# Child Death Review Team Report 2013

## Report Compiled from 2012 Data


## Inter-Agency Council on Child Abuse and Neglect

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# Introduction

The Los Angeles County ICAN Child Death Review Team (CDRT) meets monthly and 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 2012. 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 sixth year. These homicides are where the perpetrator was not a family member or caregiver.

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# Recommendations

1. **The Sheriff, LAPD, and Los Angeles County Police Chief's Association should include in their policy directives, academy training, and patrol practice that personnel responding to domestic violence calls should inquire, physically check, and document for the presence of children in the home. Officers should obtain names, ages, and relationship to the parties of the children present at the incident and/or who reside in the home of the offense. If present at the time of the incident, children should be interviewed separately and alone in an age-appropriate manner. If the incident is at a location other than the home, officers inquire and obtain the names and ages of the children who reside with either or both parties. A report should be made to DCFS for suspected risk to the children's safety and well being regardless of them being physically injured or a witness to the incident.**

   **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. There is often a co-occurrence of domestic violence and child abuse in a family. Domestic violence is also often present in families where fatal child abuse has occurred. In one of the 2012 child homicides by a mother's boyfriend, the mother was also murdered by the boyfriend. Law enforcement should assess for children in the home or belonging to either party and make a referral to DCFS for further assessment by a social worker.

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

2. **Training on Lessons Learned/Risk Factors Identified by the ICAN Child Death Review Team (CDRT) for agency staff:**

   a) **DCFS, DMH, DPSS, Probation, DPH, DHS, LACOE, DA, City Attorneys, LASD, LAPD and Independent Law Enforcement Agencies through the Police Chief's Association should work with ICAN to ensure that the lessons learned and risk factors identified in the comprehensive reviews conducted by the ICAN CDRT are shared with line staff from these departments. At a minimum, ICAN should facilitate cross-training to line staff on the following factors: (list not exclusive):**

      - **Cases with multiple prior referrals**
      - **The risk posed by having unrelated caregivers provide care to children, specifically new partners of one of the parents, due to poor attachment, lack of parenting skills and sexual jealousy**
      - **Importance of collateral contacts**
      - **Need for communication among agencies**
      - **Parents history with child protective services as minors and the cycle of abuse**
      - **Young parents**
      - **Substance abuse**
      - **Poor access to resources**
      - **Lack of family involvement**
      - **Social isolation**

   b) **The Community Child Abuse Councils should work directly with ICAN to ensure that the training discussed in letter (a) above is provided to members of the community and community based providers of child abuse prevention services.**

   **Rationale:** The ICAN Child Death Review Team has consistently and successfully focused on the analysis, review, follow up, accountability and prevention of child death in Los Angeles County. As a result of these comprehensive reviews, ICAN, in its annual Report of the Child Death Review Team, has shared identified risk factors for fatal child abuse and lessons learned to prevent future child fatalities. Unfortunately, much

of this information has never been incorporated into the training that reaches line staff. Some agencies have responded with safety checklists, protocols or changes in policy, but little of the important information from ICAN's extensive review of child fatalities has officially been shared directly with line staff. In venues where ICAN has shared some of the information learned by the CDRT, line staff clearly state that having this information is of great help to them in doing their job.

This training needs to be provided to members of the community and with professionals in community based organizations who are working directly with families. Friends, family and neighbors have an important role in helping to prevent harm to children. The more information that is provided to the community, the more likely it will be that they will report suspected abuse and take action to help a child in need.

3. **In the City of Los Angeles, 911 Dispatchers should contact LAPD as one of the first responders to any "baby not breathing" or "child injured" calls as currently done in the County and unincorporated areas of the County by the Los Angeles Sheriff's Department.**

   **Rationale:** Law enforcement should be one of the first responders in order to start an investigation and gather evidence early on in order to rule out or confirm child abuse. Delays in scene investigation can adversely impact the criminal or dependency proceedings as this allows time for suspects to alter the home scene and/or develop a "reasonable" explanation for the child's injury.

   *Note: This recommendation relates to the Multiple Caregivers and Risk Factors sections in the Lessons Learned portion of the report.*

4. **There has been an increase in the number of infant deaths paired with perinatal substance abuse in 2012. To reduce the number of fetal and infant deaths associated with maternal substance abuse, including alcohol and fetal alcohol effects, the Departments of Public Health, Health Services, Mental Health, Public Social Services, Children and Family Services, Sheriff, and other law enforcement agencies in the county should identify women who have historically or currently presented with risk factors indicative of underlying substance abuse problems that otherwise would go undetected and untreated. These departments should integrate substance abuse screening, counseling, and linkages to treatment into their clinics, hospitals, and case management services at the initial contact, and ongoing for pregnant women. This can be done by using the *Screening, Brief Intervention, Referral, and Treatment (SBIRT)* program, which is already being used on a limited basis in various pilot programs in the county.**

   **Rationale:** The number of fetal and infant deaths associated with maternal substance abuse dropped significantly from a high of 38 in 1998 to 9 in 2008. However, beginning in 2011, the number of these deaths began creeping upwards each year. In 2012, there were 15 accidental fetal or infant deaths due to maternal substance abuse. An additional 12 undetermined deaths were associated with a mother who tested positive for a substance at the birth of the deceased child, brining the total number of these deaths to 27 in 2012. By automatically screening for prenatal alcohol or substance use for all pregnant women served by these departments, counseling them about the impact on the unborn child, and ways to reduce their use and, when indicated, referring the mother for treatment services, the number of these deaths should begin to decline.

5. **All direct service agencies should continue to participate in the ICAN Task Force on Infant Safe Sleeping. These agencies should also ensure that materials discussing the importance of infant safe sleep should be widely distributed to families, medical facilities and clinics, WIC providers, DPSS, DCFS, Law Enforcement, EMTs and all service providers who may have contact with pregnant women and their families.**

   **Rationale**: ICAN has worked extensively with the community, First 5 LA and key agencies in developing a Public Awareness Campaign for Infant Safe Sleeping. ICAN initially began its efforts with the formation of a Task Force to address the alarming number of child deaths due to unsafe sleep practices. This Task developed a clear message and materials about the need for infants to sleep safely. ICAN was able to significantly ramp up its efforts in creating public awareness and working to prevent infant deaths due to unsafe sleep when it received a 2-year grant from First 5 LA. This grant period has now ended, but the need to build on the progress made through this grant remains. Thus, it is critical that all public service agencies continue to provide information about the dangers inherent in unsafe sleep practices such as bed-sharing and/or placing infants to sleep in cluttered or overheated areas to women who are pregnant or are hoping to become pregnant, and all parents and potential infant caregivers.

6. **Agencies that have direct contact with families with young children should provide specific information regarding the dangers of a) leaving young children unattended in the bathtub and b) the dangers of not carefully supervising children when there is a pool, lake or pond nearby.**

   **Rationale**: The number of child deaths due to drowning in bathtubs and pools has been slowly rising. As a result of several cases reviewed by the ICAN Child Death Review Team (CDRT), ICAN believes that prior messages about the dangers of leaving children unattended in bathtubs or unsupervised when near a body of water (including pools, lakes, ponds and even buckets) need to be reinforced. There have been a number of cases where a caregiver will leave young children unattended in the bathtub for what is purported to be a short period of time. However, it takes very little time for a young child to drown. Leaving a child alone even for an instance can create a great risk to that child. The safest practice when young children are in a bathtub, or near any body of water, is to never leave them alone.

1. **The Los Angeles County Office of Education should send a recommendation to all school districts to provide parent-involvement interviews for any student considering withdrawal from public education. In these meetings, it is critical that the student and the parents are made aware of the possible negative impact removal from social supports could have for the student should they decide to transition to an independent learning environment.**

   **Rationale:** In addition to increasing knowledge and career readiness, peers, teachers, and other caring adults in the school environment supply vital connections. In recent years, however, there has been an increase of children leaving comprehensive educational programs by opting to participate in independent study, home schooling, or distance learning programs. Unfortunately, some of these educational settings provide minimal or negligible social contact and can increase the intensity of social isolation for a vulnerable youth.

   In 42 (52%) of the 81 of cases of children who died by suicide between 2005 and 2010, the Los Angeles County Child & Adolescent Suicide Review Team (CASRT) noted there was a preceding event that involved problematic social interaction. Of greatest concern were individuals that withdrew from interaction with others. CASRT concluded that by increasing opportunities for effective relationships with peers and adults, we can decrease the number of suicides for our youth. Information should be provided and discussed with parents and students considering withdrawal from the school environment to help them understand the potential impact of losing these social supports and encourage an informed decision about the change in educational setting.

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

2. **The Los Angeles County Office of Education should recommend to all school districts that school safety policies include comprehensive LGBT protections from harassment and discrimination mandated by [California Education Code, §200]. LGBTQ youth feeling unsafe on school campuses needs to be addressed to reduce the risk of suicide in these youth. Content about the needs of LGBTQ youth in professional development trainings for staff and parents should include risk factors, warning signs, protective factors, ways to respond to the youth and resources for them. This would build the capacity in school staff and parents to respond to the needs of LGBTQ youth and provide a safe and supportive school environment.**

   **Rationale:** There is empirical evidence that lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth are at a higher risk for a suicide attempt than their heterosexual peers. In 2012, a few of the youth in Los Angeles County who died by suicide had experienced stressors stemming from their struggles with sexual orientation. It is important to note that being LGBTQ is not a risk factor in and of itself; however, the stressors that LGBTQ individuals encounter – such as discrimination, rejection and harassment – make them particularly vulnerable to depression, alcohol and substance abuse. These behaviors are directly associated with risk for suicide. Non-discrimination of LGBTQ youth and focus on school safety is a critical protective factor against suicidal ideation and attempts.

   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 glean from the 2012 child death cases follow. Most are consistent with the previous report and have continued to surface.

## Child Risk Factors

### Young Age

87% of the 2012 child homicides by a parent/relative/caregiver were age five and under; 73% were two and under; and 53% 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 to meet their needs. They also are often not visible outside the home as these families tend to be socially isolated.

51.6% of the accidental child deaths involved children age five or younger. Young children are also more at risk due to deaths such as being hit by an object, drowning and auto back up deaths because of their size and lack of adult supervision to prevent such deaths.

### Gender

The year 2012 did not discriminate as to the gender of homicide victims. Victims were almost evenly split between males and females. Males (n=8) outnumbered females (n=7) by one. In past years, male children notably outnumbered female children as victims of homicide.

### Race

59% of the 2012 child homicides victims by a parent/relative/caregiver were Hispanic, 27% African American, 7% Caucasian, and there were no Asian/Pacific Islander victims in 2012. Hispanic children were about even for the general population, Caucasian children were under represented, and African American children were over represented as homicide victims.

## Parental Risk Factors

### 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. 43% (n=6) of the 2012 child homicides involved a parent or perpetrator with a Child Protective Service (CPS) history as a child. Two of the perpetrators of homicides in 2012 involved youth who were dependents under the supervision of DCFS and the Dependency Court as a result of AB 12 which extended foster care for youth age eighteen years to twenty-one years of age.

### Mental Illness

In 2012, three children were killed by a parent, caregiver or family member with a history of, or exhibiting symptoms of mental illness. Not all individuals with mental illness place their children at risk. However, those with chronic mental disorders who are non-compliant with medication or treatment or uncooperative with family members or other supports have the potential to place children at risk including death.

### 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 and again in 2012. Child deaths with a contributing factor of maternal substance abuse remains one of the top four causes of accidental death accounting for 17% of accidental child deaths. Maternal Substance abuse was attributed to 33% of the accidental deaths of children age five and under. Additionally, there were 12 undetermined deaths associated with maternal substance use as evidenced by the mother testing positive at the birth for a substance.

### Substance Abuse

Substance abuse by a parent or caregiver is a well documented high risk factor for child abuse or neglect. Substance abuse often is identified when there is a child fatality if the parent or caregiver 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.

### Young Age

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

### Presence of Multiple Parental/Caregiver Risk Factors

Risk factors such as mental illness, history of substance use, domestic violence, social isolation, CPS contact, CPS history as a minor and young parents are usually present when a child dies at the hand of a parent or caregiver. In 2012, only three families of a homicide victim had none of these known risk factors present.

### Domestic Violence

This connection between domestic violence and child abuse/neglect continues to be evident in the 2012 child homicides in which three of the families had a history of domestic violence. In one homicide, both the child and mother were murdered by the mother's boyfriend.

## Perpetrator Relationship

### Relationship

In 2012, sixty percent of the child homicides involved a female perpetrator as opposed to 2011 when 78% of the perpetrators were male. Five of the child homicides perpetrators were the biological mother. Two perpetrators were non-related caregivers and one, the maternal grandmother.

### 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 2012, 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.

## System Factors

### Failure to Report

In 2012 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, other community agency or family member 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. Family members aware that a child might be at risk should communicate their concerns with reports to DCFS.

## Additional Risk Factor

### Unsafe Infant Sleeping

Although there has been a decline in deaths from the previous years, 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 who die 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 2012, there were 55 undetermined child deaths involving bed-sharing or unsafe sleep environments which accounted for 56% of all the undetermined child deaths. Additionally, one infant died when placed for a nap in a car seat and suffocated on the strap. The death was ruled accidental. Most unsafe or bed-sharing infant deaths are moded as undetermined by the coroner. Adding this accidental death to the undetermined ones brings the total of unsafe sleep infant deaths to 56 and is a 19 % decrease from the 69 such deaths in 2011.

# Child and Adolescent Suicide Review Team
# Risk Factors and Lessons Learned

## Suicide Rate

The suicide rate among individuals under the age of 18 years decreased from 19 suicides in 2011 to 17 in 2012. The highest number of youth suicides was in 2001 with 27 and the lowest number of 10 occurred in 2007.

## 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. This pattern shifted again in 2012 when, for the first time, female victims (n=9) of suicide outnumbered the male victims (n=8).

## Race

35% of the youth who committed suicide were Hispanic which under represents the general population of Hispanic children. 47% were Caucasian who were over represented and 17% were African American who were also over represented compared to the general population. In 2012, no Asian/Pacific Islander child committed suicide.

## Relationship Loss or Conflict

94% of the youth who committed suicide experienced a recent relationship loss or conflict with a peer, boyfriend/girlfriend or parent prior to their suicide.

## The Role of Pre-existing Mental Health Problems

Among the youth who died of suicide, 35% had a documented mental health diagnosis and 23.5% were receiving mental health services at the time of death and 29% were on psychotropic medication.

For 23.5% of the youth, there was a history of previous suicide attempts. 41% 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.

## 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. Of the youth who committed suicide in 2012, 29.4% were LGBTQ and 18% had reported experience of being bullied. Another 59% of the victim's families had contact with either DCFS or Probation at sometime in the youth's life.

## Communication Barriers between Agencies/Professionals/Parents

Perceived barriers to communication among professionals from schools and/or mental health 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 mental health 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.

## Social Networking

There was Internet social networking activity noted by others after the death of youth in most of the cases reviewed. One decedent had posted a video on her Facebook page that she was committing suicide. Authorities were alerted by a peer but they were too late. It is not known how many other children or youth had posted messages due to the inability to access pages without the youth's password. In another public suicide, the news of the suicide was immediately posted on social media by peers even before the identity of the victim was known. Postmortem information and messages to family/peers were also discovered for many of the cases reviewed.

# Team Accomplishments

In 2012 – 13, 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 prosecutors by bringing together legal, medical and other professionals who are able to provide expertise on suspicious child death case investigations.
- The Undetermined Child Death sub-committee screens all undetermined child deaths and refers cases to the Team when circumstances indicate a finding of accidental or homicide could possibly result from a full multi-disciplinary review.
- 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 19h Annual Nexus Conference.

In 2012 – 13, the ICAN Child and Adolescent Suicide Review Team (CASRT):

- ICAN continued to update and revise suicide field investigation guidelines for Coroners and Medical Examiners which were initiated by a partnership with the Gutin Family Fund of the New Hampshire Charitable Foundation and the Los Angeles County Department of Coroner-Medical Examiner.
- Prepared training curriculum for coroner investigators and medical examiners that included participation in a program-produced interactive training video to develop skills for completion and use of the suicide field investigation guidelines.
- Conducted a 6-hr training workshop to build skills in the use of the suicide investigation guidelines for coroners and medical examiners from Los Angeles County, Riverside County, Kern County, and San Luis Obispo County.
- Challenges to the continuity of care for children hospitalized for suicide risk were addressed by a joint task force consisting of representatives from the Southern California Hospital Association, hospitals and representatives from school districts and school sites. The committee is currently surveying a sample of respondents from hospitals and schools to identify training needs to address these challenges.
- Continued to search for and investigate the content of comments made on Social Networking sites for each case reviewed by the Team.

# Findings

## Overall Child Deaths

- There were 219 child deaths from homicide by a parent, relative or caregiver, accidental, suicide or undetermined cause in Los Angeles County for 2012, a 9.5% decrease from the 242 deaths in 2011.
- Fifteen children were victims of homicide by a parent, caregiver or other family member. There were 17 suicides, 89 accidental child deaths and 98 undetermined child deaths.
- The percentage of children who died in 2012 by race/ethnicity consisted of 54.3% Hispanic, 17.8% Caucasian, 21% African American and 5.1% Asian/Pacific Islander and 1.80% Unknown.
- In 2012, African American children comprised 7.5% of the child population in Los Angeles County and were disproportionately over represented in the number of child deaths. Caucasian children who comprised 17% of the child population in 2012 were 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 five years (n=150). 52% were infants under the age of one year (n=113). The majority of children who died (60%) were one year of age or younger. Twenty-one percent of the child deaths were adolescents.
- The gender gap of children who died in 2012 declined from males outnumbering females by a large margin to 55% male and 45% female.

## Homicides

- There were 15 child homicides by parents, caregivers or family members in 2012. This represents a decrease (37.5%) from 2011 when there were 24 child homicides. The number of child homicides for Los Angeles County in 2012 was significantly lower than the 15 year average of 32.5 deaths. There has been almost a fifty percent decline in child homicides in the past decade. 2012, in fact, represents the year with the fewest child homicides in the past twenty-five years.
- 86.7% percent of the children killed by their parents, caregivers or family members were five years of age or younger. This is a decrease from 2011, when 91.6% of the children were five years of age or younger. Slightly more than half (53.3%) of the children were under the age of one year.
- Only two of the 15 homicide victims were over the age of five years.
- The average age of a child homicide victim in 2012 was 1.9 years (29.48 months) which was slightly older than in 2011 when the average age was 1.35 years.
- The number of female and male children who were victims of child homicide by parents, caregivers or family members was almost evenly split in 2012. Eight males and seven females were homicide victims in 2012.
- 60% percent of the child homicide victims were battered children who died from inflicted trauma--five children died from head trauma, two died from multiple traumas, and two died from trauma to the torso/abdomen. Three children died from negligent or intentional drowning, one was a victim of stabbing, and one was a victim of strangulation and one died from poisoning/drug ingestion.
- Three newborns were abandoned and found deceased and/or killed by the mother in 2012 which is two more than in 2011. One abandoned newborn was ruled a homicide and the other two deaths were deemed undetermined. Thirteen newborns were safely surrendered in 2012 which was more than twice the number in 2011 (n=6).
- African American (n=4) children were over-represented in child homicides by a parent, caregiver or family member accounting for 26.6% of child homicides. Hispanic (n=9) children were slightly over-represented and comprised 60% of child homicides. One child was Caucasian, one child's race was unknown 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 47% (n=7) of the families in which there was a child homicide and the child died in Los Angeles County. One mother of a homicide victim had an open case with DCFS and another mother of a homicide victim was a dependent herself in an open permanent placement (PP) case at the time of the death. In a third case, the perpetrator of a child homicide was a dependent receiving PP services under DCFS supervision at the time of the homicide.
- Five children were killed by their father, stepfather or mother's boyfriend and five children were killed by their mother. One child was killed by the mother and/or boyfriend. Two children were killed by their non-related caregiver and one by the maternal grandmother while in her care. The perpetrator of a homicide involving a stillborn baby remains unknown as does the identity of the abandoned deceased "Baby Doe" infant's mother.
- There were three child homicides each by parents, caregivers or family members in February and August 2012. The second greatest number of homicides occurred in the months of October and November with two per month. There were no homicides in the months of January, July, and September. One homicide occurred in the months of March, April, May, June and December.
- Child homicides occurred throughout Los Angeles County in 2012. The Service Planning Area (SPA) in the South – SPA 6 had the greatest number of child homicides (n=6). Three child homicides each occurred in SPA 2 located in the San Fernando Valley and three in SPA 3 – San Gabriel Valley. Two child homicides occurred in the South Bay/Harbor – SPA 8 area and there was one child homicide in the Metro area – SPA 4. In 2012, no homicides occurred in the Antelope Valley – SPA 1, West Los Angeles– SPA 5 or East Los Angeles – SPA 7 areas of the County.

## Suicides

- Seventeen children and adolescents committed suicide in 2012. This is a decrease from the 19 suicides in 2011, and just under the 15-year average of 17.6 suicides per year.
- For years there was a margin of 3:1 of male to female victims of suicide. This gap decreased significantly in 2011 with 58% of the victims being male and 42% female. In 2012, for the first time, female victims (n=9) outnumbered the male victims (n=8) of suicide.
- 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 59% (n=10) of the suicides in 2012. Three youth overdosed, two used a firearm, one jumped to his death and one youth stood in front of a train.
- The act of suicide usually occurs in the youth's home. In 2012 this continued to be the case with all but three suicides occurring in the youth's home.
- Forty-seven percent (n=8) of the adolescent suicides in 2012 were by Caucasian youth and 35.3% (n=6) suicides were by Hispanic youth. The number of suicides by Hispanic youth decreased by almost half from 2011. Suicides by African American youth (n=3) increased by one from 2011 and represent 17.6% of the adolescent suicides.
- Eighty-eight percent (n=15) of the children who committed suicide in 2012 were ages 15 – 17; seven were 17 years, five victims were 15, and three were 16 years of age. The two youngest victims were 14 years of age.
- Ninety-four percent (n=16) of the adolescent suicides were precipitated by interpersonal conflicts or a recent loss. Ten of the youths' families had a prior referral or case with the Department of Children and Family Services or with the Department of Probation. Two families had an open referral or case with DCFS and one with Probation. Six youth had a history of mental health problems, four were in counseling at the time of their death and five were taking psychotropic medication. Four youth had a history of prior self-injury or cutting and four youth had previously attempted suicide. Seven youth exhibited warning signs prior to their suicide. Five of the youth who committed suicide in 2012 left a suicide note. Two youth texted their intent just prior to committing the act but did not leave a note. One youth left a video on

Facebook in addition to her note. One youth was discovered to have a positive toxicology for drugs at autopsy. Four youth did have a history of alcohol or drug use. Six youth had school discipline or truancy problems and four experienced academic problems.

- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred in the San Gabriel Valley (SPA 3) with seven. Four suicides occurred in the East (SPA 7). Two suicides occurred in South Los Angeles, SPA 6. One each occurred in Metro area (SPA 4), West Los Angeles (SPA 5), San Fernando Valley (SPA 2), and the Antelope Valley (SPA 1). No suicides occurred in the South Bay area (SPA 8).

## 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 the lowest number of 86 in 2010. In 2011, there was an increase of two accidental child deaths to 88 and, in 2012, the number increased by one to 89 accidental child deaths.
- The leading cause of accidental death for children was automobile accidents (n=28). This cause of accidental death was followed by maternal substance abuse (n=15) accounting for 17% of the accidental child deaths. Auto pedestrian (n=10) and drowning (n=10) tied as the third leading cause of accidental child death in 2012.
- Deaths associated with maternal substance abuse accounted for 11 fetal deaths and four infant deaths. Methamphetamine use by the mother is the most associated drug with these deaths (n=13) accounting for 87%. The remaining two deaths were associated with Cocaine use by the mother. Deaths associated with maternal substance abuse accounted for 16.85% of all accidental deaths in 2012, and fetal deaths associated with maternal substance abuse accounted for 12.36% of all accidental deaths.
- Accidental drowning claimed the lives of 10 children, an increase of three deaths from 2011 when there were seven such deaths. A majority of these drowning deaths were young children who drowned in residential pools. In 2011, six children drowned in a residential pool and 50% were five or younger (n=5). One adolescent drowned in a lake. For the past fifteen years, drowning has been one of the leading causes of accidental deaths of children in Los Angeles County.
- Of the 89 accidental deaths, 68 accidental child deaths involved children ages 0 – 14 years. There were 21 accidental deaths of youth's ages 15 to 17 years.
- Automobile accidents (n=21) were the leading cause of accidental death for children 14 years of age and under. Deaths due to maternal substance abuse (n=15) was the second leading cause for this age group followed by drowning (n=9). Auto pedestrian (n=6) ranked fourth and hit by an object (n=5) ranked fifth as the leading cause of accidental death of children 0 – 14 years.
- One infant suffocated in a car seat and this death was ruled accidental as opposed to undetermined.
- Of the children who died an accidental death in 2012, 39% had a DCFS or other county CPS history. Nine of the fifteen deaths from maternal substance abuse had a history with DCFS. An additional four of the maternal substance abuse associated child deaths involved a mother who had a CPS history as a minor but not as an adult.
- Hispanic children represented 63% (n=56) of all accidental child deaths in 2012. African-American children (n=8) were over-represented in accidental deaths in 2012. Asian/Pacific Islander children were under-represented in 2012 accounting for 6.7% of all accidental deaths. Forty percent of the drowning deaths involved Caucasian children and forty percent of these deaths were Hispanic children.
- As in previous years, males (n=52) outnumbered females (n=37) in accidental death.

## Undetermined Child Deaths

- There were 98 undetermined child deaths in 2012. This is a decrease from the 111 such deaths in 2011 and higher than the 15-year average of 91.6 undetermined deaths per year. Eighty-nine percent of the undetermined child deaths were age one year and under (this includes stillborn deaths). 93% of undetermined child deaths were age five years and younger. Two of the three abandoned deceased newborn infants for 2012 were ruled as undetermined child death.
- African American (n=31) children were significantly over-represented in undetermined child deaths and Asian (n=5) were under-represented. Hispanic children were under-represented with 48 undetermined deaths. There were 14 Caucasian undetermined child deaths which is a slight under representation from the general population.
- Bed-sharing and unsafe sleeping environments accounted for 56% percent of all undetermined child deaths. 46% of the undetermined child deaths were associated with bed-sharing (n=45) and 10% with an unsafe sleep environment (n=10).
- Among the bed-sharing deaths, 0% involved only one unsafe risk factor, 22% involved two, and 78% 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. Thirty-eight percent of the bed-sharing deaths and 23% of the unsafe sleeping environment child deaths were African American. African American children represent 31% of all the unsafe sleep undetermined deaths which is higher than 2011 when they comprised 25% of the undetermined deaths.
- Eighty-four percent of the infants whose deaths occurred while bed-sharing or in an unsafe sleeping environment were six months of age or younger (n=46).
- The top three sleep surfaces involving bed-sharing and unsafe infant sleep child deaths occurred in an adult bed (78%), on a couch (5%) or in a crib (5%).
- In 38% 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 slight decrease from 2011 when 40% 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. 21% (n=12) each occurred in South Bay/Harbor SPA 8 and South LA SPA 6, and 14.5% (n=8) in the Metro Area SPA 4.
- Forty-six percent (n=45) of the undetermined child deaths involved bed-sharing. This is a ten percent increase from 2011 in which 38% of undetermined child deaths involved bed-sharing.
- Fifty-eight percent (n=26) of the bed-sharing deaths were infants between 0 to 3 months of age, 31% (n=14) were infants between 3 to 6 months of age, 7% (n=3) were 6 months to 9 months of age, and 4% (n=2) were 9 months to 1 year.
- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 51% of the incidents and two adults in another 20% of the incidents.
- Ten percent (n=10) 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 percent (n=3) of the non bed-sharing deaths were infants between 0 to 3 months of age, 30% (n=3) were infants between 3 to 6 months of age, and 40% (n=4) were 6 months to 9 months of age.
- Sixty percent of the infants whose deaths occurred in a non bed-sharing unsafe sleeping environment

were six months of age or younger (n=6).

- Approximately 43% of the families with a child who died from an undetermined death had at least one contact with DCFS or another county CPS agency.
- There were 12 undetermined infant deaths in which the mother tested positive for a substance at birth. The majority involved stillborn births (n=8).
- The most frequent substance detected was methamphetamine (n=5), followed by methamphetamine and another substance (n=3) with marijuana and cocaine both with two mothers.
- Mothers of these infants had prior contact with a CPS agency in Los Angeles or another county in 58.3% of the deaths. Five of the mothers and one father had a case with a CPS agency as a minor.

# 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 2012, 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 2008 – 2012

Over the past 5 years, a parent, caregiver or other family member has killed an average of 25.6 children each year.

| | |
|---|---|
| 2008 | 34 |
| 2009 | 29[1] |
| 2010 | 26 |
| 2011 | 24 |
| 2012 | 15 |

An average of 16.6 children and adolescents each year has committed suicide over the past five years. The leading method from 2008 through 2012 was hanging.

| | |
|---|---|
| 2008 | 17 |
| 2009 | 14 |
| 2010 | 16 |
| 2011 | 19 |
| 2012 | 17 |

Over the past five years, an average of 91 children have died from preventable accidents. The most common accidental Deaths involve automobile accidents, maternal substance abuse and deaths due to auto pedestrian.

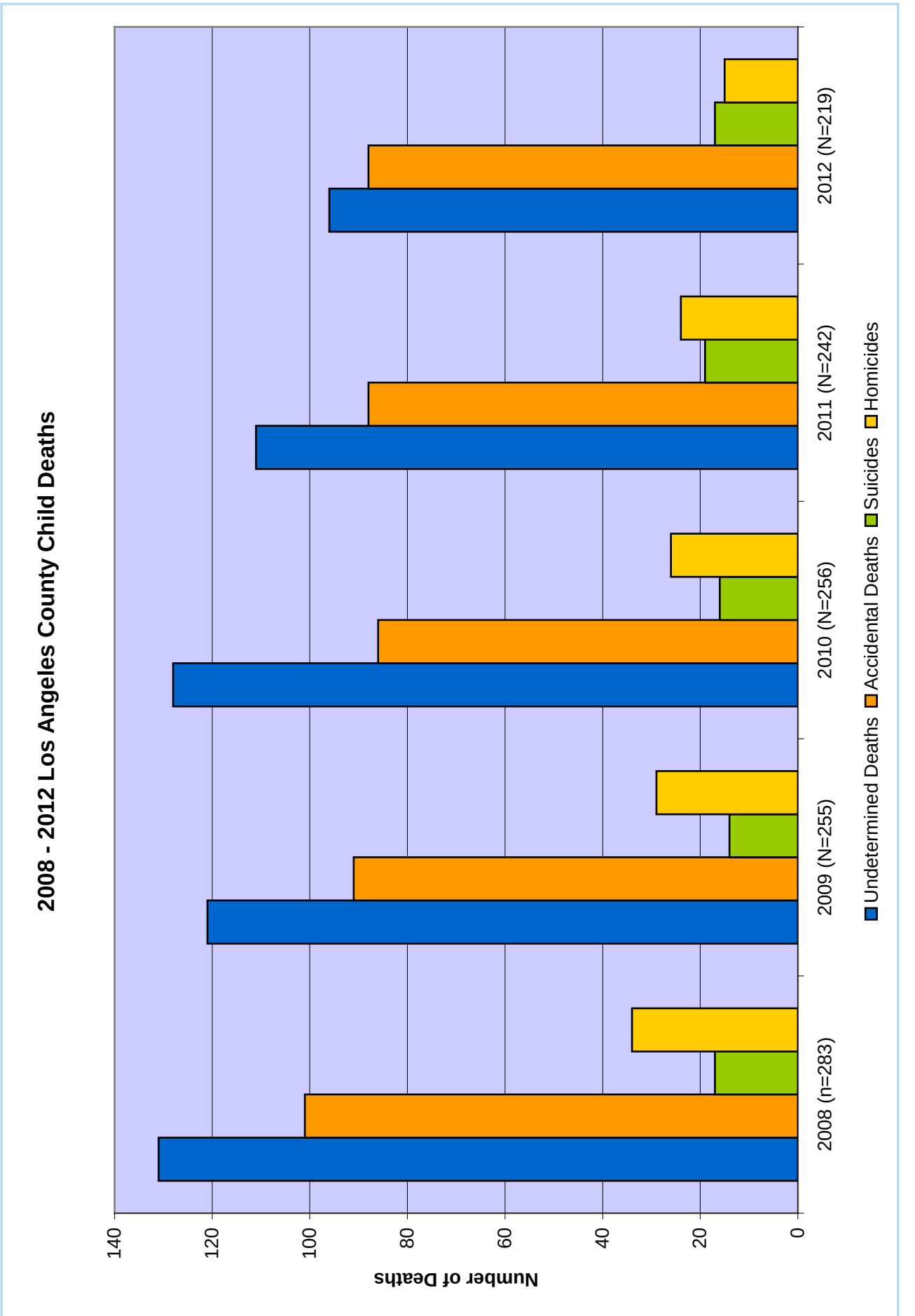
| | |
|---|---|
| 2008 | 101 |
| 2009 | 91 |
| 2010 | 86 |
| 2011 | 88 |
| 2012 | 89 |

The number of undetermined deaths has averaged 117.8 per year over the past five years.

| | |
|---|---|
| 2008 | 131 |
| 2009 | 121 |
| 2010 | 128 |
| 2011 | 111[2] |
| 2012 | 98 |

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.

2. Three Undetermined stillborn child deaths were reported after the release of the 2012 report raising the number from 108 reported to 111 Undetermined Deaths in 2011.


2008 - 2012 Los Angeles County Child Deaths
Number of Deaths
0
20
40
60
80
100
120
140
2008 (n=283)
2009 (N=255)
2010 (N=256)
2011 (N=242)
2012 (N=219)
Undetermined Deaths
Accidental Deaths
Suicides
Homicides

# Child Homicides by Parent, Caregiver, or Other Family Members 2012

## Case Summaries

## Child Homicide by Parent/Caregiver/Family Member

### Anthony

Anthony, age 2 months went into cardiac arrest and was transported to the hospital where he died. The child suffered multiple subdural hemorrhages and bilateral retinal hemorrhages. Bruising was noted on his back and face. Anthony's injuries were consistent with inflicted trauma and shaken baby syndrome. At first his mother stated she found him blue while napping. After questioning from the Coroner Investigator and Detective, the mother admitted to hitting and shaking Anthony on several occasions, including the day of his death. Anthony had a history of poor feeding and was hospitalized two weeks before his death for "gastric reflux".

Anthony's 18 year-old mother and one year old sister went back and forth between the father's and great-maternal grandmother's homes to live. The mother reported being frustrated with the infant's crying and fussiness and his not responding to her interventions. The mother had a history with DCFS as a minor and had an open case for herself at the time of Anthony's death. She is being prosecuted by the District Attorney's Family Violence Division on charges of murder and assault on a child under eight causing death.

### David

Three and a half-year old David reportedly fell off a bunk bed five days before his death. Everyone reported the child as being okay until day of his death. On the night before and morning of his death he complained of stomach pain and was vomiting. His mother and her boyfriend brought him to the hospital as his condition did not improve after treatment with Pedialyte. En route, David went into cardiac arrest and he could not be revived. He passed shortly after his arrival to the ER. He had also suffered a burn in the bathtub on his leg the week before which the mother initially treated at home but took him to the clinic for further treatment at the request of DCFS.

There were eight prior referrals for this family in Los Angeles and another County for emotional abuse, neglect and substance abuse. His mother has a history of alcohol and crystal meth abuse. The children were removed from the mother in 2009 due to her substance abuse. At the time of his removal, David was found to be failure to thrive, anemic and diagnosed with fetal alcohol syndrome. The mother did not cooperate with the case plan or visit her children for several months. David and her other children were returned to her care in April 2011 and the case was open at the time of death.

At autopsy, the David was found to have two healing rib fractures several weeks of age. He died from a single blow to the abdomen which perforated the small intestine. The resultant infection caused the death. The injury would have occurred one to three days prior to the death. The explanation that he hit his head five days earlier from a fall off a bunk bed did not explain the injury.

David's mother did not consistently follow-up on his medical needs, switched doctors/clinics and did not inform providers of his history. DCFS did not appear to closely follow his medical care when returned to the mother. David weighed the same at death as he did when returned to the mother just under one year ago.

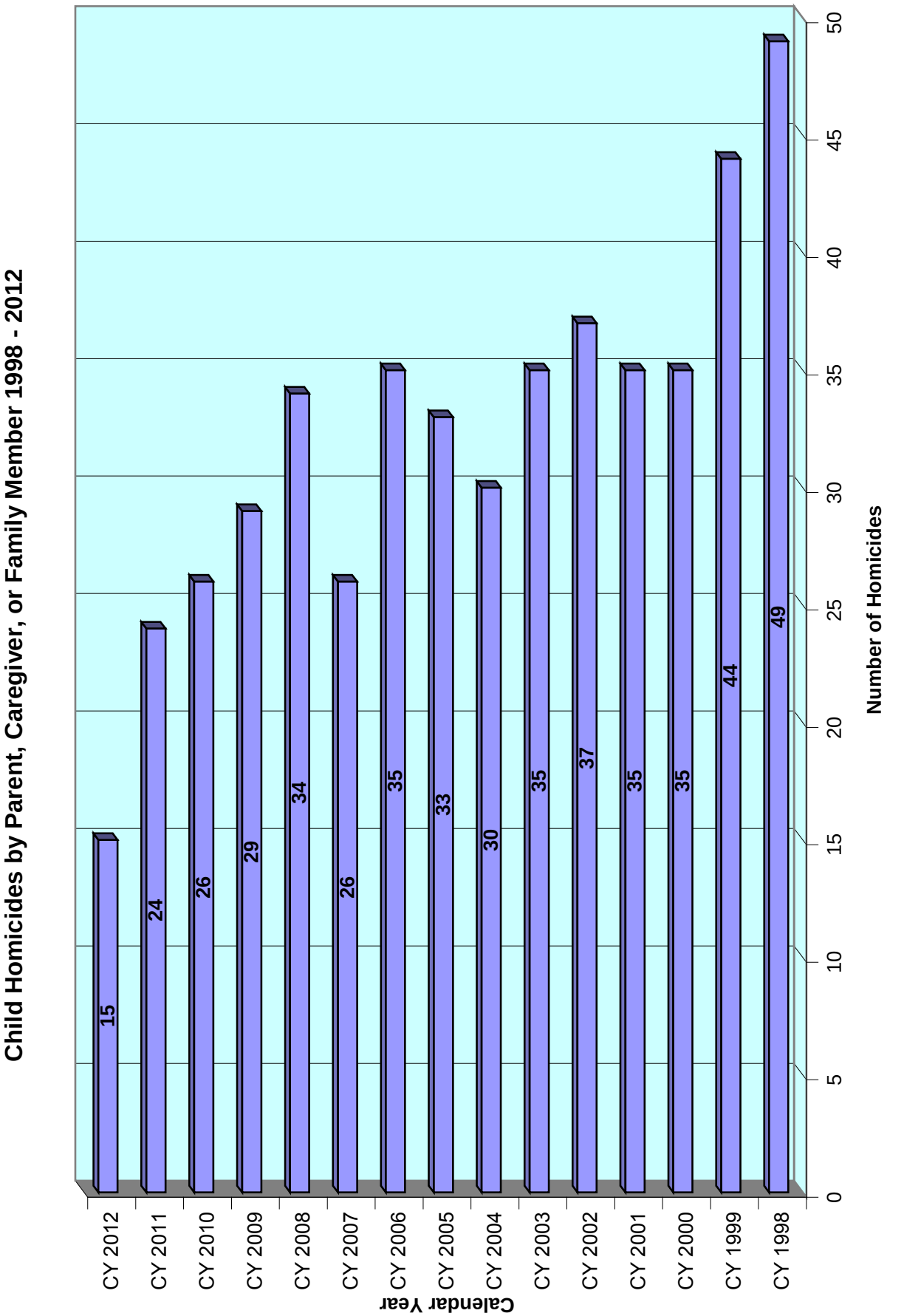
Law enforcement was not aware of the mother's extensive history with DCFS and her substance abuse history. David's siblings reported the stepfather had hit David in the stomach on several occasions. Both the mother and step-father are suspects as David was in their care. They deny any wrong doing and are no longer cooperating with law enforcement. The investigation remains open.

**Jeff**

Seven month-old Jeff resided with his 22 year-old mother, 25 year-old father and two year old sister. On the day of his death, the father was babysitting Jeff and his sister while the mother was at work. 911 was called when Jeff stopped breathing. Paramedics transported him to the hospital where a CT scan revealed two bilateral skull fractures, subdural hemorrhages and retinal hemorrhages. Jeff died a day later. The father gave conflicting stories for the injuries. He said he was holding the baby and his sister when he dropped Jeff from a standing position. He also said the baby was in a car seat, which he fell out of and hit his head.

When confronted, the father later disclosed he became frustrated with Jeff's crying and he shook Jeff, threw him on the floor and hit his head on the floor multiple times. He also admitted to having shaken Jeff on three prior occasions. The Coroner ruled the death a homicide as a result of blunt head trauma.

There was no DCFS history with this family. The father was arrested and charged with murder and child abuse resulting in the death. He remains incarcerated and is awaiting trial.


Child Homicides by Parent, Caregiver, or Family Member 1998 - 2012
Calendar Year
Number of Homicides
CY 2012
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
15
24
26
29
34
26
35
33
30
35
37
35
35
44
49
0
5
10
15
20
25
30
35
40
45
50

## Causes of Child Homicide by Parent/Caregiver/Family Member
## 1998 – 2012, Los Angeles County

| | '98 | '99 | '00 | '01 | '02 | '03 | '04 | '05 | '06 | '07 | '08 | '09 | '10 | '11 | '12 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Head Trauma | 13 | 15 | 5 | 5 | 2 | 7 | 7 | 6 | 11 | 11 | 12 | 8 | 2 | 10 | 5 | **119** |
| Multiple Trauma | 8 | 10 | 11 | 7 | 7 | 10 | 7 | 8 | 7 | 7 | 4 | 2 | 1 | 6 | 2 | **97** |
| Asphyxiation/suffocation | 3 | 6 | 3 | 8 | 5 | 6 | 5 | 5 | 6 | 6 | 3 | 2 | 3 | 2 | 0 | **63** |
| Gunshot Wounds | 10 | 4 | 3 | 2 | 1 | 4 | 3 | 6 | 1 | 1 | 8 | 7 | 4 | 2 | 0 | **56** |
| Trauma to torso/abdomen | 2 | 1 | 0 | 0 | 3 | 0 | 0 | 2 | 1 | 1 | 1 | 1 | 5 | 1 | 2 | **20** |
| Drowning | 2 | 0 | 3 | 1 | 7 | 1 | 1 | 2 | 3 | 3 | 0 | 1 | 2 | 0 | 3 | **29** |
| Fire | 4 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 3 | 3 | 1 | 0 | 0 | 0 | 0 | **12** |
| Stabbing | 2 | 1 | 4 | 1 | 2 | 0 | 3 | 2 | 2 | 2 | 2 | 4 | 6 | 1 | 1 | **33** |
| Unattended newborn | 3 | 4 | 2 | 3 | 2 | 3 | 0 | 2 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | **23** |
| Poisoning/drug ingestion | 0 | 0 | 0 | 3 | 6 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | **12** |
| Dehydration/malnutrition | 1 | 0 | 1 | 1 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | **9** |
| Strangulation | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | **5** |
| Medical neglect | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | **5** |
| Burns | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| Hyperthermia | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | **3** |
| Post-Term Gestation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | **1** |
| **TOTAL** | **49** | **42** | **34** | **34** | **35** | **35** | **29** | **33** | **35** | **35** | **34** | **29** | **26** | **24** | **14** | **454** |

**Child Homicide by Parent/Caregiver/Family Member**
**Los Angeles County – 2012 (N= 15)**

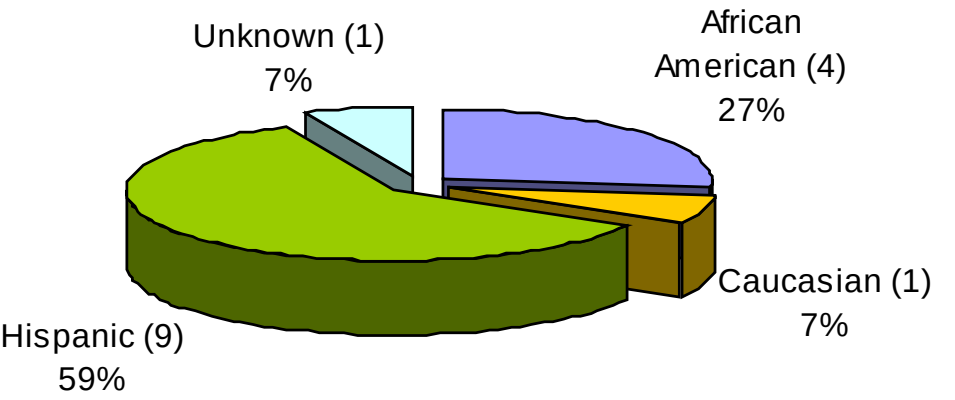
| Age | Female | Male |
|---|---|---|
| Under 1 | 3 | 5 |
| 1 year | 2 | 0 |
| 2 years | 0 | 1 |
| 3 years | 0 | 1 |
| 5 years | 1 | 0 |
| 9 years | 1 | 0 |
| 11 years | 0 | 1 |
| TOTAL | 7 | 8 |

86.7% of the child homicide victims by parents/caregivers/family member were five years of age or under.

