Ventura County

Child Death Review Team

2009 and 2010 Report

Published September 2011

Table of Contents

Mission

The mission of the Ventura County Child Death Review Team (CDRT) is to reduce child deaths associated with child abuse, neglect, and other preventable causes.

Background

California enacted legislation in 1988 which allows the development of interagency child death review teams. These teams are intended to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication involved in the investigation of such cases. Legislation enacted in 1997 requires the State Department of Social Services to collect data related to the investigations conducted in child deaths. This data, provided by child death review teams and child protective agencies, is maintained in order to identify deaths occurring in high risk family situations and aid in future identification of children at risk as a preventative measure. State law mandates each child death review team shall make available to the public the findings and recommendations, including aggregate statistical data on the incidences and causes of child deaths (SB 1668 (e) (1)). Due to the sensitivity of the material discussed, confidentiality is maintained pursuant to California Penal Code Section 11167.5

Initially, the Ventura County Child Death Review Team (CDRT) targeted their review on Sudden Infant Death Syndrome (SIDS) cases that represented possible missed child abuse as part of the Fatal Child Abuse and Neglect Surveillance (FCANS) Program which was in response to the mandate to establish and maintain a fatal child maltreatment (CM) tracking system (P.C.11174.34). The current Ventura County Child Death Review Team (CDRT) began meeting in 2009 and has expanded the focus of their activities to review and evaluate all unexpected deaths of children, ages birth through 17 years old.

The unexplained death of a child represents a sentinel event in our community that demands action on behalf of children to prevent future tragedies. Multi-disciplinary case analysis of the causes and circumstances surrounding these deaths is utilized to improve cooperation and communication among participating agencies and enhance institutional ability to protect children at risk of abuse or neglect. We also seek to promote community education and awareness of identified intervention and prevention activities that will save children's lives.

The team is comprised of designated representatives from the Ventura County Health Care Agency, including the Department of Public Health, Behavioral Health, the Ventura County Medical Center and Emergency Medical Services, the Ventura County Human Services Agency- Department of Children and Family Services,

County of Ventura District Attorney, the Child Abuse Prevention Council Advisory Board, Los Robles Medical Center, and The Partnership for Safe Families & Communities of Ventura County. Additional members on the team include representatives from the Ventura County Office of Education, Oxnard Police Department, California Highway Patrol, Community Memorial Hospital and the Adolescent Family Life Program. Selected participants are invited to attend if additional information is needed.

Intervention recommendations are outlined in this report and made available to the Ventura County Board of Supervisors, California State Child Death Review Council, as well as posted on the Ventura County Human Services Agency and the Ventura County Health Care Agency websites.

Case Intake

The Ventura County CDRT reviews and evaluates the unexpected deaths of children ages birth through 17 years reported via the Department of Public Health Office of Vital Records. Case review criteria includes all SIDS cases, all deaths by injury (accidental and intentional), all deaths that are associated with drug and alcohol use, and any other death with unexplained or unexpected circumstances. The official manner of death is taken from the death certificate or Medical Examiner/Coroner's report and utilizes the following categorical definitions:

1. **Accident**-unintentional injury death.
2. **Homicide**-intentional injury death of another.
3. **Suicide**-intentional injury death of self.
4. **Natural**- death from disease other than injury. This category includes Sudden Infant Death Syndrome (SIDS), even though no definitive cause of death had been determined.
5. **Undetermined-**death without an identifiable manner or cause. This category reflects situations where the Medical Examiner or Coroner is not able to assign a final manner and in some cases cause of death.

A list of cases is sent in advance to team members to allow time to search individual departmental case files for additional information on the child and family that may be pertinent to the CDRT review. Team discussions result in consensus that determines if a death was preventable, and what services, education, or community action could have affected the outcome. This information is entered into the National Child Death Review Database. After review, cases are closed, kept open for further review or referred to other services as needed.

Acknowledgements

The Ventura County Child Death Review Team (CDRT) is made possible by the members themselves and the agencies that commit their time to this endeavor. The CDRT pursues the answers to questions about preventable child deaths. Sincere appreciation and gratitude goes to the members who participated in the 2009 and 2010 reviews.

Judy Webber, Chair	Department of Children and Family Services- Deputy Director
Paul Russell, M.D., Co-Chair	Department of Public Health- Deputy Health Officer
Barbara Marquez -O'Neill	The Partnership for Safe Families & Communities of Ventura County
Diane Bock	Department of Public -Health Fetal Infant Mortality Review and SIDS Program
Lauri Plunkett	Department of Public Health- Vital Records Manager
Diane Emerick	Department of Public Health- Rx for Kids
Monique Ciccone-Llanos	Dept of Public Health- Childhood Injury Prevention Program
Tony Wold	Senior Deputy District Attorney
Diana Grill	Department of Public Health- Epidemiology
Steve Reid	California Highway Patrol
Tracy Van Natta	Community Memorial Hospital
Elaine Martinez Curry	Child Abuse Prevention Council Advisory Board
Graal Diaz	Ventura County Medical Center- Trauma Services
Erica Rosa	Los Robles Hospital- Trauma Services
Alice Sweet	Dept. of Public Health -Adolescent Family Life Program
Elena Gutierrez	Ventura County Medical Center- Trauma Services
Steve Carroll	Ventura County EMS Agency
Erica Escalante	Oxnard Police Department
Chris Rosa	Ventura County EMS Agency
Carol Hughes	Behavioral Health Department- Children's Mental Health
Todd Flosi, M.D.	Ventura County Medical Center- Pediatrician
Karlyn Bock	Ventura County Office of Education

Executive Summary

Forty-six cases are included in this report for deaths reviewed from January 2009 through December 2010. Data reflected in this report is derived from information obtained from the Department of Public Health Vital Records Office as well as supplemental information provided by CDRT member agencies. All deaths reviewed by the CDRT met the criteria for review. In order to protect the confidentiality of children and families, only aggregate data is presented in this report. Of the forty-six cases reviewed, 11 (24%) were under the age of one year. The remaining 35 (76%) were between the ages of 1 and 17 years.

Accident Deaths accounted for 50% (23) of child deaths and included drowning (5), motor vehicle accidents (10), poisoning/overdose or acute intoxication (3), falls or crush incidents (3) and asphyxia (2). Natural Deaths (6) accounted for 13% of total deaths. Included in the causes are pneumonia (2), cardiovascular (1), SIDS (2), and other medical condition/cardiac arrhythmia (1). Homicides (9) accounted for 19.6% of total deaths. Included in the causes are weapon (6), drowning (1) and other injury (2). Suicides (4) accounted for 8.7% of the total deaths and included asphyxiation (2) and poisoning/overdose/acute intoxication (2) as the causes. A total of four cases were classified as Undetermined manner of death by the Ventura County Medical Examiner and/or Los Angeles County Coroner, with two of those having undetermined/unknown causes.

