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 2022

Report Compiled from 2021 Data

Inter-Agency Council on Child Abuse and Neglect

Deanne Tilton Durfee, Executive Director

Los Angeles County ICAN Multi-Agency Child Death Review Team

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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

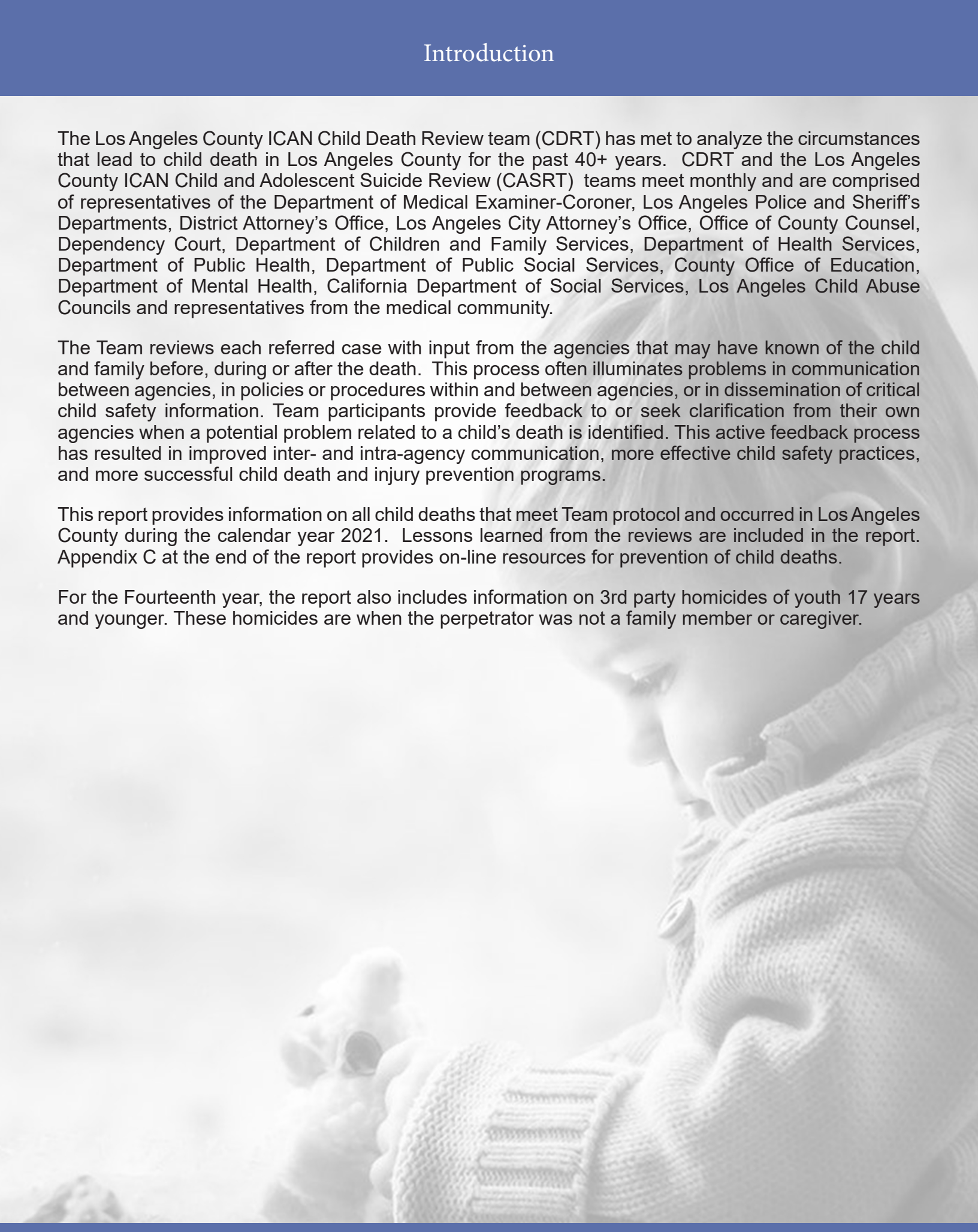
Introduction

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 40+ 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 2021. 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 2020 child death review cases are as follows:

Key Findings

The total number of child deaths in 2021 is 205.

65 children were under the age of one (32%). The deaths of these infants resulted primarily from maternal substance abuse, unsafe sleep and drowning.

77, or 38% of the children who died in 2021, were between ages 15-17. Most deaths were related to suicides and third-party homicides.

Of twenty-two third party homicide victims 19 were male and 3 were female.

In 2021, the majority of child homicide victims by caretaker were females, with four male victims and eight female victims. This was a departure from previous years when male children have been the more frequent victims of homicide by caretaker.

The ethnicity of child victims of homicide by a caretaker in 2021 was as follows; Hispanic: 50%, Caucasians 33% (4 cases), African American 16% (n=2).

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 2021, most cases of homicides by caretaker occurred in a family with at least one prior Department of Child and Family Services contact. Review of the families' histories revealed forty seven 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 4 of the cases of the child abuse homicides. In three of those cases there appeared to untreated post partum depression or psychosis..

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

Twenty-twenty one saw a shift in the proportionality in gender of perpetrators. Wherein previous years, biological fathers were the primary suspect in majority of the child homicide cases, followed by male partners, then biological mothers, in 2021, the majority of child homicides had female perpetrators.

Lack of Parenting Skills, Bonding or Poor Attachment

The poor quality of the relationship of the adult to the child continues to be a recurring factor in child 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 23 children died in 2021 because of unsafe sleep practices.

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

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

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

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

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

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

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

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

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

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

Homicides, by the coroner's definition, are deaths at the hands of another. Child deaths in which the suspected perpetrator is a parent, caregiver, or family member, meet the Team protocol for possible review. All such cases are included in the ICAN annual Team report. Homicide by parent/caregiver/

family member is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term "homicide" regardless of the criminal intent of the perpetrator or the findings of the criminal justice system. Homicide may describe circumstances ranging from tragedies to fatal attacks with clear intent.

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

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

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

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

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

Table 1

Over the past 5 years, a parent, caregiver or other family member has murdered an average of 12 children each year

Year	Number
2017	8
2018	10
2019	18
2020	14
2021	12

The average number of children and adolescents who committed suicide over the past five years is 25. The leading method from 2017 through 2021 is hanging.

Year	Number
2017	27
2018	29
2019	20
2020	26
2021	23

An average of 108 children have died from preventable accidents over the past 5 years from automobile accidents, drowning and deaths due to auto vs. pedestrian.

Year	Number
2017	98
2018	102
2019	110
2020	126
2021	104

The number of undetermined deaths has averaged 50 per year over the past five years

Year	Number
2017	54
2018	67
2019	42
2020	50
2021	41

Table 2 2021 Child Deaths Demographics - Coroner Cases		
	Number	**Percentage**
Total	205	100.0%
Gender		
Female	71	35%
Male	133	65%
Unknown	1	.49%
Age		
Under 1 Year	65	32%
1 – 4 years	21	10%
5 – 9 years	15	7%
10 – 14 years	27	13%
15 – 17 years	77	38%
Race		
African American	46	22%
Armenian	1	.49%
Asian/Pacific Islander	11	5%
American Indian	40	20%
Caucasian	1	.49%
Hawaiian	98	48%
Hispanic	109	46%
Middle Eastern	3	1%
Samoan	2	1%
Unknown	11	5%

Sample Case Summaries - Homicides

Marcie

8-month-old Marcie was under the care of her father and mother. The father reported he was caring for the child while the mother was asleep. Father reported she left the child in an infant swing as he left the room. Father returned to find the child's eyes were rolling and she was unresponsive. The parents drove the child to the hospital. The child was found to have bruising on her forehead, liver laceration, and a partially dissected spinal cord. It was found that the child was a victim of strangulation, as well. The mother has a history of removal of children from her care. Both mother and father were arrested.

Jose

16-year-old Jose was in the care of his stepmother when an altercation occurred between the two. The stepmother struck Jose approximately 12 times in his head and face. Jose was shoved to the ground, where he struck his head against a bunk bed. Jose was unresponsive and was found with clear vomit coming from his mouth. 911 was contacted and George was taken to a hospital, where he was pronounced dead. Jose was found to have old and suspicious injuries at time of death. Jose was found to have burns and deep ulcers on his body. He was also found with his ear split. An investigation found that Jose endured multiple beatings at the hand of his stepmother over the span of a year. The child's father was aware and assisted in making of a weapon that was used on Jose. The stepmother was found to be the perpetrator of Jose's murder and torture.

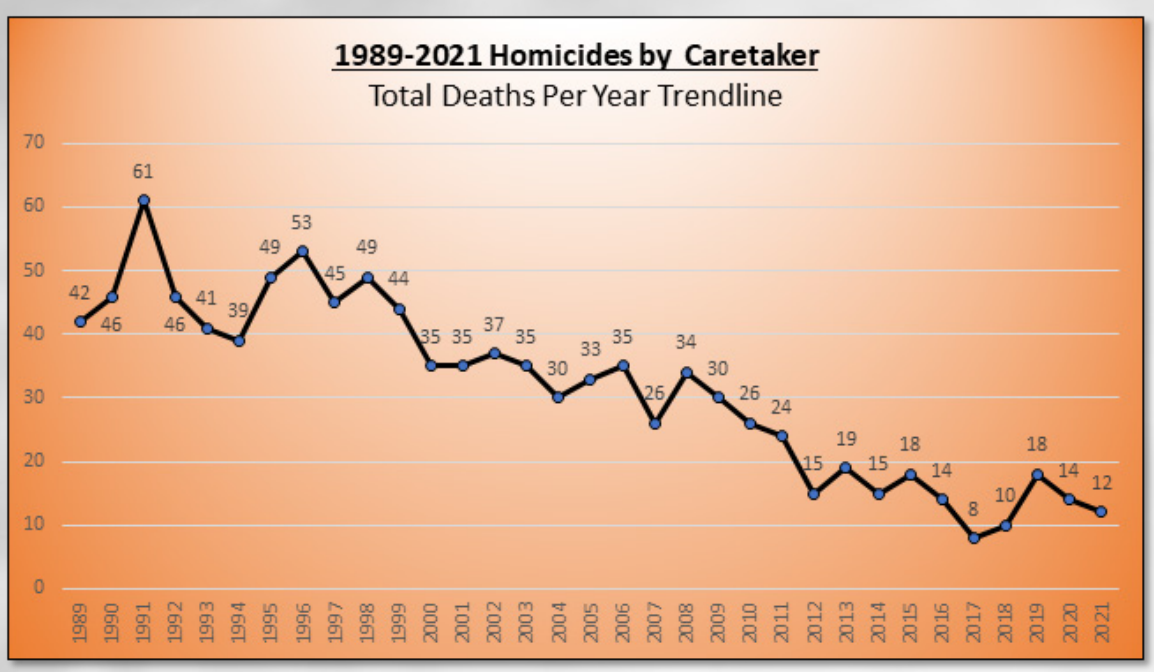
Annie

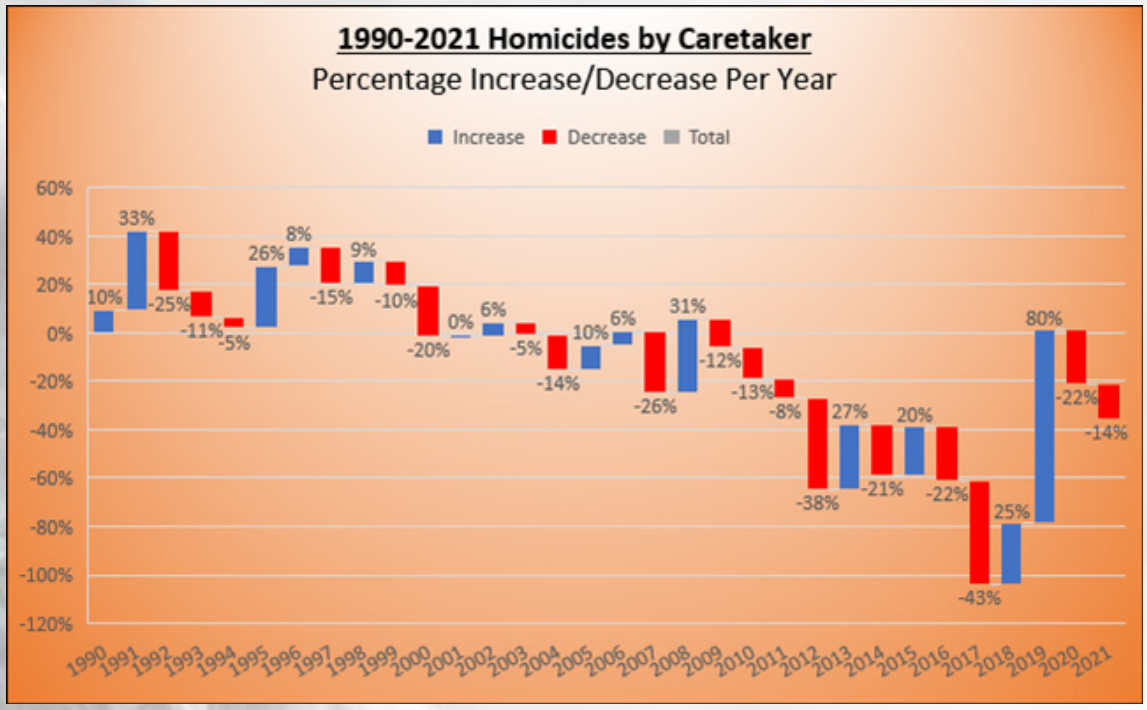
One-year-old Annie was in the care of her mother when she was found dead inside her home. The child was found with multiple stab wounds. Mother was also found deceased from self-inflicted injuries. The case was ruled a murder-suicide. The mother has a history of post-partum depression and previously had an open child welfare case, which was closed a few months prior to the incident.

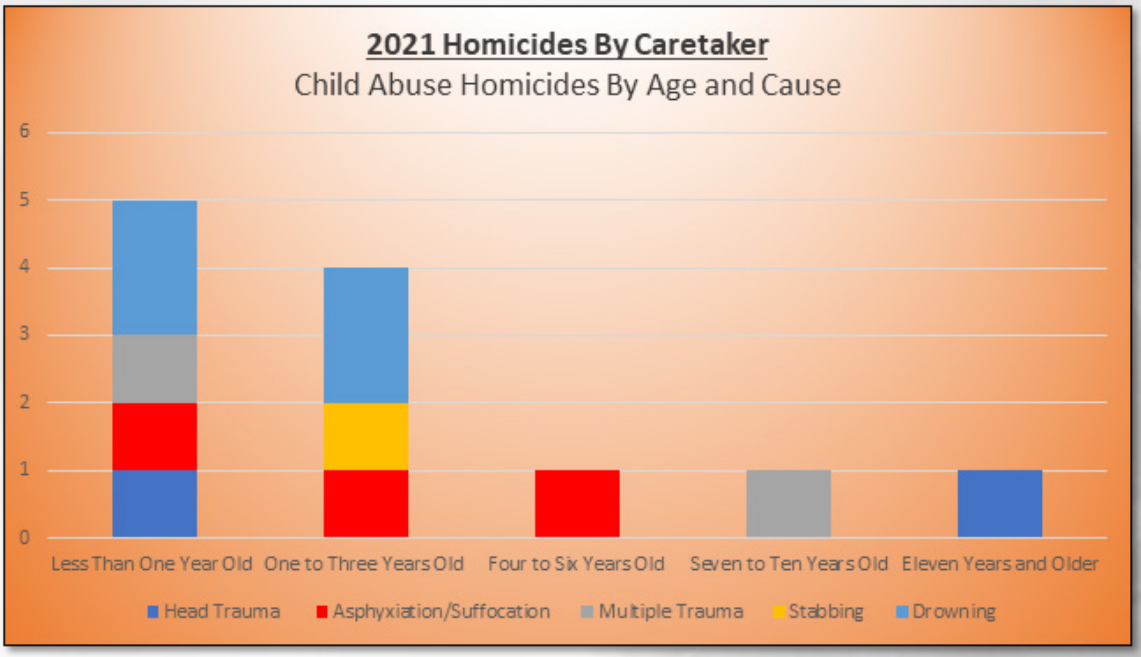
HOMICIDE BY CARETAKER

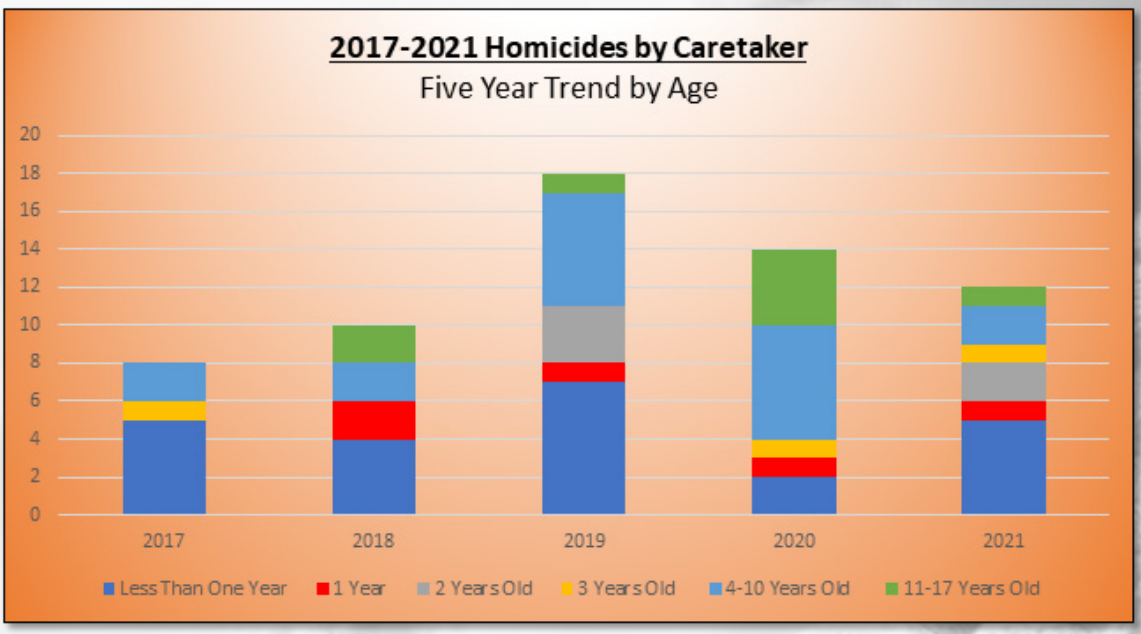
FINDINGS

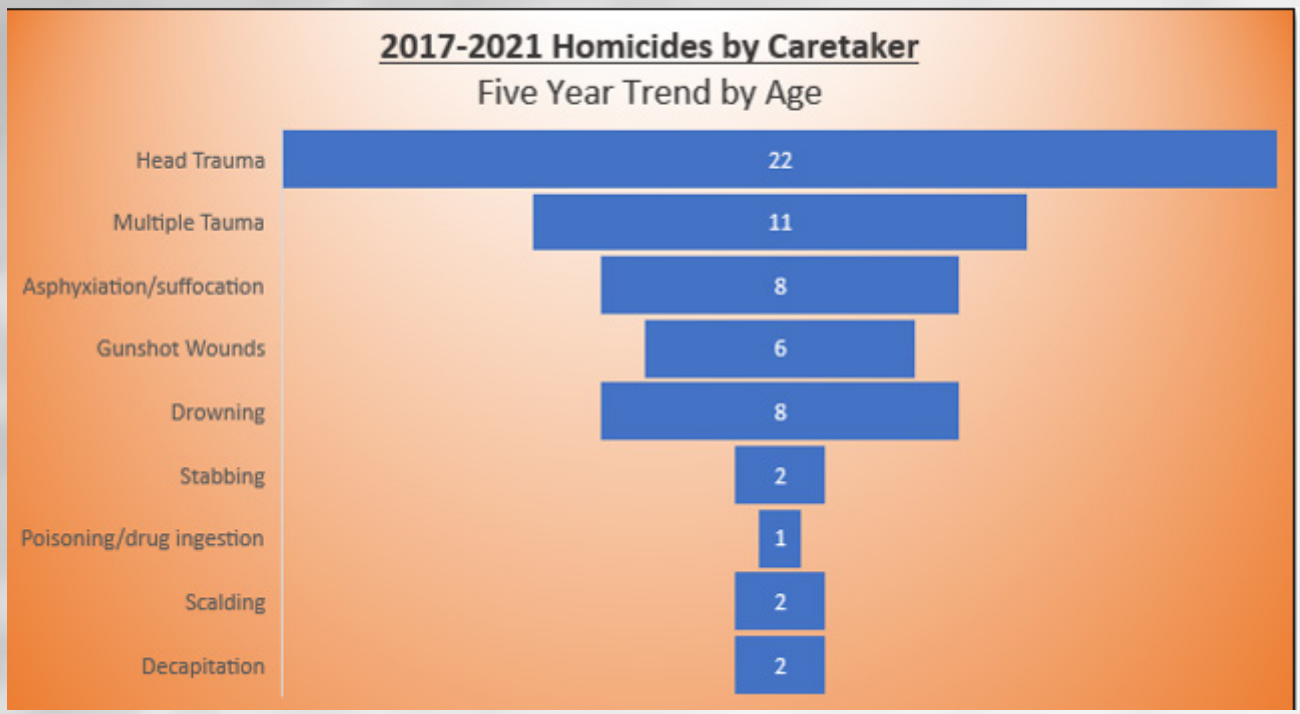
- Twelve child homicides by caretakers were reported to ICAN from the Coroner's Department in 2021.
- This was a 14% decrease from the 2020 number of 14 homicides by caretaker. The lowest number of homicides by caretaker was in 2017, with only 8 homicides and there was a spike in 2019 where there were 18 homicides. However, the overall trend in the past 10 years is a downward trend.
- Drownings were the leading cause of homicides by caretaker deaths in 2021, with 4 children dying from being drowned by their caretaker. The second leading cause was suffocation (3 deaths). This is a shift from the five-year average where head trauma and multiple traumas were the leading causes of these deaths. This shift may be since there was also a shift in the gender of perpetrators, males have historically been the perpetrators in many child abuse homicides. 2021 data demonstrate 3 females being the sole perpetrators of these deaths and three cases where both mother and father or father and girlfriend participated in committing the homicide. There was only one case in 2021 where the father was the sole perpetrator.
- The other causes of child homicides were head trauma (2), multiple trauma (2), and stabbing (1).
- Over the last five years, the top causes of death in homicides by caretaker have been head trauma, multiple trauma and gunshot wound.
- The age of child victims in 2021 represented the continuing trend of children under age one as most child homicide victims, as in previous years. In 2021, five children were under age 1 and five other children were between age 1 year old to 4 years old.
- The ethnicity of child victims of homicide by a caretaker in 2021 was as follows; Hispanic: 50%, Caucasians 33% (4 cases), African American 16% (n=2).
- 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.
- Fifty percent (6 out of the 12 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 fifty 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 Claremont Police Department, and Hawthorne Police Department.

