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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.

Child Death Review Team Report 2015

ICAN

Child Death Review Team Report 2017

Report Compiled from 2016 Data

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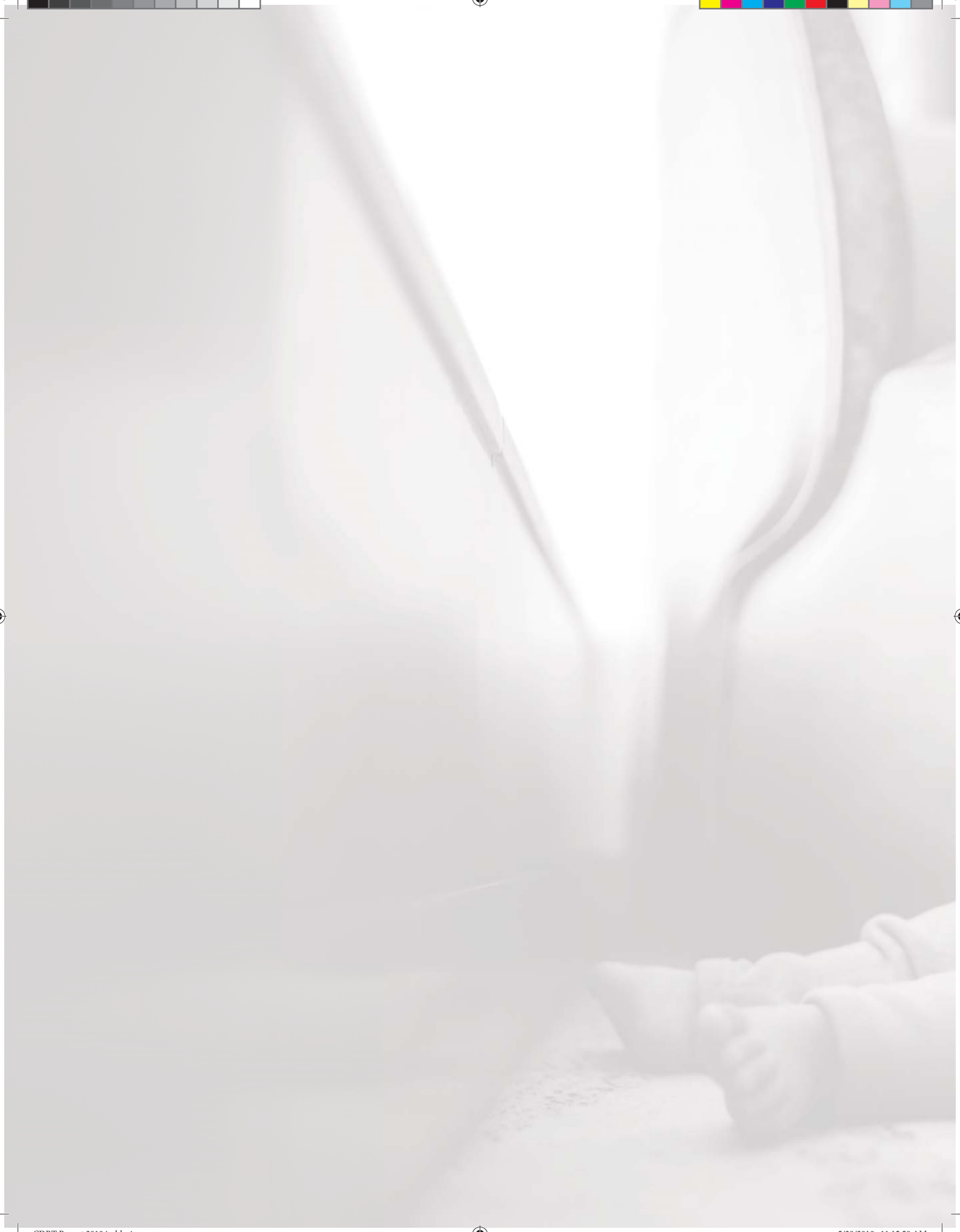

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Los Angeles County Child Death Review Team

Child Death Review Team

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Teams Include Representatives From The Following

Los Angeles County Departments

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

City of Los Angeles

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

State and Other Community Partners

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

This report is available on line at: ican4kids.org

Introduction

2016 marks the thirty-eighth year 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. 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 Los Angeles County Department of Medical Examiner-Coroner refers child deaths to the team in the age range from fetal deaths of 20 weeks up to, but not including, the 18th birthday. This excludes all natural deaths. Thereafter, cases that meet at least one of the following criteria are selected for review:

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

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. Recommendations made by the Team are not aimed at systems to place blame on any individual or organization. Rather, the recommendations reflect the lessons gleaned from case reviews that can be used to improve system responses across agencies and service providers to more effectively prevent child deaths.

This report provides information on all child deaths that meet Team protocol and occurred in Los Angeles County during 2016. Lessons learned from the reviews and ensuing recommendations are included in the report which, if implemented, should improve child safety and save lives. Appendix C at the end of the report provides on-line resources for prevention of child deaths.

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

Recommendations

The Los Angeles County Domestic Violence Council should work with ICAN agencies and community partners to address the critical need to recognize the potential fatal impact of family violence on children and promote the reporting of domestic violence incidents and provision of support services for adult and child victims.

Additionally, the ICAN Policy Committee should continue to support efforts to amend the WIC 300 code to add an allegation specifically for domestic violence.

Rationale: Each year the Team has noted, and the data has reflected, the connection between domestic violence and child abuse in the child homicides. In 2016, 64% of the child abuse homicides involved families of a perpetrator with a history of domestic violence. In fact, five of the 14 homicides occurred during a domestic violence incident. There remains a need to acknowledge and address family violence in a coordinated manner between both public and private agencies serving children and families.

The CDRT and agencies working with domestic violence have long struggled in obtaining accurate data on and identification of children impacted by domestic violence. Domestic violence is categorized as emotional abuse or general neglect in the Dependency Court. Having a clear manner in identifying cases with allegations of domestic violence will improve data collection and the provision of services by ensuring the family's history of domestic violence is addressed.

In cases of fatal family violence, the Department of Children and Family Services (DCFS), the Los Angeles County Sheriff's Department (LASD), the Los Angeles Police Department (LAPD) and Independent Law Enforcement Agencies (LEAs) should make best efforts to thoroughly evaluate the homes of both the maternal and paternal relatives prior to placement of the children. The homes and suitability of the caregivers should be assessed for safety and their ability to meet the physical and emotional needs of the children affected by family violence.

Additionally, DCFS should make every effort to ensure that the children and the caregivers receive appropriate treatment for their trauma and grief. Domestic violence advocates should be consulted to best identify appropriate resources for the children and family exposed to family violence.

Rationale: If there is a parent surviving family violence, it is usually the one who committed the murder of the other. Without intervention, this parent can designate where and with whom the children should live. Going to live with relatives of either parent can pose emotional risks to the children. When the relatives do not deal directly with their own beliefs or feelings about the violent deaths, they can consciously or unconsciously take it out on the child. Relatives of the victim may not be able to appropriately handle the child's expression of the loss of the parent responsible for the killing. Some relatives may scapegoat a child who reminds them of the person who killed their loved one. Similarly, the relatives of the perpetrating parent may talk badly about, or even blame, the victim in front of the child for causing the murder; thus further complicating the child's grieving process. Or, they may deny the trauma, not talk about it, and just "move on."

Ensuring children have access to appropriate treatment for trauma and grief is critical. Children should not be left to work out the feelings on their own. In fact, for a healthy transition, the relatives themselves would benefit from counseling. They have also lost a loved one. Complex grief that is not treated can result in unresolved emotional distress. Doing this will enable the caregivers to handle their own reactions to the homicide, opinions about the victim or the perpetrator, or the children themselves separately. This is to prevent the caregivers from imposing their beliefs on the children and/or failing to help them access adequate professional assistance.

In addition, consulting and collaborating with local domestic violence agencies is a critical step to ensuring the children are referred to professionals experienced in working with children who have witnessed domestic violence.

Recommendations

All county and community agencies and organizations that serve pregnant women or infants should assure information on safe sleep practices are provided to families. Resources should be allocated to re-establish a countywide public awareness campaign on Infant Safe Sleep.

Rationale: Expectant parents and families with babies under the age of one year need to be aware of the risk of bed-sharing and what constitutes a safe sleep environment for infants. With a grant from First 5 LA, ICAN conducted a public awareness campaign on Safe Sleep for Your Baby from 2012 to 2014. Tragic and preventable infant unsafe sleeping deaths declined over 50% by 2015, from 70 infant deaths to 24. However, since the termination of funding for this campaign, deaths from unsafe sleeping are alarmingly on the rise in Los Angeles County. Infant deaths associated with bed-sharing and unsafe sleep environments almost doubled in 2016 from the previous year.

In addition to county agencies serving children and families, birth hospitals, community health departments, local health clinics, child development networks, child care resource centers and other community agencies serving families should disseminate this information to parents and caregivers. Media and other information sharing entities should be engaged to promote life-saving safe sleep practices.

When the Department of Public Health sends a birth hospital a letter alerting them to a death associated with bed-sharing or unsafe sleep, a copy of the letter should be sent to the hospital Director of Nursing or OB/GYN Nurse Manager.

Rationale: By sending a copy of the letter to the Director of Nursing or OB/GYN Nurse Manager, the staff that has direct contact with newborns will be alerted to the death. This will hopefully bring home the importance of counseling for new parents as to safe sleep and the possible deadly consequences of bed-sharing and unsafe sleep circumstances. As stated above, there was a doubling of these preventable deaths in 2016.

The County of Los Angeles efforts toward universal home visitation for families continue to move forward, assuring all at-risk families with young children receive home visitation with connections to needed mental health, medical and social support resources.

Rationale: The ICAN Child Death Review Team has found common risk factors that are present in almost every tragic child abuse fatality. The mother is often depressed, and may have no personal connections other than to an abusive partner. Both may be abusing alcohol or drugs. The parent or parents are socially isolated. They have unreasonable expectations of their young children, and little or no knowledge about child development or how to place a baby in a safe place to sleep. Most of the children who are fatally abused are infants and toddlers

In 2016, 57% of the child abuse homicide victims were age 2 and under. Forty-seven infants suffocated because they were placed in an unsafe sleep environment or were bed-sharing. There was a substance abuse history for fifty percent of the families of child abuse homicides and 64% had a history of domestic violence.

Home visitation offers opportunities to observe parental depression or other mental states, stress, life skills, parenting skills and styles. A home visitor offers guidance, modeling and support to parents that can break social isolation and the cycle of abuse and neglect so often present in families who experience a child fatality.

Recommendations

School suicide prevention resources should be available to students throughout the year including non-school days and during summer and holiday breaks.

Rationale: School pupil personnel services staff (School counselors, school psychologists, and school nurses) and school-based mental health providers play an important role in identifying suicide risk and intervening to prevent suicide among students. From 2010 through 2016 there has been a rise in suicide among students that occurred during student recess periods. Six of the fourteen youth who took their life in 2016 were on a school break at the time of the suicide. Having a familiar pupil support service or other on-site mental health provider available during school recess times might lead an otherwise silent child to reach out for help.

The Los Angeles County Superintendent of Schools should explore the possibility that school districts extend the availability of school pupil personnel staff and school-based mental health providers throughout the year, including school recess periods (winter, spring and summer vacations). The Los Angeles County Office of Education could assist schools with models of resources to be available during school recess periods. These models could include the use of technology and social media for students to access staff during breaks.

Mental health services should be available and delivered to all students regardless of income and Medi-Cal eligibility. If this is not feasible, assistance should be provided to help them locate appropriate mental health resources.

Rationale: Mental health services are an essential component of suicide prevention. Many school districts have increased access to mental health services for students by inviting community mental health and substance abuse agencies to provide services on campus. LA County Office of Education should encourage all schools to provide these services or have a referral process to outside services.

School districts are encouraged to develop policies and procedures that utilize Employee Assistance Program resources to support school employees after the suicide death of a student.

Rationale: In the 2016 cases reviewed, there was a dramatic impact on the well-being of the educational employees. Effective grief counseling and psychological resources should be available to assist school employees in the aftermath of a student suicide. However, in the majority of cases, school pupil personnel resources are deployed to respond to a campus suicide. These resources are more geared to supporting the students rather than for supporting adult school employees. Similar to students, employees should have a process and be encouraged to take advantage of the resources available to them when they are impacted by a suicide.

Child Death Review Team Child Abuse Homicide: Risk Factors and Lessons Learned

Child Risk Factors

Young Age

57% of the 2016 child abuse homicide victims killed by a parent/relative/caregiver were two years of age or under. 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.

Further, 53% of the children who died as a result of an accident were age five years or younger. Young children are more at risk of death due to drowning, unsafe/co-sleeping, pedestrian or auto back up because of their size and/or lapses of adult supervision to prevent such deaths.

Gender

In 2016, the gender gap of victims of child abuse homicide narrowed with male (n=8) children outnumbering female (n=6) only by two. In previous years, males typically significantly outnumber the female victims.

Race

Fifty percent of the 2016 child homicide victims by a parent/relative/caregiver in 2016 were children of Hispanic descent. The next represented groups were African American and Asian/Pacific Islander with 21% each.

Parental Risk Factors

Domestic Violence

The nexus between domestic violence and child abuse/neglect continues to be evident in the 2016 child homicides. Nine or 64% of the families or the perpetrator had a history of domestic violence. Five of the child homicides can be directly tied to domestic violence. One toddler was killed during a DV incident. Four teens were killed as a result of separate domestic violence incidents in two families.

Involvement with the Child Welfare System

A key factor in the majority of the child abuse homicide cases was that the child's mother, father or the perpetrator had at least one contact with the Department of Children and Family Services (DCFS) or another Child Protective Service (CPS) agency. In 2016, DCFS contact with a parent and/or perpetrator occurred in 43% (n=6) of the families who experienced a child abuse homicide. Two of the six had a current open referral with DCFS at the time of the homicide.

Cycle of Abuse

Another common factor seen in many of the child abuse homicide cases has been that the child's mother, father or the perpetrator had a prior juvenile case 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. 36% (n=5) of the 2016 child homicides involved a parent(s) and/or perpetrator with a Child Protective Service (CPS) history as a child.

Substance Abuse by Parent or Caregiver

Substance abuse by a parent or caregiver is a well documented high risk factor for child abuse or neglect. Substance abuse is also often identified when there is a child fatality. Fifty percent of the 2016 families of homicide victims had a history of substance abuse. In three of the 2016 child homicides, the individual responsible for the child was under the influence of alcohol. Another perpetrator was found to be under the influence of methamphetamine during the incident that led to the child's death. Further, in 2016, two children died in automobile accidents that involved a parent who was under the influence of drugs or alcohol at the time of the accident.

Unrealistic developmental expectations and inability to cope with age appropriate behavior, combined with drugs and alcohol, become a lethal situation causing caregivers to make poor decisions or to lose control and harm the child. In addition, parents under the influence who sleep with their infant increase the risk of overlay or suffocation leading to the death of the child.

Prenatal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appear to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a number of fetal deaths with a contributing factor of prenatal substance abuse. Child deaths related to prenatal substance abuse remain one of the top four causes of accidental death, accounting for 22.1% (n=21) of the accidental child deaths. Further, eighty-one percent of the families in which there was an associated prenatal substance abuse related accidental death had at least one contact with the child welfare system. Additionally, there were 8 undetermined infant deaths associated with prenatal substance use as evidenced by the mother testing positive at the birth for alcohol or drugs. Half of these mothers have had at least one contact with the child welfare system prior to the birth.

Mental Illness

Undiagnosed or untreated mental illness is a risk factor seen in many of the child abuse homicide cases. Thirty-six percent (n=5) of the 2016 child abuse homicides involved a parent(s) and/or perpetrator with a history of mental illness. An additional two other mothers, one who committed suicide and one who was arrested, exhibited bizarre behavior on the day of the homicide.

Presence of Multiple Parental/Caregiver Risk Factors

A combination of risk factors, such as history of substance use, domestic violence, CPS contact, CPS history as a child and social isolation are usually present when a child dies at the hand of a parent or caregiver. Only two families of a homicide victim had none of these known risk factors present. In one of the two families, the perpetrator was a babysitter who was under the influence at the time of the fatal incident.

Perpetrator Relationship

Relationship

In 2016, there were twelve suspects in the 14 child abuse homicides (two suspects were responsible for four of the fourteen child homicides). Fifty percent of the child homicides involved a male perpetrator and fifty percent a female. Six of the primary suspects were the mother; four the mother's boyfriend; one, the father; an uncle killed two siblings and one perpetrator was the victim's babysitter.

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 homicide deaths. This is particularly important with the person who assumes a caretaking role for the child. The Team has observed that each year, many of the child homicides have been at the hands of the parent, parent's boyfriend or 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.

Child Death Review Team: Risk Factors and Lessons Learned

System Factors

Failure to Report

With the 2016 child homicides, as in previous years, the Team has reviewed cases in which a family had contact days, weeks or months before the child's death by a hospital or community agency and "red flags" were observed but not reported to DCFS or law enforcement. When abuse or neglect is suspected, a referral should be made to allow either law enforcement or DCFS to assess the family's situation. Mandated reporters are only required to report "suspected" abuse or neglect and not determine it. Additionally, when a family is involved with multiple systems - DCFS, law enforcement, medical, community social services; it is imperative that the agencies providing services to the family have ongoing communication with one another for prevention, investigation, and case management purposes.

Further, in several cases involving child homicides, there were family members or neighbors aware of ongoing domestic violence, neglect, increasing bizarre parental behavior or who observed inappropriate interactions which placed the child at risk and did not contact DCFS or law enforcement. It is important for the public to make a report when they observe something that places a child at risk as this could be life saving.

Additional Risk Factors

Unsafe Infant Sleeping

Undetermined child deaths associated with bed-sharing and/or unsafe sleep environments have declined considerably from the high of 70 set in 2009 to 24 in 2015. Unfortunately, after a recent decline, the number of these child deaths increased to 47 in 2016. Infants who die are often placed on their stomach or side on adult beds, couches and/or surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. In 2016, these bed-sharing and/or unsafe sleep environment child deaths accounted for 48% of all the undetermined child deaths.

Family Isolation

It is often observed that families of child homicide victims tend to be socially isolated with few personal or social resources available to them.

In three of the child homicides, the mother had isolated the child from family, even when living with other family members.

Child and Adolescent Suicide Review Team Risk Factors and Lessons Learned

Although the Team reviews child and adolescent suicides, a comprehensive picture of a youth's life and reason for taking one's life is often unavailable. Because there is no crime, law enforcement does not conduct an investigation. Most youth leave no note or clue to their decision. Social media accounts are often private and few parents are aware of their child's passwords. The families themselves are often blind-sided by the act and can offer few reasons for the suicide to the Coroner Investigator. School personnel participation in reviews can provide valuable insight into a youth, but they are not always present at a case review. The following are the factors that are known about the 2016 suicides:

1. **Suicide Rate**
   The suicide rate among individuals under the age of 18 years reversed the upward trend seen in 2015. Twenty-three youth took their own life in 2015, but the number declined by 39% in 2016 with 14 youth taking their lives. The number of suicides in 2016 was the same as the child abuse homicides.

2. **Gender**
   71% of the youth deaths by suicide were male (n=10) and 29% female (n=4).

3. **Race**
   36% of the youth who died by suicide were Hispanic and 36% were Caucasian. Asian/Pacific Islander children comprised 14% of children who died by suicide and 14% were African American.

4. **Age**
   Youth ages 15-17 are most vulnerable for suicide. Eight out of the 14 suicides were of this age range.

5. **Relationship Loss or Conflict**
   71% of the youth who ended their own lives experienced a recent relationship loss or conflict with a peer, boyfriend/girlfriend or parent prior to their suicide.

6. **The Role of Pre-existing Mental Health Problems**
   Among the youth who died of suicide, 50% had a documented mental health diagnosis, 36% were receiving mental health services at the time of death and 36% were on psychotropic medication. 64% of the youth exhibited a warning sign--talk of suicide, increased drug and alcohol use, feelings of depression, anxiety and hopelessness.

7. **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. Some examples of these stressors are interpersonal loses, family violence, sexual orientation, disciplinary problems, physical and sexual abuse, and being a victim of bullying.

   Of the youth who died by suicide in 2016, family dysfunction at the time of the youth's suicide was noted in 29% of the suicide cases.

   Fourteen percent had reported experience of being bullied. 7% experienced school discipline/truancy problems and 29% had academic problems. 36% of the victim's families had contact with either DCFS or Probation at some time in the youth's life.

8. **Impulsivity**
   Of the 14 youth who died by suicide in 2016, four left a note and one a text. In a group text to friends, a youth sent a picture of a gun in real time just prior to committing suicide. This reflects how youth seem not to plan their suicide over a period of time, but act impulsively at the moment.

