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.

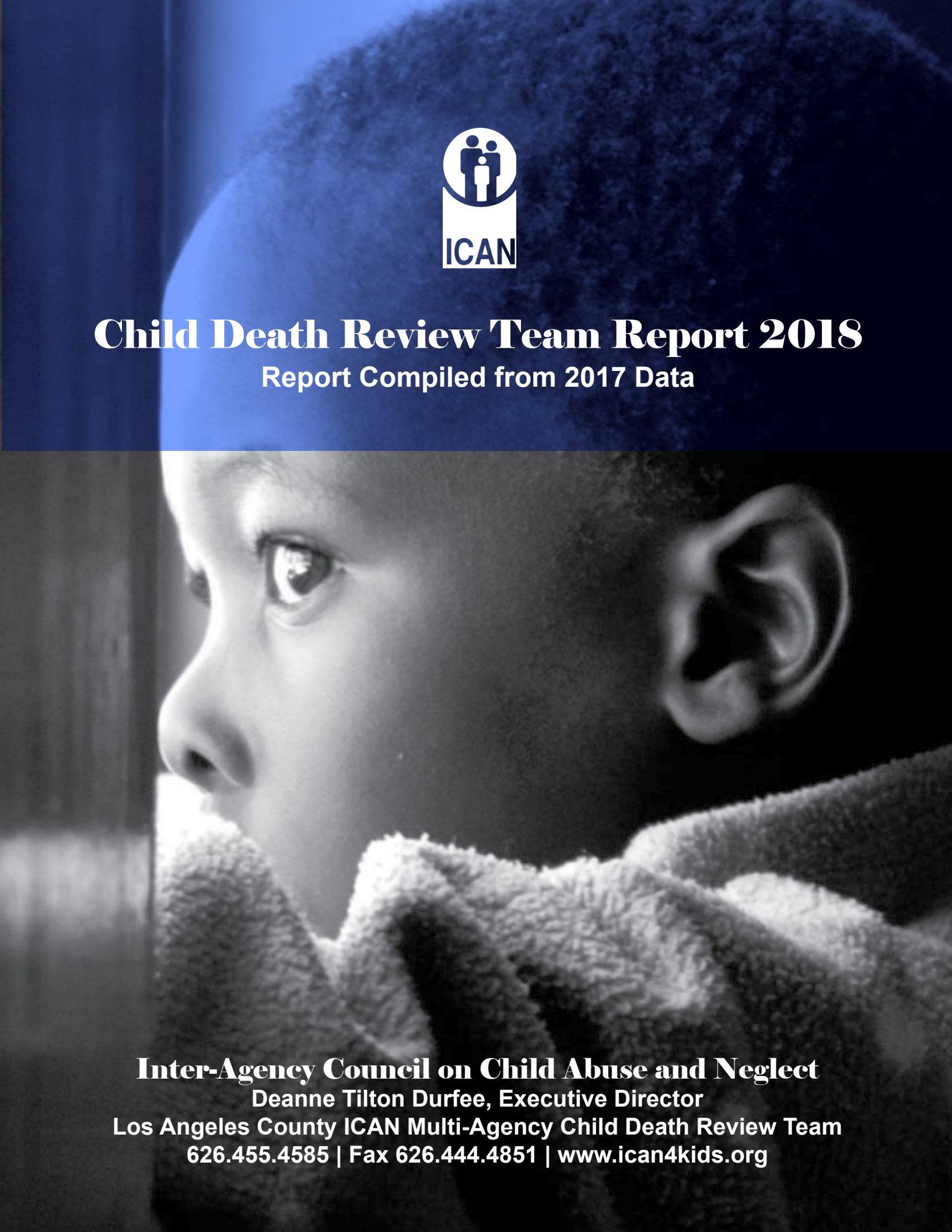
In 1977, the Los Angeles County Board of Supervisors designated the Inter-Agency Council on Child Abuse and Neglect (ICAN) as the official LA County agent to coordinate services for the prevention and treatment of child abuse and neglect.

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 2018

Report Compiled from 2017 Data

Inter-Agency Council on Child Abuse and Neglect

Deanne Tilton Durfee, Executive Director

Los Angeles County ICAN Multi-Agency Child Death Review Team

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Teams Include Representatives From The Following

Los Angeles County Departments

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

City of Los Angeles

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

State and Other Community Partners

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

This report is available on line at: ican4kids.org

Introduction

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

The Team reviews each referred case with input from the agencies that may have known of the child and family before, during or after the death. This process often illuminates problems in communication between agencies, in policies or procedures within and between agencies, or in dissemination of critical child safety information. Team participants provide feedback to, or seek clarification from their own agencies when a potential problem related to a child's death is identified. 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.

This report provides information on all child deaths that meet Team protocol and occurred in Los Angeles County during the calendar year 2017. Lessons learned from the reviews are included in the report. Appendix C at the end of the report provides on-line resources for prevention of child deaths.

For the eleventh 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.

Team case review yields valuable lessons, including identification of systematic issues in need of attention by one or various agencies impacting the welfare of children and families. Additionally, patterns of risk factors present in families surface in the cases. The lessons and risk factors noted from the 2017 child death review cases are as follows:

Child Risk Factors

Young Age

75% of the 2017 child abuse homicide victims killed by a parent/relative/caregiver were three 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, 61.2% 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, pedestrian or auto back up because of their size and/or lapses of adult supervision to prevent such deaths.

Adolescence

Youth ages 15 – 17 years are most vulnerable for suicide (16 of the 27 suicides) or be a victim of a third party homicide (19 of the 21 victims).

Gender

In 2017, the gender gap of victims of child abuse homicide remained the same as the previous year with male (n=5) children outnumbering female (n=3) only by two. In previous years, males typically outnumber the female victims.

Race

Fifty percent of the 2017 child abuse victims by a parent/relative/caregiver were children of African American descent. African American children were disproportionally over-represented as child abuse homicide victims. The next racial group of child abuse homicide victims most represented were Hispanic.

Parental/Caregiver Risk Factors

Domestic Violence

The nexus between domestic violence and child abuse/neglect continues to be evident in the 2017 child homicides. Seven or 87.5% of the families or the perpetrator had a history of domestic violence or child welfare history with DCFS or another Child Protection Agency. One family had an open referral as a result of domestic violence and one stillborn fetus was a homicide as a result of a domestic violence assault on the mother.

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 2017, DCFS contact with a parent and/or perpetrator occured in 87.5% (n=7) of the families who experienced a child abuse 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 DCFS or Probation when they were a child. Many of them parent as they were parented, thus continuing the cycle of abuse and neglect. 62.5% (n=5) of the 2017 child homicides involved a parent(s) and/or perpetrator with a Child Protective Service (CPS) history as a child.

Substance Abuse by Parent or Caregiver

Substance abuse by a parent or caregiver is a well-documented high risk factor for child abuse or neglect. Substance abuse often is also identified when there is a child fatality. Seventy-five percent of the 2017 families of homicide victims had a history of substance abuse. Further, three children died in automobile accidents in 2017 that involved a parent who was under the influence of drugs or alcohol at the time of the accident.

Prenatal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appears to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a number of fetal deaths with a contributing factor of prenatal substance abuse. Child deaths related to prenatal substance abuse remain one of the top four causes of accidental death. In 2017, deaths associated with prenatal substance abuse was the largest number of child accident deaths accounting for 28% (n=21) of the accidental child deaths. 59% of the families in which there was an associated prenatal substance abuse accidental death had at least one contact with the child welfare system. Additionally, there were 3 undetermined infant deaths associated with prenatal substance use as evidenced by the mother testing positive at the birth for alcohol or drugs. Two 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. 37.5% (n=5) of the 2017 child abuse homicides involved a parent(s) and/or perpetrator with a history of mental illness. One mother who murdered her two children had a documented history of mental illness and exhibited bizarre behavior prior to and after the deaths.

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 one family of a homicide victim had none of these known risk factors present. However, the mother in this case reported she experienced verbal threats and texts from the perpetrator which she did not experience as threatening at the time.

Perpetrator Relationship

Relationship

In 2017, there were nine suspects in the eight child abuse homicides. Seventy-five percent of the child homicides involved a male perpetrator and twenty-five percent a female. Four of the primary suspects were the father; two the mother; one, the mother's estranged husband/step-father; and the mother and father are the suspects in one homicide.

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.

System Factor

Communication Gaps between Child Welfare and Family Law and Dependency Court

Families involved with the Family Law Court in which there are child abuse or domestic violence allegations are not always referred to DCFS for a thorough investigation. Similarly, Dependency Court cases where there are sustained allegations are closed in Dependency Court and referred to Family Law Court for a custody order. At times the Family Law Court is unaware of the dependency case information, which is crucial for child safety. Better communication between Family Law and Dependency Court is needed.

Additional Risk Factors

Unsafe Infant Sleeping

Sudden unexpected infant death (SUID) refers to infants under the age of one year who die a sudden and unexpected death for which there is no obvious cause. These deaths are usually ruled as Undetermined and often occur while an infant's sleeps or in the sleep environment.

Undetermined child deaths associated with bed-sharing and/or unsafe sleep environments had declined considerably from the high of 70 in 2009 to 24 in 2015. Unfortunately, after a recent decline, the number of these child deaths increased in 2016 to 47. 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. While there was a decline in these deaths in 2017 to 39, these bed-sharing and/or unsafe sleep environments child deaths accounted for 72% of all the 2017 undetermined child deaths.

Additionally, five other infant deaths involving bed-sharing or an unsafe sleep environment were moded as an accident in 2017. These deaths primarily involved the infant being wedged between the sleep surface and a wall or another object.

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 the 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 2017 suicides:

1. **Suicide Rate**

   In 2016, 14 youth took their own life, which was a 39% decline from 2015 when 23 youth took their own life. Unfortunately, the upward trend returned in 2017 with twenty-seven youth taking their own lives. This is an increase of 48% in the number of suicides for youth from the prior year. It also represents the highest number of youth suicides occurring in Los Angeles County in a year.

2. **Gender**

   74% of the youth deaths by suicide male (n=20) and 26% female (n=7).

3. **Race**

   56% of the youth who died by suicide were Hispanic and 33% were Caucasian. Asian/Pacific Islander children comprised 4% of children who died by suicide and 7% were of African American descent.

4. **Relationship Loss or Conflict**

   56% of the youth who ended their own lives experienced a recent relationship loss or conflict with a peer, boyfriend/girlfriend or a family member prior to their suicide. 41% had a conflict with a parent(s) within hours or a day prior to the suicide.

5. **The Role of Pre-existing Mental Health Problems**

   Among the youth who died of suicide, 41% had a documented mental health diagnosis, 22% were receiving mental health services at the time of death, 22% had had been hospitalized for a prior attempt, 26% of the youth had prior known attempts and 11% were on psychotropic medication. 37% of the youth exhibited a warning sign--talk of suicide, increased drug and alcohol use, feelings of depression, anxiety and hopelessness..

6. **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 substance abuse.

   Of the youth who died by suicide in 2017, family dysfunction at the time of the youth's suicide was noted in 33% of the suicides.

   56% of the victim's families had contact with either DCFS or Probation at some time in the youth's life.

   26% of the youth had a history of substance abuse.

7. **Impulsivity**

   Of the 27 youth who died by suicide in 2017, only seven left a note and two a text. As in past years, this reflects how youth seem not to plan their suicide over a period of time, but act impulsively at the moment.

Overall Child Deaths*

- In 2017, a total of 187 child deaths, including fetal deaths were reported to the Team by the Medical Examiner-Coroner. 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 2017. This is a decrease from the 226 deaths in 2016. (There were four deaths without a final determination in 2016 and these were not included in the 2017 report. They have since been ruled as Undetermined and the reported deaths of 222 in the previous year's report increased to 226 for 2016.)

- Eight children were victims of child abuse homicide by a parent, caregiver or other family member. There were also 27 suicides, 98 accidental child deaths and 54 undetermined child deaths.

- There were a total of 32 fetal or infant deaths associated with prenatal substance use. Twenty-seven were ruled accidental by the Medical Examiner-Coroner. Twenty-five of these deaths were fetal. There were 5 undetermined prenatal substance abuse associated infant deaths all of which were fetal deaths.

- Forty-four children died with an associated bed-sharing or unsafe sleeping environment. Thirty-nine of these deaths were ruled undetermined and five as an accident.

- The percentage of children who died in 2017 by race consisted of 47.6% Hispanic, 23.5% Caucasian, 22.5% African American, 4.3% Asian/Pacific Islander, and 2.1% the race was Unknown.

- Fifty-nine percent of the children who died in 2017 were male and 40% female. There was one unknown gender child death.

Homicides by Parent, Family Member or Caregiver

- There were 8 child abuse homicides by parents, caregivers or family members in 2017. This represents a 43% decrease of homicides from 2016 when there were 14 child homicides.

- The number of child abuse homicides in 2017 for Los Angeles County was significantly lower than the 15-year average of 24. The number of child homicides in 2017 was also lower than the 5-year average of 13.8.

- 62.5% percent of the children killed by their parents, caregivers or family members were under one year of age or younger and 75% age three years or younger.

- Five males and three females were homicide victims in 2017.

- Fifty 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 asphyxiation or suffocation and one child died from multiple trauma.

- Fifty percent of the child homicide victims were of African American descent (n=4). Thirty-eight percent were of Hispanic descent (n=3) and 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 87.5% (n=7) of the families in which there was a child abuse homicide and the child died in Los Angeles County. There were two open DCFS referrals on families in which a

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

child abuse homicide occurred. However, in one case, the allegation was a false one made by the perpetrator on an older sibling days prior to the death. 62.5% of the victims' parents or the perpetrator had a child welfare history as a minor.

- Four children were killed by their father and two children were killed by their mother. One child was killed by the step-father/mother's estranged husband; and the mother and father are the suspects in one homicide.

- Child abuse homicides occurred throughout Los Angeles County in 2017. The First Supervisorial District experienced the greatest number of child homicides with four. The Third District experienced three. No child abuse homicides occurred in the Fourth or Fifth Supervisorial Districts in 2017. One homicide occurred outside of Los Angeles County but the LA County Medical-Examiner-Coroner took jurisdiction of the case.

Suicides

- Twenty-seven children and adolescents died by suicide in 2017 and represents the highest number on record of suicides occurring in Los Angeles County. The number of children and youth who died by suicide in 2017 almost doubled from the 14 such deaths in 2016.

- The gender gap continued in 2017 with 20 (74%) males and 7 (26%) females taking their lives.

- The leading method in LA County continues to be death due to hanging, which represents 63% (n=17) of the suicides in 2017. There has been an increase in the number of youth using firearms to take their life with five in 2017. Three youths overdosed; one youth jumped from a height and another suffocated.

- The act of suicide historically occurs in the youth's home. Five of the 2017 suicides occurred outside of the youth's place of residence.

- 55.6% of the child/adolescent suicides in 2017 were by youth of Hispanic descent (n=15). Caucasian youth represented 33.3% (n=9). Suicides by youth of Asian/Pacific Islander descent (n=1) represent 3.7% of the adolescent suicides and African American youth comprised 7.4% (n=2).

- Forty-four percent of the children who died by suicide in 2017 were ages 16 – 17 years. The youngest age of a child was 10 years.

- Forty-one percent (n=11) of the youth had a mental health history, six had been hospitalized at some time, three were taking psychotropic medication, and six youths were in counseling at the time of their death. Three youths had a history of prior self-injury or cutting and seven youths had previously attempted suicide. Ten youths exhibited warning signs prior to their suicide.

- Seven of the youth who died by suicide in 2017 left a suicide note. Two youth texted their intent just prior to committing the act, but did not leave a note.

- Nine of the youths' families were noted to exhibit signs of family dysfunction (pending divorce or recent divorce, parental mental illness or domestic violence). Fifty-six percent (n=15) of the child/adolescent suicides were precipitated by interpersonal conflicts or a recent loss. Forty-one percent had a conflict with a parent/guardian within a day of the act (n=11).

- Fifteen of the youths' families had a prior referral or case with the Department of Children and Family Services or another county CPS agency or Probation.

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

- Four youths had school discipline or truancy problems and eight experienced academic problems.

- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred in the Fifth Supervisorial District with eleven. Six suicides occurred in the Second District of the Board of Supervisors; three suicides in the Third and Fourth Districts.

Accidental Child Deaths

- The number of children who died from an accident increased by two in 2017 from the previous year. There were 95 accidental child deaths in 2016 and 98 in 2017.

- Prenatal substance abuse was the leading cause of accidental death for children for the first time (n=27) in 2017. Automobile with 20 deaths was the second leading cause. The third leading cause of accidental child death was involved a combination of pedestrian deaths: auto vs. pedestrian (n=11); auto rollover (n=2) and bicycle vs. vehicle (n=4) totaling 17 such deaths.

- Child deaths related to vehicles including bicycle/scooter and auto-pedestrian accounted for 38% of all accidental child deaths (n=37).

- Twenty-five of the twenty-seven deaths associated with prenatal substance abuse as determined by the Coroner, from self-report or hospital toxicology results were fetal deaths. Methamphetamine and/or amphetamine use by the mother is the most associated drug with these deaths (n=16) accounting for 59%. The mother tested positive for methamphetamine and another substance in nine other deaths. All of the accidental deaths associated with prenatal substance use accounted for 28% of the total accidental child deaths in 2017.

- Accidental drowning claimed the lives of 13 children which is an increase from the 7 drowning deaths in the previous year. Six of these drowning deaths were young children who drowned in residential pools or a jacuzzi; five in a bathtub or shower; one in a bucket and one youth was found in the LA river.

- Of the 98 accidental child deaths, 77 deaths involved children ages 0 – 14 years. There were 21 accidental deaths of youth ages 15 to 17 years. 61% of the accidental child deaths (n=60) were children age five years or younger.

- Of the children who died an accidental death in 2017, 50% had a DCFS history. Sixteen (59%) families of the twenty-seven child deaths from prenatal substance abuse had a history with DCFS.

- Hispanic children represented 50% (n=48) of the accidental child deaths in 2016. Caucasian children represented 29% (n=29), African-American children 14% (n=14) and Asian/Pacific Islander represented 5% of accidental deaths in 2017.

- As in previous years, males (n=56) outnumbered females (n=41) in accidental deaths. There was one unknown gender death.

