ICAN

Inter-Agency Council on Child Abuse and Neglect

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Child Death Review Team Report for 2007

ICAN

Report Compiled from 2006 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 29 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 Angeles County during *2006.* 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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RECOMMENDATIONS

ICAN CHILD DEATH REVIEW TEAM

Data gathered for the 2007 ICAN Child Death Review Team Report (addressing 2006 data) show that there were 115 undetermined child deaths, and of these, 38% were associated with co-sleeping. ICAN has previously made recommendations regarding the need for public awareness efforts to highlight the dangers of co-sleeping, yet co-sleeping deaths continue to occur in alarming numbers. ICAN recognizes that co-sleeping is a controversial issue tied to cultural values and supported by organizations that believe that co-sleeping helps to strengthen the bond between parent and child.

However, ICAN believes that steps need to be taken to ensure that families with newborns are enabled to make an informed choice regarding co-sleeping. Such an informed choice can only be made if these families are made aware of the risks evidenced by the large number of infant deaths associated with co-sleeping. Options for ensuring a safe sleeping environment for infants should be made available and this information should be disseminated on a wide basis. In addition, it should be noted that, anecdotally, many co-sleeping related deaths can be tied to parents who are under the influence of drugs or alcohol, thus efforts regarding co-sleeping should also target those parents with a history of substance abuse.

It is, therefore, recommended:

1) The Los Angeles County Office of Education should include information on safe sleeping practices in the curriculum currently in development on the Safely Surrendered Baby Law.

2) The Department of Health Services should provide information on safe sleeping practices to birthing hospitals for dissemination to new parents.

3) The Perinatal Advisory Council/Los Angeles County (PAC/LAC) and other Perinatal Councils should survey birthing hospitals in an effort to better determine what these hospitals

can do to provide accurate information about the possible dangers in co-sleeping and to encourage safe sleeping practices.

4) The Consumer Product Safety Commission (Commission) should include information on safe sleeping in products used for infants. In addition, the Commission should encourage the development of new products that facilitate safe sleeping, e.g., infant beds that can be used in or next to the parents' bed to allow a parent to place the infant in a safe place after feeding.

5) Law enforcement agencies should send out a training advisory informing officers who respond to "baby not breathing calls" to be cognizant of the role that substance abuse can play in co-sleeping fatalities. The responding officers should take steps to determine if a parent might have been under the influence of drugs or alcohol.

6) The Department of Health Services and First 5 Los Angeles should develop public service announcements and other public information messages encouraging safe sleeping practices.

FINDINGS

HOMICIDES

- There were 33 child homicides by parents, caregivers or family members in 2006. These remain unchanged from 2005 when there were also 33 such child homicides, but lower than the 15-year average of 40.27 homicides per year.

- Seventy-six percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is a decrease from 2005, when 79% of the children were five years of age or younger.

- Eight children were over age 5, including one seven-year old, one eight-year old, one ten-year old, two eleven-year olds, one 13-year old, one 16-year old, and one 17-year old. Fifteen of the victims were under age one.

- The average age of a child homicide victim in 2006 was 3.55 years (42.55 months). The average age of a child homicide victim in 2005 was 3.42 years (41.09 months).

- Eleven female children and 22 male children were victims of homicide by parents, caregivers or family members in 2006.

- Eleven children died from head trauma, five from multiple trauma, and one from trauma to the torso/abdomen. These include children who were victims of battered child syndrome. Six children died from asphyxiation/suffocation, three children died from drowning, three children died as a result of fire (one teenager's charred body was found in an arson-related fire and the cause of death was undetermined after autopsy, and two children were set on fire by their father), two children were victims of a stabbing, one was a victim of gunshot wounds, and one eleven-year old died from strangulation after being assaulted with a cable ligature by an adult sibling.

- Six newborns were abandoned and found deceased and/or killed by their mothers in 2006. All these deaths were moded homicide by the Coroner, which represents 18% of the total number of child homicides by a parent, caregiver or other family member. Eleven newborns were safely surrendered in 2006.

- Both Hispanic (n=22) and Asian/Pacific Islander (n=5) children were slightly over-represented in child homicides by parents, caregivers or family members. Three children were of African-American descent, two children were Caucasian, and one child was of unknown ethnic origin.

- The Department of Children and Family Services (DCFS) had prior contact with 33% (n=11) of the families in which there was a child homicide. This is a decrease from 2005 when 42% of these families had previous contact with DCFS. None of these 2006 cases were under DCFS supervision (i.e., open case or referral) when the fatality occurred.

- Fifteen children were killed by their father or mother's boyfriend and thirteen children were killed by their mother (these include six infant abandonments). Two children were killed by a sibling, one child was killed by a relative, and two children were killed by a family member but the familial relationship was not identified.

- The greatest number of child homicides by parents, caregivers, or family members occurred in April (n=6). The second greatest number of homicides occurred during the months of September and December (n=4). The fewest number of homicides occurred in the months of February and May (n=1). At least two child homicides occurred during the months of January, March, June, July, August, October and November.

- While child homicides occurred throughout Los Angeles County in 2006, there was a clustering of these child deaths in SPAs 4 and 7 (n=8). Five child homicides occurred in SPA 3, four in SPA 2, three in SPA 1 and SPA 8, two in SPA 6 and no child homicides occurred in SPA 5.

SUICIDES

- Fourteen children and adolescents committed suicide in 2006. This is a 7% decrease from the 15 such suicides in 2005 and significantly lower than the 15-year average of 23.27 suicides per year.

- As in years past, male victims outnumbered female victims by a broad margin. Nine males and five females committed suicide in 2006.

- The leading method was death due to hanging, which represents 64% (n=9) of the suicides in 2006. Two of the adolescents committed suicide by using firearms, two adolescents overdosed on prescription medication, and one 17-year old boy jumped from a bridge into a riverbed.

- Eighty-six percent (n=12) of the children who committed suicide in 2006 were ages 15 - 17; two victims were under age 15, and the youngest victim was age 13. In comparison, in 2005, three victims were under age 15 and the youngest victim was age 12. The youngest victim reviewed by the Team was age 9 in 2001.

- Suicides by Caucasians represent 36% (n=5) of the total number of adolescent suicides in 2006 and an increase from 2005 when there were only two suicides by Caucasian youth. Twenty-nine percent (n=4) of adolescent suicides were committed by Hispanics in 2006, which represents a 60% decrease from 2005 (n=10). Suicides by African-Americans remained unchanged in 2005 (n=2) from 2004 (n=2), and suicides by Asian/Pacific Islanders increased from zero in 2005 to three in 2006.

- The Child and Adolescent Suicide Team reviewed nine of the 14 youth suicides from 2006. Eight of these nine youth exhibited warning signs prior to their suicide. Six of the youth had a history of mental illness, four of whom received referrals for services. Three of these four youth who received a referral, refused the services. Five of the youth experienced a recent relationship loss or conflict and five of the youth had known academic problems. Four of the youth exhibited drug use prior to their suicide and four came from families that had prior or current involvement with DCFS or the Department of Public Social Services. Three of the youth received special education services, three youth left a suicide note, and three youth had a history of prior self injury. Two of the youth had a criminal and/or juvenile delinquency record, two youth had a positive toxicology for drugs, two youth previously attempted suicide, and two youth had school discipline problems. One youth had a history of mental health treatment.

- In 2006, a majority (n=3) of the suicides occurred during the month of February. There were two adolescent suicides each in March, May, July and November accounting for 57% of the suicides. There was one suicide per month in April, August and September. Finally, in the months of January, June, October, and December there were no adolescent suicides.

- Child and Adolescent Suicides were experienced in all areas of Los Angeles County except in SPA 6. A majority (n=6) of the incidents occurred in the northern region of the County in SPA 1 and SPA 2. Three suicides occurred in SPA 7, two in SPA 8, and one each in SPAs 3, 4 and 5.

ACCIDENTAL CHILD DEATHS

- There were 95 accidental deaths of children ages 0 through 14 years in 2006. This is a 5% decrease from the 100 such deaths for this age group reported for 2005. There were 48 accidental deaths of youth ages 15 to 17. With the inclusion of this older age group, there were 143 accidental deaths (children ages 0 through 17) in 2006, and the leading cause of accidental death was automobile accidents (n=45). Children ages 15 to 17 accounted for 51% (n=23) of automobile related deaths in 2006.

- Deaths due to maternal substance abuse (n=25) was the leading cause of accidental death for children 14 years of age and under. Automobile accidents (n=22) was the second leading cause in 2006. These data represent both auto v auto and auto solo accidents. Drowning deaths (n=12) ranked third and autopedestrian accidents (n=11) ranked fourth.

- Deaths associated with maternal substance abuse accounted for 18 fetal deaths and 7 deaths of infants up to just under age 6 months. Both methamphetamine (n=12) and cocaine (n=12) are the drugs associated with all but one of these deaths. Deaths associated with maternal substance abuse accounted for 17% of all accidental deaths in 2006, and fetal deaths associated with maternal substance abuse accounted for approximately 13% of all accidental deaths.

- Accidental drowning claimed the lives of 12 children ages 0 — 17 in 2006; a slight decrease from 2005 when drowning claimed the lives of 13 children. A majority of these drowning deaths were young children who drowned in residential pools or spas. In addition, one 14-year old girl had a seizure and drowned while bathing, and a 14-year old male drowned in a river after trying to recover his lost fishing pole. Overall, since 1992 drowning has been a leading cause of accidental deaths of children.

- Hispanic children represented 55% (n=80) of all accidental child deaths in 2006. Fifty-eight percent (n=11) of the autopedestrian deaths were Hispanic children. Caucasian children represented 19% (n=27) of the accidental deaths. They were over-represented in automobile accidents (n=13) but under-represented in drowning deaths (n=1) and deaths associated with maternal substance abuse (n=3). African-American children (n=20) were slightly over-represented in accidental deaths in 2006. Twenty-eight percent of the African-American child deaths were due to maternal substance abuse. There were 8 accidental deaths of Asian/Pacific Islander children in 2006. Two of the accidental deaths were children of Middle Eastern descent. Finally, six children were of unknown ethnicity (four of these were fetal deaths where the cause of death was intrauterine fetal demise associated with maternal drug abuse, one was a fetal death discovered during autopsy of the mother who was the victim of an automobile fatality, and one was a six-year old who died in a house fire).

