ICAN

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

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

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

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

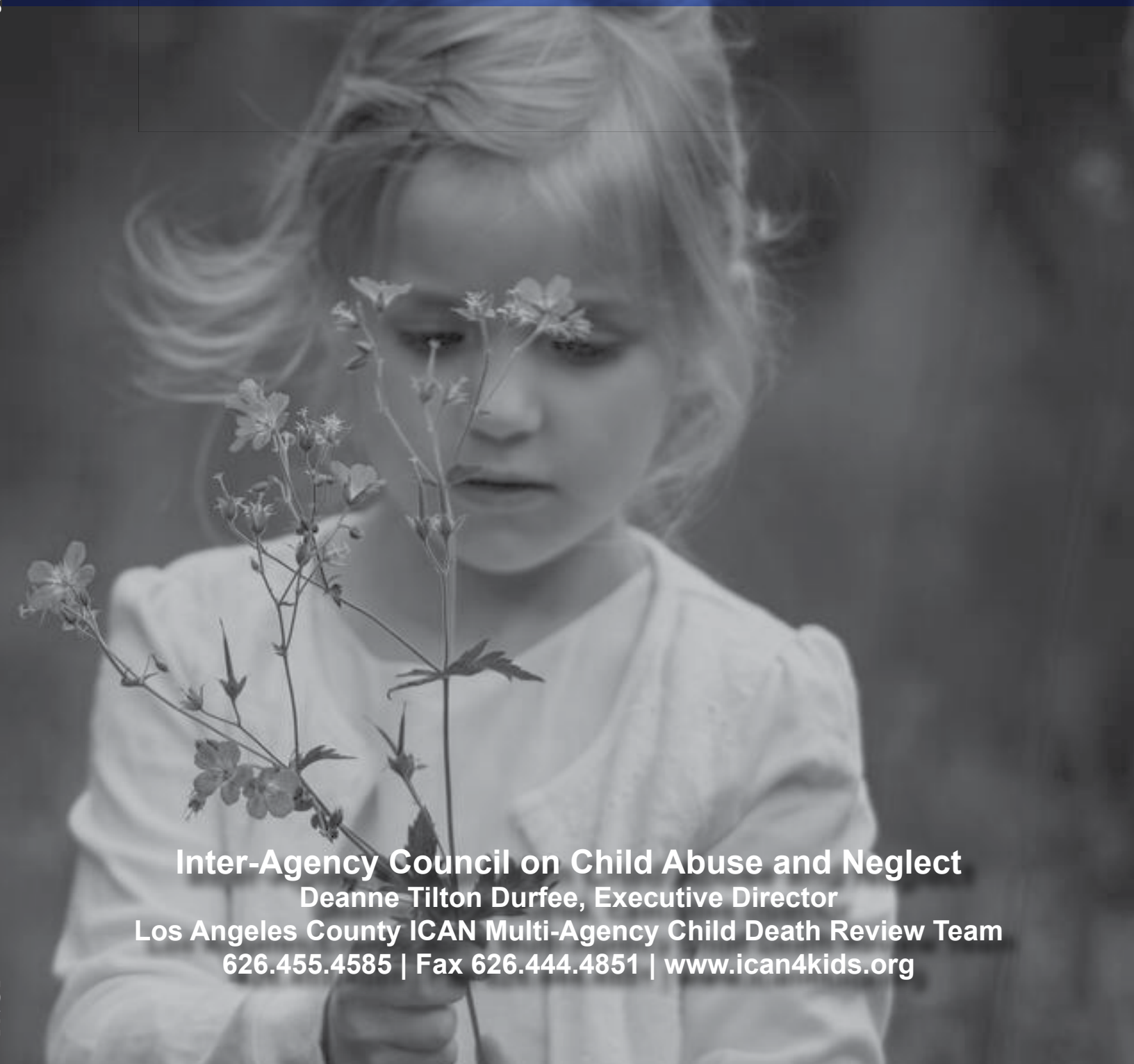
In 1996, ICAN Associates, Inc. received a grant from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, to establish the ICAN National Center on Child Fatality Review (NCFR). The mission of NCFR is to develop and promote a nationwide system of Child Fatality Review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

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

ICAN

Child Death Review Team Report 2020

Report Compiled from 2019 Data



Inter-Agency Council on Child Abuse and Neglect
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Lynda Boyd, *Los Angeles County, Department of Mental Health*

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Stephanie Murray, *Whittier Union High School District*

Teams Include Representatives From The Following

Children and Family Services
Public Health
Health Services
Office of Education
District Attorney
Los Angeles Police Department
Los Angeles Fire Department
Office of City Attorney
Los Angeles Unified School District
Edelman Children's Court
Community Care Licensing
Independent Police Agencies
Children's Hospital of Los Angeles
Community Child Abuse Councils
Chicago School of Professional Psychology
Medical Hubs
County Counsel
Public Social Services
Sheriff
Mental Health
Medical Examiner-Coroner
Probation
Fire
Community Development Commission/Housing
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

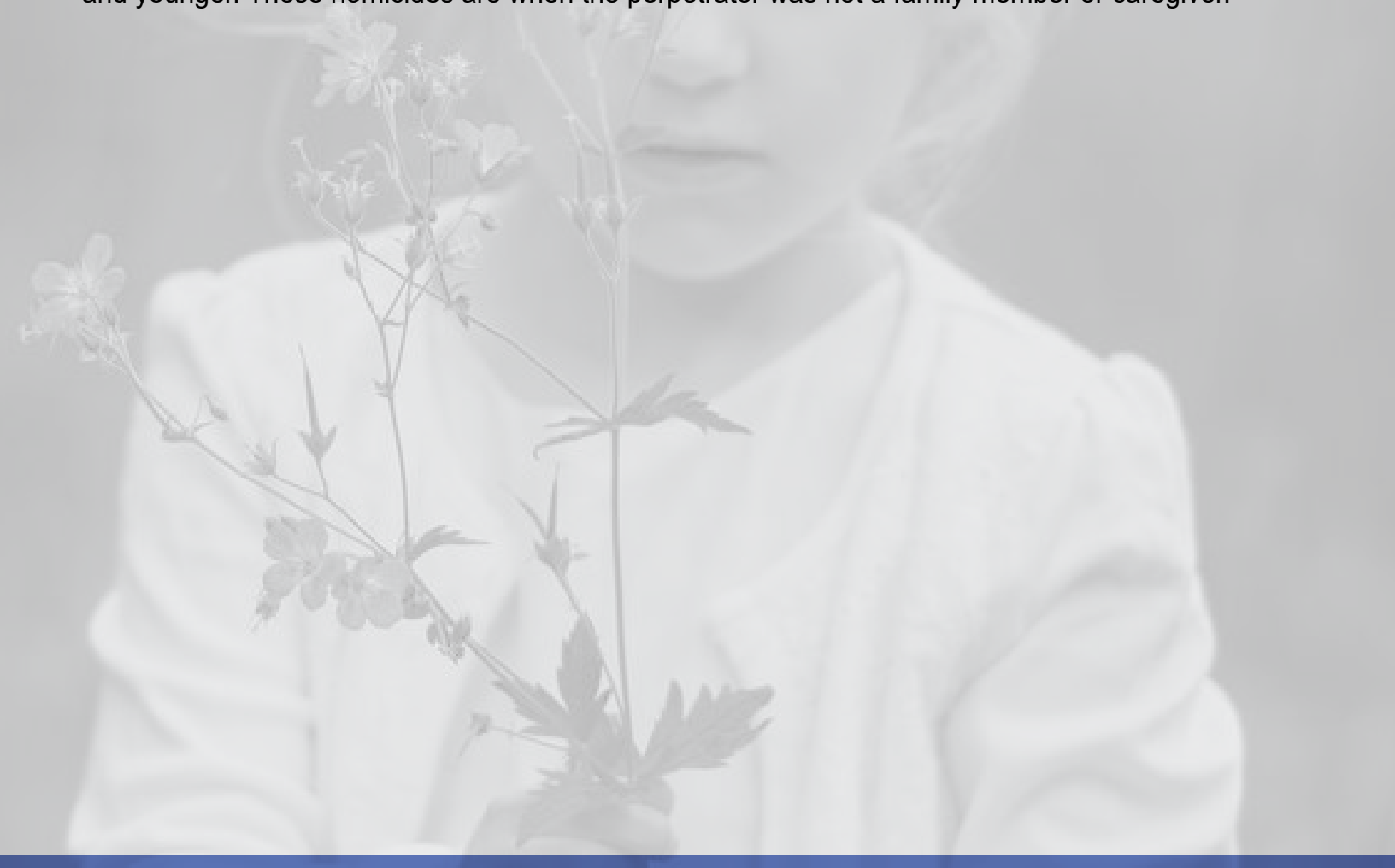
Introduction

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. 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 2019. 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 thirteenth 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 2019 child death review cases are as follows:

Child Risk Factors

Young Age

61% of the 2019 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, 36% of the children who died as a result of an accident were under age one.

Adolescence

Youth ages 15 – 17 years are most vulnerable for suicide (17 of the 20) or to be a victim of a third party homicide (21 of the 23 victims).

Gender

In 2019, the gender gap of victims of child abuse homicides remained consistent with previous years with males outnumbering the female victims by two or more. There were 13 males and 5 females victims of homicide by caretaker.

Race

Child homicides by parent/relative/caregiver included African-American, Caucasian, Hispanic and Asian. Hispanic children comprised forty-four percent (n=8) of the cases. African American children comprised thirty-three percent (6 cases) followed by Caucasians (3 cases) and Asian, one case for 2019.

Parental/Caregiver Risk Factors

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). In 2019, DCFS contact with a parent and/or perpetrator occurred in 9 of the 18 families who experienced a child abuse homicide.

Cycle of Abuse

Cycle of abuse was not readily available in documents available for review for all parents or caregiver who committed a child homicide. However, it was found that in 11 cases of the 2019 child homicides either the parent or perpetrator had a Child Protective Service (CPS) history as a child.

Substance Abuse by Parent or Caregiver

Substance abuse by a parent or caregiver is a documented high risk factor for child abuse or neglect. Substance abuse often is also identified when there is a child fatality. We did not find any significant documented history of substance abuse in 2019 cases. There was an indication of possible substance abuse by perpetrator in three of the child homicide cases. We did not find any significant documented history of substance abuse in most 2019 cases.

Mental Illness

Untreated mental illness is a risk factor seen in many of the child abuse homicide cases. Seven of the 2019 child abuse homicides involved a parent(s) and/or perpetrator with a documented history of mental illness.

Presence of multiple Parental/Caregiver Risk Factors

A combination of risk factors, such as history of substance use, domestic violence, CPS contact, CPS history as a child and social isolation are usually present when a child dies at the hand of a parent or caregiver. Only one family of a homicide victim had none of these known risk factors present and the suspect was the godfather of the child who beat the child to death.

Perpetrator Relationship

Relationship

In 2019, Biological fathers are the suspect in forty-four percent of the child homicide cases and biological mothers are the suspect in twenty-two percent. Mother's boyfriends are the suspects in twenty-two percent of the cases. The remaining two cases have both parents as a suspects and godfather as the suspect in another.

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 primary caretaking role for the child.

Additional Risk Factors

Unsafe Infant Sleeping

Sudden unexpected infant death (SUID) refers to infants who die a sudden and unexpected death. These deaths are usually ruled as Undetermined and occur while an infant is in the sleep environment.

Undetermined child deaths associated with bed-sharing and/or unsafe sleep environments declined considerably from the high of 70 in 2009. Infants who die are often placed on their stomach or side on adult beds, couches and/or surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. The data indicate that thirty-seven children (twenty-six undetermined cases and eleven accident cases) died in 2019 because of unsafe sleep practices. In 2018, there were forty-four unsafe sleep-related child deaths. The 2019 number is a 16% decrease and slightly below the five-year average of approximately forty unsafe sleep-related deaths per year.

DATA VARIANCES BETWEEN ICAN CHILD HOMICIDES AND DCFS REPORTED CHILD FATALITIES

AS A RESULT OF CHILD ABUSE AND/OR NEGLECT

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

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

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

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

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

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

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

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

The Los Angeles County Medical Examiner-Coroner must designate the manner of death to be listed

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

Homicides, by the Coroner's definition, are deaths at the hands of another. Child deaths in which the suspected perpetrator is a parent, caregiver or family member, meet the Team protocol for possible review. All such cases are included in the ICAN annual Team report. Homicide by parent/caregiver/family member is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term "homicide" regardless of the criminal intent of the perpetrator or the findings of the criminal justice system. Homicide may describe circumstances ranging from tragedies to fatal attacks with clear intent.

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

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

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

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

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

Table 1

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

Year	Number
2015	6
2016	17
2017	8
2018	10
2019	18

The average number of children and adolescents who committed suicide over the past five years is 20. The leading method from 2015 through 2019 is hanging.

Year	Number
2015	23
2016	14
2017	27
2018	29
2019	20

An average of 102 children have died from preventable accidents over the past 5 years from automobile accidents, drowning and deaths due to auto vs. pedestrian.

Year	Number
2015	104
2016	95
2017	98
2018	103
2019	110

The number of undetermined deaths has averaged 73 per year over the past five years

Year	Number
2015	44
2016	103
2017	54
2018	67
2019	42

Table 2		
2019 Child Deaths Demographics - Coroner Cases		
	Number	**Percentage**
Total	213	100.0%
Gender		
Female	77	36%
Male	135	63%
Unknown	1	.5%
Age		
Under 1 Year	82	39%
1 – 4 years	29	14%
5 – 9 years	16	8%
10 – 14 years	21	10%
15 – 17 years	65	31%
Race		
African American	43	20%
Asian/Pacific Islander	12	6%
American Indian	1	.47%
Caucasian	45	21%
Hispanic	105	49%
Unknown	7	3%

Sample Case Summaries

Nathan

Four-year-old Nathan was reported by parents to have drowned in their pool. After the child was medically examined, he was found to have healing rib fractures. The child was also found to have been severely beaten to the point of having internal organs ruptured. Nathan had marks and bruises from his head down to his toes. He was diagnosed with multi organ failure, respiratory failure, and brain injury. Nathan sustained multiple traumatic injuries that were found to be consistent with non-accidental trauma inflicted by the parents.

Johnny

Johnny was a 3-year-old boy stabbed to death by his mother who had a mental breakdown. Mother was found running in the street by a police officer who stopped to investigate. Mother was incomprehensible, however, the police officer managed to figure out where mother lived and arrived at the home which had been set on fire. It appears that after mother stabbed Johnny to death, she set his body on fire and fled her home. Mother had displayed a history of bizarre behavior to family members and co-workers for months before the incident, however, nobody had ever contacted authorities to have mother evaluated.

Layla

Eight-year-old, Layla was found on a hiking trail inside a suitcase. She appeared to be bruised and malnourished. After a thorough investigation LE was able to locate the mother and mother's boyfriend and charged both of them for the torture and murder of Layla. It was later found that food was withheld from Layla for many months. She was verbally and physically abused by both her mother and mother's boyfriend.

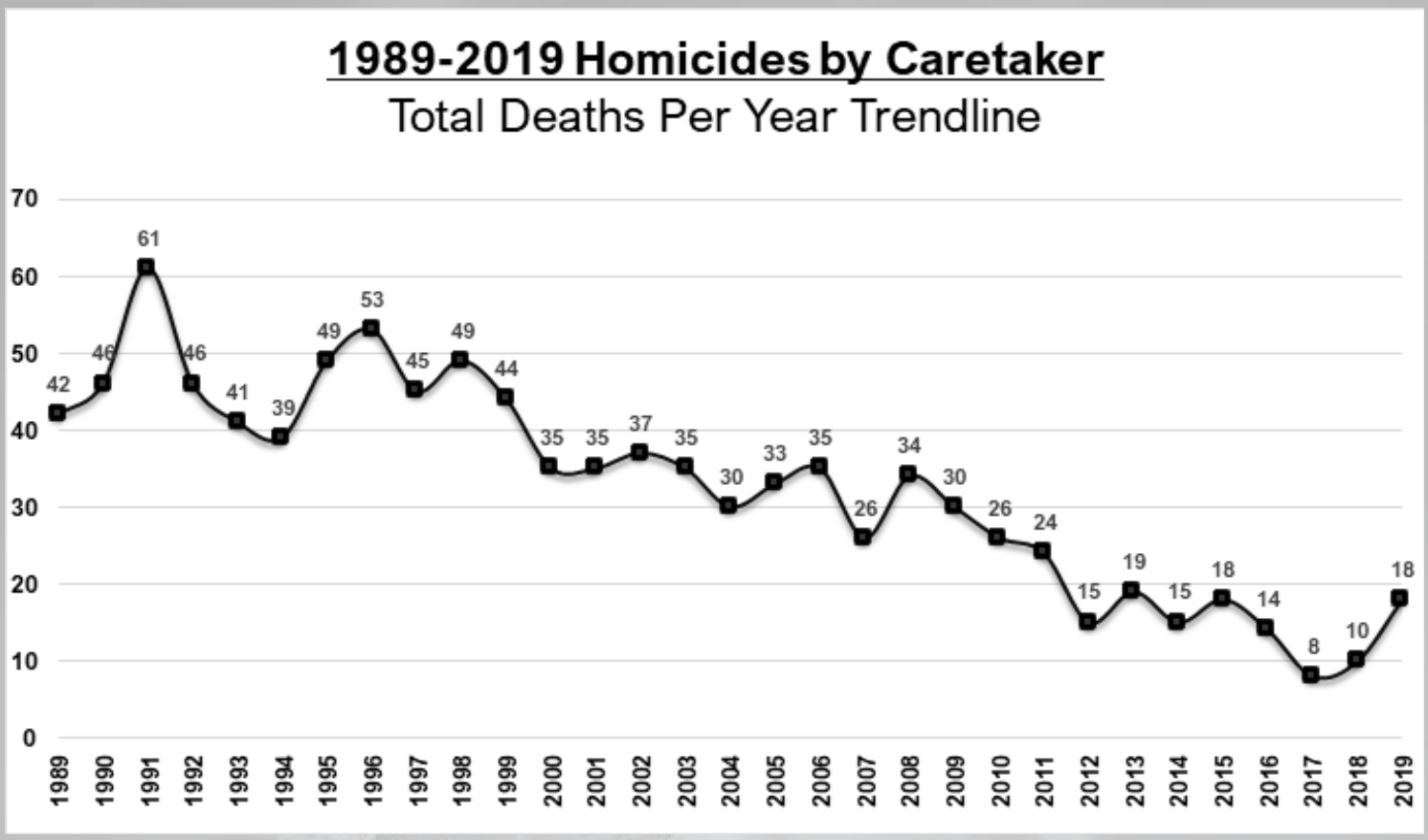
HOMICIDE BY CARETAKER

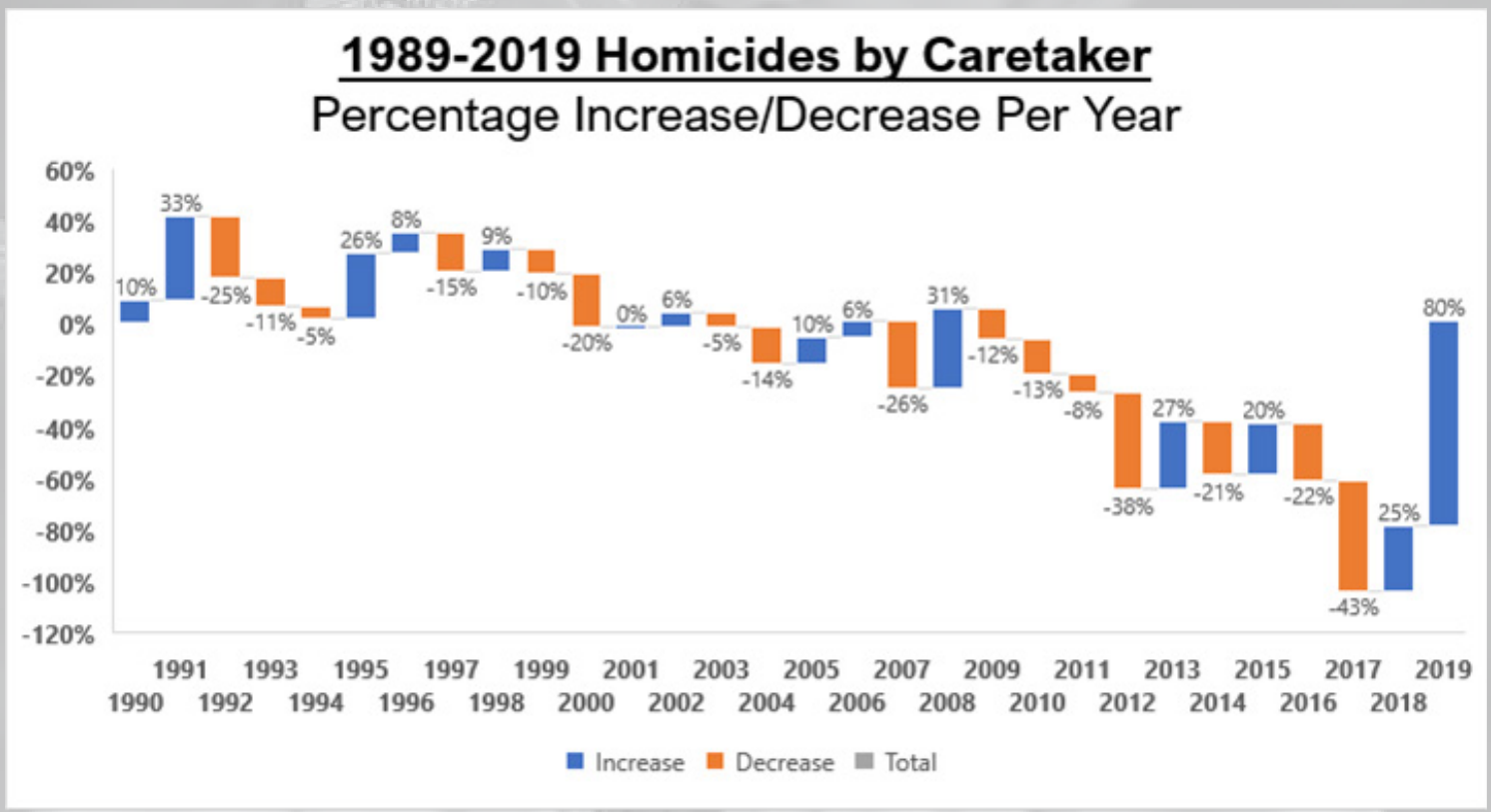
FINDINGS

- Eighteen child homicides by caretaker in 2019 were reported to ICAN from the Coroner's Department.
- This is an eighty percent increase from the ten homicides by caretaker in 2018. Although the highest number of child abuse homicides since 2015, the number has remained below 20 since 2012, and reflects the significant overall decline since 1991 when 61 children died from homicide by their caretakers. In addition, this hike in homicides appears to be unique to 2019 as the 2020 preliminary homicide data indicate 11 homicides by caretaker and 12 homicides as of the writing of this report.
- As in prior years, blunt force head trauma was the leading cause of death in homicides by caretaker. Blunt force head trauma made up fifty-six percent of the deaths in 2019, with ten children dying of this cause. This is more than triple the five-year average of three deaths per year for this cause of death.
- The other causes of child homicides were: two deaths from multiple traumas to the body, two deaths by intentional drowning, two deaths by scalding, one death by stabbing, and one death by poisoning.
- Over the last five years, the top causes of death in homicides by caretaker have been blunt force head trauma (thirty-seven percent or twenty-five deaths), multiple traumas to the body (10 deaths = 15%), and stabbing (8 deaths =12%).
- The largest percent of child victims are children under the age of 3 with Sixty-one percent (n=11). Over half of those children were under the age of 1 (n=7)
- The age breakdown of children who died at the hands of their caretaker are as follows; Thirty-nine percent (n=7) of the children killed by their caretaker were under one year of age, seventeen percent (n=3) were two-year-olds and seventeen percent (n=3) were four-year-olds. The remaining ages were: one six-year-old, one one-year-old, one nine-year-old, one ten-year-old, and one thirteen-year-old.
- In 2019, the gender gap expanded with an increase in the percentage of male children killed by their caretakers: seventy-two percent (n=13) of victims were male and twenty-eight (n=5) percent were female. By comparison - in 2018, the percentage of males was sixty percent; in 2017, it was sixty-two percent; and in 2016, it was fifty-seven percent.
- According to 2019 estimates, of the population in Los Angeles County were female . However, only twenty-eight percent of the victims of homicide by caretaker in 2019 were female. Male children (72%) were disproportionately the victims of caretaker homicide.
- Hispanic children comprised forty-four percent (n=8) of the cases for 2019. African American children comprised thirty-three percent (or six cases) followed by Caucasians (seventeen percent or three cases) and Asians (six percent or one case).
- According to 2019 estimates, for children below the age of eighteen, Los Angeles was approximately fifty-six percent Hispanic, twenty percent Caucasian, eight percent African American, and twelve percent Asian. Hispanic, Caucasians and Asian children were

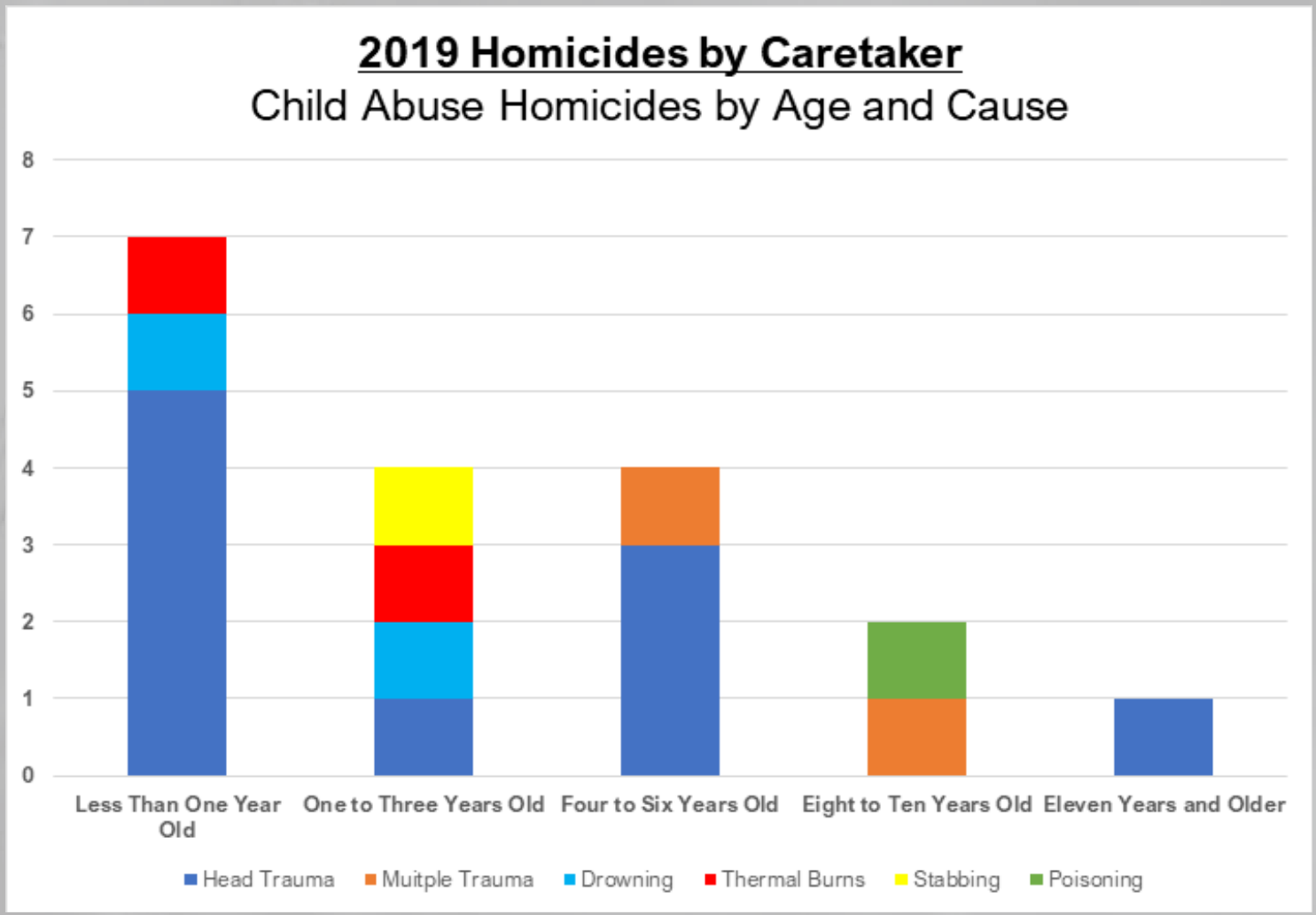
underrepresented, and African American children were overrepresented in the child homicide rate. African American homicide rate for 2019 (thirty-three percent of the cases) is four times the child population percentage for the County.

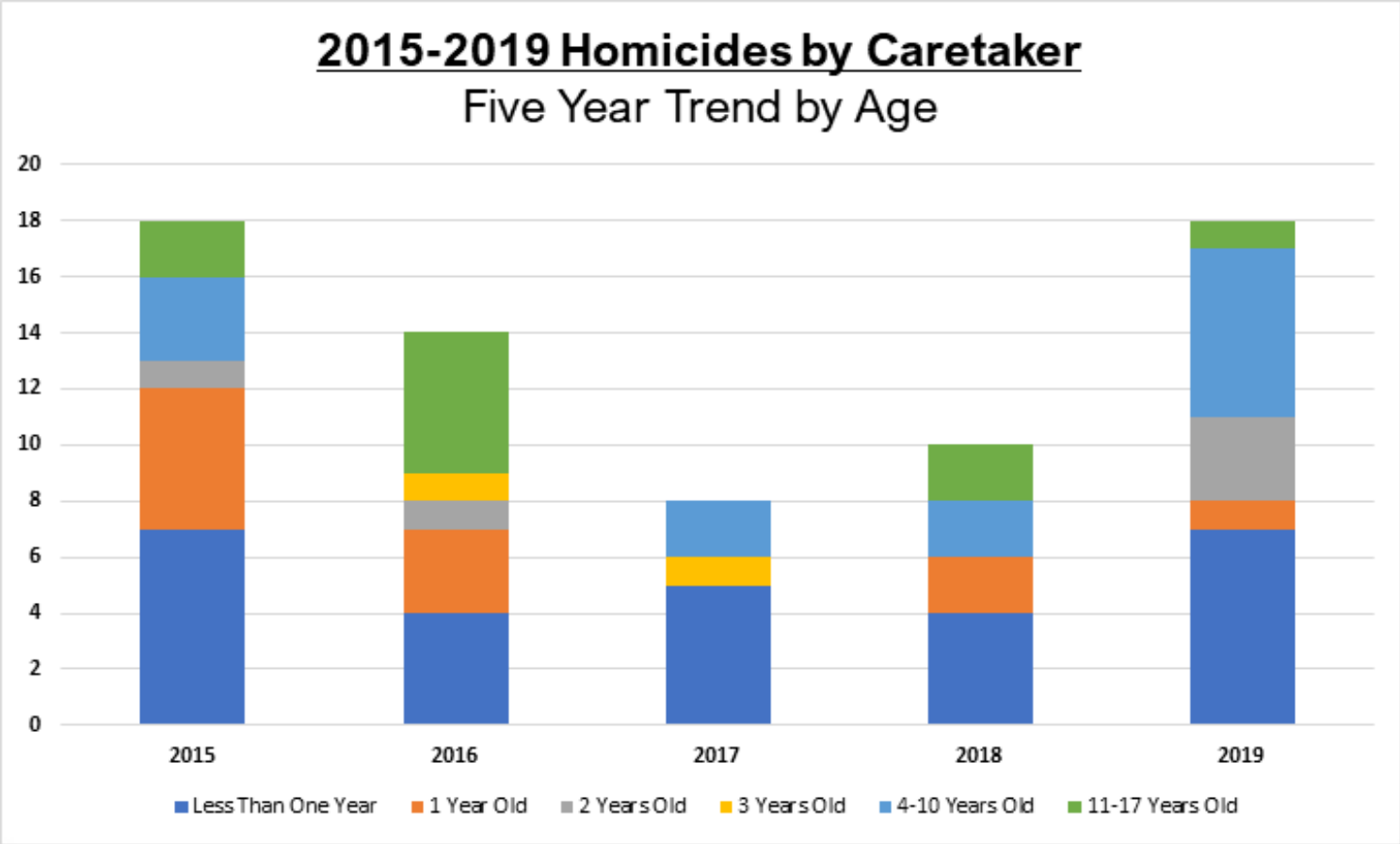
- Biological fathers are the suspect in forty-four percent of the child homicide cases and biological mothers are the suspect in twenty-two percent. Mother's boyfriend are the suspects in twenty-two percent of the cases. The remaining two cases have both parents as a suspects and godfather as the suspect in another.
- Seventy-eight percent of all the child homicides by caretaker had a male suspect. This is similar to prior gender breakdowns in most years that show male perpetrators are more common than female perpetrators.
- A five-year analysis of perpetrators shows that fathers, followed by mothers and mother's boyfriend are the person most responsible for the death of a child in their care.
- Seventy-two percent (13 out of the 18 cases) of the victims of homicide by caretakers were from a family with at least one prior Department of Child and Family Services contact. Review of the families revealed thirty-nine percent of the perpetrators had a DCFS contact as a minor themselves.00
- Over fifty percent of the child homicides by caretaker were investigated by the Los Angeles County Sheriff's Department or the Los Angeles Police Department (twenty-six percent for each organization, or five of the cases each). Two of the cases, 11%, were handled by the Downey, P.D. Each of the other cases were investigated by one of the following departments: Covina Police Department, Pomona Police Department, Redondo Beach Police Department, South Gate Police Department, Ventura Police Department, and the Long Beach Police Department.

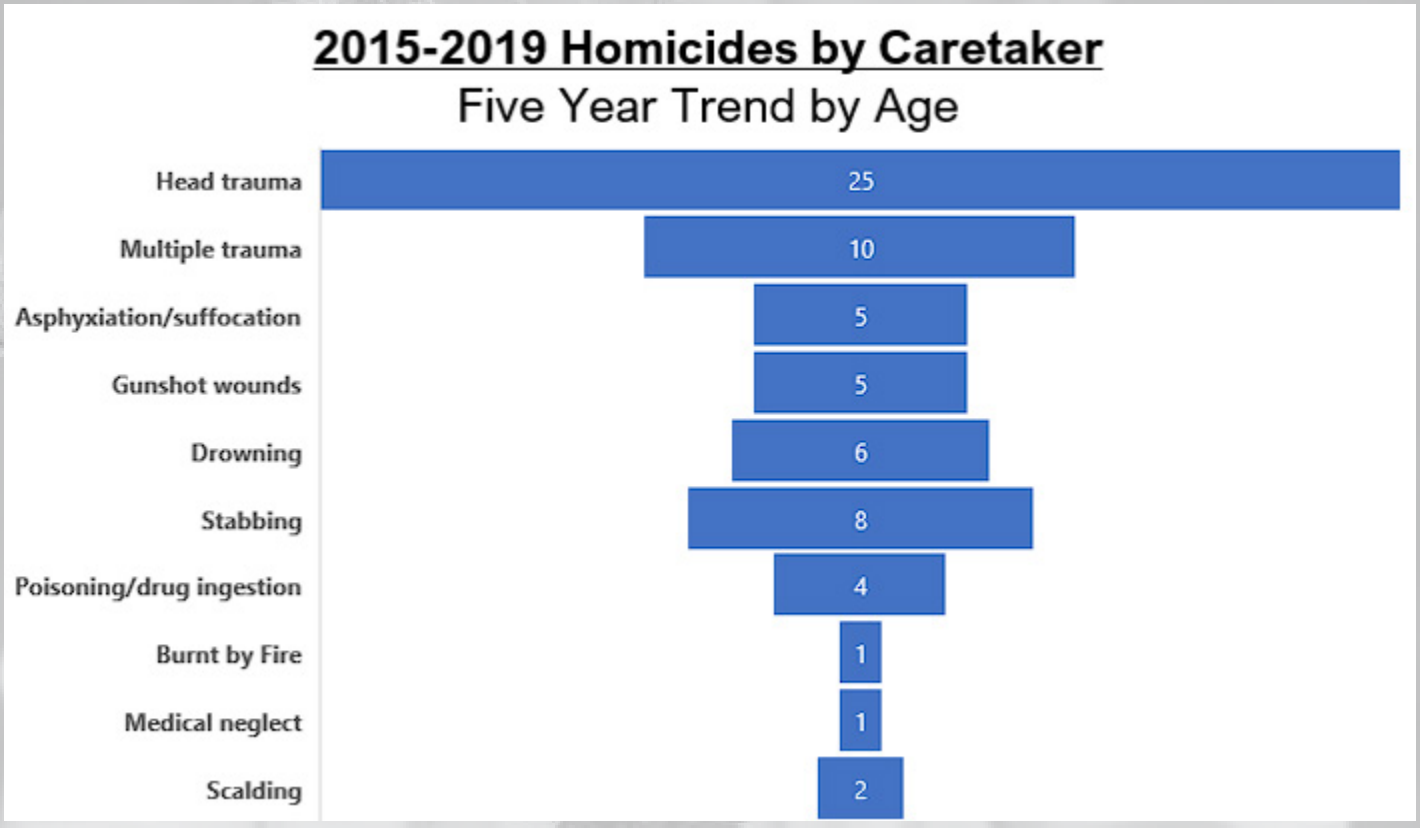

1989-2019 Homicides by Caretaker
Total Deaths Per Year Trendline
70
60
50
40
30
20
10
0
42 46 61 46 41 39 49 53 45 49 44 35 35 37 35 30 33 35 26 34 30 26 24 15 19 15 18 14 8 10 18
1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

