Inter-Agency Council on Child Abuse and Neglect

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Child Death Review Team Report 2015

Report Compiled from 2014 Data

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Introduction

The Los Angeles County ICAN Child Death Review Team (CDRT) was formed in 1978 and was the first child death review team in the nation. 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, 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 Los Angeles County Department of Medical Examiner-Coroner refers all cases it has received for children age seventeen and under to ICAN, including fetal deaths, and ICAN staff reviews these cases to determine which ones meet Team protocol. This process first involves the exclusion of all natural deaths. Thereafter, cases that meet at least one of the following criteria are selected for review:

- Homicide by caregiver, parent or other family member
- Suicide
- Accidental death
- Undetermined death

The Team reviews each referred case in detail, with input from the agencies that may have known of the child and family before, during or after the death. This process often illuminates problems in communication between agencies, in policies or procedures within and between agencies, or in dissemination of critical child safety information. Team participants provide feedback to, or seek clarification from their own agencies when a potential problem related to a child's death is identified. The information is then provided back to the Team. This active feedback process has resulted in improved inter- and intra-agency communication, more effective child safety practices, and more successful child death and injury prevention programs. The lessons gleaned from this systematic review of child deaths helps us to better understand the dynamics of the systems involved with families in order to more effectively to prevent child deaths, which is the ultimate goal of the Team.

This thirty-sixth annual report of the ICAN CDRT provides information on all child deaths that meet Team protocol and occurred in Los Angeles County during 2014. Lessons learned from the reviews and ensuing recommendations which, if implemented, should improve child safety and save lives are included in the report. Appendix C at the end of the report provides on-line resources for prevention of child deaths.

The report also includes information on 3rd party homicides of youth 17 years and younger for the eighth year. These homicides are when the perpetrator was not a family member or caregiver.

On a final note, ICAN is initiating a network of multi-agency child death review teams in Southern California counties. This network will facilitate sharing of experiences, information and resources, and address the unique issues of multi-county child death cases.

Team Chairpersons

Child Death Review Team

Michele Daniels, *Los Angeles County, Office of the District Attorney*
Carol Berkowitz, M.D., *Harbor/UCLA Medical Center*

Child and Adolescent Suicide Review Team

Michael Pines, PhD, *Chicago School of Psychology*
Rosemary Rubin, *Retired*
Lynda Boyd, *Los Angeles County, Department of Mental Health*

Teams Include Representatives From The Following:

Los Angeles County Departments

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

City Of Los Angeles:

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

State and other community partners

- Edelman Children's Court
- Community Care Licensing
- Independent Policies Agencies
- Children's Hospital of Los Angeles
- Community Child Abuse Councils
- Chicago School of Professional Psychology Almansor Center
- USC School of Medicine
- Pacific Clinics
- Burbank United School District
- Whittier-Union School District
- United American Indian Movement
- This report is available on line at: **http://ican4kids.org**

Recommendations

1. **When a patient has been treated at a hospital and becomes a Coroner case, the Office of the Medical Examiner-Coroner should have immediate access to the patients' complete medical record. The medical records would be transported with the body to the ME-C Office or the Office be given immediate electronic access to the records through ORCHID, even if as "Read Only" when it is a county facility.**

   Rationale: An autopsy is conducted within days of a death but it often takes weeks or longer for the Office to receive the deceased medical records. In cases of child death, medical records, particularly imaging studies when inflicted trauma is suspected, are a significant value to guide the medical examiner as the autopsy investigation is conducted. The Team has observed cases in which manner of death as deemed by the ME-C was declared without the full medical records. Team members, including expert child abuse pediatricians, believe, had the records, particularly, CT Scans and MRI's been reviewed prior to the autopsy, the manner of death would have been different. Further, the National Association of Medical Examiners (NAME) recommends antemortem records be obtained for the postmortem assessment of suspected head trauma in infants and young children.

2. **The Office of the Medical Examiner-Coroner should designate and train a minimum of six investigators to develop expertise in the evaluation of pediatric death scene evaluation and investigation**

   Rationale: Investigation and evaluation of child deaths requires expertise, particularly when related to maltreatment. These deaths differ by the cause of death, offender motivation, methods used to inflict injuries and the forensic and physical evidence present. Child death from inflicted trauma or ongoing neglect rarely involves traditional weapons such as guns, knives, or a blunt object. Aside from the offender or, in some cases, the other parent or caregiver, there is rarely a witness to the fatal event. Because of the differences and nuances involved with sudden child death, there is a need for the child death investigator to have the specialized knowledge necessary to investigate these deaths.

3. **The ICAN Policy Committee should request that the Board of Supervisors assure there is adequate funding for the timely completion of autopsies by the Medical Examiner-Coroner that include access to expert assessments and necessary testing, particularly in child fatality cases.**

   Rationale: The Team has reviewed several cases in which the final mode of death was not known for over one year due to delays in test results or expert assessments. The delays were caused by lack of authorization to pay for these outside resources. Not having timely results not only impedes the medical examiner's investigation, but also law enforcements. Evidence that may be crucial to both law enforcement and the ME-C can be lost. Individuals who should be held accountable for the harm done to the child are not as a result. Further, surviving siblings may be placed at risk under the care of the adult responsible for the death.

4. **The Department of Children and Family Services (DCFS), Law Enforcement, the District Attorney Similar to the Sheriff's Department and LAPD, Independent Law Enforcement agencies should include in their Academy training and patrol practice that personnel responding to domestic violence calls inquire, physically check and document for the presence of children in the home. Officers should obtain names, ages and relationship to the parties of the children present at the incident and/or who reside in the home of the offense. If present at the time of the incident, children should be interviewed separately and alone in an age-appropriate manner. If the incident is at a location other than the home, officers inquire and obtain the names and ages of the children who reside with either or both parties. A report should be made to DCFS for suspected risk to the children's safety and well being regardless of them being physically injured or an eye witness to the incident.**

Rationale: Violence between adults impacts children in the home as they are at risk for emotional and/or physical abuse as a result of the violence. There is often a co-occurrence of domestic violence and child abuse in a family. Domestic violence is also often present in families where fatal child abuse has occurred. Law enforcement should assess for children in the home or belonging to either party and make a referral to DCFS for further assessment by a social worker.

5. **The Department of Children and Family Services (DCFS), Law Enforcement, the District Attorney and the Los Angeles Office of City Attorney should begin to identify children impacted by domestic violence. This is to ensure the dynamics of domestic violence are addressed in the assessment and ongoing case plan from the initial referral to the termination of services. DCFS along with the State should create a special project tab for domestic violence on CWS/CMS to this end.**

   The ICAN Policy Committee support legislation to amend the 300 WIC code to add an allegation specifically for domestic violence.

   Rationale: The nexus between domestic violence and child abuse has been well established. Cases reviewed by the CDRT Team over the years have also demonstrated this connection. In fact, 60% of the child homicide cases in 2014 involved parents or a caregiver with a domestic violence history. Three children died as a direct result of domestic violence incidents involving murder-suicide.

   48% of the new cases in the Los Angeles County Dependency court in January 2015 involved domestic violence and 45% of the new cases in May 2015 involved domestic violence.

   Currently, there exists no way to identify children impacted by domestic violence. Domestic violence is categorized as emotional abuse or general neglect. The Dependency Court data collection took multiple steps and hundreds of hours to amass. By having a clear manner in identifying and an allegation for domestic violence as an issue in a family, tracking the involved adults and/or children with open cases or returning with new allegations will alert the case carrying worker to directly address the domestic violence.

6. **The Department of Children and Family Services, Department of Health Services, Department of Mental Health, Office of the Medical Examiner-Coroner, City and District Attorney's Offices should ensure services are provided to assist staff in dealing with the stress, grief and loss which may arise as a result of working with difficult and tragic cases involving trauma and death of children.**

   Rationale: Working closely with the injury and death of children, even when the involvement was indirect or after the death, can cause significant emotional distress for the involved professionals. For many years, law enforcement agencies and fire departments have recognized this reality and have developed specific programs and protocols for assisting their staff cope with acute and cumulative effects of investigating the deaths of children. While county agencies do offer generic Employee Assistance programs for their staff, such services are not sufficient to meet the specific needs of these impacted groups of professionals. For this reason, specific services and protocols should be developed to help staff in the agencies identified above.

7. **The Los Angeles County Departments of Health Services, Children and Family Services, Mental Health, Probation and Education should assure that all children and their families who are affected by or survive incidents of fatal or severe family violence are provided with appropriate support and services to assist them in managing their grief, mourning and traumatic stress.**

   Rationale: The Child Death Review and Child and Adolescent Suicide Review Teams frequently review cases of fatal child abuse, family violence or suicide involving surviving siblings and other family members. Such violent incidents often produce severe trauma and can have long-term debilitating effects on the survivors. Surviving children and family members need services to assist them in resolving their grief and loss which can sometimes be overlooked by the professionals involved in the process of addressing the issues related to the fatality. Competent child grief intervention and support, which may include attending funerals, grave visitation and memorabilia should be offered as soon as possible after the fatality to surviving family members.

8. **ICAN support legislation requiring medical professionals complete coursework or training regarding the identification and reporting of child abuse and neglect and provide documentation of completion.**

   Rationale: Over the years, the Team has reviewed cases in which a homicide victim was taken to a doctor, clinic or emergency room days, weeks, or within the month of their death. In many of the cases, symptoms, injuries or marks indicative of child abuse or neglect were present at the time the child was seen. The Team has discussed the problem as not always being one of resistance to report, but failure to recognize or identify child abuse and neglect. Further, in some cases, the risk the parent(s) posed for the child given their ability to appropriately respond to the child's fragile medical needs was underestimated.

   Note: The State of New York requires mandatory child abuse training for Physicians as a licensing requirement.

9. **The State of California Health & Safety regulations should prohibit the re-shelving of returned infant formula and food.**

   Rationale: This is to prevent the serious illness or death of infants from tampered formula. The Team is aware of at least one infant's death in Los Angeles County from the ingestion of formula that had been tampered with and returned to the store and resold.

10. **The Los Angeles County Superintendent of Schools should recommend school district superintendents require that materials on depression and suicide warning signs be presented to their students and parents for Elementary and Middle School levels. School personnel should be informed about the effective actions to take when students display signs of depression or suicide.** The Directors of the Department of Public Health and Mental Health should take steps to ensure that physicians, clinicians and other health providers conduct routine screening for depression and suicide risk. This screening should begin no later than 11 years of age.

    Rationale: While the majority of suicides involve children ages 15 – 17 years, younger children have taken their own lives in Los Angeles County over the past five years. Between the years 2010 and 2014, three 11 year olds and two twelve year olds have ended their lives. Currently, suicide prevention is geared toward high schools. Elementary and middle school teachers and parents should receive information on depression and other warning signs and be made aware of the potential suicidal risks and how to appropriately respond.

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 in families surface in the cases. The lessons and risk factors noted from the 2014 child death review cases follow.

Child Risk Factors

Young Age

73% of the 2014 child homicide victims killed by a parent/relative/caregiver were age five and under; 60% were two years of age or under; and only four were over age five. Infants and young children are especially vulnerable to abuse and neglect which can lead to death due to their small size, inability to defend themselves and dependence upon caregivers to meet their needs. Additionally, child homicides often coincide with developmental and independent stages. For example, toddlers in their attempts toward autonomy will show defiance and self assertiveness which can evoke an adverse response by a caregiver. The Team has also observed cases in which toddlers are victimized during the toilet training period. Importantly, infants and young children are often not visible outside the home as these families tend to be socially isolated.

Further, 62% of the children who died as a result of an accident were age five years or younger. Young children are more at risk of deaths such as drowning, pedestrian or auto back up because of their size and lapses of adult supervision to prevent such deaths.

Gender

Male (n=9) victims of homicide outnumbered the female (n=6) victims. Overall in past years, male children notably outnumbered female children as victims of homicide.

Race

66.7% of the 2014 child homicides victims by a parent/relative/caregiver were Hispanic, 20% Caucasian and 13.3% African American. There were no victims of Asian/Pacific Islander descent in 2014 (see chart on page 27).

Parental Risk Factors

Involvement with the Child Welfare System

A key factor in the majority of the child homicide cases was that the child's mother, father or the perpetrator had at least one contact with the Department of Children and Family Services (DCFS) or another Child Protective Service (CPS) agency. In 2014, DCFS contact with a parent and/or perpetrator occurred in 87% (n=13) of the families who experienced a child homicide. Five of the thirteen had a current open referral or case with DCFS at the time of the homicide.

Cycle of Abuse

A common factor seen in many of the child homicide cases had been that the child's mother, father or the perpetrator had a prior juvenile case themselves in either the Dependency Court or the Delinquency Court, or their family had contact with these agencies when they were a child. Many of them parent as they were parented, thus continuing the cycle of abuse and neglect. 27% (n=4) of the 2014 child homicides involved a parent(s) and/or perpetrator with a Child Protective Service (CPS) history as a child.

Substance Abuse by Parent or Caregiver

Substance abuse by a parent or caregiver is a well documented high risk factor for child abuse or neglect. Substance abuse often is identified when there is a child fatality if the parent or caregiver had prior reports or history of substance abuse. In two of the 2014 child homicides, the individual responsible for the child was under the influence of drugs during the incident that led to the child's death. A caregiver's unrealistic developmental expectations and inability to cope with age appropriate behavior, combined with drugs and

alcohol, become a lethal situation causing caregivers to lose control and harm the child. Forty percent of the 2014 families of homicide victims had a history of substance abuse. In addition, parents under the influence who sleep with their infant increase the risk of overlay or suffocation leading to the death of the child.

Prenatal Substance Abuse

The use of illegal drugs and inappropriate use of prescription drugs and alcohol during pregnancy appears to pose several risks to both the mother and unborn child. Possible risks include premature birth and developmental delays. Over the years, the Child Death Review Team has noted a number of fetal deaths with a contributing factor of prenatal substance abuse. Child deaths related to prenatal substance abuse remain one of the top four causes of accidental death, accounting for 21.6% of accidental child deaths. Prenatal Substance abuse was attributed to 32% of the accidental deaths of children in which the family had at least one contact with the child welfare system. Additionally, there were 8 undetermined child deaths associated with maternal substance use as evidenced by the mother testing positive at the birth for a alcohol or drugs.

Domestic Violence

The nexus between domestic violence and child abuse/neglect continues to be evident in the 2014 child homicides in which nine of the families had a documented history of domestic violence. Three of the child homicides can be directly tied to domestic violence. Two siblings were killed by their father who also committed suicide. The parents were in the process of divorcing and the father had threatened to kill the mother or the children. One homicide was by an adult sibling's boyfriend who also killed the sister and the child's mother before committing suicide. The victim's sister was breaking off the relationship and he was being asked to move out of the family home.

Presence of Multiple Parental/Caregiver Risk Factors

A combination of risk factors, such as history of substance use, domestic violence, social isolation, CPS contact, CPS history as a child and young parents are usually present when a child dies at the hand of a parent or caregiver. In 2014, only one family of a homicide victim had none of these known risk factors present.

Perpetrator Relationship

Relationship

In 2014, there were nineteen suspects in the 15 homicides. Fifty-eight percent of the child homicides involved a male perpetrator. Five of the primary suspects were the father, three the mother, two both parents, two the mother and her boyfriend, two unrelated caregivers and one the adult sister's live-in boyfriend.

Lack of Parenting Skills, Bonding or Poor Attachment

The poor quality of the relationship of the adult to the child has been a recurring factor in child homicide deaths. This is particularly important with the person who assumes a caretaking role for the child. The Team has observed that each year, many of the child homicides have been at the hands of the parent, parent's boyfriend, girlfriend, step parent or partner who was not emotionally connected to the child, yet had parenting responsibilities for the child. Lacking a connection with the child may contribute to their inability to manage stress or anger and to cope with parenting the child. This is often seen with children who die as a result of blunt force trauma to the head, chest abdomen, or multiple areas.

Denial or Lack of Understanding a Child's Medical Needs

The Team reviewed several cases in which one or both parents/caregivers either did not accept or comprehend the seriousness of a child's fragile medical condition. This was seen particularly with infants exhibiting low weight gain, possible failure to thrive, or experiencing an illness that led to rapid dehydration when not monitored appropriately.

System Factors

Failure to Recognize Child Abuse or Neglect

The Team has reviewed cases in which a homicide victim had contact days or weeks before the child's death by a pediatrician, a local medical clinic or at an emergency room. Indications of abuse/neglect were present but not recognized as possible child abuse/neglect. Additionally, the high risk to a child when one or both parents are uncooperative and/or in denial of the child's medical needs was underestimated by the medical professional.

Failure to Report

With the 2014 child homicides, as in previous years, the Team has reviewed cases in which a family had contact days, weeks or months before the child's death by an agency such as law enforcement or a community agency and "red flags" were observed but not reported to DCFS or law enforcement. When a family is involved with multiple systems - DCFS, Law Enforcement, Medical, community social services, it is imperative that the agencies providing services to the family have ongoing communication with one another for prevention, investigation, and case management purposes.

Further, in several cases involving child homicides, there were family members or neighbors aware of ongoing neglect or who observed inappropriate interactions which placed the child at risk and did not contact DCFS or law enforcement. Family members or neighbors, who are aware that a child might be at risk, should communicate their concerns to DCFS or law enforcement.

Additional Risk Factor

Unsafe Infant Sleeping

Undetermined child deaths associated with bed-sharing and/or unsafe sleep environments have declined considerably from the high of 70 set in 2009 to 35 in 2014. 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. In 2014, these bed-sharing and/or unsafe sleep environments child deaths accounted for 52% of all the undetermined child deaths.

Additionally, three infants died when placed in an unsafe manner to sleep whose deaths were ruled an accident mostly due to being wedged between an adult bed and wall. The manner of death by the Coroner in the majority of unsafe or bed-sharing infant deaths is undetermined. Adding these accidental deaths to the undetermined ones brings the total of unsafe sleep infant deaths to 38.

While there has been a decline in these child deaths, the need to proactively promote safe sleeping practices to further prevent these deaths remains

Child and Adolescent Suicide Review Team
Risk Factors and Lessons Learned

Suicide Rate

The suicide rate among individuals under the age of 18 years decreased from 13 suicides in 2013 to 10 in 2014. The highest number of youth suicides occurred in 2001 with 27 and the lowest number of 10 occurred in 2007 and 2014.

Gender

There was a significant shift in the gender rate of suicides in 2011. In prior years, the male to female ratio was consistent with males outnumbering the females by a large margin. In 2010, for every female suicide there were two male suicides. In 2011, eight of the nineteen suicides were female and eleven male. This pattern shifted again in 2012 when, for the first time, female victims (n=9) of suicide outnumbered the male victims (n=8). In 2013, the pattern reverted back to males outnumbering females with eight males and five females who died by suicide. The gender gap once again narrowed in 2014 to almost even with six males and four females.

Race

50% of the youth who died by suicide were Hispanic and 40% were African American children. One Asian child died by suicide and there were no Caucasian children who ended their lives in 2014.

Relationship Loss or Conflict

70% of the youth who ended their own lives experienced a recent relationship loss or conflict with a peer, boyfriend/girlfriend or parent prior to their suicide. Family dysfunction at the time of the youth's suicide was noted in 50% of the suicides.

The Role of Pre-existing Mental Health Problems

Among the youth who died of suicide, 60% had a documented mental health diagnosis, 20% were receiving mental health services at the time of death and 40% were on psychotropic medication. 50% of the youth exhibited a warning sign--talk of suicide, increased drug and alcohol use, feelings of depression, anxiety and hopelessness, and giving away possessions.

The Role of External Factors

The act of suicide frequently occurs in combination with external factors which seem to overwhelm youth who are already having difficulty in coping with the challenges posed by adolescence due to mental disorders. Some examples of these stressors are interpersonal loses, family violence, sexual orientation confusion, disciplinary problems, physical and sexual abuse, and being a victim of bullying.

Of the youth who died by suicide in 2014, 50% had reported experience of being bullied. 40% experienced school discipline/truancy problems and 54.5% had academic problems. Another 90% of the victim's families had contact with either DCFS or Probation at sometime in the youth's life.

Impulsivity

Of the 10 youth who died by suicide in 2014, only four left a note and one a text just prior to the act. This reflects how youth seem not to plan their suicide over a period of time, but act impulsively at the moment.

Findings

Overall Child Deaths*

- There were 196 child deaths reported to the Team by the Medical Examiner-Coroner. This included homicide by a parent, relative or caregiver, accident, suicide or undetermined cause in Los Angeles County for 2014. This is an 8.8% decrease from the 215 deaths in 2013.
- Fifteen children were victims of homicide by a parent, caregiver or other family member. There were 10 suicides, 103 accidental child deaths and 68 undetermined child deaths.
- There were a total of 30 fetal or child deaths associated with prenatal substance use. Twenty-two were ruled accidental and 8 undetermined by the Medical Examiner-Coroner.
- Thirty-eight children died with an associated bed-sharing or unsafe sleeping environment. Three of these deaths were ruled accidental and 35 as undetermined.
- The percentage of children who died in 2014 by race consisted of 51% Hispanic, 20.4% Caucasian, 22% African American, 5.6% Asian/Pacific Islander, and 1% Unknown.
- Over two thirds of the children were between the ages of 0 to five years (n=134). 47% were infants under the age of one year (n=93). Children ages 10 – 17 years comprised 25% of the total number of child deaths in 2014
- Forty percent of the children who died in 2014 were female and 59% male.

*Reported by the Medical-Examiner/Corner and does not include 3rd Party Homicides

Homicides

- There were 15 child homicides by parents, caregivers or family members in 2014. This represents a decrease of four homicides from 2013 when there were 19 child homicides. The number of child homicides in 2014 for Los Angeles County was significantly lower than the 15 year average of 28.5
- 73.3% percent of the children killed by their parents, caregivers or family members were five years of age or younger. Sixty percent of the children were under the age of two years.
- Four of the 15 homicide victims were over the age of five years.
- The average age of a child homicide victim in 2014 was 4.4 years which was older than in 2013 when the average age was 2.6 years.
- Nine males and six females were homicide victims in 2014.
- 47% percent of the child homicide victims were battered children who died from inflicted trauma—five died from multiple blunt force traumas, one child died from head trauma and one died from trauma to the torso/abdomen. In addition, four children were victims of stabbing, one a victim of asphyxia; one died from malnutrition/dehydration; and one child died as a result of medical neglect.
- There were no newborns abandoned and found deceased and/or killed by the mother in 2014. There were, however, two neonates abandoned but found alive. Eleven newborns were safely surrendered in 2014 which was three more than the number in 2013 (n=9).
- Hispanic (n=10) children comprised 66.7% of child abuse homicides. Three homicide victims were of Caucasian descent. African American (n=2) children represented 13.3% of the child homicides by a parent, caregiver or family member.
- The Department of Children and Family Services (DCFS) or another county's Child Protective Services (CPS) agency had prior contact with 80% (n=12) of the families in which there was a child homicide and

the child died in Los Angeles County. Three families of a homicide victim had an open case with DCFS and two had an open referral at the time of the child's death. In one homicide, the biological mother did not have a CPS history, but the caregiver/perpetrator the mother left the child with did have a past DCFS history with her own children.