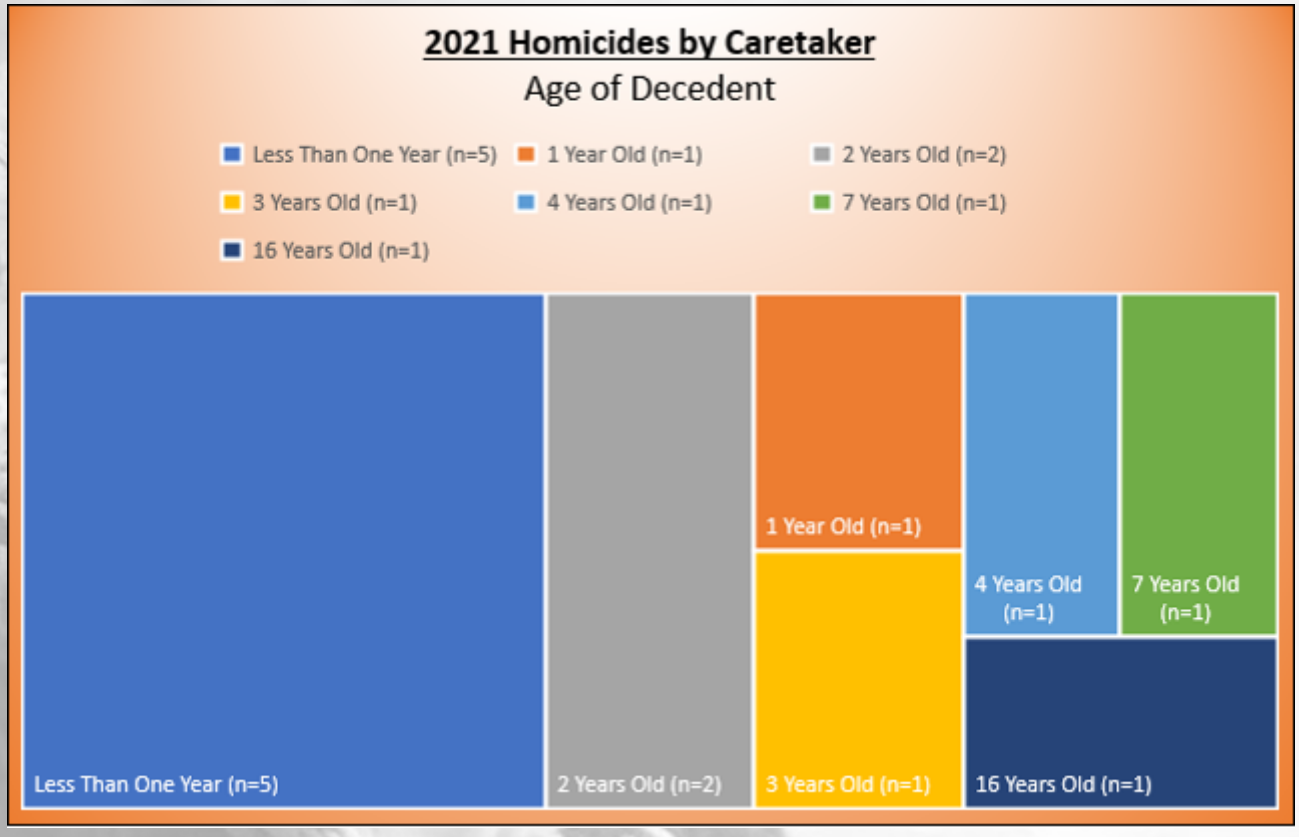

1989-2021 Homicides by Caretaker
Total Deaths Per Year Trendline
70
60
50
40
30
20
10
0
42 46 61 46 41 39 49 53 45 49 44 35 35 37 35 30 33 35 26 34 30 26 24 15 19 15 18 14 8 10 18 14 12
1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021

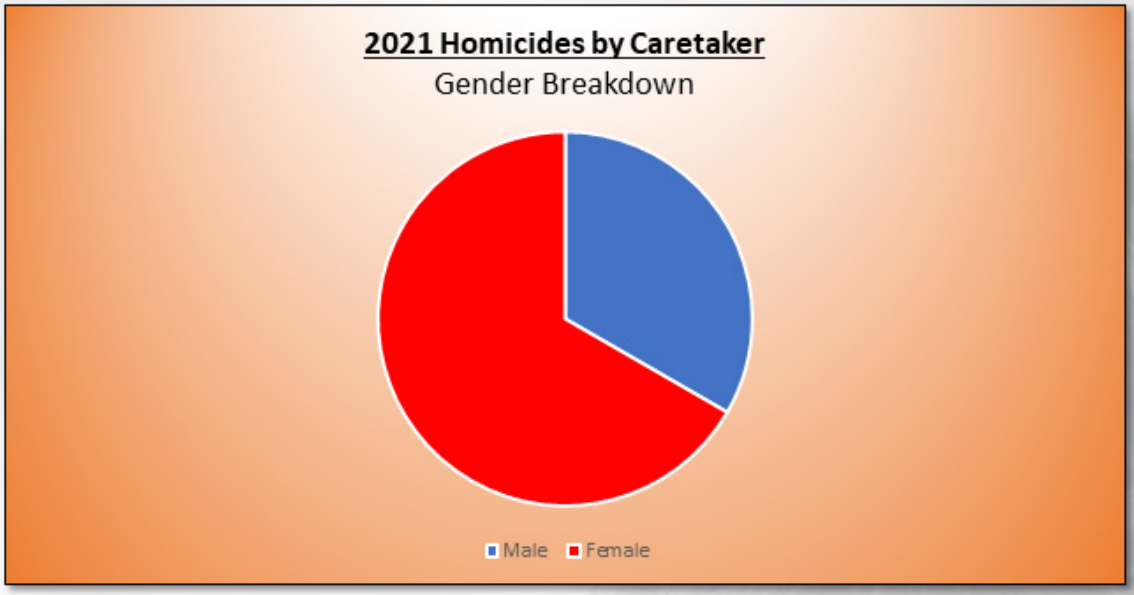

1990-2021 Homicides by Caretaker
Percentage Increase/Decrease Per Year
Increase
Decrease
Total
60%
40%
20%
0%
-20%
-40%
-60%
-80%
-100%
-120%
10% 33% -25% -11% -5% 26% 8% -15% 9% -10% -20% 0% 6% -5% -14% 10% 6% -26% 31% -12% -13% -8% -38% 27% -21% 20% -22% -43% 25% 80% -22% -14%
1990 1991 1992 1993 1994 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 2021

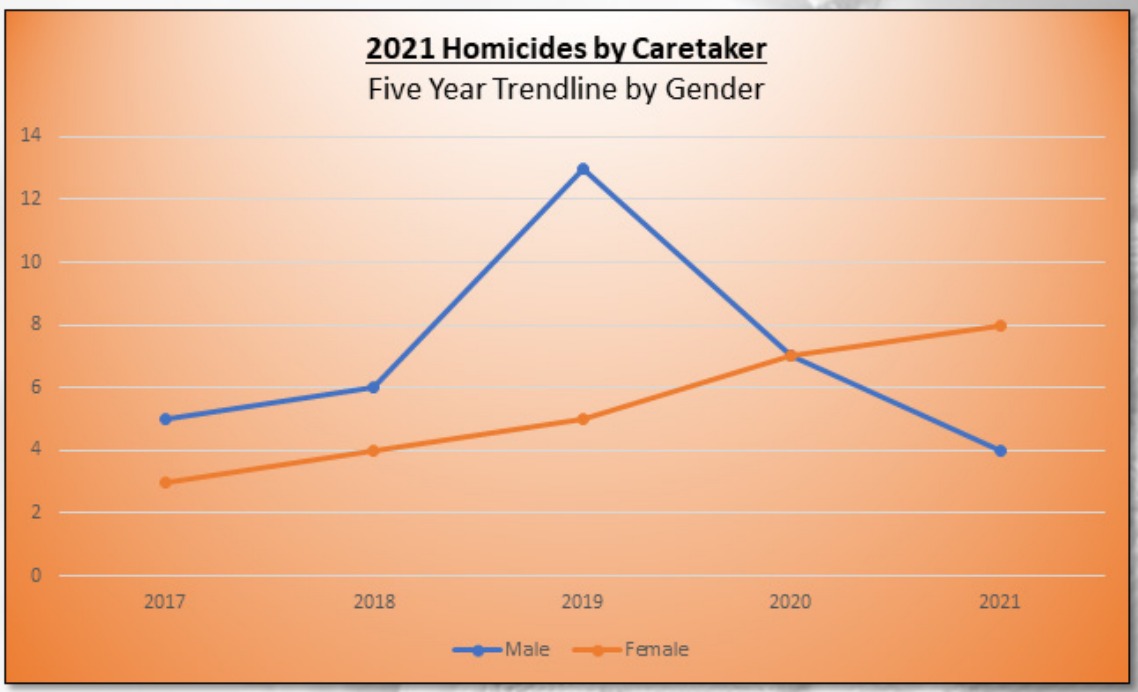

2021 Homicides By Caretaker
Child Abuse Homicides By Age and Cause
6
5
4
3
2
1
0
Less Than One Year Old
One to Three Years Old
Four to Six Years Old
Seven to Ten Years Old
Eleven Years and Older
Head Trauma
Asphyxiation/Suffocation
Multiple Trauma
Stabbing
Drowning

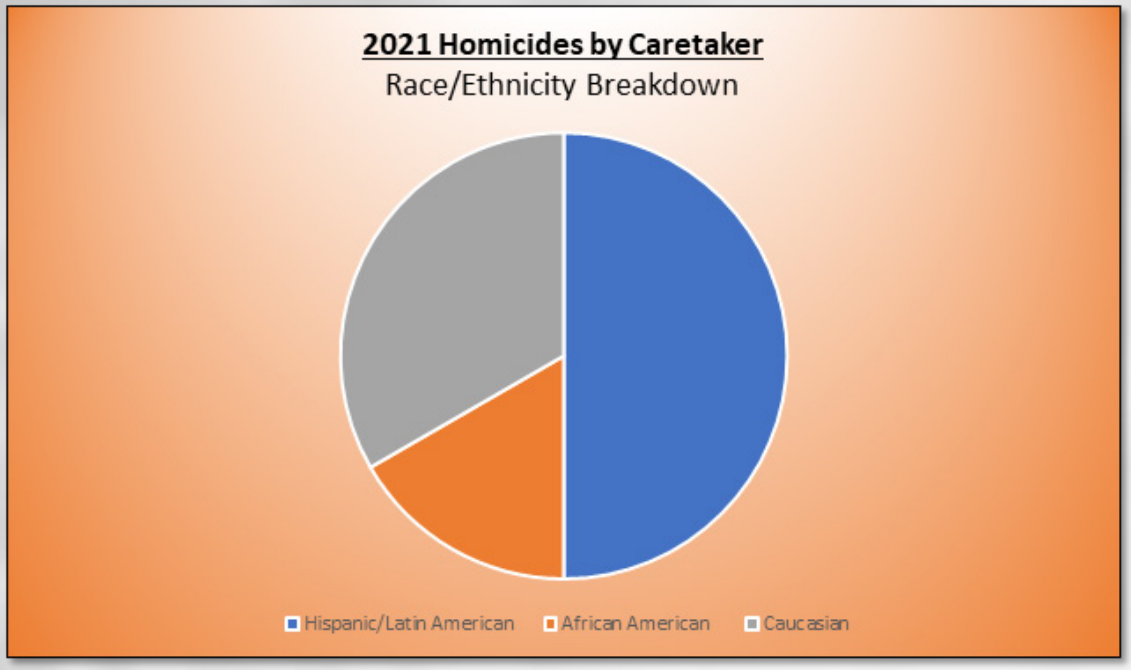

2017-2021 Homicides by Caretaker
Five Year Trend by Age
20
18
16
14
12
10
8
6
4
2
0
2017
2018
2019
2020
2021
Less Than One Year
1 Year
2 Years Old
3 Years Old
4-10 Years Old
11-17 Years Old

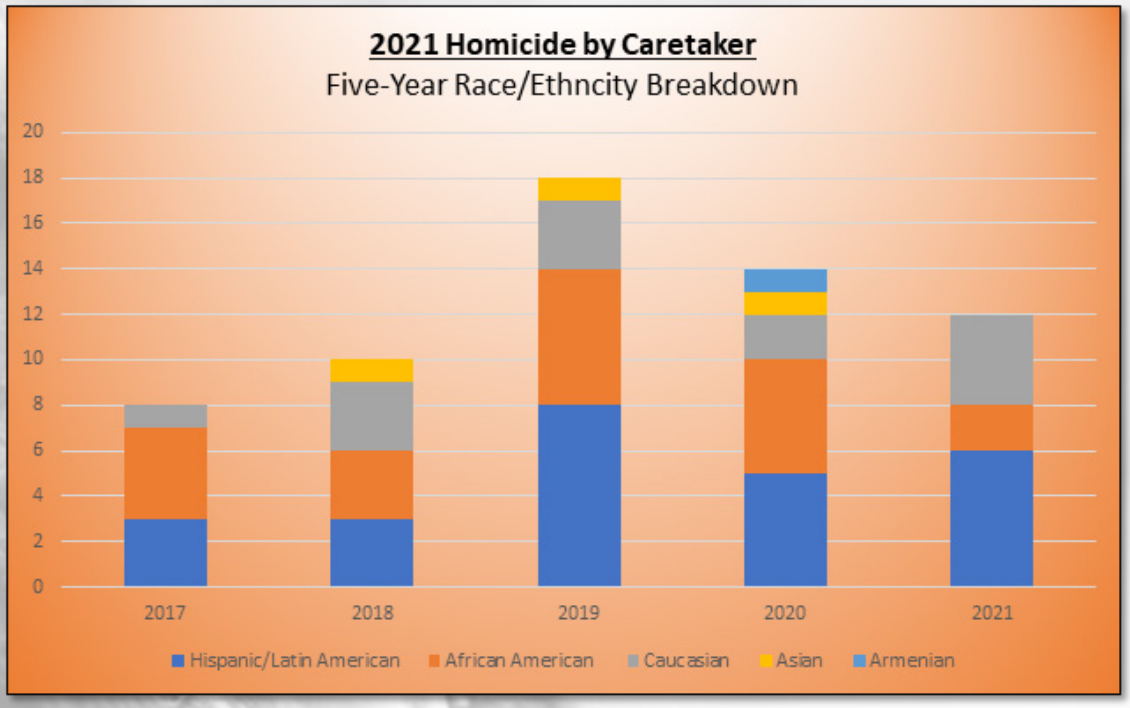

2017-2021 Homicides by Caretaker
Five Year Trend by Age
Head Trauma
22
Multiple Tauma
11
Asphyxiation/suffocation
8
Gunshot Wounds
6
Drowning
8
Stabbing
2
Poisoning/drug ingestion
1
Scalding
2
Decapitation
2


2021 Homicides by Caretaker
Age of Decedent
Less Than One Year (n=5)
1 Year Old (n=1)
2 Years Old (n=2)
3 Years Old (n=1)
4 Years Old (n=1)
7 Years Old (n=1)
16 Years Old (n=1)
Less Than One Year (n=5)
2 Years Old (n=2)
1 Year Old (n=1)
3 Years Old (n=1)
4 Years Old (n=1)
7 Years Old (n=1)
16 Years Old (n=1)

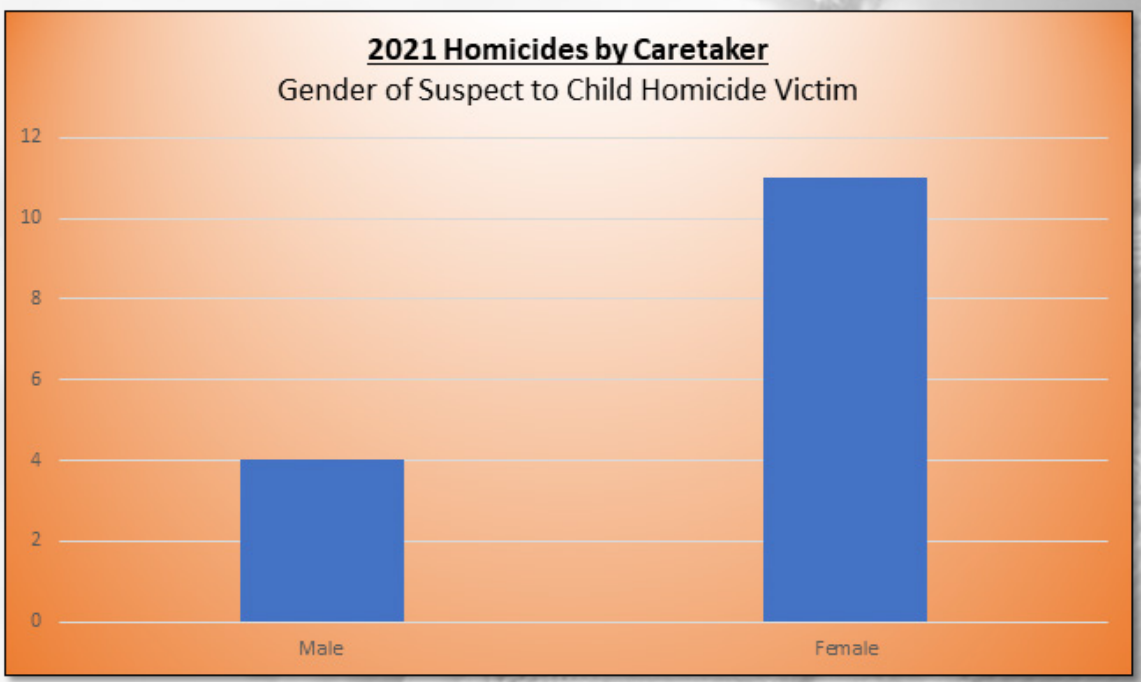

2021 Homicides by Caretaker
Gender Breakdown
Male
Female

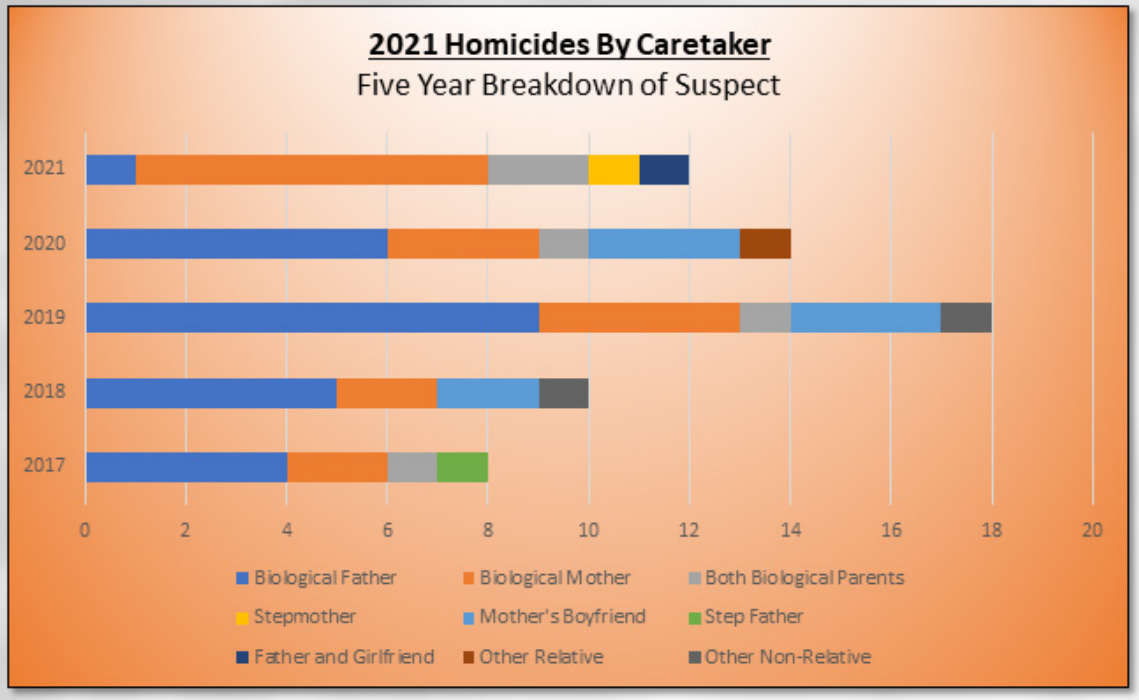

2021 Homicides by Caretaker
Five Year Trendline by Gender
14
12
10
8
6
4
2
0
2017
2018
2019
2020
2021
Male
Female

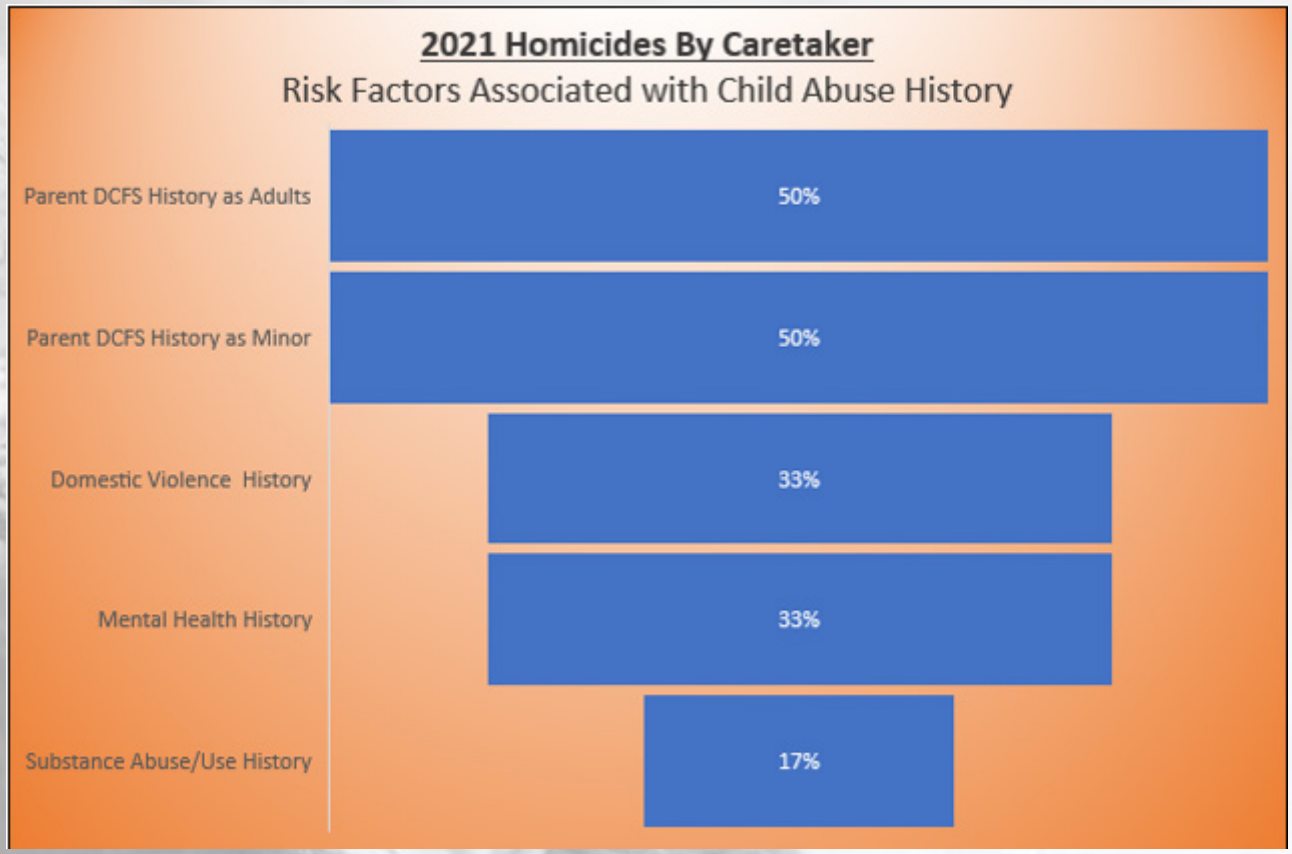

2021 Homicides by Caretaker
Race/Ethnicity Breakdown
Hispanic/Latin American
African American
Caucasian

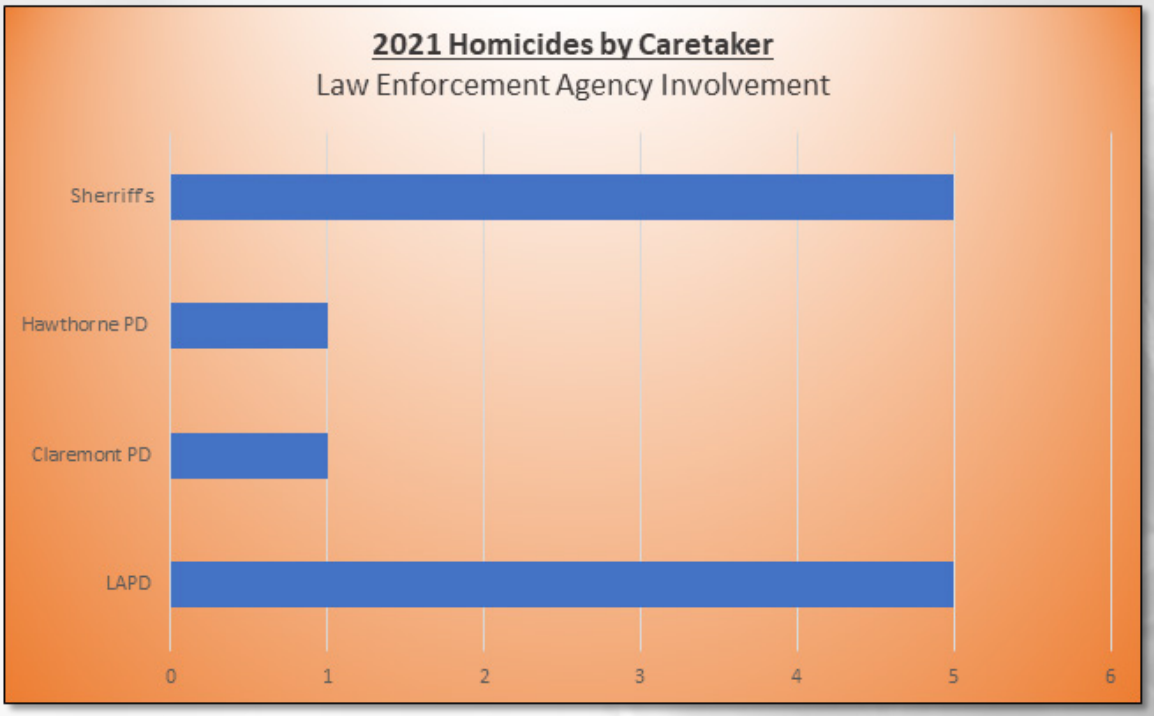

2021 Homicide by Caretaker
Five-Year Race/Ethncity Breakdown
20
18
16
14
12
10
8
6
4
2
0
2017
2018
2019
2020
2021
Hispanic/Latin American
African American
Caucasian
Asian
Armenian


2021 Homicides By Caretaker
Relationship of Suspect to Child Homicide Victim
Biological Father (n=1)
Stepmother (n=1)
Father and Girlfriend (n=1)
Both Biological Parents (n=2)
Biological Mother (n=7)


2021 Homicides by Caretaker
Gender of Suspect to Child Homicide Victim
12
10
8
6
4
2
0
Male
Female

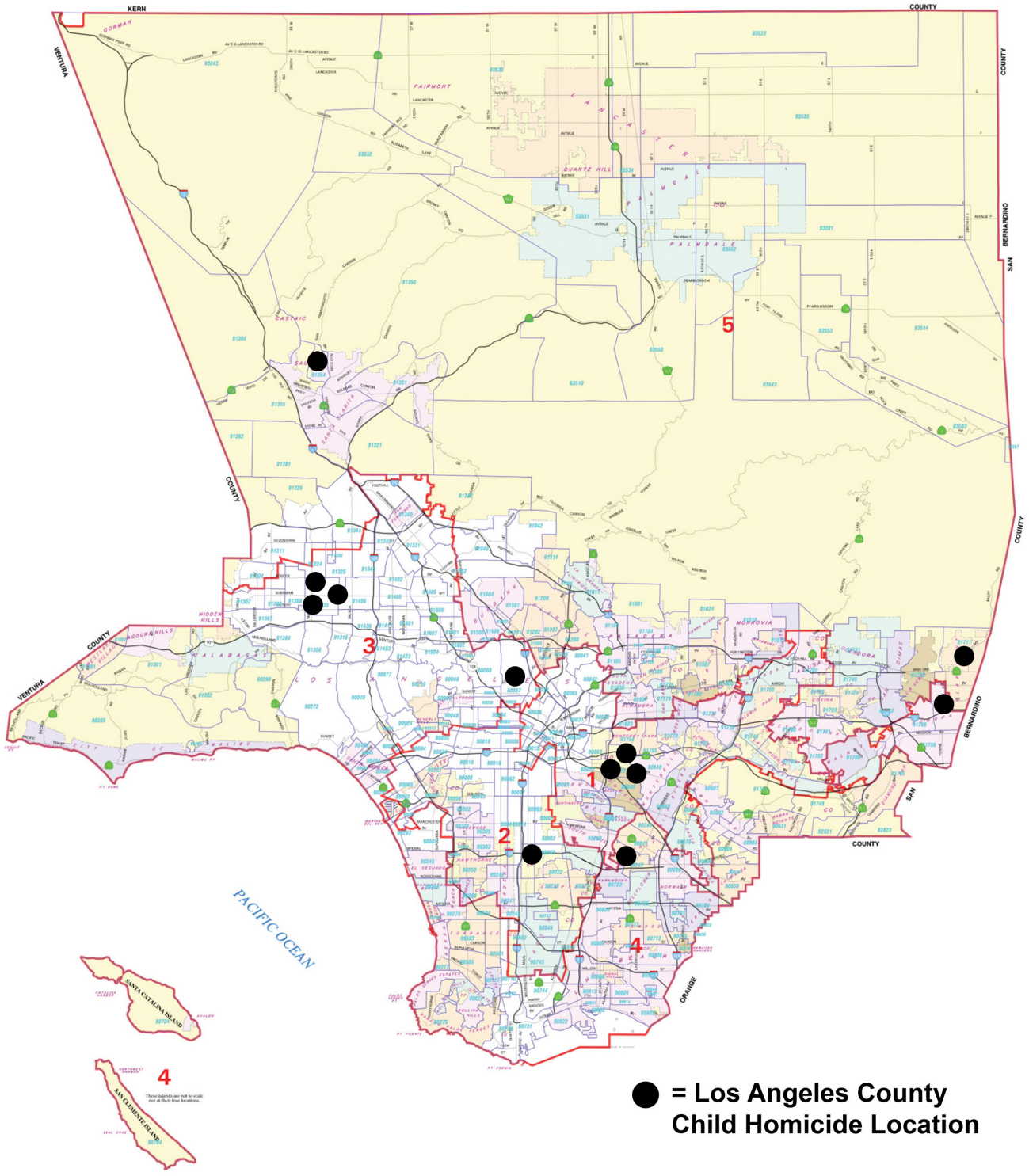

2021 Homicides By Caretaker
Five Year Breakdown of Suspect
2021
2020
2019
2018
2017
0
2
4
6
8
10
12
14
16
18
20
Biological Father
Biological Mother
Both Biological Parents
Stepmother
Mother's Boyfriend
Step Father
Father and Girlfriend
Other Relative
Other Non-Relative


2021 Homicides By Caretaker
Risk Factors Associated with Child Abuse History
Parent DCFS History as Adults
50%
Parent DCFS History as Minor
50%
Domestic Violence History
33%
Mental Health History
33%
Substance Abuse/Use History
17%


2021 Homicides by Caretaker
Law Enforcement Agency Involvement
Sherriff's
Hawthorne PD
Claremont PD
LAPD
0
1
2
3
4
5
6

2021 Child Homicides - Locations
n = 12*

***City where the homicide occurred**



Sample Case Summaries - Suicides

Nikki

Twelve-year-old Nikki was found unresponsive in her bedroom. Nikki's mother called 9-1-1 and was transported to Santa Barbara Cottage Children's Medical center where she had a seizure and was given an Ativan. Nikki went into full cardiac arrest and CPR was performed. Nikki was transferred to Children's Hospital Los Angeles and diagnosed with suicide attempt, multiorgan failure, cardiac arrest, and irreversible neurological injury. Nikki was given a poor prognosis and the family decided to withdraw care. Death was pronounced at the hospital. Nikki had a history of suicide attempts in the past. Nikki had recently moved to mother's home prior to living with father. Mom later reported finding empty bottles of Lamictal and Seroquel under the sink. The pills were Mom's unopened medication. There was no suicide note found at the scene.

