ICAN Multi-Agency Child Death Review Team Report For 1991

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on Child Abuse and Neglect

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Contents

Foreward

The ICAN Child Death Review Team began in 1978 with 7 agency members. The initial focus was on child homicides.

We now include members from 11 ICAN agencies as well as local law enforcement and private health and treatment programs. As co-chairs of the team, Detective Bobby Smith and I reflect the unique level of cooperation in this effort between the criminal justice system and health and human services.

This work involves agency and team members extending themselves in time, energy, and personal pain. The line staff of the various agencies who have personal experience with a deceased child have become a particular resource. They have responded with invaluable participation in our process of case management and system evaluation.

Our level of work improved rapidly in the last two years with the addition of Mitch Mason, M.S.W., as the ICAN staff specialist for this project. His unique skill and dedication to this project have greatly increased the sophistication and accuracy of our work, and made this report possible.

The ICAN Child Death Review team received a National Association of Counties (N.A.Co) award for our work. The Los Angeles County Counsel also received a N.A.Co. award for their internal case review.

ICAN has played a leadership role in helping establish similar child death review teams nationally. County teams now cover 27 million or 90% of California's population. County and/or state teams cover 80 million or 1/3 of the United States total population.

We are better integrated, have more information on our cases, and can now use data from the California Departments of Justice, Health, and Social Services. We will continue to increase our focus on system integration and prevention of fatal and severe injury to children.

This report is dedicated to the children whose lives we hope to save.

Michael Durfee M.D.

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Executive Summary

Executive Summary

Background and Purpose

This is the second annual ICAN Multi-Agency Child Death Review Team Report. The purpose of the report is to provide a detailed analysis of children's deaths in the county, their relationship to maltreatment, and ICAN agencies involvement with these children and families prior to and following the death.

The study of these deaths can help us better understand the dynamics of the systems involved with families. Ultimately our review will help us intervene more effectively to prevent child deaths as well as non-fatal abuse. The study of these deaths can help us better understand life.

Findings

Child Abuse Homicides

- 46 child abuse homicides, in which the perpetrator was in a caretaker role, were identified by the Team in 1990.
- 54.3% were females and 45.7% were males.
- 28% of child abuse homicide victims were under the age of 6 months. 63% were under the age of 2 years.
- 43.5% of child abuse homicides were a result of head injuries caused by 1.) shaken baby syndrome or 2.) blunt force cerebral trauma.
- The most frequent single cause of death, in 23.9% of the homicides, was gunshot wounds.
- 58.7% of the families had a history of receiving public assistance from the Department of Public Social Services.
- 21.7% of the families had a record of receiving child protective services prior to the death of the child.

Child Abuse Homicides (cont'd)

- 26% of the child abuse homicide victims had medical records with the Department of Health Services facilities.
- 60% of case investigations resulted in presentations to the District Attorney's office by the law enforcement jurisdictions.
- The DA filed on 76% of the child abuse homicide cases presented to them.
- District Attorney disposition of criminal filings were:

  28.5% - still pending trial.

  14% - over 10 years imprisonment

  28.4% - one year jail, or less, with up to 5 years probation

  2 suspects have fled and have outstanding bench warrants.

- Natural fathers were criminally charged on 38% of cases, mothers on 24% of cases and mothers' live-in male companions in 19% of cases.
- No sentences involving life imprisonment have been handed down for 1990 child abuse homicides.

Accidental Child Deaths

- 93 accidental deaths were reported to the ICAN Team for 1990, a 32.9% increase over 1989.
- The leading cause of death in accidental deaths was drowning (41.9%), followed by complications associated with maternal substance abuse (23.7%) and falls (12.9%).

Executive Summary

Accidental Child Death (cont'd)

- 51.6% of families had a history of receiving public assistance from the Department of Public Social Services.
- 23.7% of the families had a record of receiving child protective services prior to the death of the child.
- 15% of the victims had been seen at Department of Health Services facilities.
- The deceased child had siblings in 44.1% of the cases.

Natural Child Deaths

- 10 Natural deaths were identified by the Team to have a maternal substance abuse history or prior history of child protective services, a 400% decrease from 1989.
- 7 of the 10 natural deaths reviewed had a Coroner certified cause of death of Sudden Infant Death Syndrome.
- 60% of the families had a history of prior child protective services.
- 40% of the victims had been seen at Department of Health Services facilities.

Undetermined Child Deaths

- 5 Undetermined deaths were referred to the Team by the Coroner for 1990.
- Only 1 of the families was known to the Department of Children's Services prior to the death.
- 3 of the victims had been seen at Department of Health Services facilities.
- Criminal charges were filed by the District Attorney on 1 of the undetermined cases.

Adolescent Suicides

- 28 adolescent suicides were reported to ICAN's Child Death Review Team by the Coroner in 1990,a decrease of 35% over 1989.
- 67.9% of the suicide victims were male.
- 17 year old white males continued to represent the highest risk group for teen suicide.
- The Coroner certified no black child or adolescent suicides in 1990.
- In 64.3% of the cases, the method of suicide involved the use of firearms. Other methods included hanging, 32%, and overdose of drugs, 3.6%.
- 21.7% of the families with suicide victims had a history of receiving public assistance from DPSS.
- Only 10.7% of the families with suicide victims had prior involvement with the Department of Children's Services.
- 17.9% of the suicide victims had records of involvement with law enforcement and/or the Probation Department for juvenile delinquent behavior.

Fetal Deaths

- 43 fetal deaths were reported to the ICAN Death Review Team for 1990, 34.4% fewer than in 1989.
- Black families suffered 62.8% of the fetal deaths.
- In 97.7% of the fetal deaths, there was a history of maternal drug abuse present.
- 23.3% of the fetal death cases had a record of prior involvement with the Department of Children's Services, most often for drug related problems.

Executive Summary

Conclusions

Although there is a 10% increase in child abuse homicides over 1989, the increase appears related to better identification of older victims.

A gender and age profile of child abuse homicide victims reflects that girls are facing increased risk of being victimized and that very young children, ages 2 and younger, continue to be victimized at very high levels.

DCS and DHS data suggest that a minority of victims and families are known to these agencies before the death. In light of the large numbers of children and families served by these agencies, identification of potential victims is extremely challenging. Better outreach methods are necessary to recognize these high risk families and prevent child abuse homicides.

The response of agencies involved in the identification and investigation of child abuse homicides and provision of services to surviving family members is inconsistent. Cases of suspicious deaths with like circumstances are not handled in a predictable or uniform manner.

The incidence of preventable fatalities will not be reduced without broad comprehensive prevention efforts. It is necessary for the ICAN Child Death Review Team to coordinate with and support other community efforts in fatality prevention activities.

While the 35% decrease in the number of adolescent suicides in 1990 from1989 is encouraging, there is a continued need for study of this population. Broader study, including review of suicide attempts which may show a different profile, is necessary to define how agencies can better address this area.

Recommendations

ICAN should promote expanded efforts to provide outreach services to families with very young children. Such efforts may include exploring the feasibility of establishing a neonatal home visitation program.

ICAN agencies should consider either broad based training, or the specialization of handling of child death cases to promote consistent identification, investigation and provision of appropriate services to surviving family members.

ICAN agencies, and the ICAN Multi-Agency Child Death Review Team should support and participate in community efforts to prevent child fatalities including the Los Angeles County Drowning Prevention Task Force.

ICAN should establish an ad hoc committee to review relevant agencies' policies and procedures to determine how services could be more effectively delivered to prevent adolescent suicides.

ICAN should support the development of a state level Child Death Advisory Committee which would provide support to county child death review teams, build a statewide data base on child death and promote consistency between the activities of county level teams.

1991 Team Accomplishments

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In 1990-91, the ICAN Multi-Agency Child Death Review Team :

1. Maintained in-depth monthly review of selected problem cases and problem issues (24 cases for 1990) with continuing follow-up of previously reviewed cases and issues.

2. Identified and reviewed cases dealing with:
   - Shaken infant syndrome
   - Blunt force trauma without signs of subdural bleeding
   - Fatal rebleeding of originally non-fatal head injuries
   - Sodium intoxication
   - Teen suicide
   - SIDS deaths in marginal home environments
   - Medical neglect deaths due to religious beliefs
   - Murder / suicide
   - Drownings
   - Abandoned infants
   - Deaths of undetermined cause due to history inconsistent with physical findings.

3. Expanded the number of professionals involved in the Team review to include: Los Angeles County Probation Department, County Office of Education, County Forester and Fire Warden, Los Angeles City Attorney, Department of Mental Health and medical practitioners from Rancho Los Amigos Hospital and Long Beach Memorial Medical Center.

4. Reviewed and adopted formalized confidentiality guidelines to ensure the appropriate handling of case specific information from the multiple agencies involved in the review process.

5. Worked with Team representatives for improved efficiency and better use of staff's time in relating to the ICAN Team as well as improved communications between individual agency internal review teams and the ICAN Team.

6. Increased sophistication of data collection, especially from the Department of Health Services Vital Statistics section and the State Department of Justice.

7. Collaborated with the Centers for Disease Control, American Bar Association, and American Academy of Pediatrics in the initial phases of development of a national data set on child death.

8. Coordinated activities with other California counties including chairing the Southern California Death Review Consortium. Provided key assistance in the development of a network of multi-county forums throughout the state and the foundation for a state level advisory council which will provide support to county teams and build a statewide data base on child death.

9. Participated in presentations at the American Prosecutors Research Institute's National Conference on Child Abuse Fatalities, American Bar Association Center on Children and the Law Child Death Seminar, the National Center on Child Abuse and Neglect National Conference, Los Angeles County Department of Health Services Child Abuse Prevention Conference, Los Angeles Police Department Juvenile Procedure School and local community groups which included community child abuse councils and foster parent groups. ■

Introduction

Introduction

This is the second annual Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) Multi-Agency Child Death Review Team Report The purpose of the report is to provide a detailed analysis of children's deaths in the county, their relationship to maltreatment, and ICAN agencies involvement with these children and families prior to and following the death.

The study of these deaths can help us better understand the dynamics of the systems involved with families. Ultimately our review will help us intervene more effectively to prevent child deaths as well as non-fatal abuse. The study of these deaths can help us better understand life.

The ICAN Multi-Agency Child Death Review Team was formed in 1978 to review child deaths in which a caretaker was suspected of causing the death. The Team is comprised of representatives from the Department of Coroner, Los Angeles Police and Sheriff's Departments, District Attorney's Office, Office of County Counsel, Department of Children's Services, Department of Health Services, Department of Mental Health, Probation Department, Los Angeles County Fire Department and Children's Hospital of Los Angeles.

Periodically, the Child Death Review Team has released studies of the findings of its review process. In 1986, a report to the ICAN Policy Committee entitled A Profile of Suspicious Child Deaths described suspicious child deaths which occurred in Los Angeles County in 1984. In 1987, a summary of 1985 child deaths included criminal prosecution data for the first time. In 1990, Child Death and Child Abuse/Neglect in Los Angeles County, 1989, was released and received wide media coverage as part of ICAN's report of "The State of Child Abuse in Los Angeles County".

This report details the activities and findings for 1990 of the ICAN Multi-Agency Child Death Review Team and begins to provide data of trends in child deaths for the past five years.

Significant Findings

Significant Findings

Child Abuse Homicides

- **46 child abuse homicides, in which the perpetrator was in a caretaker role were identified by the Team in 1990.** This is a **9.5%** increase over the number of child abuse homicides identified by the Team in 1989.
- **54.3% were females and 45.7% were males.** There has been a steady increase in the percentage of female victims over the past 5 years. (Studies elsewhere in the United States show more male than female child abuse homicide victims.)
- **28%** of child abuse homicide victims were under the age of 6 months. **63%** were under the age of 2 years.
- **7 of the 10 oldest victims, ages 6 and older, were female.**
- **62%** of Latino victims were female. This is the second year that Latino females suffered from child abuse homicides at a higher level than any other ethnic/sex group.
- **43.5%** of child abuse homicides were a result of head injuries caused by
  1.) shaken baby syndrome or
  2.) blunt force cerebral trauma.
- **The most frequent single cause of death, in 23.9% of the homicides, was gunshot wounds.** Most frequently, guns were used in murder/suicide situations where the perpetrator committed suicide after killing all the children in the family.
- The deceased child had siblings in **43.5%** of the cases.
- **58.7%** of the families had a history of receiving public assistance from the Department of Public Social Services. (Approximately **16.9%** of the county's population are current or former recipients of assistance from DPSS.)
- **21.7%** of the families had a record of receiving child protective services prior to the death of the child. This is a **5%** decrease from 1989.
- **26%** of the child abuse homicide victims had medical records with the Department of Health Services facilities.
- **60%** of case investigations resulted in presentations to the District Attorney's office by the law enforcement jurisdictions.
- **The DA filed on 76% of the child abuse homicide cases presented to them, rejected 18%** and asked for further investigation on the remainder.
- District Attorney disposition of criminal filings were:

  28.5% - still pending trial.

