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Report Comp[illegible]

[illegible] DEATH REVIEW TEAM REPORT FOR [illegible]

FINDINGS

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CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS

- 35 child homicides committed by parents/caretakers/family members in 2001 were identified by the Team. This is the exact same number of child homicides by parents/caretakers/family members in 2000, and as in 2000 the lowest number of such deaths over the past 14 years.

- 54% (n=19) of the victims were female; 43% (n=15) were male. In addition, one deceased infant's gender could not be identified. Over the past 14 years, there have been a total of 304 male victims (52%) and 280 female victims (48%).

- 69% of the victims (n=24) were under the age of 1 year; 21 of these 24 victims were under age 6 months. Over the past 13 years, 45% (n=262) of the victims have been under the age of 1 year. In 2001, 97% of the victims were under age 5; over the past 13 years 85% (n=499) of the victims have been under the age of 5 years.

- 28% (n=10) of the victims were African American; 40 % (n=14) of the victims were Hispanic; 26% (n=9) of the victims were White and none of the victims were Asian. In addition, the ethnicity of two victims remains unknown.

- Deaths due to asphyxiation/suffocation (n=8) represented the leading cause of child homicide by parent/caretaker/family member, claiming the lives of 23% of the victims in 2001.

- Deaths due to multiple trauma represented the second leading cause of child homicide by parent/caretaker/family member, representing 20% (n=7) of the 2001 victims.

- Deaths due to head trauma (n=5) were the third leading cause of death, comprising 14% of the cases.

- Poisoning/drug ingestion and unattended/neglected newborns accounted for 3 homicides *each* in 2001. Deaths due to gunshots and medical neglect each comprised 6% (n=2 each) of child homicides deaths. Finally, there was one death each attributed to the following causes: drowning, stabbing, burns, dehydration/malnutrition, and undetermined.

- 34% (n=12) of the families had a record of contact with the Department of Children and Family Services prior to the child's death. Five of the children were in open cases at the time of their deaths.

- In 2001, three relative caregivers with whom a child was placed were identified as those responsible for the child's death, including two grandmothers and a grandfather. In addition, two children died at the hands of unrelated foster parents.

- Siblings were identified in 51% (n=18) of the child homicide cases. Domestic violence was identified in the histories of 20% (n=7) of the families and substance abuse was identified in the histories of 31% (n=11) of the families.

ACCIDENTAL CHILD DEATHS

- 137 accidental child deaths were reported to the ICAN Team for 2001, the exact same number of accidental child deaths that were reported for 2000.

- Autopedestrian deaths, deaths resulting from children hit by vehicles, were the leading cause of accidental child death in 2001. This includes children struck not only while standing or walking but also while riding bicycles and skateboards. There were 41 autopedestrian deaths, representing 30% of the total accidental child deaths in 2001.

- The second/third leading causes of accidental child death in 2001 were automobile accidents (automobile v. automobile and solo automobile accidents) and drowning. Each resulted in the deaths of 28 children.

- Deaths associated with maternal substance abuse were the fourth leading cause of accidental child death in 2001 and represented 17.5% (n=24) 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.

- 55% (n=75) of the accidental child death victims were male; 45% (n=62) were female.

- 26% (n=36) of the accidental child deaths occurred in victims under the age of one year; 31 of these 36 deaths occurred in children under six months of age.

- 50% (n=68) of the accidental child death victims were Hispanic. Hispanic children comprise 57.5% of the County child population.

- 20% (n=27) of the fatal accident victims were African American. African American children comprise 9.9% of the County child population.

- White children represented 23% (n=31) of the accidental child death victims. White children comprise 19.8% of the County child population.

- 8% (n=11) of the fatal accident victims were Asian. Asian children comprise 9% of the County child population.

- 22% (n=30) of the families had a record of receiving child protective services prior to the death of the child. 36% (n=11) of these cases involved deaths the Coroner indicated were associated with maternal substance abuse.

- The deceased child was known to have siblings in 35% (n=48) of the cases.

SUICIDES

- 27 adolescent suicides, ages 9 through 17 years, occurred in 2001 and were reported to ICAN's Child Death Review Team by the Coroner, an increase of 17% from 2000 (n=23). The average number of adolescent suicides for the past 14 years (since 1988) is 27 per year.

- 81% (n=22) of the suicide victims were male and 19% (n=5) were female. Over the past 14 years the number of male suicide victims has ranged from 12 to 37 per year with an annual average of 21.23, and the number of female victims has ranged from 2 to 11 per year with an annual average of 6.15.

- There was a substantial increase in the number of suicides committed by those under age 13. In 2000, there were no such deaths; in 2001, there were five victims under age 13, including, for the first time since data have been collected by ICAN, the suicide of a 9-year old child.

- 44% (n=12) of the adolescent suicides were committed by Hispanics. 33% (n=9) of the adolescent suicides were committed by Whites. There were 5 suicide deaths by African American adolescents, and 1 suicide by an Asian adolescent in 2001.

- In 52% (n=14) of the 2001 cases, the method of adolescent suicide was hanging. In another 26% (n=7), the method involved firearms. Other methods included jumping (n=3), drug overdose (n=2) and asphyxiation with a plastic bag (n=1).

- 26% (n=7) of the families with adolescent suicide victims had prior involvement with the Department of Children and Family Services. Two cases/referrals were open at the time of the death.

- Siblings were known to survive the suicide victim in 10 of the 2001 cases.

CHILD DEATH REVIEW TEAM REPORT FOR 2002

CHILD HOMICIDES BY PARENTS/CARETAKERS

CHILD HOMICIDES BY PARENTS/CARETAKERS

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

In 2001, fifty-three homicides meeting ICAN referral protocol were reported to the Team by the Coroner. Following a review of law enforcement records, 18 cases were determined *not* to have been perpetrated by parents caretakers family members. It should be noted, as in earlier sections of this report, that ICAN's initial referral protocol was raised from age 12 to age 14 in 2000. Of the eighteen cases determined *not* to have been perpetrated by parents/caretakers/family members, ten cases involved children age 13 or 14 who would not have been included prior to 2000. These ten cases include five gang-related homicides and two teen victims of random acts of violence. Also included are two teenage girls who were sexually assaulted and killed by strangers in separate incidents and a 14-year old girl who was shot and killed by her boyfriend in a murder-suicide pact.

In addition to the ten homicides of children age 13 and 14 excluded as they were perpetrated by other than parent/caretaker/family member, eight cases of homicide of children under age 13 were determined to have been committed by other than parent/caretaker/family member. These eight cases included four cases specifically identified as gang-related and victims ranged in age from 9 days to 11 years. The 9-day old infant was struck by gunfire in utero during a drive-by shooting in which his mother was killed. He was delivered by C-section and survived for nine days. The second youngest victim of a homicide by a perpetrator other than a parent, caretaker, or family member was a 16-month-old male who was shot twice while waiting in a van with his mother who was also shot by the same assailant. In addition, a 2-year old female was shot by gang gunfire while her father carried her to their car and an 11-year old girl caught in rival gang gunfire and died of gunshot wounds.

The other four homicides of children under 13 years of age who were *not* killed by a parent, caretaker or family member were not identified as gang-related. The first case involved a fetus who died after her 29-year old mother was struck by random gunfire. Her mother was on the sidewalk talking to friends when a gunman opened fire on them. The second case involved a 7-year old girl who was the apparent victim of a stranger abduction in 2001. Her body was not found until 2002. The third case also involved a 12-year old child; this boy was asleep in his bedroom and shot in the head when a drug deal taking place outside his home "went bad." Finally, another 12-year-old male was shot and killed during an argument between his adult sister and her boyfriend. His sister's boyfriend shot him, his sister and their grandmother. He was transported to the hospital, but resuscitative efforts failed and he was pronounced dead.

As discussed in the ICAN Child Death Review Team Report for 1999, the Team revised the intake system established with the Los Angeles County Department of the Coroner for the referral of cases and expanded the Team protocol of cases to be reviewed. As discussed in detail in the Team Protocol section of this report, the Team further expanded its case protocol in 2000 to include children ages 13 and 14 whose final mode of death was accidental or undetermined, with the exception of drowning deaths that already included children ages 0 through 17. As a result of these changes, the problems in identifying cases that existed in previous 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, data regarding the number of homicides by parents, caretakers and family members have always included homicides for age 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 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, the number of homicides should not change dramatically.

In an effort to assure that all child homicide cases meeting the protocol were identified, the Team reviewed 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 parents, caretakers or family members have been identified. Review of these indices did not identify any additional cases of homicide by a parent, caretaker or family member in 2001.

Given the above information, the Team determined that there were 35 child homicides perpetrated by parents, caretakers or family members in Los Angeles County in 2001. This is the same number of such homicides for 2000. However, it should be noted that the numbers of deaths in both 2000 and 2001 represent a decrease of 20 percent from 1999 when there were 44 child homicides by parent, caretaker, or family member. The average annual number of child homicides by parents, caretakers, or family members between 1989 and 2000 was 46. Due to the two most recent years with relatively low homicide rates, 2000 and 2001, the 13-year average has dropped to an average of 45 deaths per year. Figure 2 displays the 585 homicides by parents, caretakers and family members referred to the Team by the Coroner for years 1989 through 2001.

GENDER

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

In 2001, 54% (n=19) of the victims of child homicide by parents, caretakers or family members were female, while 43% (n=15) of the victims were male. In addition, due to the condition of the body, one infant's gender could not be identified and was designated as "unknown". Over the past thirteen years, there have been a total of 304 male victims (52%) and 280 female victims (48%). The victims whose gender is unknown (n=1) constitute 3% of the 2001 total and only 0.2% of the 1989-2001 total.

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 from 1989 through 1993, averaging 24 per year and ranging from 21 to 27. In 1994, there were 12 female victims and in 1995, there were 14. However, the number rose again in 1996 and in both 1996 and 1999, there were 25 female homicide victims. In 1997, there were 17 female victims and in 1998 there were 27, the highest annual number of female homicide victims over the last thirteen years.

The number of male victims has had much greater fluctuation over the past thirteen years. The average is 23.4 per year and has ranged from a low of 15 in both 2000 and 2001 to a high of 35 in 1991 and 1995.

AGE

The ages of victims of homicide by parent, caretaker or family member between 1989 and 2001 are displayed in Figure 4. In 2001, 60% of the victims were under the age of six months, 69% under the age of 1 year and 71% were under age 2. Ninety seven percent of victims of homicide by parent, caretaker or family member were five years of age or younger. Over the past 13 years, 45% (n=262) of the victims have been under the age of 1 year; 85%

(n=499) have been under the age of 5 years. In 2001, there was only one victim of homicide by parent, caretaker or family member who was between the ages of 6 and 10, an 8-year-old child, and there were no victims of homicide by parents/caretakers/family members over the age of 10 years.

Between 1989 and 1993, approximately 60 to 65% of child victims of homicide by parents/caretakers/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. The average age of child homicide victims in 1998 increased because of two multiple family killings, one with three children and one with 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%. For the following year, the percentage decreased to 77% and again was due, in part, to a sibling set of three children, all over age 9, who were killed in one tragic homicidal episode.

Table 1 displays the relationship between the age and sex of the victims of child homicide by parents, caretakers or family members in 2001. The average age of female victims was 1 year. This is a significant drop from 2000 when the average age of female victims was age 5–the highest average female age over the past 13 years. The average age of female child victims decreased over the previous 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. In 1999, the average age of female victims dropped to 2.1 years.

The average age of male victims in 2001 was 2 years. This is a slightly lower average than in past recorded years. Prior to 2000, the average age of male victims remained consistent with a low of 1.6 years in 1989 and a high of 2.8 years in 1998. The oldest child homicide victim by parent/caretaker/family member in 2001 was an 8-year-old boy.

ETHNICITY

In 2001, 28% of the victims of child homicide by parents/caretakers/family members were African American (n=10). This constitutes a 23% decrease from 2000, when African American victims comprised 37% (n=13). Hispanics represented 40% (n=14) of the child homicides, an 8% increase over the 37% (n=13) Hispanic homicides in 2000. There were nine White victims, representing 26% of the total, an increase of 28% from 2000 when they comprised 20% (n=7) of cases. There were two child homicide victims whose ethnicity was not identified. The children's ethnicity was categorized as "unknown".

The 2000 Census figures indicate that the child population in Los Angeles County is 57.5% Hispanic, 19.8% White, 9.9% African American and 9.0% Asian. Table 2 displays the ratio between percentages of child homicides by parents/caretakers/family members and child population by race. Figure 5 represents a multi-year perspective.

African American child homicides - When child homicides by parents/caretakers/family members are compared to child population statistics, African American children continue to be over-represented in 2001. The ratio of African American child victims has been greater than their ethnic composition within the Los Angeles community every year since 1989.

Hispanic child homicides - As in 2000, Hispanic children were under-represented by child population in 2001. Hispanic child homicides by parents/caretakers/family members increased between 1989 and

1998, not only in real numbers, but also in relationship to the percentage of Hispanic child populations. Prior to 1999, Hispanic child homicides were consistent with the Hispanic child population rate, with an exception in 1998 when Hispanic children were over-represented. However, in 1999 the number and percentage of Hispanic child homicides decreased dramatically and remained low in 2000 and 2001.

White child homicides - In 2001, as in 1999 and 2000, White children were slightly over-represented by child population rate. Prior to 1999, White children were under-represented. There was a steady decline in White child homicides by parents/caretakers/family members between 1991 and 1994. This figure increased gradually in 1995, 1996 and 1997 and then increased 26% in 1998, increased 50% in 1999 and decreased 42% in 2000.

