Inter-Agency Council on Child Abuse and Neglect

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Child Death Review Team Report 2011

Report Compiled from 2010 Data

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Forward

In 1978, the ICAN Multi-Agency Child Death Review Team (CDRT) was formed to review child deaths in which a caregiver was suspected of causing the death. The Team reviews these deaths to better understand the dynamics of the systems involved with families in order to help them intervene more effectively to prevent child deaths.

This is the thirty-third annual report of the ICAN CDRT on children's deaths that occurred in Los Angeles County during calendar year 2010. The purpose of the report has been to provide a detailed analysis of children's deaths in Los Angeles County, their relationship to maltreatment, and ICAN agencies' involvement with these children and families prior to and following the death.

The process of the Team has evolved and matured over the past thirty plus years. Initially, most cases reviewed by the Team were child homicides by a parent, caregiver or family member. Today, the Team reviews these cases along with selected undetermined or accidental child deaths. A separate team was formed in 2001 to review child and adolescent suicides in Los Angeles County.

ICAN is including child deaths by a third party for the fourth year to provide an analysis of these deaths in the hope of gaining a better overall understanding of child death in Los Angeles County.

Introduction

The ICAN Multi-Agency Child Death Review 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 and under to ICAN, including fetal deaths, and ICAN staff reviews these cases to determine which ones 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, two to three 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 *2010.* A detailed analysis of quantitative and demographic data of children killed by caregivers, youth suicides, accidental deaths and undetermined deaths is provided.

The report also includes information on 3rd party homicides of youth 17 years and younger for the fourth year. These homicides are where the perpetrator was not a family member or caregiver.

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

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Recommendations

1. **Department of Children and Family Services (DCFS) line staff who were assigned to a referral or case when a child dies or investigates a child fatality, should, whenever possible, participate in the review of the child fatality case by the Team.**

Rationale: The assigned worker to a referral or case will have first hand knowledge of the family and their circumstances. Their knowledge of the family and service providers would be invaluable to providing insight into family dynamics and how case decisions were made.

Note: This recommendation relates to the entire Lessons Learned portion of the report.

2. **Law enforcement personnel responding to domestic violence calls should inquire and physically check for the presence of children in the home. If present, children should be interviewed separately from the adults for signs of physical or emotional injury. A report should be made to DCFS regarding suspected risk to the children's safety and well being.**

Rationale: When there is violence between adults, it impacts children in the home who are at risk for emotional and/or physical abuse as a result of the violence. Domestic violence is often present in families where fatal child abuse has occurred. Law enforcement should check on children in the home and make a referral to DCFS for further assessment by a social worker.

Note: This recommendation relates to the Multiple Parental/Caregiver Risk Factors, Lack of Bonding or Poor Attachment and Domestic Violence sections in the Lessons Learned portion of the report.

3. **Training for all new DCFS staff should include multi-agency participation using the Los Angeles County Child Abuse and Neglect Protocol. This would include law enforcement, medical professionals, mental health, substance abuse counselors, domestic violence counselors, public health, school personnel, and, medical examiners/coroner investigators. Staff should be trained to make joint home calls with other appropriate agency staff such as mental health or public health nurses. They should also have names of multi-agency contacts for consultation when responding to and evaluating suspected child abuse or neglect or assessing a parent/caregiver's progress in addressing the abuse/neglect.**

Rationale: The knowledge and skill base of line staff should be based on best practice. A multi-disciplinary approach ensures professionals make efforts to communicate from the earliest opportunity, coordinate investigations, limit repeat interviews by different

agencies and multiple interviewers, and continue to share information throughout the course of the case. The goal of this approach is to reduce trauma to the child, improve coordination of service delivery, ensure forensic defensibility of services [i.e., medical and interview components], and enhance the courts' ability to protect communities. DCFS staff needs the expertise of other professionals in their assessment of abuse and neglect, gauging the risk to the child and ensuring the safety of the child in the service plans.

Note: This recommendation relates to the Multiple Referrals and Improved Communication among Agencies sections in the Lessons Learned portion of the report.

4. **DCFS staff should be trained on the connection between lack of bonding or poor attachment of the parent/caregiver with a child as a risk factor for child abuse/neglect. Workers need to know the signs of malnourishment and failure to thrive as an indication of poor attachment and high risk for the child. Additionally, information on the relationship of no or little attachment for non-biological parental figures with a child to high risk for abuse should be included in this training**

Rationale: The Team has observed that the perpetrator of child homicide is often a parent who lacked an attachment and bond with the child or was not the biological parent. Poor attachment to a child compounded with lack of parenting skills, knowledge of child development and inability to cope with stressors related to parenting can lead to tragic and lethal results.

Note: This recommendation relates to the Multiple parental/Caregiver Risk Factors, Lack of Bonding or Poor Attachment and Improved Communication among Agencies sections in the Lessons Learned portion of the report.

5. **It is recommended that universal neonatal home visitation by a public health nurse be made available to first time parents and at risk families. SPA's 6 (South Los Angeles) and 8 (South Bay/Harbor) should be targeted initially as they have the most vulnerable families at risk. Both experienced the greatest number of homicides, suicides and infant sleep related deaths in 2010. Families should have the opportunity to accept voluntary services from programs such as the Nurse-Family Partnership, Prenatal Care Guidance, Black Infant Health Program and Best Start LA.**

Rationale: Home visitation has been found to be a highly effective preventive measure to child safety. Home visitation allows for an observation of the home environment, the parent-child interaction, parental attitudes and expectations. Home visitors are trained in identifying post-partum signs of depression or other psychiatric illness and can seek assistance for a family. They can observe the physical home for safe sleeping practices, sanitary conditions, and the presence of unsafe situations such as an unfenced pool, signs of alcohol or drug abuse and domestic violence. Additionally, home visitation services include pre-natal support, parenting skills, household management, resource referrals and coping skills to support high risk families.

Note: This recommendation relates to the following sections of the Lessons Learned portion of the report: Cycle of Abuse, Domestic Violence, Multiple Risk Factors, Verifying the Identity and Relationship of the Caregiver to the Child, Lack of Bonding or Poor Attachment and Safe Infant Sleeping.

6. **First 5 LA, the Department of Public Health (DPH) and the Department of Children and Family Services (DCFS) should continue to provide information on safe sleeping practices to hospitals, community health departments, local clinics, child development networks, community partners and child care resource centers for dissemination to parents.**

7. **First 5 LA and the Department of Health Services should continue to support the pilot at Harbor-UCLA Medical Center to educate hospital staff and parents of newborns on Infant Safe Sleep and Shaken Baby Syndrome.**

8. **In partnership with First 5 LA, ICAN should conduct a Safe Infant Sleep Campaign for the public over the next two years supporting room-sharing but not bed-sharing.**

9. **All professionals who make home visits to a family with a child under the age of one year should assure there is a safe, separate and uncluttered sleeping place for the infant. This would include DCFS staff, Probation Officers, Parole Officers, Law Enforcement, Nurse home visitors, and other family service providers. Information about safe sleeping practices should be emphasized with the parent or caregiver. Training and protocols should include the assessment of safe infant sleep and the information to be provided to inform caregivers during their home visits.**

Rationale: In Los Angeles County, the number of child deaths associated with bed-sharing continues at an alarming rate. Thirty-one percent of undetermined child deaths were associated with bed-sharing in 2010. Families with infants under the age of one year need to be aware of the risks of bed-sharing. Bed-sharing, particularly with a caregiver under the influence of drugs or alcohol increases the chance of overlay or suffocation resulting in Sudden Unexpected Infant Death. Further, the AAP expanded recommendations regarding sleep related infant deaths released in October 2011 to recommend room-sharing and not bed-sharing.

In Los Angeles County, an additional 23% of the infants who died while sleeping were associated with unsafe sleeping environments. Unsafe sleep environments include: sleep surfaces not intended for an infant (adult bed, sofa, couch, chair or futon, baby swing or car seat), excessive or soft bedding; pillow; bumper guards or toys; excessive swaddling; sleeping with face or head covered and a side or prone sleep position.

Note: These recommendations are based on the Safe Infant Sleeping section in the Lessons Learned portion of the report.

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Child Death Review Team

Issues Identified/Lessons Learned

Each case reviewed by the Team yields valuable lessons or identifies systematic issues in need of attention by one, or various agencies impacting the welfare of children and families. The lessons based upon the 2010 child death cases follow. Unfortunately, most are carryovers from the previous report and have continued to surface for years.

1. Cycle of Abuse

A common factor seen in many of the child death cases is that the child's mother, father or other family member had a prior juvenile case themselves in either the Dependency Court or the Delinquency Court, or their family had contact with these agencies when they were a child. Many of them parent as they were parented, thus continuing the cycle of abuse and neglect. Ten of the 2010 child homicides involved a parent or perpetrator with a Child Protective Service (CPS) history as a child.

2. Domestic Violence

ICAN continues to sponsor the annual Nexus conference which includes a focus on the connection between domestic violence and child abuse. This connection continues to be evident in the 2010 child homicides in which nine of the families had a history of domestic violence. Seven of the nine families also had a history of contact with DCFS or another CPS agency.

3. Substance Abuse

Substance abuse by a parent or caregiver is a well documented high risk factor for child abuse or neglect. Substance abuse often plays a role when there is a child fatality if that parent or caregiver responsible for the child had prior reports or history of substance abuse. In some cases, the individual responsible for the child was under the influence during the incident that led to the child's death. A caregiver's unrealistic developmental expectations and inability to cope with age appropriate behavior, combined with drugs and alcohol, become a lethal situation causing caregivers to lose control and harm the child. In addition, parents under the influence who sleep with their infant increase the risk of overlay or suffocation leading to the death of the child. It would be important to assess for substance abuse in child abuse and neglect referrals, particularly when there has been a past history. Relapse is not an uncommon phenomenon and stress is a common trigger.

4. Mental Illness

In 2010, several children were killed by a parent, caregiver or family member with mental illness. Not all individuals with mental illness place their children at risk. However, those with chronic mental disorders who are non-compliant or uncooperative with medication, treatment, family members or other supports have the potential to place children at risk including death. Community service agencies

and treatment providers must be able to identify when a parent's mental condition puts children at risk and report it to DCFS. DCFS, in turn, needs to accurately assess for risk and develop appropriate case plans to address a caregiver's mental health needs. Additionally, the mental health needs of any family member or significant other residing in the home should be assessed.

5. Presence of Multiple Parental/Caregiver Risk Factors

Risk factors such as mental illness, history of substance use, domestic violence, social isolation, CPS contact, CPS contact as a minor and young parents are usually present when a child dies at the hand of a parent or caregiver. In 2010, only two families of homicide victims had none of these known risk factors present. Lastly, one family with no risk factors was temporarily living with extended family that did exhibit risk factors and the perpetrator was from that family.

6. Lack of Bonding or Poor Attachment

The quality of the relationship of a non-biological adult to the child should be assessed. The level of attachment and the child's responses to the adult should be part of the assessment. This is particularly important when the person assumes a caretaking role for the child. The Team has observed that each year, many of child homicides have been at the hands of the parent's boyfriend, girlfriend, step parent or partner who was not attached or bonded to the child, yet had parenting responsibilities for the child. Lacking a connection with the child may contribute to their inability to manage stress or anger and to cope with parenting the child. This is often seen with children who die as a result of blunt force trauma to the head, chest abdomen, or multiple areas.

7. Multiple Referrals

One of the best predictors of future behavior is past behavior. The Team frequently reviews cases where there have been a significant number of prior referrals to DCFS on a family. These referrals are often closed as either inconclusive or unfounded. In a number of cases, re-examining the prior referrals has determined that the finding of unfounded was an incorrect finding and would have been better determined as at least inconclusive and, in some cases, substantiated. This means the reporting to the Child Abuse Central Index (CACI) will also be inaccurate which could allow someone to obtain a child care or foster care license when there has been an allegation against them. Further, the opportunity to offer services to a family at risk is lost which might have been a preventive factor for the death.

8. Immediate Inter-county Sharing of all Referral and Case Information on the Statewide Child Welfare Services/Case Management System (CWS/CMS) among Child Protective Services (SPS) Agencies

Families are not static and move from one county to another within the state. Although a family may have no child welfare history in Los Angeles County with DCFS, they may have had contact with CPS in another county. The Team has learned that workers do not have access to the services case notes or case documents for other counties in closed referrals or cases from another county.

When there is an open court case from another county, a worker can access the court file, but not the services information located on CWS/CMS. Opening CWS/CMS and finding a previous allegation and/or case but not having immediate access to the detailed services case information seems to defeat the purpose of a statewide system. Valuable information and time is lost in assessing risk and providing services to a family.

9. Safe Infant Sleeping

The Team continues to spend a great deal of energy focusing on deaths associated with unsafe sleeping practices involving the sleep position (prone or side) of the infant and/or the sleeping environment. These deaths are tragic and are clearly preventable.

Although the issue of bed-sharing with an infant has sometimes been tied to cultural values and bonding issues, the Team continues to note a disturbing number of deaths associated with bed-sharing and has made recommendations to help prevent these deaths. Infants should be placed in a separate sleep space meant for infants, on their back, and with no soft or loose bedding. In addition, the American Academy of Pediatrics has released research confirming the risk of bed-sharing with infants and recommends against bed-sharing endorsing room-sharing with the infant instead.

The Team has observed that infants are often surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. However, statistics indicate overheating contributes to infant mortality. Infants should not be placed on soft bedding or pillows and should not be covered with blankets or dressed in layered clothing when put to sleep. Infants also should not be placed in cluttered cribs or play pens, car seats, strollers, swings, couches, chairs, futons or adult beds to sleep.

ICAN has partnered with First 5 LA and joined with the Department of Public Health, the Department of Children and Family Services, and other public and community agencies to conduct a safe sleeping campaign. A Safe Sleep Tips for Your Baby brochure has been distributed to local clinics, hospitals, county departments and agencies, and child development networks.

The office of Supervisor Mark Ridley-Thomas has provided leadership and First 5 LA has assumed a major role sponsoring the safe sleeping task force in Los Angeles County. .

10. Drowning/Accidental Death

Drowning has long been a leading cause of accidental child death and some homicides where there is a clear lack of supervision. Through the examination of drowning in various venues, the Team has learned that it is very easy for a young child to drown without anyone being aware of it. A young child's head is heavy and pulls the child under the water before he or she is able to make any sound. Further, drowning is a silent killer. Contrary to popular belief, there is no splashing, waving,

screaming or calling for help. The Team has learned that a drowning child's natural instinct is to breath and speech is secondary. Voluntary movements such as waving are not possible as the natural response is to extend one's arms laterally and press down on the waters' surface to leverage the body in order to lift one's mouth out of the water to breathe. The process of drowning is therefore undramatic and quiet.

In addition, the Team has discussed the concept of diffused responsibility in such cases (and other accidental death cases) where the parties who are supposed to be supervising the child each believe that the other(s) are watching the child; thus, as the responsibility for supervising the child has been diffused among the various adults, in fact, the child is actually unsupervised.

11. Fetal Death Associated with Maternal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appears to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a number of fetal deaths with a contributing factor of maternal substance abuse. Although the number of these deaths has been declining, they remain one of the top four causes of accidental death.

12. Improved Communication Among Agencies

When a family is involved with multiple systems, it is imperative that the agencies servicing the family have ongoing communication with one another for child safety, investigation, and case management purposes. The lack of such communication leaves individual professionals with a one-dimensional view of the case. The Family and Child Index (FCI) is a tool for investigations that alerts an agency of other various agencies having involvement with a family. DCFS, schools, Department of Health, Department of Public Health, Department of Mental Health, Department of Probation, law enforcement agencies, the District Attorney and City Attorneys, and community based agencies should also have ongoing forums to facilitate communication and connections between agencies. These forums would foster better collaboration and understanding of each other's role in child abuse cases. ICAN provides one such forum but others are needed to keep the process going.

13. Poverty/Insurance/Medi-Cal

There have been several cases where a family has been unable to obtain appropriate medical care or medication for a sick child due to a problem with medical coverage – either a lack of coverage, problem with a Medi-cal card, or co-payment. This has also been observed by the Child and Adolescent Suicide Review Team in that a child in need of therapy and/or psychotropic medication did not receive them due to problems with medical coverage or high Medi-Cal co-payments. Medical clinics should ensure that a family is referred to an appropriate medical care setting in the event they present with an ill child and no insurance coverage.

14. Community Care Licensing (CCL)

CCL is the state entity responsible for the licensing and oversight of foster care homes and child care facilities. There have been child death cases in which CCL had informed a provider not to allow certain individuals to be present at the home or day care site as they do not meet licensing standards. This is particularly true of individuals with criminal backgrounds. In many cases, these individuals were actually responsible for the child's death. When CCL bars someone from a site, they need to follow-up to assure there is compliance with their determination. CCL should make unannounced visits to the site to verify compliance.

15. Criminal Justice System

As part of the review process, the Team examines whether or not criminal charges can be filed on any given case. Often these cases are rejected for the filing of charges as there is insufficient evidence to determine the actual perpetrator of the injuries to the child, particularly when there are a number of people present at the time of the death, or the timeline for the death cannot be determined. Team members are often frustrated when charges cannot be filed, especially when the medical evidence is clear that the child suffered inflicted trauma. Despite this frustration, the District Attorney has a strong ethical duty to only file charges when they believe there is clear and convincing evidence beyond a reasonable doubt that someone has committed a crime.

The Team has also discussed the ability of the District Attorney's Office or City Attorney's Office to file charges against a "non-offending" parent for failure to protect the child when they must have been aware of the abuse that the child was suffering. This has been pursued in a limited number of cases.

Child and Adolescent Suicide Review Team

Issues Identified/Lessons Learned

1. Suicide Rate

The suicide rate among individuals under the age of 18 years increased from 14 suicides in 2009 to 16 in 2010. Despite the increase in 2010, we have seen a downward trend in youth suicides over the last ten years. The highest number of youth suicides was in 2001 with 27 which fell to 19 suicides in 2002 and 2003.

2. Law Enforcement Response

Through the review of cases, the Team has seen an increase in the impulsive behavior of youth. In 2010, only four of the youth left suicide notes. The investigative practices among law enforcement agencies vary considerably in cases when suicide is suspected. When there is no suspicion of foul play, some investigations are limited because criminal activity is not present. In such cases additional information available to investigators has value to those concerned with prevention, including the Team. Potent sources of prevention information include the youth's computer, records of the youth's Internet activities, cell phone records and interviews of the youth's friends. Friends may be privy to information that was being kept purposely hidden from parents and family. The team has discovered suicidal teens talk to friends about their mood, feelings, cognitions, behavior and suicidal intent. In addition, the team has discovered Internet communications that indicate risk factors and suicidal thinking to "virtual" friends on social networking sites.

Whenever these sources are not explored, a great opportunity to learn more about suicidal thought and motivation is lost forever. Many law enforcement agencies recognize the prevention value of conducting a thorough investigation in cases of suicidal behavior. The Los Angeles County Department of Coroner has taken the lead in its efforts to expand their investigation and documentation in suspected suicide cases. It is recommended that all law enforcement agencies also develop a protocol for suicide investigations.

3. Social Networking

The role the Internet plays in the lives of youth is an important one. Some youth use social networking to communicate to their peers about their feelings and, in some cases, the intent to end their lives. The Team has developed a social networking template and routinely checks social networking sites and the internet to gain additional information about a youth's mind set and the response to their suicide. The Team has found this to be a great tool to gain a better understanding of a youth.

An important and disturbing trend among suicidal youth is the relationship with Internet "friends." Some youth have been ostracized, bullied or otherwise socially isolated in real life. The Internet provides access to "virtual friends" from which they seek support. While satisfying in many ways, sometimes the relationships are based on "selves" and are often transitory. The internet has become an attractive home for many youth that are deficient in social skills in the actual world. Some youth may have more than one social networking account. For example, parents may have had privileges to access a Facebook page which they monitored on a regular basis. Unbeknownst to them, however, may be one or more accounts being kept private from them and from which they did not access privileges, resulting in a lost opportunity for parents to recognize and respond to suicidal clues of their children. Limited access to private Internet sites is also an obstacle to the ability of the Team to study these cases. Like many parents, the Team is not a user who was pre-authorized to access this information and the Team is prevented from collecting important information about chronic and acute risk factors and warning signs.

4. Communication Barriers between Agencies/Professionals/Parents

Perceived barriers to communication among professionals from schools and/or agencies continue to result in a significant barrier to timely communication that might have resulted in more effective intervention to prevent suicides among youth. Many private practice providers are reluctant to share timely information because they are unaware of important exceptions to legislative requirements to maintain patient confidentiality.

The Team has observed school personnel are often unaware that a students' family is under investigation for suspected child abuse. Schools should always be informed when agencies are working with children. As children spend the majority of their day at schools, they may have crucial information about a child and/or family. Knowing another agency is working with a child may help strengthen the safety net around a child.

Schools are often in a position to provide at risk students with support and they can play a crucial prevention role by monitoring the behavioral effects of medication at school. However, some parents choose to exercise their right to privacy and not disclose to schools that students are at risk and/or receiving services. All agencies providing mental heath services to youth should provide detailed information about the risks and benefits of information exchange and this should be carefully explained to families. The Team has reviewed cases in which the family was not forthcoming to schools, agencies, and social service workers with information about prior suicide attempts with tragic results.

5. Access to Mental Health Services

The Team has observed that parents may have health insurance or Medi-Cal but after the initial intervention, the family's share of cost is a barrier to continue access to mental health intervention for children and youth at risk for suicide. Children at

risk for suicide should have access to culturally competent mental health services without regard to citizenship, immigration status, language or insurance coverage.

6. Need for Monitoring Youth Prescribed Psychotropic Medication

When children at risk for suicide are receiving psychotropic medication for treatment of psychological symptoms, adherence to the medical regimen should be carefully monitored. Health professionals need to consider the financial impact of treatment to reduce non-adherence that occurs when prescriptions are not refilled on a timely basis. The importance of refilling prescriptions needs to be clearly explained to both the child and family.

Team Accomplishments

In 2010 – 11, the ICAN **Multi-Agency Child Death Review Team (CDRT):**

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

- Worked with First 5 LA, ICAN Associates, and the ICAN countywide task force on Safe Sleep to support a grant for a campaign to address preventing sleep related infant deaths.

- Continued to support the distribution of the Safe Sleep Tips for Your Baby brochure on safe sleeping practices with infants.

- Provided data and support to Harbor-UCLA for the pilot to Prevent Sleep-Related Deaths in Infants: A Hospital Quality Improvement Project.

- Provided Team feedback to hospitals who administered treatment to a child that later died.

- Assisted the State Department of Public Health, Safe and Active Communities Branch-Fatal Child Abuse and Neglect Surveillance Program with the audit of Los Angeles County 2009 Child Fatalities attributed to abuse or neglect.

- Joined with Los Angeles County Emergency Services Management (EMS) in support to have more hospitals become trained and certified to be designated Emergency Departments Approved for Pediatric services (EDAP) to improve emergency services to children. Additionally, that emergency services staff be better trained in the recognition and treatment of child abuse.

