ICAN

Inter-Agency Council on Child Abuse and Neglect

Los Angeles County • ICAN Multi-Agency Child Death Review Team
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ICAN

Report Compiled From 1999 Data

CHILD DEATH REVIEW TEAM REPORT FOR 2000

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

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

FOREWORD

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

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

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

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

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

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

Michael Durfee, M.D.

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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 adolescents, children exposed to family violence, abducted children, and siblings of children who are victims of fatal abuse. Fifteen community based inter-disciplinary child abuse councils interface with ICAN and provide valuable information to ICAN regarding many child abuse related issues. ICAN provides advice and guidance on public policy development and program implementation to improve the community's collective ability to meet the needs of abused and at-risk children with the limited resources available. ICAN Associates is a private non-profit corporation of volunteer business and community members who raise funds and public awareness for programs and issues identified by ICAN.

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

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

For further information, contact:

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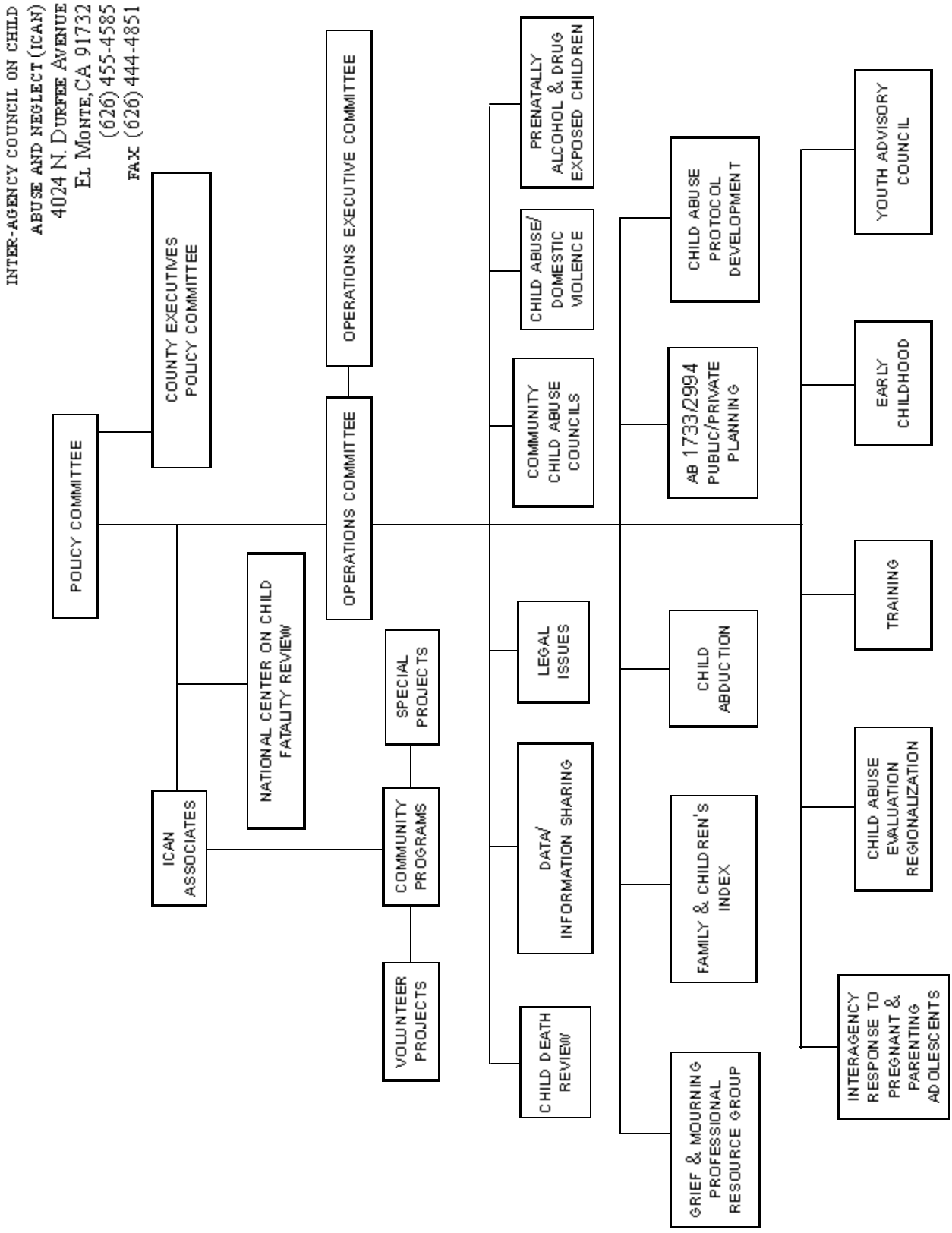


POLICY COMMITTEE
Twenty-seven department heads, UCLA, five Board appointees and the Children's Planning Council. Gives direction and forms policy, reviews the work of subcommittees and votes on major issues. (Meets in April & November, no set dates)

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 system improvement. Issues annual report. (Meets every 1st Wed., Dept. of Coroner, 1:00 p.m.) Note: This is a closed meeting.

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

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

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

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

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

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

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

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

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

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

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

CHILD ABUSE EVALUATION REGIONALIZATION

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

TRAINING

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

EARLY CHILDHOOD COMMITTEE

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

YOUTH ADVISORY COUNCIL

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

CHILD AND ADOLESCENT SUICIDE STUDY GROUP

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

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 and to establish ICAN as the National Center on Child Fatality Review (NCFR).

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

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

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

Child Death Review Team Training and the National Center on Child Fatality Review are two examples of ICAN's work to develop and improve critically important multi-disciplinary review of the intentional and pre-

ventable deaths of children. ICAN's efforts in this area continue to evolve and grow as more is learned through the sharing of information among child death review teams locally, nationally and internationally.

INTRODUCTION

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

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

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

This eleventh annual report of the ICAN Multi-Agency Child Death Review Team provides information on children's deaths that occurred in Los Angeles County during calendar year 1999 and were referred to ICAN by the Office of the Coroner. It provides a detailed analysis of children killed by caregivers, accidental deaths, undetermined deaths, fetal deaths or youth suicides. This report also contains recommen-

dations for action, which, if implemented, should improve child safety, enhance our understanding of child death and ultimately, save lives. Psychiatrist Viktor Frankel once said that the task in life is to find meaning in our existence, even in suffering. Finding meaning in the suffering and deaths of these young and innocent children will always guide our work.

FINDINGS

CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS

- 44 child homicides by parents/caretakers/family members were identified by the Team in 1999. This is a decrease of 10% from the 49 child homicides by parents/caretakers/or family members identified in 1998, but remains relatively consistent with the previous 11-year average of 47.
- 57% (n=25) of the victims were female; 43% (n=19) of the victims were male. Over the past 11 years, there have been a total of 274 male victims (53%) and 241 female victims (47%).
- 34% (n=15) of the victims were under the age of 6 months. 48% (n=21) were under the age of 1 year. 52% (n=23) were under age 2 years. Over the past 11 years, 43% (n=224) of the victims have been under the age of 1 year and 85% (n=440) have been under the age of 5 years.
- 39% (n=17) of the victims were African American; 27% (n=12) of the victims were Hispanic; 27% (n=12) of the victims were White and 7% (n=3) of the victims were Asian.
- 34% (n=15) of the fatal injuries were the result of head injuries caused by blunt force cerebral trauma, shaken baby syndrome or a combination thereof.
- 64% (n=28) of the fatal injuries were caused by direct assault, the perpetrator using no weapon other than his or her own hands.
- Deaths due to multiple trauma (n=10) and asphyxiation/suffocation (n=6) were the second/third leading cause of child homicide by parents/caretakers/ family members in 1999.
- Gunshot wounds declined from 20.4% (n=10) of the cases in 1998 to just 9% (n=4) in 1999. In the past, deaths due to gunshots have consistently been the third or fourth leading cause of child homicides by parents/caretakers/family members.
- The deceased child had siblings identified in 45% (n=20) of the child homicide cases.
- 50% (n=22) of the families had a history of receiving public assistance from the Department of Public Social Services. Between 1989 and 1999, the percentage of families with prior public assistance has ranged from 49.2% to 62.5%.
- 45.4% (n=20) of the families had a current or prior record of referral to child protective services prior to the death of the child. It is interesting to note that with one child death case involving seven prior referrals, the deceased child was never the alleged victim. Rather, the child's mother was the subject of four

referrals when she was a child and the child's father was the subject of three referrals when he was a child.

- 9% (n=4) of the victims of child homicide by parents/caretakers/family members had medical records at Los Angeles County Department of Health Services facilities. No comparison with prior years may be made as information regarding 26 of the 44 child homicide cases was unavailable from Olive-View Medical Center and King Drew Medical Center.

- 77% (n=34) of case investigations resulted in presentations to the District Attorney's Office by the law enforcement jurisdictions. The average percentage of cases presented to the District Attorney's Office by law enforcement over the past 11 years is 72%.

- 51 perpetrators were identified by law enforcement. 53% (n=27) of the perpetrators were female, most frequently the child's mother (n=19). Additional female perpetrators in 1999 included the mother's domestic partner, a paternal aunt who was the child's foster parent, 2 additional foster mothers, a foster mother's daughter and 3 female babysitters.

- 47% (n=24) of the perpetrators were men, most frequently the child's natural father (n=15) or the mother's boyfriend (n=4). The other male perpetrators in 1999 were 2 male siblings, 2 uncles (one of whom was the child's foster parent) and 1 male babysitter.

- In contrast to 1998 when no foster parents or out-of-home caretakers were identified as perpetrators, 3 sets of foster families were identified as perpetrators in 1999. These foster families included 2 foster mothers, a foster mother's daughter and an aunt and uncle who were the child's foster parents. In addition to this aunt and uncle, four other extended family members were identified as perpetrators in 1999 including 1 uncle, 1 domestic partner and 2 siblings.

- The DA filed criminal charges on 88% (n=30) of the cases presented to them. The filing of criminal charges is still being considered by the DA pending further information from law enforcement on one additional case. Over the past 11 years, the percentage of case presentations resulting in the filing of criminal charges has ranged from 66% to 97%.

- 14 fathers, 3 mothers' boyfriends, 1 foster parent/uncle and 1 male babysitter were criminally charged in 1999. 1 father and 1 brother committed suicide after the murder. 1 brother and 1 uncle were too young to be charged with a crime and the DA rejected the filing of criminal charges against 1 mother's boyfriend.

- 15 mothers, 2 foster mothers, 1 foster mother's daughter, 1 aunt and 1 female babysitter were criminally charged in 1999. Two mothers and a mother's domestic partner committed suicide after the murder. The DA rejected charges against 2 mothers and 2 female babysitters.

- There were multiple suspects in 30% (n=9) of the cases in which criminal charges were filed. In one case in which a mother and a female babysitter were implicated, no charges were filed as it could not be determined who actually

caused the death.

- District Attorney disposition of criminal filings were:

  11% - (n=4) 25 years to life
  11% - (n=4) 15 years to life
  8% - (n=4) between 11 and 13 years of imprisonment
  14% - (n=5) between 2 and 10 years of imprisonment
  22% - (n=8) 3 to 5 years probation (plus time served)
  16% - (n=6) still pending trial
  3% - (n=1) found not guilty
  3% - (n=1) dismissed
  3% - (n=1) jury conviction thrown out by judge

ACCIDENTAL CHILD DEATHS

- 134 accidental child deaths were reported to the ICAN Team for 1999, a 41% increase over 1998. However, this increase may, in part, reflect changes in the intake process used to refer cases by the Coroner's Office to the Team.
- Autopedestrian deaths - deaths resulting from children hit by cars - were the leading cause of accidental child death in 1999. There were 31 autopedestrian deaths, representing 23% of the total accidental child deaths in 1999. This number is a 63% increase over the 19 such deaths in 1998. However, it is unclear if this number represents an actual increase in the numbers of these deaths or, as stated, better identification of these deaths by the Team.
- For only the third time since ICAN began collecting this information, drowning was not the leading cause of accidental child death. Deaths due to drowning were the second leading cause of accidental child death in 1999. However, the number of accidental child deaths due to drowning increased 19% (n=25) from the 21 deaths due to drowning in 1998.
- Deaths associated with maternal substance abuse were the third leading cause of accidental child death in 1999 and represented 16% (n=21) of the total number of accidental child deaths. Deaths associated with maternal substance abuse were the leading cause of accidental child death in 1996 and 1998, the only other years when drowning was not the leading cause.
- Non-pedestrian child deaths associated with automobiles (solo automobile and automobile vs. automobile accidents) comprised 13% (n=18) of the accidental child deaths in 1999.
- 57% (n=77) of the accidental child death victims were male; 43% (n=57) were female.
- 31% (n=42) of the accidental child deaths occurred with victims under the age of one year.
- 54% (n=72) of the accidental child death victims were Hispanic. Hispanic children comprise 57.5% of the County child population.
- White children represented 21% (n=28) of the accidental child death victims. White children comprise 19.8% of the County child population.
- 18% (n=24) of the fatal accident victims were African American. African American children comprise 9.9% of the County child population.

- 7% (n=9) of the fatal accident victims were Asian. Asian children comprise 9% of the County child population. Less than 1% (n=1) of the fatal accident victims were Native American.
- 13% (n=18) of the families had a record of receiving child protective services prior to the death of the child. 33% (n=6) of these cases involved deaths the Coroner indicated were associated with maternal substance abuse.
- The deceased child had identified siblings in 26% (n=35) of the cases.
- 32% (n=43) of the victims had known medical records at Los Angeles County Department of Health Services facilities.
- Three cases were presented by law enforcement to the District Attorney. All 3 cases resulted in the filing of criminal charges. Two cases were dismissed and the third resulted in a guilty plea for misdemeanor vehicular manslaughter.

UNDETERMINED CHILD DEATHS

- 57 undetermined deaths were referred to the Team by the Coroner for 1999. This number represents the highest number of undetermined child deaths since ICAN began collecting this data. Again, this increase may, in part, reflect changes in the process used by the Coroner's Office to refer cases to the Team.
- 83% (n=47) of the undetermined child deaths involved those under 1 year of age. During the period 1989 through 1999, an average of 70.1% of the undetermined child death victims have been under the age of 1 year.
- 10 of the families were known to the Department of Children and Family Services.
- 11 of the victims had known medical records at Los Angeles County Department of Health Services facilities.
- Three cases were presented by law enforcement to the District Attorney for the filing of criminal charges. One case was rejected for prosecution. The second resulted in the filing of murder and felony child abuse charges, which remain pending. The third resulted in the filing of manslaughter charges, which also remain pending.

SUICIDES

- 27 child and adolescent suicides, ages 10 through 17 years, were reported to ICAN's Child Death Review Team by the Coroner in 1999, an increase of 80% from 1998. The average number of adolescent suicides for the past 12 years (since 1988) is 27.4 per year.
- 78% (n=21) of the suicide victims were male. 22% (n=6) of the victims were female. Over the last 12 years the number of male suicide victims has ranged from 12 to 37 per year and the number of female victims has ranged from 2 to 11 per year.
- 41% (n=11) of the suicides were committed by White youth. 33% (n=9) of the suicides were committed by Hispanic youth. There were four suicide deaths by African American youth and three by Asian youth in 1999.

- 74% (n=20) of the suicide victims were either 15, 16, or 17 years old. The youngest victims were 10 (n=1), 12 (n=2), 13 (n=1) and 14 (n=3) years of age.
- In 60% (n=16) of the cases, the method of suicide involved firearms. 197 of the 323 (61%) adolescent suicides over the past 12 years involved firearms. In another 30% (n=8) of the 1999 cases, the method of suicide was hanging. Other methods included carbon monoxide poisoning, 7% (n=2), and jumping from a structure, 3% (n=1).
- 44% (n=12) of the families with youth suicide victims had a known history of receiving public assistance from DPSS.
- 19% (n=5) of the families with youth suicide victims had prior involvement with the Department of Children and Family Services.
- 15% (n=4) of the suicide victims had records of involvement with Los Angeles County Department of Health Services facilities.
- There were siblings identified in 26% (n=7) of the cases.

FETAL DEATHS

- 39 fetal deaths were reported to the ICAN Child Death Review Team for 1999, a 3% increase over 1998. Over the past 11 years, the average number of fetal deaths has been 38 per year.
- Hispanic families suffered 33% (n=13) of the fetal deaths identified by the Team. Six of these 13 fetal deaths involved maternal drug usage. The number of fetal deaths in African American families decreased 45% from 20 in 1998 to 11 in 1999. Nine of these 11 fetal deaths involved maternal drug usage. There were 10 fetal deaths in White families in 1999 and five of the 10 fetal deaths involved maternal drug usage.
- In 75% (n=15) of the fetal accidental deaths, there was a history of maternal drug usage.
- There were no fetal homicides reported to the Team for 1999.
- Five of the families who suffered fetal deaths had a record of prior involvement with the Department of Children and Family Serivces.
- Seven of the fetal death families had a known medical record at Los Angeles County Department of Health Services facilities.
- Law enforcement presented two cases to the District Attorney for the filing of criminal charges. In one case, the 19-year old boyfriend of the victim's 13-year old mother was charged for having sexual relations with a minor. The other case involved maternal assault, and the District Attorney rejected the case due to insufficient evidence. In one additional case, the investigation into a possible illegal abortion clinic is ongoing and may result in the filing of criminal charges.

RECOMMENDATIONS

RECOMMENDATION ONE: DATABASE RECONCILIATION

The California Department of Justice (DOJ), which maintains the State's Child Abuse Central Index (CACI), should consider an annual reconciliation of the DOJ Homicide File with Los Angeles County child abuse deaths entered into CACI, with follow-up to inquire about the reasons-and possible solutions-for any discrepancies found. The findings of this annual reconciliation regarding Los Angeles County cases would be included in the annual ICAN Child Death Review Team Report.

Rationale:

CACI is the State of California's database of child abuse and severe neglect investigation results, including child abuse-related homicides. The database is created through manually entered Child Abuse Investigation Reports (SS 8583) submitted to DOJ by law enforcement agencies and child protective service agencies following their investigations. CACI data has historically under-represented child abuse and child homicide cases found in Los Angeles County. For example, ICAN identified 44 child abuse-related homicides by caregivers during 1999 in Los Angeles County. During the same period, the CACI database identified 14 child deaths in Los Angeles County and 30 statewide. The degree to which this discrepancy may reflect missing, inaccurate or incomplete referrals from the counties to CACI is unknown. DOJ is currently in the process of modernizing its database and processes. An annual internal DOJ reconciliation of its Homicide File with Los Angeles County child homicides entered into CACI would be an important step in the improvement of ongoing surveillance of fatal child abuse and neglect in the State and counties.

RECOMMENDATION TWO: REVIEW OF NON-INTENTIONAL INJURY DEATHS

The Department of Health Services (DHS) and others who work with non-intentional injuries of children should pursue a forum for multi-agency review. This forum should include reviews of child death resulting from trauma involving motor vehicles, guns (other than gun-related homicide or suicide) and drowning.

Rationale:

To date, the Child Death Review Team has largely limited its focus to comprehensive review of child homicides by parent or caregiver due to limited resources. Data on non-intentional injury deaths is currently gathered by the Team primarily for completion of this annual report. Multi-agency review of non-intentional injury deaths could provide critical information and insights for the development of policies and programs to prevent these tragic accidental deaths of children.

RECOMMENDATION THREE: YOUTH SUICIDE

The Los Angeles County Office of Education should encourage all public and non-public schools in Los Angeles County to adopt written suicide prevention policies as a component of the Comprehensive School Safety Plan. These policies should cover all issues surrounding student suicide, including confidentiality, suicide attempts and postvention. Once developed, policies should be disseminated school-wide to staff and parents. The results of these efforts should be presented at the November 2001 meeting of the ICAN Policy Committee.

Rationale:

Youth suicide continues to be a troubling reality in Los Angeles County, where twenty-seven suicides of youth age 17 or younger occurred during 1999, an increase of 80% over 1998. It is worth noting that several of these victims were quite young, including one ten-year old, two twelve-year olds, and one thirteen-year old. The public and private schools in the County, which have the most contact with youth who may be contemplating suicide, would be the most effective agents to ensure that youth and their families are informed of available suicide prevention and postvention services.

RECOMMENDATION FOUR: CHILD ABANDONMENT

The Los Angeles County Departments of Health Services (DHS), Children and Family Services (DCFS), Probation, Public Social Services (DPSS), Sheriff, Office of Education (LACOE) and Los Angeles Unified School District (LAUSD) should ensure that all employees are provided with written information on the provisions of SB 1368 which addresses the abandonment of newborns; DHS, DCFS, Probation, DPSS, LACOE and LAUSD should develop and distribute informational materials on this new law to their clients or students; and DCFS, County Counsel and DHS should each develop internal policies and procedures to implement the new law. The critical policies and procedures related to implementation of the new law should be added to the Child Abuse Protocol for Los Angles County. The results of these efforts should be presented at the November 2001 meeting of the ICAN Policy Committee.

Rationale:

On January 1, 2001 SB 1368 (Brulte) became law in California. SB 1368 allows parents or others with legal custody of a newborn less than 72 hours old to voluntarily surrender physical custody of the newborn to designated employees at any public or private hospital, or at any additional location designated by the Board of Supervisors without threat of criminal prosecution for child abandonment. Historically, there have been several abandoned infants found each year in Los Angeles County. Of course, this does not include abandoned infants who are never discovered. Systematic child death review indicates that newborn abandonment deaths often involve young mothers who feel frightened and without options. Widespread dissemination of information about this new law would increase awareness of an available alternative to abandoning a newborn

baby. The new law also requires action on the part of DCFS, DHS, County Counsel and other agencies as identified. The policy and procedural responses of these agencies must be clear, legally appropriate and well-understood by staff charged with implementation.

RECOMMENDATION FIVE: PUBLIC HEALTH DATA ON ALL CHILD DEATHS

The Department of Health Services (DHS) should provide ICAN with data on all child deaths.

Rationale:

An estimated 1,500 children die in Los Angeles County each year and approximately 650 of these deaths are referred to the Coroner. More than half involve infants and half of those are associated with very low birth weight (under 1,500 grams). Vital Statistics records regarding child deaths are available and could assist in directing policy and program decisions. Data on morbidity (e.g., child hospital discharge data) could help extend death data and death prevention efforts to the larger world of non-fatal/severe injuries.

RECOMMENDATION SIX: RELEASE OF NEWBORNS FROM STATE PRISON

The State of California Department of Corrections should develop a standard protocol for the release of infants born to inmates. The protocol should ensure that any relative or home to which the infant is released has been thoroughly investigated for appropriateness by child protective services in the county in which the child and caregiver will reside.

Rationale:

The Los Angeles County Child Death Review Team has reviewed cases in which a child born to a prisoner under the supervision of the Department of Corrections was released to a caregiver without investigation or evaluation of the caregiver's suitability to care for the infant. Child Protective Services agency investigation of the prospective caregiver's background and residence would help to ensure that children are not placed in endangering environments. The Department of Corrections should contact the Child Protective Services agency in the county where the infant and caregiver will reside to inform them of the child's placement and request follow-up to assure the child's safety and well-being.

RECOMMENDATION SEVEN: PARENT EDUCATION

The California Department of Social Services Community Care Licensing, Department of Children and Family Services, Department of Public Social Services, Department of Health Services, and Office of Education and Los Angeles Unified School District's teen parent programs should assure that parents and caregivers of toddlers and young children are provided with information on toilet training, including how to determine a child's readiness for toilet training, helpful tips, and the dangers and inappropriateness of punishment in response to toilet accidents.

Rationale:

Since the inception of ICAN's child fatality review process, numerous cases have been reviewed involving a parent or caregiver's rage and deadly response to a toddler wetting or defecating in his/her diaper or underpants. Little children have been victims of fatal blunt force trauma and have been fatally burned in bathtubs of scalding water because a parent or caregiver was angry or impatient and had unrealistic expectations of the child's ability to control his or her bodily functions. In 1999, at least two child homicides by caregivers identified toilet training issues as factors contributing to the child's death. Several other cases are suspected to have been motivated by similar issues.

RECOMMENDATION EIGHT: PROPOSITION TEN

The Los Angeles County Proposition Ten Commission should consider the findings of child fatality review in the allocation of funding for prevention, intervention, research and accountability on behalf of children prenatal to five years of age.

Rationale:

The findings of the Child Death Review Team have consistently shown that children from birth to age 5 are at the greatest risk for child abuse deaths, disease, natural and non-vehicular accidental deaths. The information from review of these cases can be invaluable in developing policies, services and public awareness to address preventable serious injuries and fatalities.