73.3% of the child homicide victims by parents/caregivers/family member were two years of age or under.

53.3%% of the child homicide victims by parents/caregivers/family member were under one year of age.

## 2012 Child Homicides - Race

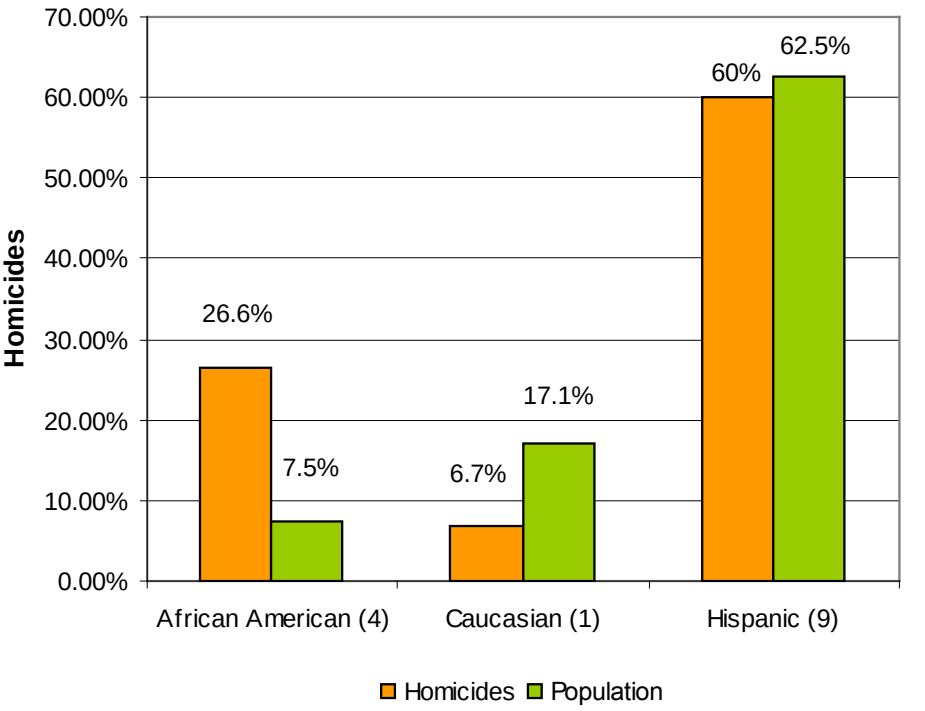



Los Angeles Child Population

Ages 0-17: 2,341,123

Hispanic 62.5%, Caucasian 17.1%, African American 7.5% , Asian/Pacific Islander 9.8%, Native Indian/Alaskan .1% and Multi-racial 3%

## Homicides of Children by Race Compared to Population - 2012



## Relationship of Suspect to Child Homicide Victim – 2012

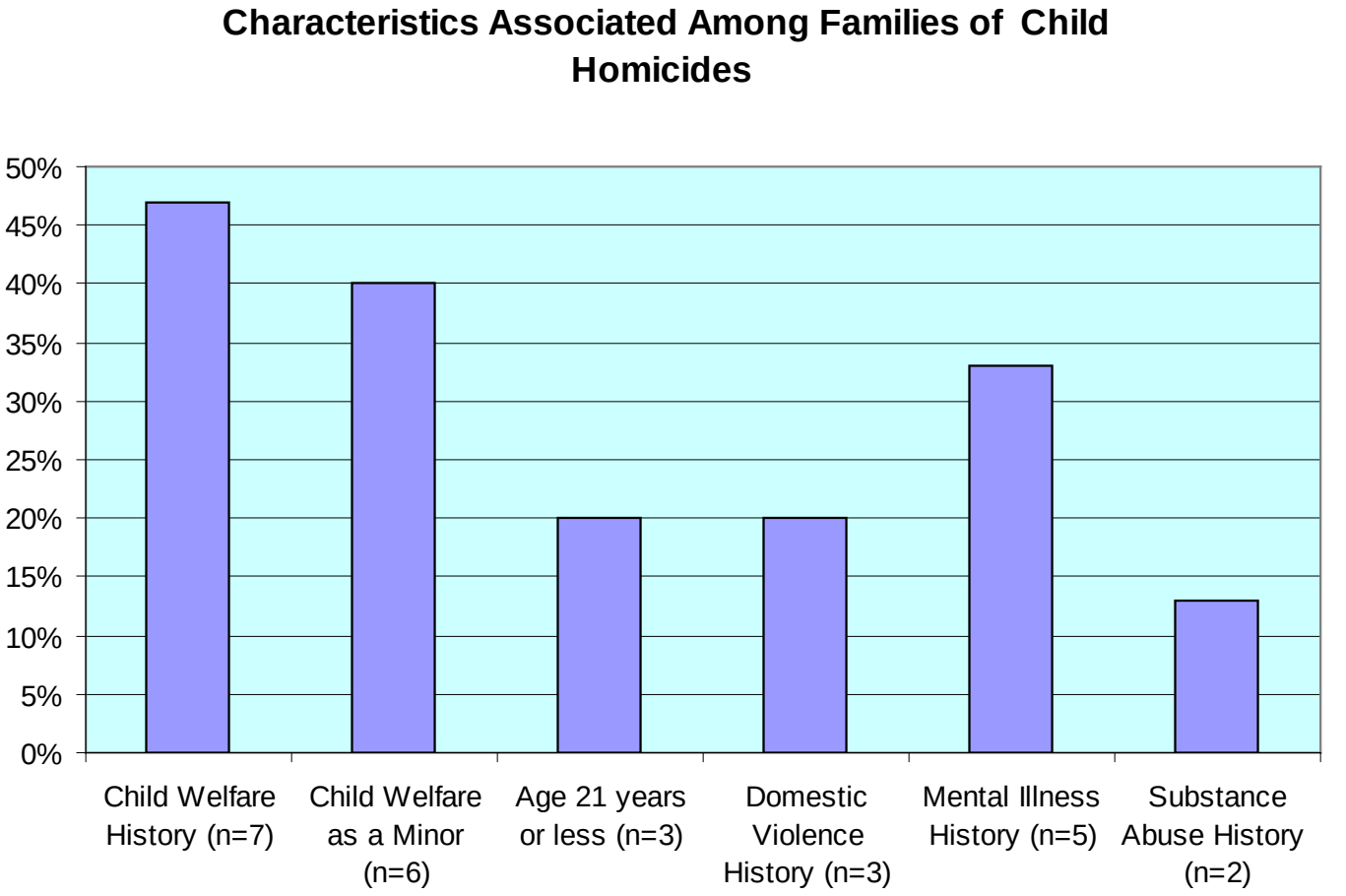
The relationship of the suspect to the child was identified by the Coroner Investigator or Law Enforcement as:

5– Father, Stepfather or mother's boyfriend
5 – Mother
1 – Mother and Boyfriend
2– Caregiver/Sitter
1 – Maternal Grandmother
1– Unknown

## Relationship and Age of Suspect to Child – 2012

| Relationship | Total | <19 Years | 19-21 Years | 22-25 years | 26-30 Years | 31-40 Years | 40+ Years |
|---|---|---|---|---|---|---|---|
| **Biological Father** | 2 | 0 | 1 | 1 | 0 | 0 | 0 |
| **Biological Mother** | 5 | 1 | 0 | 1 | 0 | 3 | 0 |
| **Mother's Boyfriend** | 3 | 0 | 0 | 0 | 1 | 1 | 1 |
| **Stepfather** | 1 | 0 | 0 | 0 | 0 | 1 | 0 |
| **Sitter** | 2 | 0 | 1 | 1 | 0 | 0 | 0 |
| **Maternal Grandmother** | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Unknown** | 2 | | | | | | |
| **Total** | **16** | **1** | **2** | **3** | **1** | **5** | **2** |

**Characteristics Present in the Families of Child Homicides**




The top three common characteristics present in families in which a homicide occurred are the family had at least one prior child welfare contact, a child welfare or probation history as a child, or history of mental illness.

## 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 2012 ICAN Child Homicide by Parent/Caregiver/ Family Member

| Agency | N | % |
|---|---|---|
| **LASD** | 4 | 26.6 |
| **LAPD ACU** | 7 | 46.6 |
| **LAPD** | 1 | 6.7 |
| **Burbank P.D.** | 1 | 6.7 |
| **Covina P.D** | 1 | 6.7 |
| **Long Beach P.D** | 1 | 6.7 |

The Los Angeles Police Department had investigative responsibility for 53% (n=8)) of the 2012 child homicides by parents/caretakers/family member The Los Angeles Sheriff's Department Homicide Bureau had investigative responsibility for 27% (n=4) of the child homicides by parents/caretakers/family member.. The LAPD Abused Child Unit was responsible for all of the LAPD investigations. Twenty-seven percent (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 2012.

There were a total of sixteen suspects in the fifteen homicide cases. Three of the 2012 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 reason for law enforcement not presenting a case was that the perpetrator's identity is unknown. One case remains under investigation and has not been presented to the District Attorney.

**Table 2**

### Law Enforcement Reasons for Not Presenting 2012 ICAN Child Homicide by Parent/ Caregiver/Family Member

| | N | % |
|---|---|---|
| **Perpetrator Unknown** | 2 | 66.7 |
| **Under Investigation** | 1 | 33.3 |
| **TOTAL** | 3 | 100 |

## Table 3

### Criminal Charges Filed on 2004 - 2012 ICAN Child Homicide by Parent/Caregiver/Family Member

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|
| Murder (187 (a) P.C.) | 32 | 20 | 21 | 20 | 13 | 16 | 13 | 11 |
| Assault on a child under 8 years resulting in death (273ab P.C.) | 20 | 15 | 17 | 16 | 11 | 7 | 14 | 8 |
| Child abuse leading to death of a child (273a(a) P.C.) | 34 | 11 | 28 | 19 | 5 | 10 | 8 | 4 |
| Child endangering (273a(1) P.C.) | 1 | | | | | | | |
| Corporal punishment or injury of child (273d P.C.) | | | 1 | | | | | |
| Voluntary manslaughter (192a P.C.) | 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.) | | | | | | | | |
| Attempted murder (664/187 (a) P.C.) | 1 | | 1 | 12 | | 3 | | |
| Attempted robbery of person (664/211 P.C.) | 1 | | | | | | | |
| Lewd and lascivious acts by force (288(b)(1) P.C.) | | | | | | | | 5 |
| Sexual penetration with unconscious victim (289(d)(a) P.C.) | | | | | | | | |
| Public exposure of private parts (314(1) P.C.) | 1 | | | | | | | |
| Kidnapping (207a P.C.) | | | 2 | | | | | |
| Unlawful detention (278 P.C.) | | | | | | | | |
| 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.) | 1 | | 1 | | 3 | 1 | | 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.) | | | | | | | | |
| Assault with semiautomatic weapon (245 (b) P.C.) | | | | | | | | |
| 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.) | | | | | | | | |
| 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 2012, 12 of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving 12 perpetrators.

Of the 12 cases, two were declined due to insufficient evidence. In both cases declined by the District Attorney, the mother was the suspected perpetrator.

The charges filed by the District Attorney in the past eight years are illustrated by Table 3. The District Attorney filed criminal charges on 83.3% (n=10) of the 12 homicide cases presented to them by law enforcement in 2012. Charges were filed against 9 perpetrators involved in the ten cases. The most frequent charge in 2011 was murder followed by child abuse. With the exception of one perpetrator, 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 - 2012 ICAN Child Homicide by Parent/Caregiver/Family Member

| Relationship | ID'd by Police | Charged By DA |
|---|---|---|
| **Mother** | 5 | 3 |
| **Father** | 2 | 2 |
| **Step father/Mother's Boyfriend** | 2 | 2 |
| **Sitter** | 2 | 2 |
| **Maternal Grandmother** | 1 | 1 |

One of the mother's charged in 2012 was responsible for the deaths of her two children and she was charged for both homicides.

## Table 5

### Criminal Case Disposition of 2004 - 2012 ICAN Child Homicides by Parent/Caretaker/ Family Member[3]

| | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|
| Life without possibility of parole | 1 | 1 | 1 | | 1 | | 2 | 2 | 1 |
| 80 years to life prison | | | | | | | 1 | 1 | |
| 56 years to life prison | | | | | | | | | 1 |
| 50 years to life prison | 1 | 2 | 1 | | | 1 | 1 | 1 | 1 |
| 40 years to life prison | | | | | | 1 | | | 1 |
| 26 years to life prison | 2 | | 2 | | | | | | |
| 25 years to life prison | 1 | 1 | 1 | 6 | 8 | 2 | 7 | 4 | 2 |
| 20 years to life prison | | | | | | | | | |
| 19 years to life prison | | | | | | 1 | | 1 | |
| 18 years to life prison | | | | | | | | | 1 |
| 17 years to life prison | | | | | | 2 | | 1 | 1 |
| 16 years to life prison | | 1 | | | | | 1 | 2 | |
| 15 years to life prison | 2 | 1 | 2 | 2 | 1 | 3 | 1 | | 2 |
| 13 years prison | | | | | | 1 | | | 1 |
| 12 years prison | | | 1 | 1 | 4 | 1 | 1 | 1 | |
| 11 years prison | 1 | 1 | 2 | 3 | 4 | 1 | 2 | 1 | 2 |
| 10 years prison | 1 | 1 | 2 | 2 | | 1 | 1 | 1 | 1 |
| 9 years prison | | 1 | 1 | | | | | | 2 |
| 8 years prison | 1 | 1 | 4 | | | | 1 | | |
| 7 years prison | | | | | | | | | 1 |
| 6 years prison | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 2 | 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 | 1 |
| 9 months jail | | | 1 | | | | | | |
| 6 months jail | | 1 | | | | | | | |
| Less than 3 months jail | 1 | 1 | 2 | | | 1 | | | |
| 6 yrs Probation | | | | | | | | | |
| 5 yrs Probation | 2 | 1 | 1 | | 2 | | | | |
| 3 yrs Probation | 2 | 3 | | | | | | | |
| Found not guilty | 1 | | | | | | | 1 | |
| Dismissed | | 3 | 3 | | | | 1 | | 1 |
| Arrest warrant | 2 | | | | | 1 | | | 1 |
| Mental competency hearing | | 1 | | 1 | 1 | 1 | | | 2 |
| Sentence pending | | | | 1 | 1 | 1 | | | |
| Pending trial | 0 | 0 | 0 | 0 | 1 | 3 | 6 | 11 | 31 |
| Pending Further Investigation | 2 | | | | | 2 | 0 | | |
| Total C/A Homicides for year | 30 | 33 | 35 | 26 | 34 | 29 | 26 | 24 | 15 |

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

Criminal disposition data for 2004 through 2012 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 2012 child homicides, none of those charged had a disposition in 2012.

In 2012, defendants received the following sentences from previous year's cases: two perpetrators were sentenced to 25 years to life in prison; two each were sentenced to 15 years, 11 years, 9 years and 6 years. One perpetrator was sentenced to life without the possibility of parole, one to 56 years to life, one received 50 years to life, and one 40 years. The remaining sentences varied from 10 to 19 years in prison. One perpetrator had their case dismissed and one received 160 months in county jail.

There are no cases pending from 2006 but one defendant whose case was filed in 2006 was sentenced in 2012 to 15 years of state prison. Of the cases from 2007, none remain pending trial. There were three convictions of 2007 cases in 2012. One defendant received a 40 year sentence, another 15 years and the third, 6 years. Only one case remains pending trial in 2012 for the 2008 cases filed by the DA. For 2009, three cases are still pending trial. Four 2009 defendants were sentenced in 2012. Two were sentenced to 11 years in state prison, one to 13 years and one to 6 years. There are six cases pending trial from the 2010 cases filed and one arrest warrant still in effect. Seven 2010 defendants were sentenced in 2012 receiving sentences ranging from 160 months in county jail to 25 years to life in state prison. One defendant had his case dismissed. Eleven of the 2011 cases filed by the DA remain pending trial as of 2012. There were seven convictions of 2011 cased in 2012. The longest sentence was for 56 years to life in state prison and the shortest sentence was for 7 years.

The most frequent sentence received in 2007 (n=6), 2008 (n=8), 2010 (n=7), 2011 (n=4) and 2012 (n=2) was 25 years to life in prison. As of 2012, the next most frequent range of sentencing for perpetrators from 2004 to 2011 was 6 to 25 years in prison.

## 2012 Child Homicides by Parents, Caregivers or Family Member
## Child Welfare Involvement 2000 – 2012*

| 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<br>0 – foster parent |
| **2001** | 35 | 12 | 7 | 5 | 3 – relative caregivers<br>2 – foster parent |
| **2002** | 37 | Not Available | Not Available | Not Available | 0 – relative caregivers<br>1 – foster parent |
| **2003** | 35 | 18 | 13 | 5 | 2 – relative caregivers<br>2 – foster parent |
| **2004** | 30 | 15 | 9 | 6 | 2 – relative caregivers<br>0 – foster parent |
| **2005** | 33 | 14 | 11 | 3 | 1– relative caregivers<br>0 – foster parent |
| **2006** | 35[4] | 11 | 9 | 2 | 1– relative caregivers<br>0 – foster parent |
| **2007** | 26 | 12 | 10 | 3[5] | 1 – relative caregivers<br>0 – foster parent |
| **2008** | 34 | 14[6] | 6 | 8 | 0 – relative caregivers<br>0 – foster parent |
| **2009** | 29[7] | 19[8] | 14 | 5[9] | 1 – relative caregivers<br>0 – foster parent |
| **2010** | 26 | 13[10] | 9 | 4 | 0– relative caregivers<br>1 – foster parent |
| **2011** | 24 | 6 | 2 | 4 | 0 – relative caregivers<br>0 – foster parent |
| **2012** | 15 | 7 | 4 | 3[11] | 0 – relative caregivers<br>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

4. 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.
5. One was open to another county.
6. 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.
7. 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.
8. Includes two deaths with a CPS history in another state and one death with history in another county.
9. One child died in LA County was under the jurisdiction of Riverside CPS.
10. One child died in LA County had history in another county but not in LA County.
11. One child was killed by a caregiver who had an open case with DCFS.

