ICAN

Inter-Agency Council on Child Abuse and Neglect

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Child Death Review Team

Report For 2006








ICAN

Report Compiled From 2005 Data

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Introduction

The ICAN Multi-Agency Child Death Review Team was formed in 1978 to review child deaths in which a caregiver was suspected of causing the death. Over the past 28 years, the activities of the Team have expanded to include review and statistical analysis of child and adolescent suicides, accidental deaths, and undetermined deaths.

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

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

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

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

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

This annual report of the ICAN Child Death Review Team provides information on *all* children's deaths that meet Team protocol and occurred in Los Angles County during 2005. It provides a detailed analysis of children killed by caregivers, youth suicides, accidental deaths and undetermined deaths. This

report also contains recommendations for action, which, if implemented, should improve child safety and save lives.

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FINDINGS

HOMICIDES

- There were 33 child homicides by parents, caregivers or family members in 2005. This is a 10% increase from the 30 such child homicides in 2004, but significantly lower than the 15-year average of 42 homicides per year.

- Seventy-nine percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is a decrease from 2004, when 83% of the children were five years of age or younger.

- Seven children were over age 5, including two eight-year olds, one nine-year old, one ten-year old, one 15-year old, one 16-year old and one 17-year old.

- The average age of a child homicide victim in 2005 was 3.42 years (41.09 months). The average age of a child homicide victim in 2004 was 2.63 years (31.60 months).

- Fifteen female children and 18 male children were victims of homicide by parents, caregivers or family members in 2005.

- Eight children died from multiple trauma, six from head trauma and two from trauma to the torso/abdomen. These include children who were victims of battered child syndrome. Six children were victims of gunshot wounds, five children died from asphyxiation, two children were victims of a stabbing, two children died from drowning – (one child was left unattended in a bathtub and the second was placed in a washing machine), one child's charred body was found in an arson-related fire and the cause of death was undetermined after autopsy, and one infant died after being left unattended in a trash dumpster.

- Four newborns were abandoned and found deceased and/or killed by their mothers in 2005. Two of these deaths were moded homicide by the Coroner, which represents 6% of the total number of child homicides by a parent, caregiver or other family member. Eight newborns were safely surrendered in 2005.

- African-American (n=9) children were over-represented in child homicides by parents, caregivers or family members. Fourteen children were of Hispanic descent, six children were Caucasian, three were Asian/Pacific Islander and one child was designated as Middle Eastern.

- Fourteen children were killed by their father or mother's boyfriend, six children were killed by their mother, and four children by both parents (these include a mother and her boyfriend). Five children were killed by a relative, three

children were killed by a sibling and one child was killed by a family member but the familial relationship was not identified.

SUICIDES

- Fifteen children and adolescents committed suicide in 2005. This is a 15% increase from the 13 such suicides in 2004 but significantly lower than the 15-year average of 23.87 suicides per year.

- As in years past, male victims outnumbered female victims by a wide margin. Eleven males and four females committed suicide in 2005.

- The leading method was death due to hanging, which represents 53% (n=8) of the suicides in 2005. Firearms were the second most frequent method of suicide in 2005; 27% (n=4) of the adolescents committed suicide by using firearms in 2005. In addition to hanging and firearm suicides in 2005, one adolescent who was visiting from out-of-state, jumped from an upper floor of a hotel after drinking alcohol, another adolescent died of carbon monoxide poisoning when he placed a portable barbecue inside a closed vehicle. Finally, a 17-year old girl overdosed on medication.

- Eighty percent of the children who committed suicide in 2005 were ages 15 – 17; three victims were under age 15, and the youngest victim was age 12. In comparison, in 2004, five victims were under age 15 and the youngest victims (n=2) were age 12. The youngest victim reviewed by the Team was age 9 in 2001.

- Suicides by Hispanics represent 67% of the total number of adolescent suicides in 2005; they increased 43% from 7 in 2004 to 10 in 2005. Thirteen percent (n=2) of adolescent suicides were committed by Caucasians in 2005, which represents a 33% decrease from 2004 (n=3). Suicides by African-Americans increased from 1 in 2004 to 2 in 2005 and suicides by Asian/Pacific Islanders decreased from 1 in 2004 to 0 in 2005. Finally, one youth who committed suicide in 2005 was designated as Middle Eastern.

- In 2005, there were three adolescent suicides each in April and May accounting for 40% of the suicides. There were 2 suicides per month in March and July. In five months, August, September, October, November and December, there was one suicide per month and in the months of January, February and June there were no adolescent suicides.

ACCIDENTAL CHILD DEATHS

- There were 100 accidental deaths of children ages 0 through 14 years in 2005. This is a 9% decrease from the 110 such deaths for this age group reported for 2004.

- For the third year in a row, deaths due to automobile accidents (n=21) was the leading cause of accidental death for children 14 years of age and under. These data represent both auto v auto and auto solo accidents. Autopedestrian accidents (n=20) was the second leading cause in 2005. These data include four boys (ranging from 9 years of age to 17 years of age) who were struck by a car while riding their bicycle. Deaths associated with maternal substance abuse (n=18) ranked third and drowning accidents (n=12) ranked fourth.

- ICAN began collecting data on children ages 15 – 17 for calendar year 2002. With the inclusion of this older age group, there were 140 accidental deaths (children ages 0 through 17) in 2005, and the leading cause of accidental death was automobile accidents (n=44). Children ages 15 to 17 accounted for 52% (n=23) of automobile related deaths in 2005.

- Deaths associated with maternal substance abuse accounted for 10 fetal deaths and 5 deaths of infants up to just under age 6 months. Methamphetamine is the drug associated with most of these deaths (n=8), followed by cocaine (n=4). Deaths associated with maternal substance abuse accounted for 11% of all accidental deaths in 2005, and fetal deaths associated with maternal substance abuse accounted for approximately 7% of all accidental deaths.

- Accidental drowning claimed the lives of 13 children ages 0 – 17 in 2005; a 50% decrease from 2004 when drowning claimed the lives of 24 children. A majority of these drowning deaths were young children who drowned in residential pools or spas. In addition, one boy lost his footing and fell into a creek, another boy drowned while swimming in a dam and two children died in a wash – one when her mother intentionally drove around barricades into swift rising water and the other, a two-year old girl, who was at the water's edge when her uncle let go of her hand to answer his cell phone.

- Hispanic children represented 52% (n=73) of all accidental child deaths in 2005. They were over-represented in drowning deaths (n=10) and in deaths associated with maternal substance abuse (n=9). Caucasian children represented 21% (n=29) of the accidental deaths. Thirty-one percent (n=9) of the accidental child deaths of Caucasians were related to automobile accidents and 21% of the deaths were due to autopedestrian accidents. African-American children (n=19) were slightly over-represented in accidental deaths in 2005. Thirty-two percent of the deaths were automobile fatalities

and 16% (n=3) were autopedestrian accidents. There were 16 deaths of Asian/Pacific Islander children in 2005. They were slightly over-represented in automobile accidents (n=5 auto v auto and n=2 auto solo) and in fire-related deaths (n=5).

- In 2005, 76 male children and 64 females died due to accidental death, which is almost a 5:4 ratio. In comparison, in 2004, 90 male children and 57 females died due to accidental death, which was almost a 3:2 ratio.

- In 2005, male children were over-represented in certain types of accidental deaths in comparison to female children. These include autopedestrian accidents in which 17 male children lost their lives as opposed to 10 female children; and hanging/strangulation deaths, in which 3 male children lost their lives due to this type of accident versus 0 female children. Both genders were equally represented in auto solo-related accidents (n=13 male and n=13 female).

UNDETERMINED CHILD DEATHS

- There were 109 undetermined child deaths in 2005. This is a 30% increase from the 84 such deaths in 2004 and significantly higher than the 15-year average of 44.6 undetermined deaths per year.

- African-American (n=28) children were over-represented in undetermined child deaths. Fifty-six children were Hispanic, 18 were Caucasian, and five were of Asian/Pacific Islander descent. One infant was designated as Middle Eastern and one aborted fetus was of unknown descent.

- Twenty-three percent (n=25) of the undetermined child deaths had a noted status of post co-sleeping. In comparison, in 2004, 43% of the undetermined deaths were associated with co-sleeping.

- Fifty-two percent (n=13) of the co-sleeping related deaths were infants between 0 to 3 months of age, 32% (n=8) were infants between 3 to 6 months of age, and 16% (n=4) were infants between 6 to 9 months of age.

- In 56% (n=14) of the undetermined deaths associated with co-sleeping, the infant was sleeping with one adult; eight of these infants were sleeping with the mother, four with the father, one with a foster mother and one with a grandfather. Nine infants were sleeping with two adults, one infant was sleeping with two adults and one sibling, and one infant was sleeping with one adult and another child.

RECOMMENDATIONS

Recommendation One: Expansion of the Legislative Authority for the Child and Adolescent Suicide Review Team

That the Office of County Counsel work with the ICAN Child and Adolescent Suicide Review Team (CASRT) to explore the drafting of legislation to allow Team review of deaths of young people through age 24 who have committed suicide.

Rationale: PC §11174.32 gives authority for the establishment of Child Death Review Teams in order to prevent child maltreatment and child abuse related fatalities. Based on this authority, the ICAN Child Death Review Team, established in 1978, reviews child abuse homicide deaths and other child deaths that appear suspicious in nature. In 2001, ICAN established a separate team - the Child and Adolescent Suicide Review Team (CASRT) in order to review cases of minor children who have committed suicide. This Team reviews suicide deaths of young people through age 17. To increase prevention efforts, the CASRT wants to expand its authority to review suicide deaths of young people through age 24. The California Strategy for Suicide Prevention recommends that counties review cases of suicides across the age span. The Mental Health Services Act recognizes that youth, ages 15 to 24, deemed "transition age youth," are a high-risk population. By reviewing these deaths, the Team could gain insight into where prevention efforts should focus their resources for this age group. Additionally, the Team could collaborate/share information with University level academic institutions to better serve young people after they matriculate into college. Legislative authority to establish similar review teams can be found in PC §11174.5 which authorizes the creation of elder abuse review teams, and PC §11163.3, which authorizes the creation of domestic violence death review teams. These code sections allow counties to review adult cases posthumously where the death involved elder abuse or domestic violence respectively.

Recommendation Two: Planning For the Care of Newborns Born to Incarcerated Women

The State Department of Corrections should consider developing a standard protocol for the release of infants born to inmates. The protocol should ensure that the Department of Corrections contacts the child protective services agency in the county in which the caregiver and child will reside and that they work in conjunction to engage the potential caregiver in a voluntary assessment of his or her home.

Rationale: The Los Angles County Child Death Review Team has recently reviewed several cases in which a child born to a prisoner under the supervision of the Department of Corrections was released to a caregiver without

investigation or evaluation of the caregiver's suitability to care for the infant. Requesting that the Department of Corrections work in conjunction with a child protective services agency to seek approval for a voluntary assessment of the potential caregiver's background and residence would help to ensure that children are placed in a safe home environment. The Department of Corrections should contact the Child Protective Services agency in the county where the infant and caregiver will reside to inform them of the infant's placement and request assistance in efforts to assure the child's safety and well-being.

Selection of Cases for Team Review

The Coroner must designate the manner of death to be listed on the death certificate as either: Homicide, Accident, Natural, Suicide or Undetermined. This report, as have the past Team reports, utilizes the Coroner's classification scheme to group the manners of child death in the County.

