Inter-Agency Council on Child Abuse and Neglect

Deanne Tilton Durfee, Executive Director

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

(626) 455-4585 • Fax (626) 444-4851 • www.ican4kids.org

Child Death Review Team Report 2014

Report Compiled from 2013 Data

Table of Contents

Cover Image by Milan6 (**http://www.freeimages.com/profile/milan6**)

Introduction

The Los Angeles County ICAN Child Death Review Team (CDRT) and Los Angeles County ICAN Child and Adolescent Suicide Review 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, County Office of Education, Department of Mental Health, California Department of Social Services and representatives from the medical community.

The Los Angeles County Department of Medical Examiner-Coroner refers all cases it has received for children age seventeen and under to ICAN, including fetal deaths, and ICAN staff reviews these cases to determine which ones meet Team protocol. This process first involves the exclusion of all natural deaths. Thereafter, cases that meet at least one of the following criteria are selected for review:

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

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

This thirty-fifth annual report of the ICAN CDRT provides information on all child deaths that meet Team protocol and occurred in Los Angeles County during 2013. A detailed analysis of quantitative and demographic data of children killed by caregivers, youth suicides, accidental deaths and undetermined deaths is provided. Lessons learned from the reviews and ensuing recommendations which, if implemented, should improve child safety and save lives are included in the report. Appendix C at the end of the report provides on-line resources for prevention of child deaths.

The report also includes information on 3rd party homicides of youth 17 years and younger for the seventh year. These homicides are where the perpetrator was not a family member or caregiver.

Team Chairpersons

Child Death Review Team

Michele Daniels, *Los Angeles County, Office of the District Attorney*
Carol Berkowitz, M.D., *Harbor/UCLA Medical Center*

Child and Adolescent Suicide Review Team

Michael Pines, PhD, *Chicago School of Psychology*
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
- 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

For additional information about this report, you may contact
Saundra DeVos, Program Administrator, ICAN, at (626) 455-4585, **devoss©dcfs.lacounty.gov**

Recommendations

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

   Rationale: Violence between adults impacts children in the home as they are at risk for emotional and/or physical abuse as a result of the violence. There is often a co-occurrence of domestic violence and child abuse in a family. Domestic violence is also often present in families where fatal child abuse has occurred. In one of the 2012 child homicides by a mother's boyfriend, the mother was also murdered by the boyfriend. Law enforcement should assess for children in the home or belonging to either party and make a referral to DCFS for further assessment by a social worker.

2. **The ICAN Policy Committee support legislation requiring Physicians initially applying for licensure in the State of California provide documentation of having completed coursework or training regarding the identification and reporting of child abuse and neglect.**

   Rationale: Over the years, the Team has reviewed cases in which a homicide victim was taken to a doctor or emergency room days, weeks, or within the month of their death. In many of the cases, symptoms, injuries or marks indicative of child abuse or neglect were present at the time the child was seen. The Team has discussed the problem as not being one resistance to report, but failure to recognize or identify child abuse and neglect.

   In 2013, several homicide victims were taken to a doctor shortly before their death. One child was seen by a physician earlier on the day of death; two were seen two days prior and two within the week of their demise.

   The State of New York is the only state in the nation that requires mandatory child abuse training for Physicians as a licensing requirement. It would serve the children of California to enact a similar requirement to save lives.

3. **The Los Angeles County Departments of Children and Family Services and Probation should require that providers of Independent Living Skill services, Transitional Housing Programs, and Teen Clubs incorporate parenting into their work with Transitional Age Youth. Emphasis should be placed on the developmental stages and appropriate parenting for children age 0 to 3 years of age.**

   Rationale: Team case reviews have borne out that there is a strong correlation with parents and/or perpetrators of homicide having a history with these systems as a child. Although not yet parents themselves, exposure to learning how to appropriately parent by responding to infants and young children's needs in an age appropriate manner may help counter the cycle of abuse so often seen in homicide cases.

4. **The County of Los Angeles Office of the Medical Examiner-Coroner review policy and practice for maintaining cases on security hold. Policy and practice should assure that the Medical Examiner is given access to the case file and informed when test results are received.**

   Law enforcement should assure the Medical Examiner-Coroner's Office is advised to release the security hold as soon as the case investigation is complete.

   Rationale: During a case review it was revealed that when a security hold is put on a case with the Medical Examiner-Coroner at the request of law enforcement, access to the case file is limited. The Medical Examiner cannot easily access the case which is placed under lock and key and is not informed when test results are received and put in the case file. As a result, law enforcement also is not informed of the receipt of test results which can greatly impact an investigation. This practice can cause delays for the Medical Examiner in closing a case and can place surviving siblings at risk. It took almost a year for the case under review to be deemed a homicide even though pertinent test results were received three months after the death.

5. **The ICAN Policy Committee support DMH, DCFS, Probation and LACOE in promoting training to all mental health and social work professionals in the core competencies of child and youth suicide prevention.**

   The Directors of the Department of Mental Health, Department of Children and Family Services and the Department of Probation should require that providers of mental health and substance abuse services for youth receive training in the core competencies for suicide risk prevention.

   Graduate schools in Los Angeles County that prepare mental health and social work professionals should include training and supervision in the core competencies of suicide prevention in their curriculum.

   ICAN write a letter of support to the Board of Behavioral Sciences to consider the adoption of graduate course work and requirements for continuing education that mental health and social work professionals to be trained in the core competencies for suicide risk prevention.

   Rationale: While numerous professionals from schools and other child protection agencies receive training to identify children and adolescents at risk for suicide, a number of mental health and substance abuse treatment providers lack adequate training in graduate schools in the competencies needed to assess and manage the suicide risk of child and adolescent clients. Additionally, the State of California does not require this training as a precursor to a license or for continuing education.

   The role of pre-existing mental health factor was reported in the Child and Adolescent Suicide Review Team Risk Factors and Lessons Learned section of this Annual Report:

   Among the youth who died of suicide, 38% had a documented mental health diagnosis, 23.5% were receiving mental health services at the time of death and 23% were on psychotropic medication.

   69% of the youth exhibited a warning sign--talk of suicide, increased drug and alcohol use, feelings of depression, anxiety and hopelessness, or giving away possessions.

   Although he vetoed AB 2198 Mental Health Professionals: suicide prevention training In 2014, Governor Brown asked the regulatory boards of mental health providers to consider the adoption of graduate course work and requirements for continuing education in this area similar to regulations currently in effect in the states of Washington (SB 2366) and Kentucky (KRS 210.366). ICAN supports the adoption of these requirements for the protection of children and adolescents at risk for suicide.

Child Death Review Team: Risk Factors and Lessons Learned

Team case review yields valuable lessons or identifies systematic issues in need of attention by one or various agencies impacting the welfare of children and families. Additionally, patterns of risk factors in families surface in the cases. The lessons and risk factors noted from the 2013 child death review cases follow. Most are consistent with the previous report and have continued to surface year after year.

Child Risk Factors

Young Age

84% of the 2013 child homicides by a parent/relative/caregiver were age five and under; 42% were infants under one year of age; and only three were over age five. 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. Additionally, child homicides often coincide with developmental and independent 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 observed toddlers are vulnerable during the toilet training period as an example. Infants and young children also are often not visible outside the home as these families tend to be socially isolated.

59% of the accidental child deaths involved children age five or younger. Young children are also more at risk due to deaths such as drowning and auto back up deaths because of their size and lapses of adult supervision to prevent such deaths.

Gender

Unlike 2012 when the sexes were almost even, in 2013, male (n=14) victims of homicide outnumbered the female (n=5) victims. Overall in past years, male children notably outnumbered female children as victims of homicide.

Race

52.6% of the 2013 child homicides victims by a parent/relative/caregiver were Hispanic, 36.8% African American, 5% Caucasian and 5% were of Asian/Pacific Islander descent in 2013. Caucasian children were under represented and Asian children were slightly under represented. African American children were disproportionally over represented as homicide victims. Hispanic children were also over represented for the general population.

Parental Risk Factors

Cycle of Abuse

A common factor seen in many of the child death cases is that the child's mother, father or 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. 47% (n=9) of the 2013 child homicides involved a family with a Child Protective Service (CPS) history as a child.

Involvement with the Child Welfare System

The most common factor seen in many of the child death cases is 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. 53% (n=10) of the families who experienced a child homicide had contact with DCFS. An eleventh family had an open case with DCFS as a result of the fatal injuries received prior to death.

Maternal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appears to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a number of fetal deaths with a contributing factor of maternal substance abuse. Although the number of these deaths had been declining in recent years, there has been an increase in child deaths associated with maternal substance use since 2011. Child deaths with a contributing factor of maternal substance abuse remains one of the top four causes of accidental death, accounting for 17% of accidental child deaths. Maternal Substance abuse was attributed to 31% of the accidental deaths of children in which the family had at least one contact with the child welfare system. Additionally, there were 8 undetermined child deaths associated with maternal substance use as evidenced by the mother testing positive at the birth for a alcohol or drugs.

Substance Abuse

Substance abuse by a parent or caregiver is a well documented high risk factor for child abuse or neglect. Substance abuse often is identified when there is a child fatality if the parent or caregiver had prior reports or history of substance abuse. In some cases, the individual responsible for the child was under the influence during the incident that led to the child's death. A caregiver's unrealistic developmental expectations and inability to cope with age appropriate behavior, combined with drugs and alcohol, become a lethal situation causing caregivers to lose control and harm the child. In addition, parents under the influence who sleep with their infant increase the risk of overlay or suffocation leading to the death of the child. Thirty-two percent of the 2013 families of homicide victims had a history of substance abuse.

Domestic Violence

This connection between domestic violence and child abuse/neglect continues to be evident in the 2013 child homicides in which five of the families had a documented history of domestic violence.

Young Age

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

Mental Illness

In 2013, two children were killed by a parent, caregiver or family member with a history of, or exhibiting symptoms of mental illness. Not all individuals with mental illness place their children at risk. However, those with chronic mental disorders who are non-compliant with medication or treatment or uncooperative with family members or other supports have the potential to place children at risk of harm including death.

Presence of Multiple Parental/Caregiver Risk Factors

Combination of risk factors such as mental illness, history of substance use, domestic violence, social isolation, CPS contact, CPS history as a child and young parents are usually present when a child dies at the hand of a parent or caregiver. In 2013, only four families of a homicide victim had none of these known risk factors present. The boyfriend and perpetrator in one of those families had a violent past with his ex-wife.

Perpetrator Relationship

Relationship

In 2013, sixty-seven percent of the child homicides involved a male perpetrator as opposed to 2012 when 60% of the perpetrators were female. Five of the child homicides perpetrators were the biological mother.

Lack of Bonding or Poor Attachment

The quality of the relationship of the adult to the child has been a recurring factor in child homicide deaths. This is particularly important when the person assumes a caretaking role for the child. The Team has observed that each year, many of the child homicides have been at the hands of the parent, parent's boyfriend, girlfriend, step parent or partner who was not 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. In 2013, there were several cases in which the biological father or mother was not emotionally attached to the child and the child was killed by that parent.

System Factors

Failure to Recognize Child Abuse or Neglect

The Team has reviewed cases in which a homicide victim had contact days, weeks or months before the child's death by a pediatrician, local medical clinic or an emergency room where signs of abuse/neglect were present but not recognized as possible child abuse or neglect. In 2013, one child was seen the day of her death; two children were seen two days prior to the death and two seen the week prior. In several of the cases, the pediatrician was given "plausible" explanations. With internal abdominal trauma, the Team has learned that some of the symptoms of trauma mimic other common illness for young children and that external bruising may not be present. One child was seen by a doctor the week before his death, and the autopsy revealed that, in addition to the fatal injury, healing internal injuries were present. When seen by the pediatrician, the child was reported by the mother to have an ear infection, decreased appetite, diarrhea and a red blotchy area on the chest. The doctor did not suspect child abuse given the child's symptoms presented as an illness.

Failure to Report

Further, with the 2013 child homicides, as in previous years, the Team has reviewed cases in which a family had contact days, weeks or months before the child's death by an agency such as law enforcement or a community agency or family member and "red flags" were observed but not reported to DCFS or law enforcement. When a family is involved with multiple systems - DCFS, Law Enforcement, Medical, community social services, it is imperative that the agencies providing services to the family have ongoing communication with one another for child safety, investigation, and case management purposes. Family members who are most likely to be aware that a child might be at risk, should communicate their concerns with reports to DCFS or law enforcement.

Security Holds at the Department of Medical Examiner-Coroner

Citing California Government Code Section 6254 Exemption of Particular Records, law enforcement will request a security hold on a case with the Medical Examiner-Coroner (DME-C) to prevent release of case information to the public while an investigation is ongoing. Security holds typically involve homicides; infants where abuse is suspected, officer involved shootings, suspect–at-large or high profile cases. The Medical Examiner-Coroner is obliged to keep the security hold until they receive a written request from law enforcement to release the hold.

A 2013 child homicide case review revealed how the process by the Medical Examiner- Coroner to adhere to a security hold can create unintended delays for the medical examiner to complete and close out a case which could put surviving siblings at risk. Security hold cases are stored in a separate room from other coroner cases and placed under lock and key. Only a few persons at the DME-C are able to access the cases. Neither the assigned Coroner Investigator nor the medical examiner who conducted the autopsy can access the case physical or electronic file. If toxicology or other test results come in on a case, they are put in the case file but the assigned medical examiner is not informed thus creating delays.

In the Team review, an autopsy of an eleven month-old revealed no trauma or sign of disease and a security hold was in place. Toxicology results came back three months later which determined the cause of death

and were placed in the case. Neuropathology test results were also pending so the case could not be closed. It was not until nine months later after the death, and seven months after the receipt of the toxicology that law enforcement became aware of the results. The neuropathology slides were under lock and key and the test not yet conducted. They were sent out and completed in a month, the case declared a homicide and the mother arrested for the death. In the meantime, child's three year old sibling was at risk in the mother's care. A better system to adhere to the security hold while permitting timelier processing of cases and communication between law enforcement and the coroner is needed.

Additional Risk Factor

Unsafe Infant Sleeping

Although there has been a decline in deaths from the previous years, the Team continues to note a disturbing number of deaths associated with bed-sharing and/or unsafe sleep environments and has made recommendations to help prevent these deaths. The Team has observed that infants who die are often placed on adult beds, couches and/or surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. In 2013, 51 undetermined child deaths involved bed-sharing or unsafe sleep environments which accounted for 57% of all the undetermined child deaths.

Additionally, six infants died when placed in an unsafe manner to sleep whose deaths were ruled accidental. Most unsafe or bed-sharing infant deaths are moded as undetermined by the Coroner. Adding these accidental deaths to the undetermined ones brings the total of unsafe sleep infant deaths to 57*****.

***By the end of 2014, this number significantly declined.**

Child and Adolescent Suicide Review Team
Risk Factors and Lessons Learned

Suicide Rate

The suicide rate among individuals under the age of 18 years decreased from 17 suicides in 2012 to 13 in 2013. The highest number of youth suicides was in 2001 with 27 and the lowest number of 10 occurred in 2007.

Gender

There was a significant shift in the gender rate of suicides in 2011. In prior years, the male to female ratio was consistent with males outnumbering the females by a large margin. In 2010, for every female suicide there were two male suicides. In 2011, eight of the nineteen suicides were female and eleven male. This pattern shifted again in 2012 when, for the first time, female victims (n=9) of suicide outnumbered the male victims (n=8). In 2013, the pattern reverted back to the previous pattern of males outnumbering females with eight males and five females committing suicide.

Race

54% of the youth who committed suicide were Hispanic which under represents the general population of Hispanic children. 23% of the youth were of Caucasian decent which over represents the general population and 8% were African American who was also slightly over represented compared to the general population. Asian/ Pacific Islander children were almost doubled in representation from the general population with 15.4% having committed suicide in 2013.

Relationship Loss or Conflict

69% of the youth who committed suicide 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 38% of the suicides.

The Role of Pre-existing Mental Health Problems

Among the youth who died of suicide, 38% had a documented mental health diagnosis and 23.5% were receiving mental health services at the time of death and 23% were on psychotropic medication.

69% of the youth exhibited a warning sign--talk of suicide, increased drug and alcohol use, feelings of depression, anxiety and hopelessness, and giving away possessions.

The Role of External Factors

The act of suicide frequently occurs in combination with external factors which seem to overwhelm youth who are already having difficulty in coping with the challenges posed by adolescence due to mental disorders. Some examples of these stressors are interpersonal loses, family violence, sexual orientation confusion, disciplinary problems, physical and sexual abuse, and being a victim of bullying. Of the youth who committed suicide in 2013, 23% had reported experience of being bullied. 38% experienced school discipline/truancy problems. Another 77% of the victim's families had contact with either DCFS or Probation at sometime in the youth's life.

Impulsivity

Of the 13 youth who committed suicide in 2013, only three left a note and one a text just prior to the act. This reflects how youth seem to not plan their suicide over a period of time, but act impulsively at the moment. In one youth suicide, the youth had been reprimanded for breaking a dish within the hour of committing suicide.

Loss of Potential Preventative Support by School Professionals

The Team noted that six of the thirteen 2013 suicides occurred in summer months when the youth were not attending school. Another youth had recently been withdrawn from the public school system and was to be receiving home schooling via a virtual academy

Schools are often in a position to provide at-risk students with support and can play a crucial prevention role by monitoring the behavioral effects of medication at school. This support is unfortunately not available when the schools are not in session during the summer months.

Team Accomplishments

In 2013 – 14, the ICAN Multi-Agency Child Death Review Team (CDRT):

- Screened all undetermined child deaths via sub-committee and refers cases to the Team when circumstances indicate a finding of accidental or homicide could possibly result from a full multi-disciplinary review. The sub-committee also is developing a form to record these deaths to provide data collection for further analysis of these deaths.
- Assisted the State Department of Public Health, Safe and Active Communities Branch-Fatal Child Abuse and Neglect Surveillance Program with the audit of Los Angeles County 2012 Child Fatalities attributed to abuse or neglect.
- Presented on lessons learned by the Team and how these lessons can help identify at risk children and families at the 19th Annual Nexus Conference. Is developing a similar training for Department of Children and Family Services Emergency Response staff.

In 2013 – 14, the ICAN Child and Adolescent Suicide Review Team (CASRT):

- Developed suicide field investigation guidelines for coroner investigators that are being implemented in Los Angeles County. These guidelines were initiated by a partnership with the Gutin Family Fund of the New Hampshire Charitable Foundation and the Los Angeles County Department of Medical Examiner-Coroner. The reader is referred to Appendix A for the guidelines
- Conducted a training workshop for completion and use of the suicide field investigation guidelines for the California State Coroners Association at their annual training conference in Visalia, California.
- Responded to the dramatic increase of youth suicide over the past three years on rail lines in Los Angeles County. The Team met with representatives from Union Pacific Railroad and Metro Link to discuss rail safety and collaborative efforts to reduce youth suicide. A committee of CASRT members and representatives from rail transportation was formed to meet and develop prevention solutions for these deaths.
- Addressed the challenges to the continuity of care for children hospitalized for suicide risk through a training conducted at Gateways Hospital and Mental Health Center. At the training professionals from the hospital and various schools met to identify common solutions to support adolescents as they transition from inpatient care to home and school. One of the solutions involves innovative ways to encourage patients and family members to sign releases permitting personnel from schools and hospitals to share information and to collaborate in safety planning. This year, the team plans to expand the training to other inpatient hospitals that serve children and adolescents.

Findings

Overall Child Deaths

- There were 215 child deaths from homicide by a parent, relative or caregiver, accidental, suicide or undetermined cause in Los Angeles County for 2013, a 1.8% decrease from the 219 deaths in 2012.
- Nineteen children were victims of homicide by a parent, caregiver or other family member. There were 13 suicides, 93 accidental child deaths and 90 undetermined child deaths.
- There were a total of 24 fetal or child deaths associated with maternal substance use. Sixteen were ruled accidental and 8 undetermined by the Medical Examiner/Coroner.
- Fifty-seven children died with an associated bed-sharing or unsafe sleeping environment. Six of these deaths were ruled accidental and 51 as undetermined.
- The percentage of children who died in 2013 by race/ethnicity consisted of 55.8% Hispanic, 14.9% Caucasian, 17.7% African American, 8.3% Asian/Pacific Islander, 2.80% Unknown and .5% American Indian.
- In 2013, African American children comprised 7.3% of the child population in Los Angeles County and were over represented in the number of child deaths. Caucasian, Hispanic and Asian children were slightly under represented in deaths.
- Over two thirds of the children were between the ages of 0 to five years (n=157). 56% were infants under the age of one year (n=121). Adolescents comprised the fewest number of child deaths representing 18% of all the child deaths in 2013.
- The gender gap of children who died in 2013 returned to males outnumbering females by almost a 3:1 ratio. Thirty-eight percent of the children who died in 2013 were female and 62% male.

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

Homicides

- There were 19 child homicides by parents, caregivers or family members in 2013. This represents an increase of four homicides or a 26.6% increase from 2012 when there were 15 child homicides. The number of child homicides in 2013 for Los Angeles County, however, was significantly lower than the 15 year average of 30.5.
- 84.2% percent of the children killed by their parents, caregivers or family members were five years of age or younger. Forty-two percent of the children were under the age of one year.
- Only three of the 19 homicide victims were over the age of five years.
- The average age of a child homicide victim in 2013 was 2.6 years (30.54 months) which was older than in 2012 when the average age was 1.9 years.
- In 2012, the number of male and female homicide victims was almost evenly split. In 2013, the pattern reverted to the number of male victims outnumbering female victims by more than a two to one margin. Thirteen males and six females were homicide victims in 2013.
- 68% percent of the child homicide victims were battered children who died from inflicted trauma—three children died from head trauma, nine died from multiple blunt force traumas, and one died from trauma to the torso/abdomen. One child was a victim of stabbing, one a victim of strangulation and one died from poisoning/drug ingestion. One child was left in a car and died from hyperthermia and another left unattended in a tub drown.

- One newborn was abandoned and found deceased and/or killed by the mother in 2013. The abandoned newborn was ruled a homicide. Nine newborns were safely surrendered in 2013 which was four fewer than the number in 2012 (n=13). Since 2001, there have been 104 safely surrendered infants.*****
- African American (n=7) children were over-represented in child homicides by a parent, caregiver or family member accounting for 36.8% of these homicides. Hispanic (n=10) children were slightly under-represented and comprised 52.6% of child abuse homicides. One child was Asian and one child was of Caucasian descent.
- The Department of Children and Family Services (DCFS) or another county's Child Protective Services agency had prior contact with 53% (n=10) 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 open case with DCFS and another had an open referral at the time of the child's death. One additional case involved a child with an open referral based on his then near fatal injuries.
- Twelve children were killed by their father, stepfather or mother's boyfriend and three children were killed by their mother. Two children were killed by the mother and boyfriend and two children were killed by the mother and father.
- There were three child homicides by parents, caregivers or family members in May of 2013. The second greatest number of homicides occurred in the months of January, September, October and December with two per month. There were no homicides in the months of April and July. One homicide occurred in the months of February, March, June, August, and November.
- Child abuse homicides occurred throughout Los Angeles County in 2013. The Second District of the Board of Supervisors (BOS) experienced the greatest number of child homicides with six. The Fifth District followed with five child homicides. The First and Fourth Districts of the BOS each had four child homicides. No child abuse homicides occurred in the Third District of the BOS.