Asian child homicides - There were no Asian child homicides by parents/caretakers/family members in 2001. Asian children have been consistently under-represented in such child homicides, except in 1991 when they were slightly over-represented.

NOTE: *Because the number of child homicides by parents/caretakers/family members is extremely small in relation to Los Angeles County's overall child population, relative increases and decreases in the number of deaths in any one ethnic group may significantly impact percentages.*

CAUSE OF DEATH

In 2001, the leading cause of death for child homicides by parents/caretakers/family members was asphyxiation/suffocation, claiming the lives of 23% (n=8) of the victims. This is the first year since ICAN has collected these data that asphyxiation/suffocation has been the leading cause and represents a significant difference from prior years' data when the leading cause of death was most often head trauma or multiple trauma. The majority of victims of asphyxiation/suffocation in 2001 were newborn children (n=5). These five children were concealed and abandoned by their mothers at birth. Four of these asphyxiated newborns were wrapped in plastic bags and hidden in their residences. The fifth was wrapped in a towel and placed in the mother's bedroom closet.

It should be noted that in addition to these 5 newborns killed by their mothers, six additional newborns died at the hands of their mothers in 2001. Three children were left unattended shortly after birth in or near trash dumpsters and died of environmental exposure, caretaker neglect and other undetermined factors. One newborn was killed by stabbing, one died of hyperthermia and dehydration when she was left in a hot car and buried in her mother's backyard, and one newborn was found wrapped in a T-shirt and burned and died of unknown causes. Tragically, the 11 newborns killed by their mothers account for 31% of the child homicides by parents/caretakers/family members in 2001.

Multiple trauma was the second leading cause of death in 2001 and represented 20% (n=7) of these cases. Deaths due to head trauma (n=5) were the third leading cause of death, comprising 14% of the cases. Poisoning/drug ingestion accounted for 3 deaths: a newborn who ingested methamphetamine through breast milk, a 4-month old boy who died of methamphetamine exposure and a 10-month old girl who died of morphine intoxication. As stated, unattended/neglected newborns also represent three of the child homicides by parents/caretakers/family members. Gunshot wounds and medical neglect comprised 6% (n=2 each) of child homicide deaths. Finally, there was one death each attributed to the following causes: drowning, stabbing, burns, dehydration/malnutrition, and undetermined.

Table 3 and Figure 6 display the various causes of child homicides by parents/caretakers/family members for the period from 1989 to 2001. The most frequent cause of death for this 13-year period, and comprising 33% of all child homicides by parents/caretakers/family members, was head trauma. Multiple trauma was

FIGURE 2

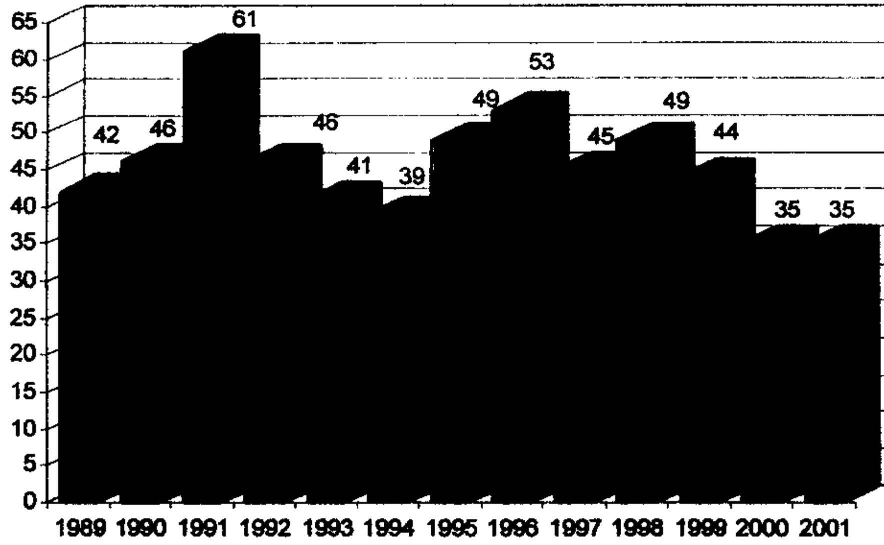
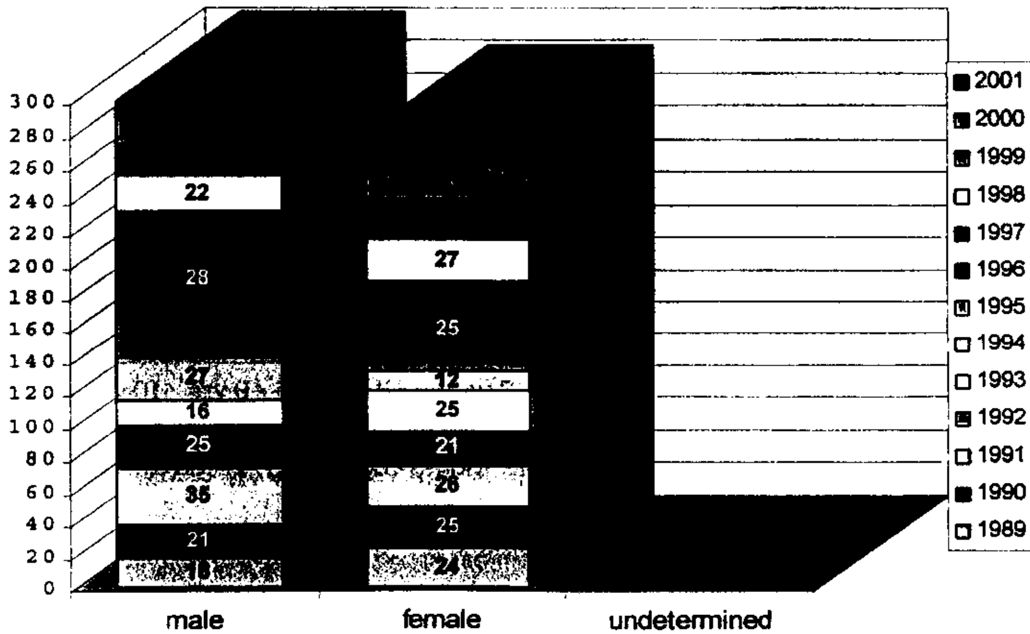


FIGURE 3



the second most frequent cause of death over this period, representing 17% of the total deaths. Homicide by guns represents 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, 2000 and 2001. Deaths due to gunshots represent 11% of the total homicides by parents/caretakers/family members over the past 13 years and stabbing deaths represent 2.7% of the total homicides by parent/caretakers/family members over this period.

Age	Male	Female	Unknown
less than 1 year	10	13	1
1 year	0	1	
2 years	1	3	
3 years	1	1	
4 years	2	1	
5 years	0	0	
6 years	0	0	
7 years	0	0	
8 years	1	0	

FIGURE 4

200
150
100
50
0
<1 1 yr 2 yr 3 yr 4 yr 5 - 9 yrs 10 yrs +
1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001

TEMPORAL PATTERN

In 2001, the highest number of child homicides by parents/caretakers/family members occurred in July (n=6). The second greatest number (n= 4 each) occurred in the months of March, May, and October. Three homicides occurred in February and December. There were two homicides in each of the following months: January, April, August, September, and November. The fewest number of homicides occurred in June (n=1).

Figure 7 displays the child homicides by parents/caretakers/family members by month for the past twelve years. During the period of 1990 through 2001, the greatest number of child homicides by parents/caretakers/family members occurred during the month of March (n=67). During the same period, the fewest such homicides occurred in the months of June (n=42) and November (n=38).

The 585 homicides by parents/ caretakers/family members during the past thirteen years translate to an average of 3.8 homicides per month. While actual deaths in any give month vary, June of 1994, July of 1997, and February of 1999 were the only months in the past 13 years in which no child homicides by parents/caretakers/family members were recorded.

CHILD PROTECTIVE SERVICE INVOLVEMENT

Of the 35 homicides by parents/ caretakers/family members in 2001, twelve families had contact with the Department of Children and Family Services (DCFS) prior to the child's death. These twelve families represent 34.28% of the total child homicides by parents/caretakers/family members in 2001. According to Prevent Child Abuse America, the average nationwide rate of prior child protective services involvement in cases of child homicides by a parent, caretaker, or family member is 40%.

Prior Contact

Figure 8 displays the number of homicides by parents/caretakers/family members with prior child protective services compared to the total number of such child homicides for the past thirteen years. 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 received prior DCFS contact; in 1994, 12 families received prior contact; in 1995, 15 families received prior contact; in 1996, 13 families received prior contact; in 1997, 15 families received prior contact; and in 1998 and 1999, 20 families per year had a record of DCFS involvement. For the year 2000, the number decreased to 15 families with prior DCFS involvement. The difference between 1999 and 2000 represented a 25% decrease.

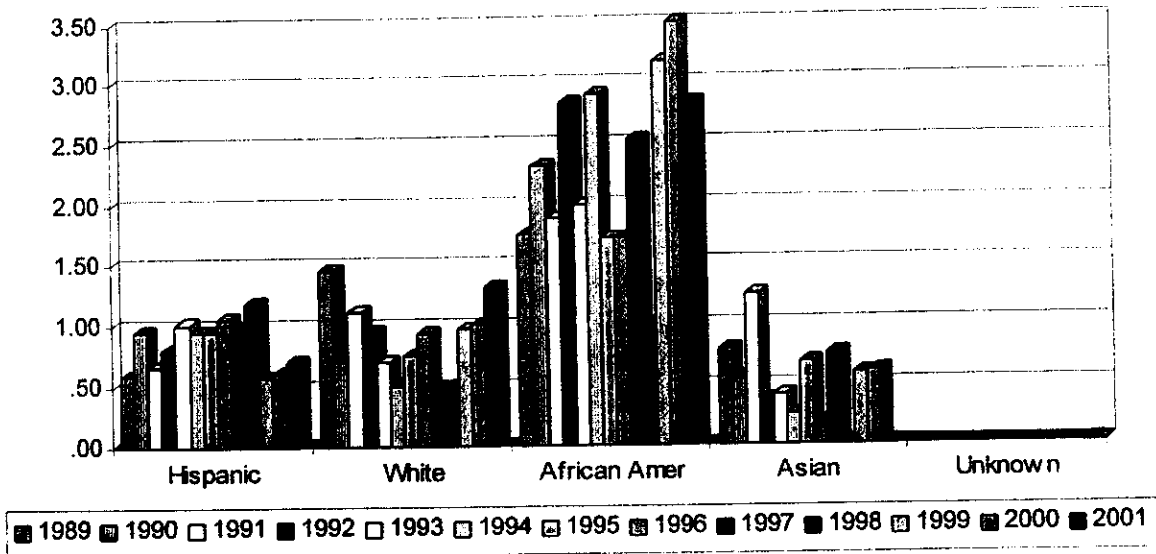
TABLE 2

2001 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS BY RACE

Race	Number	%	Child Pop	Ratio*
Hispanic	14	40	57.5	0.69
African American	9	26	19.8	1.31
White	10	28	9.9	2.82
Asian	0	7	9.0	–
Unknown	2	6	–	–

** 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



The twelve cases with prior DCFS contact in 2001 represented a total of 49 prior referrals. Of these twelve cases, 33% (n=4) of the families had one prior referral. Two families had two prior referrals each. One family had three previous referrals that occurred approximately one and two years before the child death occurred. There was a total of five referrals for one family and two additional families had six referrals each. For one of those families, all six prior referrals alleged general neglect beginning in 1997 and the family's case was open at the time of the child death. One family with nine prior referrals had open services since 1991 when the mother gave birth to an infant who tested positive for drugs and the case remained open at the time of child death. Finally, one family had a total of thirteen previous referrals and was open for services at the time of the child death.

The reasons for prior DCFS services are listed in Table 4. Fifty-six allegations were made requiring assessment. As in 1990, 1991, 1997, 1998, and 2000, the most frequent reason for prior referrals to DCFS in 2001 was general neglect. General neglect allegations constituted 38% (n=21) of the total number of allegations. Allegations of physical abuse (n=11) accounted for 20%, and allegations of severe neglect accounted for 5% (n=3) of the referrals. Caretaker absence/incapacity represented 18% (n=10) of the previous referrals. There were eight (14%) sexual abuse allegations in the referrals made for prior DCFS involvement. Severe neglect and emotional abuse allegations each accounted for five percent (n=3 each) of the referrals. For the majority of previous years (1989, 1992, 1993, 1994, 1995, 1996 and 1999), the most frequent reason for prior referral was physical abuse.

Table 5 displays the time elapsed between the DCFS closed case/referral and child's death. Of the twelve cases with prior contact, five cases/referrals were open (receiving services from DCFS) at the time of the child's death and are not included in this table.