Joe

Joe age 15, was found hanging with a rope around his neck by his father in his bedroom. Joe was living with his father and siblings. Joe's mother died due to cancer 2 years prior, and Joe's mental health declined. Joe refused mental health services and never agreed to meet with a therapist. Joe was last seen alive the night before at 11pm. Joe's father knocked on Joe's door in the morning to ensure Joe was logged in for his online class but could not see him. Joe's father opened the door more and observed Joe with a rope around his neck in his closet. Father called 9-1-1 and EMS/ Police personnel responded. Joe was pronounced dead at 08:18am. There were seven suicide notes found on Joe's desk.

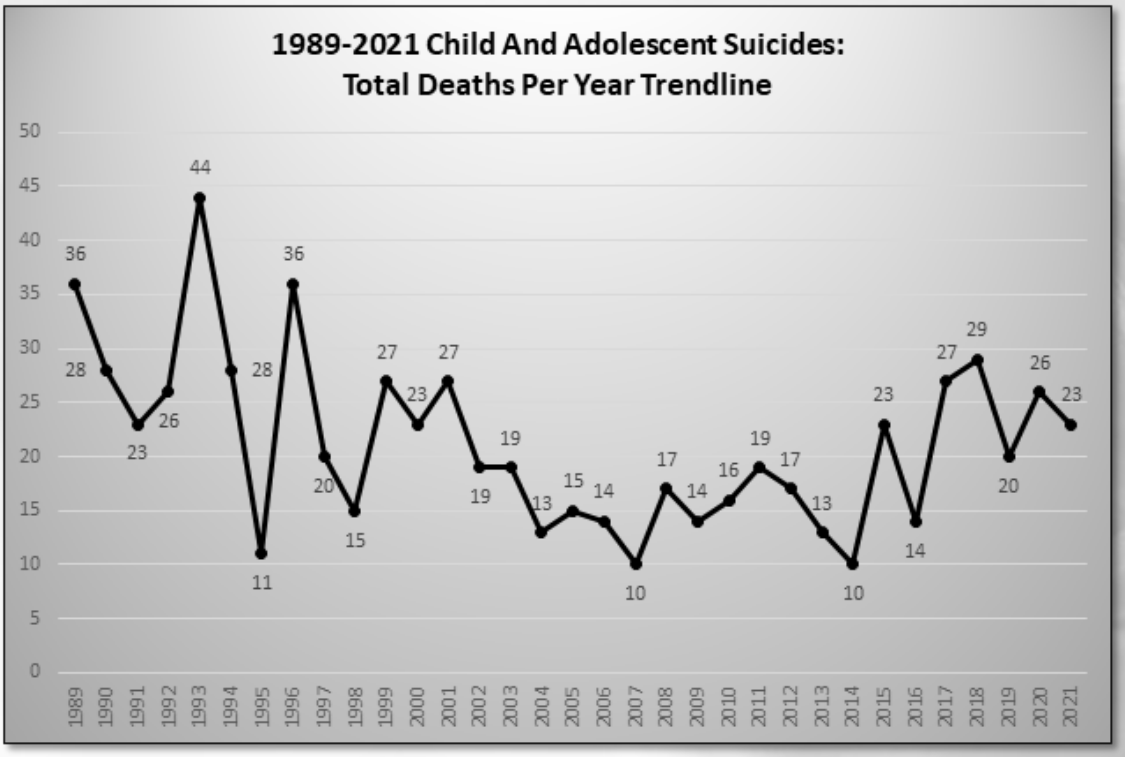
Bella

Bella age 14, was found hanging with a shoelace around her neck at a group home. Bella AKA Jeffrey was transitioning from female to male. Jeffrey did not want to return to mother's home alleging mother insulting his body image. Mother inquired to medical providers and mental health agencies to be educated on Trans youth. Mother made a safety plan to allow Jeffrey stay with a relative until Jeffrey was taken into protective custody by the Department of Children and Family Services (DCFS). Over the course of Jeffrey's DCFS stay, he was hospitalized and had history of cutting. Jeffrey did not leave a suicide note.

SUICIDES

FINDINGS

- The Coroner reported Twenty-three child and adolescent suicides to ICAN for 2021. This is a decrease from the 2020 data where there were twenty-six suicides and fall in line with the five-year average of twenty-three suicides.
- Fifty-seven percent of the suicides in 2021 were the result of hanging (n=13) and twenty-six percent were the result of gunshot wound (n=6). Seven percent of the suicides were from substance overdose (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, fifty-nine percent (n=74) of the suicides were from hanging and twenty percent (n=26) were from gunshot wound. Between the two, this accounts for eighty percent of all reported suicides.
- The gender divide for child and adolescent suicides we saw in previous years continues to diminish. Like in 2020 where there were an equal amount of males and females that died by suicide, in 2021 there were 12 males and 11 females.
- As in previous years where the leading age of suicide has been Seventeen-year-olds, the trend has returned with Seventeen-year-olds being the majority of suicide victims in 2021. As opposed to 2020, when the largest age group was Thirteen year olds.
- In 2020, Fourteen to seventeen made up 86% of all suicide deaths. The youngest suicides were two children age 12.
- As in previous years, Hispanics and Caucasians comprised the two largest racial/ethnic groups for child and adolescents' suicides. The downward trend of African American children suiciding continues in 2021 with only one African American child suiciding. There were three suicides by Asian American children. Lastly, there were two suicides of children of Middle Eastern descent and one case did not have a racial/ethnic group listed.


1989-2021 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
11
28
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
23
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
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2012
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2014
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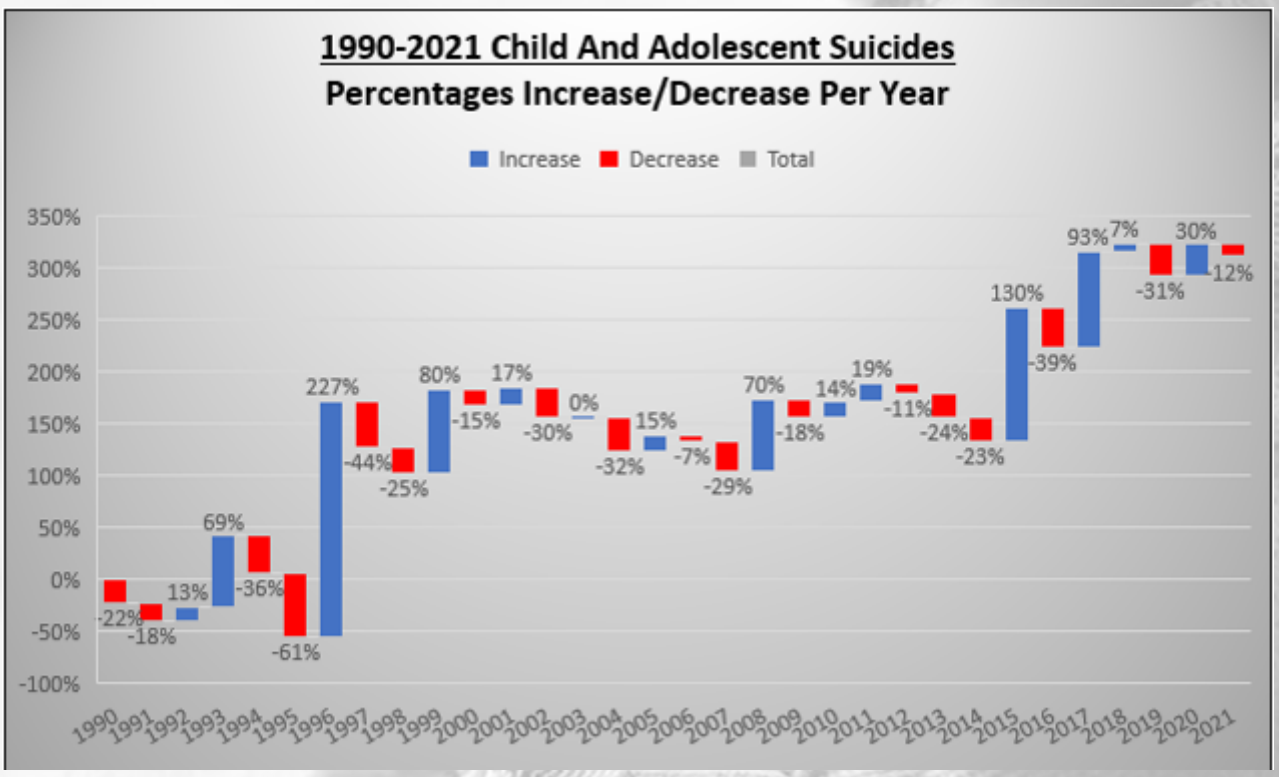
2016
2017
2018
2019
2020
2021


1990-2021 Child And Adolescent Suicides
Percentages Increase/Decrease Per Year
Increase
Decrease
Total
350%
300%
250%
200%
150%
100%
50%
0%
-50%
-100%
-22%
-18%
13%
69%
-36%
-61%
227%
-44%
-25%
80%
-15%
17%
-30%
0%
-32%
15%
-7%
-29%
70%
-18%
14%
19%
-11%
-24%
-23%
130%
-39%
93%
7%
-31%
30%
-12%
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
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2007
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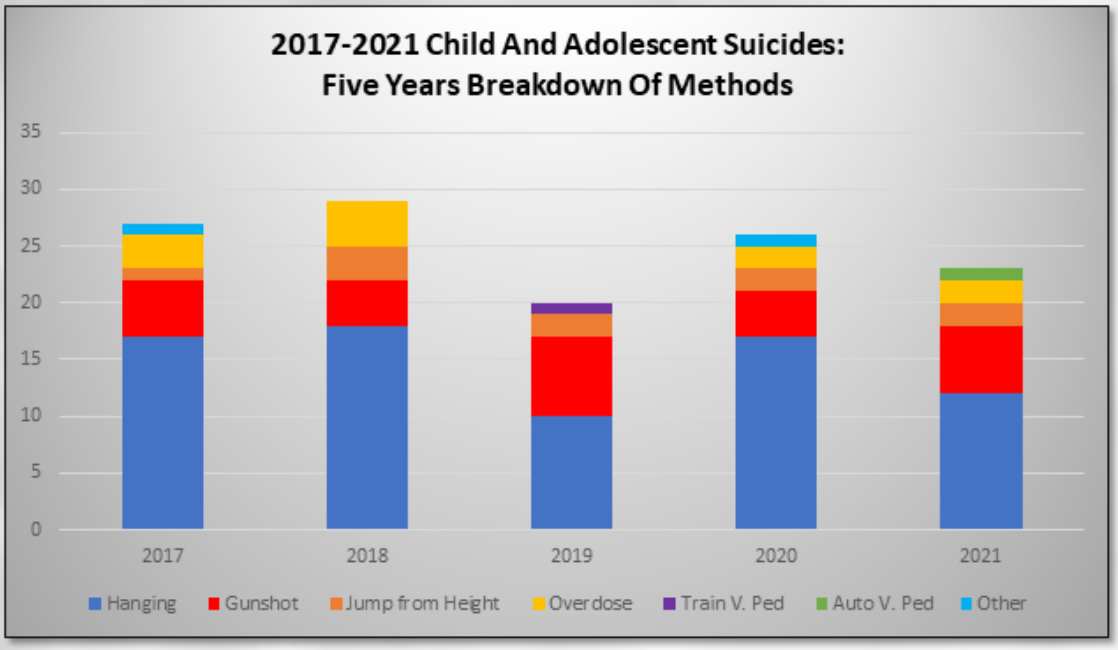
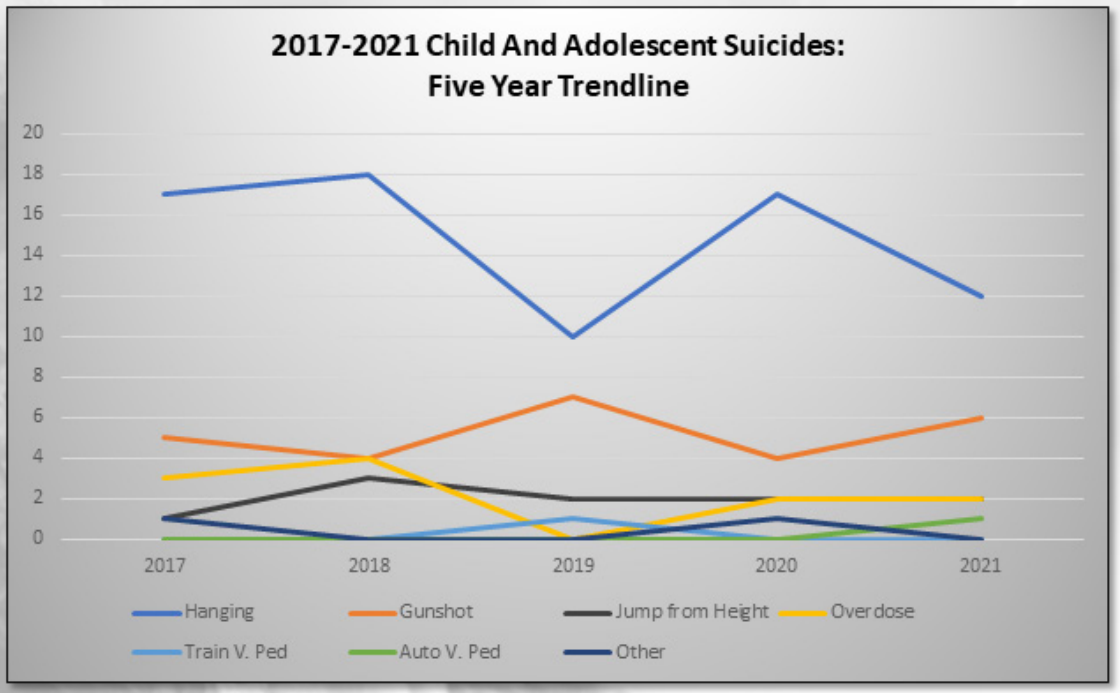
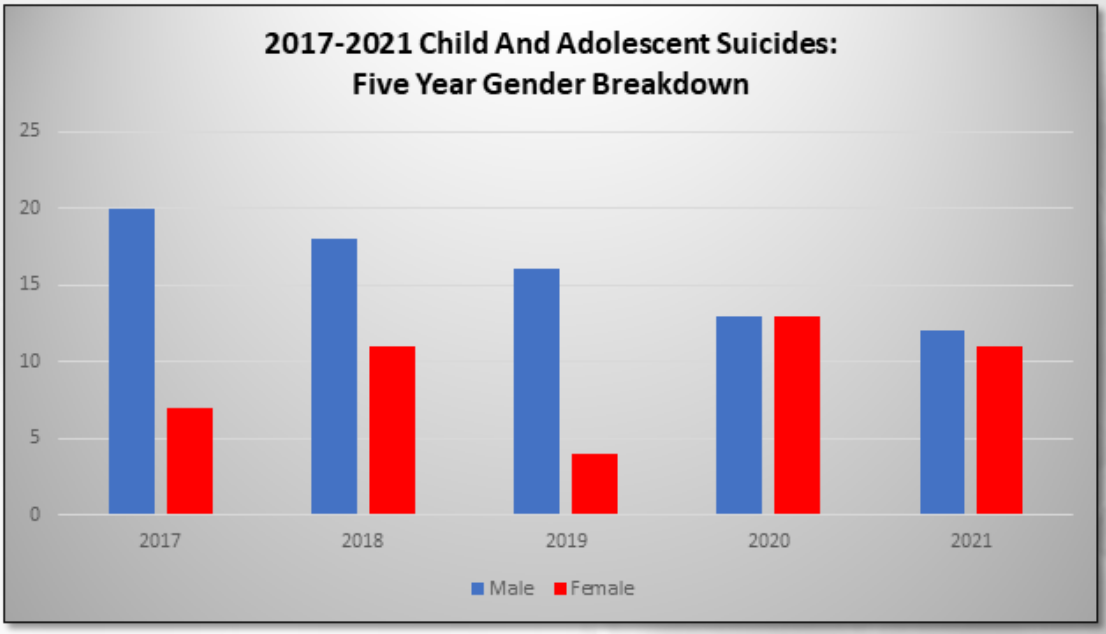
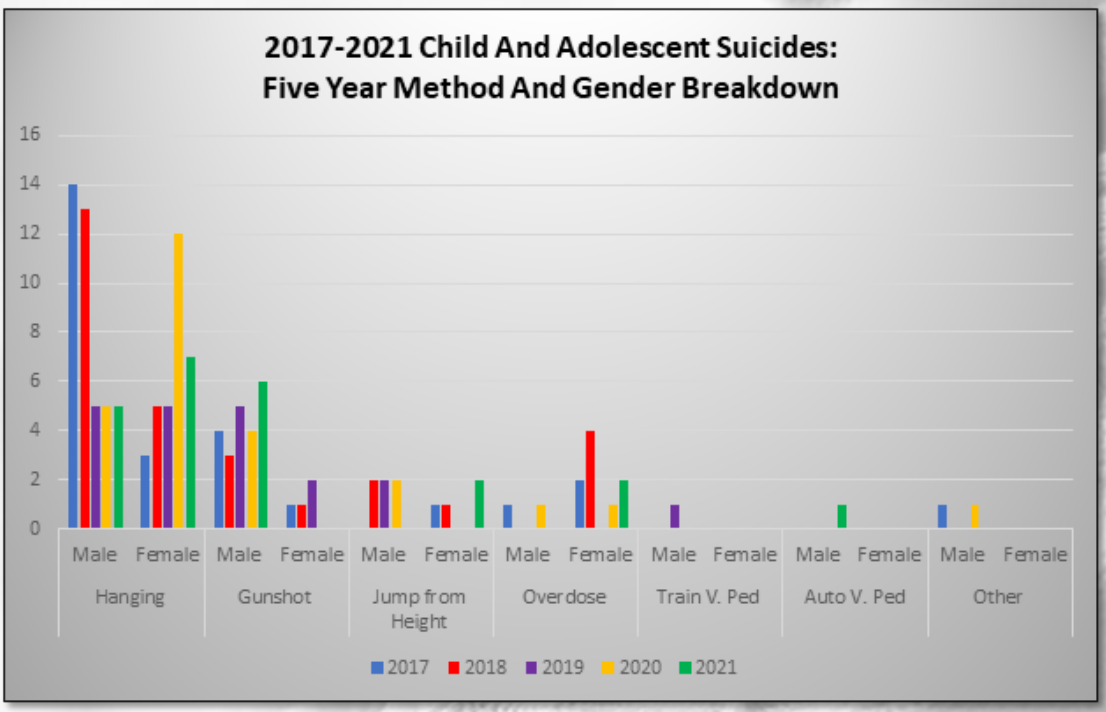
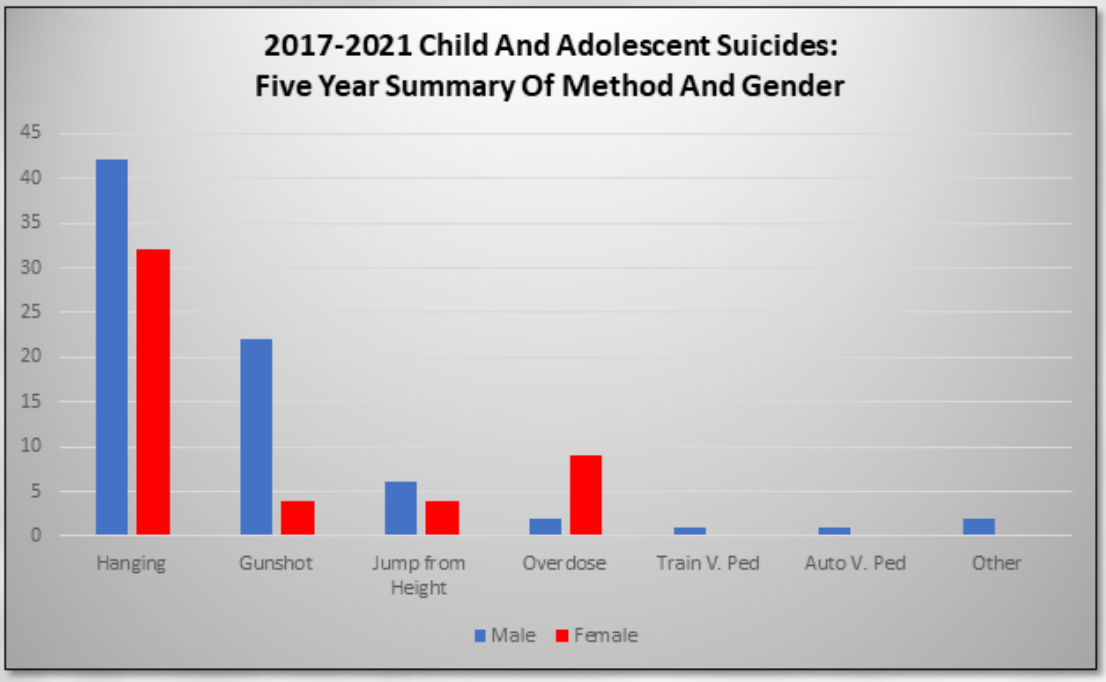
2019
2020
2021

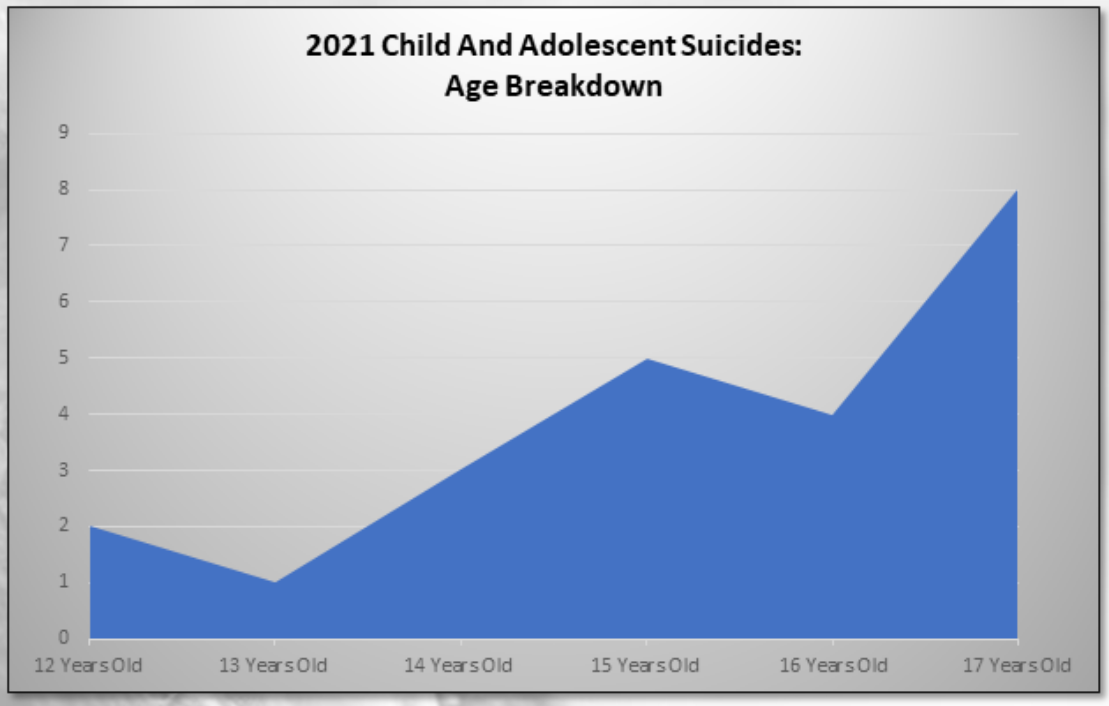

2017-2021 Child And Adolescent Suicides:
Five Years Breakdown Of Methods
35
30
25
20
15
10
5
0
2017
2018
2019
2020
2021
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Auto V. Ped
Other