***By the end of 2014, 125 infants had been safely surrendered.**

Suicides

- Thirteen children and adolescents committed suicide in 2013. This is a decrease from the 17 suicides in 2012, and fewer than the 15-year average of 17.5 suicides per year.
- For years there was a margin of 3:1 of male to female victims of suicide. This gap decreased significantly in 2011 with 58% of the victims being male and 42% female. In 2012, for the first time, female victims (n=9) outnumbered the male victims (n=8) of suicide. In 2013, the trend reversed back to the number of male victims (n=8) outnumbering the female victims (n=5).
- 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 41.6% (n=6) of the suicides in 2013. Three youth used a firearm and three youth stood in the path of a Metro Link train. One jumped to his death.
- The act of suicide historically occurs in the youth's home. However, in 2013, almost half (n=6) of the youth suicides occurred outside their place of residence.
- Fifty-four percent (n=7) of the adolescent suicides in 2013 were by Hispanic youth and 23.1% (n=3) suicides were by Caucasian youth. The number of suicides by Hispanic youth increased by one from 2012. Suicides by African American youth (n=1) decreased by two-thirds from 2012 and represent 7.7% of the adolescent suicides. Caucasian youth who committed suicide also experienced a large decrease (62.5 %) from 2012. Two of the youth were of Asian/Pacific Islander descent representing 15.4% of the adolescent suicides in 2013.
- Seventy-seven percent (n=10) of the children who committed suicide in 2013 were ages 15 – 17 (four were 16 and four were 17 years and two were 15 years of age). The youngest child who committed

suicide was 11 years of age.

- Sixty-nine percent (n=9) of the adolescent suicides were precipitated by interpersonal conflicts or a recent loss. Nine of the youths' families had a prior referral or case with the Department of Children and Family Services or with the Department of Probation. Two families had an open referral or case with DCFS and one with Probation. Five youth had a history of mental health problems, one was in counseling at the time of his death and three were taking psychotropic medication. Two youth had a history of prior self-injury or cutting and one youth had previously attempted suicide. Nine youth exhibited warning signs prior to their suicide. Three of the youth who committed suicide in 2013 left a suicide note. One youth texted their intent just prior to committing the act but did not leave a note. One youth was discovered to have a positive toxicology for drugs at autopsy. Four youth did have a history of alcohol or drug use. Five youth had school discipline or truancy problems and two experienced academic problems. Five of the youths' families were noted to exhibit signs of family dysfunction (pending divorce or recent divorce, parental mental illness or domestic violence).

- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred in the Fifth District of the Board of Supervisors with four suicides followed by the Fourth District with three. Two each occurred in the First, Second and Third Districts of the Board of Supervisors.

Accidental Child Deaths

- Overall, the rate of accidental deaths among children in Los Angeles County has continued to decline over the years. Accidental child deaths dropped from a high number of 147 in 2004 to the lowest number of 86 in 2010. In 2013, the number increased to 93 accidental child deaths from the 89 such deaths in 2012.

- The leading cause of accidental death for children was automobile accidents (n=18). Although the leading cause of death, auto accident child deaths decreased by 56% from 2012 when there were 28 auto related deaths. This cause of accidental death was followed by maternal substance abuse (n=16) accounting for 17% of the accidental child deaths. Auto pedestrian (n=15) child deaths were the third leading cause and drowning (n=14) the fourth leading cause of accidental child death in 2013.

- Deaths associated with maternal substance abuse as determined by the Coroner from self-report or hospital toxicology results, accounted for 14 fetal deaths and two infant deaths. Methamphetamine use by the mother is the most associated drug with these deaths (n=14) accounting for 87.5%. Four deaths were associated with Cocaine use by the mother and one the exact substance was unknown. Deaths associated with maternal substance abuse accounted for 17.2% of all accidental deaths in 2013. 78% of the accidental fetal deaths were associated with maternal substance use. Fetal deaths associated with maternal substance abuse accounted for 15% of all accidental deaths.

- Accidental drowning claimed the lives of 14 children, an increase of four deaths from 2012 when there were ten such deaths. A majority of these drowning deaths were young children who drowned in residential pools. In 2013, eleven children drowned in a residential pool or Jacuzzi and 50% were five or younger (n=7). Three children who drown in a residential bath tub were one year of age or younger. For the past fifteen years, drowning has been one of the leading causes of accidental deaths of children in Los Angeles County.

- Of the 93 accidental deaths, 76 accidental child deaths involved children ages 0 – 14 years. There were 17accidental deaths of youth's ages 15 to 17 years. More than half (59%) of the accidental child deaths (n=55) were children age five years or younger.

- Six 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 2013, 45% had a DCFS history. Thirteen families of the sixteen child deaths from maternal substance abuse had a history with DCFS. An additional two of the maternal substance abuse associated child deaths involved a mother who had a CPS history as a minor but not as an adult.

- Hispanic children represented 54% (n=50) of all accidental child deaths in 2013. African-American children (n=14) were over-represented in accidental deaths in 2013.

- As in previous years, males (n=61) outnumbered females (n=32) in accidental death.

Undetermined Child Deaths

- There were 90 undetermined child deaths in 2013. This is a decrease from the 98 such deaths in 2012 and lower than the 15-year average of 91.6 undetermined deaths per year. Ninety-one percent of the undetermined child deaths were age one year and under (this includes stillborn deaths). 96% of undetermined child deaths were age five years and younger

- African American (n=16) children were significantly over-represented in undetermined child deaths and Asian (n=5) were under-represented compared to the general population. Hispanic children were under-represented with 53 undetermined deaths.

- Bed-sharing and unsafe sleeping environments accounted for 57% percent of all undetermined child deaths. 34% of the undetermined child deaths were associated with bed-sharing (n=30) and 23% with an unsafe sleep environment (n=21). The reader is referred to Appendix B on How to Keep Your Baby Safe from the ICAN and First 5 LA campaign.

- Among the bed-sharing deaths, 0% involved only one unsafe risk factor, 10% involved two, and 90% 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. 13% of the bed-sharing deaths and 28.6% of the unsafe sleeping environment child deaths were African American. Although African American children represent 19.6% of the combined bed-sharing and unsafe sleep undetermined child deaths, this percentage is much lower than 2012 when they comprised 32% of these undetermined deaths

- Approximately 36% of the families with a child who died from an undetermined death had at least one contact with DCFS or another county CPS agency.

- Seventy-six percent of the infants whose deaths occurred while bed-sharing or in an unsafe sleeping environment were six months of age or younger (n=37).

- In 47% 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 an increase from 2012 when 38% of the infants were placed prone or on their side to sleep.

- Undetermined child deaths involving bed-sharing and unsafe sleeping environments occurred throughout Los Angeles County. However, three of the Board of Supervisorial Districts accounted for the majority of these deaths. 31% (n=16) in District 5, 29% (n=15) in District 2 and District 4 followed with 16% (n=8).

- Thirty-three percent (n=30) of the undetermined child deaths involved bed-sharing. This is a 33% percent decrease from 2012 in which 46% of undetermined child deaths involved bed-sharing.

- Forty-three percent (n=11) of the bed-sharing deaths were infants between 0 to 3 months of age, 37%

(n=13) were infants between 3 to 6 months of age, 17% (n=5) were 6 to 9 months of age, and 3% (n=1) were 9 months to 1 year.

- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 40% of the incidents and two adults in another 20% of the incidents.

- Twenty-three percent (n=21) 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. This is a 100% increase in these types of preventable deaths from 2012 when there were ten such undetermined child deaths.

- Thirty-eight percent (n=8) of the non bed-sharing deaths were infants between 0 to 3 months of age, 48% (n=10) were infants between 3 to 6 months of age, and 14% (n=3) were 6 months to 9 months of age.

- There were 8 undetermined infant deaths in which the mother either tested positive for a substance at birth or self-reported substance use during pregnancy. The majority involved stillborn births (n=6).

- The most frequent substance detected was methamphetamine (n=6).

- Mothers of these infants had prior contact with a CPS agency in Los Angeles or another county in 75% of the deaths. Four mothers had a case with a CPS agency as a minor.

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; the child resided with a parent or guardian or in foster care at the time of the death.

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

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

ICAN findings are based on the final mode of 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. As a result, 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 continue to be one of the largest categories of deaths reported to the Team by the Coroner and, for 2013, this mode of death represents the largest category of deaths reported by the Coroner. Several types of accidental death, such as auto pedestrian fatalities, drowning, hangings and accidental gunshot wounds, are truly unintentional in nature. However, there may be questions of the caregiver supervision in some of these cases, as well as concern regarding the preventability of these accidents. A significant number of accidental deaths involve newborns who were prenatally exposed to drugs and who subsequently died of prematurity or from other related perinatal causes.

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

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

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

Child Deaths in Los Angeles County 2009 – 2013

Over the past 5 years, a parent, caregiver or other family member has killed an average of 22.6 children each year.

2009	29[1]
2010	26
2011	24
2012	15
2013	19

An average of 15.8 children and adolescents each year have committed suicide over the past five years. The leading method from 2009 through 2013 was hanging

2009	14
2010	16
2011	19
2012	17
2013	13

Over the past five years, an average of 89.4 children have died from preventable accidents. The most common accidental Deaths involve automobile accidents, maternal substance abuse and deaths due to auto pedestrian.

2009	94
2010	86
2011	88
2012	89
2013	93

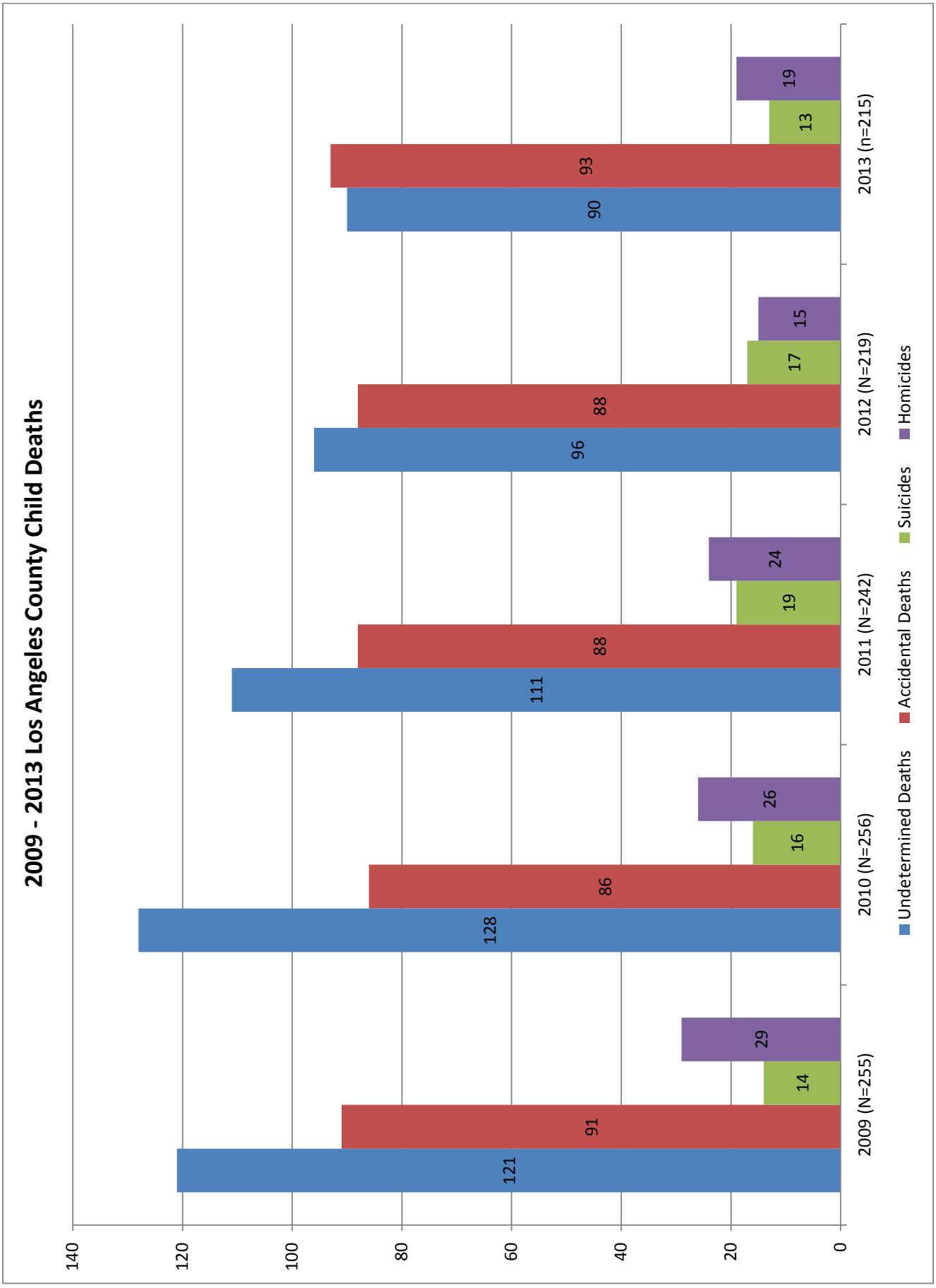
The number of undetermined deaths has averaged 109.6 per year over the past five years.

2009	121
2010	128
2011	111[2]
2012	98
2013	90

1. A homicide in which a familial relationship was initially suspected turned out to be a family acquaintance changing it to a third party homicide and decreasing the number of these for CY 2009 from 30 to 29.
2. Three Undetermined stillborn child deaths were reported after the release of the 2012 report raising the number from 108 reported to 111 Undetermined Deaths in 2011.

2013 Child Deaths Demographics

	NUMBER	PERCENTAGE
Total	215	100
Gender		
Female	81	37.7
Male	134	62.3
Age		
Under 1 year	121	56.3
1 – 4 years	33	15.3
5 – 9 years	11	5.1
10 – 14 years	21	9.8
15 – 17 years	29	13.5
Race		
African American	39	18.1
Asian/Pacific Islander	18	8.4
American Indian	1	.4
Caucasian	32	15
Hispanic	119	55.3
Unknown	6	2.8


2009 - 2013 Los Angeles County Child Deaths
140
120
100
80
60
40
20
0
2009 (N=255)
2010 (N=256)
2011 (N=242)
2012 (N=219)
2013 (n=215)
121
91
14
29
128
86
16
26
111
88
19
24
96
88
17
15
90
93
13
19
Undetermined Deaths
Accidental Deaths
Suicides
Homicides

Child Homicides by Parent, Caregiver, or Other Family Members 2013

Case Summaries

Child Homicide by Parent/Caregiver/Family Member

Javier

Javier, age 19 months was in his car seat when he began vomiting and choking. His father turned the car around and picked up the mother before taking the toddler to the emergency room. Javier passed shortly after his arrival to the ER. He had a black right eye, bruising on his forehead, chest/rib areas, pelvic area and genitals.

Javier's 44 year-old father reported the child had "poor" balance and frequently fell. A month prior Javier had fallen off a small step and broke his arm and received a black eye. The mother reported the same but when relatives were questioned by the detective, he was told three different versions as to how Javier received the injuries.

The parents were not married and did not live together. Relatives reported the father is married to another woman and he is a father and grandfather. He was upset about the mother's pregnancy and wanted her to terminate it but she refused. The mother was alone throughout her pregnancy and had not received any support from the father until about six months ago. It was also about this time when the mother moved out of a supportive family friend's home to a more distant area which was paid for by the father. The mother began to isolate herself and not bring Javier to visit the family.

The mother reported she had taken Javier for a routine physical two days before his death and was told he was fine. The final mode of death was ruled a homicide due to blunt force trauma. Javier had broken ribs, multiple bruises to the head, face and torso. He had tears and hemorrhaging to the liver. The father was arrested and is currently awaiting trial for the murder of Javier.

Susie

10 month-old Susie was found unresponsive and face down in a pack-n-play with her head on a pillow by her 28 year old mother. 911 was called and Susie was transported to the ER by paramedics. Despite multiple attempts, she could not be resuscitated and was pronounced. There were no obvious signs of trauma observed by hospital or EMR personnel.

The hospital social worker met with the mother after Susie's death. The social worker recognized the mother's name from an incident that occurred three days earlier and a report made to DCFS. The mother was a patient in the ER complaining of stomach pain and was given morphine. A test given to the mother prior to her receiving the morphine came back positive for opiates and methadone. When confronted, the mother admitted to using methadone and receiving morphine at another hospital the day before. While in the ER on the same date with the children, the father was seen injecting a substance into his arm. Both parents claimed he was a diabetic but even so, the father injected the substance in an area not usual for an insulin injection.

There were two prior referrals to DCFS on the family for neglect. One was evaluated out and the other for the incident above, closed as inconclusive. The mother had a history of methadone, heroin and methamphetamine use and the father a history of methamphetamine and marijuana use. The family was homeless at the time of Susie's death and they were staying from motel to motel.

After laboratory test results conducted for the autopsy came in months after her death, Susie was found to have died from a methadone overdose. The mother was arrested in January of 2014 when the autopsy results ruled the death a homicide. The father died of a drug overdose in June of 2014. The mother is awaiting trial and remains in custody.

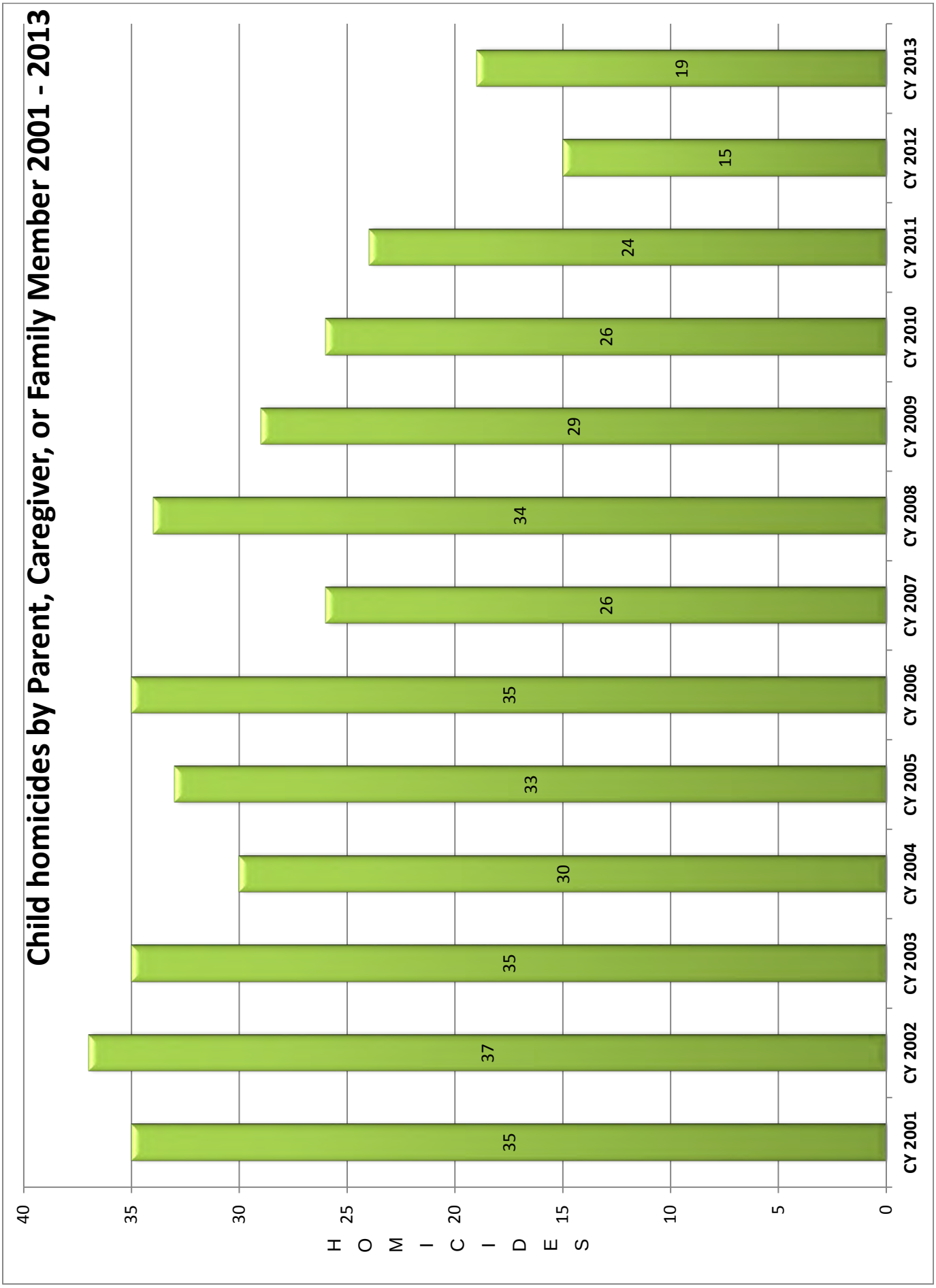
Leo

Three month-old Leo resided with his 21 year-old mother, and 20 year-old father. The mother had returned to work the day prior to his death. The father worked long hours at his job, then picked Leo up from the grandparents and went home. He reported Leo spit up formula when burped. He was giving him a bath in a plastic baby bath tub when Leo jerked his head back and hit the tub hard. He immediately became unresponsive. The father panicked and called the grandparents who instructed him to call 911.

Paramedics arrived and were able to regain a pulse. Leo was taken to the ER where a CT Scan was performed. The infant was found to have right and left skull fractures, subdural hematomas and massive retinal hemorrhages in both eyes. Leo never regained consciousness and had no brain functioning. He remained in intensive care for five days when cardiac death was pronounced.

The father changed his story saying Leo's head hit the sink the plastic tub was resting in as an explanation for the injuries. At autopsy, Leo was found to have three separate skull fractures, retinal hemorrhages and subdural hematomas which could not have occurred with one single hit. The death was ruled a homicide due to blunt head trauma.

There was no DCFS history with this family but both parents had a history as a child. The father was arrested and charged with murder and child abuse resulting in the death. He was found not guilty of homicide but guilty of causing the death of a child and was sentenced to four years in state prison.