  14% - over 10 years imprisonment

  28.4% - one year jail, or less, with up to 5 years probation

  2 suspects have fled and have outstanding bench warrants.
- There were multiple suspects on only **7.4%** of the cases where criminal charges were filed.
- **Natural fathers were criminally charged on 38%** of cases, **mothers on 24%** of cases and **mothers' live-in male companions in 19%** of cases.
- **No sentences involving life imprisonment have been handed down for 1990 child abuse homicides.**

Accidental Child Deaths

- 93 accidental deaths were reported to the ICAN Team for 1990, a 32.9% increase over 1989.
- **The leading cause of death in accidental deaths was drowning (41.9%), followed by complications associated with maternal substance abuse (23.7%)** and falls (12.9%).
- **The number of accidental deaths due to drowning increased by 34.5% over 1989.**
- 66.7% of accidental death victims were male, 33.3% were female.
- 43% of the deaths occurred in victims under the age of one year.
- **68% of the accidental deaths which involved maternal substance abuse occurred in the perinatal period,** between birth and 28 days of life.
- **34.4% of the accidental death victims were of Latino descent.** Latinos comprise 37.8% of the county population.
- 30.1% of fatal accident victims were White, compared to 40.8% of the county population.
- **30.1% of the fatal accident victims were Black,** compared to 10.5% of the county population.
- **55.9% of accidental deaths occurred during late spring and summer months** (May through September).
- 51.6% of families had a history of receiving public assistance from the Department of Public Social Services.
- 23.7% of the families had a record of receiving **child protective services** prior to the death of the child.
- The deceased child had siblings in 44.1% of the cases.
- 15% of the victims had been seen at Department of Health Services facilities.

Natural Child Deaths

- 10 Natural deaths were identified by the Team to have a maternal substance abuse history or prior history of child protective services, a **400% decrease** from 1989.
- 7 of the 10 natural deaths reviewed had a Coroner certified cause of death of Sudden Infant Death Syndrome. In all 7 cases there was a history of maternal substance abuse while the mother was pregnant with the deceased.
- 60% of the families had a history of prior child protective services.
- 40% of the victims had been seen at Department of Health Services facilities.

Undetermined Child Deaths

- 5 Undetermined deaths were referred to the Team by the Coroner for 1990. This is consistent with numbers of cases reported for the years 1987-89.
- 2 of the undetermined deaths had indications of head trauma found upon autopsy, however due to conflicting history a determination of homicide or accident could not be made.
- 2 of the undetermined deaths cause were undetermined following autopsy due to no history of the circumstances surrounding the deaths. Both were abandoned infants.
- Only 1 of the families was known to the Department of Children's Services prior to the death.
- 3 of the victims had been seen at Department of Health Services facilities.
- Criminal charges were filed by the District Attorney on 1 of the undetermined cases.

Suicides

- 28 adolescent suicides were reported to ICAN's Child Death Review Team by the Coroner in 1990, compared to 43 in 1989, a decrease of 35% over 1989.
- 67.9% of the suicide victims were male.
- **17 year old white males continued to represent the highest risk group for teen suicide.** Over a third of the total suicides were committed by this age/ ethnicity group.
- Latino males and females are at nearly equal risk for suicide while white males are at much higher risk than white females.
- The Coroner certified no black child or adolescent suicides in 1990.
- The two youngest victims, age 12 years, were female.
- In 64.3% of the cases, the method of suicide involved the use of firearms. Other methods included hanging, 32%, and overdose of drugs, 3.6%.
- 21.7% of the families with suicide victims had a history of receiving public assistance from DPSS.
- Only 10.7% of the families with suicide victims had prior involvement with the Department of Children's Services, compared with a much higher rate (28%) in 1989.
- 17.9% of the suicide victims had **records of involvement with law enforcement and/or the Probation Department** for juvenile delinquent behavior.
- There were siblings identified on 25% of the cases.

Fetal Deaths

- 43 fetal deaths were reported to the ICAN Death Review Team for 1990, 34.4% fewer than in 1989.
- Black families suffered 62.8% of the fetal deaths identified by the Team.
- In 97.7% of the fetal deaths, there was a history of **maternal drug abuse** present.
- **3 fetal homicides were reported to the Team,** a set of triplets who died as a result of their mother being assaulted. There was no criminal charges brought as the mother had an extensive drug history which may have contributed to the demise of the fetuses.
- 23.3% of the fetal death cases had a record of prior involvement with the Department of Children's Services, most often for drug related problems.

Conclusions & Recommendations

Conclusions

1. **Although there is a 10% increase in child abuse homicides over 1989, the increase appears related to better identification of older victims.**

2. **A gender and age profile of child abuse homicide victims reflects:**
   A. Girls are facing increased risk of being victimized.
   B. Very young children, ages 2 and younger, continue to be victimized at very high levels.

3. **DCS and DHS data suggest that a minority of victims and families are known to these agencies before the death.** In light of the large numbers of children and families served by these agencies, identification of potential victims is extremely challenging. Better outreach methods are necessary to recognize these high risk families and prevent child abuse homicides.

4. **The response of agencies involved in the identification and investigation of child abuse homicides and provision of services to surviving family members is inconsistent.** Cases of suspicious deaths with like circumstances are not handled in a predictable or uniform manner. This is demonstrated in:
   A. The decisions of law enforcement and Department of Children's Services to remove surviving siblings from families after a suspicious death.
   B. The decisions of law enforcement and the District Attorney to file criminal charges against perpetrators.
   C. Discrepencies in what is reported to the State Department of Justice's two automated systems which track child abuse homicides and to the Team.

5. **The incidence of preventable fatalities will not be reduced without broad comprehensive prevention efforts.** It is necessary for the ICAN Child Death Review Team to coordinate with and support other community efforts in fatality prevention activities, such as:
   A. The Department of Health Services Injury Prevention Control Project
   B. The Los Angeles County Drowning Prevention Task Force
   C. Various groups involved in prevention efforts surrounding maternal drug and alcohol use.

6. While the 35% decrease in the number of adolescent suicides in 1990 from1989 is encouraging, there is a continued need for study of this population. Broader study, including review of suicide attempts which may show a different profile, is necessary to define how agencies can better address this area. ■

Recommendations

1. ICAN should promote expanded efforts to provide outreach services to families with very young children. Such efforts may include exploring the feasibility of establishing a neonatal home visitation program.

2. ICAN agencies should consider either broad based training, or the specialization of handling of child death cases to promote consistent identification, investigation and provision of appropriate services to surviving family members.

3. ICAN agencies, and the ICAN Multi-Agency Child Death Review Team should support and participate in community efforts to prevent child fatalities including the Los Angeles County Drowning Prevention Task Force.

4. ICAN should establish an ad hoc committee to review relevant agencies' policies and procedures to determine how services could be more effectively delivered to prevent adolescent suicides.

5. ICAN should support the development of a state level Child Death Advisory Committee which would provide support to county child death review teams, build a statewide data base on child death and promote consistency between the activities of county level teams.

6. ICAN agencies that are members of the ICAN Multi-Agency Child Death Review Team should continue to participate in the child death review process, including the collection and sharing of relevant agency data and the compilation of an annual report on findings and trends in child death. ■

Team Protocols

Team Protocols For Case Referral

California law requires that all suspicious or violent deaths and those deaths where the decedent has not been seen by a physician in the 20 days prior to the death are to be reported to the Department of Coroner. The Coroner is then responsible for determining the circumstances, manner and cause of these deaths.

Every morning, the Coroner's on-duty Supervisor compiles a list of all cases that came to the Coroner's attention during the previous 24 hours. From this compilation, the Coroner has agreed to derive a new list of all children age ten (10) and under* where one or more of the following factors are present, for review and study by the ICAN Child Death Review Team:

1. Drug ingestion
2. Cause of death undetermined after investigation by Coroner
3. Head trauma (subdurals, subarachnoid, subgaleal)
4. Malnutrition/neglect/failure to thrive
5. Drownings
6. Suffocation/asphyxia
7. Fractures
8. Sudden Infant Death Syndrome (SIDS) where history or condition of body raise suspicions or the child is over age of seven months
9. Blunt force trauma
10. Homicide/child abuse/neglect
11. Burns except where cause is clearly not abuse /neglect, such as auto accident, accidental house fires, etc.
12. Sexual abuse
13. Gunshot wounds
14. Special populations - fetal deaths and suicides are part of separate studies

* *Age exceptions are made for apparent suicides and homicides (child abuse) by family member or caretaker.*

Once a case is drawn off by the Coroner, identifying case information is sent to the ICAN offices, where it is routed to Team representatives from the District Attorney's Office, Department of Children's Services, Los Angeles Police Department, Los Angeles Sheriff's Department, and Department of Health Services. Members check each case in their agencies' computers and files for previous contacts with the child or family. Record check findings are then returned to the ICAN office for compilation and analysis.

The California State Department of Justice provided a detailed listing of child homicides where the victim was under the age of 11 years old reported from Los Angeles County, which was reconciled against the Team's findings. Mental Health and Probation representatives checked records on all suicide cases to determine if any of those children were known to their agencies.

Selecting cases for in depth review by the Team is a process that takes place within the Team itself. Three to five cases that meet the above mentioned criteria are reviewed at each month's meeting. Primarily, high profile cases and cases in which a committee member requests the Team's multidisciplinary perspective, are reviewed by the team. The Team encourages agency staff involved with the cases reviewed to attend the meeting at which that case is discussed to share their observations and findings.

At the end of the year, the Coroner reports summary statistics on all cases reported to the Team to the ICAN Data Sharing Committee for its report, "ICAN Data Analysis Report". This report by the Child Death Review Team expands upon the Coroner's findings by including the results of the record searches of the other member agencies and additional analysis based upon Team discussion and knowledge.

Modes of Death

The Coroner has five choices for the mode of death listed on the death certificate: Accidental, Homicide, Natural, Suicide, and Undetermined. In the course of setting up this analysis a central focus was kept on the mode of death.

- Homicides, by definition are deaths at the hands of another, and require study by the Child Death Review Team.

- Accidental deaths are the largest number of deaths reported to the Team by the Coroner. Several of the criteria for reporting, such as drownings, head trauma from falls, suffocations and accidental gunshot wounds, are truly accidental in nature. There remains a question of caretaker supervision in these cases, as well as concern as to the preventability of these accidents.
- Natural deaths are most frequently reported to the Team due to the mother's use of drugs or alcohol during pregnancy. For example, an infant may die of sequelae of prematurity where the mother's drug use precipitated the early birth of the infant. While the mother's drug use cannot be proved to have caused the infant's death, the close association of the two factors is a concern of the Team.
- Undetermined deaths are situations where the Coroner is unable to fix a final mode of death. Usually, there is no clear indicator in these cases if the death was caused by another, or was accidental. These cases remain suspicious in nature and are of interest to the Team even though a final determination cannot be made by the Coroner.
- Suicides of adolescents are reported to the Team as a special population. The Team recognizes that suicide, most often, in and of itself, is not a result of child abuse and neglect. However, the ability of the Team to collect information on these deaths from multiple agencies is of benefit in better identifying these high risk teenagers for prevention purposes.

Fetal deaths are also handled as a special population. They are not reported with other child abuse or suspicious deaths and are reported on separately in a special section of the report. They do include fetal homicide cases which are usually a result of violence against the mother. ■

Detailed Findings

Detailed Findings

228 deaths were reported by the Department of Coroner to the ICAN Child Death Review Team in 1990.

- 43 Homicides
- 93 Accidental deaths
- 16 Natural deaths
- 5 Undetermined deaths
- 28 Suicides
- 43 Fetal deaths

Preliminary review of homicides and natural deaths, and reconciliation of the deaths referred by the Coroner to Team reviewed deaths resulted in the addition of 3 homicides and removal of 6 natural deaths. *Figure 1* summarizes how the 225 deaths were categorized and where adjustments were made. Further details on the adjustments can be found in the detail sections on homicides and natural deaths. ■

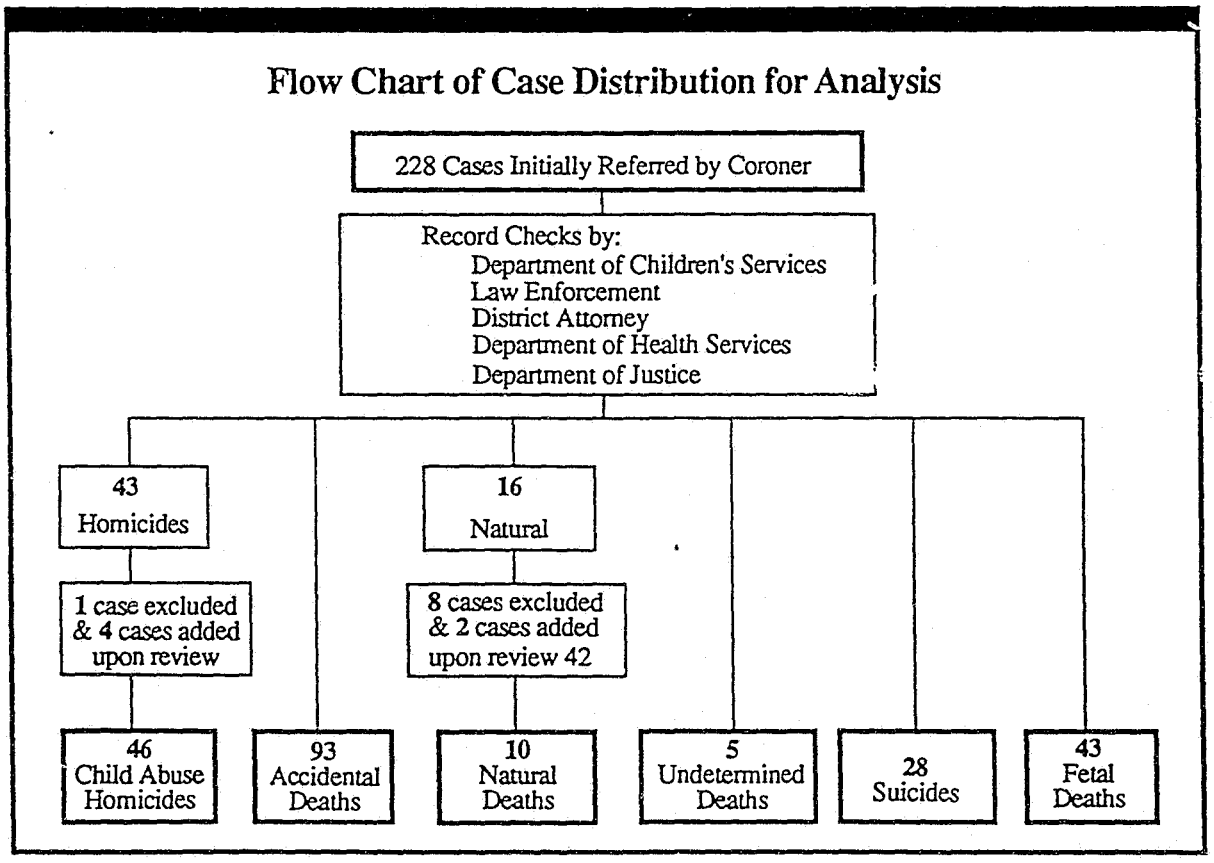

Figure 1

Child Abuse Homicides

Child Abuse Homicides Los Angeles County 1990

Sonia - 18 month old, was left with her mother's male companion while the mother took Sonia's older sisters to school. The male companion forced the mother to leave Sonia with him. When the mother returned home, she found Sonia in seizures, and she died before arriving at the hospital. The autopsy revealed a subdural hematoma indicative of shaken baby syndrome.

