



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 2024 Report Compiled from 2023 Data

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Los Angeles County Team Representatives

Child Death Review Team Chairpersons:

Carol Berkowitz, M.D., Harbor/UCLA Medical Center

Janis Johnson, 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

Almanson 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 forty-seven 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 2022. 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 Seventeenth 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.

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.

Child Death Review Team: Risk Factors and Lessons Learned

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.

Child Death Review Team: Risk Factors and Lessons Learned

Team case review yields valuable lessons, including identification of systematic issues in need of attention by one or various agencies impacting the welfare of children and families. Additionally, patterns of risk factors present in families surface in the cases. The lessons and risk factors noted from the 2023 child death review cases are as follows:

Key Findings

Total number of child deaths in 2023 was 197 of which 132 were male.

59 children were under the age of one (30%). The deaths of these infants resulted primarily from unsafe sleep, maternal substance abuse, car accidents and drownings.

74 or 38% of the children, who died in 2023, were between ages 15-17. Most deaths were related to car accidents, third party homicides and suicides.

All third party homicide victims were male in 2023.

The age of child homicide victims in 2023 saw an increasing trend in children over the age of 1 with only one child being six months old. The rest of the children were between 3 and 13 years of age.

The ethnicity of child victims of homicide by a caretaker in 2023 was as follows; African American: 4 children, Hispanic: 1 child, Korean: 1 child and Caucasian: 1 child.

Parental/Caregiver Risk Factors

Involvement with the Child Welfare System

A key factor in the majority of the child abuse homicide cases from 1989 to 2023 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 2023, we saw a shift in that most cases of homicides by caretaker did not have Department of Child and Family Services contact.

Cycle of Abuse

Cycle of abuse was not readily available in documents available for review for all parents or caregivers who committed a child homicide.

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. In 2023, there was no documented history of substance abuse by perpetrators.

Mental Illness

Untreated mental illness is a risk factor seen in two of the child abuse homicides. In three of those cases there appeared to be untreated depression and stressful life circumstances within the family.

Perpetrator Relationship

Relationship

In the year 2023, there was a return to biological fathers being the suspect in the majority of the child homicide cases followed by mother's boyfriend. Last year, (2022) there was an outlier in the data in that mothers were the primary perpetrators of child homicides. In 2023, there were no 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 abuse homicides, coupled with issues of domestic violence.

Additional Risk Factors

Unsafe Infant Sleeping

Sudden unexpected infant deaths (SUIDs) 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 24 children died in 2023 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.

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
2019	18
2020	14
2021	12
2022	11
2023	6

The average number of children and adolescents who suicided over the past five years is 23. The leading method from 2019 through 2023 is hanging.

Year	Number
2019	20
2020	26
2021	23
2022	18
2023	26

An average of 100 children have died from preventable accidents over the past 5 years from automobile accidents, drowning and deaths due to auto vs. pedestrian.

Year	Number
2019	110
2020	126
2021	104
2022	74
2023	88

The number of undetermined deaths has averaged 45 per year over the past five years

Year	Number
2019	42
2020	50
2021	41
2022	42
2023	48

Child Deaths in Los Angeles County 2019 – 2023

Table 2

2023 Child Deaths Demographics - Coroner Cases

	Number	Percentage
Total	197	100.0%
Gender		
Female	63	32%
Male	132	67%
Unknown	2	1%
Age		
Under 1 Year	59	30%
1 – 4 years	24	12%
5 – 9 years	10	5%
10 – 14 years	30	15%
15 – 17 years	74	38%
Race		
African American	38	19%
Asian/Pacific Islander	12	6%
Caucasian	31	16%
Hispanic	106	54%
Filipino	1	1%
Hawaiian	2	1%
Samoan	1	1%
Unknown	6	3%

Sample Case Summaries - Homicides

Joshua

Thirteen-year-old Joshua was in a vegetative state and died from complications due the physical abuse he endured at the age of 3, by his mother's boyfriend, under the care of his mother. The child sustained significant brain trauma, which led to severe neurological issues, resulting in the child becoming quadriplegic. He was unable to speak, and developed a seizure disorder. It was known that Joshua at age 3, had informed family members of his abuse by mother's boyfriend.

Shirley

Biological father shot five-year-old Shirley in the head before turning the gun on himself. Earlier that day, mother went to the police station to report that her husband was threatening to kill her. Mother expressed being concerned as her husband was armed and their daughter was with him at home. Upon law enforcement arriving to the residence, they observed smoke rising from the home, followed by two gunshots. Officers forced entry into the house, locating the body of the child with visible shattering injuries to the head and face. The child was pronounced deceased at the scene. The child's father was located in the same bedroom with a self-inflicted shotgun wound to the head.

Lisa

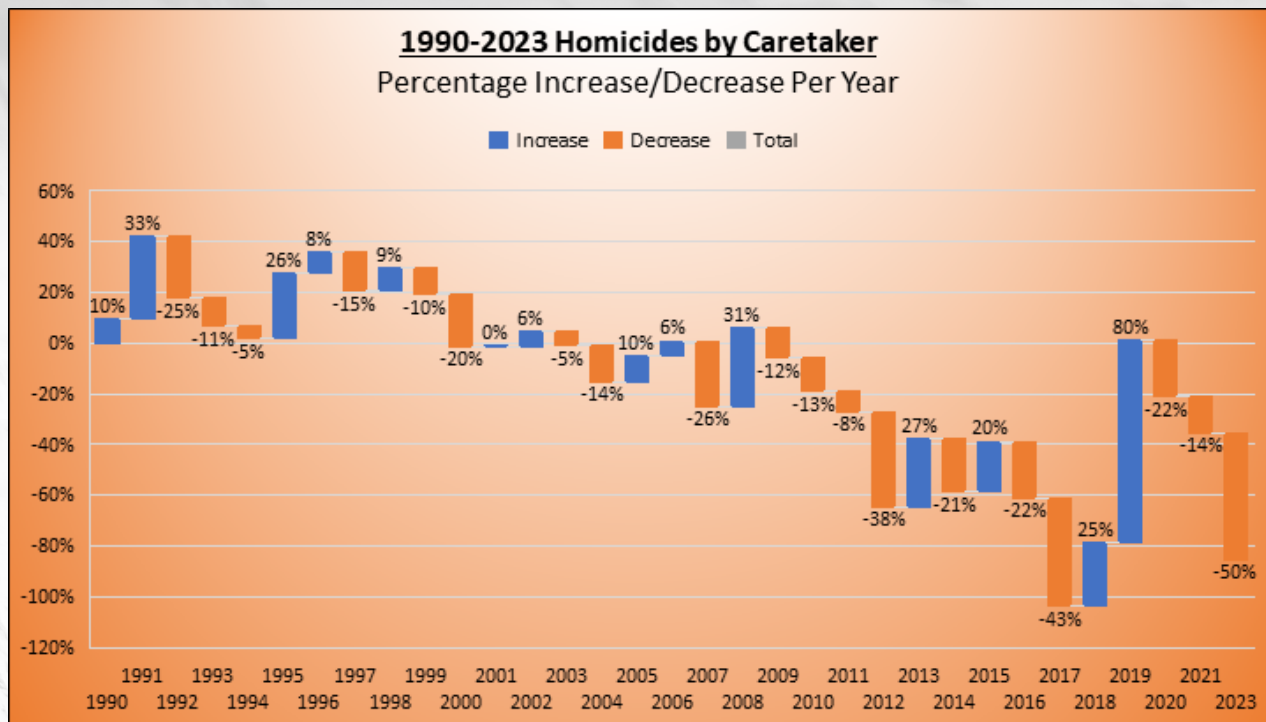
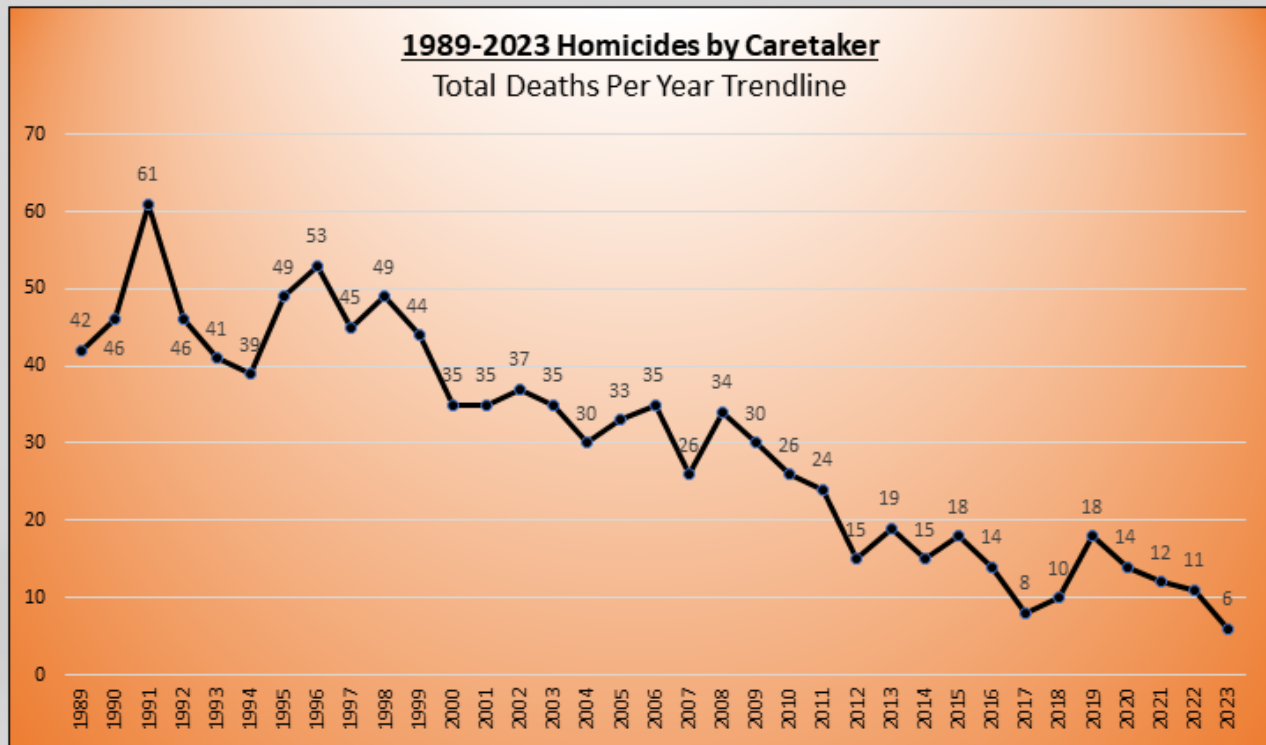
Eight-year-old, Lisa, was fatally attacked by her father. He inflicted multiple knife injuries all over her body. The father then fatally wounded his wife, the child's mother, by stabbing her with a knife multiple times all over her body, before killing himself. Father was found in the same bedroom as his daughter with self-inflicted stab wounds to his neck. Law enforcement conducted a welfare check on the family once church members expressed being concerned after not having seen the family for three days. It was reported that the father was experiencing high levels of stress and economic despair.

HOMICIDE BY CARETAKER

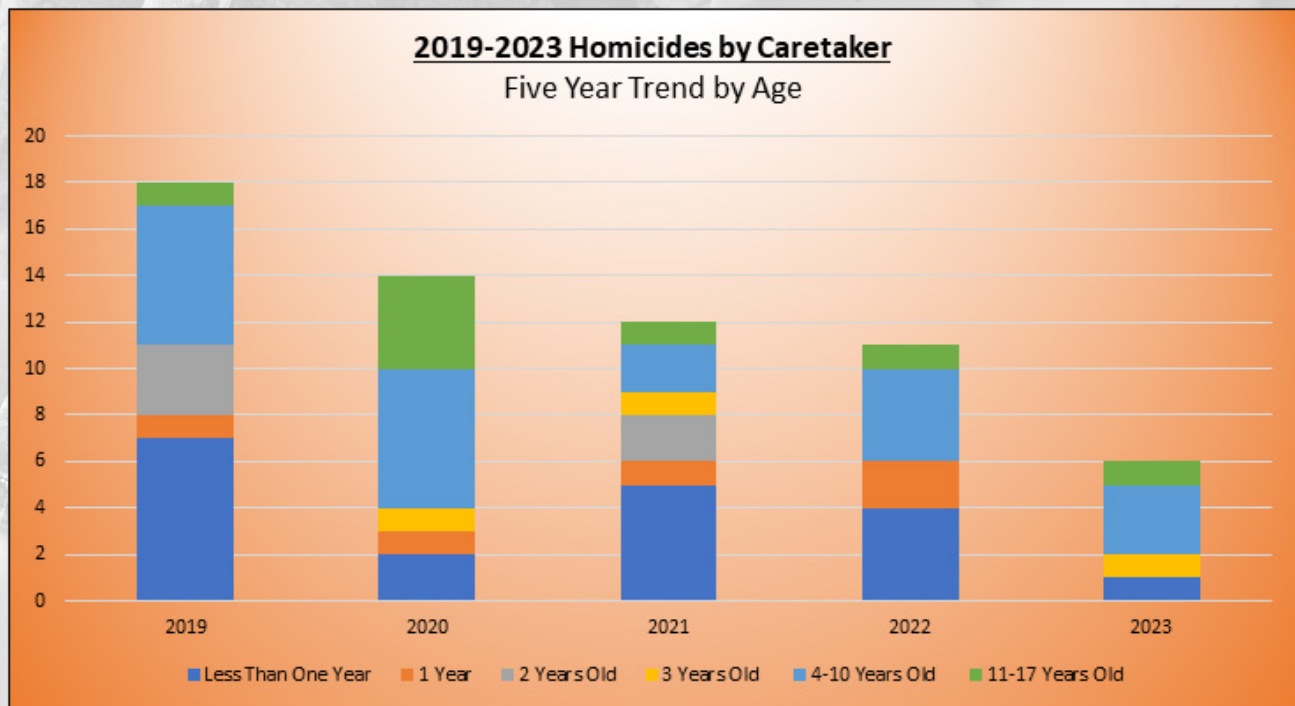
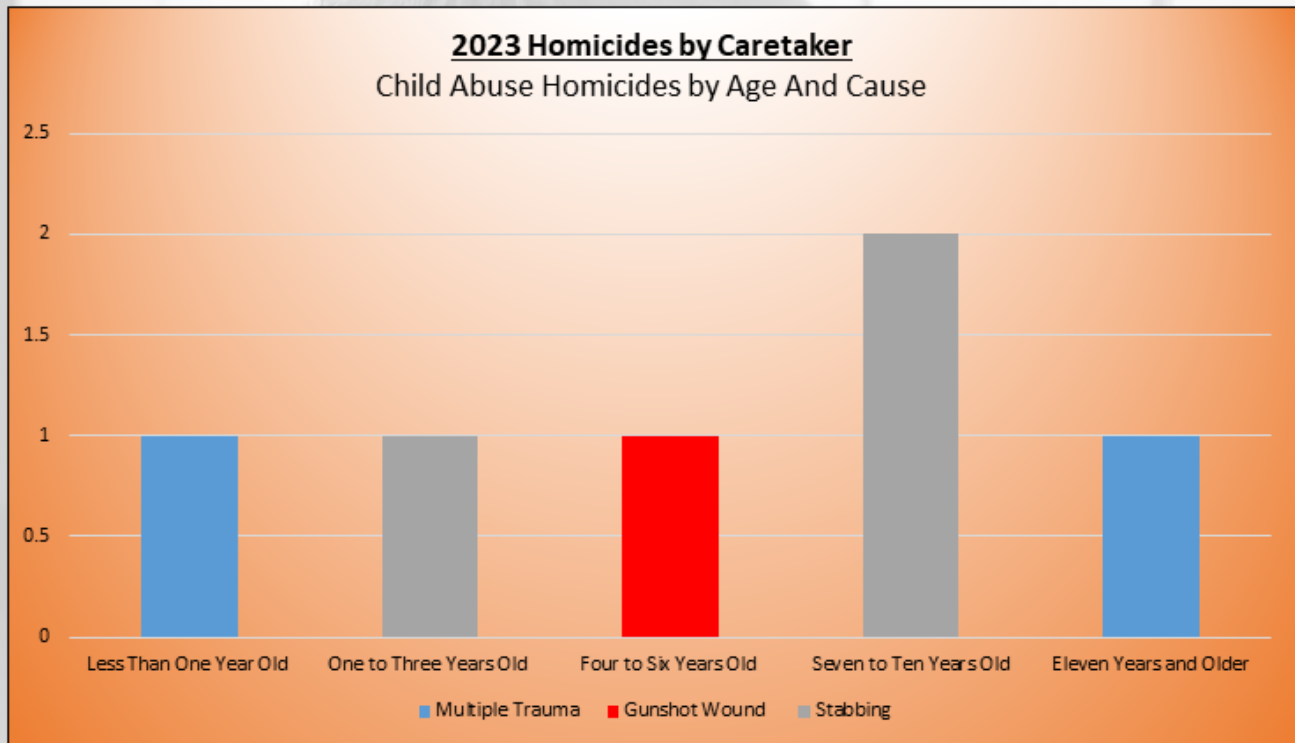
FINDINGS

- Six homicides of children by caretaker were reported to ICAN from the Coroner's Department in 2023.
- This is a significant decrease from the 2022 number of 11 homicides by caretaker. This is the lowest number of homicides by caretaker since ICAN began reviewing child fatalities in 1978. There was a spike in 2019 with 18 homicides. However, there continues to be a downward trend in the last 10 years.
- Stabbing was the leading cause of homicides by caretaker in 2023, with 3 children dying from being stabbed or cut by their caretaker. The second leading cause was gunshot wound. This is a shift from the previous year, in which drowning was the leading cause of death. The previous year also saw a shift in the proportionality in genders of perpetrators in that mothers were the primary perpetrators of homicides. In 2023, the biological father perpetrated the majority of homicides.
- The other cause of trauma was multiple trauma by mother's boyfriend.
- 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 2023 saw an increasing trend in homicides for children over the age of 1 with only one child being under the age of 1 at six months old. The rest of the children were 3, 5, 7, 8 and 13 years of age.
- The majority of children who were killed were females, with 4 female deaths and 2 male deaths in 2023.
- The ethnicity of child victims of homicide by a caretaker in 2023 was as follows; African American: 4 children, Hispanic: 1 child, Korean: 1 child and Caucasian: 1 child.
- A five-year analysis of perpetrators shows that fathers, followed by mothers, and mother's boyfriend/both parents are the most responsible for the death of the child(ren) in their care. However, in 2023 all of the perpetrators were fathers and one boyfriend.
- In 2023, only 3 of the homicide cases had prior DCFS history which included cases for domestic violence, physical abuse and/or neglect.
- The Los Angeles Sheriff's Department investigated four of the child homicides by caretaker. The remaining 2 cases were handled by Gardena Police Department, and Long Beach Police Department.

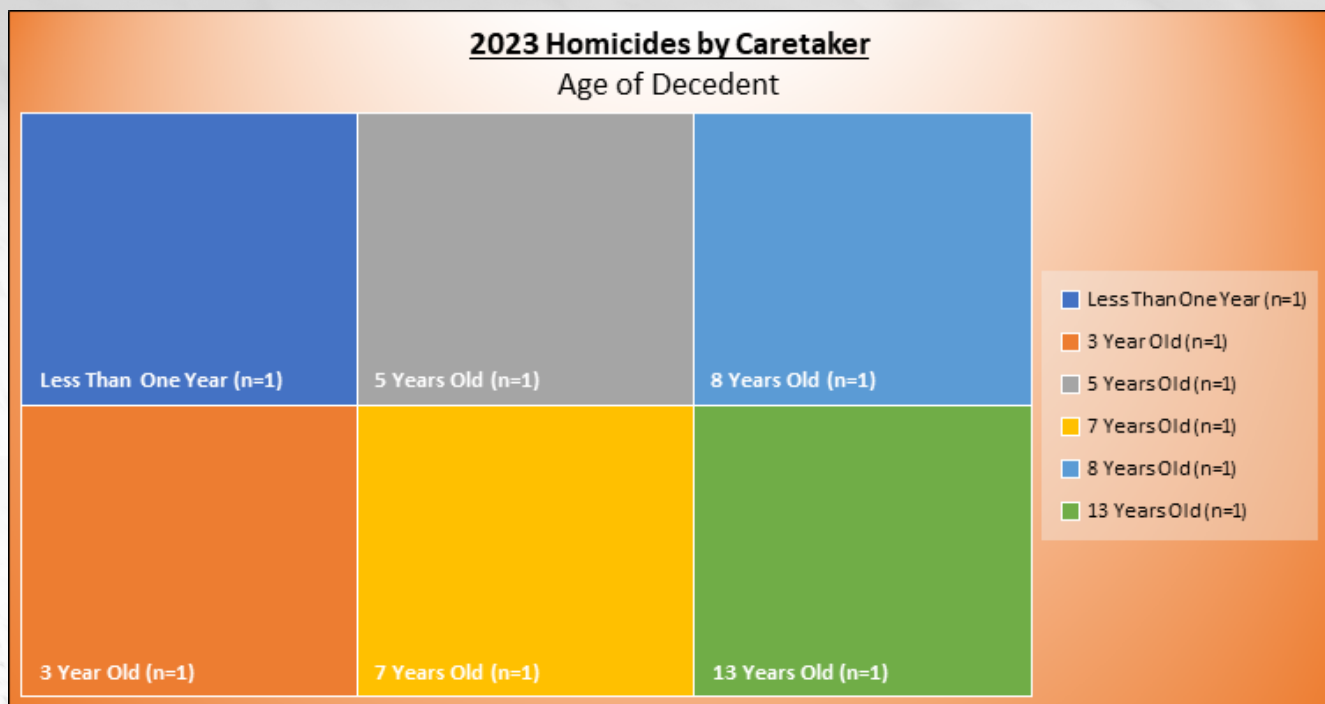
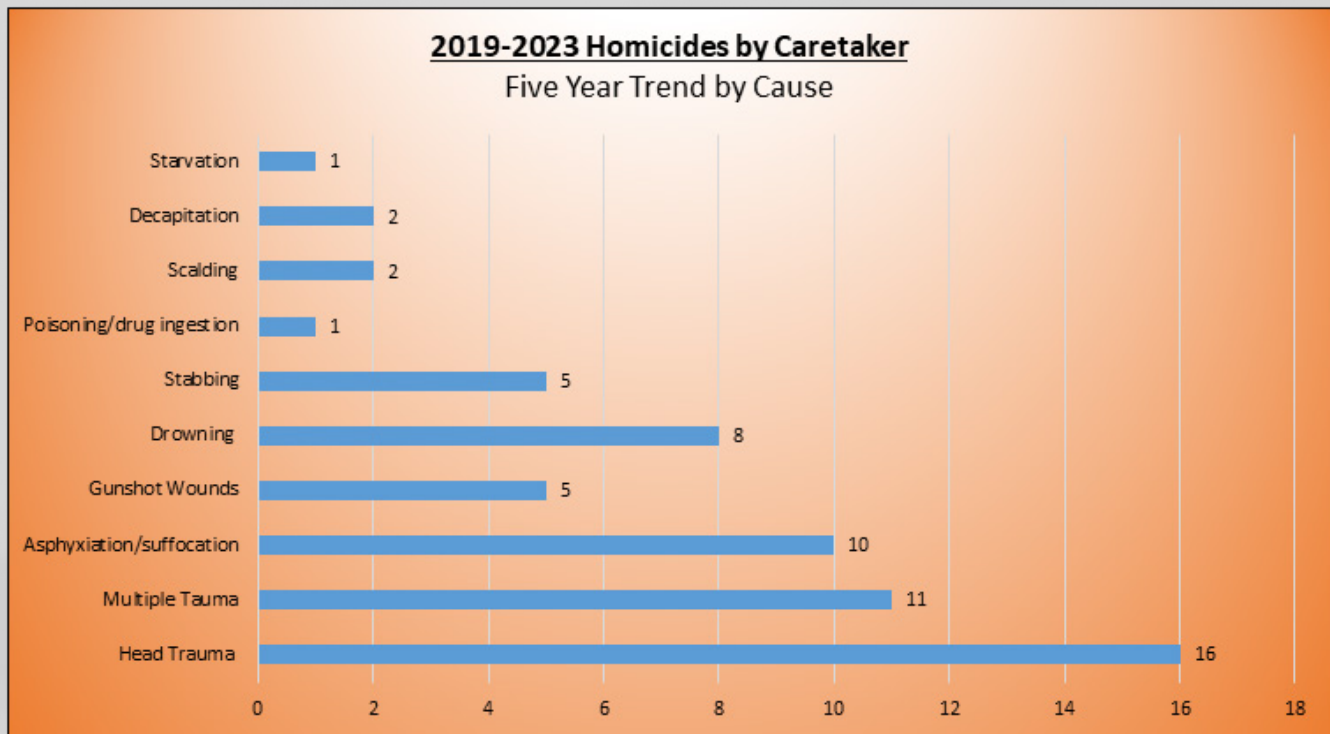
Child Homicide by Parent/Caregiver/Family Member



