





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.

In 2001, a multi-disciplinary sub-group of the ICAN Child Death Review Team, the Child and Adolescent Suicide Review Team (CASRT) was formed. The Team reviews child and adolescent suicides, analyzes trends and makes recommendations aimed at the recognition and prevention of suicide and suicidal behaviors.



**ICAN**

**Child Death Review Team Report 2023**  
**Report Compiled from 2022 Data**

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# Table of Contents

<b>Los Angeles County Team Representatives</b> . . . . .	<b>2</b>
<b>Introduction</b> . . . . .	<b>3</b>
<b>Risk Factors and Lessons Learned</b> . . . . .	<b>4</b>
<b>Senate Bill 39 Data Variances between ICAN and DCFS</b> . . . . .	<b>6</b>
<b>Child Deaths in Los Angeles County 2018-2022</b> . . . . .	<b>8</b>
<b>Child Homicides by Parent, Caregiver, or Other Family Members 2021</b> . . . . .	<b>11</b>
<b>Child and Adolescent Suicides 2022</b> . . . . .	<b>22</b>
<b>Accidental Child Deaths 2022</b> . . . . .	<b>33</b>
<b>Undetermined Child Deaths 2022</b> . . . . .	<b>43</b>
<b>Third Party Homicides 2020</b> . . . . .	<b>51</b>
<b>Appendix A - On-Line Resources</b> . . . . .	<b>58</b>
<b>Appendix B - Map of Los Angeles County By Board of Supervisor District</b> . . . . .	<b>59</b>

# Los Angeles County Team Representatives

## **Child Death Review Team Chairpersons:**

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

**Janis Johnson, Los Angeles County, Office of the District Attorney**

## **Child and Adolescent Suicide Review Team Chairpersons:**

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

**Lynda Boyd, Los Angeles County, Department of Mental Health**

**Rosemary Rubin, Retired, LAUSD**

**Stephanie Murray, Whittier Union High School District**

## **Teams Include Representatives From The Following**

Children and Family Services

Public Health

Health Services

Office of Education

District Attorney

Los Angeles Police Department

Los Angeles Fire Department

Office of City Attorney

Los Angeles Unified School District

Edelman Children's Court

Community Care Licensing

Independent Police Agencies

Children's Hospital of Los Angeles

Community Child Abuse Councils

Chicago School of Professional Psychology

Medical Hubs

County Counsel

Public Social Services

Sheriff

Mental Health

Almanson Center

USC School of Medicine

Pacific Clinics

Burbank United School District

Whittier-Union School District

United American Indian Movement

Medical Examiner-Coroner

Probation

Fire

Community  
Development  
Commission/Housing

***This report is available online at: [ican4kids.org](http://ican4kids.org)***

## Introduction

The Los Angeles County ICAN Child Death Review team (CDRT) has met to analyze the circumstances that lead to child death in Los Angeles County for the past forty-six years. CDRT and the Los Angeles County ICAN Child and Adolescent Suicide Review (CASRT) teams meet monthly and are comprised of representatives of the Department of Medical Examiner-Coroner, Los Angeles Police and Sheriff's Departments, District Attorney's Office, Los Angeles City Attorney's Office, Office of County Counsel, Dependency Court, Department of Children and Family Services, Department of Health Services, Department of Public Health, Department of Public Social Services, County Office of Education, Department of Mental Health, California Department of Social Services, Los Angeles Child Abuse Councils and representatives from the medical community.

The Team reviews each referred case 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. 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.

This report provides information on all child deaths that meet Team protocol and occurred in Los Angeles County during the calendar year 2022. Lessons learned from the reviews are included in the report. Appendix C at the end of the report provides on-line resources for prevention of child deaths.

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

# Child Death Review Team: Risk Factors and Lessons Learned

Team case review yields valuable lessons, including identification of systematic issues in need of attention by one or various agencies impacting the welfare of children and families. Additionally, patterns of risk factors present in families surface in the cases. The lessons and risk factors noted from the 2022 child death review cases are as follows:

## Key Findings

Total number of child deaths in 2022 was 173 of which 111 were male and 60 were female. Two were gender unknown.

60 children were under the age of one (35%). The deaths of these infants resulted primarily from unsafe sleep, maternal substance abuse and drownings.

64 or 37% of the children who died in 2022, were between ages 15-17. Most deaths were related to car accidents, third party homicides and suicides.

Of twenty-eight third party homicide victims 27 were male and one was female.

In 2022, the majority of child homicide victims by caretaker were males, with seven male victims and four female victims. This is consistent with previous years when male children have been the more frequent victims of homicide by caretaker.

The ethnicity of child victims of homicide by a caretaker in 2022 was as follows; Hispanic, 64%, African American 16%, Caucasians 1%.

## Parental/Caregiver Risk Factors

### Involvement with the Child Welfare System

A key factor in the majority of the child abuse homicide cases from 1989 to 2022 was that the child's mother, father or the perpetrator had at least one contact with the Department of Children and Family Services (DCFS). In 2022, we saw a shift in that most cases of homicides by caretaker did not have Department of Child and Family Services contact. Review of the families' histories revealed 18% percent of the perpetrators had a DCFS contact as a minor themselves.

### Cycle of Abuse

Cycle of abuse was not readily available in documents available for review for all parents or caregivers who committed a child homicide.

### Substance Abuse by Parent or Caregiver

Substance abuse by a parent or caregiver is a documented high risk factor for child abuse or neglect and often is identified when there is a child fatality.

## **Mental Illness**

Untreated mental illness is a risk factor seen in 4 of the child abuse homicides. In three of those cases there appeared to be untreated depression and schizophrenia.

## **Presence of multiple Parental/Caregiver Risk Factors**

A combination of risk factors, such as lack of bonding with a caregiver, history of substance use, domestic violence, CPS contact, CPS history as a child and social isolation.

## **Perpetrator Relationship**

### **Relationship**

In the year 2022 there was a return to biological fathers being the suspect in the majority of the child homicide cases followed by mother's boyfriend, and then biological mothers, or both mother and father as perpetrators.

### **Lack of Parenting Skills, Bonding or Poor Attachment**

The poor quality of the relationship of the adult to the child continues to be a recurring factor in child abuse homicides.

## **Additional Risk Factors**

### **Unsafe Infant Sleeping**

Sudden unexpected infant deaths (SUIDs) are usually ruled as Undetermined and occur while an infant is in the sleep environment.

Undetermined child deaths associated with bed-sharing and/or unsafe sleep environments declined considerably from the high of 70 in 2009. Infants who die are often placed on their stomach or side on adult beds, couches and/or surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. The data indicate that 33 children died in 2022 because of unsafe sleep practices.



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

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

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

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

A “determination” of abuse and/or neglect by Child Welfare Services or Probation is the substantiation of abuse and/or neglect allegations which resulted in the fatality; or

A law enforcement investigation concludes that the child’s death was a result of abuse and/or neglect; or

A coroner/medical examiner concludes that the child’s death was a result of abuse and/or neglect.

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

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

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 to fatal attacks with clear intent.

**Accidental** deaths are due to injury when there is no evidence of intent to harm. This manner of death comprises the largest category of child deaths reported to the Team by the Coroner. Several types of accidental death, such as automobile, auto pedestrian fatalities, drowning, and accidental gunshot wounds, are truly unintentional in nature. However, there may be questions of the caregiver supervision in some of these cases, as well as concern regarding the preventability of these accidents. A significant number of accidental deaths involve newborns who were prenatally exposed to drugs and who subsequently died of prematurity or from other related perinatal causes.

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

**Suicide**, by the Coroner’s definition, is injury that occurred with the intent to induce self-harm or cause one’s own death. 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 youths 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.

*\*Reported by the Medical Examiner-Coroner and does not include 3rd Party Homicides or Natural deaths.*

**Table 1**

**Over the past 5 years, a parent, caregiver or other family member has murdered an average of 13 children each year**

<b>Year</b>	<b>Number</b>
2018	10
2019	18
2020	14
2021	12
2022	11

**The average number of children and adolescents who committed suicide over the past five years is 23. The leading method from 2018 through 2022 is hanging.**

<b>Year</b>	<b>Number</b>
2018	29
2019	20
2020	26
2021	23
2022	18

**An average of 103 children have died from preventable accidents over the past 5 years from automobile accidents, drowning and deaths due to auto vs. pedestrian.**

<b>Year</b>	<b>Number</b>
2018	102
2019	110
2020	126
2021	104
2022	74

**The number of undetermined deaths has averaged 48 per year over the past five years**

<b>Year</b>	<b>Number</b>
2018	67
2019	42
2020	50
2021	41
2022	42

**Table 2**

**2021 Child Deaths Demographics - Coroner Cases**

	Number	Percentage
<b>Total</b>	173	100.0%
<b>Gender</b>		
Female	60	35%
Male	111	64%
Unknown	2	1%
<b>Age</b>		
Under 1 Year	60	35%
1 – 4 years	18	10%
5 – 9 years	10	6%
10 – 14 years	21	12%
15 – 17 years	64	37%
<b>Race</b>		
African American	41	24%
Armenian	2	1%
Asian/Pacific Islander	7	4%
American Indian	24	14%
Caucasian	90	52%
Hawaiian	1	1%
Hispanic	8	5%
Middle Eastern	3	1%
Samoan	2	1%
Unknown	11	5%

## Sample Case Summaries - Homicides

### **Darcie**

The father of Darcie, age, 1 picked up Darcie and her 3-year-old sibling at mother's home. The mother approved for father to take his children for a visit. Father arrived to his home address where he lived with paternal grandmother. The paternal grandmother asked father the whereabouts of the child Darcie because father brought home only one child. The father would not say anything to paternal grandmother regarding what happened to the child Darcie. The paternal grandmother made a Missing Person Report. A search was conducted, and child Darcie was found in the River. It was later discovered that father threw the child into the river. He was suffering from mental health issues and was angry at mother for not being willing to reconcile with him.

### **Melodie, Carlos and Junior**

The mother suffocated the children Melodie, age 12, Carlos, age 10 and Junior, age 8 with the help of her 16-year-old son. Mother had the eldest sibling hold down his siblings as they suffocated each child to death. Investigation later determined that mother believed the children had demons in them and they had to be killed. Mother is currently incarcerated for their deaths and the older sibling is on probation living with relatives.

### **Joey**

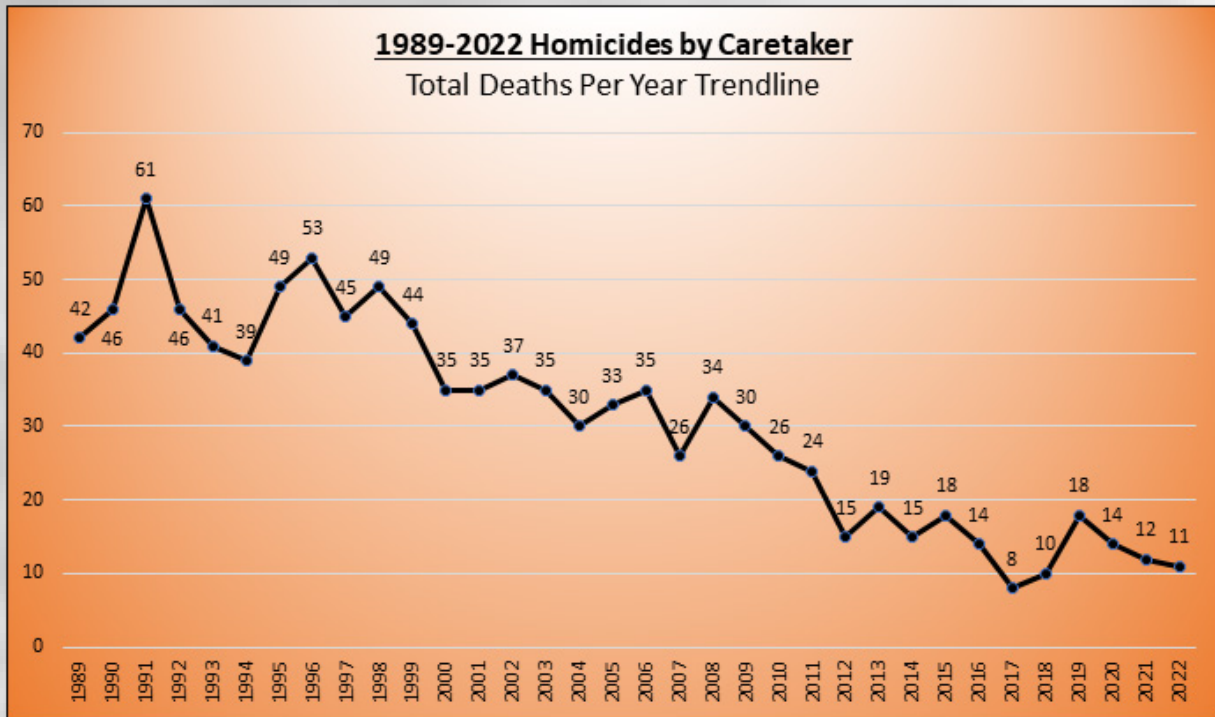
One-month old, Joey was in the care of his mother when he was found dead by a relative living with mother. The child was found face down with a pillow over his head. Mother admitted to smothering him to death. Mother had a history of schizophrenia.

## HOMICIDE BY CARETAKER

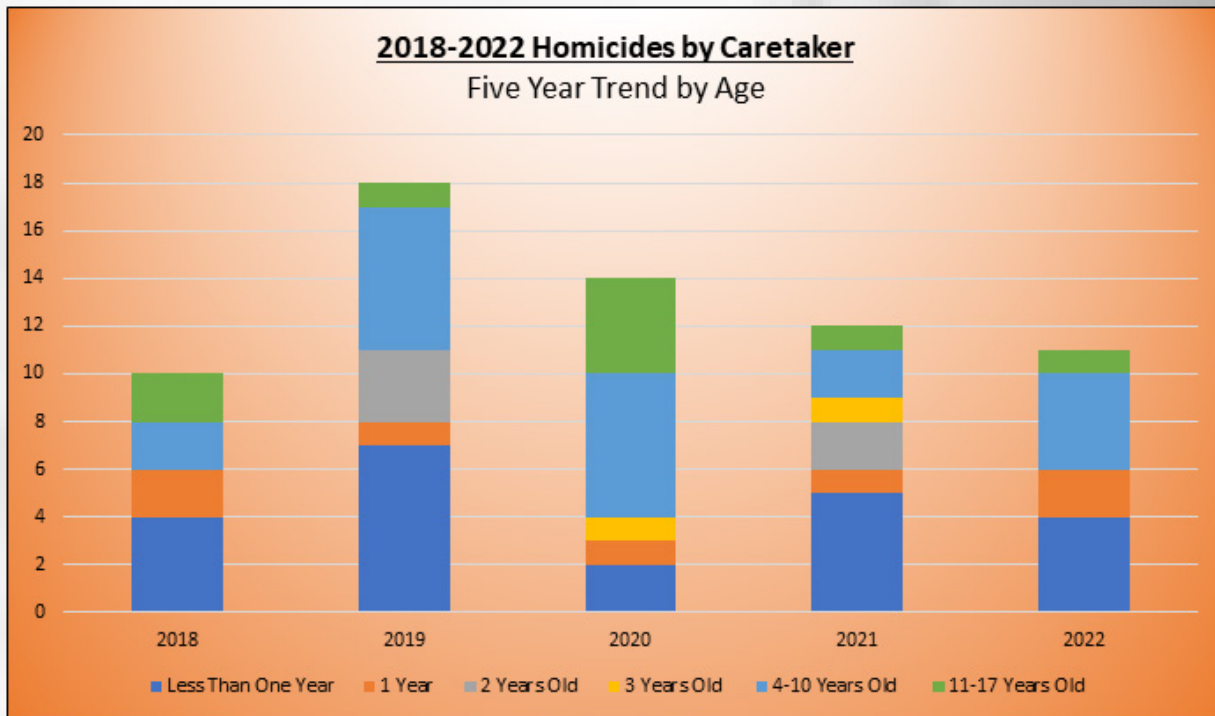
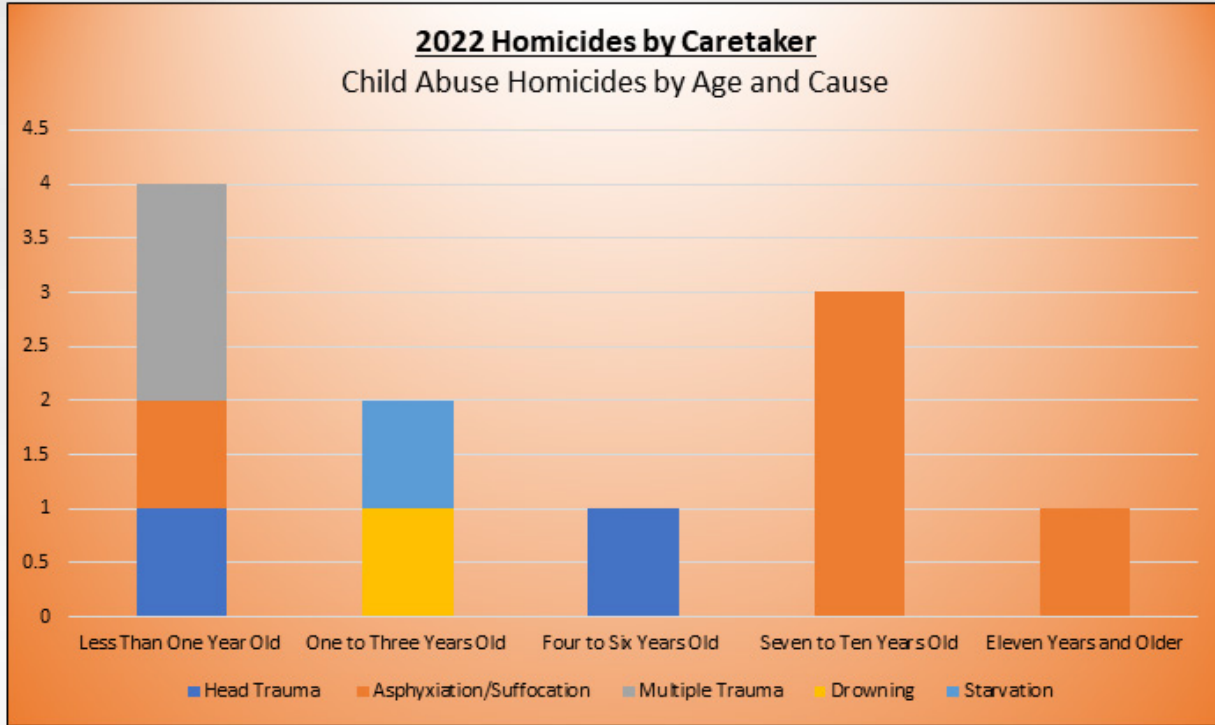
### FINDINGS

- 11 homicides of children by caretaker were reported to ICAN from the Coroner's Department in 2022.
- This was an 8% decrease from the 2021 number of 12 homicides by caretaker. The lowest number of homicides by caretaker was in 2017, with only 8 homicides and there was a spike in 2019 with 18 homicides. However, there continues to be a downward trend in the last 10 years.
- Asphyxiation/suffocation was the leading cause of homicides by caretaker in 2022, with 5 children dying from being suffocated/asphyxiated by their caretaker. The second leading cause was multiple trauma (2 deaths) and head trauma (2 deaths). This is a shift from the previous years, in which drowning was the leading cause of death. The previous year saw a shift in the proportionality in genders of perpetrators. In 2022, the majority of homicides were perpetrated by the biological father.
- The other causes of child homicides were Drowning (1) and Starvation (1).
- Over the last five years, the top causes of death in homicides by caretaker have been head trauma, multiple trauma and gunshot wound.
- The age of child victims in 2022 saw an increasing trend in homicides for children between the ages of 4-10 years old when compared to 2021 rates. However, it is tied with child homicides of children less than a year in age, showing that there continues to be a trend of homicides over-represented with children less than a year of age. The majority of children who were killed were less than a year old or between 4-10 years old, with 4 children each age group.
- The majority of children who were killed were males, with 7 male deaths in 2022. This is a sharp increase when compared to 2021, with 4 male deaths.
- The ethnicity of child victims of homicide by a caretaker in 2022 was as follows; Hispanic: 64%, African American 27% and Caucasian: 1%.
- A five-year analysis of perpetrators shows that fathers (n=5), followed by mothers (n=4), and mother's boyfriend/both parents (n=1) are the most responsible for the death of the child(ren) in their care.
- 82% (9 out of the 11 cases) of the victims of homicide by caretakers were from a family with no prior Department of Child and Family Services contact. Review of the families revealed 18% of the perpetrators had DCFS contact as a minor themselves.
- Three of the child homicides by caretaker were investigated by the Los Angeles Police Department. The remaining eight cases were handled by Inglewood Police Department, Long Beach Police Department, North Hollywood Police Department, Valley Bureau Police Department, San Bernardino Police Department, Downey Police Department, and Los Angeles Sheriff's Department (n=1).

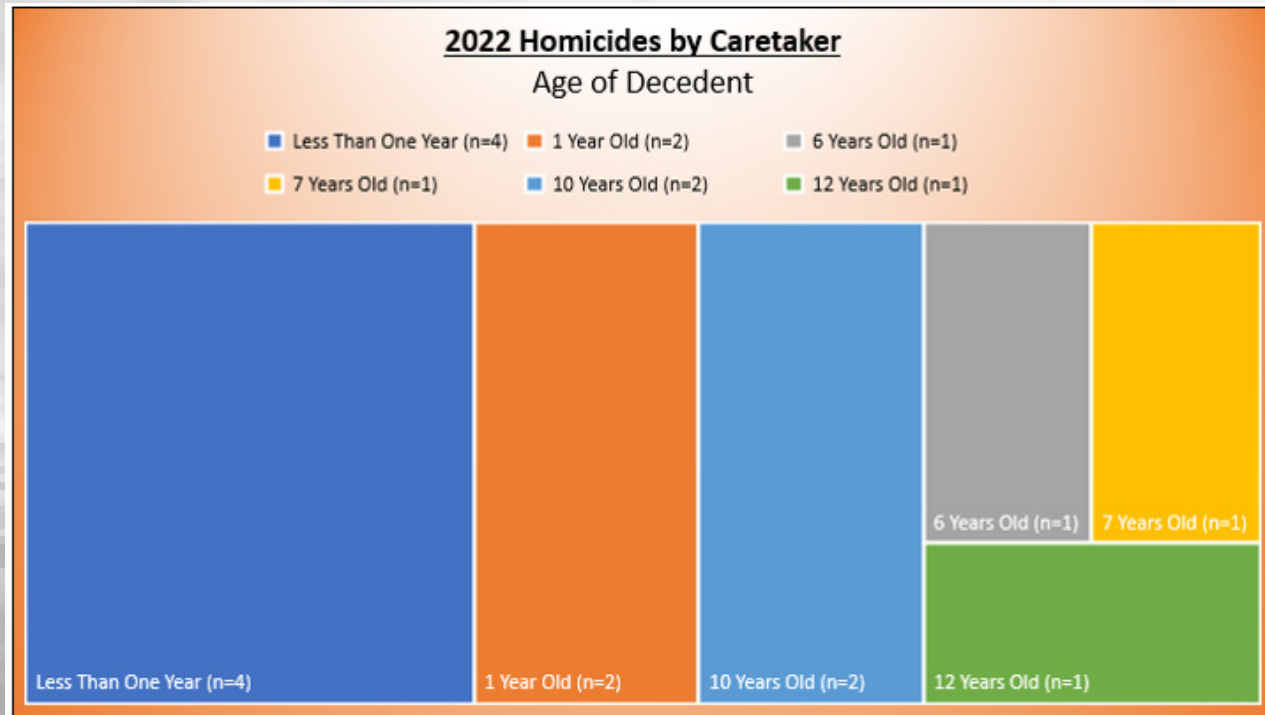
# Child Homicide by Parent/Caregiver/Family Member