The mother's male companion fled. Murder charges were filed and a warrant is outstanding for his arrest.

There was a history of domestic violence in the family. Prior domestic violence allegations were not filed, as apparently, the mother did not press charges.

This family was unknown to the Department of Children's Services before Sonia's death.

Forty three homicides were reported to the Team by the Department of Coroner in 1990. One case was deleted after in-depth review because the perpetrators were identified as unrelated and in a non-caretaker role. Analysis also revealed 3 older siblings who were killed at the same time as children reported by the Coroner on 2 cases, and one older child who's case was reviewed by the Team, but was not reported for statistical analysis. These cases were added to the homicide population resulting in 46 total homicides being identified by the Team.

Gender

Of the 46 child abuse homicide deaths, 21 or 45.7% were males and 25, or 54.3% were females. This is the second year that child abuse homicides in Los Angeles county have not been consistent with studies in other localities and states that show more male homicide victims than female. *Figure 2* displays this data graphically.

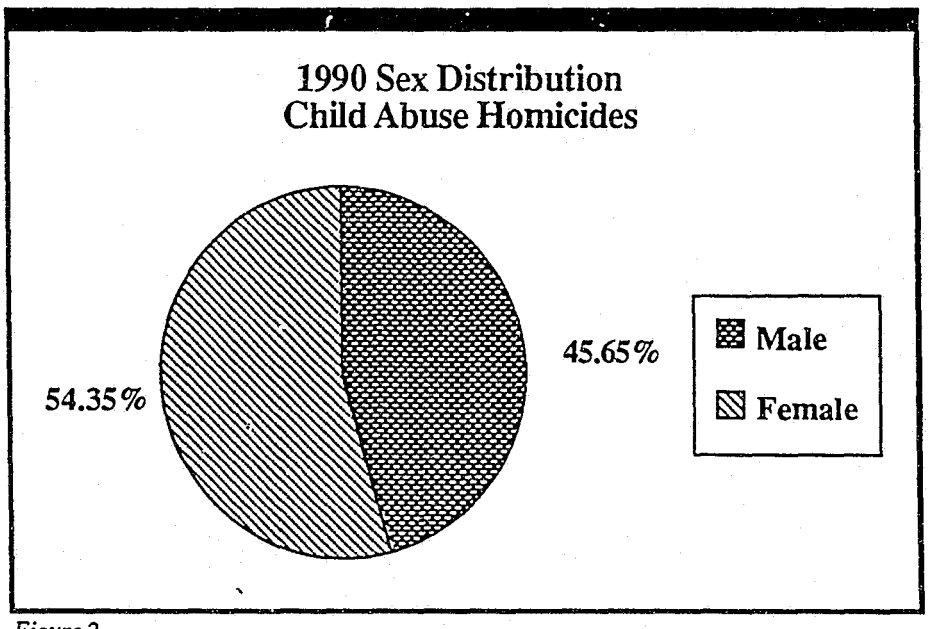

Figure 2

Figure 3 illustrates how, over the past 5 years, there has been a steady increase in both the real number and relative percentage of female child abuse homicide victims.

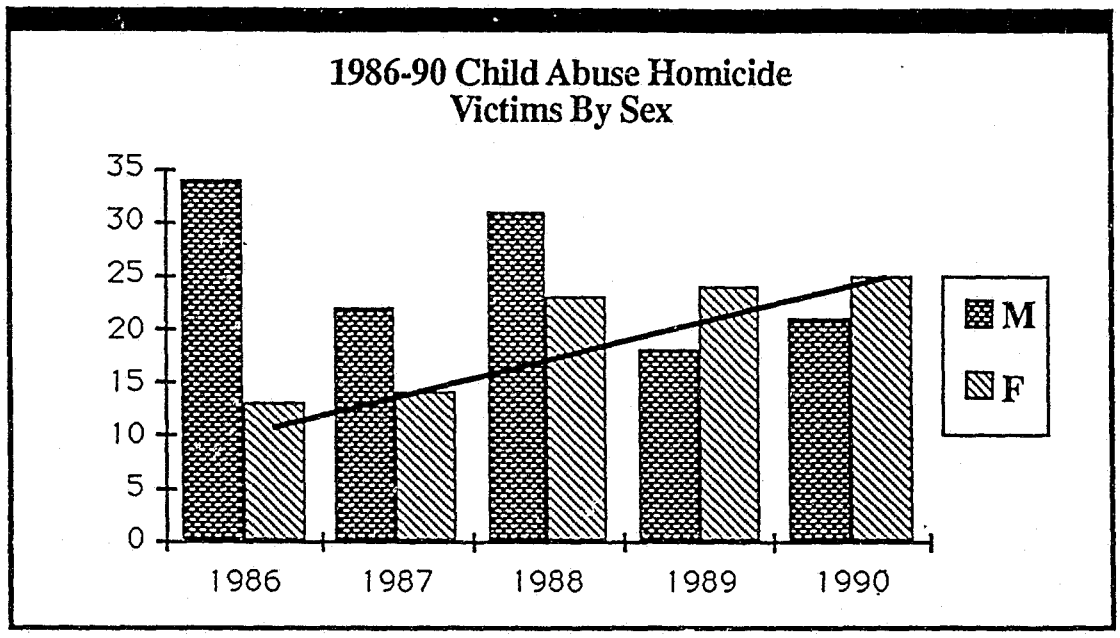

Figure 3

Age

The ages of the 1990 child abuse homicide victims is shown in *Figure 4*. 28.2% of child abuse homicide victims were under the age of 6 months. 43.5 % were under the age of 1 year. 63% were under the age of 2 years. In 1990, more child abuse homicides of children over the age of 10 years were identified. This is due to better identification of murder/suicide cases in which these older children were killed.

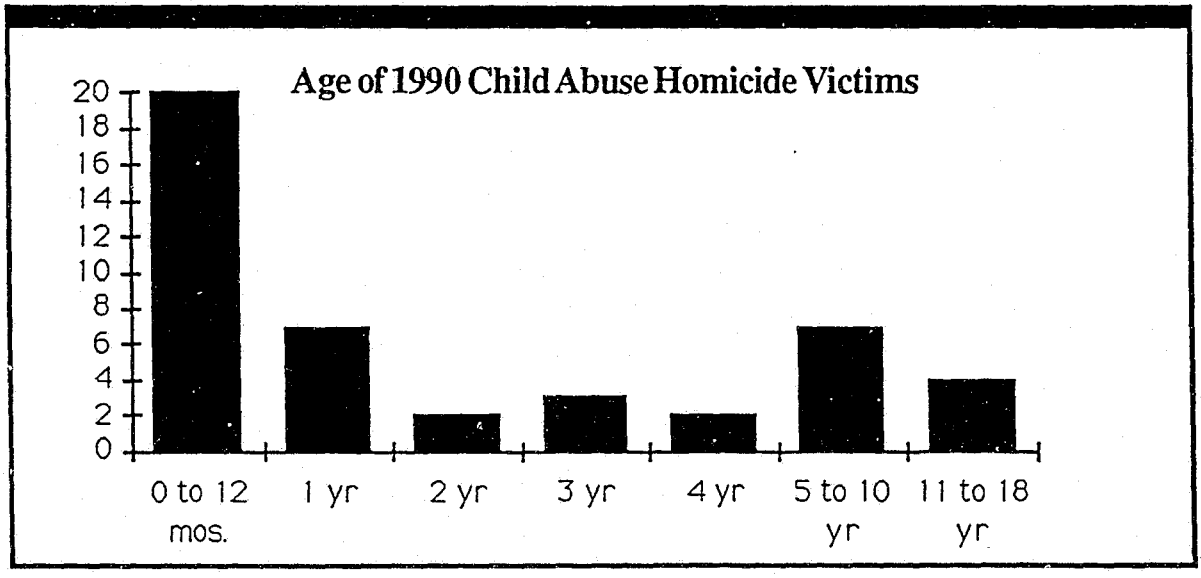

Figure 4

Table1 displays the relationship between age and sex of the child abuse homicide victims. Female victims were slightly older, on average (3.78 years), than male victims (2.67 years). Seven of the 10 oldest victims were female.

1990 Child Abuse Homicides by Sex and Age

	Age											
	<1	1	2	3	4	5	6	7	8	9	10	11+
Male	11	3	2	3			1		1			1
Female	9	4			2	1	3		1			3
Total	20	7	2	3	2	1	4		2			4

Table 1

Ethnicity

The greatest number of child abuse homicide victims were latino, 45.6%, followed by black, 28.3%, and white, 19.6%. There were two Asian and one Filipino fatalities, representing together, 6.5% of the total. Population estimates for 1990 show an ethnic breakdown in Los Angeles County of 40.8% white, 37.8% latino, 10.5% black and 10.2% Asian. When child abuse homicides are compared to the population estimates, latinos and blacks are over represented while whites and Asians are underrepresented.

Latino females were represented at a higher level than any other ethnic/sex group. 61.9% of Latino victims were female. Table 2 compares the ethnicity and sex of the victims.

1990 Child Abuse Homicides by Sex and Race

	White	Latino	Black	Other	Total
Male	4	8	7	2	21
Female	5	13	6	1	25
Total	9	21	13	3	46

Table 2

Table 2

Cause of Death

The causes of death in the child abuse homicides are displayed in *Table 3*. The most frequent single cause of death was gunshot wounds, followed by shaken baby syndrome and other forms of head injuries. In previous years, the leading cause of death has been cerebral trauma, and when shaken baby syndrome and cerebral trauma are combined, these deaths continue to outnumber those involving firearms for 1990.

Homicide by use of firearms was most frequently associated with older children. Three of the four oldest child abuse homicide victims were shot to death and the average age of those killed by firearms was 7.1 years, compared to 3.19 years for all other causes of death in homicides. There were 4 victims who were age 3 years and younger who were the victims of firearms. In 9 of the 11 deaths, firearms were used in murder/suicide situations where the parent killed themselves after killing the child.

Causes of Death in 1990 Child Abuse Homicides

	n	%
Gunshot wounds	11	23.9
Shaken baby syndrome	9	19.6
Cerebral trauma	8	17.3
Multiple traumatic injuries	5	10.9
Asphyxia	5	10.9
Burns	2	4.3
Drowning	2	4.3
Compression of neck	1	2.2
Penetrating wound to brain	1	2.2
Severe malnutrition	1	2.2
Strangulation	1	2.2

Table 3

Temporal Pattern

The incident rate of child abuse homicides for each month is displayed in *Figure 5*. The peak month for homicides was March with 8 homicides. The months with the least number of homicides were January, September, November and December, with two deaths in each of those months.

