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.

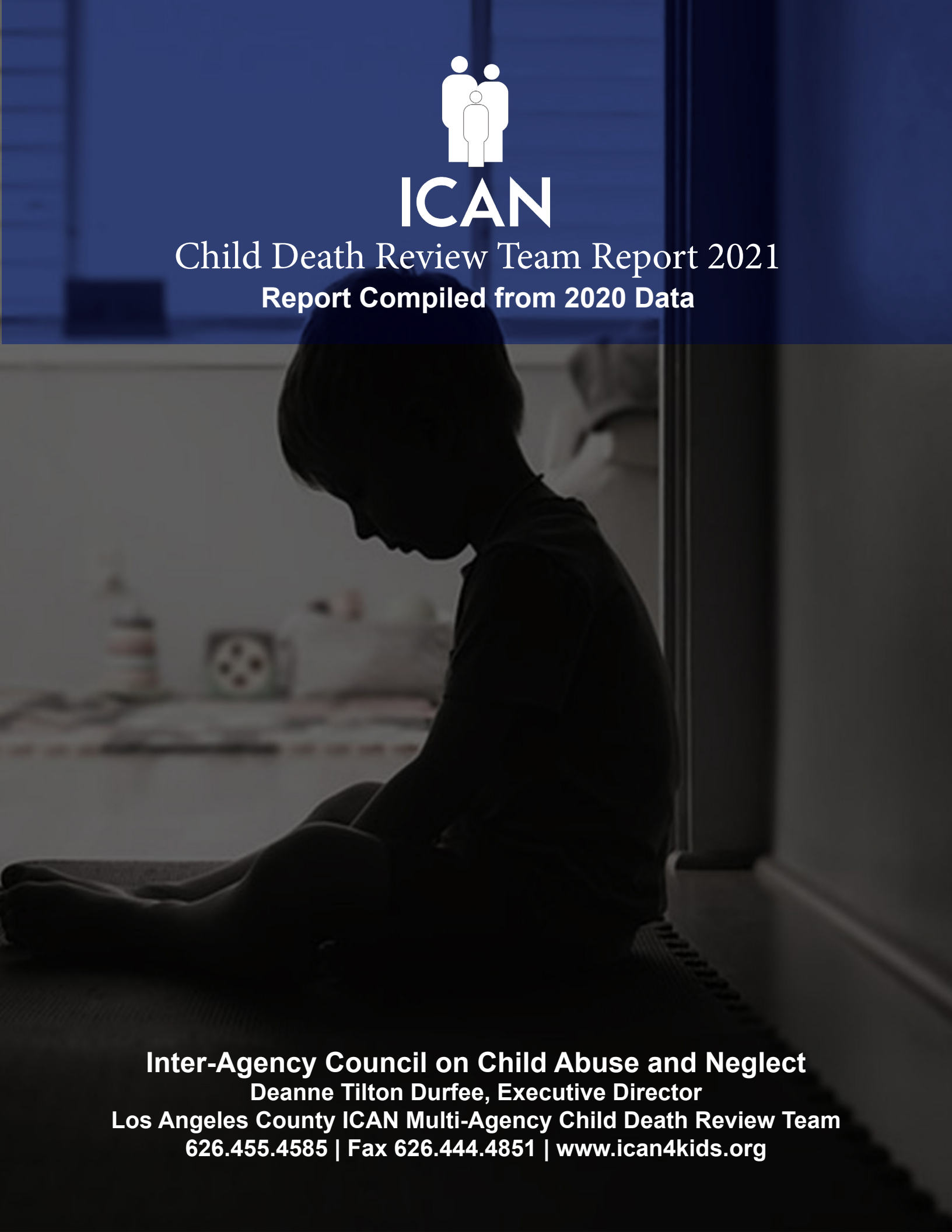
In 1977, the Los Angeles County Board of Supervisors designated the Inter-Agency Council on Child Abuse and Neglect (ICAN) as the official LA County agent to coordinate services for the prevention and treatment of child abuse and neglect.

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 2021

Report Compiled from 2020 Data

Inter-Agency Council on Child Abuse and Neglect
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Los Angeles County ICAN Multi-Agency Child Death Review Team
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Stephanie Pearl Mire, *Los Angeles County, Office of the District Attorney*

Child and Adolescent Suicide Review Team Chairpersons:

Michael Pines, PhD, *Chicago School of Psychology*

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

Rosemary Rubin, *Retired, LAUSD*

Stephanie Murray, *Whittier Union High School District*

Teams Include Representatives From The Following

Children and Family Services
Public Health
Health Services
Office of Education
District Attorney
Los Angeles Police Department
Los Angeles Fire Department
Office of City Attorney
Los Angeles Unified School District
Edelman Children's Court
Community Care Licensing
Independent Police Agencies
Children's Hospital of Los Angeles
Community Child Abuse Councils
Chicago School of Professional Psychology
Medical Hubs
County Counsel
Public Social Services
Sheriff
Mental Health
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 online 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 2020. 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 Fourteenth 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 family's surface in the cases. The lessons and risk factors noted from the 2019 child death review cases are as follows:

Key Findings

Infants and young children are especially vulnerable due to their small size, inability to defend themselves and dependence upon caregivers to meet their needs.

88 children who died in 2020 were under the age of one (37%), many due to unsafe sleep and accidents.

79, or 33% of the children who died in 2020, were between ages 15-17. Most were related to suicides, accidents and third party homicides.

In 2020, the gender gap of victims of child abuse homicides closed compared to previous years, with an equal number of male (n=7) and female victims (n=7).

Child homicides by parent/relative/caregiver included African-American, Caucasian, Hispanic and Asian. Hispanic children comprised thirty three percent (n=5) of the cases. African American children comprised thirty-three percent (n=5 cases) followed by Caucasians (2 cases), one Pilipino and one Armenian child.

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 2020, Seventy-two percent (13 out of the 18 cases) of these homicides occurred in a family with at least one prior Department of Child and Family Services contact. Review of the families' histories revealed forty six percent of the perpetrators had a DCFS contact as a minor themselves.

Cycle of Abuse

Cycle of abuse was not readily available in documents available for review for all parents or caregiver who committed a child homicide. However, almost half of all cases where a child homicide occurred the perpetrator had a history of abuse 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 and often is identified when there is a child fatality. There was an indication of possible substance abuse by perpetrator in 23% of child homicide cases.

Mental Illness

Untreated mental illness is a risk factor seen in 9 of the cases of the child abuse homicides. In five

of those cases 2 fathers had been prescribed medication and not consistently taking medication, 3 mothers suffered from depression and were not in treatment at the time of the homicide. Four of the fathers who did not have documented mental health history, however, caused 3 of the murder suicide cases and one father beheaded his children, clearly indicating mental health issues by the perpetrator.

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 including being home schooled have been documented in child homicide cases.

Perpetrator Relationship

Relationship

In 2020, Biological fathers are the suspect in fifty percent of the child homicide cases and biological mothers are the suspect in twenty-three percent. Mother's boyfriends are the suspects in twenty-three 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 as we see in one case where mother allowed access to the child after only knowing her boyfriend for 2 months and he murdered the child while in his care.

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-eight children died in 2020 because of unsafe sleep practices. In 2019, there were forty-four unsafe sleep-related child deaths. The 2020 number is a slight 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
2016	14
2017	8
2018	10
2019	18
2020	14

The average number of children and adolescents who committed suicide over the past five years is 23. The leading method from 2016 through 2020 is hanging.

Year	Number
2016	14
2017	27
2018	29
2019	20
2020	26

An average of 106 children have died from preventable accidents over the past 5 years from automobile accidents, drowning and deaths due to auto vs. pedestrian.

Year	Number
2016	95
2017	98
2018	102
2019	110
2020	126

The number of undetermined deaths has averaged 56 per year over the past five years

Year	Number
2016	103
2017	54
2018	67
2019	42
2020	50

Table 2 2020 Child Deaths Demographics - Coroner Cases		
	Number	Percentage
Total	238	100.0%
Gender		
Female	89	37%
Male	146	61%
Unknown	3	1%
Age		
Under 1 Year	88	37%
1 – 4 years	23	10%
5 – 9 years	10	4%
10 – 14 years	38	16%
15 – 17 years	79	33%
Race		
African American	49	21%
Armenian	2	1%
Asian/Pacific Islander	12	5%
American Indian	1	.4%
Caucasian	48	20%
Hawaiian	1	.4%
Hispanic	109	46%
Middle Eastern	3	1%
Samoan	2	1%
Unknown	11	5%

Sample Case Summaries - Homicides

Tommy

Two-month-old Tommy was left under the care of his father while his mother ran errands. Mother returned home and notices Tommy was in his bassinet "appearing normal, sleeping". The parents went to bed, and in the morning, Tommy was found by his mother unresponsive and purple in his bassinet. Mother tried to splash water on his face while father called 911. Tommy was taken to the hospital by paramedics. At the hospital Tommy was found to have a subdural hemorrhage, subarachnoid hemorrhages, scalp hemorrhages, and two healing posterior rib fractures, in addition to external bruising and abrasions/lacerations. The Doctor indicated that Tommy had been abused for some time since his birth. After further investigation Law Enforcement determined that father had caused the injuries and was arrested.

Cheryl & Liz

Siblings, Tom, age 13, Cheryl, age 9, Liz, age 6 and Lily, age 4, resided with their father and maternal grandmother (MGM). The mother and the father had a history of domestic violence. The mother and father had an agreement where mother would visit three days a week. On the day of the incident, the mother attempted to take the children as father had become physically aggressive towards her; however, the maternal grandmother intervened and did not allow the mother to take the children as she insisted the children remain in the father's care. Grandmother left the home with Lily. An argument ensued between the parents. Mother attempted to leave the house with Cheryl, Tom, and Liz but father was pushing the kids back into the house. Tom pulled away from the father and ran out of the house with mother. Father slammed the door shut. The mother and Tom went to the LAPD station for help and mother was instructed to return to the father's home and LE would meet her there. Upon arriving to the father's home, mother called the father's phone, but there was no answer. She called the children's names, but there was no answer from anyone inside the home. The mother managed to take the window screen off one window to have Tom jump in to open the door; however, when she looked inside, she saw the father laying with blood on his body. The Fire Department responded to the home and discovered the bodies of the children and the father. The child, Liz was found on the living room's couch with a gunshot wound to the head. The child, Cheryl was found in the back bedroom, on the bed, with a gunshot wound to the head. The father was found in the living room with a gunshot to the head. The father was found alive but later passed during the ambulance transportation.

Carlos & John

The father of Carlos, age 11 and John, age 8, had not resided in the home for three months due to marital issues as well as issues between him and the maternal grandfather. At some point, the mother and the father were discussing their relationship and during their conversation, the mother stated she wanted a divorce. Reportedly, the conversation was amicable and after the conversation ended, the father stated he was going to spend time with their sons, who were playing video games in the mother's bedroom. The mother remained in the backyard and spoke on the phone to a cousin and then to the paternal aunt. Shortly after getting off the phone with the paternal aunt, the mother received a text message from the paternal aunt asking the mother to check on the children after the paternal aunt had received a "weird text" from the father. The mother went into the house and into her bedroom and found Carlos and John lying unresponsive on the ground and father lying

next to them. There was blood around them, and the mother ran out of the home and informed the maternal grandfather of what she found, telling him to call 911. After the grandfather contacted 911 the mother reportedly went back into the room and laid down on the floor with the children, holding their hands until deputies and paramedics arrived. The Fire Department arrived at the scene and the children were pronounced dead; cause of death for the children was gunshot wound of the head. The father was also pronounced dead at the scene with a gunshot wound of the head.

Sally & Roger

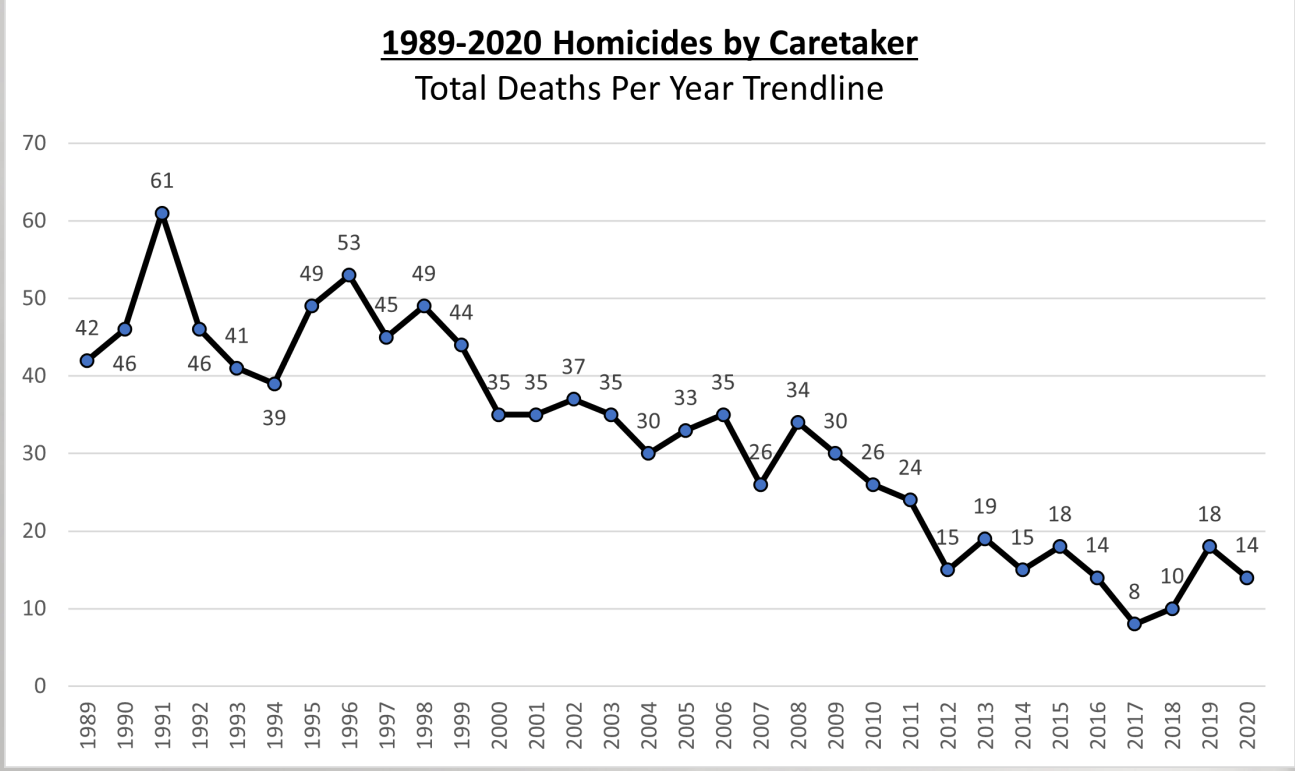
Sally age 13 and Roger aged 12, were found decapitated in their parents' home after the fire department was called out to the home due to concerns of a gas leak. It was later found that the father, who was a personal trainer, had missed many appointments with clients. One client was particularly worried about him. The client called law enforcement who had informed her that unless there was an emergency at the home, a welfare check would not be conducted. Upon further investigation, it was determined that Sally and Roger lived at home with their 2 younger siblings and both their parents. All the children were home schooled. It was found that the family played an online game about bad entities, the father had become obsessed about these characters and believed Sally and Roger were possessed by these entities and needed to be killed. The younger siblings witnessed the murders. The mother indicated that she was a victim of father's threats and did not call to get help. Both parents were arrested for the murder of Sally and Roger.

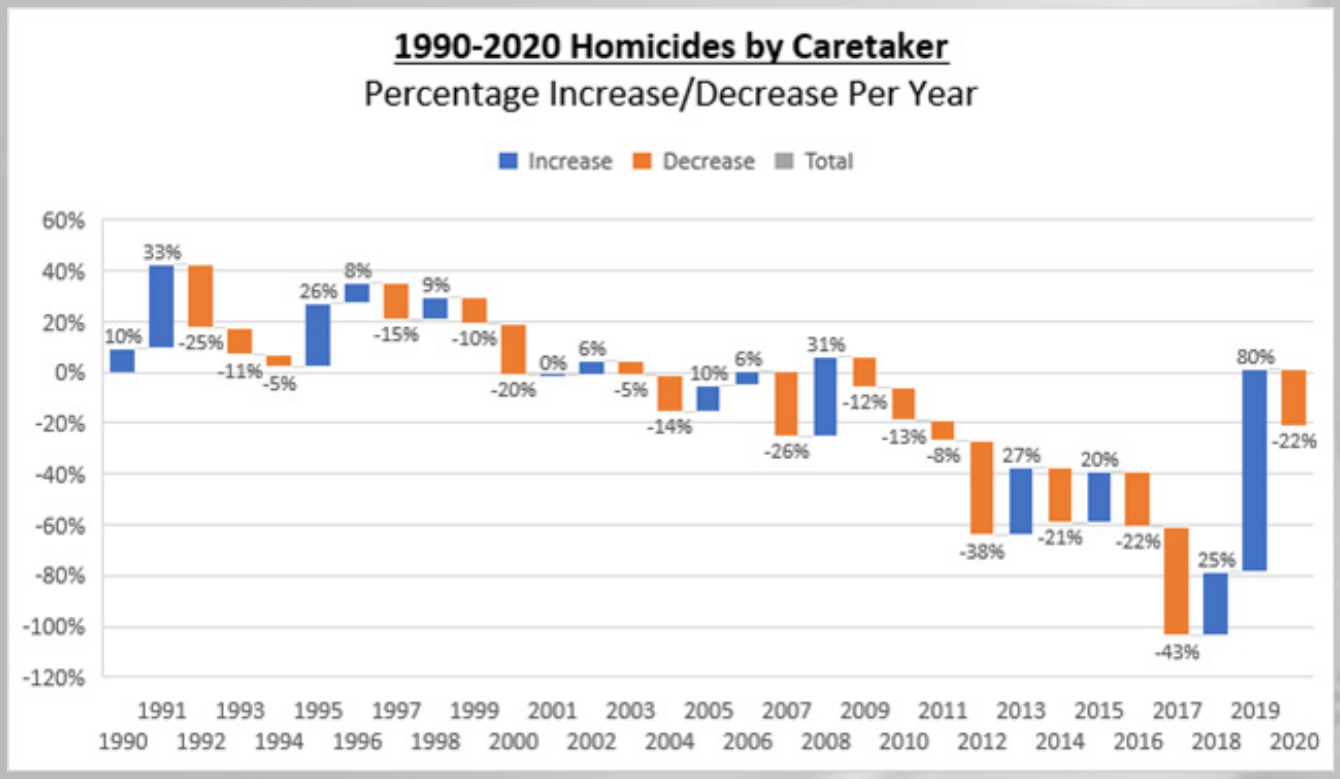
HOMICIDE BY CARETAKER

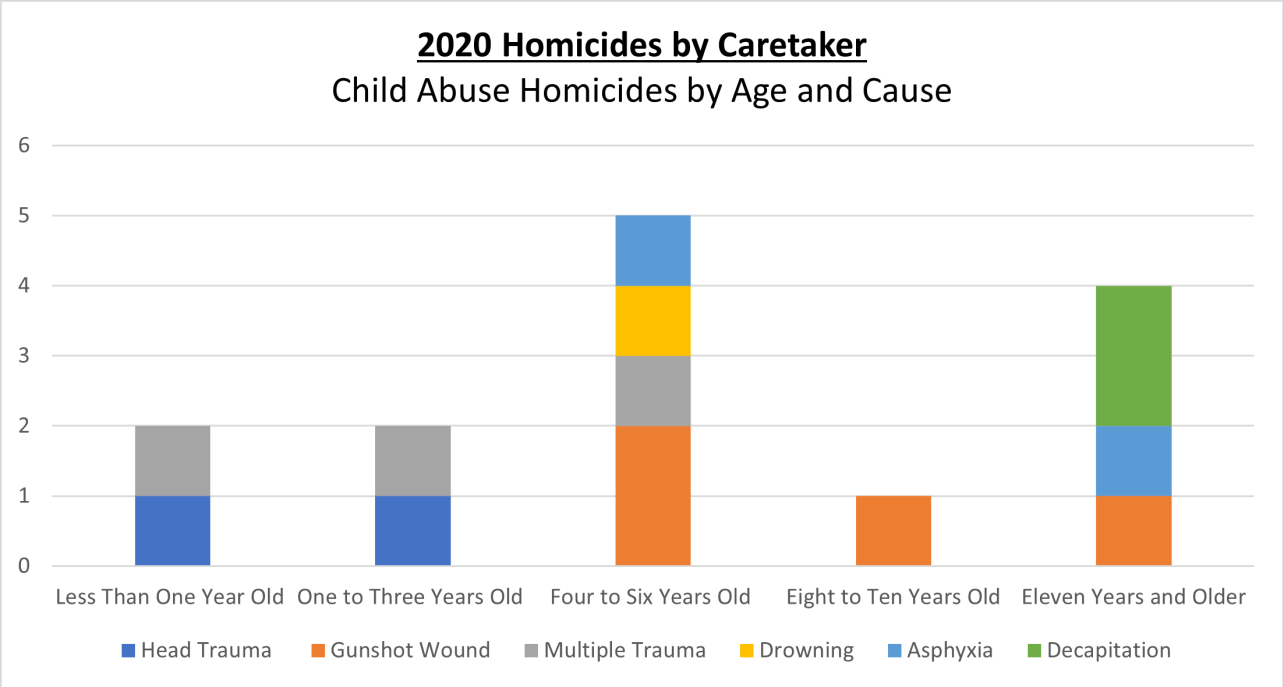
FINDINGS

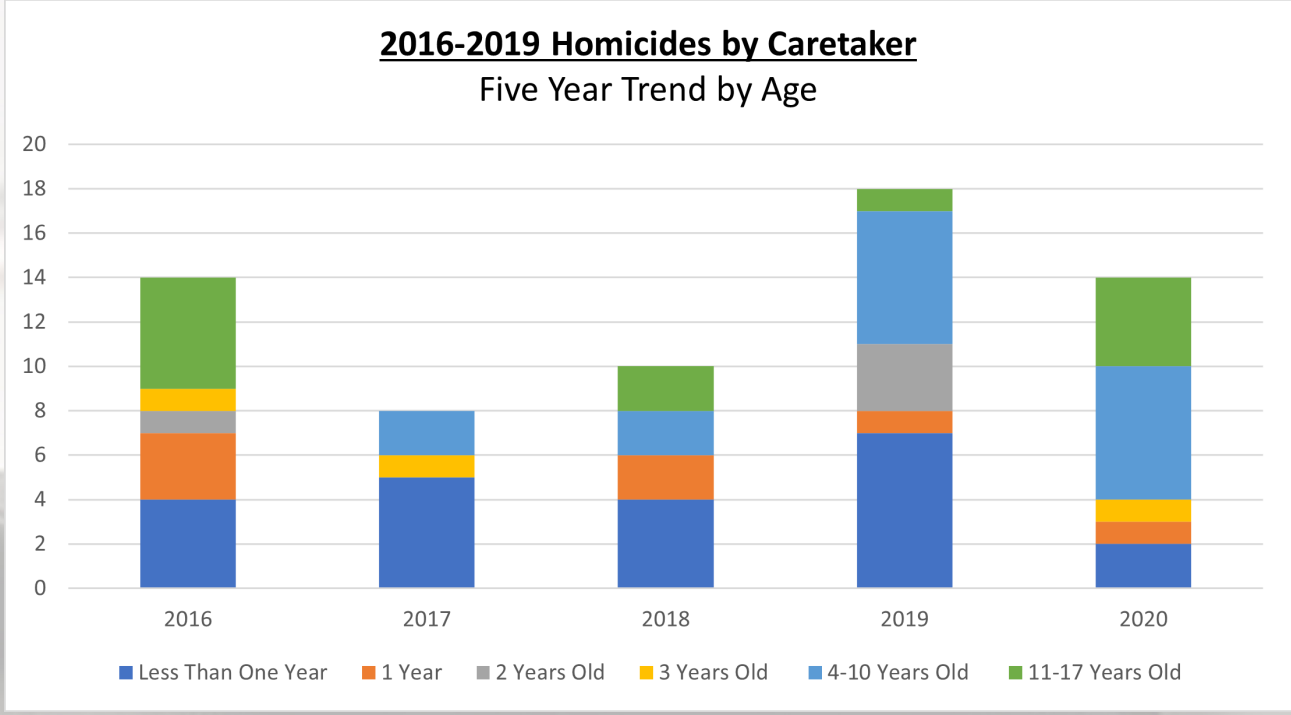
- Fourteen child homicides by caretaker were reported to ICAN from the Coroner's Department in 2020.
- This is a 38% decrease from the 2019 number of 18 homicides by caretaker, which was the largest year-to-year increase in this mode of death in thirty years. We see the number has maintained the downward trend with a preliminary number of 8 homicides for 2021 this number may increase as some possible homicides are under investigation and final mode of death has not be determined.
- Gunshot wounds were the leading cause of death in homicides by caretaker deaths in 2020, with 4 children dying from gunshot wounds. The second leading cause was multiple trauma (3 deaths).
- The other causes of child homicides were: head trauma (2), decapitation (2), intentional drowning (1), and one asphyxia.
- Over the last five years, the top causes of death in homicides by caretaker have been head trauma (27 deaths), multiple trauma (7 deaths), and gunshot wound (8 deaths).
- The age of child victims in 2020 is unique to prior years where children under the age of 3 have the highest percentage of deaths. In 2020, children between 4 and 6 represented the largest number of deaths (n=5). Second largest were zero to three years of age with 4 victims.
- In 2020, the gender gap was closed with an equal number of boys and girls killed by a caregiver. Seven boys and seven girls died at the hands of their caregiver. In comparison – 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.
- Hispanic and African American children comprised 70% percent (Hispanic n=5 and Black n=5) of the cases for 2020. Caucasians made up 14% (2 cases), while there was one case of a Pilipino child and one Armenian child who died at the hands of a parent or caregiver.
- Biological fathers were the suspect in over 50 percent of the child homicide cases and biological mothers were the suspect in 23 percent. Mother's boyfriends were the suspects in twenty-three percent of the cases. The remaining two cases have both parents as suspects and godfather as the suspect in another.
- Seventy-eight percent of all the child homicides by caretaker had a male suspect. This is consistent with 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 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 forty six percent of the perpetrators had a DCFS contact as a minor themselves.

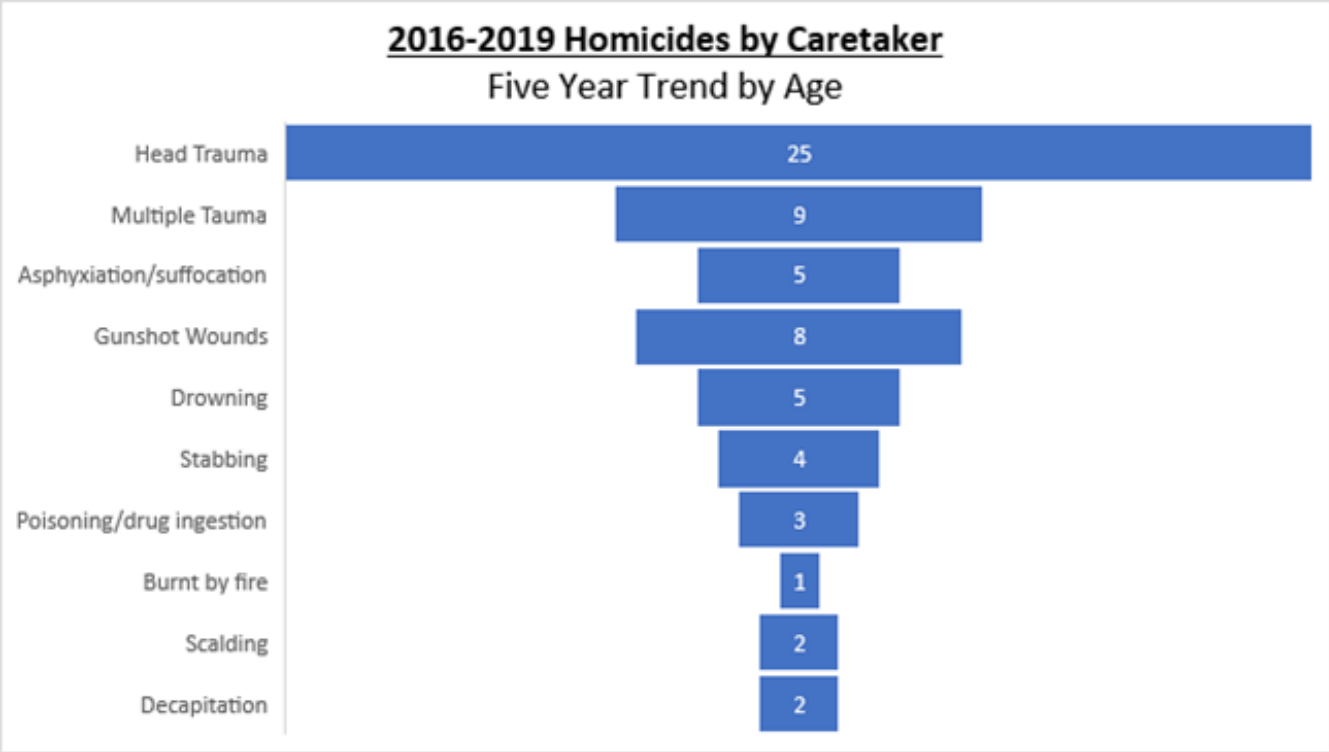
- Over fifty percent of the child homicides by caretaker were investigated by the Los Angeles County Sheriff's Department or the Los Angeles Police Department. The remaining cases were handled by Bell Police Department, Montebello Police Department and Monrovia Police Department.