Findings

Overall Child Deaths*

- In 2016, a total of 222 child deaths, including fetal deaths were reported to the Team by the Medical Examiner-Coroner. There were four deaths without a final determination in 2016 and these have not been included in the ICAN data. The reported child deaths were the result of homicide by a parent, relative or caregiver, accident, suicide or undetermined cause in Los Angeles County for 2016. This is an increase from the 189 deaths in 2015.
- Fourteen children were victims of child abuse homicide by a parent, caregiver or other family member. There were also 14 suicides, 95 accidental child deaths and 99 undetermined child deaths.
- There were a total of 29 fetal or infant deaths associated with prenatal substance use. Twenty-one were ruled accidental by the Medical Examiner-Coroner. Thirteen of these accidental child deaths were fetal. There were 8 undetermined prenatal substance abuse associated infant deaths involving four fetal deaths and four infants.
- Forty-eight children died with an associated bed-sharing or unsafe sleeping environment. Forty-seven of these deaths were ruled undetermined and one as an accident.
- The percentage of children who died in 2016 by race consisted of 44.6% Hispanic, 23% Caucasian, 20.3% African American, 9.4% Asian/Pacific Islander, .9% were American Indian and 1.8% the race was Unknown.
- Sixty-eight percent of the children were between the ages of 0 to five years (n=152). 54.5% were infants under the age of one year (n=121). Children ages 10 – 17 years comprised 28% of the total number of child deaths in 2016.
- Thirty-six percent of the children who died in 2016 were female and sixty-four percent male.

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

Findings

Homicides by Parent, Family Member or Caregiver

- There were 14 child abuse homicides by parents, caregivers or family members in 2016. This represents a decrease of four homicides from 2015 when there were 18 child abuse homicides.
- The number of child abuse homicides in 2016 for Los Angeles County was significantly lower than the 15 year average of 25.9. The number of child homicides in 2016 was also lower than the 5 year average of 16.
- 57% percent of the children killed by their parents, caregivers or family members were two years of age or younger and 64.3% age three years or younger.
- Five of the 14 homicide victims were over the age of five years.
- Eight males and six females were homicide victims in 2016.
- 36% percent of the child abuse homicide victims were battered children who died from inflicted trauma—specifically from head trauma. In addition, three children were victims of stabbing, two victims of gunshot wounds; two died from poisoning; one child was drowned and one child died as a result of fire.
- There was one unattended newborn death ruled as an undetermined child death in 2016. It should be noted that the decomposition of this infant was too severe to determine whether the infant was born alive. Two neonates were abandoned but found alive. Eight newborns were safely surrendered in 2016 which is fewer than the number surrendered in 2015 (n=18).
- Fifty percent of the child homicide victims were of Hispanic descent. African American (n=3) and Asian/Pacific Islander (n=3) children comprised 43% of child abuse homicides. There was one Caucasian child homicide by a parent, caregiver or family member.
- The Department of Children and Family Services (DCFS) or another county's Child Protective Services (CPS) agency had prior contact with 43% (n=6) of the families in which there was a child abuse homicide and the child died in Los Angeles County. Two families of a homicide victim had an open referral with DCFS at the time of the child's death. Thirty-six percent of the victims' parents or the perpetrator had a child welfare history as a minor.
- Six children were killed by their mother and one child was killed by her father. Four children were killed by the mother's boyfriend; two by their uncle and one child was killed a babysitter.
- Child abuse homicides occurred throughout Los Angeles County in 2016. The Second Supervisorial District experienced the greatest number of child homicides with four. The First, Third and Fifth Districts experienced the second largest number each with three. One occurred in the Fourth Supervisorial District.

Findings

Suicides

- Fourteen children and adolescents died by suicide in 2016. The number of children and youth who died by suicide in 2016 decreased by four from 2015 which represented the highest number of suicides since 2001 with 18.
- The suicide gender gap continued in 2016 with 10 (71%) males and 4 (29%) females taking their lives.
- The leading method in LA County continues to be death due to hanging, which represents 71% (n=10) of the suicides in 2016. Two youths used a firearm representing 14% of the suicides and this method was used exclusively by males. One youth jumped from a height and another walked onto a freeway.
- The act of suicide historically occurs in the youth's home. All but two of the 2016 suicides occurred in the youth's place of residence.
- Thirty-six percent of the child/adolescent suicides in 2016 were by Hispanic and Caucasian youth each (n=5). Suicides by youth of Asian/Pacific Islander descent (n=2) represent 14% of the adolescent suicides and African American youth also comprised 14% (n=2).
- Forty-three percent of the children who died by suicide in 2016 were ages 16 – 17 years. The youngest child was 13 years old.
- Fifty percent (n=7) of the youth had a mental health history, three had been hospitalized at some time, five were taking psychotropic medication, and five youths were in counseling at the time of their death. Four youths had a history of prior self-injury or cutting and four youths had previously attempted suicide. Nine youths exhibited warning signs prior to their suicide.
- Four of the youth who died by suicide in 2016 left a suicide note. Two youth texted their intent just prior to committing the act, but did not leave a note.
- Four of the youths' families were noted to exhibit signs of family dysfunction (pending divorce or recent divorce, parental mental illness or domestic violence). Seventy-one percent (n=7) of the child/adolescent suicides were precipitated by interpersonal conflicts or a recent loss.
- Five of the youths' families had a prior referral or case with the Department of Children and Family Services or another county CPS agency.
- Two youths had a history of drug or alcohol use.
- One youth had school discipline or truancy problems and four experienced academic problems.
- Two youths experienced bullying as reported by parents, surviving siblings or peers.
- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred in the Fourth and Fifth Supervisorial Districts, each with four. Three suicides occurred in the First District of the Board of Supervisors; two suicides in the Third District and one in the Second BOS District.

Findings

Accidental Child Deaths

- The number of children who died from an accident decreased in 2016 from the previous year. There were 104 accidental child deaths in 2015 and 95 in 2016, reversing the previous two year upward trend.

- The leading cause of accidental death for children was automobile (n=31) in 2016. Prenatal substance abuse with 21 deaths was the second leading cause. The third leading cause of accidental child death was auto pedestrian with 14 such deaths. Drowning and overdosing each tied with 7 child deaths.

- Child deaths related to vehicles including bicycle/scooter and auto-pedestrian accounted for 47% of all accidental child deaths (n=45).

- Deaths associated with prenatal substance abuse as determined by the Coroner from self-report or hospital toxicology results, accounted for 13 fetal deaths and eight infant deaths. Methamphetamine and/or amphetamine use by the mother is the most associated drug with these deaths (n=9) accounting for 42.9%. The mother tested positive for methamphetamine and another substance in ten other deaths. All of the accidental deaths associated with prenatal substance use accounted for 22% of the total accidental child deaths in 2016.

- Accidental drowning claimed the lives of 7 children which is a decline from the 13 drowning deaths in the previous year. The majority of these drowning deaths were young children who drowned in residential pools. One teenager was swept away by a rogue wave and one had been drinking alcohol prior to the incident. For the past eighteen years, drowning has been one of the leading causes of accidental deaths of children in Los Angeles County.

- Of the 95 accidental child deaths, 61 deaths involved children ages 0 – 14 years. There were 34 accidental deaths of youth ages 15 to 17 years. More than half (53%) of the accidental child deaths (n=50) were children age five years or younger.

- Of the children who died an accidental death in 2016, 49.5% had a DCFS history. Seventeen (81%) families of the twenty-one child deaths from prenatal substance abuse had a history with DCFS. Seven of these mothers also had a child welfare history as a child.

- Hispanic children represented 52% (n=49) of the accidental child deaths in 2016. Caucasian children represented 22% (n=21), African-American children 17% (n=16) and Asian/Pacific Islander represented 8% of accidental deaths in 2015.

- As in previous years, males (n=58) outnumbered females (n=37) in accidental deaths.

Findings

Undetermined Child Deaths

- There were 99 undetermined child deaths in 2016. This is a 125% increase from the 44 such deaths in 2015.
- The majority, 85% of undetermined child deaths are children age one year or younger. Seventy-two percent of the undetermined child deaths were age six months and under (this includes stillborn deaths).
- The largest number of undetermined child deaths was children of Hispanic decent representing 38.4% of such deaths. Caucasian and African American children each represented 24% of the undetermined child deaths. 8% of the children were Asian/Pacific Islander.
- Approximately 40% of the families with a child who died from an undetermined death had at least one contact with DCFS or another county CPS agency.
- After a 5 year period of declining bed-sharing and unsafe sleeping environment infant deaths, 2016 represents a significant increase in these undetermined child deaths. In 2015 there were 24 such deaths and this rose to 47 infant deaths in 2016.
- Associated bed-sharing and unsafe sleep environments accounted for 47.5% percent of all undetermined child deaths. 33.3% of the undetermined child deaths were associated with bed-sharing (n=33) and 14.1% with an unsafe sleep environment (n= 14).
- Among the bed-sharing deaths, 0% involved only one unsafe risk factor, 64% involved two, and 36% 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 bed-sharing and unsafe sleeping environment child deaths representing 27.7% of these deaths in 2016.
- Eighty-nine percent of the infants whose deaths occurred while bed-sharing or in an unsafe sleeping environment were six months of age or younger (n=42).
- In 49% 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 2015 when 33% of the infants were placed prone or on their side to sleep.
- Undetermined child deaths involving bed-sharing and unsafe sleeping environments occurred throughout Los Angeles County. However, Supervisorial District 2 accounted for 27.6% (n=13). District 1 followed with 23.4% (n=11) and District 5 with 21.3 (n=10). 15% (n=7) occurred in Districts 4 and 12.7% (n=6) in District 3 each.
- 57.5% (n=19) of the bed-sharing deaths were infants between 0 to 3 months of age, 30.3% (n=10) were infants between 3 to 6 months of age, 6.1% (n=2) were 6 to 9 months of age, 6.1% (n=2) were 9 months to 1 year.
- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 48.5% of the incidents and two adults in another 24% of the incidents. 15.1% were sleeping with one adult and a child, 6.1% two adults and a child and 6.1% one or more children.

Findings

Undetermined Child Deaths (continued)

- Fourteen percent (n=14) 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. 15.1% were sleeping with one adult and a child, 6.1% with two adults and a child and 6.1% were sleeping with one or more children.
- Three of the non bed-sharing deaths were infants between 0 to 3 months of age (21.5%) and ten were infants between 3 to 6 months of age (71%).
- 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. Four of these deaths were stillborn births.
- Methamphetamine (n=6) was most frequent substance detected.
- Four of the mothers of these infants had prior contact with a CPS agency in Los Angeles or another county.

Senate Bill 39 (SB 39): Data Variances

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

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

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

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

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

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

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

Selection of Cases for Team Review

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

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

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

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

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

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

Child Deaths in Los Angeles County 2012 - 2016

Table 1	
Over the past 5 years, a parent, caregiver or other family member has murdered an average of 15.8 children each year.	
Year	**Number**
2012	14[1]
2013	19
2014	14
2015	18
2016	14

The average number of children and adolescents who committed suicide over the past five years is 15.4. The leading method from 2012 through 2016 is hanging.	
Year	**Number**
2012	17
2013	13
2014	10
2015	23
2016	14

An average of 96.8 children have died from preventable accidents over the past five years. The most common accidental deaths involve automobile accidents, prenatal substance abuse and deaths due to auto vs. pedestrian.	
Year	**Number**
2012	89
2013	93
2014	103
2015	104
2016	95

The number of undetermined deaths has averaged 80 per year over the past five years.	
Year	**Number**
2012	99[2]
2013	90
2014	68
2015	44
2016	99

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

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

Child Deaths in Los Angeles County 2012 - 2016

Figure 1: 2012 - 2016 Los Angeles County Child Deaths

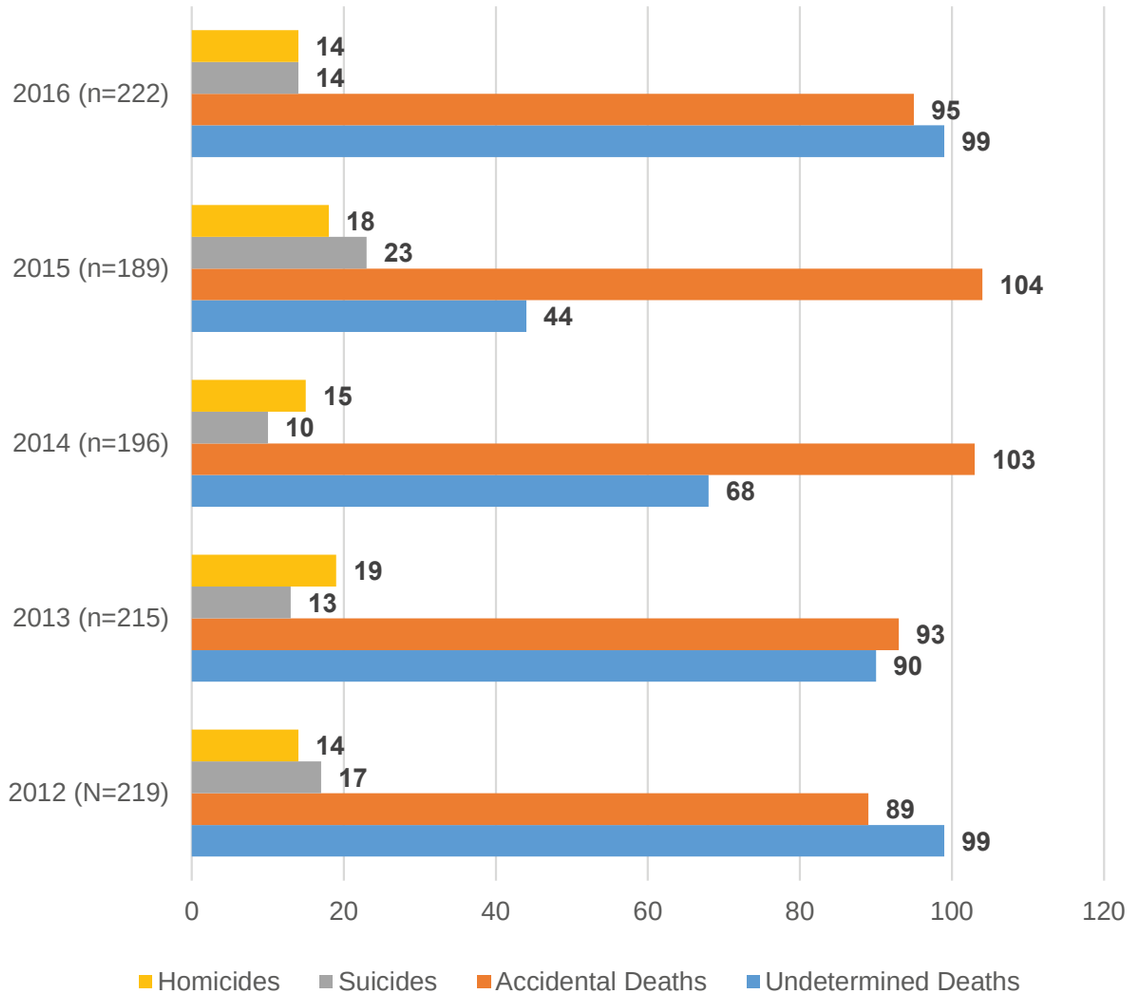
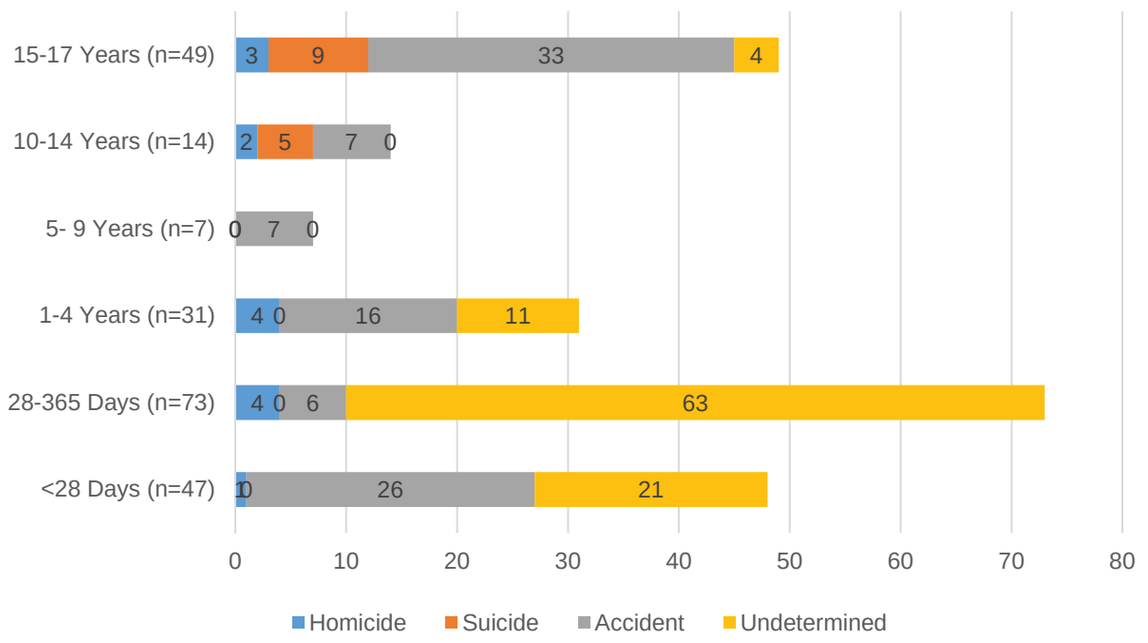


Table 2		
2016 Child Deaths Demographics - Coroner Cases		
	Number	**Percentage**
Total	222	100%
Gender		
Female	80	36%
Male	142	64%
Age		
Under 1 year	121	54.5%
1 – 4 years	31	14%
5 – 9 years	7	3.1%
10 – 14 years	14	6.2%
15 – 17 years	49	22.1%
Race		
African American	45	20.3%
Asian/Pacific Islander	21	9.4%
American Indian	2	0.9%
Caucasian	51	23%
Hispanic	99	44.6%
Unknown	4	1.8%

Figure 2: Percentage of Child Deaths by Age Group and Manner, Los Angeles County 2016 (n=222)



Child Homicides by Parent, Caregiver or Other Family Members 2016

Case Summaries

Michael

A 19 day old infant was admitted to the hospital with brain swelling and injuries consistent with a fall and blunt force trauma. Michael was also found to have had significant weight loss weighing half of his birth weight at admission. He succumbed to his injuries two days later. When interviewed by law enforcement, his 21 year old mother said she deliberately dropped Michael when he would not stop crying. The mother had revealed she did not want this child when she was pregnant. She was overwhelmed with his care and felt unsupported by family. Her mother did not like Michael's father and was angry at her for having his baby. She was angry at the father at the time and had an argument with her mother earlier in the day of the incident. She wished Michael's father was the same as her older daughter's. She wanted to love this baby, but could not because of the father.

Michael's mother had received child welfare services in 2015 for an older sibling due to domestic violence and had an open referral on Michael due to being substance exposed at birth. His mother was arrested for murder and is currently awaiting trial.

Naomi

Two year-old-Naomi lived with her mother and her mother's boyfriend. They had been dating for six months and the mother was five months pregnant with his child. The mother and boyfriend got into a verbal and then physical altercation with one another. The boyfriend began stabbing the mother with a knife. Naomi, who was napping in a bedroom, came out into the hallway where their fight was taking place. The boyfriend grabbed Naomi and began to stab the child. He fled the scene and was later arrested. The mother and her unborn child survived, but Naomi was mortally wounded in the attack.

Naomi's mother was involved with DCFS as a child and emancipated from care at the age of 18 years. There was no history for Naomi with DCFS. The boyfriend was gang involved and a substance abuser. He too, had a history with DCFS and Probation as a minor. Methamphetamine was found in his system on the day of the incident. The boyfriend remains in custody as he awaits his trial for the murder of Naomi.

Janet and Jane

Two teenage sisters were home when their mother's ex-live-in boyfriend Samuel came to visit as he had done many times before. Without warning, Samuel produced a gun and shot the girls. Hearing the commotion, their younger brother came out of his bedroom only to be confronted by Samuel. He managed to run past him out of the apartment but was shot in the back. Samuel went into the kitchen where their mother was and shot her. He then went into the mother's bedroom and turned the weapon on himself. Neighbors called 911. When law enforcement and paramedics arrived, the sisters were found down in the living room and pronounced death at the scene. The mother and brother were transported to the hospital and survived their wounds. Samuel was found in the bedroom dead from his self-inflicted wound. The mother had asked Samuel to leave the family home the month before the incident. She broke off their relationship due to his increasingly controlling and paranoid behavior toward her.