## 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.

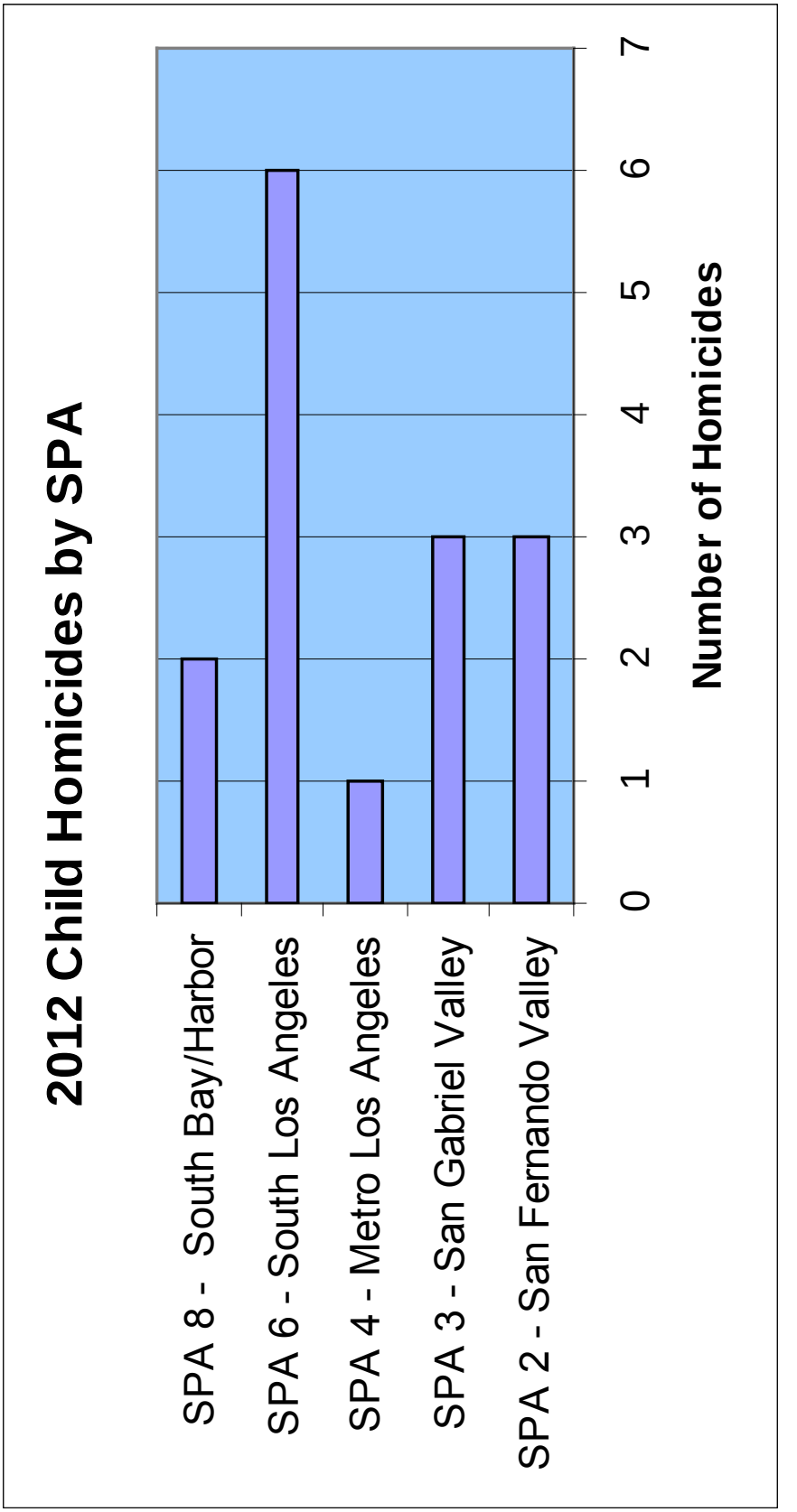
## Dates[12] of Child Homicides – 2012

0 homicides occurred in January
3 homicides occurred in February (2/03, 02/15 & 02/19/2012)
1 homicide occurred in March (3/27/2012)
1 homicide occurred in April (4/28/2012)
1 homicide occurred in May
1 homicide occurred in June (6/01/2012)
0 homicides occurred in July
3 homicides occurred in August (8/01, 8/05 and 8/21/2012)
0 homicides occurred in September
2 homicides occurred in October (10/04 and 10/24/2012)
2 homicides occurred in November (11/09 & 11/12/2012)
1 homicide occurred in December (12/10/2012)

## Locations[13] of Child Homicides – Geographic Area – 2012

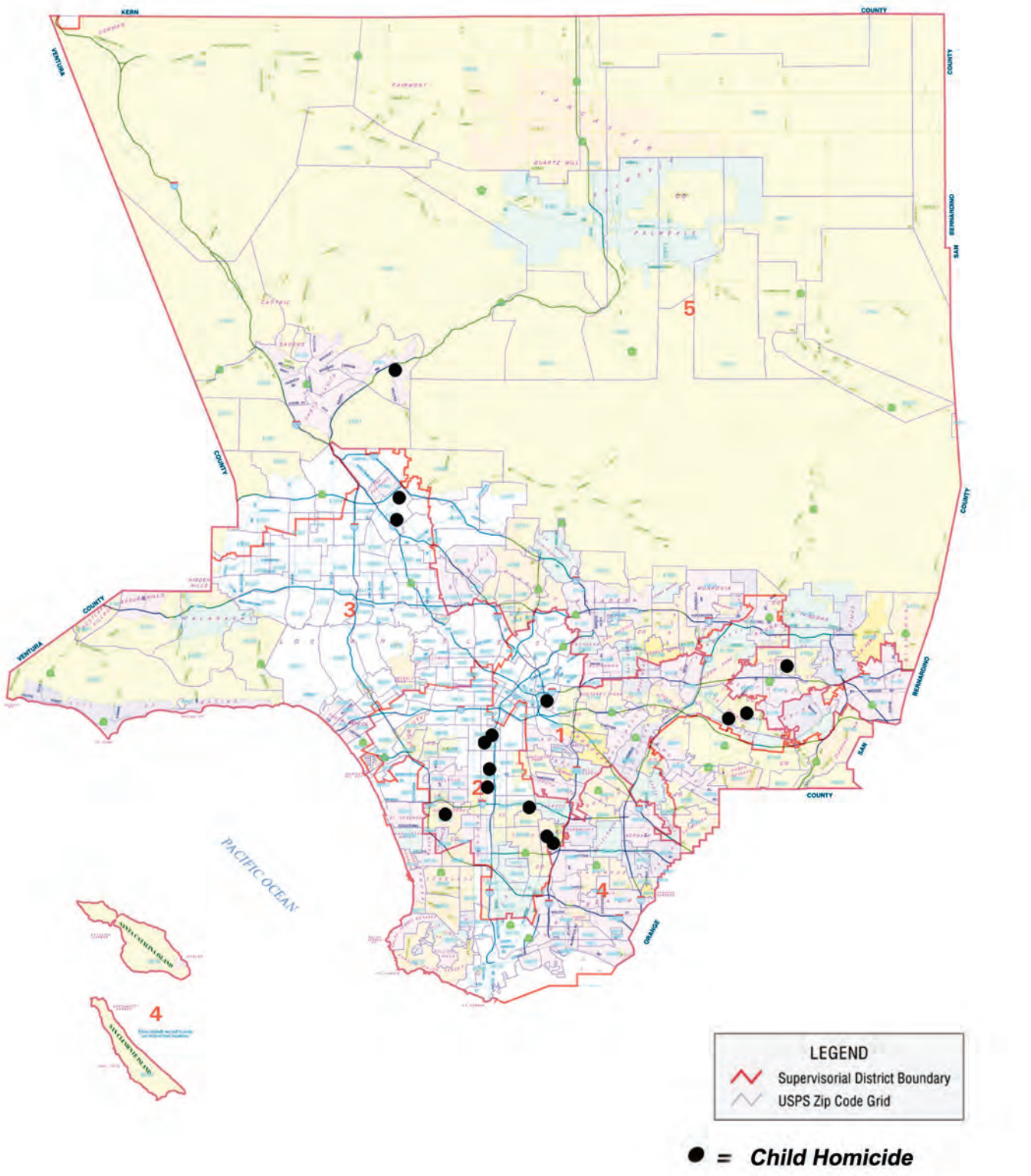
1 homicide occurred in Burbank (zip code 91331)
1 homicide occurred in Canyon Country (zip code 91387)
1 homicide occurred in City of Industry (zip code 91716)
1 homicide occurred in Compton (zip code 90221)
1 homicide occurred in Compton (zip code 90222)
1 homicide occurred in Covina (zip code 91723)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in La Puente (zip code 91744)
1 homicide occurred in Long Beach (zip code 90816)
1 homicide occurred in Los Angeles (zip code 90033)
2 homicides occurred in Los Angeles (zip code 90037)
2 homicides occurred in Los Angeles (zip code 90044)
1 homicide occurred in Pacoima (zip code 91331)

12. 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.
13. City where the fatal injury or fatality occurred


2012 Child Homicides by SPA
SPA 8 - South Bay/Harbor
SPA 6 - South Los Angeles
SPA 4 - Metro Los Angeles
SPA 3 - San Gabriel Valley
SPA 2 - San Fernando Valley
0
1
2
3
4
5
6
7
Number of Homicides

# 2012 Child Homicides

**N = 15**



## Case Summaries

### Anthony

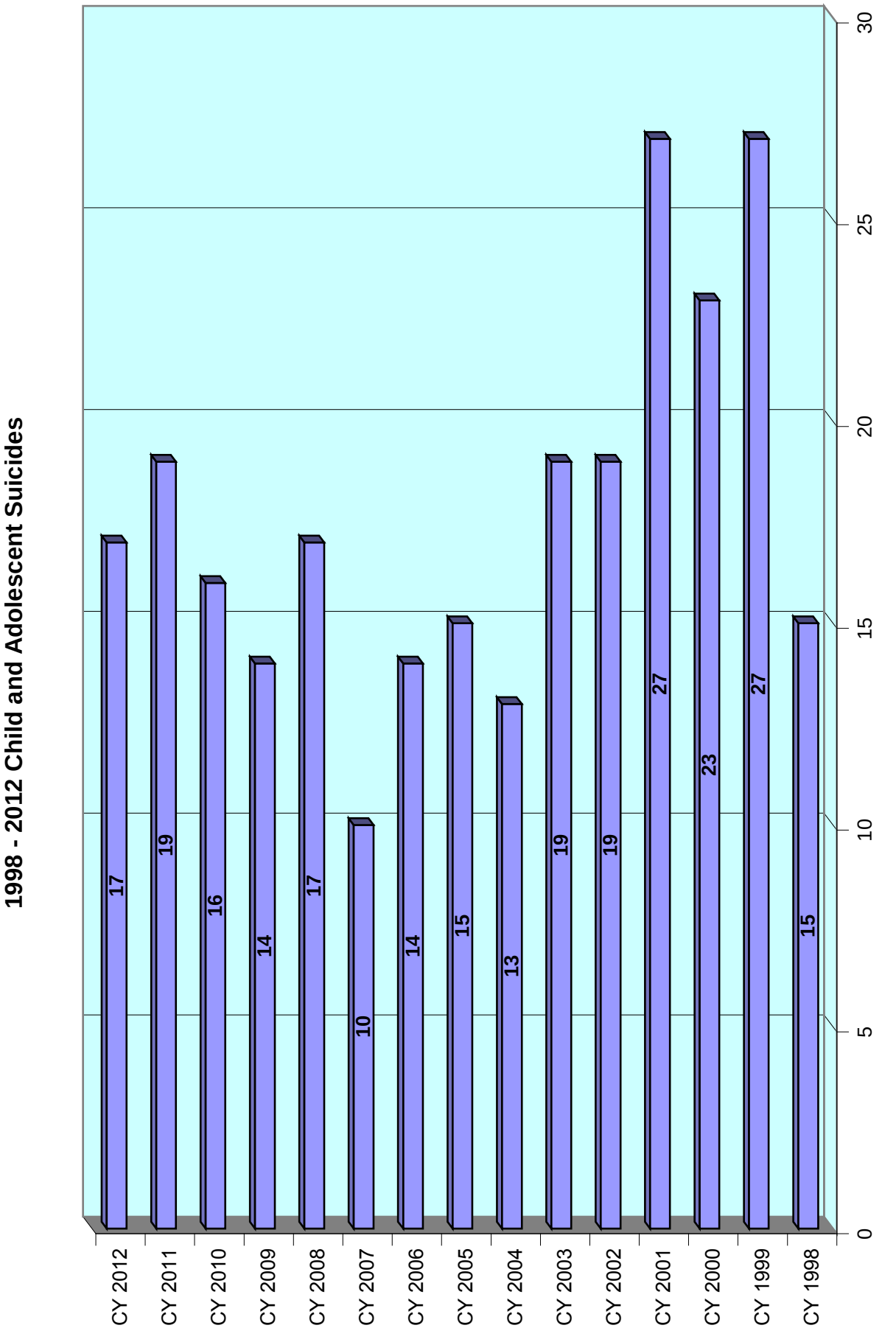
Anthony, a 14-year old, Hispanic male, was found hanging from a belt attached to a towel rack in the family bathroom. He had average grades and was an avid soccer player. Anthony, however, had a secret that he shared with only a few people. A school security officer reported that Anthony recently "confessed" he was confused and upset because he was physically attracted to other boys on the soccer team. She said that Anthony was ashamed of those feelings. When the security officer suggested that he talk with a counselor, he told her that he would work this out himself. Confused about his attraction to boys, the young man broke up with his girlfriend several weeks earlier. Anthony kept his "secret" from his girlfriend, his peers and his family. His family and friends reported they were blind-sided by his death. He had no history of suicide attempts or ideation and was not depressed. He did not drink or use drugs. His suicide came as a terrible shock to his family and friends,

### Brenda

Brenda was a 15-year-old Caucasian female with a history of depression and had thoughts about suicide 3 months prior to her death. She attempted suicide one month prior to the time of the fatal injury and was hospitalized for 72 hours. On the night before her death, she delivered gifts to a girlfriend and shortly thereafter Brenda 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. Brenda suffered from depression and she was being treated with medication and outpatient psychotherapy. At the age of twelve, Brenda and her sister were alleged to have been physically abused by their mother but upon investigation the charges were unfounded and the referral was closed.

### Susana

Susana was a 17-year-old Hispanic female with a history of depression. She was hospitalized for a second suicide attempt three years ago after taking an overdose of prescription medication. Her parents divorced about that time because her mother was convicted of the physical abuse her younger sister. Since Susanna and her sister were in the custody of her father, the family moved frequently. She was often truant from school and few friends. Although she had one close boyfriend, he died suddenly last month (suicide was suspected). Two months ago, her father decided to remove her from public school. He enrolled Susanna in Cyber Learning Academy where she would be able to complete her high school requirements at home because Suzanna was too "depressed" to go to school. When Susanna's sister returned from school one afternoon, she discovered Susanna hanging from the ceiling of her bedroom. Although Susanna was tearful and withdrawn since the death of her boyfriend, she had not threatened suicide and no suicide note was found.


1998 - 2012 Child and Adolescent Suicides
CY 2012
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
17
19
16
14
17
10
14
15
13
19
19
27
23
27
15
0
5
10
15
20
25
30

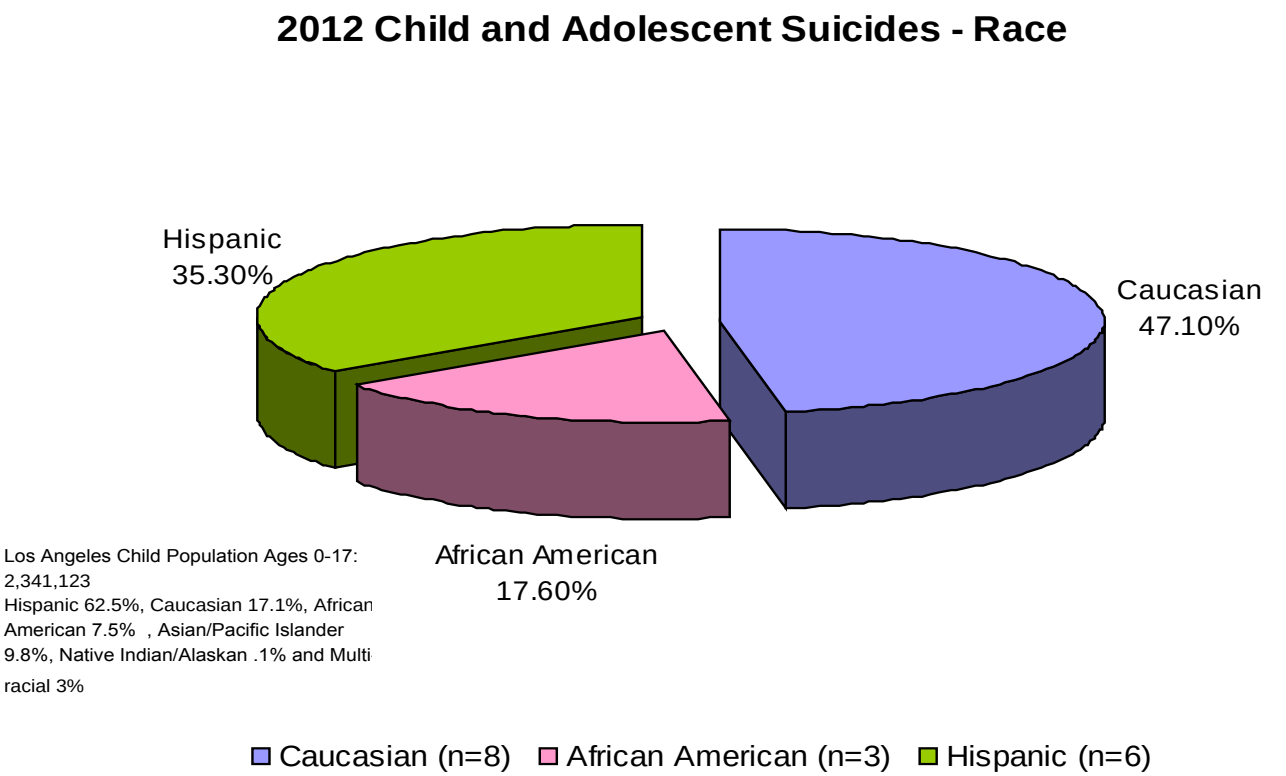
**Child and Adolescent Suicides by Method and Gender**
**Los Angeles County – 2012 (n = 17)**

| Method | Male | Female |
|---|---|---|
| **Hanging** | 4 | 6 |
| **Firearms/Gunshot** | 2 | 0 |
| **Overdose** | 1 | 2 |
| **Jump** | 1 | 0 |
| **Auto/Train vs. Ped** | 0 | 1 |
| **TOTAL** | **8** | **9** |

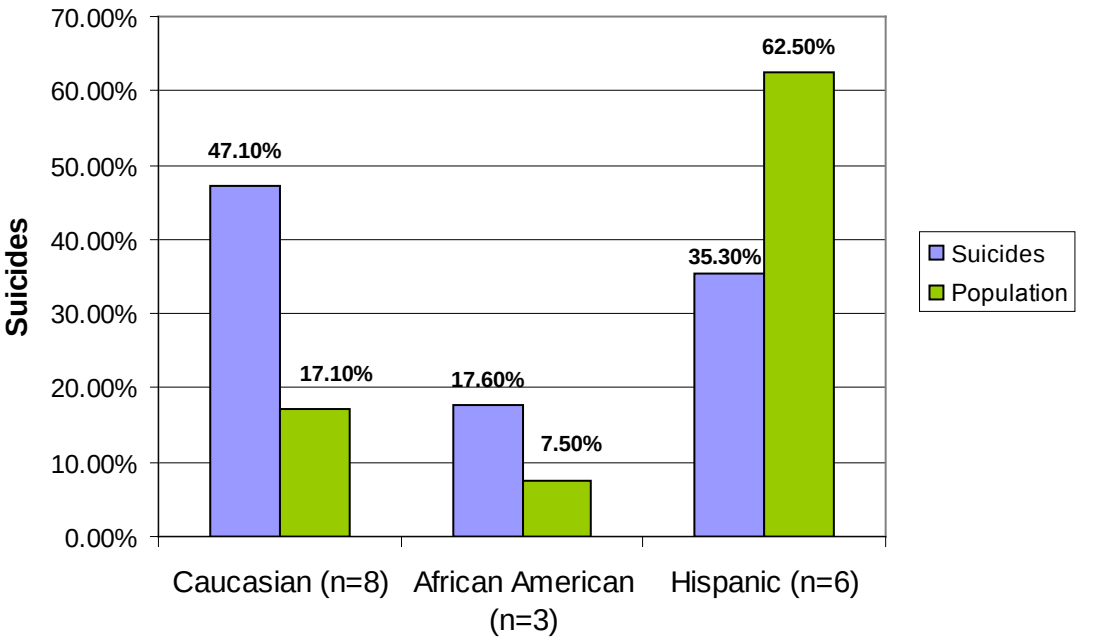
Hanging was the most frequent method of suicide among adolescents and represents 58.82% of the suicides in 2012. An overdose was the second most frequent method of suicide in 2012.

In 2012, 53% (n=9) of the adolescent suicide victims were female. 47% (n=8) of the victims of adolescent suicide in 2012 were male.

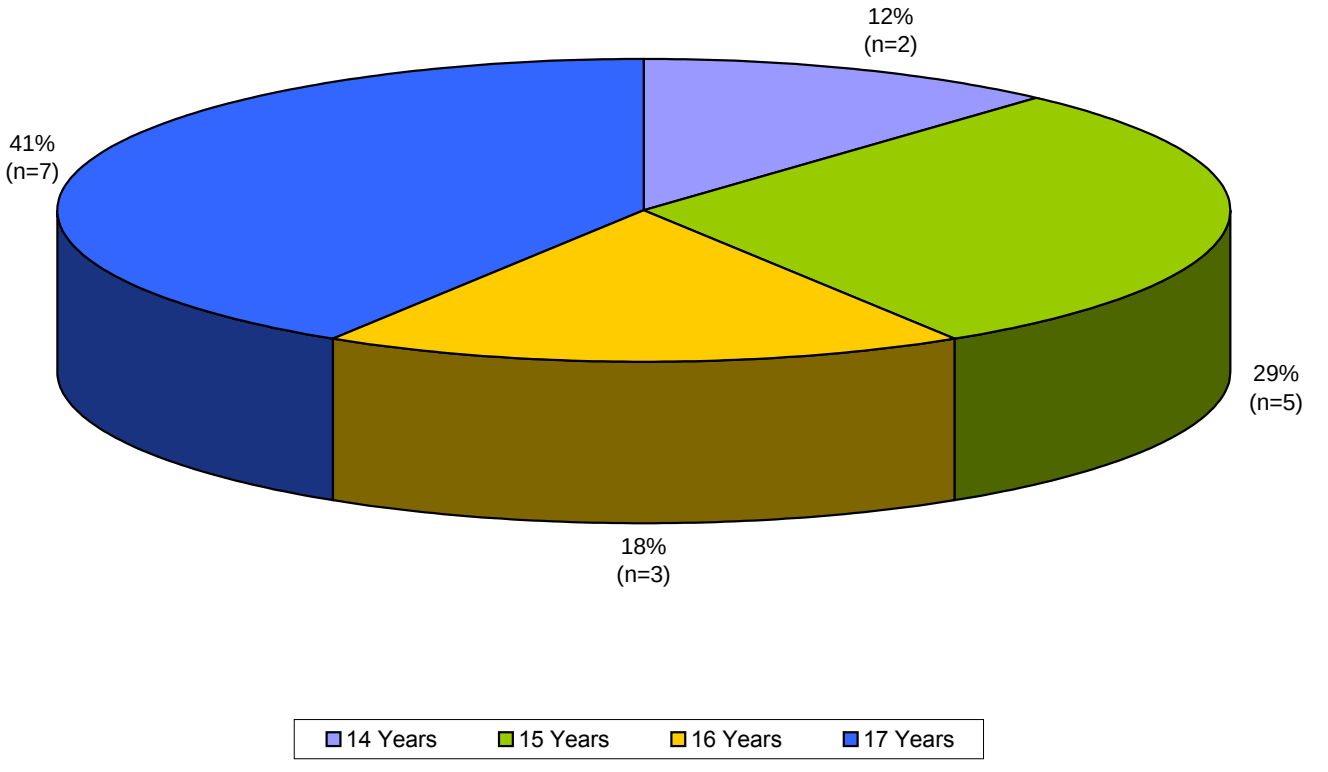
2012 is the first year female victims outnumber male victims of suicide.

