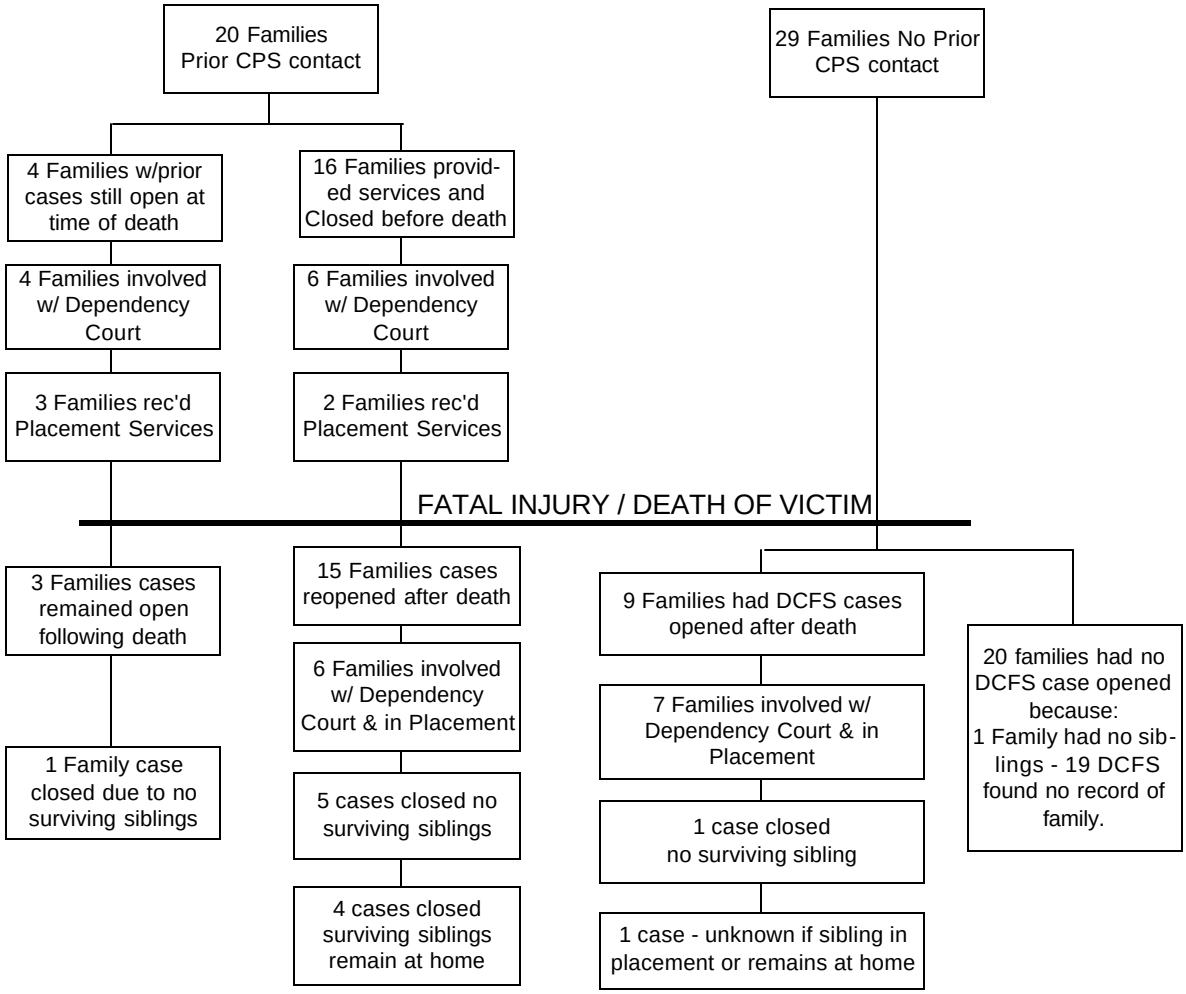
AGES OF MOTHERS IN 1998 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/ FAMILY MEMBERS

Age	n	%
Under 20 years	4	13
20 to 24 years	8	27
25 to 29 years	3	10
30 to 34 years	9	30
35 years and over	6	20

Figure 9

CHILD PROTECTIVE SERVICES ACTIVITIES ON 1998 CHILD HOMICIDES

BY PARENTS/CARETAKERS/FAMILY MEMBERS



Four cases, 8% of all 1998 child homicides by parents/caretakers/family members, were open to DCFS at the time of the death. Three of these four cases received detailed review by the Team. DCFS had proceeded with Dependency Court action on all 4 of these cases and 2 of the deceased children had at one time been placed in out-of-home care. Two of these children died while in out-of-home care, although one died while placed in a medically fragile foster home. This child had been placed in a specialized medical placement as a result of the injuries she received when she was shaken at 3 months of age and she subsequently died in this placement from complications resulting from those earlier injuries. The other child had been placed with his Maternal Aunt as a result of allegations of physical abuse, substance abuse and neglect. This child, along with several of his siblings, was abducted from this placement during a monitored visit with his mother when the Maternal Aunt went to take a shower. The mother and step-father took the children to Mexico where they subsequently beat this child to death, placed his body in a suitcase and dumped it along the side of the road. His siblings have since been recovered and remain placed in out-of-home care.

In the other two cases the children remained placed at home. In one of these cases, a referral for physical abuse was made when the child, who was 3 months of age at the time, was brought to the hospital with a spiral fracture of the right femur. An investigation concluded that this child's injury was not child abuse related but a case was opened and family preservation services initiated due to the child's young age. Less than one month later, this child was killed as a result of battered child syndrome. The finding that this child's initial injury was not the result of child abuse was made in consultation with medical professionals and is in addition to the three cases mentioned earlier where prior allegations of physical abuse were unsubstantiated based on information provided from the involved medical professionals. In the other open case, the Department had an open case for a sibling who had been abandoned by the mother. This child was residing in out-of-home care and the Department was not aware that the mother had another child and subsequently gave birth to a third child. Upon the death of this third child, age 2 months, due to blunt force trauma and battered child syndrome, the other sibling was discovered and placed in out-of-home care.

In addition to 3 of the cases that were open to DCFS at the time of the child homicide by parent/caretaker/family member, fifteen of the sixteen cases that were previously known but closed by DCFS were referred immediately following the death or fatal injury.

9 additional families previously unknown to DCFS were referred for services immediately following the death or fatal injury. The reasons for referral on the 27 families that received services following the death are displayed in Table 6. All but one of the cases were opened for physical abuse due to the death (n=26). One additional case involved allegations of severe neglect.

DCFS closed 6 of the 27 cases shortly after the death as there were no surviving siblings in the home. Another 4 cases were closed shortly after the death as DCFS determined that the surviving siblings would be safe without further intervention. In these cases, referrals for grief counseling for the surviving family members were made. In one additional case it is unclear from the information provided if the surviving sibling remains at home or was placed in out-of-home care. Conflicting information was provided in that DCFS indicated that the child remained at home with the mother while information from law enforcement indicated

that the mother had been arrested for the death of the child's sibling.

Petitions were filed in Juvenile Dependency Court on siblings of the deceased child in 16 cases following the child homicide by parent/caretaker/family member. 34 siblings in 15 families were removed from the home and placed in out-of-home care. (Note: there are 15 families from these 16 cases as there were two children from the same family who were brutally murdered by their father and buried in the Angeles National Forest. There are 5 surviving siblings from this family. In addition, there were two other families where there were multiple murders. In one of these families the father shot and killed all 3 children leaving no surviving siblings. In the other case, the mother attempted to kill all 5 of her children by deliberately setting a fire. In this case, 4 of the children were killed and 1 child survived. This child remains placed with his father.)

Figure 9 summarizes the child protective services involvement in the 1998 child homicides by parent/caretaker/family member.

The Department of Children and Family Services provides information regarding demographics of families known to either them, or the Department of Public Social Services through the Child Welfare Services/Case Management Services (CWS/CMS) Information System. These data include:

- 53% (n=26) of the families in which a child homicide by parent/caretaker occurred, had a history of receiving public assistance from the Department of Public Social Services. Between 1989 and 1997, the percentage of families with prior public assistance ranged from 49.2% to 62.5%.
- The mother's age was known in 61% (n=30) of the cases. In 1998, the average age of the mothers was 28.2 years; 40% of the mothers were under the age of 25 years at the time of their child's death. Between 1989 and 1995, the percentage of mothers whose age was below 25 ranged from 42.4% to 84%, but this percentage has dropped in the last few years. In 1996 this percentage dropped to 27.2% and in 1997, the percentage was 39%.
- The father's age at the time of death of the child was known in 42.8% (n=21) of the families. The average age of the fathers was 32.5 years.
- The deceased child had siblings in at least 53% (n=26) of the families. The percentage of families in which there were siblings has ranged from a low of 38% in 1991 to 1996's high of 72%.
- 38.7% (n=19) of the families had a known history of domestic violence.
- 14.2% (n=7) of the families had a known history of substance abuse.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

Law enforcement was called to a local hospital in response to allegations that a woman had come to the hospital and had apparently given birth, but denied that she had given birth and had no baby with her. The woman, a 19 year old immigrant from Korea, eventually admitted that she had given birth and had put the baby in a box covered with towels in her room. She further claimed that the baby was a miscarriage and that she had panicked when the baby was born. Law enforcement eventually responded to the residence and found the newborn in a trash can beneath some bloody towels. The umbilical cord and placenta were still attached to the infant, who was unresponsive and not breathing. A piece of tissue paper was lodged in the infant's mouth. No signs of external trauma were observed by law enforcement, Fire Department or Coroner's office personnel at the scene. Despite efforts to revive the baby, he never regained consciousness and died at the scene.

Following autopsy, the Coroner's office ruled the death a homicide. The baby was an apparently healthy, full-term newborn who weighed approximately 6 lbs. The placenta was still attached, and his well-aerated lungs indicated that he had taken at least several breaths after birth, and had likely cried. Reticular hemorrhages were noted, as was a compression bruise noted on the left side of his neck.

The mother, in the United States for seven years, lived at home with her parents. She claimed that she learned of her pregnancy in the seventh month, when it was too late for termination of the pregnancy. She evidently was able to hide the pregnancy from her family. On the day of the birth, she was home with her sister. The sister heard the shower running for a very long time and came into the bathroom where she found the mother sitting on the floor and bleeding, which the mother attributed to a recent car accident. The mother instructed the sister to go to her car and get some papers related to the accident. The mother wrapped the newborn, who the mother later admitted was still breathing and was crying, in some towels and hid him in a wastebasket in her upstairs bedroom. The sister then returned and took the mother to the hospital.

Once at the hospital, the mother was examined by a doctor, who quickly surmised that she had recently given birth. The mother initially denied the birth, but eventually admitted this to the doctor. The doctor convinced the mother that her mother (the grandmother of the deceased baby) should be told of the birth. The doctor called the grandmother and told her of the birth. The grandmother searched and found the baby. The grandmother then put the baby in a duffel bag and drove to the hospital, leaving the baby in the bag in the trunk of her car. The grandmother then pleaded with the doctor to advise the family how to proceed. The doctor allegedly told the grandmother that the mother should consult a lawyer, as she would likely be criminally prosecuted. He then allegedly told the family that they could send the mother back to Korea, bury the body of the baby and destroy any other evidence. The grandmother then called a family friend who came to the hospital, picked up the car, and threw the duffel bag in a trash can at the family residence. An observant nurse, not the treating doctor, eventually notified law enforcement of the baby's birth and called them to the hospital.

The District Attorney's office filed one count of P.C. 187, murder, against the mother. The jury was, however, given the option to find involuntary manslaughter in this case. The defense argued that the baby died of choking on amniotic fluid moments after birth, while the Coroner's report listed the cause of death as perinatal demise due to asphyxia, either by manual compression or manual strangulation. The mother was subsequently convicted of manslaughter and was sentenced to four years in state prison.

The actions of the doctor in this case were reported to the Medical Board. When interviewed by law enforcement about his actions and statements, he stated that he was not instructing the family what to do, but was informing them of their options. The doctor was apparently reluctant to testify in this case due to his alleged concerns about breaking doctor-patient confidentiality.

The Team was very concerned about the actions of the doctor in this case. Filing of a misdemeanor charge of failing to report the suspected child abuse/homicide, as well as possible discipline by Medical Board against the doctor is pending.

Information on criminal justice system involvement in child homicides by parents/caretakers/family members is gathered from three sources: the Los Angeles County District Attorney's Office, 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 were responsible for the investigation are shown in Table 8.

The Los Angeles Sheriff's Department had investigative responsibility for 59% (n=29) of the child homicides by parents/caretakers/family members, a 55% increase from 1997.

The Los Angeles Police Department had investigative responsibility for 20% (n=10) of the1998 child homicides by parents/caretakers/family members, a 44% decrease over 1997.

10% (n=10) of the cases were handled by jurisdictions other than LASD and LAPD. Seven different law enforcement agencies were responsible for the investigation of child homicides by parents/caretakers/family members in 1998.

63% (n=31) of the case investigations resulted in presentations to the District Attorney's Office by the law enforcement agencies, a decrease of 9% from 1997. This percentage is the lowest since 1990 when 60% of the cases were presented to the District Attorney's Office for the filing of criminal charges. The presentation percentage for the past 10 years is displayed in Figure 10.

Eighteen of the 1998 cases involving child homicide by parents/caretakers/family members were not presented to the District Attorney. The reasons that those cases were not presented are displayed in Table 9.

The 31 case presentations by law enforcement resulted in the District Attorney's Office filing criminal charges on 90% (n=28) of the 1998 cases.

The percentage of case presentations which have resulted in the District Attorney filing criminal charges has ranged from 66% to 97% in the 9 years prior to 1998. The filing percentages for the past 10 years are represented in Figure 11.