Child Homicides by Parent, Caregiver or Other Family Members 2016

Figure 3: Child Abuse Homicides, LA County 1989 - 2016

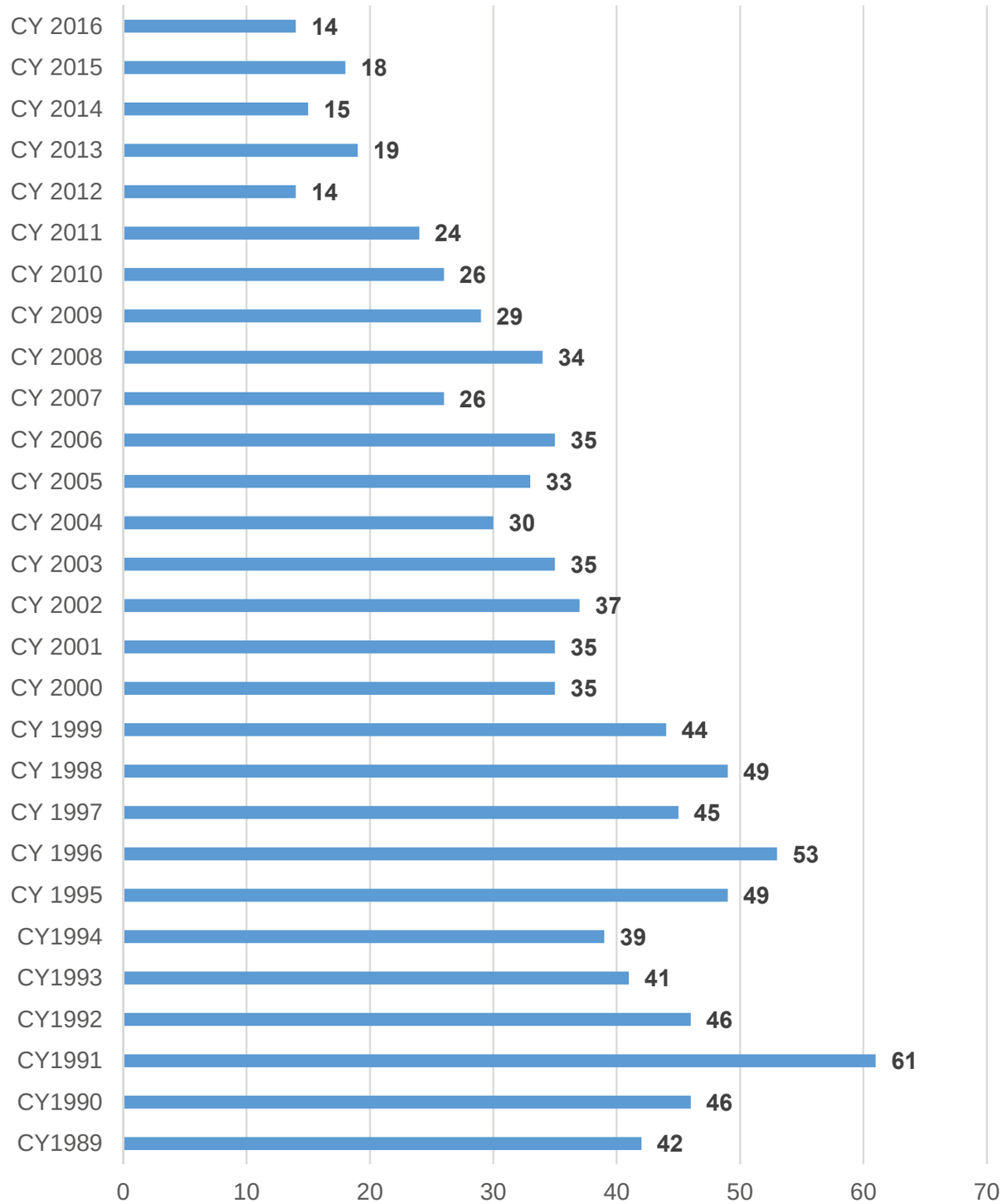


Table 3

Causes of Child Homicide by Parent/Caregiver/Family Member, Los Angeles County 2002– 2016

Cause	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	TOTAL
Head trauma	2	7	7	6	11	11	12	8	2	10	5	3	1	2	5	**92**
Multiple trauma*	7	10	7	8	7	7	4	2	1	6	2	9	5	5	0	**80**
Asphyxiation/suffocation	5	6	5	5	6	6	3	2	3	2	0	1	1	2	0	**47**
Gunshot wounds	1	4	3	6	1	1	8	7	4	2	0	0	1	1	2	**41**
Trauma to torso/abdomen	3	0	0	2	1	1	1	1	5	1	2	1	1	0	0	**19**
Drowning	7	1	1	2	3	3	0	1	2	0	3	1	0	2	1	**27**
Stabbing	2	0	3	2	2	2	2	4	6	1	1	1	4	4	3	**37**
Unattended newborn	2	3	0	2	0	0	1	2	1	0	0	1	0	0	0	**12**
Poisoning/drug ingestion	6	1	1	2	0	0	0	0	0	0	1	1	0	1	2	**13**
Dehydration/malnutrition	0	1	2	0	0	0	1	1	0	1	0	0	1	0	0	**7**
Strangulation	0	0	0	0	1	1	0	0	1	0	1	0	0	0	0	**4**
Fire	0	0	0	0	3	3	1	0	0	0	0	0	0	0	1	**8**
Medical neglect	0	0	0	0	0	0	0	1	1	0	0	0	1	1	0	**4**
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Hyperthermia	0	2	0	0	0	0	1	0	0	0	0	1	1	0	0	**4**
Post-Term gestation	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	**1**
TOTAL *includes auto injuries	**35**	**35**	**29**	**33**	**35**	**35**	**34**	**29**	**26**	**24**	**15**	**19**	**15**	**18**	**14**	**396**

Table 4										
Child Homicide by Parent/Caregiver/Family Member, Los Angeles County 2016 (N= 14)										
Age	**Under 1 year**	**1 year**	**2 years**	**3 years**	**11 years**	**13 years**	**15 years**	**16 years**	**17 years**	**TOTAL**
Female	1	1	1	1	0	1	0	1	0	6
Male	3	2	0	0	1	0	1	0	1	8

57.1% of the child homicide victims by parents/caregivers/family member were two years of age or under. 64.3% of the homicide victims were 3 years of age and under.

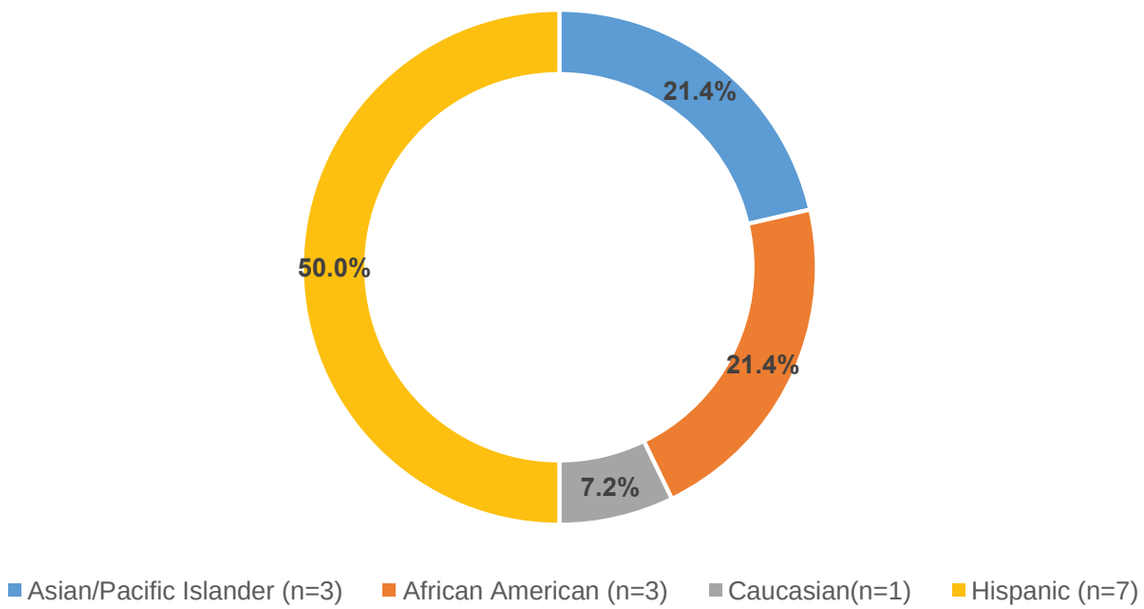
28.6% of the child homicide victims by parents/caregivers/family member were under one year of age.

57.1% of the victims were male and 42.9% were female.

Table 5						
Child Abuse Homicides by Age and Cause, 2016						
Cause	**< 6 Months**	**6 - 11 Months**	**1 - 3 Years**	**3+ - 5 Years**	**6 - 12 Years**	**≥ 13 Years**
Head trauma	2	0	1	0	0	2
Gunshot wounds	0	0	0	0	0	2
Drowning	0	1	0	0	0	0
Stabbing	1	0	2	0	0	0
Poisoning	1	0	0	0	1	0
Fire	0	0	1	0	0	0
TOTAL	**4**	**1**	**4**	**0**	**1**	**4**

Table 6								
Five Year Trend of Child Homicides by Age, 2011 - 2016								
Age	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**TOTAL**	**%**
Under 1 year	13	8	8	3	7	5	**44**	**41.9%**
1 - 2 years	8	3	6	6	6	3	**32**	**30.5%**
3 - 5 years	1	2	2	2	0	1	**8**	**7.6%**
6 - 10 years	2	1	2	2	3	0	**10**	**9.5%**
11 - 17 years	0	1	1	2	2	5	**11**	**10.5%**

Figure 4: 2016 Child Abuse Homicides - Race



Los Angeles Child Population
Ages 0-17 2016: 2,325,837
Hispanic 61.7%, Caucasian 16.9%, African American 7.4% , Asian/Pacific Islander 10.7%, Native Indian/ Alaskan .1% and Multi-racial 3.3% Kidsdata.org

Figure 5: Homicides of Children by Race Compared to the General Population, 2016

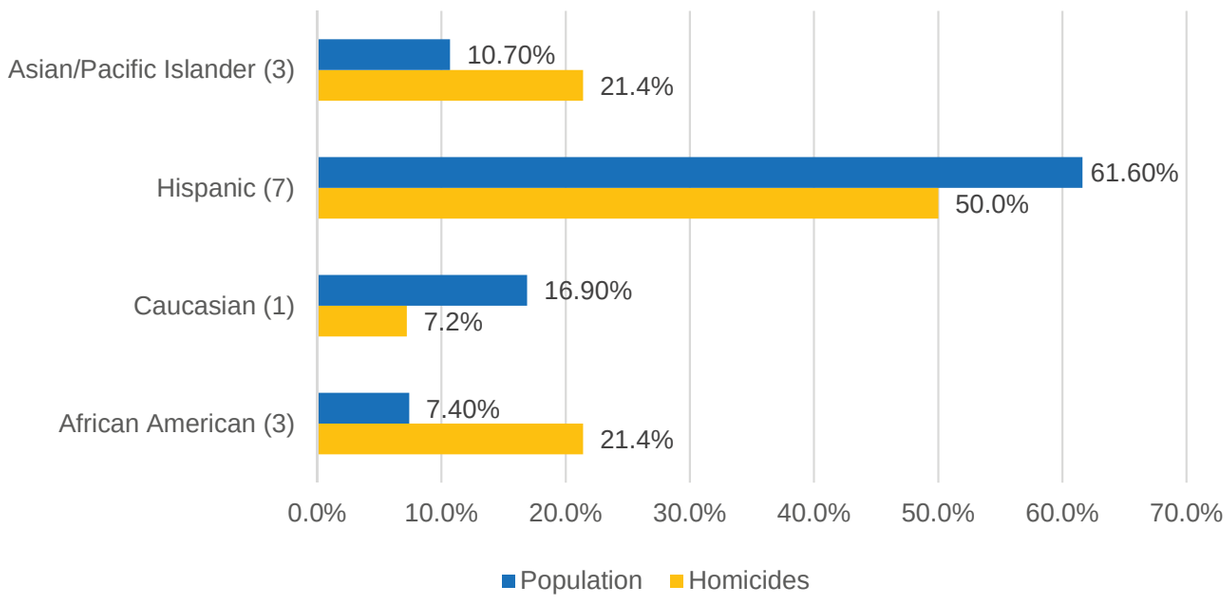


Table 7

Relationship of Suspect to Child Homicide Victim, 2016

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

- 1 – Father
- 6 – Mother
- 4 – Mother's Boyfriend
- 2 – Uncle
- 1 – Babysitter

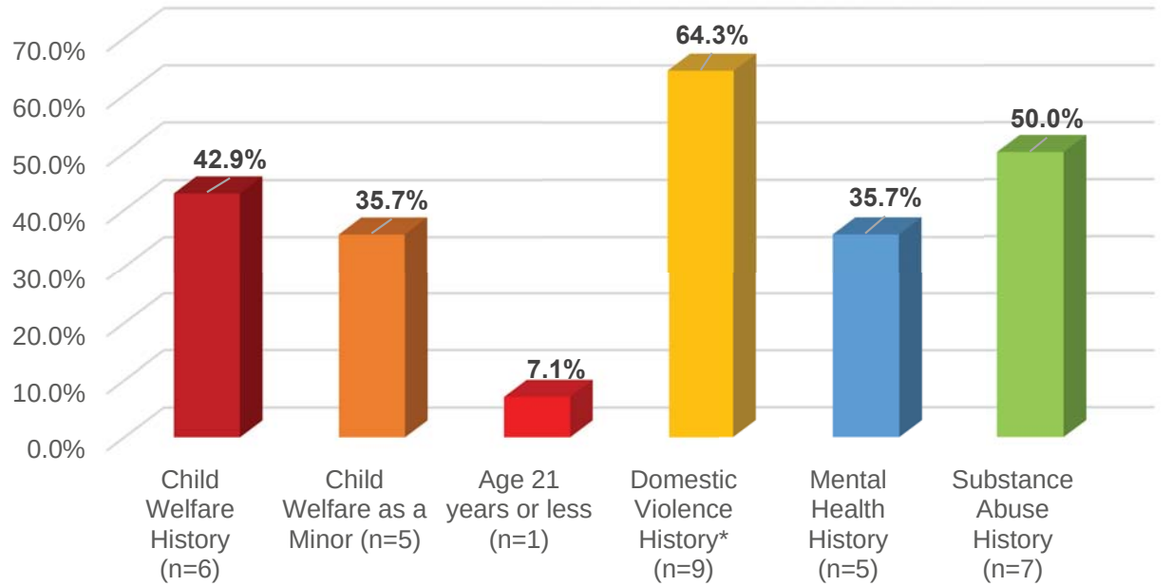
Table 8

Relationship and Age of Suspect to Child, 2016

Relationship	18-21 years	22-25 years	26-30 years	31-40 years	40+ years
Mother's Boyfriend/Stepfather	1	1	0	0	2
Biological Mother	0	3	1	2	0
Biological Father	0	0	0	1	0
Uncle	**0**	**0**	**0**	**0**	**2**
Babysitter	**0**	**0**	**1**	**0**	**0**
Total	**1**	**4**	**2**	**3**	**4**

Child Homicides by Parent, Caregiver or Other Family Members 2016

Figure 6: Risk Factors Associated with Child Homicides (n=14)



The top common characteristic present in families in which a child abuse homicide occurred was a parent(s) and/or perpetrator had a documented history of domestic violence. This was followed by a parent(s) and/or perpetrator having a substance abuse history. Almost 43% of the homicides had a contact with child welfare. A parent or perpetrator had a history of mental illness or contact with the child welfare system as a child with 35.7% of the child homicides.

Child Homicides by Parent, Caregiver or Other Family Members 2016

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 9.

Table 9

Law Enforcement Agency Involvement in 2016 ICAN Child Homicide by Parent/ Caregiver/Family Member

Agency	N	%
LASD	7	50%
LAPD	5	35.8%
Long Beach PD	1	7.1%
Baldwin Park PD	1	7.1%

Los Angeles Sheriff's Department Homicide Bureau had investigative responsibility for half of the child homicides by parent/caretaker/family member with 50% (n=7). The Los Angeles Police Department investigated 35.8% (n=7). Fourteen percent (n=2) of the cases were handled by jurisdictions other than LASD and LAPD.

There were a total of twelve suspects in the fourteen homicide cases. Five of the 2016 cases involving child homicide by parents/caregivers/family member were not presented to the District Attorney. The reasons why those cases were not presented are displayed in Table 10.

In 2016, four of the homicide cases were not submitted to the District Attorney because the perpetrator committed suicide. The second reason for law enforcement not presenting a case was that the case remains under investigation.

Child Homicides by Parent, Caregiver or Other Family Members 2016

Criminal Justice System Involvement (continued)

Table 10

Law Enforcement Reasons for Not Presenting 2016 ICAN Child Homicide by Parent/ Caregiver/Family Member to the District Attorney

	N	%
Under Investigation	1	20%
Murder/Suicide	4	80%
TOTAL	**5**	**100%**

Table 11

Relationship of Perpetrators – 2016 ICAN Child Homicide by Parent/Caregiver/Family Member

Relationship	Charged By District Attorney	%
Mother	3	33.3%
Father	1	11.1%
Mother's Boyfriend	2	22.2%
Uncle	2	22.2%
Babysitter	1	11.1%

In 2016, nine of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving eight perpetrators. The District Attorney filed charges in all nine cases.

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

Child Homicides by Parent, Caregiver or Other Family Members 2016

Criminal Justice System Involvement (continued)

Table 12

Criminal Charges Filed on 2010-2016 ICAN Child Homicide by Parent/Caregiver/ Family Member

	2010	2011	2012	2013	2014	2015	2016
Murder (187 (a) P.C.)	16	13	11	15	13	11	9
Assault on a child under 8 years resulting in death (273ab P.C.)	7	14	8	11	7	3	6
Child abuse leading to death of a child (273a(a) P.C.)	10	8	4	1	6	1	2
Child endangering (273a(1) P.C.)				1	1		
Assault with deadly weapon (245 (A) (1) P.C.)							1
Voluntary manslaughter (192a P.C.)	1	1					1
Involuntary manslaughter (192b P.C.)							
Attempted murder (664/187 (a) P.C.)	3						2
Arson (451(b)							1
Lewd and lascivious acts by force (288(b)(1) P.C.)			5				
Battery (242-243(e) 1 P.C.)	1						
Torture (206 P.C.)	1		1		1	1	1
Mayhem (203 P.C)							
Assault to commit rape/mayhem	1						
Vandalism (594 P.C.)							
Aiding and abetting a designated felony (32 P.C.)	1						
Possession of marijuana for sale (11359 H&S)	1						
Criminal storage of a weapon with access to a child	2						

Table 13

Criminal Case Disposition of 2010 – 2016 Child Homicides[5]

	2010	2011	2012	2013	2014	2015	2016
Life without possibility of parole	2	2	1			1	
80 years to life prison	1	1					
56 years to life prison			1				
50 years to life prison	2	2	1			1	2
40 years to life prison			1			1	
33 years to life prison							1
31 years to life prison					1		
25 years to life prison	7	4	2	5	3	4	3
22 years to life prison				1			
19 years to life prison							
18 years to life prison						1	
17 years to life prison		1					
16 years to life prison		1	1				
15 years to life prison	2	1	1	1	3	1	1
14 years to life prison	1	2					
26 years prison	1		2	1	1		
25 years prison				1	1		
23 years prison						1	
22 years prison					1		1
20 years prison		1	1				
19 years prison		1					
18 years prison			1				
16 years prison					1	1	
14 years prison				1			
13 years prison			2				
12 years prison	1	1					2
11 years prison	2	1	3	2		1	
10 years prison	1	1	1				1
9 years prison			2				
8 years prison	1						
7 years prison		1	1				
6 years prison	1	2	2	2	1		1
5 years prison	1	2		1			1
4 years prison	1				1		1
3 years prison							
3 years jail		1					
1 years jail	1	2	1				
Less than 3 months jail							
Found not guilty		1		1	1		
Dismissed	1		2	2	3		
Arrest warrant	1						
Mental competency hearing							
Pending Trial	0	1	1	5	3	11	9
Pending Further Investigation	3	5	2	4	2	0	0

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

Child Homicides by Parent, Caregiver or Other Family Members 2016

Criminal Justice System Involvement (continued)

Criminal disposition data for 2010 through 2016 is presented in Table 13. The table reflects the year a perpetrator was sentenced and the majority of cases are concluded one to two years after the filing date. Of the 2016 child homicides, only one of those charged had a disposition in 2016 receiving a sentence of 50 years to life in state prison.

In 2016, defendants received the following sentences: Three perpetrators were sentenced to 25 years to life in prison and two sentenced 50 years to life. One perpetrator was sentenced to 15 years to life without the possibility of parole. The remaining sentences varied from 4 to 33 years in state prison.

Three 2010 cases remain declined pending further investigation by law enforcement.

There were convictions for three 2011 defendants in 2016. One was sentenced to 25 years to life without the possibility of parole. Another defendant received 22 years and one 6 years in state prison. One of the 2011 cases filed by the DA remains pending trial as of 2016 and five remain declined pending further investigation.

One of the 2012 cases is pending trial as of 2016 and two remain declined pending further investigation.

Six of the 2013 defendants were sentenced in 2016. One defendant received 50 years to life and another 25 years to life in state prison. The remaining received sentences ranging from 4 to 15 years in state prison. Five of the 2013 cases filed by the District Attorney are awaiting trial.

In 2016, eleven of the 2014 defendants are still awaiting trial. Five were convicted and sentenced. One received 25 years to life, one 15 years to life, one 33 years state prison, one 12 years and the other 5 years of state prison.

Table 14

Child Homicides by Parents, Caregivers or Family Member Child Welfare Involvement 2002 – 2016*

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
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
2014	15	12[13]	7	5	0 – relative caregivers 0 – foster parent
2015	18	13	11	2[14]	0 – relative caregivers 0 – foster parent
2016	14	6	4	2	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[1]

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.