Figure 6 illustrates the incidence rate of child abuse homicides for the years of 1986 through 1990. There has been an average of 4 child abuse homicides per month with the peak months being February and March, and low months of April and May. ■

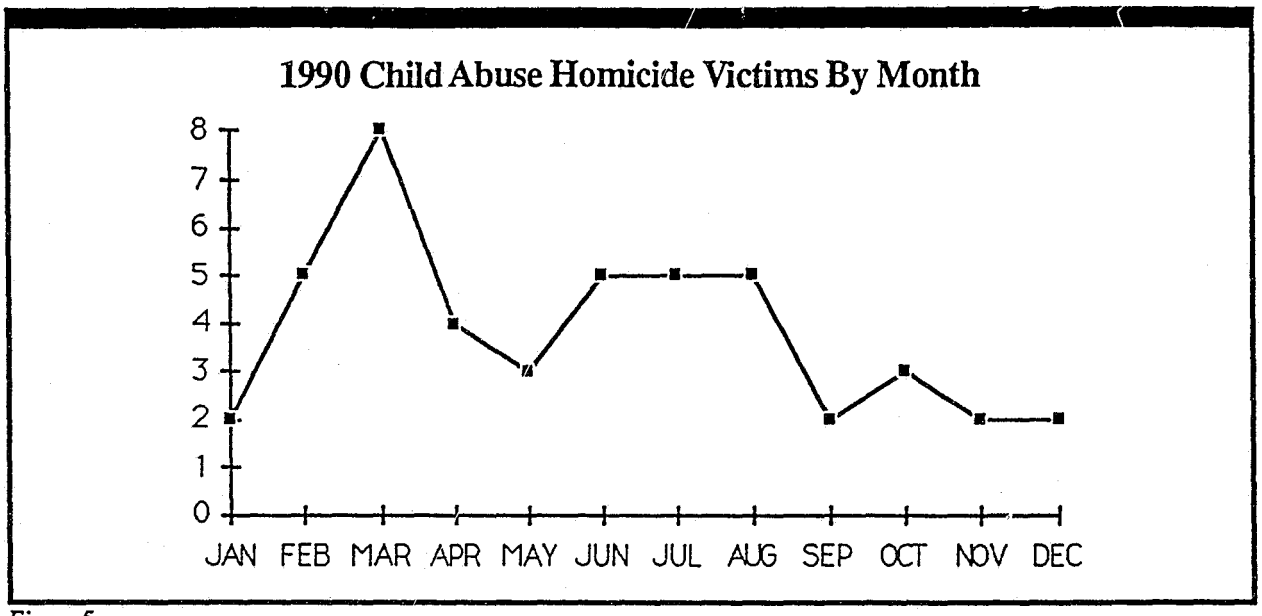

Figure 5

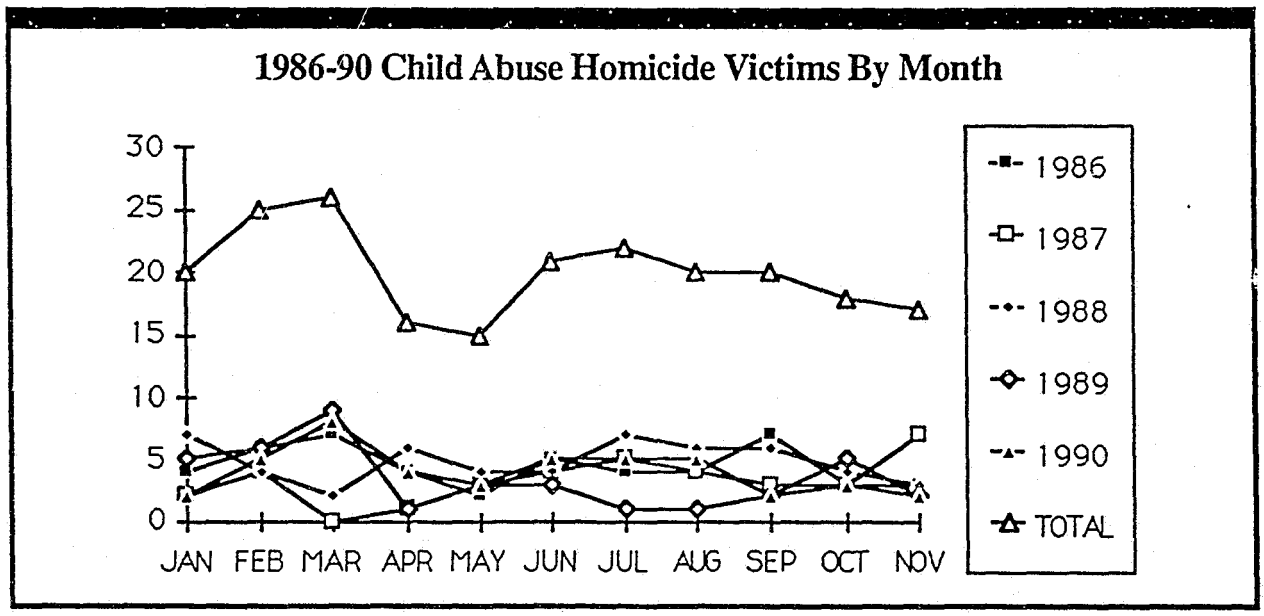

Figure 6

Child Protective Services Involvement in Child Abuse Homicide Cases

Prejedix - 11 months old, died as a result of burns suffered when a pot of boiling water spilled on her and the family did not take her for medical attention. A homicide determination was made by the Coroner on this case as the burns would not have been fatal had the child received timely medical care. The child, due to her age, was dependent on the parents for this care.

The family had previous contact with DCS in 1989 as a sibling was seriously burned. At that time the children were not removed from the home. The social worker sternly lectured that a similar, subsequent incident would result in removal of the children. This warning may have contributed to the parents decision to not seek medical care.

At the time of the death, Prejedix's 2 year old and 11 month old siblings were immediately removed from the family and placed in foster care. However, the siblings were released to the parents by the Dependency Court at a court hearing three days later and the family fled to Mexico.

The law enforcement investigators strongly believed that the parents did everything they could for the child short of taking her for medical treatment. No criminal charges were sought in regards to Prejedix's death. The District Attorney rejected the case as accidental injuries.

The above case example illustrates Department of Children's Services involvement with one of the families prior to the death.

23.9% (n=11) of the families in which there was a child abuse homicide had a record of receiving child protective services prior to the death of the child. Five, 10.9%, of the cases were open at the time of the children's death. Two of the five cases were open due to the injury that caused the death.

Information on the length of time a case had been open to DCS in relation to the date of death were compared. *Table 4* shows that a majority of the cases had been referred prior to one full year before the death.

The reasons for prior DCS services included:

- Neglect - 4 cases
- Physical abuse - 4 cases
- Sexual abuse - 1 case
- Prenatal substance abuse - 1 case
- Caretaker incapacity - 1 case

Of those cases that had prior services, DCS had proceeded with court action on 3 families, on 27% of cases known to DCS, or 6.5% of all homicides. That court action resulted in out-of-home placement in all 3 families.

In addition to the 5 cases that were open to DCS at the time of the child abuse homicide, 18 additional families were referred to DCS at the time of injuries that caused the death or immediately following the death. Four of those cases investigated had no siblings and were closed shortly after the initial investigation of the death.

The reason for referral on the 23 families that received services following the death are displayed in *Table 5*. The largest number of cases were opened for physical abuse (43.5%), followed by severe neglect (34.8%).

Comparison Between Time of DCS Prior Case Opening & Death of 1990 Child Abuse Homicides

Length of Time Open	n	%
1 Month or Less	2	18.2
1 - 6 Months	3	27.3
6 - 12 Months	0	0
1 to 2 Years	2	18.2
Over 2 Years	4	36.3

Table 4

Petitions were filed in Juvenile Dependency Court on siblings of the deceased child on 11 cases following the child abuse homicide. The deceased child had been placed following the eventually fatal injury on three cases. Siblings were removed from the home and placed in 11 families.

Figure 7 summarizes the child protective services involvement on the child abuse homicides.

The Department of Children's Services provided information regarding the constellations of families known to them. The high percentages of unknown elements are due to DCS's infrequently being involved in families when there were no surviving siblings.

- 58.7% of the families had a history of receiving public assistance from the Department of Public Social Services. DPSS indicated that 1.5 million persons (approximately 16.9% of the county population) are recorded on the DPSS computer system as as current or former recipients of assistance.

Reason For Current DCS Services on 1990 Child Abuse Homicide

Reason For DCS Services	n	%
Physical Abuse	11	43.5
Severe Neglect	8	34.8
Death of Child	2	8.7
Prenatal Substance Abuse	1	4.4
General Neglect	1	4.4

Table 5

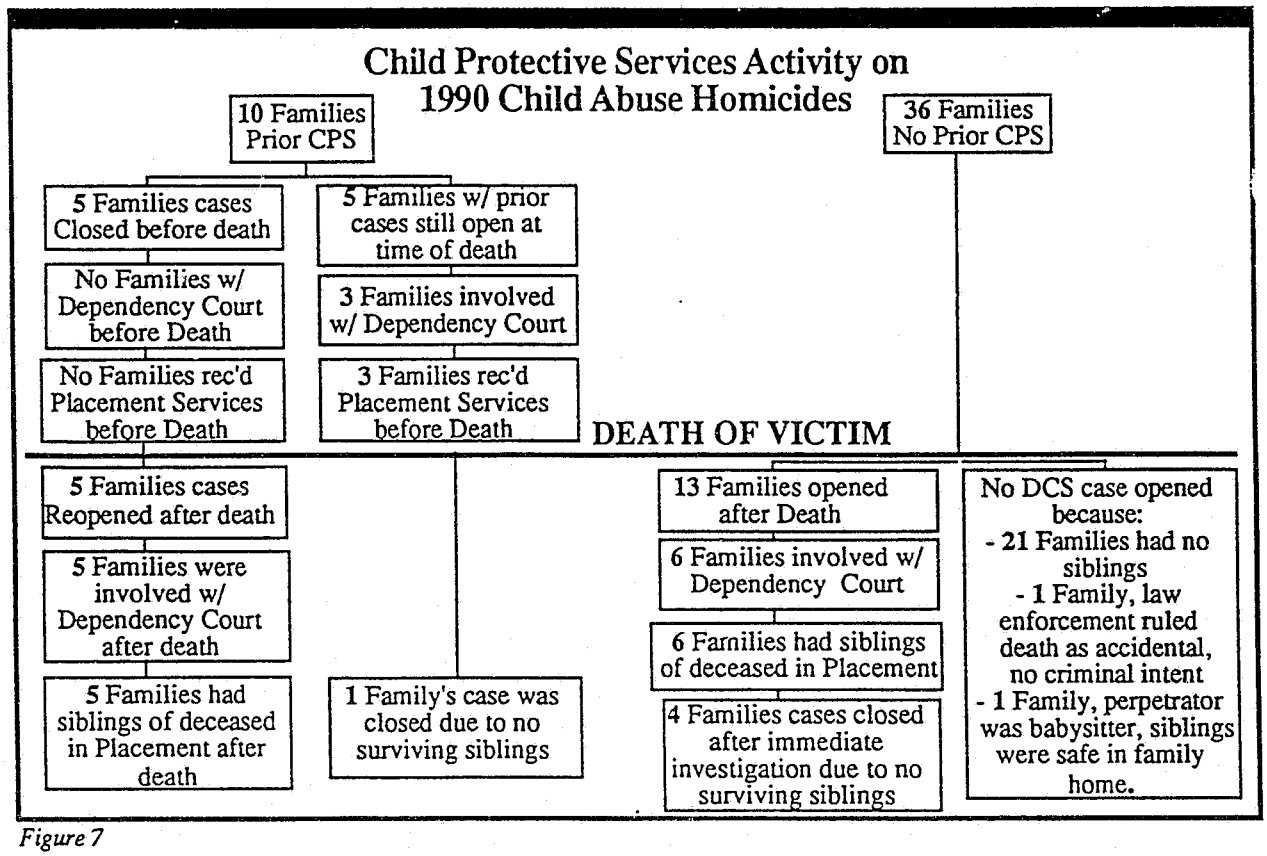

Figure 7

- The mother of the deceased child was known to be residing in the home in 56.5% of the families. The mother was known to be residing out of the home in only 2.2% of the families. The information was unavailable on 41.3% of the families.
- The mother's age at the time of death of the child was known in 63% of the families. The average age of the mothers was 26.7 years. *Table 6* gives a breakdown of the mothers ages. 48.3% of the mothers were under the age of 25 years old at the time of their child's death.
- The father was known to reside in the family home in 24% of the cases, resided out of the home in 24% of the cases and information was unavailable in 52% of the cases.
- The deceased child had siblings in 20 (43.5%) of the cases.
- There were siblings residing in the family home in 4 cases following the death. Siblings on 14 cases remained in placement out of the family home at the time of review.
- The suspect was known to reside in the home in 43.5% of the cases. The suspect was known to not reside in the home in 4.4% of the cases. The suspect was either not identified, or the relationship was not known or provided on 52.1% of the cases by DCS.
- Drug use in the family home was confirmed by DCS in 9% of the families.

Age of Mothers of Child Abuse Homicide Victims

Age	n	%
Less Than 20 Years	5	17.2
20 - 24 Years	9	31.1
25 - 29 Years	3	10.3
30 - 34 Years	7	24.2
Over 34 Years	5	17.2

Table 6

Criminal Justice System Involvement in Child Abuse Homicides

Information on criminal justice system involvement was gathered from the Los Angeles County District Attorney's Office, Los Angeles Sheriff's and Los Angeles Police Departments. From this method, criminal justice information was gathered on 45 of the 46 child abuse homicides.

The law enforcement agencies and the number of cases for which they were responsible for investigation are shown in *Table 7*. Los Angeles Police Department had investigative responsibility for 60% of child abuse homicides, a 12.5% increase over 1989. 17.8% of the child abuse homicide investigations were handled by jurisdictions other than LAPD and LASD. Five fewer law enforcement jurisdictions were responsible for the investigation of child abuse homicides in 1990 than 1989.

Law Enforcement Agency Involvement in Child Abuse Homicide

Law Enforcement Agency	n	%
LAPD	27	60.0
LASD	10	22.2
Long Beach PD	4	8.9
Compton PD	3	6.7
Bell PD	1	2.2

Table 7

Twenty seven (60%) of the case investigations resulted in presentations to the District Attorney's office by the law enforcement jurisdictions, an increase of 10% over 1989.

18 of the child abuse homicide cases were not presented to the District Attorney. The reasons that those cases were not presented are displayed in *Table 8*.