Table 8

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1998 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/ FAMILY MEMBERS

Agency	n	%
LASD	29	59
LAPD	10	20
Inglewood P.D.	3	6
Long Beach P.D.	2	4
Compton P.D.	1	2
Gardena P.D.	1	2
Glendale P.D.	1	2
Pomona P.D.	1	2
Mexico	1	2

Figure 10

1989 - 1998 LAW ENFORCEMENT PRESENTATION % OF ICAN CHILD HOMICIDES
BY PARENTS/CARETAKERS/FAMILY MEMBERS

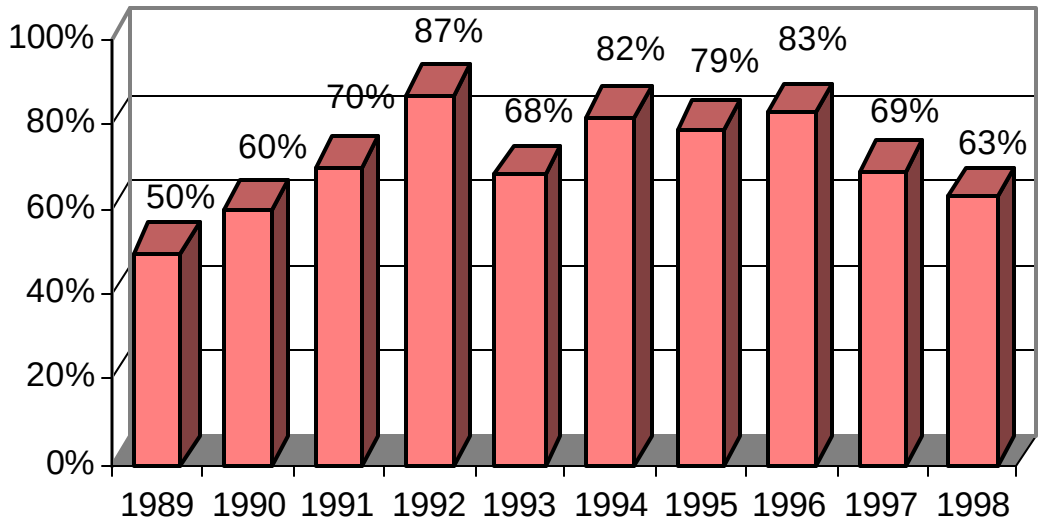


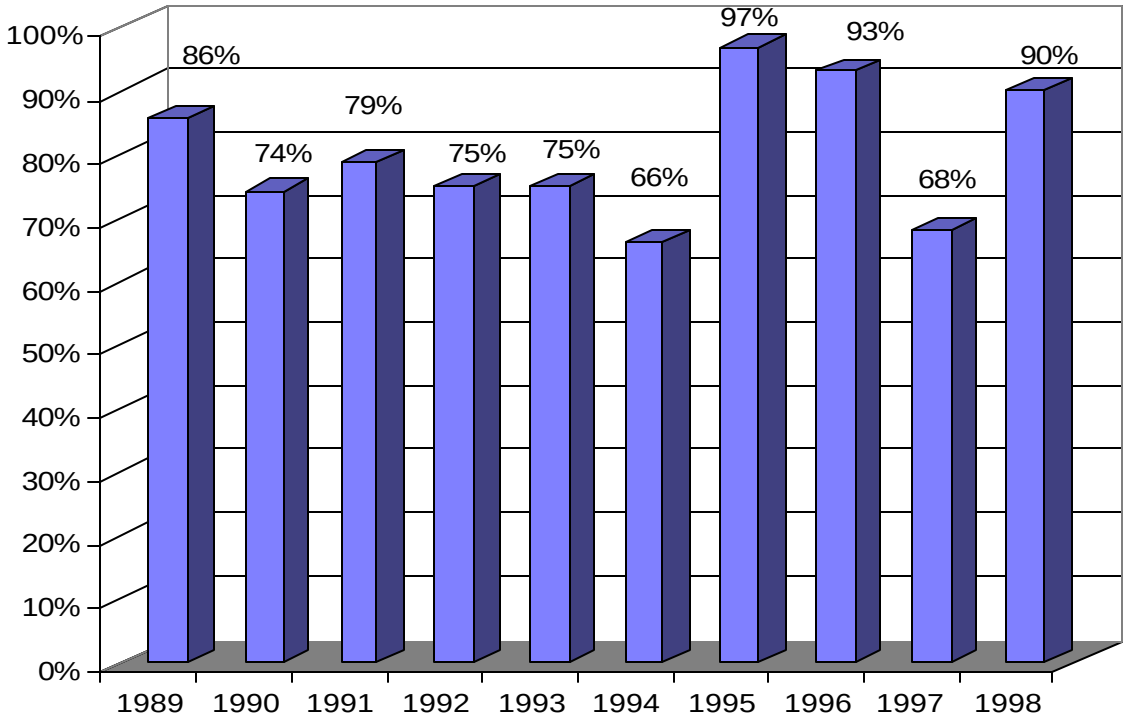
Table 9

LAW ENFORCEMENT REASONS FOR NOT PRESENTING 1998 ICAN CHILD HOMICIDES BY PARENT/CARETAKERS/ FAMILY MEMBERS

	n	%
Murder/suicide	7	38.25
Suspect's identity unknown	5	28.25
Insufficient Evidence	4	22.50
Pending further investigation	1	5.50
Death Occurred in Mexico	1	5.50

Figure 11

1989 - 1998 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS FILING RATE ON CASES PRESENTED TO THE DISTRICT ATTORNEY
BY LAW ENFORCEMENT



Three of the 1998 cases presented by law enforcement to the District Attorney were rejected. Two were rejected because of insufficient evidence of a crime. One was rejected as the District Attorney did not believe there was sufficient evidence to determine who of the many possible caretakers/suspects had actually inflicted the injury. One drowning case involving caretaker neglect was rejected by the District Attorney's Office due to insufficient evidence but was subsequently presented to the City Attorney's Office. The City Attorney then filed misdemeanor child endangerment charges against the mother. The number of cases rejected by the District Attorney's Office has fluctuated over the past 10 years. In 1989 there was only 1 rejection, in 1990 there were 5 cases rejected, in 1991 there were 7 cases rejected, in 1992 there were 10 cases rejected, in 1993 there were 5 cases rejected and in 1994 there were 11 cases rejected. However, in 1995 no cases were rejected and in 1996 (as in 1998) only 3 cases were rejected. In 1997, though, this number increased and 8 cases were rejected.

Table 10

CRIMINAL CHARGES FILED ON 1989 - 98 ICAN CHILD HOMICIDES BY PARENTS/ CARETAKERS/FAMILY MEMBERS

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Murder (187 P.C.)	14	16	28	30	12	21	32	37	19	23
Child abuse causing death (273ab P.C.)							23	16	12	16
Child endangerment (273a(a) P.C.)							9	5	6	5
Child endangering (273a(1) P.C.)	7	7	13	11	12	9	3	3		
Corporal punishment or injury of child (273d P.C.)				5	3	3	1	3	2	4
Child abuse resulting in death (273a(a)2 P.C.)						1		13		
Ex-convict in possession of a firearm (12021 P.C.)						1				
Voluntary manslaughter (192a P.C.)							1	1		
Involuntary manslaughter (192b P.C.)	5	4	6		4			2		2
Lewd and lascivious acts (288a P.C.)	4		1				3			
Use of a deadly or dangerous weapon (12022 P.C.)	1		1							
Kidnapping (207a P.C.)	1	1						1		
Accessory after the fact (37 P.C.)	1				1				2	
Possession of a controlled substance (11350 H&S)	1			1						
Dueling (232 P.C.)	1									
Unlawful detention (278 P.C.)		1								
Obstructing or resisting arrest (69 P.C.)			1							
Battery against a peace officer (243b P.C.)			1							
Conspiracy (182a(5) P.C.)					1			2		
Spousal abuse (273.5 P.C.)					1		1			
Penetration of a genital/anal opening (289 P.C)					1		1			
Sodomy (286 P.C.)							1			
Torture (206 P.C.)							1			
Forgery / uttering a bad check (476aa P.C.)							1			
Under the influence of a controlled substance (11150 H&S)							1			
Unlawfully causing a fire of any structure (451B)								6		4
Poisoning or adulterating food, drink, medicine (347A)								1		
Criminal storage of firearms (12035 B1)								1		1
Assault producing great bodily injury (245(A) P.C.)									2	

**These new Penal Code sections became effective January 1, 1995.*

Figure 12

MURDER CHARGES (187 P.C.) FILED ON 1989 - 1998 ICAN CHILD HOMICIDE
BY PARENTS/CARETAKERS/FAMILY MEMBERS

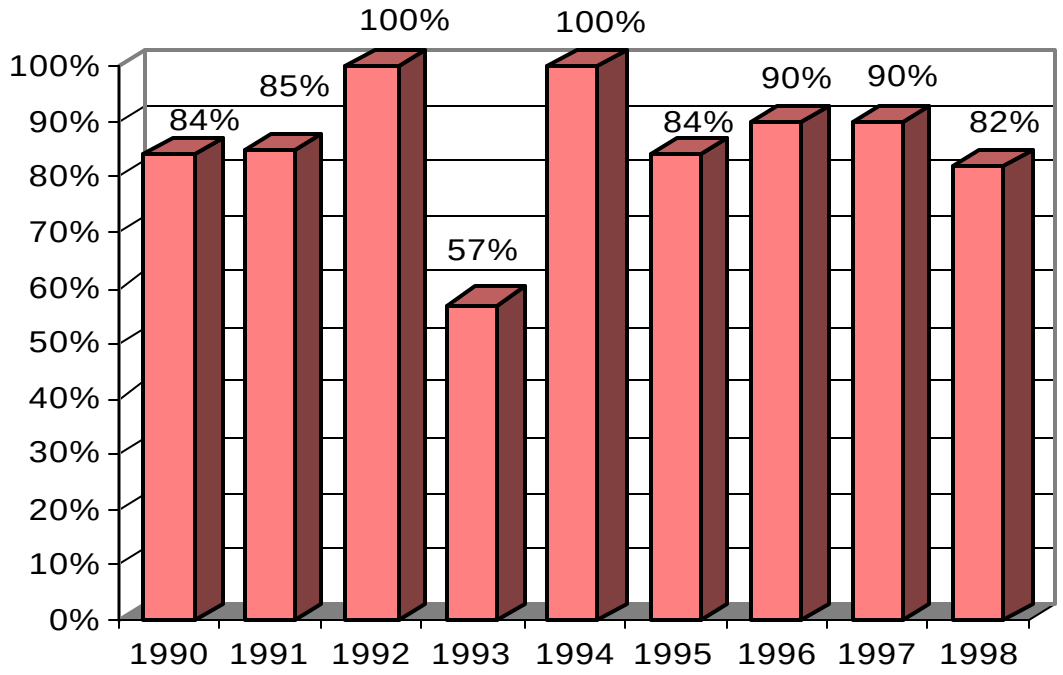


Table 11

RELATIONSHIP OF PERPETRATORS IN 1998 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS
FOR PRIOR CHILD PROTECTIVE SERVICES

Relationship	ID'd by Police	Charged by DA
Mother	23	15
Father	13	9
Mother's boyfriend	9	9
Step Father	1	1
Sibling (Male)	2	1
Sibling (Female)	1	0
Unknown	7	0

The criminal charges filed on the cases involving child homicide by parents/caretakers/family members for 1989 through 1998 are listed in Table 10. Murder charges (187 P.C.) were filed on 82% (n=23) of the cases in which charges were filed and 47% of the total number of child homicides in 1998. The rate of filings of murder (187 P.C.) charges has ranged from 66% to 100% over the past 10 years. The percentage of cases in which murder charges were filed between 1989 and 1998 is displayed in Figure 12.

Felony child abuse charges [273 ab, 273 a(a) and 273d P.C.] were filed on 86% of the 1998 cases in which criminal charges were filed. This is a slight decrease from 1997 when felony child abuse was charged in 90% of cases where charges were filed.

In 1998, as in prior years, there have been a variety of other charges filed by the District Attorney. Charges filed in the past 10 years are illustrated by Table 10.

The relationship of the perpetrators identified by law enforcement for cases in which charges were filed by the District Attorney's Office is displayed in Table 11. In 1998, for the seventh straight year with the exception of 1996, mothers have been identified by law enforcement as the category of caretaker most frequently involved in the deaths of their children.

Fathers were the second most frequent perpetrators identified in 1998. However, as in most previous years, there were more male perpetrators (n=25) identified than female perpetrators (n=24). As has been the case in previous years, more male perpetrators were criminally charged by the District Attorney than female perpetrators.

In 1998, there were multiple perpetrators identified by law enforcement and charged by the District Attorney in 5 cases. In all but one of those cases in which charges were filed, the mother was implicated along with either the child's father or the mother's boyfriend. In the other case the mother was implicated together with the child's stepfather.

Criminal disposition data for the period of 1989 through 1998 is displayed in Table 12. In 1998, 90% of the cases are still in pending status. This is a significant increase over 1997 when 57% of the cases were pending at the time the report was written.

For 1998 cases, there have not yet been any perpetrators sentenced to life in prison. In comparison, 4 perpetrators were sentenced to life in prison in 1997. The number of perpetrators sentenced to life in prison in prior years is 1 in 1996, 3 in 1995, 3 in 1994, 3 in 1993, 5 in 1992, 6 in 1991, 1 in 1990 and 9 in 1989. Some of the perpetrators for 1998 cases may be sentenced to life in prison as the pending matters are resolved.

3% (n=1) of perpetrators of child homicide by parents/caretakers/family members received an intermediate term sentence, 2 to 11 years in prison, in 1998. This compares to 14% in 1997, 10% in 1996, 26% in 1995, 14% in 1994, 28% in 1993, 8% in 1992, 23% in 1991, 0% in 1990 and 31% in 1989.

None of the 1998 perpetrators received jail time of one year or less or a probation order. This compares to 1 in 1997, 1 in 1996, 3 in 1995, 2 in 1994, 2 in 1993, 5 in 1992, 3 in 1991, 8 in 1990 and 1 in 1989.

In 1998, there have been no dismissals to date. For prior years, there has been an average of three acquittals or dismissals, with the exception of 1990, 1993 and 1997 when there was only one dismissal or acquittal for each of those years.

Table 12

CRIMINAL CASE DISPOSITION OF 1989 - 98 ICAN CHILD HOMICIDES BY PARENTS/ CARETAKERS/FAMILY MEMBERS

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Life without possibility of parole			1							
49 years to life prison				1				1		
42 years to life prison	1									
35 years to life prison									1	
30 years to life prison				1		1			1	
29 years to life prison					1					
28 years to life prison							1			
26 years to life prison			1							
25 years to life prison	2	1		2	1				1	1
24 years to life prison				1						
22 years to life prison	2				1					
21 years to life prison	1			1	1					
19 years to life prison				1						
16 years to life prison							1		1	
15 years to life prison	3		7	4	3	2	1	1	1	
14 years prison	1			1						
13 years prison	1	1								
12 years prison							1			
11 years prison		3	1	5		2	2		2	
10 years prison				1			2			
9 years prison				2	1	1		1		
8 years prison			1							
7 years prison			5				1			
6 years prison	1		2	1	1	1	2			
5 years prison	3				1					
4 years prison	1		1	2	1		2		1	1
3 years prison	2			2		1	2	2		
2 years prison	1		2		3		1			
16 months prison			1	1				1		
1 year jail	1	3	2	4	3	1	2		1	
9 months jail					1					
6 months jail				1	1		1			
Less than 3 months jail		2	2							
CYA commitment		1								
10 yrs Probation			1							
6 yrs Probation			1							
5 yrs Probation		1	1					1		
3 yrs Probation			1	1	2			1		
Juvenile probation order		1				1				
Found not guilty			2	1	1					
Dismissed	3	1	2	3		1	3	3	1	
Warrant pending		1				2		2		1
Hearings suspended due to insanity plea							1			
Sentence pending	1	1		1	1	1	1	8		
Pending trial	1	4	1		1	6	16	23	12	28
Matter on appeal prior to trial	1									
Unable to locate record	1	1	2	1	3					
TOTAL	**27**	**21**	**37**	**38**	**27**	**21**	**39**	**44**	**21**	**31**
Total C/A Homicides for year	**42**	**46**	**61**	**46**	**41**	**39**	**48**	**53**	**45**	**49**

DEPARTMENT OF HEALTH SERVICES INVOLVEMENT

Six week old Aaron was brought to a county hospital with difficulty breathing. He appeared to be very malnourished and he died not long after being admitted to the hospital. Doctors opined that he likely died of respiratory failure. The mother claimed that Aaron weighed 4lbs. 6 oz. at birth, but was released from the hospital the next day. Not long after his birth Aaron reportedly developed a respiratory infection. The mother stated that she took him to a local community health clinic, but was denied service because she had not obtained medical coverage for him. She was allegedly told to take him to a county hospital if his condition worsened.

