

# ICAN

Inter-Agency Council on Child Abuse and Neglect  
Los Angeles County • ICAN Multi-Agency Child Death Review Team

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Report Compiled From 1994 Data

**ICAN** CHILD DEATH REVIEW TEAM REPORT FOR 1995

# ICAN

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## **ICAN CHILD DEATH REVIEW TEAM REPORT FOR 1995**

*Photographs were selected from commercially available sources and are not of children in the child protective services system. Children's names in case examples have been changed to ensure confidentiality.*

ICAN CHILD DEATH REVIEW TEAM REPORT FOR 1994

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*Names of all children used in case study examples have been changed.*

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## FOREWORD

In 1975, the Inter-Agency Council on Child Abuse and Neglect (ICAN) submitted its first request to the Coroner for a list of names of deceased children for case review. The process has matured, but the theme remains the same. Stories of dead children are told, one by one.

Those first victims would have been young adults by now. Their surviving siblings are adults. Perpetrators who were convicted in the system at that time are, most likely, no longer incarcerated. Almost all of the stories surrounding those deaths are held solely in the personal memory of team members and the surviving family members.

ICAN reports and analyses on the deaths of these children began in 1990. Most of the drama of their deaths is broken into data elements, useful for developing protocols and policy, but lacking the texture of the loss of young lives and the grief and mourning that reappears throughout the lifetimes of the survivors.

Our formal activities grow and bring relief to many who will never even know that our Team exists. It must be true that some lives are spared, some children injured less severely because of our work. We manage our cases with heightened sensitivity and competence, but we can see more clearly how far we have to go.

In April, 1995, the United States Advisory Board on Child Abuse and Neglect, chaired by Deanne Tilton Durfee, released its report, "A Nation's Shame: Fatal Child Abuse and Neglect in the United States", addressing fatal child abuse on a national level. A major finding of that report was the positive effect of multi agency child death review teams. Local and national media have carried the stories of individual children with a force that has brought the issue into the personal lives of most Americans.

Most cases reviewed today by ICAN are homicides, paralleling an increased level of activity of law enforcement from multiple jurisdictions and from our District Attorney's Family Violence Division.

Policies and programs have changed for all departments with an increased focus on the very young. The Sheriff, Los Angeles Police Department, and the Department of Children And Family Services have protocols that address infants, toddlers and preschool age children .

A grief and mourning professional group has begun addressing the pain of survivors including line agency staff who have personally known these children. Team members can see the purpose of our work more clearly. This painful work is a privilege as the value of young lives becomes more vivid to each participant.

ICAN CHILD DEATH REVIEW TEAM REPORT FOR 1995

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Co-Chair

**Bobby Smith**  
Los Angeles Police Department,  
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**Report Prepared For the Team By:**

**Mitch Mason**  
ICAN Program Analyst

\* left Team during 1995

\*\* joined Team during 1995



## INTRODUCTION

Welcome to the sixth annual report of the Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) Multi-Agency Child Death Review Team.

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 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 and Family Services, Department of Health Services, Probation Department, California Department of Social Services and Children's Hospital of Los Angeles.

This report details the findings of children that died in 1994 and were referred by the Coroner to the ICAN Multi-Agency Child Death Review Team. It provides data on trends in these child deaths for the past six years.

The Team believes that 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.

In 1994, we saw decreases in all categories of deaths reported to the Team, other than those that the Coroner ruled undetermined. Overall, there was a 27.5% decrease. Homicides dropped 5%, the third year of decrease. Accidental deaths declined 32.7%, suicides declined 37%, and fetal deaths dropped by 38%.

While this decline in deaths is promising, the Team sees no simple reasons for the decrease. Simple answers should be questioned carefully. We have previously witnessed large fluctuations in death data and yet we continue to review cases where it is obvious that the system is limited in its resources to respond, investigate and deliver services.

The Team provides eleven recommendations this year which we believe will provide for better safety for our children. We remain committed to the process of child death review and believe that this important work makes a difference in the lives of all our children.





## FINDINGS

### CHILD HOMICIDES BY PARENTS/CARETAKERS

- 39 child homicides by parents/caretakers were identified by the Team in 1994. This is a 5% decrease over the number identified by the Team in 1993 and represents the third year of decrease.
- 69% (n=27) of the victims were male in 1993. This is the highest percentage of male victims and reverses a trend of more female than male victims.
- 26% (n=10) of victims were under the age of 6 months. 41% (n=16) were under the age of 1 year. 72% (n=28) were under the age of 2 years.
- 46% (n=18) of victims were Latino. 36% (n=14) of victims were African - American. 15% (n=6) of the victims were White. 3% (n=1) were Asian.
- 44% (n=17) of the fatal injuries were a result of head injuries caused by blunt force cerebral trauma, shaken baby syndrome or a combination of both.
- Nearly 80% (n=31) of the fatal injuries were caused by direct assault, the perpetrators using no weapon other than their own hands.
- There were no child homicides by parents/caretakers in June, 1994, the first month since 1989 with no such incidents.
- The deceased child had identified siblings in 69% (n=27) of the cases.
- 51% (n=20) of the families had a history of receiving public assistance from the Department of Public Social Services.
- 31% (n=12) of the families had a record of referral of children to child protective services prior to the death of the child. Four (4) of these families were previous incidents which were unfounded or unsubstantiated and closed before service. 20% (n=8) of the families received child protective services.
- 23% (n=9) of the child homicide by parents/caretakers victims had medical records in Department of Health Services.
- 82% (n=32) of case investigations resulted in presentations to the District Attorney's office by the law enforcement jurisdictions.
- 41 perpetrators were identified by law enforcement. 61% (n=25) of the perpetrators were men, most frequently (n=12) the mother's live-in boyfriend.
- The DA filed criminal charges on 66% (n=21) of the cases presented to them and rejected the remainder.
- Mothers were criminally charged on 42% (n=10) of cases in which charges were filed, mothers' live-in male companions in 37% (n=9) of cases and natural fathers in 17% (n=4) of cases.

**CHILD HOMICIDES BY PARENTS/  
CARETAKERS (CONT'D)**

- There were multiple suspects in 19% (n=4) of the cases where criminal charges were filed.
- District Attorney disposition of criminal filings were:
  - 48% - (n=10) still pending trial.
  - 24% - (n=5) over 10 years imprisonment
  - 14% - (n=3) between 2 and 10 years prison
  - 10% - (n=2) one year jail, or less, with up to 5 years probation.
  - 5% - (n=1) dismissal
- 21.4% (n=15) of the accidental deaths occurred in victims under the age of one year.
- 90.9% (n=10) of the accidental deaths which involved maternal substance abuse occurred in the neonatal period, between birth and 28 days of life.
- 50% (n=35) of the accidental death victims were Latino children. Latino children comprise 48.2% of the county child population.
- 20% (n=14) of the fatal accident victims were African American, compared to 12.3% of the county child population.

**ACCIDENTAL CHILD DEATHS**

- 70 accidental deaths were reported to the ICAN Team for 1993, a 32.7% decrease from 1993.
- The leading cause of accidental deaths continued to be drowning (50% (n=35)), followed by complications associated with maternal substance abuse (28% (n=10)) and falls (20%(n=7)).
- The number of accidental deaths due to drowning decreased 12.5% from 1993.
- 77.1% (n=54) of accidental death victims were male, 22.9% (n=16) were female.
- 47% (n=33) of families had a history of receiving public assistance from the Department of Public Social Services.
- 7% (n=5) of the families had a record of receiving child protective services prior to the death of the child.
- The deceased child had identified siblings in 46% (n=32) of the cases.
- 18.6% (n=13) of the victims had records of being seen at Department of Health Services facilities.
- 4 cases were presented by law enforcement to the District Attorney. None of the case presentations resulted in criminal charges being filed.

**UNDETERMINED CHILD DEATHS**

- 21 Undetermined deaths were referred to the Team by the Coroner for 1994.
- 4 of the families were known to the Department of Children's Services prior to the death.
- 5 of the victims had been seen at Department of Health Services facilities.
- Criminal charges were filed by the District Attorney on one of the undetermined cases.

- 21% (n=6) of the families with suicide victims had a history of receiving public assistance from DPSS.
- 18% (n=5) of the families with suicide victims had prior involvement with the Department of Children and Family Services.
- 25% (n=7) of the suicide victims had records of involvement with the Probation Department for juvenile delinquent behavior.
- There were siblings identified in 25% (n=7) of the cases.

**SUICIDES**

- 28 adolescent suicides, ages 10 through 17 years, were reported to ICAN's Child Death Review Team by the Coroner in 1994, a 37% decrease from 1993.
- 75% (n=21) of the suicide victims were male.
- 43% (n=12) of suicides were committed by Latino youths.
- 71.4% (n=20) of the suicide victims were either 16 and 17 year old.
- The youngest victim was 10 years old, the youngest aged victim of suicide ever reported to ICAN.
- In 60.7% (n=17) of the cases, the method of suicide involved the use of firearms. Other methods included hanging, 21.4% (n=6) and 17.9% (n=5) from drug overdose.

**FETAL DEATHS**

- 26 fetal deaths were reported to the ICAN Death Review Team for 1994, 38% fewer than in 1993.
- African American families suffered 38.5% (n=10) of the fetal deaths identified by the Team. There has been a decreasing trend in the number of fetal deaths reported to the Team over the past 5 years.
- In 94% (n=16) of the fetal accidental deaths, there was a history of maternal drug abuse present.
- There was one fetal homicide reported to the Team for 1994.
- None of the families who suffered fetal deaths had a record of prior involvement with the Department of Children and Family Services.

**CHILD HOMICIDES BY PARENTS/  
CARETAKERS (CONT'D)**

- There were multiple suspects in 19% (n=4) of the cases where criminal charges were filed.
- District Attorney disposition of criminal filings were:
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  - 24% - (n=5) over 10 years imprisonment
  - 14% - (n=3) between 2 and 10 years prison
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  - 5% - (n=1) dismissal
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- 90.9% (n=10) of the accidental deaths which involved maternal substance abuse occurred in the neonatal period, between birth and 28 days of life.
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- 7% (n=5) of the families had a record of receiving child protective services prior to the death of the child.
- The deceased child had identified siblings in 46% (n=32) of the cases.
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- 4 cases were presented by law enforcement to the District Attorney. None of the case presentations resulted in criminal charges being filed.

## RECOMMENDATIONS

### RECOMMENDATION 1:

In 1994, ICAN's Child Death Review Team identified:

- Siblings were known to be present in the homes of 69% of child homicides by parents/caretaker cases.
- Siblings were known to be present in the homes of 46% of accidental, preventable, deaths.

Families who have lost a child due to family violence and other preventable, unexpected deaths can greatly benefit from counseling to deal with grief and mourning.

The number of children present in homes where one parent has killed another is unknown. The impact of loss due to violence is especially traumatic.

**It is therefore recommended that:**

- ICAN agencies develop systems for identifying and referring child survivors in homes where deaths occur due to family violence and other traumatic deaths to appropriate grief and mourning counseling services.
- ICAN agencies advise therapists and others serving these families of resources available from the ICAN Family Violence Grief and Mourning Professional Resource Group.

- The ICAN Child Death Review Team work with the ICAN Family Violence Grief and Mourning Professional Resource Group to examine systems of staff support for professionals dealing with fatal and serious family violence.

### RECOMMENDATION 2:

In 1994, 46% of child homicides by parents/caretakers were perpetrated by someone other than the child's natural parent. Most commonly, these perpetrators were the parent's friend or companion, usually male, who frequently or occasionally supervised the child. These relationships may be of short duration and the companion may or may not reside in the home. These caretakers may not be competent to care for infants and very young children.

**It is therefore recommended that:**

- ICAN agency staff carefully evaluate all individuals who may have significant contact with young children in the home when assessing risk, including adults placed in parenting/caretaking roles who are not the child's natural parent.

**RECOMMENDATION 3:**

In 1994, the ICAN Child Death Review Team identified that 97% of homicides by parents/caretakers involved children under 5 years of age. 69% of accidental death victims were 4 years of age or younger.

**It is therefore recommended that:**

- All ICAN and community based child abuse service provider agencies renew their focus on providing child abuse prevention and treatment services to families with infants, toddlers and preschool age children.

**RECOMMENDATION 4:**

In 1994, only 20% of child homicides by parents/caretakers were involved with the Department of Children and Family Services for child protective services prior to the death of the child. An additional 10% of the families had been investigated for allegations of abuse or neglect but those cases were closed as unsubstantiated or unfounded. In Los Angeles County, few services specifically target at-risk families who are not under supervision of DCFS.

**It is therefore recommended that:**

- The ICAN AB 1733/2994 Planning Committee explore of the use of AB 1733/2994 funds for:
  - a. Families whose cases are assessed out of the DCFS system at the point of referral to the Child Abuse Hotline.

- b. Families whose cases are investigated and allegations are unsubstantiated.
- c. Families whose cases are investigated and allegations of abuse or neglect are unfounded but the worker indicates concern that children in the family may be at-risk for future abuse or neglect.

**RECOMMENDATION 5:**

Review of cases by the Child Death Review Team where there has been previous Dependency Court involvement with families has revealed that there are sections of the Welfare and Institutions Code which mandate the Dependency Court and DCFS to provide services when this may not be in the child's best interest. In some cases, children have been returned to the parents and were subsequently killed.

**It is therefore recommended that:**

- ICAN support legislation to amend the Welfare and Institutions Code to:
  - a. Require the court to make a finding that family reunification will not conflict with the safety, protection and wellbeing of the minor.
  - b. Allow reunification services to not be provided when the parent or guardian has willfully abandoned a child and the court finds that the abandonment was life threatening,

- c. Allow reunification services to not be provided when a child's sibling(s) had been declared dependent children of the court and removed from a parent's custody and the court has ordered termination of reunification services for those sibling(s) and developed permanent plans for them.
- d. The burden of proof should be shifted to the parents of children where parental rights have been terminated on another child and the parents should be required to demonstrate to the court why their parental rights should not be terminated at the point that the Court finds the child is a person described by Section 300 of the Welfare and Institutions Code.
- e. Require adequate qualifications and training of judicial officers assigned to Dependency Court.

**RECOMMENDATION 6:**

The Child Death Review Team has reviewed several cases where a child has been removed from the parents custody by the Dependency Court and placed with relatives. It has been Department of Children and Family Services policy for five years to conduct background checks on relatives and making home visits to evaluate the appropriateness of the home prior to releasing children to their custody. This is not a required by state law.

**It is therefore recommended that:**

- ICAN support legislation so that when a child who is the subject of dependency court proceedings is placed in the home of relatives, a criminal records check is conducted on all adults and adolescents living in that home as well as all persons who, by the nature of their relationships, may have frequent contact with the child. Further, prior to releasing a child to the home of a relative, the social worker should be required to first visit the home to ascertain the appropriateness of the placement. No child should be placed with a relative caretaker where the relative or another person either living in the home or having frequent contact with the child has been convicted of a crime that involved a child, or by its nature, represents potential harm to the safety of the child.

**RECOMMENDATION 7:**

Review of cases involving deaths of children in out-of home care has revealed that current policies do not mandate that the State Department of Social Services (SDSS) investigate deaths in homes that are certified by Foster Family Agencies. Foster Family Agencies(FFA) contract with the State to recruit, certify, monitor, and provide support to foster family homes. However, when a death or any abuse allegations occur within a FFA certified home, the FFA is the body that investigates the home for licensing violations. The Team feels that in instances of child death, there is need for an outside party to investigate these homes.

**RECOMMENDATION 3:**

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**It is therefore recommended that:**

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  - a. Require the court to make a finding that family reunification will not conflict with the safety, protection and wellbeing of the minor.
  - b. Allow reunification services to not be provided when the parent or guardian has willfully abandoned a child and the court finds that the abandonment was life threatening,

The Team was informed in late November, 1995, that DOJ will no longer provide case specific data from the Index and therefore the Team will be unable to monitor and seek to solve the problem of under reporting to the Index.

**It is therefore recommended that:**

- ICAN support legislation amending Section 11170 of the Penal Code to allow the Department of Justice to release data from the Child Abuse Central Index for the purposes of reconciling data with Child Death Review Teams and other multi-disciplinary personnel teams.

**RECOMMENDATION 11:**

Under current statute, there is no clear authority for child death review and other multidisciplinary personnel teams to share information with such teams in other counties. While individual disciplines may share information across county lines, due to the confidential nature of team proceedings, team coordinators are inhibited from facilitating communication on cases between counties. There have been incidents where multiple child deaths have occurred in different counties and it is imperative that teams be allowed to share information, developed by team review, across county lines.

**It is therefore recommended that:**

- ICAN support legislation that allows child death review and other multidisciplinary personnel teams to share case information with such teams in other counties.

**RECOMMENDATION 12:**

The 1994 Team Report recommended that participating agencies should assure that all necessary child death case data be submitted in a timely, ongoing, flow basis to the Team. This recommendation has not been implemented by all ICAN agencies.

Not only does the delay in returning data postpone the release of the annual report, it also impacts on the identification of cases needing comprehensive review by the Team. This may result in delays in identifying and protecting surviving children, and may hamper appropriate criminal action. Additionally, it impedes sharing of information between Team members as data is reconciled.

The Team is hampered, through time constraints, on the number of cases that can receive comprehensive review. A system of data collection and data sharing must be adopted which facilitates cases management of all child deaths brought to the Team's attention.

**It is therefore recommended that ICAN agencies that participate in the Child Death Review Team:**

- Evaluate the data collection process on child death cases and consider enhancement of the system to facilitate case management of deaths not receiving comprehensive review, and
- Systematically collect and, on an ongoing and timely basis, refer child death case



## 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. Blunt force trauma
9. Homicide/child abuse/neglect
10. Burns except where cause is clearly not abuse /neglect, such as auto accident, accidental house fires, etc.
11. Sexual abuse
12. Gunshot wounds
13. Special populations - fetal deaths and suicides are part of separate studies

\* Age exceptions are made for apparent suicides and homicides by family member or caretaker.

Once a case is identified by the Coroner, case specific information is sent to the ICAN offices, where it is routed to Team representatives from the District Attorney's Office, Department of Children and Family 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 18 years reported from Los Angeles County, which was reconciled against the Team's findings. The Team's Probation representative checked records on all suicide cases to determine if any of those children were known to Probation.

Selecting cases for comprehensive 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 in depth 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



These cases remain suspicious in nature and are of interest to the Team because a final determination cannot be made by the Coroner. These cases include perinatal demise of undetermined cause, which, may be child maltreatment related, if the infant was left exposed or unattended. However the Coroner may not be able to determine if the exposure caused the death or if it was due to some other cause.

- Suicides of children and adolescents are reported to the Team as a special population. The Team recognizes that suicide, most often, in and of itself, is not a result of child abuse and neglect. However, the ability of the Team to collect information on these deaths from multiple agencies is of benefit in better identifying these high risk 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 include fetal homicide cases which are a result of violence against the mother.

The gaps between the Coroner's classifications of child deaths with the public's perception of child abuse fatalities creates a dilemma regarding reporting the Team's findings.

The Child Death Review Team's purpose is to work to prevent or minimize child deaths. In order to do so, the Team must work together to confront patterns of preventable child death within the County through coordinated research and analysis of the root causes of these deaths.

#### **CORONER REFERRALS TO ICAN CHILD DEATH REVIEW TEAM - 1994**

190 deaths were reported by the Department of Coroner to the ICAN Child Death Review Team in 1994.

Preliminary review of homicides and reconciliation of the deaths referred by the Coroner to Team reviewed deaths resulted in the removal of 6 homicides. In two cases, the perpetrator of the homicide was either unknown to the victim or family. Three cases involved siblings or friends of the victim who unintentionally shot the victim with a firearm. While "death at hands of another", no criminal charges were ever brought against the child who discharged the victim or the owners of the firearms as it was determined that all were properly stored. One homicide was excluded as the victim resided in a neighboring county, the fatal injuries were inflicted in that county but the child was brought to a medical facility in Los Angeles County, where the child died. All follow-up investigation and services are being handled by that neighboring county where the injuries occurred.

Figure 1 on the next page summarizes how the 190 deaths referred by the Coroner in 1994 were categorized and where adjustments were made.