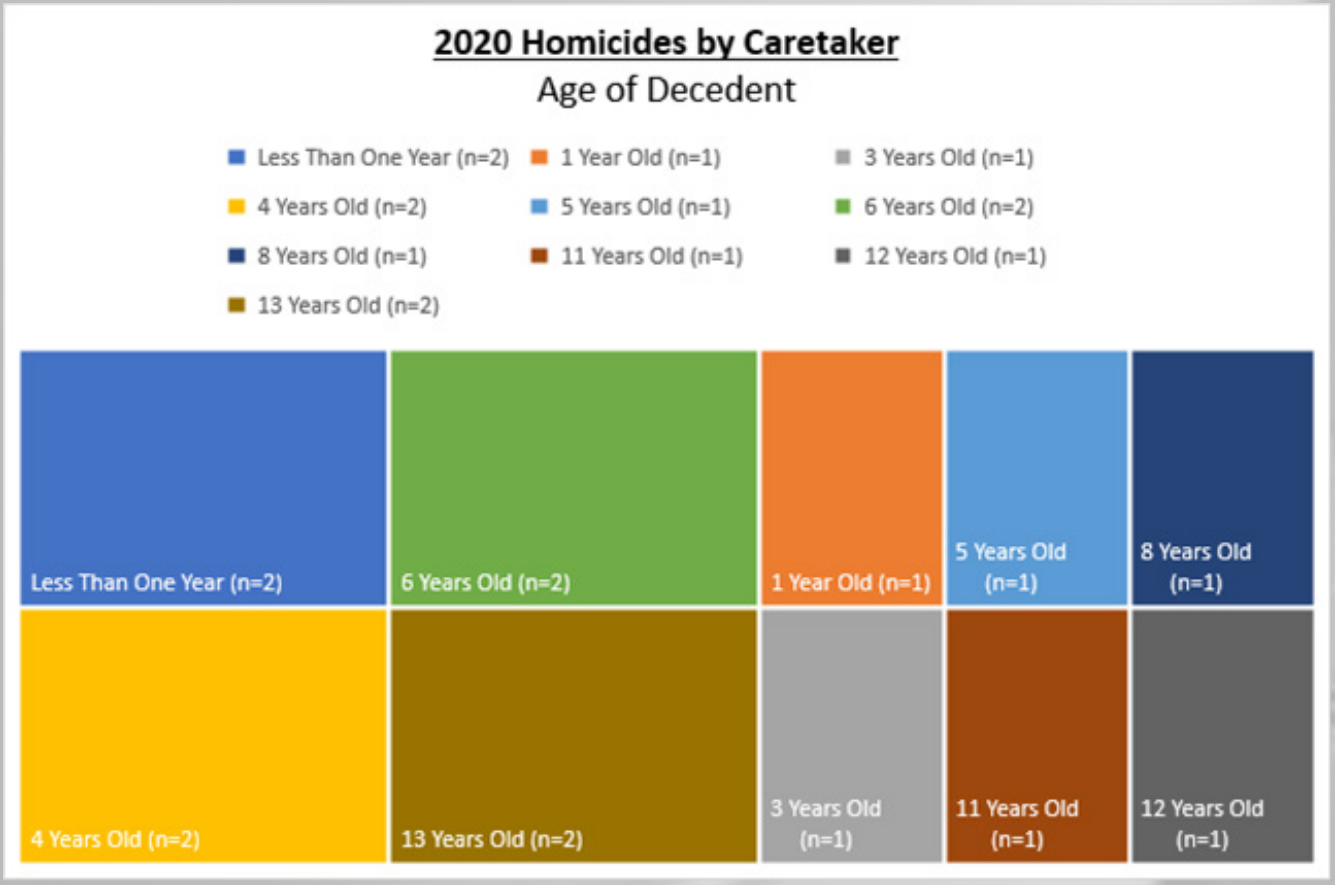

1989-2020 Homicides by Caretaker
Total Deaths Per Year Trendline
70
60
50
40
30
20
10
0
42 46 61 46 41 39 49 53 45 49 44 35 35 37 35 30 33 35 26 34 30 26 24 15 19 15 18 14 8 10 18 14
1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

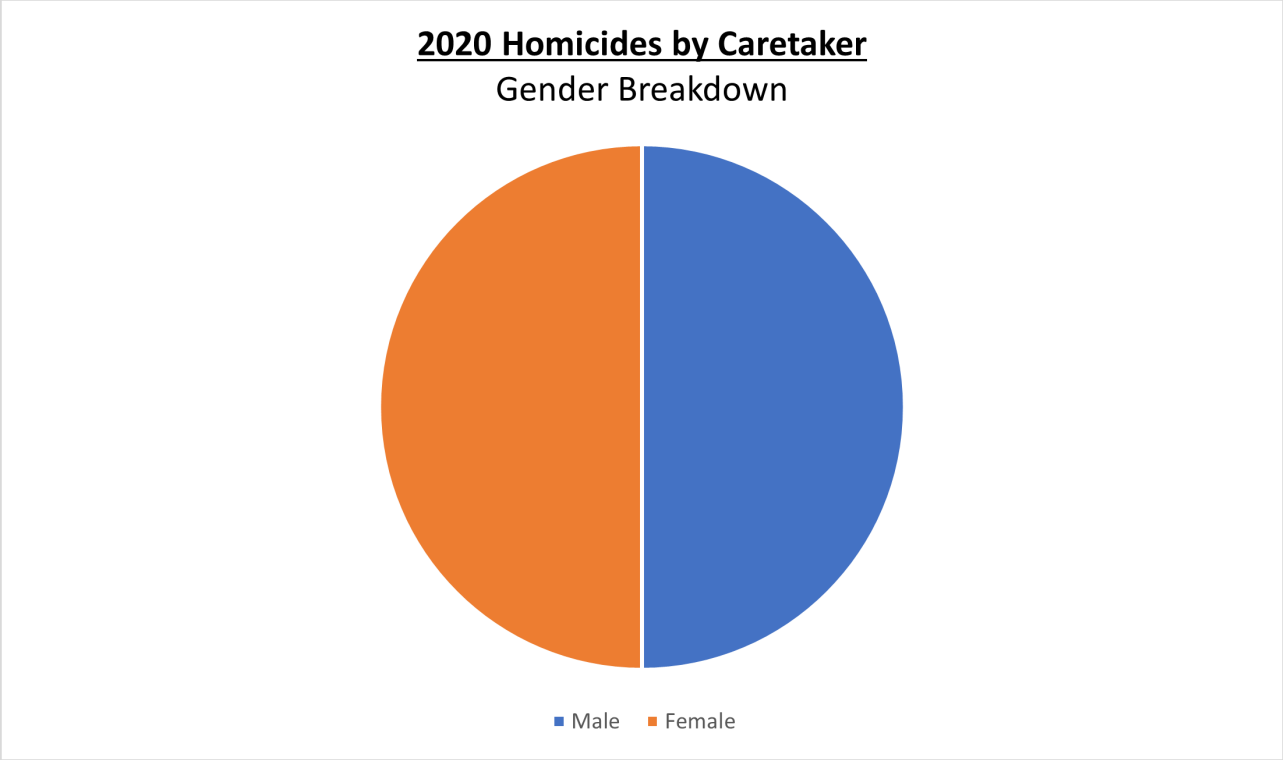

1990-2020 Homicides by Caretaker
Percentage Increase/Decrease Per Year
Increase
Decrease
Total
60%
40%
20%
0%
-20%
-40%
-60%
-80%
-100%
-120%
10% 33% -25% -11% -5% 26% 8% -15% 9% -10% -20% 0% 6% -5% -14% 10% 6% -26% 31% -12% -13% -8% -38% 27% -21% 20% -22% -43% 25% 80% -22%
1991 1993 1995 1997 1999 2001 2003 2005 2007 2009 2011 2013 2015 2017 2019
1990 1992 1994 1996 1998 2000 2002 2004 2006 2008 2010 2012 2014 2016 2018 2020

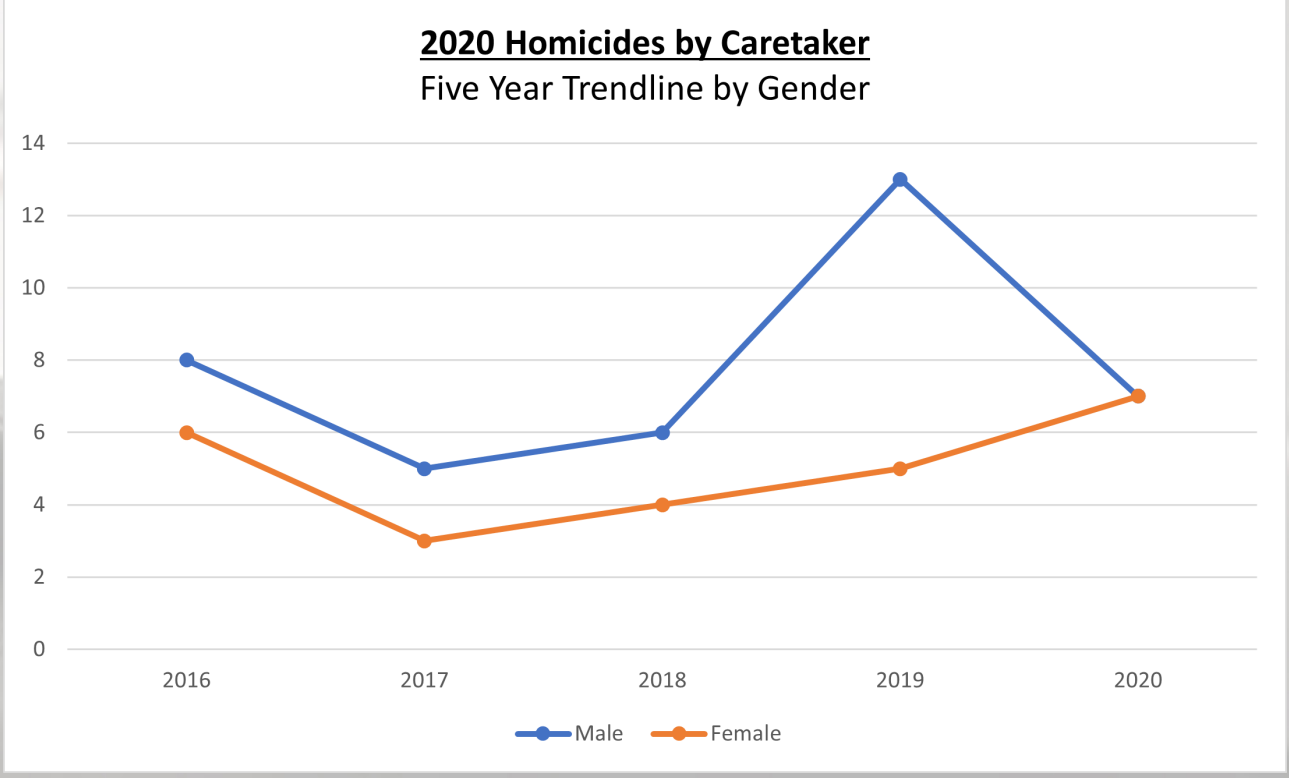

2020 Homicides by Caretaker
Child Abuse Homicides by Age and Cause
6
5
4
3
2
1
0
Less Than One Year Old
One to Three Years Old
Four to Six Years Old
Eight to Ten Years Old
Eleven Years and Older
Head Trauma
Gunshot Wound
Multiple Trauma
Drowning
Asphyxia
Decapitation

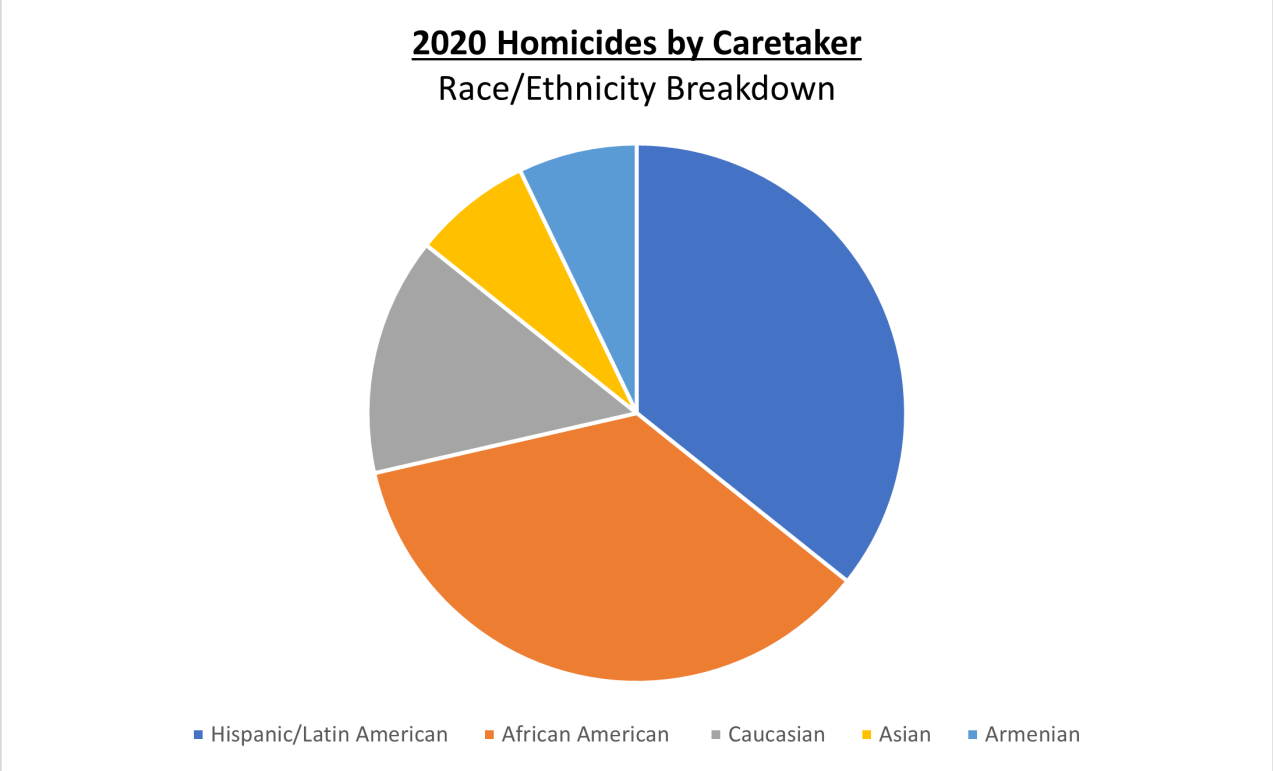

2016-2019 Homicides by Caretaker
Five Year Trend by Age
20
18
16
14
12
10
8
6
4
2
0
2016
2017
2018
2019
2020
Less Than One Year
1 Year
2 Years Old
3 Years Old
4-10 Years Old
11-17 Years Old

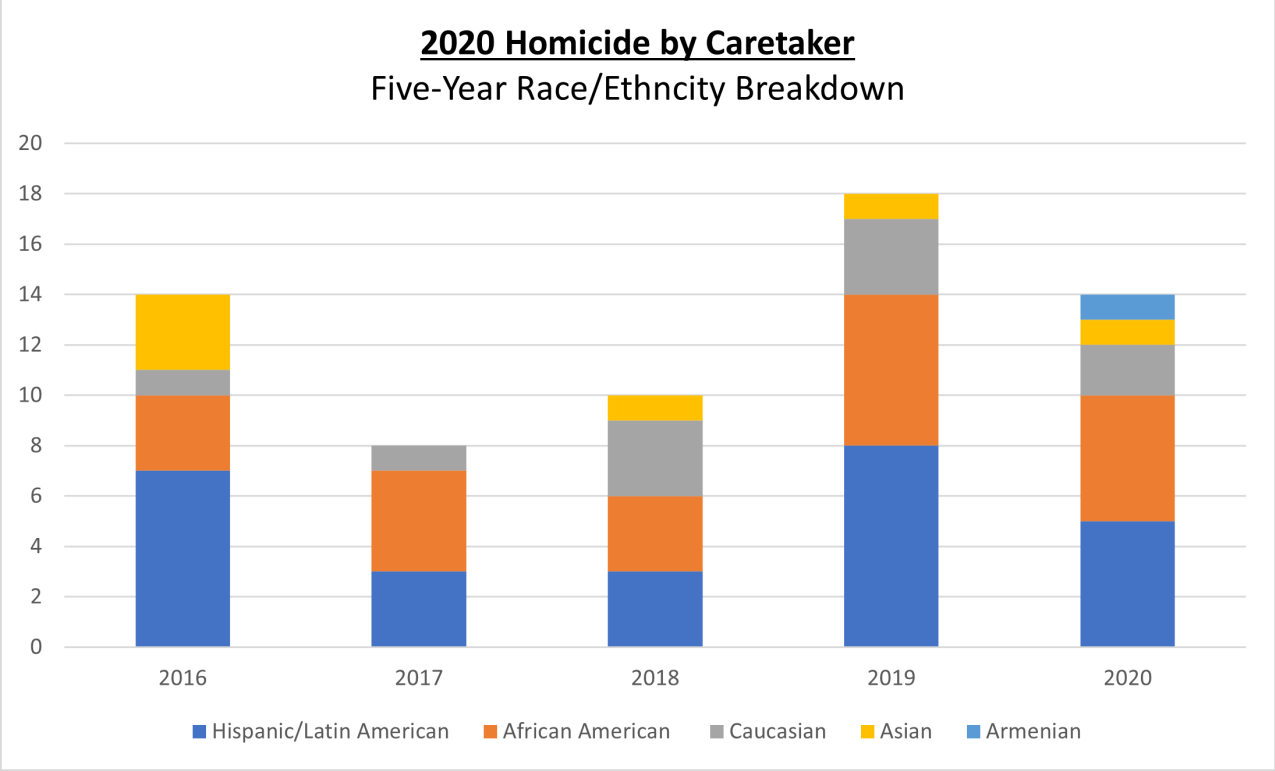

2016-2019 Homicides by Caretaker
Five Year Trend by Age
Head Trauma
25
Multiple Tauma
9
Asphyxiation/suffocation
5
Gunshot Wounds
8
Drowning
5
Stabbing
4
Poisoning/drug ingestion
3
Burnt by fire
1
Scalding
2
Decapitation
2

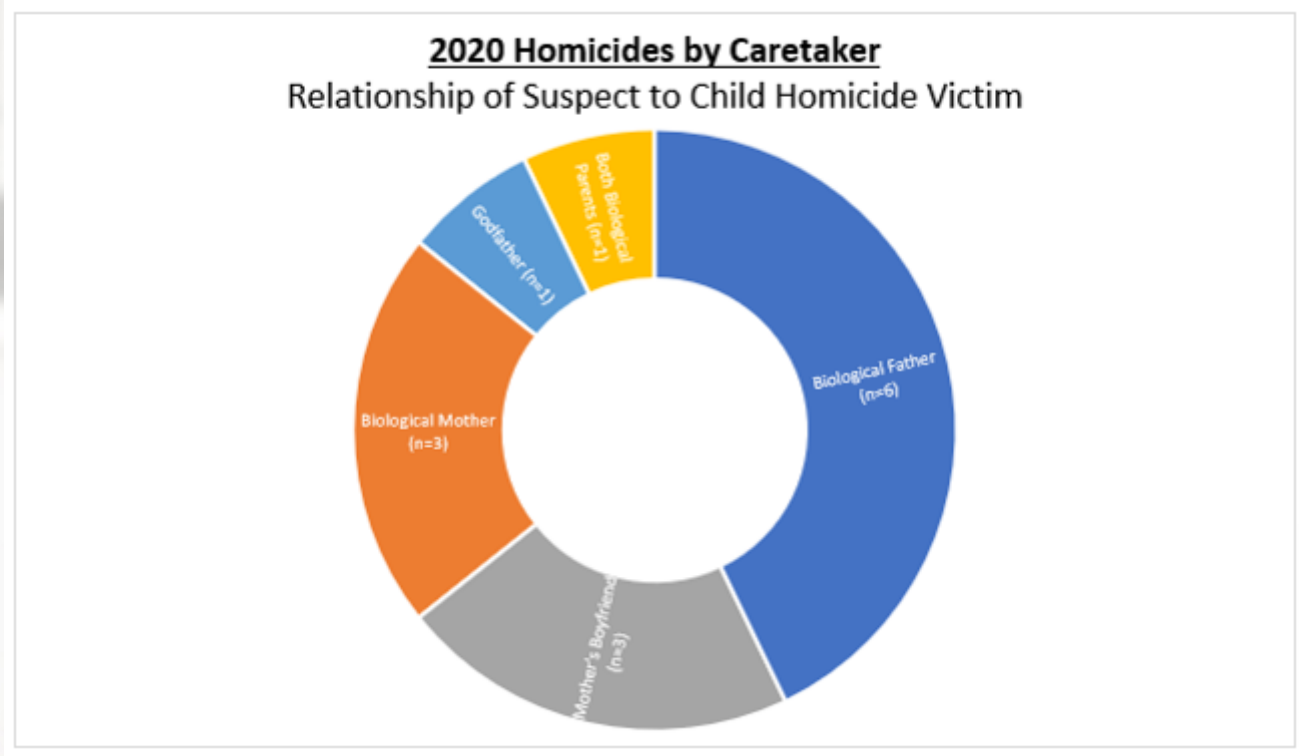

2020 Homicides by Caretaker
Age of Decedent
Less Than One Year (n=2)
1 Year Old (n=1)
3 Years Old (n=1)
4 Years Old (n=2)
5 Years Old (n=1)
6 Years Old (n=2)
8 Years Old (n=1)
11 Years Old (n=1)
12 Years Old (n=1)
13 Years Old (n=2)
Less Than One Year (n=2)
6 Years Old (n=2)
1 Year Old (n=1)
5 Years Old (n=1)
8 Years Old (n=1)
4 Years Old (n=2)
13 Years Old (n=2)
3 Years Old (n=1)
11 Years Old (n=1)
12 Years Old (n=1)

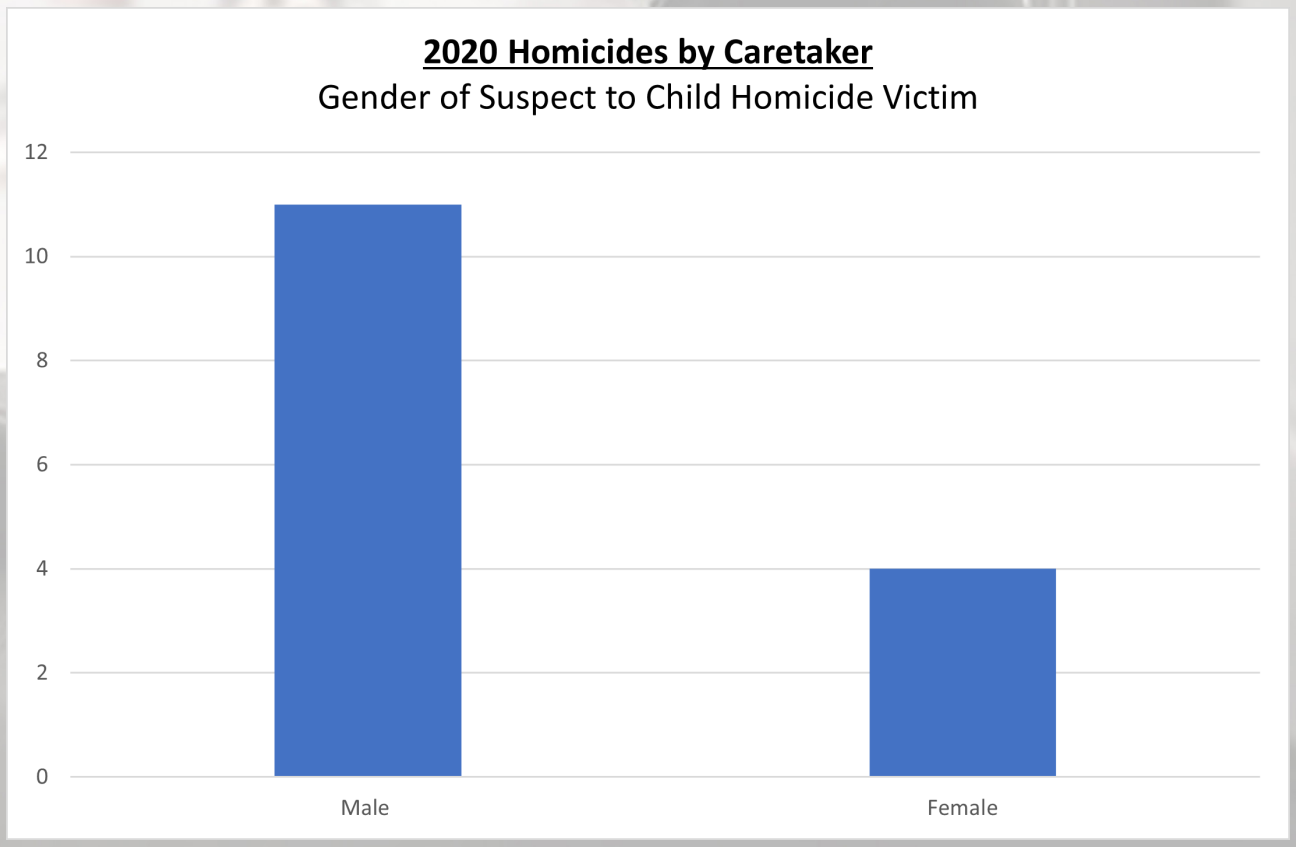

2020 Homicides by Caretaker
Gender Breakdown
Male
Female

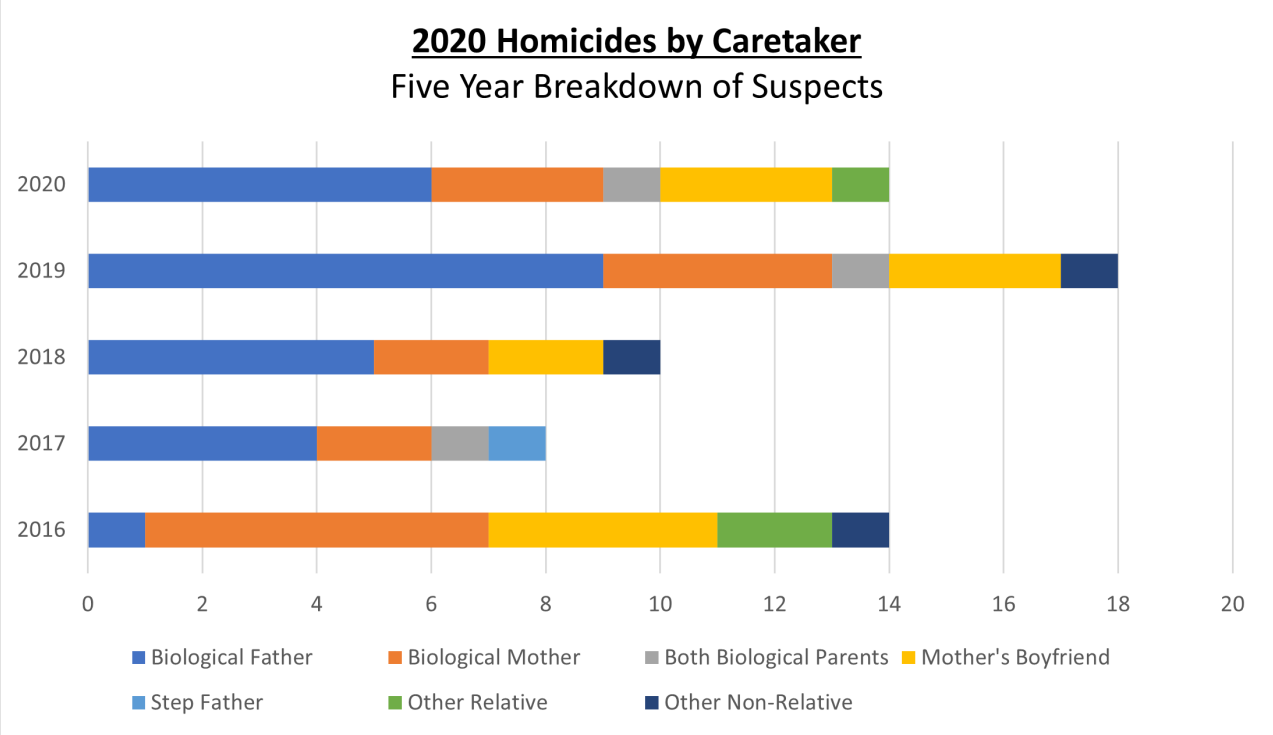

2020 Homicides by Caretaker
Five Year Trendline by Gender
14
12
10
8
6
4
2
0
2016
2017
2018
2019
2020
Male
Female

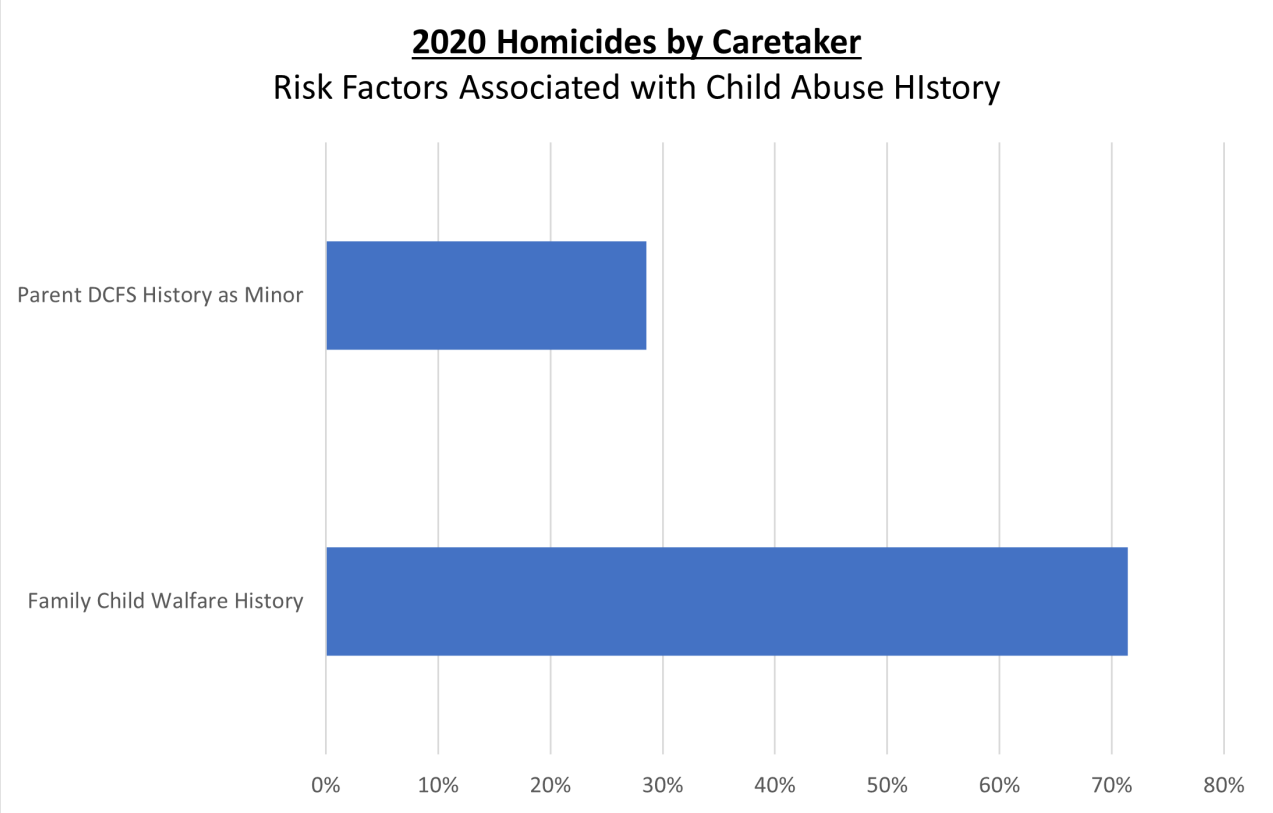

2020 Homicides by Caretaker
Race/Ethnicity Breakdown
Hispanic/Latin American
African American
Caucasian
Asian
Armenian

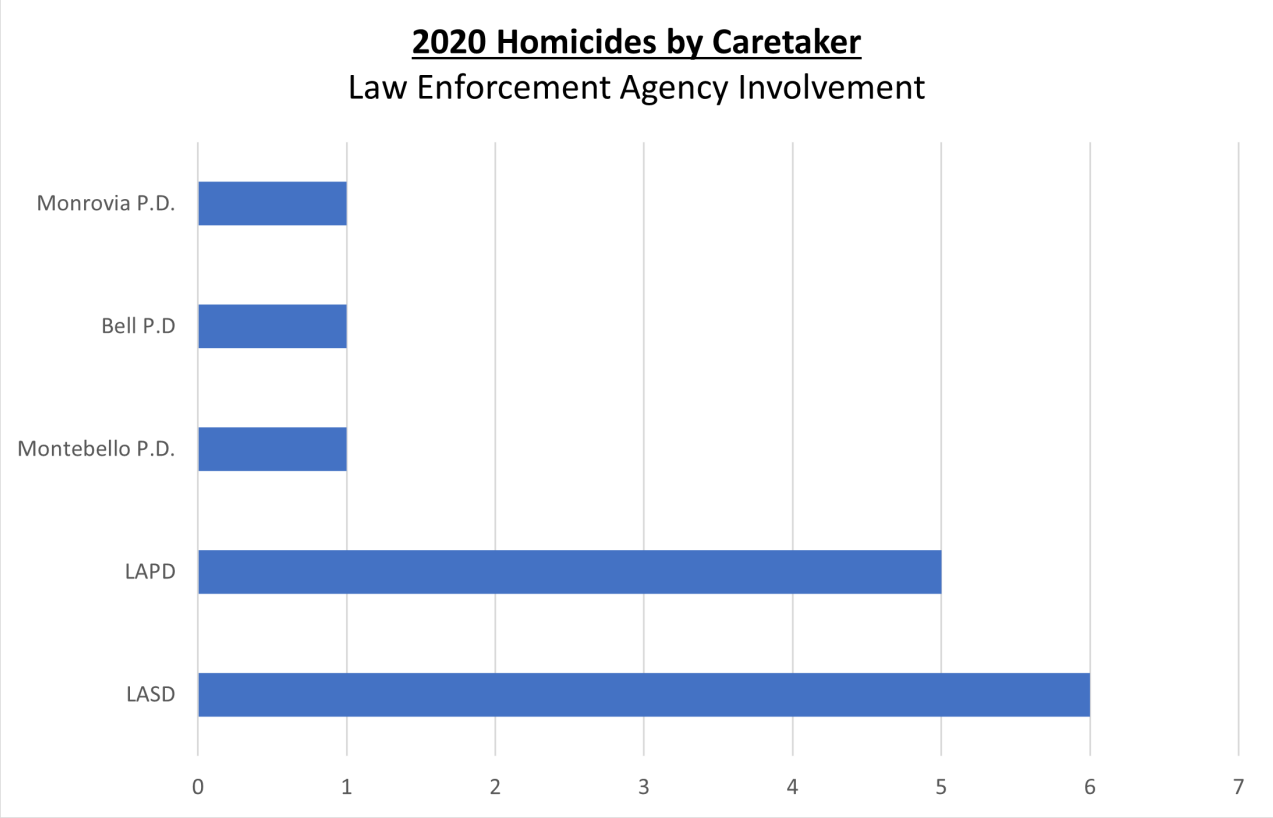

2020 Homicide by Caretaker
Five-Year Race/Ethncity Breakdown
20
18
16
14
12
10
8
6
4
2
0
2016
2017
2018
2019
2020
Hispanic/Latin American
African American
Caucasian
Asian
Armenian


2020 Homicides by Caretaker
Relationship of Suspect to Child Homicide Victim
Biological Father (n=6)
Mother's Boyfriend (n=3)
Biological Mother (n=3)
Godfather (n=1)
Both Biological Parents (n=1)


2020 Homicides by Caretaker
Gender of Suspect to Child Homicide Victim
12
10
8
6
4
2
0
Male
Female

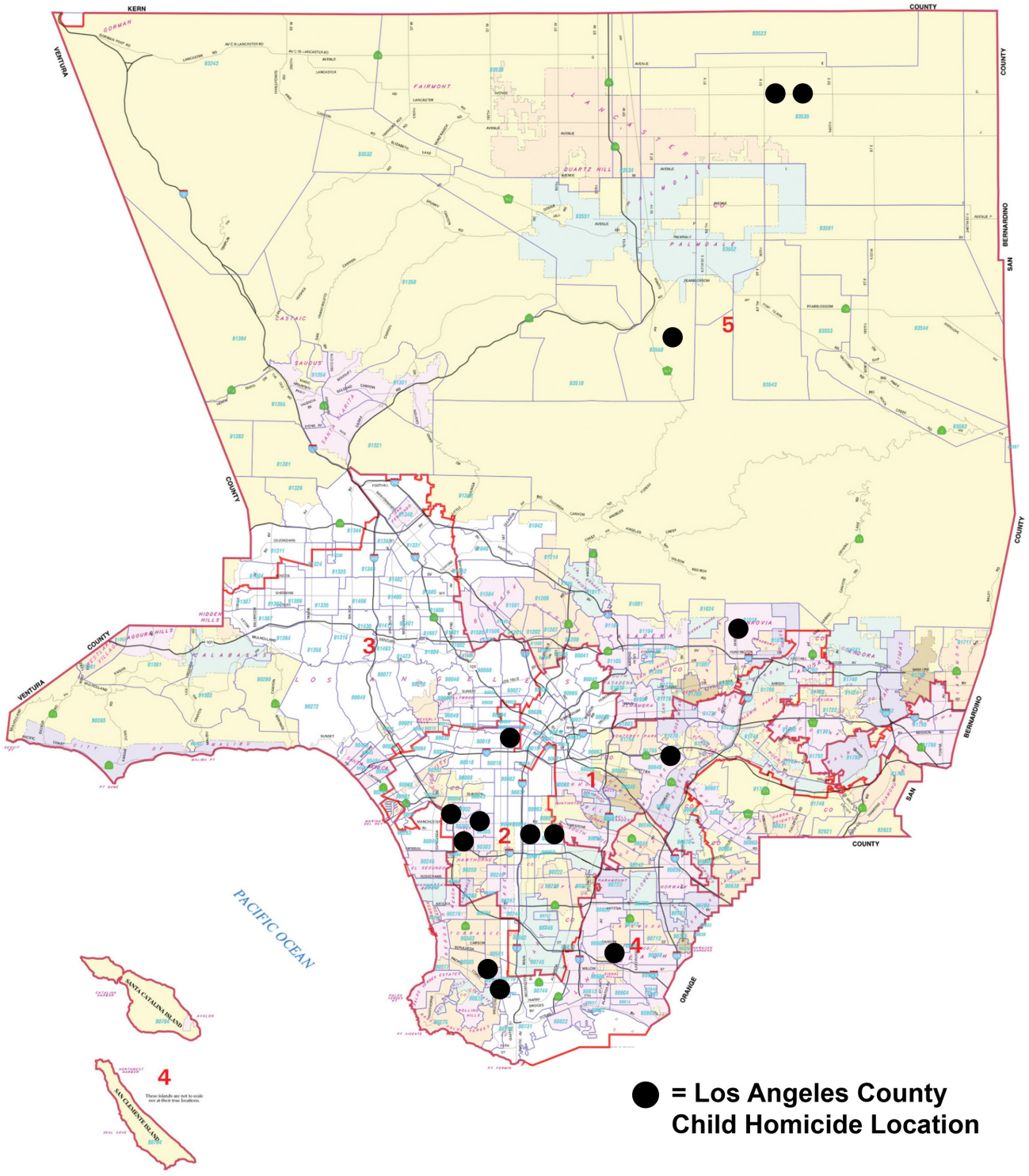

2020 Homicides by Caretaker
Five Year Breakdown of Suspects
2020
2019
2018
2017
2016
0
2
4
6
8
10
12
14
16
18
20
Biological Father
Biological Mother
Both Biological Parents
Mother's Boyfriend
Step Father
Other Relative
Other Non-Relative


2020 Homicides by Caretaker
Risk Factors Associated with Child Abuse HIstory
Parent DCFS History as Minor
Family Child Walfare History
0%
10%
20%
30%
40%
50%
60%
70%
80%


2020 Homicides by Caretaker
Law Enforcement Agency Involvement
Monrovia P.D.
Bell P.D
Montebello P.D.
LAPD
LASD
0
1
2
3
4
5
6
7

2020 Child Homicides - Locations
n = 14*

***City where the homicide occurred**



Sample Case Summaries - Suicides

Rita

Thirteen year old, Rita was found by her 8 year old cousin, hanging from a cloth belt ligature around her neck, that had been tied to a closet rod in her bedroom. Rita's aunt brought her down, called 911 and initiated CPR. Paramedics responded to the residence and transported Rita to St. Francis Medical Center. Despite resuscitative efforts Rita's death was pronounced at 2:52pm family denies any prior mental health history, past suicide attempts or knowledge of suicidal ideations for the child. There was no suicide note found at the scene.