Undetermined Child Deaths

- There were 54 undetermined child deaths in 2017. This is a 91% decrease from the 103 such deaths in 2016.
- The majority, 87% of undetermined child deaths are children age one year or younger(n=47). Seventy-two percent of the undetermined child deaths were age six months and under (this includes fetal deaths).
- Children of Hispanic descent represented the largest number of undetermined child deaths with 43% of such deaths. African American children followed with 41% which over-represents this racial group. Caucasian children represented 9% of the undetermined child deaths. Four percent of the children were Asian/Pacific Islander.
- 48% 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 period of decline in bed-sharing and unsafe sleeping environment infant deaths, 2016 represented a significant increase in these undetermined child deaths. Although there was a decrease in 2017 from 2016, the number of these deaths remain of concern. In 2016 there were 47 such deaths and these declined to 39 infant deaths in 2017.
- Associated bed-sharing and unsafe sleep environments accounted for 72% percent of all undetermined child deaths. 55.6% of the undetermined child deaths were associated with bed-sharing (n=30) and 16.7% with an unsafe sleep environment (n= 9).
- African American children are over represented in bed-sharing and unsafe sleeping environment child deaths representing 44% of these deaths in 2017.
- 82% of the infants whose deaths occurred while bed-sharing or in an unsafe sleeping environment were six months of age or younger (n=32).
- In 38% of the bed-sharing and non-bed-sharing unsafe sleep child deaths, the infant was placed in a prone or side position for sleep. One infant was placed in a seated position.
- Undetermined child deaths involving bed-sharing and unsafe sleep environments occurred throughout Los Angeles County. However, the Second Supervisorial District accounted for 41% (n=16) of these deaths. This was followed by the Fourth District with 25.7% (n=10). District One followed with 20.5% (n=8) and the Third and Fifth Districts each with 5.6% (n=2). One child was injured Out of the County but was pronounced at an LA County hospital.
- Among the bed-sharing deaths, 0% involved only one unsafe risk factor, 47% involved two, and 53% 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.
- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 46.7% of the incidents and two adults in another 26.7% of the incidents.
- Seventeen percent (n=9) of undetermined child deaths were associated with a non-bed-sharing unsafe sleeping environments which include adult bed, couch, foam mat, infant or car seat, pillows, soft or excessive bedding, excessive swaddling, stuffed toys, prone or side positioning.

- Two of the non-bed-sharing deaths were infants between 0 to 3 months of age (33%) and six were infants between 3 to 6 months of age (50%). There was one child age one-year.
- While a majority of fetal and infant deaths associated with prenatal substance exposure are moded as an accident of the Medical Examiner-Coroner, there were 3 undetermined infant deaths in which the mother either tested positive for a substance at birth or self-reported substance use during pregnancy. All three of these deaths were fetal deaths.
- Two of the mothers of these infants had prior contact with a CPS agency in Los Angeles or another county.

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

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

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

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

Table 1

Over the past 5 years, a parent, caregiver or other family member has murdered an average of 14.6 children each year.

Year	Number
2013	19
2014	14
2015	18
2016	14
2017	8

The average number of children and adolescents who committed suicide over the past five years is 17.4. The leading method from 2013 through 2017 is hanging.

Year	Number
2013	13
2014	10
2015	23
2016	14
2017	27

An average of 98.6 children have died from preventable accidents over the past five years. The most common accidental deaths involve prenatal substance abuse, automobile accidents, drowning and deaths due to auto vs. pedestrian.

Year	Number
2013	93
2014	103
2015	104
2016	95
2017	98

The number of undetermined deaths has averaged 71.8 per year over the past five years.

Year	Number
2013	90
2014	68
2015	44
2016	103[1]
2017	54

1 In the 2017 report, the number of deaths reported was 99. There were four pending deferred deaths which moded as Undetermined after the time of the report's publication.

Figure 1: Los Angeles County Child Deaths 2013 - 2017

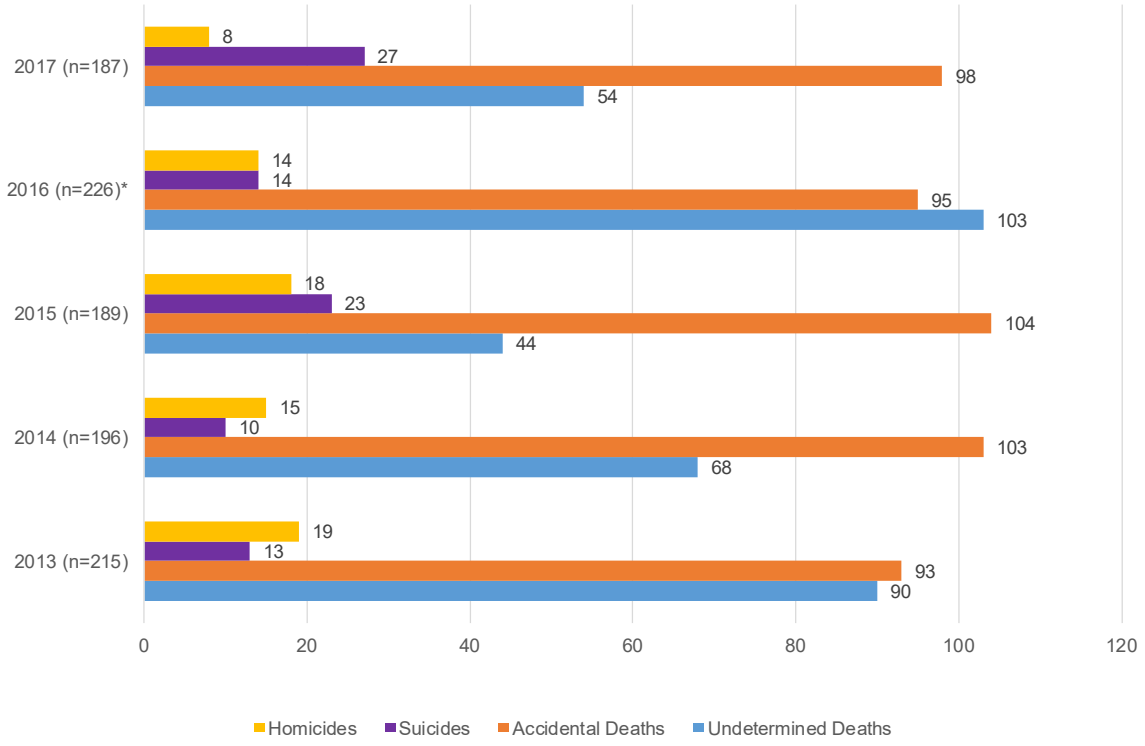
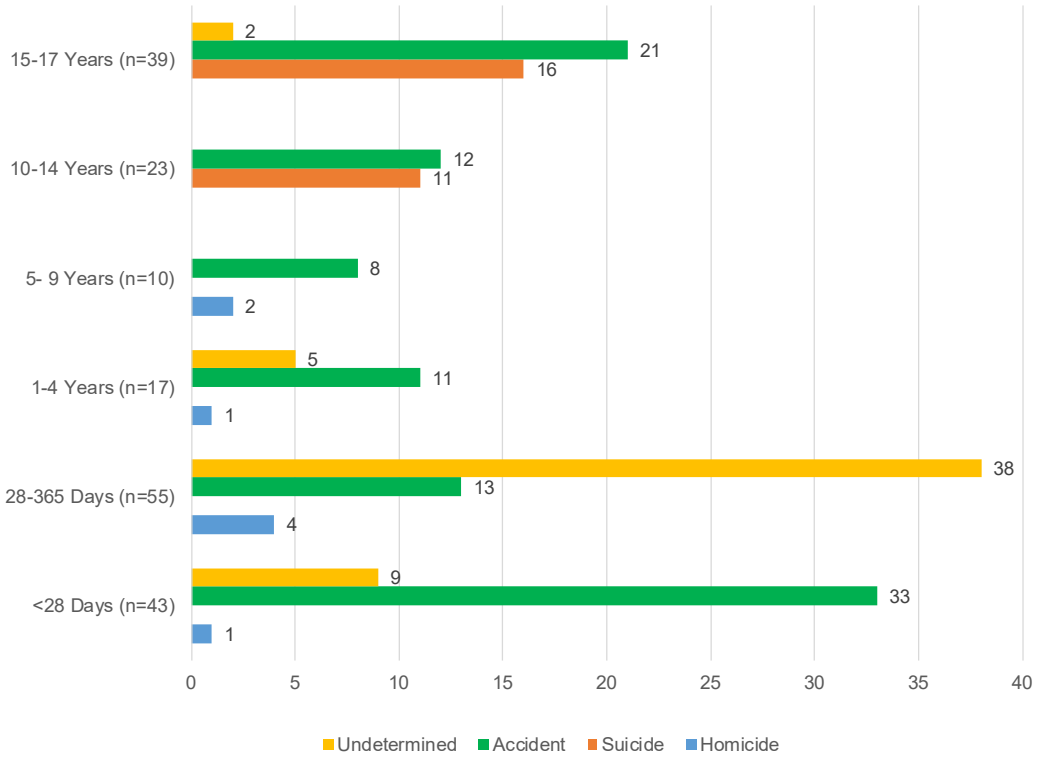


Table 2		
2017 Child Deaths Demographics - Coroner Cases		
	Number	**Percentage**
Total	187	100%
Gender		
Female	76	40.6%
Male	110	58.9%
Unknown	1	.5%
Age		
Under 1 year	98	52.4%
1 – 4 years	17	9.1%
5 – 9 years	10	5.3%
10 – 14 years	23	12.3%
15 – 17 years	39	20.9%
Race		
African American	42	22.5%
Asian/Pacific Islander	8	4.3%
American Indian	0	0%
Caucasian	44	23.5%
Hispanic	99	47.6%
Unknown	4	2.1%

Figure 2: Child Deaths by Age Group and Manner, Los Angeles County 2017 (n=187)



Sample Case Summaries

Evan

Evan, a 2-month old infant was admitted to the hospital with brain swelling, subdural hematoma and multiple rib fractures. His injuries were consistent with non-accidental trauma. Despite life saving measures, Evan was declared brain dead two days later. The mother reported the father had shaken the infant to stop him from crying.

Evan's mother had received child welfare services in 2016 due to his older sibling being substance exposed at birth. There was a second referral for domestic violence between the parents in 2016 which was closed when the family left the country. After Evan's death, DCFS opened a Dependency Court case on the older sibling. The mother received family maintenance services and was compliant with the services provided to her.

As a result of his death, Evan's father was arrested and charged with murder. He was found guilty and given a sentence of 25 years to life.

Jessie

Five-month old Jessie was brought to the hospital by his father for having choked on milk resulting in his not breathing. Jessie was found to be suffering from head trauma and seizures. Retinal hemorrhages were also found. He was diagnosed with Shaken Baby Syndrome-acceleration-deceleration injury. The father had no explanation for the child's injuries. The mother was out of town vising relatives and had left Jessie and his twin sister in the care of the father. His twin sister was found to have rib fractures consistent with being squeezed in the chest area.

The parents had split up a few months earlier but had recently resumed their relationship. The mother reported the father was attentive and denied any substance of domestic abuse. The parents did not have any history with DCFS.

The father was arrested and charged with murder and is awaiting trial. DCFS opened a court case on his twin sister but the case was dismissed with the mother stating she was re-locating out of the state.

Fernando

Fernando was born at 30 weeks gestation without signs of life. His mother had been involved in an assault with her older child's father two days prior in which she was kicked in the abdomen. Birth was induced when no fetal heat beat was detected during a clinic visit by the mother to check on her unborn child after the incident.

The step-father was arrested for domestic violence as a result of the altercation. The Medical Examiner-Coroner ruled the case a homicide which is still under investigation by law enforcement.

Note: All names have been changed.

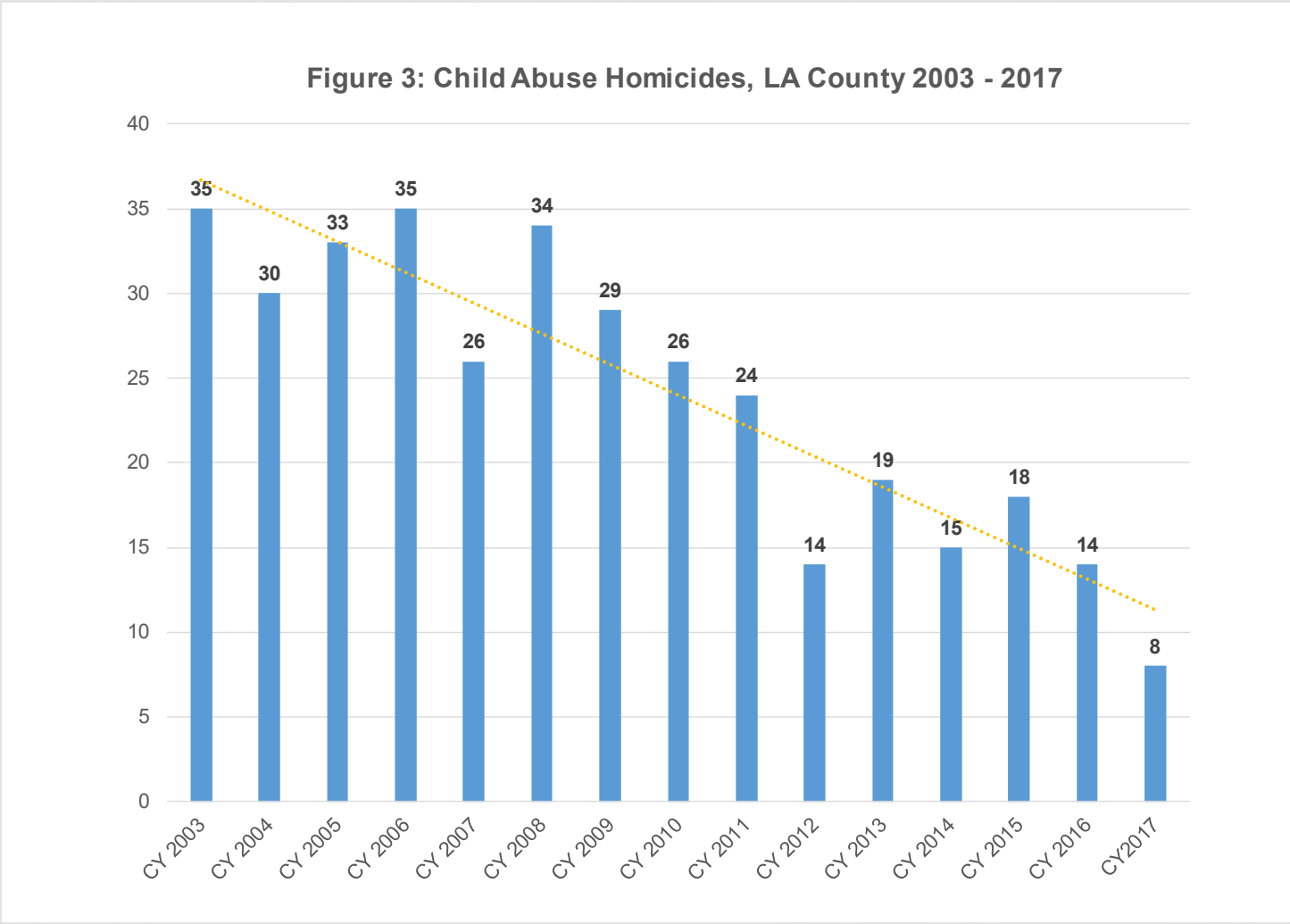


Figure 3: Child Abuse Homicides, LA County 2003 - 2017
40
35
30
25
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15
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0
35
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26
34
29
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24
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18
14
8
CY 2003
CY 2004
CY 2005
CY 2006
CY 2007
CY 2008
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
CY 2014
CY 2015
CY 2016
CY2017

Table 3

Causes of Child Homicide by Parent/Caregiver/Family Member, Los Angeles County 2003 – 2017

Cause	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	Total
Head trauma	7	7	6	11	11	12	8	2	10	5	3	1	2	5	4	**94**
Multiple trauma*	10	7	8	7	7	4	2	1	6	2	9	5	5	0	1	**74**
Asphyxiation/suffocation	6	5	5	6	6	3	2	3	2	0	1	1	2	0	3	**45**
Gunshot wounds	4	3	6	1	1	8	7	4	2	0	0	1	1	2	0	**36**
Trauma to torso/abdomen	0	0	2	1	1	1	1	5	1	2	1	1	0	0	0	**16**
Drowning	1	1	2	3	3	0	1	2	0	3	1	0	2	1	0	**20**
Stabbing	0	3	2	2	2	2	4	6	1	1	1	4	4	3	0	**35**
Unattended newborn	3	0	2	0	0	1	2	1	0	0	1	0	0	0	0	**10**
Poisoning/drug ingestion	1	1	2	0	0	0	0	0	0	1	1	0	1	2	0	**7**
Dehydration/malnutrition	1	2	0	0	0	1	1	0	1	0	0	1	0	0	0	**7**
Strangulation	0	0	0	1	1	0	0	1	0	1	0	0	0	0	0	**4**
Fire	0	0	0	3	3	1	0	0	0	0	0	0	0	1	0	**8**
Medical neglect	0	0	0	0	0	0	1	1	0	0	0	1	1	0	0	**4**
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Hyperthermia	2	0	0	0	0	1	0	0	0	0	1	1	0	0	0	**4**
Post-Term gestation	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	**1**
TOTAL *includes auto injuries	**35**	**29**	**33**	**35**	**35**	**34**	**29**	**26**	**24**	**15**	**19**	**15**	**18**	**14**	**8**	**396**

Table 4					
Child Homicide by Parent/Caregiver/Family Member, Los Angeles County 2017 (N=8)					
Age	**Under 1 year**	**3 years**	**5 years**	**7 years**	**TOTAL**
Female	1	1	0	1	3
Male	4	0	1	0	5

62.5% of the child homicide victims by parents/caregivers/family member were under one year of age. 75% of the homicide victims were 3 years of age and under.

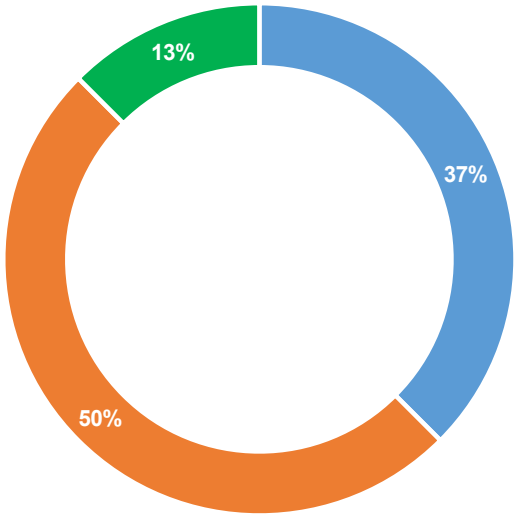
87.5% of the child homicide victims by parents/caregivers/family member were five years of age and under.