- Presented a workshop on lessons learned by the Team and how these lessons can help identify at risk children and families at the 16th Annual Nexus Conference.

In 2010 – 11, the ICAN **Child and Adolescent Suicide Review Team (CASRT):**

- Improved case outcomes resulting from Team sharing 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 victims' family and friends as well as any needed cultural advisement.

- Expanded the capacity of the Team to analyze 2010 suicides and responses to them by searching social networking sites for comments and postings.

- Began development of a condolence message for peers to be posted on social networking memorial pages regarding cases reviewed by the Team. The message will contain information about available supportive mental health services.

- Completed an agreement with the Gutin Family Fund of the New Hampshire Charitable Foundation to enable the Team to assist the Los Angeles County Department of Coroner in the development of standardized investigation guidelines for youth suicides.

- Participated in training and multi-agency communication with organizations participating in the Los Angeles County Suicide Prevention Network.

- Participated in workshops at the ICAN annual conference for Childhood Grief and Traumatic Loss and a public lecture at Captain Cook University in Singapore.

Selected Findings

Overall Child Deaths

- There were 256 child deaths in Los Angeles County for 2010, an increase of one death from 2009. Child deaths in Los Angeles County have decreased by 16% from 2006 when there were 306.

- Twenty-six children were victims of homicide by a parent, caregiver or other family member. There were 16 suicides, 86 accidental child deaths and 128 undetermined child deaths.

- The percentage of children who died in 2010 by race/ethnicity consisted of 51.6% Hispanic, 21.5% African American, 21% Caucasian, and 5.1% Asian/Pacific Islander and .8% other. African American children who comprise 8% of the child population in Los Angeles County are disproportionately represented in the number of child deaths.

- Two thirds of the children were between the ages of 0 to three years (n=164). 46% were infants under the age of one year (n=118). More than half the children who died (53%) were under two years of age. Twenty percent of the child deaths were adolescents.

Homicides

- There were 26 child homicides by parents, caregivers or family members in 2010. This represents a decrease (10.3%) from 2009 when there were 29 child homicides. The number of child homicides for Los Angeles County in 2010 was much lower than the 15 year average of 36.4 deaths.

- 77% percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is a decrease from 2009, when 80% of the children were five years of age or younger. Thirty percent of the children were under the age of one year.

- Six children were over age 5, including one 6 year old, two 7 year olds, one 10 year old, one eleven-year old, and one seventeen-year old.

- The two children who died as a result of murder-suicide were siblings and under three years of age.

- The average age of a child homicide victim in 2010 was 3.61 years (43.35 months) and was the same as the previous year.

- Fifteen female children and eleven male children were victims of child homicide by parents, caregivers or family members in 2010.

- Thirty-one percent of the child homicides involved inflicted trauma--two children died from head trauma, one died from multiple traumas, and five died from trauma to the torso/abdomen. Three children died from asphyxiation/suffocation, four from gunshot wounds, six were victims of stabbing, two from drowning, one from strangulation, one from medical neglect, and one was an unattended newborn.

- Three newborns were abandoned and found deceased and/or killed by their mothers in 2010. This is an increase of one death from 2009. The three 2010 abandoned newborns were ruled homicides. Seven newborns were safely surrendered in 2010 which is the same number as in 2009.

- Hispanic (n=11) children were under-represented and comprised 42% of child homicides by a parent, caregiver or relative. African American (n=7) children were over-represented in child homicides by a parent, caregiver or family member accounting for 27% of child homicides. Three children were Caucasian and two were of Asian descent. Caucasian children were slightly over-represented and Asian under-represented.

- The Department of Children and Family Services (DCFS) or another county's Child Protective Services agency had prior contact with 50% (n=13) of the families in which there was a child homicide and the child died in Los Angeles County. This is a decrease from 2009 when 63% of these families had previous contact with DCFS. Two homicides had an open referral on the mother with L.A. County DCFS at the time the fatalities occurred. Two other child homicide victims had an open case with L.A. County DCFS at the time of their death. In one of the two open cases, the child was killed by the foster mother. One victim's family had no history with DCFS, but the perpetrator, who was an extended family member, had a history with DCFS and Probation. There also was an open referral for a sibling of the perpetrator at the time of the homicide.

- Eight children were killed by their father, stepfather or mother's boyfriend and six children were killed by their mother (this includes the three newborn abandonments). Four children were killed by both parents and three by the mother and her boyfriend. Two children were killed by an uncle and one child by a cousin. One child was killed by a minor stepbrother and one child died at the hands of the foster mother.

- The greatest number of child homicides by parents, caregivers or family members occurred in November (n=5). The second greatest number of homicides occurred in the months of March (n=4) and April (n=4). The fewest occurred in the month of December with no homicides. In the month of July there were three child homicides. Two child homicides occurred in the months of

January, February and June. One homicide occurred in the months of May, August, September and October. Thirty-five percent of child homicides occurred in the spring of 2010.

- Child homicides occurred throughout Los Angeles County in 2010. The Service Planning Area (SPA) in the San Fernando Valley - SPA 2 had the greatest number of child homicides (n=7). Six child homicides occurred in SPA 6 located in South Los Angeles and five child homicides occurred in the South Bay - SPA 8. SPA 3 and 4 each had four child homicides and two occurred in SPA 1.

Suicides

- Sixteen children and adolescents committed suicide in 2010. This is an increase from the 14 suicides in 2009, but lower than the 15-year average of 19 suicides per year. The number of suicides has decreased by more than half since 1996 when there were 36 child and adolescent suicides.

- As in years past, male victims outnumbered female victims by a large margin. Eleven males and five females committed suicide in 2010.

- The leading method was death due to hanging, which represents 69% (n=11) of the suicides in 2010. Three of the adolescents committed suicide by overdose. One adolescent stabbed himself and another used a firearm.

- All but one of the suicides occurred at the youth's home. Most of the adolescent suicides were precipitated by interpersonal conflicts.

- Suicides by Hispanic youth represent 63% (n=10) of the total of adolescent suicides and is an increase from 2009 when 50% of suicides were by Hispanics. Twenty-five percent (n=4) of adolescent suicides in 2010 were by Caucasians which is same number as the previous year. Suicides by African Americans in 2010 (n=1) declined from 2009. There was one suicide by an Asian/Pacific Islander adolescent in 2010.

- Sixty-eight percent (n=13) of the children who committed suicide in 2010 were ages 15 – 17; four were 15 years, two victims were 16, and two were 14 years of age. The youngest victim was 11.

- Six of the youth had experienced a recent relationship loss or conflict. Seven of the youths' families had a prior referral or open case with the Department of Children and Family Services or with the Department of Probation. Three other youths' families had contact with CPS in another county. Three youth had a history of mental illness. Three youth had a history of prior self-injury. One youth had previously attempted suicide and three youth exhibited warning signs prior to their suicide. Four of the youth who committed suicide in 2010 left a suicide note. One youth also left a video. The trend of youth not leaving a suicide note

speaks to the impulsivity of the act. Three youths were discovered to have a positive toxicology for drugs at autopsy. One youth had experienced academic problems and one had school discipline or truancy problems.

- Child and youth suicides were experienced in most areas of Los Angeles County. The greatest number of incidents occurred in the South Bay SPA 8 (n=5) and South Central SPA 6 (n=3). Two suicides occurred in SPA one, three and seven each. One occurred in SPA 2 and one in Ventura County in which the adolescent died in LA County.

Accidental Child Deaths

- The rate of accidental deaths among children in Los Angeles County has continued to decline over the years. Accidental child deaths dropped from a high number of 147 in 2004 to 91 in 2009. In 2010, there was an additional decrease of accidental child deaths ages 0 - 17 to 86 from 91 in 2009.

- The two leading causes of accidental death for children ages 0 – 17 years were auto pedestrian (n=28) and automobile accidents (n=16). Of the 86 accidental deaths, 63 accidental child deaths involved children ages 0 – 14 years. This is a 7% decrease from 68 such deaths for this age group reported for 2009. Sixty-four percent of auto pedestrian deaths were children ages 0 to 14 years. There were 23 accidental deaths of youth's ages 15 to 17 years. Youth ages 15 to 17 years accounted for 31 % (n=5) of automobile related deaths in 2010.

- Auto pedestrian (n=18) deaths were the leading cause of accidental death for children 14 years of age and under. Five of these deaths involved toddlers whon who were backed over in a driveway. Deaths due to automobile accidents (n=11) were the second leading cause for this age group. Maternal substance use accounted for nine deaths. Drowning and accidental overdose (n=6 each) ranked fourth as the leading cause of accidental death of children 0 – 14 years.

- Deaths associated with maternal substance abuse accounted for 8 fetal deaths and the death of an eleven year old. Methamphetamine is the most associated drug with these deaths (n=5) accounting for 55.5% with cocaine accounting for the remainder. Deaths associated with maternal substance abuse accounted for 10% of all accidental deaths in 2009, and fetal deaths associated with maternal substance abuse accounted for 9% of all accidental deaths.

- Accidental drowning claimed the lives of 6 children ages 0 – 17 years, a decrease from 2009 when there were 10 such deaths. A majority of these drowning deaths were young children who drowned in residential pools. Drowning continues to be one of the leading causes of accidental deaths of children for the past fifteen years in Los Angeles County.

- Hispanic children represented 53.5% (n=46) of all accidental child deaths in 2009. Sixty-eight percent of the auto pedestrian deaths were Hispanic children. Caucasian children represented 31% (n=27) of the accidental deaths. Caucasian children were over-represented in auto pedestrian deaths (n=6). African-American children (n=10) were slightly over-represented in accidental deaths in 2010. Thirty percent of the African-American accidental child deaths were due to maternal substance use. Asian/Pacific Islander children were under-represented in 2010 accounting for 3.5% of all accidental deaths.

- In 2010, as in previous years, males (n=51) outnumbered females (34) in accidental death by a three to one margin. In 2009, 53 male children and 38 females died due to accidental death.

- As in past years, male children tend to over-represent female children in nearly all types of deaths.

Undetermined Child Deaths

- There were 128 undetermined child deaths in 2010. This is a slight increase from the 121 such deaths in 2009 and significantly higher than the 15-year average of 80.9 undetermined deaths per year. Seventy percent of the undetermined child deaths were age one year and under (this includes stillborn deaths). Eighty-five percent of undetermined child deaths were age five years and younger.

- African American (n=37) children were over-represented in undetermined child deaths. Sixty-five children were Hispanic, 17 Caucasian, 7 Asian/Pacific Islander and two were of unknown descents.

- Bed-sharing and unsafe sleeping environments accounted for 54% percent of all undetermined child deaths. Of these undetermined child deaths, 31% were associated with bed-sharing and 23 % with an unsafe sleep environment.

- Among the bed-sharing deaths, 17.5% involved one unsafe risk factor, 30% involved two, and 52.5% involved three or more unsafe risk factors. Risk factors included an adult bed, couch, futon, snuggie nest, soft or excessive bedding, excessive swaddling, pets, parental drug/alcohol use, and prone or side positioning.

- African American children are over represented in the percentage of both bed-sharing and unsafe sleeping environment child deaths. Twenty-eight percent of the bed-sharing deaths and 41% of the unsafe sleeping environment child deaths were African American. African American children represent 33% of all the unsafe sleep undetermined deaths.

- Fifty-one percent of the bed-sharing and unsafe sleep child deaths occurred in an adult bed, 17% on a couch and 12% in a crib.

- In 60% of the bed-sharing and unsafe sleep child deaths, the infant was placed in a prone or side position for sleep.

- Undetermined child deaths involving bed-sharing and unsafe sleeping environments occurred throughout Los Angeles County. However, three SPAs accounted for the majority of these deaths. Thirty percent (n= 21) occurred in SPA 6 and 19% (n=13) each for SPA 8 and SPA 2.

- Thirty-one percent (n=40) of the undetermined child deaths involved bed-sharing. This is a slight decrease from 2009 in which 33% of undetermined child deaths involved bed-sharing.

- Forty-five percent (n=18) of the bed-sharing deaths were infants between 0 to 3 months of age, 42.5% (n=17) were infants between 3 to 6 months of age, 7.5% (n=3) were over 6 months to 9 months of age, and 5% (n=2) were 9 months to 1 year.

- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 30% of the incidents and two adults in another 30% of the incidents.

- Twenty-three percent (n=29) of undetermined child deaths were associated with unsafe sleeping environments which Include adult bed, couch, futon, car seat, stroller, pillows, soft or excessive bedding, excessive swaddling, stuffed toys, a plastic bag, pets, bed-sharing, parental drug/alcohol use, prone or side positioning.

- Sixty-six percent (n=19) of the infants involving unsafe sleeping environments were put to sleep prone or on their side. Ten of these deaths involved pillows/soft or excessive bedding, four were in an adult bed, six on a couch and four were excessively swaddled.

- Two-thirds of the infants whose deaths occurred in unsafe sleeping environments were six months or younger.

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 of Los Angeles. Fetal deaths over 20 weeks gestation at the time of death are included in the report as a conservative cut off point for a viable fetus.

Homicides, by the 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 one of the largest categories of deaths reported to the Team by the Coroner. Several types of accidental death, such as auto pedestrian fatalities, drowning, hangings and accidental gunshot wounds, are truly unintentional in nature. However, there may be questions of the caregiver supervision in some of these cases, as well as concern regarding the preventability of these accidents. A significant number of accidental deaths involve newborns who were prenatally exposed to drugs and who subsequently died of prematurity or from other related perinatal causes

Natural deaths are rarely reposted to the Team and are not included in the Team's annual report.

Suicide, by the 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 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. For 2010, this mode of death represents the largest category of deaths reported to the Team by the Coroner. 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 bed-sharing.” In these cases, the Coroner is unable to determine the role bed-sharing may have played in the death, e.g., suffocation by accidental layover or some other cause.

Child Deaths in Los Angeles County 2006 – 2010

Over the past 5 years, a parent, caregiver or other family member has killed an average of 30 children each year.

2006	35[1]
2007	26
2008	34
2009	29[2]
2010	26

An average of 14 children and adolescents each year has *committed suicide* over the past five years. The leading method from 2006 through 2010 was hanging.

2006	14
2007	10
2008	17
2009	14
2010	16

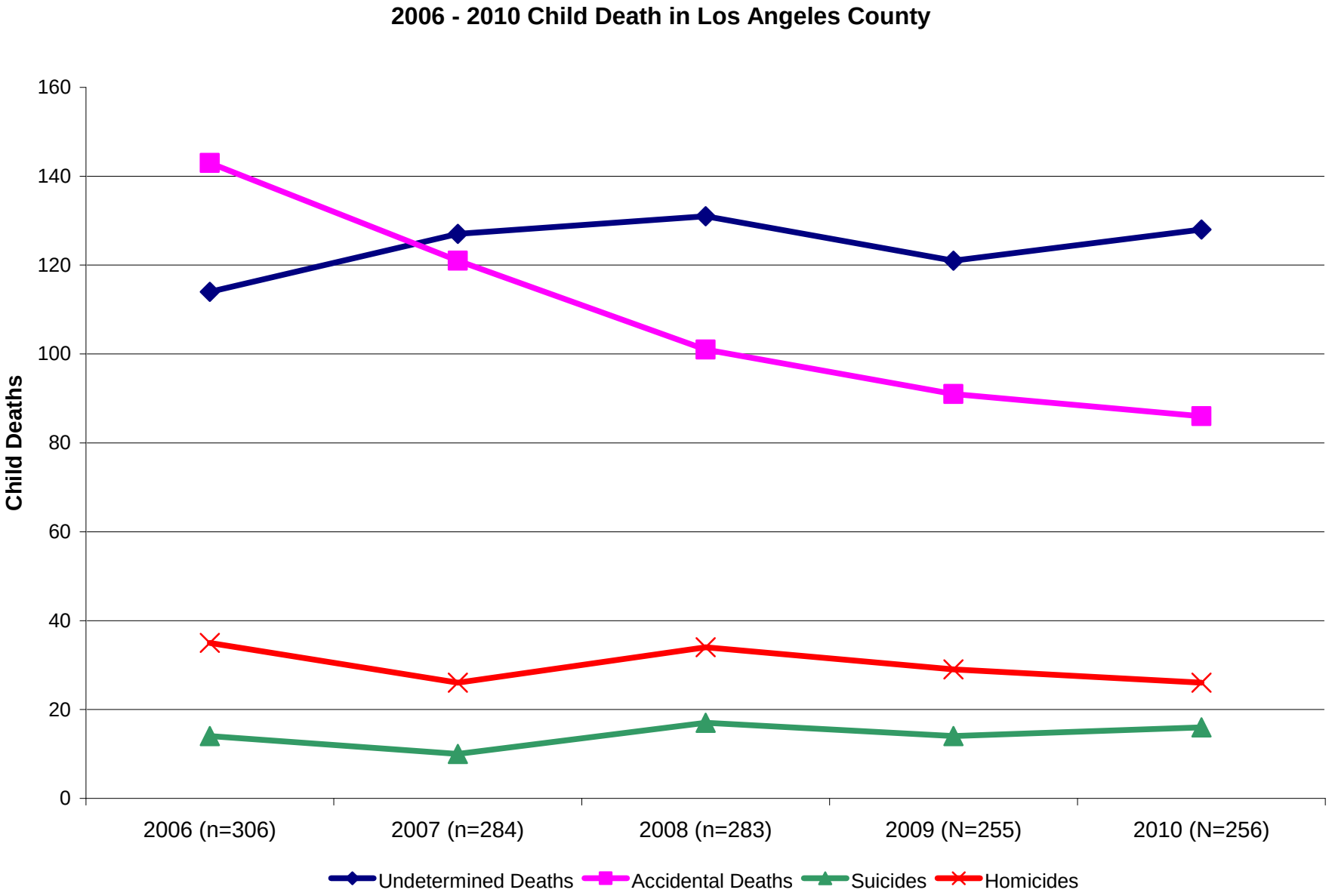
Over the past five years, an average of 108.4 children have died from preventable accidents. The most common accidental Deaths involve auto pedestrian, automobile accidents and deaths due to maternal substance abuse.

2006	143
2007	121
2008	101
2009	91
2010	86

The number of undetermined deaths has averaged 124.2 per year over the past five years.

2006	114[3]
2007	127
2008	131
2009	121
2010	128

[1] Upon review by the Team in 2008, one case moded as undetermined was reclassified as a homicide and one homicide autopsied in another county was not reported to ICAN for inclusion in the 2007 report.
[2] A homicide in which a familial relationship was initially suspected turned out to be a family acquaintance changing it to a third party homicide and decreasing the number of these for CY 2009 from 30 to 29.
[3] See 1 above.


2006 - 2010 Child Death in Los Angeles County
Child Deaths
160
140
120
100
80
60
40
20
0
2006 (n=306)
2007 (n=284)
2008 (n=283)
2009 (N=255)
2010 (N=256)
Undetermined Deaths
Accidental Deaths
Suicides
Homicides

Child Homicides by Parent, Caregiver, or Other Family Members 2010

Case Summary
Child Homicide by Parent/Caregiver/Family Member

At 7:00 pm, Los Angeles Sheriff's Deputies arrived at a residence in South Gate responding to a domestic violence call at the same time the paternal aunt was pulling up to the home. The mother, Angela, age 27 was on the front lawn bleeding profusely holding the baby and screaming that her boyfriend was inside the home killing the children. The aunt who lived just blocks away stated she received a call from the boyfriend, Fernando, to pick up the kids because he had stabbed the mother.

The mother, boyfriend and seven children resided in the two bedroom apartment. Two children ages nine and six were the boyfriend's from a former marriage and three children, ages five, eight and seven were the mother's from a previous relationship. The couple, who are not married, had two children in common ages 18 months and five months. They had been together for the past three years. Fernando worked late afternoon into the early morning and Angela took care of the children. Fernando's children had told him in the past how Angela would treat them differently, be mean and hit them when he was at work. The parents would often fight about the children.

When the deputies entered the home, they observed 5 year old Tomas on the living room floor not breathing and bleeding from the stomach and back. He was pronounced at the scene. Fernando was covered in blood sitting on a couch and there was a bloody knife on the floor next to him. A second bent bloody knife was found in the hallway of the residence. Large amounts of blood was observed in the living room, hallway and children's' bedroom. Empty beer cans were in the kitchen and living room from a now empty 24 pack of beer. The mother was transported to a hospital and survived her injuries. The rest of children had fled the residence to various neighbors' apartments in the complex. The boyfriend admitted to the stabbings because he was angry at what the mother had done to his children. He was arrested for the murder of Tomas and attempted murder of Angela. The children were located and taken into protective custody.

On the night of the incident, the older children reported to homicide detectives and the DCFS worker that the parents had been drinking. Fernando was upset with Angela for teasing his six year old son, Jesus for not finishing his dinner. The parents were watching TV in the living room and continued drinking after dinner while the children went to their bedroom. Jesus and Angela's 8 year old daughter, Desiree got into an argument because she was trying to wipe his face with soiled baby wipe. Angela came into the bed room and saw Jesus pulling Desiree's hair. Angela grabbed Jesus and brought him to the father stating "take care of your big baby." The father yelled at her to "leave him alone." He called Jesus over, whispered something in his ear and sent him back to the bedroom. Angela became enraged and followed Jesus into the hallway

grabbing and punching him with her fists. Fernando went into the kitchen and retrieved a knife and began stabbing Angela in the back as she was pushing Jesus into the bedroom. She screamed she would "leave his son alone" and turned toward Fernando who then punched her in the face and stabbed her another time. She fell onto the lower bunk of one of the beds where the five month old was and picked him up in the hope he would stop. Fernando stopped and yelled at his daughter that she got what she wanted and left the room.

All of the children were upset and crying in the bedroom. Angela tried to calm them and told them to get towels to help clean up the blood. She moved toward the living room with the baby in her arms, opened the door and ran out. Fernando started to go after her but slammed the door and went to the kitchen retrieving another knife. He went after Angela's children saying "you guys are next." Screaming, the children scattered but he caught Tomas and began to stab him. The nine year old who had been holding the 18 month old yelled at the other children to get out of the apartment and ran out after them.

The investigation revealed DCFS had two previous contacts with Angela prior to this incident. One in 2004 for domestic violence with the older children's biological father who was arrested. The referral for emotional abuse was closed as inconclusive. The second referral was for general neglect in 2007 when the mother and children lived in a dilapidated trailer. The referral was ruled unfounded and closed. There was no DCFS history on Fernando or the biological mother of his children who died in 2007. Neither Fernando nor Angela had any criminal history. The father of Angela's older children had a long violent criminal history including spousal abuse and child cruelty. He is incarcerated in state prison for possession of methamphetamine for sale and car jacking.

The children reported Fernando would discipline his own children using a belt but did not discipline Angela's children. Angela would yell at her children but would hit and pinch Fernando's children. She favored her children over her boyfriends and would treat them much better. The parents would argue verbally but it never got physical before this incident. The parents would drink a lot of beer but would usually be happy and not mad when drinking.