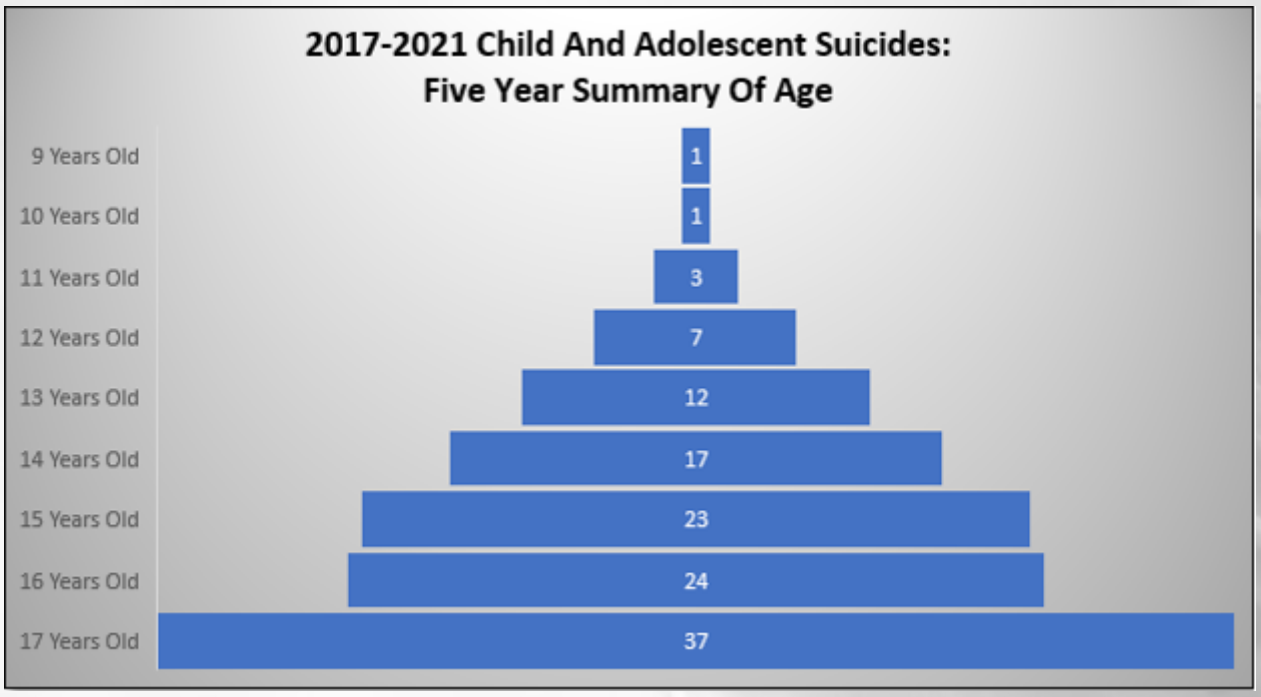

2017-2021 Child And Adolescent Suicides:
Five Year Trendline
20
18
16
14
12
10
8
6
4
2
0
2017
2018
2019
2020
2021
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Auto V. Ped
Other

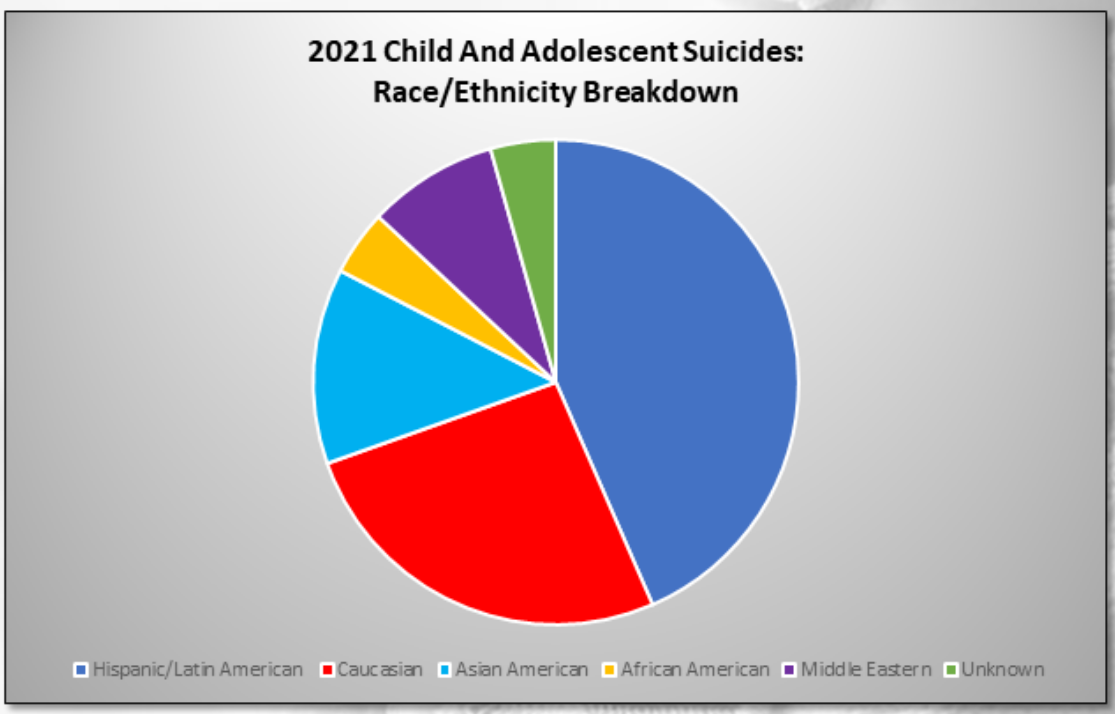

2017-2021 Child And Adolescent Suicides:
Five Year Gender Breakdown
25
20
15
10
5
0
2017
2018
2019
2020
2021
Male
Female

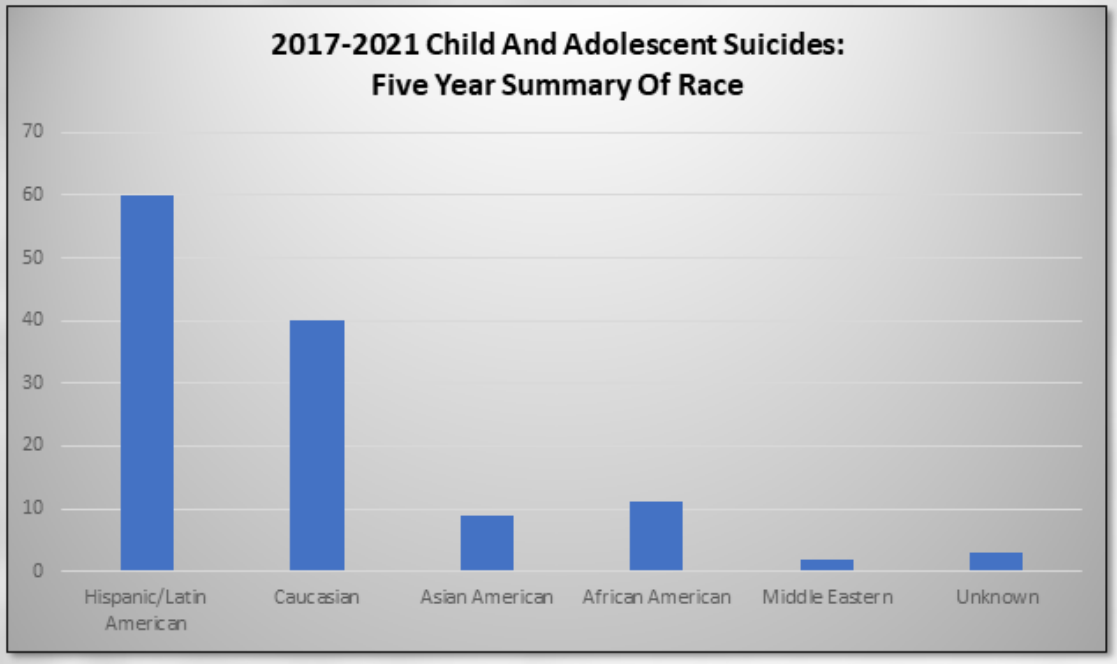

2017-2021 Child And Adolescent Suicides:
Five Year Method And Gender Breakdown
16
14
12
10
8
6
4
2
0
Male
Female
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Auto V. Ped
Other
2017
2018
2019
2020
2021

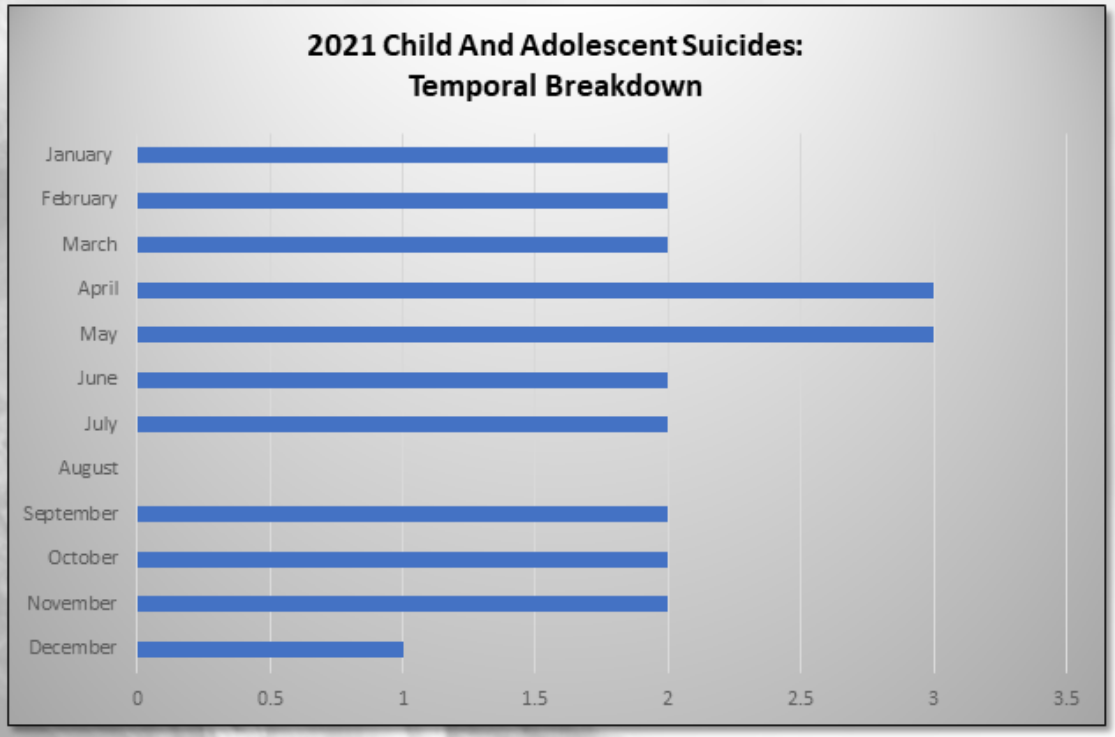

2017-2021 Child And Adolescent Suicides:
Five Year Summary Of Method And Gender
45
40
35
30
25
20
15
10
5
0
Hanging
Gunshot
Jump from Height
Overdose
Train V. Ped
Auto V. Ped
Other
Male
Female

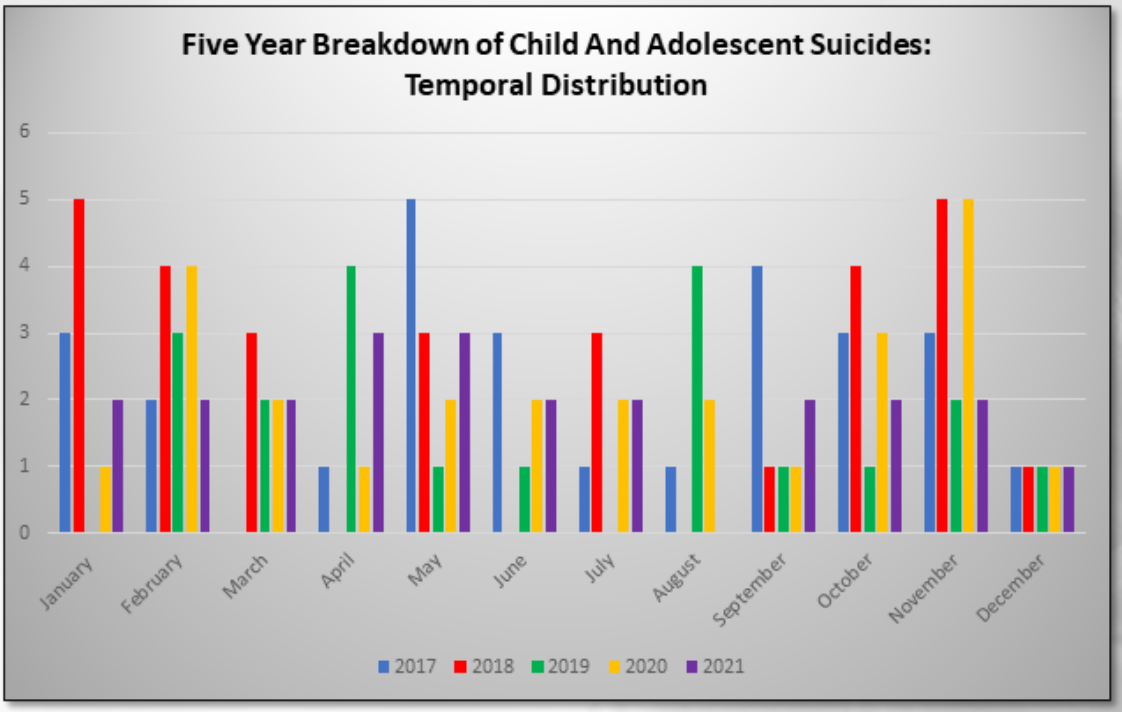

2021 Child And Adolescent Suicides:
Age Breakdown
9
8
7
6
5
4
3
2
1
0
12 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old

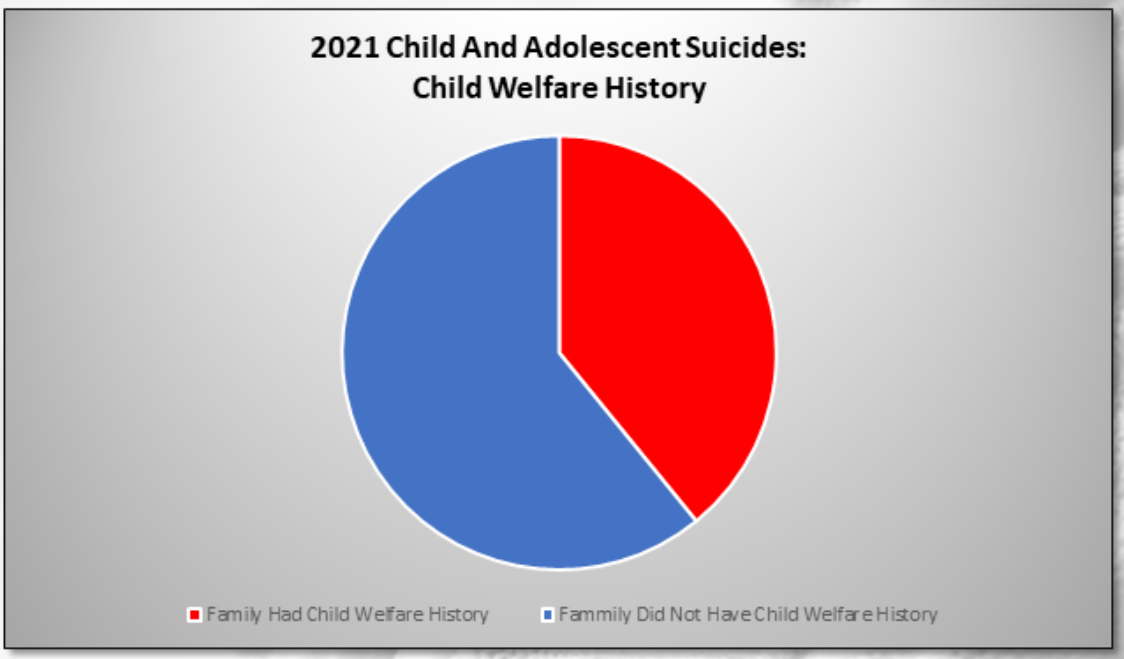

2017-2021 Child And Adolescent Suicides:
Five Year Summary Of Age
9 Years Old
10 Years Old
11 Years Old
12 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old
1
1
3
7
12
17
23
24
37

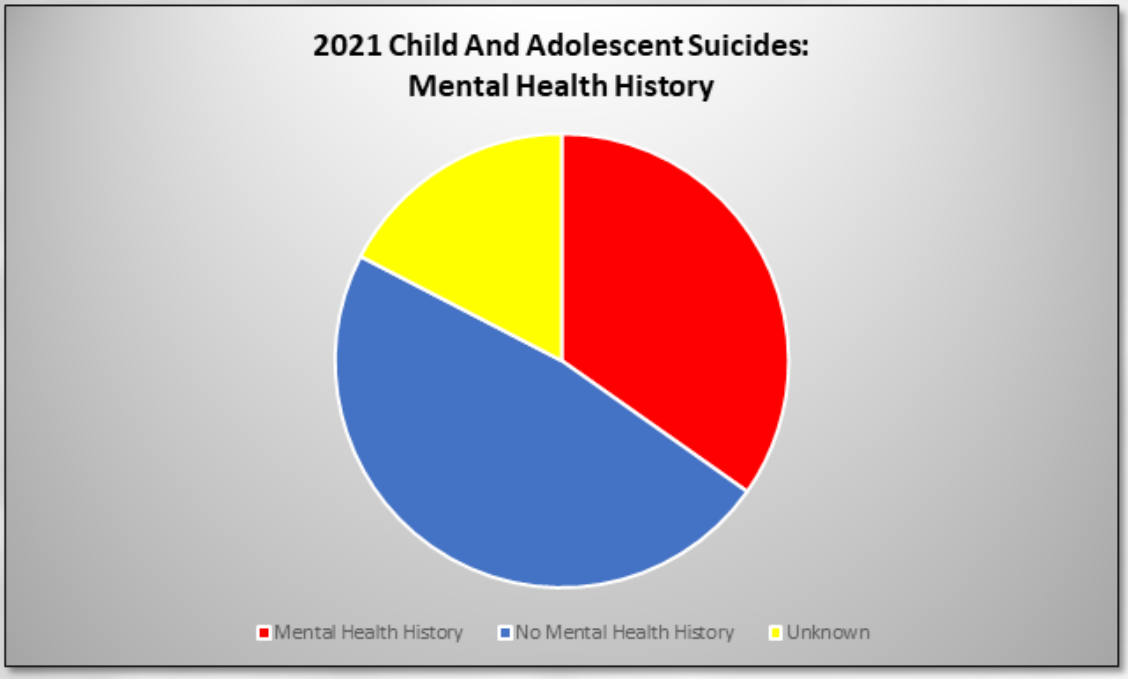

2021 Child And Adolescent Suicides:
Race/Ethnicity Breakdown
Hispanic/Latin American
Caucasian
Asian American
African American
Middle Eastern
Unknown

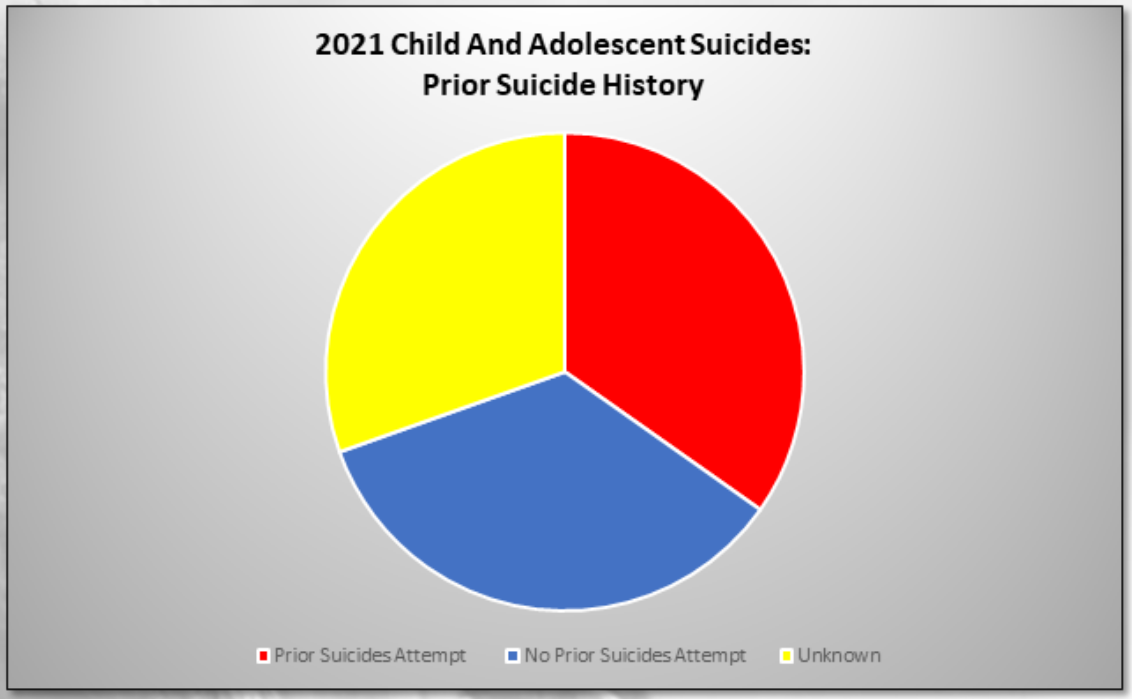

2017-2021 Child And Adolescent Suicides:
Five Year Summary Of Race
70
60
50
40
30
20
10
0
Hispanic/Latin American
Caucasian
Asian American
African American
Middle Eastern
Unknown


2021 Child And Adolescent Suicides:
Temporal Breakdown
January
February
March
April
May
June
July
August
September
October
November
December
0
0.5
1
1.5
2
2.5
3
3.5


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
2017
2018
2019
2020
2021

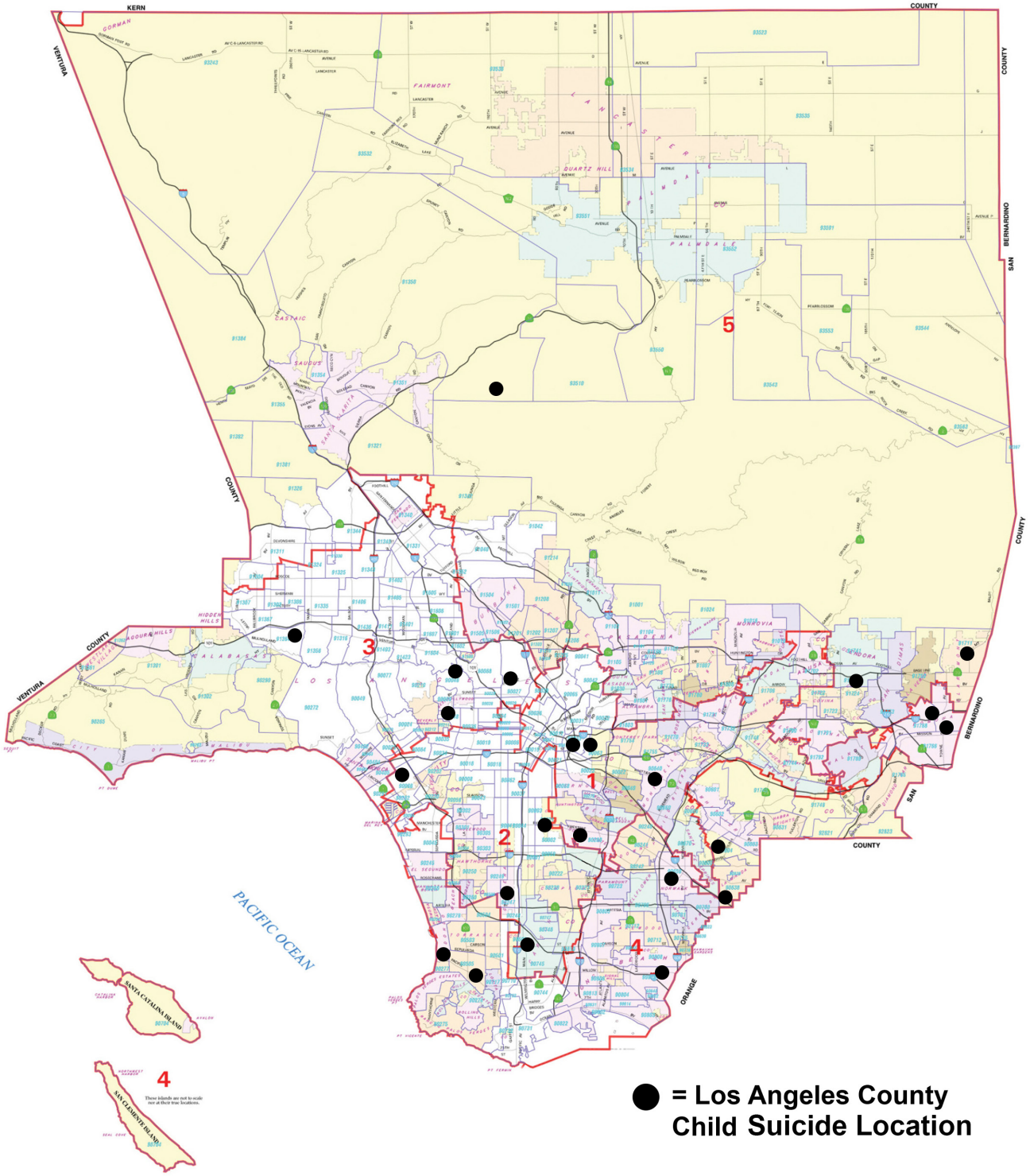

2021 Child And Adolescent Suicides:
Child Welfare History
Family Had Child Welfare History
Fammily Did Not Have Child Welfare History


2021 Child And Adolescent Suicides:
Mental Health History
Mental Health History
No Mental Health History
Unknown


2021 Child And Adolescent Suicides:
Prior Suicide History
Prior Suicides Attempt
No Prior Suicides Attempt
Unknown

2021 Child Suicides - Locations
n = 23*

***City where the suicide occurred**



Sample Case Summaries - Accidents

Kalvin

Kalvin age 17, went out with his friends. Kalvin's friends reported Kalvin taking Percocet pills. Soon after consuming the Percocet pills Kalvin became immediately unresponsive. Kalvin's friends splashed water on Kalvin's face to no avail. Kalvin's friends transported Kalvin to a local hospital unresponsive. Kalvin arrived to the hospital in cardiac arrest and was observed light blue and no pulse. Kalvin's friends dropped him off at the hospital. The hospital had Kalvin down as a 38 year old John Doe. Kalvin's brothers went searching for him and showed the hospital a picture of Kalvin. Kalvin's brother had to identify the body. Death was pronounced at the hospital.

