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

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

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

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

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

Child Death Review Team Report 2015

ICAN

Inter-Agency Council on Child Abuse and Neglect

Deanne Tilton Durfee, Executive Director

Los Angeles County • ICAN Multi-Agency Child Death Review Team

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Child Death Review Team Report 2016

Report Compiled from 2015 Data

Table of Contents

Team Chairpersons

Child Death Review Team

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Carol Berkowitz, M.D., *Harbor/UCLA Medical Center*

Child and Adolescent Suicide Review Team

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Rosemary Rubin, *Retired*
Lynda Boyd, *Los Angeles County, Department of Mental Health*

Teams Include Representatives From The Following:

Los Angeles County Departments

- Children and Family Services
- Public Health
- Public Defender
- Health Services
- Office of Education
- District Attorney
- Medical Hubs
- County Counsel
- Public Social Services
- Sheriff
- Mental Health
- Medical Examiner-Coroner
- Probation
- Fire
- Community Development Commission/Housing

City Of Los Angeles:

- Los Angeles Police Department
- Los Angeles Fire Department
- Office of City Attorney
- Los Angeles Unified School District

State and other community partners

- Edelman Children's Court
- Community Care Licensing
- Independent Policies Agencies
- Children's Hospital of Los Angeles
- Community Child Abuse Councils
- Chicago School of Professional Psychology
- Almansor Center
- USC School of Medicine
- Pacific Clinics
- Burbank United School District
- Whittier-Union School District
- United American Indian Movement

Introduction

The Los Angeles County ICAN Child Death Review Team (CDRT) was formed in 1978 and was the first child death review team in the nation. CDRT and the Los Angeles County ICAN Child and Adolescent Suicide Review CASRT) teams meet monthly and are comprised of representatives of the Department of Medical Examiner-Coroner, Los Angeles Police and Sheriff's Departments, District Attorney's Office, Los Angeles City Attorney's Office, Office of County Counsel, Department of Children and Family Services, Department of Health Services, Department of Public Health, Department of Public Social Services, County Office of Education, Department of Mental Health, California Department of Social Services, Los Angeles Child Abuse Councils and representatives from the medical community.

The Los Angeles County Department of Medical Examiner-Coroner refers child deaths in the age range of fetal deaths of 20 weeks up to, but not including, the 18th birthday to the Team. This excludes all natural deaths. Thereafter, cases that meet at least one of the following criteria are selected for review:

- Homicide by parent, caregiver or other family member
- Suicide
- Accidental death
- Undetermined death

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

This thirty-seventh annual report of the ICAN CDRT provides information on all child deaths that meet Team protocol and occurred in Los Angeles County during 2015. Lessons learned from the reviews and ensuing recommendations which, if implemented, should improve child safety and save lives are included in the report. Appendix C at the end of the report provides on-line resources for prevention of child deaths.

For the ninth year, the report also includes information on 3rd party homicides of youth 17 years and younger. These homicides are when the perpetrator was not a family member or caregiver.

Recommendations

1. **The policy of reporting subsequent child abuse allegations to the Child Abuse Hotline (CAHL) by DCFS and the HUB staff should be reinforced.**

   Rationale: The Team has reviewed cases in which a child informed the Children's Social Worker (CSW) of abuse not previously reported and this was not reported to CAHL. This has also occurred with HUB staff. The oversight appears to be due to lack of an understanding of policy or the mistaken view that it is merely additional information for the current ongoing investigation. A separate comprehensive investigation by DCFS cannot occur when new allegations of abuse are not reported. Further, with no resultant cross report to law enforcement, any investigation they might conduct would not occur. Hence, the opportunity for intervention by either DCFS or Law Enforcement that might prevent a future fatal outcome is missed.

2. **DCFS and Law Enforcement should ensure that siblings of a victim of severe or fatal child abuse incident be forensically examined and interviewed as soon as possible at a HUB or Child Advocacy Center.**

   Rationale: Siblings of abuse/neglect victims are potential victims themselves and/or witnesses to a severe or fatal incident or past abuse. These siblings should be interviewed as soon as possible to assess if they were a witness to, or, a victim of abuse. This would include siblings not necessarily residing with the victim but who had visitation in the home. Forensic interviews benefit the child by eliminating multiple interviews, assist law enforcement and prosecutors and ensure the child is connected to needed services.

3. **A "hotline" number and/or protocol should be established for CSW's to contact a HUB Child Abuse expert 24/7 to consult when there is a concern about a child's medical condition or a medical opinion.**

   Rationale: Workers rely on medical professionals' opinion of whether trauma was unintentional, inflicted, accidental or a medical condition. The child's treating medical professional may not have the knowledge and experience of a child abuse expert.

   For example, the Team has reviewed cases in which seminal injuries mimicked symptoms of illness that were missed by the treating medical professional. In one review, an infant was diagnosed a week prior to the fatal incident with pancreatitis which is not a normal diagnosis for an infant, but a red flag for abdominal trauma.

   In another CDRT review, an ER physician made a referral for suspected abuse. The CSW spoke to the current treating hospital physician but not the ER doctor who called in the referral. The child had stabilized and the current physician accepted the mother's explanation that the child had a seizure while showering. The worker did not contact the ER doctor to verify why they felt suspicious of abuse. Had a child abuse medical expert been consulted, the worker might have learned the incoming test results did not support a seizure as a cause. In addition, the body temperature at the time of admission would have caused great concern for forced submersion into cold water. Additionally, when there are conflicting opinions from medical professionals, seeking a consult with a child abuse expert would be valuable and possibly life saving.

4. **DCFS should develop and establish accountability guidelines for domestic violence, substance abuse and parenting classes or services for providers to follow. These guidelines should include monitoring for effectiveness.**

   Rationale: The Team has reviewed cases in which a family with a child welfare history received prior services and had a case closed only to return months or a year later with the same allegation, or a fatality. Case reviews reveal the parent did not complete all of the recommended services, or the services rendered were not specific to the issue or concern. Currently, there are no standards for these services, and the quality of programs available to parents involved with DCFS varies widely. It is important that DCFS require standardized and quality programs that hold both the service provider and parent accountable.

5. **ICAN should send a letter of support to the Board of Behavioral Sciences to consider the adoption of graduate coursework and continuing education for mental health and social work professionals in the assessment and management of suicide risk.**

   Rationale: In 2014 the ICAN Policy Committee voted to encourage the increased training of mental health providers and social workers in the core competencies in suicide risk assessment and intervention.The Governor recommended that regulatory boards for mental health professionals review their requirements for assessing and managing suicide and take appropriate action. The California Board of Psychology has taken the lead in sponsoring and preparing legislation to require additional training for graduate psychology students and licensed psychologists. The Board of Behavior Sciences has not yet taken action.

6. **ICAN should request that the Los Angeles County Board of Supervisors provide child friendly spaces for clients accessing services at County facilities such as DCFS, DPSS, DMH, Housing Authority, Health Services and Public Health.**

   Rationale: The Team continues to review cases of infants and toddlers killed by a parent's unrelated partner. Unable or unwilling to meet the needs of a young child, they react in anger or frustration, resulting in a fatal injury. For example, the team reviewed a case in which the mother was in danger of losing her housing having missed several appointments with the Housing Authority due to lack of child care. On the day of the fatal incident, she left the child in the care of her boyfriend who inflicted fatal head trauma. This death may not have occurred had the County provided child care at the site of her service appointment.

7. **The Los Angeles County Office of Education (LACOE) should offer training and technical support in suicide prevention as required by AB 2246 to schools in Los Angeles County. LACOE should also provide outreach and training to all K-12 education providers to develop policies and procedures to reduce the risk of suicide for all pupils.**

   Rationale: AB 2246 became effective in California on January 1, 2017. Public school districts are now required to adopt a suicide prevention policy based on a model from the California Department of Education. The policy must address suicide risk prevention, intervention, and related crisis response activities, and requires that schools implement procedures to identify groups of students at high risk.

8. **ICAN should support legislation to reduce the risk of suicide among children and youth that are not enrolled in public schools to require every K-12 education provider to have a suicide prevention policy that is now described in AB 2246.**

   Rationale: In 2014, Los Angeles County experienced an increase in suicides among youth that have dropped out of public school and opted for independent learning or alternative learning venues including on-line coursework. The Child and Adolescent Suicide Review Team noted that many students did not receive adequate suicide risk assessment or intervention in these independent learning venues. Of great concern to the Suicide Review Team is that there were indications that these young people experienced psychological and social challenges while they were still enrolled in school.

   Suicides among youth enrolled in independent learning venues in 2015 continued to be noted by the Team. It is doubtful that teachers in their independent learning settings are adequately trained to assess and manage the risk of suicide of these students. AB2246 that requires public schools to have a suicide prevention policy does not apply to independent schools and requirements should be expanded to all learning venues.

Child Death Review Team: Risk Factors and Lessons Learned

Team case review yields valuable lessons including identification of systematic issues in need of attention by one or various agencies impacting the welfare of children and families. Additionally, patterns of risk factors in families surface in the cases. The lessons and risk factors noted from the 2015 child death review cases follow.

Child Risk Factors

Young Age

72% of the 2015 child homicide victims killed by a parent/relative/caregiver were two years of age or under. Only five victims were over age two years. Infants and young children are especially vulnerable to abuse and neglect which can lead to death due to their small size, inability to defend themselves and dependence upon caregivers to meet their needs. Child homicides often coincide with developmental stages. For example, toddlers in their attempts toward autonomy will show defiance and self assertiveness which can evoke an adverse response by a caregiver. The Team has also observed cases in which toddlers are victimized during the toilet training period. Importantly, infants and young children are often not visible outside the home as these families tend to be socially isolated.

Further, 55% of the children who died as a result of an accident were age five years or younger. Young children are more at risk of deaths such as drowning, unsafe/co-sleeping, pedestrian or auto back up because of their size and/or lapses of adult supervision to prevent such deaths.

Adolescence

Youth ages 15 – 17 years are most vulnerable for suicide (16 of the 23 suicides) or be a victim of a third party homicide (26 of the 29 victims).

Gender

In 2015, male (n=14) children notably outnumbered female (n=4) children as victims of child abuse homicide as in past years.

Race

African American children and Hispanic represent the greatest number of the 2015 child homicides victims by a parent/relative/caregiver in 2015 at 38.9% each. The next racial group of homicide victims most represented were Caucasian representing 15.8% and 5.3% were of Asian/Pacific Islander descent (see chart on page 29).

Location of Injury

The Team reviewed two cases of toddlers who died of multiple traumatic injuries yet when treated by paramedics and initially seen at the ER, only a couple of bruises were noted. The team learned in the case of inflicted trauma to the abdominal area, bruising may not be evident yet the internal damage fatal. This is due to the lack of fat on the body and the resultant force of the trauma goes through the body to the internal organs. Bruising externally occurs slowly. In both cases, the child's bruises were later evident at autopsy.

The 2015 case reviews also reminded the Team of the TEN-4 Bruising Rule for infants. Bruising to the Torso, Ears, and Neck (TEN) or bruising anywhere on an infant 4 months of age or younger are significant indicators of abuse.

Parental Risk Factors

Domestic Violence

The nexus between domestic violence and child abuse/neglect continues to be evident in the 2015 child homicides. Sixteen or 89% of the families or the perpetrator had a documented history of domestic violence. Three of the child homicides can be directly tied to domestic violence. One infant was killed along with

the mother by the father. Another child was killed along with the mother who was in her third trimester of pregnancy by the father who then committed suicide. The Team has made various past recommendations that law enforcement report DV to DCFS when children reside in the home whether present at the time of an incident or not as a means to access the risk to both the children and mother.

Involvement with the Child Welfare System

A key factor in the majority of the child homicide cases was that the child's mother, father or the perpetrator had at least one contact with the Department of Children and Family Services (DCFS) or another Child Protective Service (CPS) agency. In 2015, DCFS contact with a parent and/or perpetrator occurred in 72% (n=13) of the families who experienced a child homicide. Two of the thirteen had a current open referral or case with DCFS at the time of the homicide. The family with an open case was only known to DCFS due to the incident which resulted in the fatality and had no prior history.

Cycle of Abuse

A common factor seen in many of the child homicide cases had been that the child's mother, father or the perpetrator had a prior juvenile case themselves in either the Dependency Court or the Delinquency Court, or their family had contact with these agencies when they were a child. Many of them parent as they were parented, thus continuing the cycle of abuse and neglect. 67% (n=12) of the 2015 child homicides involved a parent(s) and/or perpetrator with a Child Protective Service (CPS) history as a child.

Substance Abuse by Parent or Caregiver

Substance abuse by a parent or caregiver is a well documented high risk factor for child abuse or neglect. Substance abuse often is also identified when there is a child fatality. Sixty-seven percent of the 2015 families of homicide victims had a history of substance abuse. In one of the 2015 child homicides, the individual responsible for the child was under the influence of drugs during the incident that led to the child's death. Unrealistic developmental expectations and inability to cope with age appropriate behavior, combined with drugs and alcohol, become a lethal situation causing caregivers to lose control and harm the child. In addition, parents under the influence who sleep with their infant increase the risk of overlay or suffocation leading to the death of the child.

Prenatal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appears to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a number of fetal deaths with a contributing factor of prenatal substance abuse. Child deaths related to prenatal substance abuse remain one of the top four causes of accidental death, accounting for 17.3% of accidental child deaths. Prenatal Substance abuse was attributed to 21% of the accidental deaths of children in which the family had at least one contact with the child welfare system. Additionally, there were 5 undetermined child deaths associated with prenatal substance use as evidenced by the mother testing positive at the birth for alcohol or drugs.

Mental Illness

Another factor seen in many of the child homicide cases had been that the child's mother, father or the perpetrator had a history of mental illness. 44% (n=8) of the 2015 child homicides involved a parent(s) and/or perpetrator with a history of mental illness.

Presence of Multiple Parental/Caregiver Risk Factors

A combination of risk factors, such as history of substance use, domestic violence, CPS contact, CPS history as a child and social isolation are usually present when a child dies at the hand of a parent or caregiver. Only two families of a homicide victim had none of these known risk factors present. It is unknown whether another family involving an unattended newborn had any risk factors as the identity of the parents remains unknown.

Perpetrator Relationship

Relationship

In 2015, there were twenty-three suspects in the 18 child abuse homicides. Seventy percent of the child homicides involved a male perpetrator. Ten of the primary suspects were the father; four the mother; one, both parents; one the mother and her boyfriend; three the mother's boyfriend and one, the victim's minor brother.

Lack of Parenting Skills, Bonding or Poor Attachment

The poor quality of the relationship of the adult to the child has been a recurring factor in child homicide deaths. This is particularly important with the person who assumes a caretaking role for the child. The Team has observed that each year, many of the child homicides have been at the hands of the parent, parent's boyfriend, girlfriend, step parent or partner who was not emotionally connected to the child, yet had parenting responsibilities for the child. Lacking a connection with the child may contribute to their inability to manage stress or anger and to cope with parenting the child. This is often seen with children who die as a result of blunt force trauma to the head, chest, abdomen, or multiple areas.

Denial or Lack of Understanding a Child's Medical Needs

The Team reviewed several cases in which one or both parents/caregivers either did not accept or comprehend the seriousness of a child's fragile medical condition. This was seen particularly with infants exhibiting low weight gain, possible failure to thrive, or experiencing an illness that led to rapid dehydration when not monitored appropriately.

System Factors

Failure to Recognize Child Abuse or Neglect

As in past years, the Team has reviewed cases in which a homicide victim had contact, days or weeks before the child's death by a pediatrician, a local medical clinic or at an emergency room. Indications of abuse/neglect were present but not recognized as possible child abuse/neglect. Additionally, the high risk to a child when one or both parents are uncooperative and/or in denial of the child's medical needs was underestimated by the medical professional.

Failure to Report

With the 2015 child homicides, as in previous years, the Team has reviewed cases in which a family had contact days, weeks or months before the child's death by a hospital or community agency and "red flags" were observed but not reported to DCFS or law enforcement. When abuse or neglect is suspected, a referral should be made to allow either law enforcement or DCFS to assess the family's situation. Mandated reporters are only required to report "suspected" abuse or neglect and not assess for it. Additionally, when a family is involved with multiple systems - DCFS, law enforcement, medical, community social services; it is imperative that the agencies providing services to the family have ongoing communication with one another for prevention, investigation, and case management purposes.

Further, in several cases involving child homicides, there were family members or neighbors aware of ongoing domestic violence, neglect or who observed inappropriate interactions which placed the child at risk and did not contact DCFS or law enforcement. Family members or neighbors, who are aware that a child might be at risk, should communicate their concerns to DCFS or law enforcement.

Lack of Child Care

The Team continues to review cases in which the mother does not have access to childcare whether it is to keep and appointment with a service agency or extended hours to attend school or work. Lacking community child care, the mother relies on her unrelated partner to provide care with lethal consequences.

Additional Rist Factors

Unsafe Infant Sleeping

Undetermined child deaths associated with bed-sharing and/or unsafe sleep environments have declined considerably from the high of 70 set in 2009 to 24 in 2015. Infants who die are often placed on their stomach or side on adult beds, couches and/or surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. In 2015, these bed-sharing and/or unsafe sleep environments child deaths accounted for 55% of all the undetermined child deaths.

Additionally, eight infants died when placed in an unsafe manner to sleep whose deaths were ruled an accident mostly due to being wedged between an adult bed and wall. The manner of death by the Coroner in the majority of unsafe or bed-sharing infant deaths is undetermined. Adding these accidental deaths to the undetermined ones brings the total of unsafe sleep infant deaths to 32.

Despite the decline in these child deaths, the need to proactively promote safe sleeping practices to prevent these deaths remains.

Family Isolation

It is often observed that families of child homicide victims tend to be socially isolated with few personal or social resources available to them. A father who killed his three children was separated from his wife and homeless at the time of their deaths. Another mother shot and killed her only child with special needs as her husband was deceased and she herself terminally ill.

Child and Adolescent Suicide Review Team
Risk Factors and Lessons Learned

Suicide Rate

The suicide rate among individuals under the age of 18 years dramatically increased from 10 in 2014 to 23 in 2015. This represents the highest number of youth suicides since 2001 when 27 youth died from suicide. Suicides also outnumbered the child abuse homicides in 2015.

Gender

There was a significant shift in the gender rate of suicides in 2011. In prior years, the male to female ratio was consistent with males outnumbering the females by a large margin. In 2010, for every female suicide there were two male suicides. In 2011, eight of the nineteen suicides were female and eleven male. This pattern shifted again in 2012 when, for the first time, female victims (n=9) of suicide outnumbered the male victims (n=8). In 2013, the pattern reverted back to males outnumbering females with eight males and five females who died by suicide. The gender gap once again narrowed in 2014 to almost even with six males and four females. In 2015, the past pattern returned with 61% of the youth deaths by suicide male (n=14) and 39% female (n=9).

Race

39% of the youth who died by suicide were Hispanic and 39% were Caucasian. Asian/Pacific Islander children comprised 13% of children who died by suicide and 9% were of African American descent.

Relationship Loss or Conflict

35% of the youth who ended their own lives experienced a recent relationship loss or conflict with a peer, boyfriend/girlfriend or parent prior to their suicide. Family dysfunction at the time of the youth's suicide was noted in 43% of the suicides.

The Role of Pre-existing Mental Health Problems

Among the youth who died of suicide, 52% had a documented mental health diagnosis, 17.4% were receiving mental health services at the time of death and 35% were on psychotropic medication. 35% of the youth exhibited a warning sign--talk of suicide, increased drug and alcohol use, feelings of depression, anxiety and hopelessness, and giving away possessions.

The Role of External Factors

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

Of the youth who died by suicide in 2015, 30% had reported experience of being bullied. 35% experienced school discipline/truancy problems and 35% had academic problems. 52% of the victim's families had contact with either DCFS or Probation at sometime in the youth's life.

Impulsivity

Of the 23 youth who died by suicide in 2015, six left a note, three a text and one posted on snapchat just prior to the act. This reflects how youth seem not to plan their suicide over a period of time, but act impulsively at the moment.

Findings

Overall Child Deaths*

- There were 189 child deaths, including fetal deaths reported to the Team by the Medical Examiner-Coroner. These deaths were the result of homicide by a parent, relative or caregiver, accident, suicide or undetermined cause in Los Angeles County for 2015. This is a decrease from the 196 deaths in 2014.

- Eighteen children were victims of homicide by a parent, caregiver or other family member. There were 23 suicides, 104 accidental child deaths and 44 undetermined child deaths.

- There were a total of 23 fetal or child deaths associated with prenatal substance use. Eighteen were ruled accidental by the Medical Examiner-Coroner. Fifteen of these deaths were fetal. There were 5 undetermined prenatal substance abuse infant deaths involving four fetal deaths and one infant who lived for one hour.

- Thirty-two children died with an associated bed-sharing or unsafe sleeping environment. Eight of these deaths were ruled accidental and 24 as undetermined.

- The percentage of children who died in 2015 by race consisted of 42.6% Hispanic, 22.9% Caucasian, 23.9% African American, 8.9% Asian/Pacific Islander, and 1.7% Unknown.

- Over half of the children were between the ages of 0 to five years (n=109). 42.6% were infants under the age of one year (n=80). Children ages 10 - 17 years comprised 37% of the total number of child deaths in 2015.

- Just under thirty-six percent of the children who died in 2015 were female and 63.5% male.