- In 2006, 87 male children and 56 females died due to accidental death, which is almost a 3:2 ratio. In comparison, in 2005, 76 male children and 64 females died due to accidental death, which was almost a 5:4 ratio.

- In 2006, male children were over-represented in nearly all types of accidental deaths in comparison to female children. These include deaths associated with maternal substance abuse in which 16 male children lost their lives as opposed to 9 female children; and automobile accidents, in which 28 male

children lost their lives due to this type of accident versus 17 female children and drowning deaths in which 9 males lost their lives in comparison to 3 females.

UNDETERMINED CHILD DEATHS

- There were 115 undetermined child deaths in 2006. This is a 6% increase from the 109 such deaths in 2005 and significantly higher than the 15-year average of 51.33 undetermined deaths per year.

- African-American (n=34) children were over-represented in undetermined child deaths. Fifty-five children were Hispanic, 22 were Caucasian, and three were of Asian/Pacific Islander descent. One infant was of unknown descent.

- Thirty-eight percent (n=44) of the undetermined child deaths had a noted status of post co-sleeping. In comparison, in 2005, 23% of the undetermined deaths were associated with co-sleeping.

- Fifty-nine percent (n=26) of the co-sleeping related deaths were infants between 0 to 3 months of age, 32% (n=14) were infants between 3 to 6 months of age, and 9% (n=4) were infants between 6 to 9 months of age.

- In 54.5% (n=24) of the undetermined deaths associated with co-sleeping, the infant was sleeping with one adult; 19 of these infants were sleeping with the mother and five with the father. Ten infants were sleeping with two adults, five infants were sleeping with one adult and one or more other children, three infants were sleeping with one or more other children and no adults, and two infants were sleeping with two adults and one or more other children.

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 2006-07, 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 and strategize how to translate information obtained from these reviews into tangible outcomes.

3. Developed policy and procedure recommendations for the prevention of future child deaths. These recommendations included requesting the Office of County Counsel to draft legislation to allow Team review of deaths of young people through age 25 who have committed suicide and asking the State Department of Corrections to consider developing a standard protocol for the release of infants born to inmates.

4. Worked with the Los Angeles County Community Child Abuse Councils to create a child fatality prevention kit for countywide distribution to include materials on safe sleeping, drowning prevention, safety tips in and around cars, and shaken baby syndrome.

5. 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.

   Devoted several Team meetings to an on-going focused review of child deaths ended as undetermined by the Coroner in an effort to understand the increase in these child deaths and to develop prevention efforts.

In 2006-07, 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. Coordinated a project with the Los Angeles County Community Child Abuse Councils and the Los Angeles County Department of Coroner to produce condolence cards with grief counseling resources for families of children who have committed suicide.

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

4. 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.

5. Worked with the Chief Executive Office, the Los Angeles County Counsel and Assemblywoman Mary Hayashi's Office to propose legislation to extend the Team's ability to review cases of individuals between the ages of 18 and 25.

6. 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.

7. 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.

8. Participated on the California State Suicide Strategic Prevention Planning Committee to ensure that the establishment or participation of Suicide Death Review Teams be included as an important component of every county's surveillance activities in programs funded by the Prevention and Early Intervention section of the California Mental Health Services Act.

9. Coordinated activities of 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. Focused on the importance of thorough suicide investigation protocols for the purposes of collecting prevention data.

10. 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 33.6 children each year have *been killed by a parent, careglver or other famlly member.*

2002	37
2003	35
2004	30
2005	33
2006	33

Over the past 5 years, an average of 16 children and adolescents each year have *committed suicide.* The leading method in 2002 and 2003 was gunshot wounds; in 2004, 2005 and 2006 the leading method was hanging.

2002	19
2003	19
2004	13
2005	15
2006	14

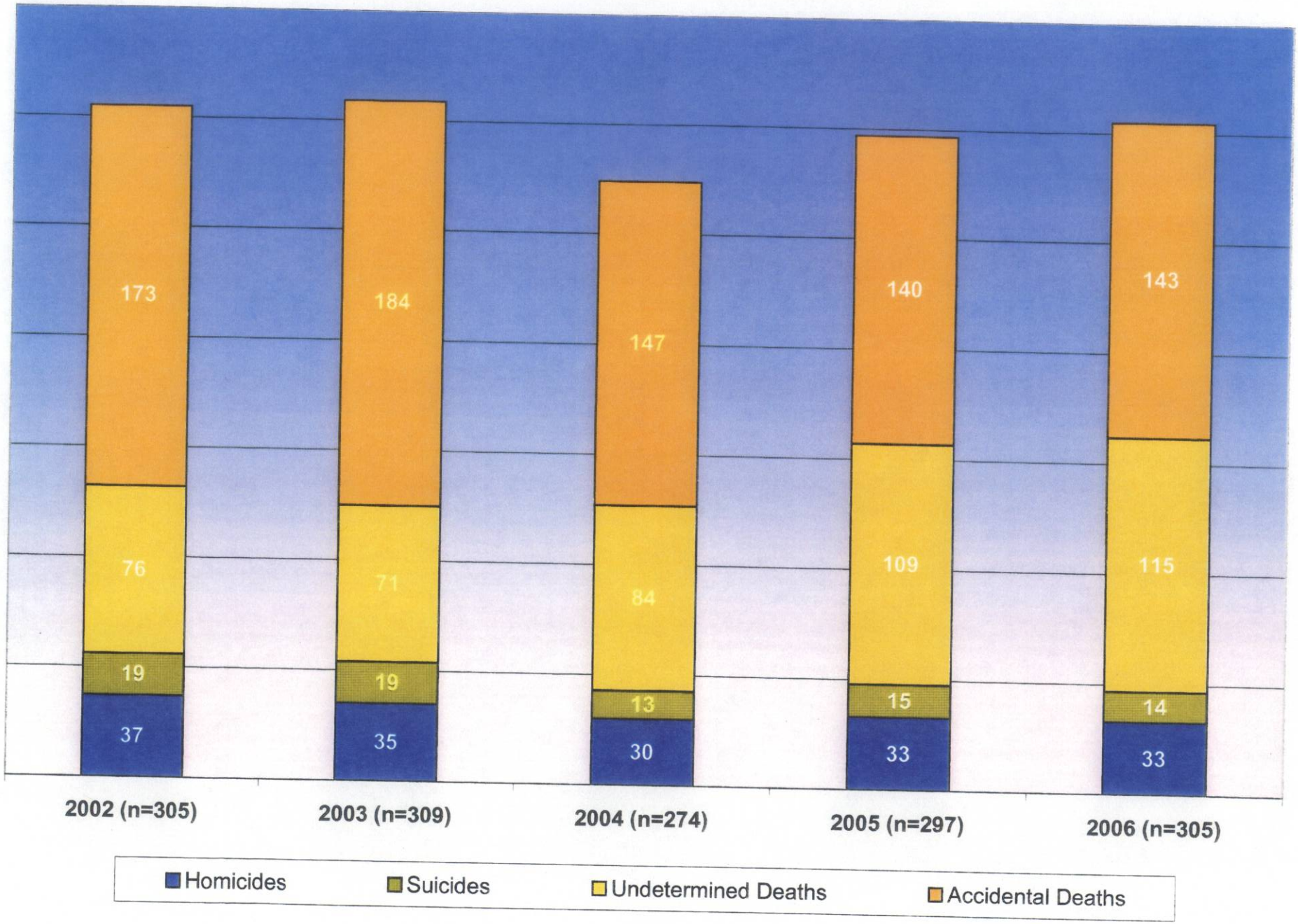
Over the past 5 years, an average of 157.4 children have died from preventable accidents. The most common accidental deaths involve automobile accidents, deaths due to maternal substance abuse, autopedestrian accidents and drowning.

2002	173
2003	184
2004	147
2005	140
2006	143

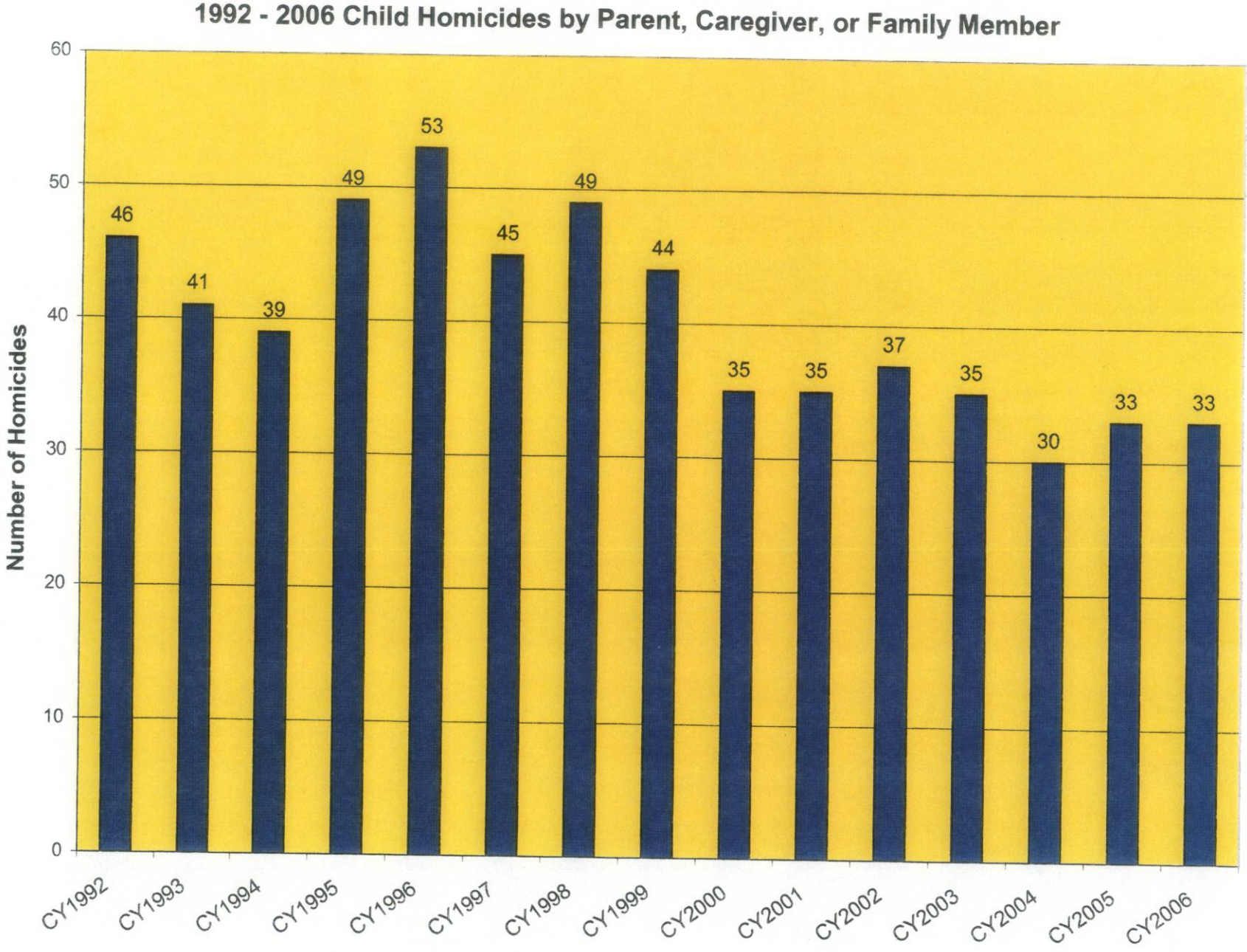
Over the past 5 years, the number of undetermined deaths has averaged 91 per year.

