Inter-Agency Council on Child Abuse and Neglect

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Child Death Review Team Report 2012

Report Compiled from 2011 Data

Table of Contents

Table of Contents i

Introduction ii

Los Angeles County Child Death Review Team Members iv

Los Angeles County Child and Adolescent SuicideTeam Members vi

Recommendations 1

Child Death Review Team Risk Factors and Lessons Learned 2

Child and Adolescent Suicide Review Team Risk Factors and Lessons Learned ... 6

Team Accomplishments 8

Findings 9

Selection of Cases for Team Review 15

Child Deaths In Los Angeles County 2007 - 2011 16

Child Homicides by Parent, Caregiver or Other Family Member 2011 18

Child and Adolescent Suicides 2011 37

Accidental Child Deaths 2011 45

Undetermined Child Deaths 2011 53

Third Party Homicides 2007– 201171 67

Appendix A 79

Introduction

The Los Angeles County ICAN Child Death Review Team (CDRT) meets monthly to review the deaths of children in our county. Often, those entrusted with a child's care and welfare - parents or caregivers - are frequently the perpetrators of the injury or incident that caused the child's death. The Team reviews tragic cases involving the death of young children, most of whom are under the age of five years, as a result of severe abuse or neglect. Other tragic deaths highlight the need for child safety efforts, product safety and public health campaigns.

The Los Angeles County ICAN 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.

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

The Team reviews each referred case in detail, with input from the agencies that may have known of the child and family before, during or after the death. This process often illuminates problems in communication between agencies, in policies or procedures within and between agencies, or in dissemination of critical child safety information. Team participants provide feedback to, or seek clarification from their own agencies when a potential problem related to a child's death is identified. The information is then provided back to the Team. This active feedback process has resulted in improved inter- and intra-agency communication, more effective child safety practices, and more successful child death and injury prevention programs. The lessons learned from this systematic review of child deaths helps us to better understand the dynamics of the systems involved with families in order more effectively to prevent child deaths which is the ultimate goal of the Team.

This thirty-fourth annual report of the ICAN CDRT provides information on *all* child deaths that meet Team protocol and occurred in Los Angeles County during *2011.* A detailed analysis of quantitative and demographic data of children killed by caregivers, youth suicides, accidental deaths and undetermined deaths is provided. Lessons learned from the reviews and ensuing recommendations which, if implemented, should improve child safety and save lives are included in the report. Appendix A at the end of the report provides on-line resources for prevention of child deaths.

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

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Recommendations

1. **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: Violence between adults impacts children in the home as they 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. In one of the 2011 child homicides by a parent, law enforcement had been to the home several times for domestic violence calls, the last one two weeks prior to the child's death. In another case, the mother had a restraining order against the father for domestic violence. 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 is a carryover from the 2011 report and 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.

2. **In addition to making the initial cross report-ESCAR, both DCFS and Law Enforcement should update assigned investigators/workers when a change occurs and should remain in active communication with each other to ensure that agencies understand what has and what has not been completed in an investigation.**

Rationale: LA County is unique with implementing an electronic cross-reporting of Suspected Child Abuse Reports system between DCFS and the various law enforcement agencies within LA County. However, the system is of little use if there is no communication between agencies after the initial report is made.
Note: This recommendation relates to the Collateral Contacts and Communication among Agencies sections in the Lessons Learned portion of the report.

3. **Youth Suicide Prevention: The Los Angeles County Department of Mental Health, the Los Angeles County Office of Education, and the Los Angeles Unified School District should increase student access to school-based prevention and early intervention programs that equip children and adolescents with resiliency skills and address interpersonal conflict.**

Rationale: In close to 90% of the suicides, there was an incident that occurred shortly before the fatal suicide. These events involved conflict with a family member, romantic partner, peer and school officials. Many were accompanied by worry and anxiety about the consequences (i.e. shame and guilt, academic discipline, legal sanctions, relationship loss).

Note: This recommendation relates to the Child and Adolescent Suicide Review Team Risk Factors and Lessons Learned portion of the report.

Child Death Review Team

Risk Factors and 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. Additionally, patterns of risk factors in families surface in the cases. The lessons and risk factors in the 2011 child death cases follow. Sadly, most are carryovers from the previous report and have continued to surface for years.

Child Risk Factors

1. Young Age

91.6% of the 2011 child homicides by a parent/relative/caregiver were age five and under; 87.5% were two and under; and 52.2% were infants under one year of age. Infants and young children are especially vulnerable to abuse and neglect which can lead to death due to their dependence upon caregivers them to meet their needs. They are also often not visible outside the home as these families tend to be socially isolated.

54.2% of the accidental child deaths involved children age five or younger. Young children are more at risk due to deaths such as being crushed by an object such as a falling television set, drowning and auto back up deaths because of their size and need for adult supervision to prevent such deaths.

2. Gender

66.6% of the 2011 child homicides victims by a parent/relative/caregiver were male. Twice as many males under age one year were victims of homicide than females.

3. Race

62.5% of the 2011 child homicides victims by a parent/relative/caregiver were Hispanic, 25% African American, 12.5% Caucasian, and there were no Asian/Pacific Islander victims in 2011. Hispanic children were about even for the general population, Caucasian children were slightly over represented, and African American children were over represented as homicide victims.

Parental Risk Factors

1. Young Age

27% of the child homicides involved one or both parents or significant other who was age 21 years or younger. Young in age, these parents may lack the maturity, skill and experience to cope with their parental role in a health manner.

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 2011

child homicides in which nine of the families had a history of domestic violence.

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.

4. 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 in recent years, there was an increase in 2011. Child deaths with a contributing factor of maternal substance abuse remains one of the top four causes of accidental death accounting for 13.6% of accidental child deaths.

5. Mental Illness

In 2011, two children were killed by a parent, caregiver or family member with a history of 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.

6. 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. 48% (n=11) of the 2011 child homicides involved a parent or perpetrator with a Child Protective Service (CPS) history as a child.

7. 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 2011, only one family of a homicide victim had none of these known risk factors present.

Perpetrator Relationship

1. Relationship

In 2011, 52% of the child homicides perpetrators were the biological father, 22% the biological mother and 26%, the mother's boyfriend. 78% of the perpetrators were males in 2011. Only three homicides involved both parents (n=2) or the mother and her boyfriend.

2. Lack of Bonding or Poor Attachment

The quality of the relationship of the adult to the child has been a recurring factor in child homicide deaths. This is particularly important when the person assumes a caretaking role for the child. The Team has observed that each year, many of the child homicides have been at the hands of the parent, 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. In 2011, there were several cases in which the biological father or mother was not emotionally attached to the child and the child was killed by that parent.

Additional Risk Factors

1. Unsafe Infant Sleeping

The Team continues to note a disturbing number of deaths associated with bed-sharing and/or unsafe sleep environments and has made recommendations to help prevent these deaths. The Team has observed that infants are often placed on adult beds, couches and/or surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. In 2011, there were 67 undetermined child deaths involving bed-sharing or unsafe sleep environments which accounted for 62% of all the undetermined child deaths. Additionally, two infants died from being wedged between a bed or couch and a wall or other furniture and were ruled accidental. Most unsafe or bed-sharing infant deaths are moded as undetermined by the coroner. Adding these accidental deaths to the undetermined ones brings the total of unsafe sleep infant deaths to 69.

System Factors

1. 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 an individual 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.

2. Collateral Contacts

The Team has observed in some cases when there was contact with DCFS and the family for allegations of child abuse or neglect, DCFS did not make use of collateral contacts to assist them in assessing the validity of the allegations and parents' explanation in determining the risk to the child before making a finding as to the allegation. This was also seen in some case histories in which children were returned home or cases were closed without using certain key collateral contacts to verify parents' compliance and progress with the service and visitation plan to ensure the circumstances that brought the family to the attention of DCFS has been adequately addressed.

3. Communication among Agencies

In 2011 child homicides, as in previous years, the Team has reviewed cases in which a family had contact days, weeks or months before the child's death by an agency such as medical, law enforcement or other community agency and "red flags" were observed but not reported or communicated to DCFS. When a family is involved with multiple systems-DCFS, Law Enforcement, Medical, community social services, it is imperative that the agencies providing services to the family have ongoing communication with one another for child safety, investigation, and case management purposes.

Child and Adolescent Suicide Review Team

Risk Factors and Lessons Learned

1. Suicide Rate

The suicide rate among individuals under the age of 18 years increased from 16 suicides in 2010 to 19 in 2011. Although there has been a downward trend in youth suicides over the last ten years, 2011 represents the second year in which there was a rise in the suicide rate. The highest number of youth suicides was in 2001 with 27 which fell to a low of ten in 2007.

2. Gender

There was a significant shift in the gender rate of suicides in 2011. In prior years, the male to female ratio was consistent with males outnumbering the females by a large margin. In 2010, for every female suicide there were two male suicides. In 2011, eight of the nineteen suicides were female and eleven male.

3. Race

53% of the suicide youth were Hispanic which under represented the general population, 32% were Caucasian and over represented in youth suicide, 10% were African American with a slight over representation and 5% were Asian/Pacific Islander and under representative of the general population.

4. Relationship Loss or Conflict

89.4% of the suicide youth experienced a recent relationship loss or conflict with a peer, boyfriend/girlfriend or parent prior to their suicide.

5. The Role of Pre-existing Mental Health Problems

Among the youth who died of suicide, 42% had a documented mental health diagnosis and 36.8% were receiving mental health services at the time of death.

Through the review of cases, the Team observed 86.5% of the youth manifested symptoms related to psychiatric or substance abuse disorder. Of the cases reviewed, 71.4% experienced mood disorders, 31.5 % had substance abuse disorders and there were previous suicide attempts in 26.3% of these cases. Sixty-three percent of the youth exhibited a warning sign--talk of suicide, increased drug and alcohol use, feelings of depression, anxiety and hopelessness, and giving away possessions.

6. The Role of External Factors

The act of suicide frequently occurs in combination with external factors which seem to overwhelm youth who are already having difficulty in coping with the challenges posed by adolescence due to mental disorders. Some examples of these stressors are interpersonal loses, family violence, sexual orientation confusion, disciplinary problems, physical and sexual abuse, and being a victim of bullying.

8. Social Networking

There was Internet social networking activity noted by others after the death of youth in all of the cases reviewed. One decedent had posted Internet and text messages immediately prior to death but investigators did not have access to that information because they did not have the password needed to access the site. It is not known how many other children or youth had posted messages. Postmortem information and messages to family/peers were discovered for all of the cases reviewed.

9. 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.

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.

Team Accomplishments

In 2011 – 12, 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.
- Formed a sub-committee to screen all undetermined child deaths and refer cases to the Team for a full review when circumstances indicate a finding of accidental or homicide could possibly result from a multi-disciplinary review.
- Formed a sub-committee to explore the development of software to gather the various agency reports and information on a case in one central location for review by Team members.
- 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 2011 Child Fatalities attributed to abuse or neglect.
- Presented 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 2011 – 12, the ICAN **Child and Adolescent Suicide Review Team (CASRT):**

- Received data collected by School of Pubic Health at Iowa State University and the Forensic Training Institute at the Southern California campus of the Chicago School of Professional Psychology containing qualitative information about cases reviewed between 2005 and 2010.
- ICAN received a grant to develop field investigation guidelines for Coroners and Medical Examiners through a partnership with the Gutin Family Fund of the New Hampshire Charitable Foundation, the Los Angeles County Department of Coroner.
- Presented a report about the investigation guidelines to coroners and medical examiners at the California State Coroner's Association training conference in Orange County. More than 20 agencies throughout California expressed interest in receiving training to use the guidelines.
- Continued to search for and investigate the content of comments made on Social Networking sites for each case reviewed by the Team.
- Continued to develop 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 support mental health services.
- Delivered training workshops at the ICAN annual NEXUS conference to introduce participants in the Orange County Office of Education Safe from the Start parent training on the effects of violence on early brain development.
- Established a task force to address the continuity of care of services for children and youth returning to school after receiving residential or out patient mental heath services in response to the risk for suicide.

Findings

Overall Child Deaths

- There were 239 child deaths from homicide by a parent, relative or caregiver, accidental, suicide or undetermined cause in Los Angeles County for 2011, a 7% decrease from the 256 deaths in 2010.

- Twenty-four children were victims of homicide by a parent, caregiver or other family member. There were 19 suicides, 88 accidental child deaths and 108 undetermined child deaths.

- The percentage of children who died in 2011 by race/ethnicity consisted of 47.1% Hispanic, 21.4% Caucasian, 20.5% African American and 7.6% Asian/Pacific Islander and 3.4% Unknown.

- African American children who comprise 7.8% of the child population in Los Angeles County are disproportionately represented in the number of child deaths. Caucasian children who comprise 17% of the child population are slightly over represented and Hispanic and Asian children are under represented in death.

- Over two thirds of the children were between the ages of 0 to three years (n=165). 53% were infants under the age of one year (n=126). The majority of children who died (61%) were one year of age or younger.

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

Homicides

- There were 24 child homicides by parents, caregivers or family members in 2011. This represents a decrease (11.5%) from 2010 when there were 26 child homicides. The number of child homicides for Los Angeles County in 2011 was much lower than the 15 year average of 34.4 deaths. In the past decade, child homicides have declined by 34%.

- 91.6% percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is a significant increase from 2010, when 77% of the children were five years of age or younger. More than half (54%) of the children were under the age of one year.

- Only two of the 24 homicide victims were over the age of five years; six year old twins who died as a result of murder-suicide.

- The average age of a child homicide victim in 2011 was 1.35 years (16.17 months) which was much younger than in 2010 when the average age was 3.61 years.

- Eight female children and sixteen male children were victims of child homicide by parents, caregivers or family members in 2011.

- 74% percent of the child homicide victims were battered children who died from inflicted trauma--ten children died from head trauma, six died from multiple traumas, and one died from trauma to the torso/abdomen. Two children died from asphyxiation/suffocation, two from gunshot wounds, one a victim of stabbing, one died from dehydration/malnutrition, and finally, one from post-term gestation .

- One newborn was abandoned and found deceased and/or killed by the mother in 2011. This is a decrease from 2010 in which there were three abandoned deceased newborns. The three 2010 abandoned newborns were ruled homicides and the single 2011 death was deemed undetermined. Six newborns were safely surrendered in 2011 which is one less than 2010.

- Hispanic (n=15) children were slightly over-represented and comprised 62.5% of child homicides by a parent, caregiver or relative. African American (n=6) children were over-represented in child homicides by a parent, caregiver or family member accounting for 25% of child homicides. Three children were Caucasian and none were of Asian descent.

- The Department of Children and Family Services (DCFS) or another county's Child Protective Services agency had prior contact with 26% (n=6) of the families in which there was a child homicide and the child died in Los Angeles County. This is almost a fifty percent decline from 2010 when 50% of these families had previous contact with DCFS. Two homicides had an open referral on the family with L.A. County DCFS at the time the fatalities occurred. One of these referrals was opened the day of the death for child abduction which ended in the child's homicide. 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's open case was a result of the near fatal trauma that resulted in death.

- Eighteen children were killed by their father, stepfather or mother's boyfriend and three children were killed by their mother. Two children were killed by both parents, and finally, one by the mother and her boyfriend.

- The greatest number of child homicides by parents, caregivers or family members occurred in May (n=4). The second greatest number of homicides occurred in the months of June (n=3), August (n=3), and October (n=3). The fewest occurred in the month of December with no homicides. Two child homicides occurred in the months of January, March, September, and November. One homicide occurred in the months of February, April and July. Sixty percent of child homicides occurred in the spring and summer months of the year.

- Child homicides occurred throughout Los Angeles County in 2011. The Service Planning Area (SPA) in the East – SPA 7 had the greatest number of child homicides (n=6). Five child homicides occurred in SPA 8 located in South Bay/Harbor and three in SPA 1 – Antelope Valley. Two child homicides each occurred in the San Fernando Valley – SPA 2, San Gabriel Valley – SPA 3, Metro – SPA 4 and South County – SPA 6. SPA 5 located in West county had one child homicide.

Suicides

- Nineteen children and adolescents committed suicide in 2011. This is an increase from the 16 suicides in 2010, and higher than the 15-year average of 17.9 suicides per year.

- As in years past, male victims outnumbered female victims. However, unlike previous years, the gap between the number of male and female victims decreased. Eleven males and eight females committed suicide in 2011.

- Although the most common method of suicide nationally is firearm, the leading method in LA County continues to be death due to hanging, which represents 47% (n=9) of the suicides in 2011. Four youth used a firearm, two jumped to their death, two pedestrian vs. train or auto, one overdosed, and one crashed his car.

- The act of suicide usually occurs in the youth's home. However, in 2011, 26.3% of the suicides occurred away from the youth's home which is a departure of the pattern from all the previous years.

- Suicides by Hispanic youth represent 53% (n=10) of the total of adolescent suicides and is a decrease from 2010 when 63% of suicides were by Hispanics. Thirty-two percent (n=6) of adolescent suicides in 2011 were by Caucasians which is one more from the previous year. Suicides by African Americans (n=2) increased by one from 2010. There was one suicide by an Asian/Pacific Islander adolescent in 2011 which remained the same as in 2010.

- Sixty-nine percent (n=13) of the children who committed suicide in 2011 were ages 15 – 17; three were 14 years, two victims were 15, and two were 13 years of age. The youngest victim, age 12 died from hanging.

- Eighty-nine percent (n=17) of the adolescent suicides were precipitated by interpersonal conflicts or a recent loss. Twelve 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. Eight youth had a mental health history. Seven were in counseling at the time of their death and four were taking psychotropic medication. Four youth had a history of prior self-injury or cutting and five youth had previously attempted suicide. Nine youth exhibited warning signs prior to their suicide. Eight of the youth who committed suicide in 2011 left a suicide note. Two of those youth also texted their intent just prior to committing the act and two other youth texted their intent but did not leave a note. None of the youth were discovered to have a positive toxicology for drugs at autopsy. Six youth did have a history of alcohol or drug use. Six youth had experienced academic problems and three had school discipline or truancy problems.

- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred in northern part of the county -Antelope Valley (SPA 1) and San Fernando Valley (SPA 2) with four each. Three suicides occurred in South LA (SPA 6). Two suicides occurred in SPA three, seven and eight. One occurred in Metro area (SPA 4) and one West Los Angeles (SPA 5).

Accidental Child Deaths

- Overall, 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 lowest number of 86 in 2010. In 2011, there was an increase of two accidental child deaths ages 0 - 17 to 88 from the 86 in 2010.

- The two leading causes of accidental death for children ages 0 – 17 years were auto pedestrian (n=25) and automobile accidents (n=17). Of the 88 accidental deaths, 68 accidental child deaths involved children ages 0 – 14 years. Seventy-six percent of auto pedestrian deaths were children ages 0 to 14 years. There were 20 accidental deaths of youth's ages 15 to 17 years. Youth ages 15 to 17 years accounted for 47 % (n=7) of automobile related deaths in 2011.

- Auto pedestrian (n=19) deaths were the leading cause of accidental death for children 14 years of age and under. Three of these deaths involved toddlers who were backed over in a driveway. Deaths due to maternal substance abuse (n=12) was the second leading cause for this age group. Automobile accidents accounted for nine deaths. Drowning (n=6) ranked fourth and crushed by an object (n=5) ranked fifth as the leading cause of accidental death of children 0 – 14 years. Four of the five young children crushed by an object were killed by falling televisions which has a trend the past two years.

- Deaths associated with maternal substance abuse accounted for 10 fetal deaths and two infant deaths. Methamphetamine is the most associated drug with these deaths (n=7) accounting for 58%. Cocaine and opiates with two each accounted for 34% and PCP with the remaining death. Deaths associated with maternal substance abuse accounted for 13% of all accidental deaths in 2011, and fetal deaths associated with maternal substance abuse accounted for 11.4% of all accidental deaths.

- Accidental drowning claimed the lives of 7 children ages 0 – 17 years, an increase of one death from 2010 when there were six such deaths. A majority of these drowning deaths were young children who drowned in residential pools. In 2011, all but one the children drowned in a residential pool and 71.4 % were five or younger (n=5). One adolescent drowned in a hotel pool while visiting the area. In the past, drowning had been one of the leading causes of accidental deaths of children in Los Angeles County.

- Two infants were suffocated having been wedged between a bed or couch and furniture or wall. These were ruled accidental as opposed to undetermined.

- Of the children who died an accidental death in 2011, 42% had a DCFS or other county CPS history. Nine of the twelve fetal deaths from maternal substance abuse had a history with DCFS.