- Five children were killed by their father and three children were killed by their mother. Two children were killed by the mother and the father; two by the mother and her boyfriend; two by a caregiver and one child was killed by his adult sister's live-in boyfriend.
- There were five child homicides by parents, caregivers or family members in May of 2014. The second greatest number of homicides occurred in the months of August and December with two per month. One homicide occurred in the months of January, March, April, June, September, and October. There were no homicides in the months of July and November.
- Child abuse homicides occurred throughout Los Angeles County in 2014. The Fourth Supervisorial District experienced the greatest number of child homicides with six. The First, Second and Fifth Districts each had three. No child abuse homicides occurred in the Third Supervisorial District

Suicides

- Ten children and adolescents died by suicide in 2014. This is a decrease from the 13 suicides in 2013, and fewer than the 15-year average of 16.4 suicides per year.
- For years there was a margin of 3:1 of male to female victims of suicide. This gap decreased significantly in 2011 with 58% of the victims being male and 42% female. In 2012, for the first time, female victims (n=9) outnumbered the male victims (n=8) of suicide. In 2013, the trend reversed back to the number of male victims (n=8) outnumbering the female victims (n=5). In 2014, the gap decreased slightly with female victims numbering 4 or 40% and males numbering 6 at 60%.
- Although the most common method of suicide nationally is firearm, the leading method in LA County continues to be death due to hanging, which represents 70% (n=7) of the suicides in 2014. Three youth used a firearm.
- The act of suicide historically occurs in the youth's home. All but two of the 2014 suicides occurred in the youth's place of residence.
- Fifty percent (n=5) of the adolescent suicides in 2014 were by Hispanic youth. Suicides by African American youth (n=4), represent 40% of the adolescent suicides. One of the youth was of Asian/Pacific Islander descent. There were no Caucasian youth who died by suicide in 2014, a downward trend for these youth and suicide.
- Seventy percent of the children who died by suicide in 2014 were ages 11 – 15 years. The youngest child who ended his life was 11 years of age.
- Seventy percent (n=7) of the adolescent suicides were precipitated by interpersonal conflicts or a recent loss. Five of the youths' families were noted to exhibit signs of family dysfunction (pending divorce or recent divorce, parental mental illness or domestic violence).
- Nine of the youths' families had a prior referral or case with the Department of Children and Family Services or with the Department of Probation. Three families had an open case with DCFS and one with Probation.
- Six youth had a history of mental health problems, two youths were in counseling at the time of their death and four were taking psychotropic medication. Three youth had a history of prior self-injury or cutting and five youths had previously attempted suicide. Five youths exhibited warning signs prior to their suicide.
- Four of the youth who died by suicide in 2014 left a suicide note. One youth texted their intent just prior

to committing the act but did not leave a note.

- Two youths were discovered to have a positive toxicology for drugs or alcohol at autopsy.

- Four youth had school discipline or truancy problems and six experienced academic problems.

- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred equally in the First and Third Districts of the Board of Supervisors with three suicides followed by the Fifth District with two suicides. One suicide occurred in the Second and Fourth Districts.

Accidental Child Deaths

- For the second year in a row, the number of accidental child deaths of children in Los Angeles County increased from the previous year. There were 93 accidental child deaths in 2013 and this increased to 103 such deaths in 2014.

- The leading causes of accidental death for children were automobile accidents and prenatal substance abuse with 22 deaths each. Auto pedestrian (n=18) child deaths were the second leading cause and drowning (n=14) the third leading cause of accidental child death in 2014.

- Child deaths related to vehicles including motorcycle and auto-pedestrian accounted for 39% of all accidental child deaths (n=40).

- Deaths associated with prenatal substance abuse as determined by the Coroner from self-report or hospital toxicology results, accounted for 15 fetal deaths and seven infant deaths. Methamphetamine and/or amphetamine use by the mother is the most associated drug with these deaths (n=16) accounting for 72.7%. Two deaths were associated with Cocaine use by the mother and four deaths poly substance abuse including alcohol. 79% of the accidental fetal deaths were associated with prenatal substance use. Fetal deaths associated with prenatal substance abuse accounted for 14.5% of all accidental deaths.

- Accidental drowning claimed the lives of 14 children which remained the same as the previous year. The majority of these drowning deaths were young children who drowned in residential pools. In 2014, twelve children drowned in a residential pool and 64% of these victims were age five years or younger (n=9). Additionally, one child drowned in a residential bath tub and one in a backyard pond. Both were one year of age or younger. For the past sixteen years, drowning has been one of the leading causes of accidental deaths of children in Los Angeles County.

- Of the 103 accidental deaths, 78 accidental child deaths involved children ages 0 – 14 years. There were 25 accidental deaths of youths ages 15 to 17 years. More than half (61%) of the accidental child deaths (n=63) were children age five years or younger.

- Three unsafe sleep infants' deaths were ruled accidental as opposed to undetermined. Most involved being wedged between a mattress and the wall.

- Of the children who died an accidental death in 2014, 43% had a DCFS history. Fourteen families of the twenty-two child deaths from prenatal substance abuse had a history with DCFS. One additional maternal substance abuse associated child death involved a mother who had a CPS history as a minor but not as an adult.

- Hispanic children represented 46% (n=47) of the accidental child deaths in 2014. African-American children represented 22%, Caucasian 28% and Asian/Pacific Islander represented 5% of accidental deaths in 2014.

- As in previous years, males (n=71) outnumbered females (n=30) in accidental deaths. Two genders were unknown

Undetermined Child Deaths

- There were 68 undetermined child deaths in 2014. This is a 24% decrease from the 90 such deaths in 2013 and lower than the 15-year average of 96.5 undetermined deaths per year.
- The majority, 94% of undetermined child deaths are children age five years or younger. Eighty-four percent of the undetermined child deaths were age one year and under (this includes stillborn deaths).
- The majority of undetermined child deaths were children of Hispanic descent representing 56% of such deaths. Twenty-four percent of the children were African American, 12% Caucasian and 7% Asian/ Pacific Islander. There were two unknown race undetermined child deaths.
- Approximately 45% of the families with a child who died from an undetermined death had at least one contact with DCFS or another county CPS agency.
- Bed-sharing and unsafe sleeping environments accounted for 52% percent of all undetermined child deaths. 42% of the undetermined child deaths were associated with bed-sharing (n=28) and 10% with an unsafe sleep environment (n= 7). This represents a 6.6% percent increase from 2013 in which 33% of undetermined child deaths involved bed-sharing.
- Among the bed-sharing deaths, 0% involved only one unsafe risk factor, 21% involved two, and 79% involved three or more unsafe risk factors. Risk factors included bed-sharing, adult bed, couch, pillows soft or excessive bedding, excessive swaddling, parental drug/alcohol use, and prone or side positioning.
- African American children are over represented in the percentage of both bed-sharing and unsafe sleeping environment child deaths. 32.1% of the bed-sharing deaths and 29% of the unsafe sleeping environment deaths involved African American children.
- Seventy-nine percent of the infants whose deaths occurred while bed-sharing or in an unsafe sleeping environment were six months of age or younger (n=24).
- In 36% of the bed-sharing and non-bed-sharing unsafe sleep child deaths, the infant was placed in a prone or side position for sleep. This is an decrease from 2013 when 47% of the infants were placed prone or on their side to sleep.
- Undetermined child deaths involving bed-sharing and unsafe sleeping environments occurred throughout Los Angeles County. However, Supervisorial District 2 accounted for 43% (n=15). 17% (n=6) occurred in Districts 4 and 5 each; 14% (n=5) in District 2 and District 4 followed with 6% (n=2).
- Forty-six percent (n=13) of the bed-sharing deaths were infants between 0 to 3 months of age, 25% (n=7) were infants between 3 to 6 months of age, 14% (n=4) were 6 to 9 months of age, 4% (n=1) were 9 months to 1 year and 11% one to three years (n=3).
- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 46% of the incidents and two adults in another 29% of the incidents.
- Ten percent (n=7) of undetermined child deaths were associated with unsafe sleeping environments which Include adult bed, couch, foam mat, infant or car seat, pillows, soft or excessive bedding, excessive swaddling, stuffed toys, prone or side positioning. This is a 67% decrease in these types of preventable deaths from 2013 when there were twenty-one such undetermined child deaths.
- Two of the non bed-sharing deaths were infants between 0 to 3 months of age (28.6%), two were infants between 3 to 6 months of age (28.6%), one was 8 months of age and two were 9 months to one year of age (28.6%).
- There were 8 undetermined infant deaths in which the mother either tested positive for a substance at birth or self-reported substance use during pregnancy. The majority involved stillborn births (n=6).
- The most frequent substance detected was methamphetamine (n=5).
- All of the mothers of these infants had prior contact with a CPS agency in Los Angeles or another county. Three of the eight mothers had a case with a CPS agency as a minor.

Senate Bill 39 (SB 39)

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
- the child resided with a parent or guardian or in foster care at the time of the death.

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

- A "determination" of abuse and/or neglect by Child Welfare Services or Probation is the substantiation of abuse and/or neglect allegations which resulted in the fatality; or
- A law enforcement investigation concludes that the child's death was a result of abuse and/or neglect; or
- A coroner/medical examiner concludes that the child's death was a result of abuse and/or neglect.

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

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

Selection of Cases for Team Review

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

Homicides, by the Coroner's definition, are deaths at the hands of another. Child deaths in which the suspected perpetrator is a parent, caregiver or family member, meet the Team protocol for possible review. All such cases are included in the ICAN annual Team report. Homicide by parent/caregiver/family member is commonly understood by the public as synonymous with child abuse murder. However, the Coroner uses the term "homicide" regardless of the criminal intent of the perpetrator or the findings of the criminal justice system. Homicide may describe circumstances ranging from tragedies that involve no clear intent, to vicious, fatal attacks with clear intent.

Accidental deaths continue to be one of the largest categories of deaths reported to the Team by the Coroner and, for 2013, this mode of death represents the largest category of deaths reported by the Coroner. Several types of accidental death, such as auto pedestrian fatalities, drowning, hangings 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 death of self-caused with intent. 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 youth 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 Deaths in Los Angeles County 2010 – 2014

Over the past 5 years, a parent, caregiver or other family member has killed an average of 19.8 children each year.

2010	26
2011	24
2012	15
2013	19
2014	15

An average of 13.3 children and adolescents each year have committed suicide over the past five years. The leading method from 2010 through 2014 was hanging.

2010	16
2011	19
2012	17
2013	13
2014	10

Over the past five years, an average of 91.8 children have died from preventable accidents. The most common accidental Deaths involve automobile accidents, maternal substance abuse and deaths due to auto vs. pedestrian.

2010	86
2011	88
2012	89
2013	93
2014	103

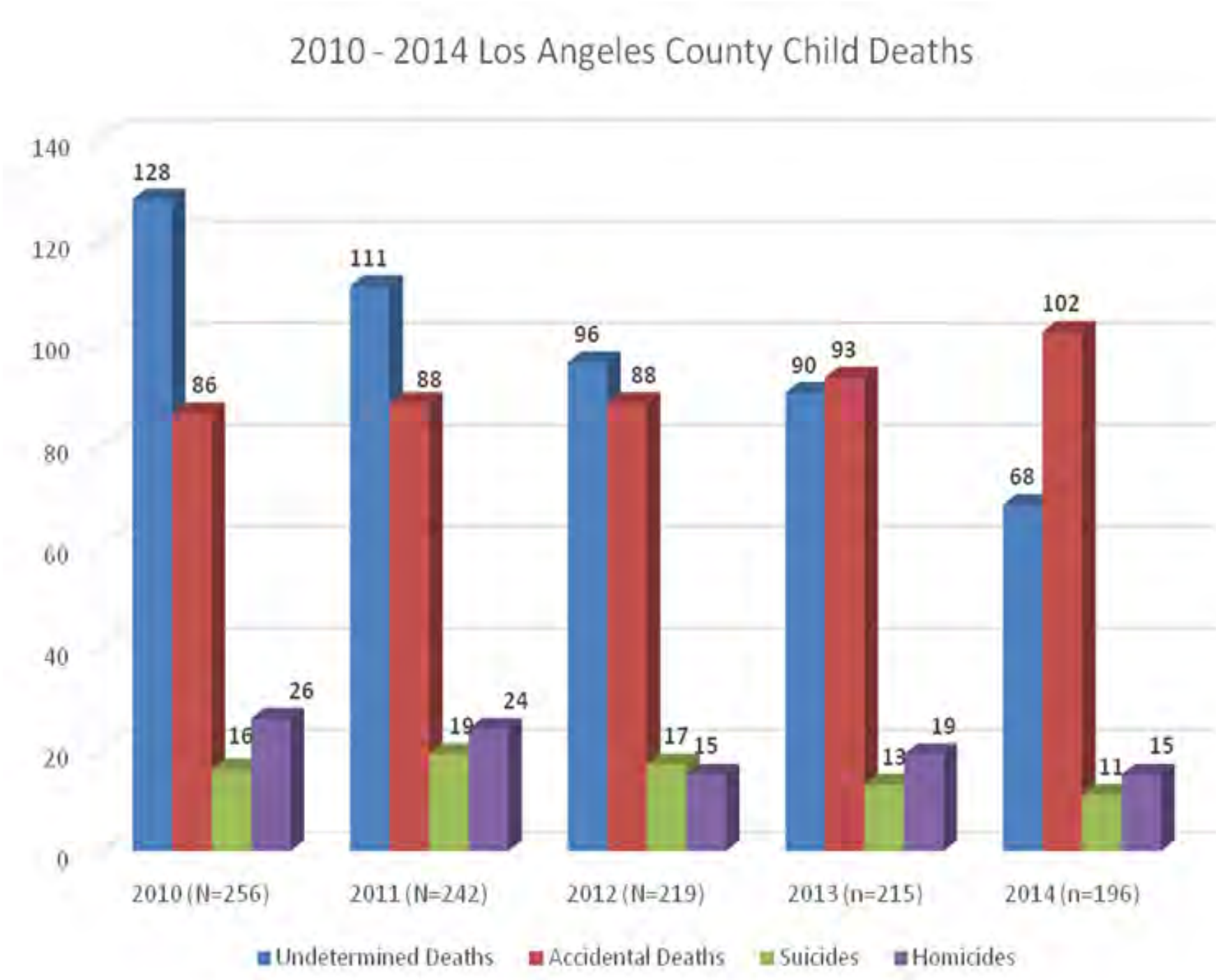
The number of undetermined deaths has averaged 98.4 per year over the past five years.

2010	128
2011	111[1]
2012	98
2013	90
2014	68

2014 Child Deaths Demographics

	NUMBER	PERCENTAGE
Total	196	100
Gender		
Female	79	40.3
Male	115	58.7
Unknown	2	1.0
Age		
Under 1 year	93	47.4
1 – 4 years	41	21.0
5 – 9 years	13	6.6
10 – 14 years	16	8.2
15 – 17 years	33	16.8
Race		
African American	43	22.0
Asian/Pacific Islander	11	5.6
American Indian	0	0
Caucasian	40	20.4
Hispanic	100	51.0
Unknown	2	1.0

1. Three Undetermined stillborn child deaths were reported after the release of the 2012 report raising the number from 108 reported to 111 Undetermined Deaths in 2011.


2010 - 2014 Los Angeles County Child Deaths
140
120
100
80
60
40
20
0
128
86
16
26
111
88
19
24
96
88
17
15
90
93
13
19
68
102
11
15
2010 (N=256)
2011 (N=242)
2012 (N=219)
2013 (n=215)
2014 (n=196)
Undetermined Deaths
Accidental Deaths
Suicides
Homicides

Child Homicides by Parent, Caregiver, or Other Family Members 2013

Case Summaries

Child Homicide by Parent/Caregiver/Family Member

Sarah

Sarah, age 10 months was reportedly found by her father face down on the floor underneath an adult bed wedged between the bed and the wall. He called 911 stating the toddler was not breathing. When LAFD arrived, she had no pulse or respiration, was cold to the touch and had lividity. Paramedics placed her on a gurney in the back of the ambulance and observed bruises on her face, buttocks and thighs. Law enforcement was notified and she was pronounced deceased at the scene. No other adult was in the home except the father at the time paramedics were called.

The father's explanation that she fell off the bed and became wedged was not consistent with the observed injuries. He also told investigators that he was not sure Sarah was his child and was asking the mother to do a paternity test. They had been together but had been separated since the mother's pregnancy with Sarah. The couple had just reunited two months prior to Sarah's death and were living with another family.

Sarah's mother had two older children ages 4 years and 3 years by another father. She had lost custody of these children to DCFS from 2008 to 2011 due to domestic violence and the mother's failure to protect them from physical abuse by their father.

The final mode of death was ruled a homicide due to blunt force trauma. Sarah was beaten to death. The father was questioned and passed a polygraph test despite the older siblings reporting he beat Sarah on the day of her death. The case remains under investigation.

Matthew

Six-year old Matthew was stabbed to death by his father while he was under the influence of methamphetamine. His father pled guilty to second degree murder and is currently serving a 16 year to life sentence in state prison.

Matthew's mother died when he was days old. He was raised by his single father and shuffled between relatives. The father had been living at his present residence for three months. Matthew had not been living with the father until the past month.

After the death, it was learned the father had a long history of alcohol and methamphetamine use. The father had been taken to a local emergency room two months prior to the death for a meth overdose. Family and the neighbors were aware of the father's substance abuse and would check on Matthew. Sadly, no one made a call to DCFS to assess the family. The father also had a history of domestic violence with the mother of his two older children.

Damien

Two year old Damien was detained from the mother and father by DCFS due to extensive domestic violence between mother and father; physical abuse of the decedent by the father and alcohol abuse by the father. The court terminated parental rights and the maternal grandmother was in the process of adopting the decedent. Despite court orders that the biological mother only have supervised visitation, the grandmother/prospective adoptive mother allowed the toddler to stay with the biological mother.

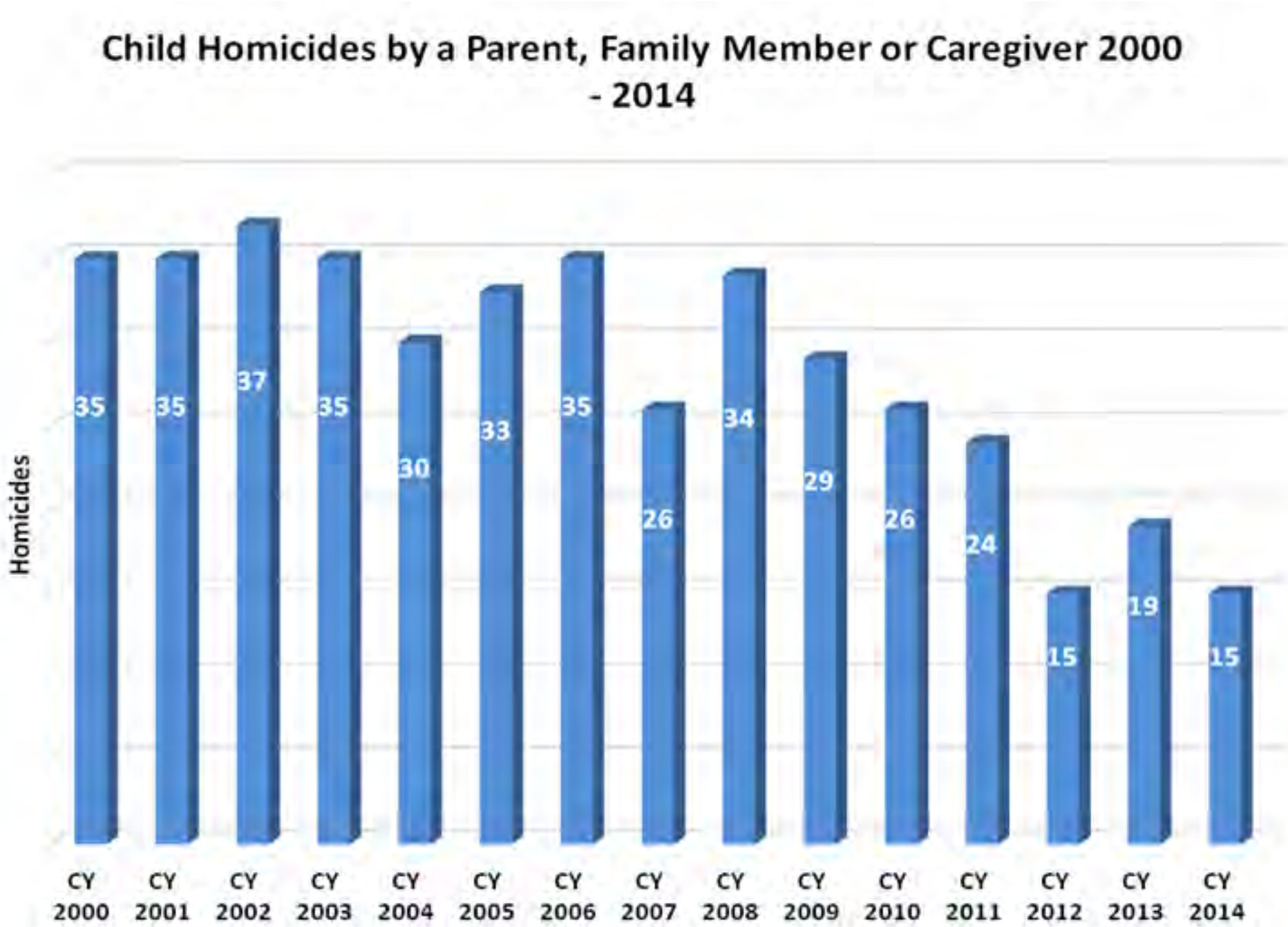
The day before his hospitalization, the mother left the decedent in the care of her friend and her friend's boyfriend who lived in a converted garage apartment. The child spent the night with the couple and the following day the mother went to the movies with her friend, leaving the decedent in the care of the friend's boyfriend. While the decedent was being babysat by the boyfriend, the child was injured and went into

cardiac arrest.

When interviewed by law enforcement, the boyfriend/caregiver reported that he had been feeding the child when the toddler vomited on him. This angered the caregiver so he punched the child in the back of his head, which caused the decedent's face to strike the table. The child began crying so the caregiver attempted to feed him and shoved a bottle in the child's mouth, which resulted in a lip laceration. The decedent vomited again; the caretaker then shook the toddler and threw him on the bed. The caregiver realized the child was no longer breathing and ran outside with the toddler and yelled for the neighbors to call 911.

Paramedics arrived and were able to regain a pulse. Damien was taken to the ER where he was found to have multiple bruises to his head, chest and abdomen. A CT Scan revealed subdural hematomas and massive retinal hemorrhages in both eyes. Damien never regained consciousness and had no brain functioning. He was declared brain dead the next day.

The caregiver was arrested for murder. He pled no contest and was sentenced to 15 years to life.


Child Homicides by a Parent, Family Member or Caregiver 2000 - 2014
Homicides
35
35
37
35
30
33
35
26
34
29
26
24
15
19
15
CY 2000
CY 2001
CY 2002
CY 2003
CY 2004
CY 2005
CY 2006
CY 2007
CY 2008
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
CY 2014

Causes of Child Homicide by Parent/Caregiver/Family Member
2000– 2014, Los Angeles County

	’00	’01	’02	’03	’04	’05	’06	’07	’08	’09	’10	’11	’12	’13	’14	Total
Head trauma	5	5	2	7	7	6	11	11	12	8	2	10	5	3	1	**95**
Multiple trauma*	11	7	7	10	7	8	7	7	4	2	1	6	2	9	5	**93**
Asphyxiation/suffocation	3	8	5	6	5	5	6	6	3	2	3	2	0	1	1	**56**
Gunshot wounds	3	2	1	4	3	6	1	1	8	7	4	2	0	0	1	**43**
Trauma to torso/abdomen	0	0	3	0	0	2	1	1	1	1	5	1	2	1	1	**19**
Drowning	3	1	7	1	1	2	3	3	0	1	2	0	3	1	0	**28**
Fire	1	0	0	0	0	0	3	3	1	0	0	0	0	0	0	**8**
Stabbing	4	1	2	0	3	2	2	2	2	4	6	1	1	1	4	**35**
Unattended newborn	2	3	2	3	0	2	0	0	1	2	1	0	0	1	0	**17**
Poisoning/drug ingestion	0	3	6	1	1	0	0	0	0	0	0	0	1	1	0	**13**
Dehydration/malnutrition	1	1	0	1	2	0	0	0	1	1	0	1	0	0	1	**9**
Strangulation	0	0	0	0	0	0	1	1	0	0	1	0	1	0	0	**4**
Medical neglect	1	2	0	0	0	0	0	0	0	1	1	0	0	0	1	**6**
Burns	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Hyperthermia	0	0	0	2	0	0	0	0	1	0	0	0	0	1	0	**4**
Post-Term gestation	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	**1**
TOTAL	**34**	**34**	**35**	**35**	**29**	**33**	**35**	**35**	**34**	**29**	**26**	**24**	**15**	**19**	**15**	**432**

*includes auto-injuries

Child Homicide by Parent/Caregiver/Family Member
Los Angeles County – 2014 (N= 15)

Age	Under 1	1 year	2 years	4 years	5 years	6 years	9 years	13 years	17 years	TOTAL
Female	2	1	1	1	1	0	0	0	0	6
Male	1	1	3	0	0	1	1	1	1	9

73.3% of the child homicide victims by parents/caregivers/family member were five years of age or under.