The mother, who was living in a homeless women's shelter at the time of Aaron's death, had previously delivered seven live babies fathered by four different fathers, none of whom was involved with the family or supported his child(ren). Aaron was not premature by date, and was negative for the presence of drugs at birth. Hospital staff were apparently not concerned about Aarons's viability, though the mother's housing status was known, the baby was noted to be slightly jittery at birth, and he was not nippling or feeding well.

Aaron's death was initially thought to be a result of SIDS. However, it was later determined that the negligent failure of the mother to ensure timely treatment for Aaron, as well as extreme malnourishment, that ultimately caused his death. For these reasons, the Corner's office ruled his death a homicide.

The Department of Children and Family Services (DCFS) did not receive a referral in this case until the Coroner's office made its determination that the death was a homicide. When the referral was received by DCFS, investigators were unable to locate the mother and Aaron's surviving siblings. To date, the mother and children remain whereabouts unknown. There is an arrest warrant out for the mother for welfare fraud.

Other than the eventual report to DCFS from the Coroner's office, no referrals were made to DCFS by any of the several agencies that had contact with the mother, family and Aaron prior to his death. Three chances to intervene with a referral to DCFS- at the hospital upon Aaron's delivery, by the community health clinic, and by the homeless shelter- were missed.

This case illustrates the reality frequently revealed at death review: that chances to intervene and potentially save a child's life are sometimes missed by several agencies and individuals involved with the child and family prior to the death. In addition, Team discussion focused on the need for expanded public health nurse home visiting programs for high-risk families following a child's birth.

Computer searches for Los Angeles County Department of Health Services (DHS) records in previous years included a search for records at 4 different county facilities, LAC/USC Medical Center, Harbor UCLA Medical Center, King Drew Medical Center and Olive-View Medical Center. In 1997, unfortunately, due to a change in computer systems, record searches were only conducted at LAC/USC. This problem is in the process of being resolved and in 1998 computer searches for some of the cases were again conducted at all 4 county health facilities. This process should improve even more over time and it is believed that more cases having a record of involvement with a Los Angeles County Department of Health Services facility will be identified in the future. Since searches could not be conducted for all of the cases, the numbers for this year, though historically low, will be significantly lower than in previous years and difficult to compare with the data from previous years.

Computer searches for 1998 indicated that 8% (n=4) of the victims of child homicide by parents/caretakers/family members had medical records at DHS facilities. 2 children had medical records at LAC/USC Medical Center and 2 children had medical records at Harbor/UCLA Medical Center. In addition, 3 of the child homicide victims previously excluded as not having been perpetrated by a parent/caretaker/family member also had medical records at DHS facilities. Two of these children had medical records at LAC/USC Medical Center and 1 child had a medical record at Harbor/UCLA Medical Center.

Over the past 10 years (excluding 1997 for the reasons indicated above), an average of 19.6% of the child victims of homicide by parents/caretakers/family members have had DHS medical records, ranging from this year's low of 8% to a high of 26% in 1990. Previous medical records are noted in large part for their absence.

Place of death data was provided by the Coroner on all 49 of the child abuse homicides. 19 of the victims were involved with a total of 15 different medical facilities at the time of their deaths. 24 of the children who were not declared dead in medical facilities died in their own residences. Three other children were murdered and then buried in different areas of the Angeles National Forest, two newborn children were killed and dumped in a trash bin, and one child was killed and dumped along the road in Mexico.

ACCIDENTAL CHILD DEATHS IN LOS ANGELES COUNTY

At approximately 11:00 p.m. LAPD units responded to the scene of an apartment fire with a child reportedly trapped inside. Police officers were met at the scene by several residents of the apartment complex, who advised officers that one year old Shirley was still trapped inside the smoke-filled apartment. Officers attempted to crawl into the apartment two times, but were forced to retreat due to thick smoke and extreme heat. The bedroom was observed to be fully engulfed in flames. Fire Department personnel arrived at the scene shortly after law enforcement and were able to extinguish the flames and enter the bedroom, where Shirley's charred body was found face down on the bed. She had fourth degree burns over her entire body and had no pulse. Her cranium had ruptured due to the extreme heat.

LAPD and Fire Department Arson investigators determined that the fire was accidentally caused by Shirley's five year old cousin playing with matches. Shirley's family and extended family occupied two adjoining downstairs apartments. On the day of the fire, the cousin had been playing with matches with other younger relatives in apparent anticipation of a birthday/birthday cake scheduled for the next day. Shirley's mother had earlier caught the cousin playing with matches and scolded her, taking the matches away. However, she apparently found matches in her grandmother's purse in the adjoining apartment. Investigators found both the birthday cake and a book of matches in the room after the fire. The cousin who set the fire initially said that a man had come into the room and thrown a match onto the bed, though she later admitted that she had had thrown a match on the bed where Shirley had been put down to sleep. When the bed caught on fire, the cousin ran next door and alerted the mother and other relatives, but it was too late to rescue Shirley.

The autopsy revealed that Shirley had died from smoke inhalation and thermal burns over her entire body. She had apparently been conscious when she was burned.

The Department of Children and Family Services (DCFS) had received and investigated a referral about three years earlier that alleged that the mother had been leaving her children alone. The allegations were not substantiated, however, and the case was closed. Following Shirley's death, DCFS opened a voluntary family maintenance case with the family and provided referrals for grief and mourning counseling for the mother and surviving siblings and cousins. In addition, the Red Cross also provided follow-up counseling services to the family after the fire.

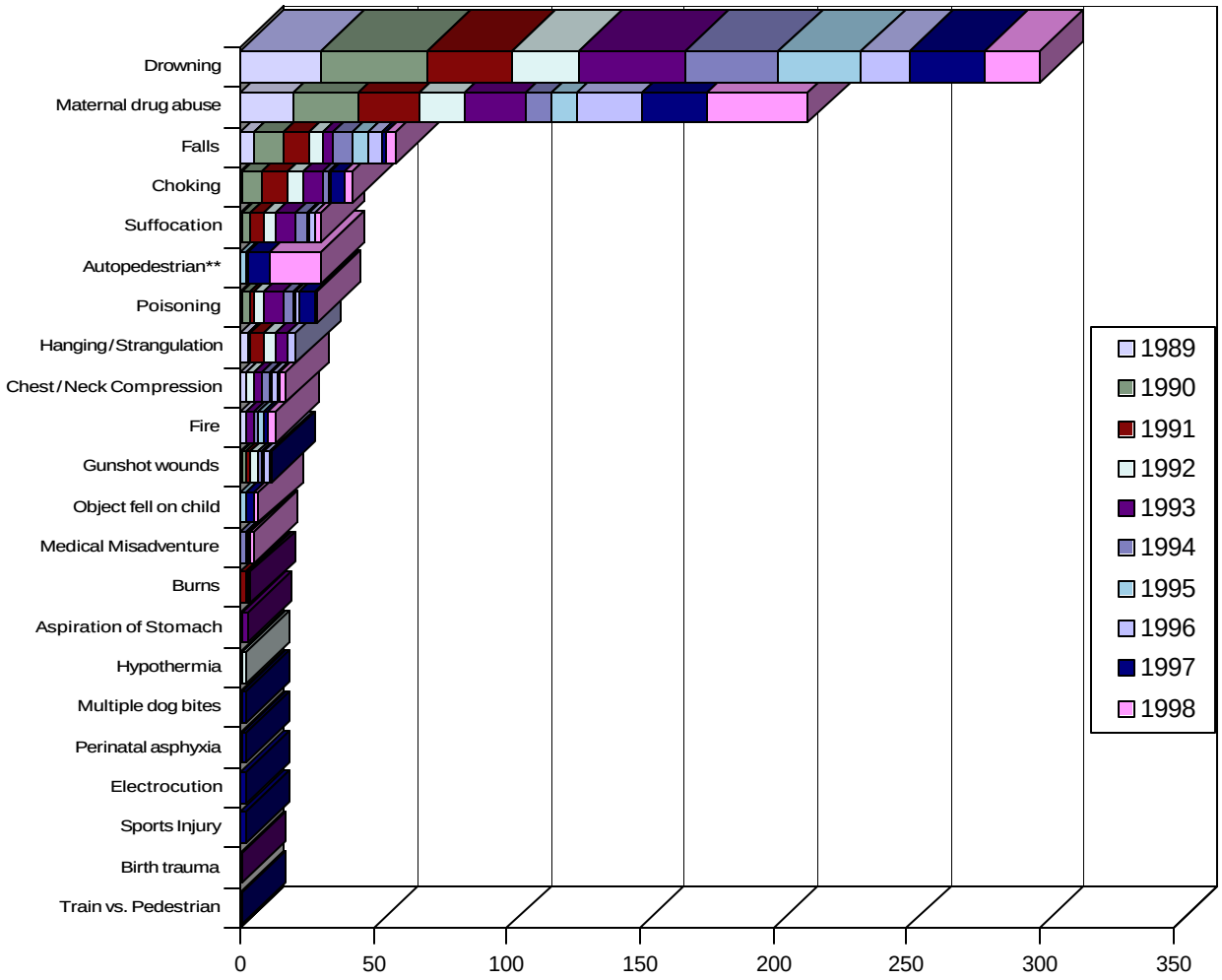
While the Team had concerns about possible lack of supervision, it was agreed by law enforcement and DCFS that there was insufficient evidence to file any charges in criminal court, or to file a petition in the dependency court. This tragic accidental fire, one of many that occur in the county each year, underscores the extreme danger of fire to children.

Ninety-five accidental deaths were reported to the Team by the Coroner for 1998. This is a 10% increase from 1997. Over the period 1989 to 1998, the number of accidental deaths reported to the Team has ranged from a low of 59 in 1995 to a high of 104 in 1993.

Accidental deaths are of interest to the Team due to questions of child safety and supervision by the care providers at the time of the accident. These deaths have been determined by the investigating agencies, law enforcement and the Coroner to be inadvertent and unintended. Many, if not all, of these deaths are preventable.

Figure 13

1989 - 1998 CAUSES OF ICAN ACCIDENTAL CHILD DEATHS



CAUSES OF ICAN ACCIDENTAL DEATHS

The causes of the Accidental deaths between 1989 and 1998 are displayed in Figure 13 and Table 13. The leading cause of accidental death in 1998 was deaths associated with maternal substance abuse, surpassing drowning as the leading cause of accidental death for the second time since ICAN began tracking this information. The only other year in which drowning was not the leading cause of accidental death was 1996 when there was a 42% decrease in the number of deaths due to drowning and deaths associated with maternal substance abuse was the leading cause of death. Deaths associated with maternal substance abuse are primarily of very young, prematurely born, infants who were prenatally exposed to drugs. In 1998, there were 38 deaths associated with maternal substance abuse, a 58% increase from the 24 such deaths in 1997. The 38 deaths associated with maternal substance abuse are the highest number of these deaths since ICAN began collecting this data. The second highest number was 25 in 1996 and the low was 9 in 1995.

The second leading cause of accidental death in 1998 was deaths due to drowning. There were 21 accidental deaths due to drowning in 1998, a 33% decrease from 1997. This number is the second lowest number of deaths due to drowning since ICAN began tracking this information. The previous low was 18 in 1996 and the high was 40 in 1990 and 1993.

Automobiles vs. Pedestrians (children hit by automobiles) was the third leading cause of accidental death in 1998, with 19 children dying as a result of being hit by a car. This number is a 138% increase over the 8 deaths due to a child being hit by a car in 1997, which represented a 700% increase over the 1 such death in 1996. Prior to 1995, accidental deaths due to automobiles vs. pedestrians were not referred to the Child Death Review Team. It is likely, however, that the large increases in the numbers of these deaths over the last two years do not represent an increase in the incidence of these deaths, but rather, reflect changes in the Team's data collection which promote greater identification of these deaths by the Team. Tragically, one child was killed when she was run over by her father and another was killed when she was run over by her Aunt.

Other causes of accidental deaths, as in prior years, range from falls, choking, fire, injuries of the neck or chest, suffocation, accidental ingestion of drugs or other poisons, including one death from carbon monoxide poisoning, and injuries suffered as a result of objects falling on young children. This array of causes of death is similar to prior year findings.

WARNING: MOTOR VEHICLES POSE A SERIOUS THREAT TO PEDESTRIAN CHILDREN

During 1998, 19 children in Los Angeles County were killed by motor vehicles while walking, biking or simply standing on sidewalks, roadways and driveways. A sampling of these deaths reveals the tragic circumstances involved:

- A two year old boy was pinned against the family's garage door as his father backed the car out, causing crushing injuries that resulted in the child's death.
- A five year old boy was struck and killed by a truck when he ran into the street to chase a ball he and several other boys were playing with.
- A two year old girl was run over by her aunt as she backed her car out of the family driveway.
- A one year old baby boy was killed when he crawled into the path of his father's car as he backed out of a driveway.
- A seven year old girl was killed after she ran into the street between two parked cars. She was chasing her puppy, who had run into the street ahead of her.
- A twelve year old boy was hit by a car while riding his bike without a helmet. He died of massive head injuries.

These tragic accidental deaths of children hit by motor vehicles highlight the danger of automobiles to child pedestrians, and underscore the importance of motorists being extra vigilant in their awareness of pedestrian children, and of teaching children about the potential dangers of automobiles, driveways and roadways.

Table 13

CAUSES OF ACCIDENTAL DEATHS 1989 - 1998

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Drowning	30	40	32	25	40	35	31	18	28	21	300
Maternal drug abuse	20	24	23	17	23	10	9	25	24	38	213
Falls	5	11	10	5	4	7	6	5	2	3	58
Choking	1	7	10	6	7	2		1	5	3	42
Suffocation	1	3	5	4	8	4	1	2		2	30
Autopedestrian**							2	1	8	19	30
Poisoning	1	3*	1	4*	7*	4	1*	1	6*	1*	29
Hanging/Strangulation	3	1	5	4	5			3			21
Chest/Neck Compression	2			3	3	3	1	2	1	2	17
Fire	2				3	2	2		1	3	13
Gunshot wounds	1	1	2	3		1	1	2	1		12
Object fell on child							2		3	2	7
Medical Misadventure						2	1	1		1	5
Burns			2	1	1						4
Aspiration of Stomach		1			2						3
Hypothermia		1		1							2
Multiple dog bites							1		1		2
Perinatal asphyxia							1		1		2
Electrocution									2		2
Sports Injury									2		2
Birth trauma					1						1
Train vs. Pedestrian									1		1
TOTAL	66	92	90	73	104	70	59	61	86	95	796

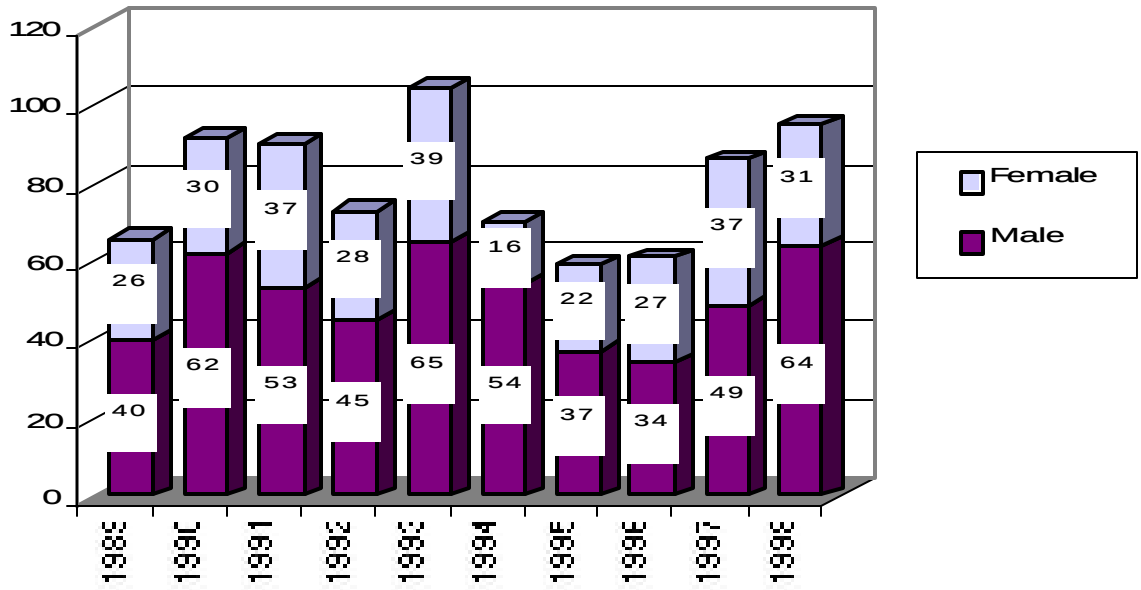
** In 1990, one poisioning was due to iron intoxication, in 1992, all 4 poisonings were due to iron intoxication, in 1993, 3 of the poisoning deaths were due to iron intoxication. In 1994, none of the poisoning deaths involved iron intoxication. In 1995, there was one iron intoxication poisoning death.*
*** Autopedestrian deaths have not been referred to the Team by the Coroner prior to 1995.*

GENDER

67% (n=64) of the 1998 accidental death victims were male while 33% (n=31) of the accidental death victims were female. Over the past 10 years, the percentage of male victims has ranged from 1996's low of 56% to a high of 77.1% in 1994. Figure 14 displays the gender breakdown of the accident victims for the past 10 years.