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

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

Table 15

Dates[15] of Child Homicides – 2016

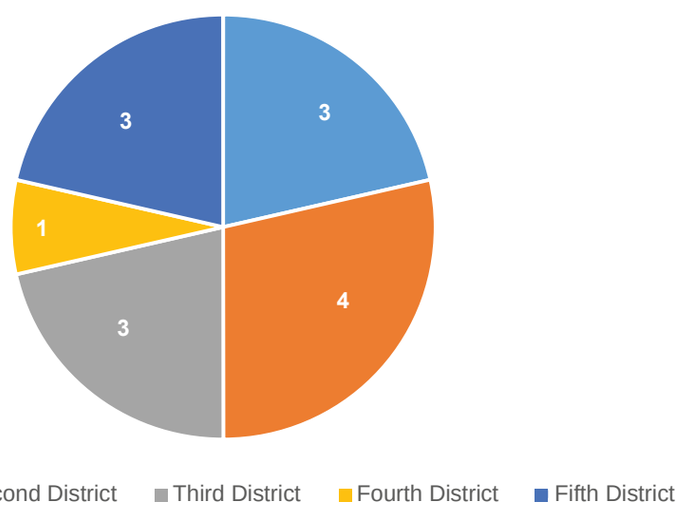
2 homicides occurred in January (two on 01/22/2016)
0 homicides occurred in February
2 homicides occurred in March (03/04 & 3/26/2016)
0 homicides occurred in April
1 homicide occurred in May (05/02/2016)
3 homicides occurred in June (two on 06/11 & one on 06/16/2016)
1 homicide occurred in July (07/16/2015)
1 homicide occurred in August (08/22/2016)
1 homicide occurred in September (09/13/2016)
2 homicides occurred in October (10/03 & 10/2016)
1 homicide occurred in November (11/01/2016)
0 homicides occurred in December

Table 16

Locations[16] of Child Homicides – Geographic Area – 2016

1 homicide occurred in Los Angeles (zip code 90001)
1 homicide occurred in Los Angeles (zip code 90017)
1 homicide occurred in Los Angeles (zip code 90018)
1 homicide occurred in Los Angeles (zip code 90061)
1 homicide occurred in Lynwood (zip code 90262)
1 homicide occurred in Long Beach (zip code 90815)
1 homicide occurred in Baldwin Park (zip code 91706)
1 homicide occurred in La Puente (zip code 91744)
1 homicide occurred in North Hollywood (zip code 91605)
1 homicide occurred in Lancaster (zip code 93534)
2 homicides occurred in Arcadia (zip code 91007)
2 homicides occurred in Panorama City (zip code 91402)

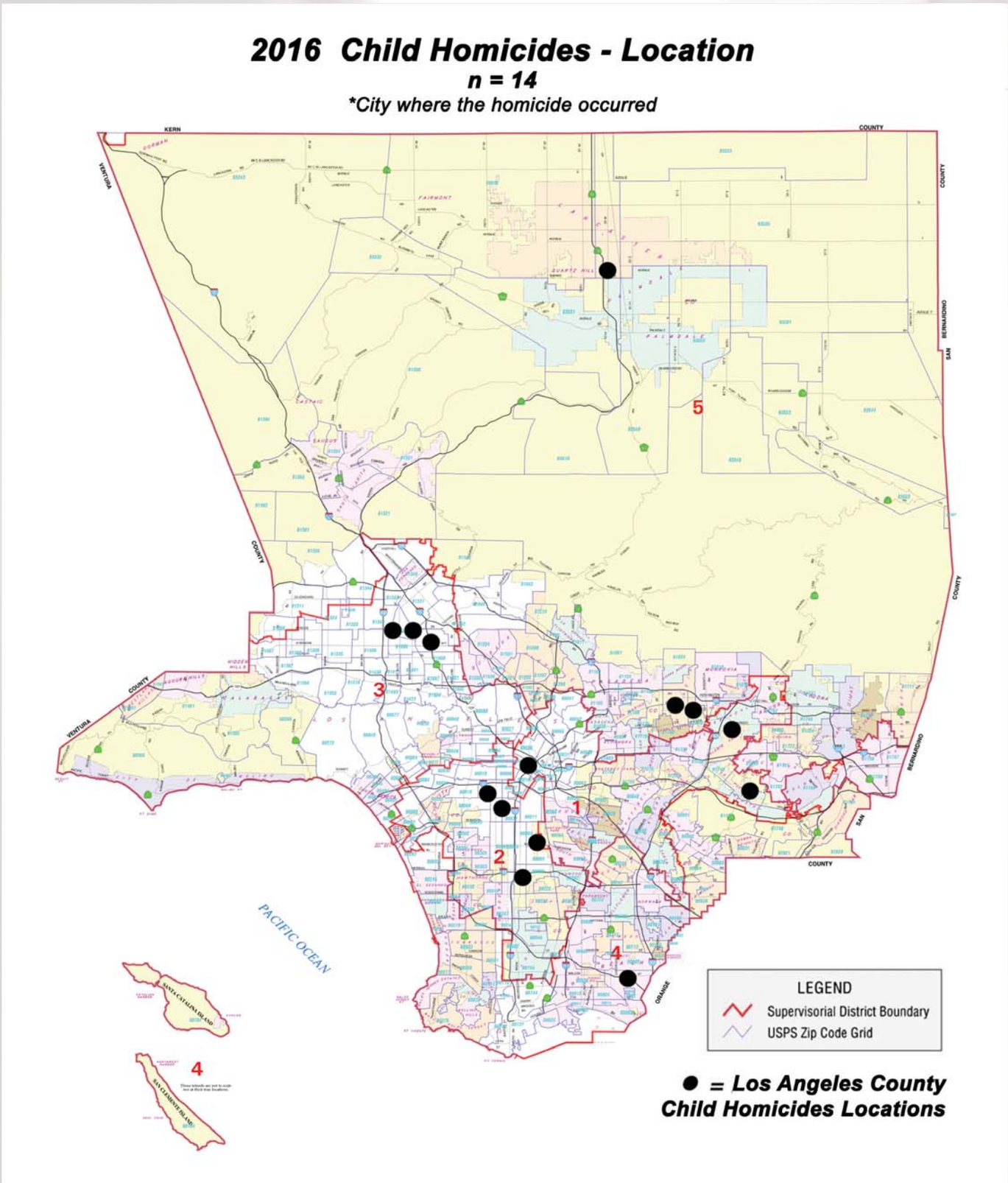
Figure 7: 2016 Child Homicides by Board of Supervisor District



[15] 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.

[16] City where the fatal injury or fatality occurred

Child Homicides by Parent, Caregiver or Other Family Members 2016



Child and Adolescent Suicides 2016

Case Summaries

Carol

Carol was a 13-year-old Caucasian female with a history of anxiety, depression and suicidal thoughts. She also had a history of cutting herself. She had one previous suicide attempt via an overdose of her medication in the past year. She also had several hospitalizations due to her severe depression. Carol was under the care of a psychiatrist and on psychotropic medication for her disorders. Since her attempted overdose, her parents administered and locked up her medication. She left behind several notes stating she was sorry that had been written days before she hung herself in the family garage. She was last seen in bed prior to midnight the night before and was found by her father in the morning. The family was devastated as nothing seemed amiss in her mood as in prior times to her being hospitalized.

Jason

Jason, a 14-year old, an African American male, was found on the ground in a parking lot. It appears he had jumped from the top floor of the four story high parking structure. His father had come home earlier in the day and called Jason to find out where he was away from the home. Jason told him he went for a walk and was on his way home. His father waited up for him but fell asleep. When his father awoke later that night and could not reach Jason by phone, he made a missing person report to police. The father told police Jason was an above average student with no history of depression or suicidal indicators. He had recently started high school and his grades began to slip. When asked if anything was wrong by the father, Jason denied any problems.

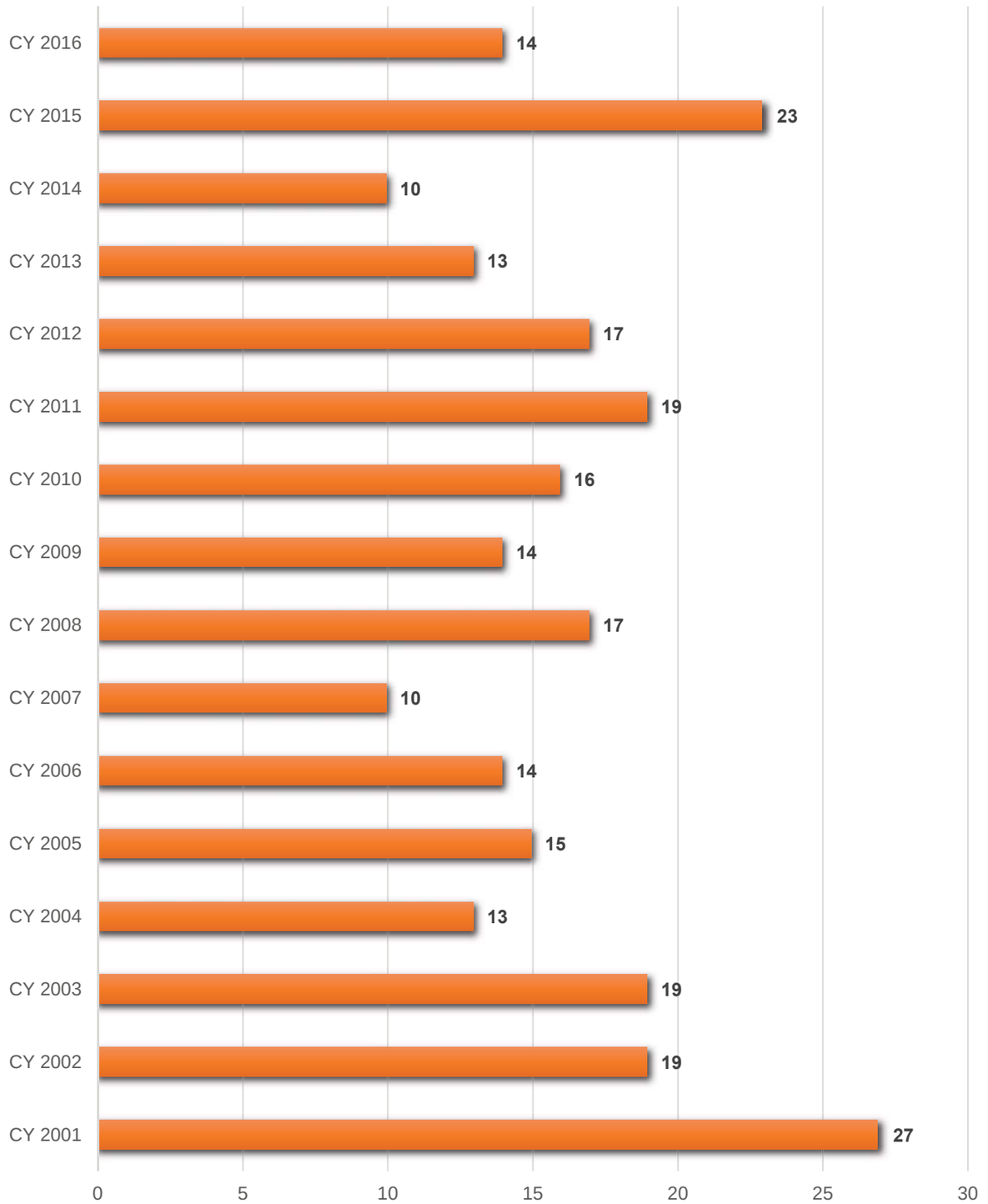
When contacted by police, his mother reported she and the father divorced the prior year and she moved out of the state this past summer. Prior to moving, she took him to counseling because of the divorce and conflict with his siblings. There was no indication from the counseling that Jason had suicidal ideation. She did report Jason had jokingly told a friend he had suicidal thoughts and wanted to jump from a building the day before his suicide. He did not leave a note.

Jose

Jose, a 17 year old Hispanic male hung himself with a belt. He had no history of depression, suicidal ideation or suicide attempts. However, he did have two friends who recently attempted suicide. He had supportive parents who were aware of his identifying himself as bisexual. He was popular with many friends and a girlfriend. His phone revealed texts to his girlfriend that he was depressed but there was no mention of suicide. His girlfriend reported that he had body image issues and they had many conversations regarding his body image. There were pictures on his phone with him wearing make-up and cosmetics. His most recent social media posts included articles on transgender equality. No note was found.

Child and Adolescent Suicides 2016

Figure 8: 2001-2016 Child and Adolescent Suicides



Child and Adolescent Suicides 2016

Table 17		
Child and Adolescent Suicides by Method and Gender, Los Angeles County - 2016 (N = 14)		
Method	**Male**	**Female**
Hanging	6	4
Firearms/Gunshot	2	0
Jump from height	1	0
Overdose	1	0
TOTAL	**10**	**4**

Hanging was the most frequent method of suicide among adolescents and represents 71% of the suicides in 2016. Use of a firearm was the second most frequent method of suicide in 2016 with two. One youth jumped to his death and one walked onto a freeway into traffic.

In 2016, the gender gap between males and females ending their own lives increased with 71.4% (n=10) of the adolescent suicide victims being male and 28.6% (n=4) female.

Table 18							
Five Year Suicide Trend-Gender							
Gender	**2012**	**2013**	**2014**	**2015**	**2016**	**Total 2011-2015**	**5 Year Average**
Male	8	5	6	14	10	43	8.6
Female	9	8	4	9	4	34	6.8
Total	17	13	10	23	14	77	15.4

Figure 9: 2016 Child Suicides - Race

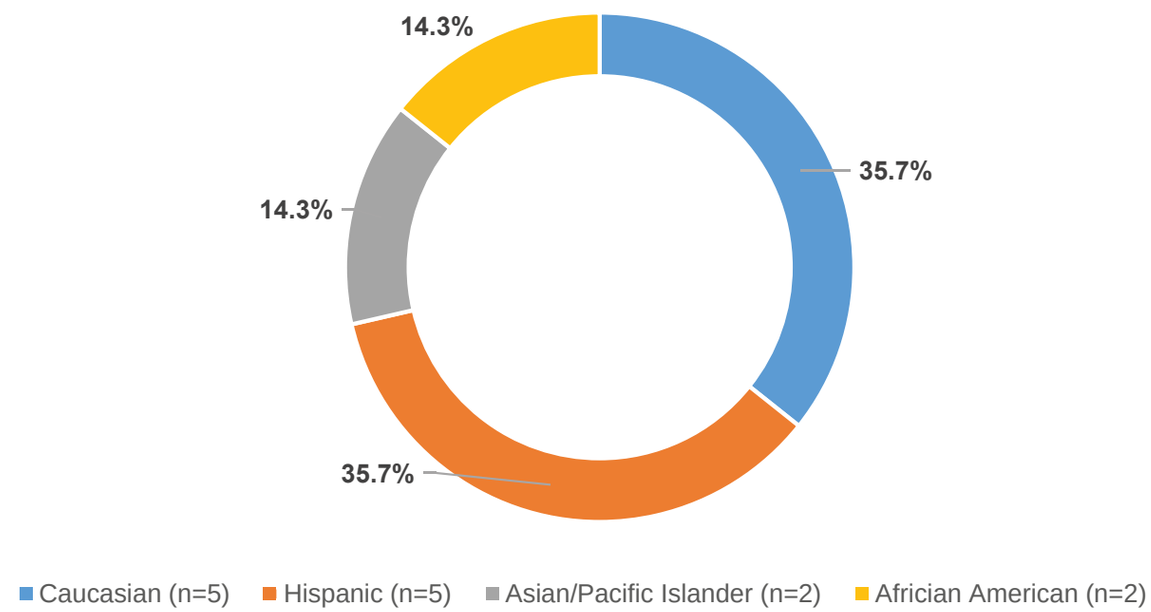
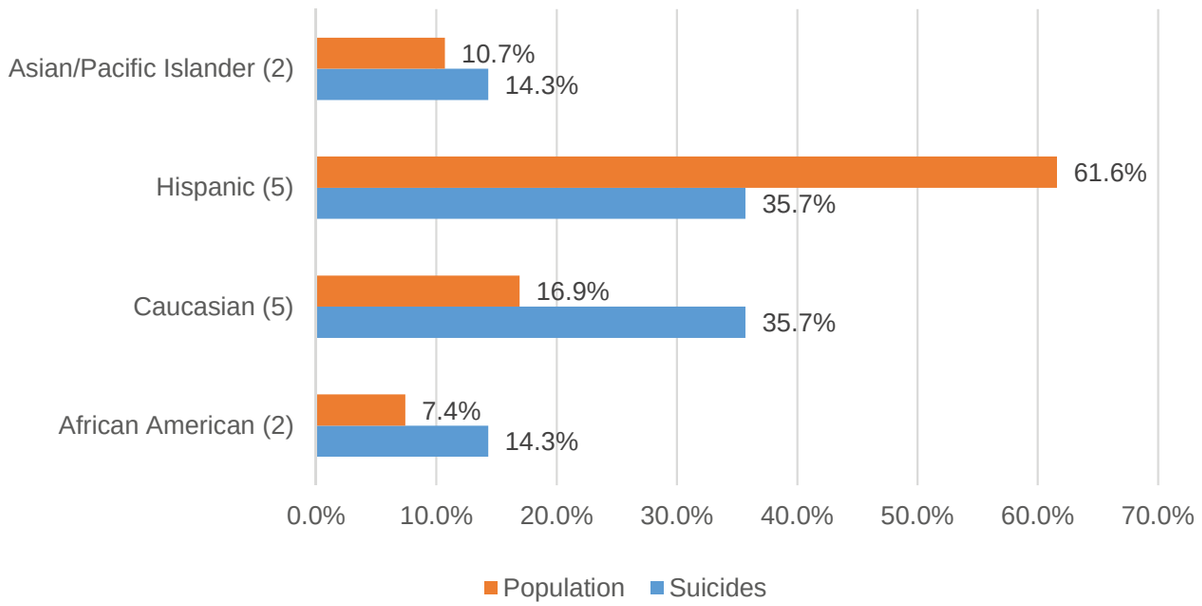


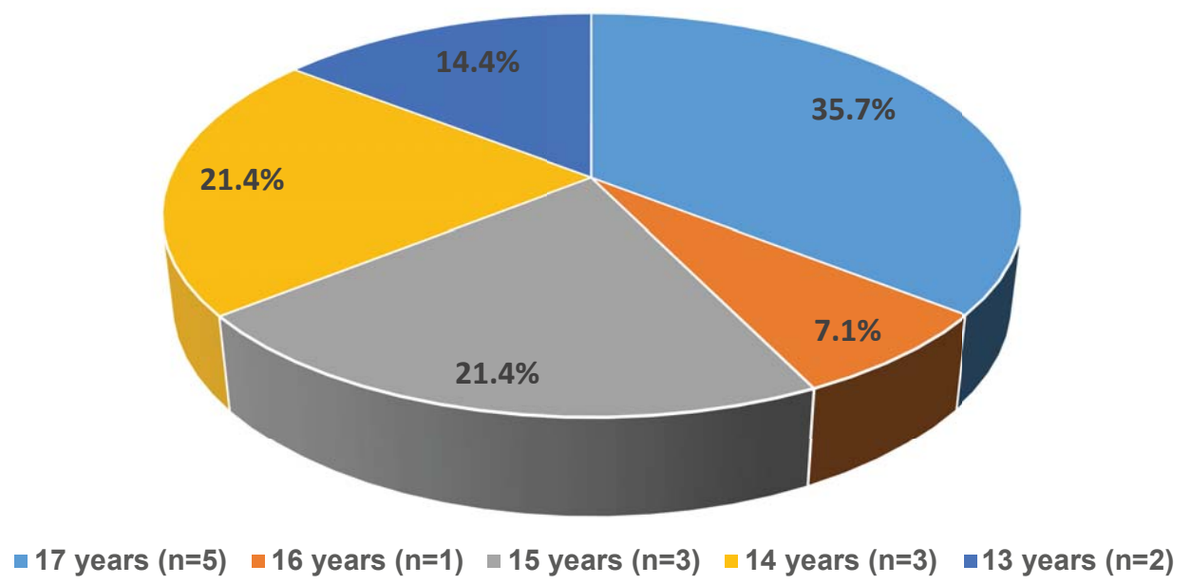
Figure 10: Suicides of Children by Race Compared to General Population - 2016



Child and Adolescent Suicides 2016

Table 19							
Five Year Trend by Age							
Age	**2012**	**2013**	**2014**	**2015**	**2016**	**Total**	**%**
17 years	7	4	1	9	5	26	33.8%
16 years	3	4	2	6	1	16	20.7%
15 years	5	2	0	1	3	11	14.3%
14 years	2	1	3	4	3	13	16.9%
13 years	0	1	2	3	2	8	10.4%
12 years	0	0	1	0.	0	1	1.3%
11 years	0	1	1	0	0	2	2.6%
Total	17	13	10	23	14	77	100%