*Reported by the Medical-Examiner/Corner and does not include 3rd Party Homicides

Homicides by Parent, Family Member or Caregiver

- There were 18 child homicides by parents, caregivers or family members in 2015. This represents an increase of three homicides from 2014 when there were 15 child homicides. The number of child homicides in 2015 for Los Angeles County was significantly lower than the 15 year average of 27.3.
- 72% percent of the children killed by their parents, caregivers or family members were two years of age or younger. There was no child homicide victim age 3 - 5 years in 2015.
- Five of the 18 homicide victims were over the age of five years.
- The average age of a child homicide victim in 2015 was 3.7 years which was younger than in 2014 when the average age was 4.4 years.
- Fourteen males and four females were homicide victims in 2015.
- 39% percent of the child homicide victims were battered children who died from inflicted trauma - five died from multiple blunt force trauma and two children died from head trauma. In addition, four children were victims of stabbing, two victims of asphyxia; two victims were drowned; one died from poisoning; and one child died as a result of medical neglect
- There was one unattended newborn ruled an undetermined child death in 2015. Four neonates were abandoned but found alive. Eighteen newborns were safely surrendered in 2015 which was seven more than the number in 2014 (n=11). .
- African American (n=7) and Hispanic (n=7) children comprised 78% of child abuse homicides. Three homicide victims were of Caucasian descent. Asian/Pacific Islander (n=1) children represented 5% of the child homicides by a parent, caregiver or family member.

- The Department of Children and Family Services (DCFS) or another county's Child Protective Services (CPS) agency had prior contact with 72% (n=13) of the families in which there was a child homicide and the child died in Los Angeles County. Two families of a homicide victim had an active case with DCFS at the time of the child's death. One had an open referral and one an open case (open as a result of the near fatal injury). Sixty-seven percent of the victims' parents or the perpetrator had a child welfare history as a minor.
- Ten children were killed by their father and four children were killed by their mother. One child was killed by the mother and the father; one by the mother and her boyfriend; three by the mother's boyfriend and one child was killed by her minor brother.
- There were three child homicides by a parent, caregiver or family member in June and September of 2015. The second greatest number of homicides occurred in the months of January, April, July and October with two per month. One homicide occurred in the months of February, March, November and December. There were no homicides in the months of May and August.
- Child abuse homicides occurred throughout Los Angeles County in 2015. The Second Supervisorial District experienced the greatest number of child homicides with eight. The First District experienced the second largest number with six. There were three in the Fourth District and one child homicide in the Fifth District. No child abuse homicides occurred in the Third Supervisorial District.

Suicides

- Twenty-three children and adolescents died by suicide in 2015. The number of children and youth who died by suicide in 2015 increased to a number not seen since 2001 when there were 27 such deaths and more than doubled the number of 2014 (n=10).
- The gender gap continued in 2015 with 14 (61%) males and 9 (39%) females taking their lives.
- Although the most common method of suicide nationally is firearm, the leading method in LA County continues to be death due to hanging, which represents 61% (n=14) of the suicides in 2015. Seven youth used a firearm representing 30% of the suicides and this method was used exclusively by males.
- The act of suicide historically occurs in the youth's home. All but three of the 2015 suicides occurred in the youth's place of residence.
- Thirty-nine percent of the child/adolescent suicides in 2015 were by Hispanic and Caucasian youth each (n=9). Suicides by youth of Asian/Pacific Islander descent (n=3) represent 13% of the adolescent suicides and African American youth comprised 9%.
- Sixty-five percent of the children who died by suicide in 2015 were ages 16 - 17 years. The youngest age of a child was 13 years in 2015.
- Fifty-two percent (n=12) of the youth had a history of mental health problems, eight were taking psychotropic medication, four youths were in counseling at the time of their death. Seven youth had a history of prior self-injury or cutting and six youths had previously attempted suicide. Eight youths exhibited warning signs prior to their suicide.
- Six of the youth who died by suicide in 2015 left a suicide note. Four youth texted or posted on Snapchat their intent just prior to committing the act but did not leave a note.
- Ten of the youths' families were noted to exhibit signs of family dysfunction (pending divorce or recent divorce, parental mental illness or domestic violence). Thirty-five percent (n=8) of the child/adolescent suicides were precipitated by interpersonal conflicts or a recent loss.
- Ten of the youths' families had a prior referral or case with the Department of Children and Family Services or with the Department of Probation. One family had an open referral/case with DCFS and one

with Probation.

- Five youths had a history of drug or alcohol use.

- Five youth had school discipline or truancy problems and eight experienced academic problems. Four youth were in Advanced Placement or Honor classes.

- Seven youth experienced bullying as reported by parents, surviving siblings or peers.

- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred in the Fourth Supervisorial District with seven. Suicides occurred equally in the First, Second and Fifth Districts of the Board of Supervisors with four suicides followed by the Third District with three suicides. One suicide occurred in another county but the child died in a Los Angeles County hospital.

Accidental Child Deaths

- For the second year in a row, the number of accidental child deaths of children in Los Angeles County increased from the previous year. The accidental child deaths in 2015 rose by one from 2014 to 104 such deaths.

- The leading cause of accidental death for children was auto pedestrian (n=24) in 2015. Prenatal substance abuse with 18 deaths was the second leading cause. The third leading cause of accidental child death was automobile accidents and drowning each with 13 child deaths.

- Child deaths related to vehicles including moped/scooter and auto-pedestrian accounted for 36% of all accidental child deaths (n=37).

- Deaths associated with prenatal substance abuse as determined by the Coroner from self-report or hospital toxicology results, accounted for 15 fetal deaths and three infant deaths. Methamphetamine and/or amphetamine use by the mother is the most associated drug with these deaths (n=6) accounting for 33.3%. The mother tested positive for marijuana in three of the deaths. Two deaths were associated with Cocaine use by the mother and five deaths poly substance abuse including alcohol. All of the accidental fetal deaths were associated with prenatal substance use and accounted for 14.4% of the accidental deaths.

- Accidental drowning claimed the lives of 13 children which is one less drowning death as the previous year. The majority of these drowning deaths were young children who drowned in residential pools. In 2014, nine children drowned in a residential pool. 61.5% of these victims were age five years or younger (n=8). Two children drowned in a Jacuzzi. Additionally, one child drowned diving in the ocean and one toddler in a canal. Two of the older children were survivors of a near drowning who finally succumbed as a result of their near fatal incident. For the past seventeen years, drowning has been one of the leading causes of accidental deaths of children in Los Angeles County.

- Of the 104 accidental deaths, 75 accidental child deaths involved children ages 0 - 14 years. There were 29 accidental deaths of youth ages 15 to 17 years. More than half (55%) of the accidental child deaths (n=57) were children age five years or younger.

- Eight co-sleeping or unsafe sleep infants' deaths were ruled accidental as opposed to undetermined. Most involved being wedged between a mattress and the wall.

- Of the children who died an accidental death in 2015, 48% had a DCFS history. Ten families of the eighteen child deaths from prenatal substance abuse had a history with DCFS. Four additional prenatal substance abuse associated child deaths involved a mother who had a CPS history as a minor but not as an adult.

- Hispanic children represented 51% (n=53) of the accidental child deaths in 2015. African-American and Caucasian children each represented 19% (n=20), Asian/Pacific Islander represented 8% of accidental deaths in 2015. The race of three children was unknown.
- As in previous years, males (n=60) outnumbered females (n=43) in accidental deaths. One gender was unknown.

Undetermined Child Deaths

- There were 44 undetermined child deaths in 2015. This is a 35% decrease from the 68 such deaths in 2014 and lower than the 15-year average of 95.4 undetermined deaths per year.
- The majority, 93% of undetermined child deaths are children age one year or younger. Sixty-two percent of the undetermined child deaths were age six months and under (this includes stillborn deaths).
- The largest number of undetermined child deaths was children of African American descent representing 36.4% of such deaths. Hispanic children followed with 27.3%. Caucasian children represented 25% of the undetermined child deaths. 11.3% of the children were Asian/Pacific Islander.
- Approximately 43% of the families with a child who died from an undetermined death had at least one contact with DCFS or another county CPS agency.
- Bed-sharing and unsafe sleeping environments accounted for 54.5% percent of all undetermined child deaths. 36% of the undetermined child deaths were associated with bed-sharing (n=16) and 19% with an unsafe sleep environment (n= 8).
- Among the bed-sharing deaths, 0% involved only one unsafe risk factor, 69% involved two, and 31% involved three or more unsafe risk factors. Risk factors included bed-sharing, adult bed, couch, pillows soft or excessive bedding, excessive swaddling, parental drug/alcohol use, and prone or side positioning.
- African American children are over represented in the percentage of both bed-sharing and unsafe sleeping environment child deaths. 43.8% of the bed-sharing deaths and 62.5% of the unsafe sleeping environment deaths involved African American children.
- Seventy-three percent of the infants whose deaths occurred while bed-sharing or in an unsafe sleeping environment were six months of age or younger (n=15).
- In 33% of the bed-sharing and non-bed-sharing unsafe sleep child deaths, the infant was placed in a prone or side position for sleep. This is a slight decrease from 2014 when 36% of the infants were placed prone or on their side to sleep.
- Undetermined child deaths involving bed-sharing and unsafe sleeping environments occurred throughout Los Angeles County. However, Supervisorial District 2 accounted for 33.3% (n=8). District 5 followed with 25% (n=6). 12.5% (n=3) occurred in Districts 1, 3 and 4 each. There was one homeless mother.
- Thirty-eight percent (n=6) of the bed-sharing deaths were infants between 0 to 3 months of age, 19% (n=3) were infants between 3 to 6 months of age, 25% (n=4) were 6 to 9 months of age, 19% (n=3) were 9 months to 1 year.
- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 62.5% of the incidents and two adults in another 19% of the incidents.
- Nineteen percent (n=8) of undetermined child deaths were associated with unsafe sleeping environments which Include adult bed, couch, foam mat, infant or car seat, pillows, soft or excessive bedding, excessive swaddling, stuffed toys, prone or side positioning.
- Two of the non bed-sharing deaths were infants between 0 to 3 months of age (25%) and six were infants between 3 to 6 months of age (75%).
- There were 5 undetermined infant deaths in which the mother either tested positive for a substance at birth or self-reported substance use during pregnancy. All involved stillborn births (n=5).

- The marijuana (n=3) was most frequent substance detected followed by methamphetamine (n=2).
- Three of the mothers of these infants had prior contact with a CPS agency in Los Angeles or another county.

Senate Bill 39 (SB 39)

DATA VARIANCES BETWEEN ICAN CHILD HOMICIDES AND DCFS REPORTED CHILD FATALITIES AS A RESULT OF CHILD ABUSE AND/OR NEGLECT

SB 39 mandates public disclosure of information and findings about children who have died as a result of abuse or neglect under the following circumstances:

- It is reasonably suspected that the child fatality is the result of abuse or neglect and the child resided with a parent or guardian or in foster care at the time of the death.

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

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

ICAN findings are based on the final mode of death as determined by the Los Angeles County Medical Examiner-Coroner. The definitions for these modes follow this page. The DCFS data set for child fatality determinations is based on SB 39 requirements, which provides for a more liberal determination that may precede Coroner findings. **DCFS can substantiate the child fatality was due to abuse or neglect or law enforcement can determine a crime occurred although the Coroner ruled the death was accidental or undetermined and not a homicide.** The number of child abuse fatalities reported by DCFS under SB 39 differs from the child **homicides** reported by ICAN as the DCFS numbers are greater and are subject to change.

ICAN reports pertain to child deaths with a mode of homicide by the Los Angeles County Medical-Examiner/Coroner. DCFS reports child fatalities by a parent or guardian with a previous history with LA County regardless of the circumstances of the current child death. DCFS involved child deaths that occur outside of Los Angeles County are not included in the ICAN report. ICAN reports child deaths with DCFS history if the child had an open referral or case at the time of death or a closed referral or case prior to the date of death; or the sibling of the child had an open referral or case at the time of death or a closed referral or case prior to the date of death; or if the parent of the child had a closed referral or case prior to the date of the death. ICAN also includes the history of out-of-county CPS involved child homicides by a parent/caregiver or family member if the child died in Los Angeles County.

Selection of Cases for Team Review

The Los Angeles County Medical Examiner-Coroner must designate the manner of death to be listed on the death certificate as either: Homicide, Accident, Natural, Suicide or Undetermined. This report, as have the past Team reports, utilizes the Coroner's classification scheme to group the manners of child death in the County of Los Angeles. Fetal deaths over 20 weeks gestation at the time of death are included in the report as a conservative cut off point for a viable fetus.

Homicides by the Coroner's definition, are deaths at the hands of another. Child deaths in which the suspected perpetrator is a parent, caregiver or family member, meet the Team protocol for possible review. All such cases are included in the ICAN annual Team report. Homicide by parent/caregiver/family member is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term "homicide" regardless of the criminal intent of the perpetrator or the findings of the criminal justice system. Homicide may describe circumstances ranging from tragedies that involve no clear intent, to vicious, fatal attacks with clear intent.

Accidental deaths comprise the largest category of child deaths reported to the Team by the Coroner. Several types of accidental death, such as automobile, auto pedestrian fatalities, drowning, and accidental gunshot wounds, are truly unintentional in nature. However, there may be questions of the caregiver supervision in some of these cases, as well as concern regarding the preventability of these accidents. A significant number of accidental deaths involve newborns who were prenatally exposed to drugs and who subsequently died of prematurity or from other related perinatal causes.

Natural deaths are rarely reported to the Team and are not included in the Team's annual report.

Suicide, by the Coroner's definition, is death of self-caused with intent. Suicides of children and adolescents are reported to the Team as a special population. The Team recognizes that suicide, most often in itself, is not a result of child abuse and neglect. However, the ability of the Team to collect information on these deaths from multiple agencies is of benefit in better identifying these high risk youth for prevention purposes. For this reason, a separate Team, the Child and Adolescent Suicide Review Team, was created in 2001 to review these cases.

Undetermined deaths reflect situations in which the Coroner is unable to fix a final mode of death. These cases often involve insufficient or conflicting information which impacts the Coroner's ability to make a final determination. Usually, there is no clear indicator in these cases whether the death was intentionally caused by another or was accidental. These cases remain suspicious in nature and are of interest to the Team because a final determination cannot be made by the Coroner.

Table 1: Child Deaths in Los Angeles County 2011 – 2015

Over the past 5 years, a parent, caregiver or other family member has murdered an average of 18 children each year.

2011	24
2012	14[1]
2013	19
2014	14
2015	18

An average of 16.4 children and adolescents have committed suicide over the past five years. The leading method from 2011 through 2015 was hanging.

2011	19
2012	17
2013	13
2014	10
2015	23

An average of 95.4 children have died from preventable accidents over the past five years. The most common accidental deaths involve automobile accidents, prenatal substance abuse and deaths due to auto vs. pedestrian.

2011	88
2012	89
2013	93
2014	103
2015	104

The number of undetermined deaths has averaged 82.4 per year over the past five years

2011	111[2]
2012	99[3]
2013	90
2014	68
2015	44

1 After a review of a homicide involving a fetal death, the Team recommended the mode be changed to undetermined. In 2016, the Medical Examiner-Coroner changed the mode to undetermined.

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

3 After a review of a homicide involving a fetal death, the Team recommended the mode be changed to undetermined. In 2016, the Medical Examiner-Coroner changed the mode to undetermined.

Figure 1: 2011 - 2015 Los Angeles County Child Deaths

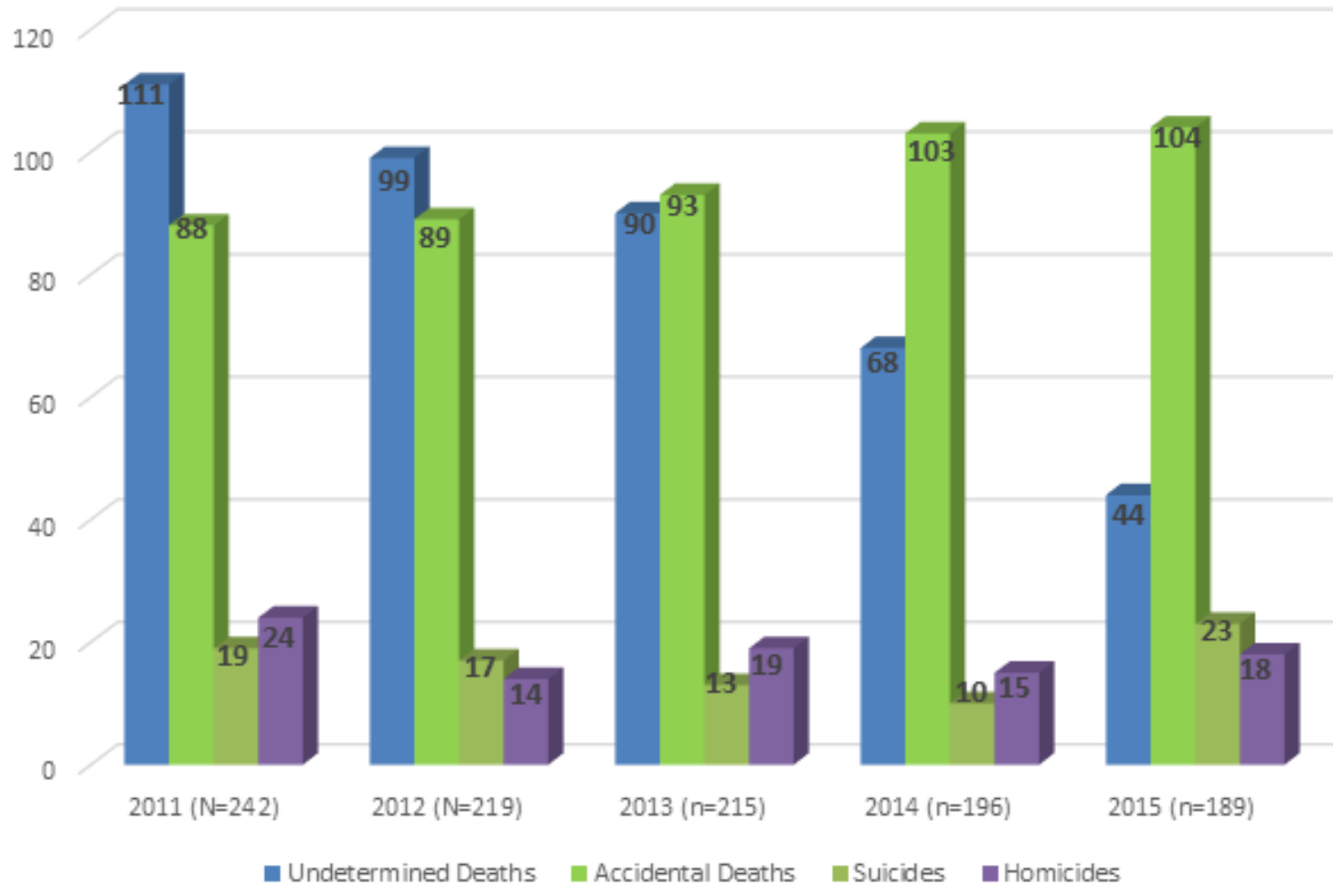
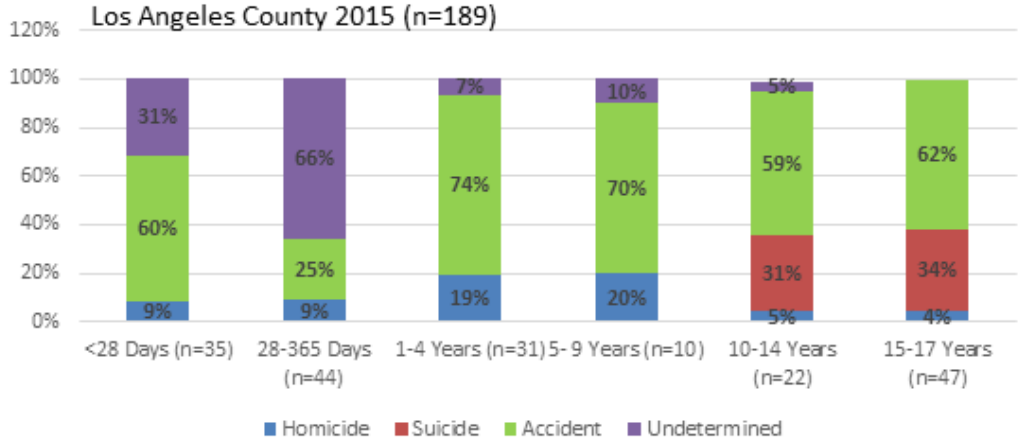


Table 2: 2015 Child Deaths Demographics - Coroner Cases

	NUMBER	PERCENTAGE
Total	189	100
Gender		
Female	68	36
Male	120	63.5
Unknown	1	.5
Age		
Under 1 year	80	42.3
1 – 4 years	30	15.8
5 – 9 years	10	5.3
10 – 14 years	22	11.6
15 – 17 years	47	25
Race		
African American	45	23.8
Asian/Pacific Islander	17	8.9
American Indian	0	0
Caucasian	43	22.8
Hispanic	81	42.9
Unknown	3	1.6

Figure 2: Percentage of Child Deaths by Age Group and Manner, Los Angeles County 2015 (n=189)



Child Homicides by Parent, Caregiver, or Other Family Members 2015

Case Summaries

Child Homicide by Parent/Caregiver/Family Member

James

A 2 year old was beaten to death yet paramedics did not see any bruising and hospital personnel did not note much bruising when brought into the ER. His mother was not home and the children were in the care of the boyfriend. The boyfriend has remained consistent in his explanation and denies any abuse toward James. James's 4 year old sibling stated in interviews that the boyfriend bumped her brother in the bathroom and bedroom. At one interview she said her mother told her to go to her room. Although the boyfriend is the prime suspect, the timeline makes it possible the mother could have been the abuser and/or present.