Homicides, by Coroner's definition, are deaths at the hands of another. Child deaths in which the suspected perpetrator is a parent, caregiver or family member, meet the Team protocol for possible review. All such cases are included in the ICAN annual Team report. Homicide by parent/caregiver/family member is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term "homicide" regardless of the criminal intent of the perpetrator or the findings of the criminal justice system. Homicide may describe circumstances ranging from tragedies that involve no clear intent, to vicious, fatal attacks with clear intent.

Accidental deaths continue to be the largest category of deaths reported to the Team by the Coroner. Several types of accidental death, such as drownings, autopedestrian fatalities, suffocations and accidental gunshot wounds, are truly unintentional in nature. However, there may be questions of caregiver supervision in some of these cases, as well as concern regarding the preventability of these accidents. A significant number of the accidental deaths involve newborns who were prenatally exposed to drugs and who subsequently died of prematurity or other related perinatal causes. The relationship between precipitous drug-induced delivery of newborns and child maltreatment fatalities has generated much discussion and concern on the part of the Team.

Natural deaths are rarely reported to the Team and, as such, are not included in the Team's annual report.

Suicide, by Coroner's definition, is death of self caused with intent. Suicides of children and adolescents are reported to the Team as a special population. The Team recognizes that suicide, most often in and of itself, is not a result of child abuse and neglect. However, the ability of the Team to collect information on these deaths from multiple agencies is of benefit in better identifying these high-risk youth for prevention purposes. For this reason, a separate Team, the Child and Adolescent Suicide Review Team, was created in 2001 to review these cases.

Undetermined deaths reflect situations in which the Coroner is unable to fix a final mode of death. These cases often involve insufficient or conflicting information which impacts the Coroner's ability to make a final determination. Usually, there is no clear indicator in these cases whether the death was intentionally caused by another or was accidental. These cases remain suspicious in nature and are of interest to the Team because a final

determination cannot be made by the Coroner. Undetermined death cases include perinatal demise of an undetermined cause, which may be child maltreatment related if the infant was left exposed or unattended as is the case with abandoned deceased infants. However, the Coroner may be unable to determine if the exposure caused the death or if the death was due to some other cause. Additionally, a significant portion of the undetermined deaths have a noted status of “post co-sleeping.” In these cases the Coroner is unable to determine the role that the co-sleeping may have played in the death, e.g., suffocation by accidental layover or some other cause.

Team Accomplishments

In 2004-05, the ICAN **Multi-Agency Child Death Review Team (CDRT):**

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

2. Participated in a daylong retreat for Team representatives to discuss and improve Team review process issues.

3. Began development of a new member resource guide to help new members become acquainted with Team protocols.

4. Developed policy and procedure recommendations for the prevention of future child deaths. These recommendations included requesting Los Angeles County law enforcement agencies to file death reports for stillborn deaths associated with prenatal drug exposure and asking the Los Angeles County Department of Health Services (DHS) to provide a status report to the Team regarding their progress in implementing a public information campaign on safe sleeping practices.

5. Worked with Team representatives to engage in a thorough examination of cross-reporting compliance by child protective services staff and law enforcement.

6. Reviewed and updated Team confidentiality guidelines to ensure the appropriate handling of case specific information from multiple agencies involved in the review process.

7. Worked with the Los Angeles County Child Abuse Councils Project Coordinator to create a poster that provided information for the public as to actions that could be taken in the event someone should witness or suspect child abuse. These posters were distributed and posted countywide.

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

In 2004-05, the ICAN **Child and Adolescent Suicide Review Team (CASRT):**

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

2. Continued to work with the Los Angeles County Child Abuse Councils and the Los Angeles County Sheriff's Department to produce primary and secondary prevention informational wallet-sized suicide resource cards. These cards, available in three languages – English, Spanish and Korean, are updated annually and available in two formats – prevention cards which list the signs of depression, and postvention cards, which list the grief process stages. Both cards include LA County suicide prevention hotlines and resources.

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

4. Supported mental health/suicide prevention screening activities in a local school district. This effort utilized a nationally recognized screening tool that was administered to school students to help identify youth who might be at risk for suicide. The effort began in 2005 and has successfully screened over 150 youth. At-risk youth are then referred for secondary prevention services.

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

6. Worked with Los Angeles County Counsel to spearhead the drafting and passage of a Joint Resolution (AJR 22) to encourage the amending of the Family Educational Rights and Privacy Act (FERPA) so as to strengthen the legislative authority for Child Death Review Teams, including the CASRT, and to enable child death review teams to have access to public school student records and allow school personnel to share information with these Teams without parental consent.

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

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

9. Established the Educators' Suicide Prevention Network (ESPN), a unique partnership of secondary school and university counselors and psychologists formed for the purpose of collecting data and developing joint data-driven suicide outreach and prevention activities.

10. Helped to save lives through Team intervention activities. For instance, while preparing for a presentation about a popular website among youth, a Team member discovered a blog detailing a teenager's suicidal ideation on the Website. As a result of this person's involvement with the Team, a staff person at the student's school was contacted and the school was able to intervene in a timely manner.

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

Child Death in Los Angeles County

Over the past 5 years, an average of 34 children each year have *been killed by a parent, caregiver or other family member*.

2001	35
2002	37
2003	35
2004	30
2005	33

Over the past 5 years, an average of 18.6 children and adolescents each year have *committed suicide*. The leading method in 2002 and 2003 was gunshot wounds; in 2001, 2004 and 2005 the leading method was hanging.

2001	27
2002	19
2003	19
2004	13
2005	15

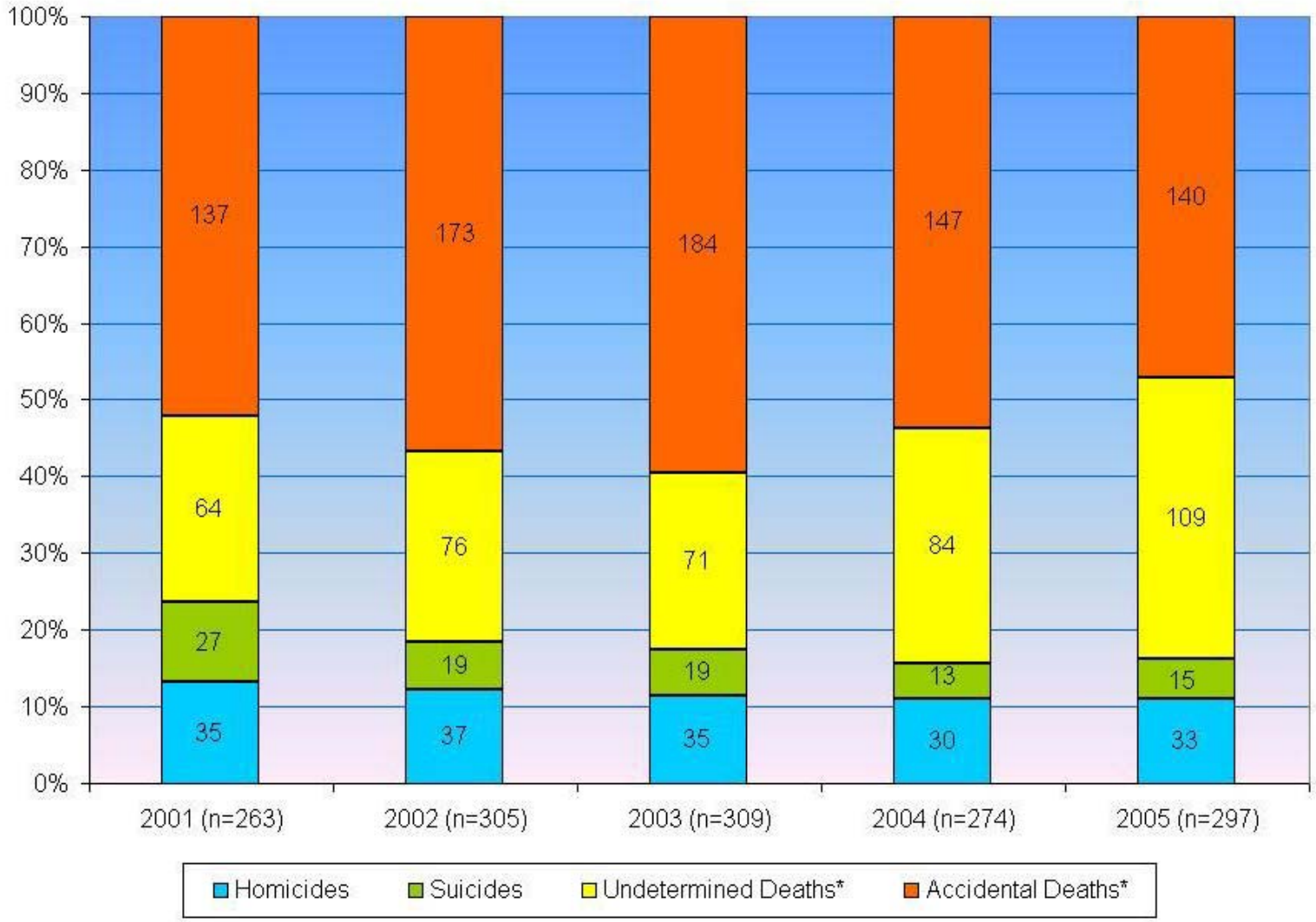
Over the past 5 years, an average of 124.2 children age 14 and younger have died from preventable accidents. The most common accidental deaths involve automobile accidents, deaths due to maternal substance abuse, autopedestrian accidents and drowning.

2001	137
2002	127
2003	147
2004	110
2005	100

Over the past 5 years, the number of undetermined deaths has averaged 80.8 per year.