Child Homicide by Parent/Caregiver/Family Member



Child Homicide by Parent/Caregiver/Family Member



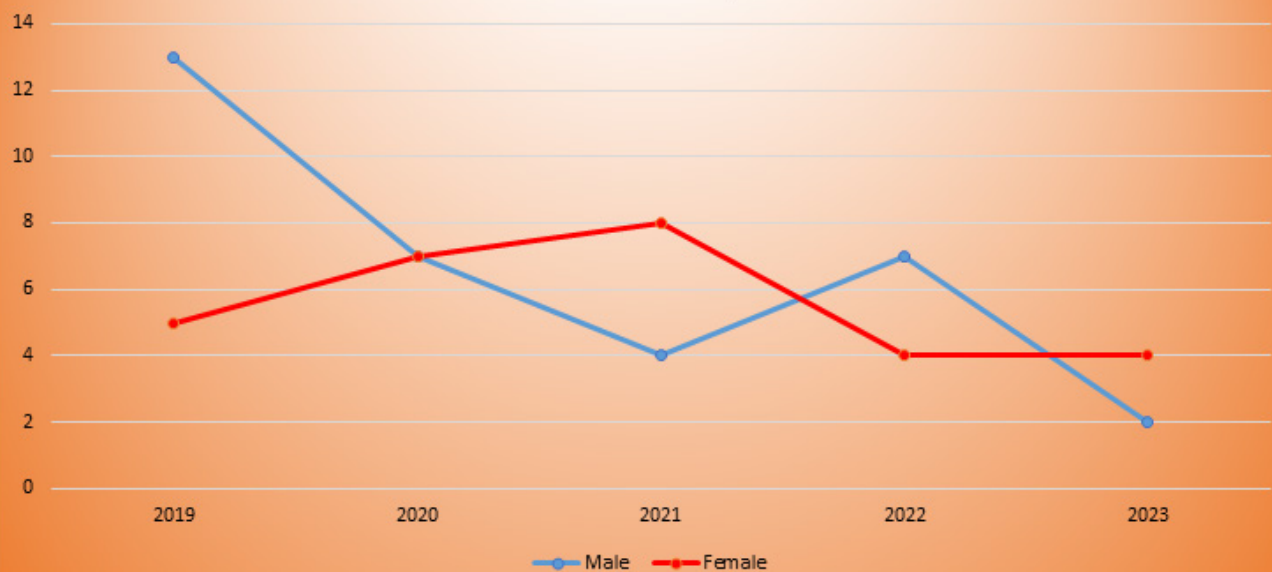
2023 Homicides by Caretaker

Gender Breakdown

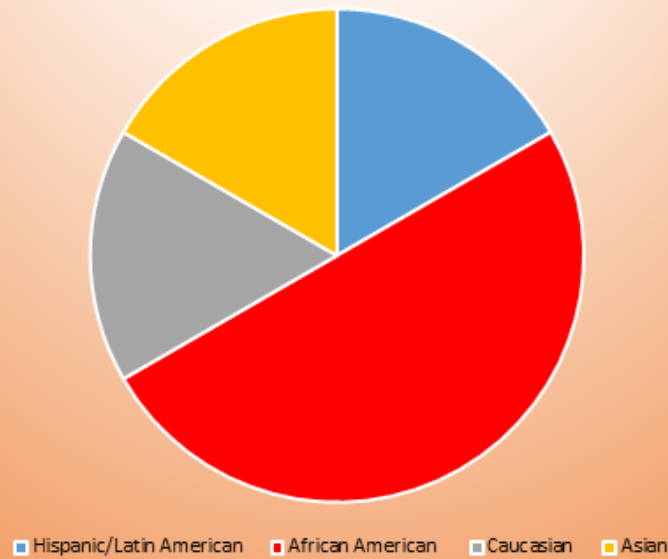


2023 Homicides by Caretaker

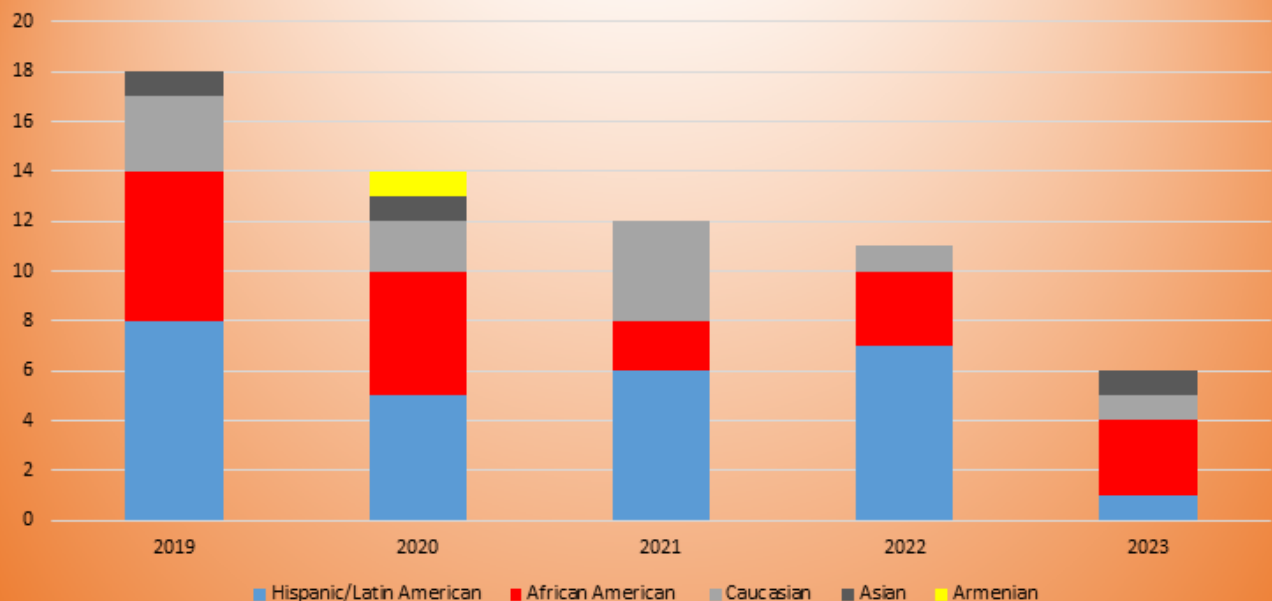
Five Year Trendline by Gender



2023 Homicides by Caretaker
Race/Ethnicity Breakdown

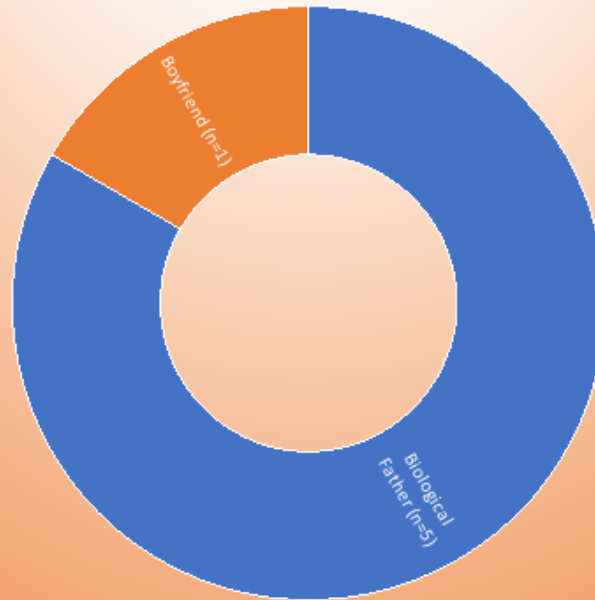


2023 Homicides by Caretaker
Five-Year Race/Ethnicity Breakdown



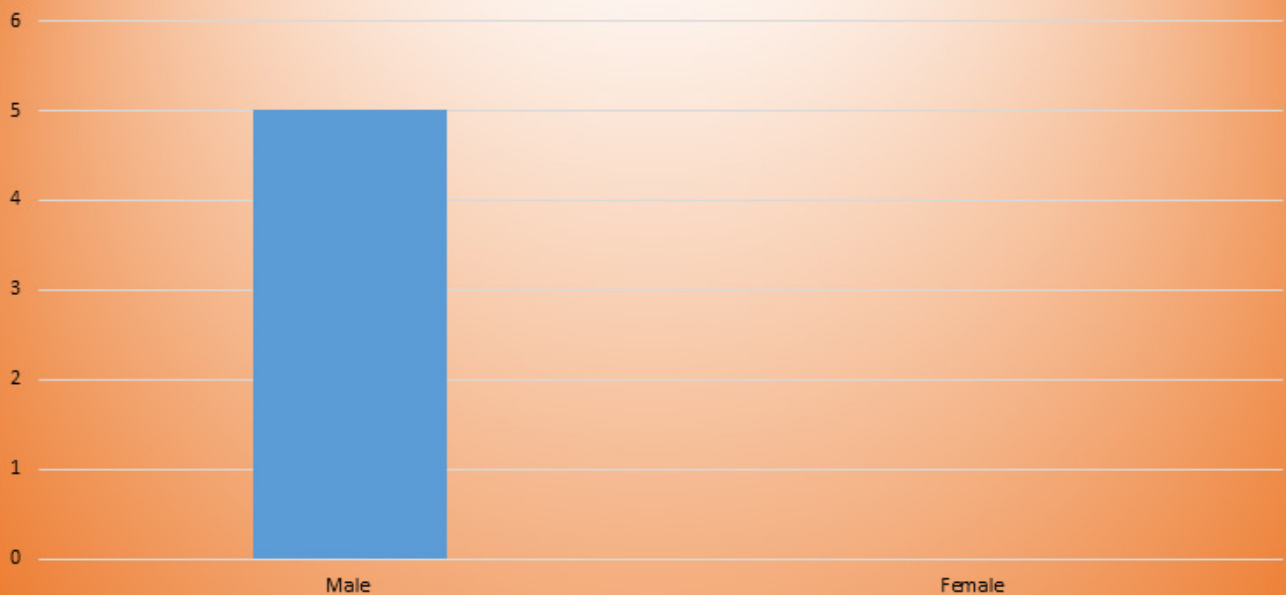
2023 Homicides by Caretaker

Relationship of Suspect to Child Homicide Victim

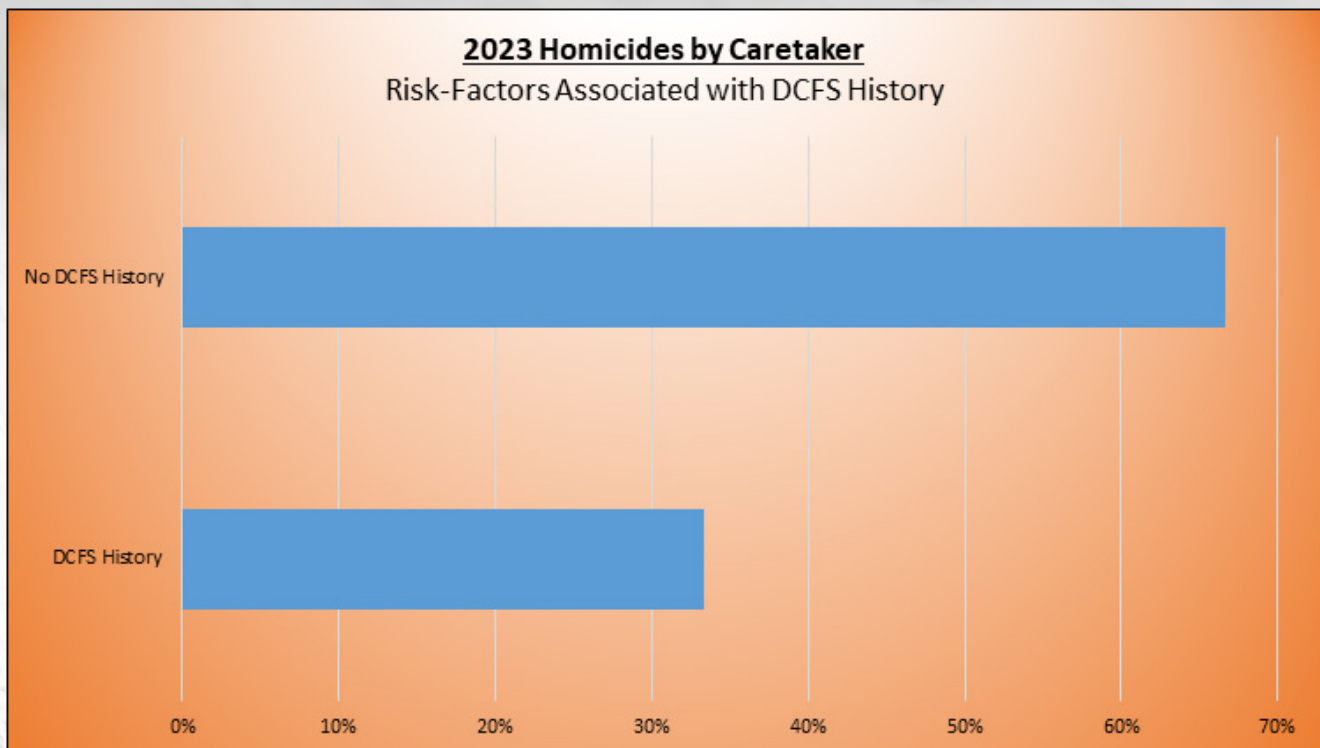
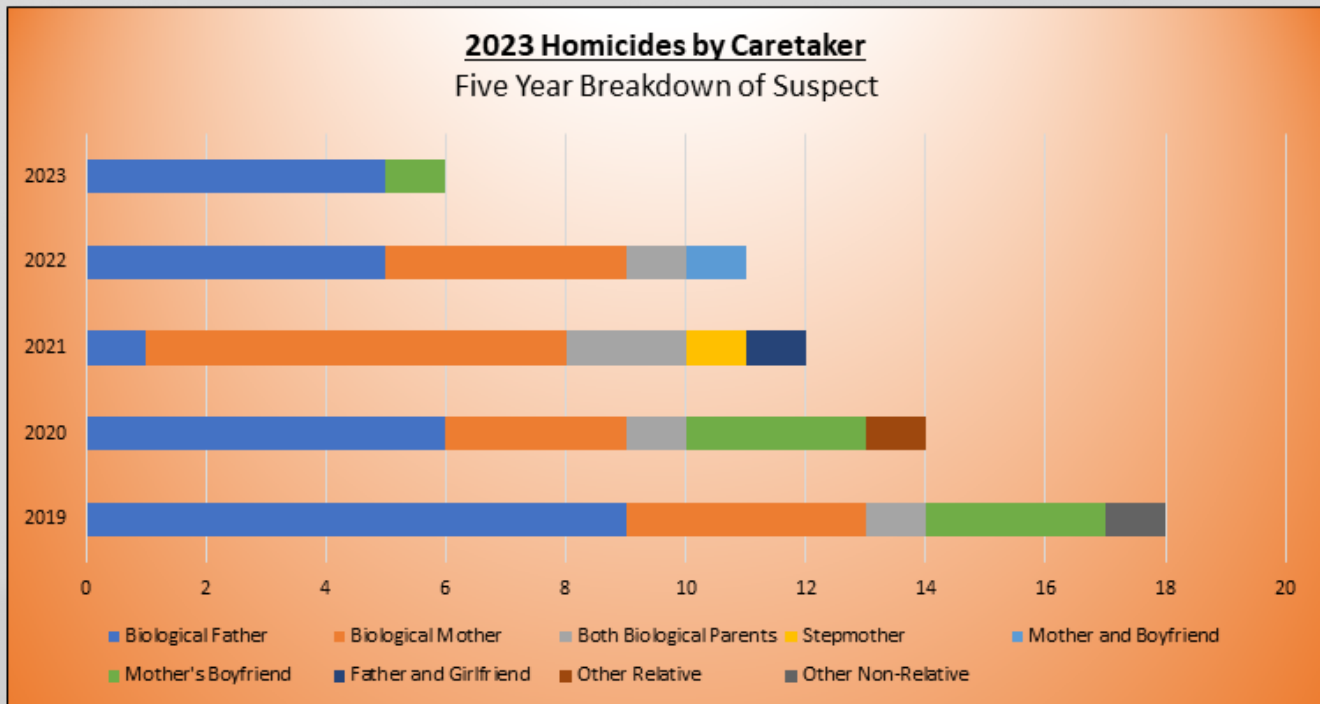


2023 Homicides by Caretaker

Gender of Suspect to Child Homicide Victim



Child Homicide by Parent/Caregiver/Family Member



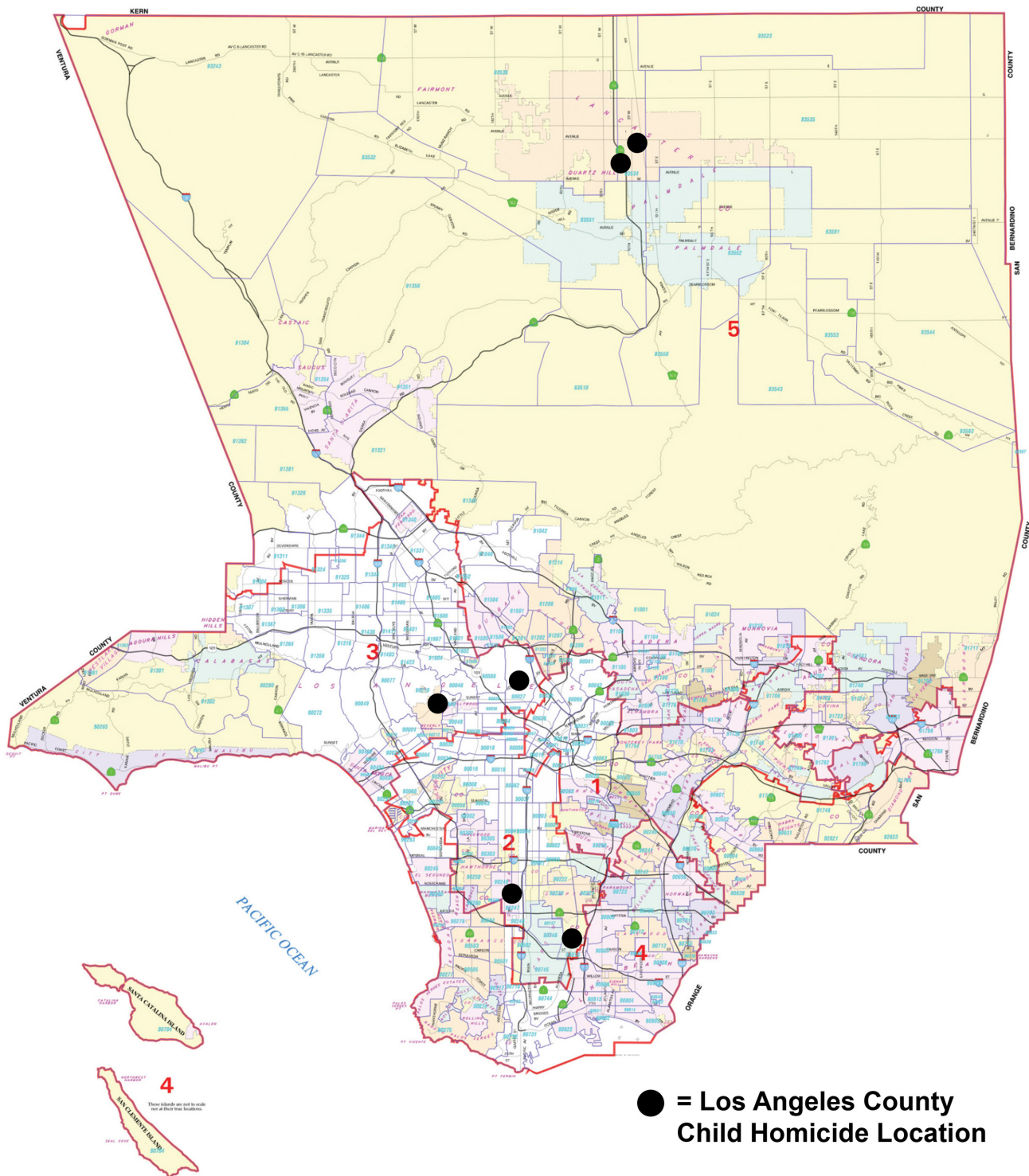
Child Homicide by Parent/Caregiver/Family Member



2023 Child Homicides - Locations

n =6*

*City where the homicide occurred



Sample Case Summaries - Suicides

Mark

Mark age seventeen was found by his father unresponsive in bed. A 10-page suicide note and an empty medication bottle were found on the scene. 9-1-1 was called and Los Angeles County Fire Department responded to the scene. Paramedics found no vital signs and pronounced him dead on scene. Mark has been living with his father since March 2022 after being kicked out by his mother in February 2022. Mark had a mental health history of depression, PTSD, dissociative identity disorder and dyslexia. At the time, Mark was prescribed psychotropic medications. Mark had two prior suicide attempts. Mark expressed in his note the physical and emotional abuse experienced and inflicted by mother.

Lily

Thirteen-year-old Lily was found hung with a belt from the top of her bunk bed by maternal aunt. Lily did not have a history of suicide attempts. However, she was seeing a school therapist where she was learning new coping skills to manage her emotions. In 2015, Lily and her older sibling moved to the father's home due to their mother being homeless. Lily's mother suffered from severe mental health issues. Eventually, Lily's older sibling moved to maternal aunt's home as there were allegations of emotional abuse by father that were investigated by DCFS. In 2022, the father was unable to maintain stable housing for Lily and himself living in various hotels and at times in father's car. Lily then moved to maternal aunt's home. Ten months later, Lily died by suicide. No suicide note was found on scene.