The following case demonstrates a case where law enforcement was not able to file criminal charges:

SANTOS' - 10 weeks old, family had been known to child protective services for several years due to severe neglect, transiency, and the parents' inability to provide regular care for the children. Santos had 9 brothers and sisters, all of whom had been removed from the parents custody. The child protective worker involved with the family was unaware of Santo's birth, even though the hospital, AFDC worker, and a church that had been helping the parents were all aware that the infant was at high risk due to the parents' history of mental disability and homelessness.

Despite the parents' disabilities and mother's history with the Regional Center for Developmental Disabilities, no psychological evaluation or treatment was ever undertaken as part of child protective services or court involvement.

Santos died from intracranial trauma, a result of shaking. Criminal action was not taken against the parents as investigators were unable to prove which parent caused the fatal injuries to the child.

The 27 case presentations by law enforcement resulted in the District Attorney filing criminal charges in 20 cases, 5 rejections and 2 requests for further investigation by the law enforcement agency. *Table 9* provides the reasons for rejection by the District Attorney's Office.

Murder charges were filed on 84% of the cases accepted by the DA. Child endangering charges were filed in 37% of the cases. Charges filed on these cases are displayed in *Table 10.*

Natural fathers were charged most frequently in the death of their children, followed by mothers and mothers' male companions. *Table 11* illustrates the various relationships of suspects on the child abuse homicides in which charges were filed.

There were multiple suspects on only 1 case for 1990, compared to 6 cases in 1989.

Law Enforcement Agency Reasons For Not Presenting 1990 Child Abuse Homicides Cases to The District Attorney

Reason	n	%
Murder/Suicide	9	50.0
Ruled Accidental by Law Enforcement, no Criminal Intent	4	22.1
Insufficient Evidence to Identify Suspect Beyond a Reasonable Doubt	2	11.1
Unable to Prove Criminal Intent Due to Young Age of Suspect	1	5.6
Still Under Investigation	1	5.6
Medically Fragile Infant Whose Condition Confounded Prosecution	1	5.6

Table 8

District Attorney Reasons for Rejection / Not Filing Criminal Charges on 1990 Child Abuse Homicides

Reason For Rejection	n
Insufficient Evidence to Identify Suspect Beyond a Reasonable Doubt	3
Unable to Prove Criminal Intent	2

Table 9

Charges Filed on 1990 Child Abuse Homicides

Charge		n	%*
187 PC	Murder	16	84.2
273A(1) PC	Willful Cruelty to Children (Child Abuse)	7	36.8
192b PC	Involuntary Manslaughter	4	21.1
207 PC	Kidnapping	1	5.3
278 PC	Unlawful Detention	1	5.3

Table 10 * *percentage totals over 100% as there were multiple suspects on 1 case*

The disposition status of the cases in which criminal charges were filed are displayed in *Table 12*. 28.5% percent of the filings are still in pending status. However, on those cases which have reached final disposition, the sentences are less severe than those handed down in the 1989 cases. In 1989, 8 perpetrators received sentences of at least 15 years to life prison, compared to no life sentences have been handed down for 1990 cases to date. 4 suspects originally charged with murder in 1990 cases pled to manslaughter charges and 2 suspects originally charged with manslaughter pled to child endangering charges.

Relationship of Perpetrator on 1990 Child Abuse Homicides Where Criminal Charges Were Filed

Relationship	n	%
Father	7	36.8
Mother	6	31.6
Mother's Live-in Male Companion	3	15.8
Stepfather	1	5.3
Babysitter	1	5.3
Aunt's Male Companion	1	5.3
Uncle	1	5.3

Table 11

Murder Suicide Cases

GISELLA - This family was known to child protective services due to allegations of the father molesting Gisella, his 14 year old daughter. The case was closed within one month as the mother took appropriate steps to protect her children; she expelled the father from the home, secured a temporary restraining order, started divorce proceedings and started attending counseling with Gisella.

While the child protection system handles thousands of child sexual abuse cases in a similar manner each year, there are few services in place for the fathers who are involved in these potentially volatile situations. No one in the system monitored this distraught, violent man. He subsequently broke into the family home, shot and killed the Gisella and his wife, and seriously injured Gissela's 13 year old sister before turning the gun on himself and committing suicide.

In 1990, 9 children, in 5 families, died as a result of murder/suicide situations, wherein, after killing the children, the perpetrator committed suicide. This is a 200% increase over 1989. The cause of death for all victims were gunshot wounds. As reported previously, the average age of the victims was older, and involved all but 1 of the victims reported to the Team who were over the age of 10 years.

Five of the children, in 3 families, were killed by their natural fathers. The other four children, involving 2 families, were killed by their natural mothers.

Criminal Case Disposition of 1990 Child Abuse Homicides

Case Status	n	%
Pending Trail	6	28.5
Pled Guilty, Pending Sentence	1	4.8
13 Years Prison	1	4.8
11 Years Prison	2	9.5
Juvenile Commitment to California Youth Authority	1	4.8
1Year Jail and 5 Years Probation	3	14.1
Less Than 3 Months Jail and 3 Years Probation	2	9.5
5 Years Probation With No Jail Time	1	4.8
Juvenile Home on Probation Order	1	4.8
Bench Warrant Outstanding	1	4.8
Unable to Locate Information	1	4.8
Dismissed at Pre-Trial Hearing	1	4.8

Table 12

California State Department of Justice Involvement in Child Abuse Homicides

The California State Department of Justice (DOJ) receives reports from law enforcement on all crimes committed in the state via the Uniform Crime Report system. From this system, DOJ runs summary statistics on crime and the criminal justice system response for agencies throughout the state. DOJ maintains a separate, second, Child Abuse Index system, to which all child protective services agencies, both law enforcement and child welfare agencies, are required to report all cases of child abuse and neglect other than general neglect and prenatal drug exposure. The Department of Justice reported findings from both of their systems for inclusion in this report.

In 1990 the Uniform Crime Report system identified 41 homicides reported from Los Angeles County where the victim was under the age of 10 years. 17 of those cases were not initially reported to ICAN by the Coroner. These cases were researched and subsequently 8 of these deaths were added to the ICAN population by the Coroner. The remaining 9 deaths were homicides by unrelated parties. Three of these deaths were gang related drive-by shootings.

Eleven cases that were in the ICAN database were not in the DOJ - UCR database. The responsible law enforcement agencies were notified by ICAN to investigate the discrepancy in their reports. Those cases that were not in the DOJ index were cases where the law enforcement agency ruled the case as accidental, were unable to prove criminal intent on the part of the suspect, or where a criminal filing was rejected by the District Attorney's Office.

The DOJ Automated Child Abuse System reported that 16 child abuse investigation reports were received for 1990 from Los Angeles County child protective services agencies in which the death of the victim was identified. 10 of those deaths were known to the Team. Three of the 6 deaths on this index, which were unknown to the Team, were added after review. The other 3 were not added for a variety of reasons: one was the surviving sibling of a child reported to the Team, one was the victim of a stranger related homicide, and the other appeared to be be the result of a data entry error, as there was no indication in the DCS record, who was the reporting agency, of the child being deceased.

33 child abuse homicides known to the Team were not on the State Department of Justice Automated Child Abuse (DOJ ACA) System. Both LAPD and LASD Team representatives were notified of the cases missing on the index. LAPD researched the cases within their jurisdiction and reported filing 11 additional reports with the DOJ ACA System after reviewing the case situations. They determined not to file reports on 2 cases, one where the suspect was unknown and the other where the incident was ruled accidental by the investigator. Only 2 of the 9 murder/suicides were listed on the DOJ ACA System prior to review by LAPD. The reasons given for not filing reports with the system included that the investigator was waiting to file the report at the conclusion of their investigation, and in the cases of the murder/suicide, a lack of awareness by Homicide Detectives that these reports are required and that these homicides fall within the context of child abuse.

Health Systems Involvement in Child Abuse Homicides

Cindy - seven month old, died as a result of severe malnutrition. Cindy had been taken to a county hospital on several occasions but her condition did not improve. The parents then contacted a faith healer. The parents reportedly fed the child fruit juices, vegetables and herbal teas in an effort to treat her ongoing illness.

The Coroner indicated that the child may have had a preexisting brain condition that could have contributed to her failure to thrive.

Involuntary manslaughter charges were filed against the parents, and they plead guilty to involuntary manslaughter charges. The parents served less than 60 days in jail and were placed on 3 years probation..

All medical records, other than birth records, could not be located at the hospital for ICAN review despite being seen by attorneys during the parents' criminal proceedings. However, information was received that the hospital contacted the parents and told them that the infant was anemic and needed to be brought into the hospital for blood tests. The parents complied. The hospital had a difficult time drawing the blood and the infant cried tremendously during the procedure. It is unknown what impact this painful procedure may have had on the parents' decision not to seek further medical care for Cindy.

Computer search for Los Angeles County Department of Health Services records for 1990 indicated that 26%, 12 of the 46, child abuse homicides had records in DHS facilities. This is a 16% increase in the number of cases with identified DHS records over 1989. This increase is probably due to improvements in the Team's ability to access DHS databases. No systematic review of these records currently takes place within DHS or the Team structure. Even when computerized systems indicate medical records, DHS representatives indicate that they have difficulties accessing physical case records for review.

Therefore, previous medical records are noted in large part for their absence or incompleteness. Individual case review frequently reveals no previous health records, superficial reference to medical care or specific reference to the lack of medical information. Birth records and regular health records of care for the life of the child are almost always absent. Whether this situation is a result of families lack of access to medical care, failure to obtain care or multiple complex medical records systems with problems in the retrieval of records, can not be ascertained. ■

Accidental Child Deaths

Accidental Child Deaths in Los Angeles County - 1990

Jeffery - 3 years old, died as a result of an accidental drowning. Law enforcement indicated that his grandmother took Jeffery to a friend's house, and while they were visiting, Jeffery went outside, unsupervised, and five minutes later was found in the pool dead.

Jeffery's family was known to the Department of Children's Services. Jeffery had previously been a dependent child of the court, but jurisdiction was terminated after Jeffery had been released to the non-offending father. There was a sibling with an open DCS case due to prenatal drug exposure. That social worker was unaware of Jeffery's death as Jeffery resided in a separate household.

93 accidental deaths were reported to the Team by the Coroner for 1990 ,a 32.9% increase over 1989. These cases are analyzed by the Team due to potential questions of child safety and supervision by the caretakers. These deaths have been determined by investigating agencies, law enforcement and the Coroner, to be inadvertent and unintended. The pain the families feel as a result of these deaths is great. Most, if not all, are preventable.

Causes of Death

The causes of accidental deaths are displayed in *Table 13*. The leading cause of accidental death is drownings followed by effects of maternal drug abuse, falls from heights, and choking on food.

The number of accidental deaths by drowning increased by 34.5% over 1989.

Current ICAN protocols do not require the Coroner to report traffic fatalities or deaths due to burns to the ICAN Team, except where the cause is clearly abuse or neglect related.

Causes of Death in 1990 Child Abuse Homicides

	n	%
Drownings	39	41.9
Maternal drug abuse	22	23.7
Falls	12	12.9
Asphyxia / choking	7	7.5
Asphyxia / suffocation	3	3.2
Accidental overdose of drugs	3	3.2
Hyperthermia	1	1.1
Hanging	1	1.1
Gunshot wound	1	1.1
Other	4	4.3

Table 13

Gender

The sex distribution of the accidental deaths, as is shown in *Figure 8*, was 66.7% male and 33.3% female.

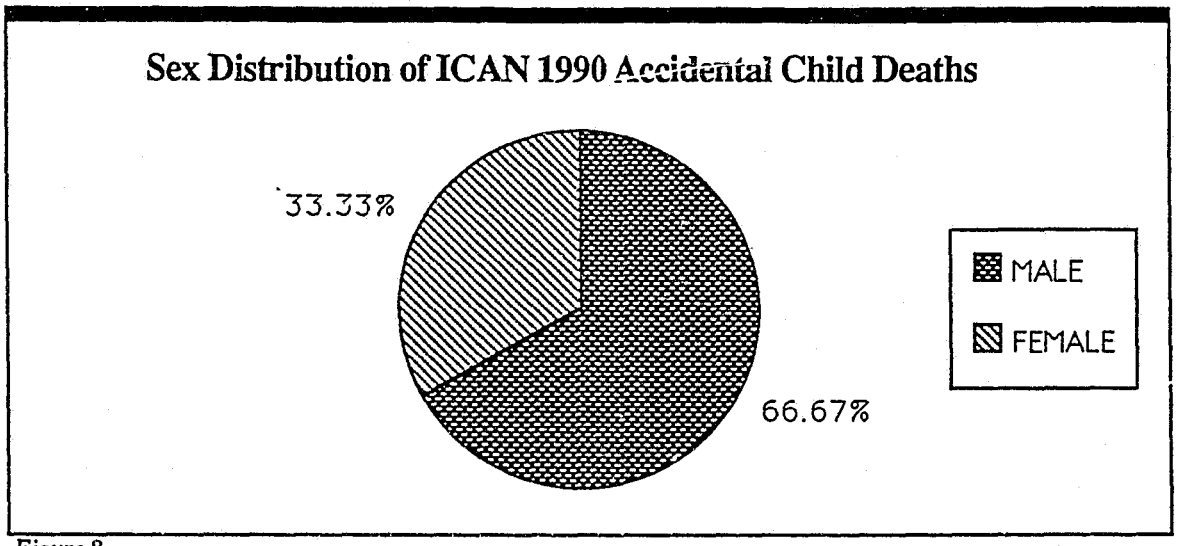

Figure 8

Age

The ages of the accident victims is shown in *Figure 9*. 43% of the victims were under the age of one year. Deaths from drownings occurred between the ages of 5 months and 6 years of age, with the greatest frequency occurring between the ages of 1 and 3 years of age.