Bertha

Seventeen year old Bertha was standing on the seats of a friend's vehicle while it was moving in order to take a video/photos through the sunroof. The friend who was driving also pulled out her phone to take a photo/video causing her to lose control of the vehicle and became involved in a motor vehicle accident. Bertha suffered multiple traumatic injuries. Bertha was transferred to a higher level of care due to her injuries. Despite continued lifesaving efforts, Bertha's condition did not improve and was pronounced dead on 03/25/2021 at 10:30pm, two days after the vehicle collision.

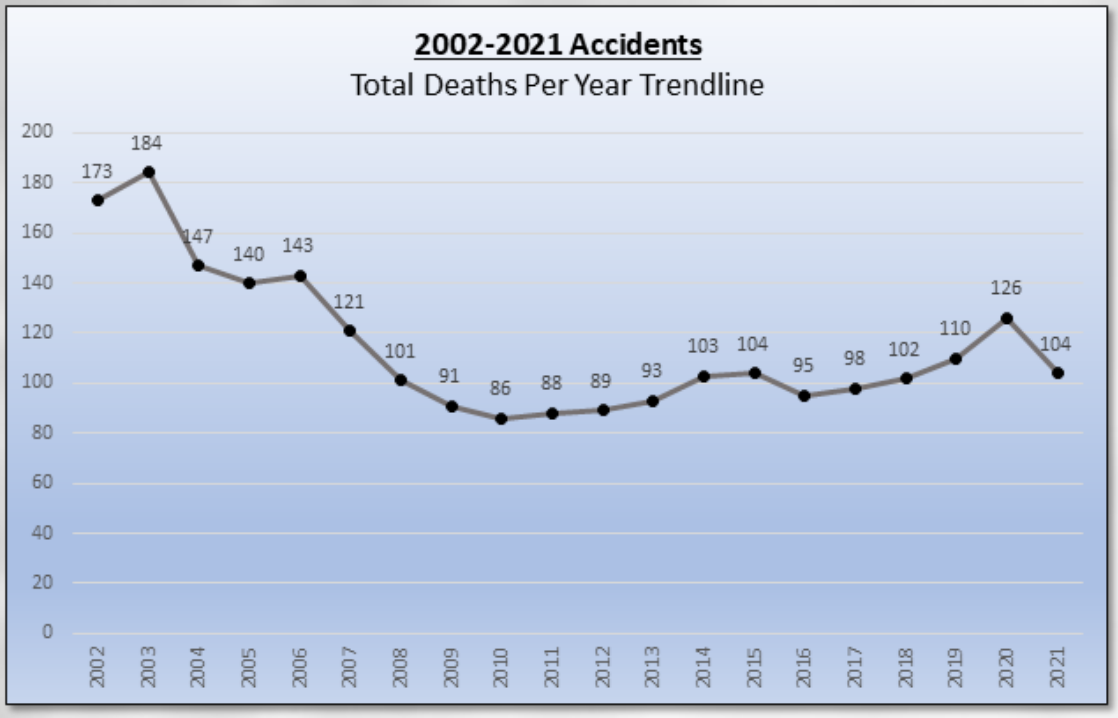
Johnny

Johnny age 1, was with his grandparents selling tamales on the southeast corner of the intersection. Two vehicles were involved in a traffic collision. A vehicle turning south onto the intersection where Johnny and his grandparents were located were struck by a vehicle traveling westbound. Following the collision, the vehicle turning left that struck Johnny remained on the scene as the vehicle traveling west fled the scene. 9-1-1 was called and paramedics from Los Angeles Fire Department Rescue Ambulance responded to the scene. Johnny was transported to the local hospital via ambulance. Johnny was in cardiac arrest. Johnny was intubated and CPR provided however, despite all lifesaving measures Johnny was unable to be resuscitated and was pronounced dead at the hospital.

ACCIDENTS

FINDINGS

- One hundred and four accidental child deaths were reported to ICAN by the Coroner for 2021. This is a decrease from the 2020 of one hundred thirty one deaths and it is also above the five-year average of one hundred deaths per year.
- In the prior years, automobile death and prenatal substance abuse have been the leading causes of accidental child death. In 2021, overdose (n=21), prenatal substance abuse (n=17) automobile vs. pedestrian deaths (n=11) and drownings (N=10) made up 56% of child accidental deaths.
- Unsafe sleep deaths can be moded as accidents by the coroner, however, in 2021 there appears to be a downward trend of moding unsafe sleep cases as accidents with only 3 cases being moded accidents. These cases are counted in our unsafe sleep death with the undetermined cases.
- The majority (47%) of accidental child deaths were children of Hispanic/Latin background. The next highest was Black children who made up a N=26 of the deaths. This is an increase for Black child deaths. Next highest deaths are by Caucasian children (N=23).
- Children dying in an automobile accident, either as a driver or as a passenger, accounted for 34 of the accidental child deaths in 2021. This is roughly a thirty-increase in this cause of child death from 2018. The age range for victims spans from one year of age to seventeen years of age with the higher number of deaths being between fourteen and seventeen years old. In 2021, the demographics are slightly more female than male (60% female vs. 40% male) and majority Hispanic (65%).
- Seventeen children died of prenatal substance abuse in 2021. The number one drug was methamphetamine. This is consistent with the last five years where methamphetamine continues to be the number one illicit drug in prenatal substance abuse deaths.


2002-2021 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
104
2002
2003
2004
2005
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2007
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2011
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2013
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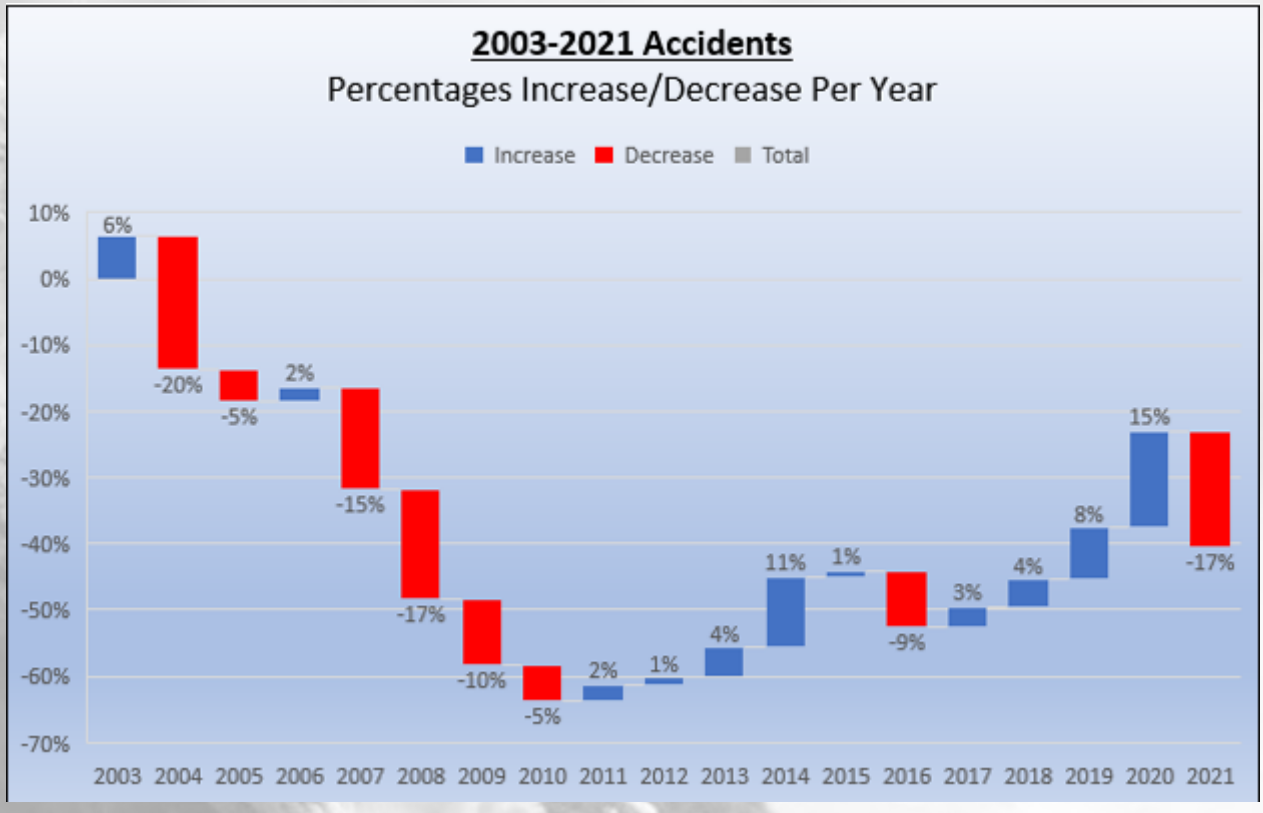
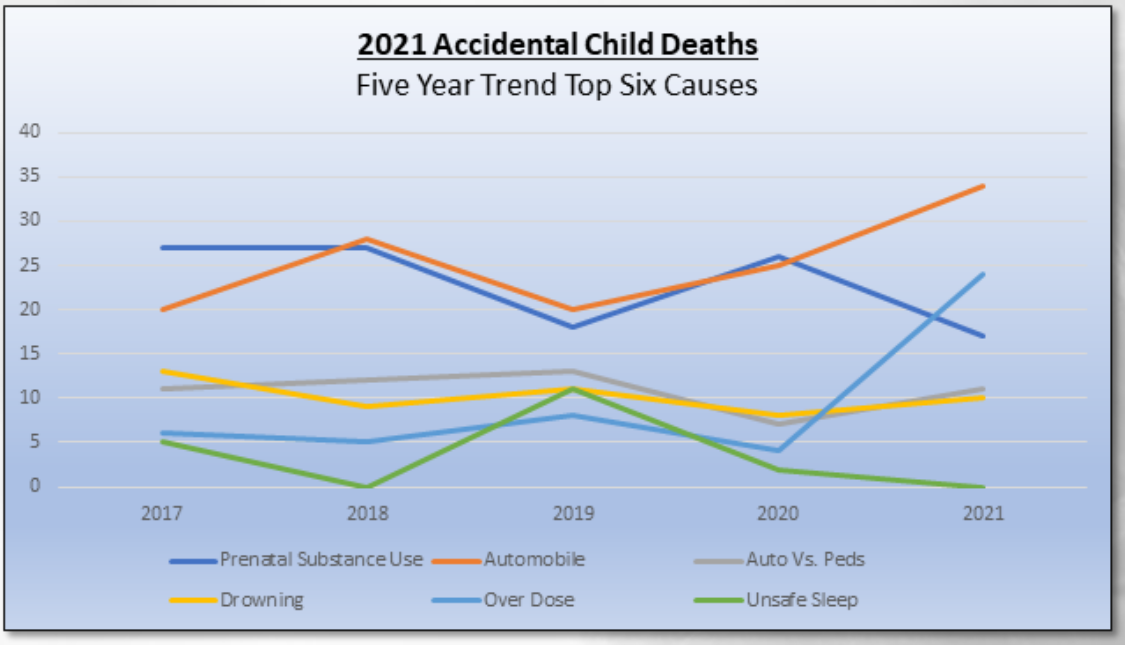
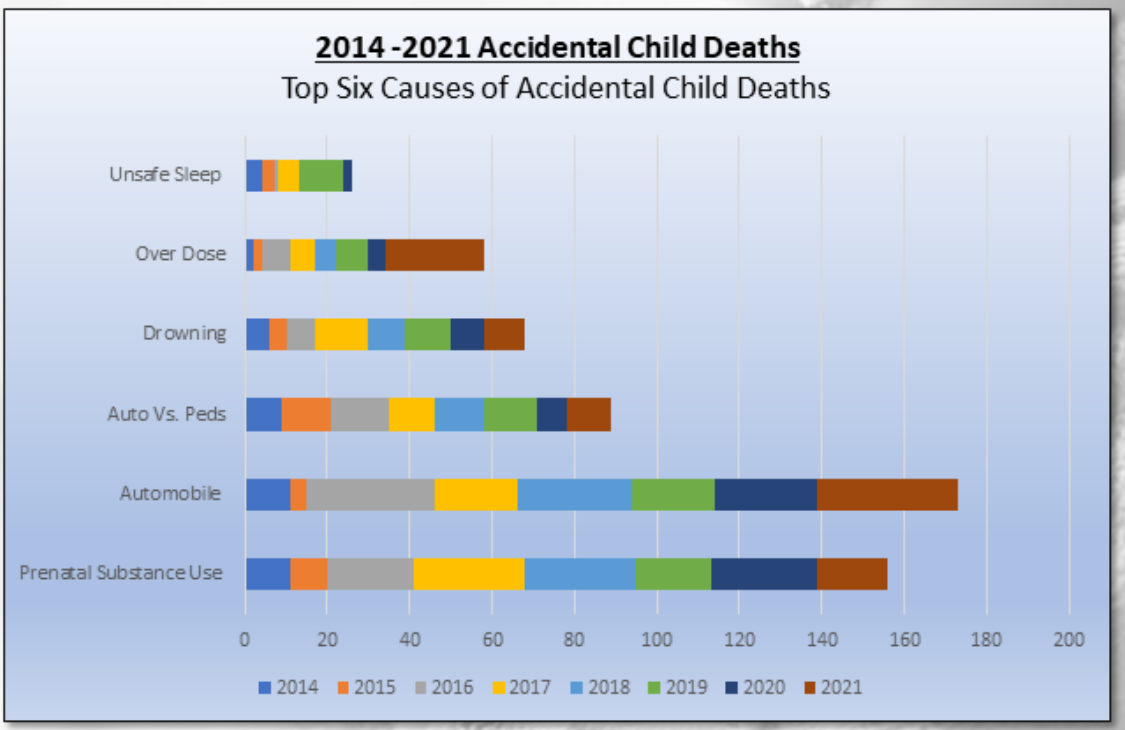
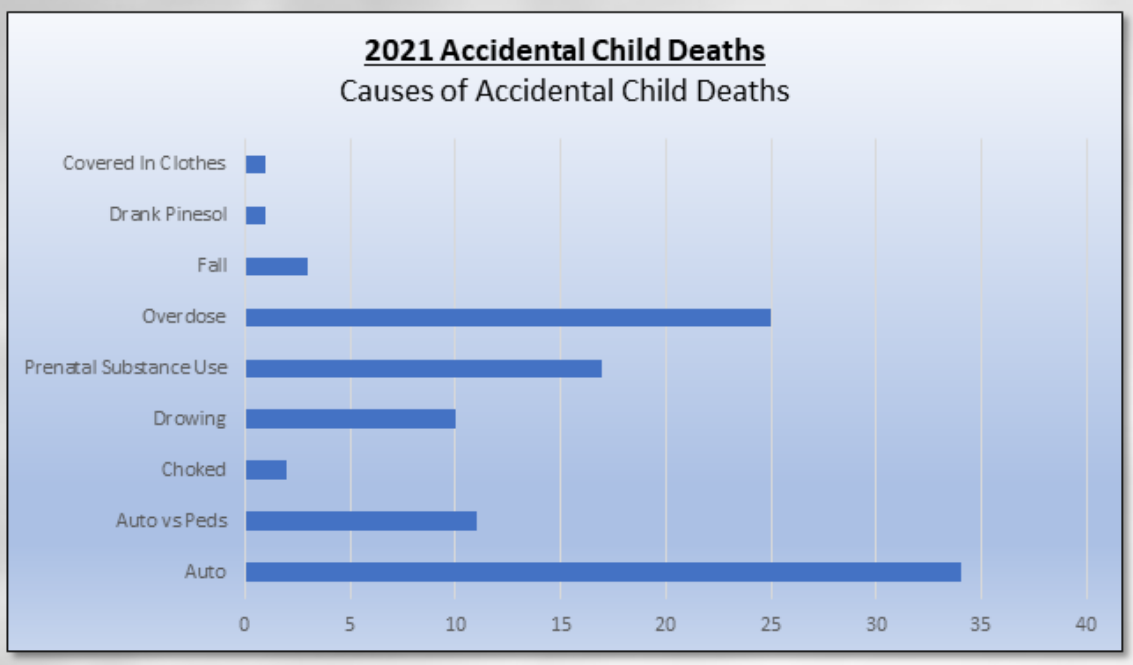
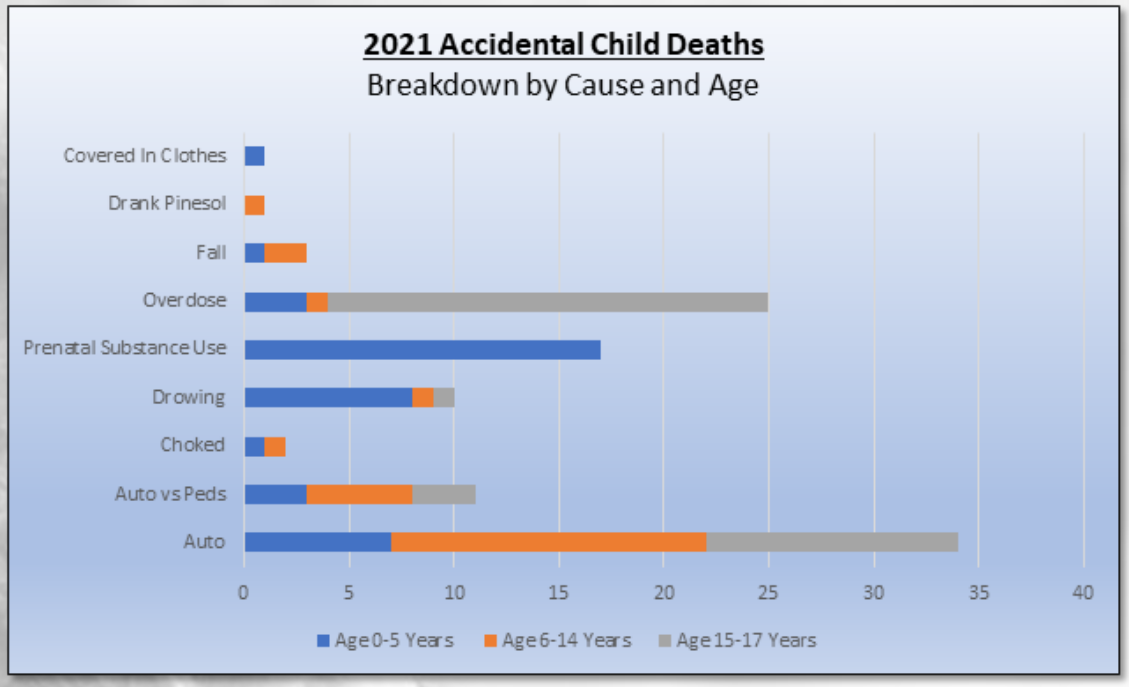
2015
2016
2017
2018
2019
2020
2021

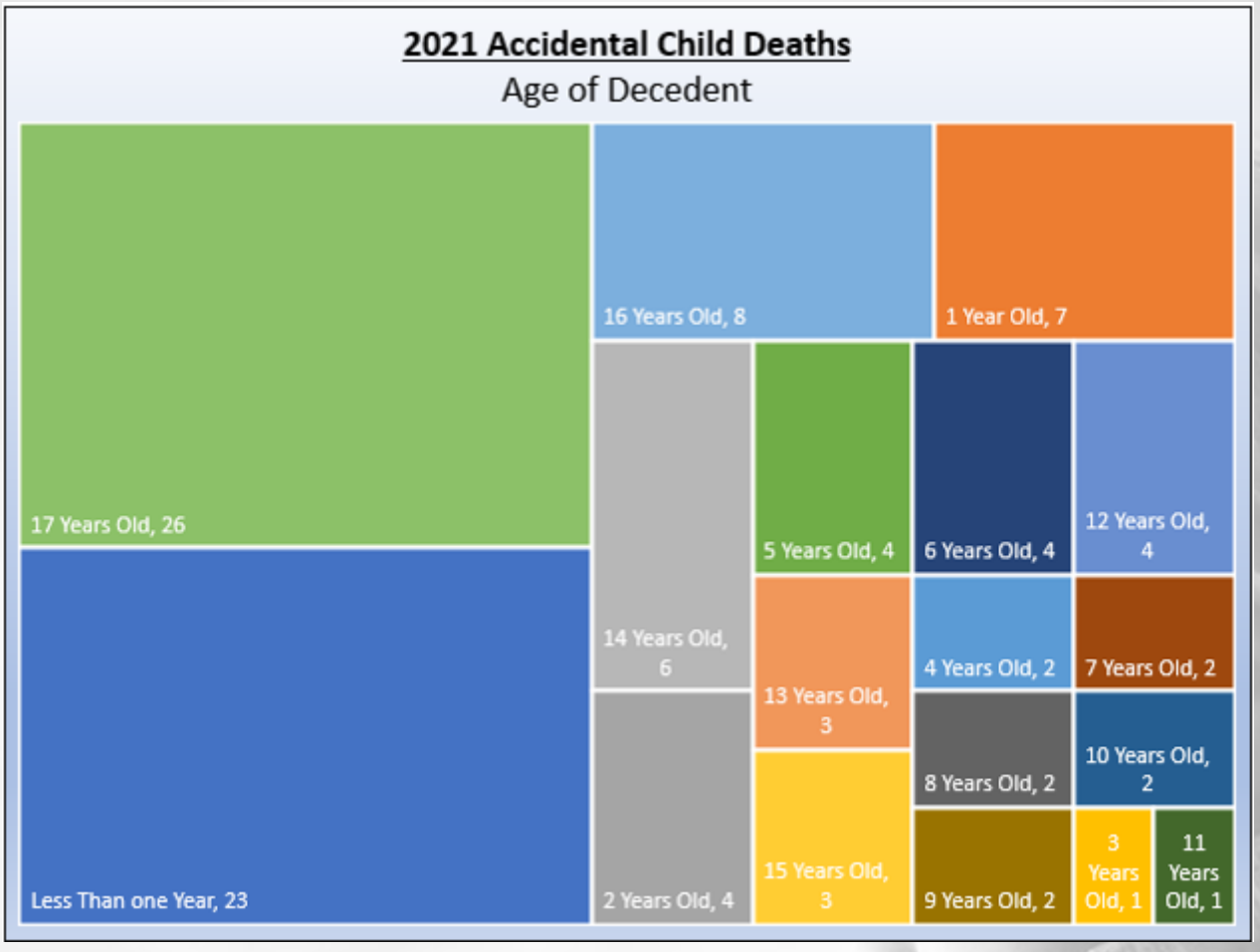

2003-2021 Accidents
Percentages Increase/Decrease Per Year
Increase
Decrease
Total
10%
0%
-10%
-20%
-30%
-40%
-50%
-60%
-70%
6%
-20%
-5%
2%
-15%
-17%
-10%
-5%
2%
1%
4%
11%
1%
-9%
3%
4%
8%
15%
-17%
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021

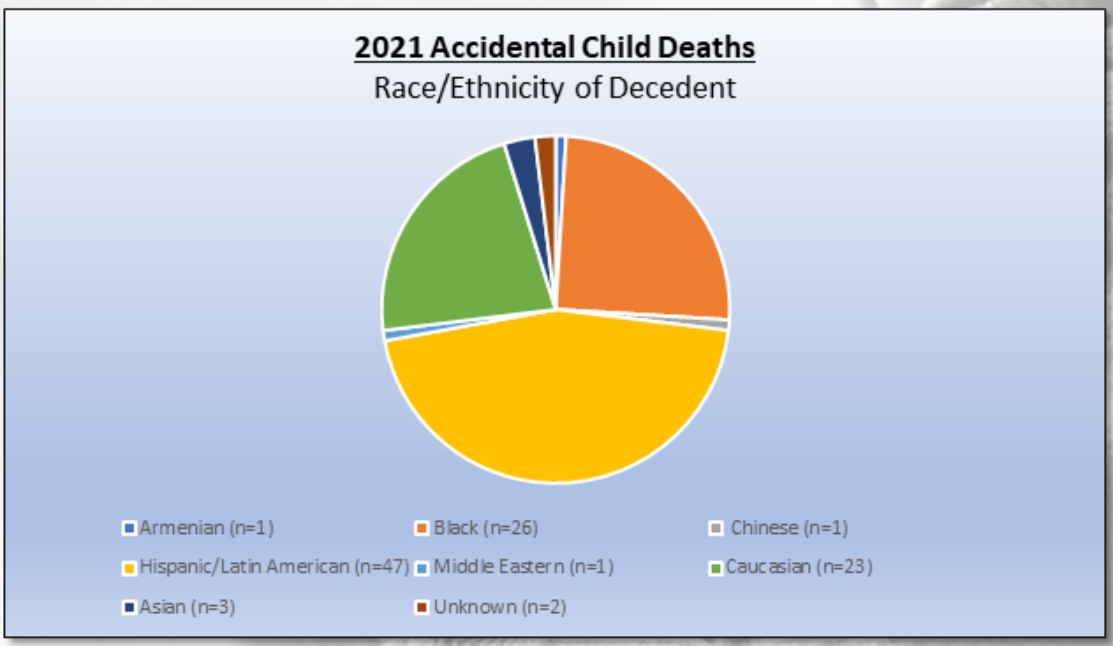

2021 Accidental Child Deaths
Five Year Trend Top Six Causes
40
35
30
25
20
15
10
5
0
2017
2018
2019
2020
2021
Prenatal Substance Use
Automobile
Auto Vs. Peds
Drowning
Over Dose
Unsafe Sleep