62.5% of the victims were male and 37.5% were female.

Table 4								
Five Year Trend of Child Homicides by Age, 2012 - 2017								
Age	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**TOTAL**	**%**
Under 1 year	8	8	3	7	5	5	**36**	**40.4%**
1 - 2 years	3	6	6	6	3	0	**24**	**27%**
3 - 5 years	2	2	2	0	1	2	**9**	**10.1%**
6 - 10 years	1	2	2	3	0	1	**9**	**10.1%**
11 - 17 years	1	1	2	2	5	0	**11**	**12.4%**

Table 6						
Child Abuse Homicides by Age and Cause, 2017						
Cause	**< 6 Months**	**6 - 11 Months**	**1 - 3 Years**	**3+ - 5 Years**	**6 - 12 Years**	**≥ 13 Years**
Head trauma	2	0	1	0	0	0
Head & Neck	1	1	0	0	0	0
Asphyxiation	1	0	0	1	1	0
TOTAL	**4**	**1**	**1**	**1**	**1**	**0**

Figure 4: 2017 Child Abuse Homicides - Race



Los Angeles Child Population
Ages 0-17 2017: 2,310,266
Hispanic 61.2%, Caucasian 17.9%, African American 7.2% Asian/Pacific Islander 10.4%, Native Indian/Alaskan .1% and Multi-racial 3.2% Kidsdata.org

Figure 5: Homicides of Children by Race Compared to the General Population, 2017

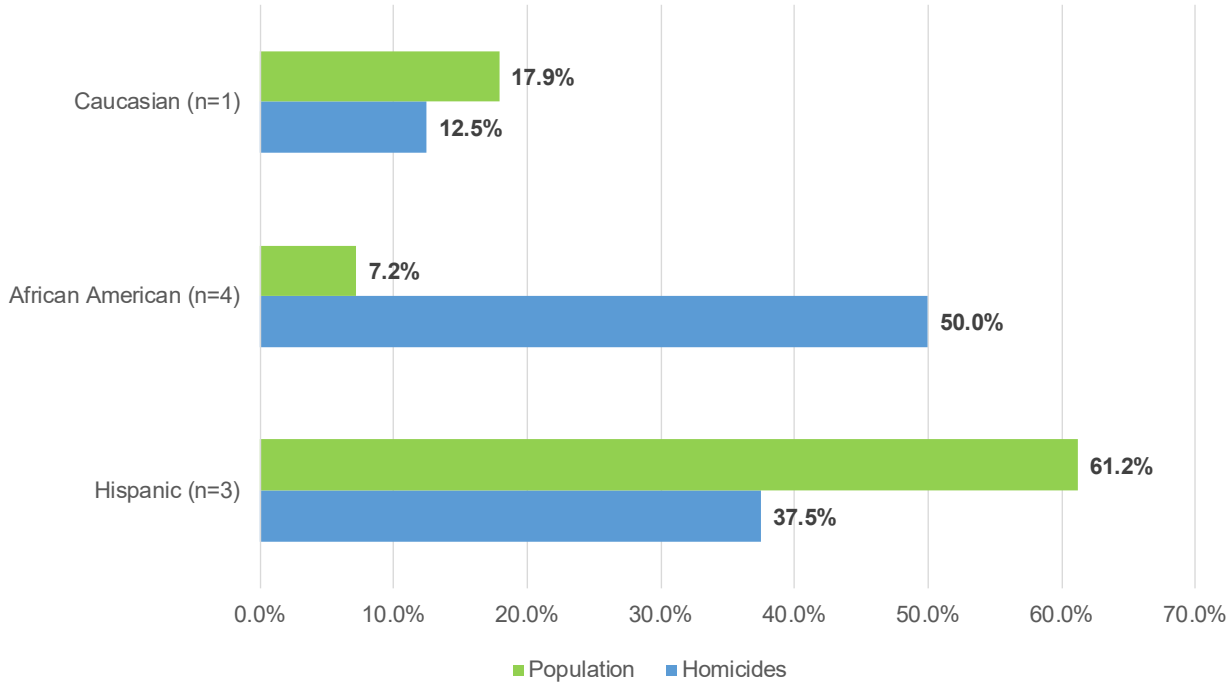


Table 7

Relationship of Suspect to Child Homicide Victim, 2017

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

4 – Father

2 – Mother

1 – Step-father

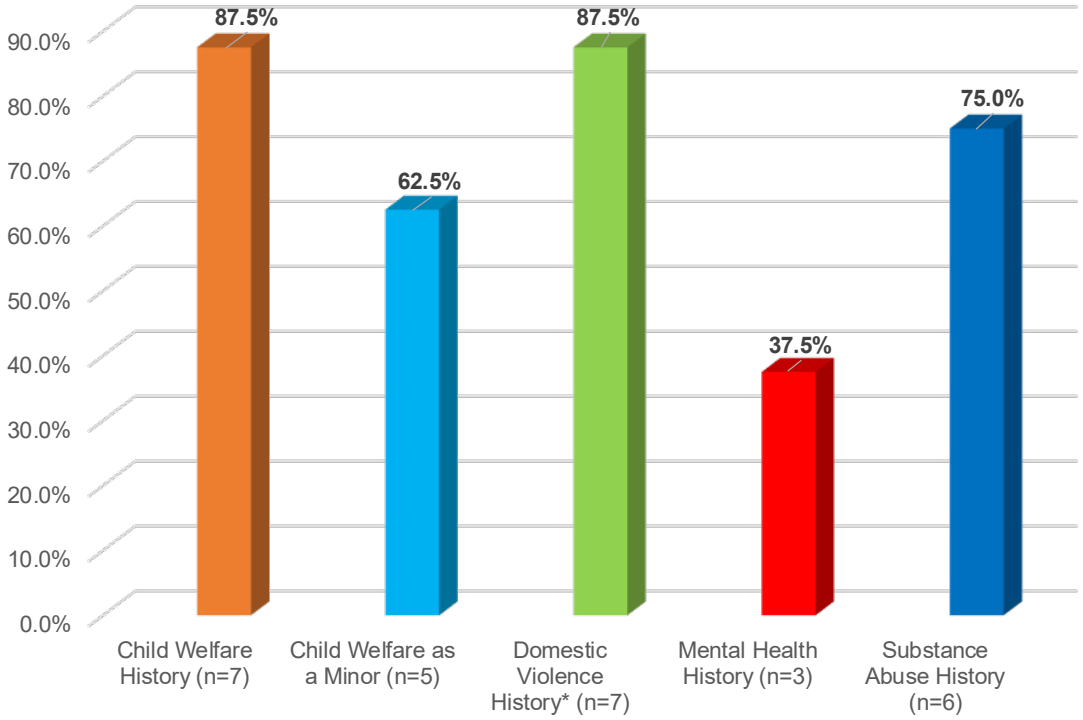
1 – Mother and father

Table 8

Relationship and Age of Suspect to Child, 2017

Relationship	26-30 years	31-40 years	40+ years
Biological Mother's and Father	1	1	0
Biological Mother	2	0	0
Biological Father	1	3	0
Step-father	**0**	**0**	**1**
Total	**4**	**4**	**1**

Figure 6: Risk Factors Associated with Child Abuse Homicides 2017 (n=8)



**includes emotional/verbal abuse*

The two top common characteristics present in families in which a child abuse homicide occurred was a parent(s) and/or perpetrator had a child welfare history or documented history of domestic violence. This was followed by a parent(s) and/or perpetrator having a substance abuse history. Almost 63% of the homicides had a contact with child welfare as a child. A parent or perpetrator had a history of mental illness with 37.5% of the child homicides.

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

Table 9

Law Enforcement Agency Involvement in 2017 ICAN Child Homicide by Parent/ Caregiver/Family Member

Agency	N	%
LAPD	3	37.5%
LASD	2	25%
Huntington Park PD	2	25%
Pomona PD	1	12.5%

Los Angeles Police Department had investigative responsibility for a majority of the child homicides by parent/ caretaker/family member with 37.5% (n=3). The Los Angeles Sheriff's Homicide Bureau and Huntington Park P.D. each investigated 25% (n=2). Pomona P.D. was responsible for one homicide case.

There were a total of nine suspects in the eight homicide cases. Five of the 2017 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 2017, two of the homicide cases were not submitted to the District Attorney because they remain under investigation.

Table 10

Law Enforcement Reasons for Not Presenting 2017 ICAN Child Homicide by Parent/ Caregiver/Family Member to the District Attorney

	N	%
Under Investigation	2	25%
TOTAL Child Abuse Homicides	**8**	**100%**

Table 11		
Relationship of Perpetrators – 2017 ICAN Child Homicide by Parent/Caregiver/Family Member		
Relationship	**Charged By District Attorney**	**%**
Mother	2	25%
Father	3	37.5%
Stepfather	1	12.5%

In 2017, six 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 six cases.

The charge filed by the District Attorney in the past seven years is illustrated by Table 12.

Table 12

Criminal Charges Filed on 2014-2017 ICAN Child Homicide by Parent/Caregiver/ Family Member

	2014	2015	2016	2017
Murder (187 (a) P.C.)	13	11	9	4
Assault on a child under 8 years resulting in death (273ab P.C.)	7	3	6	4
Child abuse leading to death of a child (273a(a) P.C.)	6	1	2	1
Child endangering (273a(1) P.C.)	1			
Assault with deadly weapon (245 (A) (1) P.C.)			1	
Voluntary manslaughter (192a P.C.)			1	
Involuntary manslaughter (192b P.C.)				
Attempted murder (664/187 (a) P.C.)			2	
Arson (451(b)			1	
Lewd and lascivious acts by force (288(b)(1) P.C.)				
Battery (242-243(e) 1 P.C.)				
Torture (206 P.C.)	1	1	1	
Burglary (459)				1
Violation of protective order (273.6)				1

Table 13

Criminal Case Disposition of 2014 – 2017 Child Homicides[2]

	2014	2015	2016	2017
Life without possibility of parole		1		
80 years to life prison				
56 years to life prison				
50 years to life prison		1	2	
40 years to life prison		1		
33 years to life prison			1	
31 years to life prison	1			
30 years to life prison				1
25 years to life prison	3	4	3	3
19 years to life prison				
18 years to life prison		1		
17 years to life prison				
16 years to life prison				
15 years to life prison	3	1	1	1
11 years to life prison				
26 years prison	1			
25 years prison	1			
23 years prison		1		
22 years prison	1		1	
20 years prison				
19 years prison				
18 years prison				
16 years prison	1	1		
15 years prison				
13 years prison				
12 years prison			2	
11 years prison		1		1
10 years prison			1	
9 years prison				
8 years prison				
7 years prison				
6 years prison	1		1	
5 years prison			1	
4 years prison	1		1	
3 years prison				
3 years jail				
1 years jail				
Less than 3 months jail				
Found not guilty	1			
Dismissed	3	1		
180 days County Jail				
Mental competency hearing				
Pending Trial	1	7	7	5
DA Requesting Further Investigation	0	0	0	0

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

Criminal Justice System Involvement

Criminal disposition data for 2014 through 2017 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 2017 child homicides, only one of those charged had a disposition in 2017 receiving a sentence of 25 years to life in state prison. The rest of the 2017 cases filed by the District Attorney are pending trial.

In 2017, defendants received the following sentences: Three perpetrators were sentenced to 25 years to life in prison and two sentenced 30 years to life. One perpetrator was sentenced to 15 years and one 11 years in state prison. Shortest sentence received by a perpetrator was 180 days in county jail.

There were two 2017 convictions for cases filed in 2014. One perpetrator received 25 years to life and another 15 years to life in state prison. There is one case still pending trial as of 2017.

There are seven 2015 child homicide cases pending trial as of 2017. One 2015 case was dismissed due to the defendent passing away. One perpetrator was convicted of 30 years to life in state prison and another received 180 days in county jail. In 2017, seven of the 2016 defendants are still awaiting trial. One perpetrator received a sentence of 25 years to life and another 11 years in state prison.

Table 14

Child Homicides by Parents, Caregivers or Family Member Child Welfare Involvement 2003 – 2017*

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
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[3]	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3[4]	1– relative caregivers 0 – foster parent
2008	34	14[5]	6	8	0 – relative caregivers 0 – foster parent
2009	29[6]	19[7]	14	5[8]	1 – relative caregivers 0 – foster parent
2010	26	13[9]	9	4	0 – relative caregivers 1 – foster parent
2011	24	6	2	4	0– relative caregivers 0 – foster parent
2012	15	7	4	3[10]	0 – relative caregivers 0 – foster parent
2013	19	11	7	4[11]	0 – relative caregivers 0 – foster parent
2014	15	12[132]	7	5	0 – relative caregivers 0 – foster parent
2015	18	13	11	2[13]	0 – relative caregivers 0 – foster parent
2016	14	6	4	2	0 – relative caregivers 0 – foster parent
2017	8	7	5	2[14]	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

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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.

One was open to another county.

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.

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.

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

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

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

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

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

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.

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

One referral involved false allegations by the suspect on the older half-sibling.

Table 15

Dates[15] of Child Homicides – 2017

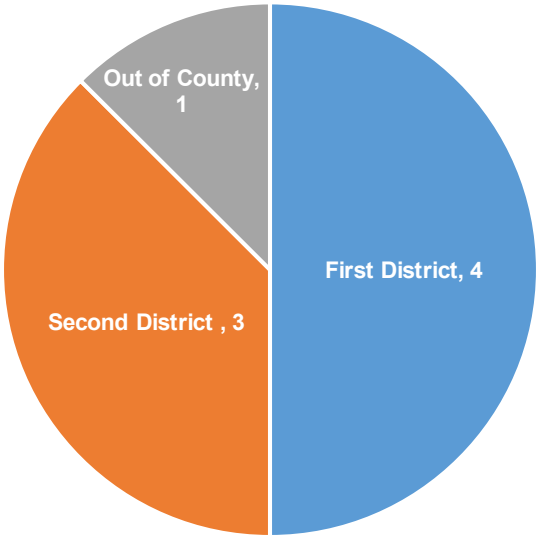
0 homicides occurred in January
1 homicide occurred in February (02/03/20170
1 homicides occurred in March (03/09/2017)
0 homicides occurred in April
0 homicides occurred in May
1 homicide occurred in June (two on 06/30/2017)
0 homicides occurred in July
1 homicide occurred in August (08/31/2017)
1 homicide occurred in September (09/28/2017)
2 homicides occurred in October (10/19 & 10/20/2017)
0 homicides occurred in November
1 homicide occurred in December (12/20/2017)

Table 16

Locations[16] of Child Homicides – Geographic Area – 2017

1 homicide occurred in Los Angeles (zip code 90007)
2 homicide occurred in Los Angeles (zip code 90011)
1 homicide occurred in Lynwood (zip code 90262)
1 homicide occurred in Pomona (zip code 91767)
2 homicides occurred in Huntington Park (zip code 90255)
1 homicide occurred out of the County (zip code 93460)

Figure 7: 2017 Child Abuse 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.

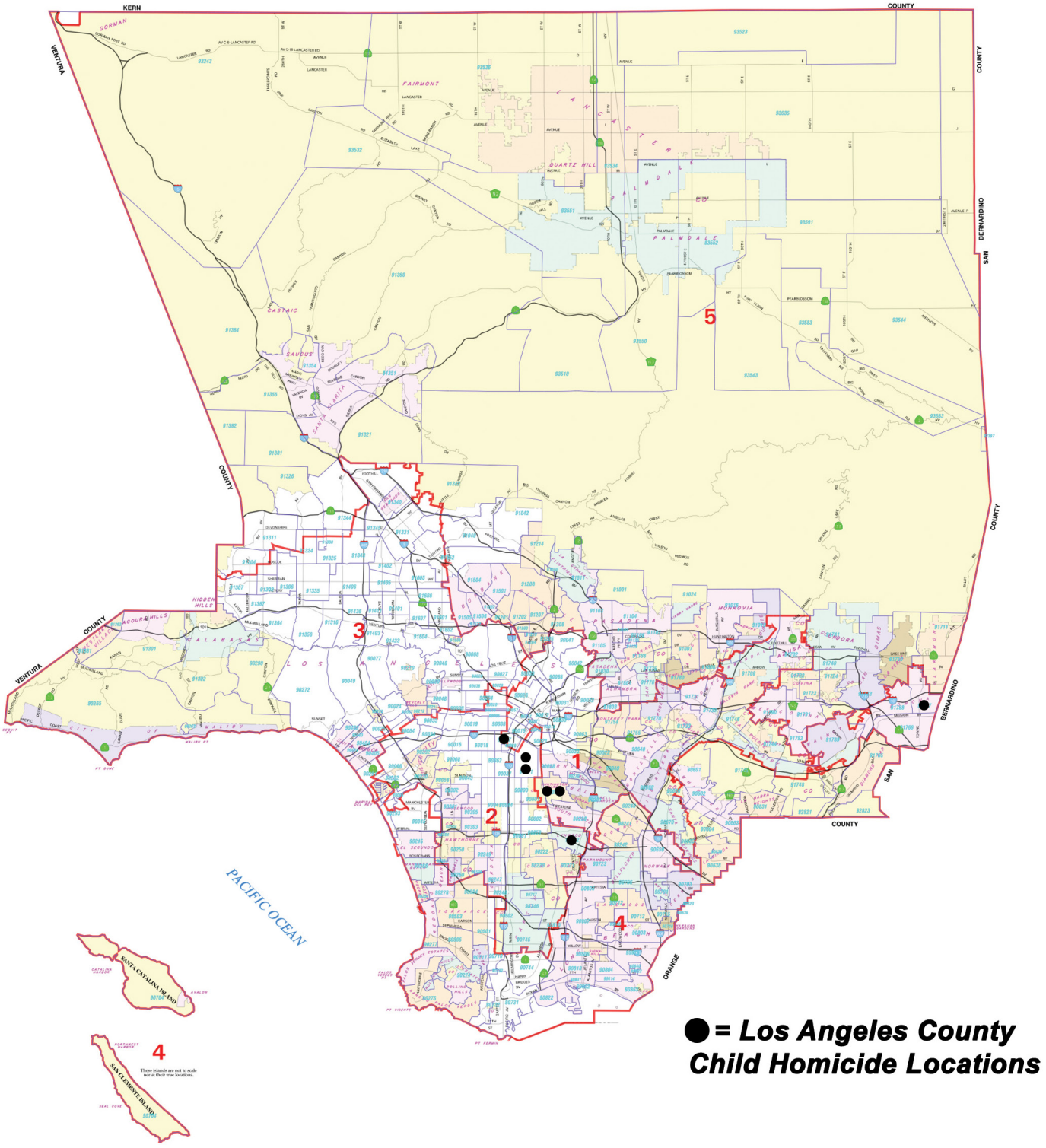
[16] City where the fatal injury or fatality occurred

2017 Child Homicides - Locations

n = 8**

**City where the homicide occurred*

**One occurred outside Los Angeles County*



Sample Case Summaries

William

William was a 13-year-old Caucasian male with no history of depression or suicide ideation. He was an A student involved with numerous activities and had lots of friends. He was active on social media and his parents monitored it with his knowledge. On the day of the incident William seemed to be in a good mood when he came home from school. His parents were getting ready to take him to his sporting event when they heard a gunshot outside. They ran outside and found him with a wound to the head 911 was called and he was transported to a hospital but pronounced two days later when life support was withdrawn. The family owned the gun and William was taken to the shooting range and taught gun safety. The gun was kept in a locked safe but he was trusted with the key. He left behind a note stating he was sorry and his act had nothing to do with his parents. He also left a note for his girlfriend saying he was sorry. The family was devastated as nothing seemed amiss at home or school with William. He had no history of depression or suicidal ideation.