The deaths in which maternal drug abuse was a factor occurred in infants from ages 1 hour to 19 months old. 68.2% (n=15) of the 22,drug involved infants died within the perinatal period, that is, between birth and 28 days of life.

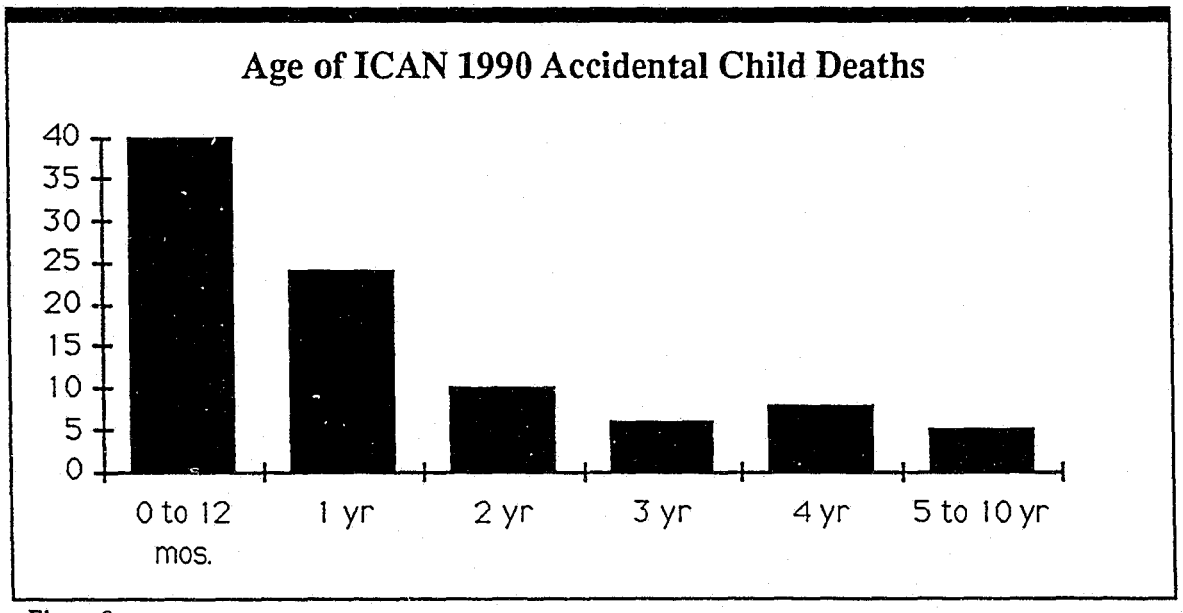

Figure 9

Ethnicity

Latino children suffered the highest rate of accidental deaths, 34.4%. When compared to population estimates for Los Angeles County, black children suffered from accidental deaths at a higher rate than the ethnic makeup of the county. All other ethnic groups are underrepresented.

Analysis shows that latino and whites suffer equal number of drowning deaths while black children suffer the highest incidence of drug related accidental deaths. All Asian children that were reported as accidental death victims died from drowning. *Table 14* displays the causes of accidental death for the children of different ethnic groups.

Causes of Death in ICAN 1990 Accidental Child Deaths				
	Latino	Black	White	Asian
Drownings	15	4	15	5
Maternal drug abuse	2	16	6	0
Falls	5	2	4	0
Asphyxia	7	2	1	0
Accidental overdose of drugs	0	1	0	0
Other	3	1	0	0
Total	32	28	28	5
%	34.4	30.1	30.1	5.4

Table 14

Temporal Pattern

Figure 10 displays the incident rate of accidental deaths for each month of ICAN 1990. The peak month for accidents was August, the lowest month being February. When drowning deaths are compared to the trend of all accidental deaths, the seasonal variation of those deaths, occurring most frequently in spring and summer months, can be easily observed. 55.9% of accidental deaths occurred during late spring and summer months (May through September).

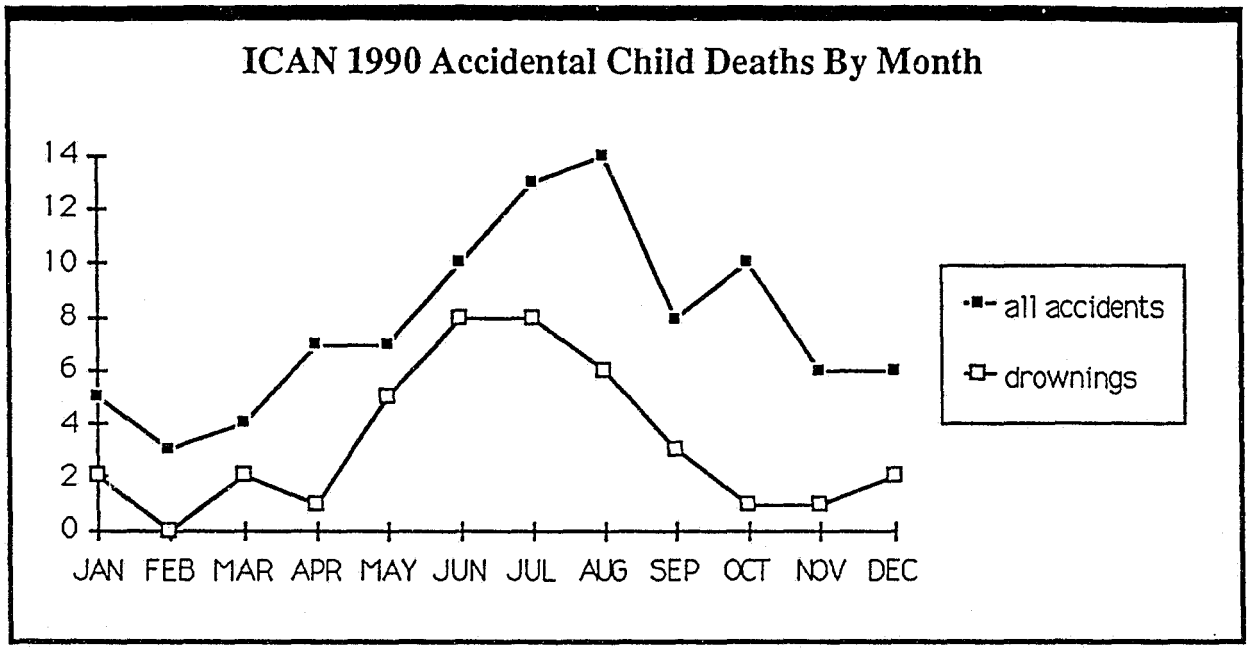

Figure 10

Child Protective Services Involvement in ICAN 1990 Accidental Child Deaths

23.7% (n=22) of the families had a record of receiving child protective services prior to the death of the child. 84.6% of these cases were families where the Coroner noted maternal substance abuse as contributing to the cause of death.

The reasons for prior DCS services is shown in *Table 14*. The parental use of drugs is reflected in the services reasons. Frequently, the parents' use of drugs resulted in severe neglect of their children and/or made them incapable of caring for their children's needs.

Of those cases that had prior services, DCS had proceeded with court action and out-of-home placement before the death on 63.6%, 14 of the 13, families.

68.2%, (n=15) of the cases that were known to DCS were open to the agency at the time of the children's death.

In addition to the 15 cases that were open to DCS at the time of the accidental death, 14 additional families were referred to DCS at the time of the death. The reason for referral on the 14 families that received services following the death are displayed in *Table 15*.

Petitions were filed in Juvenile Dependency Court on siblings of the deceased child on 3 cases following the accidental child death. Siblings in 2 of these families were provided out-of-home placement services.

Figure 11 summarizes the child protective services on the accidental child deaths.

Reason For Prior DCS Services on ICAN 1990 Accidental Child Deaths

Reason For DCS Services	n
Severe Neglect	5
Prenatal Substance Abuse	4
Caretaker Absence / Incapacity	3
Information Unavailable	1

Table 14

Reason For Current DCS Services on ICAN 1990 Accidental Child Deaths

Reason For DCS Services	n	%
Severe Neglect	5	40.0
Death of Child	4	26.7
Physical Abuse	3	20.0
Prenatal Substance Abuse	2	13.3

Table 15

- 51.6% of the families had a history of receiving public assistance from the Department of Public Social Services. DPSS indicated that 1.5 million persons (approximately 16.9% of the county population) are recorded on their computer systemas current or former recipients of assistance from DPSS.

The Department of Children's Services provided information regarding the constellations of families known to them. The high percentages of unknown elements are due to DCS's infrequently being involved in families when there are no surviving siblings.

- The mother of the deceased child was known to be residing in the home in 43.1% of the families. The mother was known to be residing out of the home in 7.5% of the families. The information was unavailable on 47.7% of the families primarily due to no DCS involvement with the families.

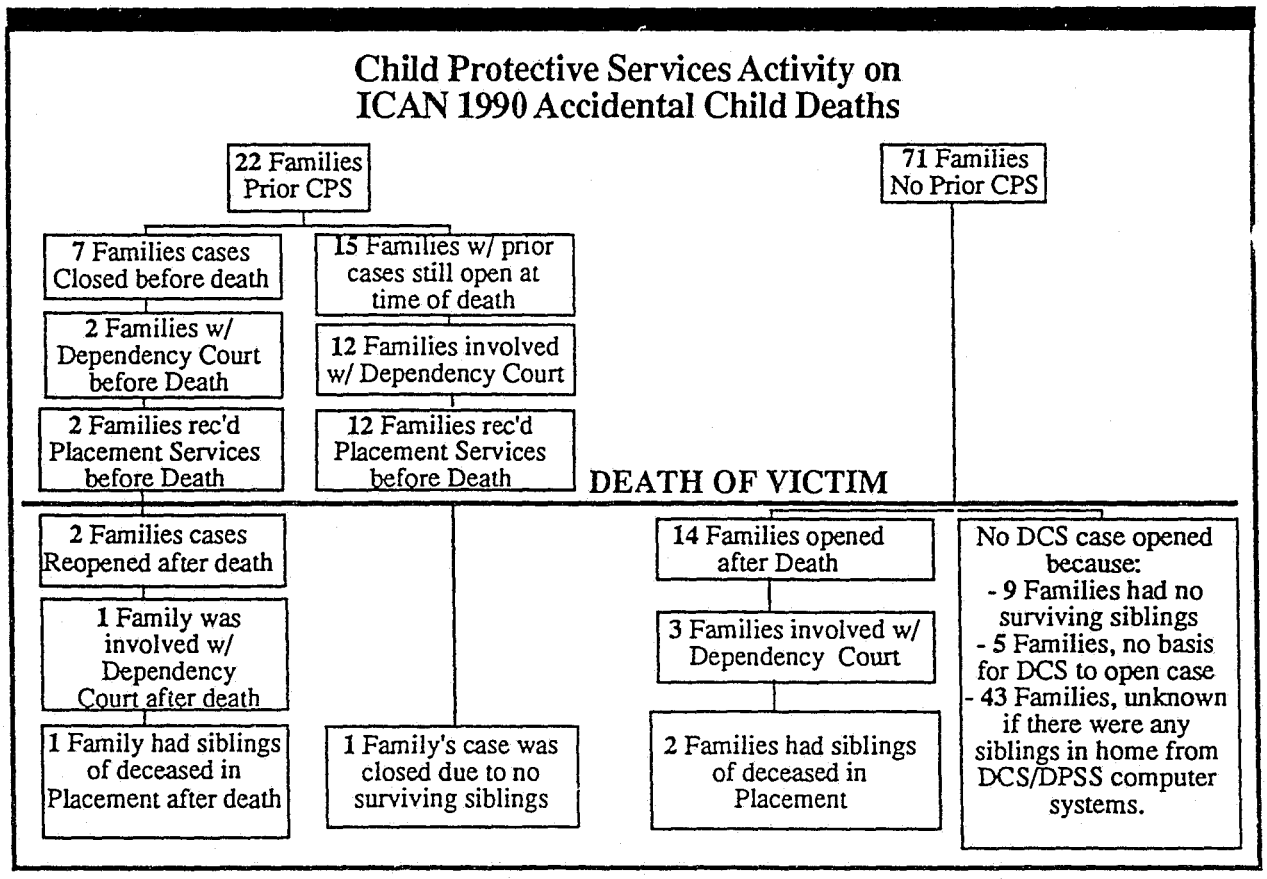

Figure 11

- The mother's age at the time of death of the child was known in 53.7% of the families. *Table 16* gives a breakdown of the mothers ages. The mean age of the mothers were higher for accidental deaths than for the mothers of known child abuse homicides.
- The father was known to reside in the family home in 16.1% of the cases, resided out of the home in 16.1% of the cases and information was unavailable in 67.8% of the cases.
- The deceased child had siblings in 44.1% of the cases. 9.7% of the families were known to not have any other children other than the victim. It was unknown to DC S if there were siblings in 46.2% of the families.
- Siblings on 13 of the cases remained in placement out of the family home at the time of review.There were siblings residing in the family home on 26 cases following the death.