TEAM PROTOCOLS FOR CASE REFERRAL

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

MANNER OF DEATH

The Coroner must designate the manner of death to be listed on the death certificate as either: Homicide, Accidental, Natural, Undetermined or Suicide. This report, as have the 10 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. If the suspected perpetrator is a parent, caretaker or family member, these cases require evaluation by the Child Death Review Team. Homicide by parent/caretaker/family member is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term "homicide" regardless of the criminal intent of the perpetrator or the findings of police, the District Attorney, courts or juries. Homicide may describe circumstances ranging from tragedies that involve no clear intent, to vicious, fatal attacks with clear intent.
- **Accidental** deaths are the largest category of deaths reported to the Team by the Coroner. Several types of accidental death, such as drownings, head trauma from falls, suffocations and accidental gunshot wounds, are truly unintentional in nature. However, there may be questions of caretaker supervision in some of these cases, as well as concern regarding the preventability of these accidents. A portion of the accidental deaths involves 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 has 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 the condition of the body raises a suspicion of child abuse or neglect. SIDS deaths are considered to be Natural deaths and are reviewed at the request of the Department of Health Services SIDS Project. Very few of the estimated 1,500 natural child deaths that occur in Los Angeles County are brought to the Team's attention.
- **Undetermined** deaths reflect situations in which 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. Undetermined death 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 be unable to determine if the exposure caused the death or if the death 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 youth for prevention purposes.
- **Fetal** deaths are also handled as a special population. They are not reported with other child abuse or suspicious deaths but 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 creates 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.

CORONER CASE REFERRAL

In the past, the system for case referral to the ICAN Child Death Review Team from the Department of Coroner required the Coroner's on-duty Supervisor to compile a list of all cases that came to the Coroner's attention during the previous 24 hours. From this compilation, the Coroner derived a list of all children ages twelve (12) and under* for whom one or more of the following factors were present, for review and study by the ICAN Child Death Review Team:

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

**Age exceptions were made for apparent suicides, homicides (child abuse) by parents, caretakers or family members and deaths due to drowning. All children ages 17 and under who fit one of these criteria were referred to the Team.*

As discussed in prior year reports, however, the Team discovered that occasionally cases that fit this protocol were missed and not referred by the Coroner to the ICAN Child Death Review Team. In response to

this problem, ICAN, the agency responsible for staffing the Team, decided to re-evaluate this referral system. After review, it was determined that the best way to assure that cases are not missed is for ICAN staff, rather than Coroner staff, to review the Coroner deaths of all children ages seventeen (17) and under to determine which cases meet the criteria established by protocol and which cases should be excluded. As a result, a new intake system was developed whereby each week the Coroner's Office electronically sends all cases where the decedent was age 17 or under to the ICAN office. ICAN then reviews each case and determines if the case fits the protocol as established or if the case should be excluded and deleted from the database.

ICAN PROTOCOL

The protocol for determining which cases to review has also been expanded. Prior to 1998, the protocol included all children ages ten (10) and under for whom one or more of the conditions listed above was present. In 1998, this protocol was expanded to include all children ages twelve (12) and under for whom one or more of the above factors was present. In addition, the protocol was expanded to include all drowning deaths for ages seventeen (17) and under. In 1999, the protocol was further expanded to require Team review of all deaths (i.e. not solely those deaths in which one or more of the elements listed above were present) where the child was age twelve (12) or under with the exception of natural deaths. It should be noted that homicides that are not perpetrated by a parent, caretaker or family member are briefly mentioned in the Homicide section but are not given the same comprehensive analysis. The most significant change with this new protocol expansion is that the Team now reviews all accidental deaths including motor vehicle deaths. In the past, the Team did not review motor vehicle deaths and only began collecting data on autopedestrian deaths in 1995.

With the changes in the case referral process and the expansion of the protocol, the number of cases receiving Team review in 1999 has increased significantly. This increase makes cross-year comparisons in the Accidental, Undetermined and Fetal sections of the report problematic, as increases identified in these sections may merely reflect the improved case referral system and the expansion of the protocol. However, the changes in the case referral system and the protocol should not significantly affect comparisons in the Homicide and Suicide sections of the report as the protocol for these sections has not changed. The Team has always reviewed homicides by parent, caretaker or family member and suicides for ages seventeen (17) and under and in the past the Team has made special efforts to identify all of these types of deaths through cross checks with other sources.

TEAM REVIEW

Once cases have been selected as meeting the protocol, they are subject to Team review. All cases that fit the protocol are 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. These Team representatives check each case in their agency's computer databases and files for records of contact with the child or family and provide these findings to ICAN for compilation and analy-

sis. All cases meeting protocol criteria receive this level of review.

In addition to this multi-agency fact-finding process, the Team itself selects three to five cases each month for a more comprehensive review. Primarily, high profile cases and cases for which a Team member requests the Team's multidisciplinary perspective are selected. The Team encourages agency staff involved with each case selected to attend the meeting at which the case will be discussed to share their observations and findings.

REPORTING

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 the Committee's report entitled 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.

CORONER REFERRALS TO ICAN CHILD DEATH REVIEW TEAM - 1999

268 deaths were reported by the Department of Coroner to the ICAN Child Death Review Team in 1999.

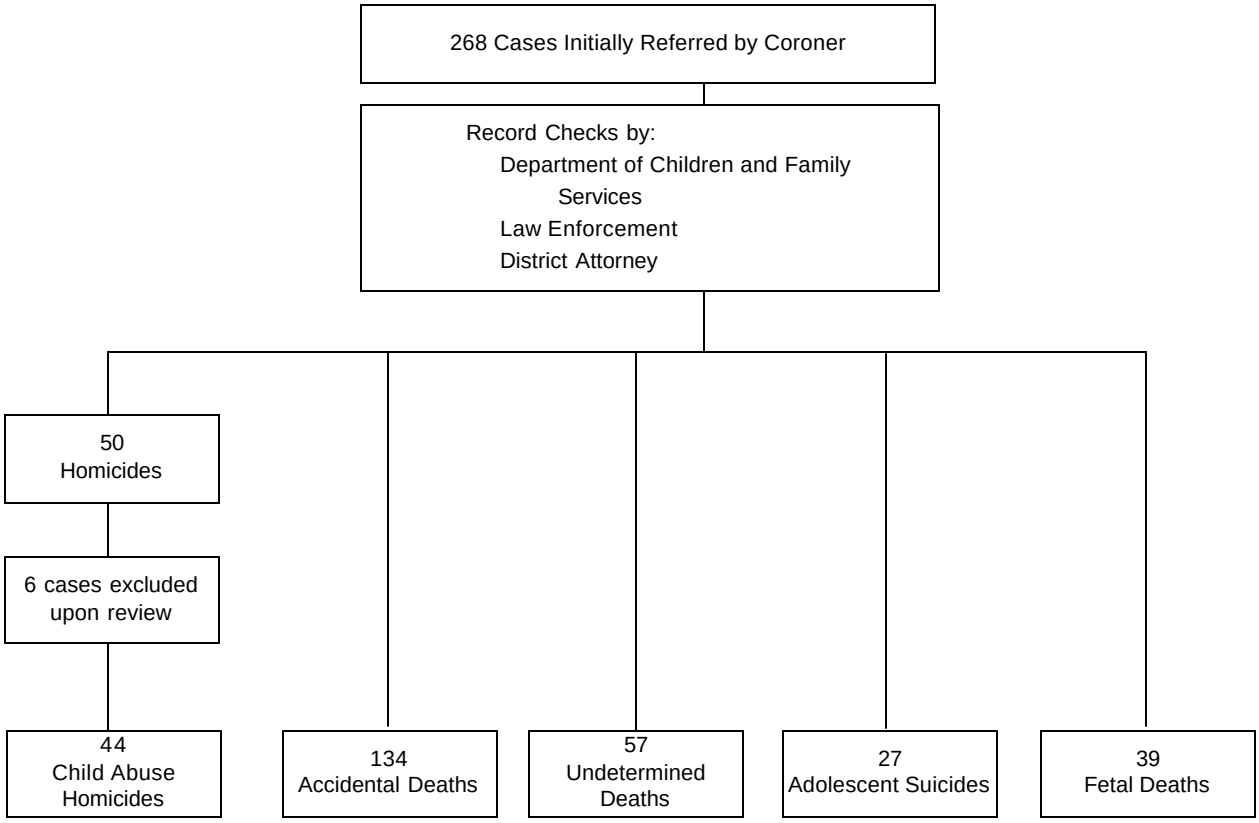
Preliminary review of homicides and reconciliation of the deaths referred by the Coroner resulted in the exclusion of 6 out of the 50 homicides that were originally referred to the Team. Of these six cases, five involved gunshots, including two gang-related shootings. In both of these gang-related shootings the victim was an innocent bystander; one was killed while eating dinner at a restaurant with his family and one was killed while standing on his front porch. Two additional gunshot cases involved young teenage boys who were killed in their residences when playmates found loaded guns and unintentionally shot the victims. The fifth gunshot case involved a nine-year old boy who was playing at a private Fourth of July party and was struck by stray gunfire. In four of the shooting cases, no suspect has been identified. In addition a non-gunshot case was excluded. In this case, a 12-year old girl was killed when the car in which she was a passenger was forced off a freeway overpass by the angry boyfriend of one of the other teenage passengers.

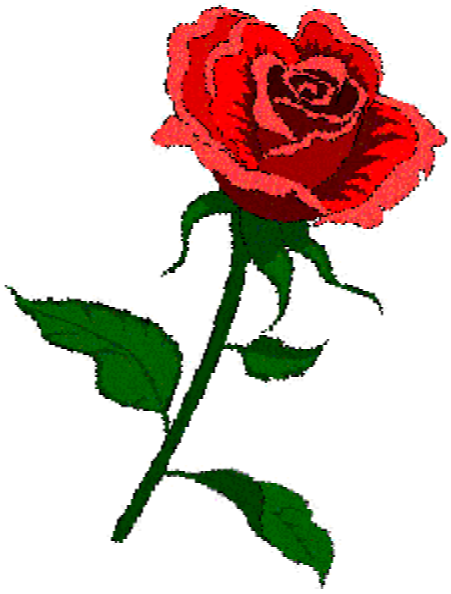
In addition to the 50 homicides (44 by parent/caretaker/family member), 134 accidental deaths, 27 adolescent suicides, 57 undetermined deaths and 39 fetal deaths were referred to the Team. No natural deaths were referred to the Team in 1999.

Figure 1 on the next page summarizes how the 268 deaths referred by the Coroner in 1999 were categorized and how adjustments were made.

Figure 1

FLOW CHART OF CASE DISTRIBUTION FOR ANALYSIS





"A person is a person no matter how small"

("Horton Hears a Who" by Dr. Seuss)

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

Two-year-old Dani arrived with her mother at a local hospital in cardiac arrest, and died despite almost an hour of intensive efforts to revive her. Doctors at the Emergency Room initially suspected that Dani died as a result of some form of blood disorder, as they had not noted any obvious injuries and had determined that she had a low blood hemoglobin level. After being autopsied at the Coroner's office, however, it became clear that Dani was a victim of intentional abuse. She was a homicide victim.

The Coroner found that Dani suffered external bruising to her head, swelling and hemorrhage of her brain, recent acute retinal hemorrhages to both eyes, a lacerated liver, and posterior rib fractures of widely varying ages (some 4-6 weeks old, some 2-3 weeks old, and some as recent as within the two weeks before her death). The location and nature of the rib fractures, in addition to the brain and eye injuries noted, indicated that Dani had been squeezed and violently shaken, and likely on more than one occasion. In addition, toxicological studies determined that Dani had small traces of cocaine metabolites in her system.

Prior to her death, Dani resided in the home with her mother, her mother's boyfriend, and a two-month-old sibling who is the biological child of the mother's boyfriend. According to detectives who investigated the case, the mother appeared to be intellectually delayed, and had difficulty understanding the concepts being discussed. Her boyfriend admitted to being a cocaine addict, and there was a history of domestic violence in the home. In the days following Dani's death, neighbors told investigators of hearing the boyfriend raging at the mother and/or Dani on several occasions. The level of verbal and presumed physical abuse apparently was so great that these neighbors confronted the boyfriend about their concerns, and were met with the threatening admonition to "mind their own business." In spite of this apparent history of abuse, the mother was reportedly highly supportive and defending of the boyfriend.

The mother reported that on the night of Dani's death, Dani was lethargic and sleepy. Earlier in the evening, Dani was alone in a room with the mother's boyfriend when she began to loudly scream and cry. The mother stated that when she went in to get Dani, she did not appear to be harmed. The mother also denied any awareness of previous abuse of Dani by the boyfriend.

Following Dani's death, DCFS investigated the family situation and assessed the surviving sibling's welfare. With the autopsy and cause of death still pending, DCFS placed the infant sibling into protective custody with a foster parent. Initially, law enforcement relied on the assessment of the Emergency Room doctors that Dani's condition appeared to be a result of some form of blood disorder, and they did not investigate the case as a case of child homicide. Mother's boyfriend was arrested and incarcerated for an unrelated parole violation shortly after Dani's death. He was not interviewed in detail about the death until weeks later while he was incarcerated for that violation. When interviewed in jail, he denied any abuse of Dani or even being alone with her during the hours preceding her death, but admitted that on the night of her death he was out of the home on a "cocaine binge." Despite his claimed lack of involvement in Dani's death, the boyfriend refused to take a voice stress analysis test offered by the detectives on the case.

Review of this tragic death by the Child Death Review Team produced several interesting findings and results. First, it was learned that the mother requested and received the completed autopsy report prior to the detectives on the case, as they had not requested a security hold on the results, an action which would have prevented the mother (and presumably, the boyfriend) from learning of the manner and mode of the death. In addition, a law enforcement hold was not placed on Dani's remains, thus allowing her mother to have the remains cremated shortly after the autopsy. Further, an expert pediatrician on the team noted that the Emergency Room medical personnel erred in failing to consider "hemorrhage" first, and cancer, leukemia or other "blood disorder" second when presented with low hemoglobin levels in a dead or near-dead young child.

When the detectives initially presented their findings to the District Attorney's office, the case was not filed, as it could not be clearly established who was alone with the child during the period in which the fatal injuries were inflicted. However, when the case was reviewed by the Team, the Deputy District Attorney on the Team believed that a criminal filing could be pursued. Based upon the nature of the injuries, the auditory witnesses to violence in the home, the presence of cocaine metabolites in Dani's system coupled with the boyfriend's admission of frequent cocaine use, and the acknowledged caretaker roles of the mother and the boyfriend, she instructed the detectives to bring all of their evidence to her office for review. Within days of the Team meeting, detectives met with the DA again to discuss their case, and homicide charges against the mother and boyfriend were subsequently filed, ultimately resulting in convictions for manslaughter.

Fifty homicides meeting ICAN referral protocol were reported to the Team by the Coroner for 1999. Following review of law enforcement records, six cases were determined not to have been perpetrated by parents, caretakers or family members. Of these six cases, five involved gunshots. Two gunshot cases involved young teenage boys killed in separate incidents when playmates found loaded guns in their residences and unintentionally shot the victims. Two other gunshot cases involved gang-related shootings. In one gang-related case, a twelve-year old boy was shot and killed as he and his brother and parents sat and ate in a restaurant. A gang member rushed in to the restaurant and aimed his gun at the table behind the victim and his family, but hit the child victim instead. In the second gang-related shooting, an eight-year old boy was shot and killed by gang gunfire while standing on his front porch. The fifth gunshot case involved a nine-year old boy who was playing at a private Fourth of July party and was struck by stray gunfire.

In addition to these five gunshot deaths, a sixth child homicide case was determined to have been perpetrated by someone other than a parent/caretaker/family member. A twelve-year old girl was killed on her way to a high school football game with her older sister and sister's friends. Their car was intentionally forced off a freeway overpass by the angry boyfriend of one of the other teenage passengers, and the child victim died of massive blunt head trauma. The Team discussed whether to include this case with the child homicide cases discussed in more detail below as this child's death was a tragic result of a situation involving domestic violence. Over the years there have been numerous cases of child homicides that were the direct result of domestic violence between the child's caretakers and thus, this case could arguably be included in this section. However, it was decided that this case did not clearly fit the protocol as established, as the incidence of domestic violence that ultimately resulted in the death of this child did not occur with the child's parents, caretakers, or family members but rather involved friends of the child's sister.

As discussed in the ICAN Child Death Review Team Report for 1999, the Team was working to revise the intake system established with the Los Angeles County Department of Coroner for the referral of cases and to expand the Team protocol of cases to be reviewed. This year, as discussed in detail in the Team Protocol section of this report, the Team was successful both in changing the intake system developed for the referral of cases from the Los Angeles County Coroner's office and in expanding the Team's protocol. As a result of these changes, the problems in identifying cases that existed in the past few years have been significantly reduced.

It should be noted that although the Team made the changes mentioned above and discussed more fully in the Team Protocol section of this report, the data regarding the number of homicides by parents, caretakers or family members will not be significantly affected by these changes. The Team protocol for homicides by parents, caretakers and family members has always included such homicides for ages 17 and under and thus, this portion of the protocol could not be expanded. In addition, the Team has previously been able to effectively identify most of these homicides through intensive work with the Coroner's office and by utilizing the

case reconciliation process (UCR-SHR, CACI and Vital Statistics) described below. Thus, other than the typical fluctuations that occur from year to year, these numbers should not change dramatically.

Traditionally, in an effort to assure that all child homicide cases meeting the protocol were identified, the Team received data from the California Department of Justice Uniform Crime Reports-Supplemental Homicide File (UCR-SHR), the California Department of Justice Child Abuse Central Index (CACI) and the California Department of Health Services Vital Statistics. The child homicide cases listed in these indices were then reconciled with the child homicide cases received from the Coroner's office. Often through this process, additional cases of child homicide by parent, caretaker or family member were identified. This year (and last year) the data from these three state indices were not received in time to complete this case reconciliation process. It is possible that if these data had been received there would be cases of child homicide by parent, caretaker or family member identified that were not discovered through the current intake system set up with the Coroner's office.

Given the above information, the Team has determined that there were 44 child homicides perpetrated by parents, caretakers or family members in Los Angeles County in 1999. This is a decrease of 10 % from the 49 child homicides by parents, caretakers or family members in 1998 and is consistent with the 11-year average of 47. Figure 2 displays by year the 515 child homicides by parents, caretakers or family members referred to the Team by the Coroner for the period of 1989 through 1999.

GENDER

In 1999, 57% (n=25) of the victims of child homicide by parents, caretakers or family members were female, while 43% (n=19) of the victims were male. Over the past 11 years, there have been a total of 274 male victims (53%) and 241 female victims (47%).

The percentage of female victims has ranged from a 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 27. However, in both 1996 and 1999 there were 25 female homicide victims and in 1998 there were 27. 1998's number of 27 is the highest number of female homicide victims over the last eleven years.

The number of male victims has had a much greater fluctuation over the past eleven years. The average has been 24.9 per year, and has ranged from a low of 16 in 1993 to a high of 35 in 1991 and 1995.

Figure 3 displays the gender breakdown of the child homicide victims for the past 11 years.

AGE

The ages of the victims of homicide by parents, caretakers or family members between 1989 and 1999 are displayed in Figure 4. In 1999, 34% of the victims were under the age of six months, 48% under the age of 1 year and 52% were under age 2. 93% of the victims were age 5 or younger. In 1999, there were three victims of homicide by parents, caretakers or family members who were between the ages 6 and 10. There were no victims of homicide by parents/caretakers/family members over the age of 10 years, a significant decrease from 1998 when there were eight such victims.

Over the past 11 years, 43% (n=224) of

Figure 2

1989 - 1999 ICAN CHILD HOMICIDES
BY PARENTS/CARETAKERS/FAMILY MEMBERS

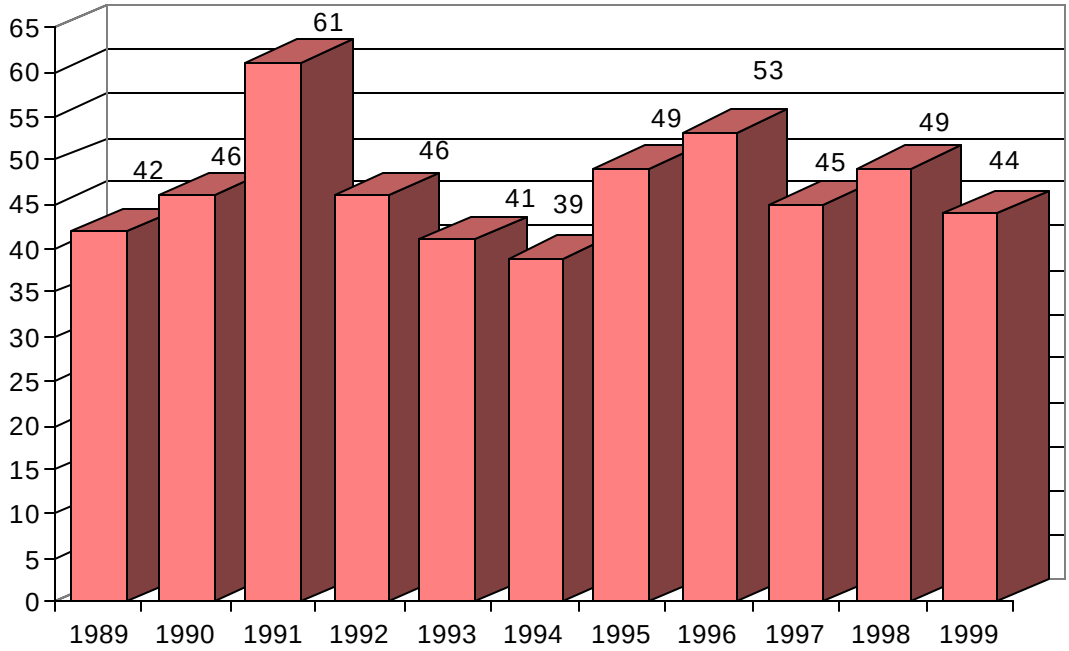
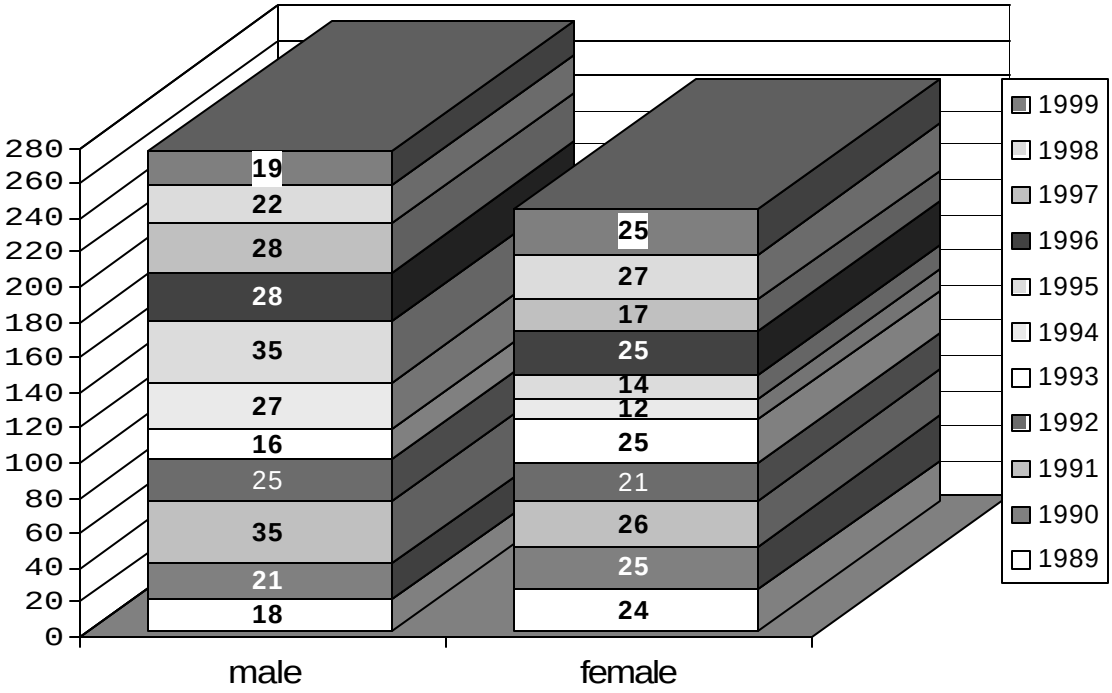


Figure 3

1989 - 1999 ICAN CHILD HOMICIDES
BY PARENTS/CARETAKERS/FAMILY MEMBERS BY GENDER



the victims have been under the age of 1 year; 85% (n=440) have been under the age of 5 years.