Child homicides by Parent, Caregiver, or Family Member 2001 - 2013
HOMICIDES
0
5
10
15
20
25
30
35
40
CY 2001
CY 2002
CY 2003
CY 2004
CY 2005
CY 2006
CY 2007
CY 2008
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
35
37
35
30
33
35
26
34
29
26
24
15
19

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

	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	Total
Head Trauma	15	5	5	2	7	7	6	11	11	12	8	2	10	5	3	**109**
Multiple Trauma	10	11	7	7	10	7	8	7	7	4	2	1	6	2	9	**98**
Asphyxiation/suffocation	6	3	8	5	6	5	5	6	6	3	2	3	2	0	1	**61**
Gunshot Wounds	4	3	2	1	4	3	6	1	1	8	7	4	2	0	0	**46**
Trauma to torso/abdomen	1	0	0	3	0	0	2	1	1	1	1	5	1	2	1	**19**
Drowning	0	3	1	7	1	1	2	3	3	0	1	2	0	3	1	**28**
Fire	0	1	0	0	0	0	0	3	3	1	0	0	0	0	0	**8**
Stabbing	1	4	1	2	0	3	2	2	2	2	4	6	1	1	1	**32**
Unattended newborn	4	2	3	2	3	0	2	0	0	1	2	1	0	0	1	**21**
Poisoning/drug ingestion	0	0	3	6	1	1	0	0	0	0	0	0	0	1	1	**13**
Dehydration/malnutrition	0	1	1	0	1	2	0	0	0	1	1	0	1	0	0	**8**
Strangulation	0	0	0	0	0	0	0	1	1	0	0	1	0	1	0	**4**
Medical neglect	0	1	2	0	0	0	0	0	0	0	1	1	0	0	0	**5**
Burns	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Hyperthermia	0	0	0	0	2	0	0	0	0	1	0	0	0	0	1	**4**
Post-Term Gestation	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**1**
TOTAL	**42**	**34**	**34**	**35**	**35**	**29**	**33**	**35**	**35**	**34**	**29**	**26**	**24**	**15**	**19**	**459**

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

Age	Female	Male
Under 1	4	4
1 year	0	4
2 years	1	1
3 years	1	0
4 years	0	1
7 years	0	1
8 years	0	1
11 years	0	1
TOTAL	**6**	**13**

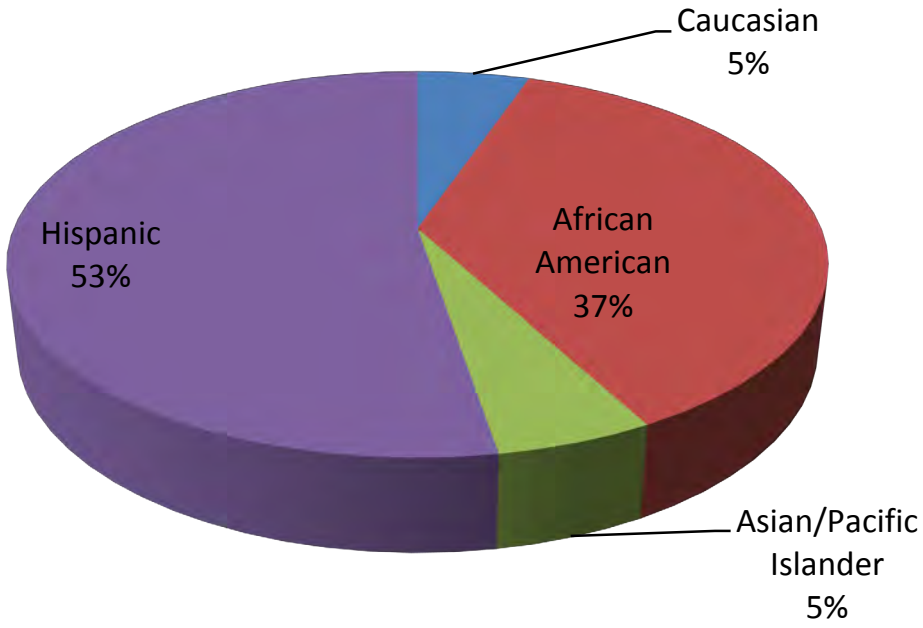
84.2% of the child homicide victims by parents/caregivers/family member were five years of age or under.

73.7% of the child homicide victims by parents/caregivers/family member were two years of age or under.

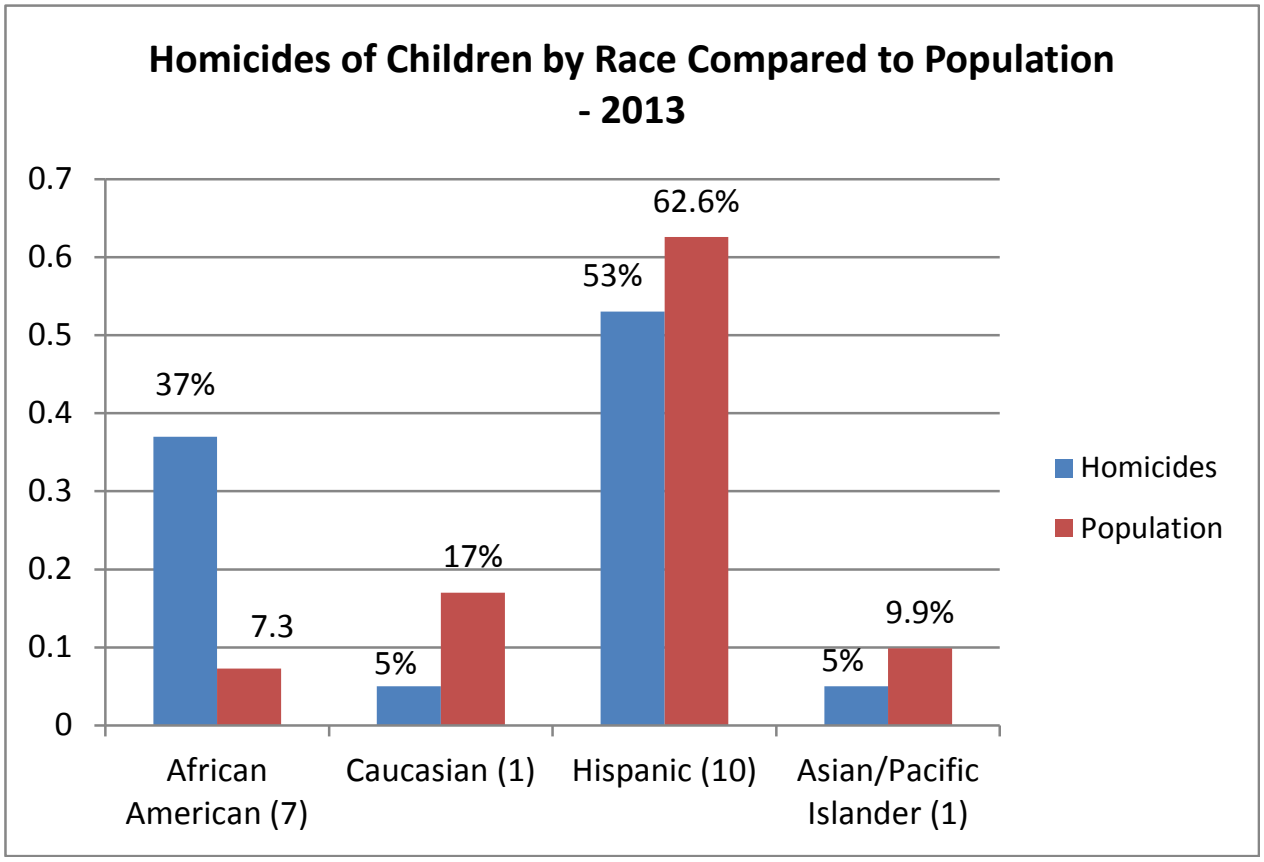
42.1%% of the child homicide victims by parents/caregivers/family member were under one year of age.

68.4% of the victims were male and 31.6% were female.

2013 Child Homicides - Race



Los Angeles Child Population
Ages 0-17: 2,329,494
Hispanic 62.6%, Caucasian 17%, African American 7.3% , Asian/Pacific Islander 9.9%, Native Indian/Alaskan .1% and Multi-racial 3.1% Kidsdata.org



Relationship of Suspect to Child Homicide Victim – 2013

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

12– Father, Stepfather or mother's boyfriend

3 – Mother

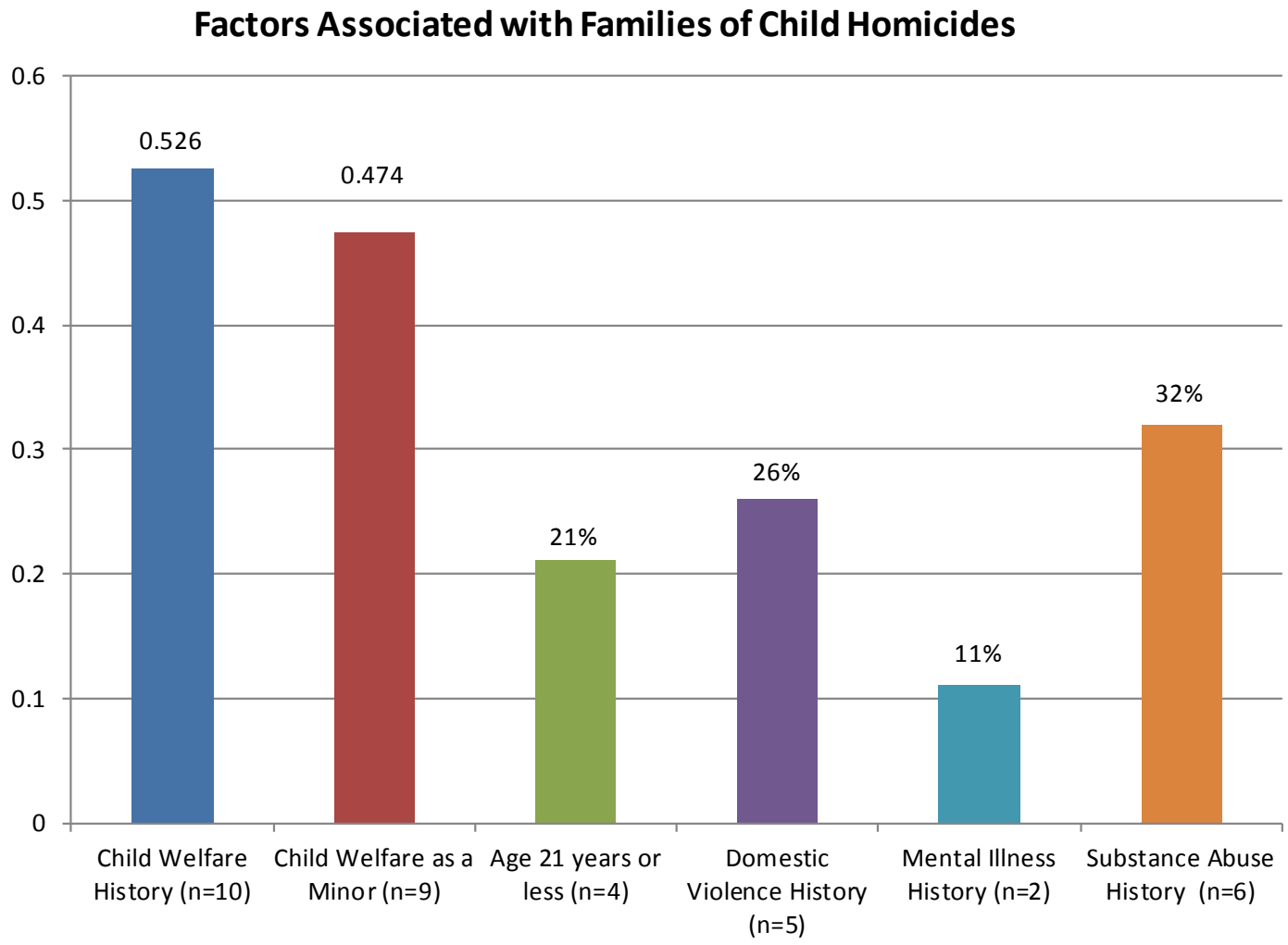
2 – Mother and Father

2 – Mother and Boyfriend

Relationship and Age of Suspects to Child – 2013

Relationship	Total	<19 years	19-21 years	22-25 years	26-30 years	31-40 years	40+ years
Biological Father	9	0	3	1	2	1	2
Biological Mother	7	0	1	3	3	0	0
Mother's Boyfriend/ Stepfather	7	0	0	2	3	1	1
Total	**23**	**0**	**4**	**6**	**8**	**2**	**3**

Characteristics Present in the Families of Child Homicides



The top two common characteristics present in families in which a homicide occurred are the family had at least one prior child welfare contact and the parent had a child welfare or probation history as a child. Substance Abuse History as determined by whether there was a presence at the time of death or family history occurred in 32% 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 1.

Table 1

Law Enforcement Agency Involvement in 2013 ICAN Child Homicide by Parent/Caregiver/Family Member

Agency	N	%
LASD	10	52.6
LAPD ACU	3	15.8
LAPD	1	5.3
Downey P.D.	2	10.4
Long Beach P.D.	1	5.3
Inglewood P.D	1	5.3
Covina P.D	1	5.3

The Los Angeles Sheriff's Department Homicide Bureau had investigative responsibility for 53% (n=10) of the child homicides by parents/caretakers/family member. The Los Angeles Police Department had investigative responsibility for 21.1% (n=4) of the 2013 child homicides by parents/caretakers/family member. The LAPD Abused Child Unit was responsible for all but one of the LAPD investigations. 26.3% (n=5) of the cases were handled by jurisdictions other than LASD and LAPD.

There were a total of twenty-three suspects in the nineteen homicide cases. Three of the 2013 cases involving child homicide by parents/caregivers/family member were not presented to the District Attorney. The reasons why those cases were not presented are displayed in Table 2.

In 2013, the singular reason for law enforcement not presenting a case was that the case remains under investigation and has not been presented to the District Attorney. One case involving a bath tub drowning remains under investigation as does an abandoned deceased newborn homicide case. The third case remains under investigation on both parents in which a clear timeline and perpetrator cannot be criminally sufficiently proven.

Table 2

Law Enforcement Reasons for Not Presenting 2013 ICAN Child Homicide by Parent/Caregiver/Family Member

	N	%
Under Investigation	3	100
TOTAL	3	100

Table 3

Criminal Charges Filed on 2006 - 2013 ICAN Child Homicide by Parent/Caregiver/Family Member

	2006	2007	2008	2009	2010	2011	2012	2013
Murder (187 (a) P.C.)	20	21	20	13	16	13	11	15
Assault on a child under 8 years resulting in death (273ab P.C.)	15	17	16	11	7	14	8	11
Child abuse leading to death of a child (273a(a) P.C.)	11	28	19	5	10	8	4	1
Child endangering (273a(1) P.C.)								1
Corporal punishment or injury of child (273d P.C.)		1						
Voluntary manslaughter (192a P.C.)	1	5	1		1	1		
Involuntary manslaughter (192b P.C.)		1	1					
Vehicular manslaughter DUI with gross negligence (191.5(a) P.C.)		1						
Vehicular manslaughter (192 (c) P.C.)								
Vehicular manslaughter for financial gain (192(c)(3) P.C.)								
Attempted murder (664/187 (a) P.C.)		1	12		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.)		2						
Battery (242-243(e) 1 P.C.)		1			1			
Torture (206 P.C.)		1		3	1		1	
Mayhem (203 P.C)								
Assault to commit rape/mayhem					1			
Vandalism (594 P.C.)		1						
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			
Assault to commit rape/mayhem						1		
Vandalism (594 P.C.)			1					
Discharge of firearm inhabited dwelling (246 P.C.)								
Assault with semiautomatic weapon (245 (b) P.C.)								
Unlawfully causing a fire of any structure (451B)	1							
Aiding and abetting a designated felony (32 P.C.)	3					1		
Financial gain from prospective adoptive parents (273(d)(a) P.C.)								
Possession of marijuana for sale (11359 H&S)	2					1		
Unlawful to drive while DUI (23153(a) V.C.)	1							
Unlawful to drive with .08% or more DUI (23153(b) V.C.)	1							
Failure to stop @ accident scene resulting in injury/ death (20001(a) V.C.)	1							
Flight of peace officer causing serious bodily harm (2800.3 V.C.)	1							
Fleeing pursuing peace officer (2800.2(a) V.C.)	1							
Criminal storage of a weapon with access to a child						2		

In 2013, 16 of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving 19 perpetrators.

Of the 16 cases, two were declined due to insufficient evidence. In one of the cases declined by the District Attorney, the father was the suspected perpetrator for having left his child in a car. The second case was referred back to law enforcement for further investigation in which the mother and stepfather are potential suspects.

The charges filed by the District Attorney in the past eight years are illustrated by Table 3. The District Attorney filed criminal charges on 87.5% (n=14) of the 16 homicide cases presented to them by law enforcement in 2013. Charges were filed against 16 perpetrators involved in the fourteen cases. Defendants were charged with Murder (187 (a) P.C.) on all the cases in which charges were filed.

Table 4

Relationship of Perpetrators - 2013 ICAN Child Homicide by Parent/Caregiver/Family Member

Relationship	ID'd by Police	Charged By DA
Mother	7	3
Father	9	7
Step father/Mother's Boyfriend	7	6

Table 5

Criminal Case Disposition of 2005 - 2013 ICAN Child Homicides by Parent/Caretaker/ Family Member[3]

	2005	2006	2007	2008	2009	2010	2011	2012	2013
Life without possibility of parole	1	1		1		2	2	1	
80 years to life prison						1	1		
56 years to life prison								1	
50 years to life prison	2	1			1	1	1	1	
40 years to life prison					1			1	
31 years to life prison									1
26 years to life prison		2							
25 years to life prison	1	1	6	8	2	7	4	2	5
22 years to life prison									1
19 years to life prison					1		1		
18 years to life prison								1	
17 years to life prison					2		1	1	
16 years to life prison	1					1	2		
15 years to life prison	1	2	2	1	3	1		2	1
14 years to life prison									1
13 years prison					1			1	
12 years prison		1	1	4	1	1	1		
11 years prison	1	2	3	4	1	2	1	2	2
10 years prison	1	2	2		1	1	1	1	
9 years prison	1	1						2	
8 years prison	1	4				1			
7 years prison								1	
6 years prison	1	1	2	2	1	1	2	2	1
5 years prison				1		1	2		1
4 years prison	1		2		1	1			
2 years prison	3	1	2	1					
16 months prison		1		1					
3 years jail							1		
1 year jail	1	1				1	2	1	
9 months jail		1							
6 months jail	1								
Less than 3 months jail	1	2			1				
6 yrs Probation									
5 yrs Probation	1	1		2					
3 yrs Probation	3								
Found not guilty							1		1
Dismissed	3	3				1		1	
Arrest warrant					1			1	
Mental competency hearing	1		1	1	1			2	
Sentence pending									
Pending trial					1	3	10	6	16
Pending Further Investigation					2				

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

Criminal disposition data for 2005 through 2013 is presented in Table 5. The table reflects the year a perpetrator was sentenced and the majority of cases are concluded one to two years after the filing date. Of the 2013 child homicides, none of those charged had a disposition in 2013.

In 2013, defendants received the following sentences from previous year's cases: Five perpetrators were sentenced to 25 years to life in prison and two were sentenced to 11 years. One perpetrator was sentenced to one to 31 years to life. The remaining sentences varied from 5 to 22 years in prison. One perpetrator was acquitted of all charges.

There are no cases pending from 2007 but one defendant whose case was filed in 2007 was sentenced in 2013 to 25 years to life. Two defendants from 2008 cases were sentenced in 2013. One received 11 years and the other 25 years to life in state prison. For 2009, two cases are still pending trial. One 2009 defendant was sentenced to 25 years to life in 2013. One 2010 defendant was sentenced to 25 years to life in 2013. A second 2010 defendant was acquitted of all charges in 2013. Ten of the 2011 cases filed by the DA remain pending trial as of 2013. There was one conviction for a 2011defendant who was sentenced to 22 years in state prison. Six of the 2012 cases remain pending trial as of 2013. Five 2012 defendants were convicted in 2013 and received sentences ranging from 6 years in state prison to 31 years.

2013 Child Homicides by Parents, Caregivers or Family Member
Child Welfare Involvement 2001 – 2013*

Year	Total # of homicides by parent/care giver/family member	Total # of homicides with DCFS family history(prior contact OR open case)	Of total with DCFS family history, the # of homicides that had PRIOR DCFS contact only	Of total with DCFS family history, the # of homicides in OPEN DCFS case or referral	# Killed by out-of-home caregiver
2000	35	15	7	8	2 – relative caregivers 0 – foster parent
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[4]	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3[5]	1 – relative caregivers 0 – foster parent
2008	34	14[6]	6	8	0 – relative caregivers 0 – foster parent
2009	29[7]	19[8]	14	5[9]	1 – relative caregivers 0 – foster parent
2010	26	13[10]	9	4	0– relative caregivers 1 – foster parent
2011	24	6	2	4	0 – relative caregivers 0 – foster parent
2012	15	7	4	3[11]	0 – relative caregivers 0 – foster parent
2013	19	11	7	4[12]	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

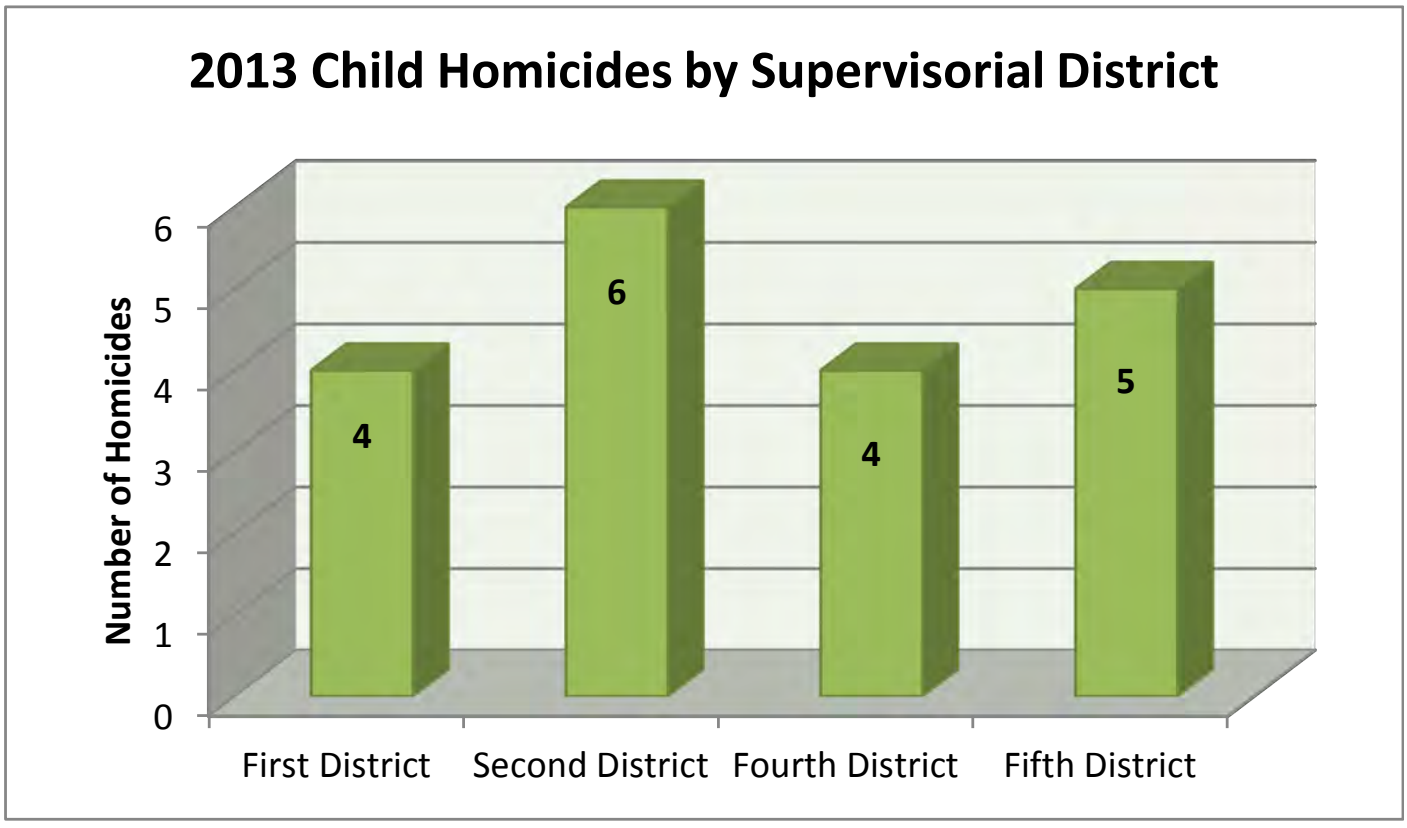
4. The CDRT reviewed an undetermined child fatality and changed the manner of death to "homicide". The case was open to DCFS when the fatality occurred. Another open DCFS case with a homicide was autopsied in another county and not reported to ICAN for inclusion in the 2007 report.
5. One was open to another county.
6. ICAN counts only deaths in LA County ruled a homicide by the Coroner. Two children died in LA County but were injured in another county and under that county's CPS supervision.
7. In 2011, a homicide suspected of a familial relationship turned out to be a family acquaintance and it became a 3rd Party homicide. The 2009 homicides decreased from 30 to 29 as a result.
8. Includes two deaths with a CPS history in another state and one death with history in another county.
9. One child died in LA County was under the jurisdiction of Riverside CPS.
10. One child died in LA County had history in another county but not in LA County.
11. One child was killed by a caregiver who had an open case with DCFS.
12. One case was open due to the child's injuries before death. The family had no prior DCFS history.