The family blamed a relative who had been living in the home for causing the death due to food poisoning which led to hospitalization a week earlier. James was also seen two weeks prior to this at another hospital for vomiting. He was diagnosed with pancreatitis at the time which according to Team child abuse expert pediatricians was a red flag for abuse.

The mother had received child welfare services from 2011 to 2014 for an older sibling when the mother left the sibling infant with a relative with no plan. She completed her services and DCFS closed the case.

At autopsy, bruising was observed that was not evident at his admission to the ER. This child was brutalized with internal injuries to the head, neck, spine, abdomen and he bled out from a lacerated artery. The final mode of death was ruled a homicide. The case remains under investigation by law enforcement.

Carlos

Carlos, age one year was transported to the hospital after reportedly vomiting and becoming lethargic. He was found to have internal injuries to the spleen, liver, pancreas, bowel and healing and acute rib fractures. His abdomen was full of blood and he died three weeks later after four surgeries.

Three weeks prior to his fatal injuries, he was taken to an ER for vomiting and trouble breathing. Bruising was present on his chest. An x-ray was taken among other tests and while in the ER, his condition improved-he stopped vomiting, and was breathing better. He was diagnosed with a virus. No rib fractures were reported by the radiologist and the mother stated the child fell asleep on his toys as an explanation for the bruising on the chest. A couple of days later, the boyfriend brought the child into the kitchen where the mother was and said the child's eyes rolled back and he became stiff. She noticed his upper teeth to be bloody. She did not take him to an ER as he improved and she thought he had a seizure. She took him to her pediatrician the next day who advised they should have gone to the ER. He too, did not make a report for the bruises on the chest.

The mother's boyfriend admitted to punching the child with a closed fist 4-5 times. He was arrested and charged with murder. He was found guilty and sentenced to 50 years of prison.

Both of these cases demonstrate the difficulty of ferreting out abuse vs. illness. ER staff is more likely to be biased more toward illness rather than non-accidental trauma. In this case, the radiologist did not report rib fractures but was probably focused on looking for other findings to explain his difficulty breathing.

Henry

Law enforcement received a call from 17 year old Henry's mother stating she just shot her son. When they arrived on the scene, a motel, they found the teenager lying on the bed with two gunshot wounds to the torso. He was pronounced deceased and not transported to a hospital. His mother told officers that she was terminally ill with cancer and her husband deceased. She reported Henry was severely mentally ill and there was no living relative to care for him upon her death. She was fearful of what would happen to her son once she was gone and did not want him to harm anyone. She did not turn the gun on herself because she wanted to suffer for what she had done.

She was arrested for his murder and charged by the District Attorney. She died nine months later while in custody awaiting trial.

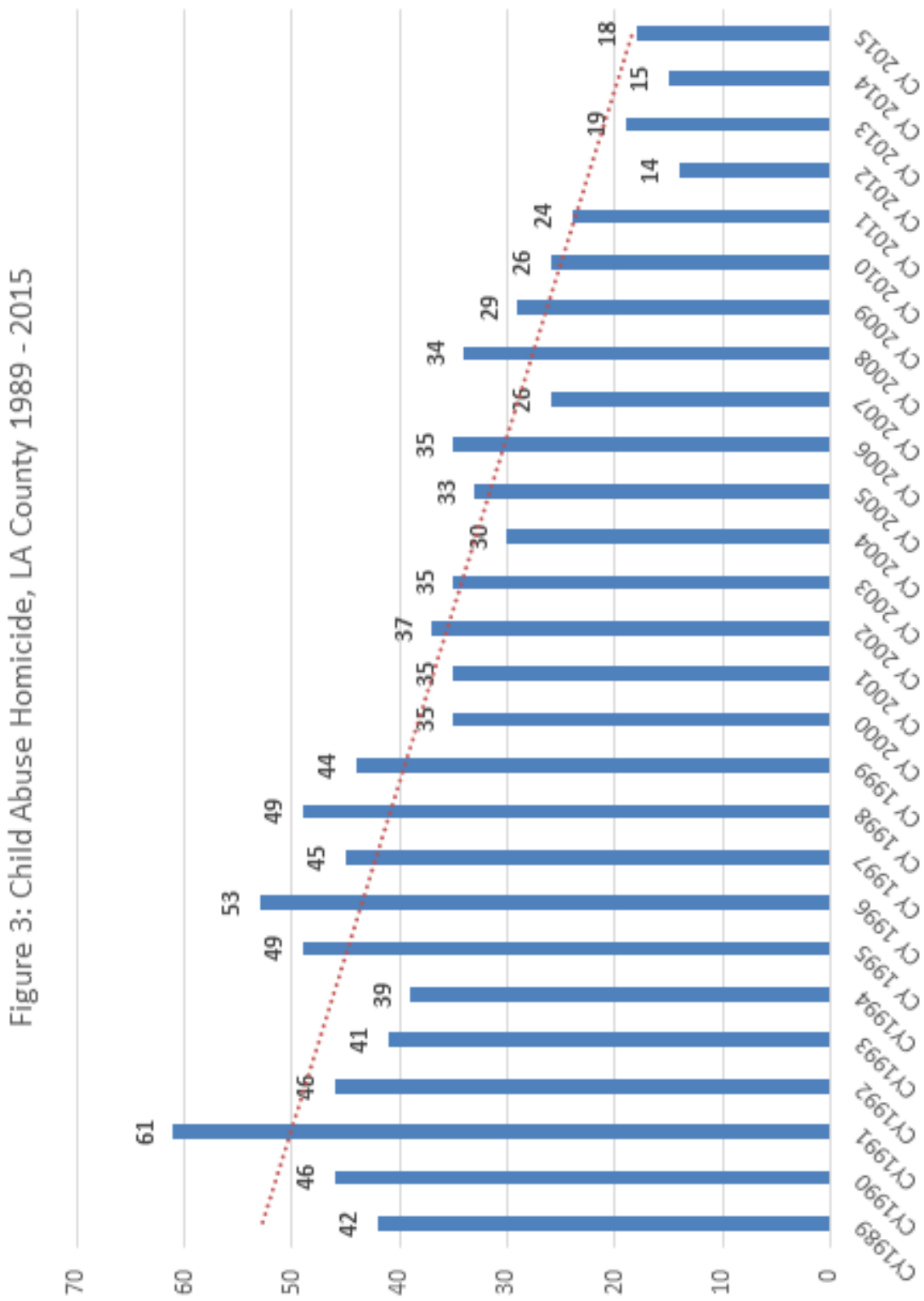


Figure 3: Child Abuse Homicide, LA County 1989 - 2015
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Table 3: Causes of Child Homicide by Parent/Caregiver/Family Member 2001– 2015, Los Angeles County

	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	Total
Head trauma	5	2	7	7	6	11	11	12	8	2	10	5	3	1	2	**92**
Multiple trauma*	7	7	10	7	8	7	7	4	2	1	6	2	9	5	5	**87**
Asphyxiation/suffocation	8	5	6	5	5	6	6	3	2	3	2	0	1	1	2	**55**
Gunshot wounds	2	1	4	3	6	1	1	8	7	4	2	0	0	1	1	**41**
Trauma to torso/abdomen	0	3	0	0	2	1	1	1	1	5	1	2	1	1	0	**19**
Drowning	1	7	1	1	2	3	3	0	1	2	0	3	1	0	2	**27**
Stabbing	1	2	0	3	2	2	2	2	4	6	1	1	1	4	4	**35**
Unattended newborn	3	2	3	0	2	0	0	1	2	1	0	0	1	0	0	**15**
Poisoning/drug ingestion	3	6	1	1	2	0	0	0	0	0	0	1	1	0	1	**14**
Dehydration/malnutrition	1	0	1	2	0	0	0	1	1	0	1	0	0	1	0	**8**
Strangulation	0	0	0	0	0	1	1	0	0	1	0	1	0	0	0	**4**
Fire	0	0	0	0	0	3	3	1	0	0	0	0	0	0	0	**7**
Medical neglect	2	0	0	0	0	0	0	0	1	1	0	0	0	1	1	**6**
Burns	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Hyperthermia	0	0	2	0	0	0	0	1	0	0	0	0	1	1	0	**4**
Post-Term gestation	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	**1**
TOTAL	**34**	**35**	**35**	**29**	**33**	**35**	**35**	**34**	**29**	**26**	**24**	**15**	**19**	**15**	**18**	**416**

*includes auto injuries

Table 4: Child Homicide by Parent/Caregiver/Family Member
Los Angeles County – 2015 (N= 18)

Age	Under 1	1 year	2 years	8 years	9 years	10 years	15 years	17 years	TOTAL
Female	3	0	0	0	0	0	1	0	4
Male	4	5	1	1	1	1	0	1	14

72.2% of the child homicide victims by parents/caregivers/family member were two years of age or under. There were no child abuse homicide victims between the ages of 3 – 5 years in 2015.

38.9% of the child homicide victims by parents/caregivers/family member were under one year of age.

77.8% of the victims were male and 26.3% were female.

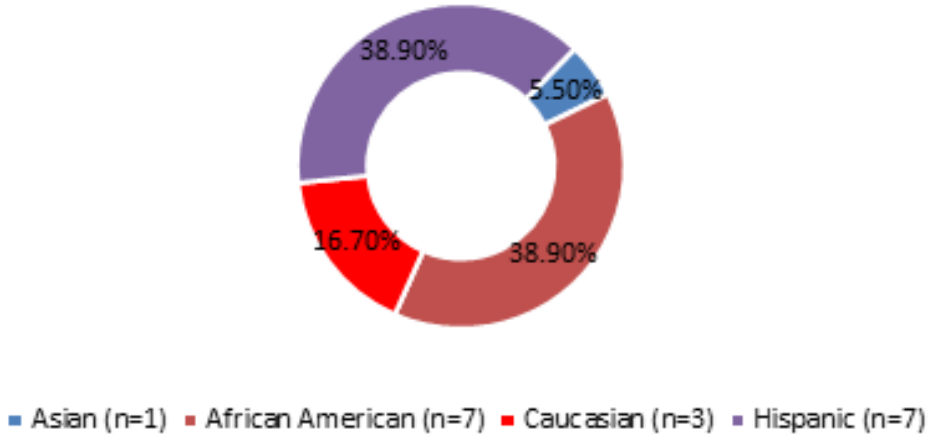
Table 5: Child Abuse Homicides by Age and Cause - 2015

	< 6 Months	6 - 11 Months	1 - 3 Years	3+ - 5 Years	6 - 12 Years	≥ 13 Years
Head trauma	0	0	2	0	0	0
Multiple trauma	3	0	2	0	0	0
Asphyxiation	0	1	1	0	0	0
Gunshot wounds	0	0	0	0	0	1
Drowning	2	0	0	0	0	0
Stabbing	0	0	0	0	3	1
Poisoning	1	0	0	0	0	0
Medical Neglect	0	0	1	0	0	0
TOTAL	**6**	**1**	**6**	**0**	**3**	**2**

Table 6: Five Year Trend of Child Homicides by Age

	2010	2011	2012	2013	2014	2015	Total	%
Under 1 year	8	13	8	8	3	7	47	40.2
1 - 2 years	10	8	3	6	6	6	39	33.3
3 - 5 years	2	1	2	2	2	0	9	7.7
6 - 10 years	4	2	1	2	2	3	14	12
11 - 17 years	2	0	1	1	2	2	8	6.8

Figure 4: 2015 Child Homicides - Race



Los Angeles Child Population
Ages 0-17: 2,325,047
Hispanic 61.7%, Caucasian 17%, African American 7.5% , Asian/Pacific Islander 10.5%, Native Indian/Alaskan .1% and Multi-racial 3.2% Kidsdata.org

Figure 5: Homicides of Children by Race Compared to the General Population 2015

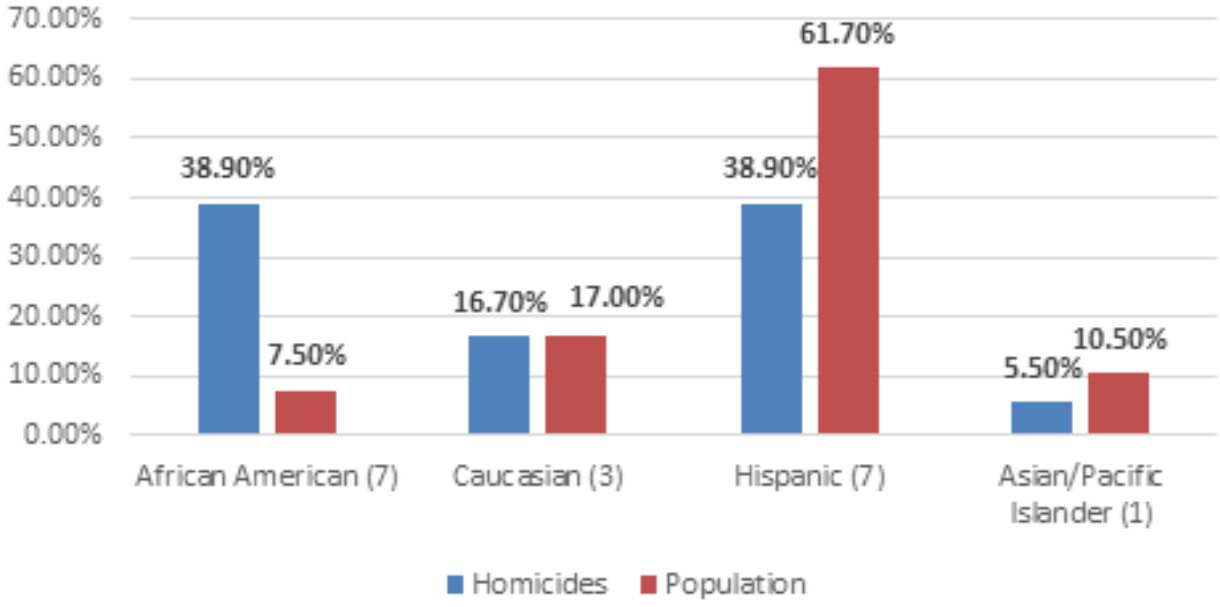


Table 7: Relationship of Suspect to Child Homicide Victim – 2015

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

10 – Father

4 – Mother

3 – Mother's Boyfriend

1 – Mother and Father

1 – Mother and Mother's Boyfriend

1 – Minor Brother

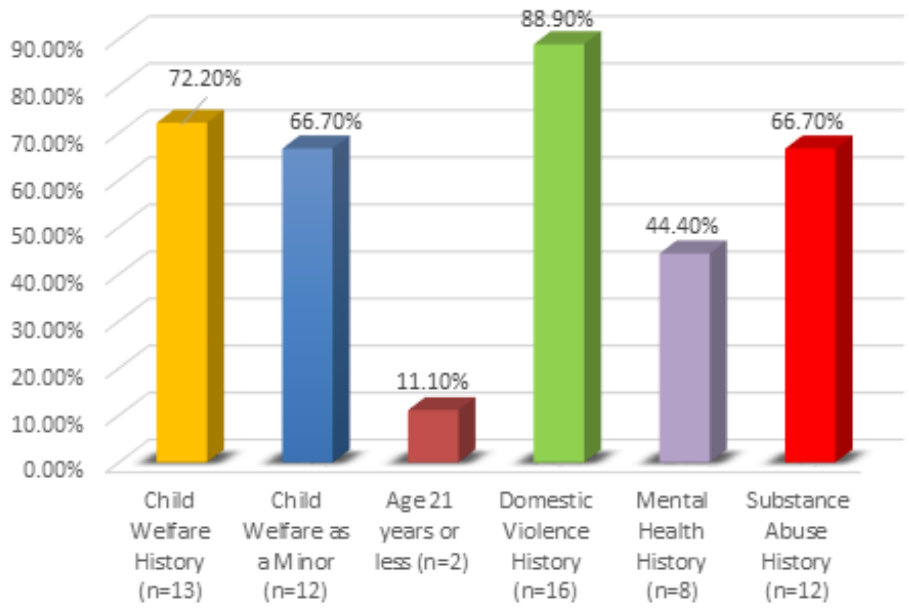
Table 8: Relationship and Age of Suspect to Child – 2015

Relationship	Total	< 18 years	18-21 years	22-25 years	26-30 years	31-40 years	40+ years
Mother's Boyfriend/ Stepfather	4	0	0	3	1	0	0
Biological Mother *	7	0	1	3	2	0	1
Biological Father	10	0	0	0	6	4	0
Brother	**1**	**1**	**0**	**0**	**0**	**0**	**0**
Total	**22**	**1**	**1**	**6**	**9**	**4**	**1**

2

* The age and identity of one mother is unknown

Figure 6: 2015 Risk Factors Associated With Child Homicides (n=19)



The top common characteristic present in families in which a child abuse homicide occurred was a parent(s) and/or perpetrator had a documented history of domestic violence. This was followed by a parent(s) and/or perpetrator having had at least one prior child welfare contact. Sixty-three percent of the homicides had substance abuse history, as determined by the presence at the time of death or a family history and sixty-seven percent had a contact with child welfare or probation as a minor. A parent or perpetrator having a history of mental illness occurred in 44% or the child homicides.

Criminal Justice System Involvement

Information on the criminal justice system involvement in child homicides by parent/caregiver/family member is gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). Other police agencies participate in Team review of cases they have investigated. The law enforcement agencies and number of cases for which they are responsible for the investigation are shown in Table 8.

Table 9

Law Enforcement Agency Involvement in 2015 ICAN Child Homicide by Parent/Caregiver/Family Member

Agency	N	%
LASD*	6	33.3
LAPD	7	38.8
Downey P.D.	2	11.1
Huntington Park P.D.	1	5.6
Inglewood P.D.	1	5.6
Claremont P.D.	1	5.6

*LASD Homicide took over an investigation at the request of Hawthorne P.D.

The Los Angeles Police Department and had investigative responsibility for a majority of the child homicides by parents/caretakers/family member with 38.8% (n=7). Los Angeles Sheriff's Department Homicide Bureau investigated 33.3% (n=6). Twenty-eight percent (n=5) of the cases were handled by jurisdictions other than LASD and LAPD.

There were a total of twenty-two suspects in the nineteen homicide cases. Six of the 2015 cases involving child homicide by parents/caregivers/family member were not presented to the District Attorney. The reasons why those cases were not presented are displayed in Table 10.

In 2015, two of the homicide cases involving siblings were not submitted to the District Attorney because the perpetrator committed suicide. The second reason for law enforcement not presenting a case was that the case remains under investigation. One open investigation case pertains to a child whose formula was poisoned and the suspect is not cooperating with law enforcement. Another open investigation involves a child who died due to medical neglect. Although deemed a homicide by the coroner, law enforcement is not investigating a case involving a stillborn deemed to be nonviable given the estimated gestation age of 21 weeks.

Table 10		
Law Enforcement Reasons for Not Presenting 2015 ICAN Child Homicide by Parent/Caregiver/ Family Member to the District Attorney		
	N	**%**
Under Investigation	4	50
Murder/Suicide	2	33.3
No Investigation	1	16.7
TOTAL	7	100

Table 11		
Relationship of Perpetrators – 2015 ICAN Child Homicide by Parent/Caregiver/Family Member		
Relationship	**Charged By District Attorney**	**%**
Mother	3	23.1
Father	6	46.1
Mother's Boyfriend	3	23.1
Brother	1	7.7

In 2014, 13 of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving 11 perpetrators. The District Attorney filed charges in all thirteen cases.

The charge filed by the District Attorney in the past seven years is illustrated by Table 12. Defendants were charged with Murder (187 (a) P.C.) on all the cases in which charges were filed.