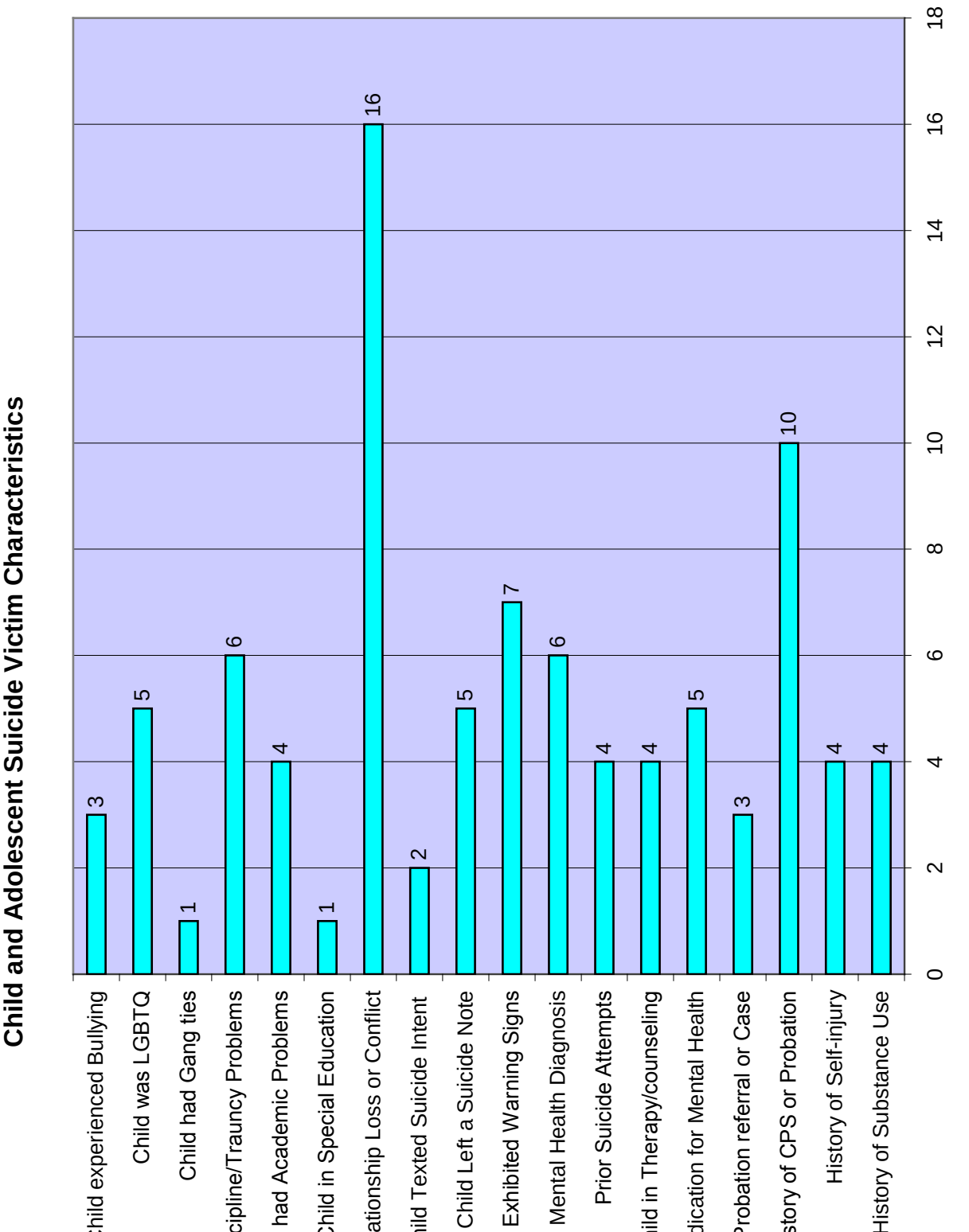


**Suicides of Children by Race Compared to Population - 2012**




**2012 Child and Adolescent Sucides - Age**




Child and Adolescent Suicide Victim Characteristics
Child experienced Bullying
Child was LGBTQ
Child had Gang ties
Child had School Discipline/Traucny 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
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 referral or Case
Family History of CPS or Probation
History of Self-injury
History of Substance Use
3
5
1
6
4
1
16
2
5
7
6
4
4
5
3
10
4
4
0
2
4
6
8
10
12
14
16
18

## Dates of Child and Adolescent Suicides – 2012

0 suicides occurred in January
1 suicide occurred in February (02/10/12)
1 suicide occurred in March (03/06/2012)
3 suicides occurred in April (04/11, 04/13 and 04/30/2012)
0 suicides occurred in May
0 suicides occurred in June
2 suicides occurred in July (07/10 and 07/11/2012)
2 suicides occurred in August (08/03 & 08/25/2012)
3 suicides occurred in September (09/06, 09/12 & 09/22/2012)
3 suicides occurred in October two on (10/18, 10/24 and 10/29/2012)
2 suicides occurred in November (11/08 and 11/22/12)
0 suicides occurred in December

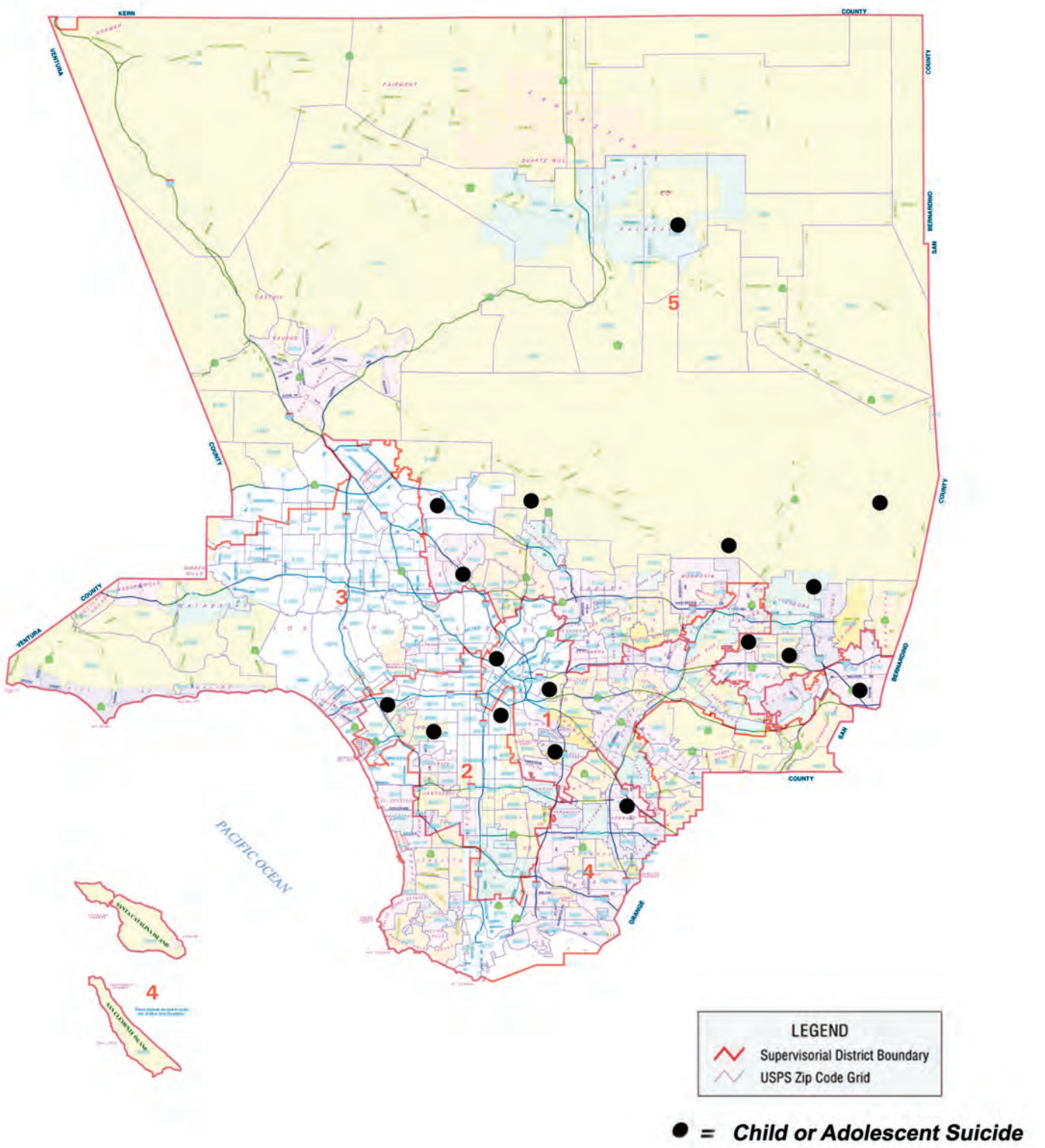
## Locations[14] of Child and Adolescent Suicides – Geographic Area – 2012

1 suicide occurred in Los Angeles (zip code 90011)
1 suicide occurred in Los Angeles (zip code 90026)
1 suicide occurred in Los Angeles (zip code 90034)
1 suicide occurred in Los Angeles (zip code 90043)
1 suicide occurred in Los Angeles (zip code 90063)
1 suicide occurred in Bell Gardens (zip code 90201)
1 suicide occurred in Norwalk (zip code 90650)
1 suicide occurred in Cerritos (zip code 91703)
1 suicide occurred in Monrovia (zip code 91016)
1 suicide occurred in Shadow Hills (zip code 91040)
1 suicide occurred in La Crescenta (zip code 91214)
1 suicide occurred in Burbank (zip code 91502)
1 suicide occurred in Covina (zip code 91722)
1 suicide occurred in Covina (zip code 91724)
1 suicide occurred in La Verne (zip code 91750)
1 suicide occurred in Pomona (zip code 91766)
1 suicide occurred in Palmdale (zip code 93552)

14. City where the suicide occurred.

## 2012 Adolescent and Child Suicides

**N = 17**



## Case Summaries

### Jorge and Damian

Jorge, age 14 years and Damian, age 17 years were both crossing railroad tracks on separate occasions and were struck and killed by a train. Jorge was hit by a MTA train and Damian, by a Metrolink train.

Both boys were wearing earbuds and despite the train engineers' sounding the train horn and flashing the lights, neither youth seemed to be aware of the approaching train. Death was pronounced at the scene. One youth was crossing the tracks as a short cut and the other was at a designated crossing not cognizant of the down crossing arms with flashing lights and bells.

Pedestrians being hit by trains in Los Angeles County have been on the rise in recent years. Sadly for these youth, their death may have been prevented if they were not distracted by their cell phones.

### Iris

Twenty-nine year old Iris presented to the ER in labor. She had no prenatal care and stated she did not know she was pregnant. Her baby boy was stillborn at 27 weeks weighing less than 3 pounds. Iris tested positive for marijuana and methamphetamines and has a long history of drug use. Iris admitted to smoking medical marijuana due to pain from a back injury but denied using methamphetamines.

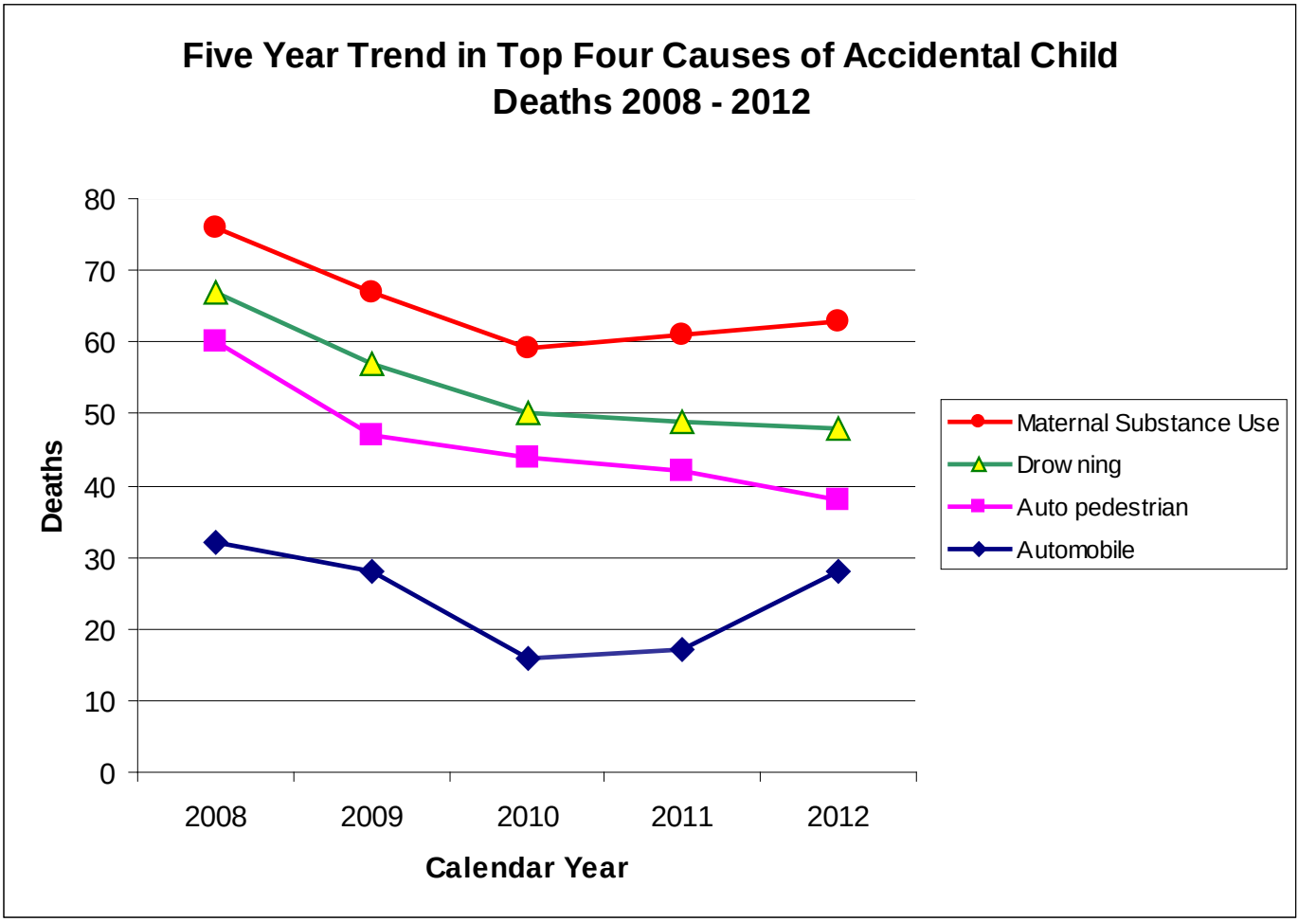
The hospital made a referral to the DCFS hotline, but the referral was "evaluated out" as there were no other children in the mother's care. The mother had a history with DCFS both as a parent and as a minor. She lost custody or her other child, now 8 years of age over a year ago and this child was adopted.

### Elizabeth

2-year old Elizabeth and her family had just returned home from a weekend trip to her grandparents. The family was going in and out of the open front door unpacking from the trip. Elizabeth's mother went into the kitchen and let the family dog out into the back yard and returned to unpacking food items in the kitchen. At one point, Elizabeth was playing in the front yard on her tricycle with her dad and eleven year old brother.

About ten minutes later, her mother noticed the kitchen sliding door to the backyard was half-way open and she went to close it. Out of the corner of her eye, she saw Elizabeth floating face down in the deep end of the pool. She ran screaming for the father to call 911 and started CPR on Elizabeth. When paramedics and police arrived they noted there was no fence around the pool. Elizabeth was transported to the hospital where she later died.

The parents reported that each thought the other had an eye on Elizabeth. There was an alarm on the sliding glass door but it had never worked since the family moved into the home. Elizabeth knew not to go into the pool unless family was present. Elizabeth loved to swim and when she wanted to swim, she would bring her purple floaties to her parents to put on her. She could not unlatch the sliding door and neither parent had seen her push it open on her own. Her father speculated that while trying to go around a chair between a post and the pool, she must have fallen into the pool. No one heard her scream or splash.




The chart above depicts the top four causes of accidental child death over a five year period from 2008 to 2012. The "top four" causes-automobile, auto pedestrian, drowning and maternal substance use accounted for 70.8% of all accidental child deaths in 2012. While drowning and auto pedestrian deaths appear to be on a downward trend, there has been a an upward trend in Automobile and maternal substance abuse accidental deaths.

## Causes of Accidental Child Deaths, Ages 0 – 17
## 2012– Los Angeles County (N = 89)

| | | |
|---|---|---|
| Automobile – multi-vehicle | 17 | 19.1% |
| Automobile – solo vehicle | 11 | 12.36% |
| Auto pedestrian | 10 | 11.24% |
| Drowning | 10 | 11.24% |
| Hit by an Object | 3 | 3.37% |
| Overdose | 5 | 5.62% |
| Maternal drug use | 15 | 16.85% |
| Fire | 1 | 1.12% |
| Medical mishaps | 2 | 4.5% |
| Fall | 2 | 2.25% |
| Choking | 3 | 3.37% |
| Suffocation | 2 | 2.25% |
| Train vs. Pedestrian | 4 | 4.5% |
| Electrocution | 1 | 1.12% |
| Kicked by horse | 1 | 1.12% |
| Solo bike – no helmet | 1 | 1.12% |
| Sport injury | 1 | 1.12% |
| **TOTAL** | **89** | **100%** |

## Causes of Accidental Child Deaths by Age
## 2012 – Los Angeles County (N = 89)

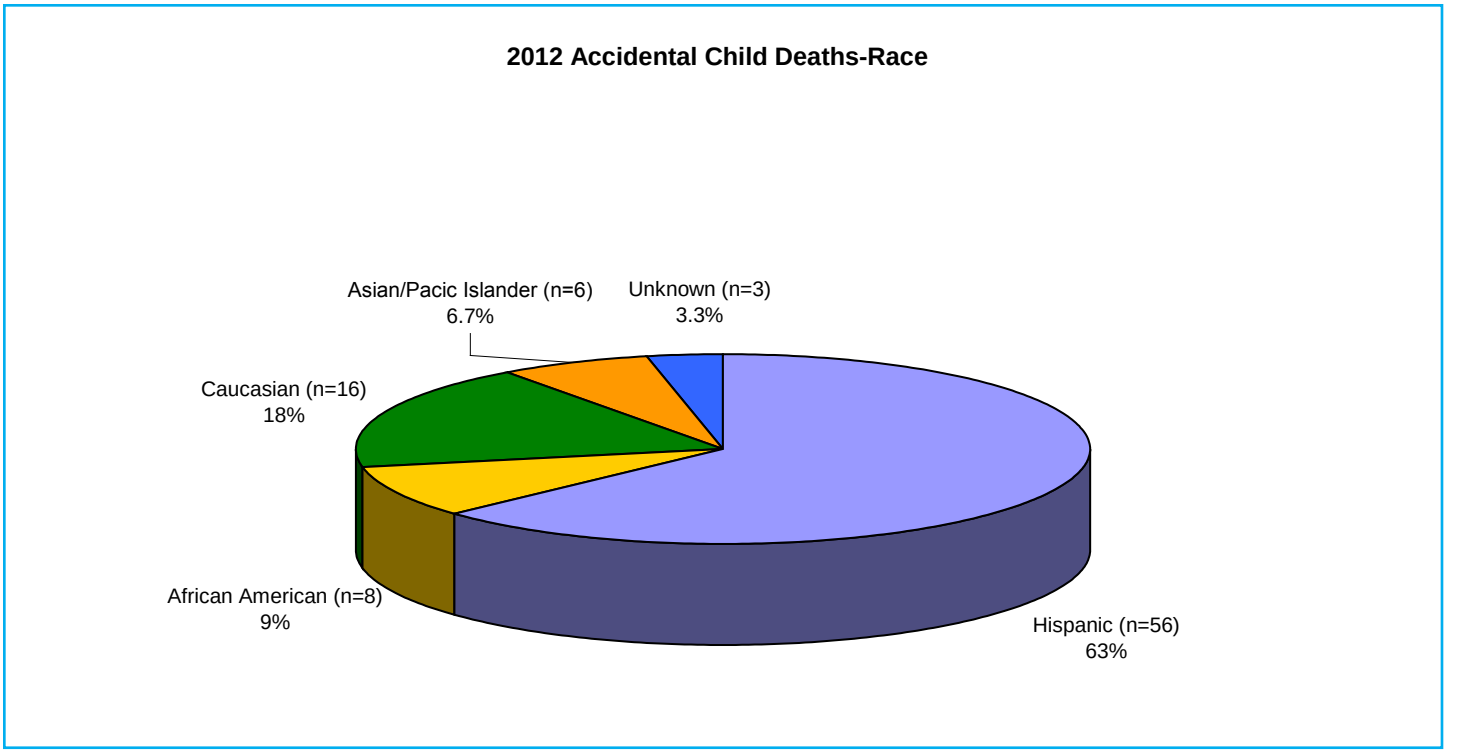
| | Age 0 – 5 years | Age 6 – 14 years | Age 15 – 17 years |
|---|---|---|---|
| Automobile – multi-vehicle | 9 | 5 | 3 |
| Automobile – solo vehicle | 3 | 4 | 4 |
| Auto pedestrian | 4 | 2 | 4 |
| Hit by Object | 3 | 0 | 0 |
| Drowning | 5 | 4 | 1 |
| Overdose | 1 | 0 | 4 |
| Fall | 0 | 1 | 1 |
| Fire | 0 | 1 | 0 |
| Maternal drug use | 15 | 0 | 0 |
| Medical mishaps | 1 | 1 | 0 |
| Choking | 3 | 0 | 0 |
| Suffocation | 1 | 1 | 0 |
| Train vs. pedestrian | 0 | 1 | 3 |
| Electrocution | 1 | 0 | 0 |
| Kicked by horse | 0 | 1 | 0 |
| Solo bike – no helmet | 0 | 1 | 0 |
| Sport injury | 0 | 0 | 1 |
| **TOTAL** | **46** | **22** | **21** |