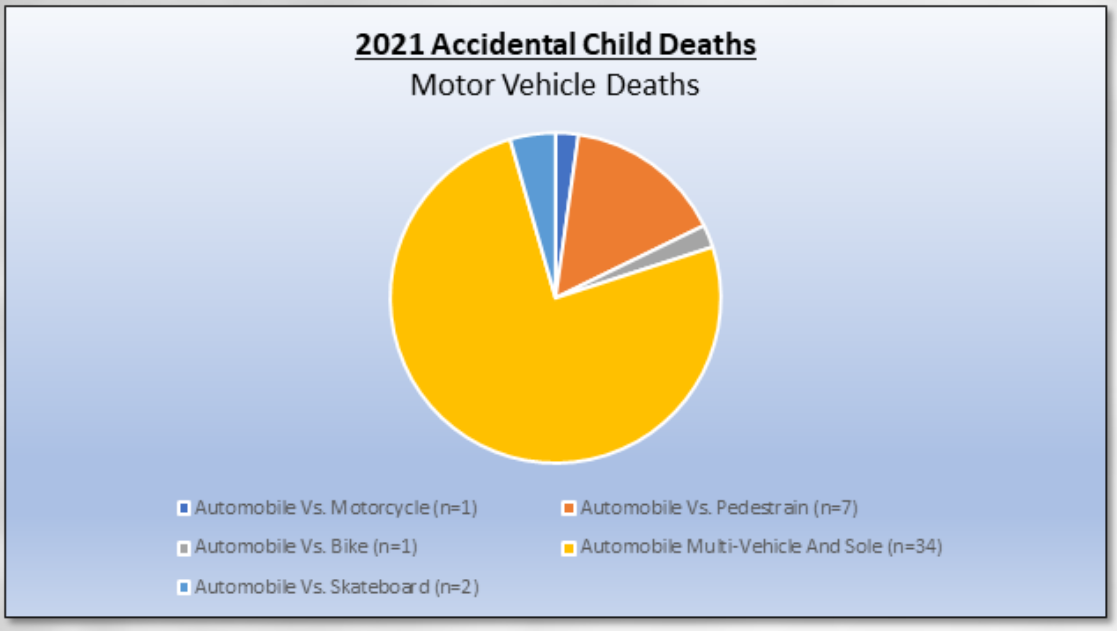

2014 -2021 Accidental Child Deaths
Top Six Causes of Accidental Child Deaths
Unsafe Sleep
Over Dose
Drowning
Auto Vs. Peds
Automobile
Prenatal Substance Use
0
20
40
60
80
100
120
140
160
180
200
2014
2015
2016
2017
2018
2019
2020
2021

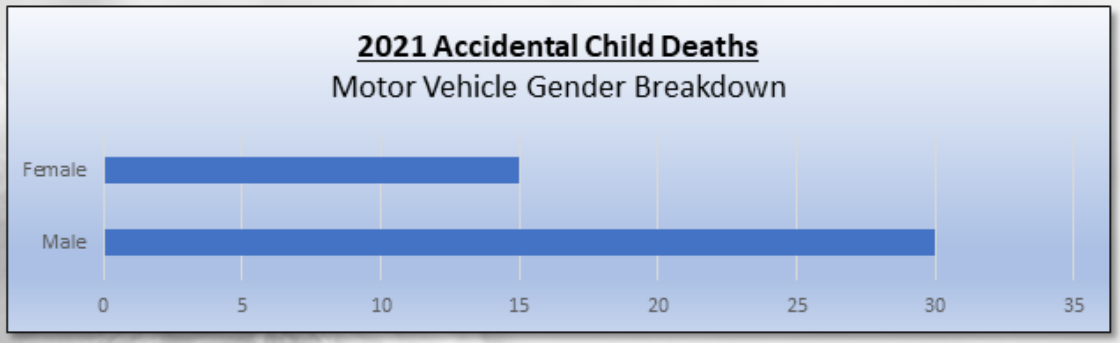

2021 Accidental Child Deaths
Causes of Accidental Child Deaths
Covered In Clothes
Drank Pinesol
Fall
Overdose
Prenatal Substance Use
Drowing
Choked
Auto vs Peds
Auto
0
5
10
15
20
25
30
35
40

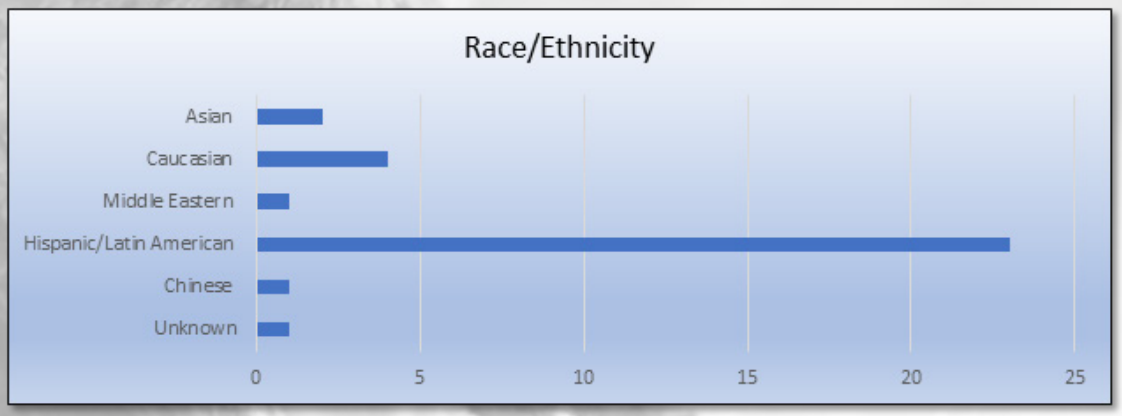

2021 Accidental Child Deaths
Breakdown by Cause and Age
Covered In Clothes
Drank Pinesol
Fall
Overdose
Prenatal Substance Use
Drowing
Choked
Auto vs Peds
Auto
0
5
10
15
20
25
30
35
40
Age 0-5 Years
Age 6-14 Years
Age 15-17 Years

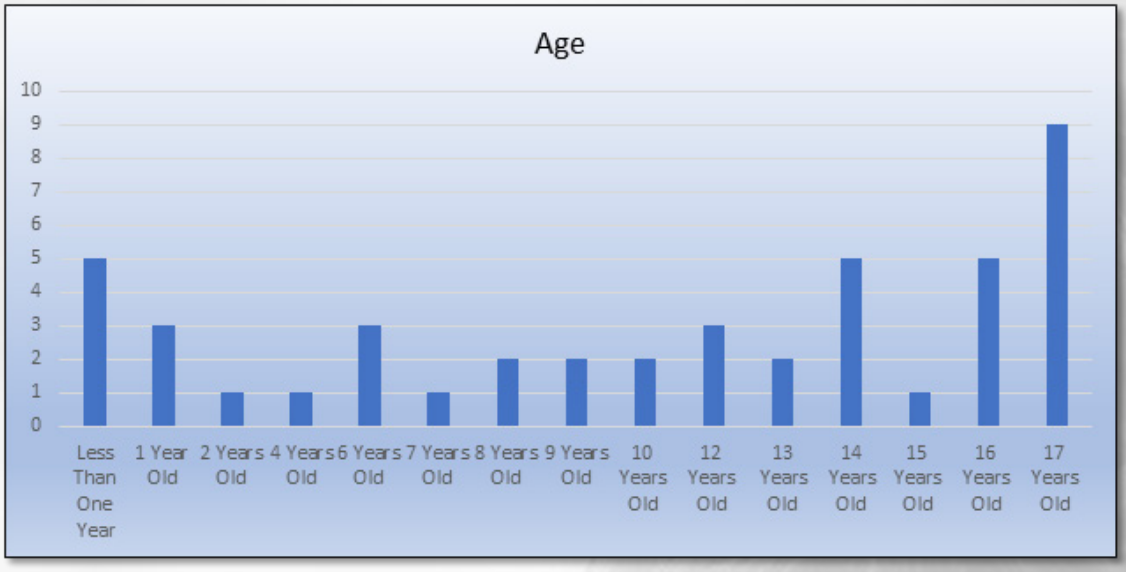

2021 Accidental Child Deaths
Age of Decedent
17 Years Old, 26
16 Years Old, 8
1 Year Old, 7
Less Than one Year, 23
14 Years Old, 6
5 Years Old, 4
6 Years Old, 4
12 Years Old, 4
13 Years Old, 3
4 Years Old, 2
7 Years Old, 2
8 Years Old, 2
10 Years Old, 2
2 Years Old, 4
15 Years Old, 3
9 Years Old, 2
3 Years Old, 1
11 Years Old, 1

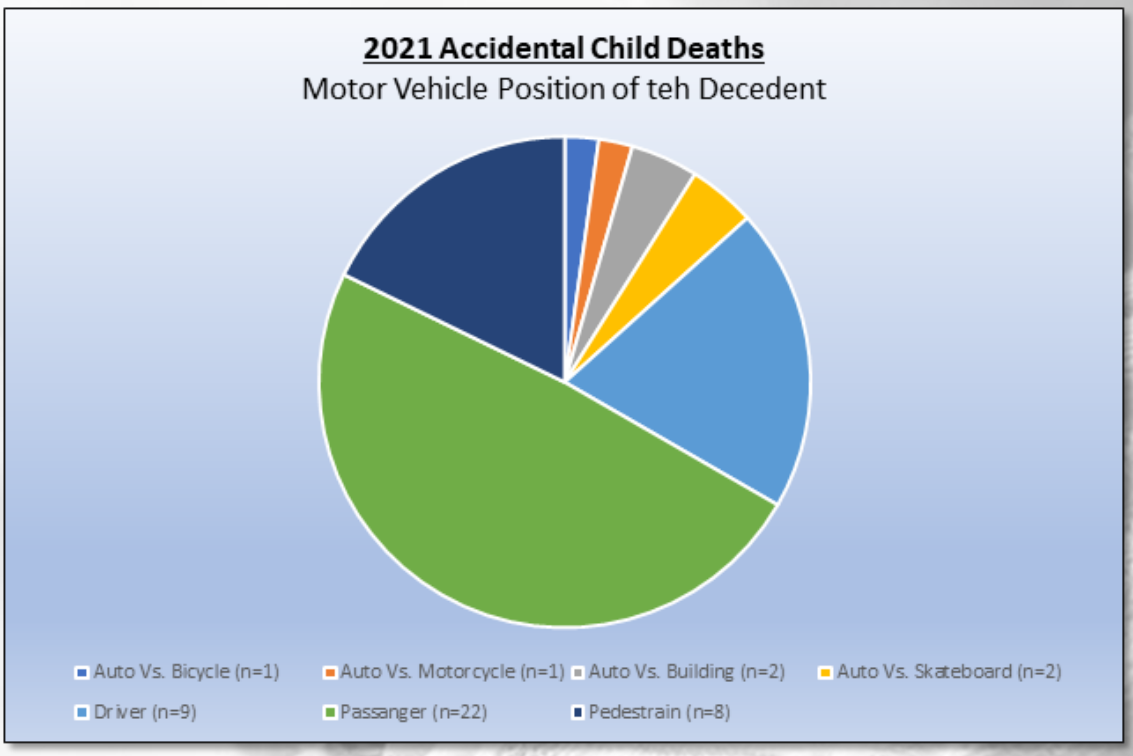

2021 Accidental Child Deaths
Race/Ethnicity of Decedent
Armenian (n=1)
Black (n=26)
Chinese (n=1)
Hispanic/Latin American (n=47)
Middle Eastern (n=1)
Caucasian (n=23)
Asian (n=3)
Unknown (n=2)

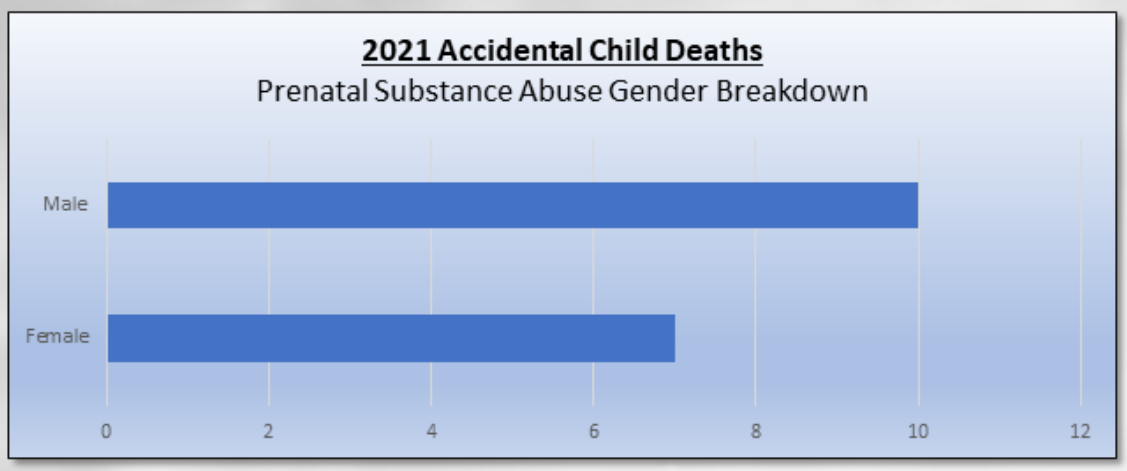

2021 Accidental Child Deaths
Motor Vehicle Deaths
Automobile Vs. Motorcycle (n=1)
Automobile Vs. Pedestrain (n=7)
Automobile Vs. Bike (n=1)
Automobile Multi-Vehicle And Sole (n=34)
Automobile Vs. Skateboard (n=2)


2021 Accidental Child Deaths
Motor Vehicle Gender Breakdown
Female
Male
0
5
10
15
20
25
30
35

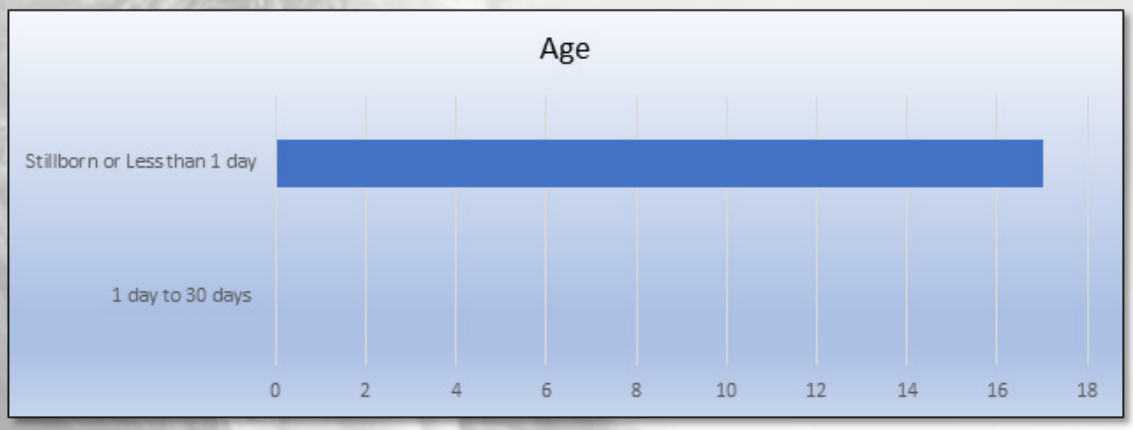

Race/Ethnicity
Asian
Caucasian
Middle Eastern
Hispanic/Latin American
Chinese
Unknown
0
5
10
15
20
25

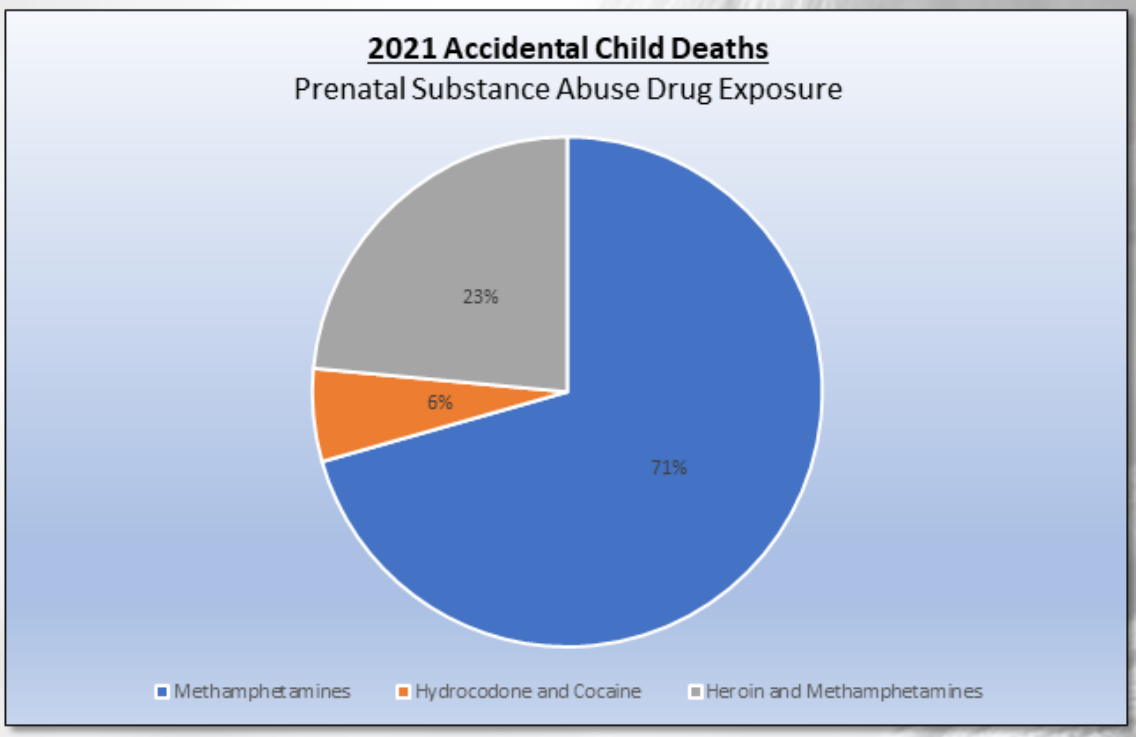

Age
10
9
8
7
6
5
4
3
2
1
0
Less Than One Year
1 Year Old
2 Years Old
4 Years Old
6 Years Old
7 Years Old
8 Years Old
9 Years Old
10 Years Old
12 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old


2021 Accidental Child Deaths
Motor Vehicle Position of teh Decedent
Auto Vs. Bicycle (n=1)
Auto Vs. Motorcycle (n=1)
Auto Vs. Building (n=2)
Auto Vs. Skateboard (n=2)
Driver (n=9)
Passanger (n=22)
Pedestrain (n=8)


2021 Accidental Child Deaths
Prenatal Substance Abuse Gender Breakdown
Male
Female
0
2
4
6
8
10
12


Race/Ethnicity
Caucasian
Hispanic/Latin American
Black
0
1
2
3
4
5
6
7
8
9


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


2021 Accidental Child Deaths
Prenatal Substance Abuse Drug Exposure
23%
6%
71%
Methamphetamines
Hydrocodone and Cocaine
Heroin and Methamphetamines

Sample Case Summaries - Undetermined

Darlene

Darlene, age 16 reported not feeling well and had symptoms of pain in her chest, congestion and body aches. Darlene agreed to go with her family on a family outing to the movies. Upon leaving the movie theatre, parents went outside to get the car and Darlene and her sibling went to the restroom. Darlene was said to be jumped by a group of girls. Darlene declined to go to the hospital but informed mother that she believed to be hit with a rod or a metal object. The family was located in a remote area approximately 25 mile out in the desert. Once home, Darlene tried to participate in a family workout but felt ill. Darlene went inside the trailer and expressed blurry vision. The sibling checked in on Darlene and she slumped over the sibling. Mother entered the trailer and placed Darlene on the bed splashing water on her face and step-father doing CPR. Mother called 9-1-1 however paramedics and firefighters were unable to locate the family for 45 to 60 minutes due to the family living off the grid. Paramedics observed Darlene had multiple bruises on her arms and legs. The death was undetermined. Mother reported Darlene died from COVID-19 as autopsy confirmed the positive results. Three months after Darlene's death, a sibling reported mother and step-father beat up Darlene causing her death.

Joey

Joey was a 11 month old child found unresponsive in the bathtub. Father was initially in the bathroom bathing Joey. Father left the child in the bath tub unsupervised and went in the bedroom with mother. Mother asked father, 'Where is the baby?' father humped up, went back in the bathroom and found the child unresponsive in the bath tub. It is unknown how long father left the child unsupervised. Family called 9-1-1, paramedics responded to the home and transferred the child to Children's Hospital L.A. Joey died due to a cardiac arrest. Father was not cooperative and did not provide statements to law enforcement or the Department of Children and Family Services.

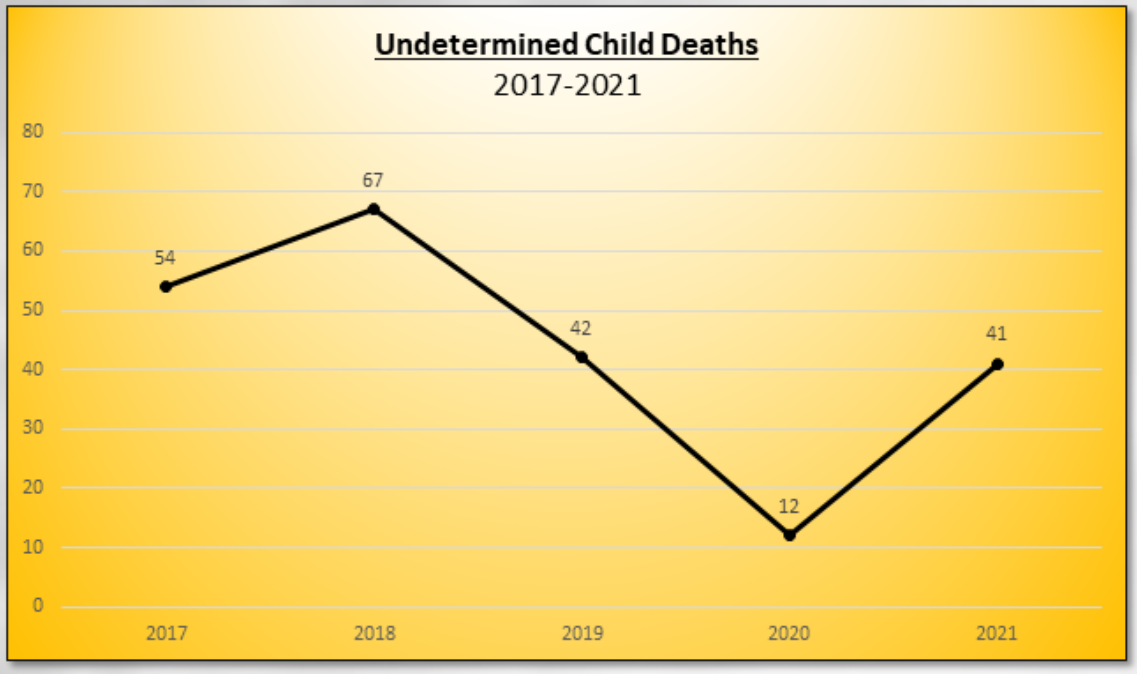
Damien

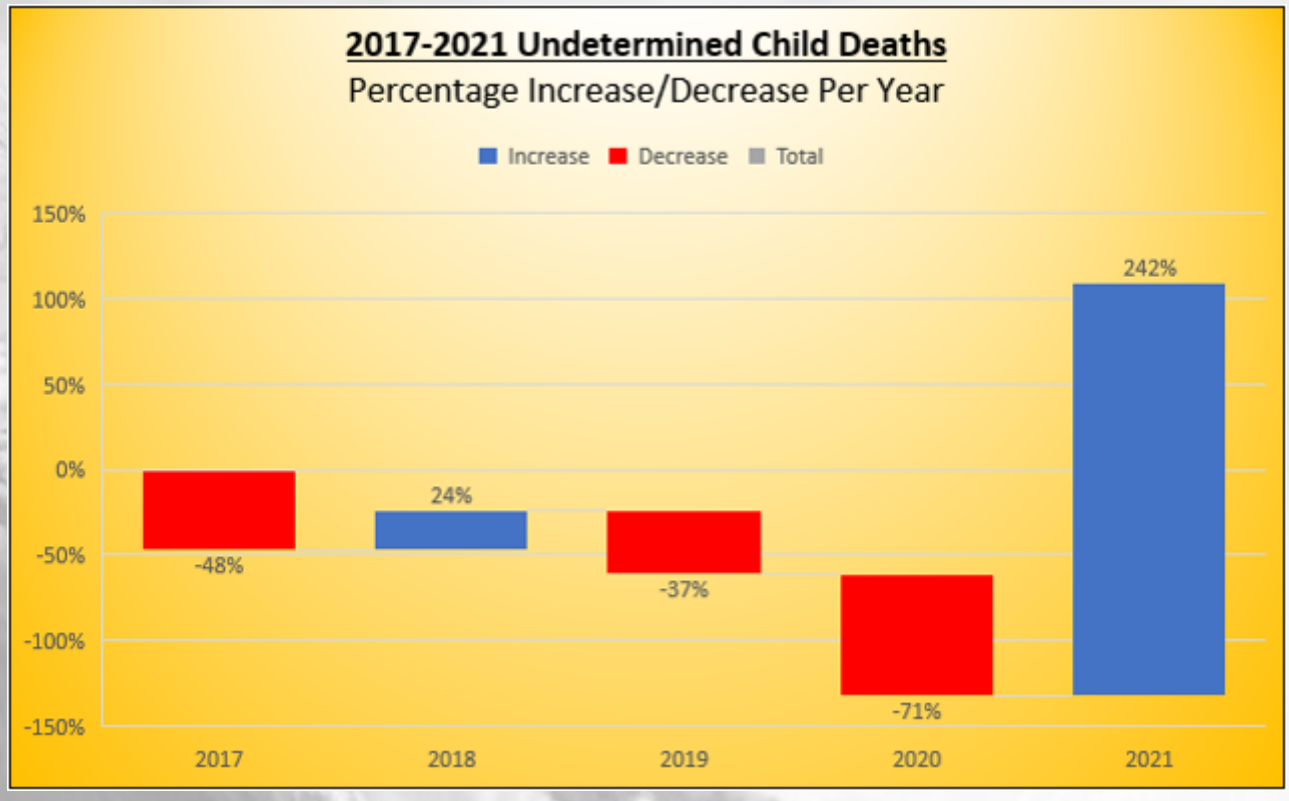
Damien was a 6 month old child. Mother placed Damien down for a nap on parents bed next to father who was also asleep. Mother notified father that she was placing Damien next to father. Mother propped up a 4-5 oz bottle of formula milk for Damien to self-feed on and mother left the bedroom. The father woke up shortly after and observed Damien to be fine and asleep. The father left the bedroom so that Damien could nap. Mother returned to the bedroom after realizing Damien was napping too long and discovered Damien to be unresponsive in the same position with milk vomit residue all over his face and a small tip of the blanket covering his face. Parents called 9-1-1- and attempted CPR. Paramedics and Fire Department continued resuscitative efforts and pronounced dead. Damien was a twin and no reports where his twin was located at the time of incident.