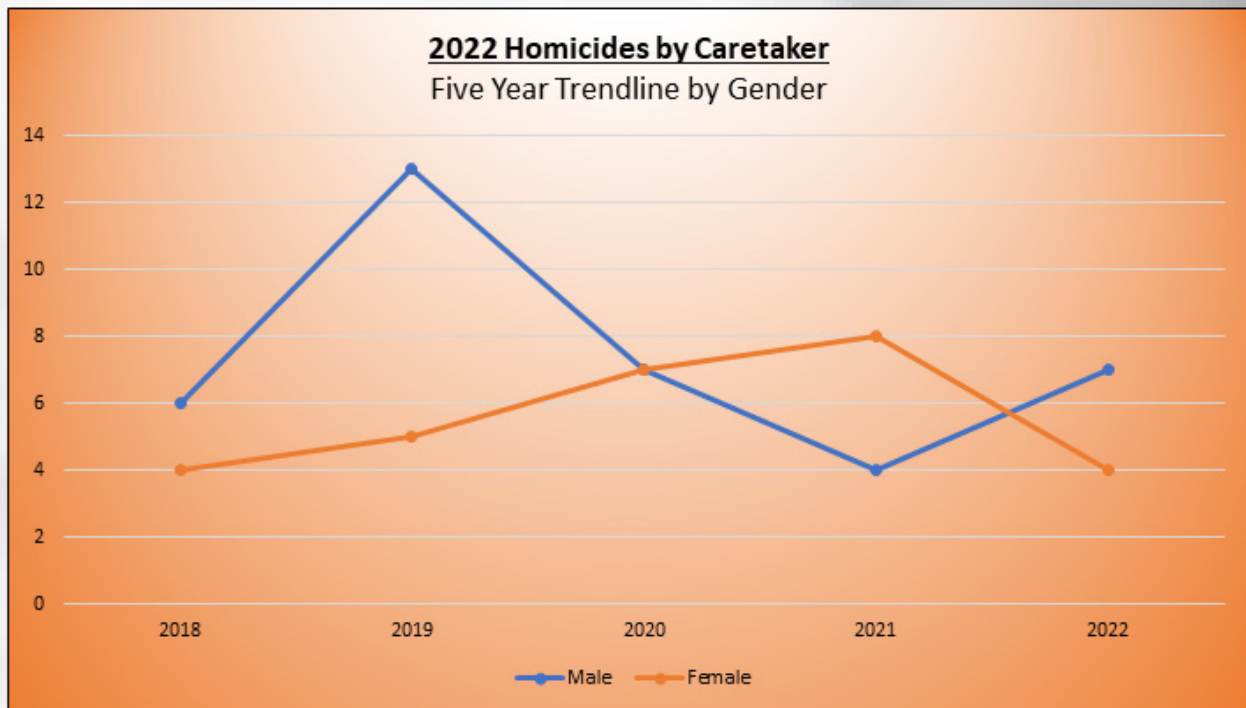
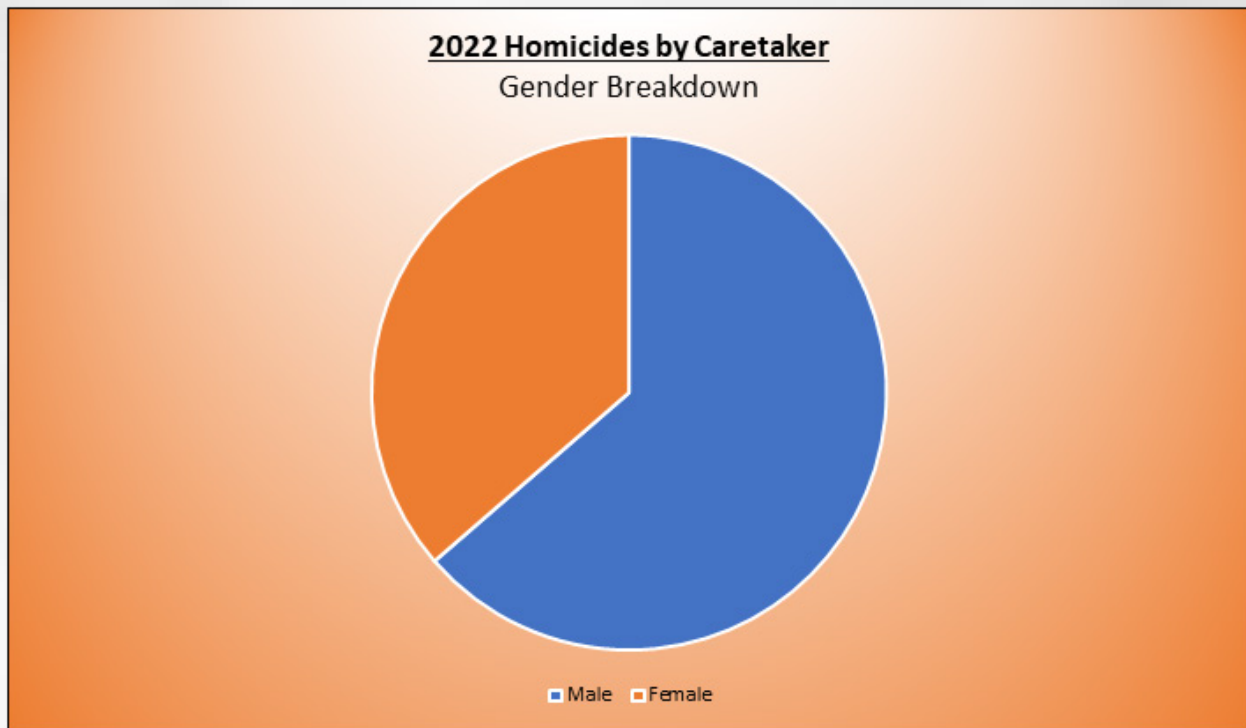


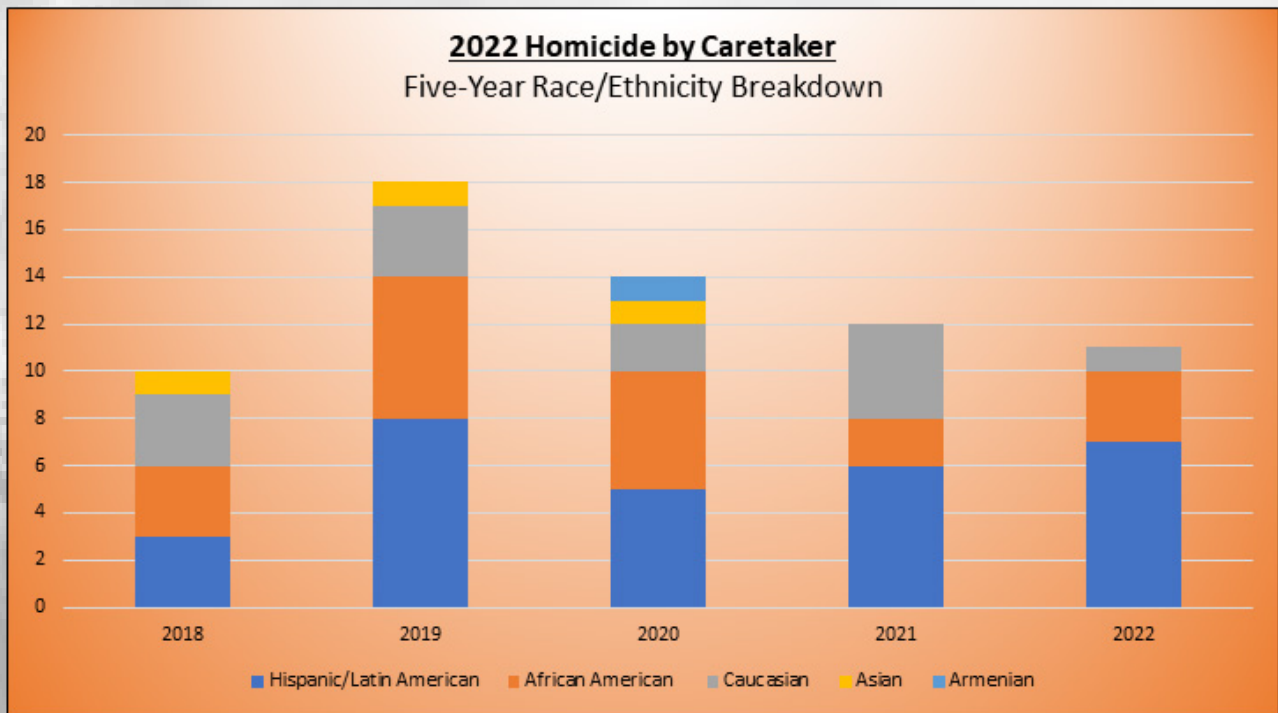
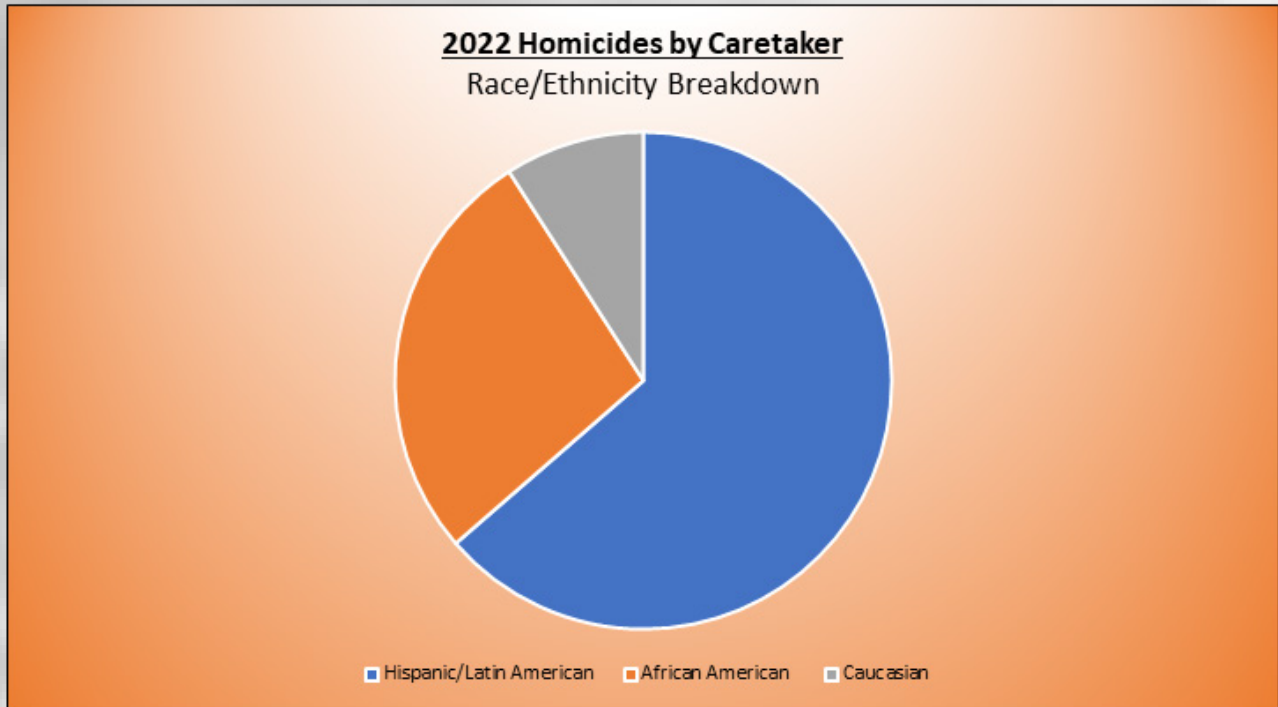
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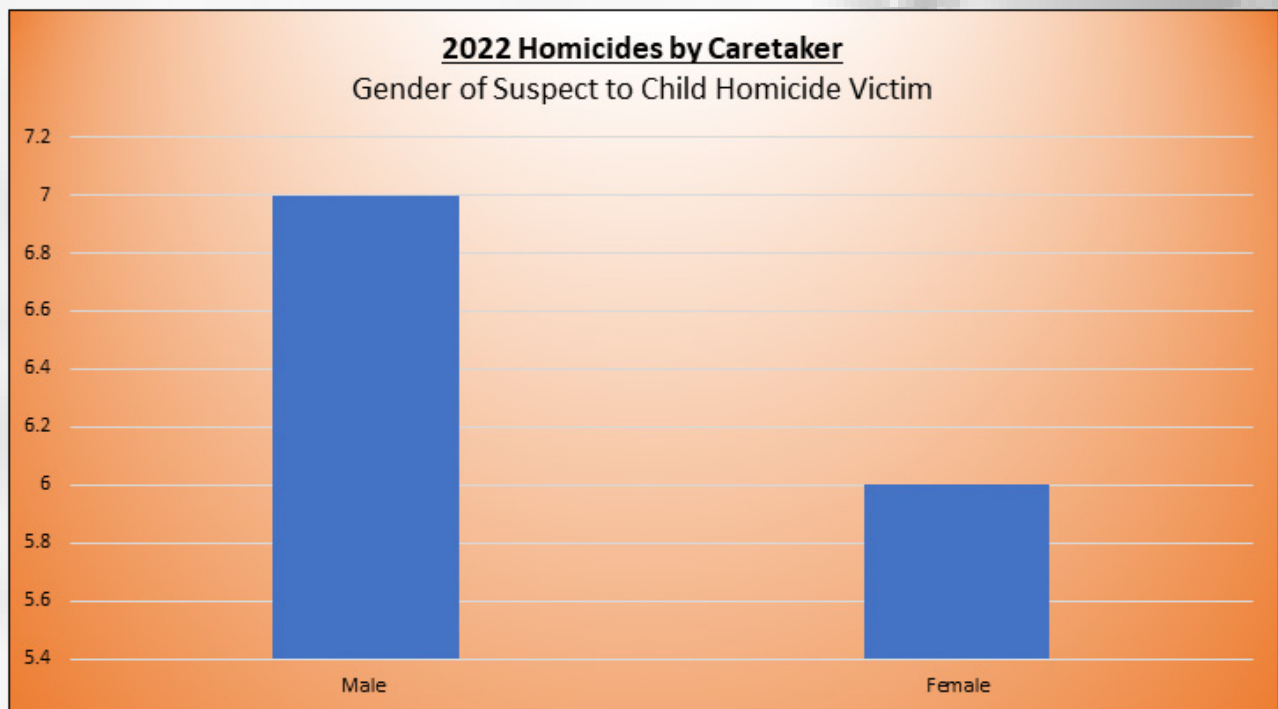
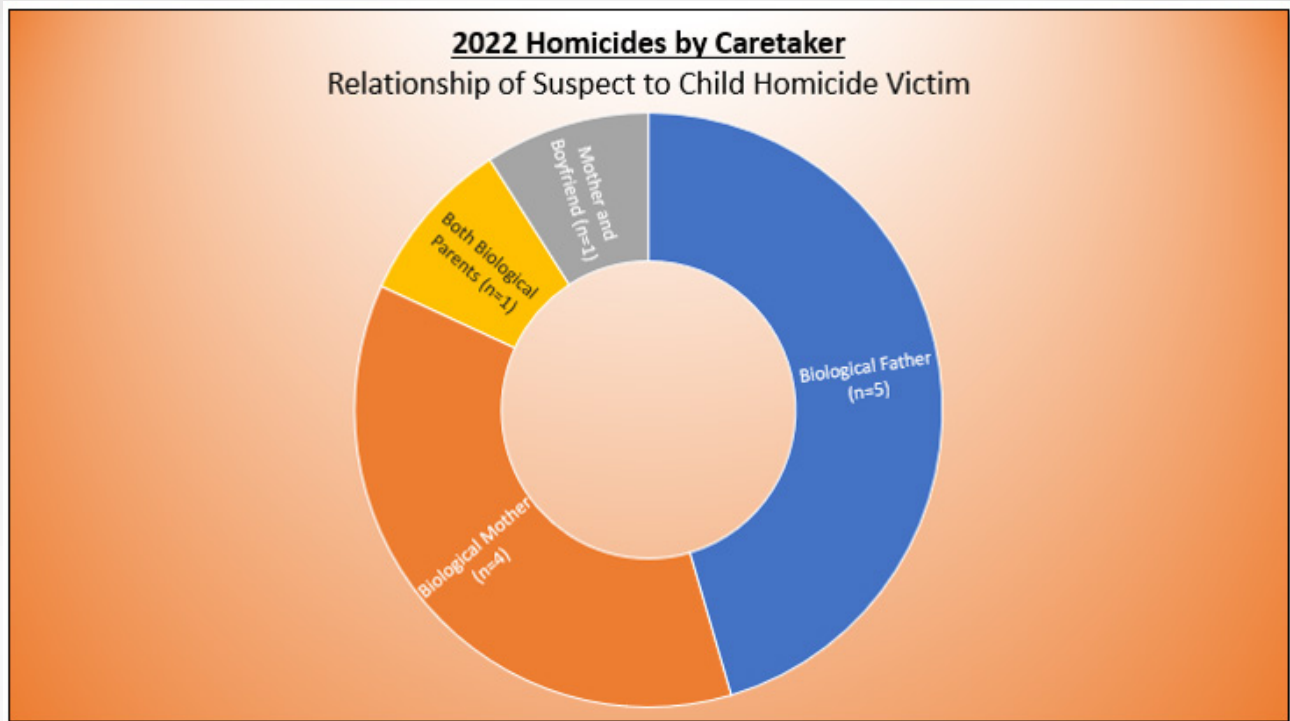




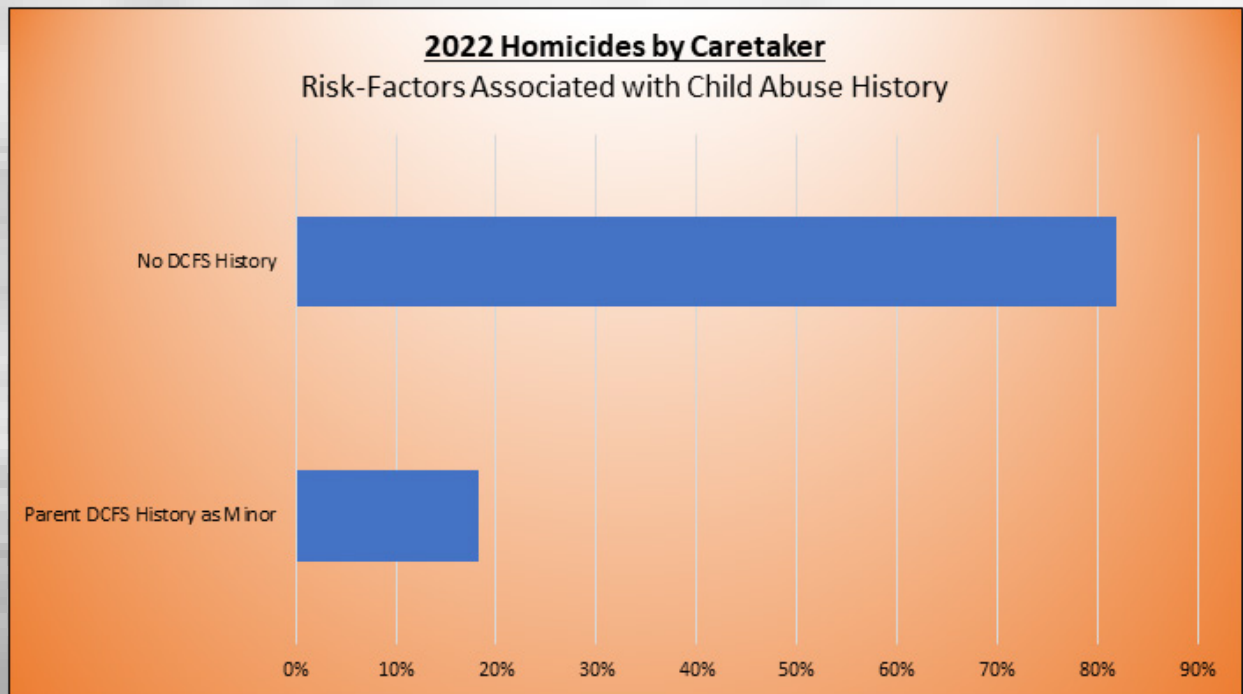
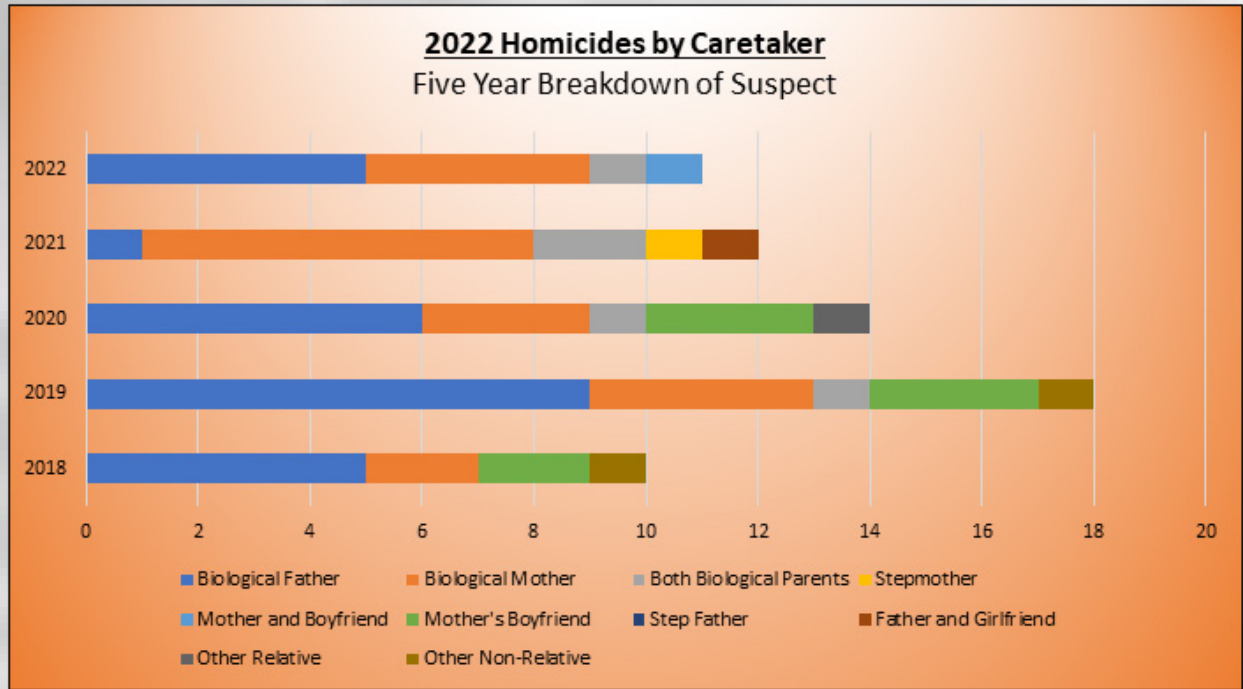


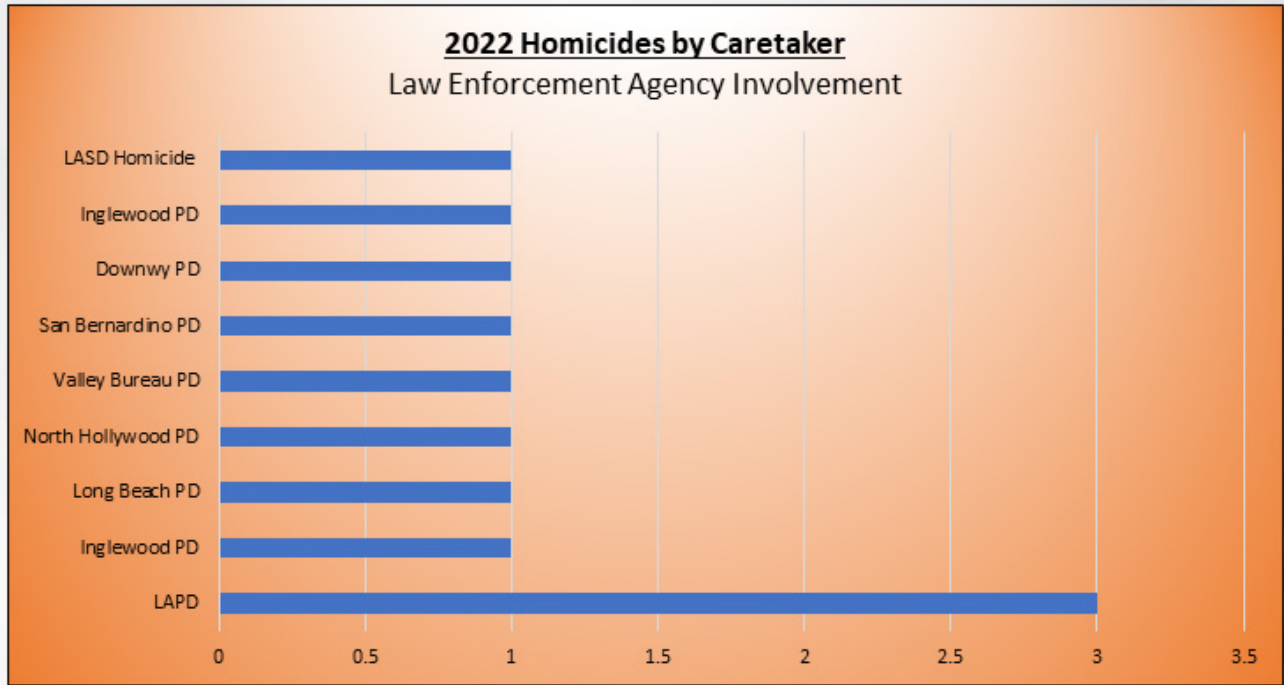






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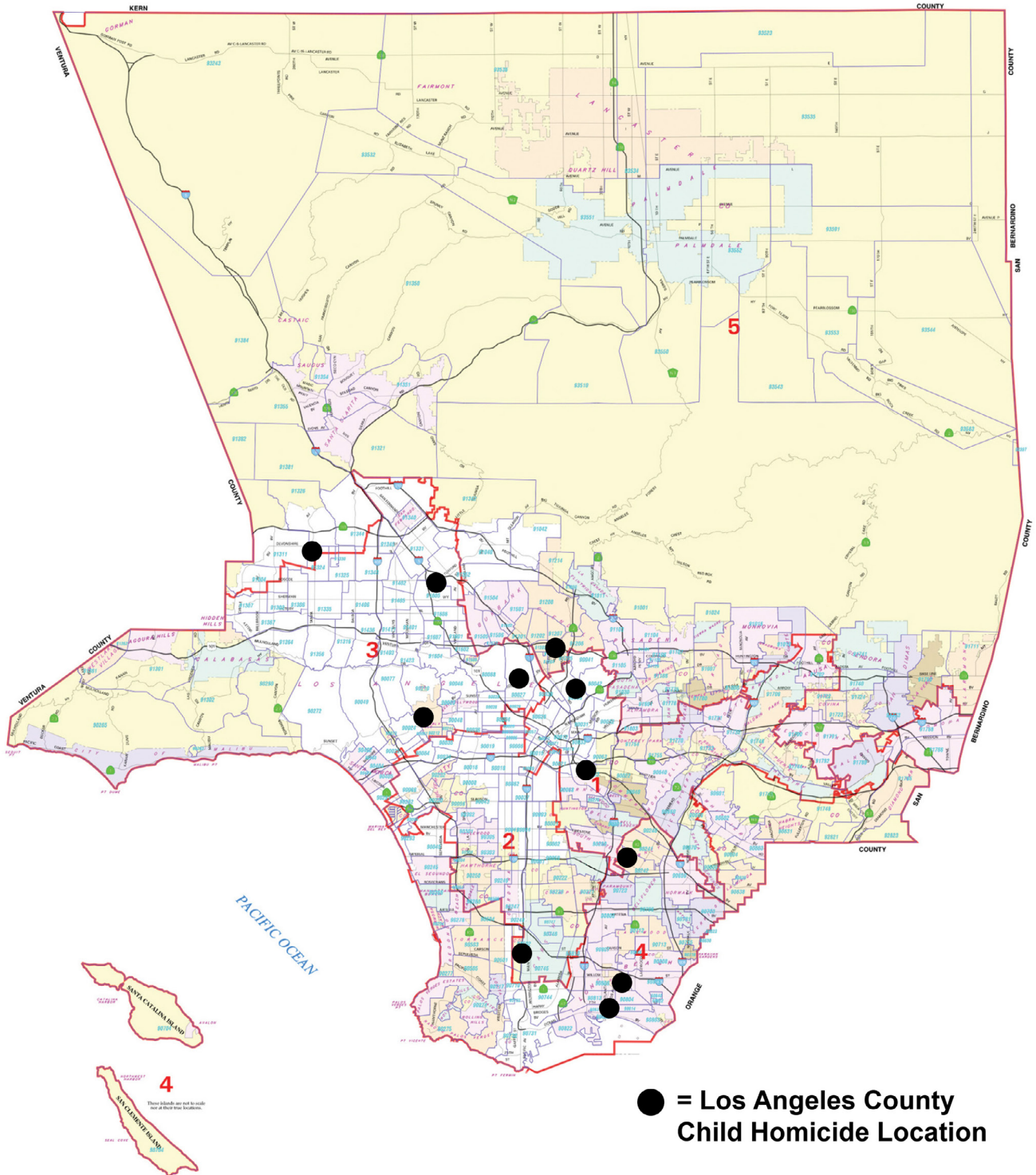




### 2022 Child Homicides - Locations

n = 11\*

\*City where the homicide occurred



## Sample Case Summaries - Suicides

### Cleo

Sixteen-year-old, Cleo was found hanging with a belt around her neck. 9-1-1 was called and LA County Fire Department was first on scene. LA Fire Department pronounced her death on the scene. Cleo was prescribed Zoloft for approximately two years ago due to her depression. She did not have history of alcohol or drug use. Cleo had one previous suicide attempt in May 2022. Mother minimized Cleo's mental health as noted in prior child abuse and neglect investigations.