**Race of Accidental Child Deaths, Ages 0 – 17**
**Los Angeles County – 2012 (N = 89)**

| | Hispanic | African-American | Caucasian | Asian/Pacific Islander | Other |
|---|---|---|---|---|---|
| Automobile – multi-vehicle | 11 | 1 | 3 | 1 | 1 |
| Automobile – solo vehicle | 9 | 0 | 1 | 0 | 1 |
| Auto pedestrian | 6 | 2 | 2 | 0 | 0 |
| Choking | 2 | 0 | 0 | 1 | 0 |
| Drowning | 4 | 1 | 4 | 1 | 0 |
| Overdose | 3 | 0 | 1 | 0 | 1 |
| Fire | 0 | 1 | 0 | 0 | 0 |
| Fall | 0 | 0 | 1 | 1 | 0 |
| Suffocation | 0 | 1 | 1 | 0 | 0 |
| Maternal drug use | 12 | 1 | 2 | 0 | 0 |
| Medical mishaps | 1 | 1 | 0 | 0 | 0 |
| Hit by object | 2 | 0 | 0 | 1 | 0 |
| Train vs. pedestrian | 3 | 0 | 0 | 1 | 0 |
| Electrocution | 0 | 0 | 1 | 0 | 0 |
| Sport injury | 1 | 0 | 0 | 0 | 0 |
| Bike-no helmet | 1 | 0 | 0 | 0 | 0 |
| Kicked by horse | 1 | 0 | 0 | 0 | 0 |
| **TOTAL** | **56** | **8** | **16** | **6** | **3** |

## Causes of Accidental Child Deaths, Ages 0 - 14
## 1998-- 2012

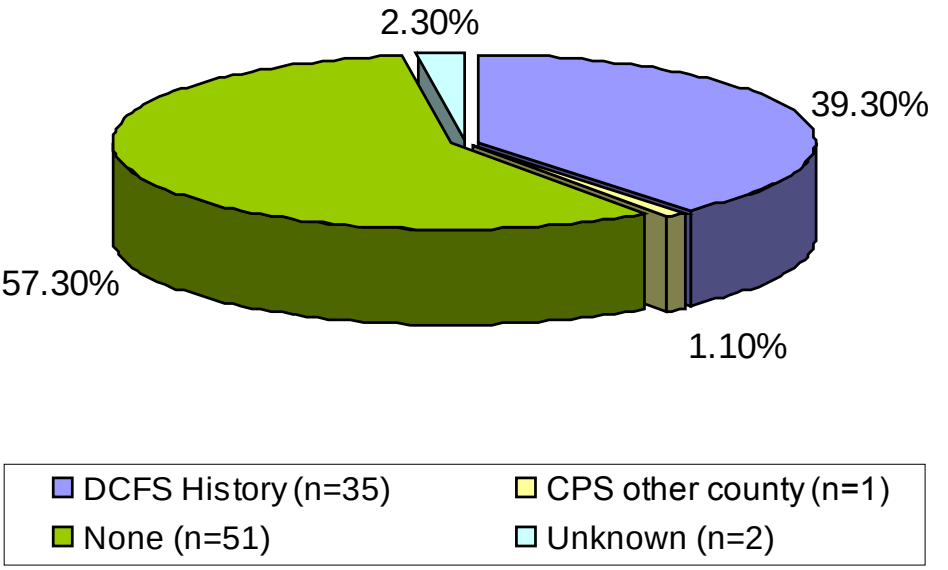
| | '98 | '99 | '00 | '01 | '02 | '03 | '04 | '05 | '06 | '07 | '08 | '09 | '10 | '11 | '12 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Drowning | 21 | 25 | 23 | 28 | 16 | 19 | 21 | 12 | 12 | 11 | 7 | 9 | 6 | 6 | 9 | 244 |
| Maternal drug abuse | 38 | 21 | 22 | 24 | 25 | 32 | 21 | 15 | 25 | 15 | 9 | 10 | 9 | 12 | 15 | 293 |
| Auto pedestrian | 19 | 31 | 30 | 41 | 33 | 25 | 21 | 20 | 11 | 25 | 25 | 15 | 18 | 19 | 6 | 339 |
| Automobile[1] | 0 | 18 | 24 | 28 | 20 | 47 | 25 | 21 | 22 | 14 | 17 | 19 | 11 | 9 | 21 | 296 |
| Falls | 3 | 5 | 1 | 1 | 3 | 2 | 3 | 1 | 2 | 1 | 1 | 0 | 5 | 4 | 1 | 33 |
| Choking | 3 | 6 | 10 | 2 | 8 | 4 | 1 | 3 | 1 | 1 | 2 | 0 | 2 | 3 | 3 | 49 |
| Suffocation | 2 | 4 | 1 | 3 | 0 | 1 | 1 | 2 | 2 | 0 | 0 | 0 | 1 | 2 | 1 | 20 |
| Poisoning | 1 | 4 | 4 | 1 | 0 | 2 | 2 | 1 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 18 |
| Fire | 3 | 7 | 4 | 3 | 7 | 0 | 2 | 6 | 7 | 2 | 0 | 0 | 1 | 2 | 1 | 45 |
| Hanging/strangulation | 0 | 0 | 6 | 3 | 1 | 2 | 4 | 1 | 3 | 4 | 0 | 0 | 2 | 0 | 1 | 27 |
| Chest/neck compression | 2 | 0 | 1 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 7 |
| Gunshot wounds | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Crushed/hit by object | 2 | 1 | 1 | 0 | 1 | 0 | 1 | 5 | 2 | 2 | 0 | 6 | 4 | 5 | 3 | 33 |
| Sports injury | 0 | 2 | 2 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 10 |
| Burns/Thermal Injury | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Dog bites | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Medical complications2 | 1 | 5 | 6 | 2 | 8 | 7 | 3 | 3 | 2 | 7 | 5 | 5 | 2 | 4 | 2 | 62 |
| Perinatal asphyxia | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 |
| Electrocution | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 4 |
| Birth trauma | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 5 |
| Hyperthermia | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Airplane related | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| Train v. pedestrian | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 3 |
| Elective abortion | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Forklift injury | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Drug intake/Overdose | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 5 |
| Motor vehicle (not auto3 | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 1 | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 9 |
| Impaled | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Gas Leak | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 3 |
| **TOTAL** | **95** | **134** | **137** | **137** | **127** | **147** | **112** | **100** | **95** | **83** | **73** | **67** | **63** | **68** | **68*** | **1525** |




## Causes of Accidental Child Deaths by Gender
## 2012 – Los Angeles County (N = 89)

| | Female | Male |
|---|---|---|
| Automobile – multi-vehicle | 10 | 7 |
| Automobile –single | 5 | 6 |
| Auto pedestrian | 4 | 6 |
| Drowning | 3 | 7 |
| Overdose | 2 | 3 |
| Maternal drug use | 6 | 9 |
| Medical mishaps | 2 | 0 |
| Hit by object | 2 | 1 |
| Fire | 1 | 0 |
| Choking | 2 | 1 |
| Fall | 0 | 2 |
| Suffocation | 0 | 2 |
| Train vs. pedestrian | 0 | 4 |
| Electrocution | 0 | 1 |
| Bike –no helmet | 0 | 1 |
| Sport injury | 0 | 1 |
| Kicked by horse | 0 | 1 |
| **TOTAL** | **37** | **52** |

## Accidental Child Deaths 2012 - Child Welfare History




### Causes of Accidental Deaths with Child Welfare History - 2012

| | Number | Percentage |
|---|---|---|
| Automobile | 10 | 27.8 |
| Auto pedestrian | 4 | 11.1 |
| Drowning | 4 | 11.1 |
| Overdose | 3 | 8.2 |
| Maternal drug use | 9 | 25 |
| Fire | 1 | 2.8 |
| Hang | 1 | 2.8 |
| Electrocuted | 1 | 2.8 |
| Kicked by horse | 1 | 2.8 |
| Train vs. Pedestrian | 2 | 5.6 |

## Case Summaries Undetermined Child Deaths

## Unsafe Sleep Practices and/or Environments and Maternal Substance Use

### Adam – Age 3 months

Adam was placed on his side facing his mother who was also on her side in the bed. Adam's father was lying next to Adam's other side facing the wall while all three slept. He was wearing an onsie and not covered with a blanket. When the mother fell asleep, Adam was in the crook of her arm. The mother awoke at 3:00 am to feed Adam. When she awoke, the mother was in a prone position and so was Adam. He was not breathing and his lips were blue. 911 was called by the grandmother while the mother did CPR. Adam was not able to be resuscitated and he was pronounced at the scene. The bassinet in the room was used for storage as the parents reported Adam did not like sleeping in it.

### Mary– Age 8months

Mary was placed to sleep on floor in a Boppy pillow. Her head was resting on the center of the horseshoe shaped pillow and her body was between the two open ends. The mother went to sleep with Mary's two older siblings on the couch. Mary was covered with a blanket to her waist. On the floor, three feet from Mary, a floor heater was in use during the night. The mother awoke in the morning but couldn't move because one of the siblings was lying on top of her. She went to pick Mary up and noticed she was all wet with some white foam and brown mucus draining from her nose.

Officers arrived and took over CPR from the mother to no avail.

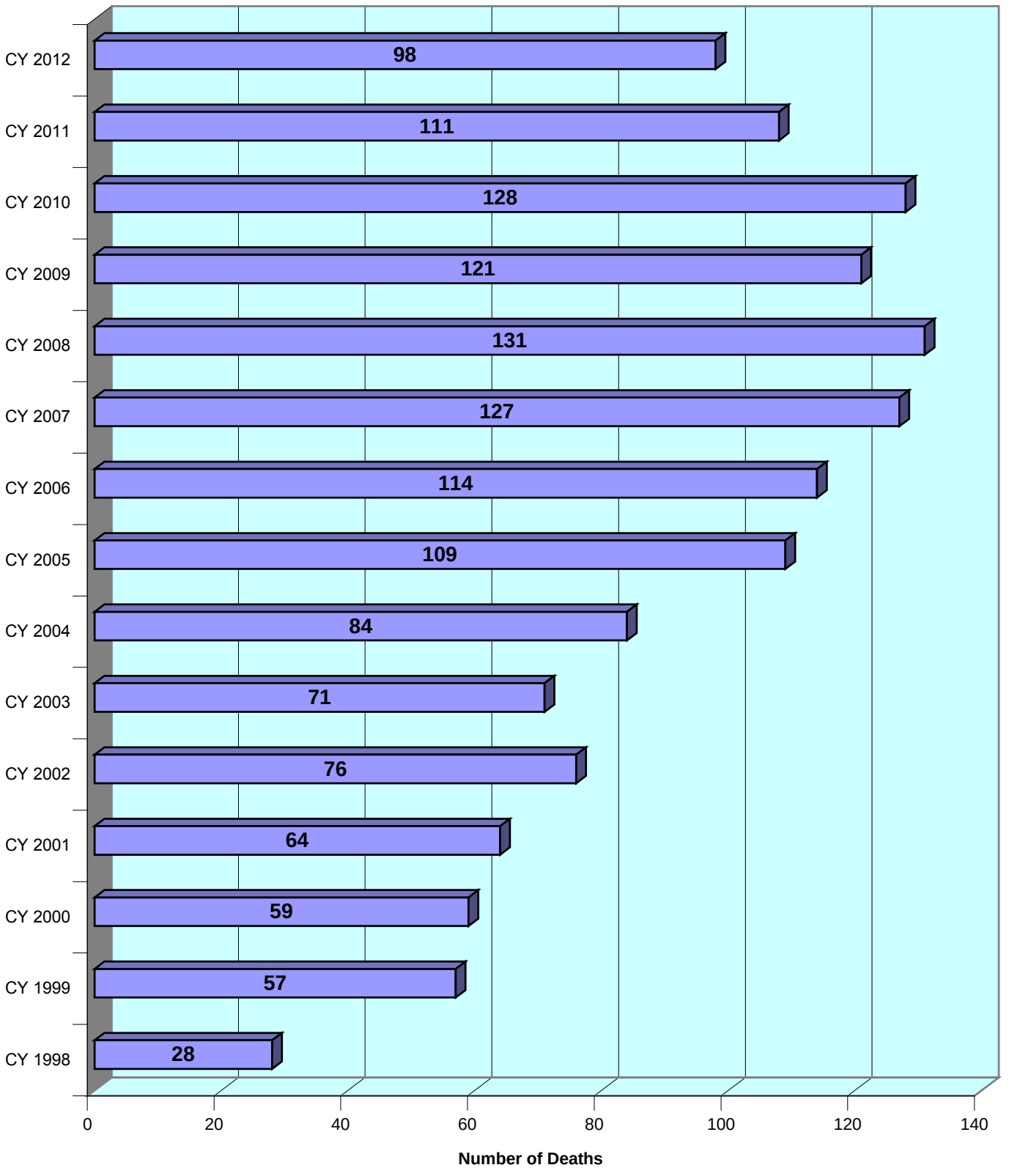
### Linda – Age 3 1/2 months

The father placed Linda in a crib on her side with on a mattress with a fitted sheet that was covered with folded thick polyester fleece comforter. He checked her a few hours later and she was in a prone position with her head to the side and appeared fine. When she returned home from work, the mother went to check on Linda and found her face down in the crib. The bedding underneath her was wet. The father ran to the fire station down the street for help with Mary. She was transported to the hospital by paramedics but pronounced dead shortly after her arrival the ER. The father told the coroner investigator that he takes psychotropic medication and medical marijuana as prescribed by his physician. He denied being impaired the night of her death. The investigator observed an open wine bottle in the kitchen with a small amount of liquid left in the bottle.

### Baby Girl Rivas – Stillborn

The 31 year old mother learned she was pregnant three days earlier after she went to the doctor due to two weeks of vaginal bleeding. The doctor estimated she was 25 – 27 weeks along. She came to the ER due to abdominal cramping. Baby girl was delivered stillborn four hours later by cesarean section. The mother admitted to the hospital social worker that she routinely used methamphetamine. She tested positive for methamphetamine and marijuana. DCFS records indicated the mother's three older children were in permanent placement with a legal guardian.

## 1998 to 2012 Undetermined Child Deaths



**Undetermined Child Deaths – 2012 (N = 98)**

| Race | Number/Percentage of Undetermined Child Deaths |
|---|---|
| **African-American** | 31 (31.63%) |
| **Asian/Pacific Islander** | 5 (5.1%) |
| **Caucasian** | 14 (14.29%) |
| **Hispanic** | 48 (48.98%) |

| Age | Number of Undetermined Child Deaths |
|---|---|
| **Stillborn** | 12 |
| **1 day to 30 days** | 20 |
| **1 month to 5 months** | 38 |
| **6 months to 1 year** | 17 |
| **2 years** | 1 |
| **3 years** | 1 |
| **4 years** | 2 |
| **5 years** | 0 |
| **6 years** | 1 |
| **7 years** | 0 |
| **8 years** | 0 |
| **9 years** | 0 |
| **10 years** | 0 |
| **11 years** | 1 |
| **12 years** | 2 |
| **13 – 17 years** | 3 |

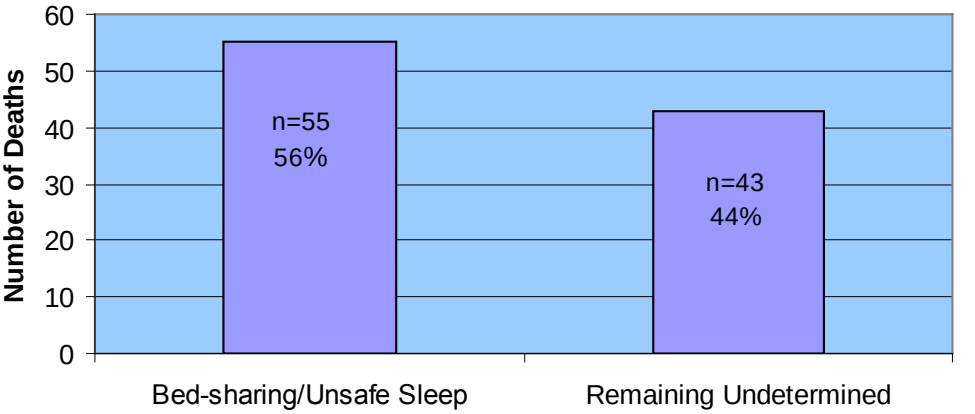
| Gender | Number of Undetermined Child Deaths |
|---|---|
| **Female** | 45 |
| **Male** | 52 |

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

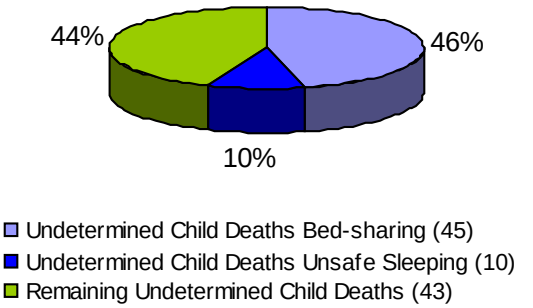
89% of the undetermined child deaths were under one year of age.

93% of the undetermined child deaths were 5 years of age or under.

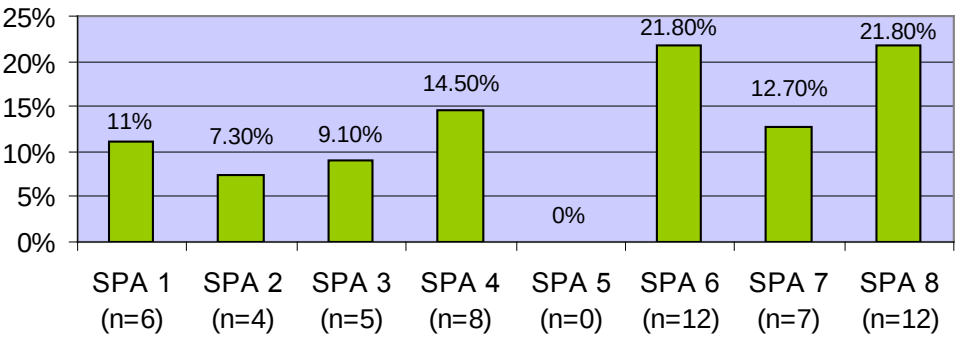
## Bed-sharing and Unsafe Sleeping Environments Undetermined Child Deaths 2012




## Undetermined Child Deaths Associated with Bed-sharing and Unsafe Sleeping Practices - 2012




## Bed-sharing and Unsafe Sleeping Practice Child Deaths By SPA*




*Excludes one death where the incident occurred in another county

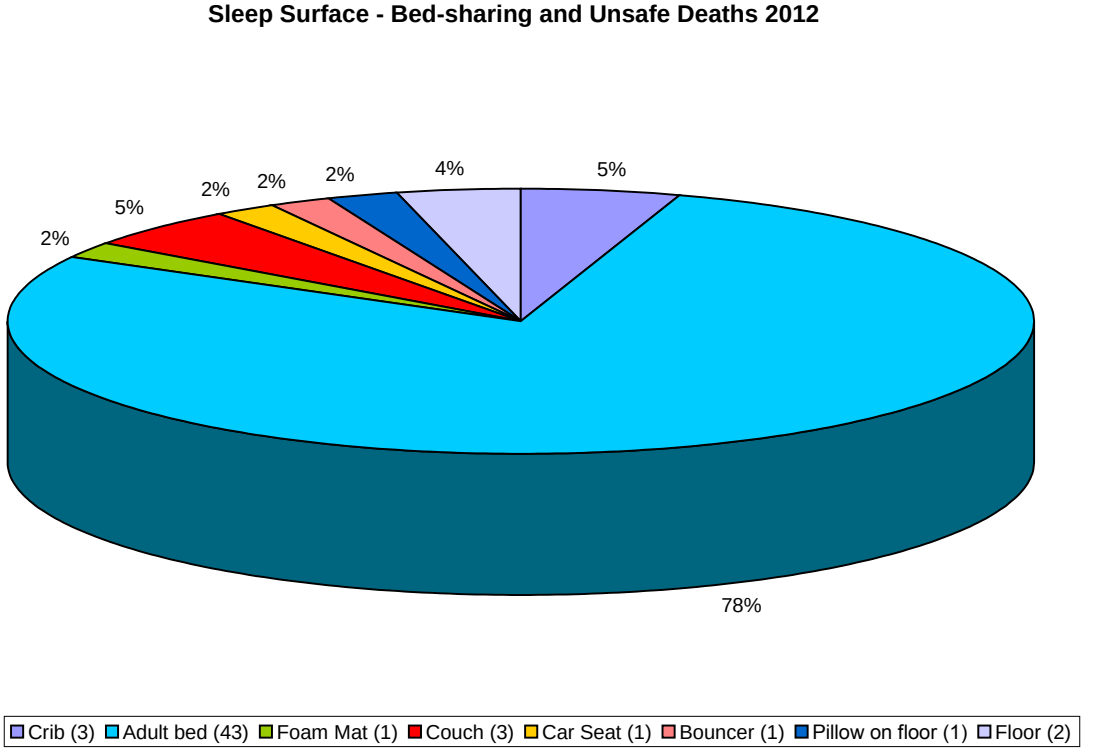
## Undetermined Child Deaths – Bed-sharing and Unsafe Sleeping Environment (N = 55)

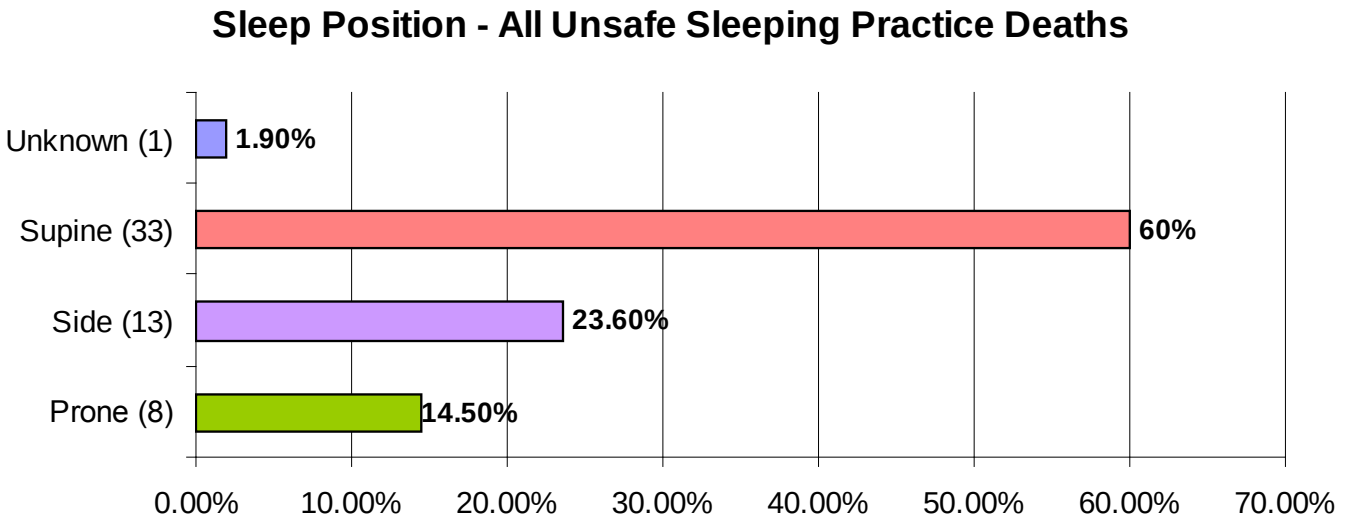
| Bed-sharing* (N=45) | Number/Percentage of Child Deaths |
|---|---|
| One Unsafe Risk Factor | 0 (0%) |
| Two Unsafe Risk Factors | 10 (22%) |
| Three or more Unsafe Risk Factors | 45 (78%) |

| Unsafe Sleeping Environment (N=10) | Number/Percentage of Child Deaths |
|---|---|
| One Unsafe Risk Factor | 3 (30%) |
| Two Unsafe Risk Factors | 3 (30%) |
| Three or more Risk Factors | 4 (40%) |

*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.