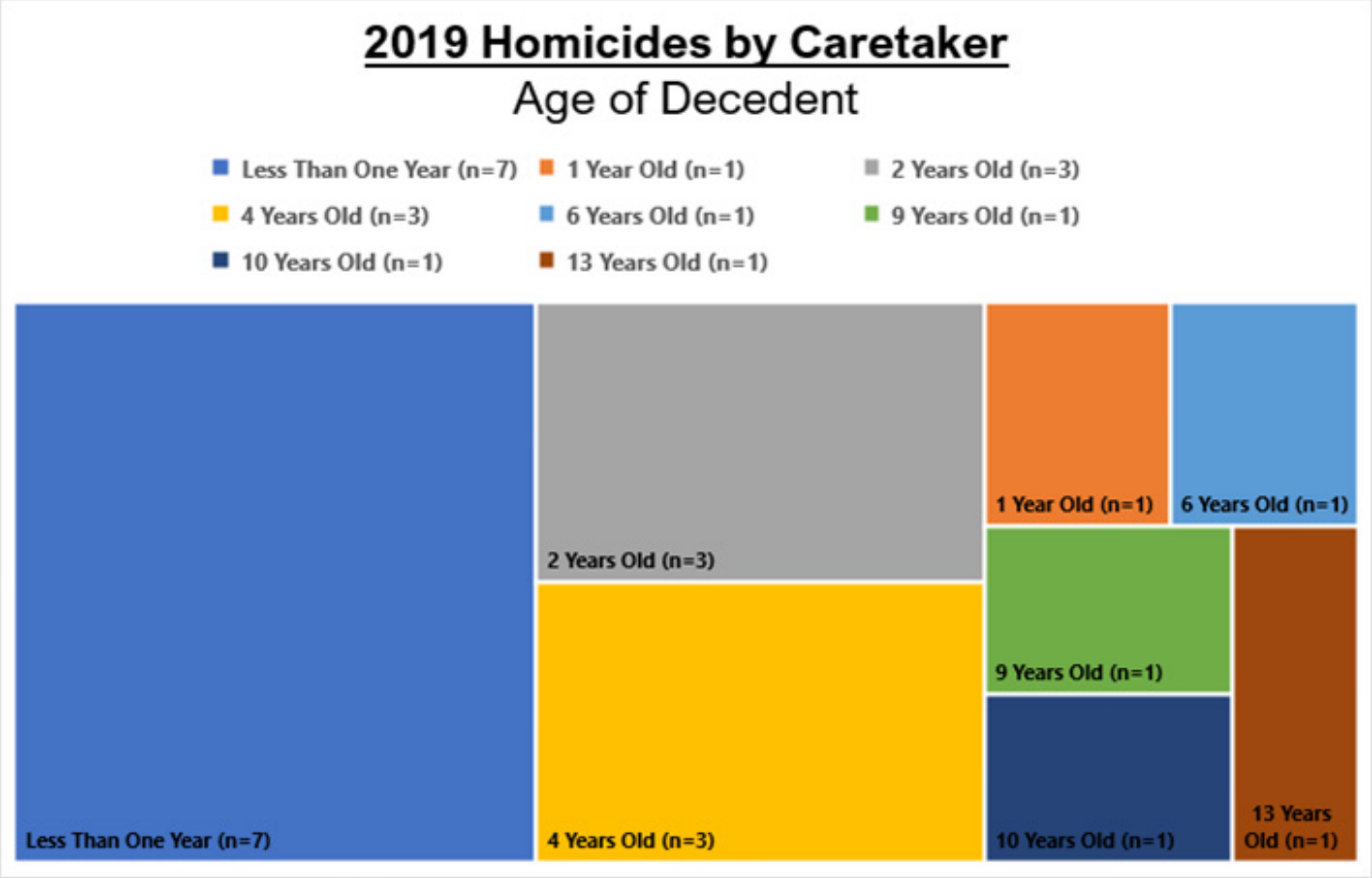

1989-2019 Homicides by Caretaker
Percentage Increase/Decrease Per Year
60%
40%
20%
0%
-20%
-40%
-60%
-80%
-100%
-120%
10% 33% -25% -11% -5% 26% 8% -15% 9% -10% -20% 0% 6% -5% -14% 10% 6% -26% 31% -12% -13% -8% -38% 27% -21% 20% -22% -43% 25% 80%
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019
Increase
Decrease
Total

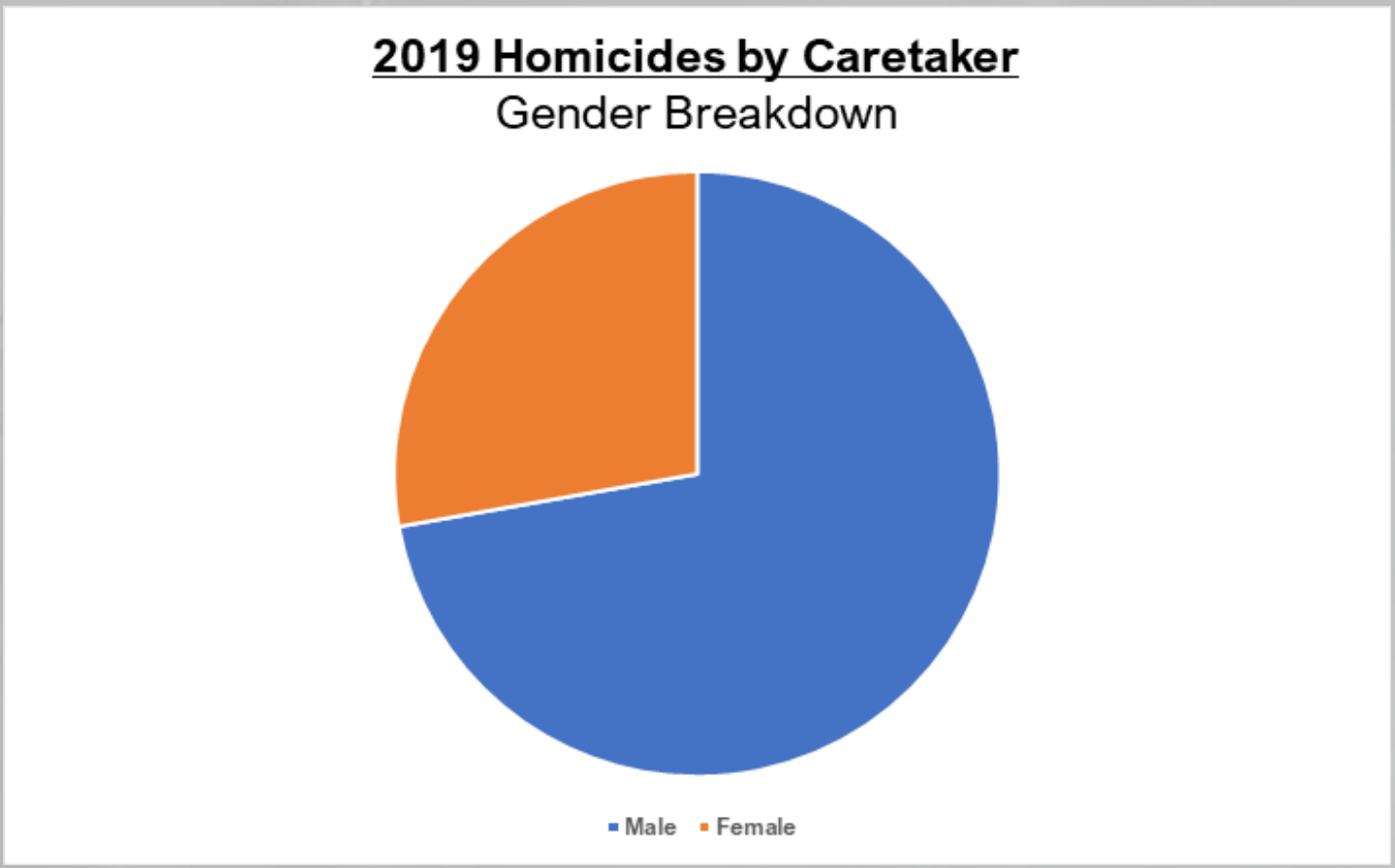
Cause of Death	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Head trauma	8	2	10	5	3	1	2	5	4	4	10
Multiple trauma	2	1	6	2	9	5	5	0	1	2	2
Asphyxiation/suffocation	2	3	2	0	1	1	2	0	3	0	0
Gunshot wounds	8	4	2	0	0	1	1	2	0	2	0
Trauma to torso/abdomen	1	5	1	2	1	1	0	0	0	0	0
Drowning	1	2	0	3	1	0	2	1	0	1	2
Stabbing	4	6	1	1	1	4	4	3	0	0	1
Unattended newborn	2	1	0	0	1	0	0	0	0	0	0
Poisoning/drug ingestion	0	0	0	1	1	0	1	2	0	0	1
Dehydration/malnutrition	1	0	1	0	0	1	0	0	0	0	0
Strangulation	0	1	0	1	0	0	0	0	0	0	0
Burnt by Fire	0	0	0	0	0	0	0	1	0	0	0
Medical neglect	1	1	0	0	0	1	1	0	0	0	0
Scalding	0	0	0	0	0	0	0	0	0	0	2
Hyperthermia	0	0	0	0	1	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0	0	0	0	0	0
Post-Term gestation	0	0	1	0	0	0	0	0	0	0	0

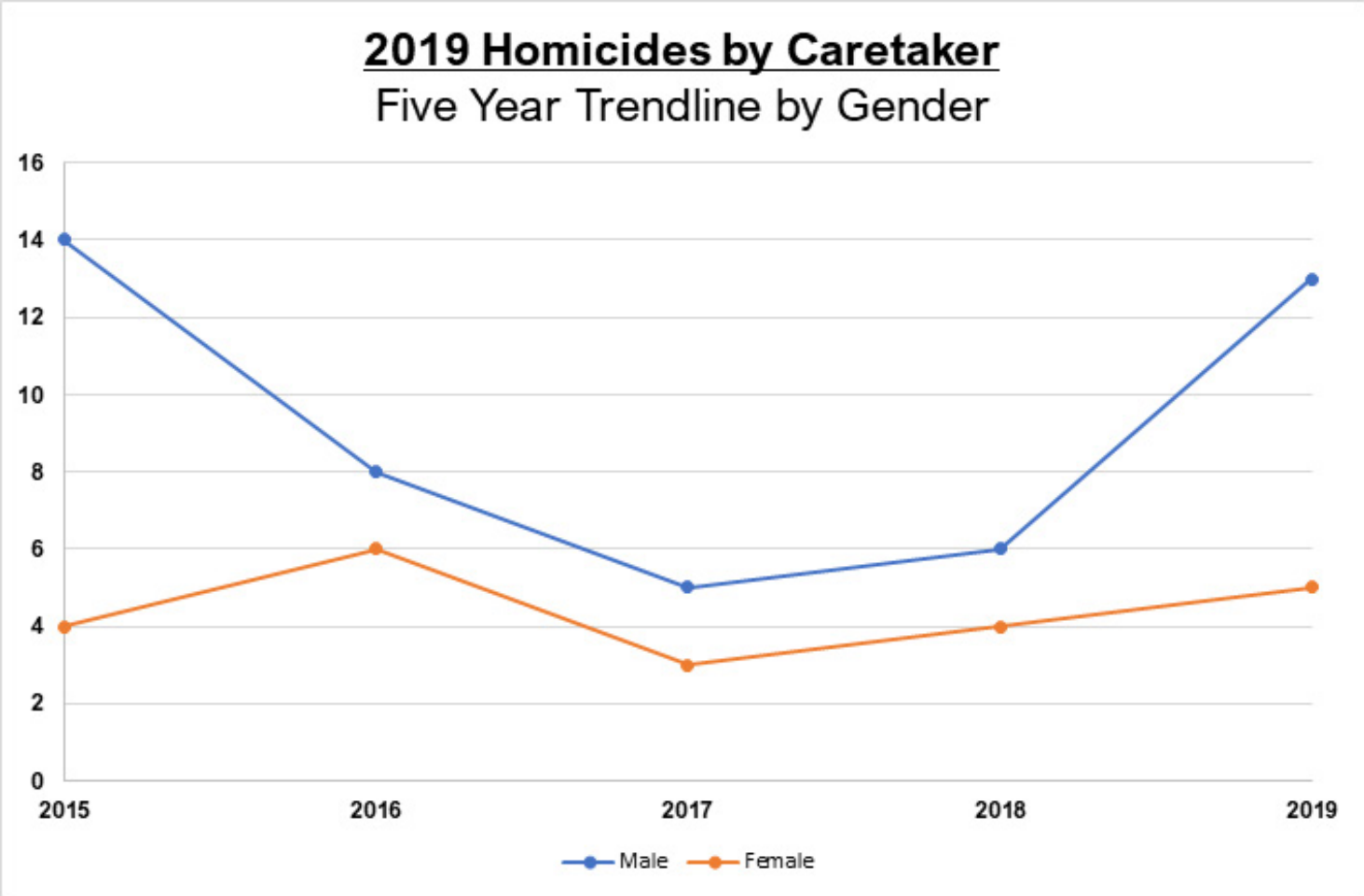


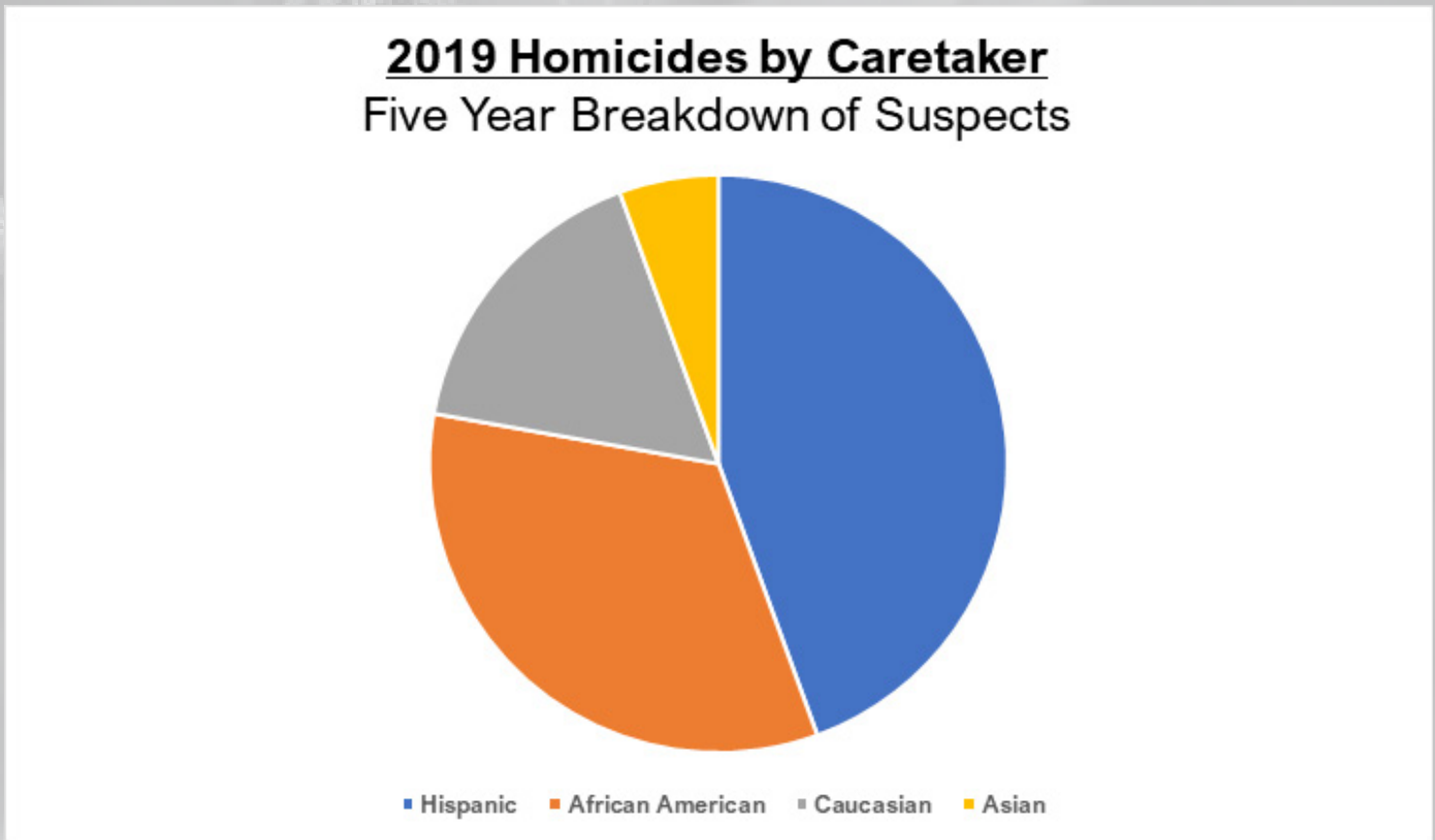

2015-2019 Homicides by Caretaker
Five Year Trend by Age
20
18
16
14
12
10
8
6
4
2
0
2015
2016
2017
2018
2019
Less Than One Year
1 Year Old
2 Years Old
3 Years Old
4-10 Years Old
11-17 Years Old

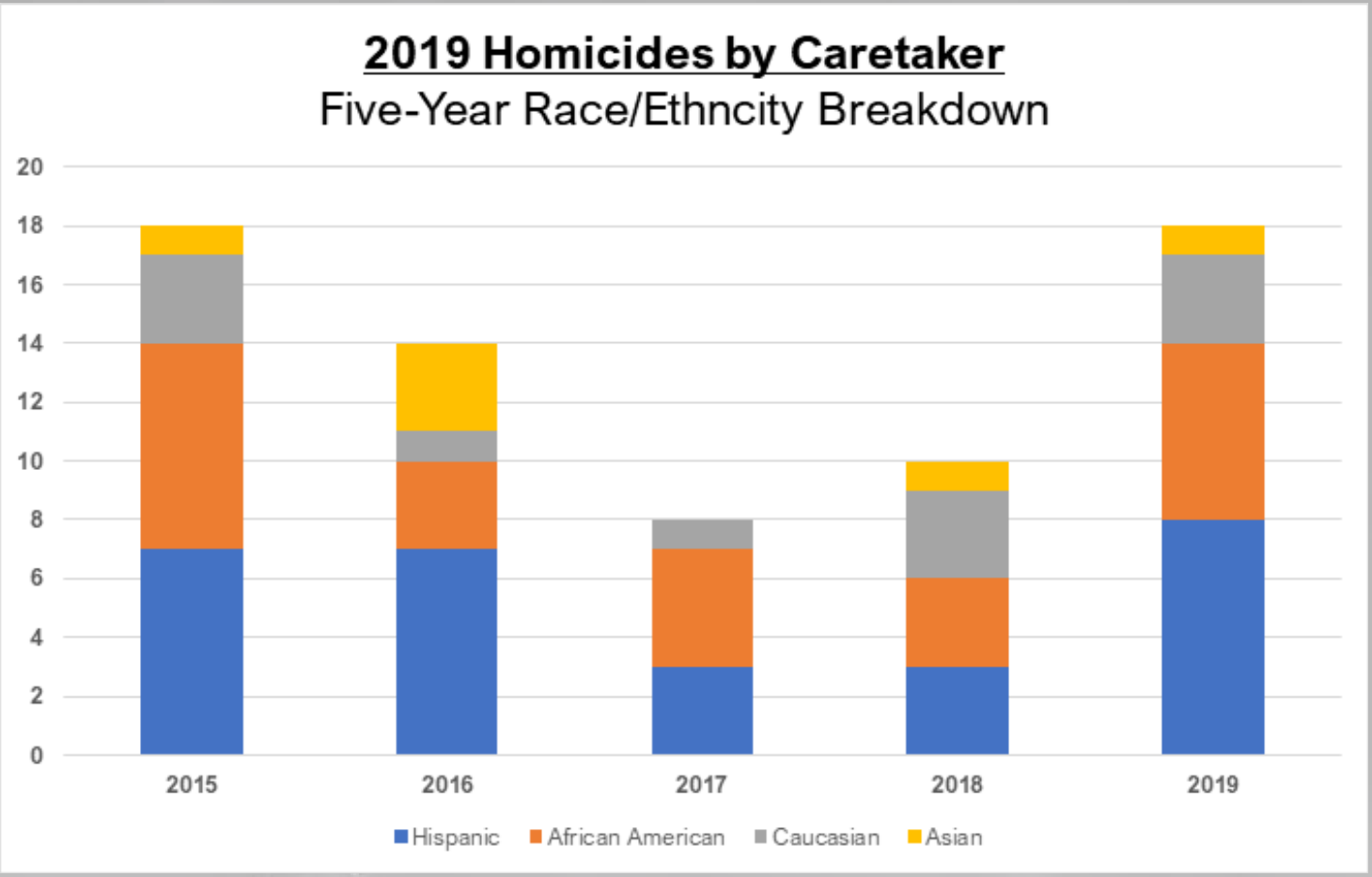

2015-2019 Homicides by Caretaker
Five Year Trend by Age
Head trauma
25
Multiple trauma
10
Asphyxiation/suffocation
5
Gunshot wounds
5
Drowning
6
Stabbing
8
Poisoning/drug ingestion
4
Burnt by Fire
1
Medical neglect
1
Scalding
2

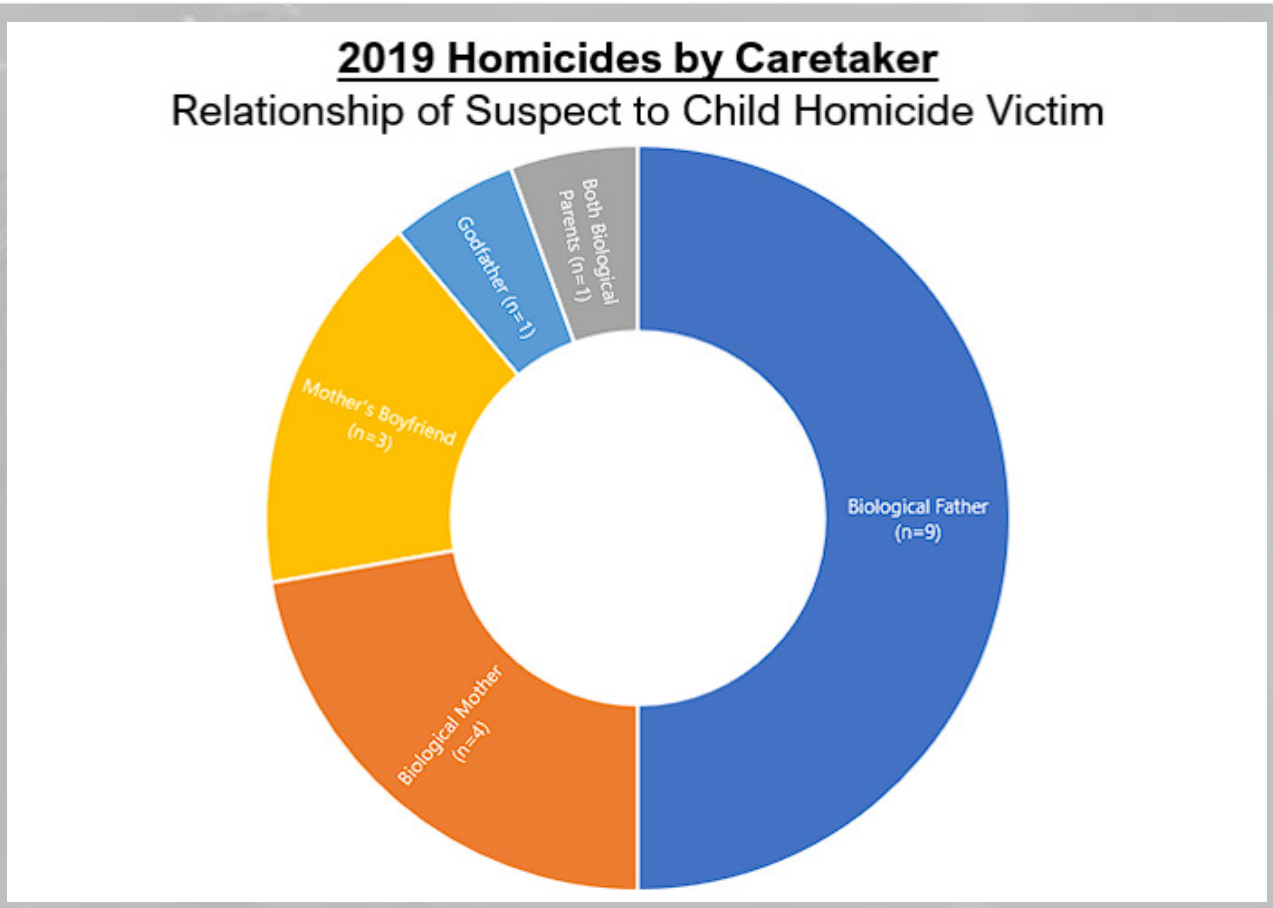

2019 Homicides by Caretaker
Age of Decedent
Less Than One Year (n=7)
1 Year Old (n=1)
2 Years Old (n=3)
4 Years Old (n=3)
6 Years Old (n=1)
9 Years Old (n=1)
10 Years Old (n=1)
13 Years Old (n=1)
Less Than One Year (n=7)
2 Years Old (n=3)
1 Year Old (n=1)
6 Years Old (n=1)
9 Years Old (n=1)
4 Years Old (n=3)
10 Years Old (n=1)
13 Years Old (n=1)

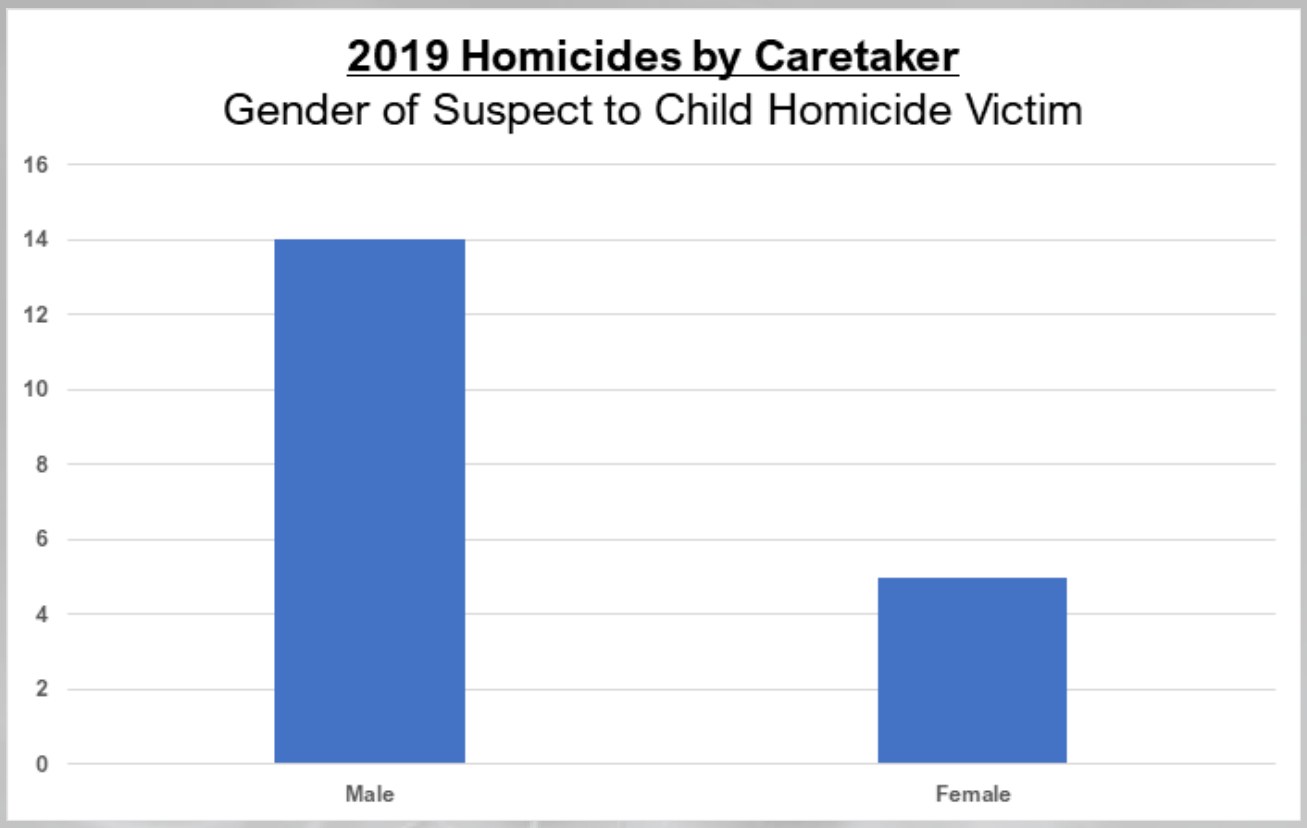

2019 Homicides by Caretaker
Gender Breakdown
Male
Female

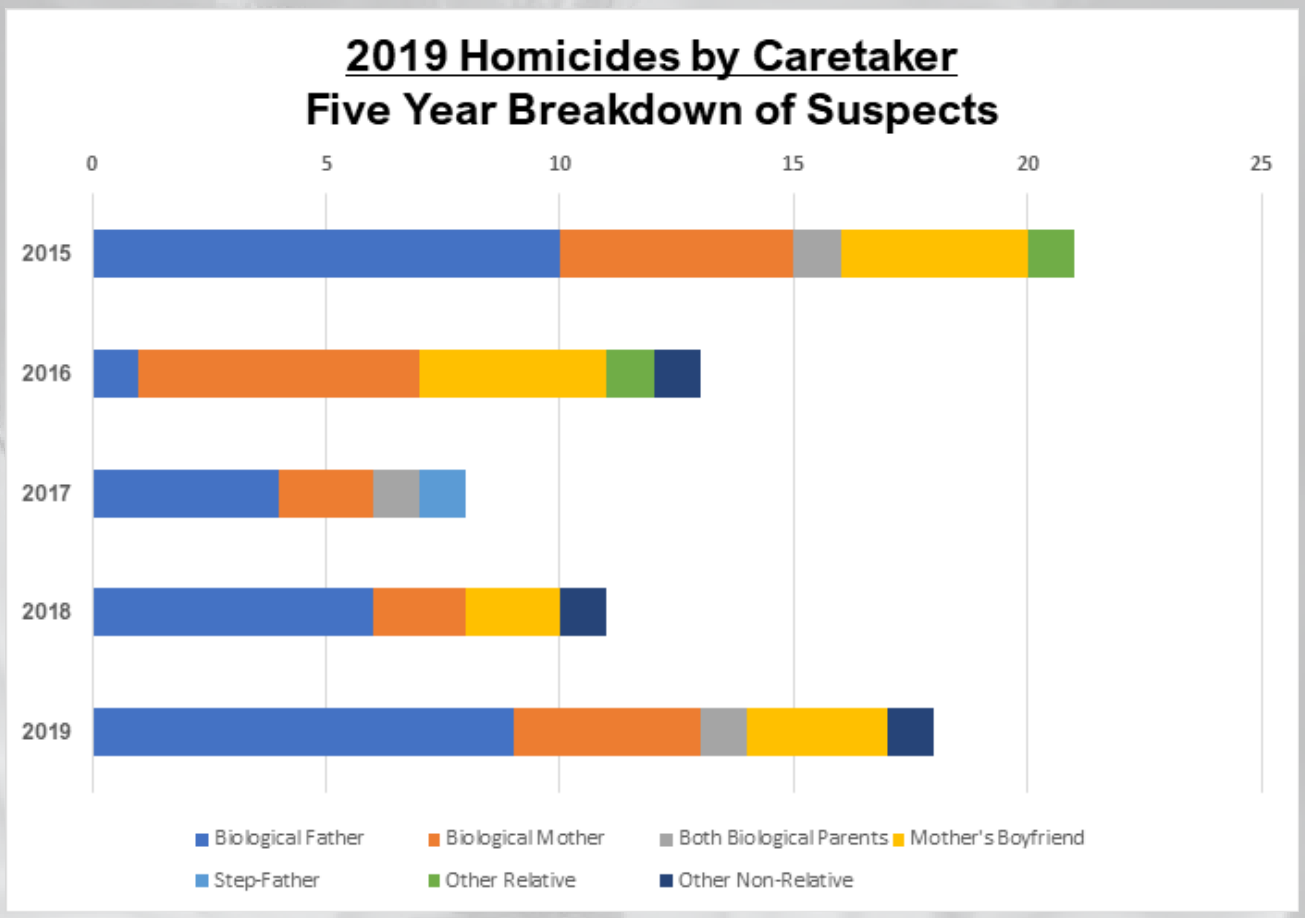

2019 Homicides by Caretaker
Five Year Trendline by Gender
16
14
12
10
8
6
4
2
0
2015
2016
2017
2018
2019
Male
Female

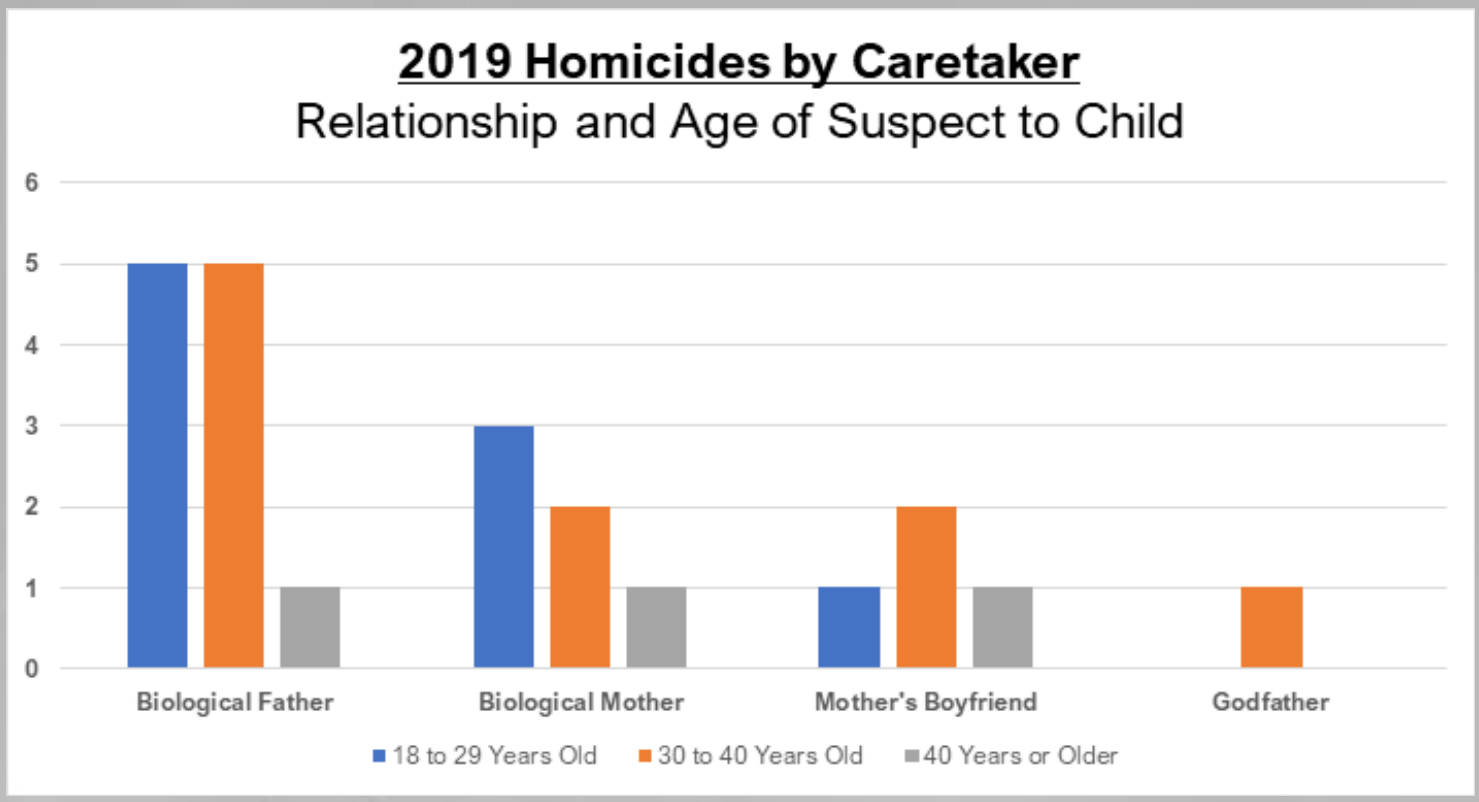

2019 Homicides by Caretaker
Five Year Breakdown of Suspects
Hispanic
African American
Caucasian
Asian

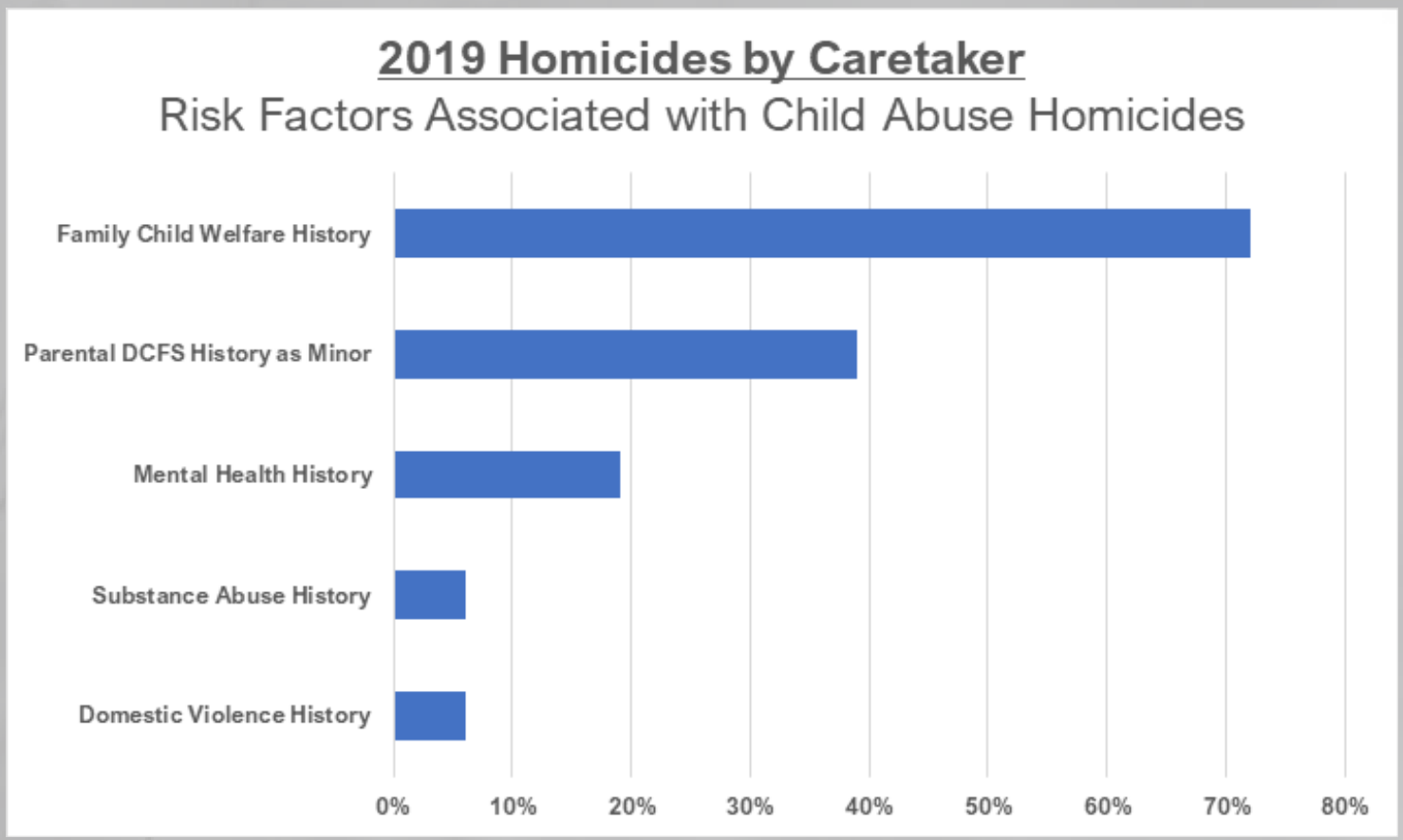

2019 Homicides by Caretaker
Five-Year Race/Ethncity Breakdown
20
18
16
14
12
10
8
6
4
2
0
2015
2016
2017
2018
2019
Hispanic
African American
Caucasian
Asian