Ventura County Child Death Review
2009/2010 Findings and Recommendations

In reviewing the 2009/2010 data, the Child Death Review Team has determined the need for a CDRT Community Action Taskforce (CAT) that will be responsible for ensuring the development and follow through of the recommended actions listed below. The Community Action Taskforce will develop a work plan which will focus on coordinating the recommendation activities with community agencies and programs. In addition, CAT will report updates quarterly to the general membership of the Child Death Review Team.

1. Accident Deaths

A. Poisonings, Overdose, Acute Intoxication Deaths:

In 2009/2010 three deaths were attributed to poisoning, overdose or acute intoxication. One death was a result of heroin being administered through an eye dropper snorted directly into the nose.

CDRT Recommendations:

- **Disseminate child death data to primary care physicians and encourage education of parents and adolescents regarding the growing danger of alcohol and prescription drug use.**
- **Actively partner with Ventura County Behavioral Health Department Straight Up Program to share this data with parents and teens.**

B. Drowning Deaths:

Drowning rates have fallen steadily over the past two decades, but it is still the second-leading cause of accidental death among children aged 1-19 in the United States. It is an everyday risk that families need to consider, but with the necessary precautions, that risk can be minimized.

In 2009/2010 a total of five deaths were attributed to drowning**.** All accidental drowning deaths involved lack of supervision and/or barriers to the pool, hot tub or lake. It continues to be of the highest importance to raise community and personal awareness about the dangers surrounding water, especially with young children.

CDRT Recommendations:

- **Collaborate with community agencies serving children and families to distribute water safety information.**
- **Share child death data with county primary care providers to enhance family education regarding safety.**

C. Fall or Crush Deaths:

In 2009/2010 three deaths were attributed to falling or being crushed, with one death directly caused by an unsecured television set sitting atop a dresser. Two other children have died in 2011 from furniture tipover accidents.

A child dies every two weeks in the U.S. when a TV, furniture, or appliance falls on him or her. Data from the U.S. Consumer Product Safety Commission shows that children between the ages of one and five were found to be at the highest risk of being involved in a fatal furniture tip over accident; over 90% of the tip over related deaths involved children five years old or younger.

More than 16,000 children five years old and younger were treated in U.S. emergency rooms due to injuries associated with TVs, furniture, and appliance tip over's in 2006.

Many Ventura County parents are unaware of the risk unsecured televisions, dressers and large furniture pose. The CDRT feel strongly that prevention activities regarding this issue are timely.

CDRT Recommendations:

- **Disseminate a safety brochure to consumer product outlets, primary care physician's offices, day care providers, and other community organizations serving children and families.**
- **Investigate legislation pertaining to safety labels on T.V.'s, dressers and large furniture items.**

D. Motor Vehicle Deaths:

In 2009/2010 ten deaths were attributed to motor vehicle accidents. An equal number of child deaths occurred as a passenger of a vehicle and as a pedestrian. According to the Child Trends Data Bank, more than one-third of all teen deaths in the U.S. are the result of motor vehicle crashes. In 2008, about 3,500 youth ages 15 to19 were killed, and approximately 350,000 were treated in emergency departments for injuries suffered in motor vehicle crashes.

The Center for Disease control reports that during 2008, 968 children ages 14 years and younger died as occupants in motor vehicle crashes, and approximately 168,000 were injured. Many of these deaths can be prevented by placing children in age and size appropriate car seats and booster seats.

As pedestrians, children are at even greater risk of injury or death from traffic crashes due to their small size, inability to judge distances and speeds, and lack of experience with traffic rules.

CDRT Recommendations:

- **Disseminate and expand pedestrian safety education to local schools.**
- **Disseminate motor vehicle child death data to Health Care Professionals and encourage their staff to obtain certification as a Child Passenger Safety Technician.**

2. Homicide Deaths

In 2009/2010 there were a total of nine homicide deaths, two of which involved child maltreatment and resulted in prosecution for child abuse. Both deaths were caused by blunt force trauma to the head of children under the age of one year and were officially determined to be homicides. One additional death evaluated by the CDRT was initially determined to be an accident, however, this death is currently under review by law enforcement.

3. Suicide Deaths

There were four suicides in Ventura County in 2009/2010, ranging in ages from 13 to 17 years old. Two had a reported history of depression. The other two had not been identified as being depressed. Among young people ages 15-24 in the United States, suicide is the 3rd leading cause of death, behind accidents and homicide. The number has tripled in recent years. Every day in the U.S. approximately 14 young people between the ages of 15-24 die at their own hands. That's one suicide every 1 hour and 40 minutes.

CDRT Recommendations:

- **Disseminate Suicide Risk Factor information sheet to Public Agencies and Community Based Organizations.**

Suicide Risk Factors

TEENS WHO ARE AT HIGHER RISK

- Teenagers with little self-esteem.
- Teenagers who have attempted suicide previously, especially if problems and other recurring concerns were not completely resolved.
- Teenagers in trouble with the law.
- Teenagers who are suffering from depression.
- Teenagers who have been abused, molested, or neglected.
- Teenagers who abuse drugs and/or alcohol.
- Teenagers who are struggling with sexual orientation (LGBTQQ).
- Teenagers who are in dysfunctional families.
- Teenagers who fail in school-potential dropouts.

WARNING SIGNS OF SUICIDE

- A recent suicide of a friend or family member.
- Trouble coping with recent losses such as death, divorce, moving, break-ups, etc.
- Experiencing a traumatic event.
- Making final arrangements, such as writing a will or eulogy, or taking care of details (i.e. closing a bank account).
- Gathering of lethal weapons (purchasing weapons, collecting pills, etc.).
- Giving away prized possessions such as clothes, CD's, sports equipment, treasured jewelry, etc.
- Preoccupation with death, such as death and/or 'dark' themes in writing, art, music lyrics, etc. Note that today's music has more of this and is not necessarily related to suicidal feelings.
- Sudden changes in personality or attitude, appearance, chemical use, or school behavior.

VERBAL SIGNS OF SUICIDE

- "I can't go on anymore."
- "I wish I was never born."
- "I wish I were dead."
- "I won't need this anymore."
- "My parents won't have to worry about me anymore."
- "Everyone would be better off if I was dead."
- "Life sucks. Nobody cares if I live or die."

4. Natural Deaths

In 2009/2010 there were six child deaths attributed to natural causes, or death from disease other than injury. This category includes Sudden Infant Death Syndrome (SIDS), even though no definitive natural cause of death had been determined. Ventura County had two infants die from SIDS in 2009-2010.