Alice

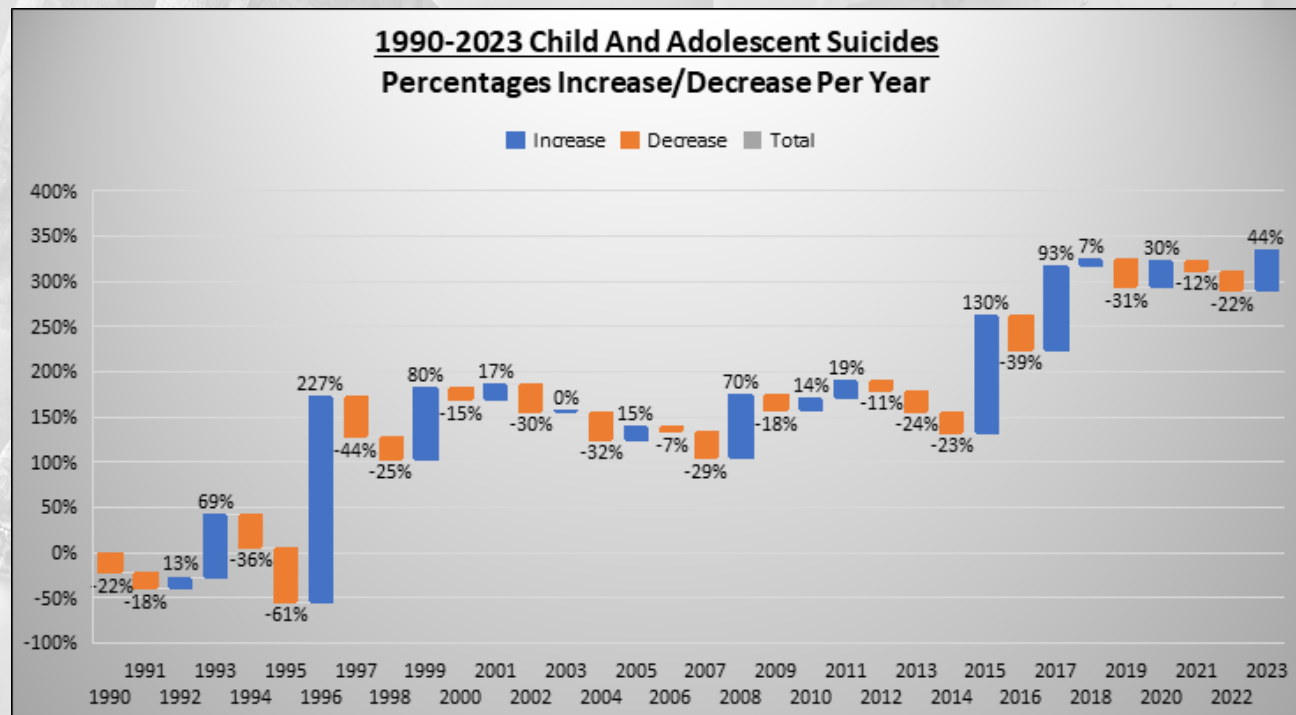
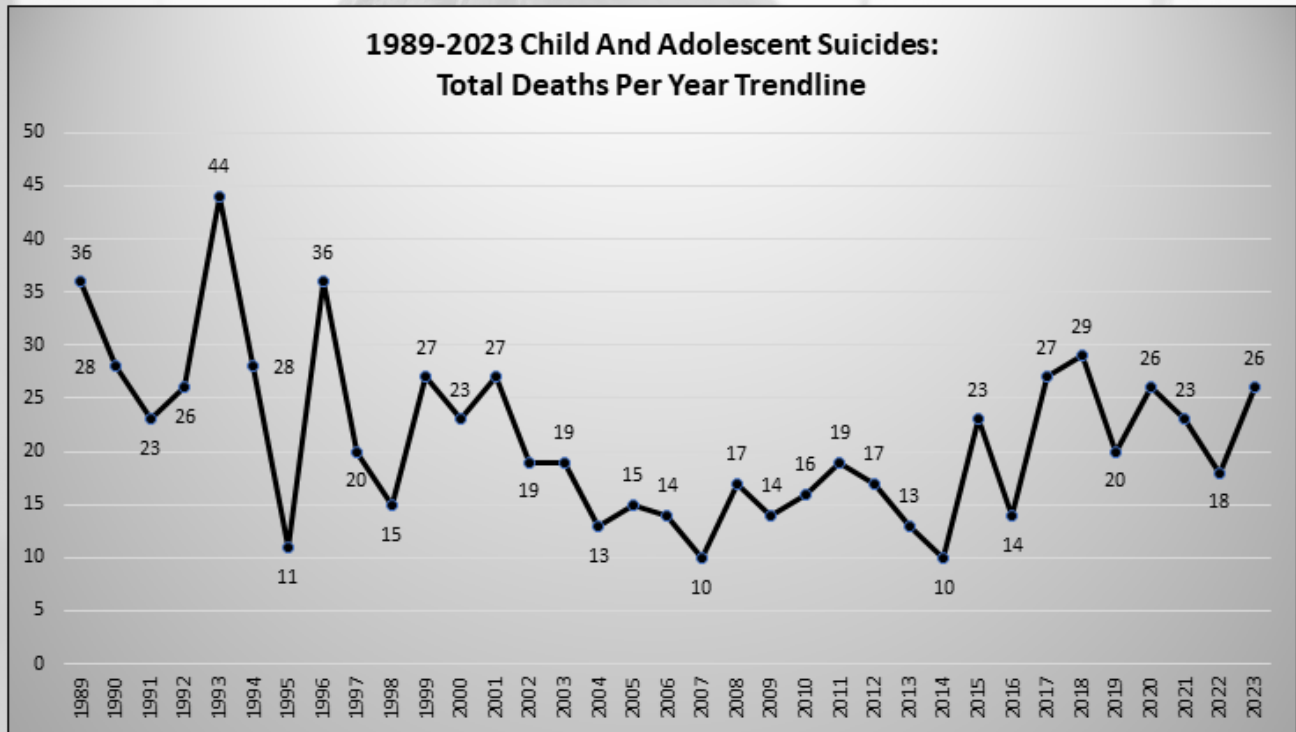
Sixteen-year-old Alice was found with a gunshot wound to the head, bleeding and unconscious in her bedroom by her father. No suicide note was found. 9-11 was called and Fire Department responded. Alice was pronounced deceased on scene. A day before, Alice spent the day fishing with the father and her boyfriend. In the evening after their fishing trip, Alice texted her boyfriend that she "didn't feel special to him and didn't feel appreciated." The morning of the incident, Alice texted him that "it was not his fault" and to "have a good life" before she died by suicide. Alice was her school's USB vice-president and had been active in sports. Alice had no history of mental health issues, suicidal ideation or prescribed medication. Alice's boyfriend also died by suicide just four days later. Additionally, family history indicated older sibling had a prior suicide attempt due to the parents' high expectations encouraging academic excellence and striving in extracurricular activities.

SUICIDES

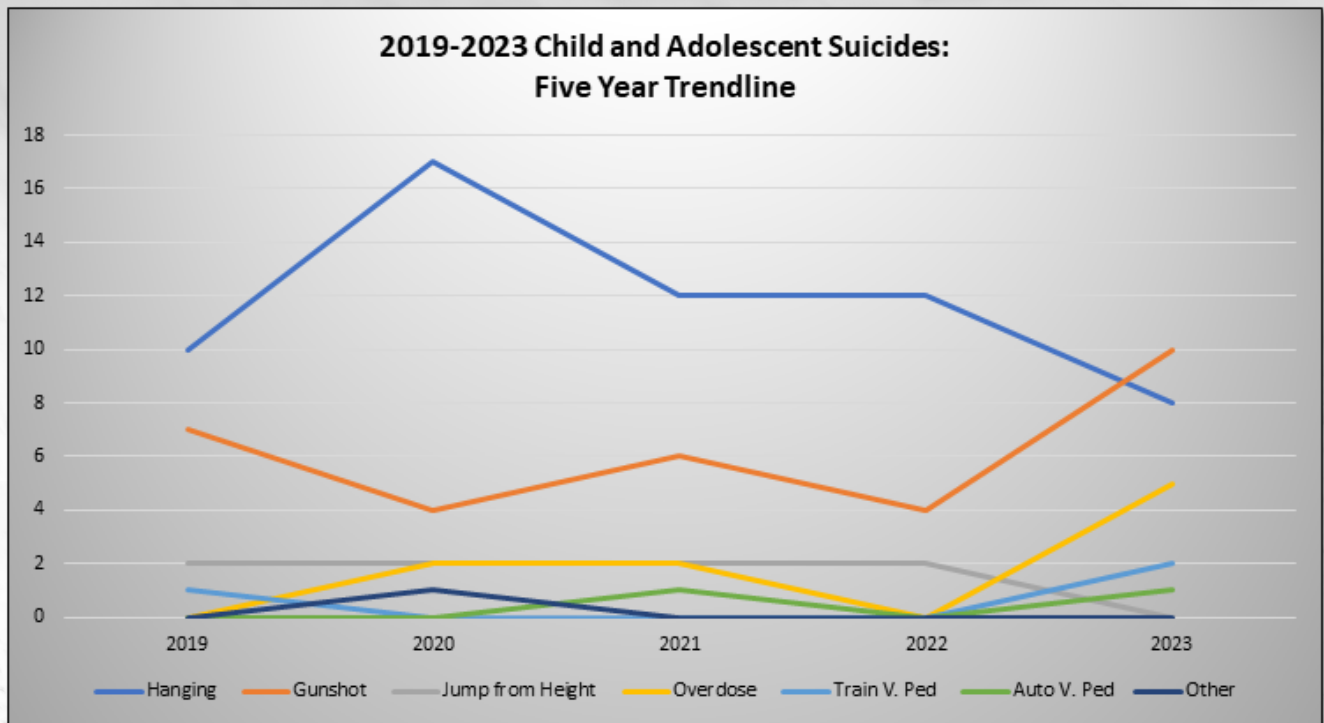
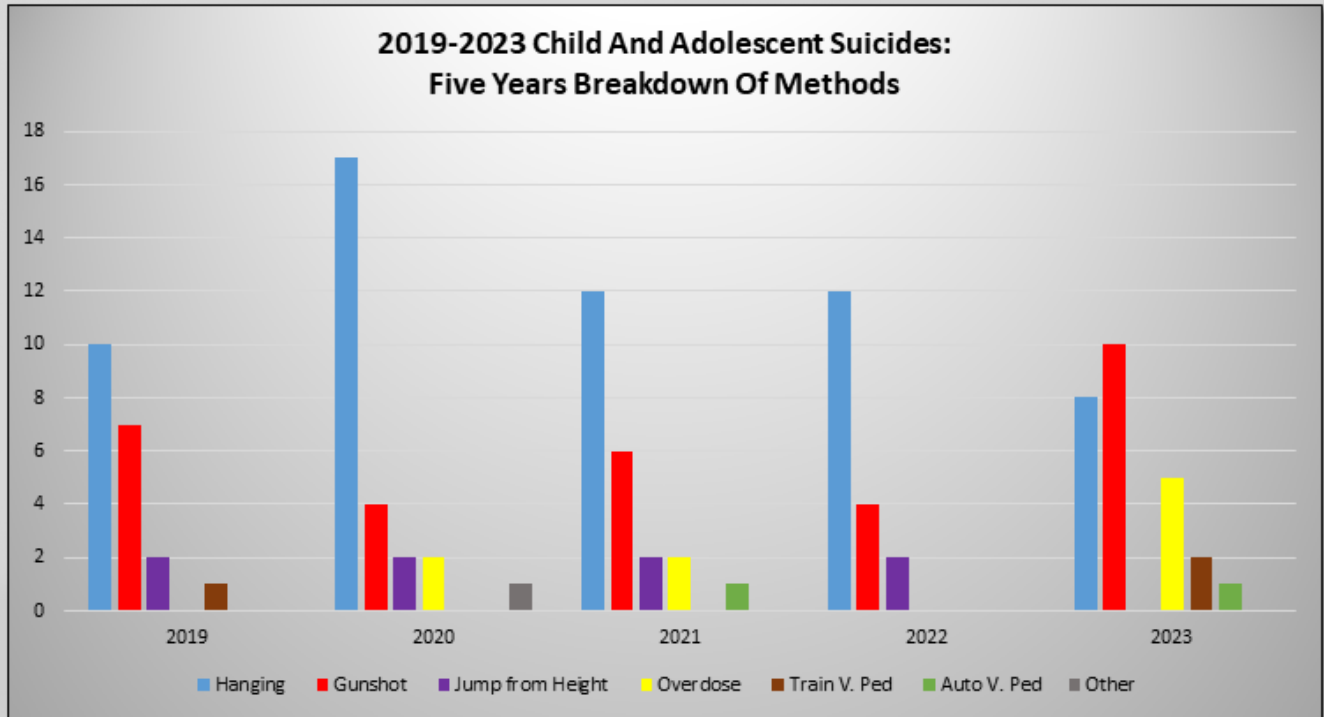
FINDINGS

- The Coroner reported twenty-six child and adolescent suicides to ICAN for 2023. This is a forty-four percent increase from the 2022 data where there were eighteen suicides. Although, there was a suicide rate increase, this figure falls in line with the five-year suicide average of twenty-three suicides.
- In 2023, thirty-eight percent of the suicides were the result of gunshot (n=10). This figure illustrates an increase in comparison with suicide by gunshot in 2022 (n=4). Thirty-one percent of the suicides in 2023 were the result of hanging (n=8).
- Nineteen percent of the suicides were by overdose (n=5) in 2023. This figure is the highest within the last five years surpassing the average five-year rate of approximately two suicides by overdose per year.
- Gunshot wound and hanging remain the leading methods of suicide for children and adolescents in 2023. During the last five years, suicides by hanging comprised fifty-two percent (n=59) of all suicides. Correspondingly, suicides by gunshot wound comprised twenty-seven percent (n=31) of all suicides. As the leading suicide methods, they account for seventy nine percent of all reported child and youth suicides in the last five-years.
- In 2023, there was an equal amount of suicides among males (n=13) and females (n=13). Despite yearly figures between genders slightly fluctuating, males have a higher rate of death by suicide. In the last five years, an average of thirteen males have died by suicide in comparison to an average of nine females.
- In 2023, the leading age of suicide was sixteen year-olds (n=10). Sixteen years-old is the leading age of suicide for the second consecutive year with 38%. The second largest group is youth aged seventeen years old with at nineteen percent (n=5). Data indicates that within the last five years, sixteen year-olds and seventeen year-olds comprise approximately fifty-three percent of suicides.
- As in previous years, Hispanics and Caucasians comprised the two largest racial/ethnic groups for child and adolescents' suicides. In the last five years, Hispanic children and youth comprise approximately forty three percent of suicides among this population. Similarly, Caucasian children and youth comprise 29% of suicides.
- Additional data insight demonstrate that sixty-two percent of child and youth who died by suicide had no mental health history. In comparison, thirty-eight percent of suffered from mental health issues.

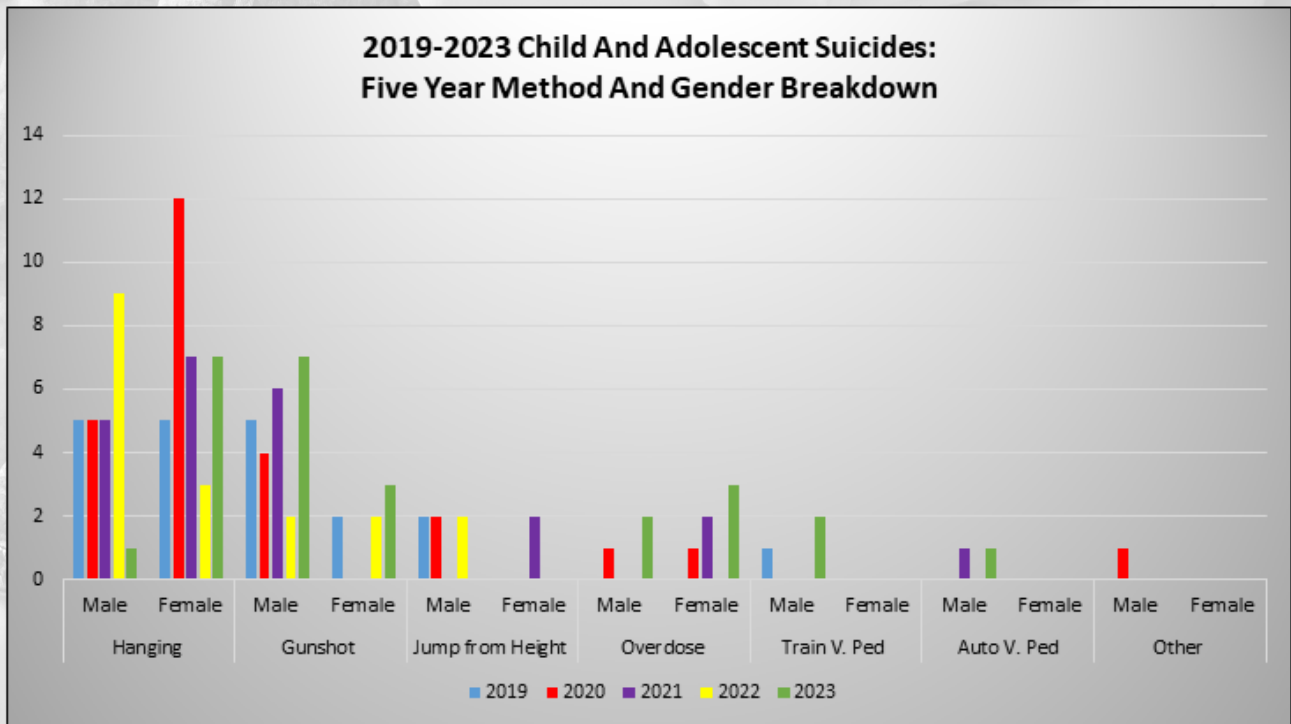
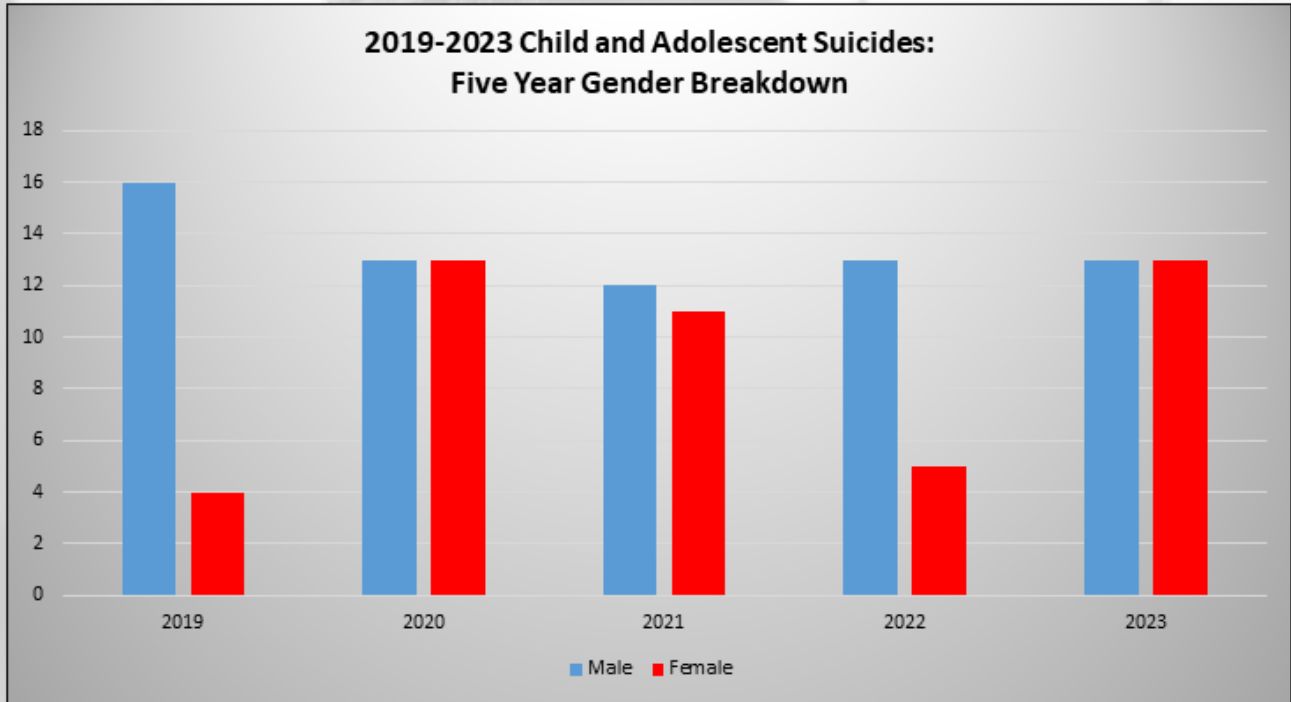
Child and Adolescent Suicides



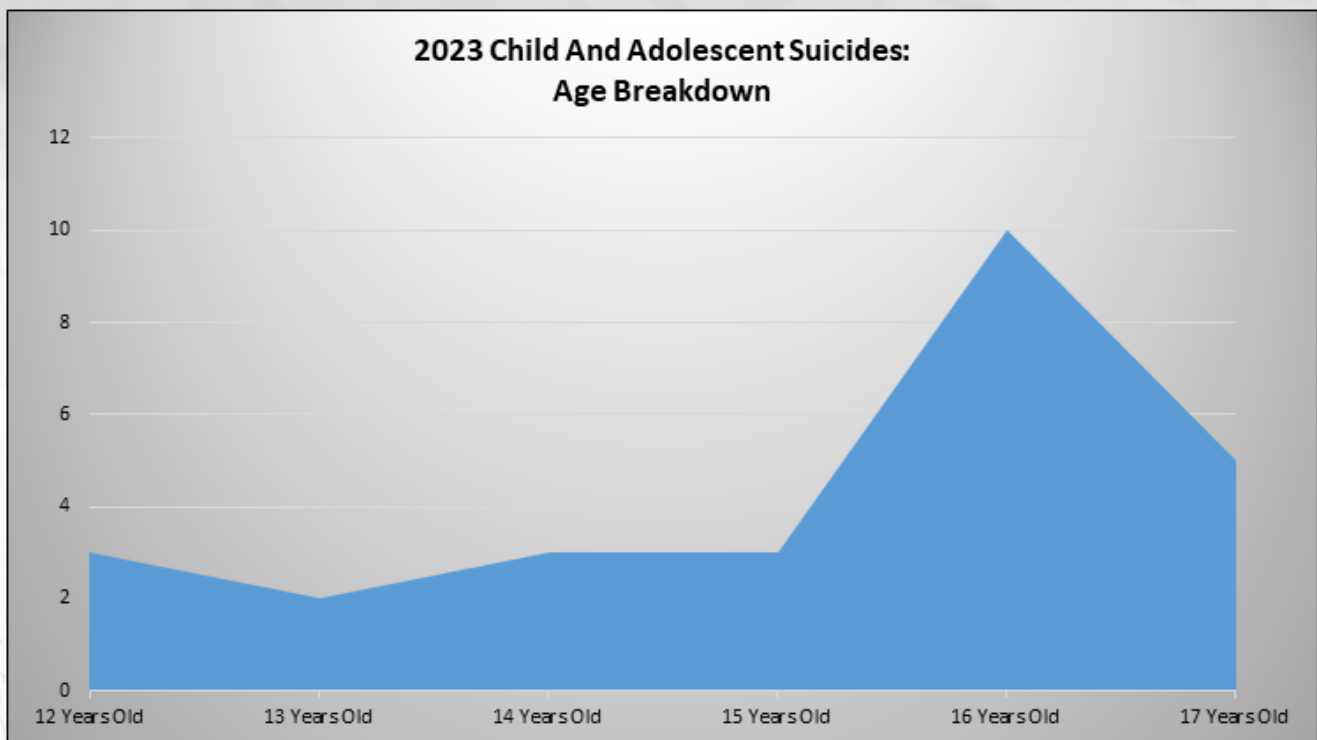
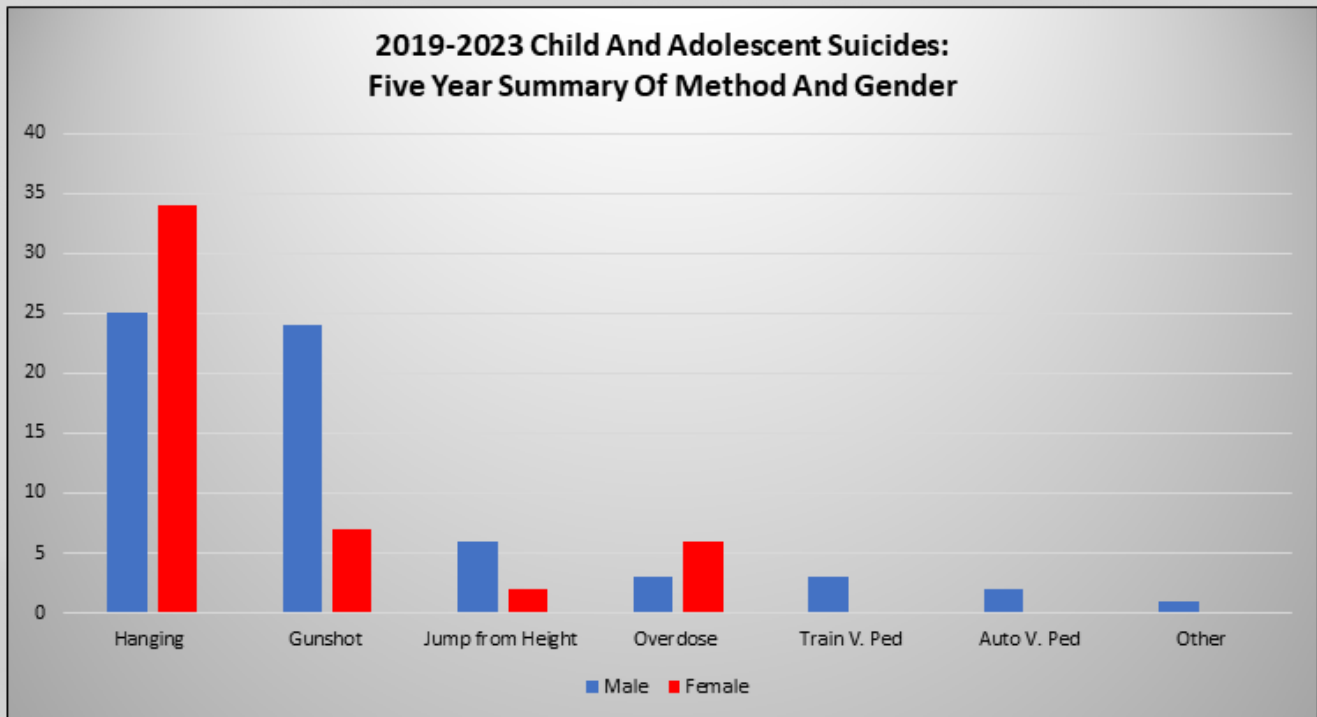
Child and Adolescent Suicides