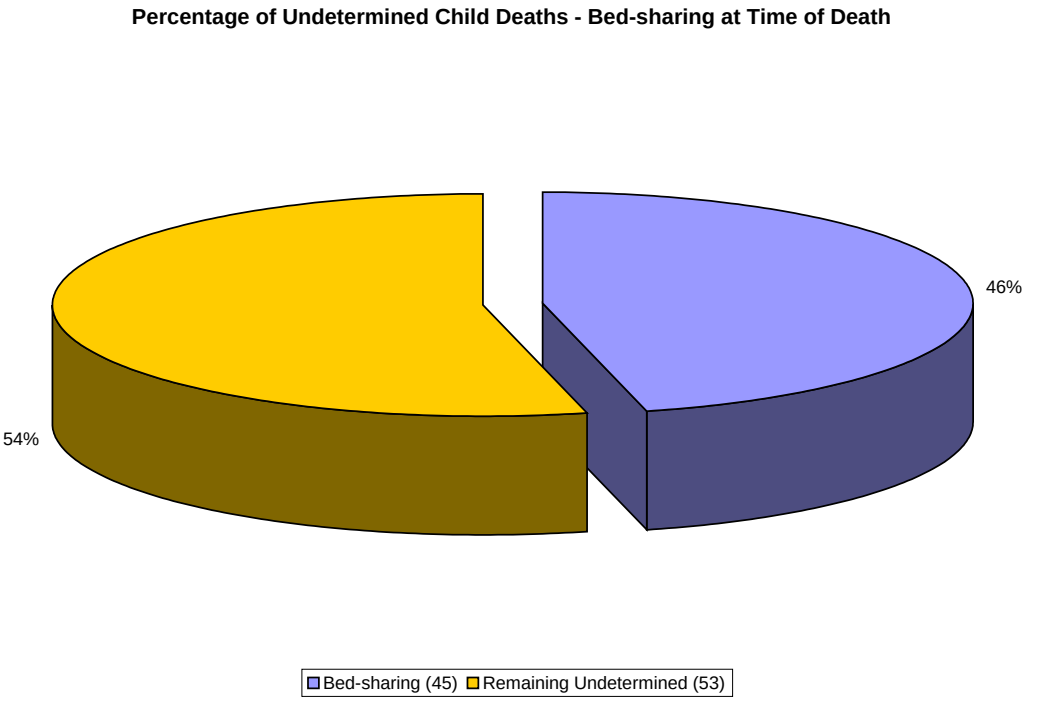
**Includes adult bed, couch, futon, chair, foam mat, nest box, car seat, stroller, swing, bouncer, pillows, soft or excessive bedding, excessive swaddling, blanket rolls, stuffed toys, plastic bag, pets, parental drug/alcohol use, prone or side positioning.



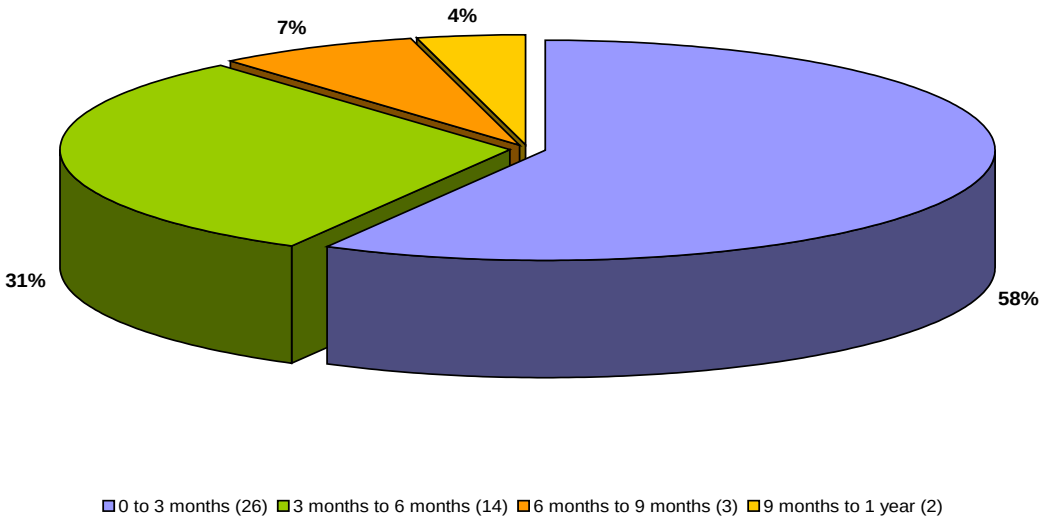



| Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 55) | Number | Percentage |
|---|---|---|
| Pillow(s) | 27 | 49% |
| Sleep Sack | 1 | 1.9% |
| Soft and/or excessive bedding | 10 | 18.1% |
| Excessive Swaddling | 7 | 12.7% |
| Rolled blanket/sheet | 1 | 1.9% |
| Parental Drug/Alcohol Use | 9 | 16.4% |

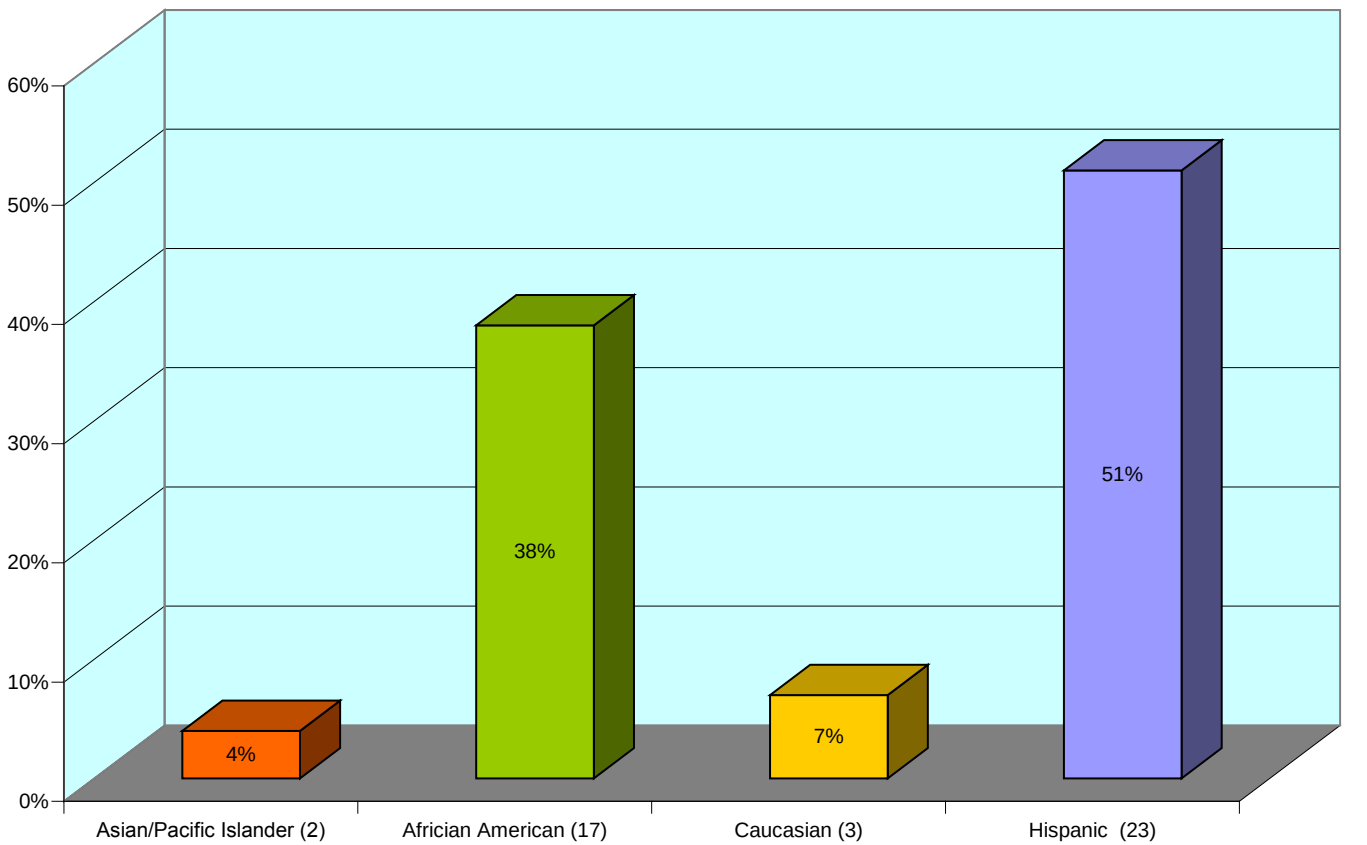
*excludes bed-sharing, sleep surface and infant position.



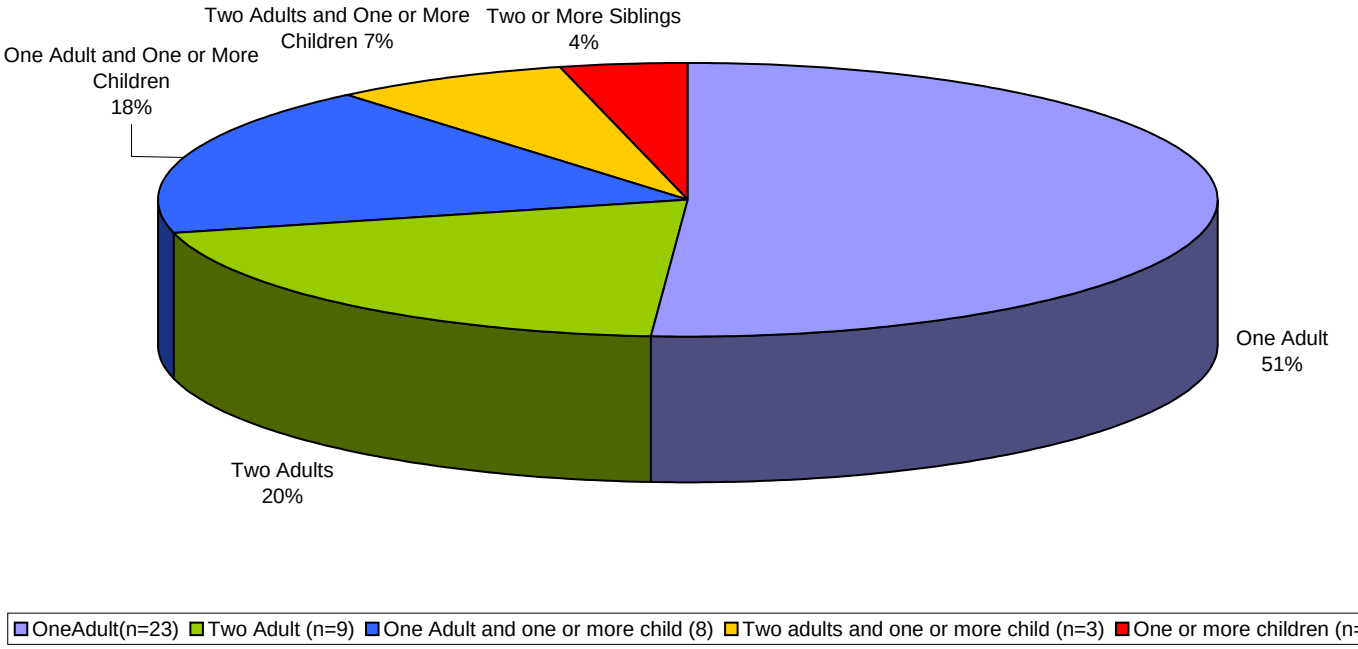
**2012 Undetermined Bed-sharing Child Deaths - Age**



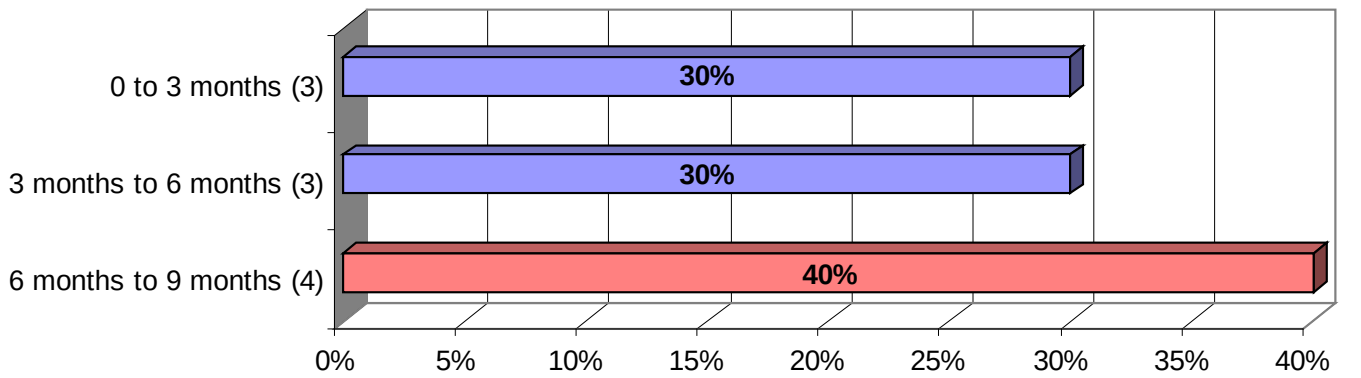

**2012 Bed-sharing Child Deaths - Race**



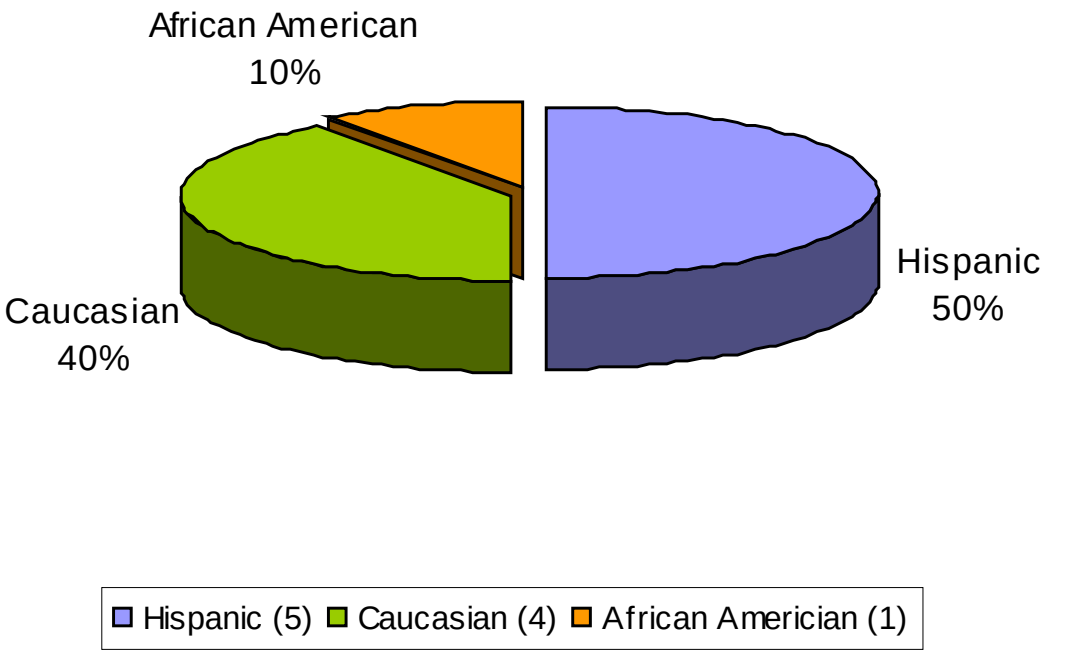
**2012 Bed-sharing Deaths- Number of Persons Sleeping with Child**




**2012 Non-bed sharing Unsafe Sleeping Deaths - Age**



## 2012 Non-bed sharing Unsafe Deaths - Race




| Unsafe Non-bed sharing Child Deaths Sleeping Environment - 2012 | |
|---|---|
| Soft and/or excessive bedding | 5 |
| Pillow(s) | 2 |
| Adult bed | 2 |
| Crib | 3 |
| Rolled blanket/sheet | 1 |
| Parental Drug/Alcohol Use | 1 |
| Foam Mat | 1 |
| Car Seat | 1 |
| Bouncer | 1 |
| Excessive Swaddling | 1 |

## 2012 Undetermined Infant Deaths- Mother Tested Positive for a Substance at Birth

| Infant Death- Mother Tested Positive for a Substance at Birth (N = 12) | | |
|---|---|---|
| **Substance** | **Number** | **Percentage** |
| Marijuana | 2 | 16.7% |
| Methamphetamine and Marijuana | 2 | 16.7% |
| Cocaine | 2 | 16.7% |
| Methamphetamine and Cocaine | 1 | 8.3% |
| Methamphetamine | 5 | 41.6% |

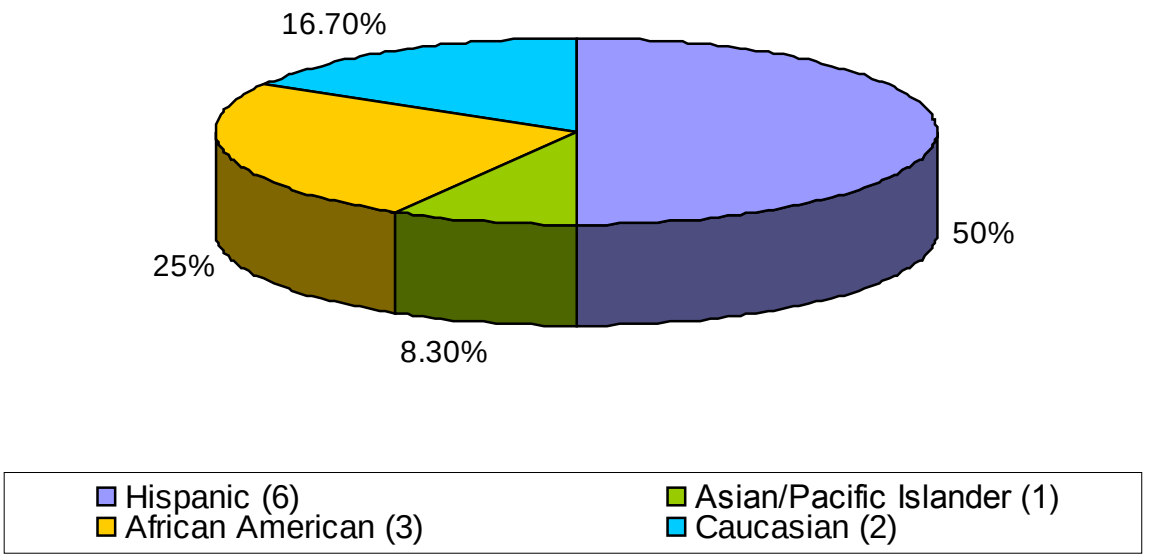
## 2012 Undetermined Infant Deaths- Mother Tested Positive for a Substance at Birth – Child Welfare Involvement

| Year | Total # of Infant Deaths- Mother Tested Positive for a Substance | Total # of with CPS family history (prior contact OR open case) | Of total with CPS history, the # of families that had PRIOR DCFS contact only | Of total with CPS history, the # of families in OPEN DCFS case or referral | # of Mothers with a CPS history as a minor |
|---|---|---|---|---|---|
| **2012** | 12 | 7 (58.3%) | 4 (57.1%) | 3 (42.9%) | 5 (41.7%) |

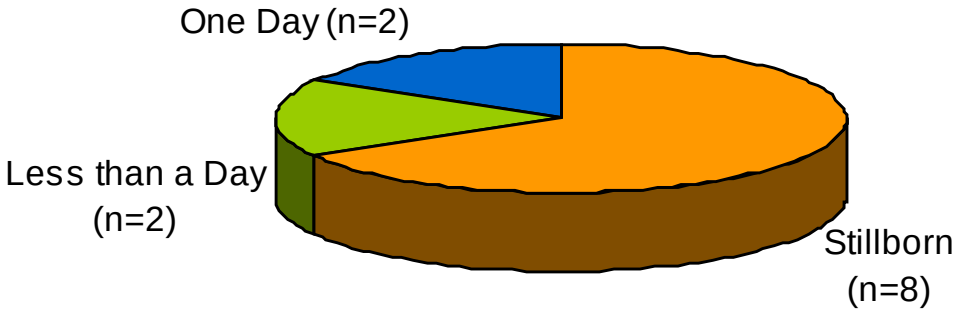
## Location of Family by Zip code and SPA

| Zip code | SPA |
|---|---|
| | |
| 90016 | 6 |
| 90044 | 6 |
| 90605 | 7 |
| 90640 | 7 |
| 90731 | 8 |
| 90810 | 8 |
| 91324 | 2 |
| 91605 | 2 |
| 91766 | 3 |
| 91768 | 3 |
| 91768 | 3 |
| 93534 | 1 |

## Undetermined Infant Deaths - Mother Tested Postive for a Substance 2012 - Race




## 2012 Undetermined Infant Deaths - Mother Tested Postive for a Substance - Age



# Third Party Homicide

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=32) 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]

Fourteen month-year old, Raul was in his father's arms as the father stood on the sidewalk outside of their home. A male rode up on a bicycle, stopped and fired a weapon toward them. Raul was hit in the torso multiple times as was his father. Both were taken to the hospital. Sadly, Raul died in the operating room.