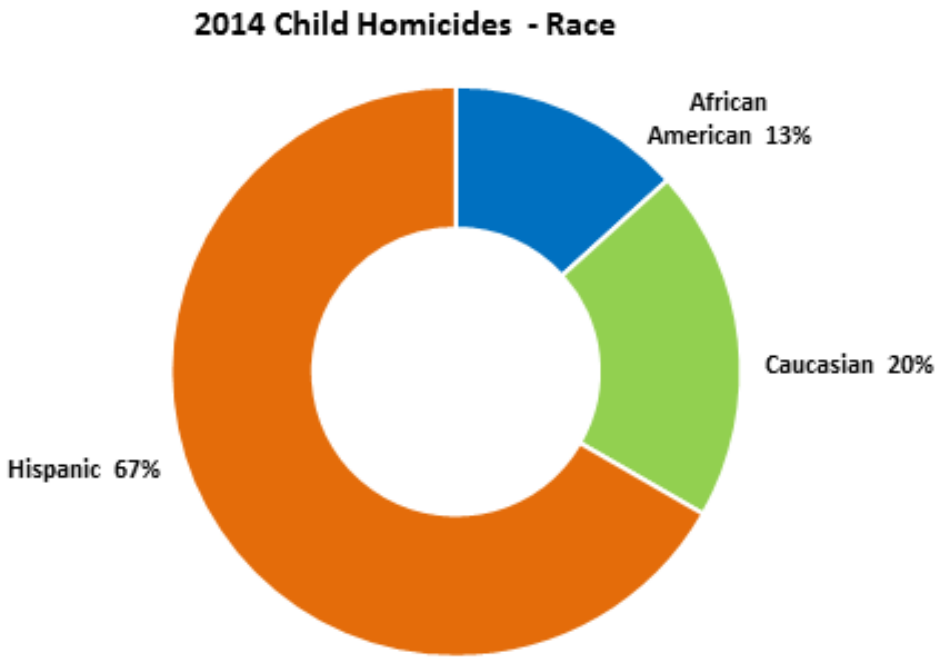
60% of the child homicide victims by parents/caregivers/family member were two years of age or under.

20% of the child homicide victims by parents/caregivers/family member were under one year of age.

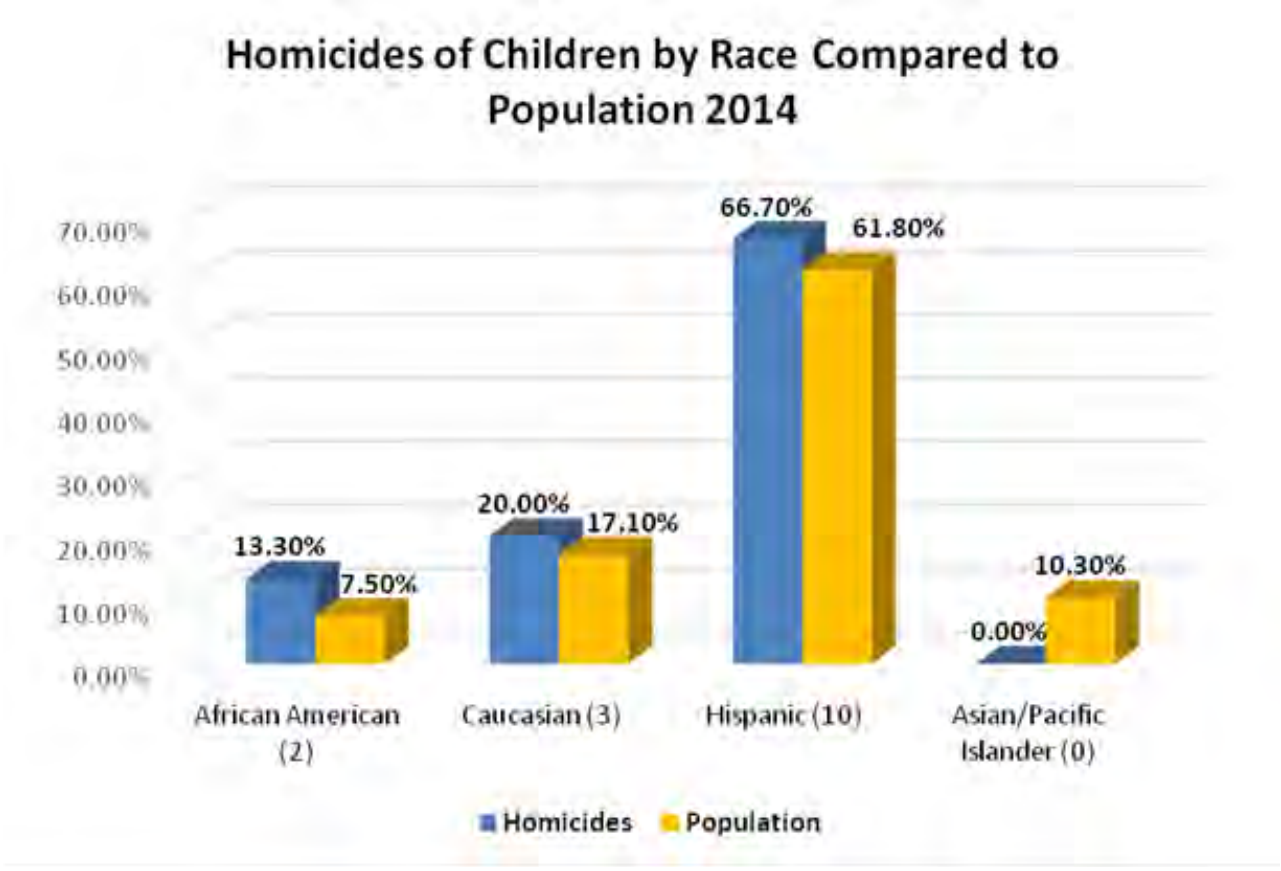
60% of the victims were male and 40% were female.

Five Year Trend of Child Homicides by Age

	2010	2011	2012	2013	2014	Total
Under 1 year	8	13	8	8	3	40
1 - 2 years	10	8	3	6	6	33
3 - 5 years	2	1	2	2	2	9
6 - 10 years	4	2	1	2	2	11
11 - 17 years	2	0	1	1	2	6



Los Angeles Child Population
Ages 0-17: 2,328,466
Hispanic 61.8%, Caucasian 17.1%, African American 7.5% , Asian/Pacific Islander 10.3%, Native Indian/Alaskan .1% and Multi-racial 3.1% Kidsdata.org



Relationship of Suspect to Child Homicide Victim – 2014

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

5 – Father

3 – Mother

2 – Mother and Father

2 – Mother and Boyfriend

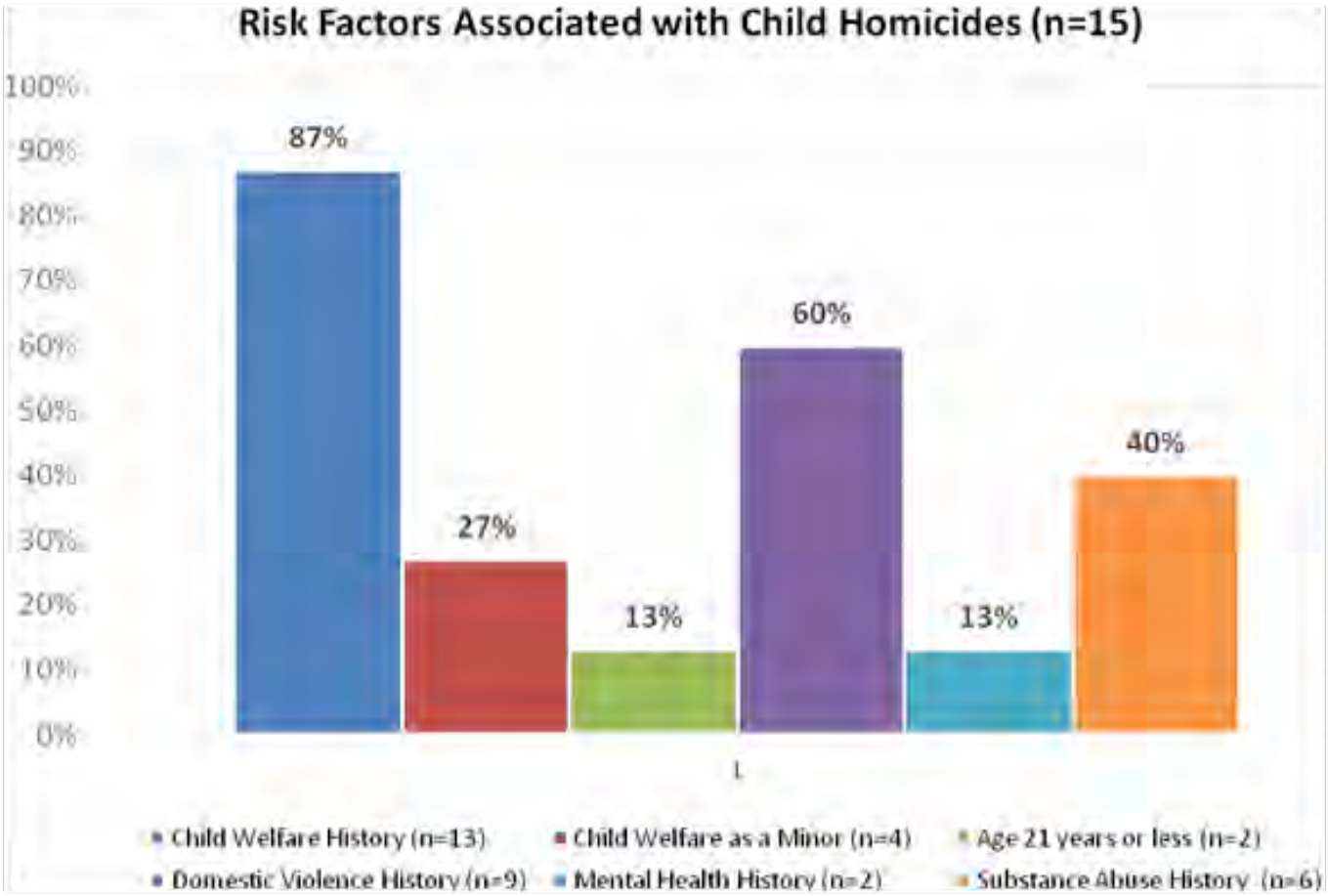
2 – Caregiver

1 – Adult's sister's live-in boyfriend

Relationship and Age of Suspects to Child – 2014

Relationship	Total	18-21 years	22-25 years	26-30 years	31-40 years	40+ years
Mother's Boyfriend/ Stepfather	2	0	2	0	0	0
Biological Mother	5	1	1	4	0	1
Biological Father	7	1	0	1	2	3
Caregiver	**2**	**0**	**1**	**0**	**0**	**1**
Adult Sister' Boyfriend	**1**	**0**	**0**	**1**	**0**	**0**
Total	**19**	**2**	**4**	**6**	**2**	**5**

Characteristics Present in the Families of Child Homicides



The top common characteristic present in families in which a homicide occurred was a parent(s) and/or perpetrator with at least one prior child welfare contact. Sixty percent of the homicides had either a parent and/or the perpetrator with a documented history of domestic violence. Substance Abuse History, as determined by the presence at the time of death or a family history occurred in 40% or the child homicides.

Criminal Justice System Involvement

Information on the criminal justice system involvement in child homicides by parent/caregiver/family member is gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD) and the Los Angeles Sheriff's Department (LASD). Other police agencies participate in Team review of cases they have investigated. The law enforcement agencies and number of cases for which they are responsible for the investigation are shown in Table 1.

Table 1

Law Enforcement Agency Involvement in 2014 ICAN Child Homicide by Parent/Caregiver/Family Member

Agency	N	%
LASD	8	53.3
LAPD	4	26.7
Pomona P.D.	1	6.7
California Highway Patrol	2	13.3

The Los Angeles Sheriff's Department Homicide Bureau had investigative responsibility for a majority of the child homicides by parents/caretakers/family member with 53.3% (n=8). The Los Angeles Police Department had investigative responsibility for 26.7% (n=4) of the 2014 child homicides by parents/caretakers/family member. Twenty percent (n=3) of the cases were handled by jurisdictions other than LASD and LAPD.

There were a total of nineteen suspects in the fifteen homicide cases. Five of the 2014 cases involving child homicide by parents/caregivers/family member were not presented to the Dis-trict Attorney. The reasons why those cases were not presented are displayed in Table 2.

In 2014, three of the homicide cases were not submitted to the District Attorney because the perpetrator committed suicide. The second reason for law enforcement not presenting a case was that the case remains under investigation. One open investigation case pertains to a child who was beaten to death and the suspect passed a polygraph test. The other open investiga-tion involved a child who died due to medical neglect.

Table 2

Law Enforcement Reasons for Not Presenting 2014 ICAN Child Homicide by Parent/Caregiver/Family Member

	N	%
Under Investigation	2	40
Murder/Suicide	3	60
TOTAL	5	100

Table 3

Relationship of Perpetrators – 2014 ICAN Child Homicide by Parent/Caregiver/Family Member*

Relationship	ID'd by Police	Charged By DA
Mother	7	6
Father	5	3
Mother's Boyfriend	2	2
Caregiver	2	2

*excludes murder/suicide cases

The charges filed by the District Attorney in the past eight years are illustrated by Table 4. In 2014, 10 of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving 13 perpetrators. The District Attorney filed charges in all ten cases. Defendants were charged with Murder (187 (a) P.C.) on all the cases in which charges were filed.

Table 4

Criminal Charges Filed on 2008-2014 ICAN Child Homicide by Parent/Caregiver/Family Member

	2007	2008	2009	2010	2011	2012	2013	2014
Murder (187 (a) P.C.)	21	20	13	16	13	11	15	13
Assault on a child under 8 years resulting in death (273ab P.C.)	17	16	11	7	14	8	11	7
Child abuse leading to death of a child (273a(a) P.C.)	28	19	5	10	8	4	1	6
Child endangering (273a(1) P.C.)							1	1
Corporal punishment or injury of child (273d P.C.)	1							
Voluntary manslaughter (192a P.C.)	5	1		1	1			
Involuntary manslaughter (192b P.C.)	1	1						
Vehicular manslaughter DUI with gross negligence (191.5(a) P.C.)	1							
Vehicular manslaughter (192 (c) P.C.)								
Vehicular manslaughter for financial gain (192(c)(3) P.C.)								
Attempted murder (664/187 (a) P.C.)	1	12		3				
Attempted robbery of person (664/211 P.C.)								
Lewd and lascivious acts by force (288(b)(1) P.C.)						5		
Kidnapping (207a P.C.)	2							
Battery (242-243(e) 1 P.C.)	1			1				
Torture (206 P.C.)	1		3	1		1		1
Mayhem (203 P.C)								
Assault to commit rape/mayhem				1				
Vandalism (594 P.C.)	1							
Aiding and abetting a designated felony (32 P.C.)				1				
Financial gain from prospective adoptive parents (273(d)(a) P.C.)								
Possession of marijuana for sale (11359 H&S)				1				
Fleeing pursuing peace officer (2800.2(a) V.C.)								
Criminal storage of a weapon with access to a child				2				
Assault to commit rape/mayhem						1		
Vandalism (594 P.C.)			1					
Discharge of firearm inhabited dwelling (246 P.C.)								
Assault with semiautomatic weapon (245 (b) P.C.)								
Unlawfully causing a fire of any structure (451B)	1							
Aiding and abetting a designated felony (32 P.C.)	3					1		
Financial gain from prospective adoptive parents (273(d)(a) P.C.)								
Possession of marijuana for sale (11359 H&S)	2					1		
Unlawful to drive while DUI (23153(a) V.C.)	1							
Unlawful to drive with .08% or more DUI (23153(b) V.C.)	1							
Failure to stop @ accident scene resulting in injury/ death (20001(a) V.C.)	1							
Flight of peace officer causing serious bodily harm (2800.3 V.C.)	1							
Fleeing pursuing peace officer (2800.2(a) V.C.)	1							
Criminal storage of a weapon with access to a child						2		

Table 5

Criminal Case Disposition of 2009 – 2014 Child Homicides[2]

	2009	2010	2011	2012	2013	2014	2013	2014
Life without possibility of parole		2	2	1			15	13
80 years to life prison		1	1					
56 years to life prison				1				
50 years to life prison	1	1	1	1				
40 years to life prison	1			1				
31 years to life prison					1	1		
26 years to life prison								
25 years to life prison	2	7	4	2	5	3		
22 years to life prison					1			
19 years to life prison								
18 years to life prison								
17 years to life prison	1		1					
16 years to life prison				1				
15 years to life prison	2		1	1		3		
14 years to life prison		1	2					
26 years prison	3	1		2	1	1		
25 years prison					1	1		
16 years prison						1		
13 years prison	1			1				
12 years prison	1	1	1					
11 years prison	1	2	1	2	2			
10 years prison	1	1	1	1				
9 years prison				2				
8 years prison		1						
7 years prison				1				
6 years prison	1	1	2	2	1	1		
5 years prison		1	2		1			
4 years prison	1	1				1		
2 years prison								
16 months prison								
3 years jail			1					
1 year jail		1	2	1				
9 months jail								
Less than 3 months jail	1							
5 yrs Probation								
Found not guilty			1		1			
Dismissed		1		1		3		
Arrest warrant		1						
Mental competency hearing	1							
Pending trial			5	3	15	13		
Pending Further Investigation	2				4			

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

Criminal disposition data for 2009 through 2014 is presented in Table 5. The table reflects the year a perpetrator was sentenced and the majority of cases are concluded one to two years after the filing date. Of the 2014 child homicides, none of those charged had a disposition in 2014.

In 2014, defendants received the following sentences from previous year's cases: Three perpetrators were sentenced to 25 years to life in prison and three were sentenced to 15 years to life. One perpetrator was sentenced to one to 31 years to life. The remaining sentences varied from 4 to 26 years in prison.

For 2009, two cases are still under investigation. One 2010 defendant was sentenced to 31 years to life in 2014. Two 2010 defendants were found guilty of murder and are still awaiting sentencing. Five of the 2011 cases filed by the DA remain pending trial as of 2014. There were convictions for 2011defendants in 2014. One was sentenced to 26 years in state prison and one 15 years to life. A third defendant is awaiting sentencing. Three of the 2012 cases remain pending trial as of 2014. Three 2012 defendants were convicted in 2014 and received sentences ranging from 6 years in state prison to 25 years. Fifteen of the 2013 cases filed by the District Attorney are awaiting trial. Three defendants were found guilty. One was sentenced to 4 years and one 15 years to life in state prison. The third defendant is awaiting sentencing.

Table 6

Child Homicides by Parents, Caregivers or Family Member
Child Welfare Involvement 2000 – 2014*

Year	Total # of homicides by parent/care giver/family member	Total # of homicides with DCFS family history(prior contact OR open case)	Of total with DCFS family history, the # of homicides that had PRIOR DCFS contact only	Of total with DCFS family history, the # of homicides in OPEN DCFS case or referral	# Killed by out-of-home caregiver
2000	35	15	7	8	2 – relative caregivers 0 – foster parent
2001	35	12	7	5	3 – relative caregivers 2 – foster parent
2002	37	Not Available	Not Available	Not Available	0 – relative caregivers 1 – foster parent
2003	35	18	13	5	2 – relative caregivers 2 – foster parent
2004	30	15	9	6	2 – relative caregivers 0 – foster parent
2005	33	14	11	3	1– relative caregivers 0 – foster parent
2006	35[3]	11	9	2	1– relative caregivers 0 – foster parent
2007	26	12	10	3[4]	1 – relative caregivers 0 – foster parent
2008	34	14[5]	6	8	0 – relative caregivers 0 – foster parent
2009	29[6]	19[7]	14	5[8]	1 – relative caregivers 0 – foster parent
2010	26	13[9]	9	4	0– relative caregivers 1 – foster parent
2011	24	6	2	4	0 – relative caregivers 0 – foster parent
2012	15	7	4	3[10]	0 – relative caregivers 0 – foster parent
2013	19	11	7	4[11]	0 – relative caregivers 0 – foster parent
2014	15	12[12]	7	5	0 – relative caregivers 0 – foster parent

*Data is based on the Coroner's findings as Homicide and not the broader definition used by DCFS based on SB 39 Child Fatality Reporting and Disclosure Requirements

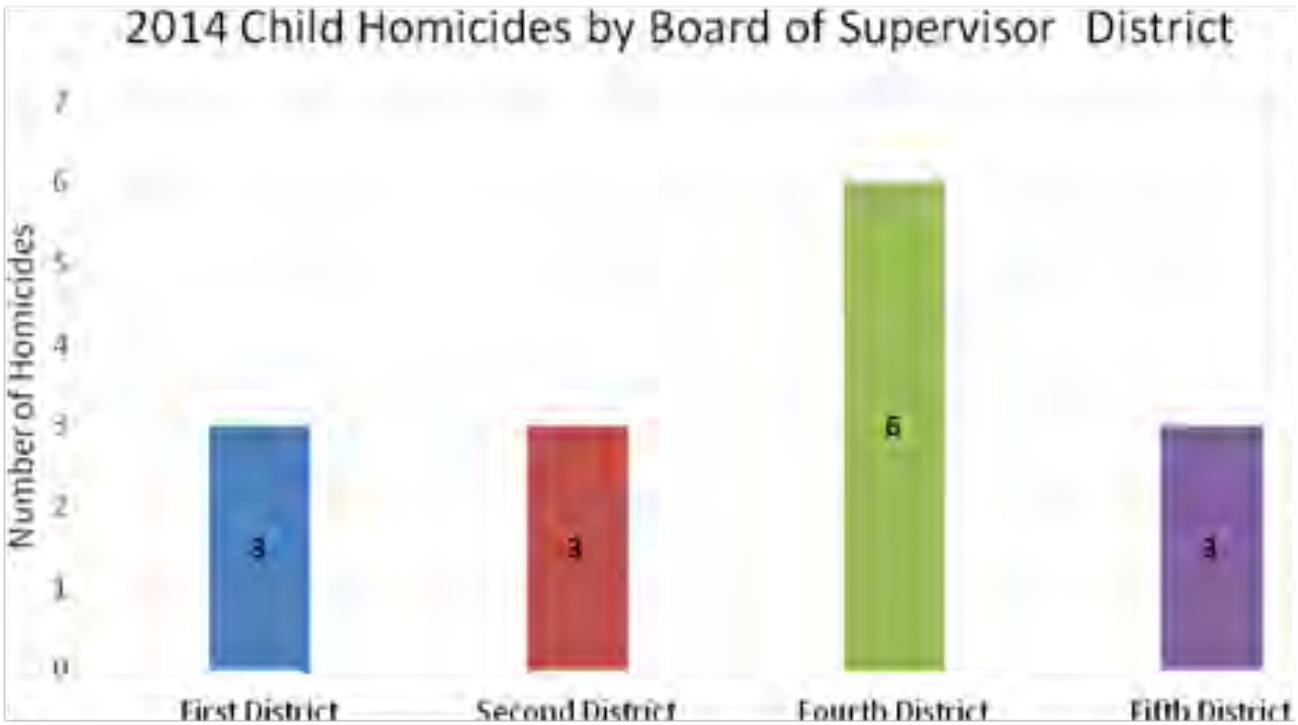
3. The CDRT reviewed an undetermined child fatality and changed the manner of death to "homicide". The case was open to DCFS when the fatality occurred. Another open DCFS case with a homicide was autopsied in another county and not reported to ICAN for inclusion in the 2007 report.
4. One was open to another county.
5. ICAN counts only deaths in LA County ruled a homicide by the Coroner. Two children died in LA County but were injured in another county and under that county's CPS supervision.
6. In 2011, a homicide suspected of a familial relationship turned out to be a family acquaintance and it became a 3rd Party homicide. The 2009 homicides decreased from 30 to 29 as a result.
7. Includes two deaths with a CPS history in another state and one death with history in another county.
8. One child died in LA County was under the jurisdiction of Riverside CPS.
9. One child died in LA County had history in another county but not in LA County.
10. One child was killed by a caregiver who had an open case with DCFS.
11. One case was open due to the child's injuries before death. The family had no prior DCFS history.
12. The mother in one case did not have a history with DCFS but the caregiver/perpetrator did. This case is not reflected in this table as the child was not placed with the caregiver by DCFS but by the mother.