Vanessa

Vanessa, a 15-year old, a Hispanic female, was found unresponsive hanging in her closet when her father went to wake her for school. Vanessa had a history of psychiatric hospitalization for depression and a prior suicide attempt two years earlier. After her release from the hospital, Vanessa attended therapy and terminated having made positive progress. She enrolled in a private school where she excelled and made numerous friends. She was also very active in social events. Vanessa recently learned that her best friend had started going out with a boy. Her father believes Vanessa may have had feelings for her best friend and was affected by this news. She also found out that despite her doing well in school, she probably would not qualify for the college she had her heart set on attending. A journal revealed that she was depressed and had feelings of worthlessness. Her death was a shock to her friends and family. She had not outwardly exhibited any signs of depression or suicide ideation in the months prior to her death.

Andrew

Andrew, a 17-year-old Hispanic male hung himself in the family's garage. He had expressed feeling depressed in the past year after a friend took his life, however, he was never diagnosed as being depressed. Several months earlier, he talked about wanting to hurt himself but had no specific plan or ideation. He had no prior attempts of suicide or hospitalizations. He was not in therapy or taking any medication. He did not have any history of drug or alcohol use. No note was found, but text messages on his phone indicated Andrew felt depressed.

Note: All names have been changed.

Figure 8: 2003 - 2017 Child and Adolescent Suicides

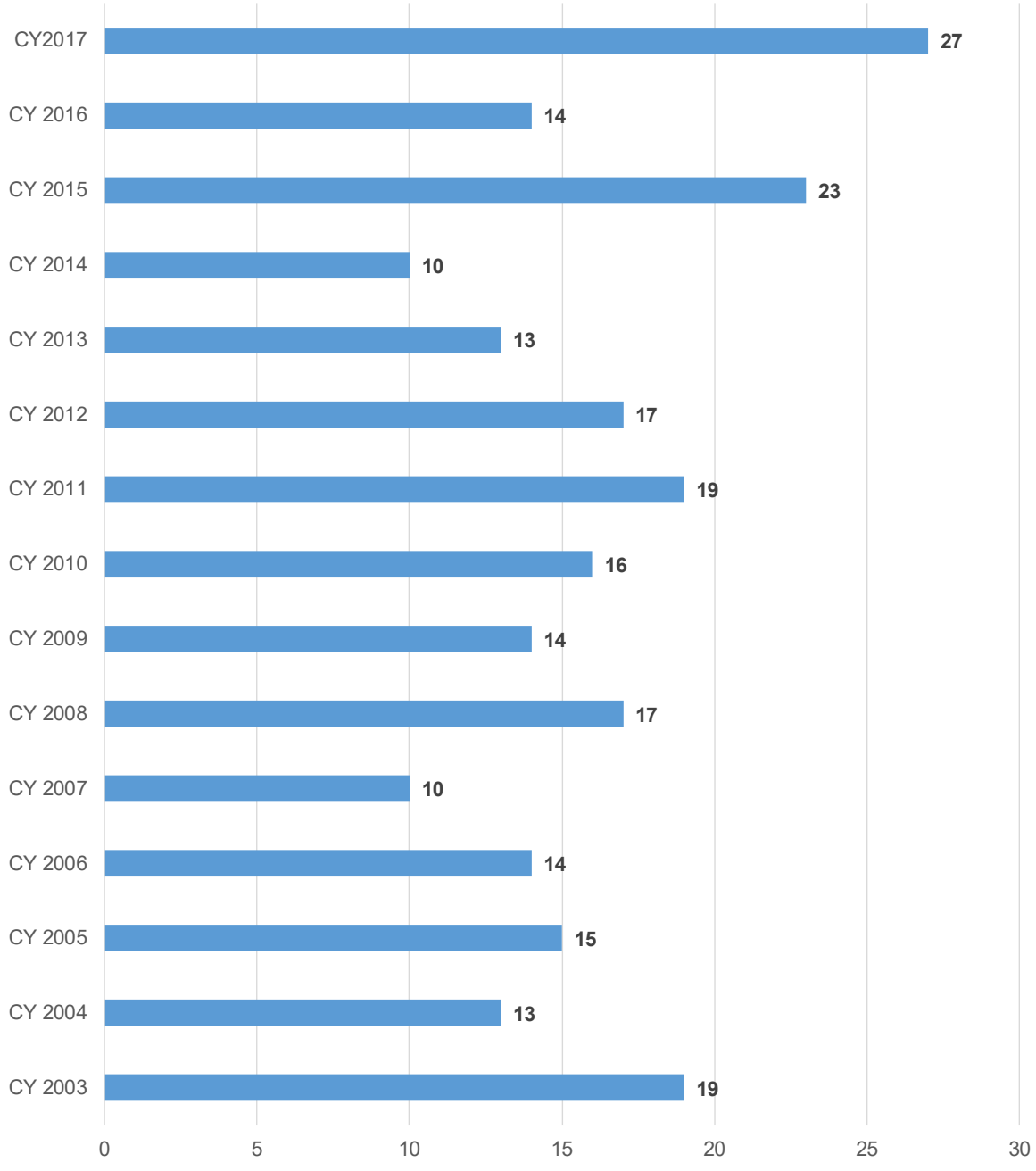


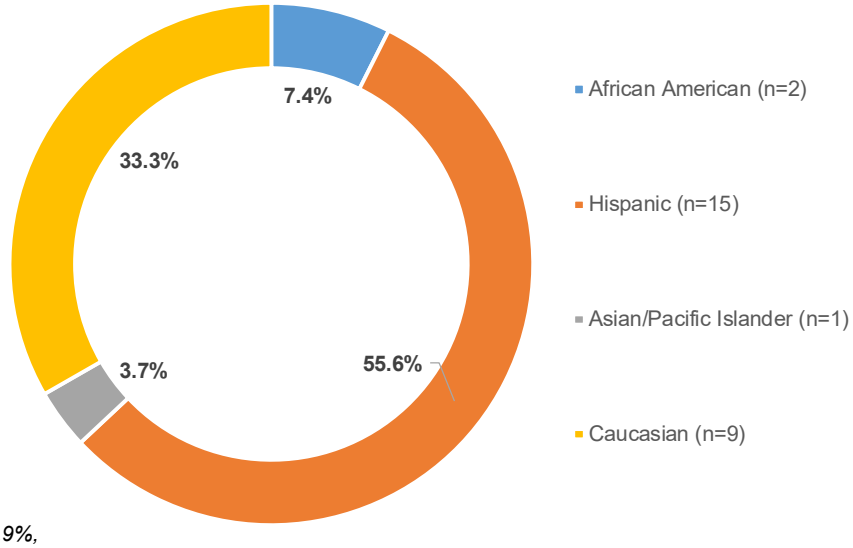
Table 17		
Child and Adolescent Suicides by Method and Gender, Los Angeles County - 2017 (N = 27)		
Method	**Male**	**Female**
Hanging	14	3
Firearms/Gunshot	4	1
Jump from height	0	1
Overdose	1	2
Asphyxia	1	0
TOTAL	**20**	**7**

Hanging was the most frequent method of suicide among adolescents and represents 63% of the suicides in 2017. Use of a firearm was the second most frequent method of suicide in 2017 with five. Three youth overdosed. One youth jumped to her death and one asphyxiated himself with a bag over his head.

In 2017, the gender gap between males and females ending their own lives decreased slightly with 74% (n=20) of the adolescent suicide victims being male and 26% (n=7) female.

Table 18							
Five Year Suicide Trend-Gender							
Gender	**2013**	**2014**	**2015**	**2016**	**2017**	**Total 2013-2017**	**5 Year Average**
Male	5	6	14	10	20	55	11
Female	8	4	9	4	7	32	6.4
Total	13	10	23	14	27	87	17.4

Figure 9: 2017 Child Suicides - Race



Los Angeles Child Population
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Hispanic 61.2%, Caucasian 17.9%,
African American 7.2%, Asian/Pacific Islander 10.4%,
Native Indian/Alaskan .1% and Multi-racial 3.2% Kidsdata.org

Figure 10: Suicides of Children by Race Compared to General Population - 2017

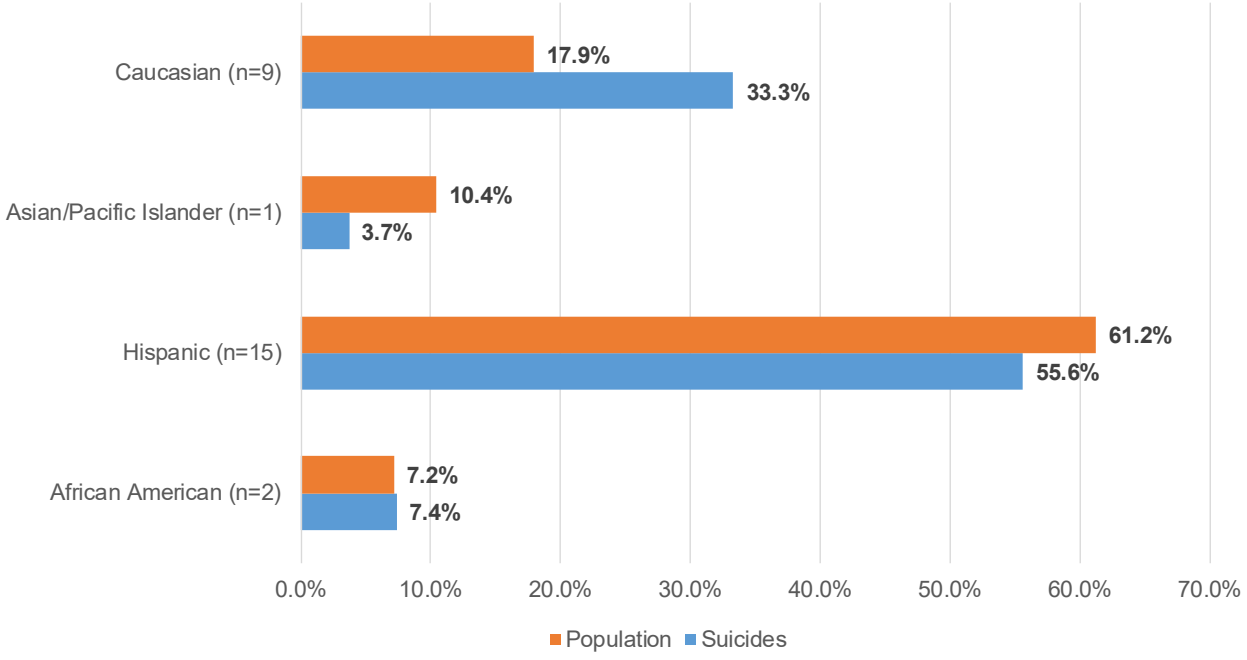


Table 19							
Five Year Trend by Age							
Age	**2013**	**2014**	**2015**	**2016**	**2017**	**Total**	**%**
17 years	4	1	9	5	9	28	32.2%
16 years	4	2	6	1	3	16	18.4%
15 years	2	0	1	3	4	10	11.5%
14 years	1	3	4	3	4	15	17.2%
13 years	1	2	3	2	4	12	13.8%
12 years	0	1	0.	0	2	3	3.5%
11 years	1	1	0	0	0	2	2.3%
10 years	0	0	0	0	1	1	1.1%
Total	13	10	23	14	27	87	100%