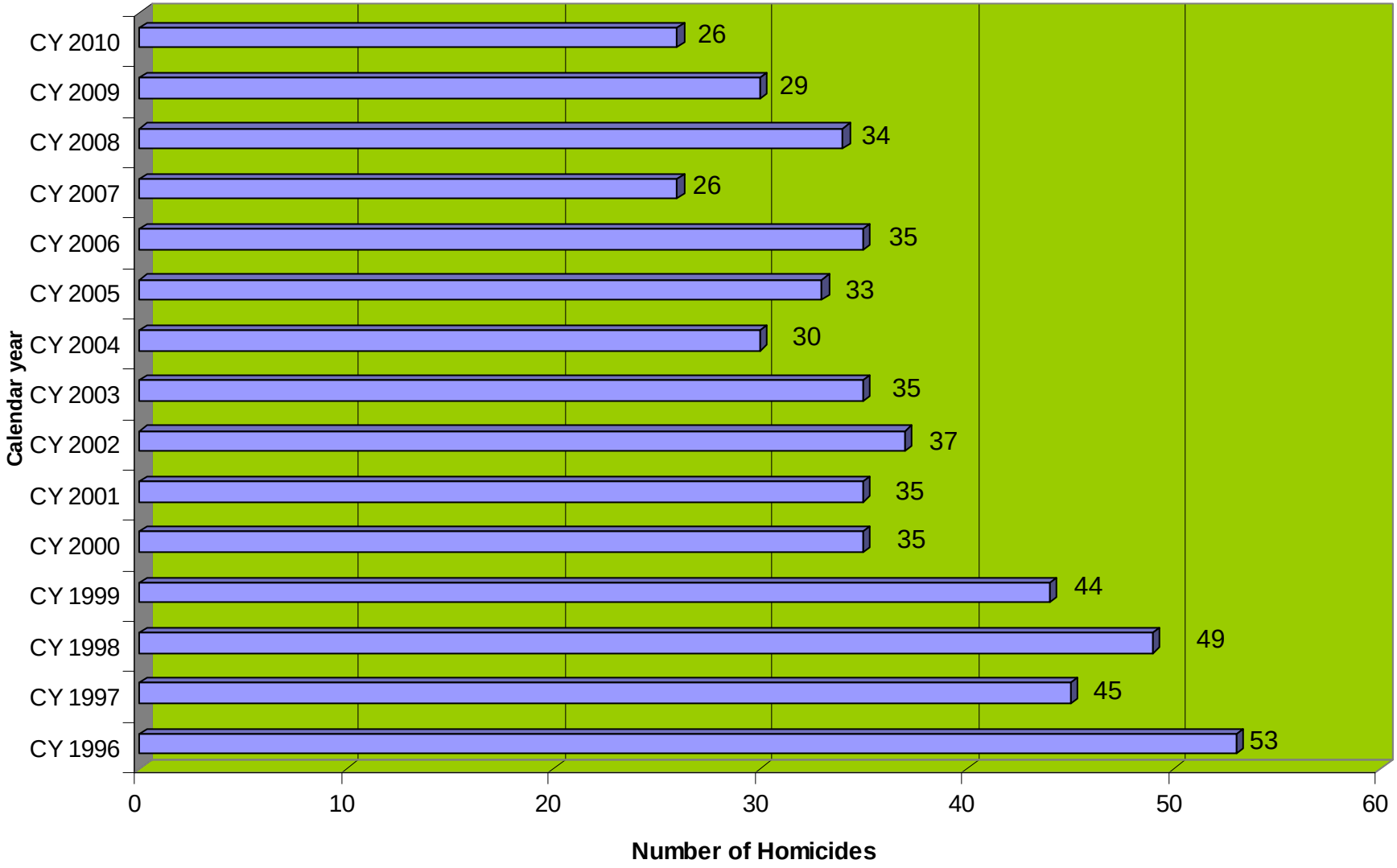
Relatives were shocked to hear what happened. Everyone described Fernando as nice, passive, with no history of violence toward women, and a good, loving father. Maternal relatives expressed they would have expected this from the older children's father, who constantly beat up the mother, especially when under the influence. Police were called numerous times to the home and he was arrested for domestic violence several times.

The Team reviewed the case and noted in the 2007 referral to DCFS, the father was arrested for domestic violence and yet the referral was closed as inconclusive. As in other cases reviewed, the finding of "inconclusive" seemed inappropriate and should have been sustained. The mother and children may have then received services for domestic violence and parenting. It was surmised Angela continued to replicate the dynamics involved with the cycle of abuse with Fernando having not addressed her victimization from her previous relationship. The need for additional staff training on referral findings was recommended.

There were many common red flags present in the family as seen in other child homicide case reviews in addition to the history of domestic violence. There was a history of substance abuse and current abuse. Both Angela and Fernando were drinking the night Tomas was killed. It was revealed the parents also smoked marijuana on the day of the incident. This was a blended family and the lack of attachment of each parent to the other's children was apparent. Tomas was not liked by Fernando because he constantly teased Jesus and Angela would not intervene. Angela's differential treatment toward Fernando's children indicated her lack of attachment to them. The Team wondered how much support Fernando received for grief over his wife's death a few years earlier.

Fernando was sentenced to 25 years to life in prison for murder and attempted murder. The children were placed with various relatives and Angela offered family reunification services in Dependency Court. The children were enrolled in age appropriate play therapy and grief counseling. No family reunification services were ordered for both fathers who remain incarcerated.

1996 - 2010 Child Homicides by Parent, Caregiver, or Family Member



Causes of Child Homicide by Parent/Caregiver/Family Member
1996 – 2010, Los Angeles County

	’96	’97	’98	’99	’00	’01	’02	’03	’04	’05	’06	’07	’08	’09	’10	Total
Head Trauma	15	12	13	15	5	5	2	7	7	6	11	11	12	8	2	131
Multiple Trauma	7	10	8	10	11	7	7	10	7	8	7	7	4	2	1	106
Asphyxiation/suffocation	4	4	3	6	3	8	5	6	5	5	6	6	3	2	3	69
Gunshot Wounds	4	7	10	4	3	2	1	4	3	6	1	1	8	7	4	65
Trauma to torso/abdomen	5	4	2	1	0	0	3	0	0	2	1	1	1	1	5	26
Drowning	0	2	2	0	3	1	7	1	1	2	3	3	0	1	2	28
Fire	8	0	4	0	1	0	0	0	0	0	3	3	1	0	0	20
Stabbing	2	0	2	1	4	1	2	0	3	2	2	2	2	4	6	33
Unattended newborn	0	1	3	4	2	3	2	3	0	1	0	0	1	2	1	23
Poisoning/drug ingestion	2	0	0	0	0	3	6	1	1	0	0	0	0	0	0	13
Dehydration/malnutrition	1	1	1	0	1	1	0	1	2	0	0	0	1	1	0	10
Strangulation	2	2	1	0	0	0	0	0	0	0	1	1	0	0	1	8
Medical neglect	0	0	0	0	1	2	0	0	0	0	0	0	0	1	1	5
Neck compression	2 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Burns	0	1	0	1	0	1	0	0	0	0	0	0	0	0	0	3
Hyperthermia	0	0	0	0	0	0	0	2	0	0	0	0	1	0	0	3
TOTAL	51	44	49	42	34	34	35	35	29	33	35	35	34	29	26	544

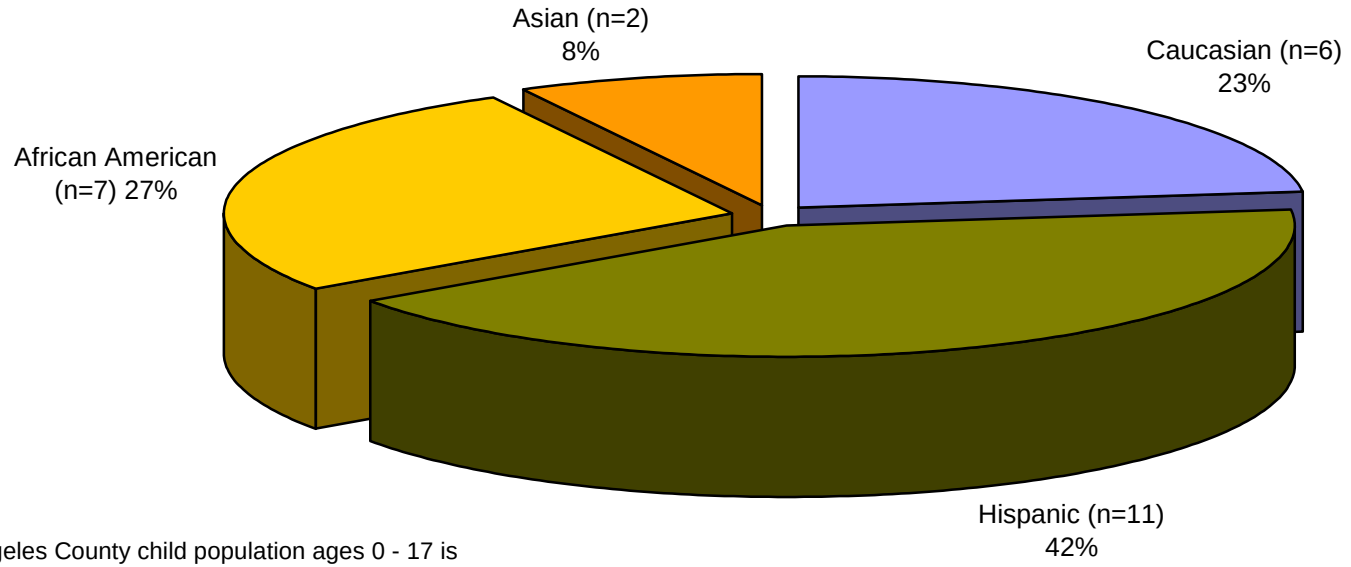
Child Homicide by Parent/Caregiver/Family Member
Los Angeles County – 2010 (N= 26)

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

30% of the child homicides by parents/caregivers/family member were under one year of age.

77% of the child homicides by parents/caregivers/family member were five years of age or under.

2010 Child Homicides by Parent, Caegiver, or Family Member



Los Angeles County child population ages 0 - 17 is 2,718,551 . 62.4% are Hispanic, 17.3% are Caucasian, 9.4% are Asian American, 8% are African American, 2.7% are Multi-racial and .2% Native American. Kidsdata.org 2011.

Criminal Justice System Involvement

Information on the criminal justice system involvement in child homicides by parent/caregiver/family member is gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). Other police agencies participate in Team review of cases they have investigated. The law enforcement agencies and number of cases for which they are responsible for the investigation are shown in Table 1.

Table 1

Law Enforcement Agency Involvement in 2010 ICAN Child Homicide by Parent/Caregiver/Family Member

Agency	N	%
LASD	7	27
LAPD ACU	8	30.8
LAPD	3	11.5
Inglewood P.D.	1	3.8
Long Beach P.D.	2	7.8
Covina P.D.	1	3.8
Alhambra P.D.	3	11.5
Redondo Beach P.D.	1	3.8

The Los Angeles Police Department had investigative responsibility for 42.3% (n= 11) of the 2010 child homicides by parents/caretakers/family member. The LAPD Abused Child Unit was responsible for eight of the investigations. The Los Angeles Sheriff's Department had investigative responsibility for 30.9% (n=7) of the child homicides by parents/caretakers/family member. Slightly more than thirty percent (n=8) of the cases were handled by jurisdictions other than LASD and LAPD. Eight different law enforcement agencies were responsible for the investigation of child homicides by parents/caregivers/family member in 2010.

There were a total of thirty-six suspects in the twenty-six homicide cases. Eight of the 2010 cases involving child homicide by parents/caregivers/family member were not presented to the District Attorney. The reasons why those cases were not presented are displayed in Table 2.

The most common reasons for law enforcement not presenting a case were that the perpetrator committed suicide after killing the child, there was insufficient evidence to file or the investigation is ongoing. One child homicide occurred outside of Los Angeles County and was covered by another jurisdiction. Two cases remain under investigation. In the cases with insufficient evidence, a clear perpetrator or timeline could not be established in one case and was closed. The other case involving a parent bed-sharing with an infant while under the influence was not filed on by law enforcement. Lastly, one homicide of an adolescent was ruled a case of self-defense by law enforcement.

Table 2

Law Enforcement Reasons for Not Presenting 2010 ICAN Child Homicide by Parent/Caregiver/Family Member

	n	%
Murder/suicide	2	25
Under Investigation	2	25
Insufficient Evidence	2	25
Homicide Ruled Self-Defense	1	12.5
Injury did not occur in LA County	1	12.5
TOTAL	**8**	**100**

Table 3

Criminal Charges Filed on 2004 - 2010 ICAN Child Homicide by Parent/Caregiver/Family Member	2004	2005	2006	2007	2008	2009	2010
Murder (187 (a) P.C.)	27	32	20	21	20	13	16
Assault on a child under 8 years resulting in death (273ab P.C.)	23	20	15	17	16	11	7
Child abuse (273a(a) P.C.)	24	34	11	28	19	5	10
Child endangering (273a(1) P.C.)		1					
Corporal punishment or injury of child (273d P.C.)				1			
Child abuse resulting in death (273a(a) 2 P.C.)							
Voluntary manslaughter (192a P.C.)	2	1	1	5	1		1
Involuntary manslaughter (192b P.C.)		5		1	1		
Vehicular manslaughter DUI with gross negligence (191.5(a) P.C.)		1		1			
Vehicular manslaughter (192 (c) P.C.)		5					
Vehicular manslaughter for financial gain (192(c)(3) P.C.)		1					
Attempted voluntary manslaughter (664/192 (a) P.C.)	1						
Attempted murder (664/187 (a) P.C.)	1	1		1	12		3
Attempted robbery of person (664/211 P.C.)		1					
Lewd and lascivious acts by force (288(b)(1) P.C.)	1						
Sexual penetration with unconscious victim (289(d)(a) P.C.)	3						
Public exposure of private parts (314(1) P.C.)		1					
Kidnapping (207a P.C.)				2			
Unlawful detention (278 P.C.)	4						
Assault against a peace officer (245 © P.C.)		2					
Battery (242-243(e) 1 P.C.)				1			1
Threat of death or great bodily harm to immediate family (422 P.C.)		1					
Spousal abuse (273.5 P.C.)		1					
Torture (206 P.C.)	4	1		1		3	1
Mayhem (203 P.C)		1					
Assault to commit rape/mayhem							1
Vandalism (594 P.C.)				1			
Discharge of firearm inhabited dwelling (246 P.C.)	1						
Assault with semiautomatic weapon (245 (b) P.C.)	2						
Unlawfully causing a fire of any structure (451B)		1					
Aiding and abetting a designated felony (32 P.C.)		3					1
Financial gain from prospective adoptive parents (273(d)(a) P.C.)	3						
Possession of marijuana for sale (11359 H&S)		2					1
Unlawful to drive while DUI (23153(a) V.C.)		1					
Unlawful to drive with .08% or more DUI (23153(b) V.C.)		1					
Failure to stop @ accident scene resulting in injury/death (20001(a) V.C.)		1					
Flight of peace officer causing serious bodily harm (2800.3 V.C.)		1					
Fleeing pursuing peace officer (2800.2(a) V.C.)		1					
Criminal storage of a weapon with access to a child							2

In 2010, 18 of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving 24 perpetrators.

Of the 18 cases, one was referred back for further investigation by law enforcement and another was declined due to insufficient evidence. The case referred back for further investigation involved one perpetrator, a mother of an abandoned deceased infant. The case declined for insufficient evidence involved a mother and her boyfriend.

The charges filed by the District Attorney in the past five years are illustrated by Table 3. The District Attorney filed criminal charges on 89% (n=16) of the 18 homicide cases presented to them by law enforcement. Charges were filed against 21 perpetrators. The most frequent charge in 2010 was murder followed by child abuse. With the exception of three perpetrators, murder charges (187 (a) P.C.) were filed on the cases in which charges were filed. In one case, the parents were charged with allowing the minor child, who was the perpetrator, access to a firearm. The third perpetrator did not kill the child but was charged with child abuse leading to the death of a child.

Table 4

Relationship of Perpetrators - 2010 ICAN Child Homicide by Parent/Caregiver/Family Member

Relationship	ID'd by Police	Charged By DA
Mother	13	6
Father	6	3
Stepfather	2	2
Mother's Boyfriend	6	4
Foster Mother	1	1
Foster Mother's Boyfriend	1	1
Uncle	2	2
Cousin	1	1

In 2010, there were multiple perpetrators identified by law enforcement and charged by the District Attorney in five cases. In three cases in which charges were filed, the mother was implicated along with the mother's boyfriend or stepfather. In one case, the foster mother and her boyfriend were charged.

Table 5

Criminal Case Disposition of 2004 - 2011 ICAN Child Homicides by Parent/Caretaker/ Family Member[4]	2004	2005	2006	2007	2008	2009	2010
Life without possibility of parole	1	1	1		1		2
80 years to life prison							1
50 years to life prison	1	2	1			1	1
40 years to life prison						1	
35 years to life prison							
26 years to life prison	2		2				
25 years to life prison	1	1	1	6	8	2	7
24 years to life prison							
22 years to life prison							
19 years to life prison						1	
17 years to life prison						2	
16 years to life prison		1					1
15 years to life prison	2	1	2	2	1	3	1
14 years prison							
13 years prison						1	
12 years prison			1	1	4	1	1
11 years prison	1	1	2	3	4	1	2
10 years prison	1	1	2	2		1	1
9 years prison		1	1				
8 years prison	1	1	4				1
6 years prison	1	1	1	2	2	1	1
5 years prison					1		1
4 years prison	1	1		2		1	1
3 years prison							
2 years prison	1	3	1	2	1		
16 months prison			1		1		
3 years jail							
1 year jail	1	1	1				1
9 months jail			1				
6 months jail		1					
Less than 3 months jail	1	1	2			1	
6 yrs Probation							
5 yrs Probation	2	1	1		2		
3 yrs Probation	2	3					
Found not guilty	1						
Dismissed		3	3				1
Arrest warrant	2					1	
Mental competency hearing		1		1	1	1	
Sentence pending				1	1	1	
Pending trial	1	1	1	2	2	19	22
Pending Further Investigation	2					4	1
Total C/A Homicides for year	**30**	**33**	**35**	**26**	**34**	**29**	**26**

[4] Criminal Disposition is the year a case concluded and includes cases filed in previous years.

Criminal disposition data for 2004 through 2010 is presented in Table 5. The table reflects the year a perpetrator was sentenced and the majority of cases are concluded one to two years after the filing date. In 2010, eight perpetrators were sentenced to 25 years to life in prison, two to life without the possibility of parole, one to 80 years to life and one 50 years to life. One perpetrator was sentenced to 1 year in county jail and five years of probation. The remaining sentences varied from 4 to 16 years in prison. One case was dismissed by the court.

The status of the 2004 cases has changed from 2009, and there are now two arrest warrants outstanding and two cases referred for further investigation. For 2005, one continues for mental competency and one case is still pending trial. One 2006 case remains pending trial in 2010. Two cases are still pending trial from 2007. Of the 19 pending cases from 2008, only two remain pending. Nineteen of the 26 cases from 2009 are still awaiting trial in 2010. With the exception of one case referred back for further investigation and one conviction of 25 years to life in prison, the 2010 cases are pending trial.

The most frequent sentence received in 2007 (n=6), 2008 (n=8) and 2010 (n=7) was 25 years to life in prison. As of 2010, the next most frequent range of sentencing for perpetrators from 2004 to 2010 was 10 to 15 years in prison.

2010 Child Homicides by Parents, Caregivers or Family Member Child Welfare Involvement 1996 – 2010*

Year	Total # of homicides by parent/care giver/ 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
1996	53	13	7	6	2 – relative caregivers 2 –foster parent
1997	45	15	8	7	2– relative caregivers 2 foster parent
1998	49	20	16	4	1 relative caregivers 0– foster parent
1999	44	20	12	8	2– relative caregivers 2 – foster parent
2000	35	15	7	8	2 – relative caregivers 0 – foster parent
2001	35	12	7	5	3 – relative caregivers 2 – foster parent
2002	37	Not Available	Not Available	Not Available	0 – relative caregivers 1 – foster parent
2003	35	18	13	5	2 – relative caregivers 2 – foster parent
2004	30	15	9	6	2 – relative caregivers 0 – foster parent
2005	33	14	11	3	1– relative caregivers 0 – foster parent
2006	35[5]	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3[6]	1 – relative caregivers 0 – foster parent
2008	34	14[7]	6	8	0 – relative caregivers 0 – foster parent
2009	29[8]	19[9]	14	5[10]	1 – relative caregivers 0 – foster parent
2010	26	13[11]	9	4	0– relative caregivers 1 – foster parent

***Data is based on the Coroner's findings as Homicide and not the broader definition used by DCFS based on SB 39 Child Fatality Reporting and Disclosure Requirements**

[5] The CDRT reviewed an undetermined child fatality and changed the manner of death to "homicide". The case was open to DCFS when the fatality occurred. Another open DCFS case with a homicide was autopsied in another county and not reported to ICAN for inclusion in the 2007 report.
[6] One was open to another county.
[7] ICAN counts only deaths in LA County ruled a homicide by the Coroner. Two children died in LA County but were injured in another county and under that county's CPS supervision.
[8] In 2011, a homicide suspected of a familial relationship turned out to be a family acquaintance and it became a 3rd Party homicide. The 2009 homicides decreased from 30 to 29 as a result.
[9] Includes two deaths with a CPS history in another state and one death with history in another county.
[10] One child died in LA County was under the jurisdiction of Riverside CPS.
[11] One child died in LA County had history in another county but not in LA County

SENATE BILL 39 (SB 39)

DATA VARIANCES BETWEEN ICAN CHILD HOMICIDES AND DCFS CHILD FATALITIES

SB 39 mandates public disclosure of information and findings about children who have died as a result of abuse or neglect under the following circumstances:

> It is reasonably suspected that the child fatality is the result of abuse or neglect; the child resided with a parent or guardian or in foster care at the time of the death; and the abuse and neglect was substantiated by the Coroner, law enforcement or DCFS.

ICAN findings are based on the final mode determined by the Coroner. The DCFS data set for child fatality determinations is based on SB 39 requirements, which provides for a more liberal determination that may precede Coroner findings. DCFS can substantiate the child fatality was due to abuse or neglect or law enforcement can determine a crime occurred although the Coroner ruled the death as accidental or undetermined and not a homicide. As a result, the number of child fatalities reported by DCFS under SB 39 differs from ICAN and is subject to change.

Additionally, DCFS reports child fatalities by a parent or guardian with a previous history with LA County. ICAN reports pertain to child deaths with a mode of **homicide** by the Los Angeles County Coroner. DCFS involved homicides that occur outside of Los Angeles County are not included in the ICAN report. ICAN also includes the history of out-of-county CPS involved child homicides by a parent/caregiver or family member if the child died in Los Angeles County.