Dates[13] of Child Homicides – 2014

1 homicide occurred in January (01/06/2014)
0 homicides occurred in February
1 homicide occurred in March (03/21/2014)
1 homicide occurred in April (04/16/2014)
5 homicides occurred in May (05/09, 3 on 5/20 & 5/27/2014)
1 homicide occurred in June (6/30/2014)
0 homicides occurred in July
2 homicides occurred in August (08/10 & 08/31/2014)
1 homicide occurred in September (09/09/2014)
1 homicide occurred in October (10/05/2014)
0 homicides occurred in November
2 homicides occurred in December (both on 12/08/2014)

Locations[14] of Child Homicides – Geographic Area – 2014

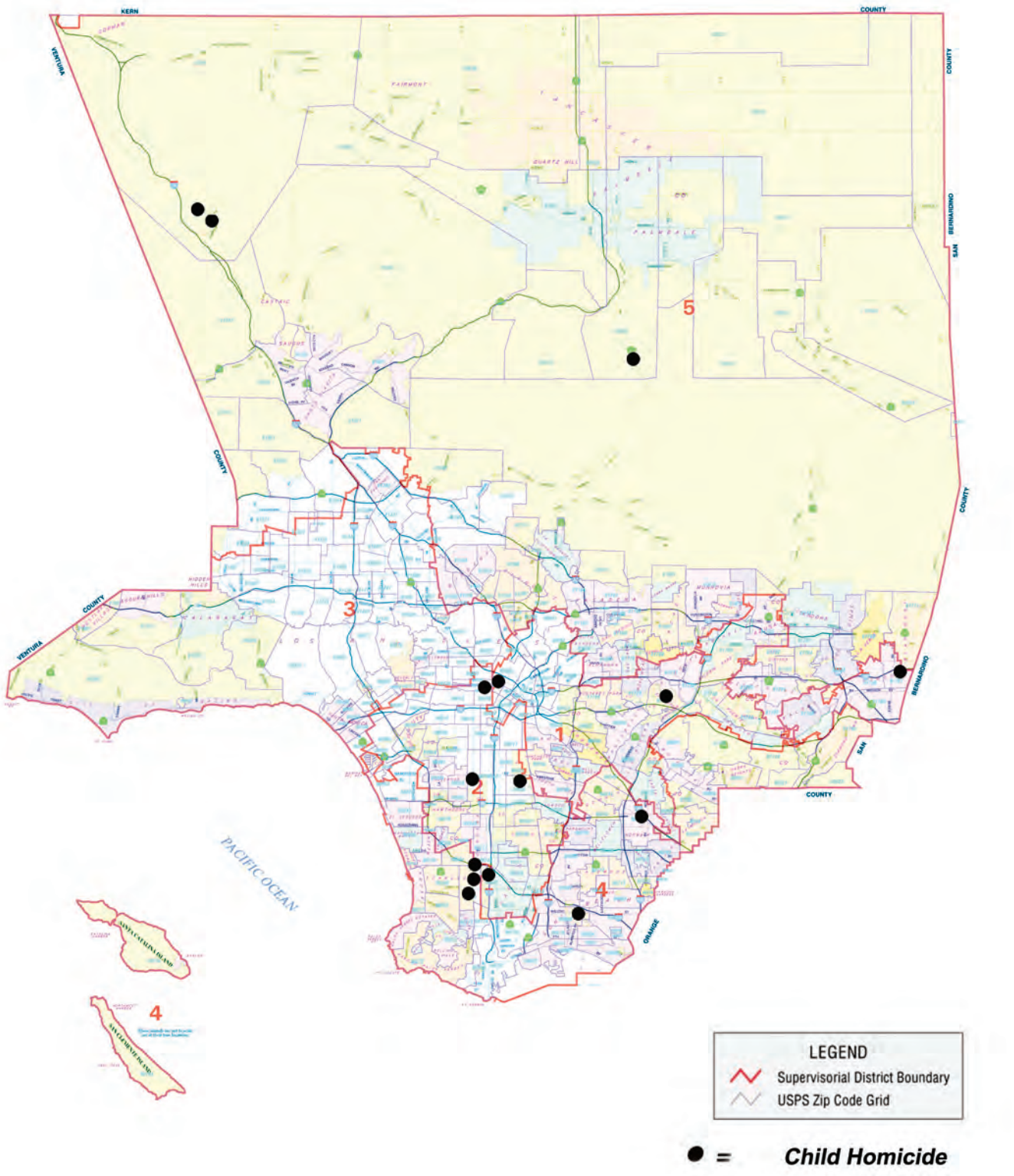
1 homicide occurred in Los Angeles (zip code 90004)
1 homicide occurred in Los Angeles (zip code 90037)
1 homicide occurred in Los Angeles (zip code 90043)
1 homicide occurred in Los Angeles (zip code 90057)
1 homicide occurred in Whittier (zip code 90605)
1 homicide occurred in Covina (zip code 91723)
1 homicide occurred in Hawthorne (zip code 90250)
1 homicide occurred in La Puente (zip code 91744)
1 homicide occurred in Inglewood (zip code 90302)
1 homicide occurred in South El Monte (zip code 91733)
1 homicide occurred in Baldwin Park (zip code 91706)
2 homicides occurred in Downey (zip code 90242)
2 homicides occurred in Palmdale (zip code 93550)
2 homicides occurred in Lancaster (zip code 93534)
1 homicide occurred in Long Beach (zip code 90806)
1 homicide occurred in Carson (zip code 90746)



13. This is the date of death, which, in the majority of cases coincides with the date the injury occurred leading to the child's death.
14. City where the fatal injury or fatality occurred

2014 Child Homicides

N = 15



Case Summaries

Alejandra

Alejandra was a 16-year-old Hispanic female with a history of depression and suicidal thoughts in the year prior to her death. She also had a history of cutting behavior. She had ended her relationship with her boyfriend two weeks prior to her death. Alejandra was residing with relatives due to her mother being incarcerated. She was reported to be depressed because of her mother's absence. Her Aunt and Uncle went to attend a family function which Alejandra declined to attend. When they returned home, they could not find Alejandra. The family searched the home and found Alejandra hanging from a beam in the garage by a belt. They immediately cut her down and called 911. Paramedics arrived and death was called at the scene. No suicide note was found but she had sent various texts to families saying "good-bye" hours before she was found.

David

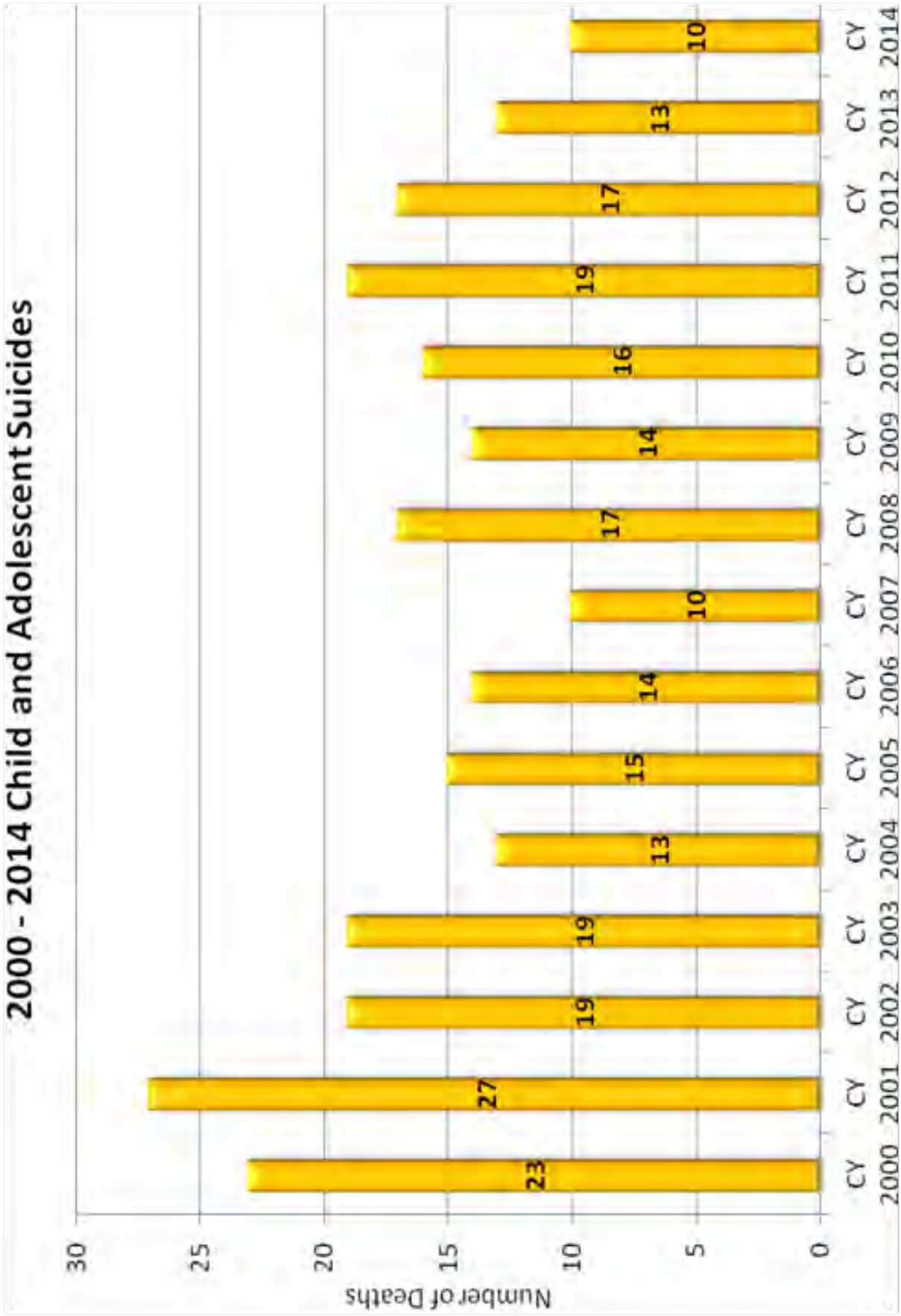
David, a 14-year old, Asian male, was found with a gunshot to the head in the family bathroom after his mother went to check on him. She had heard a loud thud but not a gunshot. 911 was immediately called but he was pronounced at the scene. David was identified early on as an at risk child by the school district that conducts a universal depression screening on all 9th graders in their district. Some of the David's behaviors were described as having difficulty with social cues, attention deficit, difficulty with homework, poor grades, and poor peer relations. There were also concerns noted by the his school counselor. Resources and services were offered to the David; however, the family declined any assistance offered by the school. The gun belonged to David's father who kept it locked in a box in the parent's bedroom closet. The key was hidden under some papers in a drawer. The key was found in the drawer after the suicide. His parents did not believe he took his own life and think he was trying to take a picture with the cell phone found in the bathroom. No suicide note was found.

Hector

Hector, a 12 year old Hispanic male, hung himself with a belt in his bedroom closet. His mother had returned from work and found him hanging. She ran to the kitchen to grab a knife and cut him down. She laid him on the floor and called 911.

The mother was asked about her son and she told the responding officer that she believed her son was suffering from depression, but had not been diagnosed. There were no arguments before the decedent went to school that day. She did, however, report two prior suicide attempts. One year ago, Hector was found by his older brother in a bathtub with an extension cord wrapped around his neck. Two weeks ago, he was found again with red marks around his neck but shrugged them off when asked.

His mother reported that he began having behavioral problems in school this past year. He had a cleft palate and was a bullying victim. The school said he was doing well this year and playing sports, but there were rumors around school of a breakup with his girlfriend. He had been seeing a school counselor for the past year and had been recently referred for additional mental health treatment. He reportedly hated therapy sessions, felt stressed and disliked them greatly. There was a current open DCFS referral of emotional abuse regarding a verbal altercation and possible domestic violence in the home between the mother and her boyfriend. He did not leave any note or indication as to why he might take his life.


2000 - 2014 Child and Adolescent Suicides
Number of Deaths
0
5
10
15
20
25
30
CY 2000
CY 2001
CY 2002
CY 2003
CY 2004
CY 2005
CY 2006
CY 2007
CY 2008
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
CY 2014
23
27
19
19
13
15
14
10
17
14
16
19
17
13
10

Child and Adolescent Suicides by Method and Gender

Los Angeles County – 2014 (n = 10**)**

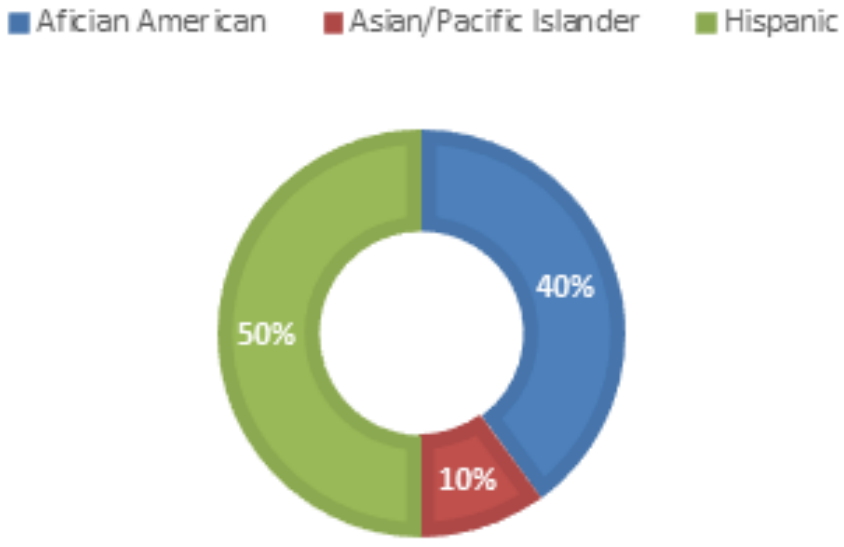
Method	Male	Female
Hanging	3	4
Firearms/Gunshot	3	0
TOTAL	6	4

Hanging was the most frequent method of suicide among adolescents and represents 70% of the suicides in 2014. Use of a firearm was the second most frequent method of suicide in 2014 with three.

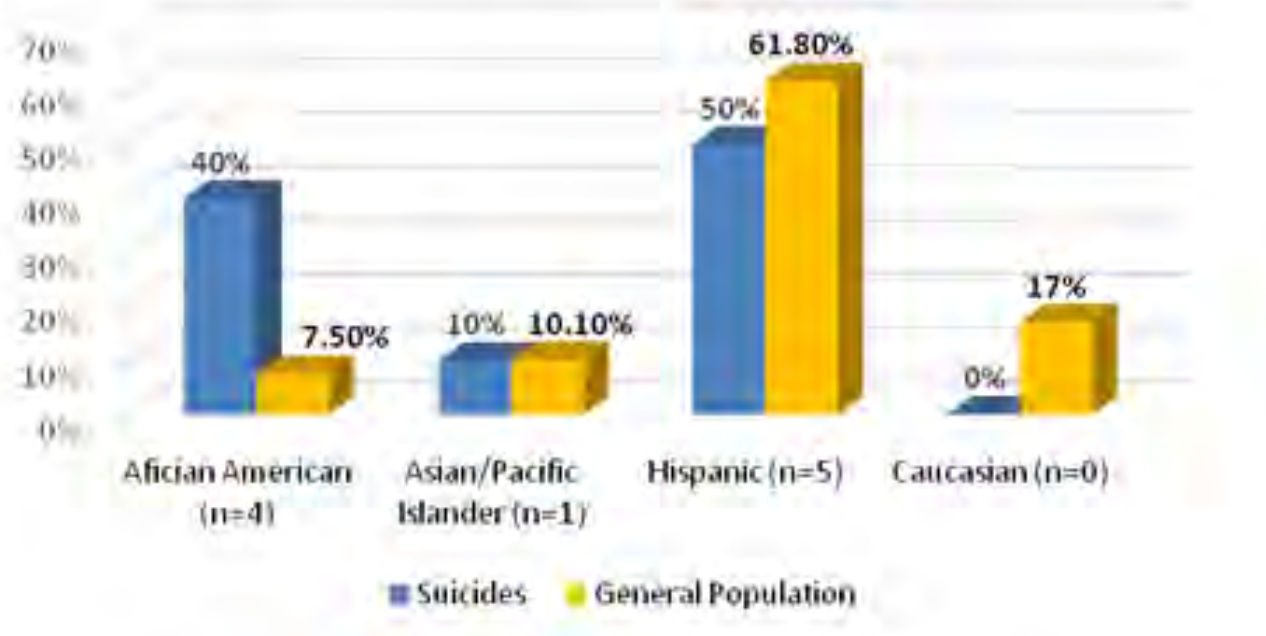
In 2014, the gap between males and females ending their own lives declined to almost even numbers. 40% (n=4) of the adolescent suicide victims were female. 60% (n=6) of the victims of adolescent suicide in 2014 were male. The shift to male and female victims having similar rates began in 2011. Prior to 2012, males generally outnumbered the females by a 3:1 margin.

Gender	2010	2011	2012	2013	2014	Total 2010-2014	5 Year Average
Male	11	11	8	5	6	41	8.2
Female	5	8	9	8	4	34	6.8
Total	16	19	17	13	10	75	15.0

2014 CHILD AND ADOLESCENT SUICIDES - RACE

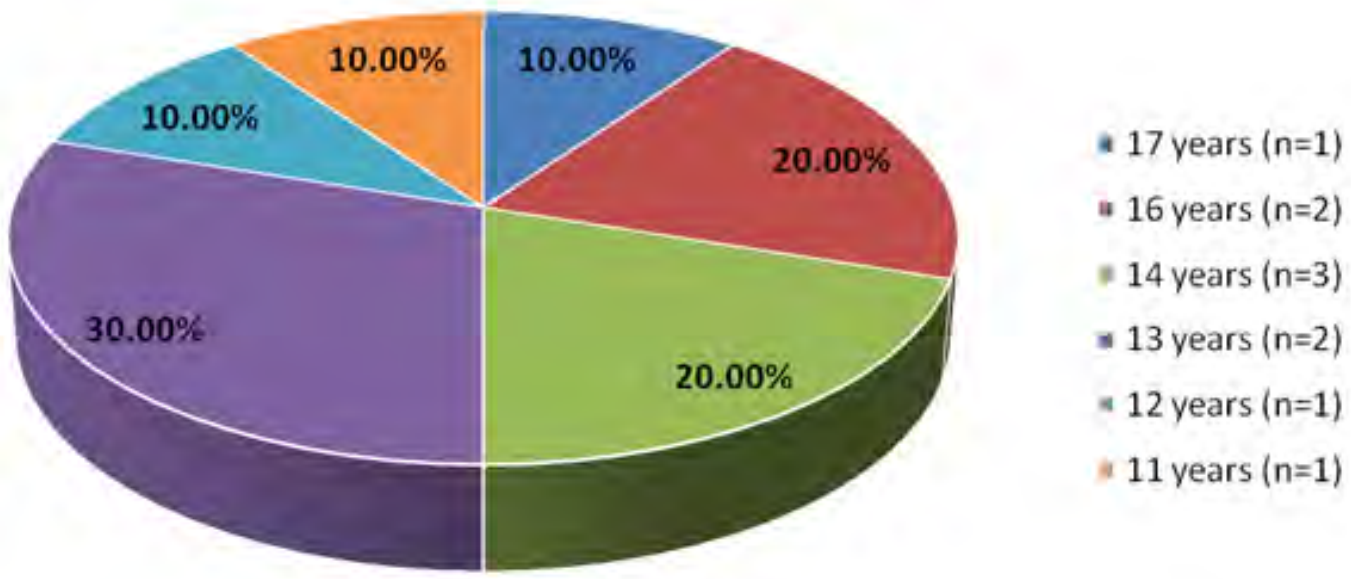


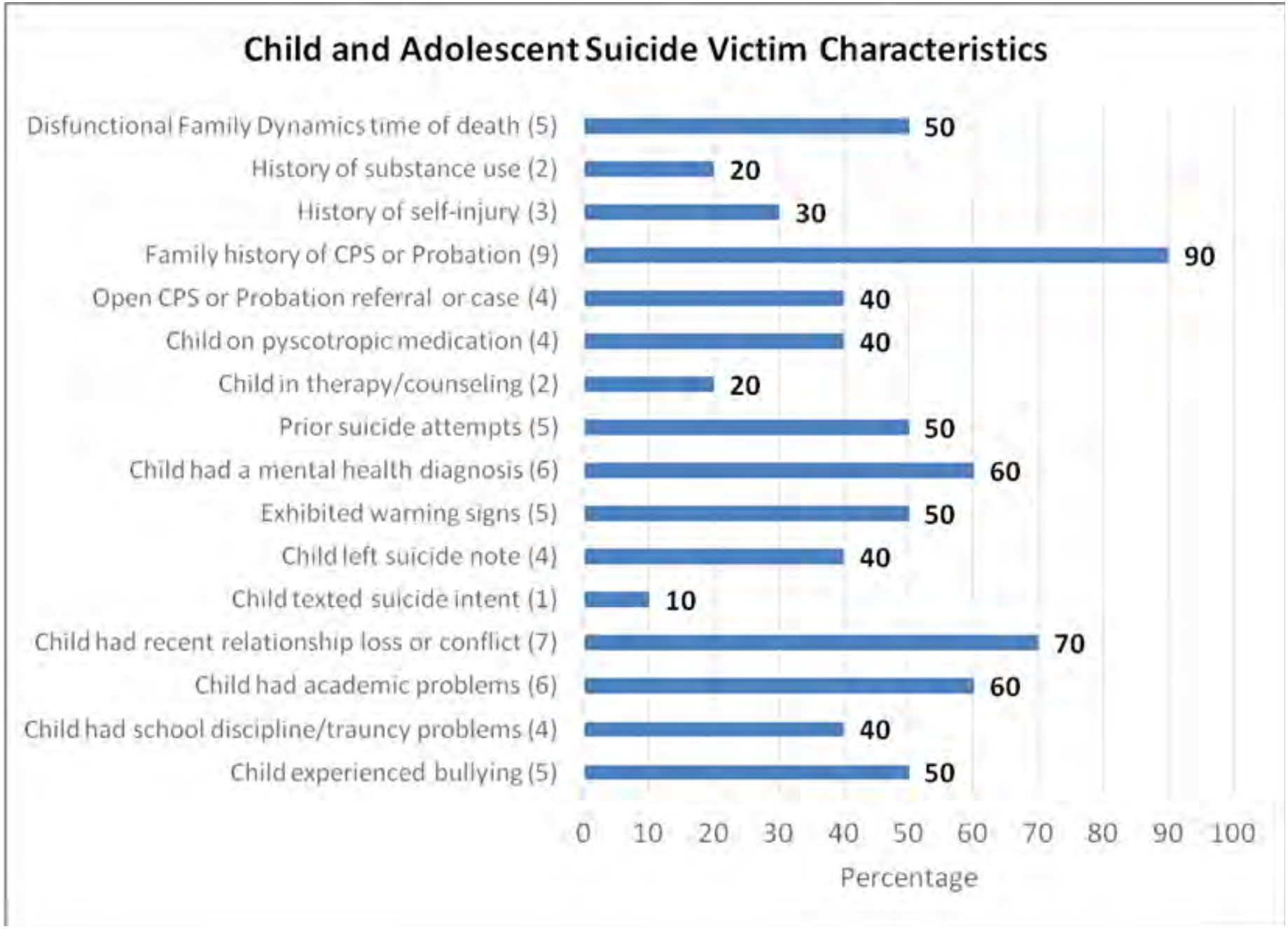
Suicides of Children by Race Compared to General Population 2014



Five Year Trend by Age							
	2010	2011	2012	2013	2014	Total	Percentage
Age							
17 years	7	6	7	4	1	25	33.3
16 years	2	5	3	4	2	16	21.3
15 years	4	3	5	2		14	18.7
14 years	2	2	2	1	3	10	13.3
13 years		2		1	2	5	6.7
12 years		1			1	2	2.7
11 years	1			1	1	3	4.0
Total	16	19	17	13	10	75	100