Table 12

Criminal Charges Filed on 2009-2015 ICAN Child Homicide by Parent/Caregiver/ Family Member

	2009	2010	2011	2012	2013	2014	2015
Murder (187 (a) P.C.)	13	16	13	11	15	13	11
Assault on a child under 8 years resulting in death (273ab P.C.)	11	7	14	8	11	7	3
Child abuse leading to death of a child (273a(a) P.C.)	5	10	8	4	1	6	1
Child endangering (273a(1) P.C.)					1	1	
Corporal punishment or injury of child (273d P.C.)							
Voluntary manslaughter (192a P.C.)		1	1				
Involuntary manslaughter (192b P.C.)							
Vehicular manslaughter DUI with gross negligence (191.5(a) P.C.)							
Vehicular manslaughter (192 (c) P.C.)							
Vehicular manslaughter for financial gain (192(c)(3) P.C.)							
Attempted murder (664/187 (a) P.C.)		3					
Attempted robbery of person (664/211 P.C.)							
Lewd and lascivious acts by force (288(b)(1) P.C.)				5			
Kidnapping (207a P.C.)							
Battery (242-243(e) 1 P.C.)		1					
Torture (206 P.C.)	3	1		1		1	1
Mayhem (203 P.C)							
Assault to commit rape/mayhem		1					
Vandalism (594 P.C.)							
Aiding and abetting a designated felony (32 P.C.)		1					
Financial gain from prospective adoptive parents (273(d)(a) P.C.)							
Possession of marijuana for sale (11359 H&S)		1					
Fleeing pursuing peace officer (2800.2(a) V.C.)							
Criminal storage of a weapon with access to a child		2					

Table 13

Criminal Case Disposition of 2009 – 2015 Child Homicides[5]

	2009	2010	2011	2012	2013	2014	2015
Life without possibility of parole		2	2	1			1
80 years to life prison		1	1				
56 years to life prison				1			
50 years to life prison	1	2	2	1			1
40 years to life prison	1			1			1
31 years to life prison						1	
26 years to life prison							
25 years to life prison	2	7	4	2	5	3	4
22 years to life prison					1		
19 years to life prison							
18 years to life prison							1
17 years to life prison	1		1				
16 years to life prison			1	1			
15 years to life prison	2	2	1	1	1	3	1
14 years to life prison		1	2				
26 years prison	3	1		2	1	1	
25 years prison					1	1	
23 years prison							1
22 years prison						1	
20 years prison			1	1			
19 years prison			1				
18 years prison				1			
16 years prison	1					1	1
14 years prison					1		
13 years prison	1			2			
12 years prison	1	1	1				
11 years prison	1	2	1	3	2		1
10 years prison	1	1	1	1			
9 years prison				2			
8 years prison		1					
7 years prison			1	1			
6 years prison	1	1	2	2	2	1	
5 years prison		1	2		1		
4 years prison	1	1				1	
3 years prison	1						
3 years jail			1				
1 years jail		1	2	1			
Less than 3 months jail	1						
Found not guilty	1		1		1	1	
Dismissed		1		2	2	3	
Arrest warrant		1					
Mental competency hearing	1						
Pending Trial	1	2	4	2	12	7	9
Pending Further Investigation	2	3	5	3	4	2	1

[5] Criminal Disposition is the year a case concluded and includes cases filed in previous years

Criminal disposition data for 2009 through 2015 is presented in Table 13. The table reflects the year a perpetrator was sentenced and the majority of cases are concluded one to two years after the filing date. Of the 2014 child homicides, none of those charged had a disposition in 2015.

In 2015, defendants received the following sentences: Four perpetrators were sentenced to 25 years to life in prison and one sentenced 50 years to life. One perpetrator was sentenced to one to life without the possibility of parole. The remaining sentences varied from 10 to 23 years in state prison.

For 2009, one case is still under investigation. One 2010 defendant was sentenced to 25 years to life in 2015 and one was sentenced to 23 years state prison. A third defendant was sentenced to 15 years of state prison.

Two 2010 defendants are still awaiting trial. Four of the 2011 cases filed by the DA remain pending trial as of 2015.

There were convictions for 2011 defendants in 2015. One was sentenced to life without the possibility of parole. Another defendant received to 20 years and one 18 years in state prison. Three of the 2011 cases remain pending trial as of 2015.

One 2012 defendant was convicted in 2015 and received a 25 years to life sentence in state prison. Two of the 2012 cases remain pending trial as of 2015.

One 2013 defendant was sentenced to 25 years to life in 2015. Twelve of the 2013 cases filed by the District Attorney are awaiting trial.

In 2015, seven of the 2014 defendants are still awaiting trial. Two were convicted and sentenced. One received 16 years to life and the other 11 years of state prison.

Table 14

Child Homicides by Parents, Caregivers or Family Member
Child Welfare Involvement 2000 – 2015*

Year	Total # of homicides by parent/care giver/family member	Total # of homicides with DCFS family history(prior contact OR open case)	Of total with DCFS family history, the # of homicides that had PRIOR DCFS contact only	Of total with DCFS family history, the # of homicides in OPEN DCFS case or referral	# Killed by out-of-home caregiver
2001	35	12	7	5	3 – relative caregivers 2 – foster parent
2002	37	Not Available	Not Available	Not Available	0 – relative caregivers 1 – foster parent
2003	35	18	13	5	2 – relative caregivers 2 – foster parent
2004	30	15	9	6	2 – relative caregivers 0 – foster parent
2005	33	14	11	3	1 – relative caregivers 0 – foster parent
2006	35[6]	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3	1– relative caregivers 0 – foster parent
2008	34	14[8]	6	8	0 – relative caregivers 0 – foster parent
2009	29[9]	19[10]	14	5[11]	1 – relative caregivers 0 – foster parent
2010	26	13[12]	9	4	0 – relative caregivers 1 – foster parent
2011	24	6	2	4	0– relative caregivers 0 – foster parent
2012	15	7	4	3[13]	0 – relative caregivers 0 – foster parent
2013	19	11	7	4[14]	0 – relative caregivers 0 – foster parent
2014	15	12[15]	7	5	0 – relative caregivers 0 – foster parent
2015	18	13	11	2[16]	0 – relative caregivers 0 – foster parent

*Data is based on the Coroner's findings as Homicide and not the broader definition used by DCFS based on SB 39 Child Fatality Reporting and Disclosure Requirements[3]

6 The CDRT reviewed an undetermined child fatality and changed the manner of death to "homicide". The case was open to DCFS when the fatality occurred. Another open DCFS case with a homicide was autopsied in another county and not reported to ICAN for inclusion in the 2007 report.

7 One was open to another county.

8 ICAN counts only deaths in LA County ruled a homicide by the Coroner. Two children died in LA County but were injured in another county and under that county's CPS supervision.

9 In 2011, a homicide suspected of a familial relationship turned out to be a family acquaintance and it became a 3rd Party homicide. The 2009 homicides decreased from 30 to 29 as a result.

10 Includes two deaths with a CPS history in another state and one death with history in another county.

11 One child died in LA County was under the jurisdiction of Riverside CPS.

12 One child died in LA County had history in another county but not in LA County

13 One child was killed by a caregiver who had an open case with DCFS.

14 One case was open due to the child's injuries before death. The family had no prior DCFS history.

15 The mother in one case did not have a history with DCFS but the caregiver/perpetrator did. This case is not reflected in this table as the child was not placed with the caregiver by DCFS but by the mother.

16 One case was open due to the incident leading to the fatality. The family had no prior DCFS history.

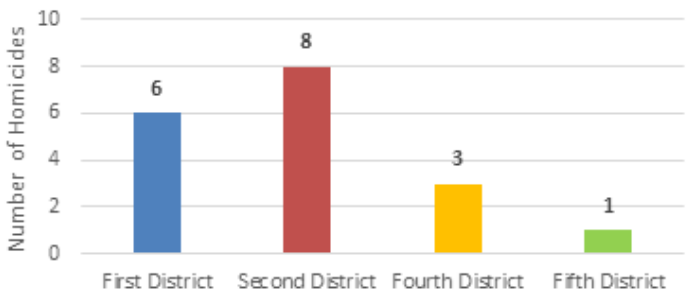
Table 15: Dates[17] of Child Homicides – 2015

2 homicides occurred in January (01/06 & 01/24/2014)
1 homicide occurred in February (02/27/2015)
1 homicide occurred in March (03/27/2014)
2 homicides occurred in April (04/16, 04/24 & 4/25/2014)
0 homicides occurred in May
3 homicides occurred in June (6/04, 06/12 & 06/25/2015)
2 homicides occurred in July (07/24 & 07/27/2015)
0 homicides occurred in August
3 homicides occurred in September (all on 09/09/2015)
2 homicides occurred in October (10/21 & 10/25/2015)
1 homicide occurred in November (11/04/2015)
1 homicide occurred in December (12/20/2015)

Table 16: Locations[18] of Child Homicides – Geographic Area – 2015

1 homicide occurred in Los Angeles (zip code 90002)
1 homicide occurred in Los Angeles (zip code 90003)
3 homicides occurred in Los Angeles (zip code 90011)
2 homicides occurred in Los Angeles (zip code 90044)
1 homicides occurred in Los Angeles (zip code 90047)
1 homicide occurred in Newhall (zip code 91321)
1 homicide occurred in Claremont (zip code 91711)
1 homicide occurred in Rosemead (zip code 91770)
1 homicide occurred in Compton (zip code 90221)
2 homicides occurred in Downey (zip code 90241)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in Huntington Park (zip code 90255)
1 homicide occurred in Inglewood (zip code 90301)
1 homicide occurred in Whittier (zip code 90650)

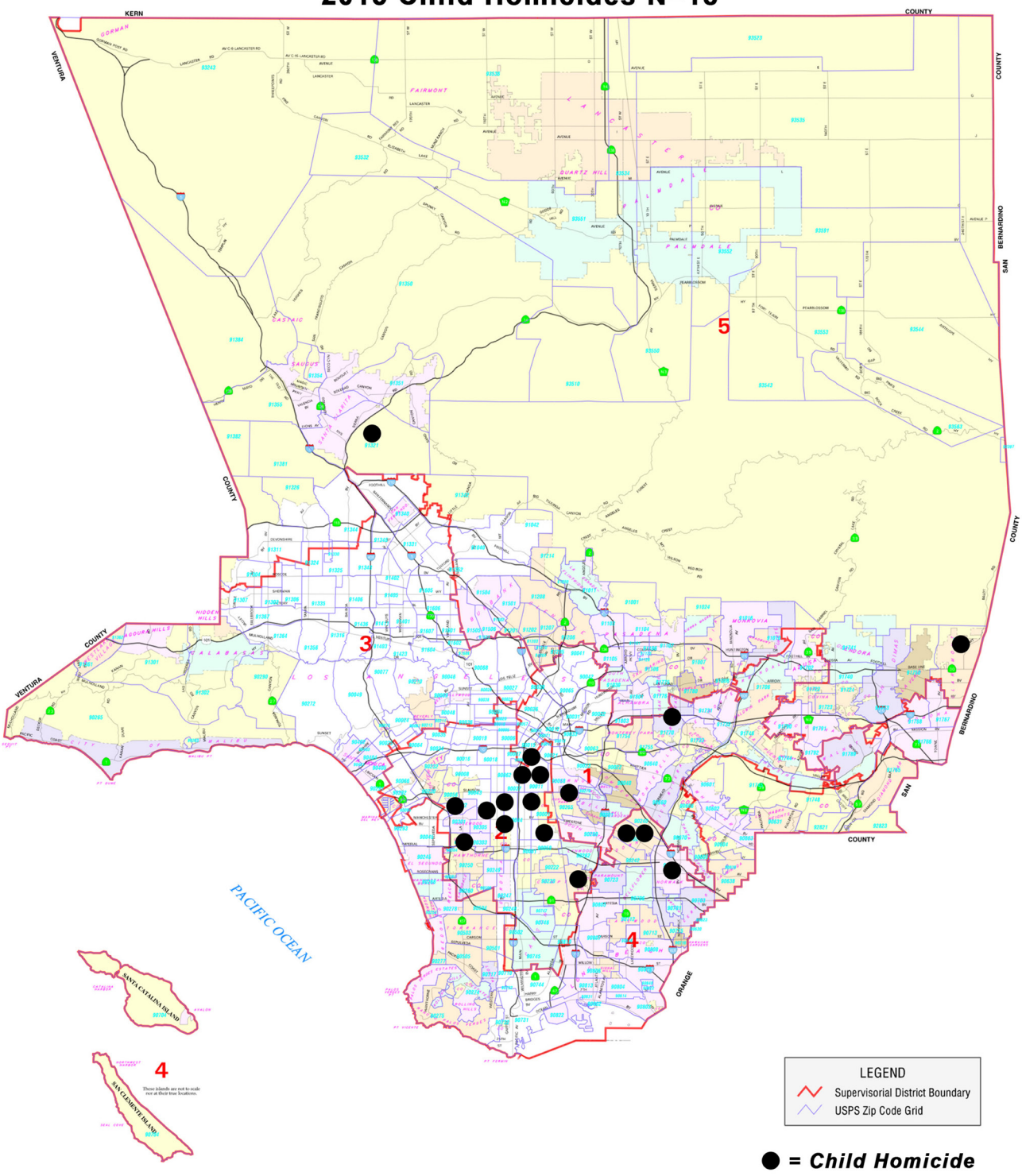
Figure 7: 2015 Child Homicides by Board of Supervisor District



17 This is the date of death, which, in the majority of cases coincides with the date the injury occurred leading to the child's death.

18 City where the fatal injury or fatality occurred

2015 Child Homicides N=18



Case Summaries

Child Homicide by Parent/Caregiver/Family Member

Ricardo

Ricardo was a 17-year-old Hispanic male with a history of depression and suicidal thoughts in the year prior to his death. He was not taking any medication. A year ago, he told his mother he was feeling suicidal and he attempted suicide by cutting himself. He was hospitalized after this attempt and prescribed medication. Once released from the hospital, he stopped taking the medication because he did not like the way it made him feel. He was not seeing his therapist on a regular basis. He also quit high school shortly after his hospitalization. In the days leading up to his suicide,Ricardo was having problems with his girlfriend and displaying mood swings ranging from anger to sadness. He was punching holes in walls and frequently seen crying. He did not drink alcohol but smoked marijuana regularly. His mother last saw him as she left for work. When she returned home later in the day, she found him hanging by a belt from a door. No note was found.

Daniel

Daniel, a 14-year old, Caucasian male, was found in his backyard with a gunshot to the chin by his mother who just returned home from a PTA meeting. Daniel was a straight A student with no history of depression or suicidal indicators. He had many friends, played sports and was well liked. His suicide shocked his family, friends and school as no one saw any indication that he was suicidal.The gun belonged to Daniel's father who kept it locked in a gun safe. Daniel did know how to use a gun and how to unlock the safe. He left a note that stated he couldn't take it anymore and that he held on too long. He considered himself mean but not a bully. The note didn't really state a reason for his decision to end his life.

Janet

Janet, a 14 year old Hispanic female, hung herself with a belt in her walk-in bedroom closet. Her mother went to get her to come eat dinner when she was found. Janet had a history of depression and multiple psychiatric hospitalizations for depression and suicidal ideation or attempts. She also had a history of cutting. Her parents had thought she was doing better and stopped her medication three months earlier. She had been going out more socially with friends. She attended continuation school as she missed too much school due to her past hospitalizations. She left a note stating she was unhappy and the world was mean. Her older brother reported she was questioning her sexual identity and saw herself as bisexual and possibly a lesbian. Her parents were unaware of this but he felt they would have been accepting.

Figure 8: 2001 - 2015 Child and Adolescent Suicides

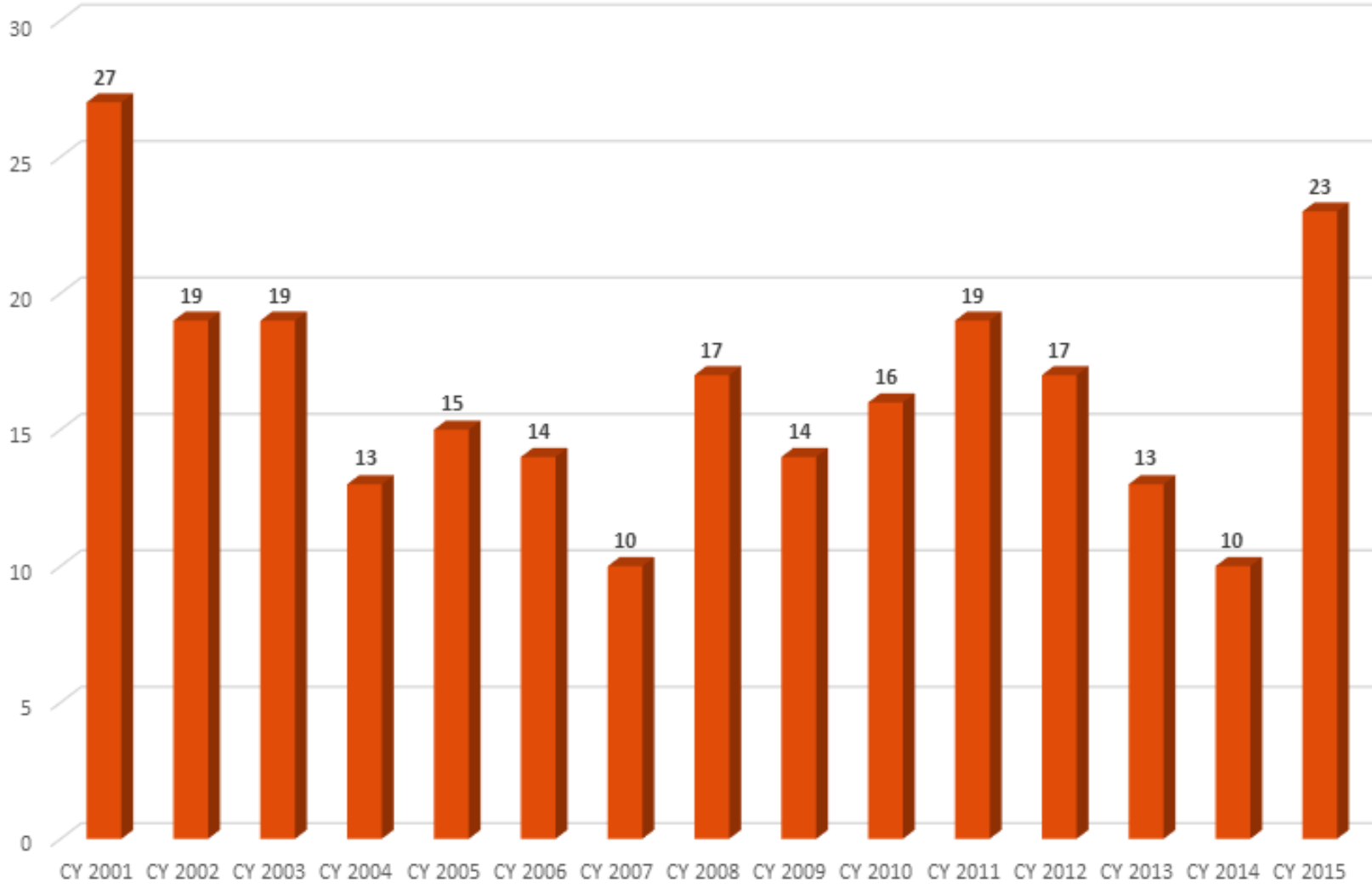


Table 17: Child and Adolescent Suicides by Method and Gender

Los Angeles County – 2015 (n = 23**)**

Method	Male	Female
Hanging	6	8
Firearms/Gunshot	7	0
Jump from height	1	0
Overdose	0	1
TOTAL	14	9

Hanging was the most frequent method of suicide among adolescents and represents 61% of the suicides in 2015. Use of a firearm was the second most frequent method of suicide in 2014 with seven. One youth jumped to his death and one overdosed.

In 2015, the gender gap between males and females ending their own lives increased with 61% (n=14) of the adolescent suicide victims being male and 39% (n=9) female.