Figure 11: 2017 Child and Adolescent Suicides - Age

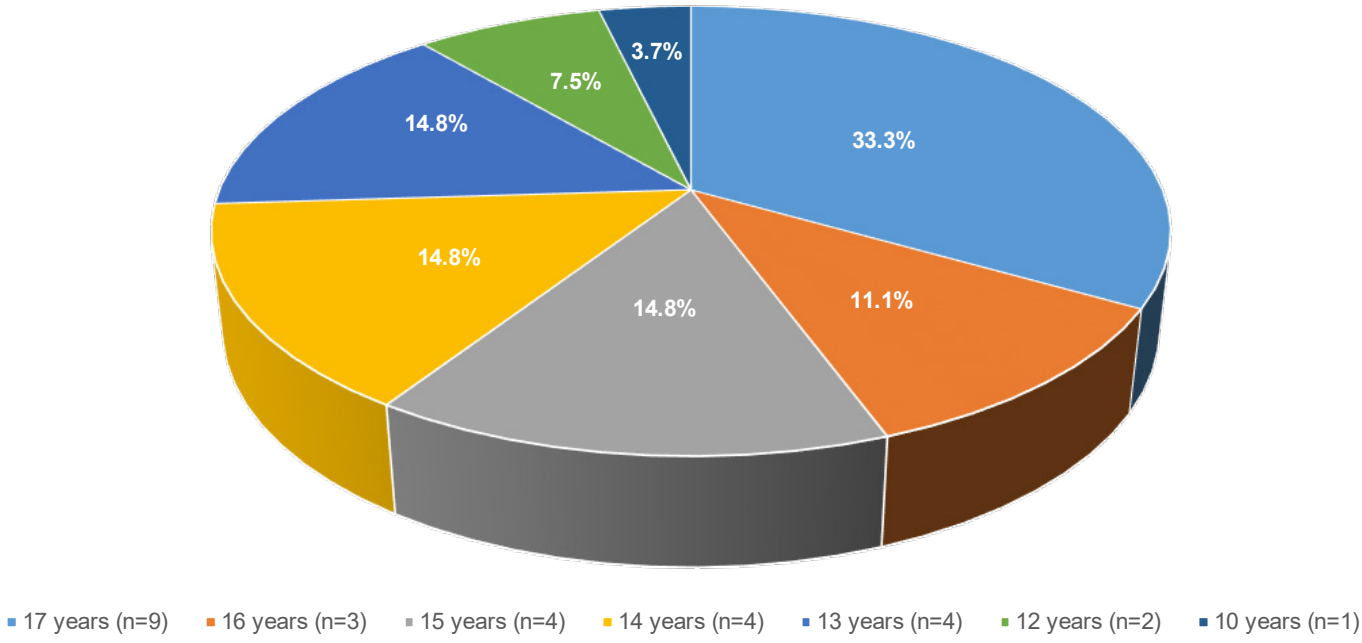


Figure 12: Percentage of Child and Adolescent Suicide Victim Factors

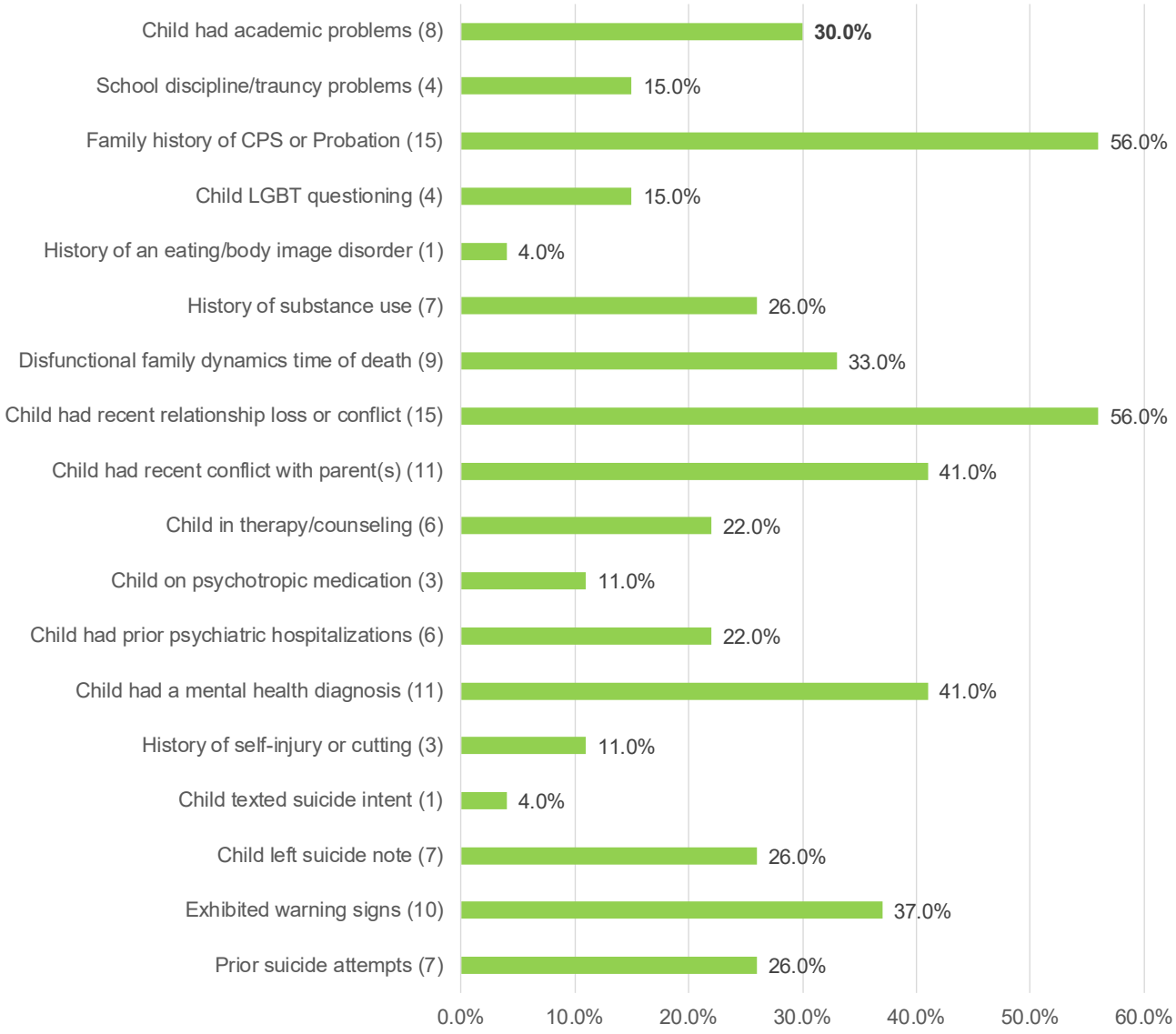
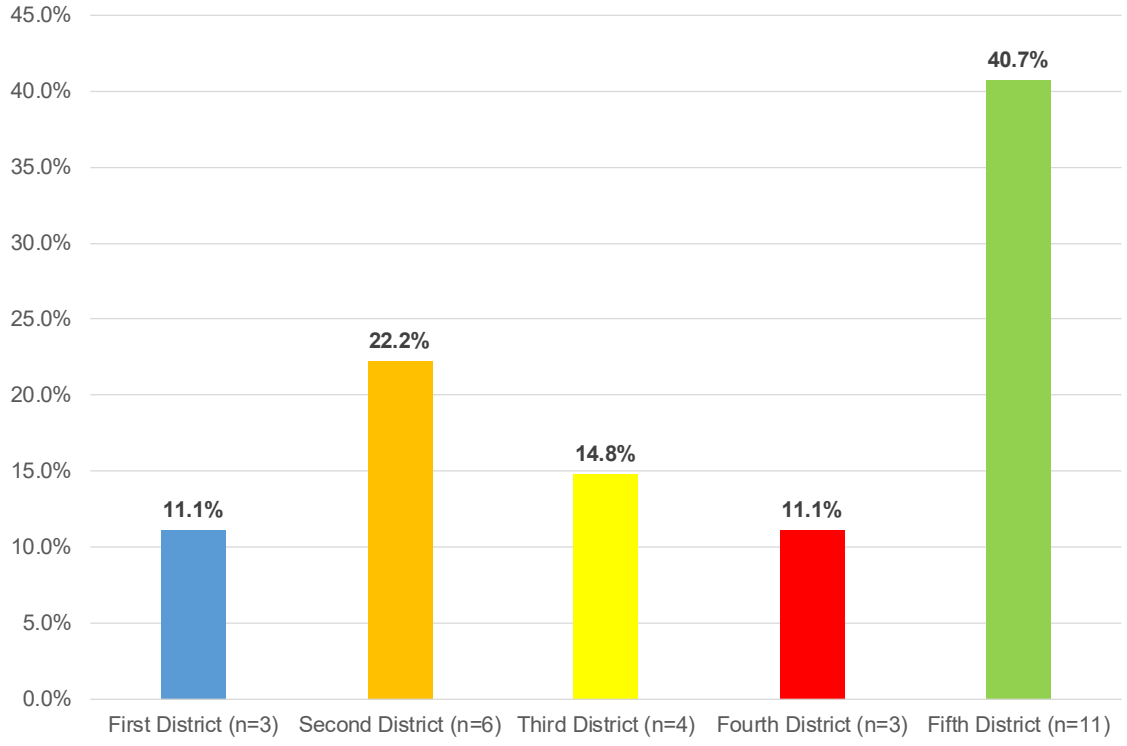


Table 20
Dates of Child and Adolescent Suicides – 2017
3 suicides occurred in January (01/01, 01/08 & 01/09)
2 suicides occurred in February (02/17 & 02/24)
0 suicides occurred in March
1 suicide occurred in April (04/01/2017)
5 suicides occurred in May (05/01, 05/02, 05/13, 05/17 & 05/27)
3 suicides occurred in June (06/18, 06/20 & 06/23)
1 suicide occurred in July (07/19)
1 suicide occurred in August (08/20)
4 suicides occurred in September (2 on 09/05, 09/08 & 09/13)
3 suicides occurred in October (10/09, 10/11 and 10/31)
3 suicides occurred in November (11/05, 11/17, & 11/26)
1 suicide occurred in December (12/19)

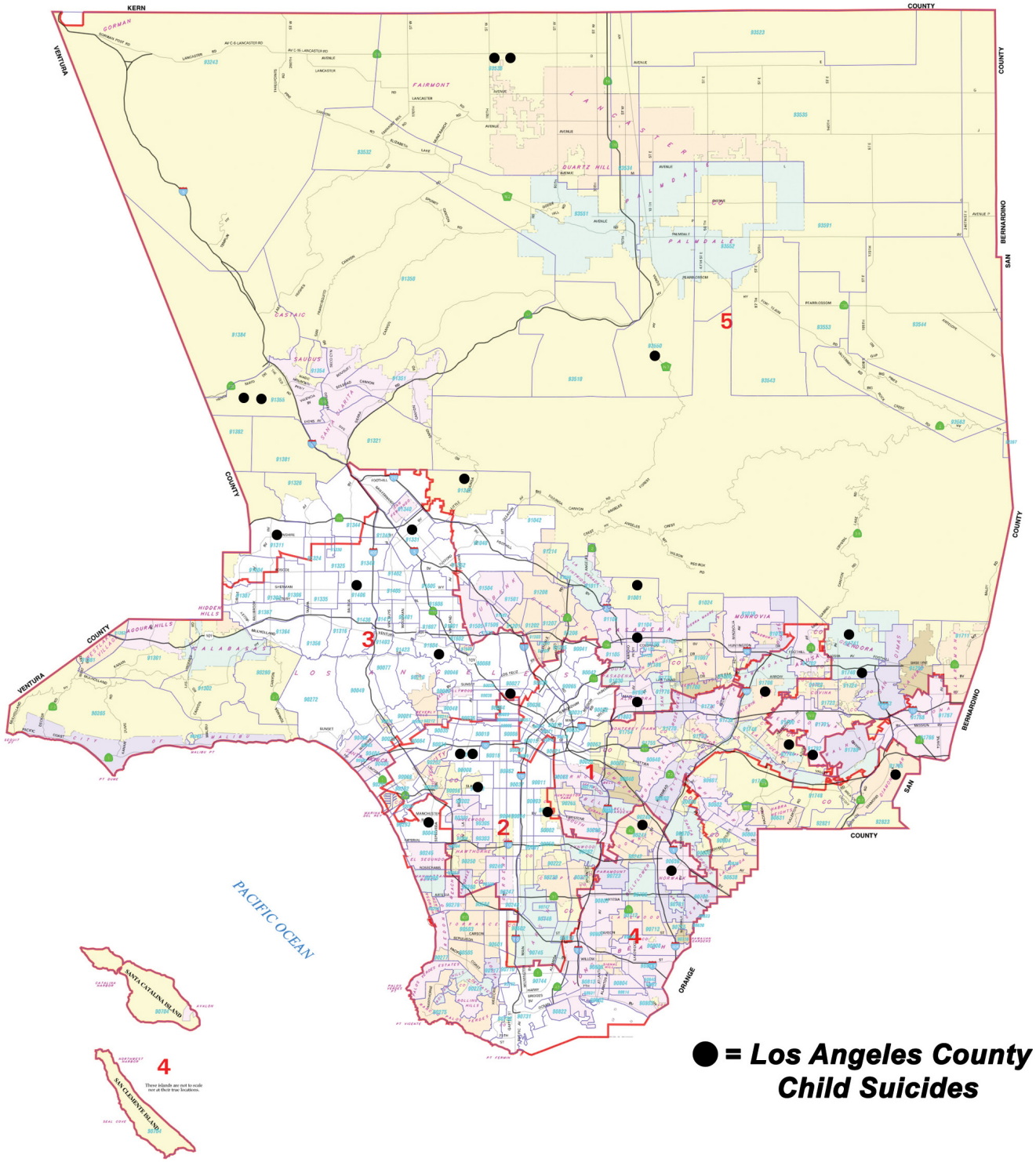
Figure 13: Location of Suicide by Board of Supervisor District



2017 Child and Adolescent Suicide - Locations

n = 27*

**City where the homicide occurred*



Sample Case Summaries

Cynthia

Three-month-old female Cynthia was riding with her parents in the family automobile. She was sitting unrestrained in her mother's lap while her father drove. Another car ran a red light and broadsided their vehicle on the mother's side. Paramedics were called and she was rushed to the hospital. She was found to have multiple blunt force trauma to her head and body which was untreatable. She succumbed to her injuries a few hours later.

Randy

Randy, age one year was in the care of his aunt at his grandmother's home. Both the aunt and Randy fell asleep in a bedroom in the early evening. When the aunt awoke, the toddler was no longer on the bed or in the room. She went searching for Randy in the house and could not find him. She went to the back sliding glass door which was ajar and spotted him floating in the swimming pool. She dove into the pool and fetched him from the water and started CPR. Neighbors had called 911 hearing her screams. Paramedics arrived and pronounced his death at the scene. The pool was surrounded by a fence. According to his mother, Randy was capable of unlatching and opening the sliding glass door. He had been scolded in the past for doing it. No one knew why the pool gate was open as it is usually closed and latched.

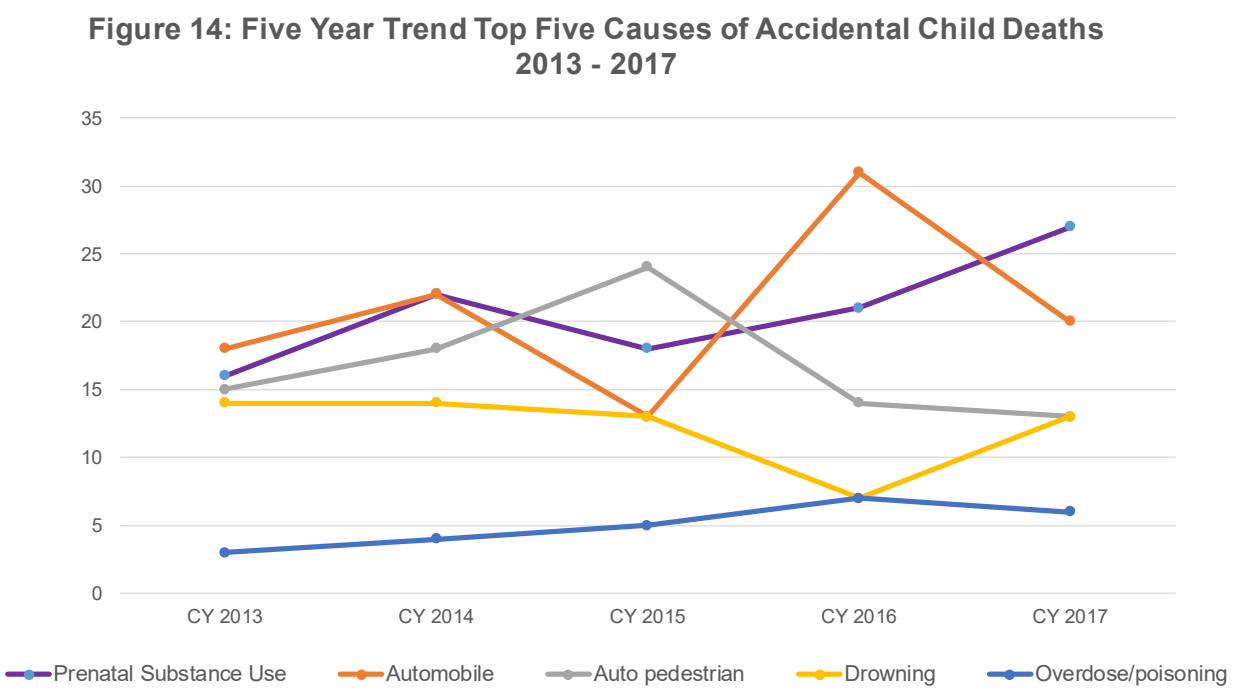
Leticia

Leticia arrived at the hospital bleeding and with contractions. She was examined and noted to be about 25 weeks into her pregnancy. She informed hospital staff that she was unaware she was pregnant and had not received any prenatal care. The infant was stillborn via C-section due to intra-uterine demise and abruption placentae. Leticia tested positive for methamphetamine and had a history of methamphetamine use. She was currently homeless. She had five other live births and all of these children were under the care of DCFS in foster care.

Janet

Seventeen-year-old Janet was found unresponsive in the morning by her grandparents with whom she resided. Paramedics were called but she could not be revived. Janet had spent the prior evening with a male friend. When interviewed, he admitted he was using various prescription opioids to deal with his heroin addiction. He said she may have taken some of his medications. Janet had a history of abusing drugs and was on probation at the time of her death. Her autopsy revealed she died from an overdose of multiple drugs with a fatal dose of buprenorphine.

Note: All names have been changed.



The chart above depicts the top five causes of accidental child death over a five-year period from 2013 to 2017. Prenatal substance use accidental deaths continue on an upward trend. Drowning deaths had remained fairly steady but increased by almost half from seven in 2016 to 13 in 2017. There was a large decline in automobile related deaths in 2017 (n=20) from 2016 (n=31). Auto pedestrian and overdose child deaths remained about the same. The "top five" causes - auto pedestrian (includes roll over), prenatal substance abuse automobile, drowning and overdose/poisoning accounted for 84.7% of all accidental child deaths in 2017.

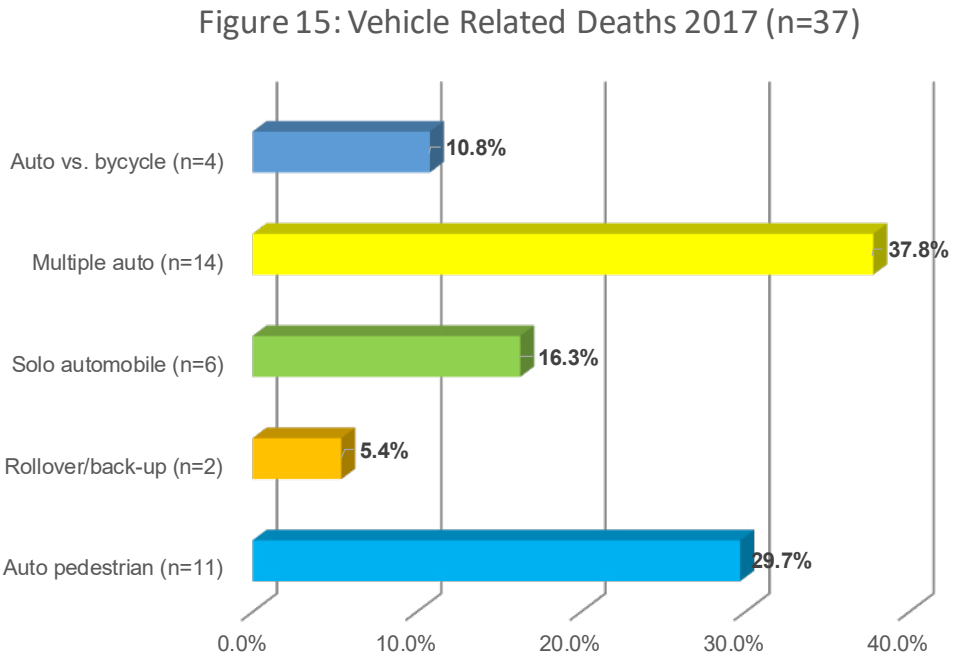


Figure 16: Motor Vehicle Related Deaths by Position of the Decedent, 2017 (n=37)

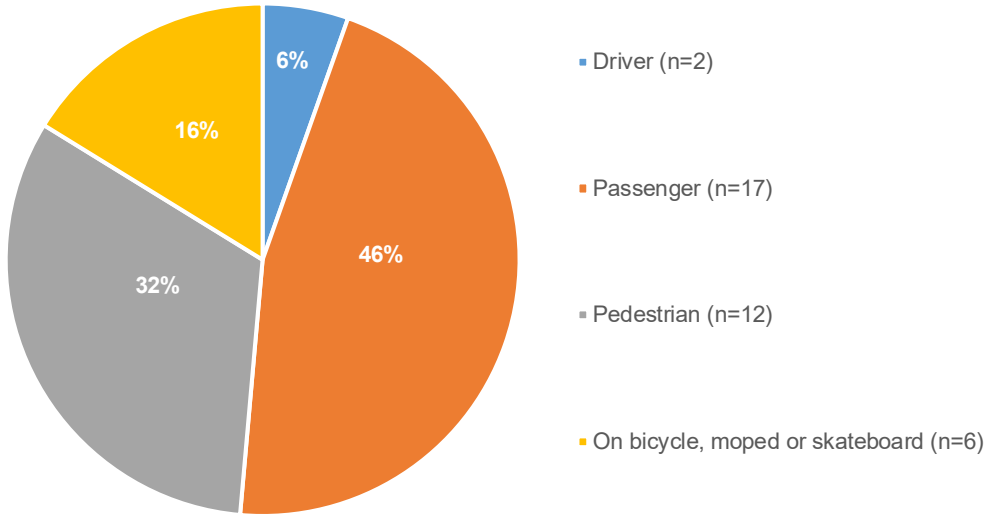


Table 21

Causes of Accidental Child Deaths, Ages 0 – 17, 2017 – Los Angeles County (N = 98)