Figure 14

1989 - 1998 ICAN ACCIDENTAL CHILD DEATHS BY GENDER



AGE

Figure 15 displays the ages of the 1998 accidental death victims. 41% (n=39) were under the age of 1 year, 38% (n=38) were under the age of 6 months.

The average age of the drowning victims was 4.8 years old. The ages of the drowning victims have increased slightly as the Team protocol was expanded to include drowning deaths for ages 17 and under. Three of the 7 accident victims over the age of 10 years died from drowning. 57%, twelve of the 21 drowning victims were 2 years old or younger. The two oldest victims were 17 years old and both died as a result of swimming fatigue. Three of the drowning victims drowned in a jacuzzi or hottub and 3 drowned in a lake. None of the 1998 drowning victims died in the bathtub.

35 of the 38 infants under the age of 6 months died due to complications of maternal substance abuse. 30 drug exposed infants died on their day of birth, 1 died within one day of birth, 1 died within 10 days of birth and 1 died within the peri-natal period, the first month after birth. The oldest child from a drug exposed death was age 9 years.

The nineteen children who died as a result of being hit by a car in 1998 ranged in age from 1 year to 12 years old; eight of them were age 3 or younger.

Figure 15

1998 ICAN ACCIDENTAL CHILD DEATHS BY AGE

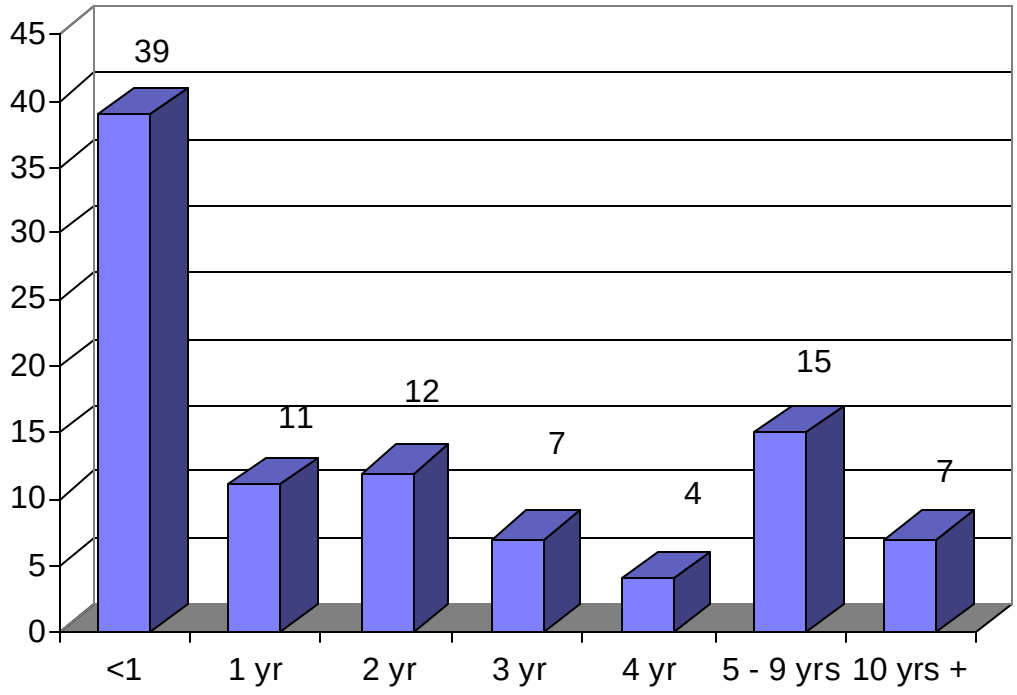


Table 14

ETHNICITY OF ICAN ACCIDENTAL DEATHS 1998

	HISPANIC	AFR-AM	WHITE	ASIAN
Maternal drug abuse	5	22	9	2
Drowning	12	3	6	0
Autopedestrian	12	3	3	1
Choking	3	0	0	0
Falls	2	1	0	0
Fire	3	0	0	0
Suffocation	1	0	1	0
Chest/Neck compression	2	0	0	0
Object fell on child	2	0	0	0
Poisoning	0	0	1	0
Medical Misadventure	0	1	0	0
TOTAL	**42**	**30**	**20**	**3**

ETHNICITY

Table 14 displays the causes of accidental deaths in 1998 for the children of different ethnic groups. Hispanic children represented 44% (n=42) of all the accidental deaths in 1998. They suffered the most deaths due to drowning (n=12) and deaths due to a child being hit by a car (n=12). They also suffered all the deaths due to choking (n=3), fire (n=3) objects falling on a child (n=2) and chest/neck compression (n=2).

African American children represented 32% (n=30) of the 1998 accidental child deaths. As in most previous years they suffered the most deaths related to maternal substance abuse; in 1998 they suffered 58% (n=22) of all maternal substance abuse deaths, which is 73% of the 30 total accidental deaths suffered by African American children.

White children represented 21% (n=20) of the accidental child deaths in 1998. 24% (n=9) of the deaths related to maternal substance abuse were white children as were 29% (n=6) of the deaths due to drowning.

There were 3 accidental child deaths of Asian children in 1998, 2 due to maternal substance abuse and one child who was killed by a hit and run driver.

TEMPORAL PATTERN

Figure 16 and Table 15 display the incidence of accidental deaths for each month of 1998. The month with the greatest number of accidental deaths was March.

As in past years, the monthly pattern of drowning deaths was compared to all accidental deaths. In 1998, more drowning deaths occurred in the spring and summer (17 of the 21 drowning deaths occurred between April and September). As deaths due to drowning are the most frequent cause of accidental death and as the majority of the drowning deaths occur in the spring and summer, they influence the temporal pattern a great deal. The month of the most non-drowning accidental deaths was November.

Figure 16

1998 ICAN ACCIDENTAL CHILD DEATHS BY MONTH

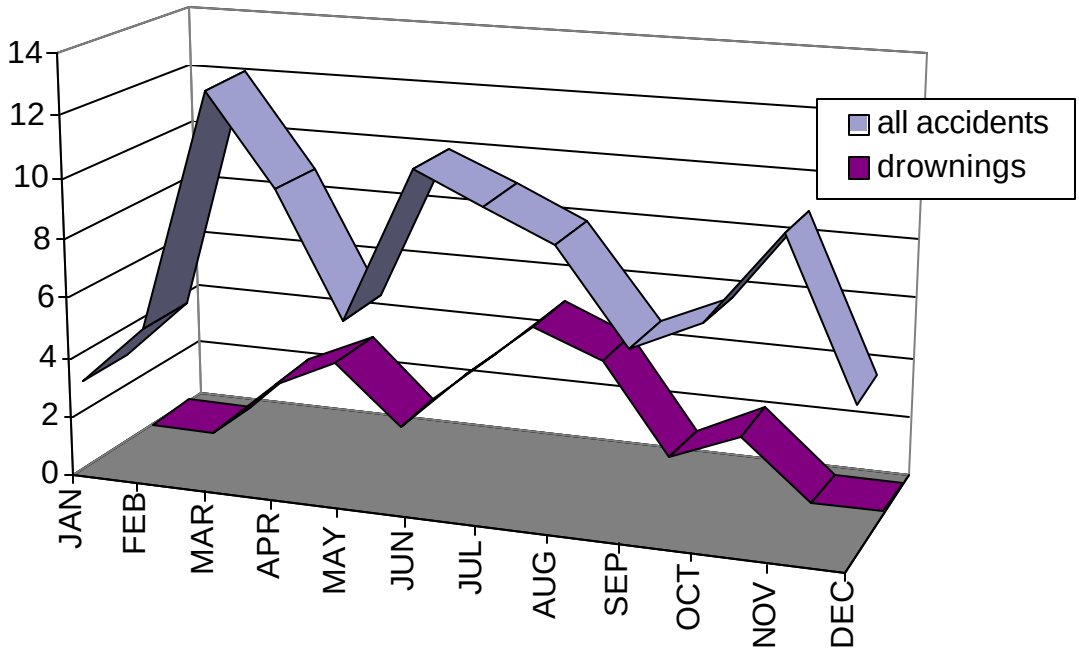


Table 15

1998 ICAN ACCIDENTAL CHILD DEATHS MONTHLY PATTERN

ALL ACCIDENTS VS. DROWNINGS

	All Accidents	Drownings
January	3	0
February	5	0
March	13	2
April	10	3
May	6	1
June	11	3
July	10	5
August	9	4
September	6	1
October	7	2
November	10	0
December	5	0

CHILD PROTECTIVE SERVICES INVOLVEMENT

23% (n=22) of the families with accidental child death victims had a history of receiving child protective services prior to the child's death. 50% (n=11) of those cases involved families where the Coroner indicated that the death was associated with maternal substance abuse. This percentage, while comparable to previous years when 41% to 85% of the accidental death victims with prior child protective services died as a result of maternal substance abuse, is low considering that deaths related to maternal substance abuse were the leading cause of accidental death. 23% (n=5) of the cases with prior protective services involvement were cases where the child was hit by a car.

Table 16 provides the reasons the 22 cases were known to DCFS.

Of the 22 cases with prior child protective services, three were opened and closed before the birth of the child that died.

DCFS proceeded with court action and out-of-home placement before the death in 45% (n=10) of the families in which they had received referrals for service. 41% (n=9) of the cases that were known to DCFS were open at the time of the children's death. Two other cases, both for allegations of neglect, were closed within one month prior to the child's death. In one of these cases the child was killed when he was hit by a car, in the other, the child died from complications related to maternal substance abuse. All 9 cases that were open to DCFS at the time of the accidental death were open as a result of parental substance abuse. In all but one of these cases, the siblings had been in out-of-home care at the time of the death and remained in out-of-home care after the death.

In addition to the 9 cases that were open to DCFS at the time of the accidental death, 13 additional families were referred to DCFS at the time of the death. Four of the cases that had been opened and closed before the death were reopened. The reason for referrals on the 13 families who had cases opened after the death are displayed in Table 17.

Petitions were filed in Juvenile Court on siblings of the deceased child on 4 cases following the deaths and the siblings were placed in out-of-home care in 2 cases. Of the 9 cases that were open to DCFS at the time of the accidental death, 8 remained open after the death.

Figure 17 summarizes the child protective services on the accidental child deaths.

The Department of Children and Family Services provided information regarding the constellations of families known to them:

- 48% (n=46) of the families had a history of receiving public assistance from the Department of Public Social Services.
- The mother's age at the time of death of the child was known in 32% (n=30) of the families. Table 18 provides a breakdown of the mothers' ages.
- The deceased child had siblings in 29% (n=28) of the cases. 5% (n=5) of the families were known to not have any children other than the victim. It was unknown if there were siblings in 65% (n=62) of the families.

Table 16

1998 ICAN ACCIDENTAL CHILD DEATHS
REASONS FOR PRIOR CHILD PROTECTIVE SERVICES

Reason	n	%
Severe neglect	2	9
General neglect	3	14
Caretaker absence/incapacity	5	23
Physical abuse	3	14
Child Endangerment	1	5
Prenatal substance abuse	5	23
Unknown	3	14

Table 17

1998 ICAN ACCIDENTAL CHILD DEATHS
REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING DEATHS

Reason	n	%
Severe neglect	5	38
Lack of Supervision	5	38
Substance abuse	3	23

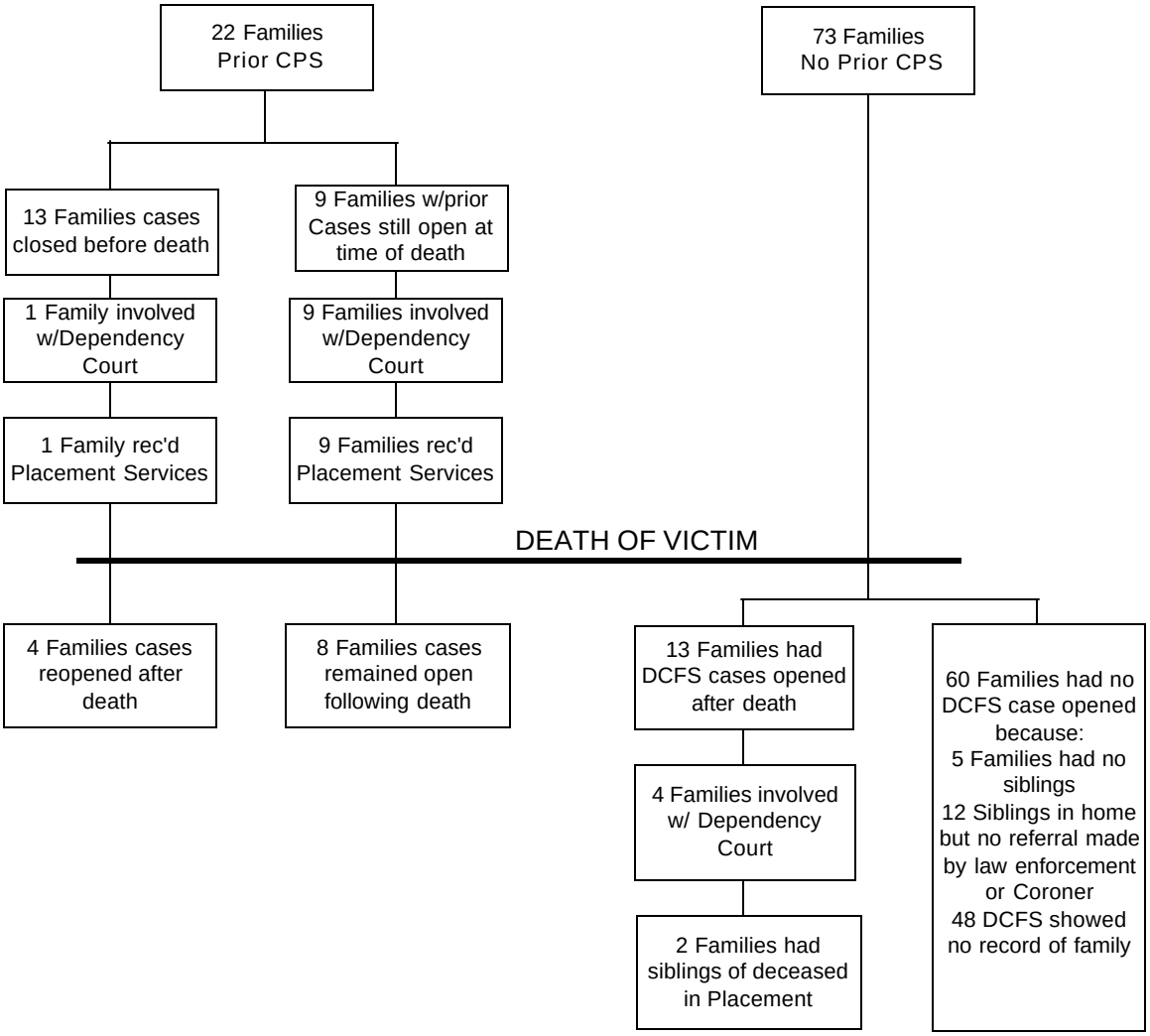
Table 18

1998 ICAN ACCIDENTAL CHILD DEATHS
AGE OF MOTHERS

Reason	n	%
Less than 25 years	5	17
25 to 29 years	7	23
30 to 39 years	14	47
40 years and older	4	13

Figure 17

CHILD PROTECTIVE SERVICES ACTIVITIES ON 1998 ACCIDENTAL CHILD DEATHS



CRIMINAL JUSTICE SYSTEM INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

Information on criminal justice system activity on accidental child deaths was gathered from the Los Angeles Sheriff's Department, Los Angeles Police Department and the Los Angeles District Attorney's Office.

