INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT

CHILD DEATH REVIEW REPORT 2003

Report Compiled from 2002 Data

FINDINGS

Homicides

- There were 37 child homicides by parents, caregivers or family members in 2002. This is a slight increase over 2000 and 2001, when 35 such child homicides were reported per year.

- 86% of the children killed by their parents, caregivers or family members were five years of age or younger.

- Five children were over age 5, including three members of a five-member sibling set killed at the hands of their father. Without inclusion of the sibling set, 94% of the child victims were age five or younger.

- The average age of child homicide victim in 2002 was 2.62 years (31.45 months); without inclusion of the 5-member sibling set (which included children ages 3, 4, 6, 7 and 10), the average age of child homicide victim in 2002 was 2.05 years (24.06 months).

- Twenty female children and 17 male children were victims of homicide by parents, caregivers or family members in 2002.

- Seven children died from multiple trauma, and seven were left unattended and drowned in bathtubs or ponds due to caregiver neglect.

- Eight newborns were abandoned and/or killed by their mothers in 2002, a decrease from eleven newborns in 2001. Seven of these deaths were moded homicide by the Coroner and one was moded undetermined. Eight children were safely surrendered during this year.

- Deaths due to poisoning represented the third leading cause of homicide; 6 children died of poisoning, including five siblings who died of carbon monoxide poisoning and a toddler who died of cocaine ingestion after accessing her father's supply.

- Both Hispanic (n=26) and African American (n=7) children were overrepresented in child homicides by parents, caregivers or family members.

Suicides

- Nineteen children and adolescents committed suicide in 2002. This is a significant decrease (30%) from the 27 such suicides in 2001 and lower than the 15-year average of 26.5 suicides per year.

- As in years past, male victims outnumber female victims by a wide margin. Thirteen males and six females committed suicide in 2002.

- After two years with hanging as the leading method, in 2002 it was death due to gunshot, which was the leading method in 13 of the past 15 years. Other methods in 2002 included jumping from high places, standing in the path of an oncoming train and drowning.

- 84% of the children who committed suicide in 2002 were age 15 - 17; three victims were under age 15, and the youngest victim was age 13. In comparison, in 2001, seven victims were under age 15, including a nine-year old boy.

- Caucasian children (n=7) were over-represented in suicide deaths in 2002 while African American children (n=0) were under-represented.

Accidental Child Deaths

- There were 127 accidental deaths of children age 0 through 14 years in 2002. This is slightly lower than the 137 such deaths for this age group reported for 2001.

- The leading cause of accidental death for children 14 years of age and under remained autopedestrian accidents for the 4th consecutive year. These represent 33 children who were hit by a car or truck while crawling, walking or riding bicycles or skateboards. Five children over age 14 were also killed in autopedestrian accidents in 2002.

- ICAN began collecting data on children age 15 - 17 for calendar year 2002. With the inclusion of this older age group, there were 173 accidental deaths (children age 0 through 17) and the leading cause of accidental death was automobile accidents (n=50).

- Deaths associated with maternal substance abuse accounted for 17 fetal deaths and 8 deaths to infants age 1 day to just under age 5 months. Cocaine is the drug associated with most of these deaths (n=1 7), followed by methamphetamine (n=8).

- Accidental drowning claimed the lives of eighteen children age 0 - 17 in 2002; these were primarily toddlers and young children who drowned in residential pools, spas or decorative ponds. In addition, two older children died in bathtubs and one teen each died in the ocean and a recreational dam area.

- Hispanic children were over-represented in autopedestrian deaths, African American children were over-represented in deaths related to maternal substance abuse, and Caucasian children were over-represented in drowning deaths.

Child Death in Los Angeles County

Over the past 5 years, an average of 40 children each year have *been killed by a parent, caregiver or other family member.*

1998 49
1999 44
2000 35
2001 35
2002 37

Over the past 5 years, an average of 22.2 children and adolescents each year have *committed suicide.* The leading method in 1998, 1999 and 2002 was gunshot wounds; in 2000 and 2001, the leading method was hanging.

1998 15
1999 27
2000 23
2001 27
2002 19

Over the past 5 years, an average of 126 children age 14 and younger have died from preventable accidents. The most common accidental deaths involve autopedestrian accidents, drowning, deaths due to maternal substance abuse and automobile accidents.

1998 95
1999 134
2000 137
2001 137
2002 127

CHILD HOMICIDES BY PARENTS, CAREGIVERS AND OTHER FAMILY MEMBERS

1989 - 2002

CASE SUMMARY #1
CHILD HOMICIDE BY PARENT/CAREGIVER/FAMILY MEMBER

Four-year old Jonathan was admitted to the hospital with a subdural hematoma, cerebral bleeding and multiple bruising over his body. Jonathan's mother, Ms. Lee, told hospital staff that Jonathan had run into the house on his new bicycle. Doctor's believed that Jonathan's injuries were more consistent with child abuse than with the mother's story and they notified police. Jonathan remained in the hospital until his death two days later.

Team review of this case revealed that Ms. Lee is Asian and immigrated from Asia with Mr. Canard, an American military person she met while he was performing service in her country. Eventually, Jonathan and his grandmother joined Ms. Lee and Mr. Canard in America. Upon his arrival, Jonathan began to be brutalized by Mr. Canard. It was reported that upon the day that Jonathan died, Mr. Canard took him to a baseball game where an usher observed Jonathan's bruises and asked Jonathan if he was okay. However, Jonathan spoke no English and Mr. Canard intervened and made excuses for Jonathan's injuries.

The review of this case revealed some horrifying details. When law enforcement interviewed family members several different accounts of the injuries were related. During the interview with Mr. Canard he eventually admitted to physically abusing Jonathan over the last week. In one incident he admitted to punching Jonathan in the mouth with his fist and knocking out several teeth. On the day that Jonathan was admitted to the hospital, Mr. Canard had told Ms. Lee that he had been taking a shower with Jonathan when the child slipped and fell striking his head. During his interview with the police Mr. Canard admitted to becoming irritated with Jonathan because he was crying. He struck Jonathan in the chest with his fist, started choking him with both hands and picked him up off the floor by the neck. He then grasped his arms, shook him violently and threw him against the wall. He picked him up again and threw him to the floor. His head made a loud thud when it hit the floor and Jonathen began to posture and shake as if he were about to have a seizure. At this point, paramedics were called.

The autopsy revealed that Jonathan had multiple injuries, including external bruises on the face, chest, abdomen, back, buttocks, arms and legs, rib fractures, internal abdominal injuries, subdural hemorrhages and retinal hemorrhages. The injuries were in various stages of healing and were not consistent with having all occurred at the same time.

The Department of Children and Family Services (DCFS) had three prior referrals for this family.

The first referral alleged general neglect of Jonathan's sibling, Michael, by Ms. Lee. Reportedly, domestic violence issues were discussed with Ms. Lee and Michael's father, Mr. Johnson as Mr. Johnson had hit Ms. Lee during her pregnancy with Michael. DCFS wanted to open a voluntary family maintenance contract with Ms. Lee but she refused and the referral was closed. The second referral was for emotional abuse and caretaker absence. The referral was found to be inconclusive but Ms. Lee and Mr. Johnson were arrested for domestic violence. It was agreed that Mr. Johnson's parents would care for Michael until they could get help. Ms. Lee went to a shelter and the referral was closed. The third referral alleged that Michael was at substantial risk as Ms. Lee had attempted suicide. This allegation was substantiated and a court case opened. The case was subsequently closed when Mr. Johnson was given full custody of Michael. Upon Jonathan's death, DCFS opened a case for his younger sibling, Scott. The case plan is for Scott to be adopted by his foster care providers.

The Team questioned what the outcome for Jonathan might have been had the usher at the stadium contacted police after seeing Jonathan's injuries. The Team also highlighted the language and cultural barriers associated with this case as reportedly Ms. Lee and her mother did not speak English, did not know American customs and felt very isolated. The strong correlation between child abuse and domestic violence was also discussed as Team reviews have frequently revealed this correlation.

CASE SUMMARY #2
CHILD HOMICIDE BY PARENT/CAREGIVER/FAMILY MEMBER
CHILD PROTECTIVE SERVICES INVOLVMENT

14-month-old Anthony was brought by his mother, Mrs. Gonzalez, to the hospital, not breathing. Upon examination, doctors noted that Anthony had numerous bruises to his face, toenails, legs, penis and an injury to his anus. Law enforcement was notified immediately.

Team review of this case revealed a troubling history. Reportedly, Mrs. Gonzalez stated that Anthony had been sleeping in her room and when she went to change his diaper she found that he was not breathing. Mrs. Gonzalez stated that she called her Aunt to take her and Anthony to the hospital after first dropping Anthony's siblings (ages 4 and 6) off at their grandmother's home. Upon further investigation, however, it was discovered that a male driver had driven Mrs. Gonzalez to the hospital and that this man disappeared soon after dropping them off. Mrs. Gonzalez initially reported that no males lived in the home but it was later discovered that Anthony's father, Mr. Gonzalez, had been residing in the home, despite Dependency Court orders that he not be allowed in the home. It was also learned that Mr. Gonzalez was with Anthony when he was found not breathing. Upon this discovery, Mr. Gonzalez stated that he had rolled over onto Anthony. Rather than rolling over onto Anthony, though, Mr. Gonzalez had beaten Anthony to death.