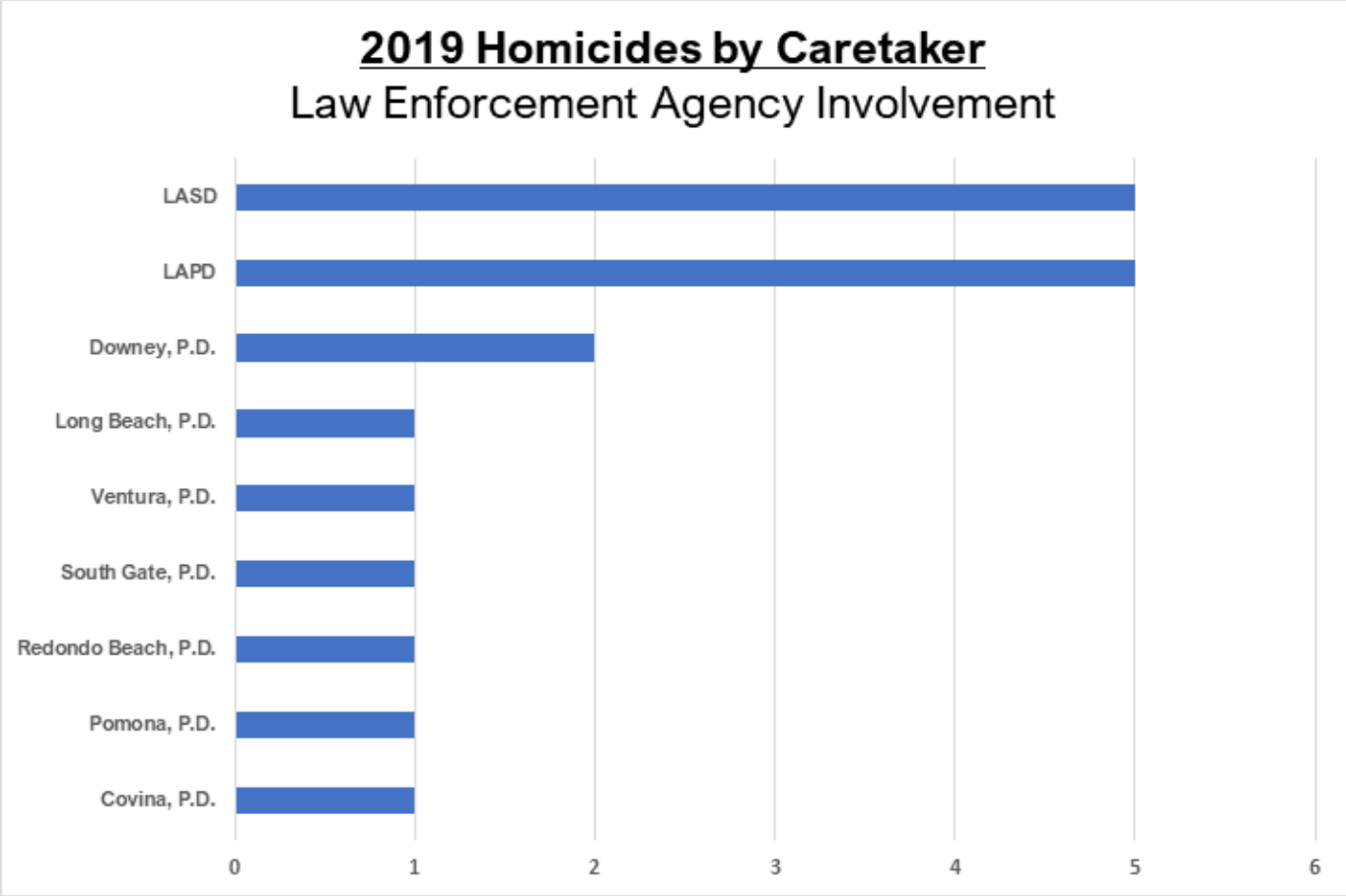

2019 Homicides by Caretaker
Relationship of Suspect to Child Homicide Victim
Biological Father (n=9)
Biological Mother (n=4)
Mother's Boyfriend (n=3)
Godfather (n=1)
Both Biological Parents (n=1)

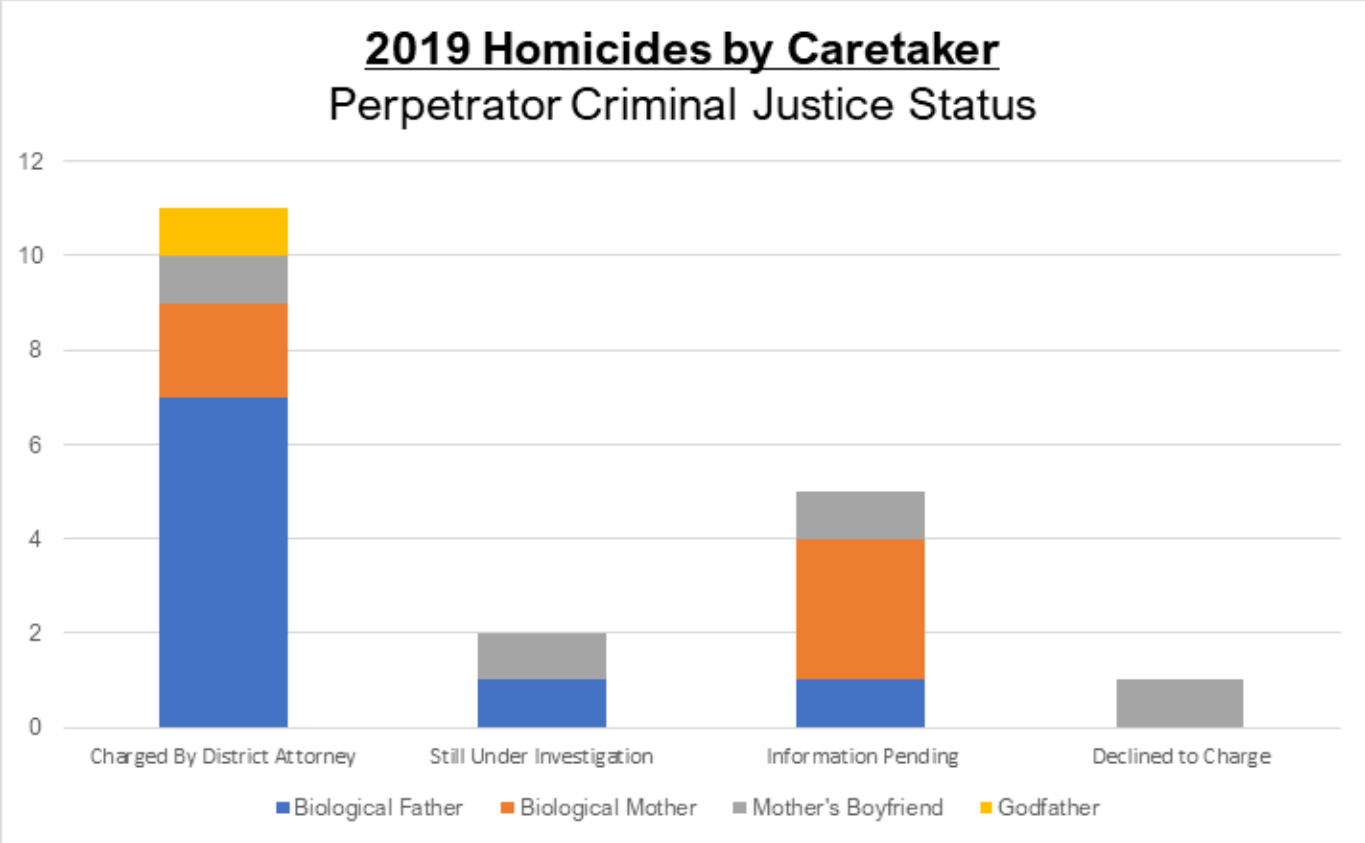

2019 Homicides by Caretaker
Gender of Suspect to Child Homicide Victim
16
14
12
10
8
6
4
2
0
Male
Female


2019 Homicides by Caretaker
Five Year Breakdown of Suspects
0
5
10
15
20
25
2015
2016
2017
2018
2019
Biological Father
Biological Mother
Both Biological Parents
Mother's Boyfriend
Step-Father
Other Relative
Other Non-Relative


2019 Homicides by Caretaker
Relationship and Age of Suspect to Child
6
5
4
3
2
1
0
Biological Father
Biological Mother
Mother's Boyfriend
Godfather
18 to 29 Years Old
30 to 40 Years Old
40 Years or Older

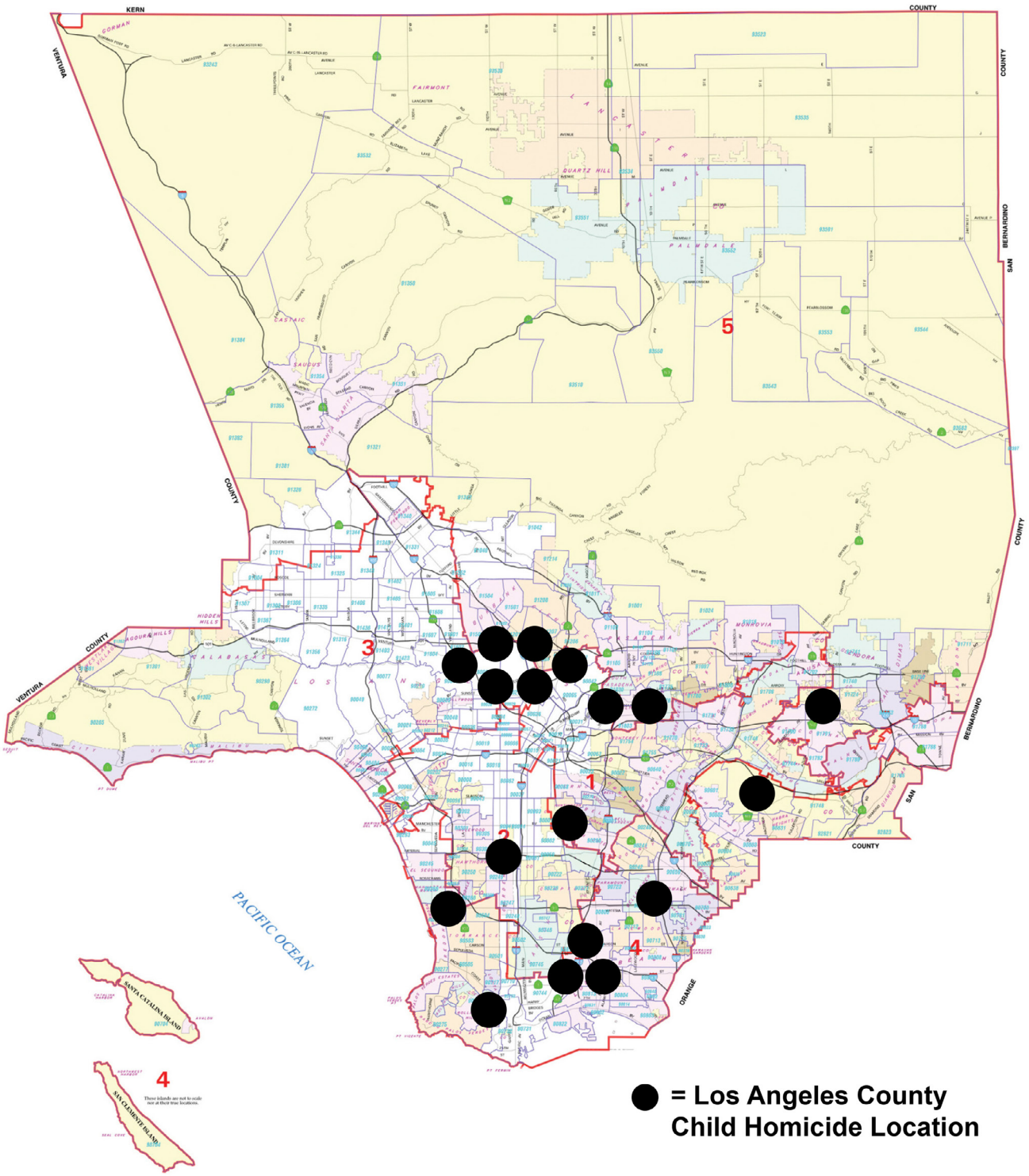

2019 Homicides by Caretaker
Risk Factors Associated with Child Abuse Homicides
Family Child Welfare History
Parental DCFS History as Minor
Mental Health History
Substance Abuse History
Domestic Violence History
0%
10%
20%
30%
40%
50%
60%
70%
80%


2019 Homicides by Caretaker
Law Enforcement Agency Involvement
LASD
LAPD
Downey, P.D.
Long Beach, P.D.
Ventura, P.D.
South Gate, P.D.
Redondo Beach, P.D.
Pomona, P.D.
Covina, P.D.
0
1
2
3
4
5
6


2019 Homicides by Caretaker
Perpetrator Criminal Justice Status
12
10
8
6
4
2
0
Charged By District Attorney
Still Under Investigation
Information Pending
Declined to Charge
Biological Father
Biological Mother
Mother's Boyfriend
Godfather

2019 Child Homicides - Locations
n = 18*

***City where the homicide occurred**



Sample Case Summaries

Joshua

Joshua was a 16-year-old male who was a suspect in a shooting at his high school. After being pursued by school police, he sustained a self-inflicted gunshot wound to his head.

Zack

Zack was a 17-year-old male found hanging from his bedroom door by his mother. After cutting him down he was transported to the hospital where he was determined deceased. A two-page suicide note was found in his room.

Javier

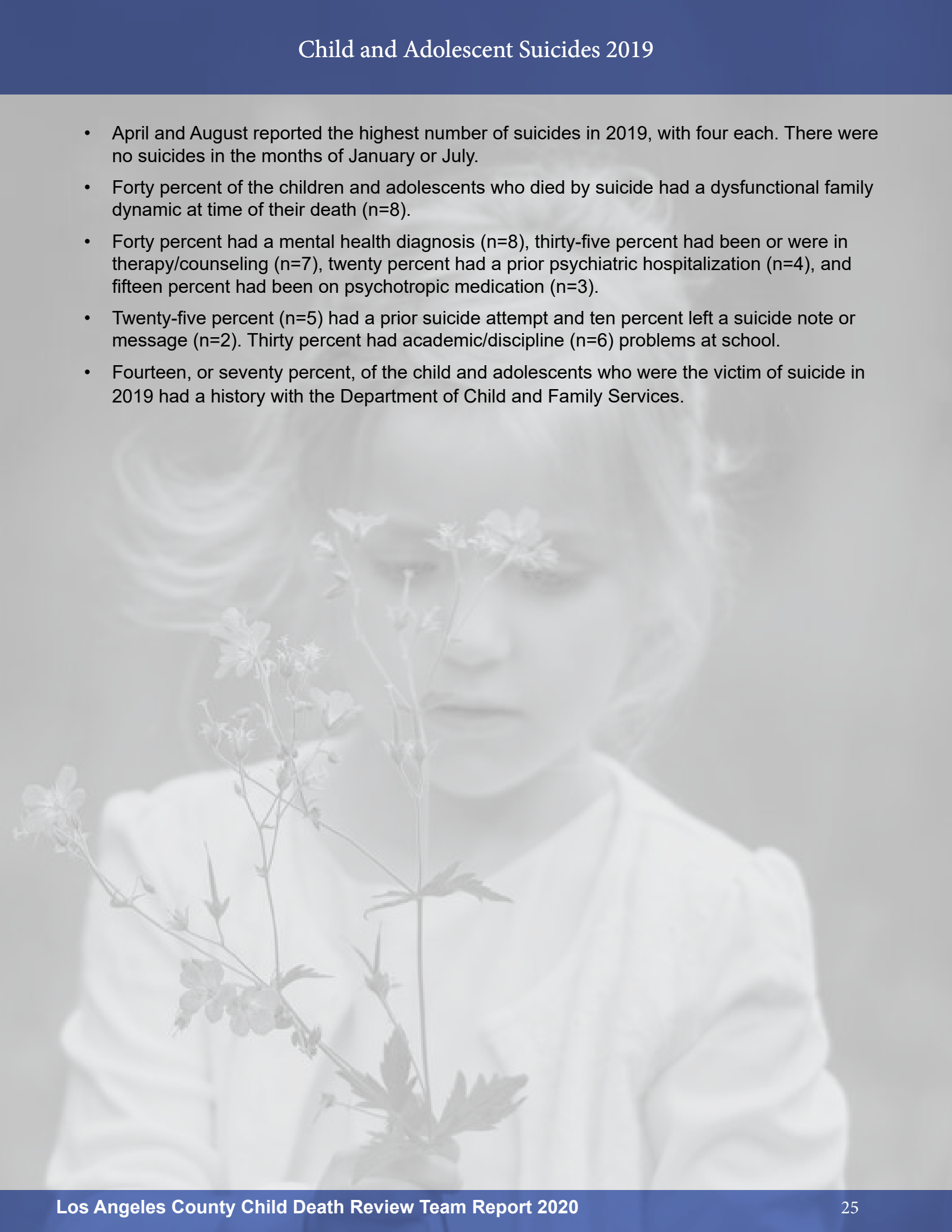
11 year old Javier was advised by his mother to stay in his room because he was grounded. She subsequently left the home to pick up dinner and when she returned to the residence, she went to check on Javier. After entering Javier's bedroom, mother discovered him hanging from the side of his bunk bed with a belt around his neck. Mother broke the bed in order to bring Javier down, and a neighbor called 911 after hearing mother's screams. Los Angeles County Fire Department responded to the scene and assessed Javier. Javier's death was pronounced at the hospital.

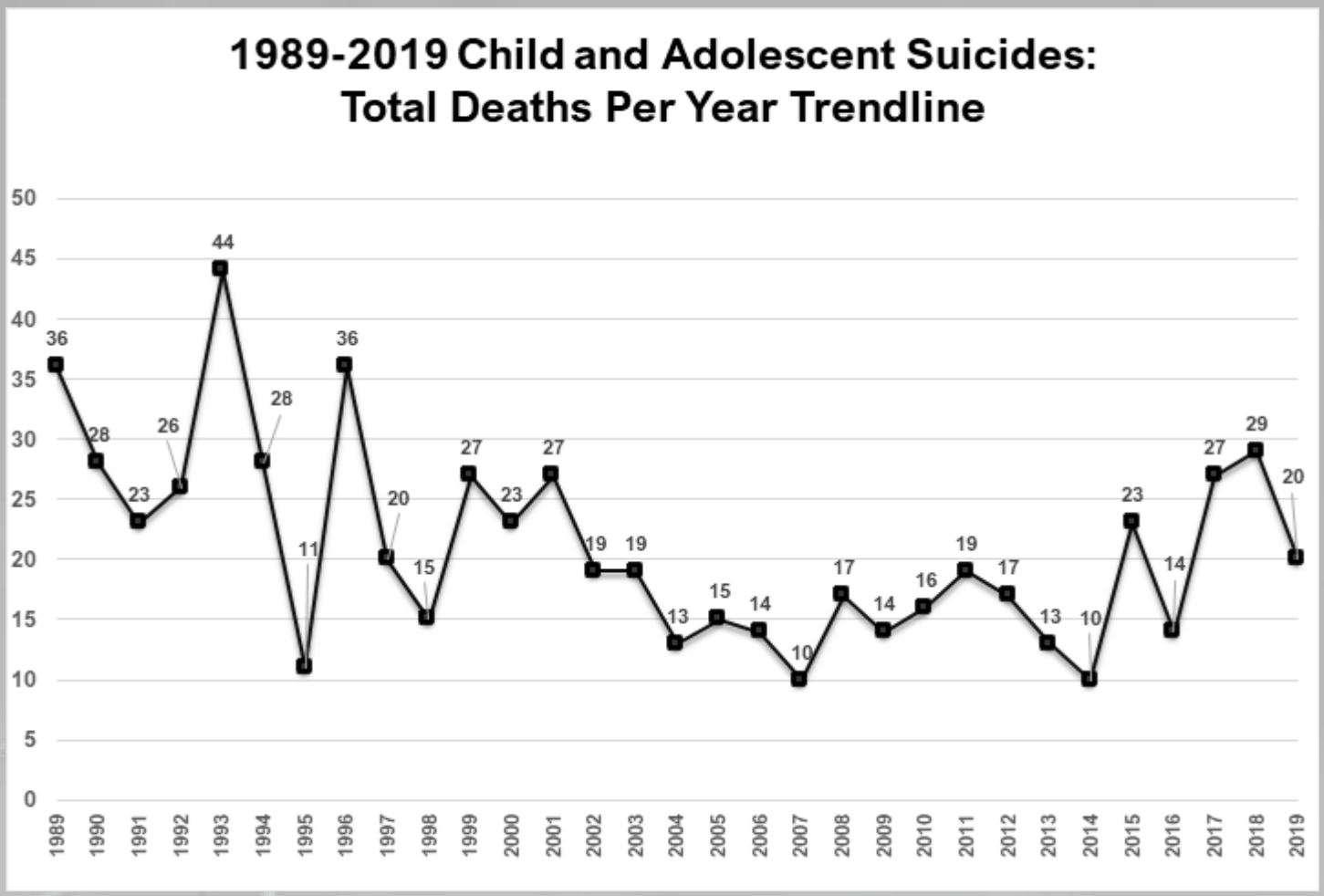
SUICIDES

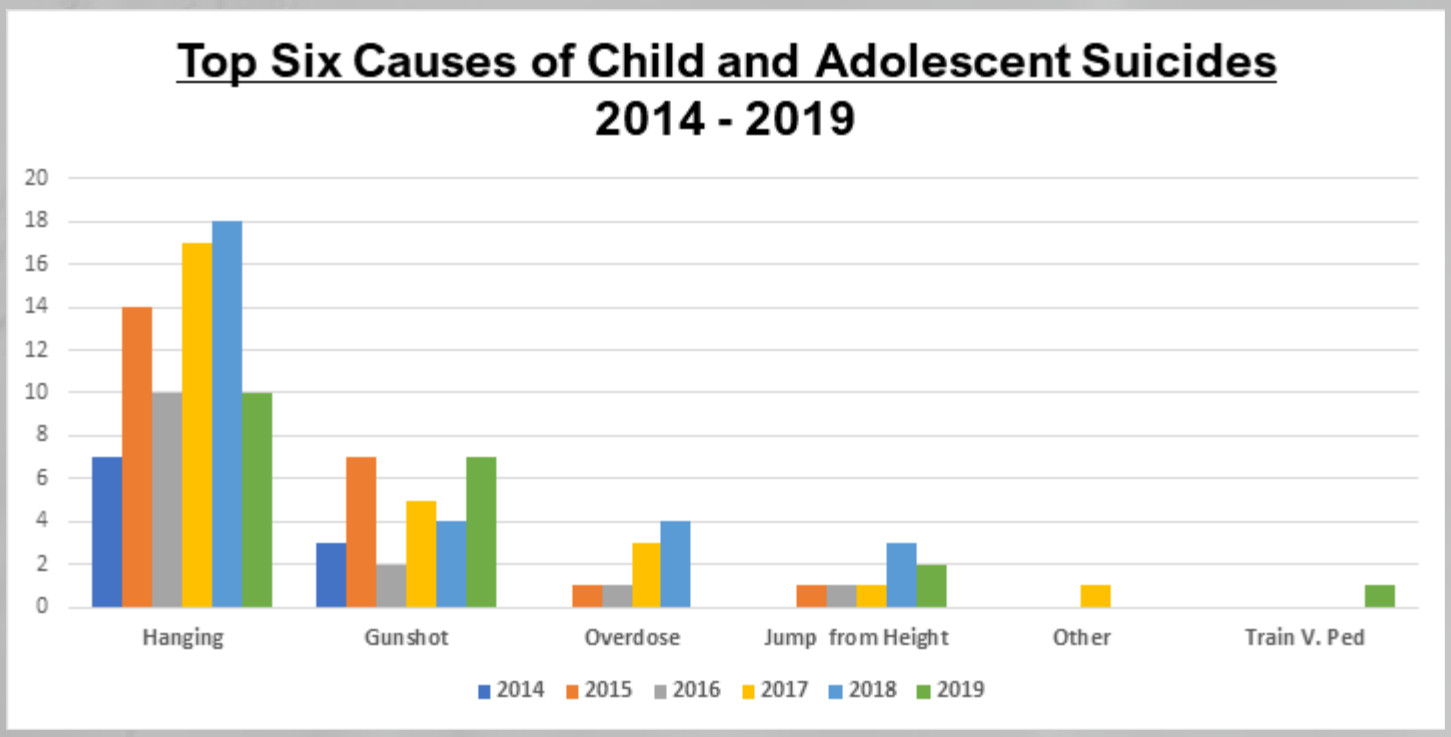
FINDINGS

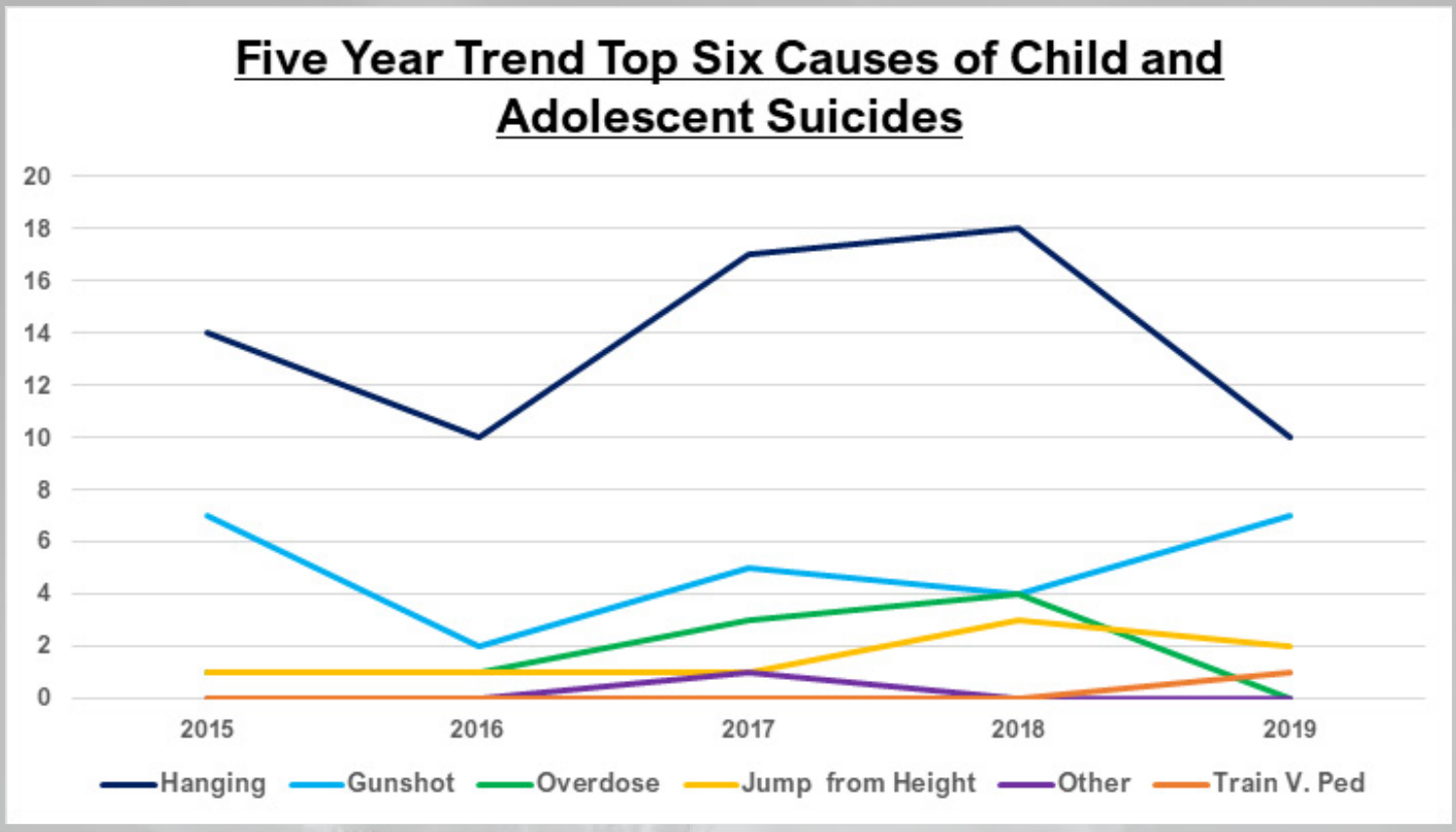
- Twenty child and adolescent suicides were reported to ICAN by the Coroner for 2019. This is a thirty-one percent decrease from the 2018 number of twenty-nine suicides and equal to the five-year average of twenty.
- In the last five years, sixty-one percent of the child and adolescent suicides were the result of hanging, twenty-one from self-inflicted gunshot wound, and eight percent each from overdose and jumping from a great height.
- Death from hanging and gunshot wound continue to be the leading methods of suicide for children and adolescents. While hanging remains the number one method and gunshot wound remains the second leading method, there was a substantial fifty-five percent decrease in hangings and a forty-three percent increase in gunshot wounds for 2019. Suicide via drug overdose, the third leading cause, also saw a small uptick.
- For 2019, sixteen males and four females were the victims of suicide. This is above the five-year average of fourteen for males and below the five-year average of seven for females. The gender gap for 2019 grew significantly from the previous year: eighty percent of the suicides were male and twenty percent female. For comparison, the ratio for 2018 was sixty-two percent male and thirty-eight percent female.
- The decline in hanging as a method of suicide for 2019 is not the direct result of the decline in the percentage of female suicide. While it is true from the data that hanging is the overwhelmingly prevalent method of suicide for females, the total percentage of hangings for males in 2019 saw a much greater decrease (male use of hanging declined seventy-seven percent).
- Seventeen-year-old adolescents remained the largest age group for suicides (forty percent). Sixteen-year-old adolescents were the second largest age group composing thirty-five percent of the suicides. Together these two-age groups made up three-fourths of the all the cases for 2019. The remaining five cases were: two fifteen-year-olds, one fourteen-year-old, one thirteen-year-old, and one eleven-year-old.
- In the last five years, thirty-five percent of all child and adolescent suicides have been seventeen-year-olds; nineteen percent have been sixteen-year-olds; seventeen percent have been fifteen-year-olds, twelve percent have been fourteen-year-olds and eleven percent were thirteen-year-olds. These groups between thirteen and seventeen years of age have made up ninety-four percent of all suicides. The remaining six percent have been made up of eight twelve-year-olds, four eleven-year-olds, and two ten-year-olds.
- For 2019, as in previous years, Hispanics and Caucasians comprised the two largest racial/ethnic groups for child and adolescents' suicides. Hispanics were forty percent, Caucasians were thirty-five percent, African Americans were fifteen percent, and Asians made up one percent.
- The five-year average for racial/ethnic groups, including 2019; is eleven per year for Hispanics, eight per year for Caucasians, two per year for African Americans, and one per year for Asians. This would make 2019 below the average for Hispanics and Caucasians.

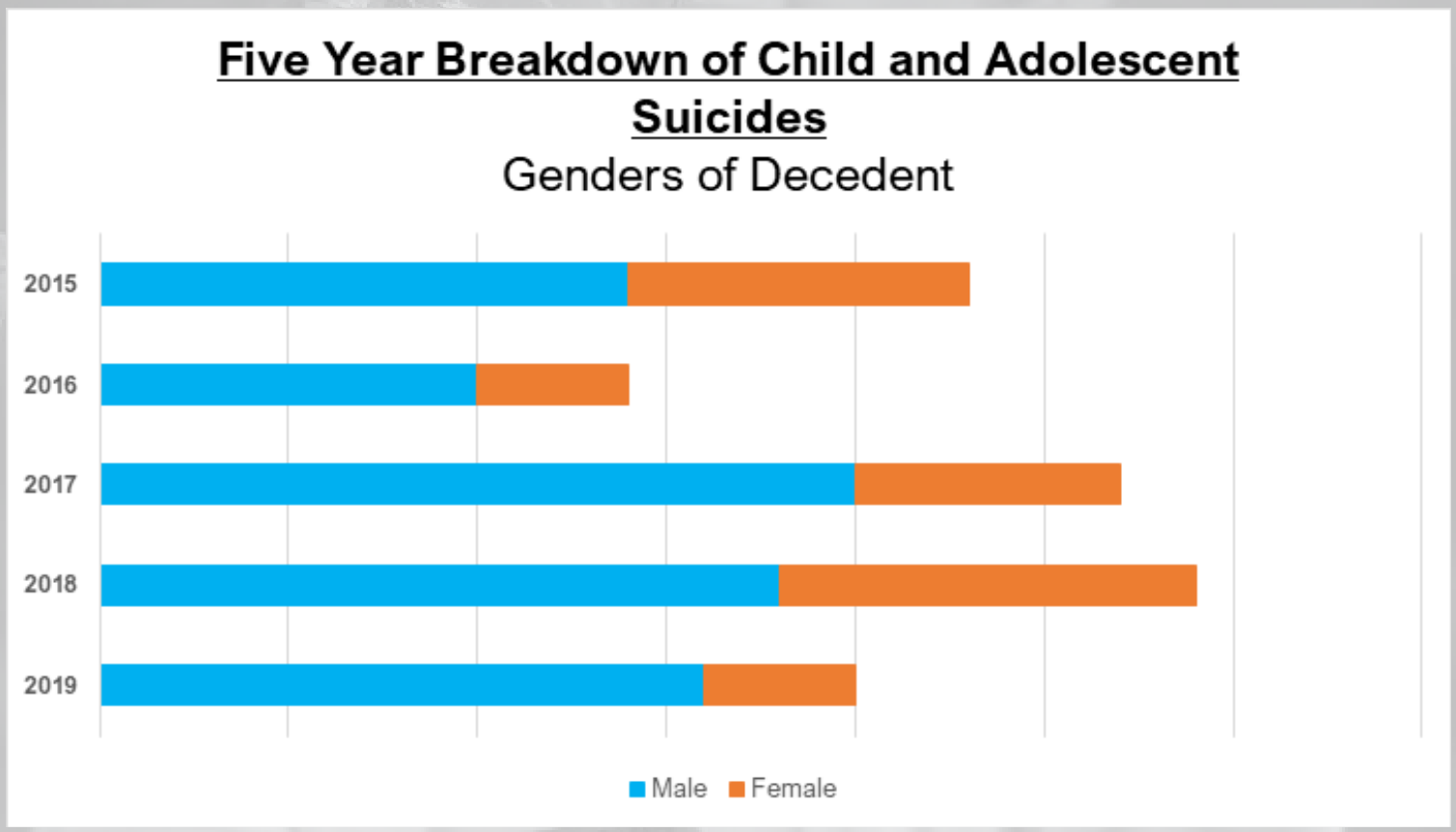
- April and August reported the highest number of suicides in 2019, with four each. There were no suicides in the months of January or July.
- Forty percent of the children and adolescents who died by suicide had a dysfunctional family dynamic at time of their death (n=8).
- Forty percent had a mental health diagnosis (n=8), thirty-five percent had been or were in therapy/counseling (n=7), twenty percent had a prior psychiatric hospitalization (n=4), and fifteen percent had been on psychotropic medication (n=3).
- Twenty-five percent (n=5) had a prior suicide attempt and ten percent left a suicide note or message (n=2). Thirty percent had academic/discipline (n=6) problems at school.
- Fourteen, or seventy percent, of the child and adolescents who were the victim of suicide in 2019 had a history with the Department of Child and Family Services.