Dates[13] of Child Homicides – 2013

2 homicides occurred in January (01/17 & 01/18)
1 homicide occurred in February (02/28)
1 homicide occurred in March (03/01)
1 homicide occurred in April (04/24)
3 homicides occurred in May (05/10, 05/24 & 05/27)
1 homicide occurred in June (6/12)
0 homicides occurred in July
2 homicides occurred in August (08/09 & 08/25)
3 homicides occurred in September (09/09, 09/18 & 09/22)
2 homicides occurred in October (10/03 and 10/13)
1 homicide occurred in November (11/28)
2 homicides occurred in December (12/14 & 12/31)

Locations[14] of Child Homicides – Geographic Area – 2013

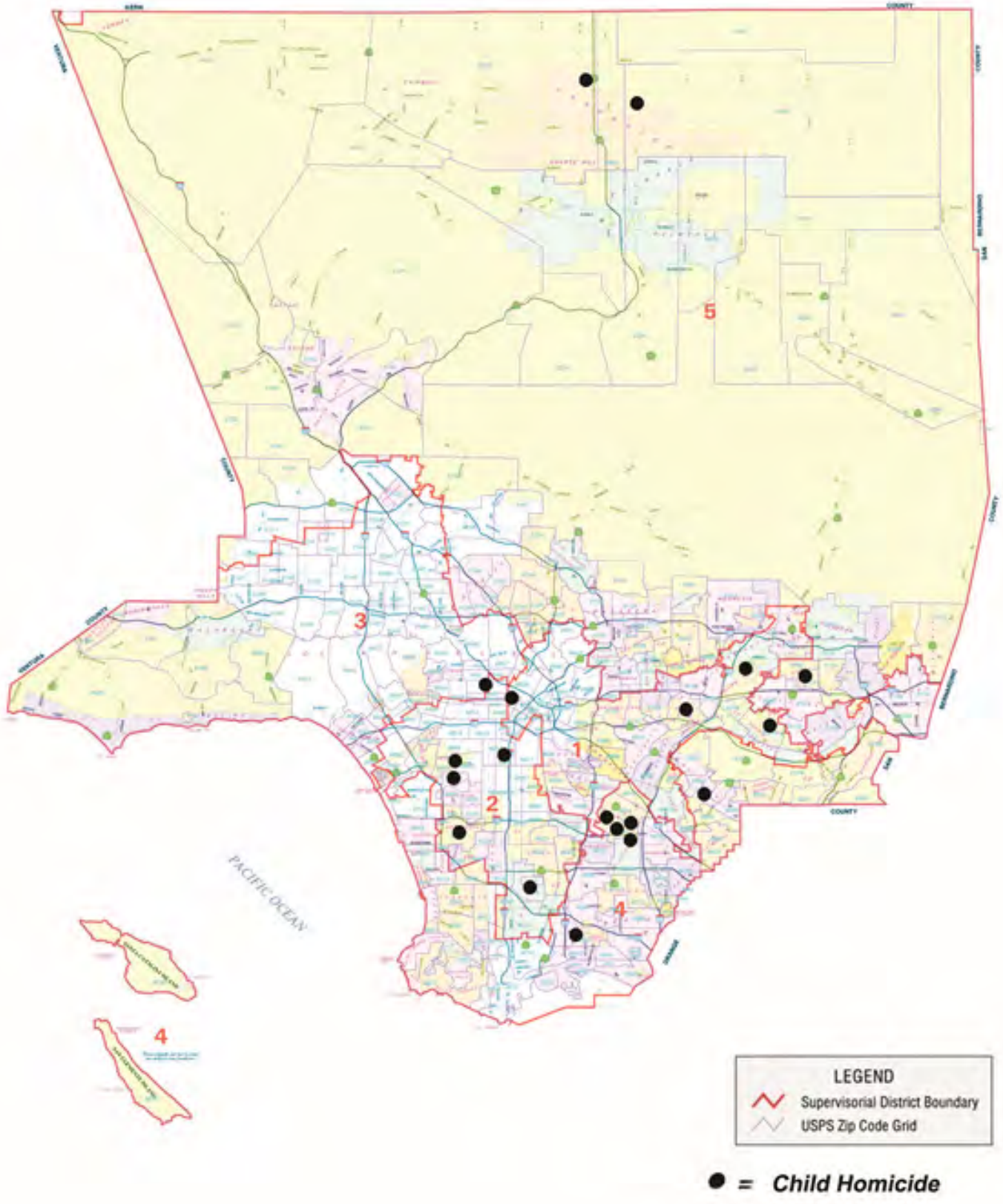
1 homicide occurred in Los Angeles (zip code 90004)
1 homicide occurred in Los Angeles (zip code 90037)
1 homicide occurred in Los Angeles (zip code 90043)
1 homicide occurred in Los Angeles (zip code 90057)
1 homicide occurred in Whittier (zip code 90605)
1 homicide occurred in Covina (zip code 91723)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in La Puente (zip code 91744)
1 homicide occurred in Inglewood (zip code 90302)
1 homicide occurred in South El Monte (zip code 91733)
1 homicide occurred in Baldwin Park (zip code 91706)
2 homicides occurred in Downey (zip code 90242)
2 homicides occurred in Palmdale (zip code 93550)
2 homicides occurred in Lancaster (zip code 93534)
1 homicide occurred in Long Beach (zip code 90806)
1 homicide occurred in Carson (zip code 90746)



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

2013 Child Homicides

N = 19



Case Summaries

Victoria

Victoria was a 16-year-old Hispanic female with a history of depression and suicidal thoughts in the year prior to her death. Her ex-boyfriend had committed suicide in that same year. Victoria's family had recently re-located from one part of the county to another. Her parents removed her from public school and were home schooling her at the time of her death. They reported Victoria had been acting up, smoking cigarettes, drinking alcohol, dressing up Goth and wearing make-up that they did not approve. She told her parents she was not happy but had no specific suicide plan. After an argument with her parents, Victoria left the home. A few hours later, she walked into the path of a Metro Link train. Her backpack was found at the scene and a suicide note written in a journal was inside the backpack.

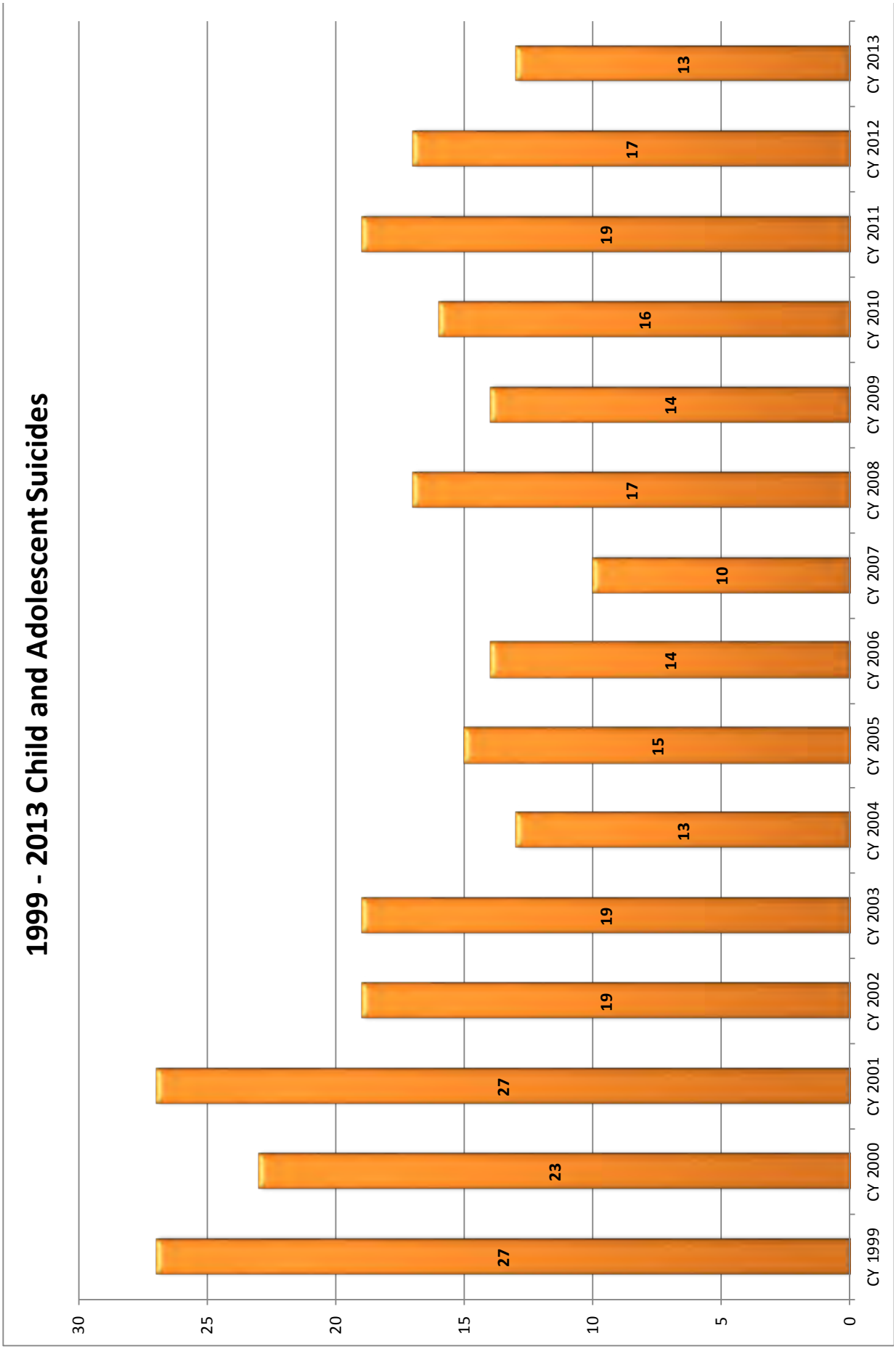
Kevin

Kevin, a 15-year old, Hispanic male, had been reluctant to go to school for the past two months but never gave a reason and would always end up going. His mother knew a parent/teacher conference was coming up but Kevin kept putting her off as to the exact date. He finally told her that it was later in the week when she threatened to call the school. While waiting in the car to take him to the conference, there was a loud bang from the home. Kevin's older brother came running out screaming as Kevin just shot himself in the bathroom. He was pronounced at the scene. The gun belonged to his father and was always kept in a locked gun safe unloaded. His family and friends reported they were blind-sided by his death. He had no history of suicide attempts or ideation and was not depressed. He did not drink or use drugs. No note was found. The parent/teacher conference was a normally schedule one the school provides for all students. Kevin did not have any discipline issues at school and his grades were average. He had complained in elementary school about being picked on by other children but there was no record of this continuing in middle or high school.

Charlene

Charlene was a 17-year-old Caucasian female with a history of depression and had thoughts about suicide since being raped two years earlier. She was in counseling and on anti-depressants until three months prior to her death when she abruptly stopped. She never attempted suicide before but did some "cutting" on her wrists the year before and would make suicidal threats. She was a friend of a youth who had committed suicide the year before. She had recently learned that a favorite coach was terminally ill. On the evening of her death, Charlene had snuck out of the house to go to a party. When she returned late that night, she had an argument with her mother and was grounded for sneaking out. When she was not in her bedroom the next morning, the family began to search for her. Her father found her hanging in the garage.

She did not leave a note.


1999 - 2013 Child and Adolescent Suicides
30
25
20
15
10
5
0
CY 1999
CY 2000
CY 2001
CY 2002
CY 2003
CY 2004
CY 2005
CY 2006
CY 2007
CY 2008
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
27
23
27
19
19
13
15
14
10
17
14
16
19
17
13

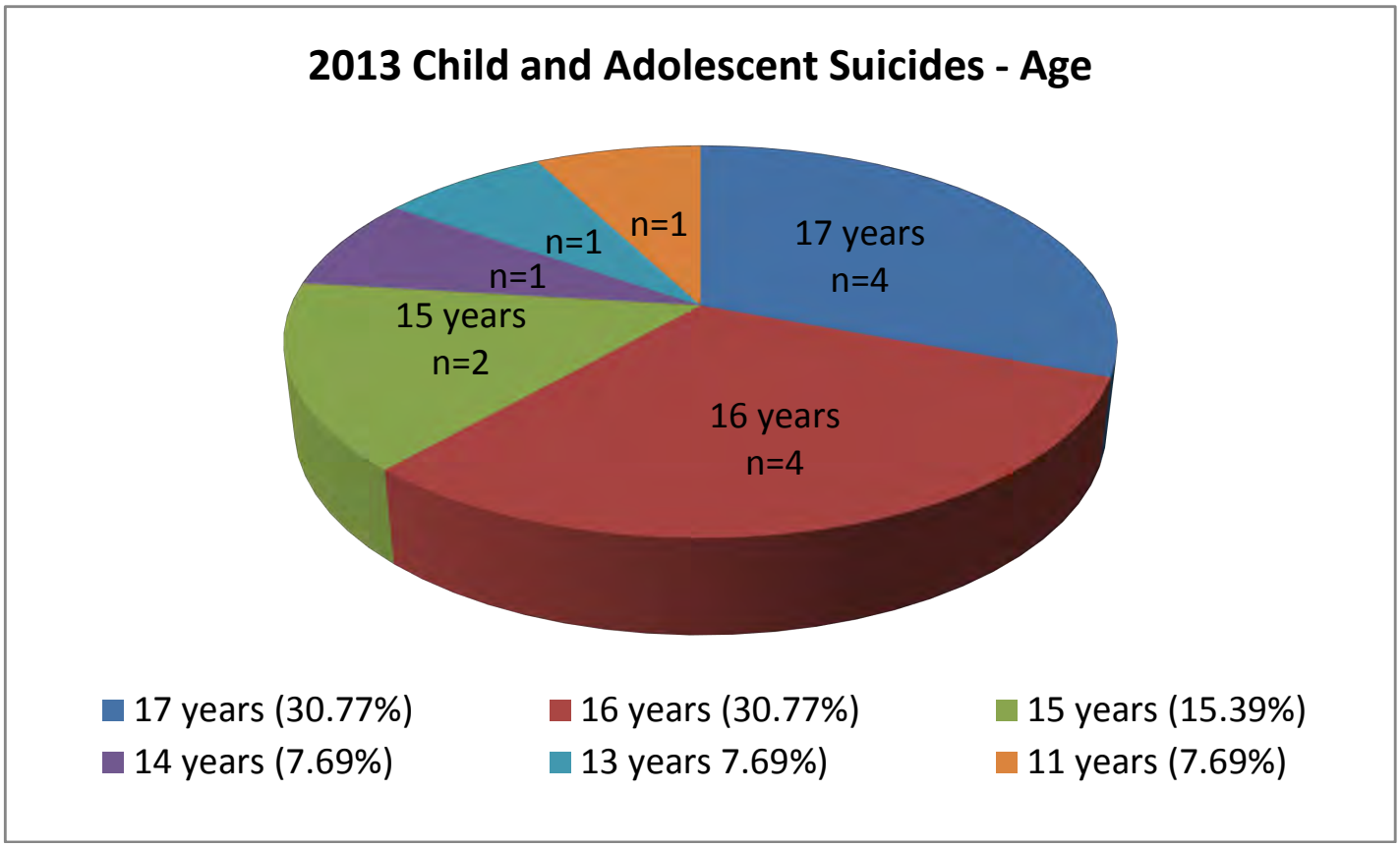
Child and Adolescent Suicides by Method and Gender
Los Angeles County – 2013 (n = 13)

Method	Male	Female
Hanging	2	4
Firearms/Gunshot	3	0
Jump	1	0
Train vs. Ped	2	1
TOTAL	8	5

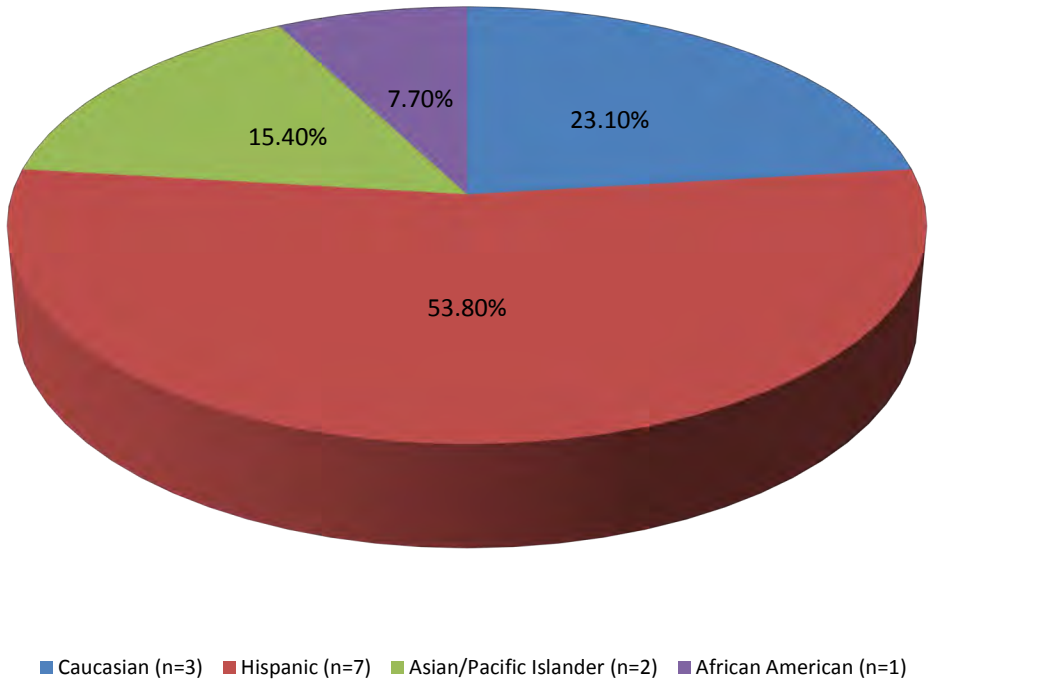
Hanging was the most frequent method of suicide among adolescents and represents 46.1% of the suicides in 2013. Gunshot and Train vs. Pedestrian was the second most frequent method of suicide in 20123with three each.

In 2013, 38.5% (n=5) of the adolescent suicide victims were female. 61.5% (n=8) of the victims of adolescent suicide in 2013 were male.

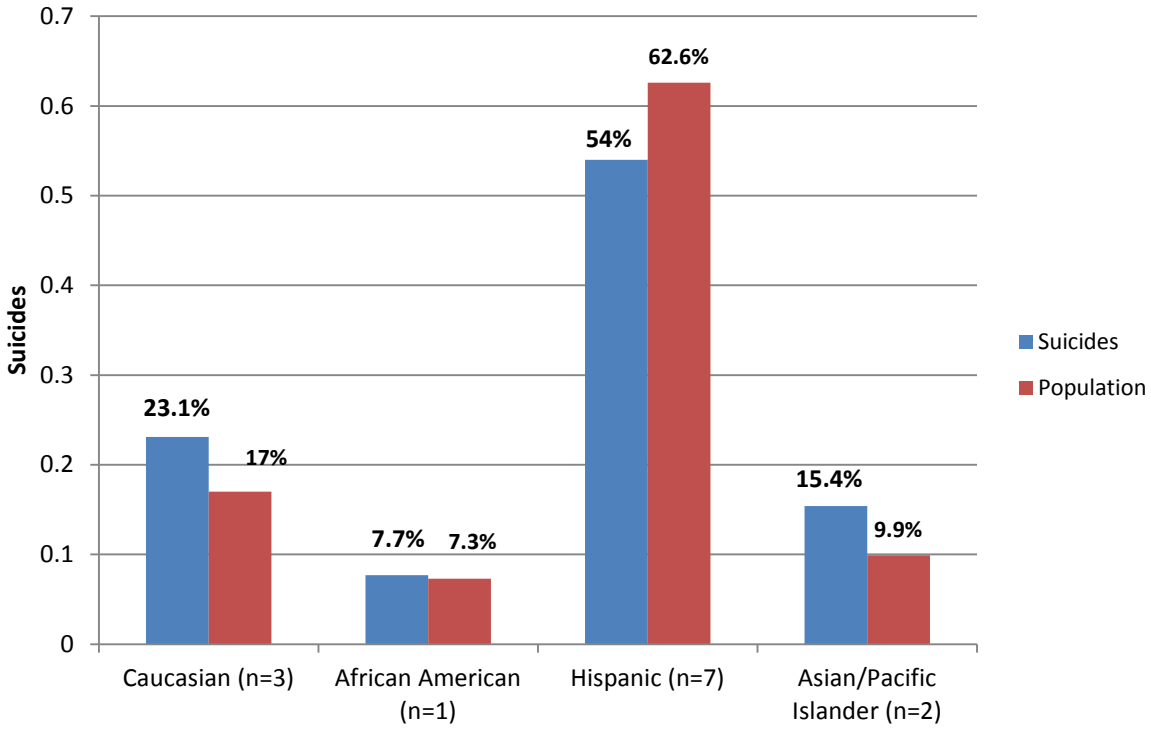
2013 returned to the trend of previous years with male victims outnumbering female victims of suicide.