Los Angeles Police Department had investigative responsibility for 46% (n=44) of the accidental child deaths. Los Angeles Sheriff's Department had responsibility for 26% (n=25) of the cases. Table 19 displays the 15 different police departments that were involved in 1998 accidental child deaths.

Four of the accidental child deaths were presented to the District Attorney's Office for the consideration of filing criminal charges in 1998. As in prior years, very few acci-

dental deaths receive consideration by the District Attorney due to the Coroner's ruling that the death was accidental. Three of the four cases presented involved deaths where the child was hit by a car. The other case presented was a fetal death due to maternal substance abuse. Of these cases, two of the cases where a child was hit by a car were rejected by the District Attorney's Office. One case was rejected because it was determined that there was no criminal negligence and one, where it was believed that the driver of the car had been driving under the influence of alcohol, was rejected because there was insufficient evidence of a crime. Apparently, the suspect's blood alcohol level was never taken. The case relating to maternal substance abuse was also rejected by the District Attorney's Office. One case where a child was hit by a car did result in the filing of charges by the District Attorney. In this case the suspect was charged with one count of assault with a deadly weapon (PC 245) and two counts for hit and run (VC 20001). A bench warrant for the suspect in this case has been issued but he remains at large.

Table 19

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1998 ACCIDENTAL CHILD DEATHS

LAPD	44
LASD	25
Long Beach P.D.	7
California Highway Patrol	4
Compton P.D.	3
Pasadena P.D.	3
Azusa P.D.	1
Baldwin Park P.D.	1
Bell P.D.	1
Inglewood P.D.	1
Monterey Park P.D.	1
Pomona P.D.	1
San Gabriel P.D.	1
West Covina P.D.	1
Whittier P.D.	1

HEALTH SYSTEMS INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

As noted in the homicide section of this report, record searches for some of the 1998 cases were able to be conducted at all 4 Los Angeles County Department of Health Services facilities. Records for 15 of the 95 children who died as the result of an accidental death were found. 8 records were found at Harbor/UCLA Medical Center, 4 at LAC/USC Medical Center, 2 at Olive View Medical Center and 1 at King Drew Medical Center. Multiple records were found for 2 children.

35 different medical facilities were identified as the place of death for 86 of the children who died from accidental deaths. In addition, eight of the children who died from an accidental death had their residence listed as their place of death and one had the street where he was killed when he was hit by a car listed as the place of death.

UNDETERMINED DEATHS IN LOS ANGELES COUNTY

LAPD responded to the scene of an unresponsive 10 month old child. The child's mother, age 16, reported that Melinda had been fed, was laid on the floor to sleep, and when she returned to check on her ten minutes later, Melinda was not breathing. However, when officers noted what appeared to be ligature marks around Melinda's neck, they confronted the mother, who then admitted that Melinda had been put down to sleep in a makeshift hammock tied with ropes, a common sleeping practice in the mother's culture. The mother claimed that when she checked on Melinda she had fallen out of the hammock and was on her knees, with rope from the hammock tangled around her neck. When she discovered Melinda she became scared and took the hammock down. Detectives later had the mother recreate how the hammock was made and how she found Melinda. The detectives determined that the story made sense and explained the injuries noted on Melinda.

The Coroner found that the pattern of ligature marks on Melinda matched the texture of the rope used to hang the hammock. The autopsy also revealed that Melinda had a torn upper frenulum, as well as tears to her anus and vagina. A catheter used at the hospital could possibly have caused the vaginal tear. A sexual abuse kit was negative, and the Coroner could not say if the noted anal and vaginal tears were caused by sexual abuse, though this possibility could not be excluded, either. Melinda died as a result of asphyxia. Given the torn frenulum and vaginal and anal tears, however, the Coroner ruled the mode of death as undetermined.

A doctor on the Team with many years of experience in sexual abuse exams reviewed the autopsy photos and determined that the torn anus appeared to be very consistent with penetration, but cautioned that such injuries are more visible post-mortem, thus while the noted injuries were very suggestive of sexual abuse, they were not diagnostic of abuse.

The Department of Children and Family Services detained Melinda's mother and the other minor children in the home due to the possibility that sexual abuse may have occurred. At the time of Melinda's death, there were three sets of families living in the home, and seven people were in the home at the time of the death. The sixteen year old mother denied having a boyfriend and was very evasive about the identity of Melinda's father. There was suspicion that Melinda's father could have been one of the adult men residing in the home, or perhaps even her own maternal grandfather. When the final Coroner's report and law enforcement investigations were completed without any clearly identified sexual abuse, the dependency court case was dismissed and the minor children were returned to the home.

The Team was very concerned about the mother and minor children returning to the home, given concerns about the still unexplained causes of the vaginal and anal injuries suffered by Melinda. Cases such as this serve to reinforce the Team's support for expanded home visiting programs for high-risk parents and families following a birth.

Twenty-eight undetermined child deaths were reported by the Coroner to the Team in 1998. This is an increase of 8% over the 26 undetermined child deaths reported in 1997. The number of undetermined deaths reported to the Team in prior years has ranged from 3 in 1989 to this year's high of 28. The average of the past 10 year period, including 1998, is 15.2 per year.

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

As these cases are often suspicious in nature, they are of interest to the Team and often warrant detailed Team review in an attempt to determine what actually happened on the case. In 1998, four of the twenty-eight undetermined deaths (14%) received in-depth review by the Team. Two more of the twenty-eight are pending review, for a total of 6 (21%) reviewed.

GENDER

In 1998, fifteen (54%) of the undetermined deaths were male, twelve (43%) were female and one body was so badly decomposed that the gender could not be determined. In eight of the past ten years there have been more male undetermined deaths than female.

AGE

In 1998, 71% (n=20) of the undetermined deaths were of infants under one year of age. Three victims were one year old, two victims were two years old, one was six, one was ten and one was eleven years old.

In the period of 1989 through 1998, an average of 69.7% of the undetermined death victims have been under the age of one year.

ETHNICITY

43% (n=12) of the undetermined deaths were Hispanic, a 25% decrease from 1997. 25% (n=7) were African-American, a 17% increase over 1997. 21% (n=6) were White, which is a 100% increase over 1997. One undetermined death was of Asian ethnicity and two bodies were partial fetal remains for which the ethnicity could not be determined. Over the past 10 years, the ethnicity has fluctuated between each year, but has averaged 45% Hispanic, 28% African-American, 24% White, and 3% Other.

CAUSE OF DEATH

The most frequent cause of undetermined deaths was "undetermined" (n=11). The second most frequent cause was "undetermined after autopsy and toxicological examination" (n=7). The third most frequent cause was "intrauterine fetal demise" (n=4).

In 1998, there were several deaths that were of a suspicious nature but that lacked the information the Coroner needed to make a final determination of homicide. One case came in as a possible Sudden Infant Death

Syndrome (SIDS) death of a 3-month-old boy, but upon investigation, it was found that the victim had a twin sister that died at the age of 13 days from an undetermined cause. The mother had a history of substance abuse and had gone to sleep on a couch with her 3-month old son by her side. When she awoke, she found him not breathing. The cause of death for this child and for his 13-day-old twin sister could not be determined by the Coroner and both cases are still under investigation. In another similar case, the mother had been feeding her 2-month old daughter when she fell asleep. Upon awakening, she found that her daughter was "still" and got no response when she attempted to arouse her. The child was transported to the hospital where she was pronounced dead. However, the Coroner was unable to determine a cause of death. In another case involving an interuterine death, law enforcement reported that the mother had been strangled by her boyfriend, leading to her death and the death of her fetus. However, the mother also had a history of cocaine use and her cause of death could not be determined by the Coroner. In yet another case, a 1-year-old boy was found not breathing by his grandmother. At the hospital, it was noted that the child had blood in his mouth and airway. However, no signs of trauma could be found and the cause of death could not be determined.

Four of the undetermined deaths in 1998 involved infants whose bodies had been dumped; one in a sewer line, one in an aquaduct, and two in trash cans.

The diversity of causes of undetermined deaths is consistent with prior year findings.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVOLVEMENT

Eleven (39%) of the undetermined deaths in 1998 had prior child protective services involvement, and four of those cases were open to the Department of Children and Family Services at the time of the death.

The reasons for involvement included substance abuse of parents, physical abuse, emotional abuse, and severe neglect. Two families had 2 prior referrals to DCFS, and six families had 1 prior referral. Other than the four cases that were open to the Department of Children and Family Services at the time of the death, none of the cases with prior DCFS involvement resulted in court action or out-of-home placement.

On one case with a prior referral to DCFS due to the minor's testing positive for drugs at birth, the case was closed after 2 months. It is unclear from the information provided what services were provided to the family. Three months after the case was closed, the mother left her infant son with some friends to care for him overnight. When they checked on him in the night they found that he was having trouble breathing and they called 911. The child was taken to the hospital where he died a few days later. The cause of death is related to acute bronchopneumonia and other undetermined factors. The mother is now whereabouts unknown. In another case of two twins, a female who died 13 days after birth and a male who died 3 months after birth, DCFS had a prior referral on the family 4 years prior to the birth of these children. The reason for this referral is unknown. In this case, the mother has a history of substance abuse and in both cases the Coroner has been unable to determine a

cause of death. It is unclear from the information provided if the siblings were placed in out-of-home care after the deaths of these two children or if they remain at home with the mother.

In one of the cases open to DCFS at the time of the death, the case had been opened just 2 days prior to the child's death. The 1-month-old boy had been placed in foster care after he had been physically abused by his father. The mother stated that the father had continuously hit and spanked this child since his birth but that she always overlooked this abuse because of cultural reasons. The minor was placed in foster care but 2 days later his foster mother found him not breathing. She called 911 but the child was pronounced dead at the foster home. There are no other siblings, and the other children who were in this foster home remain as placed as there were no signs of abuse. This child's death is likely related to the prior abuse by his father but at autopsy there were no signs of bruising or trauma and the Coroner was unable to determine the cause of death. In another case open to DCFS, the 11-year old male had been placed in foster care in 1996 due to his mother's substance abuse. His father was deceased. This child had hung himself in his bedroom closet, however, the Coroner listed the mode of death as Undetermined rather than Suicide because this child was retarded and had the mental capacity of a 9-year old. The Coroner stated that 9-year olds do not usually have the frame of mind or intent to kill themselves. In addition, this child had a history of engaging in self-destructive behavior designed to scare his foster mother and it is believed that this death could have been accidental. In yet another case open to DCFS, the 2-year old female had been placed with her Paternal Grandmother due to her parents' substance abuse. Reportedly, this child died in her sleep after she came into the house from playing outside with her sister. However, no cause of death could be determined. The surviving sibling who was placed with her at the Paternal Grandmother's home is now placed with the Maternal Grandmother where 2 other surviving siblings had previously been placed.

In addition to the four cases that were open at the time of the death, three cases were referred to DCFS after the death. None of these referred cases resulted in court involvement or out-of-home placement for the surviving siblings. In one of these cases, the Coroner's Office had contacted DCFS as the deceased child had unexplained fractures that were in the healing stages on both upper arms and her thigh. However, these injuries did not cause the death and the final cause of death could not be determined. The surviving sibling was assessed and found to be healthy with no signs of abuse. The case was then closed and the surviving sibling remains at home. In another case, a referral after death was made for severe neglect and emotional abuse. This child had died as a result of choking on some uncooked macaroni. The father, upon learning of the child's death, physically assaulted the child's mother. However, the surviving siblings were assessed and it was determined that they were not in any danger. The mother was given referrals so that she could obtain a restraining order against the father and for grief counseling and the case was closed. In one additional case, a referral was made after the death as the mother's story as to how the child died did not fit with the

Coroner's findings. This child died from asphyxia and other undetermined causes. She also had a dilated and torn anus. Ultimataely, it was determined that the mother had taken an infant seat and hung it in the doorway so that it would act like a swing for the infant. However, the baby was not strapped in well and slipped, thereby strangling herself in the seat's straps. No explanation for the torn anus was ever determined but the case was closed as there were no siblings.

In the past, deaths related to undetermined causes have not usually resulted in court involvement and/or out-of-home placement for the surviving siblings.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

The Los Angeles Police Department was the investigating law enforcement agency on 32% (n=9) of the undetermined deaths and the Los Angeles Sheriff's Department was responsible for the investigations on 36% (n=10) of the cases. Four cases were handled by the Long Beach Police Department and five other cases were handled by five different police agencies.

One case was presented to the District Attorney's Office by law enforcement for the filing of criminal charges. This number is an 86% decrease from the seven cases that were presented in 1997. In the case that was presented by law enforcement, the mother's boyfriend had strangled her resulting in her death and the death of her fetus. It is likely that murder charges will be filed in this case but the investigation is on-going and no charges have been filed yet. In two additional cases, law enforcement has not yet presented the cases to the District Attorney's Office for the filing of criminal charges but the investigations remain open and the cases may be presented upon completion of these investigations. In one case, a 9-month old male had been in the care of his babysitter and was found unconscious and unresponsive in his crib. He was subsequently pronounced dead by paramedics at the babysitter's home. At the time of death no signs of trauma were noted. Upon autopsy, it was discovered that the infant had healing rib fractures that were likely from a prior inflicted injury. However, no cause of death could be determined by the Coroner. The circumstances surrounding the death and this prior injury are suspicious but law enforcement stated that there was insufficient evidence to present the case for the filing of criminal charges. The investigation also remains open in the deaths of two twins, one who died after 13 days and one who died after 3 months. Both cases may be related to maternal substance abuse but the Coroner was unable to determine a cause of death in both of these cases and there is insufficient evidence of a crime at this time.