One of the deaths attributed to natural causes was a 17 year old with an exercise-induced cardiac arrhythmia who had continued running after a recommendation to restrict physical activity had been given by a physician.

There are thousands of high school students in Ventura County, many who participate in extracurricular athletics. Screening athletes for disorders capable of provoking sudden death is a challenge because of the low prevalence of disease, and the cost and limitations of available screening tests. Current recommendations for cardiovascular screening call for a careful history and physical examination performed by a knowledgeable health care provider. Specialized testing is recommended only in cases that warrant further evaluation. However, many of the teenage athletes receiving a brief pre-participation physical exam do not receive a comprehensive assessment by a primary care physician. Given the other very real risks that teenagers can potentially engage in outlined in this report, it is important that the preventive role of the primary care physician not be undermined by the pre-participation physical exam.

CDRT Recommendation:

- **Disseminate information to School Districts and High School Athletic Directors regarding the importance of completing a comprehensive assessment for adolescents.**

5. Undetermined Deaths

In 2009/2010 four deaths were categorized as undetermined. Two infant deaths listed as undetermined had their autopsies performed by the Los Angeles County Coroner. There has been variation among California counties and across the U.S. regarding the official cause of unexpected infant deaths. Medical Examiners and Coroners have been moving away from classifying deaths as Sudden Infant Death Syndrome (SIDS) and calling more deaths accidental suffocation or unknown cause. This suggests that diagnostic and reporting practices have changed. Inconsistent practices in investigation and cause-of-death determination were hampering the ability to monitor national trends, ascertain risk factors, and design and evaluate programs to prevent these deaths. In response to this variation, the Center for Disease Control (CDC) embarked on its

Sudden Unexpected Infant Death (SUID) Initiative. The Center for Disease Control and its partners began activities aimed at improving the investigation and reporting practices of Sudden Infant Death Syndrome and other Sudden Unexplained Infant Deaths.

Each year in the United States, more than 4,500 infants die suddenly of no immediately obvious cause. Half of the Sudden Unexpected Infant Deaths are due to Sudden Infant Death Syndrome, the leading cause of SUID and of all deaths among infants ages 1–12 months.

For a Medical Examiner or Coroner to determine the cause of death, a thorough case investigation including examination of the death scene and a review of the infant's clinical history must be conducted. A complete autopsy including a post-mortem skeletal survey to rule out occult skeletal trauma in sudden unexplained infant deaths, needs to be performed. Even when a thorough investigation is conducted, it may be difficult to separate Sudden Infant Death Syndrome from other types of Sudden Unexpected Infant Deaths, especially accidental suffocation in bed.

After a thorough case investigation, many of these Sudden Unexpected Infant Deaths may be explained. Poisoning, metabolic disorders, hyper or hypothermia, neglect, homicide, and suffocation are all explainable causes of Sudden Unexplained Infant Deaths.

The goals of the CDC SUID Initiative are to:

1. Standardize and improve data collected at death scene.
2. Promote consistent classification and reporting of cause of death.
3. Improve national reporting of SUID.
4. Reduce SUID by using improved data to identify those at risk.

CDRT Recommendation:

- **Engage in activities supporting the CDC SUID Initiative.**

Ventura County Prevention Activities

It is important to note some of the current prevention and intervention programs throughout Ventura County that specifically address issues of motor vehicle safety, child injury prevention, water safety and Sudden Infant Death Syndrome.

In the area of motor vehicle safety the Ventura County Medical Center in coordination with the California Highway Patrol, facilitates the teen driving programs Start Smart and Every 15 Minutes. The Start Smart program is designed to help new drivers and their parents or guardians to understand that driving comes with responsibilities. The Every 15 Minutes program is a two-day program focusing on high school juniors and seniors, which challenges them to think about drinking, driving, personal safety, the responsibility of making mature decisions and the impact their decisions have on family, friends, and many others.

Ventura County Public Health facilitates the Childhood Injury Prevention Program which consists of a Child Passenger Safety Program, the Safe Kids Ventura County Coalition, and community education components on childhood injury prevention. This program conducts monthly child passenger safety classes and distributes car seats to low income parents. In addition, three permanent car seat inspection stations have been established in collaboration with Ventura County Fire Department.
http://www.vchca.org/public-health/mcah/childhood-injury-prevention.aspx

The Sudden Infant Death Syndrome (SIDS) Program, coordinated by Ventura County Public Health provides SIDs prevention services which include education, literature and resources for child caregivers, health educators, hospital maternity departments, health providers, and any other interested community groups involved with infants. **http://www.vchca.org/public-health**

Straight Up is a Ventura County youth development project for ages 12-25 that promotes social change regarding underage and binge drinking and impaired driving using improvisation and interactive techniques to engage discussion, explore issues, and develop personal and community solutions to these issues. Straight Up is made possible through funding from Ventura County Health Care Agency Behavioral Health Department, Alcohol and Drug Programs. **http://straightupvc.org**

The Child Abuse Prevention Program (CAPP) is a result of an interagency collaborative effort between Human Services Agency (HSA), Juvenile Dependency (JD) and Public Health (PH). This program is unique because Public Health Nurses (PHNs) are integrated into the Domestic Violence, Drug and Juvenile courts.

The goal of the program is to keep children out of the child welfare system and to reduce the rate of children re-entering the juvenile justice system. This is accomplished through individual and community assessments, screenings and preventive education about the causes, prevention and remediation of health related needs, family violence, and child abuse and neglect prevention. Community outreach activities include providing violence prevention classes to teenagers at our local schools and providing parent-child education to parents in recovery programs. **http://www.vchca.org/public-health/mcah**

The Partnership for Safe Families & Communities of Ventura County Child Abuse and Neglect Education Committee disseminates prevention information on safe parenting practices and preventative education on child abuse and neglect along with family and community violence.