Amari

Amari age 9, was found hanging with a rope around her neck by her 10-year-old sister. The children were living with a maternal legal guardian after having seen their mother being murdered with a machete in El Salvador. The children went to live with maternal grandmother after mother's murder. Amari was having bad dreams and difficulty feeling safe in El Salvador. It was then decided the children would come to the United States with a cousin. During the trip, the cousin was detained and arrested by ICE. That is how the children were placed with Legal Guardian. During guardianship Amari's sister Debbie confessed that she had something to do with her sister Amari taking her life. The child stated to her guardian that she helped her sister look for videos on how to successfully commit suicide. The guardian indicated that Debbie did not like her sister Amari, and she knowingly led her to her death by exploring videos online that demonstrate ways on how to effectively commit suicide. Child, Debbie was also talking about wanting to die so that she could be with her mother also. DCFS intervened and was providing support to Debbie and legal guardian.

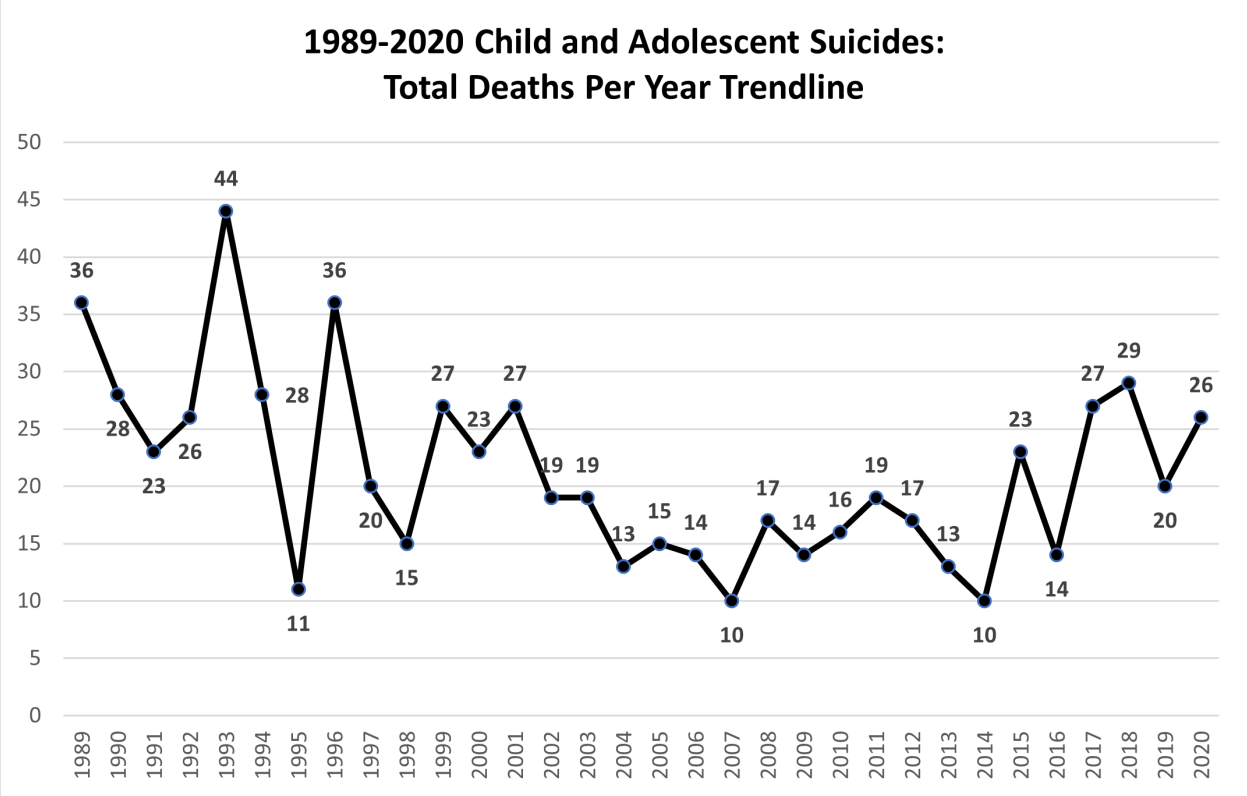
Tommy

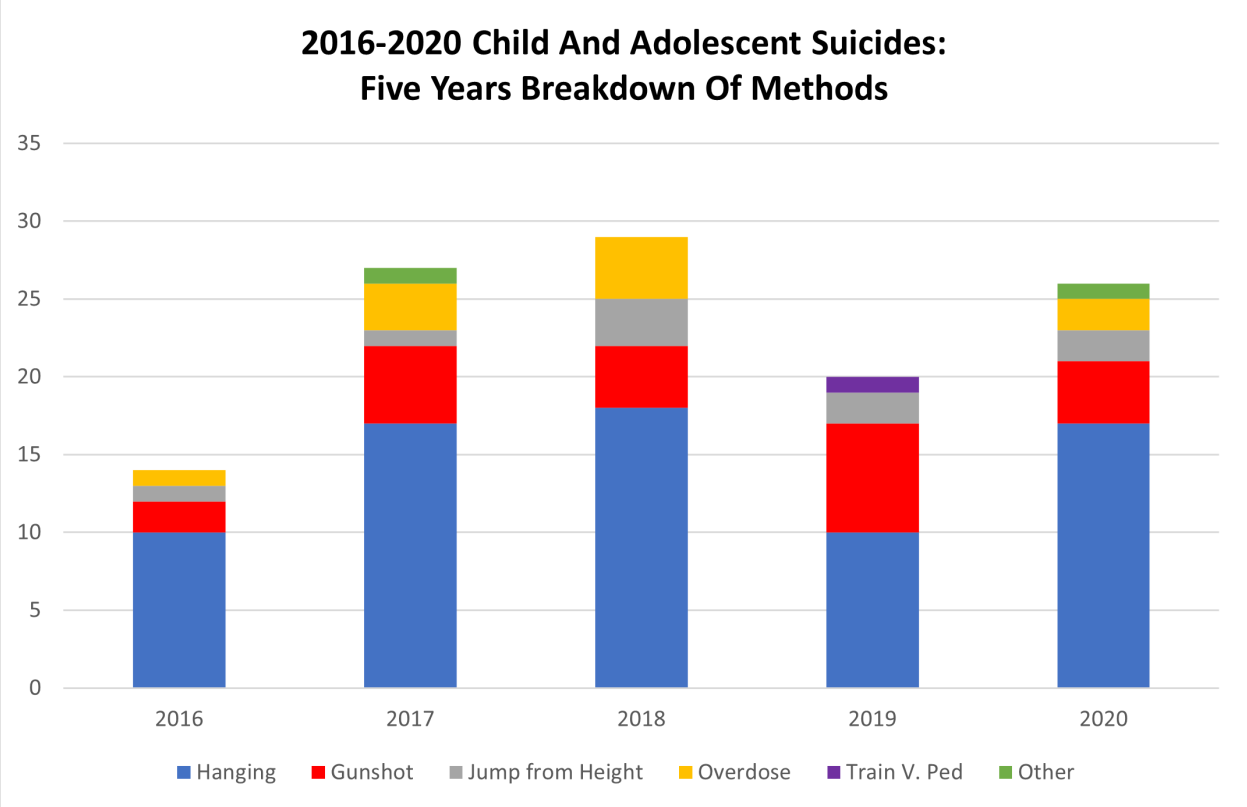
Tommy, age 14 texted multiple friends an apparent suicide message. One of the friends contacted the Tommy's sister. The sister checked her phone for messages and found that Tommy had sent her an address and noted that a written letter was in there home. The sister found the written message and noted that it was an apparent suicide note. She and her father responded to the location in the text message and found Tommy deceased. The father and sister saw Tommy standing on the top floor of a parking structure. The structure is suspected of being approximately five floors in height. The decedent then jumped off the parking structure and landed on the ground level as father and the sister watched. Tommy had a history of depression but was not taking any medication or in therapy at the time of his death.

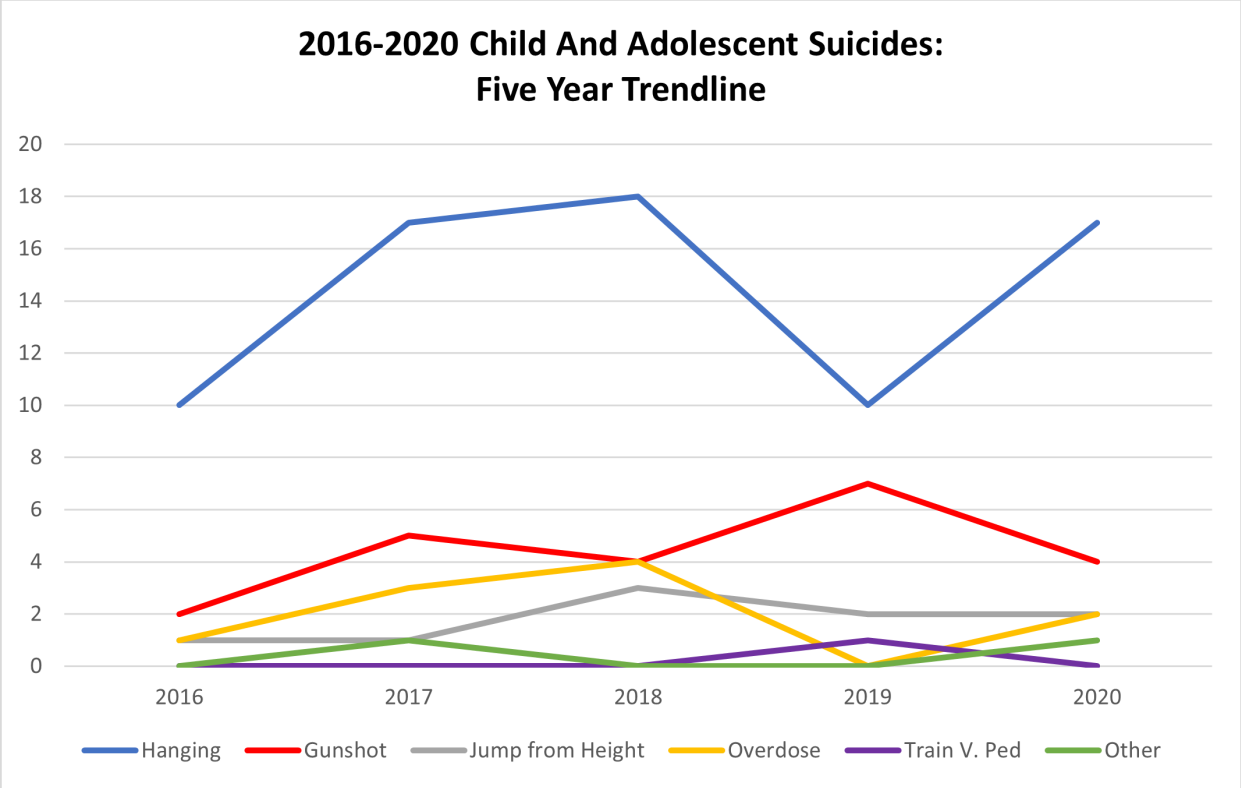
SUICIDES

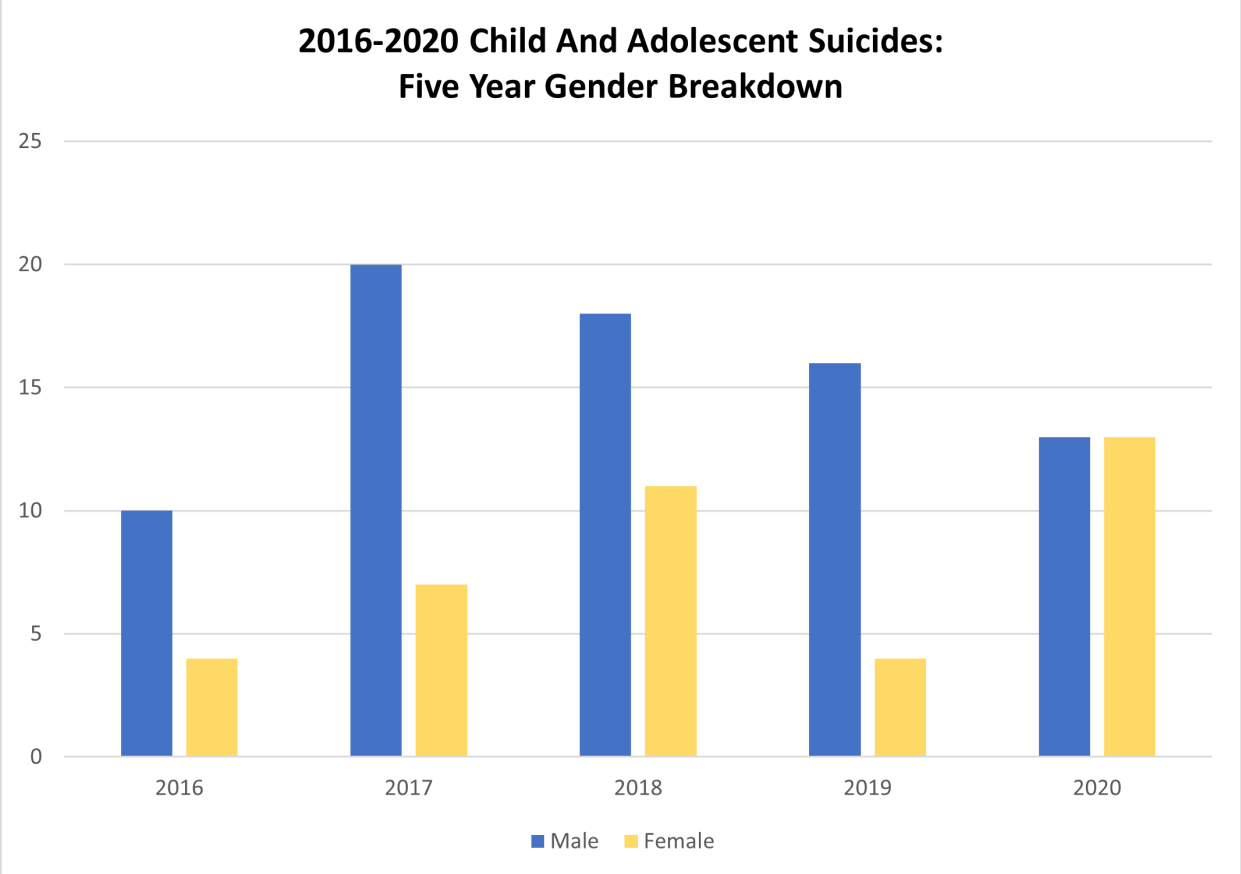
FINDINGS

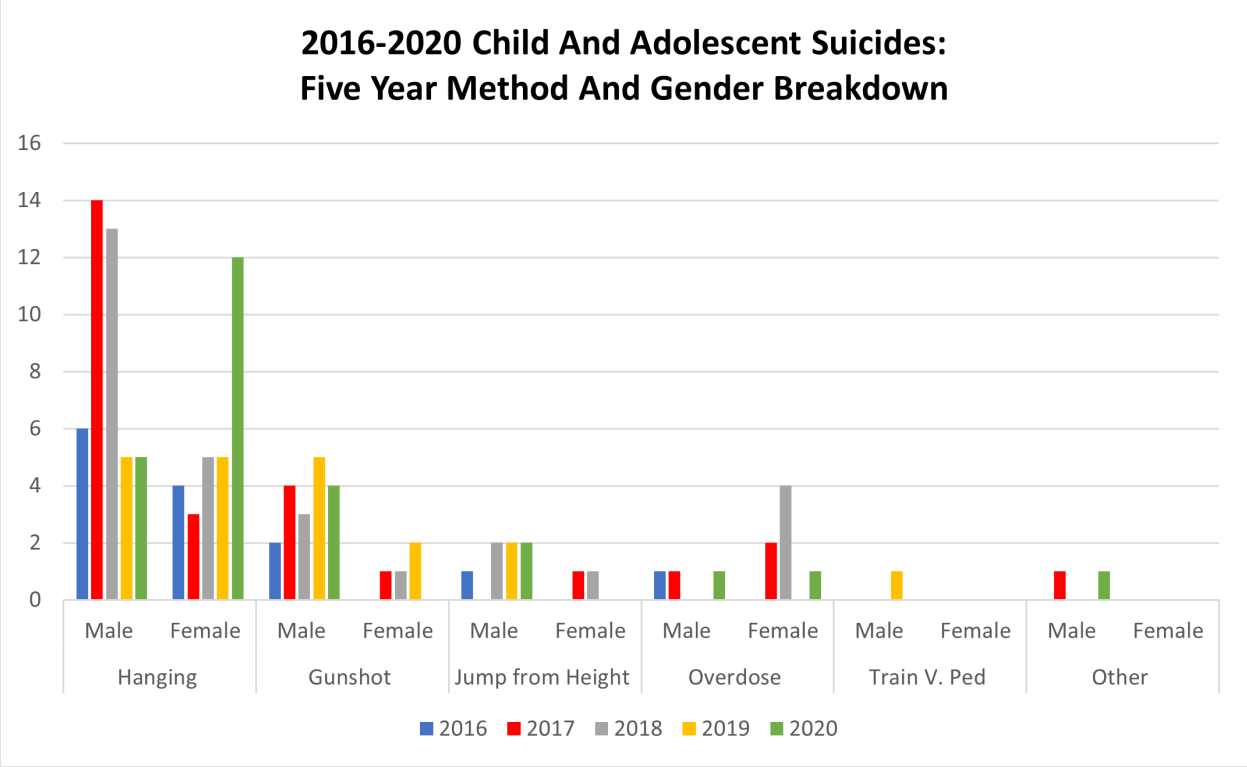
- Twenty-six child and adolescent suicides were reported to ICAN by the Coroner for 2020. This is a thirty percent increase from the 2019 number of twenty suicides and above the five-year average of twenty-three suicides.
- Sixty-five percent of the suicides in 2020 were the result of hanging (n=17) and fifteen percent were the result of gunshot wound (n=4). Eight percent of the suicides were from substance overdose (n=2) and eight percent were from jumping from a high place (n=2). One death was from the adolescent jumping in front of a vehicle.
- Death from hanging and gunshot wound continue to be the leading methods of suicide for children and adolescents. In the last five-years, sixty-one percent (n=69) of the suicides were from hanging and twenty-two percent (n=25) were from gunshot wound. Between the two, this accounts for eighty-three percent of all reported suicides.
- Hanging has increased fifteen percent as the method of suicide from 2019 and gunshot wound has decreased twenty percent.
- The gender divide for child and adolescent suicides in 2020 was equal between males and females. Given that, in 2019, eighty percent of the suicides were male – this is a considerably large increase for females. This fifty-fifty split for 2020 is below the five-year average for males of seventy percent and above the five-year average for females of thirty percent.
- As opposed to previous years where the leading age of suicide has been Seventeen-year-olds, in 2020, the largest age group was Thirteen year-olds (twenty-seven percent or n=7). For reference, in 2019, there was a single case of a fourteen-year-old death by suicide. In 2020, Sixteen-year-old adolescents were the second largest age group comprising twenty-three (n=6) percent of the suicides. Fourteen-year-olds were the next largest group (n=4). Between the large increase in the number of Fourteen-year-old and Thirteen-year-olds, 2020 saw a shift towards younger adolescents. The remaining age groups for 2020 are as follows: three Seventeen-year-olds, three Fifteen-year-olds, one Twelve-year-old, one Eleven-year-old, and one n=Nine-year-old.
- As in previous years, Hispanics and Caucasians comprised the two largest racial/ethnic groups for child and adolescents' suicides. However, unlike in 2019, there has been a decrease in African American suicides and an increase in Asian American suicides. Hispanics were forty-two percent (n=11), Caucasians were thirty-one percent (n=8), Asian Americans were fifteen percent (n=4), and African Americans were eight percent (n=2). One case did not have a racial/ethnic group listed.
- The five-year average for racial/ethnic groups 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 2020 slightly above the average for Hispanics, equal to the average for Caucasians and African Americans. The number of Asians, however, was higher than their five-year average.

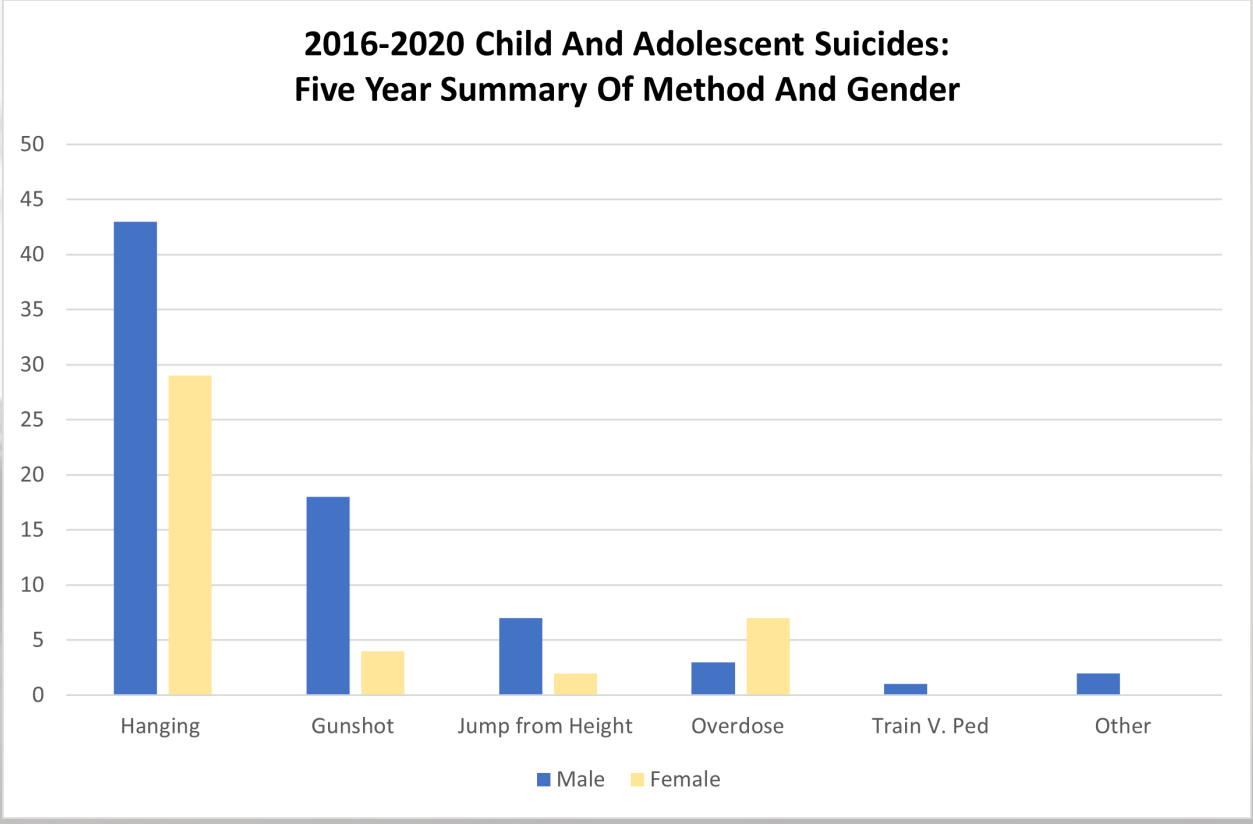

1989-2020 Child and Adolescent Suicides:
Total Deaths Per Year Trendline
50
45
40
35
30
25
20
15
10
5
0
36
28
23
26
44
28
11
36
20
15
27
23
27
19
19
13
15
14
10
17
14
16
19
17
13
10
23
14
27
29
20
26
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020

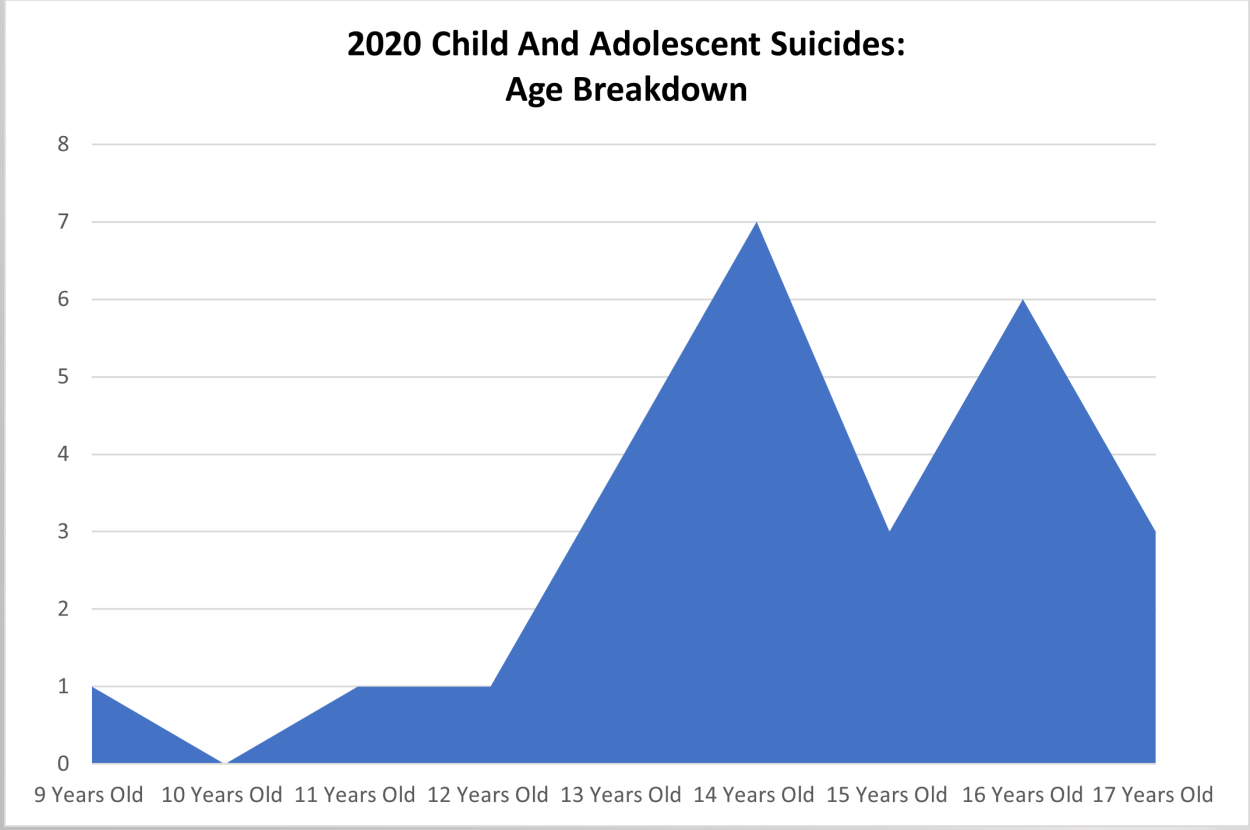

2016-2020 Child And Adolescent Suicides:
Five Years Breakdown Of Methods
35
30
25
20
15
10
5
0
2016
2017
2018
2019
2020
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Other

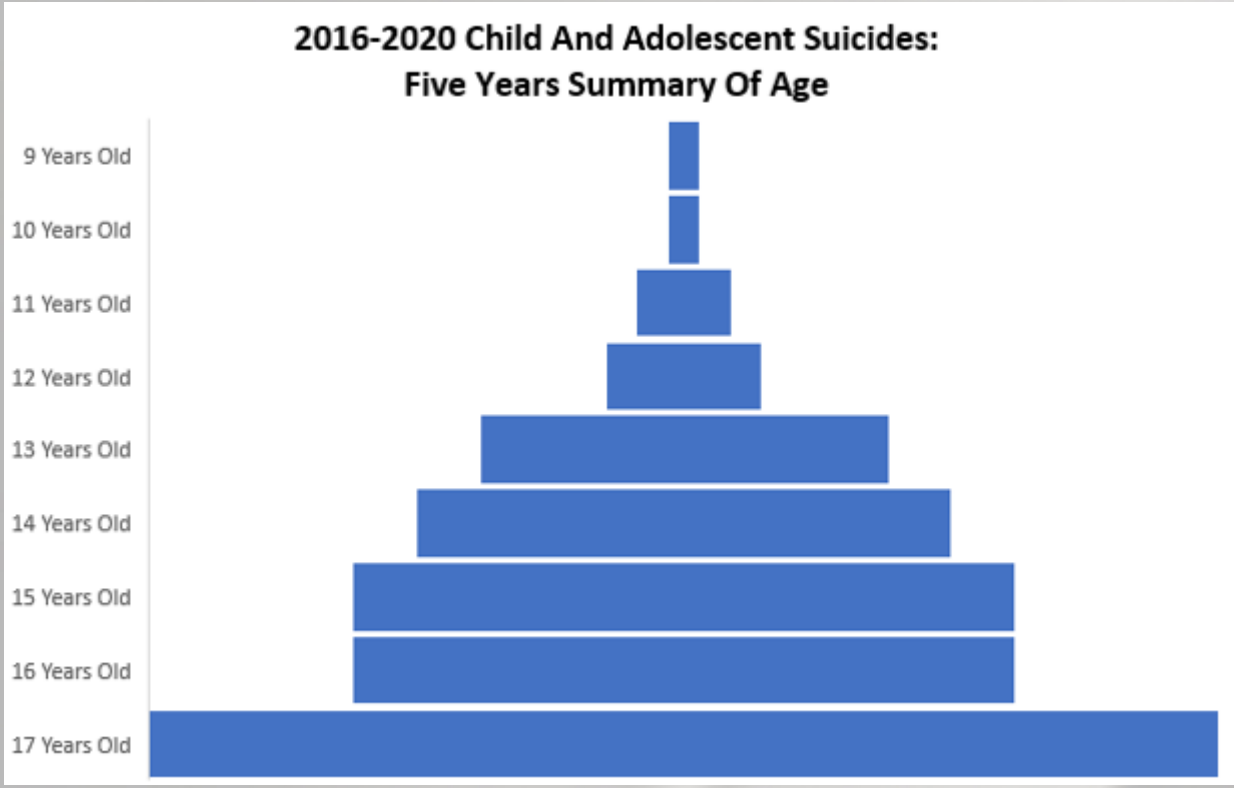

2016-2020 Child And Adolescent Suicides:
Five Year Trendline
20
18
16
14
12
10
8
6
4
2
0
2016
2017
2018
2019
2020
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Other

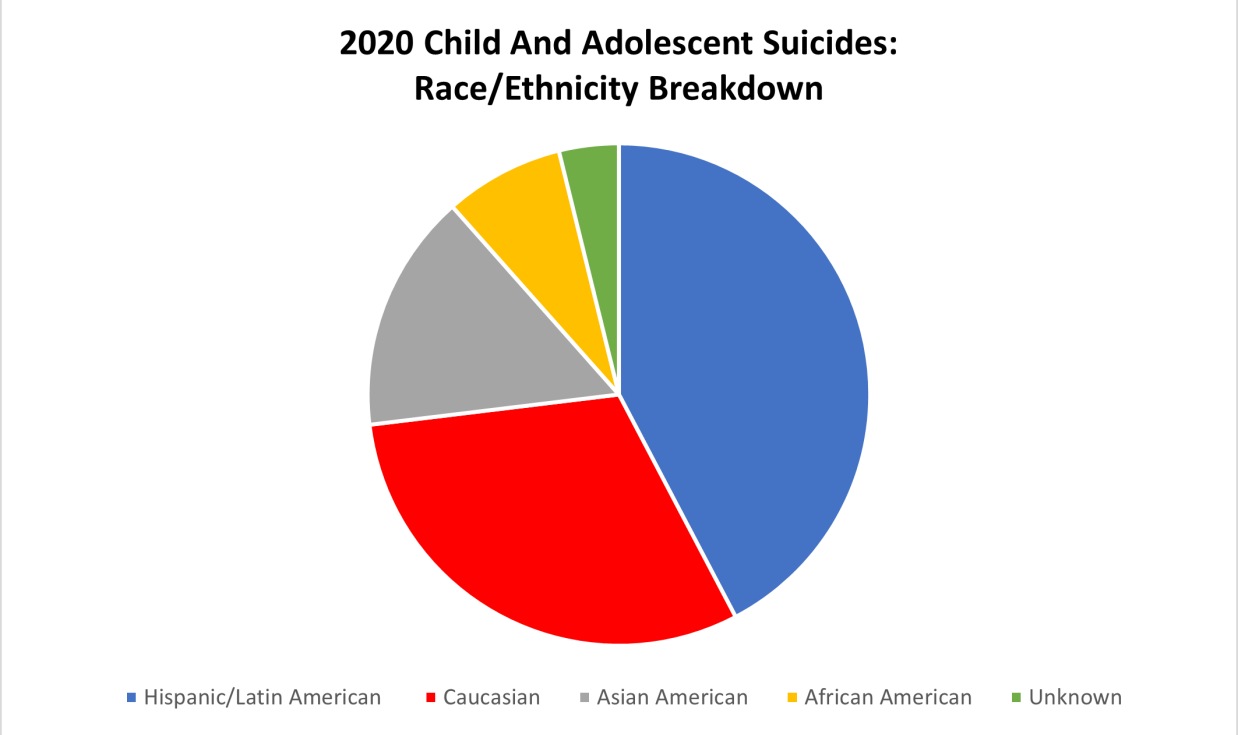

2016-2020 Child And Adolescent Suicides:
Five Year Gender Breakdown
25
20
15
10
5
0
2016
2017
2018
2019
2020
Male
Female