### Allison

Thirteen-year-old Allison was found in the restroom by father with a gunshot wound to the head. Allison did not have history of suicide attempts or medication. Allison was previously residing with her mother in another county when she got into trouble at school. It resulted with Allison moving in with her father. On the day of the incident, father went to work and texted Allison who did not respond. Father left work and drove home as he was worried about Allison. Upon his return father discovered Allison in the bathroom with an apparent gunshot wound to the head. It is unknown how long Allison had been unresponsive prior to father's arrival. Father called 9-1-1. Allison was transported to the hospital. She was intubated and found to have observable cranial defects in addition to exposed brain tissue. Her family made the decision to withdraw care. No suicide note was found on scene.

### Joey

Joey aged fifteen was found unresponsive at a parking lot of a local university. Joey jumped from a four-story building at the university. He sent a TikTok to his friend saying, "it all ends today." Campus police and his mother were notified. Mother thought Joey was at school. Mother contacted law enforcement, as Joey was not at home or school. A missing child's report was completed. Approximately an hour after Joey TikTok his friend, he was located at a parking structure of the university. Joey had history of cutting. His friends disclosed a few days after his death that his mother was abusing Joey. The friend shared she has videos, photos and messages regarding the alleged abuse. Per friend, she did not report the abuse due to Joey asking her not to say anything. No suicide note was found on scene.

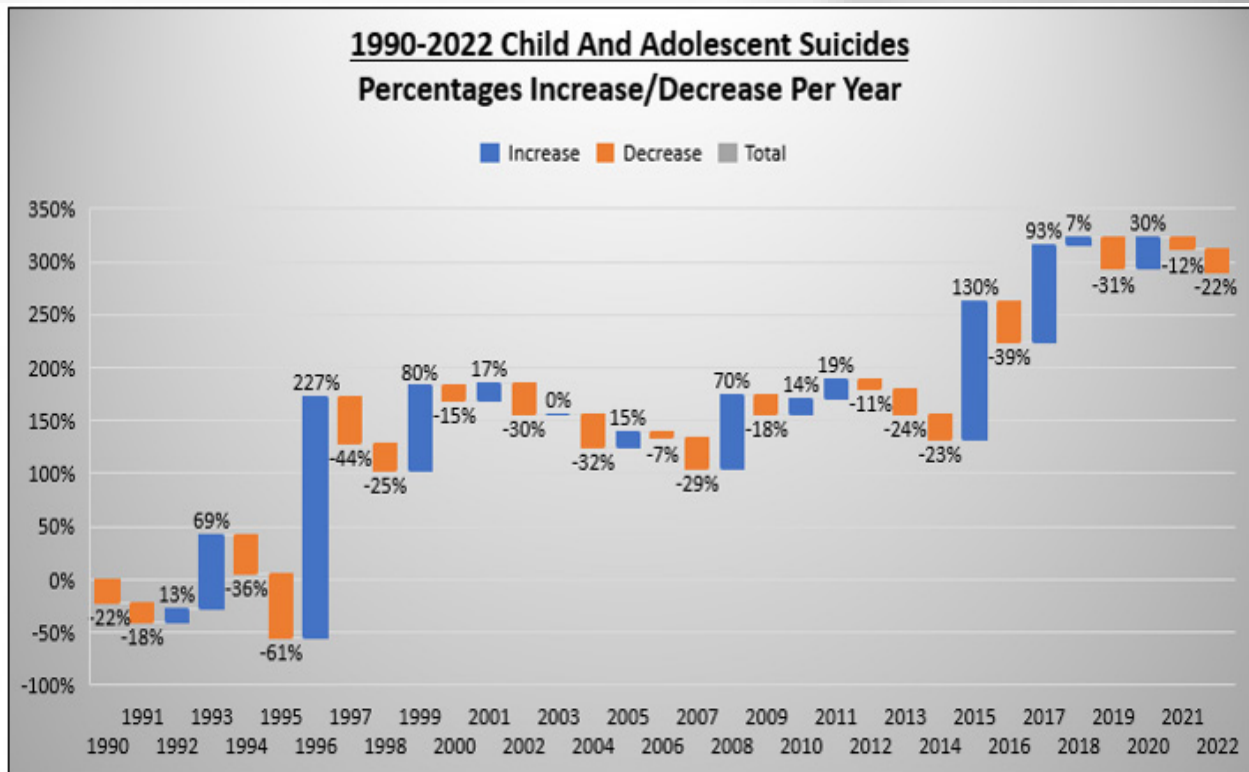
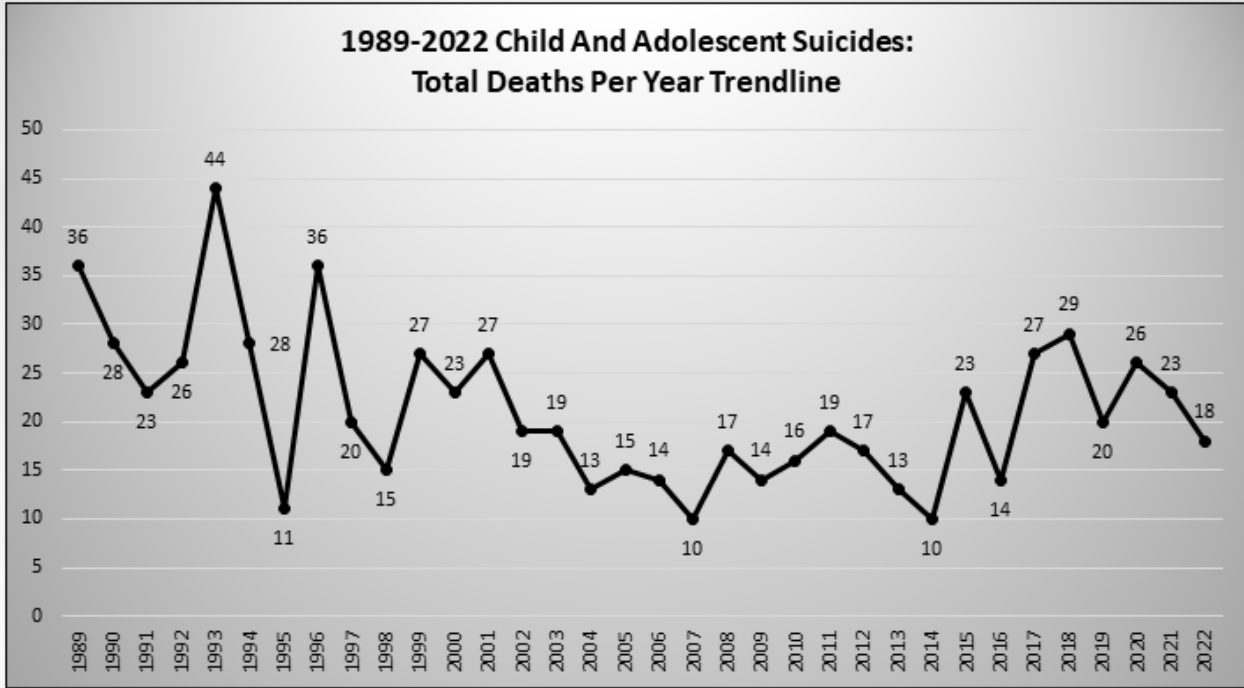


## SUICIDES

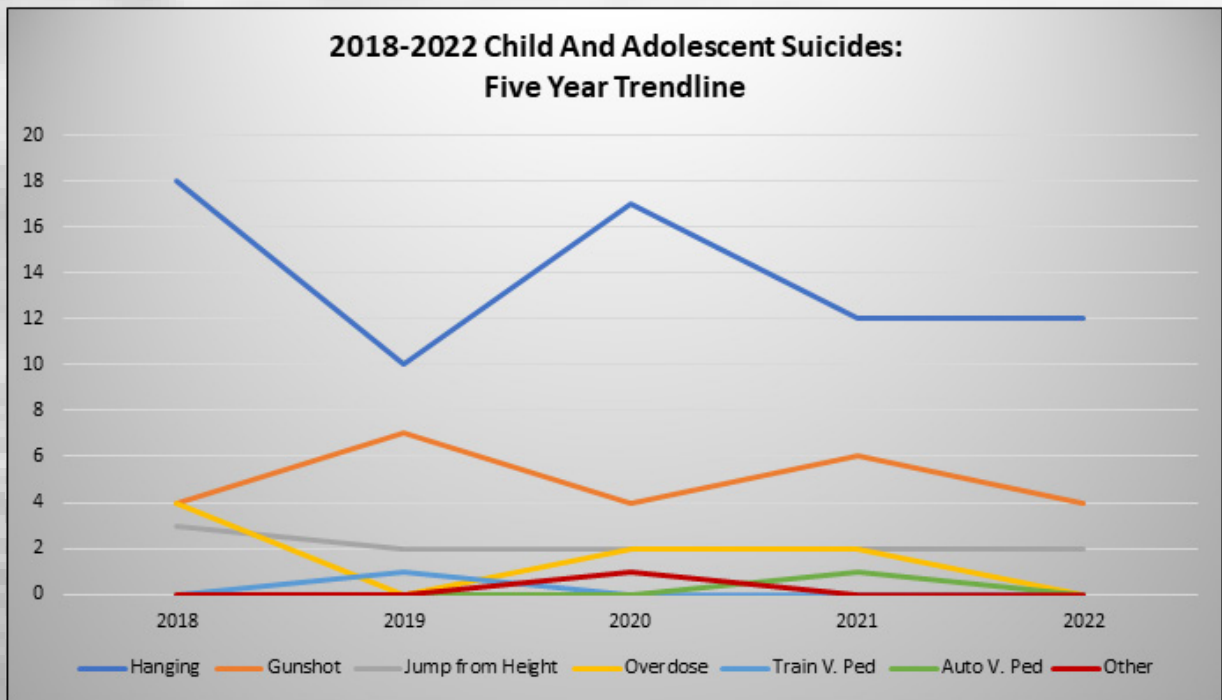
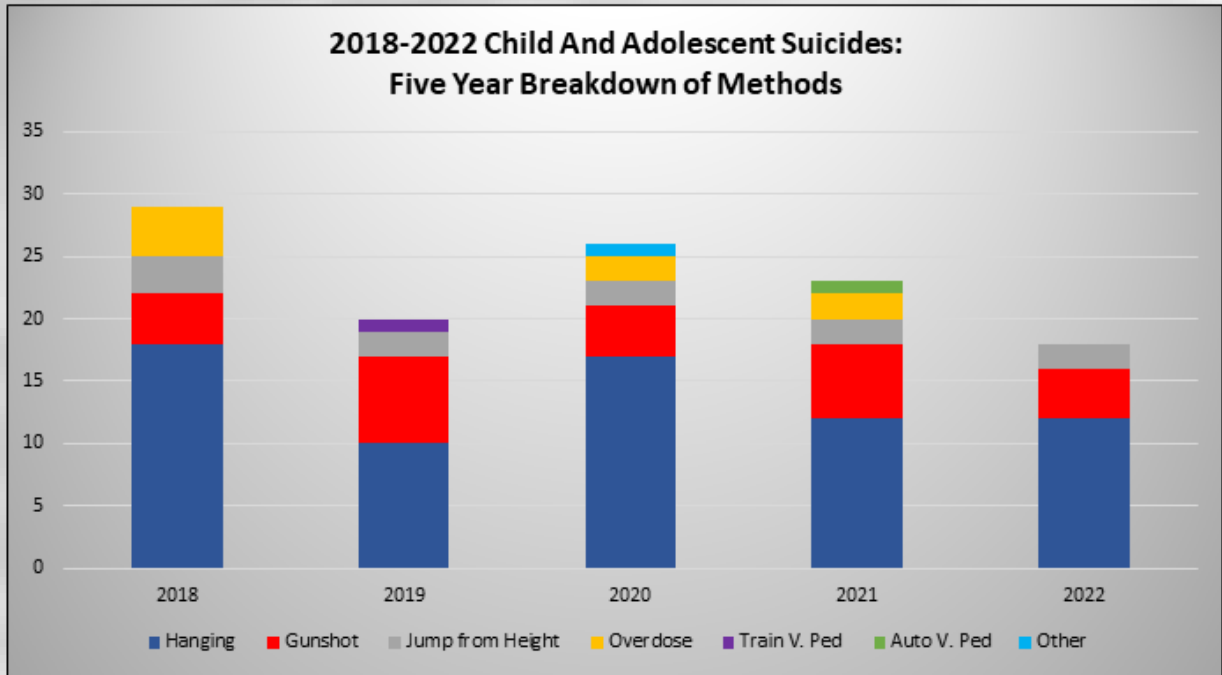
### FINDINGS

- The coroner reported eighteen child and adolescent suicides to ICAN for 2022. This is a twenty-two percent decrease from the 2021 data where there were twenty-three suicides that fell in line with the five-year average of twenty-three suicides.
- Sixty-seven percent of the suicides in 2022 were the result of hanging (n=12) and twenty-two percent were the result of gunshot wound (n=4). Eleven percent of the suicides were from jumping from high places (n=2).
- Death from hanging and gunshot wound continue to be the leading methods of suicide for children and adolescents. In the last five years, fifty-nine percent (n=69) of the suicides were from hanging and twenty-two percent (n=25) were from gunshot wound. Between the two, this accounts for eighty-one percent of all reported youth suicides.
- The gender divide for child and adolescent suicides we saw in previous years continues to diminish. Given that, in 2021, we observed an almost equal number of males and females who died by suicide. In 2022, there was an increase by males with 13 and 5 female suicides.
- As opposed to previous years where the leading age of suicide has been Seventeen-year-olds, in 2022, the largest age group was Sixteen-year-olds (33% or n=6). Thirteen-year-olds were the second largest age group comprising twenty-two percent (n=4) of the suicides. In a split, ages Fifteen-year-olds and Seventeen-year-olds were the next largest group (n=3). The remaining age groups for 2022 are two Twelve-year-old children.
- As in previous years, Hispanics and Caucasians comprised the two largest racial/ethnic groups for child and adolescents' suicides. However, unlike in 2021, there has been a slight increase in African American suicides with two children suiciding. There was a decrease of Asian American suicides with only one.

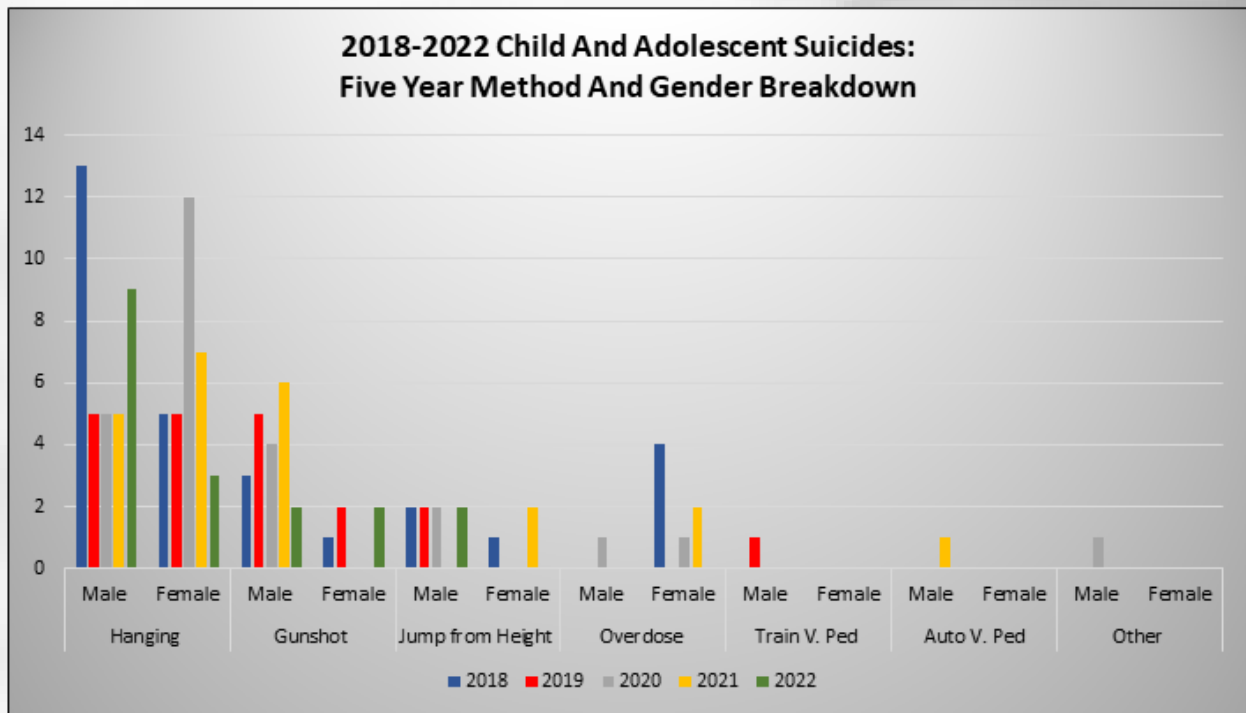
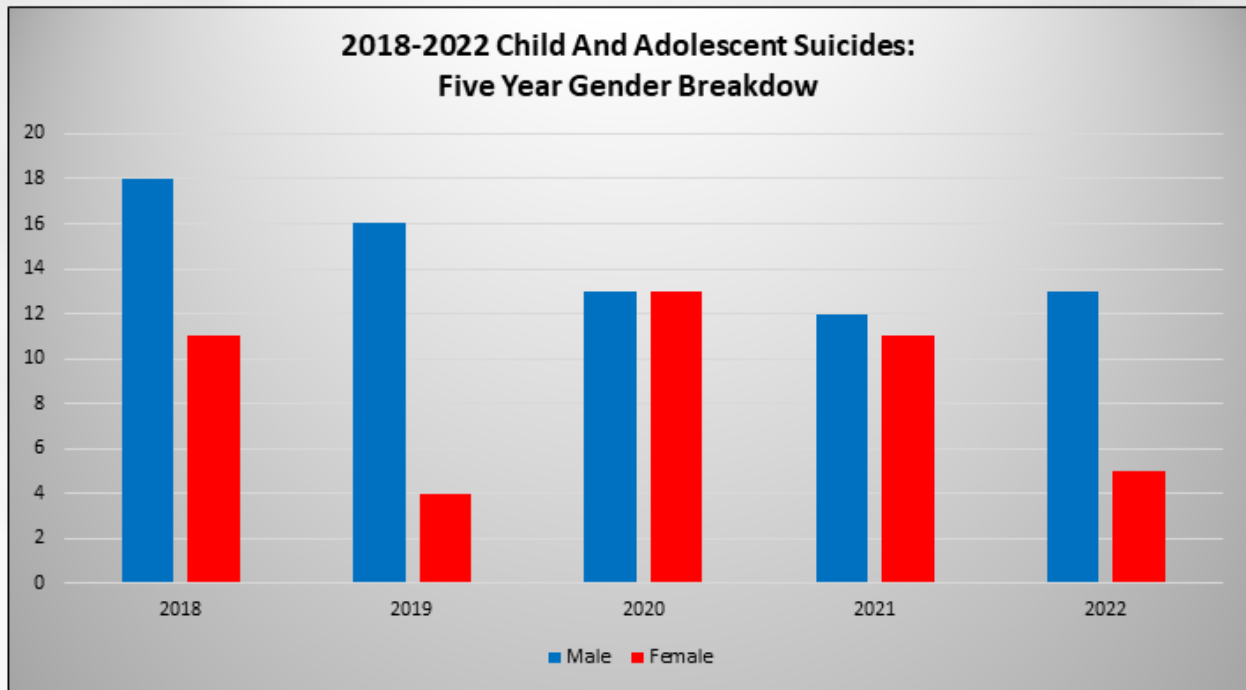
# Child and Adolescent Suicides



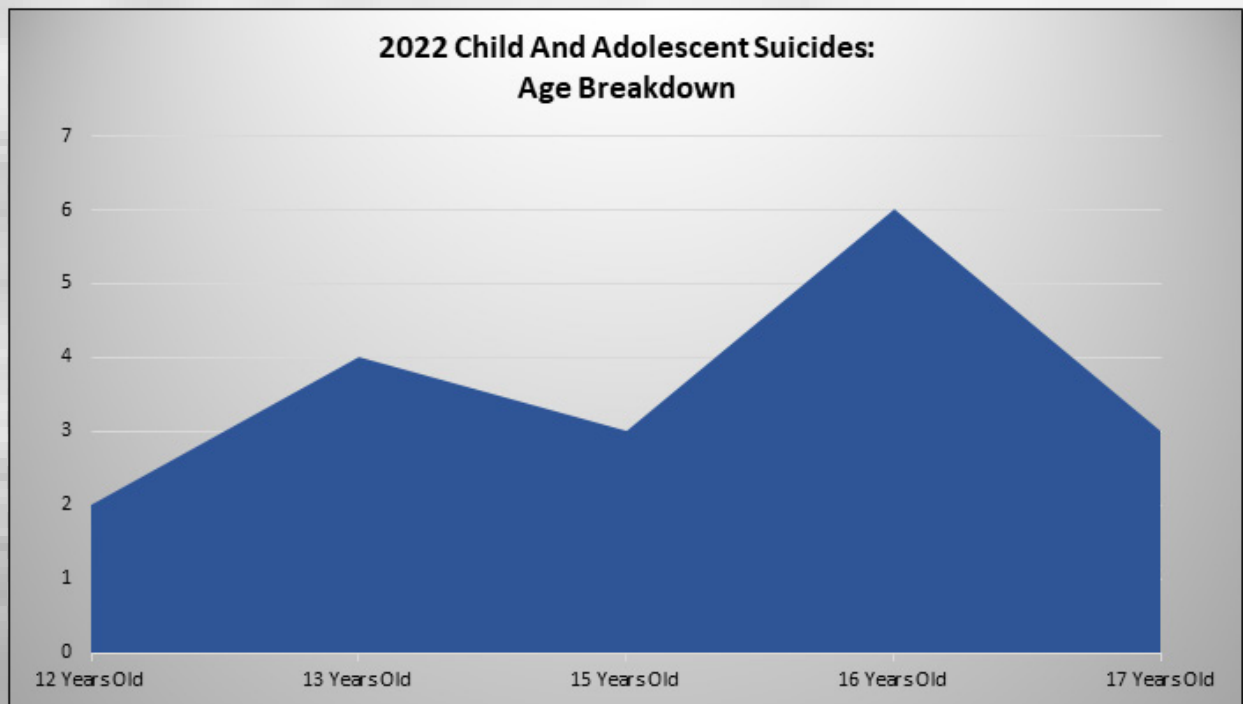
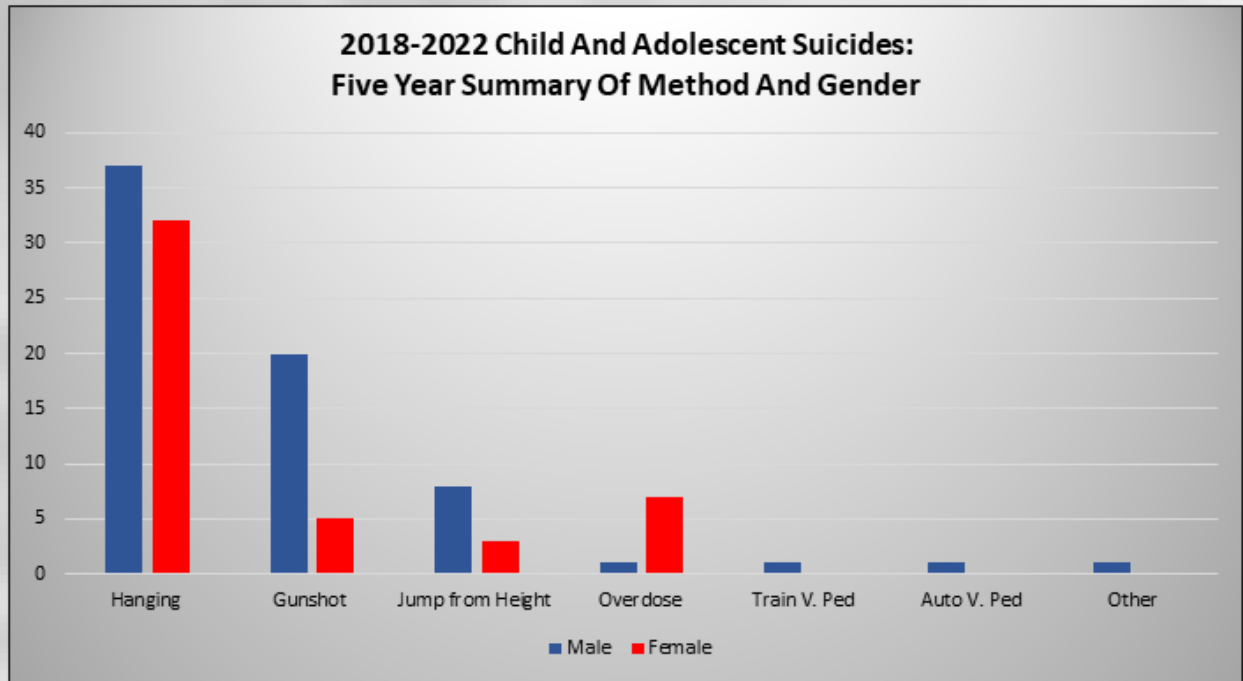
# Child and Adolescent Suicides