Figure 1

**FLOW CHART OF CASE DISTRIBUTION FOR ANALYSIS**

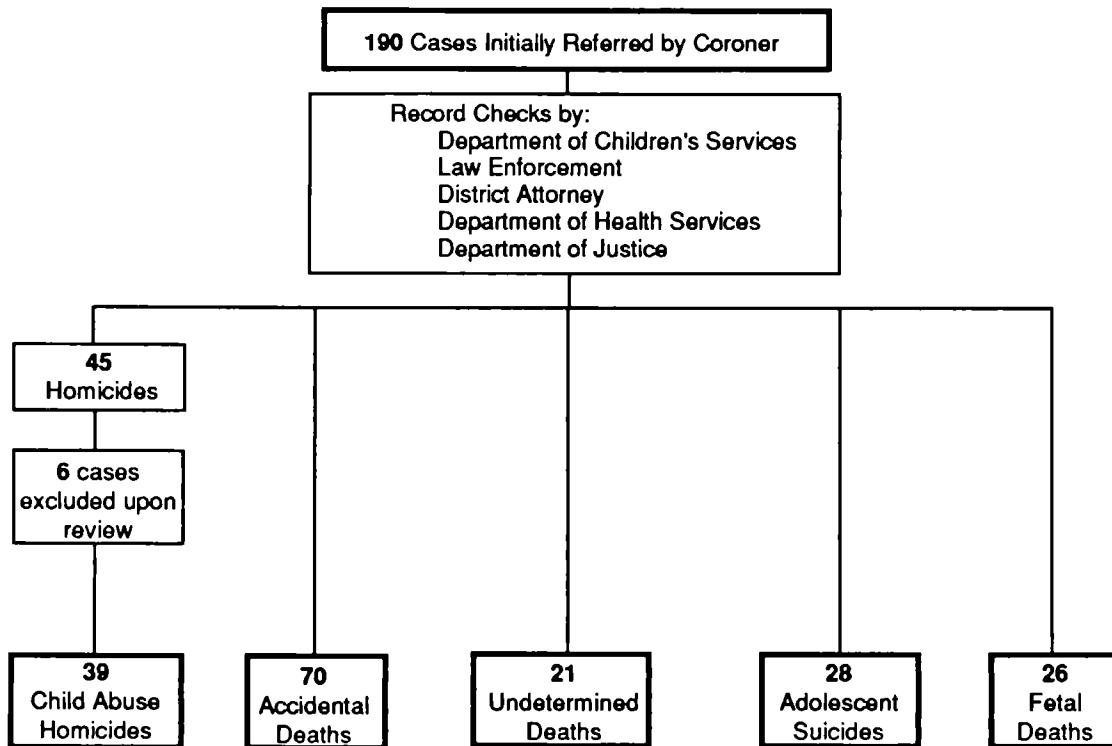
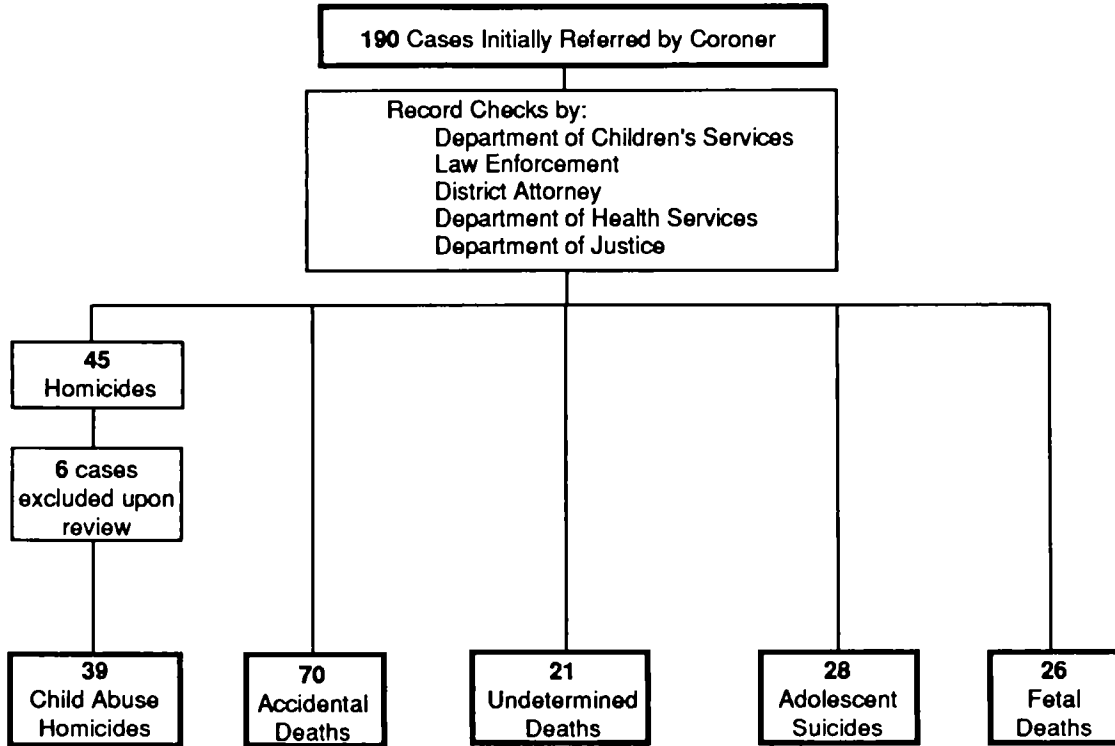


Figure 1

**FLOW CHART OF CASE DISTRIBUTION FOR ANALYSIS**



## CHILD HOMICIDES BY PARENTS/CARETAKERS IN LOS ANGELES COUNTY

*Jane, 1 year old, died as a result of traumatic head injuries. Her mother was 22 years old. The mother's boyfriend had lived in the home for 8 months. There was a 3 year old sibling. The paramedics were called to the home 3 days prior to the death as Jane was not breathing. The initial story was that while the boyfriend was showering with Jane, she sat on the floor and fell over. The emergency room physician felt the injuries were not consistent with the boyfriend's story. There was both old and new head trauma. The old trauma was approximately 2 weeks old.*

*The boyfriend reported that two days prior to the fatal incident, a disassembled crib fell on Jane. The sibling was interviewed but the interview was not productive. The mother never mentioned the crib during her interview. She did state that she noticed some of Jane's hair missing and remembered the boyfriend previously pulling the sister's hair. The mother's story was very inconsistent. During the boyfriend's interview he indicated that "the baby was always asking for too much love." Both the mother and boyfriend were arrested for child endangering (273(a)P.C. and the sibling was taken into protective custody.*

*The District Attorney initially rejected the case as the medical examiner findings were consistent with the fatal injuries being caused by the crib and that the neighbors had seen the injuries prior to Jane's hospitalization.*

*The Coroner reviewed the autopsy findings. The injuries from the crib were not the fatal injuries. The old injuries may have been caused from the falling crib however, the lethal injuries were fresh. Whoever had physical custody at the time that Jane lost consciousness caused the death. The neuropathology report was very definitive that the injuries occurred immediately prior to the hospital admission. The injuries were a result of impact and shaking trauma. There was a skull fracture on the rear of the head.*

*As a result of this new information, District Attorney representatives indicated that they would file charges on the boyfriend as he was alone with the children at both times that the injuries occurred.*

*The District Attorney subsequently filed murder charges against the mother's boyfriend and child endangerment charges against the mother. The case is pending trial.*

*DCFS reported that they received a referral one month prior to the death alleging that the boyfriend physically abused the 3 year old sibling with a belt. The local police responded but did not take the children into custody as there were no bruises. DCFS investigated and found the allegation of physical abuse unsubstantiated since there were no marks or bruises. Lacking jurisdiction to provide services, the family was referred to parenting classes and the case was closed prior to Jane's death.*

**F**orty-five homicides were reported to the Team by the Coroner for 1994. Following review of law enforcement records, six cases were determined not to be perpetrated by parents or caretakers. In two cases, the perpetrator of the homicide was unknown to either the victim or family. Both of these cases were drive-by shootings. One case involved a child who was a resident of an adjacent county and died in that county but was transported to a Los Angeles County medical facility where death was declared. Three cases involved siblings or friends of the victims who unintentionally shot the victims with a firearm. There was no prosecution of the parent/caretaker on any of these cases as the firearm was stored properly.

Given these adjustments, the Team has determined that there were 39 child homicides perpetrated by parents/caretakers in Los Angeles County in 1994. This is a decrease of 5% from the 42 child homicides by parents/caretakers in 1993 and represents the lowest number of child homicides by parents/caretakers since and including 1989. Figure 2 displays, by year, the 275 child homicides by parents/caretakers referred to the Team by the Coroner for the period of 1989 through 1994.

## GENDER

In 1994, 69% (n = 27) of the victims of child homicide by parents/caretakers were male, while only 31% (n = 12) of the victims were female. Over the past 6 years, there have been a total of 142 male victims (51.6%) and 133 female victims (48.4%).

The percentage of female victims has ranged from this year's low of 31% to a high of 61% in 1993. The number of female victims had varied little up

until 1994, averaging 24.2 per year and ranging from 21 to 26.

The number of male victims has had a much greater fluctuation over the past six years. The average has been 23.7 per year, and has ranged from a low of 16 in 1993 to a high of 35 in 1991.

Figure 3 displays the gender breakdown of the child abuse homicide victims for the past 5 years.

## AGE

The ages of the victims of homicide by parents/caretakers between 1989 and 1994 is displayed in Figure 4. In 1994, 41% of the victims were under the age of one year, 26% under the age of 6 months. 72% of the victims were under the age of 2 years. 97% were under the age of 5 years. In 1994, only 1 victim of homicide by parents/caretakers over the age of 10 years was identified.

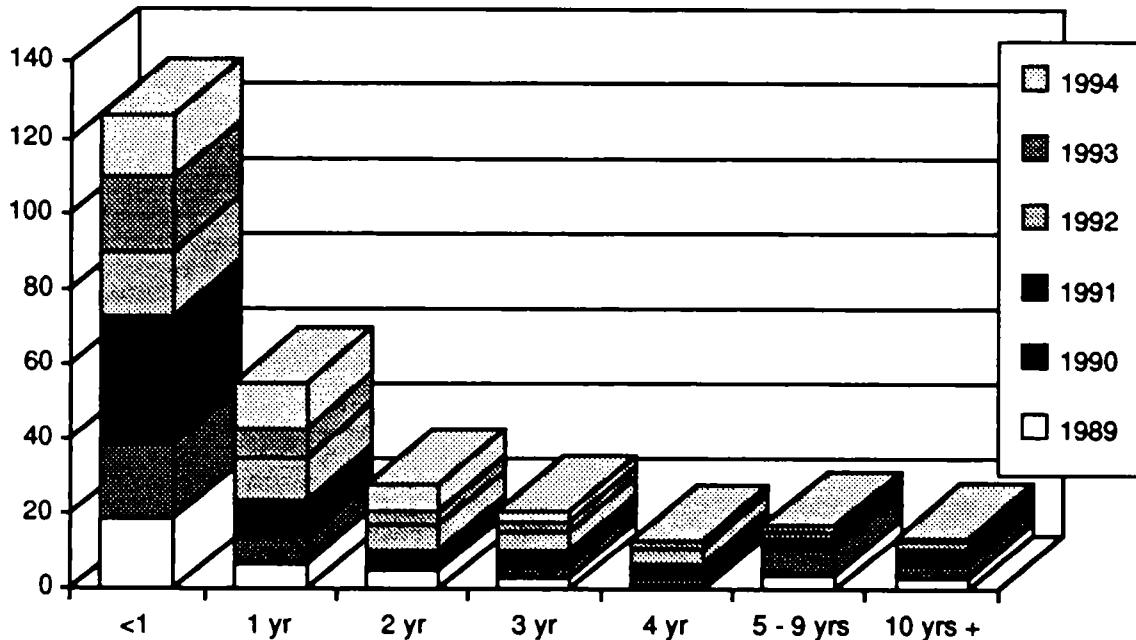
Over the past 6 years, 46% (n=126) of the victims have been under the age of 1 year, 88% (n=243) have been under the age of 5 years.

The ages of the victims in 1994 is comparably younger than the homicides between 1989 and 1993. In prior years, approximately 60% to 65% of child homicide by parents/caretakers victims have been under the age of 2 years. In 1994 that level rose to 72%. In previous years, 90% or more have been under the age of 5 years. The percentage of children under the age of one has ranged from 40% to 56% over the past 6 years.

Table 1 displays the relationship between the age and sex of the child homicide by parents/caretakers victims in 1994. The average age of female victims was 1.3 years, the median, 388 days or

Figure 4

1989 - 94 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS BY AGE



slightly higher than 12 months. The average age of female child victims of homicide by parents/caretakers has decreased over the past six years. In 1989, the average age was 3.1 years, increasing to 3.8 years in 1990, then decreased to 2.2 years in 1991, 1.7 years in 1992 and 1.6 years in 1993. The decrease in 1994 was primarily due to the relatively greater number (n = 5) of female infants under the age of 1 year than older victims. The youngest victim, killed on the day of birth, was female.

The average age of the male victims in 1994 was 1.7 years, with the median being 1 year 3 months. In 1989, the average age was 1.6 years, in 1990, 2.7 years, in 1991, 2.2 years, in 1992 it was 2.3 years and in 1993 it was 2.0 years.

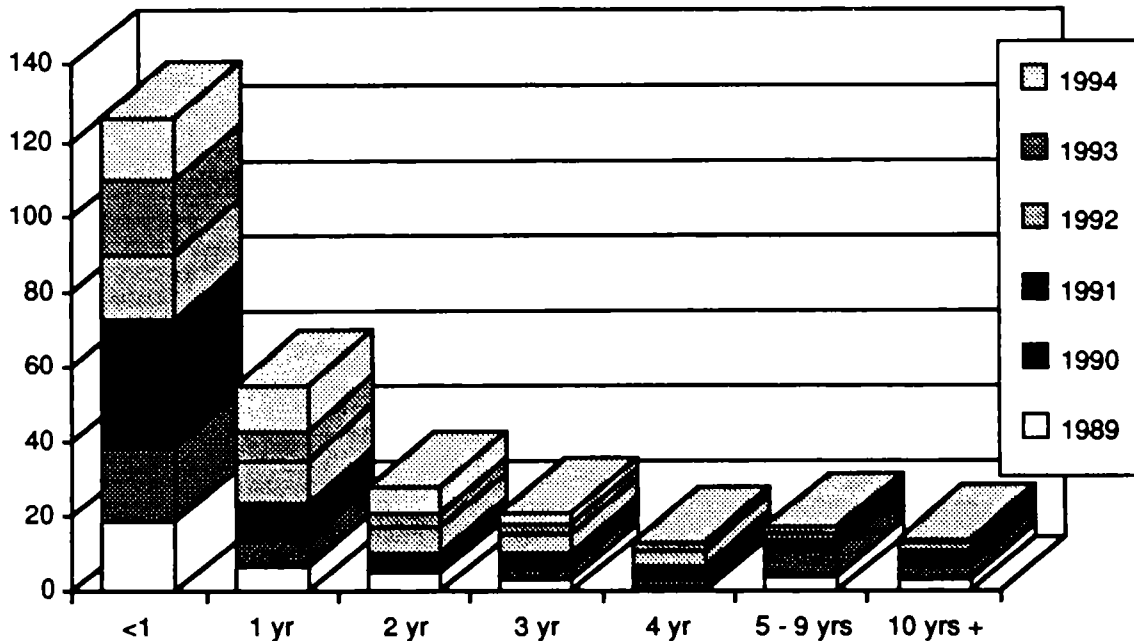
Table 1

1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS - AGE AND SEX

Age	Male	Female
less than 1 year	11	5
1 year	9	3
2 years	4	3
3 years	2	1
12 years	1	0

Figure 4

1989 - 94 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS BY AGE



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2 years	4	3
3 years	2	1
12 years	1	0

## ETHNICITY

In 1994, 46% of the victims of child homicide by parents/caretakers victims were Latinos (n=18), a 3% decrease from 1993. African-Americans represented 36% (n=14) of the child homicide by parents/caretakers, an increase of 40% from 1993. There were 6 White victims, representing 15% of the total and 1 Asian homicide, representing 3% of the total.

1990 U.S. Census figures show the child population in Los Angeles County to be 48.2% Latino, 27.9% White, 12.3% African American and 12.0% Asian. When the child homicides by parents/caretakers are compared to these child population statistics, African American children continue to be the only racial/ ethnic group that is overrepresented. Latinos are approximately equal to their child population rate, while White and Asian children are underrepresented. Table 2 displays the ratio between the child homicide by parents/caretaker percentages

and child population percentages.

From a multi-year perspective, as illustrated in Figure 5, the ratio of African American children that are victims of homicide by parents/caretakers every year from 1989 has been greater than their composition within the Los Angeles community. Latino child homicides by parents/caretakers have increased, not only in real numbers, but also in relationship to Latino's percentage of child population. Asian children have been consistently under-represented in child homicides by parents/caretakers except in 1991. White children have shown a steady decline in child homicide by parents/caretakers incidents. Because the number of child homicide by parents/caretakers is extremely small in relationship to Los Angeles County's overall child population, relative increases or decreases of deaths in any one racial/ethnic group may make the percentages vary a great deal.

Table 2

### 1994 ICAN CHILD HOMICIDES BY PARENTS/ CARETAKERS - RACE

Race	Number	%	Child Pop %	Ratio*
Latino	18	46	48.2	0.95
African American	14	36	12.3	2.9
White	6	15	27.9	0.5
Asian	1	3	12.0	0.25

\* Ratio = % of deaths by race / % child population by race. A ratio of 1.00 would mean that the % of child abuse homicides is the same as that racial/ethnic groups % of children in Los Angeles County.

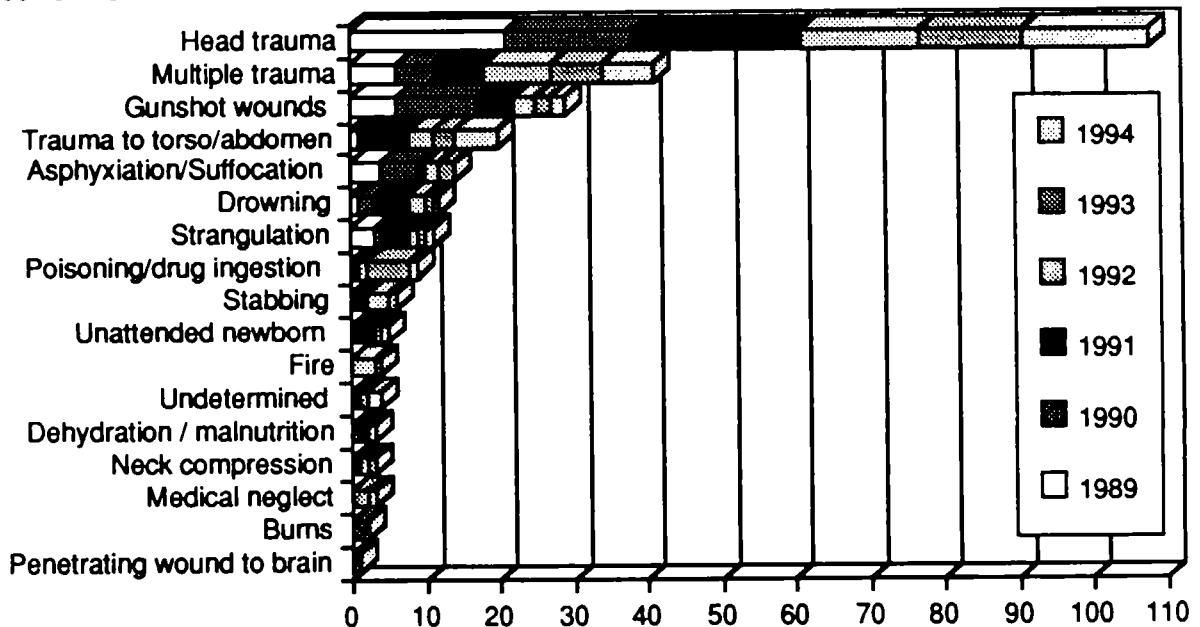
Table 3

**CAUSES OF CHILD HOMICIDES BY PARENTS/CARETAKERS 1989 - 94**

	1989	1990	1991	1992	1993	1994	TOTAL
Head trauma	21	17	23	16	14	17	108
Multiple trauma	6	5	7	9	7	7	41
Gunshot wounds	6	11	5	3	2	2	29
Trauma to torso/abdomen	1		7	3	3	6	20
Asphyxiation/Suffocation	4	5	1	2	2		14
Drowning	1	2	5	2	1	1	12
Strangulation	3	1	4	1	1	1	11
Poisoning/drug ingestion			1	1	6	1	9
Stabbing			2	3	1		6
Fire				3	1		4
Unattended / neglected newborn			3	1		1	5
Dehydration / malnutrition		1	1	1			3
Neck compression		1		1	1		3
Medical neglect					2	1	3
Burns		2					2
Undetermined			1		1	2	4
Penetrating wound to brain		1					1
<b>TOTAL</b>	<b>42</b>	<b>46</b>	<b>61</b>	<b>46</b>	<b>41</b>	<b>39</b>	<b>275</b>

Figure 6

**1989 -94 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS - CAUSES OF DEATH**



**TEMPORAL PATTERN**

In 1994, the greatest number of child homicides by parents/caretakers occurred in May (n=8). The second greatest number of homicides occurred during March (n=7). There were no homicides in June.