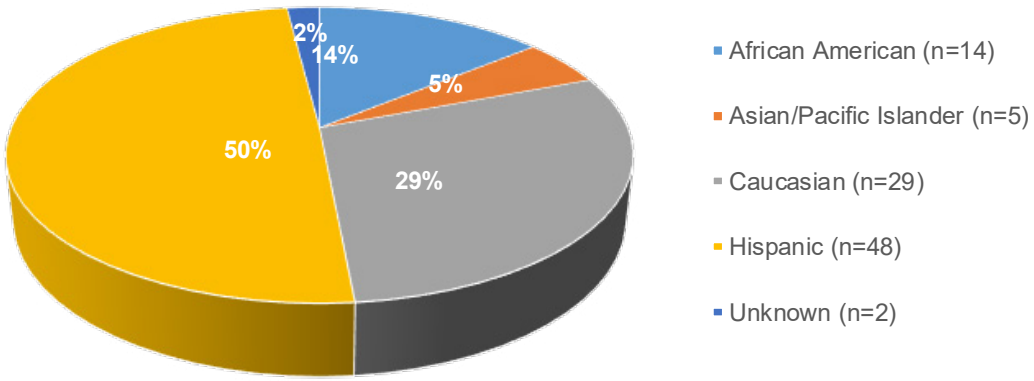
	N	%
Automobile – multi-vehicle	14	14.3%
Automobile – solo vehicle	6	6.1%
Auto pedestrian*	11	11.2%
Auto rollover	2	2.0%
Train vs. pedestrian	1	1.0%
Bicycle vs. auto/bus	4	4.1%
Prenatal Substance Abuse	27	27.6%
Drowning**	13	13.3%
Fall	1	1.0%
Fire	1	1.0%
Overdose	6	6.1%
Asphyxia	2	2.0%
Maternal air embolism	2	2.0%
Unsafe/Co-sleep	5	5.1%
Choking	2	2.0%
Hang	1	1.0%

**includes skateboard*
***includes seguelae to drowning*

Table 22			
Causes of Accidental Child Deaths by Age, 2017 – Los Angeles County (N = 98)			
	Age 0 - 5 Years	**Age 6 -14 Years**	**Age 15 - 17 Years**
Automobile – multi-vehicle	7	5	2
Automobile – solo vehicle	1	1	4
Auto pedestrian*	1	4	6
Auto rollover	2	0	0
Train vs. pedestrian	0	1	0
Bicycle vs. auto/bus	0	2	2
Prenatal Substance Abuse	27	0	0
Drowning**	10	3	0
Fall	0	0	1
Fire	1	0	0
Overdose	1	0	5
Asphyxia	2	0	0
Maternal air embolism	1	0	1
Unsafe/Co-sleep	5	0	0
Choking	2	0	0
Hang	0	1	0
Total	60	17	21

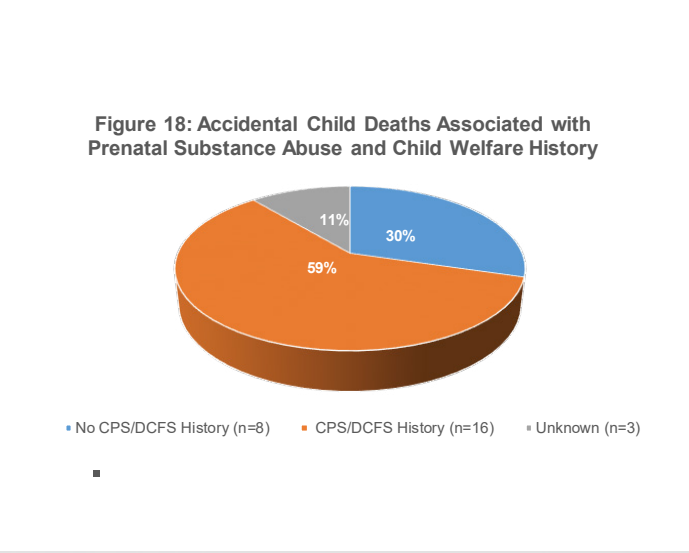
*includes rollover, moped, bus
**includes sequelae of drowning

Figure 17: 2017 Accidental Child Deaths - Race



Los Angeles Child Population Ages 0-17 2017: 2,310,266
Hispanic 61.2%, Caucasian 17.9%, African American 7.2%, Asian/Pacific Islander 10.4%, Native Indian/Alaskan .1% and Multi-racial 3.2% Kidsdata.org

Table 23			
Causes of Accidental Child Deaths by Gender 2017 - Los Angeles County (N = 98)			
	Female	**Male**	**Unknown**
Automobile – multi-vehicle	9	4	1
Automobile –single	2	4	0
Auto rollover	3	8	0
Auto Pedestrian*	0	2	0
Drowning	1	0	0
Overdose/poisoning	1	3	0
Prenatal Substance Abuse	14	13	0
Medical mishaps	4	9	0
Hit by object	0	1	0
Fire	0	1	0
Fall	3	3	0
Choking	1	1	0
Sharp Object	1	1	0
Unsafe/Co-sleep	1	4	0
Gunshot Wound	1	1	0
Bicycle vs. wall	0	1	0
TOTAL	**41**	**56**	**1**



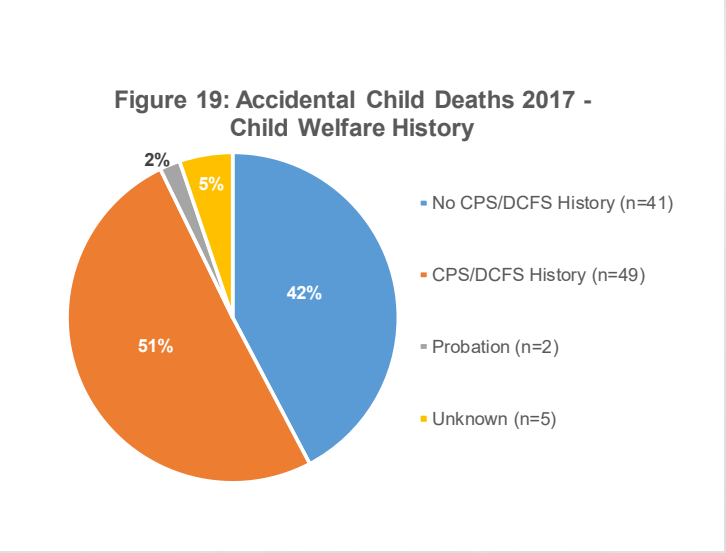


Table 24 Accidental Child Deaths Associated with Prenatal Substance Abuse (PSA) 2017 - Los Angeles County (N=27)		
Race	**Number of PSA Deaths**	**Percentage**
African American	1	3.7%
Asian/Pacific Islander	0	0%
Caucasian	12	44.4%
Hispanic	12	44.4%
Unknown	2	7.5%
Gender		
Female	14	48.1%
Male	13	51.9%
Age		
Stillborn or less than 1 day	25	92.6%
1 day to 30 days	2	7.4%
Substance		
Methamphetamines	16	59.3%
Opiates	1	3.7%
Cocaine	1	3.7%
Methamphetamine and opiates	2	7.4%
Methamphetamine and cocaine	1	3.7%
Methamphetamine and marijuana	5	18.5%
Methamphetamine and medications	1	3.7%

Table 25 Causes of Accidental Deaths with Child Welfare History, 2017 (N=49)		
	Number	**Percentage**
Automobile	9	18.5%
Auto pedestrian*	11	22.5%
Drowning	6	12.2%
Overdose/poisoning	3	6.1%
Prenatal Substance Abuse	16	32.7%
Fire	1	2%
Hang	1	2%
Maternal Air Embolism	1	2%
Unsafe/Co-sleeping	1	2%
TOTAL	49	100%

*includes moped and bicycle **includes sequelae of drowning

Sample Case Summaries - Undetermined Child Deaths

Lilly- Age 2 months

Lilly's mother was seated on the couch with her after a feeding. Lilly ate well and both mother and Lilly fell asleep on her mother's chest. The father came home to see the mother still seated asleep on the far end of the couch. To her side lay Lilly on a pillow on her back with another pillow to her side. Lilly had a small amount of blood draining from her nose and she was not breathing. The father woke the mother and called 911. While waiting for the paramedics, the mother performed CPR. Lilly was transported to the hospital but could not be revived.

Randy – Stillborn

Randy's mother presented to the hospital in active labor. The mother stated she was homeless and did not know she was pregnant. Randy was born at 30 weeks gestation with no signs of life. His mother admitted to methamphetamine use and she tested positive for methamphetamine at the birth. A bruise was noted on the left side of Randy's head. The mother refused to say if she was assaulted. She left the hospital against medical advice the next day.

Sean – 25 days

Sean and his family spent the day at his grandparents and returned late in the evening. Sean and his mother went to sleep in the parents' bed while the father stayed up to watch T.V. The father fell asleep while watching T.V. He was awakened by the mother stating Sean was unresponsive. The mother called 911 but the father took Sean and to the hospital in his car. Sean was pronounced shortly after arriving to the ER. Both parents reported they had a couple of drinks of alcohol at the family barbeque but denied being under the influence. The family had previous contact with DCFS.

Jorge – 9 months

Jorge had out grown his bassinet and slept with his mother in an adult bed. On the night of his death, Jorge went to sleep as usual with his mother. He awoke twice during the night and was feed, burped and placed on a pillow on his back next to his mother. When his mother woke up in the morning, Jorge was no longer next to her or on the bed. His mother frantically searched for him and spied his head facing the wall between the mattress and the wall. When she pulled him back onto the bed, he was unresponsive and not breathing. 911 was called and paramedics transported him to the hospital but he could not be revived. The mother reported the family was receiving services from DCFS.

Note: All names have been changed.

Figure 20: 2003 - 2017 Undetermined Child Deaths

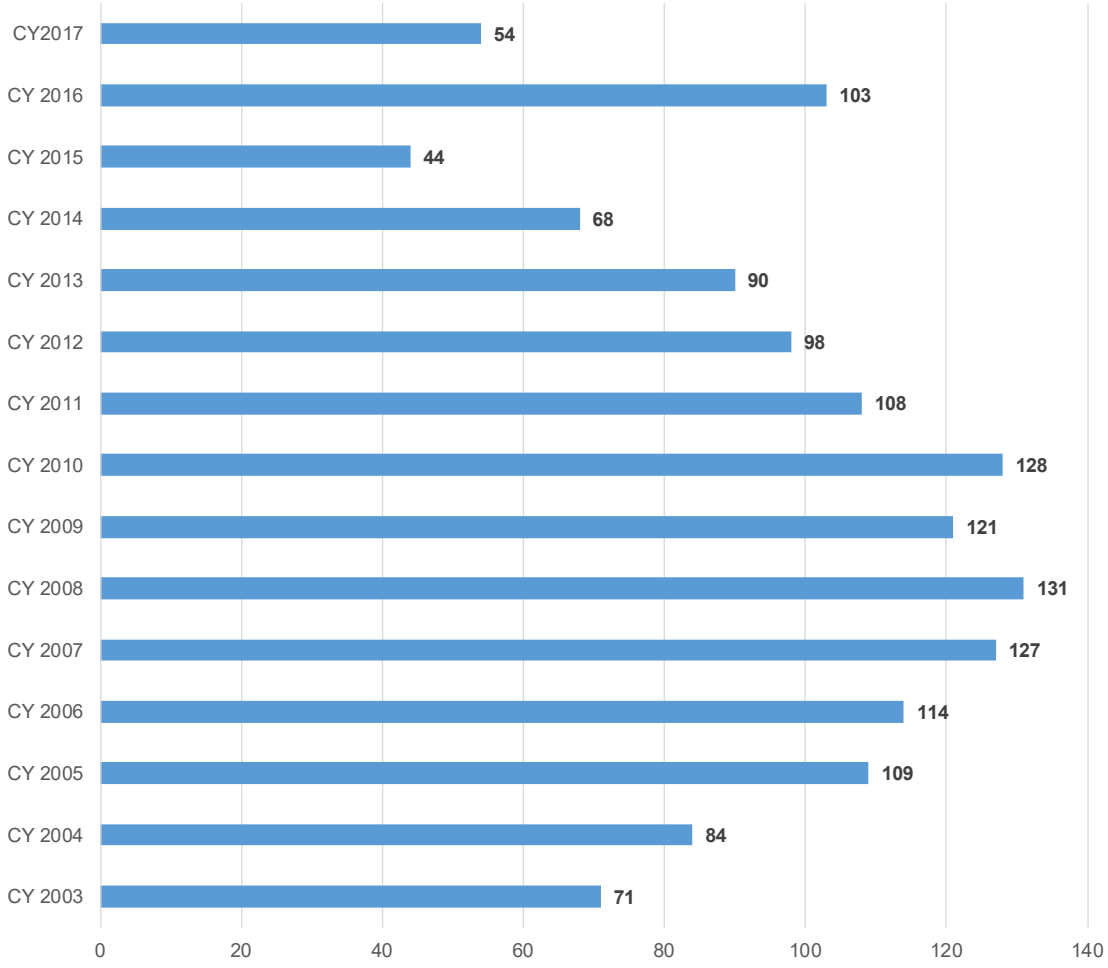


Table 26		
Undetermined Child Deaths – 2017 (N=54)		
Race	**Number**	**Percentage**
African American	22	40.7%
Asian/Pacific Islander	2	3.7%
Caucasian	5	9.3%
Hispanic	23	42.6%
Unknown	2	3.7%

Gender	Number	Percentage
Female	25	46.3%
Male	29	53.7%

Age	Number
Stillborn	5
Less than 1 day	0
1 day to 30 days	4
1 month to 5 months	30
6 months to 1 year	8
1 year to 2 years	4
3 years	1
16 years	1
17 years	1

Child Welfare History	Number	Percentage
At least one contact with CPS	26	48%
Contact as a child with CPS	21	39%

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

87% of the undetermined child deaths were age one year or under.

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

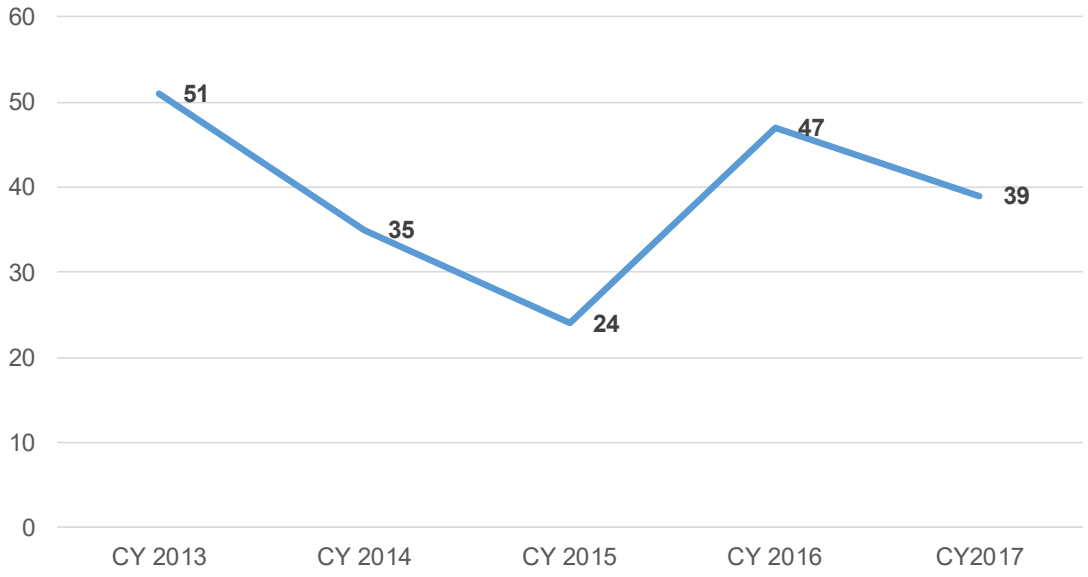


Figure 22: Bed-sharing and Unsafe Sleeping Undetermined Child Deaths 2017

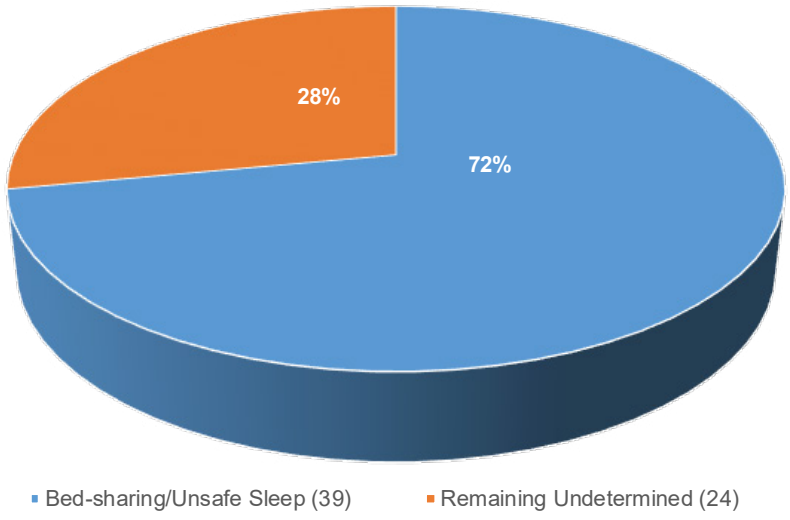


Figure 23: Unsafe Sleep and Bed-sharing Child Deaths Compared to Remaining Undetermined Child Deaths 2017

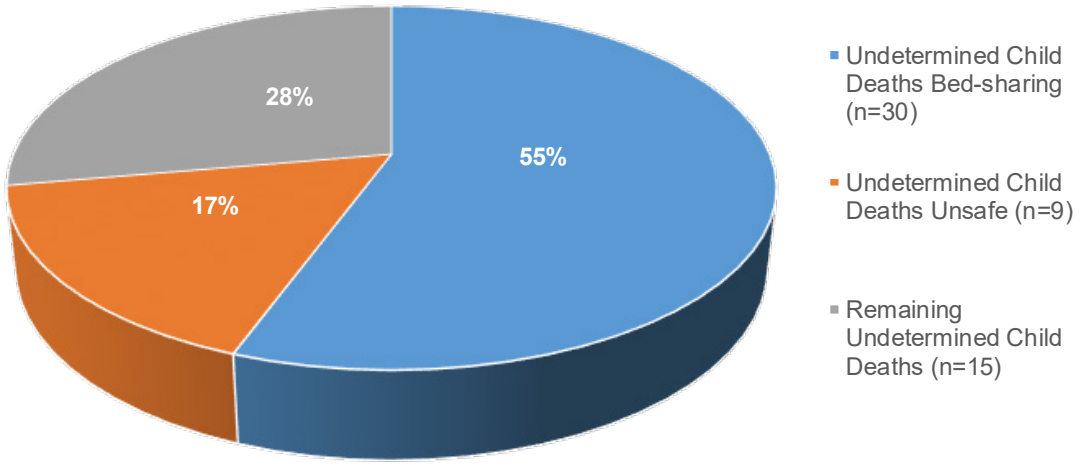


Figure 24: Bed-sharing and Unsafe Sleep Child Deaths by Board of Supervisor District - 2017