Child and Adolescent Suicides

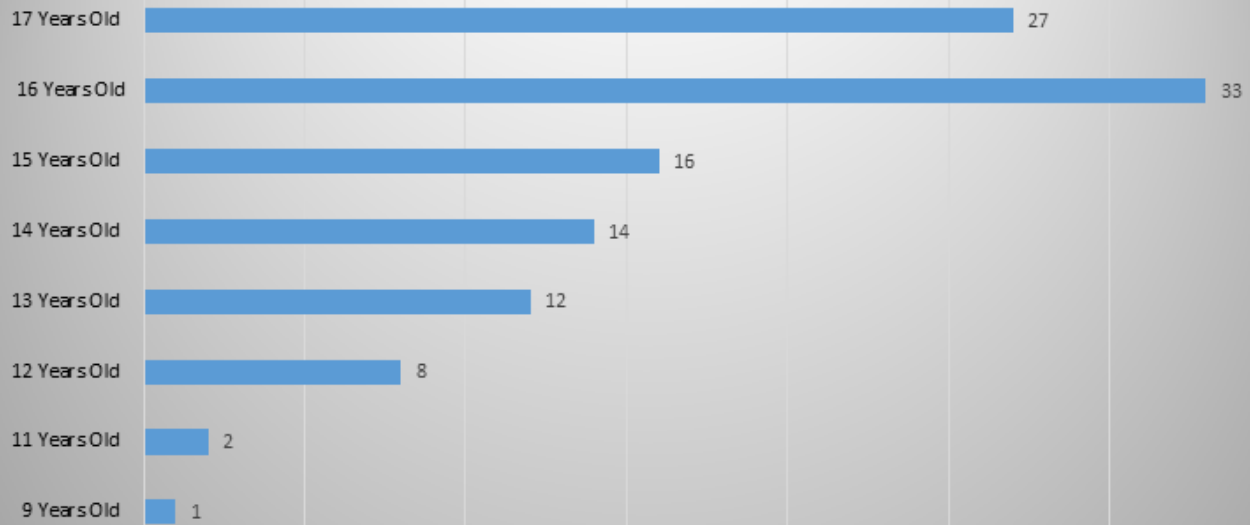


Child and Adolescent Suicides

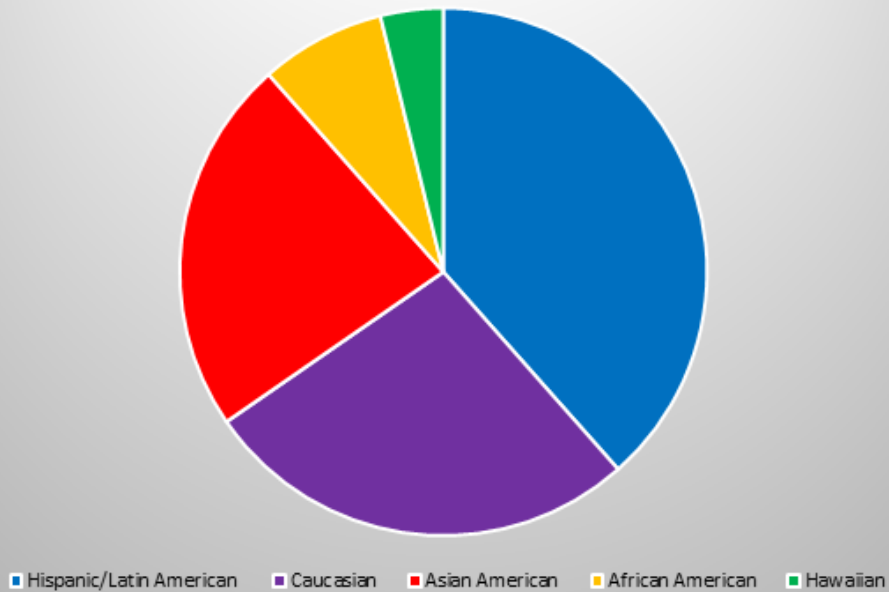


Child and Adolescent Suicides

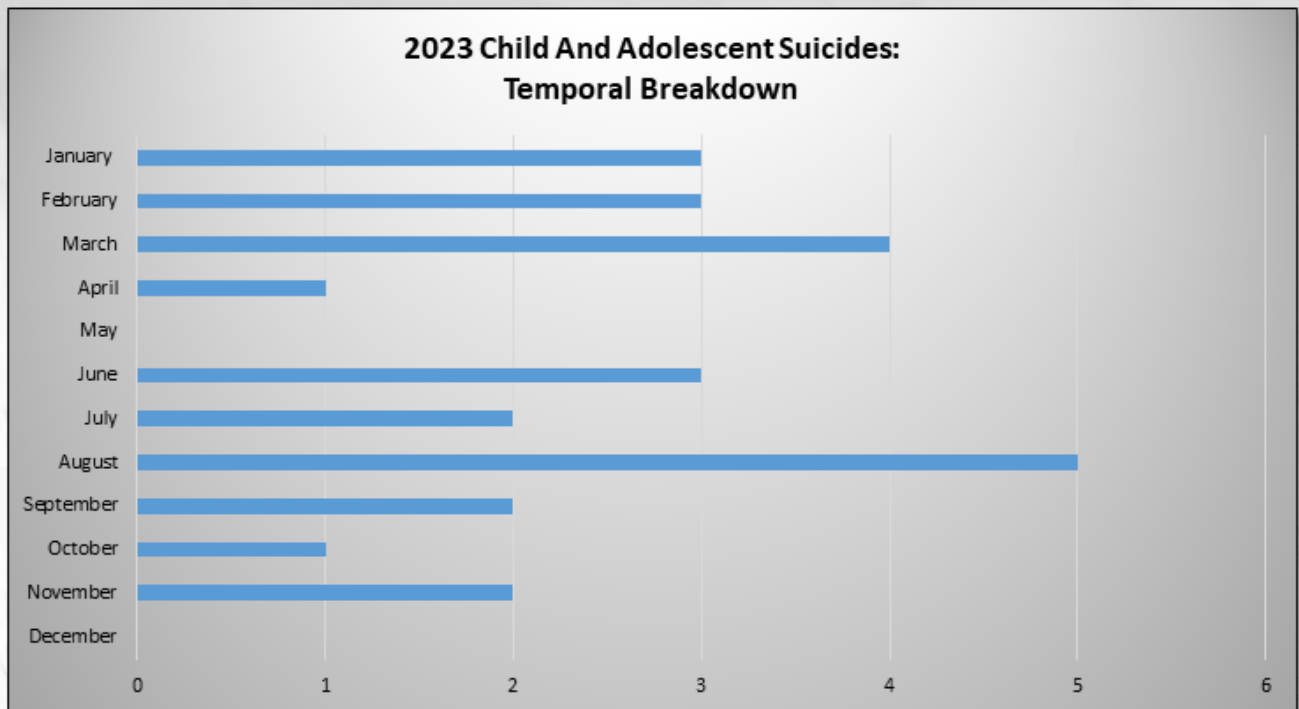
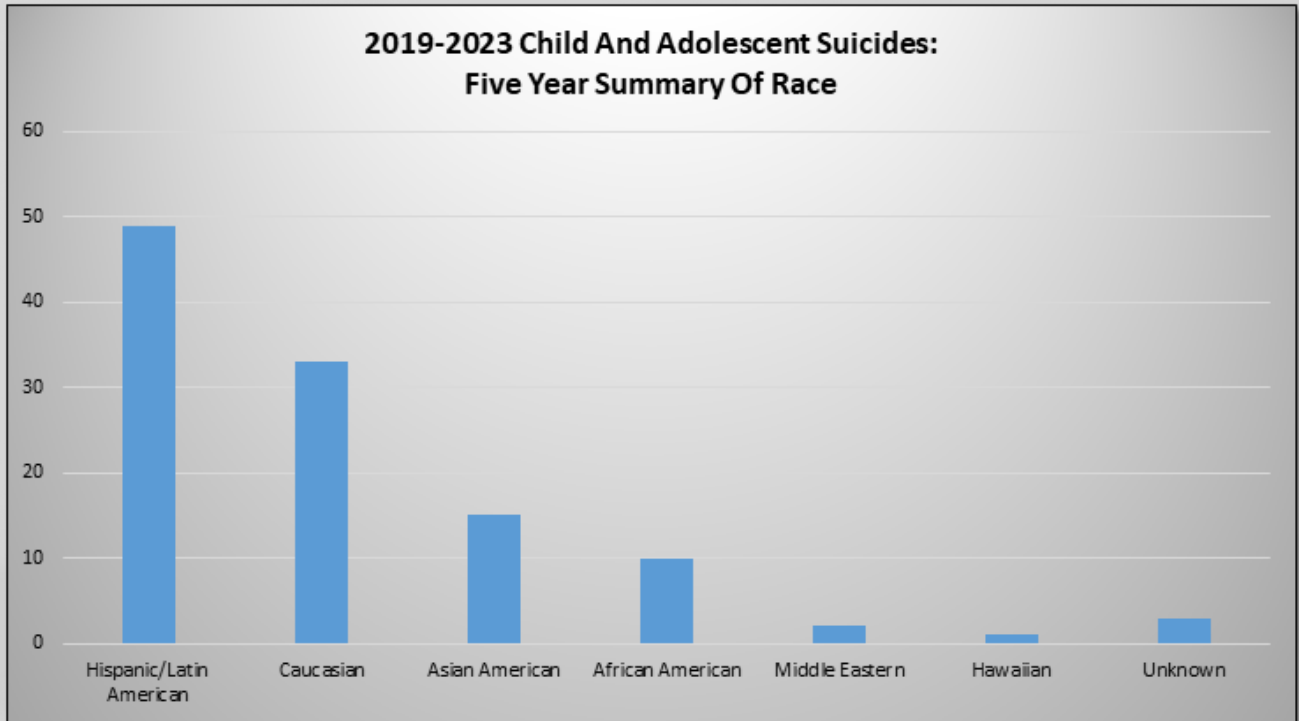
**2019-2023 Child And Adolescent Suicides:
Five Year Summary Of Age**



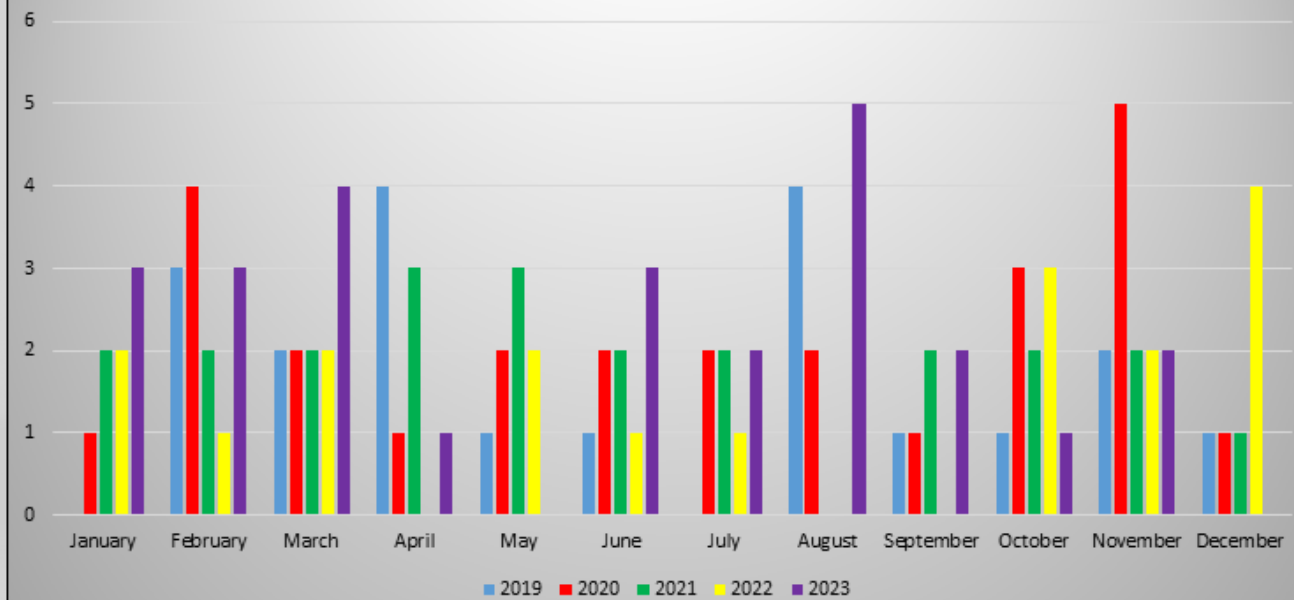
**2023 Child And Adolescent Suicides:
Race/Ethnicity Breakdown**



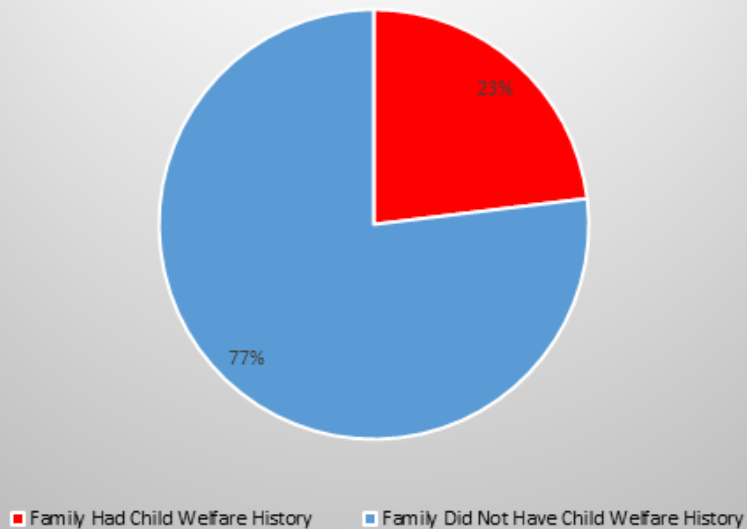
Child and Adolescent Suicides



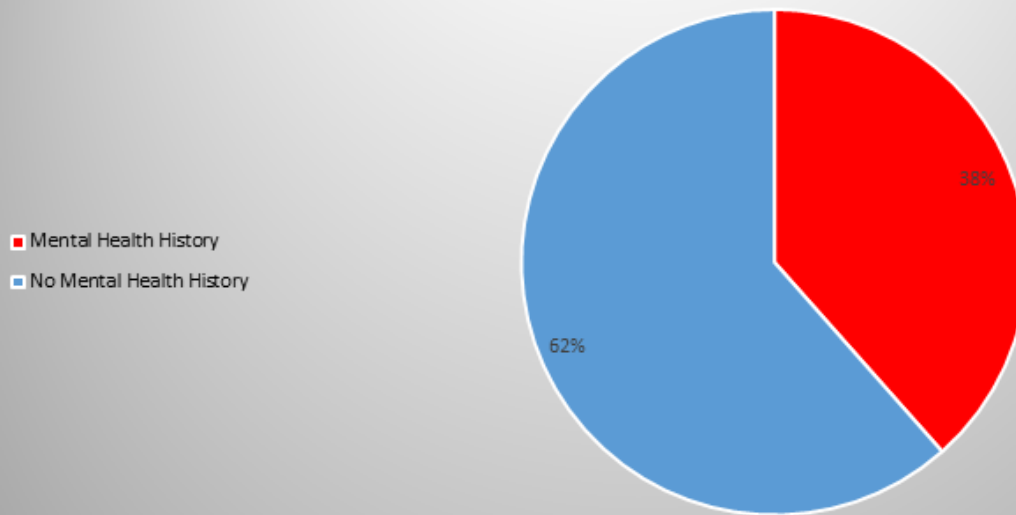
**Five Year Breakdown of Child And Adolescent Suicides:
Temporal Distribution**



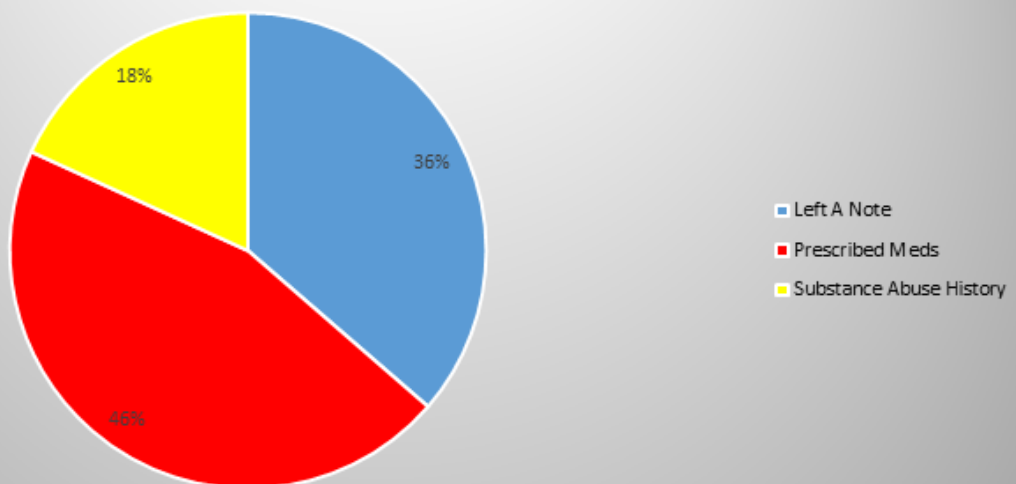
**2023 Child And Adolescent Suicides:
Child Welfare History**



**2023 Child And Adolescent Suicides:
Mental Health History**

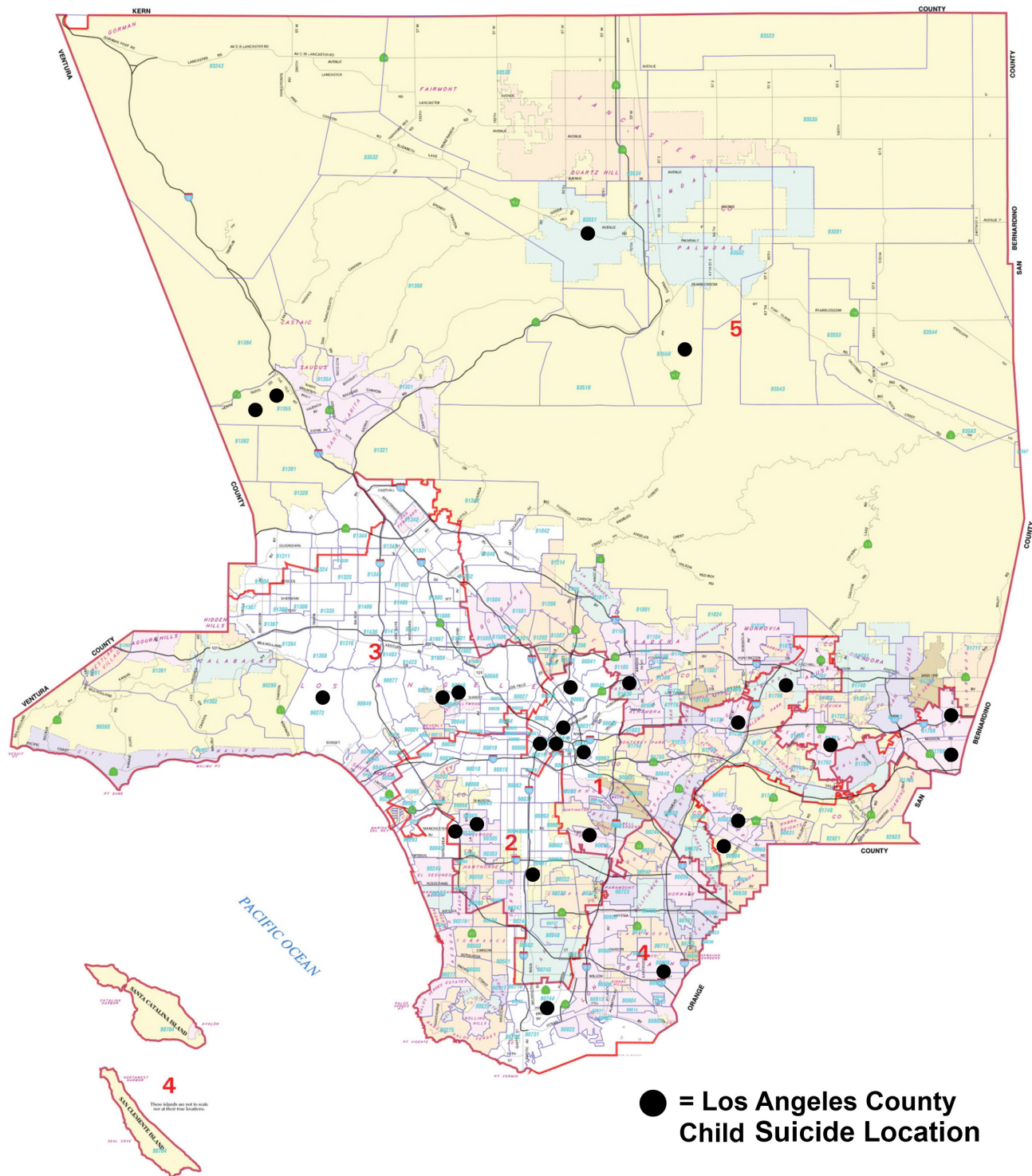


**2023 Child And Adolescent Suicides:
Additional Insights**



2023 Child Suicides - Locations n = 26*

**City where the suicide occurred*



Sample Case Summaries - Accidents

Mike

Fifteen year-old, Mike was found unresponsive by family members. Mike appeared to have been unresponsive for about an hour when found. Mike was transported while in cardiac arrest to the emergency room. Medical providers administered Narcan with no results. He was pronounced dead at the ER. Cause of death was overdose. Mike had history of using marijuana mixed with fentanyl and LSD recreationally. No trauma or foul play suspected and he did not have any prior suicide ideology.