TABLE 3

	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	TTL
Head trauma	21	17	23	16	14	17	19	15	12	13	15	5	5	**192**
Multiple trauma	6	5	7	9	7	7	10	7	10	8	10	11	7	**104**
Gunshot wounds	6	11	5	3	2	2	4	4	7	10	4	3	2	**63**
Trauma to torso/abdomen	1		7	3	3	6	2	5	4	2	1			**34**
Asphyxiation/Suffocation	4	5	1	2	1		4	4	4	3	6	3	8	**45**
Drowning	1	2	5	2	1	1	4	0	2	2		3	1	**24**
Fire				3	1		3	8		4		1		**20**
Strangulation	3	1	4	1	1	1		2	2	1				**16**
Poisoning/drug ingestion			1	1	6	1		2					3	**14**
Stabbing			2	3	1			2		2	1	4	1	**16**
Unattended/neglected newborn			3	1		1	1		1	3	4	2	3	**19**
Undetermined			2		1	2		2	1		2	1	1	**12**
Dehydration/malnutrition		1	1	1			1	1	1	1		1	1	**9**
Neck compression		1		1	1		1	1						**5**
Medical neglect					2	1						1	2	**6**
Burns		2							1		1		1	**5**
Penetrating wound to brain			1											**1**
TOTAL	**42**	**46**	**61**	**46**	**41**	**39**	**49**	**53**	**45**	**49**	**44**	**35**	**35**	**585**

FIGURE 6

Head trauma
Multiple trauma
Gunshot wounds
Trauma to torso/abdomen
Asphyxiation/Suffocation
Drowning
Fire
Strangulation
Poisoning/drug ingestion
Stabbing
Unattended/neglected newborn
Undetermined
Dehydration/malnutrition
Neck compression
Medical neglect
Burns
Penetrating wound to brain

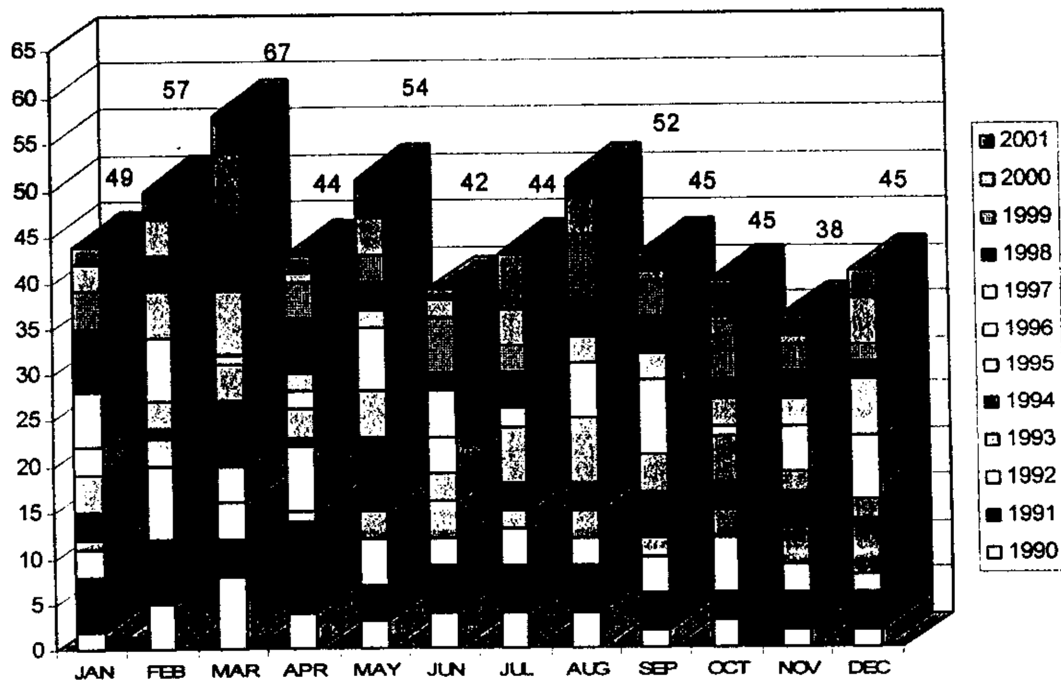
0 20 40 60 80 100 120 140 160 180 200

1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001

In two of the seven closed referrals/cases, the most recent contact took place less than six months prior to the child's death. In the first of these two cases, three prior referrals were investigated for the family with allegations of general neglect and sexual abuse. The first referral alleged that the mother neglected to provide her children with food and a clean, safe living environment. The referral was closed as inconclusive after the investigating worker found no evidence of neglect. The second referral alleged that the children in the mother's care were not receiving appropriate supervision. The worker determined that the allegations were unfounded and closed the investigation. The third referral occurred less than one year after the second referral was initiated. The mother accused the children's father of sexually abusing their 3-year old daughter. There was no medical evidence of abuse, the investigation was closed, and the allegation of sexual abuse was deemed unfounded. Approximately four and a half months after the closing of the third referral, the youngest child in the home, a 2-month old twin, died. The mother and her children were living in transient, impoverished circumstances in various hotels. On the day of the death, the infant's mother noticed the infant was unresponsive when she placed her in a car seat on the hotel floor but did not immediately attend to the child. She reported that the night prior to the baby's death, the child had "matter" in the corner of her eye, that she had called to schedule a medical appointment and planned to take the child to the doctor in the morning. The child died of acute meningitis and the Coroner moded the death a homicide due to mother's failure to provide medical care for a severely ill infant. The child's four surviving siblings were placed into protective custody by DCFS; two siblings were placed with a relative caregiver and two went into unrelated foster care.

In the second case where DCFS had contact with the family less than six months before the child's death, an allegation of physical abuse of the deceased child's 2-year old sibling was investigated.

FIGURE 7



Note: Data from 1993 are missing month of occurence for three cases.

The referral alleged that the mother's boyfriend (who did not reside with mother and her children) regularly hit the 2-year old with a belt. The Children's Social Worker (CSW) investigated the allegation and interviewed mother and mother's boyfriend who denied the physical abuse allegation. The 2-year old did not provide a statement since he was pre-verbal. According to the CSW, there were no marks or bruises on this child or his 8-month old sister at the time of the investigation. However, the CSW requested that the mother take the 2-year old to the doctor for medical treatment as he had a fungus on his head that caused several bald spots. The mother complied with the CSW's recommendation and sought medical attention for the child. The investigating worker found no evidence of abuse and therefore closed the referral as unfounded. Twelve days after the investigation was closed, the 2-year old's 8-month old sister arrived at an area hospital with massive head trauma. Hospital staff reported that she had marks and bruises on her face and body and arrived at the hospital in full cardiac arrest. She was pronounced dead two days after being admitted. Police officers immediately questioned the mother, her boyfriend, and the boyfriend's adult brother about the injuries to the child. The mother and her boyfriend were subsequently charged with inflicting corporal injury on a child, and the deceased's 2-year old brother was immediately placed into protective custody where he remains under DCFS/Dependency Court supervision.

One child homicide occurred between six and twelve months of DCFS' most recent referral/case closure. This family had two prior referrals investigated by DCFS with a total of five allegations. The first referral alleged physical abuse and general neglect against the mother who was a single parent. The general neglect allegation was generated because mother reportedly failed to obtain adequate medical care for her child. The investigating worker deemed the general neglect allegation inconclusive. However, the physical abuse allegation was substantiated. The second referral was initiated on the day of the child's mother's death; the mother was killed in a drive-by shooting. The referral alleged that the child had no caretaker as the mother was now deceased and the father's whereabouts were unknown. The child's maternal aunt, however, indicated she wanted to care for her niece and agreed to seek long-term, legal custody. The investigating worker referred the maternal aunt to probate court where she could obtain legal guardianship. The referral was closed as there was a relative caretaker in place and a plan for the child's continuing care. Eight and a half months after the second referral was closed, hospital staff reported that the child, a 4 ½-year old girl, arrived at the Emergency Room with blunt force trauma and signs that she had experienced a severe beating. Police officers interviewed everyone living with the child, determined that the maternal aunt was responsible for the child's death, and arrested her.

In addition to these three cases of child homicide that occurred within 12 months of DCFS case/referral closure, two child homicides occurred within one to two years of closure and two child homicides occurred more than two years after case/referral closure. It should be noted that in one case with a referral more than two years prior to the child death, there was no actual contact with the family by DCFS. In this case, a referral was made to DCFS for sexual abuse of the child's mother when she was a minor. The alleged perpetrator of sexual abuse was not a caretaker or relative and as such did not meet the criteria for DCFS investigation. The allegation was cross-reported to law enforcement.

OPEN CASES

For the 15 families (representing a total of 49 referrals) previously known to DCFS, the Department had proceeded with Dependency Court action on five cases and these five cases (14% of child homicides) were open to DCFS at the time of the child's death. Three of these five cases received detailed review by the Team. There were no children in the care of their parents in an open DCFS case/referral at the time of the child homicide in

2001. By contrast, in 2000 five referrals cases were open to DCFS in which children who were living with their parents were the victims of homicide by parents/caregivers/family members. In 1999, two such referrals/cases were open to DCFS.

All five of the children in open cases at the time of death had been placed in out-of-home care and were allegedly killed by their caregivers. Three of these children were placed with relatives and two were placed in the homes of unrelated foster parents. The first case of a child residing with a relative involved an 8-year old boy placed with his maternal grandparents due to substantiated physical abuse allegations. Approximately a year and half after placement, this child and his maternal aunt were shot and killed by the boy's grandfather who complained that he was tired of caring for them. The grandfather subsequently turned the gun on himself but survived his wounds and was charged with the deaths of his daughter and grandson. The second child killed by a relative caregiver was a two-year old boy who had been placed with his grandmother shortly after birth when he tested positive for drugs. He died of multiple traumatic injuries allegedly inflicted by his grandmother and was identified by the Coroner as a "battered child." The third child in relative care involved an 11-month old boy who resided in his grandmother's home since birth due to drug exposure. This child, too, died as a "battered child" and was noted by the Coroner to have suffered from starvation and neglect.

The first of two children who died at the hands of unrelated foster parents was a five-month old boy who died of closed head trauma (a fractured skull) and identified by the Coroner as a "battered child." This infant had been placed in three foster homes in his short life due to *in utero* substance exposure and resided in his last foster home for two months. The Coroner stated that the injuries that resulted in his death were of recent origin and the current foster mother was identified as the perpetrator.

In the second case of a child who died in unrelated foster care, a 2 ½-year old girl died of shaken impact syndrome. The child's five older siblings had all been placed in out-of-home care due to their mother's substance abuse and when this child tested positive for drugs at birth, she, too, was removed from her mother's care. She was initially placed with a woman who had been identified as a relative and wished to adopt her. However, the child was replaced out of the home when it was determined the woman was not a "close enough" relative and would need to be licensed or approved to adopt to provide for her care. Tragically, while the woman's adoption home study was being conducted and shortly before the child was set to return to her care, the toddler died of acute, traumatic brain injuries allegedly inflicted by her foster father. Both foster mother and foster father were arrested in this child's death.

POST-DEATH SERVICES

The five cases open to DCFS at the time of the child homicide by parent/caretaker/family member were referred immediately following the death or fatal injury. Four of the five cases remained open after the child homicide in order to provide services for the surviving siblings. The fifth case was closed as the child had no siblings.

Five of the seven cases that were previously known but closed by DCFS were also immediately referred for investigation following the death or fatal injury. In the two other cases, a referral was not investigated by DCFS since it was known at the time of the child's death that there were no siblings in the home. Two of the referrals investigated by DCFS resulted in the removal of the surviving siblings from parental custody with Dependency Court supervision. DCFS workers assessed the remaining three referrals; two were closed because there were no surviving siblings and in one there was no risk to the siblings because they did not live in the home where the child homicide occurred.

In addition, fourteen families who were unknown to DCFS prior to the child death were referred for services immediately following the child death or fatal injury. The allegations for these 14 families are displayed in Table 6. It should be noted that more than one allegation per referral was made in several instances. The majority of referrals were made for severe neglect (n=12). Referrals were also made for physical abuse (n=11), substantial risk (n=9), caretaker absence/incapacity (n=3), and general neglect (n=1). DCFS closed five of the 14 cases/referrals shortly after they were opened for investigation, as there were no surviving siblings in the home. In addition, three families could not be located by DCFS during the course of the investigation and the investigations were closed without contact with the families. Finally, in six cases, petitions were filed in Dependency Court for siblings of the deceased child. These silblings were removed from the home and placed into out-of-home care.

Nine families who had no prior DCFS contact had no DCFS referral/case opened after the child death. At the time of the child death, it was reported to DCFS that five of the nine families had no siblings in the home. In the remaining four cases, there was no way to locate the family because the cases involved abandoned newborns who could not be identified. It was not possible to determine who their families were, and as a result investigations could not be initiated.

Figure 9 summarizes the child protective services involvement in the 2001 child homicides by parents/caretakers/family members.

Additional Information

DCFS provides information regarding demographics of families known to them through the Child Welfare Services/Case Management System (CWS/CMS). These data include:

- The mother's age was known in 83% (n=29) of the cases (see Table 7). In 2001, the average age of the mothers was 25.41 years; 34% 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 46% (n=16) of the cases. The average age of the fathers was 29.25 years.

- The deceased child was known to have had siblings in 51% (n=18) of the families. There were thirteen families known not to have any siblings. In four of the child homicides, it is unknown whether or not the deceased child had siblings. The percentage of families in which there were known to be siblings has ranged from a low of 38% in 1991 to 1996's high of 72%.

- 20% (n=7) of the families had a known history of domestic violence.

- 31% (n=11) of the families had a known history of substance abuse.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT

Information regarding 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 (DA), Los Angeles Police Department (LAPD) and Los Angeles County Sheriff's Department (LASD). Additional law enforcement agencies participate in Team reviews of cases they investigated. The number of cases for which each law enforcement agency was responsible is shown in Table 8.

LAPD had investigative responsibility for 57% (n=20) of the 2001 child homicides by parents/caretakers/family members, a 54% increase over the 13 cases investigated in 2000. LASD

investigated 26% (n=9) of the child homicides by parents/caretakers/family members, a 31% decrease from the 13 cases they investigated in 2000. 17% (n=6) of the child homicides committed in 2001 were handled by jurisdictions outside LAPD and LASD. The five additional law enforcement agencies responsible for these six investigations in 2001 are identified in Table 8.