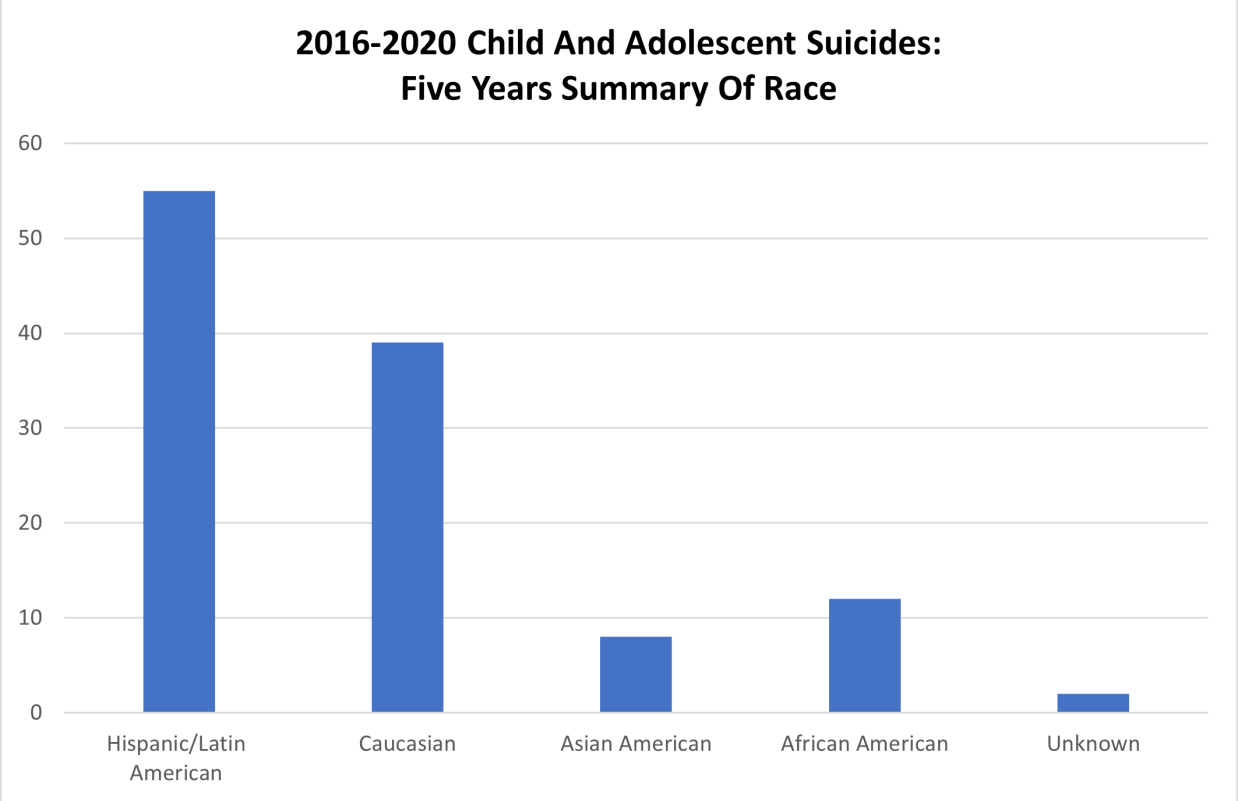

2016-2020 Child And Adolescent Suicides:
Five Year Method And Gender Breakdown
16
14
12
10
8
6
4
2
0
Male
Female
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Other
2016
2017
2018
2019
2020

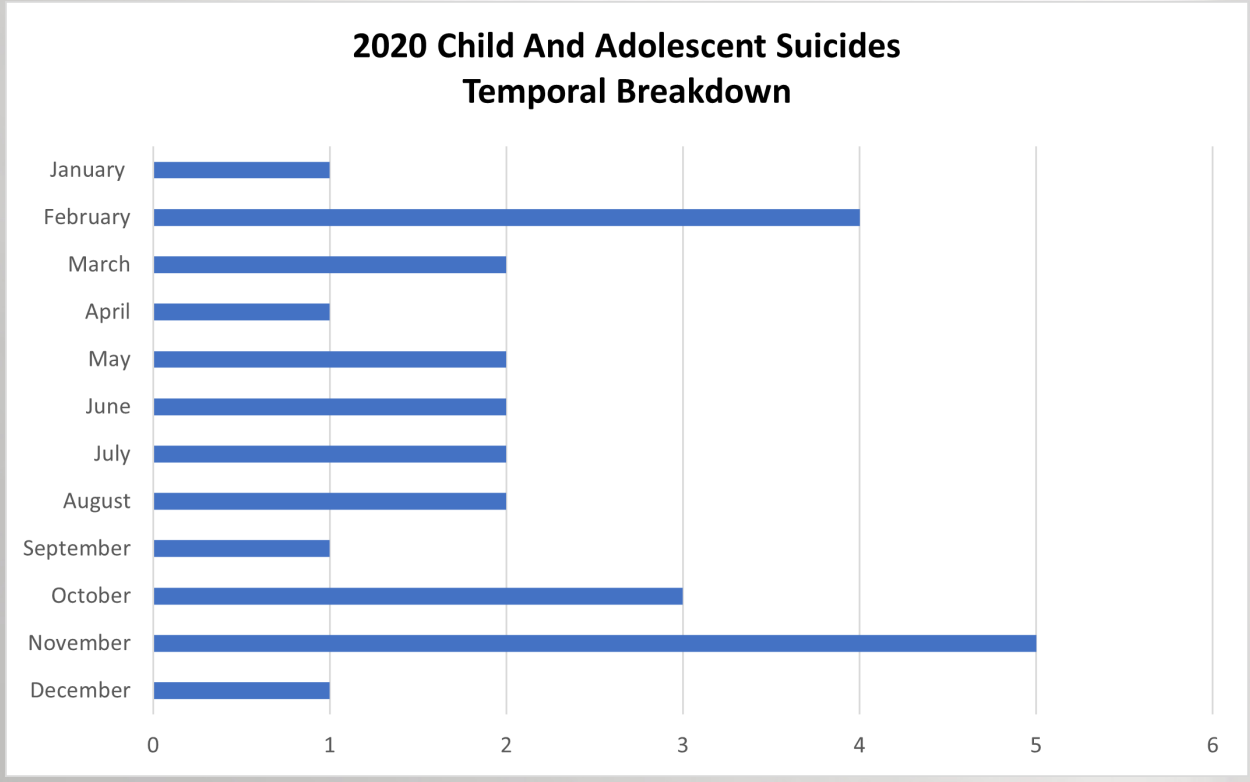

2016-2020 Child And Adolescent Suicides:
Five Year Summary Of Method And Gender
50
45
40
35
30
25
20
15
10
5
0
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Other
Male
Female

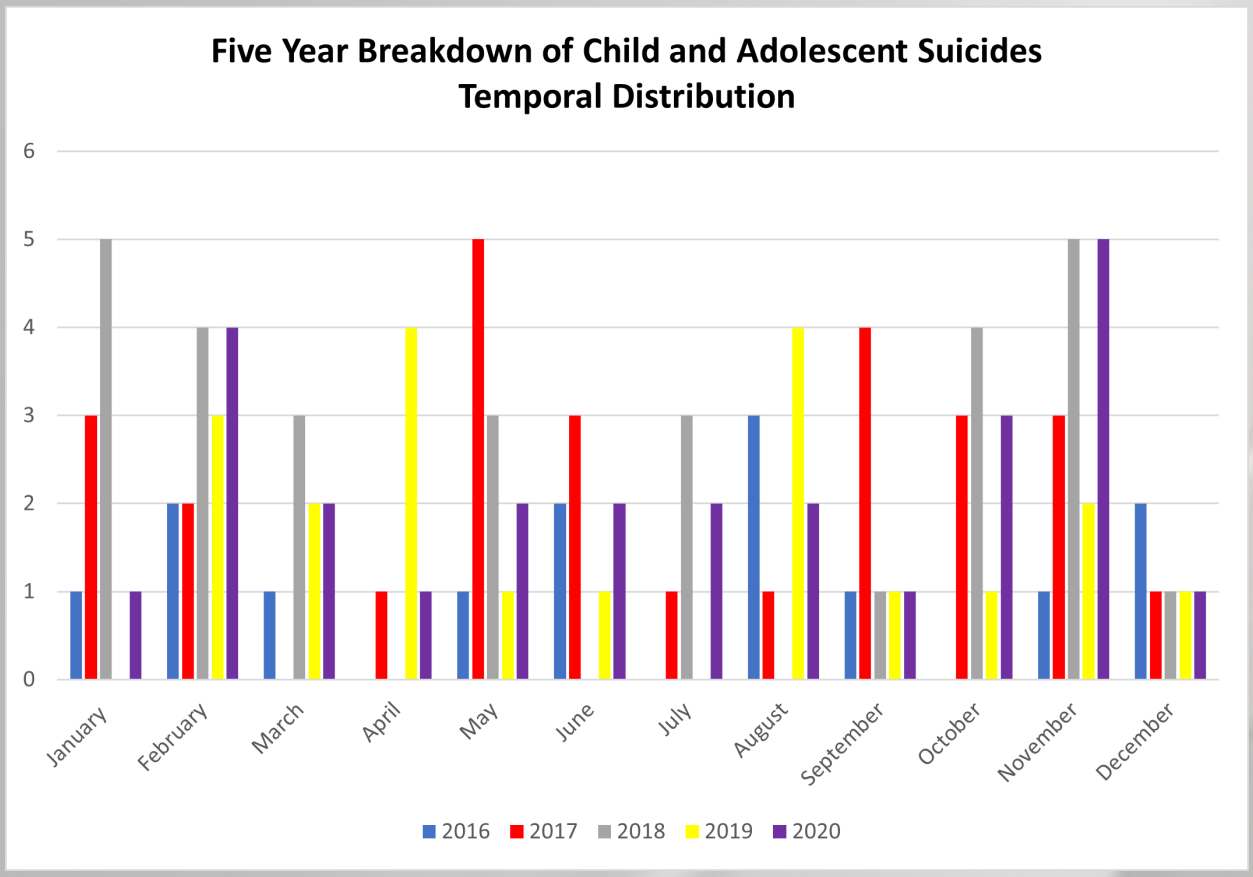

2020 Child And Adolescent Suicides:
Age Breakdown
8
7
6
5
4
3
2
1
0
9 Years Old
10 Years Old
11 Years Old
12 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old


2016-2020 Child And Adolescent Suicides:
Five Years Summary Of Age
9 Years Old
10 Years Old
11 Years Old
12 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old


2020 Child And Adolescent Suicides:
Race/Ethnicity Breakdown
Hispanic/Latin American
Caucasian
Asian American
African American
Unknown

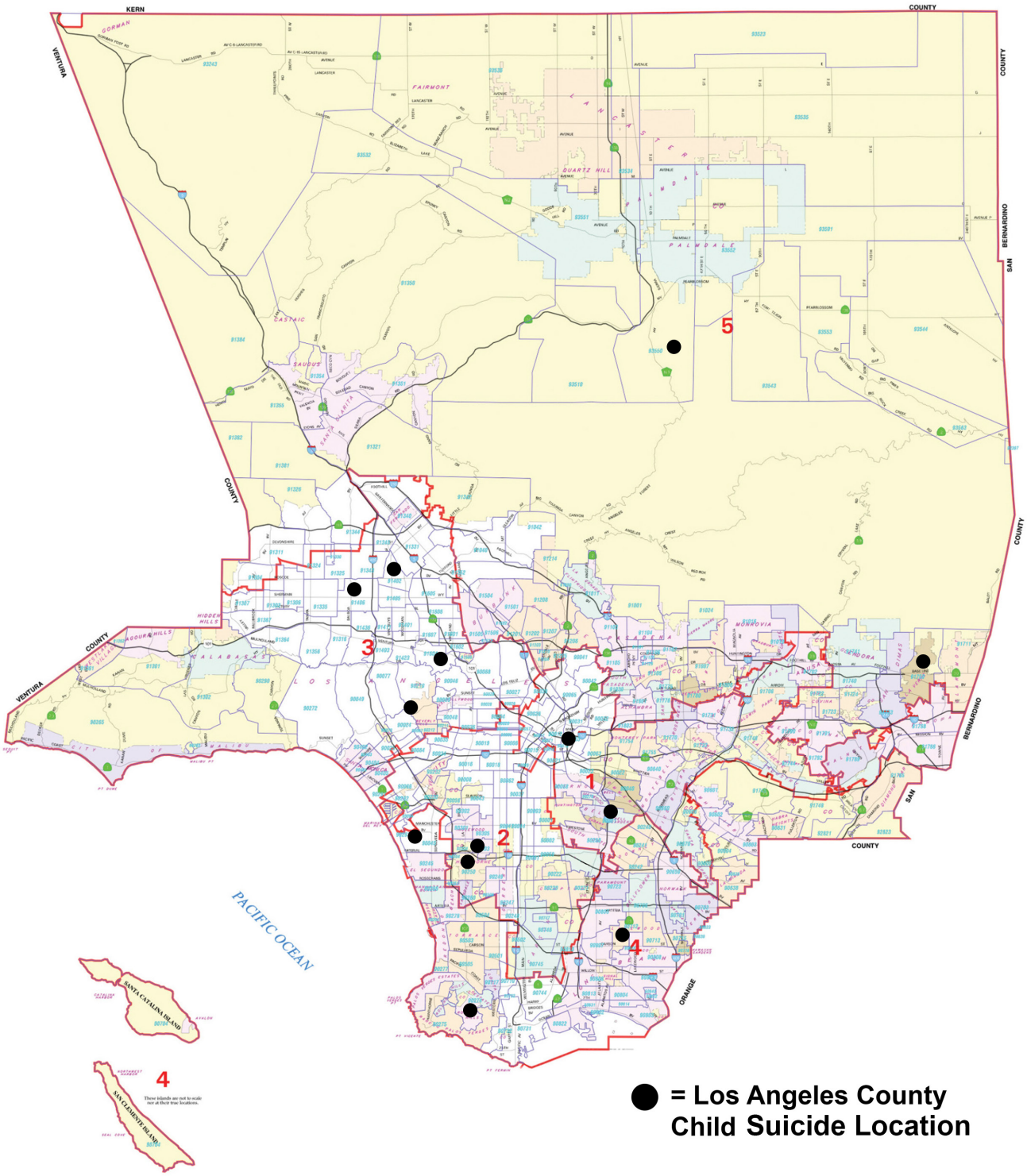

2016-2020 Child And Adolescent Suicides:
Five Years Summary Of Race
60
50
40
30
20
10
0
Hispanic/Latin American
Caucasian
Asian American
African American
Unknown


2020 Child And Adolescent Suicides
Temporal Breakdown
January
February
March
April
May
June
July
August
September
October
November
December
0
1
2
3
4
5
6


Five Year Breakdown of Child and Adolescent Suicides
Temporal Distribution
6
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December
2016
2017
2018
2019
2020

2020 Child Suicides - Locations
n = 13*

City where the suicide occurred



Sample Case Summaries - Accidents

Shylo

Mother of Shylo, age 4 was involved in an auto accident. Shylo along with her three siblings were in the vehicle with mother. Shylo was in critical condition and her siblings had minor injuries. When paramedics arrived at the scene Shylo was unconscious and not breathing. Shylo was air-lifted to the hospital. Mother was injured and required surgery. A LAPD vehicle observed the mother's vehicle driving 70-80 mph. As the LAPD vehicle attempted to make a U-turn to conduct a traffic stop, they observed the mother's vehicle crossing over into oncoming traffic and colliding head on with another SUV. Police personnel responded to the collision and observed that none of the passengers were restrained. The windshield was cracked and two of the children may have struck it. All the children were badly injured, including lacerations, broken ribs, and internal injuries. Shylo had the most life-threatening injuries and did not survive the accident despite all medical interventions possible. Homicide charges were presented to the district attorney for the mother who had a BAC (Blood Alcohol Concentration) level of 0.18.

Terry

Terry, age 13, was performing skating tricks while skating down a hill when the skateboard slipped out from underneath him, and he fell back. Terry was not wearing a helmet. He was taken to the hospital by paramedics where it was found that he had a hematoma, to be bleeding from the right ear, his pupils had a right gaze, and he had decerebrate posture and snoring respirations. Terry was transported to LAC+USC Medical Center; he was intubated, and immediately taken to the operating room for decompression and hematoma evacuation. Multiple skull base fractures including a right temporal bone fracture were found. Despite all efforts, Terry experienced multiorgan failure and brain death. His family made the decision for a compassionate extubation.

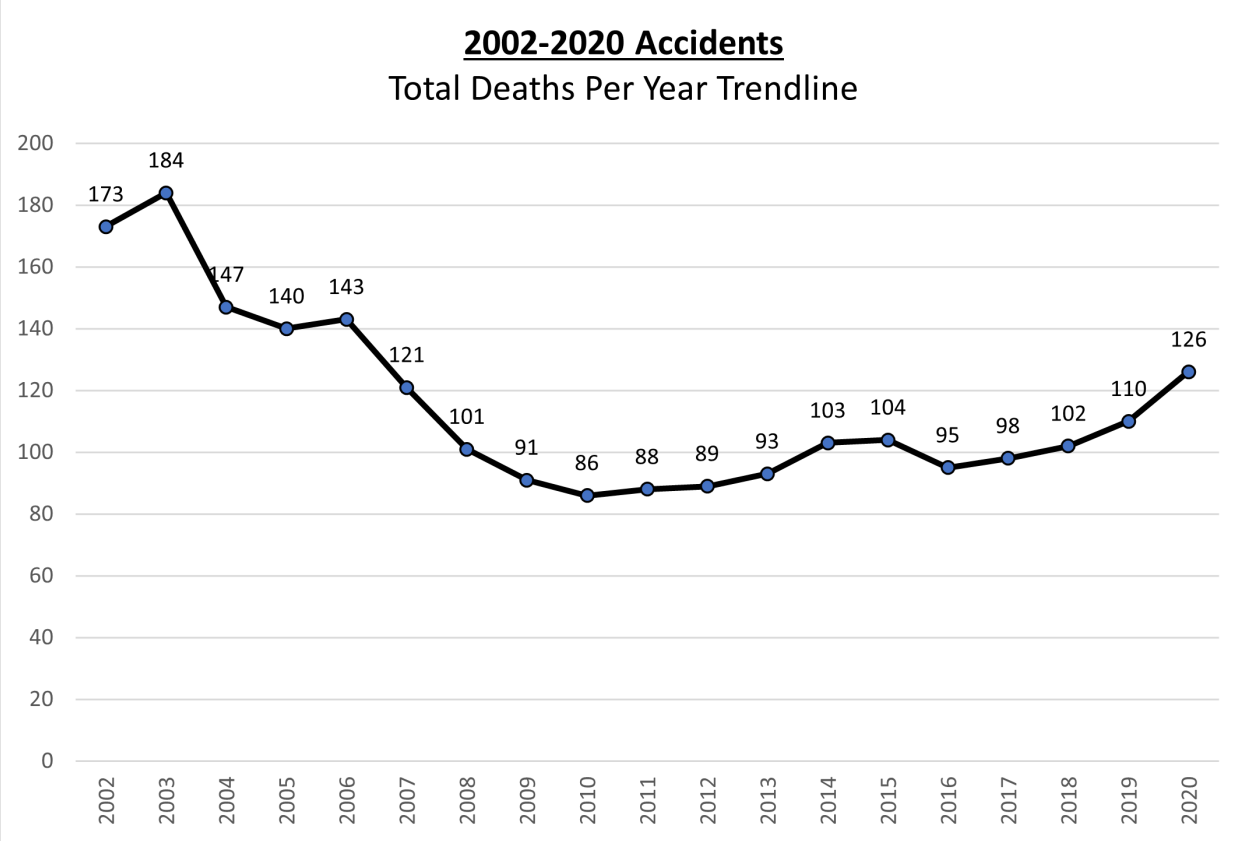
Jesse

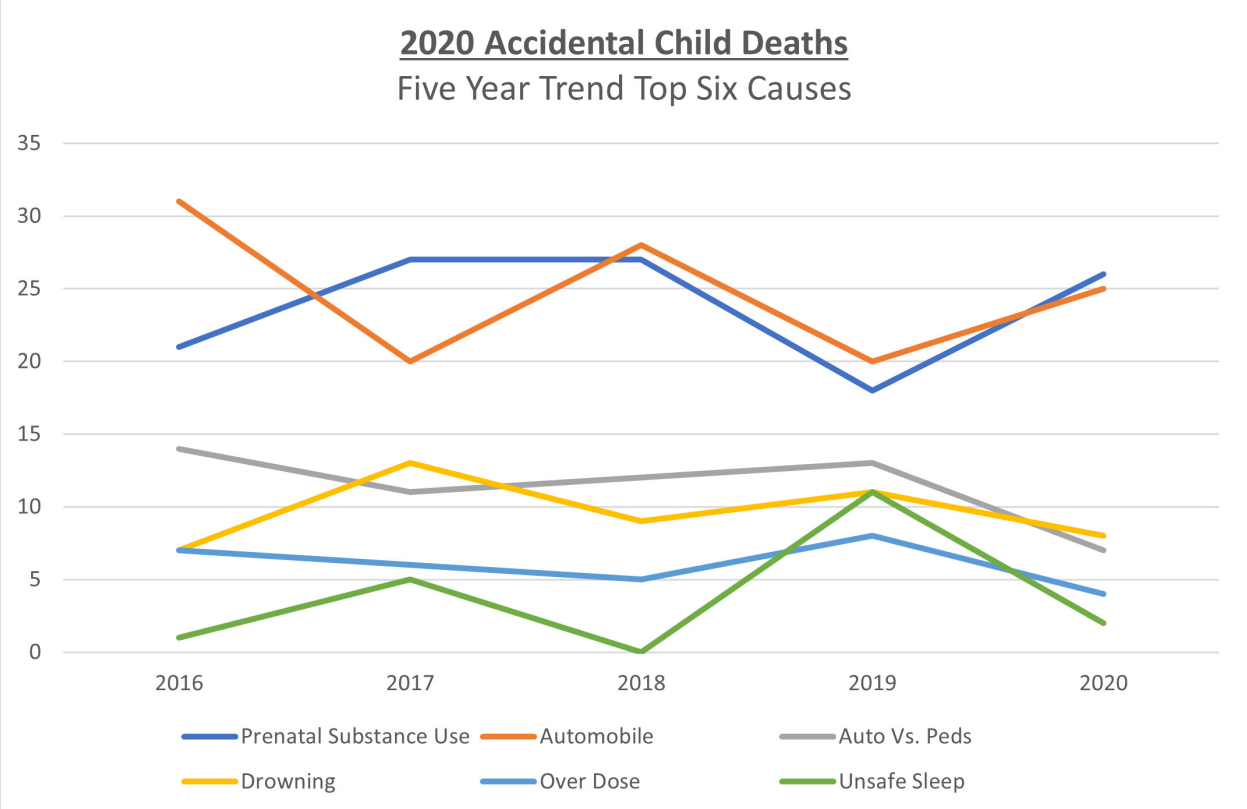
Eleven-year-old Jesse lived near a street where cars often illegally race. Jesse was crossing this street during daytime hours when two cars illegally racing hit Jesse and he flew in the air and landed on his head as witnesses described. Paramedics were called and he was pronounced dead at the scene.

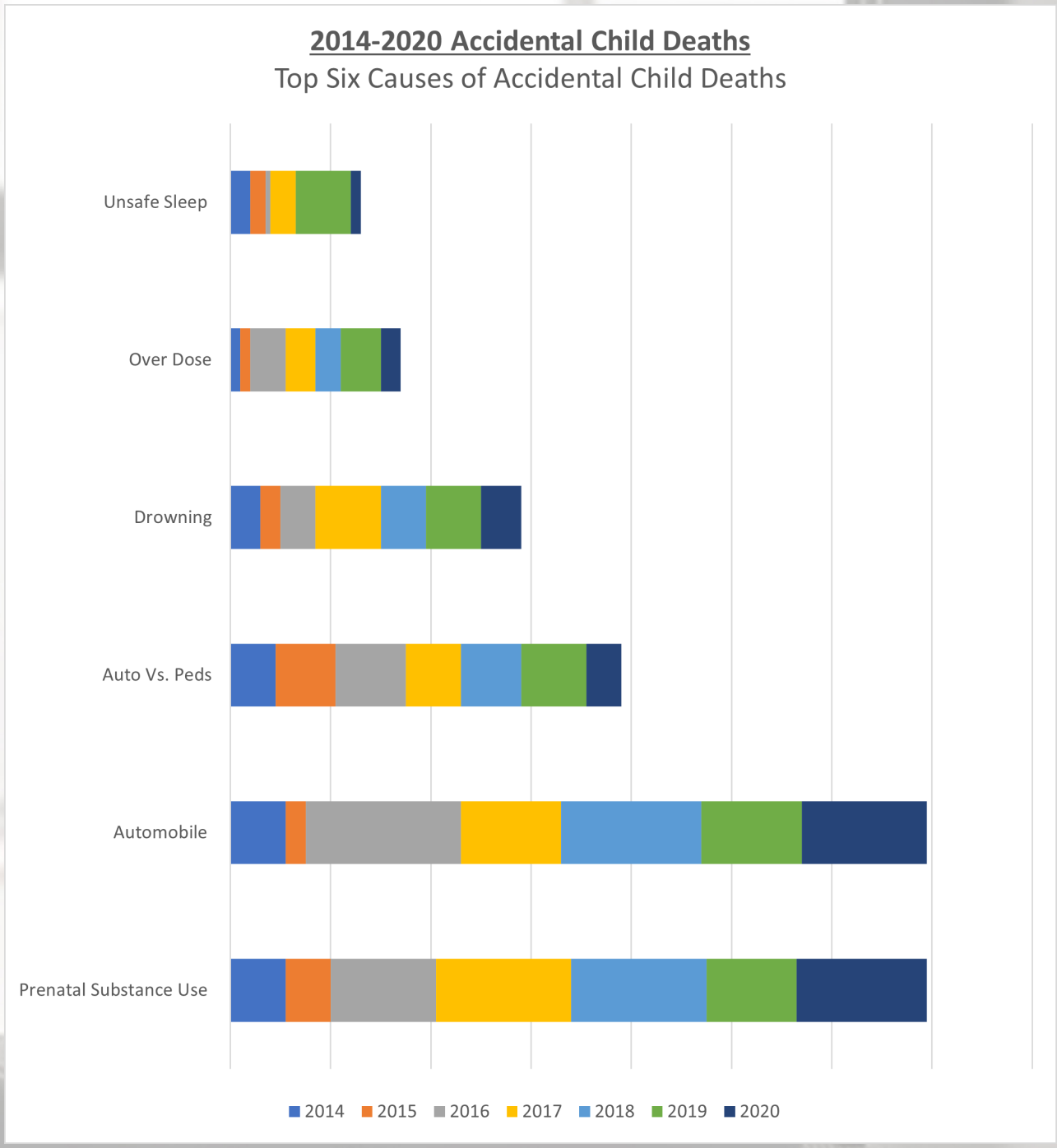
ACCIDENTS

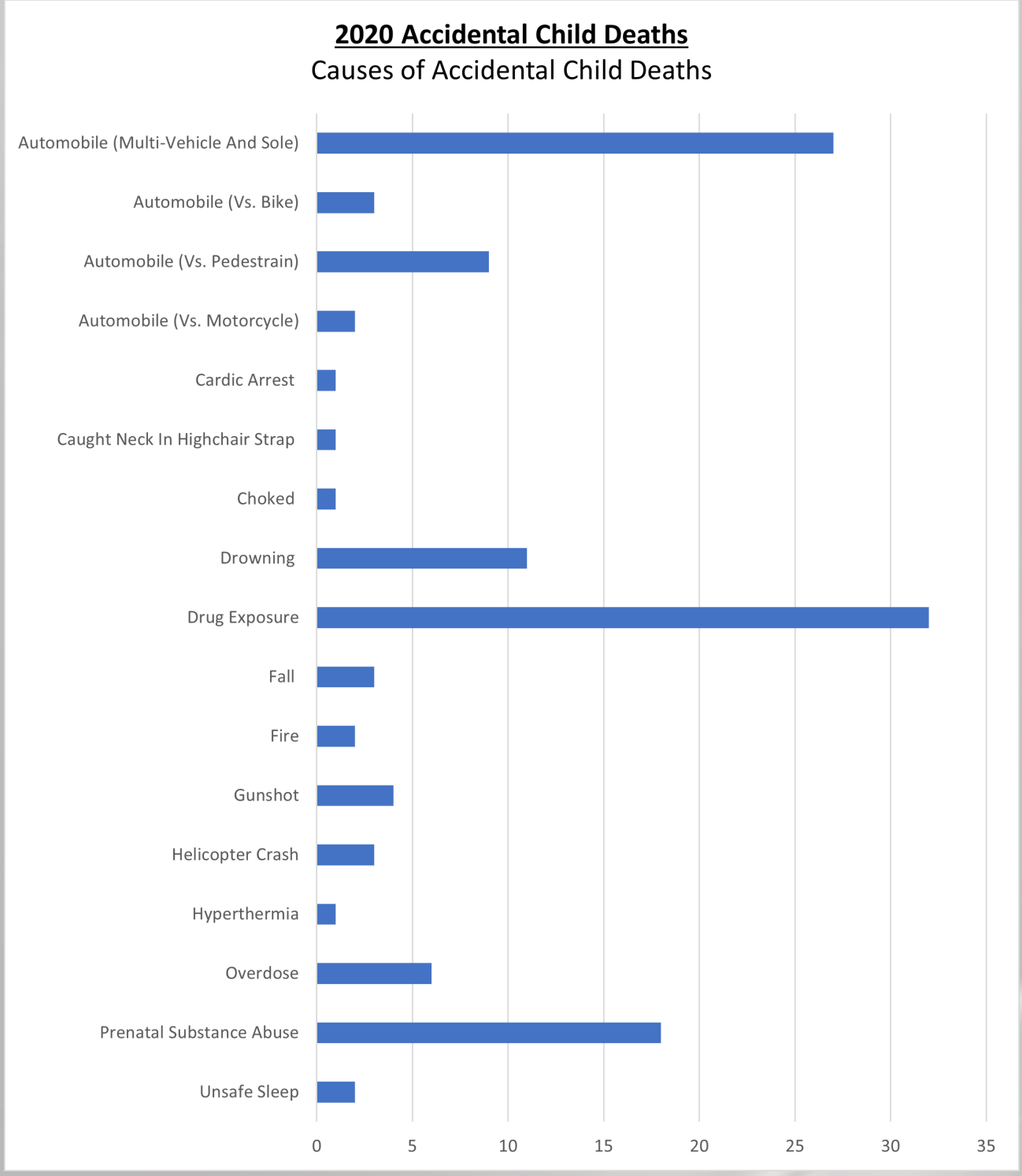
FINDINGS

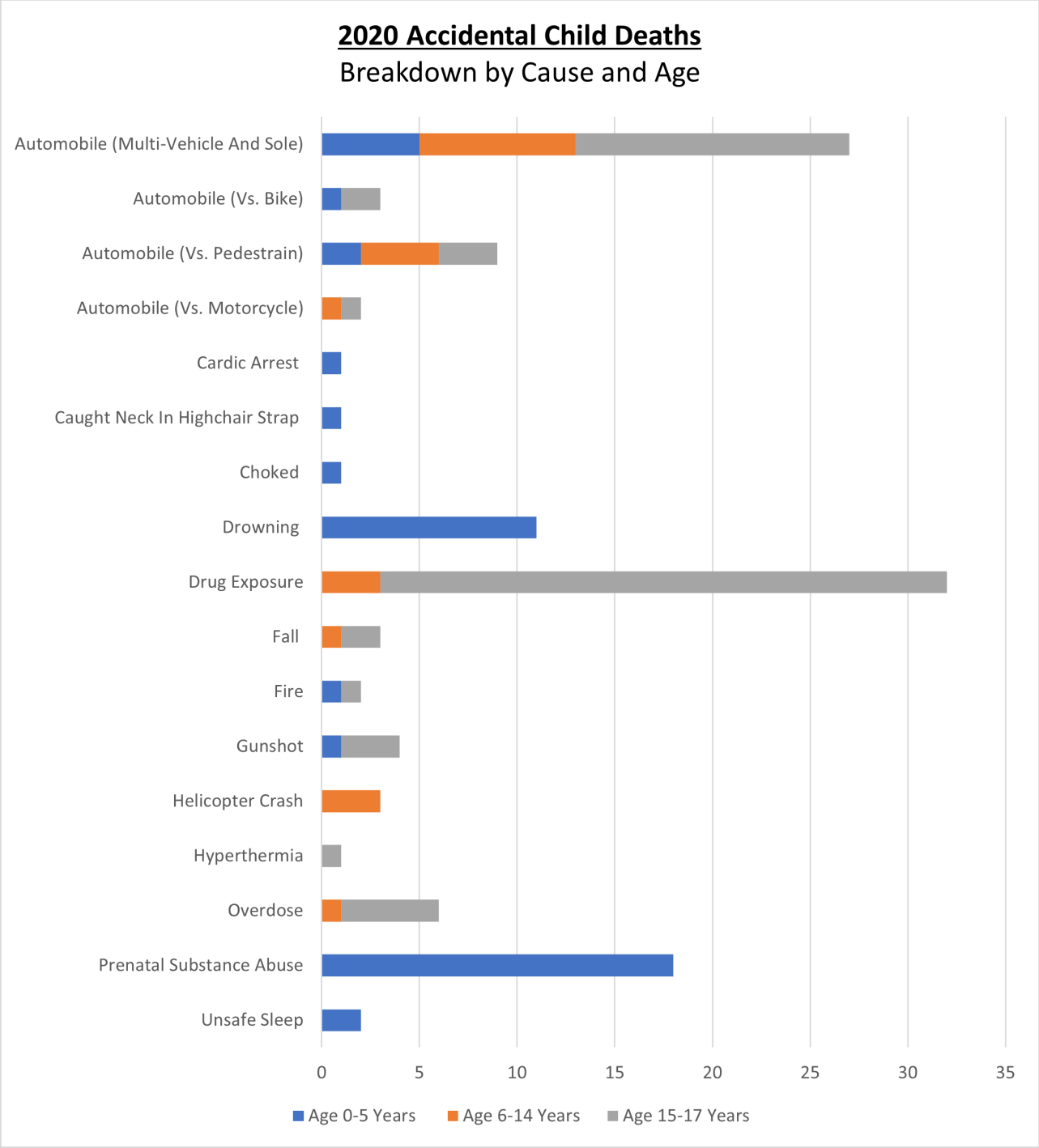
- One hundred and twenty-six accidental child deaths were reported to ICAN by the Coroner for 2020. This is a 13% increase from the 2019 number of one hundred ten deaths and it is also above the five-year average of one hundred deaths per year. This is also the highest number of accidental child deaths in thirteen years (since 2007) and reflects an upward five-year trend in this mode of death.
- In the prior years, automobile death and prenatal substance abuse have been the leading causes of accidental child death. In 2020, automobile deaths made up 25% and accidental overdose 22% representing the leadings causes of the accidental child deaths. These two types of death are followed by Substance abuse (21%), Drowning (8%), Other (7%), and Auto vs pedestrian (6%).
- Over one third (38%) of the accidental child deaths happened to children less than one-year-old. Fifty-four percent of these children were the result of prenatal substance abuse, and the remaining forty-six percent were the result of several different causes. The next largest age group was seventeen-year-old children who made up 22% of the accidental child deaths. In this seventeen-year-old age group, the number one cause of death was drug overdose (51%) followed by automobile accident (34%)
- The majority (50%) of accidental child deaths were children of Hispanic/Latin background. The next highest was Caucasian who made up a quarter (19%) of the deaths. This is consistent/slightly above the six-year average (which is 48% for Hispanics and 24% for Caucasians) which continues the trend of Hispanics and Caucasian children being the predominant victims of this mode of death.
- Children dying in an automobile accident, either as a driver or as 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 old. In 2020, the demographics are slightly more female than male (60% female vs. 40% male) and majority Hispanic (65%). In nearly all of these cases (19 of the 20 deaths), the child was the passenger in the vehicle and not the driver.
- Twenty-eight children died of prenatal substance abuse in 2020 – a sixty-four percent increase from last year. The number one drug was methamphetamine, which as the sole cause of abuse, made up eighty-nine percent in 2020. This is consistent with the last six years where methamphetamine continues to be the number one illicit drug in prenatal substance abuse deaths. Caucasians and Hispanic/Latin Americans also continue to be over-represented given their population in the County and matched as the highest group that suffered a child loss due to prenatal drug use. Seventy-eight of the prenatal substance abuse deaths were from families with a Department of Children and Family Services history. This is also consistent within the last six years where most of these cases were from families with such history.