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 fell to 51% and rose slightly in 1999 to 52%. Until 1998, 90% or more of the victims were under the age of 5 years, whereas in 1998, only 73% of the victims were under the age of 5. It is believed that the average age of child homicide victims in 1998 increased because of two multiple family killings, one of three children and one of four children, ranging in age between 4 and 13 who were killed by their father and mother respectively. In 1999, the number of child homicide victims under age 5 increased to 91%.

Table 1 displays the relationship between the age and sex of the victims of child homicide by parents, caretakers or family members in 1999. The average age of female victims was 2.1 years. The average age of female child victims has decreased over the previous 10 years, with the exception of 1996 and 1998. In 1989, the average age was 3.1 years, increasing to 3.8 years in 1990, then decreasing to 2.2 years in 1991, 1.7 years in 1992, 1.6 years in 1993, 1.3 years in 1994, 1.6 years in 1995 and 1.9 years in 1997. In 1998, however, the average age of female child victims increased to 4.3 years reaching the highest level since 1996 when the average age was 4.8 years, the highest it has ever been. One of the female victims in 1999 was killed on the day she was born and the oldest homicide victim was a ten-year old girl.

The average age of the male victims in 1999 was 1.9 years. The average age of male victims has remained fairly constant over the last 10 years with a low of 1.6 years in 1989 and a high of 2.8 years in 1998. Three of the four 1999 victims who were killed on the day they were born were male.

Figure 4

1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS BY AGE

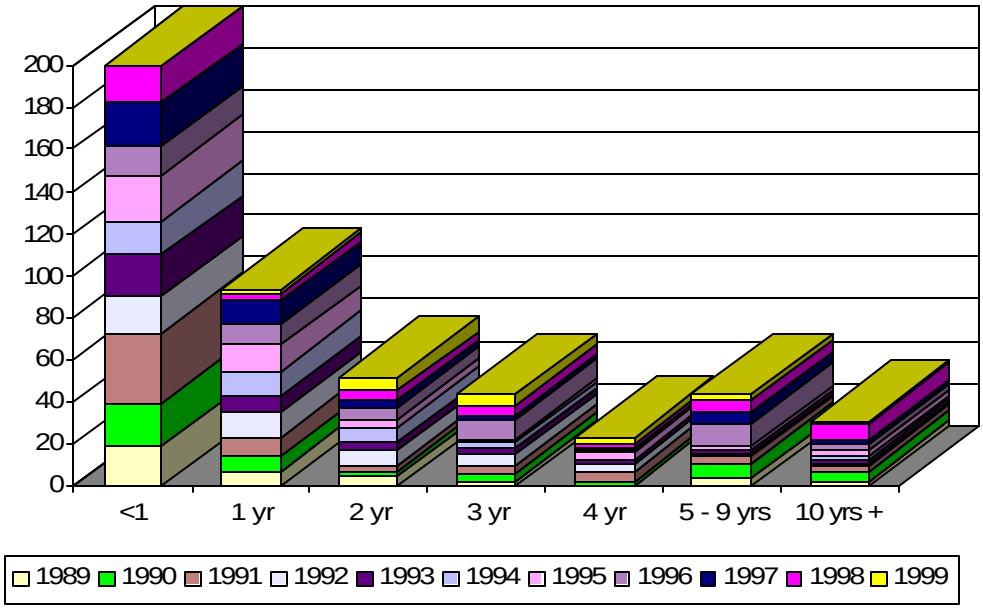


Table 1

1999 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS BY AGE AND SEX

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

ETHNICITY

In 1999, 39% of the victims of child homicide by parents, caretakers or family members were African American (n=17). This is a 55% increase over 1998. Hispanics represented 27% (n=12) of the child homicides by parents, caretakers or family members, a decrease of 57% from 1998. There were 12 White victims, representing 27% of the total, an increase of 50%. There were 3 Asian homicides, representing 7% of the total.

2000 U.S. Census figures show the child population in Los Angeles County to be 57.5% Hispanic, 19.8% White, 9.9% African American and 9.0% Asian. When 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 about equal to their child population rate, with an exception in 1998 when they were over-represented. In previous years, White children have been under-represented, but in 1999 are slightly over-represented by their child population rate. Asian children, as in prior years, are under-represented. Table 2 displays the ratio between the percentages of child homicides by parents/caretakers/family members by child population.

From a multi-year perspective, as illustrated in Figure 5, the ratio of African American 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 increased between 1989 and 1998, not only in real numbers, but also in relationship to the Hispanic percentage of child population. However, in 1999, the number and percentage of Hispanic child homicides decreased dramatically. Asian children have been consistently under-represented in child homicides by parents, caretakers and family members, except in 1991. Since 1991, White children showed a steady decline in child homicides by parents, caretakers and family members until 1995 and 1996. While this number again declined in 1997, there was an increase of 26% in these numbers in 1998 and an increase of 50% in 1999. 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

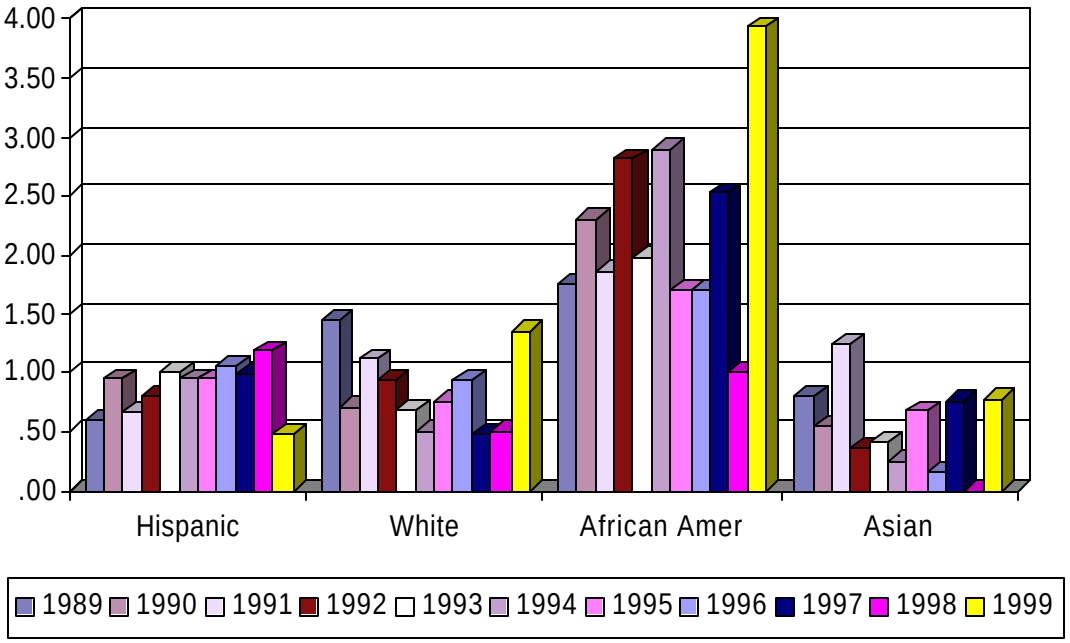
1999 ICAN CHILD HOMICIDES
BY PARENTS/CARETAKERS/FAMILY MEMBERS BY RACE

Race	Number	%	Child Pop	Ratio*
Hispanic	12	27	57.5	0.47
White	12	27	19.8	1.36
African American	17	39	9.9	3.93
Asian	3	7	9.0	0.77

** 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 - 1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
- ETHNICITY % COMPARED TO POPULATION %



CAUSE OF DEATH

In 1999, the leading cause of death in child homicides by parents, caretakers and family members was head trauma, claiming the lives of 34% (n=15) of the victims. Deaths due to multiple trauma (n=10) and asphyxiation/suffocation (n=6) were the second/third leading causes of death comprising 36% of the cases. Gunshot wounds, in most recent years the second leading cause of death, comprised 9% (n=4) of child homicide deaths. Unattended/neglected newborns also comprised 9% (n=4) of child homicide deaths.

Table 3 and Figure 6 display the different causes of child homicide by parents/caretakers/family members for the period between 1989 and 1999. The most frequent cause of death for all eleven years, and comprising 35.3% of all child homicides by parents/caretakers/family members, was head trauma. Multiple trauma was the second most frequent cause of death, representing 16.6% of the total deaths. Homicide by guns represented the third or fourth most frequent cause of death over the initial nine-year period becoming the second leading cause of death in 1998 and dropping again in 1999. Deaths due to gunshots represent 11.3% of the total homicides by parents/caretakers/family members over the past eleven years. Gunshot victims in 1999 included a two-year old girl shot by her mother's domestic partner who then shot and killed herself and a four-year old boy shot by his teenage brother who subsequently shot and killed their parents and himself. Gunshot victims also included a seven-year old girl killed by her intoxicated father and a three-year old girl shot by her five-year old brother when he found a loaded shotgun under their uncle's bed.

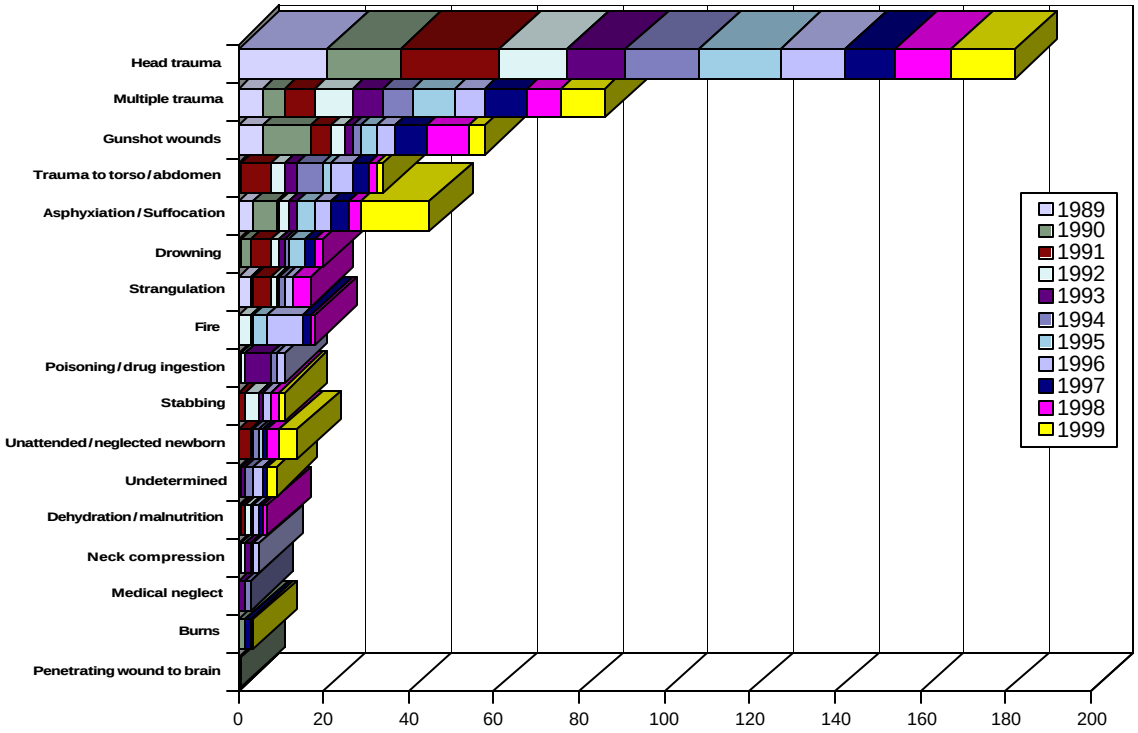
Table 3

CAUSES OF CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS 1989 - 99

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	TOTAL
Head trauma	21	17	23	16	14	17	19	15	12	13	15	**182**
Multiple trauma	6	5	7	9	7	7	10	7	10	8	10	**86**
Gunshot wounds	6	11	5	3	2	2	4	4	7	10	4	**58**
Trauma to torso/abdomen	1		7	3	3	6	2	5	4	2	1	**34**
Asphyxiation/Suffocation	4	5	1	2	2		4	4	4	3	6	**35**
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	1	**11**
Unattended/neglected newborn				3	1		1	1	1	3	4	**14**
Undetermined			1		1	2		2	1		2	**9**
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		1	**4**
Penetrating wound to brain		1										**1**
TOTAL	**42**	**46**	**60**	**46**	**42**	**39**	**49**	**53**	**45**	**49**	**44**	**515**

Figure 6

1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS - CAUSES OF DEATH



TEMPORAL PATTERN

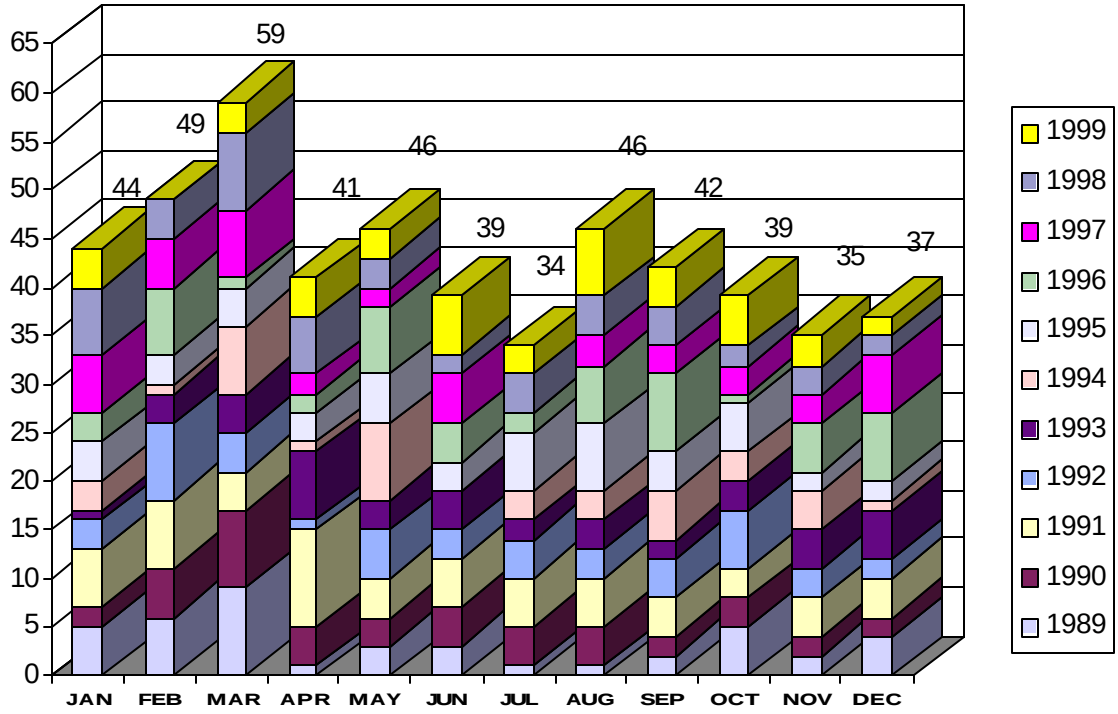
In 1999, the greatest number of child homicides by parents/caretakers/family members occurred in August (n=7). The second greatest number of homicides occurred during June (n=6). The fewest number of homicides occurred in February (n=0) and December (n=2). At least 2 child homicides by parents/caretakers/family members occurred in every month of 1999 with the exception of February.

Figure 7 displays the child homicides by parents/caretakers/family members by month for the past eleven years. During the period of 1989 through 1999, the greatest number of child homicides by parents/caretakers/family members occurred during the month of March. The least number of such child homicides have occurred during July and November.

The 515 homicides by parents/caretakers/family members during the past eleven years translates to an average of 3.9 per month. While actual deaths in any given month vary, June 1994, July 1997 and February 1999 were the only months in the past eleven years in which no child homicides by parents/caretakers/family members were recorded.

Figure 7

1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS BY MONTH



CHILD PROTECTIVE SERVICE INVOLVEMENT

27-month-old Tyeshia was brought by her foster parent, Ms. Jones, to King/Drew Medical Center in an unresponsive and comatose state. Ms. Jones reported that Tyeshia had fallen in the bathtub the previous day, and had fallen again earlier in the day before coming to the hospital. When questioned by hospital staff about her delay in seeking treatment for Tyeshia, Ms. Jones admitted that she had hit her with a bath brush on her back, and she feared that when the bruises on her back were observed, Tyeshia and other foster children in her care would be removed. Doctors diagnosed a severe head injury and operated on Tyeshia to relieve pressure on her brain, but she died five days later.

Team review of this case revealed a troubling history. Tyeshia's older sibling, Cherise, was originally placed in protective custody in 1995 due to the mother's long history of alcoholism and associated neglect of Cherise. Cherise was subsequently placed in the care of her maternal grandmother. When Tyeshia was born less than two years later, she, too, was placed in the care of the grandmother. The grandmother subsequently obtained legal guardianship of both girls in 1997. Not long after guardianship was ordered, DCFS filed a petition on behalf of the girls, alleging that the grandmother had provided sub-standard care for them, and that her home was found to be filthy, rodent-infested, strewn with animal feces and generally unfit for the children. The girls were placed with another relative, but removed soon thereafter due to the relative's inability to care for the girls. The girls were then moved to a foster home, only to be moved once again to the home of Ms. Jones, a certified foster parent of a fast-growing Foster Family Agency (FFA).

Investigation by DCFS and Community Care Licensing (CCL) following Tyeshia's death revealed that neighbors had frequently heard yelling and crying coming from Ms. Jones' residence, sometimes late at night. Yet, no one ever called the FFA or the DCFS Child Abuse Hotline about their concerns. In addition, several incidents of concern in the home had been documented prior to Tyeshia's death. In 1997, a foster child in the home suffered a broken leg after allegedly falling out of a van following a church event. In another incident six months later, the same child suffered a fractured radius and ulna. Both of these incidents were investigated by the FFA and DCFS social workers and determined to be accidental. In another incident in 1998, a child in the home suffered a fractured elbow after allegedly falling in the bathtub. Again, FFA investigators and a DCFS social worker concluded that the injury was accidental.

Tyeshia's autopsy revealed numerous injuries. She had a 5" by 3" contusion to her scalp; a 1" tear to the gallea; a 3" by 1" skull fracture; residual blood in the skull; optic nerve damage; brain stem herniation into the cerebellum; bruises and scars to her forehead, chin, neck, hands and back; and scars on her foot and abdomen. When interviewed by homicide detectives, Ms. Jones admitted that she had hit Tyeshia with a shower brush when she tried to get out of the bathtub. She claimed that Tyeshia had fallen twice after making such attempts to get out of the tub, and that she may have hit her head as a result of these falls. The Coroner ruled, however, that the injuries noted must have been inflicted and were not accidental.

The Team discussion of this case focused on how the "red flags" of injured children in the home were assessed. It was learned that the FFA in

question had grown very rapidly, resulting in an inadequate number of FFA social workers to provide supervision and support of the certified homes. In addition, DCFS relied on the assessments of the FFA investigators that the previously noted injuries in the home were accidental. In the years before Tyeshia's death, FFAs conducted their own investigations of injuries and allegations of abuse in their certified homes. In 1999, however, California law changed, giving CCL responsibility to investigate allegations of abuse or other mistreatment in FFA certified homes.

The Team also focused on the needs of Tyeshia's surviving sibling, Cherise. DCFS arranged for Cherise to be notified of Tyeshia's death and to receive appropriate grief and mourning therapy. In addition, given Cherise's multiple placements and tragic history, the Team suggested that she be assigned a Court-Appointed Special Advocate (CASA). DCFS and County Counsel subsequently arranged for Cherise to obtain the support and advocacy of a CASA. Cherise remains in long-term foster care.

Ms. Jones was arrested shortly after Tyeshia's death. She was subsequently charged with PC 187, murder, and was later found guilty of the charge of PC 273ab, child abuse resulting in death. She is now serving 25 years to life in state prison for the killing of Tyeshia.

Twenty of the child victims of homicide by parents/caretakers/family members were members of families that had a record of contact with the Department of Children and Family Services (DCFS) prior to the death of the child. These 20 families represent 45.4% of the total child homicides by parents/caretakers/family members. This rate is comparable to the national average of 40% reported by Prevent Child Abuse America (1998). Eight cases were open to DCFS at the time of the child's death.

For the period of 1989 through 1992, there were eleven families each year with DCFS contact prior to the child's death. In 1993, 13 families had received prior DCFS contact; in 1994, 12 families received prior 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. Last year (1998), 20 families had a record of DCFS involvement. Figure 8 displays the number of homicides by parents/caretakers/family members with prior child protective services involvement when compared to the total number of cases for the past 11 years.

The twenty cases with prior referrals to DCFS in 1999 accounted for a total of 47 prior referrals. Of these twenty cases, 40% (n=8) of the families had one prior referral and 30% (n=6) had two prior referrals. There were also three families that had three prior referrals, one family that had five prior referrals, and two families that had seven prior referrals to DCFS. It should be noted that in one family that had seven referrals, three referrals were made alleging abuse of the deceased child's father when he was a minor and four referrals alleged abuse of the deceased child's mother when she was a minor. There were no previous referrals alleging abuse or neglect of the child himself who later died at his father's hands. In the second family that had seven prior referrals to DCFS, referrals were made alleging physical abuse and caretaker incapacity for the deceased child's siblings prior to the deceased child's birth.

The reasons for prior DCFS services are listed in Table 4. In 1999, 34.6% (n=18) of the prior case openings were for allegations of physical abuse. Allegations of neglect (n=17) accounted for 32.6%, and allegations for caretaker absence/incapacity and sexual abuse each accounted for 11.5% (n=6) of the referrals. There were also allegations of emotional abuse (n=3) and prenatal drug exposure (n=1). In one case, the reason for the prior referral was unknown. As in 1989, 1992, 1994, 1995 and 1996, the most frequent reason for referral to DCFS in 1999 was physical abuse. In 1990, 1991, 1997 and 1998, the most frequent reason was neglect. In 1993, the most frequent reason was prenatal substance abuse.