Leo

Leo, age three, drowned in the pool at home. Leo's mother found him in the pool. The mother took Leo out of the pool and initiated CPR. Paramedics arrived on scene and transported Leo to the ER. An epinephrine dose was given during transport and a second one at arrival at the ER. Leo was then intubated and shortly after pronounced dead at the hospital.

Amy

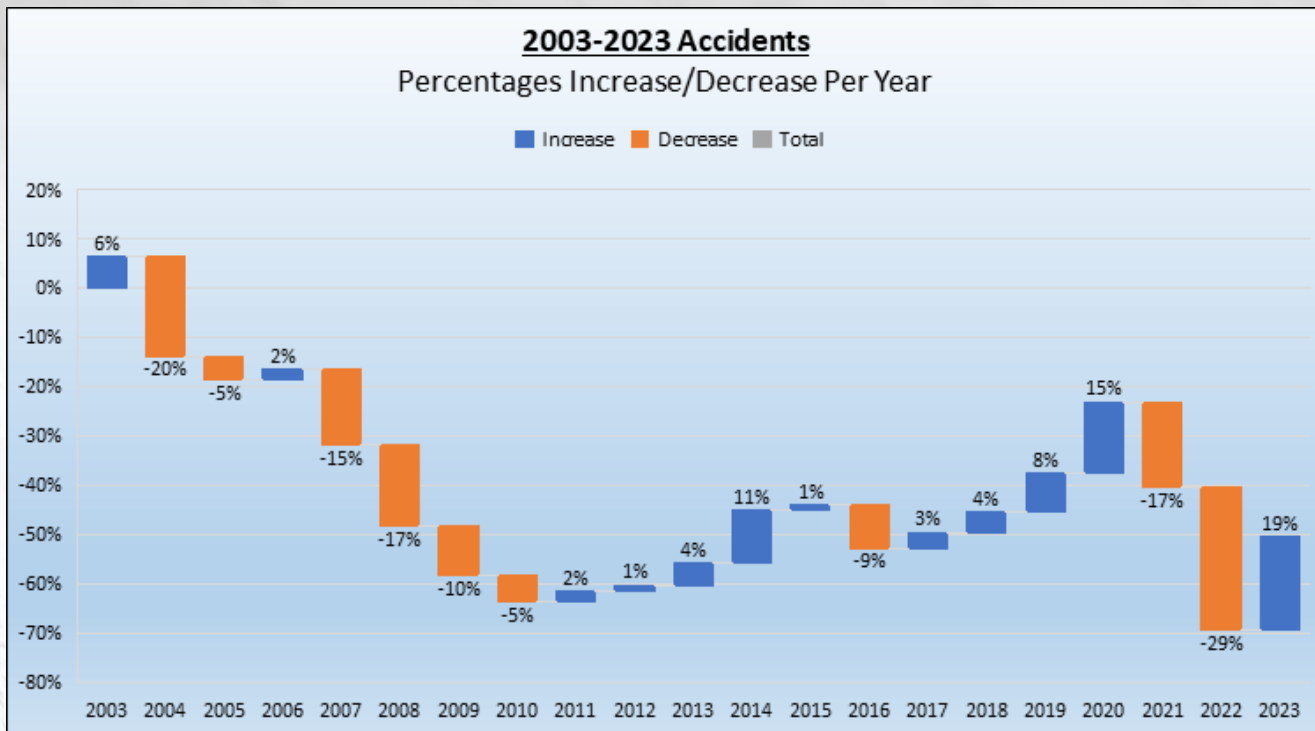
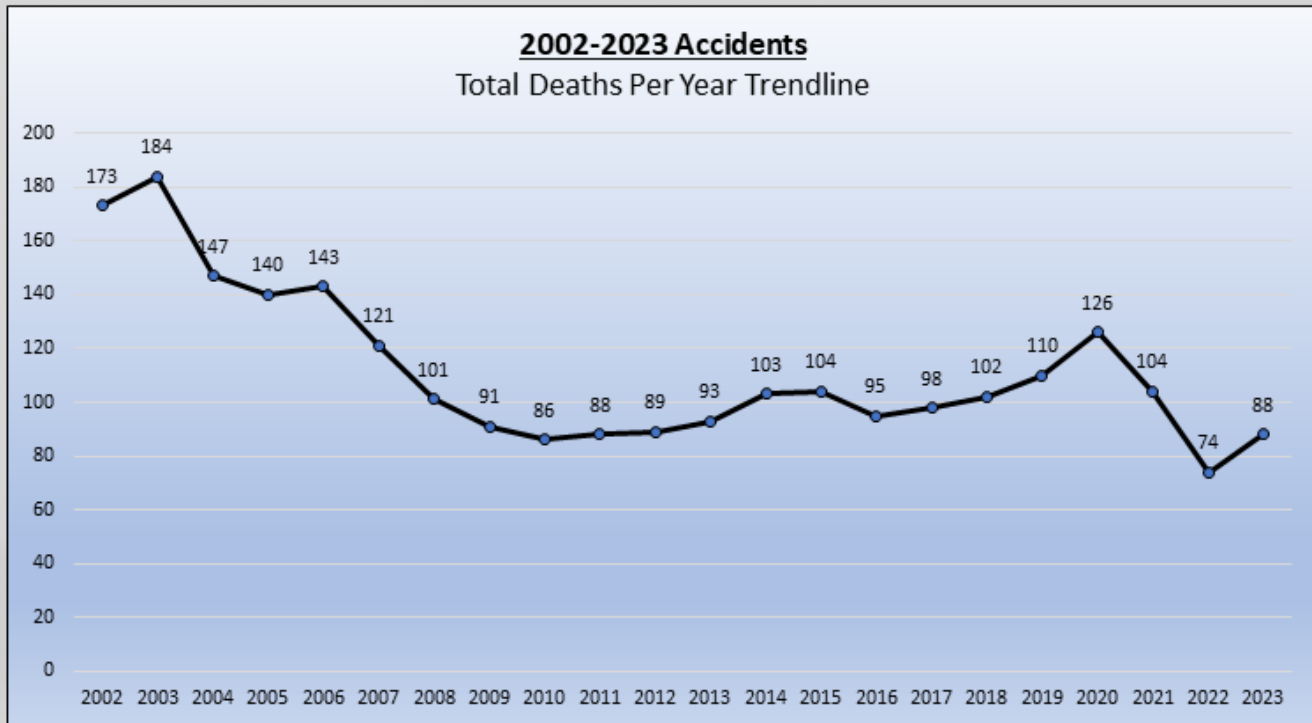
Amy, two-years-old, was struck by a vehicle while playing in the street unsupervised. 9-1-1 was called and the Fire Department responded. Amy was transported to the ER and was observed to be in cardiac arrest. Amy was given multiple rounds of epinephrine with no results. Amy had severe head trauma with a large and open wound expelling brain matter. Amy was also bleeding from ears and nose. Amy was pronounced dead in the ER.

ACCIDENTS

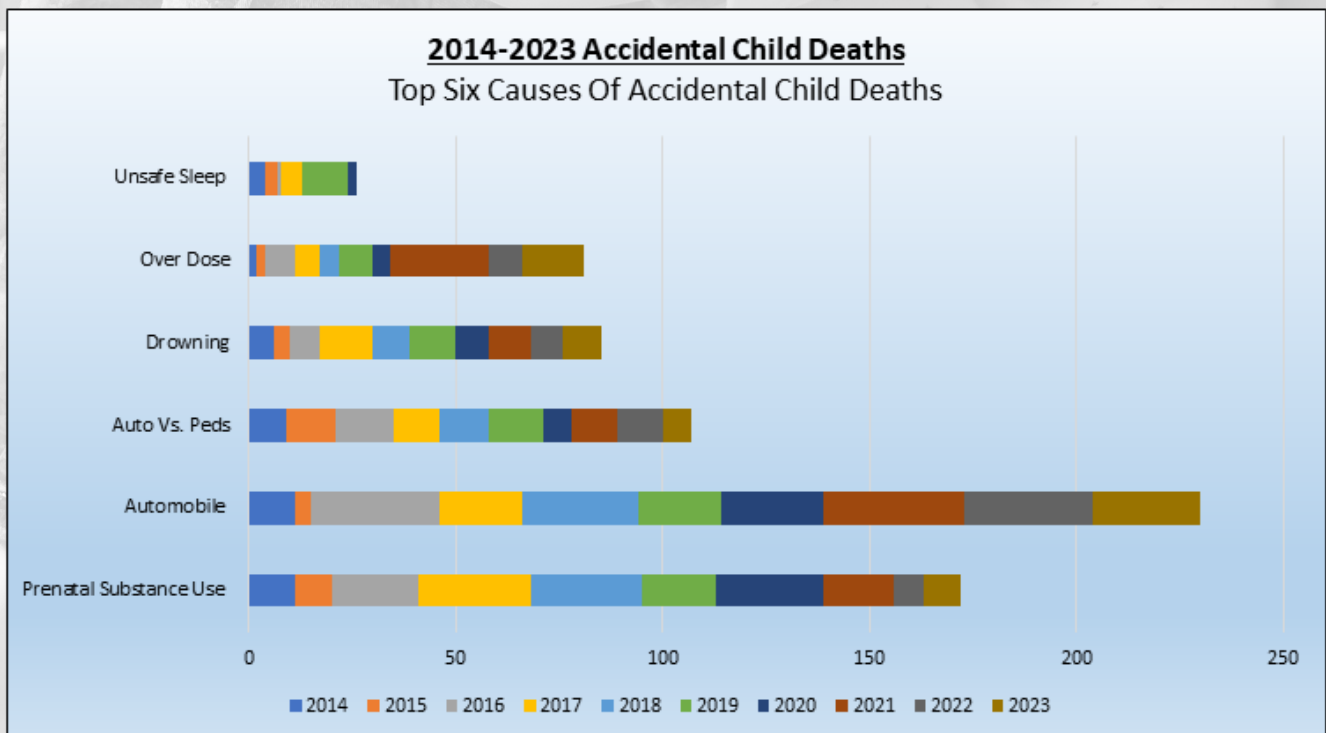
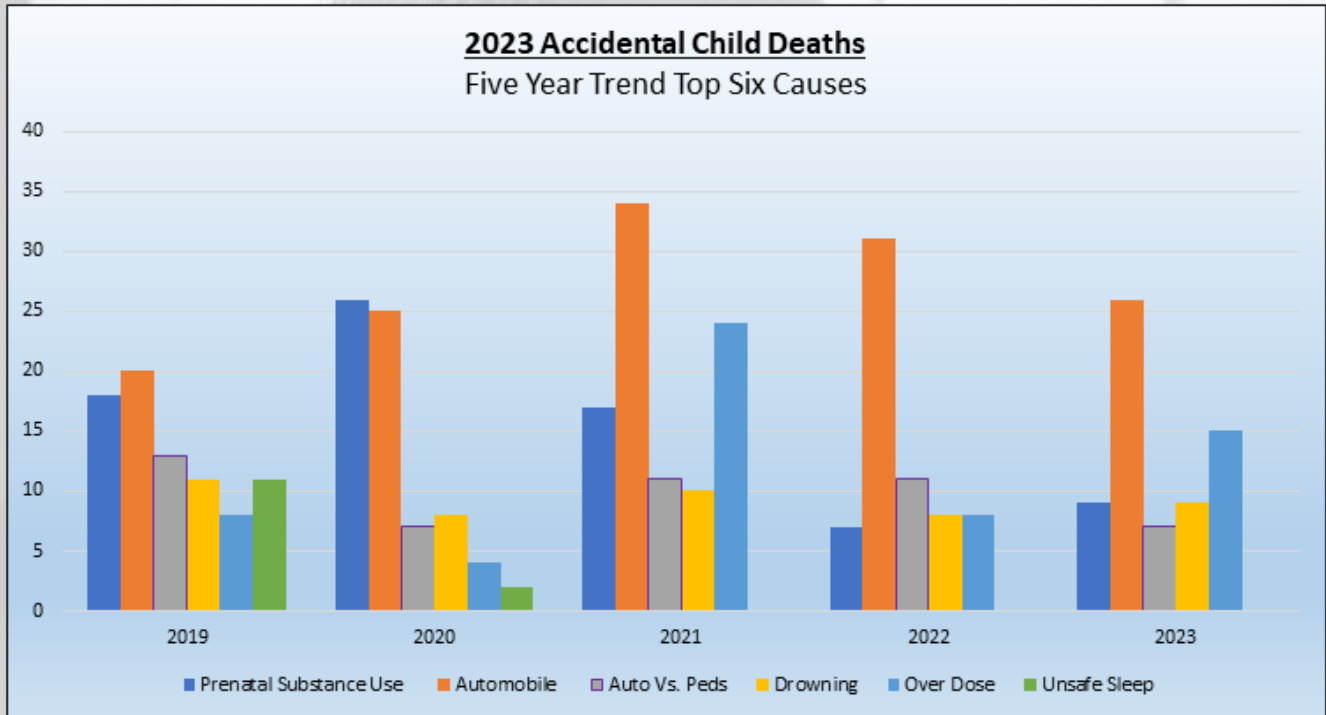
FINDINGS

- The Coroner reported Eighty-eight accidental deaths to ICAN for 2023. This figure represents a 19% increase compared to seventy-four accidental deaths occurred in 2022. This figure remains below the five-year average.
- In 2023, automobile deaths remained the leading cause of accidental child deaths (N=33). This figure represents a decrease of 21.43% from previous year of forty-two automobile deaths. Automobile deaths (N=33), drownings (N=9), prenatal substance use (N=9), and overdose (N=15) made up 75% of child accidental deaths.
- Children aged less than one-year-old had the highest rate of accidental deaths with a 22% (N=19) of all accidental deaths. Sixteen of these children's deaths were the results of prenatal substance use and drowning.
- In 2023, accidental death by overdose resurfaced as a leading cause of accidental child deaths with fifteen overdose child deaths. This figure represents an increase of 87.5% from previous year of eight overdose child deaths. This figure represents an alarming increase that requires further intervention with the youth population. Children between the ages of fifteen and seventeen years old represented the majority of accidental death by overdose (N=11).
- In 2023, children under the following age ranges—less than one-year-old and fifteen to seventeen years old—comprised almost 75% of all accidental child deaths. This shows that children within these age-ranges have greater predisposition to be affected by prenatal substance use, illicit use of substances and automobile accidents.
- Twenty-six children accounted for automobile deaths, either as a driver or as passengers in 2023. As in previous years, the victim ranges from one-year-old to seventeen years of age with the highest number of deaths being by fifteen-year-olds and seventeen-year-olds.
- The majority (63%) of accidental child deaths were children of Hispanic/Latin American background. Black and Caucasian children were at 14% for accidental child deaths.
- As in the previous five years, methamphetamines remains the number one drug used by mothers in prenatal substance abuse. In 2023, nine children died of prenatal substance abuse. All nine child deaths by prenatal substance abuse were stillborn or less than one-day old. Hispanic/Latin American and Caucasians remain the ethnicities with the highest group that suffered a child death by prenatal substance use.
- Unsafe sleep deaths can be coded as accidents by the coroner. In 2023, there were five unsafe sleep deaths coded as accidents by the coroner. These cases are considered preventable deaths related to unsafe sleep practices and have been counted in the undetermined section of this report.

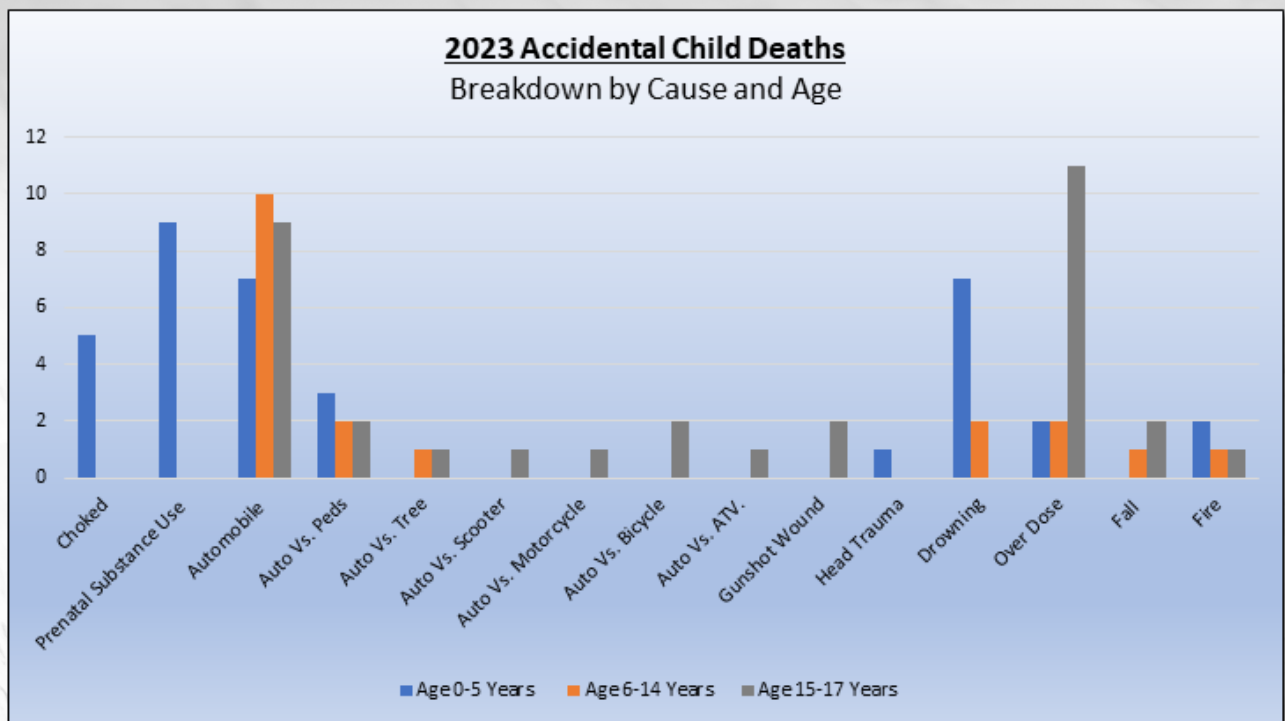
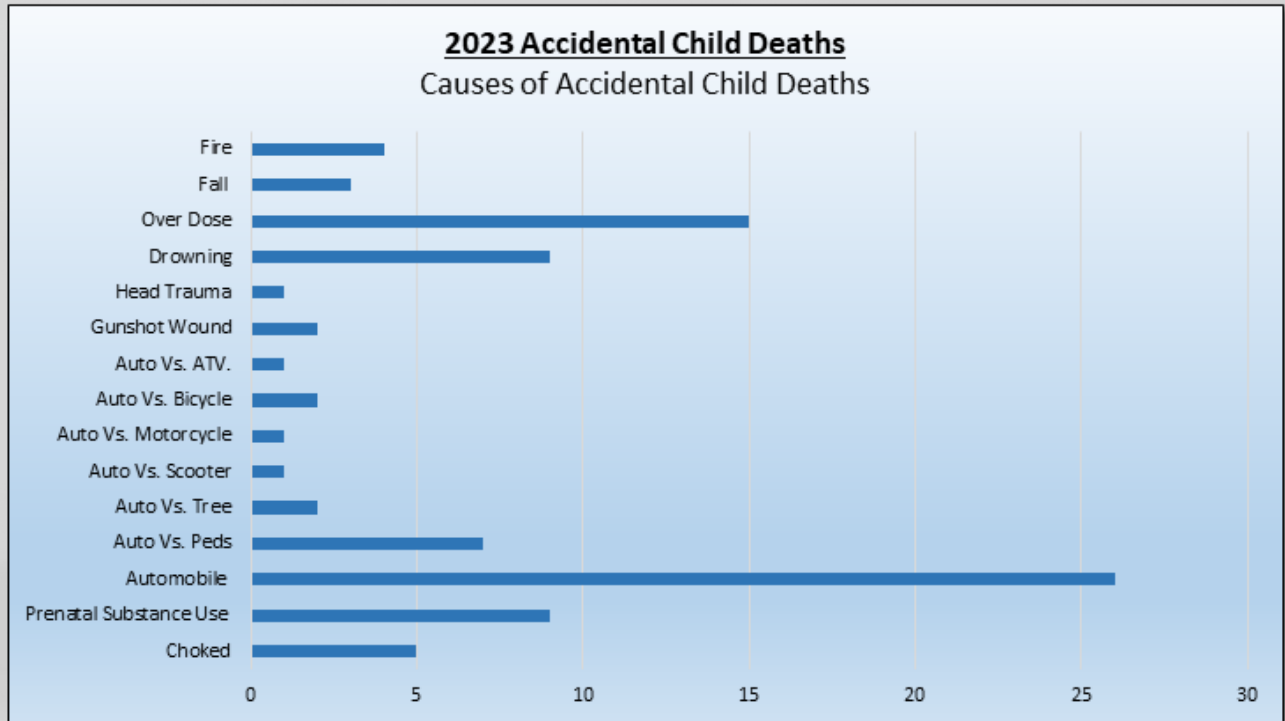
Accidental Child Deaths