PLACE OF DEATH DATA

Place of death data were provided by the Coroner for 2001 homicides. Twenty-one of the victims were involved with a total of 15 different medical facilities at the time of death. Seven of the children who were not declared dead in medical facilities died in their own residences. In addition, three newborns were found in dumpsters, two were found in alleys, and one died in her mother's car. Finally, one victim died in a hotel room.

FIGURE 8

1989-2001 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS
CHILD PROTECTIVE SERVICES INVOLVEMENT

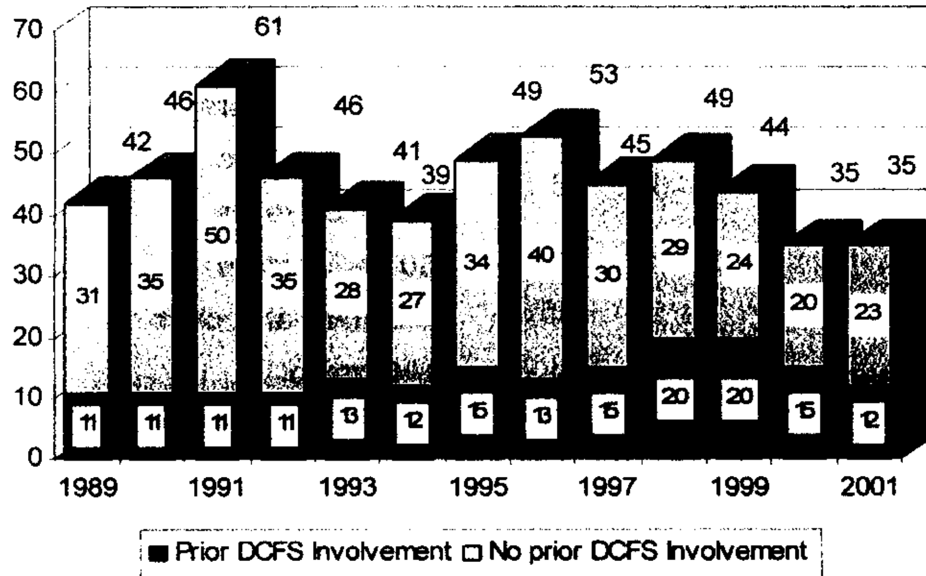


TABLE 4

2001 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS REASONS FOR PRIOR CHILD PROTECTIVE SERVICES INVOLVEMENT

Reason	n	%
General neglect	21	38
Physical abuse	11	20
Severe neglect	3	5
Caretaker Absense/incapacity	10	18
Sexual Abuse	8	14
Emotional Abuse	3	5

TABLE 5

1990-2001 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS LENGTH OF TIME BETWEEN PRIOR DCFS CASE REFERRAL CLOSURE AND DATE OF DEATHS

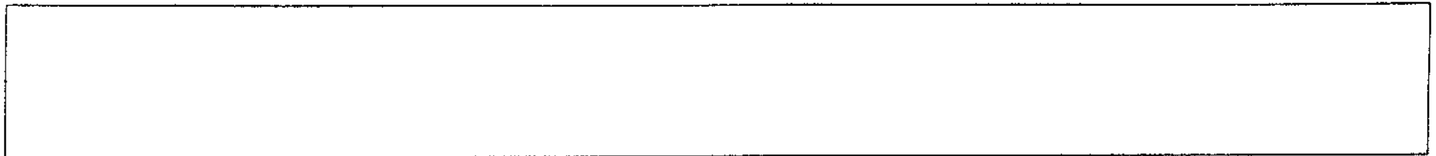
Time Frame	n	%
1 to 6 months	2	28.5
6 to 12 months	1	14.5
1 to 2 years	2	28.5
2 years or more	2	28.5

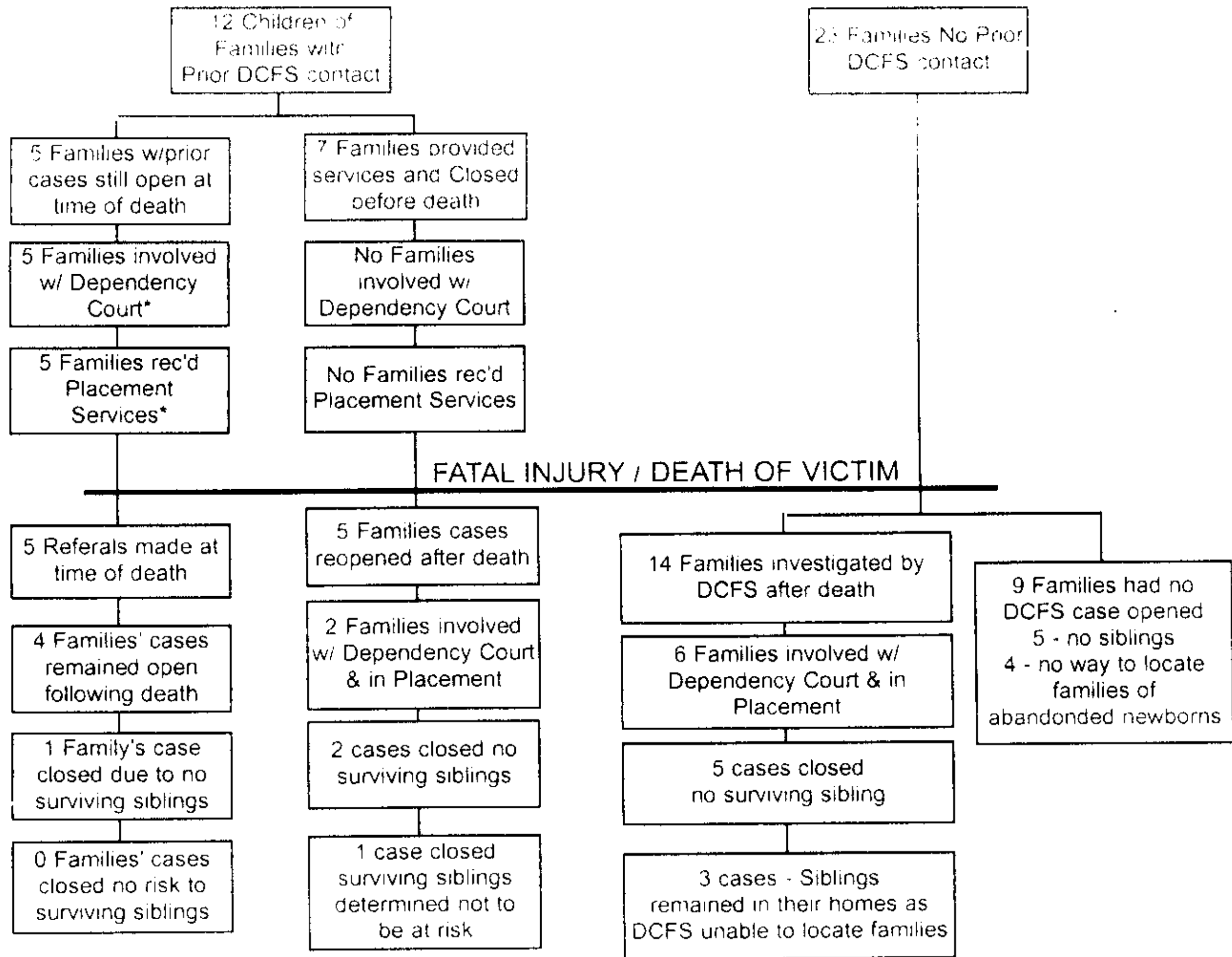
TABLE 6
2001 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS
REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING THE DEATH

Reason	n	%
Physical abuse	11	31
General neglect	1	3
Severe neglect	12	33
Substantial Risk	9	25
Caretaker absence/incapacity	3	8

TABLE 7
2001 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS/FAMILY MEMBERS
AGES OF MOTHERS

Age	n	%
Under 20 years	6	17
20 to 24 years	6	17
25 to 29 years	10	29
30 to 34 years	4	11
35 years and over	3	9
Unknown	6	17




12 Children of Families with Prior DCFS contact
23 Families No Prior DCFS contact
5 Families w/prior cases still open at time of death
7 Families provided services and Closed before death
5 Families involved w/ Dependency Court*
No Families involved w/ Dependency Court
5 Families rec'd Placement Services*
No Families rec'd Placement Services
FATAL INJURY / DEATH OF VICTIM
5 Referals made at time of death
5 Families cases reopened after death
14 Families investigated by DCFS after death
9 Families had no DCFS case opened
5 - no siblings
4 - no way to locate families of abandonded newborns
4 Families' cases remained open following death
2 Families involved w/ Dependency Court & in Placement
6 Families involved w/ Dependency Court & in Placement
1 Family's case closed due to no surviving siblings
2 cases closed no surviving siblings
5 cases closed no surviving sibling
0 Families' cases closed no risk to surviving siblings
1 case closed surviving siblings determined not to be at risk
3 cases - Siblings remained in their homes as DCFS unable to locate families

CHILD DEATH REVIEW TEAM REPORT FOR 2002

ACCIDENTAL CHILD DEATHS

ACCIDENTAL CHILD DEATHS

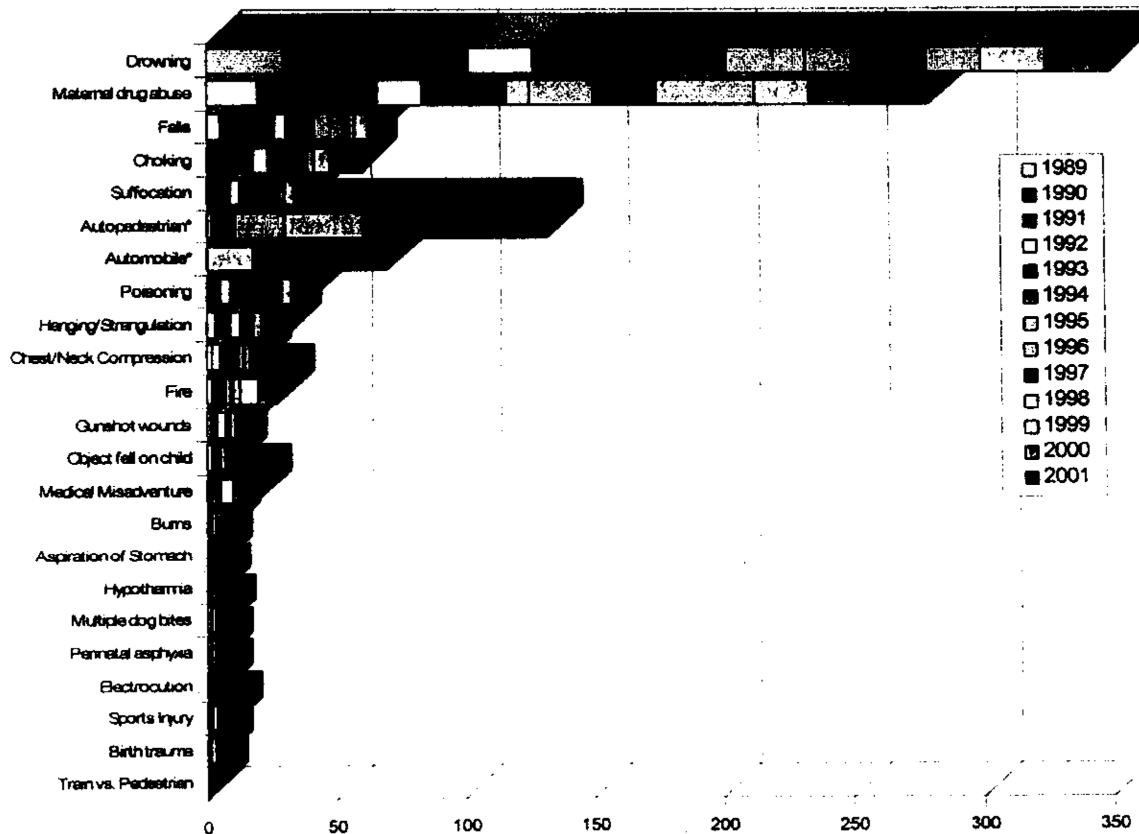
ACCIDENTAL CHILD DEATHS IN LOS ANGELES COUNTY

One of the Team's primary missions is to identify strategies to prevent child deaths. Accidental deaths are of interest to the Team as the Team looks at child safety issues and supervision by care providers at the time of the accident. Accidental deaths have been determined by investigating agencies, law enforcement and the Coroner to be inadvertent and unintended. Many, if not all, of these deaths are preventable.

One hundred thirty-seven accidental child deaths were reported to the Team by the Coroner for 2001. This is the same number of accidental child deaths reported for 2000 and a slight (2%) increase over the 134 accidental child deaths reported for 1999. It should be noted that the protocol was expanded in 2000 to include accidental deaths up through age 14 rather than through age 12 as in 1999 (with the exception of drowning deaths, which already included through age 17). Inclusion of accidental deaths for children ages 13 and 14 accounts for 10 of the 137 accidental deaths in 2001. If 13 and 14-year olds other than drowning deaths were excluded as they were in 1999, 127 accidental deaths would

FIGURE 13

1989-2001 CAUSES OF ICAN ACCIDENTAL CHILD DEATHS



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

have been reported for 2001, a decrease of 5% from reported 1999 accidental deaths. Over the past twelve-year period (1989 to 2001), the number of accidental deaths reported to the Team has ranged from a low of 59 in 1995 to a high of 137 in 2000 and 2001.