Table 5 provides a comparison between the date that DCFS closed the family's most recent prior child protective services case and the date of the child's death. The eight cases that were still open at the time of the child's death are not included. In two of the twelve cases with previous contact, the most recent child protective services case was closed within six months of the child's death. In one case, DCFS investigated a referral of general neglect involving a three-month old girl. An emergency medical facility contacted DCFS, expressing concern that a father was not properly supervising his children. He had brought his three-month old daughter to the facility explaining

Figure 8

1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
CHILD PROTECTIVE SERVICES INVOLVEMENT

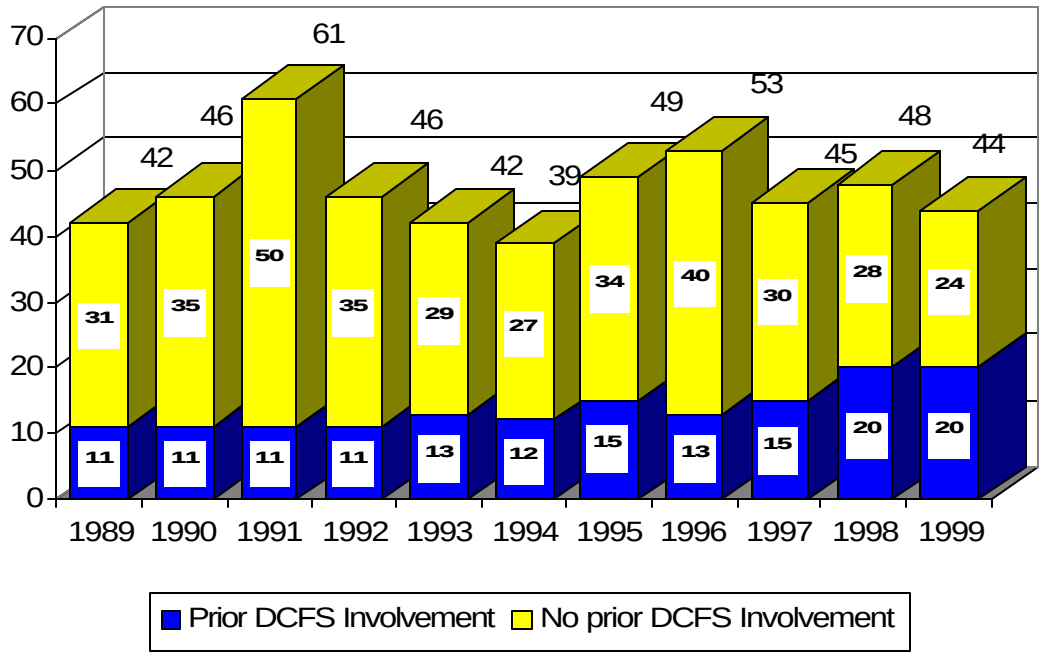


Table 4

1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
REASONS FOR PRIOR CHILD PROTECTIVE SERVICES

Reason	n	%
Physical abuse	18	35
General and/or medical neglect	17	33
Caretaker Absence/incapacity	6	11
Sexual abuse	6	11
Emotional abuse	3	6
Prenatal substance abuse	1	2
Unknown	1	2

Table 5

1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
LENGTH OF TIME BETWEEN PRIOR DCFS CASE CLOSURE AND DATE OF DEATH

Time Frame	n	%
1 day to 6 months	2	17
6 to 12 months	3	25
1 to 2 years	4	33
more than 2 years	3	25

Table 6

1999 ICAN CHILD HOMICIDES BY PARENTS / CARETAKERS / FAMILY MEMBERS
REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING THE DEATH

Reason	n	%
Physical abuse	20	76
Severe neglect	4	16
General negelect	2	8

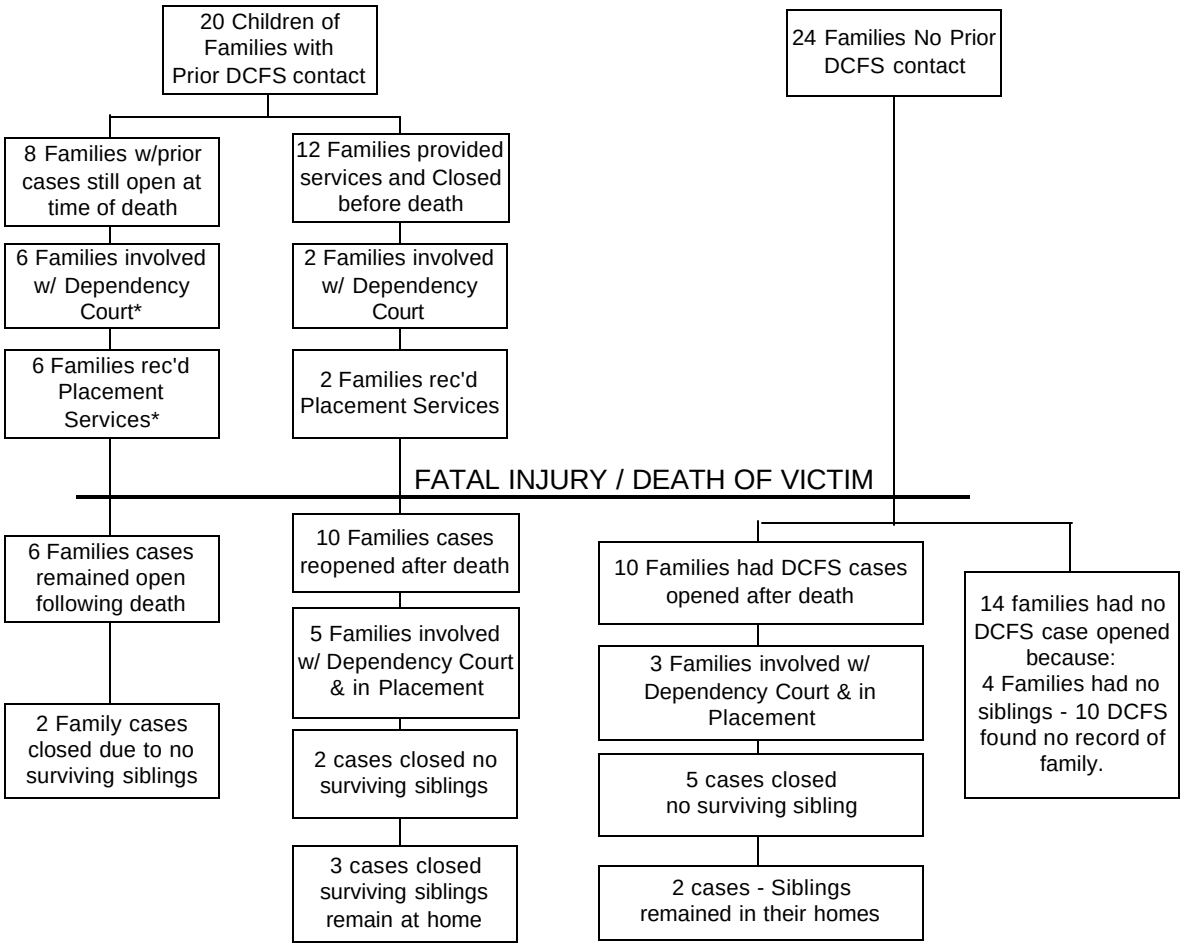
Table 7

1999 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS AGES OF MOTHERS

Age	n	%
Under 20 years	7	23
20 to 24 years	6	20
25 to 29 years	6	20
30 to 34 years	5	17
35 years and over	6	20

Figure 9

CHILD PROTECTIVE SERVICES ACTIVITIES ON 1999 CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS



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

that she was injured when his older daughter, age two, pulled her off the couch and onto the floor. DCFS investigated the concerns about the father's ability to properly supervise his children and requested the emergency medical facility conduct a CT scan on the injured three-month old. The facility refused to do so stating that this procedure was unnecessary. DCFS found the allegation to be unsubstantiated and closed the case. Seven days later, the three-month old girl was dead from what the Coroner listed as "battered child syndrome." The Coroner also noted that the child had unexplained evidence of "anal penetration."

The second child homicide with previous DCFS contact within six months involved a newborn baby. In this case, four previous referrals alleging physical abuse and caretaker absence/incapacity were made regarding a fifteen-year old girl and her three brothers between 1994 and 1999. All four allegations were found to be inconclusive and the cases were closed. Approximately five months later, the fifteen-year old girl gave birth to a full-term male infant in the family toilet. Afraid that her parents would know she had been pregnant, she wrapped the baby in plastic and hid him in her closet; the child died of drowning and asphyxiation.

Three child homicides occurred within 6 to 12 months of DCFS' most recent case closure. In one case, one sexual abuse and two physical abuse referrals were made to DCFS between May 1998 and March 1999 for a family with three children; all three allegations were determined to be unfounded and the cases were closed. Six months and one day after the last referral was closed, the family's three-year old son reportedly choked on a baloney sandwich. However, upon autopsy, the Coroner determined that the child had not died from food asphyxiation but from being battered, and the death was classified as a homicide. In the two other child homicides with DCFS case closure within 6 to 12 months, a referral of sexual and physical abuse was investigated for two siblings, ages 5 ½ months and 4 years, and determined to be inconclusive. Both children were murdered by their father nine months later when he drowned them, wrapped their bodies in plastic and dumped their bodies in a trash dumpster.

In addition to these five cases of child homicide that occurred within twelve months of the DCFS case closure, 4 child homicides occurred within one to two years of case closure and 3 child homicides occurred more than two years after case closure.

In the twenty cases (totaling 47 referrals) that had prior DCFS contact, DCFS had proceeded with Dependency Court action on eight. In the other twelve 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 five of these twelve cases.

Eight cases, 18% of all 1999 child homicides by parents/caretakers/family members, were open to DCFS at the time of the death. Four of these eight cases received detailed review by the Team. DCFS had proceeded with Dependency Court action and placed five of these children in out-of-home care. These five children continued to reside in out-of-home placements at the time of their deaths. One child died while placed in a medically fragile foster home; she had been placed in this specialized medical facility due to injuries she received

when she was beaten in 1995 by her father at 3 years of age. She subsequently died in this placement in 1999 from complications resulting from those earlier injuries. Two of the other children who died in out-of-home care had been placed with their paternal aunts as a result of allegations of physical abuse, substance abuse and neglect by their parents. One of these children, a 2 ½-year old girl was beaten to death by her aunt; the other, a 2-year old girl, was killed by her father when the paternal relatives permitted the father to have unmonitored contact with the child in violation of Juvenile Court orders. The other children killed in out-of-home care, a three year-old boy and three year-old girl, died at the hands of unrelated foster care providers.

In two of the other open DCFS cases, the children remained at home. In one of these cases, a referral for neglect was made when the child, who was 3 years of age at the time, was brought to the hospital for an illness and diagnosed as malnourished. Hospital personnel reported that the child's mother was being unexpectedly admitted for kidney cancer and had made no provisions for the care of this child and his two older siblings. The older siblings were released to the care of paternal relatives while the three-year old was released to the care of his maternal uncle. DCFS was investigating the referral when the three-year old boy died of multiple injuries as a "battered child."

The second open case with a child remaining at home, involved an infant born to an eighteen-year old woman who had recently emancipated from Juvenile Court supervision. DCFS initiated a Voluntary Family Maintenance Agreement with the mother and her boyfriend, the baby's father, to monitor the child's care. In less than six months, the child had been shaken to death by the mother.

The final open DCFS case involved a referral alleging possible sexual abuse of a four-year old boy. The doctor who made the referral reported that the child's mother was adamant that he document physical findings of sexual abuse of the boy, although the doctor found no such evidence. The doctor reported that the mother was acting "strange." The DCFS social worker made six attempts to see the family and enlisted the assistance of law enforcement but was unable to make contact with the family. Tragically, the mother killed the child and subsequently committed suicide within four days of the DCFS referral. DCFS had previously substantiated physical abuse against the mother and the child had been placed in out-of-home care for two years with court supervision. The child had been returned to the mother; at the time of the doctor’s referral, DCFS was unable to assess child safety or provide services to the family.

Six of the cases that were open to DCFS at the time of the child homicide by parent/caretaker/family membe and ten of the twelve cases that were previously known but closed by DCFS were referred immediately following the death or fatal injury.

Ten additional families previously unknown to DCFS were referred for services immediately following the death or fatal injury. The reasons for referral for the 26 families that received services following the death are displayed in Table 6. All but six of the cases were opened for physical abuse due to the death (n=20). The other six cases involved allegations of general neglect or severe neglect.

DCFS closed 9 of the 26 cases shortly after the death as there were no surviving siblings in the home. Another 5 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 provided.

Petitions were filed in Juvenile Dependency Court on siblings of the deceased child in 8 cases following the child homicide by parent/caretaker/family member. Thirteen siblings in 8 families were removed from the home and placed in out-of-home care.

Figure 9 summarizes the child protective services involvement in the 1999 child homicides by parent/caretaker/family member. The Department of Children and Family Services provides information regarding demographics of families known to them or the Department of Public Social Services through the Child Welfare Services/Case Management Services (CWS/CMS) Information System. These data include:

- 50% (n=22) 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 1999, the percentage of families with prior public assistance has ranged from 49.2% to 62.5%.
- The mother's age was known in 68% (n=30) of the cases (see Table 7). In 1999, the average age of the mothers was 27.7 years; 43% of the mothers were under the age of 25 years at the time of their child's death. Between 1989 and 1995, the percentage of mothers whose age was below 25 ranged from 42.4% to 84%, but this percentage dropped slightly in 1996 (27.2%), 1997 (39%) and 1998 (40%).
- The father's age at the time of the child's death was known in 50% (n=22) of the families. The average age of the fathers was 32.6 years.
- The deceased child was known to have had siblings in at least 45% (n=20) of the families. In 7 of the child homicides, it is unknown if the deceased child had siblings. The percentage of families in which there were siblings known has ranged from a low of 38% in 1991 to 1996's high of 72%.
- 25% (n=11) of the families had a known history of domestic violence.
- 25% (n=11) of the families had a known history of substance abuse.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

Isaac and his half-sibling were removed from their parents' care by the Department of Children and Family Services in 1996, when Isaac's half-sibling was seriously physically abused by Isaac's father. Isaac's father was tried in criminal court and was convicted of physically abusing the sibling, resulting in a state prison sentence. Isaac's mother testified on the father's behalf at the criminal trial and Isaac and his brother remained in foster care.

In 1999, three-year-old Isaac lived in placement with his foster parent and her twenty-three year old daughter, who resided in the home and assisted with Isaac's care. One morning, the foster parent went to work, and her daughter was home with Isaac. The daughter reported that she was filling the bathtub to take a bath before leaving for work when Isaac told her that he had to use the bathroom. She alleged that she placed him on the toilet as the tub filled, while she went into another room to finish ironing her clothes. She stated that when Isaac seemed to be taking too long in the bathroom, she went in to check on him and found him sitting up in the tub. She claimed that she removed him from the tub, and that he was not crying or complaining. She indicated that she then noticed that his skin was blistering and called her mother at work. Her mother returned to the home immediately and noticed the apparent damage to Isaac's skin. She called the assigned Children's Social Worker (CSW), who reportedly told her to stay at home as she was going to come over immediately. When the CSW arrived at the residence, she observed Isaac's blistered and reddened skin and instructed the caregiver to call 911. The CSW also called the Child Abuse Hotline to report the incident as a serious accidental injury of a dependent child.

When patrol officers from LAPD arrived at the scene, the foster mother, her daughter and the CSW informed them that Isaac had accidentally been scalded while getting in the tub. The officers and paramedics who responded initially accepted this version of what had occurred, though at least one paramedic who responded to the scene expressed concern about Isaac's "sagging skin." Isaac was transported to a county hospital trauma center, where an expert on pediatric burns was called in for consultation. The burn expert immediately identified the injury he observed as a non-accidental immersion burn and a report was made to the Child Abuse Hotline. An official hospital hold was faxed to the hospital two days later.

About one week after the incident, while Isaac remained in the hospital in critical condition, detectives from LAPD began their investigation into the circumstances of Isaac's scalding. Isaac died about one week after their investigation began, and the case was then transferred to the LAPD Homicide Bureau. Detectives determined that the injuries that claimed Isaac's life were not accidental as claimed by the caregivers and that the responders on the morning of the incident were too quick to accept the explanation of accidental scalding.

Detectives went to the scene of the scalding and conducted tests of the hot water system. The caregiver had arranged for a plumber to come out and lower the temperature of the water heater on the day of the incident, so detectives raised the setting back to its hottest level, in order to assess the possible water temperature at the time of Isaac's scalding. With the tub filled with pure hot water, a temperature of 128 degrees was reached.

Isaac's death was a result of multiple system failures related to severe thermal burns. According to the Coroner's report, paramedics arrived at

the scene at 12:23 p.m., and the scalding occurred sometime between 11:00 a.m. and 11:30 a.m. According to the Coroner, the temperature of the water and the length of time in the water were key factors in determining how the injury might have occurred. Based upon the severity of his burns, Isaac was either in the water longer than the 3-4 minutes reported by the caregiver's daughter or the water temperature was higher than measured by detectives. The Coroner further opined that burns such as those suffered by Isaac, which covered 40% of his body, can be survivable, but immediate treatment is critical. In this case, the long delay in treatment may have contributed to Isaac's death.

Law enforcement investigators arrested the foster mother's daughter for murder and the foster mother for child endangerment based upon her negligence in responding to the medical emergency posed by Isaac's scalding. The District Attorney's office subsequently filed 2nd degree murder charges against the foster mother's daughter, as well as misdemeanor child endangerment charges against the foster mother. Both the foster mother and her daughter pled not guilty and their cases were set for trial.

Following a trial by jury, the foster mother's daughter was acquitted of 2nd degree murder in Isaac's death. According to the Deputy District Attorney who tried the case, the jury was apparently swayed by testimony of a plumbing expert, who testified that the temperature in the old, cast iron tub in which the scalding occurred could have been hotter than 150 degrees Farenheit at the time of Isaac's scalding. This testimony implied that the immersion time in the water required to sustain the burns was less than had been suspected by investigators; this helped support the defense position that it was a relatively quick, accidental immersion. The foster mother was convicted of misdemeanor child endangerment in this case, but following her daughter's acquittal the judge later overturned the conviction.

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 (LAPD) and the Los Angeles Sheriff's Department (LASD). Other police agencies participate in Team review of cases they have investigated. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 8.

The Los Angeles Sheriff's Department had investigative responsibility for 41% (n=18) of the child homicides by parents/caretakers/family members, a 30% decrease from 1998.

The Los Angeles Police Department had investigative responsibility for 39% (n=17) of the1999 child homicides by parents/caretakers/family members, a 95% increase over 1998.

20% (n=9) of the cases were handled by jurisdictions other than LASD and LAPD. Eight additional law enforcement agencies were responsible for the investigation of child homicides by parents/caretakers/family members in 1999.

77% (n=34) of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies, an increase of 22% over 1998. This percentage of presentations to the District Attorney's Office is slightly higher than the 11-year average of 72%. The presentation percentages for the past 11 years are displayed in Figure 10. In one case in which the child had been shaken and battered, the law enforcement agency responsible for investigating the death did not initially present the case to the District Attorney for the filing of charges. The case was not presented as law enforcement did not believe they had enough information to determine who had inflicted the numerous injuries that the child suffered. However, this case was later reviewed in detail by the Team and the law enforcement detectives were encouraged to present the case to the Family Violence Division of the District Attorney's office. The case was subsequently presented for the filing of charges and ultimately both the mother and the mother's boyfriend were convicted for the brutal death of this child.

Ten of the 1999 cases involving child homicide by parents/caretakers/family members were not presented to the District Attorney's office for the filing of criminal charges. The reasons that these ten cases were not presented are displayed in Table 9. Five of these cases were not presented as the perpetrator committed suicide after killing the child. In four additional cases there was insufficient information to determine who among the child's caretakers inflicted the fatal injury. In one of these cases, which received extensive Team review, a child in an adoptive placement fell from a 5th floor balcony at the hotel where the adopting family was staying for a family reunion. The Coroner stated that the railing was too high for this child to climb herself and she was either pushed or assisted over the railing. There was a great deal of discussion as to whether or not this child would have been able to climb this railing herself and the Team was unable to reach a definitive conclusion. The law enforcement detectives who investigated the incident stated that they believed that it was possible that the child fell and had not been pushed or assisted and they were unable to identify a suspect. In the 5th case, the suspect was the 5-year old brother of the deceased child

and was, thus, too young to file charges against.

The District Attorney filed criminal charges on 88% (n=30) of the 34 homicide cases presented to them by law enforcements. The filing of charges is still under consideration by the District Attorney's office for one case pending further information from law enforcement.

The percentage of case presentations which have resulted in the District Attorney filing criminal charges has ranged from 66% to 97% in the 10 years prior to 1999. The filing percentages for the past 11 years are represented in Figure 11.

Three of the 1999 cases presented by law enforcement to the District Attorney for the filing of criminal charges were rejected. One case was rejected because the District Attorney believed there was insufficient evidence to identify who was actually with the child at the time of the child's death. This case is still under investigation. Another case was rejected for similar reasons in that the District Attorney did not believe that there was sufficient evidence to identify who actually caused the death. In this case, the primary suspect was the 15-year old female cousin/babysitter of the child, however, the child had been taken to the Emergency Room five days prior to her death as the child had reportedly fallen while in the care of her father. There was also information that the child had fallen off her bed and hit her head on the crib frame approximately two weeks prior to her death. Finally, law enforcement indicated that there was information that on the day of the child's death, the child's mother had also shaken her prior to being transported to the hospital. A final case was rejected as the identified suspect was the 10-year old uncle of the child and the District Attorney did not believe that intent could be established. Their investigation indicated that the two children had been wrestling at the time of the fatal injury. However, the Coroner's Office found that the deceased child had been a battered child and a prior referral to the Department of Children and Family Services showed that at the time of the referral the deceased child had been malnourished.

The number of cases rejected by the District Attorney's Office has fluctuated over the past 11 years. In 1989 only 1 case was rejected; in 1990, 5 cases were rejected; in 1991, 7 cases were rejected; in 1992, 10 cases were rejected; in 1993, 5 cases were rejected and in 1994, 11 cases were rejected. However, in 1995, no cases were rejected and in 1996 and 1998 (as in this year), only 3 cases were rejected. In 1997, this number had increased and 8 cases were rejected.

The criminal charges filed on the cases involving child homicide by parents/caretakers/family members for 1989 through 1999 are listed in Table 10. Murder charges (187 P.C.) were filed on 93% (n=28) of the cases in which charges were filed and 64% of the total number of child homicides in 1999. The rate of filings of murder (187 P.C.) charges has ranged from 57% to 100% over the past 11 years. The percentage of cases in which murder charges were filed between 1989 and 1999 is displayed in Figure 12.

Felony child abuse charges [273 ab, 273 a(a) and 273d P.C.] were filed on 93% of the 1999 cases in which criminal charges were filed. This is an 8% increase over 1998 when felony child abuse was charged in 86% of the cases in which charges were filed.

In 1999, as in prior years, there have been a variety of other charges filed by the District Attorney. Table 10 illustrates the

Figure 10

1989 - 1999 LAW ENFORCEMENT PRESENTATION % OF ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

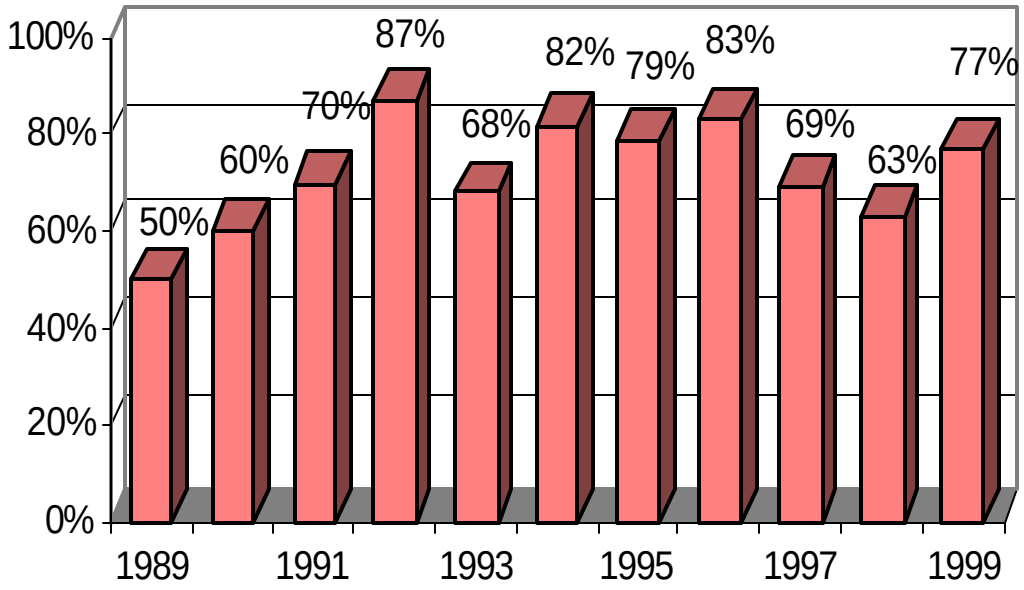


Table 8

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1999 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/ FAMILY MEMBERS

Agency	n	%
LASD	18	41
LAPD	17	39
Long Beach P.D.	2	5
Alhambra P.D.	1	2
Claremont P.D.	1	2
Downey P.D.	1	2
Gardena P.D.	1	2
Pasadena P.D.	1	2
Pomona P.D.	1	2
West Covina P.D.	1	2

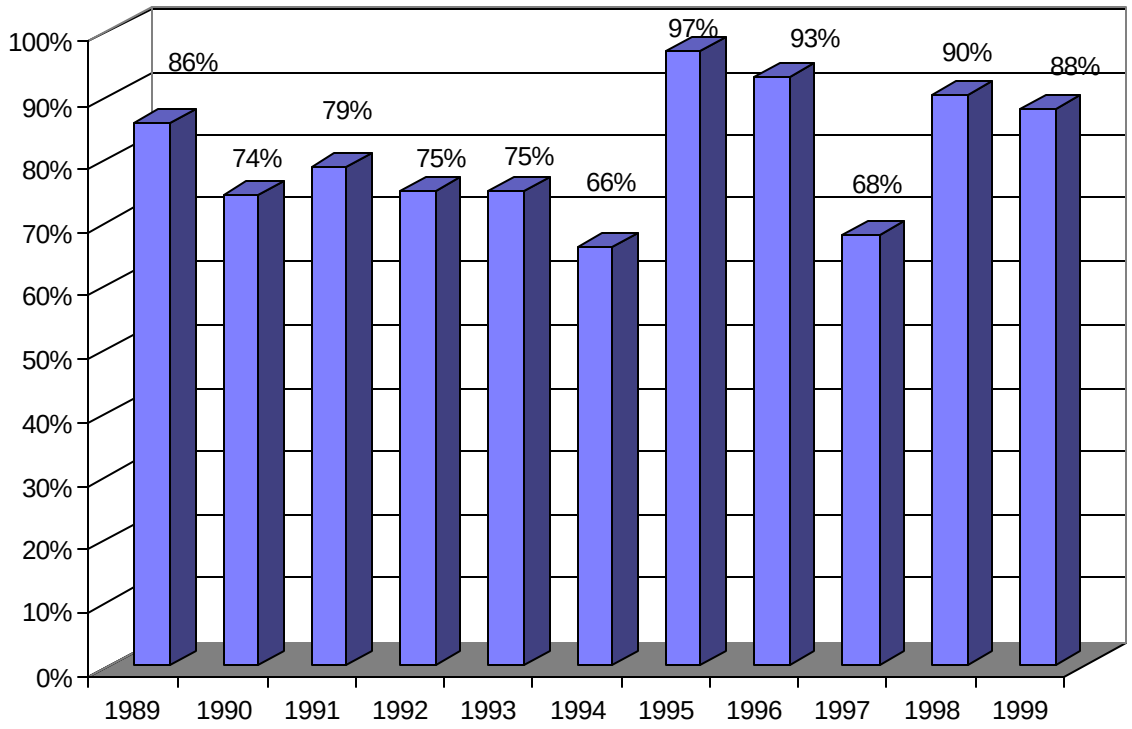
Table 9

LAW ENFORCEMENT REASONS FOR NOT PRESENTING 1999 ICAN CHILD HOMICIDES BY PARENT/CARETAKERS/ FAMILY MEMBERS

Reason	n	%
Murder/suicide	5	50
Suspect's identity unknown	4	40
Suspect too young	1	10

Figure 11

1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS FILING RATE ON CASES PRESENTED TO THE DISTRICT ATTORNEY
BY LAW ENFORCEMENT



charges filed in the past 11 years.