Table 18: Five Year Suicide Trend-Gender

Gender	2011	2012	2013	2014	2015	Total 2011-2015	5 Year Average
Male	11	8	5	6	14	44	8.8
Female	8	9	8	4	9	38	7.6
Total	19	17	13	10	23	82	16.4

Figure 9: 2015 Child Suicides-Race

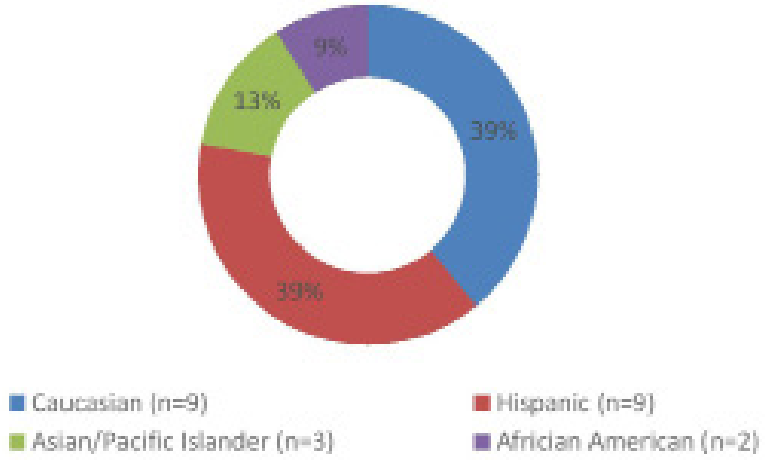


Figure 10: Suicides of Children by Race Compared to General Population 2015

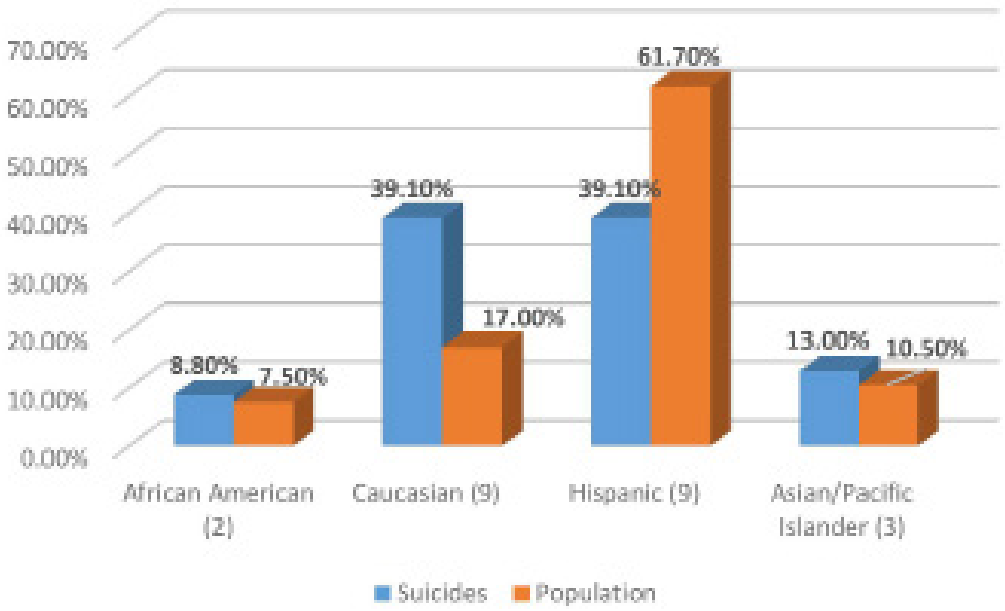
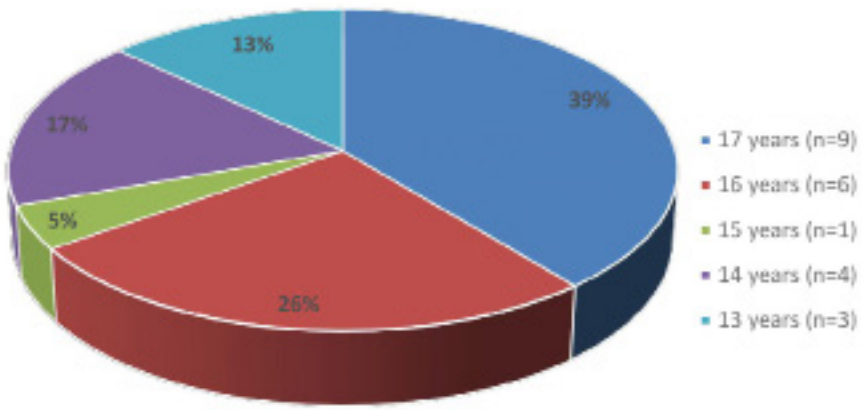


Table 19: Five Year Trend by Age							
	2011	2012	2013	2014	2015	Total	Percentage
Age							
17 years	6	7	4	1	9	27	33.0
16 years	5	3	4	2	6	20	24.4
15 years	3	5	2		1	11	13.4
14 years	2	2	1	3	4	12	14.6
13 years	2		1	2	3	8	09.8
12 years	1			1		2	02.4
11 years			1	1		2	02.4
Total	19	17	13	10	23	82	100

Figure 11: 2015 Child and Adolescent Suicides - Age



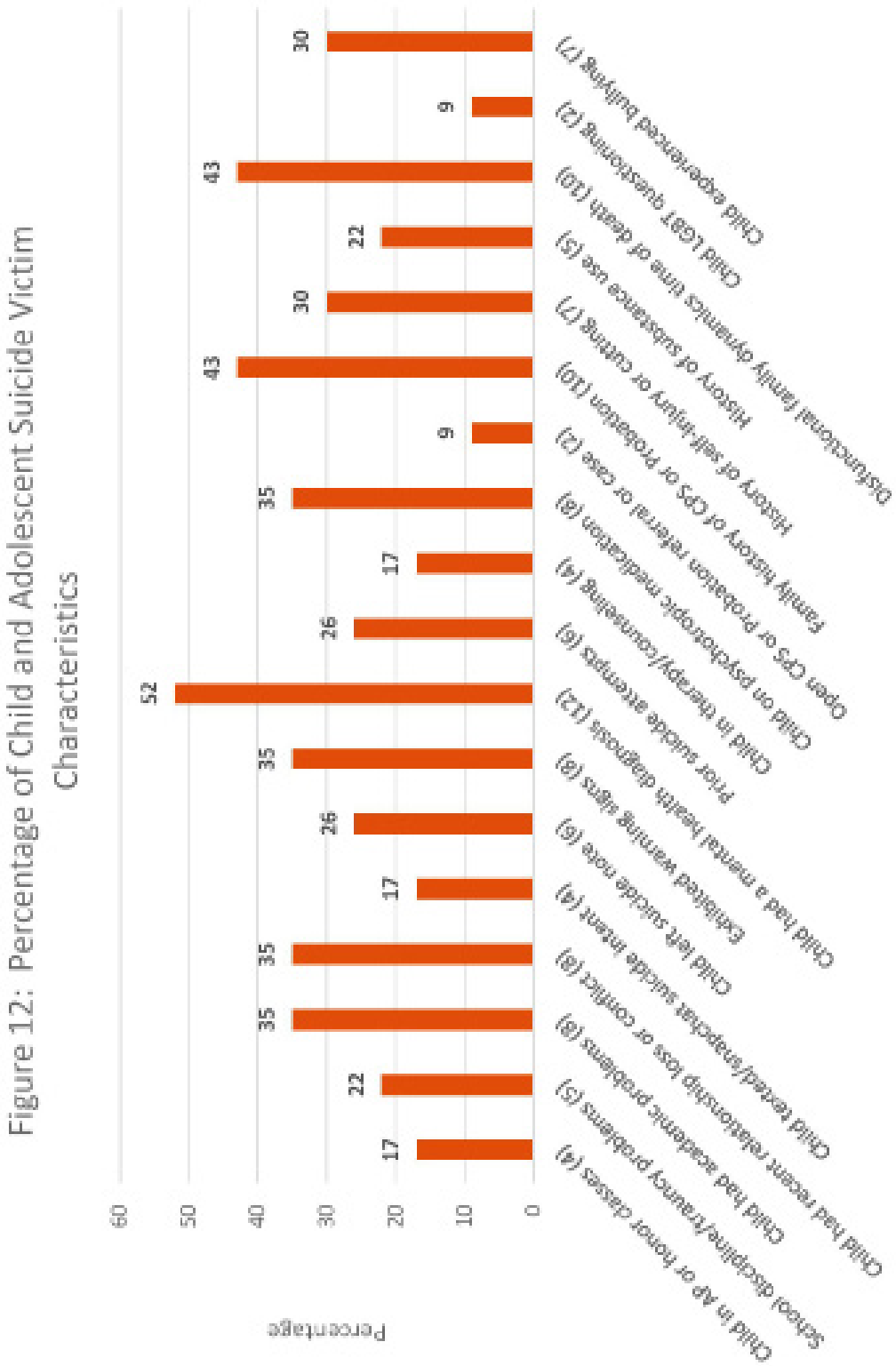


Figure 12: Percentage of Child and Adolescent Suicide Victim Characteristics
Percentage
0
10
20
30
40
50
60
17
22
35
35
26
17
35
52
26
17
35
9
43
30
22
43
9
30
Child in AP or honor classes (4)
School discipline/truancy problems (5)
Child had academic problems (8)
Child had recent relationship loss or conflict (8)
Child had recent/suspected suicide threat (4)
Child left suicide note (6)
Exhibited warning signs (8)
Child had a mental health diagnosis (12)
Prior suicide attempts (6)
Child in therapy/counseling (4)
Child on psychotropic medication (8)
Open CPS or Probation referral or case (2)
Family history of CPS or Probation (10)
History of self-injury or cutting (7)
History of substance use (5)
Child LGBT questioning (2)
Child experienced bullying (7)
Dysfunctional family dynamics time of death (10)

Table 20: Dates of Child and Adolescent Suicides – 2015

2 suicides occurred in January (01/22 & 01/25/2015)

3 suicides occurred in February (02/02, 02/16 & 02/17/2015)

3 suicides occurred in March (03/6, 03/11 & 03/29/2015)

1 suicide occurred in April (04/14/2015)

5 suicides occurred in May (05/12, 05/15, 05/18 & 2 on 05/19/2015)

1 suicide occurred in June (06/01/2015)

2 suicides occurred in July (07/11 & 07/14/2015)

1 suicide occurred in August (08/03/2015)

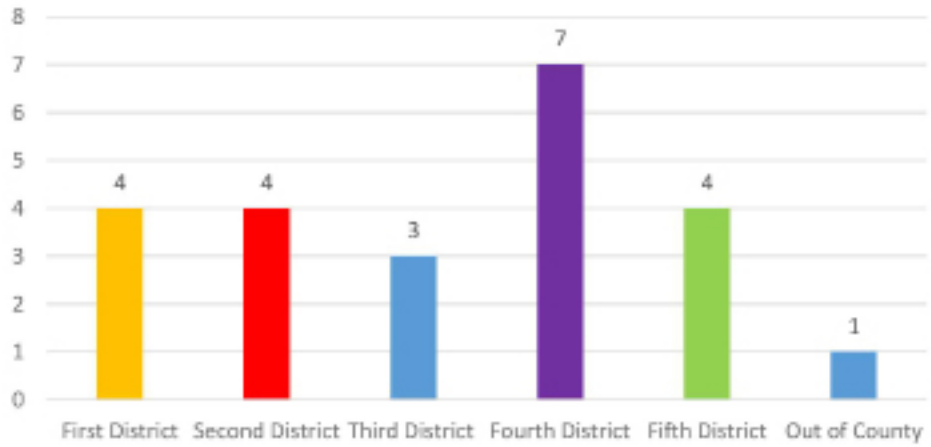
1 suicide occurred in September (09/17/2015)

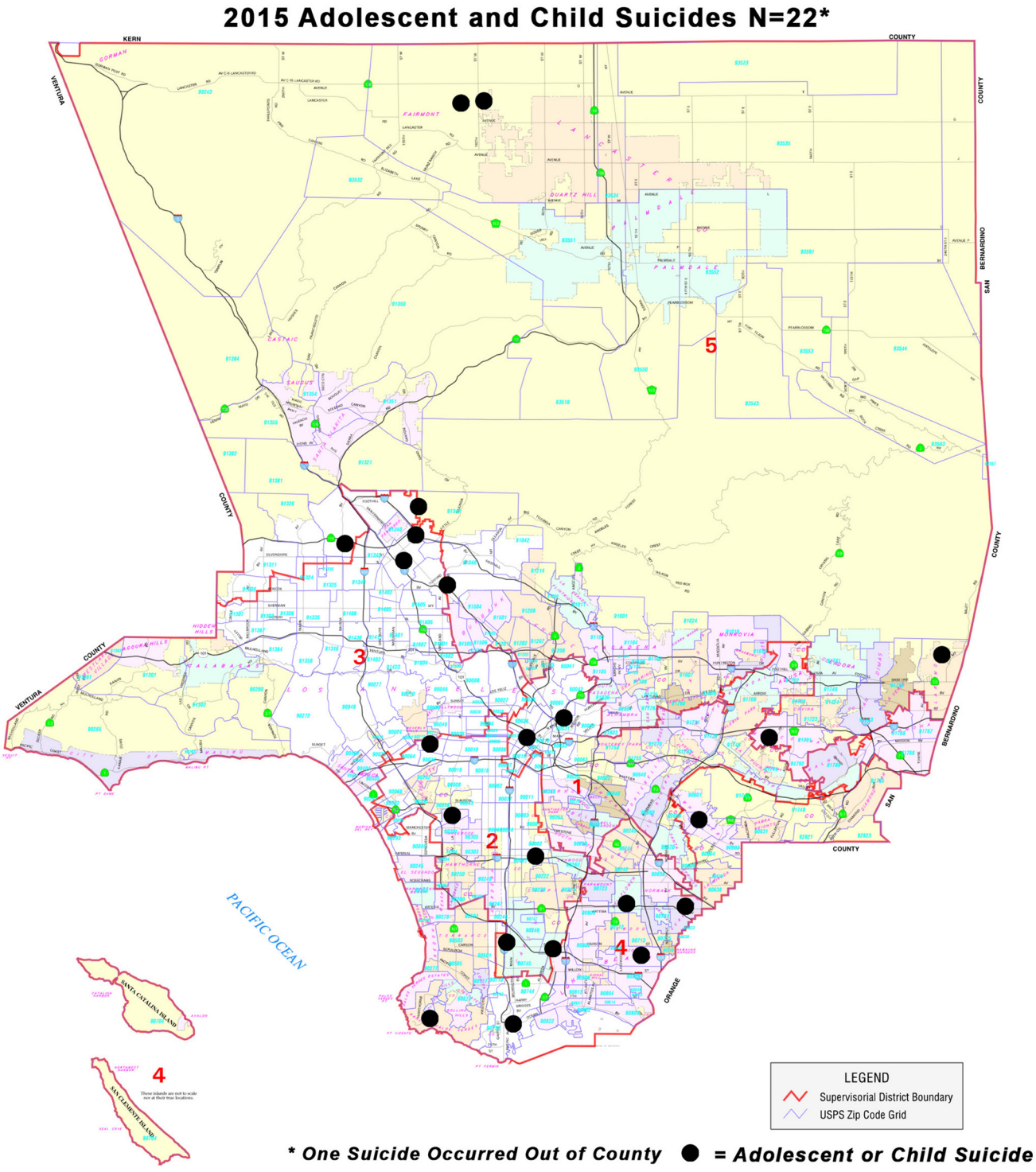
2 suicides occurred in October (10/06 & 10/15/2015)

1 suicide occurred in November (11/20/2015)

1 suicide occurred in December (12/22/2015)

Figure 13: Location of Suicide by Board of Supervisor District




2015 Adolescent and Child Suicides N=22*
KERN
COUNTY
VENTURA
COUNTY
BERNARDINO
SAN
COUNTY
5
3
1
2
4
PACIFIC OCEAN
SANTA CATALINA ISLAND
4
SAN CLEMENTE ISLAND
These islands are not to scale nor at their true locations.
ORANGE
LEGEND
Supervisorial District Boundary
USPS Zip Code Grid
* One Suicide Occurred Out of County
= Adolescent or Child Suicide

Case Summaries

Baby Girl Carlos

Twenty-four year old Naomi went to the hospital after she went to the rest room and a bag of water came out. A urine toxicology screen at the hospital yielded positive results for amphetamine and opiates. She had not received prenatal care. Baby girl was born via a spontaneous vaginal birth and weighed 370 grams at 24 weeks gestation. She was placed in the neonatal intensive care in an isolette for comfort care measures. She died within an hour and no resuscitative efforts were performed. This was Angela's fourth pregnancy. She had two live births and one abortion. DCFS detained her two children as a result of her drug use and the home found to be in a filthy condition.

Wendy

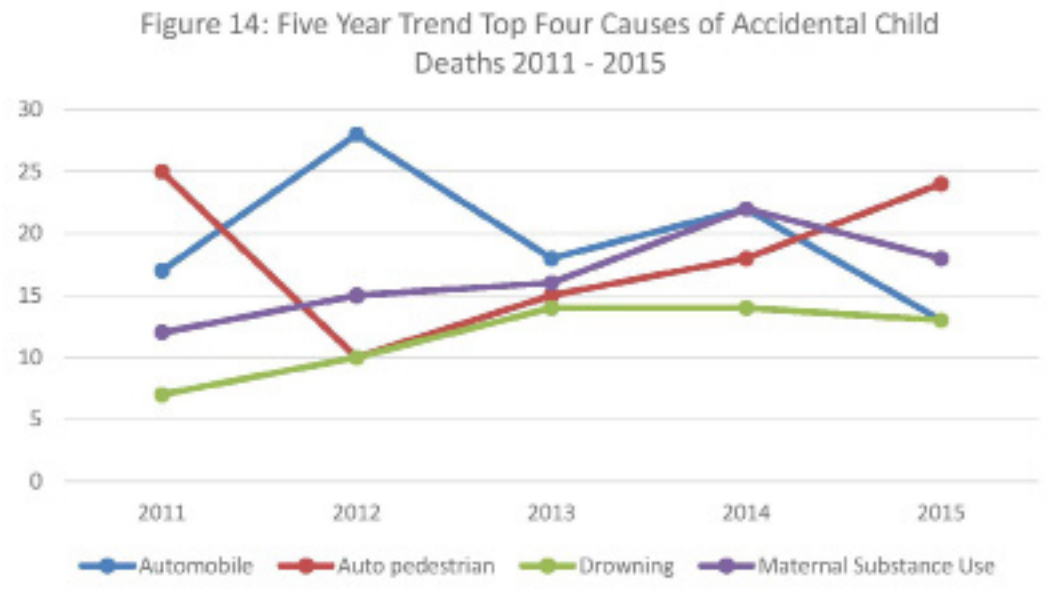
Four-old Wendy was walking with her mother in the early evening. They were returning to their home when her mother noticed one of Wendy's toys was missing. She looked across the street and saw it lying on the sidewalk. The mother crossed the street to retrieve the toy. Excited to see her toy, Wendy ran out between two parked cars to cross the street to her mother. As she stepped into the roadway, she was struck by a car going about 35 miles per hour. Wendy was thrown 60 feet and into the rear of a parked car along the street. The driver of the car failed to stop and sped off. Wendy was transported to the hospital but succumbed to her multiple injuries a short time later.

Dana

Three year old Dana was out with her family all day returning home in the late afternoon with her three older siblings. The family got out of the car and went inside. The parents assumed one of the siblings had helped Dana out of her car seat as that was the routine. The parents subsequently took a nap being tired from the outing. When the mother awoke, she realized Dana was not in the home. She ran outside to find her still strapped in the car seat drenched in sweat. She was unresponsive and hot to the touch. Dana was transported to the hospital in full cardiac arrest and pronounced in the ER.

Kate

Twenty-one month old Kate was with her family visiting relatives. She was put down for an afternoon nap. A half hour later, a cousin went to check on her and found the bed empty. Family members searched the home but she was not found. An uncle went into the backyard and observed her face down in the swimming pool. She was pulled from the pool and CPR started while 911 was called. Despite life saving attempts, she could not be resuscitated and her death was pronounced. Normally the pool is not accessible but someone had left the gate open and the toddler must have entered through the open gate.



The chart above depicts the top four causes of accidental child death over a five year period from 2011 to 2015. The "top four" causes-auto pedestrian (includes roll over), prenatal substance abuse automobile and drowning accounted for 65.3% of all accidental child deaths in 2015.

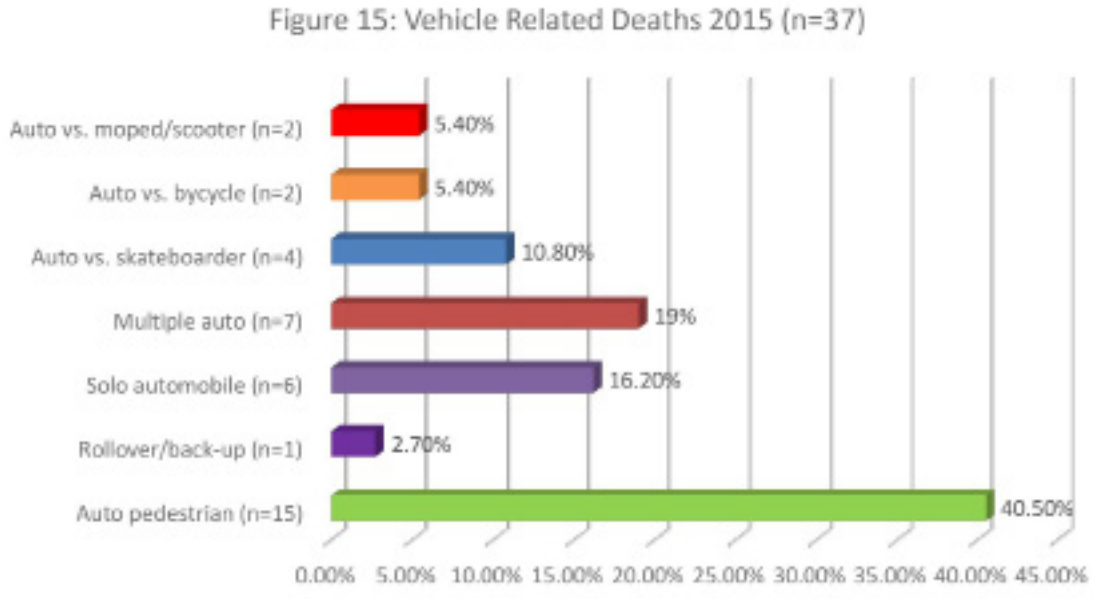


Figure 16: Drowning Victims by Age 2015

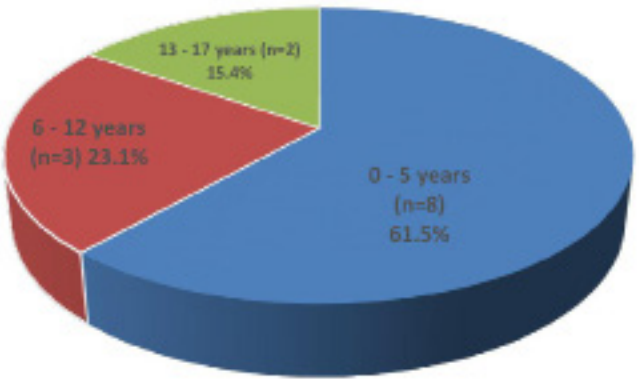


Table 21: Causes of Accidental Child Deaths, Ages 0 - 17 2015 - Los Angeles County (N = 104)