2014 Child and Adolescent Suicides - Age




Child and Adolescent Suicide Victim Characteristics
Disfunctional Family Dynamics time of death (5)
50
History of substance use (2)
20
History of self-injury (3)
30
Family history of CPS or Probation (9)
90
Open CPS or Probation referral or case (4)
40
Child on pyscotropic medication (4)
40
Child in therapy/counseling (2)
20
Prior suicide attempts (5)
50
Child had a mental health diagnosis (6)
60
Exhibited warning signs (5)
50
Child left suicide note (4)
40
Child texted suicide intent (1)
10
Child had recent relationship loss or conflict (7)
70
Child had academic problems (6)
60
Child had school discipline/trauncy problems (4)
40
Child experienced bullying (5)
50
0 10 20 30 40 50 60 70 80 90 100
Percentage

Dates of Child and Adolescent Suicides – 2014

1 suicide occurred in January (01/14/2014)
1suicide occurred in February (02/03/2014)
0 suicides occurred in March
0 suicides occurred in April
3 suicides occurred in May (05/06, 05/12 & 05/16/2014)
0 suicides occurred in June
1 suicide occurred in July (07/02/2014)
1 suicide occurred in August (08/01/2014)
0 suicides occurred in September
1 suicide occurred in October (10/31/2014)
2 suicides occurred in November (11/03 & 11/23/2014)
0 suicides occurred in December

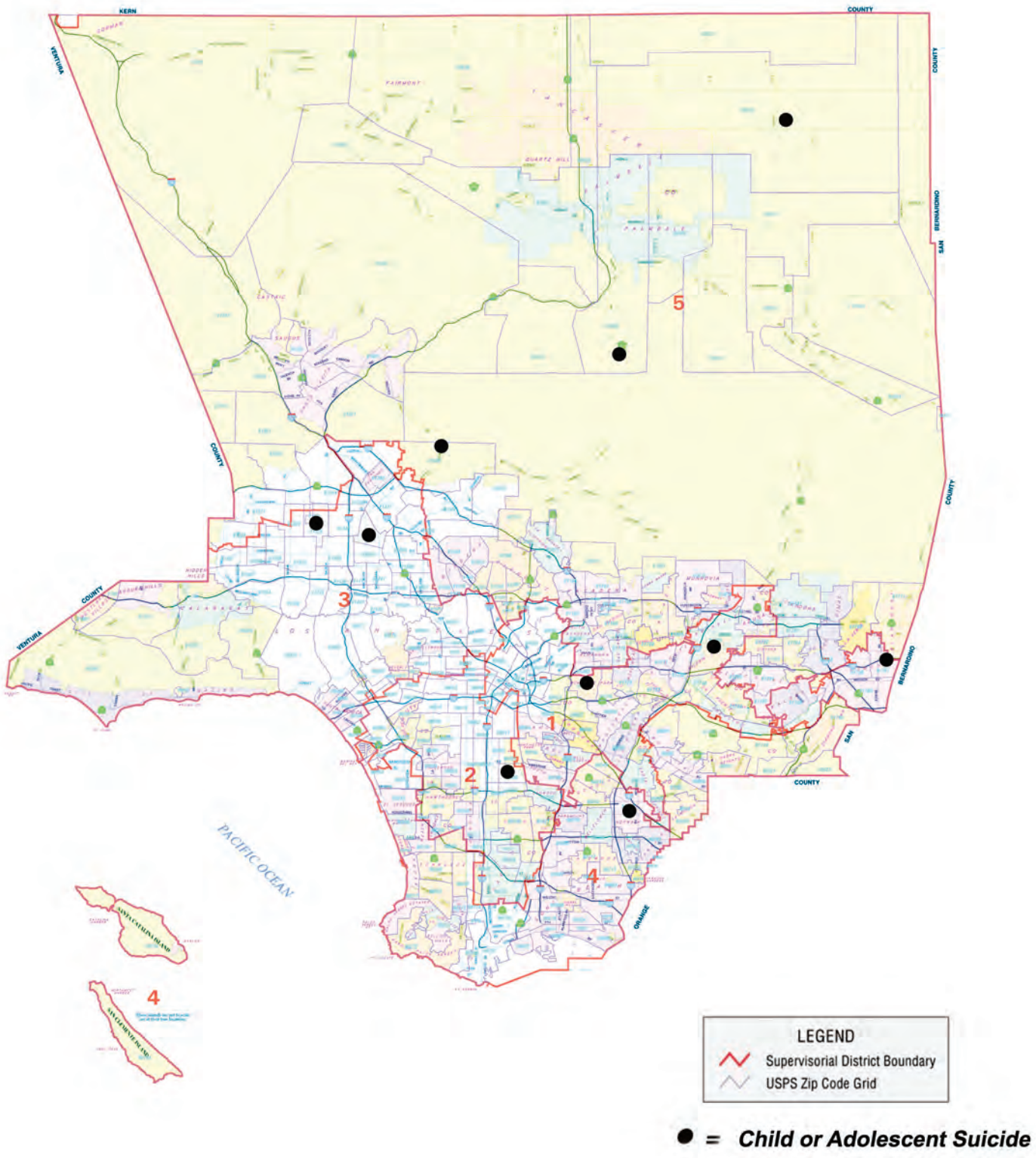
Locations[15] of Child and Adolescent Suicides – Board of Supervisorial District – 2014

First District – 3
Second District – 1
Third District – 3
Fourth District – 1
Fifth District – 2

15. City where the suicide occurred.

2014 Adolescent and Child Suicides

N = 10



Case Summaries

Jenny

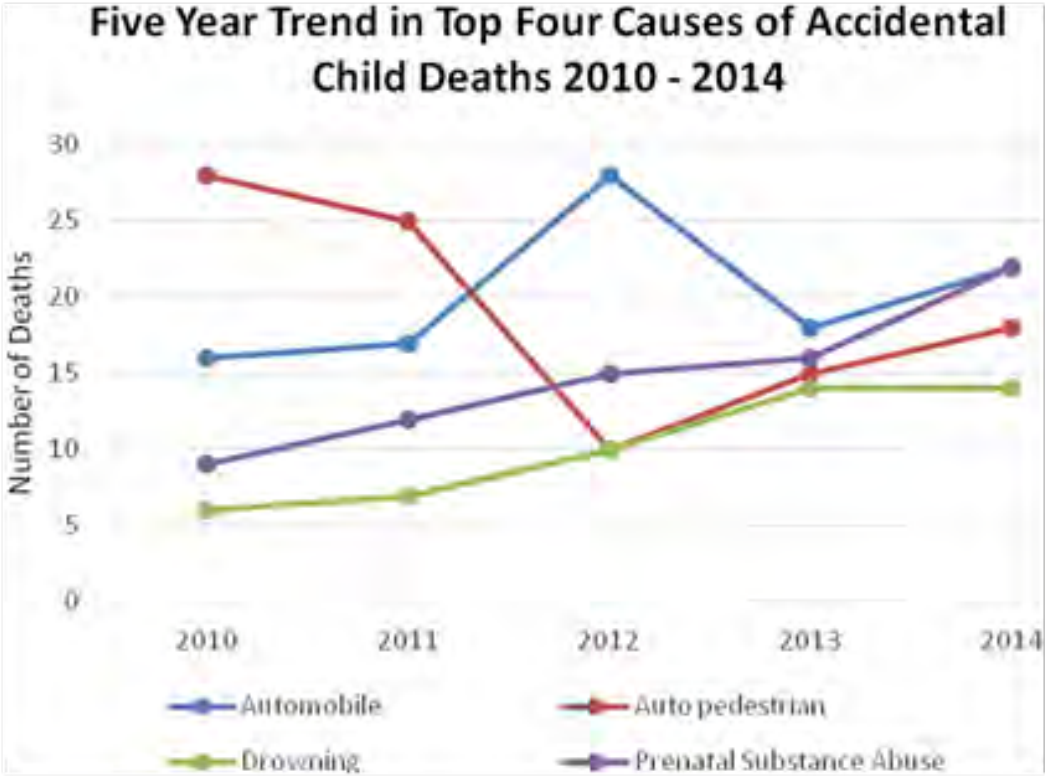
Sixteen month-old Jenny was at home with her family. The front door to the home was open and her seven-year old and five-year old siblings were playing in the front yard. Her grandparents were on their way to the market. The grandfather was slowly backing out of the driveway in his SUV when he heard a loud noise and stopped. The grandparents got out of the car and saw Jenny lying on the ground under the car. The parents rushed her to the local hospital that transferred her to County LAC+USC by ambulance for a higher level of care. She had multiple traumatic internal injuries and passed later that day. The grandparents' car was an older model and did not have a back-up camera. The grandfather reported he looked in his mirrors while backing up but did not see the toddler.

Maria

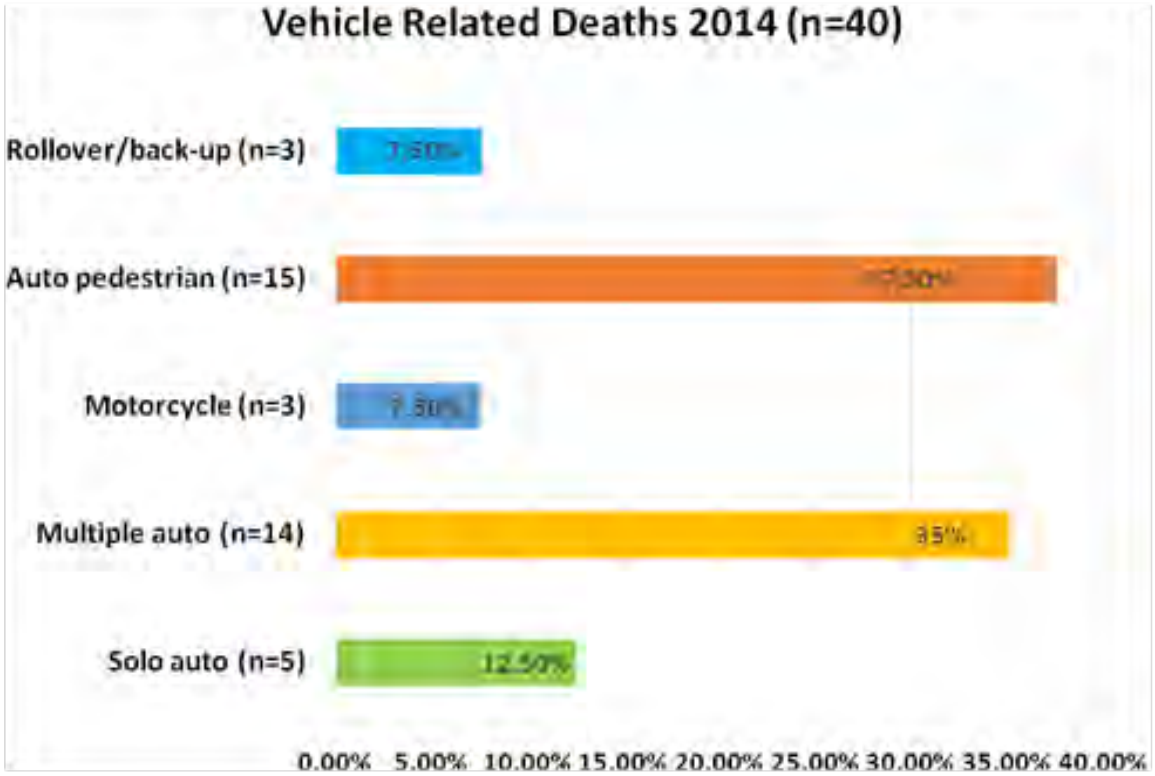
Twenty year old Maria went to the hospital with abdominal pain. She tested positive for amphetamine and methamphetamine and reported she did not know she was pregnant. She was discharged from the hospital the next day. Two months later, she returned to the hospital in labor. She had not received prenatal care. An abruptio placenta was diagnosed and her baby was born via cesarean section. The infant girl weighed two pounds eleven ounces and was 29 weeks gestation. She was placed in the neonatal intensive care unit where she developed respiratory distress and went into cardiac arrest. Maria reported she had used methamphetamine just prior to her hospital admission and she tested positive for methamphetamine. Maria had referrals to DCFS when she was a minor. DCFS detained her 1 year-old child as a result of her drug use and the home found to be in a filthy condition.

Abel

18 month-old Abel was playing with his older siblings in a bedroom while his father was doing laundry. After a few minutes, the father went to check on the children and Abel was not with his siblings who were watching TV. He went through the house than to the back patio searching for Abel. He saw him floating face up in the deep end of the pool. The father pulled Abel out of the pool. A neighbor heard his scream and called 911 and assisted with CPR. Foam was noted during chest compressions and Abel was transported to the hospital where he was pronounced. The family surmised he had crawled through the doggie door to the patio. They had seen him chase the dog and go through the door in the past. Normally, there is a locked gate blocking the patio from the rest of the backyard. The gate was supposed to self-shut but needs to be intentionally closed to lock. Abel must have been able to push the gate open and fell into the pool



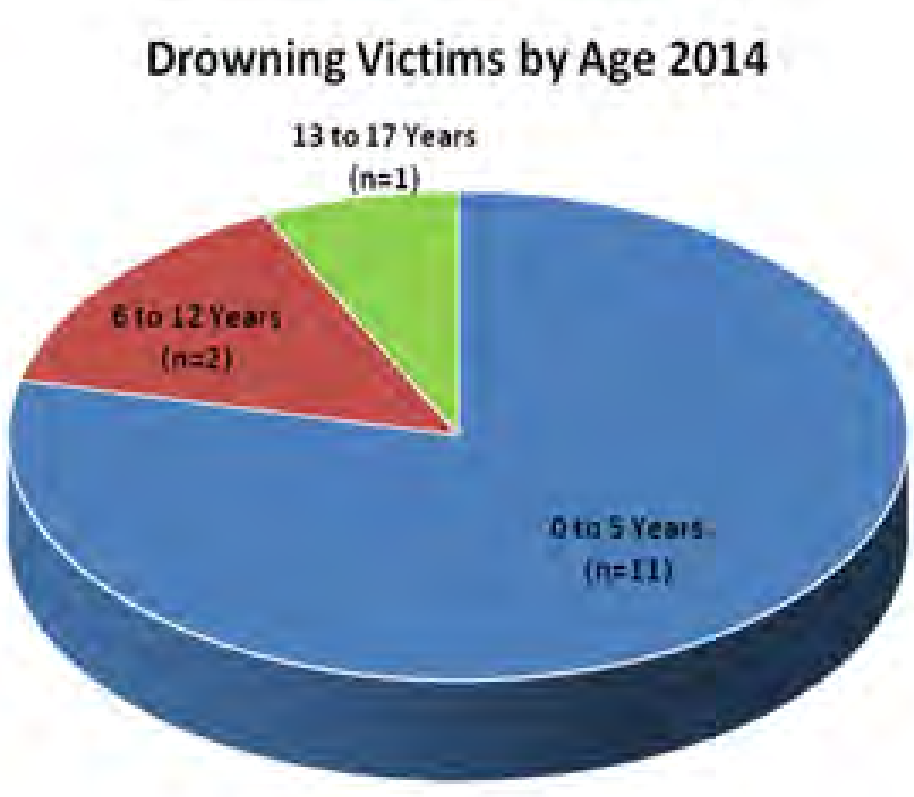
The chart above depicts the top four causes of accidental child death over a five year period from 2010 to 2014. The "top four" causes-automobile, auto pedestrian (includes roll over), drowning and prenatal substance abuse accounted for 73.8% of all accidental child deaths in 2014.

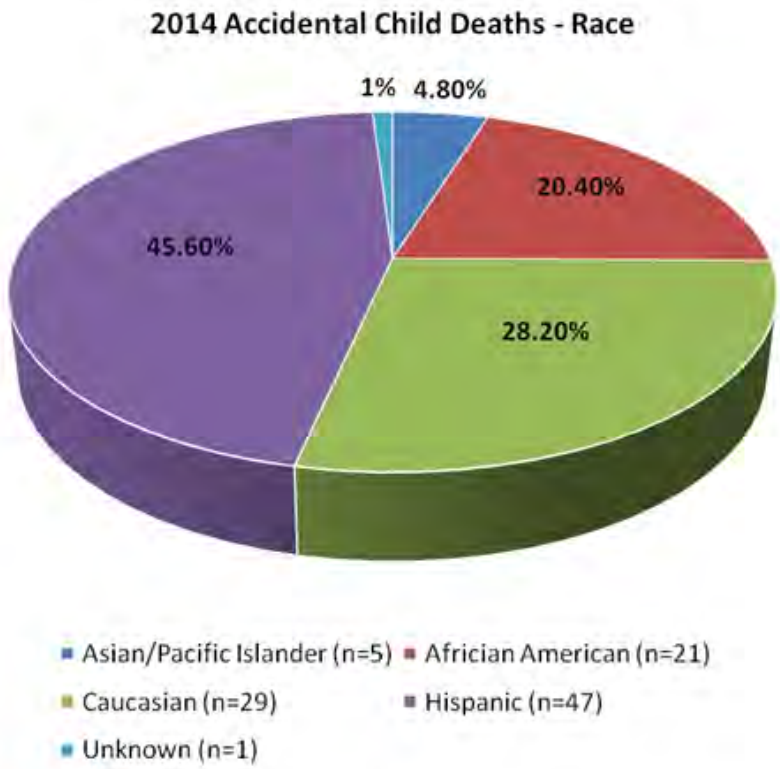


Causes of Accidental Child Deaths by Age, 2014 – Los Angeles County (N = 104)

	Age 0 – 5 years	Age 6 – 14 years	Age 15 – 17 years	Total	Percentage
Automobile – multi-vehicle	6	4	4	14	13.6%
Automobile – solo vehicle	0	1	4	5	4.9%
Motorcycle	0	0	3	3	2.9%
Auto pedestrian*	9	3	6	18	17.5%
Train vs. pedestrian	0	0	1	1	1.0%
Prenatal Substance Abuse	22	0	0	22	21.3%
Drowning	11	3	0	14	13.6%
Hit by Object	2	0	1	3	2.9%
Overdose	0	0	4	4	3.9%
Fall	0	0	1	1	1.0%
Fire	0	2	0	2	1.9%
Medical mishaps	2	1	0	3	2.9%
Choking	2	0	0	2	1.9%
Asphyxia	5	0	1	1	1.0%
Unsafe/Co-sleep	3	0	0	3	2.9%
Anaphylaxis	1	0	0	6	5.8%
Hypothermia	1	0	0	1	1.0%
TOTAL	64	14	25	103	100%

*includes auto-rollover. Rollover totals included in parenthesis.





Los Angeles Child Population Ages 0-17: 2,328,466

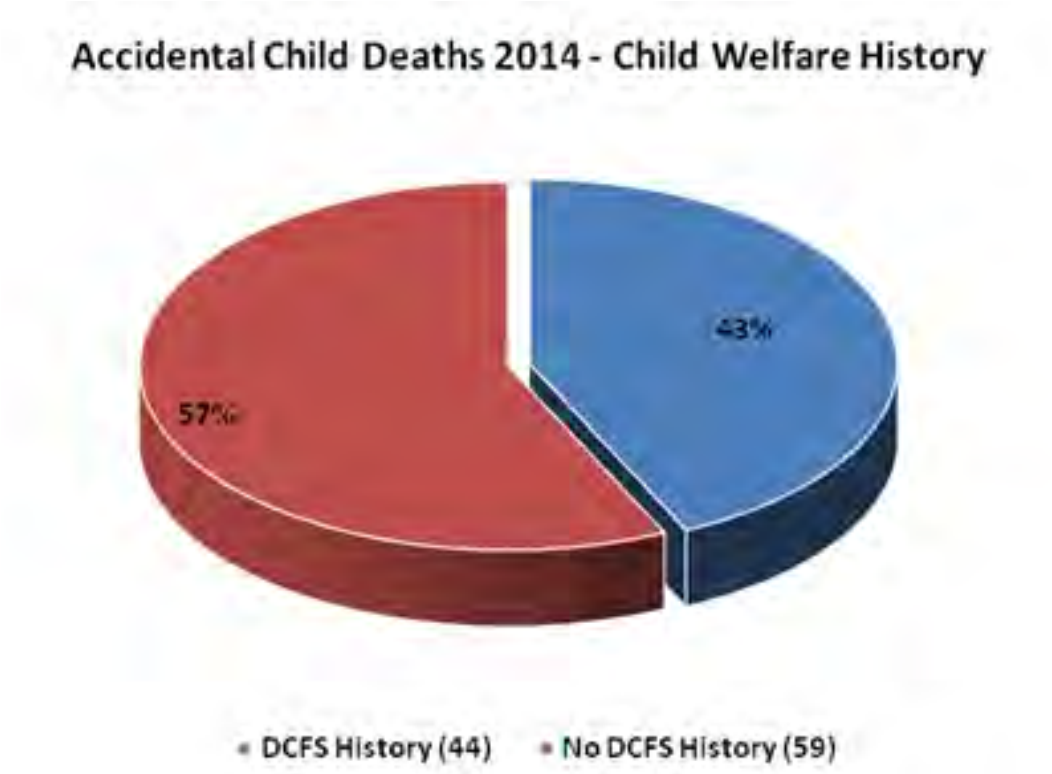
Hispanic 61.8%, Caucasian 17.1%, African American 7.5% , Asian/Pacific Islander 10.1%, Native Indian/Alaskan .1% and Multi-racial 3.1% Kidsdata.org

Causes of Accidental Child Deaths by Gender 2014 – Los Angeles County (N = 103)

	Female	Male	Unknown
Automobile – multi-vehicle	5	9	0
Automobile –single	2	3	0
Motorcycle	0	3	0
Auto rollover	1	2	0
Auto Pedestrian	4	11	0
Drowning	2	11	1
Overdose	2	2	0
Prenatal Substance Abuse	5	16	1
Medical mishaps	0	3	0
Hit by object	1	2	0
Fire	1	1	0
Choking	0	2	0
Fall	0	1	0
Asphyxia	5	1	0
Anaphylaxis	0	1	0
Unsafe/Co-sleep	1	2	0
Hypothermia	0	1	0
Train vs. Pedestrian	1	0	0
TOTAL	30	71	2

Accidental Child Deaths Associated with Prenatal Substance Abuse (PSA)
2014 (N = 22)

Race	Number/Percentage of PSA Deaths
African American	6 (27%)
Caucasian	4 (18%)
Hispanic	11 (50%)
Unknown	1 (5%)
Gender	
Female	16 (73%)
Male	5 (23%)
Unknown	1 (4%)
Age	
Stillborn	18 (82%)
1 day to 30 days	4 (18%)



Causes of Accidental Deaths with Child Welfare History - 2014 (n=44)

	Number	Percentage
Automobile*	4	9
Auto pedestrian**	11	25
Drowning	6	13.6
Overdose	2	4.5
Prenatal Substance Abuse	14	32
Choking	1	2.3
Asphyxia	2	4.5
Medical mishap	1	2.3
Hit by object	2	4.5
Hypothermia	1	2.3
TOTAL	44	100

*includes motorcycle

**includes rollover

Case Summaries Undetermined Child Deaths

Unsafe Sleep Practices and/or Environments and Maternal Substance Use

Lisa – Age 23 days

Lisa's mother breast fed her and went to bed. The father stayed up and heard Lisa cry. He attempted to have the mother feed Lisa but the infant did not want to eat. He changed her diaper and swaddled her in a wrap with Velcro closures. He placed the infant next to the mother who breast fed her as Lisa was lying in the center of the bed between the parents. Everyone fell asleep. The mother awoke three hours later to find Lisa near the edge of the bed. She was limp and warm. Some blood had drained from her nose and mouth. The father performed CPR while the mother called 911. Lisa was transported to the hospital where she never regained consciousness.

Daniel – Age 1 year

Daniel's mother routinely slept with him in her queen size bed. She awoke in the morning and got up to fix Daniel a bottle. When she returned to feed him, he was lying prone with his face turned toward the bedding. His eyes were closed and his body was stiff. His arms were warm and hung down. She attempted to wake him and he did not respond. 911 was called by the grandfather and Daniel was pronounced at the scene. The mother reported only she and Daniel were in the bed. When interviewed, his five year-old sister reported that she, and, her two year-old brother were also sleeping in the bed. The three year-old cousin placed by DCFS was sleeping in Daniel's crib.

Hector – Age 1 day

Hector was born via caesarian section with multiple physical abnormalities 32 weeks gestation. He died within hours of his birth. His mother denied any drug or alcohol abuse and reported she had received prenatal care out of state. The hospital tested both the mother and newborn and they were positive for methamphetamine. The mother has prior contacts with DCFS and multiple drug and willful cruelty to a child arrests. She was currently receiving family reunification services from DCFS for older siblings.