Criminal Justice System Involvement In Accidental Child Deaths

Information on criminal justice system activity was gathered primarily from the Los Angeles Sheriff's Department, Los Angeles Police Department and the Los Angeles County District Attorney's Office. From this method, information was gathered on 87 of the 93 accidental child deaths.

Los Angeles Police Department had investigative responsibility for the greatest number of accidental child deaths, 46.2%, followed by the Los Angeles Sheriffs Department, 21.7%. 25.6% of the potentially suspicious child death investigations were handled by jurisdictions other than LAPD and LASD. The law enforcement agencies and the number of cases for which they were responsible for investigating is shown in *Table 17*.

Two cases of the 87 with information provided was presented to the District Attorney's Office for the possible filing of criminal charges. Both were rejected, one as there was inadequate evidence to prove criminal intent on a bathtub drowning, and the other as it could not be proven that the mother was sufficiently warned about the deliterious effects of cocaine use by her physician during her prenatal care.

Age of Mothers of ICAN 1990 Accidental ChildDeaths

Age	n	%
Less Than 20 Years	1	2
20 - 29 Years	29	58
30 - 39 Years	18	36
Over 39 Years	2	4

Table 16

Law Enforcement Agency Involvement in ICAN 1990 Accidental ChildDeaths

	n	%
LAPD	43	46.2
LASD	20	21.7
Compton PD	4	4.3
Alhambra PD	2	2.1
Arcadia PD	2	2.1
Azusa PD	2	2.1
Huntington Park PD	2	2.1
Torrance PD	2	2.1
West Covina PD	2	2.1
Burbank PD	1	1.1
El Monte PD	1	1.1
Hawthorne PD	1	1.1
Montebello PD	1	1.1
San Gabriel PD	1	1.1
Out of county	3	3.2
Jurisdiction unknown	6	6.5

Table 17

Health Systems Involvement In Accidental Child Deaths

As in child abuse homicides, previous medical records for accidental child deaths were noted in large part for their absence or incompleteness. Individual case review has revealed no previous health records, superficial reference to medical care or specific reference to the lack of medical information. Birth records and regular health records of care for the life of the child are almost always absent.

Computer search for DHS records for 1990 noted 14 of the 93 accidental child deaths (15.1%) had records in Department of Health Services facilities, primarily the county hospitals. ■

Natural Child Deaths

Natural Child Deaths in Los Angeles County - 1990

David's - 11 month old, death was certified as Sudden Infant Death Syndrome, per the Coroner. The autopsy gave no indications of neglect contributing to the death.

David was born with a positive drug screen for amphetamines. David had 3 siblings, found living in a filthy van at the time of David's death. The 1 1/2 year old sibling was medically neglected. The parents had a long standing substance abuse history. All the children were malnourished and developmentally delayed.

Public Health was unable to make contact with the family following the death. The nurse was only able to contact the manager of the trailer park, who related that the family had left David on their doorstep for 2 hours after he died. It was only when an uncle came to visit the home that David's body was discovered and the authorities were called.

Very few natural deaths are reported to the Team during the course of the Coroner's handling of these cases. For 1990, only 16 natural deaths were reported to the Team. This contrasts with 64 natural deaths in 1989, a 400% decrease. The major reason for this dramatic decrease was that reporting procedures within the Department of Coroner were modified in 1990 to ensure that cases were not reported to the Team prior to the cause of death being certified. Team protocol calls for natural deaths to be reported to the Team for two reasons:

- Sudden Infant Death Syndrome (SIDS) where history or condition of the body raise suspicions or the child is over the age of seven months, and/or
- Any other natural death where history or condition of the body raise suspicion of child abuse or neglect, including prenatal substance abuse.

Preliminary review of all natural deaths reported to the Team is necessary before meaningful analysis of those deaths can be made. Natural deaths were removed from the list if all the below were true:

- There was no evidence of abuse/neglect at autopsy.
- There was no record of child protective services being provided to the family, either prior to the death or following the death.
- There was no family history of substance abuse.

Natural death cases with any of the above factors were kept as part of the population for further review and inclusion in this analysis.

The natural deaths include "soft" or "gray" cases which remain only because of a notation of substance abuse or previous child protective services to the child or family. The substance abuse history may, in fact, be irrelevant and/or the previous child abuse or neglect allegations may have been unsubstantiated or unfounded. However, these "gray" cases remain included due to the potential relationship between these factors and the death.

As a result of the review of these deaths, 8 cases were deleted from the population. In all cases, the cause of death was Sudden Infant Death Syndrome and the child was over the age of 7 months of age at death.

The cases of 2 children, ages 1 month and 5 months, whose cases were reviewed by the Team, but not reported by the Coroner for statistical analysis were added to the population. **This results in a total of 10 cases being discussed in this section of the analysis.** Due to the small number of cases and the large decrease in the number from 1989, this section of the report must be considered with reservation.

Causes of Death

Seven of the ten deaths were attributed to Sudden Infant Death Syndrome. The other causes of death included: one each sequelae of prematurity, entercolitis, and drowning.

Gender

Six of the natural death victims were male, 4 were female.

Age

Nine of the 10 natural death victims were under the age of 1 year of age, 5 under the age of 6 months.

Ethnicity

Five of the 10 victims were black, 3 were white and 2 were latino. *Figure 12* displays this data graphically.

Child Protective Services Involvement in ICAN 1990 Natural Deaths

Six of the ten families were known to the Department of Children's Services prior to the death. Four of those cases were open at the time of the death, and had been open to DCS prior to the birth of the deceased.

Three of the six families were known to DCS due to the mother having given birth to a prenatally drug exposed infant. The other 2 cases were referred to DCS due to allegations of neglect. Drug use by the parents were confirmed in all but one of the cases known to DCS.

DCS services included placement and court involvement on 3 of the six cases known to them before the death. However, only one of the deceased children was placed out of home at the time of death.

Subsequent to the death, DCS opened cases on 4 of the cases which were not already open to them.

Criminal Justice System Involvement In ICAN 1990 Natural Deaths

Los Angeles Sheriff's Department and Los Angeles Police Department were responsible for 9 of the 10 law enforcement investigations of the natural deaths. As all of the deaths were certified by the Coroner as natural deaths, no presentations were made to the District Attorney on these cases and all case investigations have been closed.

Health System Involvement in ICAN 1990 Natural Deaths

Computer search for DHS records for 1990 noted 4 of the 10 natural child deaths had records in Department of Health Services facilities, primarily at Martin Luther King Hospital. ■

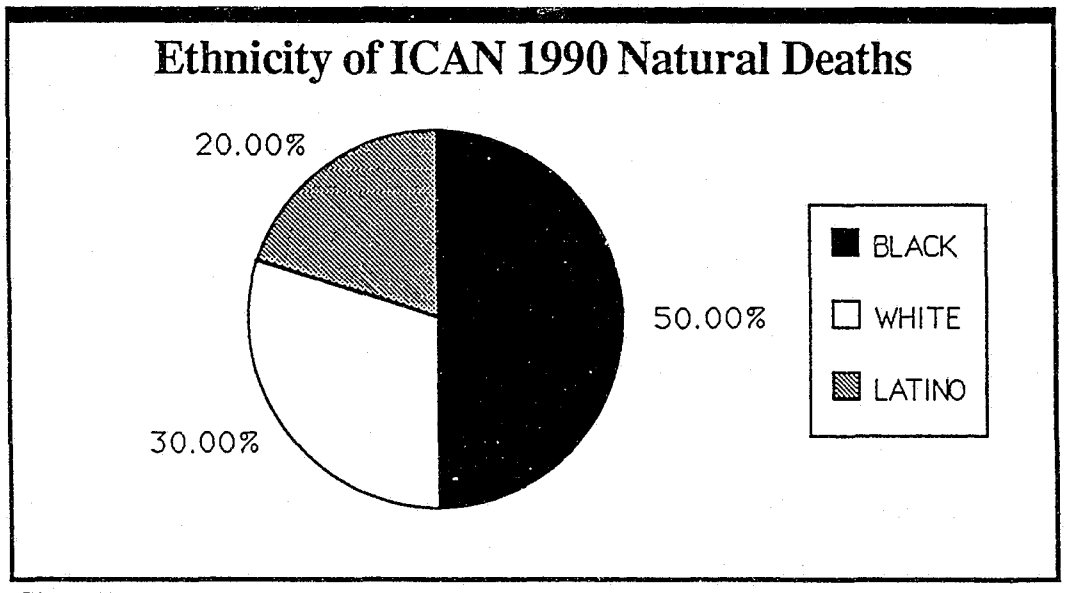

Figure 12

Undetermined Child Death

Undetermined Child Deaths in Los Angeles County - 1990

Baby Jane Doe - estimated to be 6 months old, was found dead on the doorstep of a church. At the time she was found, the baby was dressed in new clothes, was wearing a religious medallion on a necklace around her neck, and was left with her toy stuffed monkey. Law enforcement indicated that they canvassed the neighborhood for days following the discovery of the body and no one saw the baby dropped off at the church. They circulated pictures of the medallion, the clothes and monkey to try to identify any of the articles without success.. A year after the baby's death, there are no leads in trying to identify the baby or solve the case.

The Coroner reported that cause of death is undetermined due to their having no social history on the child or family. If the social history revealed no unusual elements, the death would be ruled a SIDS.

Only 5 undetermined deaths were reported by the Coroner to the Team in 1990. While they represent the smallest category of deaths reported to the Team, they are some of the most troubling.

Undetermined deaths are situations where the Coroner is unable to fix a final mode of death. Usually, there is no clear indicator in these cases if the death was caused by another, or was accidental. As in the case illustrated above, these cases frequently involve lack of information on which to base a cause of death. These cases remain suspicious in nature and are of interest to the Team because a final determination cannot be made by the Coroner.

Gender

Four of the undetermined death victims were female, one was male.

Age

Two of the undetermined death victims were under the age of 6 months, one was 1 year old, one was 3 years old and the other 4 years old.

Ethnicity

Three of the undetermined death victims were Latino, 2 were Black.

Cause of Death

Only two of the five undetermined cases had the same cause of death; undetermined following autopsy and toxicological examination. The 3 other causes of deaths were listed as: 1.) Cardiomyopathy with intersititial fibrosis, chronic myocardia, and cocaine ingestion, 2.) acute and chronic subdural hematoma and associated seizure disorder, and 3.) severe blunt force trauma to the head.

Child Protective Services Involvement in Undetermined Child Deaths

Only 1 of the 5 families of undetermined death victims were previously known to the Department of Children's Services. That child had been in placement and the case was open to DCS at the time of the death. That family was known to DCS due to allegations of caretaker absence/incapacity.

There was only one other case where there were known siblings and DCS became involved with the family at the time of the death and DCS removed the siblings from the family home due to suspicion of the parents causing the death of the child.

Criminal Justice System Involvement In ICAN 1990 Undetermined Deaths

Alma - was a 3 1/2 month old twin born to a 15 year old mother. The cause of death was severe blunt force trauma. The parents' initial story was that the baby simply failed to wake from her nap. Upon autopsy, multiple skull fractures were found, but no hemorrhages. The Coroner's theory was that the infant suffered brain stem trauma which caused lack of hemorrhages. However, one of the other physicians present at the autopsy strongly believes that the skull fractures were suffered after death.

After extensive interview, the father admitted to accidently hitting the infant against a door jam while in a panic, trying to resuscitate the child. There were lines found on the scalp which matched these injuries. The infant was suffering from extensive scabies and was probably crying extensively from pain. The parents admitted to not checking on the child for 12 hours on the day of death. The mother gave a conflicting story that she saw the father step on the infant's head after the child died. The investigating law enforcement officer indicated that the home was filthy, with clogged drains, feces, etc.

The case was presented to the DA and the father's case is pending trial. The assigned DA is extremely concerned however, about the conflicting statements from the pathologists.

Los Angeles Sheriff's Department was responsible for investigating 3 of the undetermined deaths, Los Angeles Police Department was responsible for investigating the other 2.

Only 1 of the cases was presented to the District Attorney's office for the filing of criminal charges. Two of the other cases remain under investigation by law enforcement.

Health System Involvement in ICAN 1990 Undetermined Deaths

Three of the 5 victims of undetermined death had health records in the Department of Health Services system. All 3 records were in the county hospitals. ■

Adolescent Suicides

Adolescent Suicides in Los Angeles County - 1990

Twenty eight suicides were reported to ICAN's Child Death Review Team by the Coroner in 1990, compared to 43 in 1989 and 34 in 1988.

Gender

67.9% (n=9) of the victims were male. This is a decrease from 1989 when 75% of the victims were male. *Figure 13* displays that the largest part of the total decrease in the 1990 suicides were male victims.

Ethnicity

The largest number of suicides were committed by white males, followed by latino males. Female hispanics were represented at nearly the same level as their male counterparts. There were no suicides by black adolescents reported by the Coroner in 1990.

Table 18 compares the sexes and races of the victims.