Figure 11: 2016 Child and Adolescent Suicides - Age



Child and Adolescent Suicides 2016

Figure 12: Percentage of Child and Adolescent Suicide Victim Factors

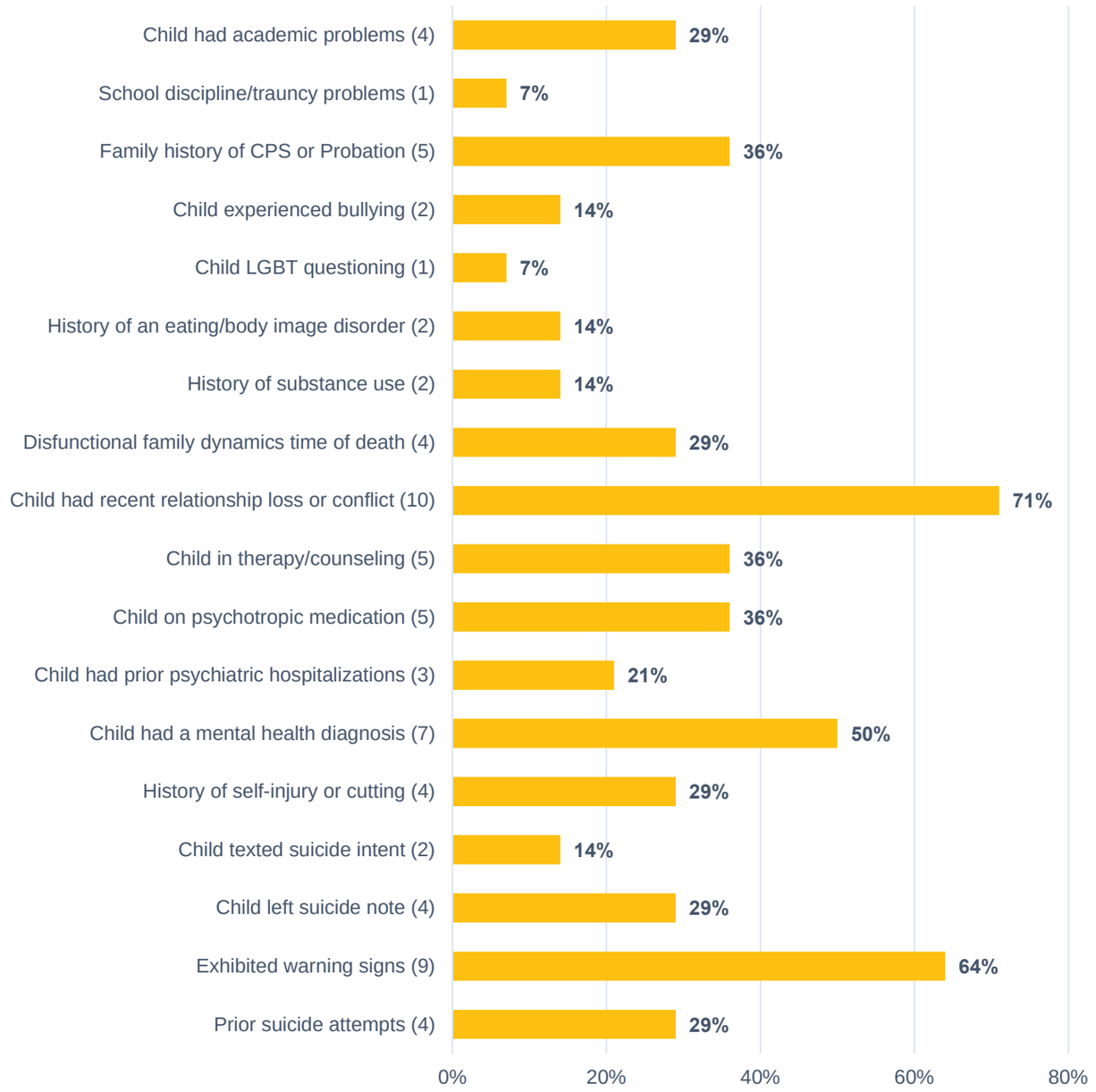


Table 20

Dates of Child and Adolescent Suicides – 2016

1 suicide occurred in January (01/01/2016)

2 suicides occurred in February (02/13 & 02/22/2016)

1 suicide occurred in March (03/06/2016)

0 suicides occurred in April

1 suicide occurred in May (05/18/2016)

2 suicides occurred in June (06/03 & 06/19/2016)

0 suicides occurred in July

3 suicides occurred in August (08/03, 08/09 & 08/31/2016)

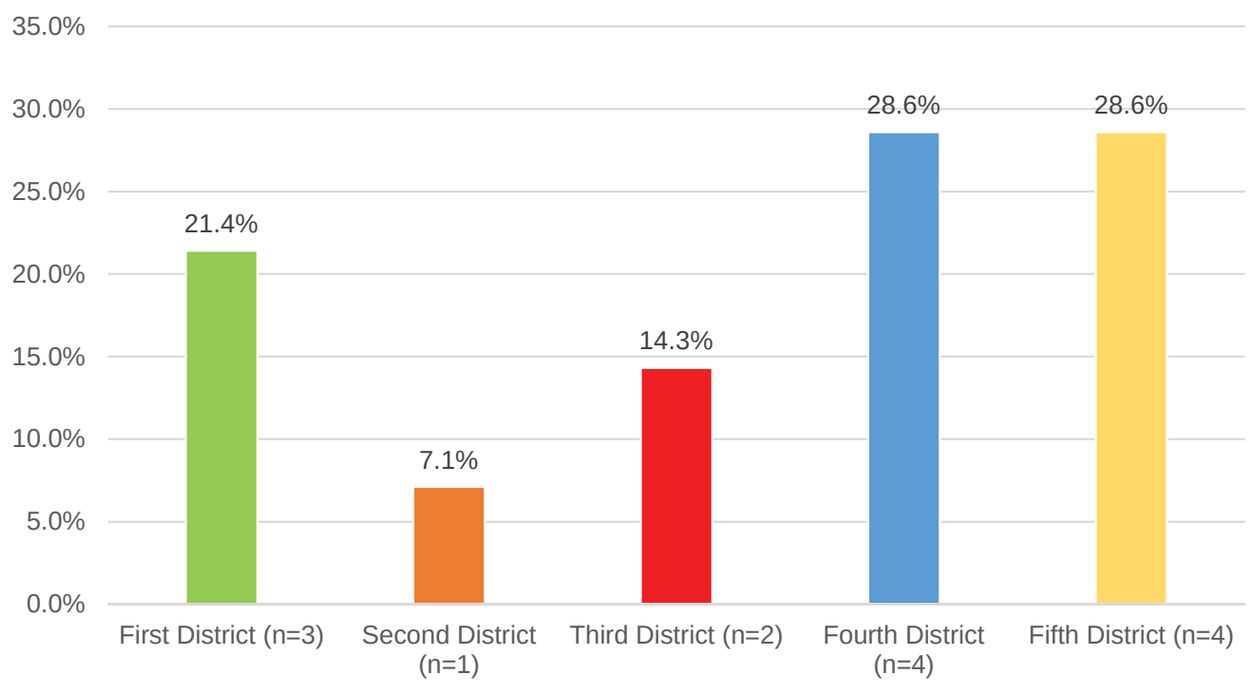
1 suicide occurred in September (09/16/2016)

0 suicides occurred in October

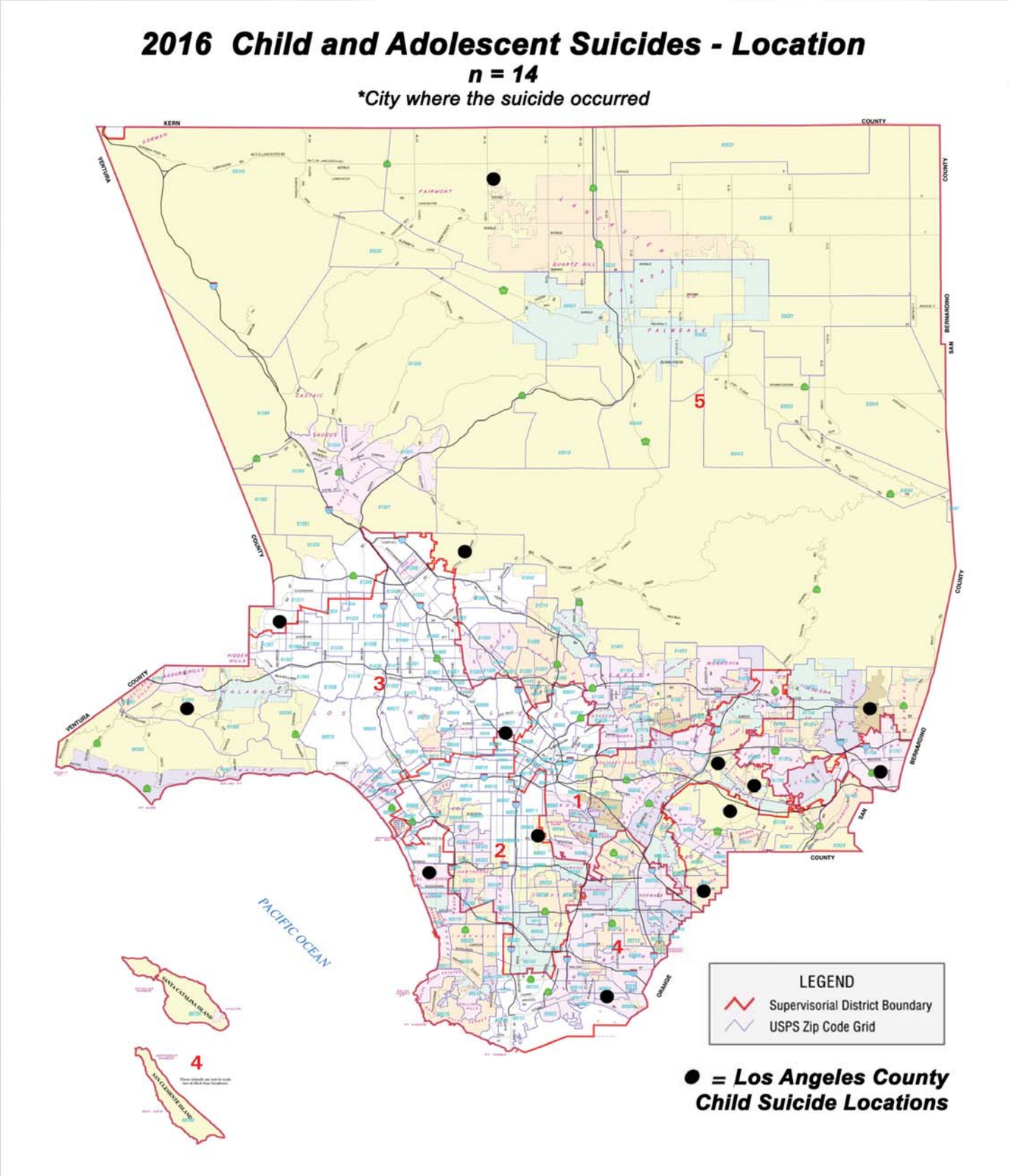
1 suicide occurred in November (11/07/2016)

2 suicides occurred in December (12/13 & 12/20/2016)

Figure 13: Location of Suicide by Supervisor District



Child and Adolescent Suicides 2016



Accidental Child Deaths 2016

Case Summaries

Karen

Seventeen-year-old female Karen had a history of substance abuse. She was known to abuse heroin, methamphetamines and prescription pills. She was using methamphetamine while out with a friend during the day. Later in the night, she took some prescription pills, drank a couple of beers and snorted a white powder. She and her friend smoked some cigarettes and went to sleep. The next morning, Karen was found unresponsive in bed. Paramedics were called and pronounced her death at the scene.

Neal

China, age 22 years presented to the ER with decreased fetal movement for the past week. She had not received any prenatal care and admitted to methamphetamine, marijuana and tobacco use. She was currently homeless and had poor hygiene. She spontaneously delivered stillborn baby Neal at 36 weeks. China's first born child had also been born substance exposed and was in the custody of a relative under the supervision of DCFS.

James

Three year old James was with his mother and sister at a friend's pool party. The party was ending so she took James to the bathroom. She told him to wait for her by the door while she helped his older sister in the bathroom. When she came out, James was gone. His mother searched the home and then went outside but did not see him. She went to the pool and saw him at the bottom near the deep end. She jumped in and pulled him out while the friend called 911. Paramedics arrived and he was taken to the hospital. Despite all the life saving efforts, James could not be resuscitated. There was a fence around the pool but it was unknown if the gate was locked at the time of the incident.

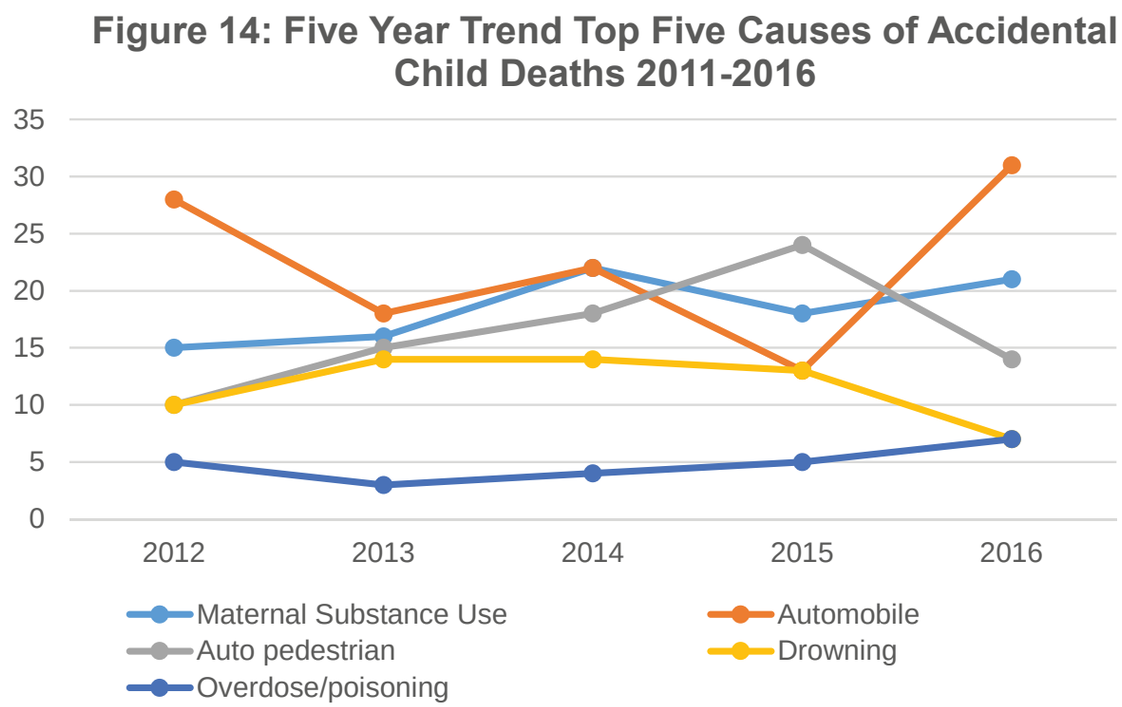
Andrew

Seventeen-year-old Andrew took his parent's car without permission and picked up a friend. Both youths were driving around and drinking alcohol. The car was driving at a high rate of speed and California Highway Patrol (CHP) began to pursue them to conduct a stop. The car began to slow as if it was pulling over, but then started to accelerate again at a high rate of speed. CHP were in pursuit for about a mile when Andrew lost control of the car and stuck a light pole. He was transported to the hospital with multiple traumatic injuries and remained in a coma until his death four days later. His friend survived the crash.

Maria

Nine-year-old Maria and her mother had gotten on the wrong bus. They departed at the next stop and in an effort to catch the correct bus across the street, crossed against traffic controls and outside a crosswalk. Maria was struck by a car going about 40 miles per hour. The driver stopped and rendered aid. Unfortunately, she had sustained a fatal head injury and was pronounced dead at the scene. Her mother was not injured.

Accidental Child Deaths 2016



The chart above depicts the top five causes of accidental child death over a five year period from 2012 to 2016. Maternal substance use and overdose/poisoning deaths have been slowly increasing. Drowning deaths have been decreasing over the five year period. There was a large increase in automobile related deaths from 2015 in 2016. Auto pedestrian child deaths had been increasing but decreased in 2016 from 2015. The "top five" causes - auto pedestrian (includes roll over), prenatal substance abuse automobile, drowning and overdose/poisoning accounted for 84.2% of all accidental child deaths in 2016.

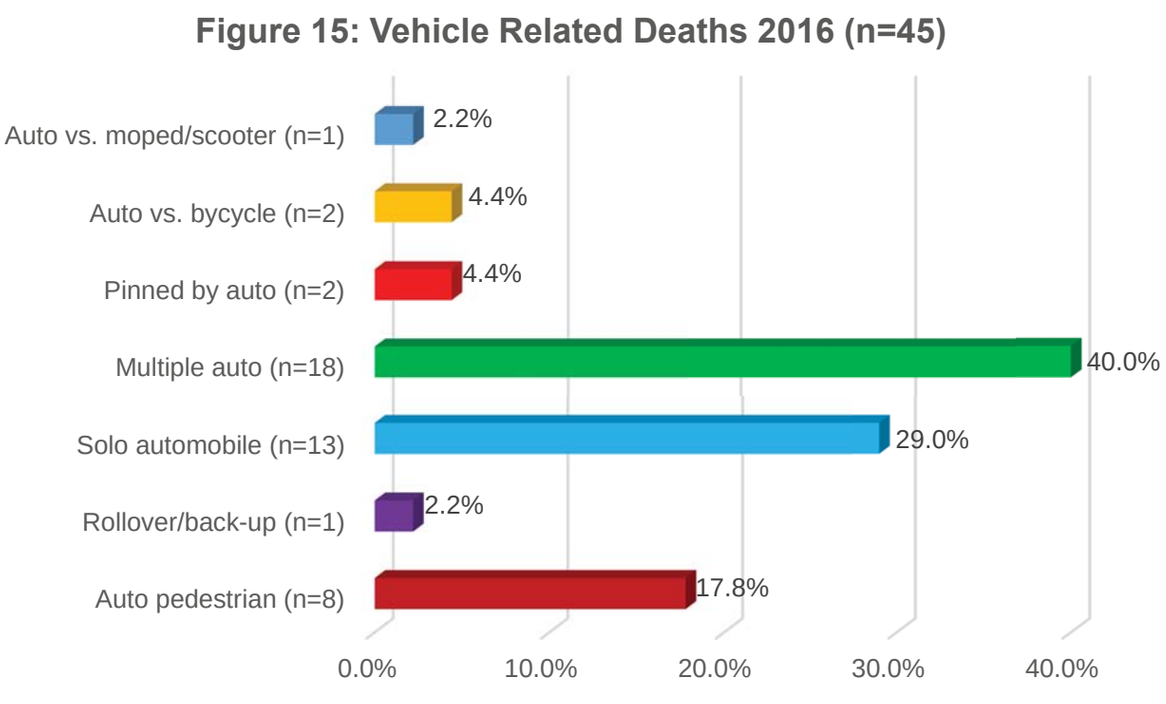


Figure 16: Motor Vehicle Related Deaths by Position of Decedent, 2016 (n=45)

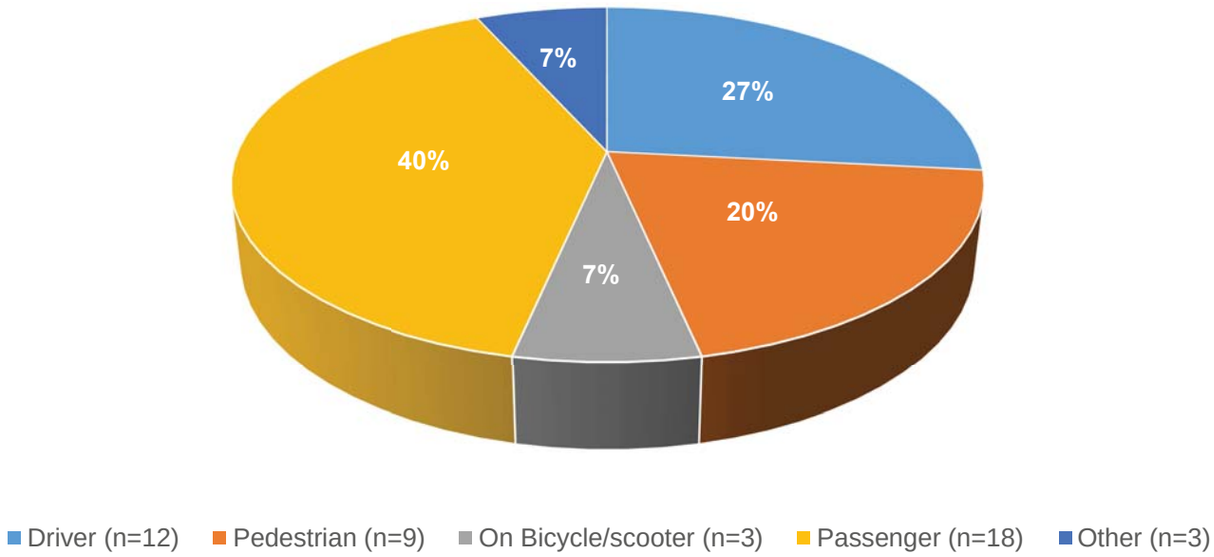


Table 21

Causes of Accidental Child Deaths Ages 0 - 17, Los Angeles County 2016 (N=95)