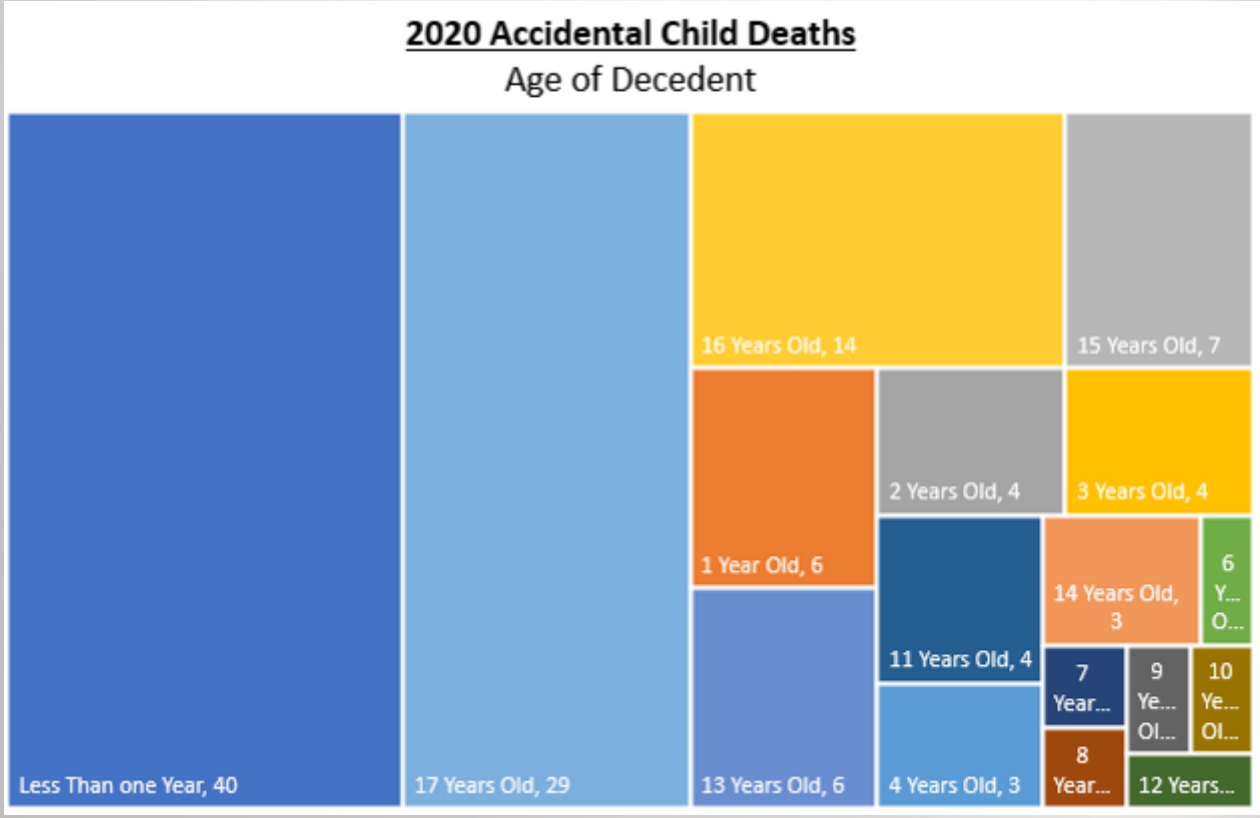

2002-2020 Accidents
Total Deaths Per Year Trendline
200
180
160
140
120
100
80
60
40
20
0
173
184
147
140
143
121
101
91
86
88
89
93
103
104
95
98
102
110
126
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020

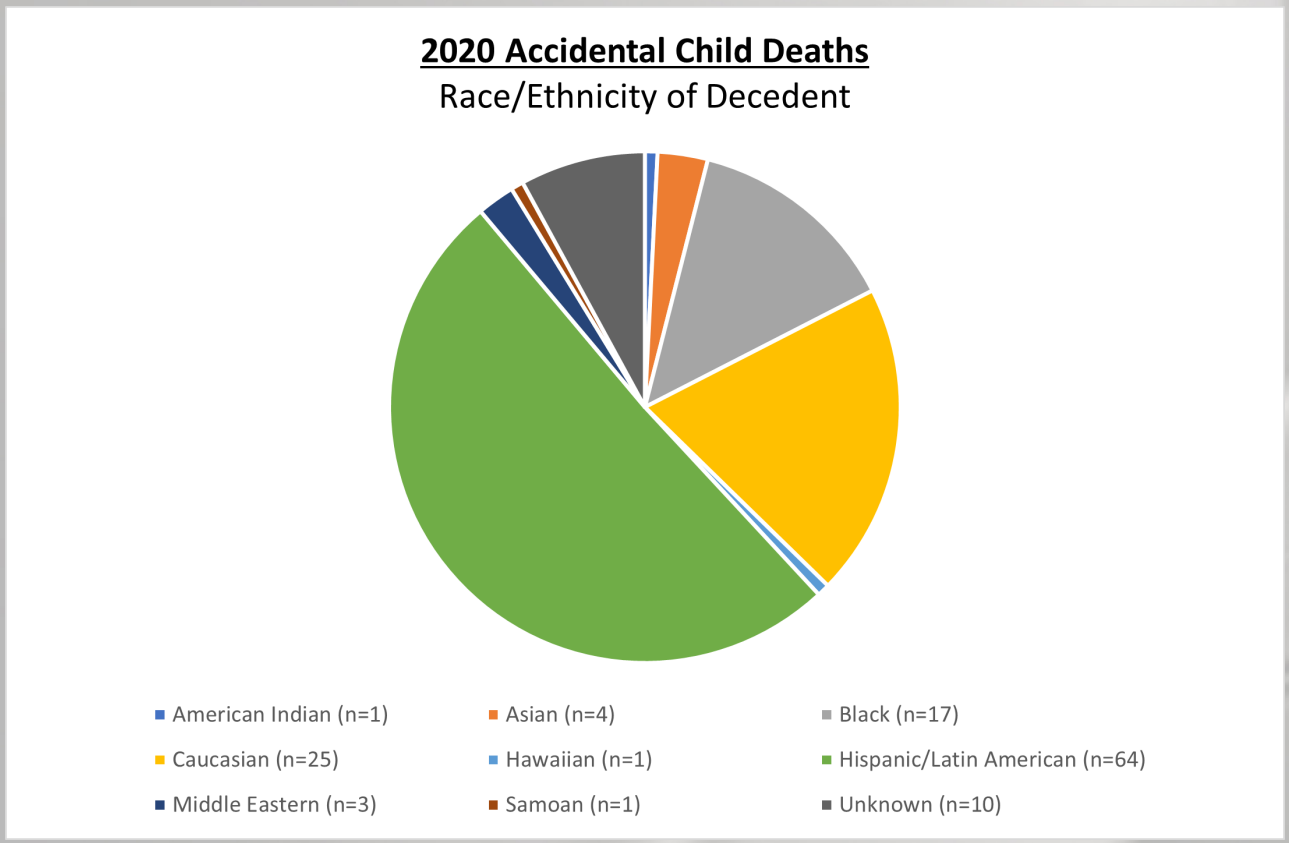

2020 Accidental Child Deaths
Five Year Trend Top Six Causes
35
30
25
20
15
10
5
0
2016
2017
2018
2019
2020
Prenatal Substance Use
Automobile
Auto Vs. Peds
Drowning
Over Dose
Unsafe Sleep

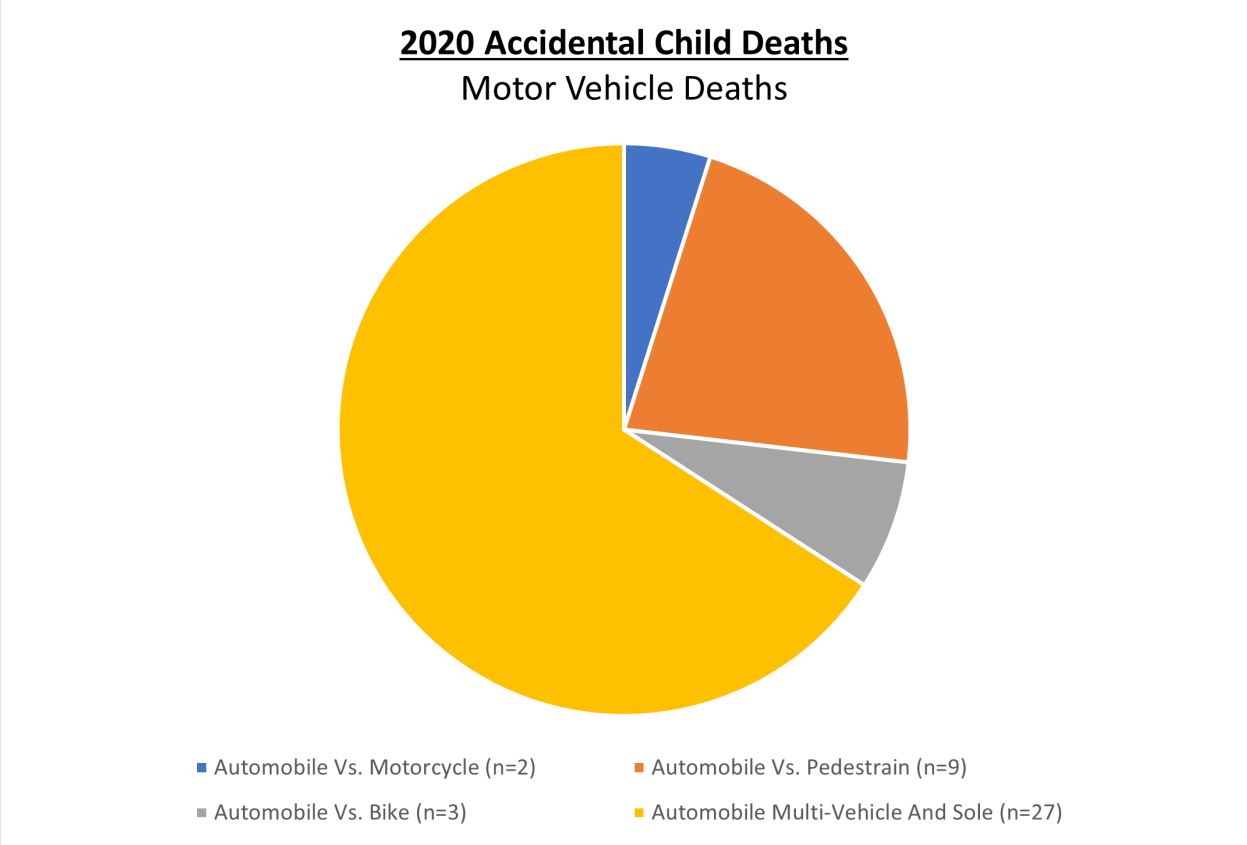

2014-2020 Accidental Child Deaths
Top Six Causes of Accidental Child Deaths
Unsafe Sleep
Over Dose
Drowning
Auto Vs. Peds
Automobile
Prenatal Substance Use
2014
2015
2016
2017
2018
2019
2020

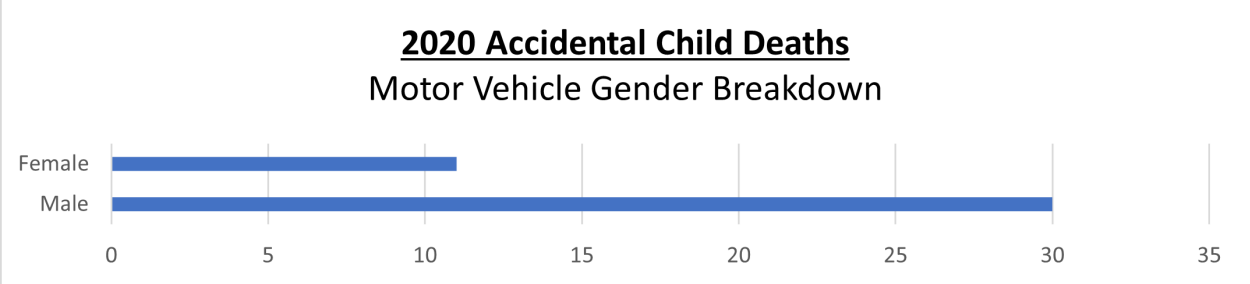

2020 Accidental Child Deaths
Causes of Accidental Child Deaths
Automobile (Multi-Vehicle And Sole)
Automobile (Vs. Bike)
Automobile (Vs. Pedestrain)
Automobile (Vs. Motorcycle)
Cardic Arrest
Caught Neck In Highchair Strap
Choked
Drowning
Drug Exposure
Fall
Fire
Gunshot
Helicopter Crash
Hyperthermia
Overdose
Prenatal Substance Abuse
Unsafe Sleep
0
5
10
15
20
25
30
35

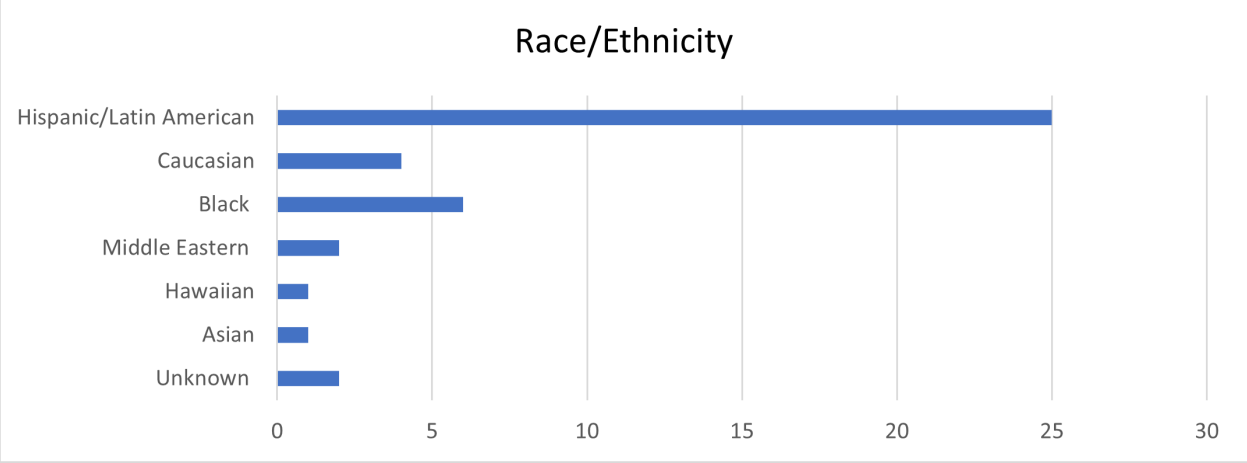

2020 Accidental Child Deaths
Breakdown by Cause and Age
Automobile (Multi-Vehicle And Sole)
Automobile (Vs. Bike)
Automobile (Vs. Pedestrain)
Automobile (Vs. Motorcycle)
Cardic Arrest
Caught Neck In Highchair Strap
Choked
Drowning
Drug Exposure
Fall
Fire
Gunshot
Helicopter Crash
Hyperthermia
Overdose
Prenatal Substance Abuse
Unsafe Sleep
0
5
10
15
20
25
30
35
Age 0-5 Years
Age 6-14 Years
Age 15-17 Years

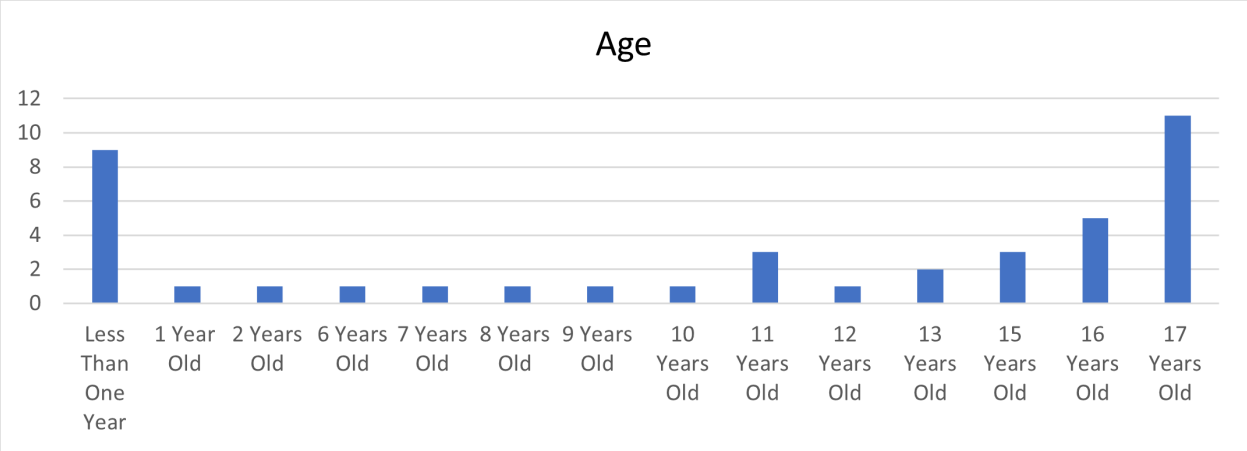

2020 Accidental Child Deaths
Age of Decedent
Less Than one Year, 40
17 Years Old, 29
13 Years Old, 6
4 Years Old, 3
11 Years Old, 4
1 Year Old, 6
16 Years Old, 14
2 Years Old, 4
15 Years Old, 7
3 Years Old, 4
14 Years Old, 3
6 Y... O...
7 Year...
9 Ye... Ol...
10 Ye... Ol...
8 Year...
12 Years...

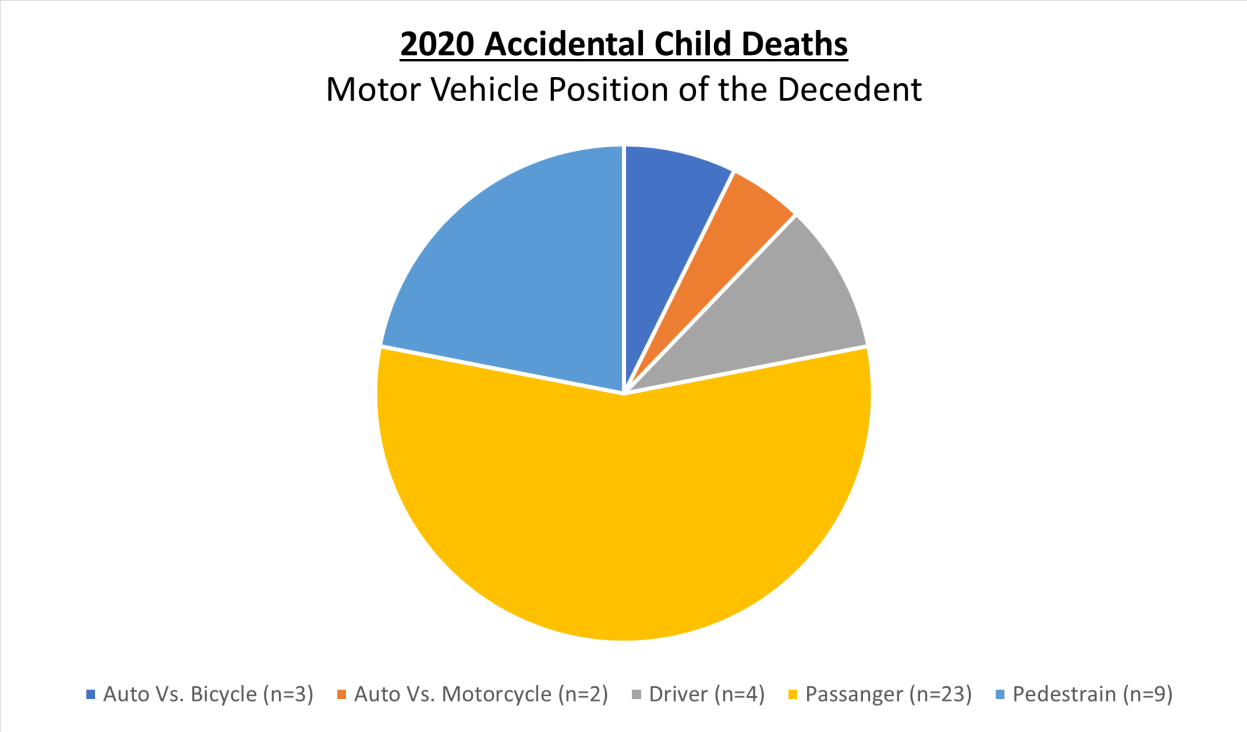

2020 Accidental Child Deaths
Race/Ethnicity of Decedent
American Indian (n=1)
Asian (n=4)
Black (n=17)
Caucasian (n=25)
Hawaiian (n=1)
Hispanic/Latin American (n=64)
Middle Eastern (n=3)
Samoan (n=1)
Unknown (n=10)

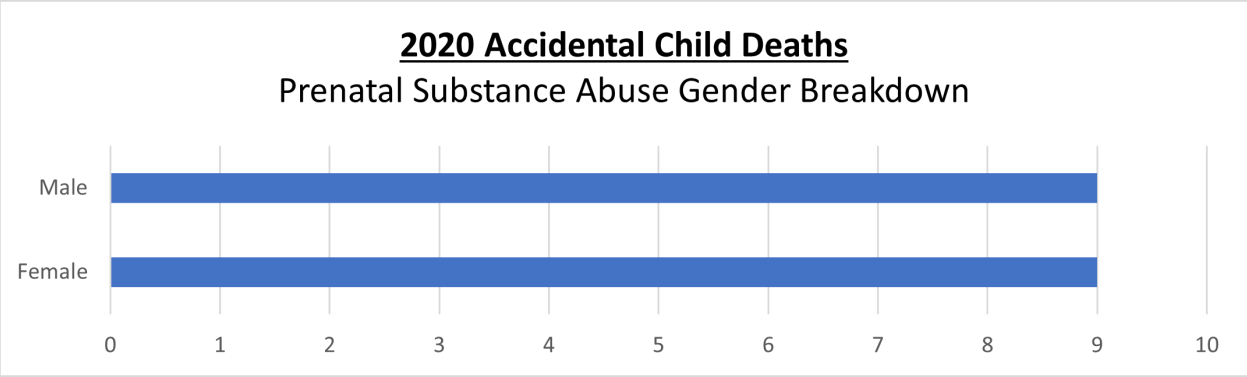

2020 Accidental Child Deaths
Motor Vehicle Deaths
Automobile Vs. Motorcycle (n=2)
Automobile Vs. Pedestrain (n=9)
Automobile Vs. Bike (n=3)
Automobile Multi-Vehicle And Sole (n=27)

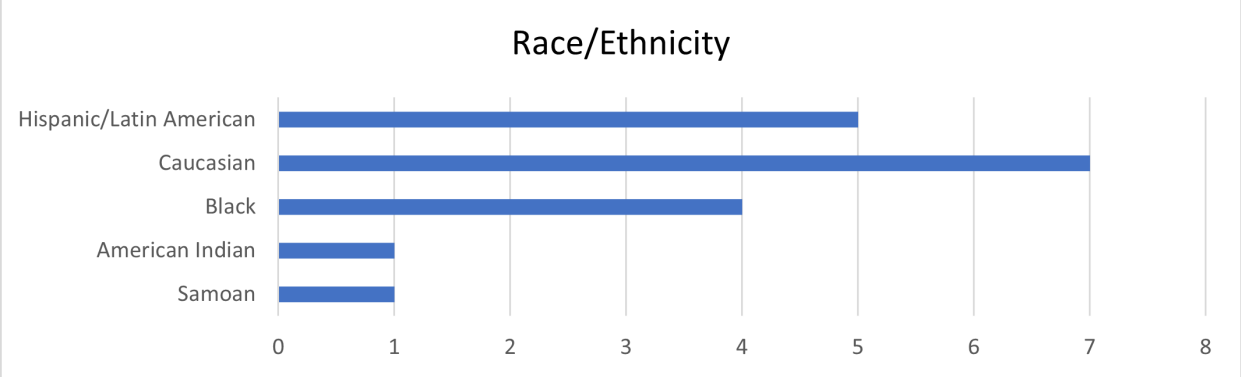

2020 Accidental Child Deaths
Motor Vehicle Gender Breakdown
Female
Male
0
5
10
15
20
25
30
35

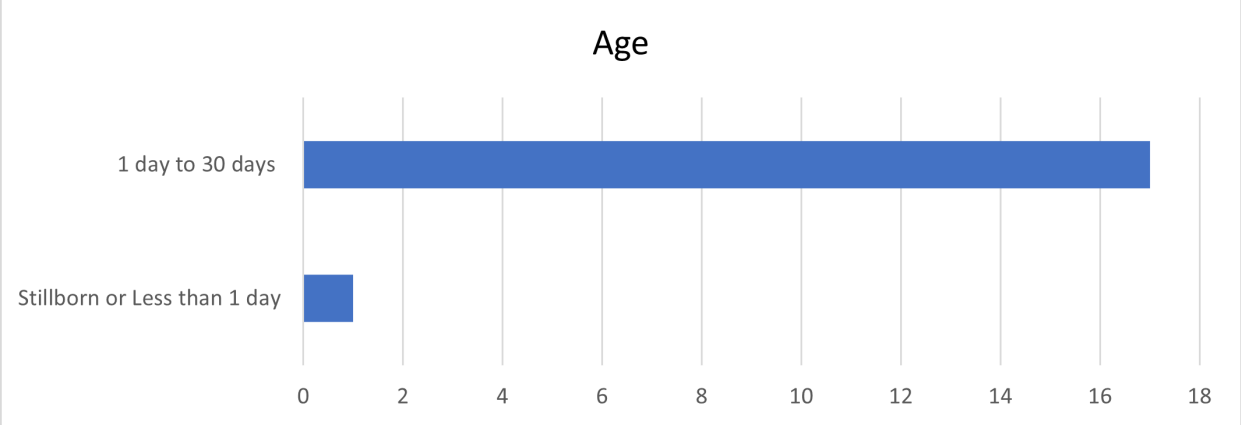

Race/Ethnicity
Hispanic/Latin American
Caucasian
Black
Middle Eastern
Hawaiian
Asian
Unknown
0
5
10
15
20
25
30

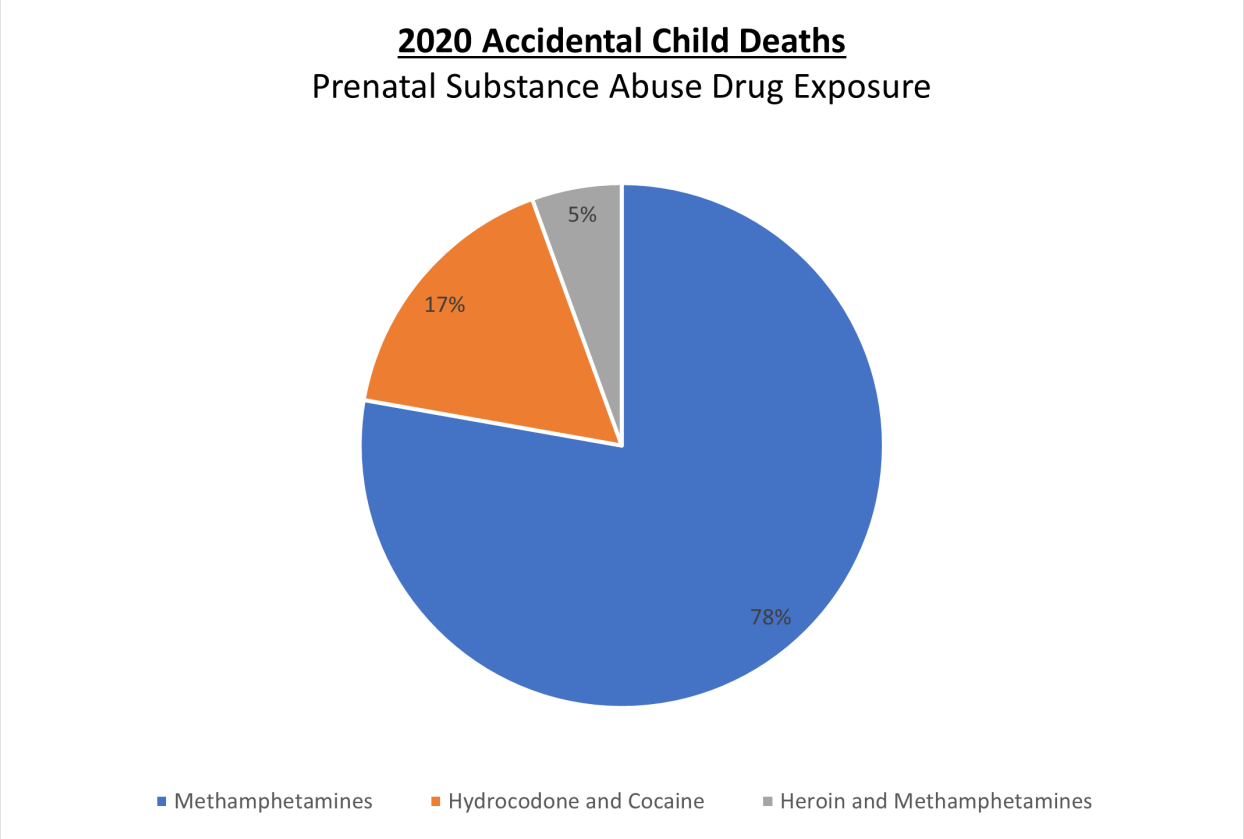

Age
12
10
8
6
4
2
0
Less Than One Year
1 Year Old
2 Years Old
6 Years Old
7 Years Old
8 Years Old
9 Years Old
10 Years Old
11 Years Old
12 Years Old
13 Years Old
15 Years Old
16 Years Old
17 Years Old


2020 Accidental Child Deaths
Motor Vehicle Position of the Decedent
Auto Vs. Bicycle (n=3)
Auto Vs. Motorcycle (n=2)
Driver (n=4)
Passanger (n=23)
Pedestrain (n=9)


2020 Accidental Child Deaths
Prenatal Substance Abuse Gender Breakdown
Male
Female
0
1
2
3
4
5
6
7
8
9
10


Race/Ethnicity
Hispanic/Latin American
Caucasian
Black
American Indian
Samoan
0
1
2
3
4
5
6
7
8


Age
1 day to 30 days
Stillborn or Less than 1 day
0
2
4
6
8
10
12
14
16
18


2020 Accidental Child Deaths
Prenatal Substance Abuse Drug Exposure
5%
17%
78%
Methamphetamines
Hydrocodone and Cocaine
Heroin and Methamphetamines

Sample Case Summaries - Undetermined

Melody

Melody was a 3-month-old child who was in the father's care in October 2020. Reportedly, the father placed Melody on an infant flat pillow in a bedroom and then propped the bottle near her so she could feed. The father reported he left the room to clean the home. After approximately 5 minutes, he heard Melody choking. He saw Melody had vomited and he then finger swept her mouth to clean her airway and Melody was still not breathing. The father immediately called law enforcement, and while on the phone with dispatcher, the father was instructed to perform CPR on Melody. Law enforcement arrived within 2 minutes of father's call and the father was relieved of CPR. Melody was pronounced deceased at the scene. There was no suspicion of any malicious intent. Melody's mother was not at the scene.

Sally

One month old Sally was found unresponsive by her mother, and she called 911. When paramedics arrived at the home Sally was pronounced dead. Mother related having gone out drinking the night before and came home to breastfeed Sally. Mother admitted to falling asleep during the feeding and smothering Sally.