Automobile – multi-vehicle	7	6.70%
Automobile – solo vehicle	6	5.80%
Auto pedestrian	23	22.10%
Auto rollover	1	1.00%
Prenatal Substance Abuse	18	17.30%
Drowning	13	12.50%
Fall	8	7.70%
Fire	2	1.90%
Overdose/Poisoning	5	4.80%
Medical mishaps	4	3.80%
Hit by and Object	1	1.00%
Unsafe/Co-sleep	8	7.70%
Choking	1	1.00%
Asphyxia	1	1.90%
Dehydration	1	1.00%
Hypothermia	2	1.90%
Over eating	1	1.00%
Bicycle vs. wall	1	1.00%
Burns	1	1.00%
TOTAL	104	100%

Table 22: Causes of Accidental Child Deaths by Age 2015 - Los Angeles County (N = 104)

	Age 0 - 5 Years	Age 6 -14 Years	Age 15 - 17 Years
Automobile – multi-vehicle	0	2	5
Automobile – solo vehicle	0	3	3
Auto pedestrian*	5	5	14
Prenatal Substance Abuse	18	0	0
Drowning	8	4	1
Fall	3	3	2
Fire	2	0	0
Overdose/poisoning	2	1	2
Medical mishaps	4	0	0
Hit by object	1	0	0
Unsafe/Co-sleep	8	0	0
Choking	1	0	0
Asphyxia	1	0	0
Dehydration	1	0	0
Hypothermia	2	0	0
Over eating	0	0	1
Bicycle vs. wall	0	0	1
Burns	1	0	0
TOTAL	57	18	29

*includes rollover, moped, scooter and bike

Figure 17: 2015 Accidental Child Deaths - Race

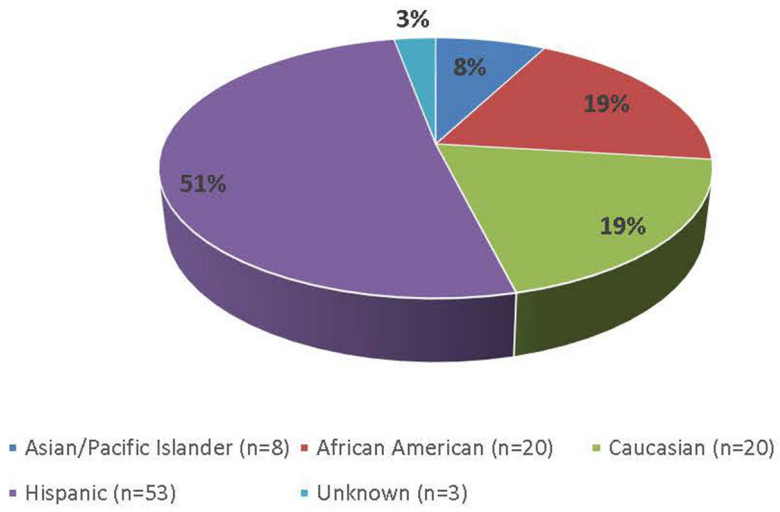


Table 23: Causes of Accidental Child Deaths by Gender 2015 – Los Angeles County (N = 104)

	Female	Male	Unknown
Automobile – multi-vehicle	2	5	0
Automobile –single	3	3	0
Auto rollover	0	1	0
Auto Pedestrian	6	17	0
Drowning	4	9	0
Overdose/poisoning	3	2	0
Prenatal Substance Abuse	11	6	1
Medical mishaps	2	2	0
Hit by object	1	0	0
Fire	2	0	0
Fall	4	4	0
Choking	0	1	0
Asphyxia	0	1	0
Unsafe/Co-sleep	3	5	0
Hypothermia	2	0	0
Dehydration	0	1	0
Burns	0	1	0
Over eating	0	1	0
Bicycle vs. wall	0	1	0
TOTAL	43	60	1

Table 24: Accidental Child Deaths Associated with Prenatal Substance Abuse (PSA) 2015 (N = 18)

Race	Number/Percentage of PSA Deaths
African American	5 (27.8%)
Caucasian	2 (11.1%)
Hispanic	9 (50%)
Asian/Pacific Islander	2 (11.1%)
Gender	
Female	11 (61.1%)
Male	6 (33.3%)
Unknown	1 (5.6%)
Age	
Stillborn	15 (83.3%)
1 day to 30 days	3 (16.7%)
Substance	
Methamphetamines	6 (33.3%)
Opiates	4 (22.2%)
Cocaine	2 (11.1%)
Marijuana	3 (16.7%)
Marijuana and methamphetamines	2 (11.1%)
Marijuana and cocaine	2 (11.1%)
Marijuana and opiates	1 (5.6%)

Figure 18: Accidental Child Deaths 2015 - Child Welfare History

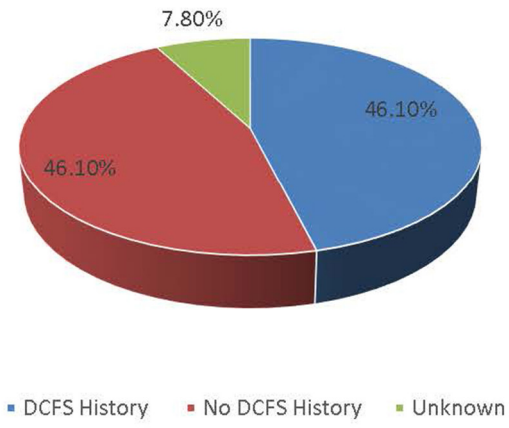


Table 25: Causes of Accidental Deaths with Child Welfare History - 2015 (n=44)

	Number	Percentage
Automobile*	4	9
Auto pedestrian**	11	25
Drowning	6	13.6
Overdose	2	4.5
Prenatal Substance Abuse	14	32
Choking	1	2.3
Asphyxia	2	4.5
Medical mishap	1	2.3
Hit by object	2	4.5
Hypothermia	1	2.3
TOTAL	44	100

*includes motorcycle

**includes rollover

Case Summaries Undetermined Child Deaths

Unsafe Sleep Practices and/or Environments and Maternal Substance Use

Burnett – Age 3 months

Burnett's mother was visiting with a friend. She fed the infant 5 ounces of formula and burped him. She put him down for a nap on the friend's queen size bed which was "made". He was placed in the middle of the bed on his back. There were no pillows, toys or other objects on the bed. When she returned to check on him a half hour later, Burnett had rolled over to his right and was now "facing down" on the bed. She rolled the infant over and noticed the baby had vomited formula from the mouth and nose. When she picked him up, she realized he wasn't breathing and more formula drained from his mouth and nose. She called out to her friend to call 911 and began CPR.

Jason – Age 2 months

Jason's parents routinely slept with him in their queen size bed. The mother breast fed him around four o'clock in the morning and placed him on his side next to her left side. She fell back to sleep and did not awaken until seven the next morning. The father got up first and went to pick Jason up. He was cold to the touch and not moving. Jason was found on his side next to his mother's back. A boppy pillow had been placed behind his backside and he was swaddled. A small amount of blood was observed on the sheet below where he was found. 911 was called and CPR initiated by the mother. Jason was pronounced at the scene by paramedics.

Cesar– Age 18 days

Cesar was born naturally without complications. He routinely slept on his back in either a bassinet or his parents' queen size bed. He was in good health. Both awoke at 3:00 am and the mother breast fed him as she was sitting on the bed. She burped him and put him on his back propped up by a pillow. He was not using a pacifier and was not swaddled. He was covered with an infant blanket and both went back to sleep. She was lying down on her side facing Cesar. The mother woke up at nine and looked at Cesar whose face was blue. He was not moving, cold to the touch and not breathing. The father called 911 and began CPR at the operator's instruction. Cesar was transported to the hospital but could not be revived.

Noah – 4 months

Noah was fed formula by his father, burped and placed face down in his bassinet for a nap. Noah's father had swaddled him prior to putting him down for a nap. The father went to check on Noah an hour later and found him in the same position but unresponsive and not breathing. Unable to wake him, the father called 911. Paramedics arrived and transported him to the hospital. Despite medical intervention, death was pronounced. The father stated he felt Noah slept better when placed on his stomach.

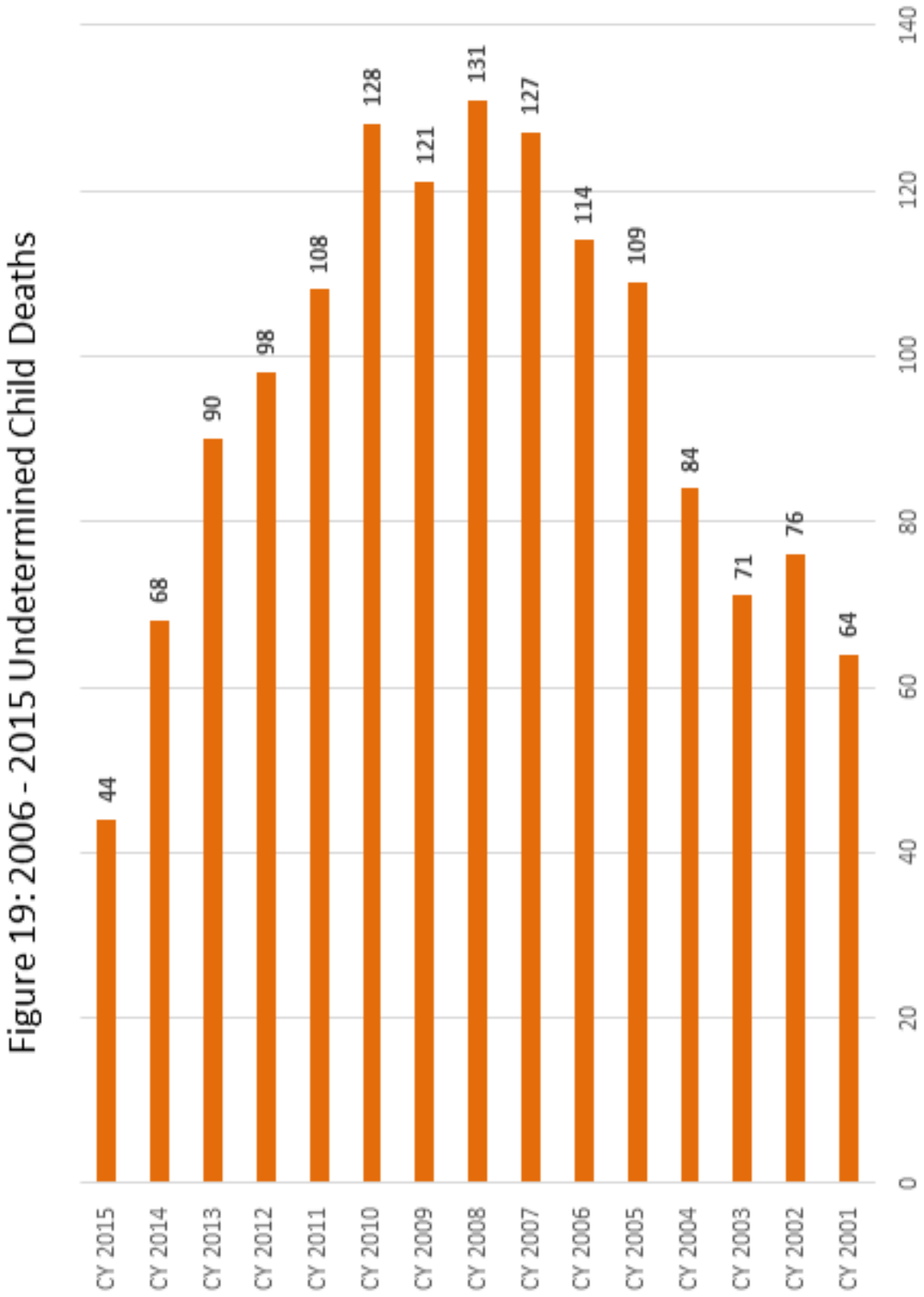


Figure 19: 2006 - 2015 Undetermined Child Deaths
CY 2015
CY 2014
CY 2013
CY 2012
CY 2011
CY 2010
CY 2009
CY 2008
CY 2007
CY 2006
CY 2005
CY 2004
CY 2003
CY 2002
CY 2001
44
68
90
98
108
128
121
131
127
114
109
84
71
76
64
0
20
40
60
80
100
120
140

Table 26: Undetermined Child Deaths – 2015 (N = 42)

Race	Number/Percentage of Undetermined Child Deaths
African American	16 (36.4%)
Asian/Pacific Islander	5 (11.3%)
Caucasian	11 (25%)
Hispanic	12 (27%)

Age	Number of Undetermined Child Deaths
Stillborn	5
Less than 1 day	1
1 day to 30 days	5
1 month to 5 months	16
6 months to 1 year	14
8 years	1
13 years	1

Gender	Number of Undetermined Child Deaths
Female	10 (22.7%)
Male	32 (77.3%)

61% of the undetermined child deaths were under six months of age.

93% of the undetermined child deaths were age one year or under.

Undetermined Child Deaths – Bed-sharing and Unsafe Sleeping Environment (N = 24)

Figure 20: Five Year Trend Bed-sharing/Unsafe Sleep Child Deaths

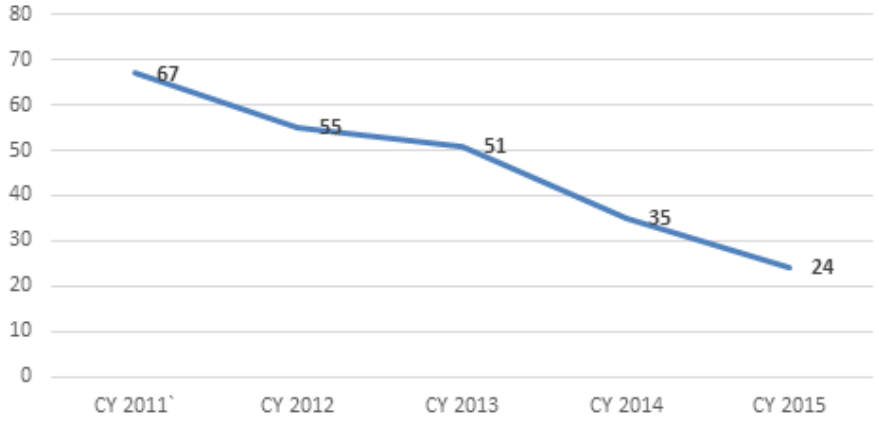


Figure 21: Bed-sharing and Unsafe Sleeping Undetermined Child Deaths 2015

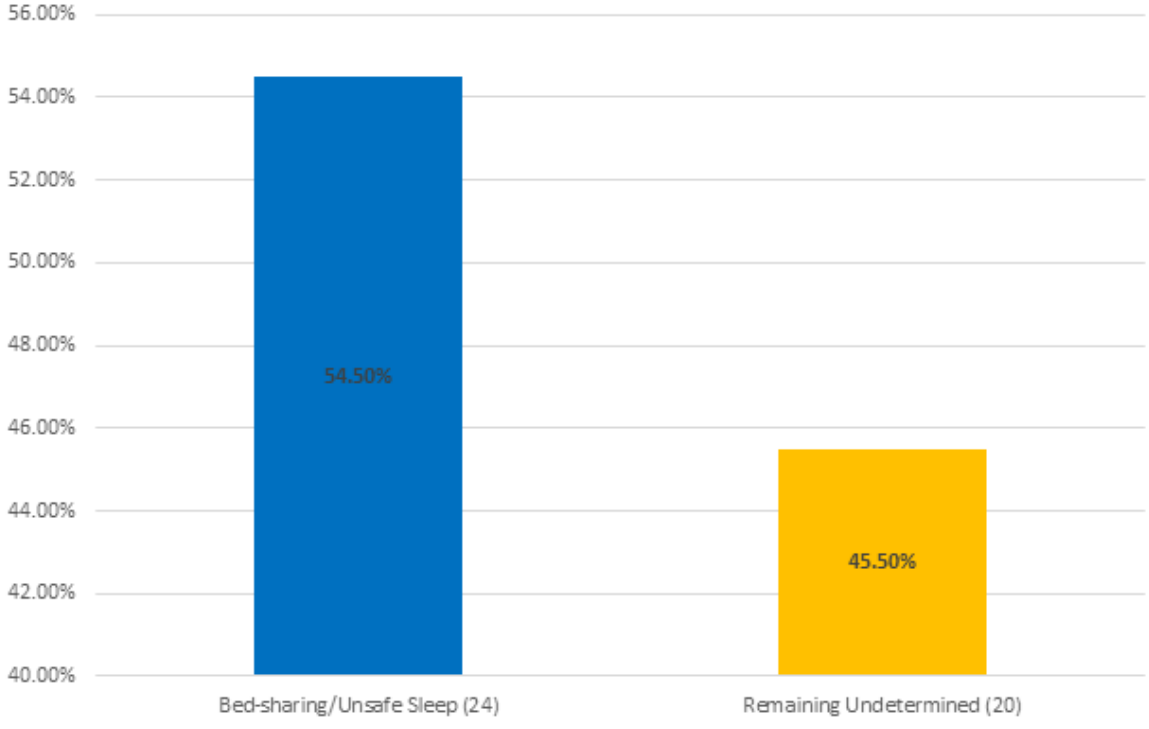


Figure 22: Unsafe Sleep and Bed-sharing Undetermined Deaths Compared to Remaining Undetermined Child Deaths - 2015

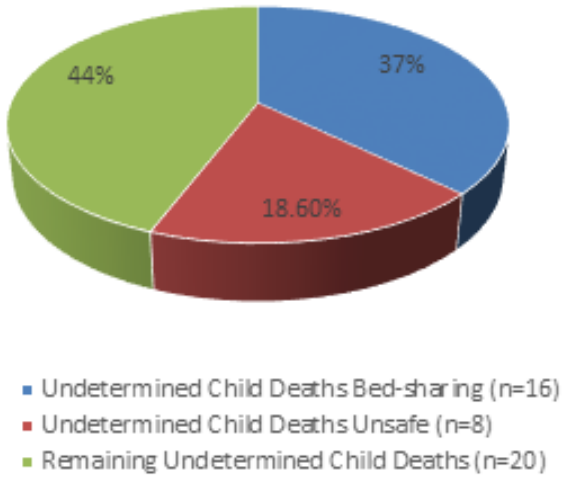


Figure 23: Bed-sharing and Unsafe Sleep Child Deaths by Board of Supervisor District - 2015

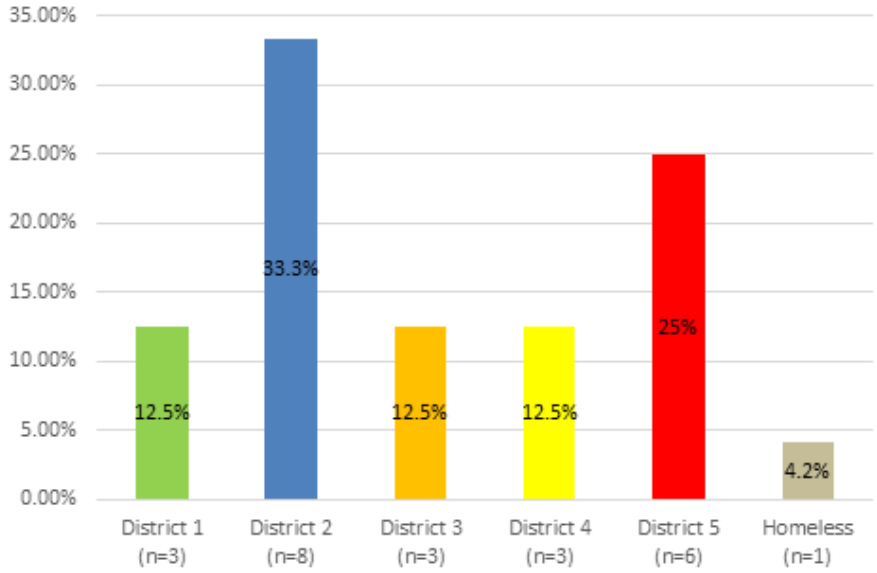


Table 27: Bed-sharing and Unsafe Sleeping Environments- Number of Risk Factors Present at Time of Death

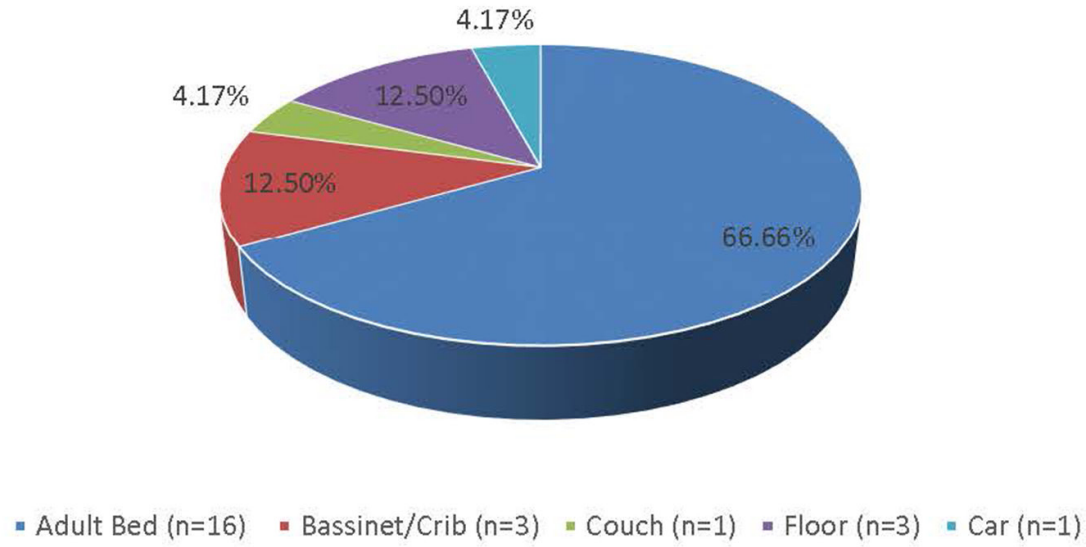
Bed-sharing* (N=16)	Number/Percentage of Child Deaths
One Unsafe Risk Factor	0 (0%)
Two Unsafe Risk Factors	11 (69%)
Three or more Unsafe Risk Factors	5 (31%)

Unsafe Sleeping Environment** (N=8)	Number/Percentage of Child Deaths
One Unsafe Risk Factor	2 (25%)
Two Unsafe Risk Factors	4 (50%)
Three or more Risk Factors	2 (25%)

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

**Includes adult bed, pillows, soft or excessive bedding, excessive swaddling, blanket rolls, stuffed toys, prone or side positioning.