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 1999, for the eighth 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 1999. However, differing from previous years, in 1999 there were more female perpetrators (n=27) identified than male perpetrators (n=24). In most prior years, more male perpetrators had been identified. In addition, in 1999 more female perpetrators were criminally charged by the District Attorney than male perpetrators. This differs significantly from prior years when the pattern had been for more male perpetrators to be criminally charged. It should also be noted that in 1999 there was a diverse group of perpetrators, including: a female domestic partner, a 10-year old uncle, 4 babysitters (3 female and 1 male), 2 male siblings, 2 foster mothers and the daughter of one of the foster mothers, and a paternal aunt and uncle who were also foster parents for the deceased child.

In 1999, there were multiple perpetrators identified by law enforcement and charged by the District Attorney in 10 cases. In eight of the cases in which charges were filed, the mother was implicated along with either the

Table 10

CRIMINAL CHARGES FILED ON 1989 - 99 ICAN CHILD HOMICIDES BY PARENTS/ CARETAKERS/FAMILY MEMBERS

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Murder (187 P.C.)	14	16	28	30	12	21	32	37	19	23	28
Child abuse causing death (273ab P.C.)							23	16	12	16	14
Child endangerment (273a(a) P.C.)							9	5	6	5	10
Child endangering (273a(1) P.C.)	7	7	13	11	12	9	3	3			4
Corporal punishment or injury of child (273d P.C.)				5	3	3	1	3	2	4	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	1
Lewd and lascivious acts (288a P.C.)	4		1				3				
Use of a deadly or dangerous weapon (12022 P.C.)	1		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		
Possession of drugs for sale (11378 H&S)											2
Juvenile Defendant/Murder (602WIC/187P.C.)											2
Juvenile Defendant/Child Endangerment (602WIC/273a(a)P.C.)											1

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

Figure 12

MURDER CHARGES (187 P.C.) FILED ON 1989 - 1999 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

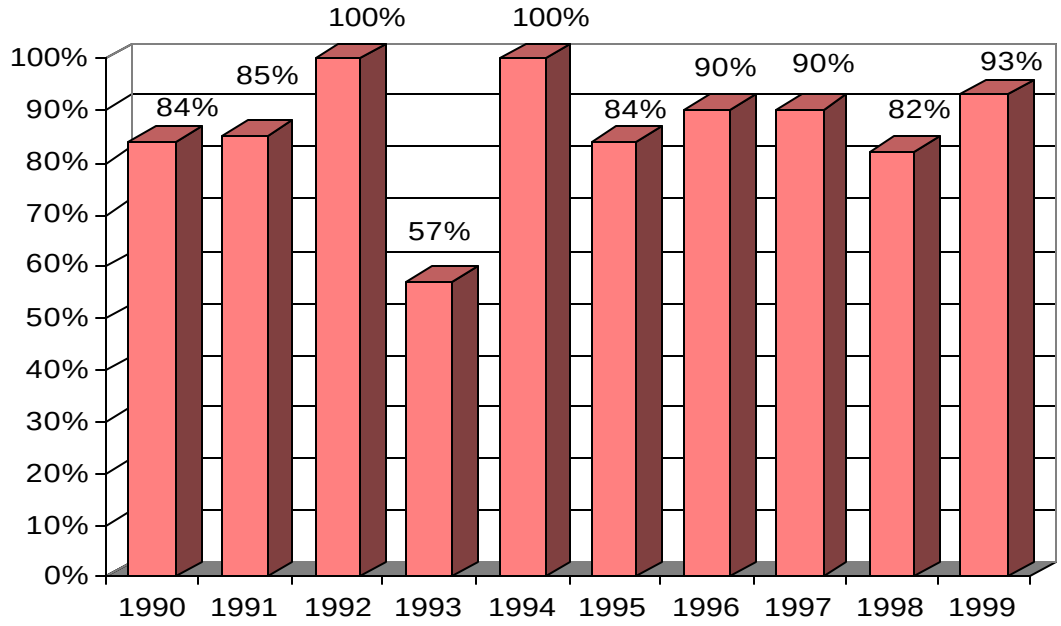


Table 11

RELATIONSHIP OF PERPETRATORS - 1999 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

Relationship	ID'd by Police	Charged by DA
Mother	19	15
Father	15	14
Mother's Boyfriend	4	3
Mother's Domestic Partner	1	0
Sibling (Male)	2	0
Uncle	1	0
Paternal Aunt (Foster Parent)	1	1
Paternal Uncle (Foster Parent)	1	1
Foster Mother	2	2
Foster Mother's Daughter	1	1
Babysitter (Female)	3	1
Babysitter (Male)	1	1
Unknown	3	0

child's father, the mother's boyfriend or the female babysitter. In another case a foster mother was implicated together with her daughter and in a final case, a paternal aunt and uncle who were foster parents were implicated together.

Criminal disposition data for the period of 1989 through 1999 is displayed in Table 12. Quite significantly, in 1999, the percentage of cases that are still in pending status has dropped from 90% in 1998 to only 16% in 1999. The reasons for this tremendous drop are not fully clear but probably reflect better responses from the District Attorney and the various law enforcement agencies involved and ICAN staff's enhanced efforts to obtain better follow-up information.

In 1999, 4 perpetrators were sentenced to 25 years to life and 4 perpetrators were sentenced to 15 years to life. In compari-

son, none of the perpetrators identified in 1998 had received a life sentence by the time the report was written. However, as 90% of the cases in 1998 were still in pending status, it is likely that some of those perpetrators have since received life sentences. The number of perpetrators sentenced to life in prison in prior years was 4 in 1997, 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.

24% (n=9) of perpetrators of child homicide by parents/caretakers/family members received an intermediate term sentence, 6 to 13 years in prison, in 1999. This compares to only 3% in 1998, 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.

Eight of the 1999 perpetrators received jail time of one year or less or a probation order. This compares to none in 1998, 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 1999, there was one dismissal. 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. In addition, in 1999 one perpetrator (foster mother's daughter) was found not guilty and, in the same case, a jury convicted a second defendant (foster mother) of misdemeanor child abuse, but the judge in the case threw out the jury's verdict.

Table 12

CRIMINAL CASE DISPOSITION OF 1989 - 99 ICAN CHILD HOMICIDES

	89	90	91	92	93	94	95	96	97	98	99
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	4
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		4
14 years prison	1			1							
13 years prison	1	1									1
12 years prison							1				1
11 years prison		3	1	5		2	2		2		2
10 years prison				1			2				1
9 years prison				2	1	1		1			
8 years prison			1								1
7 years prison			5				1				2
6 years prison	1		2	1	1	1	2				1
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
4 yrs Probation											2
3 yrs Probation			1	1	2			1			3
Juvenile probation order		1				1					
Found not guilty			2	1	1					1	1
Dismissed	3	1	2	3		1	3	3	1		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	6
Matter on appeal prior to trial	1										
Unable to locate record	1	1	2	1	3						3
Jury conviction thrown out by judge											1
TOTAL	**27**	**21**	**37**	**38**	**27**	**21**	**39**	**44**	**21**	**31**	**37**
Total C/A Homicides for year	**42**	**46**	**61**	**46**	**41**	**39**	**48**	**53**	**45**	**49**	**44**

DEPARTMENT OF HEALTH SERVICES INVOLVEMENT

Detectives from LAPD's Abused Child Unit were called to Childrens Hospital regarding a possible child abuse-related death. Upon their arrival at the hospital at 1:00 a.m., a doctor informed the detectives that three-year-old Sheri had been pronounced brain dead and was on life support systems. The doctor reported that she suspected that Sheri had been physically abused, due to the presence of a subdural hematoma and several suspicious bruises on her body. Sheri subsequently died at 3:40 a.m.

The parents reported to hospital staff that Sheri had been suffering from headaches for several days before she died. They claimed that on the day before she died, Sheri had complained of a bad headache and had eventually lost consciousness. The parents, who had no car, carried her to a local community medical clinic, but were denied service based upon Sheri's serious condition and the clinic's inability to deal with such cases. Clinic staff, in spite of their concerns, did not call 911 or otherwise arrange transport to an appropriate facility. The clinic doctor instructed the family to take Sheri to nearby Good Samaritan Hospital. The parents carried Sheri several blocks to Good Samaritan, where she was admitted in respiratory arrest. She was stabilized and transferred to Childrens Hospital about five hours later.

The primary physician who treated Sheri at Childrens Hospital informed detectives that the parents had told her that Sheri was prone to bruising easily and to excessive bleeding. They denied any other knowledge of how the noted bruising may have occurred. The hospital conducted tests to check for hemophilia, leukemia and other disorders which could account for the bruising, but results were negative. Additional testing at Childrens Hospital revealed the subdural hematoma, which prompted the hospital's call to law enforcement.

Detectives interviewed the parents at the hospital. The parents informed the detectives that they had another child who was being cared for by an uncle. Detectives sent officers to the uncle's residence and placed the sibling into protective custody, pending the outcome of their investigation. As the detectives interviewed the parents about the circumstances leading up to Sheri's death, the mother admitted that she had hit her with a belt and pulled her ear when she had urinated on herself while sitting at the table earlier in the day before she died. She further admitted that she had frequently used a belt to discipline Sheri. Sheri's father initially denied ever hitting Sheri. However, detectives arranged for the father to take a polygraph exam, and just prior to taking the exam, he admitted to hitting Sheri in the abdomen several times, shaking her, and dropping her to the floor because she had defecated on the floor earlier in the day before she died. The father subsequently agreed to be videotaped demonstrating how he had hit and shaken Sheri. Based upon the parents' admissions, the mother was charged with Penal Code 273a(1), Willful Cruelty to a Child, while the father was charged with Penal Code 187, Murder.

Sheri's autopsy revealed a disturbing history of abuse. She had several scalp hemorrhages, one less than 24 hours old, and two between 2-4 days old. She had old scars to her buttocks and chest, including a looped scar on her chest, indicating that she had been hit with a belt or cord on her torso. She had numerous bruises of varying ages, including facial bruises. She had a large subdural hematoma less than 24 hours old, bilateral retinal hemorrhages less than 2-4 days old, and bilateral optic nerve hemorrhag-

es. Toxicology, metabolic and coagulation studies ruled out disease or other factors as causes of Sheri's numerous injuries. She was a battered child who died of her injuries.

The mother had another child following Sheri's death, and both the new baby and Sheri's surviving sibling were placed in foster care, with no reunification planned for the parents, who were convicted of the crime and are serving time in state prison.

Computer searches for Los Angeles County Department of Health Services (DHS) involved 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.

Computer searches for 1999 indicated that 9% (n=4) of the victims of child homicide by parents/caretakers/family members had medical records at these DHS facilities. Three children had medical records at LAC/USC Medical Center and one child had a medical record at Harbor/UCLA Medical Center. In addition, 4 of the child homicide victims previously excluded as they were not killed by a parent/caretaker/family member also had medical records at DHS facilities. Three of these children had medical records at LAC/USC Medical Center and 1 child had a medical record at Harbor/UCLA Medical Center. It should be noted that Olive View Medical Center and King-Drew Medical Center were unable to determine if they had records for 26 of the 44 child homicide cases.

Over the past 11 years (excluding 1997 when computer searches were available for LAC/USC only), 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 44 of the child abuse homicides. Twenty-five of the victims were involved with a total of 12 different medical facilities at the time of their deaths. Twelve of the children who were not declared dead in medical facilities died in their own residences. Five newborn children were killed and dumped in trash bins, one child died in an overheated parked car and one child died on a hotel balcony after a multi-level fall.

ACCIDENTAL CHILD DEATHS IN LOS ANGELES COUNTY

Four and a half-month old Gary died as a result of injuries suffered in a car accident. Another child, age seven months, was also injured in the accident. He was strapped into a child safety car seat in the back seat, but the car seat itself was not strapped to the back seat seatbelt, and he suffered a cut lip and bruises. The children's caregiver, a foster parent, was also a passenger in the car and suffered a broken clavicle. She initially told investigators that Gary had been strapped into a car seat, but eventually admitted that Gary had been sitting on her lap in the front passenger seat at the time of the accident. Investigating officers found another child car seat in the rear seat, but it was not used to secure Gary. The investigation determined that the driver of the car, the foster parent's adult son, had fallen asleep at the wheel. Incredibly, the adult son acted as the "designated driver" for the foster home, despite the fact that he was known to suffer from narcolepsy and to have fallen asleep at the wheel before.

Gary was originally placed in protective custody following his premature birth to a cocaine-addicted mother. Gary's mother had seven other children under the supervision of the Department of Children and Family Services (DCFS) and one child who had emancipated at the time of Gary's birth. Gary resided in a foster home certified by a Foster Family Agency (FFA) and was referred to the Adoptions Division of DCFS shortly before his death.

Community Care Licensing (CCL), an agency of the California Department of Social Services, licenses, certifies and investigates foster homes, group homes, child care facilities and FFAs. In the investigation that followed Gary's death, CCL discovered that the driver of the car was not approved to be a caregiver or driver of children in the home, and his narcolepsy was never reported to the FFA. To act as a caregiver or regular driver for an FFA-certified home, the applicant must have a TB test, fingerprint and child abuse clearances, and CPR certification. The driver met none of these requirements. In addition, there was no insurance for the car or driver involved in the accident. Investigators from the Traffic Division of LAPD also investigated the circumstances of the accident and presented their findings to the District Attorney's office, but no criminal charges were filed.

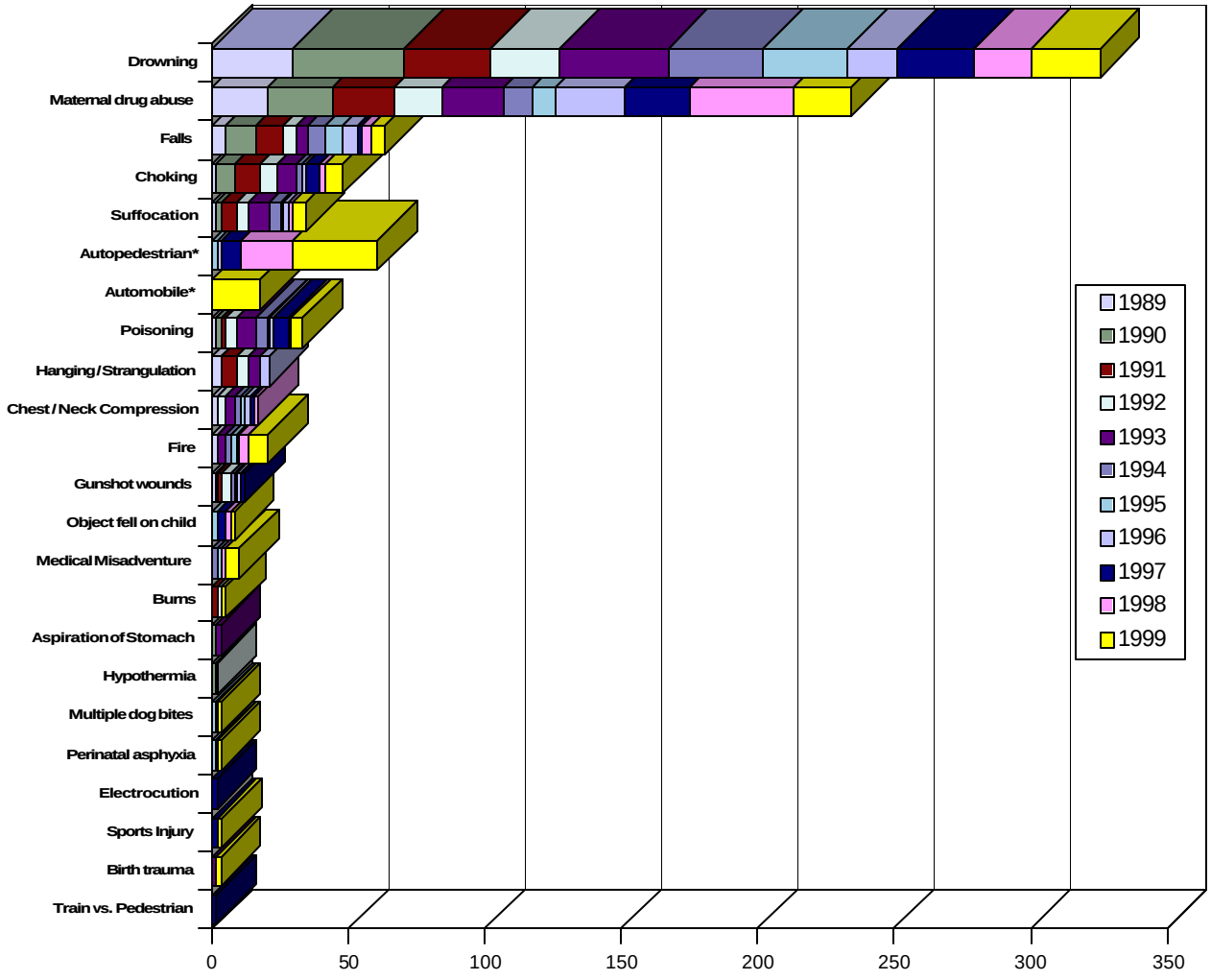
Gary's accidental death could have been avoided. While auto accidents and subsequent death of occupants are unavoidable realities, Gary's death is a good example of the many accidental deaths reviewed by the Team that could have been prevented with improved vigilance regarding child safety by the caregiver(s), or with improved vigilance by systems and agencies charged with the care and safety of children.

One hundred thirty-four accidental deaths were reported to the Team by the Coroner for 1999. This is a 41% increase over 1998. However, as noted in other sections of this report, increases in numbers of cases reported to the Team may be due, in part, to improved referral procedures now utilized by the Team. Over the previous ten-year period (1989 to 1998), the number of accidental deaths reported to the Team 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 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 - 1999 CAUSES OF ICAN ACCIDENTAL CHILD DEATHS



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

CAUSE OF DEATH

The causes of the accidental deaths between 1989 and 1999 are displayed in Figure 13 and Table 13. The leading cause of accidental death in 1999 was autopedestrain deaths (including two children on bicycles and one in utero death when the mother was hit by a car as a pedestrian). Thirty-one children died as a result of auto-pedestrian accidents, an increase of 63% over 1998 (n=19). In 1996, there was only one such death. Prior to 1995, accidental deaths due to automobiles vs. pedestrians were not referred to the Child Death Review Team. It is possible, however, that the large increases in the numbers of these deaths over the last three years do not represent an increase in the incidence of these deaths, but instead reflect changes in the Team's data collection which promote greater identification of these deaths by the Team.

The second leading cause of accidental death in 1999 was drowning. There were 25 accidental drowning deaths in 1999, a 19% increase over 1998. Eighteen of the drowning victims drowned in a pool, 3 drowned in the ocean and 2 drowned in a lake. Two of the 1999 drowning victims died in the bathtub. The lowest number of child drowning deaths was 18 in 1996 and the highest was 40 in 1990 and 1993.

Deaths associated with maternal substance abuse were the third leading cause of accidental death in 1999. Such deaths occur primarily in very young, prematurely born infants who were prenatally drug-exposed. In 1999, there were 21 deaths associated with maternal substance abuse, a 45% decrease from 38 such deaths in 1998. The 38 deaths associated with maternal substance abuse in 1998 were the highest number of these deaths since ICAN began collecting this data. The second highest number was 25 in 1996 and the lowest was 9 in 1995.

As in prior years, other causes of accidental deaths range from automobile accidents; falls; choking; fire; suffocation; accidental ingestion of drugs or other poisons, including one death from carbon monoxide poisoning; medical procedure errors and injuries suffered as a result of objects falling on young children.

Table 13

CAUSES OF ACCIDENTAL DEATHS 1989 - 1999

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	Total
Drowning	30	40	32	25	40	35	31	18	28	21	25	325
Maternal drug abuse	20	24	23	17	23	10	9	25	24	38	21	234
Falls	5	11	10	5	4	7	6	5	2	3	5	63
Choking	1	7	10	6	7	2		1	5	3	6	48
Suffocation	1	3	5	4	8	4	1	2		2	4	34
Autopedestrian**							2	1	8	19	31	61
Automobile***											18	18
Poisoning	1	3	1	4	7	4	1	1	6	1	4	33
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	7	20
Gunshot wounds	1	1	2	3		1	1	2	1			12
Object fell on child							2		3	2	1	8
Medical Misadventure						2	1	1		1	5	10
Burns			2	1	1						1	5
Aspiration of Stomach		1			2							3
Hypothermia		1		1								2
Multiple dog bites							1		1		1	3
Perinatal asphyxia							1		1		1	3
Electrocution									2			2
Sports Injury									2		2	4
Birth trauma					1						2	3
Train vs. Pedestrian									1			1
TOTAL	66	92	90	73	104	70	59	61	86	95	134	930

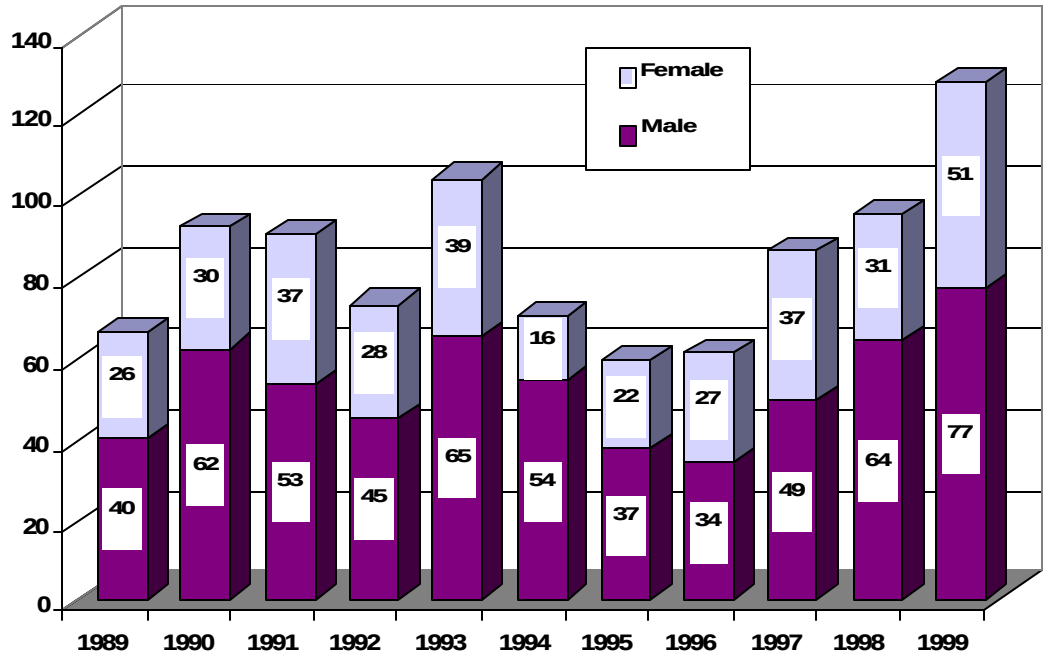
*** Autopedestrian deaths were not referred to the Team prior to 1995.*
****Automobile deaths were not referred to the Team prior to 1999.*

GENDER

57% (n=77) of the 1999 accidental death victims were male and 43% (n=57) of the accidental death victims were female. Over the past 11 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 11 years.