- Hispanic children represented 53% (n=47) of all accidental child deaths in 2011. Seventy-two percent of the auto pedestrian deaths were Hispanic children. Caucasian children represented 20% (n=18) of the accidental deaths. Caucasian children were over-represented in maternal substance abuse deaths (n=5). African-American children (n=15) were over-represented in accidental deaths in 2011. Asian/Pacific Islander children were slightly under-represented in 2011 accounting for 6% of all accidental deaths. Sixty percent (n=3) of the accidental Asian child deaths were auto-pedestrian.

- As in previous years, males (n=49) outnumbered females (n=39) in accidental death. However, for the first year, the gap between males and females has decreased significantly.

Undetermined Child Deaths

- There were 108 undetermined child deaths in 2011. This is a decrease from the 128 such deaths in 2010 and significantly higher than the 15-year average of 86.9 undetermined deaths per year. Eighty-five percent of the undetermined child deaths were age one year and under (this includes stillborn deaths). Eighty-seven percent of undetermined child deaths were age five years and younger. The one abandoned deceased newborn infant for 2011 was ruled an undetermined child death.

- African American (n=27) children were significantly over-represented in undetermined child deaths and Hispanic (n=40) were underrepresented. There were 24 Caucasian and 12 Asian/ Pacific Islander undetermined child deaths which is a slight over representation from the general population. Lastly, five undetermined child deaths were of unknown descent.

- Bed-sharing and unsafe sleeping environments accounted for 62% percent of all undetermined child deaths. 38% of the undetermined child deaths were associated with bed-sharing (n=41) and 24 % with an unsafe sleep environment (n=26).

- Among the bed-sharing deaths, 0% involved one unsafe risk factor, 15% involved two, and 85% involved three or more unsafe risk factors. Risk factors included bed-sharing, 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-nine percent of the bed-sharing deaths and 23% of the unsafe sleeping environment child deaths were African American. African American children represent 25% of all the unsafe sleep undetermined deaths but are lower than 2010 when they comprised 33% of the undetermined deaths.

- The top three sleep surfaces involving bed-sharing and unsafe infant sleep child deaths occurred in an adult bed (64%), on a couch (13%) or in a crib (8%).

- In 40% of the bed-sharing and non-bed-sharing unsafe sleep child deaths, the infant was placed in a prone or side position for sleep. This is a decrease from 2010 when 60% of the infants were placed prone or on their side to 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. 28% (n=19) occurred in South Bay/Harbor SPA 8, 24% (n=16) in South LA SPA 6 and 16% (n=11) in the San Fernando Valley SPA 2.

- Thirty-eight percent (n=41) of the undetermined child deaths involved bed-sharing. This is an increase from 2010 in which 31% of undetermined child deaths involved bed-sharing.

- Fifty-five percent (n=22) of the bed-sharing deaths were infants between 0 to 3 months of age, 27% (n=11) were infants between 3 to 6 months of age, 12% (n=5) were 6 months to 9 months of age, and 7% (n=3) were 9 months to 1 year.

- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 54% of the incidents and two adults in another 22% of the incidents.

- Twenty-four percent (n=26) 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.

- Thirty-one percent (n=8) of the non bed-sharing deaths were infants between 0 to 3 months of age, 42% (n=11) were infants between 3 to 6 months of age, 15% (n=4) were 6 months to 9 months of age, and 12% (n=3) were 9 months to 1 year.

- Seventy-three percent of the infants whose deaths occurred in unsafe sleeping environments were six months or younger (n=19).

- Approximately 40% of the families with a child who died from an undetermined death had at least one contact with DCFS or another county CPS agency.

Selection of Cases for Team Review

The Los Angeles County 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 reported 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 2011, 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.

Child Deaths in Los Angeles County 2007 – 2011

Over the past 5 years, a parent, caregiver or other family member has killed an average of 27.8 children each year.

2007	26
2008	34
2009	29[1]
2010	26
2011	24

An average of 15.2 children and adolescents each year has *committed suicide* over the past five years. The leading method from 2007 through 2011 was hanging.

2007	10
2008	17
2009	14
2010	16
2011	19

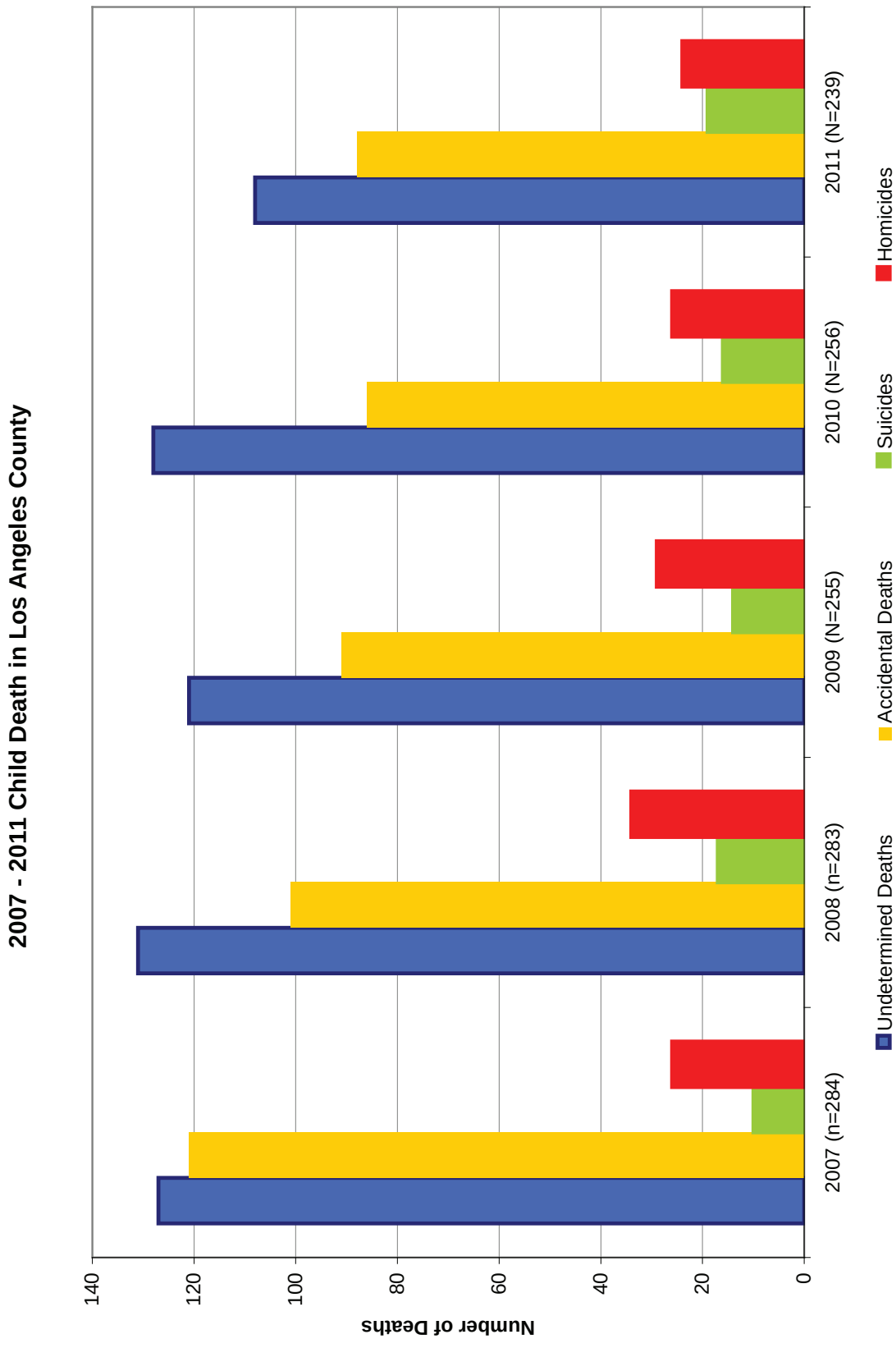
Over the past five years, an average of 97.4 children have died from preventable accidents. The most common accidental Deaths involve auto pedestrian, automobile accidents and deaths due to maternal substance abuse.

2007	121
2008	101
2009	91
2010	86
2011	88

The number of undetermined deaths has averaged 123 per year over the past five years.

2007	127
2008	131
2009	121
2010	128
2011	108

[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 decreasing the number of these for CY 2009 from 30 to 29.


2007 - 2011 Child Death in Los Angeles County
Number of Deaths
0
20
40
60
80
100
120
140
2007 (n=284)
2008 (n=283)
2009 (N=255)
2010 (N=256)
2011 (N=239)
Undetermined Deaths
Accidental Deaths
Suicides
Homicides

Case Summaries
Child Homicide by Parent/Caregiver/Family Member

James

James, age 22 months old died from injuries that were inflicted three days earlier. The boyfriend of the child's mother babysat the child while the mother worked. He called the child's mother at work to report the child was having difficulty breathing. The boyfriend refused multiple requests by the mother to call 911. The mother returned home and the boyfriend, a reputed gang member, left because he claimed he wanted nothing to do with the police. The child was ultimately transported to the hospital. The child suffered a subdural hematoma, laceration of the liver, bruising throughout the lower half of the body, retinal hemorrhages typical of shaken baby and hemorrhage of the pancreas consistent with a forceful punch to the area. The child died after three days on a ventilator. The boyfriend had no prior DCFS history. He initially claimed James was perfectly fine until he developed breathing problems. After deputies confronted him, he changed his story and stated the child had been sick a couple of days. The boyfriend is being prosecuted by the District Attorney's Family Violence Division on charges of murder and assault on a child under eight causing death.

Sylvia

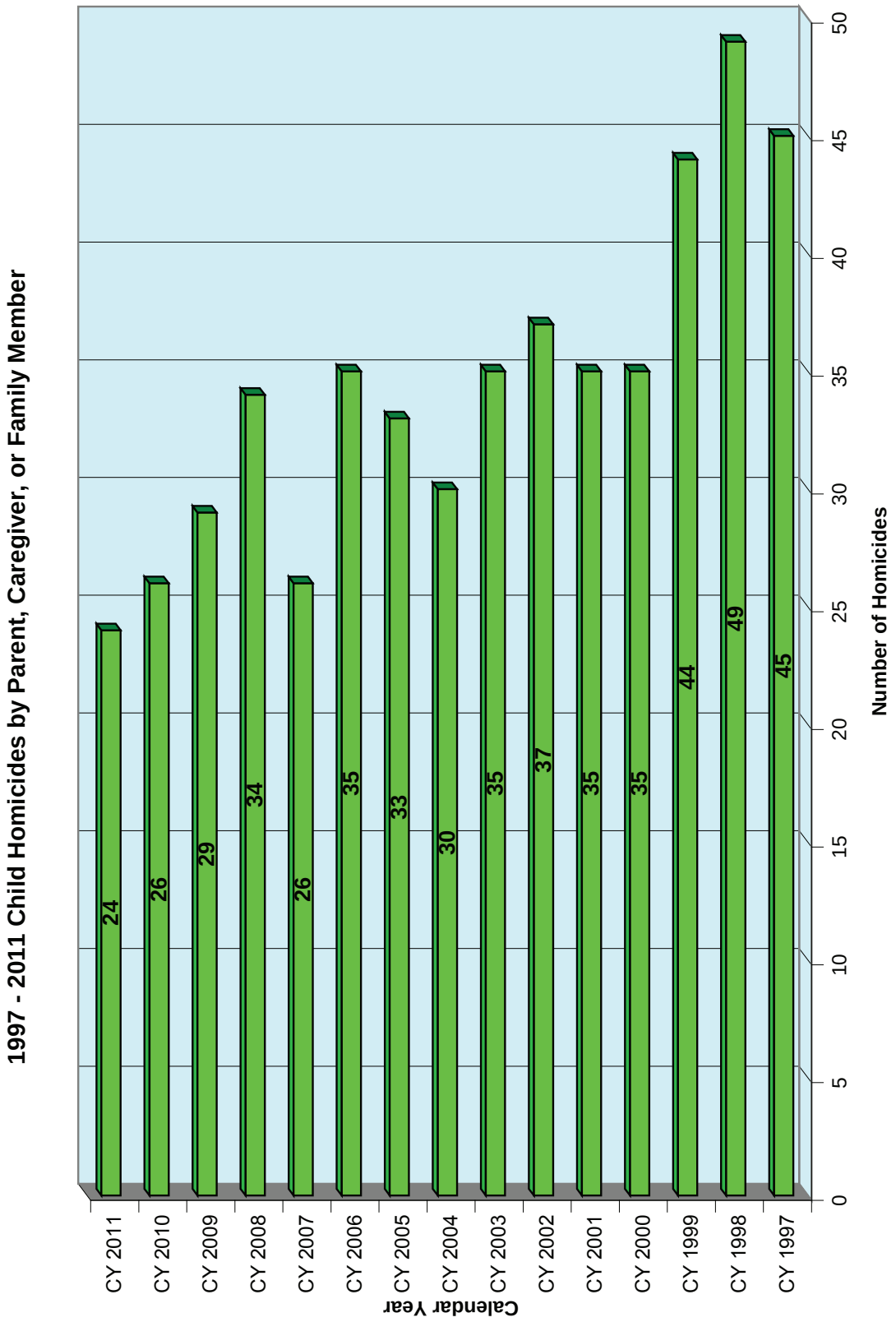
Two year old Sylvia was a developmentally delayed little girl. She allegedly suffered two falls over two days in June 2011. On the first day, the Sylvia allegedly fell, struck her head, and vomited. Reportedly, she had done this before in the past. On the second day, the father claimed she fell and struck her head in the tub during a bath and became unresponsive prompting him to call 911. The child was taken to a local hospital and then transferred to another hospital with a pediatric intensive care unit. Her condition failed to improve and she died. Her injuries included a lacerated liver, healing rib fractures, three acute rib fractures, and an advanced stage of pneumonia that may have been due to the broken ribs or another cause. The cause of death was blunt force trauma to the torso. The coroner felt the child must have been struck hard two to three times in order for the lacerated liver to occur.

Criminal charges were filed against both the mother and the father on the theory that at least one of them inflicted the injuries and the other was guilty by omission for failing to protect the child from such crippling injuries. The charges filed included murder and assault causing death to a child under eight. DCFS records revealed twelve previous referrals. The mother had given birth to ten other children in addition to Sylvia. One older brother and a newborn still resided with the mother, but the remaining children had been put in permanent placements elsewhere.

Jessica

Jessica age 1 ½ years resided with her mother, Wendy and father, Darren. Jessica's godmother, Mrs. Jones had been at the home the past week for a visit. Darren had been living in the home for only the past month. Both parents were twenty-one years of age. On the day of her death, the father was babysitting Jessica while the mother was at work. The father left the home without warning and when Mrs. Jones went to check on Jessica, she was unresponsive. The medical examiner ruled the death to be a homicide caused by asphyxia. The injury was due to suffocation with body compression underwater in a bath tub.

There was no DCFS history with this family. The father, however, did have history with DCFS as a minor. Darren was arrested and charged with murder and child abuse resulting in the death. He denies any wrong doing and has refused to cooperate with law enforcement. He remains incarcerated and is awaiting trial.


1997 - 2011 Child Homicides by Parent, Caregiver, or Family Member
Calendar Year
Number of Homicides
CY 2011
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
24
26
29
34
26
35
33
30
35
37
35
35
44
49
45
0
5
10
15
20
25
30
35
40
45
50

Causes of Child Homicide by Parent/Caregiver/Family Member
1997 – 2011, Los Angeles County

	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	Total
Head Trauma	12	13	15	5	5	2	7	7	6	11	11	12	8	2	10	126
Multiple Trauma	10	8	10	11	7	7	10	7	8	7	7	4	2	1	6	105
Asphyxiation/suffocation	4	3	6	3	8	5	6	5	5	6	6	3	2	3	2	67
Gunshot Wounds	7	10	4	3	2	1	4	3	6	1	1	8	7	4	2	63
Trauma to torso/abdomen	4	2	1	0	0	3	0	0	2	1	1	1	1	5	1	22
Drowning	2	2	0	3	1	7	1	1	2	3	3	0	1	2	0	28
Fire	0	4	0	1	0	0	0	0	0	3	3	1	0	0	0	12
Stabbing	0	2	1	4	1	2	0	3	2	2	2	2	4	6	1	32
Unattended newborn	1	3	4	2	3	2	3	0	2	0	0	1	2	1	0	24
Poisoning/drug ingestion	0	0	0	0	3	6	1	1	0	0	0	0	0	0	0	11
Dehydration/malnutrition	1	1	0	1	1	0	1	2	0	0	0	1	1	0	1	10
Strangulation	2	1	0	0	0	0	0	0	0	1	1	0	0	1	0	6
Medical neglect	0	0	0	1	2	0	0	0	0	0	0	0	1	1	0	5
Neck compression	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Burns	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	3
Hyperthermia	0	0	0	0	0	0	2	0	0	0	0	1	0	0	0	3
Post-Term Gestation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
TOTAL	**44**	**49**	**42**	**34**	**34**	**35**	**35**	**29**	**33**	**35**	**35**	**34**	**29**	**26**	**24**	**518**

Child Homicide by Parent/Caregiver/Family Member
Los Angeles County – 2011 (N= 24)

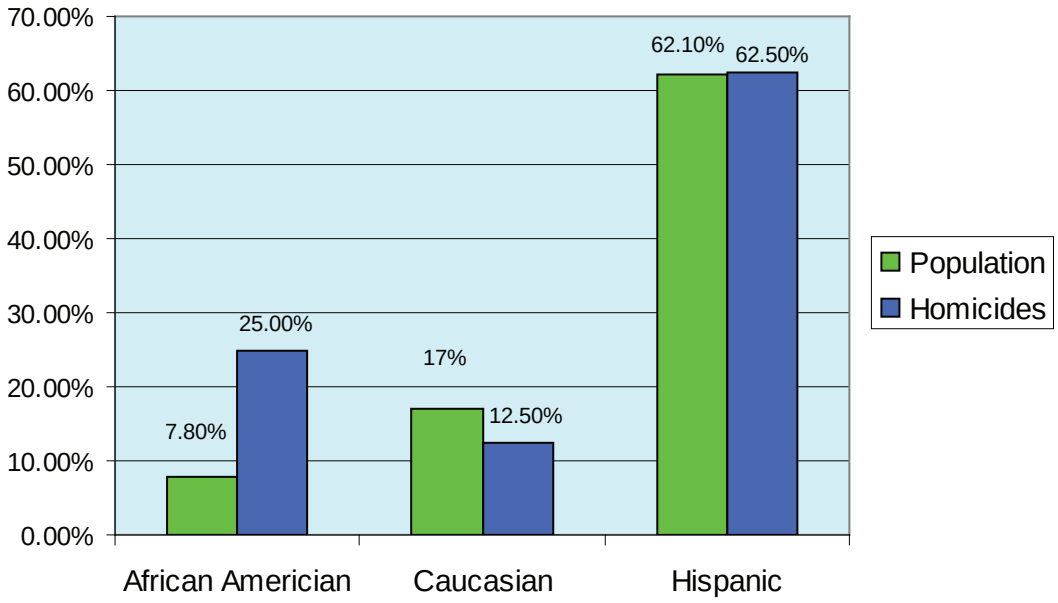
Age	Female	Male
Under 1	4	9
1 year	2	3
2 years	1	2
3 years	0	1
4 years	0	0
5 years	0	0
6 years	1	1
TOTAL	**8**	**16**

91.6% of the child homicide victims by parents/caregivers/family member were five years of age or under.

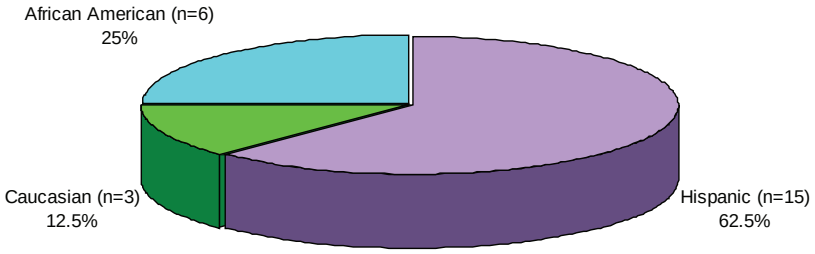
87.5% of the child homicide victims by parents/caregivers/family member were two years of age or under.

54.2% of the child homicide victims by parents/caregivers/family member were under one year of age.