Figure 24: Sleep Surface - Unsafe and Bed-sharing Deaths 2015



Fugure 25: Sleep Position - All Unsafe Sleeping Practice Deaths

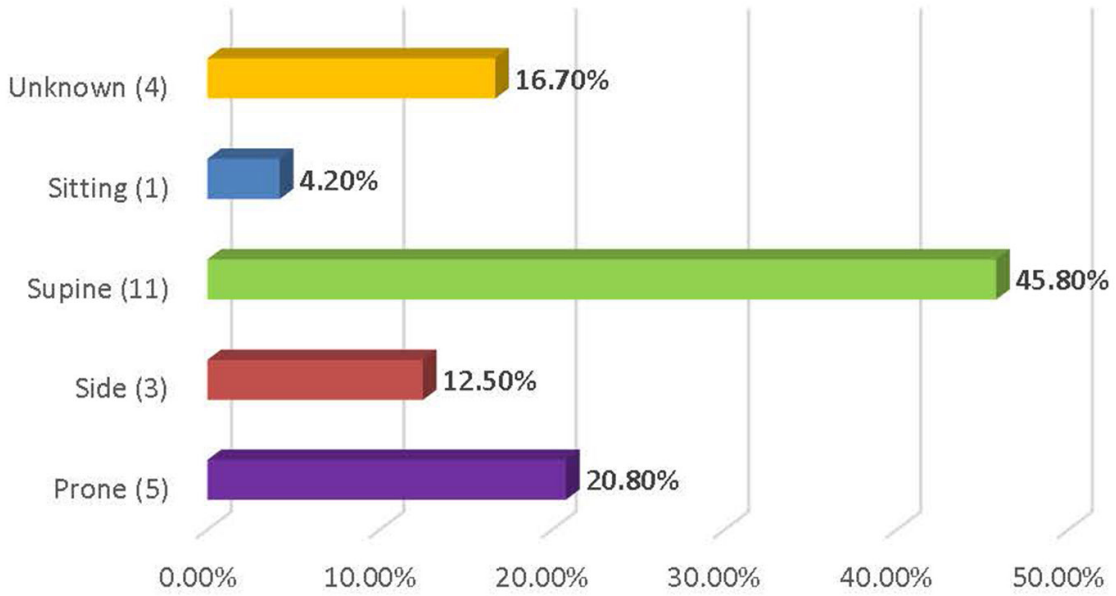


Table 28: Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 35)	Number
Pillow(s)	12
Soft and/or excessive bedding	7
Excessive Swaddling	1
Stuffed animals/toys	1
Parental Drug/Alcohol Use	2

*Excludes bed-sharing, sleep surface and infant position

Table 28a: Bed-sharing and Unsafe Sleeping Environment Child Welfare History	Number	Percentage
Total Unsafe Sleep/Bed-sharing	24	100%
Total Unsafe Sleep/Bed-sharing with Child Welfare History	12	50%

Figure 26: Percentage of Undetermined Child Deaths - Bed-sharing at the Time of Death

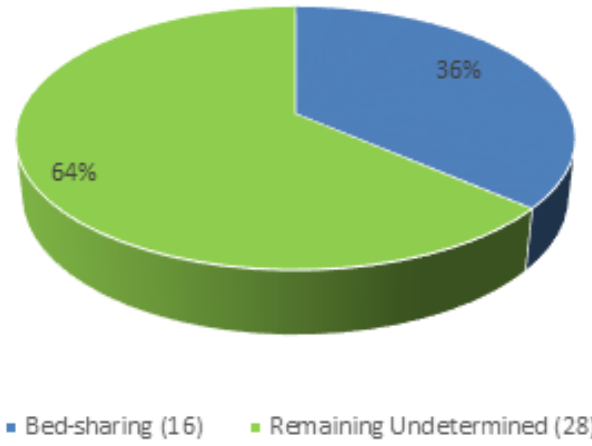


Figure 27: 2015 Bed-sharing Deaths - Number of Persons Sleeping with Child

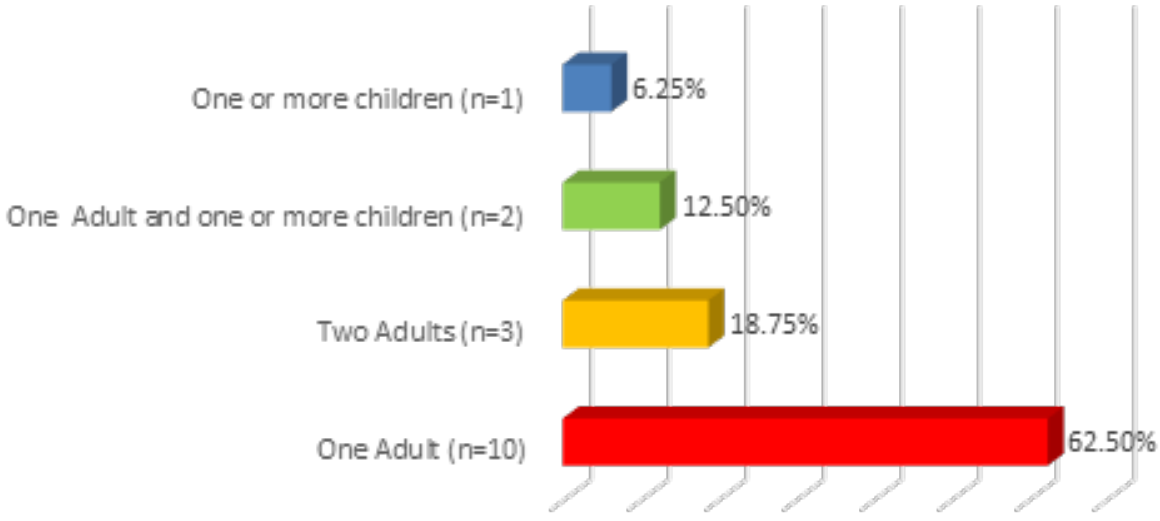


Figure 28: 2015 Undetermined Bed-sharing Child Deaths - Age

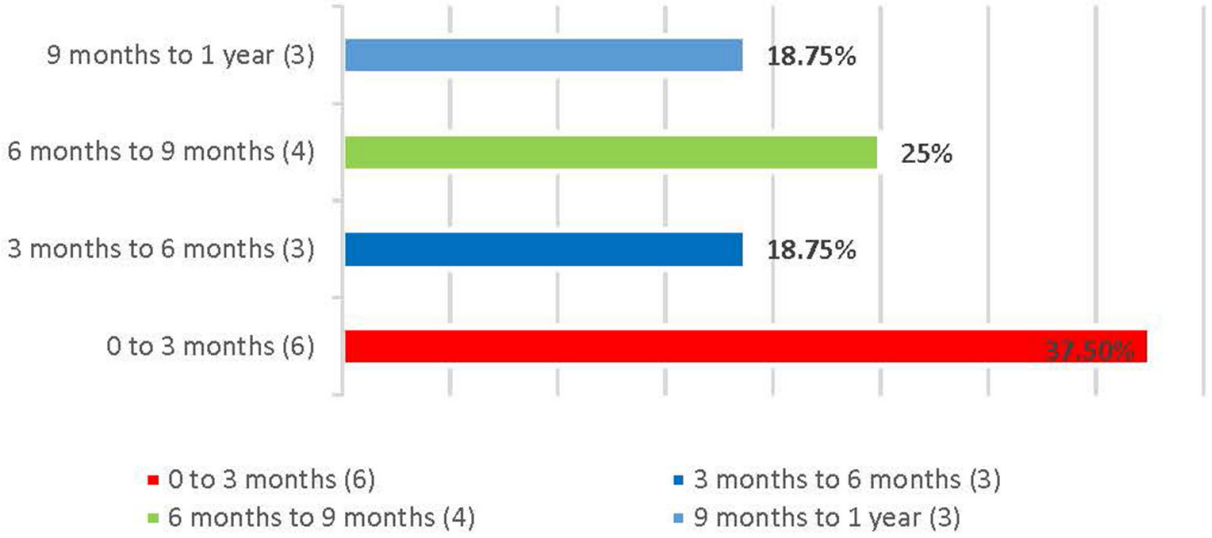
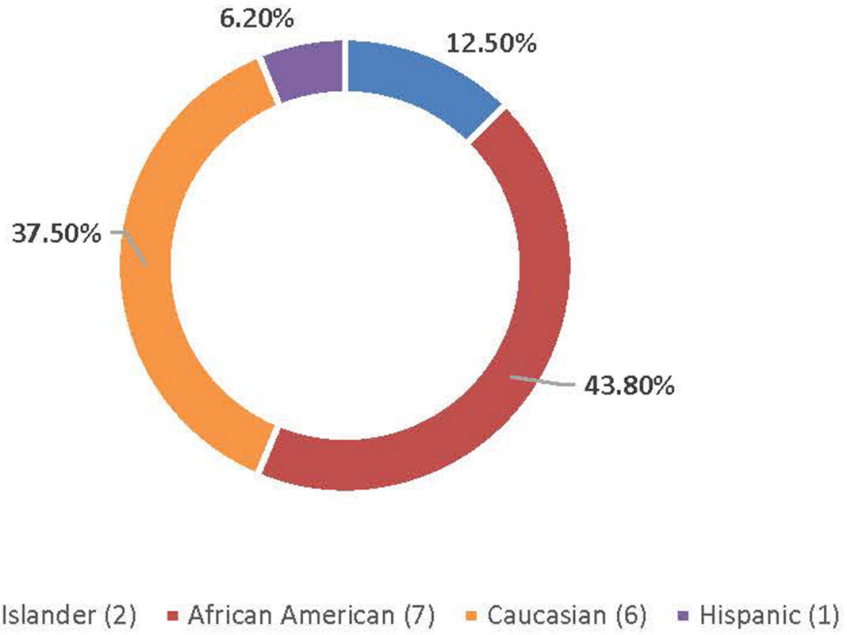


Figure 29: 2015 Bed-sharing Child Deaths - Race



2015 Undetermined Child Deaths: Non-Bed-Sharing Unsafe Sleeping Practices

Figure 30: 2015 Non-bedsharing Unsafe Sleeping Deaths -Age

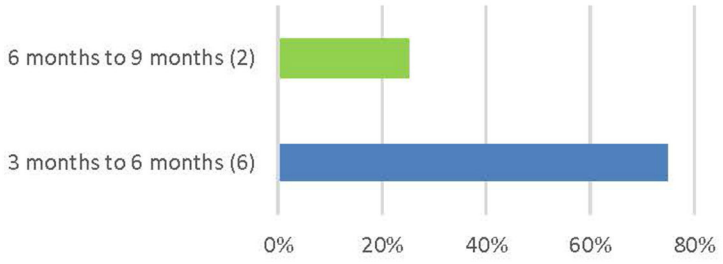


Figure 31: 2015 Non-bedsharing Unsafe Sleep - Race

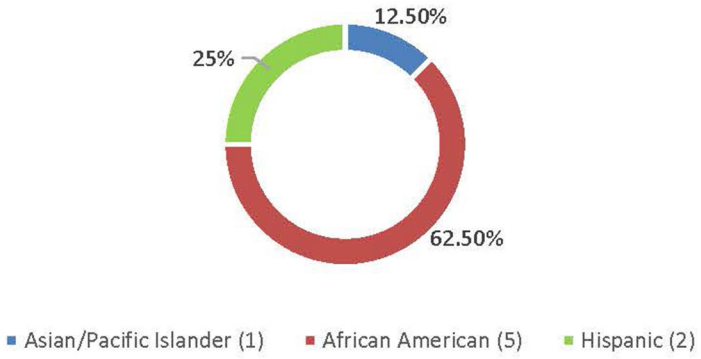


Table 29: Unsafe Non-bed sharing Child Deaths Sleeping Environment* - 2015	
Soft and/or excessive bedding	4
Pillow(s)	5
Adult bed	3
Prone Position	2
Couch	1
Excessive Swaddling	1

*More than one factor could have been present in the environment such as both pillows and excessive bedding.

Table 30: 2015 Undetermined Fetal and Newborn Deaths - Mother Self-reported or Tested Positive for a Substance at Birth

Infant Death- Mother Tested Positive for a Substance at Birth (N = 5)		
Substance	**Number**	**Percentage**
Marijuana	3	60%
Methamphetamine	2	40%

Undetermined Fetal and Newborn Deaths- Mother Tested Positive for a Substance at Birth - Child Welfare Involvement*

Year	Total # of Deaths - Mother Tested Positive for a Substance	Total # of with CPS family history (prior contact OR open case)	Of total with CPS history, the # of families that had PRIOR DCFS contact Only	Of total with CPS history, the # of families in OPEN DCFScase or referral	# of Mothers with a CPS history as a minor
2012	12	7 (58%)	4 (57%)	3 (43%)	5 (42%)
2013	8	6 (75%)	4 (50%)	2 (25%)	4 (50%)
2014	8	8 (100%)	5 (57%)	3 (43%)	3 (43%)
2015	5	2 (40%)	2 (100%)	0 (0%)	1 (50%)

*This data provided by the Coroner and DCFS. The eighth family's father had a history with DCFS with another mother. He also had a history as a minor.

Race	Number	Percentage
African-American	1	20%
Hisptanic	4	80%
Total	5	

Age	Number	Percentage
Stillborn	6	80%
Less than 1 month	1	20%

Introduction
Third Party Homicides

Historically, the ICAN Child Death Review Team report has included only those cases which have met Team protocol. For the eighth year, however, the report includes a special supplement to provide data on youth who are victims of a third party homicide. Unlike the child homicides perpetrated by a parent, caregiver, or family member, these homicides are where the perpetrator was not the caregiver or family member.

The information contained in this section is from two primary sources – the Los Angeles County Coroner's office and the local law enforcement agencies within Los Angeles County. The Coroner's Office provided demographic data as well as information on the cause and manner of death. Law enforcement provided information as to which agency conducted the criminal investigation, and whether the case was presented to the District Attorney's office for the filing of criminal charges and the type of charges filed. Also, in some cases, the Los Angeles Sheriff's Department (LASD) provided information about the relationship of the perpetrator to the suspect and some brief details about the victim's circumstances or activities prior to being killed.

The purpose of this information is to provide a broader analysis of children and youth deaths in Los Angeles County. It also seemed relevant to provide an analysis of these third party homicide deaths in hopes to provide a better understanding of child death in Los Angeles County. Ultimately, it is hoped that the study of these deaths will help us intervene more effectively.

A trend chart shows there has been a consistent downward pattern in these third party homicides over the past seven years. One possible theory to explain this downward trend is the diligent efforts of our law enforcement and prosecutorial agencies to decrease gang activity as well as the implementation of various gang prevention efforts. Regardless of the reason, the numbers paint a much welcomed picture.

Case Summaries[1]
Third Party Homicides

Trevor, age fifteen, was crossing the street with friends. As they were crossing the street, a car was stopped at the intersection. The car was blocking the crosswalk so the group passed behind the vehicle and continued crossing the street. As they approached the curb, shots were fired from occupants at a car that had been stopped at the light. Trevor was shot in the chest and lower back. He collapsed on the sidewalk and was pronounced by paramedics when they arrived at the scene. It is unknown whether Trevor was involved with gangs but two of his older brothers are known gang members. His case remains under investigation by law enforcement.

Seventeen-year old Roberto was schizophrenic and functioned well when taking his medication. His family reported his behavior and demeanor changes suddenly when he is off his medication. Roberto was with friends who just left an impromptu internet party. They were standing at a bus stop with several other people. His friends were checking or on their phones while waiting. Roberto suddenly became belligerent and talking to himself irritating the people around him. He was seen holding his neck and then suddenly collapsed in the gutter. He had been stabbed in the neck by an unknown assailant. Several people fled the scene. He was transported to the hospital but did not survive. No suspect is in custody.

Samuel, age 15 years was walking home from school with a friend when the suspect approached him on foot. The suspect asked them where they were from and the teens answered “nowhere” and said they played football. The suspect then asked Samuel for his backpack and he said no. There was a brief struggle when the suspect pulled out a knife. He stabbed Samuel in the chest and fled. Samuel continued to walk but collapsed a short time later. Samuel was not in gangs and played sports. The suspect was later arrested and is a gang member now waiting trial on murder charges.

Gabriel, age 17 years was shot multiple times by an unknown assailant while standing outside of a private residence. He and the suspect were arguing when the suspect produced a gun and shot Gabriel. 911 was called and Gabriel was pronounced deceased at the scene. Gabriel belonged to a gang and it is believed the shooting was gang-related. Gabriel had an active case with Probation at the time of his death. The case remains under investigation and no suspect is in custody.

According to law enforcement, Ricardo, age 17 years was spray painting graffiti on a residential wall while his girlfriend was acting as a look out. A vehicle drove by and gunshots were fired at the pair, striking both. The occupants in the vehicle fled the scene. Neighbors called 911. Ricardo, a known gang member, died at the scene. His girlfriend was transported to the hospital and survived. No suspects are in custody and the incident is believed to be gang related. [1]

1 Case identities were changed

Third Party Homicides

• There were 30 third party homicides in 2015. This is a 37% increase from 2014 in which the number of third party homicides were 19. 2015 represents the first time these deaths increased since ICAN began tracking them in 2007.

• Seventy-seven percent (n=23) of the youth were victims of gunshot wounds.

• Of the victims not killed by a gunshot, five were stabbed and two died as a result of a fire.

• As in the previous five years, male victims outnumbered female victims by a broad margin. Twenty-eight males and two females were homicide victims in 2015.

• Sixty percent (n=18) of the children who were victims of a third party homicide in 2015 were ages 16 – 17. All of the third party homicide victims were 14 years of age or older.

• The majority of the victims were Hispanic youth with 23 victims. Four African-American youth and two Caucasian youth were victims of a third party homicide. There was one Asian/Pacific Islander victim and one American Indian victim.

• The greatest number of homicides occurred during the months of October and November (n=5). The seconded greatest number occurred in the month of September (n=4) and the third greatest in the months of January, April, May and August (n=3). The fewest number of homicides occurred during the month December when there was no third party homicide.

• While third party homicides occurred throughout Los Angeles County in 2015, the majority (n=12) of these deaths occurred in the 1st Board of Supervisorial (BOS) District which was followed by the 2nd BOS District with 11 third party homicides. Five occurred in the 3rd BOS and two in the 4th BOS District. There were no third party homicides in the 5th BOS District.

• The Los Angeles Sheriff's Department (LASD) had investigative authority for 54.9% of the third party homicide cases in 2015. 38.7 percent of the cases were under the jurisdiction of the Los Angeles Police Department (LAPD), and 3.2% of the cases were handled by Pomona and Long Beach P.D.

• Where the relationship of the perpetrator was identified by law enforcement, 53% of the perpetrators were a gang member, and 57% of the victims were also gang or tagging crew involved. Finally, 47% (n=14) of the case investigations resulted in the filing of criminal charges by the District Attorney's Office. When this information was collected, some of the cases were still under investigation or unsolved and therefore, had not been presented to the District Attorney's Office. The suspects and motives for many of the 2015 3rd Party Homicides remain unknown.

• Eighty-seven percent of the victims had a history with either DCFS or Probation. Nineteen of the victims had a history with DCFS or another CPS agency and two of the victims had a history with the Probation Department. Three had a current case with Probation and two had an open case with DCFS.