Relationship of Suspect to Child Homicide Victim – 2010

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

11– Father, Stepfather or mother's boyfriend

12 – Mother

1– Both parents

2 – Mother and Boyfriend

1– Step-brother [12]

2 – Uncle

1 – Foster Mother

1 – Foster Mother's boyfriend

1– Cousin

Dates[13] of Child Homicides – 2010

2 homicides occurred in January (1/08 & 1/26/2010)

2 homicides occurred in February (2/25 & 2/26/2010)

4 homicides occurred in March (two on 3/03, 3/04 and 3/20/2010)

4 homicides occurred in April (4/1, 4/08/, 4/10 and 4/29/2010)

1 homicide occurred in May (05/14/2010)

2 homicides occurred in June (6/9 & 6/13/2010)

3 homicides occurred in July (two on 7/09 & 7/22/2010)

1 homicide occurred in August (8/03/2010)

1 homicide occurred in September (9/16/2010)

1 homicide occurred in October (10/06/2010)

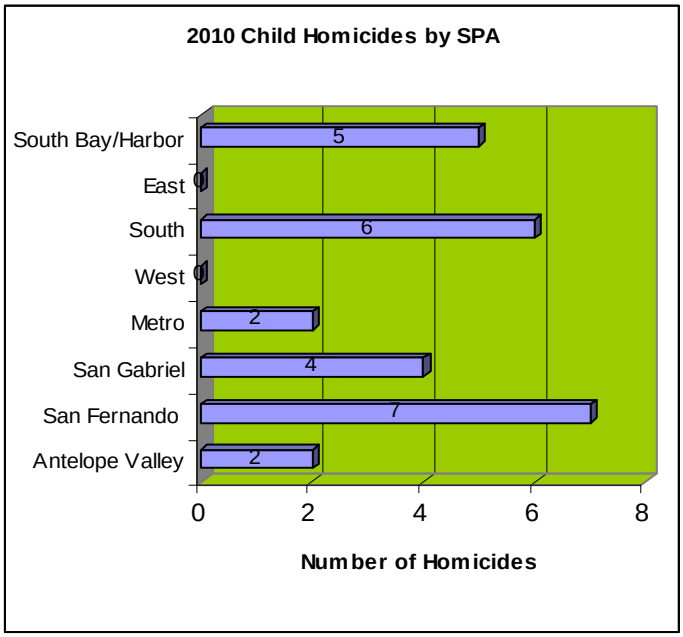
5 homicides occurred in November (11/01, 11/08, 11/12, 11/19 & 11/22/2010)

[12] Although the minor stepbrother was directly responsible for the child's death, the mother and stepfather were charged and not the minor.

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

Locations[14] of Child Homicides – Geographic Area – 2010

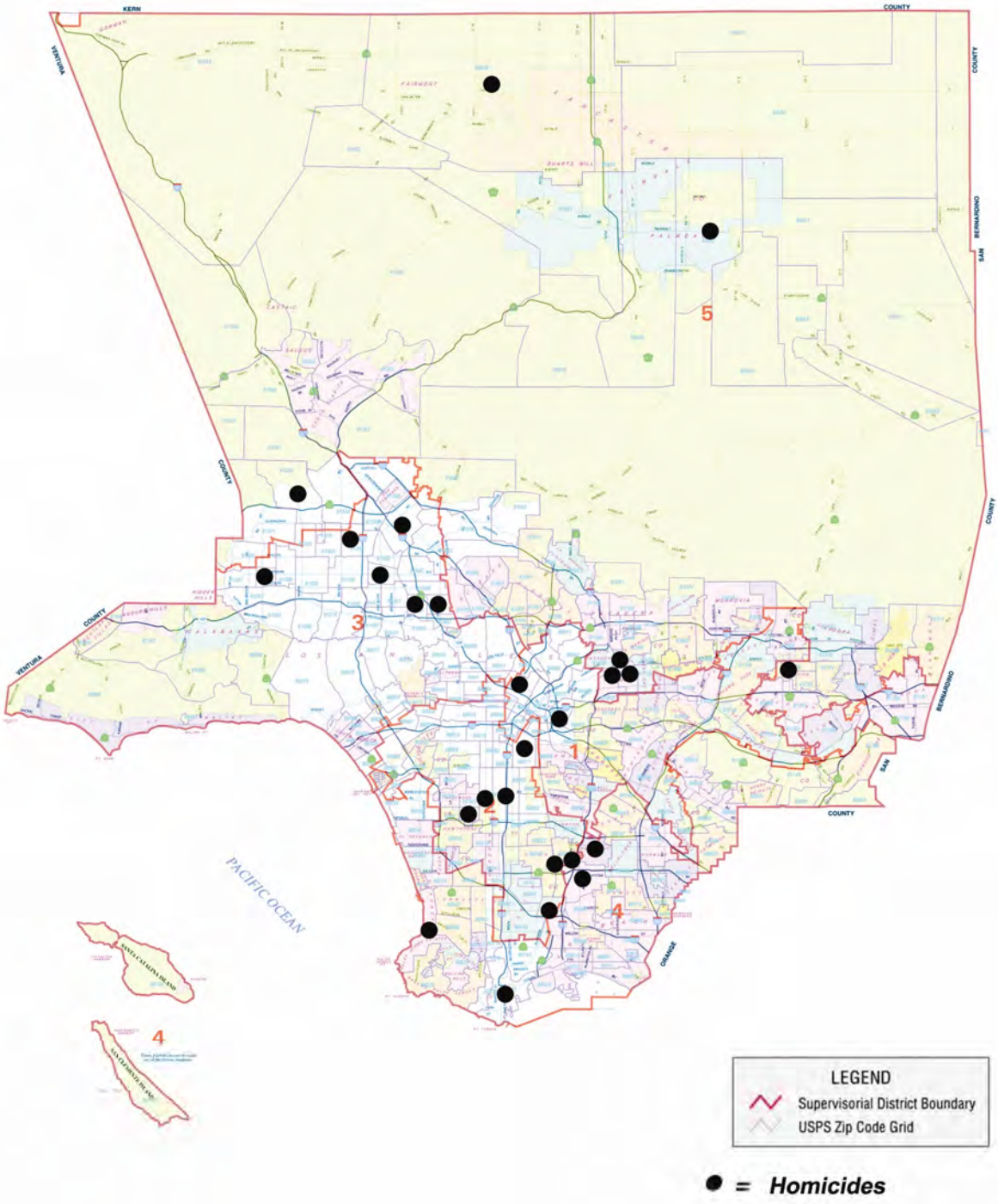
3 homicides occurred in Alhambra (zip code 91801)
1 homicide occurred in Canoga Park (zip code 91303)
2 homicides occurred in Compton (zip code 90221)
1 homicide occurred in Covina (zip code 91722)
1 homicide occurred in Inglewood (zip code 90303)
1 homicide occurred in Littlerock (zip code 93552)
1 homicide occurred in Lancaster (zip code 93536)
1 homicide occurred in Lakeview Terrace (zip code 91331)
1 homicide occurred in Los Angeles (zip code 90003)
1 homicide occurred in Los Angeles (zip code 90011)
1 homicide occurred in Los Angeles (zip code 90033)
1 homicide occurred in Los Angeles (zip code 90026)
1 homicide occurred in Los Angeles (zip code 90047)
1 homicide occurred in Long Beach (zip code 90805)
1 homicide occurred in Long Beach (zip code 90810)
1 homicide occurred in Monrovia (zip code 91326)
1 homicide occurred in North Hollywood (zip code 91601)
1 homicide occurred in Northridge (zip code 91343)
1 homicide occurred in Paramount (zip code 90723)
1 homicide occurred in Redondo Beach (zip code 90277)
1 homicide occurred in San Pedro (zip code 90731)
1 homicide occurred in Studio City (zip code 91607)
1 homicide occurred in Van Nuys (zip code 91405)



[14] City where the injury/fatality occurred

2010 Homicides

N = 26



Case Summary
Adolescent Suicide

Vanessa, age 17, was rushed to the hospital in full cardiac arrest and was pronounced upon her arrival to the emergency room. Earlier in the evening, Vanessa had an argument with her mother about not having cleaned her room. Vanessa went to her bedroom and locked herself in the room. About 10 minutes later, she texted her best friend, "I love you don't forget that". The friend had no idea Vanessa had suicidal thoughts or plans. The father forced entry into the bedroom and found her hanging by a scarf on the post to the bunk bed.

Family, friends and her teachers were all caught off guard and her death was totally unexpected. Vanessa was an honors student and had several close friends. She was known to communicate well with adults and staff and was never in trouble at school. There were no known incidents in which she attempted to harm herself. She had no history of depression or psychological problems.

A toxicology screen done at autopsy revealed no drugs or alcohol were present. There were no marks or scars on her wrists indicating previous attempts. There were also no other risk scars found on the body. The only bruise found was from the ligature around her neck. No suicide note was found.

Vanessa's cell phone records were checked but no check of the family computer was conducted. There was no computer in her bedroom.

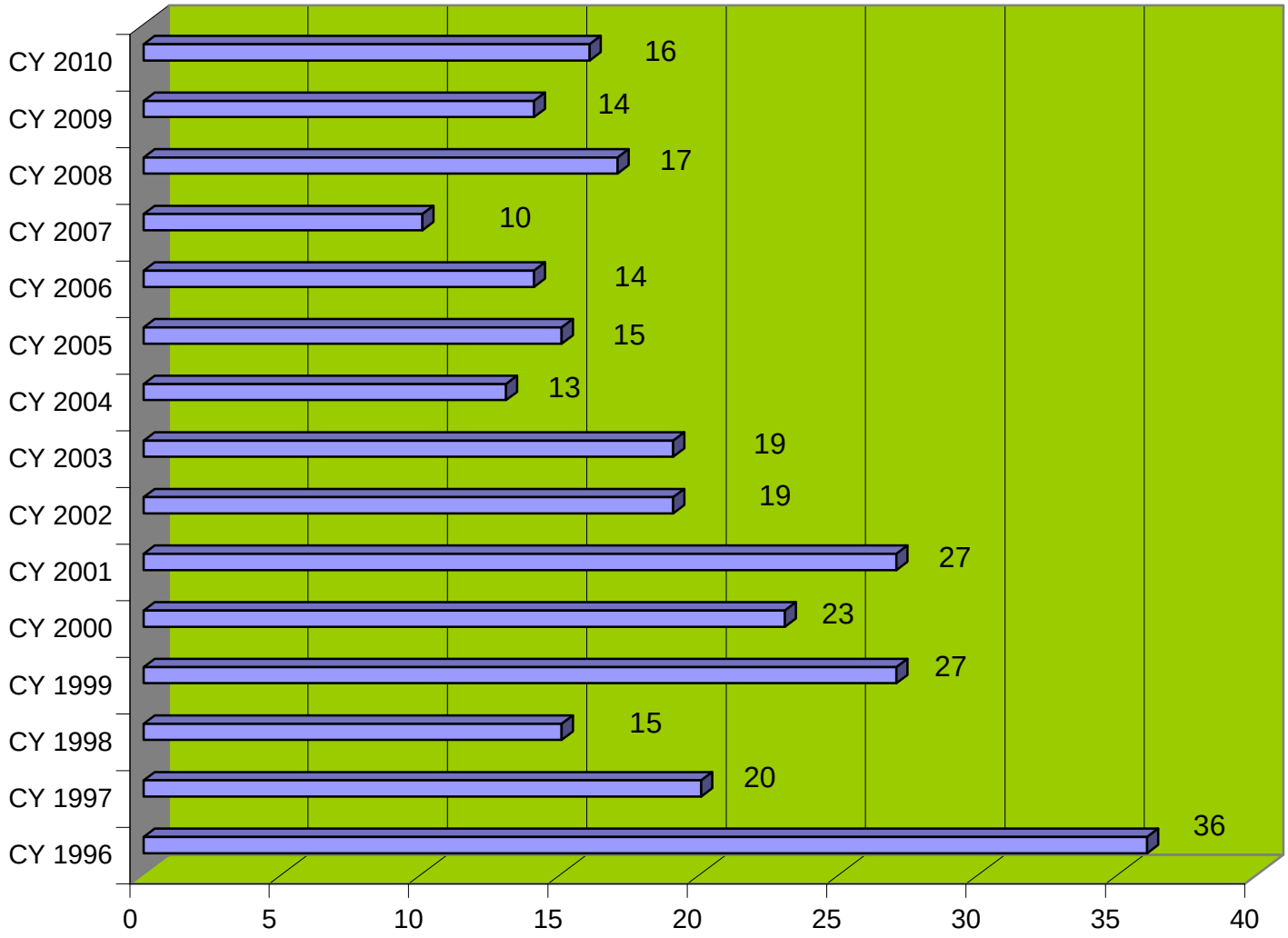
The Department of Children and Family Services (DCFS) had one prior referral in 1998 – allegation of general neglect due to the parents working multiple jobs and leaving the children alone. DCFS assisted the parents with childcare and the referral was closed as inconclusive.

The Child and Adolescent Suicide Review Team examined Vanessa's case. It was learned her peer group consisted of 1st generation bilingual Latinas. They were high achievers. The group just began partying doing club drugs and promiscuous behavior. Grades were dropping and conflicts with parents escalating. The group was described as spiraling out of control in which neither the students nor parents were equipped to deal with. The crisis response at the school was focused on grief. There was one copycat girl with a wrist slashing weeks later who had a history of mental health problems.

There was much discussion on the effects of cultural clashes between generations when parents are new immigrants and the children are born in the United States. Children of immigrants must navigate a bi-cultural path with one foot in the "old ways" of

the parents and the other under the stress of the majority culture and wanting to fit in. There was also discussion on how youth at her age are very good at covering up their true feelings, think in black and white, and act impulsively. The Team once again discussed the need to openly talk about depression, anxiety and suicide to teens; having prevention posters and material available; training faculty and staff to recognize signs of teens at risk; teaching the teens on how to be more supportive; and identify when friends might need some kind of services.

1996 - 2010 Child and Adolescent Suicides



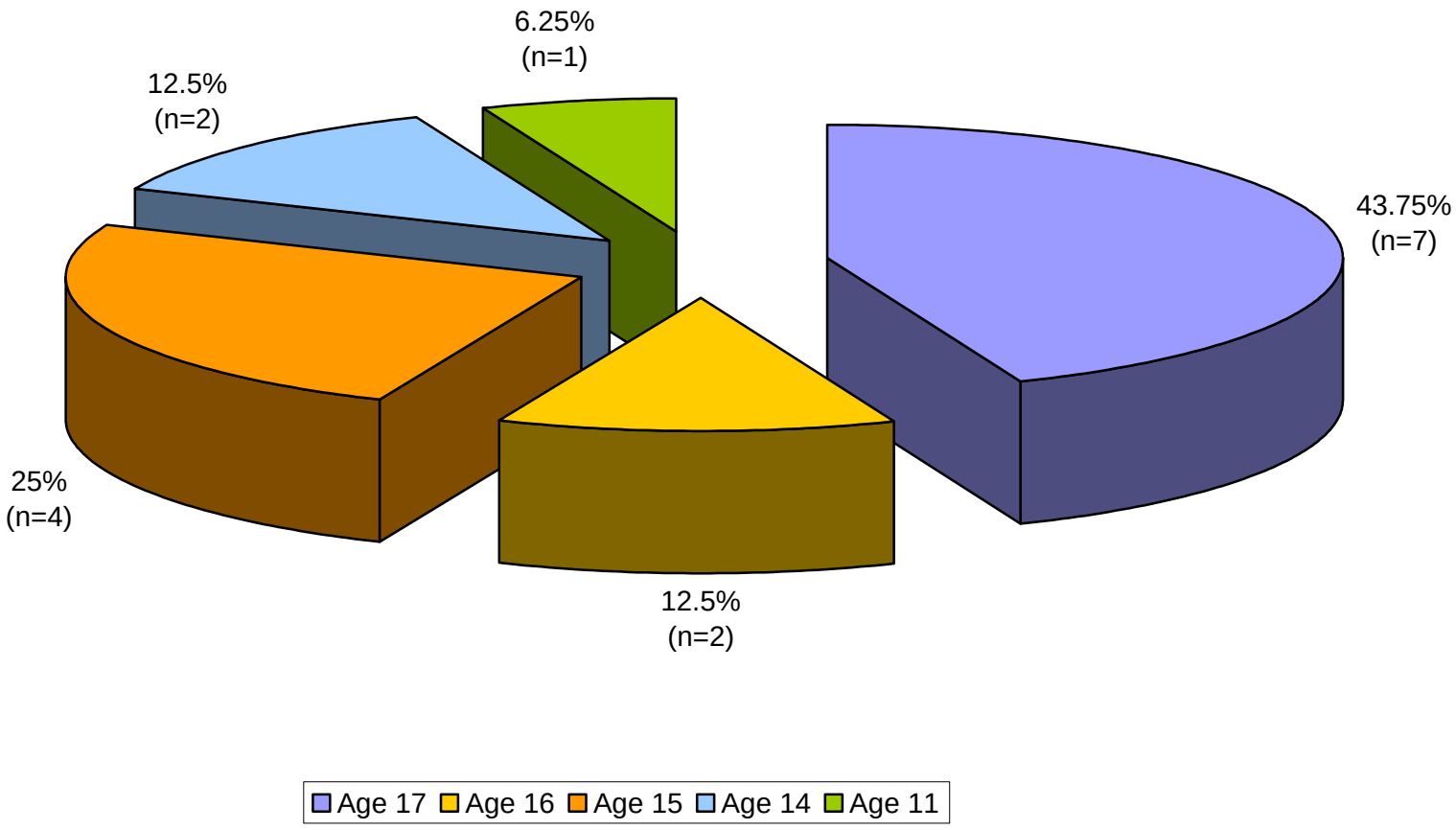
Child and Adolescent Suicides by Method and Gender
Los Angeles County – 2010 (n = 16)

Method	Male	Female
Hanging	7	4
Firearms/Gunshot	1	0
Stabbing	1	0
Overdose	2	1
TOTAL	11	5

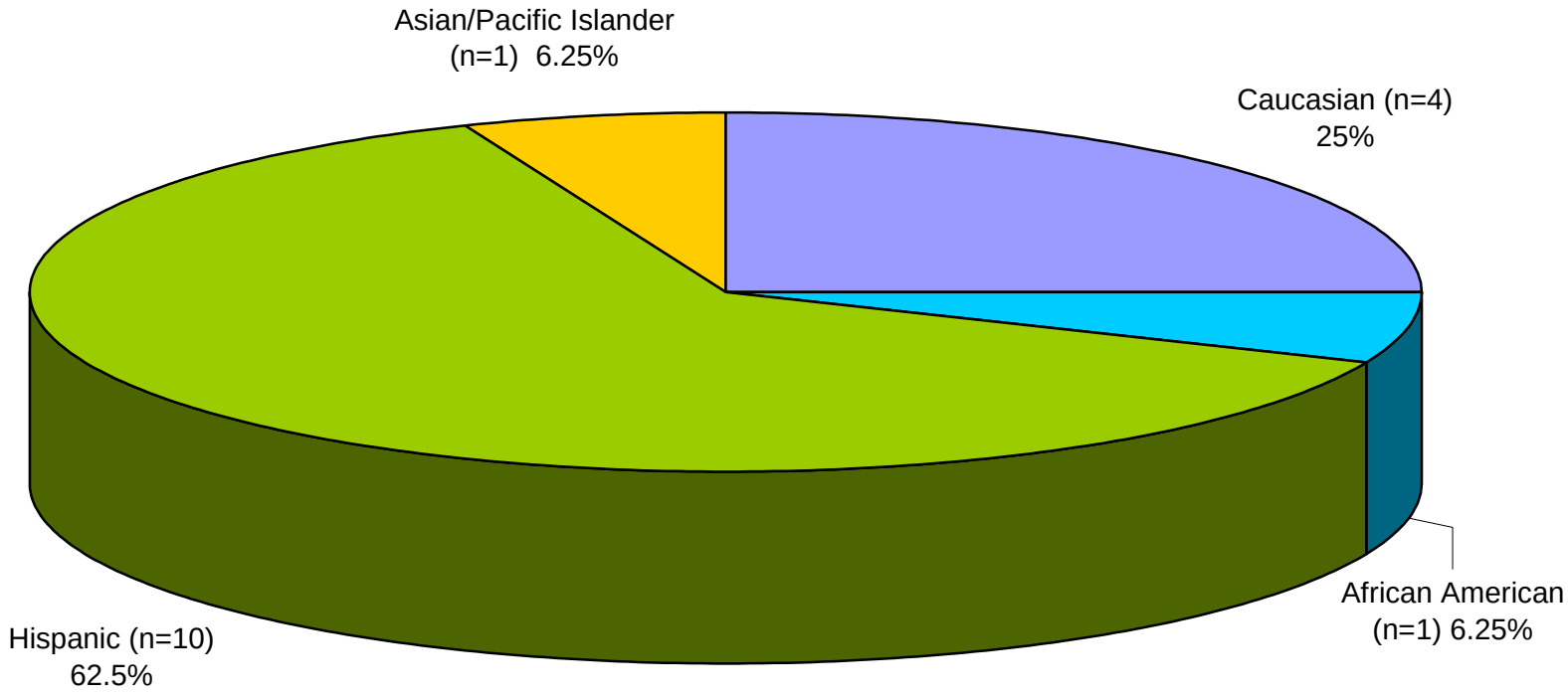
Hanging was the most frequent method of suicide among adolescents and represents 68.75% of the suicides in 2010. An overdose was the second most frequent method of suicide in 2010.

In 2010, 68.75% (n=11) of the adolescent suicide victims were male. 31.25% (n=5) of the victims of adolescent suicide in 2009 were female. As in previous years, males outnumber female suicide victims by a large margin.

2010 Child and Adolescent Suicides - Age



2010 Child and Adolescent Suicides - Race



Los Angeles County child population ages 0 - 17 is 2,718,551 . 62.4% are Hispanic, 17.3% are Caucasian, 9.4% are Asian American, 8% are African American, 2.7% are Multi-racial and .2% Native American. Kidsdata.org 2011.

Child and Adolescent Suicide Victim Characteristics – 2010

Three of the youth exhibited warning signs prior to their suicide.

Three of the youth had a history of mental illness.

Four of the youth left a suicide note. One youth left a video with a note.

One of the youth had previously attempted suicide

Three of the youths were discovered to have a positive toxicology for drugs or alcohol at autopsy.

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

Seven of the youths' families had a prior history and/or an open referral or case with the Department of Children and Family Services or with the Department of Probation. An additional three of the youths' families had a history or open case with CPS in another county.

Three youths had a history of self-injury.

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

One of the youth had known academic problems and

One youth had school discipline or truancy problems.