2002	76
2003	71
2004	84
2005	109
2006	115

Child Death in Los Angeles County 2002 - 2006



CHILD HOMICIDES BY PARENTS, CAREGIVERS OR OTHER FAMILY MEMBERS
1992 - 2006


1992 - 2006 Child Homicides by Parent, Caregiver, or Family Member
Number of Homicides
60
50
40
30
20
10
0
46
41
39
49
53
45
49
44
35
35
37
35
30
33
33
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
CY2003
CY2004
CY2005
CY2006

CAUSES OF CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS
1992 - 2006, Los Angeles County

	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	Total
Head Trauma	16	14	17	19	15	12	13	15	5	5	2	7	7	6	11	**164**
Multiple Trauma	9	7	7	10	7	10	8	10	11	7	7	10	7	8	5	**123**
Asphyxiation/suffocation	2	1	0	4	4	4	3	6	3	8	5	6	5	5	6	**62**
Gunshot Wounds	3	2	2	4	4	7	10	4	3	2	1	4	3	6	1	**56**
Trauma to torso/abdomen	3	3	6	2	5	4	2	1	0	0	3	0	0	2	1	**32**
Drowning	2	1	1	4	0	2	2	0	3	1	7	1	1	2	3	**30**
Fire	3	1	0	3	8	0	4	0	1	0	0	0	0	0	3	**23**
Stabbing	3	1	0	0	2	0	2	1	4	1	2	0	3	2	2	**23**
Unattended newborn	1	0	1	1	0	1	3	4	2	3	2	3	0	1	0	**22**
Poisoning/drug ingestion	**1**	6	1	0	2	0	0	0	0	3	6	**1**	1	0	0	**21**
Undetermined/Unknown	0		2	0	2	1	0	2	1	1	2	0	1	1	0	**14**
Dehydration/malnutrition	1	0	**0**	**1**	1	1	1	**0**	1	1	0	1	2	0	0	**10**
Strangulation	1	1	1	0	2	2	1	0	0	0	0	0	0	0	1	**9**
Medical neglect	0	2	1	0	0	0	0	0	1	2	0	0	0	0	0	**6**
Neck compression	1	1	0	1	1	0	0	0	0	0	0	0	0	0	0	**4**
Burns	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0	**3**
Hypertherm is	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	**2**
TOTAL	**46**	**41**	**39**	**49**	**53**	**45**	**49**	**44**	**35**	**35**	**37**	**35**	**30**	**33**	**33**	**604**

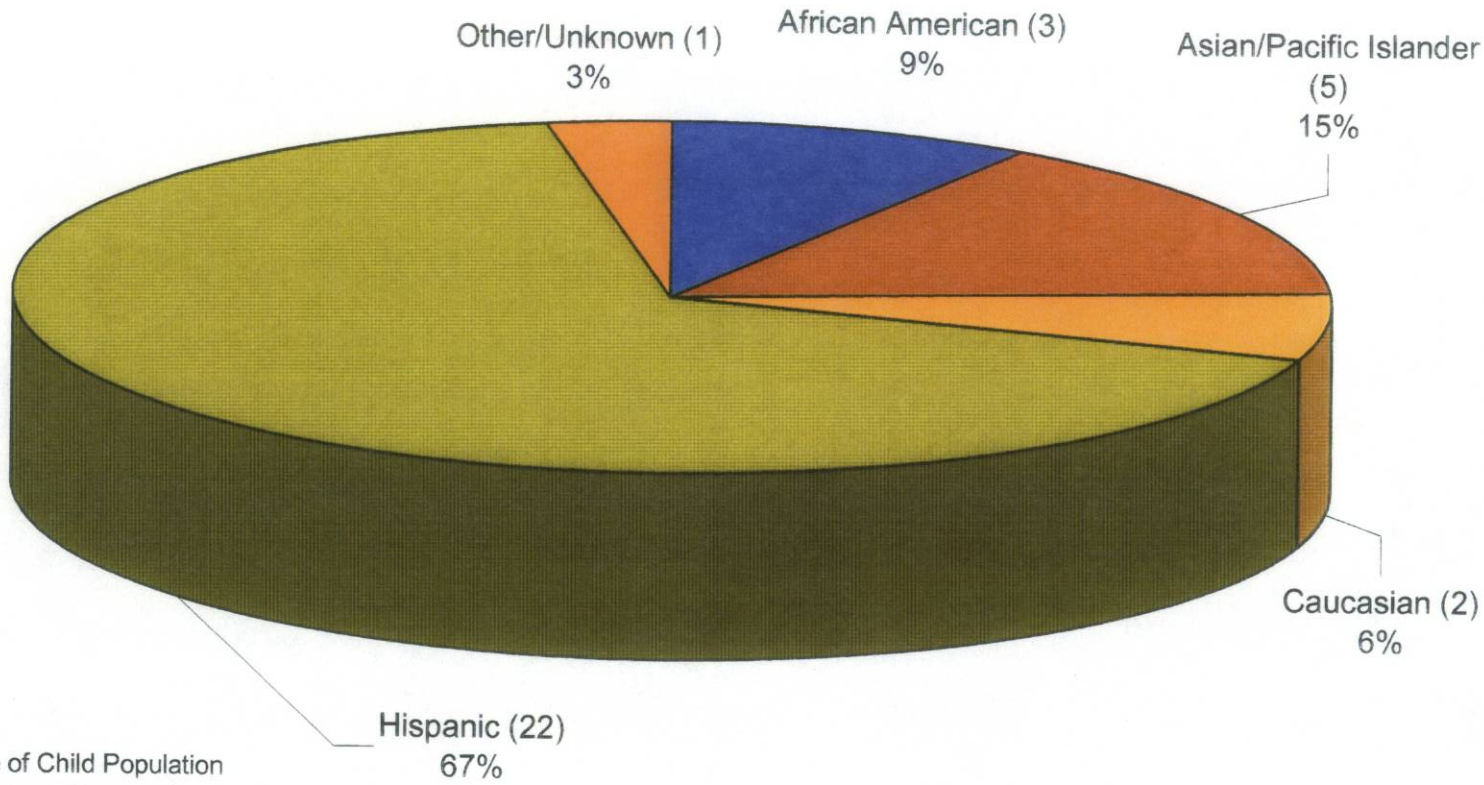
CHILD HOMICIDES BY PARENTS/CAREGIVERS/FAMILY MEMBERS
LOS ANGELES COUNTY — 2006 (N = 33)

Age	Female	Male
Under 1	6	9
1 **year**	1	4
2 years	**0**	**1**
3 years	2	1
4 years	0	1
5 years	0	0
6 years	**0**	0
7 years	**0**	**1**
8 years	**0**	1
9 years	0	0
10 **years**	0	1
11 years	**1**	**1**
12 years	**0**	0
13 — 17 years	1	2
Total	**11**	22

45 % of the child homicides by parents/caregivers/family members were under one year of age.

76 % of the child homicides by parents/caregivers/family members were 5 years of age or under.

2006 Child Homicides by Parent, Caregiver, or Family Member - Race



Percentage of Child Population
in Los Angeles County[1]
Hispanic 59.5%
Caucasian 20%
African American 9.8%
Asian/Pacific Islander 10.4%
American Indian 0.2%

[1] From Los Angeles County Children's Planning Council Scorecard 2006

2006 Child Homicides by Parents, Caregivers, or Family Members
DCFS Involvement 1992 — 2006

Year	Total # of homicides by parent/caregiver/ family member	Total # of homicides that had previous DCFS Contact (prior contact OR open case)	Of total with previous DCFS contact, the # of homicides that had PRIOR DCFS contact only	Of total with previous DCFS contact, the # of homicides in OPEN DCFS case or referral	# killed by out-of-home caregiver
1992	46	11	5	6	0 — foster parents unable to determine relative caregivers
1993	41	13	6	7	0 — foster parents unable to determine relative caregivers
1994	39	12	5	7	0 — relative caregivers 1 — foster parent
1995	49	16	5	11	3 — relative caregivers 0 — foster parents
1996	53	13	7	6	2 — relative caregivers 2 — foster parents
1997	45	15	8	7	0 relative caregivers 1 — foster parent
1998	49	20	16	4	0 relative caregivers 0 foster parents
1999	44	20	12	8	1 — relative caregiver 2 — foster parents
2000	35	15	7	8	2 — relative caregivers 0 — foster parents
2001	35	12	7	5	3 — relative caregivers 2 — foster parents
2002	37	Not Available	Not Available	Not Available	0 — relative caregivers 0 — foster parents
2003	35	18	13	5	2 — relative caregivers 2 — foster parents
2004	30	15	9	6	2 — relative caregivers 0 — foster parents
2005	33	14	9	5	1 — relative caregiver 0 — foster parents
2006	33	11	11	0	0 —relative caregiver 0 —foster parents

Relationship of Suspect to Child Homicide Victim - 2006

The relationship of the suspect to the child was identified by the Coroner Investigator or Law Enforcement as:

15 — Father or mother's boyfriend'
13 — Mother[2]
2 — Brother
1 — Cousin[3]
2 — Undetermined[4]

In one case, the mother stated that her relationship with the male suspect was platonic in nature. In another case, the suspect was identified as the child's step-father.