Anthony's autopsy revealed multiple external bruises. There were purple lesions of varying ages that were consistent with bite marks. Anthony's upper frenulum was tom and he had a subgaleal hemorrhage. Anthony had numerous rib fractures, including evidence of prior healing rib fractures. As a result of the numerous rib fractures Anthony showed signs of an evolving bronchopneumonia, which caused his death. In addition to the rib fractures, there was acute trauma to the penis and possible anal and buttock trauma. It is unclear if Anthony was sexually assaulted, though it is probable that he was only assaulted physically. Of note, when Anthony's six-year-old brother, Tyrone, was interviewed after Anthony's death, he stated that Mr. Gonzalez was upset because Anthony had peed in his bed. Anthony was forced to wear underwear because Mr. Gonzalez believed Anthony was too old to be in diapers. The crime scene indicated that Anthony had been severely beaten in the bathroom.

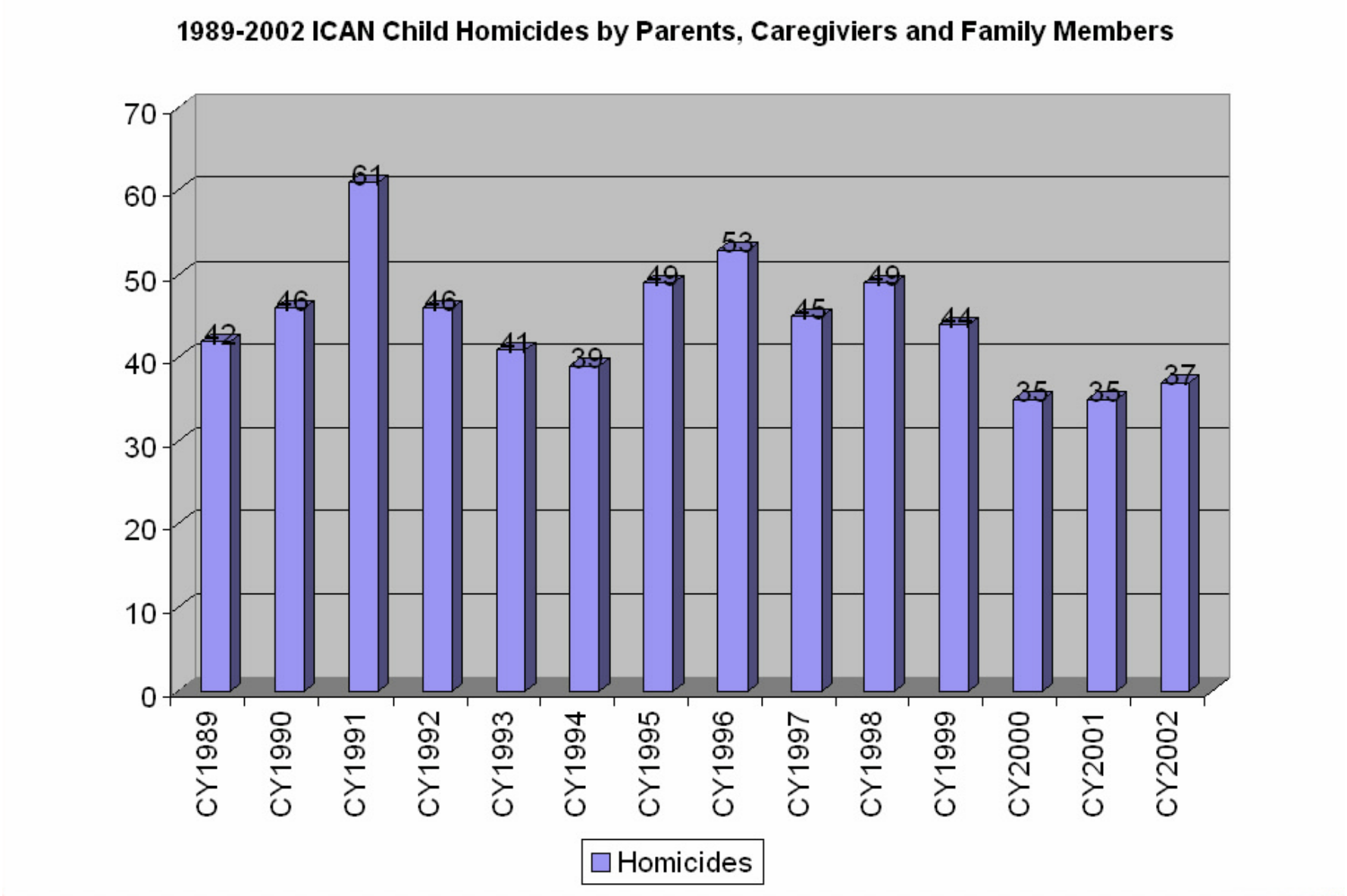
Team reviewed revealed that the Gonzalez family had numerous referrals and an open case with the Department of Children and Family Services (DCFS) prior to Anthony's birth. In 2000 Mr. Gonzalez had sexually and physically abused Anthony's 4-year old sister, Madeline. Reportedly, Mr. Gonzalez had beaten Madeline because she had pooped in her pants and he

then assaulted Mrs. Gonzalez when she tried to intervene. As a result of this incident, Mr. Gonzalez pled guilty to willful infliction of corporal injury and was sentenced to one year in county jail. Mr. Gonzalez was released after serving six months of his one-year sentence. Prior to this incident, three referrals were made to DCFS for physical abuse, sexual abuse, general neglect and emotional abuse due to domestic violence. These allegations were either unfounded or inconclusive and the referrals closed. In addition to these referrals, three referrals were made alleging that Anthony's siblings, Madeline and Tyrone, were being abused by their foster mother. These allegations were all unfounded. Upon Anthony's birth, he was detained as his siblings were in foster care. Family maintenance services were ordered and Anthony was allowed to remain at home with Mrs. Gonzalez provided that a relative resided there as well until Family Preservation services could be put in place.

Reportedly, the Dependency Court had been moving towards a slow release of the children back to Mrs. Gonzalez after the previous physical and sexual abuse charges against Mr. Gonzalez. Mrs. Gonzalez complied completely with her case plan and was doing everything she was supposed to do. The family was provided with Family Preservation services and social workers went out to the home on a regular basis. In addition, Mrs. Gonzalez completed a 52-week course on domestic violence. However, Mrs. Gonzalez subsequently allowed Mr. Gonzalez back into the home. The Team review indicated that Mr. Gonzalez was a heavy heroin user and had a strong history of gang involvement.

Criminal charges were filed against both Mr. and Mrs. Gonzalez as Mrs. Gonzalez had failed to protect Anthony by allowing Mr. Gonzalez back into the home. Mr. Gonzalez was charged with murder, assault resulting in the death of a child under age 8 and willful harm or injury to a child. Mrs. Gonzalez was charged with willful harm or injury to a child. They are both currently awaiting trial.

Team members expressed frustration as this family had been provided with numerous services and had appeared to be doing well, yet Anthony was killed despite these services. The Team acknowledged the incredible difficulties of working with families when there is a long history of domestic violence and substance abuse. The Team also noted that a significant percentage of physical abuse cases stem from toilet training issues and discussed the need for further education and training in this area.


1989-2002 ICAN Child Homicides by Parents, Caregiviers and Family Members
70
60
50
40
30
20
10
0
42
46
61
46
41
39
49
53
45
49
44
35
35
37
CY1989
CY1990
CY1991
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
Homicides

CAUSES OF CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS
1989 – 2002, Los Angeles County

	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	Total
Head Trauma	21	17	23	16	14	17	19	15	12	13	15	5	5	2	194
Multiple Trauma	6	5	7	9	7	7	10	7	10	8	10	11	7	7	111
Gunshot Wounds	6	11	5	3	2	2	4	4	7	10	4	3	2	1	64
Trauma to torso/abdomen	1	0	7	3	3	6	2	5	4	2	1	0	0	3	37
Asphyxiation/suffocation	4	5	1	2	1	0	4	4	4	3	6	3	8	5	50
Drowning	1	2	5	2	1	1	4	0	2	2	0	3	1	7	31
Fire	0	0	0	3	1	0	3	8	0	4	0	1	0	0	20
Strangulation	3	1	4	1	1	1	0	2	2	1	0	0	0	0	16
Poisoning/drug ingestion	0	0	1	1	6	1	0	2	0	0	0	0	3	6	20
Stabbing	0	0	2	3	1	0	0	2	0	2	1	4	1	2	18
Unattended newborn	0	0	3	1	0	1	1	0	1	3	4	2	3	2	21
Undetermined/Unknown	0	0	2	0	1	2	0	2	1	0	2	1	1	2	14
Dehydration/malnutrition	0	1	1	1	0	0	1	1	1	1	0	1	1	0	9
Neck compression	0	1	0	1	1	0	1	1	0	0	0	0	0	0	5
Medical neglect	0	0	0	0	2	1	0	0	0	0	0	1	2	0	6
Burns	0	2	0	0	0	0	0	0	1	0	1	0	1	0	5
Penetrating brain wound	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Total	42	46	61	46	41	39	49	53	45	49	44	35	35	37	622