Figure 32: 2007 - 2015 Third Party Child Homicides

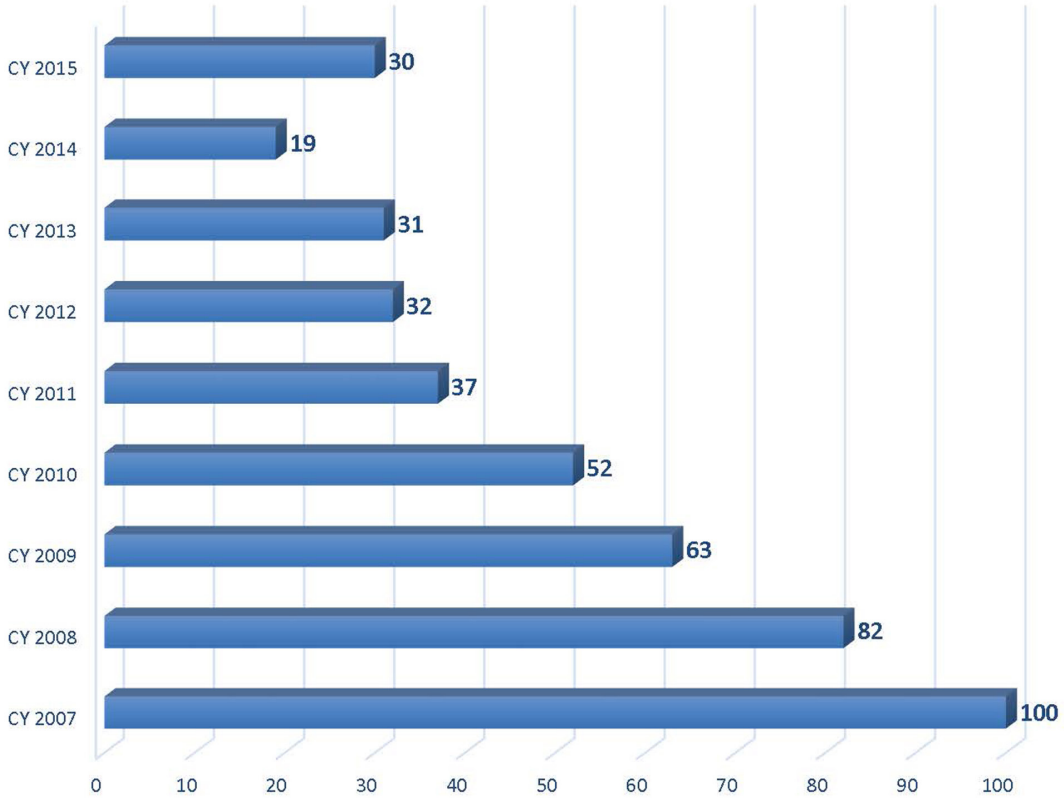
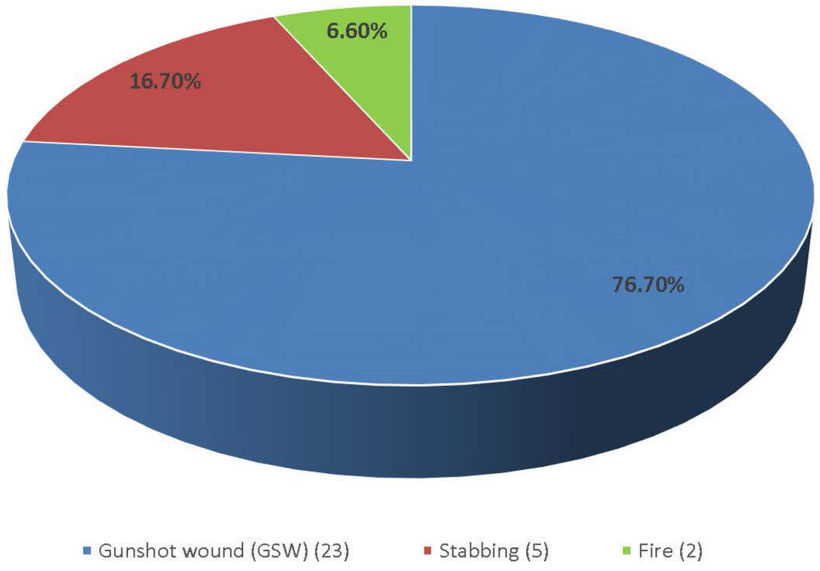


Figure 33: 2015 Third Party Homicides - Cause



Third Party Homicides

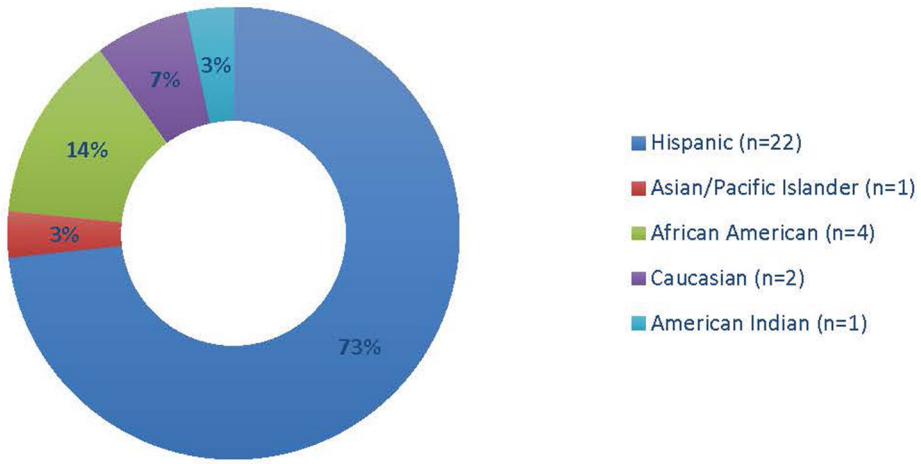
LOS ANGELES COUNTY – 2015 (N = 30)

Age	Female	Male
14 years	0	4
15 years	0	8
16 years	1	2
17 years	1	14
Total	2	28

93.3% of the third party homicide victims were male.

60% of the third party homicide victims were 16 to 17 years of age.

Figure 34: 2015 Third Party Homicides - Race



Los Angeles Child Population
Ages 0-17: 2,325,047
Hispanic 61.7%, Caucasian 17%, African American 7.5% , Asian/Pacific Islander 10.5%, Native Indian/Alaskan .1% and Multi-racial 3.2% Kidsdata.org

Table 32: Dates[1] of Third Party Homicides - 2015

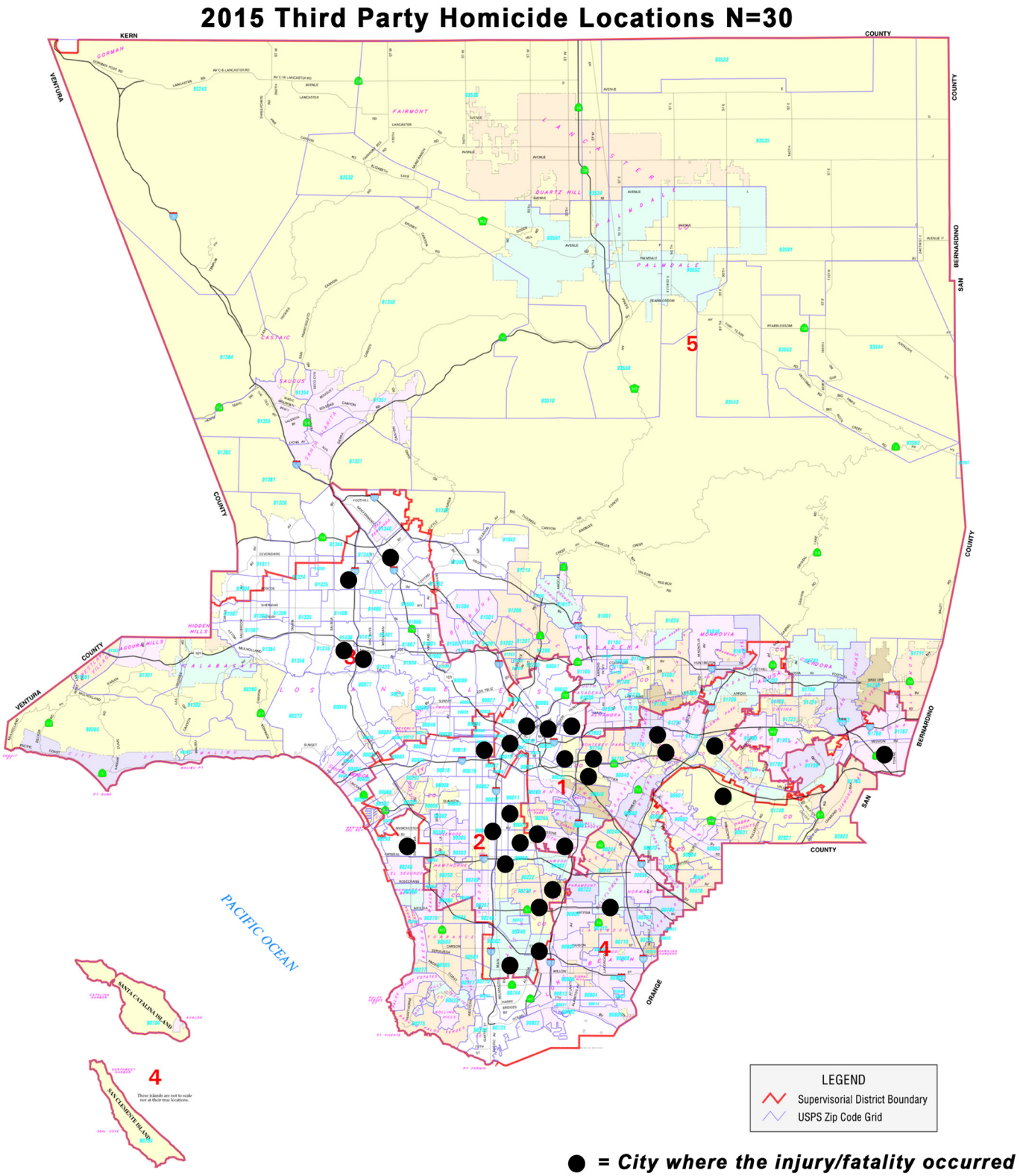
3 homicides occurred in January (01/23, 01/29 & 1/30)
1 homicide occurred in February (02/06)
2 homicides occurred in March (03/03 & 03/12)
3 homicides occurred in April (two on 04/25 & one 4/28)
3 homicides occurred in May (05/12, 05/23 & 05/25)
1 homicide occurred in June (06/21)
1 homicide occurred in July (07/11)
2 homicides occurred in August (08/04 & 08/28)
4 homicides occurred in September (9/09, 09/20, 09/23 & 09/27)
5 homicides occurred in October (10/07, 10/17, 10/23, 10/26 & 10/28)
5 homicides occurred in November (11/01, 11/08, 11/14, 11/15 & 11/17)
0 homicides occurred in December

Table 33: Locations[2] of Third Party Homicides – Geographic Area - 2015

1 homicide occurred in Carson zip code 90745)
1 homicide occurred in Bellflower (zip code 90706)
2 homicides occurred in South El Monte (zip code 91733)
3 homicides occurred in Los Angeles (zip codes 90029, 90032 & 90033)
2 homicides each occurred in Los Angeles (zip codes 90002, 90004, 90022 & 90031)
4 homicides occurred in Los Angeles (zip codes 90044, 90045, 90061 & 90063)
1 homicide occurred in La Puente (zip code 91746)
1 homicide occurred in Long Beach (zip code 90810)
3 homicides occurred in Compton (zip codes 90220 & 90221)
1 homicide occurred in North Hills (zip code 91343)
1 homicide occurred in Sherman Oaks (zip code 91403)
1 homicide occurred in Pomona (zip code 91766)
1 homicide occurred in Hacienda Heights (zip code 91745)[1]

1 This is the date of death, which, in a majority of the cases coincides with the date the injury occurred leading to the youth's death.

2 City where the injury/fatality occurred


2015 Third Party Homicide Locations N=30
KERN
COUNTY
VENTURA
COUNTY
SAN BERNARDINO
COUNTY
LOS ANGELES
COUNTY
ORANGE
COUNTY
PACIFIC OCEAN
SANTA CATALINA ISLAND
SAN CLEMENTE ISLAND
These islands are not to scale nor at their true locations.
1
2
3
4
5
LEGEND
Supervisorial District Boundary
USPS Zip Code Grid
● = City where the injury/fatality occurred

Information on criminal justice system involvement in third party homicide cases was gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD), and the Los Angeles Sheriff's Department (LASD). In 2015, there were 29 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 34 below. .

Table 34

Agency	Number of cases	%
LAPD	16	53.3
LASD	12	40
Long Beach P.D.	1	3.3
Pomona P.D.	1	3.3

Table 35 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation. It should be pointed out that few of the law enforcement agencies were able to provide much detail about the suspect's circumstances which is why so many of the cases fall under the "no information provided" category. The majority of these cases remain under investigation and the suspect(s) is unknown.

Table 35

Perpetrator's Relationship to Victim	Number of cases
Gang Member	16
No Information Provided or Unknown	14

Table 36, provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved.

Table 36

Victim Information	Number of cases
No Information provided	2
Shot in a walk-up shooting	11
Shot during a drive-by shooting	4
Gang member or tagger	17
Physical altercation with a peer	2
Alcohol/Illicit substance in system	1
Child Welfare History	7
Open DCFS Case	2
Probation History	2
Active Probation Case	3

According to the information provided by the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD), and the Los Angeles Sheriff's Department (LASD), 15 of the 30 cases of third party homicides were referred to the District Attorney's Office in 2015. The fourteen cases had criminal charges of murder filed by the District Attorney's Office in 2015. Five of thirty cases remain under investigation. It should be noted that there was no information found for 10 cases. For cases under investigation or where no information was provided, this means that law enforcement has not identified the assailants or not yet submitted the case for review to the District Attorney for some other reason.

APPENDIX A - ICAN Youth Suicide Coroner/Medical Examiner Procedural Guide

ICAN Youth Suicide Coroner/Medical Examiner Investigation Procedural Guide

Language Interviewed in: ☐ English ☐ Other _____

Translated by: _____

Case Number: _____

Decedent: _____

DOD: ____/____/____ Date of Interview: ____/____/_____

Investigator: _____

(Do not release with copy of Autopsy Report)

Mental Health

Recent Mental Health, Substance Abuse/Dependency Treatment History < 2 months *(Acute)* *i.e. diagnosis, outpatient therapy, hospitalization, detox, rehab., recent sobriety*

Mental Health, Substance Abuse/Dependency TX History > 2 months (*Chronic)*
i.e. diagnosis, outpatient therapy, hospitalization, detox, rehab

Presence of Trigger Events <2 months *(Acute)* *i.e. actual/anticipated loss of relationship, conflict with parents, conflict with school/job or other authorities, court appearance*

Prescribed Medication
i.e. compliance, recent change, psychotropic medication

Self-Injurious/Risk-Taking Behavior *i.e. substance use/abuse, cutting and burning, auto-erotic asphyxiation, alcohol use/abuse, "choking game", "Russian Roulette"*

Mental Health

Depression and Other Psychological Symptoms *i.e. impaired mental status, perceived burdensomeness, perceived pain, stress, agitation, hopelessness, self-hate, worthlessness, depressed mood, anxiety/panic, anger, anhedonia, guilt, impulsivity, poor reality testing, sleep/eating disturbances, command hallucinations, intoxication, aggressive tendencies, recent changes in behavior, recklessness.*

Acute <2 months	Chronic >2 months

Suicide Exposure & Behavior

Prior Suicide Attempts *(indicate dates, times, methods, medical care needed)*

Exposure to Others' Behavior i.e. *completed Suicides or attempts of family, friends or role models*

Discussion of Suicide, and Notes *i.e. verbal, written or online/electronic thoughts communicated to family, peers, teachers, post-mortem messages left for family, peers, teachers*

Access to Lethal Means

When appropriate *(indicate information about secure access to weapons, such as firearms, medication, etc. Did the decedent have familiarity with weapon? Parental supervision? Were the weapons secured - Firearm locked in storage cabinet? Ammunition kept separate or firearm kept loaded?*

Funding for the *ICAN CORONER SUICIDE GUIDELINES* was provided in part by the *JEFFREY GUTIN FUND FOR YOUNG ADULTS* of the New Hampshire Charitable Foundation

Scan and Email this form and completed Report to Tom Fraser at fraset@dcfs.lacounty.gov

Medical

Physician or Clinic Visits within last 12 months *(specify physical and psychological complaints, conditions affecting activities of daily living)*

Emergency Department Visits within the last 2 Months *(specify physical and psychological complaints)*

Hospitalizations within the last 12 Months *(indicate dates, duration, diagnosis, discharge, plan, conditions affecting activities of daily living)*

Education, Occupation

School_____ **Grade** _____

i.e. special education, truancy/attendance problems, academic pressure, discipline, social challenges, recent school changes, bullying

Worksite_____

i.e. discipline, conflicts with peers, supervisors, public, performance pressures

Support Systems and Other Involvement

Suspected Child Abuse ☐ Yes ☐ No

Family or Loved Ones, and other Significant Relationships

Protective *i.e. supportive, engaged, involved, new romantic partner, positive change of residence*	**Risk** *i.e. conflicts, parental separation/divorce, change in placement/address, grief/loss, illness*

Peers

Protective *i.e. group membership, sports involvement*	**Risk** *i.e. problems with friends, bullying, friendship/significant other break up*

Faith-Based/Spirituality

Protective *i.e. acceptance, non-judgmental, belief in a higher power*	**Risk** *i.e. intolerant messages, estrangement, condemnation, judgmental*

Identity Issues *i.e. gender, acculturation, other cultural challenges*

Social Networks ***(Request email passwords to computer, Facebook page, text messages etc.)*** *i.e. actual social relationships or online social networking activity*

Additional comments/thoughts/opinions

APPENDIX B - How to Keep Your Baby Safe

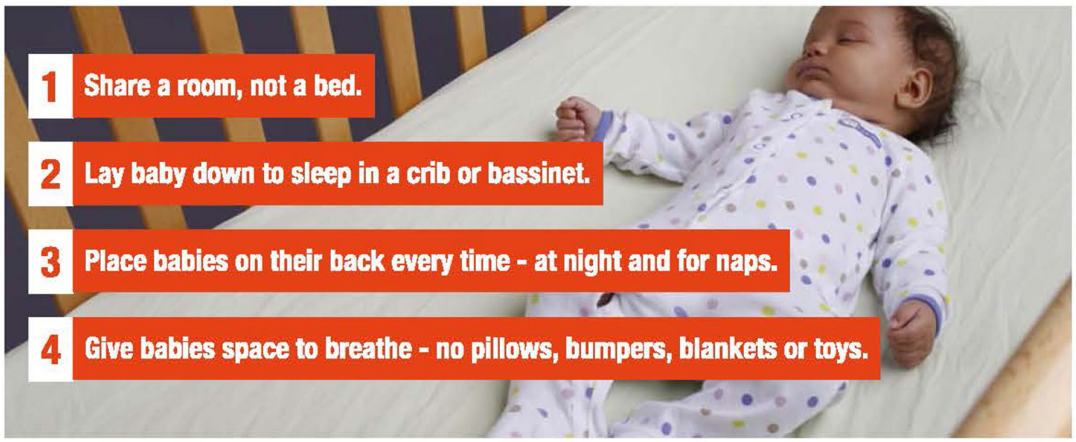
en Español

HOME | A PROBLEM IN L.A. | HOW TO KEEP YOUR BABY SAFE | GET EDUCATED

safe sleep for baby — Don't wake up to a tragedy

How to Keep Your Baby Safe

Parents and caregivers can reduce the risk of infant death from suffocation by being aware of and following these safe sleeping practices.



Questions You May Have

Is it safe to put a baby to sleep in a car seat or stroller?
No, because of the way the baby is positioned in these carriers. Babies should always be placed on their back to sleep.

Can I swaddle my baby?
Yes, but be sure to use a light receiving blanket because other blankets, such as San Marcos blankets, can be too heavy and warm for infants. Once babies reach 5-6 months, swaddling is no longer needed and parents can simply continue to dress their baby in a onesie or sleeper.

What if I am breastfeeding?
Breastfeeding is encouraged, and moms should place their baby in a crib or bassinet after nursing.

What if my baby likes sleeping on his stomach?
The safest way for babies to sleep is on their back. When babies sleep on their stomach or side, they can choke or suffocate.

My baby has trouble breathing – what's the best way to put my baby to sleep?
If your baby has a medical condition, talk to your doctor about any special care your child may need.

Like us on Facebook for the latest updates. Like 1.4k

Contact
ICAN Associates
4024 N. Durfee Avenue
El Monte, CA 91732
626-455-4585
Info@safesleepforbaby.com

Safe Sleep Task Force
The Infant Safe Sleeping Task Force oversees the Safe Sleep for Baby campaign. This section includes information and resources for Task Force members.

Task Force Information

ICAN ican4kids.org

FIRST 5 LA
Champions For Our Children
www.First5LA.org

APPENDIX C - On-Line Resources

Safe Sleeping Resources

- safesleepforbaby.com
- nichd.nih.gov.sts
- firstcandle.org

Child Abuse

- dontshake.org
- child-abuse.com
- dcfs.co.la.ca.us
- ican4kids

Domestic Violence

- dvcouncil.lacounty.gov
- lapdonline.org/StopDV
- thehotline.org

Suicide-Youth

- preventsuicide.lacoe.edu
- suicideinfo.ca/youthatrisk
- suicidehotlines.com/california.html
- thetrevorproject.org

Water Safety

- poolsafety.gov
- abcpoolsafety.org

Fire Safety

- fire.lacounty.gov/safety-measures/fire-safety-tips
- firefacts.org

Biking Safety

- Sheriffsyouthfoundation.org
- Nhtsa.gov/bicycles

In and Around Cars

- chp.ca.gov/program&services
- nhtsa.gov
- kidsandcars.org

Pedestrian

- kidsandcars.org
- safekids.org
- ntsa.gov/pedestrian

Teen Drivers

- ntsa.gov

APPENDIX D - MAP OF LOS ANGELES COUNTY BY BOARD OF SUPERVISOR DISTRICT