2001	64
2002	76
2003	71
2004	84
2005	109

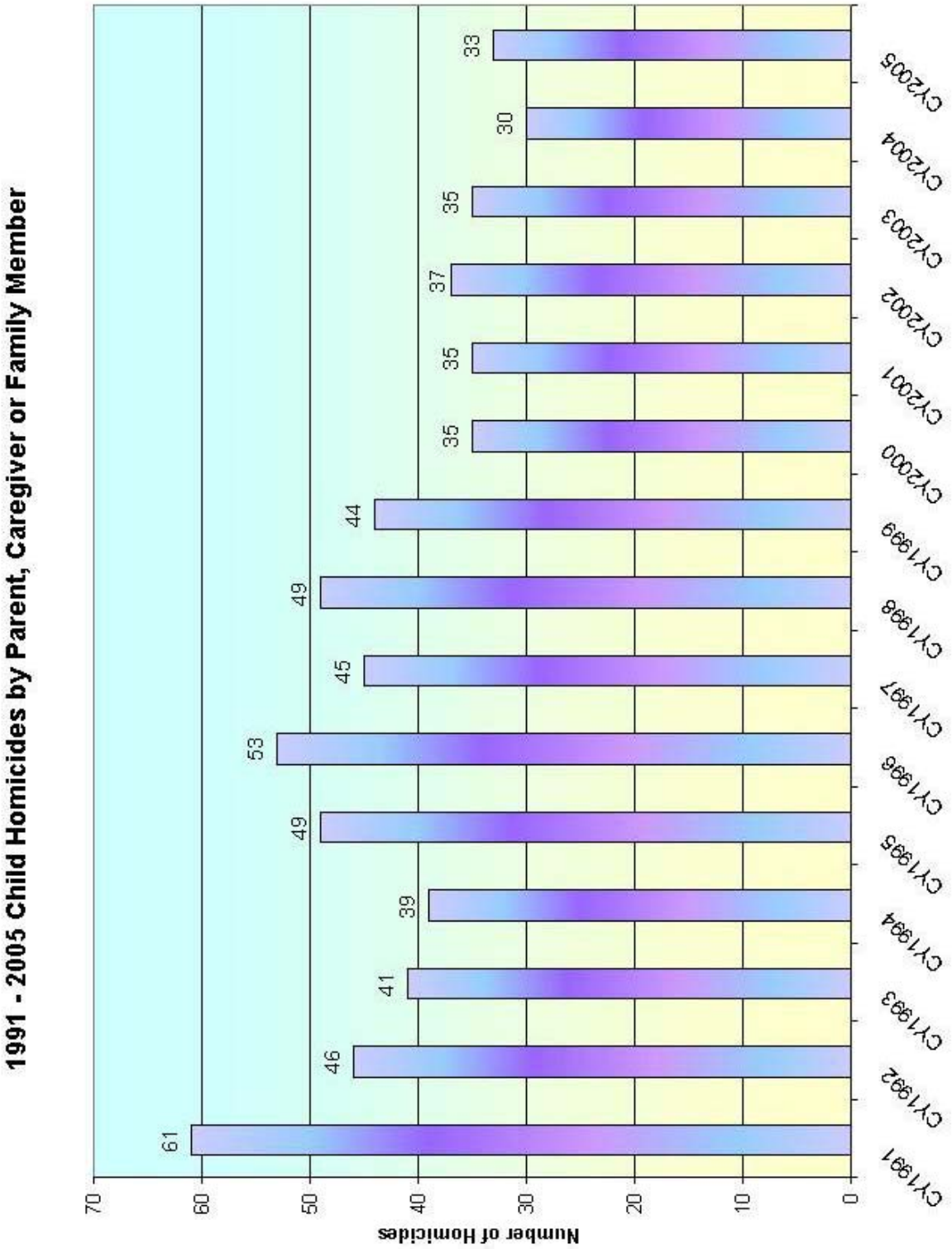
Child Death in Los Angeles County 2000 - 2005



*Undetermined and accidental deaths were captured:
Age 0 - 14 (except accidental drowning deaths through age 17) in 2001.
0 - 17 from 2002 on.

CHILD HOMICIDES BY PARENTS, CAREGIVERS OR OTHER FAMILY MEMBERS

1991 – 2005


1991 - 2005 Child Homicides by Parent, Caregiver or Family Member
Number of Homicides
0
10
20
30
40
50
60
70
61
46
41
39
49
53
45
49
44
35
35
37
35
30
33
CY1991
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
CY2003
CY2004
CY2005

CAUSES OF CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS
1991 – 2005, Los Angeles County

	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	05	Total
Head Trauma	23	16	14	17	19	15	12	13	15	5	5	2	7	7	6	**176**
Multiple Trauma	7	9	7	7	10	7	10	8	10	11	7	7	10	7	8	**125**
Gunshot Wounds	5	3	2	2	4	4	7	10	4	3	2	1	4	3	6	**60**
Trauma to torso/abdomen	7	3	3	6	2	5	4	2	1	0	0	3	0	0	2	**38**
Asphyxiation/suffocation	1	2	1	0	4	4	4	3	6	3	8	5	6	5	5	**57**
Drowning	5	2	1	1	4	0	2	2	0	3	1	7	1	1	2	**32**
Fire	0	3	1	0	3	8	0	4	0	1	0	0	0	0	0	**20**
Strangulation	4	1	1	1	0	2	2	1	0	0	0	0	0	0	0	**12**
Poisoning/drug ingestion	1	1	6	1	0	2	0	0	0	0	3	6	1	1	0	**22**
Stabbing	2	3	1	0	0	2	0	2	1	4	1	2	0	3	2	**23**
Unattended newborn	3	1	0	1	1	0	1	3	4	2	3	2	3	0	1	**25**
Undetermined/Unknown	2	0	1	2	0	2	1	0	2	1	1	2	0	1	1	**16**
Dehydration/malnutrition	1	1	0	0	1	1	1	1	0	1	1	0	1	2	0	**11**
Neck compression	0	1	1	0	1	1	0	0	0	0	0	0	0	0	0	**4**
Medical neglect	0	0	2	1	0	0	0	0	0	1	2	0	0	0	0	**6**
Burns	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0	**3**
Hyperthermia	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	**2**
TOTAL	**61**	**46**	**41**	**39**	**49**	**53**	**45**	**49**	**44**	**35**	**35**	**37**	**35**	**30**	**33**	**632**

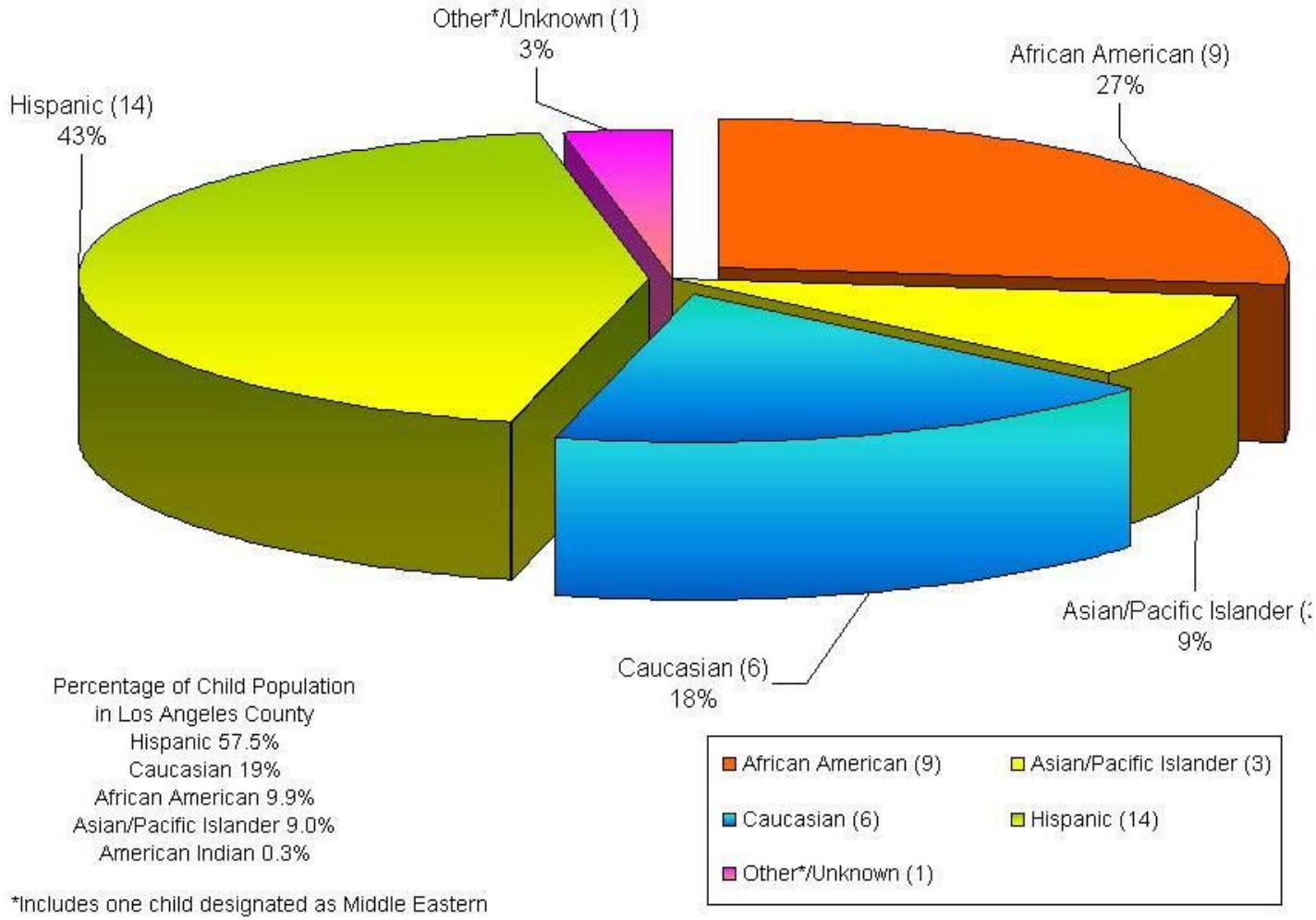
CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS
LOS ANGELES COUNTY – 2005 (N = 33)

Age	Female	Male
Under 1	4	10
1 year	1	3
2 years	2	0
3 years	3	2
4 years	1	0
5 years	0	0
6 years	0	0
7 years	0	0
8 years	1	1
9 years	1	0
10 years	1	0
11 years	0	0
12 years	0	0
13 – 17 years	1	2
Total	15	18

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

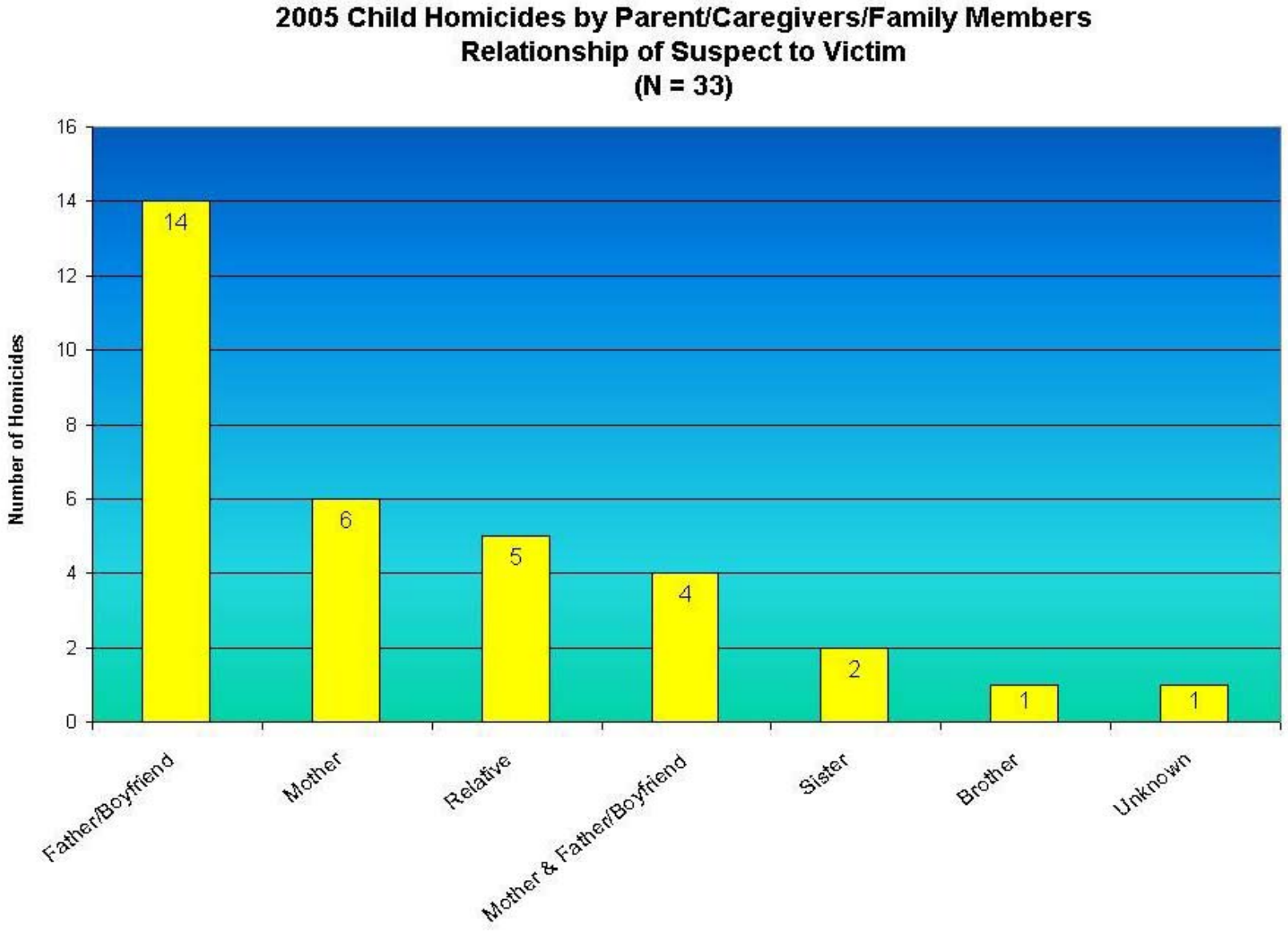
79 % of the child homicides by parents/caregivers/family members were 5 years of age or under.