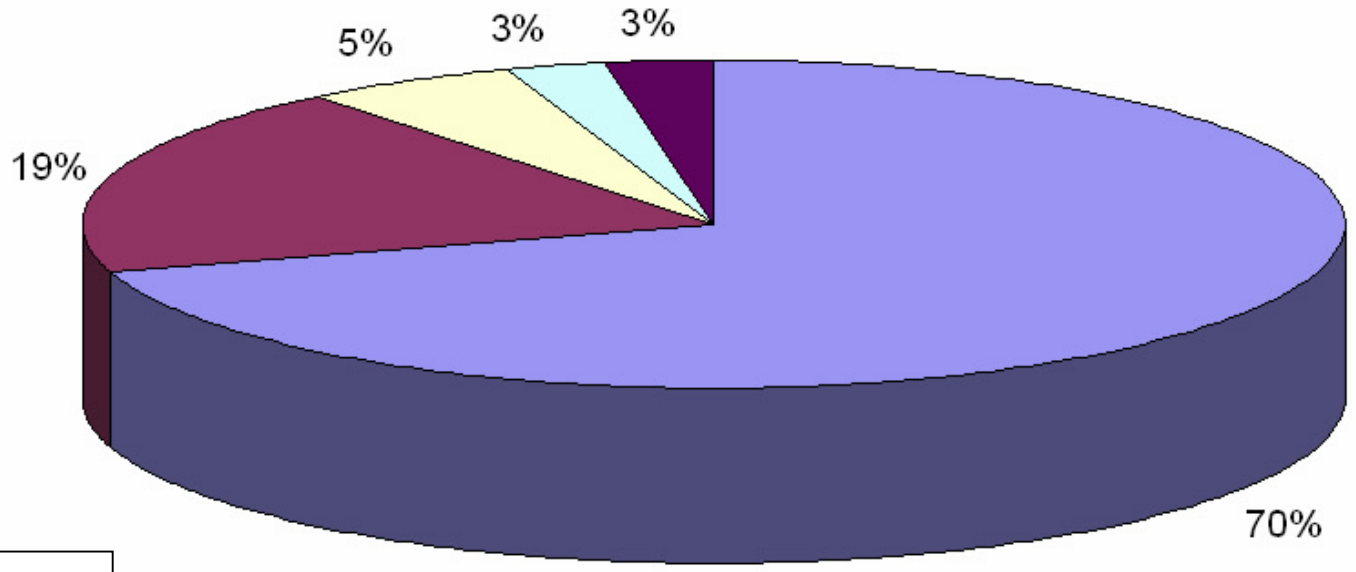
CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS LOS ANGELES COUNTY – 2002 (N = 37)

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

38 % of the child homicides by parents/caregiviers/family members were under one year of age.

86 % of the child homicides by parents/caregiviers/family members were 5 years of age or under.

2002 Child Homicides by Parents, Caregiviers and Family Members - Ethnicity



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

Hispanic (26) African American (7) Caucasian (2) Asian (1) Unknown (1)

CHILD AND ADOLESCENT SUICIDES

1988-2002

CASE SUMMARY
SUICIDE

Sally was reportedly a happy 16-year old female with no history of depression who had expressed no suicidal ideation. She was a good student and played on the Junior Varsity tennis team. On the day of her death, she and her mother went shopping and to lunch. Later that evening, between 11:00 and 11:30, a security guard in Sally's complex heard a loud thud, but could find nothing. He reported that a planter might have fallen from one of the balconies. Sally's mother checked on Sally about an hour and a half later. She found that Sally was not in bed and that her bedroom window was open. She also found a suicide note by the window of their 17th floor unit. She went outside and found Sally's body in the bushes about ten minutes later.

The City's Mayor's Crisis Response Team was called to the scene and responded. When they arrived, mother was reportedly drinking heavily and refused assistance. There was a report that mother was combative but this is unclear. Sally's father reportedly killed himself years earlier. However, when investigators asked Sally's mother about this, she became uncooperative and refused to answer questions. Sally's friends indicated that Sally had never told them of the suicide. Her friends saw her the day before her death and reported that she had not acted any differently, that she had no complaints. Sally called all her friends the night she killed herself and did not tell her friends of her plans or say anything unusual.

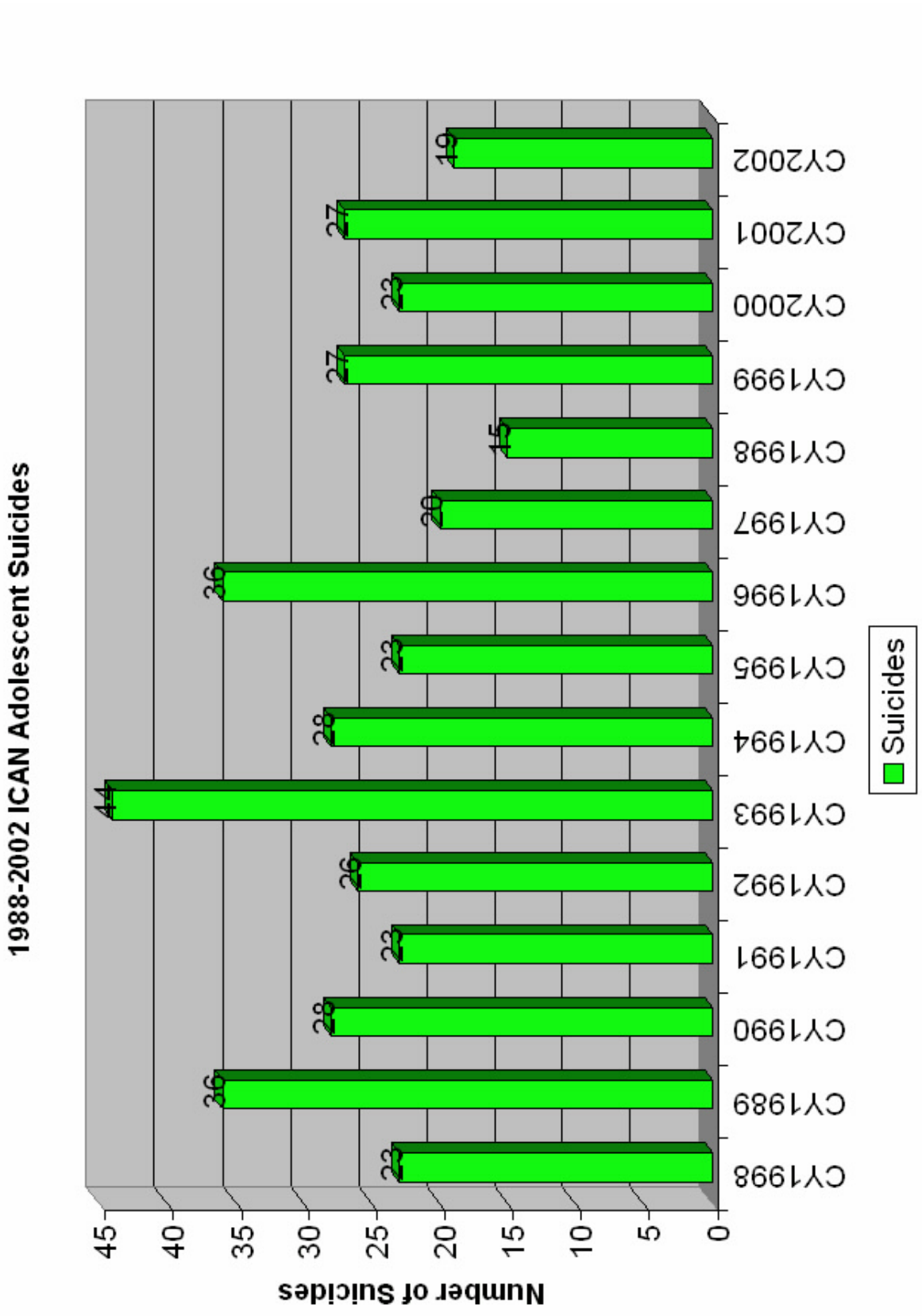
Sally's suicide note was handwritten and printed. She stated that she loved her mother and that her suicide was not her mother's fault, that her mother was a great mother. She did not want her mother to feel guilty. She stated that she could not take the stress and stated that she had a history of messing up close relationships. She asked that her friends be told that she had loved them.

The Coroner notified the Los Angeles County Office of Education (LACOE) of Sally's death by 8 a.m. the next morning and LACOE notified Sally's school, a small, private school known for high academic expectations. The school had already been notified of Sally's death by one of Sally's friends and her friend's mother. At this time, they were unaware that the death was a suicide. The school psychologist, Dr. Brown, reported that she met with Sally's friends during first period and that a school assembly was set for second period. The students were kept on campus as they were agitated, and a priest, rabbi and another counselor were available. A smaller assembly was held thereafter for students who wished to talk.

At about 10:30, school personnel were informed that the death had been a suicide. Dr. Brown invited Sally's closest friends and their parents to a meeting with several mental health experts. Sally's friends did not want to believe that Sally had killed herself. They stated that sometimes Sally studied on a bureau next to the window and believed she had accidentally fallen out of the window. However, they also related that Sally sometimes called them to say that her mother had stayed out all night and that she was alone. Sally's friends expressed anger that she had not shared her feelings with them. The possibility that Sally's mother pressured her a great deal was discussed. Sally had an SAT coach, tutors, etc. and while she was an average student, her mother paid her $100 for every "A" she received on a test or quiz. The school has recently been addressing the issue of academic pressure with students' parents.