HEALTH SYSTEM INVOLVEMENT

Three of the undetermined deaths had records at Los Angeles County Department of Health Services facilities: 2 at Harbor/UCLA Medical Center and 1 at King Drew Medical Center. In all three of these cases, these facilities were not listed as the place of death.

Place of death data provided by the Coroner indicated that 14 different medical facilities were involved in the undetermined deaths. Three of these victims died in Los Angeles County Department of Health Services facilities. The remaining victims either died at their residence or at other

medical facilities, or were fetuses that were dumped. As previously noted, two were dumped in trash bins, one was dumped in the sewer and one was dumped in an aquaduct.

ADOLESCENT SUICIDES IN LOS ANGELES COUNTY

Fifteen year old Raymond was found by his mother hanging by an electrical cord from the rafters of the family garage. He and his mother had recently moved to the area and he had reportedly been depressed about school and family problems.

Fifteen year old Andrew was found hanging from a bedsheet tied to a bunk bed in a cell at a juvenile detention center. He was incarcerated pending trial on sexual molestation charges, and he had spent most of his young life involved with the juvenile justice system.

Seventeen year old Serena placed a rifle in her mouth and pulled the trigger. There had been no previous involvement with child protective services or the juvenile justice system. She left no note explaining why she killed herself.

Thirteen year old Janelle placed her head between the wrought iron bars bordering her residence. Responding officers found a suicide note at her feet.

Seventeen year old Danny had an argumenmt with his father, after which he went to his room, which was a detached structure adjacent to the family residence. When he was not seen for a couple of hours, his father went to his room and found him dead with a gunshot wound through his eye. He was found gripping a .44 caliber revolver in his right hand.

Sixteen year old Ronald was upset about learning of his father's plan to move the family from their current residence. The father went outside after arguing with his son about the pending move. When he entered the house a short time later, he found his son in a hallway, dead from a gunshot wound to the head. No suicide note was left.

These cases illustrate the continuing tragedy of youth suicide. Data from 1998 indicate that there were 15 suicides of youth aged 12 to 17, the fewest since ICAN began collecting and reporting data on such suicides in 1988. Between 1988 and 1997, an average of 28.7 youth suicides per year were reported to ICAN.

Fifteen suicides, where the victim was 17 years old or younger, were reported to the ICAN Child Death Review Team for 1998. This is a 25% decrease from 1997 when there were 20 adolescent suicides. The 15 adolescent suicides reported in 1998 is the lowest number since ICAN began collecting this data. The average number of adolescent suicides referred to the Team since tracking of this population began in 1988 is 27.5 per year.

While the Team does not primarily focus on this population, clearances from law enforcement, Department of Children and Family Services, Probation and the Department of Health Services provide a picture of these children and families and their interactions with public agencies prior to their deaths.

GENDER

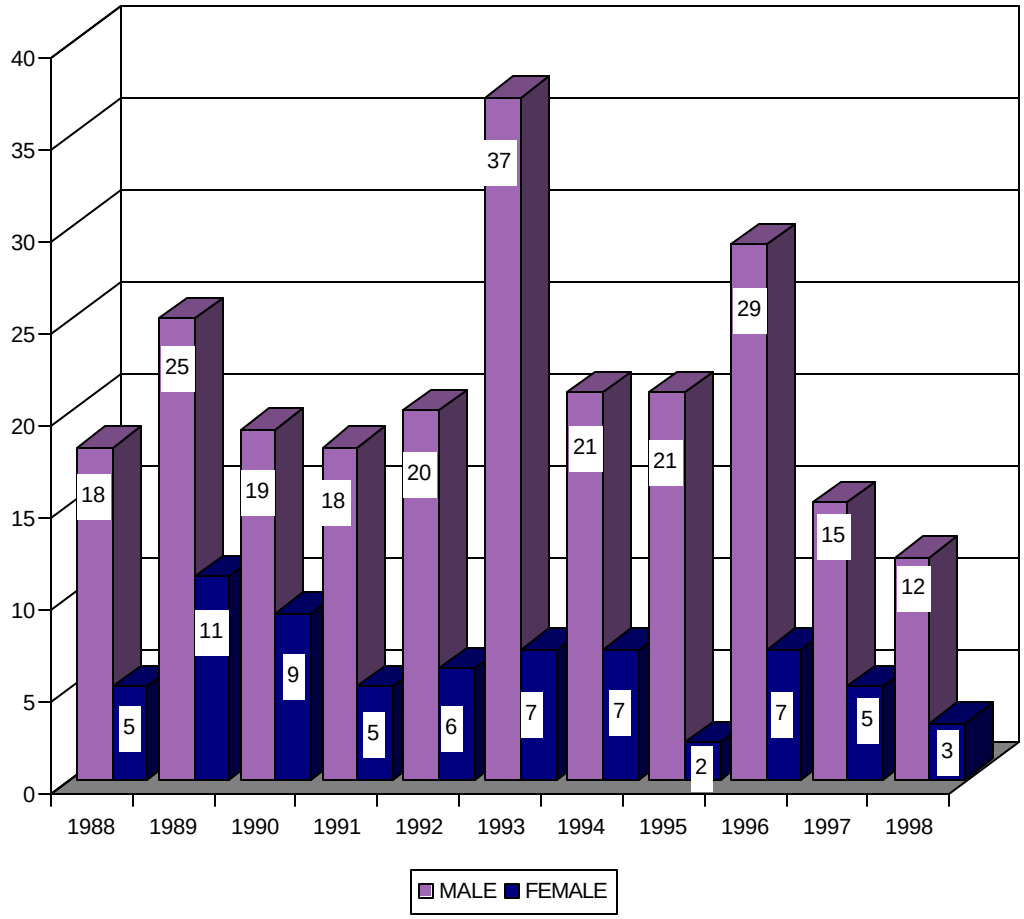
80% (n=12) of the 1998 adolescent suicide victims were male. Over the past 10 years, the percentage of male victims has ranged from 68 to 90%. The average number of male victims over the past 10 years has been 21.7, with a range of 12 to 37.

20% (n=3) of the victims of adolescent suicide in 1998 were female, a decrease of 20% from 1997. The average number of female victims over the past 10 years is 6.2. The number of female victims between 1989 and 1998 has ranged from 2 to 11 victims per year. The greatest number of female victims was in 1989 with 11 females.

Figure 18 displays the gender breakdown of the suicide victims for the past 10 years.

Figure 18

1988 - 1998 ICAN ADOLESCENT SUICIDES BY GENDER



AGE

In 1998, the average age of adolescent suicide victims increased from 14.6 years to 15.2 years, the same as in 1996. This increase may primarily be due to the decrease in the number of 11, 12 and 13 year olds who committed suicide in 1998 as compared to previous years. There were decreases in the number of suicides of most ages with the exception of age 14 where there was an increase (from 0 in 1997 to 2 in 1998). The largest decrease was in the number of 13 year olds, from 4 in 1997 to 1 in 1998. Table 20 displays this data, as does Figure 19.

The two youngest victims in 1998 were 12 and 13 years old. There were two 14 year old and four 15 year old victims. 11 of the 15 victims were 15, 16 or 17 years old. 1998 is the third straight year since ICAN began collecting this data that there were more 16 year old victims than 17 year old victims.

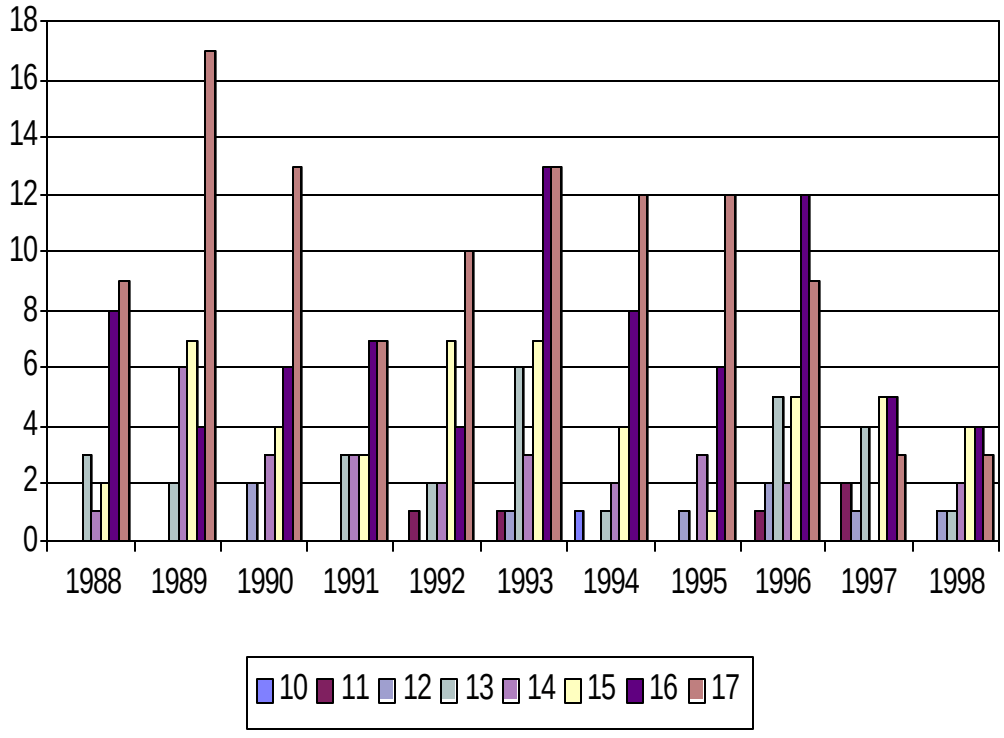
Table 20

AGE BREAKDOWN OF ADOLESCENT SUICIDES 1988 - 1998

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
10	0	0	0	0	0	0	1	0	0	0	0	1
11	0	0	0	0	1	1	0	0	1	2	0	5
12	0	0	2	0	0	1	0	1	2	1	1	8
13	3	2	0	3	2	6	1	0	5	4	1	27
14	1	6	3	3	2	3	2	3	2	0	2	27
15	2	7	4	3	7	7	4	1	5	5	4	49
16	8	4	6	7	4	13	8	6	12	5	4	77
17	9	17	13	7	10	13	12	12	9	3	3	108
TOTAL	23	36	28	23	26	44	28	23	36	20	15	302

Figure 19

1988 - 1998 ICAN ADOLESCENT SUICIDES BY AGE



ETHNICITY

In 1998, 80% of adolescent suicides were committed by Hispanics (n=12). This represents a 33% increase from 1997. The number of White adolescents decreased from 13 in 1996 to 6 in 1997 and now to 3 in 1998, a 50% decrease and 20% of the total number for 1998. The number of African-American adolescent suicides decreased as there were 4 in 1997 and none in 1998. The number of Asian youth who committed suicide also decreased as there was 1 in 1997 and none in 1998.

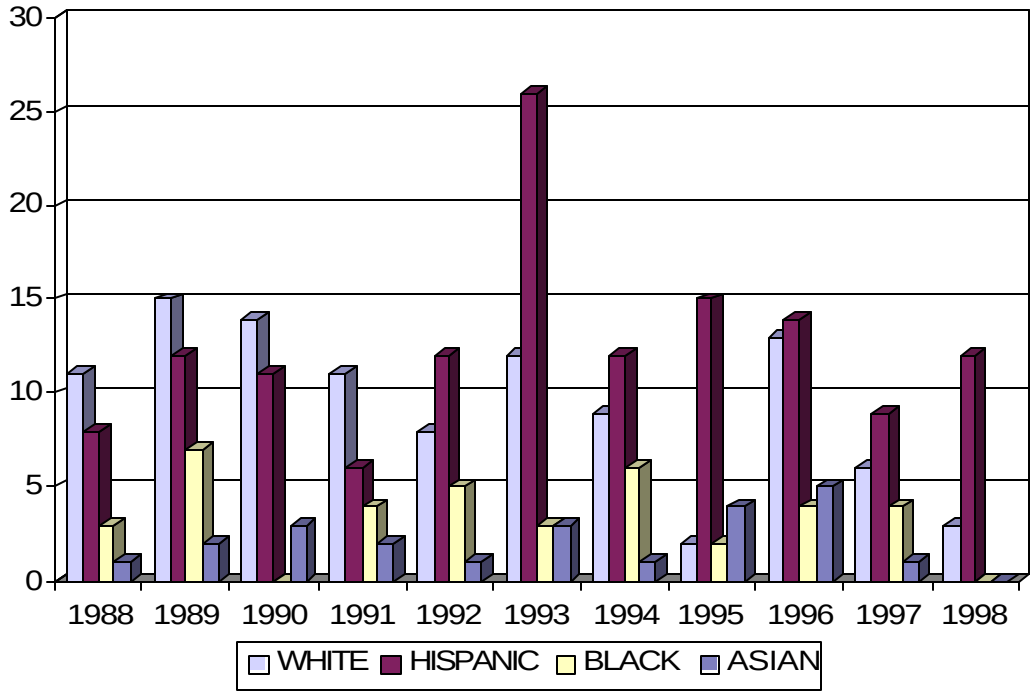
When compared to child population statistics, Hispanic youth were significantly over-represented in 1998 while African-American, White and Asian adolescents were underrepresented.

From a multi-year perspective, as illustrated in Figure 20, Hispanic youth average the greatest number of suicides (x = 12.9), with White youth following (x = 9.3). The number of White youth committing suicide decreased in 1997 and 1998, after an increase in 1996, but consistent with the prior five years of a decrease in these numbers. There continues to be an increasing percentage of Hispanic youth committing suicide, just as the number of Hispanic youth in the population continues to increase. In 1998, an extremely high percentage of the adolescent suicides (80%) were committed by Hispanic youth.

The number of African-American youth who have committed suicide over the past 10 years has averaged 3.5 per year, with a range of 0 to 8. The number of Asian adolescents committing suicide has averaged 2.2 per year, with a range of 0 this year to 1996's high of 5.

Figure 20

1988 - 1998 ICAN ADOLESCENT SUICIDES BY ETHNICITY



CAUSE OF DEATH

In 1998, 60% (n=9) of the adolescents committed suicide by using firearms. Firearms have been the predominant method of suicide over the past 11 years. 181 of the 296 (61%) of the youth suicides over the past eleven years involved firearms. The percentage of total suicides involving firearms has ranged from 1996's low of 40% to a high of 73% in 1992.

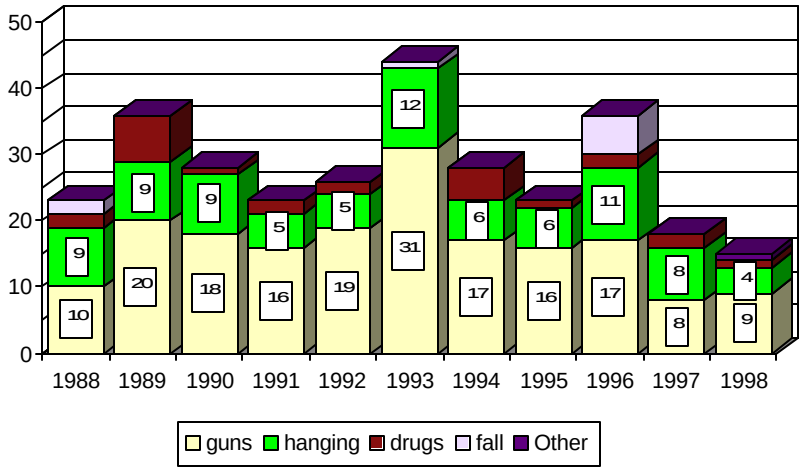
Hanging is the second most frequent cause of suicidal deaths among adolescents. Four hangings were reported for 1998. There have been 84 adolescent suicides by hanging over the past 11 years.