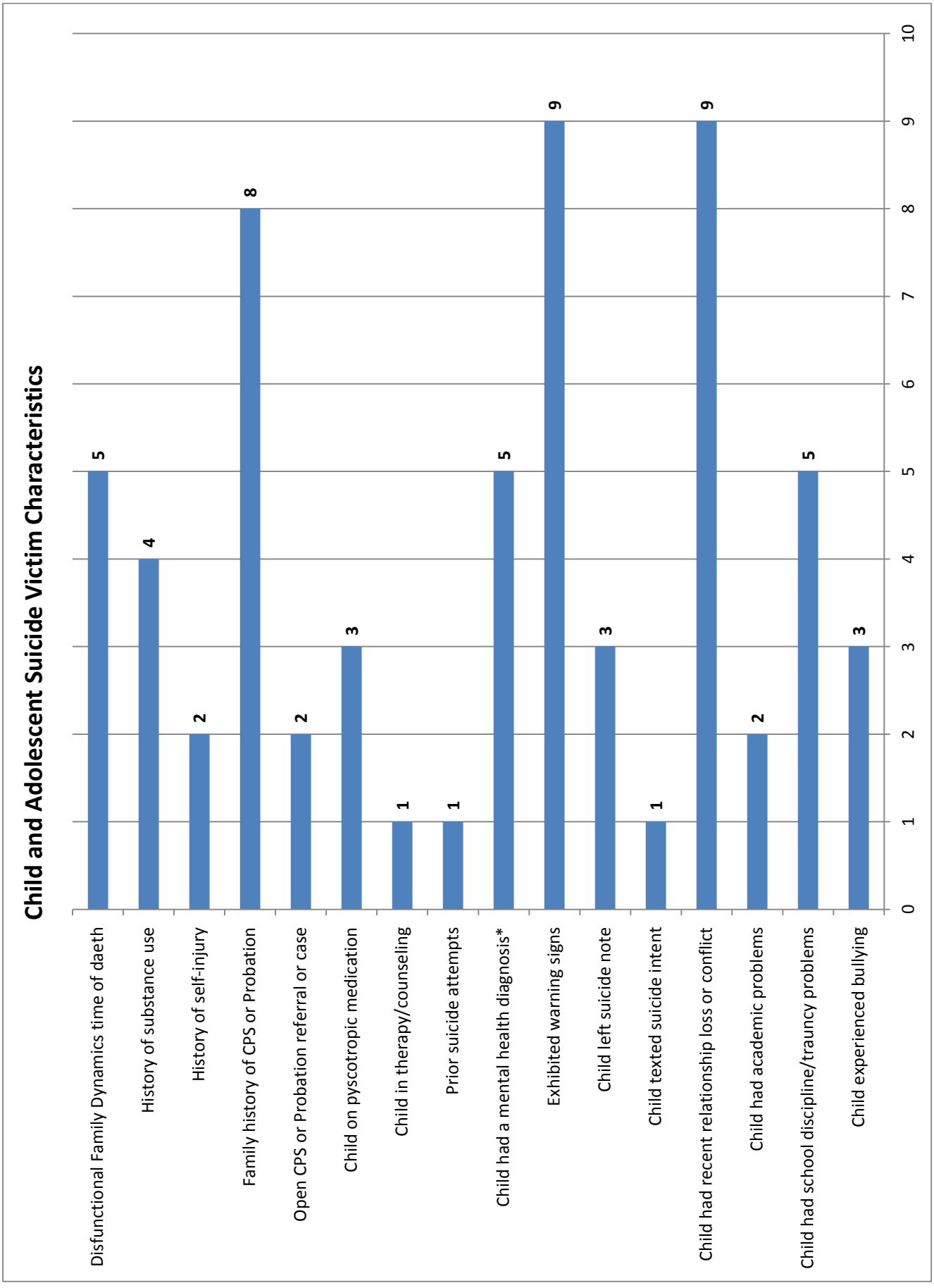


2013 Child and Adolescent Suicides - Race



Suicides of Children by Race Compared to General Population - 2013




Child and Adolescent Suicide Victim Characteristics
Disfunctional Family Dynamics time of daeth
History of substance use
History of self-injury
Family history of CPS or Probation
Open CPS or Probation referral or case
Child on pyscotropic medication
Child in therapy/counseling
Prior suicide attempts
Child had a mental health diagnosis*
Exhibited warning signs
Child left suicide note
Child texted suicide intent
Child had recent relationship loss or conflict
Child had academic problems
Child had school discipline/trauncy problems
Child experienced bullying
5
4
2
8
2
3
1
1
5
9
3
1
9
2
5
3
0
1
2
3
4
5
6
7
8
9
10

Dates of Child and Adolescent Suicides – 2013

0 suicides occurred in January
0 suicides occurred in February
1 suicide occurred in March (03/01/2013)
1 suicide occurred in April (04/15/2013)
1 suicide occurred in May (05/28/2013)
0 suicides occurred in June
2 suicides occurred in July (07/08 and 07/14/2013)
4 suicides occurred in August (08/07, 08/25, 08/27 & 08/28/2013)
3 suicides occurred in September (09/01, 09/19 & 09/30/2013)
0 suicides occurred in October
1 suicide occurred in November (11/0/2013)
0 suicides occurred in December

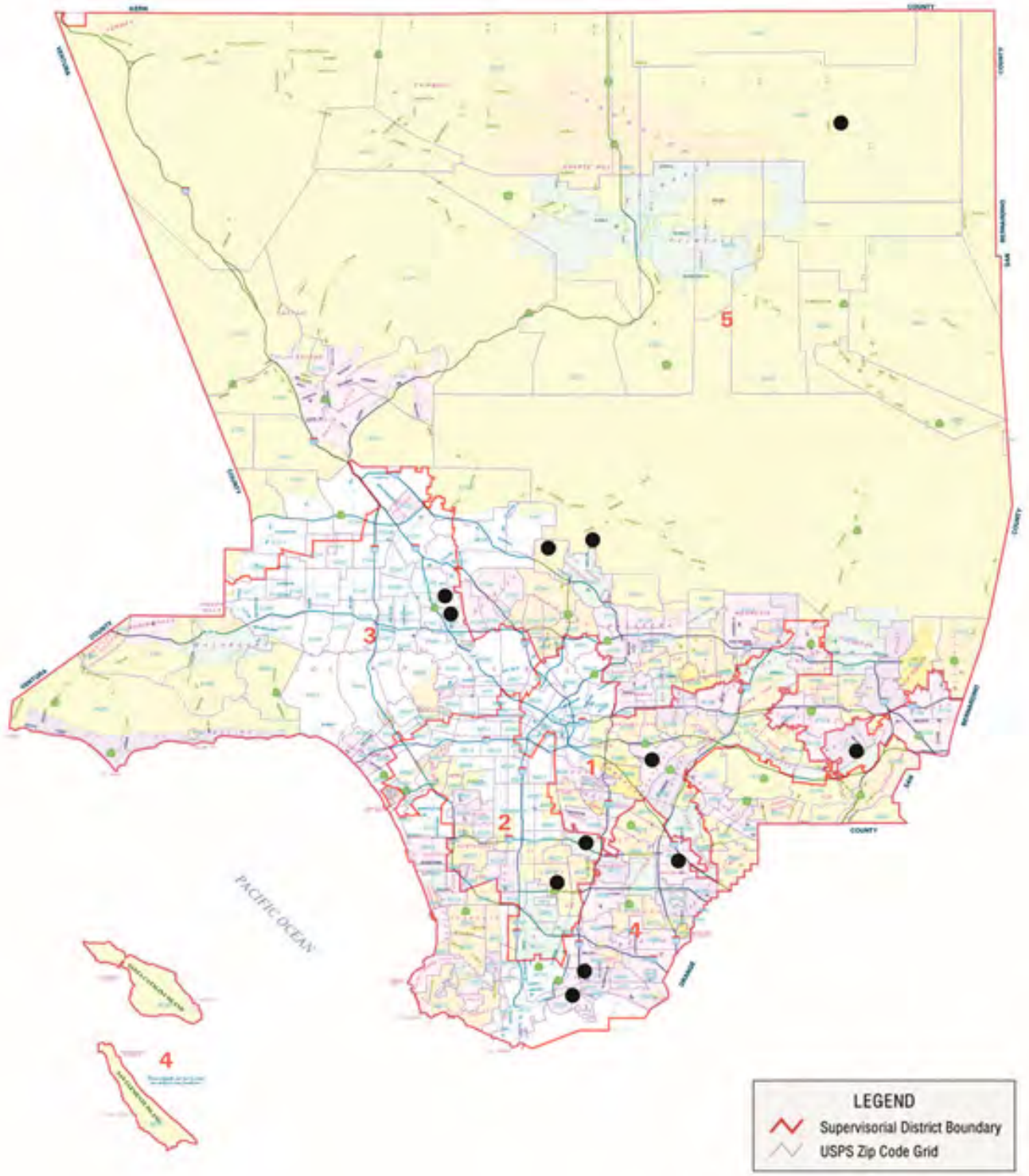
Locations[15] of Child and Adolescent Suicides – Board of Supervisorial District – 2013

First District – 2
Second District – 2
Third District – 2
Fourth District – 3
Fifth District – 4

15. City where the suicide occurred.

2013 Adolescent and Child Suicides

N = 12*



● = *Child or Adolescent Suicide*

*one suicide occurred in Kern County

Case Summaries

Joanne

Twenty-nine year old Joanne gave birth in the shower at the father's home of her two teenage daughters. She reported she was homeless and had not felt any fetal movement for two days. The infant was estimated to be 36 weeks gestation was stillborn. This was Joanne's ninth pregnancy. She had three adult children and the two teenagers who were in the father's full custody. She had sporadic prenatal care and intended to give the baby to a relative for adoption. She had a long history with CPS in various California counties. Joanne reported she used to use cocaine and crack but had not since 1991. Her stillborn baby boy tested positive for methamphetamine.

Thomas and Joshua

Joshua and Thomas age 17 years were both crossing railroad tracks on separate occasions and were struck and killed by a Metro Link train.

Joshua and some other boys were spray painting a wall next to the tracks a train was traveling on. The Engineer sounded the train horn to warn the boys. The boys around Joshua began running away from the train tracks. However, Joshua continued to spray paint on the wall. Just as the train was about to pass, Joshua turned around into the path of the train and was struck.

Thomas was attempting to jump onto a moving train when he fell and was hit by the train. He suffered multiple traumatic injuries and died two days later.

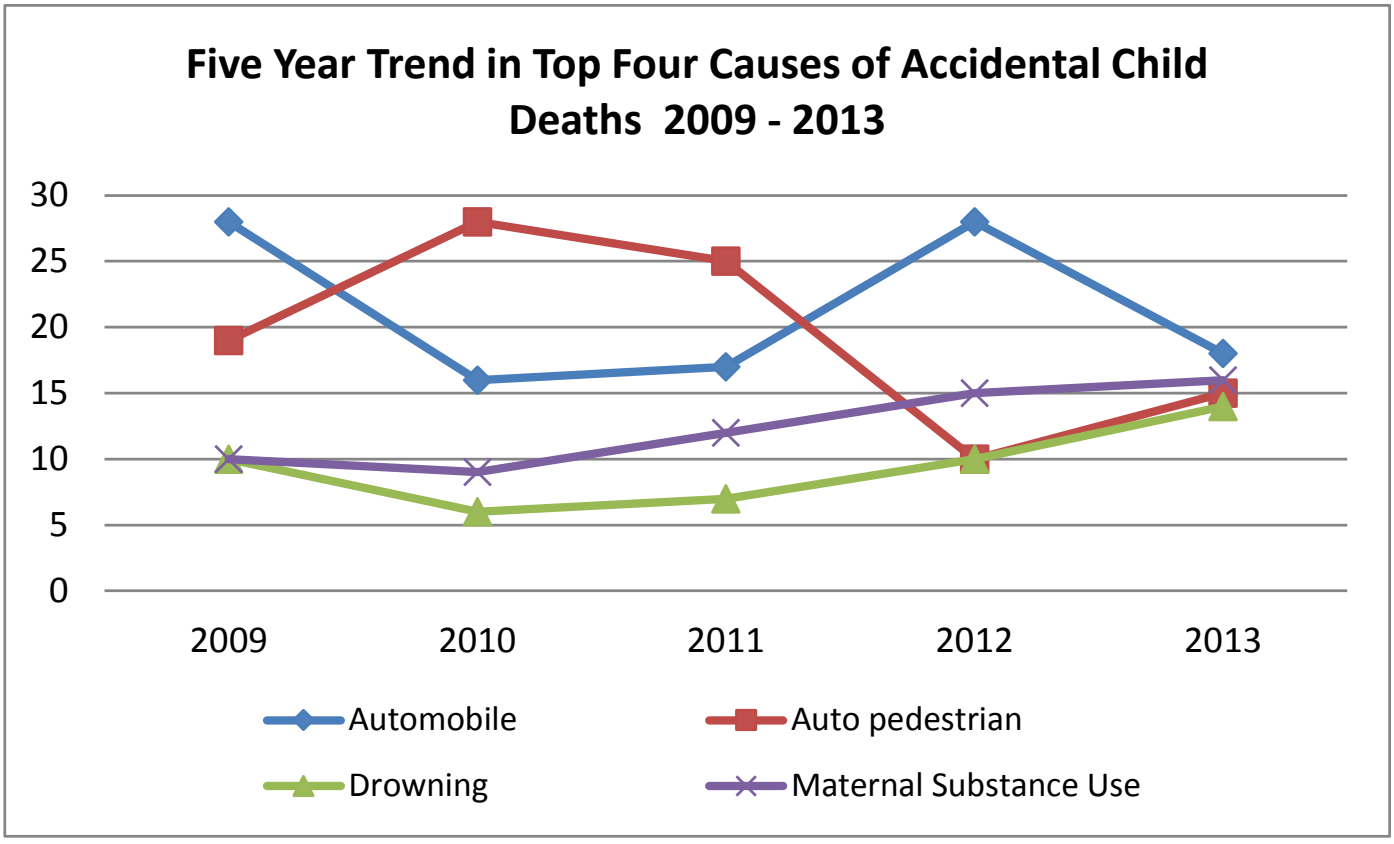
Randy

2-year old Randy's mother was visiting with a friend and they took Randy and the other children to the community pool. The mother and his older toddler sibling, her friend, and her friend's child were sitting at the steps of the big pool. Randy could not swim and was not wearing any flotation device. He was going back and forth between the big pool and separate spa. It was routine for Randy to sit on the steps of the spa and play with toys that were floating. He was left unattended while playing at the spa which was not in the mother's line of sight.

About five minutes later, his mother called for him but he did not respond. She went over to the spa to check on Randy and found him floating face down above the step. No one heard a splash or scream.

Lee

Four month old Lee was placed to sleep on his parents' bed. He was near the center of the bed, but closer to the headboard with his head facing the wall. Two pillows were wedged between the mattress and the wall. The father lay with Lee while he dozed off. Lee turned over into a prone position which was his usual sleep position with his head toward his left shoulder. The father got up after Lee fell asleep. He checked on him twenty minutes later and found Lee with his head against the pillow with his face wedged between the mattress and pillow. 911 was called but, Lee, who was limp and pulseless could not be resuscitated.



The chart above depicts the top four causes of accidental child death over a five year period from 2009 to 2013. The "top four" causes-automobile, auto pedestrian, drowning and maternal substance use accounted for 67.7% of all accidental child deaths in 2013. While automobile and auto pedestrian deaths appear to be on a downward trend, there was an increase in pedestrian deaths from 2012. Drowning and maternal substance abuse accidental deaths have continued in an upward trend in 2013.

Causes of Accidental Child Deaths, Ages 0 – 17
2013– Los Angeles County (N = 93)

Automobile – multi-vehicle	12	12.90%
Automobile – solo vehicle	6	6.50%
Auto pedestrian	15	16.00%
Drowning	14	15.10%
Hit by an Object	1	1.10%
Overdose	3	3.20%
Maternal drug use	16	17.20%
Fire	1	1.10%
Medical mishaps	4	4.30%
Fall	5	5.40%
Choking	3	3.20%
Suffocation	1	1.10%
Train vs. Pedestrian	2	2.10%
Unsafe/Co-sleep	6	6.50%
Golf Cart rollover	1	1.10%
Suffocation in infant sling	1	1.10%
Skateboard-no helmet	1	1.10%
Scooter vs. auto	1	1.10%
TOTAL	93	100%

Causes of Accidental Child Deaths by Age
2013 – Los Angeles County (N = 93)

	Age 0 – 5 years	Age 6 – 14 years	Age 15 – 17 years
Automobile – multi-vehicle	4	5	3
Automobile – solo vehicle	0	5	1
Auto pedestrian	6	4	5
Hit by Object	1	0	0
Drowning	10	2	2
Overdose	0	2	1
Fall	4	0	1
Fire	0	1	0
Maternal drug use	16	0	0
Medical mishaps	4	0	0
Choking	3	0	0
Suffocation	1	1	0
Train vs. pedestrian	0	0	2
Unsafe/Co-sleep	6	0	0
Golf cart rollover	0	1	0
Suffocation in infant sling	1	0	0
Skateboard – no helmet	0	0	1
Scooter vs. auto	0	0	1
TOTAL	55	21	17

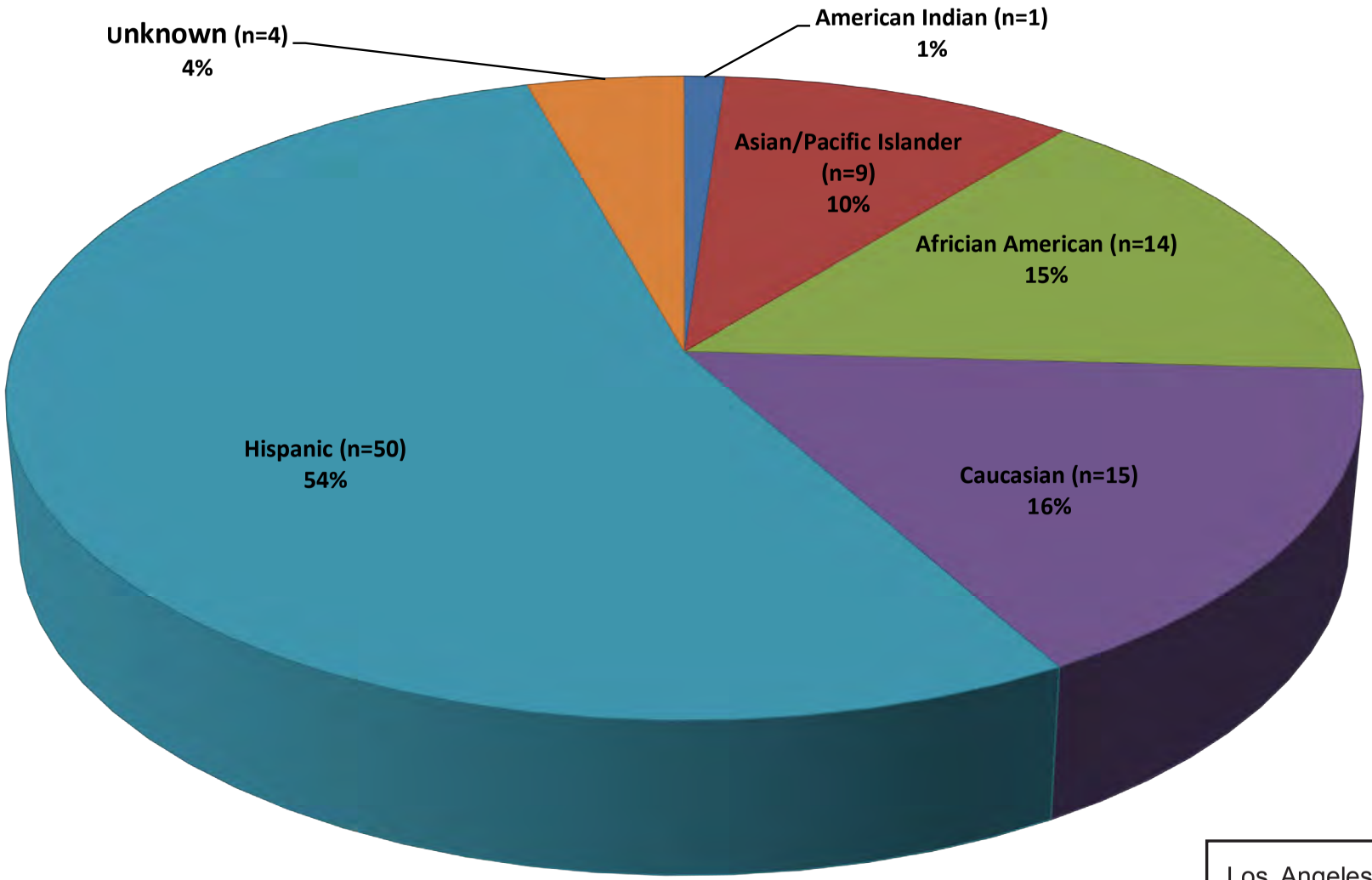
Race of Accidental Child Deaths, Ages 0 – 17
Los Angeles County – 2013 (N = 93)

	Hispanic	African-American	Caucasian	Asian/Pacific Islander	American Indian	Unk
Automobile – multi-vehicle	7	1	4	0	0	0
Automobile – solo vehicle	2	3	1	0	0	0
Auto pedestrian	8	3	3	0	0	1
Choking	2	1	0	0	0	0
Drowning	6	3	2	3	0	0
Overdose	1	1	1	0	0	0
Fire	1	0	0	0	0	0
Fall	3	0	0	2	0	0
Gold Cart Rollover	1	0	0	0	0	0
Suffocation	1	0	0	0	0	0
Maternal drug use	8	1	4	0	1	2
Medical mishaps	2	0	0	1	0	1
Hit by object	1	0	0	0	0	0
Train vs. pedestrian	2	0	0	0	0	0
Unsafe/Co-sleep	4	0	0	2	0	0
Suffocation in infant sling	0	1	0	0	0	0
Skateboard-no helmet	1	0	0	0	0	0
TOTAL	50	14	15	9	1	4

Causes of Accidental Child Deaths by Gender
2013 – Los Angeles County (N = 93)

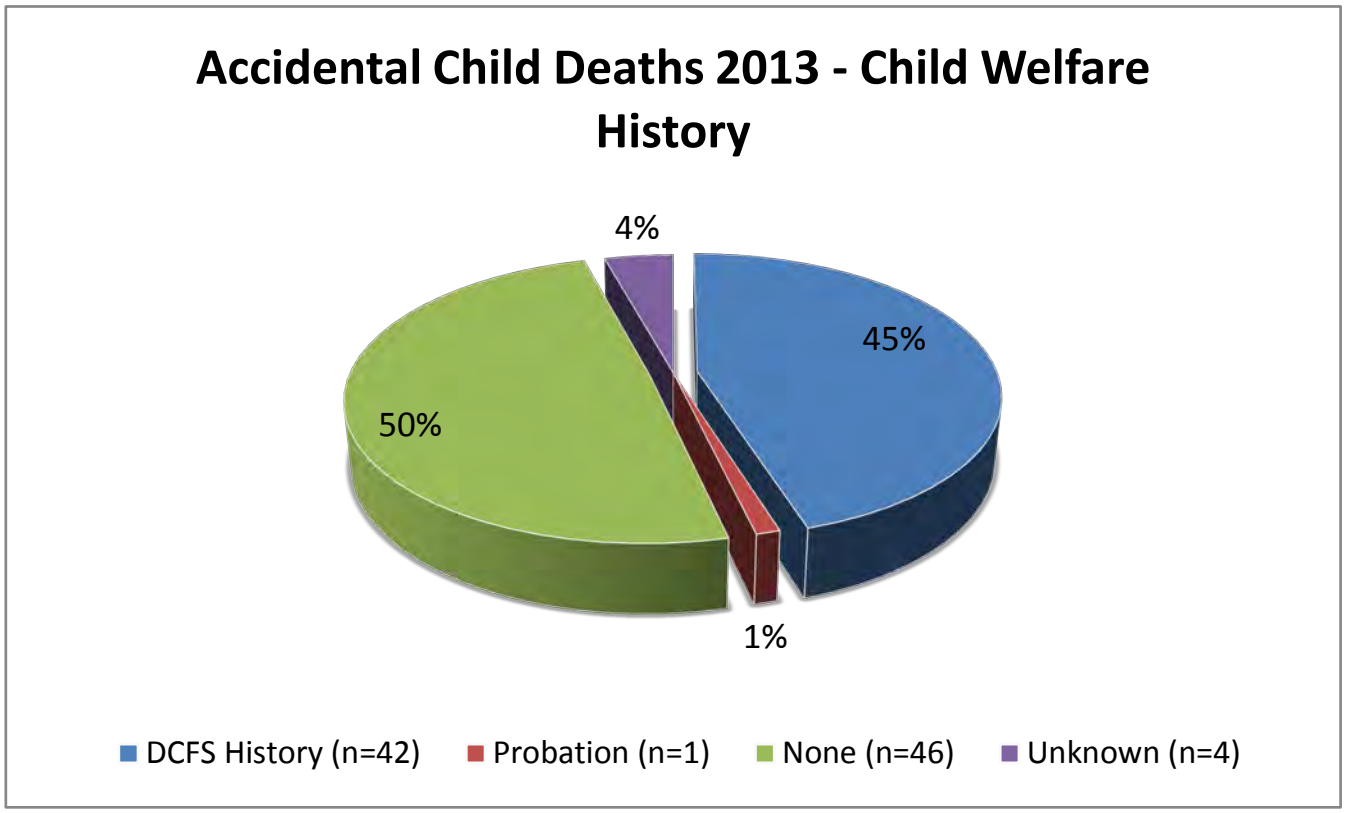
	Female	Male
Automobile – multi-vehicle	6	6
Automobile –single	2	4
Auto pedestrian	3	12
Drowning	5	9
Overdose	3	0
Maternal drug use	6	10
Medical mishaps	1	3
Hit by object	0	1
Fire	1	0
Choking	1	2
Suffocation in infant sling	0	1
Fall	2	3
Golf Cart Rollover	0	1
Suffocation	0	1
Train vs. pedestrian	0	2
Unsafe/Co-sleep	2	4
Skateboard –no helmet	0	1
Unsafe/Co-sleep	0	1
TOTAL	32	61

2013 Accidental Child Deaths -Race



Los Angeles Child Population Ages 0-17: 2,329,494

Cacausian 17%, African American 7.3%, Hispanic 62.6%, Pacific Islander 9.9%, Native Indian/Alaskan .1% and Multi-racial 3.1% Kidsdata.org



Causes of Accidental Deaths with Child Welfare History - 2012

Causes of Accidental Deaths with Child Welfare History – 2013 (n=42)	Number	Percentage
Automobile	9	21.3
Auto pedestrian	6	14.3
Drowning	3	7.1
Overdose	1	2.4
Maternal drug use	13	31
Fire	1	2.4
Fall	2	4.8
Unsafe sleep	2	4.8
Train vs. Pedestrian	2	4.8
Other	3	7.1

Case Summaries Undetermined Child Deaths

Unsafe Sleep Practices and/or Environments and Maternal Substance Use

Maria – Age 2 ½ months

Maria was placed prone with her head turned to her right on a San Marcos blanket that was covering an adult bed with a pillow top mattress. Her mother left the room to get something to eat. The maternal grandfather went into the room to check on Maria ten minutes later. She noticed Maria was blue in color and blood drained from her nose. The grandmother picked Maria up and she was limp and unresponsive. 911 was called but she was pronounced at the scene. There had been a referral to DCFS at her birth because she tested positive for marijuana. The Department had an open case with the family due to the referral at the time of her death. Maria's 20 year-old mother had a case history with DCFS as a minor as well.