http://www.partnershipforsafefamilies.org

Ventura County Child Death Review

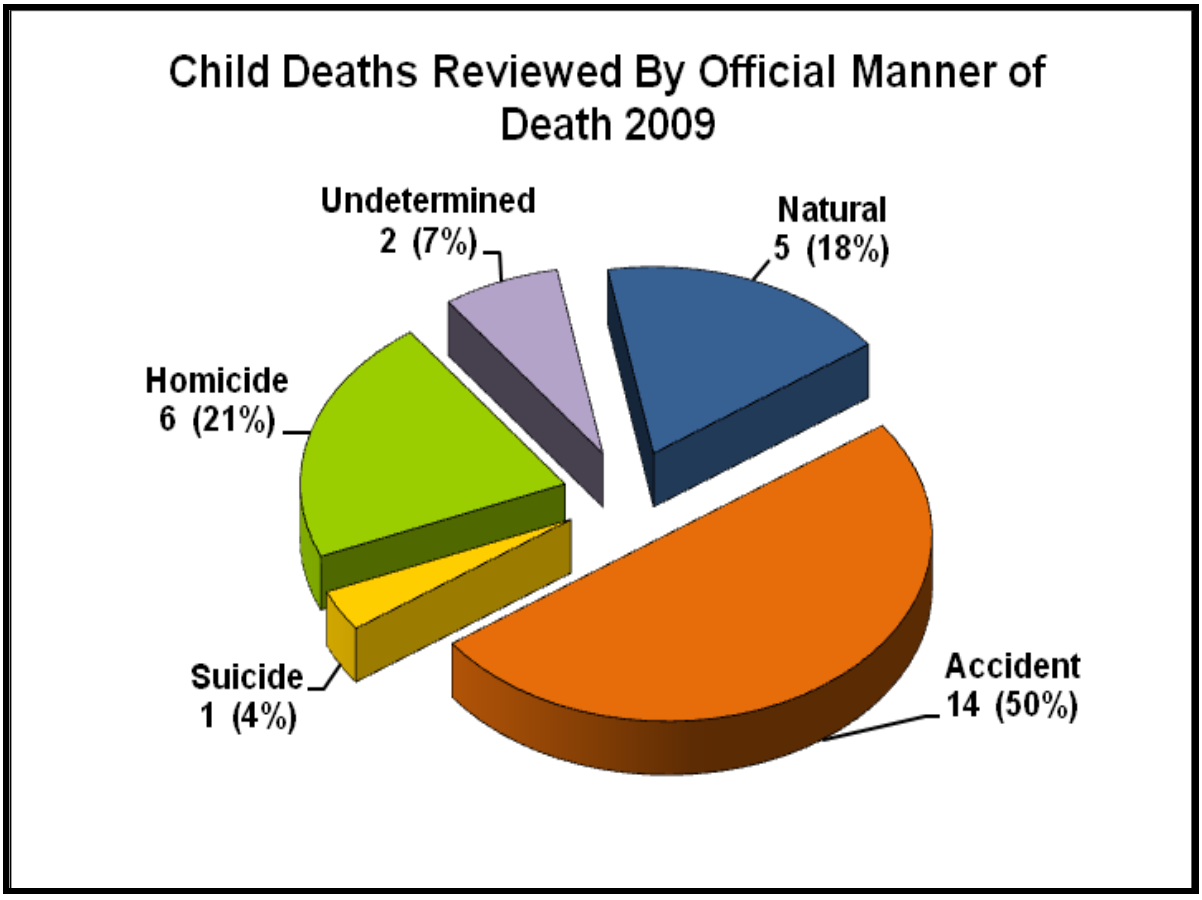
2009 & 2010 Data

Ventura County Child Death Review

2009

Official Manner of Death

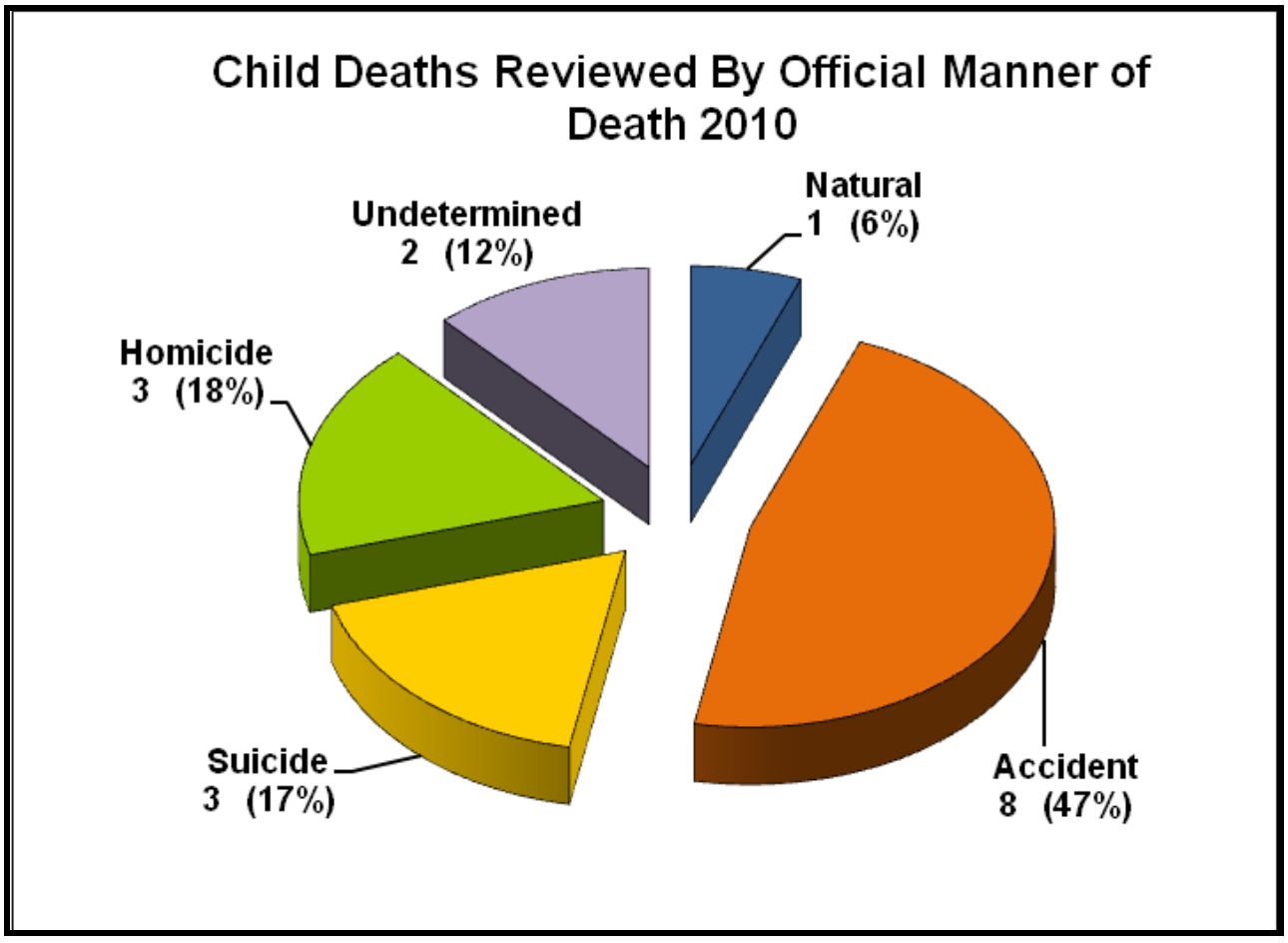
Official Manner of Death	Number	Percentage
Natural	5	**17.9%**
Accident	15	**50.0%**
Suicide	1	**3.6%**
Homicide	6	**21.4%**
Undetermined	2	**7.1%**
Total Deaths Reviewed	**29**	**100.0%**