In 1998, one adolescent died from a suicidal drug overdose. There has been an average of 2 deaths from drug overdoses over the previous 11 years. In 1998, there was also a 13-year old girl who placed her head between the bars of wrought iron fence and died from asphyxia and neck compression. She had left a suicide note near the location where she was found.

Figure 21 graphically displays the different methods of suicide over the past 11 years.

Figure 21

1988 - 1998 ICAN ADOLESCENT SUICIDES BY CAUSE



TEMPORAL PATTERN

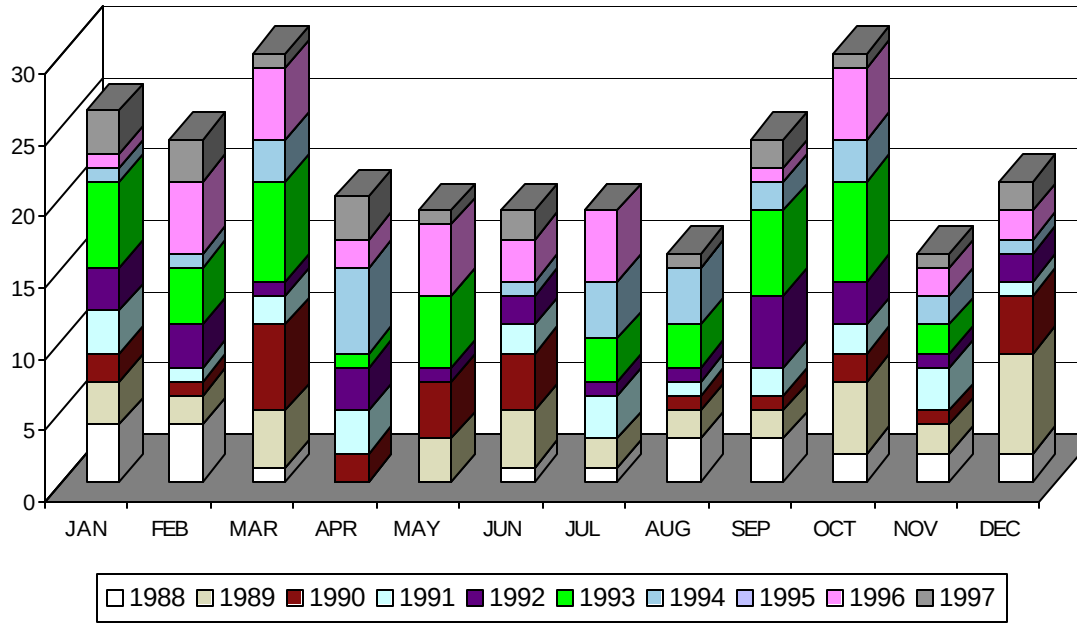
Figure 22 displays the temporal pattern of adolescent suicide deaths from 1988 through 1998.

In 1998, there were six adolescent suicides in February, two in March and two in April. In other words, one period of three consecutive months (25% of the year) accounted for 67% of the suicides. In five months (January, May, August, September and October) there was one adolescent suicide each and in four months (June, July, November and December) there were no adolescent suicides.

Over the period 1988-1998, the months having the greatest number of suicides are March, October, February and January.

Figure 22

1988 - 1998 ICAN ADOLESCENT SUICIDES BY MONTH



CHILD PROTECTIVE SERVICES INVOLVEMENT

In 1998, the Department of Children and Family Services had prior contact with 40% (n=6) of the families with suicide victims. The average length of time between the period when DCFS was involved with the families and the death was 4 years and ranged from 6 months to almost 8 years. In 1998, there was one case where there were seven prior referrals for the family. The prior referrals involved allegations of neglect, physical abuse, caretaker absence/incapacity and sexual abuse. All of the allegations were unsubstantiated except for two referrals for sexual abuse that were founded. It is unclear from the information provided by DCFS, however, what, if any, services were provided to the family regarding the sexual abuse. The 14-year old boy who was the subject for all the prior referrals committed suicide 6 months after the last case for sexual abuse by an Uncle had been closed. There were no other siblings and no referral after the death for this family. There were two cases that had 4 prior referrals each. In one, the referrals involved allegations of physical abuse and lack of supervision. The allegations of physical abuse were founded but the situation was stabilized and the case was closed after 1 month. In this case, the 17-year old male had a number of specialized mental health and educational placements, but none of these placements were through DCFS. The last case for this family had been closed for over three years prior to the suicide of the 17-year-old boy. In the other family, all 4 of the prior referrals involved allegations of general neglect and all 4 were unsubstantiated. The last case had been closed for just over 16 months prior to the suicide of the 17-year-old boy. In another case, the family had 2 prior referrals, both for allegations of sexual abuse of the victim's sibling by the father. The allegations were founded and the father was arrested. The children remained at home as the mother had responded appropriately and appeared able to protect the children. However, a second referral for sexual abuse was made 8 months after the prior case was closed as the mother had let the father back into the home. This case was subsequently closed when the sibling who was the subject of the referral recanted. This last case was closed 4 years prior to the death of the 15-year old male sibling. The number of prior referrals in another case is unclear from the information provided, but there were several referrals alleging caretaker absence, neglect and use of the children for purposes of stealing. In this case, the mother had given her children to her sister to care for them and the court recognized this Maternal Aunt as the primary caregiver for the children. The 14-year old male who committed suicide had 5 involuntary 5150 hospitalizations and killed himself while hospitalized. It is unclear from the information provided if the siblings remained with the Maternal Aunt or if they were placed in out-of-home care after the death. In the final case with prior DCFS contact, there had been 1 prior referral for physical abuse. In this case there had been an on-going custody dispute between the parents and a non-detained petition was filed by DCFS. This petition was dismissed, however, as there was an existing family law order. The case was subsequently closed, 4 ½ years prior to the suicide of the 13-year old girl.

The reasons for involvement included physical abuse (5 cases), sexual abuse (4

cases), general neglect (8 cases), and caretaker absence/incapacity (1 case). In one case the reason for referral was unknown. Table 21 displays the reasons for prior DCFS services on cases between 1989 and 1998.

From the information provided, it does not appear that any of the cases with prior DCFS involvement were open to DCFS at the time of the death. Over the past 10 years, the average percent of families of suicide victims with prior DCFS involvement is 23.5%, ranging from a low of 4% (1 of 23 cases) in 1995 to this year's and last year's high of 40% (8 of 20 cases). In 1998, there were no DCFS cases opened to assess siblings as the result of the suicide.

DEPARTMENT OF PUBLIC SOCIAL SERVICES INVOLVEMENT

33% (n=5) of the families of adolescent suicide victims had a history of receiving public assistance from the Department of Public Social Services. Three of the families that had a history of DPSS involvement also had a history of DCFS involvement.

Over the past 10 years, the number of families known to DPSS has averaged 26.7%, ranging from 1995's low of 13% to 1992's and last year's high of 35%.

In 1998, it was known that there were siblings on 4 cases. Two of these cases were known to DCFS and 2 of these cases were known both to DCFS and to DPSS. On one additional case known to DCFS, it was known that there were no siblings. For the remaining 10 cases, it is unknown if there were any siblings.

Table 21

REASONS FOR PRIOR DCFS SERVICES FOR ADOLESCENT SUICIDES 1989 - 1998

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Sexual Abuse	1		3		3	1		3	3	4	18
Physical Abuse	1	1	1		2	2		2	5	5	19
Severe Neglect	3			1	1			1			6
General Neglect	1			1	3	1		1	1	8	16
Emotional Abuse					3		1				4
Caretaker absence									1	2	3
Info. unavailable	6	2	1	2	2	1		2	1	1	18
TOTAL	**12**	**3**	**5**	**4**	**14**	**5**	**1**	**9**	**11***	**20***	**84**

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

LAW ENFORCEMENT INVOLVEMENT

Five different law enforcement agencies were involved in the investigations of the 15 adolescent suicides in 1998. The Los Angeles Police Department was responsible for the investigation of 5 of the suicides and the Los Angeles Sheriff's Department was responsible for the investigation of 7. Three other law enforcement agencies (Bell Gardens, Compton, and Long Beach) were responsible for the investigation of the remaining 3 suicides.

Table 22 shows the law enforcement agencies involved in all suicides reported to the Team for 1998. Station and Division area detail are reported for Los Angeles Sheriff and Police Departments.

PUBLIC HEALTH SYSTEM INVOLVEMENT

Computer searches for Department of Health Services records noted that 40% (n=6) of the1998 adolescent suicide victims had records at County Medical Facilities, 4 at LAC/USC Medical Center, 1 at Harbor/UCLA Medical Center and 1 at Olive View Medical Center. No comparison with last year is possible, due to incomplete data for 1997.

Place of death data provided by the Coroner indicated that one of the 1998 suicide victims died at a Los Angeles County Department of Health Services facility, Martin Luther King Medical Center. In addition, one each of the 1998 suicide victims died at St. Francis, Greater El Monte, West Hills, Coast Plaza, and Long Beach Memorial medical facilities. The remaining nine suicide victims died at their place of residence.

MENTAL HEALTH SYSTEM INVOLVEMENT

Two of the adolescent suicide victims had contact with the Los Angeles County Department of Mental Health or their contract clients prior to their deaths. In one case, DCFS became involved as a result of the youth's mental and behavioral problems. Referrals were received alleging physical abuse by his father, and alleging that the youth was out of control due to his seizure condition. There was concern that this youth was physically abusing his parents and siblings. As a result of his mental/behavioral condition, the youth had a number of specialized mental and educational placements, though these placements were not through DCFS and DCFS had no further involvement with the family after the last referral in 1995. This 17-year old male committed suicide by ingesting a number of medications. In the other case, DCFS had been involved with the family because the mother had given her children to her sister to raise. There were allegations that the Maternal Aunt neglected these children and used them to steal. The 14-year old male victim had required 5 involuntary 5150 hospitalizations, though the reason for these hospitalizations is unclear. However, while hospitalized, he hooked his belt over the automatic door closer at the top of the door to his room and hung himself.

Table 22

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1998 ADOLESCENT SUICIDES

LAPD	
Harbor Division	2
West Valley	2
Northwest Division	1
LASD Homicide	7
Bell Gardens P.D.	1
Compton P.D.	1
Long Beach P.D.	1

FETAL DEATHS IN LOS ANGELES COUNTY

Twenty-one year old Diana walked into the emergency room of a county hospital complaining of vaginal bleeding. She was seven months pregnant and had gone into pre-term labor. The fetus was delivered stillborn within minutes of the mother's arrival at the emergency room. Blood and urine tests of both the mother and the fetus revealed that both had cocaine in their systems. The mother admitted that she had used cocaine earlier in the day, and that she began to have labor pains immediately after her last "hit" of cocaine.

The mother, who had two other drug-exposed babies earlier in her life, indicated that she had used cocaine "off and on" during the pregnancy and had not received any prenatal health care. She also admitted that she drank beer "to help with sleep" during the pregnancy as well. Diana's two surviving children were in separate homes, awaiting formal termination of parental rights. The fathers of the children were whereabouts unknown, and the mother had failed to comply with the court-ordered case plan, which included substance abuse treatment.

The Department of Children and Family Services had been involved with the mother for many years, first as a dependent of the court herself, then as a parent. She had entered drug treatment on three separate occasions, but failed to commit to the programs each time, dropping out as her cocaine addiction dominated her life. She had very limited extended family support, and had difficulty finding stable housing. At the time of the fetal death, she had been staying at a homeless women's shelter.

The Coroner's report report revealed that the fetus died of intrauterine cocaine exposure and cocaine-induced pre-term delivery. The fetus was noted to be very small for his gestational age, apparently due to the maternal cocaine and alcohol abuse and poor nutrition and health care during the pregnancy.

This case was typical of fetal deaths reported by the Coroner to ICAN during 1998, the majority of which involved fetal deaths due to maternal abuse of drugs and/or alcohol. These cases provide additional evidence of the great risk to fetal and maternal health posed by the abuse of drugs and alcohol by expectant mothers.

Thirty-eight fetal deaths determined to warrant ICAN review were reported to the Team by the Coroner in 1998, a 15% increase from 1997. The number of fetal deaths reported to the Team in the past nine years has ranged from a low of 11 in 1995 to a high of 66 in 1989.

For the purposes of the Coroner's records, fetal deaths are those where an unborn is over 20 weeks gestation. The number of fetal deaths reported to the Coroner, and therefore to the Team, fluctuates greatly from year to year. Over the past 10 years, the average number of fetal deaths has averaged 38.1 per year.

Very few fetal death cases come to the Coroner's attention. It is unclear what criteria any given physician uses to refer a fetal death to the Coroner rather than sign the fetal death certificate at the hospital. Maternal substance abuse appears to be a factor in that decision.

The Coroner is not required to report a manner of death to the State Department of Health Services on fetal death certificates. However, the Coroner does provide this information to the Team for the purposes of this analysis.

MANNER AND CAUSE OF DEATH

The most frequent manner of fetal deaths was accidental (n=30), followed by undetermined (n=6), and homicide (n=2).

The most frequent cause listed for accidental fetal deaths continues to be intrauterine fetal demise (n=26). Other causes of death were primary pulmonary atelectasis (n=3) and stillbirth (n=1). The Coroner reported that there was a history of maternal drug abuse present in all 30 of the accidental fetal deaths.

The causes of the undetermined fetal deaths were similar to the accidental deaths. In 4 of the undetermined deaths, the cause was listed as intrauterine fetal demise, in 1 the cause was listed as non-certifiable fetal death and in 1 the cause remained undetermined due to the discovery of partial fetal remains. Maternal drug abuse was noted in 4 of the 6 undetermined fetal deaths.

The cause of death for the two fetal homicides was intrauterine fetal demise due to maternal assault. In both of these cases the mother was assaulted by another which resulted in the death of both the mother and the fetus.

ETHNICITY

Table 24 lists the manners of death for the fetal deaths broken down by the ethnicity of the victims. Hispanic families represented 16% of the fetal deaths in 1998. The number of fetal deaths to Hispanic women decreased by 45% from 11 in 1997 to 6 in 1998. One of the undetermined deaths and one of the fetal homicides were in Hispanic families. Four of the six deaths involved maternal drug usage. The number of fetal deaths in African American families increased 100% from 10 in 1997 to 20 in 1998. Two of the undetermined fetal deaths and one of the undetermined fetal homicides were in African-American families. Seventeen of the twenty fetal deaths involved maternal drug usage. The number of fetal deaths to Whites decreased 20% from 10 in 1997 to 8 in 1998. One of the undetermined fetal deaths was in a White family. Seven of the eight fetal deaths involved maternal substance abuse. There were two fetal deaths belonging to Asian families in 1998. This is the first time since 1989 that there were any fetal deaths in an

Asian family. Both of these deaths involved maternal substance abuse. In two of the fetal death cases, the ethnicity was unknown. Figure 21 shows the comparative rates of fetal deaths among the different ethnicities.