CAUSE OF DEATH

The causes of accidental deaths between 1989 and 2001 are displayed in Figure 13 and Table 13. As in 1999 and 2000, the leading cause of accidental death in 2001 was autopedestrian mishaps. Forty-one children died as a result of autopedestrian deaths, including three children on bicycles and two children riding on skateboards. Prior to 1995, accidental deaths due to automobiles v. pedestrians were not reviewed by the Child Death Review Team; however, since that time, the number of autopedestrian deaths has steadily increased until this year when there was a considerable increase of 37% from thirty deaths in 2000 to forty-one in 2001. In 1995, two autopedestrian deaths were reported to the Team; in 1996, one death; in 1997, eight deaths; in 1998, 19 deaths; and in 1999, 31 deaths. It is possible that the large increase in the number of autopedestrian deaths between 1995 and 1999 does not represent an actual increase in the incidence of these deaths, but instead reflects changes in the Team's data collection processes which have provided greater identification of these deaths by the Team. A more affirmative effort on the part of the Team to include autopedestrian deaths began in 1998 and is reflected in the increased numbers of such accidental deaths.

The second/third leading causes of accidental child death in 2001 were automobile accidents and drowning. There were 28 automobile accident fatalities (including automobile v. automobile and solo automobile accidents) for children age 0 through 14. The Team first began looking at automobile deaths in 1999; in that year, there were 18 such deaths. As previously noted, accidental deaths of children age 13 and 14 were included for the first time in last year's report addressing 2000 data (with the exception of accidental drowning deaths which continued to be reviewed through age 17). Thirteen and 14-year olds represent two of the automobile accident deaths in 2001 and contribute to the increase in the number of automobile deaths reviewed by the Team. Without their inclusion, there were 26 automobile accident deaths for children age 0 to 12, a number more consistent with the 19 automobile accident deaths reported for 2000.

Drowning also represented 28 accidental deaths in 2001, a 22% increase over 2000 (n=23). Twenty-five of the drowning victims drowned in residential pools and one each drowned in a bathtub, lake and ocean. The lowest number of child drowning deaths occurred 1996 (n=18), followed by 21 in 1998 and 23 in 2000. The highest number of drowning deaths occurred in 1990 and 1993 (n=40 each).

Deaths associated with maternal substance abuse represented the fourth leading cause of accidental death in 2001. Such deaths are primarily reflected in fetal deaths and very young, prematurely born infants with prenatal exposure. In 2001, there were 24 accidental deaths associated with maternal substance abuse, a number which remains fairly constant with the 22 such deaths reported in 2000. The 38 deaths associated with maternal substance abuse in 1998 reflect the highest number of these deaths since ICAN began collecting these data. The second highest number occurred in 1996 (n=25) and the lowest (n=9) occurred in 1995.

As in prior years, other causes of accidental deaths included choking, hanging, asphyxiation/suffocation, fire, ingestion of drugs or other poisons, sports injuries, falls, and medical procedure errors.

TABLE 13

CAUSES OF ACCIDENTAL DEATHS 1989-2001

	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	Total
Drowning	30	40	32	25	40	35	31	18	28	21	25	23	28	376
Maternal drug abuse	20	24	23	17	23	10	9	25	24	38	21	22	24	280
Falls	5	11	10	5	4	7	6	5	2	3	5	1	1	65
Choking	1	7	10	6	7	2		1	5	3	6	10	2	60
Suffocation	1	3	5	4	8	4	1	2		2	4	1	3	38
Autopedestrian**							2	1	8	19	31	30	41	132
Automobile***											18	24	28	70
Poisoning	1	3	1	4	7	4	1	1	6	1	4	4	1	38
Hanging/Strangulation	3	1	5	4	5			3				6	3	30
Chest/Neck Compression		2			3	3	3	1	2	1	2		1	18
Fire	2				3	2	2		1	3	7	4	3	27
Gunshot wounds	1	1	2	3		1	1	2	1					12
Object fell on child							2		3	2	1	1		9
Medical Misadventure						2	1	1		1	5	6	2	18
Burns			2	1	1						1			5
Aspiration of Stomach		1			2									3
Hypothermia		1		1										2
Multiple dog bites							1		1		1	1		4
Perinatal asphyxia							1		1		1			3
Electrocution									2			1		3
Sports Injury									2		2	2	1	7
Birth trauma					1						2			3
Train vs. Pedestrian									1					1
TOTAL	**66**	**92**	**90**	**73**	**104**	**70**	**59**	**61**	**86**	**95**	**134**	**137**	**137**	**1204**

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

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

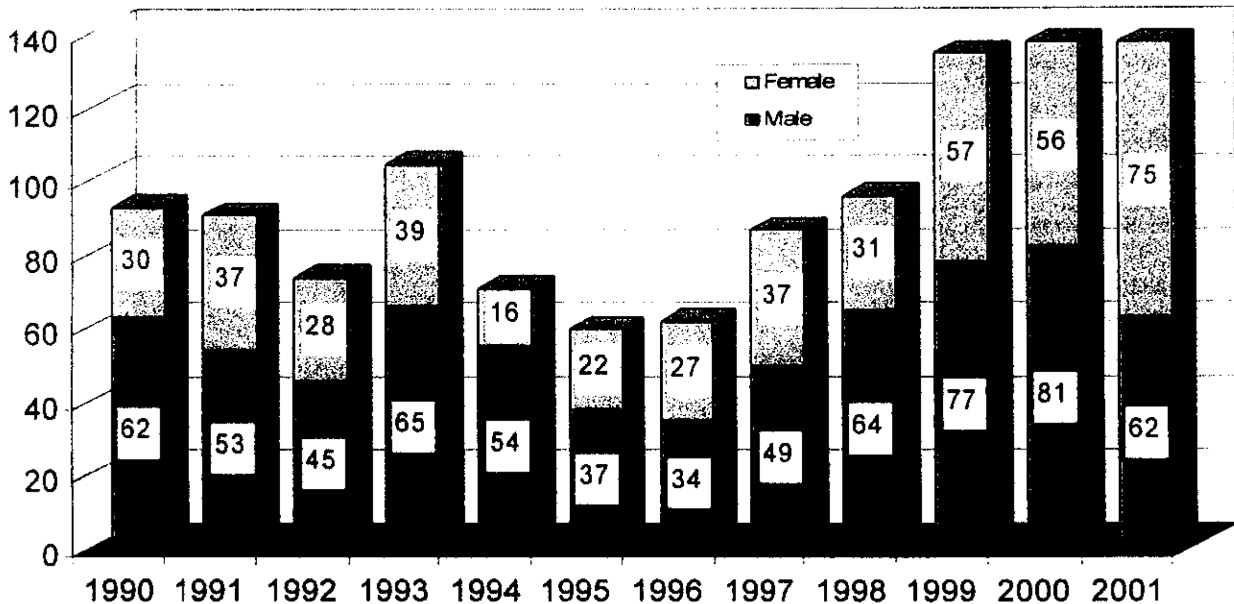
GENDER

Figure 14 displays the gender breakdown of the accident victims for the past twelve years. In 2001, 55% (n=75) of the accidental death victims were male and 45% (n=62) were female. Over the past twelve years, the percentage of male victims has ranged from this year's low of 55% to a high of 77.1% in 1994. Males have outnumbered females since data began to be collected in 1989.

AGE

Figure 15 displays the ages of the 2001 accidental death victims. As in past years, the highest number of accidental child deaths have occurred in children under one year of age. Twenty-six percent (n=36) were under the age of one year; of these, 31 or 23% of the accidental deaths, were under the age of six months. Twenty-four of the 31 accidental deaths that occurred in those under age six months involved complications of maternal substance abuse. These deaths included 18 fetal deaths, two drug-exposed newborns who died on the day they were born, two who died the day after their birth and

FIGURE 14



two infants who died at two months of age due to complications associated with in utero exposure. The number of accidental deaths decreased for children between age one and four (age 1, n=17; age 2, n=9; age 3, n=6; age 4, n=9) and increased again for children age five to nine (n=31) and age ten years and over (n=29).

The 41 children who died as a result of being hit by an automobile in 2001 ranged in age from zero to 14 years of age and averaged age 6 ½; sixteen children were age three or younger. There were eight autopedestrian deaths for youth age 12 to 14 in 2001, including a 12 year-old boy hit by a car while riding his bike.

The 28 children who died in automobile accidents (automobile v. automobile and solo automobile accidents) in 2001 ranged in age from 0 (three fetal deaths that occurred when mothers were injured or killed in automobile accidents) to 14. The average age of the child automobile accident victim was 5 ½ years.

Drowning victims ranged from eleven months to seventeen years of age, and the average age of drowning victims was six years old. The average age of drowning victims increased slightly in 1997 when the Team protocol was expanded to raise the age of drowning deaths through age 17. Fifty percent of the 28 drowning victims in 2000 were two years of age or younger. While in 2000 the oldest drowning victim was age ten, in 2001 there were seven drowning victims ages 10 through 17. It should be noted, however, that for two of these teenagers, a 13-year old boy and 17-year old boy, the drowning injuries that resulted in their deaths in 2001 actually occurred years earlier when they were each three years of age.

ETHNICITY

Table 14 displays the causes of accidental child deaths in 2001 by ethnicity. Hispanic children represented 50% (n=68) of all accidental child deaths in 2001. They suffered in great disproportion the number of autopedestrian and automobile deaths (n=24, n=20) as well as the most drowning (n=10), hanging/strangulation (n=2) and choking (n=1) deaths. They also suffered the only sports injury death.

FIGURE 15

[illegible] BY AGE

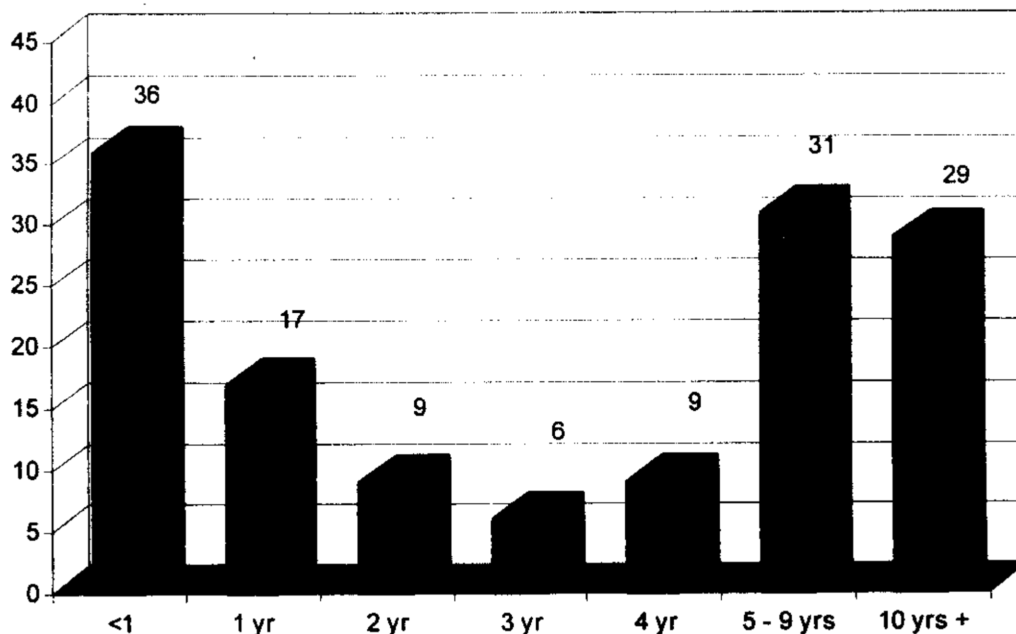


TABLE 14

ETHNICITY OF [illegible] ACCIDENTAL DEATHS 2001

	HISPANIC	AFR-AM	WHITE	ASIAN	UNKNOWN
Maternal drug abuse	7	9	7	1	0
Drowning	10	6	10	2	0
Autopedestrian	24	5	7	5	0
Automobile	20	4	3	1	0
Choking	1	0	1	0	0
Falls	0	0	1	0	0
Fire	1	1	0	1	0
Suffocation	1	0	2	0	0
Chest/Neck compression	0	0	0	0	0
Object fell on child	0	0	0	0	0
Poisoning	0	0	0	1	0
Medical Misadventure	1	1	0	0	0
Hanging/Strangulation	2	1	0	0	0
Other	1	0	0	0	0
TOTAL	68	27	31	11	0

African American children represented 20% (n=27) of the 2001 accidental child deaths. As in most previous years, they suffered the most deaths related to maternal substance abuse; in 2001, they suffered 37.5% (n=9) of all accidental maternal substance abuse deaths, which is 33% of the 27 total accidental deaths suffered by African American children. African American children also suffered 21% (n=6) of the drowning deaths and 12% (n=5) of the autopedestrian deaths.

White children represented 23% (n=31) of the accidental child deaths in 2001. Twenty-nine percent (n=7) of the accidental deaths related to maternal substance abuse were suffered by White children as were 36% (n=10) of the deaths due to drowning.

There were eleven accidental deaths of Asian children in 2001, five due to autopedestrian accidents, two due to drowning and one each due to maternal substance abuse, an automobile accident, a residential fire and an overdose of the street drug Ecstasy.