Dates of Child and Adolescent Suicides – 2010

4 suicides occurred in January (01/1, 01/07, 01/10 & 01/19/10)
3 suicides occurred in February (02/21, 02/27 & 02/2810)
1 suicide occurred in March (03/10/10)
1 suicide occurred in May (05/16/10)
3 suicides occurred in June (06/06, 06/10 & 06/30/10)
2 suicides occurred in July (07/01 & 07/18/10)
2 suicides occurred in November (11/14/10)

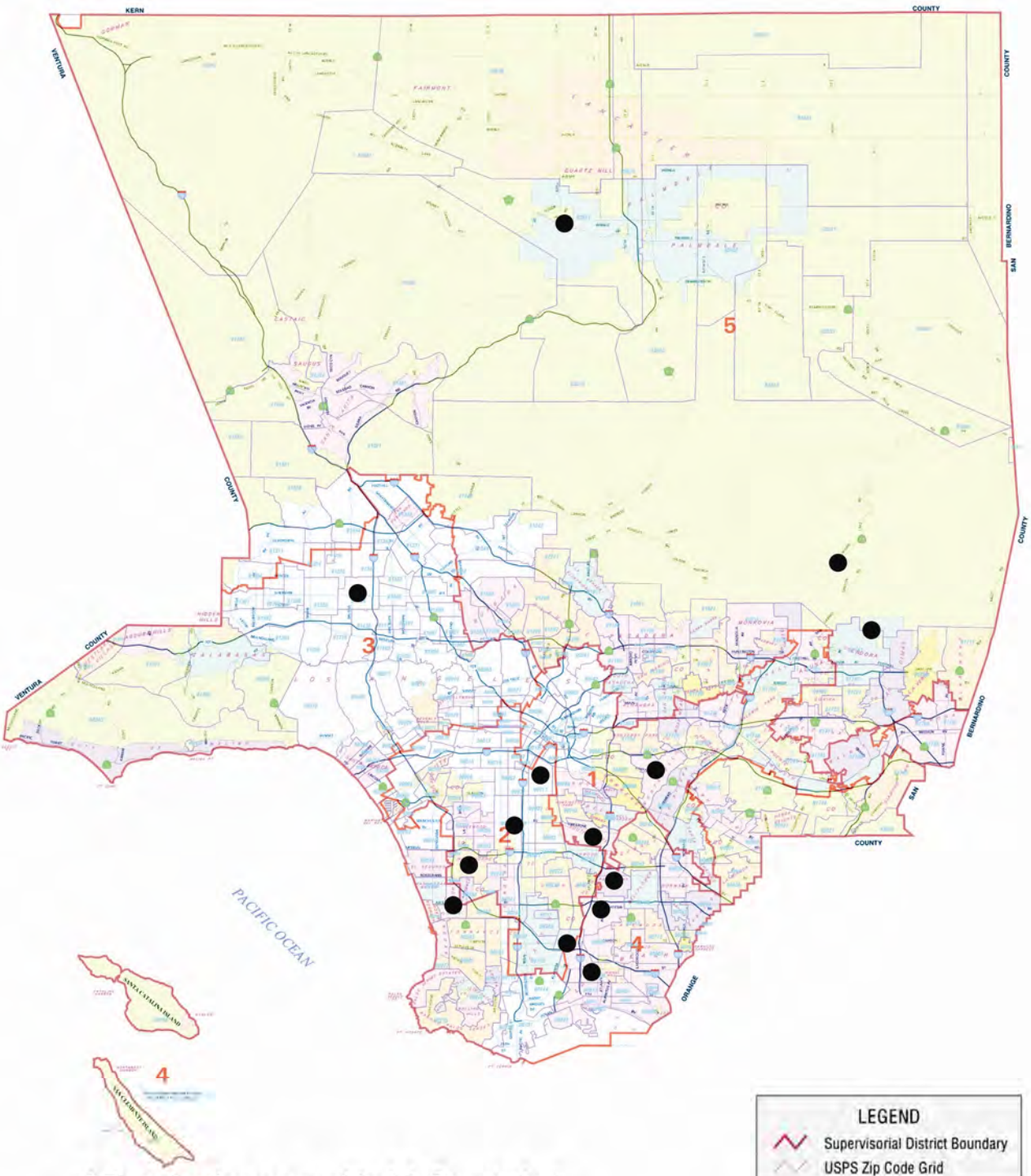
Locations[15] of Child and Adolescent Suicides – Geographic Area – 2010

1 suicide occurred in Los Angeles (zip code 90003)
1 suicide occurred in Los Angeles (zip code 90011)
1 suicide occurred in South Gate (zip code 90280)
1 suicide occurred in Long Beach (zip code 90810)
1 suicide occurred in Long Beach (zip code 90805)
1 suicide occurred in Long Beach (zip code 90806)
1 suicide occurred in Paramount (zip code 90723)
1 suicide occurred in Palmdale (zip code 93551)
1 suicide occurred in Van Nuys (zip code 91406)
1 suicide occurred in Montebello (zip code 90640)
1 suicide occurred in Redondo Beach (zip code 90278)
1 suicide occurred in Glendora (zip code 91741)
1 suicide occurred in Hawthorne (zip code 90250)
1 suicide occurred in Azusa (zip code 91702)
1 suicide occurred in Agoura Hills (zip code 91301)
1 suicide occurred in Fillmore (zip code 93015)

[15] City where the suicide occurred.

2010 Adolescent and Child Suicides

N = 16*



* Two deaths occured in LA County but victims resided in another County

● = *Child or Adolescent Suicide*

Case Summary
Accidental Death

Katrina, 11 years old, lived with her mother, grandmother and three older siblings.

On a September morning, Katrina, her mother and teenage sister left the home walking to go to the swap meet. They were eight blocks from the family home waiting at a crosswalk for the light to change. The light turned green for their flow of traffic and they began to cross the street going north. The posted speed limit for the street was 35 miles per hour.

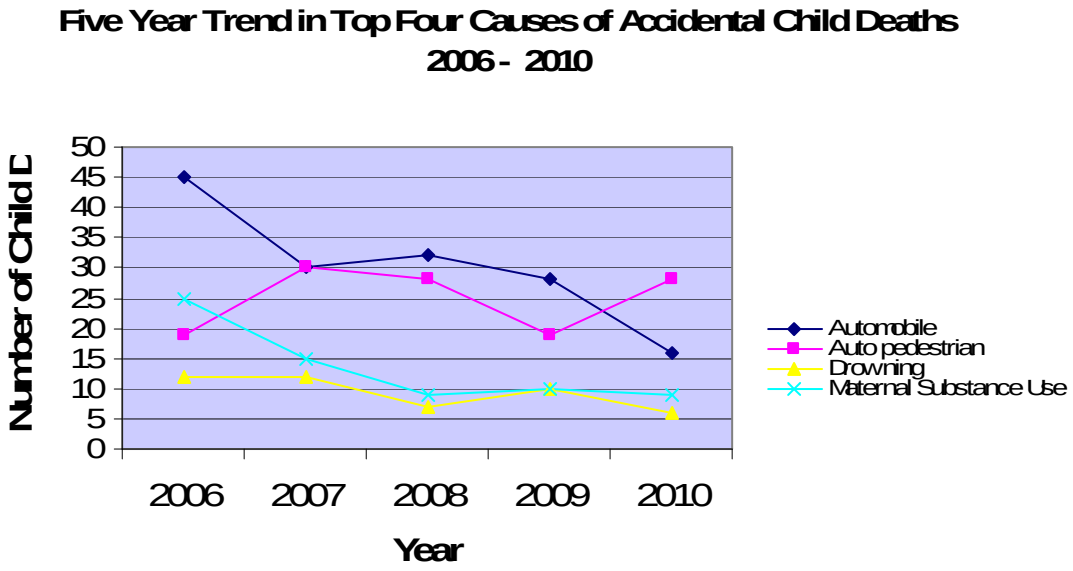
Katrina and her mother were walking side by side and the sister, wearing headphones listening to music, was behind of them. The group almost made it to the other side of the busy street in the crosswalk when a car going eastbound ran the red light and struck them. Witnesses reported the driver of the older model Toyota was exceeding the speed limit. The sister and mother were transported to a local hospital where the mother was pronounced dead upon arrival. The sister was seriously injured and listed in critical condition but was expected to survive. Katrina was flown by helicopter to Children's Hospital due to the extent of her injuries.

Katrina presented at the emergency room with a large abrasion to her forehead, a fractured humerus, and abrasions to her face, abdomen, chest and extremities. She was ventilated and had decreased breath sounds to her left chest, her body was cold and pupils were fixed. She was intubated and transferred for a CT scan. She was found to have a skull fracture, scapular fractures, cerebral edema, humerus fracture, hemorrhage, splenic laceration and internal bleeding. Katrina was rushed to surgery and her injuries were repaired but the bleeding continued. She was transferred to the PICU. Her condition was discussed with her adult brother and grandmother as she was not expected to survive. The brother and extended family decided to stop mechanical ventilation and allow a natural death. Her death was pronounced shortly thereafter and the family donated her organs.

The investigation by Traffic Division revealed the driver; 19 year old Sarah reported the sun was shinning brightly in the windshield and she did not see the red light. She saw the teenager at the last minute and swerved to try to miss hitting Katrina and her mother. She stopped after the accident and called 911. Sarah was found to not be intoxicated or otherwise impaired. Her car was impounded and she was not arrested pending further investigation.

A referral was made to DCFS for caretaker absence due to the mother's death and the presence of other children in the home. The family had one prior referral for general neglect in 2001 to DCFS that was unfounded. The DCFS worker learned the father had passed away six months earlier from a heart attack. Julia, the 15 year old injured in the accident was not as critically injured as first reported and had been released from the hospital. Both she and the 17 year old brother Darren were interviewed and found to be

healthy and adjusted, given the circumstances. There were two adult siblings, the grandmother and other extended family to support the children. The community and school also had rallied around the family. The worker was contacted by a counselor with Masada Homes who reported she is providing the family grief, family and individual counseling. The counselor informed the CSW that this counseling was arranged through the school when they were informed of the tragic death of Katrina's father six months earlier. She reported that she has been involved with the children since then so they are familiar with her and she will continue providing services in the home for the children. Given the family had support systems in place and were already receiving services, DCFS closed the referral for severe neglect as unfounded.



The chart above depicts the top four causes of accidental child death over a five year period from 2006 to 2010. With the exception of auto pedestrian deaths, there has been a downward trend for the top accidental causes. The most dramatic decreases have been in maternal substance use and automobile deaths. The “top four” causes-automobile, auto pedestrian, drowning and maternal substance use accounted for 69% of all accidental child deaths in 2010.

Causes of Accidental Child Deaths, Ages 0 – 17
2010 – Los Angeles County (N = 86)

Automobile – multi-vehicle	10
Automobile – solo vehicle	6
Auto pedestrian	28
Drowning	6
Crushed by an Object	4
Overdose	6
Maternal drug use	9
Fire	2
Medical mishaps	3
Fall	5
Hanging	2
Choking	2
Train vs. pedestrian	2
Suffocation	1
TOTAL	**86**

Causes of Accidental Child Deaths by Age
2010 – Los Angeles County (N = 86)

	Age 0 – 5 years	Age 6 – 14 years	Age 15 – 17 years
Automobile – multi-vehicle	5	3	2
Automobile – solo vehicle	2	1	3
Auto pedestrian	8	10	10
Crushed by Object	4	0	0
Drowning	5	1	0
Overdose	0	1	5
Fall	4	1	0
Fire	0	1	1
Maternal drug use	8	1	0
Medical mishaps	3	0	0
Hanging	1	1	0
Choking	1	1	0
Train vs. pedestrian	0	0	2
Suffocation	1	0	0
TOTAL	**42**	**21**	**23**

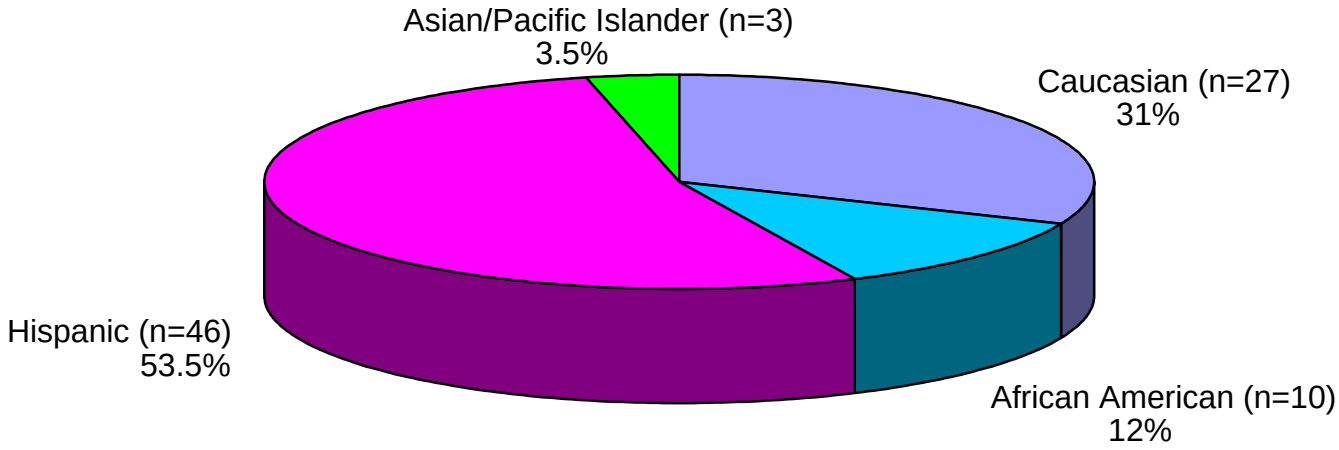
Race of Accidental Child Deaths, Ages 0 – 17
Los Angeles County – 2010 (N = 86)

	Hispanic	African-American	Caucasian	Asian/Pacific Islander
Automobile – multi-vehicle	6	1	2	0
Automobile – solo vehicle	3	0	2	1
Auto pedestrian	19	2	6	1
Choking	1	0	1	0
Drowning	2	2	2	0
Overdose	2	0	4	0
Fire	0	0	2	0
Fall	3	0	1	1
Suffocation	0	0	1	0
Hanging	1	0	1	0
Maternal drug use	3	3	3	0
Medical mishaps	1	2	0	0
Crushed by object	3	0	1	0
Train vs. pedestrian	2	0	0	0
TOTAL	**46**	**10**	**27**	**3**

Causes of Accidental Child Deaths, Ages 0 – 14
1996—2010

	’96	’97	’98	‘99	’00	’01	’02	’03	’04	’05	’06	’07	’08	’09	‘10	Total
Drowning	18	28	21	25	23	28	16	19	21	12	12	11	7	9	6	256
Maternal drug abuse	25	24	38	21	22	24	25	32	21	15	25	15	9	10	9	315
Auto pedestrian[1]	1	8	19	31	30	41	33	25	21	20	11	25	25	15	18	323
Automobile[2]	0	0	0	18	24	28	20	47	25	21	22	14	17	19	11	266
Falls	5	2	3	5	1	1	3	2	3	1	2	1	1	0	5	35
Choking	1	5	3	6	10	2	8	4	1	3	1	1	2	0	2	49
Suffocation	2	0	2	4	1	3	0	1	1	2	2	0	0	0	1	19
Poisoning	1	6	1	4	4	1	0	2	2	1	2	0	1	0	0	25
Fire	0	1	3	7	4	3	7	0	2	6	7	2	0	0	1	43
Hanging/strangulation	3	0	0	0	6	3	1	2	4	1	3	4	0	0	2	29
Chest/neck compression	2	1	2	0	1	0	0	3	0	0	0	0	1	0	0	10
Gunshot wounds	2	1	0	0	0	0	0	0	0	0	0	0	0	1	0	4
Crushed by object	0	3	2	1	1	0	1	0	1	5	2	2	0	6	4	28
Sports injury	0	2	0	2	2	1	0	0	0	1	0	0	2	2	0	12
Burns/Thermal Injury	0	0	0	1	0	0	1	0	1	0	0	0	0	0	0	3
Dog bites	0	1	0	1	1	0	0	0	0	1	0	0	0	0	0	4
Medical complications[3]	1	0	1	5	6	2	8	7	3	3	2	7	5	5	2	57
Perinatal asphyxia	0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	3
Electrocution	0	2	0	0	1	0	0	1	0	1	0	0	0	0	0	5
Birth trauma	0	0	0	2	0	0	0	0	0	2	0	0	0	0	1	5
Hypothermia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hyperthermia	0	0	0	0	0	0	0	0	0	2	1	0	0	0	0	3
Airplane related	0	0	0	0	0	0	2	2	0	0	0	0	0	0	0	4
Train v. pedestrian	0	1	0	0	0	0	0	0	0	1	0	1	0	0	0	3
Elective abortion	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Forklift injury	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Drug intake/Overdose	0	0	0	0	0	0	0	0	2	0	0	0	0	0	1	3
Motor vehicle (not auto)[4]	0	0	0	0	0	0	0	0	4	1	3	0	1	0	0	9
Impaled	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Gas Leak	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
TOTAL[5]	**61**	**86**	**95**	**134**	**137**	**137**	**127**	**147**	**112**	**100**	**95**	**83**	**73**	**67**	**63**	**1517**

2010 Accidental Child Deaths - Race



Los Angeles County child population ages 0 - 17 is 2,718,551. 62.4% are Hispanic, 17.3% are Caucasian, 9.4% are Asian American, 8% are African American, 2.7% are Multi-racial and .2% Native American. Kidsdata.org 2011.

Causes of Accidental Child Deaths by Gender
2010 – Los Angeles County (N = 86)

	Female	Male	Unknown
Automobile – multi-vehicle	5	5	0
Automobile –single	2	4	0
Auto pedestrian	11	17	0
Drowning	2	4	0
Overdose	3	3	0
Train vs. Pedestrian	0	2	0
Maternal drug use	4	4	1
Medical mishaps	0	3	0
Crushed	1	3	0
Fire	0	2	0
Hanging	1	1	0
Choking	1	1	0
Fall	3	2	0
Suffocation	1	0	0
TOTAL	**34**	**51**	**1**

Case Summaries Undetermined Child Deaths
Unsafe Sleep Practices and/or Environments

Manuel – Age 5 days

The Coroner's Investigator reported the child was sleeping in a twin size bed with the mother when he was found unresponsive with some blood on his face. There was a crib in the corner of the room being used for storage. The mother reported she put Manuel on his side facing her for sleep and found him in a prone position upon awakening.

Maria – Age 4 months

The mother placed Maria in a crib on her side with a pillow beneath her head and shoulders. Another pillow was in front of her and a rolled blanket along her back. In the morning, Maria was discovered in a prone position face down in the pillows.

Victor – Age 2 months

The mother breast fed Victor at 4:00 am and then put him to bed between her and the father. The mother checked on Victor between 5 a.m. and 6 a.m. and he was sleeping. At approximately 7:40 a.m., the mother checked on Victor and found him unresponsive, cold to the touch and stiff. There were no obvious signs of external or foul play. The Coroner's Office found that Victor's death was due to sudden unexpected infant death (SUID).

Mark– Age 7 months

Mark slept on the couch and the mother on the floor next to the couch. The mother placed a thin sheet on the couch and placed Mark on his back on the sheet. He was clad in a pair of socks, a "onesie" and a diaper. At 6:00 a.m. the mother awoke and saw the Mark lying on his side facing the couch. She picked him up and he was stiff and cold to the touch. She called 911 and was told to start CPR until the paramedics arrived. When the EMTs arrived, it was clear Mark had passed and he was pronounced dead at the scene.

Sandra – Age 25 days

Mother reported "she swaddled" Sandra in blankets and placed her in the bed where her father was sleeping. The bed had an abundance of bedding, five pillows and three blankets. The mother reported she placed Sandra on her back on a pillow. She fell asleep and woke up later than usual. The mother reported she found Sandra face down on a pillow with the bedding wet underneath her. The infant was sweaty and limp.

Joseph – Age 1 month

Although Joseph routinely slept in the crib, the mother took him to bed with her to feed him at 2:00 a.m. The father and sibling were also in the bed. The mother and others in the bed fell asleep and

woke up at 4:30 a.m. when the mother found Joseph limp and called 911. The infant never regained consciousness.

Emily – Age 24 days

The grandmother swaddled Emily with her arms at her sides and placed her to sleep on her side on an adult pillow top mattress. No more than fifteen minutes later she was found face down with blood from her nose and mouth. She was resuscitated at the hospital with no brain function. Artificial support was withdrawn the following day.

Samuel – Age 3 months

Samuel's parents reported they were sleeping with him on the same bed when they woke up and found he was not breathing. They called 911 and on the way to the hospital, Samuel died and efforts to resuscitate him were not successful.

Camilla– Age 2 months

The father swaddled Camilla in a polyester fleece blanket and placed her in a supine position in the crib. He then covered her with four blankets and put two stuffed animals in the crib with her. The heater in the room was set on high and both the doors and windows of the room were closed. The father went to sleep in his bed. He woke to discover her unresponsive, purple in color and sweaty.

Pedro – Age 8 months

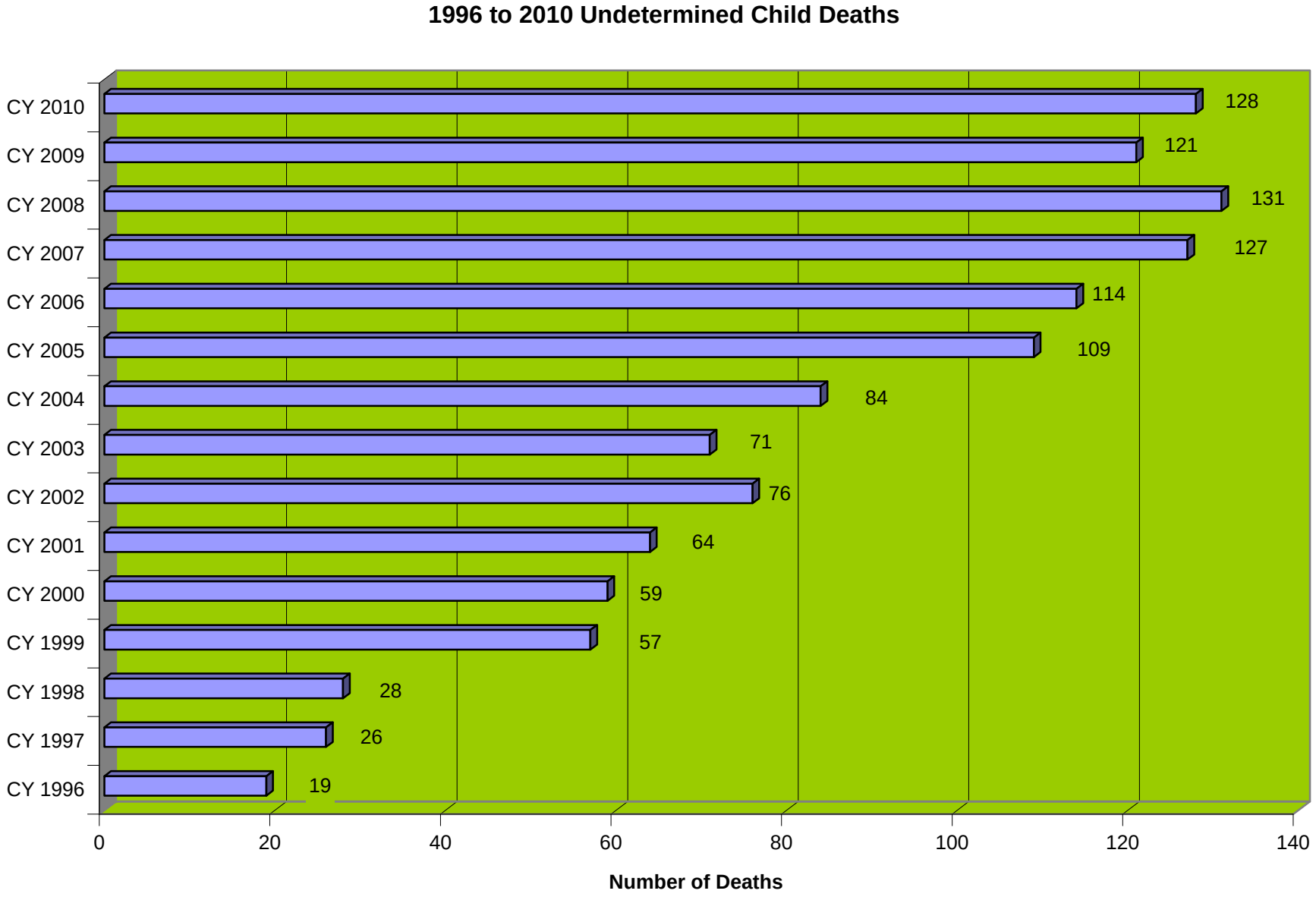
Pedro's mother placed him on the living room couch on his back after he fell asleep from breastfeeding. She went into the kitchen to clean up after the family breakfast. When she returned ten minutes later to check on him, she found him on his side with his face in the couch back pillow. He was limp and unresponsive. 911 was called and he was transported to the hospital as paramedics got a heart beat. When he arrived at the hospital, he went into cardiac arrest and further efforts to resuscitate him failed.