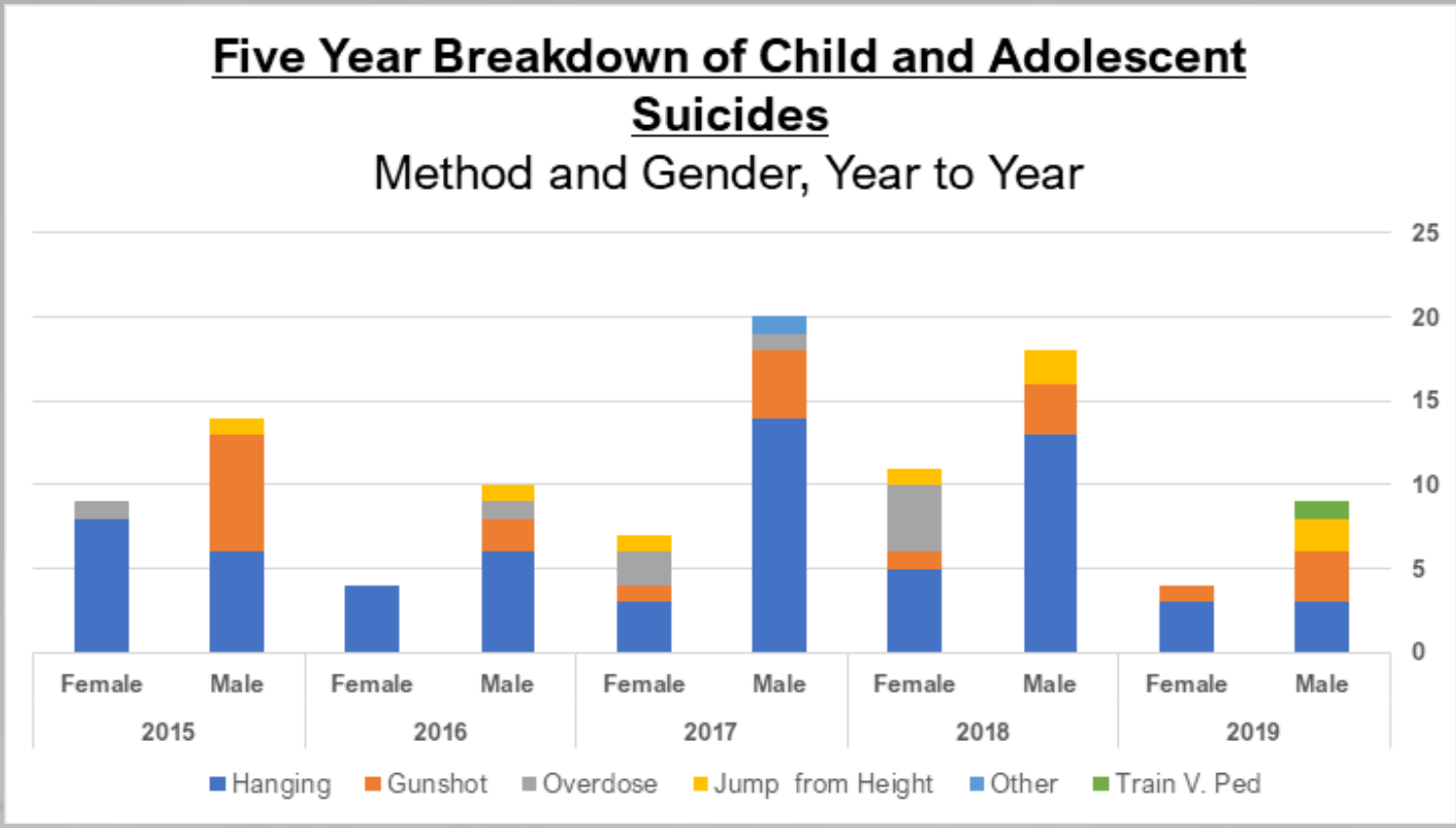


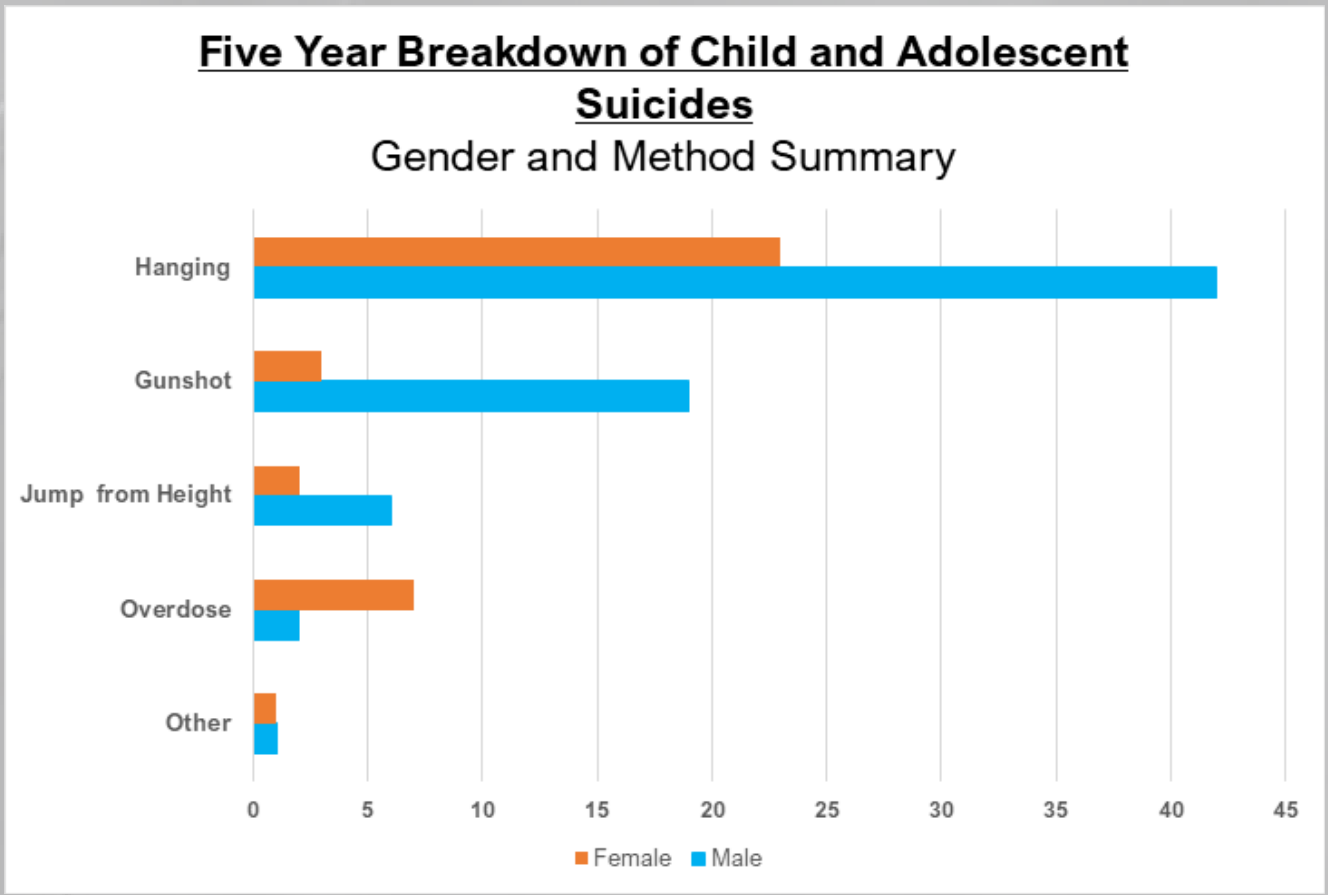

1989-2019 Child and Adolescent Suicides:
Total Deaths Per Year Trendline
50
45
40
35
30
25
20
15
10
5
0
36
28
23
26
44
28
11
36
20
15
27
23
27
19
19
13
15
14
10
17
14
16
19
17
13
10
23
14
27
29
20
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019

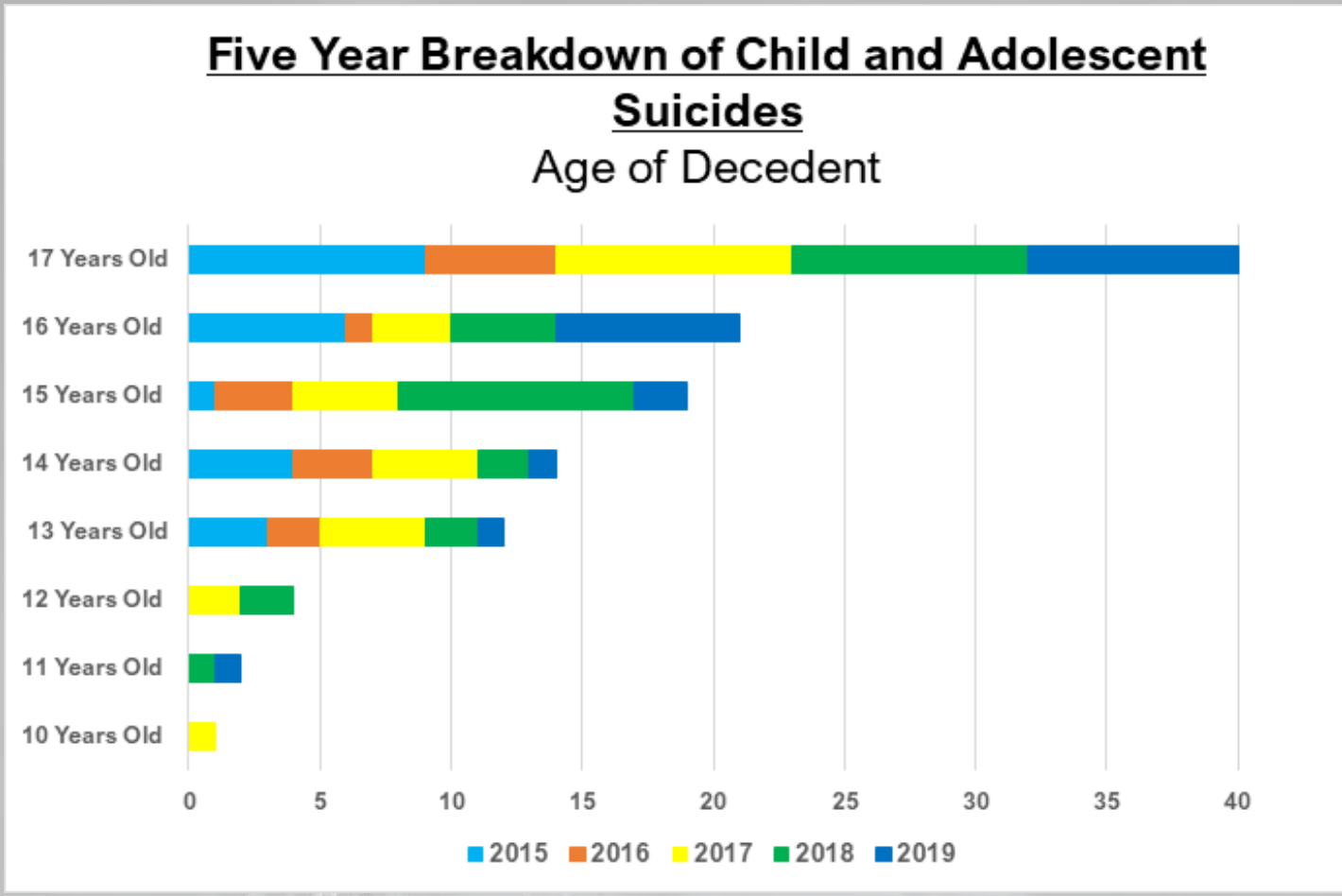

Top Six Causes of Child and Adolescent Suicides
2014 - 2019
20
18
16
14
12
10
8
6
4
2
0
Hanging
Gunshot
Overdose
Jump from Height
Other
Train V. Ped
2014
2015
2016
2017
2018
2019

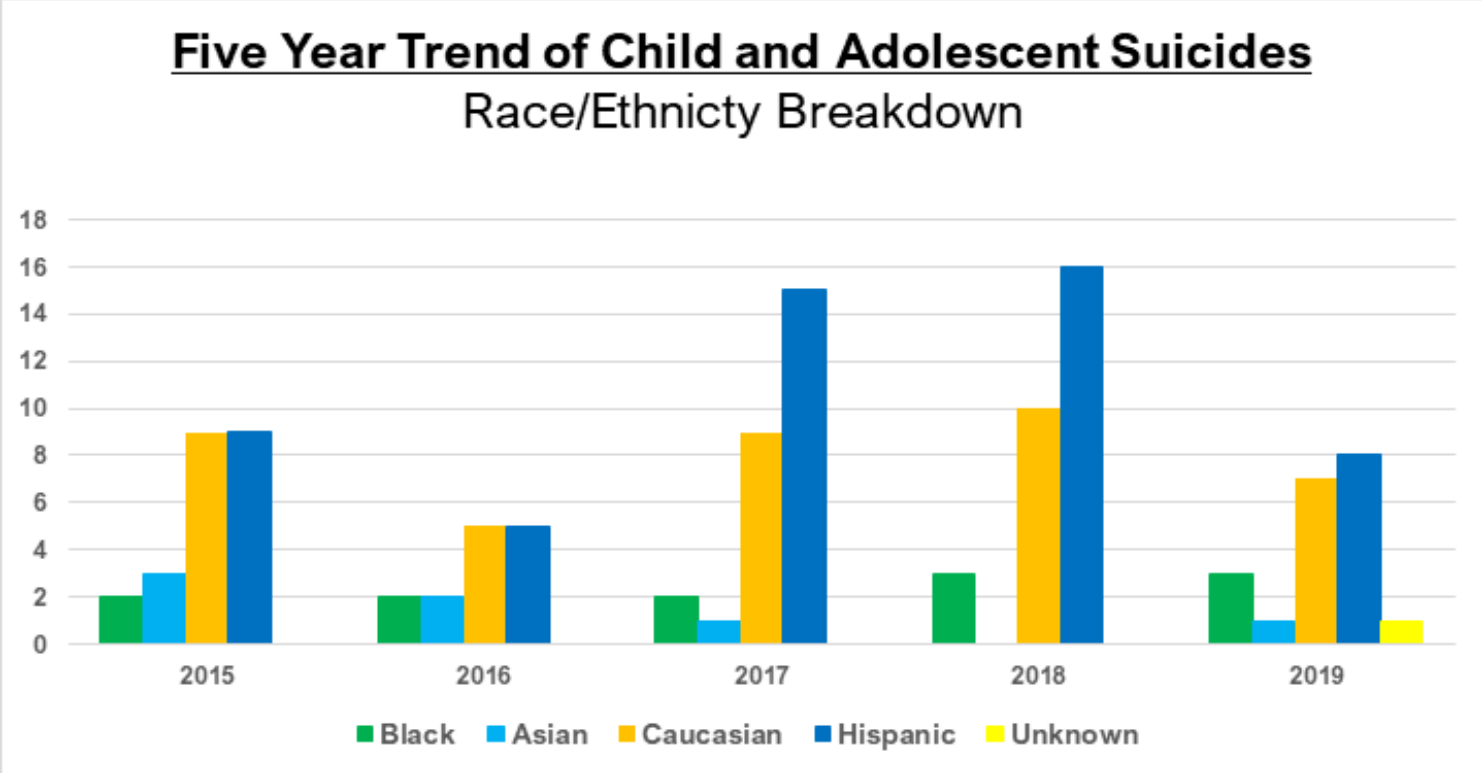

Five Year Trend Top Six Causes of Child and Adolescent Suicides
20
18
16
14
12
10
8
6
4
2
0
2015
2016
2017
2018
2019
Hanging
Gunshot
Overdose
Jump from Height
Other
Train V. Ped

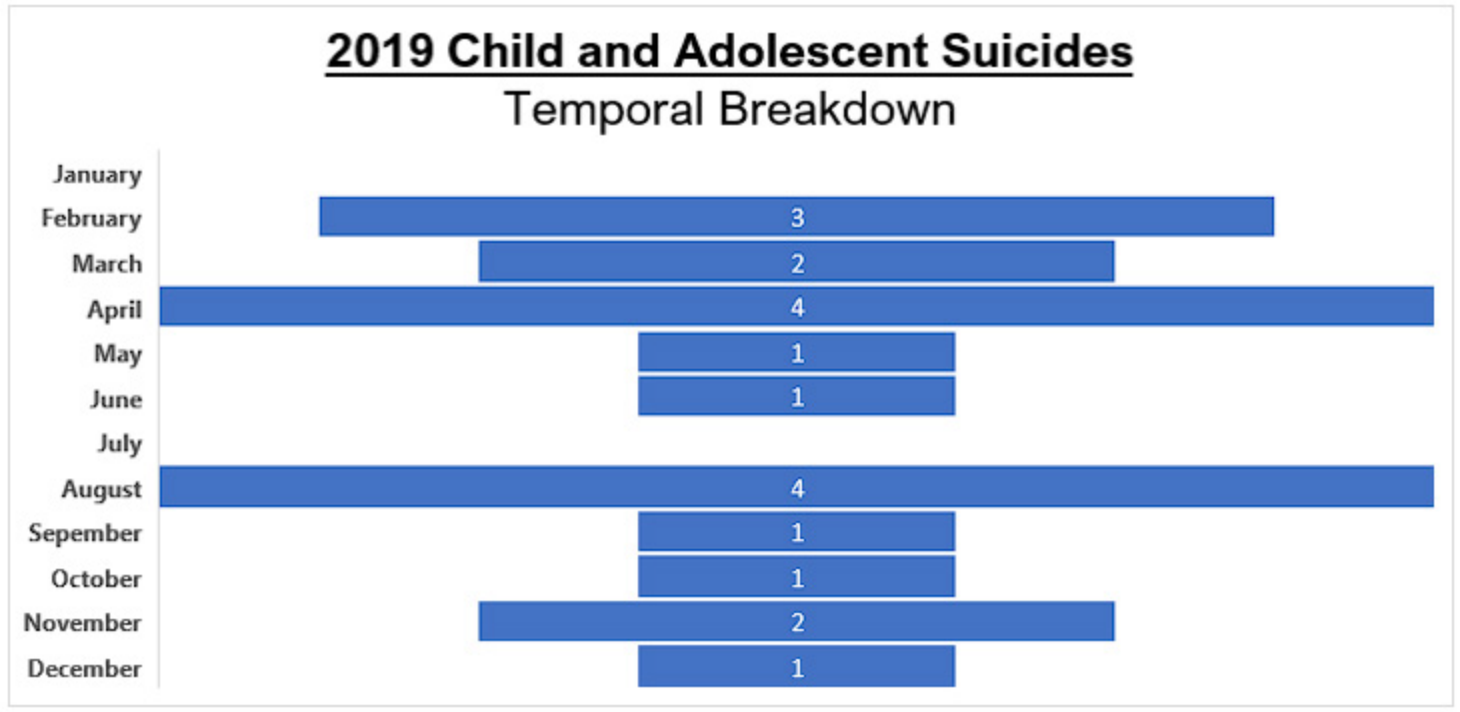

Five Year Breakdown of Child and Adolescent Suicides
Genders of Decedent
2015
2016
2017
2018
2019
Male
Female

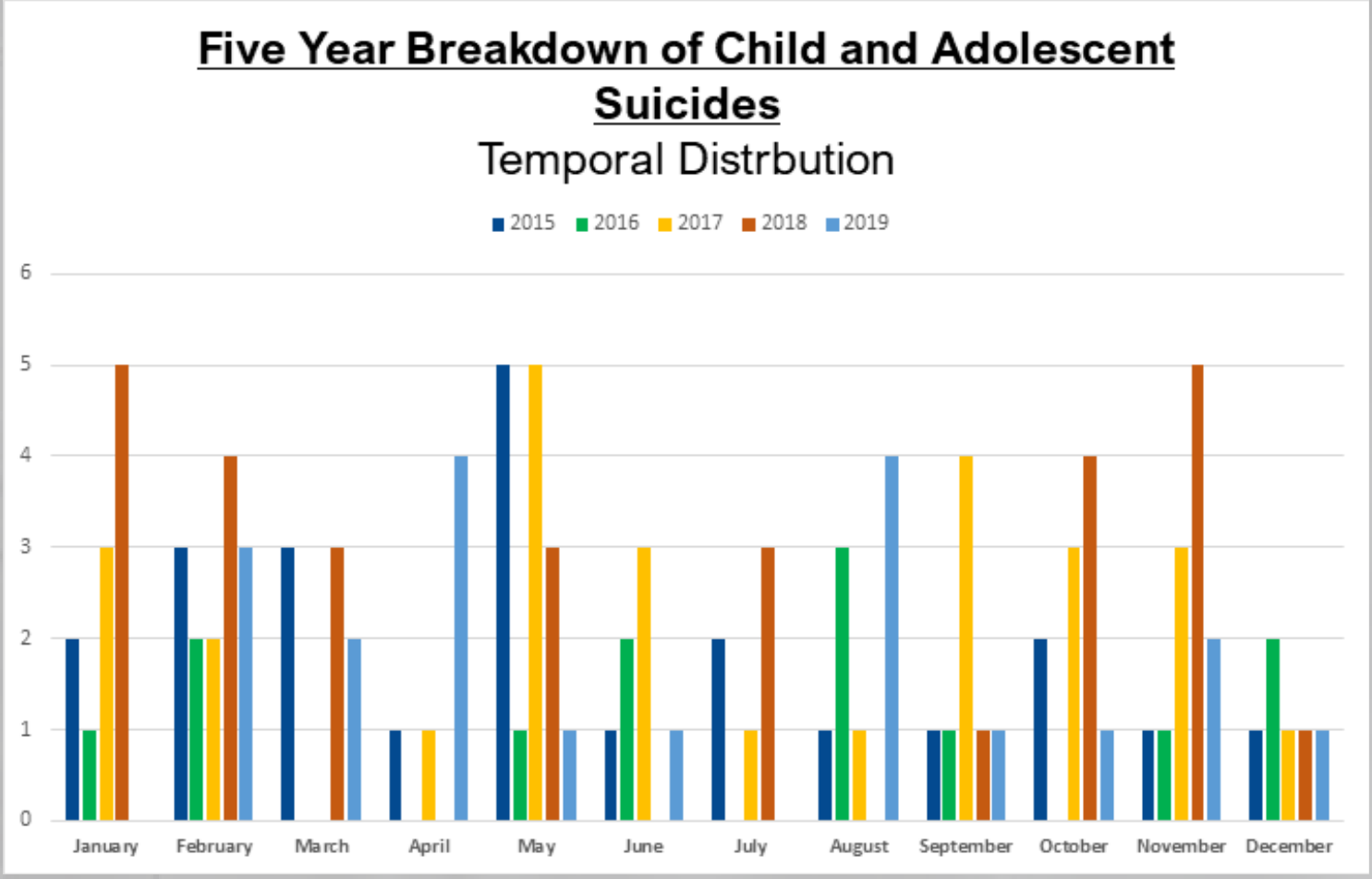

Five Year Breakdown of Child and Adolescent Suicides
Method and Gender, Year to Year
25
20
15
10
5
0
Female
Male
2015
2016
2017
2018
2019
Hanging
Gunshot
Overdose
Jump from Height
Other
Train V. Ped

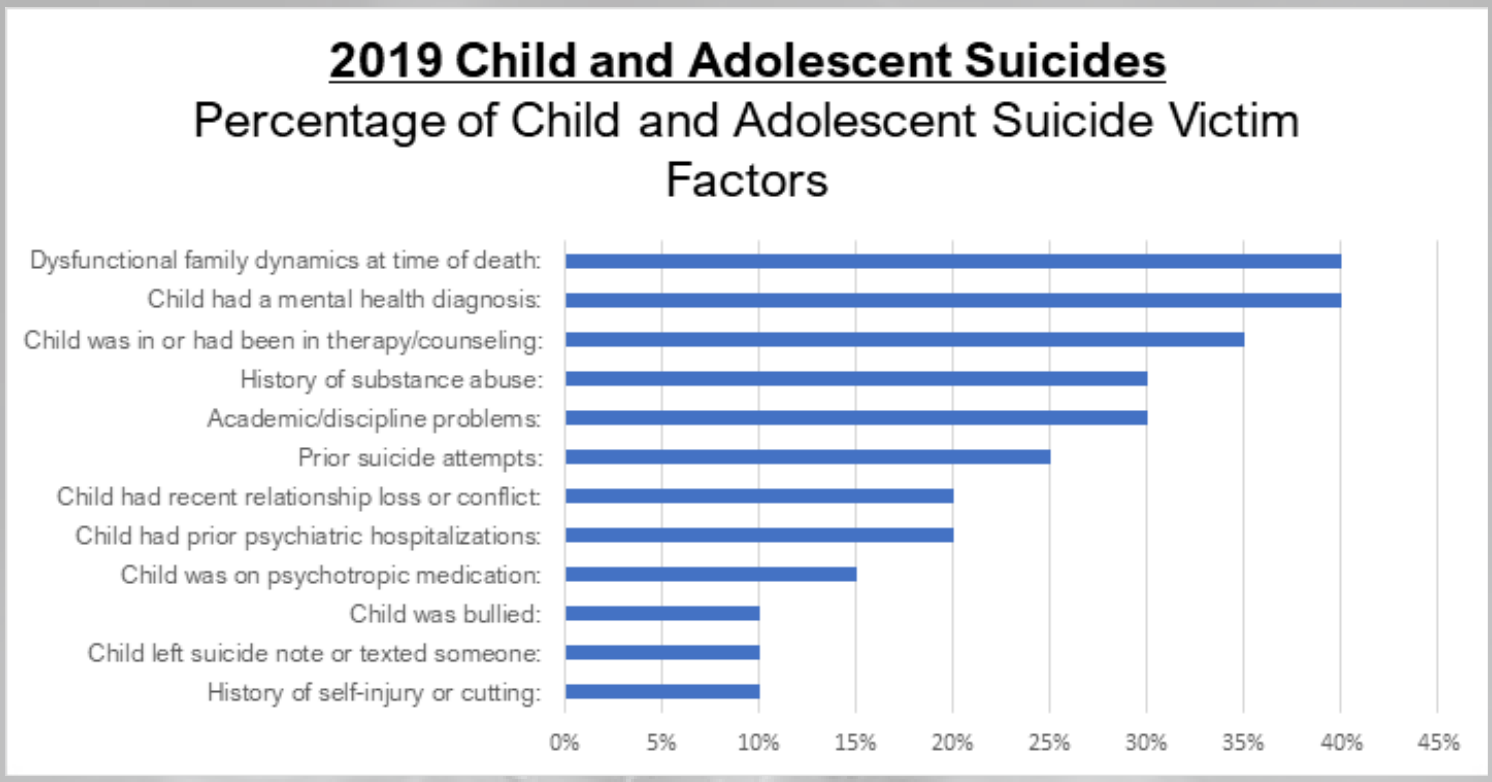

Five Year Breakdown of Child and Adolescent Suicides
Gender and Method Summary
Hanging
Gunshot
Jump from Height
Overdose
Other
0
5
10
15
20
25
30
35
40
45
Female
Male

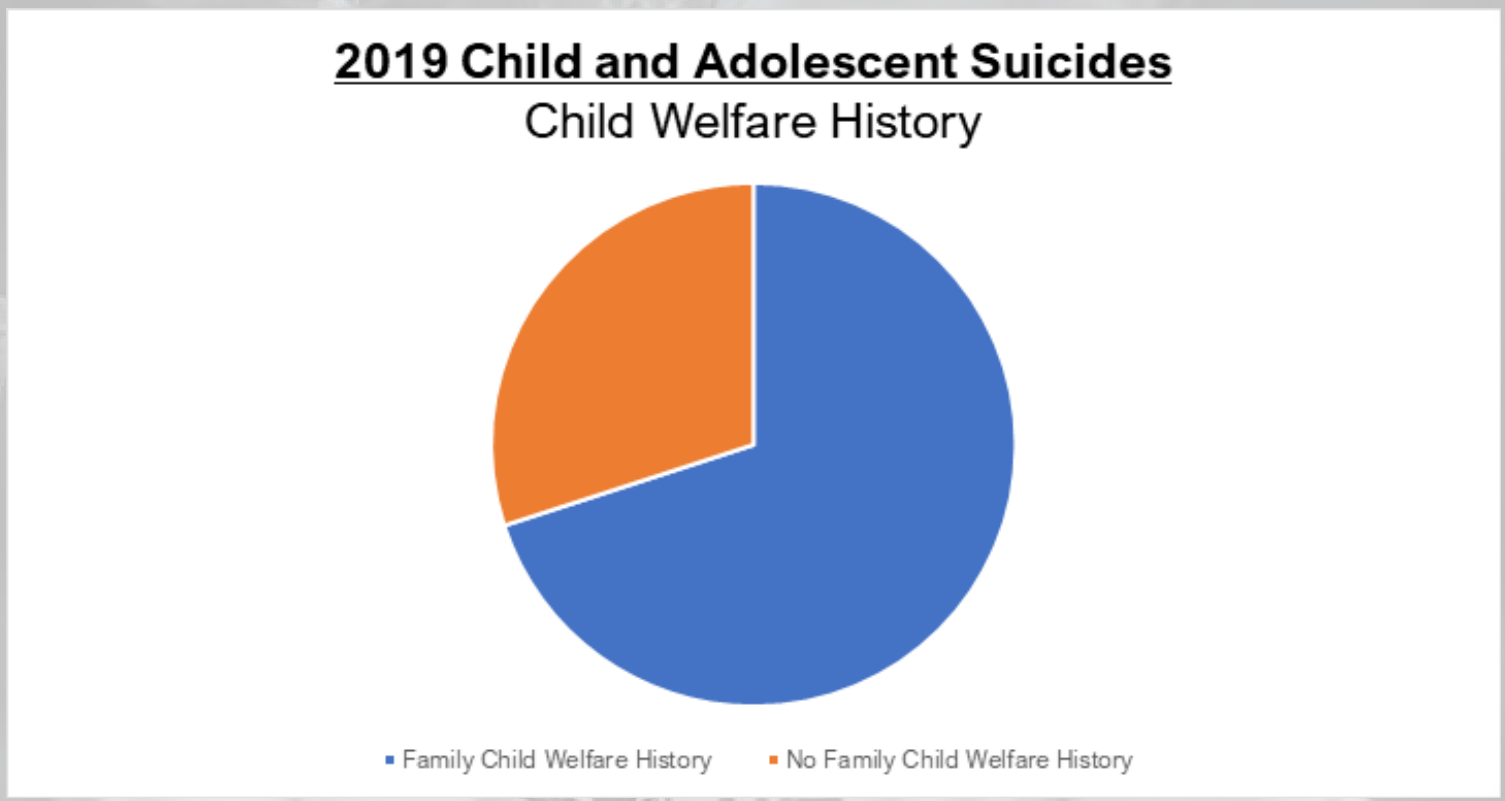

Five Year Breakdown of Child and Adolescent Suicides
Age of Decedent
17 Years Old
16 Years Old
15 Years Old
14 Years Old
13 Years Old
12 Years Old
11 Years Old
10 Years Old
0
5
10
15
20
25
30
35
40
2015
2016
2017
2018
2019


Five Year Trend of Child and Adolescent Suicides
Race/Ethnicty Breakdown
18
16
14
12
10
8
6
4
2
0
2015
2016
2017
2018
2019
Black
Asian
Caucasian
Hispanic
Unknown


2019 Child and Adolescent Suicides
Temporal Breakdown
January
February
March
April
May
June
July
August
Sepember
October
November
December
3
2
4
1
1
4
1
1
2
1

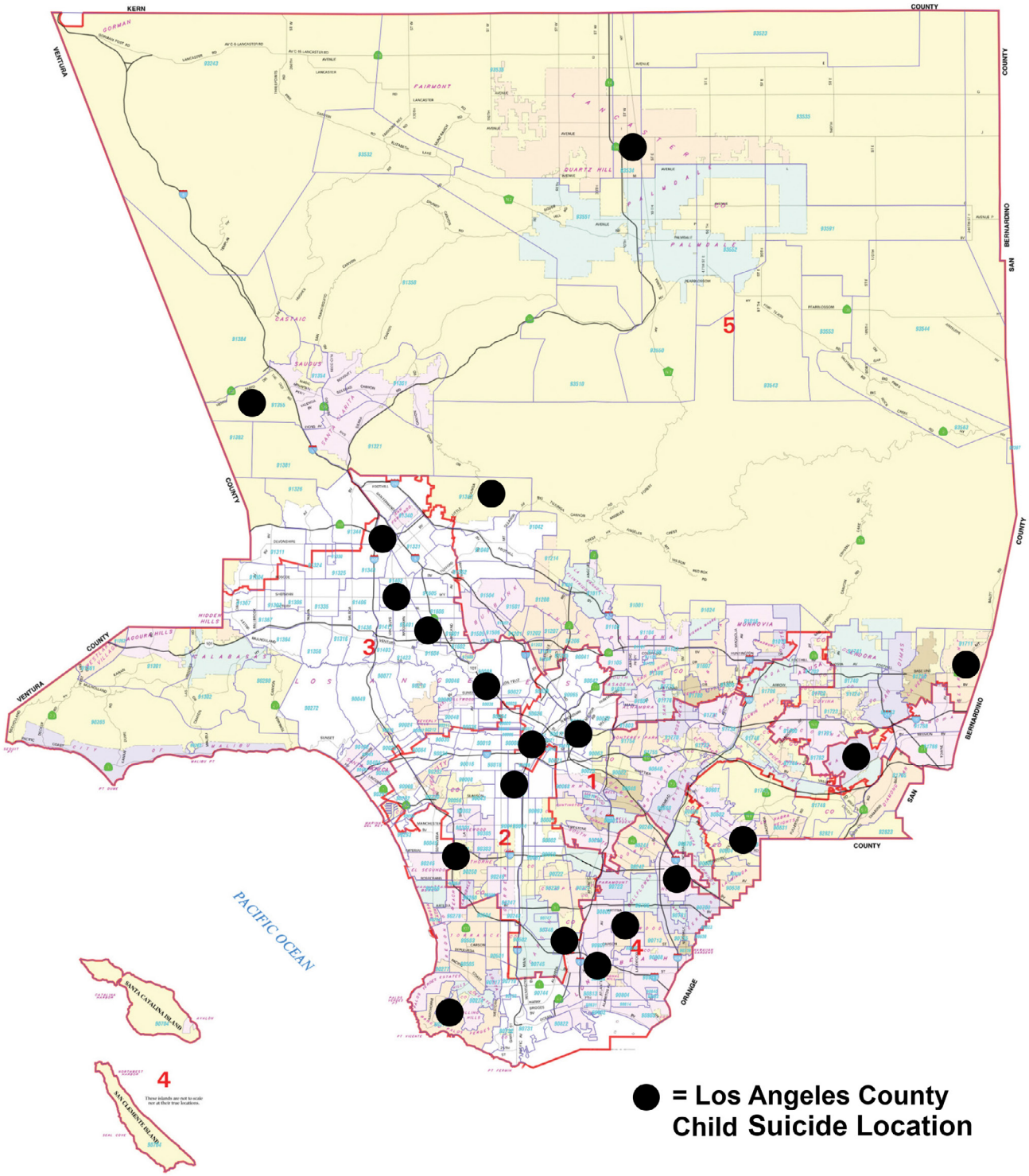

Five Year Breakdown of Child and Adolescent Suicides
Temporal Distrbution
2015
2016
2017
2018
2019
6
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December


2019 Child and Adolescent Suicides
Percentage of Child and Adolescent Suicide Victim Factors
Dysfunctional family dynamics at time of death:
Child had a mental health diagnosis:
Child was in or had been in therapy/counseling:
History of substance abuse:
Academic/discipline problems:
Prior suicide attempts:
Child had recent relationship loss or conflict:
Child had prior psychiatric hospitalizations:
Child was on psychotropic medication:
Child was bullied:
Child left suicide note or texted someone:
History of self-injury or cutting:
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%


2019 Child and Adolescent Suicides
Child Welfare History
Family Child Welfare History
No Family Child Welfare History

2019 Child Suicides - Locations
n = 20*

City where the suicide occurred



Sample Case Summaries

Sean

Sixteen-year-old Sean was warned by his parents not to ride his motorized bike without a helmet. On one late afternoon Sean was riding his bike when he was struck by a vehicle and was pronounced dead that scene.

Audrey

Mother left 2-year-old Audrey in the living room while she stepped away to the laundry room for about 3 to 5 minutes. When mother came back into the living room, she did not see Audrey and began looking for her in and outside the house. Little Audrey was found by mother floating in the pool. Mother called 911 and Audrey was transported to the hospital and provided resuscitation measures. However, Audrey was pronounced dead at the hospital.

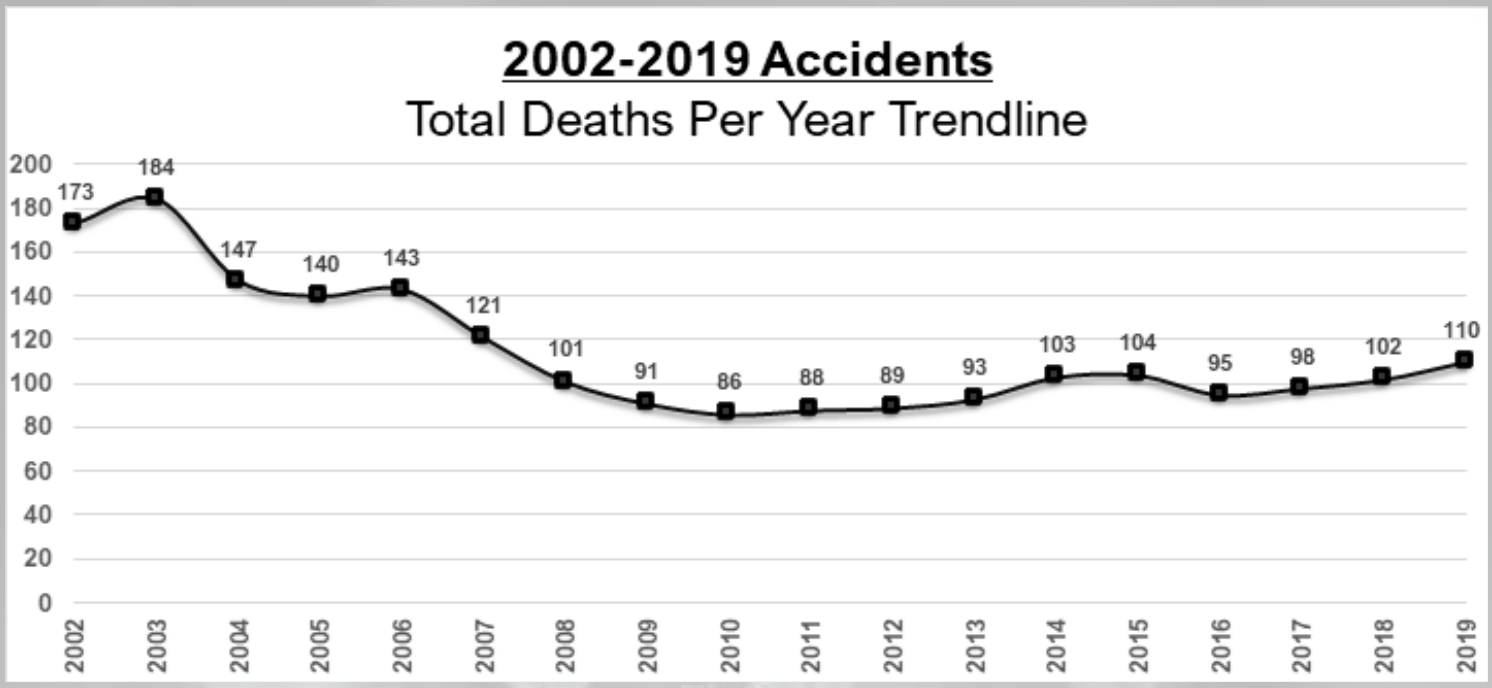
Angel

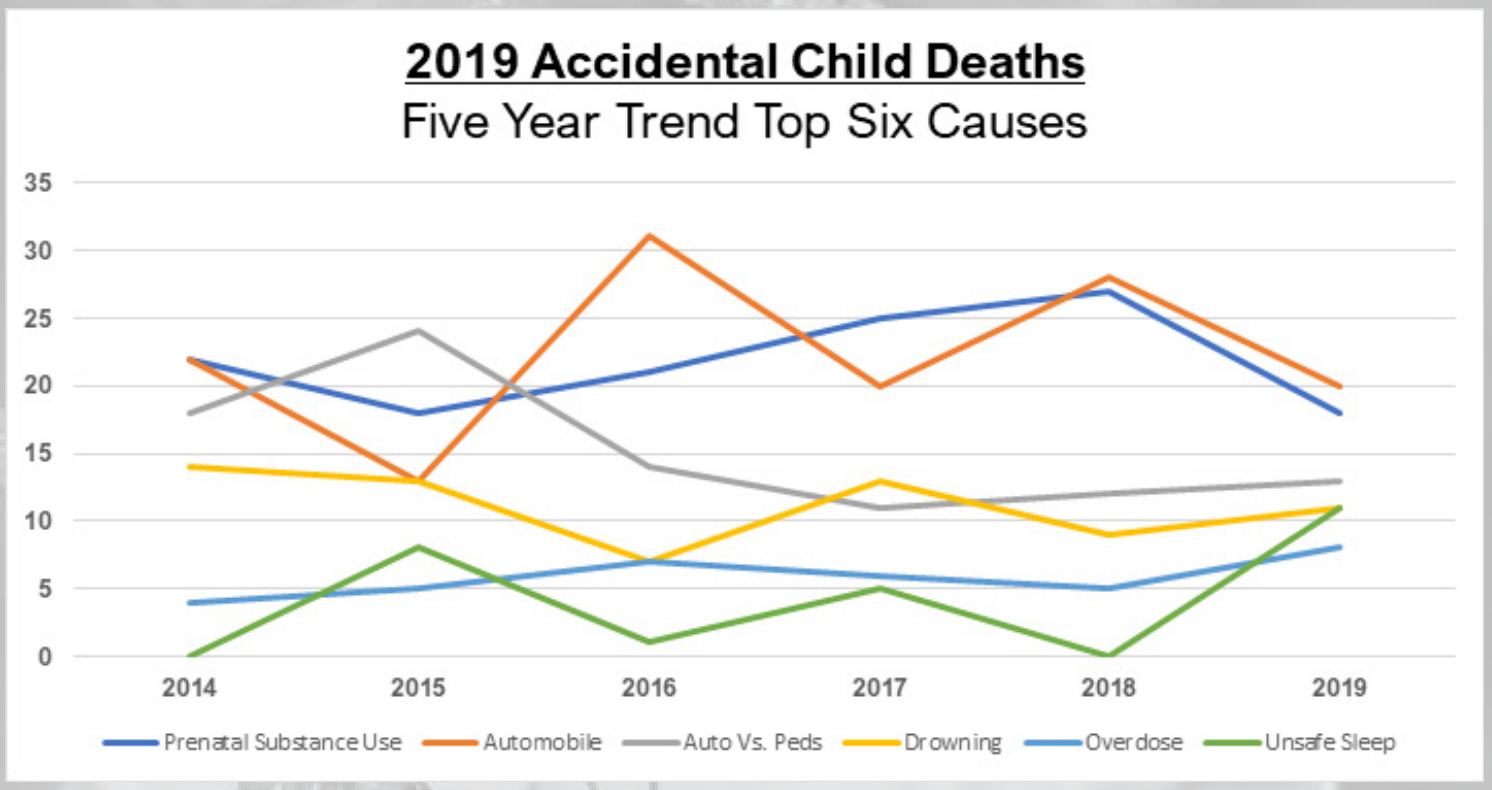
One year old, Angel was last seen eating popcorn while mother was cleaning the house. After not hearing Angel for a few minutes mother went in to check on him and found him unresponsive and called 911. Emergency personnel arrived and attempted aspiration and life saving measures, however, Angel was not responding. Angel was transported to the hospital where he was examined and found to be a healthy boy and there were no signs of abuse.