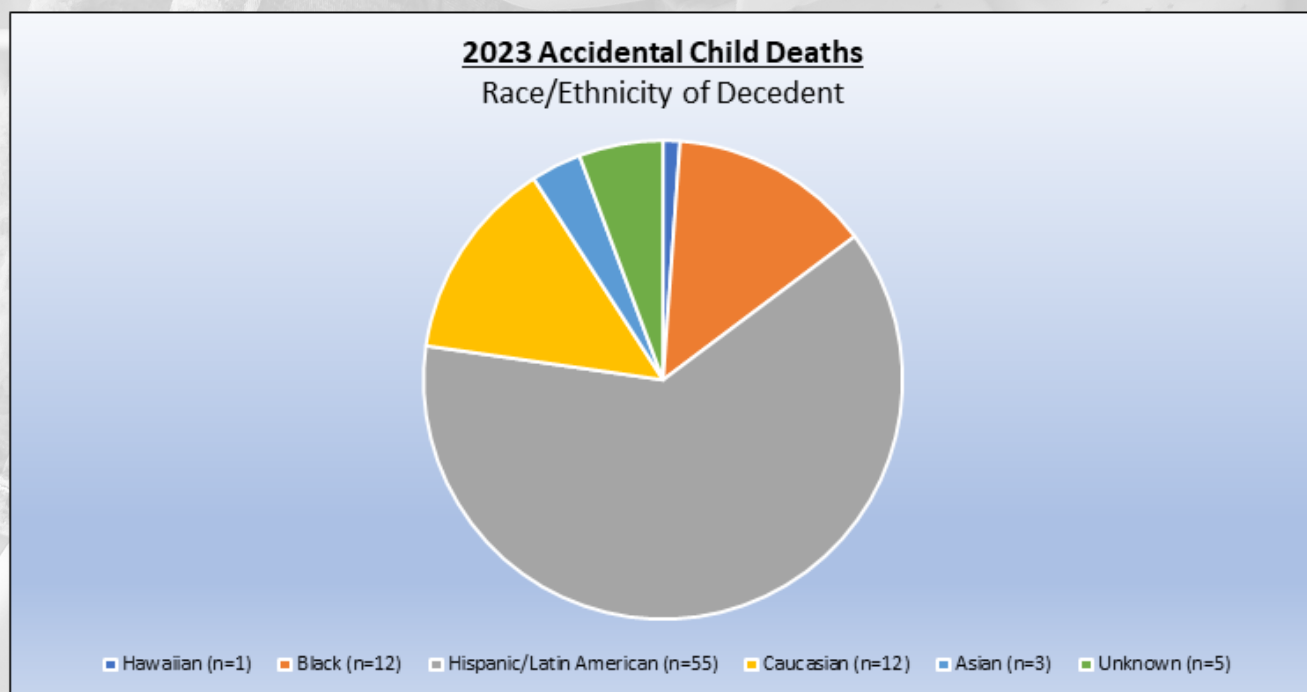
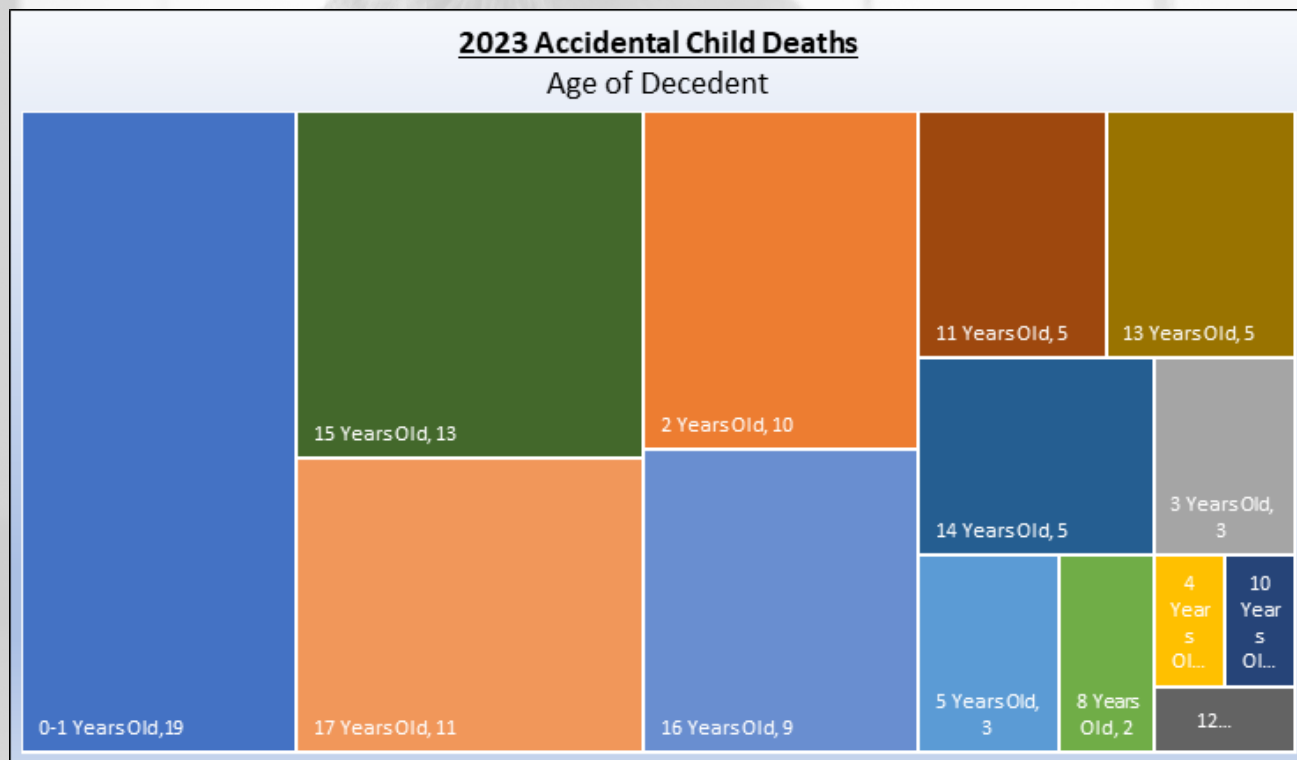
Accidental Child Deaths



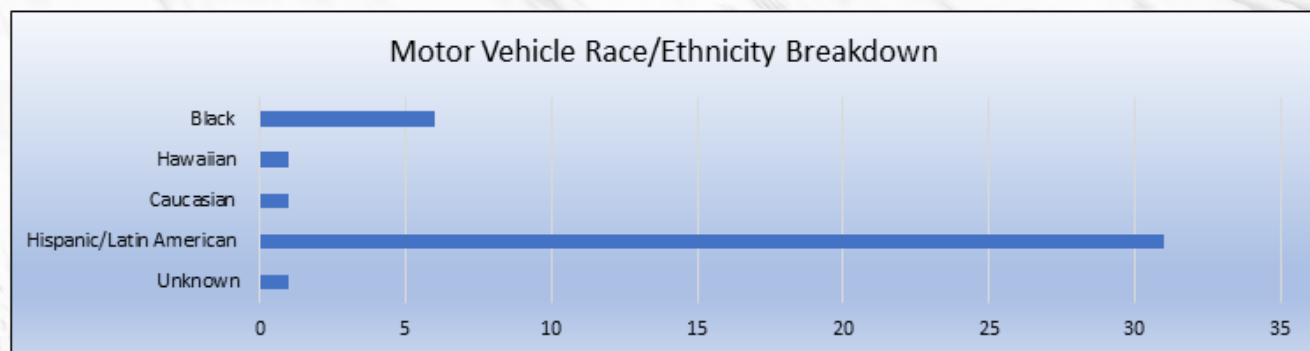
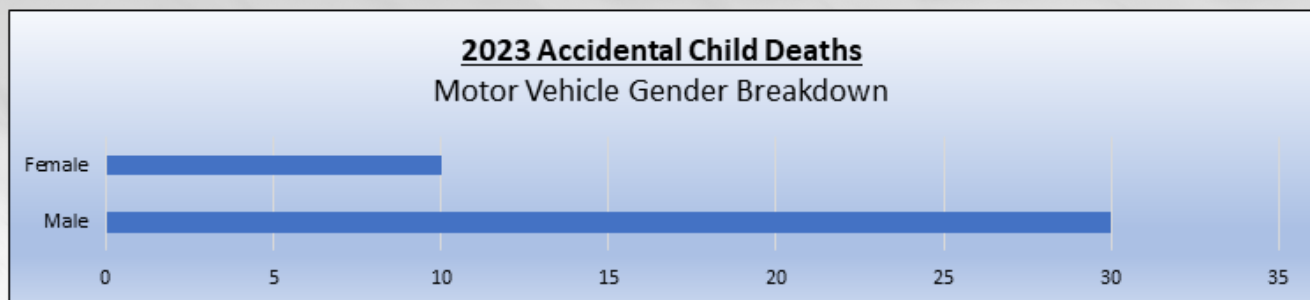
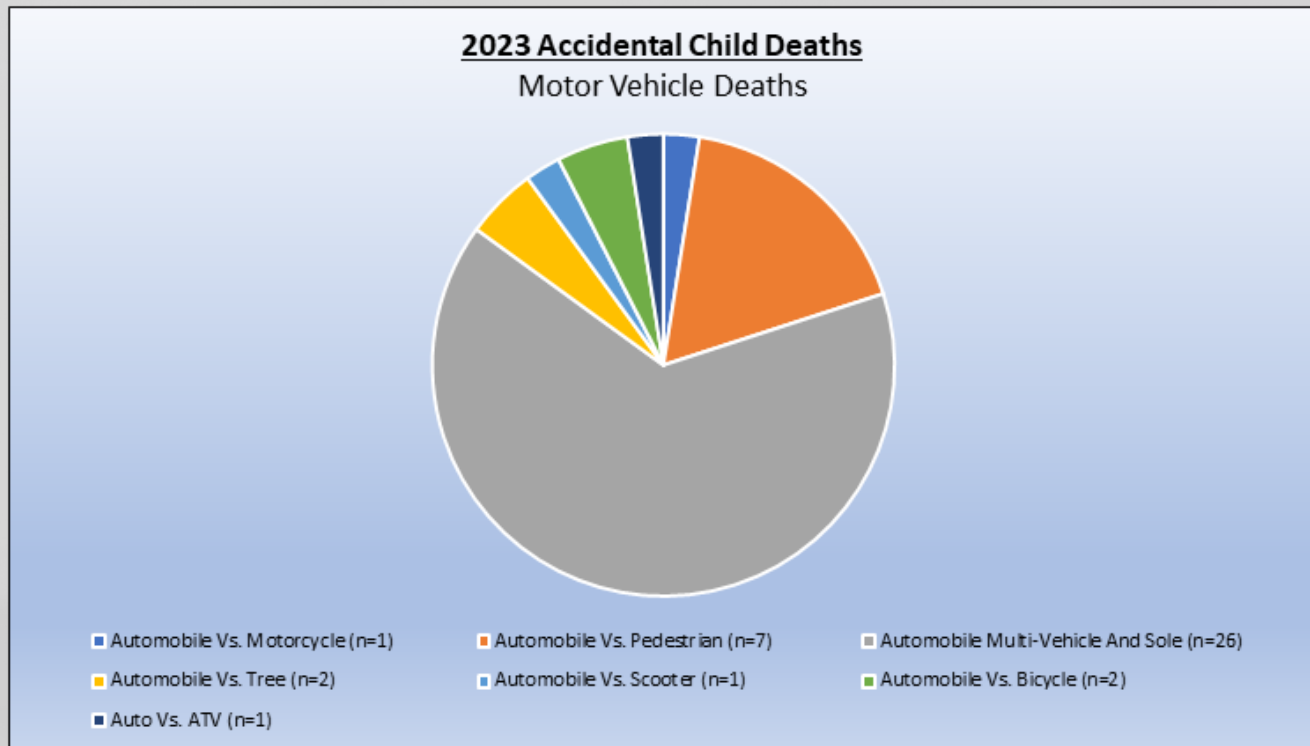
Accidental Child Deaths



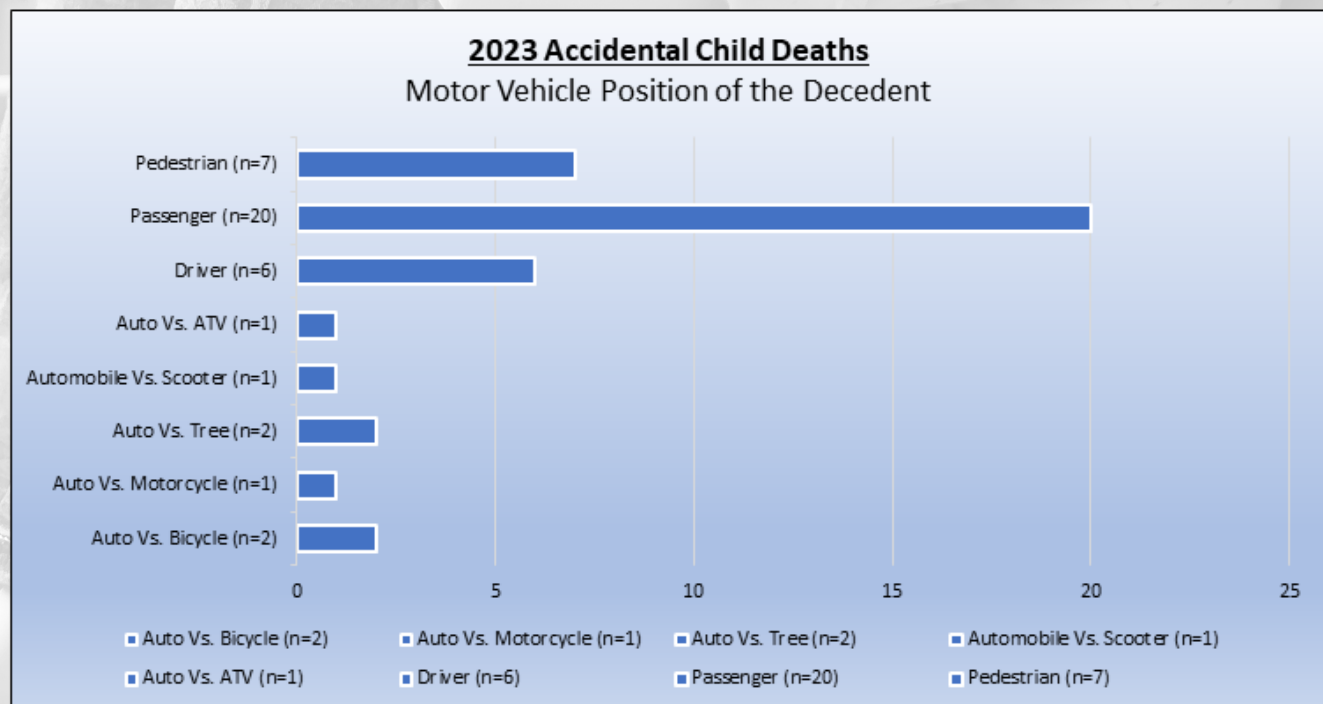
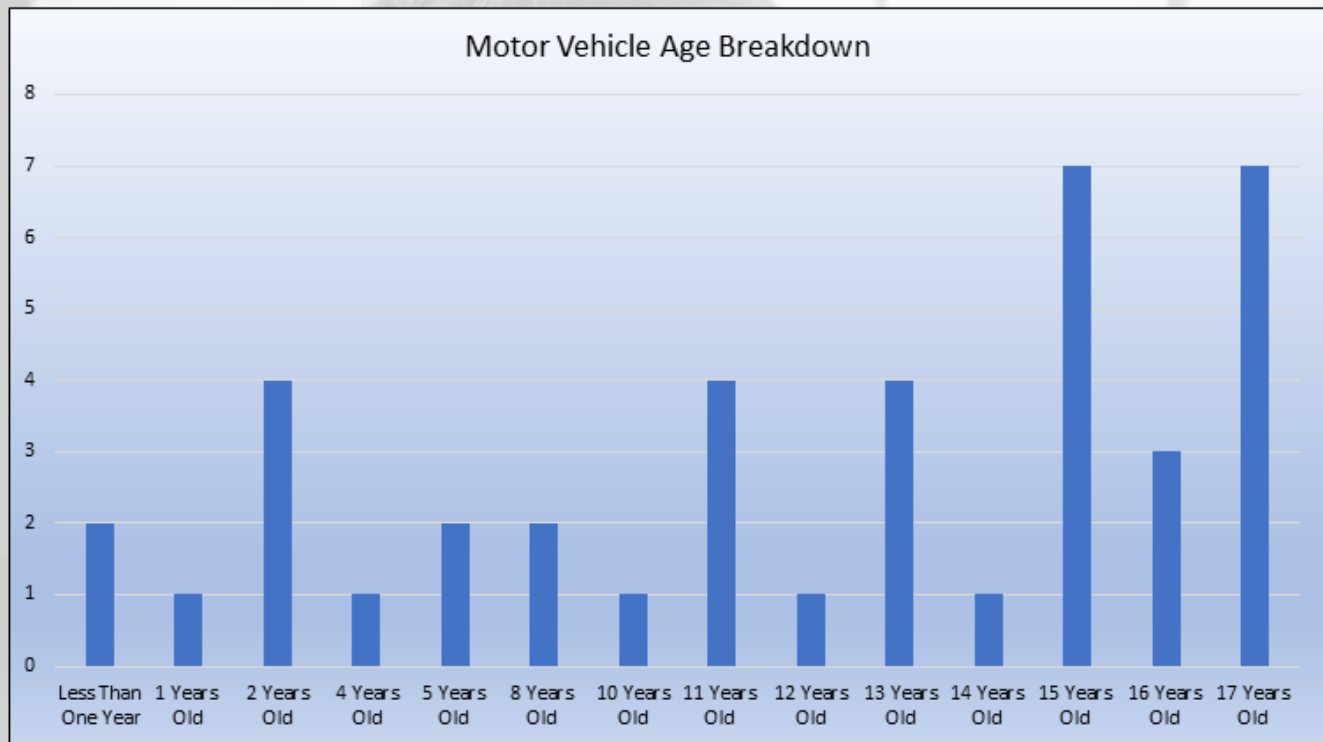
Accidental Child Deaths



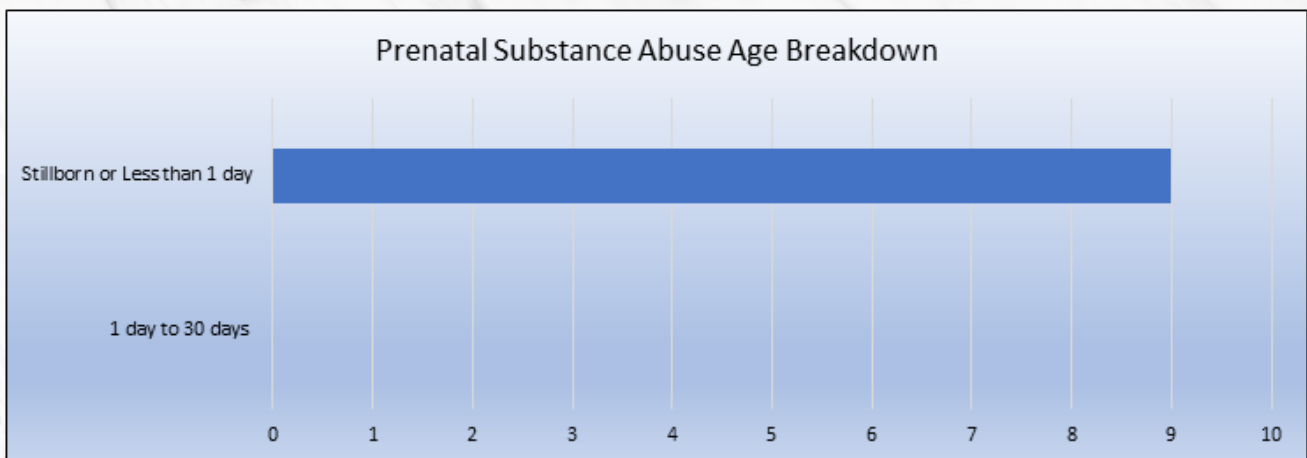
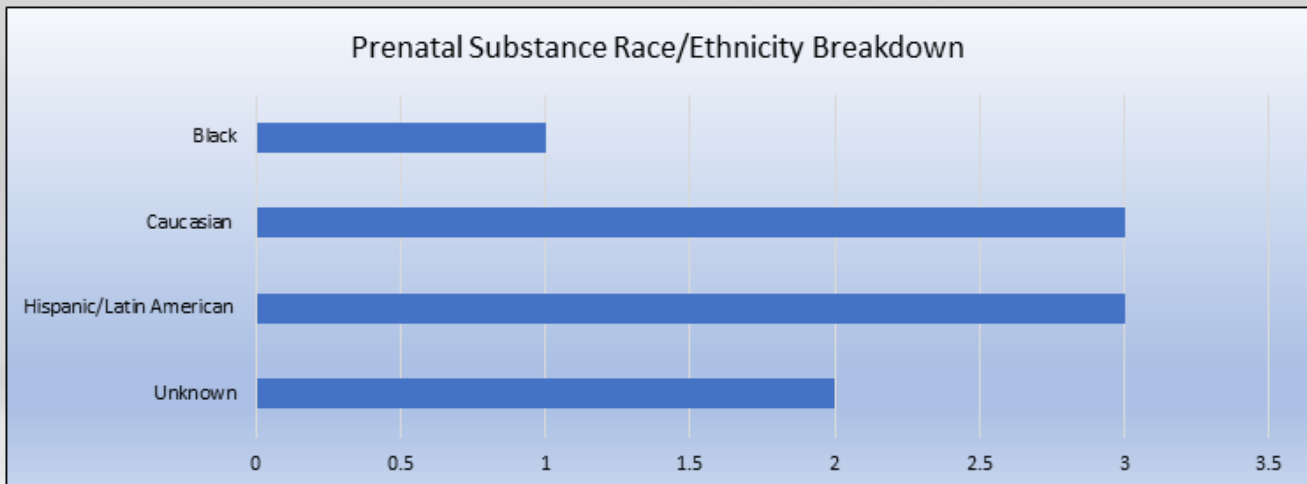
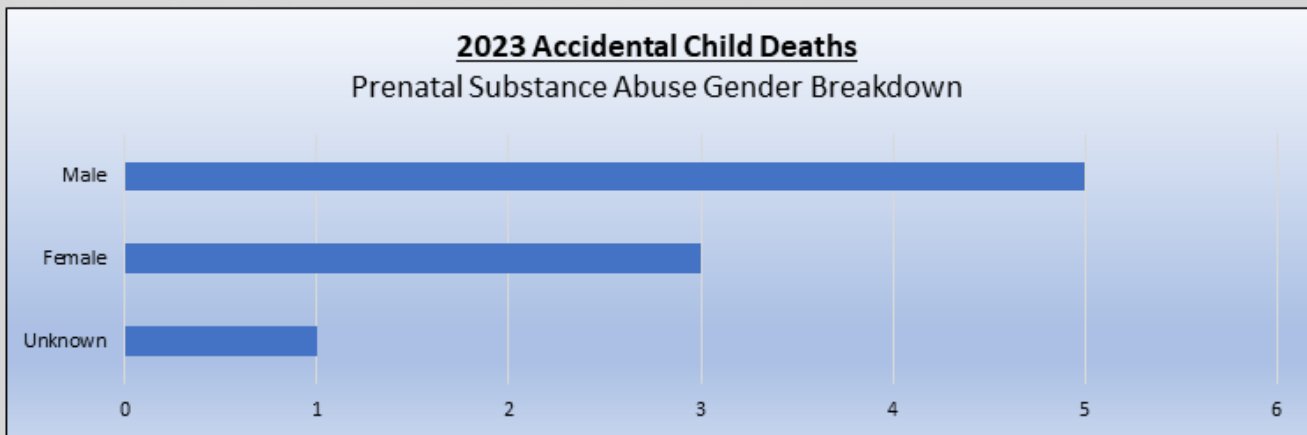
Accidental Child Deaths

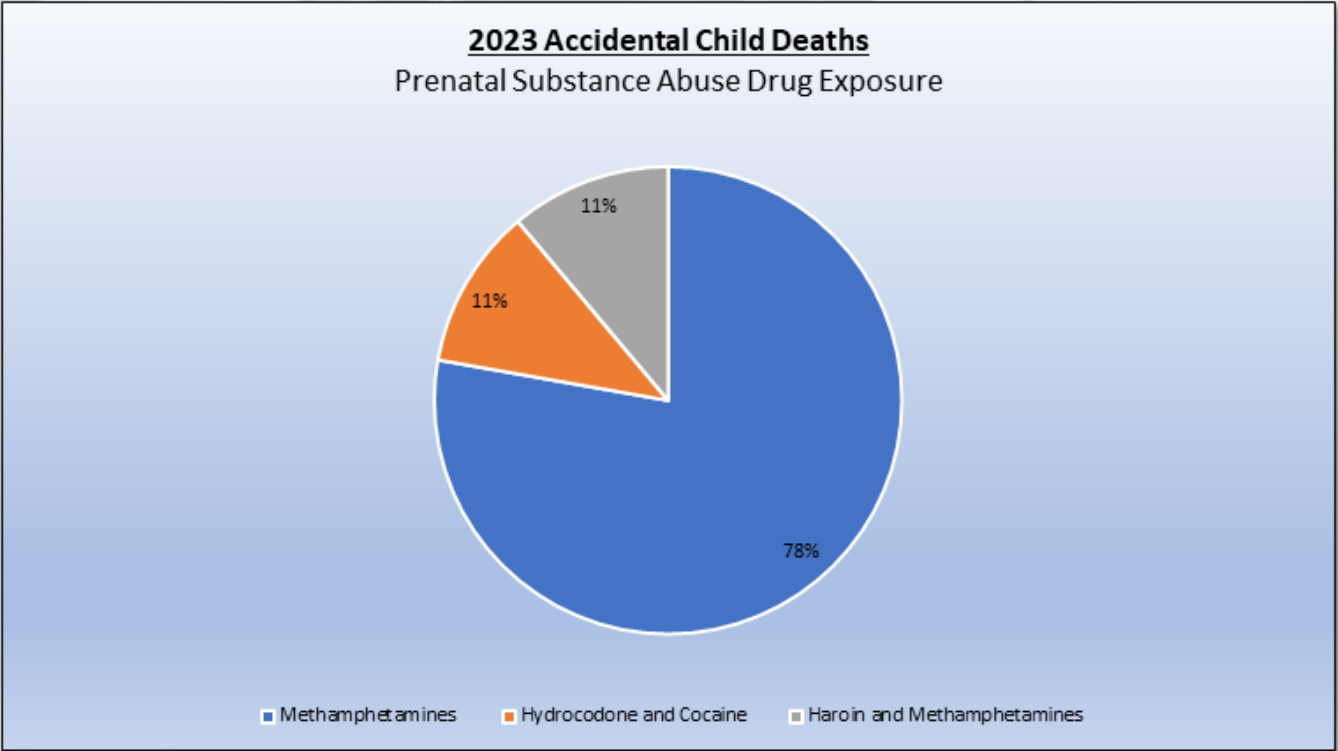


Accidental Child Deaths



Accidental Child Deaths





Sample Case Summaries - Undetermined

Charlie

Three-month-old Charlie was discovered unresponsive on the floor by his mother. 911 was called and he was transported to the ER in full arrest. Mother later admitted that the baby had been sleeping on the couch with father when he was found dead on the floor by the couch.