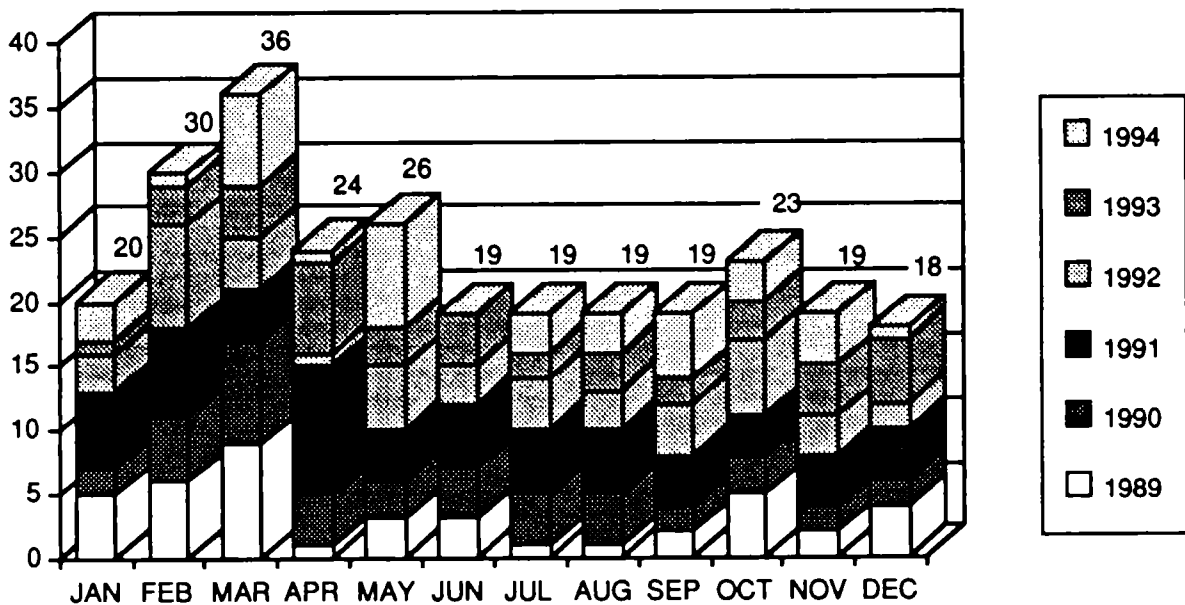
Figure 7 displays the child homicides by parents/caretakers by month for the past six years. During the period of 1989 through 1994, the greatest number of child abuse homicides occurred during the

month of March. The least number of child homicides by parents/caretakers have occurred during December.

The 275 homicides by parents/ caretakers during the past six years translates to an average of 3.8 per month. While actual deaths in any given month vary, June, 1994 was the only month in the past six years in which there was recorded no child homicides by parents / caretakers.

Figure 7

**1989 - 93 CHILD HOMICIDES BY PARENTS/CARETAKERS BY MONTH**



**CHILD PROTECTIVE SERVICE  
INVOLVEMENT**

*Denise, 2 years old, died as a result of blunt abdominal trauma. She died in Mexico after being taken there by her parents for medical treatment. They were afraid to take Denise for medical treatment in the U.S. as the Department of Children and Family Services had been involved with the family for 2 years and they feared DCFS would remove her from their custody. The criminal investigation was complicated due to multiple jurisdictions and involvement of Mexican authorities. The timeline of events and interviews with the suspects were reviewed.*

*Denise had an autopsy in Tijuana in which her death was ruled accidental. Her body was then taken to a mortuary in San Diego. They had started to embalm her prior to recovery by L.A. County officials. Autopsy in Los Angeles indicated 3 blows to the abdomen, one within 24 hours of death. There was scar tissue indicating chronic abuse.*

*Despite extensive investigation, the circumstances surrounding Denise's death were unclear. Her stepfather, mother, and 13 year old uncle were all suspects in the death. While in Mexico, the uncle confessed to sexually abusing Denise and hitting her in the abdomen. However, his statements were not corroborated by physical evidence and there was concern that his confession was coerced. Upon his return to California, he denied abusing Denise.*

*The District Attorney initially rejected the case when it was presented to them shortly after the death. There was extensive follow-up investigation after those presentations. The DA Family Violence Unit agreed to review the case.*

*DCFS history was reviewed. The family had been referred to DCFS for physical abuse of Denise when she was one month old. All of the children had been detained and the court ordered Family Reunification services. The children had been placed with the maternal grandmother. The children were eventually returned to the parents and provided family maintenance services.*

*Denise and her two siblings had been seen at a Department of Health Services multi-disciplinary child abuse assessment center two months prior to her death due to allegations of sexual abuse. The Center's involvement with the family was reviewed. Denise's mother provided a history that Denise and her siblings bruised easily, the children had shaved heads, and appeared neglected and unkept. The evaluation, however, revealed no positive findings for sexual or physical abuse.*

*Following Denise's death, her 3 year old and 9 month old siblings were removed from the parents and placed in foster care. The mother was pregnant at the time of Denise's death and when that infant was born, he was also*

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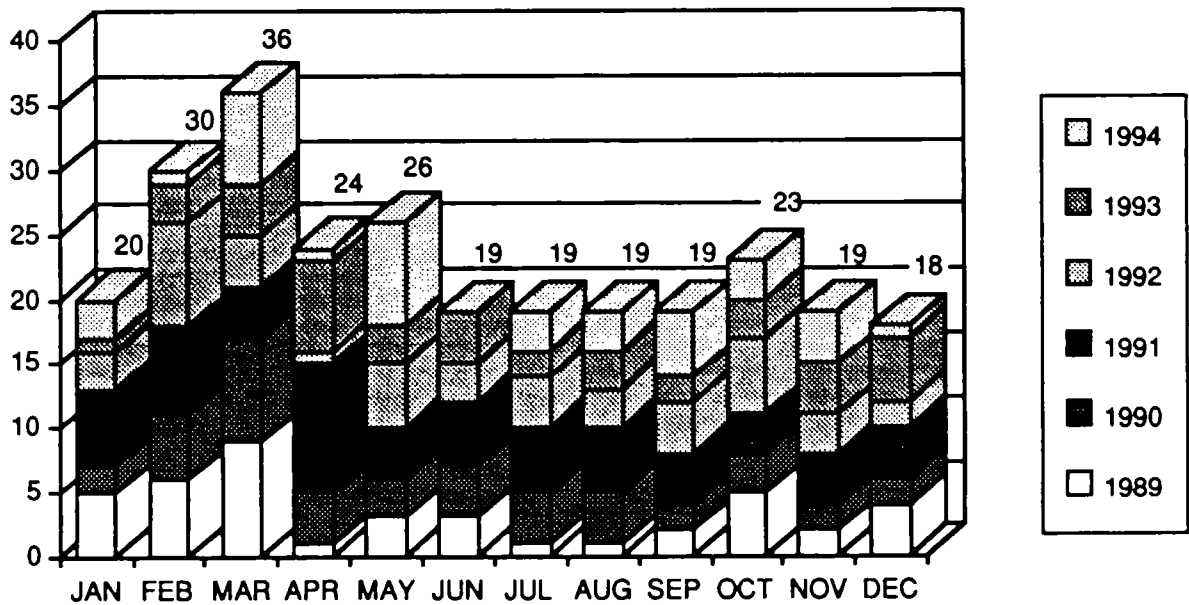


Figure 8

**1989 - 94 CHILD HOMICIDES BY PARENTS/CARETAKERS  
CHILD PROTECTIVE SERVICES INVOLVEMENT**

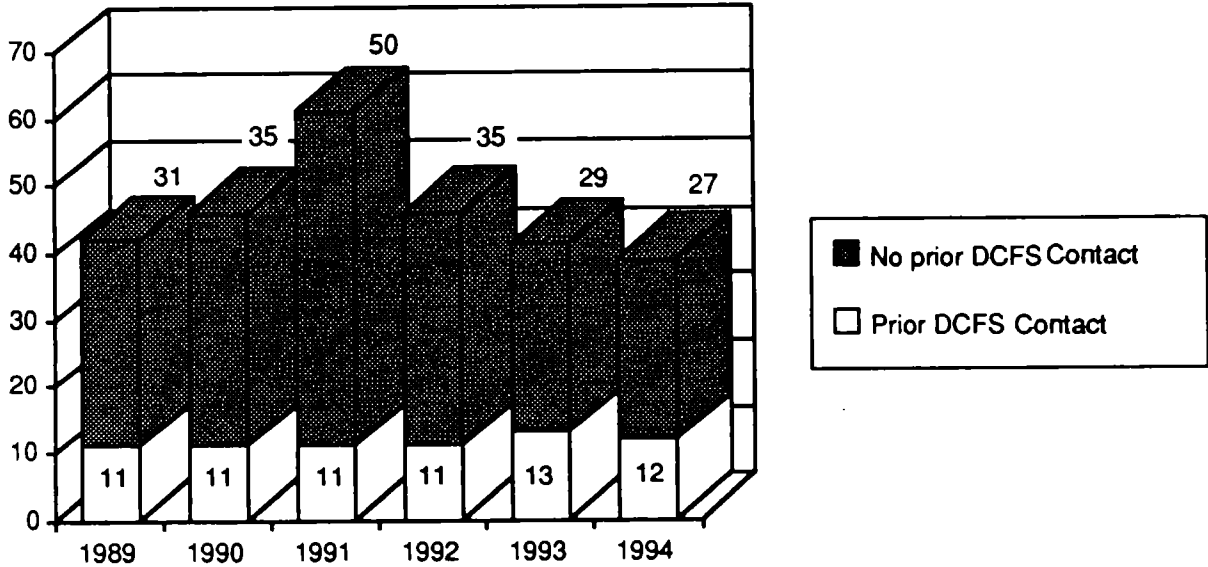


Table 4

**1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS - REASONS FOR PRIOR CHILD PROTECTIVE SERVICES**

Reason	n	%
Physical abuse	6	50
Prenatal substance abuse	3	25
Severe neglect	3	25

Table 5

**1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS - LENGTH OF TIME BETWEEN PRIOR DCFS CASE OPENING AND DATE OF DEATH**

Reason	n	%
Less than 1 month	2	17
1 to 6 months	3	25
6 to 12 months	0	0
1 to 2 years	3	25
2 years or more	4	33

Table 6

**1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS - REASONS FOR CHILD PROTECTIVE SERVICES FOLLOWING THE DEATH**

Reason	n	%
Physical abuse	23	77
Severe neglect	6	20
Substance abuse	1	3

Table 7

**AGES OF MOTHERS IN 1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS**

Age	n	%
Under 20 years	3	10
20 to 24 years	14	45
25 to 29 years	9	29
30 to 34 years	4	13
35 years and over	1	3

Figure 9

**CHILD PROTECTIVE SERVICES ACTIVITIES ON 1994 CHILD HOMICIDES BY PARENTS/CARETAKERS**

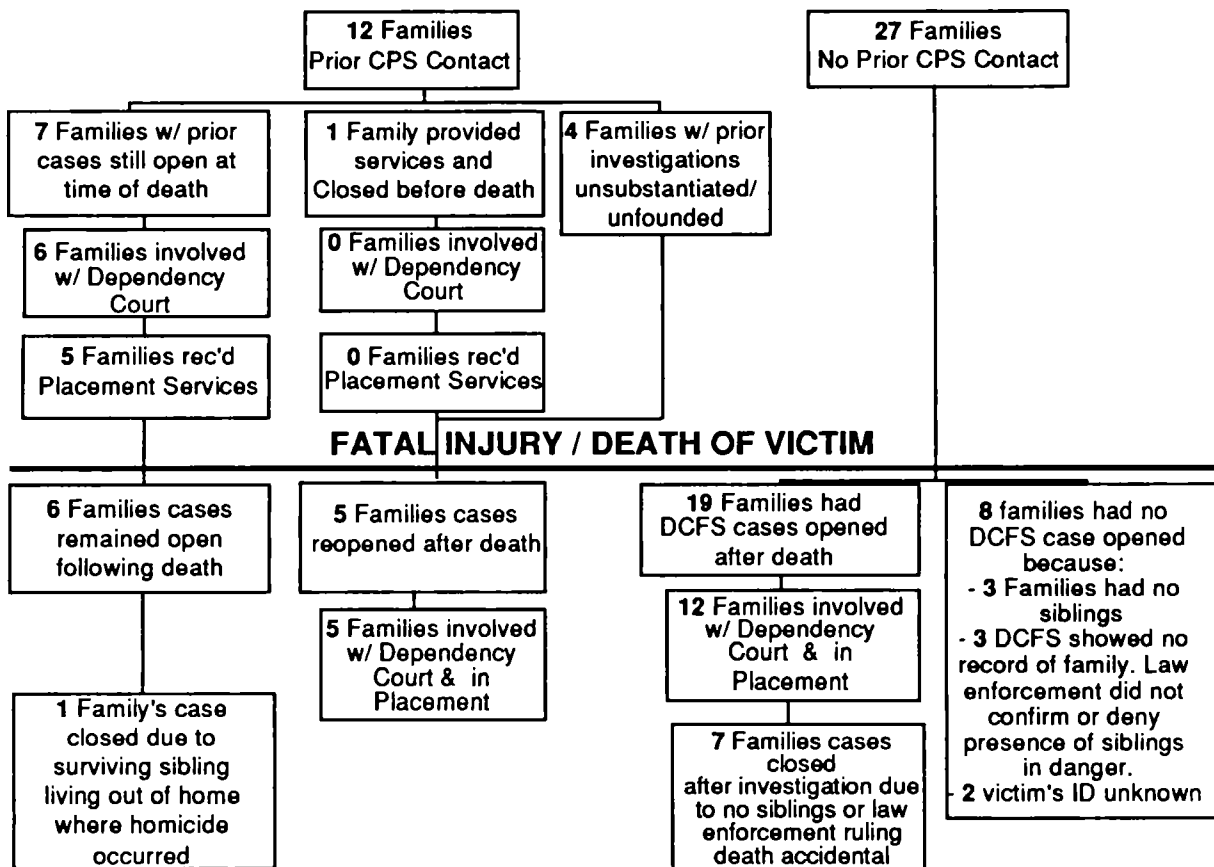


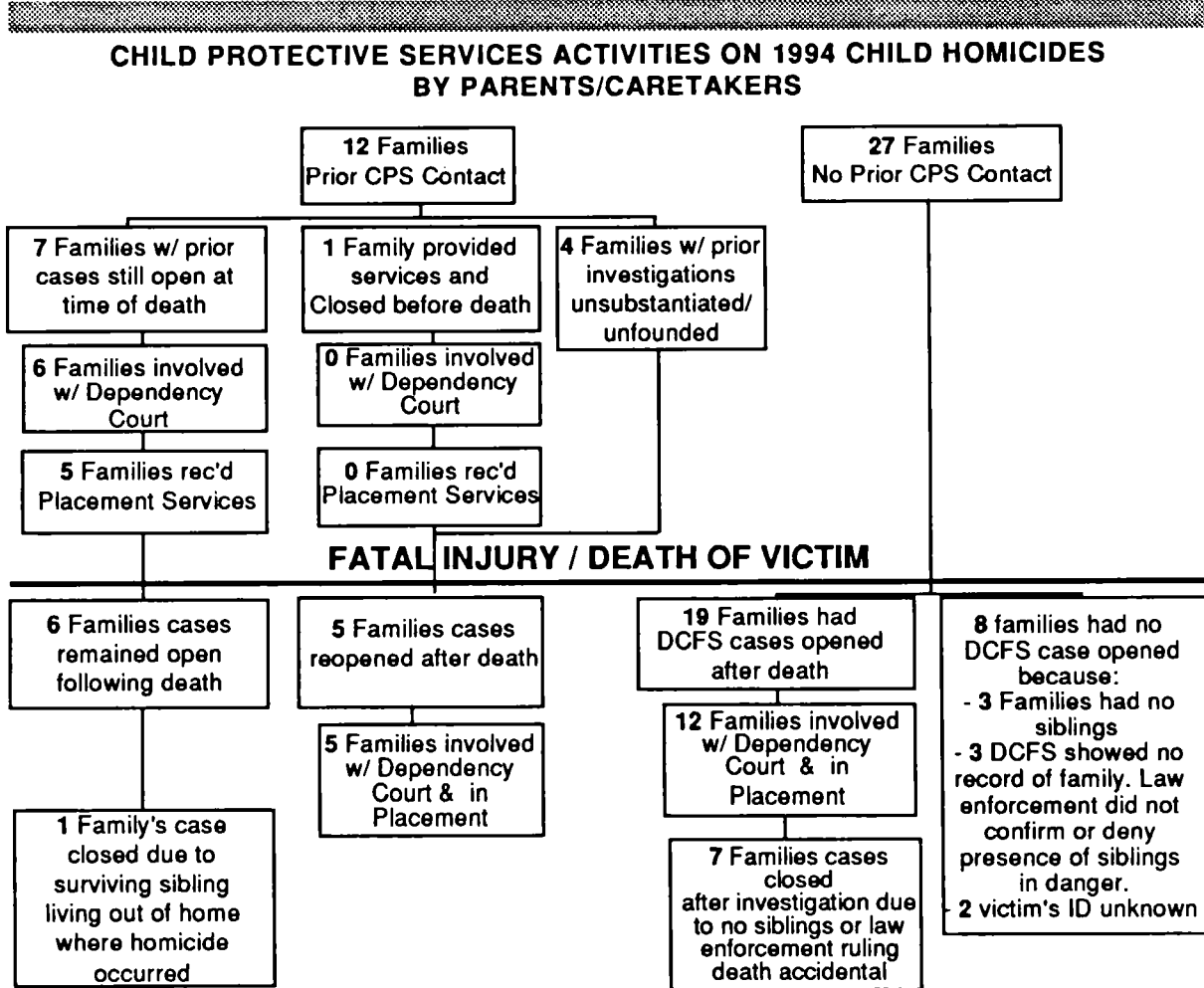
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Figure 9



Dependency Court action on 6 of these families and 5 of the deceased children had at one time been placed in out of home care. Only one of these children died while in out of home care.

In addition to the 7 cases that were open to DCFS at the time of the child homicide by parent/caretaker, 5 families that were previously known to DCFS had cases reopened after the death. 19 additional families that were previously unknown to DCFS were referred immediately following the death or fatal injury.

The reason for referral on the 30 families that received services following the death are displayed in Table 6. The largest number of cases were opened for physical abuse (n=23).

DCFS closed 8 of the 30 cases shortly after the death, either due to no siblings in the home, the sibling not residing in the home where the homicide occurred, or being told by law enforcement that the death was accidental, there was no criminal intent and that siblings were safe in the home.

Petitions were filed in Juvenile Dependency Court on siblings of the deceased child in 17 cases following the child homicide by parent/caretaker. 53 Siblings in 23 families were removed from the home and placed in out-of-home care.

Figure 9 summarizes the child protective services involvement in the 1994 child homicides by parent/caretaker.

The Department of Children and Family Services provides information regarding family demographics of families known to either them, or the Department of Public Social Services through the

Welfare Case Management Information System (WCMIS). This data includes:

- 51% of the families had a history of receiving public assistance from the Department of Public Social Services. Between 1989 and 1993, the percentage of families with prior public assistance ranged from 49.2% to 61%.
- The mother's age was known in 79% (31 of 39) of the cases. The average age of the mothers was 24.5 years. Table 7 gives a breakdown of the mothers ages. 84% of the mothers were under the age of 25 years at the time of their child's death in 1994. Between 1989 and 1993, the percentage of mothers whose age was below 25 years ranged from 42.4% to 55.5%.
- The father's age at the time of death of the child was known in only 19% of the families. The average age of the fathers was 27.7 years.
- The deceased child had siblings in 69% (n=27) of the families. DCFS had no record of the family in 5 cases and law enforcement did not indicate if there were siblings present in those families or the identity of the victim and family were unknown. The percentage of families in which there were multiple children has ranged from a low of 38% in 1991 to this year's high of 69%.

Table 8

**LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS**

Agency	n	%
LAPD	14	36
LASD	13	33
Long Beach PD	3	8
Inglewood PD	2	5
Pomona PD	2	5
Azusa PD	1	2.6
Compton PD	1	2.6
Glendora PD	1	2.6
Pasadena PD	1	2.6
Whittier PD	1	2.5

child homicides by parents/caretakers, an 18% increase from 1993 .