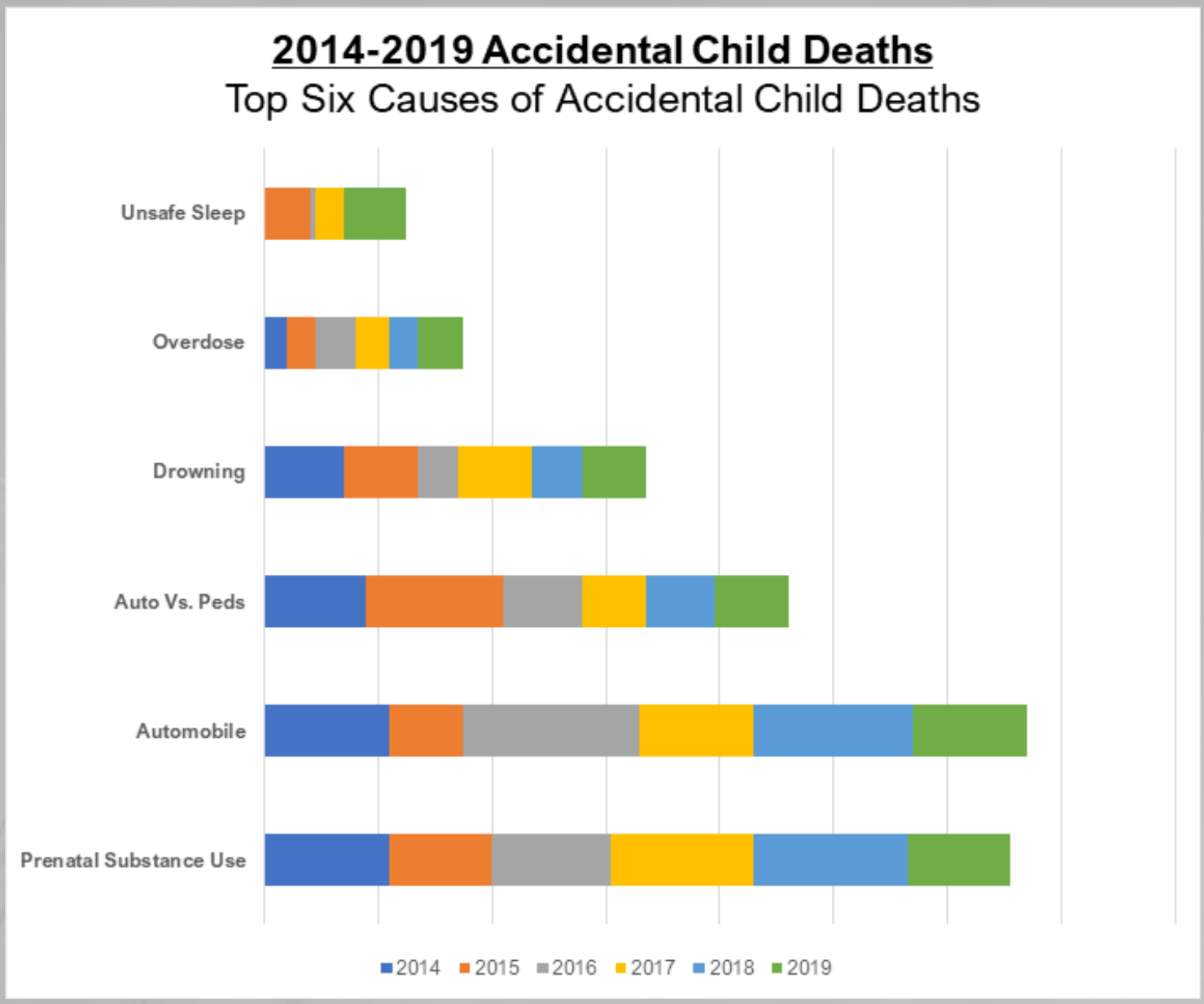
ACCIDENTS

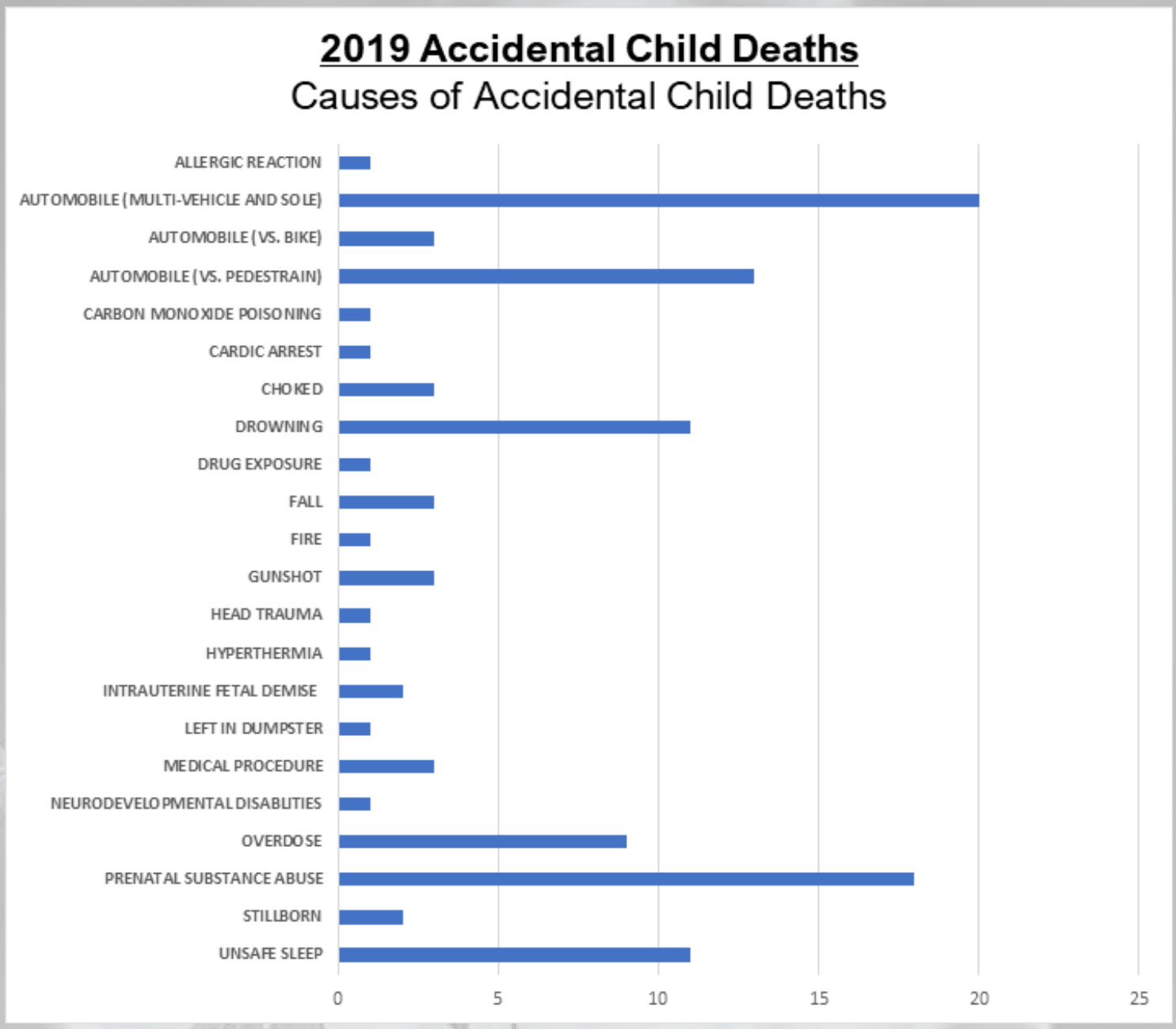
FINDINGS

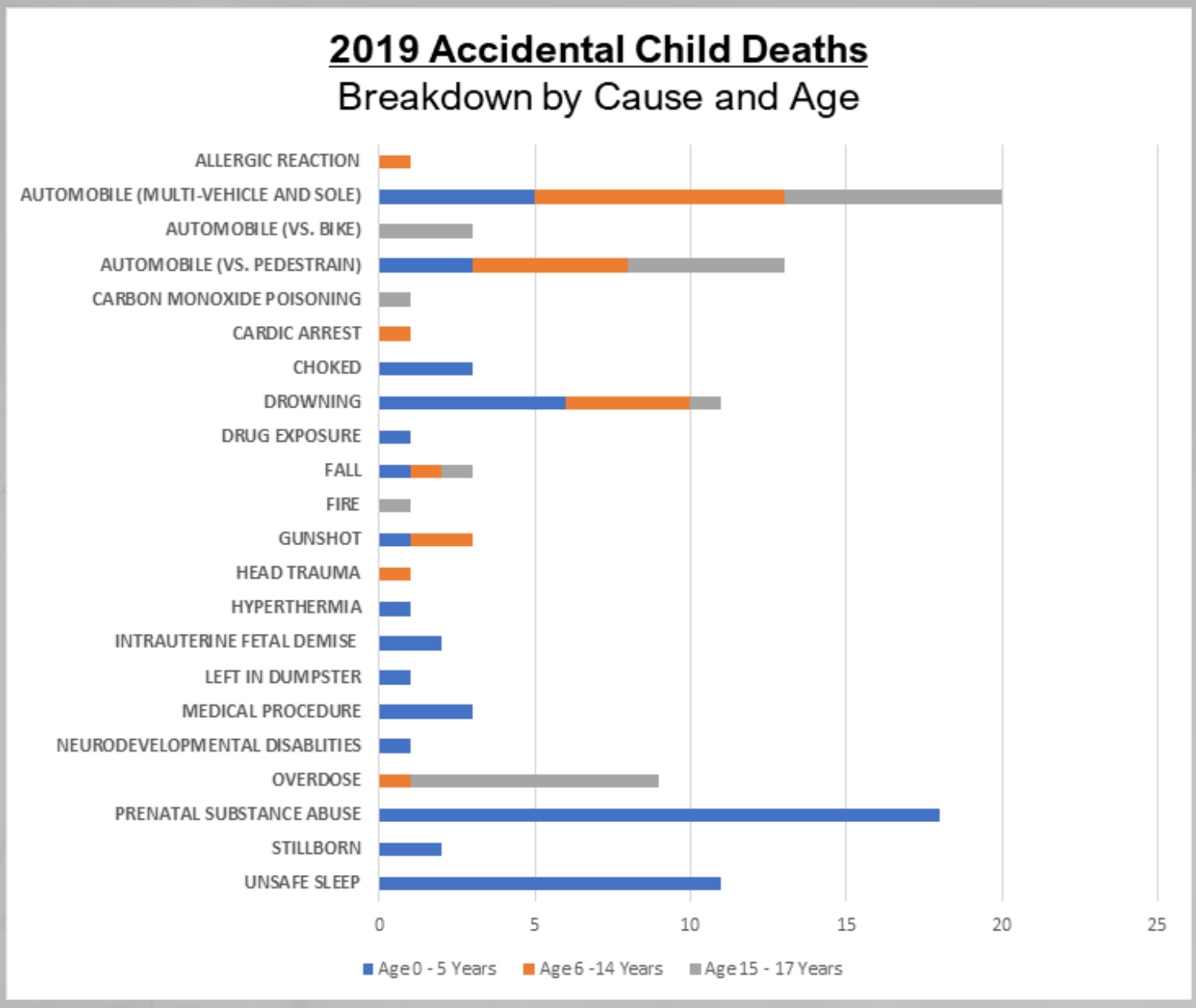
- One hundred and ten accidental child deaths were reported to ICAN by the Coroner for 2019. This is an eight percent increase from the 2018 number of one hundred and two deaths and above the five-year average of one hundred deaths per year. This is also the highest number of accidental child deaths in twelve years (since 2007) and reflects a four-year trend upward in this mode of death.
- In the prior years, automobile death and prenatal substance abuse have been the leading causes of accidental child death. This remains true for 2019, with automobile deaths making up eighteen percent and prenatal substance abuse making sixteen percent of the accidents. These two types of death are followed by Automobile Vs Pedestrian (twelve percent), Unsafe Sleep (ten percent), Drowning (ten percent), and overdose (eight percent).
- Over one third (thirty-six percent) of the accidental child deaths happened to children less than one year old, primarily from prenatal substance abuse and unsafe sleep. The next largest age group was seventeen-year-old children who made up fourteen percent of the accidental child death. In this seventeen-year-old age group, the number one cause of death was an automobile accident (forty-seven percent) followed by drug overdose (thirty percent).
- The majority (fifty-one percent) of accidental child deaths were children of Hispanic background. The next highest were Caucasian children who made up a quarter (twenty-five percent) of the deaths. This is consistent/slightly above the five-year average (which is forty-eight for Hispanics and twenty-four for Caucasians) and continues the trend with these two race/ethnicities being the predominant victims of accidental death.
- Children dying in an automobile accident, either as a driver or a passenger, accounted for 20 of the accidental child deaths in 2019. This is roughly a thirty-percent decrease in this cause of child death from 2018. The age range for victims spans from one year of age to seventeen years of age with the higher number of deaths being between fifteen and seventeen years ago. In 2019, the demographics are slightly more female than male (sixty percent female vs. forty percent male) and majority Hispanic (sixty-five percent). In nearly all the cases (19 of the 20 deaths), the child was the passenger in the vehicle and not the driver.
- Eighteen children died of prenatal substance abuse in 2019 – a thirty-six percent decrease from 2018. The number one drug cause of prenatal substance abuse was methamphetamine, which as the sole cause of death, made up eighty-three percent in 2019. This is consistent with the last five years where methamphetamine continues to be the number one agent in prenatal substance abuse deaths. Caucasians also continue to be over-represented given their population in the County and are, for the third year, the highest group with a child loss due to prenatal drug use.
- Seventy-eight of the prenatal substance abuse deaths were from families with a Department of Child and Family Services history. This is also consistent within the last five years where most of these cases were from families with such history. Thirty-three percent of the mothers had their own DCFS history as minors.

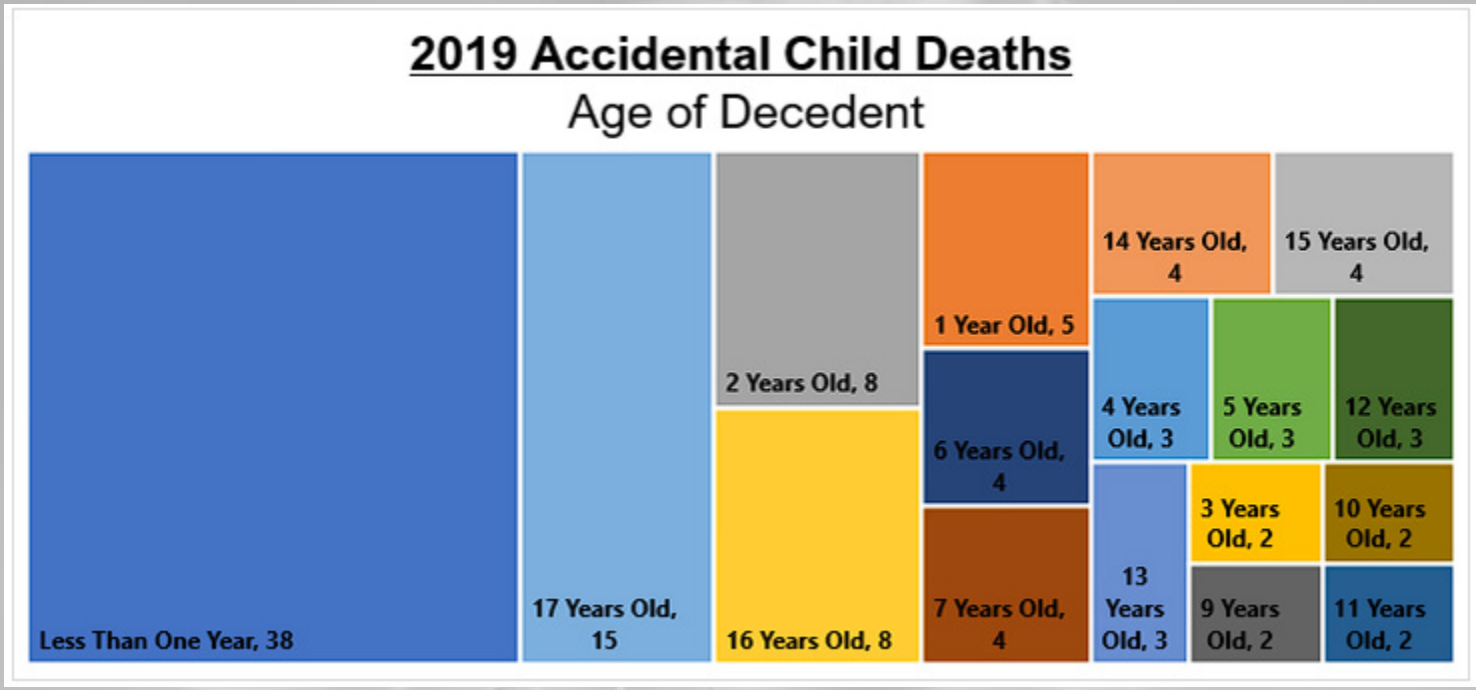

2002-2019 Accidents
Total Deaths Per Year Trendline
200
180
160
140
120
100
80
60
40
20
0
173
184
147
140
143
121
101
91
86
88
89
93
103
104
95
98
102
110
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019

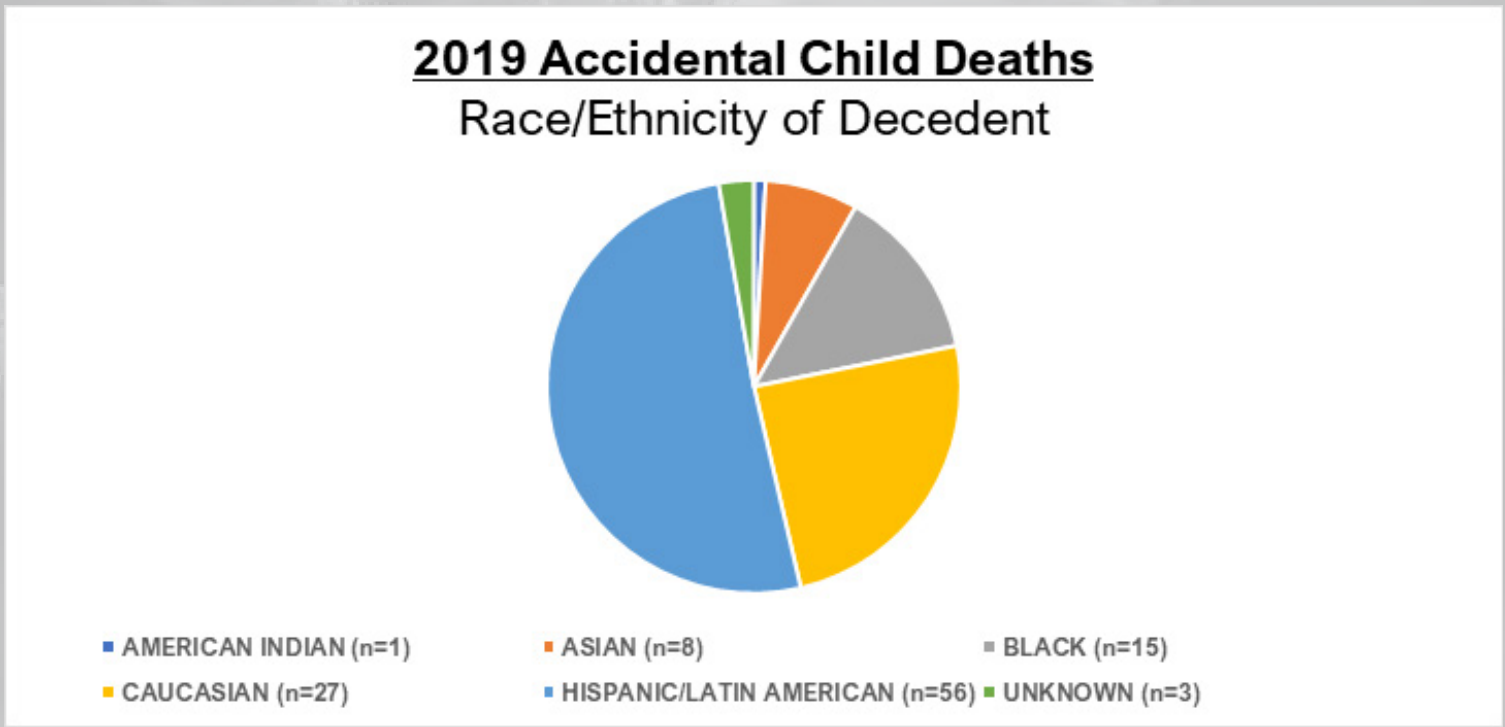

2019 Accidental Child Deaths
Five Year Trend Top Six Causes
35
30
25
20
15
10
5
0
2014
2015
2016
2017
2018
2019
Prenatal Substance Use
Automobile
Auto Vs. Peds
Drowning
Overdose
Unsafe Sleep

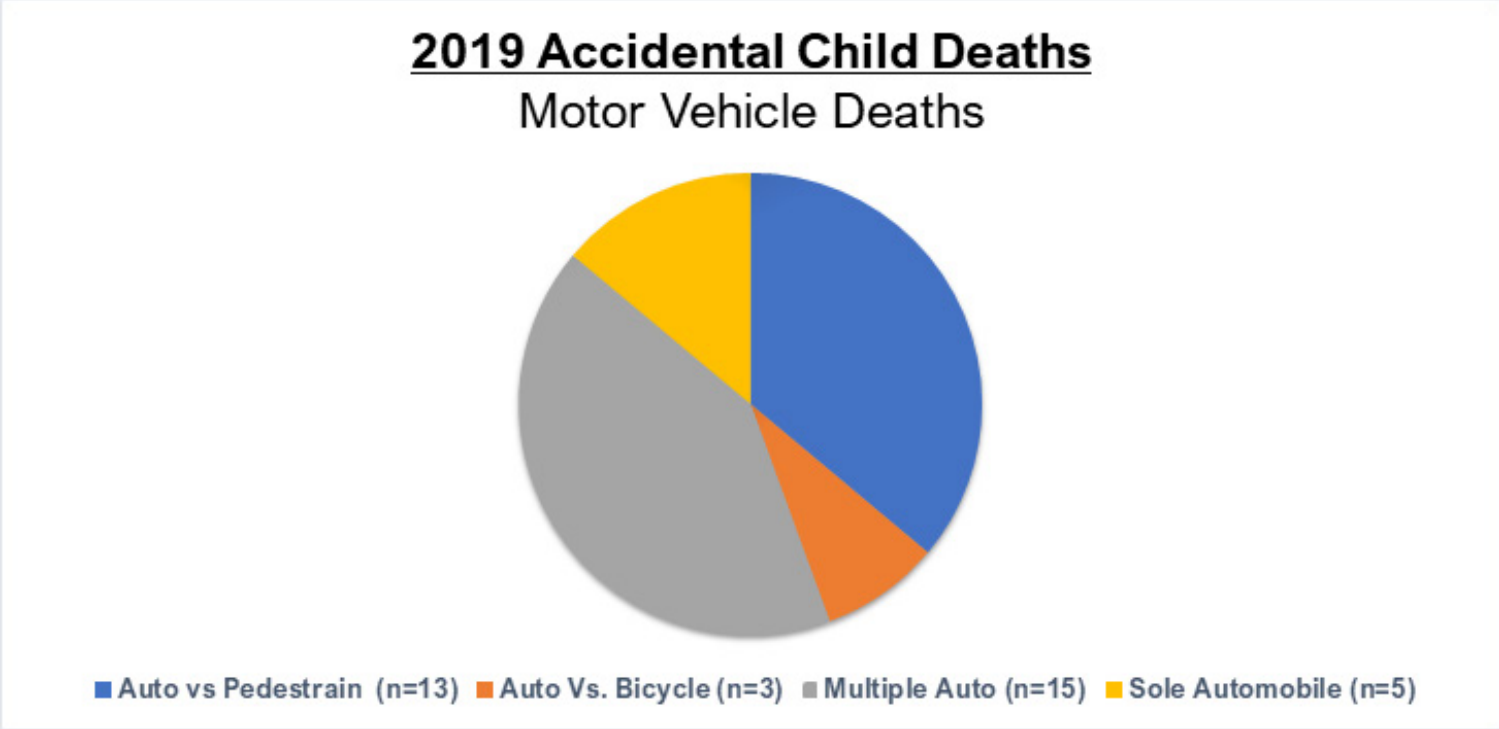

2014-2019 Accidental Child Deaths
Top Six Causes of Accidental Child Deaths
Unsafe Sleep
Overdose
Drowning
Auto Vs. Peds
Automobile
Prenatal Substance Use
2014
2015
2016
2017
2018
2019

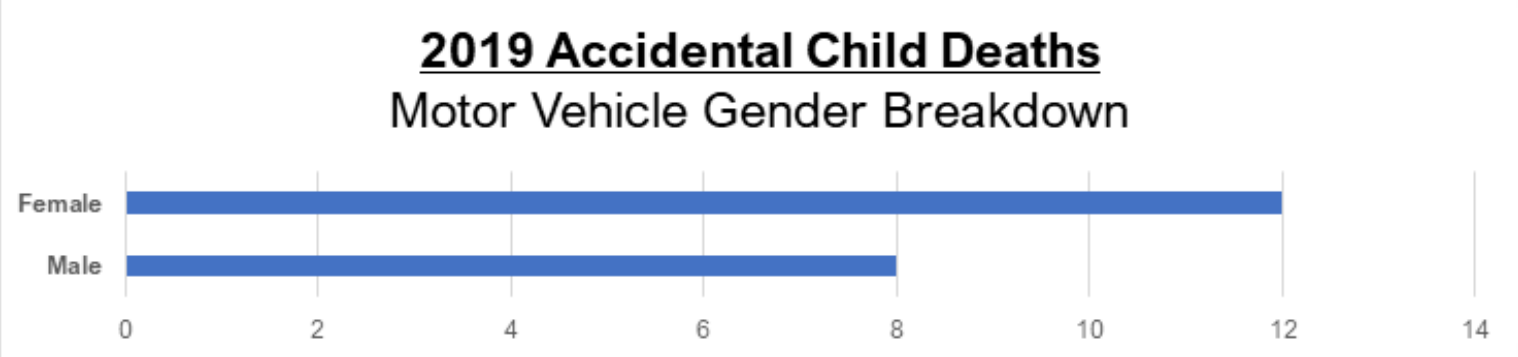

2019 Accidental Child Deaths
Causes of Accidental Child Deaths
ALLERGIC REACTION
AUTOMOBILE (MULTI-VEHICLE AND SOLE)
AUTOMOBILE (VS. BIKE)
AUTOMOBILE (VS. PEDESTRAIN)
CARBON MONOXIDE POISONING
CARDIC ARREST
CHOKED
DROWNING
DRUG EXPOSURE
FALL
FIRE
GUNSHOT
HEAD TRAUMA
HYPERTHERMIA
INTRAUTERINE FETAL DEMISE
LEFT IN DUMPSTER
MEDICAL PROCEDURE
NEURODEVELOPMENTAL DISABLITIES
OVERDOSE
PRENATAL SUBSTANCE ABUSE
STILLBORN
UNSAFE SLEEP
0
5
10
15
20
25

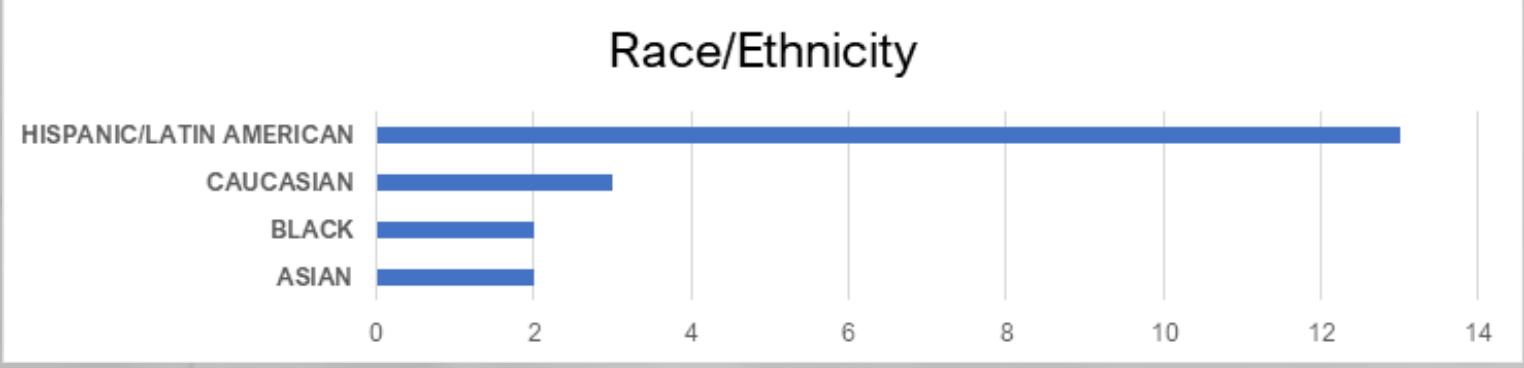

2019 Accidental Child Deaths
Breakdown by Cause and Age
ALLERGIC REACTION
AUTOMOBILE (MULTI-VEHICLE AND SOLE)
AUTOMOBILE (VS. BIKE)
AUTOMOBILE (VS. PEDESTRAIN)
CARBON MONOXIDE POISONING
CARDIC ARREST
CHOKED
DROWNING
DRUG EXPOSURE
FALL
FIRE
GUNSHOT
HEAD TRAUMA
HYPERTHERMIA
INTRAUTERINE FETAL DEMISE
LEFT IN DUMPSTER
MEDICAL PROCEDURE
NEURODEVELOPMENTAL DISABLITIES
OVERDOSE
PRENATAL SUBSTANCE ABUSE
STILLBORN
UNSAFE SLEEP
0
5
10
15
20
25
Age 0 - 5 Years
Age 6 -14 Years
Age 15 - 17 Years

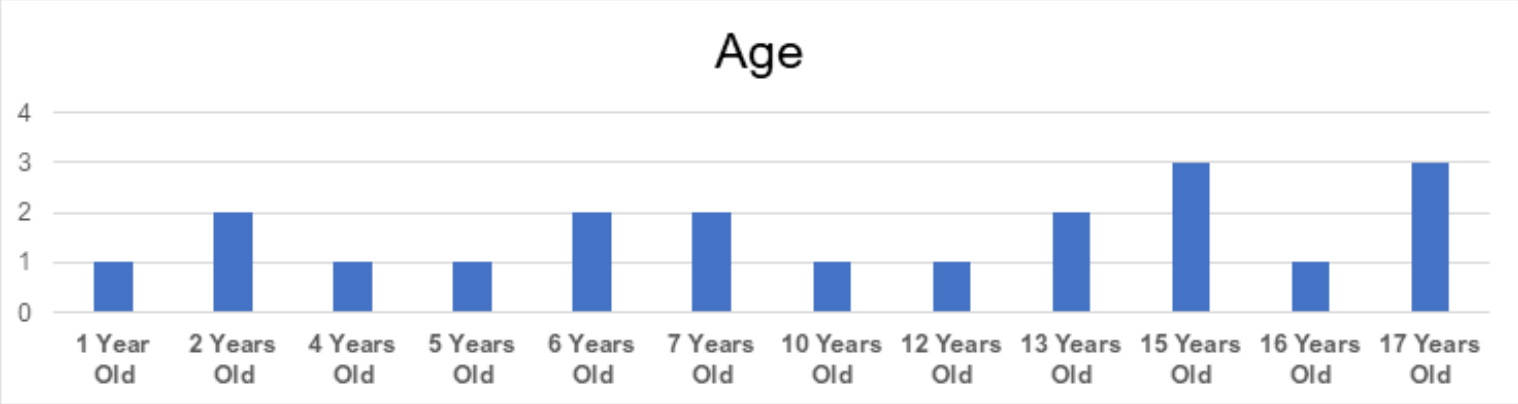

2019 Accidental Child Deaths
Age of Decedent
Less Than One Year, 38
17 Years Old, 15
2 Years Old, 8
16 Years Old, 8
1 Year Old, 5
6 Years Old, 4
7 Years Old, 4
14 Years Old, 4
15 Years Old, 4
4 Years Old, 3
5 Years Old, 3
12 Years Old, 3
13 Years Old, 3
3 Years Old, 2
10 Years Old, 2
9 Years Old, 2
11 Years Old, 2

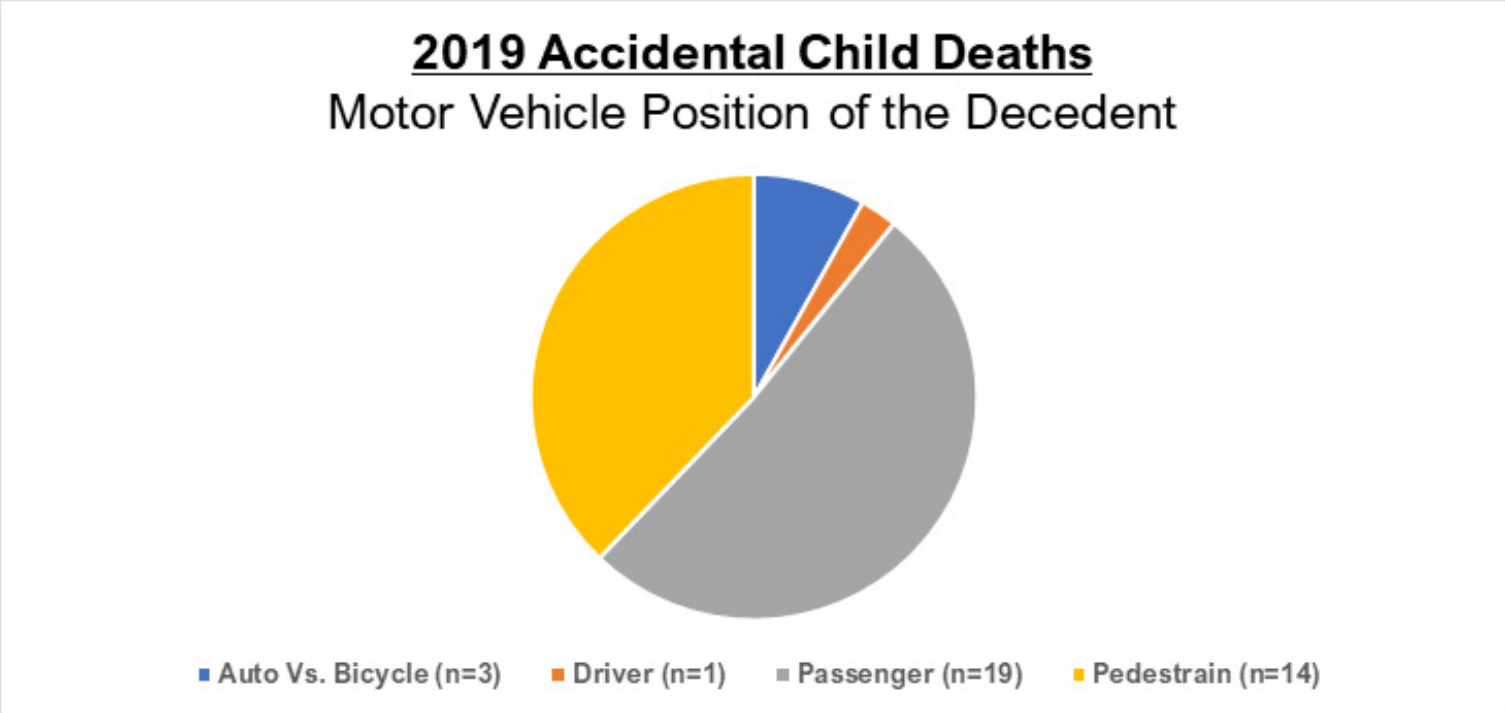

2019 Accidental Child Deaths
Race/Ethnicity of Decedent
AMERICAN INDIAN (n=1)
ASIAN (n=8)
BLACK (n=15)
CAUCASIAN (n=27)
HISPANIC/LATIN AMERICAN (n=56)
UNKNOWN (n=3)

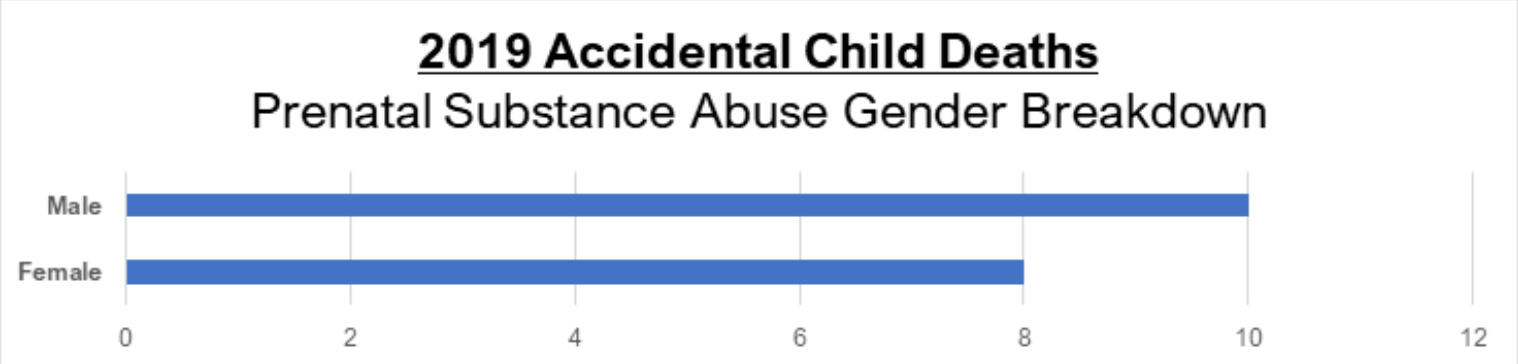

2019 Accidental Child Deaths
Motor Vehicle Deaths
Auto vs Pedestrain (n=13)
Auto Vs. Bicycle (n=3)
Multiple Auto (n=15)
Sole Automobile (n=5)