Diana– Age 7 months

Diana routinely slept with her parents and was a healthy baby. Her mother breast fed her and gave her solids. She had recently begun rolling over in the past few weeks. Diana was placed to sleep between her parents lying on her back just below her parent's pillows. When her mother awoke the next day, Diana was on her side just below the pillow. She was unresponsive and cold to the touch.

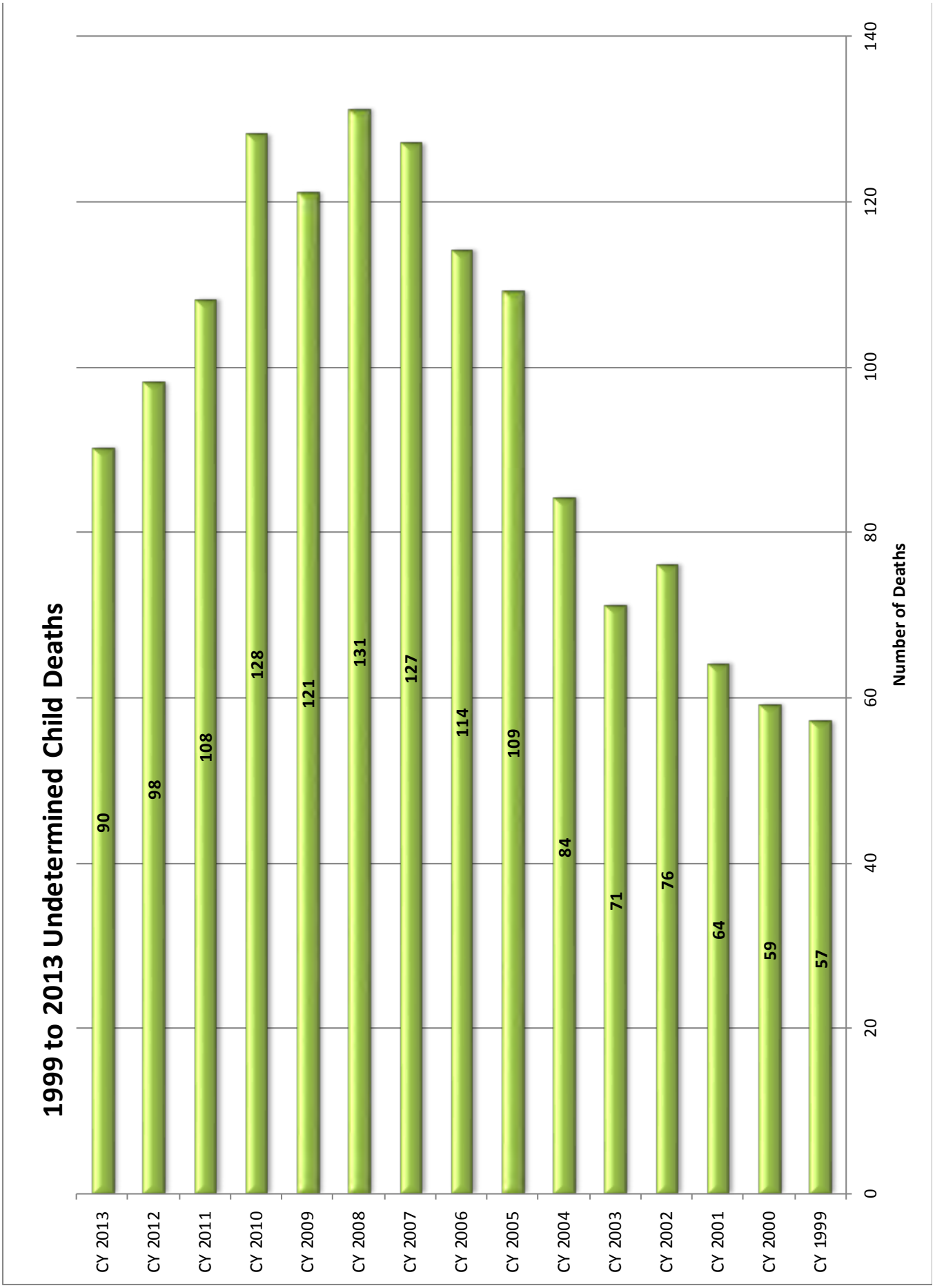
Gayle – Age 2 months

Gayle was placed on a pillow on a couch in a prone position for an evening nap. Her mother lay down on the floor next to the couch and also took a nap. Two hours later, the mother awoke and Gayle was in the same position. She got up and made some food for Gayle's siblings and went outside to smoke a cigarette. When she went to wake Gayle to eat, she noticed the baby did not appear to be breathing. When paramedics arrived Gayle was limp, not breathing and had no movement. She was transported to the Emergency Room where she was declared deceased. Gayle's diaper was saturated with urine. Although the mother stated she had given her a bath that morning, grime was observed in skin folds, behind her ear and under her nails. The mother admitted she had drunk three glasses of wine throughout the afternoon and took a store brand sleeping pill and had been asleep for six hours before awakening.

Baby Boy Jones – Stillborn

The 22 year old mother was eight months pregnant and delivered at home. She had not received any prenatal care and her baby boy was stillborn. Paramedics transported the mother and infant to the hospital. The mother was reported to be bi-polar and had a long substance abuse history. Both mother and infant tested positive for cocaine and methamphetamine

.


1999 to 2013 Undetermined Child Deaths
Number of Deaths
0
20
40
60
80
100
120
140
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
CY 2000
CY 1999
90
98
108
128
121
131
127
114
109
84
71
76
64
59
57

Undetermined Child Deaths – 2013 (N = 90)

Race	Number/Percentage of Undetermined Child Deaths
African American	16 (17.8%)
Asian/Pacific Islander	6 (6.7%)
Caucasian	13 (14.4%)
Hispanic	53 (58.9%)
Unknown	2 (2.2%)

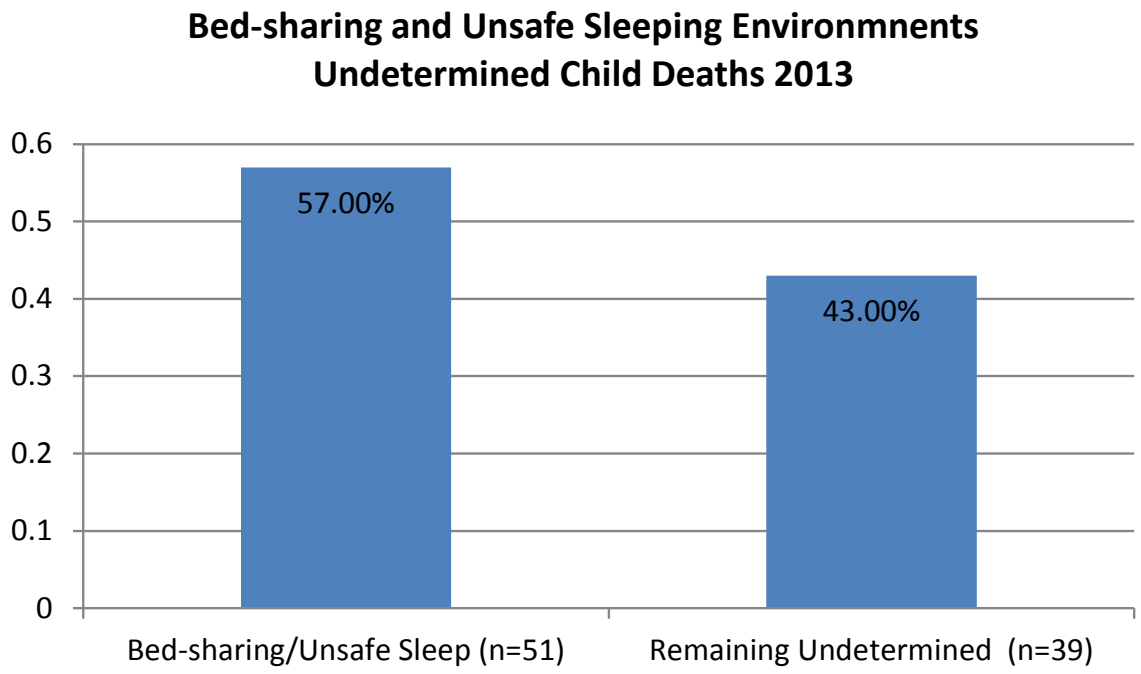
Age	Number of Undetermined Child Deaths
Stillborn	13
1 day to 30 days	6
1 month to 5 months	46
6 months to 1 year	17
2 years	1
3 years	2
4 years	1
5 years	0
6 years	0
7 years	0
8 years	1
9 years	0
10 years	0
11 years	0
12 years	0
13 – 17 years	3

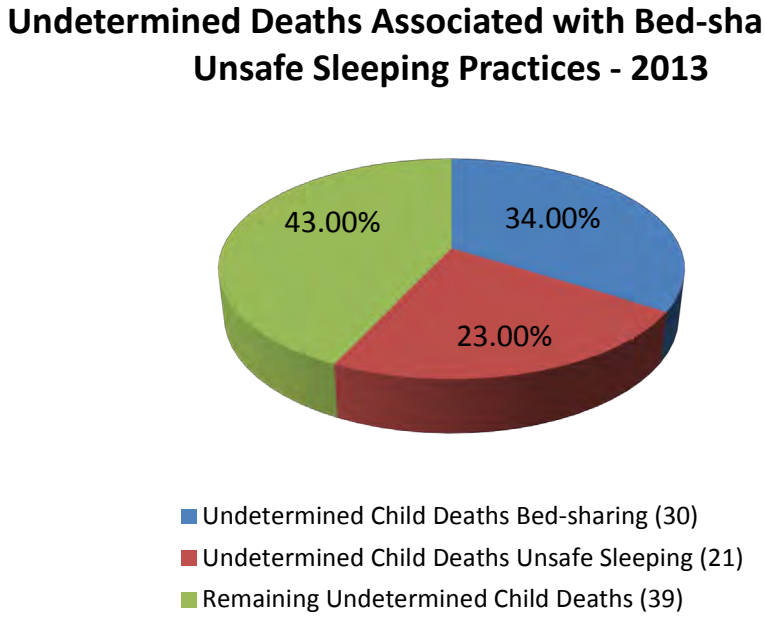
Gender	Number of Undetermined Child Deaths
Female	38
Male	52

72% of the undetermined child deaths were under one year of age.

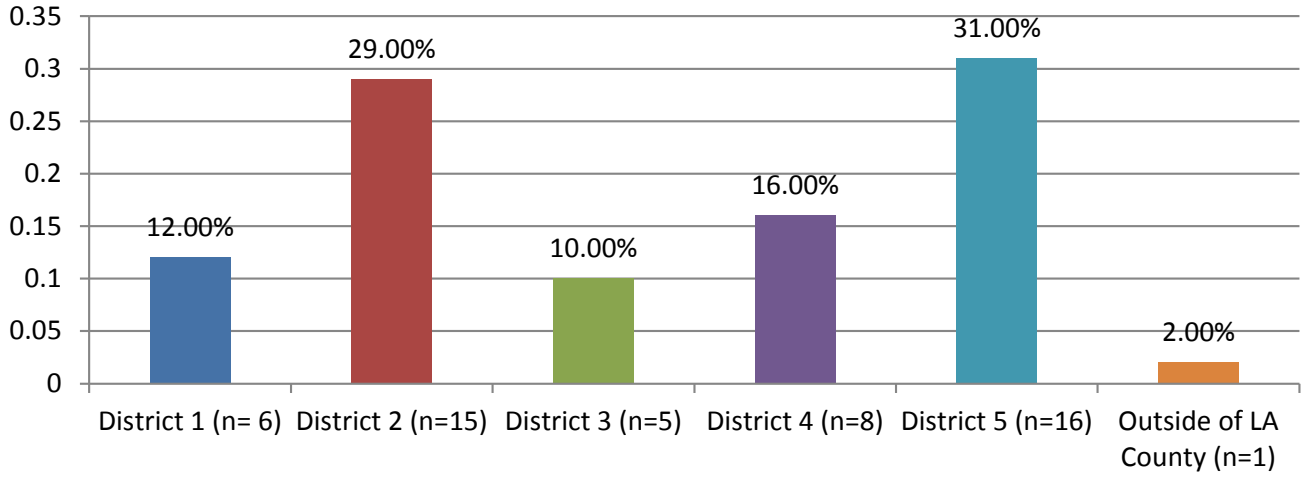
94% of the undetermined child deaths were 5 years of age or under.

Undetermined Child Deaths – Bed-sharing and Unsafe Sleeping Environment (N = 51)





Bed-sharing and Unsafe Sleeping Practice Child Deaths by Board of Supervisor District - 2013



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

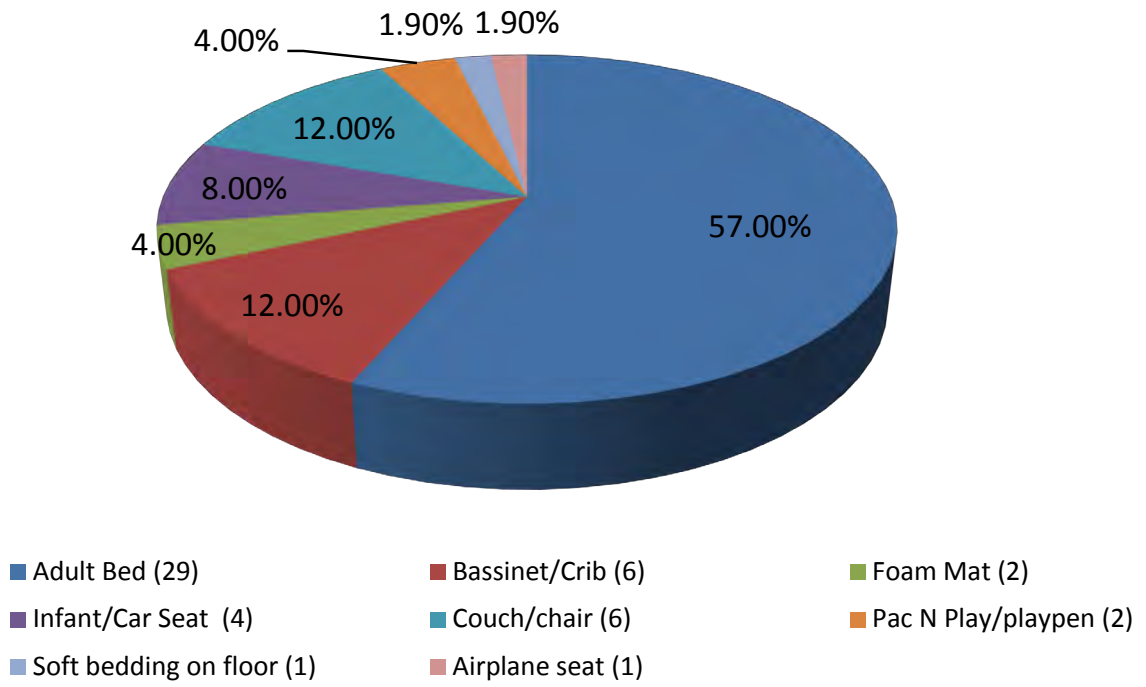
Bed-sharing* (N=30)	Number/Percentage of Child Deaths
One Unsafe Risk Factor	0 (0%)
Two Unsafe Risk Factors	3 (10%)
Three or more Unsafe Risk Factors	27 (90%)

Unsafe Sleeping Environment** (N=21)	Number/Percentage of Child Deaths
One Unsafe Risk Factor	6 (29%)
Two Unsafe Risk Factors	8 (38%)
Three or more Risk Factors	7 (33%)

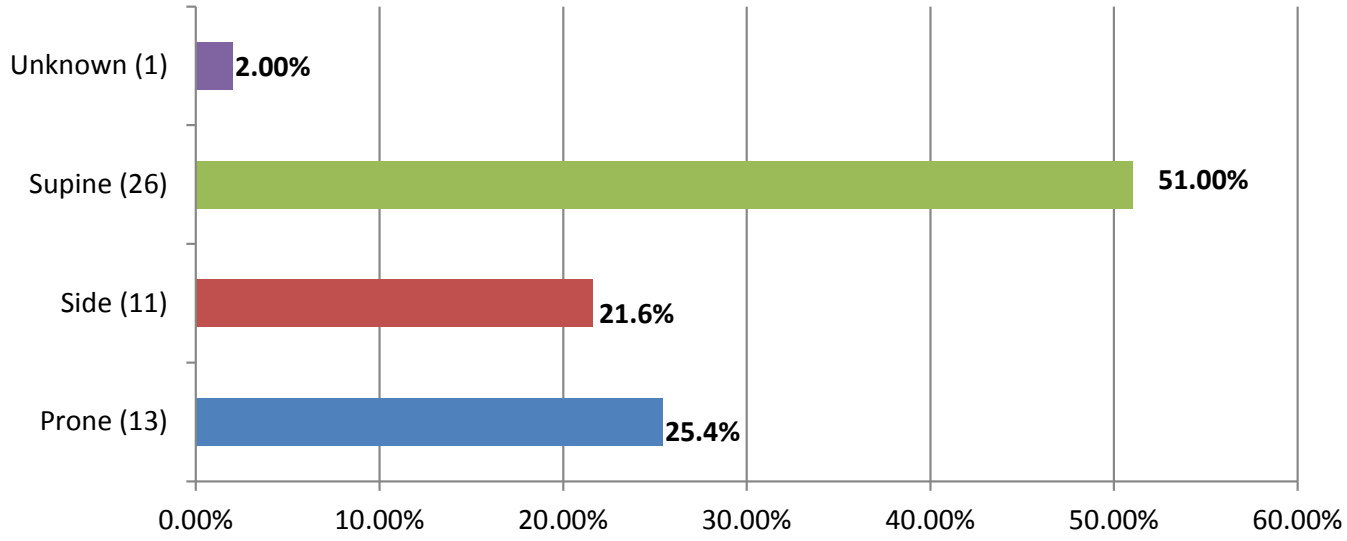
*Includes bed-sharing, adult bed, couch, futon, chair, nest box, pillows, soft or excessive bedding, excessive swaddling, blanket rolls, stuffed toys, pets, parental drug/alcohol use, prone or side positioning

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

Sleep Surface: Bed-sharing and Unsafe Sleep Deaths 2013



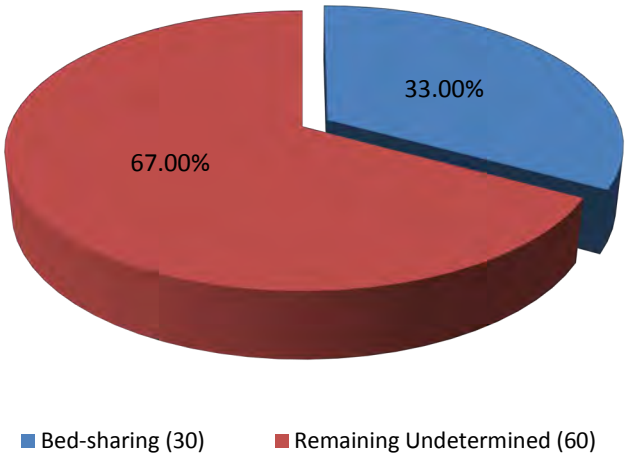
Sleep Position - All Unsafe Sleeping Practice Deaths



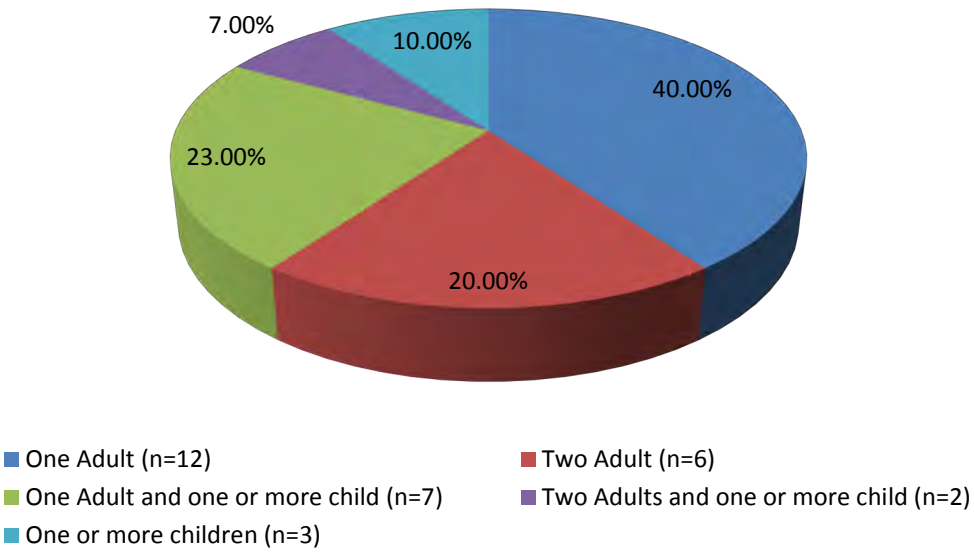
Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 51)	Number	Percentage
Pillow(s)	18	35.30%
Infant/car seat	4	7.80%
Soft and/or excessive bedding	13	25.50%
Excessive Swaddling	5	9.80%
Stuffed animals/toys	2	3.90%
Rolled Blanket	1	2%
Parental Drug/Alcohol Use	8	15.70%