TABLE 15
2001 ICAN ACCIDENTAL CHILD DEATHS MONTHLY PATTERN

ALL ACCIDENTS VS. DROWNINGS

	All Accidents	Drowning
January	18	2
February	7	0
March	7	2
April	8	1
May	11	2
June	15	6
July	10	5
August	18	7
September	11	2
October	10	1
November	9	0
December	13	0

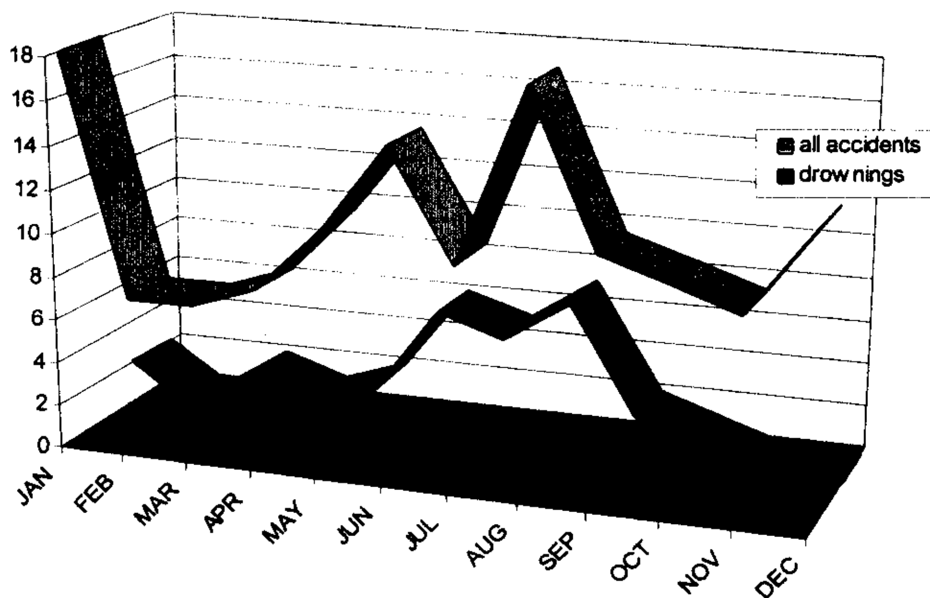
TEMPORAL PATTERN

Table 15 and Figure 16 display the incidence of accidental death for each month in 2001. The months with the greatest number of accidental child deaths were January and August (n=18 each), followed closely by June with 15 deaths. The fewest accidental child deaths occurred in February and March (n=7 each).

As in past years, the monthly pattern of drowning deaths was compared to all accidental deaths (see Table 15). As might be expected, most drowning deaths occurred in the spring and summer months. 23 of the 28 drowning deaths occurred between April and September. Eighteen, or 64%, of the 28 drowning deaths, occurred during the three-month period of June through August. As deaths due to drowning are one of the most frequent causes of accidental death and the majority of drowning deaths occur in the spring and summer, they impact the temporal pattern for all accidental child deaths.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

Figure 17 summarizes the child protection services provided to the families of the accidental child death victims. Twenty-two percent (n=30) of the families of accidental child death victims had histories of receiving child protective services prior to the child's death and 36% (n=11) of these cases involved a death that the Coroner indicates was associated with maternal substance abuse. This percentage is low in comparison to previous years when 41% to 85% of the accidental child death victims whose families had prior child protective services died as a result of maternal substance abuse and when considering that deaths related to maternal substance abuse were the fourth leading cause of accidental death in 2001. Of the other cases with prior protective services involvement, 41% (n=9) involved autopedestrian deaths, 22.7% (n=5) involved automobile accidents, and 18% (n=4) involved children who drowned. In addition, one



child died in a residential fire.

Table 16 provides the reasons the 30 accidental child death cases were known to the Department of Children and Family Services (DCFS) prior to the child's death. One hundred and thirteen previous referrals were made on these 30 families. It should be noted that more than one type of allegation was made simultaneously (e.g., emotional abuse and caretaker absence/incapacity) in several previous referrals. Thirty percent (n=9) of the families had one previous DCFS referral and 23% (n=7) had two previous referrals. Four families had three referrals, two families had four referrals and one family had five referrals. In addition, three families had six referrals, one family had ten referrals, two families had twelve referrals and one family had thirteen prior referrals.

Of the 30 cases with prior protective services, 17 were closed before the child death; two of these were opened on siblings and closed before the birth of the child that died. Several cases had been closed fairly recently at the time of the child's death. In one case, allegations of general neglect were assessed as a 6 ½ year old boy was reportedly coming to school dirty and unkempt and complaining that he was not being fed at home. The referral was closed as inconclusive. Six weeks later, this child tragically died when he ran out into the street and was hit by an ice cream truck. In another case, a referral was made with allegations of general neglect as an infant was reportedly not receiving necessary medical care. The referral was closed as unfounded and approximately two months later, this infant's older brother, age four, died when he fell out of the bed of a pickup truck and was struck by the vehicle. A third case involved a family with a long history of reported substance abuse and six referrals to DCFS for general neglect. The six children in this family had been taken into protective custody and placed into foster care under Juvenile Court supervision between 1992 and 1993 when five separate referrals for neglect were made. The children were eventually returned to their mother's care in 1999. In early 2001, a referral was made alleging that the home

was in poor condition and the children were neglected. The referral was closed as inconclusive. Five months later one of the children, an eight-year old boy, drowned in a friend's pool while in his grandmother's care.

Forty-three percent (n=13 of 30) of the accidental death cases that were known to DCFS were open at the time of the child's death. Ten of the deaths in these open cases were the result of maternal substance abuse; in all ten cases, the deceased child's siblings no longer resided in their mother's care. In nine of these cases, siblings had already been removed from the parent(s) and placed in out-of-home care by DCFS at the time of the death. The tenth cases involved siblings who resided with their father at the time of the death under a Voluntary Family Maintenance agreement, a period of time in which the family voluntarily agreed to receive services while the children remained in the home.

In the other three cases, children resided in their parents' care at the time of their deaths. The first such case involved a family that had been reported the Child Protection Hotline on six occasions for allegations of neglect and caretaker absence as the mother reportedly had a substance abuse problem which affected her ability to care for her three young children. Allegations of neglect were substantiated and the family agreed to participate in a Voluntary Family Maintenance program. Tragically, during this period of supervision, the family's five-year old son died when he was struck by a car while crossing the street. The family continued to receive voluntary services, including grief counseling, for the year following his death.

The second and third deaths involved open referrals. The first referral involved a nine-year old boy who died in a residential fire. This child's family had been reported to the Child Protection Hotline on twelve occasions for various allegations, including severe neglect, physical abuse and caretaker absence/incapacity. The twelfth referral, made by a mandated reporter, alleged that the children were running around the neighborhood without supervision. This allegation was being assessed when the 9-year old child succumbed in the residential fire. The child's mother was not found to be negligent in the fire and the referral was closed with an inconclusive finding regarding the supervision of her surviving children.

TABLE 16

REASONS FOR PRIOR CHILD PROTECTIVE SERVICES

Reason	n	%
General neglect	48	38
Physical Abuse	24	19
Caretaker absence/incapacity	13	11
Severe Neglect	18	14
Emotional Abuse	7	6
Sexual Abuse	4	3
Substancial Risk	5	4
At-Risk Sibling	6	5

TABLE 17

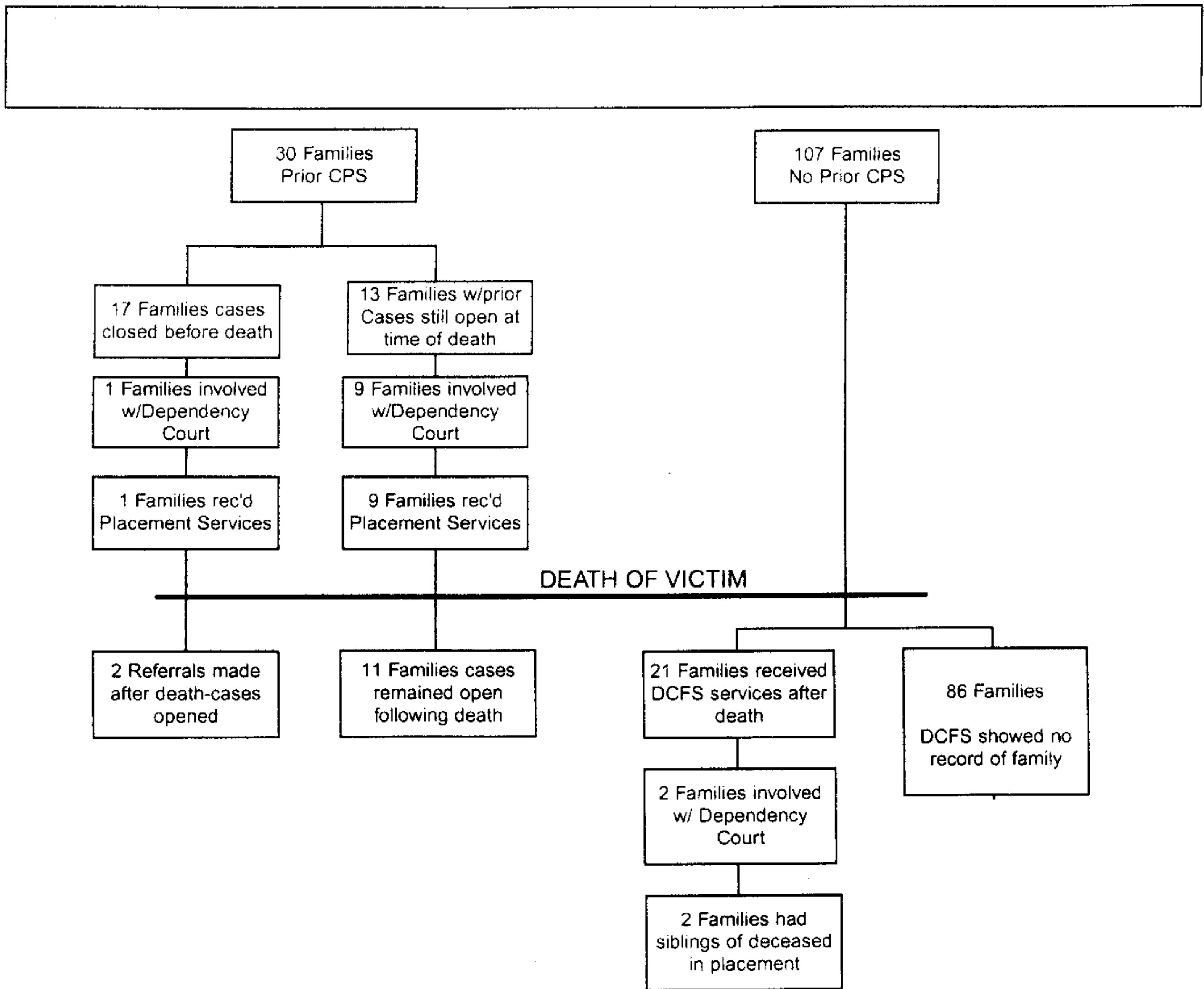
REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING DEATHS

Reason	n	%
Severe Neglect	15	44
General Neglect	3	9
Caretaker absence/incapacity	4	12
Emotional Abuse	2	6
Substancial Risk	10	29

TABLE 18

AGE OF MOTHER

Age	n	%
Less than 25 years	12	24
25 to 29 years	12	24
30 to 39 years	14	28
40 years and older	12	24



The second open referral involved a 3-year old boy who died in an automobile accident. This child's family had been reported to the Child Abuse Hotline on three occasions for emotional abuse, general neglect, severe neglect and caretaker absence/incapacity, and the family had previously received six months of Voluntary Family Maintenance services. The third referral alleged that the children had untreated head lice and that the parents were negligent in seeking medical care. During the assessment of this referral, the 3-year old child died in an automobile accident. The referral was found to be inconclusive and closed.

Of the thirteen referrals/cases that were open to DCFS at the time of the accidental death, eleven remained open after the death. Surviving siblings were already in out-of-home placements in nine of these twelve referrals/cases and required ongoing DCFS services, and in the tenth and eleventh cases the families continued to receive ongoing Voluntary Family Maintenance Services for an additional year. The final two referrals were closed as allegations that were being investigated at the time of the child deaths were found to be inconclusive and surviving siblings were not deemed at risk.

In addition to these thirteen open cases, 23 additional families received DCFS services after their child's death. Two of these cases previously received DCFS services and had been closed but were subsequently reopened at the time of the death. Referrals were also received for 21 families with whom DCFS had no previous contact. The reasons for referrals on the 23 families who received services after the death are displayed in Table 17. It should be noted that several families were simultaneously referred for more than one type of allegation (e.g., severe neglect and substantial risk). Two of the referrals made on these 23 cases resulted in the removal of surviving siblings from their homes and Juvenile Court supervision. The remaining families were provided with grief counseling referrals and their referrals to DCFS were closed.

In addition, the following demographic information is known about the families of 2001 accidental child death victims:

- The mother's age at the time of the death was known in 36% (n=50) of the families. Table 18 provides a breakdown of the mothers' ages.

- The deceased child was known to have siblings in 35% (n=48) of the cases. Three of the families were known to have no other children than the victim. It was unknown if there were siblings in 63% (n=86) of the families.

CRIMINAL JUSTICE SYSTEM INVOLVEMENT IN ACCIDENTAL CHILD DEATHS

Information on criminal justice system activity for 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 31% (n=43) of the accidental deaths, and the Los Angeles Sheriff's Department had responsibility for 22% (n=30) of the cases. Independent law enforcement agencies were responsible for investigating 37% (n=51) of the accidental child deaths. Investigative agencies were unidentified for 13 accidental child death cases. Table 19 displays the 24 different law enforcement agencies known to have responded to the 2001 accidental child deaths.

Agency	Number
Alhambra PD	1
Azuza PD	1
Bell Gardens PD	1
Burbank PD	1
California Highway Patrol	21
El Monte PD	1
El Segundo PD	1
Glendale PD	1
Huntington Park PD	1
Inglewood PD	4
LAFD Arson	1
LAPD	43
LASD	30
Long Beach PD	4
Maricopa County Sheriff	1
Maywood PD	1
Monrovia PD	1
Pasadena PD	1
Pomona PD	3
Redondo Beach PD	1
Torrance PD	1
Ventura County Sheriff	1
West Covina PD	2
Whittier PD	1
Unknown	13

PLACE OF DEATH

Place of death data provided by the Coroner indicate that 24 of the child accident victims died in Los Angeles County Department of Health Services facilities and 95 victims died at one of 35 other medical facilities. Place of death for the remaining victims is listed as a street (2), freeway (2), residence (2), vehicle (2), hotel/motel (1), ocean (1), parking lot (1) and sidewalk (1).