Ventura County Child Death Review
2010

Official Manner of Death

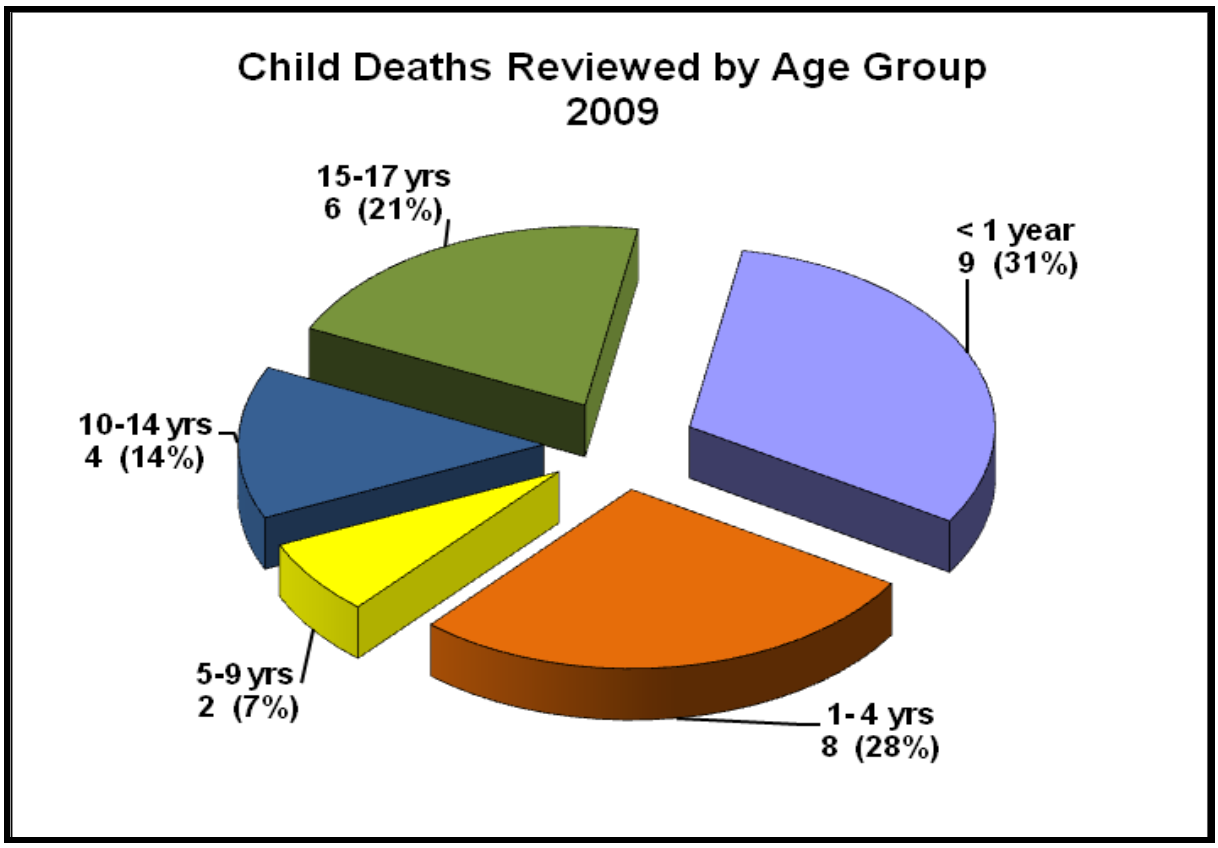
Official Manner of Death	Number	Percentage
Natural	1	**5.9%**
Accident	8	**47.1%**
Suicide	3	**17.6%**
Homicide	3	**17.6%**
Undetermined	2	**11.8%**
Total Deaths Reviewed	**17**	**100.0%**



Ventura County Child Death Review
2009

Manner of Death By Age Group

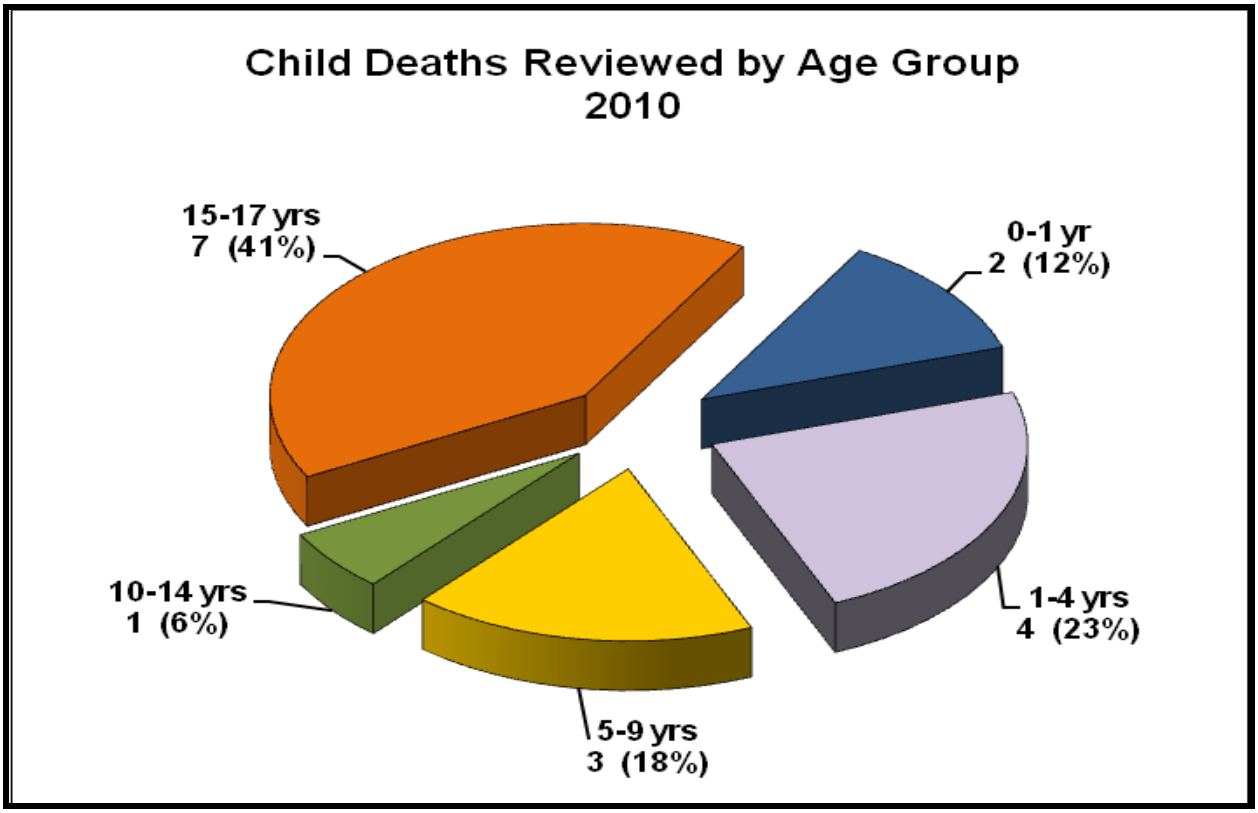
Manner	<1	1-4	5-9	10-14	15-17	Total	Percentage
Natural	3	1	0	0	1	**5**	**17.9%**
Accident	3	6	1	2	3	**15**	**50.0%**
Suicide	0	0	0	0	1	**1**	**3.6%**
Homicide	2	0	1	2	1	**6**	**21.4%**
Undetermined	1	1	0	0	0	**2**	**7.1%**
Total	**9**	**8**	**2**	**4**	**6**	**29**	
Percentage	**31%**	**27.6%**	**6.9%**	**13.8%**	**20.7%**		**100%**