2005 Child Homicides by Parent, Caregiver or Family Member - Race



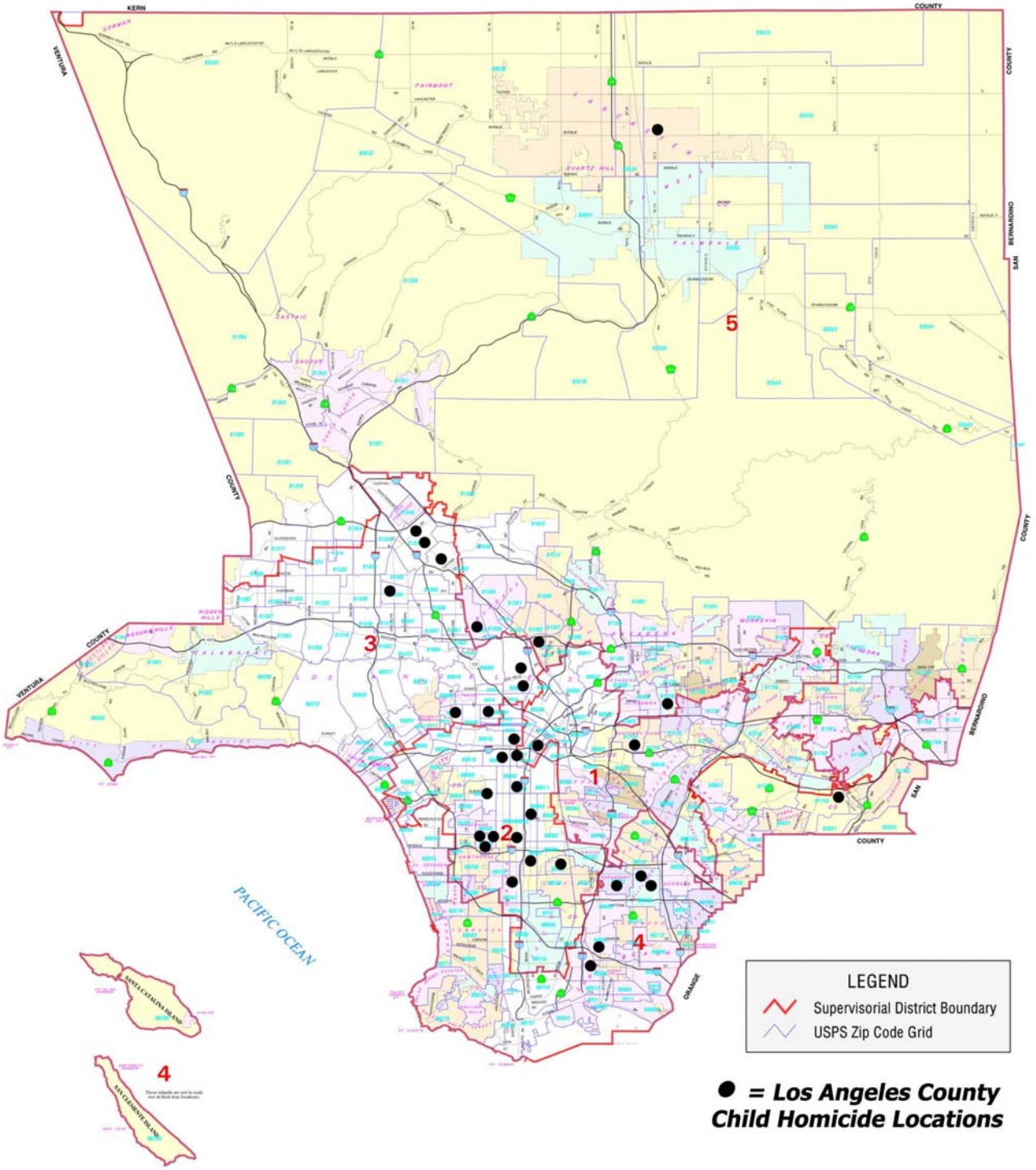
Percentage of Child Population
in Los Angeles County
Hispanic 57.5%
Caucasian 19%
African American 9.9%
Asian/Pacific Islander 9.0%
American Indian 0.3%

*Includes one child designated as Middle Eastern


2005 Child Homicides by Parent/Caregivers/Family Members
Relationship of Suspect to Victim
(N = 33)
Number of Homicides
16
14
12
10
8
6
4
2
0
14
6
5
4
2
1
1
Father/Boyfriend
Mother
Relative
Mother & Father/Boyfriend
Sister
Brother
Unknown

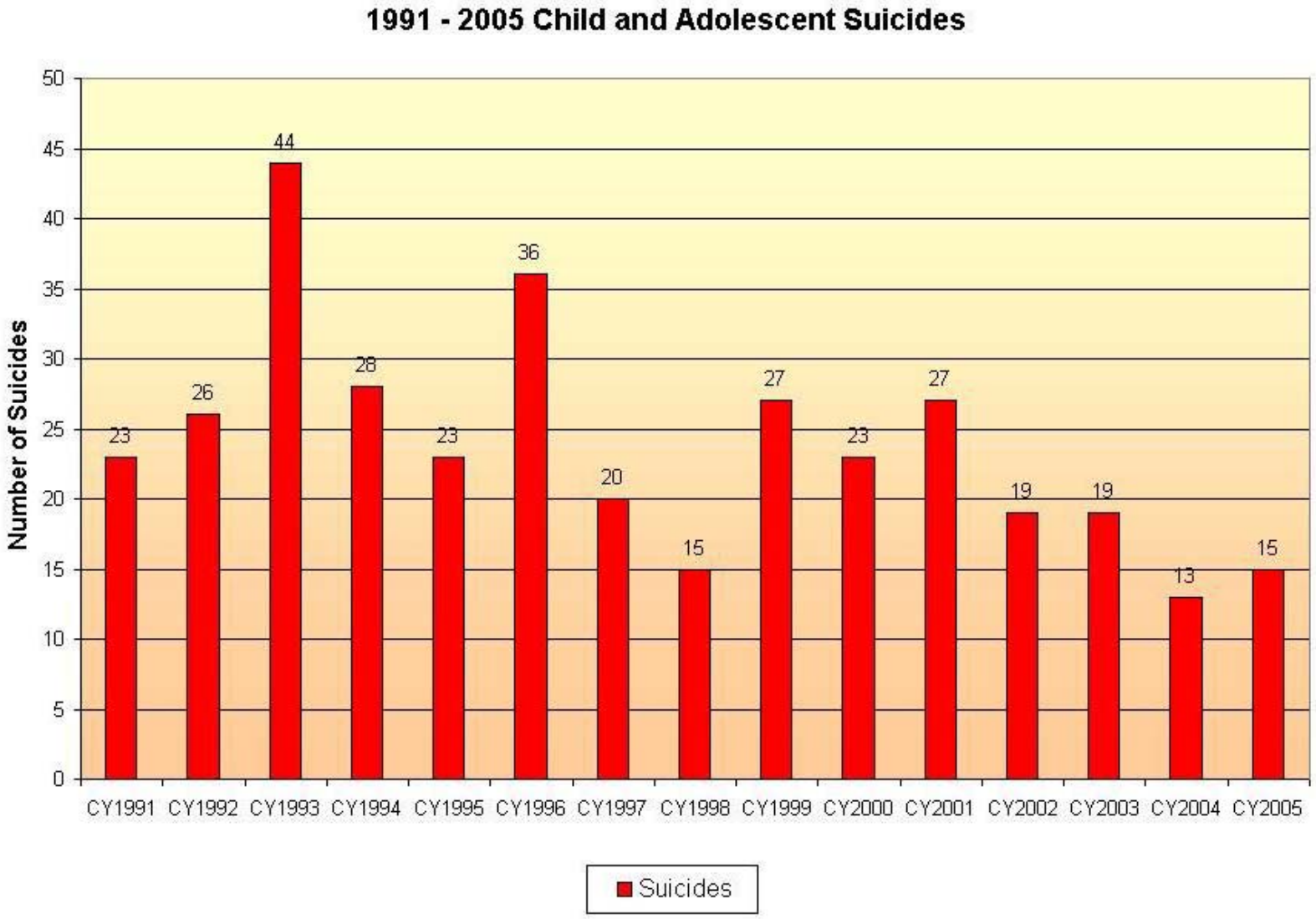
2005 Child and Adolescent Homicides - Location

n = 33



CHILD AND ADOLESCENT SUICIDES

1991 – 2005


1991 - 2005 Child and Adolescent Suicides
Number of Suicides
50
45
40
35
30
25
20
15
10
5
0
23
26
44
28
23
36
20
15
27
23
27
19
19
13
15
CY1991
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
CY2003
CY2004
CY2005
Suicides