Hailey – Age two and a half months

Hailey was placed to sleep on her parents' bed for a nap. She was swaddled in a thick San Marcos blanket and placed on her side. When her mother went to wake her, she was found face down in the pillow top mattress unresponsive. Her mother called 911 and performed CPR until paramedics arrived. Hailey was transported to the ER but she could not be resuscitated.

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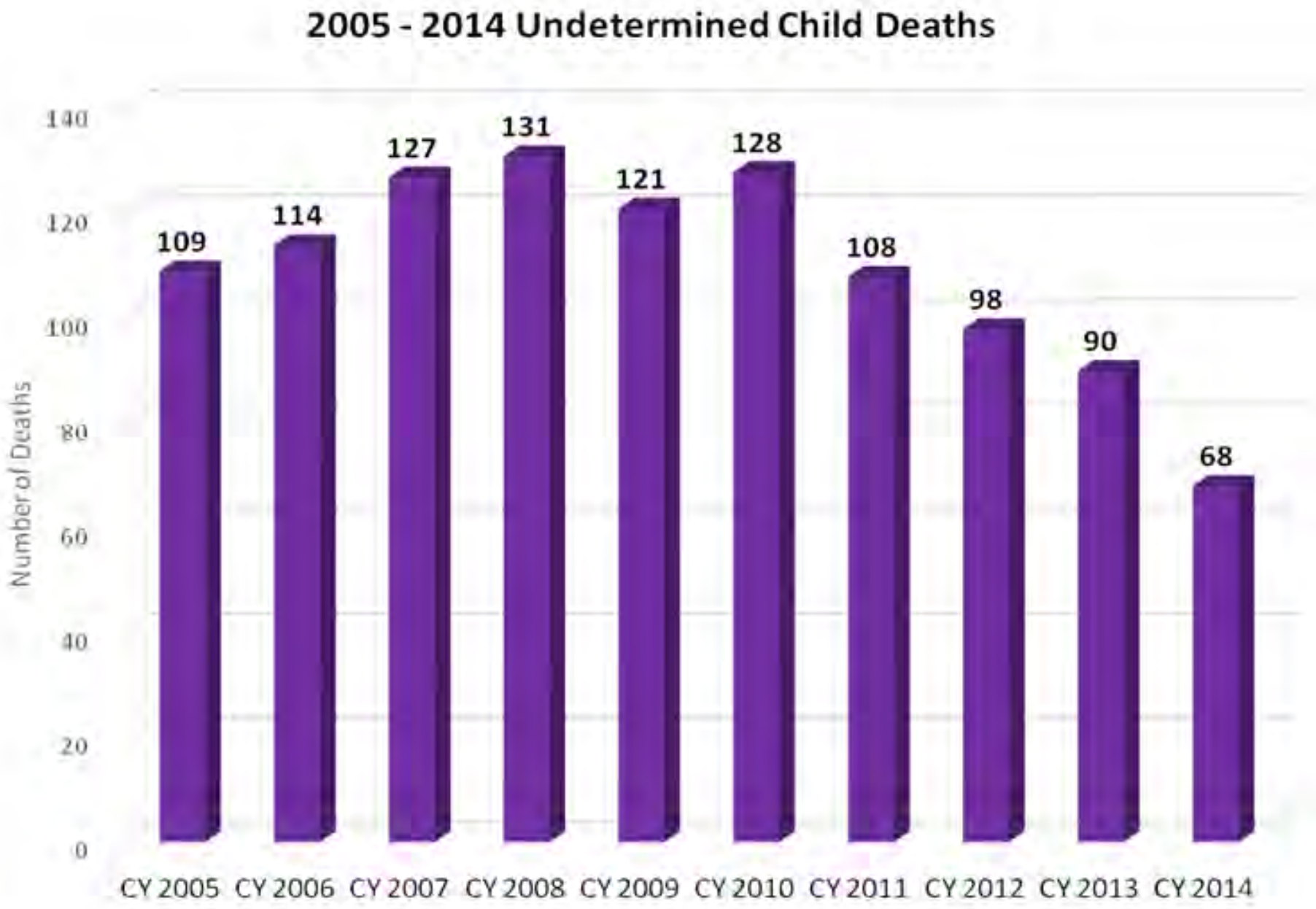

2005 - 2014 Undetermined Child Deaths
Number of Deaths
140
120
100
80
60
40
20
0
109
114
127
131
121
128
108
98
90
68
CY 2005
CY 2006
CY 2007
CY 2008
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
CY 2014

Undetermined Child Deaths – 2014 (N = 68)

Race	Number/Percentage of Undetermined Child Deaths
African American	16 (24%)
Asian/Pacific Islander	5 (7%)
Caucasian	8 (12%)
Hispanic	38 (56%)
Unknown	1 (1%)

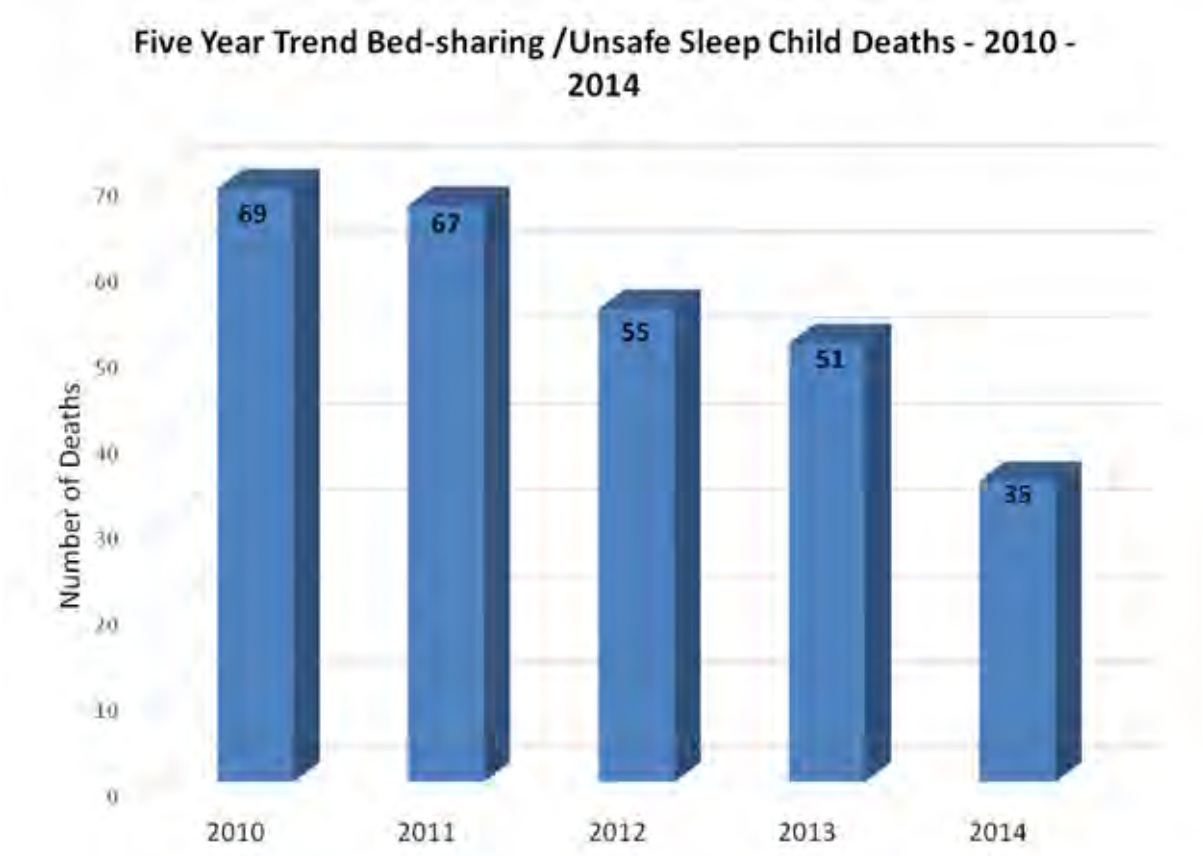
Age	Number of Undetermined Child Deaths
Stillborn	8
1 day to 30 days	11
1 month to 5 months	26
6 months to 1 year	14
2 years	4
3 years	1
13 – 17 years	4

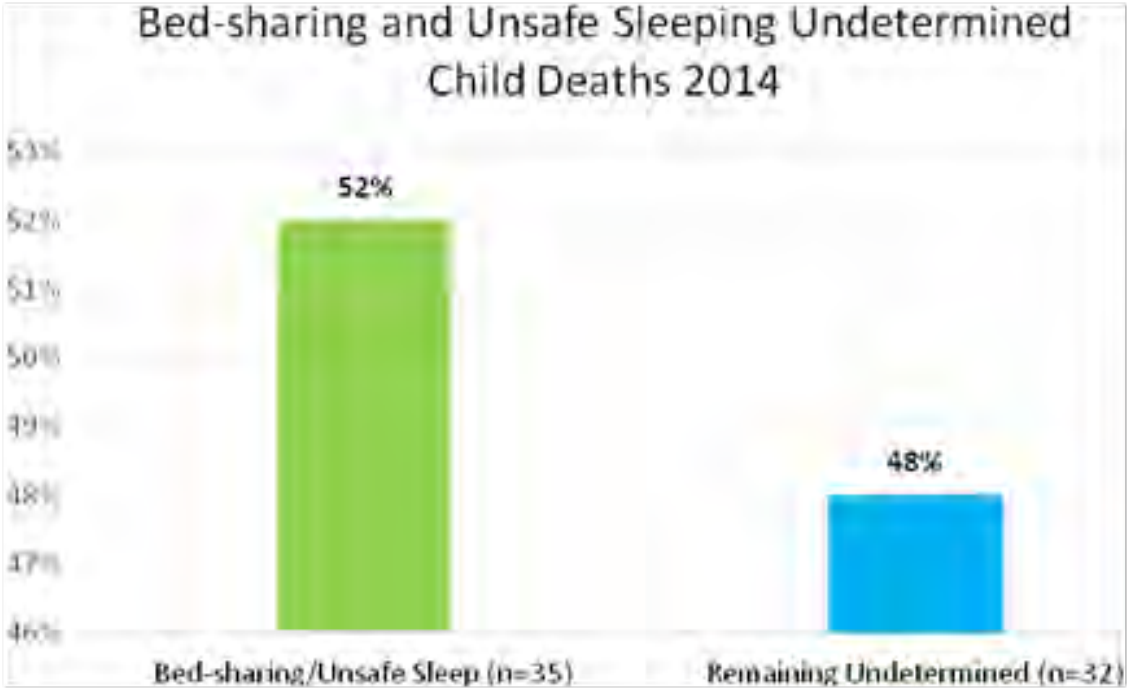
Gender	Number of Undetermined Child Deaths
Female	39
Male	29

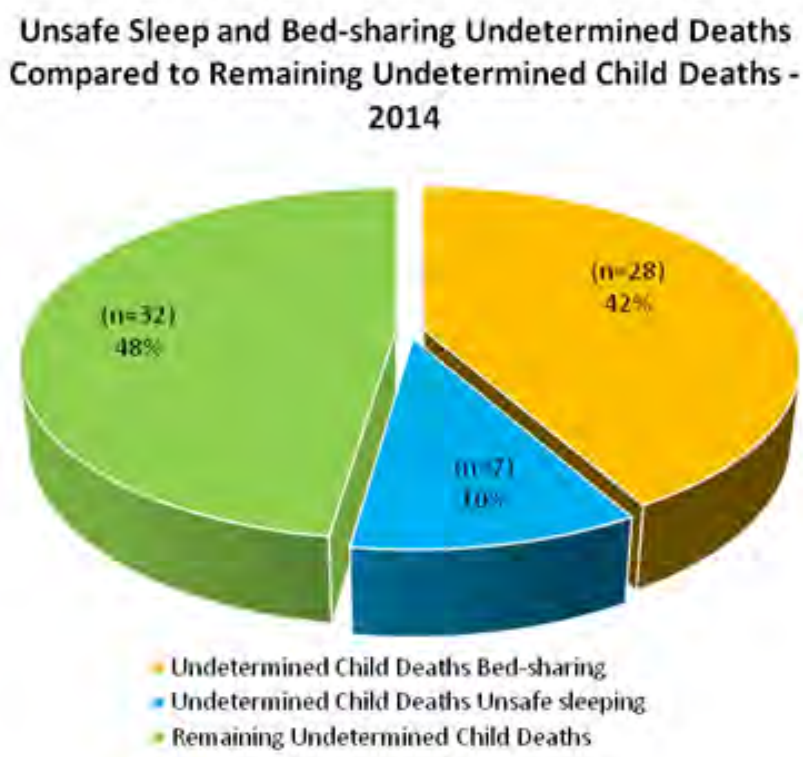
87% of the undetermined child deaths were under one year of age.

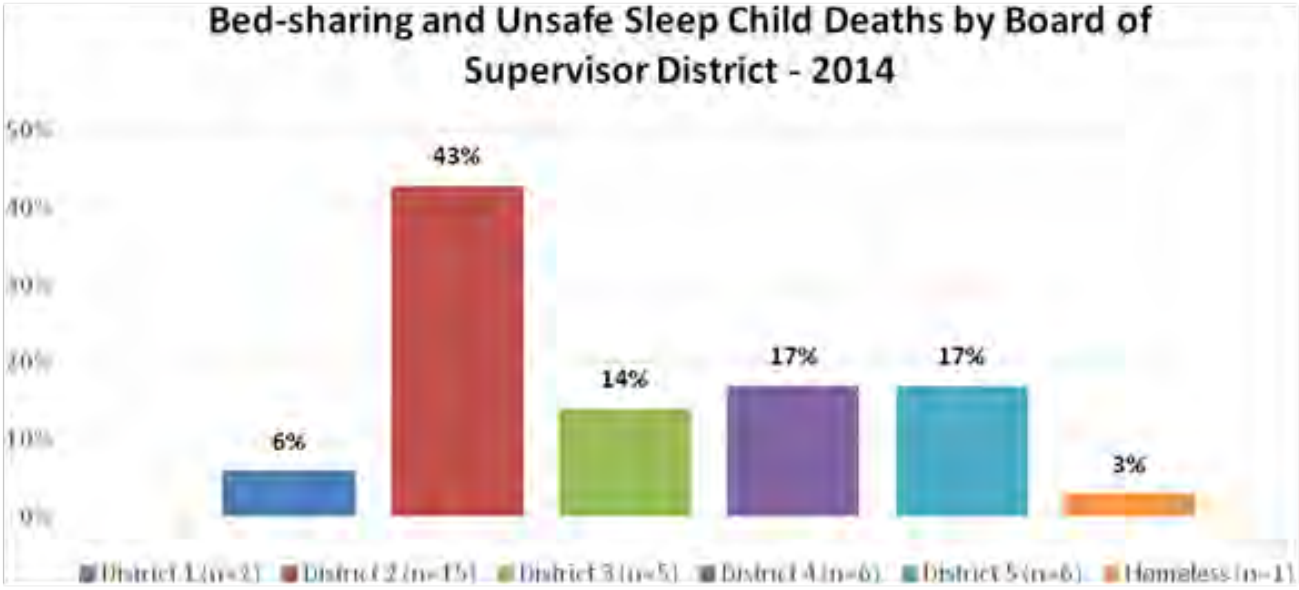
94% of the undetermined child deaths were 5 years of age or under.

Undetermined Child Deaths – Bed-sharing and Unsafe Sleeping Environment (N = 35)






Unsafe Sleep and Bed-sharing Undetermined Deaths Compared to Remaining Undetermined Child Deaths - 2014
(n=28)
42%
(n=32)
48%
(n=7)
10%
Undetermined Child Deaths Bed-sharing
Undetermined Child Deaths Unsafe sleeping
Remaining Undetermined Child Deaths


Bed-sharing and Unsafe Sleep Child Deaths by Board of Supervisor District - 2014
50%
40%
30%
20%
10%
0%
6%
43%
14%
17%
17%
3%
District 1 (n=2)
District 2 (n=15)
District 3 (n=5)
District 4 (n=6)
District 5 (n=6)
Homeless (n=1)

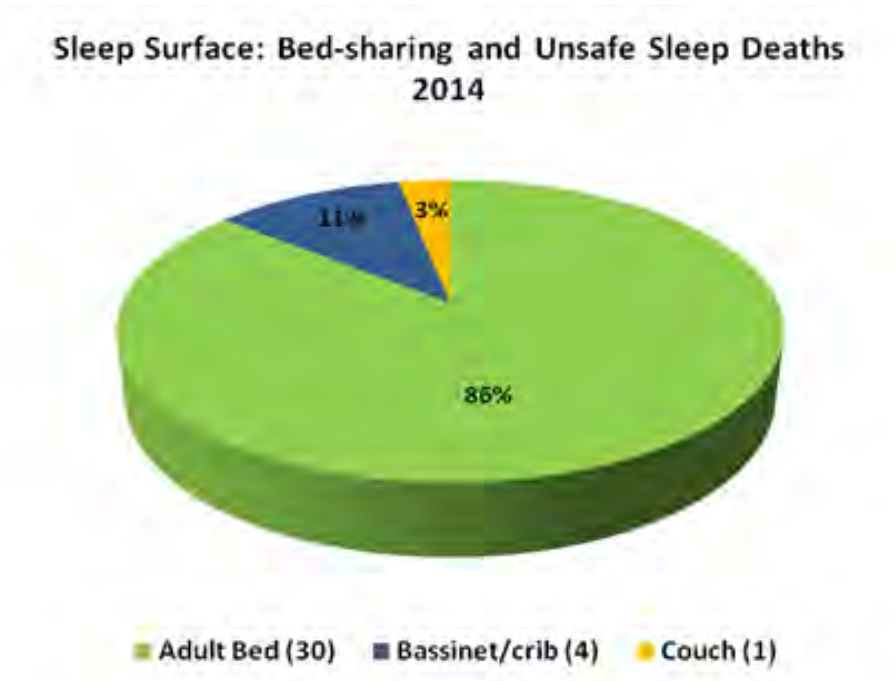
Bed-sharing and Unsafe Sleeping Environments- Number of Risk Factors Present at Time of Death

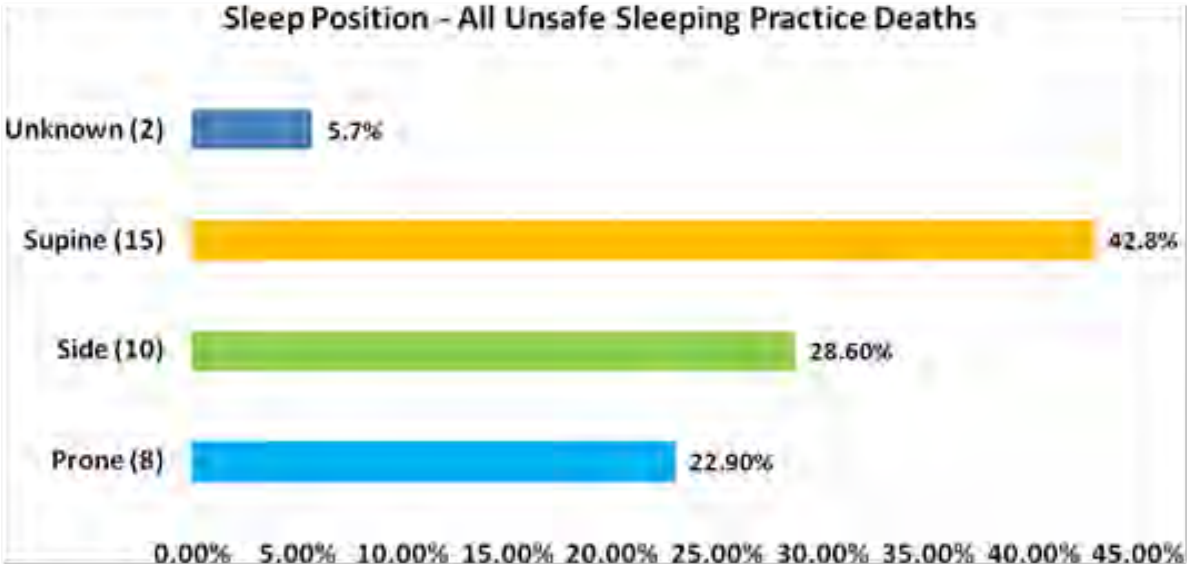
Bed-sharing* (N=28)	Number/Percentage of Child Deaths
One Unsafe Risk Factor	0 (0%)
Two Unsafe Risk Factors	6 (21%)
Three or more Unsafe Risk Factors	22 (79%)

Unsafe Sleeping Environment** (N=7)	Number/Percentage of Child Deaths
One Unsafe Risk Factor	1 (14%)
Two Unsafe Risk Factors	3 (43%)
Three or more Risk Factors	3 (43%)

*Includes bed-sharing, adult bed, couch, pillows, soft or excessive bedding, excessive swaddling, blanket rolls, stuffed toys, parental drug/alcohol use, prone or side positioning.

**Includes adult bed, pillows, soft or excessive bedding, excessive swaddling, blanket rolls, stuffed toys, prone or side positioning.