Homicides of Children by Race Compared to Poulation - 2011



2011 Child Homicides- Race



Los Angeles Child Population
Ages 0-17: 2,402,208
Hispanic 62.1%, Caucasian 17%
African American 7.8%
Asian/Pacific Islander 9.7%
Multiple or other Ethnicities 3.3%

Relationship of Suspect to Child Homicide Victim – 2011

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

18– Father, Stepfather or mother's boyfriend

6 – Mother

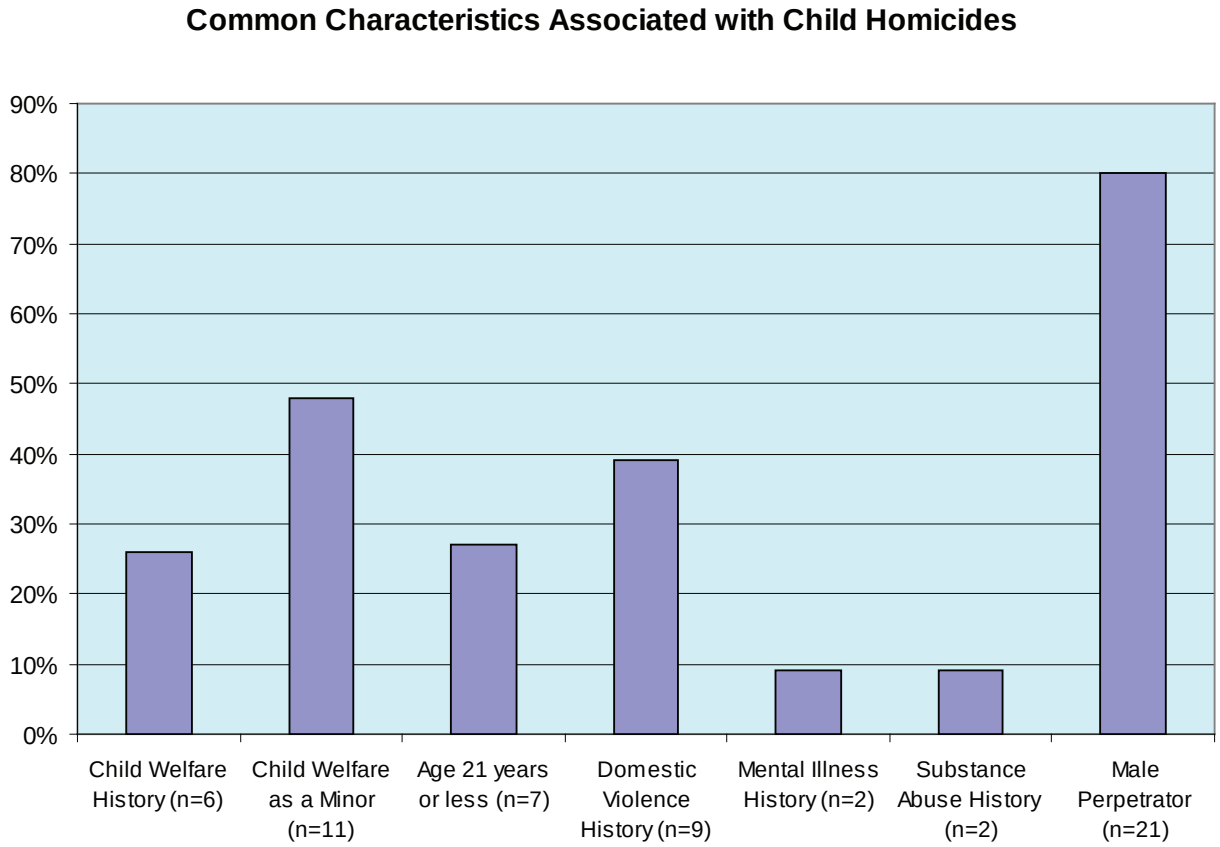
2– Both parents

1 – Mother and Boyfriend

Relationship and Age of Suspect to Child – 2011

Relationship	Total	<19 years	19-21years	22-25 years	26-30 years	31-40 years	40+ years
Biological Father	14	1	3	3	2	2	3
Biological Mother	6	1	0	3	2	0	0
Mother's Boyfriend	7	0	2	2	3	0	0
Total	27	2	5	8	7	2	3
Percentage	100%	7.4%	18.5%	29.6%	26%	7.4%	11.1%

Common Characteristics Present in the Family



The top four common characteristics present in families in which a homicide occurred are the suspect was male, had a child welfare or probation history as a child, young age (21 or younger) and domestic violence in the relationship.

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 2011 ICAN Child Homicide by Parent/ Caregiver/Family Member

Agency	N	%
LASD	13	54.2
LAPD ACU	7	29
Pasadena P.D.	1	4.2
Long Beach P.D.	1	4.2
Inglewood P.D.	1	4.2
Oxnard P.D.	1	4.2

The Los Angeles Sheriff's Department Homicide Bureau had investigative responsibility for 54.2% (n=13) of the child homicides by parents/caretakers/family member. The Los Angeles Police Department had investigative responsibility for 29% (n=7) of the 2011 child homicides by parents/caretakers/family member. The LAPD Abused Child Unit was responsible for all of the LAPD investigations. Slightly more than 16% (n=4) of the cases were handled by jurisdictions other than LASD and LAPD. Three other law enforcement agencies were responsible for the investigation of child homicides by parents/caregivers/ family member in 2011. One police agency was from Ventura County as the child resided and was injured in their jurisdiction, but died in a Los Angeles County hospital.

There were a total of twenty-seven suspects in the twenty-four homicide cases. Eight of the 2011 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. Four cases remain under investigation. Lastly, one father who was the perpetrator was killed by the police in a standoff.

Table 2

Law Enforcement Reasons for Not Presenting 2011 ICAN Child Homicide by Parent/Caregiver/Family Member

	n	%
Murder/suicide	2	25
Under Investigation	4	50
Perpetrator Shot by Police	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	2011
Murder (187 (a) P.C.)	27	32	20	21	20	13	16	13
Assault on a child under 8 years resulting in death (273ab P.C.)	23	20	15	17	16	11	7	14
Child abuse leading to death of a child (273a(a) P.C.)	24	34	11	28	19	5	10	8
Child endangering (273a(1) P.C.)		1						
Corporal punishment or injury of child (273d P.C.)				1				
Voluntary manslaughter (192a P.C.)	2	1	1	5	1		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 2011, 16 of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving 22 perpetrators.

Of the 16 cases, three were declined due to insufficient evidence. One case declined for insufficient evidence involved a mother and her boyfriend, another case the mother and father and the third case, the father was the suspected perpetrator.

The charges filed by the District Attorney in the past five years are illustrated by Table 3. The District Attorney filed criminal charges on 81.25% (n=13) of the 16 homicide cases presented to them by law enforcement in 2011. Charges were filed against 18 perpetrators involved in the thirteen cases. The most frequent charge in 2011 was murder followed by child abuse. With the exception of two perpetrators, murder charges (187 (a) P.C.) were filed on the cases in which charges were filed. The parents in the later case were charged with child abuse causing the death of a child.

Table 4

Relationship of Perpetrators - 2011 ICAN Child Homicide by Parent/Caregiver/Family Member

Relationship	ID'd by Police	Charged By DA
Mother	5	5
Father	14	6
Mother's Boyfriend	7	6

In 2011, there were multiple perpetrators identified by law enforcement and charged by the District Attorney in four cases. In two cases in which charges were filed, the mother was implicated along with the mother's boyfriend or stepfather. In two cases, both parents were charged with the death of the child.

Table 5

Criminal Case Disposition of 2004 - 2011 ICAN Child Homicides by Parent/Caretaker/ Family Member[2]	2004	2005	2006	2007	2008	2009	2010	2011
Life without possibility of parole	1	1	1		1		2	2
80 years to life prison							1	1
50 years to life prison	1	2	1			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	4
24 years to life prison								
22 years to life prison								
19 years to life prison						1		1
17 years to life prison						2		1
16 years to life prison		1					1	2
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	1
11 years prison	1	1	2	3	4	1	2	1
10 years prison	1	1	2	2		1	1	1
9 years prison		1	1					
8 years prison	1	1	4				1	
6 years prison	1	1	1	2	2	1	1	2
5 years prison					1		1	2
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
1 year jail	1	1	1				1	2
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							1
Dismissed		3	3				1	
Arrest warrant	2					1		
Mental competency hearing		1		1	1	1		
Sentence pending				1	1	1		
Pending trial	0	1	1	4	2	10	12	22
Pending Further Investigation	2					4	1	
Total C/A Homicides for year	**30**	**33**	**35**	**26**	**34**	**29**	**26**	**23**

[2] 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. Of the 2011 child homicides, none of those charged had a disposition in 2011. In 2011, defendants received the following sentences from previous years cases: four 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. Two perpetrators were sentenced to 1 year in county jail and one to three years in county jail. One perpetrator was a juvenile sentenced to 8 years in the California Youth Authority and is not reflected in the table. The remaining sentences varied from 5 to 19 years in prison. One perpetrator was acquitted by a trial jury.

Of the cases from 2005, only one remains pending due to the mental competency of the defendant. For 2006, one case is still pending trial. Four of the 2007 cases remain pending trial in 2011. One defendant was sentenced to 25 years to life. Two cases are still pending trial from 2008. Of the 19 pending cases from 2009, ten remain pending. There were ten convictions in 2011 of the 2010 homicide cases. Twelve remain pending trial.

The most frequent sentence received in 2007 (n=6), 2008 (n=8), 2010 (n=7) and 2011 (n=4) was 25 years to life in prison. As of 2011, the next most frequent range of sentencing for perpetrators from 2004 to 2011 was 6 to 15 years in prison.

2011 Child Homicides by Parents, Caregivers or Family Member
Child Welfare Involvement 2000 – 2011*

Year	Total # of homicides by parent/care giver/ family member	Total # of homicides with DCFS family history (prior contact OR open case)	Of total with DCFS family history, the # of homicides that had PRIOR DCFS contact only	Of total with DCFS family history, the # of homicides in OPEN DCFS case or referral	# Killed by out-of-home caregiver
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[3]	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3[4]	1 – relative caregivers 0 – foster parent
2008	34	14[5]	6	8	0 – relative caregivers 0 – foster parent
2009	29[6]	19[7]	14	5[8]	1 – relative caregivers 0 – foster parent
2010	26	13[9]	9	4	0– relative caregivers 1 – foster parent
2011	24	6	2	4	0 – relative caregivers 0 – 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**

[3] 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.
[4] One was open to another county.
[5] 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.
[6] 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.
[7] Includes two deaths with a CPS history in another state and one death with history in another county.
[8] One child died in LA County was under the jurisdiction of Riverside CPS.
[9] 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.

A determination that the fatality was the result of abuse and/or neglect exists when one of the following conditions is met:

> A "determination" of abuse and/or neglect by Child Welfare Services or Probation is the substantiation of abuse and/or neglect allegations which resulted in the fatality; or
>
> A law enforcement investigation concludes that the child's death was a result of abuse and/or neglect; or
>
> A corner/medical examiner concludes that the child's death was a result of abuse and/or neglect.

ICAN findings are based on the final mode of **homicide** as determined by the Los Angeles County 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 abuse 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 reports child deaths with DCFS history if the parent of the child had a closed referral or case prior to the date of the death; the child had an open referral or case at the time of death or a closed referral or case prior to the date of death; or the sibling of the child had an open referral or case at the time of death or a closed referral or case prior to the date of death. 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.

Dates[10] of Child Homicides – 2011

2 homicides occurred in January (1/09 & 1/15/2011)

1 homicide occurred in February (2/17/2011)

2 homicides occurred in March (3/01 & 3/03/2011)

1 homicide occurred in April (4/07/2011)

4 homicides occurred in May (two on 05/07, 5/13 and 5/20/2011)

3 homicides occurred in June (6/07, 6/20 & 6/28/2011)

1 homicide occurred in July (7/15/2011)

3 homicides occurred in August (8/11, 8/15 and 8/17/2011)

2 homicides occurred in September (9/15 and 9/17/2011)

3 homicides occurred in October (two on 10/29 and 10/30/2011)

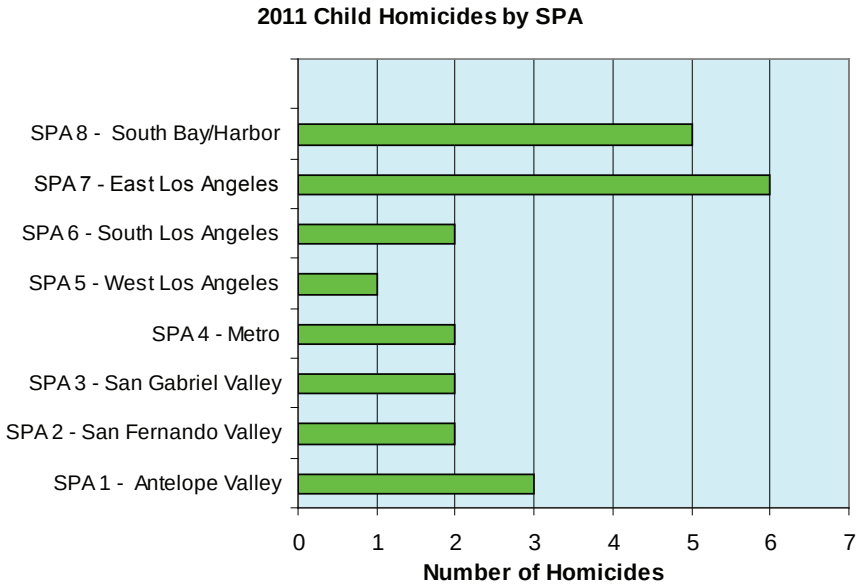
2 homicides occurred in November (11/22 & 11/26/2011)

0 homicides occurred in December

[10] 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[11] of Child Homicides – Geographic Area – 2011

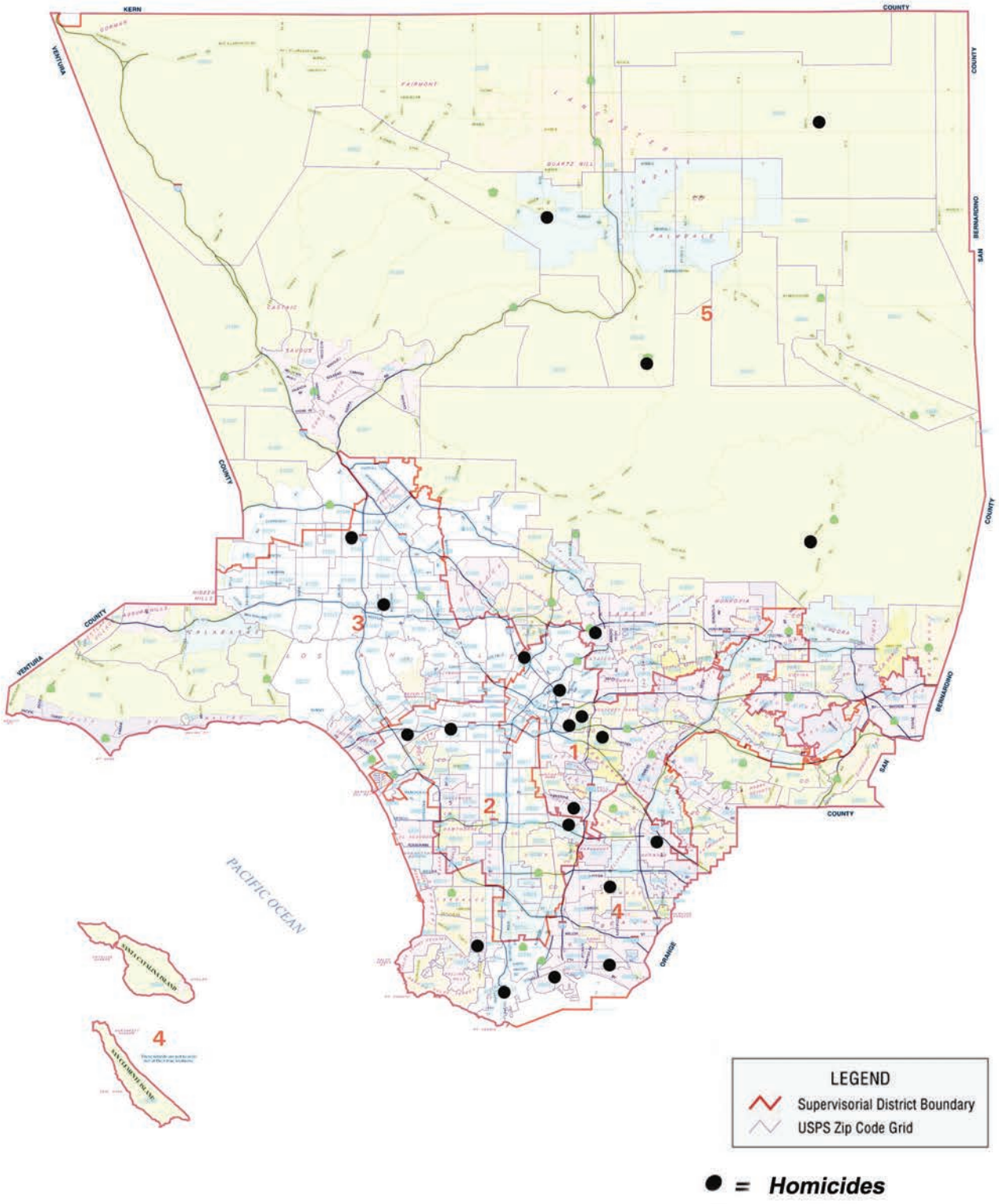
1 homicide occurred in Azusa (zip code 91702)
1 homicide occurred in Lakewood (zip code 90712)
1 homicide occurred in Lancaster (zip code 93535)
1 homicide occurred in Los Angeles (zip code 90016)
1 homicide occurred in Los Angeles (zip code 90022)
1 homicide occurred in Los Angeles (zip code 90031)
1 homicide occurred in Los Angeles (zip code 90034)
1 homicide occurred in Los Angeles (zip code 90039)
2 homicides occurred in Los Angeles (zip code 90063)
1 homicide occurred in Lomita (zip code (90717)
1 homicide occurred in Long Beach (zip code 90802)
1 homicide occurred in Long Beach (zip code 90814)
1 homicide occurred in Lynwood (zip code 90262)
1 homicide occurred in Norwalk (zip code 90650)
1 homicide occurred in Northridge (zip code 91343)
1 homicide occurred in Panorama City (zip code 91407)
1 homicide occurred in Palmdale (zip code 93550)
1 homicide occurred in Palmdale (zip code 93551)
1 homicide occurred in Pasadena (zip code 91105)
1 homicide occurred in San Pedro (zip code 90731)
1 homicide occurred in South Gate (zip code 90280)
1 homicide occured in Inglewood (zip code 90302)
1 homicide occurred in Oxnard (zip code 93030)



[11] City where the fatal injury or fatality occurred

2011 Child Homicides

N = 23



Case Summaries

Mario

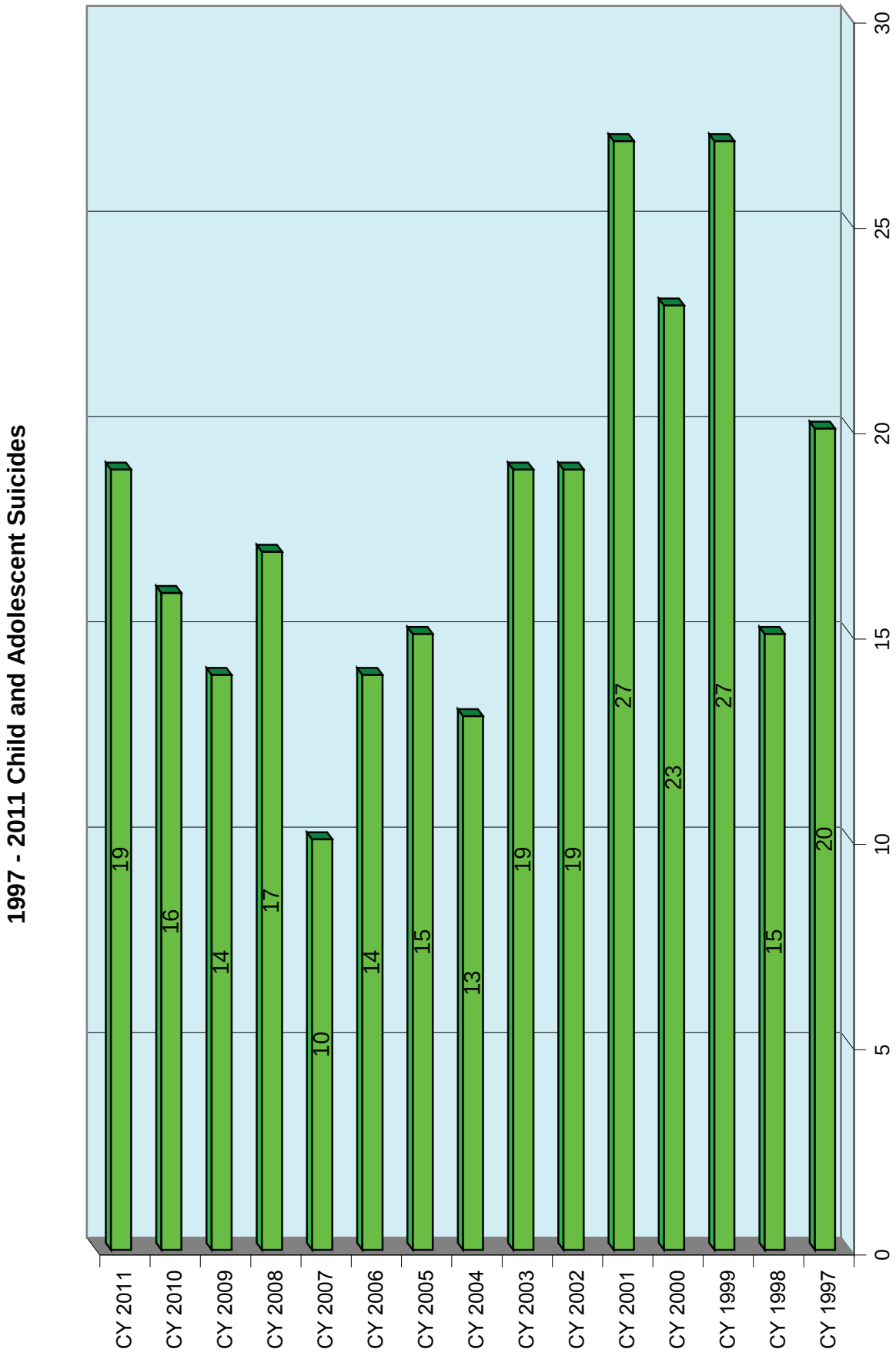
Mario, age 15 was found hanging from a belt attached to a towel rack in the family bathroom. He was a good kid who got average grades and was an avid soccer player. He had many friends at school and from his soccer team. He had no history of suicide attempts or ideation and was not depressed. Mario lost a friend the year prior in a drive-by shooting. He did not drink or use drugs. He broke up with his girlfriend several months ago but they remained friends. His family and friends reported they were blind-sided by his death. He had not given any indication he was going to take his life. He had told some friends that he was "bored" but they did not think anything about the remark. They did note Mario started wearing the T-shirt with the picture of his friend Jesus who was murdered last year in recent days. No suicide note was found. There was one prior referral to DCFS in 2002– allegation of physical abuse. DCFS investigated the referral and found the mother to be appropriate and already connected to services. The referral was closed unfounded.