James – Age 3 months

The infant was placed on his back on the mother's bed. The bed was a pillow top mattress that was covered with a thick comforter. Pillows were surrounding him, but there was no pillow beneath his head and he was not covered or swaddled in a blanket. No pacifier was in use. The mother went to check on him an hour later and found him on his stomach not breathing and he was limp.

Jason, age 14 days

Jason was sleeping between his parents and the father awoke to use the bathroom. When he returned to the bed, he checked Jason and he was not breathing. The mother called 911 while the father administered CPR. Jason was rushed to the hospital. When the parents arrived, staff noticed the smell of alcohol on the mother. When questioned, the mother admitted to drinking on the day before his death at a family function. There was concern the infant's death was due to a layover while sleeping with the parents.


1996 to 2010 Undetermined Child Deaths
CY 2010
CY 2009
CY 2008
CY 2007
CY 2006
CY 2005
CY 2004
CY 2003
CY 2002
CY 2001
CY 2000
CY 1999
CY 1998
CY 1997
CY 1996
128
121
131
127
114
109
84
71
76
64
59
57
28
26
19
0
20
40
60
80
100
120
140
Number of Deaths

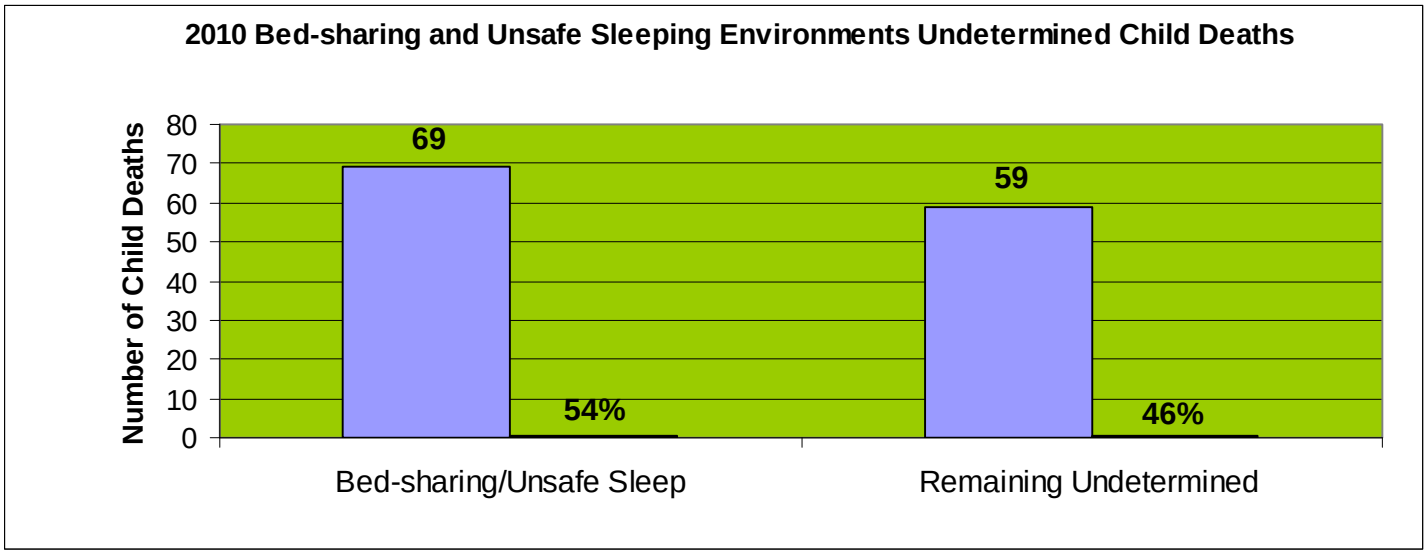
Undetermined Child Deaths – 2010 (N = 128)

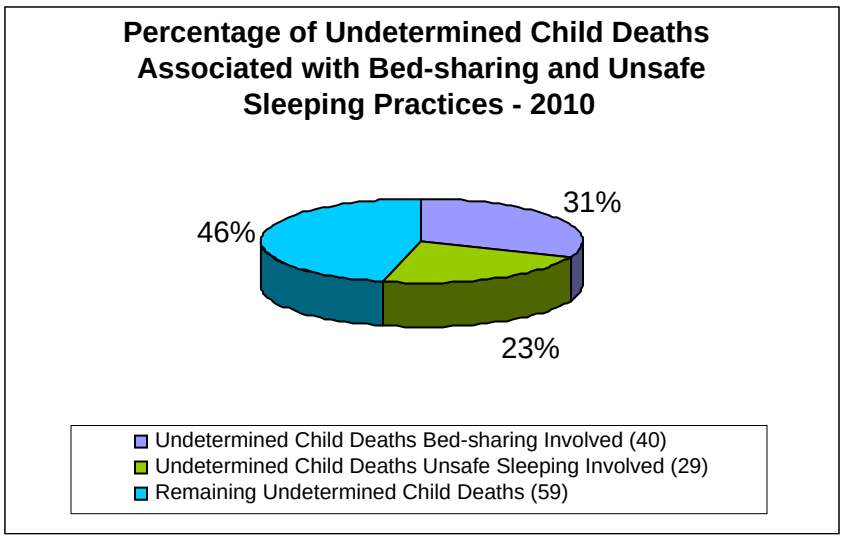
Race	***Number/Percentage of Undetermined Child Deaths***
African American	37 (29%)
Asian/Pacific Islander	7 (5.5%)
Caucasian	17 (13%)
Hispanic	65 (51%)
Unknown	2 (1.5%)

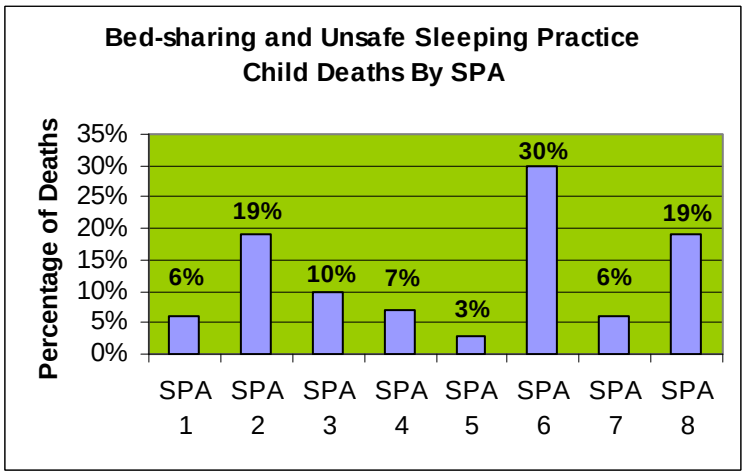
Age	***Number of Undetermined Child Deaths***
Under 1	90
1year	10
2 years	5
3 years	2
4 years	0
5 years	2
6 years	2
7years	2
8 years	2
9 years	2
10 years	3
11 years	1
12 years	0
13 – 17 years	7

Gender	***Number of Undetermined Child Deaths***
Female	48
Male	80

African American children were over-represented in undetermined child deaths.
70% of the undetermined child deaths were under one year of age.
85% of the undetermined child deaths were 5 years of age or under.


2010 Bed-sharing and Unsafe Sleeping Environments Undetermined Child Deaths
Number of Child Deaths
80
70
60
50
40
30
20
10
0
69
54%
59
46%
Bed-sharing/Unsafe Sleep
Remaining Undetermined


Percentage of Undetermined Child Deaths Associated with Bed-sharing and Unsafe Sleeping Practices - 2010
46%
31%
23%
Undetermined Child Deaths Bed-sharing Involved (40)
Undetermined Child Deaths Unsafe Sleeping Involved (29)
Remaining Undetermined Child Deaths (59)


Bed-sharing and Unsafe Sleeping Practice Child Deaths By SPA
Percentage of Deaths
35%
30%
25%
20%
15%
10%
5%
0%
6%
19%
10%
7%
3%
30%
6%
19%
SPA 1
SPA 2
SPA 3
SPA 4
SPA 5
SPA 6
SPA 7
SPA 8

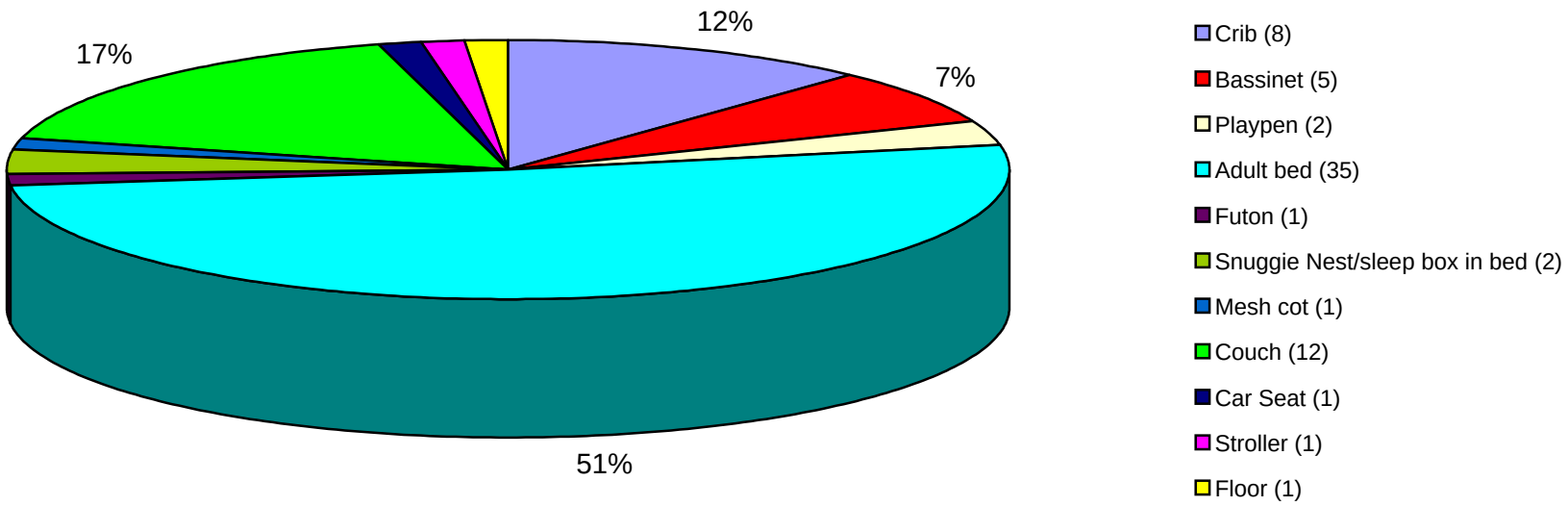
Undetermined Child Deaths – Bed-sharing and Unsafe Sleeping Environment* (N = 69)

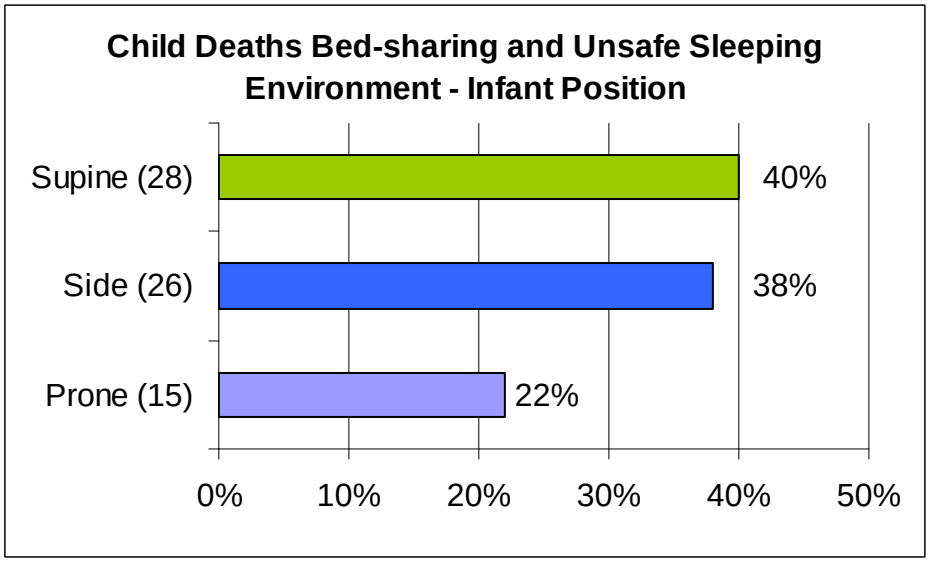
Bed-sharing (N=40)	***Number/Percentage of Child Deaths***
One Unsafe Risk Factor	7 (17.5%)
Two Unsafe Risk Factors	12 (30%)
Three or more Unsafe Risk Factors	21 (52.5%)

Unsafe Sleeping Environment (N=29)	***Number/Percentage of Child Deaths***
One Unsafe Risk Factor	10 (35%)
Two Unsafe Risk Factors	16 (55%)
Three or more Risk Factors	3 (10%)

*Includes adult bed, couch, futon, snuggie nest, car seat, stroller, pillows, soft or excessive bedding, excessive swaddling, stuffed toys, plastic bag, pets, parental drug/alcohol use, prone or side positioning.

Sleep Surface – Bed-sharing and Unsafe Deaths

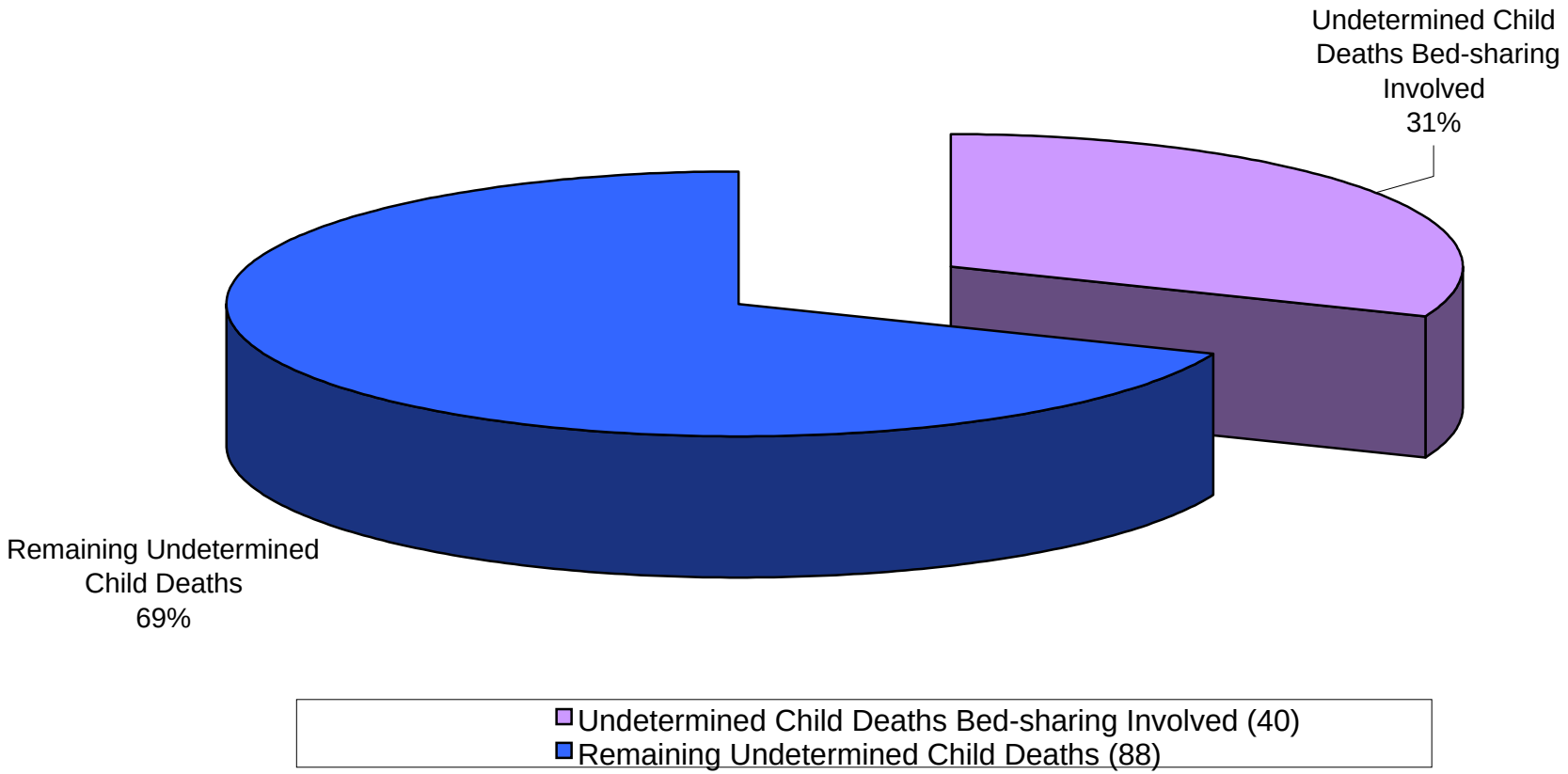




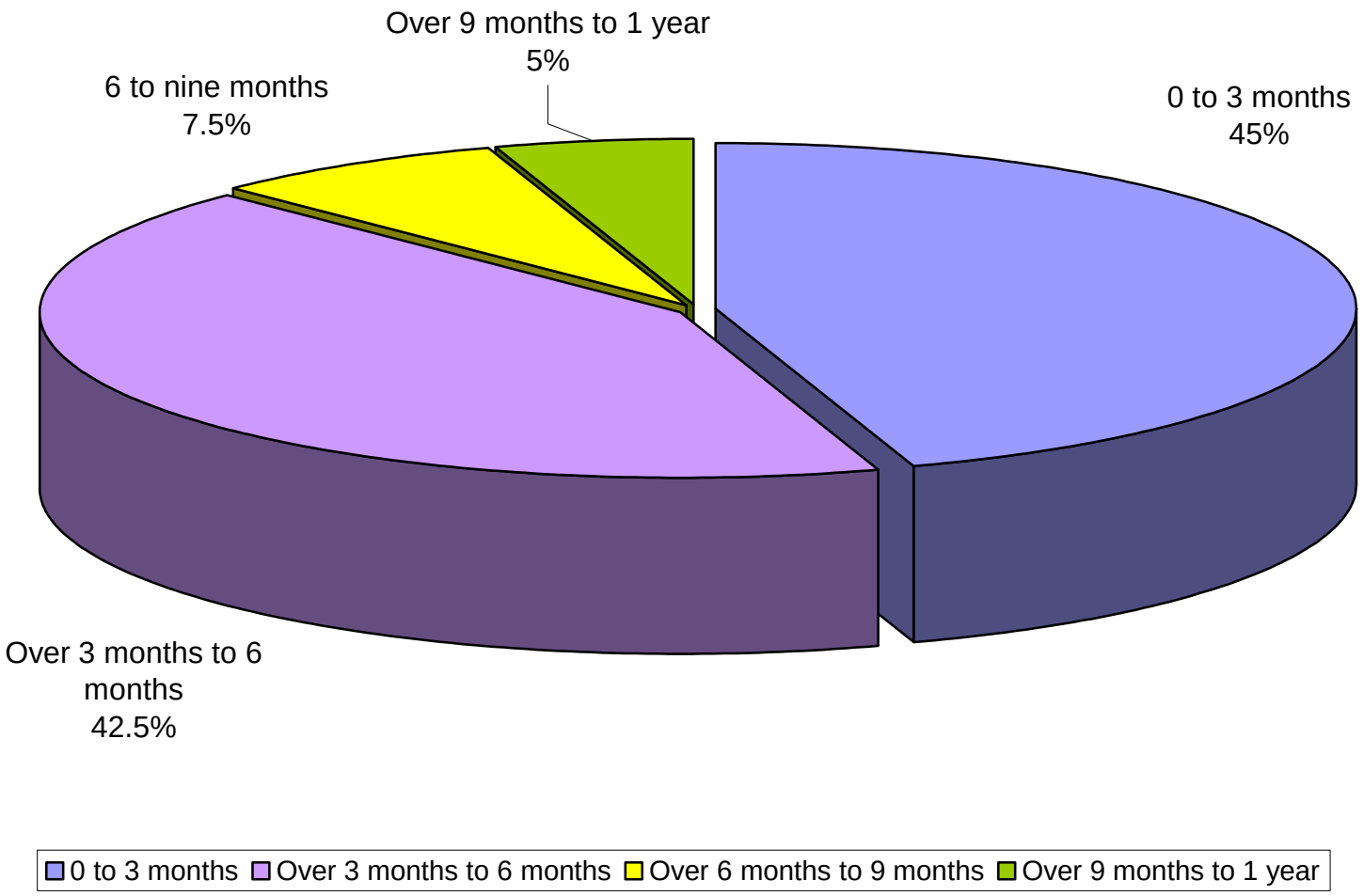
Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 69)	Number	Percentage
Pillow(s)	22	32%
Stuffed toys	2	3%
Soft and/or excessive bedding	12	17%
Excessive Swaddling	5	7%
Plastic bag	1	1%
Pets	1	1%
Parental Drug/Alcohol Use	7	10%