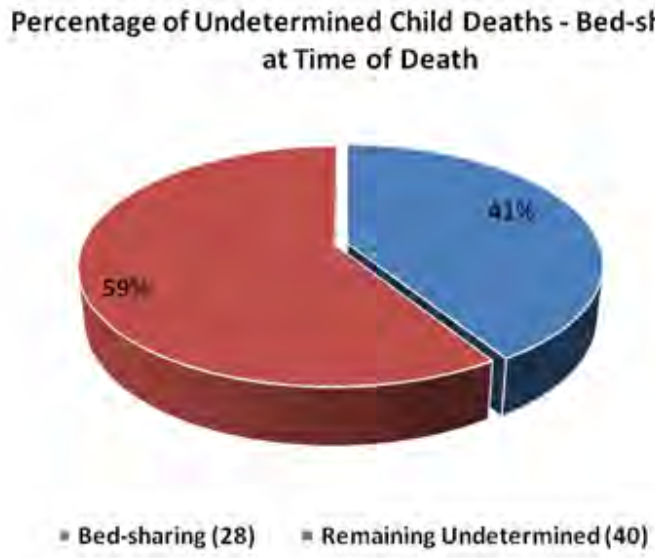




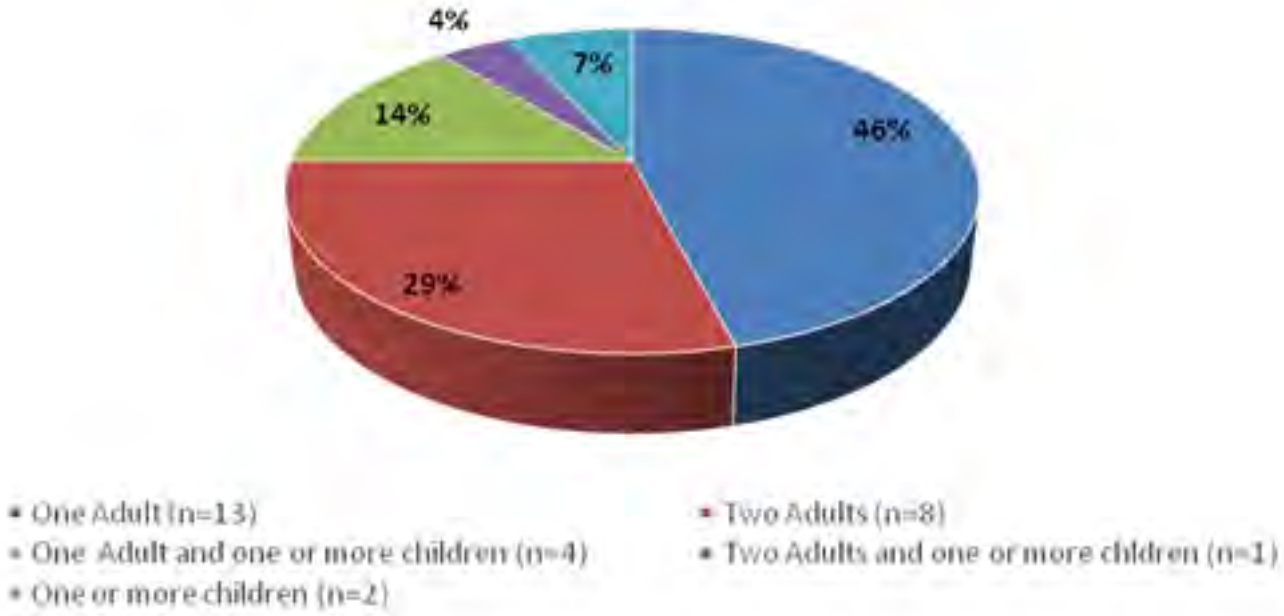
Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 35)	Number
Pillow(s)	15
Soft and/or excessive bedding	10
Excessive Swaddling	7
Stuffed animals/toys	1
Rolled Blanket	1
Parental Drug/Alcohol Use	2

*Excludes bed-sharing, sleep surface and infant position

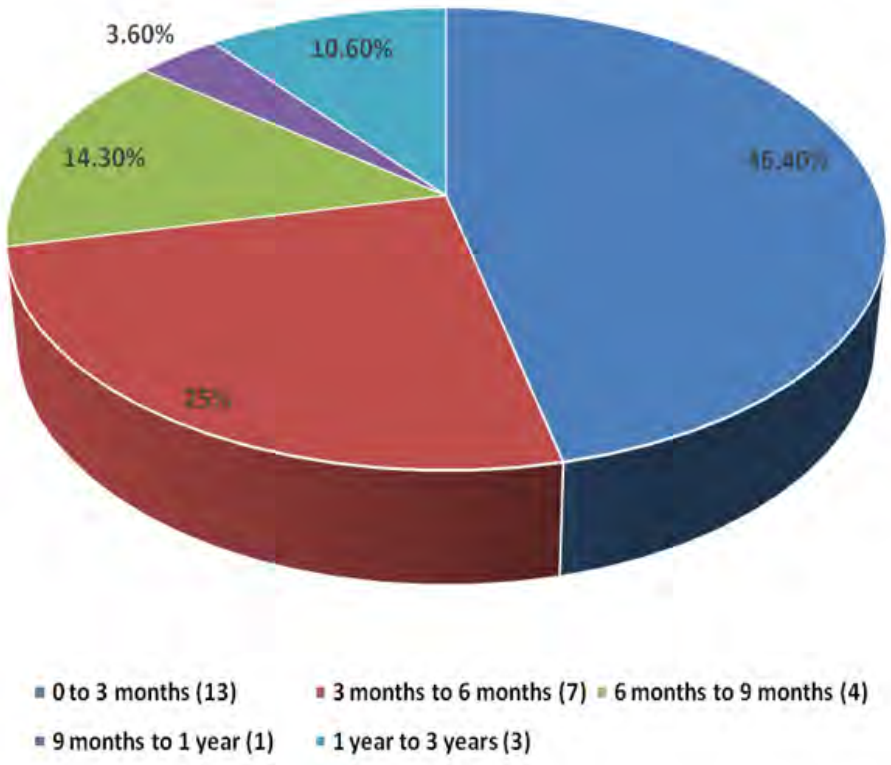
Bed-sharing and Unsafe Sleeping Environment Child Welfare History	Number	Percentage
Total Unsafe Sleep/Bed-sharing	35	100%
Total Unsafe Sleep/Bed-sharing with Child Welfare History	16	45.7%

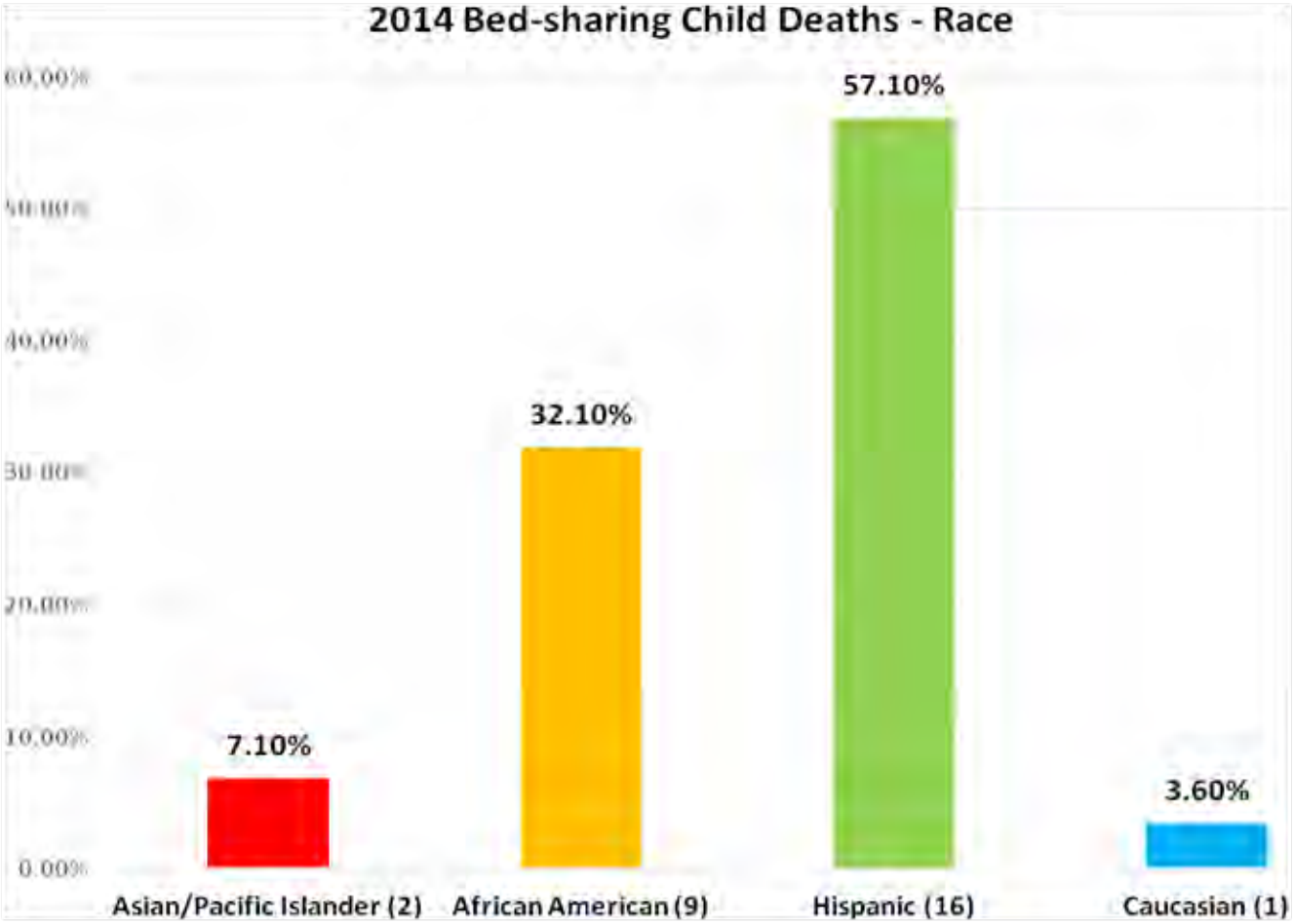


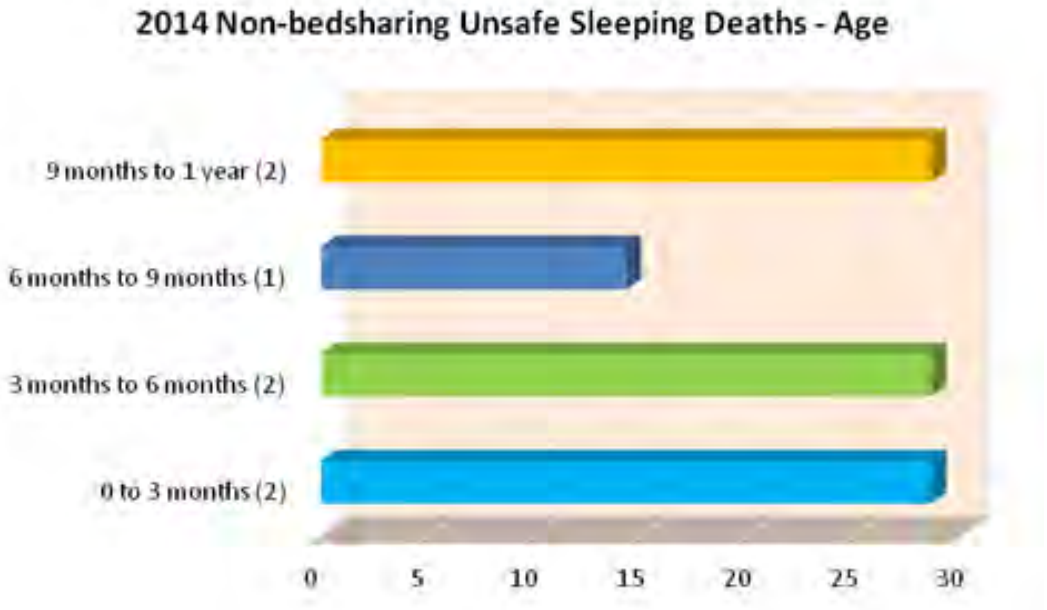
2014 Bed-sharing Deaths - Number of Persons Sleeping with Child

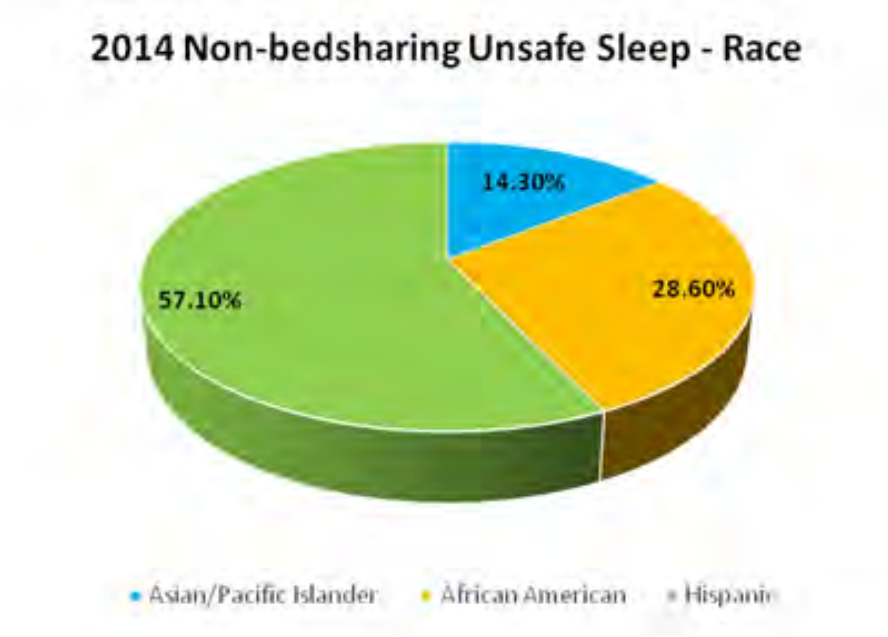


2014 Undetermined Bed-sharing Child Deaths - Age




2014 Bed-sharing Child Deaths - Race
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
7.10%
32.10%
57.10%
3.60%
Asian/Pacific Islander (2)
African American (9)
Hispanic (16)
Caucasian (1)


2014 Non-bedsharing Unsafe Sleeping Deaths - Age
9 months to 1 year (2)
6 months to 9 months (1)
3 months to 6 months (2)
0 to 3 months (2)
0
5
10
15
20
25
30



Unsafe Non-bed sharing Child Deaths Sleeping Environment* - 2014	
Soft and/or excessive bedding	4
Pillow(s)	6
Adult bed	5
Chair/couch	3
Rolled blanket	1
Parental Drug/Alcohol Use	3
Foam Mat	1
Infant/Car Seat	4
Excessive Swaddling	3

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

2014 Undetermined Infant Deaths- Mother Tested Positive for a Substance at Birth

Infant Death- Mother Tested Positive for a Substance at Birth (N = 8)		
Substance	**Number**	**Percentage**
Methamphetamine, Opiates and Marijuana	1	12.5%
Cocaine and Marijuana	1	12.5%
Methamphetamine	5	62.5%
Alcohol	1	12.5%

2014 Undetermined Infant Deaths- Mother Tested Positive for a Substance at Birth – Child Welfare Involvement

Year	Total # of Infant Deaths –Mother Tested Positive for a Substance	Total # of with CPS family history(prior contact OR open case)	Of total with CPS history, the # of families that had PRIOR DCFS contact only	Of total with CPS history, the # of families in OPEN DCFS case or referral	# of Mothers with a CPS history as a minor
2012	12	7 (58%)	4 (57%)	3 (43%)	5 (42%)
2013	8	6 (75%)	4 (50%)	2 (25%)	4 (50%)
2014	8	8 (100%)	5 (57%)	3 (43%)	3 (43%)

*This data provided by the Coroner and DCFS. The eighth family's father had a history with DCFS with another mother. He also had a history as a minor.

Race	Number	Percentage
African-American	2	25%
Hisptanic	6	75%
Total	8	

Age	Number	Percentage
Stillborn	6	75%
Less than 1 month	1	12.5%
One to Four Months	1	12.5%

Third Party Homicide

Historically, the ICAN Child Death Review Team report has included only those cases which have met Team protocol. For the eighth year, however, the report includes a special supplement to provide data on youth who are victims of a third party homicide. Unlike the child homicides perpetrated by a parent, caregiver, or family member, these homicides are where the perpetrator was not the caregiver or family member.

The information contained in this section is from two primary sources – the Los Angeles County Coroner's office and the local law enforcement agencies within Los Angeles County. The Coroner's Office provided demographic data as well as information on the cause and manner of death. Law enforcement provided information as to which agency conducted the criminal investigation, and whether the case was presented to the District Attorney's office for the filing of criminal charges and the type of charges filed. Also, in some cases, the Los Angeles Sheriff's Department (LASD) provided information about the relationship of the perpetrator to the suspect and some brief details about the victim's circumstances or activities prior to being killed.

The purpose of this information is to provide a broader analysis of children and youth deaths in Los Angeles County. It also seemed relevant to provide an analysis of these third party homicide deaths in hopes to provide a better understanding of child death in Los Angeles County. Ultimately, it is hoped that the study of these deaths will help us intervene more effectively.

A trend chart shows there has been a consistent downward pattern in these third party homicides over the past seven years. One possible theory to explain this downward trend is the diligent efforts of our law enforcement and prosecutorial agencies to decrease gang activity as well as the implementation of various gang prevention efforts. Regardless of the reason, the numbers paint a much welcomed picture.

Case Summaries[16]

Anita was 37 weeks pregnant with her first child. She pulled into the driveway of her mother's house. While waiting for someone to open the driveway gate, a car pulled up behind her car. A male Latino exited the car and shot Anita multiple times. The male got back into the car and sped away. 911 was called and Anita was rushed to the hospital. Dennis was born by an emergency C-section. He remained hospitalized for a week but his status declined and he passed at 8 days old. Anita recovered from her wounds. No suspect has been caught.

Giselle, age fifteen, was outside her home standing in the stairwell. She was approached by a male who had a handgun. He shot Giselle in the chest and fled. Giselle was transported by paramedics to the hospital but she was pronounced shortly after her arrival to the ER. It is unknown if the shooting was gang related and the suspect is also unknown. Toxicology at autopsy revealed she had methamphetamine and marijuana in her system at the time of her death.

Sixteen-year old Mark was walking on the street with a friend about one block from his home. A male approached the pair and asked where Mark was from. Mark answered "no where". The male pulled out a hand gun from his jacket and fired several shots at Mark. Mark collapsed to the ground and the suspect fled on foot. Neighbors called paramedics who arrived shortly, but it was too late. No weapon was found but a deputy found four 45 caliber shell casings on the sidewalk near to where Mark collapsed. No suspects have been identified and the case remains under investigation. Law enforcement believes it was a walk up gang-related shooting.

Seventeen-year old, David was walking with a friend when an unknown individual or individuals jumped out of a car and fired a gun toward David. David tried to run away and jumped into a car that was stopped at an intersection. The driver sped away as his car was sprayed by bullets. He stopped at a near-by alley and called 911. Paramedics arrived and David was unresponsive in the front passenger seat. The driver was taken to the hospital with gunshot wounds. David was wearing a red shirt. He was an A student and not in a gang. His family was devastated and believes he was shot due to his wearing a red shirt. No suspects are in custody.

Samuel, age 17 years was shot four times by an unknown assailant while standing in the driveway of a private residence. 911 was called and Samuel was pronounced deceased at the scene. Samuel belonged to a tagging crew and it is believed the shooting was gang-related. Samuel had several past arrests for tagging and burglary. He did not have any contact with DCFS but was under the supervision of the Probation Department at one time. Although Samuel died as a result of his GSW, toxicology results at autopsy revealed marijuana and methamphetamine in his system

16. Case identities were changed.

Findings

- There were 19 third party homicides in 2014. This is a 39% decrease from 2013 in which the number of third party homicides were 31. The number of third party homicides has continued to decline since ICAN began tracking them in 2007.

- Eighty-four percent (n=16) of the youth were victims of gunshot wounds.

- Of the three victims not killed by a gunshot, two were stabbed and one died as a result of a fire.

- As in the previous five years, male victims outnumbered female victims by a broad margin. Sixteen males and three females were homicide victims in 2014.

- Eighty percent (n=15) of the children who were victims of a third party homicide in 2014 were ages 16 – 17. The youngest victim was 23 days old born as a result of his mother's homicide from a gunshot wound.

- Hispanic and African-American youth each had nine youth who were victims of a third party homicide. There was one Caucasian victim.

- Sixty-three percent of the victims were found to have a drugs or alcohol at autopsy in their sys-tem. Six of the youth tested positive for marijuana and methamphetamine, five for marijuana and one for alcohol and marijuana.

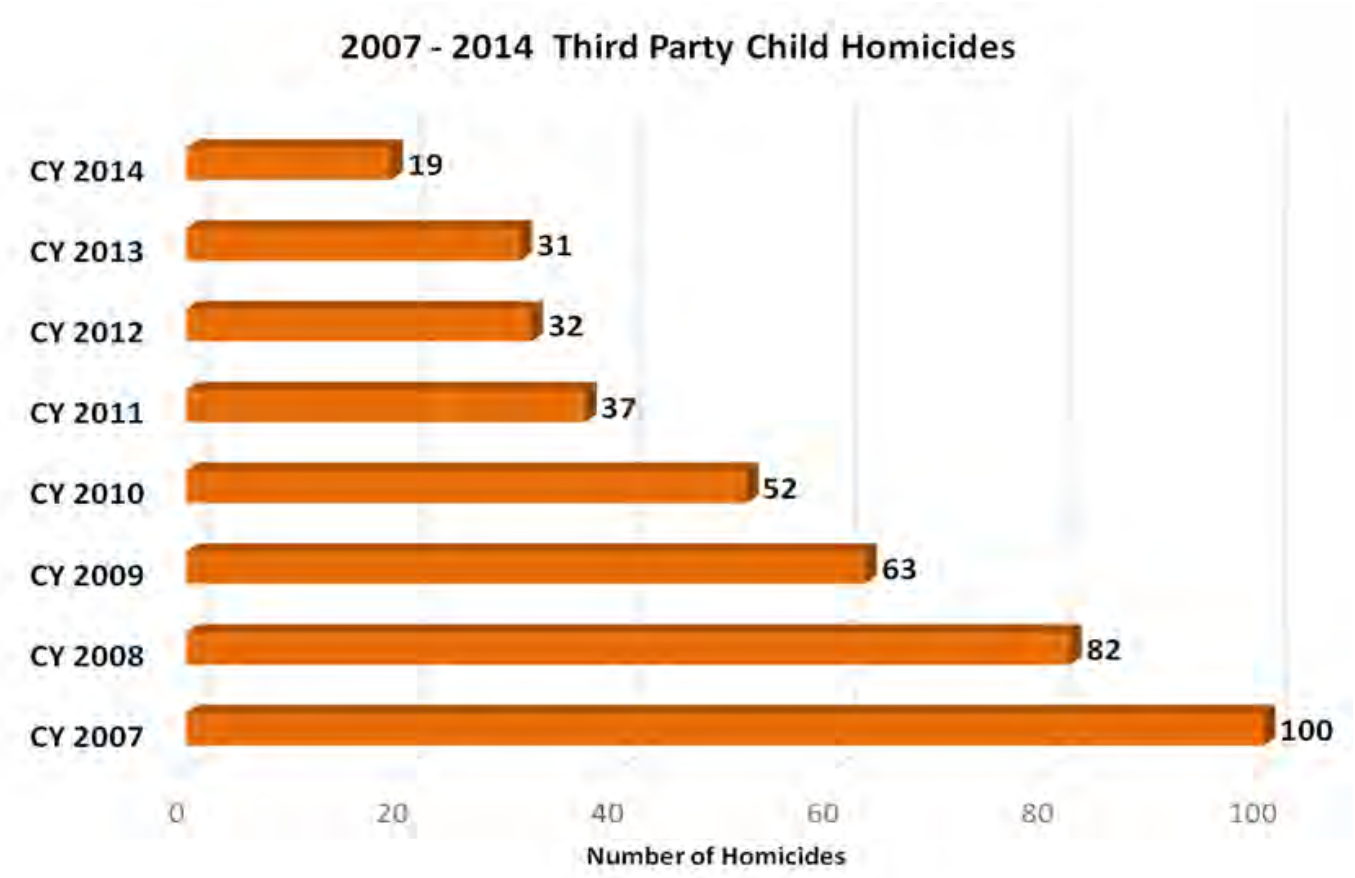
- The greatest number of homicides occurred during the month of December (n=4). The second-ed greatest number occurred in the months of March and September (n=3) and the third great-est in the months of March, May, June and August (n=2). The fewest number of homicides oc-curred during the months of October and November when there were no third party homicides. One third party homicide occurred in each of the months of January, February and July.

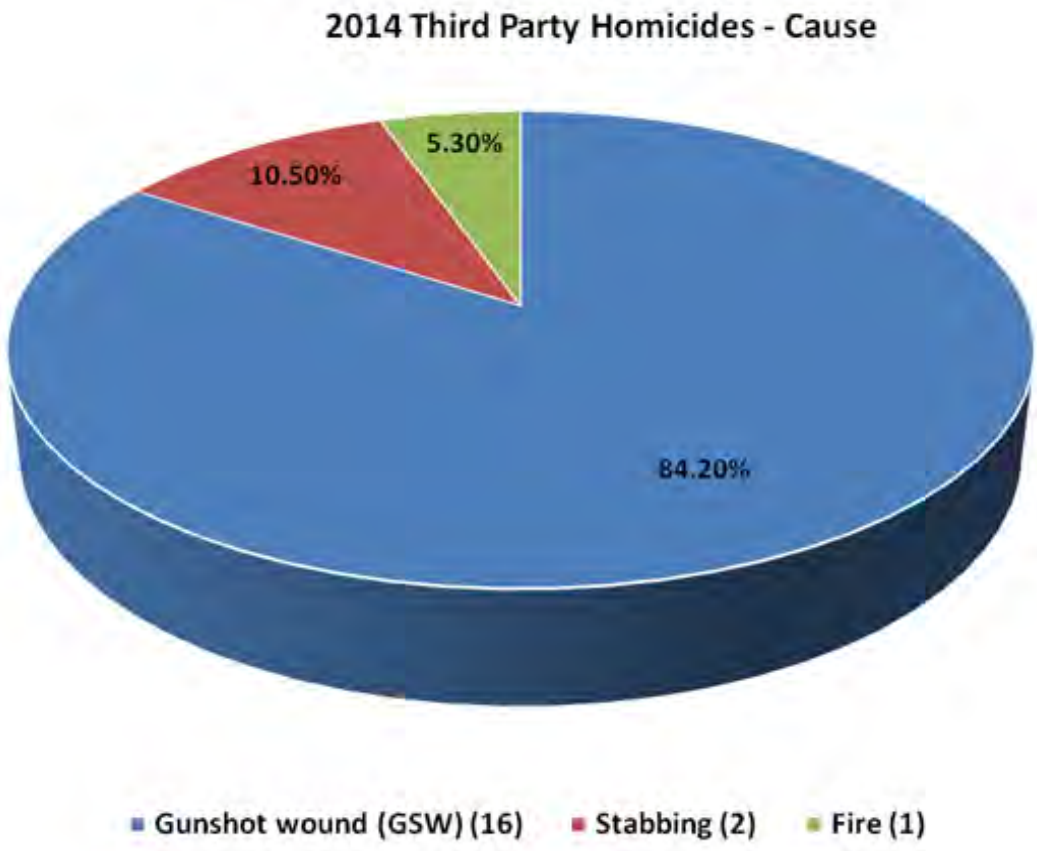
- While third party homicides occurred throughout Los Angeles County in 2014, the majority (n=13) of these deaths occurred in the 2nd Board of Supervisorial (BOS) District which was fol-lowed by the 1st BOS District with 4 third party homicides. One occurred in the 4th BOS and one in the 5th BOS District. There were no third party homicides in the 3rd BOS District.