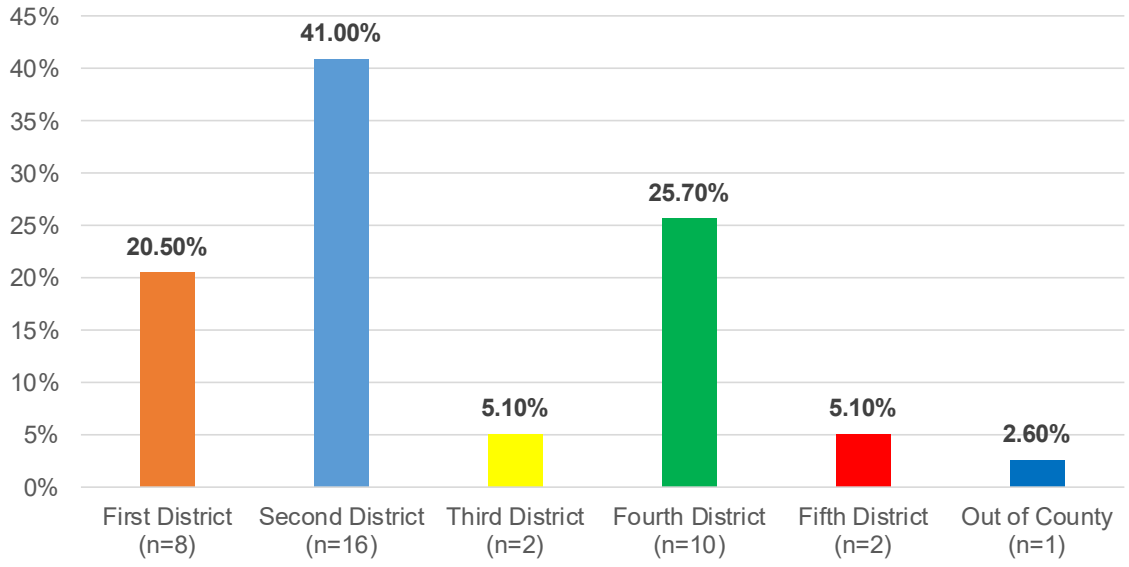


Table 27		
Bed-sharing and Unsafe Sleeping Environments- Number of Risk Factors Present at Time of Death 2017		
Bed-Sharing* (n=30)	**Number**	**Percentage**
One Unsafe Risk Factor	0	0%
Two Unsafe Risk Factors	14	47%
Three or more Unsafe Risk Factors	16	53%

Unsafe Sleeping Environment** (N=9)	Number	Percentage
One Unsafe Risk Factor	0	0%
Two Unsafe Risk Factors	7	78%
Three or more Unsafe Risk Factors	2	22%

*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 - 2017

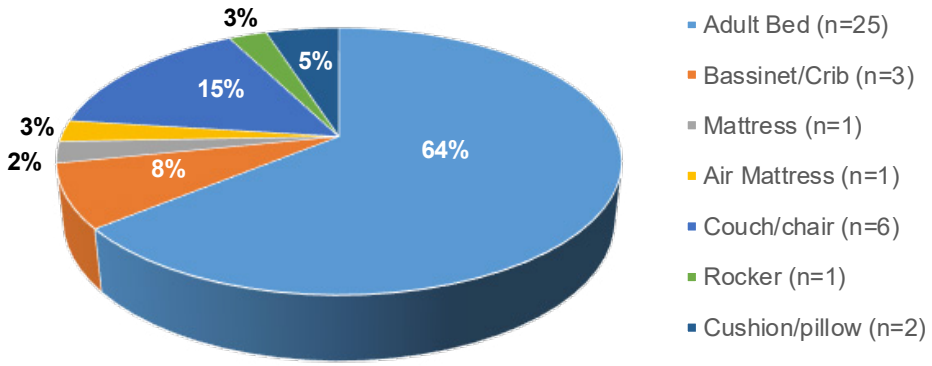


Figure 26: Sleep Position All Unsafe Sleep Practice Deaths (n=40)

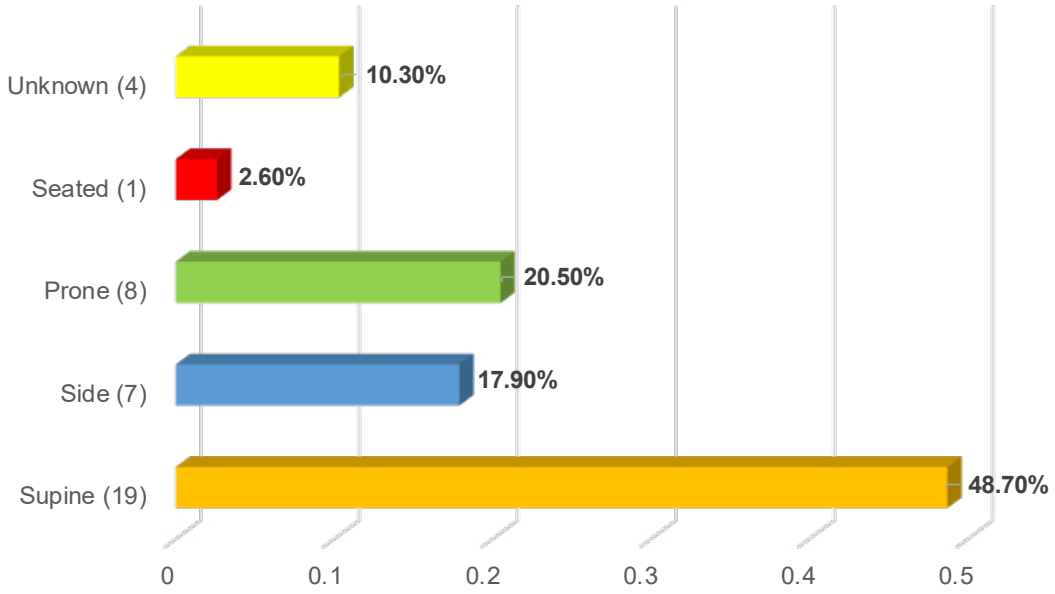


Table 28

Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 39)

	Number
Pillow(s)	16
Soft and/or excessive bedding	7
Excessive swaddling	3
Propped bottle	1
Parental drug/Alcohol use**	2

*Excludes bed-sharing, sleep surface and infant position
**Detected on parents at time of death

Table 29

Bed-sharing and Unsafe Sleeping Environment Child Welfare History

	Number	Percentage
Unsafe Sleep/Bed-sharing with Caregiver Child Welfare History	18	46%
Unsafe Sleep/Bed-sharing with Caregiver Child Welfare History as a Minor	16	38%
Total Unsafe Sleep/Bed-sharing	39	100%

Figure 27: Percentage of Undetermined Child Deaths - Bed-sharing

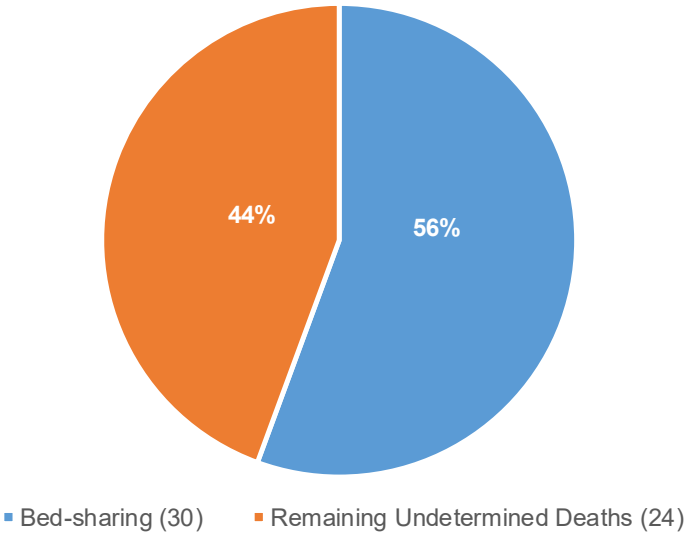


Figure 28: 2017 Bed-sharing Deaths - Number of Persons Sleeping with Child

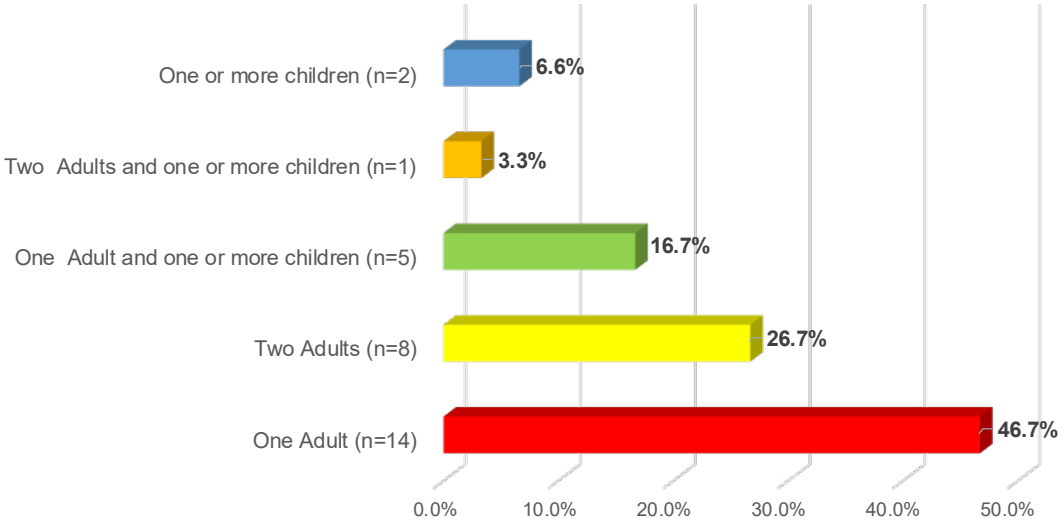


Figure 29: Undetermined Bed-sharing Child Deaths - Age

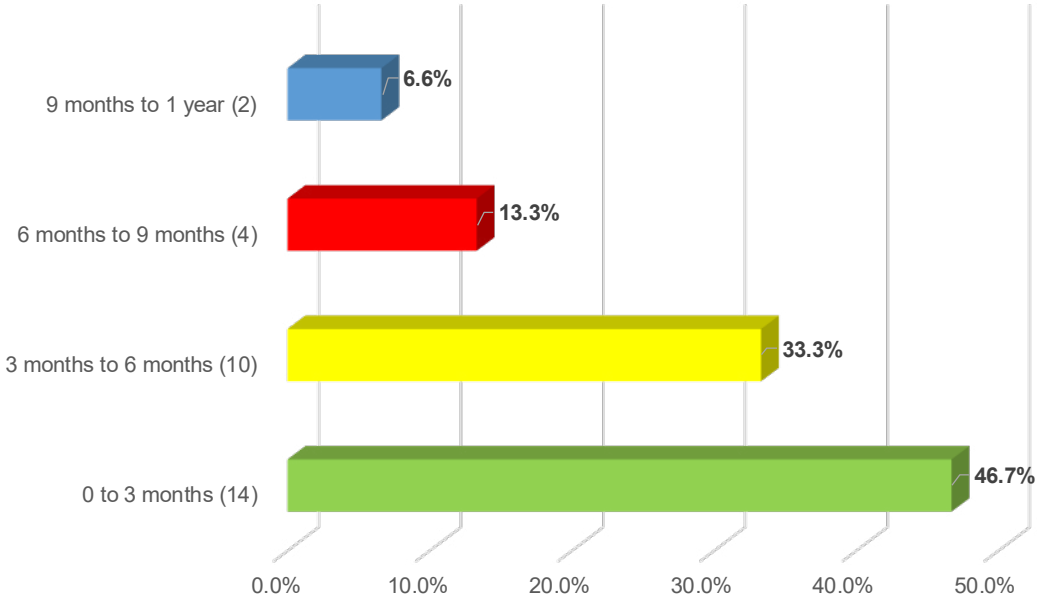


Figure 30: 2017 Bed-sharing Child Deaths - Race

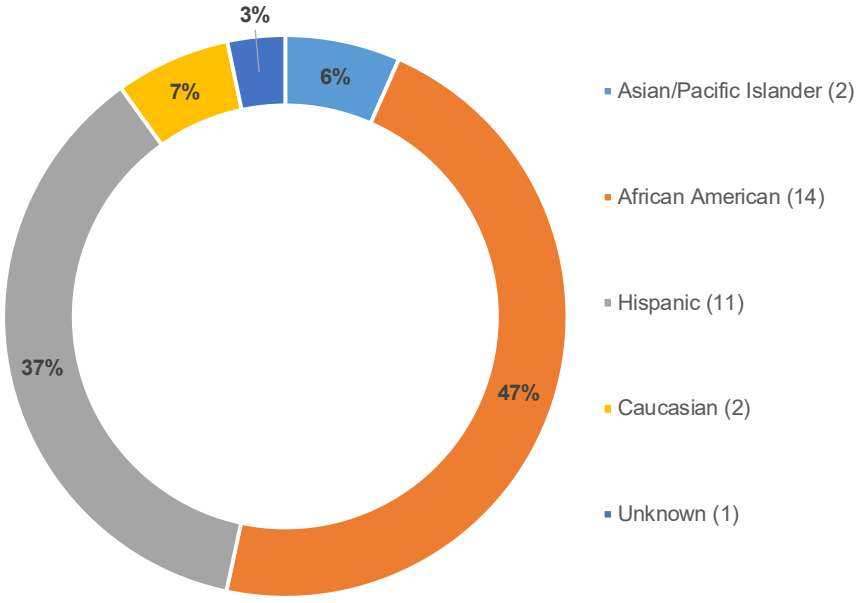


Figure 31: Non-bed-sharing Unsafe Sleep Deaths - Age

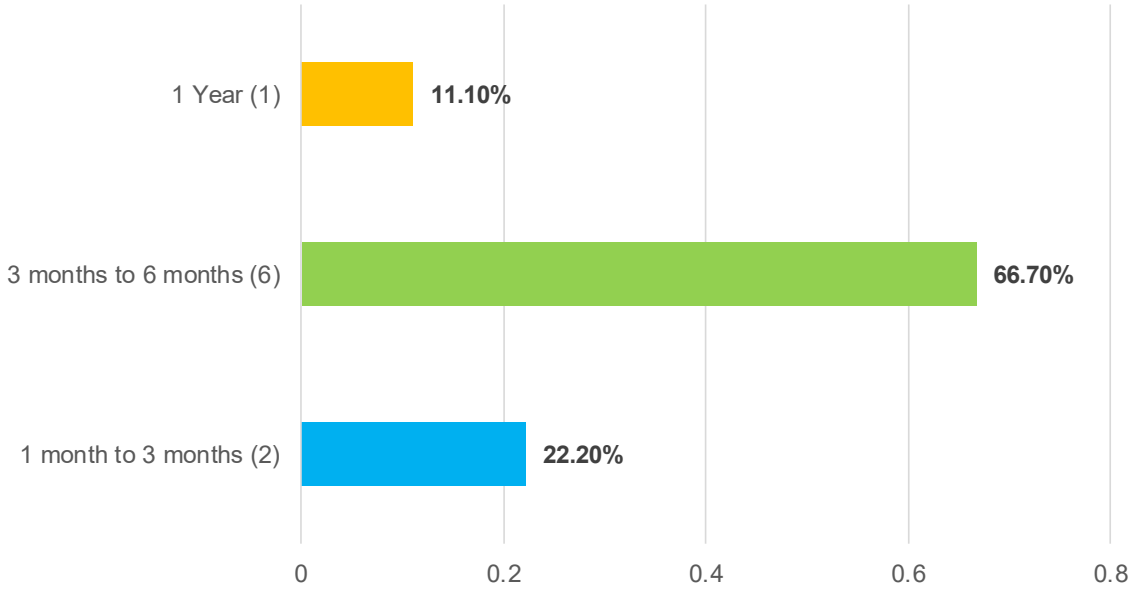
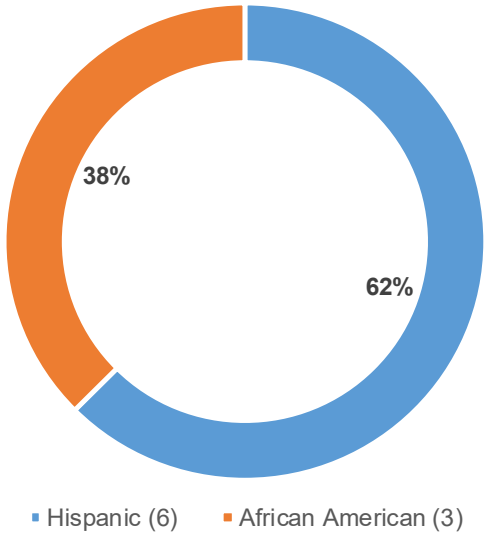


Figure 32: 2017 Non-bed Sharing Unsafe Sleep - Race



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

Table 30	
Unsafe Non-bed Sharing Child Deaths Sleeping Environment* - 2017	
	Number
Soft and/or excessive bedding	4
Pillow(s)	5
Adult bed	4
Prone position	5
Couch	1
Excessive swaddling	2
Sleep sack	1

Table 31

2017 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 = 3)

Substance	Number	Percentage
Methamphetamine	1	33%
Cocaine	1	33%
Unknown	1	33%

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%)
2017	3	0 (0%)	1 (33%)	1 (33%)	2 (67%)

*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.

Table 32

Unsafe Non-bed Sharing Child Deaths Sleeping Environment* - 2017

Race	Number	Percentage
African-American	2	67%
Unknown	1	33%
Total	**3**	**100%**

Age	Number	Percentage
Stillborn	3	50%

Introduction

The ICAN Child Death Review Team report has historically 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 eleven years. However, between the years 2013 – 2017, the downward trend has been more flat with an average of 25.6 homicides with a range of 19 to 31 per year. Regardless, the decline from 100 such deaths to in 2007 to 21 in 2017 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.

Sample Case Summaries

Mark

911 was called by residents after hearing gun shots fired at 2:00 am. Upon arriving to the location, deputies noted a blood trail along a sidewalk and followed it to a closed stairwell door. They encountered Mark, age 16 years, slumped on the stairs suffering from multiple gunshot wounds. Paramedics arrived and pronounced Mark at the scene. A damaged spray can and multiple casings were located in the area next to where Mark was found. He was known tagger and it is suspected his death was gang-related. His case remains under investigation, and there are no suspects in custody at this time.