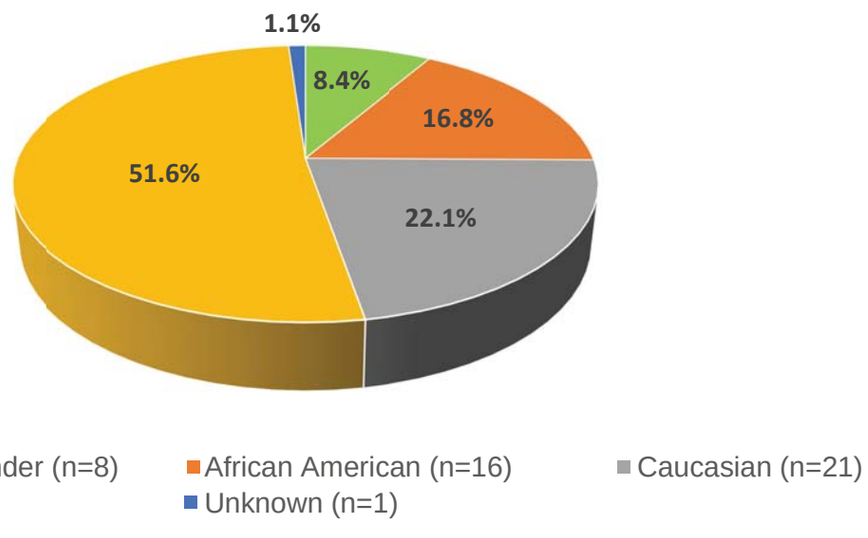
	N	%
Automobile – multi-vehicle	19	20.0%
Automobile – solo vehicle	12	12.6%
Auto pedestrian	13	13.7%
Auto rollover	1	1.00%
Prenatal Substance Abuse	21	22.1%
Drowning	7	7.3%
Fall	2	2.0%
Fire	2	2.0%
Overdose/Poisoning	7	7.3%
Medical mishaps	4	4.2%
Hit by and Object	1	1.0%
Unsafe/Co-sleep	1	1.0%
Choking	2	2.0%
Sharp Object	1	1.0%
Gunshot Wound	1	1.0%
Bicycle vs. wall	1	1.0%
TOTAL	**95**	**100%**

Accidental Child Deaths 2016

Table 22			
Causes of Accidental Child Deaths by Age, Los Angeles County 2016 (N = 95)			
	Age 0 - 5 Years	**Age 6 -14 Years**	**Age 15 - 17 Years**
Automobile – multi-vehicle	12	2	5
Automobile – solo vehicle	0	2	10
Auto pedestrian*	4	2	8
Prenatal Substance Abuse	21	0	0
Drowning	3	2	2
Fall	1	0	1
Fire	2	0	0
Overdose/poisoning	0	1	6
Medical mishaps	4	0	0
Hit by object	0	1	0
Unsafe/Co-sleep	1	0	0
Choking	2	0	0
Sharp Object	1	0	1
Gunshot Wound	0	0	1
Bicycle vs. wall	0	1	0
TOTAL	50	11	34

*includes rollover, moped, scooter and bike

Figure 17: 2016 Accidental Child Deaths - Race



Accidental Child Deaths 2016

Table 23		
Causes of Accidental Child Deaths by Gender, Los Angeles County 2016 (N = 95)		
	Female	**Male**
Automobile – multi-vehicle	9	10
Automobile –single	7	5
Auto rollover	1	0
Auto Pedestrian*	5	8
Drowning	2	5
Overdose/poisoning	3	4
Prenatal Substance Abuse	9	12
Medical mishaps	0	4
Hit by object	1	0
Fire	0	2
Fall	0	2
Choking	0	2
Sharp Object	0	1
Unsafe/Co-sleep	0	1
Gunshot Wound	0	1
Bicycle vs. wall	0	1
TOTAL	**37**	**58**

Figure 18: Accidental Child Deaths 2016 - Child Welfare History

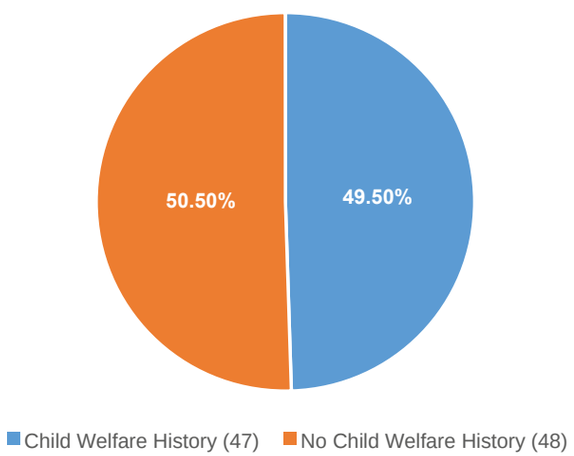


Figure 19: Accidental Child Deaths Associated with Prenatal Substance Abuse and Child Welfare History

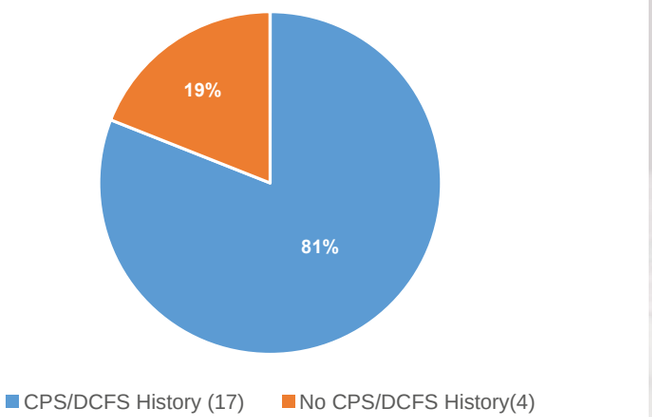


Table 24		
Accidental Child Deaths Associated with Prenatal Substance Abuse (PSA), Los Angeles County 2016 (N=21)		
Race	**Number of PSA Deaths**	**Percentage**
African American	5	23.8%
Asian/Pacific Islander	1	4.8%
Caucasian	4	19%
Hispanic	9	42.9%
Unknown	2	9.5%
Gender		
Female	9	42.9%
Male	12	57.1%
Age		
Stillborn or less than 1 day	18	85.7%
1 day to 30 days	2	9.5%
1 - 2 Months	1	4.8%
Substance		
Methamphetamines	9	42.9%
Opiates	1	4.8%
Cocaine	1	4.8%
Methamphetamine and opiates	3	14.2%
Methamphetamine and cocaine	3	14.2%
Methamphetamine and marijuana	3	14.2%
Methamphetamine and MDMA	1	4.8%

Table 25		
Causes of Accidental Deaths with Child Welfare History, 2016 (N=47)		
	Number	**Percentage**
Automobile	8	17%
Auto pedestrian*	6	12.8%
Drowning	2	4.2%
Overdose/poisoning	6	12.8%
Prenatal Substance Abuse	17	36.2%
Fire	2	4.3%
Fall	2	4.3%
Gunshot Wound	1	2.1%
Hit by object	1	2.1%
Unsafe/Co-sleeping	1	2.1%
Bicycle vs. wall	1	2.1%
TOTAL	47	100%

*includes house hit by car

Undetermined Child Death 2016

Case Summaries

Jessica - Stillborn

Jessica was born via an emergency c-section at 32 weeks when fetal demise was determined due to blunt force abdominal trauma including uterine rupture. Her mother, age 27 years came to the emergency room complaining of abdominal pain. Upon admission, it was learned she was beaten by her boyfriend the day before. Jessica was born with no signs of life. Jessica's mother underwent additional surgery for a lacerated spleen and liver. She also tested positive for marijuana and methamphetamine. Jessica's mother had a history with DCFS and had lost custody of her oldest child. Jessica's mother later denied she had been beaten, but hospital staff felt her trauma was consistent with an automobile accident or domestic violence incident.

Unsafe Sleep Practices/Environments

Andrew – Age 3 months

After feeding Andrew in the middle of the night, his mother swaddled him in a fleece blanket and placed him prone with his head turned to the side in his crib. When she awoke the next morning, he was found face down in the mattress and unresponsive. He was cool to the touch, but there was no liquid noted near his mouth or nose. His mother called 911 and began CPR. Paramedics responded and could not revive him. His crib was observed to have a bumper, several stuffed animals and pillows.

Tommy – Age 2 months

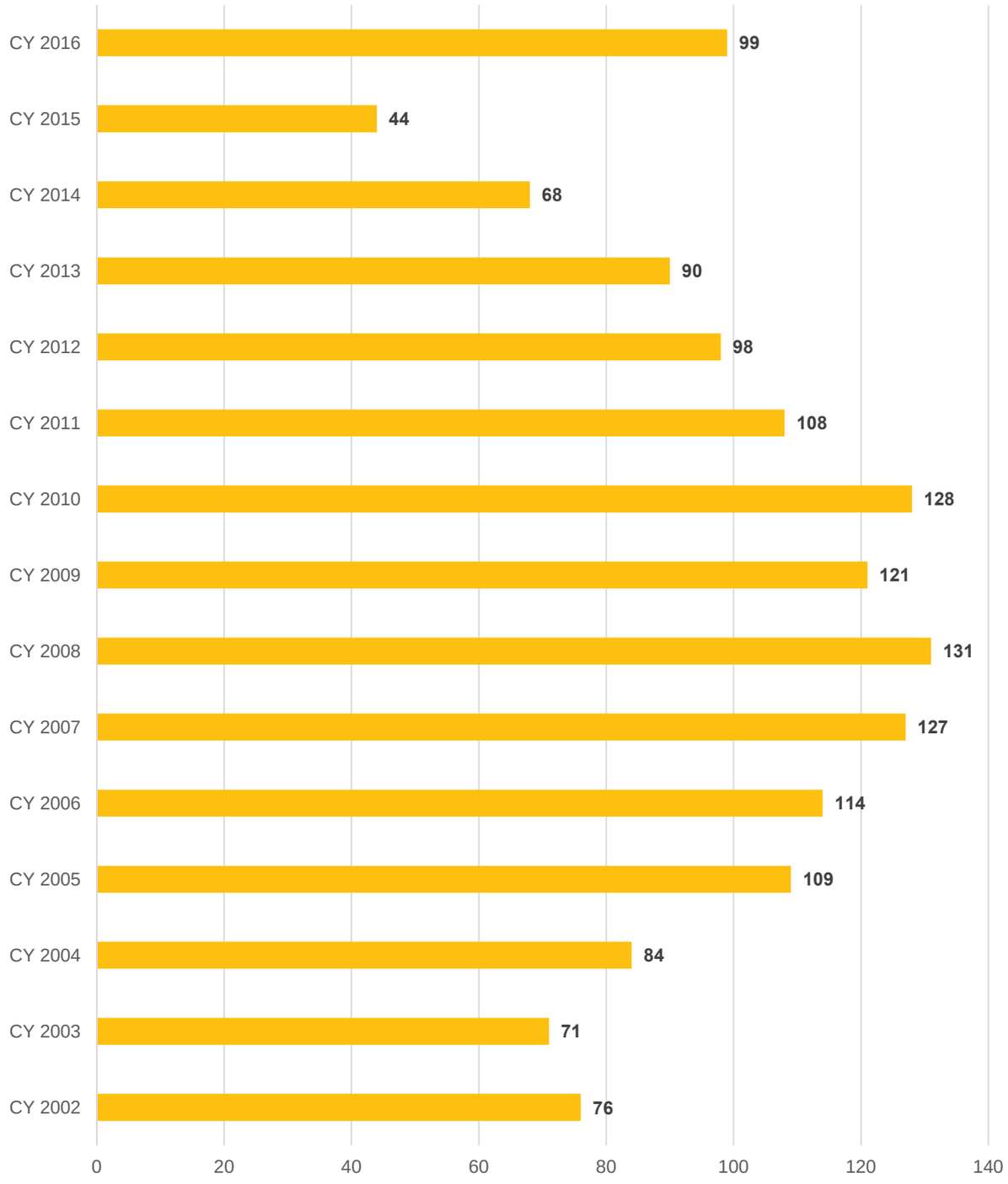
Tony normally slept in his bassinet next to his parent's bed. At midnight, Tommy's mother was asleep in bed when he woke up and started to cry. His father picked him up placed him in bed with him holding him in his arms. He held him rubbing his stomach and both fell asleep. At 5:30 AM, the father awoke and checked on Tony. Tony was face down on top of the comforter and unresponsive. 911 was called and CPR started by his mother. Paramedics arrived and pronounced his death at the home.

Eric – 4 months

Eric's mother breast fed him and placed him on her queen size bed for a nap. She laid him on his side against a long body pillow to prop him up. She placed a blanket to his mid-abdomen. She then went into the kitchen to cook breakfast for the family. Two hours later, his father checked on him and re-adjusted the body pillow. She heard him fussing about a half hour later and went to wake him ten minutes later. She found him underneath the body pillow, limp, ashen in color and with clear liquid seen under his nose and mouth. His father performed CPR until the paramedics arrived and transported him the ER. He was never resuscitated and pronounced dead shortly after his arrival to the ER.

Undetermined Child Death 2016

Figure 20: 2002 - 2016 Undetermined Child Deaths



Undetermined Child Death 2016

Table 26		
Undetermined Child Deaths – 2016 (N=99)		
Race	**Number**	**Percentage**
American Indian	2	2.0%
African American	24	24.2%
Asian/Pacific Islander	8	8.2%
Caucasian	24	24.2%
Hispanic	38	38.4%
Unknown	3	3.0%

Gender	Number	Percentage
Female	33	33.3%
Male	66	66.7%

Age	Number
Stillborn	8
Less than 1 day	3
1 day to 30 days	12
1 month to 5 months	48
6 months to 1 year	13
1 year to 2 years	11
15 years	2
16 years	1
17 years	1

72% of the undetermined child deaths were under six months of age.

85% of the undetermined child deaths were age one year or under.

Undetermined Child Deaths

Bed-sharing and Unsafe Sleeping Environment (N = 47)

Figure 21: Five Year Trend Bed-sharing/Unsafe Sleep Child Deaths

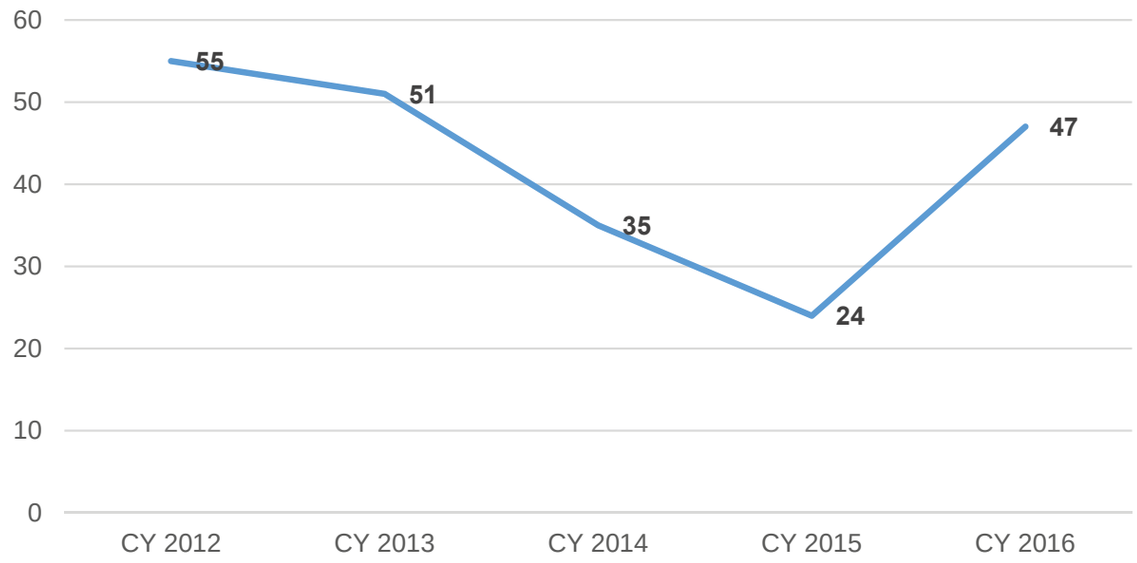


Figure 22: Bed-sharing and Unsafe Sleeping Undetermined Child Deaths 2016

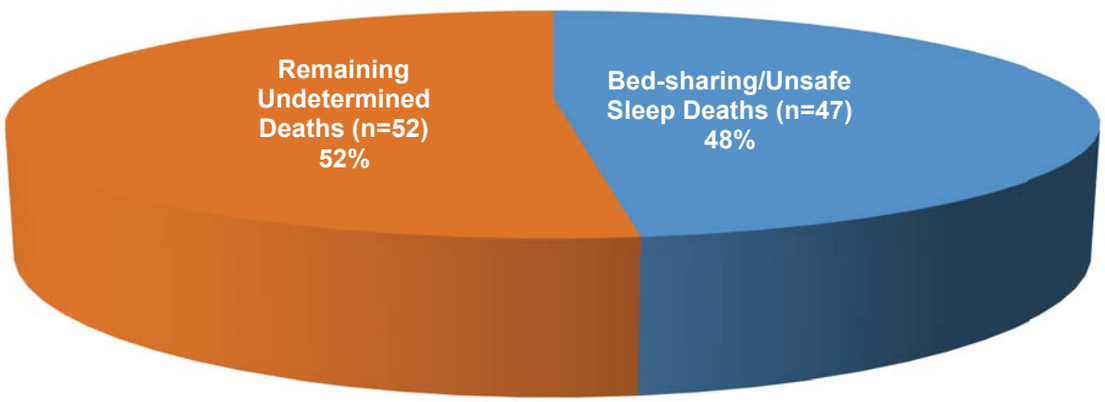


Figure 23: Unsafe Sleep and Bed-shatring Child Deaths Compared to Remaining Undetermined Child Deaths 2016

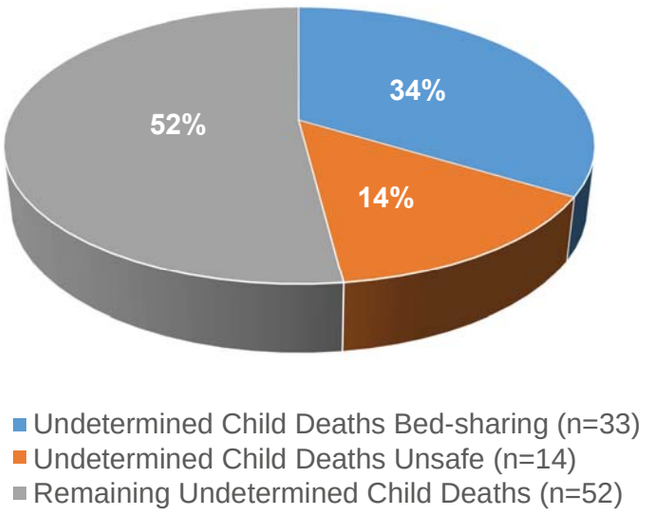


Figure 24: Bed-sharing and Unsafe Sleep Child Deaths by Board of Supervisor District - 2016

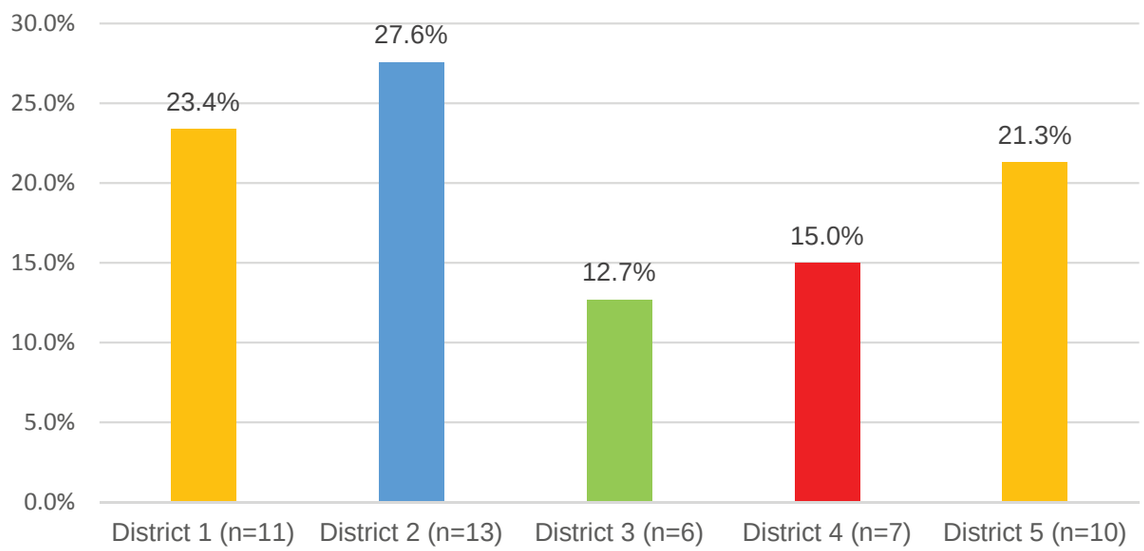


Table 27		
Bed-sharing and Unsafe Sleeping Environments- Number of Risk Factors Present at Time of Death		
Bed-sharing* (N=33)	**Number**	**Percentage**
One Unsafe Risk Factor	0	0%
Two Unsafe Risk Factors	21	63.6%
Three or more Unsafe Risk Factors	12	36.4%