Amanda

Amanda was a 15-year-old Hispanic female with a history of depression and had thoughts about suicide 3 months prior to her death. Amanda attempted suicide one month prior to the time of the fatal injury and she was hospitalized for 72 hours. On the night before her death she delivered gifts to a girlfriend and shortly thereafter Amanda was stuck and killed by a car on the freeway. A suicide note with apologies and a note addressed to a female romantic friend saying her final goodbyes were found in a pocket. Only minutes before her death, she sent a text message to a teacher in whom she confided but before he could intervene, she had taken her life. Her death was determined to be due to suicide. Amanda suffered from depression and she was being treated with medication and outpatient psychotherapy. At the age of twelve, Amanda and her sister alleged to be physically abused by there mother but upon investigation the charges were unfounded and the referral was closed.

Richard

Richard was a 17year-old Caucasian male with a history of depression and was seeing a psychiatrist. He was hospitalized for a suicide attempt one year ago for taking an overdose of prescription medication. He had become very depressed in the past few days and had suicide ideation the night before. The family was keeping a close watch on him and they had spent the day together. He had seemed fine all day. His girlfriend came over and they were in his bedroom when they began to argue. She left the room to go talk to Richard's father. Moments later, they heard a gunshot and entered the bedroom to find Richard unresponsive with a gunshot wound to the head. The weapon had been missing from a locked box for the past three months and Richard had denied having it in his possession.


1997 - 2011 Child and Adolescent Suicides
CY 2011
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
19
16
14
17
10
14
15
13
19
19
27
23
27
15
20
0
5
10
15
20
25
30

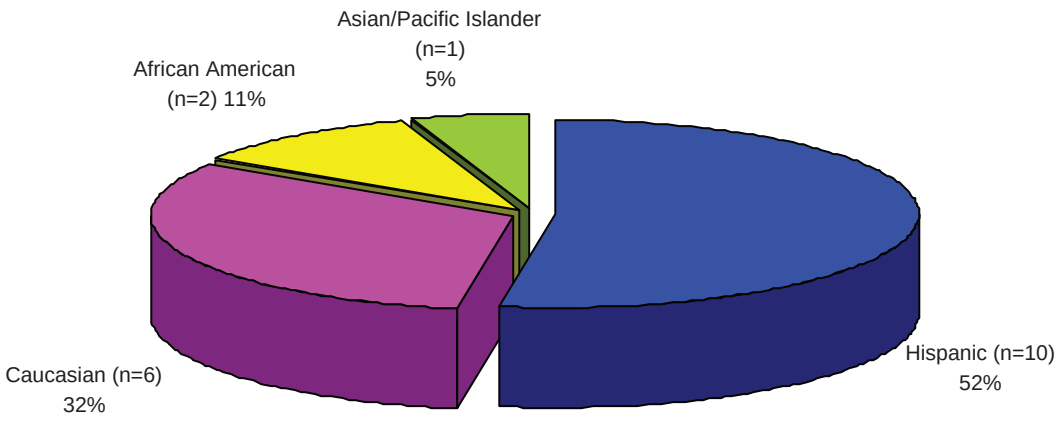
Child and Adolescent Suicides by Method and Gender
Los Angeles County – 2011 (n = 19)

Method	Male	Female
Hanging	5	4
Firearms/Gunshot	3	1
Solo Auto	1	0
Overdose	0	1
Jump	2	0
Auto/Train vs. Ped	0	2
TOTAL	11	8

Hanging was the most frequent method of suicide among adolescents and represents 47.36% of the suicides in 2011. Gun Shot Wound was the second most frequent method of suicide in 2011.

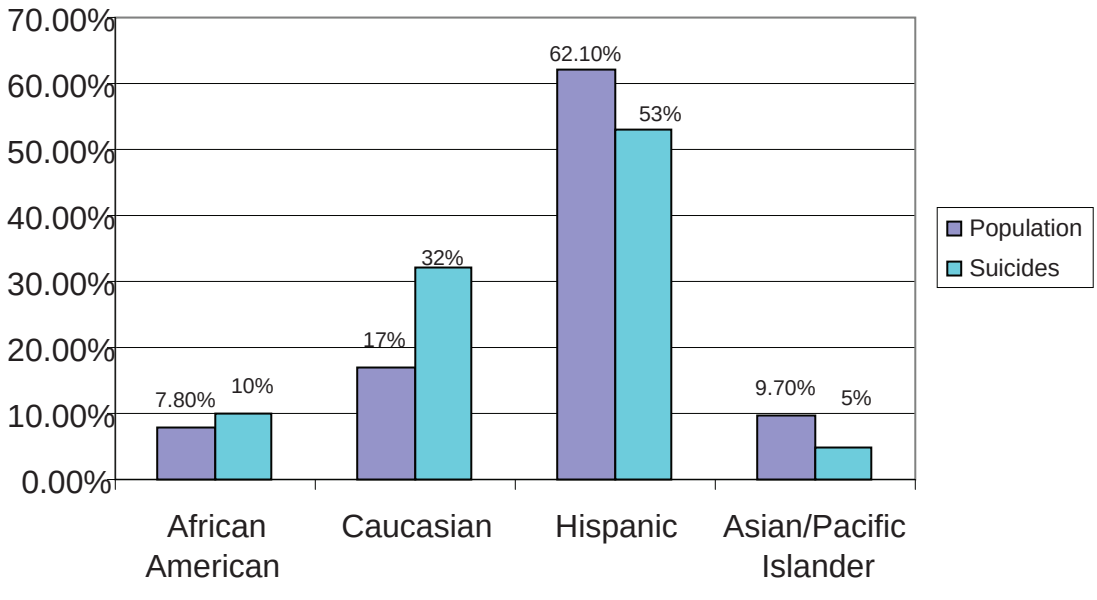
In 2011, 58% (n=11) of the adolescent suicide victims were male. 42% (n=8) of the victims of adolescent suicide in 2011 were female

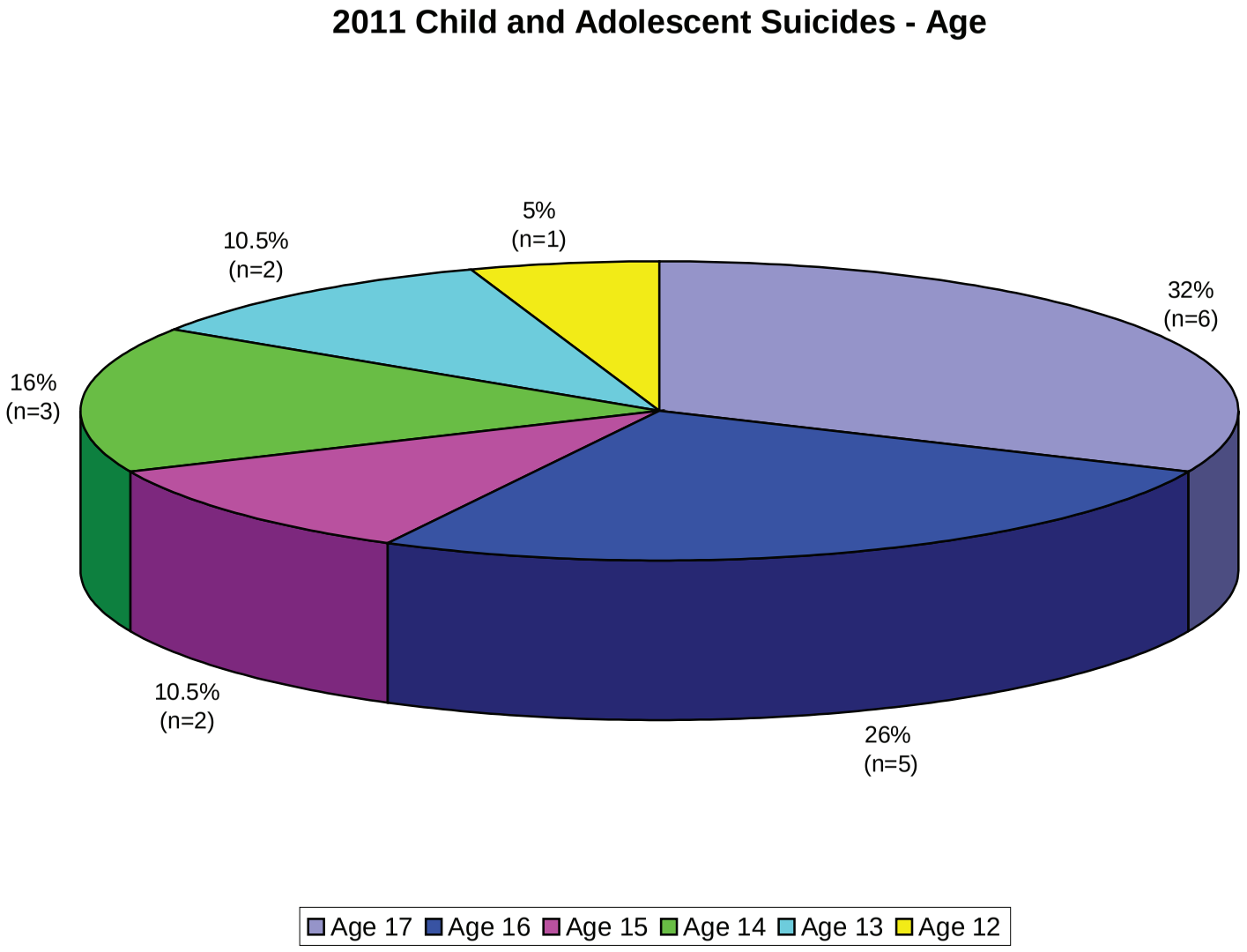
2011 Child and Adolescent Suicides - Race

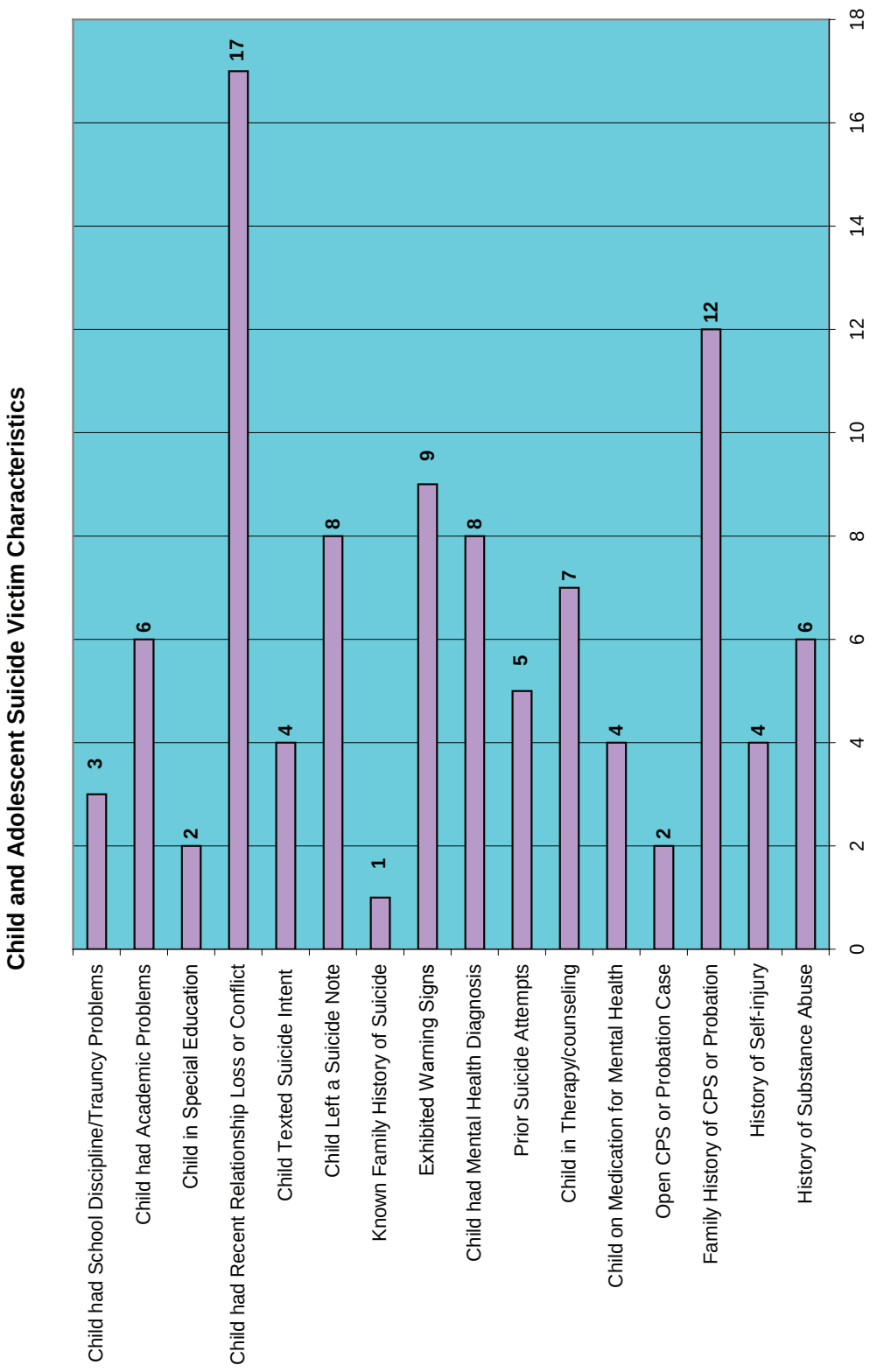


Los Angeles Child Population
Ages 0-17: 2,402,208
Hispanic 62.1%, Caucasian 17%
African American 7.8%
Asian/Pacific Islander 9.7%, Multiple or other Ethnicities 3.3%, Native American .1%

Suicides of Children by Race Compared to Population - 2011




2011 Child and Adolescent Suicides - Age
5%
(n=1)
10.5%
(n=2)
32%
(n=6)
16%
(n=3)
10.5%
(n=2)
26%
(n=5)
Age 17
Age 16
Age 15
Age 14
Age 13
Age 12


Child and Adolescent Suicide Victim Characteristics
Child had School Discipline/Trauncy Problems
Child had Academic Problems
Child in Special Education
Child had Recent Relationship Loss or Conflict
Child Texted Suicide Intent
Child Left a Suicide Note
Known Family History of Suicide
Exhibited Warning Signs
Child had Mental Health Diagnosis
Prior Suicide Attempts
Child in Therapy/counseling
Child on Medication for Mental Health
Open CPS or Probation Case
Family History of CPS or Probation
History of Self-injury
History of Substance Abuse
3
6
2
17
4
8
1
9
8
5
7
4
2
12
4
6
0
2
4
6
8
10
12
14
16
18

Dates of Child and Adolescent Suicides – 2011

4 suicides occurred in January (01/5, 01/13, 01/15 & 01/18/2011)
1 suicide occurred in February (02/06/11)
0 suicides occurred in March
2 suicides occurred in April (04/17 and 04/25/2011)
1 suicide occurred in May (05/08/2011)
0 suicides occurred in June
0 suicides occurred in July
2 suicides occurred in August (08/23 & 08/24/2011)
1 suicide occurred in September (09/08/2011)
4 suicides occurred in October two on 10/14 and two on 10/31/2011)
1 suicide occurred in November (11/17/11)
3 suicides occurred in December (12/19, 12/24 & 12/28/2011)

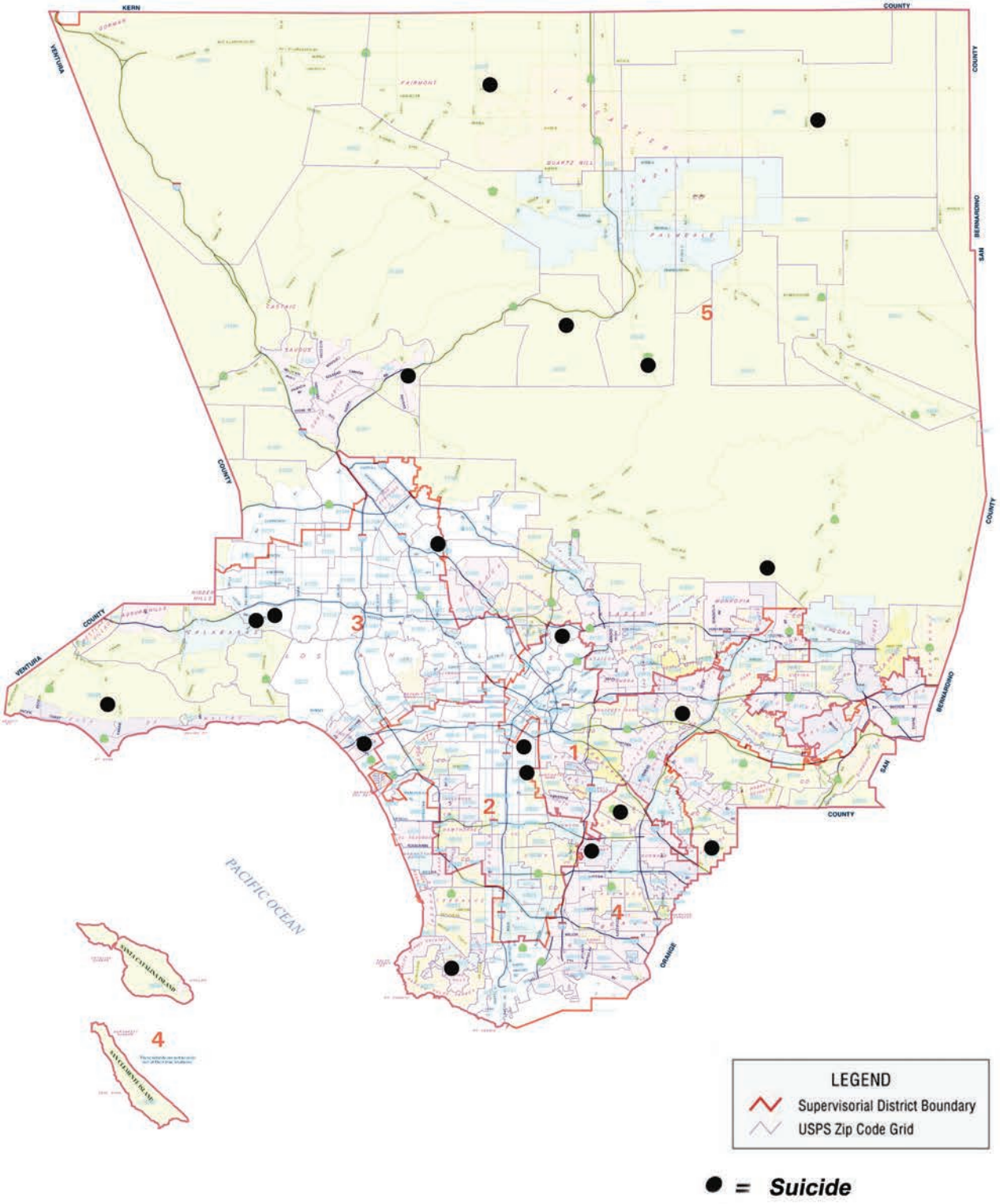
Locations[12] of Child and Adolescent Suicides – Geographic Area – 2011

1 suicide occurred in Los Angeles (zip code 90001)
1 suicide occurred in Los Angeles (zip code 90011)
1 suicide occurred in Los Angeles (zip code 90041)
1 suicide occurred in Canyon Country (zip code 91387)
1 suicide occurred in Sun Valley (zip code 91352)
1 suicide occurred in Lancaster (zip code 93535)
1 suicide occurred in Lancaster (zip code 93536)
1 suicide occurred in Paramount (zip code 90723)
1 suicide occurred in Downey (zip code 90241)
1 suicide occurred in South El Monte (zip code 91733)
1 suicide occurred in Santa Monica (zip code 90405)
1 suicide occurred in Rolling Hills (zip code 90274)
1 suicide occurred in Monrovia (zip code 91016)
1 suicide occurred in Malibu (zip code 90265)
1 suicide occurred in Acton (zip code 93510)
2 suicides occurred in Woodland Hills (zip code 91364)
1 suicide occurred in La Mirada (zip code 90638)
1 suicide occurred in Palmdale (zip code 93550)

[12] City where the suicide occurred.