Figure 14

1989 - 1999 ICAN ACCIDENTAL CHILD DEATHS BY GENDER



AGE

Figure 15 displays the ages of the 1999 accidental death victims. 31% (n=42) were under the age of 1 year; 26% (n=35) were under the age of 6 months.

The average age of the drowning victims was 4.6 years old. The ages of the drowning victims increased slightly in 1997 when the Team protocol was expanded to include drowning deaths for ages 17 and under. Eight of the 22 accident victims over the age of 10 years died from drowning. 52%, thirteen of the 25 drowning victims, were 2 years old or younger. The two oldest victims, aged 15 and 16, died as a result of swimming fatigue.

21 of the 35 infants under the age of 6 months died due to complications of maternal substance abuse. 15 drug exposed infants died on their day of birth, 2 died within five days of birth, 1 died within 18 days, 2 died within three months and 1 died at age six months.

The thirty-one children who died as a result of being hit by an automobile in 1999 ranged in age from 0 (fetus whose pregnant mother was hit by a car) to 11 years old; fifteen were age 3 or younger.

Figure 15

1999 ICAN ACCIDENTAL CHILD DEATHS BY AGE

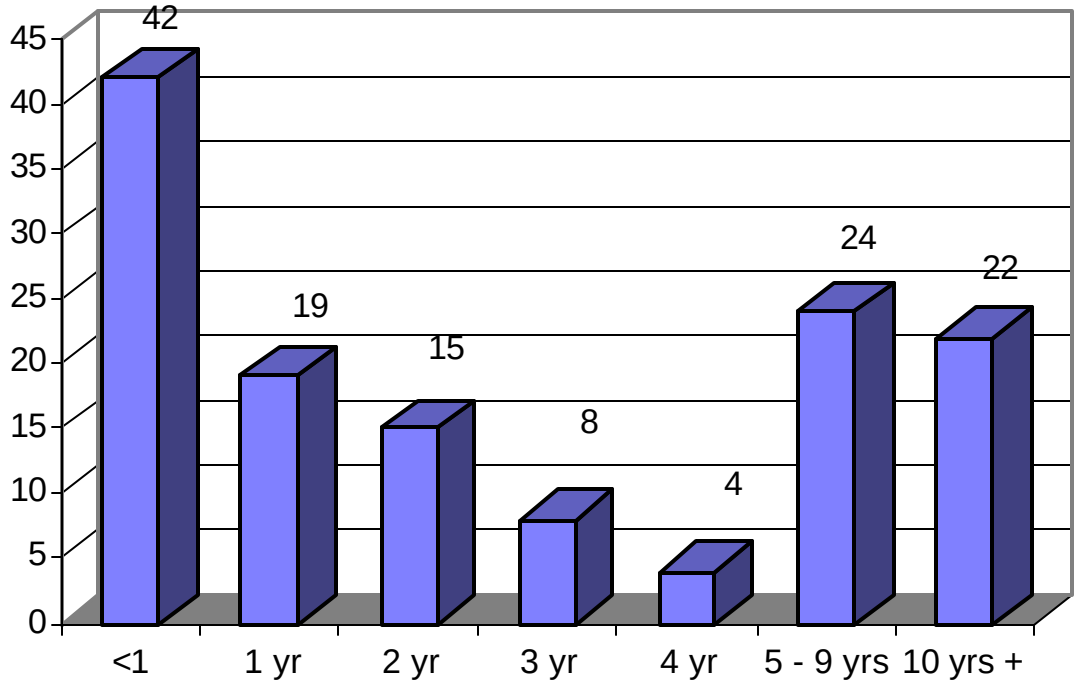


Table 14

ETHNICITY OF ICAN ACCIDENTAL DEATHS 1999

	Hispanic	African American	White	Asian	Native American
Maternal drug abuse	7	11	3	0	0
Drowning	10	3	10	1	1
Autopedestrian	20	2	5	4	0
Automobile	12	2	3	1	0
Choking	6	0	0	0	0
Falls	4	0	1	0	0
Fire	2	4	0	1	0
Suffocation	1	1	0	2	0
Chest/Neck compression	0	0	0	0	0
Object fell on child	1	0	0	0	0
Poisoning	3	0	1	0	0
Medical Misadventure	1	1	3	0	0
Other	5	0	2	0	0
TOTAL	72	24	28	9	1

ETHNICITY

Table 14 displays the causes of accidental deaths in 1999 for the children of different ethnic groups. Hispanic children represented 54% (n=72) of all accidental deaths in 1999. They suffered the most deaths due to poisoning (n=3), falls (n=4), drowning (n=10), automobile accidents (n=12) and deaths due to being hit by a car (n=20). They also suffered all the deaths due to choking (n=6), and objects falling on a child (n=1).

African American children represented 18% (n=24) of the 1999 accidental child deaths. As in most previous years, they suffered the most deaths related to maternal substance abuse; in 1999 they suffered 53% (n=11) of all maternal substance abuse deaths, which is 46% of the 24 total accidental deaths suffered by African American children.

White children represented 21% (n=28) of the accidental child deaths in 1999. 14% (n=3) of the deaths related to maternal substance abuse were White children as were 40% (n=10) of the deaths due to drowning.

There were 9 accidental child deaths of Asian children in 1999: none due to maternal substance abuse; 1 each due to drowning, fire and automobile accident; 2 due to suffocation and 4 due to autopedestrian accidents.

The one accidental death suffered by a Native American child was due to drowning.

Figure 16

1999 ICAN ACCIDENTAL CHILD DEATHS BY MONTH

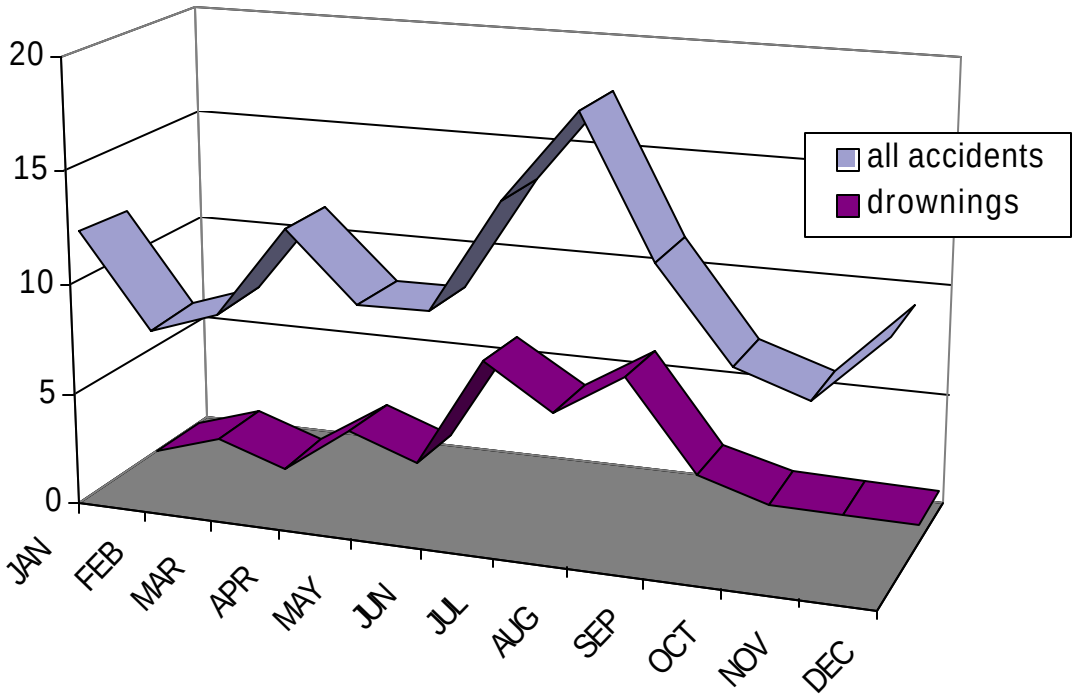


Table 15

1999 ICAN ACCIDENTAL CHILD DEATHS MONTHLY PATTERN

ALL ACCIDENTS VS. DROWNINGS

	All Accidents	Drownings
January	12	0
February	8	1
March	9	0
April	13	2
May	10	1
June	10	6
July	15	4
August	19	6
September	10	2
October	9	1
November	8	1
December	11	1

TEMPORAL PATTERN

Figure 16 and Table 15 display the incidence of accidental deaths for each month in 1999. The month with the greatest number of accidental deaths was August (n=19); the fewest accidental deaths occurred in February (n=8) and November (n=8).

As in past years, the monthly pattern of drowning deaths was compared to all accidental deaths. In 1999, most drowning deaths occurred in the spring and summer; 21 of the 25 drowning deaths occurred between April and September. As deaths due to drowning are one of the most frequent causes of accidental death and the majority of the drowning deaths occur in the spring and summer, they significantly impact the temporal pattern. The months of the most non-drowning accidental deaths were January (n=12) and August (n=13).

DEPARTMENT OF CHILDREN & FAMILY SERVICES INVOLVEMENT

13% (n=18) of the families of accidental child death victims had histories of receiving child protective services prior to the child's death. 33% (n=6) of these cases involved a child death that the Coroner indicated was associated with maternal substance abuse. This percentage is low in comparison to previous years when 41% to 85% of the accidental death victims whose families had prior child protective services died as a result of maternal substance abuse and very low considering that deaths related to maternal substance abuse were the third leading cause of accidental death in 1999. Of the cases with prior protective services involvement, 17% (n=3) involved children who drowned, and 17% (n=3) involved children who died in house fires. In addition, two child death cases involving prior child protective services involved automobile accidents and one case each involved a child that fell, suffocated, was hit by a car or died as the result of a medical misadventure at birth.

Table 16 provides the reasons the 18 accidental death cases were known to DCFS prior to the child's death. 47 previous referrals were made on these families. 55% (n=10) of the families had one previous referral and 17% (n=3) had three previous referrals. In addition, one family each had 2, 5, 6, 7, and 8 previous referrals each. It should be noted that more than one category of allegation (e.g., emotional abuse and caretaker absence/incapacity) were made simultaneously in several previous referrals.

Of the 18 cases with prior child protective services, ten were closed before the child death; five were opened and closed before the birth of the child that died. One case involving allegations of neglect and emotional abuse was closed less than two months prior to the child's death. This child died when he fell from a third story window. DCFS proceeded with court action and out-of-home placement before the death in 39% (n=7) of the families that had received prior referrals for services.

44% (n=8) of the cases that were known to DCFS were open at the time of the child's death. Four of the cases that were open to DCFS at the time of the accidental death were open as a result of parental substance abuse. In all four of these cases, the deceased child's siblings had been in out-of-home care at the time of the death and remained in out-of-home care after the death. An additional open case involved a drug-exposed newborn who died before he

could leave the hosptial and be placed into foster care. Another baby in an open case was placed into foster care as her parents were unable to provide for her special needs associated traumatic birth injuries. This baby died of associated injuries while placed in foster care. An additional child, age 2, drowned while in placement with her grandmother. Finally, a four-month old child died in a car accident while placed in foster care.

In addition to the 8 cases that were open to DCFS at the time of the accidental death, 10 additional families recieved DCFS services after the child's death. One of these cases was previously opened and closed and was reopened at the time of death. The reasons for referrals on the 10 families who received services after the death are displayed in Table 17. Please note that one family was simultaneously referred for allegations of severe neglect and caretaker absence/incapacity.

A petition was filed in Juvenile Court for siblings of one deceased child and this child was placed in out-of-home care. Of the 8 cases that were open to DCFS at the time of the accidental death, 5 remained open after the death. Two were closed as there were no surviving siblings requiring services, and one was closed as surviving siblings were previously adopted and no longer part of the protective service system.

Figure 17 summarizes the child protective services provided for the accidental child deaths.

The Department of Children and Family Services provided the following information:

- The mother's age at the time of death was known in 31% (n=42) of the families. Table 18 provides a breakdown of the mothers' ages.
- The deceased child had identified siblings in 26% (n=35) of the cases. 5% (n=7) of the families were known not to have any children other than the victim. It was unknown if there were siblings in 69% (n=92) of the families.

Table 16

ICAN ACCIDENTAL CHILD DEATHS
REASONS FOR PRIOR CHILD PROTECTIVE SERVICES

Reason	n	%
General neglect	27	52
Severe neglect	5	10
Parental substance abuse	5	10
Physical abuse	5	10
Sexual abuse	4	7
Caretaker absence/incapacity	4	7
Emotional abuse	2	4

Table 17

ICAN ACCIDENTAL CHILD DEATHS
REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING DEATHS

Reason	n	%
Severe neglect	6	55
General neglect	4	36
Caretaker absence/incapacity	1	9

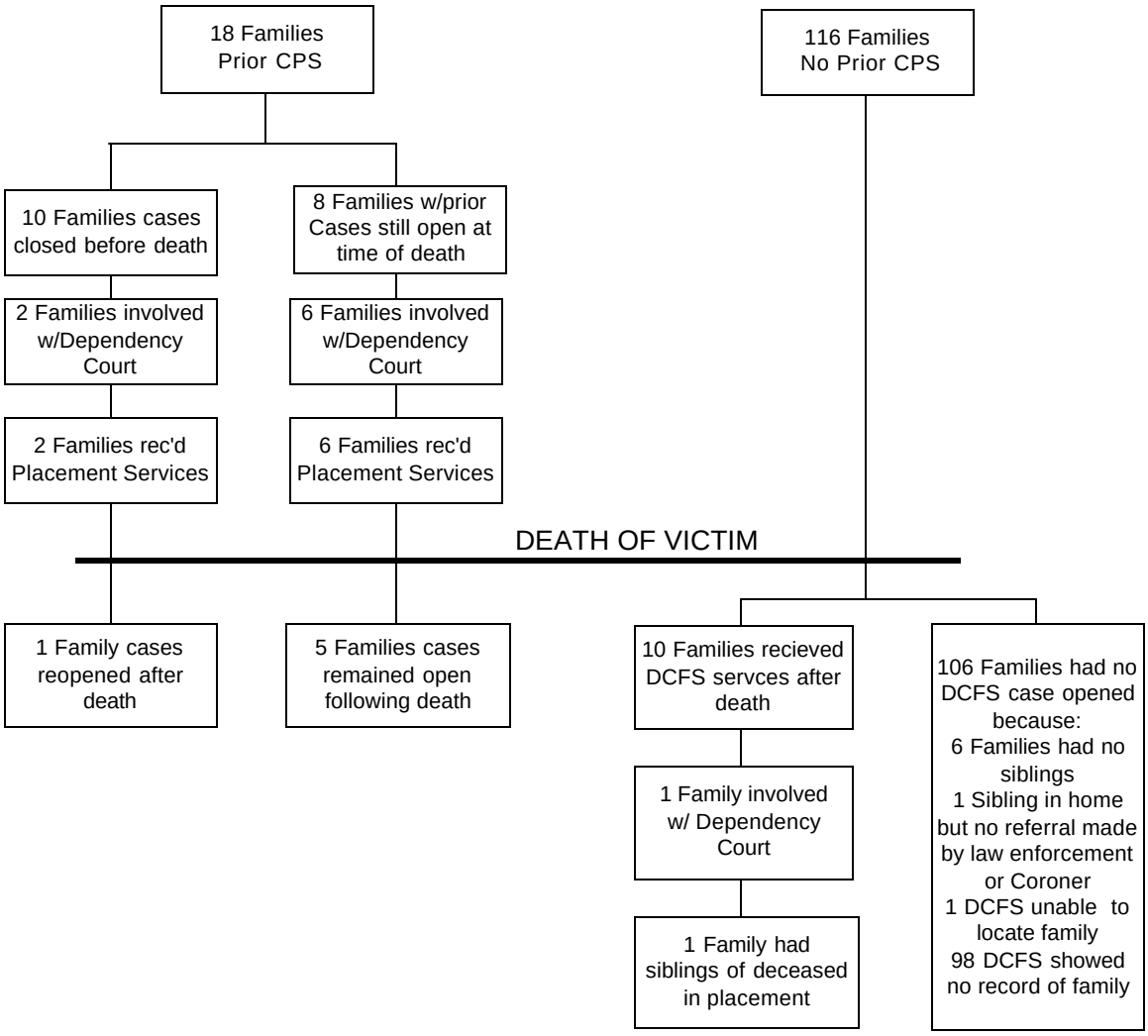
Table 18

ICAN ACCIDENTAL CHILD DEATHS
AGE OF MOTHERS

Age	n	%
Less than 25 years	10	24
25 to 29 years	6	14
30 to 39 years	21	50
40 years and older	5	12

Figure 17

CHILD PROTECTIVE SERVICES ACTIVITIES ON 1999 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 Police Department, Los Angeles Sheriff's Department and Los Angeles District Attorney's Office. The Los Angeles Police Department had investigative responsibility for 30% (n=40) of the accidental child deaths. The Los Angeles Sheriff's Department had responsibility for 21% (n=28) of the cases. Independent law enforcement agencies had responsibility for investigation of 49% (n=66) of the 1999 accidental child deaths. Table 19 displays the 29 different law enforcement agencies known to have involvement with the 1999 accidental child deaths.

As in prior years, very few accidental deaths in 1999 received consideration by the District Attorney due to the Coroner's ruling that the deaths were accidental. However, three accidental child deaths were presented to the District Attorney's Office for

the consideration of filing criminal charges in 1999. All three were automobile-related deaths. The first involved a solo automobile accident in which the mother lost control of her car and skidded off the roadway. None of the four rear passengers, including her one-year old son, were belted or in car safety seats. The one-year old was ejected from the car and died of head trauma. His mother was charged with child abuse and misdemeanor vehicular manslaughter. She pled guilty to misdemeanor vehicular manslaughter and was sentenced to 60 days in County Jail and 3 years probation. The other two accidents involving District Attorney filings were autopedestrian mishaps. In the first, a 2 ½-year old boy was struck and killed when he ran out into the street in front of his house. The driver was initially charged with misdemeanor vehicular manslaughter but charges were dismissed due to lack of evidence. The second autopedestrian accident involved a one-year old girl who was struck by a car as her mother carried her across the street. Mother and child were not in a marked crosswalk and both died at the scene. Initial charges of misdemeanor vehicular manslaughter brought against the driver were dismissed due to lack of evidence.

HEALTH SYSTEMS INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

Forty-three of the accidental deaths had medical records at Los Angeles County Department of Health Services facilities: 21 at Los Angeles County/University of Southern California Medical Center, 15 at King-Drew Medical Center, 6 at Harbor/UCLA Medical Center and 1 at Olive View Medical Center. It should be noted that King-Drew Medical Center and Olive View Medical Center was unable to determine if they had records for 58 accidental cases.

Place of death data provided by the Coroner indicates that twenty-six of the child accident victims died in Los Angeles County Department of Health Services facilities and sixty-eight victims died at one of 31 other medical facilities. The remaining victims died at private residences or public roadways or drowned in bodies of water (swimming pools, lakes or the Pacific Ocean).

Table 19

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1999 ACCIDENTAL CHILD DEATHS

LAPD	40
LASD	28
LAFD Arson	1
Alhambra P.D.	1
Azusa P.D.	1
Bell Gardens P.D.	1
Beverly Hills P.D.	2
California Highway Patrol	14
Compton F.D.	2
Compton P.D.	3
Covina P.D.	1
Downey P.D.	1
El Monte P.D.	2
Gardena P.D.	1
Glendora P.D.	1
Inglewood P.D.	2
Long Beach P.D.	2
Manhattan Beach P.D.	1
Montebello P.D.	3
Morro Bay P.D.	1
Pasadena P.D.	1
Pomona P.D.	5
San Gabriel P.D.	2
Santa Monica P.D.	1
South Gate P.D.	1
West Covina P.D.	1
Whittier P.D.	1
Ventura Sheriff's Department	1
Unknown	13

UNDETERMINED CHILD DEATHS IN LOS ANGELES COUNTY

Early one morning in 1999, 13-month-old Lupe was found dead in a camper. She and her family had been residing in the camper due to financial limitations, and the night before her death had been especially cold. Lupe's mother and boyfriend found her unresponsive and transported her to a local hospital. She was pronounced dead on arrival at the hospital, and law enforcement was immediately called. Based upon the reported history and the lack of any noticeable external injury, hospital staff and law enforcement initially believed that she had possibly died of hypothermia.

Law enforcement interviewed the mother and Lupe's six-year old brother at the hospital. Lupe's brother indicated to investigators that the mother's boyfriend had frequently hit him, tied him up and put a pillow over his mouth as "discipline." He further indicated that Lupe had been subjected to similar abuse. Based upon the brother's statements, he was placed in protective custody with his maternal grandmother by Children and Family Services. As the autopsy report was pending at the time of the detention hearing in court, no mention of Lupe's death was made in the initial detention report.

The autopsy report regarding Lupe's death indicated that she displayed evidence of possible asphyxiation. Lupe's birth was three months premature, and at autopsy she was found to have sepsis (systemic infection), pneumonia, an infection of the trachea, and a subdural neomembrane which could have been indicative of a chronic subdural hematoma. Her thymus also had petechial (small, pinpoint-sized) hemorrhages. There was no skeletal trauma or injury to her eyes. The Coroner's office suspected possible asphyxiation, based upon the findings and the statement of her sibling that the boyfriend had previously placed a pillow over Lupe's face. Law enforcement investigators believed, however, that there was no foul play involved in this case, and believed that some of the observed injuries could have resulted from CPR efforts carried out at the hospital. The Coroner's Office, however, ruled out CPR or other resuscitation efforts as the cause of the observed injuries.

The Coroner's Office, as it does in many such cases, consulted an expert pediatrician regarding Lupe's death. The pediatrician reviewed the case history and autopsy findings in detail. She reported that Lupe had a high fever at the time of her death, which indicated infection and that the mother had given Lupe a decongestant to help treat the apparent infection. The pediatrician further reported that people, especially young children, can die within 24 hours of developing a Staphylococcus Aureus infection and pneumonia. However, given the history of sleeping in the unheated camper, post-birth head trauma and noted hemorrhages, the doctor opined that suffocation could not be excluded as the cause of death.

Investigation by the Department of Children and Family Services (DCFS) and law enforcement also revealed that there was a significant history of conflict in the family. The family was residing in the camper (actually a camper shell over a small pickup truck) because the mother's family, with whom the family had previously resided, did not like the boyfriend and had told

the mother to "choose" between him or her family, and to leave the home if she chose to remain with him. In addition, there was a history of abuse of the mother by the boyfriend; the mother obtained a restraining order against the boyfriend in the weeks following Lupe's death. As the investigation following the death continued, the boyfriend fled and was whereabouts unknown. He has not returned, and given the undetermined mode of Lupe's death, there has been no arrest or criminal filing in this case.

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

Fifty-seven undetermined child deaths were reported by the Coroner to the Team in 1999. This is an increase of more than 100% above the 28 undetermined child deaths reported in 1998. As noted in other sections of this report, increases in numbers of cases reported to the Team may be due, in part, to improved referral procedures utilized by the Team. The number of undetermined deaths reported to the Team in prior years has ranged from 3 in 1989 to this year's high of 57. The average of the past 10-year period (1989 to 1998) was 15.2 per year.

Undetermined deaths are those for which 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 1999, four of the fifty-seven undetermined deaths received in-depth review by the Team.

GENDER

In 1999, thirty-one (54%) of the undetermined deaths were male and twenty-six (46%) were female. In nine of the past eleven years there have been more male undetermined deaths than female.

AGE

In 1999, 83% (n=47) of the undetermined deaths were of infants under one year of age. Five victims were one year old, one victim was two years old, one was three, one was five and one was ten years old. One victim's age could not be determined by the Coroner.

In the period 1989 through 1999, an average of 70.1% of the undetermined death victims have been under the age of one year.

ETHNICITY

44% (n=25) of the undetermined deaths were Hispanic; 21% (n=12) were African American and 25% (n=14) were White. Two undetermined deaths were of Asian ethnicity and four bodies were fetal remains for which the ethnicity could not be determined. Over the past 10 years, ethnicity of undetermined deaths has fluctuated, but has averaged 45% Hispanic, 28% African American, 24% White, and 3% Other.

CAUSE OF DEATH

The diversity of causes of undetermined deaths is consistent with prior year findings. The most frequent cause of the undetermined deaths in 1999 was "undetermined after autopsy" (n=19). The second most frequent cause was "intrauterine fetal demise" (n=14). The third most frequent cause was "undetermined" (n=9).