Dr. Brown met with the faculty and advised them on how to talk with students, and no homework or tests were given for the remainder of the week. She also met with parents, providing them with information on how to deal with their children's grief. Dr. Brown also met with members of the tennis team. Group grief counseling was provided, but the girls who came attended only one session and then found reasons not to attend additional sessions. A memorial service was held that Wednesday and was open to all students. About two-thirds of the upper school and some middle school students attended the service where a slide show and photographs were shared. Students brought flowers and developed a memorial site for about a week. A staff person from the Los Angeles Unified School District was involved in the crisis response and advised the school about the difficulties associated with memorials and glamorizing suicides. It was suggested that those who wished to memorialize Sally make donations to a suicide prevention center.

Dr. Brown stated that the Yellow Ribbon campaign would be presented to their 11th graders shortly. She has been asked to screen the whole school and asked the Child and Adolescent Suicide Review Team about a tool for adolescents. The difficulty in assessing adolescents with their normal ups and downs and problems inherent in stating that results won't be shared, when they may if there are serious concerns were discussed. It was recommended that Dr. Brown rely on her clinical expertise and the eyes and ears of the faculty. Dr. Brown reported that there has been an increase in reports of concerning student activities (e.g., cutting themselves, bulimic episodes) since Sally's death and Dr. Brown shared her own struggle with concerns that she'll "miss a kid" at risk. She shared her feelings with the rest of the counseling staff who related similar feelings. The importance of mental health debriefing for faculty and staff was raised.


1988-2002 ICAN Adolescent Suicides
Number of Suicides
0
5
10
15
20
25
30
35
40
45
CY1988
CY1989
CY1990
CY1991
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
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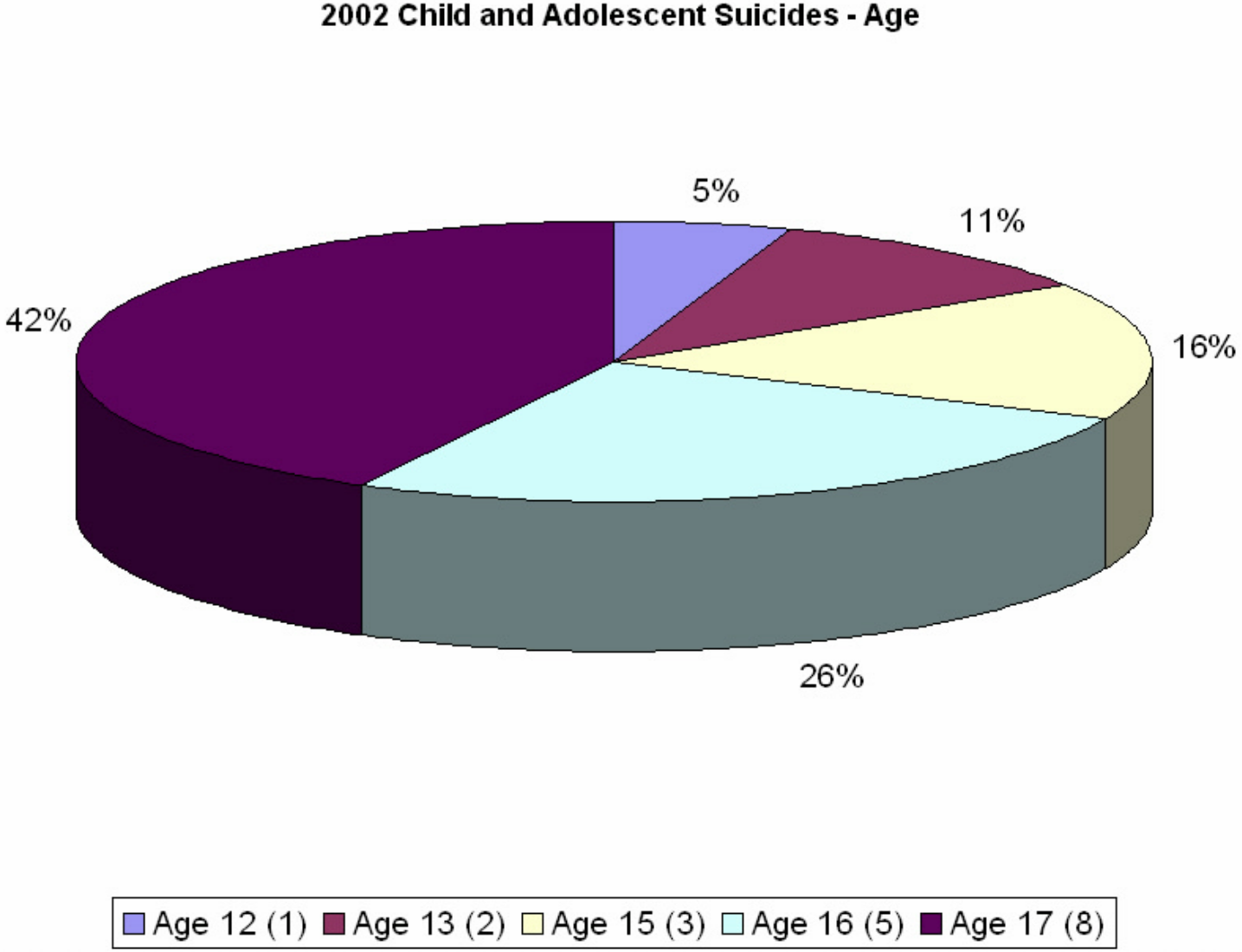
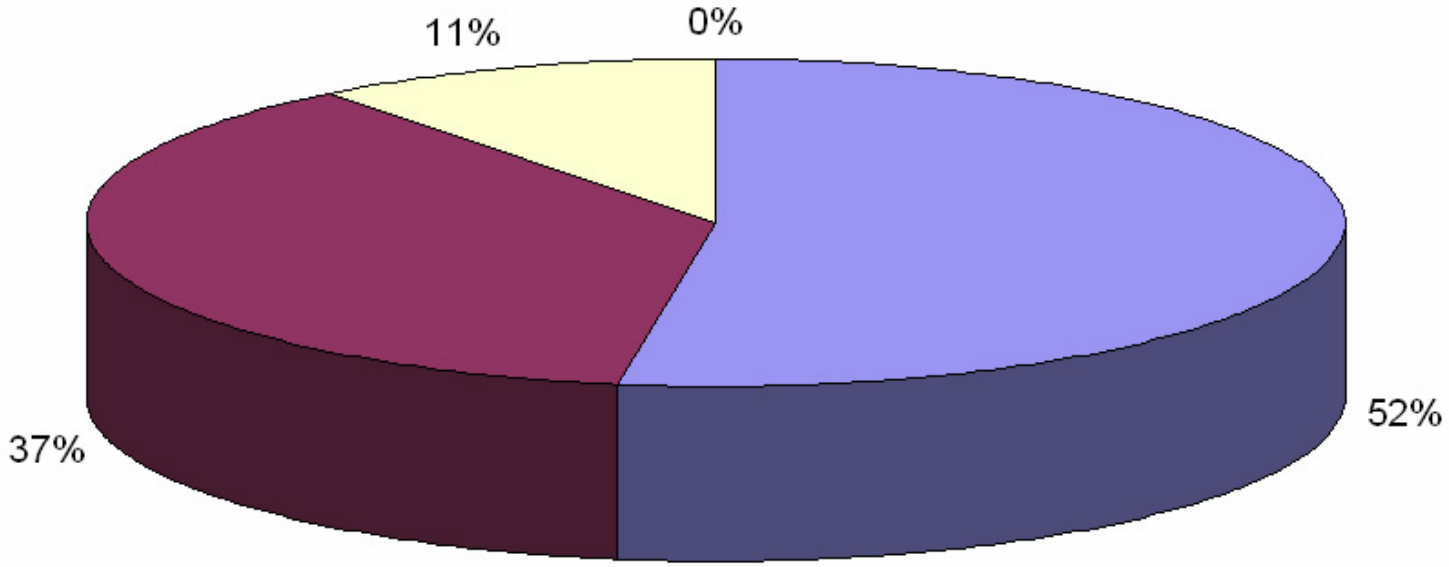
36
20
15
27
23
27
19
Suicides


2002 Child and Adolescent Suicides - Age
5%
11%
16%
26%
42%
Age 12 (1)
Age 13 (2)
Age 15 (3)
Age 16 (5)
Age 17 (8)

2002 Child and Adolescent Suicides - Ethnicity



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

Hispanic (10) Caucasian (7) Asian/Pacific Islander (2) African-American (0)

ACCIDENTAL CHILD DEATHS

1989-2002

CASE SUMMARY
ACCIDENTAL DEATH

Twenty-month old Christopher died as a result of being run over by his mother in their driveway. Christopher's mother, Catherine, and grandmother, Nadine, had returned home from a family visit. Nadine asked Catherine to run some errands for her. Catherine got into the family car, a large Sport Utility Vehicle (SUV) and drove out the driveway and down the street on her way to the store. A short time later, Nadine realized that Christopher was not in the house so she assumed that Catherine had taken him with her. However, a few minutes later there was a knock at the door and a neighbor was yelling for Nadine to come outside as he had found Christopher lying in the driveway, dead. Paramedics and the police were called.