Darla

Darla, age 5 months was bed sharing with her mother when mother rolled over Darla while sleeping. Mother awoke to find Darla underneath her suffocated. 911 was called and Darla was transported to the hospital, able to gain pulse back and then transported to a second hospital unresponsive. Darla was put on ventilator, and medication. However, she was determined brain dead and was pulled off the ventilator.

Harvey

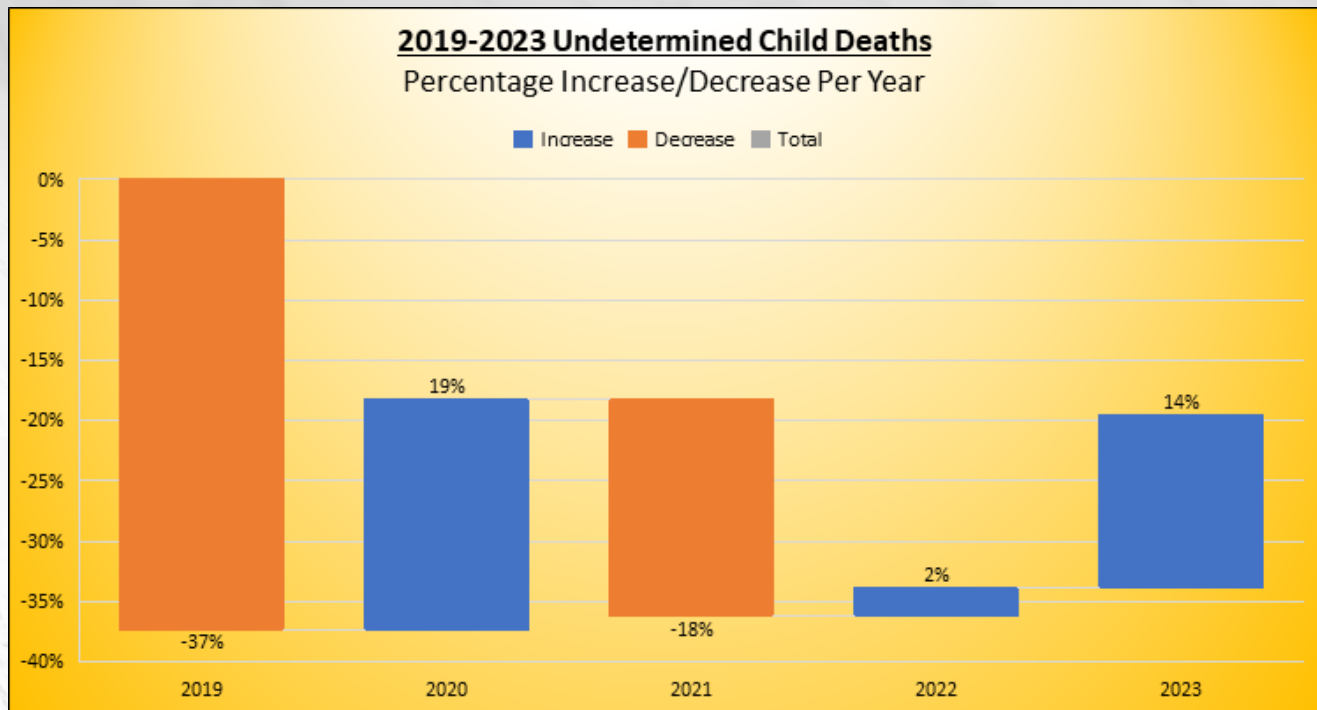
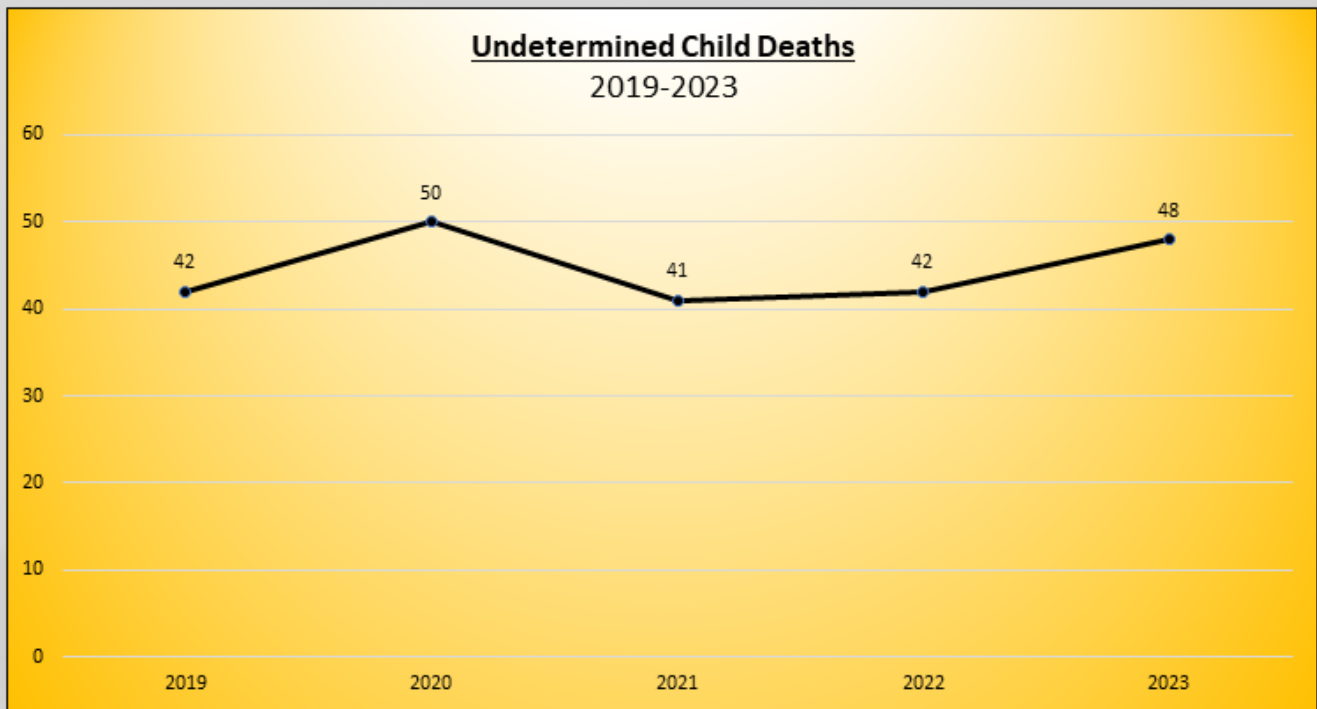
Harvey was a 2 month old found unresponsive by mother. Mother had placed Harvey to sleep and wrapped in a swaddle in the crib and was later found unresponsive. Mother called 9-1-1 and Harvey was transported via ambulance to the local hospital where Doctor pronounced him dead. Harvey was born premature and had been suffering with a bad cold.

UNDETERMINED

FINDING

- Forty eight undetermined child deaths were reported to ICAN from the Coroner's Office in 2023.
- Forty three of those children were under the age of 1 and were majority male with 29 males and 19.
- Twenty-four 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. ICAN also reviewed 6 unsafe sleep related deaths coded as accidents and added them to the unsafe sleep count.
- The 2023 number of 24 unsafe sleep deaths is a decrease from 2022 and below the five-year average of approximately 48 unsafe sleep-related deaths per year.
- Ninety two percent of the unsafe sleep-related deaths involved the practice of co-sleeping; bed sharing with an adult and/or children. This is an alarming increase in bed sharing compared to last year where there was almost an equal amount of bed sharing and unsafe sleep environment, which includes unsafe sleep such as swing, couch, a car seat, a sleep space filled with blankets, pillows or toys.
- The children most vulnerable to unsafe sleep related deaths were infants zero to 12 months of age, which comprised 92% of the cases.
- In 2023, Hispanic (63%) and African American (25%) children were the most common victim of unsafe sleep related deaths. Caucasians made up 12% percent.
- Of the 24 unsafe sleep cases, 58% were male and 42% were female.
- Only 8 of the unsafe sleep cases had DCFS history whereas last year, almost half of all unsafe sleep cases had a DCFS history.
- 24 of the undetermined deaths for 2023 were not a result of unsafe sleep practices.
- Those 24 deaths consisted of fetal demise, medical anomalies and infants dying of medical complications due to illness such as flu and cold.

Undetermined Child Deaths



Undetermined Child Deaths:
Bed-Sharing and Unsafe Sleeping Environment

2023 Undetermined Child Deaths
Age Breakdown



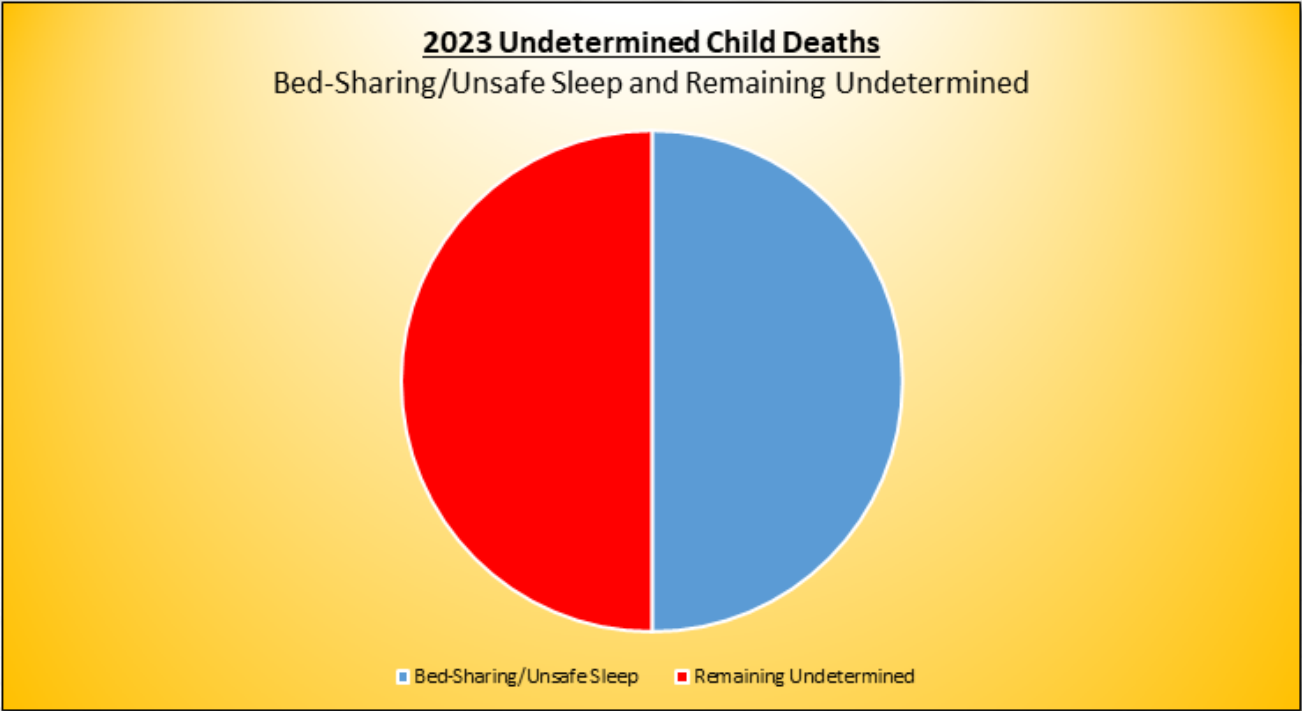
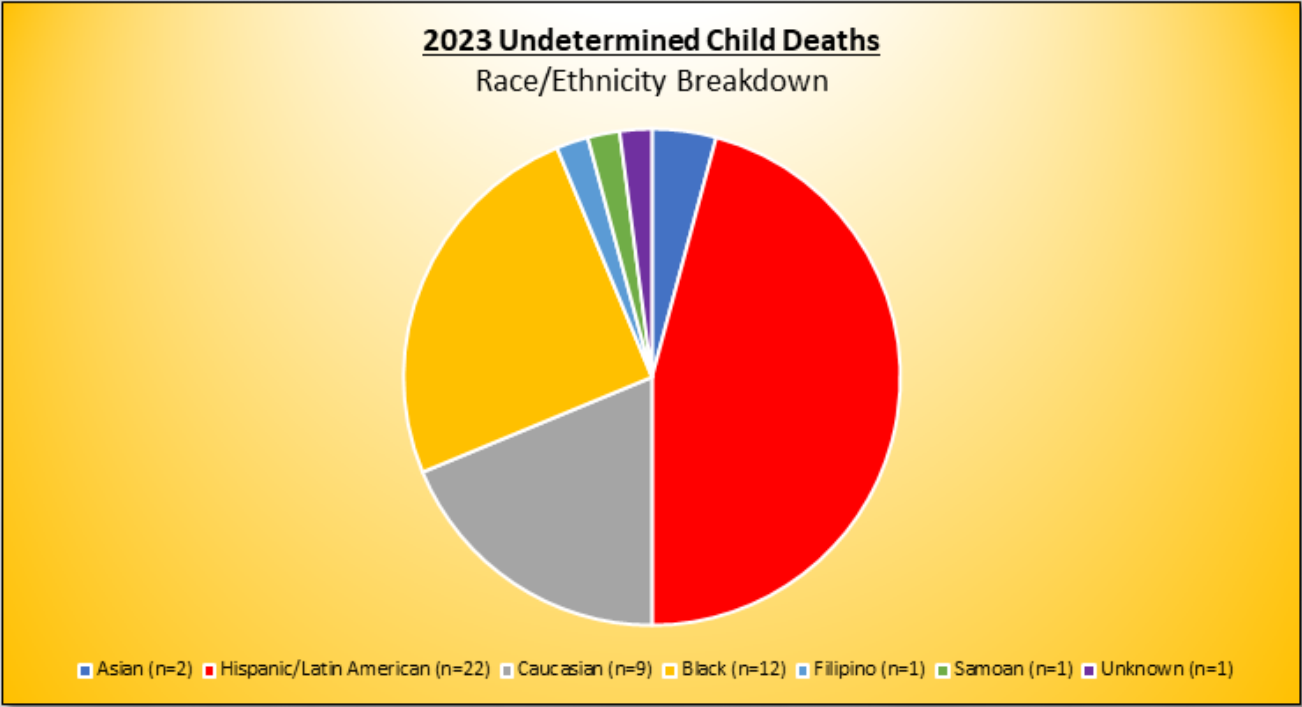
■ Less Than One Year ■ One Year Old ■ Three Years Old ■ Six Years Old

2023 Undetermined Child Deaths
Gender Breakdown



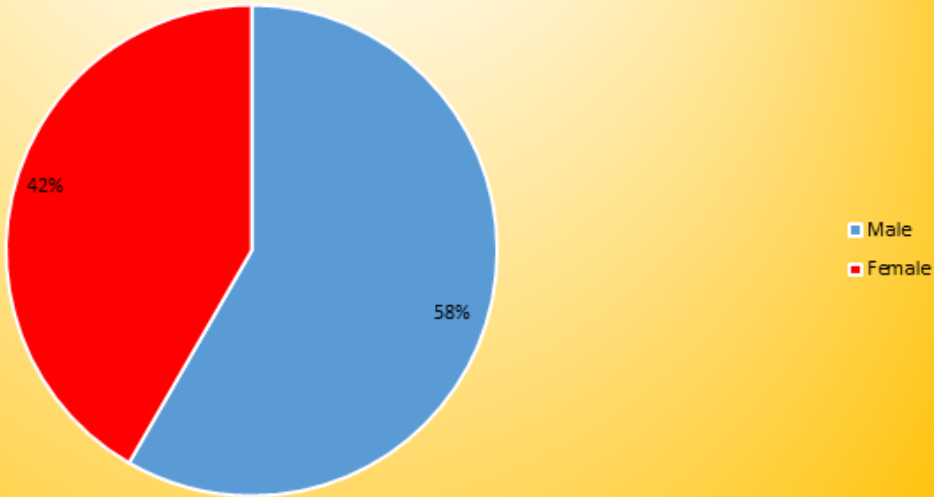
■ Male ■ Female ■ Unknown

Undetermined Child Deaths:
Bed-Sharing and Unsafe Sleeping Environment

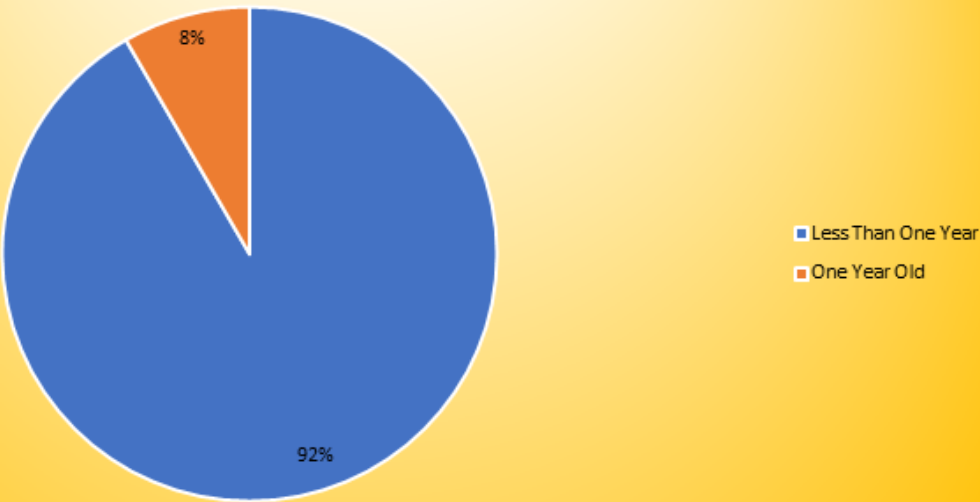


Undetermined Child Deaths:
Bed-Sharing and Unsafe Sleeping Environment

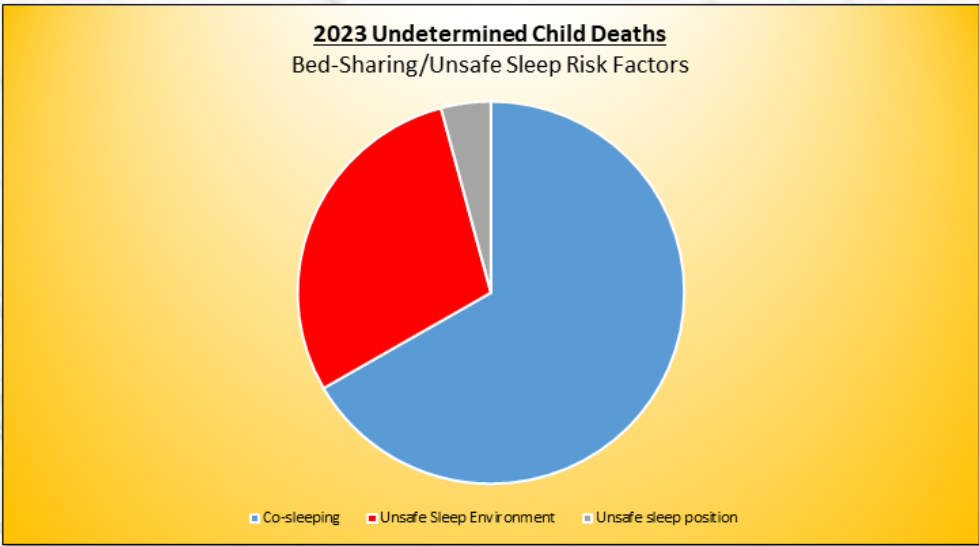
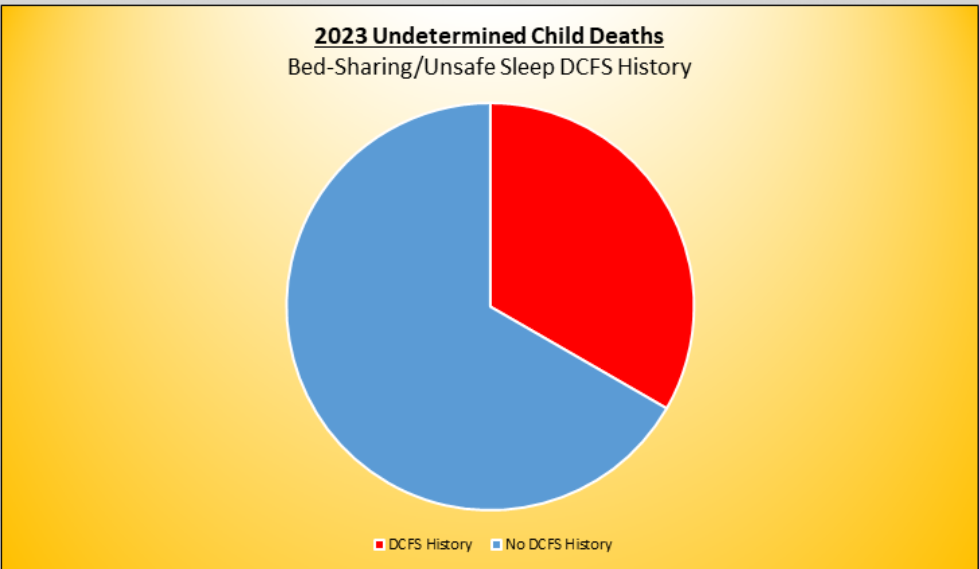
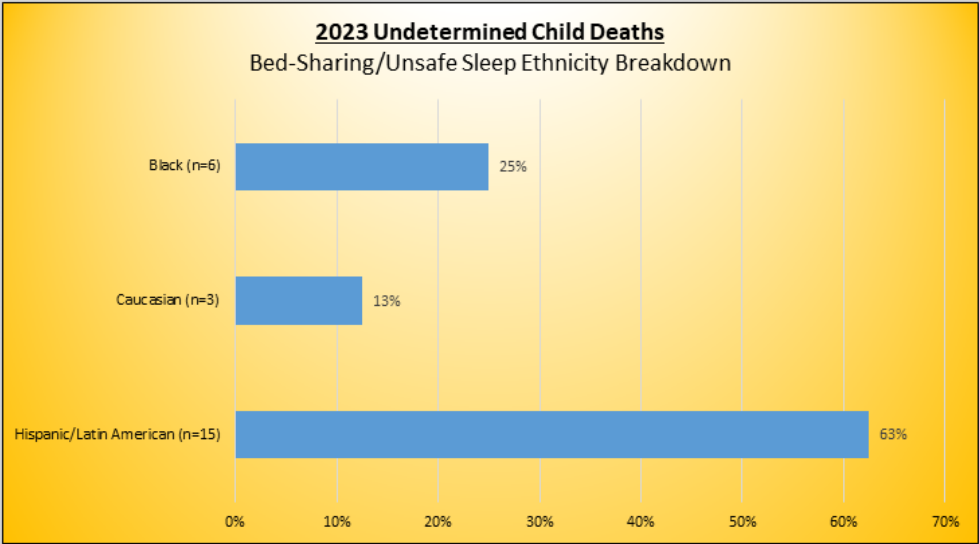
2023 Undetermined Child Deaths
Bed-Sharing/Unsafe Sleep Gender Breakdown