CHILD DEATH REVIEW TEAM REPORT FOR 2002

ADOLESCENT SUCIDES

ADOLESCENT SUICIDES

YOUTH SUICIDES IN LOS ANGELES COUNTY

Twenty-seven suicides of victims 17 years of age or younger occurred in 2001 and were reported to the ICAN Child Death Review Team. This is a slight (17% increase) from 2000 when there were 23 adolescent suicides. The average number of youth suicides referred to the Team since tracking this population began in 1988 is 27 per year.

Since 2001, the Child and Adolescent Suicide Review Team, under the auspices of ICAN and the Los Angeles County Office of Education, has begun to closely examine child and adolescent suicides in Los Angeles County. The Team's efforts are consistent with the goals and objectives of the U.S. Department of Health and Human Services' *National Strategy for Suicide Prevention*. The Team meets regularly to conduct multi-disciplinary case reviews based on information provided by members of law enforcement, the Office of Education, the Los Angeles Unified School District, the Department of Children and Family Services, the Department of Health Services and other interested parties. Reviews assist the Team in gaining a better understanding of child and adolescent suicide and effective prevention practices. The Team's recommendations in this regard are included in the Findings and Recommendations section of this report.

GENDER

Figure 18 displays the gender breakdown of the adolescent suicide victims for the past 14 years. In 2001, 81% (n=22) of the adolescent suicide victims were male. Over the last 14 years, the percentage of male victims has ranged from 68% to 90%. The average annual number of male victims has been 21.23 with a range of 12 (1998) to 37 (1993) deaths per year. 19% (n=5) of the victims of adolescent suicide in 2001 were female, a slight decrease from the 7 female suicides reported in 2000. The average number of female victims over the last 14 years has been 6.15 per year and the number of female victims has ranged from 2 victims in 1995 to 11 victims in 1989.

AGE

Table 20 and Figure 19 display the age breakdown of suicide victims from 1988-2001. The average age of adolescent suicide victims decreased from 16.93 years in 2000 to 15.85 in 2001 and there was a substantial increase in the number of suicides for victims under age 13. In 2000, there were no victims in this age group, while in 2001 there were five victims under age 13, including the suicide of a 9-year old boy. This 9-year old child represents the youngest suicide victim since ICAN began collecting these data. In the oldest age group (ages 16 and 17), there were 21 suicides in 2000 and 19 suicides in 2001.

ETHNICITY

Hispanic suicides represent 44% of the total number of adolescent suicides in 2001; Hispanic suicides decreased slightly from 13 in 2000 to 12 in 2001. 33% (n=9) of adolescent suicides were committed by White youth which represent a slight increase from 2000 (n=7). The number of Asian adolescents who committed suicide decreased as there were 3 victims in 2000 and 1 victim in 2001. The number of African American adolescent suicides increased dramatically from 0 in 2000 to 5 in 2001.

From a multi-year perspective, as illustrated in Figure 20, Hispanic adolescents averaged the greatest number of suicides over the past 14 years ($\bar{x}$=12.21), with White adolescents following ($\bar{x}$=9.36). The percentage of Hispanic adolescent suicides has generally risen as the number of

Hispanic youth in the population has increased with the exception of decreases in 1997 and 1999. The number of White adolescents who committed suicide increased in 1999 after decreases in 1997 and 1998. With the exception of 1995 (n=2) and 1998 (n=3), the number of White adolescent suicides in 2001 (n=9) is consistent with years 1988 to 2000. The number of African American adolescents who have committed suicide over the past 14 years has averaged 3.35 per year, with a range of 0 to 7. The number of Asian adolescents who have committed suicide has averaged 2.14 per year, with a range of 0 in 1998 to 1996's high of 5.

CAUSE OF DEATH

Figure 21 graphically displays the different methods of suicide over the past 13 years. Hanging has been the most frequent cause of suicide among adolescents and represents 52% of the adolescent suicides in 2001. Fourteen hanging suicides were reported, including the death of the youngest victim, a 9-year old boy who hung himself with his shoelaces from a bedroom closet in his foster home. There have been 117 adolescent suicides by hanging in Los Angeles County over the past 14 years.

Firearms were the second most frequent method of suicide in 2001; 26% (n=7) of the adolescents committed suicide by using firearms in 2001. This is the second year since these data have been tracked that firearms were not the leading method. Firearms have been the predominant method of adolescent suicide over the past 14 years; 214 of the 379 adolescent suicides, or 56%, during this period have involved firearms. The percentage of total suicides involving firearms ranged from 1996's low of 40% to a high of 73% in 1992.

In addition to hanging and firearm suicides, three adolescents jumped to their death in 2001. In separate incidents, a 16-year old boy and a 17-year old boy jumped from apartment buildings, and a 17-year old girl jumped from a cliff overlooking the ocean. In addition, a 17-year old boy asphyxiated himself with a plastic bag and, in separate incidents, a 16-year old boy and 17-year old girl committed suicide by overdosing on medication.

TEMPORAL PATTERN

Figure 22 displays the temporal patterns of adolescent suicides from 1989 through 2001. In 2001, there were five adolescent suicides in the month of March, four suicides in February and three suicides each in the months of April, May and November. During the months of February and March, there were 9 suicides; in other words, these two months (17% of the year) accounted for 33% of the suicides in 2001. There were two suicides each in January, September and December; one suicide each in June and October; and no suicides in August of 2001. Between 1988 and 2001, the months in which the greatest number of adolescent suicides have occurred are March and October.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVOLVEMENT

In 2001, the Department of Children and Family Services (DCFS) had prior contact with 26% (n=7) of the families of adolescent suicide victims. During the past 14 years, the percentage of such families with DCFS involvement has ranged from a low of 4% (1 of 23 cases) in 1995 to a high of 40% in 1997 (8 of 20 cases) and 1998 (6 of 15 cases).

Two of the families with whom DCFS had prior contact were open for services at the time of the suicide. In the first case, a referral alleging general neglect (failure to take a child to counseling) was made in September, 2001. The allegation was assessed and found to be inconclusive. After assessment, services to the family ceased and the referral was ready for closure. However, the referral was not closed and technically it remained open two months later, when a 17-year old sibling committed suicide by overdosing on prescription medication. The second family with open services involved a 9-year old boy who committed suicide in his foster home, where he had resided for over four years. Five referrals had been made on the boy's

behalf between 1993 and 1996, alleging sexual abuse (1 referral), physical abuse (2 referrals), and caretaker absence/incapacity (2 referrals). The first four referrals were assessed as unfounded. However, the fifth referral, which alleged caretaker absence/incapacity was substantiated and the boy, then age 5, and his siblings were placed into foster care. The boy had not seen his mother in over 4 years at the time of his death and had a history of behavioral and emotional problems. He hung himself with his shoelaces from a closet rod while his foster brother and a friend watched television in the next room. Although the boy's siblings were already placed in separate foster homes, a referral was made to the Child Protection Hotline at the time of his death and an assessment of the child's foster home was conducted.

In addition, to the open referral and open case, the Department of Children and Family Services had prior contact with five families whose services had been terminated at the time of the suicide. The average length of time between the period when DCFS was involved with the families and the 2001 suicides was 15 months and ranged from 5 months to 2 years. In the first case, a referral was made alleging that an estranged father was emotionally abusing his son. DCFS assessed the allegation as inconclusive and provided the boy's mother with counseling referrals. Five months later, the child's half-brother, age 13, committed suicide by hanging himself with a rope from a backyard tree. No referral was made to the Child Protection Hotline at the time of the suicide. In the second case with prior contact only, two referrals were made alleging that parents were neglecting a child's mental health needs; the child, a teenage girl, had notified school personnel that she wanted to kill herself, and while the school had notified the parents, the girl was not enrolled in any type of counseling. A third referral was made alleging that the mother had physically abused the girl and her younger sister. These referrals were closed as inconclusive nine months before the suicide, after the parents agreed to obtain treatment for the girl. Finally, a fourth referral was made as the girl had disappeared and was not attending school. When her parents were contacted by the school, they allegedly expressed little interest in their daughter's disappearance. Unbeknownst to the school and parents at the time of this referral, the girl, age 17, had already committed suicide by jumping from a cliff and her body remained unidentified for almost two months. Upon identification of the girl's body, a referral was made to DCFS for the girl's surviving sibling and the Department provided the family with services for eight months.

The third case with prior contact only involved an 11-year old boy for whom DCFS had twice assessed allegations of physical abuse by the parents and found them to be unfounded. A year and a half after the last referral was closed, the boy shot himself in the head after an argument with his mother about falling grades. A referral was made to the Hotline at the time of his death, and services were provided to the surviving sibling and parents for seven months. The fourth case with prior contact only involved a 16-year old boy who hung himself with a bedsheet while incarcerated in a youth correctional facility. DCFS had assessed an allegation of caretaker absence/incapacity for the boy two years prior and placed the youth with his grandmother. He subsequently ran away from his grandmother's care, committed a juvenile offense and was incarcerated. DCFS had closed its case on the youth almost two years prior to this death. No call to the Child Protection Hotline was made at the time of the suicide. The final case with prior contact only involved a 17-year old boy who jumped to his death from an apartment building. The boy lived with his father and allegations had been made two years prior that the father's home was filthy. These allegations were assessed and the referral was closed as unfounded. The boy's surviving sibling resided with their mother at the time of the suicide and no referral was made to the Hotline at this time.

In addition to services provided prior to these adolescent suicides, DCFS received calls to the Child Protection Hotline on four cases of suicide. In one case, there were no minor children to assess for risk; in two cases, allegations of neglect were