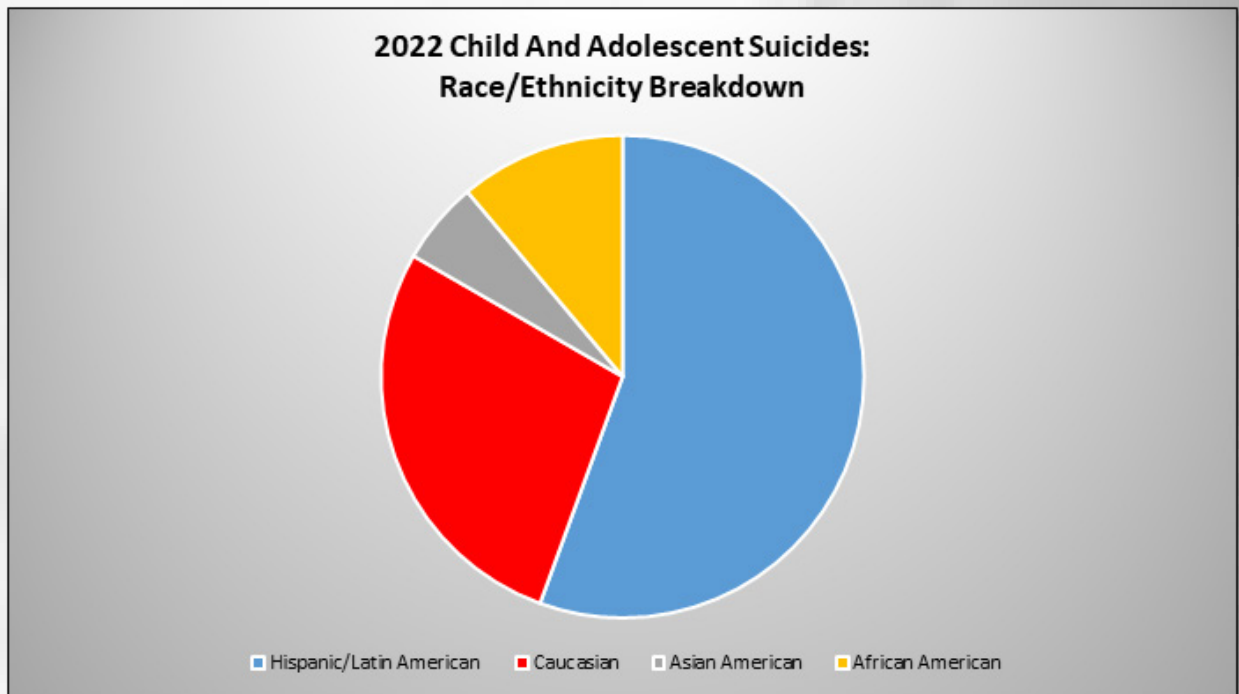
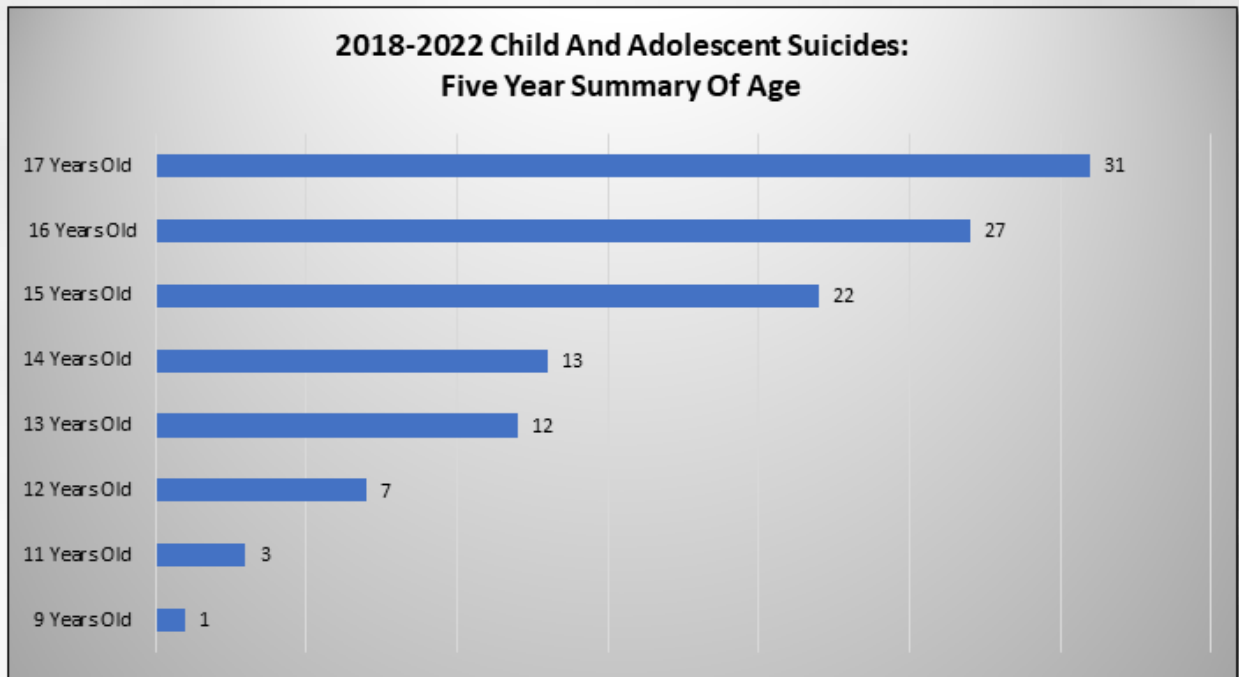
# Child and Adolescent Suicides



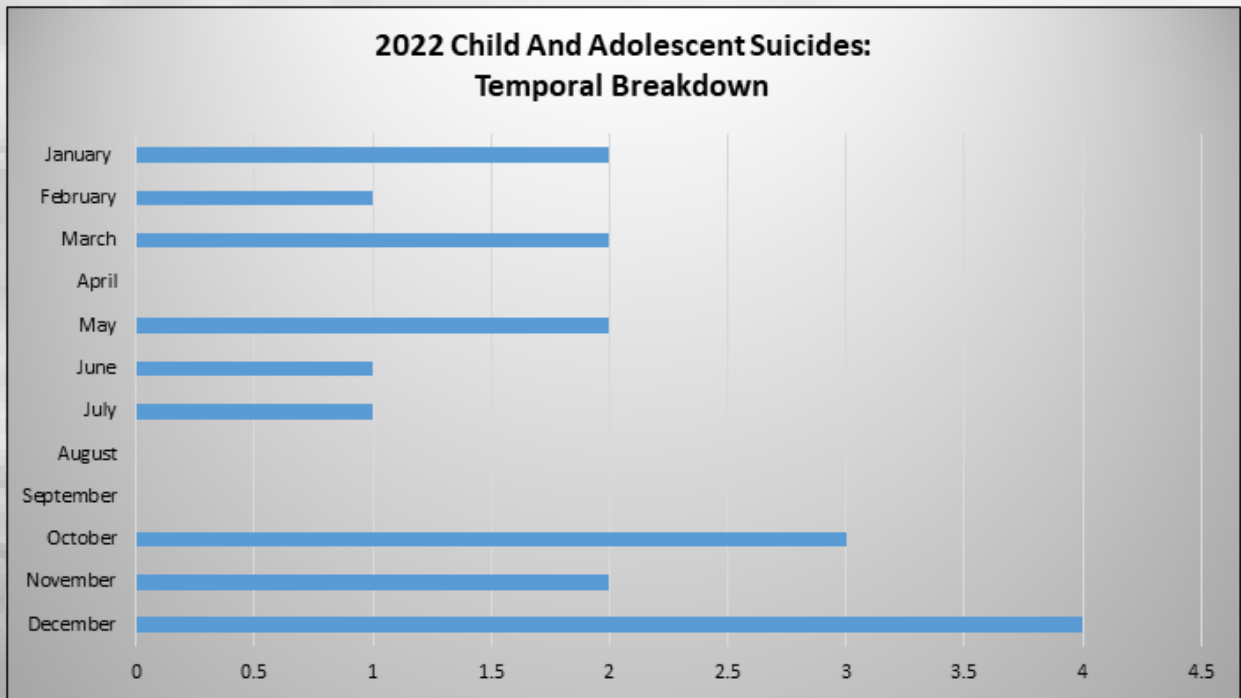
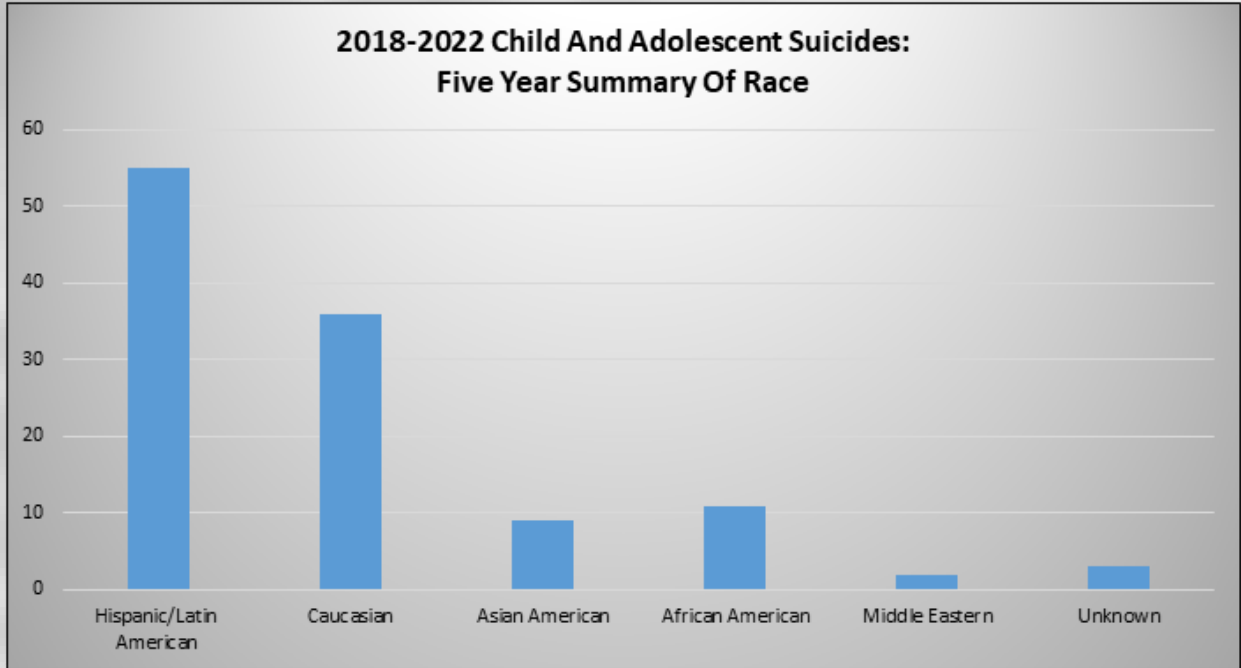
# Child and Adolescent Suicides

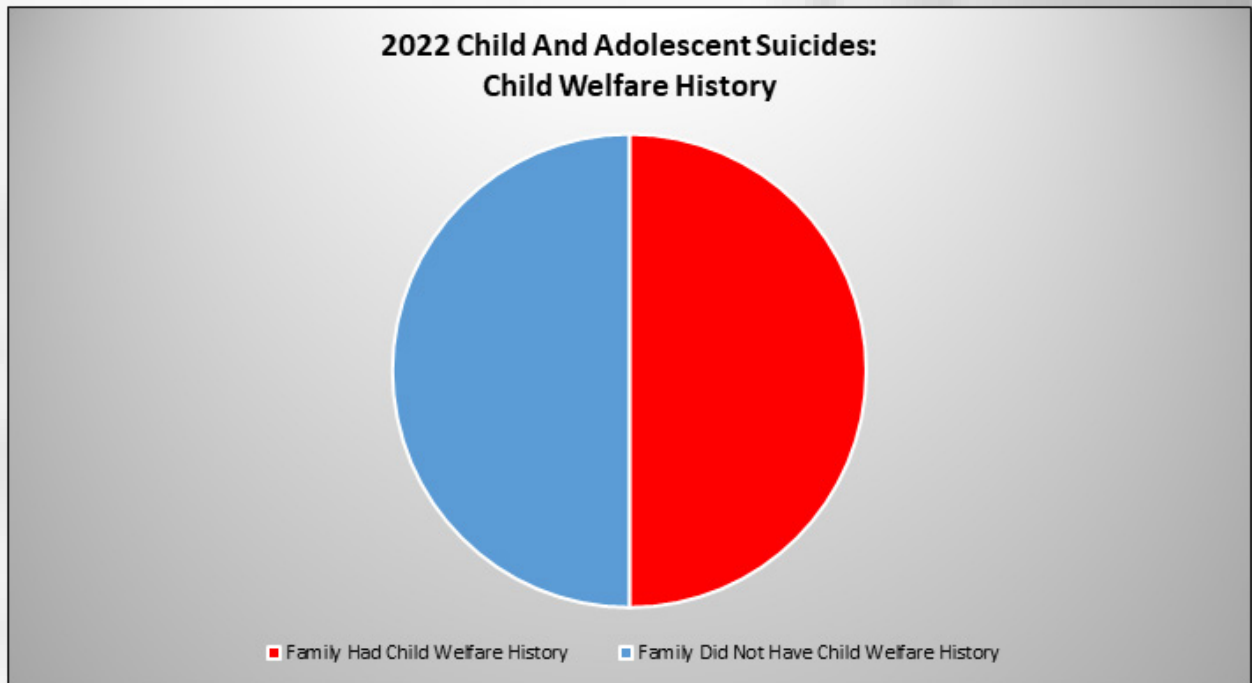
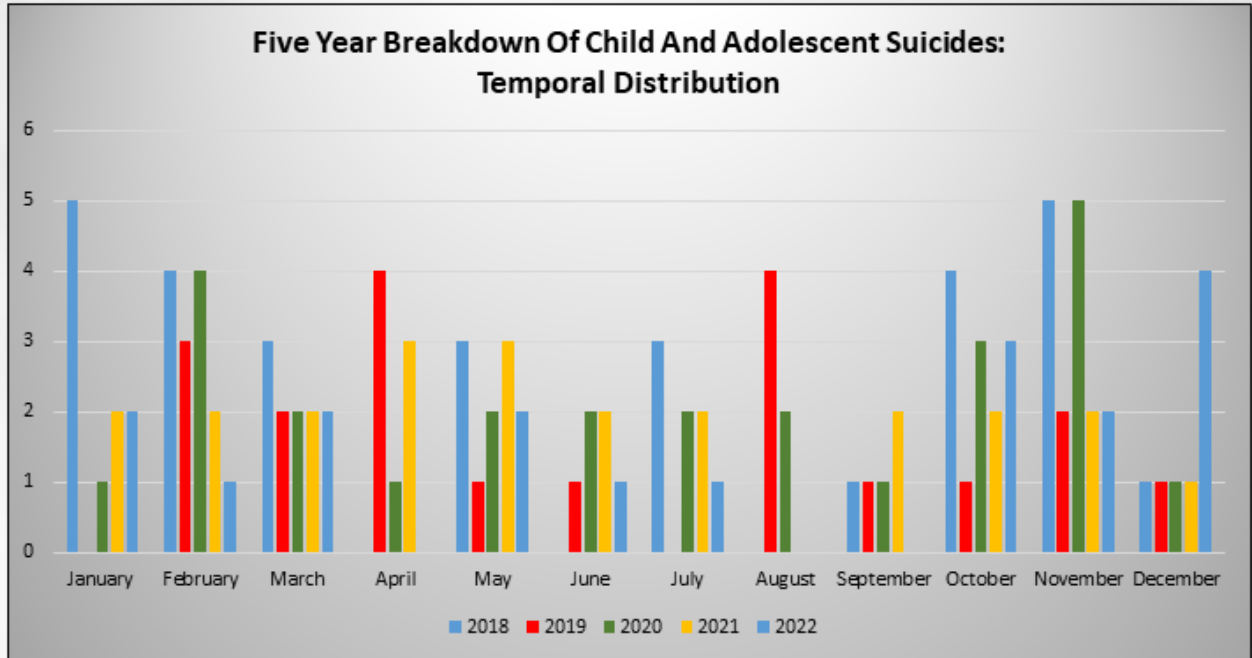


# Child and Adolescent Suicides



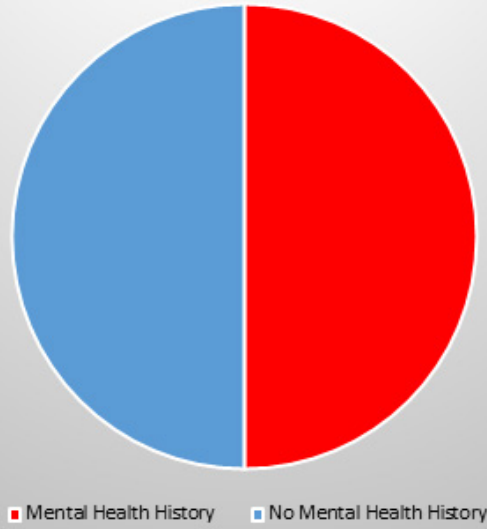
# Child and Adolescent Suicides



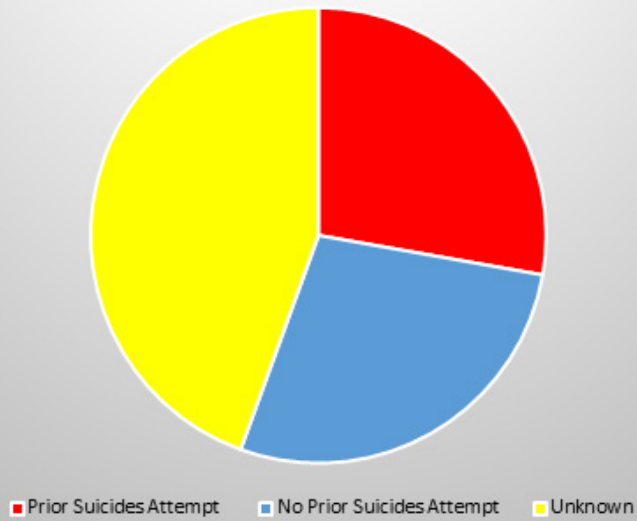




### 2022 Child And Adolescent Suicides: Mental Health History

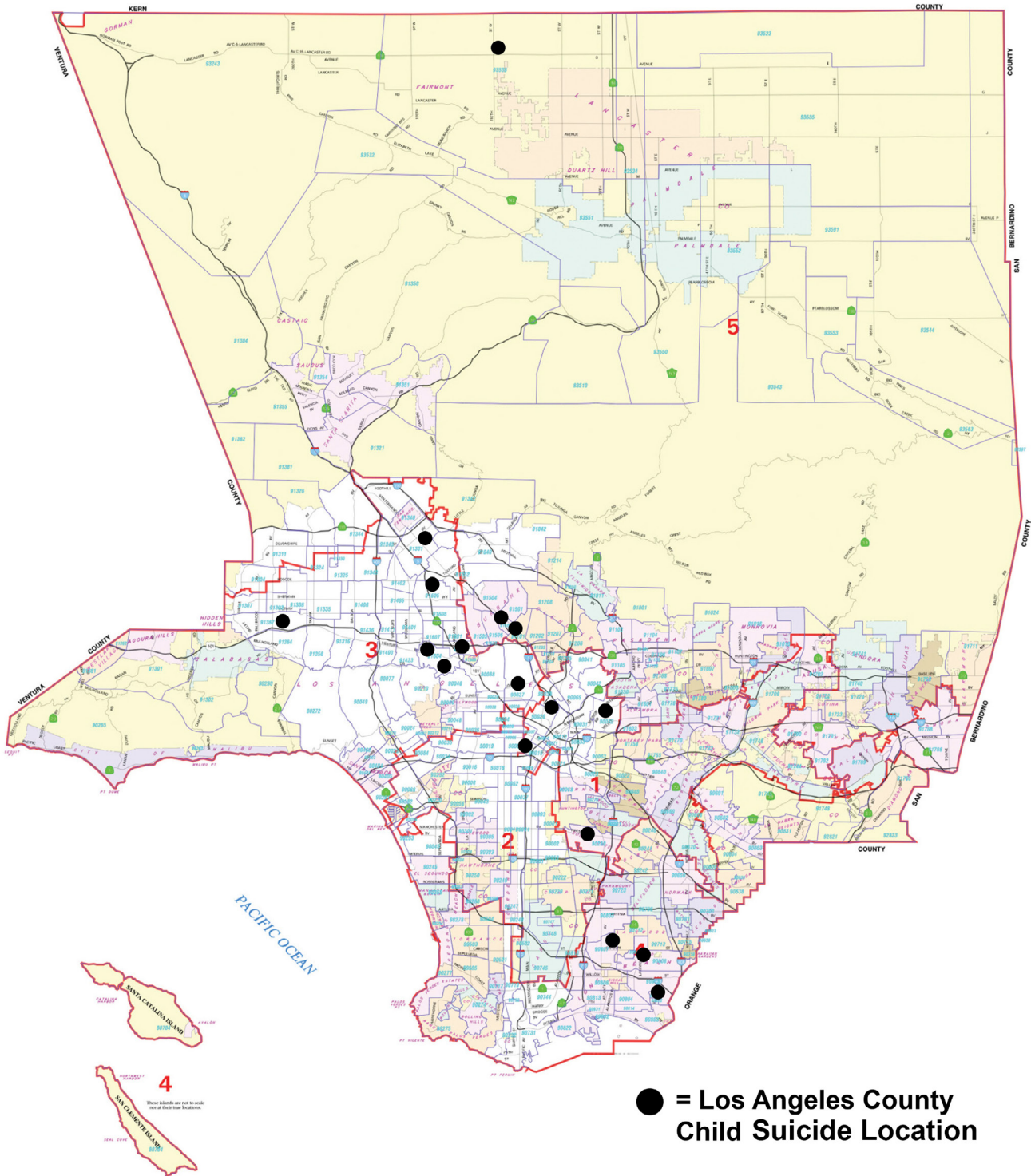


### 2022 Child And Adolescent Suicides: Prior Suicide History



### 2022 Child Suicides - Locations n = 18\*

\*City where the suicide occurred



### Sample Case Summaries - Accidents

#### **Lisa and Andy**

Andy age, 4 and his sister, Lisa age, 3 drowned near a lake by their residence. The children were missing from their yard where they played daily and when mother and neighbors went looking for the children, they were found unresponsive in the pond. They were air lifted to the hospital in cardiac arrest. The children were pronounced dead at the hospital. There were no concerns or evidence of trauma or child abuse.

#### **Amir**

Seventeen-year-old Amir got into the bed of his friend's truck and his friend began doing circles around an empty parking lot. Amir flew out of the bed of the truck and sustained life-threatening injuries to his head and body.