[2] Includes one case where the suspect was identified as the father's girlfriend. Six of these 13 homicides were cases of infant abandonment.

[3] The one-year old child victim was left in the care of an adult uncle and two cousins. This one-year old drowned after being left unattended in the bath by one of his cousins.

[4] These were killed by a caregiver, but the familial relationship was not identified because the case was still under investigation.

Dates[5] of Child Homicides - 2006

2 homicides occurred in January (1/09 & 1/26/06)
1 homicide occurred in February (2/22/06)
2 homicides occurred in March (3/03 & 3/12/06)
6 homicides occurred in April (two on 4/02, 4/09, 4/10, 4/24, & 4/28/06)
1 homicide occurred in May (5/02/06)
3 homicides occurred in June (6/05, 6/11, & 6/16/06)
2 homicides occurred in July (7/02 & 7/16/06)
3 homicides occurred in August (8/04, 8/14, & 8/19/06)
4 homicides occurred in September (9/01, 9/19, 9/20, & 9/21/06)
3 homicides occurred in October (10/08, 10/13, & 10/20/06)
2 homicides occurred in November (11/16 & 11/17/06)
4 homicides occurred in December (12/01, 12/16, 12/18 & 12/20/06)

[5] This is the date of death, which, in a majority of the cases coincides with the date the injury occurred leading to the child's death.

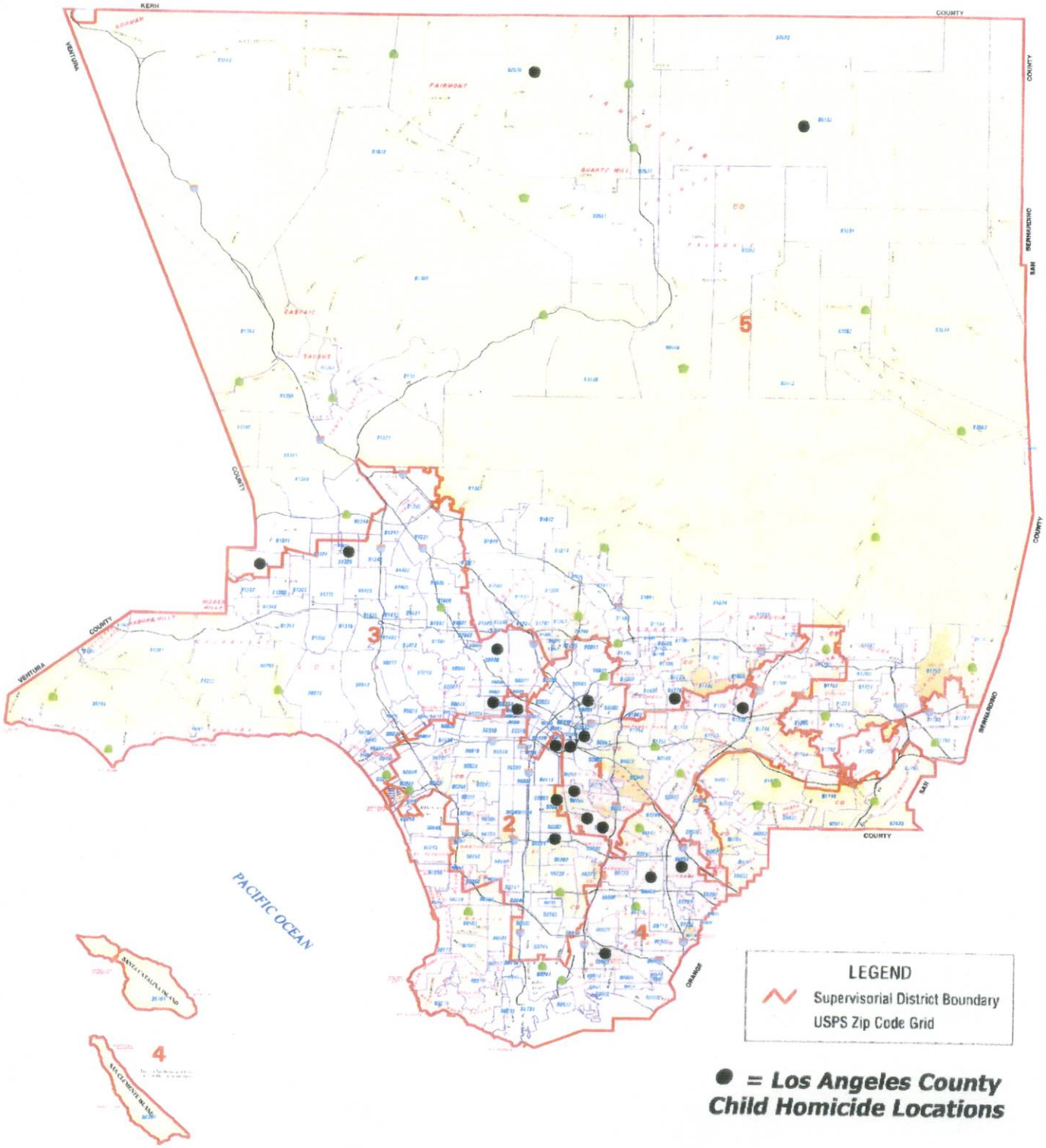
Locations[6] of Child Homicides — Geographic Area - 2006

1 homicide occurred in Alhambra (zip code 91803)
1 homicide occurred in Azusa (zip code 91702)
1 homicide occurred in Baldwin Park (zip code 91706)
1 homicide occurred in Bellflower (zip code 90706)
1 homicide occurred in Canoga Park (zip code 91304)
1 homicide occurred in El Monte (zip code 91732)
1 homicide occurred in Hollywood (zip code 90068)
1 homicide occurred in Huntington Park (zip code 90255)
2 homicides occurred in Lancaster (zip codes 93535 & 93536)
2 homicides occurred in Long Beach (zip codes 90806 & 90808)
10 homicides occurred in Los Angeles (zip codes 90001, 90004, 90020, two in 90021, 90022, 90031, 90032, 90033, & 90059)
1 homicide occurred in Montebello (zip code 90640)
1 homicide occurred in Newhall (zip code 91321)
1 homicide occurred in Northridge (zip code 91325)
1 homicide occurred in Norwalk (zip code 90605)
1 homicide occurred in Palmdale (zip code 93550)
1 homicide occurred in San Gabriel (zip code 91776)
1 homicide occurred in Signal Hill (zip code 90755)
3 homicides occurred in South Gate (all three in zip code 90280)
1 homicide occurred in Van Nuys (zip code 91405)

[6] City where the injury/fatality occurred

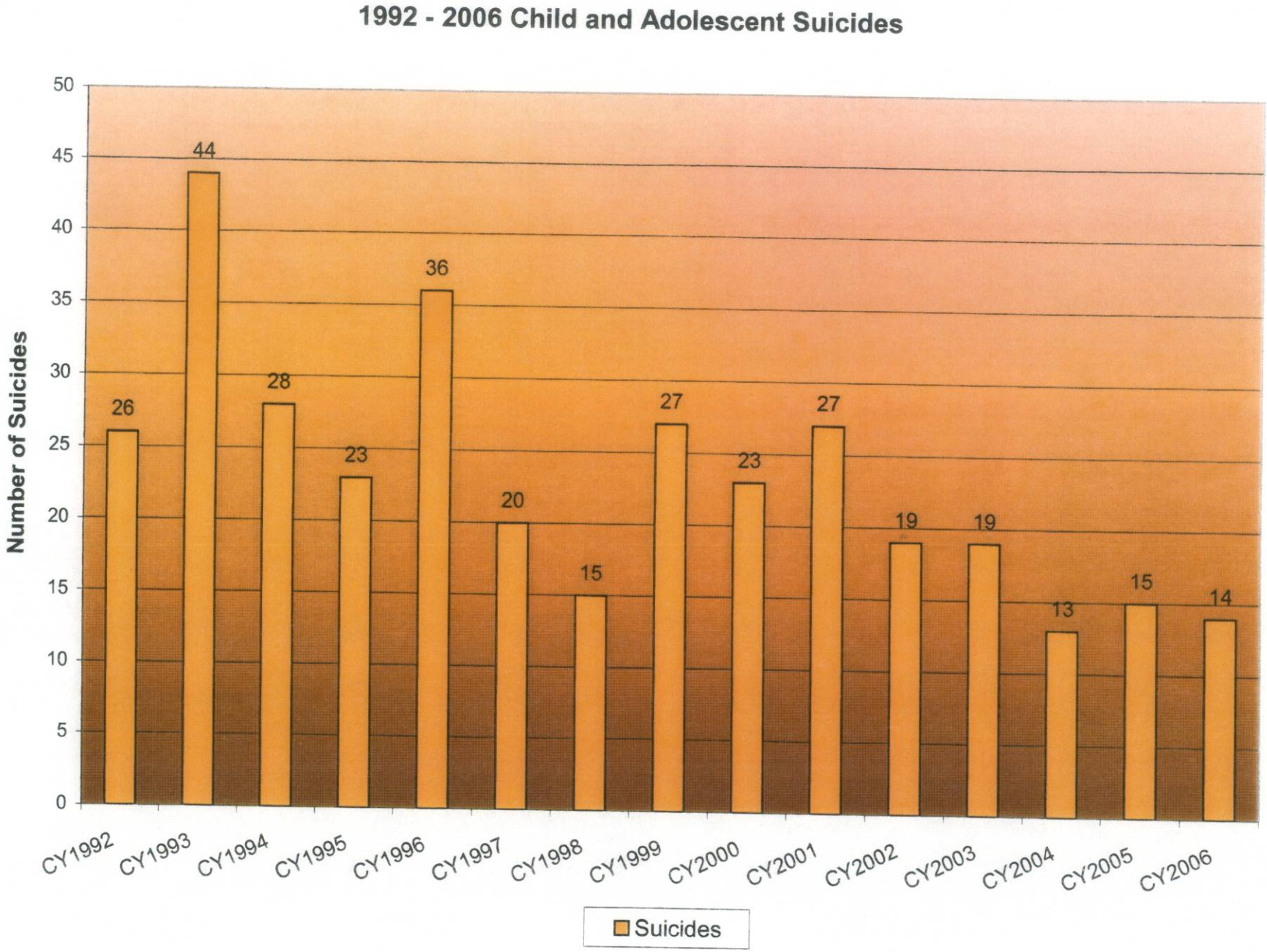
2006 Child Homicides by Parent, Caregiver, or Family Member - Location

n = 33



CHILD AND ADOLESCENT SUICIDES

1992 - 2006


1992 - 2006 Child and Adolescent Suicides
Number of Suicides
50
45
40
35
30
25
20
15
10
5
0
26
44
28
23
36
20
15
27
23
27
19
19
13
15
14
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
CY2003
CY2004
CY2005
CY2006
Suicides