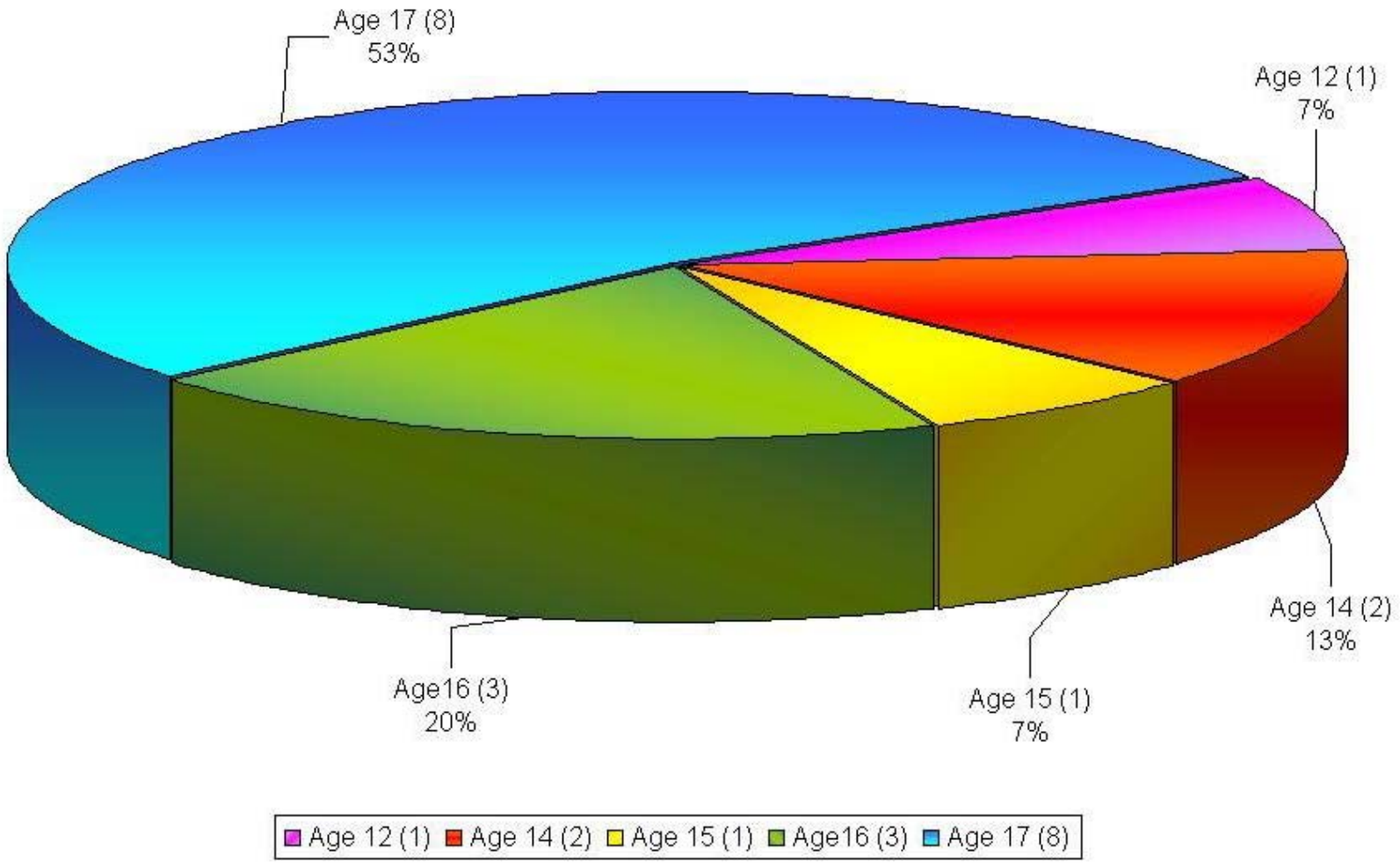
CHILD AND ADOLESCENT SUICIDES
BY METHOD AND GENDER
LOS ANGELES COUNTY – 2005 (N = 15)

Method	Male	Female
Hanging	5	3
Firearms/Gunshot	4	0
Overdose	0	1
Poisoning	1	0
Jumping	1	0
Total	11	4

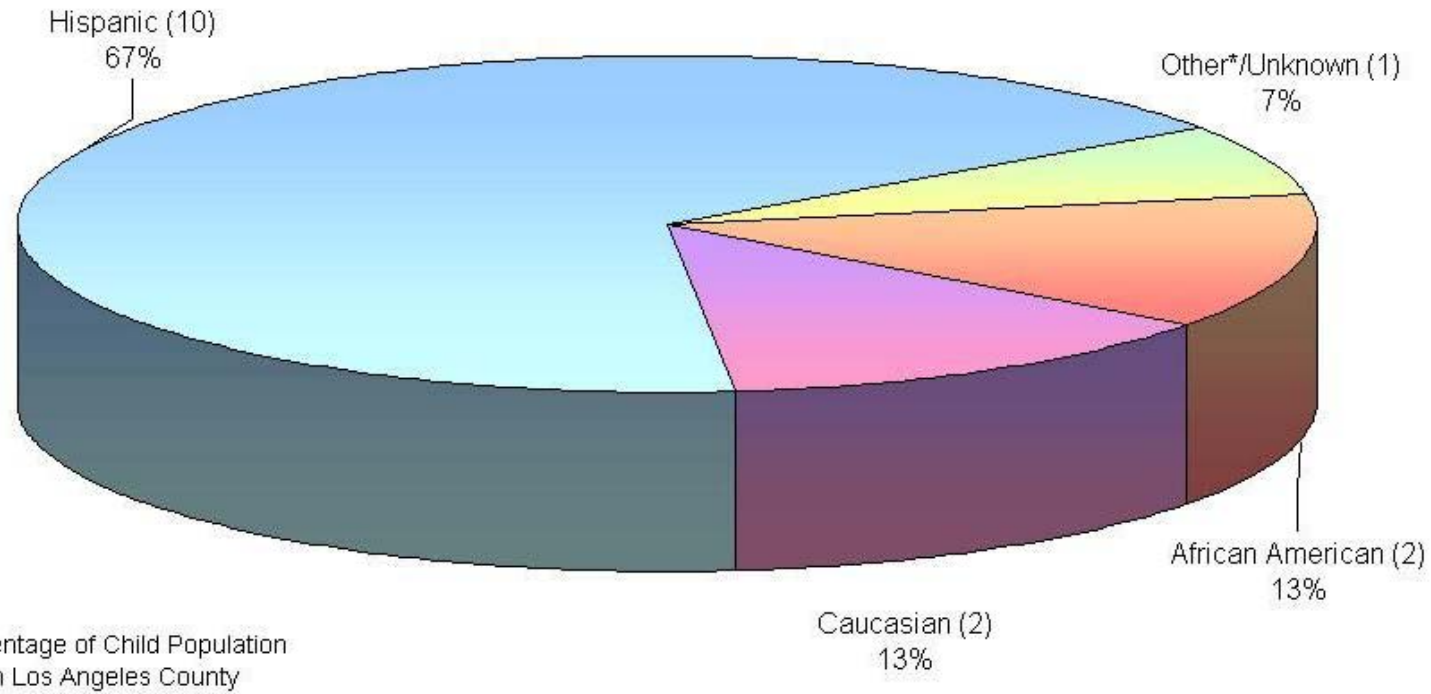
Hanging was the most frequent cause of suicide among adolescents and represents 53% of the suicides in 2005. 27% of the male adolescents used firearms as the preferred method, making this the second most frequent cause of suicide in 2005.

In 2005, 73% (n=11) of the adolescent suicide victims were male. 27% (n=4) of the victims of adolescent suicide in 2005 were female.

2005 Child and Adolescent Suicides - Age

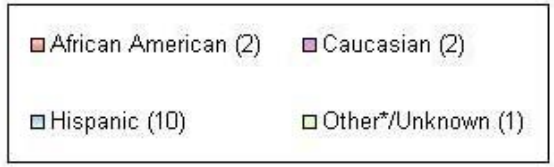


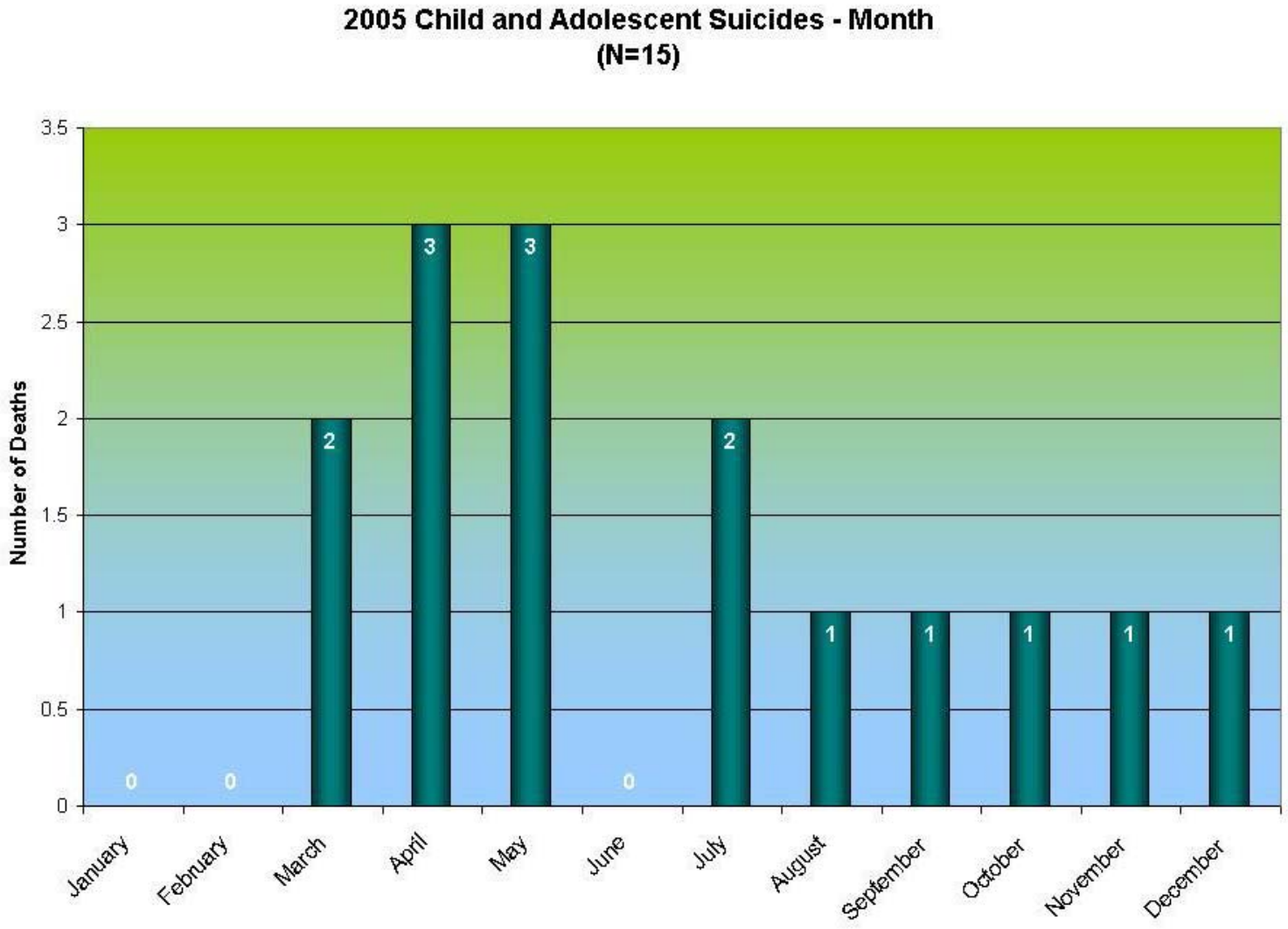
2005 Child and Adolescent Suicides - Race



Percentage of Child Population
in Los Angeles County
Hispanic 57.5%
Caucasian 19%
African American 9.9%
Asian/Pacific Islander 9.0%
American Indian 0.3%