Unsafe Sleeping Environment** (N=14)	Number	Percentage
One Unsafe Risk Factor	0	0%
Two Unsafe Risk Factors	10	71%
Three or more Risk Factors	4	29%

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

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

Figure 25: Sleep Surface - Unsafe and Bed-sharing Deaths - 2016

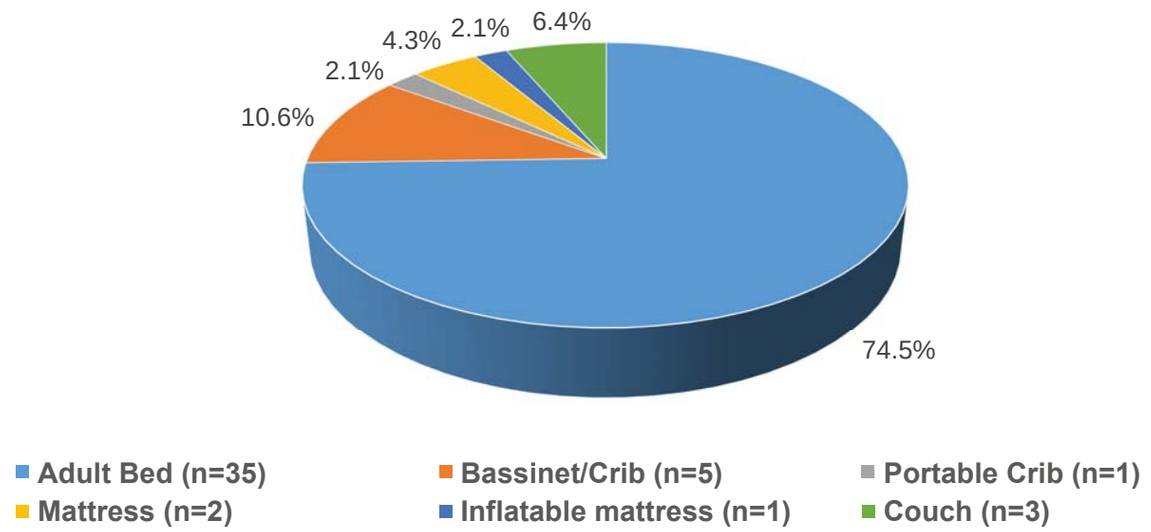


Figure 26: Sleep Position All Unsafe Sleep Practice Deaths

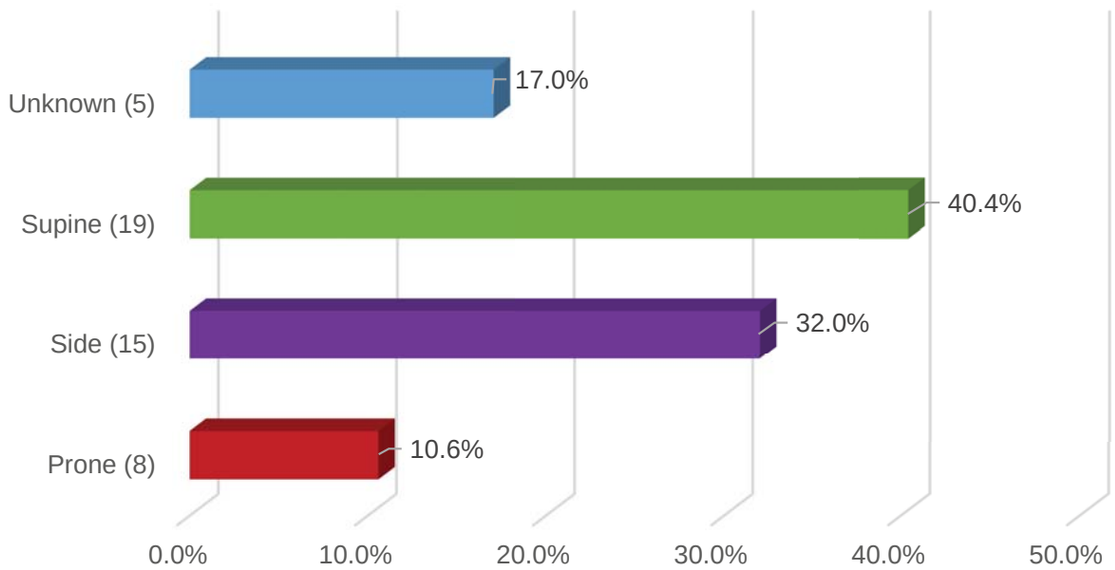


Table 28	
Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 47)	
	Number
Pillow(s)	14
Soft and/or excessive bedding	9
Excessive Swaddling	6
Stuffed animals/toys	1
Parental Drug/Alcohol Use**	3

*Excludes bed-sharing, sleep surface and infant position

**Methamphetamine was found at autopsy in one infant.

Table 29		
Bed-sharing and Unsafe Sleeping Environment Child Welfare History		
	Number	**Percentage**
Total Unsafe Sleep/Bed-sharing	47	100%
Total Unsafe Sleep/Bed-sharing with Child Welfare History	18	38%

Bed-sharing

Figure 27: Percentage of Undetermined Child Deaths - Bed-sharing at the Time

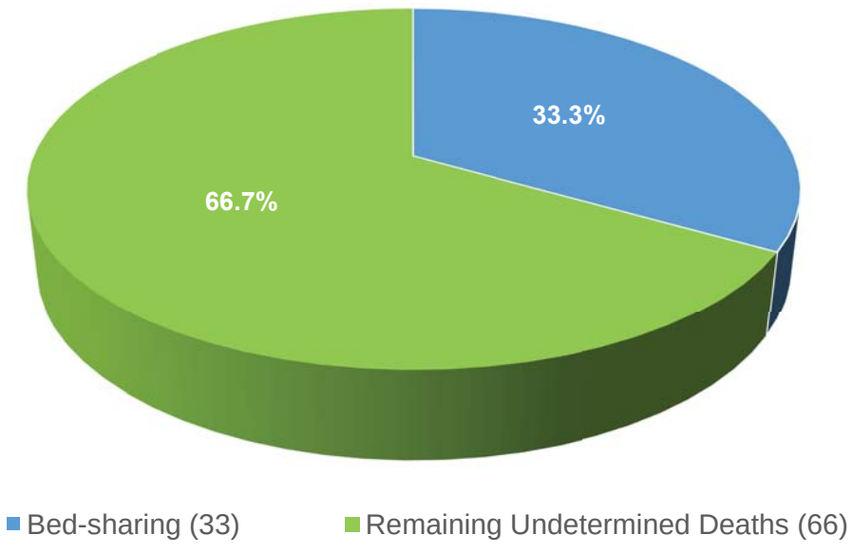


Figure 28: 2016 Bed-sharing Deaths - Number of Persons Sleeping with Child

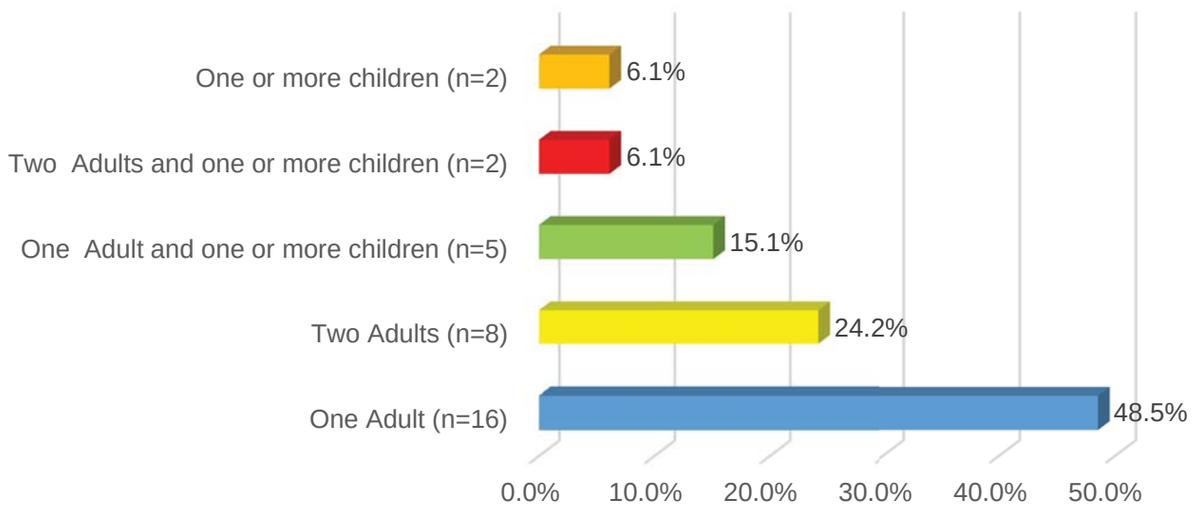


Figure 29: 2016 Undetermined Bed-sharing Child Deaths - Age

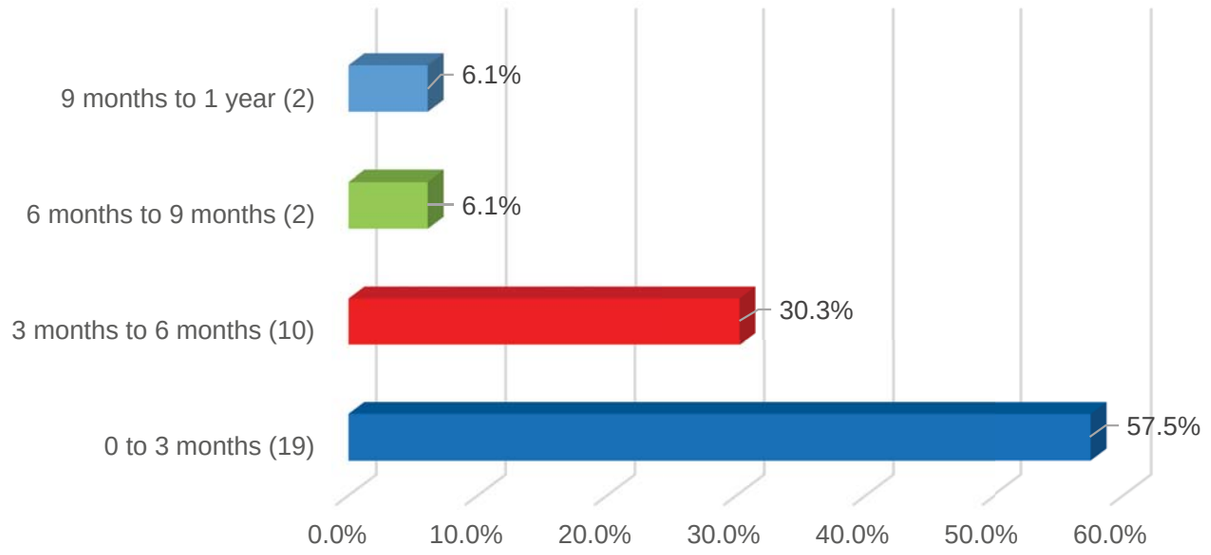
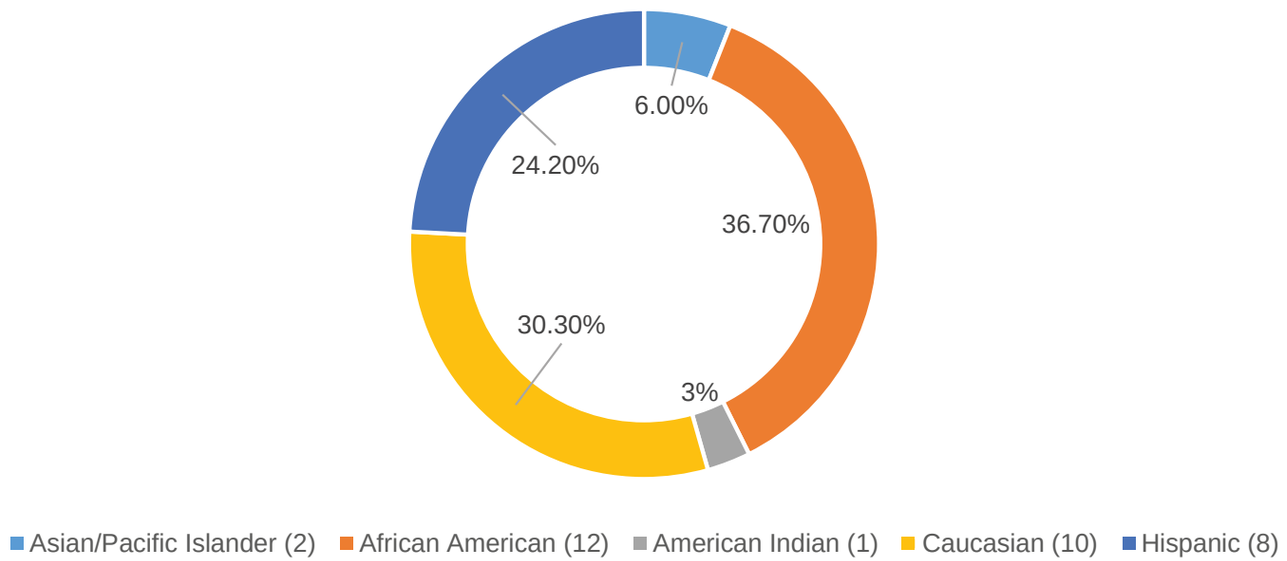


Figure 30: 2016 Bed-sharing Child Deaths - Race



Non-Bed-Sharing Unsafe Sleeping Practices

Figure 31: 2016 Non-bed-sharing Unsafe Sleeping Deaths - Age

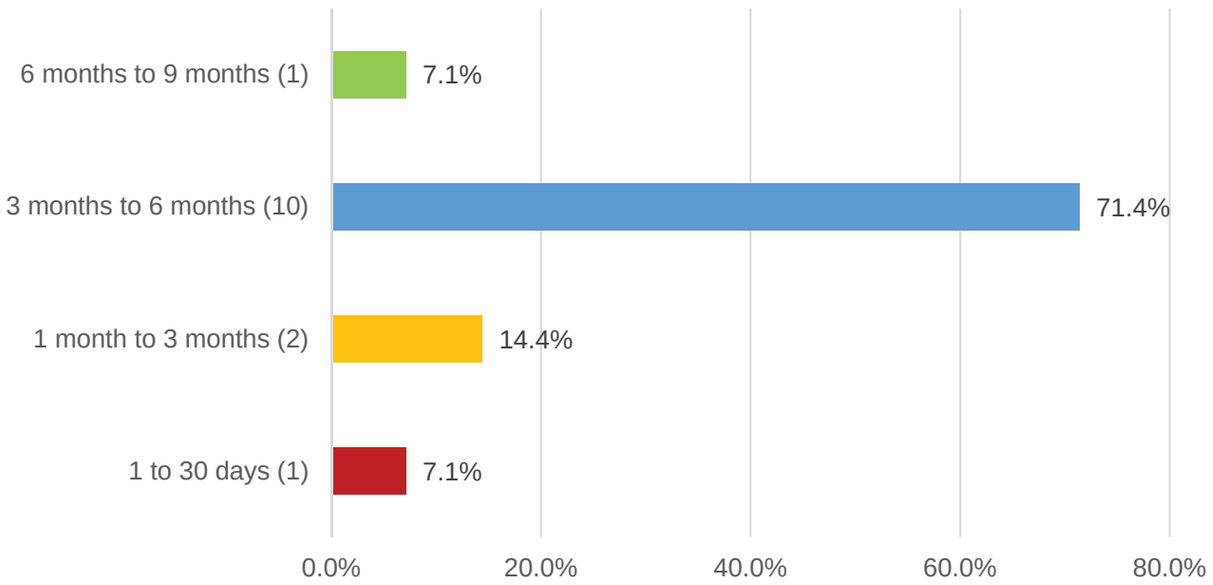


Figure 32: 2016 Non-bedsharing Unsafe Sleep - Race

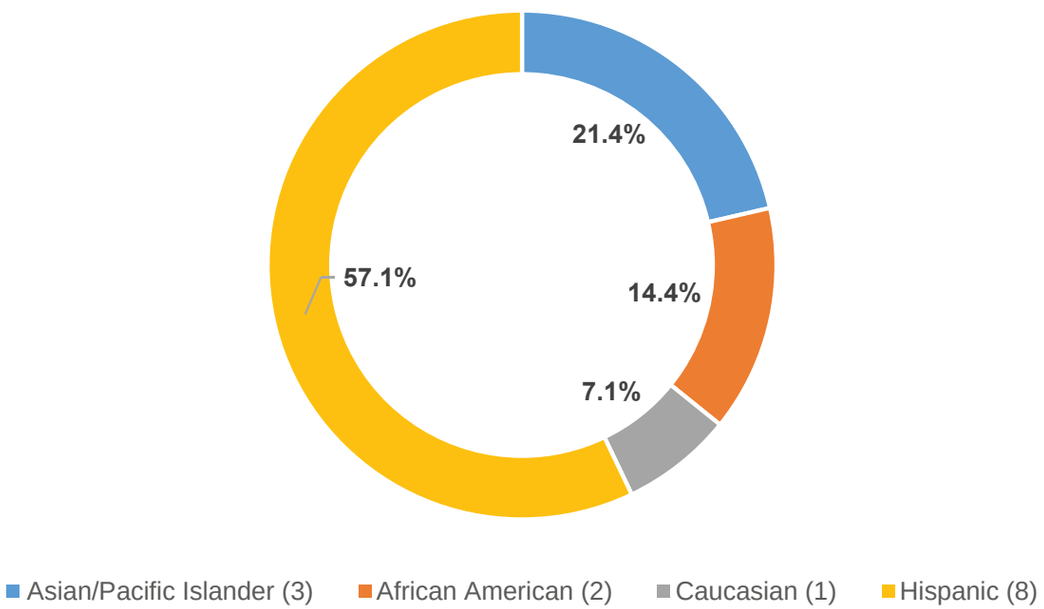


Table 30

Unsafe Non-bed Sharing Child Deaths Sleeping Environment* - 2016

	Number
Soft and/or excessive bedding	8
Pillow(s)	5
Adult bed	7
Prone Position	7
Couch	1
Excessive Swaddling	3

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

Table 31

2016 Undetermined Fetal and Newborn Deaths - Mother Self-reported or Tested Positive for a Substance at Birth

Infant Death- Mother Tested Positive for a Substance at Birth (N = 8)

Substance	Number	Percentage
Methamphetamine	6	75%
Opiates	1	12.5%
Alcohol	1	12.5%

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

Year	Total # of Deaths - Mother Tested Positive for a Substance	Total # of with CPS family history (prior contact OR open case)	Of total with CPS history, the # of families that had PRIOR DCFS contact Only	Of total with CPS history, the # of families in OPEN DCFScase or referral	# of Mothers with a CPS history as a minor
2012	12	7 (58%)	4 (57%)	3 (43%)	5 (42%)
2013	8	6 (75%)	4 (50%)	2 (25%)	4 (50%)
2014	8	8 (100%)	5 (57%)	3 (43%)	3 (43%)
2015	5	2 (40%)	2 (100%)	0 (0%)	1 (50%)
2016	8	4 (50%)	3 (75%)	1 (25%)	0 (0%)

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

Race	Number	Percentage
African-American	2	25%
Hispanic	4	50%
Caucasian	2	25%
Total	**8**	**100%**

Age	Number	Percentage
Stillborn	4	50%
Less than 1 month	1	12.5%
One to 6 months	3	37.5%

Third Party Homicides

Introduction

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

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

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

A trend chart shows there has been an overall downward pattern in these third party homicides over the past ten years. However, between the years 2012 – 2016, the downward trend has been more flat with an average of 26.8 homicides with a range of 19 to 31 per year. Regardless, the decline from 100 such deaths to 27 is a positive indication that law enforcement and prosecutorial agencies efforts to decrease and prevent gang activity among the youth of Los Angeles continues to be successful.

Third Party Homicides

Case Summaries[1]

Crystal, age one year, was at home with her parents. The family was living in a converted garage attached to a residence. At 7:00 PM, a car drove up to the residence and an unknown person exited the vehicle, walked up to the garage, and opened fire. Crystal was hit in her head by one of the bullets. 911 was called and paramedics transported her to the hospital. She was pronounced dead shortly after her arrival. Crystal's father was associated with a local gang and the incident gang related. Three suspects were arrested and charged with her murder. The family had an open case with DCFS at the time of her murder.

Anthony, age 16 years, was standing in the driveway by the parking gate to a row of townhouses with his friend. They were approached on foot by a group of males who suddenly began shooting at them. Anthony tried to run, but collapsed from his wounds. A witness reported one of the shooters walked up to Anthony and shot him while he lay wounded. The group then fled in all directions. Anthony was pronounced at the scene. Sheriff Deputies were familiar with Anthony and had interactions with him on several occasions. He was known to be gang involved and it is suspected his death was gang-related. His case remains under investigation, and there are no suspects in custody at this time.