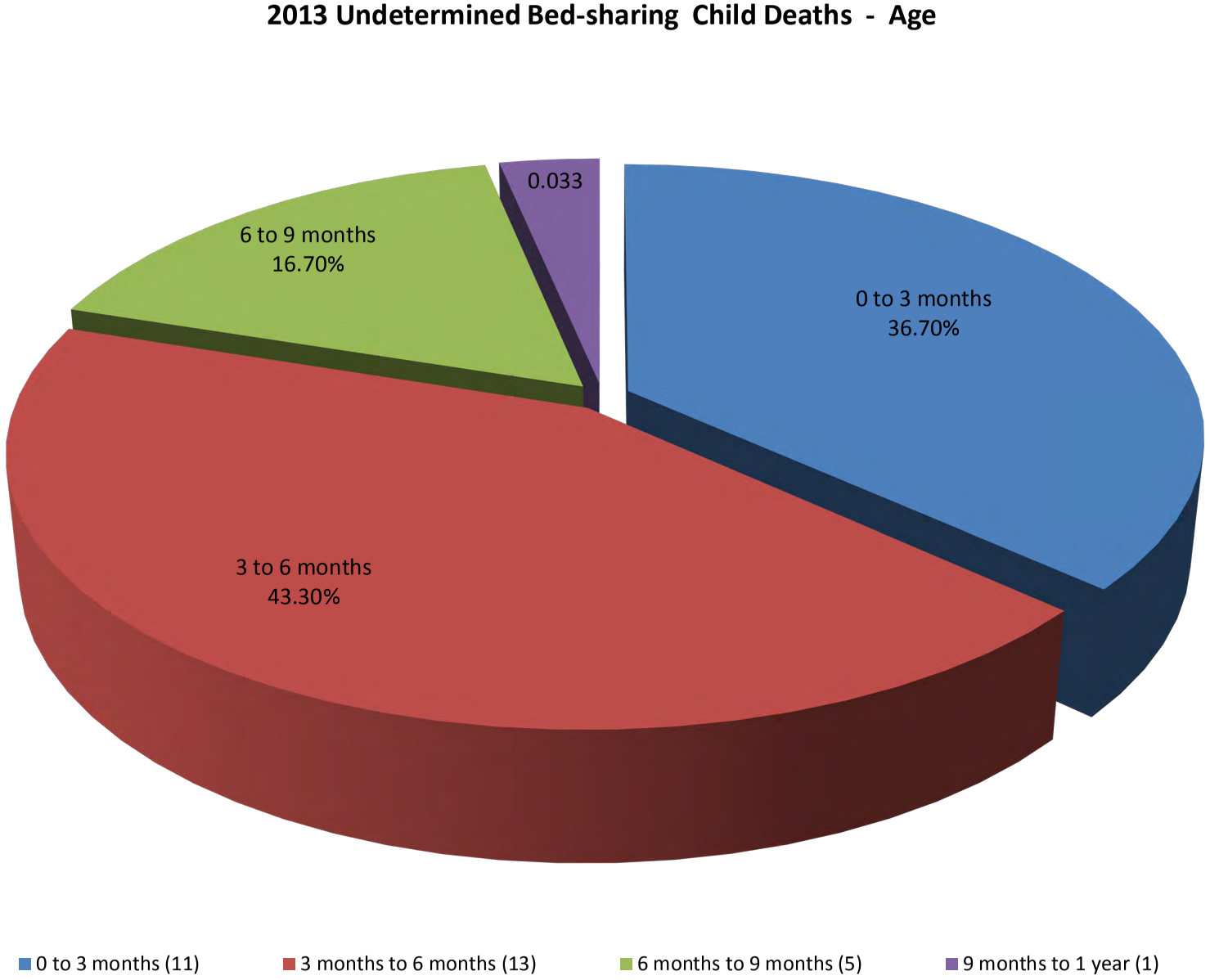
*excludes bed-sharing, sleep surface and infant position.

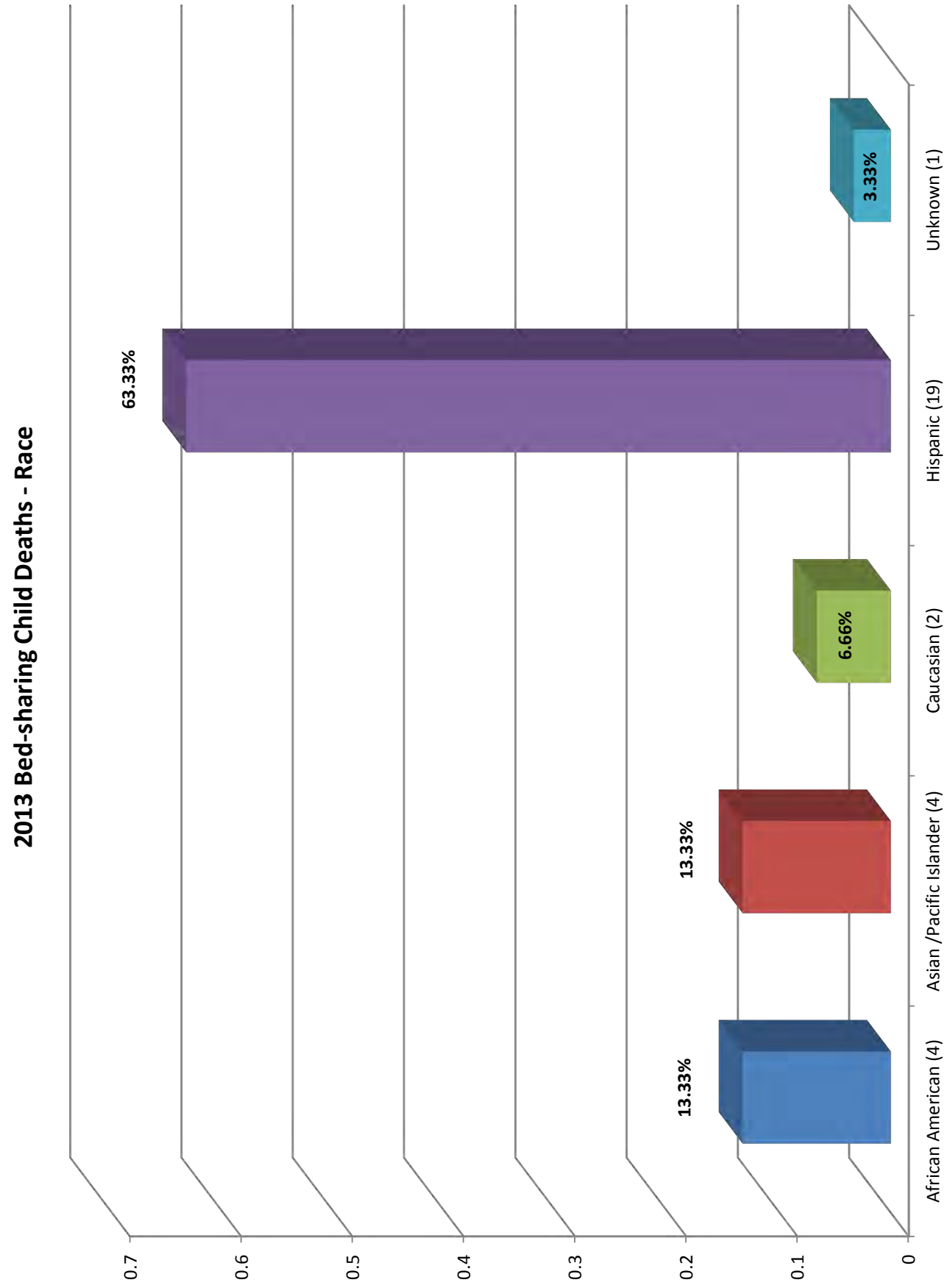
Percentage of Undetermined Child Deaths - Bed-sharing at Time of Death



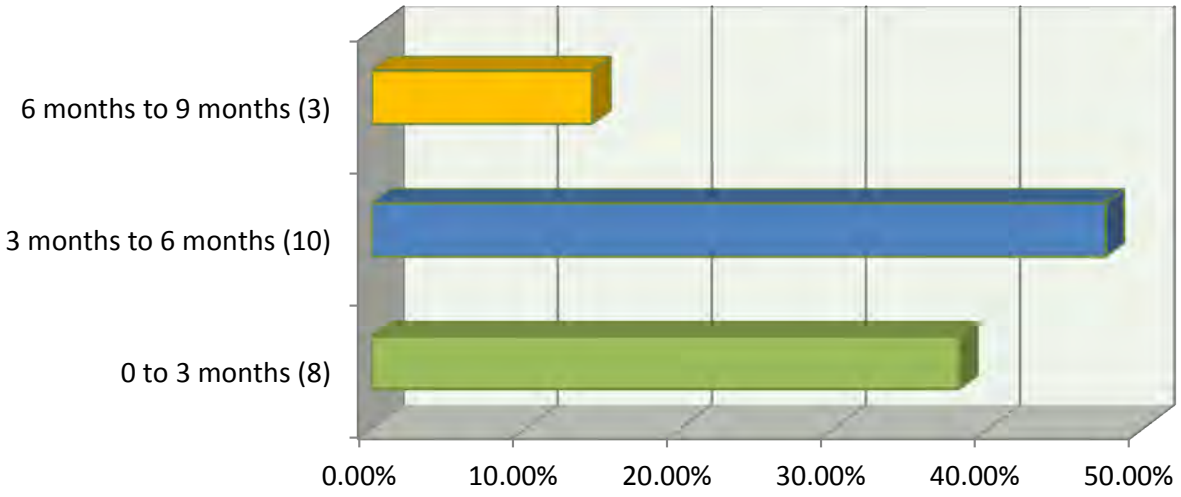
2013 Bed-sharing Deaths - Number of Persons Sleeping with Child



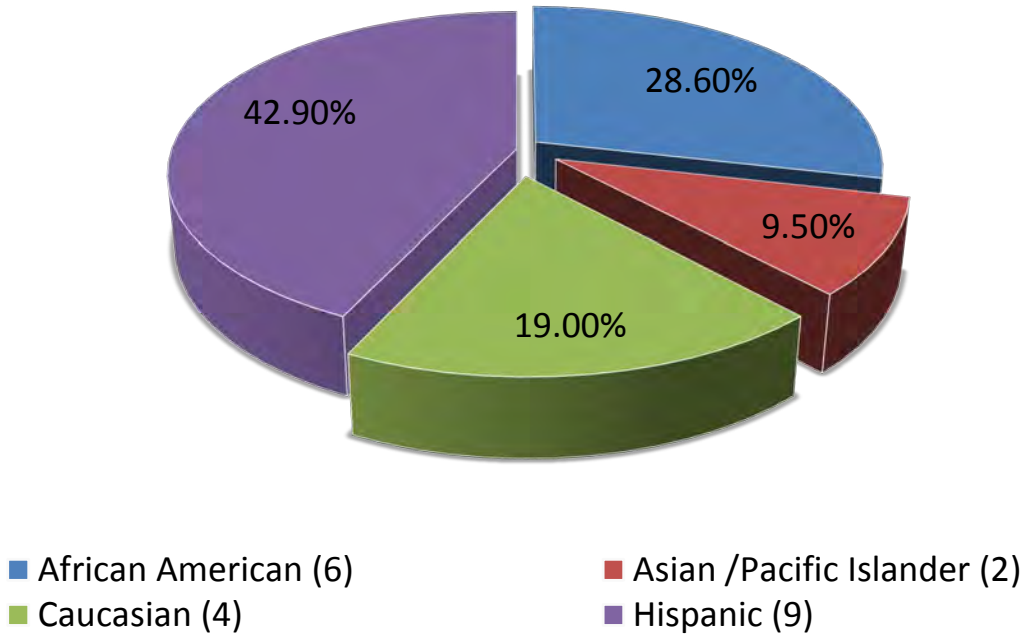

2013 Undetermined Bed-sharing Child Deaths - Age
0.033
6 to 9 months
16.70%
0 to 3 months
36.70%
3 to 6 months
43.30%
0 to 3 months (11)
3 months to 6 months (13)
6 months to 9 months (5)
9 months to 1 year (1)


2013 Bed-sharing Child Deaths - Race
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
63.33%
13.33%
13.33%
6.66%
3.33%
African American (4)
Asian /Pacific Islander (4)
Caucasian (2)
Hispanic (19)
Unknown (1)

2013 Non-bed sharing Unsafe Sleeping Deaths - Age



2013 Non-bed sharing Unsafe Deaths- Race



Unsafe Non-bed sharing Child Deaths Sleeping Environment* - 2013	
Soft and/or excessive bedding	4
Pillow(s)	6
Adult bed	5
Chair/couch	3
Rolled blanket	1
Parental Drug/Alcohol Use	3
Foam Mat	1
Infant/Car Seat	4
Excessive Swaddling	3
Excessive Swaddling	1

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

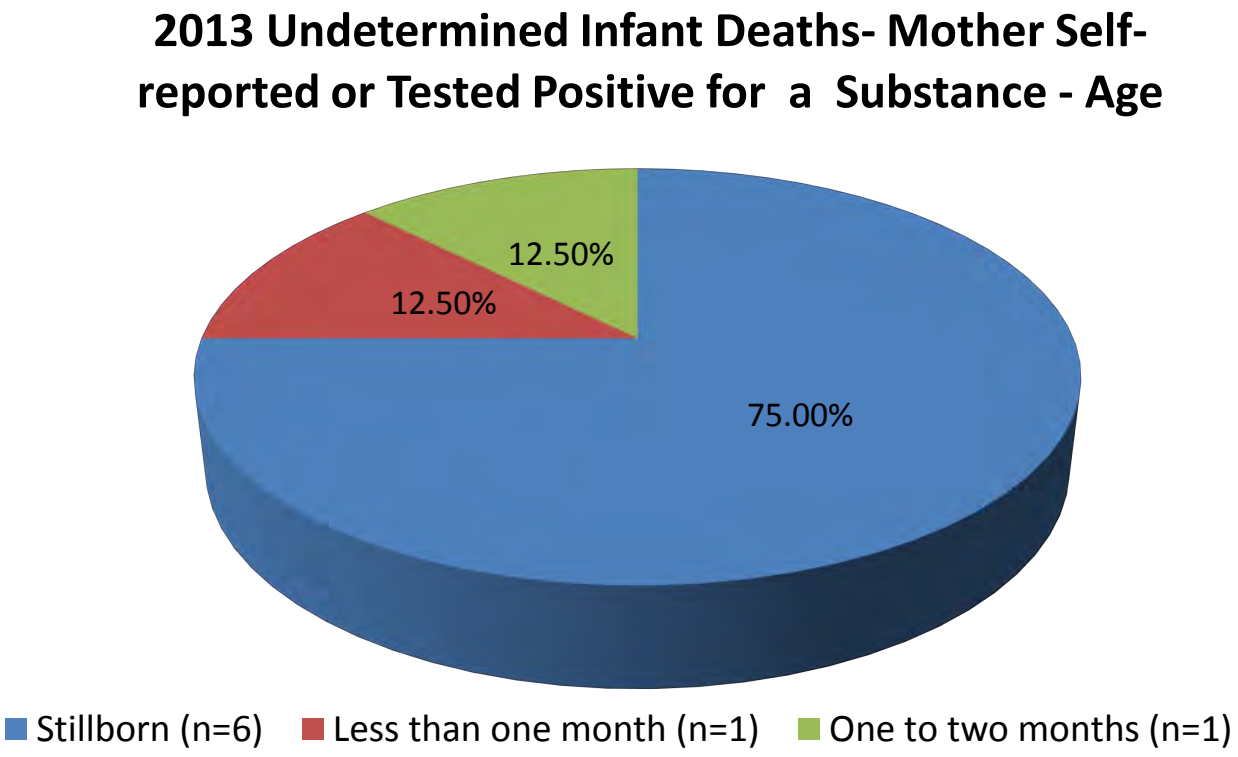
2012 Undetermined Infant Deaths- Mother Tested Positive for a Substance at Birth

Infant Death- Mother Tested Positive for a Substance at Birth (N = 8)		
Substance	**Number**	**Percentage**
Methamphetamine and Marijuana	1	12.50%
Cocaine	1	12.50%
Methamphetamine	6	75.00%
Methamphetamine and Cocaine	1	8.3%
Methamphetamine	5	41.6%

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

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

*This data provided by the Coroner and DCFS



Third Party Homicide

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

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

The purpose of this information is to provide a broader analysis of children and youth deaths in Los Angeles County. Since the number is significant (n=31) it seemed relevant to provide an analysis of these third party homicide deaths in hopes to provide a better understanding of child death in Los Angeles County. Ultimately, it is hoped that the study of these deaths will help us intervene more effectively.

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

Case Summaries[1]

Seven year old, Dorian was sitting next to his mother in the rear seat of a car. Three to four suspects approached on foot and fired into the car at the direction of the front seat where their intended target was sitting. Dorian was shot in the back No one else was seriously injured by the gun fire. Dorian was rushed to the ER where he underwent life saving surgery. After the surgery, he remained unstable and was resuscitated from several cardiac arrests. He remained comatose and his parents agreed to allow a natural death. He was removed from life support and passed within the hour. Three suspects were later arrested and charged with murder. They are awaiting trial for his murder.

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

Thirteen year old Mark and seventeen-year old, Javier were walking in an alleyway. While walking, they were approached by an unknown individual or individuals and shot five times with a semi-automatic handgun. No weapons or cartridge casings were found at the scene. Both Mark and Javier were pronounced at the hospital. No suspects have been identified and the case remains under investigation. Law enforcement believes it was a walk up gang-related shooting.

Seventeen-year old, Robert was at a party when a fight broke out. He was attacked by several suspects, one of which brandished a knife. Robert was stabbed three times in the abdomen. The assailant fled the scene on foot and paramedics were called. He was found lying in the street unresponsive and pulseless. He was rushed to the hospital and despite emergency surgery, passed shortly after his arrival. No suspects are in custody.

Sixteen-year old, Lisa was at home with her 16-year old boyfriend alone in her bedroom. The boyfriend stated he was “playing” with a hand gun when the gun went off and shot Lisa. She was struck in the back of the head and was later pronounced brain dead at the hospital. The crime scene did not seem to be consistent with the boyfriend’s explanation. He initially told arriving officers that Lisa had intentionally shot herself in the head. He then reported he accidently shot her while playing with the gun. The case remains under investigation.

Charles, age 17 years was leaving his girlfriend’s home in the projects. He was stopped in his car at an intersection leaving the housing complex when confronted by a suspect on foot. A second suspect jumped out of some bushes demanding to know “where you from?” Without warning, he began to fire multiple rounds at Charles’s car. Both Charles and his car were struck multiple times. He died at the scene. His mother reported Charles was not in a gang and was attending a charter school. He was to be amongst the first graduating class of the school this spring. The suspects were arrested and are awaiting trial for Charles’s murder.

Joseph, age sixteen, was with some friends hanging out in the neighborhood. They noticed some gang members tagging a wall and confronted them. Somehow, Joseph, his friends and the gang members all ended up in the parking lot of an apartment complex where a fight ensued. One of the gang members pulled out a gun and shot at both Joseph and his friends. His friends, the suspect and his friends all fled leaving Joseph lying on the ground. Joseph was shot multiple times and died at the scene. His murder remains under investigation and no arrest have been made.

[1]Case identities were changed.

Findings

- There were 31 third party homicides in 2013. This is one less than 2012 and a 69% decrease from 2007 when these data were first collected.

- Eighty-seven percent (n=27) of the youth were victims of gunshot wounds. These include 18 youth who were victims of homicides perpetrated by suspects with possible gang involvement. For the nine remaining youths, two were shot by law enforcement during confrontations, one by her boyfriend and for the remaining six, the suspects are unknown.

- Of the four victims not killed by a gunshot, two were stabbed, one died as a result of an altercation and one died from blunt force trauma from being thrown from an automobile.

- As in the previous four years, male victims outnumbered female victims by a broad margin. Twenty-seven males and four females were homicide victims in 2013.

- Seventy-seven percent (n=24) of the children who were victims of a third party homicide in 2013 were ages 16 – 17; two victims were age 14, one age 15 years, two were age 7, and, the youngest victim was three months old.

- In 2013, there were 18 third party homicides of Hispanic youth, eleven African-American youth, two Caucasian youth and there were no third party homicides of Asian American youth.

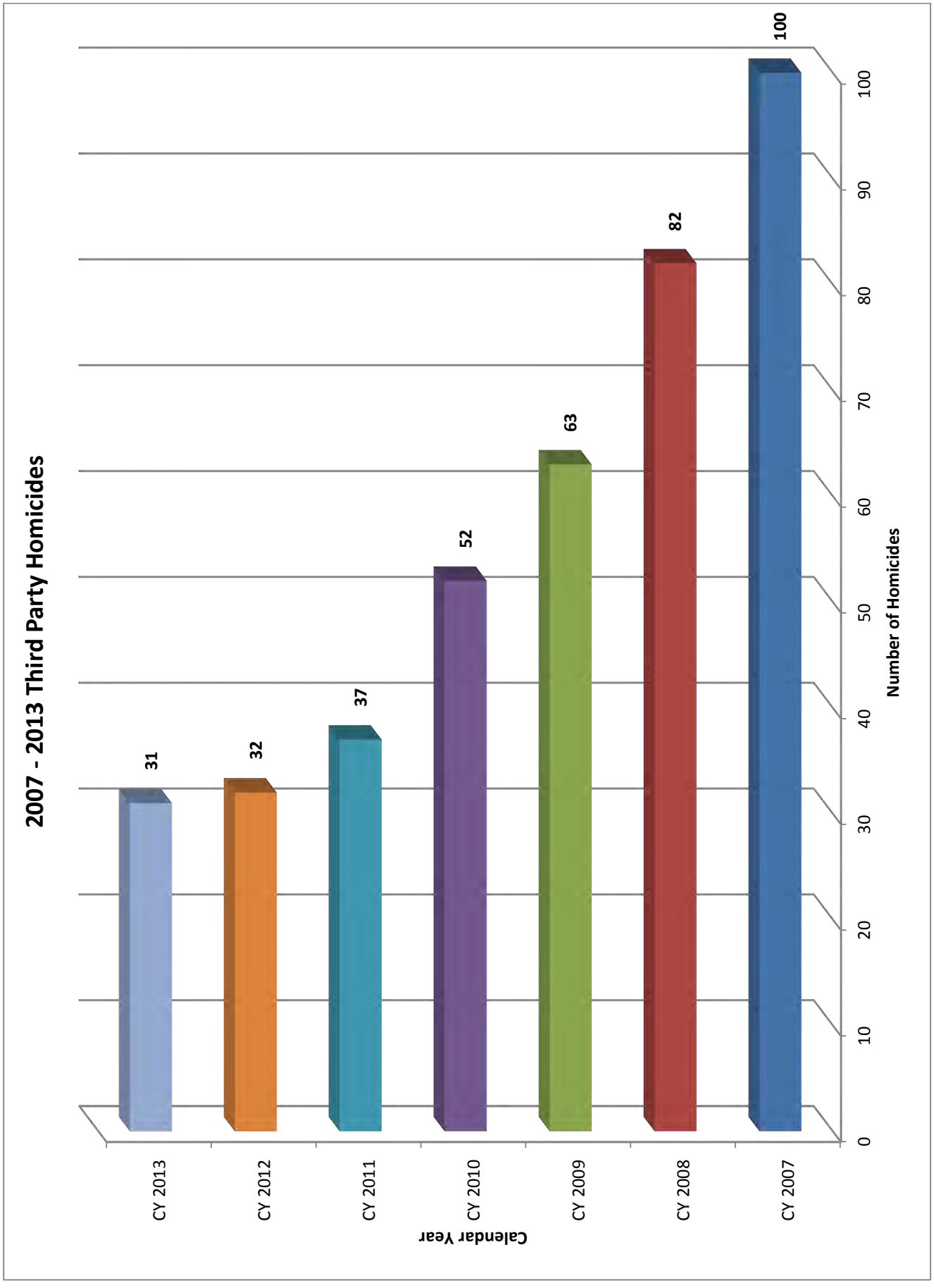
- The greatest number of homicides occurred during the month of December (n=5). The seconded greatest number occurred in the months of March and July (n=4) and the third greatest in the months of January, February, August and September (n=3). The fewest number of homicides occurred during the month of May when there were no third party homicides. Two third party homicides occurred during the months of April and June. Finally, one third party homicide occurred in each of the months of July and October.