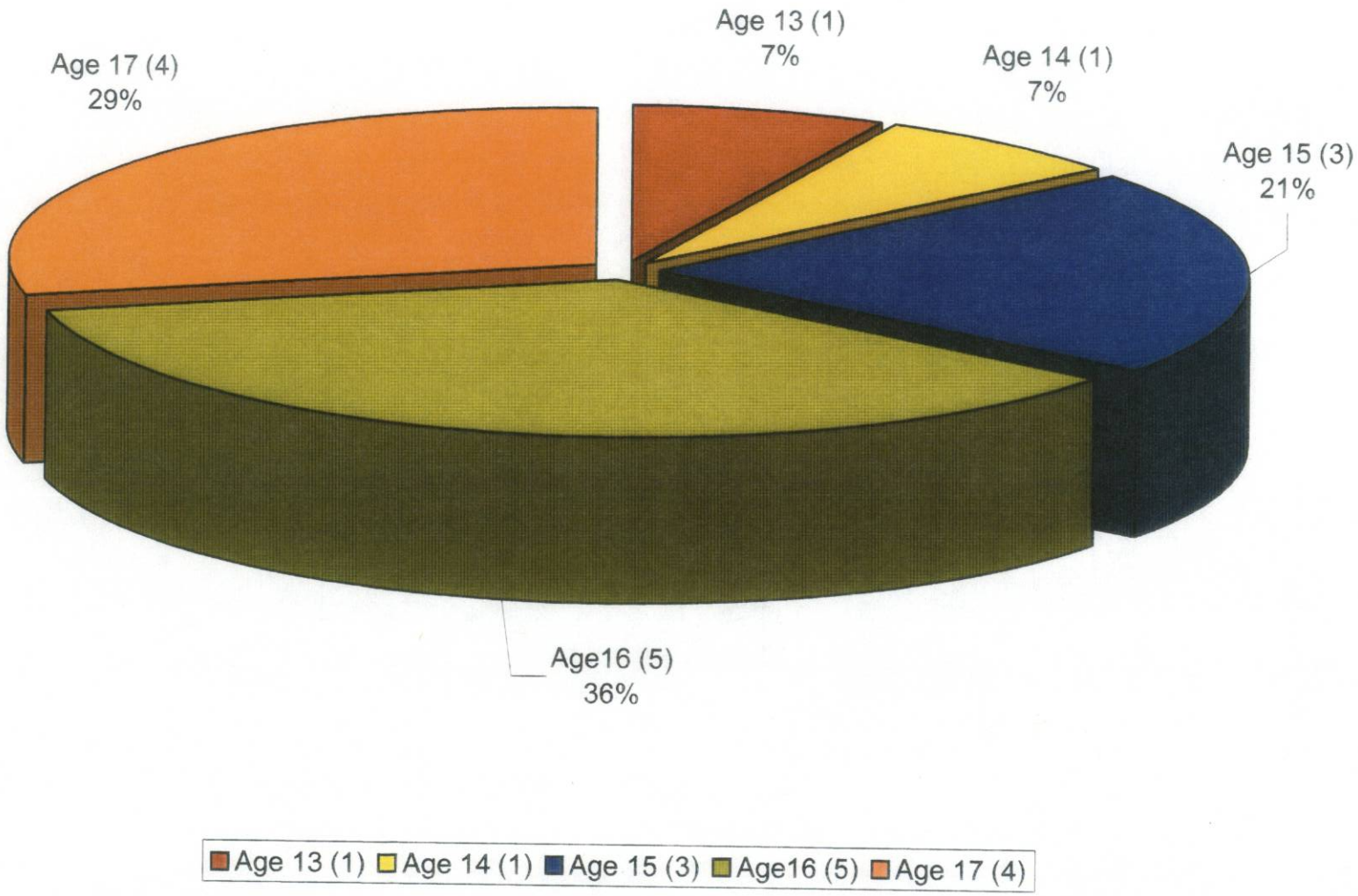
CHILD AND ADOLESCENT SUICIDES
BY METHOD AND GENDER
LOS ANGELES COUNTY — 2006 (N = 14)

Method	**Male**	**Female**
Hanging	5	4
Firearms/Gunshot	2	0
Overdose	1	1
Jumping	1	0
Total	**9**	**5**

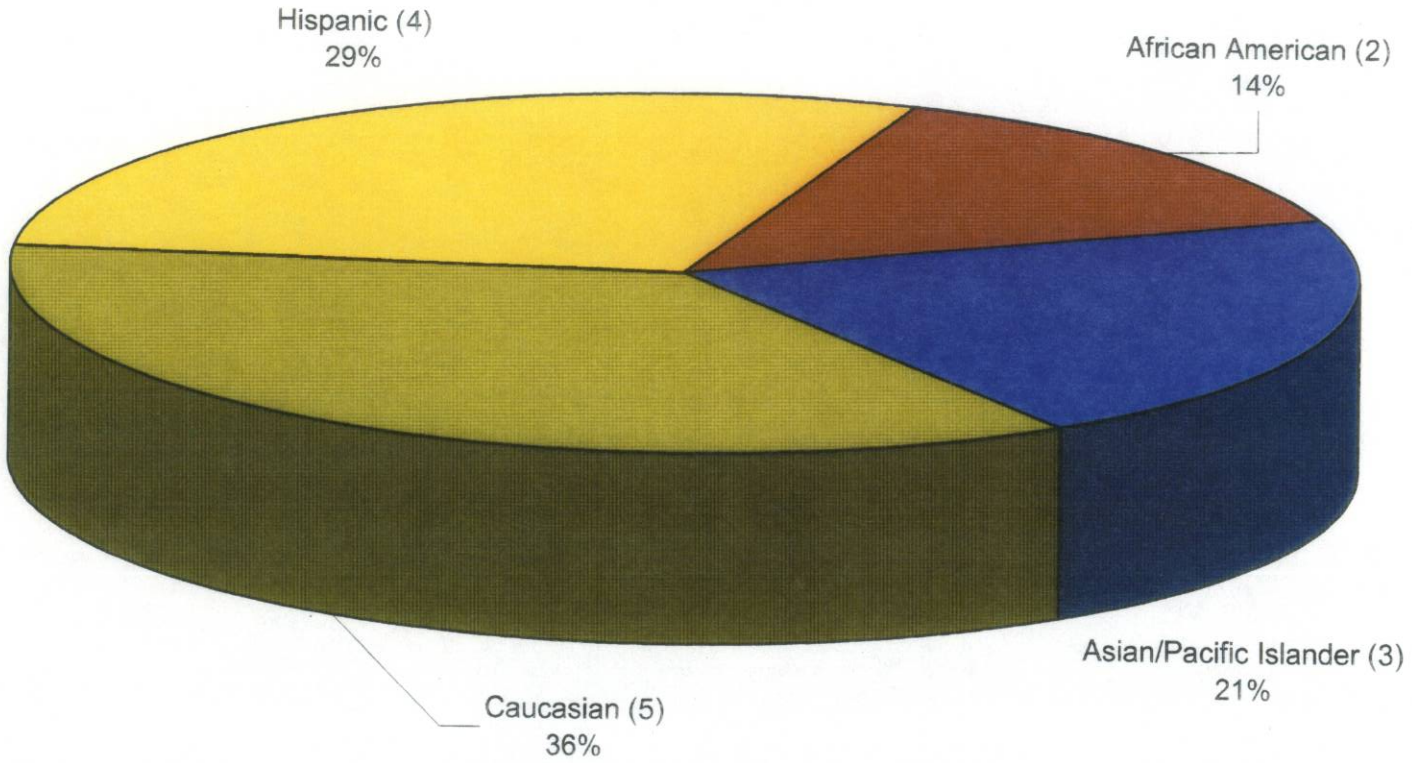
Hanging was the most frequent method of suicide among adolescents and represents 64% of the suicides in 2006. Firearms/gunshot and overdose were tied as the second most frequent method of suicide in 2006.

In 2006, 64% (n=9) of **the** adolescent suicide victims were male. 36% (n=5) of the victims of adolescent suicide in 2006 were female.

2006 Child and Adolescent Suicides - Age



2006 Child and Adolescent Suicides - Race



Percentage of Child Population
in Los Angeles County[1]
Hispanic 59.5%
Caucasian 20%
African American 9.8%
Asian/Pacific Islander 10.4%
American Indian 0.2%

[1] From Los Angeles County Children's Planning Council Scorecard 2006

Child and Adolescent Suicide Victim Characteristics - 2006

The Child and Adolescent Suicide Review Team reviewed **nine** of the **14** cases of youth suicide from 2006. From these **nine** cases the following was revealed:

Eight of the youth exhibited warning signs prior to their

suicide. **Six** of the youth had a history of mental illness.

One of the youth had a history of mental health treatment.

Four of the youth had been given prior referrals for services, **three** of who refused these services.

Three of the youth left a suicide note.

Two of the youth had previously attempted suicide.

Two of the youth during autopsy were discovered to have had a positive toxicology for drugs.

Four of the youth had exhibited evidence of drug use prior to their suicide.

Four of the youths' families had a prior or open case with the Department of Children and Family Services or with the Department of Public Social Services.

Two of the youth had a criminal and/or juvenile delinquency record.

Three of the youth had a history of prior self-injury.

Five of the youth had experienced a recent relationship loss or conflict.

Three of the youth had received special education services.

Five of the youth had known academic problems and

Two of the youth had school discipline or truancy problems.