Ventura County Child Death Review
2010

Manner of Death By Age Group

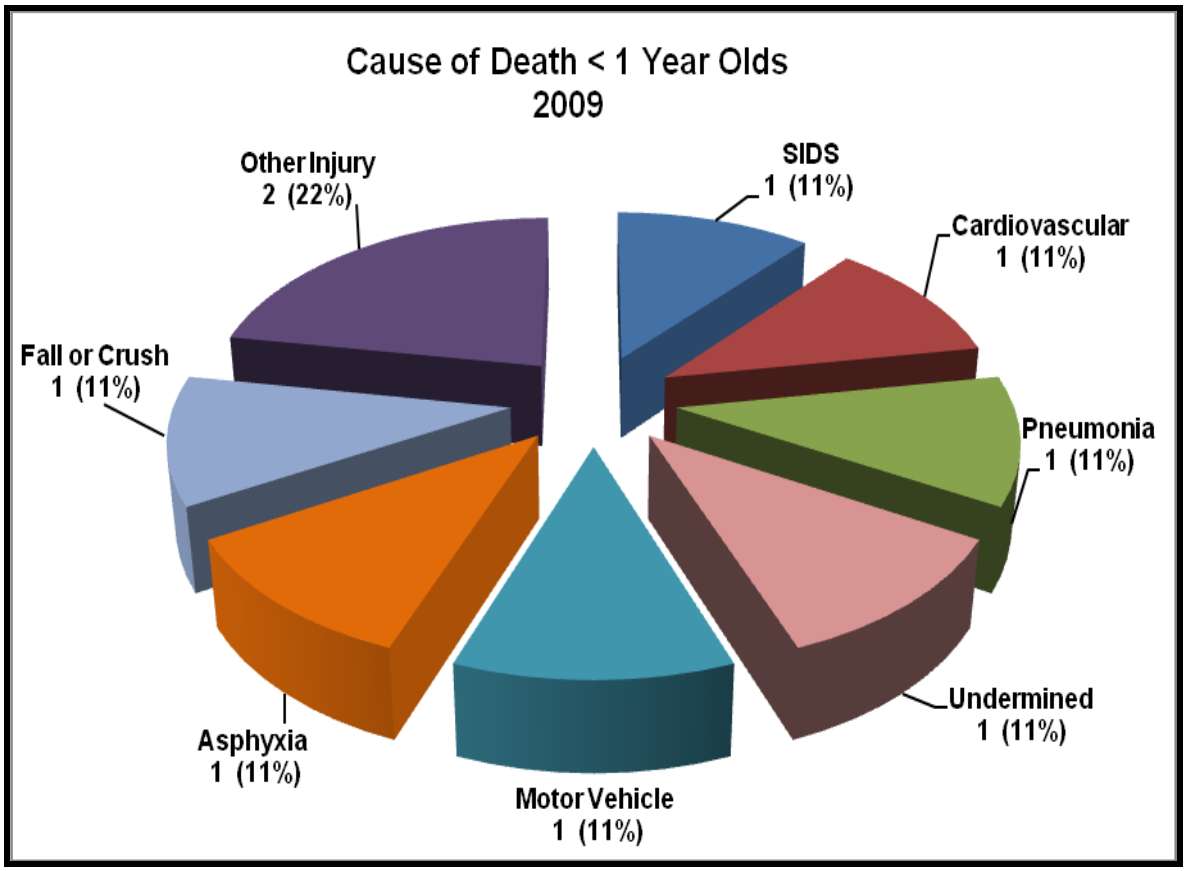
Manner	<1	1-4	5-9	10-14	15-17	Total	Percentage
Natural	1	0	0	0	0	**1**	**5.9%**
Accident	0	4	1	0	3	**8**	**47.1%**
Suicide	0	0	0	1	2	**3**	**17.6%**
Homicide	0	0	1	0	2	**3**	**17.6%**
Undetermined	1	0	1	0	0	**2**	**11.8%**
Total	**2**	**4**	**3**	**1**	**7**	**17**	
Percentage	**11.8%**	**23.5%**	**17.6%**	**5.9%**	**41.2%**		**100.0%**