FIGURE 18

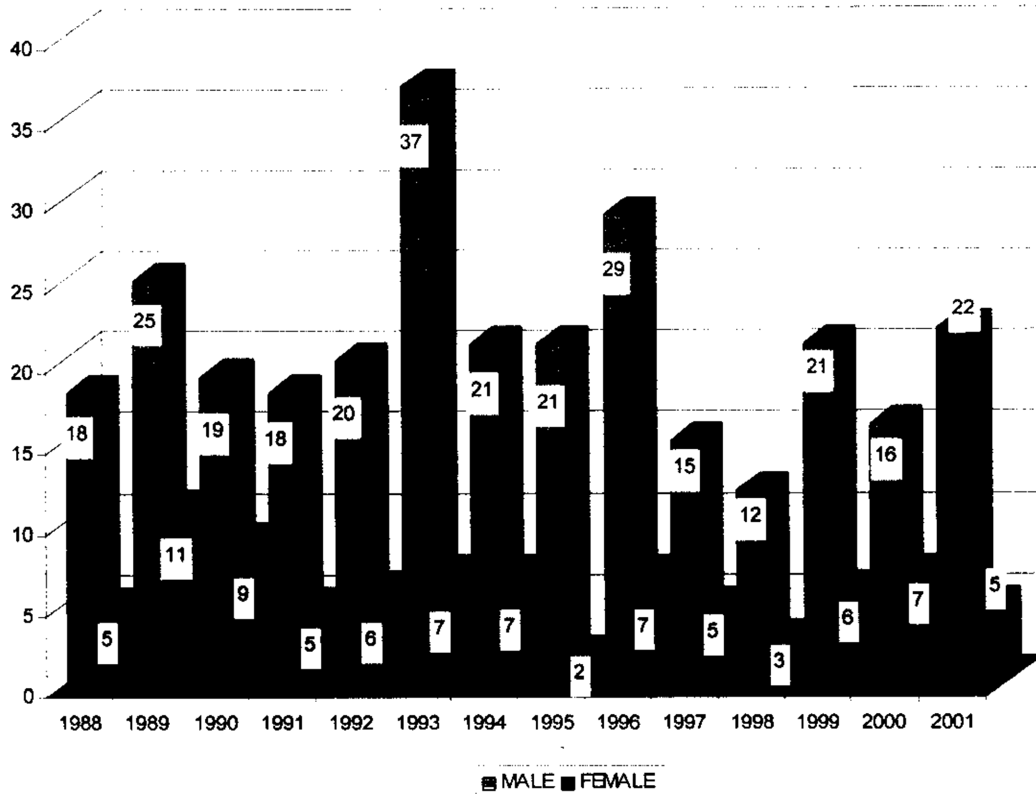


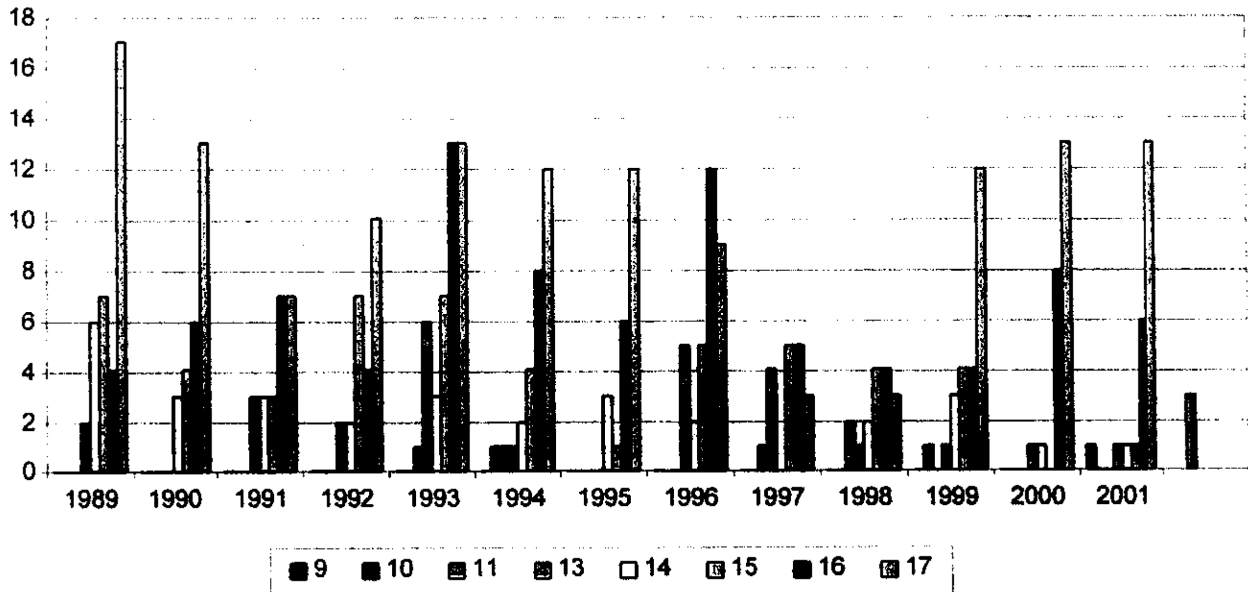
TABLE 20

AREA BREAKDO[illegible] ADOLESCENT SUICIDES 1988-2001

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	TOTAL
9	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
10	0	0	0	0	0	0	1	0	0	0	0	1	0	0	2
11	0	0	0	0	1	1	0	0	1	2	0	0	0	3	8
12	0	0	2	0	0	1	0	1	2	1	1	2	0	1	11
13	3	2	0	3	2	6	1	0	5	4	1	1	1	1	30
14	1	6	3	3	2	3	2	3	2	0	2	3	1	1	32
15	2	7	4	3	7	7	4	1	5	5	4	4	0	1	54
16	8	4	6	7	4	13	8	6	12	5	4	4	8	6	95
17	9	17	13	7	10	13	12	12	9	3	3	12	13	13	146
TOTAL	**23**	**36**	**28**	**23**	**26**	**44**	**28**	**23**	**36**	**20**	**15**	**27**	**23**	**27**	**379**

FIGURE 19

1989-2001 ICAN ADOLESCENT SUICIDES BY AGE



assessed as unfounded; and in one case, allegations of risk to three surviving siblings were substantiated and services were provided to the family for eight months.

The reasons for prior DCFS involvement in the adolescent suicide cases included physical abuse (6 referrals), general neglect (3 referrals) caretaker absence/incapacity (3 referrals), emotional abuse (2 referrals) and sexual abuse (1 referral). Table 21 displays the reasons for prior DCFS services on suicide cases between 1989 and 2001. Although there was only one prior referral for sexual abuse for 2001 cases, in prior years sexual abuse and physical abuse allegations were consistently the leading reasons for previous referrals in cases where children later committed suicide.

It was known that there were sibling survivors in 10 of the suicide cases. For the remaining 17 cases, it is unknown if there were surviving siblings.

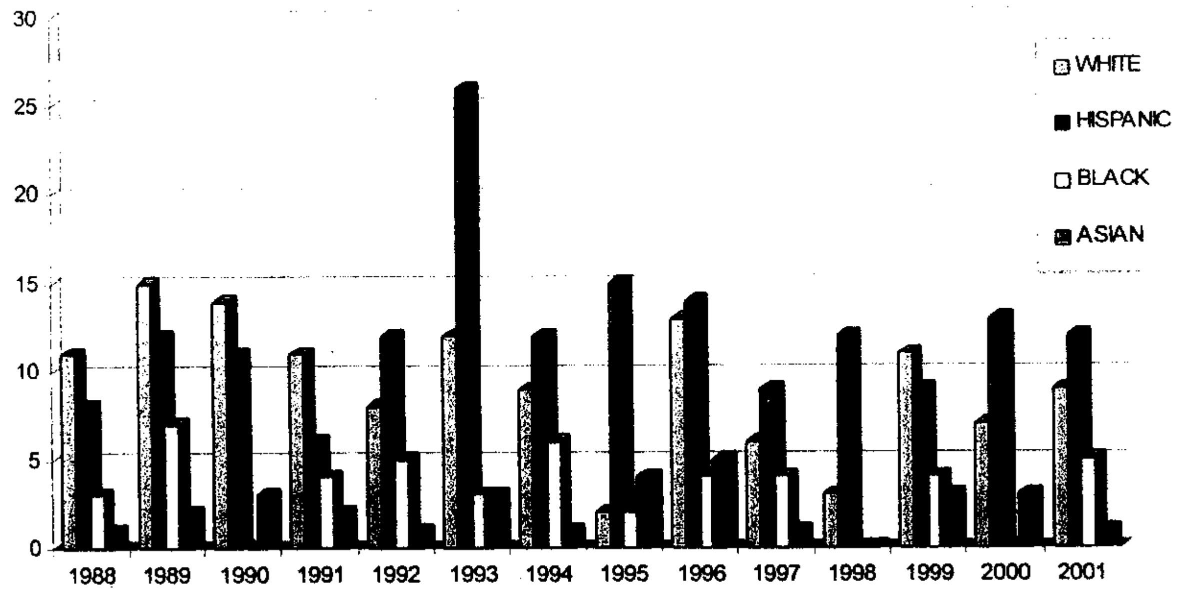
LAW ENFORCEMENT INVOLVEMENT

Seven different law enforcement agencies were involved in the investigations of the 27 adolescent suicides in 2001. The Los Angeles Sheriff's Department was responsible for the investigation of 11 of these suicides, and the Los Angeles Police Department was responsible for the investigation of 10 cases. Five additional law enforcement agencies (Downey, Inglewood, Long Beach, Pomona, and Santa Monica Police Departments) were responsible for the investigation of the remaining six suicides.

Table 22 shows the law enforcement agencies involved in all adolescent suicides reported to the Team for 2001. Division area detail is provided for the Los Angeles Police Department.

FIGURE 20

1988-2001 ICAN [illegible]



PLACE OF DEATH

Place of death data provided by the Coroner indicate that three of the 2001 suicide victims died at Los Angeles County Department of Health Services facilities. In addition, Antelope Valley Hospital, Downey Community Hospital, Downey Regional Medical Center, Daniel Freeman Memorial Hospital, East Los Angeles Doctors' Hospital, Greater El Monte Community Hospital, Henry Mayo Newhall Memorial Hospital, Lakewood Community Hospital, Norwalk Community Hospital, Sherman Oaks Hospital and Santa Monica/UCLA Medical Center were each listed as place of death for one or more suicide victims. Five of the suicide victims died at their place of residence and one each died in an alley, field, sidewalk, beach and high school athletic field.

FIGURE 21
1989-2001 [illegible] SUICIDES BY CAUSE

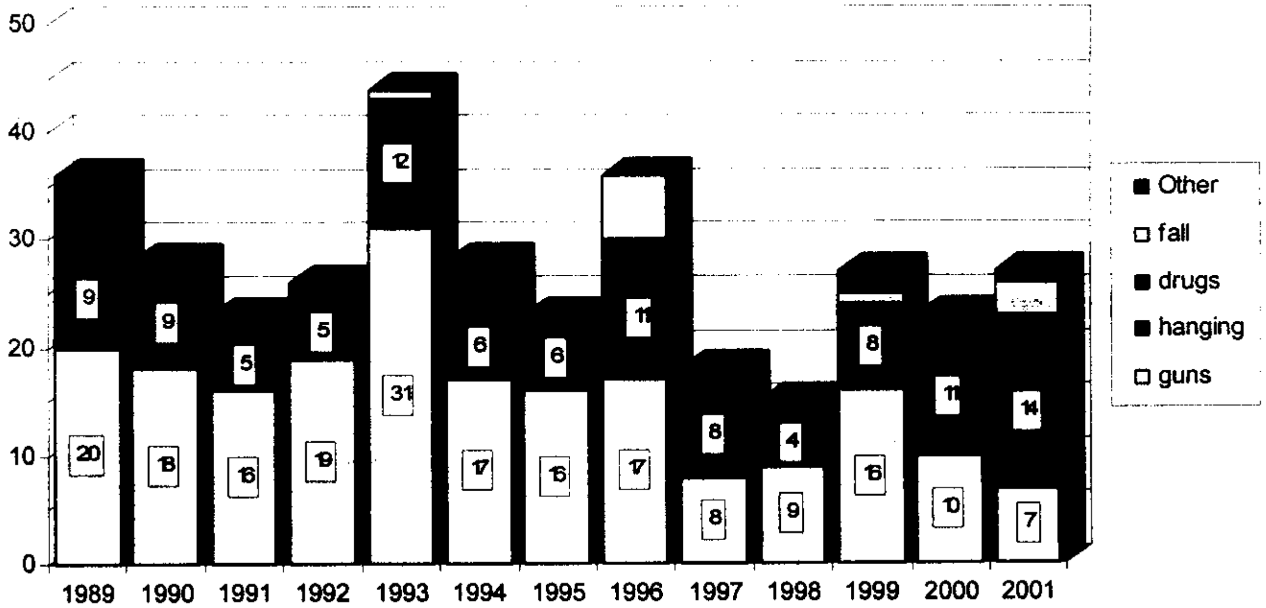


FIGURE 22
1989-2001 ICAN ADOLESCENT SUICIDES BY MONTH

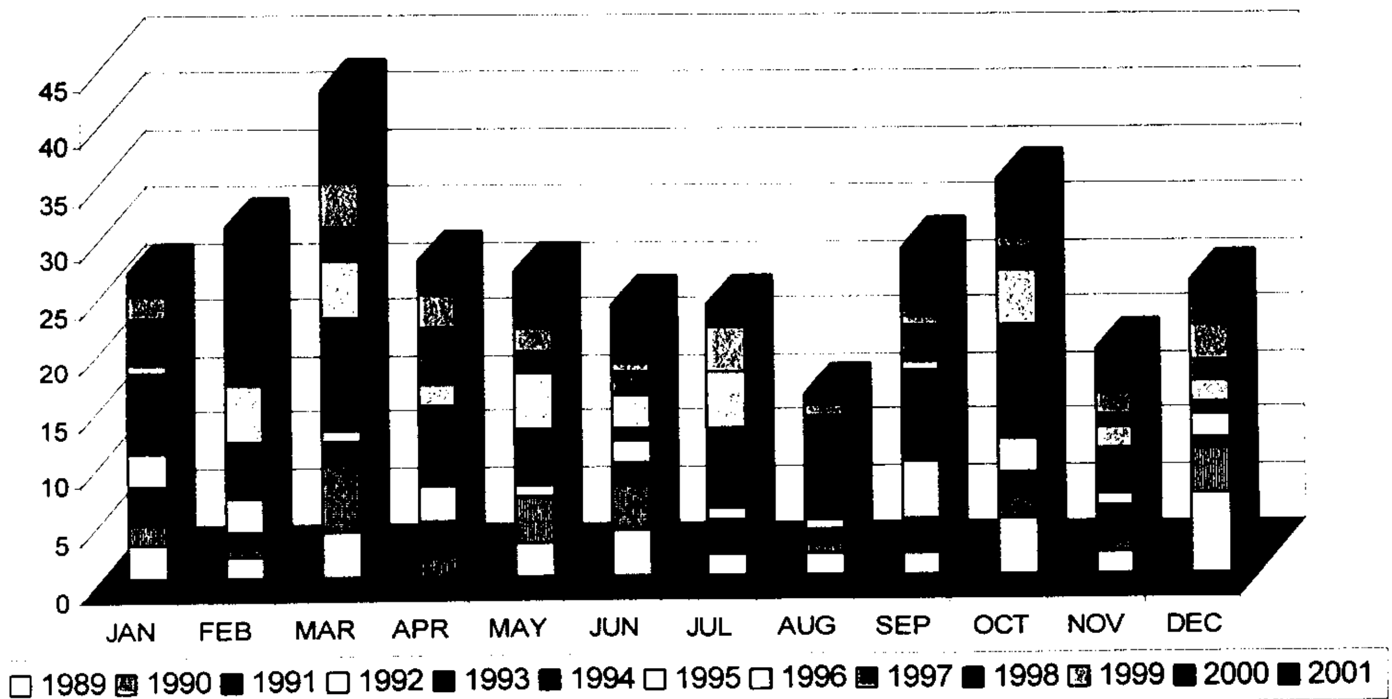


TABLE 21
[illegible]

	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	TTL
Sexual Abuse	1		3		3	1		3	3	4	4	5	1	28
Physical Abuse	1	1	1		2	2		2	5	5	4	3	6	32
Severe Neglect	3			1	1			1			1	1		8
General Neglect	1			1	3	1		1	1	8	1		3	20
Emotional Abuse					3		1					1	2	7
Caretaker absence									1	2	2	1	3	9
Info. unavailable	6	2	1	2	2	1		2	1	1				18
TOTAL	**12**	**3**	**5**	**4**	**14**	**5**	**1**	**9**	**11**	**20**	**12**	**11**	**15**	**122**

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

TABLE 21
LAW ENFORCEMENT AGENCY INVOLVEMENT IN 2001 ADOLESCENT SUICIDES

LASD Homicide	11
LAPD	
Foothill	1
Pacific	2
Rampart	1
Robbery	1
Southwest	1
Van Nuys	1
West Los Angeles	1
Wilshire	2
Downey P.D.	1
Inglewood P.D.	1
Lond Beach P.D.	2
Pomona P.D.	1
Santa Monica P.D.	1