Dates of Child and Adolescent Suicides - 2006

3 suicides occurred in February (2/03, 2/05, & 2/13/06)
2 suicides occurred in March (3/02 & 3/24/06)
1 suicide occurred in April (4/12/06)
2 suicides occurred in May (5/16 & 5/24/06)
2 suicides occurred in July (7/01 & 7/12/06)
1 suicide occurred in August (8/24/06)
1 suicide occurred in September (9/13/06)
2 suicides occurred in November (11/08 & 11/26/06)

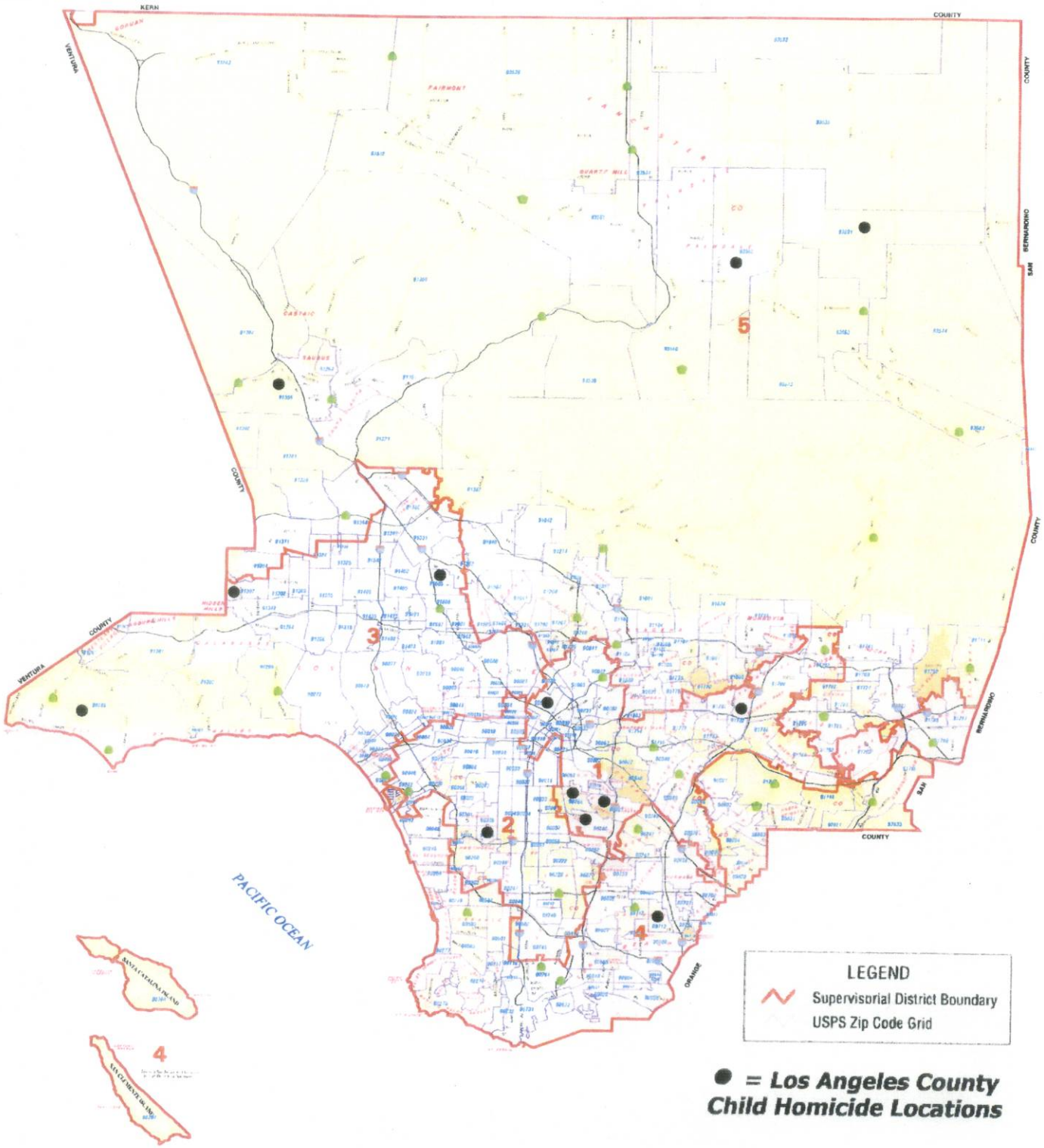
Locations' of Child and Adolescent Suicides — Geographic Area - 2006

1 suicide occurred in Bell (zip code 90201)
1 suicide occurred in El Monte (zip code 91732)
1 suicide occurred in Inglewood (zip code 90303)
1 suicide occurred in Lake Los Angeles (zip code 93591)
1 suicide occurred in Lakewood (zip code 90713)
1 suicide occurred in Los Angeles (zip code 90026)
1 suicide occurred in Malibu (zip code 90265)
1 suicide occurred in North Hollywood (zip code 91605)
1 suicide occurred in Palmdale (zip code 93552)
1 suicide occurred in South Gate (zip code 90280)
1 suicide occurred in Sylmar (zip code 91342)
1 suicide occurred in Valencia (zip code 91355)
1 suicide occurred in Walnut Park (zip code 90255)
1 suicide occurred in West Hills (zip code 91307)

[1] City where the suicide occurred

2006 Child and Adolescent Suicides - Location

n = 14



ACCIDENTAL CHILD DEATHS

1992 - 2006

CAUSES OF ACCIDENTAL CHILD DEATHS, AGES 0 -14
1992 - 2006, Los Angeles County

	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	Total
Drowning	25	40	35	31	18	28	21	25	23	28	16	19	21	**12**	**12**	**354**
Maternal drug abuse	17	23	10	9	25	24	38	21	22	24	25	32	21	15	25	**331**
Autopedestrian[1]				2	1	8	19	31	30	41	33	25	21	20	11	**242**
Automobile[2]								18	24	28	20	47	25	21	**22**	**205**
Falls	5	4	7	6	5	2	3	5	1	1	3	2	3	**1**	2	**50**
Choking	6	7	2	0	1	5	3	6	10	2	8	4	1	3	1	**59**
Suffocation	4	8	4	1	2	0	2	4	1	3	0	1	1	2	2	**35**
Poisoning	4	7	4	1	1	6	1	4	4	1	0	2	2	1	2	**40**
Fire	0	3	2	2	0	1	3	7	4	3	7	0	2	6	7	**47**
Hanging/strangulation	4	5	0	0	3	0	0	0	6	3	1	2	4	1	3	**32**
Chest/neck compression	3	3	3	1	2	1	2	0	1	0	0	3	0	0	0	**19**
Gunshot wounds	3	0	1	1	2	1	0	0	0	0	0	0	0	0	**0**	**8**
Crushed by object	0	0	0	2	0	3	2	1	**1**	0	1	0	1	5	2	**18**
Sports injury	0	0	0	0	0	2	0	2	2	1	0	0	0	1	0	**8**
Burns/Thermal Injury	1	1	0	0	0	0	0	1	0	0	1	0	1	0	0	**5**
Dog bites	0	0	0	1	0	1	0	1	1	0	0	0	0	1	0	**5**
Medical complications[3]	0	2	2	1	1	0	1	5	6	2	8	7	3	3	2	**43**
Perinatal asphyxia	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	**3**
Electrocution	0	0	0	0	0	2	0	0	1	0	0	**1**	0	1	0	**5**
Birth trauma	0	1	0	0	0	0	0	2	0	0	0	0	0	2	0	5
Hypothermia	1	0	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	2	1	3
Airplane related	0	0	0	0	0	0	0	0	0	0	2	2	0	0	0	4
Train v. pedestrian	0	0	0	0	0	**1**	**0**	**0**	**0**	0	0	0	0	1	0	2
Elective abortion	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	**1**
Forklift injury	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Drug intake/Overdose	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	**2**
Motor vehicle (not auto)'	0	0	0	0	0	0	0	0	0	0	0	0	4	1	3	5
Impaled	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
TOTAL[5]	**73**	**104**	**70**	**59**	**61**	**86**	**95**	**134**	**137**	**137**	**127**	**147**	**110**	**100**	**95**	**1535**

[1]Autopedestrian deaths were not reported to the Team prior to 1995. [2]Automobile deaths were not referred to the Team prior to 1999. [3]Data in this category was previously included in other categories, e.g, medical misadventure, aspiration of stomach, etc. 'These include minibikes, dirt bikes, scooters, go-carts. motorcycles, and all-terrain vehicles (ATVs). [5]The totals for years 1994 to 2001 have been slightly adjusted from the 2005 report.

CAUSES OF ACCIDENTAL CHILD DEATHS, AGES 0 — 17
2006 - Los Angeles County
(N=143)

Automobile — multi-vehicle	22
Automobile — solo vehicle	23
Autopedestrian	19
Choking	3
Crushed by object	2
Drowning	12
Drug intake	3
Falls	5
Fire	7
Hanging/Strangulation	3
Hyperthermia	1
Maternal drug abuse	25
Medical complications	6
Motor vehicle other than auto'	5
Poisoning	4
Suffocation	2
Train v pedestrian	1
Total	**143**

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

CAUSES OF ACCIDENTAL CHILD DEATHS BY AGE 2006 - Los Angeles County (N=143)

	Age 0 — 5 years	Age 6 — 14 years	Age 15 — 17 years
Automobile — multi-vehicle	7	7	8
Automobile — solo vehicle	3	5	**15**
Autopedestrian	7	4	8
Choking	0	1	2
Crushed by object	2	0	0
Drowning	4	8	0
Drug intake	0	0	3
Falls	1	1	3
Fire	6	1	0
Hanging/Strangulation	2	1	0
Hyperthermia	0	1	0
Maternal drug abuse	25	0	0
Medical complications	2	0	4
Motor vehicle other than auto'	0	3	2
Poisoning	1	1	2
Suffocation	2	0	0
Train v pedestrian	0	0	1
Total	**62**	**33**	**48**