Ventura County Child Death Review
2009

Manner/Cause of Death for <1 Year Olds

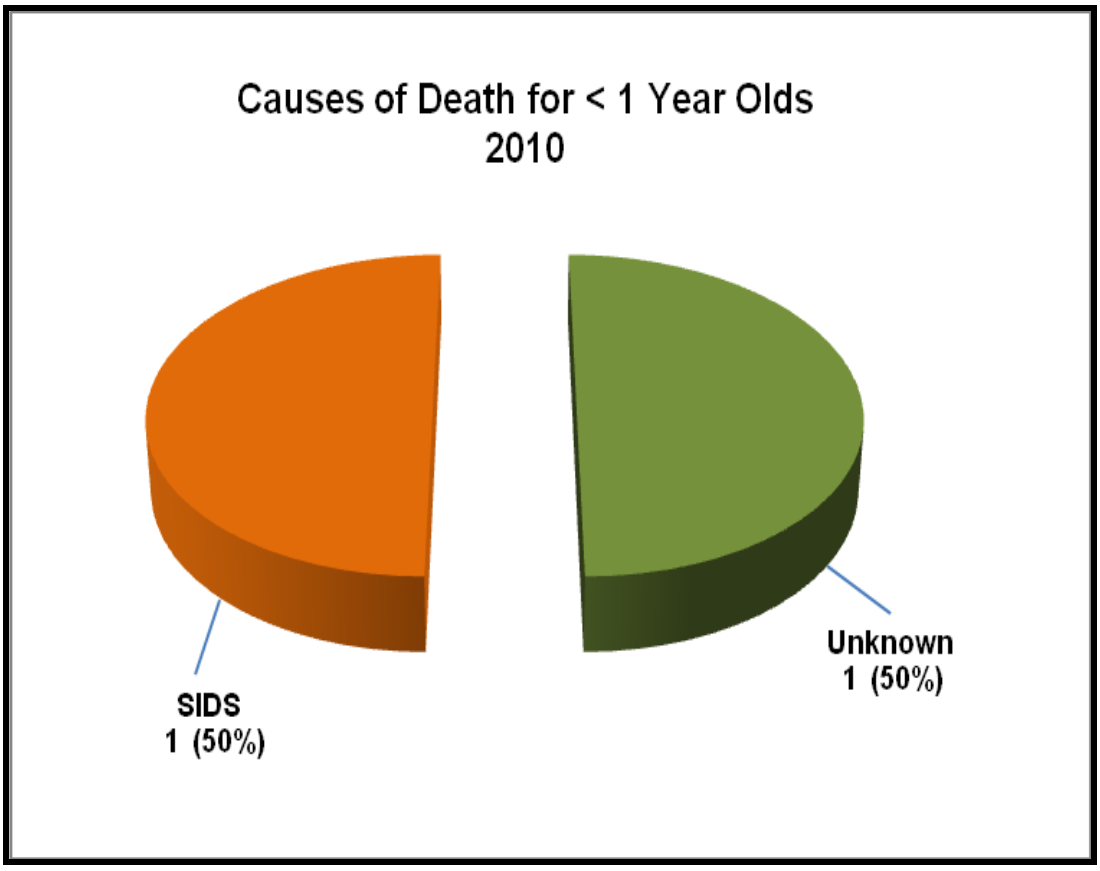
Manner	Cause	Number	Percentage
Natural	SIDS	1	**11.1%**
Natural	Cardiovascular	1	**11.1%**
Natural	Pneumonia	1	**11.1%**
Undetermined	Unknown	1	**11.1%**
Accident	Motor vehicle	1	**11.1%**
Accident	Asphyxia	1	**11.1%**
Accident	Fall or crush	1	**11.1%**
Homicide	Other injury	2	**22.3%**
Total		**9**	**100.0%**



Ventura County Child Death Review
2010

Manner/Cause of Death for < 1 Year Olds

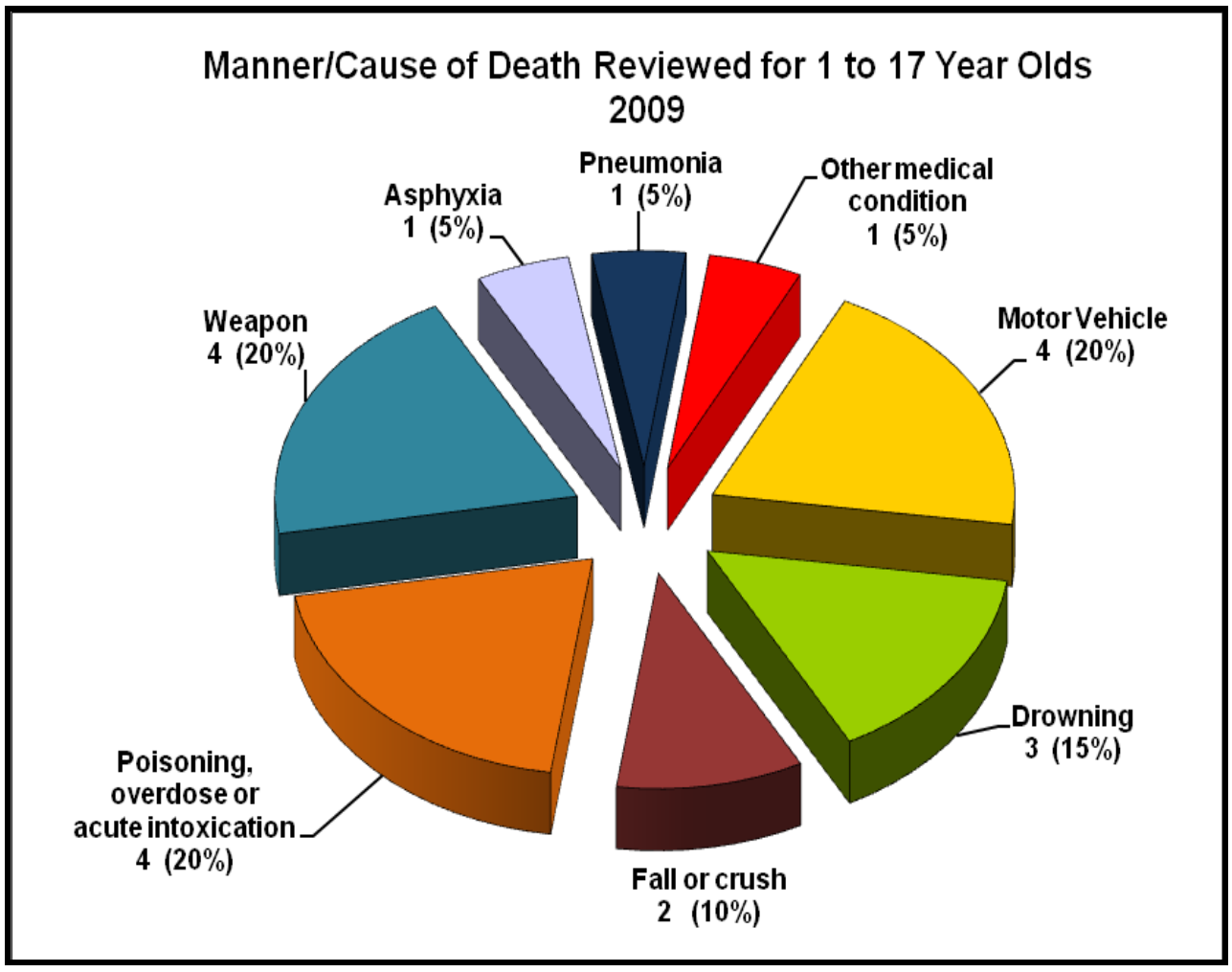
Manner	Cause	Number	Percentage
Natural	SIDS	1	50%
Undetermined	Unknown	1	50%
Total		**2**	**100%**