#### **Tony**

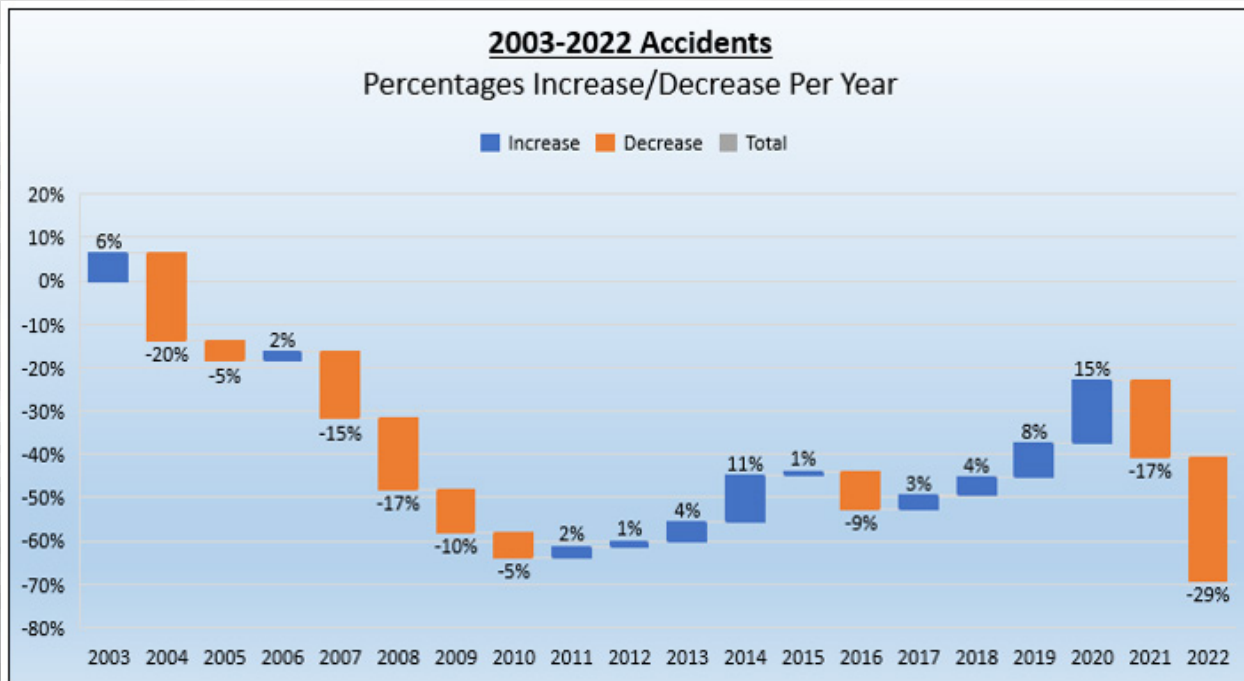
Tony age, 2, fell from his two-story house out of a window. 911 was contacted and Tony was transported to the hospital where he was found to have severe traumatic brain injury with multiple skull fractures. He was pronounced dead by attending doctor.

## ACCIDENTS

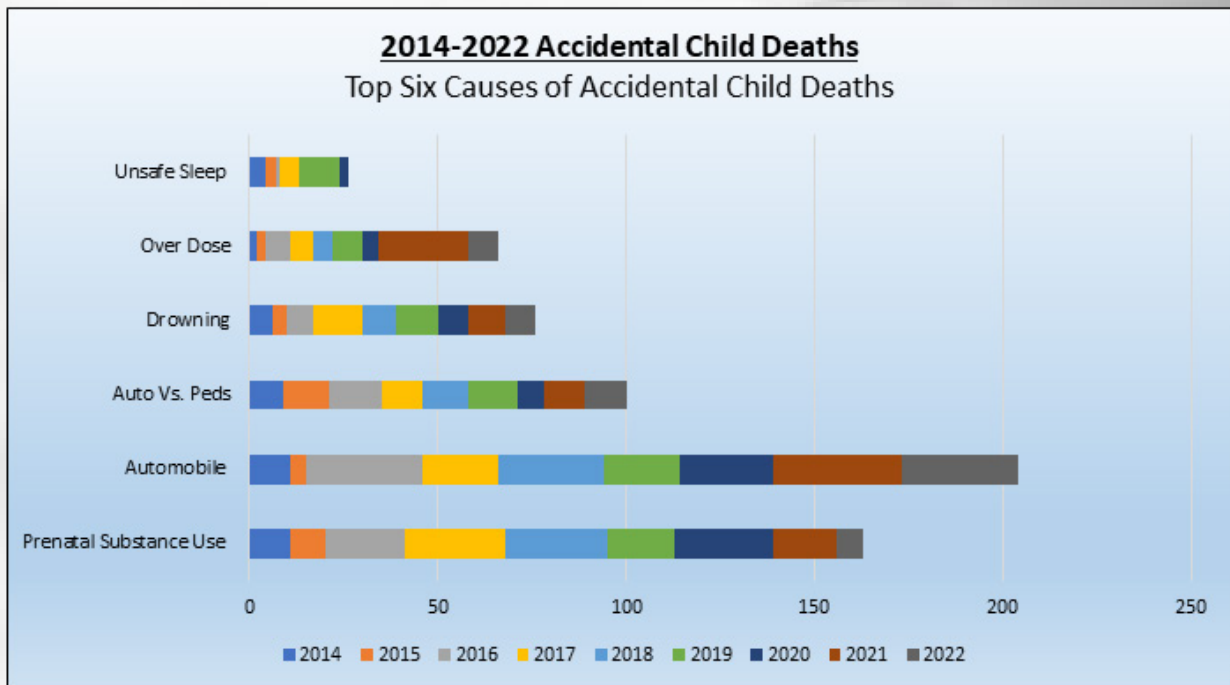
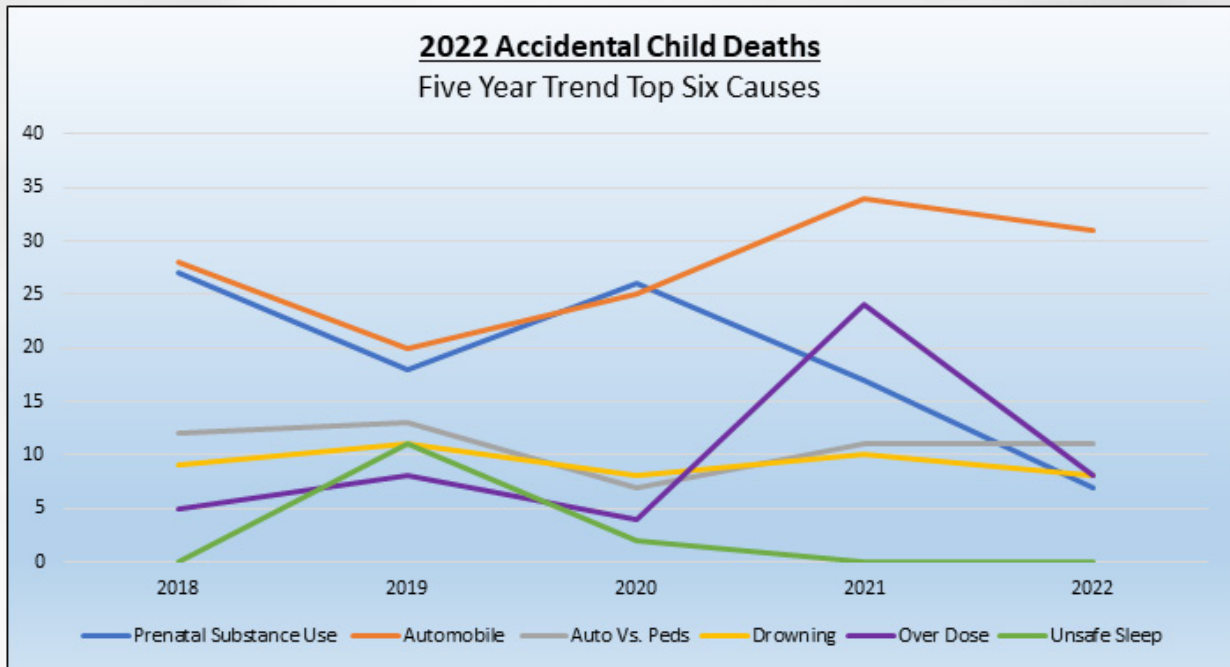
### FINDINGS

- The coroner reported Seventy-four accidental child deaths to ICAN for 2022. This is a 29% decrease from the 2021 of one hundred and four deaths and it is also below the five-year average.
- In the prior years, automobile death and prenatal substance abuse have been the leading causes of accidental child deaths. In 2022, automobile deaths (n=42), drownings (N=8) and overdose (N=8) made up 79% of child accidental deaths.
- Unsafe sleep deaths can be coded as accidents by the coroner. In 2022 there were 8 cases being coded accidents. These cases are counted in our unsafe sleep death with the undetermined cases as they are considered preventable deaths if safe sleep practices had been put into place.
- One-third (23%) of the accidental child deaths happened to children less than one-year-old. Fourteen of these children's deaths were the result of prenatal substance abuse and drowning. The next largest age group was seventeen-year-old children who made up 22% of the accidental child deaths. In this seventeen-year-old age group, the number one cause of death was automobile accident (34%). Unlike last year where overdoses was the second largest accidental deaths of seventeen-year-olds.
- The majority (53%) of accidental child deaths were children of Hispanic/Latin background. Next highest deaths are by Caucasian children with 18%.
- Children dying in an automobile accident, either as a driver or as a passenger, accounted for 34 of the accidental child deaths in 2022. This is roughly a thirty-percent increase in this cause of child death from 2018. The age range for victims spans from one year of age to seventeen years of age with the higher number of deaths being between fourteen and seventeen years old.
- Twenty children died of prenatal substance abuse in 2022. The number one drug used by mothers in prenatal substance abuse was methamphetamine. This is consistent with the last 5 years where methamphetamine continues to be the number one illicit drug in prenatal substance abuse deaths. Caucasians and Hispanic/Latin Americans also continue to be the ethnicities with the highest groups that suffered a child loss due to prenatal drug use.

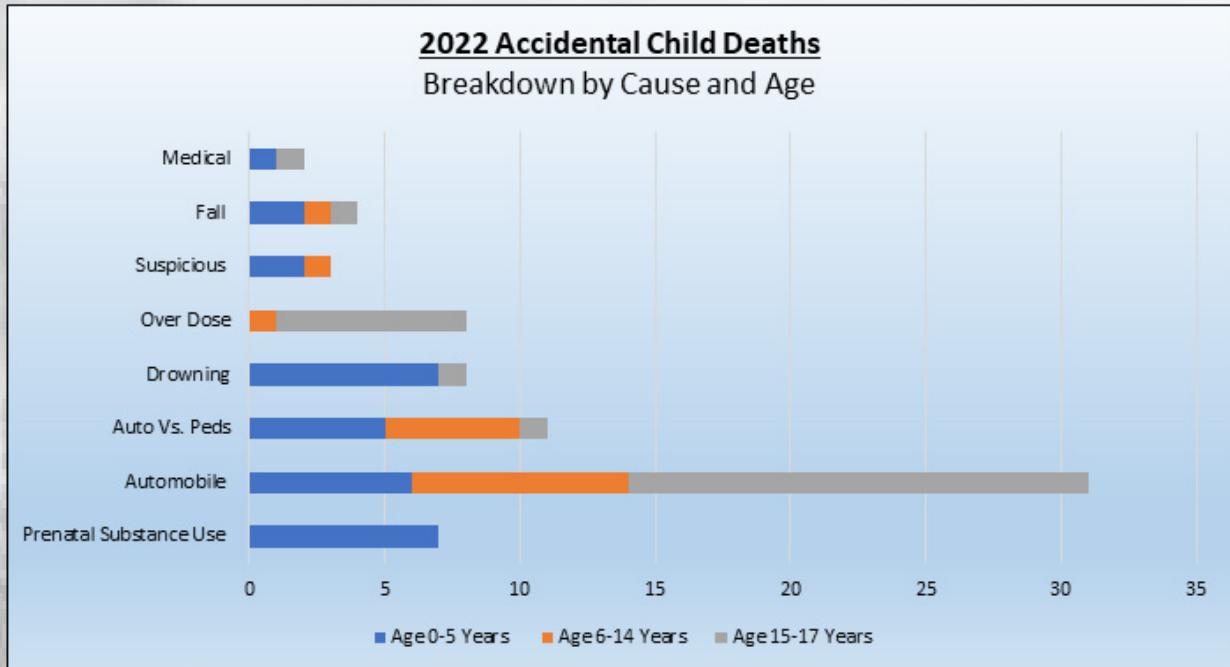
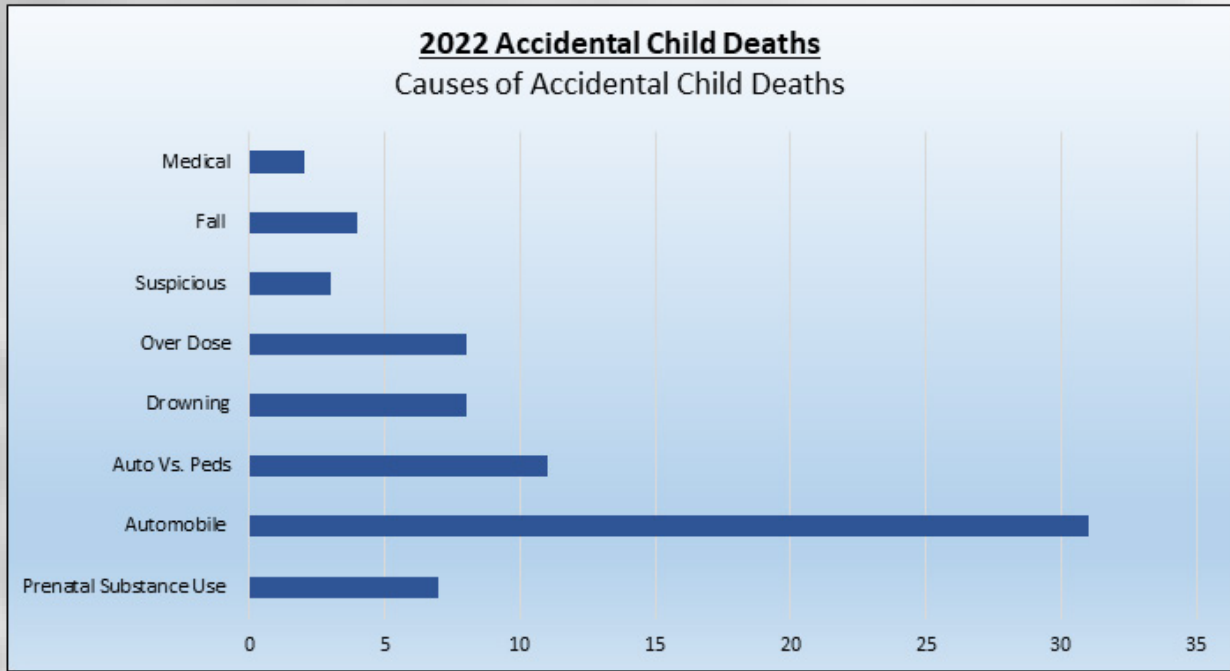
# Accidental Child Deaths



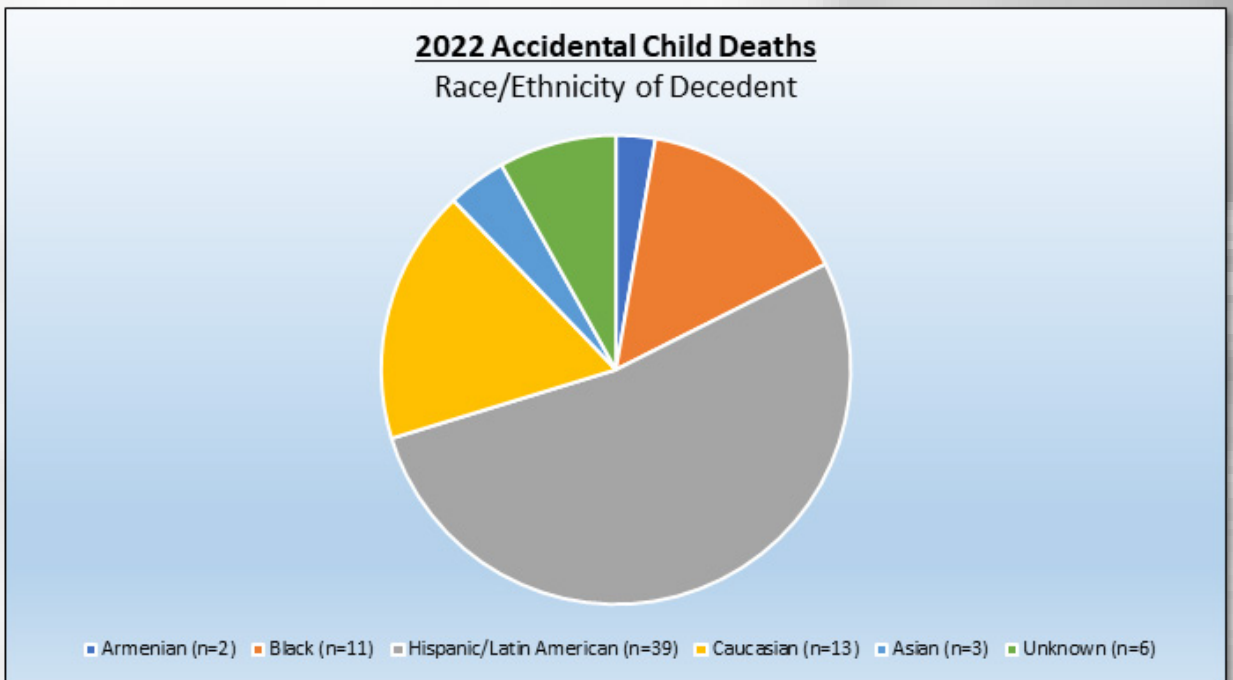
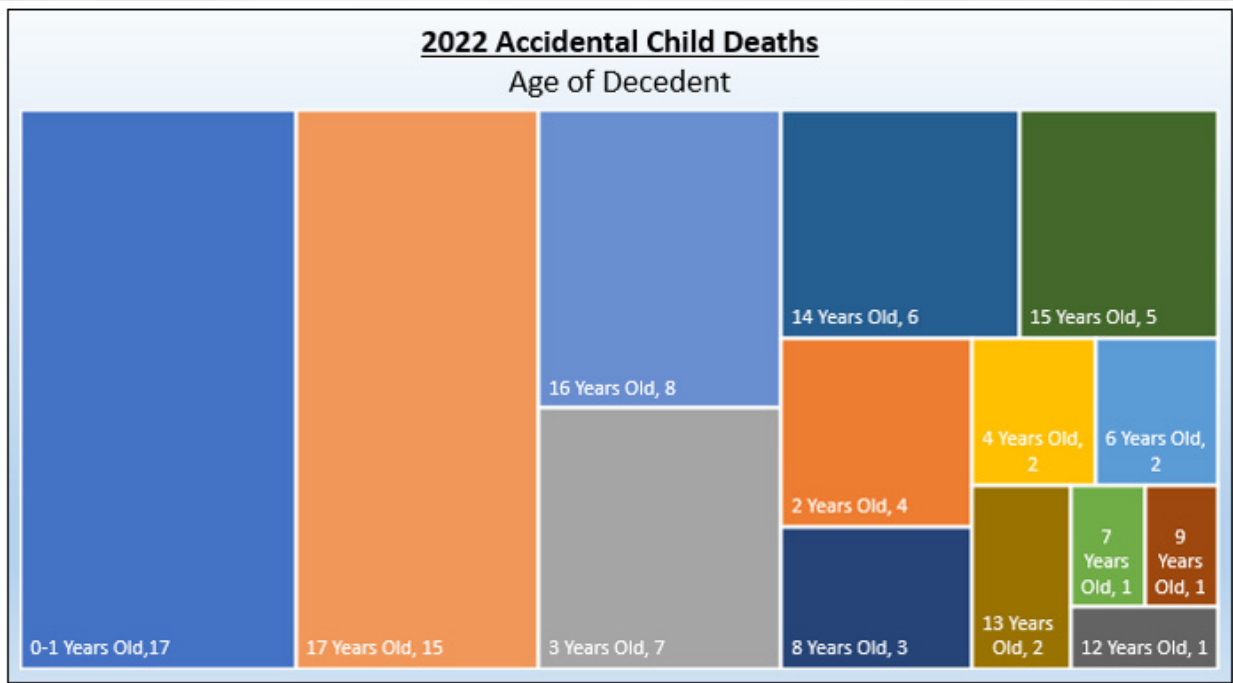
# Accidental Child Deaths



# Accidental Child Deaths

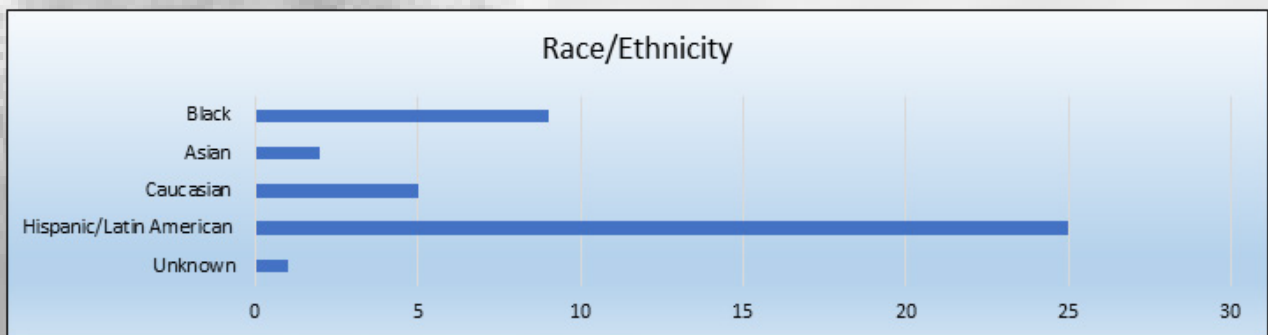
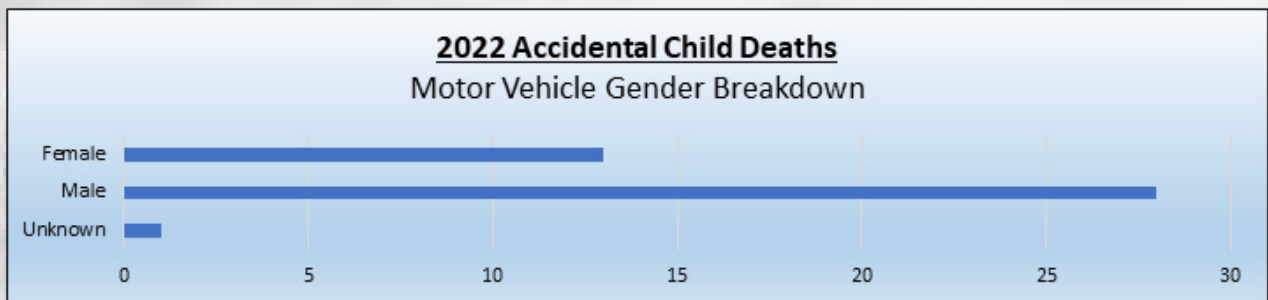
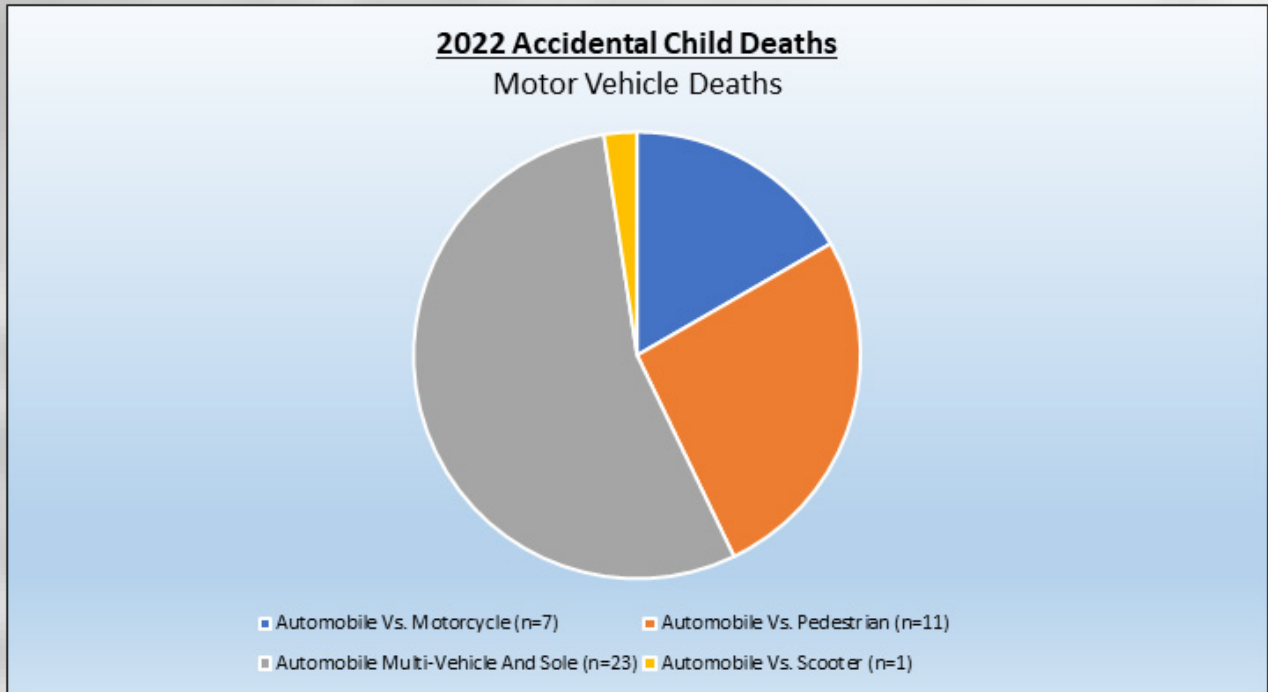