2011 Suicides

N = 19



Accidental Child Deaths 2011

Case Summaries

Randy
Randy, age 3 and his five year old brother, Mark were alone in their parents' bedroom watching TV. The two boys began to tussle with one another when Mark bumped into the dresser the television was on causing it to fall onto Randy's head and torso. The 32 inch TV had been on a swivel stand on a small, unstable wooden dresser.

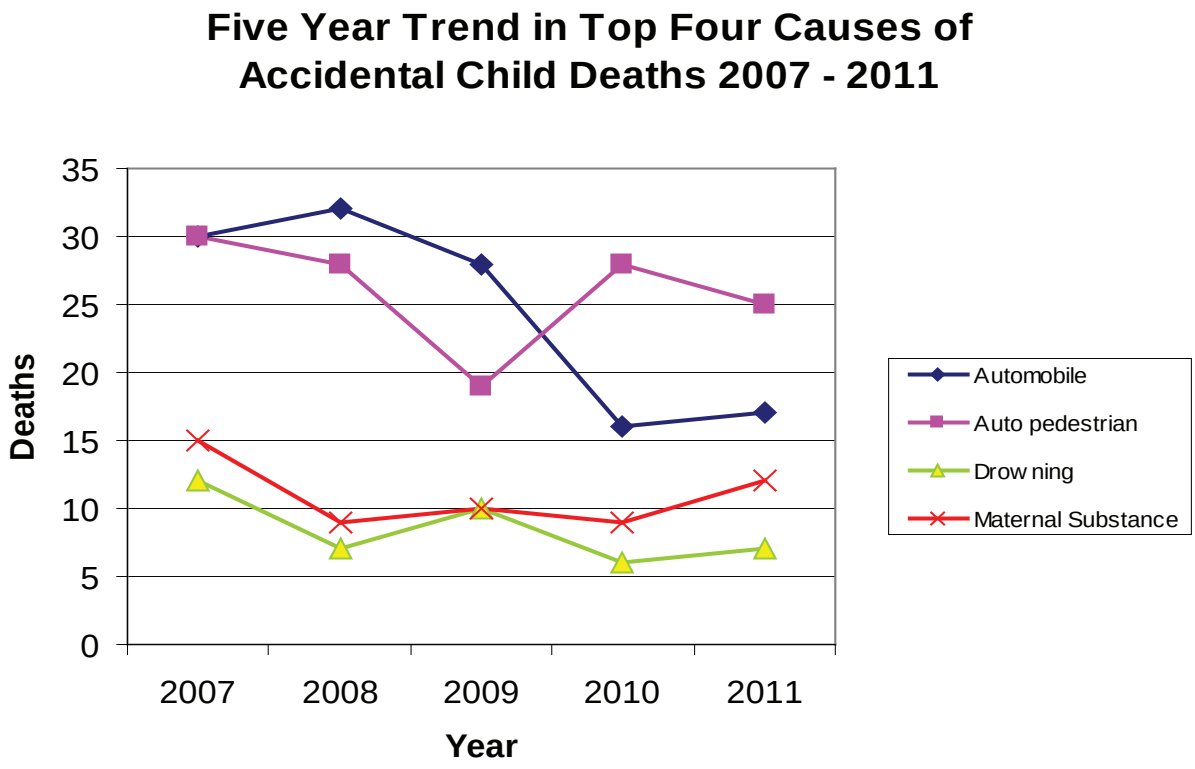
Randy was rushed to the emergency room by LA City paramedics while the family followed in their car. He was in cardiac arrest when he presented to the emergency room. A CT scan was performed and revealed extensive bilateral skull fractures and an extensive subarachnoid hemorrhage. He also had blunt abdominal trauma. He was admitted to the Pediatric Intensive Care Unit but his condition continued to decline. Brain death was pronounced six hours later.

Randy's death was preventable had the television been secured to stop it from falling. Many of the deaths in which a young child is crushed by an object involve televisions or other large objects that are not fastened to prevent such accidents.

Maria
Sixteen month old Maria was found floating face down in the family swimming pool. She had been out of her mother's sight for approximately ten minutes while the mother placed the wash in the dyer. Maria was last seen watching a video in the living room. She must have wandered out of the house looking for her mother who was in the detached garage doing the laundry and fell or went into the family pool. 911 was called while her mother preformed CPR. She was pronounced dead at the home by paramedics.

Drowning is a silent and quick process in spite of the popular myth of victims splashing and calling for help. Infants, toddlers and young children can drown in water that is inches deep. An adult should be within arm's length, providing "touch supervision" whenever infants, toddlers, or young children are in or around water to prevent these tragic deaths.

Martha
Twenty-two year old Martha presented to the ER in labor. She had no prenatal care and her baby boy was stillborn at 36 weeks weighing 3 lbs. 4 ozs. Martha tested positive for marijuana and methamphetamines and had a long history of drug use.
The hospital made a referral to the DCFS hotline, but the referral was "evaluated out" as there were no other children in the mother's care.



The chart above depicts the top four causes of accidental child death over a five year period from 2007 to 2011. With the exception of auto pedestrian deaths, there has been a slight upward trend for the top accidental causes from the previous year. The "top four" causes-automobile, auto pedestrian, drowning and maternal substance use accounted for 68% of all accidental child deaths in 2011.

Causes of Accidental Child Deaths, Ages 0 – 17
2011– Los Angeles County (N = 88)

Automobile – multi-vehicle	6	6.8%
Automobile – solo vehicle	11	12.5%
Auto pedestrian	25	28.4%
Drowning	7	8%
Crushed by an Object	5	5.7%
Overdose	3	3.4%
Maternal drug use	12	13.6%
Fire	2	2.3%
Medical mishaps	4	4.5%
Fall	5	5.7%
Choking	4	4.5%
Suffocation	2	2.3%
Other	2	2.3%
TOTAL	**88**	**100%**

Causes of Accidental Child Deaths by Age
2011 – Los Angeles County (N = 88)

	Age 0 – 5 years	**Age 6 – 14 years**	**Age 15 – 17 years**
Automobile – multi-vehicle	3	2	1
Automobile – solo vehicle	2	2	7
Auto pedestrian	9	10	6
Crushed by Object	4	1	0
Drowning	5	1	1
Overdose	0	1	2
Fall	2	2	1
Fire	2	0	0
Maternal drug use	12	0	0
Medical mishaps	2	2	0
Choking	3	0	1
Suffocation	2	0	0
Other	0	1	1
TOTAL	**46**	**22**	**20**

Race of Accidental Child Deaths, Ages 0 – 17
Los Angeles County – 2011 (N = 88)

	Hispanic	African-American	Caucasian	Asian/Pacific Islander	Other
Automobile – multi-vehicle	3	1	2	0	0
Automobile – solo vehicle	6	1	3	0	1
Auto pedestrian	18	3	1	3	0
Choking	4	0	0	0	0
Drowning	4	1	1	0	1
Overdose	1	1	1	0	0
Fire	1	1	0	0	0
Fall	0	2	3	0	0
Suffocation	2	0	0	0	0
Maternal drug use	4	2	5	0	1
Medical mishaps	1	1	0	2	0
Crushed by object	2	2	1	0	0
Other	1	0	1	0	0
TOTAL	**47**	**15**	**18**	**5**	**3**

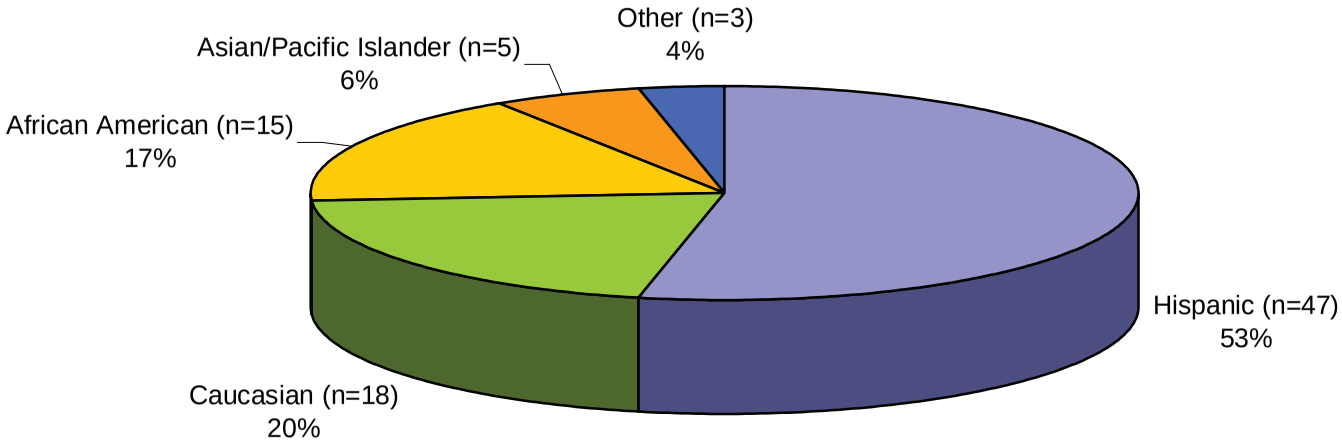
Causes of Accidental Child Deaths, Ages 0 – 14
1997—2011

	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	Total
Auto pedestrian	8	19	31	30	41	33	25	21	20	11	25	25	15	18	19	341
Maternal drug abuse	24	38	21	22	24	25	32	21	15	25	15	9	10	9	12	302
Automobile[1]	0	0	18	24	28	20	47	25	21	22	14	17	19	11	9	275
Drowning	28	21	25	23	28	16	19	21	12	12	11	7	9	6	6	244
Medical complications[2]	0	1	5	6	2	8	7	3	3	2	7	5	5	2	4	60
Choking	5	3	6	10	2	8	4	1	3	1	1	2	0	2	3	51
Fire	1	3	7	4	3	7	0	2	6	7	2	0	0	1	2	45
Falls	2	3	5	1	1	3	2	3	1	2	1	1	0	5	4	34
Crushed by object	3	2	1	1	0	1	0	1	5	2	2	0	6	4	5	33
Hanging/strangulation	0	0	0	6	3	1	2	4	1	3	4	0	0	2	0	26
Poisoning	6	1	4	4	1	0	2	2	1	2	0	1	0	0	0	24
Suffocation	0	2	4	1	3	0	1	1	2	2	0	0	0	1	2	19
Sports injury	2	0	2	2	1	0	0	0	1	0	0	2	2	0	0	12
Motor vehicle (not auto[3]	0	0	0	0	0	0	0	4	1	3	0	1	0	0	0	9
Chest/neck compression	1	2	0	1	0	0	3	0	0	0	0	1	0	0	0	8
Electrocution	2	0	0	1	0	0	1	0	1	0	0	0	0	0	0	5
Birth trauma	0	0	2	0	0	0	0	0	2	0	0	0	0	1	0	5
Dog bites	1	0	1	1	0	0	0	0	1	0	0	0	0	0	0	4
Airplane related	0	0	0	0	0	2	2	0	0	0	0	0	0	0	0	4
Drug intake/Overdose	0	0	0	0	0	0	0	2	0	0	0	0	0	1	1	4
Burns/Thermal Injury	0	0	1	0	0	1	0	1	0	0	0	0	0	0	0	3
Perinatal asphyxia	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	3
Hyperthermia	0	0	0	0	0	0	0	0	2	1	0	0	0	0	0	3
Train v. pedestrian	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0	3
Gunshot wounds	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2
Elective abortion	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Forklift injury	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Impaled	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
Gas Leak	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
TOTAL[4]	**86**	**95**	**134**	**137**	**137**	**127**	**147**	**112**	**100**	**95**	**83**	**73**	**67**	**63**	**68**	**1524**

1Automobile deaths were not referred to the Team prior to 1999. 2Data in this category was previously included in other categories, e.g, medical misadventure, aspiration of stomach,etc.

'These include minibikes, dirt bikes, scooters, go-carts, motorcycles, and all-terrain vehicles (ATVs).4The totals for years 1994 to 2001 have been adjusted from the 2005 report.

2011 Accidental Child Deaths-Race

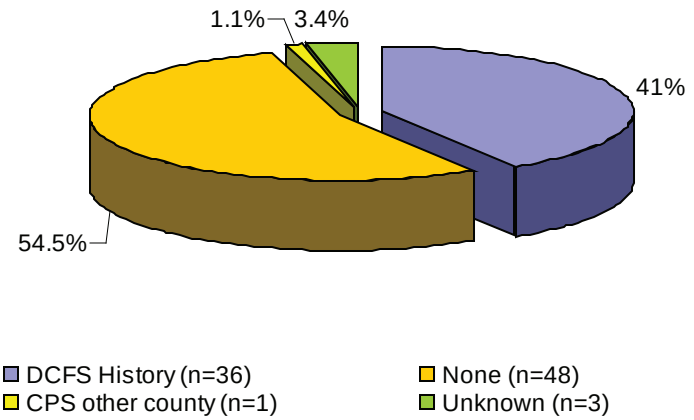


Los Angeles Child Population
Ages 0-17: 2,402,208
Hispanic 62.1%
Caucasian 17%
African American 7.8%
Asian/Pacific Islander 9.7%
Multiple or other Ethnicities 3.3%
Native American .1%

Causes of Accidental Child Deaths by Gender
2011 – Los Angeles County (N = 88)

	Female	Male
Automobile – multi-vehicle	3	3
Automobile –single	5	6
Auto pedestrian	10	15
Drowning	1	15
Overdose	2	1
Maternal drug use	7	5
Medical mishaps	3	1
Crushed	1	4
Fire	0	2
Choking	2	2
Fall	1	4
Suffocation	2	0
Other	2	0
TOTAL	**39**	**49**

Accidental Child Deaths 2011 - Child Welfare History



Causes of Accidental Deaths with Child Welfare History - 2011	Number	Percentage
Automobile	8	21.6
Auto pedestrian	7	19
Drowning	2	5.4
Overdose	2	5.4
Maternal drug use	9	24.3
Medical mishaps	1	2.7
Crushed	2	5.4
Fire	2	5.4
Fall	2	5.4
Bed-sharing/Unsafe	1	5.4
Cold Water	1	2.7

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

Mario – Age 2 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 twenty minutes later and found him on his side, next to a pillow not breathing, and he was limp.

David– Age 4 months

David 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 David 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 David had passed and he was pronounced dead at the scene.

Linda – Age 3 1/2 months

The mother placed Linda 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, Linda was discovered unresponsive and face down in the pillows.

Samuel – Age 14 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 Samuel on his side facing her for sleep and found him in a prone position upon awakening.

Pedro – Age 2 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.

Samuel – Age 8 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.

James – Age 6 months

The mother breast fed James 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 James 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 James's death was due to sudden unexpected infant death (SUID).

Emily – Age 17 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.

Jasmine– Age 1 month

Although Jasmine routinely slept in the crib, the mother took her 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 Jasmine limp and called 911. The infant never regained consciousness.

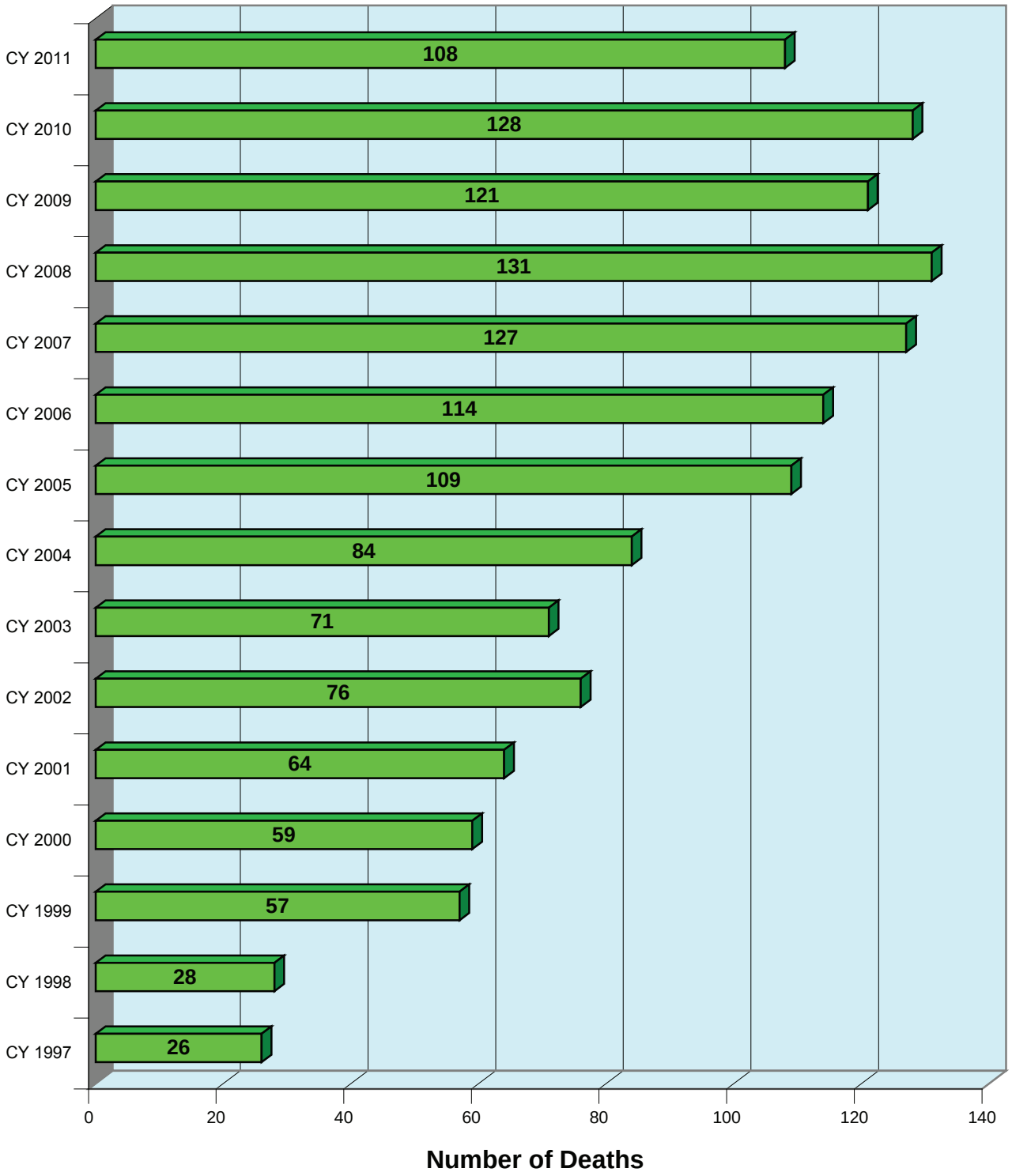
Moniq**ue– Age 21 days**

The father swaddled Monique 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.

Maria– Age 8 days

Mother reported she swaddled Maria in a blanket 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 Maria on her back and crawled in bed next to her. She fell asleep and woke up later than usual. Maria was found face down between the parents.