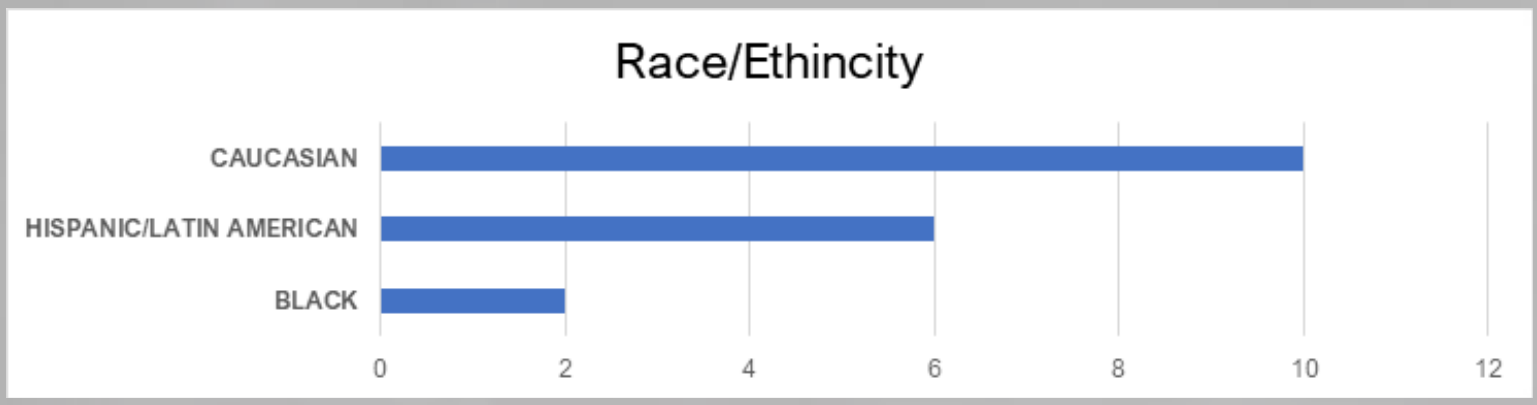

2019 Accidental Child Deaths
Motor Vehicle Gender Breakdown
Female
Male
0
2
4
6
8
10
12
14

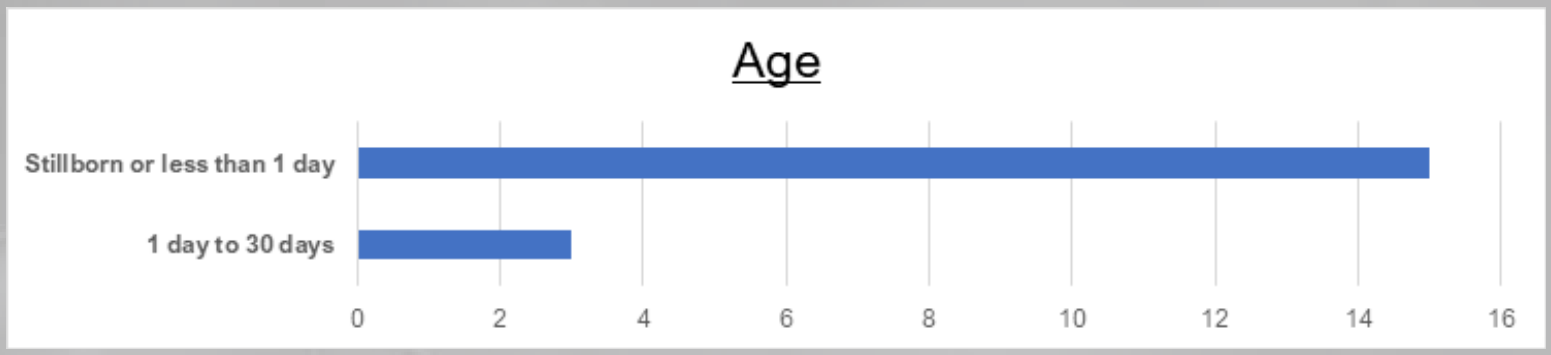

Race/Ethnicity
HISPANIC/LATIN AMERICAN
CAUCASIAN
BLACK
ASIAN
0
2
4
6
8
10
12
14

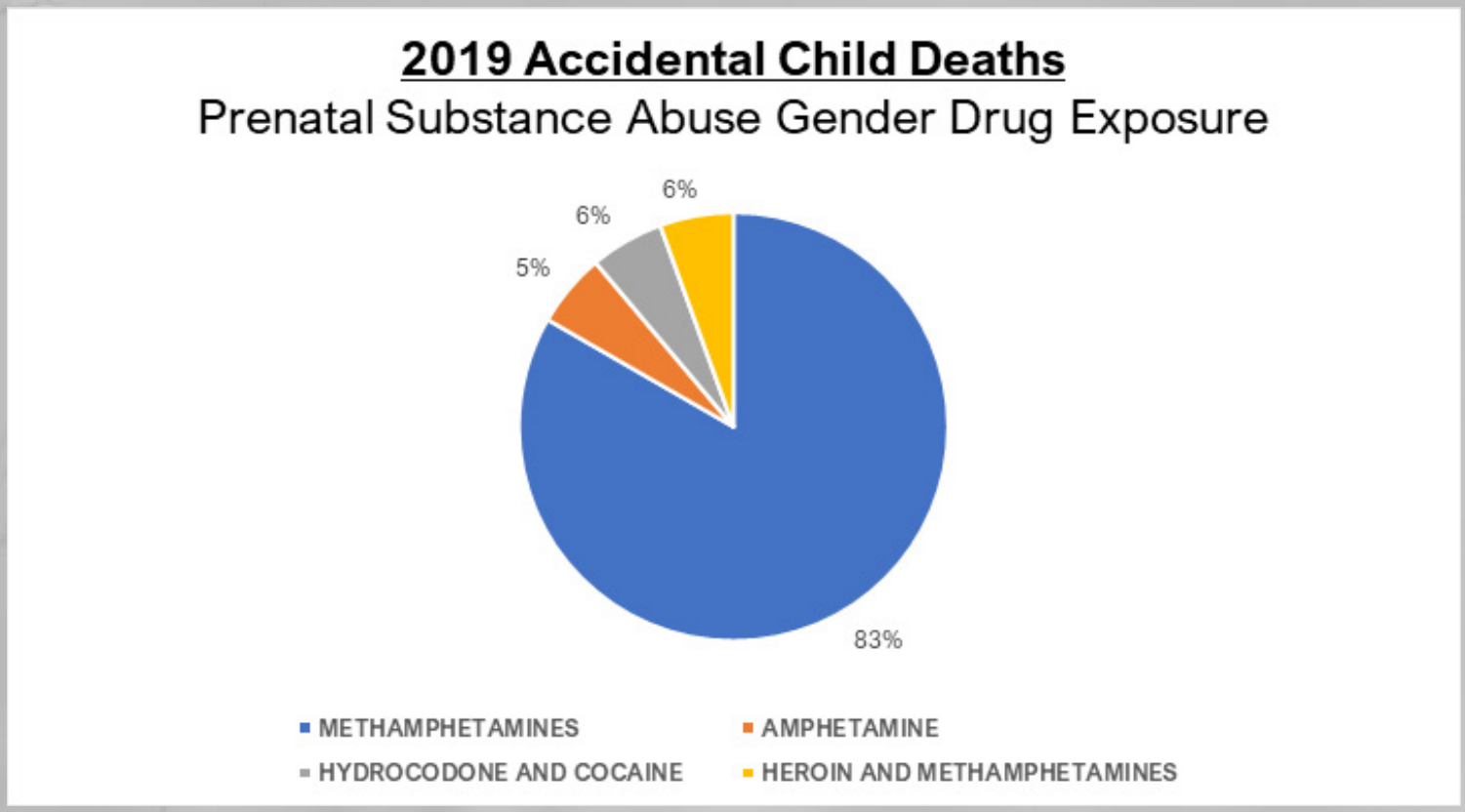

Age
4
3
2
1
0
1 Year Old
2 Years Old
4 Years Old
5 Years Old
6 Years Old
7 Years Old
10 Years Old
12 Years Old
13 Years Old
15 Years Old
16 Years Old
17 Years Old


2019 Accidental Child Deaths
Motor Vehicle Position of the Decedent
Auto Vs. Bicycle (n=3)
Driver (n=1)
Passenger (n=19)
Pedestrain (n=14)


2019 Accidental Child Deaths
Prenatal Substance Abuse Gender Breakdown
Male
Female
0
2
4
6
8
10
12

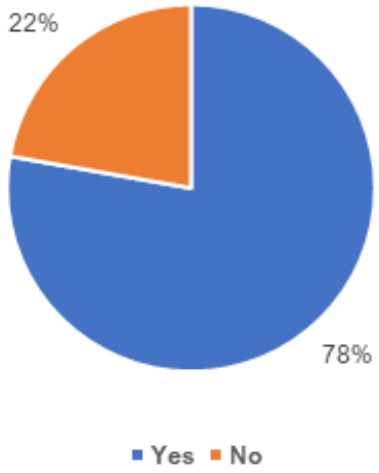

Race/Ethincity
CAUCASIAN
HISPANIC/LATIN AMERICAN
BLACK
0
2
4
6
8
10
12


Age
Stillborn or less than 1 day
1 day to 30 days
0
2
4
6
8
10
12
14
16


2019 Accidental Child Deaths
Prenatal Substance Abuse Gender Drug Exposure
6%
6%
5%
83%
METHAMPHETAMINES
AMPHETAMINE
HYDROCODONE AND COCAINE
HEROIN AND METHAMPHETAMINES

2019 Accidental Child Deaths

Prenatal Substance Abuse Child Welfare History



2019 Accidental Child Deaths

Prenatal Substance Abuse - Mother's with DCFS History as Minors

Sample Case Summaries

Steven

Seven-month-old, Steven had no known medical history. He was not taking any prescription medications and was not known to be sick. On the day of his death, he was placed prone in an adult bed for a nap. A few hours later, he was found by his mother supine with a blanket over his face and vomit on the bed and in his mouth. 911 was called and LAFD responded. Steven was transported to the Hospital where he was declared deceased.

Sheila

One month old Sheila was found unresponsive with sight of at nose by her parents in her car seat upon arriving at school to drop off their other school aged child. She was taken of the car seat and 911 was called. Paramedics transported Sheila to the hospital and was pronounced dead at arrival. Sheila had no past medical history, was a full-term baby and there were no signs of illness. A head scan was found to be normal and there were no signs of abuse.

Charlie

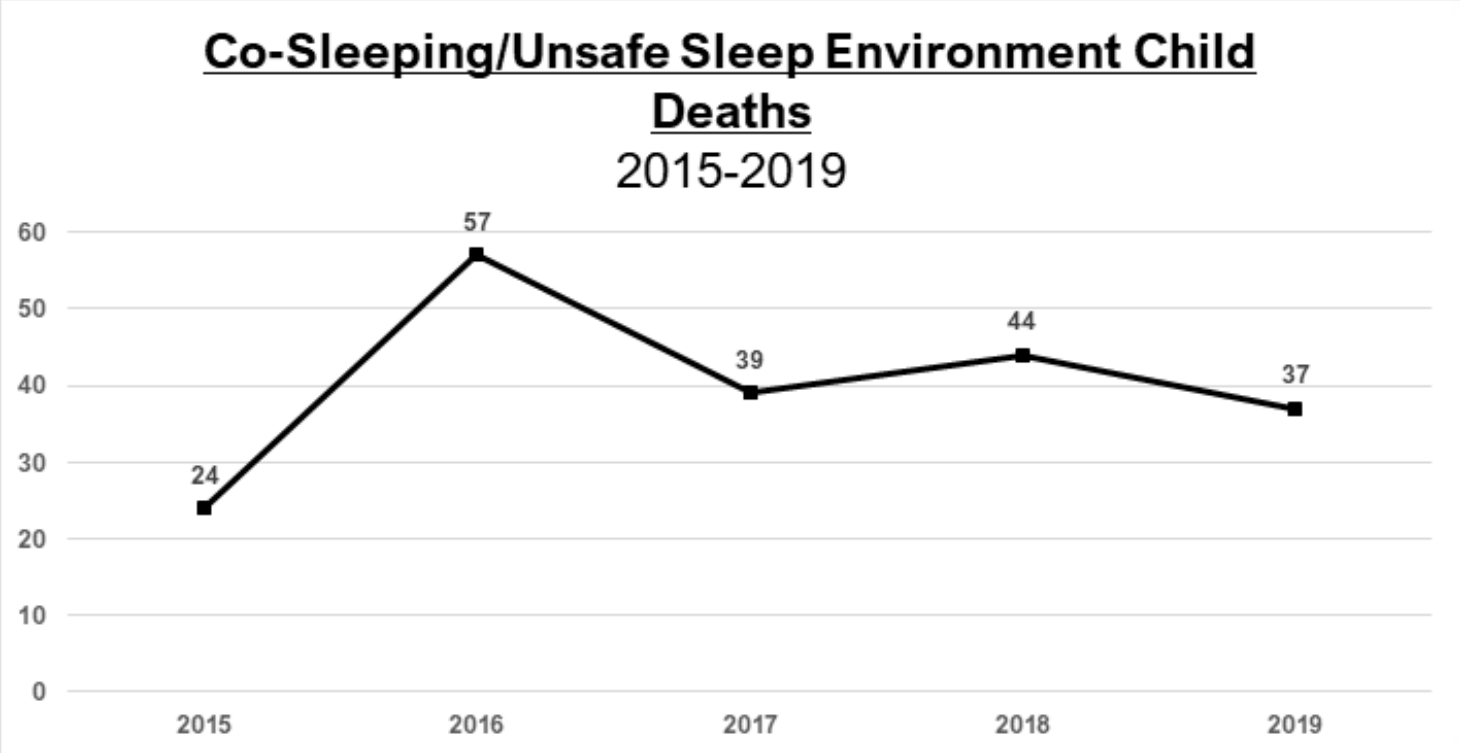
Nine day old Charlie was born full term and healthy. Mother was lying in bed with her shoulders propped by pillows while Charlie was resting on her chest breastfeeding. Mother and Charlie would typically both fall asleep after breastfeeding and Charlie mostly co-slept with mother. Charlie was positioned with his anterior side against mother's chest/abdominal area when he fell asleep. Mother subsequently would fall asleep too. Grandmother who lived in the home with mother entered mother's room to bring in some laundry when she noticed Charlie was face down and not moving when she went to go check on the baby and wake mother she noticed that Charlie was not breathing or moving. Baby was found to be healthy and there were no signs of abuse.

UNDETERMINED

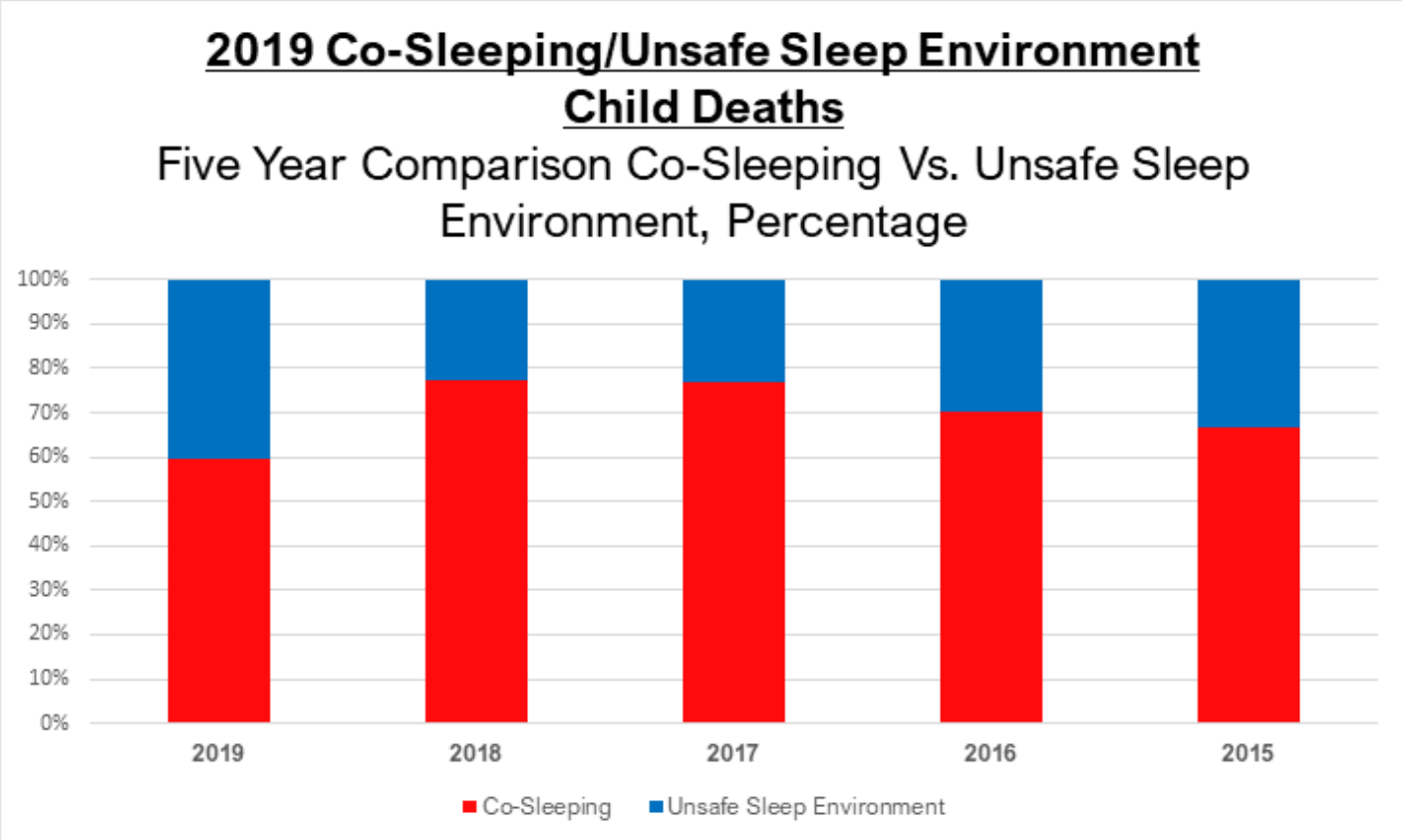
FINDING

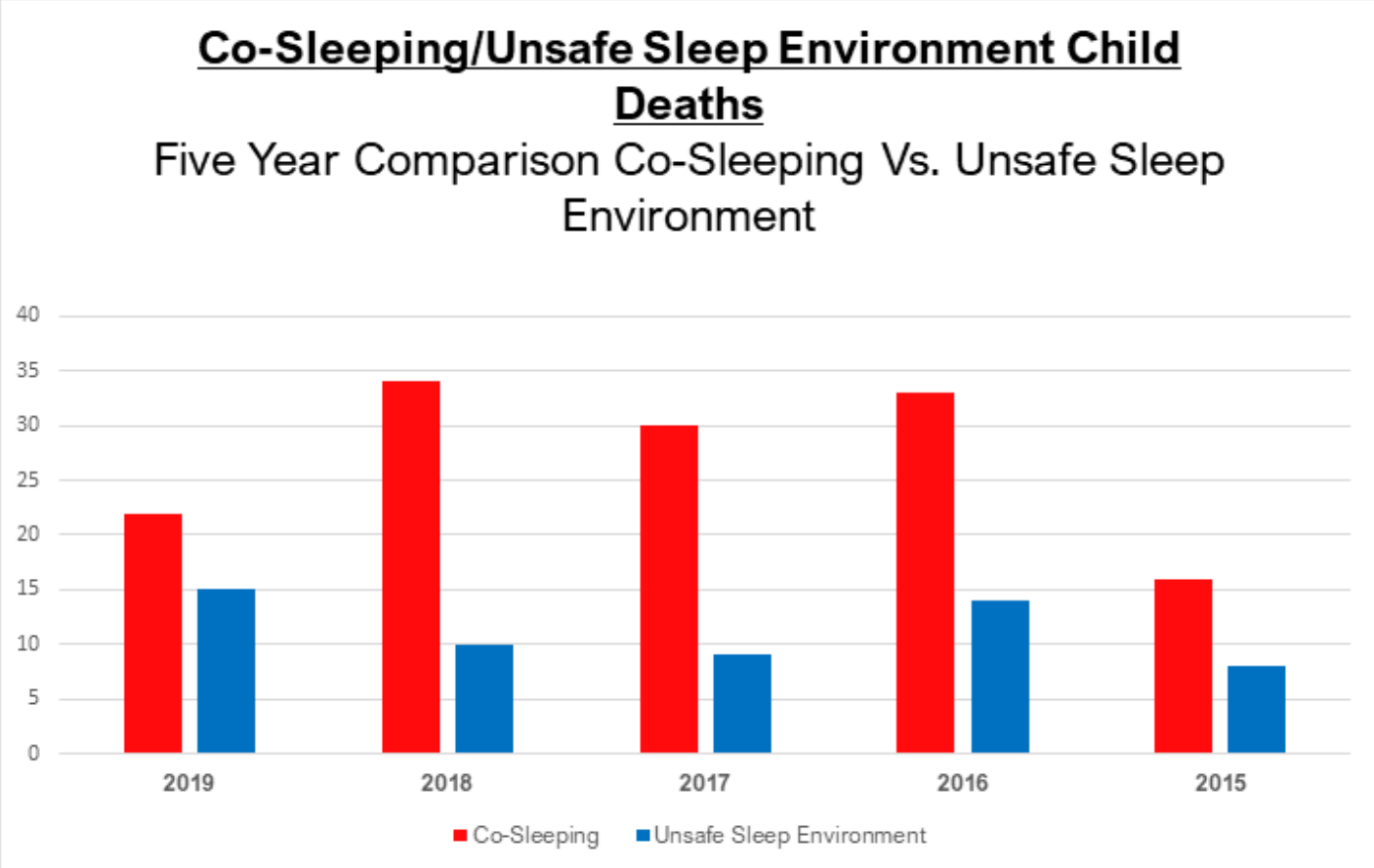
- Forty-three undetermined child deaths were reported to ICAN from the Coroner's Department in 2019. Twenty-six of the child victims were determined by ICAN to be the result of unsafe sleep practices, whether because of co-sleeping with an adult/child, an unsafe sleep environment, or a combination of both.
- To create a comprehensive dataset to analyze all unsafe sleep cases together, we have included eleven cases that were moded by the Coroner's Department as accidental deaths. ICAN determined that these eleven deaths were the result of unsafe sleep practices due to the explanation by the coroner that the infant was either bed sharing and was suffocated by a larger sibling or adult or the accidental death had an unsafe sleeping environment or circumstance that resulted in the infant's death.
- The data indicate that thirty-seven children (twenty-six undetermined cases and eleven accident cases) died in 2019 because of unsafe sleep practices.
- In 2018, there were forty-four unsafe sleep-related child deaths. The 2019 number is a sixteen percent decrease and slightly below the five-year average of approximately forty unsafe sleep-related deaths per year.
- Fifty-nine percent (n=22) of the unsafe sleep-related deaths involved the practice of co-sleeping; bed-sharing with an adult and/or children. The remaining forty-one percent (n=15) of the child deaths did not involve co-sleeping but were the result of the child being placed in an unsafe sleep environment. While this split is typical in the last few years, 2019 show a greater share of the deaths related to sleep environment.
- The majority (fifty-four percent) of unsafe sleep-related child deaths involved a single, although fatal, risk factor. In fifty-five percent of these cases, the single risk factor was co-sleeping. The remaining forty-five percent of single risk factor unsafe sleep-related child deaths were various factors such as: unsafe sleep position, unsafe sleep surface, or unsafe items in the sleep environment.
- Twenty-five percent of unsafe sleep-related child deaths involved two unsafe risk factors. Eleven percent involved three or more factors.
- Seventy-six percent (n=28) of unsafe sleep-related child death involved a situation where the child was placed on an unsafe sleep surface (adult bed, couch, etc.). Fifty-nine percent (n=22) of the unsafe sleep-related deaths also involved the practice of co-sleeping. Forty-nine percent (n=18) involved the child being placed in an unsafe sleeping position.
- Seventy-one percent of the unsafe sleep surfaces were adult beds. The remaining unsafe sleep surfaces involved couches, an infant being held in the arms of an adult, or a car seat. Forty-four of the unsafe sleep positions were children put to sleep on their sides and thirty-nine percent were placed in the prone position.
- Forty percent of the co-sleeping situations involved the child sleeping with one adult and twenty-three percent involved two adults. Twenty-seven percent of the child deaths resulted from situations where adults and sibling sleep with the child and nine percent where cases were the child sent with siblings and no adults.

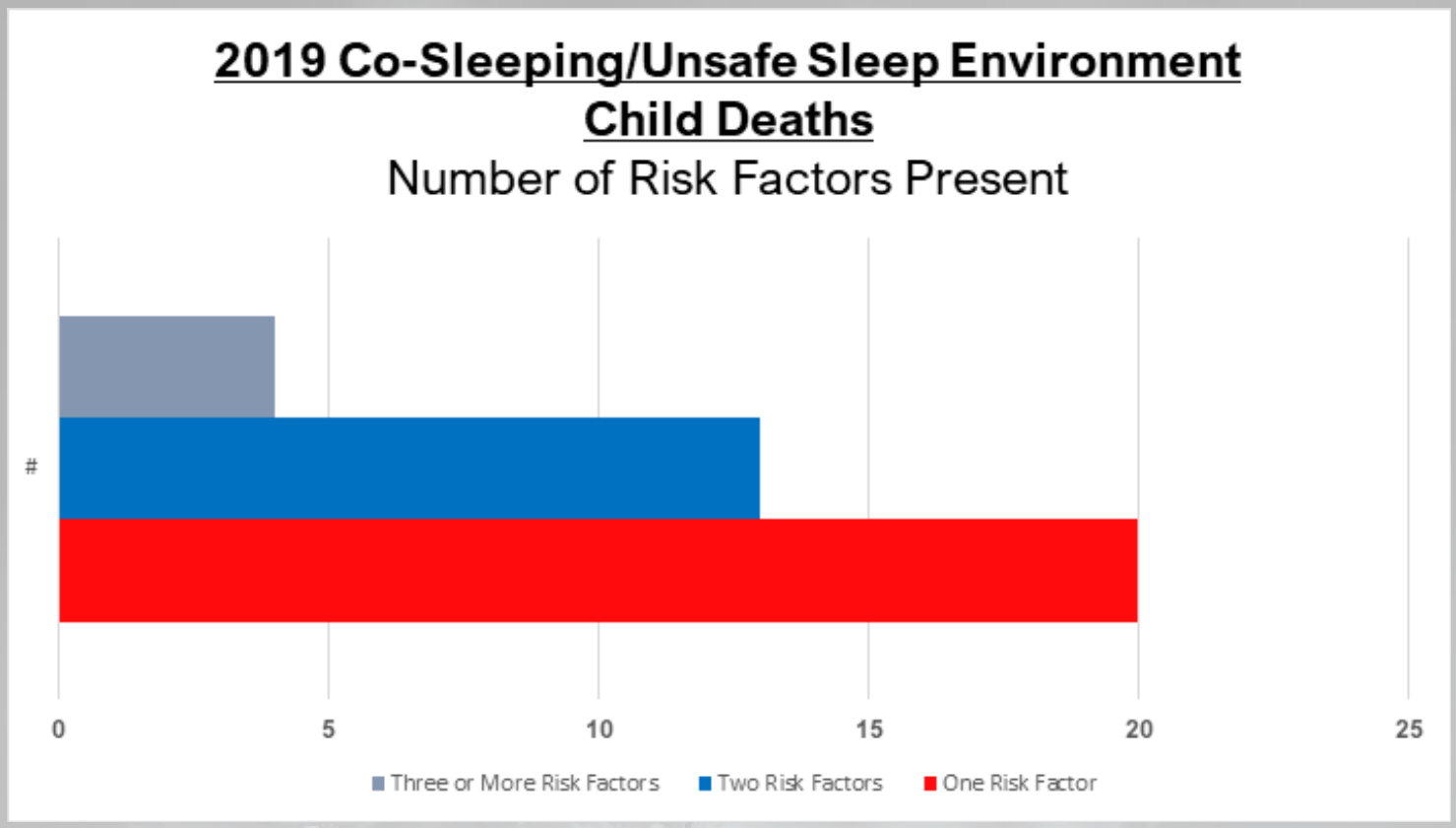
- Of the eighteen cases of children being placed in an unsafe sleep position, forty-four were placed on their sides and thirty-nine were placed on their stomach. Two children died while being held by their caregiver and one child died in a car seat.
- The children most vulnerable to unsafe sleep related deaths comprised of children zero to two months of age which made up 57% of the cases. In this age group, fifteen of the cases involved co-sleeping. The next group of children at risk of a co-sleeping death were 3 to 5 month old children comprising of 37% of co-sleeping deaths.
- The 2019 data further indicated that unsafe sleep deaths of children between the ages of six months and ten months were not due to co-sleeping and instead died of unsafe sleep environment such as blankets and pillows or an unsafe sleeping position.
- In 2019, Hispanic (forty-seven percent) and African American (thirty-nine percent) children were the. most common victim of unsafe sleep related death. Caucasians made up eleven percent and Asians made up three percent.
- Fifty-nine percent of the unsafe sleep related deaths were male and forty-one percent were female. Of the twenty-two co-sleeping cases, half were male and half were female.
- Fifty-nine percent of the victims of unsafe sleep related deaths came from families with child welfare history. Only eleven percent of the children had an open case at the time of death. Seventy percent of the children had a least one parent with child welfare history as a minor.
- Seventeen of the undetermined deaths for 2019 were not a result of unsafe sleep practices. Among these deaths, fifty-nine (n=10) percent were identified by the Coroner as the result of “Sudden Unexpected Infant/Child Death”.
- The other causes of death for undetermined were asphyxia, blunt force head trauma, heat stroke, hyperthymia, and undetermined.
- Of the non-unsafe sleep related deaths: sixty-five percent were below the age of one year. Hispanic child made up fifty-nine percent, African American children twenty-four percent, and Caucasian children eighteen percent. The gender split was fifty-three percent male, forty-seven percent female.

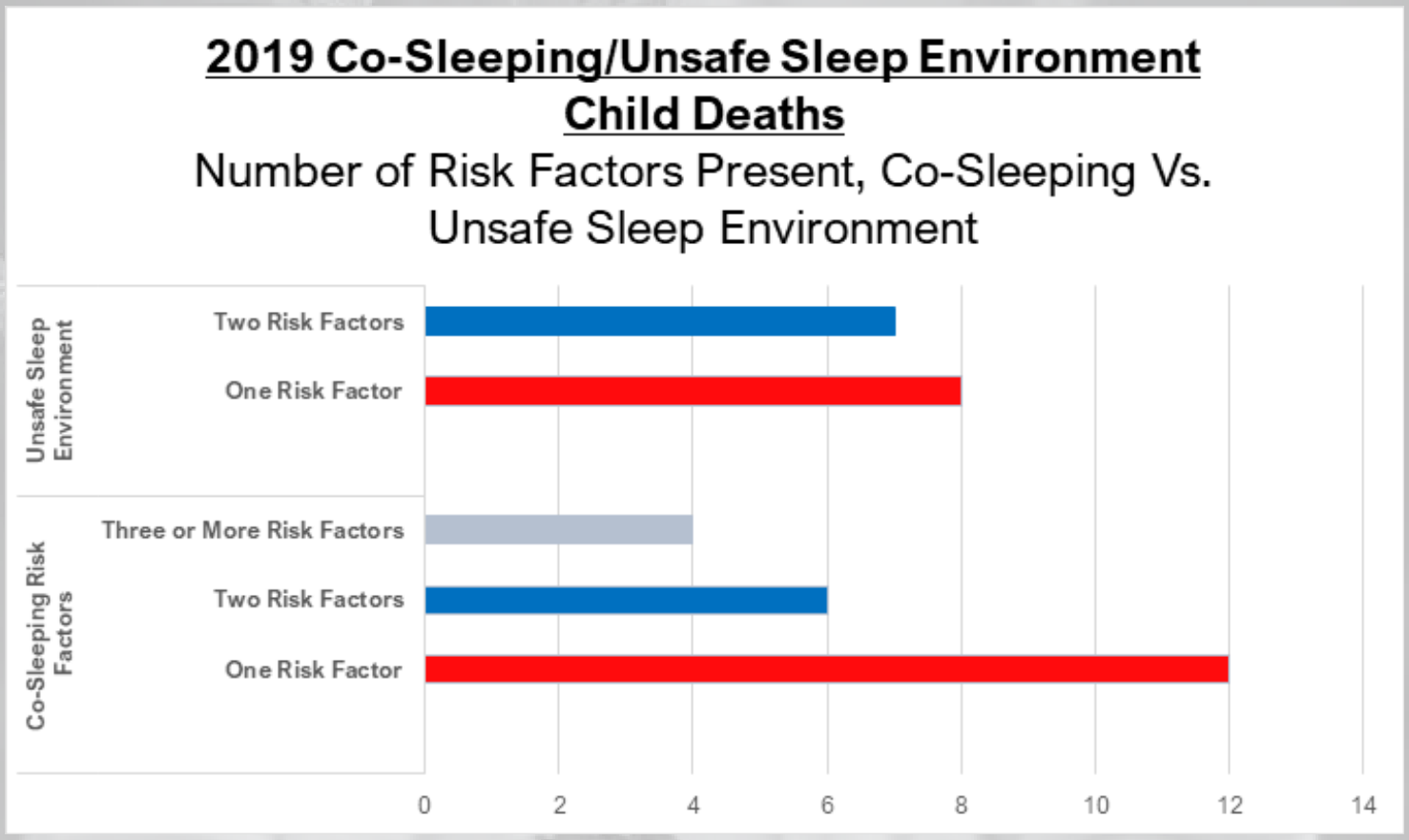

Co-Sleeping/Unsafe Sleep Environment Child Deaths
2015-2019
60
50
40
30
20
10
0
24
57
39
44
37
2015
2016
2017
2018
2019

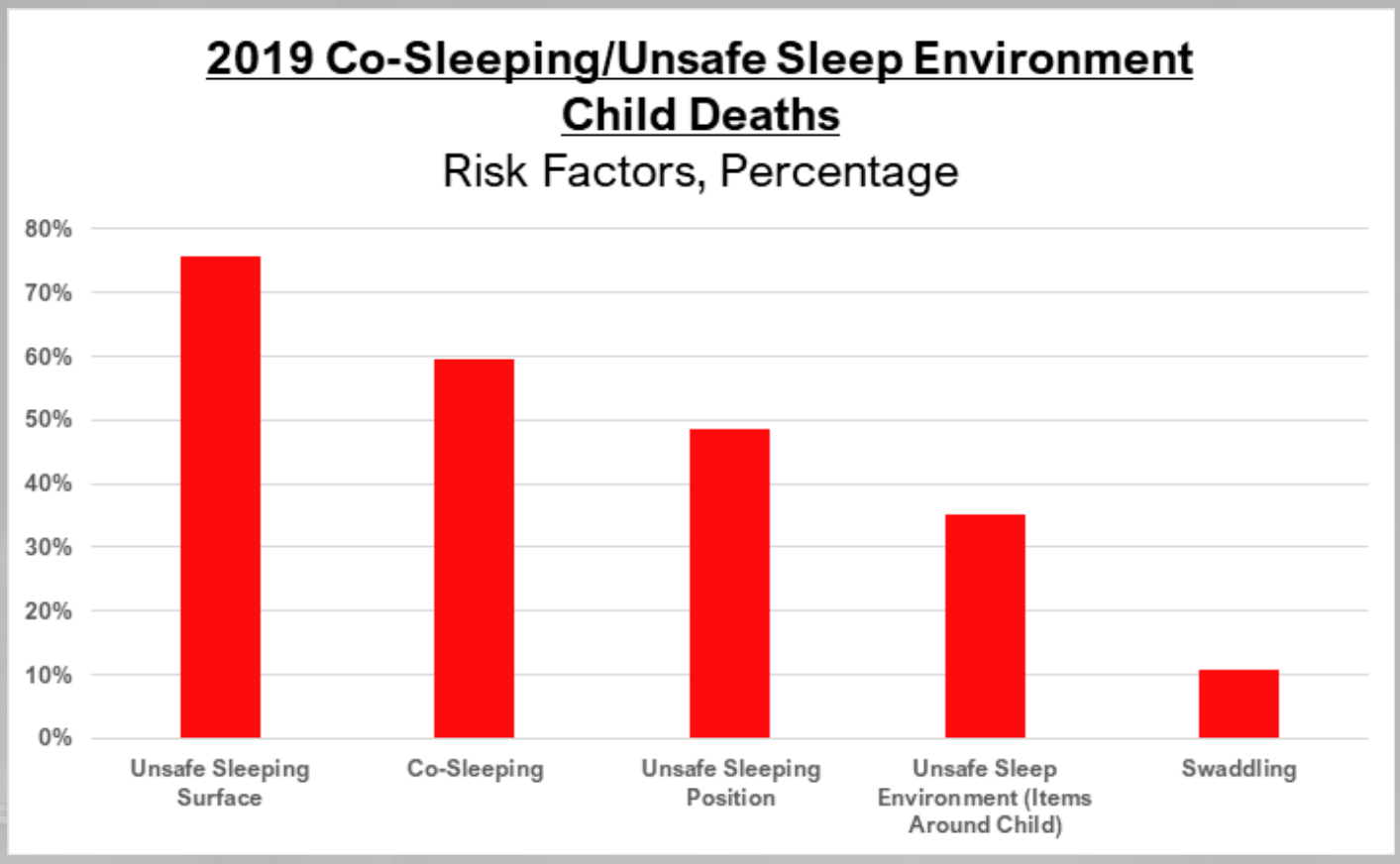

2019 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Co-Sleeping Vs. Unsafe Sleep Environment
Co-Sleeping
Unsafe Sleep Environment

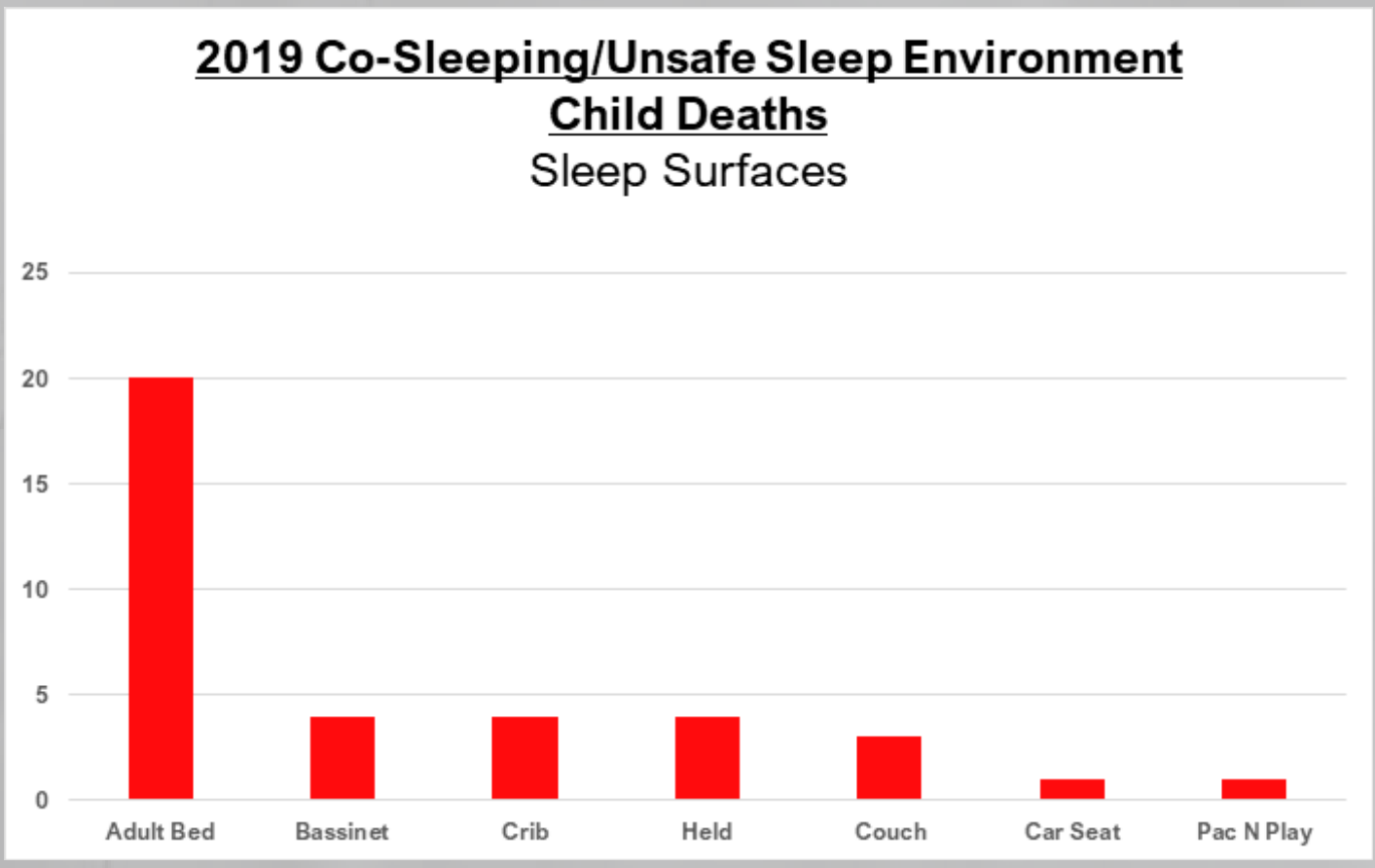

2019 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Five Year Comparison Co-Sleeping Vs. Unsafe Sleep Environment, Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2019
2018
2017
2016
2015
Co-Sleeping
Unsafe Sleep Environment