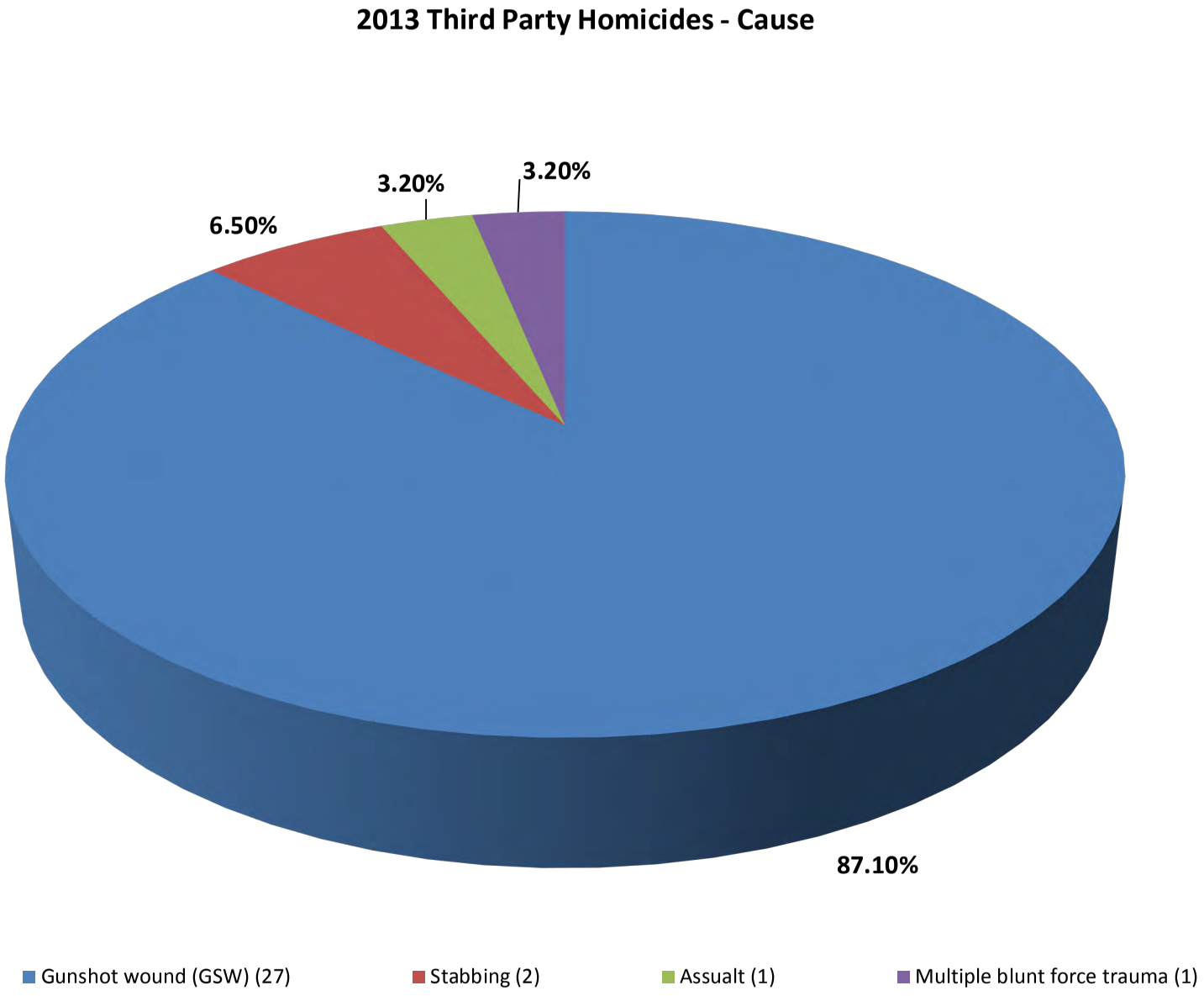
- While third party homicides occurred throughout Los Angeles County in 2013, the majority (n=13) of these deaths occurred in the 2nd Board of Supervisorial (BOS) District and was followed by the 1st BOS District with 12 third party homicides. Five occurred in the 5th BOS District and one in the 3rd District. There were no third party homicides in the 4th BOS District.

- The Los Angeles Police Department (LAPD) had investigative authority for 45.2% of the third party homicide cases in 2013. 38.7 percent of the cases were under the jurisdiction of the Los Angeles Sheriff's Department, and 16.1% of the cases were handled by jurisdictions other than LAPD and LASD.

- Where the relationship of the perpetrator was identified by law enforcement, 41% of the perpetrators were a gang member, and at least 19% of the victims were gang involved. Finally, 26% (n=8) 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.

- Twenty-one of the victims had a history with DCFS. Twelve of the victims had a history with the Probation Department. Ten of the twelve had a current case with Probation.


2007 - 2013 Third Party Homicides
31
32
37
52
63
82
100
CY 2013
CY 2012
CY 2011
CY 2010
CY 2009
CY 2008
CY 2007
Calendar Year
0
10
20
30
40
50
60
70
80
90
100
Number of Homicides


2013 Third Party Homicides - Cause
3.20%
3.20%
6.50%
87.10%
Gunshot wound (GSW) (27)
Stabbing (2)
Assualt (1)
Multiple blunt force trauma (1)

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

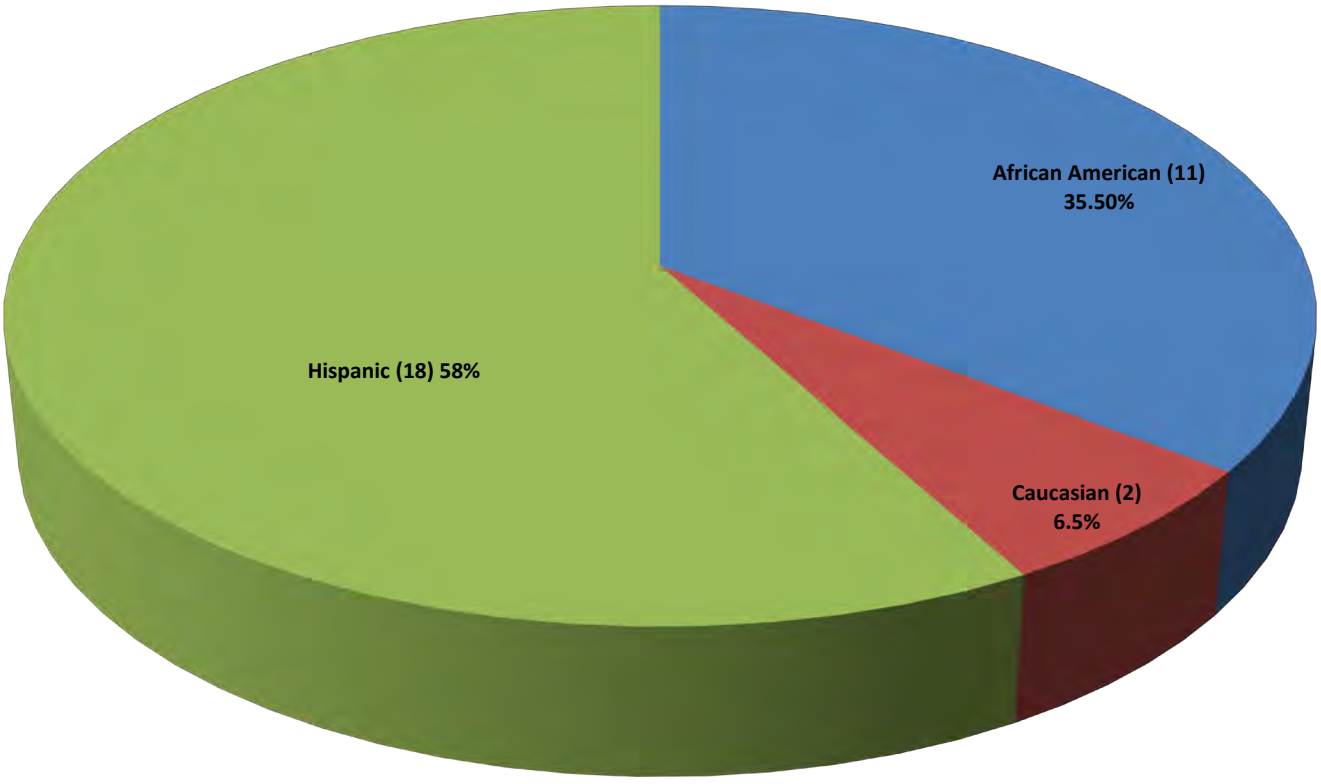
Age	Female	Male
1 year or under	0	1
2 – 12 years	1	1
13 years	0	1
14 years	1	1
15 years	0	1
16 years	1	7
17 years	1	15
Total	4	27

88% of the third party homicide victims were male.

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

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

2013 Third Party Homicides - Race



Los Angeles Child Population Ages 0-17: 2,329,494
Hispanic 62.6%, Caucasian 17%, African American 7.3%,
Asian/Pacific Islander 9.9%, Native Indian/Alaskan .1%
and Multi-racial 3.1% **Kidsdata.org**

Dates[1] of Third Party Homicides - 2013

3 homicides occurred in January (01/03, 01/10, & 1/13)

3 homicides occurred in February (2/16, 2/17 & 2/18)

4 homicides occurred in March (3/10, 3/27, 3/29 & 3/30)

2 homicides occurred in April (two on 04/13)

0 homicides occurred in May

2 homicides occurred in June (6/15 & 06/21)

1 homicide occurred in July (7/30)

3 homicides occurred in August (8/27, 8/28 & 8/31)

3 homicides occurred in September (9/01, 09/05 & 9/21)

1 homicide occurred in October (10/03)

4 homicides occurred in November (two on 11/09, 11/13 & 11/27)

5 homicides occurred in December (12/03, 12/12, 12/14, 12/23, & 12/25)

Locations[2] of Third Party Homicides – Geographic Area - 2013

1 homicide occurred in Bell Gardens (zip code 90201)

4 homicides occurred in Pomona (zip codes 91766 & 91768)

1 homicide occurred in Maywood (zip code 90270)

14 homicides occurred in Los Angeles (zip codes 90003, 90015, 90017, 90018, 90019, 90031, 90034, 90037, 90042, 90044, 90047, 90059 & 90061)

1 homicide occurred in Panorama City (zip code 91402)

1 homicide occurred in Van Nuys (zip code 91406)

1 homicide occurred in Palmdale (zip code 93552)

1 homicide occurred in Lancaster (zip code 93535)

1 homicide occurred in Santa Fe Springs (zip code 90606)

1 homicide occurred in Norwalk (zip code 90650)

1 homicide occurred in Duarte (zip code 91010)

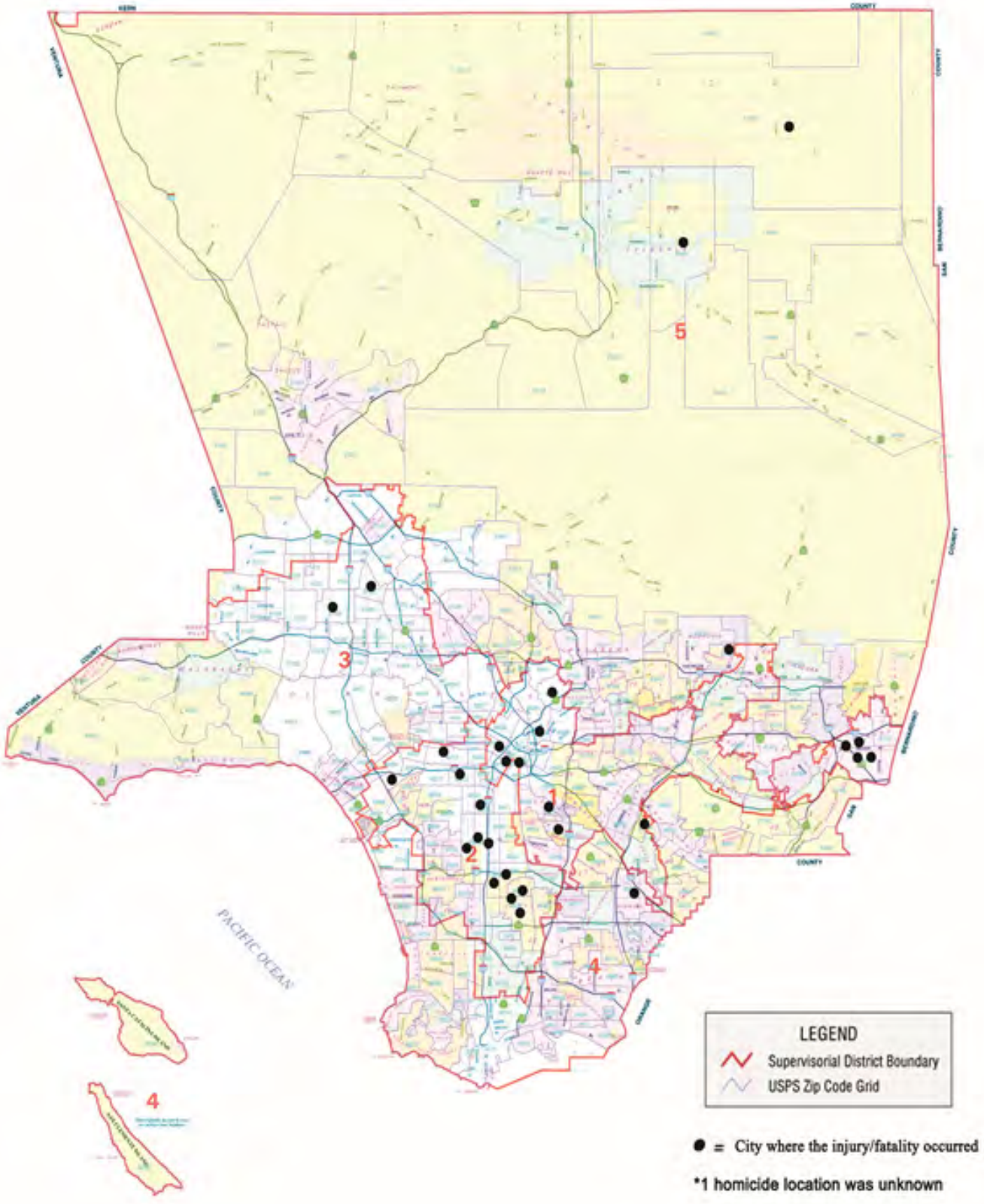
3 homicides occurred in Compton (zip code 90220 & 90222)

1 homicide location was unknown

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

2013 Third Party Homicide Locations*

N = 31



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 2013, there were 31 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 1 below.

Table 1

Agency	Number of Cases	Percentage1
LAPD	14	45.2%
LASD	12	38.7%
CHP	1	3.2%
Pomona P.D.	4	12.9%

Table 2 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation.

Table 2

Perpetrator's Relationship to Victim	Number of Cases
Gang Member	13
Officer Involved	2
Boyfriend	1
No Information Provided or Unknown	15

Table 3, on the following page, provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved. It should be pointed out that few of the law enforcement agencies provided much detail about the victim's circumstances which is why so many of the cases fall under the "no information provided" category.

Table 3

Victim Information	Number of Cases
Shot by Boyfriend	1
Shot in a walk-up shooting	9
Shot during a drive-by shooting	6
Gang member or tagger	6
Physical altercation with a peer	4
Active Probation Case	10
No information provided	6

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), 8 of the 31 cases of third party homicides were referred to the District Attorney's Office in 2013. The eight cases had criminal charges of murder filed by the District Attorney's Office in 2013. Seven of the thirty-one cases remain under investigation. It should be noted that there was no information found for 16 cases. This may mean that law enforcement has not identified the assailants, not submitted the case for review or for some other reason.

Appendix A -
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

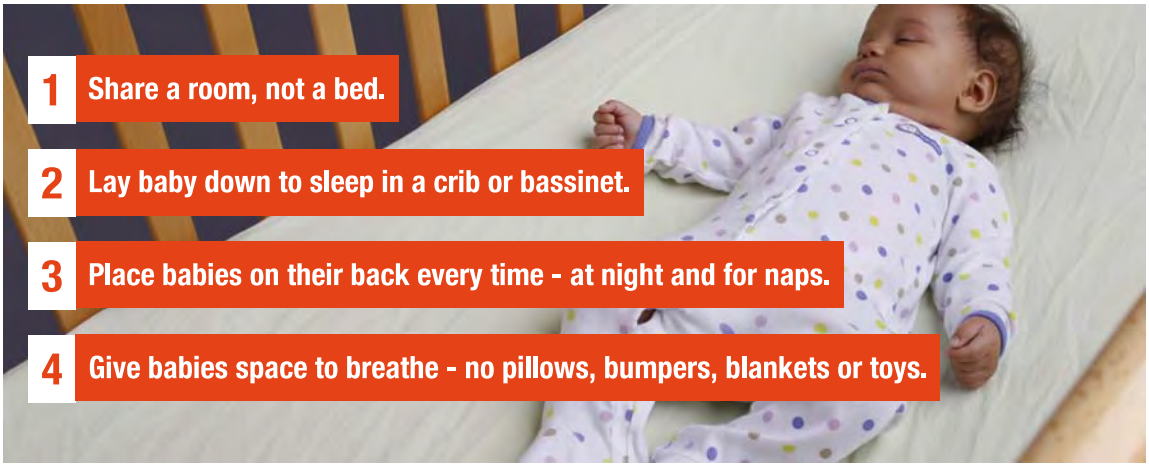
en Español

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

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

Water Safety

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

Biking Safety

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

Child Abuse

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

Fire Safety

http://www.redcross.org/prepare/disaster/home-fire
http://fire.lacounty.gov/FirePrevention/FirePrevFirePreventionTips.asp

In and Around Cars

http://www.usa.safekids.org/skbu/cars/spotthetot.html
http://www.nhtsa.dot.gov/people/injury/pedbimot/ped/BackoversTry2/index.htm
http://www.kidsandcars.org/
http://www.chp.ca.gov/community/safeseat.html
http://www.aap.org/family/carseatguide.htm

Pedestrian

http://www.kidsandcars.org/
http://www.chp.ca.gov/html/walkwithcare.html
http://www.chp.ca.gov/html/skateboard.html

Teen Drivers

http://ww.nhtsa.dot.gov
http://www.youtube.com/watch?v=vgDgcWNXBcI&feature=related
http://coroner.co.la.ca.us/htm/yddvp1.htm

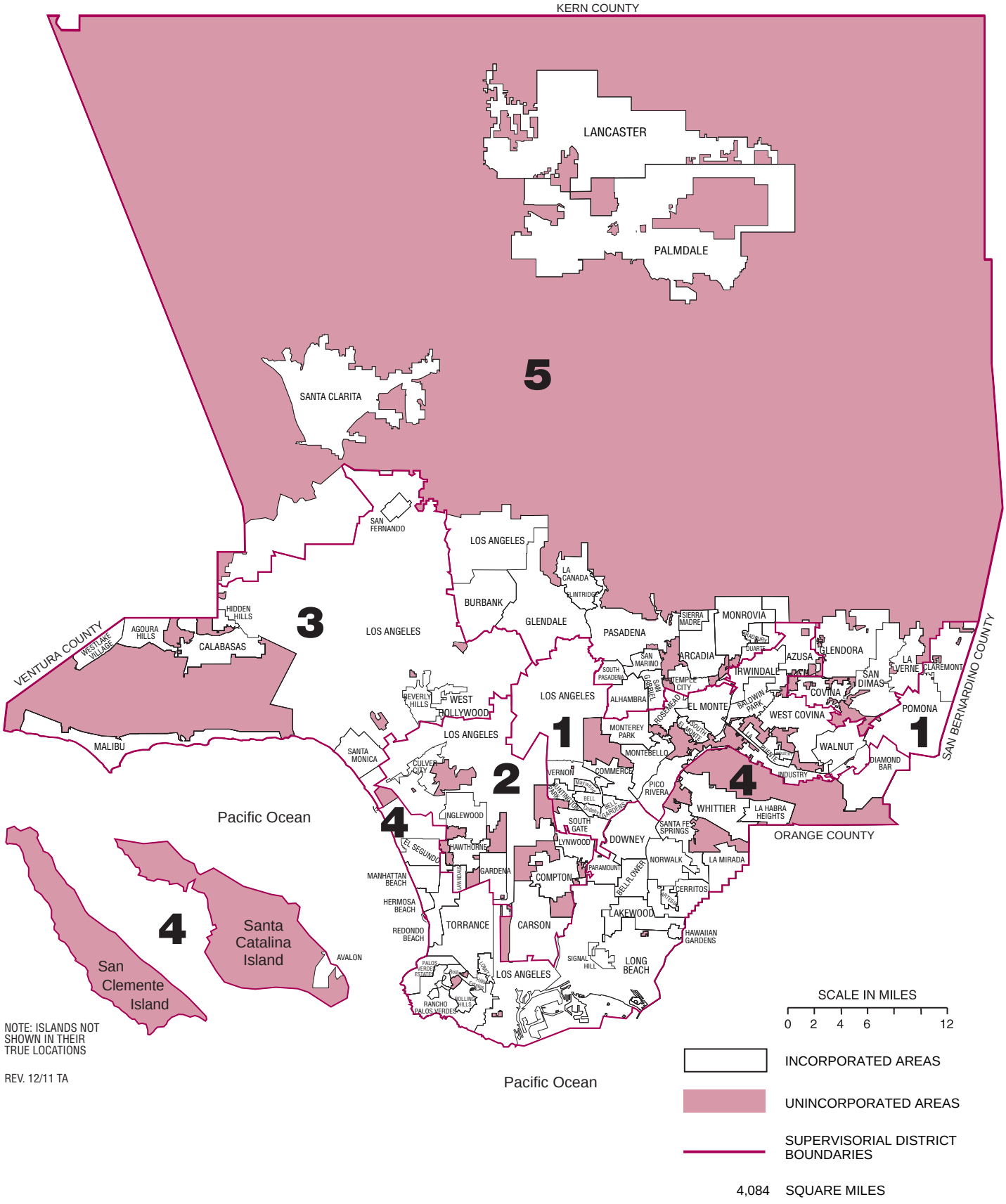
Grief and Mourning

http://www.californiasids.com/Universal/MainPage.cfm?p=10
http://ww.compassionatefriends.org
http://griefcenterforchildren.org

Suicide-Youth

http://www.preventsuicide.lacoe.edu
http://ww.suicideinfo.ca/youthatrisk
http://suicidehotlines.com/california.html
http://www.spyc.sanpedro.com/suicide.htm
http://www.uaii.org/uaiiinc_007.htm
http://ww.youtube.com/watch?v=iCaMpd2L2kQ
http://www.youtube.com/watch?v=CHynDpYv1Gw&NR=1

Appendix D -
Map Of Los Angeles County By Board Of Supervisor District



ICAN

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

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

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

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

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