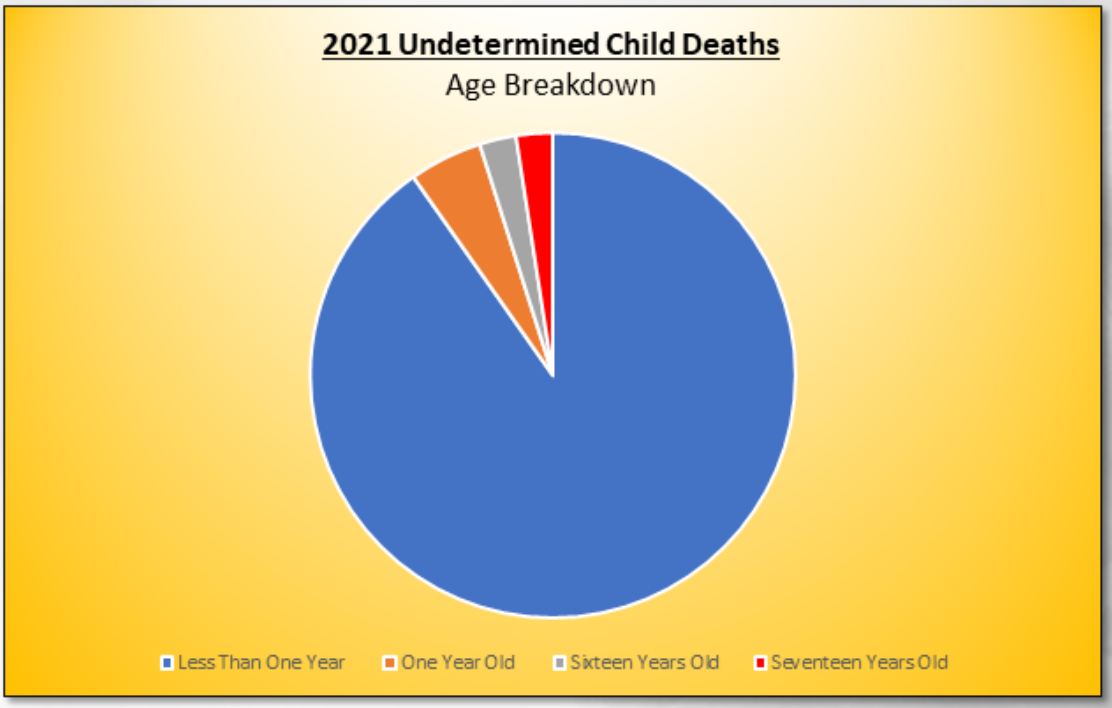
UNDETERMINED

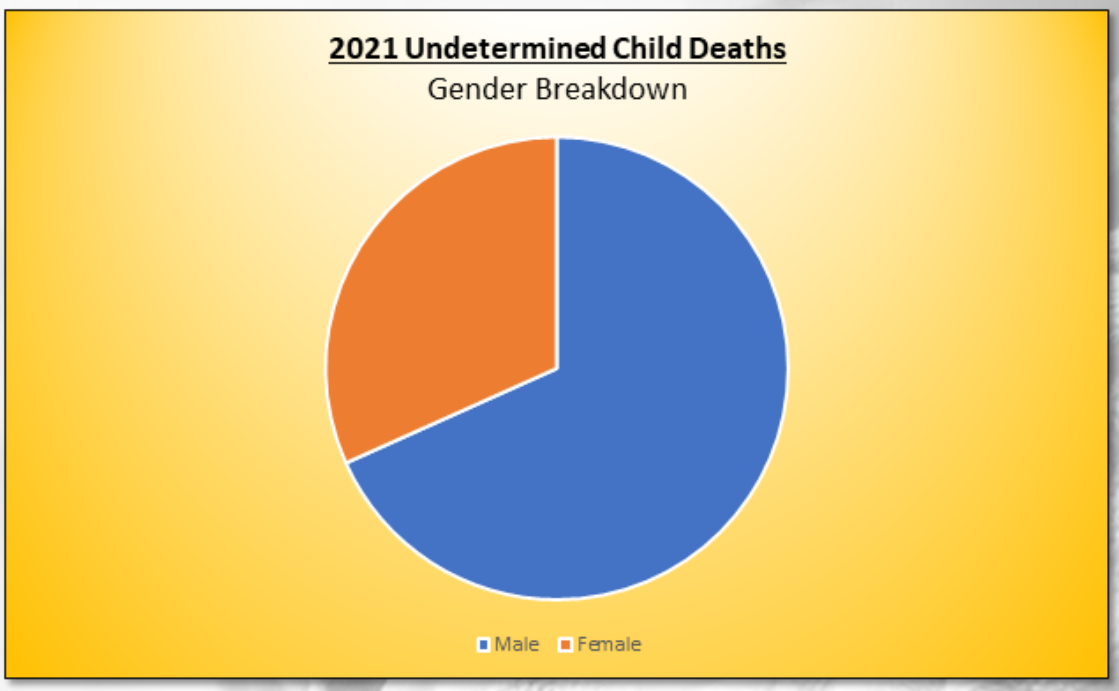
FINDING

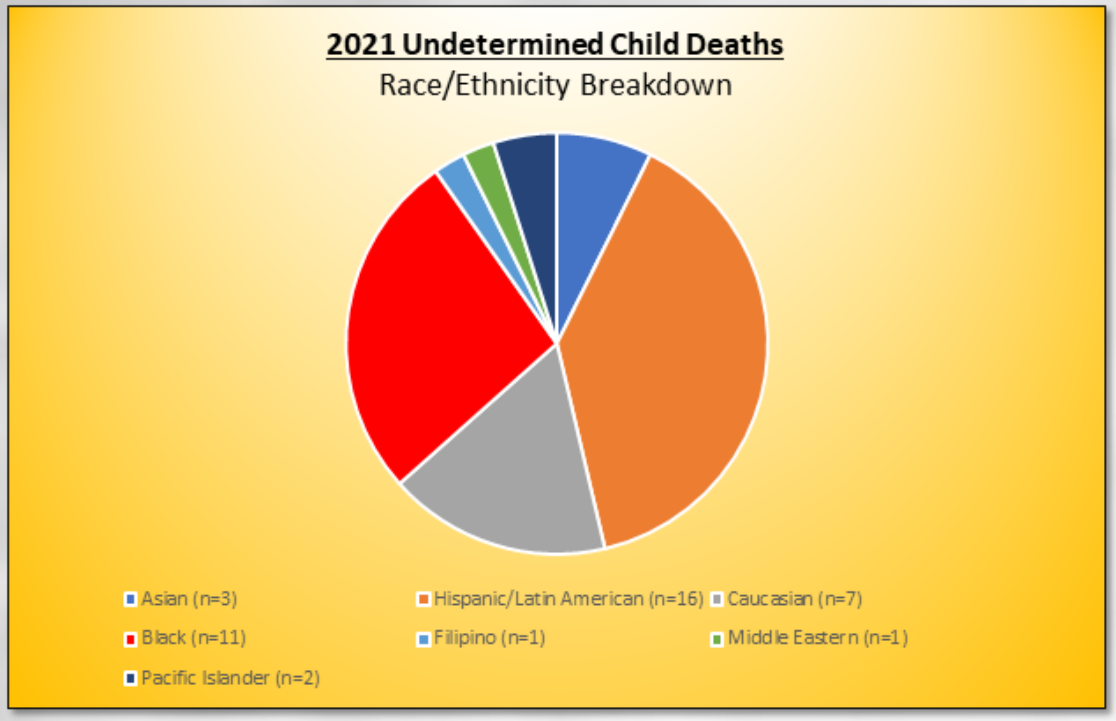
- Forty one undetermined child deaths were reported to ICAN from the Coroner's Department in 2021. Twenty-three of the child victims were determined to be the result of unsafe sleep practices, whether because of co-sleeping with an adult/child, an unsafe sleep environment, or a combination of both.
- The 2021 number of 23 unsafe sleep deaths is a slight decrease from 2020 and below the five-year average of approximately 50 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.
- The children most vulnerable to unsafe sleep related deaths were infants zero to 11 months of age which comprised 91% of the cases.
- In 2021 Hispanic (N-8) (35%) and African American (n-6) (76%) children were the most common victim of unsafe sleep related death. Caucasians (n=4) made up 17% percent and Asians (9%) and the last three ethnicities, Pilipino, Middle Eastern and Pacific Islander, had one child death
- Of the twenty-three unsafe sleep cases, 28 were male and 13 were female.
- 18 of the undetermined deaths for 2021 were not a result of unsafe sleep practices.These deaths were related to complications due to prematurity and sudden unexpected infant death possibly related to unknown health issues.

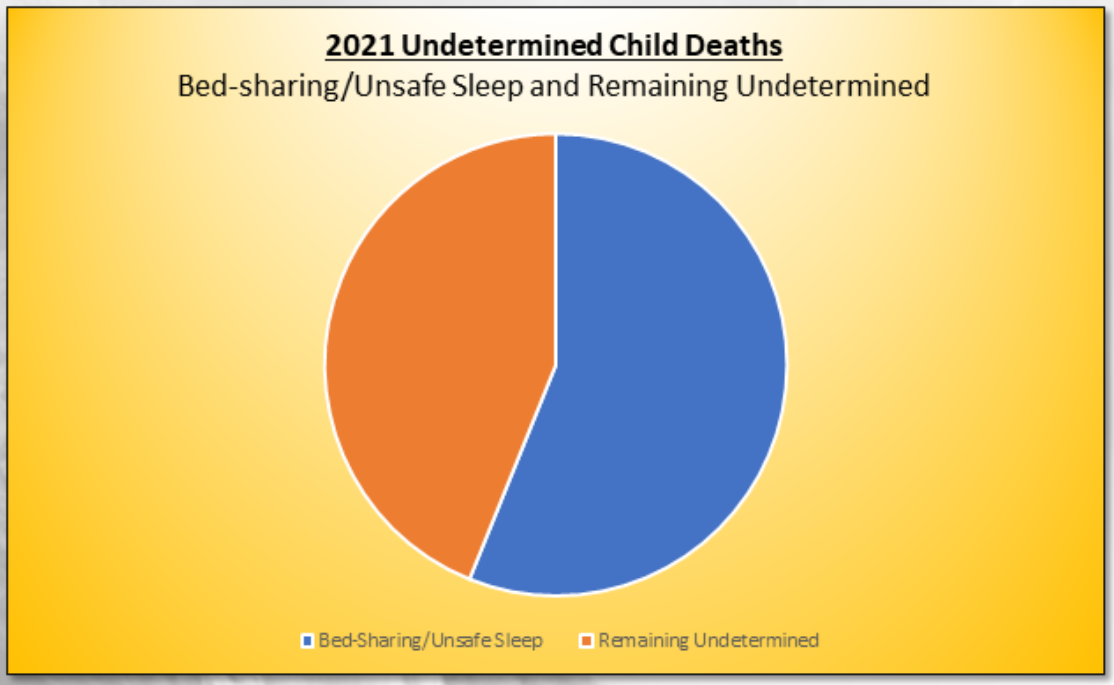

Undetermined Child Deaths
2017-2021
80
70
60
50
40
30
20
10
0
54
67
42
12
41
2017
2018
2019
2020
2021

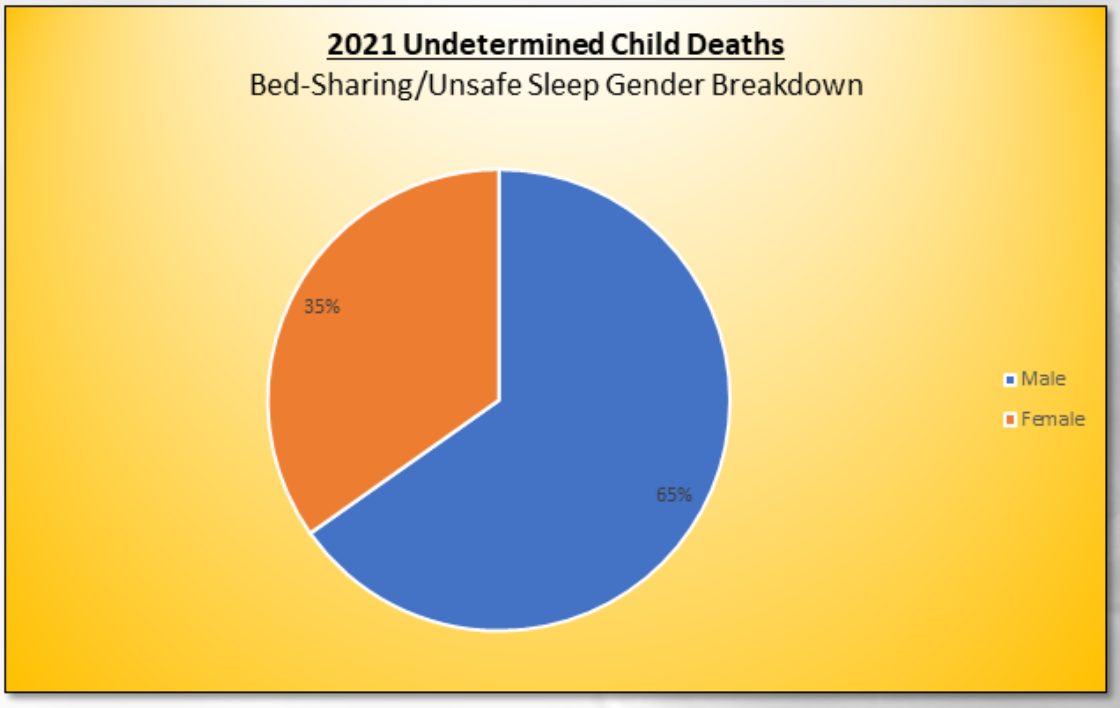

2017-2021 Undetermined Child Deaths
Percentage Increase/Decrease Per Year
Increase
Decrease
Total
150%
100%
50%
0%
-50%
-100%
-150%
-48%
24%
-37%
-71%
242%
2017
2018
2019
2020
2021

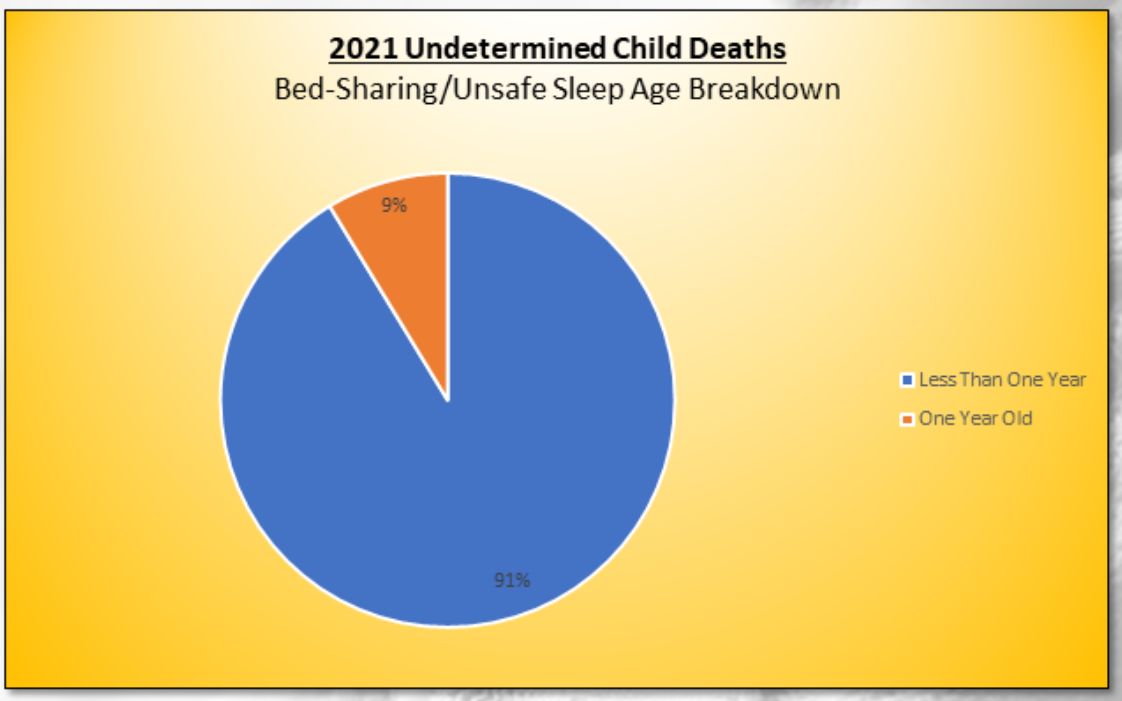

2021 Undetermined Child Deaths
Age Breakdown
Less Than One Year
One Year Old
Sixteen Years Old
Seventeen Years Old

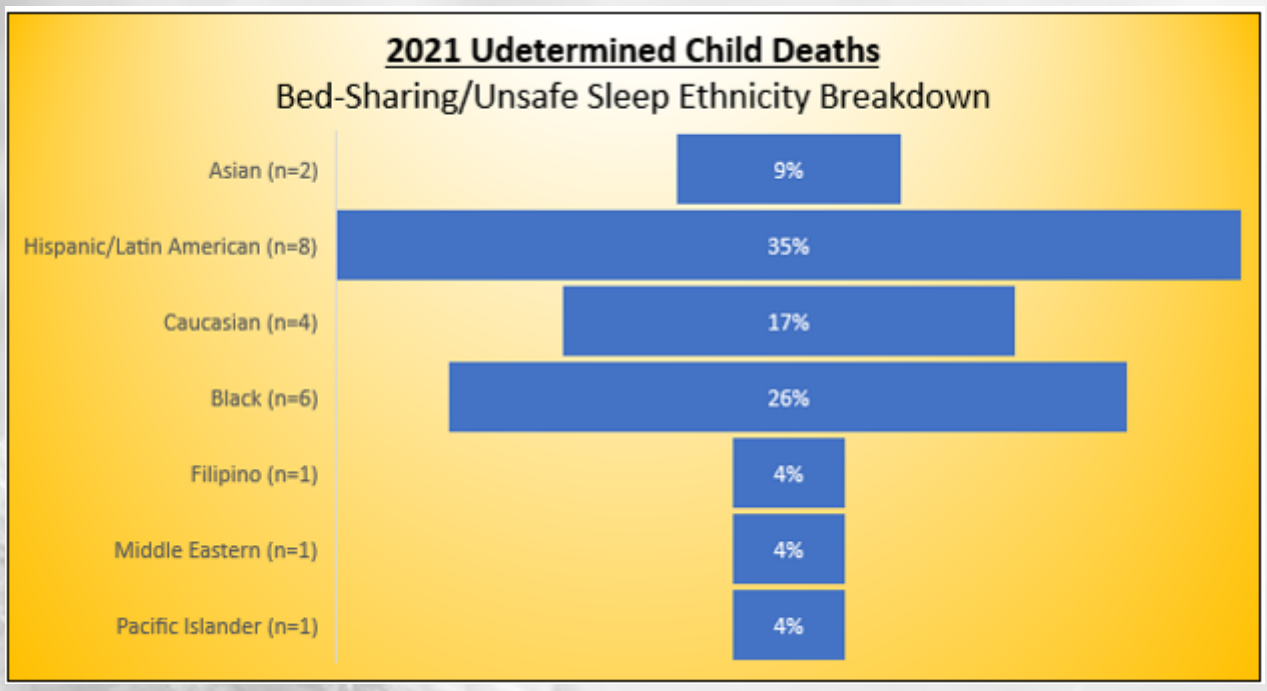

2021 Undetermined Child Deaths
Gender Breakdown
Male
Female


2021 Undetermined Child Deaths
Race/Ethnicity Breakdown
Asian (n=3)
Hispanic/Latin American (n=16)
Caucasian (n=7)
Black (n=11)
Filipino (n=1)
Middle Eastern (n=1)
Pacific Islander (n=2)


2021 Undetermined Child Deaths
Bed-sharing/Unsafe Sleep and Remaining Undetermined
Bed-Sharing/Unsafe Sleep
Remaining Undetermined

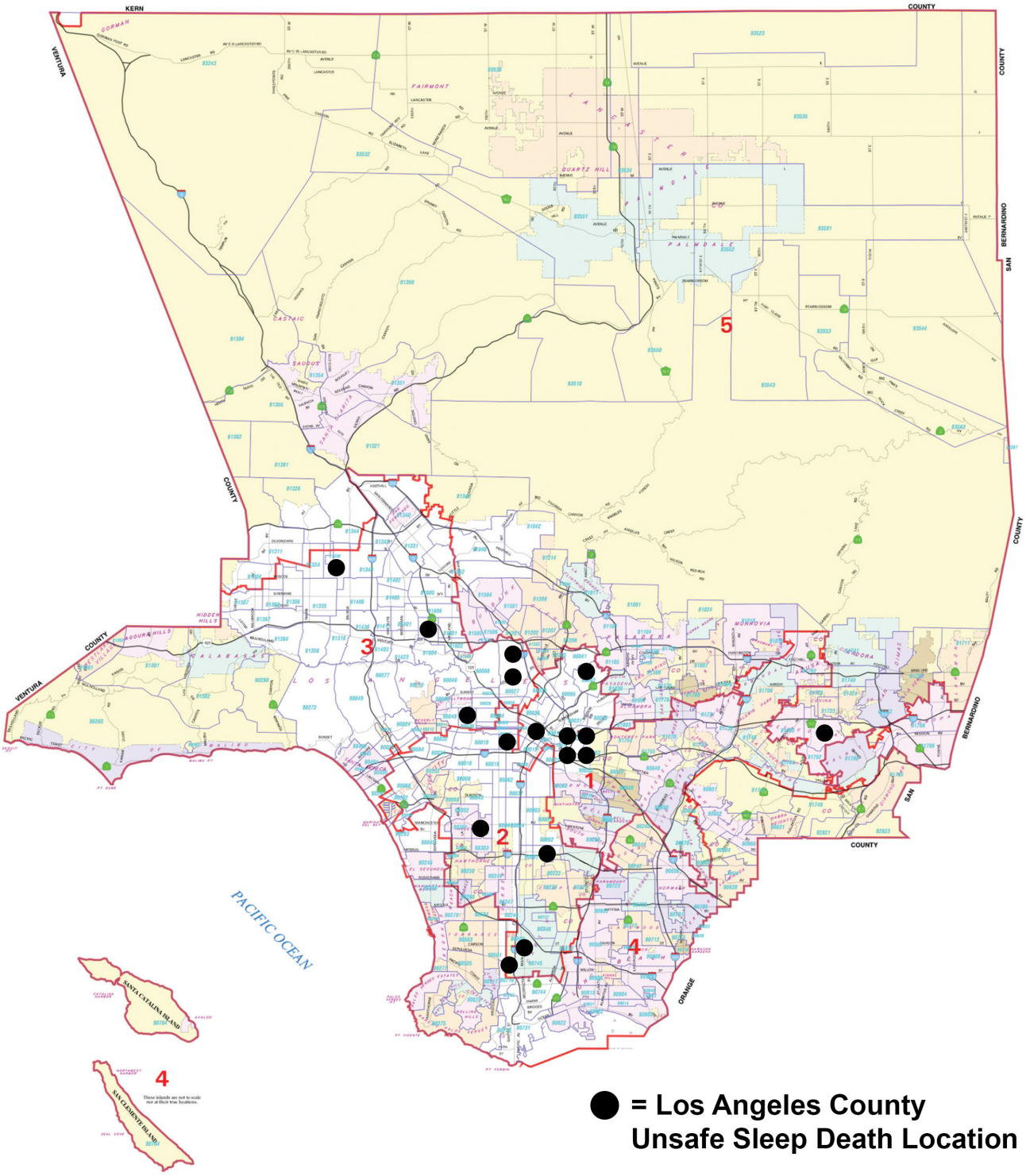

2021 Undetermined Child Deaths
Bed-Sharing/Unsafe Sleep Gender Breakdown
35%
65%
Male
Female


2021 Undetermined Child Deaths
Bed-Sharing/Unsafe Sleep Age Breakdown
9%
91%
Less Than One Year
One Year Old


2021 Udetermined Child Deaths
Bed-Sharing/Unsafe Sleep Ethnicity Breakdown
Asian (n=2)
9%
Hispanic/Latin American (n=8)
35%
Caucasian (n=4)
17%
Black (n=6)
26%
Filipino (n=1)
4%
Middle Eastern (n=1)
4%
Pacific Islander (n=1)
4%

2021 Unsafe Sleep Death - Locations
n = 17*

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



Sample Case Summaries - Third Party Homicides

Isaac

Isaac age 13, was in his bedroom playing video games, when there were two gunshots fired outside his home. One bullet went through the window and struck Isaac in the chest. Isaac stumbled into the living room and collapsed. 911 was called by the family and Police arrived in under two minutes and performed CPR until paramedics arrived. Paramedics arrived on scene and transported Isaac to Huntington Memorial Hospital. Isaac was intubated. Isaac was determined to have a Glasgow Coma Scale of 3, with a transthoracic gunshot wound. A thoracotomy performed, a right chest tube placed, and Isaac was given an intracardiac injection of epinephrine. It was determined that Isaac had sustained two cardiac injuries, one to the posterior right ventricle and one to the anterior left ventricle; both sutured. Isaac also sustained injuries to his right flank, right diaphragm, liver, and left lung. Despite all life saving measures, his treating doctor pronounced Isaac's death in the operating room. Isaac was a straight A student and was not gang affiliated.

Sara

Fourteen-year-old Sara sustained a gunshot wound while in a dressing room at Burlington Coat Factory during an officer involved shooting that occurred with a suspect. The suspect was acting erratic, stealing clothing, and assaulting customers, including severely injuring a female customer. One of the three officer's bullet penetrated the wall into the dressing room where Sara was trying on pants. LAFD responded and paramedic/firefighter determined death at scene. The suspect was also shot and died at the scene.