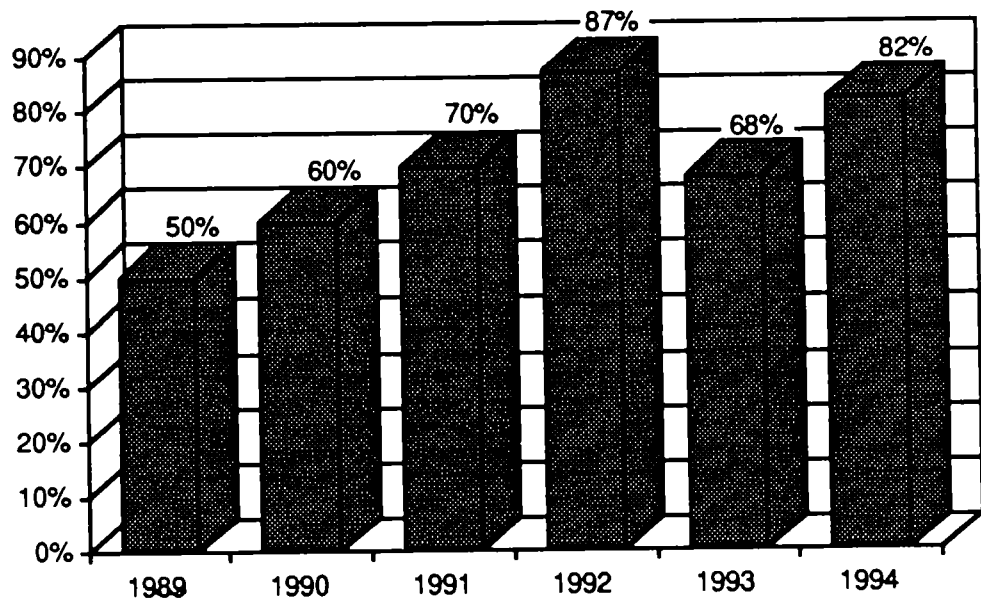
31% (n=12) of the cases were handled by jurisdictions other than LAPD and LASD. Ten different law enforcement agencies were responsible for the investigation of child homicides by parents/caretakers in 1994.

82% (n=32) of the case investigations resulted in presentations to the District Attorney's Office by the law enforcement agencies, an increase of 14% from 1993. The presentation percentage for the past 6 years is displayed in Figure 10.

7 of the 1994 cases involving child homicide by parents/caretakers cases were not presented to the District Attorney. The reasons that those cases were not presented are displayed in Table 9.

Figure 10

**1989 - 1994 LAW ENFORCEMENT PRESENTATION % OF ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS**



The 32 case presentations by law enforcement resulted in the District Attorney's Office filing criminal charges on 65.6% (n=21) of the 1994 cases. One case is pending a filing decision.

The percentage of case presentations which have resulted in the District Attorney filing criminal charges has ranged from 74% to 86% in the 5 years prior to 1994. The filing percentages for the past 6 years is represented in Figure 11.

Eleven of the 1994 cases presented by law enforcement to the District Attorney were rejected. This represents the greatest number of child homicides by parents/caretakers rejected by the District Attorney since the Team has tracked this data. The number of cases rejected by the District

Table 9

**LAW ENFORCEMENT REASONS FOR NOT PRESENTING 1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS**

	n	%
Pending further investigation	3	43
Suspect's identity unknown	2	28.5
Murder/suicide	2	28.5

Attorney's Office has fluctuated over the past 5 years. In 1989 there was only 1 rejection, in 1990 there were 5 cases rejected, in 1991 there were 7 cases rejected, in 1992 there were 10 cases rejected and in 1993 there were 5 cases rejected. The reasons for rejection for the past 6 years are displayed in Table 10.

Figure 11

**1989 - 1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS**

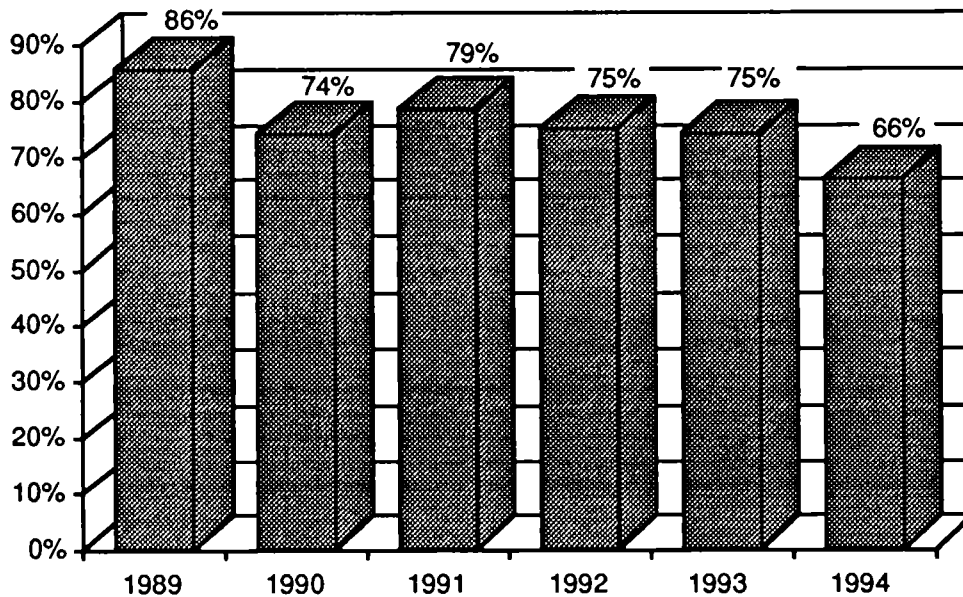


Table 10

**DISTRICT ATTORNEY REASONS FOR REJECTION / NOT FILING CRIMINAL CHARGES  
ON 1989 - 94 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS**

	1989	1990	1991	1992	1993	1994	Total
Insufficient evidence to identify suspect	1	3	1	5	3	4	17
No criminal intent		2	4	2	2	3	13
Interest of justice			1	1			2
Further investigation				1		4	5
Unqualified/unreliable witness(es)				1	1		2
Inadmissible evidence			1				1
Total	1	5	7	10	6	11	40

The criminal charges filed on the 21 cases involving child homicide by parents/caretakers cases for 1989 through 1994 are listed in Table 11. Murder charges (187 P.C.) were filed on 100% of the cases in which charges were filed and 54% of the total number of child homicides in 1994. The 1994 percentage is the same as 1992, after a one year drop to 57% in 1993. The percentage of cases in which murder charges was filed between 1989 and 1994 is displayed in Figure 12.

Felony child abuse charges [273a(1) and 273d P.C.] were filed on 53% of the 1994 cases in which criminal charges were filed. This is a decrease from 1993 when felony child abuse was charged in 71% of cases where charges were filed.

In prior years there have been a variety of other charges filed by the District Attorney, while in 1994, the only other charge filed was 12021 P.C., (ex-convict in possession of a firearm.) Charges filed in the past 6 years is illustrated by Table 11.

The relationship of the perpetrators identified by law enforcement and in those cases in which charges were filed by the District Attorney's Office is displayed in Table 12. In 1994, for the fourth straight year, mothers have been identified by law enforcement as most frequently being involved in the deaths of their children.

Mothers' boyfriends were the second most frequent perpetrators identified in 1994. As in previous years, more male perpetrators have been identified and charged in these cases than females.

The 32 case presentations by law enforcement resulted in the District Attorney's Office filing criminal charges on 65.6% (n=21) of the 1994 cases. One case is pending a filing decision.

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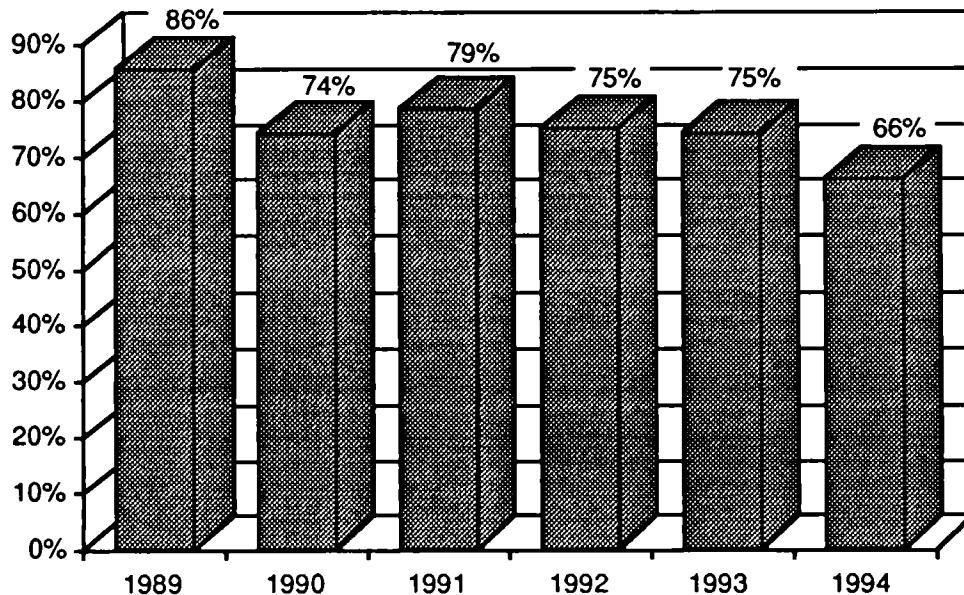


Figure 12

**MURDER CHARGES (187 P.C.) FILED  
ON 1989 - 1994 ICAN CHILD HOMICIDES BY PARENTS/CARETAKERS**

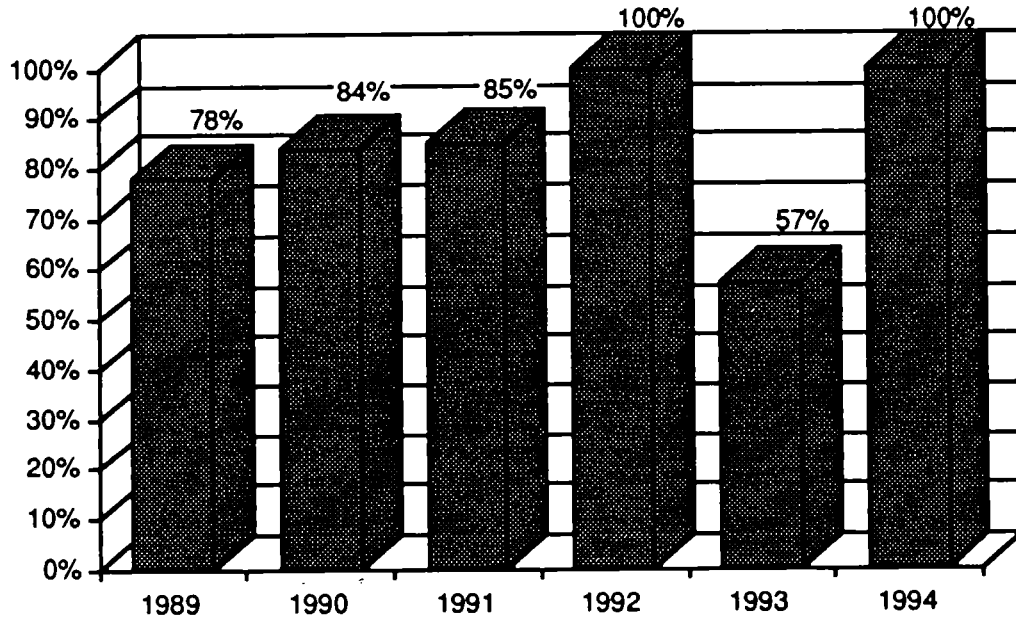


Table 12

**RELATIONSHIP OF PERPETRATORS IN  
1994 ICAN CHILD HOMICIDES BY  
PARENTS/CARETAKERS**

Relationship	ID'd by Police	Charged by DA
Mother	15	10
Mother's Boyfriend	12	9
Father	8	4
Stepfather	2	1
Brother	1	-
Foster father	1	-
Foster mother	1	-
Uncle	1	-
Unknown	5	-

In 1994, there were multiple perpetrators identified by law enforcement in 7 cases and charged by the District Attorney in 4 cases. In all of those cases in which charges were filed, the mother was implicated along with either the mother's boyfriend or the child's father. In those multiple perpetrator cases involving mothers, the mothers are most often charged with child endangering only while the father or boyfriend are charged with murder.

Criminal disposition data for the period of 1989 through 1994 is displayed in Table 13. In 1994, 48% of the cases are still in pending status. This is considerably higher than the 36% of 1993 cases which were pending at the time the report was written last year.

Table 13

**CRIMINAL CASE DISPOSITION  
OF 1989 - 94 CHILD HOMICIDES BY PARENTS/CARETAKERS**

	1989	1990	1991	1992	1993	1994
Life without possibility of parole			1			
49 years to life prison				1		
42 years to life prison	1					
30 years to life prison				1		1
29 years to life prison					1	
26 years to life prison			1			
25 years to life prison	2	1		2	1	
24 years to life prison				1		
22 years to life prison	2				1	
21 years to life prison	1			1	1	
19 years to life prison				1		
15 years to life prison	3		7	4	3	2
14 years prison	1			1		
13 years prison	1	1				
11 years prison		3	1	5		2
10 years prison				1		
9 years prison				2	1	1
8 years prison			1			
7 years prison			5			
6 years prison	1		2	1	1	1
5 years prison	3				1	
4 years prison	1		1	2	1	
3 years prison	2			2		1
2 years prison	1		2		3	
16 months prison			1	1		
1 year jail	1	3	2	4	3	1
9 months jail					1	
6 months jail				1	1	
Less than 3 months jail		2	2			
CYA commitment		1				
10 yrs Probation			1			
6 yrs Probation			1			
5 yrs Probation		1	1			
3 yrs Probation			1	1	2	
Juvenile probation order		1				1
Found not guilty			2	1	1	
Dismissed	3	1	2	3		1
Warrant pending		1				2
Hearings suspended due to insanity plea						1
Sentence pending	1	1		1	1	1
Pending trial	1	4	1		1	6
Matter on appeal prior to trial	1					
Unable to locate record	1	1	2	1	3	
Total	27	21	37	38	27	21
Total C/A Homicides for year	42	46	61	46	41	39

Table 13

**CRIMINAL CASE DISPOSITION  
OF 1989 - 94 CHILD HOMICIDES BY PARENTS/CARETAKERS**

	1989	1990	1991	1992	1993	1994
Life without possibility of parole			1			
49 years to life prison				1		
42 years to life prison	1					
30 years to life prison				1		1
29 years to life prison					1	
26 years to life prison			1			
25 years to life prison	2	1		2	1	
24 years to life prison				1		
22 years to life prison	2				1	
21 years to life prison	1			1	1	
19 years to life prison				1		
15 years to life prison	3		7	4	3	2
14 years prison	1			1		
13 years prison	1	1				
11 years prison		3	1	5		2
10 years prison				1		
9 years prison				2	1	1
8 years prison			1			
7 years prison			5			
6 years prison	1		2	1	1	1
5 years prison	3				1	
4 years prison	1		1	2	1	
3 years prison	2			2		1
2 years prison	1		2		3	
16 months prison			1	1		
1 year jail	1	3	2	4	3	1
9 months jail					1	
6 months jail				1	1	
Less than 3 months jail		2	2			
CYA commitment		1				
10 yrs Probation			1			
6 yrs Probation			1			
5 yrs Probation		1	1			
3 yrs Probation			1	1	2	
Juvenile probation order		1				1
Found not guilty			2	1	1	
Dismissed	3	1	2	3		1
Warrant pending		1				2
Hearings suspended due to insanity plea						1
Sentence pending	1	1		1	1	1
Pending trial	1	4	1		1	6
Matter on appeal prior to trial	1					
Unable to locate record	1	1	2	1	3	
Total	27	21	37	38	27	21
Total C/A Homicides for year	42	46	61	46	41	39

In 1994, there have been 3 perpetrators sentenced to life in prison, compared to 3 in 1993, 5 in 1992, 6 in 1991, 1 in 1990 and 9 in 1989. The number of perpetrators sentenced to life in prison for 1994 cases may increase as the pending matters are resolved.

14% (n = 3) of perpetrators of child homicide by parents/caretakers received an intermediate term sentence, 2 to 10 years prison, in 1994. This compares to 8% in 1992, 23% in 1991, 0% in 1990 and 31% in 1989.

Two of the 1994 perpetrators have received jail time of one year or less or probation orders. This compares to 2 in 1993, 5 in 1992, 3 in 1991, 8 in 1990 and 1 in 1989.

In 1994, there has been one dismissal to date. For prior years, there have been an average of three acquittals or dismissals, with the exception of 1990 and 1993 when there were only one dismissal or acquittal each year.

## CALIFORNIA STATE DEPARTMENT OF JUSTICE RECORDS

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 criminal justice system response for agencies throughout the state. DOJ maintains a separate Child Abuse Central Index system, to which all child protective 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 substance exposure. The Department of Justice provided a detail listing of those cases reported to both the Uniform Crime Report and Child Abuse Central Index systems

to the Team for reconciliation and report.

In 1994, the Uniform Crime Report (UCR) System identified 192 homicides reported from Los Angeles County where the victim was under the age of 18 years, 33 in which the victim was 10 years old or younger. After reconciliation with Team records, 4 homicides were added to the Team population. 14 cases in the Team's database were not in the UCR system at the time of the reconciliation.

In March, 1995, the DOJ Child Abuse Central Index (CACI) System reported that 16 child abuse investigation reports in which the death of the victim was identified had been received for 1994 from Los Angeles County child protective services agencies. Only 9 of those reports were on cases that had been reported to the Team as homicides by parents/caretakers.

Team records were reconciled and notices were sent to 9 law enforcement agencies requesting that they research 25 cases that had been reported to the Team at that time and did not have a record with DOJ CACI.

In November 1995, DOJ re-ran the CACI system and 18 victims were identified using the same criteria. However, due to changes in policies within DOJ, a detailed case listing was not provided to the Team for further reconciliation.

Problems with reconciliation of the Team's records with the Department of Justice have been ongoing since initiated in 1990. The Team has had varied success in having cases added to the Index. In 1990, 11 additional reports were generated as a result of reconciliation, in 1991 there were 12 additional reports, in 1992 there were 10 additional reports filed, and in 1993 12 additional child homicides by parents/caretakers were entered into the Index following Team reconciliation.

DHS could not find records for 1 child who, according to the Coroner, died in a DHS facility.

8

**REVIEW OF RECORDS AT ONE OF THE COUNTY MEDICAL CENTERS**

A chart review of 14 medical records at Harbor/UCLA Medical Center on child homicides between 1990 and 1993 was conducted in late 1995. Team record clearance indicated 20 children had medical records at the Medical Center. 4 charts were missing and 2 children showed no record of being seen at the Medical Center at the time of the chart review.

Of the 14 medical records found, ten of the children were boys, four were girls. Six of the children were African American, 6 were White, 1 was Latino and 1 was Asian. The average age of the children was 27 months at death.

Three of the victims were born at Harbor/UCLA Medical Center. One was a normal delivery, one was a premature drug exposed infant who was referred to DCFS and the other was a premature birth with maternal substance abuse history.

One child was seen at the cardiology clinic. The child was discharged from the service after multiple failed appointments.

Three children were seen at the ER prior to their fatal injuries. One was for loose stool, one for colic and cough and the third for slipping out of an infant carrier.

Six children were seen at the time of their fatal injuries. Four of the six had injuries which were diagnosed at the hospital as abuse related.

One child was seen twice, in the ER and again at death. Child abuse was indicated at both visits for this child.