Family members then went out to find Catherine. They found her a few blocks away and screamed at her to get home as soon as possible. Catherine came home and was told that Christopher was dead. Catherine had seen a woman she did not know talking on a cell phone and she assumed that this woman had hit Christopher and was calling her family for help. However, police informed Catherine that she was the one who had hit Christopher. Catherine insisted that she could not have hit Christopher as she had looked carefully before backing out and she prepared a statement to that effect. Unfortunately, though, tests on the tires of her SUV showed physical signs that her car had hit Christopher.

The Team discussed the fact that autopedestrian deaths have become the leading cause of accidental deaths and agreed that a public service campaign should be commenced. The Team also discussed the dangers of large SUVs as they have many blind spots and discussed development of both informational and technological prevention tools.

CAUSES OF ACCIDENTAL CHILD DEATHS, Ages 0 – 14
1989 – 2002, Los Angeles County

	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	Total
Drowning	30	40	32	25	40	35	31	18	28	21	25	23	28	16	392
Maternal drug abuse	20	24	23	17	23	10	9	25	24	38	21	22	24	25	305
Autopedestrian**							2	1	8	19	31	30	41	33	165
Automobile***											18	24	28	20	90
Falls	5	11	10	5	4	7	6	5	2	3	5	1	1	3	68
Choking	1	7	10	6	7	2	0	1	5	3	6	10	2	8	68
Suffocation	1	3	5	4	8	4	1	2	0	2	4	1	3	0	38
Poisoning	1	3	1	4	7	4	1	1	6	1	4	4	1	0	38
Fire	2	0	0	0	3	2	2	0	1	3	7	4	3	7	34
Hanging/strangulation	3	1	5	4	5	0	0	3	0	0	0	6	3	1	31
Medical Misadventure	0	0	0	0	0	2	1	1	0	1	5	6	2	8	26
Chest/neck compression	2	0	0	3	3	3	1	2	1	2	0	1	0	0	18
Gunshot wounds	1	1	2	3	0	1	1	2	1	0	0	0	0	0	12
Object fell on child	0	0	0	0	0	0	2	0	3	2	1	1	0	1	10
Sports injury	0	0	0	0	0	0	0	0	2	0	2	2	1	0	7
Burns	0	0	2	1	1	0	0	0	0	0	1	0	0	1	6
Dog bites	0	0	0	0	0	0	1	0	1	0	1	1	0	0	4
Aspiration of stomach	0	1	0	0	2	0	0	0	0	0	0	0	0	0	3
Perinatal asphyxia	0	0	0	0	0	0	1	0	1	0	1	0	0	0	3
Electrocution	0	0	0	0	0	0	0	0	2	0	0	1	0	0	3
Birth trauma	0	0	0	0	1	0	0	0	0	0	2	0	0	0	3
Hypothermia	0	1	0	1	0	0	0	0	0	0	0	0	0	0	2
Airplane v. pedestrian	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Train v. pedestrian	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Elective abortion	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Forklift injury	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
TOTAL	**66**	**92**	**90**	**73**	**104**	**70**	**59**	**61**	**86**	**95**	**134**	**137**	**137**	**127**	**1331**

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

CAUSES OF ACCIDENTAL CHILD DEATHS, AGES 0 - 17
2002, Los Angeles County

Autopedestrian	38
Automobile - solo vehicle	27
Maternal substance abuse	25
Automobile - multi-vehicle	23
Drowning	18
Medical Misadventure	9
Choking	8
Fire	8
Poisoning	3
Fall	3
Hanging	2
Airplane v. Pedestrian	2
Object fell on child	2
Elective abortion	1
Forklift	1
Burns	1
Train v. Pedestrian	1
Unknown	1

CAUSES OF ACCIDENTAL CHILD DEATHS
2002, Los Angeles County

	Age 0-5 years	Age 15-17 years
Autopedestrian	19	5
Automobile – solo vehicle	3	20
Maternal substance abuse	25	0
Automobile – multi-vehicle	9	10
Drowning	13	2
Medical Misadventure	6	1
Choking	6	0
Fire	6	1
Poisoning	0	3
Fall	2	0
Hanging	0	1
Airplane v. Pedestrian	1	0
Object fell on child	0	1
Elective abortion	1	0
Forklift	0	0
Burns	1	0
Train v. Pedestrian	0	1
Unknown	0	1

ETHNICITY OF ICAN ACCIDENTAL CHILD DEATHS, AGES 0 – 17
LOS ANGELES COUNTY – 2001 AND 2002

	Hispanic		Afr-American		Caucasian		Asian		Unknown	
	01	**02**	**01**	**02**	**01**	**02**	**01**	**02**	**01**	**02**
Autopedestrian	24	23	5	6	7	5	5	4	0	0
Automobile	20	24	4	8	3	14	1	4	0	0
Maternal drug use	7	5	9	14	7	5	1	0	0	1
Drowning	10	4	6	3	10	8	2	3	0	0
Choking	1	5	0	0	1	2	0	1	0	0
Falls	0	0	0	1	1	0	0	2	0	0
Fire	1	4	1	2	0	2	1	0	0	0
Suffocation	1	0	0	0	2	0	0	0	0	0
Object fell on child	0	2	0	0	0	0	0	0	0	0
Poisoning	0	2	0	0	0	1	1	0	0	0
Medical misadventure	1	5	1	1	0	3	0	0	0	0
Hanging/strangulation	2	2	1	0	0	0	0	0	0	0
Other/unknown	1	2	0	0	0	0	0	0	0	0
Airplane v. pedestrian	0	0	0	0	0	0	0	2	0	0
Train v. pedestrian	0	1	0	0	0	0	0	0	0	0
Forklift injury	0	1	0	0	0	0	0	0	0	0
Burns	0	1	0	0	0	0	0	0	0	0
Total	**68**	**81**	**27**	**35**	**31**	**40**	**11**	**16**	**0**	**1**

SAFELY SURRENDERED AND ABANDONED INFANTS

1999-2004

CASE SUMMARIES
SAFELY SURRENDERED BABY LAW

CASE #1: ABANDONED DECEASED INFANT

Juana, a 19-year old Latina, and her husband Frank, a 20-year old African American, resided with Frank's parents in a middle class neighborhood in East Los Angeles. Juana and Frank had been married two years prior, shortly after Juana became pregnant with their daughter, Julie. Neither Juana's or Frank's parents were pleased when Juana became pregnant as the couple had plans to attend college and these plans were thwarted by their early parenthood. Frank's parents agreed to let the young couple and child live in their home but did not hesitate to express their displeasure that they had to financially support the couple.

Although Juana and Frank were careful, Juana again became pregnant. The couple was terrified that both sets of parents would be angry with them, as the couple could not afford to care for Julie let alone a new baby. Juana would not consider abortion as it violated her religious beliefs and, although the couple discussed adoption, they made no efforts to contact an adoption agency. They later stated that they "just wished it would go away." They hid Juana's pregnancy and told no one of her condition.

Juana went into labor in her 8th month of pregnancy while Frank was out playing pool with friends. She gave birth by herself in the residence bathroom, cut the umbilical cord and wrapped her newborn son tightly in plastic bags to prevent him from crying. After her in-laws had gone to bed, she placed the plastic bag in a trash dumpster near their home. The infant was found deceased in the dumpster by a transient who notified law enforcement. Coroner records indicate that the child died of asphyxiation and caregiver neglect and the death was moded a homicide. Juana was eventually located by police who traced her by way of a receipt found in the plastic bag in which the infant died. She was arrested for Penal Code 187, murder, and awaits trial at this time.

CASE #2: SAFELY SURRENDERED INFANT

Susan, a 21-year old single Caucasian woman, became pregnant by a casual acquaintance she met at a fraternity party. Susan was a junior in college in New York and did not discover that she was pregnant until she was five months along and the father was nowhere to be found. She did not feel capable of having an abortion while carrying a 5-month gestational fetus and struggled with what to do about her pregnancy. She realized that she would be returning to her family's home for summer break near the time she was due and did not want her parents to

know of her pregnancy.

Susan returned to her parents' home in an upper class suburb of Los Angeles when she was seven months pregnant. Although her parents observed her weight gain, she explained it as "dorm food" and her parents believed her. She was very confused and afraid, so she continued to hide her pregnancy. One day she began having some pain and decided she should go to a clinic to be examined. She was examined and the clinic doctor told her that she was only having some slight contractions. She did not put her correct name or address on the clinic forms and refused all offers of assistance. However, while at the clinic, she saw a poster that advertised "Safe Arms for Newborns," a law that would allow her to confidentially leave her baby in a hospital emergency room without prosecution for child abandonment.