1997 to 2011 Undetermined Child Deaths



Undetermined Child Deaths – 2011 (N = 108)

Race	Number/Percentage of Undetermined Child Deaths
African American	27 (25%)
Asian/Pacific Islander	12 (11.1%)
Caucasian	24 (22.2%)
Hispanic	40 (37%)
Unknown	5 (4.7%)

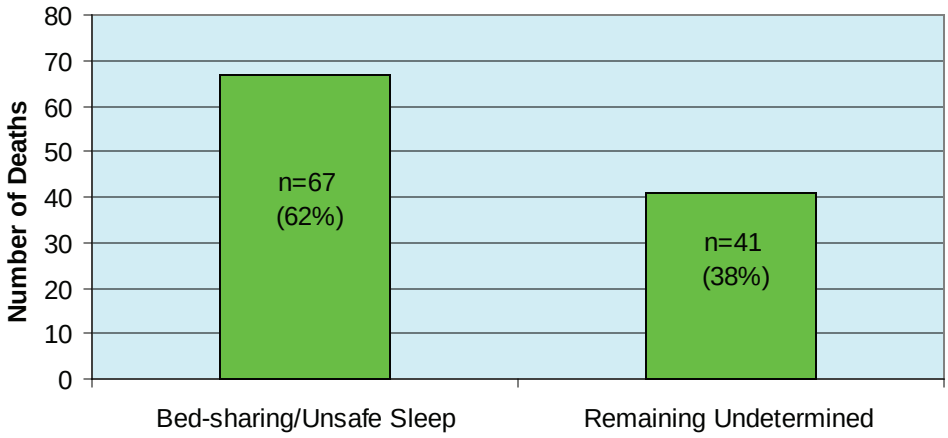
Age	Number of Undetermined Child Deaths
Stillborn	14
1 day to 30 days	14
1 month to 5 months	46
6 months to 1 year	27
2 years	1
3 years	0
4 years	0
5 years	0
6 years	0
7 years	1
8 years	0
9 years	0
10 years	0
11 years	0
12 years	0
13 – 17 years	5

Gender	Number of Undetermined Child Deaths
Female	44
Male	64

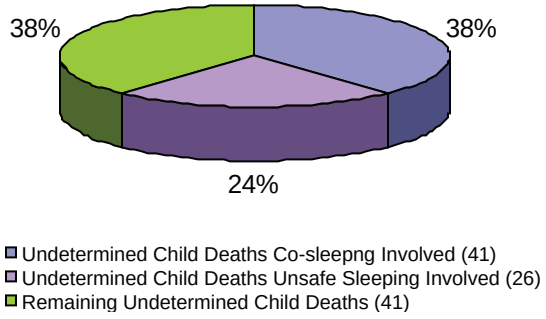
African American children were over-represented in undetermined child deaths. Caucasian and Asian/pacific islanders were slightly over-represented and Hispanic children under-represented.

85% of the undetermined child deaths were under one year of age.
87% of the undetermined child deaths were 5 years of age or under.

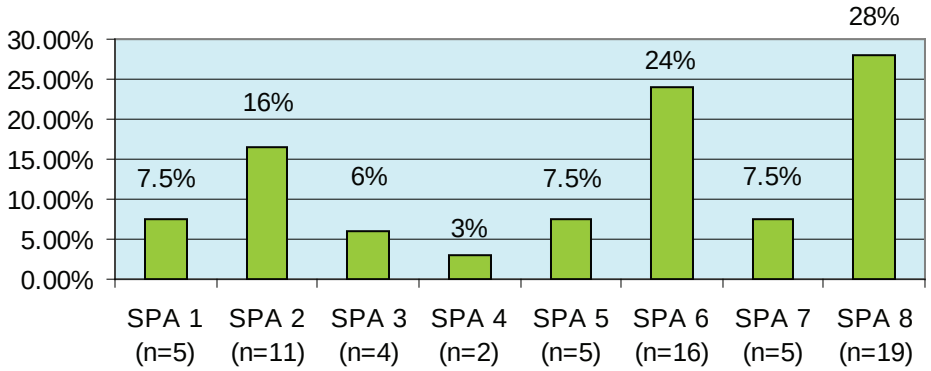
Bed-sharing and Unsafe Sleeping Envornments Undetermined Child Deaths 2011*



Percentage of Undetermined Child Deaths Associated with Bed-sharing and Unsafe Sleeping Practices - 2011



Bed-sharing and Unsafe Sleeping Practice Child Deaths by SPA



*Excludes two accidental child deaths involving wedging between a wall or furniture and a couch or bed

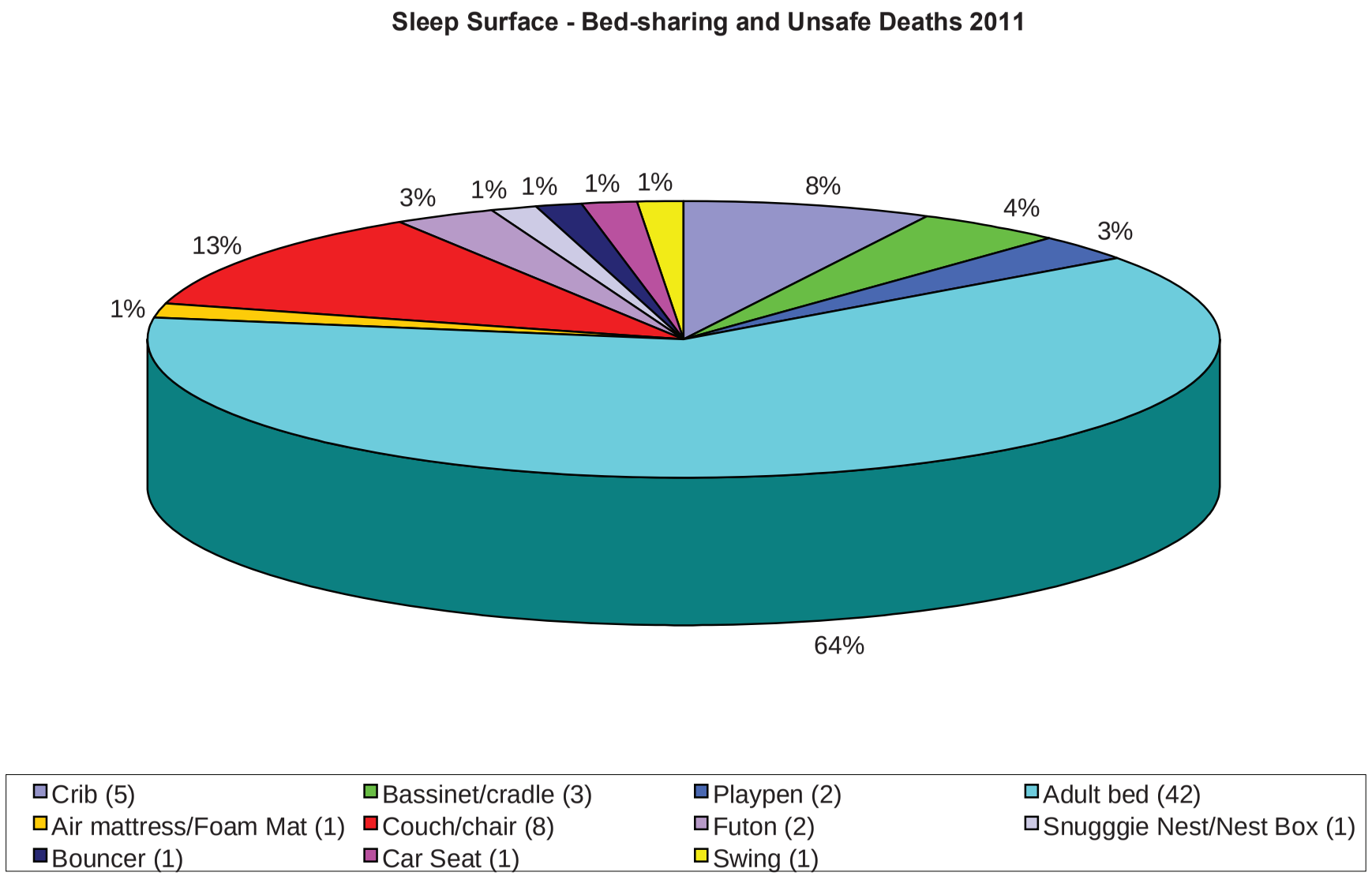
Undetermined Child Deaths – Bed-sharing and Unsafe Sleeping Environment (N = 67)

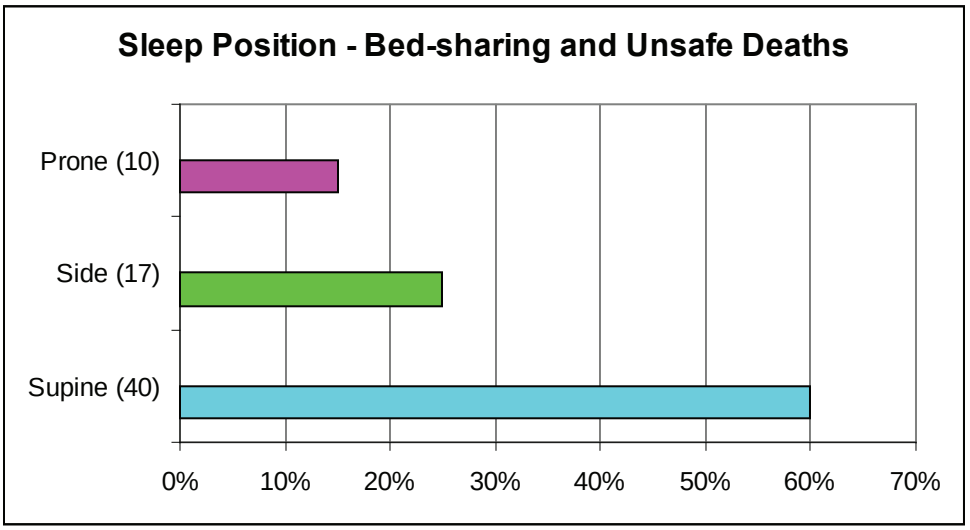
Bed-sharing* (N=41)	**Number/Percentage of Child Deaths**
One Unsafe Risk Factor	0 (0%)
Two Unsafe Risk Factors	6 (15%)
Three or more Unsafe Risk Factors	35 (85%)

Unsafe Sleeping Environment (N=26)	**Number/Percentage of Child Deaths**
One Unsafe Risk Factor	7 (27%)
Two Unsafe Risk Factors	10 (38%)
Three or more Risk Factors	9 (35%)

*Includes bed-sharing, adult bed, couch, futon, chair, nest box, pillows, soft or excessive bedding, excessive swaddling, blanket rolls, stuffed toys, pets, parental drug/alcohol use, prone or side positioning.

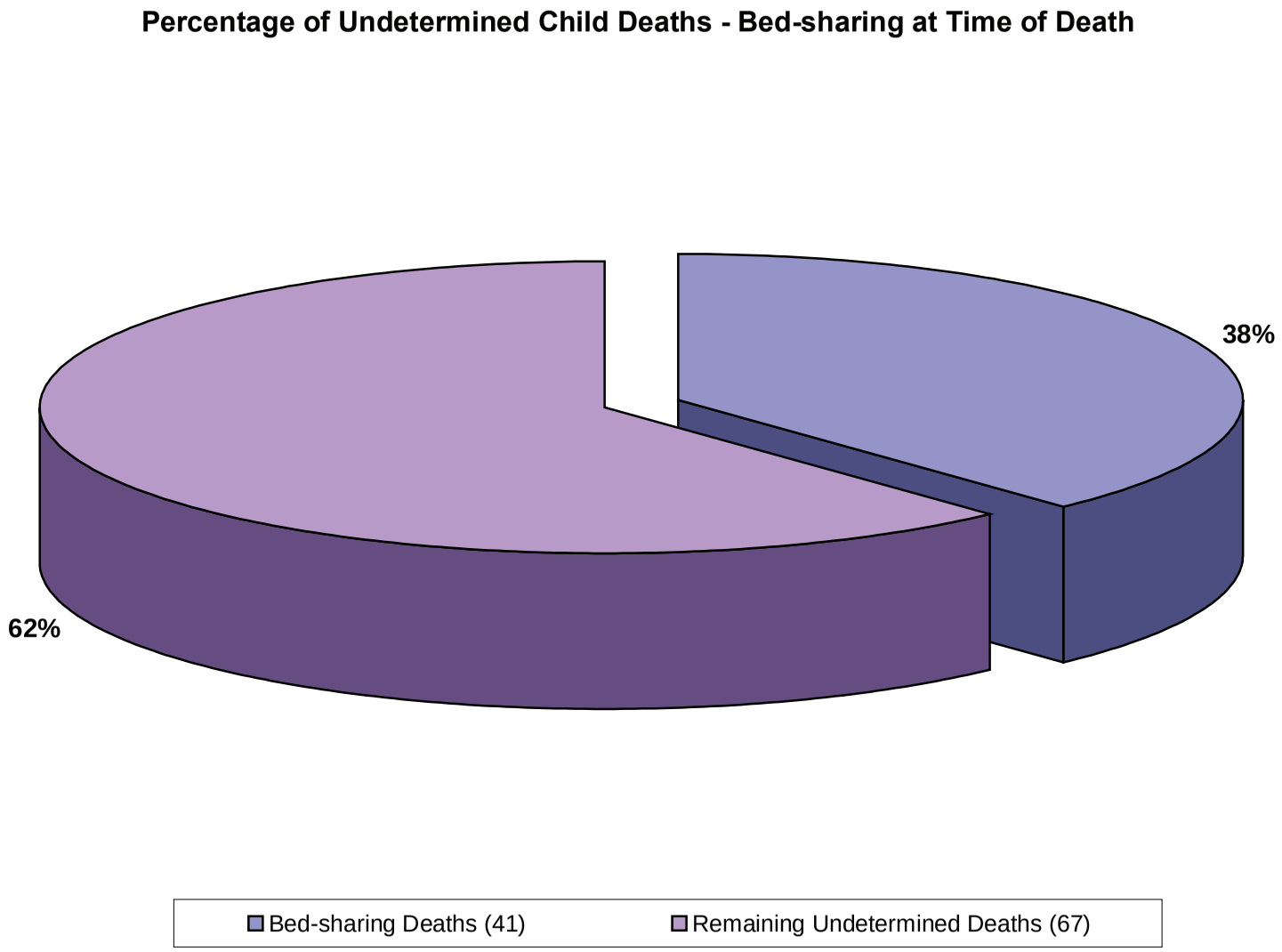
**Includes adult bed, couch, futon, chair, foam mat, nest box, car seat, stroller, swing, bouncer, pillows, soft or excessive bedding, excessive swaddling, blanket rolls, stuffed toys, plastic bag, pets, parental drug/alcohol use, prone or side positioning.

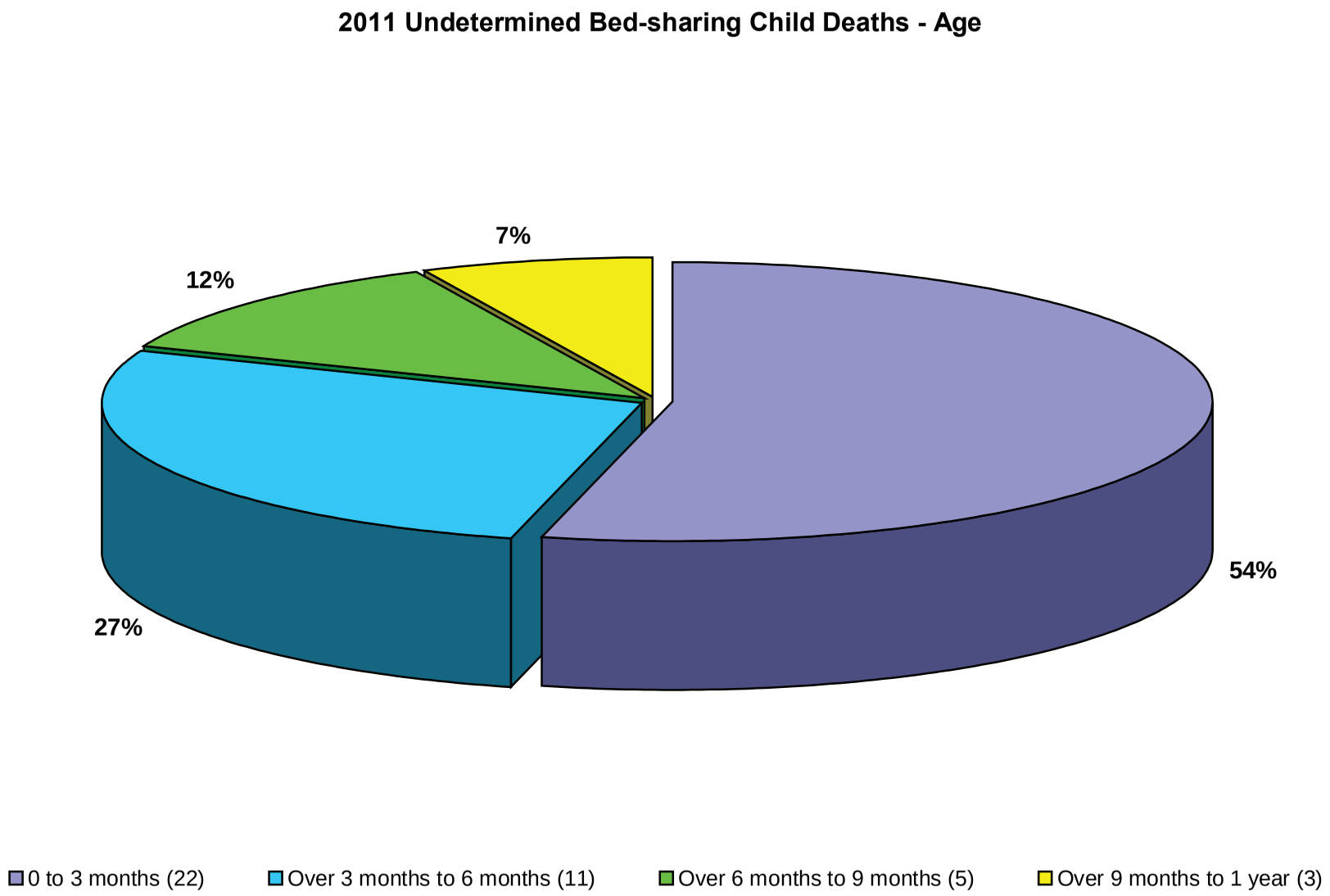

Sleep Surface - Bed-sharing and Unsafe Deaths 2011
8%
4%
3%
64%
1%
13%
3%
1%
1%
1%
1%
Crib (5)
Bassinet/cradle (3)
Playpen (2)
Adult bed (42)
Air mattress/Foam Mat (1)
Couch/chair (8)
Futon (2)
Snugggie Nest/Nest Box (1)
Bouncer (1)
Car Seat (1)
Swing (1)