ICAN CHILD DEATH REVIEW TEAM REPORT FOR 1994

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## ACCIDENTAL CHILD DEATHS IN LOS ANGELES COUNTY

*Dennis, 3 months old, died as a result of apnea associated with prematurity. Dennis had been prenatally exposed to cocaine and was placed in a foster home at the time of death. He weighed 3 pounds at birth, was a twin, and was on an apnea monitor. Dennis had been gaining weight and weighed 12 pounds at time of death.*

*Dennis' foster mother was not in the home at the time of death. She had left Dennis in the care of her 18 year old granddaughter. There was conflicting information on whether or not Dennis was on his monitor at the time of death. There was also a question of whether he was being administered medications at proper levels. At autopsy, his medication level was low.*

*The California Department of Social Services revoked the foster mother's license due to the granddaughter being left to care for Dennis and a four hour period when no one checked on him. It was only when the DCFS social worker called the foster home that the granddaughter found Dennis dead.*

*Another child who had been diagnosed as failure to thrive had been removed from the home a few days prior to the death. That removal came at the request of the child's physician. There was no hold placed on the home at that time and law enforcement was not involved. Procedures for placing holds on foster homes was reviewed.*

*The Team discussed grief and survivor issues.*

*DCFS referred the foster mother for grief counseling. The social worker was receiving support from her supervisor as well as other staff in her office.*

*The Team discussed training for foster parents on medically fragile children. State law requires special training for foster parents before a medically fragile child or a child with special medical or emotional disorders may be placed in the home. In this case, the foster mother, who was a nurse, had received this specialized training.*

*Review indicated that Dennis had many risk factors for SIDS/apnea. Use of apnea monitors in SIDS cases was discussed. There is a lot of misinformation about monitors. Parents frequently try to "wean" babies from monitors. There is a way to monitor usage of monitors, through event recordings. MediCal does not pay for this however.*

*Issues around medication, theophylline, and it's possible contribution to the death were discussed. Theophylline is not effective in all cases. Almost all infants are weaned from it prior to release from the hospital.*

*There was concern that the twin sibling was at high risk for SIDS. DCFS was monitoring the twin's care and indicated that the twin was thriving.*

Seventy accidental deaths were reported to the Team by the Coroner for 1994. This is a 32.7% decrease from 1993. Over the period 1989 to 1993, the number of accidental deaths reported to the Team has ranged from a low of 70 in 1989 to a previous high of 104 in 1993.

Accidental deaths are of interest to the Team due to questions of child safety and supervision by the care providers at the time of the accident. These deaths have been determined by the investigating agencies, law enforcement and the Coroner to be inadvertant and unintended. Many, if not all of these deaths are preventable.

### CAUSES OF ACCIDENTAL DEATHS

The causes of the Accidental deaths between 1989 and 1994 are displayed in Figure 12 and Table 14. The leading cause of accidental death in 1994 continued to be drowning. In 1994, 35 children died of accidental drownings, a 12.5% decrease from 1994. From 1989 to 1994, the number of drownings ranged from a low of 25 in 1992 to a high of 40 in 1993.

The second leading cause of accidental death in 1995, as in the five preceeding years, was associated with maternal substance abuse. These deaths are primarily of very young, prematurely born, live infants who were prenatally exposed to drugs.

Other causes of accidental deaths, as in prior years, range from falls, choking on food, suffocation, accidental ingestion of drugs or other poisons, injuries of the neck or chest, gunshot wounds, injuries suffered as a result of fire and medical misadventure. This array of causes of death is similar to prior year findings.

### MAKING A DIFFERENCE:

In the 1994 Team Report, the Team recommended that the Los Angeles County Board of Supervisors address the tragedy of accidental drownings of young children through building code modifications and development of a public awareness campaign as to the dangers of drowning.

In February, 1995, ICAN presented a detailed plan to the Board of Supervisors for a comprehensive, countywide, drowning prevention program. This program had four elements:

1. Adoption of an ordinance to require barrier pool fencing and other safety features for all newly constructed and remodeled residential swimming pools, spas and hot tubs;
2. Exploration of the use of redevelopment funds to provide loans to county residents in order to retrofit existing swimming pools with safety features;
3. Development of a county-wide public awareness campaign by the Department of Health Services (DHS) and Department of Forester and Fire Warden (DFFW);
4. Issue a communication to all cities within L.A. County regarding the extent of the problem of childhood drowning and requesting them to adopt barrier pool fencing measures.

On August 1, 1995, the Board of Supervisors adopted Ordinance No. 95-0039 requiring barriers on newly constucted and remodeled swimming pools.

DHS and DFFW have worked with KABC-TV, KMEX-TV, Baywatch Television Productions, the County Office of Education and Walnut School District to develop and implement a television campaign and elementary school curriculum on drowning prevention.

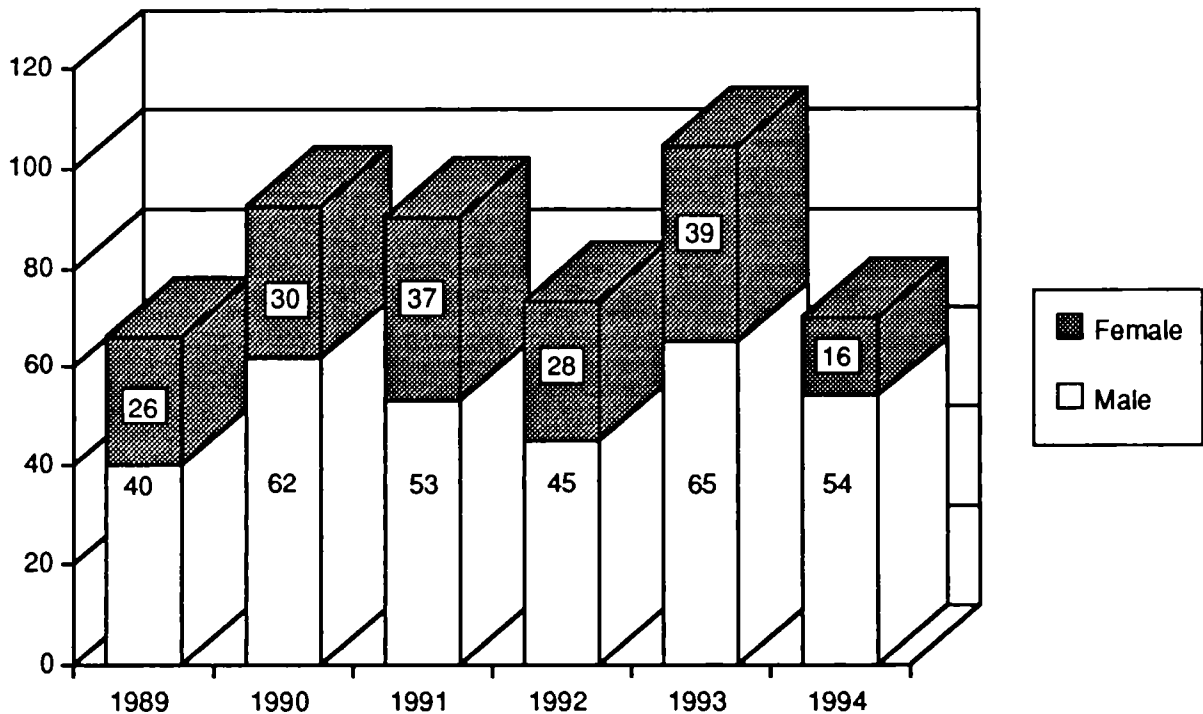
**GENDER**

77.1% (n=54) of the 1994 accidental death victims were male. Over the past 5 years, the percentage of male victims has ranged from a low of 58.2% in 1990 to a previous high of 66.7% in 1991.

Figure 13 displays the gender breakdown of the accident victims for the past 5 years.

*Figure 13*

**1989 - 1994 ICAN ACCIDENTAL CHILD DEATHS BY GENDER**

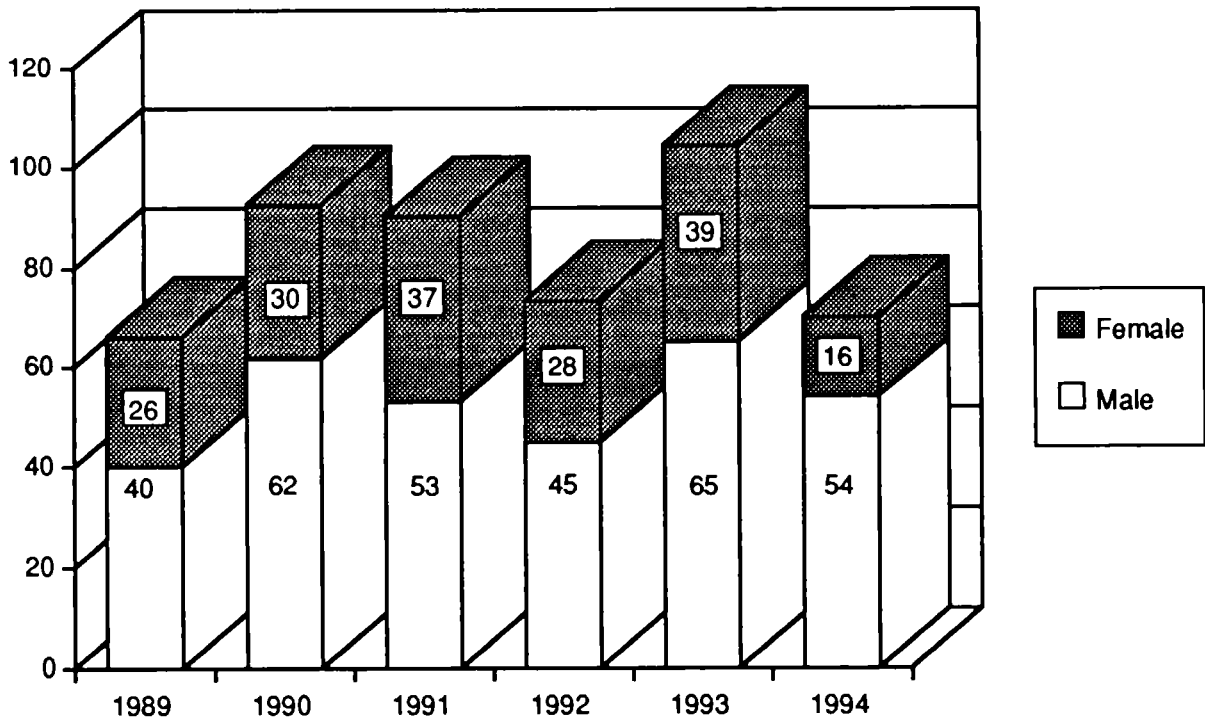


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*Figure 13*

**1989 - 1994 ICAN ACCIDENTAL CHILD DEATHS BY GENDER**



**AGE**

Figure 14 displays the ages of the 1994 accidental death victims. 21.4% (n=15) were under the age of 1 year, 15.8% (n=11) were under the age of 6 months.

The average age of the drowning victims was 4.6 years. Four of the 9 accident victims over the age of 10 years died from drowning. 54.3%, 19 of the 35 drowning victims were 2 years old or younger. The oldest victim was 17 years old and drowned in a lake. The youngest drowning victim, 8 months old, was left unattended in a bathtub by her mother.

9 of the 11 infants under the age of 6 months died due to complications of maternal substance abuse. 2 drug exposed infants died on their day of birth. 8 died within the perinatal period, the first month after birth. The oldest drug exposed death was 2 years old. This is comparable to prior years.

The seven children who died from falls in 1994 ranged in age from 15 months to 14 years old. The youngest victim fell while learning to walk. The oldest victim fell off of a semi-truck and trailer while it was moving.

Figure 14

**1993 ICAN ACCIDENTAL DEATHS BY AGE**

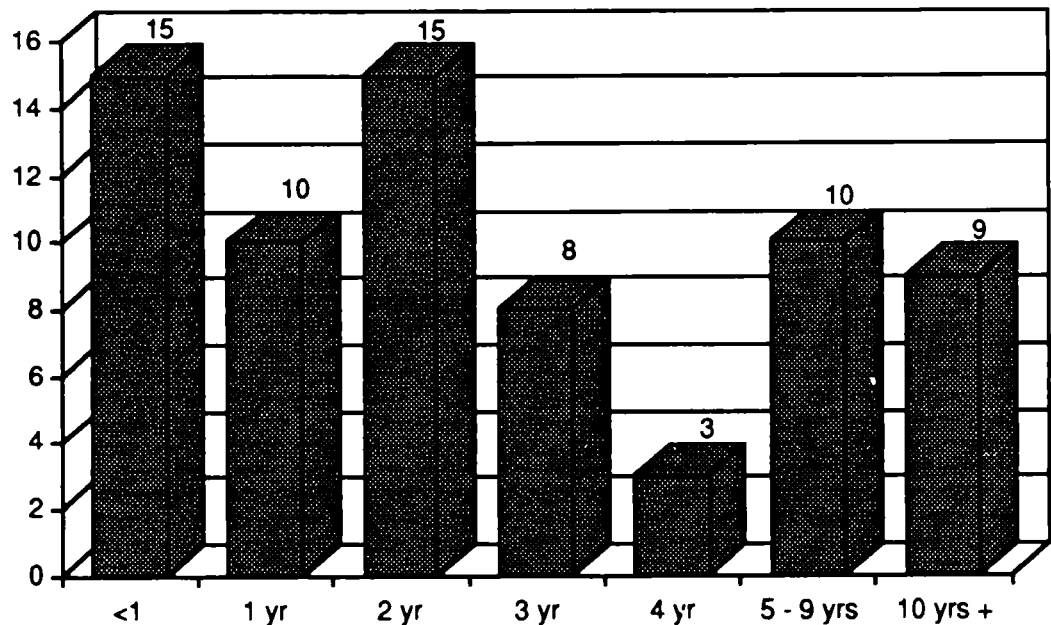
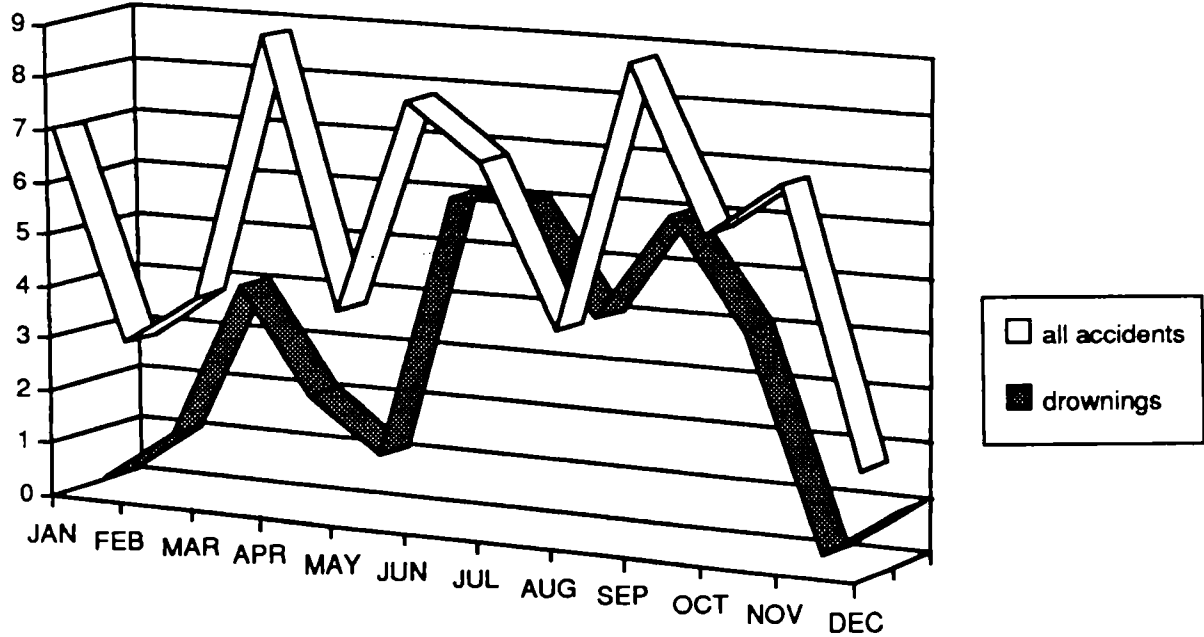


Figure 15

**1994 ICAN ACCIDENTAL CHILD DEATHS BY MONTH**



**CHILD PROTECTIVE SERVICES INVOLVEMENT**

7% (n=5) of the families with accidental child death victims had a history of receiving child protective services prior to the child's death. 40% (n=2) of those cases were families where the Coroner indicated that the death was related to maternal substance abuse. This percentage is lower than previous years when 45% to 85% of the accidental death victims with prior child protective services died as a result of maternal substance abuse.

Table 16 provides the reasons the 5 cases were known to DCFS. In 1994, 2 of the 5 cases were referred for allegations of prenatal substance exposure. 1 had been referred for allegations of physical abuse.

Of the 5 cases with prior child protective services, only one was opened before the birth of the child that died.

Table 16

**1994 ICAN ACCIDENTAL CHILD DEATHS REASONS FOR PRIOR CHILD PROTECTIVE SERVICES**

Reason	n	%
Prenatal substance abuse	2	40
Physical abuse	1	20
Caretaker absence/incapacity	1	20
Unknown	1	20

DCFS proceeded with court action and out-of-home placement before the death in 60% (3 of 5) of the families in which they had received referrals for service.

60% (n=3) of the cases that were known to DCFS were open at the time of the children's death.

In addition to the 3 cases that were open to DCFS at the time of the accidental death, 17 additional families were referred to DCFS at the time of the death. Neither of the cases that had been opened and closed before the death were reopened despite siblings present in the home. The reason for referrals on the 17 families who had cases opened after the death are displayed in Table 17.

Petitions were filed in Juvenile Court on siblings of the deceased child on two cases following the deaths and had siblings placed in out-of-home care.

Figure 16 summarizes the child protective services on the accidental child deaths.

The Department of Children and Family Services provided information regarding the constellations of families known to them:

- 47% (n=33) of the families had a history of receiving public assistance from the Department of Public Social Services.
- The mother's age at the time of death of the child was known in 49% of the families. Table 18 provides a breakdown of the mothers' ages.
- The deceased child had siblings in 46% (n=32) of the cases. 19% of the families were known to not have any children other than the victim. It was unknown if there were siblings in 35% (n=25) of the families.

Table 17

**1993 ICAN ACCIDENTAL CHILD DEATHS  
REASONS FOR CHILD PROTECTIVE  
SERVICES FOLLOWING DEATHS**

Reason	n	%
Severe neglect	10	59
General neglect	2	12
Physical abuse	3	17
Substance abuse	1	6
Emotional abuse	1	6

Table 18

**AGE OF MOTHERS IN 1993 ICAN  
ACCIDENTAL CHILD DEATHS**

Age	n	%
Less than 20 years	3	9
20 to 29 years	13	38
30 to 39 years	16	47
40 years and older	2	6

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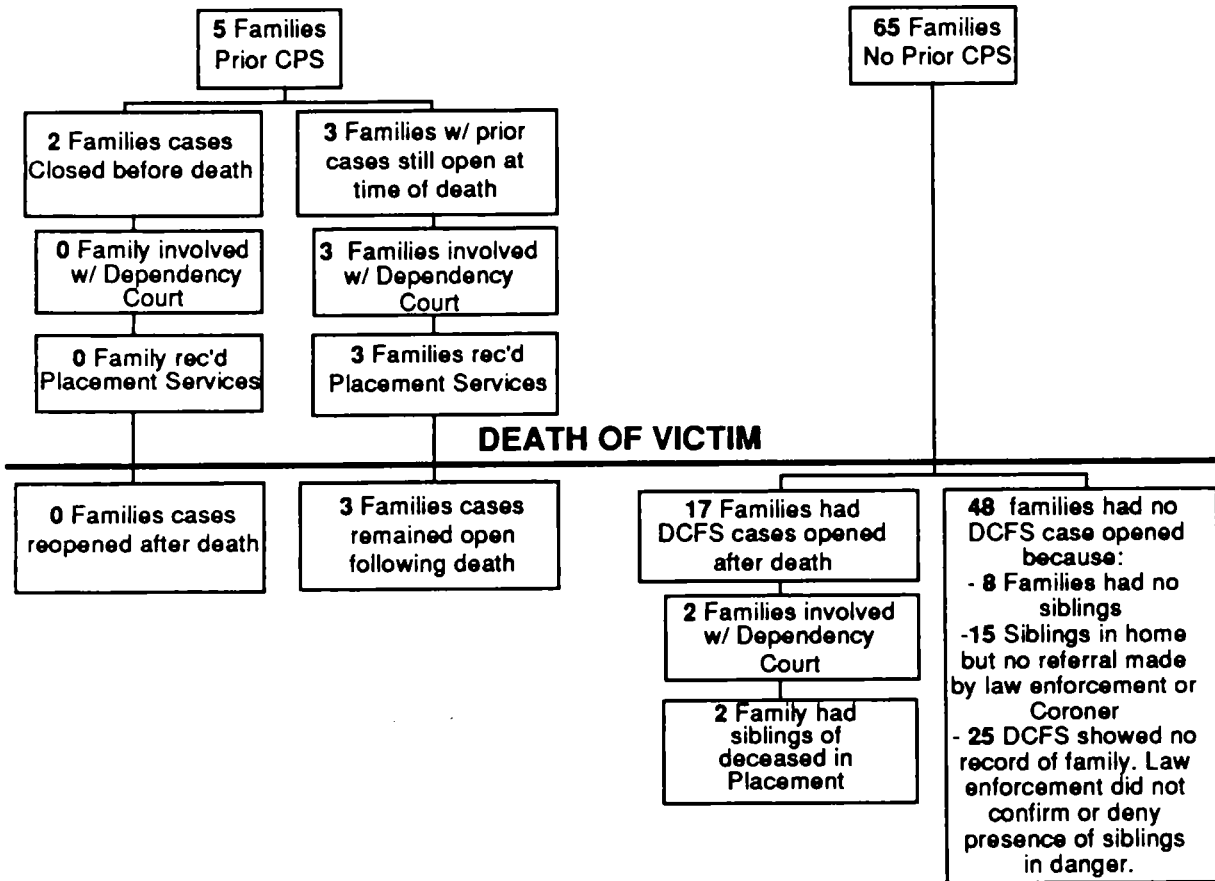
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Figure 16

**CHILD PROTECTIVE SERVICES ACTIVITIES ON 1994 ACCIDENTAL CHILD DEATHS**



**CRIMINAL JUSTICE SYSTEM INVOLVEMENT IN ACCIDENTAL CHILD DEATHS**

Information on criminal justice system activity on accidental child deaths was gathered from Los Angeles Sheriff's Department, Los Angeles Police Department and the Los Angeles District Attorney's Office. Information was gathered on 51 of the 70 accidental child deaths.