*excludes bed-sharing, sleep surface and infant position

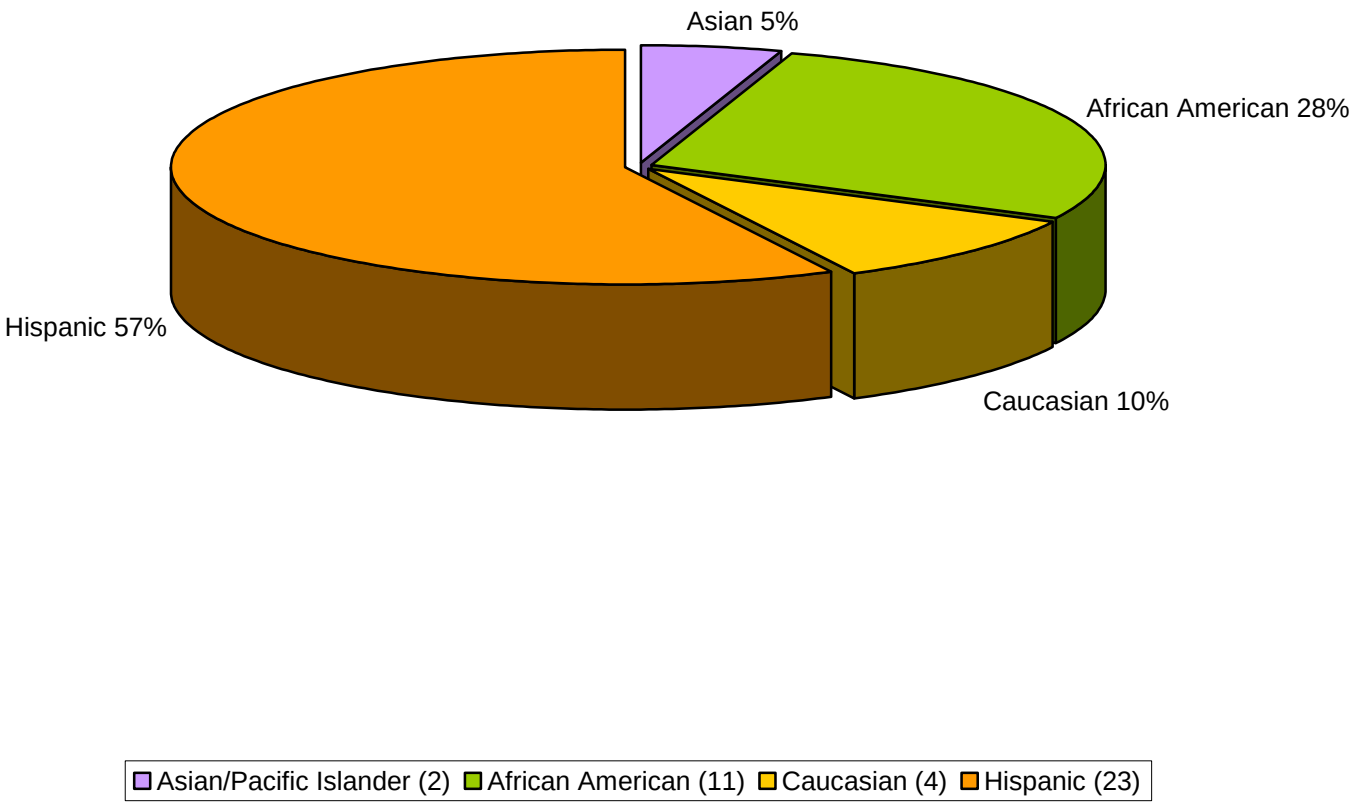
Percentage of Undetermined Child Deaths Involving Bed-sharing 2010



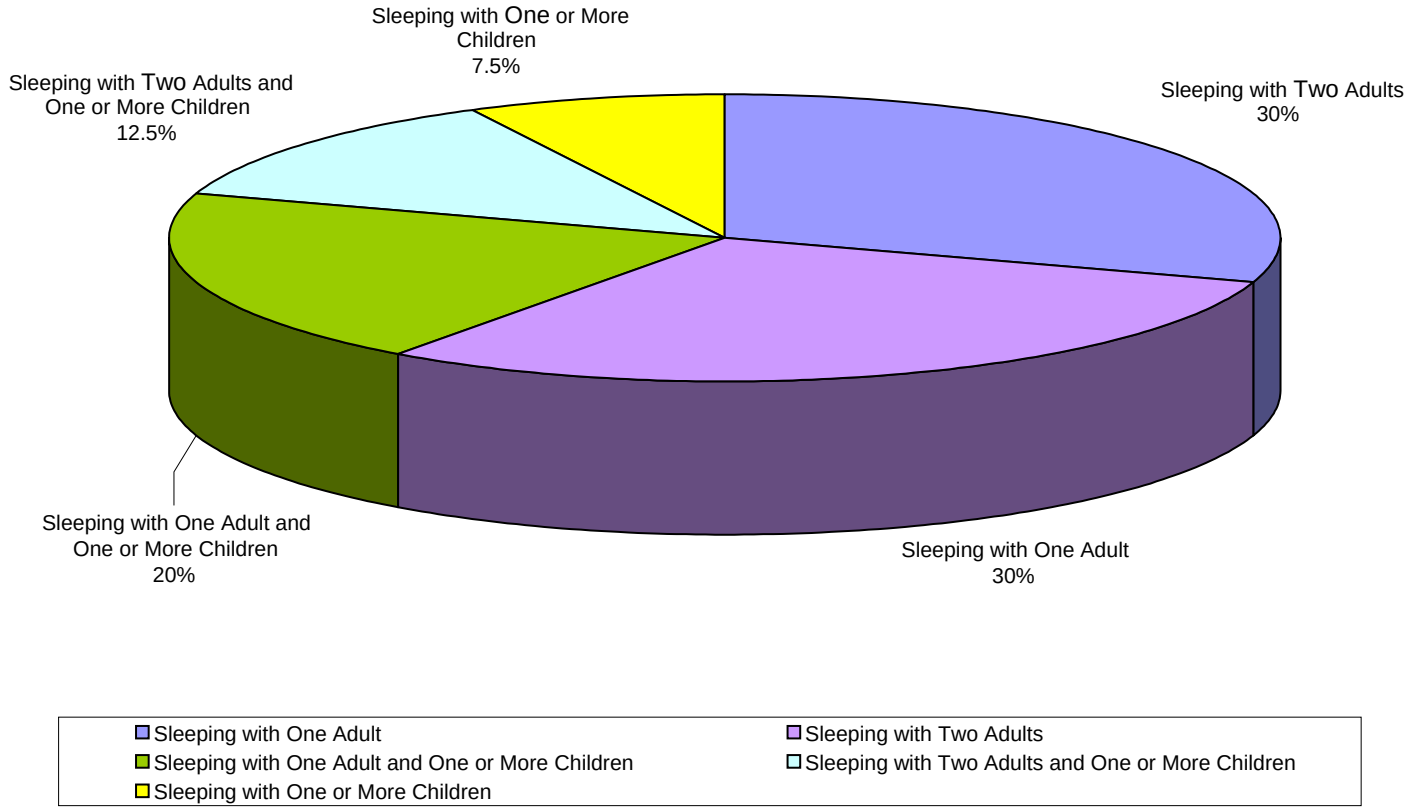
2010 Undetermined Bed-sharing Child Deaths - Age

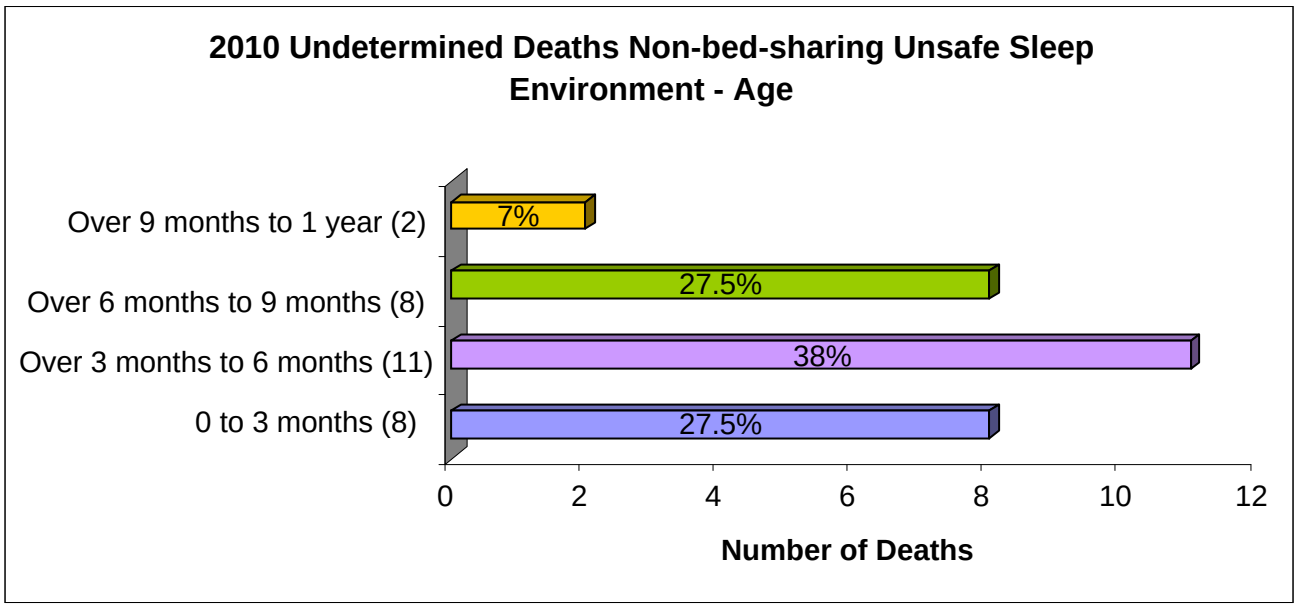


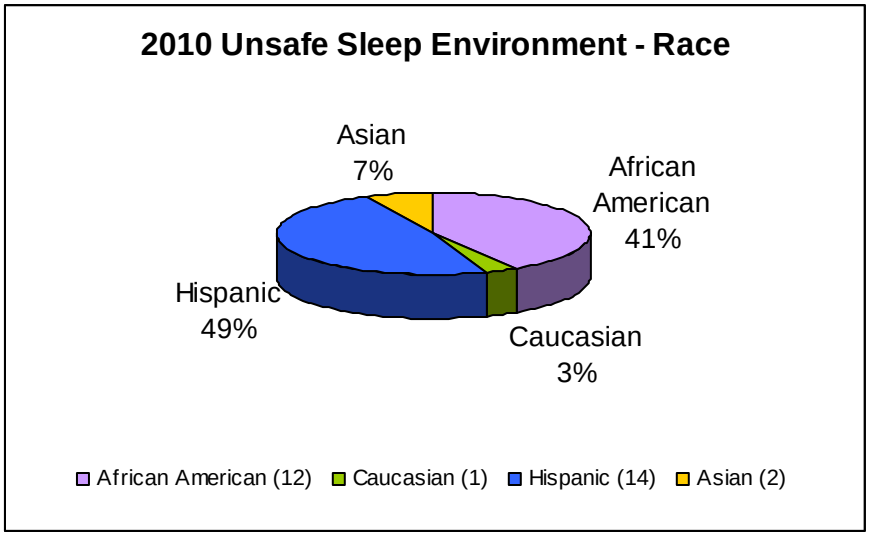
2010 Undetermined Child Deaths Involving Bed-sharing - Race

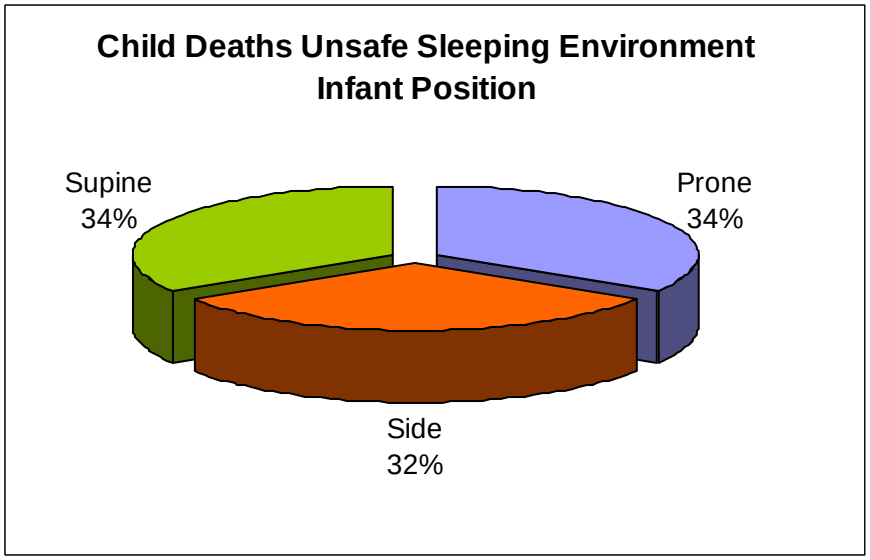


2010 Undetermined Bed-sharing Child Deaths - Number of Persons




2010 Undetermined Deaths Non-bed-sharing Unsafe Sleep Environment - Age
Over 9 months to 1 year (2)
Over 6 months to 9 months (8)
Over 3 months to 6 months (11)
0 to 3 months (8)
7%
27.5%
38%
27.5%
0
2
4
6
8
10
12
Number of Deaths


2010 Unsafe Sleep Environment - Race
Asian 7%
African American 41%
Hispanic 49%
Caucasian 3%
African American (12)
Caucasian (1)
Hispanic (14)
Asian (2)


Child Deaths Unsafe Sleeping Environment Infant Position
Supine 34%
Prone 34%
Side 32%

THIRD PARTY HOMICIDES 2010

Introduction

Historically, the ICAN Child Death Review Team report has included only those cases which have met Team protocol. For the fourth year, however, the report includes a special supplement to provide data on youth who are victims of a third party homicide. Unlike the child homicides perpetrated by a parent, caregiver, or family member, these homicides are where the perpetrator was not the caregiver or family member.

The information contained in this section is from two primary sources – the Los Angeles County Coroner's office and the local law enforcement agencies within Los Angeles County. The Coroner's Office provided demographic data as well as information on the cause and manner of death. Law enforcement provided information as to which agency conducted the criminal investigation, and whether the case was presented to the District Attorney's office for the filing of criminal charges and the type of charges filed. Also, in some cases, the Los Angeles Sheriff's Department (LASD) provided information about the relationship of the perpetrator to the suspect and some brief details about the victim's circumstances or activities prior to being killed.

The purpose of this information is to provide a broader analysis of children and youth deaths in Los Angeles County. Since the number is significant (n=52) it seemed relevant to provide an analysis of these third party homicide deaths in hopes to provide a better understanding of child death in Los Angeles County. Ultimately, it is hoped that the study of these deaths will help us intervene more effectively.

For the first time since collecting these data, a trend chart has been included. This chart shows there has been a consistent downward trend in these third party homicides over the past four years. One possible theory to explain this downward trend is the diligent efforts of our law enforcement and prosecutorial agencies to decrease gang activity as well as the implementation of various gang prevention efforts. Regardless of the reason, the numbers paint a much welcomed picture.

Case Summaries[1]
Third Party Homicides

Conner, age 15, was walking along the sidewalk after just leaving his girlfriend's house. Suddenly, and seemingly out of nowhere, Conner was shot multiple times causing him to run back to his girlfriend's home. Upon arrival, Conner said he had been shot so 911 was called and he was taken to the hospital by ambulance. Despite all life saving measures, Conner died shortly after his arrival.

Fifteen-year old Roberto and his cousin were riding bikes when a car drove by alongside them and the occupants asked Roberto and his cousin where they were from. Before Roberto could respond, the occupants shot at both of them. They were brought to the hospital where Roberto was pronounced dead from multiple gunshot wounds.

One summer evening, twelve-year old Cesar was riding his skateboard with his cousin along a busy street. Cesar decided to ride the skateboard while lying on his stomach down steep section of the road in traffic lanes. Cesar's cousin, upon noticing on-coming traffic warned Cesar to get out of the way. Cesar tried to get out of the way but was partially run over by a car. Cesar then fell off his skateboard and was struck by a second car that fled the scene.

Shortly before Christmas, fourteen-year old Jesse was walking home and just before reaching the gate to his front door, shots were fired from a passing car. Jesse was struck in the chest. Jesse was a student in the eighth grade and not known to be involved in any gangs. His family was known to the Department of Children and Family Services. Jesse was pronounced dead shortly after arrival to the hospital.

Kyle, age 15, was at a park with friends when they were approached by another group who opened fired on Kyle and his friends. Kyle and several friends were struck by bullets. The suspects then fled the scene and 911 was called. Kyle was airlifted and taken to the hospital where he was diagnosed with traumatic brain injury post gunshot to the head. Kyle remained in the hospital until his death. Another victim was also killed as a result of this incident. The shooting appeared to be gang related.

Sixteen-year old Steven was at home when he received a text message from friends to come out to the front of his home. Steven, did as requested, and was struck by gunfire. Paramedics and police were called and he was taken to the hospital, where he was pronounced shortly after arrival to the emergency room. Reportedly, Steven was a known tagger and his brothers were possible involved with gangs.

Sixteen-year-old Gabriel who lived in the local community was seen following another male youth across the nearby freeway pedestrian overpass. The two walked to the location and began talking. After a short conversation, the other

male youth pulled a handgun and began shooting at Carlos. Carlos was struck multiple times and collapsed to the ground. Law enforcement personnel responded to the location along with paramedics. Carlos was examined and pronounced dead at the scene. Carlos was a known gang member.

Fourteen-year old, Samantha was celebrating July 4th with her family by lighting fireworks in the street when unknown suspects approached on foot. The suspects, for reasons unknown, fired several shots at the family. Samantha was struck by a bullet and immediately transported to the hospital. However, medical intervention was unsuccessful and Samantha was pronounced dead before the day's end.

Alberto, age 16, was hanging out with friends in a carport when the group was approached by two male suspects who arrived on foot. Alberto's friends, after noticing these two suspects, immediately fled. One of the suspects produced a handgun and began firing at Alberto who was struck multiple times then collapsed. The suspects then fled on foot. Neighbors called 911 to report the gunfire. Law enforcement responded and secured the scene. Death was pronounced without medical intervention.

Fifteen-year old, Miguel, for reasons unknown, got in a fist fight with another boy. Reportedly, Miguel was slammed to the ground and struck repeatedly in the face. He was transported to a nearby hospital and unresponsive upon arrival. Miguel was determined to be brain dead and if placed on life support to never regain consciousness. After brain death protocols were confirmed, Miguel was pronounced dead of his injuries two days later.

Fourteen-year old Thandie was attending a party at a private residence along with several party-goers who were affiliates of a local gang. Shortly after midnight, several members of a rival gang walked into the party, shouted the name of their gang and began firing indiscriminately into the crowd. These shooters then fled the scene. Thandie was found unresponsive when paramedics and law enforcement arrived. She was taken to the hospital where she expired shortly after admission. Six other shooting victims, all of whom had no life-threatening injuries, were transported to various hospitals.

Five-year old, Derek was backyard of his home in the company of his uncle and grandfather. The backyard was separated from an alley by a chain link fence. Some gang members were walking in the alley and fired a gun over the fence in the direction of Derek and his family. Derek was shot twice in the head. The grandfather and uncle had minor injuries. Derek was taken to the hospital but was unable to survive his injuries. A few days later suspects were arrested and taken into custody.

[1]Case identities were changed.

THIRD PARTY HOMICIDES

- There were 52 third party homicides in 2010. This is a 17% decrease from 2009 when there were 63 such deaths and a 48% decrease from 2007 when these data were first collected.

- Ninety-six percent (n=50) of the youth were victims of gunshot wounds. These include 15 youth who were victims of homicides perpetrated by suspects with possible gang involvement. For the two remaining youth, one was killed by an automobile while riding his skateboard and another died as a result of blunt force trauma to the head after getting into a fist fight.

- As in the previous three years, male victims outnumbered female victims by a broad margin. Forty-seven males and five females were homicide victims in 2010.

- Sixty-three percent (n=33) of the children who were victims of a third party homicide in 2010 were ages 16 – 17; ten victims were 15 years of age, six were age 14, and three victims were 12 years of age or under with the youngest victim being five years of age.

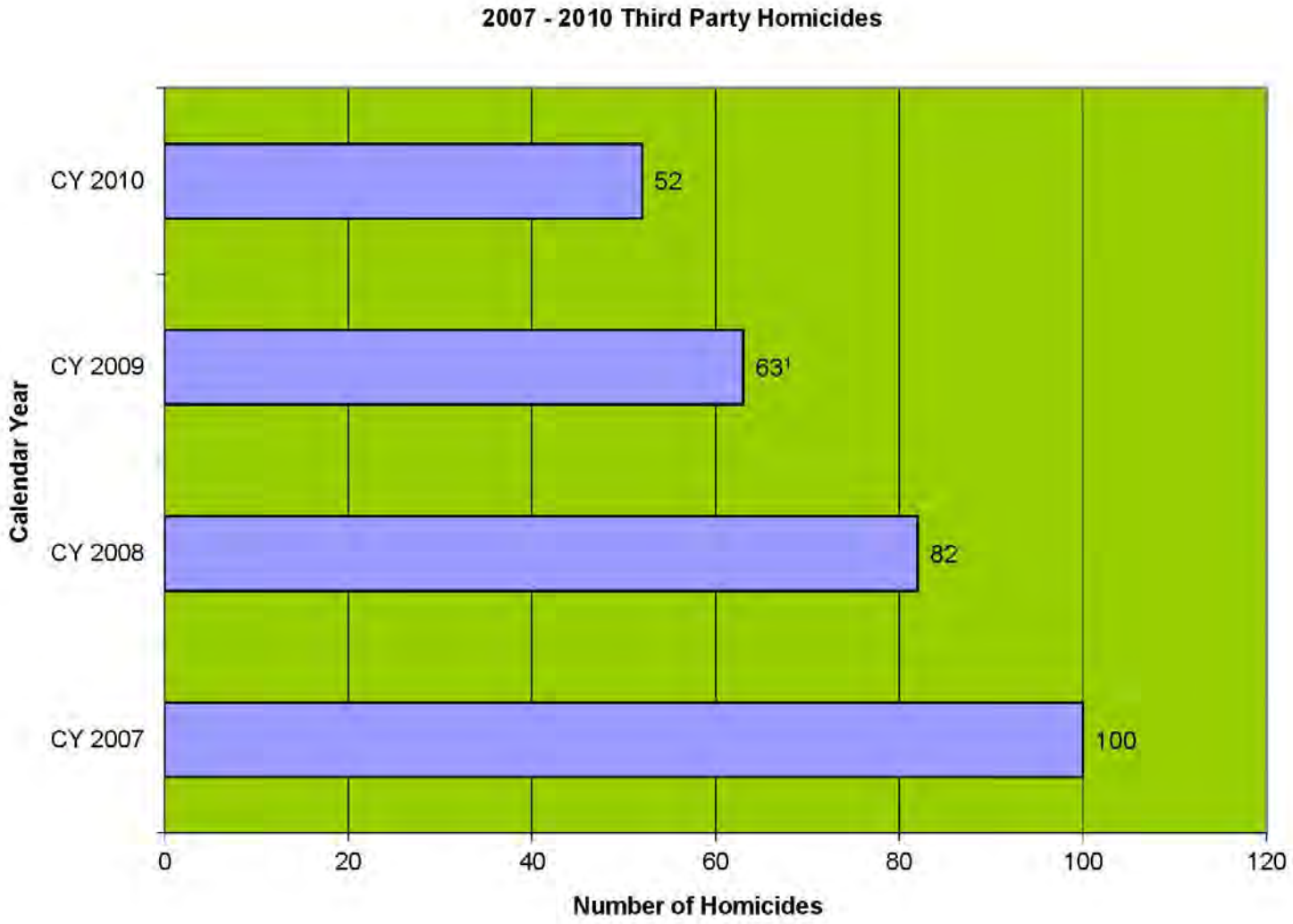
- African-American (n=14) youth were over-represented in third party homicides in 2010. There were 35 third party homicides of Hispanic youth, two third party homicides of Asian American youth, and one of the victims was of Caucasian descent.