In 1999, 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. In one case, the Coroner's investigator initially identified the death as a possible homicide but subsequently moded the death as undetermined. A 1 ½-year old child was reportedly found unresponsive in bed by her father. Paramedics were called and arrived on the scene, reporting that the child had "cuts on her face and bruises on her head." While the autopsy found old skeletal fractures, some explained, some not, there were no fresh injuries and the Coroner stated there was no clear-cut cause of death. Asphyxia could not be ruled out, but the autopsy findings were not diagnostic of asphyxia. The child's family had a history of protective services involvement due to the mother's drug abuse and there were concerns with the level of care provided to this child and her older sibling. Because there was no clear causation in this child's death, it was moded as undetermined.

A second suspicious undetermined case initially presented as an accidental/natural death. An eight-month old boy was reportedly found unresponsive in his crib by his father who flagged down a passing motorist and rushed the baby to the hospital. The Coroner initially believed that the death was due to asphyxiation from excessive blood in the child's lungs. However, there was no trauma found at autopsy and the emergency room doctor indicated that the child was vomitous; the blood in the lungs was recent blood that could have come from this vomiting or a postmortem event. The findings were somewhat consistent with Sudden Infant Death Syndrome (SIDS), but the Coroner indicated that an eight-month old child is a bit old for a SIDS death and suffocation could not be ruled out.

Three of the undetermined deaths in 1999 involved abandoned fetuses--one found in a storm drain, one on a school playground and one found buried in a residential construction site.

DEPARTMENT OF CHLDREN AND FAMILY SERVICES INVOLVEMENT

Ten (39%) of the undetermined child deaths in 1999 had prior child protective services involvement, and three of these cases were open to the Department of Children and Family Services at the time of death.

The reasons for invovlement included substance abuse by parents, physical abuse, sexual abuse, emotional abuse, general neglect and severe neglect. One family had 5 prior referrals to DCFS, three families had 4 prior referrals, two families had 2 prior referrals, and one family had 1 prior referral. In addition to the three open cases, one of the cases with prior DCFS involvement resulted in court action and out-of-home placement for the deceased child's siblings. This child died at birth as a result of prenatal drug exposure. Her siblings had previosuly been placed in foster care due to their mother's substance abuse and were placed into care again after this child's death.

In one open DCFS case, a 6 1/2-year old boy died in foster care where he had lived for over 4 years. He possibly died of sepsis; there were no suspicions that abuse or neglect led to his death. In the second open case, a 7-month old girl was placed into foster care when her mother was incarcerated. She died of unknown causes approximately 6 weeks later. The Coroner indicated there was no suspicion of abuse or neglect leading to this child's death. In the third open case, a 2 1/2-month old girl died while her mother and siblings received DCFS services while residing in their home. This child had been born very premature with prenatal drug exposure. After her death, her twin sister and older siblings were placed into foster care.

In addition to the three open cases, 17 cases were referred to DCFS after the death. Four of these referred cases resulted in court involvement and out-of-home placement for the surviving siblings. In an additional case, the referral resulted in the provision of voluntary services for the mother and surviving siblings while the siblings remained at home. In another, the surviving siblings were permitted to remain in the home but the father was prohibited from residing there.

In 7 of the referred cases, DCFS determined that there was no risk to the surviving siblings. Referrals for grief counseling were provided and the children remained at home without court or DCFS supervision. Finally, in 4 of the referred cases, there were no surviving siblings. As in the past, deaths related to undetermined casues have not usually resulted in court involvement and/or out-of-home placement for surviving siblings.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

The Los Angeles Sheriff's Department was the investigating law enforcement agency on 39% (n=22) of the undetermined deaths, and the Los Angeles Police Department was responsible for the investigation of 26% (n=15) of the cases. Twelve cases were handled by independent police agencies, including Baldwin Park, El Monte, Gardena, Glendale, Inglewood, Long Beach, Pomona, Southgate and the San Bernardino Sheriff's Department. Law enforcement agencies could not be identified in 8 undetermined cases.

Three cases were presented to the District Attorney's Office by law enforcement for the filing of criminal charges. In the first case, charges of willful infliction of corporal injury (273.5 P.C.) were brought due to maternal spousal abuse; that is, an unborn female child died as a result of assault against her mother by her father. In this case, the prosecutor rejected the filing, citing insufficient evidence. In the second undetermined case, murder and felony child abuse charges [187a, 273ab and 273a(a) P.C.] were filed against a father due to the choking death of his nine-month old son. Disposition of these charges is pending. Finally, manslaughter charges (192 P.C.) were filed against a father in the undetermined death of his three-month old son who died of suffocation when the father reportedly rolled on top of the infant while intoxicated. Disposition of this charge is also pending.

HEALTH SYSTEM INVOLVEMENT

Eleven of the undetermined deaths had records at Los Angeles County Department of Health Services facilities: 5 at Los Angeles County/University of Southern California Medical Center, 3 at Harbor/UCLA Medical Center, 2 at King-Drew Medical Center and one at Olive View Medical Center. It should be noted that King-Drew Medical Center and Olive View Medical Center were unable to determine if they had records for 36 undetermined cases.

Place of death data provided by the Coroner indicated that 29 different medical facilities were involved in the undetermined deaths. Nine 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 abandoned fetuses. As previously noted, one fetus was found in a storm drain, one on a school playground and one buried in a residential construction site.

YOUTH SUICIDES IN LOS ANGELES COUNTY

- *Seventeen-year old Jason had a history of suicide threats and attempts due to school problems and difficulties with girlfriends. He drove his car to a hilly residential area of Los Angeles County and placed a garden hose from his car's exhaust pipe into the mostly closed rear passenger side window. He was found unconscious due to carbon monoxide poisoning by a passerby who notified emergency personnel. Paramedics initiated life-saving measures but were unsuccessful. Although no suicide note was ever discovered, emergency personnel located song lyrics describing "pain, death and general gloom" and "love notes" from Jason's ex-girlfriend inside Jason's backpack.*
- *Fourteen-year old Ivan emigrated from Russia to California when his mother married an American citizen. Ivan reportedly arrived in this country with a fear of the police that was exacerbated by a recent arrest for shoplifting. On the date of his death, Ivan was involved in a minor accident while trying to park his car. He fled the scene and called his mother from a pay phone. When told that a police report could not be avoided, Ivan became agitated and hung up the phone. He went to the sixth story of a multi-level parking structure, placed his personal items on the ledge, and leaped to his death.*
- *Ten-year old Juan placed a belt around his neck and told his seven-year old sister that he was going to kill himself, stating "no one loves me." His sister ran and got their mother out of the shower and 911 was called. Emergency personnel found Juan hanging from his bunk bed by his belt, with no respiration or pulse. Despite extensive life-saving efforts, Juan died en route to the hospital. In the year preceding his death, Juan and his younger sister had been referred to protective services due to allegations of physical and sexual abuse at the hands of their step-father. These allegations were found to be unsubstantiated and the cases were closed. Juan's suicide occurred ten days after the most current case was closed.*
- *Sixteen-year old Lindsay was diagnosed with a thyroid condition that would require daily medication and regular monitoring. Lindsay, who had no previous history of emotional problems, became depressed about her condition but expressed no suicidal ideation or threats of suicide. While preparing dinner one evening, Lindsay's mother heard a single gunshot from the living room of their residence. She found Lindsay unresponsive on the couch, bleeding from an apparent gunshot wound to her right temple. A small automatic handgun was clutched in her right hand, which was resting on her chest. Three suicide notes were found on a nearby desk.*
- *Seventeen-year old Garth's mother found a suicide note in his backpack and subsequently discovered that he had left their home and taken his parents' car without permission. His parents became alarmed and began looking for him along with several of their family friends. One family friend spotted Garth and began following him in his car. When Garth discovered he was being followed, he stopped his car, got*

out, and pointed the muzzle of a shotgun at his chin saying "Back off or I'll shoot myself." He got back in his car and the friend called law enforcement from his cell phone. A short time later, officers arrived on the scene; as they approached Garth's car, he shot himself. Garth reportedly had a history of behavioral problems and was taking the prescribed medication Ritalin. He had a history of two prior suicide attempts, once trying to hang himself with a belt and once trying to shoot himself with a gun.

These cases illustrate the continuing tragedy of youth suicide. Data from 1999 indicate that there were almost twice as many youth suicides in 1999 (n=27) as 1998 (n=15).

Twenty-seven suicides of victims 17 years old or younger, were reported to the ICAN Child Death Review Team for 1999. This is an 80% increase from 1998 when there were 15 adolescent suicides. The average number of youth suicides referred to the Team since tracking of this population began in 1988 is 27.4 per year.

While the Team does not primarily focus on this population, clearances from law enforcement, Department of Children and Family Services and the Department of Health Services provide a picture of these children and families and their interactions with public agencies prior to their deaths. Although this report addresses 1999 data, it is worth noting that ICAN, in conjunction with several County agencies, most notably the Los Angeles County Office of Education, established the Child and Adolescent Suicide Review Team in late 2000. It is hoped that the work of this Team will contribute to the understanding of youth suicide.

GENDER

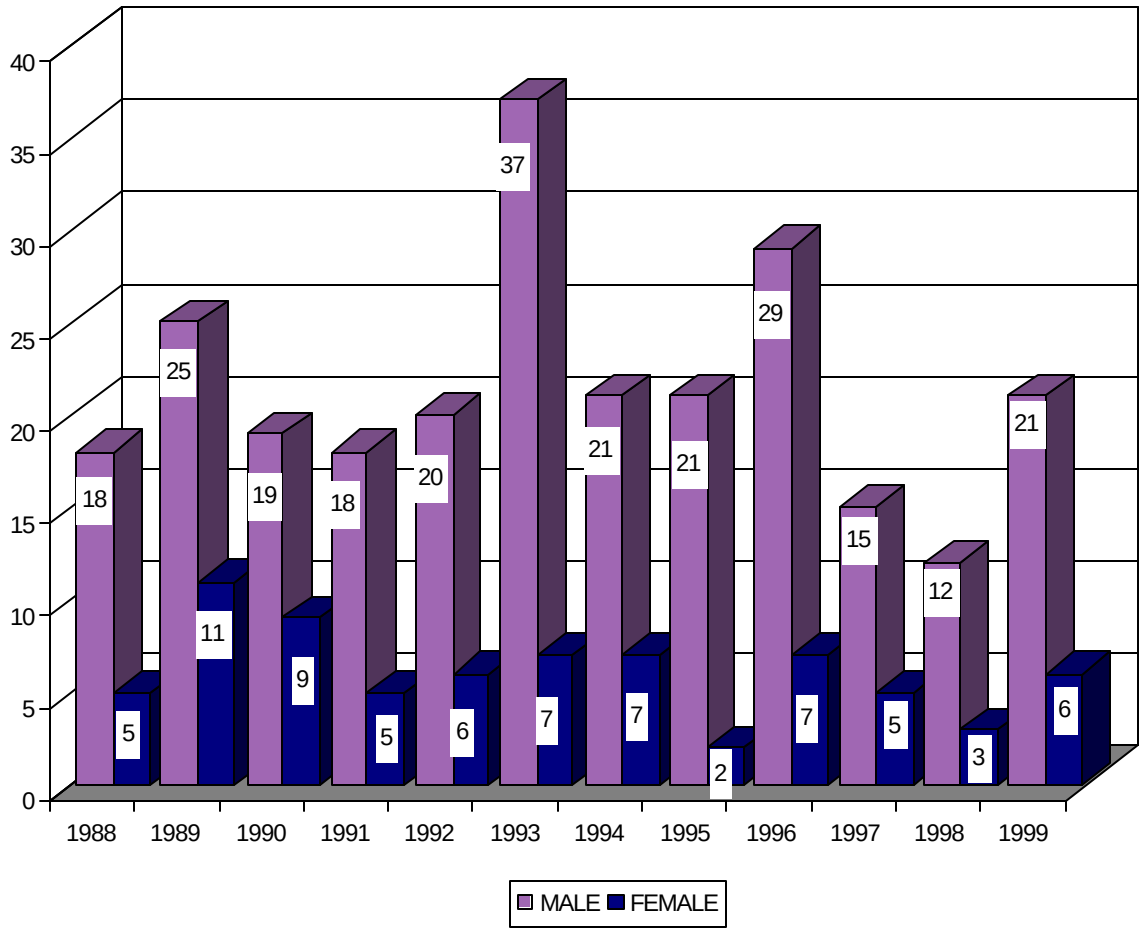
78% (n=21) of the 1999 youth suicide victims were male. Over the past 10 years, the percentage of male victims has ranged from 68 to 90%. The average number of male victims over the past 12 years has been 21.33, with a range of 12 to 37 per year.

22% (n=6) of the victims of youth suicide in 1999 were female, an increase of 100% from 1998. The average number of female victims over the past 12 years is 6.1 per year. The number of female victims between 1989 and 1999 has ranged from 2 to 11 victims per year with the greatest number of female victims in 1989 (n=11).

Figure 18 displays the gender breakdown of the suicide victims for the past 12 years.

Figure 18

1988 - 1999 ICAN YOUTH SUICIDES BY GENDER



AGE

The average age of youth suicide victims increased slightly from 15.2 years in 1998 to 15.44 in 1999. There were increases in the number of suicides of all ages with the exception of ages 11 (n=0), 13 (n=1), 15 (n=4) and 16 (n=4), when the number remained constant. The largest increase was in the number of 17-year olds, from 3 in 1998 to 12 in 1999. Table 20 displays this data, as does Figure 19.

The youngest victim in 1999 was ten years old. This is the first suicide of a 10-year old since 1994 and only the second of a child this young since 1988. There were also two suicides of 12-year olds, one 13-year old and three 14-year olds in 1999.

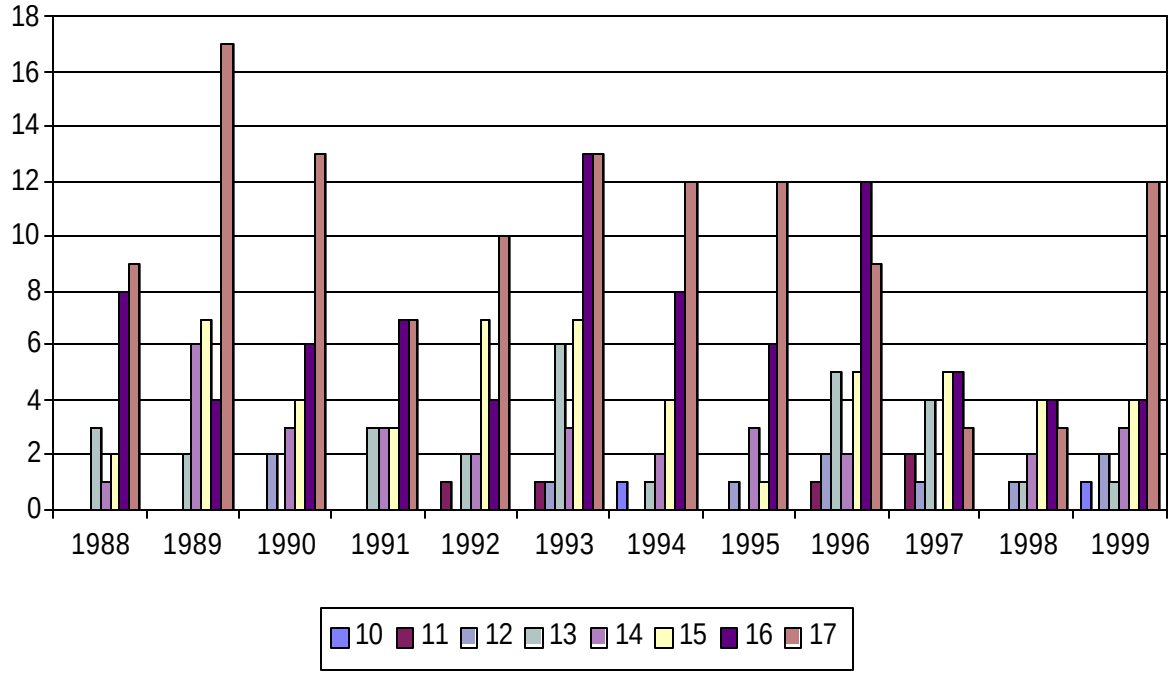
Table 20

AGE BREAKDOWN OF YOUTH SUICIDES 1988 - 1999

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	Total
10	0	0	0	0	0	0	1	0	0	0	0	1	**2**
11	0	0	0	0	1	1	0	0	1	2	0	0	**5**
12	0	0	2	0	0	1	0	1	2	1	1	2	**10**
13	3	2	0	3	2	6	1	0	5	4	1	1	**28**
14	1	6	3	3	2	3	2	3	2	0	2	3	**30**
15	2	7	4	3	7	7	4	1	5	5	4	4	**53**
16	8	4	6	7	4	13	8	6	12	5	4	4	**81**
17	9	17	13	7	10	13	12	12	9	3	3	12	**120**
TOTAL	23	36	28	23	26	44	28	23	36	20	15	27	**329**

Figure 19

1988 - 1999 ICAN YOUTH SUICIDES BY AGE



ETHNICITY

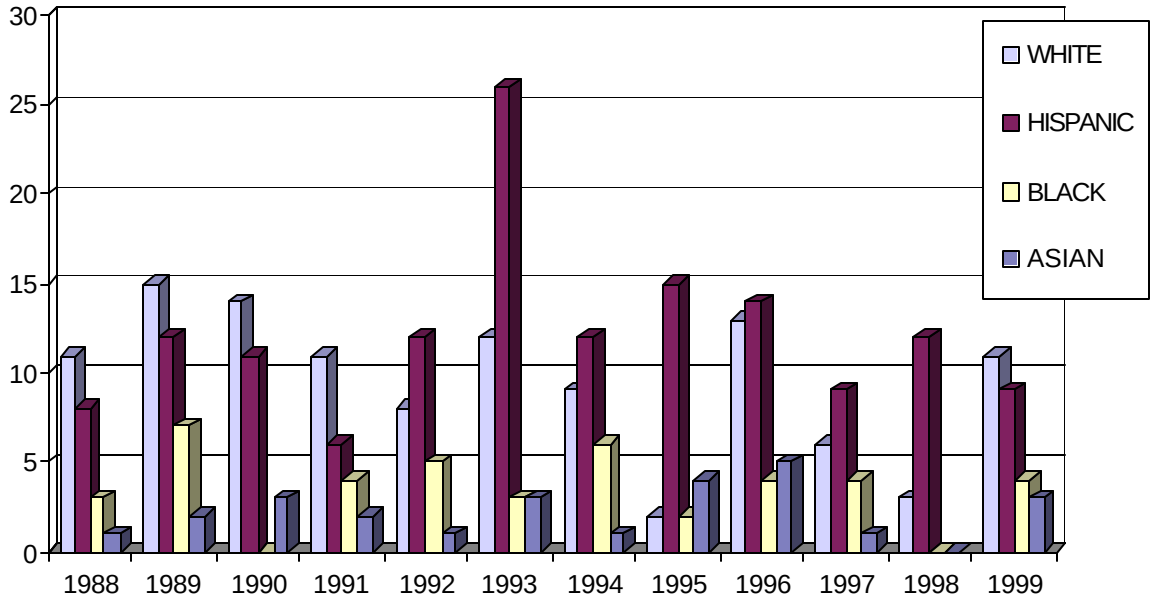
In 1999, 41% of youth suicides were committed by White youth (n=11). This represents a 375% increase from 1998 (n=3). The number of Hispanic youth suicides decreased by 25% from 12 in 1998 to 9 in 1999. Hispanic youth suicides represent 33% of the total number of suicides in 1999. The number of African American adolescent suicides increased from none in 1998 to four in 1999. The number of Asian youth who committed suicide also increased as there were none in 1998 and three in 1999.

From a multi-year perspective, as illustrated in Figure 20, Hispanic youth average the greatest number of suicides (x = 11.66), with White youth following (x = 9.83). Prior to 1999's decline, the percentage of Hispanic youth committing suicide rose as the number of Hispanic youth in the population increased. The number of White youth committing suicide increased in 1999 after a decrease in 1997 and 1998. With the exception of 1995 (n=2), the number of White youth suicides in 1999 is consistent with prior years 1989 to 1994.

The number of African American youth who have committed suicide over the past 11 years has averaged 3.5 per year, with a range of 0 to 8. The number of Asian adolescents committing suicide has averaged 1.9 per year, with a range of 0 in 1998 to 1996's high of 5.

Figure 20

1988 - 1999 ICAN YOUTH SUICIDES BY ETHNICITY



CAUSE OF DEATH

In 1999, 60% (n=16) of the youth committed suicide by using firearms. Firearms have been the predominant method of suicide over the past 12 years. 197 of the 323 youth suicides (61%) over the past twelve 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.

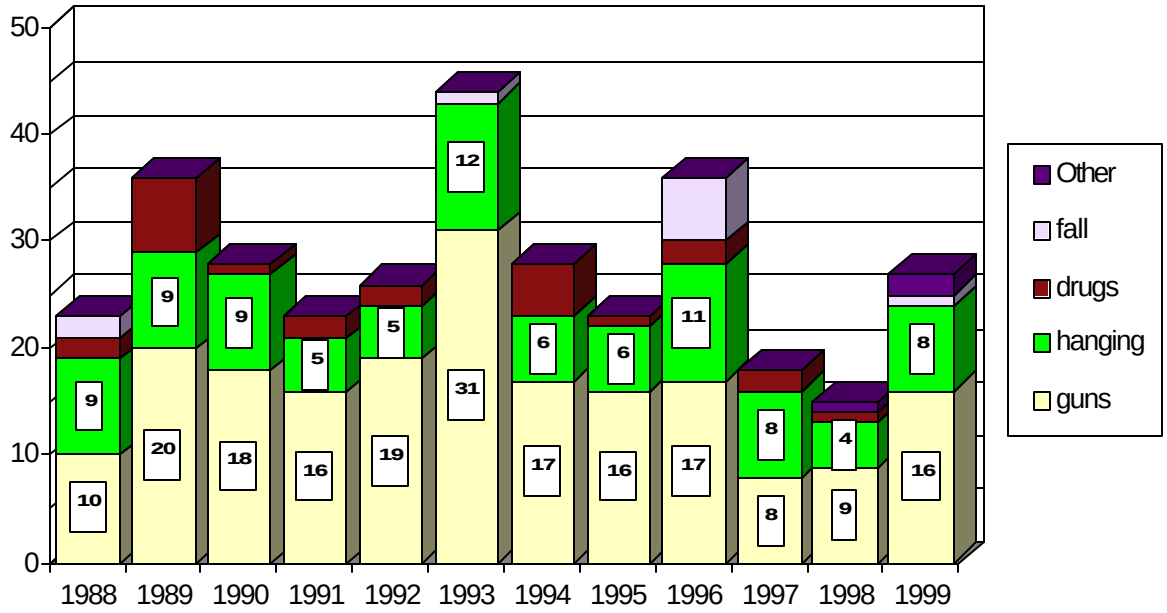
Hanging is the second most frequent cause of suicidal deaths among youth. Eight hangings were reported for 1999, including the death of a 10-year old boy who hung himself with a belt. Hangings represent 30% of the youth suicides in 1999. There have been 92 adolescent suicides by hanging over the past 12 years.

In 1999, two adolescents (both 17 years of age) died of carbon monoxide poisoning when they channeled automobile exhaust into their vehicles. One 14-year old youth jumped to his death from a multi-level parking structure. Although there have been an average of two drug overdose suicides per year in the past eleven years, there were no suicides attributed to drug overdose in 1999.

Figure 21 graphically displays the different methods of suicide over the past 12 years.