Los Angeles Police Department had investigative responsibility for 38% (n = 27) of the accidental child deaths. Los Angeles Sheriff's

Department had responsibility for 18.6% of the cases. Table 19 displays the 23 different police departments that were involved in the 1994 accidental child deaths.

Four of the accidental child deaths were presented to the District Attorney's Office for the consideration of filing criminal charges in 1994. As in prior years, very few accidental deaths receive consideration by the District Attorney due to the Coroner's ruling of accidental death.

## UNDETERMINED DEATHS IN LOS ANGELES COUNTY

*Gabriela and Graciela, 2 month old twins, were found dead at the same time. Their family had suffered a prior SIDS death in 1980. This case was referred to the Team by the Department of Health Services SIDS Program as they had concerns about environmental health issues in the residence. They considered the home to be filthy with extremely poor ventilation. There were 19 people residing in this two bedroom home. The residents were keeping chickens, in violation of environmental health regulations.*

*The Coroner reported that the cause and manner of death was undetermined. At autopsy, one child had signs of pneumonia. The other's autopsy was negative. Were it not for the environmental factors and pneumonia, the Coroner would have ruled these deaths Sudden Infant Death Syndrome (SIDS).*

*The Department of Children and Family Services (DCFS) reported that they received a referral on the family as a result of the deaths. They had no prior involvement with the family. There were actually three families involved. The families voluntarily placed the surviving children with relatives out of the home and thoroughly cleaned up the residence. The social worker visited the home weekly to supervise the clean-up. DCFS closed the case once the cleaning was complete and the children were returned. There was no other evidence of abuse or neglect.*

*The Team discussed the issue of simultaneous SIDS deaths in twins. While extremely rare, there are several studies about this in the literature. Children's Hospital of Los Angeles has a policy that when one twin dies from SIDS, the other twin is hospitalized and followed with an in-home monitor. In twins where one is large and the other is small for gestational age, SIDS incidence in the smaller twin is higher.*

*The Team also discussed concerns relating to the environmental condition of the home. Questions about the possibility of toxic inhalation or lead exposure were raised. The poor sanitation of the environment would have led to increased chances of exposure to bacteria and other toxins. Toxicology studies on the twins were negative.*

*The issue of serial SIDS was also raised. Serial SIDS raises suspicion of serial homicide, as soft suffocation of infants is indistinguishable from SIDS. Certain in-born metabolic birth defects can also be indistinguishable from SIDS.*

**T**wenty one undetermined child deaths were reported by the Coroner to the Team in 1994, the greatest number of undetermined deaths reported to the Team over the past 11 years. The number of undetermined deaths reported to the Team has ranged from 2 to 14 in prior years. The average of the previous 10 year period was 10.1 per year.



Undetermined deaths are those where the Coroner is unable to assign a manner of death. Usually, there is no clear indicator if the death was caused by another or was accidental. As illustrated in the above case, these cases involve either a lack of information or conflicting information, which confounds the Coroner's ability to make a final determination.

These cases are suspicious in nature and are of interest to the Team because a final determination cannot be made by the Coroner. Eight of the 21 undetermined deaths (38%) received in-depth review by the Team.

## **GENDER**

In 1994, fourteen of the undetermined deaths were male and seven were female. In five of the past six years there have been more male undetermined deaths than female.

## **AGE**

In 1994, 81% (n = 17) of the undetermined deaths were of infants under one year of age and 14.3% (n = 3) were one year olds. The oldest victim was 13 years old.

In the period of 1989 through 1994, an average of 70.3% of the undetermined death victims have been under the age of one year.

## **ETHNICITY**

43% (n = 9) of the undetermined deaths were African-American and 35.3% (n = 7) were Latino. Over the past 6 years, the ethnicity has fluctuated between each year, but averaged 33% Latino, 33% African-American and 33% White.

## **CAUSE OF DEATH**

The most frequent cause of undetermined deaths was "undetermined after autopsy and toxicological examination" (n = 13).

Two cases showed evidence of subdural hematoma. The reason for the injury was unknown. Two other cases had evidence of subdural neomembranes which is evidence of head injury. The Coroner was unable to rule out inflicted trauma on these cases.

In two cases, the Coroner ruled that the cause of death was failure to thrive. The investigation revealed that one of the infants was allergic to the infant formulas used and became malnourished and underweight.

There were two cases of asphyxiation. One child had an adult tooth obstructing his airway yet none of the adults in the home were missing any teeth.

One case involved drowning in a bathtub. Foul play could not be ruled out by the Coroner due to remote head trauma.

This diversity of causes of undetermined deaths is consistent with prior year findings.

## **DEPARTMENT OF CHILDREN AND FAMILY SERVICES INVOLVEMENT**

4 of the undetermined deaths had prior child protective services involvement. 3 of those cases were open to the Department of Children and Family Services at the time of the deaths.

4 cases have been referred to the Department of Children and Family Services since the death. 2 were referred for allegations of physical abuse and 2 were referred for allegations of neglect.

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These findings are similar to prior years' DCFS activity with families involved with undetermined deaths.

### **CRIMINAL JUSTICE SYSTEM INVOLVEMENT**

Los Angeles Police Department was the investigating law enforcement agency on 42.9% (n = 9) of the undetermined deaths, Los Angeles Sheriff's Department was responsible for the investigations on 28.6% (n = 6) of the cases. The remaining cases were handled by Long Beach Police Department (n = 3), Gardena Police Department (n = 1) and Burbank Police Department (n = 1). The law enforcement agency could not be located for one case.

1 of the cases was presented to the District Attorney's Office by law enforcement. The District Attorney filed murder (187 P.C.) and child endangering charges (273 a1 P.C.) on the case. The suspect, who was the victim's mother, pled guilty to voluntary manslaughter (192b P.C.) and was sentenced to one year county jail and three years probation.

### **HEALTH SYSTEM INVOLVEMENT**

Five of the undetermined death victims had records found at Los Angeles County Department of Health Services facilities; four at LAC+USC Medical Center and one at King Drew Medical Center.

Place of death data provided by the Coroner indicated that 10 different medical facilities were involved in the undetermined deaths. 7 died in Los Angeles County Department of Health Services facilities; four at King Drew Medical Center, 2 at LAC+USC Medical Center, and one at Harbor/UCLA Medical Center.

Five of the undetermined death victims died in a setting other than a hospital, in 4 cases, the child's residence.

## ADOLESCENT SUICIDES IN LOS ANGELES COUNTY

*Dear Mom:*

*I am very sorry that I caused you to be so upset with me. I know that I am too selfish and that I don't deserve anything I have. Once again, I am very sorry. Perhaps I did stand in the way of your happiness. Well, that will soon be taken care of. As for me, I am stupid! I am a failure! Nothing I do is right - I am never going to amount to anything in my life. I am not cut out for college. All of my life I was afraid of disappointing you and all of my life I end up disappointing you! What you did not take care of 17 years ago, I will take care of now! I love you Mommy, I really do! Tell everyone I love them ...*

*Love, S.R."*

This note, left by a sixteen year old girl who shot herself to death, illustrates the despair and confusion of teens who commit suicide.

Twenty eight suicides, where the victim was 17 years old or younger, were reported to the ICAN Child Death Review Team for 1994. This is a 37% decrease from 1993. The average number of adolescent suicides referred to the Team since tracking of this population began in 1988 is 29.7 per year.

While the Team does not focus on this population, clearances from law enforcement, Department of Children and Family Services, Probation and the Department of Health Services provide a picture of these children and families and their interactions with public agencies prior to their deaths.

Brief case examples of some of these deaths show the desperate nature of these acts:

*Corey, 17 years old, had been a constant runaway, had dropped out of school and, using drugs, became distraught and shot himself in the head while in his bedroom.*

*Lela, 15 years old, used her mother's anti-depressant medication to commit suicide. Letters that Lela left indicated that she too was depressed.*

*Paul, 16 years old, had been adopted at the age of one year old. He had been diagnosed as manic depressive and prescribed medication. He ingested 50 to 60 tablets at one time.*

*Fidel, 17 years old, had made several suicide threats and was being treated for depression. He was found in the family garage after hanging himself.*

### GENDER

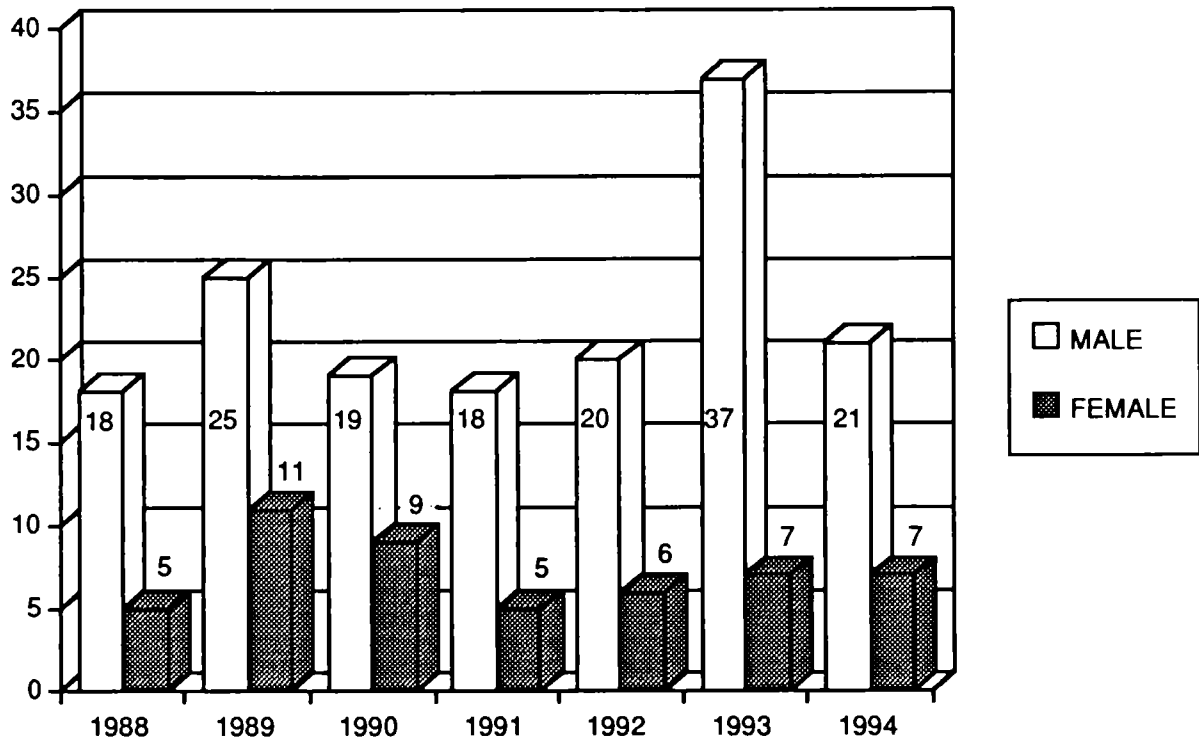
75% (n=21) of the 1994 adolescent suicide victims were male. Over the past 7 years, the percentage of male victims has ranged from 68 to 84%. The average number of male victims over the past 7 years has been 22.6, with a range of 18 to 37.

There were 7 female victims in 1994, unchanged from 1993. The average number of female victims over the past six years is 7.1. The number of female victims between 1988 and 1994 has ranged from 5 to 11 victims per year. The greatest number of female victims was in 1989 with 11 females.

Figure 17 displays the gender breakdown of the suicide victims for the past 6 years.

Figure 17

1988 - 1994 ICAN ADOLESCENT SUICIDES BY GENDER

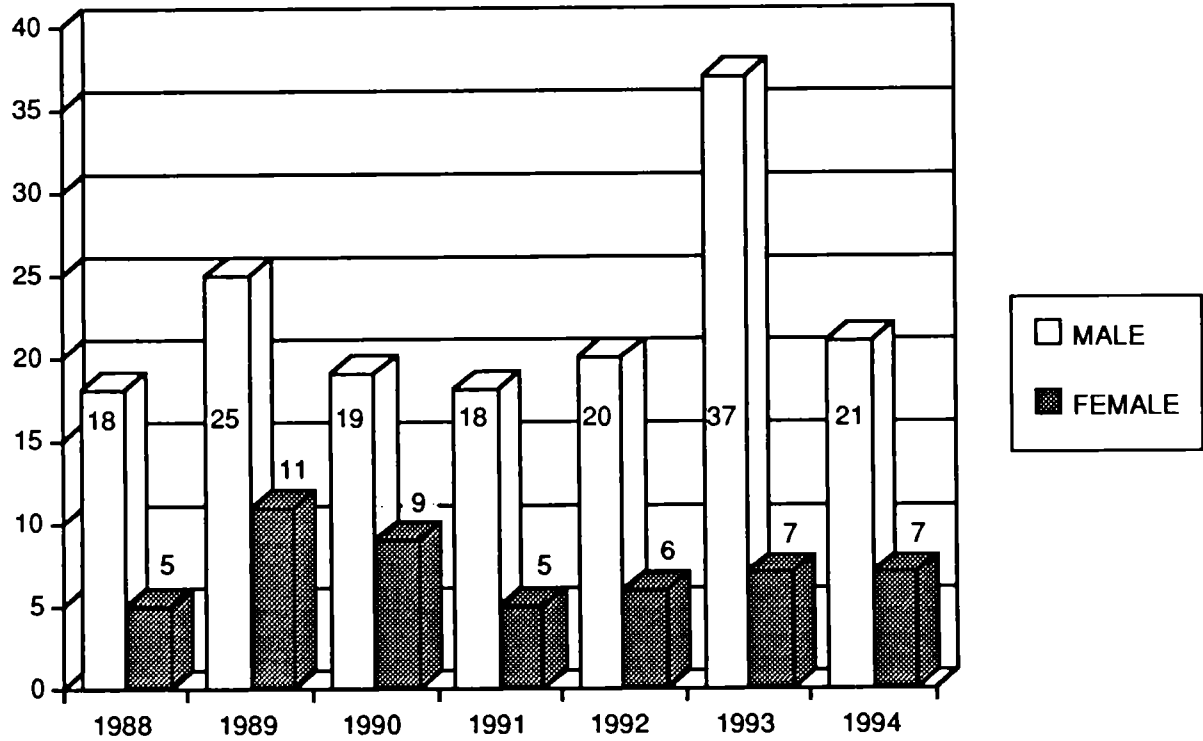


**AGE**

In 1994, the average age of adolescent suicide victims increased slightly from 15.4 years to 15.8 years. This was primarily due to a decrease in the number of 11, 12 and 13 year olds who committed suicides from 8 in 1993 to 1 in 1994. There were decreases in the number of suicides of all ages with the smallest decrease in the number of 17 year olds. Table 21 displays this data, as does Figure 18.

Figure 17

1988 - 1994 ICAN ADOLESCENT SUICIDES BY GENDER



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ADOLESCENT SUICIDES

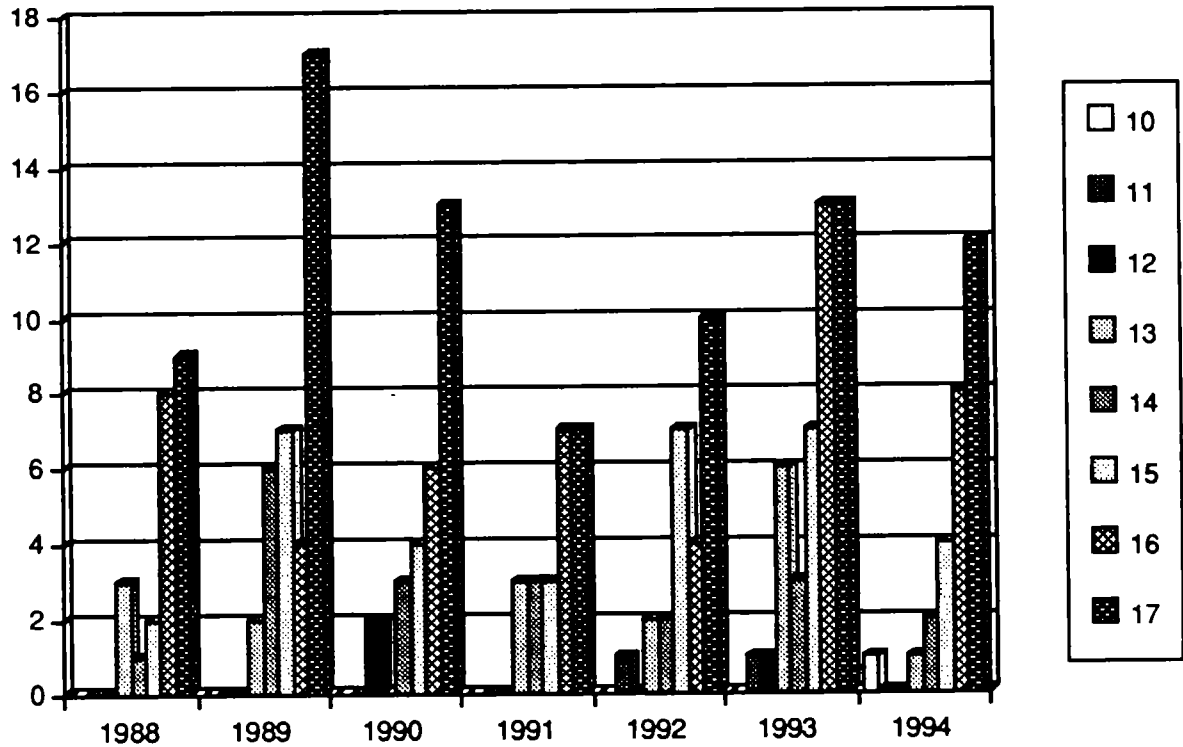
Table 21

AGE BREAKDOWN OF ADOLESCENT SUICIDES 1988 - 94

	1988	1989	1990	1991	1992	1993	1994	TOTAL
10	0	0	0	0	0	0	1	1
11	0	0	0	0	1	1	0	2
12	0	0	2	0	0	1	0	3
13	3	2	0	3	2	6	1	17
14	1	6	3	3	2	3	2	20
15	2	7	4	3	7	7	4	34
16	8	4	6	7	4	13	8	50
17	9	17	13	7	10	13	12	81
TOTAL	23	36	28	23	26	44	28	208

Figure 18

1988 -94 ICAN ADOLESCENT SUICIDES BY AGE



**CAUSE OF DEATH**

In 1994, 60.7%(17) of the adolescents committed suicide by using firearms. Firearms have been the predominant method of suicide over the past 7 years. 131 of the 208 (63%) of the youth suicides over the past seven years involved firearms. The percentage of total suicides involving firearms has ranged from 43% in 1988 to a high of 73% in 1992.