2023 Undetermined Child Deaths
Bed-Sharing/Unsafe Sleep Age Breakdown



Undetermined Child Deaths: Bed-Sharing and Unsafe Sleeping Environment

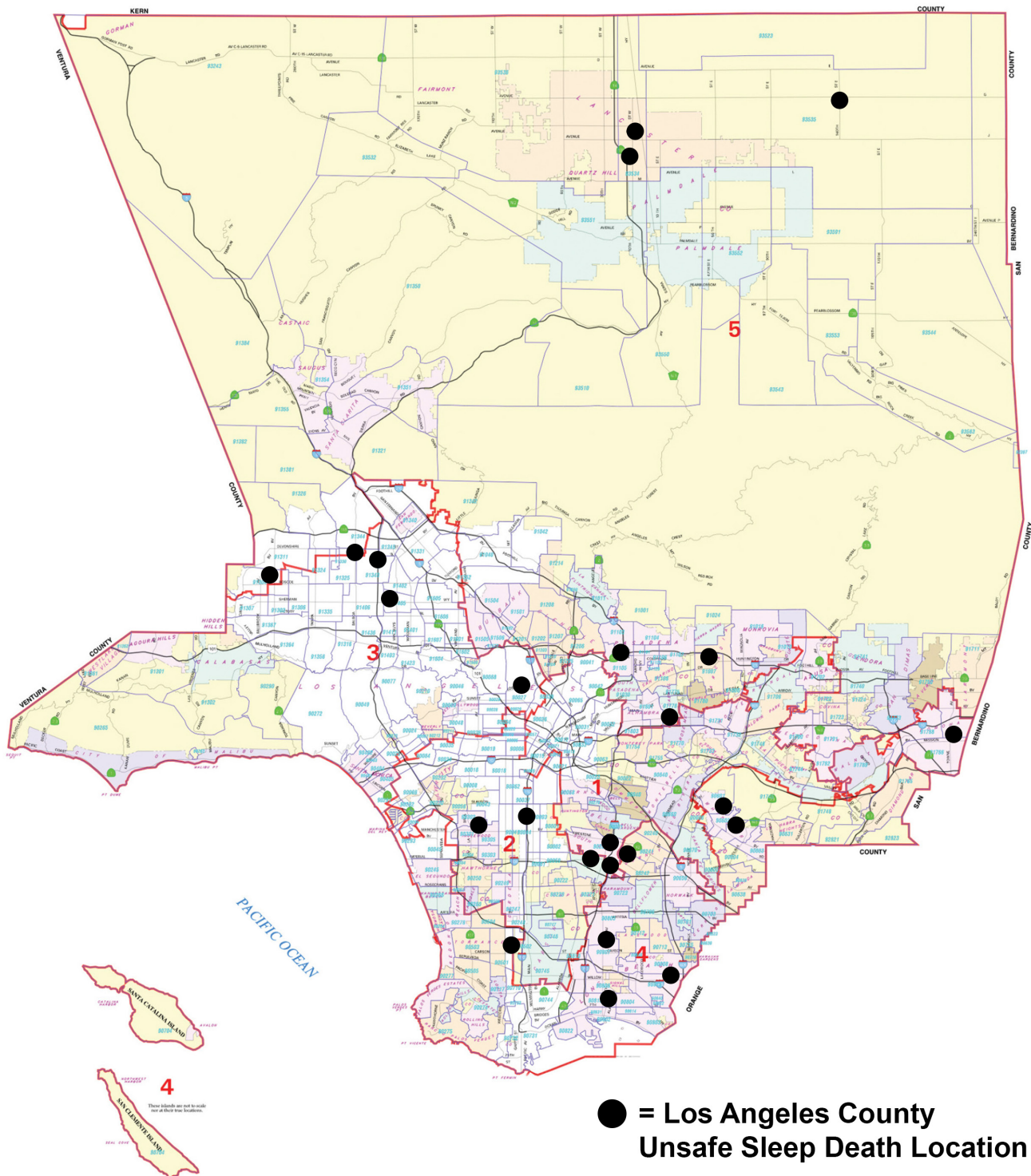


Undetermined Child Deaths: Bed-Sharing and Unsafe Sleeping Environment

2023 Unsafe Sleep Death - Locations

n = 24*

**City where the unsafe sleep death occurred*



Sample Case Summaries - Third Party Homicides

Sean

Sean, 17-year-old black male was shot in the head and run over by the suspect at a gas station in Los Angeles before the suspect fled the scene. Sean was transported to the hospital with a gunshot wound to the head. Sean's health declined and he was pronounced deceased in the Intensive Care Unit.

Joaquin

Six-year-old Joaquin suffered a gunshot wound to the head. He was with his family watching fireworks at their residence on 4th of July when a bullet fell onto his head. Joaquin was taken to the hospital after he suffered a large bleed to his head. A drain was placed at the hospital. He was pronounced deceased after suffering a large stroke on the right side of his brain.

Jose

Four-year-old, Jose arrived at the Emergency Room with gunshot wounds, two entry wounds. He was pronounced deceased in the ER. He was brought to the hospital by his parents. His parents reported being involved in an altercation with another motorist who shot at the car. Jose was a victim of road rage.

THIRD PARTY HOMICIDES

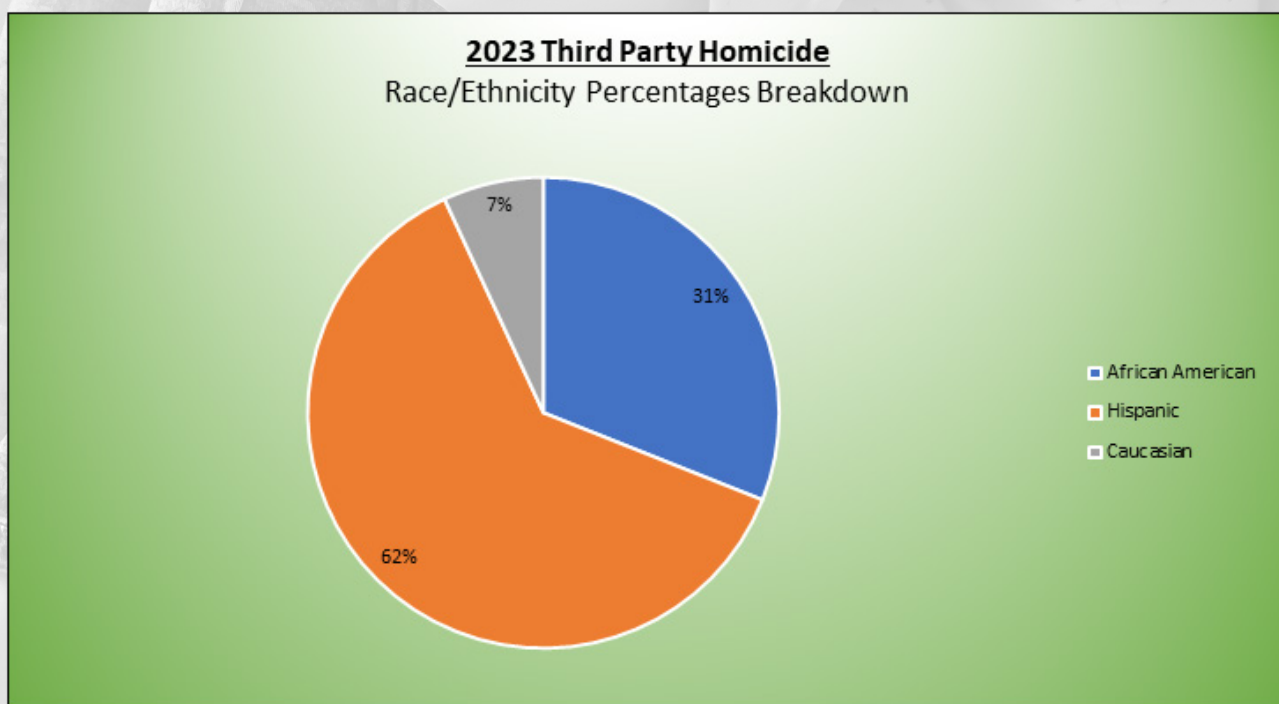
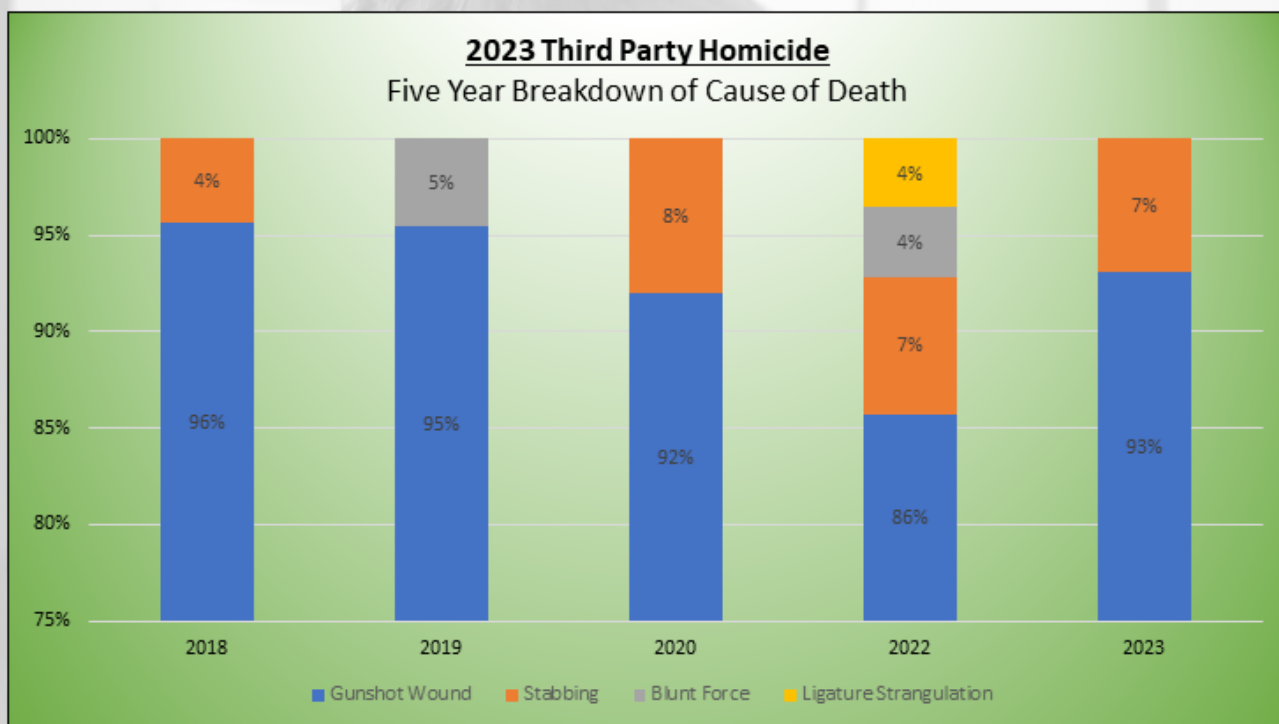
FINDINGS

- Twenty-nine third-party homicides were reported to ICAN by the Coroner for 2023. From 2022 to 2023, there was a 4% increase in third-party homicides. The five-year average is 25.4 third-party homicides per year.
- For the past five years, gunshot wounds have continued to be the leading cause of third-party homicide. For the year 2023, 93% of the victims succumbed to gunshot injuries, in comparison to 86% from 2022.
- Of the twenty-nine third-party homicide victims, 100% were male victims in 2023. During the past five years, female deaths from third-party homicides have continued to diminish. In 2023, the gender ratio is above the five-year average.
- Unlike past years, the youngest victim of third-party homicide in 2023 is 4 years old. The 4-year-old male victim was a victim of a road rage.
- Third-party homicide victims ranged from four to seventeen years old in 2023. Older children made up the largest percentage of the victims, with fifteen, sixteen, and seventeen-year-olds composing seventy-nine percent of deaths. Additionally, there was one fourteen-year-old child, one thirteen-year-old child, two twelve-year-old children, one six-year-old and one 4-year-old. The youngest child was a four-year-old boy.
- Sixty-two percent of the victims of third-party homicides in 2023 were of Hispanic background, thirty-one percent were of African American descent, and seven percent were Caucasian. These three groups made up 100% of the deaths in 2023, with no Asian victims reported. Hispanic victims of third-party homicides continue to saturate the five-year average trend significantly. For the 2023 third-party homicide, there was a significant spike in deaths reported for the months of January, March, July, and November, as reflected in the temporal pattern.
- 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.).

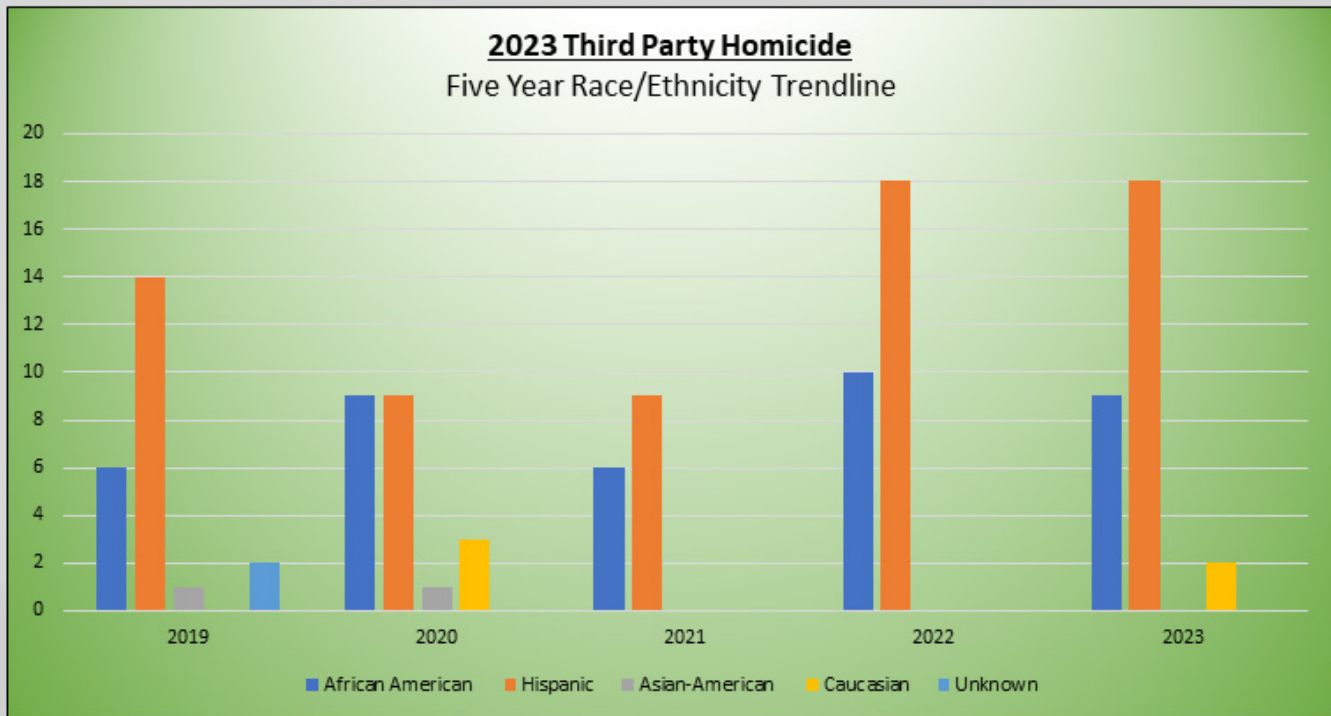
Third Party Homicides



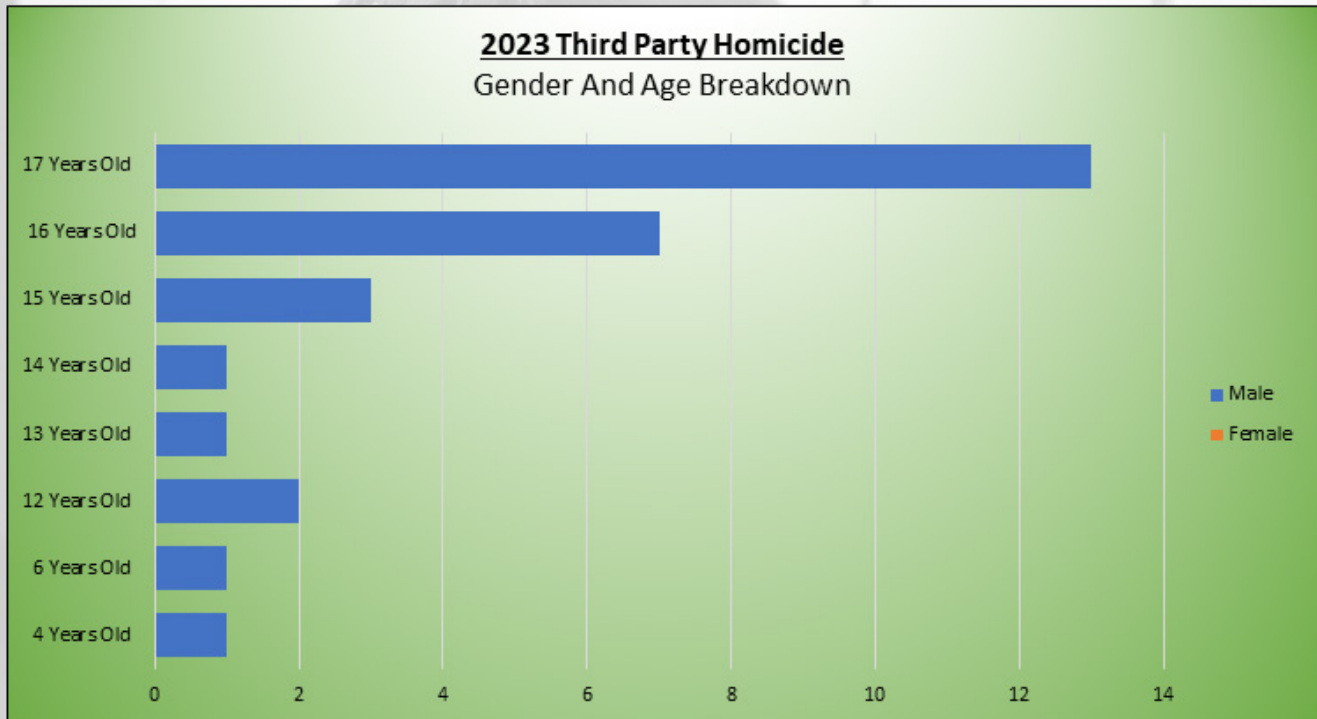
Third Party Homicides



Third Party Homicides



Third Party Homicides



Third Party Homicides

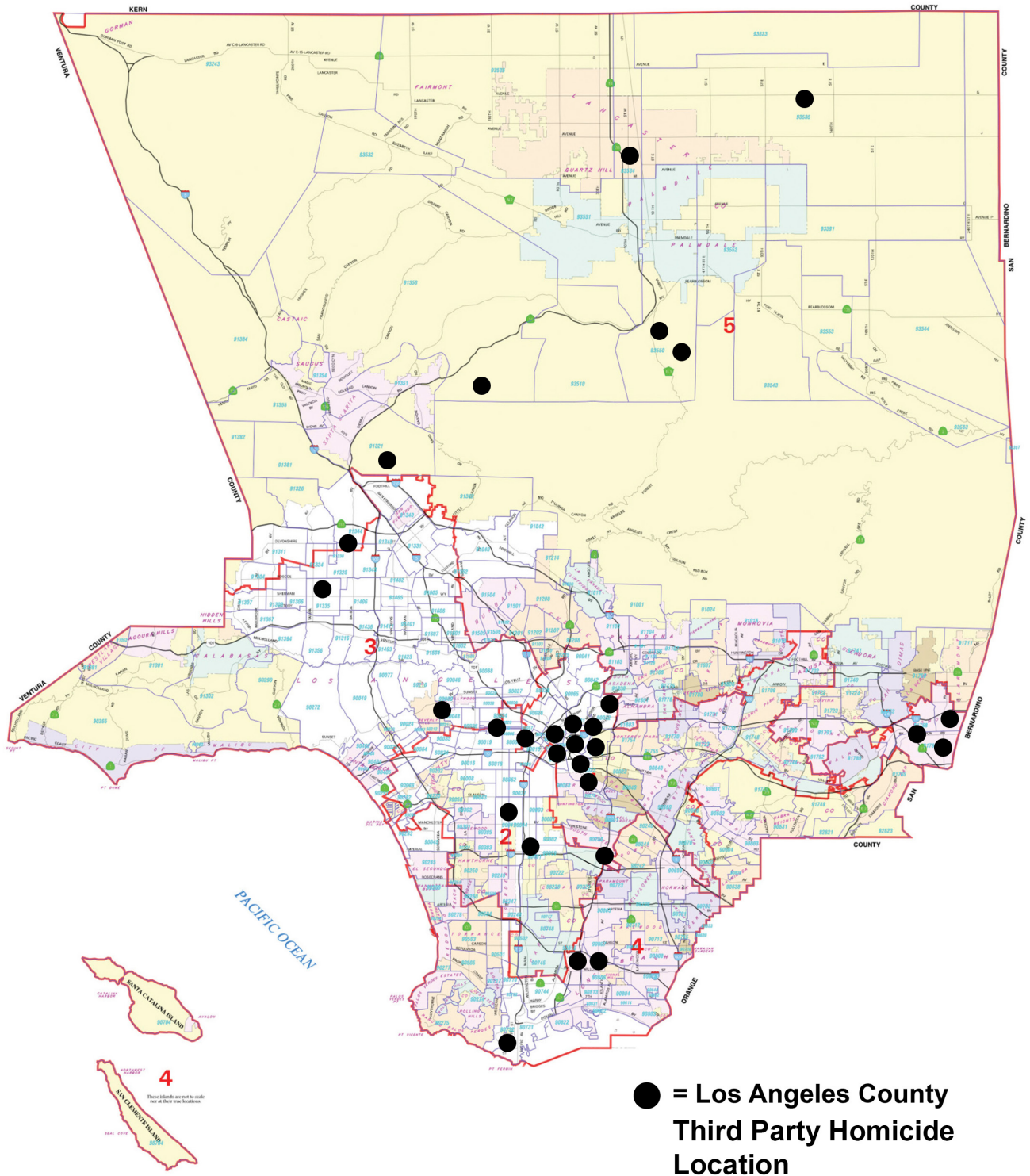


Third Party Homicides

2023 Third Party Homicides - Locations

n = 29*

*City where the homicide occurred



Safe Sleeping Resources

safesleepforbaby.com
[nichd.nih.gov.sts](https://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