- The greatest number of third party homicides occurred in June (n=6). The second greatest number of homicides occurred during the months of March, April, May, July, August, November, and December (n=5) and the third greatest number occurred in the month of January (n=4). The fewest number of homicides occurred during the months of February and October (n=2). Finally, three third party homicides occurred during the month of September.

- While third party homicides occurred throughout Los Angeles County in 2010, the majority (n=19) of these deaths occurred in Service Planning Area 6 (SPA 6/South Los Angeles). Nine third party homicides occurred in SPA 8 (South Bay/Harbor), eight in SPA 3 (San Gabriel Valley), five in SPA 7 (East Los Angeles), four each in SPA 2 (San Fernando Valley) and SPA 4 (Metro), two in SPA 1 (Antelope Valley), and one in SPA 5 (West Los Angeles).

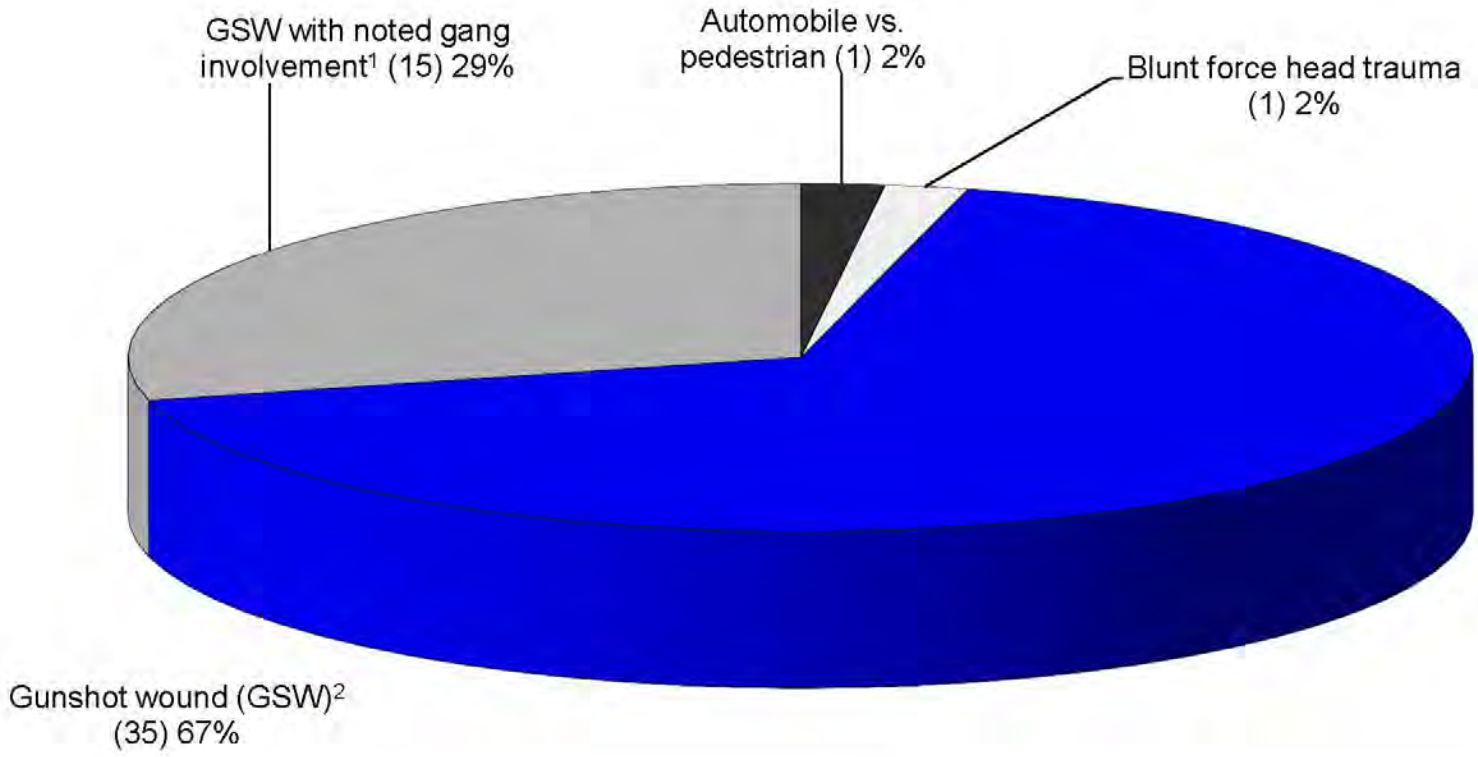
- The Los Angeles Police Department (LAPD) had investigative authority for 42% of the third party homicide cases in 2010. Thirty-five percent of the cases were under

the jurisdiction of the Los Angeles Sheriff's Department, and 23% of the cases were handled by jurisdictions other than LAPD and LASD. Where the relationship of the perpetrator was identified by law enforcement, 29% of the perpetrators were a gang member, and 20% of the victims were gang involved. Finally, 36% (n=19) of the case investigations resulted in the filing of criminal charges by the District Attorney's Office. When this information was collected, some of the cases were still under investigation or unsolved and therefore, had not been presented to the District Attorney's Office.



[1]A homicide in which a familial relationship was initially suspected turned out to be a family acquaintance changing it to a third party homicide and increasing the number of these for CY 2009 from 62 to 63.

2010 Third Party Homicides - Cause



1 Noted from the Coroner Investigative Narrative
2 Gang involvement unknown

THIRD PARTY HOMICIDES

LOS ANGELES COUNTY – 2010 (N = 52)

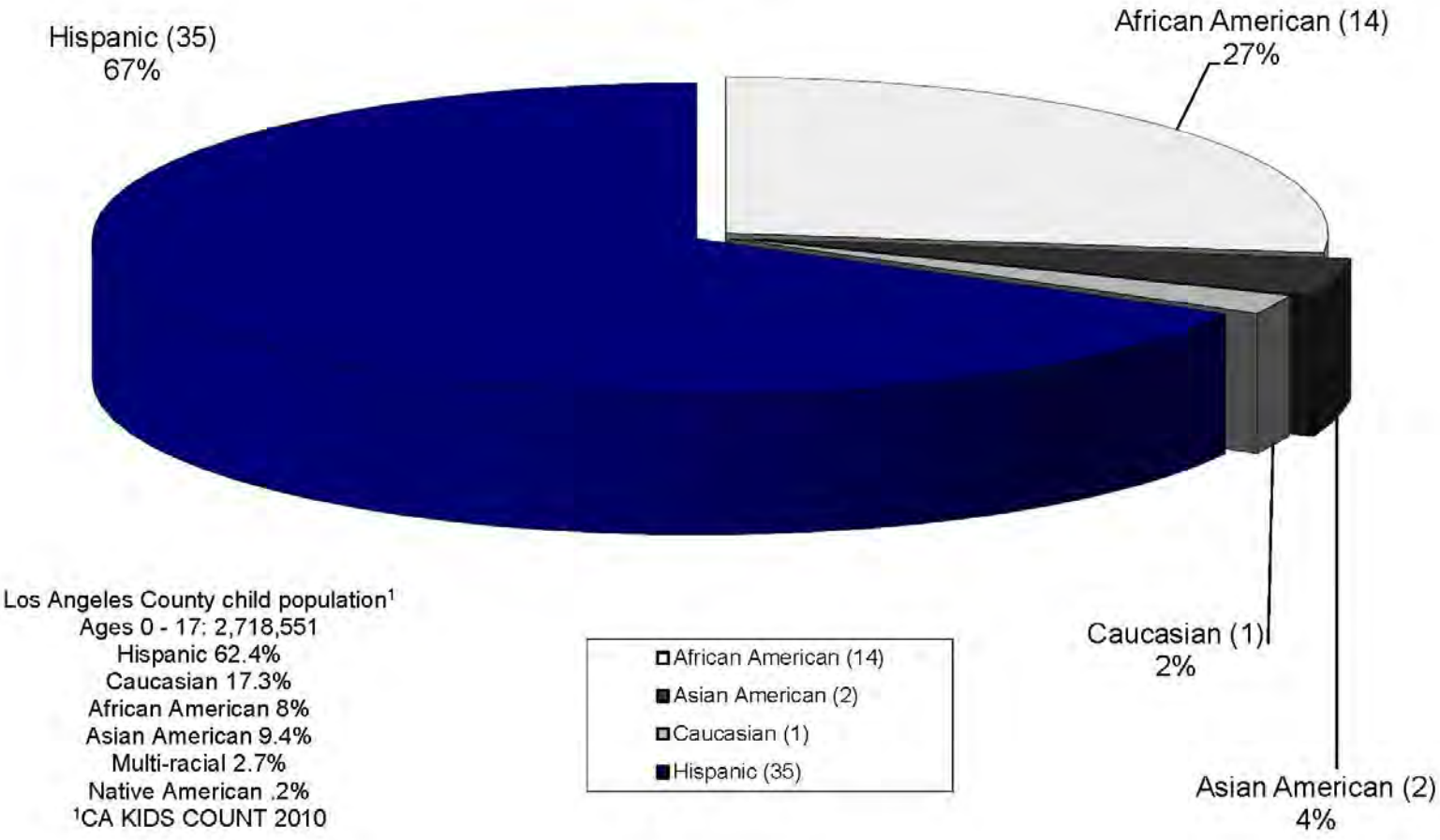
Age	Female	Male
1 year or under	0	0
2 – 12 years	0	3
13 years	0	0
14 years	2	4
15 years	1	9
16 years	0	12
17 years	2	19
Total	5	47

90% of the third party homicide victims were male.

Less than 6% of the third party homicide victims were 12 years of age or younger.

63% of the third party homicide victims were 16 to 17 years of age.

2010 Third Party Homicides - Race
(N=52)



Los Angeles County child population[1]
Ages 0 - 17: 2,718,551
Hispanic 62.4%
Caucasian 17.3%
African American 8%
Asian American 9.4%
Multi-racial 2.7%
Native American .2%
[1]CA KIDS COUNT 2010

Dates[1] of Third Party Homicides - 2010

4 homicides occurred in January (1/08, 1/15, 1/20, & 1/29/10)
2 homicides occurred in February (2/02, & 2/22/10)
5 homicides occurred in March (3/07,3/08, 3/16, & two on 3/30/10)
5 homicides occurred in April (4/06, two on 4/17, 4/22, & 4/28/10)
5 homicides occurred in May (5/10, 5/11, 5/23, 5/30, & 5/31/10)
6 homicides occurred in June (6/07, 6/11, 6/15, 6/22, & two on 6/27/10)
5 homicides occurred in July (7/04, 7/05, 7/10, 7/17, & 7/18/10)
5 homicides occurred in August (two on 8/10, two on 8/25, & 8/28/10)
3 homicides occurred in September (9/01, 9/05, & 9/28/10)
2 homicides occurred in October (10/02, & 10/13/10)
5 homicides occurred in November (two on 11/01, 11/14, 11/17, & 11/20/10)
5 homicides occurred in December (12/02, 12/13, 12/23, & two on 12/29/10)

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

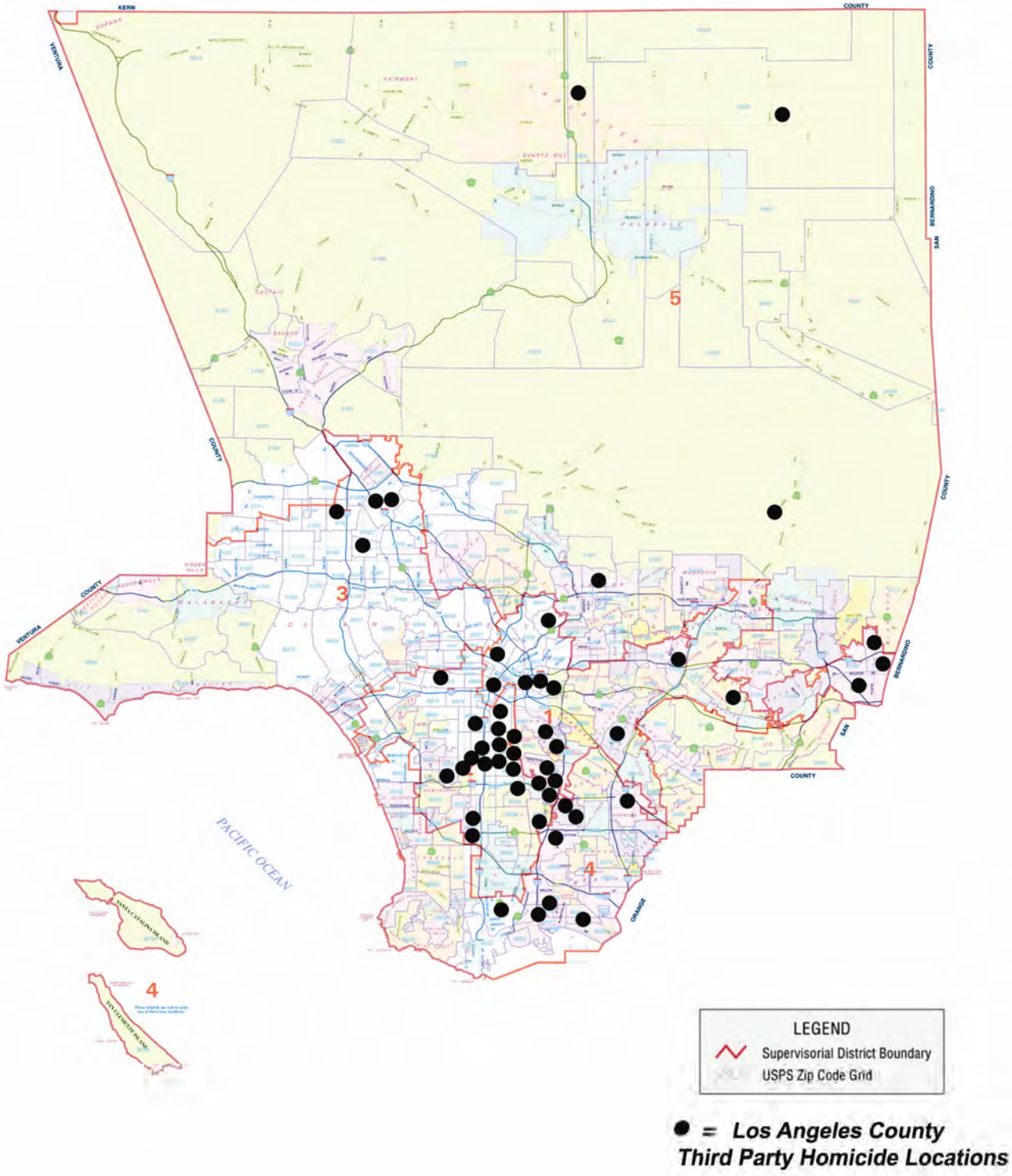
Locations[2] of Third Party Homicides – Geographic Area - 2010

1 homicide occurred in Azusa (zip code 91702)
1 homicide occurred in Bell Gardens (zip code 90201)
2 homicides occurred in Compton (zip codes 90221, & 90222)
1 homicide occurred in El Monte (zip code 91732)
1 homicide occurred in Gardena (zip code 90248)
2 homicides occurred in Inglewood (zip codes 90202, & 90303)
1 homicide occurred in La Puente (zip code 91744)
2 homicides occurred in Lancaster (zip codes 93534, & 93535))
4 homicides occurred in Long Beach (zip codes 90805, 90813, & 90814)
20 homicides occurred in Los Angeles (zip codes 90001, 90002, 90003, 90011, 90015, 90019, 90026, 90033, 90037 90042, 90044, 90047, 90063, & 90247
2 homicides occurred in Lynwood (zip code 90262)
1 homicide occurred in Maywood (zip code 90270)
1 homicide occurred in Mission Hills (zip code 91343)
1 homicide occurred in Norwalk (zip code 90650)
2 homicides occurred in Pacoima (zip code 91331)
2 homicides occurred in Paramount (zip code 90723)
1 homicide occurred in Pasadena (zip code 91104)
1 homicide occurred in Pico Rivera (zip code 90660)
3 homicides occurred in Pomona (zip code 91766, & 91767)
1 homicide occurred in South Gate (zip code 90280)
1 homicide occurred in Van Nuys (zip code 91405)
1 homicide occurred in Wilmington (zip code 90744)

[2] City where the injury/fatality occurred

2010 Third Party Homicides - Location

N = 52



Information on criminal justice system involvement in third party homicide cases was gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). In 2010, there were 52 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 1 below.

Table 1

Agency	Number of Cases	Percentage[1]
LAPD	22	42%
LASD	18	35%
Long Beach P.D.	4	8%
Pomona P.D.	3	6%
Inglewood P.D.	2	4%
Azusa P.D.	1	2%
Pasadena P.D.	1	2%
South Gate P.D.	1	2%

Table 2 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation. It should be pointed out that only LASD provided this information which explains the excessive number of cases in the "no information provided" category and why these data on the perpetrator's gang involvement vary from those found in the chart on page 80.

Table 2

Perpetrator's Relationship to Victim	Number of Cases
Gang Member	15
Stranger	1
No Information Provided or Unknown	36

Table 3 provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved. As above, only LASD provided the information needed for this Table.

Table 3	
Victim Information	**Number of Cases**
Shot in front of home after receiving a text message to come outside	1
Shot accidentally by a friend who was playing with a gun	1
Killed after initiating a fight and receiving blunt force trauma to the head	1
Shot while riding a bike through an alley	1
Killed after being run over by two vehicles while skateboarding down a steep hill.	1
Shot during a drive-by shooting	2
Gang member	11
No information provided	34

According to the information provided by the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD), 19 of the 52 cases of third party homicides had criminal charges filed by the District Attorney's Office in 2010. It should be pointed out that of the 22 cases under LAPD jurisdiction, three were presented to the District Attorney but not filed on and one case is pending review. Also, of the 26 cases under LASD jurisdiction, one was treated as a traffic accident. Finally, of the 12 cases reviewed by the LADA, information was found for only five cases. This may mean that law enforcement has not identified the assailants, not submitted the case for review or some other reason.Table 4 displays the number of filings by the type of criminal charge.

Table 4	
Type of Criminal Charges Filed	**Number of Cases**
Murder (187 (a) P.C)	17
Attempted Murder (664/187 (a) P.C.)	3
Assault with Deadly Weapon	1
Participation in a Criminal Street Gang	4
Discharge of firearm inhabited dwelling (246 P.C.)	1
Lying in Wait (190.2(4)(15) P.C.)	1
Attempted Extortion (644/552 P.C.)	1

[1] Percentages were rounded to the nearest whole number explaining the reason the total slightly exceeds 100%.

APPENDIX A
ON-LINE RESOURCES

Safe Sleeping Resources

hhtp://www.first5la.org/articles/safe-sleep-brochure
http://lacdcfs.org/news/documents/Safety%20Precautions.pdf
http://www.cpsc.gov/cpscpub/pubs/5049.html
http://www.cpsc.gov/cpscpub/pubs/5030.html
http://www.cpsc.gov/cpscpub/pubs/5091.html
http://www.californiasids.com/Universal/MainPage.cfm?p=10
http://www.firstcandle.org/

Water Safety

http://www.cpsc.gov/cpscpub/pubs/drown.html
http://www.cpsc.gov/cpscpub/pubs/5097.html
http://www.cpsc.gov/cpscpub/pubs/359.pdf
http://www.redcross.org/www-files/Documents/pdf/Preparedness/SummerSafety/ItOnlyTakesaMoment.pdf
http://www.redcross.org/www-files/Documents/pdf/Preparedness/SummerSafety/IsYourPoolSafe.pdf
http://fire.lacounty.gov/SafetyPreparedness/SafetyPrep_Pool_safety.asp

Biking Safety

http://www.cpsc.gov/cpscpub/pubs/343.html
http://www.chp.ca.gov/html/bicycleriding.html
http://lasd.org/bear/index.html

Child Abuse

http://www.dontshake.org/
http://www.endabuse.org/
http://www.child-abuse.com/
http://safestate.org/index.cfm?navID=6

Fire Safety

http://www.redcross.org/portal/site/en/menuitem.1a019a978f421296e81ec89e43181aa0/?vgnextoid=f8676768b6280210VgnVCM10000089f0870aRCRD&vgnextfmt=default
http://fire.lacounty.gov/FirePrevention/FirePrevFirePreventionTips.asp

In and Around Cars

http://www.usa.safekids.org/skbu/cars/spotthetot.html
http://www.nhtsa.dot.gov/people/injury/pedbimot/ped/BackoversTry2/index.htm
http://www.kidsandcars.org/
http://www.chp.ca.gov/community/safeseat.html
http://www.aap.org/family/carseatguide.htm

Pedestrian

http://www.kidsandcars.org/
http://www.chp.ca.gov/html/walkwithcare.html
http://www.chp.ca.gov/html/skateboard.html

Teen Drivers

http://ww.nhtsa.dot.gov
http://www.youtube.com/watch?v=vgDgcWNXBcI&feature=related
http://coroner.co.la.ca.us/htm/yddvp1.htm

Grief and Mourning

http://www.californiasids.com/Universal/MainPage.cfm?p=10
http://ww.compassionatefriends.org
http://griefcenterforchildren.org

Suicide-Youth

http://www.preventsuicide.lacoe.edu
http://ww.suicideinfo.ca/youthatrisk
http://suicidehotlines.com/california.html
http://www.spyc.sanpedro.com/suicide.htm
http://www.uaii.org/uaiiinc_007.htm
http://ww.youtube.com/watch?v=iCaMpd2L2kQ
http://www.youtube.com/watch?v=CHynDpYv1Gw&NR=1