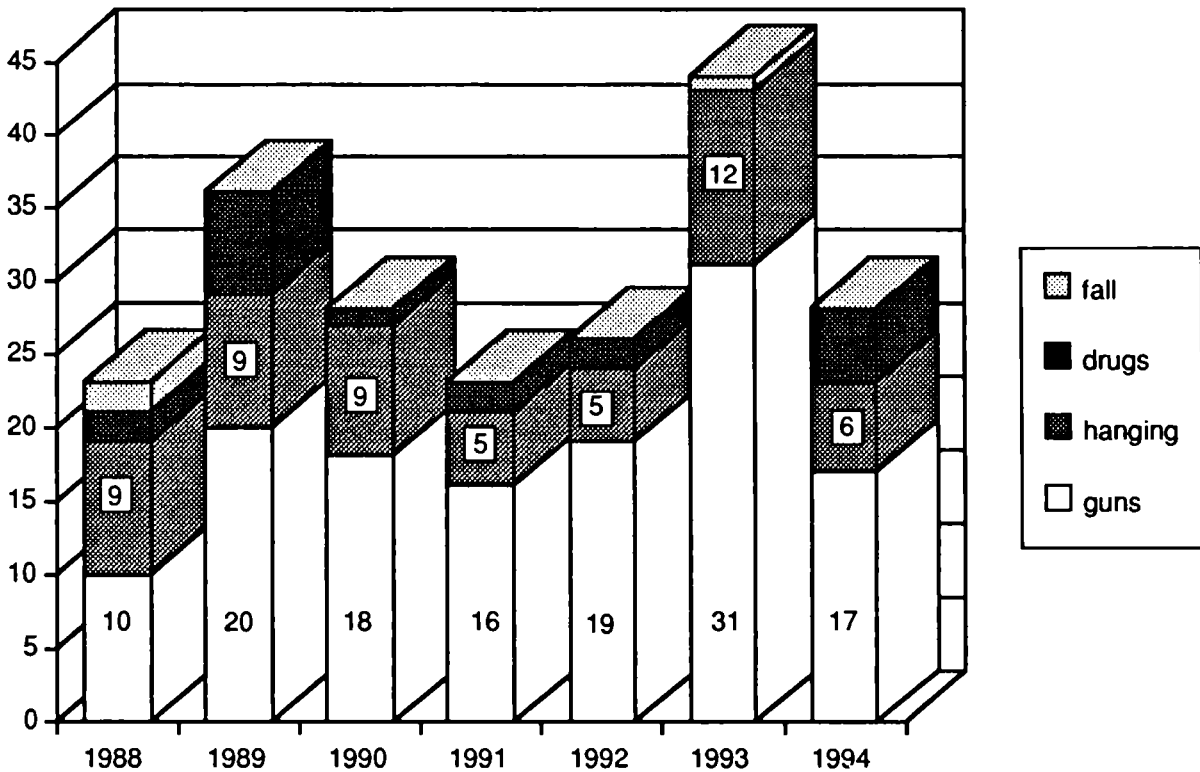
Hanging is the second most frequent cause of suicidal deaths among adolescents. Six hangings were reported for 1994, 55 over the past 7 years.

In 1994, 5 adolescents died from suicidal drug overdoses, up from the average of 2 deaths from this cause over the previous 6 years.

Figure 19 graphically displays the different methods of suicide over the past six years.

*Figure 19*

**1988 -94 ICAN ADOLESCENT SUICIDES BY CAUSE**



**TEMPORAL PATTERN**

Figure 20 displays the temporal pattern of adolescent suicide deaths from 1988 through 1994.

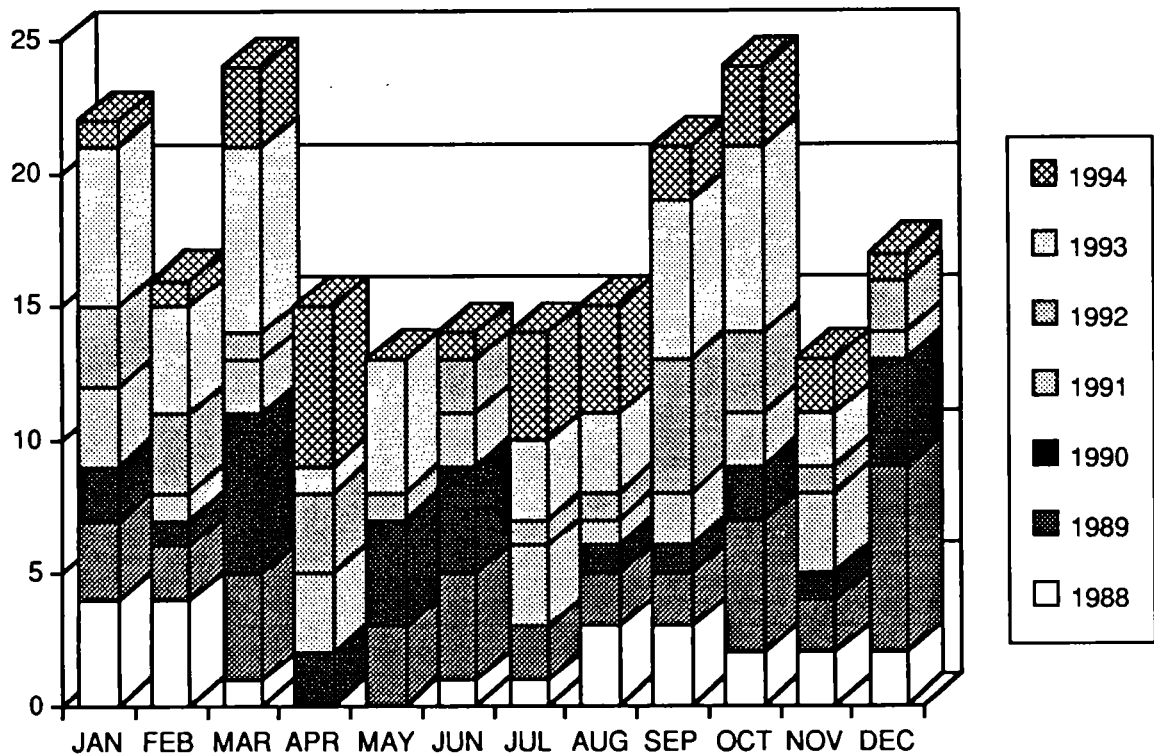
In 1994, the greatest number of adolescent suicides occurred in April, with 6 deaths occurring that month. 4 adolescent suicides occurred in July and August, 1994. There were no suicides reported for May, 1994.

Over the period 1988 - 1994, the average number of suicides per month is 17.3, with a range of 13 to 24. The months having the greatest number of suicides are March and October.

1994 had an atypical pattern of adolescent suicides when compared to the six prior years. The greatest number of deaths occurred in April, July and August, months that historically had lower than average suicide incidents.

Figure 20

**1988 -94 ICAN ADOLESCENT SUICIDES BY MONTH**



**TEMPORAL PATTERN**

Figure 20 displays the temporal pattern of adolescent suicide deaths from 1988 through 1994.

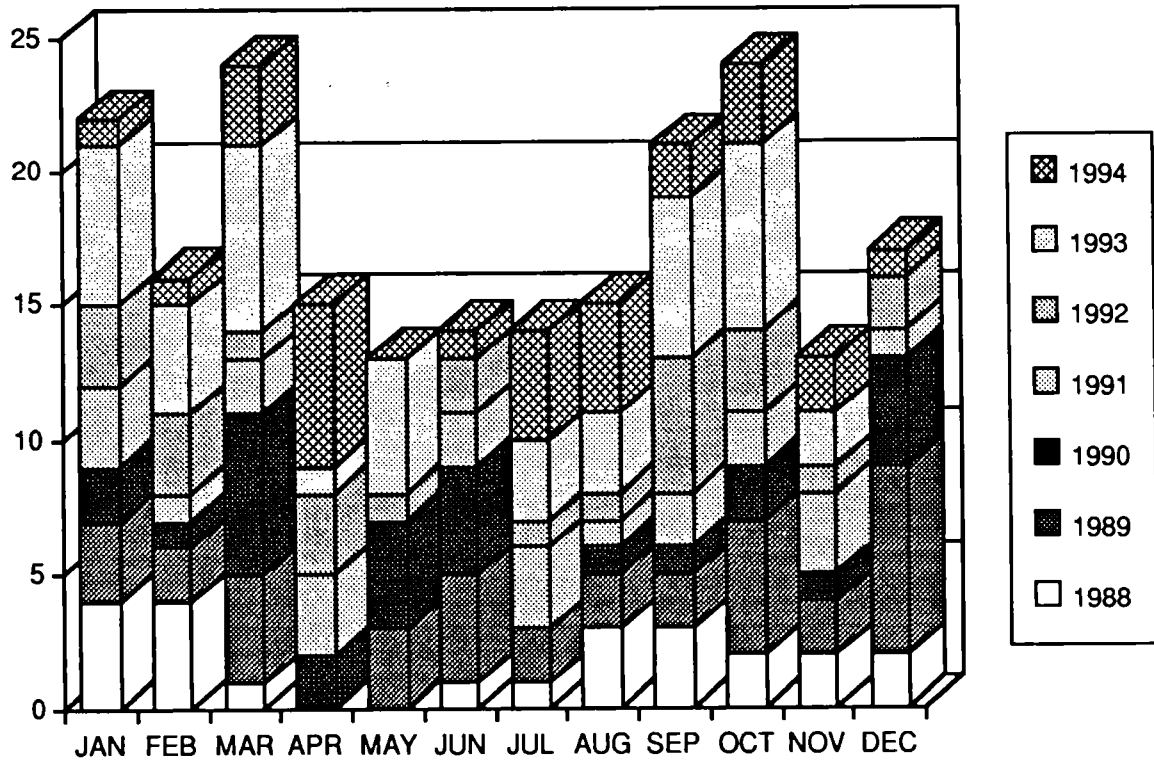
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**1988 -94 ICAN ADOLESCENT SUICIDES BY MONTH**



**CHILD PROTECTIVE SERVICES INVOLVEMENT**

In 1994, the Department of Children and Family Services had prior involvement with 18% (n = 5) of the families with suicide victims. The average time between the time DCFS was involved with the families and the death was 1.7 years and ranged from 1 year prior to the death to 3.75 years prior. The reasons for involvement included physical abuse (2 case), sexual abuse (1 case), and general neglect (1 case). The reason for involvement was not available on 1 case. Table 22 displays the reasons for prior DCFS services on cases between 1989 and 1994. There is no pattern apparent.

Over the past 6 years, the average percent of families of suicide victims with prior DCFS involvement is 20%, ranging from a low of 11% (3 of 28 cases) in 1990 to a high of 33% (12 of 36) in 1989.

None of the 1994 cases with prior DCFS involvement was open to DCFS at the time of death.

It is very rare for a family's case to be open to DCFS at the time of a suicide. In the past 6 years, only 4 of the 208 reported adolescent suicides were open to DCFS at the time of the suicide.

In 1994, one DCFS case was opened to assess siblings as the result of the suicide. Services were provided by DCFS for 1 month and the case was closed as the siblings were assessed as safe in the home.

**DEPARTMENT OF PUBLIC SOCIAL SERVICES INVOLVEMENT**

21% (n = 6) of the families of adolescent suicide victims had a history of receiving public assistance from the Department of Public Social Services. Only 1 of the families that had a history of DPSS involvement also had a history of DCFS involvement.

Over the past 6 years, the number of families known to DPSS has averaged 30%, ranging from a low of 21% in 1990 and 1994 to 1992's high of 35%.

In 1994, there were siblings known to DCFS or DPSS on 25% (n = 7) of the cases. For 64% of the cases, it was unknown if there were siblings as neither DCFS or DPSS had a record of the family.

In 1994, the number of siblings averaged 2.0 per family, averaging from 1 to 6.

*Table 22*

**REASONS FOR PRIOR DCFS SERVICES FOR ADOLESCENT SUICIDES 1989 - 94**

	1989	1990	1991	1992	1993	1994	TOTAL
Sexual abuse	1		3		3	1	8
Physical abuse	1	1	1		2	2	7
Severe neglect	3			1	1		5
General neglect	1			1	3	1	6
Emotional abuse					3		3
Info. unavaible	6	2	1	2	2	1	14
TOTAL	12	3	5	4	14	5	43

## FETAL DEATHS IN LOS ANGELES COUNTY

*Baby Girl H. and Baby Boy H. were stillborn twins. Their mother had been assaulted and thrown to the ground. She reported immediate discomfort and went to bed. Her water broke 4 hours later and she was subsequently transported by paramedics to the hospital. The mother did not report the assault during her hospitalization. She did not report it to LAPD until the following day.*

*LAPD reported that they confronted the mother about the delay in her reporting the assault. The Team considered cultural issues of the African-American community not reporting assaults to law enforcement. LAPD indicated that they had also contacted the mother's physician. Up until the assault, the pregnancy had been normal with no problems noted.*

*The Coroner had deferred the cause and manner of death pending literature review for over 2 months. There was no evidence of trauma to the fetuses or placenta at autopsy. To call the case a homicide, the Coroner needed to show a temporaneous relationship between the maternal trauma and stillbirth.*

*Complications on this case included twins being at a greater risk of spontaneous abortion, the mother failing to notify authorities of her assault for over 24 hours, and a 4 to 5 hour delay in membrane rupture following the assault. The Coroner found no literature on the relationship between assault and membrane*

*rupture but did find substantial literature on the relationship between trauma and induction of labor.*

*It was recommended that LAPD seek an obstetric consult as the Coroner did not have an obstetrician available to their Office. The Team agreed to assist LAPD in locating an obstetric referral resource.*

*The Coroner agreed to continue to defer the case until after the obstetric consult, but indicated that they would base classification of the case on the pathological condition of the fetuses and placenta. Even with obstetric consult, the Coroner called the case undetermined.*

*The DA indicated that Coroner classification of the deaths would mean the difference between charging simple assault or second degree murder with special circumstances charges against the suspect. If convicted of the latter, the suspect could receive a sentence of life without possibility of parole. There were two witnesses to the assault, a neighbor and close relative.*

*There was no DCS involvement with this family.*

*Three months after initial review, follow-up was provided by LAPD regarding obstetric consult results. Based on the consult and the Coroner ruling of undetermined manner of death, the DA rejected the filing, as there was no way to ascertain whether deaths were caused by the assault.*

**T**wenty six fetal deaths were reported to the Team by the Coroner in 1994, a 38% decrease from 1993 and the lowest number of fetal deaths reported to the Team since tracking began in 1987. Three of the deaths received comprehensive review by the Team.

For the purpose of the Coroner's records, fetal deaths are those where an unborn is over 20 weeks gestation. The number of fetal deaths reported to the Coroner, and therefore to the Team, fluctuates greatly from year to year. Over the past 8 years, the average number of fetal deaths has averaged 45.4 per year, with the highest number, 67, reported in 1987.

The total number of fetal deaths in Los Angeles County for 1992, the last year that data is available, was 1247. Very few of these cases come to the Coroner's attention. It is unclear what criteria any given physician uses to refer a fetal death to the Coroner rather than sign the fetal death certificate at the hospital. Maternal substance abuse appears to be a factor in that decision.

The Coroner is not required to report a manner of death to the State Department of Health Services on fetal death certificates. However, the Coroner does provide this information to the Team for the purposes of this analysis.

#### **MANNER AND CAUSE OF DEATH**

The most frequent manner of fetal deaths was accidental (n = 17), followed by undetermined (n = 7), and homicide (n = 2).

The most frequent cause listed for accidental fetal deaths continues to be intrauterine fetal demise from unknown cause (n = 13). Other causes of death were prematurity (n = 2), stillbirth associated with

maternal drug use (n = 1), and non-viable fetus due to death of mother (n=1). The Coroner reported that there was a history of maternal drug abuse present in 16 of 17 of the accidental fetal deaths.

The causes of the undetermined fetal deaths were similar to the accidental deaths. In 4 of the undetermined deaths, the cause was listed as intrauterine fetal demise. Other causes listed were stillbirth, perinatal demise and undetermined cause. Maternal drug abuse was noted in none of the 7 undetermined fetal deaths.

The cause of one fetal homicide was intrauterine fetal demise with a notation that the mother was kicked by another person. The other fetal homicide was caused by perinatal demise of undetermined cause with a notation of maternal neglect and other undetermined factors as the fetus had been dumped and abandoned.

#### **ETHNICITY**

Table 24 lists the manners of death for the fetal deaths broken down by ethnicity of the victims. African-American families represented 38.5% of the fetal deaths in 1994. While still comprising a significant over-representation when compared to child population figures for L.A. County, there is a decreasing trend over the past 6 years, from 63% of all Coroner fetal deaths in 1990 to 38.5% in 1994. Figure 21 shows this trend graphically.

After increasing for 4 years, the percentage of Latino fetal deaths decreased in 1994, while the percentage of White fetal deaths increased from 16.7% in 1993 to 28% in 1994.

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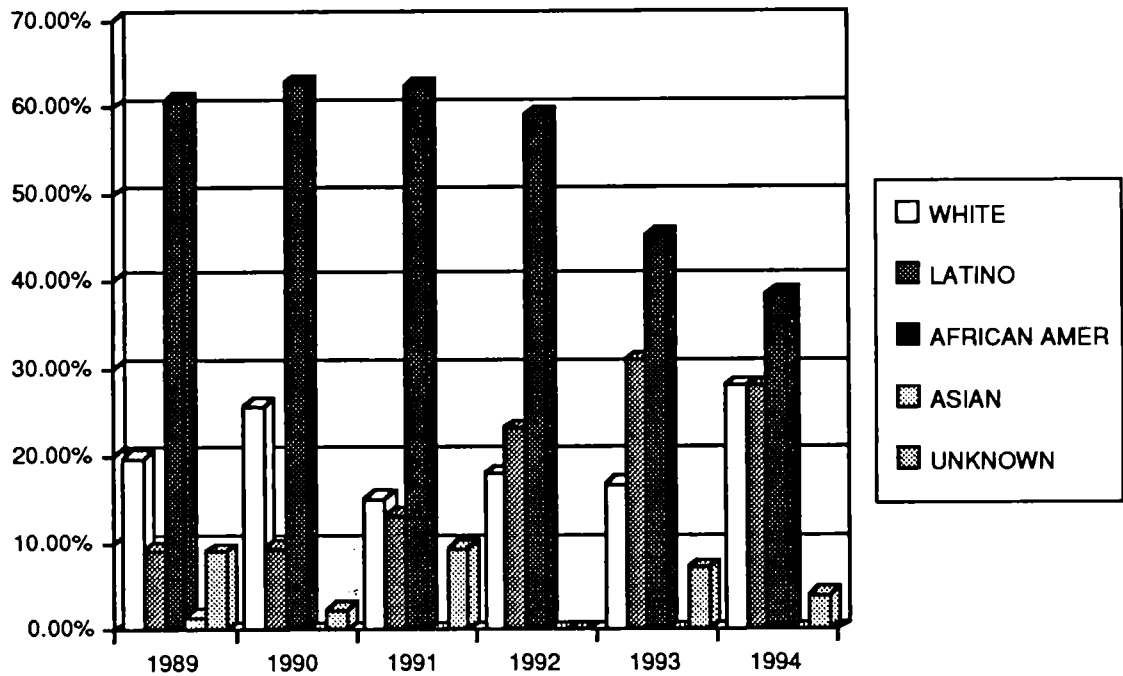
Table 24

**ICAN 1994 FETAL DEATHS BY ETHNICITY AND MANNER OF DEATH**

	AFRICAN-AMER	LATINO	WHITE	ASIAN	UNKNOWN	TOTAL
Accident	6	5	5	0	1	17
Undetermined	3	1	2	0	1	7
Homicide	1	1	0	0	0	2
<b>TOTAL</b>	<b>10</b>	<b>7</b>	<b>7</b>	<b>0</b>	<b>2</b>	<b>26</b>

Figure 21

**1988 -94 FETAL DEATH PERCENTAGES BY ETHNICITY**



**CRIMINAL JUSTICE SYSTEM INVOLVEMENT IN 1994 FETAL DEATHS**

Seven law enforcement agencies were involved in the investigations of the fetal deaths in 1994. 11 case investigations involved Los Angeles Sheriff's Department. 9 of the case investigations involved Los Angeles Police Department. Table 25 shows the law enforcement agencies involved in all fetal deaths reported to the Team for 1994. Station and Division area detail are reported for Los Angeles Sheriff and Police Departments.

Six of the fetal deaths were presented to the District Attorney's Office for consideration of filing criminal charges. Two of these were the deaths described in the opening of this section. Two other undetermined deaths were presented. One was rejected for insufficient evidence. The other involved a juvenile mother who was charged with murder.

One fetal homicide was presented to the District Attorney and was rejected due to restrictions in the murder statute. The other fetal homicide was not presented as the identity of the mother and other parties was unable to be determined.

**HEALTH SYSTEM INVOLVEMENT IN 1994 FETAL DEATHS**

Only 1 of the 26 fetal death cases reported to ICAN in 1994 had records found in a Los Angeles County Department of Health Services facility, Los Angeles County + University of Southern California Medical Center.

Place of death data provided by the Coroner indicated that 16 different hospitals were involved in the fetal deaths. 4 fetuses were abandoned and dumped.

Table 25

**LAW ENFORCEMENT AGENCY INVOLVEMENT IN 1994 FETAL DEATHS**

<b>LASD</b>	11
Antelope Valley Station	4
Century Station	2
Pico Rivera Station	2
Lakewood Station	1
Lennox Station	1
Temple City Station	1
<b>LAPD</b>	9
Child Abuse Unit	2
Detective Headquarters	2
Foothill Division	2
South Bureau	2
Devonshire Division	1
<b>Pomona PD</b>	2
<b>Bell Gardens PD</b>	1
<b>Glendale PD</b>	1
<b>Long Beach PD</b>	1
<b>South Gate PD</b>	1

When comparing place of death data reported by the Coroner, 2 records should have been found at Harbor/UCLA Medical Center, 3 records at Olive View Medical Center, 2 records at King Drew Medical Center and one additional record at LAC+USC.