Two months later Susan gave birth alone in her family's bathroom while her parents were at work. She wrapped her baby in a sheet and drove herself and her newborn daughter to a local hospital emergency room where she turned the child over to an emergency room nurse. She asked the nurse what would happen to her child and was notified that the baby would be placed for adoption unless Susan returned within 14 days to reclaim the child. The nurse asked Susan to complete a medical form regarding her medical history so that the child and the child's adoptive family would have this information and gave Susan an ID bracelet that would identify her as the baby's mother in the event she wished to reclaim the child. Susan took the medical history form with her and left the hospital without obtaining recommended medical treatment for herself. She was afraid but believed she was doing the right thing for her baby and herself. She completed the medical questionnaire at home and mailed it to the hospital in the envelope they had provided.

Susan did not return to the hospital to reclaim her child and the baby was placed for adoption with a couple who had been approved by the Department of Children and Family Services Adoptions Division. The couple had waited several years to adopt and was thrilled to adopt the baby who they named Nicolette. They are grateful to Nicolette's birth mother and were pleased to have medical information for their child; however, they wish the mother had provided identifying information to the adoption agency so that Nicolette could make connection with her birth relatives when she is older if she desires to do so.

Safely Surrendered and Abandoned Infants
Los Angeles County
1999 – 2004

	1999	2000	2001	2002	2003	2004
Safely Surrendered			0	10	8	10
Abandoned Surviving	?	?	3	5	1	1
Abandoned Deceased	6	3	11	8	7	7

Safely Surrendered and Abandoned Infants in Los Angeles County - 2002
as of 12/31/02

Safely Surrendered (10)

03/21/02 female Hispanic, White Memorial Hospital, Los Angeles 90033, mother age 31
03/26/02 female African American, Glendale Memorial Hospital, mother age 17
07/30/02 female Caucasian, Kaiser Bellflower (note: DCFS may not consider this safe surrender as child born in hospital)
08/22/02 female Hispanic, Citrus Valley Health Partners, Covina, mother age 42
10/31/02 male Hispanic, Downey Fire Station
11/21/02 female Hispanic, El Monte Community Hospital
11/26/02 male African American, King Drew Medical Center (DOB: 11/22/02)
11/27/02 male Hispanic, Wilmington Fire Station
12/16/02 female Hispanic, Downey Regional Medical Center
12/26/02 male African American, Long Beach Memorial Hospital, mother age 25

Abandoned - Surviving (5)

01/20/02 male African American, found in a dumpster, Arcadia, mother age 16
02/04/02 male Hispanic, found in West Hills Hospital parking lot
06/13/02 female Hispanic, found in bushes in Panorama City
06/30/02 male Hispanic, found on residential doorstep in Los Angeles 90011
12/16/02 male Hispanic, found in trash receptacle near Makee Avenue and 66th Street, Los Angeles

Abandoned - Deceased (8)

01/05/02 female Caucasian, wrapped/hidden under residence bathroom sink, Palmdale, mother age 21
02/09/02 female African American, buried in Moreno Valley (mother gave birth in Inglewood), mother age 34
06/10/02 female Hispanic, found on conveyer belt of a trash company in City of Industry
07/02/02 female African American, found in a dumpster in Los Angeles 90002
07/09/02 male African American, found in trash bag at recycling plant in Carson
11/16/02 male Hispanic, child left in toilet as mother trying to hide the child in Los Angeles 90011
12/10/02 unknown sex/ethnicity, washed ashore in Long Beach
12/10/02 male unknown ethnicity, found on residence doorstep in Los Angeles 9002

Safely Surrendered and Abandoned Infants in Los Angeles County - 2003
as of 12/31/03

Safely Surrendered (8)

01/11/03 male Hispanic, surrendered to Lakewood Paramedics, mother reportedly age 23
01/20/03 male African American, surrendered at Gardena Hospital, mother age 26
05/02/03 male Hispanic, surrendered to personnel at Echo Park Fire Department
06/13/03 male Hispanic, surrendered at Arcadia Methodist Hospital, mother age 19
06/24/03 female Caucasian, surrendered at Pomona Valley Medical Center
11/11/03 female African American, surrendered at Antelope Valley Hospital, mother age 19
12/23/03 male Caucasian, surrendered at Northridge Hospital, mother age 30
12/25/03 male Hispanic, surrendered at Pico Rivera Fire Station

Abandoned - Surviving (1)

06/27/03 female Hispanic, abandoned on apartment porch steps in Los Angeles, 90037

Abandoned - Deceased (7)

01/28/03 female Caucasian, found in trash dumpster, Westchester
02/04/03 male of unknown ethnicity, found in trash dumpster, Santa Clarita
02/12/03 male Filipino, mother asphyxiated child by stuffing tissue in his mouth and wrapping umbilical cord around his neck, Carson, mother age 16
05/03/03 male of unknown ethnicity, found in the ocean at Marina del Rey
08/11/03 male Filipino, mother strangled infant in residence bathroom upon delivery and hid the infant's body in a suitcase, Northridge, mother age 23
10/26/03 female Hispanic, found in residential backyard, Los Angeles, 90023
12/31/03 female African American, left wrapped in a sheet on church entrance steps, Los Angeles, 90043

Safely Surrendered and Abandoned Infants in Los Angeles County - 2004
as of 12/31/04

Safely Surrendered (10)

01/02/04 female Hispanic, surrendered at Mission Community Hospital, Panorama City 91402
01/21/04 male, ethnicity unknown, surrendered at Los Alamitos Hospital, Los Alamitos, 90720
03/18/04 male, ethnicity unknown (possibly Caucasian or Hispanic) surrendered at Downey Fire Station, Downey, 90242
03/20/04 male African American, surrendered at Long Beach Memorial Hospital, Long Beach, 90807
04/08/04 female Hispanic, surrendered at East Los Angeles Doctors Hospital, Los Angeles, 90022
04/09/04 male Caucasian, surrendered at Pomona Valley Medical Center, Pomona, 91769
05/24/04 male African American, surrendered at Fire Department #116, Carson, 90746
09/06/04 female Caucasian, surrendered at Fire Station #57, South Gate, 90280
09/27/04 male Caucasian, surrendered at Fire Station #123, Santa Clarita, 91351
11/13/04 female African American, surrendered at Fire Station #57, Los Angeles, 90044

Abandoned - Surviving (1)

01/13/04 female Hispanic found in plastic bag in residential yard, Los Angeles, 90038

Abandoned – Deceased (7)

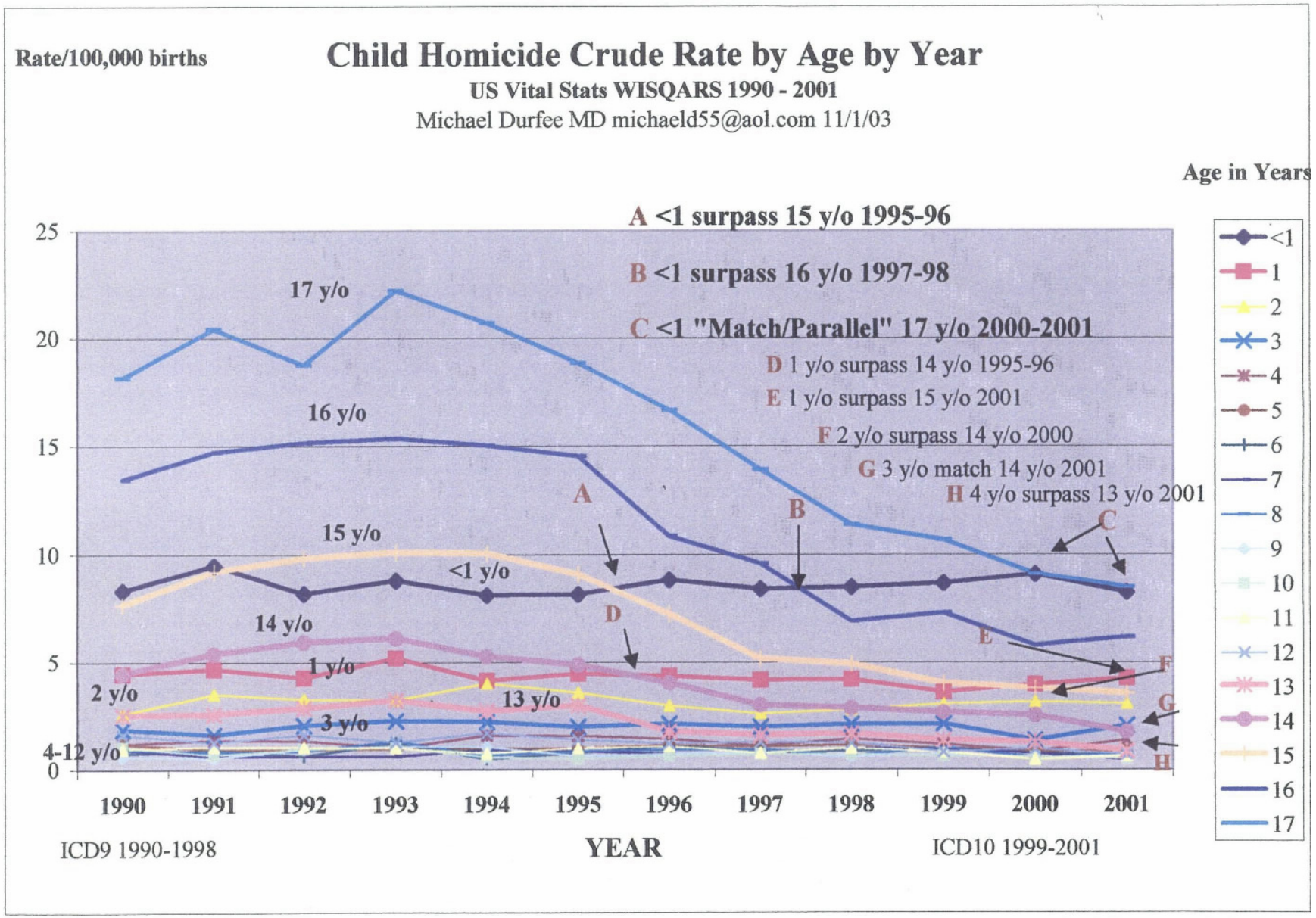
01/25/04 female Hispanic found in canvas bag under residence bed, San Dimas, 91773, mother age 15
04/22/04 female Caucasian left in dumpster, Central Los Angeles, 90007, mother age 19
05/31/04 male Hispanic found in residential trash, Whittier, 90606
09/22/04 female Caucasian left in dumpster, Sylmar, 91342
09/30/04 female Hispanic found in trash recovered from Avalon (Long Beach, 90808)
11/10/04 female Hispanic/Filipina found in trash can in Pacoima, 91331, mother age 18
12/22/04 female of unknown ethnicity found in crawl space beneath apartments, Los Angeles 90023