Charlie

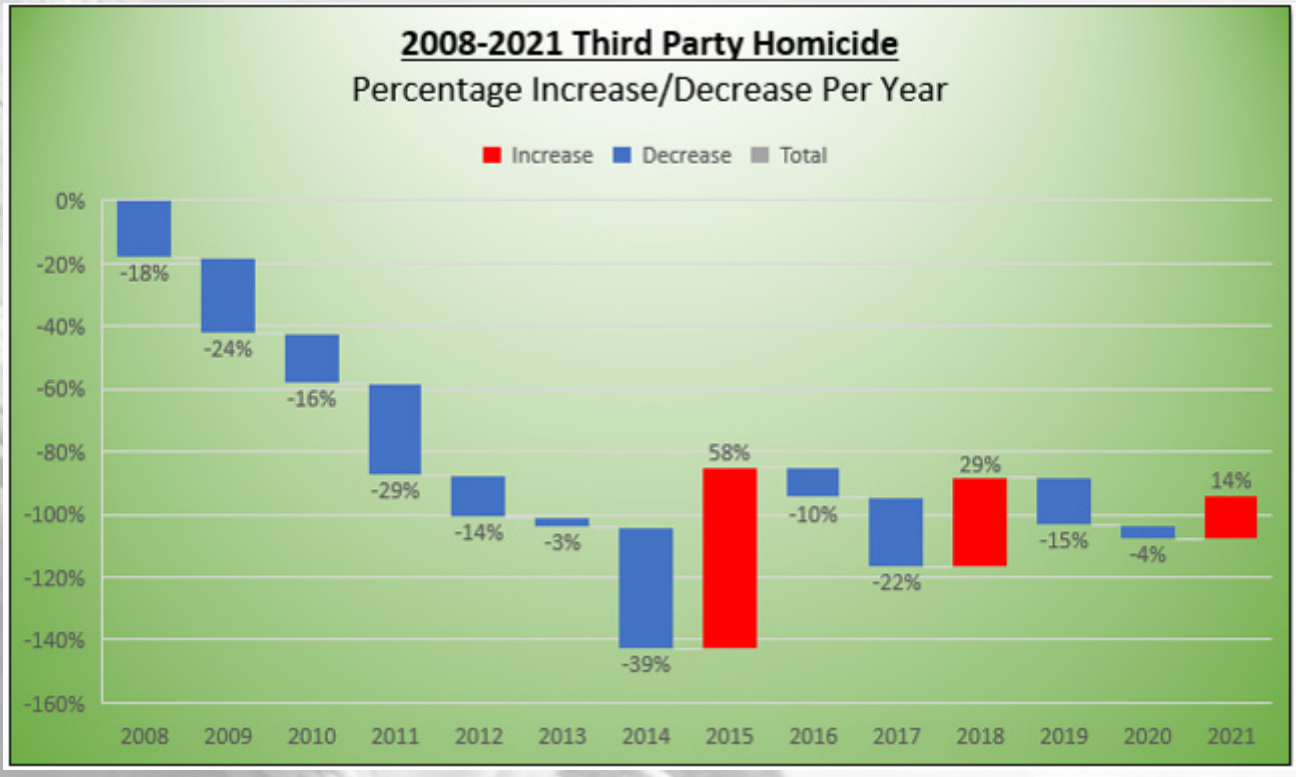
Charlie age 17 and 5 other adolescents attempted a home invasion in Long Beach. Charlie and his friends believed there was a large quantity of money and marijuana in this home. The homeowner shot Charlie and one of the other adolescents. Charlie was a foster child and was also being supervised by probation. He had been detained from his mother due to physical abuse and neglect and mother was completing treatment programs to regain custody of Charlie.

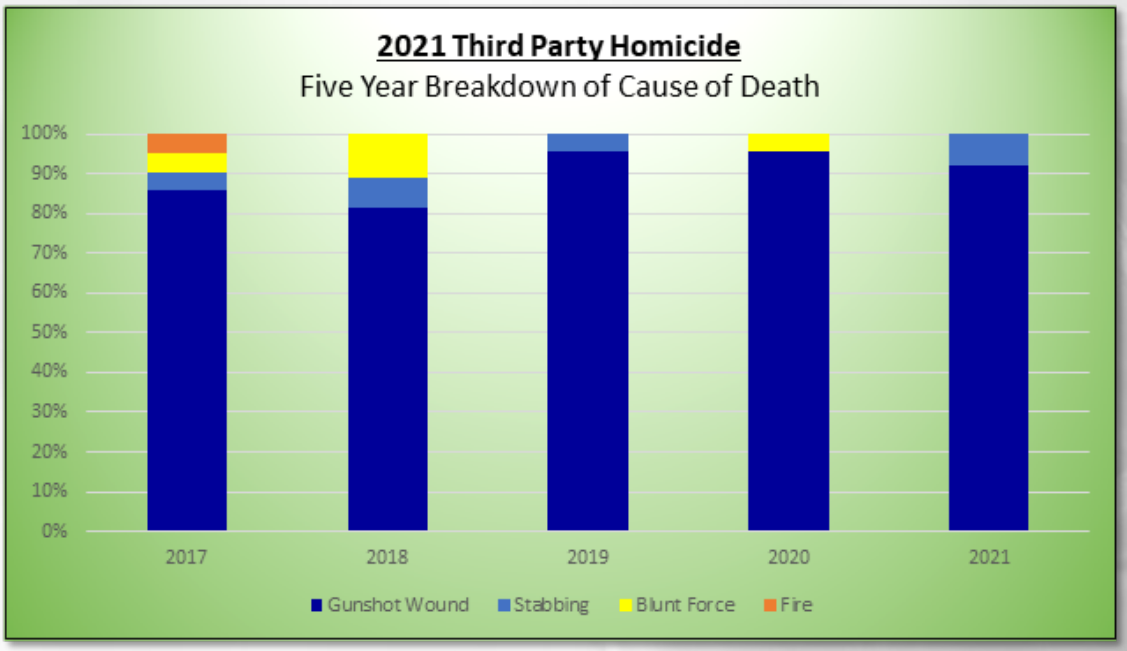
THIRD PARTY HOMICIDES

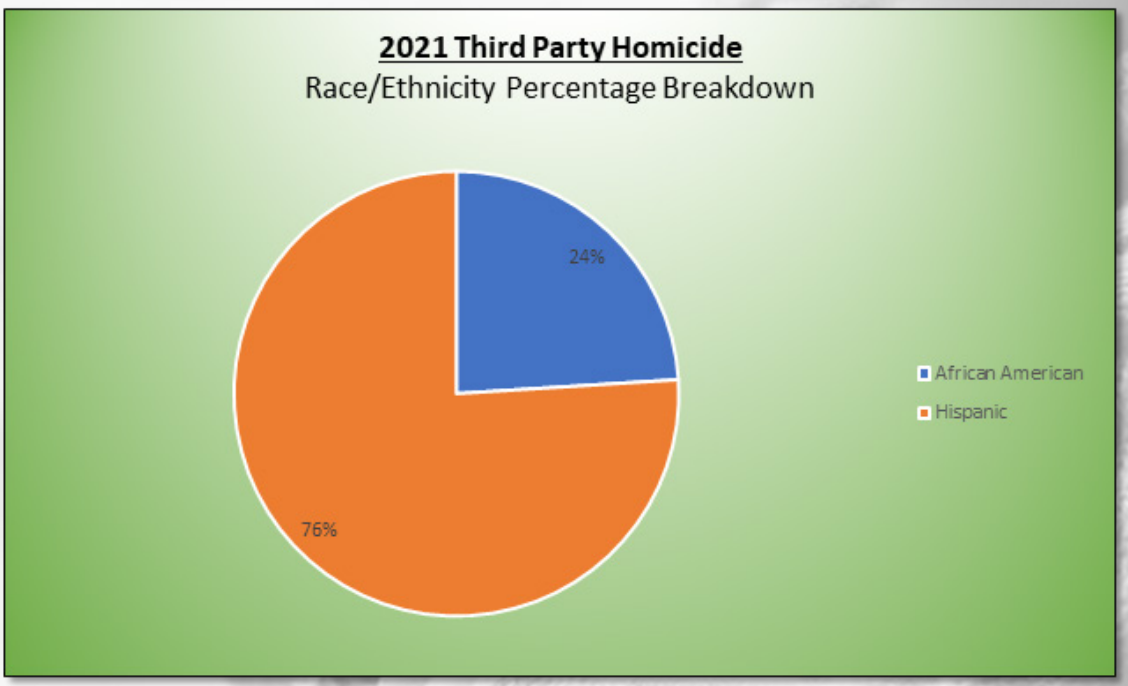
FINDINGS

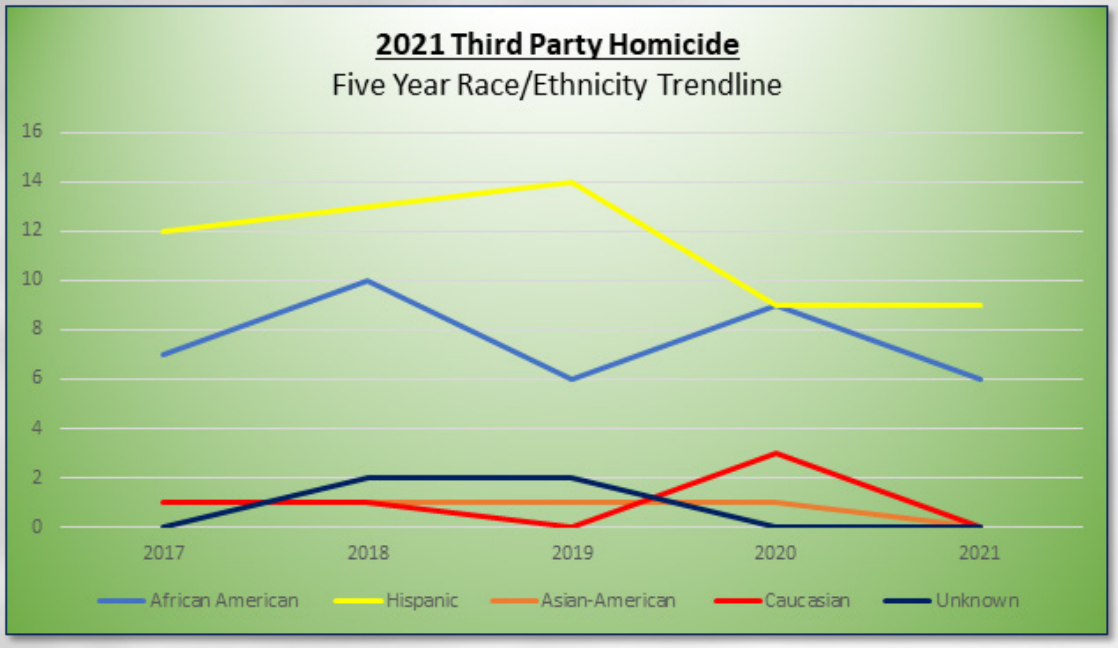
- Twenty-five third party homicides were reported to ICAN by the Coroner for 2021 – which is only one more case than last year. The five-year average is 24 third party homicides per year.
- ICAN began including third party homicides in the CDRT Report in 2007.
- As in prior years, the number one cause of third-party homicide is gunshot wound. This year, 95% of the victims succumbed to gunshot injuries.
- Of the twenty-five third party homicide victims, twenty-three were male and two were female in 2021. This continues the trend of the last few years of a decline in female victims. This year, males make up 92% of the victims. In 2018 and 2017, the percentages of males were 78% and 63%, respectively. 2021's gender ratio is above the five-year average, which is 79% for males and 21% for females.
- Third-party homicide victims ranged from 12 to seventeen in 2021. Older children made up the largest percentage of the victims with fifteen, sixteen and seventeen-year-olds composing seventy six percent. Additionally, there were two fourteen-year-old children, one thirteen-year-old child, one thirteen-year-old child, one twelve year old child.
- Seventy six percent of the victims of third-party homicides in 2021 were of Hispanic background, and 24% were of African American descent. These two groups made up 100% of the deaths in 2021 with no Caucasian or Asian victims. This a large increase in Hispanic victims compared to previous years.

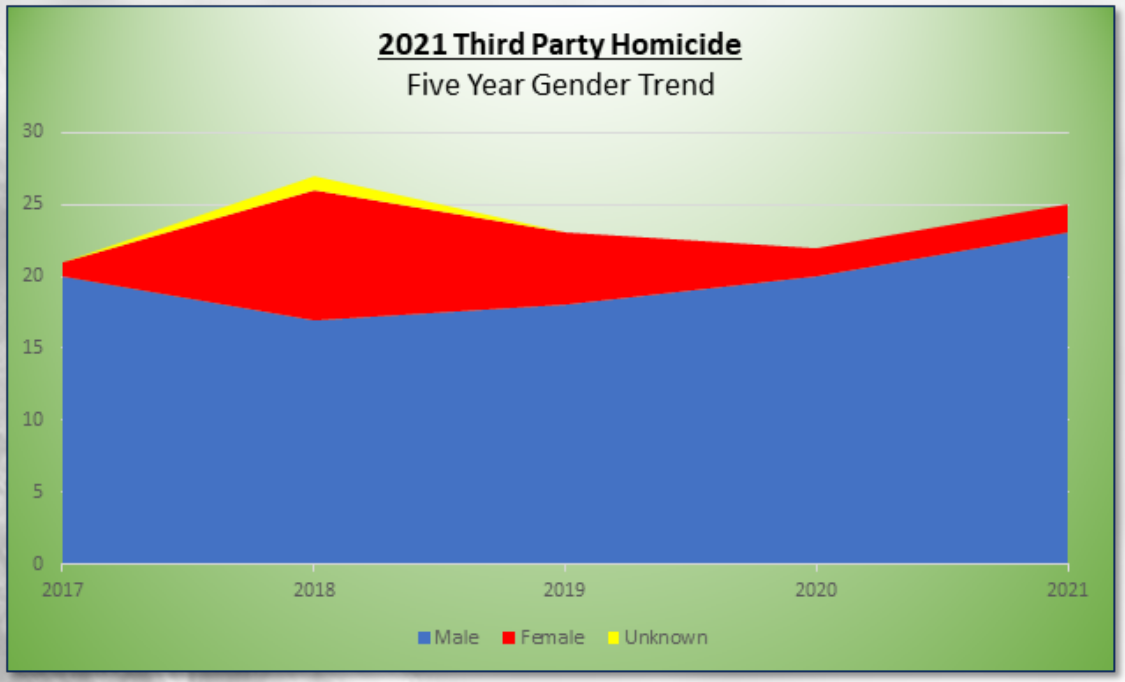

2007-2021 Third Party Homicide
Total Deaths Per Year Trending
120
100
80
60
40
20
0
100
82
62
52
37
32
31
19
30
27
21
27
23
22
25
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021

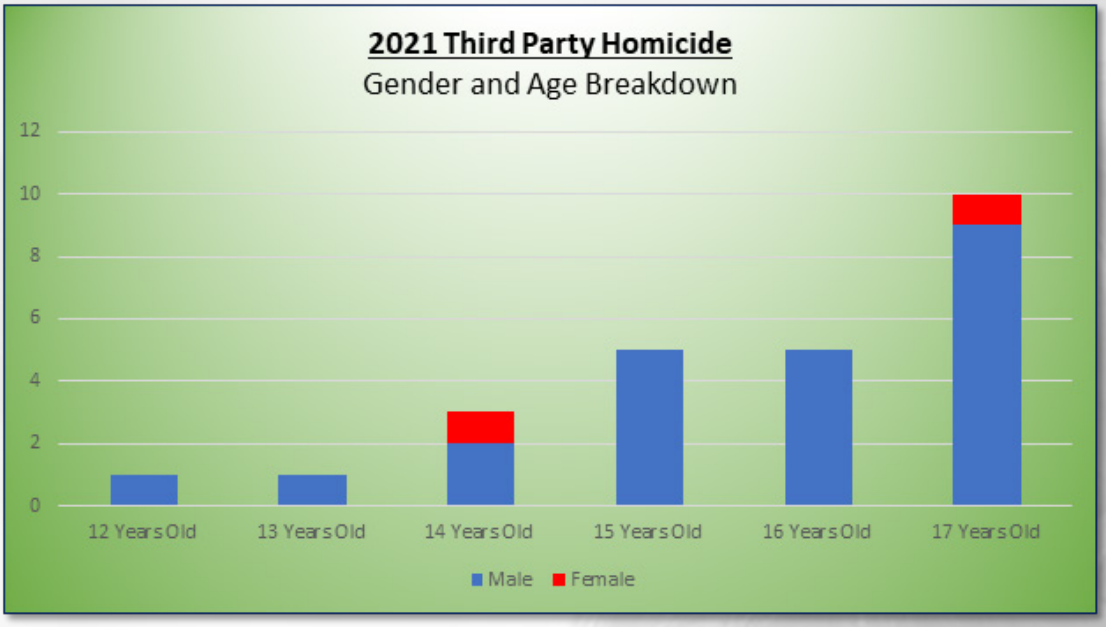

2008-2021 Third Party Homicide
Percentage Increase/Decrease Per Year
Increase
Decrease
Total
0%
-20%
-40%
-60%
-80%
-100%
-120%
-140%
-160%
-18%
-24%
-16%
-29%
-14%
-3%
-39%
58%
-10%
-22%
29%
-15%
-4%
14%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021

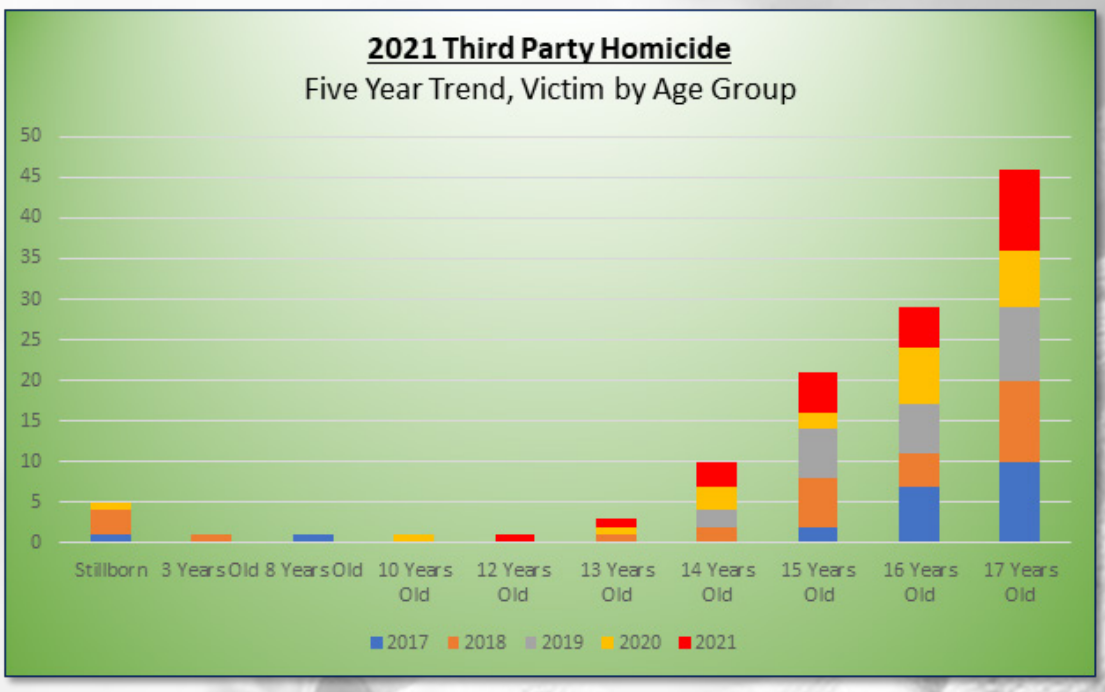

2021 Third Party Homicide
Five Year Breakdown of Cause of Death
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2017
2018
2019
2020
2021
Gunshot Wound
Stabbing
Blunt Force
Fire

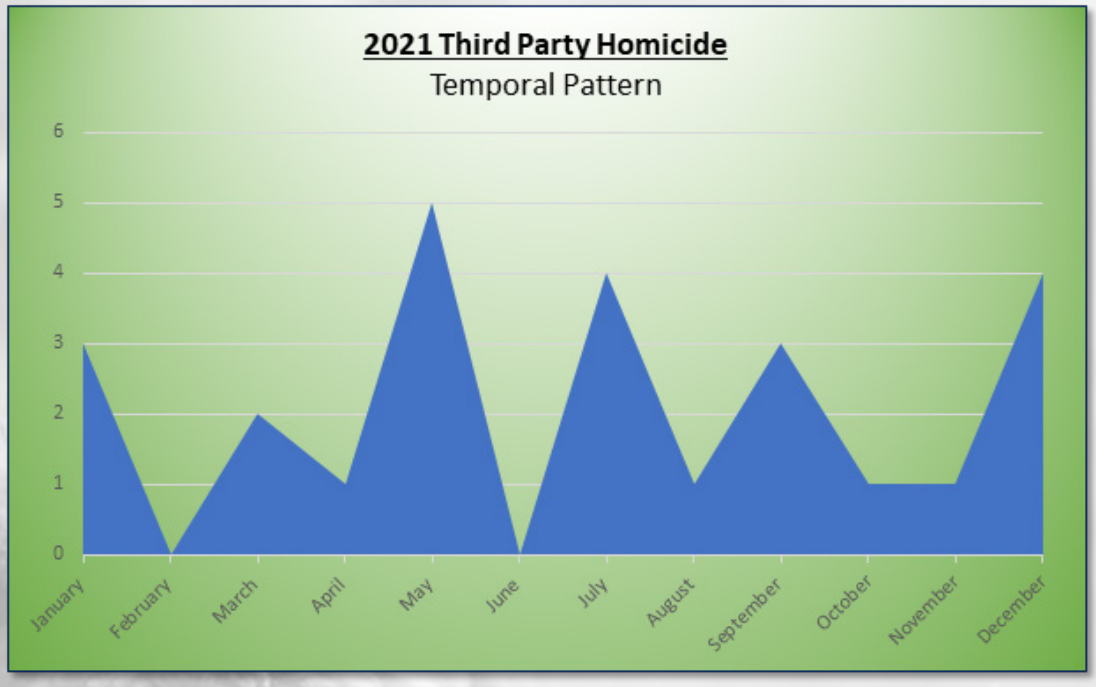

2021 Third Party Homicide
Race/Ethnicity Percentage Breakdown
24%
76%
African American
Hispanic


2021 Third Party Homicide
Five Year Race/Ethnicity Trendline
16
14
12
10
8
6
4
2
0
2017
2018
2019
2020
2021
African American
Hispanic
Asian-American
Caucasian
Unknown


2021 Third Party Homicide
Five Year Gender Trend
30
25
20
15
10
5
0
2017
2018
2019
2020
2021
Male
Female
Unknown

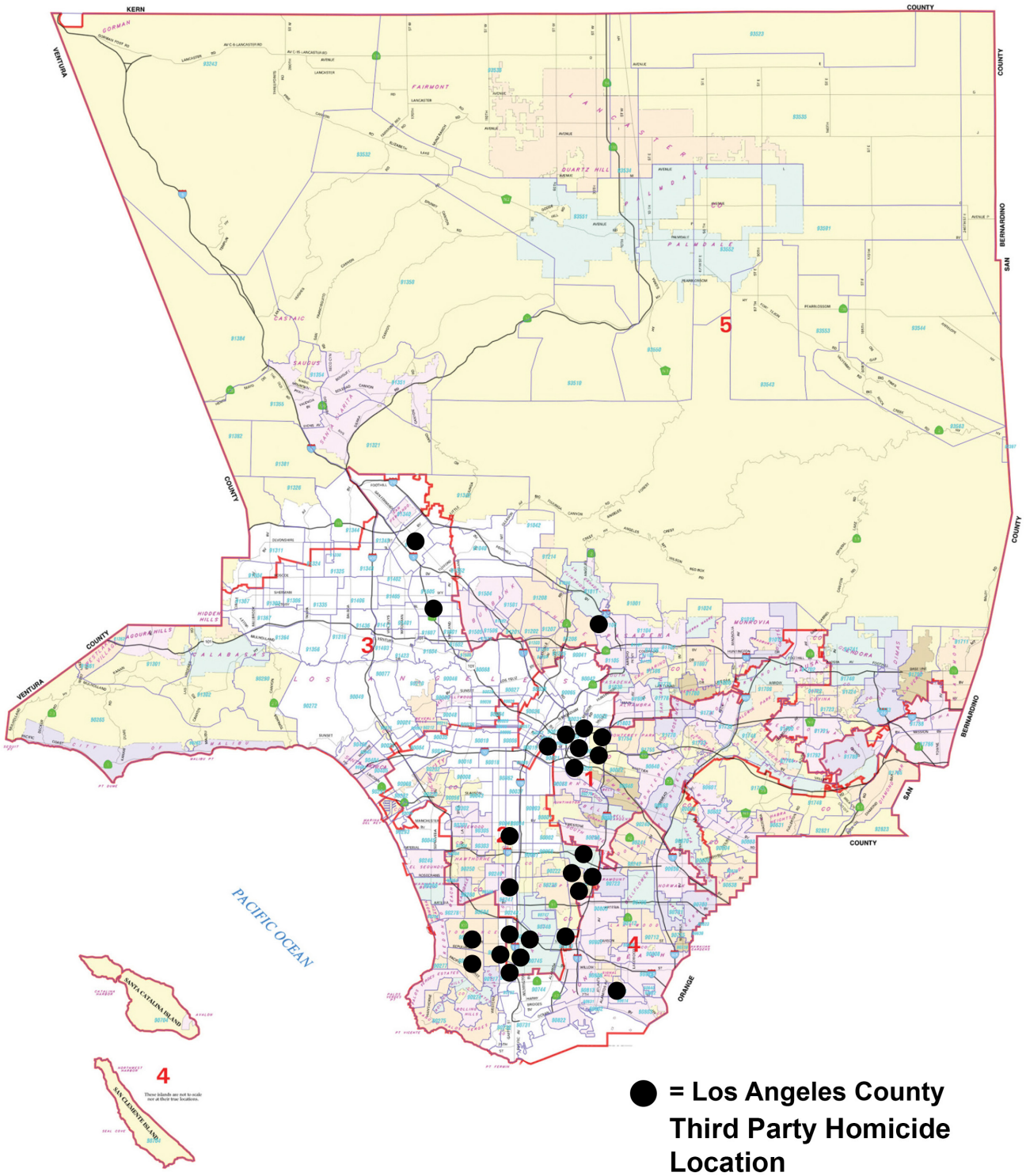

2021 Third Party Homicide
Gender and Age Breakdown
12
10
8
6
4
2
0
12 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old
Male
Female


2021 Third Party Homicide
Five Year Trend, Victim by Age Group
50
45
40
35
30
25
20
15
10
5
0
Stillborn
3 Years Old
8 Years Old
10 Years Old
12 Years Old
13 Years Old
14 Years Old
15 Years Old
16 Years Old
17 Years Old
2017
2018
2019
2020
2021


2021 Third Party Homicide
Temporal Pattern
6
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December

2021 Third Party Homicides - Locations
n = 25*

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