ICAN CHILD DEATH REVIEW TEAM REPORT FOR 1994

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Pamphlet, "Los Angeles County Inter-Agency Council on Child Abuse and Neglect," 2 pgs.

## The Response

The Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) serves as the official County agent to coordinate development of services for the prevention, identification and treatment of child abuse and neglect.

27 County, City, State and Federal agencies are members of ICAN, along with UCLA and five private sector members appointed by the Board of Supervisors. ICAN's Policy Committee is comprised of the heads of each of the member agencies. The ICAN Operations Committee includes designated child abuse specialists from member agencies as well as community representatives, and carries out the activities of ICAN through various standing and ad hoc subcommittees.

This strong multi-level, multi-disciplinary and community network provides a framework through which ICAN is able to identify those issues critical to the well-being of children and families. The Council is then able to advise the Board on relevant issues and to develop strategies to implement programs that will improve the community's collective ability to meet the needs of abused and at-risk children with the limited resources available.

Through its relationship with the California Consortium for the Prevention of Child Abuse, the National Committee for the Prevention of Child Abuse and the United States Advisory Board on Child Abuse and Neglect, ICAN has established strong ties to state and federal agencies which effect local programs and services to children.

ICAN has received national recognition as a model for inter-agency coordination for the protection of children. All ICAN Policy and Operations Committee meetings are open to the public. Interested professionals and community volunteers are encouraged to attend and participate.

## ICAN Policy Committee Members

**Sheriff Sherman Block** - Chairperson  
**Michelle Barker-Hellpern** - Principal,  
Barker & Young Communications

**Lynn W. Bayer** - Director, Community & Senior Citizens  
Services

**Sal B. Castro** - Educator  
**DeWitt Clinton** - County Counsel  
**Rodney E. Cooper** - Director, Parks and Recreation  
**Areta Crowell, Ph.D.** - Director, Mental Health  
**G. Peter Digre** - Director, Children's Services  
**Jerome DImaggio** - Regional Administrator,  
Department of Corrections

**P. Michael Freeman** - Fire Chief, Forester and Fire Warden  
**Gil Garcetti** - District Attorney  
**Robert Gates** - Director, Health Services  
**James Hahn** - L.A. City Attorney  
**Nancy Hayes, LCSW** - UCLA Medical Center  
**Anthony Hernandez** - Director, Department of Coroner  
**Dr. Donald Ingwerson** - Superintendent, Office of Education  
**Carlos Jackson** - Executive Director, Community  
Development Commission/Housing Authority

**Michael Judge** - Public Defender  
**Edward M. Kritzman** - Executive Officer/Clerk,  
Administratively Unified Courts  
**Daniel E. Lungren** - California Attorney General  
**Nora M. Manella** - United States Attorney  
**Richard Montes** - Presiding Judge, Juvenile Court  
**Barry Nidorf** - Chief Probation Officer  
**France Nuyen** - Performing Artist  
**Linda Otto** - Producer/Director  
**Sally R. Reed** - Chief Administrative Officer  
**Sandra Rueben** - County Librarian, Public Library  
**L. Sathyavagiswaran, MD** - Chief Medical Examiner - Coroner  
**William Stewart** - Director, Internal Services  
**Eddy S. Tanaka** - Director, Public Social Services  
**Sidney A. Thompson** - Superintendent,  
L. A. Unified School District

**Sharon Watson, Ph.D.** - Executive Director, Children's  
Planning Council

**Willie Williams** - Chief, Los Angeles Police Department

### Staff:

**Deanne Tilton**, Executive Director  
**Penny Weiss**, Assistant Director  
**Mitch Mason**, Program Analyst



# Los Angeles County Inter-Agency Council on Child Abuse and Neglect

4024 North Durfee Avenue  
El Monte, California 91732  
(818) 575-4362

## The Challenge

Reports of suspected child abuse and neglect in Los Angeles County have increased by over 120% in the past ten years. Over 164,000 children were reported for abuse or neglect to Los Angeles County Department of Children's Services in 1993. The number of identified child abuse deaths has risen as well, to 46 in 1992.

Media attention, dramatic productions and special reports about child abuse have become more and more common. Public awareness of the incidence, effects and nature of child abuse has grown at the same time.

The response to child abuse encompasses far more than one discipline or profession. Children's services, law enforcement, health, mental health and schools are all involved in the assessment and provision of services to families and children at-risk of abuse and neglect. Other agencies, such as libraries, parks and recreation, and community services have a role in prevention and identification of child abuse.

The need for these different disciplines to work together to coordinate their services and resources for families and children is evident. Equally important is the participation of community groups, volunteers, media and child and family advocates.

## The Results

ICAN's commitment to cooperative interaction has resulted in the following benefits to children in Los Angeles County:

**Advocacy** - ICAN has successfully advocated for state and federal legislation to improve services to children, including development of a countywide High Risk Family and Children's Index, funding of Child Abuse Prevention and Treatment programs, and numerous other programs of benefit to children and families of Los Angeles County and throughout the state. ICAN has also advocated and been key in accessing state and federal grants to meet the needs of Los Angeles County's children.

**Child Death Review** - Arising from concerns over the handling and preventability of cases in which children have died at the hands of their caretakers, ICAN established the first Multi-agency Child Death Review Team in the nation. This project has been replicated in 45 California counties and 38 states across the nation and credited widely in national media and professional journals.

**Prenatal Substance Exposure** - In response to the dramatic increase of reports of infants affected by prenatal exposure to drugs and alcohol, ICAN developed an inter-agency collaboration of providers to improve the assessment and delivery of services to children and families as well as promote innovative prevention programs to high risk women and families.

**ICAN Associates** -- Through this private non-profit charity, ICAN has developed a successful partnership with volunteer business and community members who raise funds and public awareness for programs and issues identified by ICAN as well as organizing special events for children. Interested volunteers and others wishing further information may contact ICAN Associates at (818) 575-4343.

**Community Child Abuse Councils** - Fifteen community based child abuse councils representing different ethnic groups and geographical areas are coordinated through the Community Child Abuse Council Coordination Project. This network of over 1000 active participants throughout the county provides ICAN a forum to identify and assist in resolving issues and concerns of local communities and government agencies.

**Child Sexual Abuse Evaluation** - In recognition of the need for expertise in dealing with the trauma of child sexual abuse, ICAN has advocated for multi-disciplinary centers which bring together medical, social services and law enforcement professionals who are specially trained and sensitive to the issues and needs of these difficult cases.

**Child Abduction** - 90% of child abductions involve parents in custody disputes, using the child as a pawn in their anger. Frequently, allegations of child abuse arise as a reason for abducting these children. The need for specialized assessment and therapeutic intervention, as well as appropriate law enforcement involvement has resulted in ICAN's development of its Reunification of Missing Children Project.

**Information Sharing** - The ICAN Office has many resource materials available on child abuse prevention, incidence, and treatment, including an extensive video library. Contact the ICAN Office at (818) 575-4362 as to the availability of these materials.



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# ICAN ASSOCIATES IN TOUCH

QUARTERLY NEWSLETTER • FALL 1996 • VOLUME 6 • ISSUE 2

Private Fund-Raising Associates of the Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN)  
4024 North Durfee Avenue, El Monte, California 91732. Telephone 818-455-4587

## IN MEMORY OF ROXIE ROKER

Roxie Roker, a founding Board member of ICAN Associates, dedicated herself to bringing joy into the lives of abused and neglected children and laughter into the homes of millions of families. The children of Los Angeles County and throughout the world have lost a very special friend.

Roxie was known for her groundbreaking role as "Helen Willis" on "The Jeffersons". A graduate of Howard University, she studied at the Shakespeare Institute in Stratford-on-Avon, England. Her work was recognized with many awards, including the Obie and the Tony. In 1986, Roxie was honored by her Alma Mater with an alumni award for Distinguished Post Graduate Achievement in the Performing Arts. In 1983, she was honored by the Southern California Chapter of the Howard University Alumni Association as Alumna of the Year. She received both Los Angeles City and Los Angeles County citations for her Outstanding Contributions to the Community.



In 1984, Roxie received the ICAN "Woman of the Year" award. She was one of the most active members of ICAN Associates, never missing an opportunity to help ICAN build resources for children or to visit the children in McLaren Children's Center or in community treatment programs. She was a beautiful, deeply compassionate and unselfish woman. She never lost track of her friends and always put the needs of others before her own.

Roxie is survived by her father, Albert Roker, her son, musician Lenny Kravitz, granddaughter Zoe and her aunt, Mable Bosfield.

ICAN Associates has established a Roxie Roker Memorial Fund to assist families and abused children in the community of Watts.

Barbara Avery will serve as ICAN Associates Chairperson of this project in honor of Roxie. For information about this fund, please contact the ICAN Associates office.

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Private Fund-Raising Associates of the Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN)  
4024 North Durfee Avenue, El Monte, California 91732 Telephone 818-455-4587

## President's Address

by Joel Henrie

The Board of Directors of ICAN Associates remains committed to helping prevent the needless abuse and neglect of children.

We are deeply concerned that over 165,000 children were reported for suspected abuse and neglect in Los Angeles County alone last year. Three million reports of child abuse and neglect were made nationally. Most tragically, at least five children a day die at the hands of their parents or caretakers.

Our hearts and minds are devastated by these cruel facts. However, we are inspired to redouble our efforts to prevent children's pain and suffering. We are also proud to be part of ICAN's state-of-the-art effort to address the problems that cause and result from child abuse, and to influence similar efforts across the country. We call upon our friends, associates and colleagues to join in these critically important endeavors.

Allow me to update you on some of our current activities and plans for the future.

*continues on page 5*



Joel Henrie

## Art Works For Children Fundraiser A Unique Evening Of Culture, Elegance And Success

ICAN Associates Board members **Marie Christopher and Joan Simon Menkes**, backed by an impressive group of volunteers, chaired an inspiring ICAN Associates fundraiser at the Menkes home in Beverly Hills. The "Art Works for Children" event featured elegant and cleverly decorated boxes created by some of California's foremost artists. As Vice-Chair of the Beverly Hills Art Commission, Joan knew just how to create an evening that would enchant the attendees, and inspire bids for the artwork resulting in a presentation of \$37,000 to the Center for the Vulnerable Child. **Dr. Astrid Heger**, Director of the Center, gratefully accepted the donation. Special guests included **Secretary of**

**State Warren Christopher**, who was joined by his wife **Marie** and daughter **Kristen** for the entire beautiful evening.



**Marie Christopher, Secretary of State Warren Christopher, Joan Simon Menkes and Dr. John Menkes** at "Art Works for Children" benefit.

## U.S. Advisory Board Releases Comprehensive Report

*On April 26, 1995, the U.S. Advisory Board on Child Abuse and Neglect released the Board's fifth report entitled "A Nation's Shame: Fatal Child Abuse and Neglect in the United States," at a national press conference in Washington D.C. Following are excerpts from the comments of Advisory Board Chairperson, Deanne Tilton Durfee at that press conference.*

Let me start by stating the obvious — children are not supposed to die. It is unnatural. It is painful for any of us to accept. When disease, accidents or disaster take the lives of children, our

*continues on page 8*



**First Lady Hillary Rodham Clinton and Deanne Tilton Durfee** in Washington D.C. following release of the U.S. Advisory Board Report "A Nation's Shame: Fatal Child Abuse and Neglect in the United States."



# INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT

## County of Los Angeles

### COUNCIL MEMBERS

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Sheriff

LYNN W. BAYER  
Director, Community and Senior  
Services

LEVAN BELL  
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Department of Corrections

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GIL GARCETTI  
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FRANCE NUYEN  
Performing Artist

LINDA OTTO  
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Superintendent, L. A. Unified School District

SHARON WATSON, PH.D.  
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Chief, Los Angeles Police Department

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PENNY WEISS, Assistant Director

MITCHELL MASON, Program Analyst

# ICAN

# SUMMARY INFORMATION

# 1996



## **INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT (ICAN)**

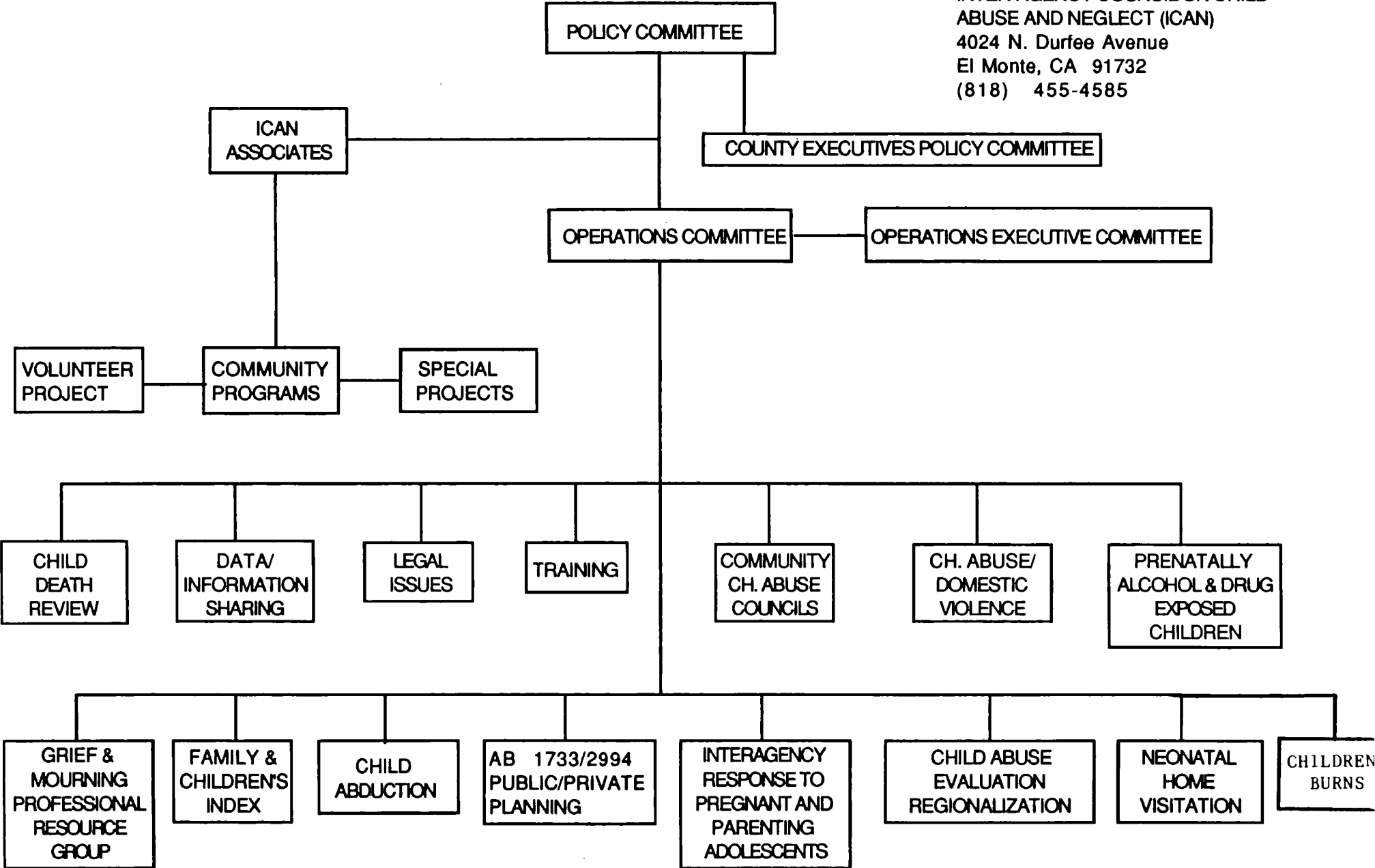
The Inter-Agency Council on Child Abuse and Neglect (ICAN) was established in 1977 by the Los Angeles County Board of Supervisors. ICAN serves as the official County agent to coordinate development of services for the prevention, identification and treatment of child abuse and neglect.

27 County, City, State and Federal agency heads are members of the ICAN Policy Committee, along with UCLA and five private sector members appointed by the Board of Supervisors. ICAN's Policy Committee is comprised of the heads of each of the member agencies. The ICAN Operations Committee, which includes designated child abuse specialists from each member agency, carries out the activities of ICAN through its work as a committee and through various standing and ad hoc subcommittees. 18 community based inter-disciplinary child abuse councils interface with ICAN and provide valuable information to ICAN regarding many child abuse related issues. ICAN Associates is a private non-profit corporation of volunteer business and community members who raise funds and public awareness for programs and issues identified by ICAN.

This strong multi-level, multi-disciplinary and community network provides a framework through which ICAN is able to identify those issues critical to the well-being of children and families. The council is then able to advise the Board on relevant issues and to develop strategies to implement programs that will improve the community's collective ability to meet the needs of abused and at-risk children with the limited resources available.

ICAN has received national recognition as a model for inter-agency coordination for the protection of children. All ICAN Policy and Operations Committee meetings are open to the public. All interested professionals and community volunteers are encouraged to attend and participate.

INTER-AGENCY COUNCIL ON CHILD  
ABUSE AND NEGLECT (ICAN)  
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**POLICY COMMITTEE**

Twenty-seven Department heads, UCLA, five Board appointees. Forms policy and votes on major issues. (Meets twice annually)

**COUNTY EXECUTIVES POLICY COMMITTEE**

Nine County Department heads. Forum to consider issues of mutual concern. (Meets as needed)

**OPERATIONS COMMITTEE**

Member agency and community council representatives in a working body. (Meets Monthly)

**OPERATIONS EXECUTIVE COMMITTEE**

Leadership for Operations and liaison to Policy Committee. (Monthly)

**ICAN ASSOCIATES**

Private incorporated fundraising arm of ICAN. (Monthly)

**COMMUNITY PROGRAMS**

Eight multiservice community-based programs meeting ICAN standards. (As needed)

**SPECIAL PROJECTS**

Special projects sponsored by the ICAN Associates. (As needed)

**VOLUNTEER PROJECT**

Recruit/mobilize volunteers for projects. (Monthly)

**CHILD DEATH REVIEW TEAM**

Multiagency review for better case management and for system review. (Monthly)

**DATA/INFORMATION SHARING**

Intra and inter agency system of information sharing and accountability. (Monthly)

**LEGAL ISSUES**

Analyzes relevant legal issues and legislation. (Monthly)

**TRAINING**

Provides and facilitates intra and inter agency training. (As needed)

**CHILD ABUSE COUNCILS**

Interface of membership of 18 community child abuse councils with ICAN. Councils are interdisciplinary with open membership and organized geographically, culturally, and ethnically. (Monthly)

### **CHILD ABUSE/DOMESTIC VIOLENCE**

Examine relationship between child abuse and domestic violence; develop interdisciplinary protocols and training for professionals. (Monthly)

### **PRENATALLY ALCOHOL/DRUG EXPOSED CHILDREN**

Improve the system rendering services to drug/alcohol exposed children and their families. (Monthly)

### **GRIEF AND MOURNING PROFESSIONAL RESOURCE GROUP**

A counseling peer group which serves as a resource pool of experts in grief and loss therapy to those providing mental health interventions to surviving family members of fatal family violence. (Monthly)

### **FAMILY AND CHILDREN'S INDEX**

Developing an interagency database which will allow agencies access to whether other agencies had relevant previous contact with a child or family in order to form multidisciplinary personnel teams. (Monthly)

### **CHILD ABDUCTION**

Public/private partnership to respond to needs of children who have experienced abduction. (Monthly)

### **AB 1733/AB 2994 PLANNING**

Conducts needs assessments for child abuse services; participates in RFP process and develops recommendations for funding for private agencies. (As needed)

### **INTERAGENCY RESPONSE TO PREGNANT AND PARENTING ADOLESCENTS**

Focuses on review of ICAN agency policies, guidelines and protocols that relate to pregnant and parenting adolescents and the development of strategies which provide for more effective interventions with this high risk population. (Monthly)

### **CHILD ABUSE EVALUATION REGIONALIZATION**

Coordinates efforts to facilitate and expand availability of quality medical exams for child abuse victims throughout the County. (As needed)

### **NEONATAL HOME VISITATION**

Developing recommendations on how neonatal home visitation, which has been shown to be an effective child abuse prevention strategy, can be systematically implemented throughout Los Angeles County. (As needed)

### **CHILDREN'S BURNS**

This committee reviews issues surrounding children's burn injuries that result from parental abuse or neglect. Meets at the Grossman Burn Center. (Monthly)