STATE AND NATIONAL COMPARATIVE DATA

INFANT HOMICIDES

ICAN NATIONAL CENTER ON CHILD FATALITY REVIEW (NCFR)

WWW.ICAN-NCFR.ORG


Rate/100,000 births
Child Homicide Crude Rate by Age by Year
US Vital Stats WISQARS 1990 - 2001
Michael Durfee MD michaeld55@aol.com 11/1/03
Age in Years
A <1 surpass 15 y/o 1995-96
B <1 surpass 16 y/o 1997-98
C <1 "Match/Parallel" 17 y/o 2000-2001
D 1 y/o surpass 14 y/o 1995-96
E 1 y/o surpass 15 y/o 2001
F 2 y/o surpass 14 y/o 2000
G 3 y/o match 14 y/o 2001
H 4 y/o surpass 13 y/o 2001
17 y/o
16 y/o
15 y/o
<1 y/o
14 y/o
1 y/o
2 y/o
13 y/o
3 y/o
4-12 y/o
25
20
15
10
5
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
ICD9 1990-1998
YEAR
ICD10 1999-2001
<1
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3
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7
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14
15
16
17

51 State Comparison

Large States: Infant homicide rates for States with child births over 15000 in the year 2000

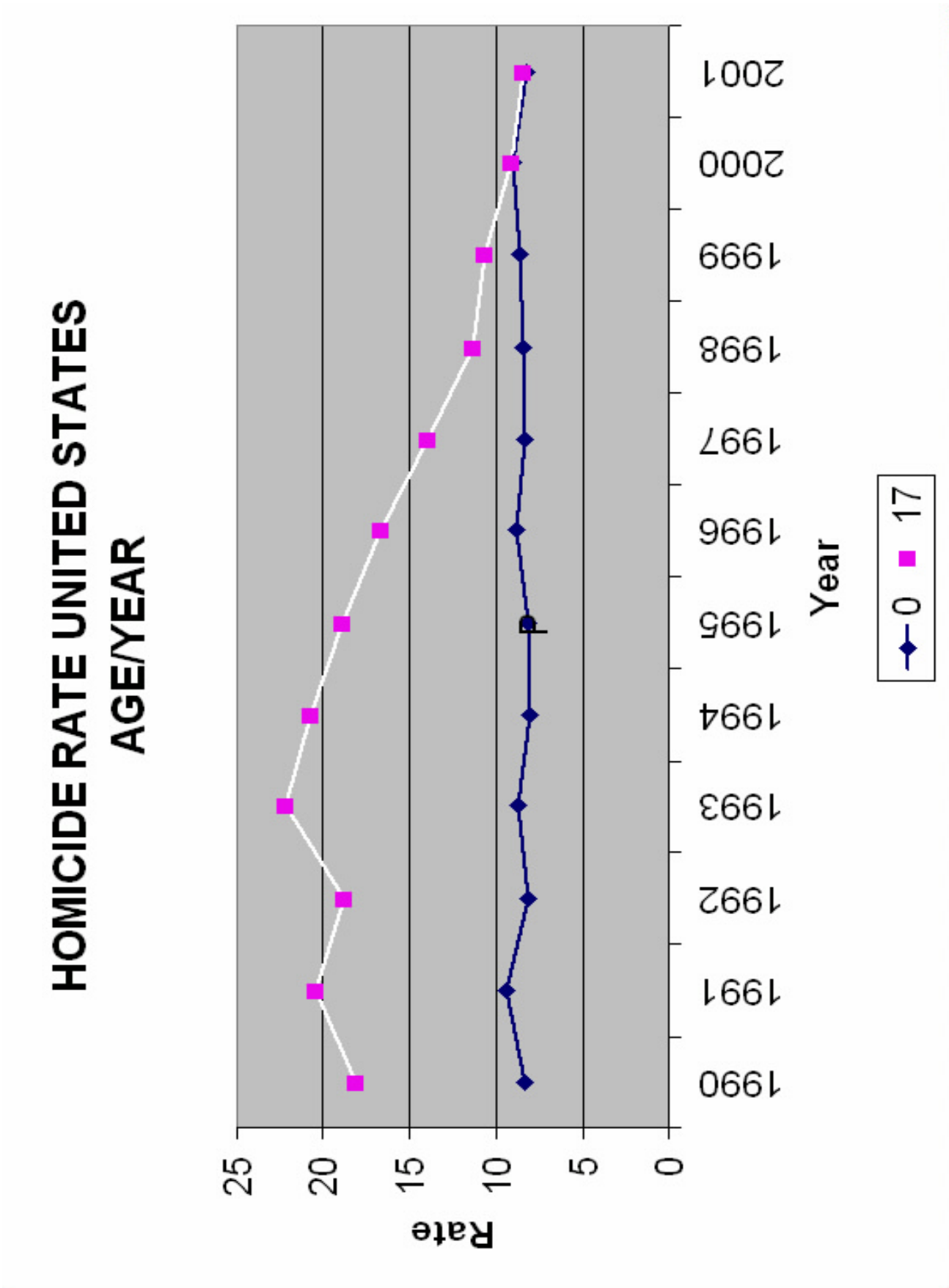
State	1999 [1]	2000 [1]	2001 [1]	Ave/Year	2000 Total Births[2]	infant homicide rate*100000
Missouri	11	10	14	11.67	76463	15.26
Maryland	10	10	11	10.33	74316	13.90
Indiana	14	13	9	12.00	87699	13.68
Louisiana	8	9	10	9.00	67898	13.26
Arkansas	3	4	8	5.00	37783	13.23
New Mexico	7	1	2	3.33	27223	12.24
Mississippi	5	6	5	5.33	44075	12.10
Illinois	21	24	21	22.00	185036	11.89
Oklahoma	7	5	5	5.67	49782	11.38
Nevada	5	1	4	3.33	30829	10.81
South Carolina	4	7	7	6.00	56114	10.69
Alabama	6	11	3	6.67	63299	10.53
Michigan	19	14	10	14.33	136171	10.53
Virginia	10	10	11	10.33	98938	10.44
Hawaii	1	2	2	1.67	17551	9.50
Tennessee	8	9	5	7.33	79611	9.21
Wisconsin	6	5	8	6.33	69326	9.14
Georgia	12	14	10	12.00	132644	9.05
Kentucky	6	6	3	5.00	56029	8.92
Florida	20	18	16	18.00	204125	8.82
North Carolina	9	12	9	10.00	120311	8.31
Arizona	6	9	6	7.00	85273	8.21
Texas	26	25	34	28.33	363414	7.80
Utah	2	5	4	3.67	47353	7.74
Kansas	2	1	6	3.00	39666	7.56
Ohio	9	7	18	11.33	155472	7.29
New York	17	24	15	18.67	258737	7.21
Pennsylvania	10	9	12	10.33	146281	7.06
Iowa	0	5	3	2.67	38266	6.97
Oregon	4	2	3	3.00	45804	6.55
Idaho	1	0	3	1.33	20366	6.55
New Jersey	5	11	6	7.33	115632	6.34
LA County	**16**	**7**	**6**	**9.67**	**157391**	**6.14**
Colorado	3	6	3	4.00	65438	6.11
Minnesota	3	3	5	3.67	67604	5.42
California with LA	**30**	**26**	**24**	**26.67**	**531959**	**5.01**
West Virginia	2	1	0	1.00	20865	4.79
Connecticut	3	1	2	2.00	43026	4.65
California without LA	**14**	**19**	**18**	**17.00**	**374568**	**4.54**
Washington	1	7	2	3.33	81036	4.11
Nebraska	0	1	2	1.00	24646	4.06
Massachusetts	4	1	4	3.00	81614	3.68
Total Large States	**350**	**361**	**349**			