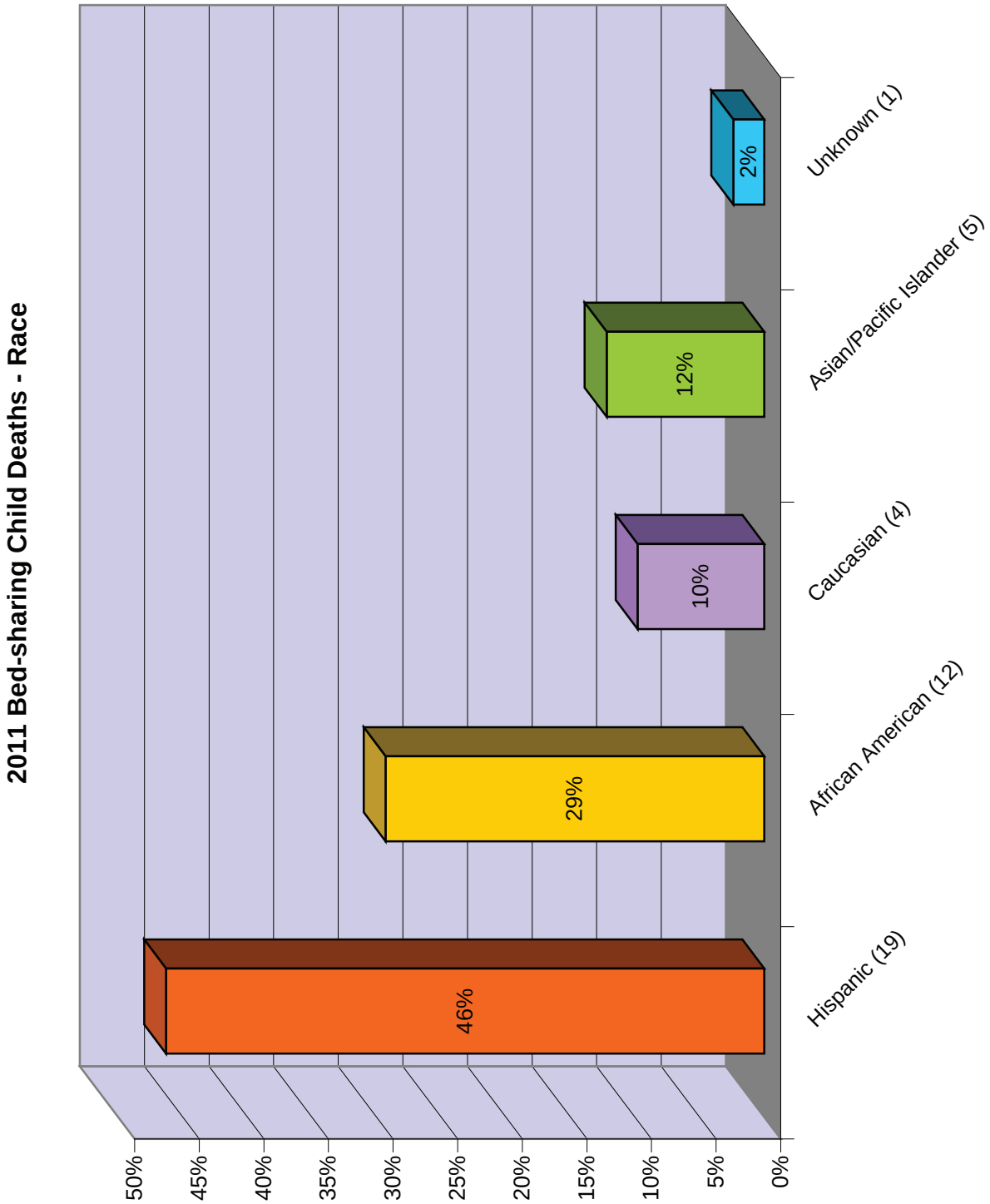


Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 67)	Number	Percentage
Pillow(s)	39	58%
Stuffed toys	1	1.5%
Soft and/or excessive bedding	24	36%
Excessive Swaddling	1	1.5%
Rolled blanket/sheet	5	7.5%
Parental Drug/Alcohol Use	8	12%

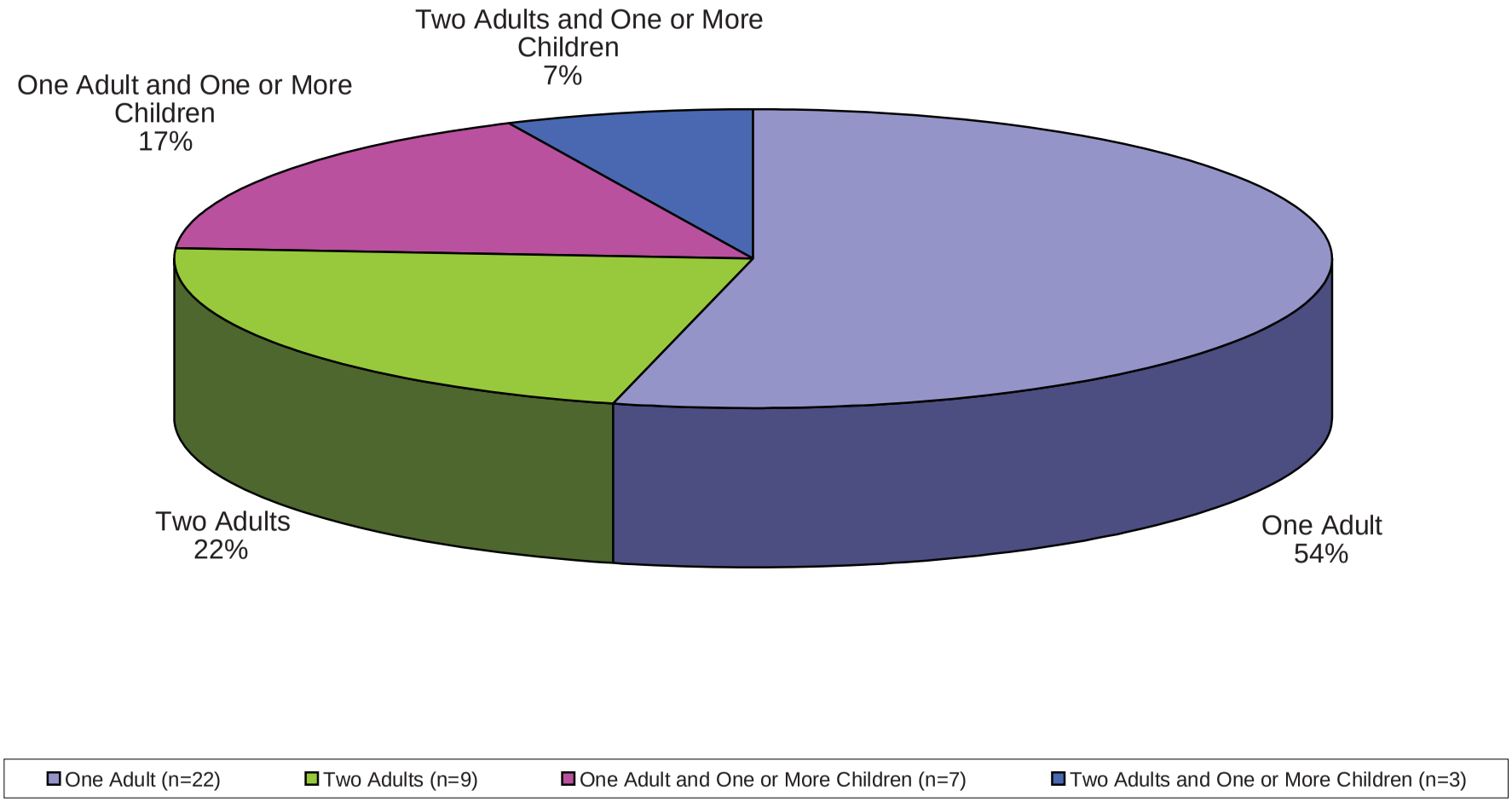
*excludes bed-sharing, sleep surface and infant position and the two accidental child deaths with unsafe/ bed-sharing circumstances.

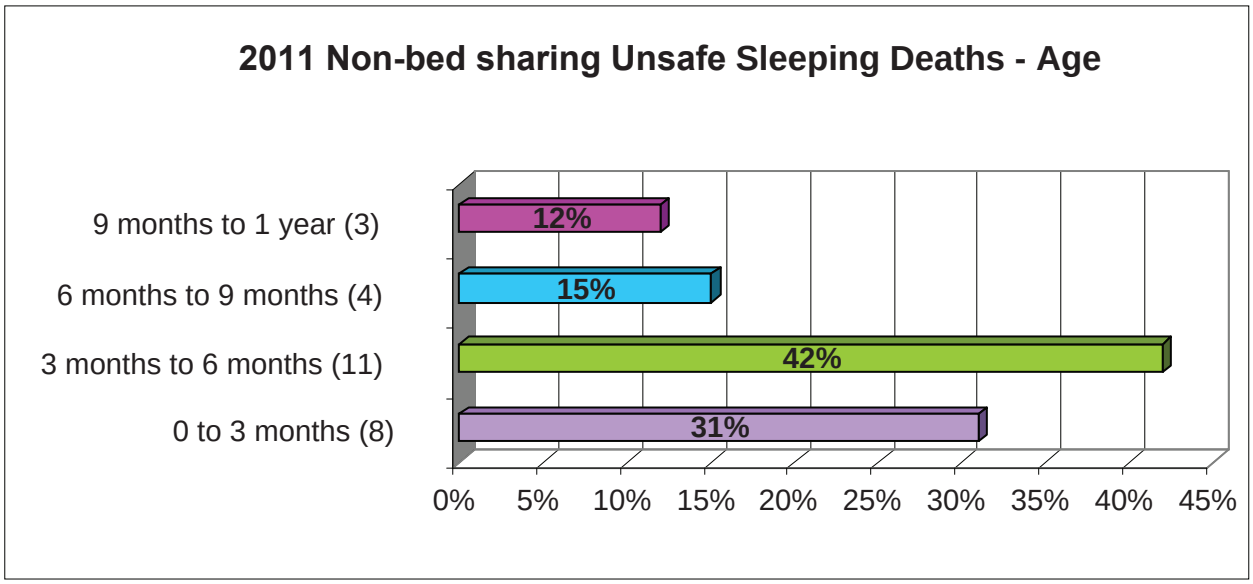

Percentage of Undetermined Child Deaths - Bed-sharing at Time of Death
38%
62%
Bed-sharing Deaths (41)
Remaining Undetermined Deaths (67)

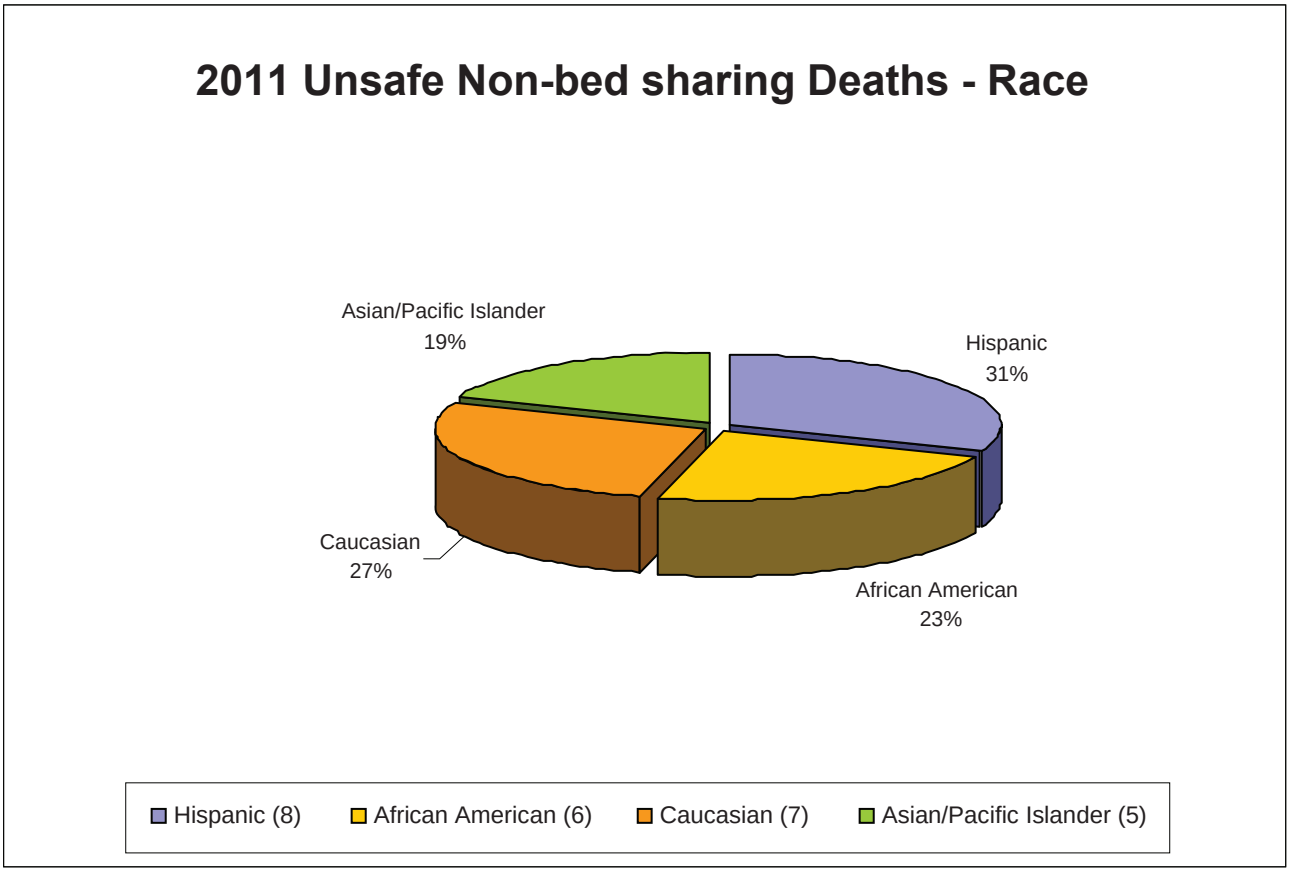

2011 Undetermined Bed-sharing Child Deaths - Age
7%
12%
54%
27%
0 to 3 months (22)
Over 3 months to 6 months (11)
Over 6 months to 9 months (5)
Over 9 months to 1 year (3)


2011 Bed-sharing Child Deaths - Race
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
46%
29%
10%
12%
2%
Hispanic (19)
African American (12)
Caucasian (4)
Asian/Pacific Islander (5)
Unknown (1)

2011 Undetermined Bed sharing Deaths - Number of Persons Sleeping with the Child




2011 Non-bed sharing Unsafe Sleeping Deaths - Age
9 months to 1 year (3)
6 months to 9 months (4)
3 months to 6 months (11)
0 to 3 months (8)
12%
15%
42%
31%
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%


2011 Unsafe Non-bed sharing Deaths - Race
Asian/Pacific Islander
19%
Hispanic
31%
Caucasian
27%
African American
23%
Hispanic (8)
African American (6)
Caucasian (7)
Asian/Pacific Islander (5)

Unsafe Non-bed sharing Child Deaths Sleeping Environment - 2011

Soft and/or excessive bedding	12
Pillow(s)	10
Adult bed	7
Crib	5
Rolled blanket/sheet	4
Bassinet	2
Playpen	2
Couch	2
Futon	2
Parental Drug/Alcohol Use	2
Foam Mat	1
Car Seat	1
Chair	1
Swing	1
Bouncer	1
Cradle	1
Stuffed toys	1
Excessive Swaddling	1

THIRD PARTY HOMICIDES 2011

Introduction

Historically, the ICAN Child Death Review Team report has included only those cases which have met Team protocol. For the fifth 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=37) 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.

A trend chart shows there has been a consistent downward pattern in these third party homicides over the past five 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

Noah, age seventeen, was walking along the sidewalk while speaking on his cell phone to his girlfriend. Suddenly, during mid-conversation, the girlfriend heard Noah arguing with someone and then his cell phone went dead. Family and nearby residents heard what sounded like multiple gunshots which prompted them to go investigate. Upon their arrival, Noah was found lying on the curb side. Paramedics were called and Noah was taken to the hospital where he was pronounced.

Thirteen-year old, Miguel was standing on the corner with a couple other males when a car stopped in front and fired multiple shots at the group. Miguel was struck multiple times to his torso area. Miguel was transported to the hospital, but despite medical intervention he later died.

Walter, age fifteen, was walking down an alley when an unknown individual approached Walter and shot at him multiple times. Walter fled the scene on foot and collapsed on a sidewalk a few blocks away. 911 was called and law enforcement responded to the scene. Walter was found lying supine on the sidewalk with multiple gunshot wounds. Death was pronounced without medical intervention.

Seventeen-year old, Trevon was riding a mini bike when, for unknown reasons, he dumped the bike and ran up to the front porch of an apartment complex. A car then drove up and its occupants exchanged words with Trevon. The occupants then started firing shots striking Trevon and another person who was standing in the apartment walkway. The assailants fled the scene and paramedics were called. Trevon was pronounced at the scene. The shooting was suspected to have been gang related.

Sixteen-year old, Kimberly was sitting in a car as a passenger when another vehicle approached an opened fire. Kimberly was struck in the head and was later pronounced brain dead at the hospital.

In April, shortly past midnight, a transient found the nude body of seventeen-year old Emily along the side of a freeway off ramp. Law enforcement and the Coroner were called to the scene to investigate. Abrasions and dirt were seen on both of Emily's knees as well as abrasions on the upper and lower left outer thigh. Fly eggs were also seen on her forehead. After Emily was identified, her father was contacted and notified of her death. The Coroner determined that the cause of death was asphyxia by strangulation.

One-year old, Andrew was in his uncle's arms as the uncle stood on the rear porch of their home. Gunshots were fired on the street and a stray bullet struck Andrew and his uncle. The toddler was shot in the head. Andrew was crying upon arrival at the emergency room. Despite life saving efforts, Andrew did not respond and his death was pronounced with his mother at bedside.

Lenny, age sixteen, was with some friends in front of an apartment complex when two males approached them on foot. One of the males asked Lenny and his friends where they were from when Lenny and one of his friends tried to runaway. One of the males then fired a weapon towards Lenny and the friend striking them both. Lenny was pronounced at the hospital after sustaining multiple gunshot wounds.

Seventeen-year old, Armand was riding his bicycle through the streets of a residential neighborhood when he was cut off by a car filled with opposition gang members. The driver of the car drove Armand into the curb preventing his escape. A verbal altercation followed as the gang members piled from the car and attacked Armand. Armand was overcome by the numbers and beaten to the ground then shot multiple times. Paramedics responded, but due to the severity of his injuries, Armand's death was pronounced at the scene.

Sixteen-year old, Isaac went to visit a friend and the friend came to the door with a shotgun. The friend pointed the gun at Isaac and the weapon discharged shooting Isaac in the torso area. There was no known animosity between the two boys so law enforcement speculated the friend was trying to scare Isaac by displaying the shotgun. Isaac was taken to the hospital but did not survive his injury.

Ramon, age seventeen, was in a car along with several friends when they pulled up in front of a party. Shortly thereafter, an unknown suspect opened fire on the vehicle. Ramon was struck in the head and hand. His friends drove Ramon to the hospital where he was eventually pronounced. The shooting was suspected to have been gang related.

Janet, age seventeen, was at work at an optometry office when her former boyfriend entered the office, produced a hand gun and shot Janet. A bullet struck below Janet's right eyebrow. The former boyfriend then locked himself in the restroom and witnesses called 911. Law enforcement and paramedics arrived on the scene a few minutes later. Janet was taken to the hospital but due to the severity of the wound, Janet succumbed to her injury and death was pronounced.

[1]Case identities were changed.

THIRD PARTY HOMICIDES

- There were 37 third party homicides in 2011. This is a 29% decrease from 2010 when there were 52 such deaths and a 63% decrease from 2007 when these data were first collected.

- Ninety-seven percent (n=36) of the youth were victims of gunshot wounds. These include 20 youth who were victims of homicides perpetrated by suspects with possible gang involvement. For the one remaining youth, she was killed by strangulation.

- As in the previous three years, male victims outnumbered female victims by a broad margin. Thirty-two males and five females were homicide victims in 2011.

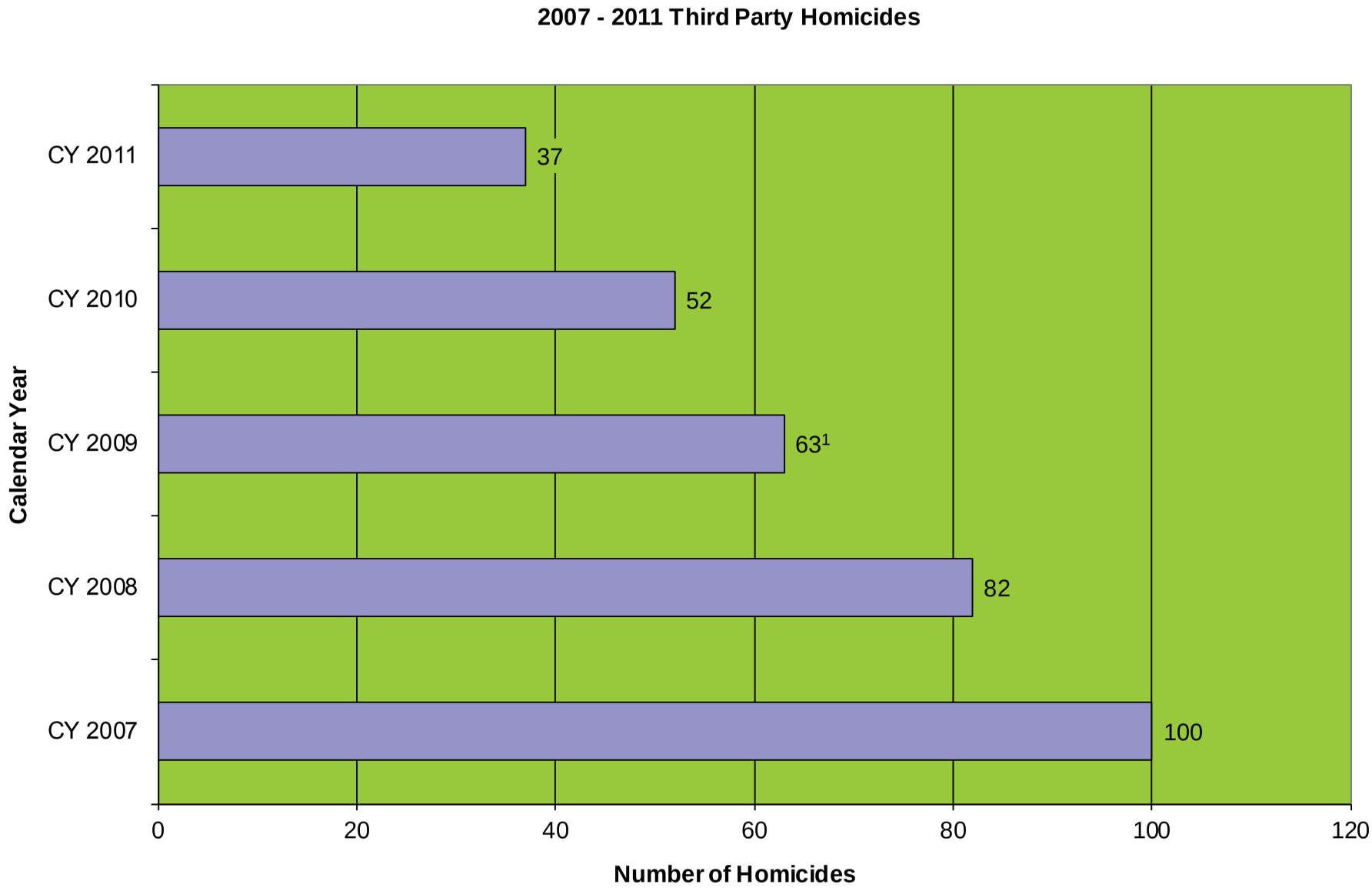
- Eighty-six percent (n=32) of the children who were victims of a third party homicide in 2011 were ages 16 – 17; three victims were 15 years of age, one was age 13, and the youngest victim was one year old.