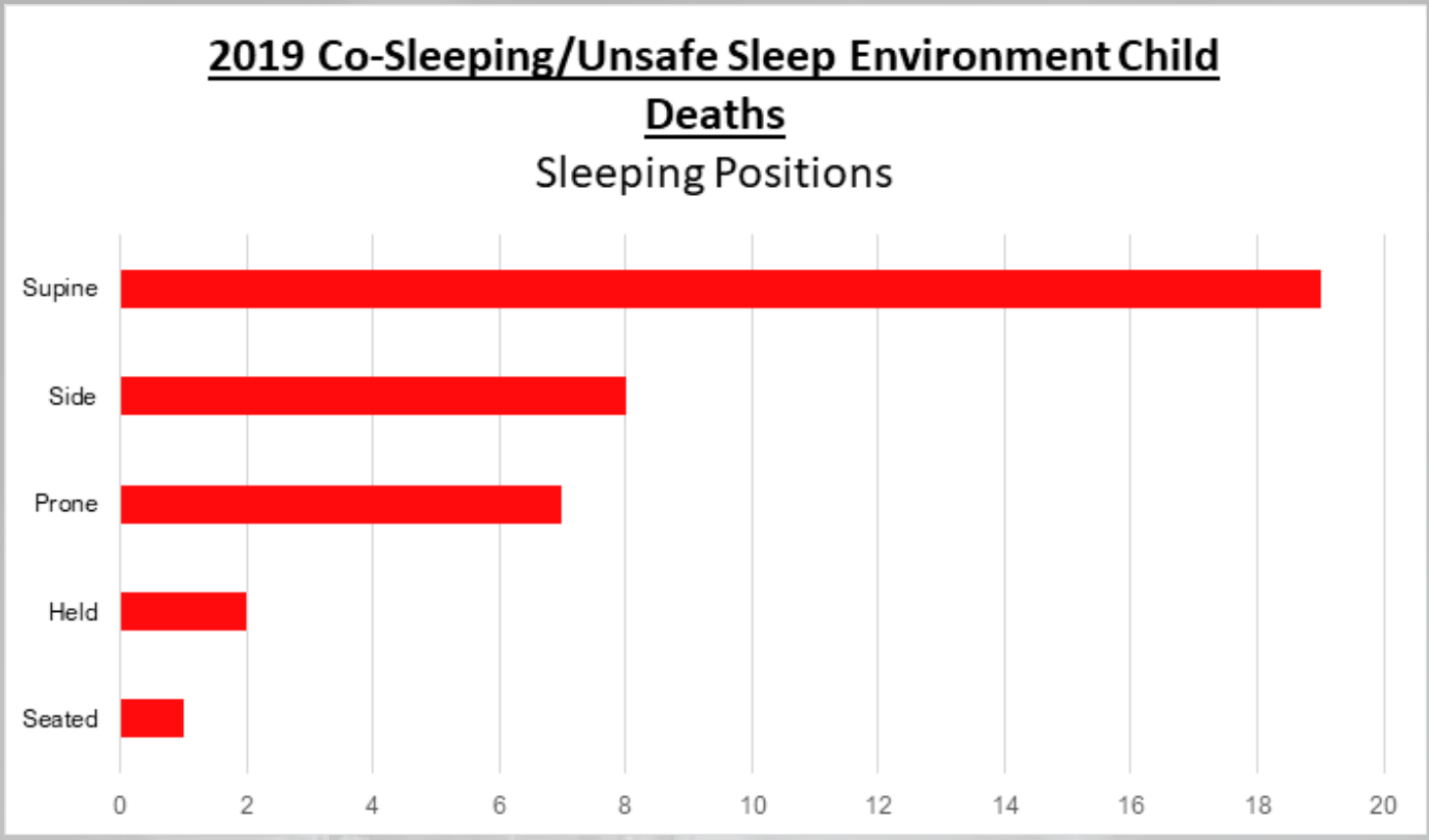

Co-Sleeping/Unsafe Sleep Environment Child Deaths
Five Year Comparison Co-Sleeping Vs. Unsafe Sleep Environment
40
35
30
25
20
15
10
5
0
2019
2018
2017
2016
2015
Co-Sleeping
Unsafe Sleep Environment

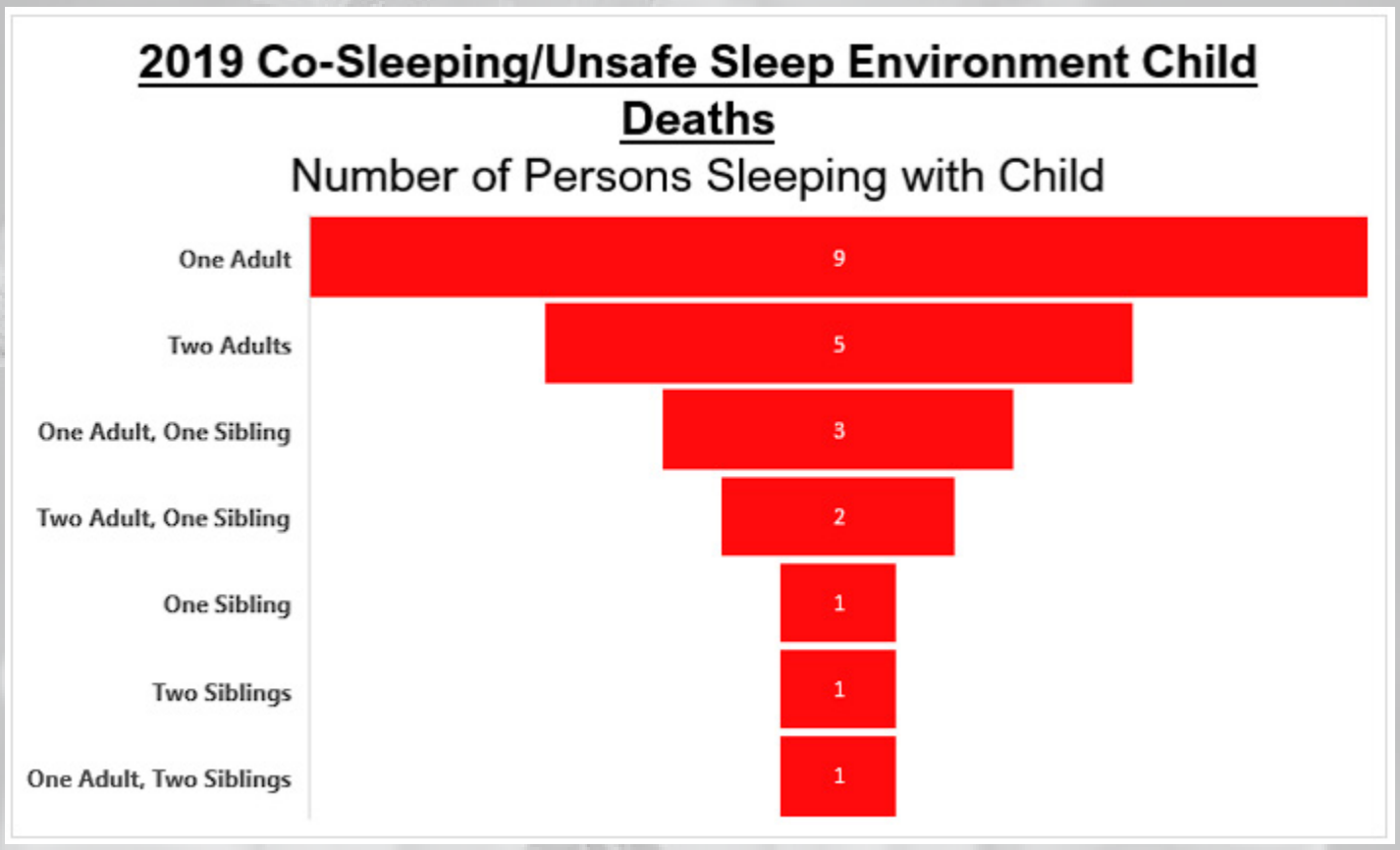

2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Number of Risk Factors Present
#
0
5
10
15
20
25
Three or More Risk Factors
Two Risk Factors
One Risk Factor

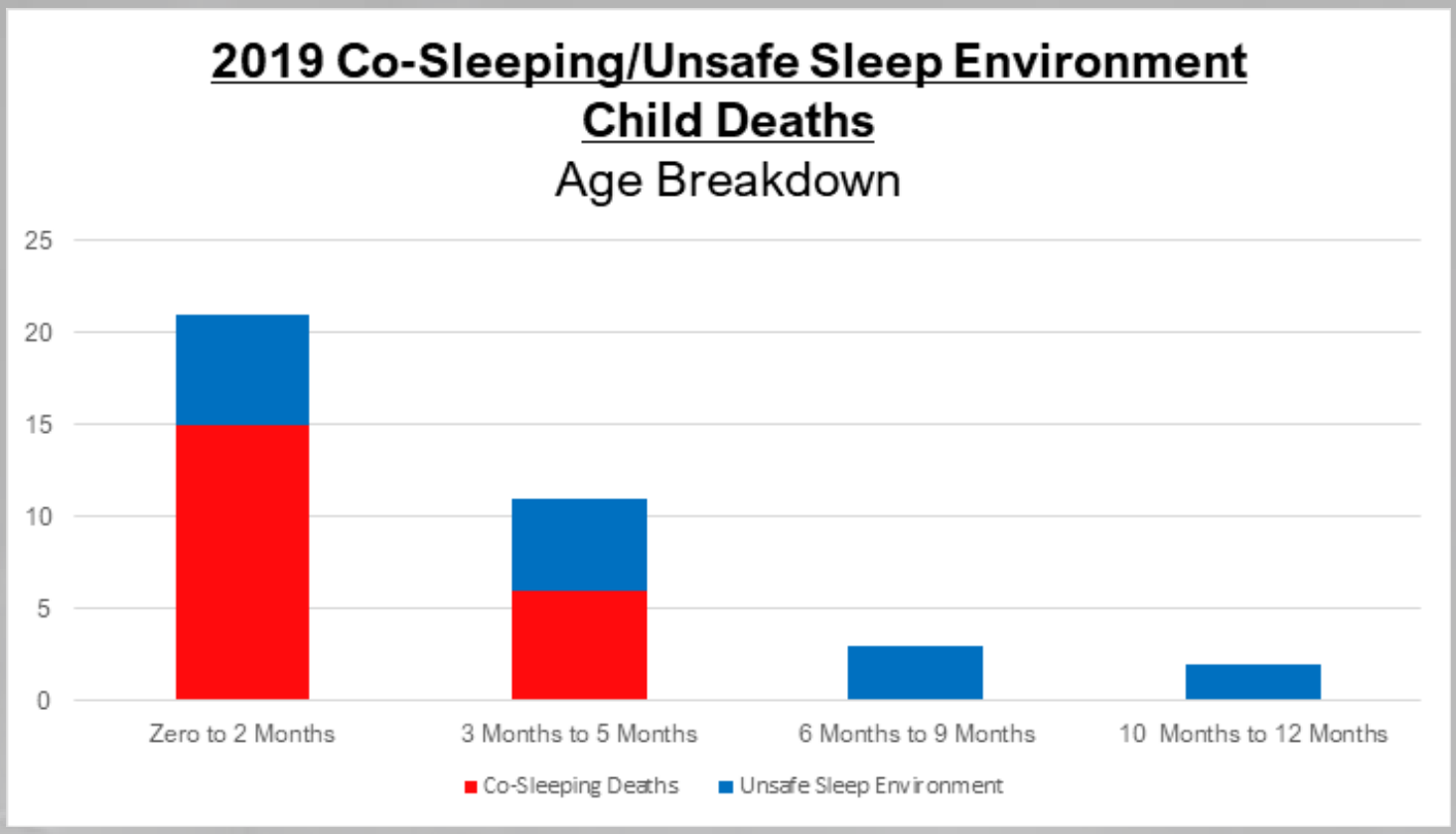

2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Number of Risk Factors Present, Co-Sleeping Vs.
Unsafe Sleep Environment
Unsafe Sleep Environment
Two Risk Factors
One Risk Factor
Co-Sleeping Risk Factors
Three or More Risk Factors
Two Risk Factors
One Risk Factor
0
2
4
6
8
10
12
14

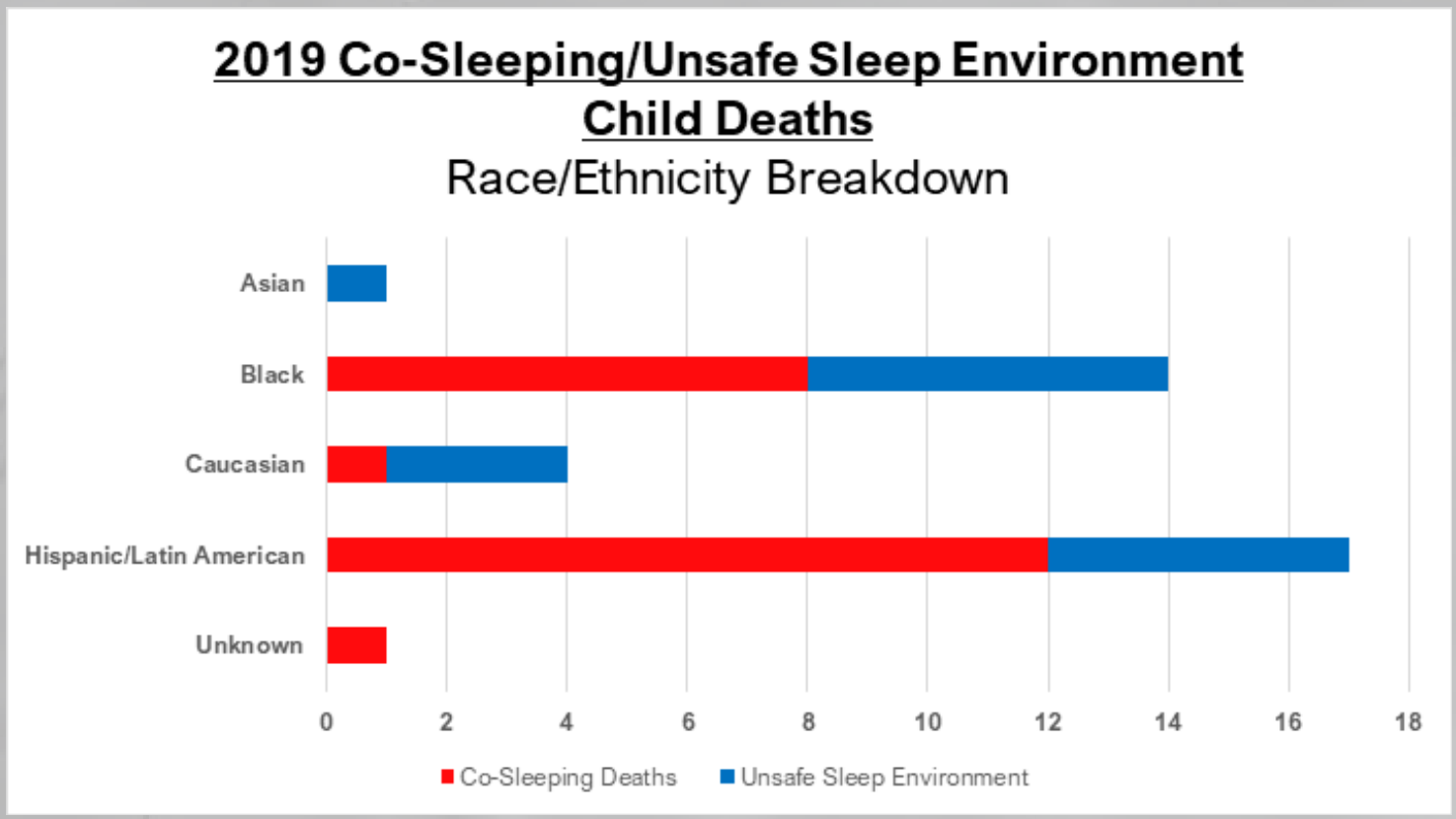

2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Risk Factors, Percentage
80%
70%
60%
50%
40%
30%
20%
10%
0%
Unsafe Sleeping Surface
Co-Sleeping
Unsafe Sleeping Position
Unsafe Sleep Environment (Items Around Child)
Swaddling

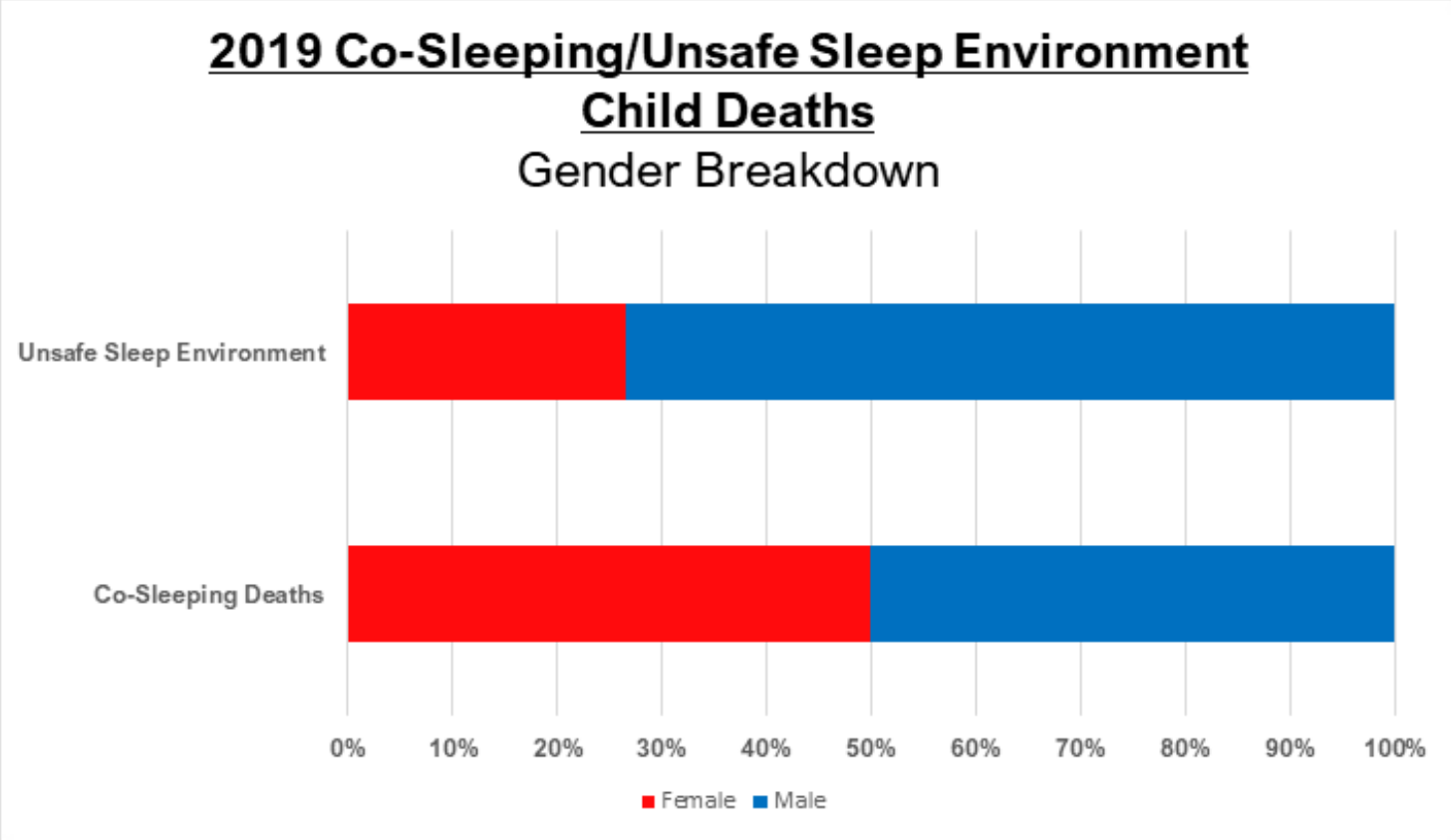

2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Sleep Surfaces
25
20
15
10
5
0
Adult Bed
Bassinet
Crib
Held
Couch
Car Seat
Pac N Play

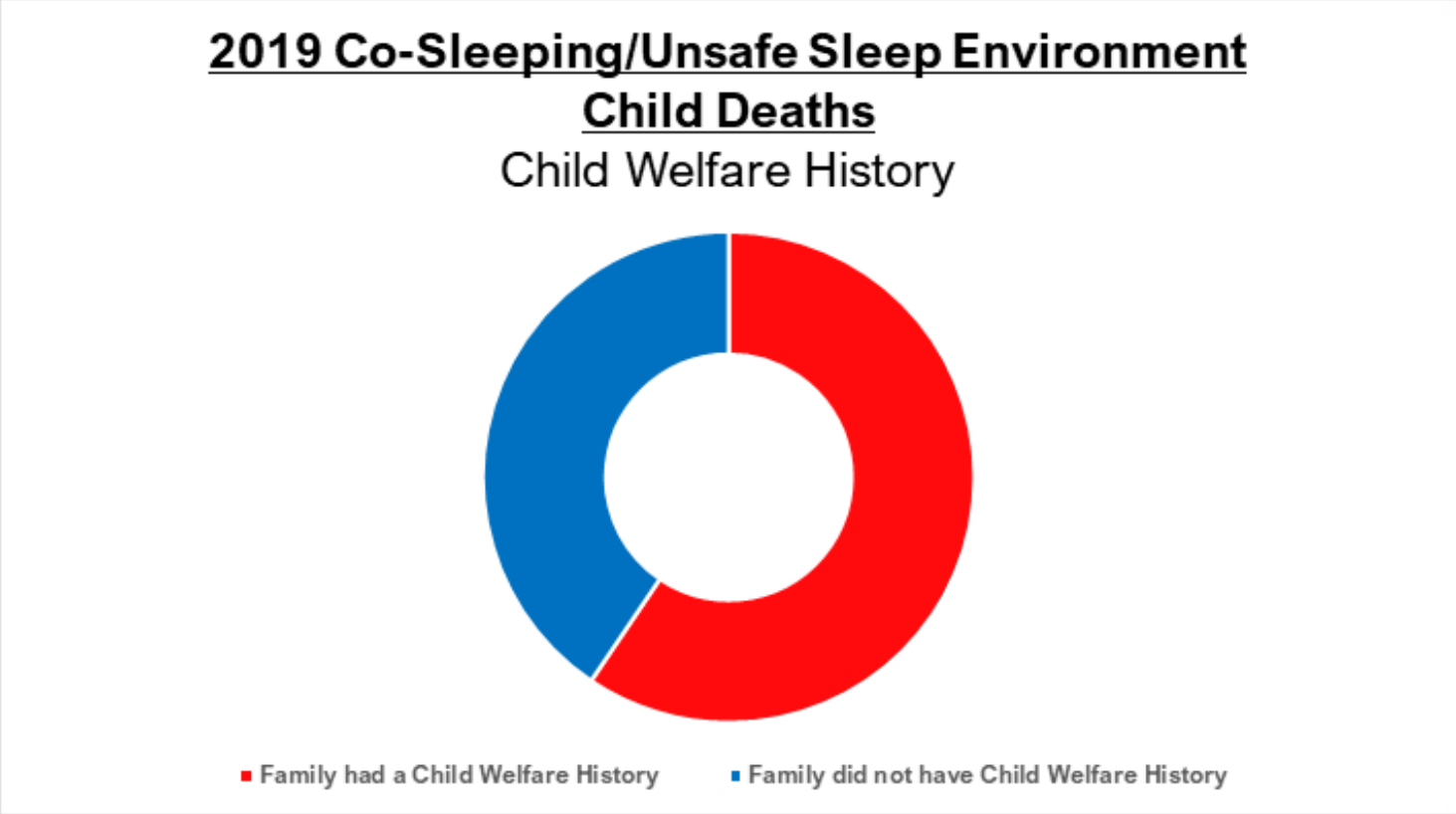

2019 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Sleeping Positions
Supine
Side
Prone
Held
Seated
0
2
4
6
8
10
12
14
16
18
20

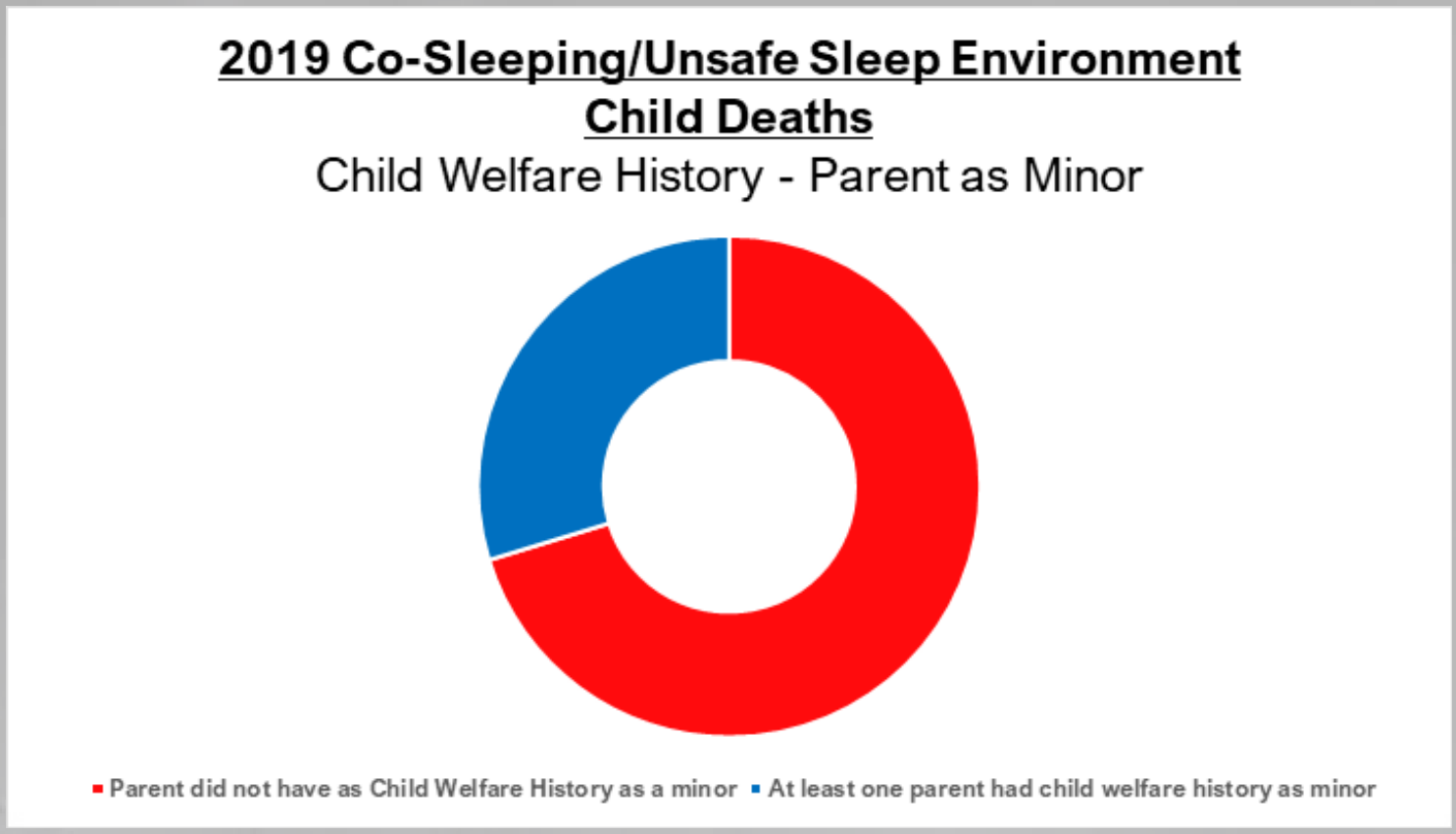

2019 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Number of Persons Sleeping with Child
One Adult
9
Two Adults
5
One Adult, One Sibling
3
Two Adult, One Sibling
2
One Sibling
1
Two Siblings
1
One Adult, Two Siblings
1

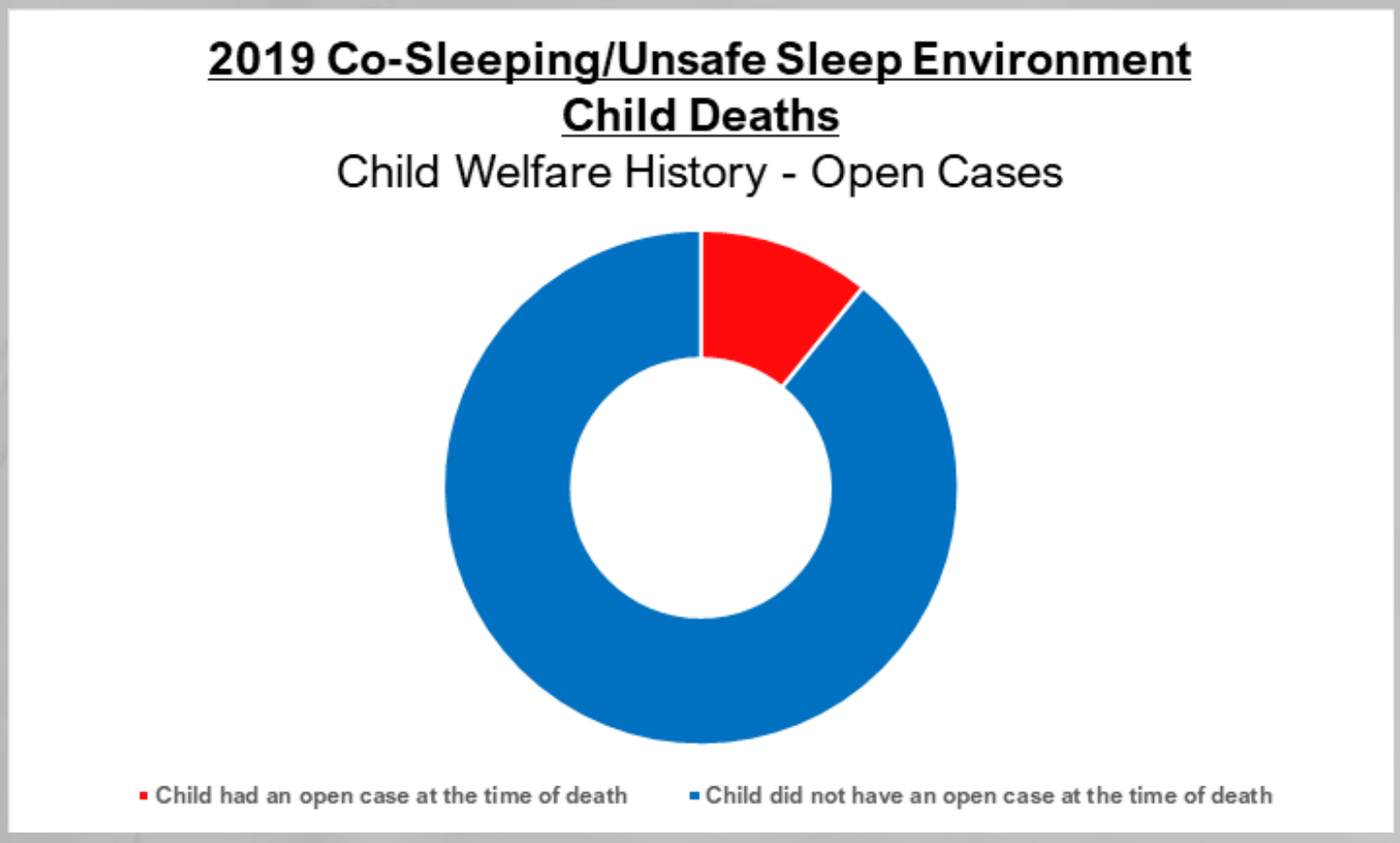

2019 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Age Breakdown
25
20
15
10
5
0
Zero to 2 Months
3 Months to 5 Months
6 Months to 9 Months
10 Months to 12 Months
Co-Sleeping Deaths
Unsafe Sleep Environment


2019 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Race/Ethnicity Breakdown
Asian
Black
Caucasian
Hispanic/Latin American
Unknown
0
2
4
6
8
10
12
14
16
18
Co-Sleeping Deaths
Unsafe Sleep Environment


2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Gender Breakdown
Unsafe Sleep Environment
Co-Sleeping Deaths
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Female
Male

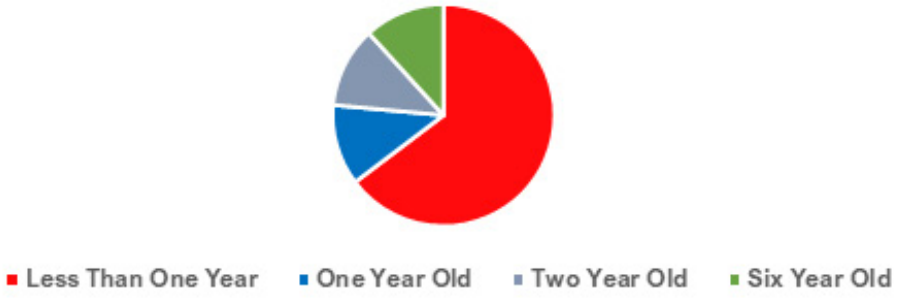

2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Child Welfare History
Family had a Child Welfare History
Family did not have Child Welfare History


2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Child Welfare History - Parent as Minor
Parent did not have as Child Welfare History as a minor
At least one parent had child welfare history as minor


2019 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Child Welfare History - Open Cases
Child had an open case at the time of death
Child did not have an open case at the time of death

2019 Non-Unsafe Sleep Related Undetermined Deaths

Age Breakdown



2019 Non-Unsafe Sleep Related Undetermined Deaths

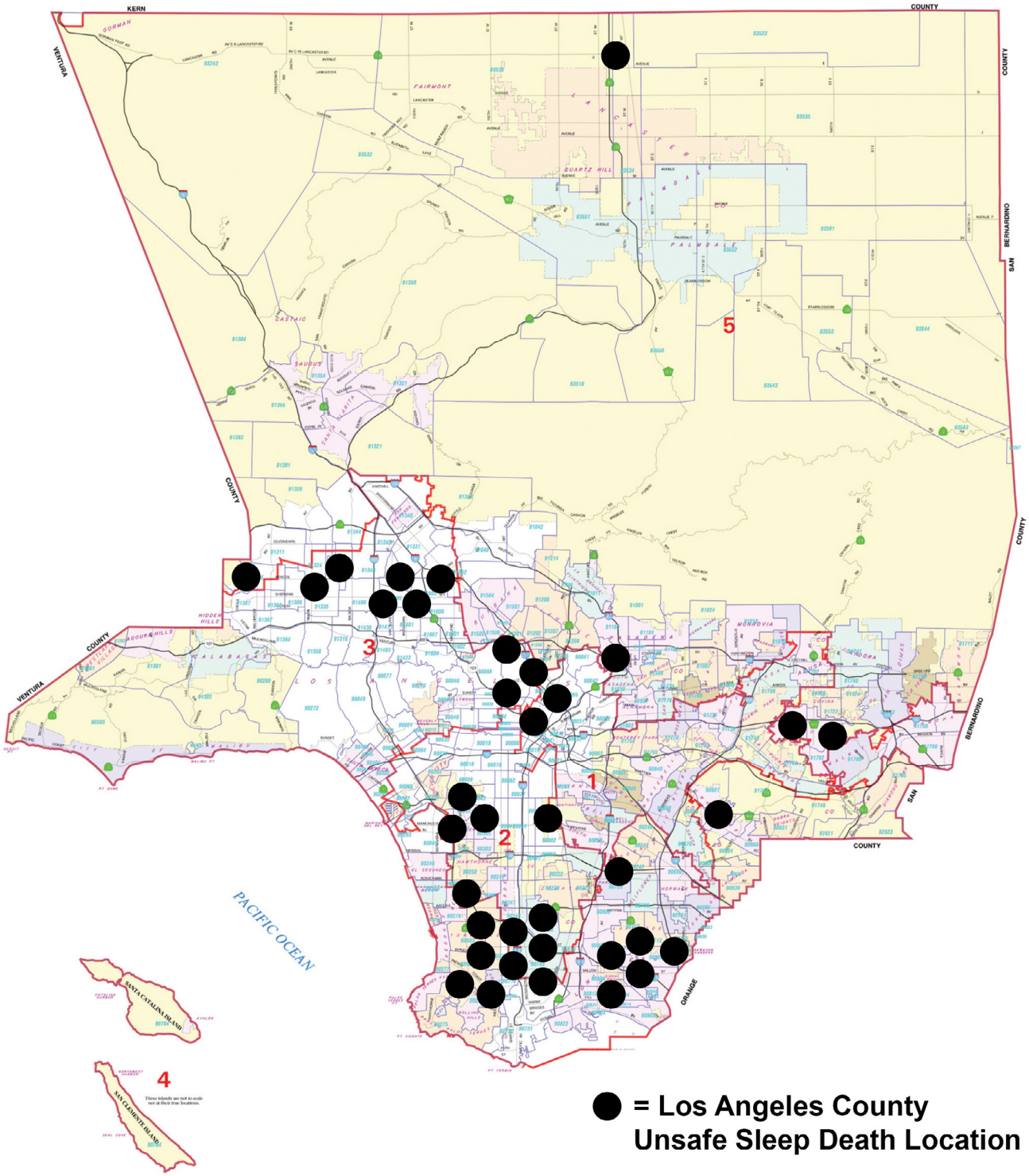
Gender Breakdown

2019 Non-Unsafe Sleep Related Undetermined Deaths

Race/Ethnicity Breakdown

2019 Unsafe Sleep Death - Locations
n = 37*

***City where the unsafe sleep death occurred**



Sample Case Summaries

Samuel

17-year-old, Samuel was at a party and was seen by witnesses getting into a physical altercation with another male. Samuel stabbed the male he was fighting with and the male took out a gun and shot Samuel in the head. The male who shot Samuel ran from the party and there were no arrests made.

Sara

Fifteen-year-old Sara was at school when another student shot Sara. The suspect was another student at Sara's high school and was arrested. The adolescent suspect was prosecuted for the shooting and death of Sara.

Patrick

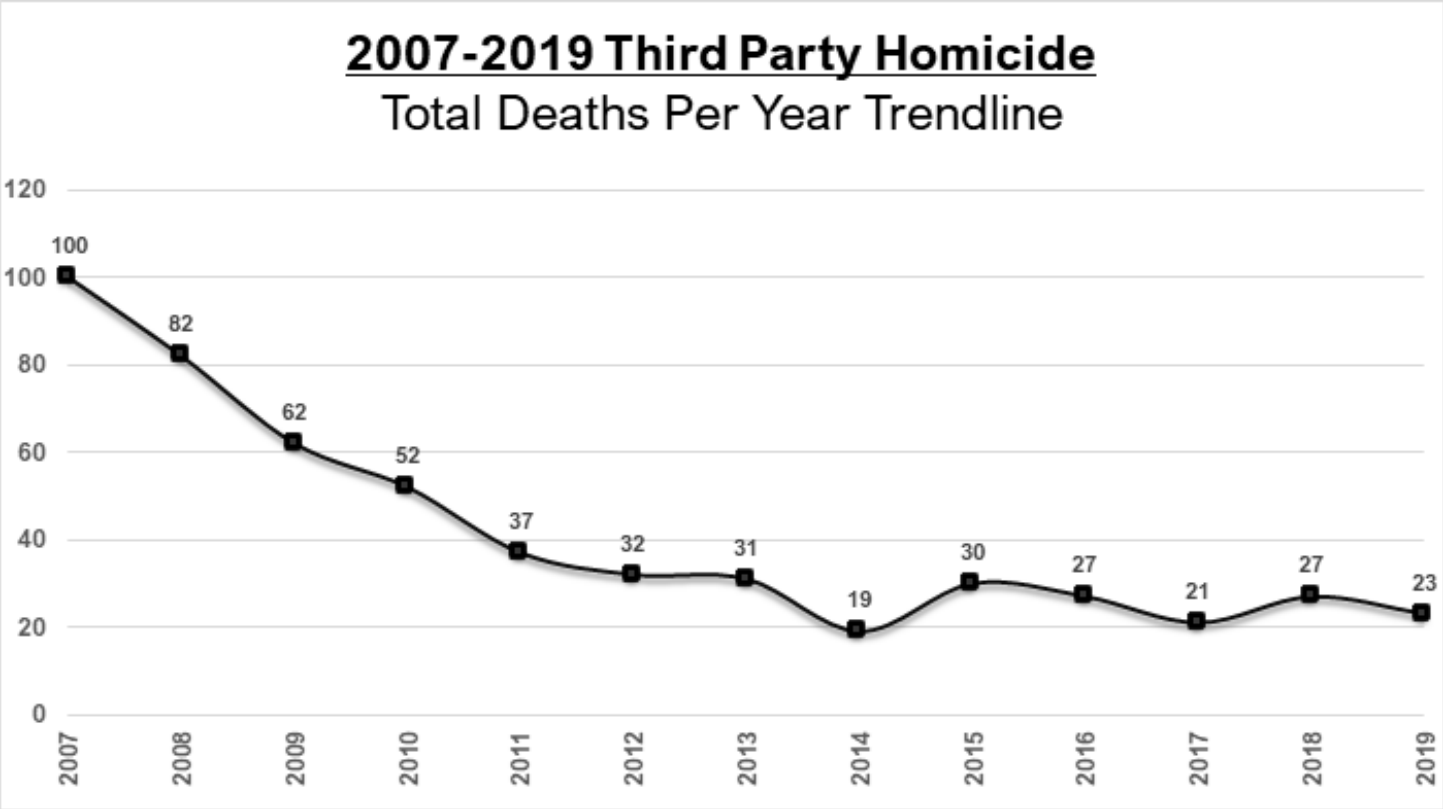
Sixteen-year-old Patrick was outside a friend's residence when witnesses heard two shots and ran up to him to find him unresponsive. Patrick's friend called 911 and fire and paramedics responded. He was taken to the ER. The suspect and weapon were never identified.