Christian

Christian, age eight years, was visiting a family friend with his parents. Around 6:30 in the evening, the family was in the living room when multiple gunshots were fired from outside the house into the living room area. Angel was hit in the head by one of the bullets. 911 was called and paramedics transported him to the hospital. He was pronounced dead shortly after arriving to the ER. A 36-year old man was later arrested for his death. He had allegedly shot at the home on other occasions when no one was home before and after the murder. Police were not sure why he targeted the home. He was found guilty by a jury and sentenced to life without parole.

Oscar

Oscar, age 17 years, was standing on the street with a group of friends. The suspects drove into a nearby alley and got out of the vehicle. One suspect approached the group and fired several rounds striking Oscar numerous times. The suspect fled back to the vehicle and it took off. The group of friends had scattered and no one else except Oscar was hit by the gun fire. Oscar and the people he was standing with were known to be associated with a gang. Oscar was on active probation at the time of his death. The case remains under investigation, and no suspect is in custody.

Baby Girl's mother

According to law enforcement, officers responded to a "woman down" radio call. They found Baby Girl's mother, lying unresponsive on the ground with multiple gunshot wounds. She was transported by paramedics to the hospital. She was found to be about 30 weeks into her pregnancy and her uterus had been perforated by a bullet. She underwent an emergency C-section delivering a stillborn Baby Girl. Despite the five wounds she received in the upper chest and torso, Baby Girl's mother survived her wounds and was hospitalized in serious but stable condition. No suspects are in custody and her case remains under investigation.

Note: All names have been changed.

Findings

- There were 21 third party homicides in 2017. This is a decrease from 2016 in which the number of third party homicides were 27.
- Eighty-six percent (n=18) of the youth were victims of gunshot wounds.
- As in the previous five years, male victims outnumbered female victims. Twenty males and one female were homicide victims in 2017.
- Eighty-one percent (n=17) of the children who were victims of a third party homicide in 2017 were ages 16 – 17. One victim was eight-years old and another stillborn as a result of an assault on the mother.
- The majority of the victims were Hispanic youths with 12 victims. Seven 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 June (n=5). The second greatest number occurred in the months of January (n=3) and May (n=3). The third greatest number occurred in the months of February, September and December (n=2). The least number of homicides occurred during the months of March, April, October and November with one each. No third party homicide occurred in the months of July and August
- While third party homicides occurred throughout Los Angeles County in 2017, the majority (n=9) of these deaths occurred in the 2nd Board of Supervisorial (BOS) District, which was followed by the 4th BOS and 5th Districts each with 5 third party homicides. Two occurred in the 1st BOS and there were no third party homicides in the 3rd BOS District.
- The Los Angeles Police Department (LAPD) had investigative authority for 47.6% of the third party homicide cases in 2017. 42.8 percent of the cases were under the jurisdiction of the Los Angeles Sheriff's Department (LASD). Long Beach PD and Pomona PD each handled one homicide.
- Two of the third party homicides were law enforcement officer involved shootings. It should be noted that one of these shootings involved a youth robbing an officer out of uniform who fired in self-defense.
- When the relationship of the perpetrator was identified by law enforcement, three of the homicide perpetrators were a gang member, 62% of these homicides were suspected to be gang-related and 24% of the victims were also gang or tagging crew involved (n=5). Finally, 29% (n=6) 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 2017 third party homicides remain unknown as in previous years.
- Eighty-six percent of the victims had a history with DCFS, another county child welfare agency or Probation. Fourteen of the victims had a history with DCFS or another Child Welfare agency and four of the victims had a history with the Probation Department. Two had an open case with DCFS and three had an open case with the Probation Department at the time of the victim's death. One youth was recently arrested but not on active probation at the time of his death.

Figure 33: 2007 - 2017 Third Party Homicides

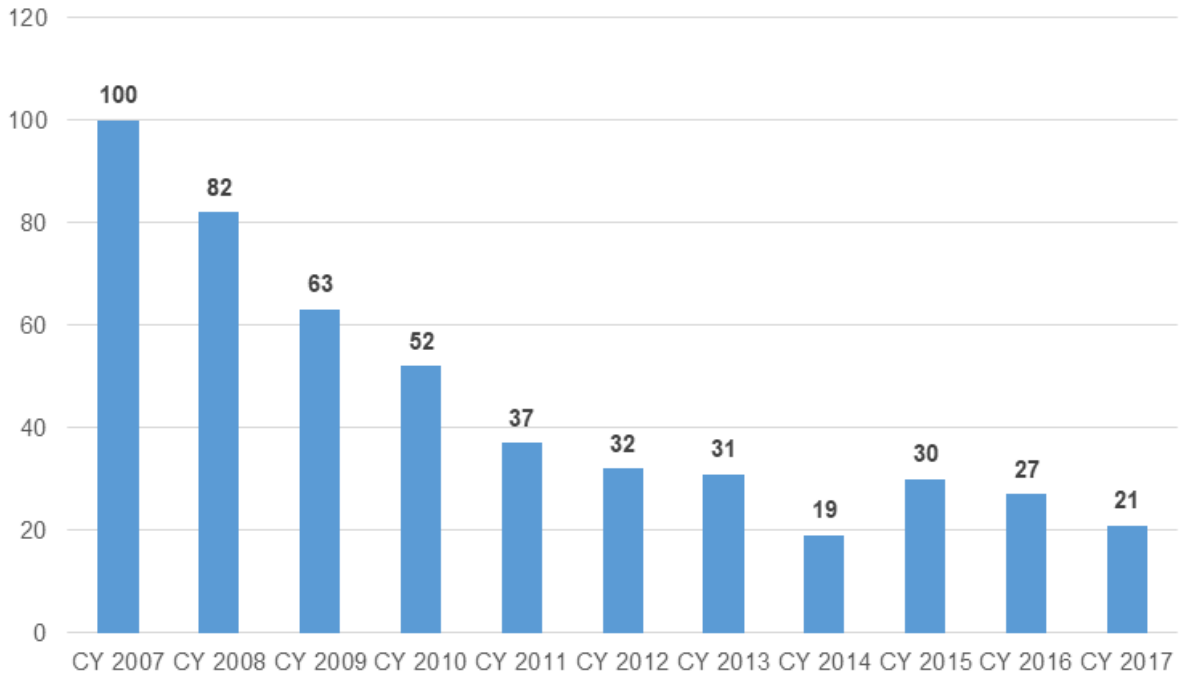


Figure 34: 2017 Third Party Homicides - Cause

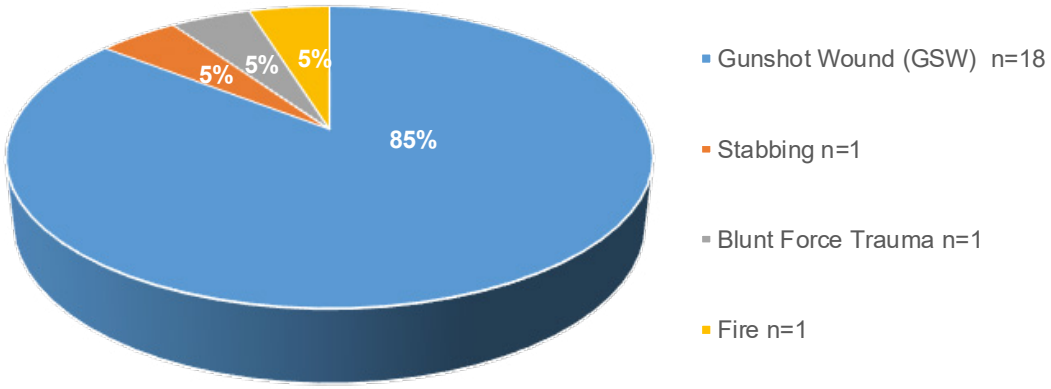
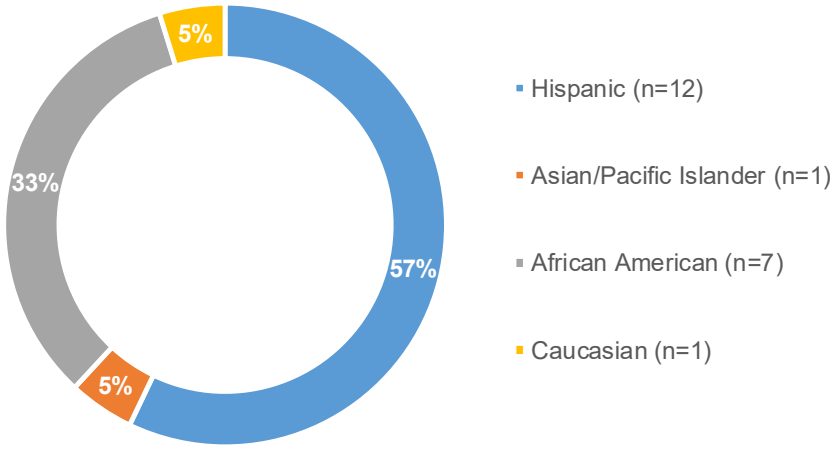


Table 33		
Third Party Homicides by Age and Sex Los Angeles County		
Age	**Female**	**Male**
Stillborn	1	0
8 years	0	1
15 years	0	2
16 years	0	7
17 years	0	10
Total	**1**	**20**

95.2% of the third party homicide victims were male.

81% of the third party homicide victims were 16 to 17 years of age.

Figure 35: 2017 Third party Homicides - Race



Los Angeles Child Population
Ages 0-17: 2,310,266 Hispanic 61.2%, Caucasian 17.9%, African American 7.2%, Asian/Pacific Islander 10.4%, Native Indian/Alaskan .1% and Multi-racial 3.2% Kidsdata.org

Table 34

Dates[1] of Third Party Homicides - 2017

3 homicides occurred in January (01/08, 01/13 & 1/28)
2 homicides occurred in February (02/20 & 02/23)
1 homicide occurred in March (03/04)
1 homicide occurred in April (04/04)
3 homicides occurred in May (05/23, 5/25 & 05/27)
5 homicides occurred in June (06/04, 06/06, 06/22, 06/23 & 06/27)
0 homicides occurred in July
0 homicides occurred in August
2 homicides occurred in September (9/11 & 09/16)
1 homicide occurred in October (10/16)
1 homicide occurred in November (11/13)
2 homicides occurred in December (12/11 & 12/15)

Table 35

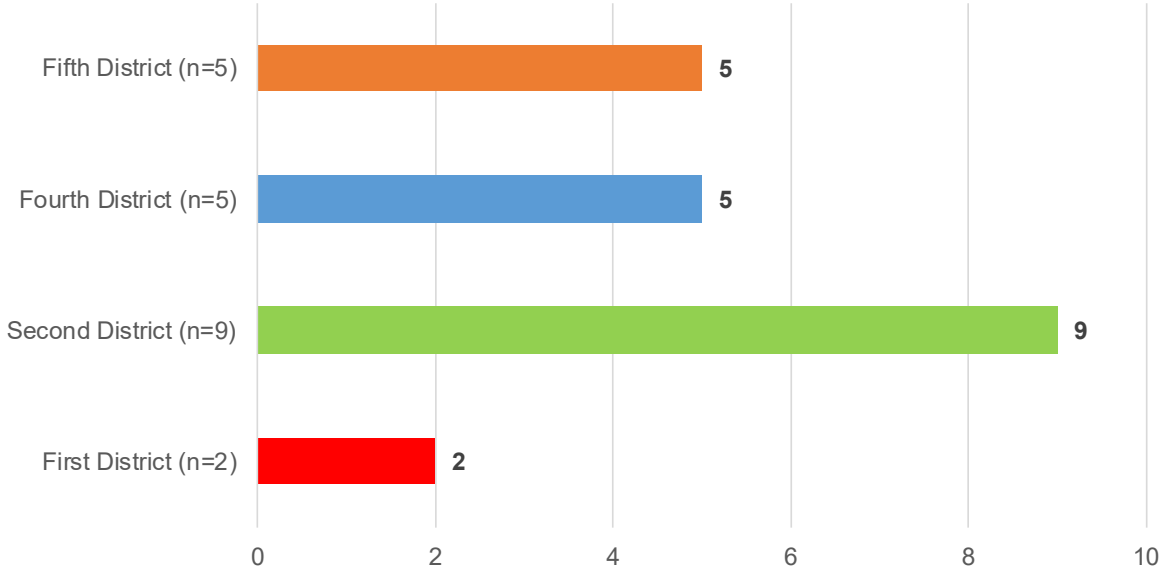
Locations[2] of Third Party Homicides – Geographic Area - 2017

2 homicides each occurred in Los Angeles zip codes 90001 & 90044)
1 homicide each occurred in Los Angeles (zip codes 90002, 90003, 90011, 90023, 90043)
2 homicides occurred in Wilmington (zip code 90744)
1 homicide occurred in Long Beach (zip code 90813)
1 homicide occurred in Harbor City (zip code 90710)
1 homicide occurred in Lynwood (zip code 90262)
1 homicide occurred in Bellflower (zip code 90706)
1 homicide occurred in Arcadia (zip code 91006)
1 homicide occurred in Duarte (zip code 91010)
1 homicide occurred in Palmdale (zip code 93550)
1 homicide occurred in Lancaster (zip code 93536)
1 homicide occurred in Sylmar zip code 91342)
1 homicide occurred in Pomona (zip code 91766)

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

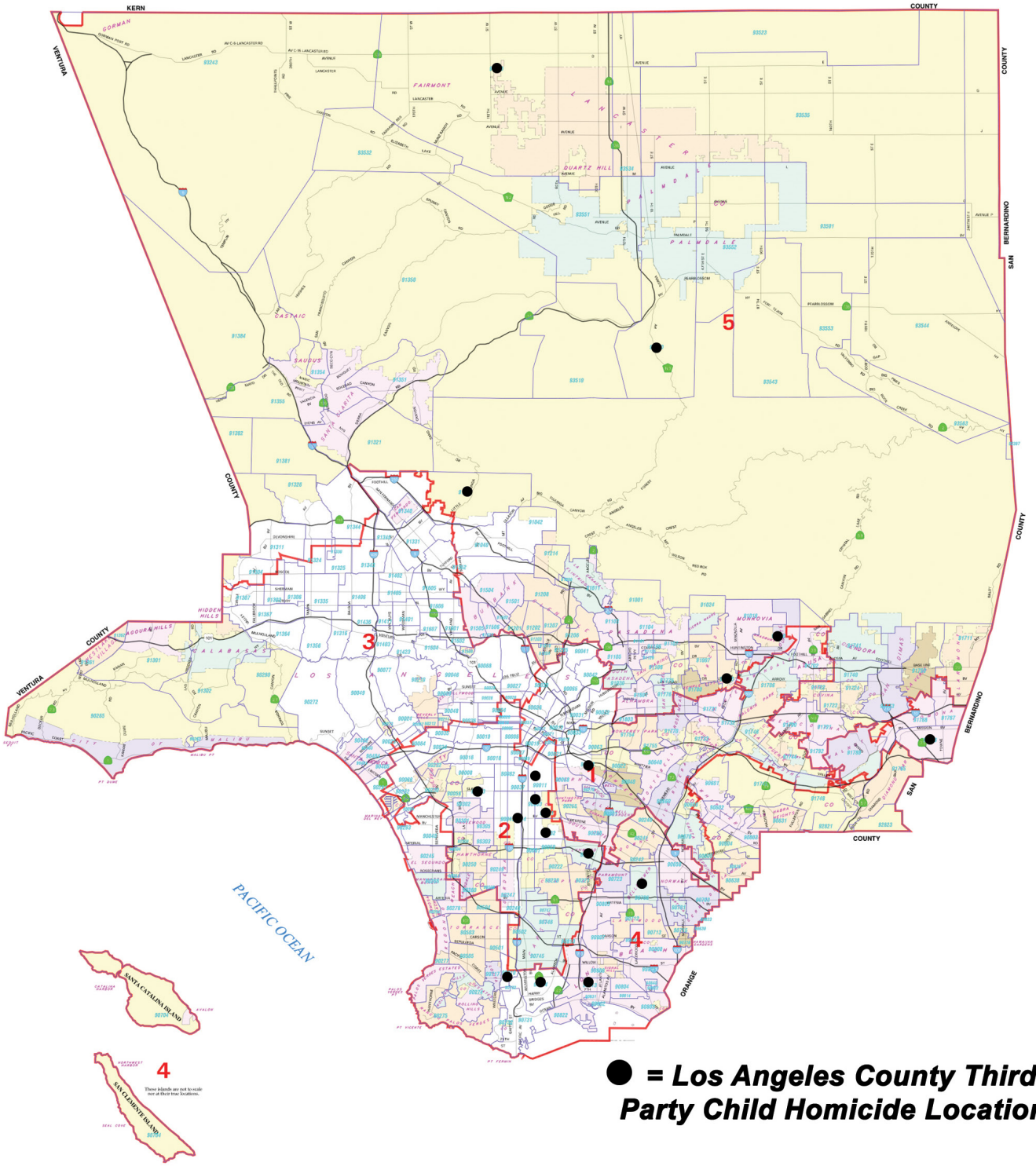
Figure 36: Third Party Homicides by Board of Supervisor District



2017 Third Party Homicide - Location

*n = 21**

**City where the homicide occurred*



Third Party Homicides

Information on the criminal justice system involvement in third party homicide cases was gathered from three sources: Los Angeles County District Attorney's office, Los Angeles Police Department (LAPD), and the Los Angeles Sheriff's Department (LASD). In 2017, there were 21 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	10	47.6%
LASD	9	42.8%
Long Beach PD	1	4.8%
Pomona PD	1	4.8%

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 not all of the law enforcement agencies were able to provide much detail about the suspect's circumstances, which is why cases fall under the "no information provided" or ":suspected" categories. 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
Not a Gang Member	3
No Information Provided or Unknown	3
Gang Member	10
Officer Involved	2
Suspected to be Gang Related	3

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	6
Shot during a drive-by shooting	5
Officer Involved	2
Gang member or tagger	5
Not a Gang Member	10
Child Welfare History	18
Open DCFS Case	2
Active Probation Case	3

According to the information provided by the Los Angeles County District Attorney's office, Los Angeles Police Department (LAPD), and the Los Angeles Sheriff's Department (LASD), 6 of the 21 cases of third party homicides were referred to the District Attorney's office in 2017. Six cases had criminal charges of murder filed by the District Attorney's office in 2017. Two of the twenty-one were officer involved and no charges were filed. The remaining cases continue to be under investigation.

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

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

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.org

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