- The Los Angeles Sheriff's Department LASD) had investigative authority for 52.6% of the third party homicide cases in 2013. 36.8 percent of the cases were under the jurisdiction of the Los Angeles Police Department (LAPD), and 10.5% of the cases were handled by Inglewood P.D.

- Where the relationship of the perpetrator was identified by law enforcement, 26% of the per-petrators were a gang member, and at least 21% of the victims were gang or tagging crew in-volved. Finally, 16% (n=3) of the case investigations resulted in the filing of criminal charges by the District Attorney's Office. When this information was collected, some of the cases were still under investigation or unsolved and therefore, had not been presented to the District Attorney's Office. The suspects and motives for majority of the 2014 3rd Party Homicides remain un-known.

- Eighty-four percent of the victims had a history with either DCFS or Probation. Nine of the vic-tims had a history with DCFS and seven of the victims had a history with the Probation Depart-ment. Two had a current case with Probation and two had an open case with DCFS.


2007 - 2014 Third Party Child Homicides
CY 2014
19
CY 2013
31
CY 2012
32
CY 2011
37
CY 2010
52
CY 2009
63
CY 2008
82
CY 2007
100
0
20
40
60
80
100
Number of Homicides


2014 Third Party Homicides - Cause
5.30%
10.50%
84.20%
Gunshot wound (GSW) (16)
Stabbing (2)
Fire (1)

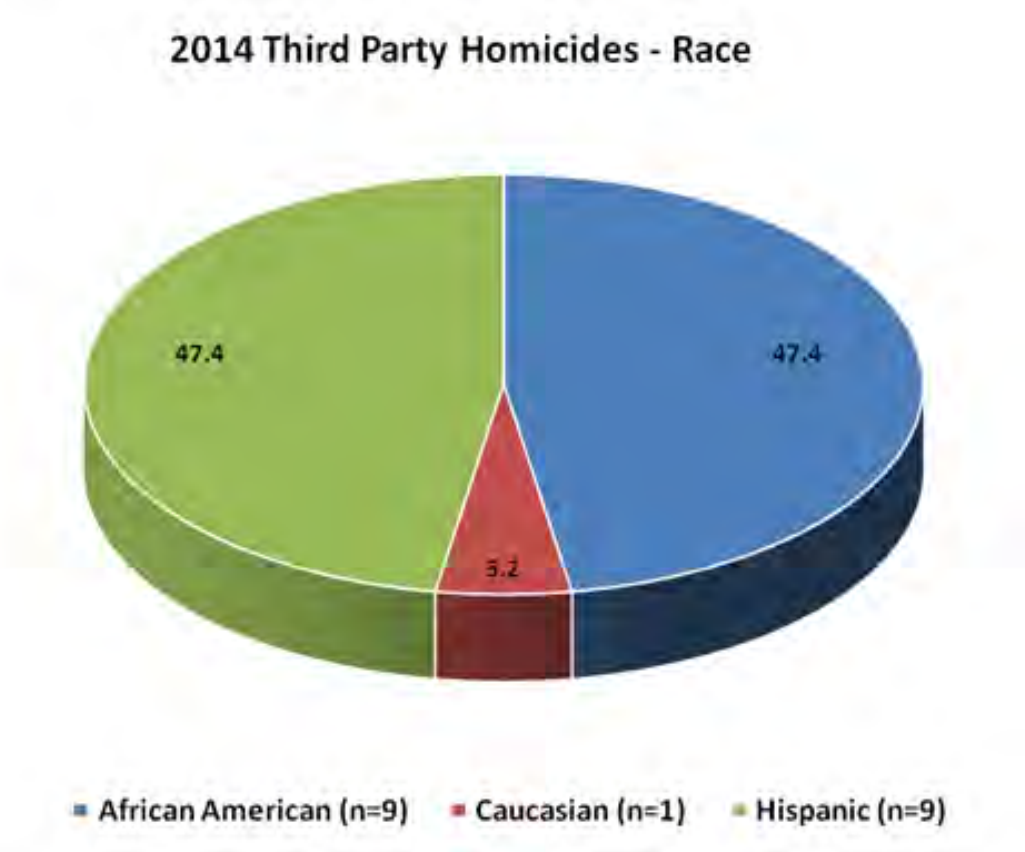
Third Party Homicides
Los Angeles County – 2012 (N = 32)

Age	Female	Male
1 year or under	0	2
2 – 12 years	0	0
13 years	0	0
14 years	1	0
15 years	1	0
16 years	0	5
17 years	1	9
Total	3	16

84% of the third party homicide victims were male.

16% of the third party homicide victims were 14 years of age or younger.

80% of the third party homicide victims were 16 to 17 years of age.



Los Angeles Child Population

Ages 0-17: 2,328,466

Hispanic 61.8%, Caucasian 17.1%, African American 7.5% ,

Asian/Pacific Islander 10.3%, Native Indian/Alaskan .1%

and Multi-racial 3.1% Kidsdata.org

Dates[17] of Third Party Homicides - 2014

1homicide occurred in January (01/19)
1 homicide occurred in February (02/21)
2 homicides occurred in March (03/05 & 03/27)
1 homicide occurred in April (04/23)
2 homicides occurred in May (05/08 & 05/29)
2 homicides occurred in June (06/08 & 06/27)
1 homicide occurred in July (07/17)
2 homicides occurred in August (08/18 & 08/22)
3 homicides occurred in September (9/05 & two on 09/09)
0 homicides occurred in October
0 homicides occurred in November
4 homicides occurred in December (12/07, two on 12/19 and one on 12/20)

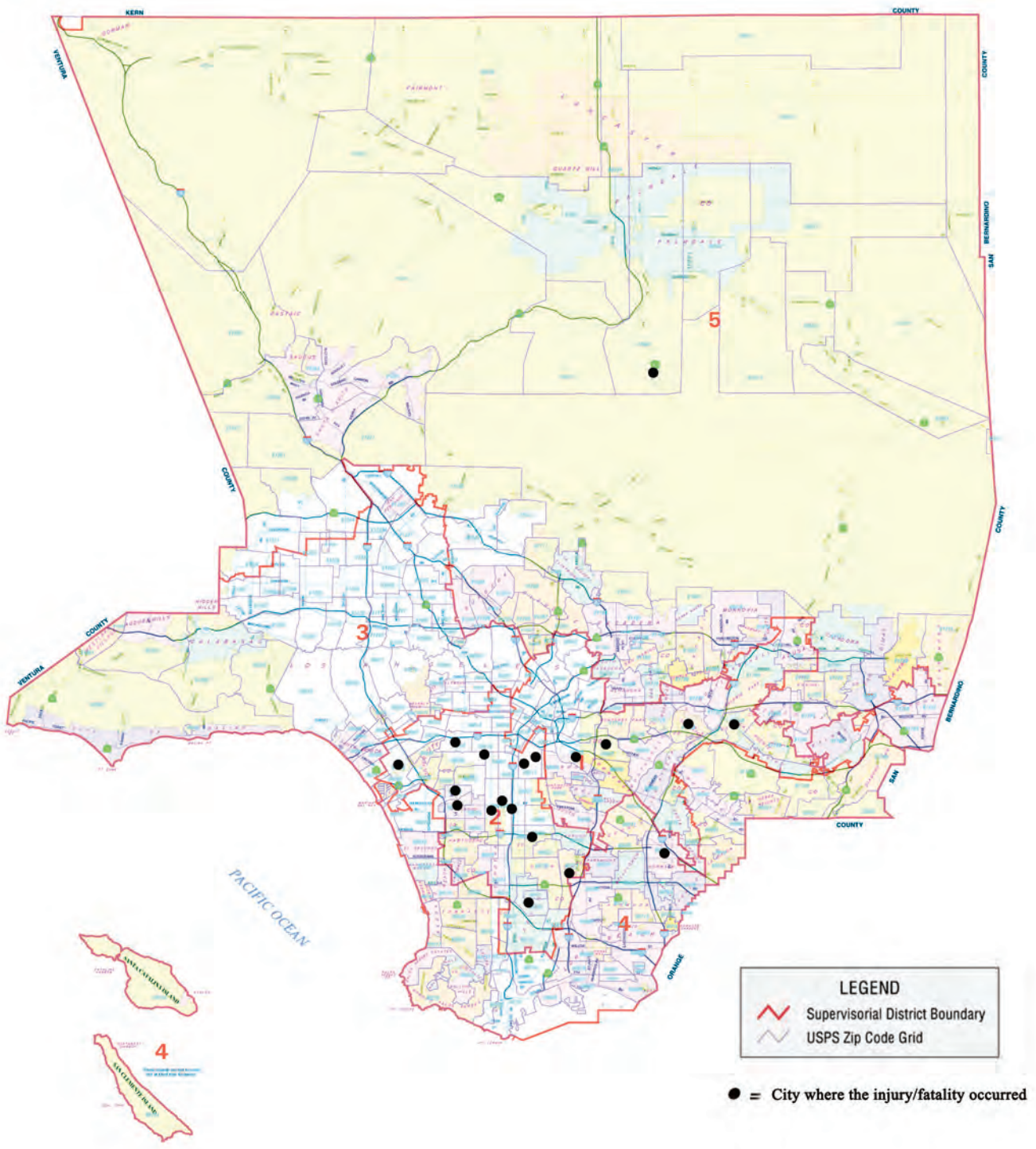
Locations[18] of Third Party Homicides – Geographic Area - 2013

1 homicide occurred in Carson zip code 90746)
2 homicides occurred in Inglewood (zip codes 90301 & 90302)
1 homicide occurred in South El Monte (zip code 91733)
6 homicides occurred in Los Angeles (zip codes 90016, 90022, 90023, 90047, 90062, & 90066)
2 homicides occurred in Los Angeles (zip code 90011)
2 homicides occurred in Los Angeles (zip code 90044)
1 homicide occurred in La Puente (zip code 91746)
1 homicide occurred in Willowbrook (zip code 90059)
1 homicide occurred in Compton (zip code 90221)
1 homicide occurred in Palmdale (zip code 93550)
1 homicide occurred in Norwalk (zip code 90650)

17. This is the date of death, which, in a majority of the cases coincides with the date the injury occurred leading to the youth's death.
18. City where the injury/fatality occurred

2014 Third Party Homicide Locations

N = 19



Information on criminal justice system involvement in third party homicide cases was gathered from three sources: the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD), and the Los Angeles Sheriff's Department (LASD). In 2014, there were 19 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 1 below.

Table 1

Agency	Number of Cases	Percentage1
LAPD	7	36.8%
LASD	10	52.6%
Inglewood P.D.	2	10.5%

Table 2 provides information on the perpetrator's relationship to the victim, including whether the perpetrator was involved in a gang as revealed during the criminal investigation. It should be pointed out that few of the law enforcement agencies were able to provide much detail about the suspect's circumstances which is why so many of the cases fall under the "no information provided" category. The majority of these cases remain under investigation and the suspect(s) is unknown.

Table 2

Perpetrator's Relationship to Victim	Number of Cases
Gang Member	5
No Information Provided or Un-known	14

Table 3, on the following page, provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved

Table 3

Victim Information	Number of Cases
No Information provided	5
Shot in a walk-up shooting	9
Shot during a drive-by shooting	3
Gang member or tagger	4
Physical altercation with a peer	2
Alcohol/Illicit substance in system	12
DCFS History	7
Probation History	5
Active Probation Case	2

According to the information provided by the Los Angeles County District Attorney's Office, Los Angeles Police Department (LAPD), and the Los Angeles Sheriff's Department (LASD), 3 of the 19 cases of third party homicides were referred to the District Attorney's Office in 2014. The three cases had criminal charges of murder filed by the District Attorney's Office in 2014. Eleven of the nineteen cases remain under investigation. It should be noted that there was no information found for 5 cases. For cases under investigation or where no information was provided, this means that law enforcement has not identified the assailants or not yet submitted the case for review to the District Attorney for some other reason.

Sixty-three percent of the victims tested positive for alcohol, marijuana and/or methamphetamine at autopsy. Six of the twelve testing positive had methamphetamine in their system at autopsy.

Appendix A -
ICAN Youth Suicide Coroner/Medical Examiner Procedural Guide

ICAN Youth Suicide Coroner/Medical Examiner Investigation Procedural Guide

Case Number: _____

Decedent: _____

Language Interviewed in: ☐ **English** ☐ **Other** _____

Translated by: _____

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

Investigator: _____

(Do not release with copy of Autopsy Report)

Mental Health

Recent Mental Health, Substance Abuse/Dependency Treatment History < 2 months *(Acute)* *i.e. diagnosis, outpatient therapy, hospitalization, detox, rehab., recent sobriety*

Mental Health, Substance Abuse/Dependency TX History > 2 months (*Chronic)*
i.e. diagnosis, outpatient therapy, hospitalization, detox, rehab

Presence of Trigger Events <2 months *(Acute)* *i.e. actual/anticipated loss of relationship, conflict with parents, conflict with school/job or other authorities, court appearance*

Prescribed Medication
i.e. compliance, recent change, psychotropic medication

Self-Injurious/Risk-Taking Behavior *i.e. substance use/abuse, cutting and burning, auto-erotic asphyxiation, alcohol use/abuse, "choking game", "Russian Roulette"*

Mental Health

Depression and Other Psychological Symptoms *i.e. impaired mental status, perceived burdensomeness, perceived pain, stress, agitation, hopelessness, self-hate, worthlessness, depressed mood, anxiety/panic, anger, anhedonia, guilt, impulsivity, poor reality testing, sleep/eating disturbances, command hallucinations, intoxication, aggressive tendencies, recent changes in behavior, recklessness.*

Acute <2 months	**Chronic >2 months**

Suicide Exposure & Behavior

Prior Suicide Attempts *(indicate dates, times, methods, medical care needed)*

Exposure to Others' Behavior i.e. *completed Suicides or attempts of family, friends or role models*

Discussion of Suicide, and Notes *i.e. verbal, written or online/electronic thoughts communicated to family, peers, teachers, post-mortem messages left for family, peers, teachers*

Access to Lethal Means

When appropriate *(indicate information about secure access to weapons, such as firearms, medication, etc. Did the decedent have familiarity with weapon? Parental supervision? Were the weapons secured - Firearm locked in storage cabinet? Ammunition kept separate or firearm kept loaded?*

Funding for the ***ICAN CORONER SUICIDE GUIDELINES*** was provided in part by the ***JEFFREY GUTIN FUND FOR YOUNG ADULTS*** of the New Hampshire Charitable Foundation

Scan and Email this form and completed Report to Tom Fraser at fraset@dcfs.lacounty.gov

Medical

Physician or Clinic Visits within last 12 months *(specify physical and psychological complaints, conditions affecting activities of daily living)*

Emergency Department Visits within the last 2 Months *(specify physical and psychological complaints)*

Hospitalizations within the last 12 Months *(indicate dates, duration, diagnosis, discharge, plan, conditions affecting activities of daily living)*

Education, Occupation

School_____ **Grade** _____

i.e. special education, truancy/attendance problems, academic pressure, discipline, social challenges, recent school changes, bullying

Worksite_____

i.e. discipline, conflicts with peers, supervisors, public, performance pressures

Support Systems and Other Involvement

Suspected Child Abuse ☐ Yes ☐ No

Family or Loved Ones, and other Significant Relationships

Protective *i.e. supportive, engaged, involved, new romantic partner, positive change of residence*	**Risk** *i.e. conflicts, parental separation/divorce, change in placement/address, grief/loss, illness*

Peers

Protective *i.e. group membership, sports involvement*	**Risk** *i.e. problems with friends, bullying, friendship/significant other break up*

Faith-Based/Spirituality

Protective *i.e. acceptance, non-judgmental, belief in a higher power*	**Risk** *i.e. intolerant messages, estrangement, condemnation, judgmental*

Identity Issues *i.e. gender, acculturation, other cultural challenges*

Social Networks ***(Request email passwords to computer, Facebook page, text messages etc.)*** *i.e. actual social relationships or online social networking activity*

Additional comments/thoughts/opinions

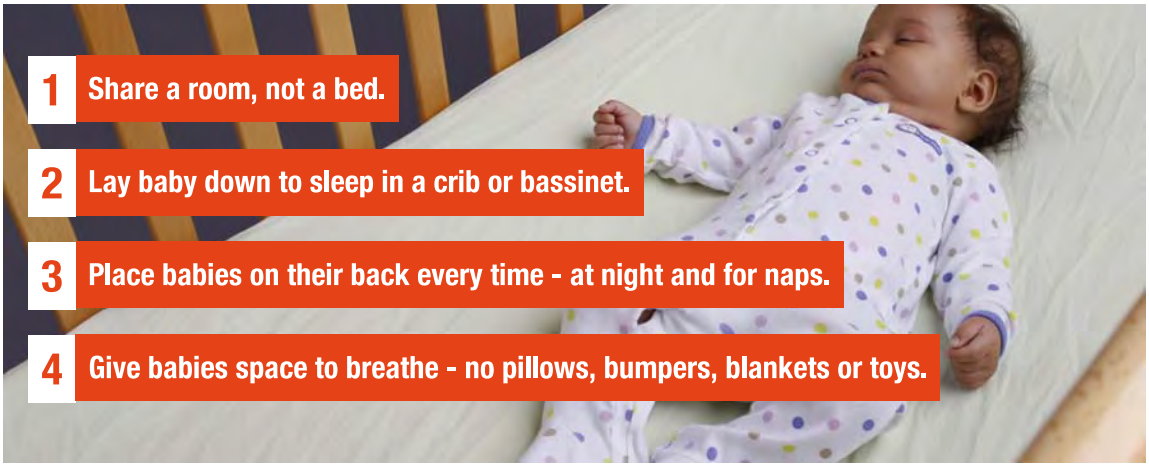
en Español

HOME | A PROBLEM IN L.A. | HOW TO KEEP YOUR BABY SAFE | GET EDUCATED

safe sleep for baby
Don't wake up to a tragedy.

How to Keep Your Baby Safe

Parents and caregivers can reduce the risk of infant death from suffocation by being aware of and following these safe sleeping practices.



Questions You May Have

Is it safe to put a baby to sleep in a car seat or stroller?
No, because of the way the baby is positioned in these carriers. Babies should always be placed on their back to sleep.

Can I swaddle my baby?
Yes, but be sure to use a light receiving blanket because other blankets, such as San Marcos blankets, can be too heavy and warm for infants. Once babies reach 5-6 months, swaddling is no longer needed and parents can simply continue to dress their baby in a onesie or sleeper.

What if I am breastfeeding?
Breastfeeding is encouraged, and moms should place their baby in a crib or bassinet after nursing.

What if my baby likes sleeping on his stomach?
The safest way for babies to sleep is on their back. When babies sleep on their stomach or side, they can choke or suffocate.

My baby has trouble breathing – what's the best way to put my baby to sleep?
If your baby has a medical condition, talk to your doctor about any special care your child may need.

Like us on Facebook for the latest updates. Like 1.4k

Contact

ICAN Associates
4024 N. Durfee Avenue
El Monte, CA 91732
626-455-4585
info@safesleepforbaby.com

Safe Sleep Task Force

The Infant Safe Sleeping Task Force oversees the Safe Sleep for Baby campaign. This section includes information and resources for Task Force members.

Task Force Information

ICAN icanfkids.org

FIRST 5 LA Champions For Our Children www.First5LA.org

Appendix C - On-Line Resources

Safe Sleeping Resources

safesleepforbaby.com

nichd.nih.gov.sts

firstcandle.org

Child Abuse

dontshake.org

child-abuse.com

dcfs.co.la.ca.us

ican4kids

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

youtube.com/watch?v=vgDgcWNXBcI&feature=related

coroner.co.la.ca.us/htm/yddvp1.htm

Grief and Mourning

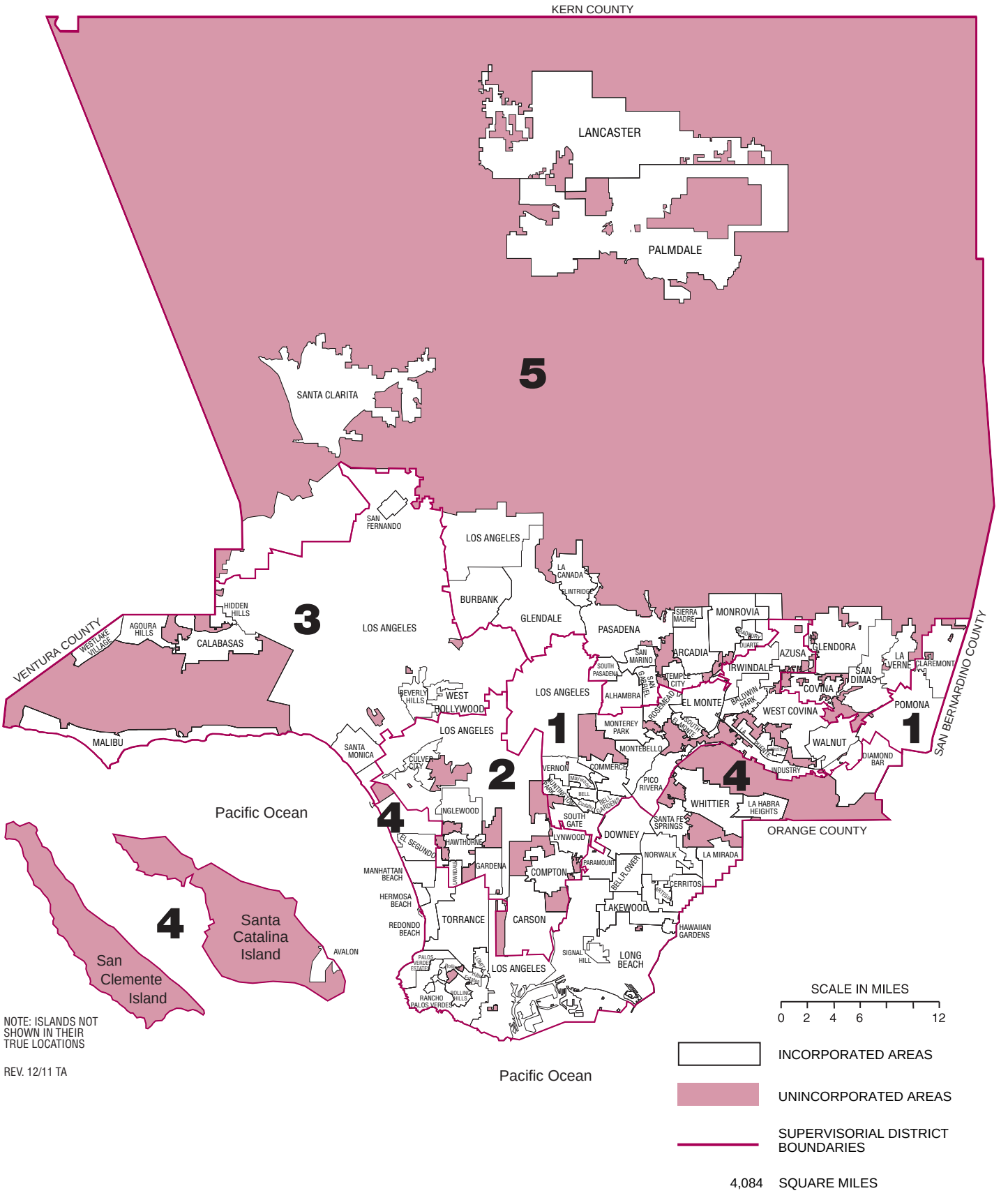
mec.lacounty.gov/griefresources

compassionatefriends.org

griefcenterforchildren.org

firstcandle.org

Appendix D -
Map Of Los Angeles County By Board Of Supervisor District



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.