Ventura County Child Death Review
2009

Manner/Cause of Death for 1 to17 Year Olds

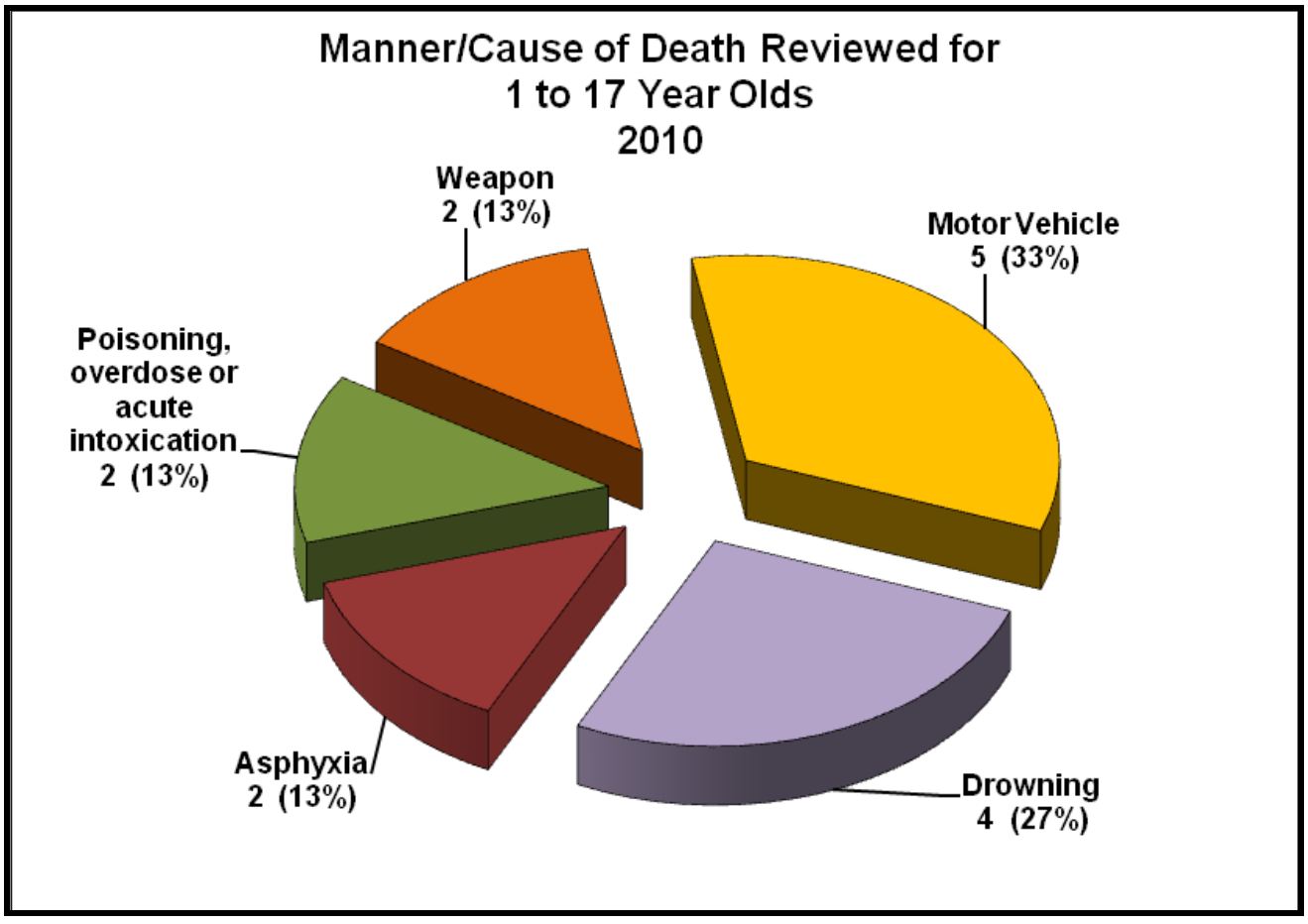
Manner	Cause	Number	Percentage
Natural	Pneumonia	1	**5.3%**
Natural	Other medical condition	1	**5.3%**
Accident	Motor Vehicle	4	**21.1%**
Accident	Drowning	3	**15.8%**
Accident	Fall or crush	2	**10.5%**
Accident (2) Suicide (1) Undetermined (1)	Poisoning, overdose or acute intoxication	4	**15.8%**
Homicide	Weapon	4	**21.1%**
Accident	Asphyxia	1	**5.3%**
	Total	**20**	**100.0%**



Ventura County Child Death Review
2010

Manner/Cause of Death for 1 to17 Year Olds

Manner	Cause	Number	Percentage
Accident	Motor Vehicle	5	**33.3%**
Accident (2) Homicide (1) Undetermined (1)	Drowning	4	**26.8%**
Suicide	Asphyxia	2	**13.3%**
Accident (1) Suicide (1)	Poisoning , overdose, acute intoxication	2	**13.3%**
Homicide	Weapon	2	**13.3%**
	Total	**15**	**100.0%**



Ventura County Child Death Review

Manner of Death by Zip Code/ City

2009

Location of Death Zip Code Ventura Co.	City	Number of Deaths	Manner of Death	Percentage
91301	Agoura Hills	1	Accident	**3.4%**
93012, 93010	Camarillo	5	Accidents	**17.3%**
93225	Frazier Park	1	Homicide	**3.4%**
93023	Ojai	1	Homicide	**3.4%**
93065, 93063	Simi Valley	3	Accidents	**10.4%**
93033,93036, 93030	Oxnard	6	1- Accident 2- Natural 1- Suicide 1- Homicide 1- Undetermined	**20.8%**
93040	Piru	1	Accident	**3.4%**
93041	Port Hueneme	2	Natural	**6.9%**
91360,91362, 91363	Thousand Oaks	3	Homicides	**10.4%**
93001, 93003	Ventura	4	3- Accidents 1- Natural	**13.8%**
Location of Death Zip Code Other County	**City**	**Number of Deaths**	**Manner of Death**	**Percentage**
93219 (Kern County)	Earlimart	1	Accident	**3.4%**
90095 (Los Angeles)	Los Angeles	1	Accident	**3.4%**
Total		**29**		**100%**

Ventura County Child Death Review

Manner of Death by Zip Code/ City

2010

Location of Death Zip Code Ventura Co.	City	Number of Deaths	Manner of Death	Percentage
93015	Fillmore	1	Suicide	**5.9%**
91320	Newbury Park	1	Suicide	**5.9%**
93022	Oak View	1	Accident	**5.9%**
93033, 93035, 93036	Oxnard	4	3- Accidents 1- Homicide	**23.5%**
93060	Santa Paula	2	1- Suicide 1- Accident	**11.8%**
93065	Simi Valley	2	Undetermined	**11.8%**
93001, 93003	Ventura	5	2- Accident 1- Natural 2-Homicide	**29.3%**
91361	Westlake Village	1	Accident	**5.9%**
Total		**17**		**100%**