Karla

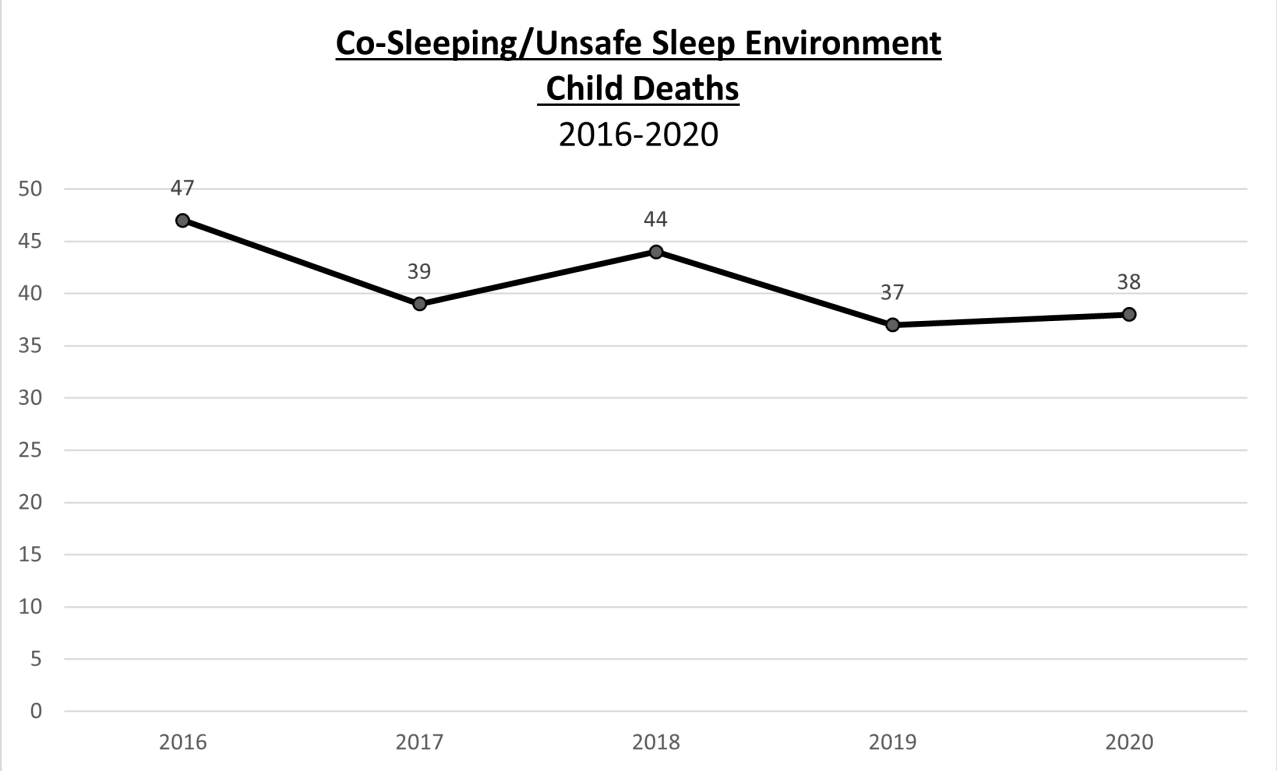
Karla and her twin sister Katy, 8 months old were often put to sleep together in one of the twin's crib filled with pillows, toys and blankets. Mother described putting the girls down for a nap for about 30 minutes and when she came in to check on them Karla was not breathing. Karla was in full cardiac arrest by the time paramedics arrived at the home.

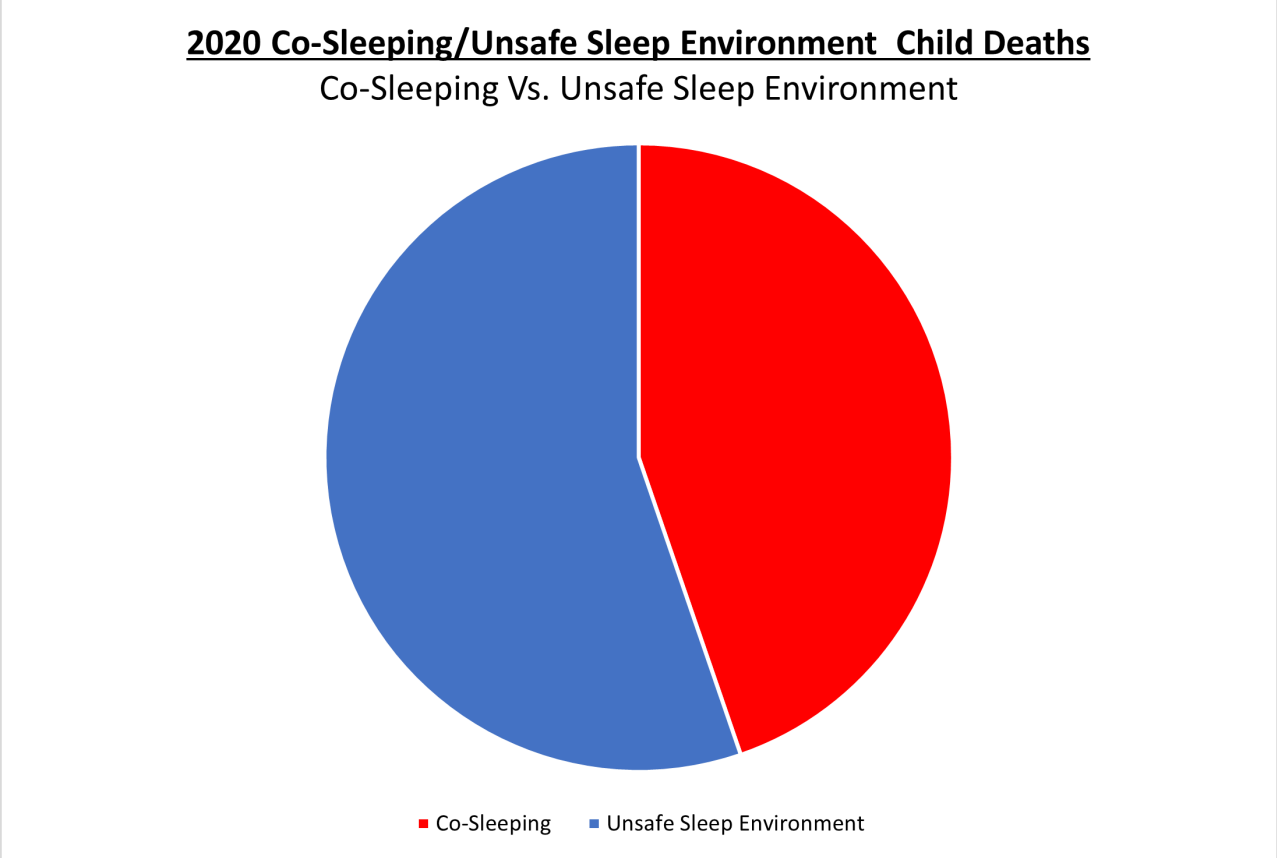
UNDETERMINED

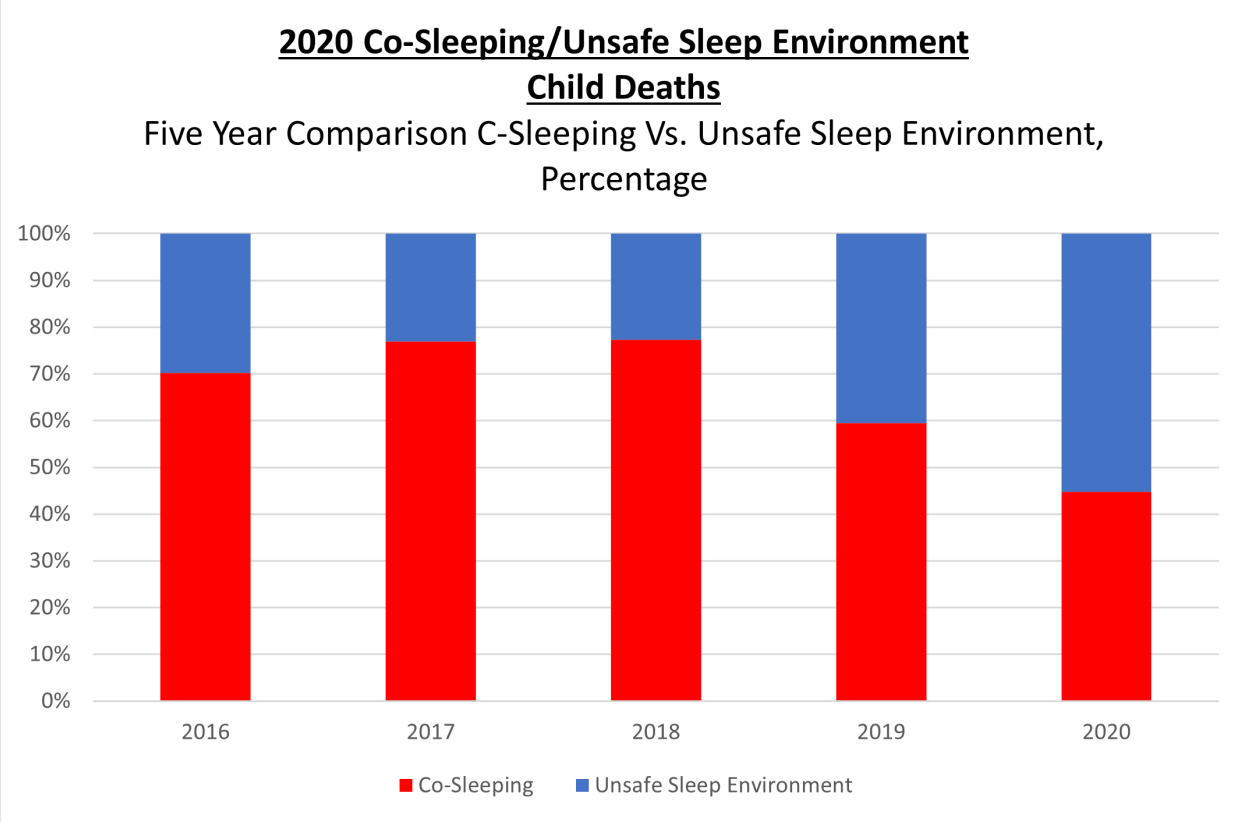
FINDING

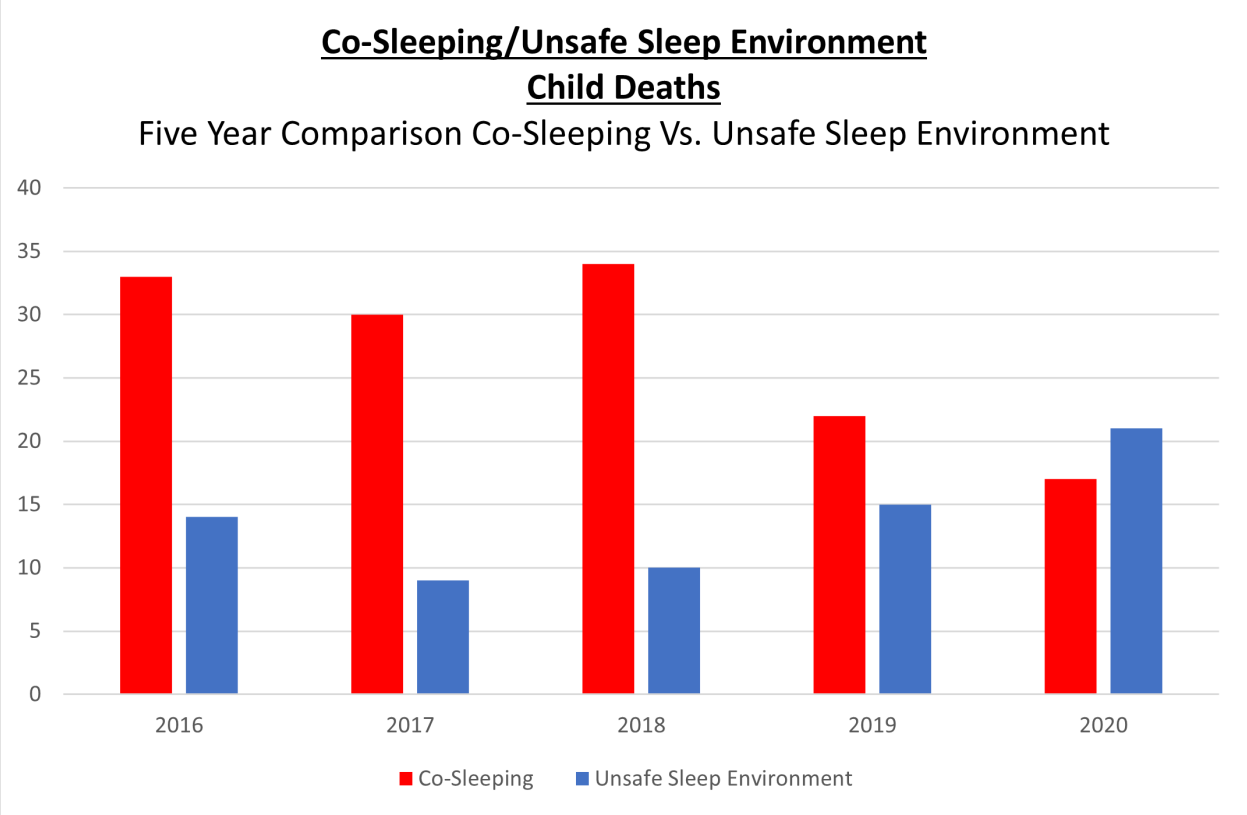
- Fifty undetermined child deaths were reported to ICAN from the Coroner's Department in 2020. Thirty-eight of the child victims were determined by ICAN to be the result of unsafe sleep practices, whether because of co-sleeping with an adult/child, an unsafe sleep environment, or a combination of both.
- The 2020 number of 38 unsafe sleep deaths is a slight increase from 2019 and slightly below the five-year average of approximately forty unsafe sleep-related deaths per year.
- Fifty-five percent (n=21) of the unsafe sleep-related deaths involved unsafe sleep environment and the remaining 45% were due to the practice of co-sleeping; bed-sharing with an adult and/or children. While this split is typical in the last few years, 2020 shows a greater share of the deaths related to sleep environment.
- Most unsafe sleep-related child deaths involved a single, although fatal, risk factor. In seventy four percent of these cases, the single risk factor was unsafe sleep environment followed by co-sleeping (34%).
- Eighty-seven percent of unsafe sleep-related child deaths involved two unsafe risk factors. Thirteen percent involved only one risk factor.
- Twenty of the 38 unsafe sleep surfaces were adult beds. The remaining unsafe sleep surfaces involved cribs, couches, an infant being held in the arms of an adult, bassinet, pack and play and parent falling asleep in the bathtub with baby.
- The children most vulnerable to unsafe sleep related deaths were infants zero to two months of age which comprised 50% of the cases. In this age group, nine of the cases involved co-sleeping. The next group of children at risk of a co-sleeping death were 3- to 5-month-old infants comprising 11% of co-sleeping deaths.
- The 2020 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 adult bed, blankets and pillows or an unsafe sleeping position.
- In 2020, Hispanic (N-17) (45%) and African American (n-12) (32%) children were the most common victim of unsafe sleep related death. Caucasians (n=6) made up 16%percent and Asians and Samoans made up 8%.
- Of the thirty-eight unsafe sleep cases, half were male and half were female.
- Thirty of the victims of unsafe sleep related deaths came from families with child welfare history. Seventeen of the children had a least one parent with child welfare history as a minor.
- Twelve of the undetermined deaths for 2020 were not a result of unsafe sleep practices.
- Six were determined to be sudden infant death syndrome.
- The other causes of death for undetermined were complications of Zellweger disease, acute diffuse anoxic – ischemic encephalopathy and undetermined.
- Of the non-unsafe sleep related deaths: Nine were below the age of one year. Hispanic children made up twenty five percent, African American children and white children made up

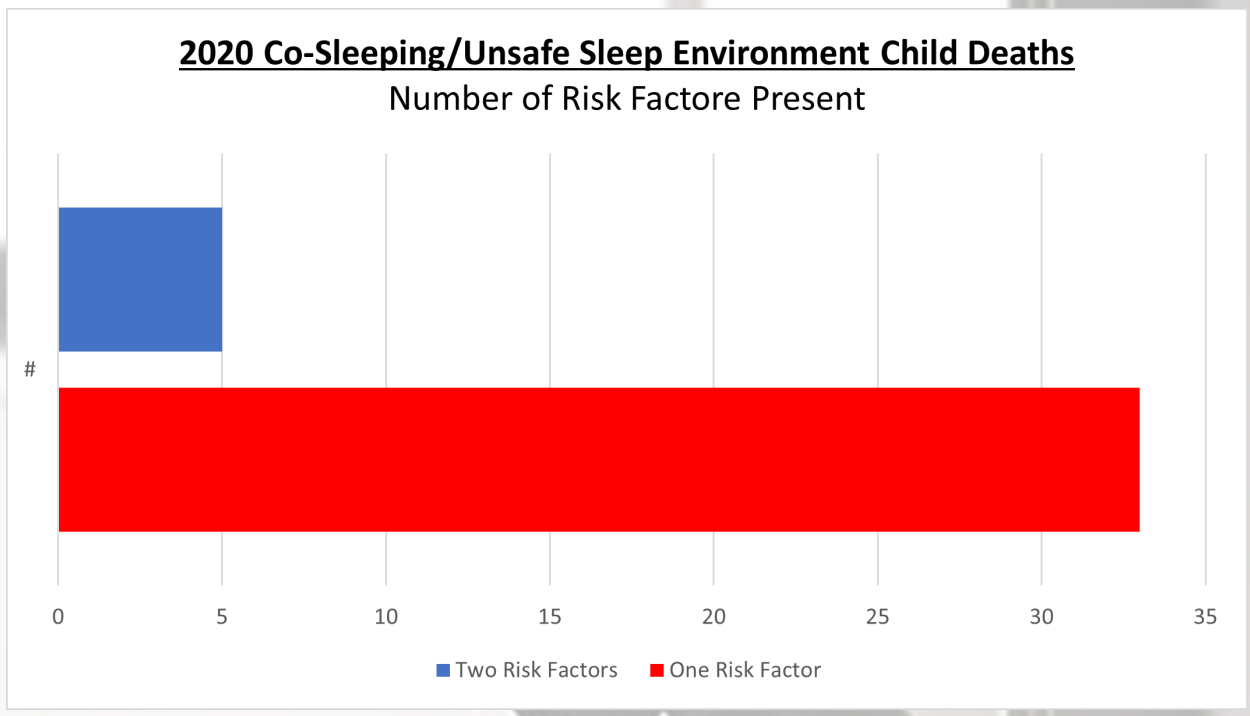
33% each, and eight percent were Armenian. The gender split was Sixty-six percent male, thirty-three percent female.

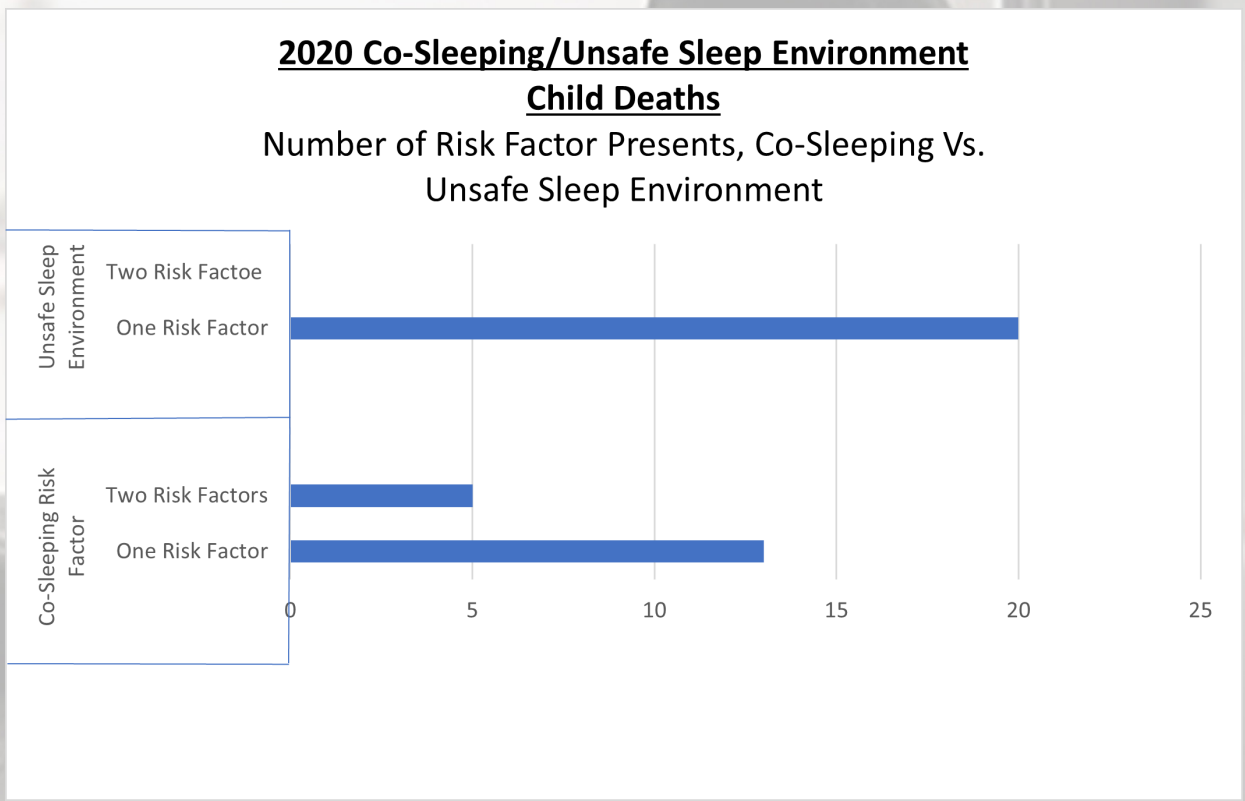

Co-Sleeping/Unsafe Sleep Environment
Child Deaths
2016-2020
50
45
40
35
30
25
20
15
10
5
0
47
39
44
37
38
2016
2017
2018
2019
2020

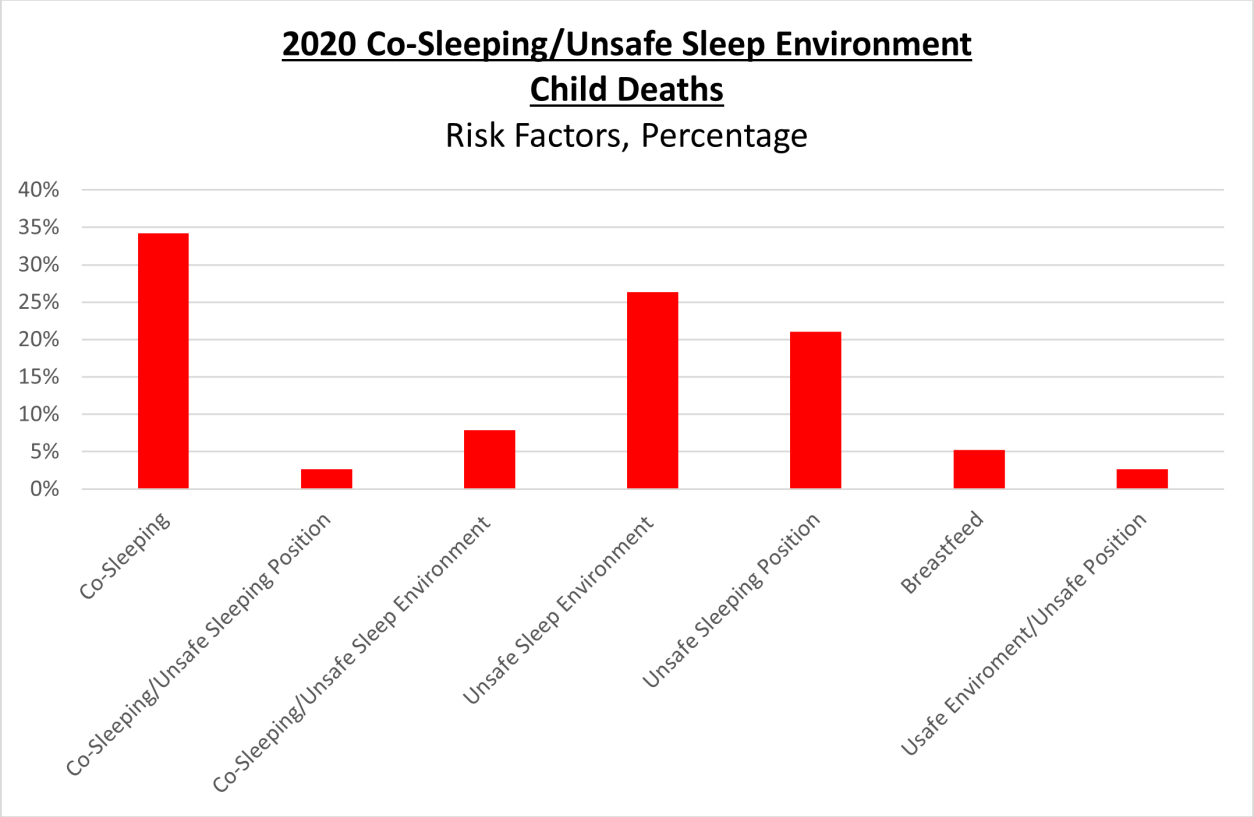

2020 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Co-Sleeping Vs. Unsafe Sleep Environment
Co-Sleeping
Unsafe Sleep Environment

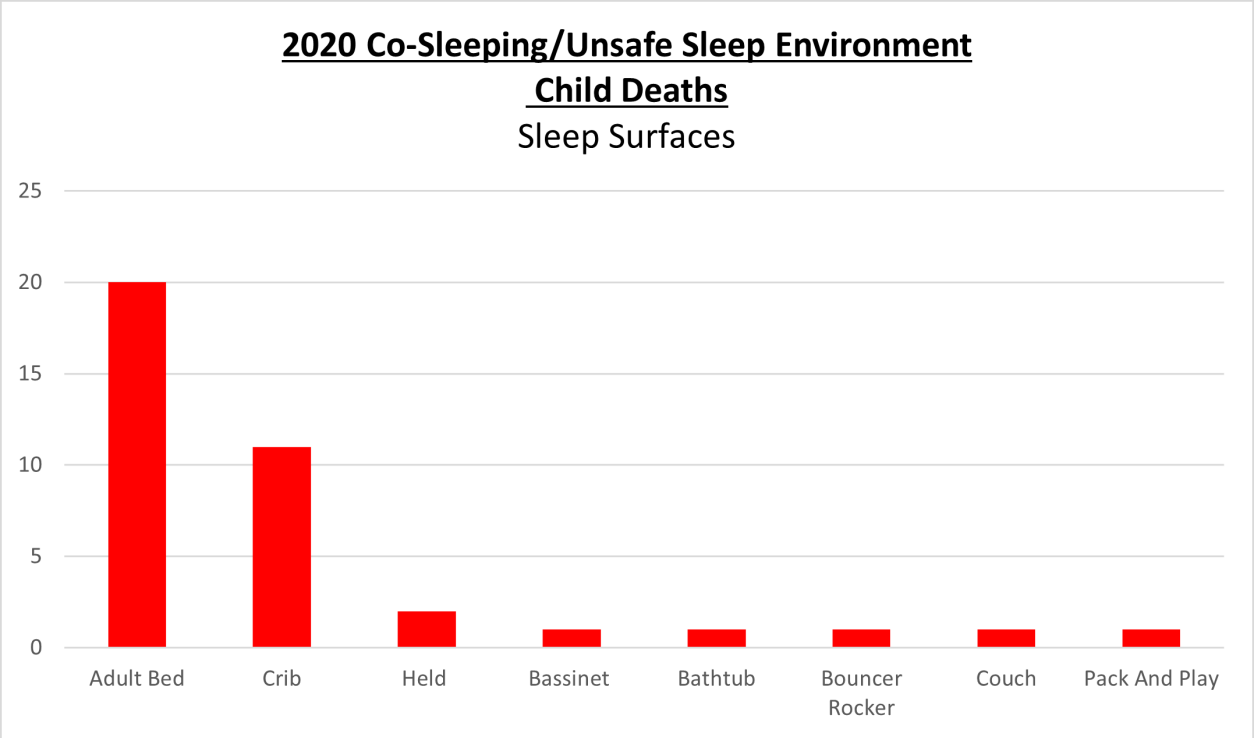

2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Five Year Comparison C-Sleeping Vs. Unsafe Sleep Environment, Percentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2016
2017
2018
2019
2020
Co-Sleeping
Unsafe Sleep Environment

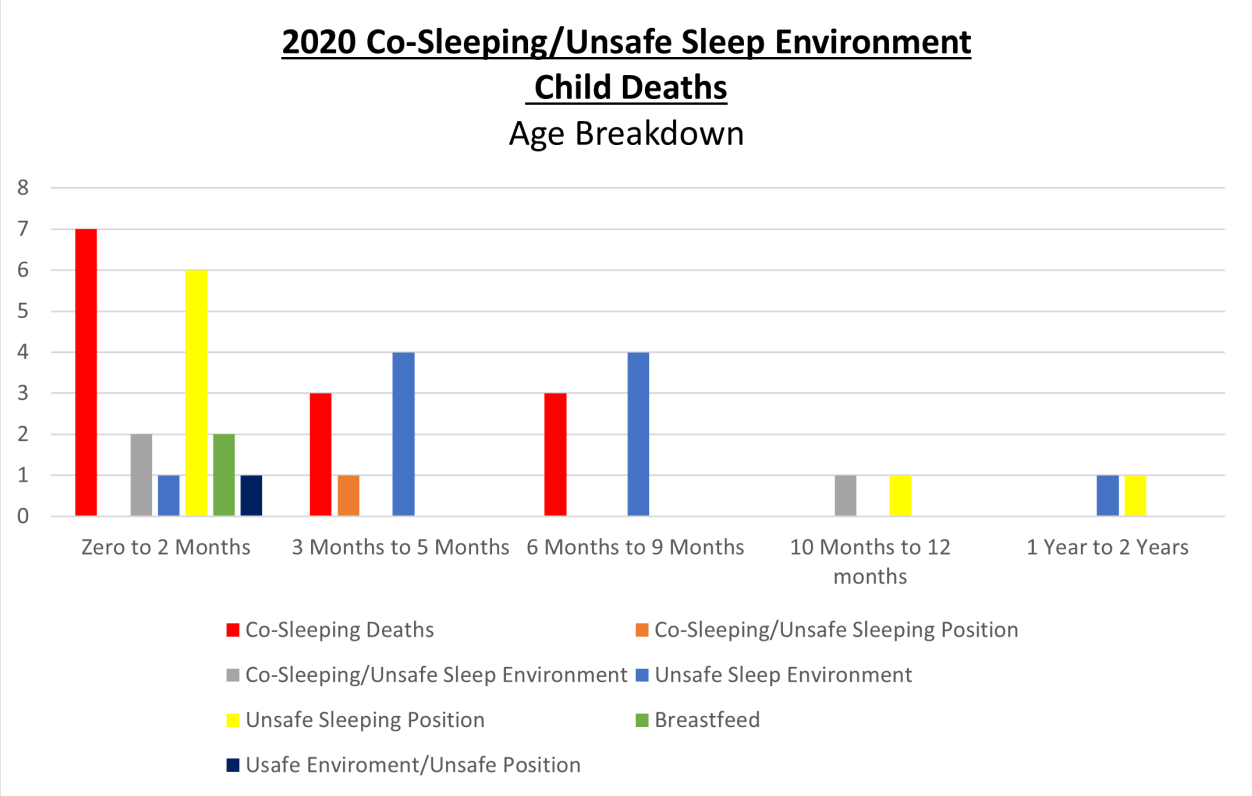

Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Five Year Comparison Co-Sleeping Vs. Unsafe Sleep Environment
40
35
30
25
20
15
10
5
0
2016
2017
2018
2019
2020
Co-Sleeping
Unsafe Sleep Environment

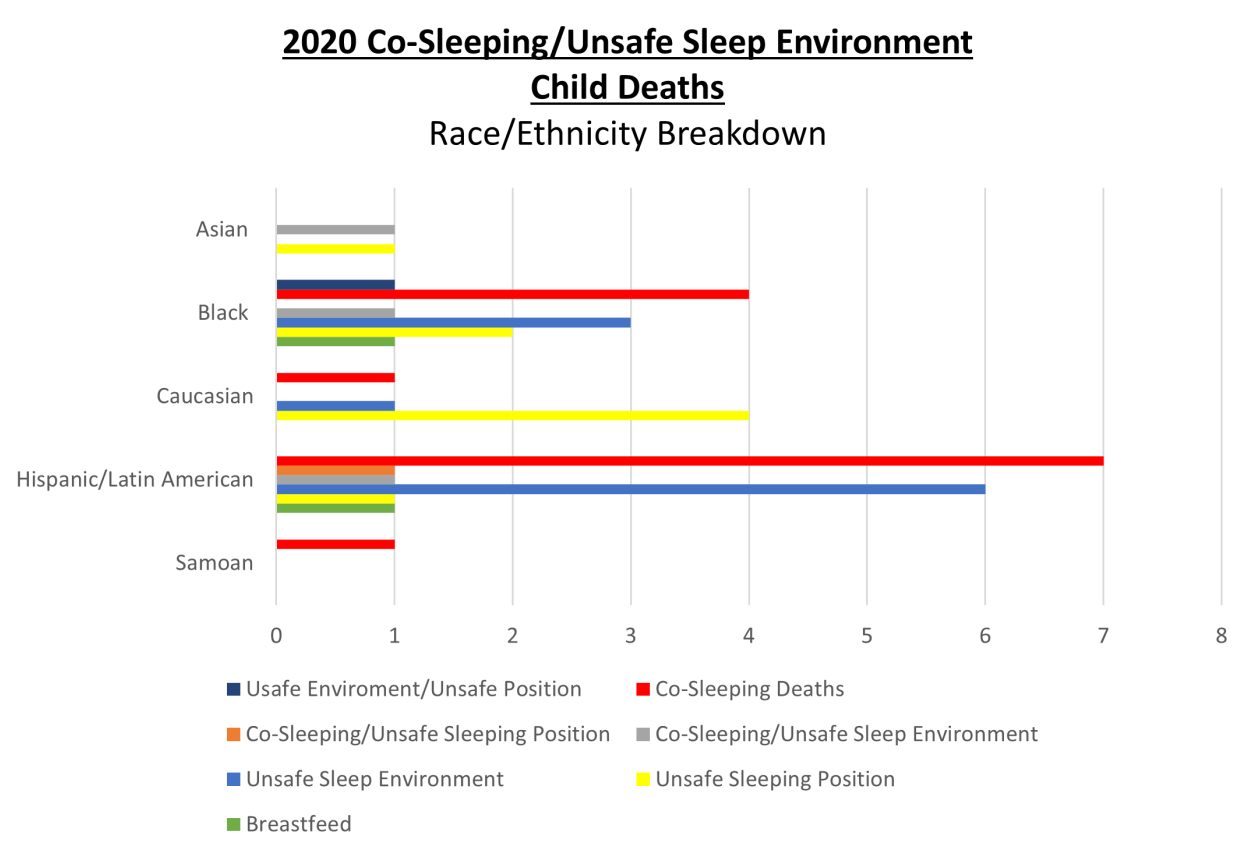

2020 Co-Sleeping/Unsafe Sleep Environment Child Deaths
Number of Risk Factore Present
#
0
5
10
15
20
25
30
35
Two Risk Factors
One Risk Factor