Nathan, age seventeen, was walking along the sidewalk with his 18 year-old friend. Suddenly, a vehicle drove up, starting shooting and fled the scene. Nearby residents heard the multiple gunshots which prompted them to go investigate. Upon their arrival, Nathan and his friend were found lying on the curb side. Paramedics were called. Nathan was pronounced at the scene and his friend was taken to the hospital where he was pronounced. Neither youth had any gang ties.

Seventeen-year old, Andrew was involved in an argument with a neighbor. A dispute had been on-going for approximately one year. The neighbor brandished a handgun toward Andrew. Andrew left the scene and told his mother and other relatives about the argument. Andrew and his mother then returned to the scene and confronted the neighbor who was still in possession of the gun. The argument quickly escalated and the neighbor fired the gun multiple times hitting Andrew in the torso area. Witnesses called 911 and detained the neighbor who was arrested. Andrew was transported to the hospital, but despite medical intervention he later died.

Jesus, age fifteen and his friend were breaking into an apartment when the resident who was in a back bedroom heard breaking glass. The homeowner grabbed his registered pistol and fired two shots through the bedroom door when he heard footsteps approaching. Jesus was hit and fell to the ground and his friend fled the apartment. The elderly homeowner called 911. Jesus was transported to the hospital where he later died. The homeowner was not arrested as law enforcement deemed the circumstances to be self-defense.

Seventeen-year old, Tony was leaning against a car talking on a cell phone. A male walked up to him and fired three to four rounds hitting Tony in the arm and torso. The assailant fled the scene on foot and paramedics were called. Tony was pronounced at the scene. The shooting was gang related as Tony was a member of a local gang.

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

In September, shortly past midnight, 911 was called due to a burning object in the alley. Upon the fire department's arrival, it was determined to be a body on fire. Law enforcement and the Coroner were called to the scene to investigate. After Jessica was identified, her mother was contacted and notified of her death. Her mother was about to report her as missing when informed of her death.

Johnny, age fifteen, was with some friends in a rear alley of his home smoking marijuana when two males from a rival gang approached them on foot. An argument ensued and one of the males pulled out a gun and shot Johnny. Both males fled and no other injuries were reported. Johnny collapsed and fell to the ground. He was pronounced at the hospital after sustaining multiple gunshot wounds. No weapon was recovered and no suspects are in custody.

Sixteen year old, Chris was tagging when a car drove up. It was not yet established whether he had gotten on his bicycle to flee the car as he was found next to his bike. Witnesses reported hearing four to six gunshots. Paramedics transported him to the hospital where death was pronounced without intervention.

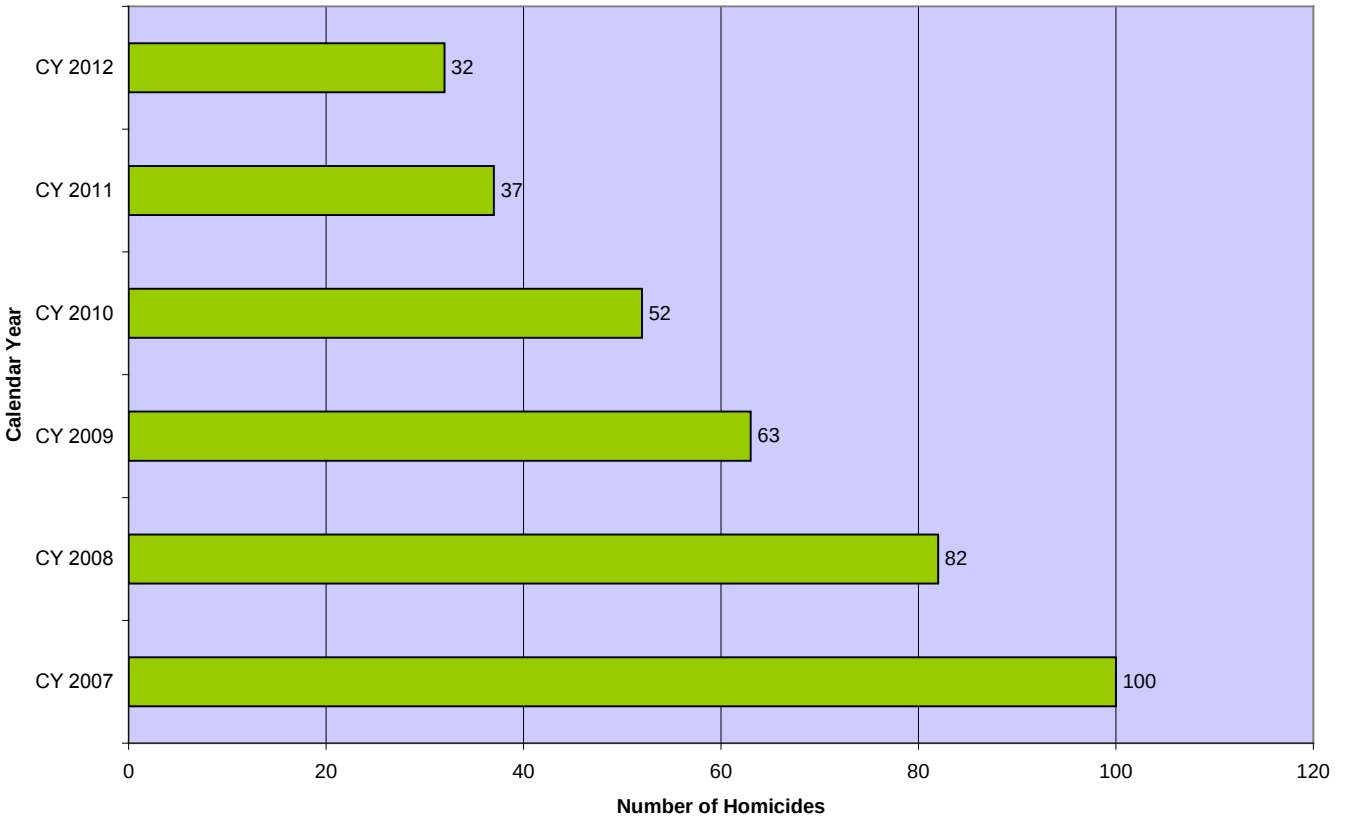
Fourteen-year old, Sandra was standing on a sidewalk outside her home talking with family and friends. Two males were standing near-by when one of them suddenly began firing shots into the crowd. Sandra along with others was struck by the gunfire. She was transported to the hospital by paramedics where she was pronounced dead. The two males fled the scene on foot and remain at large.

[1]Case identities were changed.

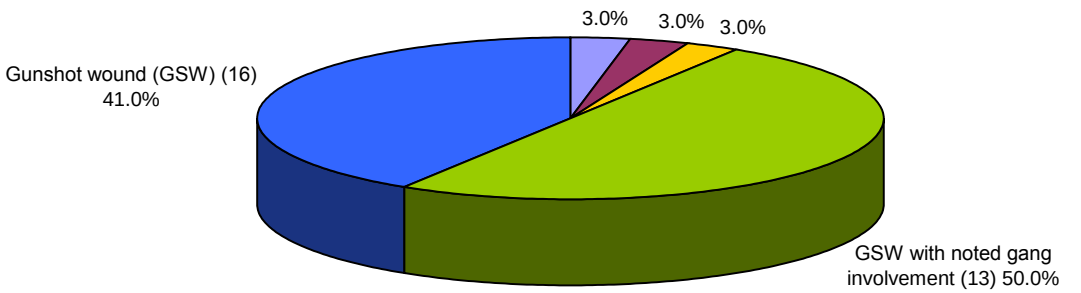
## FINDINGS

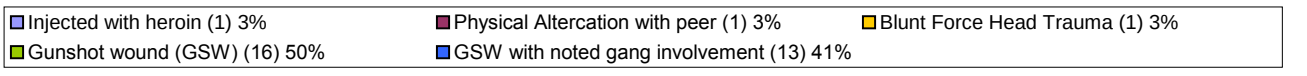
- There were 32 third party homicides in 2012. This is a 13.5% decrease from 2011 when there were 37 such deaths and a 68% decrease from 2007 when these data were first collected.
- Ninety-one percent (n=29) of the youth were victims of gunshot wounds. These include 25 youth who were victims of homicides perpetrated by suspects with possible gang involvement. For the five remaining youths, two were shot by a neighbor, two youth were shot by the homeowner whose home they were breaking into, and one youth was shot by a friend while playing with a gun.
- Of the three youths not killed by a gunshot, one was assaulted and set on fire, one died after a physical altercation with a peer, and one was injected with heroin by a friend.
- As in the previous four years, male victims outnumbered female victims by a broad margin. Twenty-eight males and four females were homicide victims in 2012.
- Eighty-eight percent (n=22) of the children who were victims of a third party homicide in 2012 were ages 16 – 17; three victims were 14 and 15 years of age each, one was age 4, one 10 and one 13 years of age, and the youngest victim was one year old.
- In 2012, there were 19 third party homicides of Hispanic youth, eight African-American youth, five Caucasian youth and there were no third party homicides of Asian American.
- The greatest number of homicides occurred during the months of January, February, and October (n=5). The seconded greatest number occurred in the month of July (n=4) and the third greatest in the months of March and August (n=3). The fewest number of homicides occurred during the months of April and May when there were no third party homicides. Two third party homicides occurred during the months of September, November and December. Finally, one third party homicide occurred in the month of June.
- While third party homicides occurred throughout Los Angeles County in 2012, the majority (n=13) of these deaths occurred in Service Planning Area 6 (South Los Angeles), which has been the case since collecting these data. Six third party homicides occurred in SPA 8 (South Bay/Harbor), five each in SPA 2 (San Fernando Valley) and SPA 7 (East Los Angeles), two in SPA 4 (Metro), and one in SPA 1 (Antelope Valley). SPA 3 (San Gabriel Valley) and SPA 5 (West Los Angeles) had none.
- The Los Angeles Police Department (LAPD) had investigative authority for 62.5% of the third party homicide cases in 2012. 31.5 percent of the cases were under the jurisdiction of the Los Angeles Sheriff's Department, and 6% of the cases were handled by jurisdictions other than LAPD and LASD. Where the relationship of the perpetrator was identified by law enforcement, 41% of the perpetrators were a gang member, and at least 9% of the victims were gang involved. Finally, 31% (n=10) 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.
- Nineteen of the victims had a history with DCFS. Of those nineteen, five also had a history with Probation. Another youth had a Probation history, but no DCFS contact.

**2007 - 2012 Third Party Homicides**




**2012 Third Party Homicides - Cause**



## Third Party Homicides
## Los Angeles County – 2012 (N = 32)

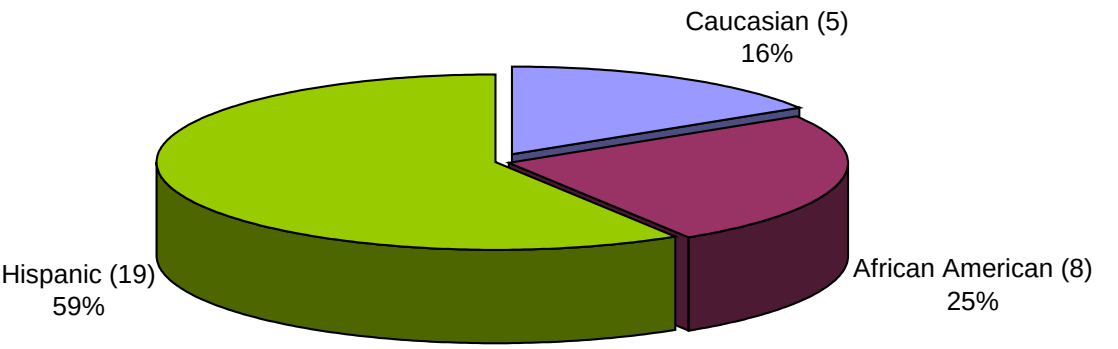
| Age | Female | Male |
|---|---|---|
| 1 year or under | 0 | 1 |
| 2 – 12 years | 0 | 2 |
| 13 years | 0 | 1 |
| 14 years | 1 | 2 |
| 15 years | 0 | 3 |
| 16 years | 2 | 2 |
| 17 years | 1 | 17 |
| **Total** | **4** | **28** |

88% of the third party homicide victims were male.

9% of the third party homicide victims were 12 years of age or younger.

69% of the third party homicide victims were 16 to 17 years of age.

**2012 Third Party Homicides - Race**




Los Angeles Child Population Ages 0-17: 2,341,123
Hispanic 62.5%, Caucasian 17.1%, African American 7.5% , Asian/Pacific Islander 9.8%, Native Indian/Alaskan .1% and Multi-racial 3%

## Dates[1] of Third Party Homicides - 2012

5 homicides occurred in January (01/01, 01/09, 01/11, 1/15, & 1/19/12)
5 homicides occurred in February (2/02, 2/08 2/24, & 2/26/12, two)
3 homicides occurred in March (3/21, 3/22, & 3/26/12)
0 homicides occurred in April
0 homicides occurred in May
1 homicide occurred in June (6/04/12)
4 homicides occurred in July (7/04, 7/05, 7/11, & 7/17/12)
3 homicides occurred in August (8/08, 8/17 & 8/25/12)
2 homicides occurred in September (9/17, & 9/24/12)
5 homicides occurred in October (10/01, 10/10, 10/20, 10/28 & 10/31/12)
2 homicides occurred in November (11/06 & 11/14/12)
2 homicides occurred in December (12/16, & 12/22/12)

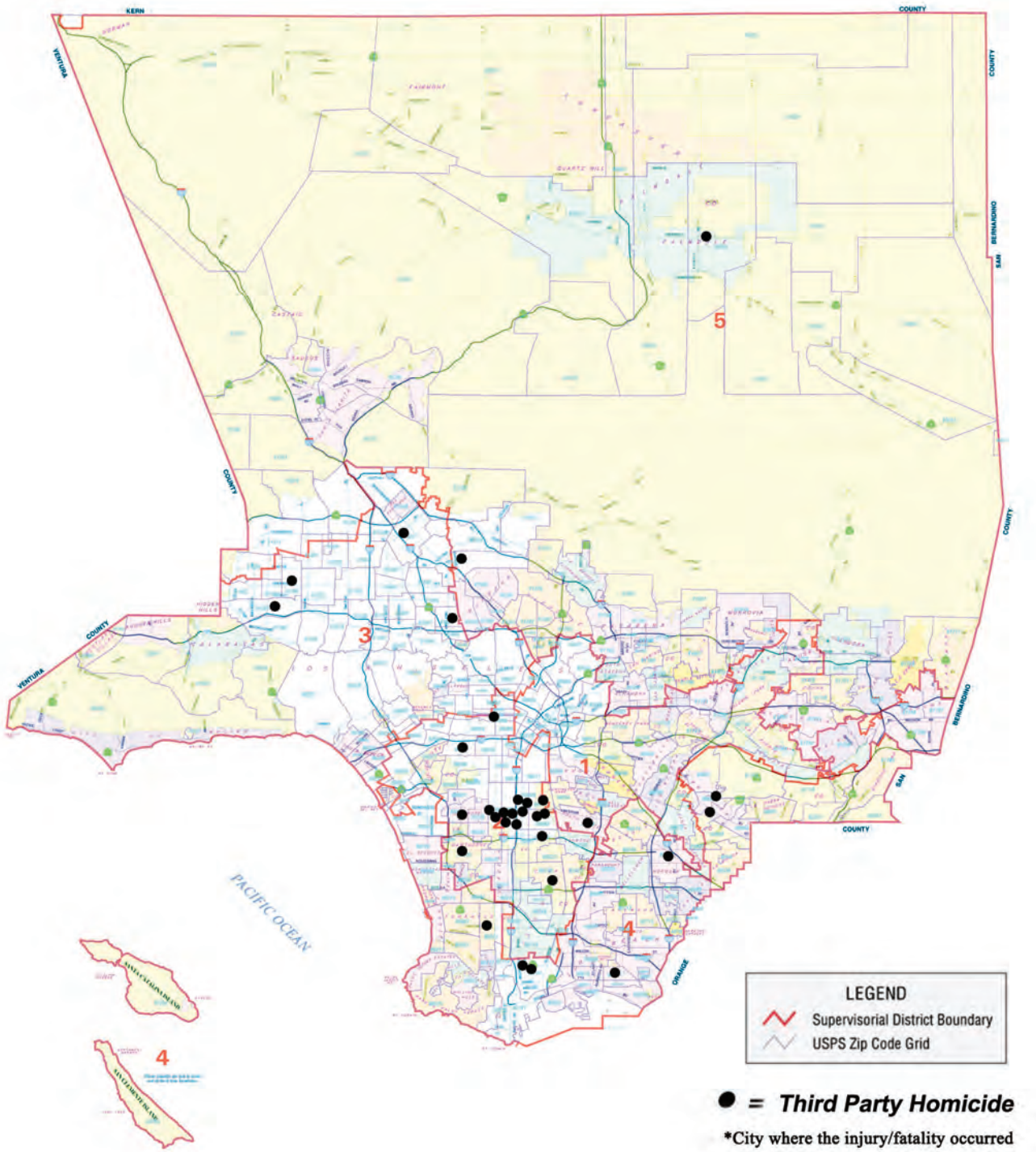
## Locations[2] of Third Party Homicides – Geographic Area - 2012

2 homicides occurred in Canoga Park (zip codes 91306 & 91367)
1 homicide occurred in Compton (zip code 90220)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in Inglewood (zip code 90301)
2 homicides occurred in Whittier (zip code 90602 & 90650)
1 homicide occurred in Long Beach (zip code 90804)
14 homicides occurred in Los Angeles (zip codes 90001, 90002, 90003, 90005, 90016, 90044, 90047, & 90059)
1 homicide occurred in North Hollywood (zip code 91601)
1 homicide occurred in Pacoima (zip code 91331)
1 homicide occurred in Palmdale (zip code 93552)
1 homicide occurred in Sun Valley (zip code 91352)
1 homicide occurred in Norwalk (zip code 90605)
1 homicide occurred in South Gate (zip code 90280)
2 homicides occurred in Wilmington (zip code 90744)
1 homicide occurred in Torrance (zip code 90501)

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

# 2012 Third Party Homicides

**N = 32***



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 2012, there were 32 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* |
|---|---|---|
| LAPD | 20 | 64% |
| LASD | 10 | 30% |
| Inglewood P.D. | 1 | 3% |
| Long Beach 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 | 13 |
| Neighbor | 2 |
| Friend | 2 |
| Peer | 1 |
| Homeowner | 2 |
| No Information Provided or Unknown | 12 |

**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 few 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 by neighbor | 2 |
| Shot while breaking into a private residence | 2 |
| Shot during a drive-by shooting | 2 |
| Gang member | 4 |
| Physical altercation with a peer | 1 |
| Injected with heroin by a peer | 1 |
| Assaulted and set on fire | 1 |
| Shot accidentally by a friend who was playing with a gun | 1 |
| No information provided | 18 |

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), 11 of the 32 cases of third party homicides were referred to the District Attorney's Office in 2012. Ten of the eleven had criminal charges filed by the District Attorney's Office in 2012. The DA declined to file on the case involving a physical altercation between peers. Law enforcement ruled three cases as involving self-defense and one suspect committed suicide. Those four cases were not referred to the District Attorney's Office. It should be noted that there was no information found for 17 cases. This may mean that law enforcement has not identified the assailants, not submitted the case for review or for some other reason.

# Appendix - A: On-Line Resources

## Safe Sleeping Resources

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

## Water Safety

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

## Biking Safety

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

## Child Abuse

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

## Fire Safety

http://www.redcross.org/portal/site/en/19a978f421296e81ec89e43181aa0/?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

ICAN

The Inter-Agency Council on Child Abuse and Neglect is comprised of Los Angeles County City, State and Federal Agencies, as well as community organizations, and individuals from the private sector. ICAN's mission is to coordinate the development of services for the prevention, identification and treatment of child abuse and neglect throughout Los Angeles County.

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.