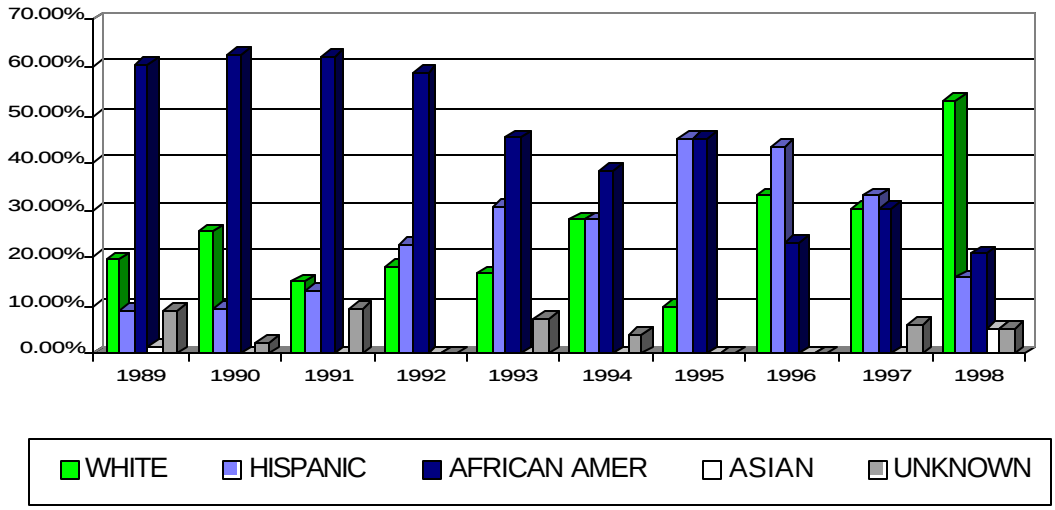
Table 23

ICAN 1998 FETAL DEATHS BY ETHNICITY AND MANNER OF DEATH

	AFRICAN-AMER	HISPANIC	WHITE	ASIAN	UNKNOWN	TOTAL
Accident	4	17	7	2	0	30
Undetermined	1	2	1	0	2	6
Homicide	1	1	0	0	0	2
TOTAL	**6**	**20**	**8**	**2**	**2**	**38**

Figure 23

1988 - 98 FETAL DEATH PERCENTAGES BY ETHNICITY



TEMPORAL PATTERN

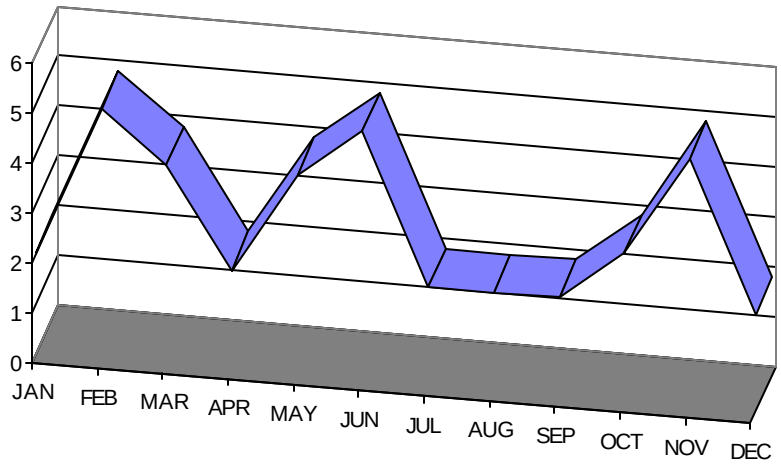
The number of fetal deaths per month for each month is displayed in Figure 24. The number of deaths ranged from 2 to 5 deaths in any given month. There were no months without any fetal deaths. February and November had the most fetal deaths with 5 each. The largest number of fetal deaths for one month ever reported was the 10 fetal deaths reported for June 1994 and the second largest number reported was the 7 fetal deaths reported for April 1996.

DEPARTMENT OF CHILDREN & FAMILY SERVICES INVOLVEMENT

The Department of Children and Family Services had a record of prior involvement with 6 of the families where there was a fetal death. 5 of these cases were open to DCFS at the time of the fetal death. All 5 of these cases were open due to allegations of substance abuse and in all of these cases the siblings were placed in out-of-home care at the time of the fetal death. In all 5 of these open cases the siblings remained placed in out-of-home care after the fetal death. There was 1 case with prior DCFS involvement that had been closed prior to the fetal death. In this case, there had been 3 prior referrals and all referrals were for allegations of general neglect. These allegations were unfounded on two occasions and unsubstantiated on the other. At the time of the fetal death, the mother admitted that she had used cocaine three days prior to the birth and that she had not received any prenatal care. After the fetal death, the 2 surviving siblings were placed in out-of-home care. In addition to this family, DCFS opened a case on 2 other families as a result of the fetal death. In one of these cases there was a referral for general neglect but after an investigation the allegations were unsubstantiated. The home environment was found to be appropriate with an adequate supply of food and the mother had subsequently tested negative for drugs. As a result of these findings, the case was closed and the siblings remained at home. In the other case there was a referral after the death for general neglect. At this time, the mother admitted that she had previously had twins who had died as a result of her substance abuse. As a result, the 4 surviving siblings were placed in out-of-home care.

Figure 24

1998 ICAN FETAL DEATHS BY MONTH



DEPARTMENT OF PUBLIC SOCIAL SERVICES INVOLVEMENT

DPSS records revealed that 26% (n=10) of the families had a record of receiving public assistance. It is known that there were siblings present on 7 of the 10 DPSS cases. In addition to the 4 cases with a DPSS record already open to DCFS, a referral was made to DCFS following the fetal death on 2 additional cases with a record of DPSS involvement. The other 4 cases with DPSS involvement had no record with DCFS.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

Eight law enforcement agencies were involved in the investigations of the fetal deaths in 1998. 6 of the case investigations involved the Los Angeles Sheriff's Department and 18 of the case investigations involved the Los Angeles Police Department. Six additional police agencies were involved in 14 of the fetal death investigations. Table 24 shows the law enforcement agencies involved in all fetal deaths reported to the Team for 1998. Division area detail is reported for the Los Angeles Police Department.

Two of the fetal deaths were presented to the District Attorney's Office for consideration of filing criminal charges. One of these cases involved maternal drug usage, but the case was rejected by the District Attorney's Office due to insufficient evidence. In the other case, a maternal assault case, the District Attorney's Office filed murder charges against the mother's boyfriend for the murder of the mother and her fetus. The disposition on this case is unknown. On two additional cases, charges are pending. In one case, a maternal substance abuse case, the mother was arrested for violation of her parole. In the other case, a maternal assault case, law enforcement believes that the mother and her fetus were killed by the mother's boyfriend. However, there is currently insufficient evidence to present the case to the District Attorney's Office for the filing of criminal charges. The investigation remains open.

Table 24

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1998 FETAL DEATHS

LAPD	**15**
Northeast Division	5
Southwest Division	3
Rampart Division	2
Wilshire Division	2
Central Division	1
Devonshire Division	1
Foothill Division	1
Hollenbeck Division	1
Van Nuys	1
77th Division	1
LASD	6
Long Beach P.D.	7
Inglewood P.D.	3
Compton P.D.	1
Monterey Park P.D.	1
Pasadena P.D.	1
Redondo Beach P.D.	1

HEALTH SYSTEM INVOLVEMENT

Three of the 38 fetal death cases reported to ICAN in 1998 had records at a Los Angeles County Department of Health Services facility. All three of these records were found at Harbor/UCLA Medical Center.

Place of death data provided by the Coroner indicated that 20 different hospitals were involved in the fetal deaths.

When comparing place of death data reported by the Coroner, 4 records should have been found at LAC/USC Medical Center, 3 records should have been found at King Drew Medical Center and 1 record should have been found at Olive View Medical Center. An additional 2 records should also have been found at Harbor/UCLA Medical Center as the two cases that had records at Harbor/UCLA Medical Center did not list Harbor/UCLA as the place of death. Two of the fetuses showed the residence as the place of death and two of the fetuses were abandoned and found dumped in the trash or in the sewer. In addition, in a maternal assault case, the car where the mother and her fetus were shot was listed as the place of death.

INTRODUCTION TO "HOW TO" GUIDE FOR CHILD FATALITY REVIEW TEAMS

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

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

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

"HOW TO" GUIDE FOR CHILD FATALITY REVIEW TEAMS

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

Case One

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

Case Two

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

Case Three

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

Case Four

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

Case Five

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

RESPONSES

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

I. What are Child Fatality Review Teams?

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

II. Why and How Teams are Forming and Expanding

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

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

1. Child deaths, particularly preventable abusive deaths, create great pain for line professionals who have known the child. This pain creates motivation that pushes individuals to create a larger group of people to share that pain, and to address the facts and follow-up to the death.
2. Expanding information systems and computer technology help to make the multi-agency team process both familiar and available to professionals and advocates from the line level to the senior management level. The team review model provides a tool for these individual professionals and agencies to work together to

be more effective in addressing the many issues involved in child deaths. As a result of team review, agencies may change official protocols and policies, particularly as they relate to multi-agency intervention.

3. When professionals and agencies are connected in a collaborative way, they can then build a more open system of multi-agency cooperation and can form alliances that address possible fatal and severe child abuse/neglect.
4. Child Fatality Review Teams have shown that it is possible to continue past the "child abuse deaths" to address other non-fatal family violence and many other forms of preventable "accidental" and "natural" deaths.
5. Teams that are working together on issues pertaining to child death also learn how to develop a multi-agency focus on infants, toddlers and high-risk pregnancies, which can lead to the development of prevention and early intervention programs.
6. Team reports that address child deaths and highlight recommendations aimed at prevention can be shared across state and national boundaries and can provide a tool for the sharing of information and resources.
7. Neighboring Teams can visit each other and share resources. They may also want to join together to form a Regional Team Review process.
8. State Teams can provide a forum for the sharing of resources and can support local data collection for use in the development of state mandates and state reports.
9. Over time, Teams can expand to engage in a retrospective review of old cases, which will be augmented by the knowledge and experience gained from earlier team reviews.
10. The national interaction of State Teams, National Associations and Federal Agencies can provide a forum for the development of a national system for the Child Fatality Review Process. International contacts can provide the resources to coordinate this process on an international basis.

III. Basic Team Structure, Philosophy and Process

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

A. Core Membership

1. Coroner/Medical Examiner: Responsible for providing critical information on the manner and cause of death for all unexpected and/or unexplained child deaths including trauma deaths such as homicides, suicides, and accidents.
2. Law Enforcement: Responsible for investigating potential suspicious deaths.
3. Prosecuting Attorneys: Responsible for prosecuting provable criminal deaths.
4. Child Protective Services: Responsible for intervention with familial child abuse/neglect.
5. Health (the most varied of the Core Team Members): Responsible for providing evaluation and treatment to injured children, reporting suspected child abuse/neglect, engaging in outreach to children at risk of abuse/neglect through public health nursing programs, and keeping vital records of births and deaths.

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

B. Team Philosophy

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

C. Review Process

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

IV. Team Variation

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

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

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

V. Central Log or Data Systems

A. Minimum Log/Data System

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

B. Demographic Data/Team Reports

With time, the data collected can be expanded to include more demographic data including the age, gender and race of the child victim. Factors including the date and location of the injury, previous records or agency contacts with the family, including any prior child protective services and risk factors including domestic violence, violent criminal records and substance abuse can be tracked and recorded. This information can then be compiled into team reports which provide data analysis and recommendations based on the case data collected and examined.

C. Computerized Data

Teams can eventually keep data by computer making data queries and data analysis

both easier to do and more complex in scope. For instance, death data may be mixed with other population data to analyze the rates and distinctions between the prevalence and the incidence of death.

D. Systematic County Level Demographic Data Set

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

E. County/State/National Triple Data Set

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

1. Law enforcement child homicides recorded in the Federal Bureau of Investigation - Uniform Crime Reports - Supplemental Homicide Reports (FBI-UCR-SHR). These are "child homicides" as determined by law enforcement.
2. Vital statistics child homicides as recorded in vital statistics kept by public health agencies, typically through death certificates. These are those child deaths that a Coroner determines fits the "homicide" mode of death.
3. "Fatal child abuse/neglect" as noted in state Child Abuse Central Indices. These are deaths due to child abuse or neglect which are reported to the state index by law enforcement and/or child protective services.

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

VI. Common Problems/Answers

A. One Agency Won't Cooperate

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

B. Records Can't Be Found

It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. It is also hard to find records from multiple counties and to connect state and county record systems. As teams grow, they tend to pursue more information and are able to search with more accuracy. A team might

develop a written protocol on how to search for records and may give team members a monthly "report card" noting which files have been found and which remain missing. A monthly team "report card" of found or missing records helps to keep members up to date on themselves and each other.

C. Team Stopped Meeting and Needs To Restart

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

D. Confidentiality

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

E. Failure To Write a Report On Team Activity

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

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

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

G. Increased Sophistication Requiring Training

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

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

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

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

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

VII. Extensions of Process

A. Domestic Violence Fatality Review

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

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

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

C. FIMR and SIDS Programs

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

D. Multi-County and Multi-State Case Review

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

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

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

F. Prevention Program Addressing Perinatal and Infant Toddler Issues

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

VIII. Grief and Mourning

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

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

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

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

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

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

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

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

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

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

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

IX. Prevention / Health

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

Campaigns and programs addressing child deaths which value prevention include:

1. Public education on the potential hazard of accessible 5 gallon buckets to young toddlers resulting in toddler drownings.
2. Infant automobile safety seat campaigns that provide donated seats for families who have limited funds.
3. Child-proof drug containers, particularly for presciption pills or iron pills that resemble candy.
4. Traffic safety campaigns and the provision of speed bumps in neighborhoods with large numbers of young children.
5. The enacting of ordinances for four-sided fencing to help prevent pool and spa drownings and river safety programs that utilize warning signs in multiple languages.
6. The provision of smoke detectors for substandard homes (particularly homes where infants and toddlers reside) by child protective service agencies.
7. More intensive evaluations for home safety through the use of multi-agency records.
8. An increased awareness of the needs of infants and toddlers by both law enforcement and child protective services.
9. Multi-agency joint home visits by public health nurses, child protective services and law enforcement.
10. Perinatal intervention programs for women in jails and juvenile facilities.
11. Parenting programs for incarcerated parents, particularly young fathers.
12. Multi-agency integrated data systems to coordinate and monitor services to children and families with multiple problems.

Glossary of Terms

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

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

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

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

C.A.T. Scan (computerized axial tomography) - a radiological study using x-rays translated by computer to show body cross sections (see M.R.I.)

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

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

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

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

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

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

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

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

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

Death - loss of life (see fatality)

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

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

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

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

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

Fatality - loss of life (see death)

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

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

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

Forensic - having to do with the study of criminal acts

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

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

Homicide- (official) death caused by another with the intent to kill or severely injure

Homicide -(common but not official) death at the hands of another (without reference to intent)

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

Injury - caused by physical trauma

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

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

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

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

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

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

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

Neonate - infant under one month of age

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

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

Pediatrician - physician who has completed residency training in pediatrics

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

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

Retinal hemmorhage - bleeding in the retina of the eye

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

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

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

Stillborn - potentially viable fetus born dead

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

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

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

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

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

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