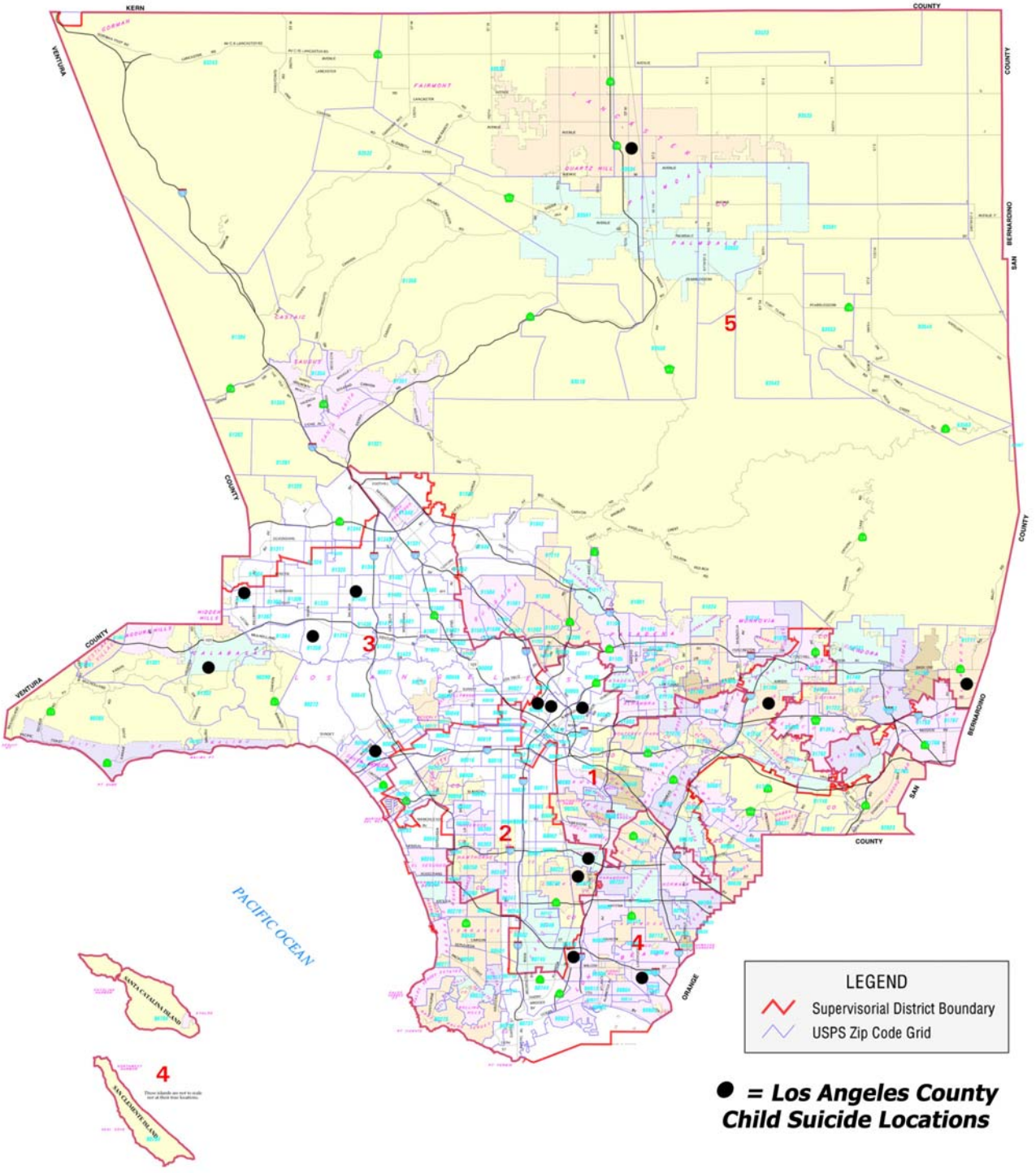
*Includes one child designated as Middle Eastern




2005 Child and Adolescent Suicides - Month
(N=15)
Number of Deaths
3.5
3
2.5
2
1.5
1
0.5
0
0
0
2
3
3
0
2
1
1
1
1
1
January
February
March
April
May
June
July
August
September
October
November
December

2005 Child and Adolescent Suicides - Location

n = 15



ACCIDENTAL CHILD DEATHS

1991 – 2005

CAUSES OF ACCIDENTAL CHILD DEATHS, AGES 0 –14
1991 – 2005, Los Angeles County

	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	Total
Drowning	32	25	40	35	31	18	28	21	25	23	28	16	19	21	12	**374**
Maternal drug abuse	23	17	23	10	9	25	24	38	21	22	24	25	32	21	15	**329**
Autopedestrian*					2	1	8	19	31	30	41	33	25	21	20	**231**
Automobile**									18	24	28	20	47	25	21	**183**
Falls	10	5	4	7	6	5	2	3	5	1	1	3	2	3	1	**58**
Choking	10	6	7	2	0	1	5	3	6	10	2	8	4	1	3	**68**
Suffocation	5	4	8	4	1	2	0	2	4	1	3	0	1	1	2	**38**
Poisoning	1	4	7	4	1	1	6	1	4	4	1	0	2	2	1	**39**
Fire	0	0	3	2	2	0	1	3	7	4	3	7	0	2	6	**40**
Hanging/strangulation	5	4	5	0	0	3	0	0	0	6	3	1	2	4	1	**34**
Medical misadventure	0	0	0	2	1	1	0	1	5	6	2	8	7	3	0	**36**
Chest/neck compression	0	3	3	3	1	2	1	2	0	1	0	0	3	0	0	**19**
Gunshot wounds	2	3	0	1	1	2	1	0	0	0	0	0	0	0	0	**10**
Crushed by object	0	0	0	0	2	0	3	2	1	1	0	1	0	1	5	**16**
Sports injury	0	0	0	0	0	0	2	0	2	2	1	0	0	0	1	**8**
Burns/Thermal Injury	2	1	1	0	0	0	0	0	1	0	0	1	0	1	0	**7**
Dog bites	0	0	0	0	1	0	1	0	1	1	0	0	0	0	1	**5**
Medical complications***	0	0	2	0	0	0	0	0	0	0	0	0	0	0	3	**5**
Perinatal asphyxia	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	**3**
Electrocution	0	0	0	0	0	0	2	0	0	1	0	0	1	0	1	**5**
Birth trauma	0	0	1	0	0	0	0	0	2	0	0	0	0	0	2	**5**
Hypothermia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Hyperthermia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	**2**
Airplane related	0	0	0	0	0	0	0	0	0	0	0	2	2	0	0	**4**
Train v. pedestrian	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	**2**
Elective abortion	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Forklift injury	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Drug intake/Overdose	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	**2**
Motor vehicle (not auto)****	0	0	0	0	0	0	0	0	0	0	0	0	0	4	1	**5**
Impaled	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**1**
TOTAL***	**90**	**73**	**104**	**70**	**59**	**61**	**86**	**95**	**134**	**137**	**137**	**127**	**147**	**110**	**100**	**1530**

*Autopedestrian deaths were not reported to the Team prior to 1995. **Automobile deaths were not referred to the Team prior to 1999. ***Data in this category was previously included in other categories, e.g, aspiration of stomach, etc. ****These include minibikes, dirt bikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs). *****The totals for years 1994 to 2001 have been slightly adjusted from the 2005 report.

CAUSES OF ACCIDENTAL CHILD DEATHS, AGES 0 – 17
2005 - Los Angeles County
(N=140)

Automobile – multi-vehicle	18
Automobile – solo vehicle	26
Autopedestrian	27
Birth Trauma	2
Choking	4
Crushed by object	5
Dog bites	1
Drowning	13
Drug intake	3
Electrocution	1
Falls	2
Fire	6
Gunshot wounds	1
Hanging/Strangulation	3
Hyperthermia	2
Impaled	1
Maternal drug abuse	15
Medical complications	4
Motor vehicle other than auto*	1
Poisoning	1
Sports Injury	1
Suffocation	2
Train v pedestrian	1
Total	**140**

*Category includes minibikes, dirt bikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

CAUSES OF ACCIDENTAL CHILD DEATHS BY AGE 2005 - Los Angeles County (N=140)

	Age 0 – 5 years	Age 6 – 14 years	Age 15 – 17 years
Automobile – multi-vehicle	6	4	8
Automobile – solo vehicle	5	6	15
Autopedestrian	8	12	7
Birth Trauma	2	0	0
Choking	1	2	1
Crushed by object	3	2	0
Dog bites	1	0	0
Drowning	11	1	1
Drug intake	0	0	3
Electrocution	0	1	0
Falls	1	0	1
Fire	0	6	0
Gunshot wounds	0	0	1
Hanging/Strangulation	0	1	2
Hyperthermia	1	1	0
Impaled	0	1	0
Maternal drug abuse	15	0	0
Medical complications	1	2	1
Motor vehicle other than auto*	0	1	0
Poisoning	0	1	0
Sports Injury	0	1	0
Suffocation	1	1	0
Train v pedestrian	0	1	0
Total	**56**	**44**	**40**

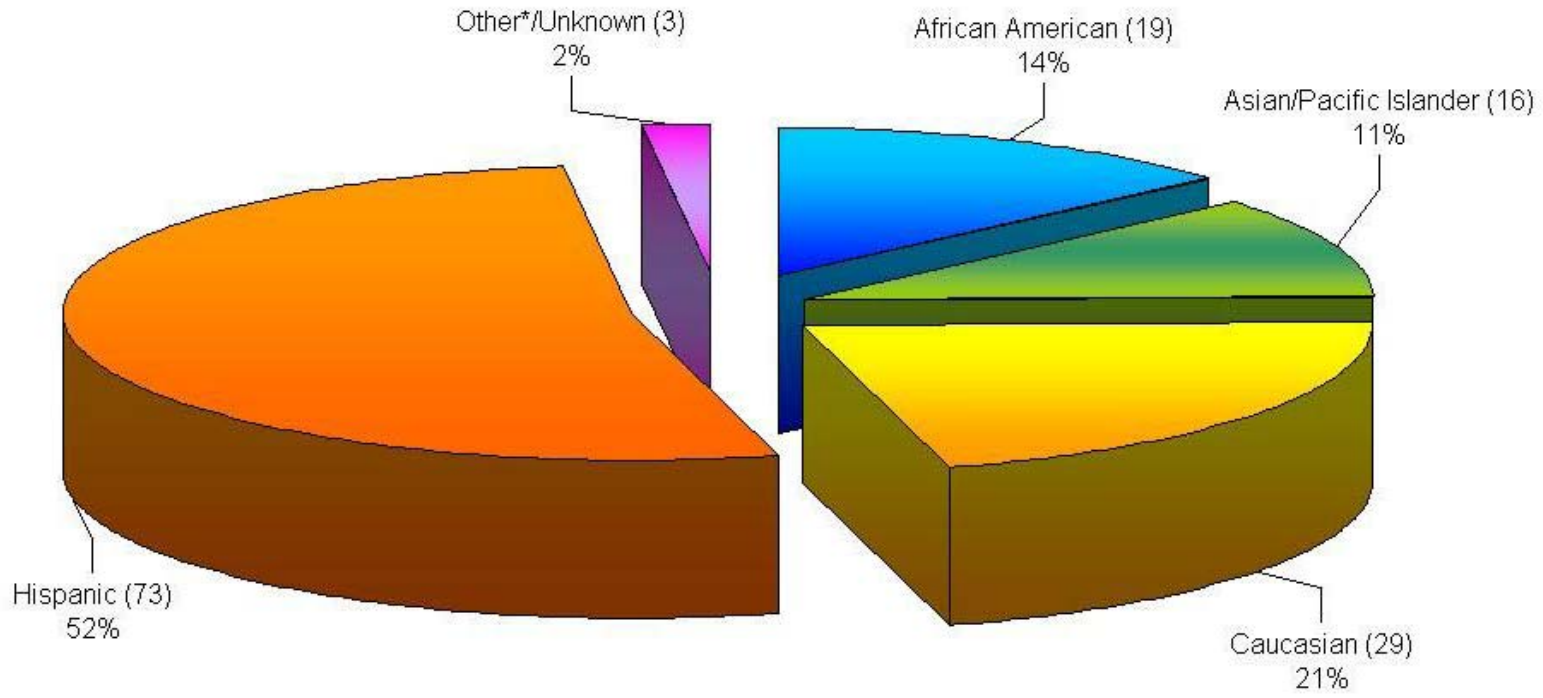
*Category includes minibikes, dirt bikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