# Accidental Child Deaths

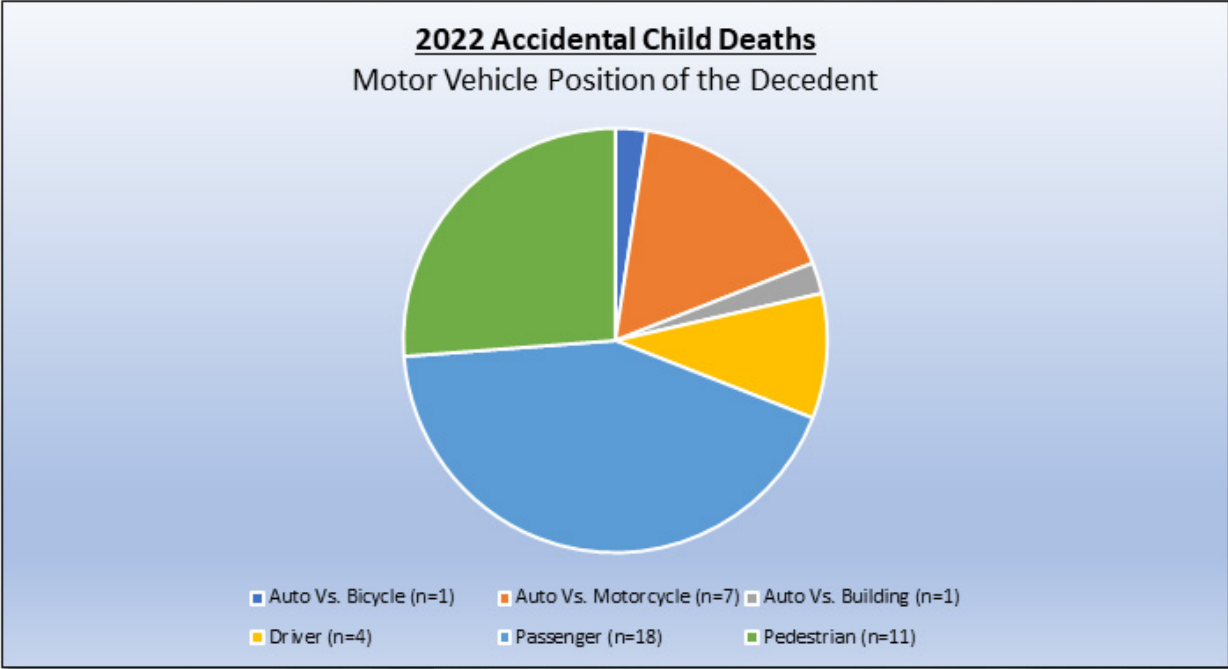
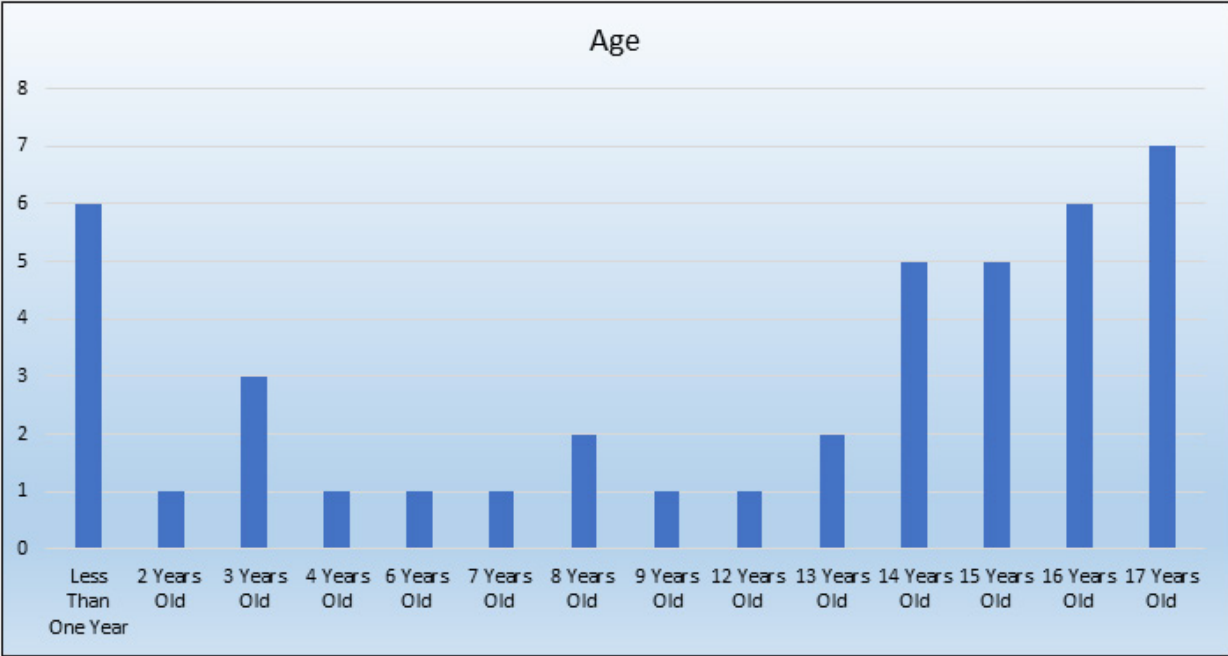




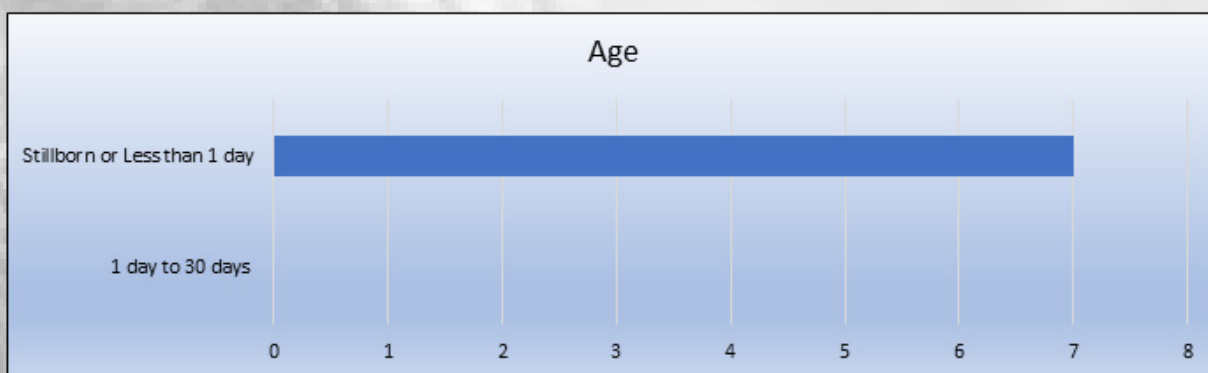
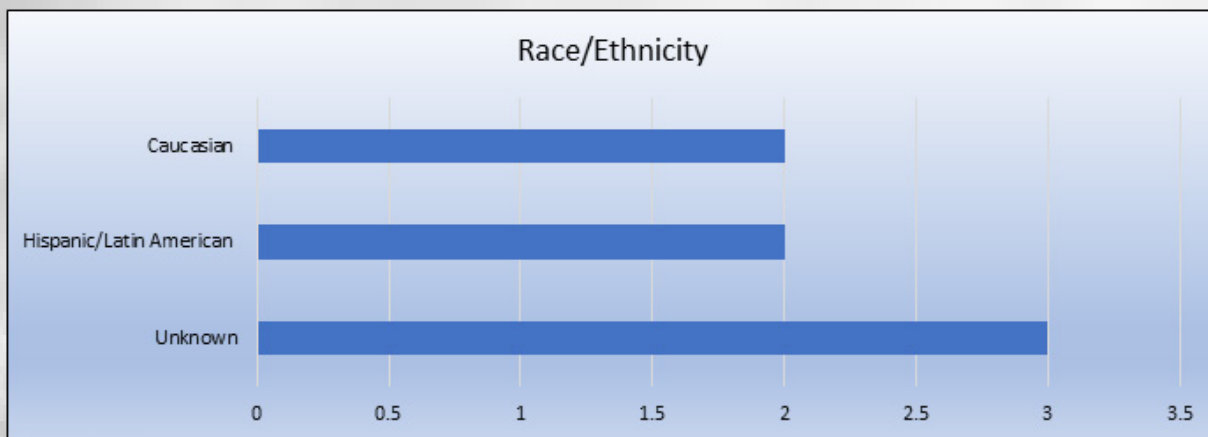
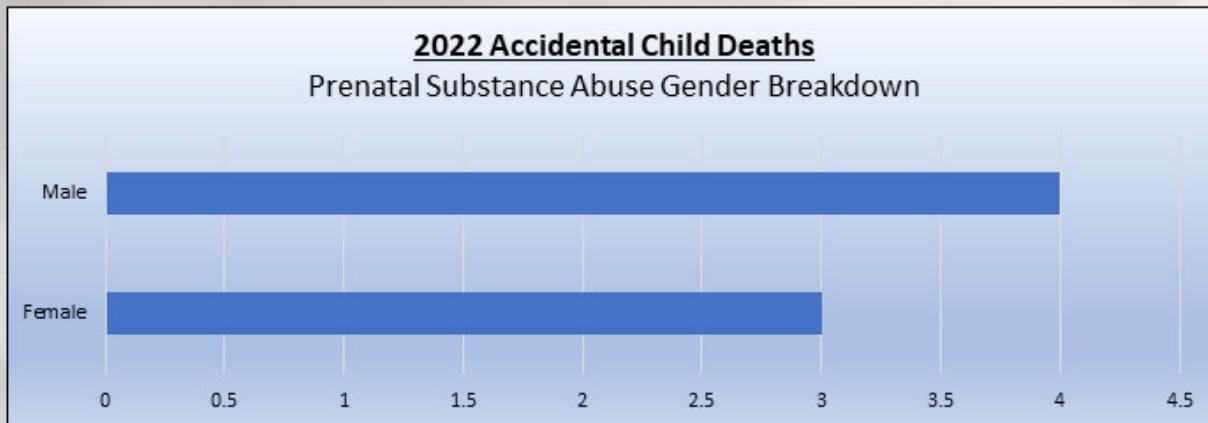
# Accidental Child Deaths

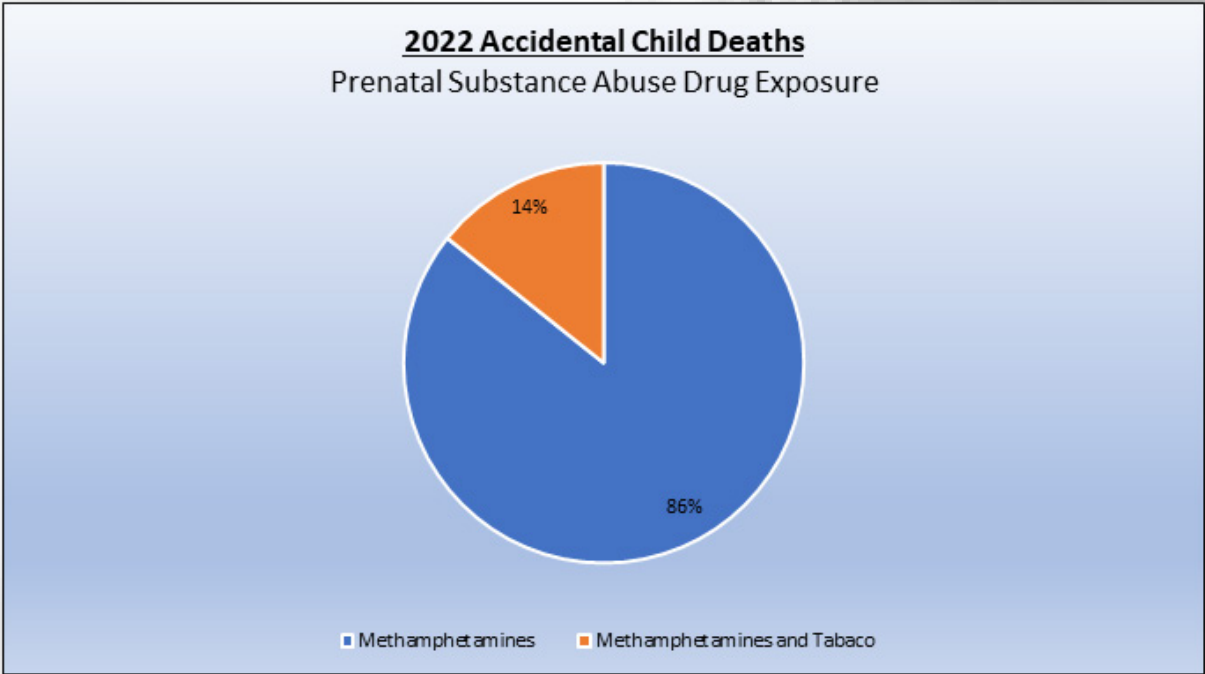


# Accidental Child Deaths



# Accidental Child Deaths





## Sample Case Summaries - Undetermined

### **Belen**

Belen was a 2-month-old child found unresponsive in her crib. Mother breastfed the child at 5am and placed Belen back in her crib on her back. A few hours mother woke up and found Belen unresponsive, not breathing with foaming at the mouth and nose. Mother called 9-1-1 where first responders attempted to resuscitate the child. Child was transported to the hospital where the doctor pronounced Belen deceased.

### **Nick**

Nick was a 2-year-old when mother found him unresponsive in his crib. Father had placed Nick on his back in his crib with a pillow under his head and a blanket covering his waist and legs to sleep the night before he was found unresponsive. The following day, mother checked in on Nick where she observed Nick lying on his stomach with his blanket underneath his face and torso. Mother observed Nick's head and feet were located in the opposite position he is typically placed in for bed and his face appeared purple. Father called 9-1-1 and initiated chest compressions. Los Angeles Fire Department Rescue Ambulance responded to the scene to continue lifesaving measures. Despite all lifesaving measures, paramedics pronounced Nick death at the scene.

### **Lily**

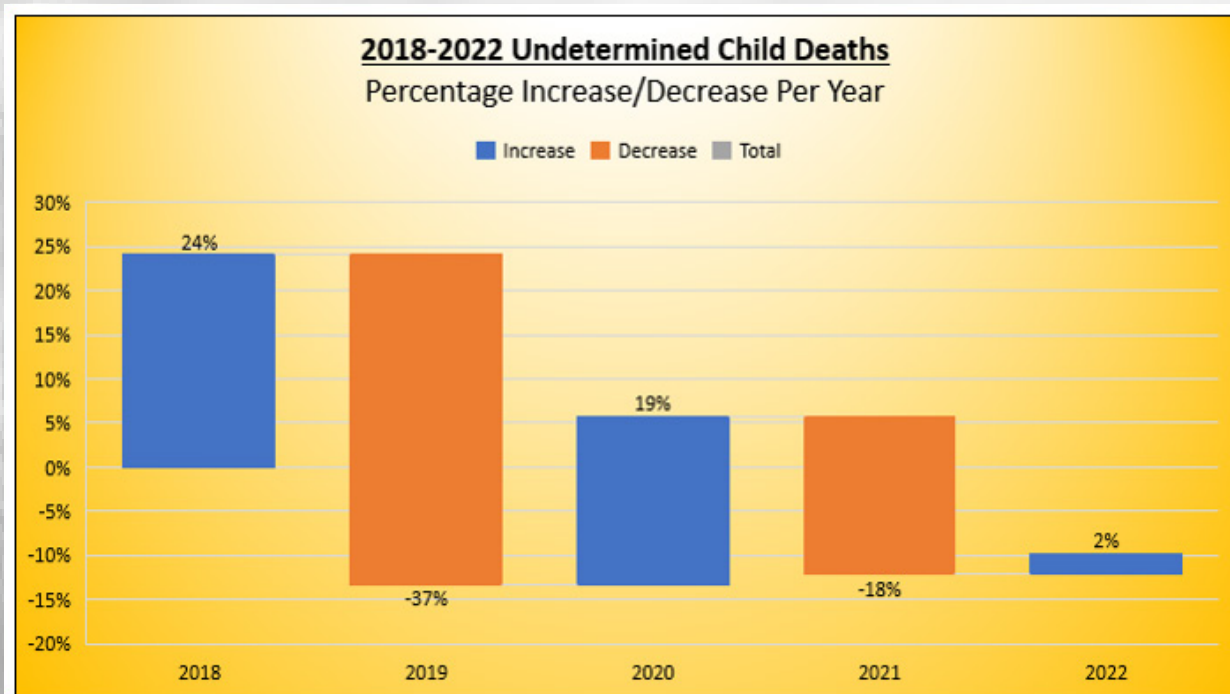
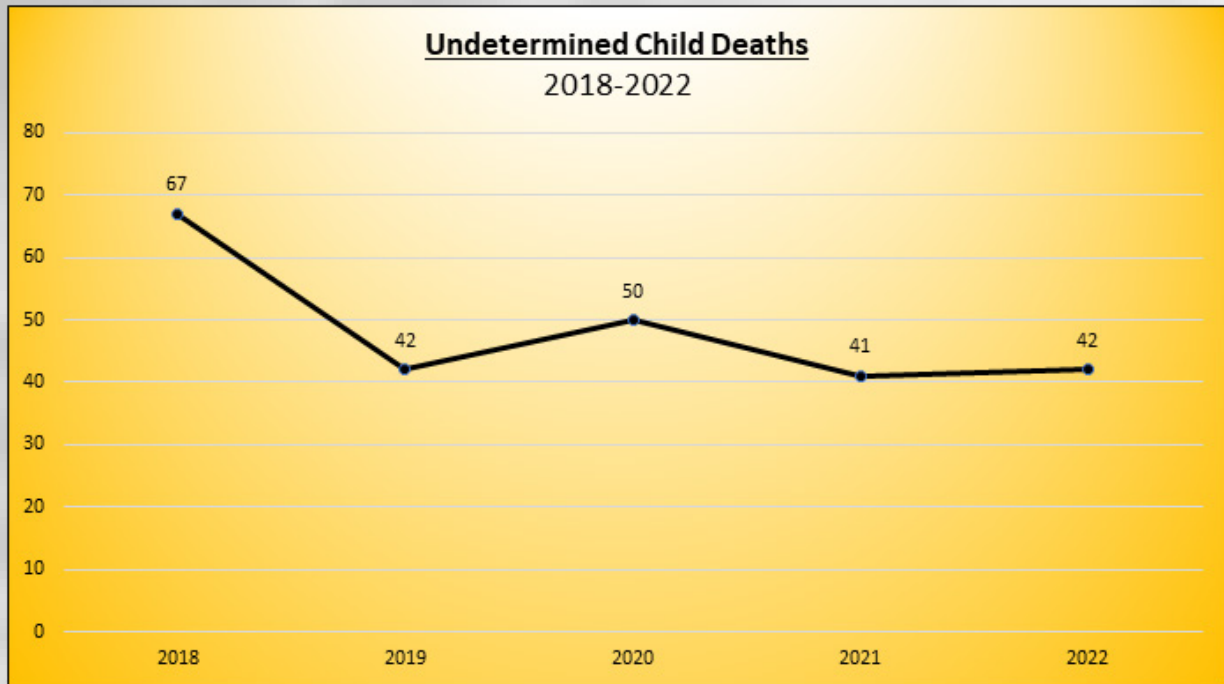
Lily was a 2.5-month-old found unresponsive by father. Father had placed Lily to sleep and wrapped in a swaddle in a pack and play crib approximately 15 minutes after a formula feed. After 3 hours, father went to wake up Lily and found her unresponsive. Father had Lily swaddled in a blanket when he laid her on her left side between two pillows placed in a "V" shape in a Pack n' Play in her room. When father returned to check in on Lily, he found her laying face-down between the two pillows. Father picked the baby up, observed she had "formula all over her face," and realized that she was not breathing. Father called 9-1-1 and attempted resuscitation efforts until paramedics arrived. Lily was transported via ambulance to the local hospital where Doctor pronounced her death.

## UNDETERMINED

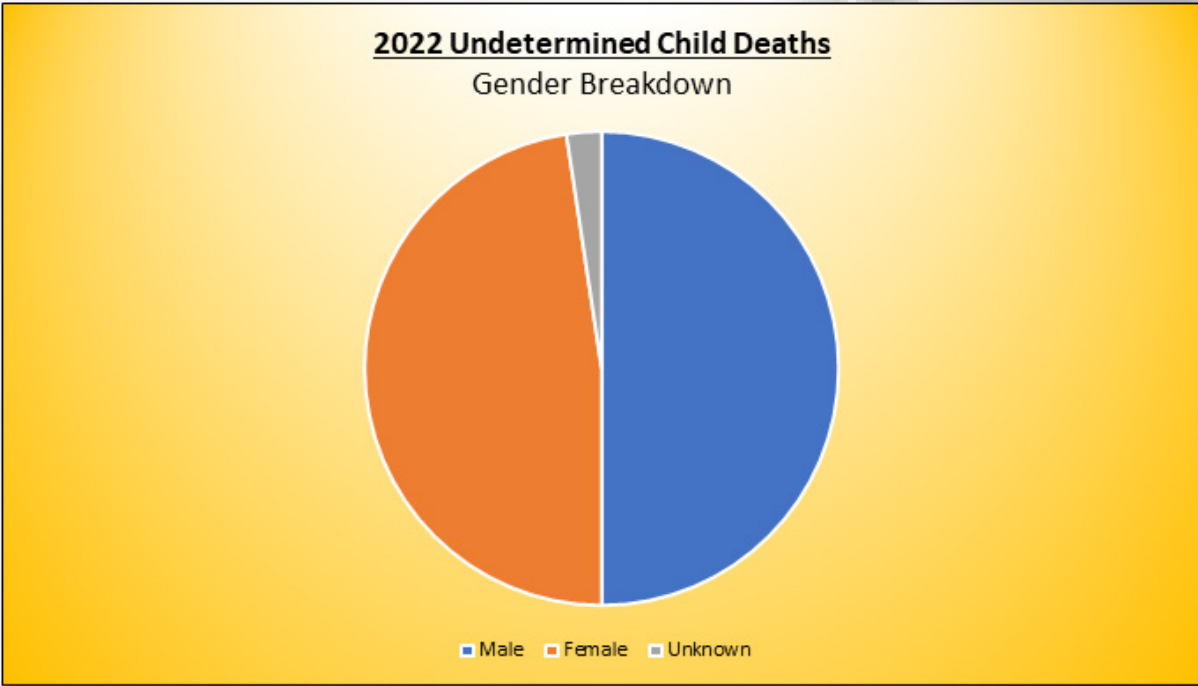
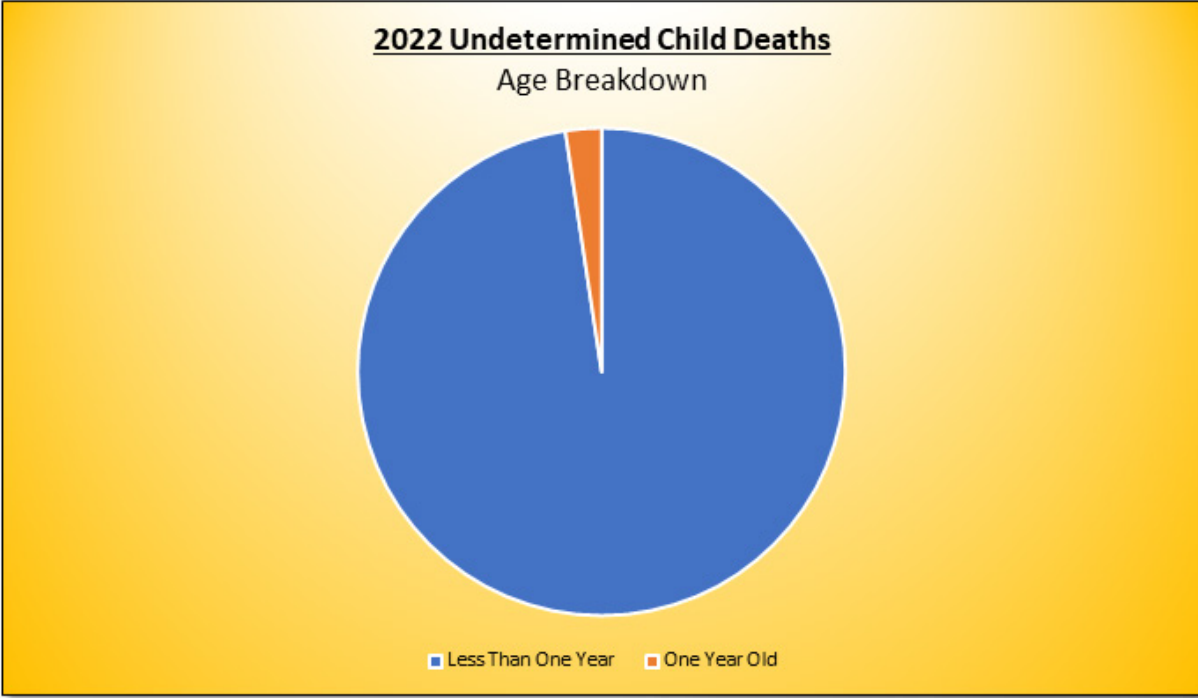
### FINDING

- Forty-two undetermined child deaths were reported to ICAN from the Coroner's Office in 2022. Twenty-five of the child victims were determined to be the result of unsafe sleep practices, whether because of co-sleeping with an adult/child, an unsafe sleep environment, or a combination of both. ICAN also reviewed 8 unsafe sleep related deaths coded as accidents and added them to the unsafe sleep count which totals 33 unsafe sleep deaths.
- The 2022 number of 33 unsafe sleep deaths is an increase from 2021 and below the five-year average of approximately 48 unsafe sleep-related deaths per year.
- Fifty-five percent of the unsafe sleep-related deaths involved unsafe sleep environment and the remaining 45% were due to the practice of co-sleeping; bed sharing with an adult and/or children. While this split is typical in the last few years, 2022 shows a greater share of the deaths related to sleep environment.
- The children most vulnerable to unsafe sleep related deaths were infants zero to 12 months of age, which comprised 98% of the cases.
- In 2022, Hispanic (41%) and African American (37%) children were the most common victim of unsafe sleep related death. Caucasians made up 7% percent and Asians (7%), Pilipino 4% and 4% were of unknown ethnicity.
- Of the 33 unsafe sleep cases, 52% were male and 48% were female.
- Almost half of all unsafe sleep cases had a DCFS history.
- Sixteen of the undetermined deaths for 2022 were not a result of unsafe sleep practices.
- Those 16 deaths consisted of fetal demise, medical anomalies and infants dying of medical complications due to illness such as flu, cold or in one case severely constipated.