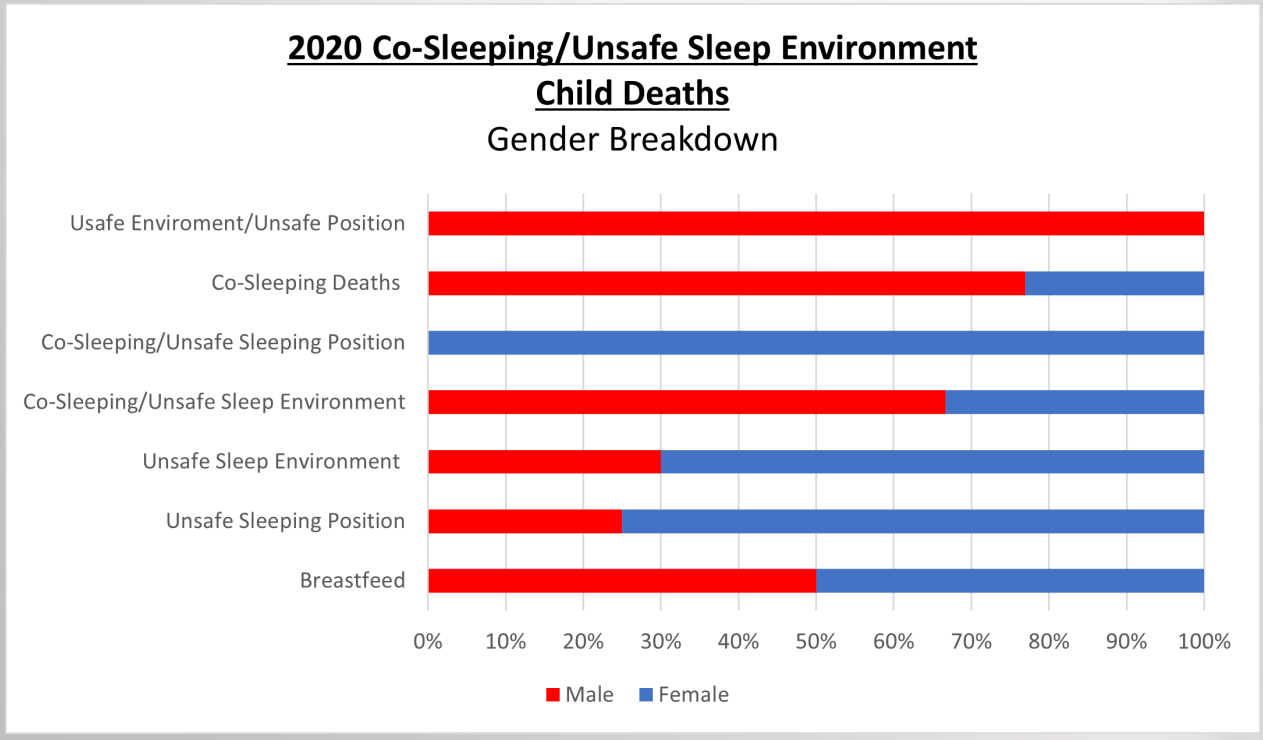

2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Number of Risk Factor Presents, Co-Sleeping Vs.
Unsafe Sleep Environment
Unsafe Sleep Environment
Two Risk Factoe
One Risk Factor
Co-Sleeping Risk Factor
Two Risk Factors
One Risk Factor
0
5
10
15
20
25

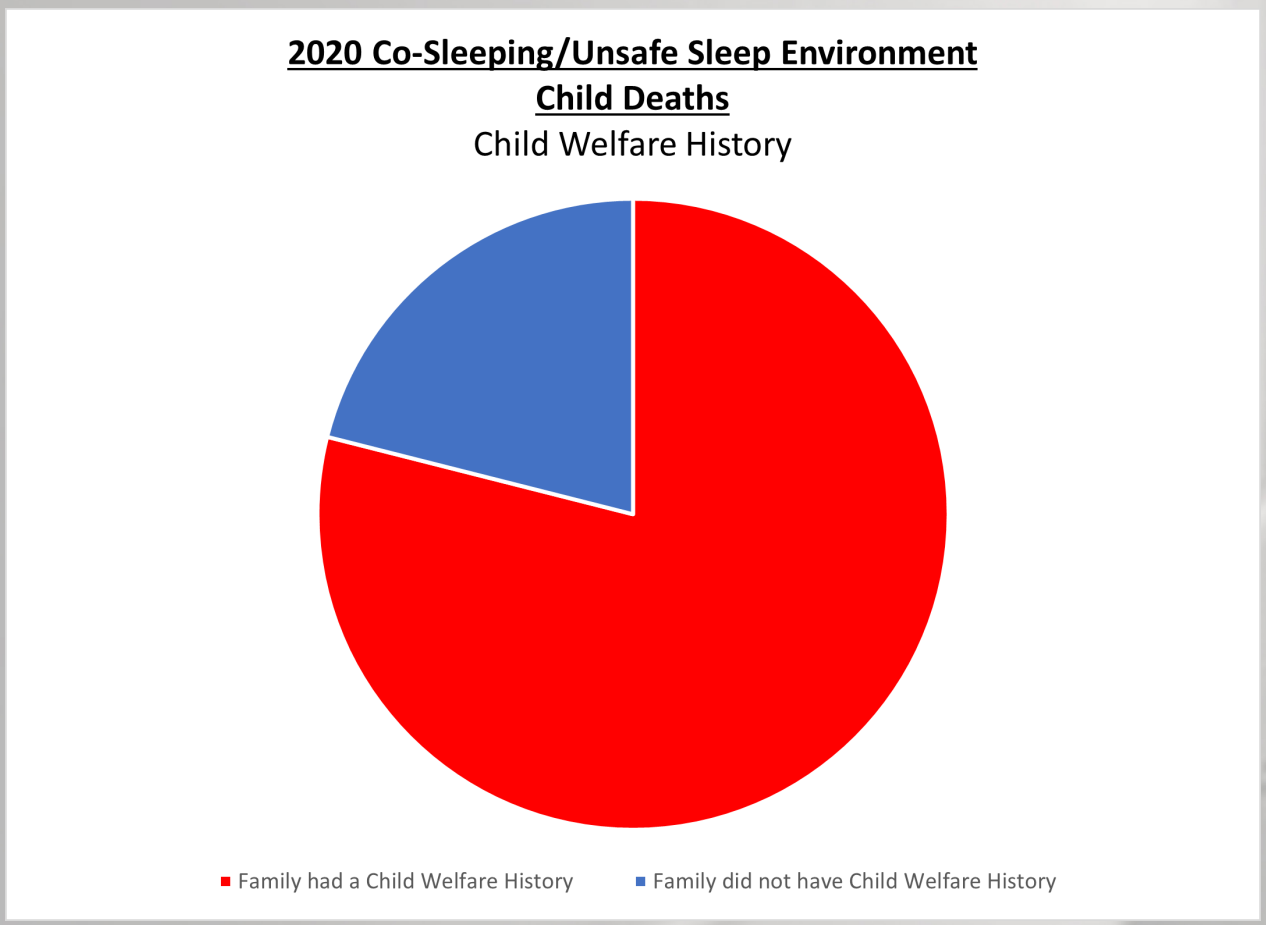

2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Risk Factors, Percentage
40%
35%
30%
25%
20%
15%
10%
5%
0%
Co-Sleeping
Co-Sleeping/Unsafe Sleeping Position
Co-Sleeping/Unsafe Sleep Environment
Unsafe Sleep Environment
Unsafe Sleeping Position
Breastfeed
Usafe Enviroment/Unsafe Position

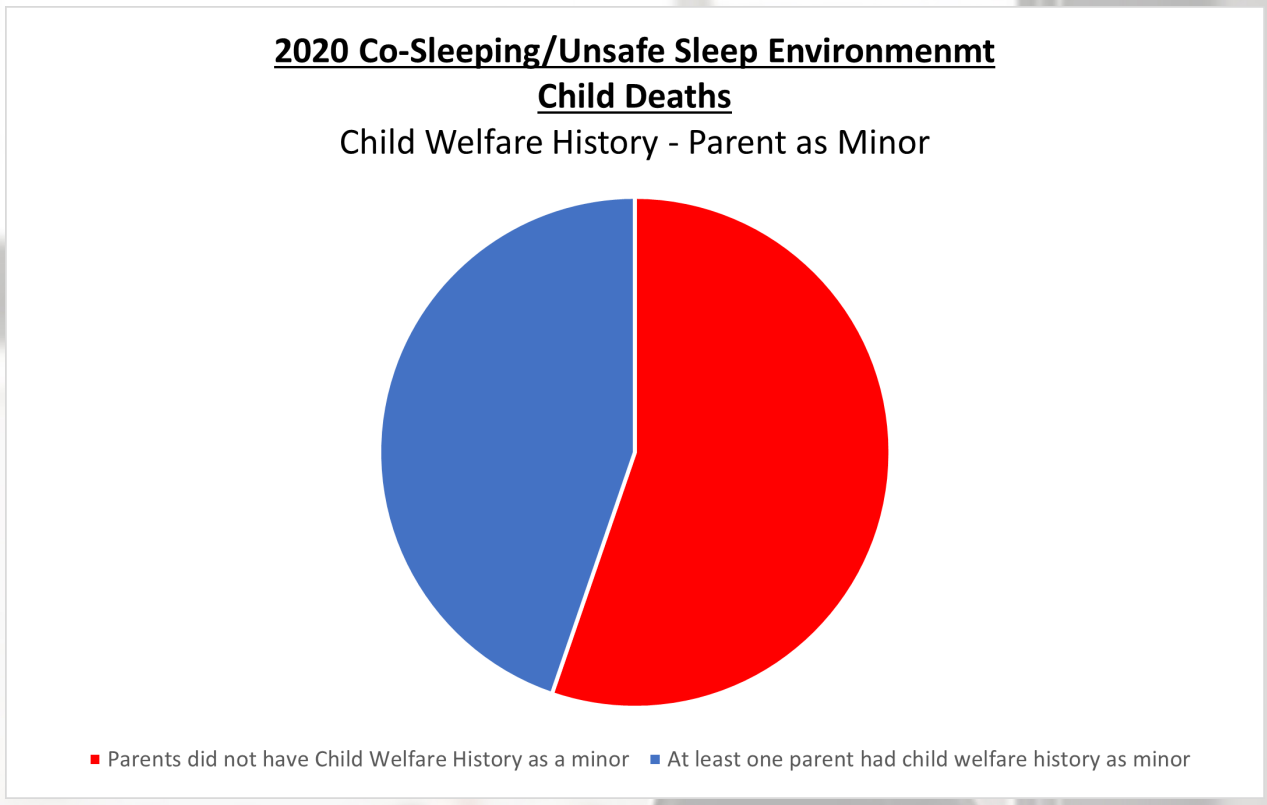

2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Sleep Surfaces
25
20
15
10
5
0
Adult Bed
Crib
Held
Bassinet
Bathtub
Bouncer
Rocker
Couch
Pack And Play

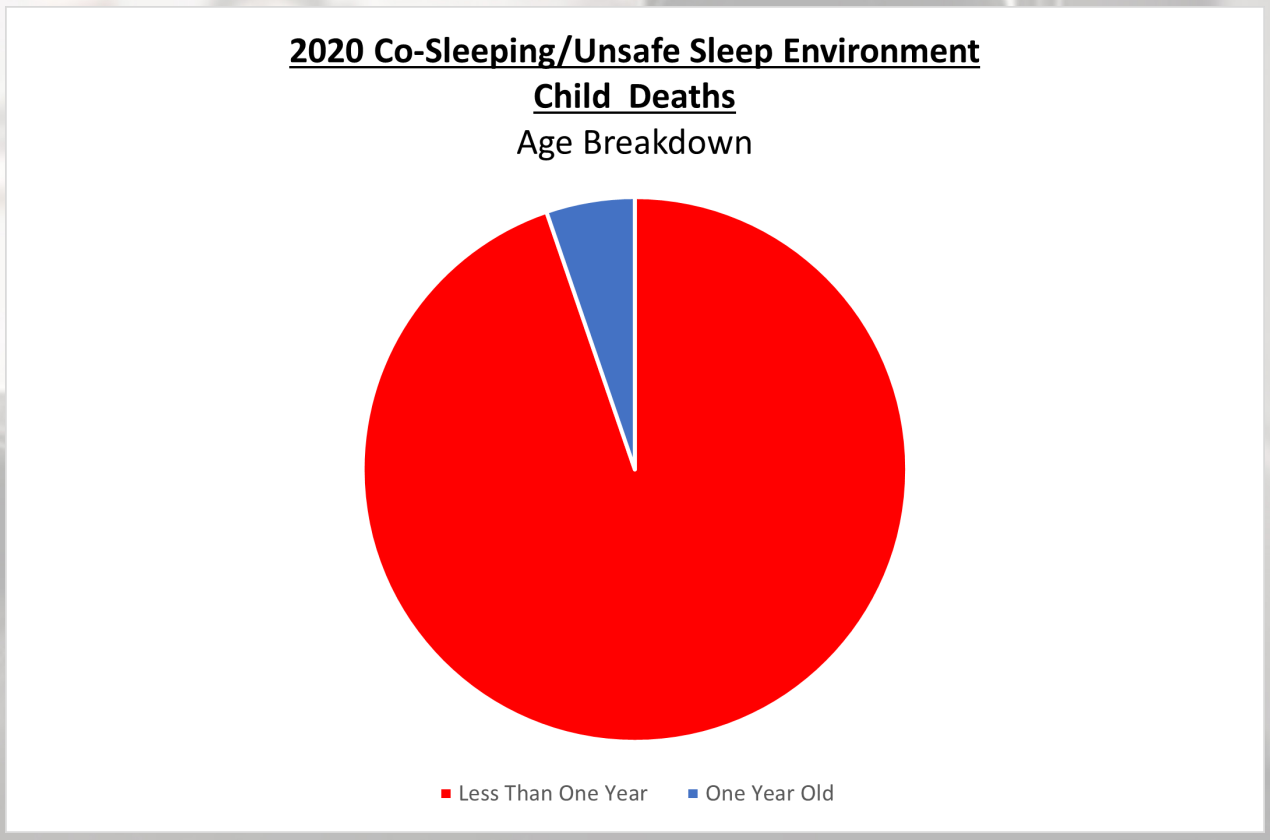

2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Age Breakdown
8
7
6
5
4
3
2
1
0
Zero to 2 Months
3 Months to 5 Months
6 Months to 9 Months
10 Months to 12 months
1 Year to 2 Years
Co-Sleeping Deaths
Co-Sleeping/Unsafe Sleeping Position
Co-Sleeping/Unsafe Sleep Environment
Unsafe Sleep Environment
Unsafe Sleeping Position
Breastfeed
Usafe Enviroment/Unsafe Position


2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Race/Ethnicity Breakdown
Asian
Black
Caucasian
Hispanic/Latin American
Samoan
0
1
2
3
4
5
6
7
8
Usafe Enviroment/Unsafe Position
Co-Sleeping Deaths
Co-Sleeping/Unsafe Sleeping Position
Co-Sleeping/Unsafe Sleep Environment
Unsafe Sleep Environment
Unsafe Sleeping Position
Breastfeed

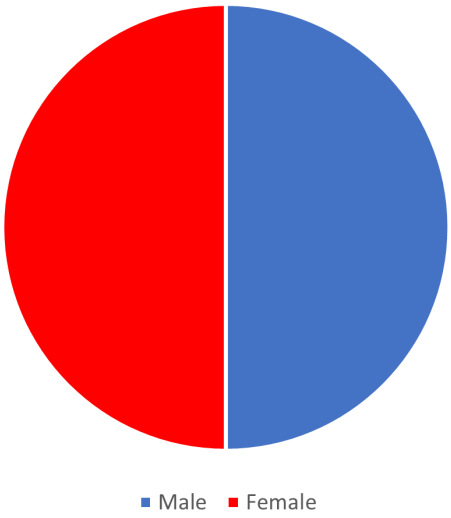

2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Gender Breakdown
Usafe Enviroment/Unsafe Position
Co-Sleeping Deaths
Co-Sleeping/Unsafe Sleeping Position
Co-Sleeping/Unsafe Sleep Environment
Unsafe Sleep Environment
Unsafe Sleeping Position
Breastfeed
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Male
Female


2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Child Welfare History
Family had a Child Welfare History
Family did not have Child Welfare History

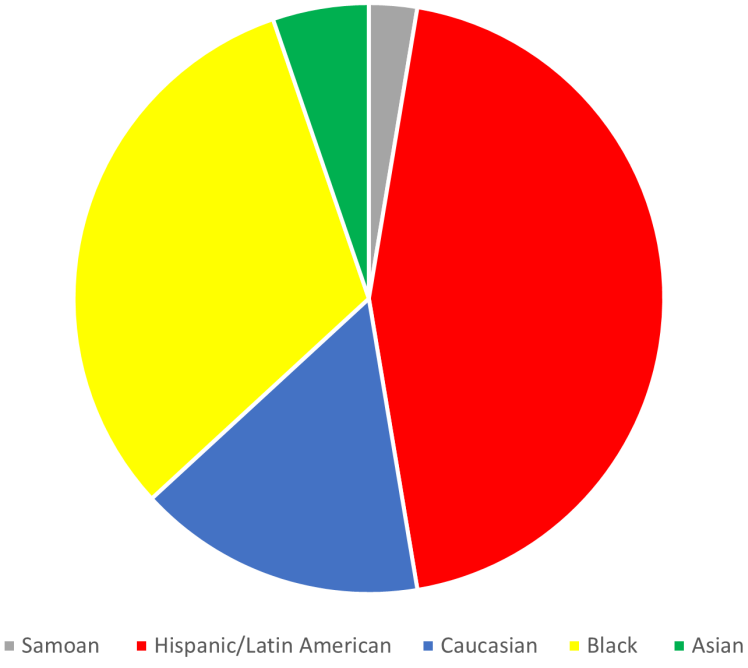

2020 Co-Sleeping/Unsafe Sleep Environmenmt
Child Deaths
Child Welfare History - Parent as Minor
Parents did not have Child Welfare History as a minor
At least one parent had child welfare history as minor

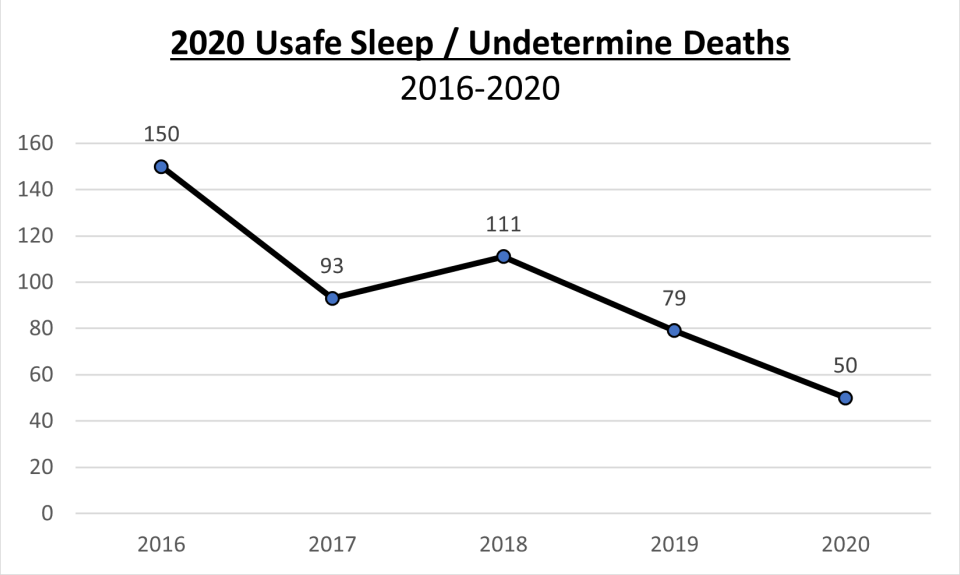

2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Age Breakdown
Less Than One Year
One Year Old

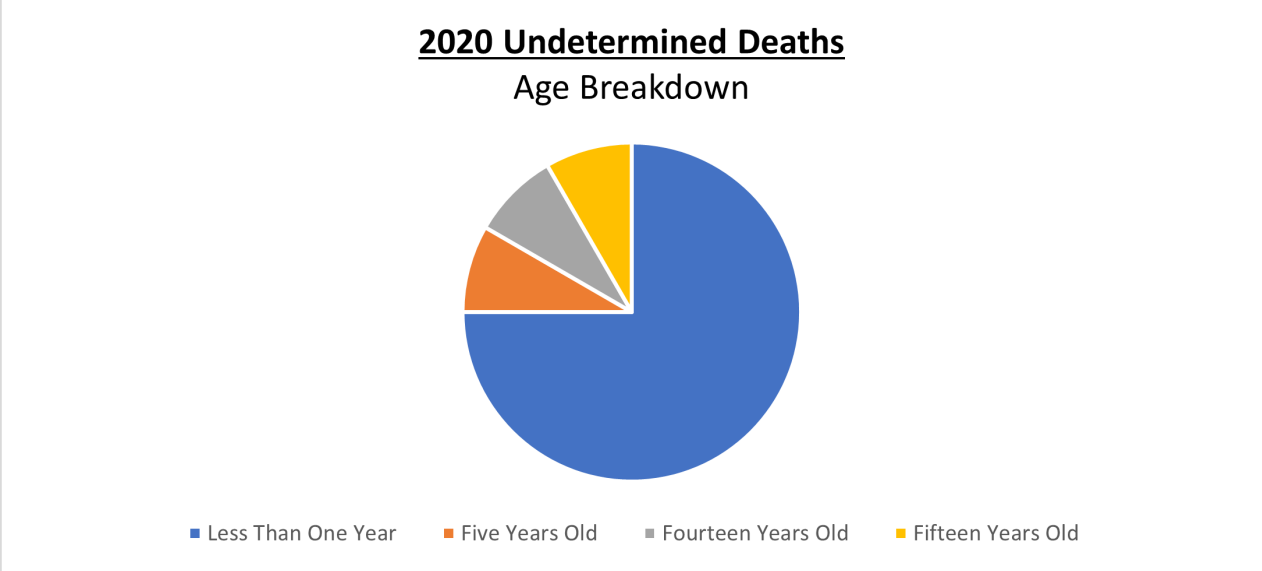
2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Gender Breakdown

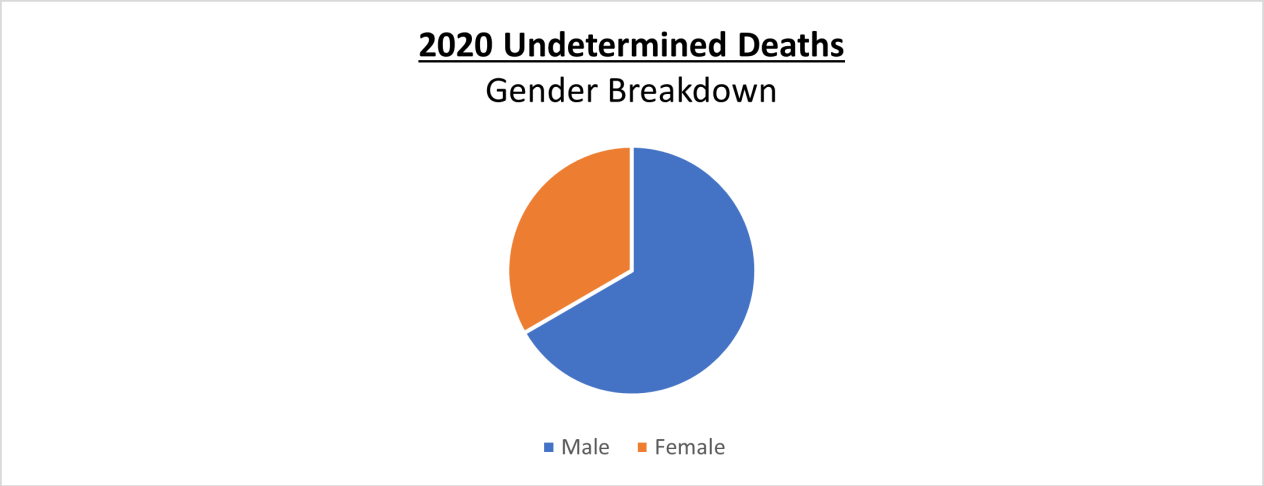


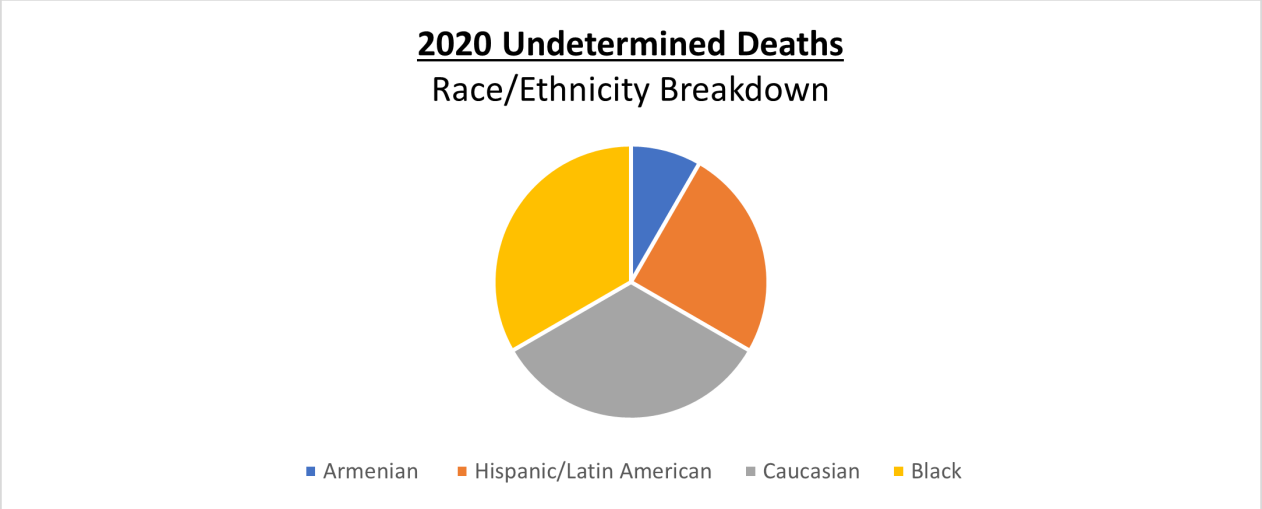
2020 Co-Sleeping/Unsafe Sleep Environment
Child Deaths
Race/Ethnicity Breakdown




2020 Usafe Sleep / Undetermine Deaths
2016-2020
160
140
120
100
80
60
40
20
0
150
93
111
79
50
2016
2017
2018
2019
2020

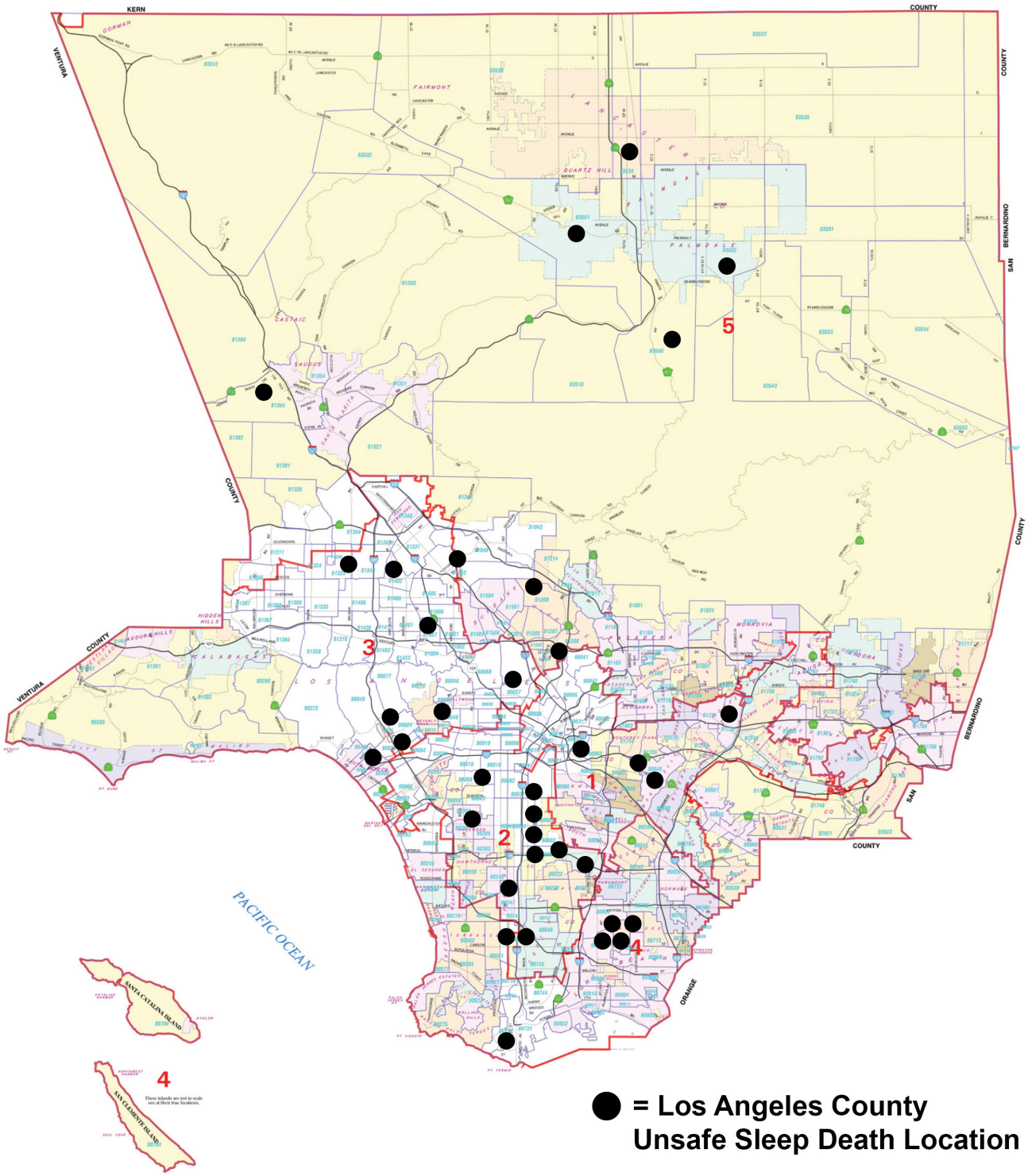

2020 Undetermined Deaths
Age Breakdown
Less Than One Year
Five Years Old
Fourteen Years Old
Fifteen Years Old


2020 Undetermined Deaths
Gender Breakdown
Male
Female


2020 Undetermined Deaths
Race/Ethnicity Breakdown
Armenian
Hispanic/Latin American
Caucasian
Black

2020 Unsafe Sleep Death - Locations
n = 36*

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



Sample Case Summaries - Third Party Homicides

Sara

Thirteen-year-old Sara was with her family in their vehicle. The family stopped their vehicle in the parking lot in front of a food business. The parents left Sara, along with her three minor siblings, inside of the running vehicle and entered the food business. The suspect approached the running vehicle and got in. Sara's siblings jumped out of the vehicle; Sara was the last child to jump out of the vehicle as it was traveling at a high speed and collided with a fire hydrant on the sidewalk. 9-1-1 was called and paramedics responded to the scene and put Sara in the back of the ambulance. Sara's death was pronounced by paramedics. The suspect continued driving in the vehicle and was involved in two alleged collisions, two car jackings, and an altercation before being arrested by Los Angeles Sherriff's.

Jacob

Jacob, age 17, was with multiple friends at an intersection when a vehicle pulled up to the group. Andrew and his friends reportedly approached the vehicle, when a suspect opened fire on the group striking Jabob in the head. A friend from Jacob's group fired back at the vehicle and the vehicle fled the scene. 911 was called and Jacob was transported to the hospital and presented with a gunshot wound to the head. A CT scan showed subdural hematoma with basilar with frontal/temporal/parietal/occipital lobes edema and hemorrhage through the gunshot wound tract. A decompressive craniectomy was performed despite Jacob having a poor prognosis. However, he succumbed to his injuries.