RACE OF ACCIDENTAL CHILD DEATHS, AGES 0 – 17
Los Angeles County – 2005

	Hispanic	African-American	Caucasian	Asian/ Pacific Islander	Other*/ Unknown
Automobile – multi-vehicle	9	3	1	5	0
Automobile – solo vehicle	11	3	9	2	1
Autopedestrian	16	3	6	2	0
Birth Trauma	1	0	0	1	0
Choking	1	2	1	0	0
Crushed by Object	3	1	1	0	0
Dog bites	1	0	0	0	0
Drowning	10	2	0	0	1
Drug intake	0	1	2	0	0
Electrocution	0	0	0	1	0
Falls	2	0	0	0	0
Fire	1	0	0	5	0
Gunshot wounds	0	1	0	0	0
Hanging/Strangulation	2	0	1	0	0
Hyperthermia	1	1	0	0	0
Impaled	0	0	1	0	0
Maternal drug abuse	9	2	3	0	1
Medical complications	3	0	1	0	0
Motor vehicle other than auto*	0	0	1	0	0
Poisoning	1	0	0	0	0
Sports injury	0	0	1	0	0
Suffocation	1	0	1	0	0
Train v pedestrian	1	0	0	0	0
Total	**73**	**19**	**29**	**16**	**3**

*Includes two children designated as Middle Eastern
**Category includes minibikes, dirt bikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

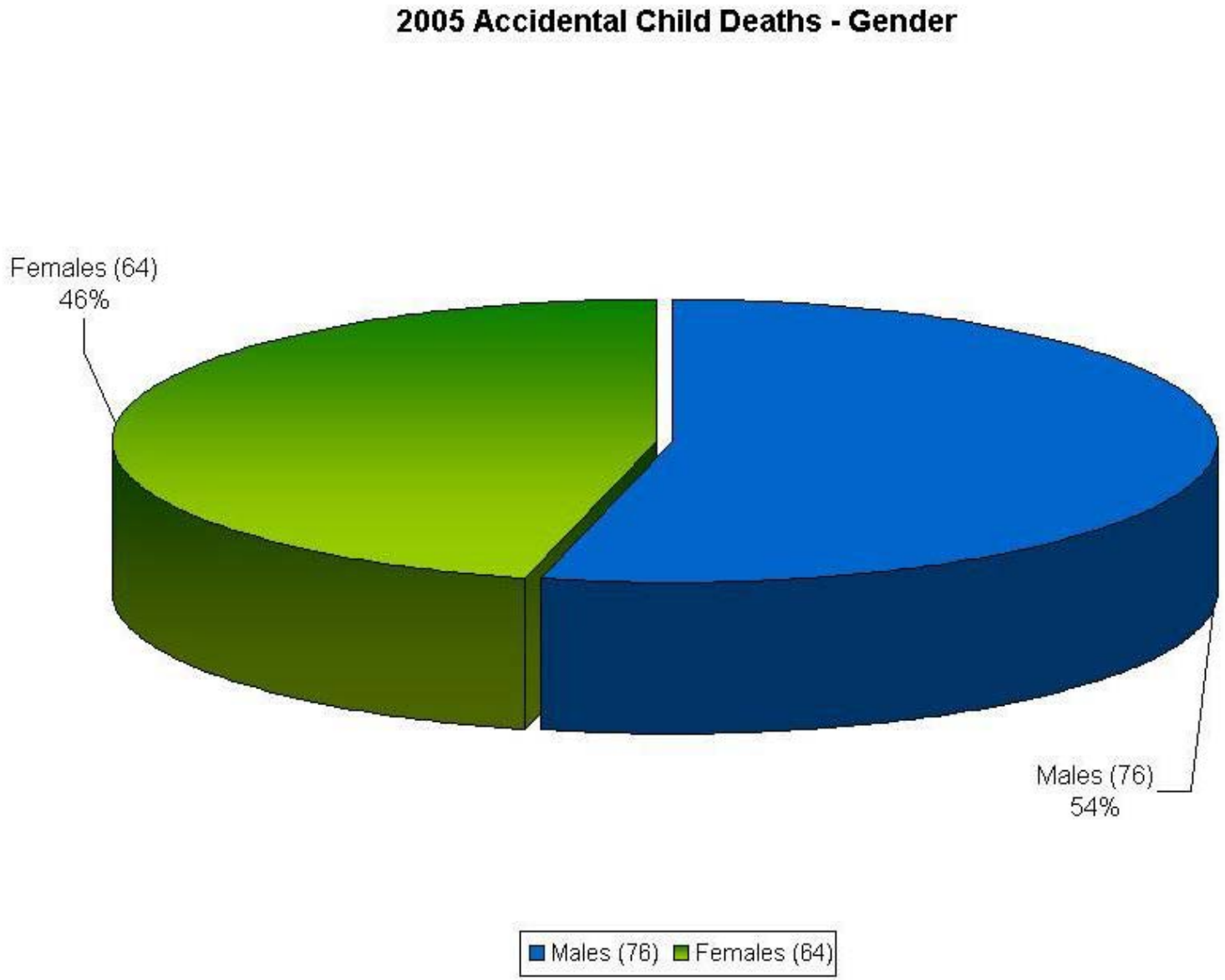
2005 Accidental Child Deaths - Race



Percentage of Child Population
in Los Angeles County
Hispanic 57.5%
Caucasian 19%
African American 9.9%
Asian/Pacific Islander 9.0%
American Indian 0.3%

African American (19)
Asian/Pacific Islander (16)
Caucasian (29)
Hispanic (73)
Other*/Unknown (3)

*Includes two children designated as Middle Eastern


2005 Accidental Child Deaths - Gender
Females (64)
46%
Males (76)
54%
Males (76)
Females (64)

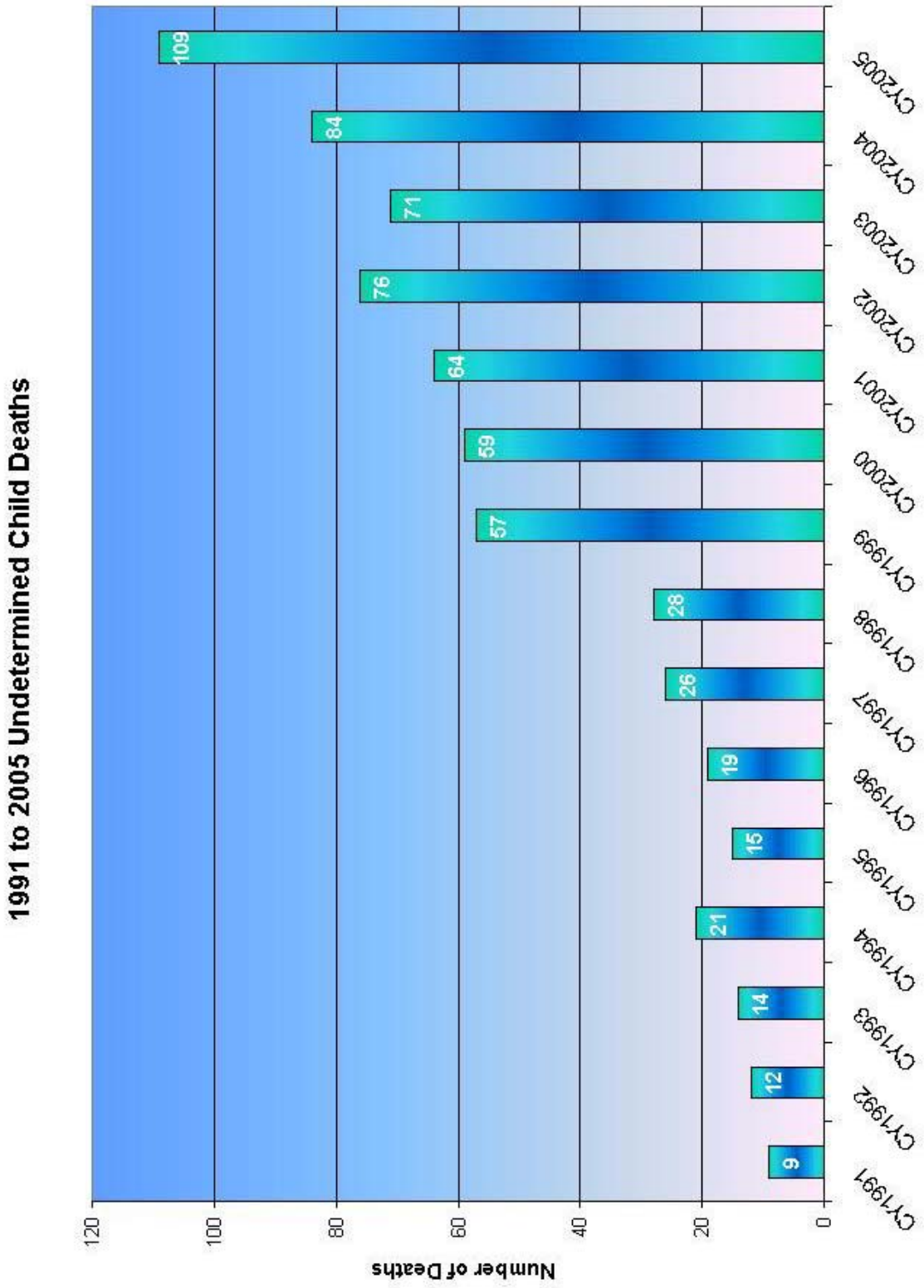
CAUSES OF ACCIDENTAL CHILD DEATHS BY GENDER 2005 - Los Angeles County (N=140)

	Female	Male
Automobile – multi-vehicle	7	11
Automobile – solo vehicle	13	13
Autopedestrian	10	17
Birth Trauma	2	0
Choking	1	3
Crushed by object	2	3
Dog bites	1	0
Drowning	7	6
Drug intake	1	2
Electrocution	0	1
Falls	2	0
Fire	5	1
Gunshot wounds	0	1
Hanging/Strangulation	0	3
Hyperthermia	1	1
Impaled	0	1
Maternal drug abuse	6	9
Medical complications	4	0
Motor vehicle other than auto*	0	1
Poisoning	0	1
Sports Injury	1	0
Suffocation	1	1
Train v pedestrian	0	1
Total	**64**	**76**

*Category includes minibikes, dirt bikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

UNDETERMINED CHILD DEATHS

1991 – 2005


1991 to 2005 Undetermined Child Deaths
Number of Deaths
0
20
40
60
80
100
120
9
12
14
21
15
19
26
28
57
59
64
76
71
84
109
CY1991
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
CY2003
CY2004
CY2005

Undetermined Child Deaths – 2005
(N = 109)

Race	Number/Percentage of Child Deaths
African American	28 (26%)
Asian/Pacific Islander	5 (5%)
Caucasian	18 (16%)
Hispanic	56 (51%)
Other*/Unknown	2 (2%)