# Undetermined Child Deaths

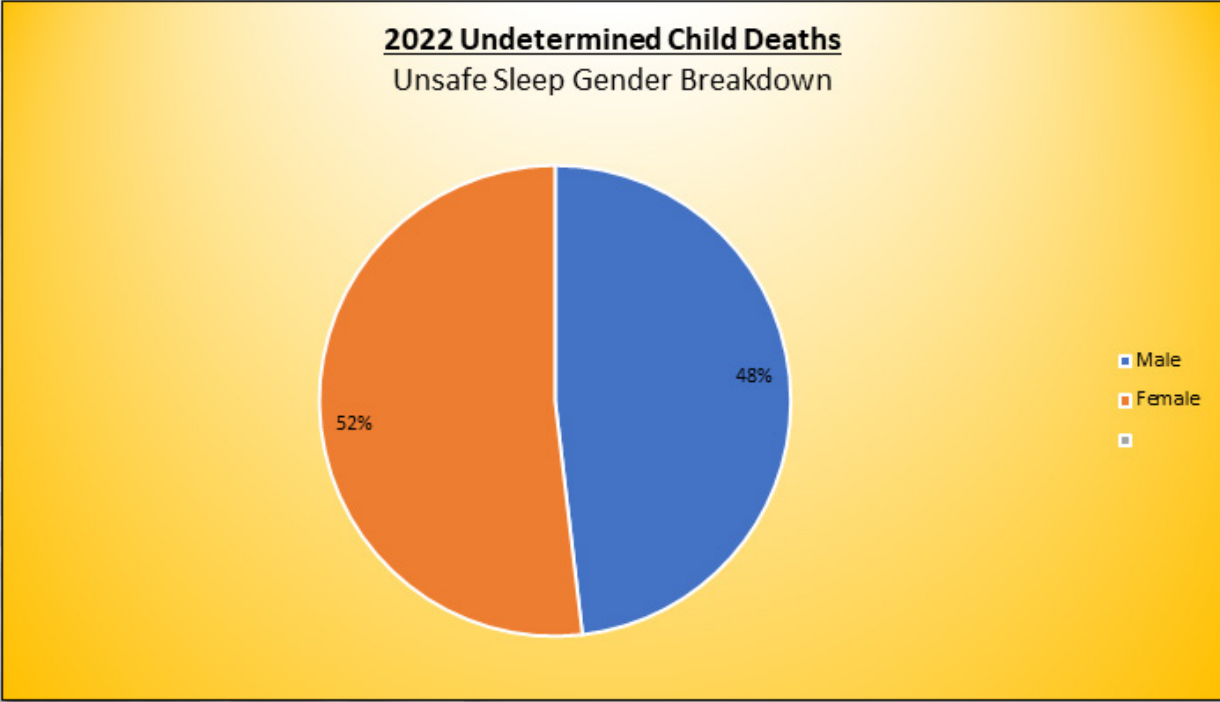
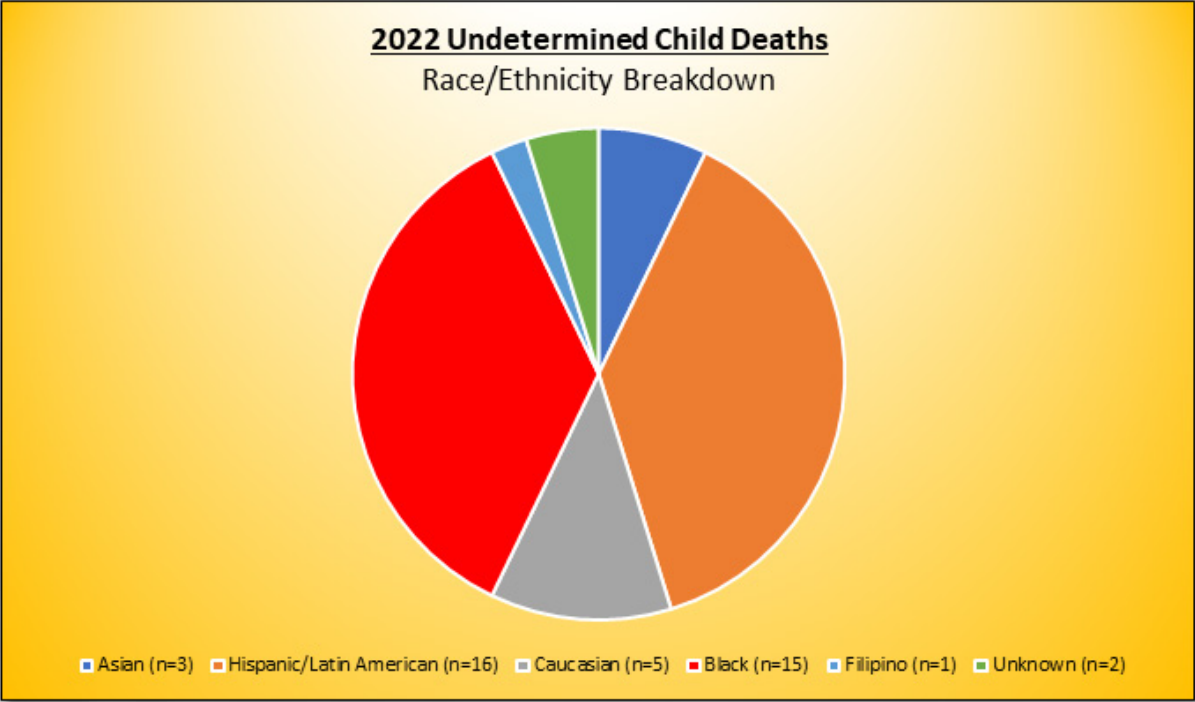


# Undetermined Child Deaths: Bed-Sharing and Unsafe Sleeping Environment

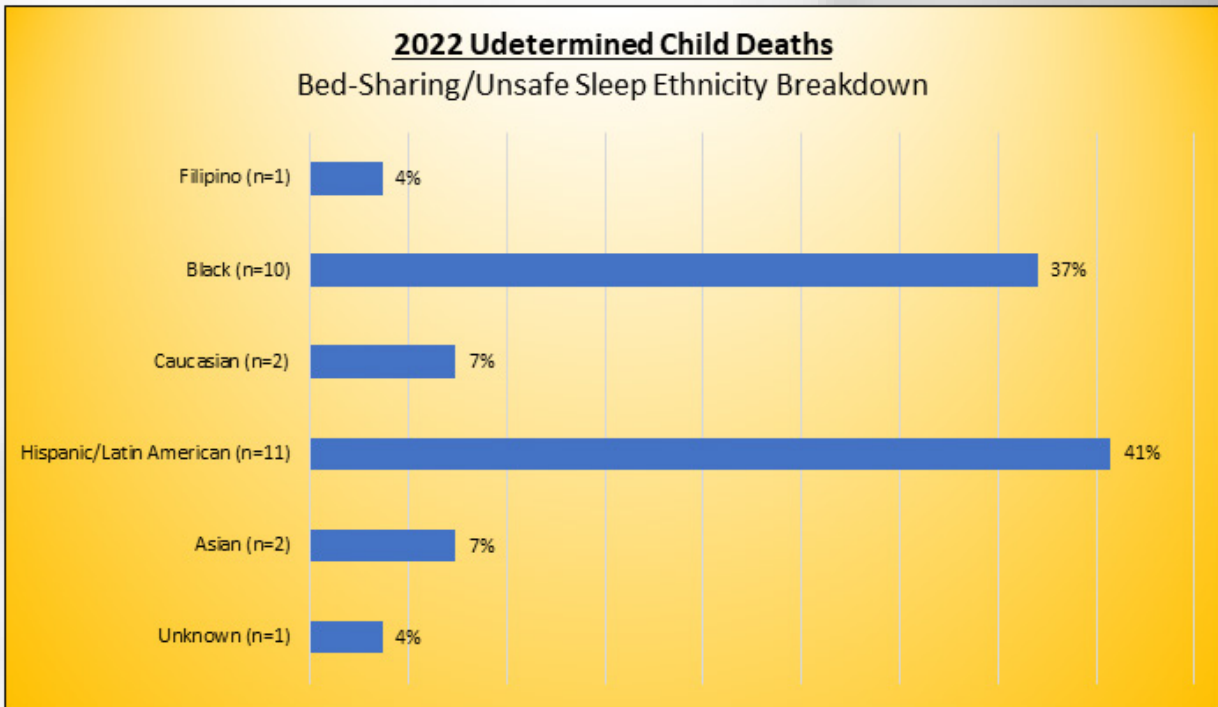
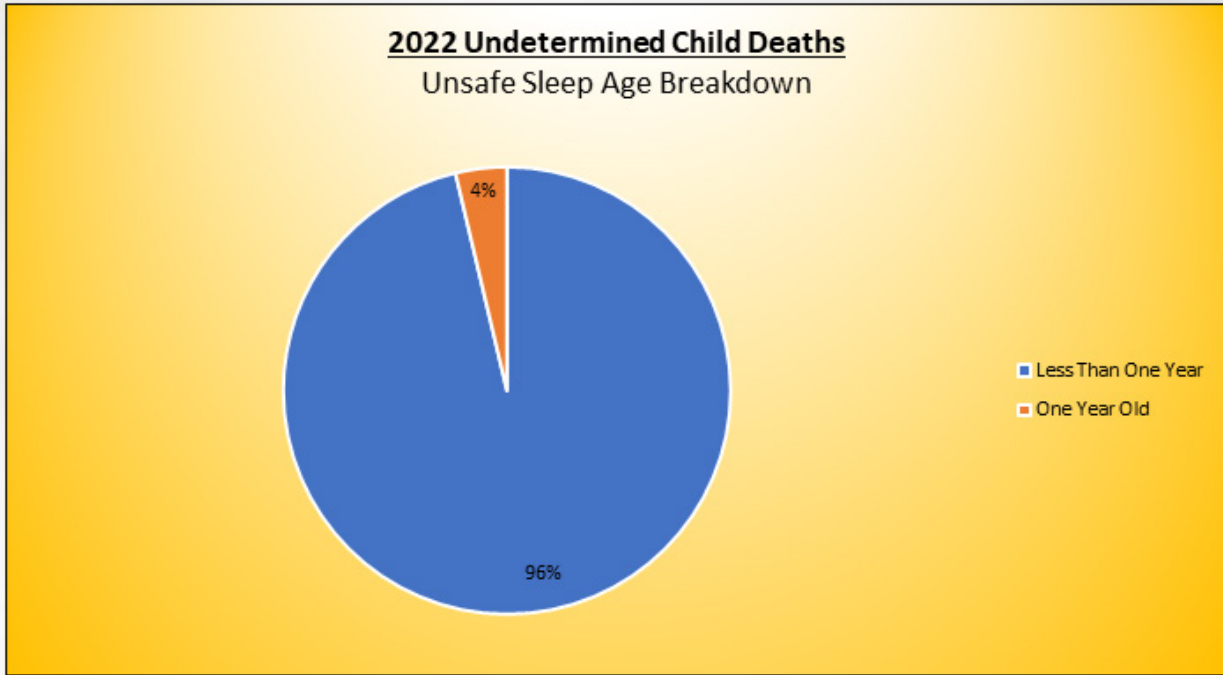




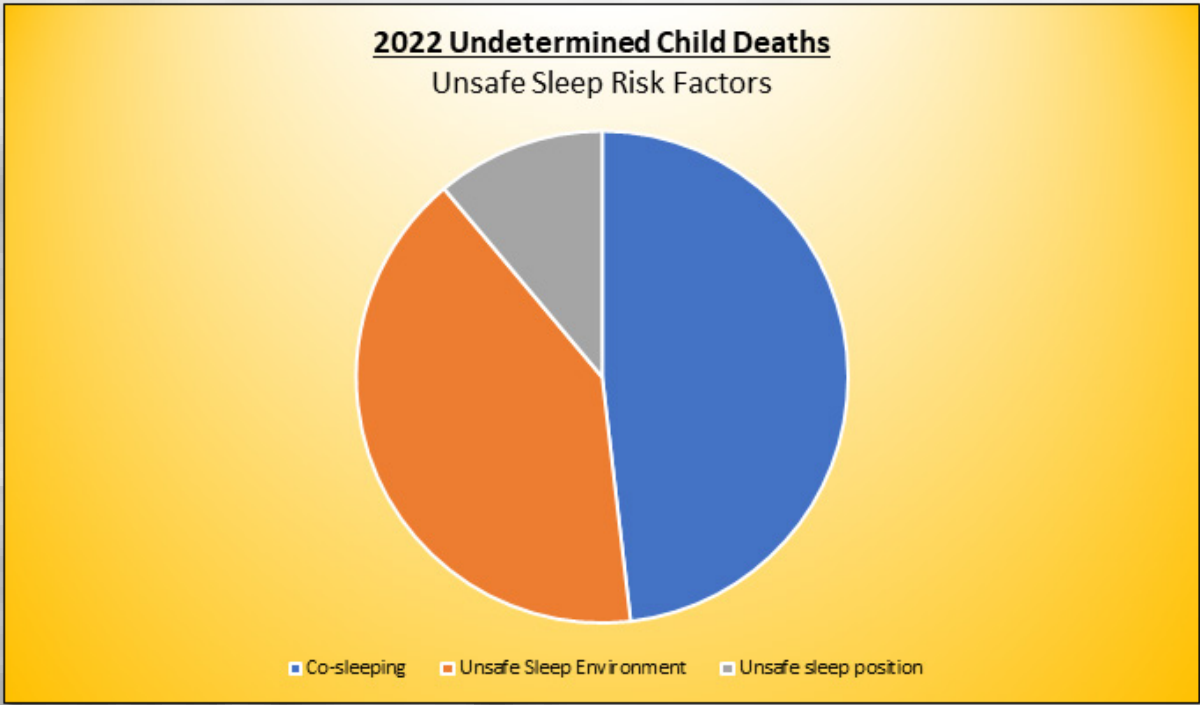
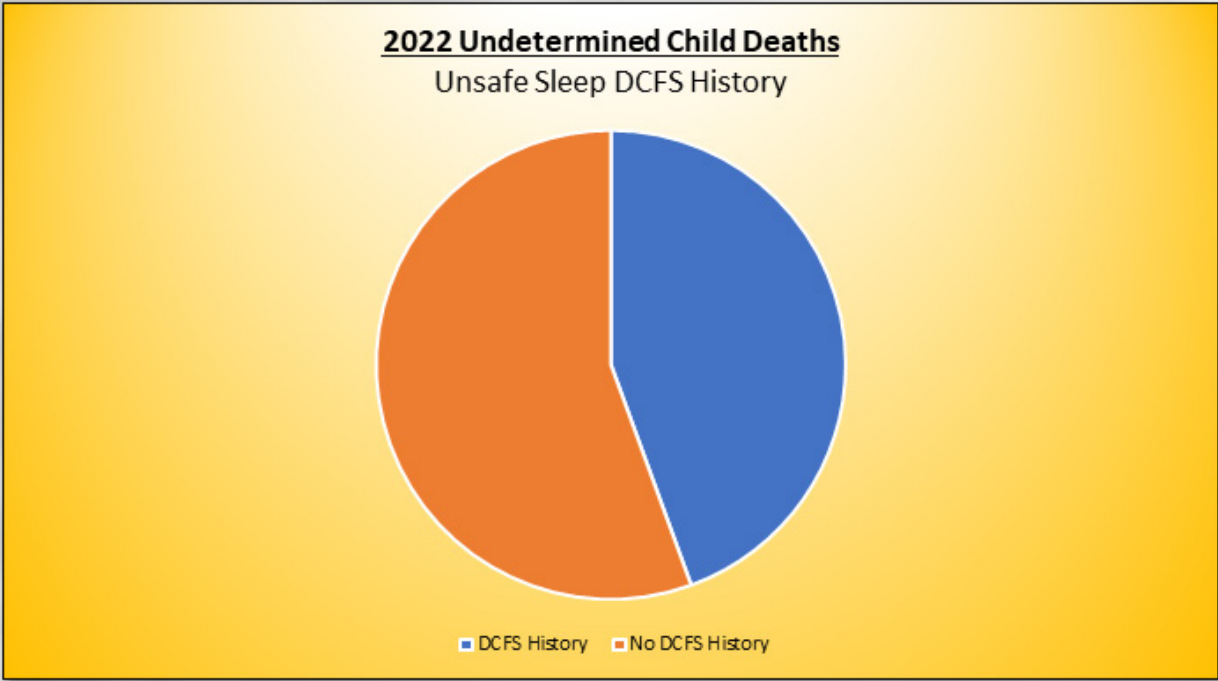
# Undetermined Child Deaths: Bed-Sharing and Unsafe Sleeping Environment



# Undetermined Child Deaths: Bed-Sharing and Unsafe Sleeping Environment



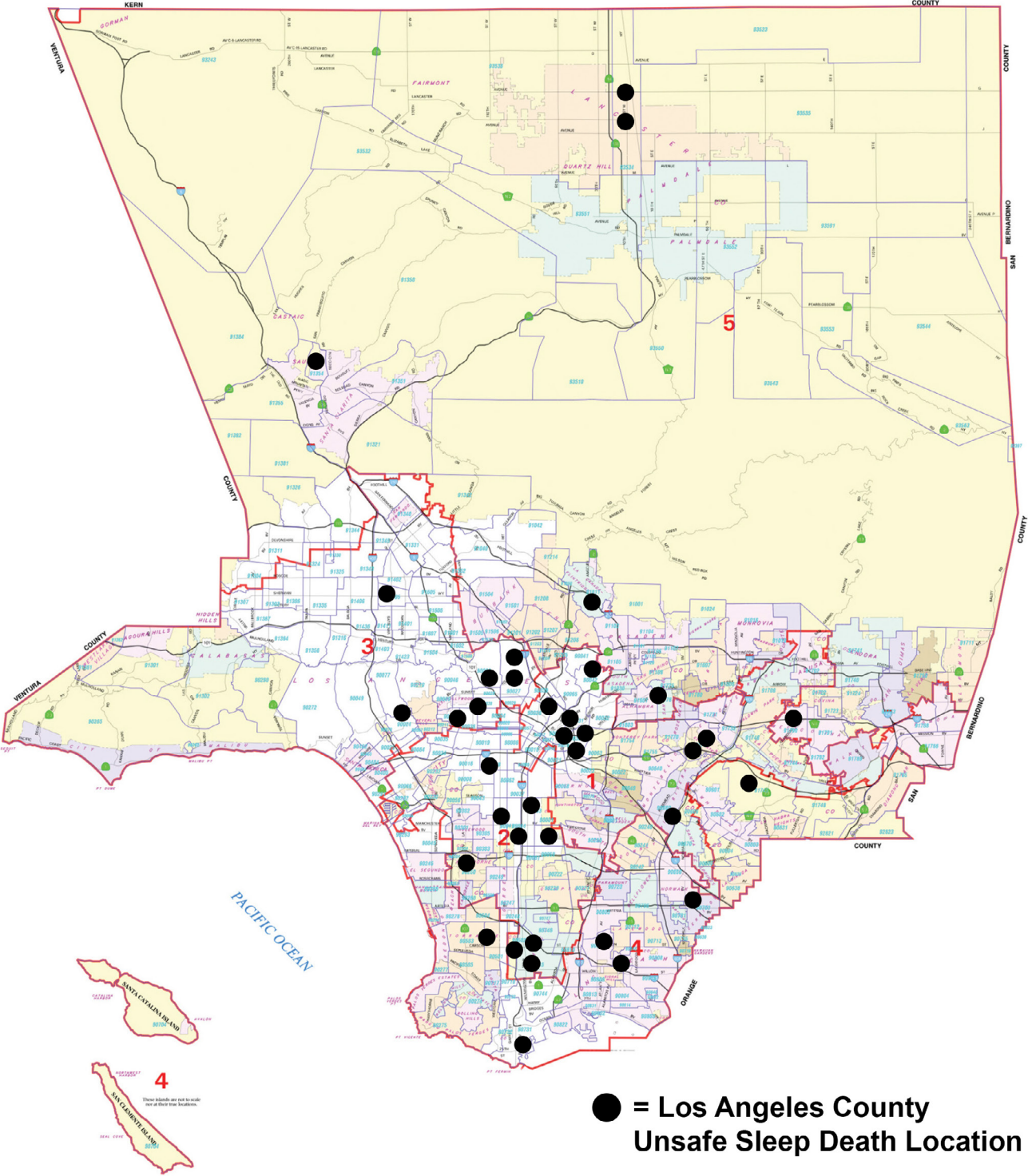
# Undetermined Child Deaths: Bed-Sharing and Unsafe Sleeping Environment



Undetermined Child Deaths:  
Bed-Sharing and Unsafe Sleeping Environment

## 2022 Unsafe Sleep Death - Locations n = 33\*

*\*City where the unsafe sleep death occurred*



## Sample Case Summaries - Third Party Homicides

### **Saskia**

Saskia is a 16-year-old female found naked lying face down on the shoulder of the freeway with a bloody grocery bag over her head. She appeared to have been dumped and there was no missing person report on her. No suspects in custody and it remains an open investigation.

### **Jose**

Jose, 6 years old was with his mother in a car when they were both shot. His mother was pronounced dead at the scene. Jose was transported to the hospital, as he was still alive however, his health continued to decline, and he was pronounced dead at the hospital.

### **Charlie**

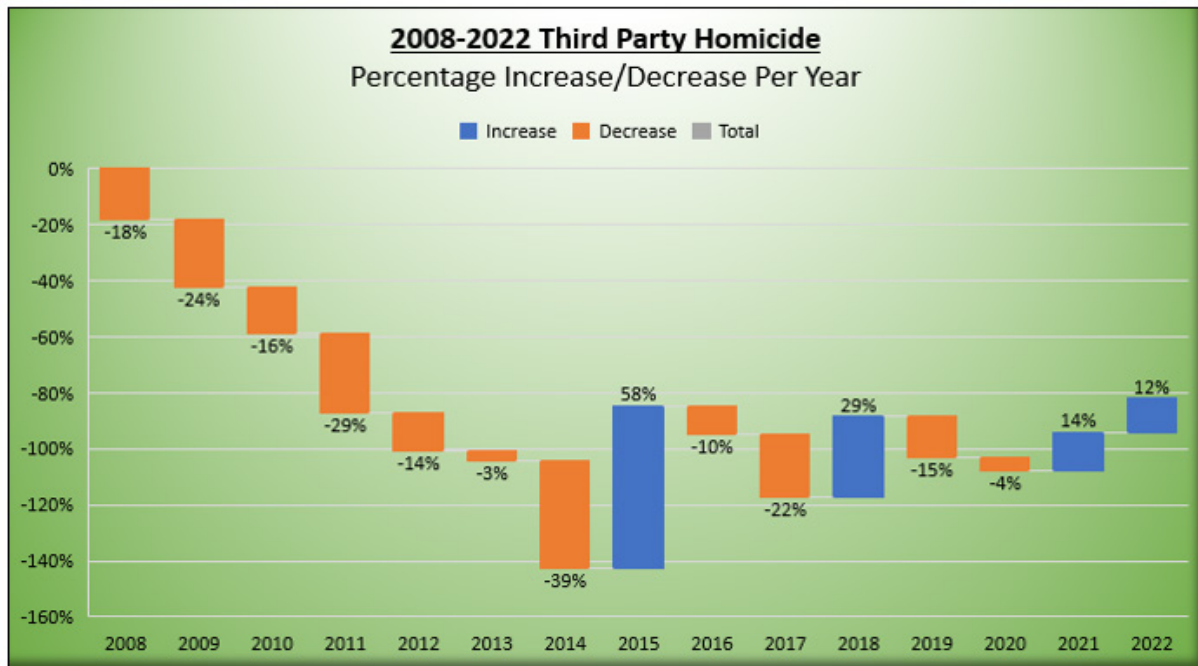
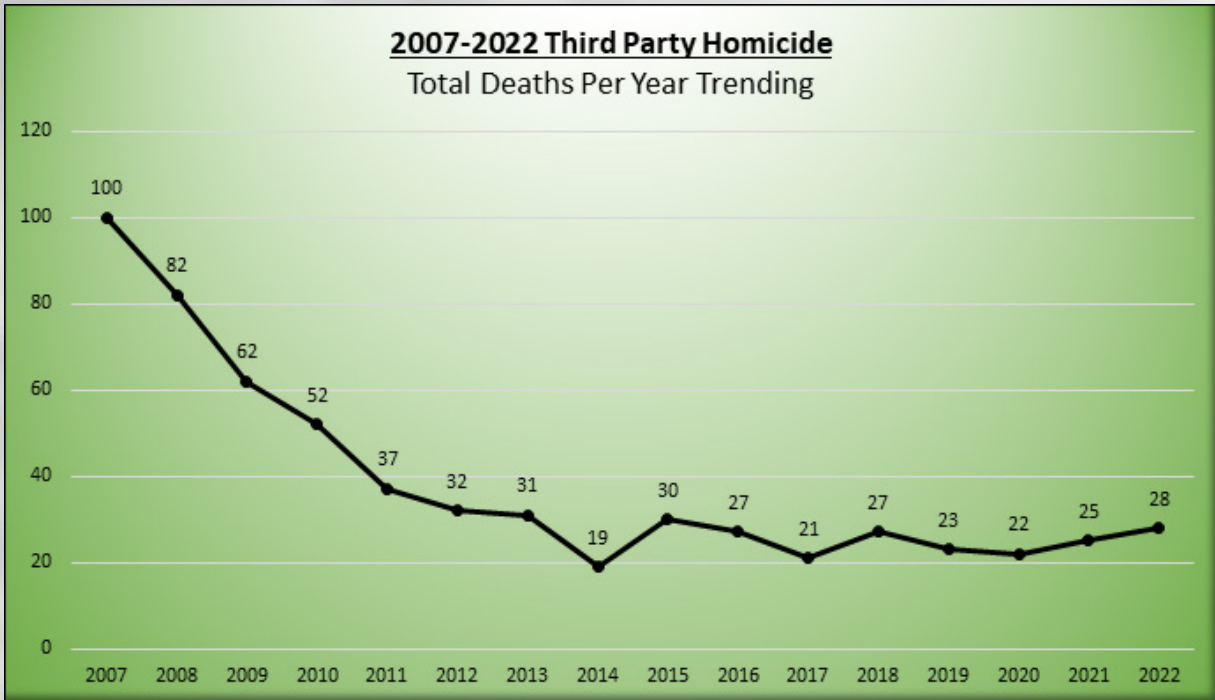
Charlie aged 16 was standing outside his home with friends when an unknown assailant came up to him and shot him in the face. Charlie was transported to the hospital; however, he died in route to the hospital.