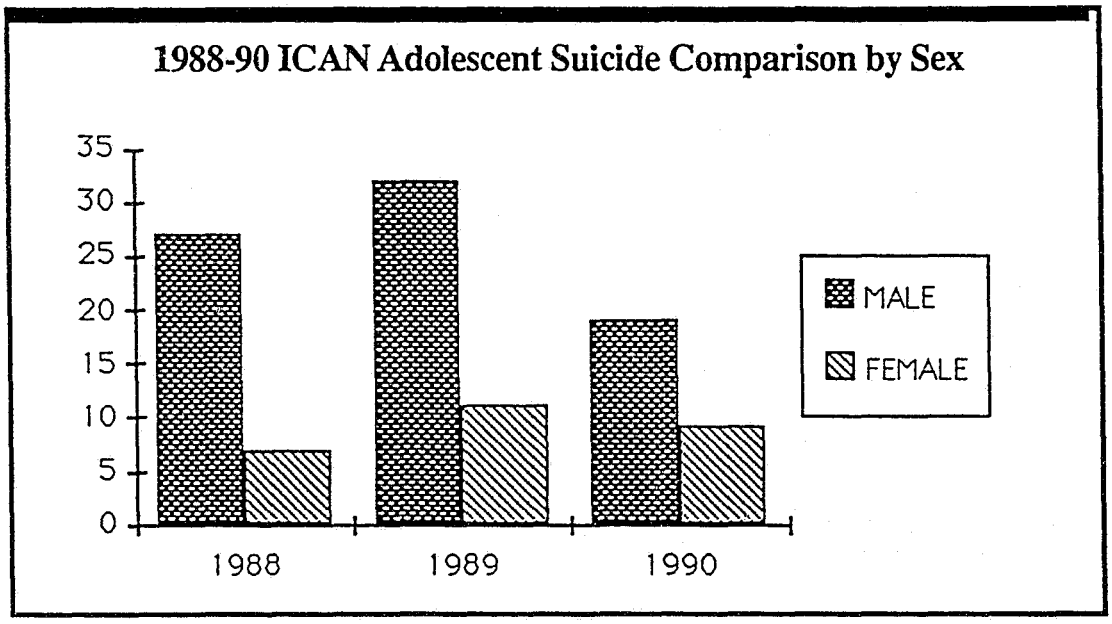

Figure 13

ICAN 1990 Suicides by Race and Sex

	White	Latino	Black	Filipino	Total
Male	10	6	0	3	19
Female	4	5	0	0	9
Total	14	11	0	3	28

Table 18

Age

When the age and sex of the suicide victims are compared, as is displayed in *Figure 14*, it can be clearly seen that 17 year old males represent the highest risk group. Over a third of the total suicides were committed by this group. This is the second year that the incidence rate in this age/sex group has been this high.

This year, two 12 year old females were reported as committing suicide. This is the first year that suicides have been reported for any pre-teenagers.

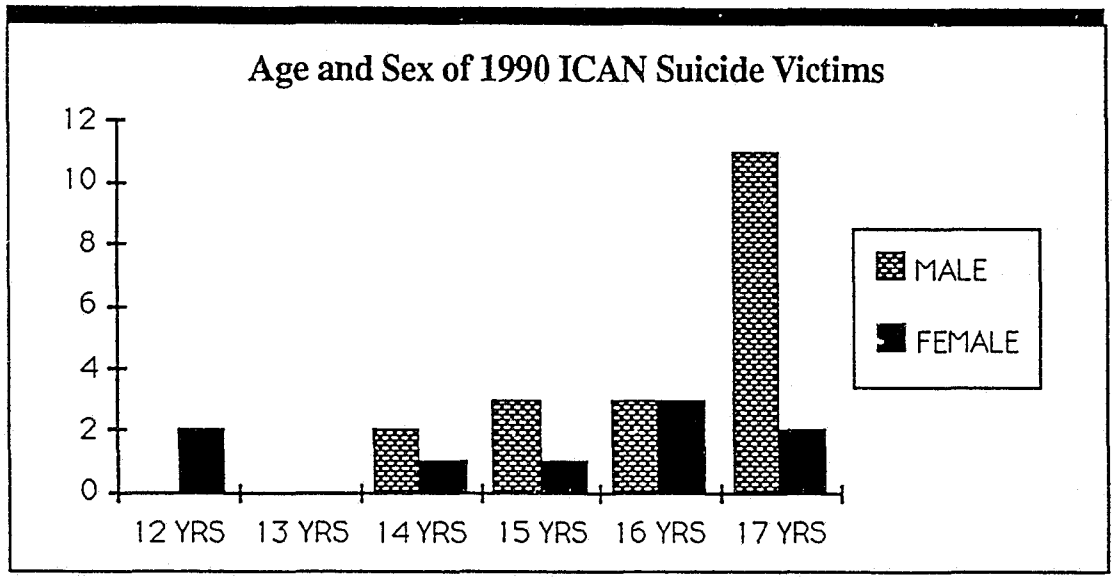

Figure 14

Cause of Death

The predominant method of suicide was the use of firearms. 64.3% (n=18) of the victims used firearms to kill themselves. The other predominate method was hanging, 32% (n=9).

The number of deaths from drug overdose decreased most dramatically, there being only 1 fatality recorded in 1990, compared to 8 in 1989. *Table 19* displays the method of suicide broken out by sex of the victim.

Methods of 1990 ICAN Suicides by Sex

	Firearms	Hanging	Drugs	Total
Male	13	6	0	19
Female	5	3	1	9
Total	18	9	1	28

Table 19

Temporal Pattern

The greatest number of suicides in 1990 occurred in the month of March. All other months ranged from 0 to 4 suicides per month, with no suicides occurring in April.

Suicides were plotted against time for the years 1988 through 1990 and are displayed in *Figure 19*.

In 1989, more suicides occurred in December than in any other month since data has been collected by the Team. This one month variance continues to dominate the overall statistics. The average number of suicides over the past three years is slightly less than 3 per month.

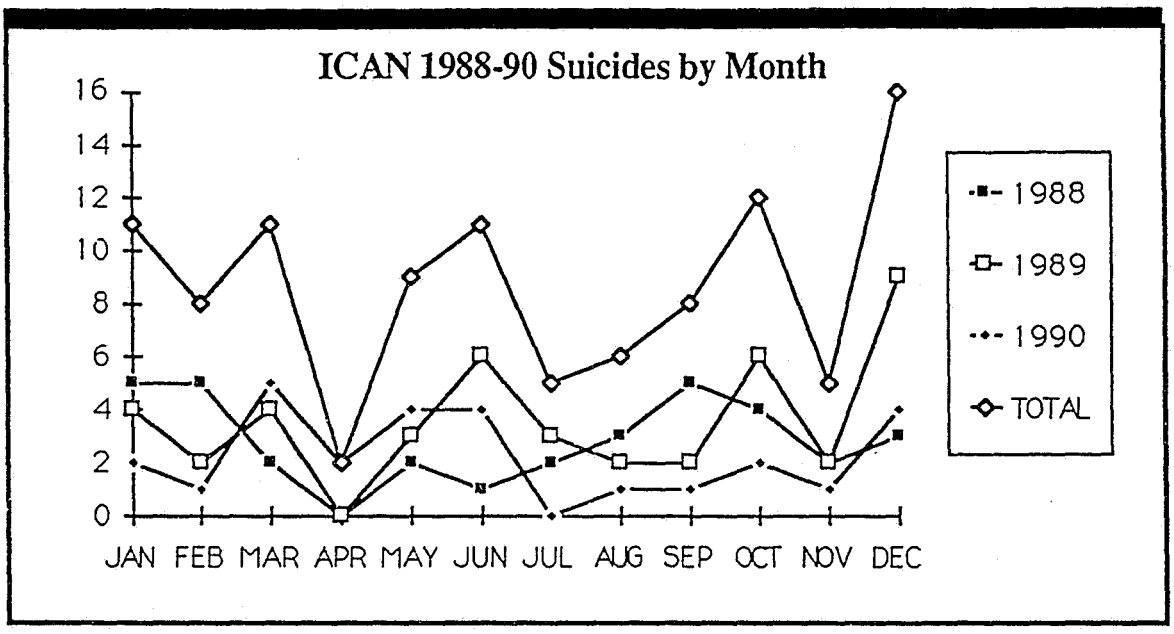

Figure 19

Child Protective Services Involvement in 1990 Suicides

The Department of Children's Services had prior involvement with 10.7% (n=3) of the families with suicide victims, far fewer than the 28% reported in 1989. There were no suicide cases reported that were open to DCS at the time of the suicide.

21.4% of the families had a history of receiving public assistance from the Department of Public Social Services.

There were siblings known to DCS on 25% of the cases.

The mother's ages were known on only 6 of the cases. The age of the mother at the time of the death ranged from 34 to 46 years.

Probation Department Involvement With 1990 Suicides

In an effort to find out more about the backgrounds of these adolescents, a search of Probation records was made to see if any if the victims had contacts with that Department. 17.9% (n=5) of the suicide victims had records with the Probation Department for engaging in juvenile delinquent behavior. Charges filed varied and ranged from attempted murder, assault with a deadly weapon, grand theft auto, trespassing, battery, burglary, vandalism, theft and receiving stolen property. There were no indications of involvement in drug related criminal activity from the charges filed.

All 5 of the victims with Probation records were male and 4 of the 5 were 17 years old.

Intervention by the Probation Department and Juvenile Court could not be fully ascertained from the record search provided. 3 of the 5 had indications of receiving Probation Department services in the home of their parents in the two years proceeding the suicide.

Fetal Deaths

Fetal Deaths In Los Angeles County - 1990

For the purposes of the Coroner's records, fetal deaths are those where an unborn is over 20 weeks gestation. A total of 43 fetal deaths were reported to the ICAN Death Review Team for 1990, a 34.5% decrease from 1989. The numbers of fetal deaths reported to the Coroner is highly variable and does not reflect the total number of fetal deaths throughout the county.

The Coroner does not report a mode of death to the State Department of Health Services on the fetal death certificate. However, the Coroner does provide this information to the Team for the purposes of this analysis. *Table 20* describes the modes of death for this population as broken down by the ethnicity of the victims.

Black families suffered the greatest number of fetal deaths representing 62.8% of the total. The Coroner made note that of the 39 accidental and natural fetal deaths, there was a history of maternal drug abuse present in all but 1.

Cause of Death

The most frequent cause listed for accidental and natural fetal death was intra-uterine fetal demise with 48.8% (n=21). Other causes of death included prematurity (n=8), macerated stillbirth (n=5), intrauterine pneumonia (n=2), uterine anoxia (n=2), acute chorioamniotis (n=1), aspiration of amniotic sac contents (n=1), congenital syphilis (n=1), perinatal asphyxia (n=1), and unknown natural cause (n=1).

A homicide designation is used in fetal cases when someone assaults or kills the pregnant mother. The 3 homicides reported this year were triplets born of the same mother, who reported that she was the victim of an assault. The case was presented to the District Attorney by law enforcement. The DA declined to file criminal charges as the autopsy report and attending physician indicated that the mother's substance abuse may have been primarily responsible for the deaths. Further, there were no witnesses to the assault.

ICAN 1990 Fetal Deaths by Race and Mode of Death

	Black	White	Latino	Unknown	Total
Accident	25	7	3	0	35
Natural	2	1	1	0	4
Homicide	0	3	0	0	3
Undetermined	0	0	0	1	1
Total	27	11	4	1	43

Table 20

Temporal Pattern

The number of fetal deaths per month were plotted against time and are reported in *Figure 16*. The number of deaths ranged from 0 to 8 deaths per month, the most deaths occurring in January. 74% of the fetal deaths were reported as occurring in the first six months of 1990, which may indicate some changes in reporting procedures to the Team by the Coroner.

Department of Children's Services Involvement in ICAN 1990 Fetal Deaths

The Department of Children's Services had record of prior involvement with the older siblings in families on 10, or 23.3% of the fetal cases. All of the cases were open to DCS at the time of the fetal death. The reason for DCS services included: Sibling born as drug exposed infant (n=3), severe neglect (n=3) and caretaker absence/ incapacity (n=2). This information was unavailable on 3 of the cases.

Child protective services cases were opened on 3 or 7%, of the cases after the fetal death, primarily due to drug allegations and the presence of siblings in the home. A large percentage of these cases, 69.8% (n=30), of the families had no contact with Children's Services in relation to these deaths. ■

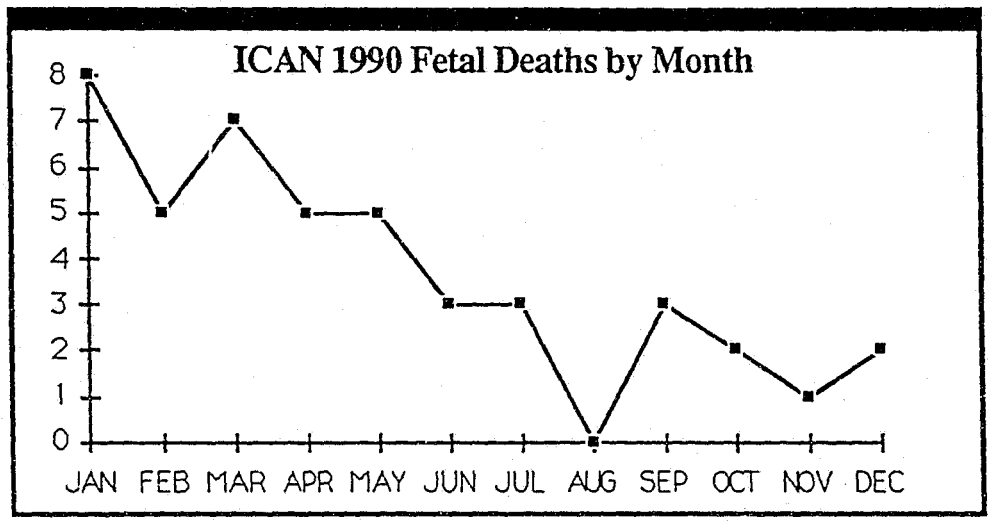

Figure 16