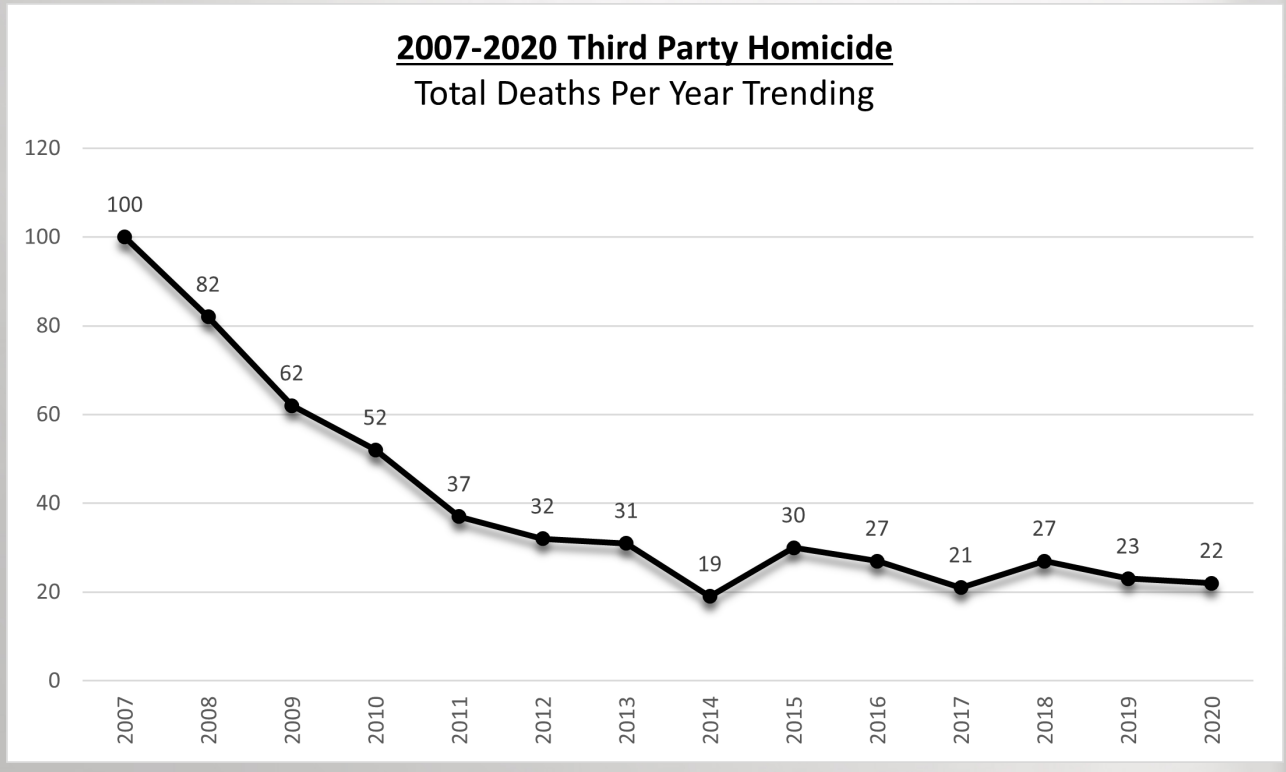
Jobe

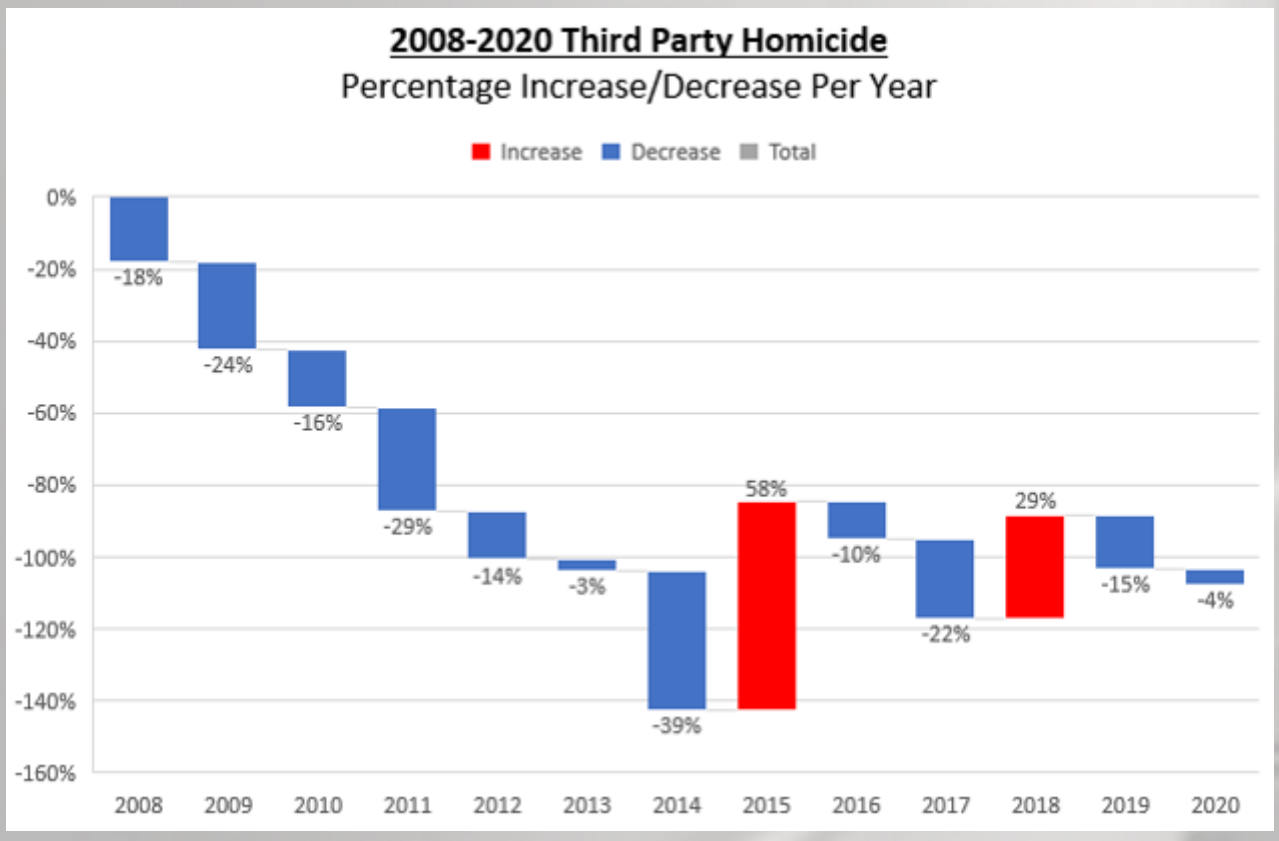
Fourteen-year-old Jobe was in an argument inside an apartment where he lived. During the argument he was shot by one of the persons inside the apartment. He managed to make it outside into the courtyard where he collapsed. Neighbors called paramedics, however, Jobe was pronounced dead at the scene. The police were not able to locate a suspect as no one was willing to disclose who the shooter was. No weapons were found at the scene.

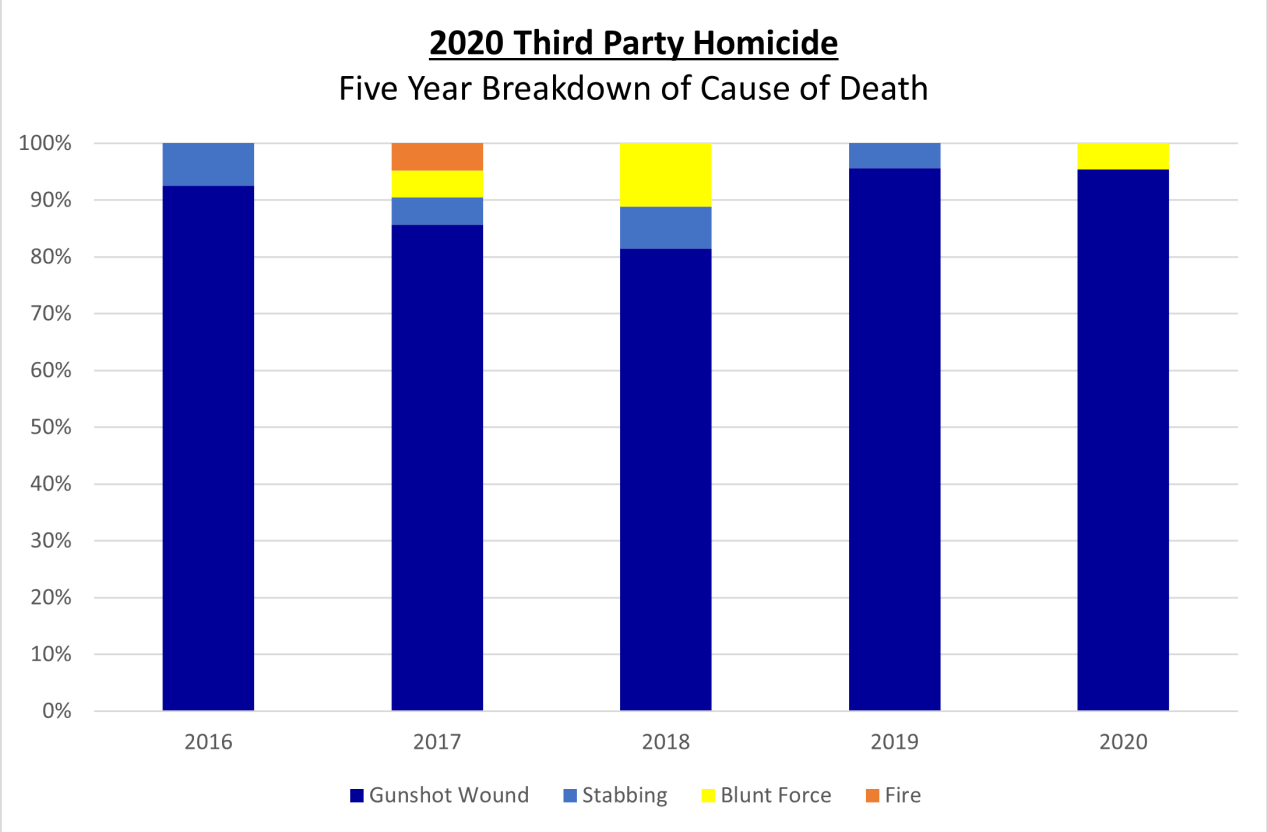
THIRD PARTY HOMICIDES

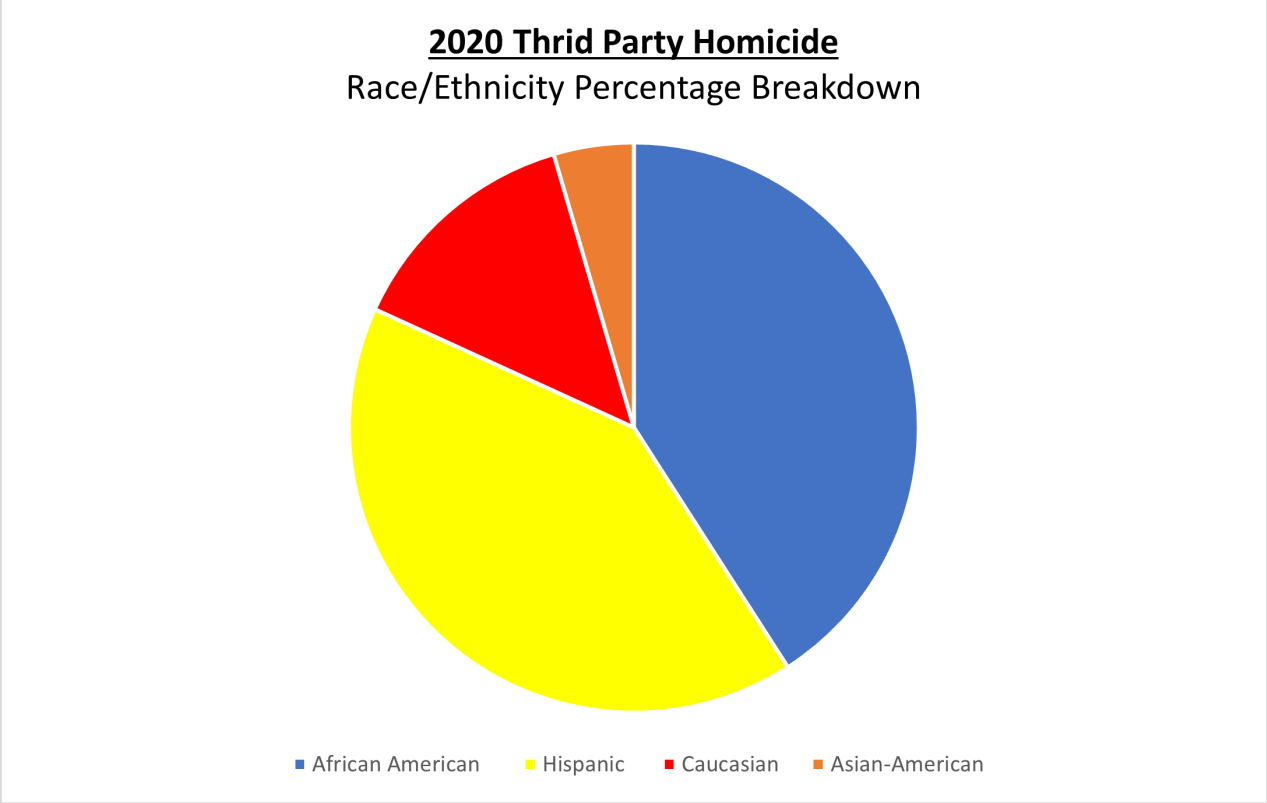
FINDINGS

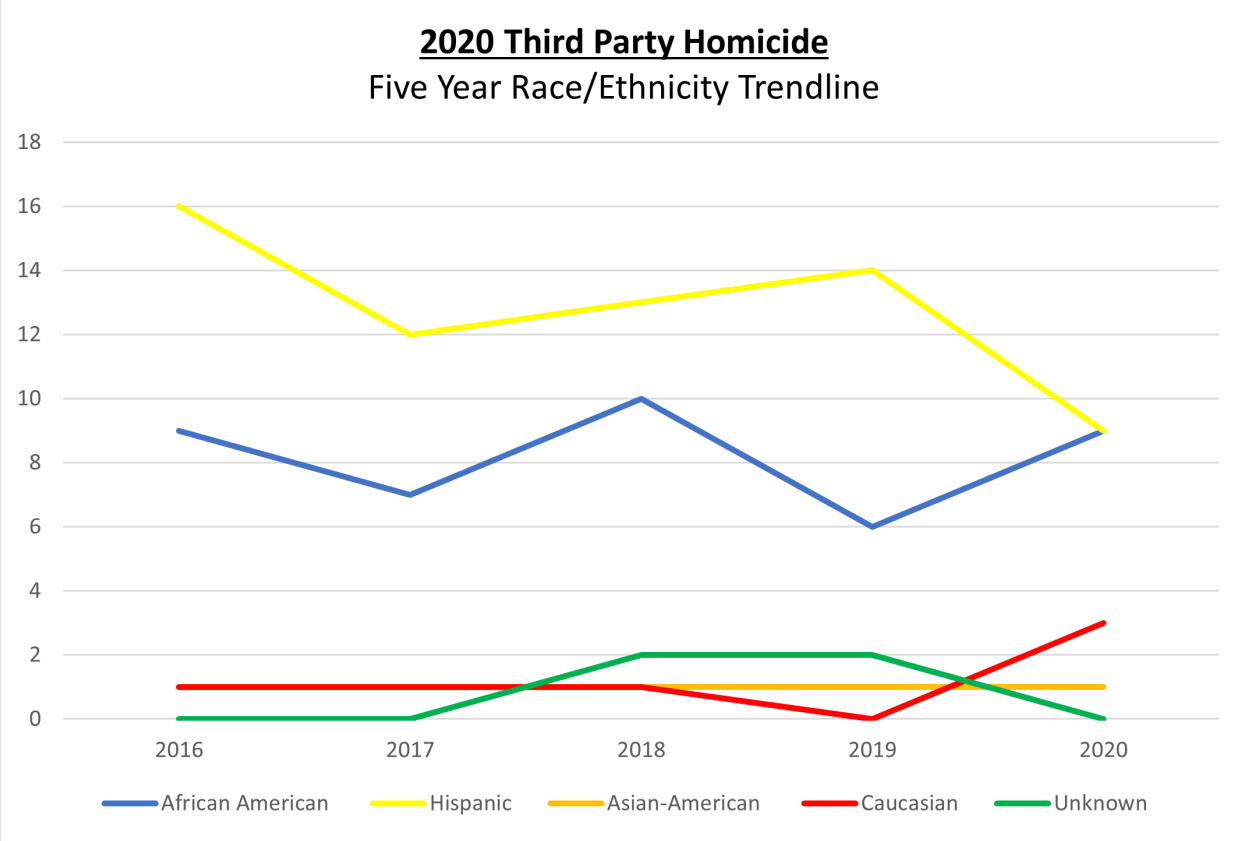
- Twenty-two third party homicides were reported to ICAN by the Coroner for 2020 – which is only one case fewer than was reported in 2019. This decrease reflects the third year that the number of third-party homicides has declined in Los Angeles County. 2020 is below the five-year average of 24 third party homicides per year.
- This is the lowest number of third-party homicides in the last six years and the second lowest number of deaths since ICAN began including third party homicides in the CDRT Report in 2007.
- As in prior years, the number one cause of third-party homicide is gunshot wound. This year, 95% of the victims succumbed to gunshot injuries. The single non-gunshot death was the result of fatal injuries that occurred during a car crash caused by a carjacking with the child in the vehicle at the time of the accident.
- Of the twenty-two third party homicide victims, nineteen were male and three were female in 2020. This continues the trend of the last few years of a decline in female victims. This year, males make up 87% of the victims. In 2018 and 2017, the percentages of males were 78% and 63%, respectively. 2020's gender ratio is above the five-year average, which is 79% for males and 21% for females.
- Third-party homicide victims ranged from zero to seventeen in 2020. Older children made up the largest percentage of the victims with seventeen-and sixteen-year-olds composing sixty-four percent (each twenty-two percent or seven children each, respectively) of the deaths. Additionally, there were two fifteen-year-old children, three fourteen-year-old children, one thirteen-year-old child, one ten-year-old child, and one fetal death.
- Eighty-two percent of the victims of third-party homicides in 2020 were of an African American or Hispanic background, each making up forty-one percent of the deaths with nine deaths each. These two groups made up 86% of the deaths in 2019, so this is a slight decline. This is above the five-year average for African American victims of 35% and below for the five-year average for Hispanic victims of 54%. The remaining victims were fourteen white and four percent Asian or three white victims and one Asian victim. This is a large increase of white victims from 2019, in which there were none.
- Both July and October had four third-party homicide deaths in 2020. February, May, and November each had three. January and February each had two. All the remaining months, except for March, June, and September in which there were no deaths, had one death.
- The Los Angeles Police Department (LAPD) had investigative authority for exactly half of the 2020 third-party homicide cases. The next largest law enforcement organization was the Los Angeles Sheriff's Department which handled 32% of the cases. The remaining deaths were investigated by local police departments (Whittier P.D., Long Beach P.D., Pomona P.D., and Inglewood P.D.).

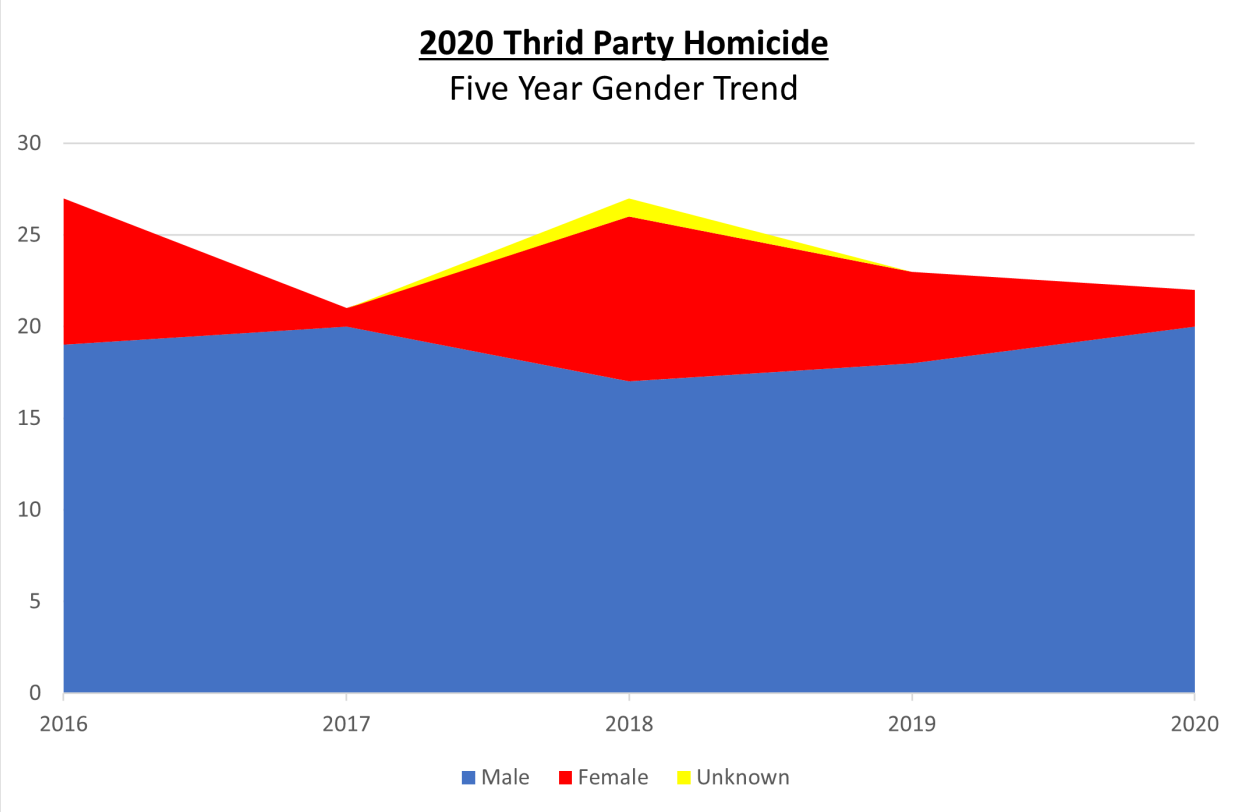

2007-2020 Third Party Homicide
Total Deaths Per Year Trending
120
100
80
60
40
20
0
100
82
62
52
37
32
31
19
30
27
21
27
23
22
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020

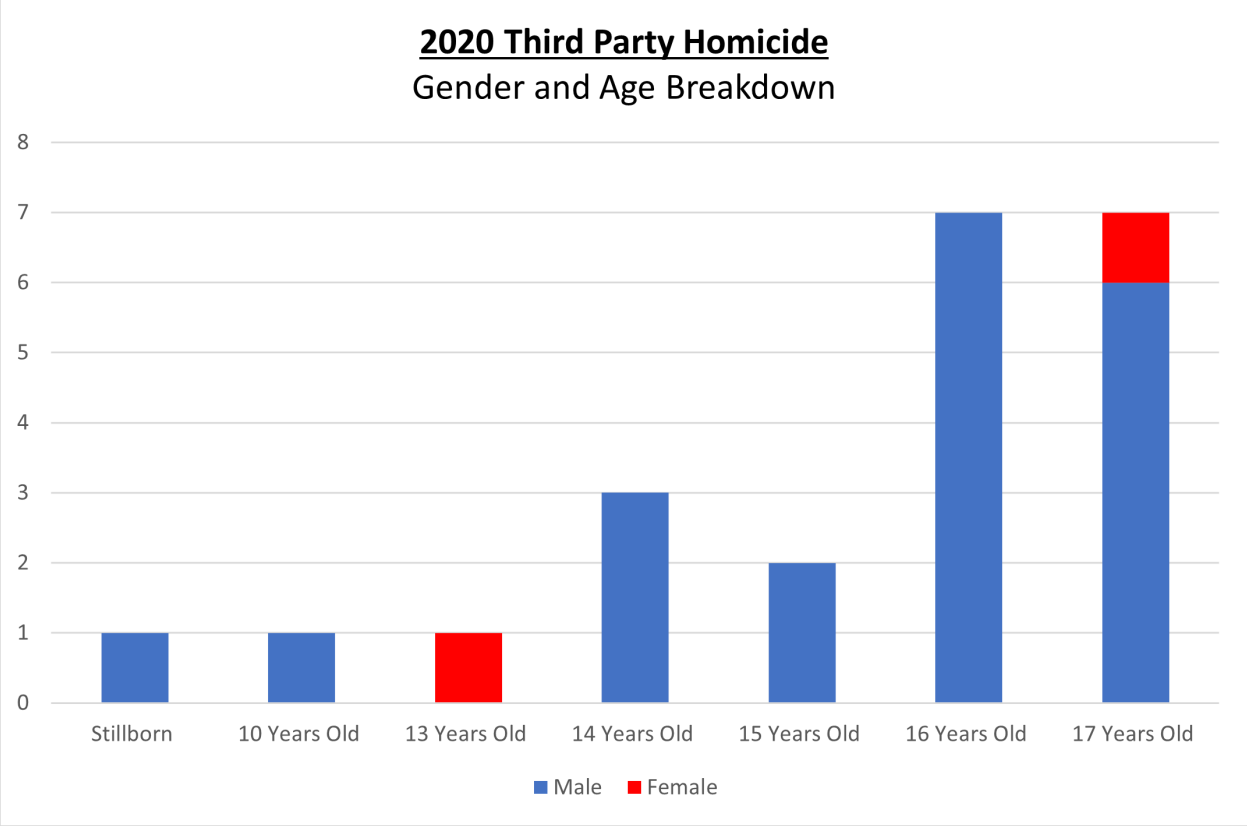

2008-2020 Third Party Homicide
Percentage Increase/Decrease Per Year
Increase
Decrease
Total
0%
-20%
-40%
-60%
-80%
-100%
-120%
-140%
-160%
-18%
-24%
-16%
-29%
-14%
-3%
-39%
58%
-10%
-22%
29%
-15%
-4%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020

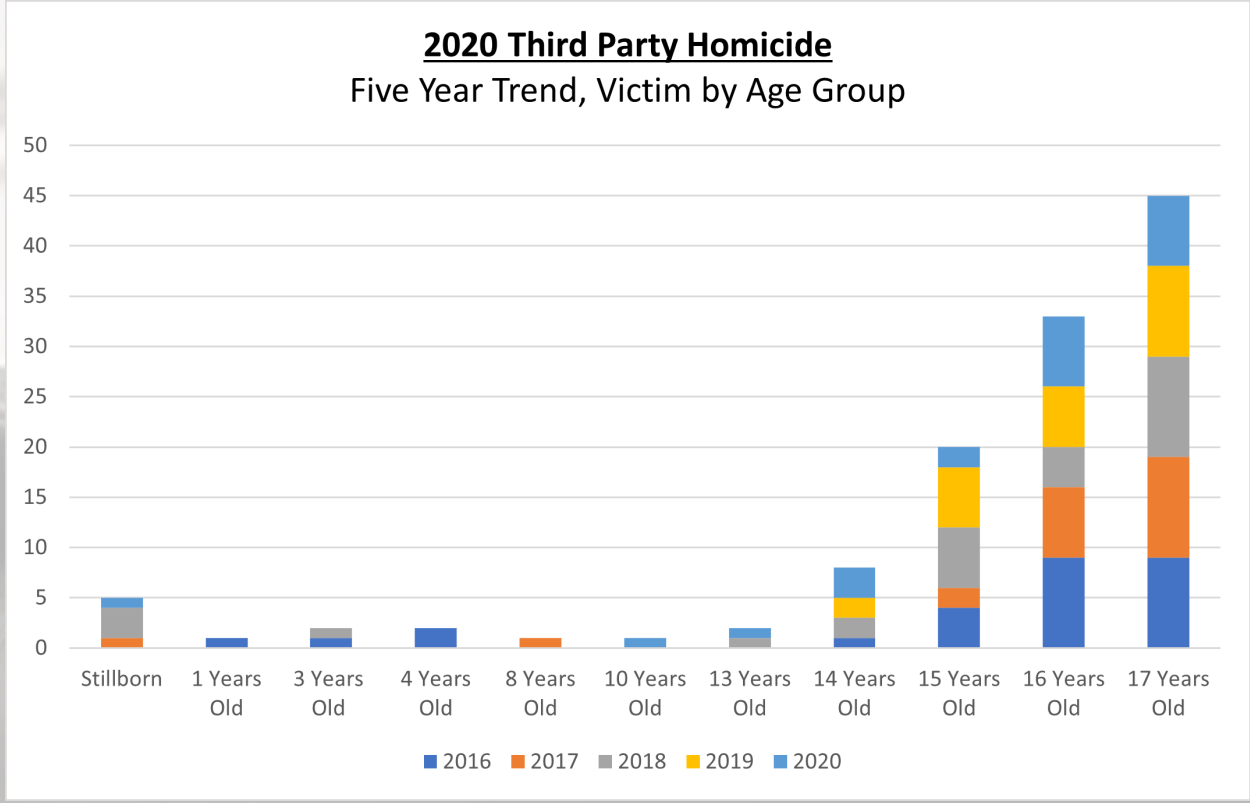

2020 Third Party Homicide
Five Year Breakdown of Cause of Death
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2016
2017
2018
2019
2020
Gunshot Wound
Stabbing
Blunt Force
Fire

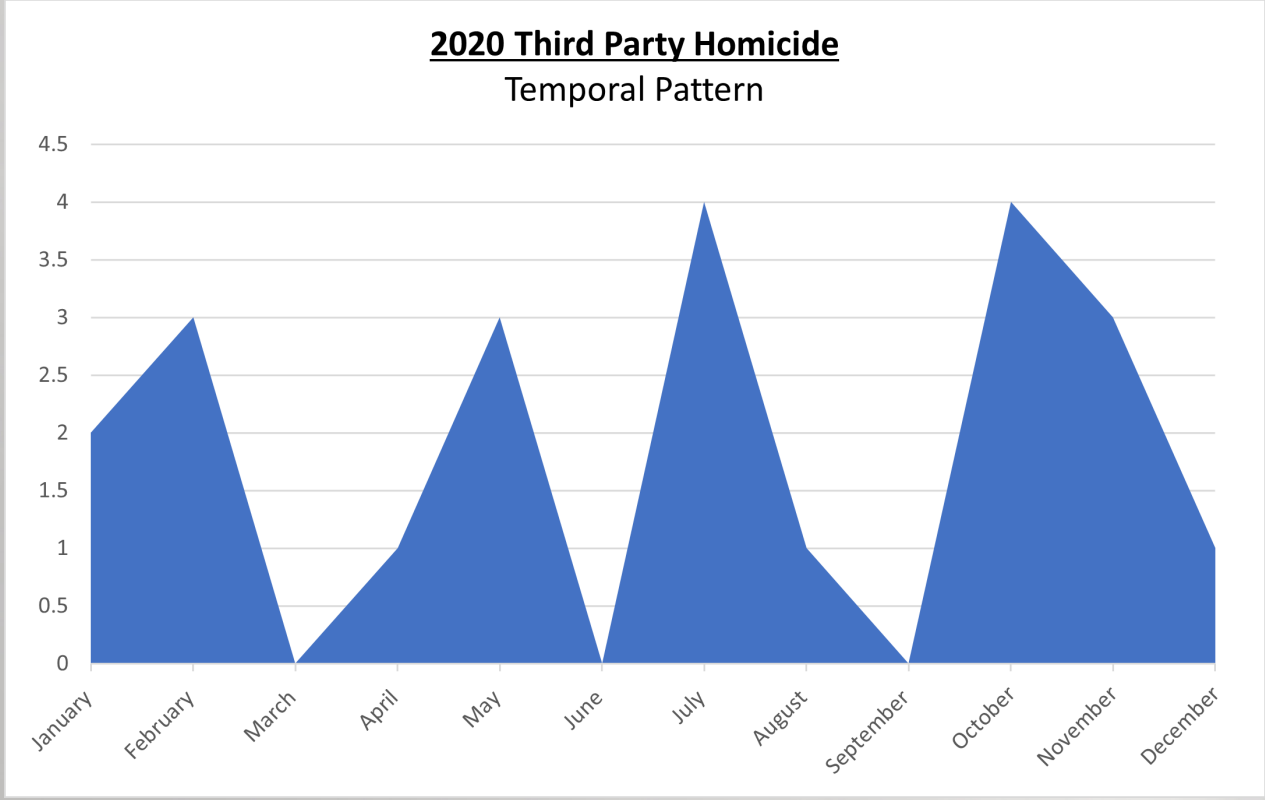

2020 Thrid Party Homicide
Race/Ethnicity Percentage Breakdown
African American
Hispanic
Caucasian
Asian-American


2020 Third Party Homicide
Five Year Race/Ethnicity Trendline
18
16
14
12
10
8
6
4
2
0
2016
2017
2018
2019
2020
African American
Hispanic
Asian-American
Caucasian
Unknown


2020 Thrid Party Homicide
Five Year Gender Trend
30
25
20
15
10
5
0
2016
2017
2018
2019
2020
Male
Female
Unknown

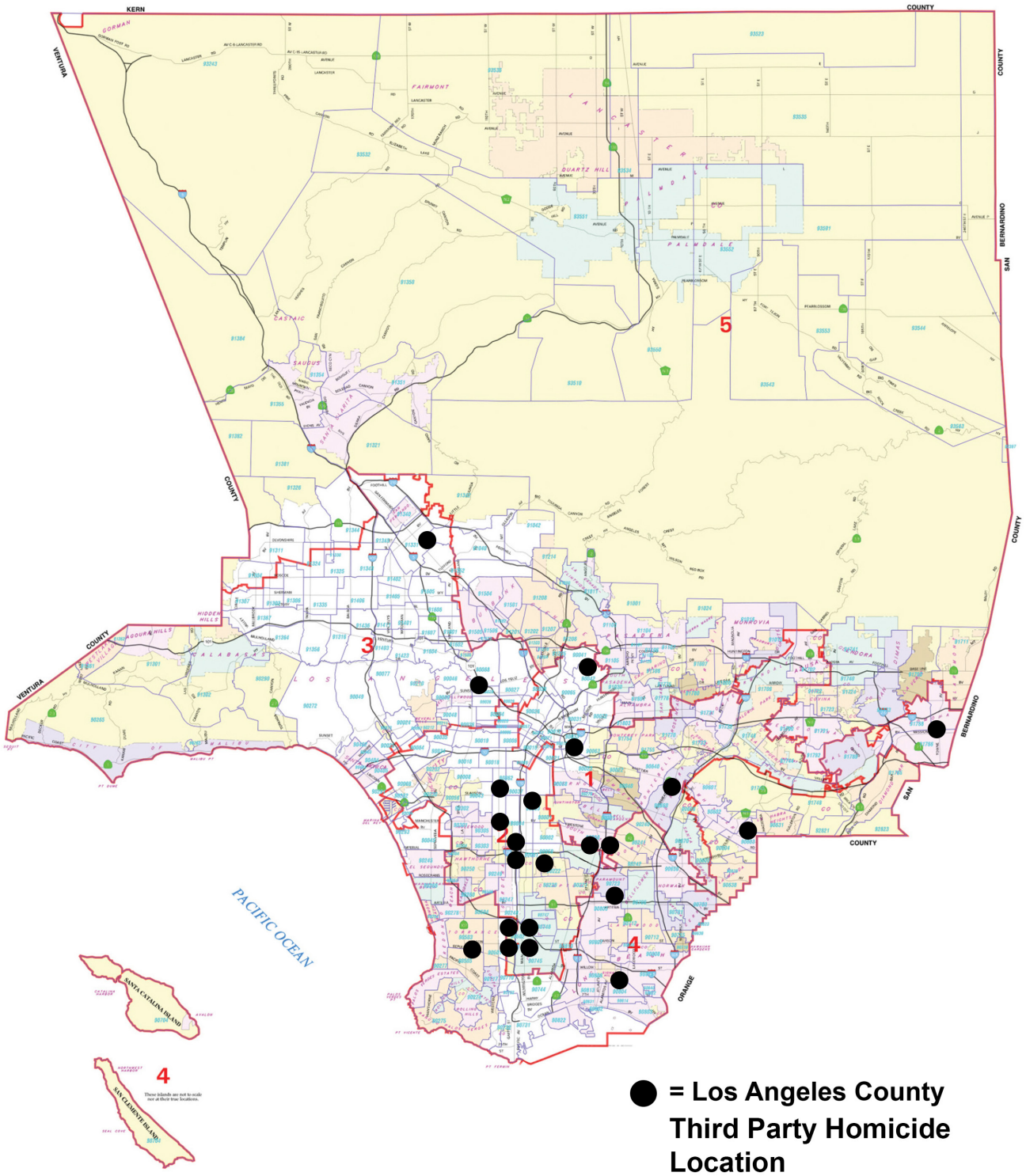

2020 Third Party Homicide
Gender and Age Breakdown
8
7
6
5
4
3
2
1
0
Stillborn
10 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old
Male
Female


2020 Third Party Homicide
Five Year Trend, Victim by Age Group
50
45
40
35
30
25
20
15
10
5
0
Stillborn
1 Years Old
3 Years Old
4 Years Old
8 Years Old
10 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old
2016
2017
2018
2019
2020


2020 Third Party Homicide
Temporal Pattern
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
January
February
March
April
May
June
July
August
September
October
November
December

2020 Third Party Homicides - Locations
n = 22*

City where the homicide occurred



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 B - Map of Los Angeles County Board of Supervisor District