Figure 21

1988 - 1999 ICAN YOUTH SUICIDES BY CAUSE



TEMPORAL PATTERN

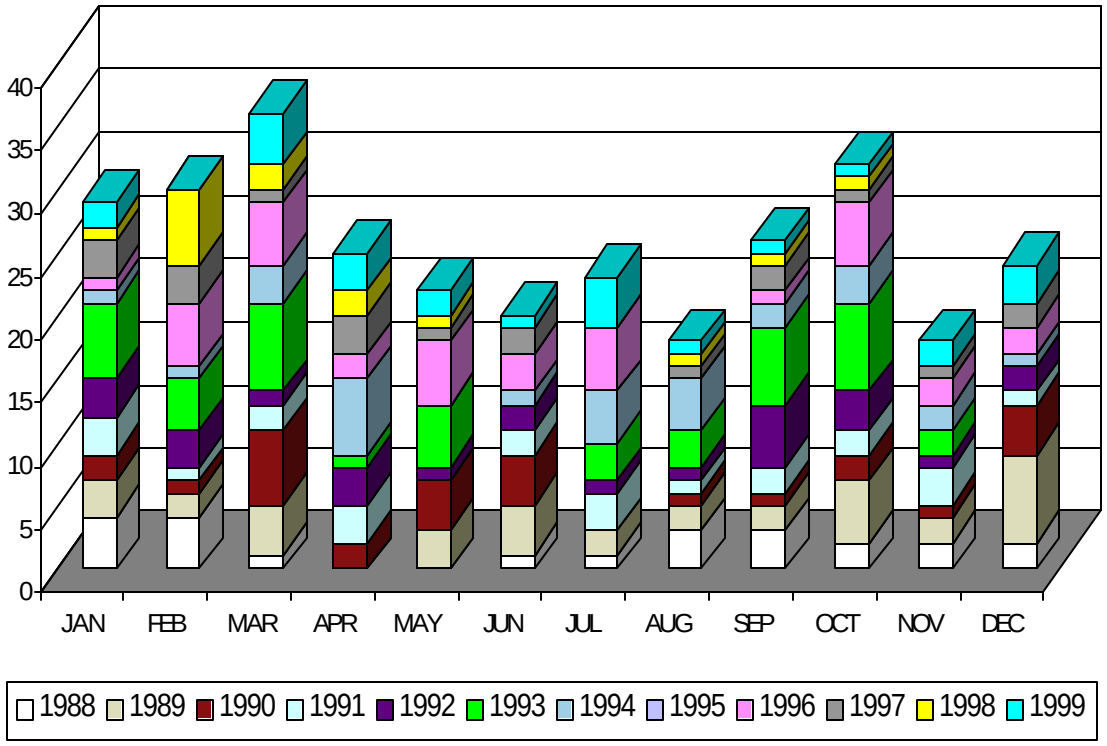
Figure 22 displays the temporal pattern of youth suicides from 1988 through 1999.

In 1999, there were four youth suicides each in March, July and November. In other words, these three months (25% of the year) accounted for 45% of the suicides. In two months (April and December) there were three youth suicides each, and in three months (January, May and October) there were two youth suicides each. In three months (June, August and September) there was one suicide each, and in the month of February there were no youth suicides.

Over the period 1988-1999, the months having the greatest number of youth suicides are March and October.

Figure 22

1988 - 1999 ICAN YOUTH SUICIDES BY MONTH



CHILD PROTECTIVE SERVICES INVOLVEMENT

In 1999, the Department of Children and Family Services (DCFS) had prior contact with 19% (n=5) 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 1 year 1 month and ranged from 10 days to 3 years.

Three cases had two previous DCFS referrals for the family. In one case, one referral alleging general neglect and one referral alleging severe neglect were made in 1998 regarding a single mother and her six children. Both allegations were determined to be unfounded and the cases were closed. DCFS next had contact with the family nine months later when the hanging suicide of the family's twelve-year old daughter was reported and DCFS assessed the well-being of the surviving children. At that time, it was learned that the family's youngest child, age 2, had died of an AIDS-related condition in late 1998 and the mother, also HIV-positive, had subsequently committed suicide by hanging. The children had gone to live with two different maternal relatives, and the 12-year old girl had never recovered from the loss of her younger brother and mother. DCFS assessed that the surviving children were safe in their respective relative homes, provided referrals for grief counseling and closed the case.

In the second suicide case with two DCFS referrals, allegations of sexual abuse were made in two separate, but identical, referrals; a sixteen-year old female who had moved out of her home alleged that her step-father had sexually molested her for a number of years. DCFS assessed that the children who remained in the home were not at risk and the case was closed. One and a half years later, DCFS was notified of the death of the girl's 15-year old brother who had hung himself with an electrical cord. The third suicide case that had two prior DCFS referrals involved a mother, step-father and three children. A referral alleging physical abuse of the nine-year old boy by the step-father was found to be inconclusive in mid-1998; a referral for sexual abuse of his three-year old brother was determined to be unfounded in mid-1999. Ten days after this latest case closing, the then-ten-year old son hung himself. DCFS provided the family with Family Preservation Services, including grief and mourning services, and closed the case a year later.

Two suicide cases had one prior referral to DCFS. Each case involved a report of physical and sexual abuse of siblings of the child who later committed suicide and both were determined to be unsubstantiated. In the first case, a 17-year old boy committed suicide by carbon monoxide poisoning one year after the referral was closed; in the second, a 17-year old girl shot herself in the head one year and three months after the case closing.

The reasons for DCFS involvement included physical abuse (4 referrals), sexual abuse (4 referrals), caretaker incapacity (2 referrals), general neglect (1 referral) and severe neglect (1 referral). Table 21 displays the reasons for prior DCFS services on cases between 1989 and 1999.

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. During the past 12 years, the average percentage 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 1997's and 1998's high of 40% (8 of 20 cases).

In 1999, it was known that there were siblings on 7 cases. For the remaining 20 cases, it is unknown if there were any siblings. Three DCFS cases were opened to assess siblings as the result of a child's suicide. In two cases, the siblings were already residing outside of the family home with extended relatives and it was determined that ongoing DCFS services were unnecessary. In the third case, the surviving sibling was assessed in her mother's home and determined not to be at risk. She and her mother were provided with referrals for grief counseling and their case was closed.

DEPARTMENT OF PUBLIC SOCIAL SERVICES INVOLVEMENT

44% (n=12) of the families of adolescent suicide victims had a known history of receiving public assistance from the Department of Public Social Services (DPSS). All five cases that were known to DCFS prior to the child's suicide were also known to DPSS. Over the past 11 years, the number of families known to DPSS has averaged 26.7%, ranging from 1995's low of 13% to 1992's and this year's high of 44%.

Table 21

REASONS FOR PRIOR DCFS SERVICES FOR YOUTH SUICIDES 1989 - 1999

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	Total
Sexual Abuse	1		3		3	1		3	3	4	4	22
Physical Abuse	1	1	1		2	2		2	5	5	4	23
Severe Neglect	3			1	1			1			1	7
General Neglect	1			1	3	1		1	1	8	1	17
Emotional Abuse					3		1					4
Caretaker absence									1	2	2	5
Info. unavailable	6	2	1	2	2	1		2	1	1		18
TOTAL	**12**	**3**	**5**	**4**	**14**	**5**	**1**	**9**	**11***	**20***	**12**	**96**

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

LAW ENFORCEMENT INVOLVEMENT

Eight different law enforcement agencies were involved in the investigations of the 27 adolescent suicides in 1999. The Los Angeles Police Department was responsible for the investigation of 11 of the suicides, and the Los Angeles Sheriff's Department was responsible for the investigation of 8. Six other law enforcement agencies (Compton, Inglewood, Pasadena, South Pasadena, West Covina and Whittier) were responsible for the investigation of the remaining 8 suicides.

Table 22 shows the law enforcement agencies involved in all suicides reported to the Team for 1999. Division area detail is reported for the Los Angeles Police Department.

PUBLIC HEALTH SYSTEM INVOLVEMENT

Computer searches for Department of Health Services records noted that 15% (n=4) of the1999 youth suicide victims had records at County Medical Facilities, 3 at LAC/USC Medical Center and 1 at Harbor/UCLA Medical Center. It should be noted that Olive View Medical Center and King-Drew Medical Center were unable to determine if they had records for 11 of the 27 suicide cases.

Place of death data provided by the Coroner indicated that one of the 1999 suicide victims died at a Los Angeles County Department of Health Services facility, Los Angeles County/University of Southern California Medical Center. In addition, Children's Hospital of Los Angeles, Henry Mayo Hospital and Daniel Freeman Medical Center each reported one 1999 youth suicide victim. Sixteen of the suicide victims died at their place of residence. Three died in parked vehicles, one died in a parking lot and one died on a residential street. In addition, one youth committed suicide in a Youth Correctional Facility and one committed suicide in a cemetery mausoleum.

Table 22

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1999 YOUTH SUICIDES

LAPD	
77th Street Division	1
Abused Child Unit	1
Devonshire Division	3
Foothill Division	2
Northeast Division	2
South Bureau Homicide	1
Southwest Division	1
LASD Homicide	8
Compton P.D.	2
Inglewood P.D.	2
Pasadena P.D.	1
South Pasadena P.D.	1
West Covina P.D.	1
Whittier P.D.	1

FETAL DEATHS IN LOS ANGELES COUNTY

- *Sara was traveling on the 14 freeway at 1:30 a.m. when she evidently fell asleep at the wheel, hitting a car parked along the side of the road. She was rushed to a local hospital, where she died. Sara was eight months pregnant at the time of the accident. The hospital delivered her fetus immediately upon arrival in an attempt to save the child's life, but tragically, the fetus had died in utero. An autopsy revealed that the fetus, who was a healthy and viable girl before the accident, had died of asphyxia in the mother's womb as a result of the mother's death.*
- *Janice, a woman with a history of abusing controlled substances and a transient lifestyle, arrived in labor at the emergency room of a large county hospital. She was carrying twins whom she delivered prematurely at 22 weeks gestation. The first twin was dead on delivery, while the second twin survived the birth, but died five days later. Janice admitted that she had used cocaine approximately 2 weeks prior to delivery. Exactly one year earlier, Janice had delivered another set of twins prematurely, both of whom died at birth.*
- *Paula, age 15, arrived from Mexico with her boyfriend who was 19 years old. They went to a county hospital emergency room, where Paula complained of cramping and abdominal pain. Shortly thereafter, Paula unfortunately expelled her male fetus while in the waiting room. The hospital determined that Paula had been approximately six months pregnant. She told hospital staff that she had fallen down some stairs earlier in the day and also recalled either "slipping or falling about a week ago." Hospital personnel noted that Paula had numerous bruises and scratches to her body in various stages of healing. She denied physical abuse. Her boyfriend advised hospital staff that Paula had fallen and "that's why she lost our baby." He was arrested for unlawful sex with a minor and Paula was taken into protective custody by the Department of Children and Family Services.*
- *Jacqueline was nine months pregnant, HIV-positive and addicted to crack cocaine, which she regularly smoked and injected. She called paramedics when she went into labor and arrived at a local hospital emergency room via ambulance, where she subsequently delivered a stillborn baby girl. Jacqueline reportedly had no prenatal care.*

- *38-year-old Susan, a woman with a long history of cocaine use and prostitution, arrived at a local hospital in labor. She tested positive for cocaine upon admission to the hospital, and subsequently delivered a stillborn fetus of 38 weeks gestation. The fetus was found to have high levels of cocaine in her system. Susan's two older children had been removed from her care due to neglect and were in long-term foster care at the time of the fetal death. Susan requested that the county dispose of the fetal remains and shortly after delivering her stillborn fetus, left the hospital against medical advice. Attempts to locate her were unsuccessful.*

These cases are typical of the fetal deaths reported by the Coroner to ICAN during 1999, the majority of which involved fetal deaths due to maternal drug and/or alcohol abuse. Many of these cases continue to provide evidence of the great risk to fetal health posed by the abuse of drugs and alcohol by expectant mothers.

Thirty-nine fetal deaths determined to warrant ICAN review were reported to the Team by the Coroner in 1999, a 3% increase over 1998. 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 Coroner records, fetal deaths are those in which an unborn child is over 20 weeks gestation. The number of fetal deaths reported to the Coroner, and therefore to the Team, fluctuates greatly from year to year. Over the past 11 years, the average number of fetal deaths has been 38 per year.

Very few fetal death cases come to the Coroner's attention. It is unclear what criteria physicians use to determine whether to refer a fetal death to the Coroner or sign the fetal death certificate themselves. One factor that may encourage the referral of a fetal death to the Coroner is a history of maternal substance abuse.

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=20), closely followed by undetermined (n=19). There were no fetal homicides reported by the Coroner for 1999.

The most frequent cause of death listed for accidental fetal deaths continues to be intrauterine fetal demise or intrauterine fetal death (n=15). The 5 additional accidental fetal deaths were each attributed to a different cause, including: intrauterine asphyxia, multiple congenital anomalies, extreme prematurity, immature delivery and stillbirth. The Coroner reported that there was a history of maternal drug abuse present in 15 of the 20 accidental fetal deaths (75%) whereas in 1998, all accidental fetal deaths were attributed to maternal drug use. In 1999, 5 accidental fetal deaths were associated with automobile mishaps (four automobile accidents and one fetus killed when the mother was struck by a car as a pedestrian).

The causes of the undetermined fetal deaths were similar to the accidental fetal deaths. In 14 of the undetermined fetal deaths, the cause was listed as intrauterine fetal demise, in 2, the cause was extreme prematurity and in 3 cases, the cause remained undetermined after autopsy. Maternal drug abuse was noted in 6 of the 19 undetermined fetal deaths. Two of the undetermined fetal deaths may have been related to assaults on the mother and the undetermined fetal deaths of one set of twins occurred after the mother had undergone amniocentesis.

ETHNICITY

Table 23 lists the manner of death for the fetal deaths broken down by the ethnicity of the victims. Hispanic families represented 33% of the fetal deaths in 1999. The number of fetal deaths to Hispanic women increased by 116% from 6 in 1998 to 13 in 1999. Six of the undetermined fetal deaths and seven of the fetal accidental deaths were in Hispanic families. Six of the 13 deaths involved maternal drug usage. The number of fetal deaths in African American families decreased by 45% from 20 in 1998 to 11 in 1999. Four of the undetermined fetal deaths and seven of the accidental fetal deaths were in African American families. Nine of the 11 fetal deaths involved maternal drug usage. The number of fetal

deaths in White families increased 25% from 8 in 1998 to 10 in 1999. Five of these ten fetal deaths involved maternal substance abuse. Five undetermined fetal deaths were in a White family. There was one fetal death in an Asian family in 1999 when the mother was struck by a car as a pedestrian. This is the second year since 1989 that there was a fetal death in an Asian family. Finally, ethnicity was unknown in four additional fetal death cases. Figure 23 shows the comparative rates of fetal deaths among the different ethnicities.

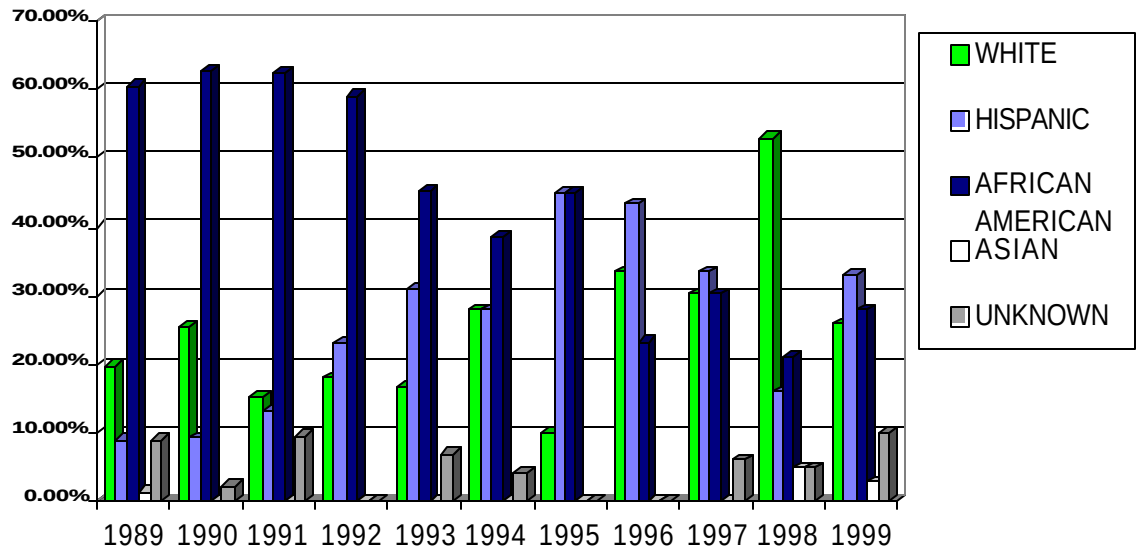
Table 23

ICAN 1999 FETAL DEATHS BY ETHNICITY AND MANNER OF DEATH

	AFRICAN-AMER	HISPANIC	WHITE	ASIAN	UNKNOWN	TOTAL
Accident	7	7	5	1	0	**20**
Undetermined	4	6	5	0	4	**19**
Homicide	0	0	0	0	0	**0**
TOTAL	**11**	**13**	**10**	**1**	**4**	**39**

Figure 23

1989 - 99 FETAL DEATH PERCENTAGES BY ETHNICITY



TEMPORAL PATTERN

The number of fetal deaths per month is displayed in Figure 24. The number of deaths ranged from 1 to 6 deaths in any given month. There were no months without any fetal deaths. September (n=7), April (n=6) and March (n=5) had the most fetal deaths. The largest number of fetal deaths for one month ever reported was 10 fetal deaths reported for June 1994 and the second largest number reported was 7 fetal deaths reported for April 1996 and now, in September 1999.

DEPARTMENT OF CHILDREN & FAMILY SERVICES INVOVLEMENT

The Department of Children and Family Services had a record of prior involvement with 5 of the families in which there was a fetal death. Three of these cases were open to DCFS at the time of the fetal death. All 3 of these cases were open due to allegations of substance abuse and the siblings were already placed in out-of-home care where they remained after the fetal death. Two fetal death cases had prior DCFS involvement and were closed prior to the fetal death. In one case with prior DCFS involvement, the family had two prior referrals for neglect and had successfully completed voluntary services at the time of this fetal death. The family was referred for grief counseling and agreed to received additional services while the mother participated in a substance abuse program. In the second case with previous referrals, the family had been reported on four occasions for physical abuse, caretaker absence/incapacity and emotional abuse. These referrals were unsubstantiated. No referral was made to DCFS at the time of this fetal death.

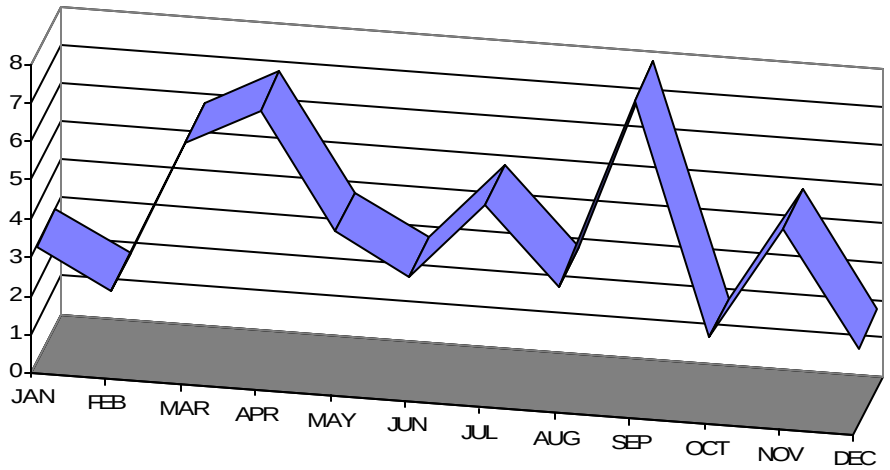
Finally, one fetal death resulted in a referral for a family that had no prior DCFS services. This was a referral for emotional abuse as the mother reported to hospital staff that she had been assaulted by the fetus' father while pregnant. DCFS was unable to locate the mother and surviving sibling and closed the case without making contact.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

Seven law enforcement agencies were known to be involved in the investigations of fetal deaths in 1999. 13 of the case investi-

Figure 24

1999 ICAN FETAL DEATHS BY MONTH



gations involved the Los Angeles Sheriff's Department and 10 of the case investigations involved the Los Angeles Police Department. Five additional police agencies were involved in 8 of the fetal death investigations. In 8 additional fetal death cases, the investigating law enforcement agency is unknown. Table 24 shows the law enforcement agencies involved in all fetal deaths reported to the Team for 1999. Division area detail is reported for the Los Angeles Police Department.

Four of the fetal death cases had involvement with the criminal justice system. In one case involving maternal spousal abuse, law enforcement filed charges (P.C. 273.5/assault against spouse) against mother's boyfriend, but these charges were rejected by the District Attorney's Office due to insufficient evidence. In the second case, the victim's mother was 13-years old and reported that she and her 19-year old live-in boyfriend were having sexual intercourse when she began experiencing abdominal pain and vaginal bleeding. The mother went to the hospital and had an emergency cesarean section but the fetus was already dead, possibly due to an abruption of the placenta. In this case, the boyfriend was arrested for having sexual relations with a minor (288 P.C.). In the third case, the mother went to an unknown clinic to receive a laminaria, a process of self-abortion. She told the staff at the clinic she was 18 weeks pregnant and was given laminarias sticks, which when inserted into the cervix, cause the cervix to expand and detach the fetus, resulting in abortion. The mother was on a bus returning from the clinic when she had severe cramping. Paramedics were called and she was transported to the hospital where she aborted the fetus. The fetus was aged at 25 weeks. A homicide investigation as to whether or not this clinic was a legal abortion clinic is pending. In the final case involving the criminal justice system, the mother had been arrested for possession of a controlled substance (11353 H&S) and was in county jail when she complained of labor pains. A stillborn female was delivered. After the birth, the mother told the hospital staff that she had not felt the baby move in her womb for approximately 2 weeks.

HEALTH SYSTEM INVOLVEMENT

Seven of the 39 fetal death cases reported to ICAN in 1999 had records at a Los Angeles County Department of Health Services facility. Three of these records were found at King-Drew Medical Center, two were found at Los Angeles

Table 24

LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1999 FETAL DEATHS

LASD		**13**
LAPD		**10**
Foothill Division	2	
Harbor Division	2	
Hollywood Division	1	
Northeast Division	1	
Rampart Division	1	
South Traffic	1	
Southeast Division	1	
Valley Traffic	1	
Long Beach P.D.		3
Glendale P.D.		2
CHP Newhall		1
CHP West Valley		1
Santa Monica P.D.		1
Unknown		8

County/University of Southern California Medical Center (LAC/USC), one was found at Harbor/UCLA Medical Center, and one was found at Olive View Medical Center. It should be noted that King-Drew Medical Center and Olive View Medical Center were unable to determine if they had medical records for 17 fetal deaths.

Place of death data provided by the Coroner indicated that 17 different hospitals were involved in the fetal deaths.

Three fetuses were abandoned; one was found in a storm drain, one on a school playground and one was found buried in a residential construction site. "Residence" was listed as the place of death for four fetuses and in one automobile accident case, the car in which the mother and her fetus were driving 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 Review Team Training Project. This Training Project, conducted under the auspices of the Office of Criminal Justice Planning and the California Department of Social Services, Office of Child Abuse Prevention, is designed to provide a core training program for professionals interested in the Child Fatality Review Process. To date, 6 on-site Regional Training Sessions and a National Satellite Training Broadcast have been completed and more on-site Regional Training Sessions are anticipated for the coming year.

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

"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 profes-

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

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

III. Basic Team Structure, Philosophy and Process

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

A. Core Membership

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

Most teams grow with time to include others including: Juvenile or Civil Court attorneys, representatives from schools, mental health departments, probation departments,

fire emergency technicians (EMT), clergy, child life specialists and child advocates.

B. Team Philosophy

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

C. Review Process

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

IV. Team Variation

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

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

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

V. Central Log or Data Systems

A. Minimum Log/Data System

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

B. Demographic Data/Team Reports

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

C. Computerized Data

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

D. Systematic County Level Demographic Data Set

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

E. County/State/National Triple Data Set

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

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

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

VI. Common Problems/Answers

A. One Agency Won't Cooperate

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

B. Records Can't Be Found

It may be particularly difficult to find previous health records if there are multiple hospitals or clinics where care was provided. It is also hard to find records from multiple counties and to connect state and county record systems. As teams grow, they tend

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

C. Team Stopped Meeting and Needs To Restart

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

D. Confidentiality

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

E. Failure To Write a Report On Team Activity

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

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

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

G. Increased Sophistication Requiring Training

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

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

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

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

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

VII. Extensions of Process

A. Domestic Violence Fatality Review

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

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

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

C. FIMR and SIDS Programs

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

D. Multi-County and Multi-State Case Review

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

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

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

F. Prevention Program Addressing Perinatal and Infant Toddler Issues

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

VIII. Grief and Mourning

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

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

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

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

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

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

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

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

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

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

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

IX. Prevention / Health

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

Campaigns and programs addressing child deaths which value prevention include:

1. Public education on the potential hazard of accessible 5 gallon buckets to young toddlers resulting in toddler drownings.
2. Infant automobile safety seat campaigns that provide donated seats for families who have limited funds.
3. Child-proof drug containers, particularly for presciption pills or iron pills that resemble candy.
4. Traffic safety campaigns and the provision of speed bumps in neighborhoods with large numbers of young children.
5. The enacting of ordinances for four-sided fencing to help prevent pool and spa drownings and river safety programs that utilize warning signs in multiple languages.
6. The provision of smoke detectors for sub-standard 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