## THIRD PARTY HOMICIDES

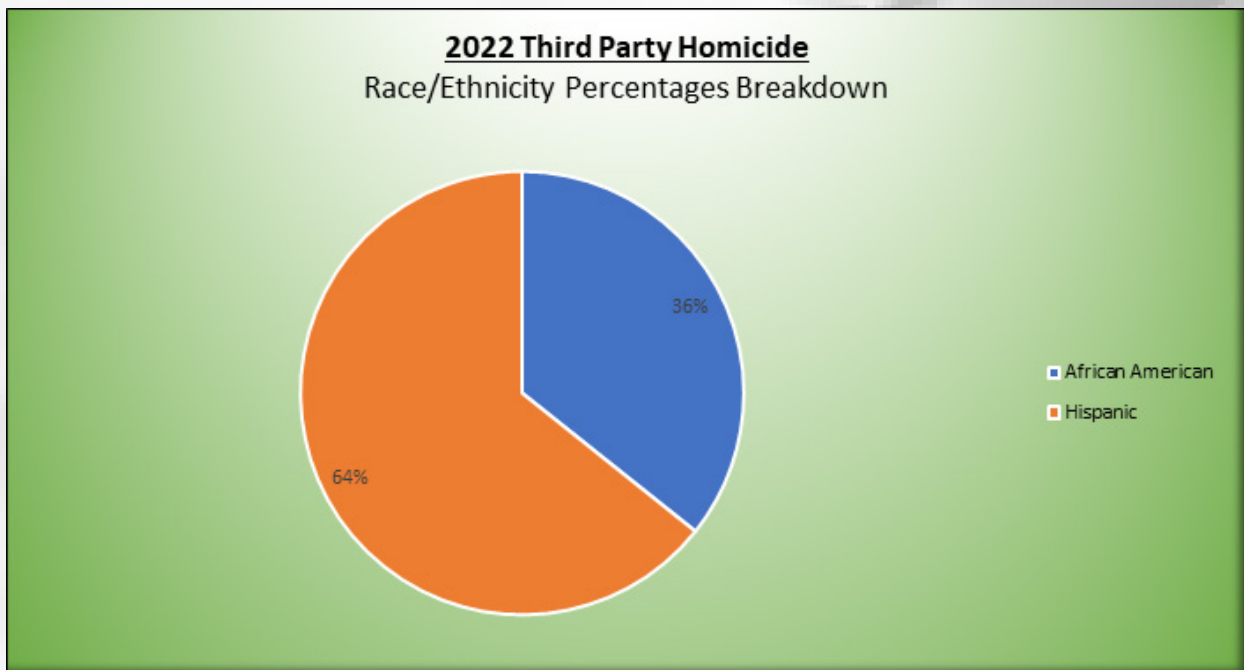
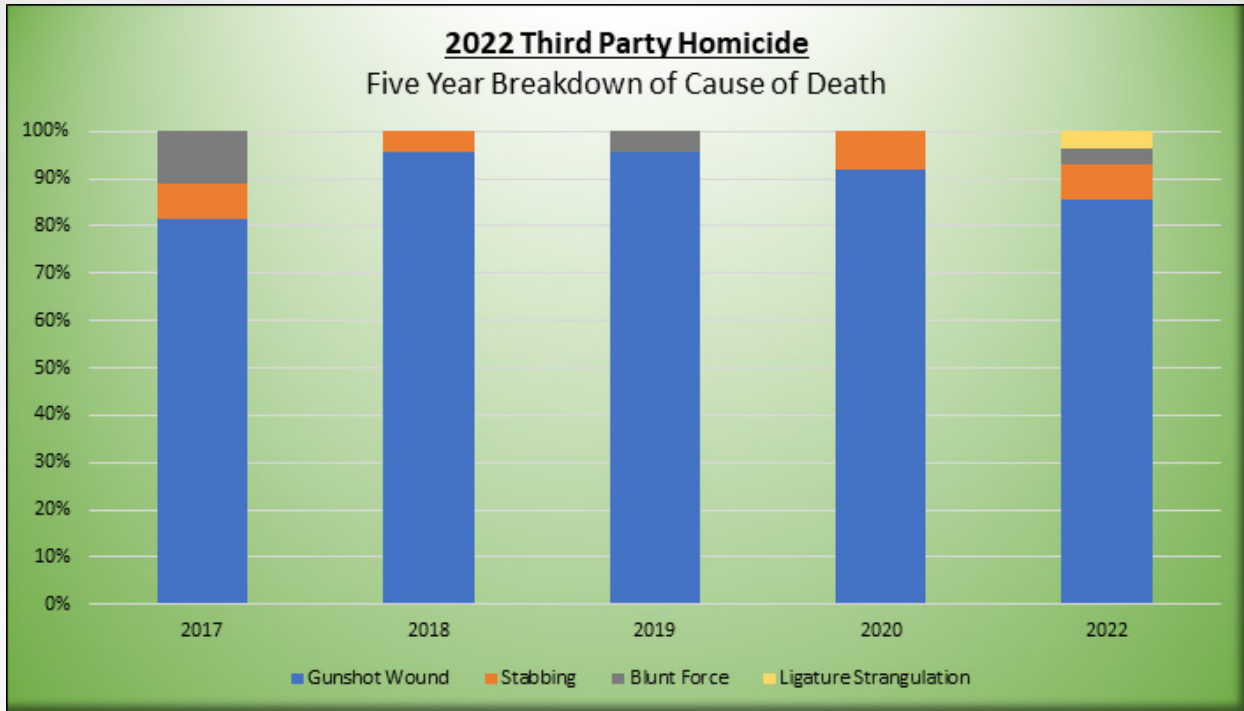
### FINDINGS

- Twenty-eight third party homicides were reported to ICAN by the Coroner for 2022 which is four more cases than last year, a 12% increase. The five-year average is 25 third party homicides per year.
- ICAN began including third party homicides in the CDRT Report in 2007.
- As in prior years, the number one cause of third-party homicide is gunshot wound. This year, 86% of the victims succumbed to gunshot injuries.
- Of the twenty-eight third party homicide victims, twenty-seven were male and one was female in 2022. This continues the trend of the last few years of a decline in female victims. This year, males make up 96% of the victims. In 2022, the gender ratio is above the five-year average
- Third-party homicide victims ranged from six to seventeen years old in 2022. Older children made up the largest percentage of the victims with fifteen, sixteen and seventeen-year-olds composing eighty-two percent of deaths. Additionally, there was one fourteen-year-old child, one twelve-year-old child, and one ten-year old. The youngest child was a six-year-old boy
- Sixty four percent of the victims of third-party homicides in 2022 were of Hispanic background, and 36% were of African American descent. These two groups made up 100% of the deaths in 2022 with no Caucasian or Asian victims. This continues the five-year average trend with Hispanic victims being a major portion of third-party homicides.

# Third Party Homicides

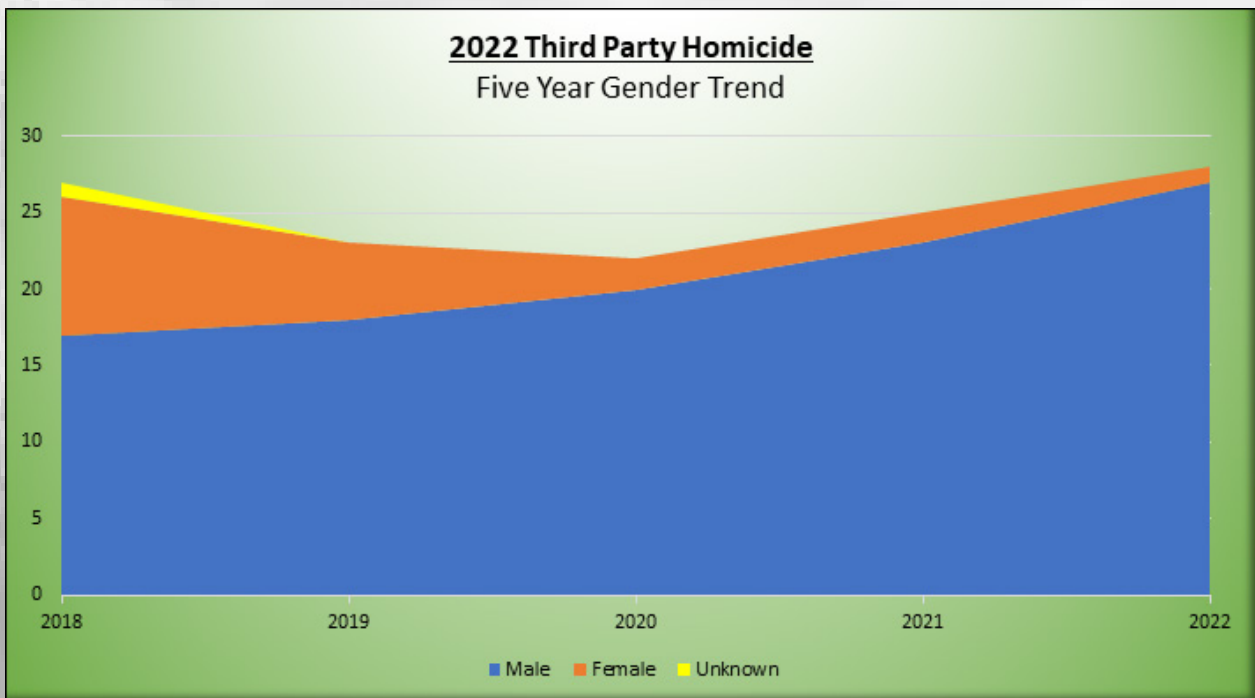
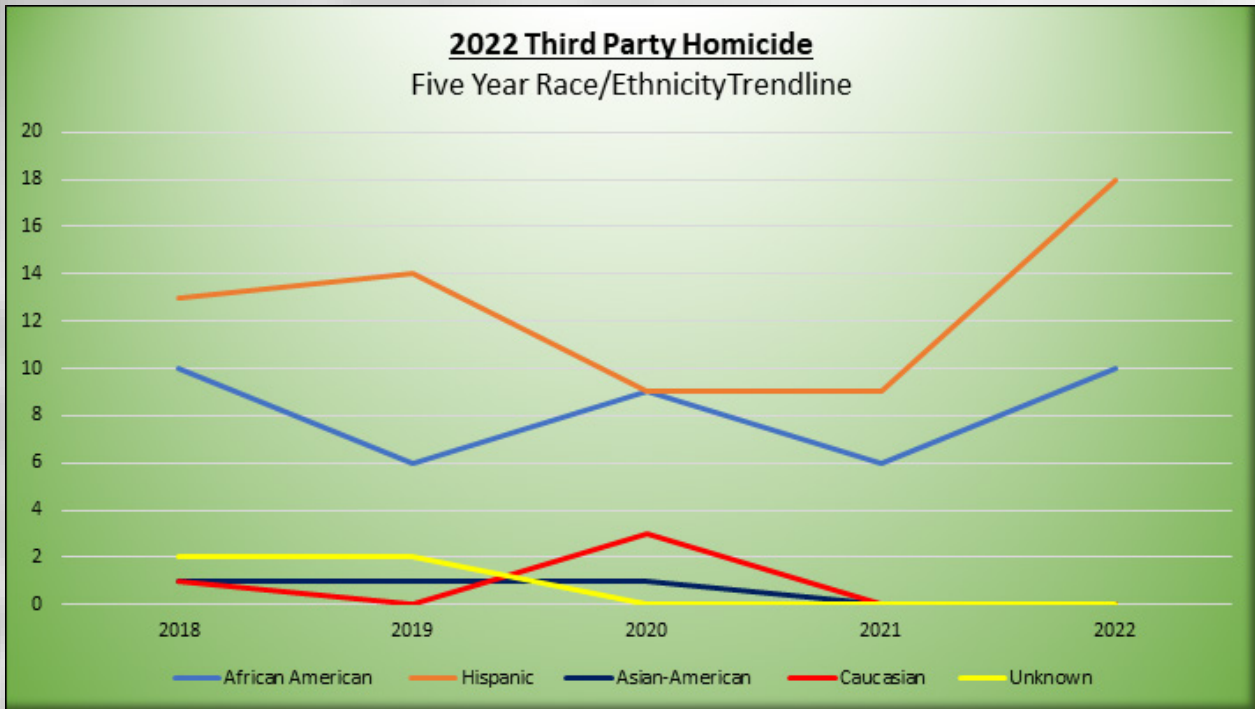


# Third Party Homicides

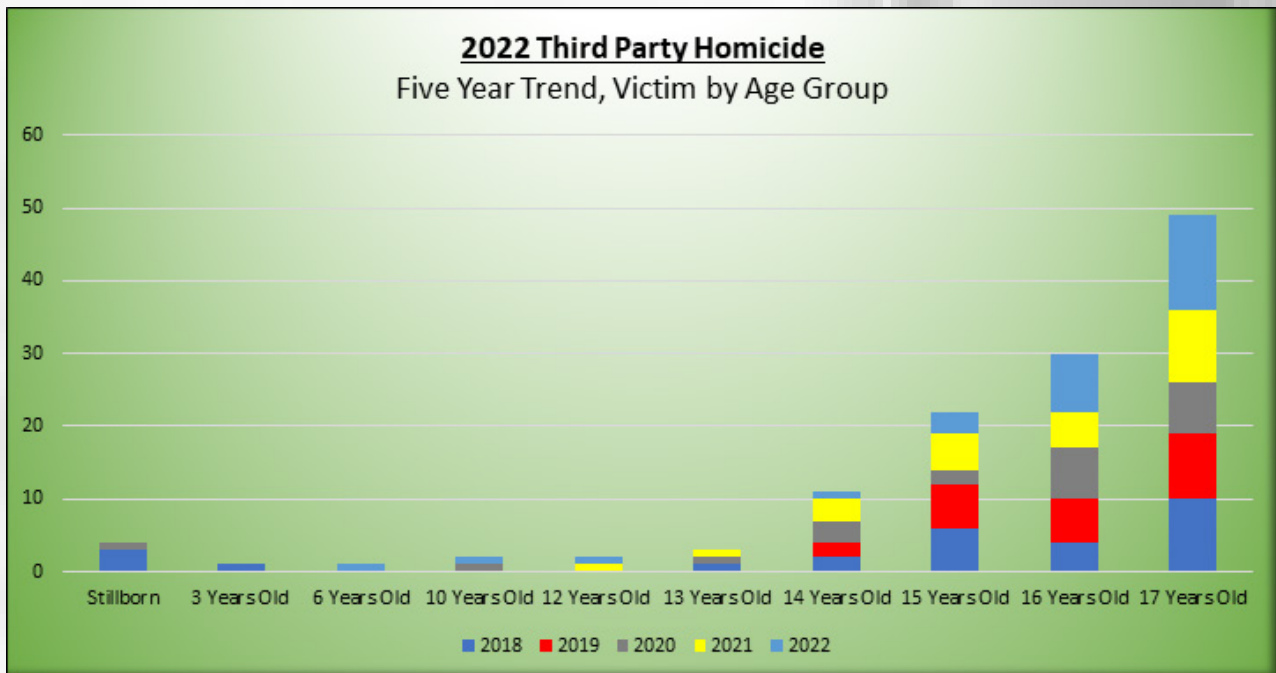
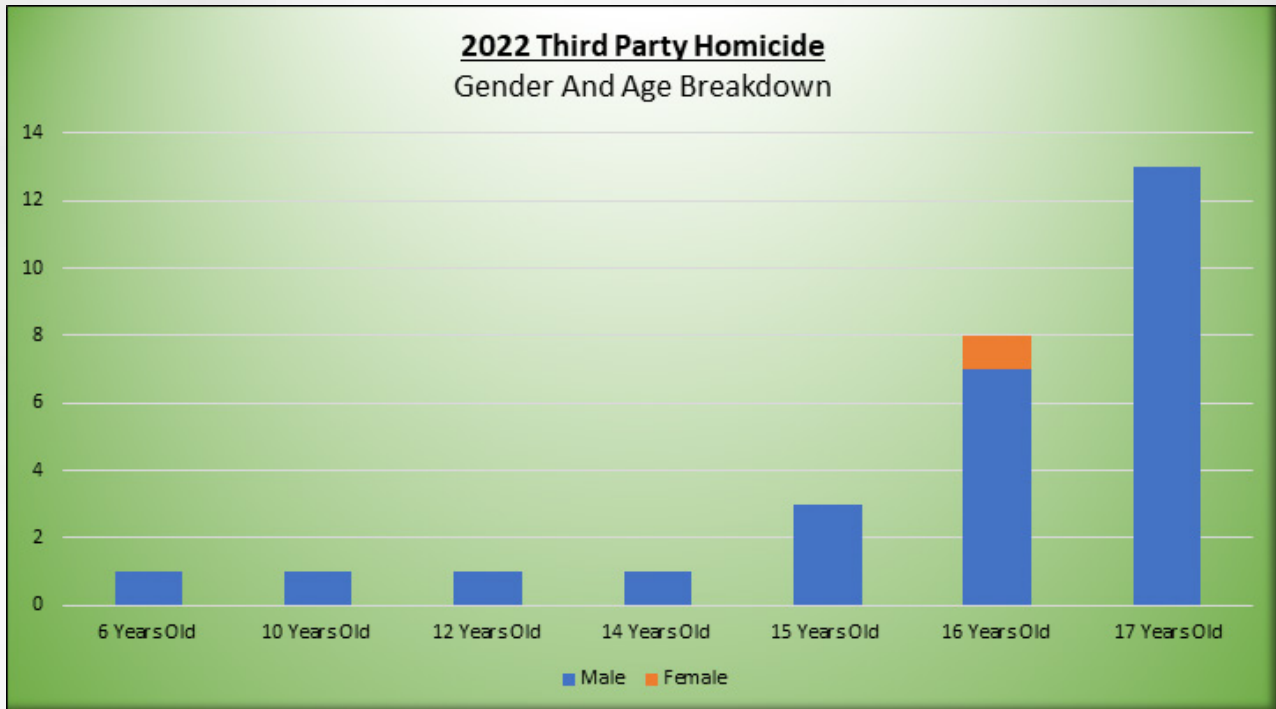




# Third Party Homicides



# Third Party Homicides



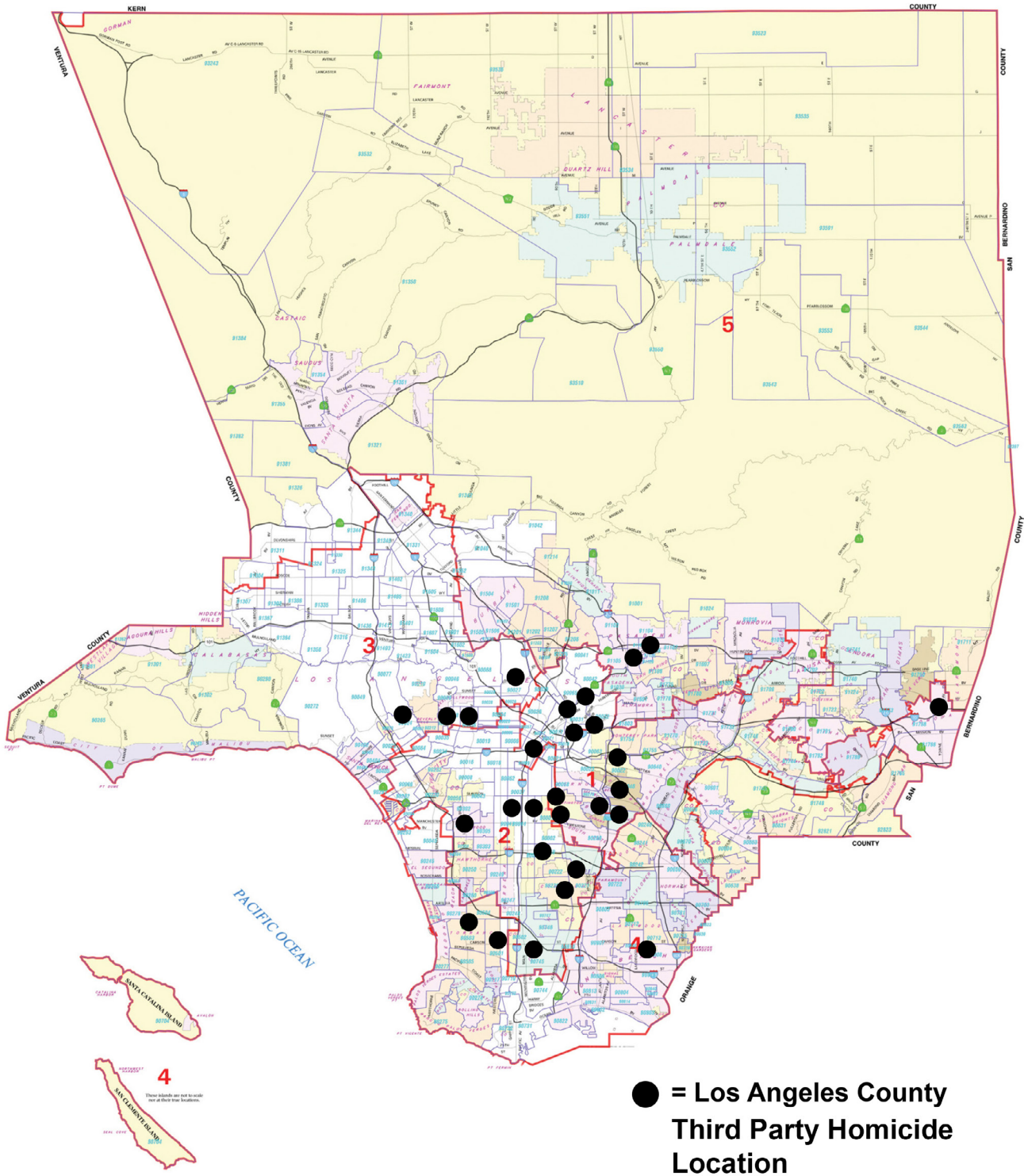
# Third Party Homicides



# Third Party Homicides

## 2022 Third Party Homicides - Locations n = 28\*

\*City where the homicide occurred



**Safe Sleeping Resources**

[safesleepforbaby.com](http://safesleepforbaby.com)  
[nichd.nih.gov/sts](http://nichd.nih.gov/sts)  
[firstcandle.org](http://firstcandle.org)

**Child Abuse**

[dontshake.org](http://dontshake.org)  
[child-abuse.com](http://child-abuse.com)  
[dcfs.co.la.ca.us](http://dcfs.co.la.ca.us)  
[ican4kids.org](http://ican4kids.org)

**Domestic Violence**

[dvcouncil.lacounty.gov](http://dvcouncil.lacounty.gov)  
[lapdonline.org/StopDV](http://lapdonline.org/StopDV)  
[thehotline.org](http://thehotline.org)

**Suicide-Youth**

[preventsuicide.lacoe.edu](http://preventsuicide.lacoe.edu)  
[suicideinfo.ca/youthatrisk](http://suicideinfo.ca/youthatrisk)  
[suicidehotlines.com/california.html](http://suicidehotlines.com/california.html)  
[thetrevorproject.org](http://thetrevorproject.org)

**Water Safety**

[poolsafety.gov](http://poolsafety.gov)  
[abcpoolsafety.org](http://abcpoolsafety.org)

**Fire Safety**

[fire.lacounty.gov/safety-measures/fire-safety-tips](http://fire.lacounty.gov/safety-measures/fire-safety-tips)  
[firefacts.org](http://firefacts.org)

**Biking Safety**

[Sheriffsyouthfoundation.org](http://Sheriffsyouthfoundation.org)  
[Nhtsa.gov/bicycles](http://Nhtsa.gov/bicycles)

**In and Around Cars**

[chp.ca.gov/program&services](http://chp.ca.gov/program&services)  
[nhtsa.gov](http://nhtsa.gov)  
[kidsandcars.org](http://kidsandcars.org)

**Pedestrian**

[kidsandcars.org](http://kidsandcars.org)  
[safekids.org](http://safekids.org)  
[ntsa.gov/pedestrian](http://ntsa.gov/pedestrian)

**Teen Drivers**

[ntsa.gov](http://ntsa.gov)

# APPENDIX B - Map of Los Angeles County Board of Supervisor District