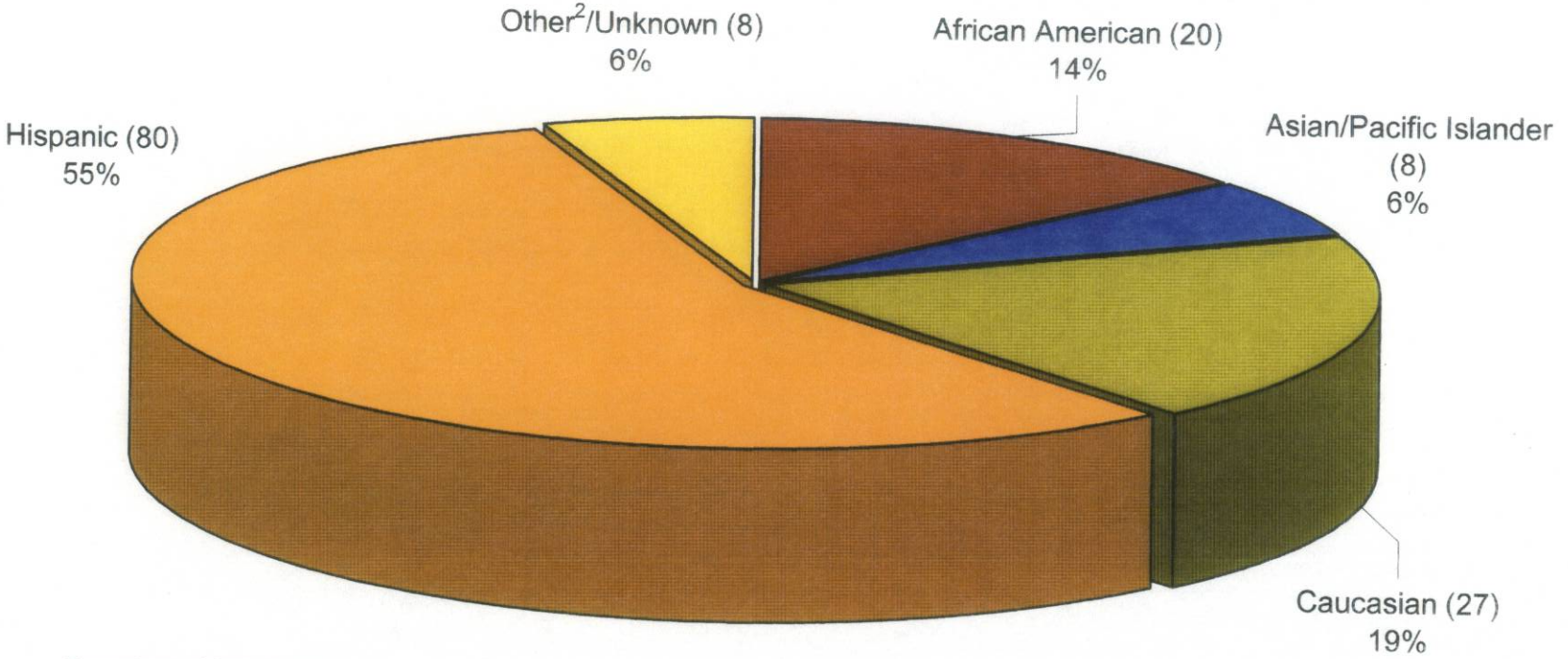
'Category includes minibikes, dirt bikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs)

RACE OF ACCIDENTAL CHILD DEATHS, AGES 0 - 17
Los Angeles County - 2006
(N=143)

	Hispanic	African-American	Caucasian	Asian/ Pacific Islander	Other'/ Unknown
Automobile — multi-vehicle	9	3	9	1	0
Automobile — solo vehicle	15	2	4	1	1
Autopedestrian	11	3	4	1	0
Choking	3	0	0	0	0
Crushed by Object	2	0	0	0	0
Drowning	7	2	1	1	1
Drug intake	1	0	1	0	1
Falls	4	0	1	0	0
Fire	6	0	0	0	1
Hanging/Strangulation	2	0	0	1	0
Hyperthermia	1	0	0	0	0
Maternal drug abuse	9	7	3	2	4
Medical complications	4	2	0	0	0
Motor vehicle other than auto[2]	2	0	2	1	0
Poisoning	3	0	1	0	0
Suffocation	0	1	1	0	0
Train v pedestrian	1	0	0	0	0
Total	**80**	**20**	**27**	**8**	**8**

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

2006 Accidental Child Deaths - Race

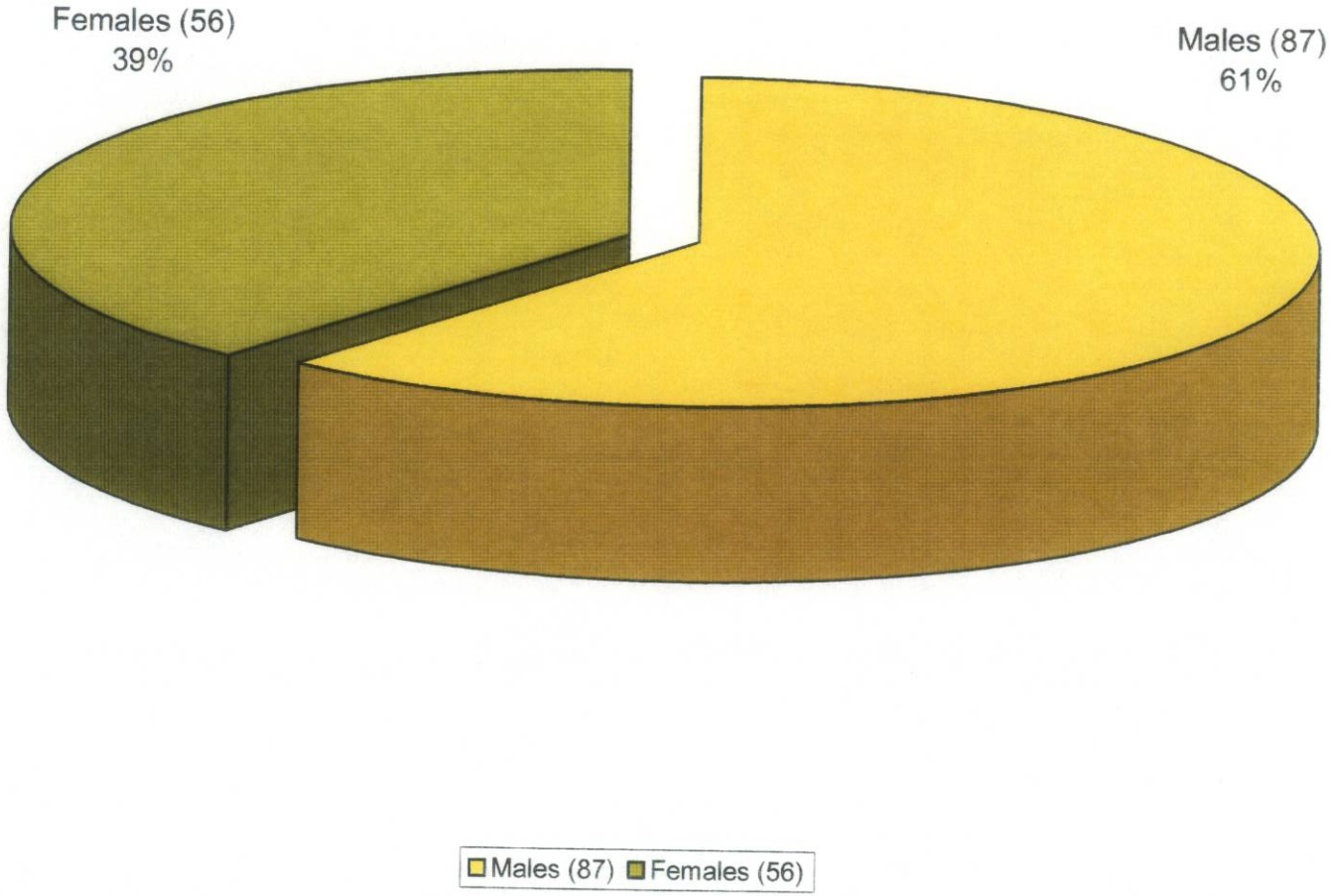


Percentage of Child Population
in Los Angeles County[1]
Hispanic 59.5%
Caucasian 20%
African American 9.8%
Asian/Pacific Islander 10.4%
American Indian 0.2%

[1] From Los Angeles County Children's Planning Council Scorecard 2006

[2] Includes two children designated as Middle Eastern

2006 Accidental Child Deaths - Gender



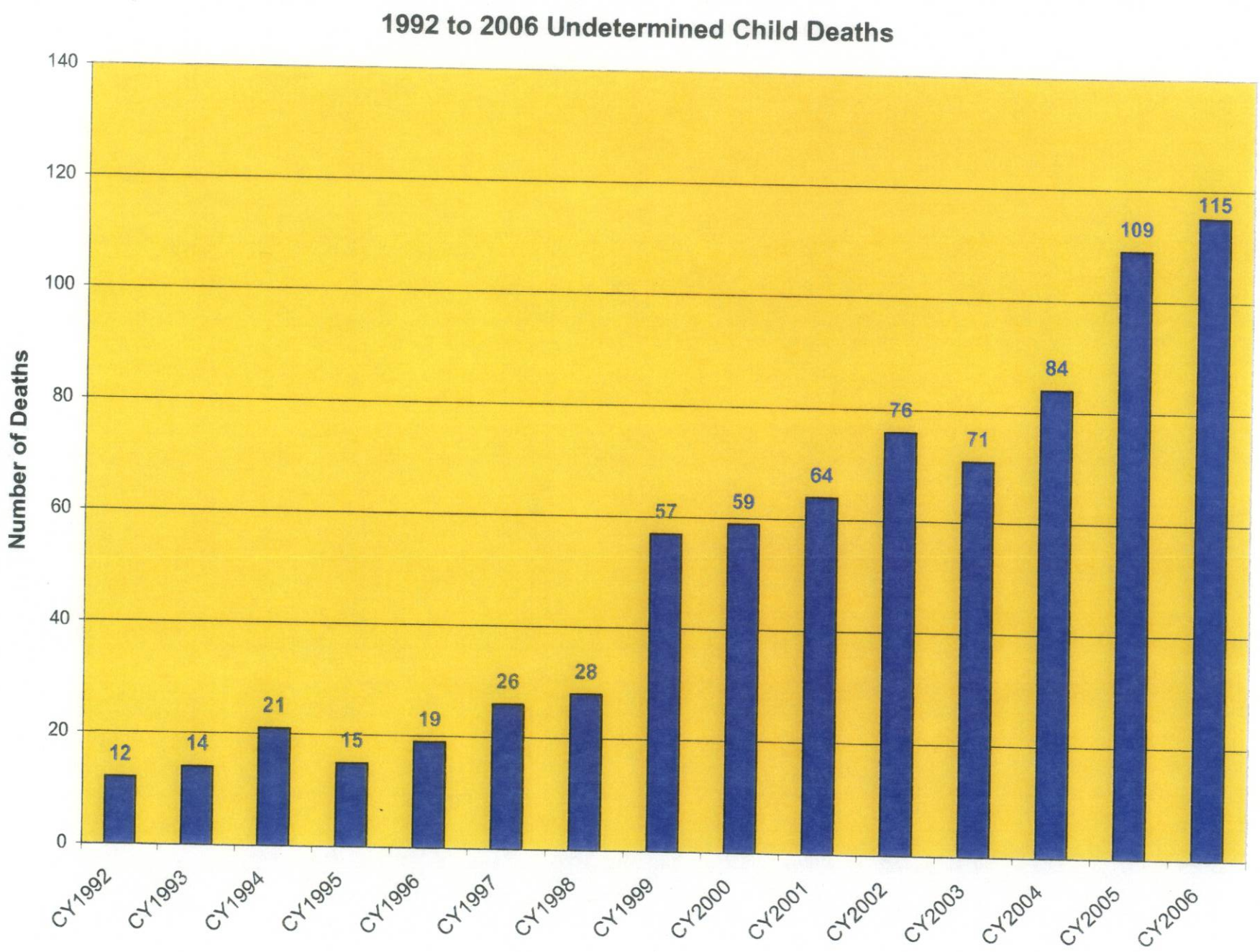
CAUSES OF ACCIDENTAL CHILD DEATHS BY GENDER 2006 - Los Angeles County (N=143)