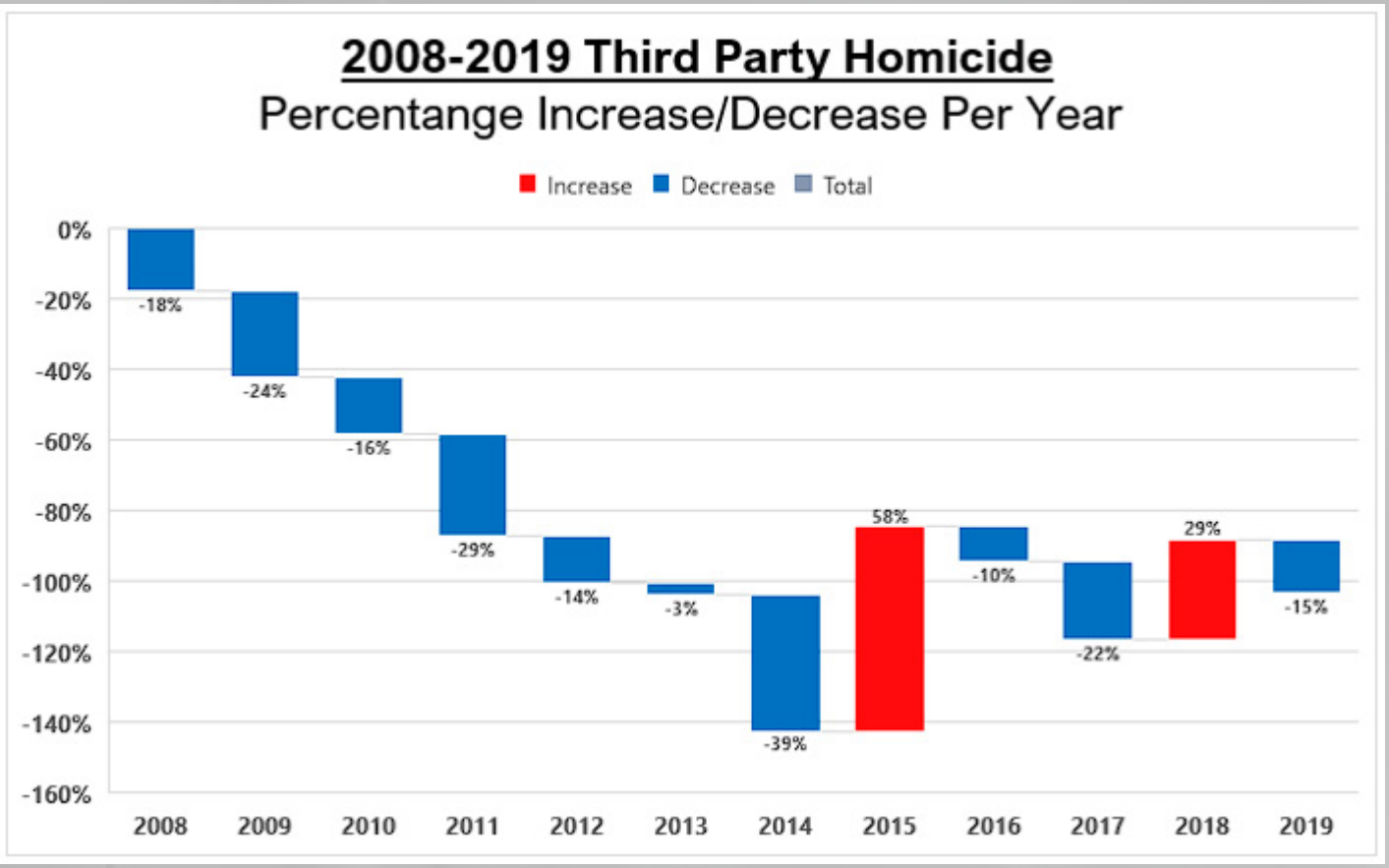
THIRD PARTY HOMICIDES

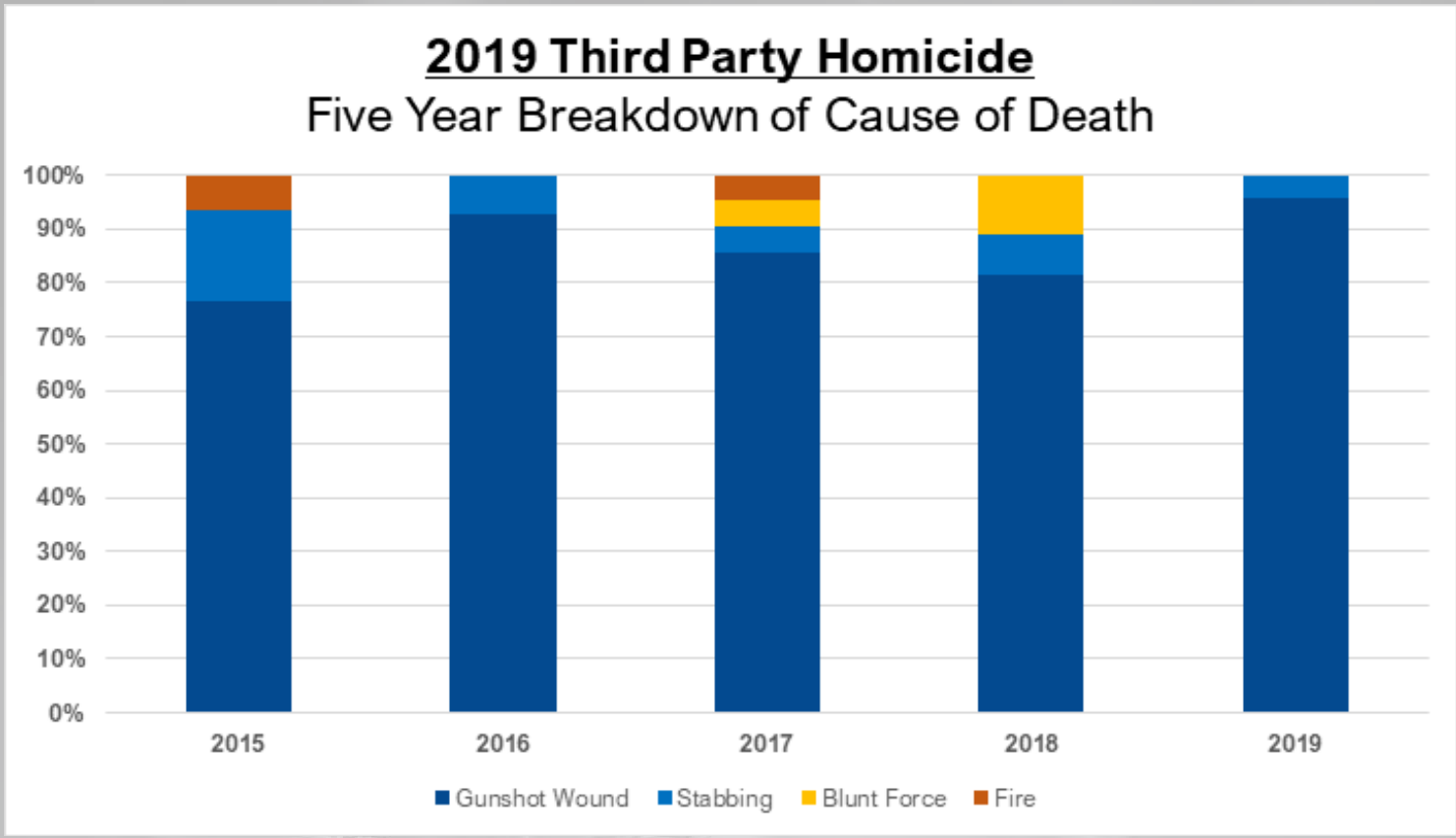
FINDINGS

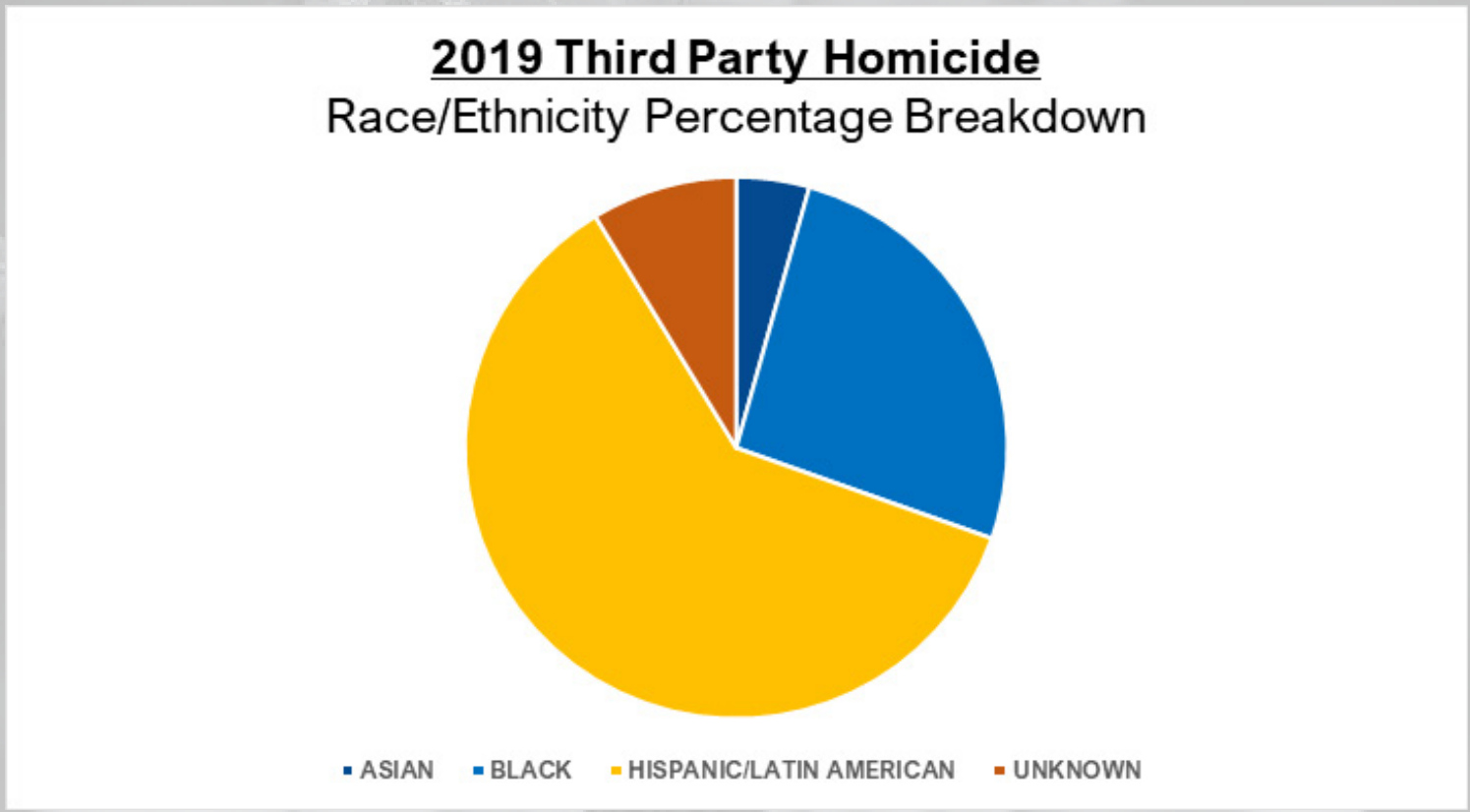
- Twenty-three third party homicides were reported to ICAN by the Coroner for 2019. This is a 17% decrease from the 2018 number of 27 and slightly below the five-year average of 24.8 per year.
- Additionally, this is the lowest number of third-party homicides in the last five years and the second lowest number of deaths since ICAN began including third party homicides in the CDRT Report in 2007.
- Ninety-six percent of third-party homicide victims were killed by gunshot wounds – an increase in this cause of death from last year's percent of 81% and a higher percent than the five-year average of 84% for victims of gun violence. The remaining four percent of third-party homicide in 2019 were the result of a single case of stabbing where the victim suffered a fatal stab wound to the chest.
- Consistent with this type of death, most of the victims were male. Of the twenty-three third party homicide victims, eighteen were male and five were female in 2019. This year's percent (78%) is a large increase for males compared to 2018 where males made up 63% percent of the victims, but this year is closer to the five-year average for males which is 80% of all death by third party homicide.
- In 2019, all victims of third-party homicides were between the ages of fourteen and seventeen. Nine percent were fourteen years old (n=2), 26% were fifteen years old (n=6), 26% were sixteen years old (n=6), and 39% were seventeen years old (n=9).
- Sixty percent (n=14) of the victims of third-party homicide were of Hispanic/Latin American descent and 26% (n=6) were African American. These percentages are consistent with the average for the past five years which shows that Hispanics and African Americans are reported as 70% of the total third-party homicides (fifty-seven percent for Hispanics and thirty-three percent of African Americans). Given the overall percentage of the population for each race/ethnicity, these numbers show an over-representation. The remaining victims were one victim of Asian descent and two of unknown race/ethnicity
- In 2019, there were five third-party homicides that occurred in the month of February. There were three deaths each in March, June, November, and December. There were two deaths each in September and May and one death each in January and October. There were no deaths in April, July, or August.
- While third party homicides occurred throughout Los Angeles County, in 2019 the First and Second Supervisorial District accounted for 60% (n=8) and (n=8) of these deaths. This was followed by the Fourth District with 19% (n=5). District Five 15% (n=4) and the Third District had two, 3% of the deaths.
- The Los Angeles Police Department (LAPD) had investigative authority for 78% of the third-party homicide cases and 9% by the Los Angeles Sheriff's Department. The remaining deaths were investigated by local police departments (Gardena P.D, Long Beach P.D., Pomona P.D., and Ontario P.D.)
- Sixty-seven percent of the victims had a history with DCFS, another county child welfare

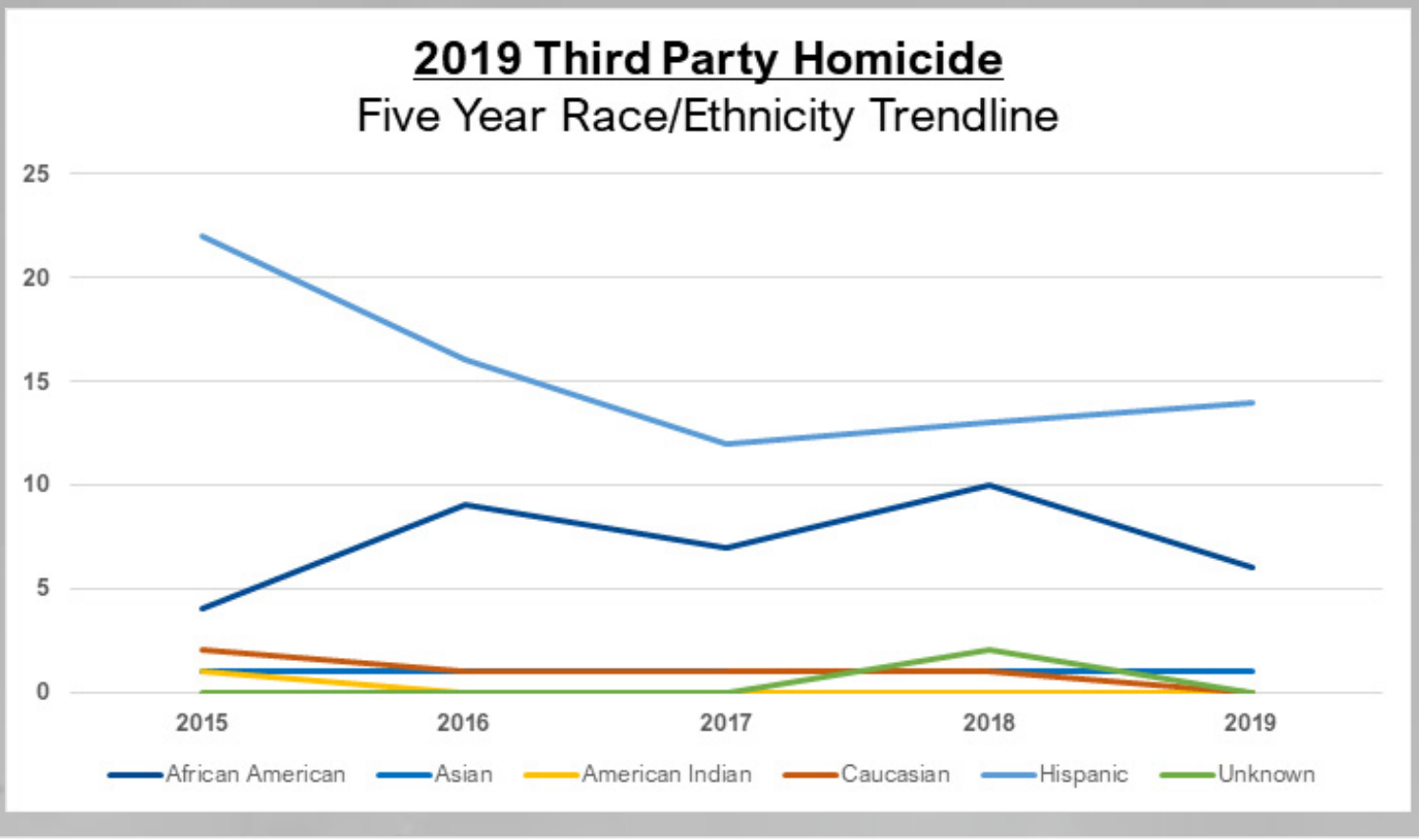
agency or Probation. Seventeen of the victims had a history with DCFS or another child welfare agency and four of the victims had a history with the Probation Department. Two victims had an open case with DCFS and four had an open case with the Probation Department. In four out of the twenty-three cases, at least one parent had a history of child welfare or Probation as a minor.

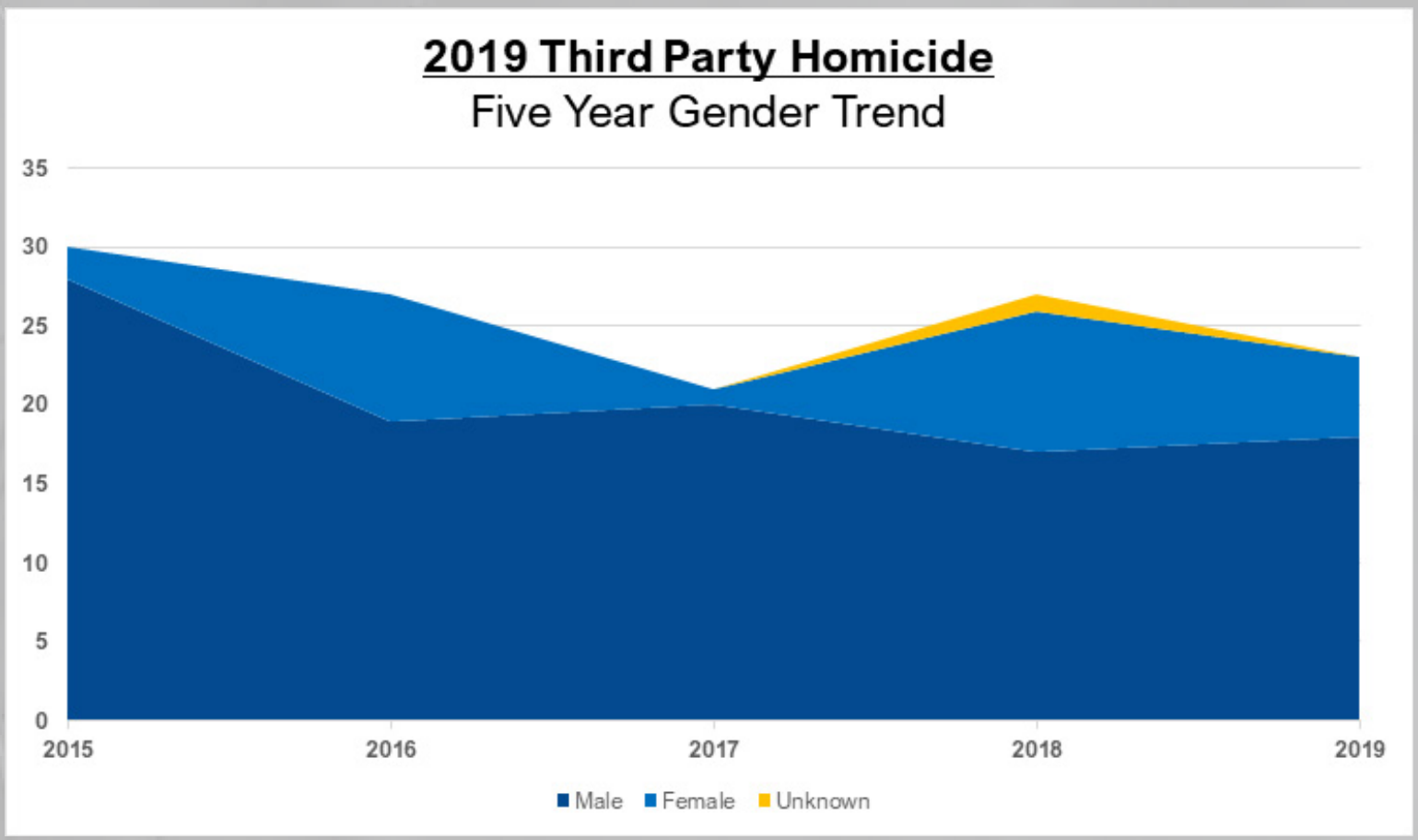

2007-2019 Third Party Homicide
Total Deaths Per Year Trendline
120
100
80
60
40
20
0
100
82
62
52
37
32
31
19
30
27
21
27
23
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019

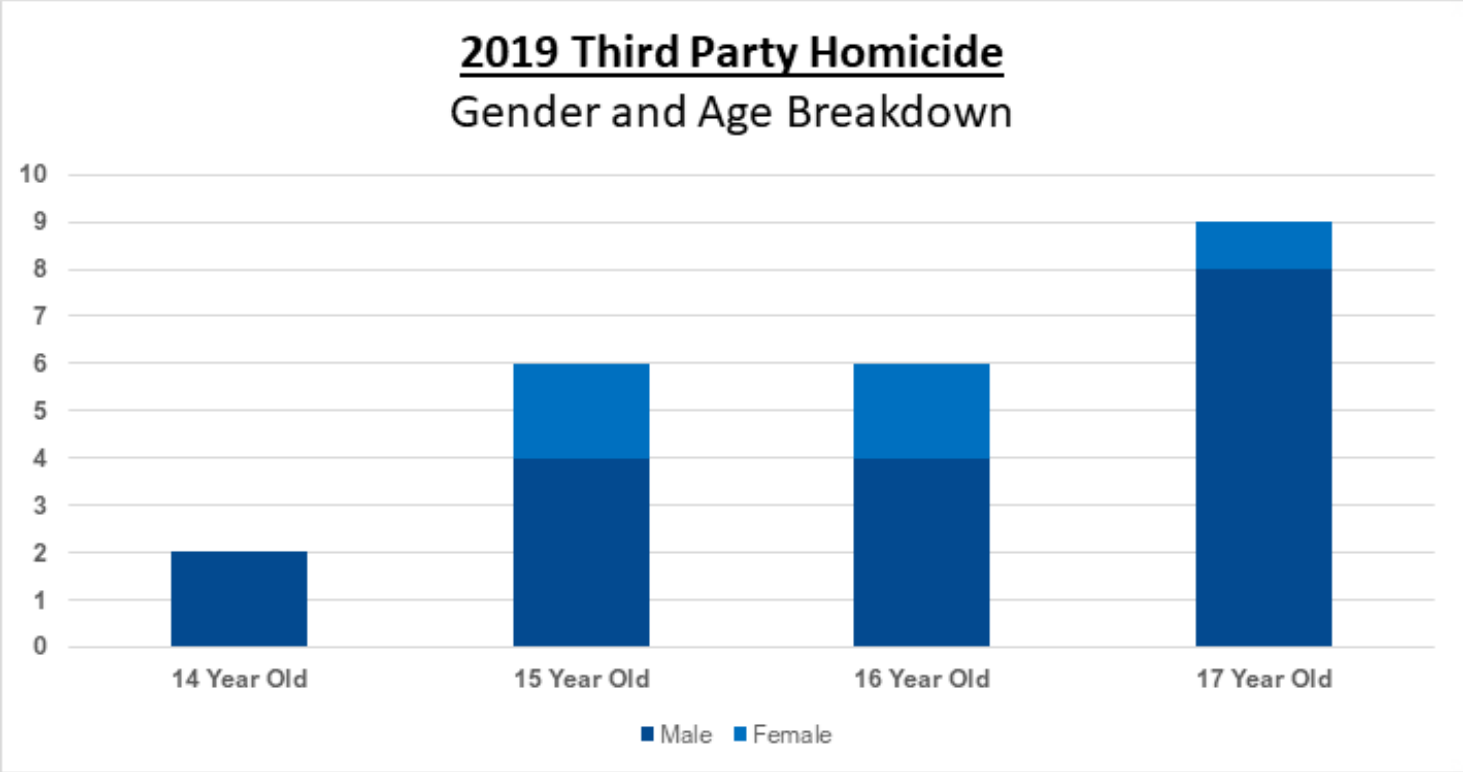

2008-2019 Third Party Homicide
Percentange Increase/Decrease Per Year
Increase
Decrease
Total
0%
-20%
-40%
-60%
-80%
-100%
-120%
-140%
-160%
-18%
-24%
-16%
-29%
-14%
-3%
-39%
58%
-10%
-22%
29%
-15%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019

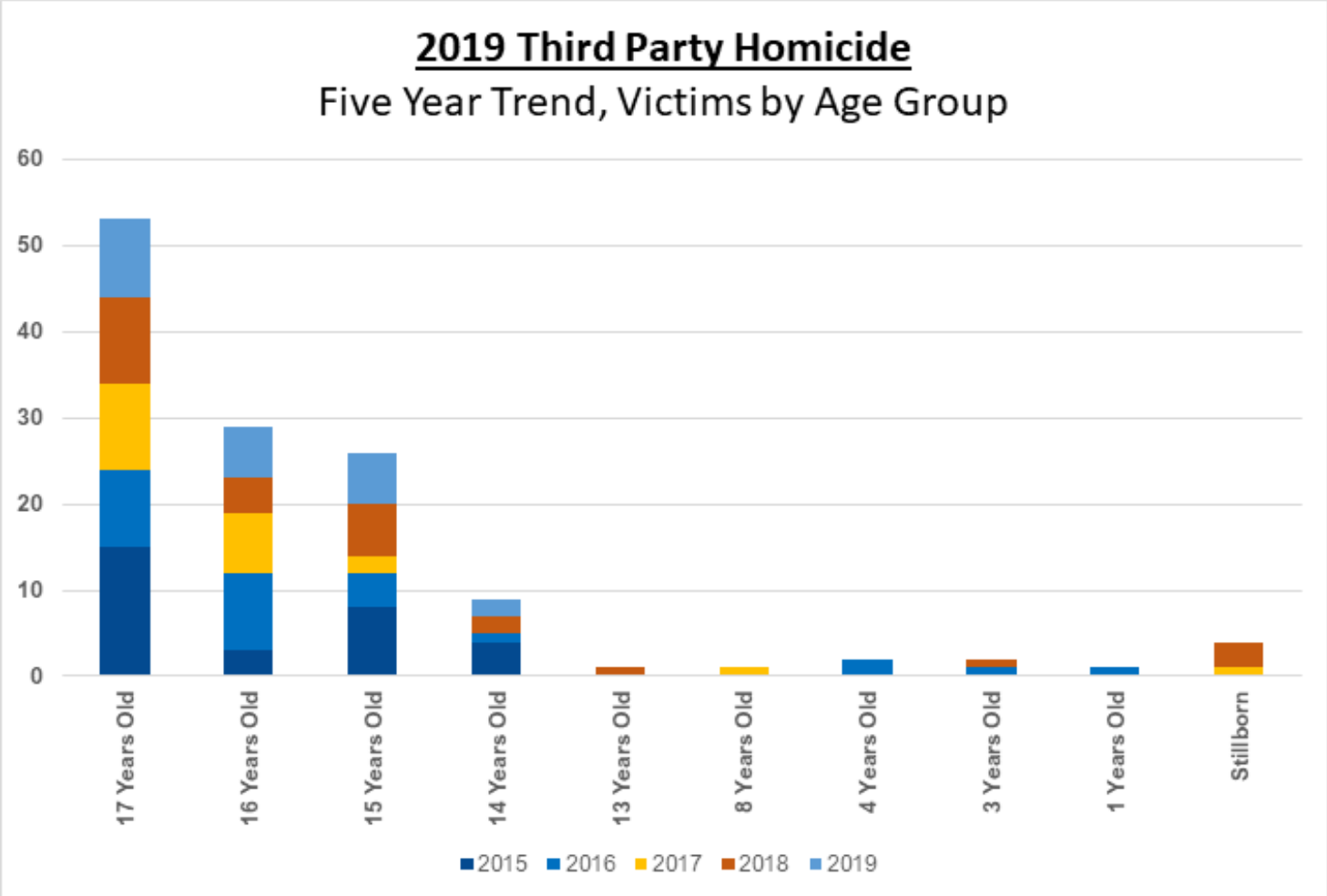

2019 Third Party Homicide
Five Year Breakdown of Cause of Death
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2015
2016
2017
2018
2019
Gunshot Wound
Stabbing
Blunt Force
Fire

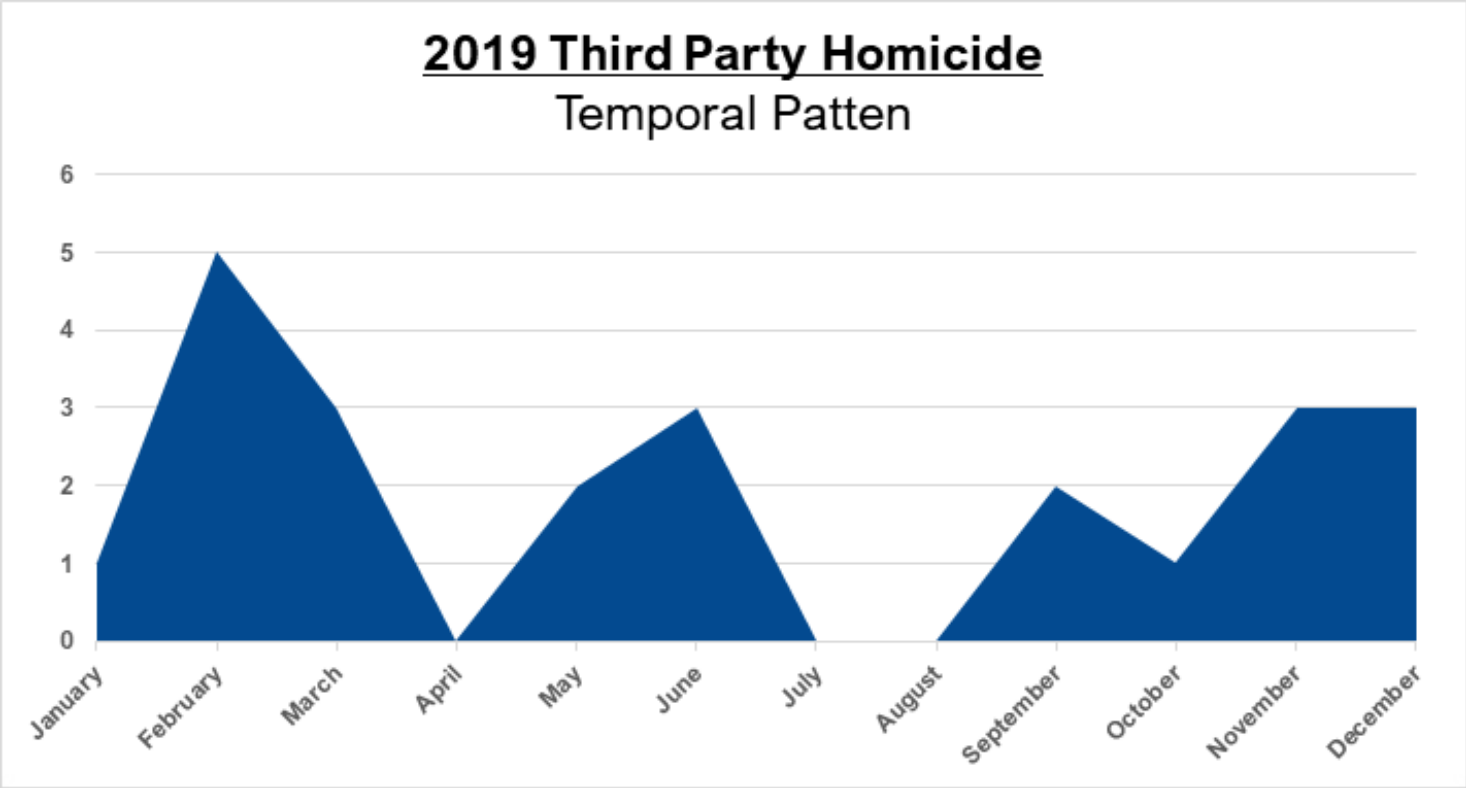

2019 Third Party Homicide
Race/Ethnicity Percentage Breakdown
ASIAN
BLACK
HISPANIC/LATIN AMERICAN
UNKNOWN


2019 Third Party Homicide
Five Year Race/Ethnicity Trendline
25
20
15
10
5
0
2015
2016
2017
2018
2019
African American
Asian
American Indian
Caucasian
Hispanic
Unknown


2019 Third Party Homicide
Five Year Gender Trend
35
30
25
20
15
10
5
0
2015
2016
2017
2018
2019
Male
Female
Unknown

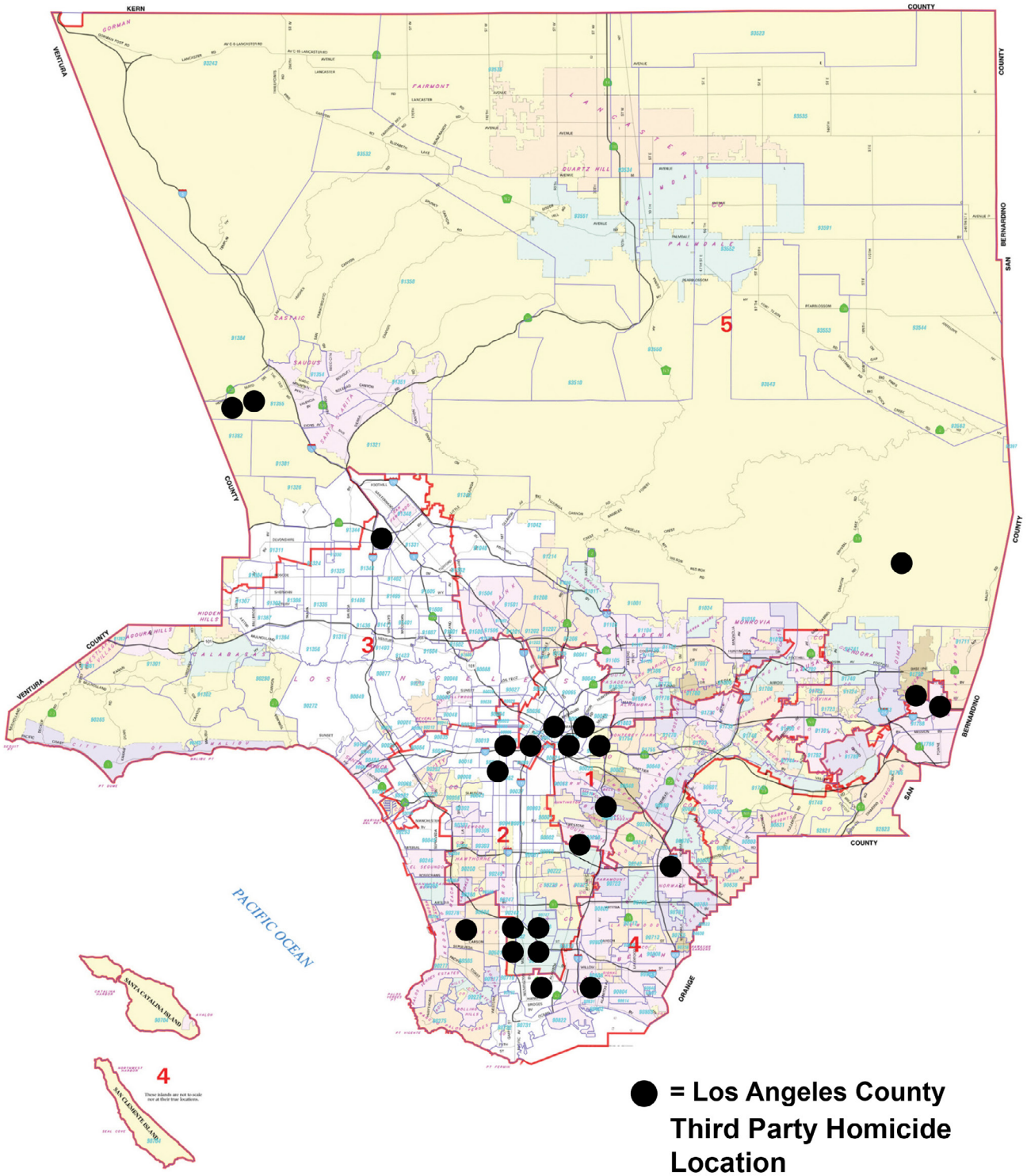

2019 Third Party Homicide
Gender and Age Breakdown
10
9
8
7
6
5
4
3
2
1
0
14 Year Old
15 Year Old
16 Year Old
17 Year Old
Male
Female


2019 Third Party Homicide
Five Year Trend, Victims by Age Group
60
50
40
30
20
10
0
17 Years Old
16 Years Old
15 Years Old
14 Years Old
13 Years Old
8 Years Old
4 Years Old
3 Years Old
1 Years Old
Stillborn
2015
2016
2017
2018
2019


2019 Third Party Homicide
Temporal Patten
6
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December

2019 Third Party Homicides - Locations
n = 23*

***City where the homicide occurred**



ICAN Youth Suicide Coroner/Medical Examiner Investigation Procedural Guide

Case Number: _____

Decedent: _____

Language Interviewed in: ☐ English ☐ Other _____

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

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
IT TAKES SECONDS FOR A BABY TO SUFFOCATE.
EVERY 5 DAYS, A BABY IN LOS ANGELES COUNTY SUFFOCATES WHILE SLEEPING.
Don't sleep with your baby
IS YOUR BABY SLEEPING SAFELY?
CORONER
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
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
first 5 la

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