Juan, age 4 years, was at home with his family. He was put to bed and his mother fell asleep next to him. About an hour later, his mother woke up and went to the bathroom. When she returned to the bedroom, Juan was no longer asleep on the bed and not in the room. She went into the living room and saw him standing at the front door. At that time, 13-15 gun shots were fired at the residence. Juan was hit in the head by one of the shots. Another adult in the living room was also struck with a non-fatal wound. Both were transported in the ER. Juan did not survive his wound. It was alleged that his mother's boyfriend had an argument with gang members earlier in the evening. The case remains under investigation, and no suspect is in custody.

According to law enforcement, Elizabeth, age 17 years, was the rear passenger in a parked car. Her sister's boyfriend was the driver of the car and sister in the front passenger seat. The car was parked after hours in a mini mall lot. The trio was meeting with a male in a reported drug deal. The male brandished a gun in an attempt to rob the car occupants. When they didn't comply, he fired shots at the driver's side of the car and fled. Only Elizabeth was hit by the gunfire and sustained a head wound. 911 was called and paramedics responded pronouncing Elizabeth at the scene. A large quantity of marijuana was found in the vehicle and taken into custody as part of the investigation.

[1]Case identities were changed.

Third Party Homicides

Findings

- There were 27 third party homicides in 2016. This is a 10% decrease from 2015 in which the number of third party homicides were 30.
- Ninety-three percent (n=25) of the youth were victims of gunshot wounds.
- The remaining two victims died as a result of stabbings.
- As in the previous five years, male victims outnumbered female victims. Nineteen males and eight females were homicide victims in 2016.
- Sixty-six percent (n=18) of the children who were victims of a third party homicide in 2016 were ages 16 – 17. The youngest victims were a year old and a four-year-old.
- The majority of the victims were Hispanic youths with 16 victims. Nine of the youths were African-American; one Caucasian and one Asian/Pacific Islander victim were among the victims.
- The greatest number of third party homicides occurred during the month of January (n=5). The second greatest number occurred in the months of February (n=4) and August (n=4). The third greatest number occurred in the months of May, June, July, October, November and December (n=2). The fewest number of homicides occurred during the months of April and September with one each. No third party homicide occurred in the month of March.
- While third party homicides occurred throughout Los Angeles County in 2016, the majority (n=16) of these deaths occurred in the 2nd Board of Supervisorial (BOS) District, which was followed by the 4th BOS District with 5 third party homicides. Three occurred in the 1st BOS and two in the 5th BOS District. There was one third party homicide in the 3rd BOS District.
- The Los Angeles Sheriff's Department (LASD) had investigative authority for 44.4% of the third party homicide cases in 2016. 37% of the cases were under the jurisdiction of the Los Angeles Police Department (LAPD), 11% were under the jurisdiction of Long Beach PD and 3.7% of the cases were handled by Whittier and Inglewood PD.
- Three of the third party homicides were law enforcement officer involved shootings. It should be noted that one of these shootings involved a youth with a history of depression and suicide attempts who deliberately engaged law enforcement with a gun.
- When the relationship of the perpetrator was identified by law enforcement, three of the homicide perpetrators were a gang member, 55.6% of these homicides were suspected to be gang-related and 37% of the victims were also gang or tagging crew involved. Finally, 26% (n=7) of the case investigations resulted in the filing of criminal charges by the District Attorney's Office. When this information was collected, some of the cases were still under investigation or unsolved and therefore, had not been presented to the District Attorney's office. The suspects and motives for many of the 2016 third party homicides remain unknown.
- Seventy percent of the victims had a history with DCFS, another county child welfare system or Probation.
- Fourteen of the victims had a history with DCFS or another Child Welfare agency and ten of the victims had a history with the Probation Department. Three had an open case with DCFS and all ten of the Probation cases were open at the time of the victim's death.

Third Party Homicides

Figure 33: 2007 - 2016 Third Party Child Homicides

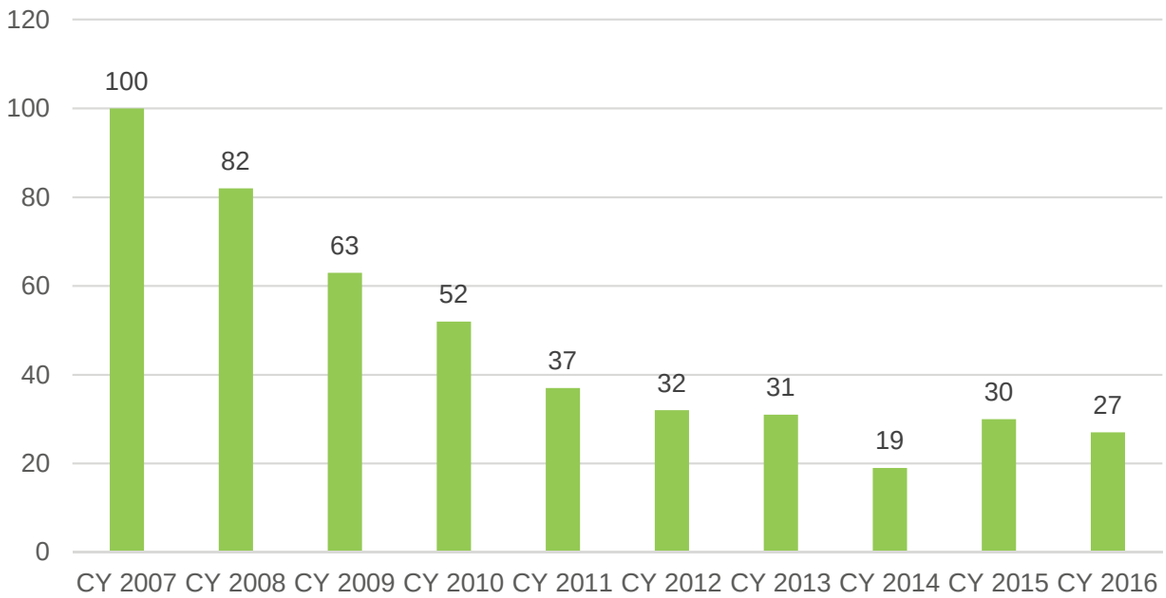
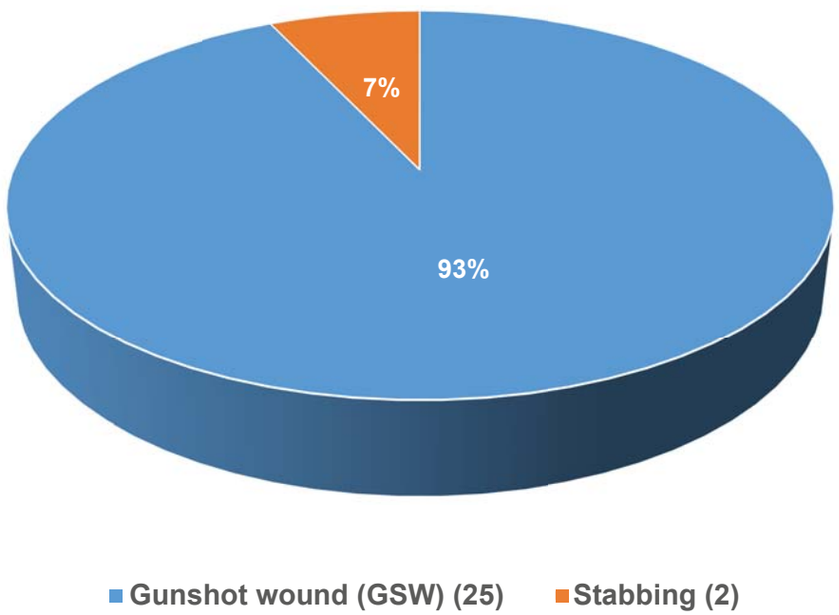


Figure 34: 2016 Third Party Homicides - Cause



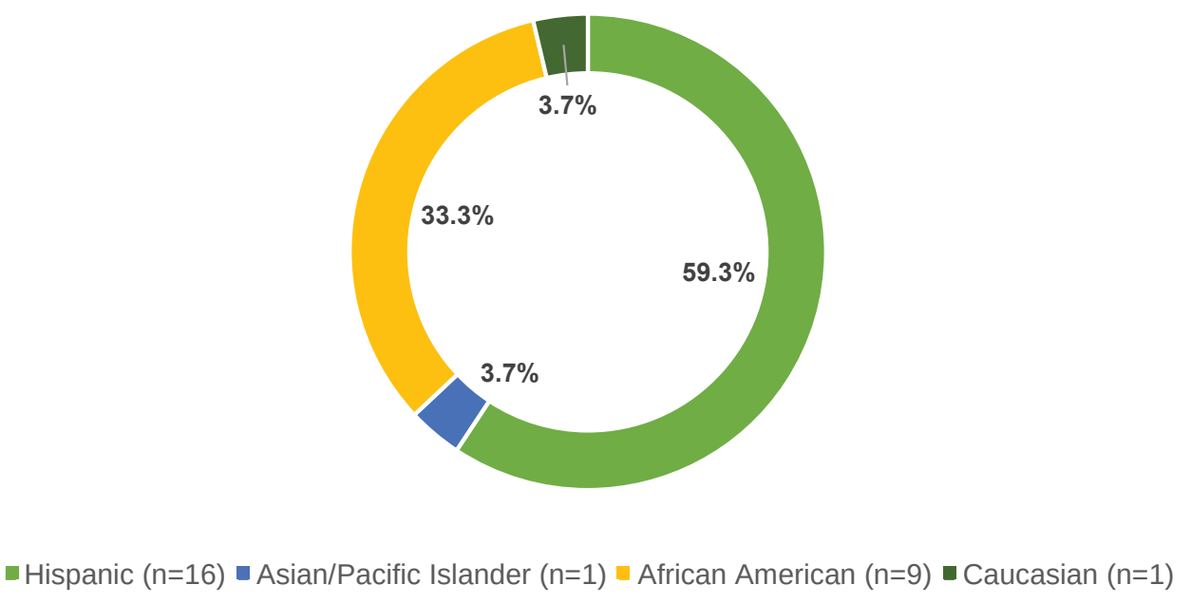
Third Party Homicides

Table 33		
Third Party Homicides by Age and Sex Los Angeles County – 2016 (N = 30)		
Age	**Female**	**Male**
1 year	1	0
3 years	1	0
4 years	1	1
14 years	0	1
15 years	1	3
16 years	3	6
17 years	1	8
Total	**8**	**19**

70.4% of the third party homicide victims were male.

66.6% of the third party homicide victims were 16 to 17 years of age.

Figure 35: 2016 Third Party Homicides - Race



Los Angeles Child Population
Ages 0-17: 2,324,837
Hispanic 61.6%, Caucasian 16.9%, African American 7.4%,
Asian/Pacific Islander 10.7%, Native Indian/Alaskan .1%
and Multi-racial 3.3% Kidsdata.org

Third Party Homicides

Table 34

Dates[1] of Third Party Homicides - 2016

5 homicides occurred in January (01/01, 01/06, 01/23, 01/25 & 1/30)
4 homicides occurred in February (02/06, 02/07, 02/09 & 02/17)
0 homicides occurred in March
1 homicide occurred in April (04/01)
2 homicides occurred in May (05/03 & 05/06)
2 homicides occurred in June (06/01 & 06/26)
2 homicides occurred in July (07/06 & 07/16)
4 homicides occurred in August (08/04, 08/07, 08/09 & 08/12)
1 homicide occurred in September (9/30)
2 homicides occurred in October (10/02 & 10/30)
2 homicides occurred in November (11/06 & 11/23)
2 homicides occurred in December (12/10 & 12/18)

Table 35

Locations[2] of Third Party Homicides – Geographic Area - 2016

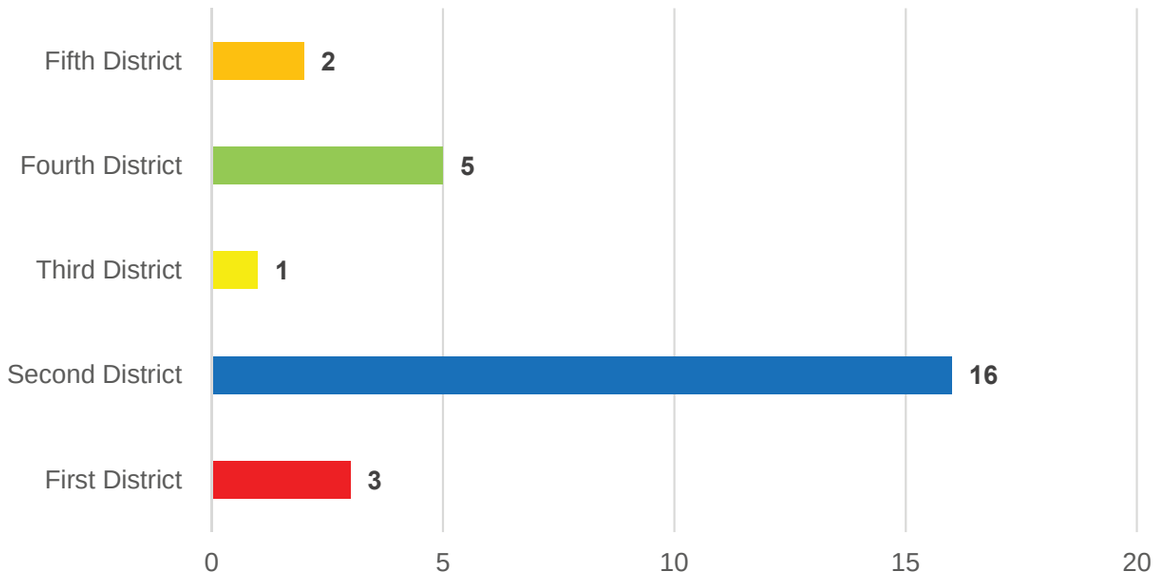
2 homicides each occurred in Los Angeles zip codes 90003 & 90044)
1 homicide each occurred in Los Angeles (zip codes 90011, 90021, 90023, 90033, 90043 & 90062)
2 homicides occurred in Long Beach (zip codes 90813)
1 homicide occurred in Long Beach (zip code 90805)
1 homicide occurred in Altadena (zip code 91001)
3 homicides occurred in Compton (zip codes 90221)
1 homicide occurred in Compton (zip code 90220)
1 homicide occurred in Whittier (zip code 90670)
1 homicide occurred in Lynwood (zip code 90262)
1 homicide occurred in Inglewood (zip code 90304)
1 homicide occurred in Pacoima (zip code 91331)
1 homicide occurred in Palmdale (zip code 93550)
1 homicide occurred in Artesia (zip code 90701)
1 homicide occurred in Pico Rivera (zip code 90660)
1 homicide occurred in Carson zip code 90745)
1 homicide occurred in Marina Del Rey (zip code 90292)

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

Third Party Homicides

Figure 36: Third Party Homicides by Board of Supervisor District



Third Party Homicides

Criminal Justice System Involvement

Information on the 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 2016, there were 27 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 36 below.

Table 36

Agency	Number of cases	%
LAPD	12	44%
LASD	10	37%
Long Beach PD	3	11%
Inglewood PD	1	4%
Whittier PD	1	4%

Table 37 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation. It should be pointed out that few of the law enforcement agencies were able to provide much detail about the suspect's circumstances, which is why so many of the cases fall under the "no information provided" category. The majority of these cases remain under investigation and the suspect(s) is unknown. Most of these cases also involve either walk-up or drive-by shootings.

Table 37

Perpetrator's Relationship to Victim	Number of cases
No Information Provided or Unknown	19
Gang Member	3
Officer Involved	3
Suspected to be Gang Related	12

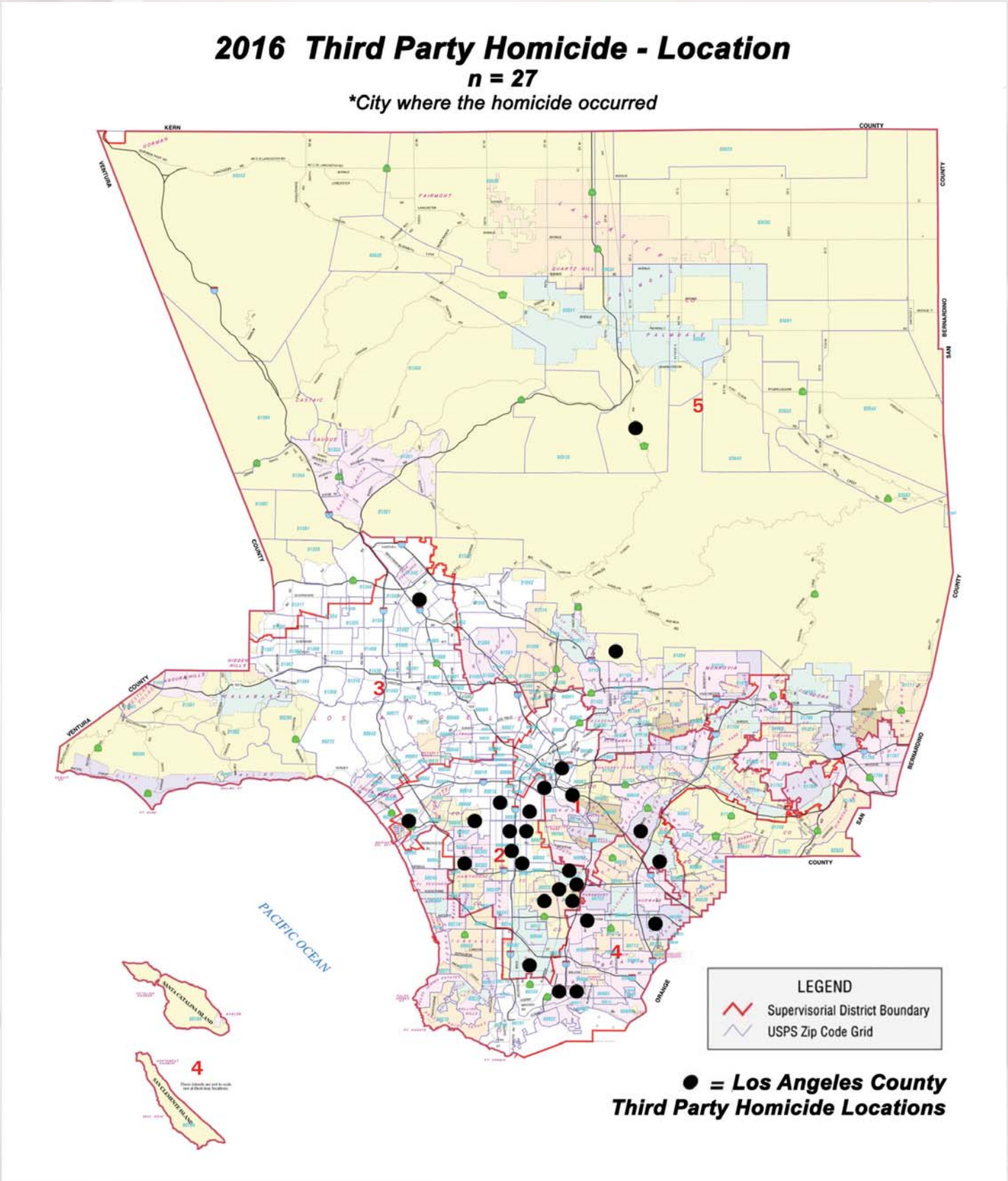
Table 38, below, provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved.

Table 38

Victim Information	Number of cases
No Information provided	6
Shot in a walk-up shooting	7
Shot during a drive-by shooting	6
Officer Involved	3
Gang member or tagger	10
Physical altercation with a peer	3
Substance Abuse history	7
Child Welfare History	14
Open DCFS Case	3
Active Probation Case	10

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), 7 of the 27 cases of third party homicides were referred to the District Attorney's office in 2016. The seven cases had criminal charges of murder filed by the District Attorney's office in 2016. A suspect in one murder became a murder victim himself in what appears to have been a case of retaliation. Three of the twenty-seven were officer involved. The remaining cases continue to be under investigation

Third Party Homicides



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

ICAN Youth Suicide Coroner/Medical Examiner Investigation Procedural Guide

Case Number: _____

Decedent: _____

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

Language Interviewed in: ☐ English ☐ Other _____

Translated by: _____

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

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

Medical

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

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

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

Education, Occupation

School_____ **Grade** _____

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

Worksite_____

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

Support Systems and Other Involvement

Suspected Child Abuse ☐ Yes ☐ No

Family or Loved Ones, and other Significant Relationships

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

Peers

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

Faith-Based/Spirituality

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

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

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

Additional comments/thoughts/opinions

APPENDIX B - How to Keep Your Baby Safe

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.

IS YOUR BABY SLEEPING SAFELY?

Get Safe Sleep Tips

Watch the PSA

Take the E-Learning Course

Like us on Facebook for the latest updates. Like 1.3K

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
Giving kids the best start

APPENDIX C - On-Line Resources

Safe Sleeping Resources
- safesleepforbaby.com
- nichd.nih.gov.sts
- firstcandle.org

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

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

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

Water Safety
- poolsafety.gov
- abcpoolsafety.org

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

Biking Safety
- Sheriffsyouthfoundation.org
- Nhtsa.gov/bicycles

In and Around Cars
- chp.ca.gov/program&services
- nhtsa.gov
- kidsandcars.org

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

Teen Drivers
- ntsa.gov

APPENDIX D - Map of Los Angeles County Board of Supervisor District