- In 2011, there were 29 third party homicides of Hispanic youth, seven African-American youth, and there were no third party homicides of Asian American or Caucasian youth. One of the victims was of unknown descent.

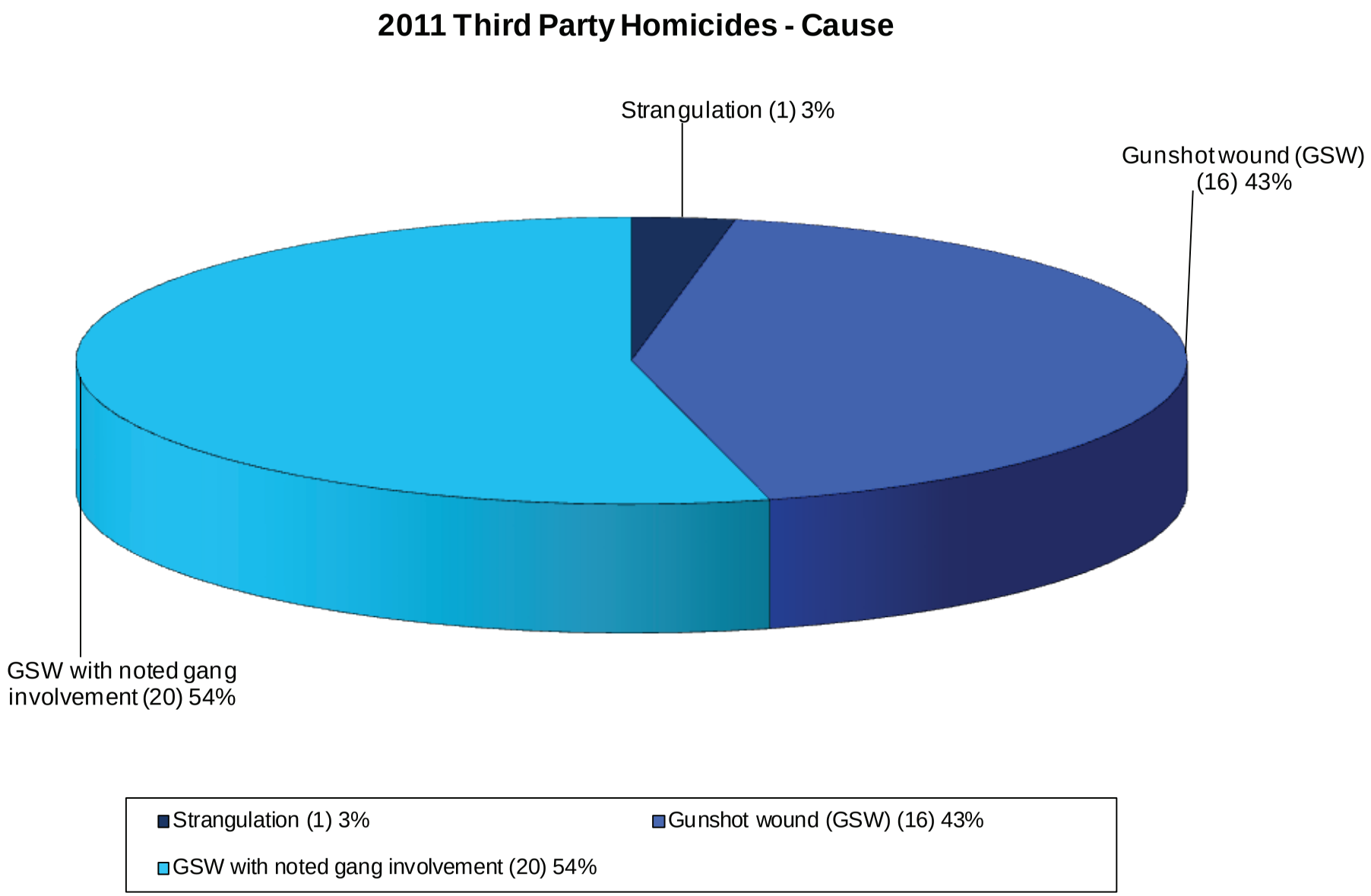
- The greatest number of third party homicides occurred in November (n=6). The second greatest number of homicides occurred during the months of February, March, April, and May, (n=4) and the third greatest number occurred in the months of January, July, and October (n=3). The fewest number of homicides occurred during the month of August when there were no third party homicides. Finally, two third party homicides occurred during the months of June, September, and December.

- While third party homicides occurred throughout Los Angeles County in 2011, the majority (n=13) of these deaths occurred in Service Planning Area 6 (SPA 6/South Los Angeles), which has been the case since collecting these data. Eight third party homicides occurred in SPA 8 (South Bay/ Harbor), six each in SPA 2 (San Fernando Valley) and SPA 4 (Metro), two in SPA 5 (West Los Angeles), one each in SPA 1 (Antelope Valley), and SPA 3 (San Gabriel Valley), and none in SPA 7 (East Los Angeles).

- The Los Angeles Police Department (LAPD) had investigative authority for 78% of the third party homicide cases in 2011. Thirteen percent of the cases were under the jurisdiction of the Los Angeles Sheriff's Department, and 9% of the cases were handled by jurisdictions other than LAPD and LASD. Where the relationship of the perpetrator was identified by law enforcement, 73% of the perpetrators were a gang member, and at least 8% of the victims were gang involved. Finally, 43% (n=16) 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.


2011 Third Party Homicides - Cause
Strangulation (1) 3%
Gunshot wound (GSW) (16) 43%
GSW with noted gang involvement (20) 54%
Strangulation (1) 3%
Gunshot wound (GSW) (16) 43%
GSW with noted gang involvement (20) 54%

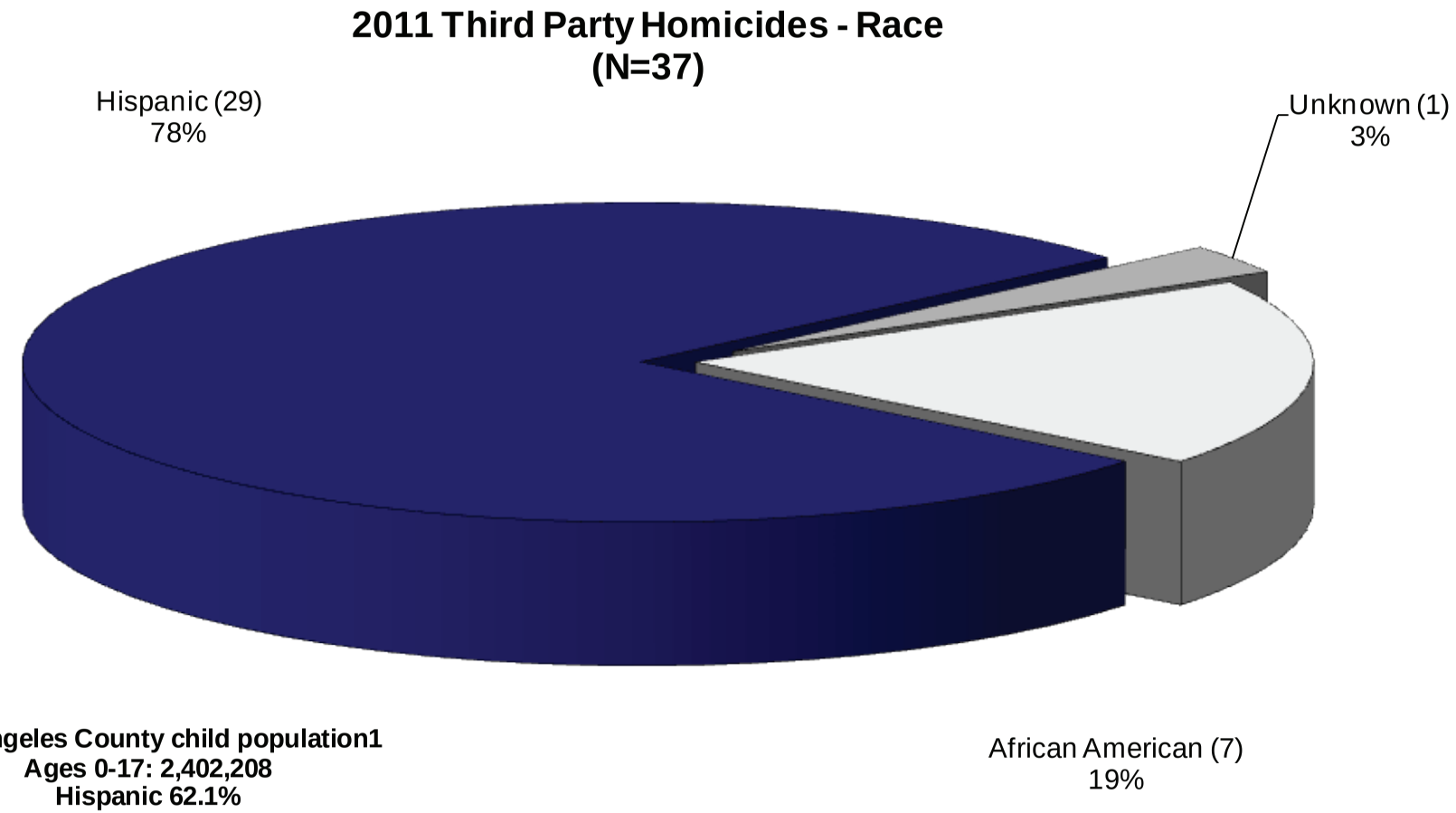
THIRD PARTY HOMICIDES
LOS ANGELES COUNTY – 2011 (N = 37)

Age	Female	Male
1 year or under	0	0
2 – 12 years	0	1
13 years	0	1
14 years	0	0
15 years	1	2
16 years	1	12
17 years	3	16
Total	5	32

86% of the third party homicide victims were male.

Less than 3% of the third party homicide victims were 12 years of age or younger.

86% of the third party homicide victims were 16 to 17 years of age.



Los Angeles County child population1
Ages 0-17: 2,402,208
Hispanic 62.1%
Caucasian 17%
African American 7.8%
Asian/Pacific Islander 9.7%
Multiple or Other Ethnicities 3.3%
Native American .1%

[1] From 2010 Census
CA Dept. of Finance
Demographic Research Unit

Dates[1] of Third Party Homicides - 2011

3 homicides occurred in January (1/18, 1/23, & 1/25/11)
4 homicides occurred in February (2/10, two on 2/21, & 2/27/11)
4 homicides occurred in March (3/01, 3/02, 3/06, & 3/26/11)
4 homicides occurred in April (4/09, 4/17, 4/26, & 4/29/11)
4 homicides occurred in May (5/04, 5/05, 5/23, & 5/24/11)
2 homicides occurred in June (6/18, & 6/22/11)
3 homicides occurred in July (7/07, 7/15, & 7/16/11)
0 homicides occurred in August
2 homicides occurred in September (9/10, & 9/21/11)
3 homicides occurred in October (10/10, 10/16 & 10/18/11)
6 homicides occurred in November (11/07, 11/20, 11/22, 11/26 & two on 11/27/11)
2 homicides occurred in December (12/03, & 12/11/11)

Locations[2] of Third Party Homicides – Geographic Area - 2011

1 homicide occurred in Canoga Park (zip code 91304)
3 homicides occurred in Harbor City (zip code 90710)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in Inglewood (zip code 90301)
1 homicide occurred in Lakeview Terrace (zip code 91342)
1 homicide occurred in Long Beach (zip code 90813)
21 homicides occurred in Los Angeles (zip codes 90001, 90002, 90003, 90011, 90015[3], 90017, 90019, 90031, 90033[4], 90043, 90044, 90047, 90059, & 90071)
1 homicide occurred in North Hollywood (zip code 91605)
1 homicide occurred in Pacoima (zip code 91331)
1 homicide occurred in Palmdale (zip code 93551)
1 homicide occurred in Panorama City (zip code 91402)
1 homicide occurred in Pomona (zip code 91768)
1 homicide occurred in San Pedro (zip code 90731)
1 homicide occurred in Van Nuys (zip code 91406)
1 homicide occurred in Wilmington (zip code 90744)

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[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.

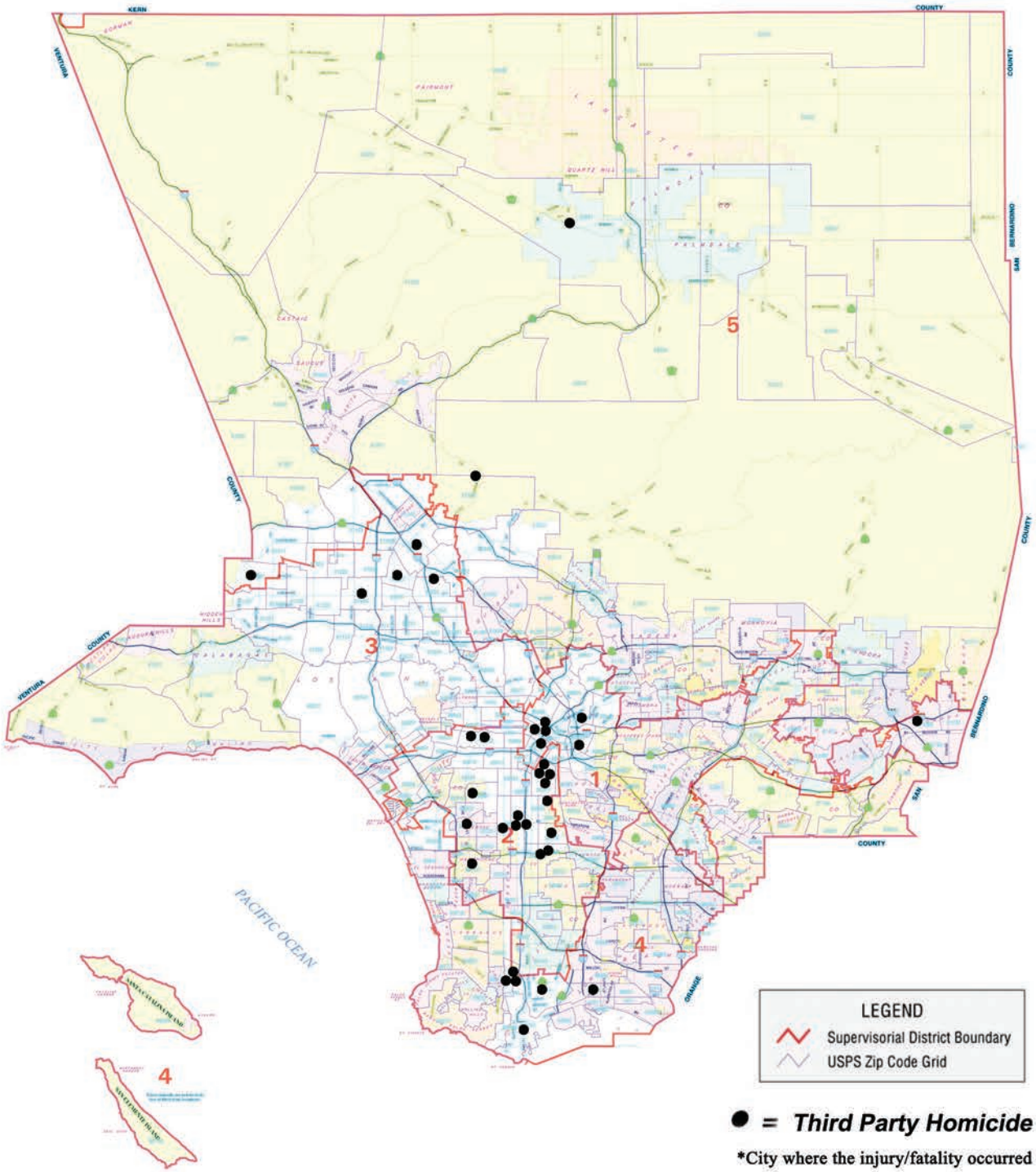
[2] City where the injury/fatality occurred

[3] Body was dropped off at a fire station at this location. It is unknown where the fatality occurred.

[4] Body was dumped adjacent to a freeway off ramp and found in this location. It is unknown where the fatality occurred.

2011 Third Party Homicides

N = 37*



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 2011, there were 37 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	29	78%
LASD	5	13%
Inglewood P.D.	1	3%
Long Beach P.D.	1	3%
Pomona P.D.	1	3%

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.

Table 2

Perpetrator's Relationship to Victim	Number of Cases
Gang Member	27
Law Enforcement Officer[1]	2
Friend	1
No Information Provided or Unknown	7

Table 3, on the following page, provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved. It should be pointed out that none of the law enforcement agencies provided much detail about the victim's circumstances which is why so many of the cases fall under the "no information provided" category.

Table 3	
Victim Information	**Number of Cases**
Shot accidentally by a friend who was playing with a gun	1
Shot after engaging in a parental abduction and attempted stabbing of the abducted child	1
Shot during a drive-by shooting	2
Gang member	3
No information provided	30

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), 16 of the 37 cases of third party homicides had criminal charges filed by the District Attorney's Office in 2011. It should be noted that of the 3 cases reviewed by the LADA, information was not found for any of these cases. This may mean that law enforcement has not identified the assailants, not submitted the case for review or some other reason.

[1] These shootings occurred during a criminal pursuit.

APPENDIX A
ON-LINE RESOURCES

Safe Sleeping Resources

hhttp://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

In 1977, the Los Angeles County Board of Supervisors designated the Inter-Agency Council on Child Abuse and Neglect (ICAN) as the official LA County agent to coordinate services for the prevention and treatment of child abuse and neglect.

In 1978, ICAN Associates was recognized as LA County's first inter-agency public/private partnership for the prevention of child abuse and neglect.

Also in 1978, Dr. Michael Durfee convened a group of professionals to analyze suspicious and preventable child deaths. Dr. Durfee's pioneering work soon became a central part of ICAN. This association has resulted in much greater public awareness of child abuse and neglect-related severe injuries and fatalities in Los Angeles County , as well as in national and international communities.

In 1996, ICAN Associates, Inc. received a grant from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, to establish the ICAN National Center on Child Fatality Review (NCFR). The mission of NCFR is to develop and promote a nationwide system of Child Fatality Review Teams to improve the health, safety and well being of children and reduce preventable child fatalities and severe injuries. NCFR's Mission is accomplished through the establishment, support and expansion of a national network of multi-agency, multi-disciplinary, local, regional and state Child Fatality Review Teams.

One of the primary vehicles to accomplish the NCFR mission is the Website. The NCFR Website offers users a variety of services, such as:

Cutting edge information about death and severe injury review and prevention
Searchable directories of individuals and organizations involved in fields related to child fatality review
Upcoming training events and the new CDR Curriculum and Training Manual
Virtual library of documents and reports
Information and data about child fatality review activities in each state
Links to related Websites
Listservs linking child fatality review professionals from the United States and abroad in an ongoing online dialog.
NCFR and its Website, like the field of child fatality review itself, continues to grow and evolve as more is learned about the needs of the professionals who review the tragic deaths of


ICAN