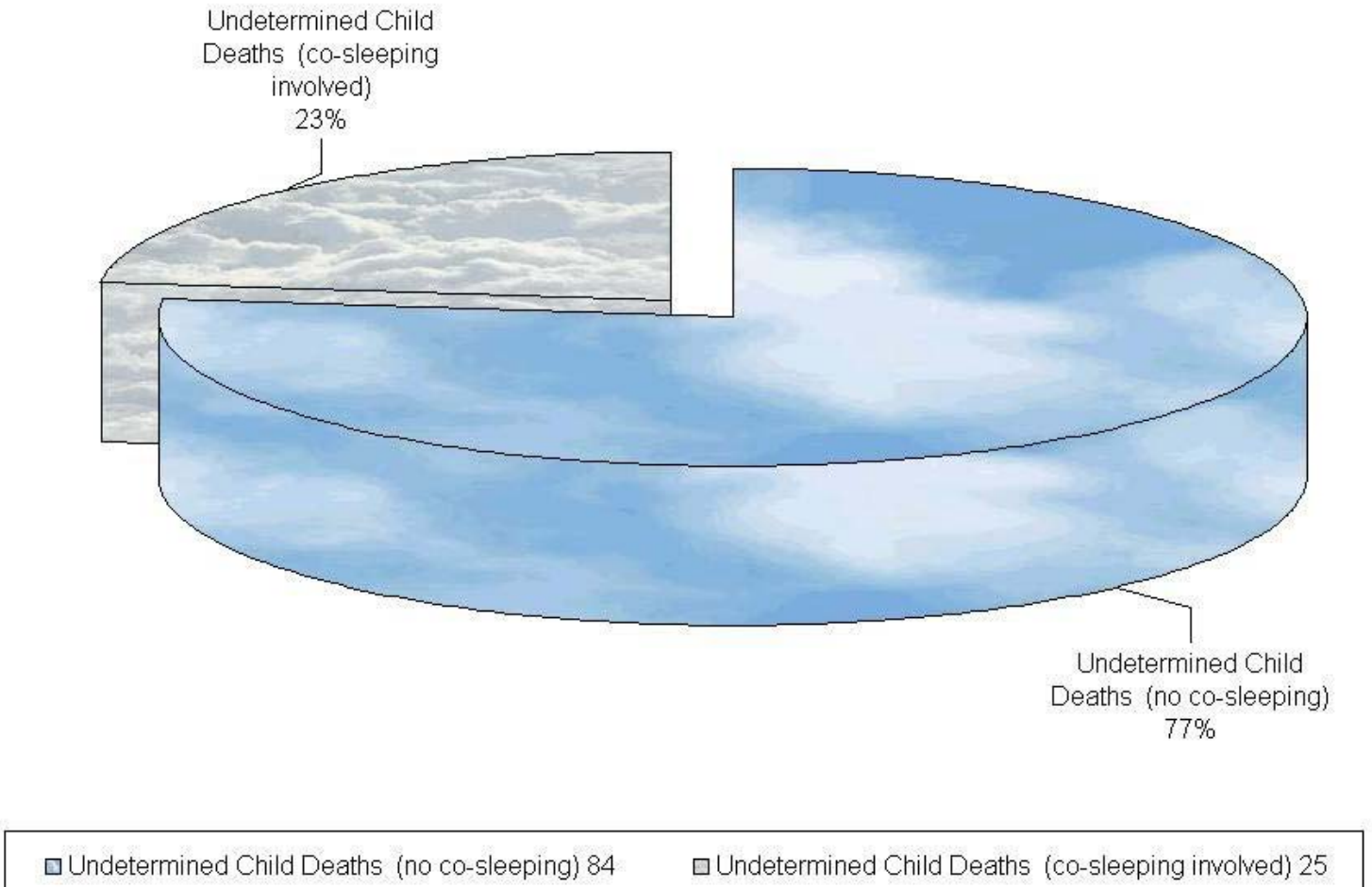
Age	Number of Child Deaths
Under 1	89
1 year	4
2 years	1
3 years	1
4 years	1
5 years	5
6 years	2
7 years	1
8 years	0
9 years	0
10 years	0
11 years	0
12 years	0
13 – 17 years	5

Gender	Number of Child Deaths
Female	51
Male	57
Unknown	1

African American children were over-represented in undetermined child deaths.
82% of the undetermined child deaths were under one year of age.
93% of the undetermined child deaths were 5 years of age or under.

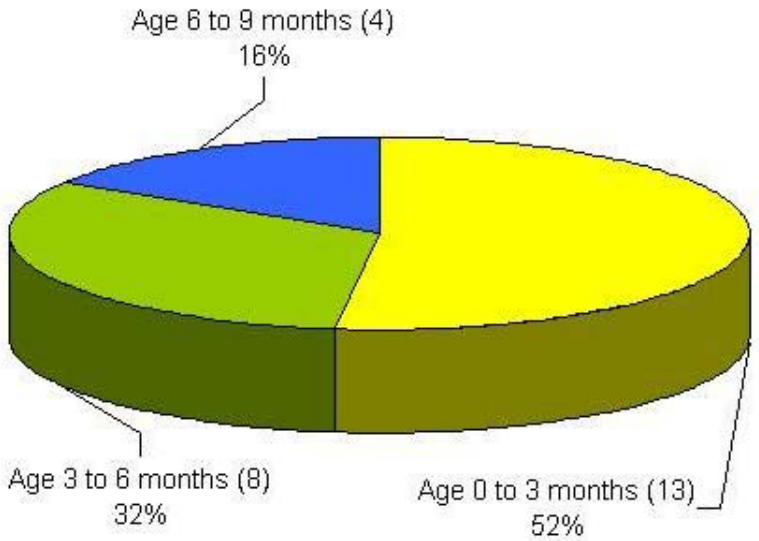
*Includes one infant designated as Middle Eastern

Percentage of Undetermined Child Deaths with a Noted Status Post Cosleeping - 2005

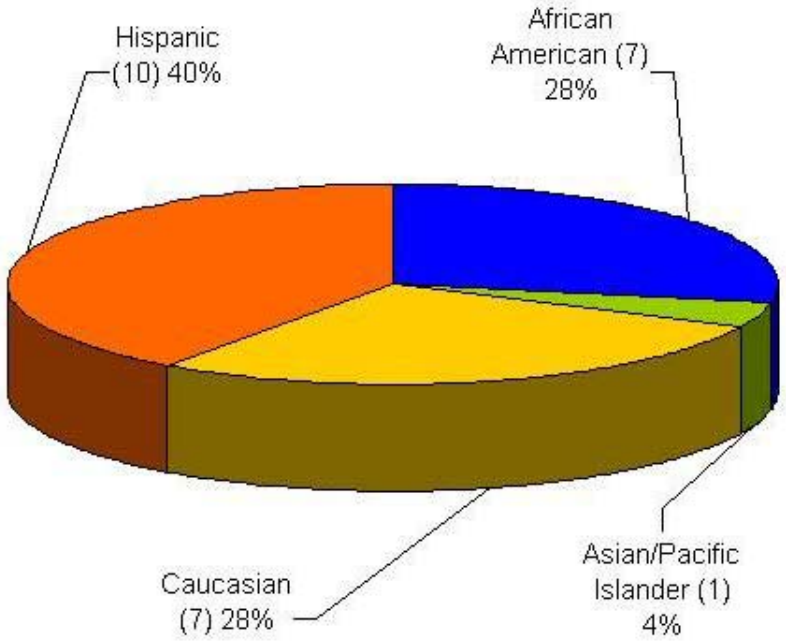


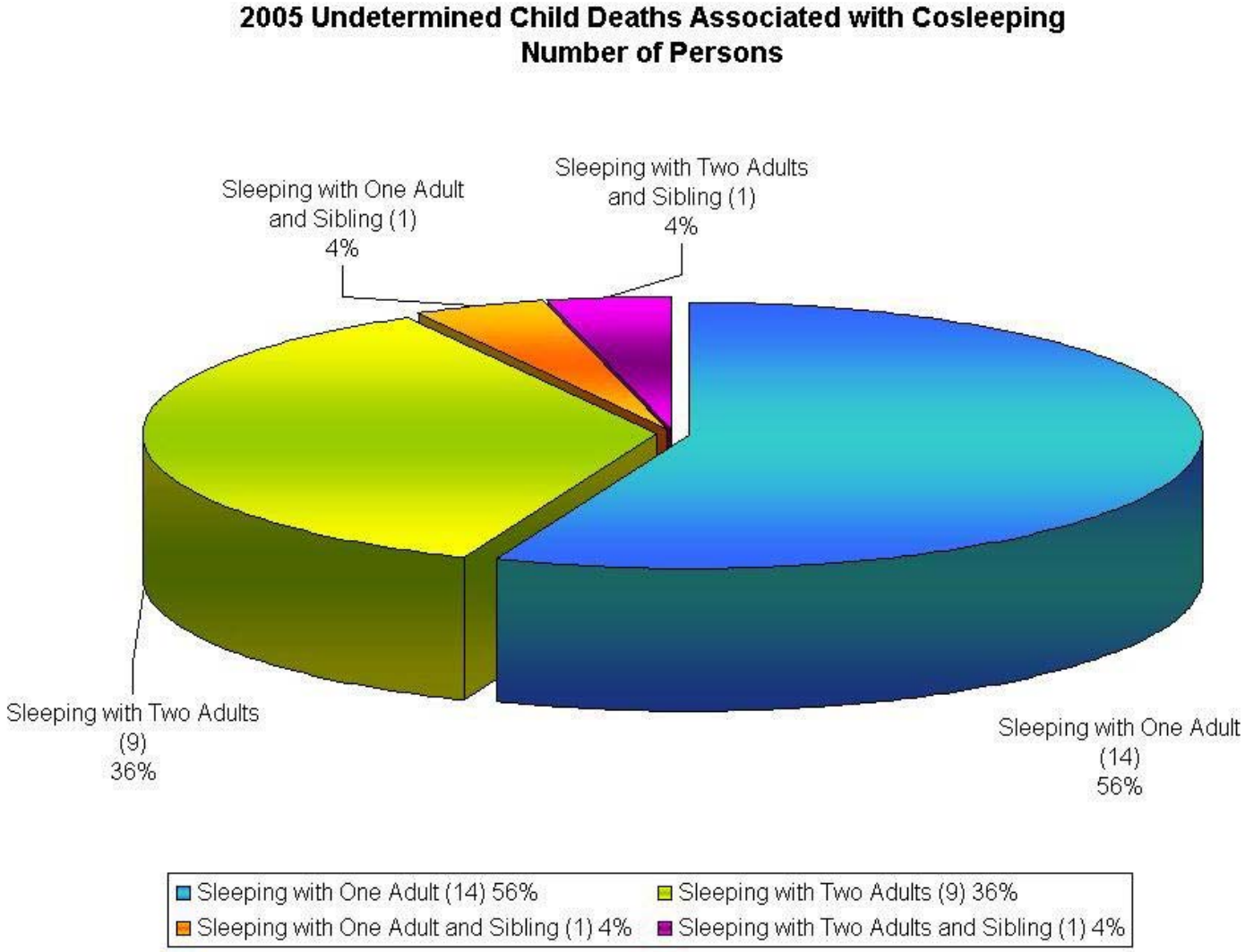
2005 Undetermined Child Deaths Associated with Cosleeping - Age and Race

Age



Race




2005 Undetermined Child Deaths Associated with Cosleeping
Number of Persons
Sleeping with One Adult and Sibling (1) 4%
Sleeping with Two Adults and Sibling (1) 4%
Sleeping with Two Adults (9) 36%
Sleeping with One Adult (14) 56%
Sleeping with One Adult (14) 56%
Sleeping with Two Adults (9) 36%
Sleeping with One Adult and Sibling (1) 4%
Sleeping with Two Adults and Sibling (1) 4%