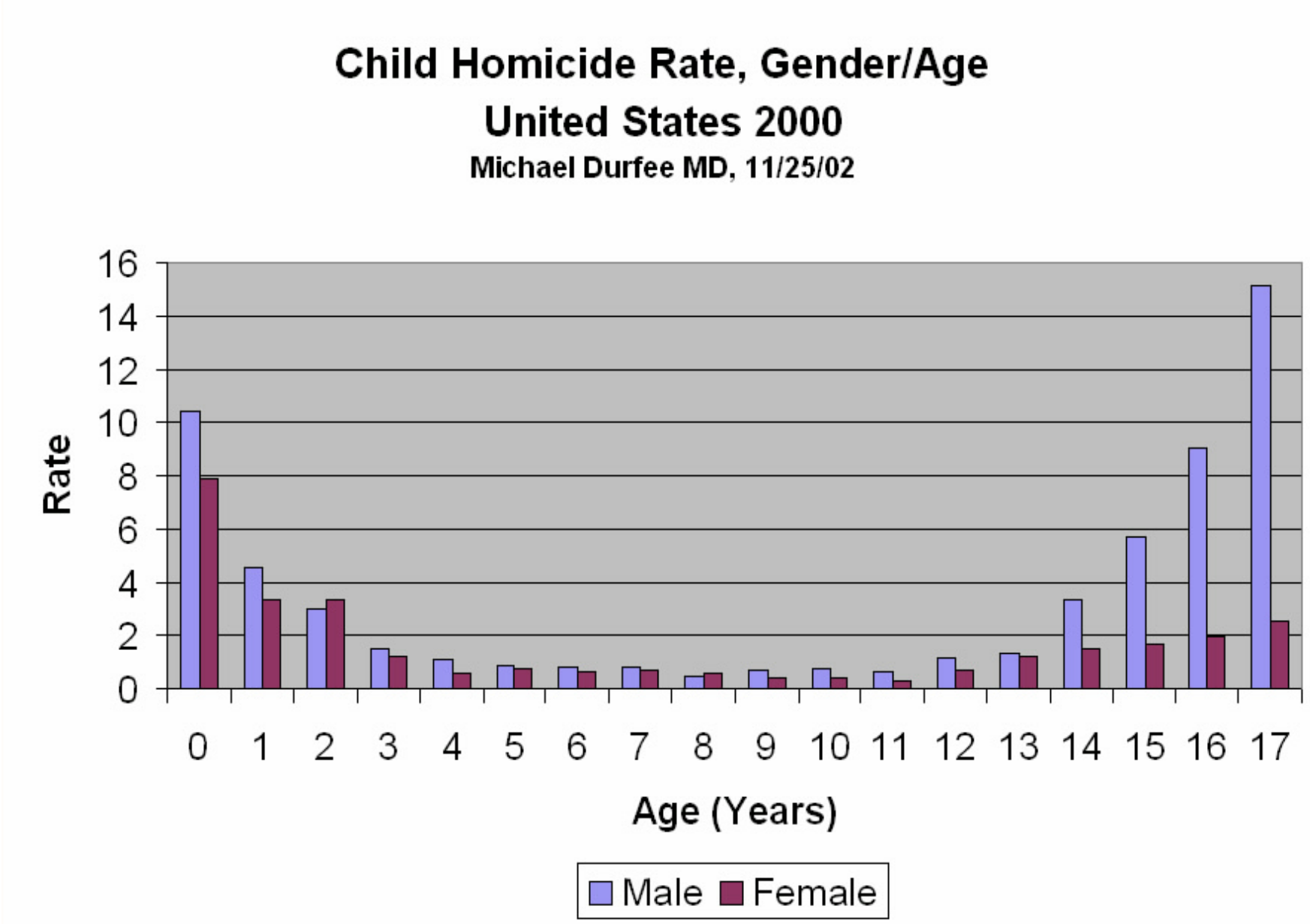
Small States: Infant homicide rates for States with child births under 15000 in the year 2000

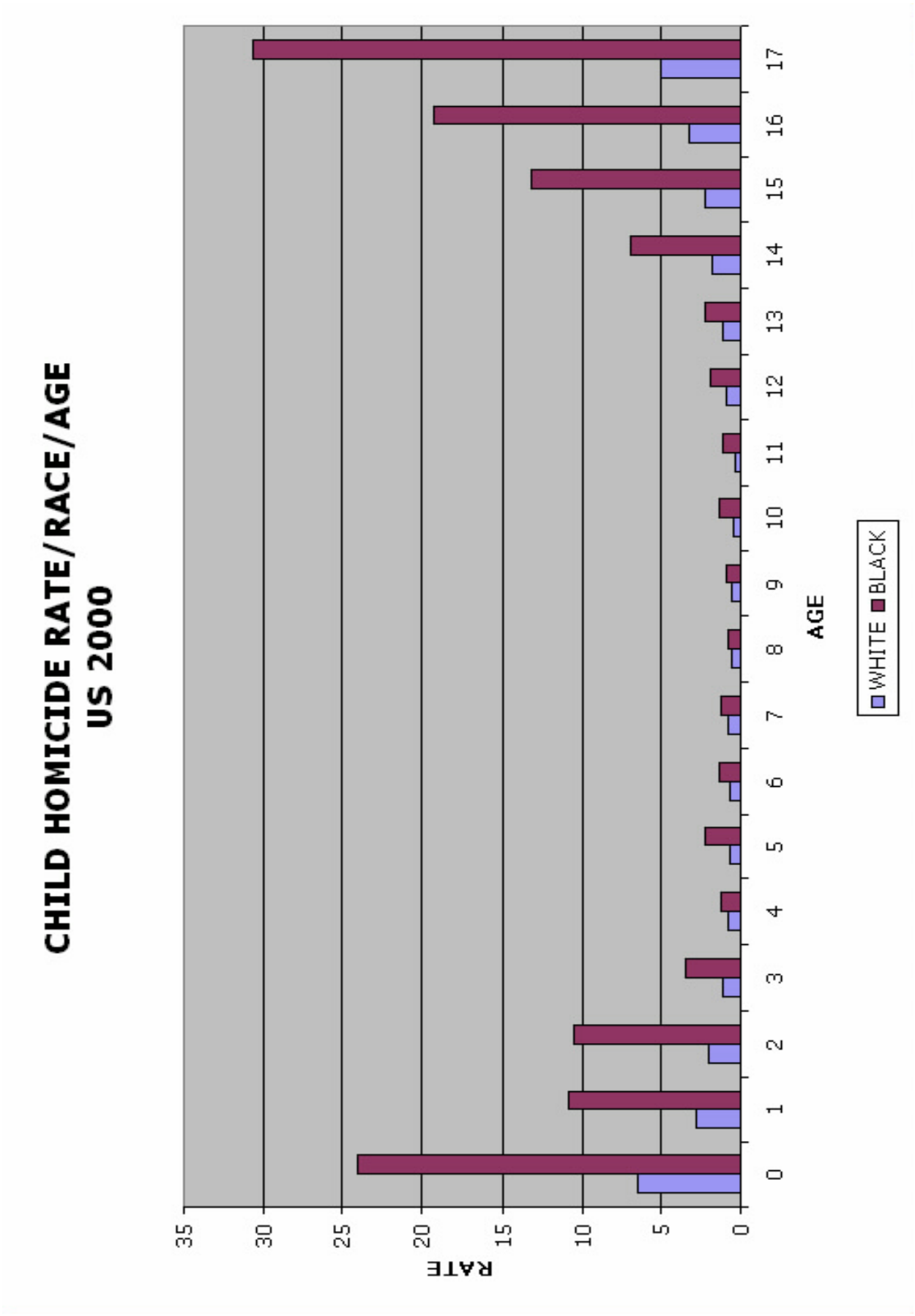
State	1999 [1]	2000 [1]	2001 [1]	Ave/Year	2000 Total Births[2]	infant homicide rate*100000
Alaska	2	5	2	3.00	9974	30.08
DC	2	2	0	1.33	7666	17.39
South Dakota	2	2	0	1.33	10345	12.89
Vermont	1	0	1	0.67	6500	10.26
Wyoming	0	1	1	0.67	6253	10.66
New Hampshire	1	2	1	1.33	14609	9.13
Montana	1	1	1	1.00	10957	9.13
North Dakota	1	0	0	0.33	7676	4.34
Delaware	0	0	1	0.33	11051	3.02
Rhode Island	0	1	0	0.33	12505	2.67
Maine	1	0	0	0.33	13603	2.45
Total US	**11**	**14**	**7**			

[1] Centers for Disease Control and Prevention. WISQARS Injury Mortality Reports, 1999-2001, Death Counts Only. National Center for Injury Prention and Control, CDC (producer). Retreived 16 May 2004

[2] Martin, Joyce A., Hamilton, Brady E., et al. "Births: Final Data for 2000." National Vital Statistics Reports; vol. 50 no. 5. February 2002. Retrieved 16 May 2001


HOMICIDE RATE UNITED STATES
AGE/YEAR
Rate
25
20
15
10
5
0
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
Year
0
17


Child Homicide Rate, Gender/Age
United States 2000
Michael Durfee MD, 11/25/02
Rate
16
14
12
10
8
6
4
2
0
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
Age (Years)
Male
Female


CHILD HOMICIDE RATE/RACE/AGE
US 2000
RATE
0
5
10
15
20
25
30
35
AGE
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
WHITE
BLACK