	Female	Male
Automobile — multi-vehicle	9	13
Automobile — solo vehicle	8	15
Autopedestrian	8	11
Choking	0	3
Crushed by object	1	**1**
Drowning	3	9
Drug intake	2	1
Falls	2	3
Fire	4	3
Hanging/Strangulation	2	1
Hyperthermia	0	1
Maternal drug abuse	9	16
Medical complications	2	4
Motor vehicle other than auto*	1	4
Poisoning	4	0
Suffocation	0	2
Train v pedestrian	1	0
Total	**56**	**87**

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

UNDETERMINED CHILD DEATHS

1992 - 2006


1992 to 2006 Undetermined Child Deaths
Number of Deaths
0
20
40
60
80
100
120
140
12
14
21
15
19
26
28
57
59
64
76
71
84
109
115
CY1992
CY1993
CY1994
CY1995
CY1996
CY1997
CY1998
CY1999
CY2000
CY2001
CY2002
CY2003
CY2004
CY2005
CY2006

Undetermined Child Deaths - 2006
(N = 115)

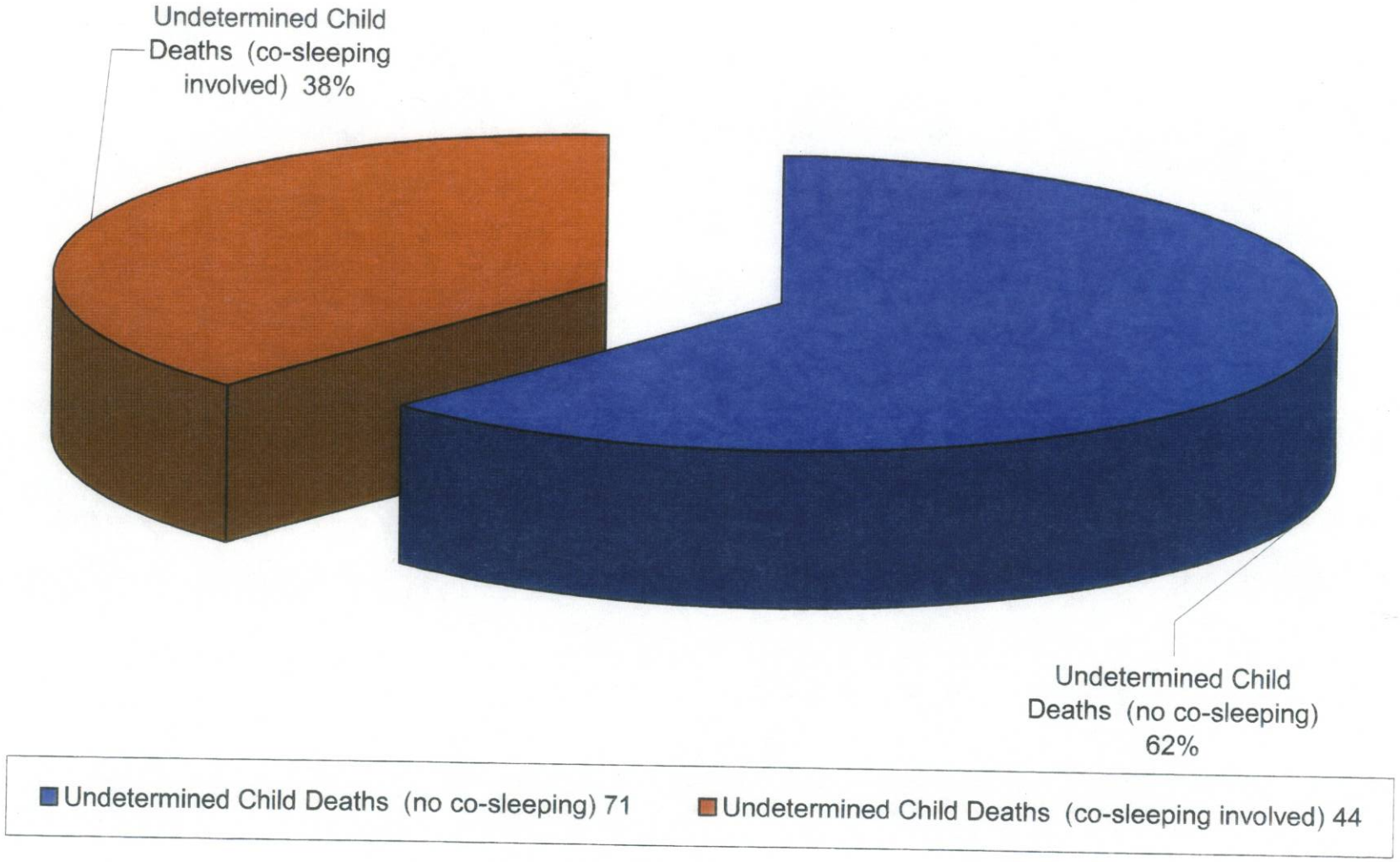
Race	Number/Percentage of Undetermined Child Deaths
African American	34 (29.5%)
Asian/Pacific Islander	3 (2.5%)
Caucasian	22 (19%)
Hispanic	55 (48%)
Other/Unknown	1 (1%)

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

Gender	Number of Undetermined Child Deaths
Female	43
Male	72

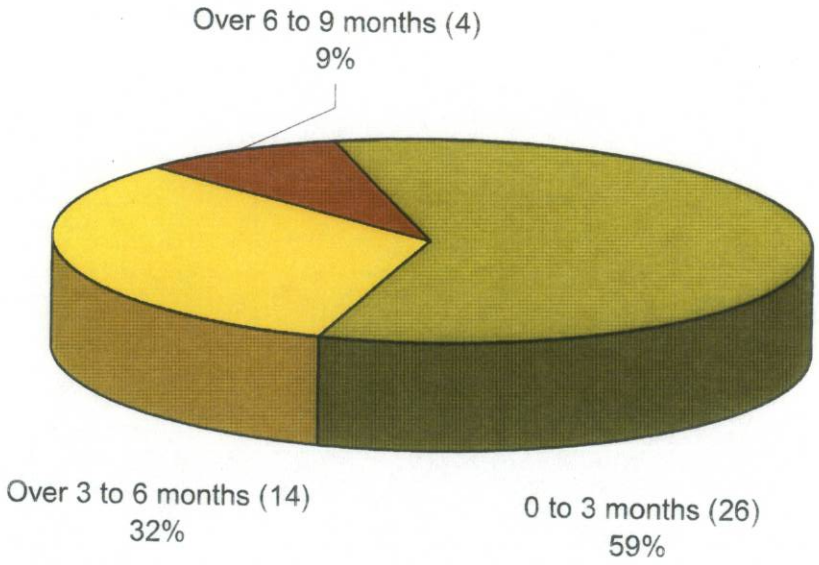
African American children were over-represented in undetermined child deaths.
77% of the undetermined child deaths were under one year of age.
91% of the undetermined child deaths were 5 years of age or under.

Percentage of Undetermined Child Deaths with a Noted Status Post Cosleeping - 2006

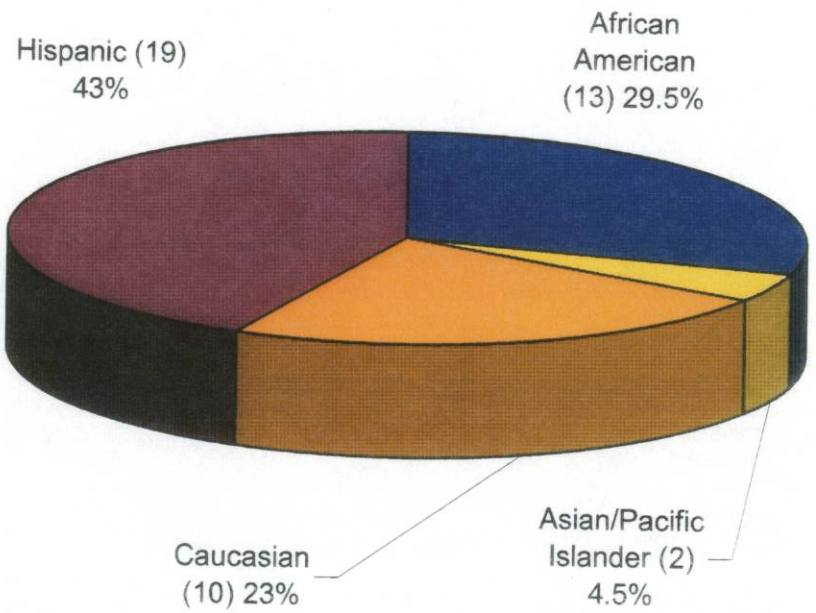


2006 Undetermined Child Deaths Associated with Cosleeping - Age and Race

Age



Race



Percentage of Child Population
in Los Angeles County[1]
Hispanic 59.5%
Caucasian 20%
African American 9.8%
Asian/Pacific Islander 10.4%
American Indian 0.2%

[1] From Los Angeles County Children's Planning Council Scorecard 2006

2006 Undetermined Child Deaths Associated with Cosleeping
Number of Persons