CONTRA COSTA MENTAL HEALTH COMMISSION

CONTRA COSTA MENTAL HEALTH COMMISSION
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cchealth.org/mentalhealth/mhc

Mental Health Commission (MHC)

Wednesday, June 1st, 2022, ◊ 4:30 pm - 6:30 pm

VIA: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195
Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. **Call to Order/Introductions (10 minutes)**

II. **Public Comments (2 minutes per person max.)**

III. **Commissioner Comments (2 minutes per Commissioner max.)**

IV. **Chair Comments/Announcements (5 minutes)**
   i. **MHC Orientation Module before the July 6th Commission meeting will be either "Financing Mental Health" or a repeat of "Introduction to the Mental Health Commission"**
   ii. **Participated in "May in Mental Health Awareness Month" presentation to the Board of Supervisors (BoS)**
   iii. **Resignation of Commissioner Alana Russaw, District IV**
   iv. **Welcome newest Commissioner: Tavane Payne, District IV**

V. **APPROVE May 4th, 2022 Meeting Minutes (5 minutes)**

VI. **"Get to know your Commissioner" – Commissioner Yanelit Madriz Zarate (5 minutes)**

VII. **Update Commission Membership and open seats, Angela Beck, Executive Assistant (5 minutes)**

VIII. **Review procedure for resigning from the Commission and procedure and time-frame for applying for another term, Angela Beck, Executive Assistant (5 minutes)**

IX. **Update on Site Visits, Commissioner Laura Griffin (5 minutes)**

(Agenda Continued on Page Two)

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

Mental Health Commission (MHC) Agenda (Page Two)

Wednesday, June 1st, 2022 ◊ 4:30 pm - 6:30 pm

X. UPDATE on BHS Behavioral Health Care Infrastructure Program (BHCIP) Needs Assessment Findings presentation on May 16th, Commissioner Laura Griffin (5 minutes)

XI. Report on Committees (10 minutes)

- **Justice Systems Committee, Commissioner Geri Stern**
- **Finance Committee, Commissioner Douglas Dunn**
- **Quality of Care Committee, Commissioner Barbara Serwin**

XII. Review progress on MHC 2022 goals (5 minutes)

XIII. PRESENT "Changing the Response: Youth Suicide Response in Contra Costa County and Evaluating the Response in Los Angeles and Fresno Counties", Commissioner Graham Wiseman (15 minutes)

XIV. Behavioral Health Services Director's report, Dr. Suzanne Tavano (15 minutes)

- **Crestwood Overview**
- **Next steps for CCBHS BHCIP Needs Assessment**
- **Progress on Children and Adolescent Crisis Stabilization Unit**
- **Remodel of Psychiatric Emergency Services (PES)**

XV. Adjourn @ 6:30 pm.

ATTACHMENTS:

A. Board of Supervisors "May is Mental Health Awareness Month" Presentation
B. "May is Mental Health Awareness Month" Resolution
C. CCBHS Behavioral Health Care Infrastructure Program (BHCIP) Needs Assessment Findings
D. Child Death Review Team Report 2019, Inter-Agency Council on Child Abuse and Neglect (ICAN) Los Angeles County (www.ican4kids.org)

Celebrating
May is Mental Health Awareness Month

Celebrating Progress

- Priority: Raising awareness and destigmatizing mental health illness
- COVID-19 impact: Dramatic increase in mental health symptoms
- Positive effect: Nation-wide discourse ➔ increase in awareness
- Positive result: Wide ranging, tangible responses
- Still work to do: Discussion ➔ Action ➔ Lasting change

Celebrating Youth Mental Health

- Honor Young Adult Leaders who are speaking up and reaching out

- Spotlight: **Vicente High School "Anyone, Anyone…" video** by Dominique Gonzalez, Salem Orchard, Victoria Bruno, Karla Rodriguez, Grace Chappell, and Alyssa Cardenas (Advisor Amy Specter, LMFT)
  - One of five "Directing Change" videos dedicated to mental health and suicide prevention produced by San Vicente students

- LINK TO VIDEO

Celebrating BHS New Initiatives

- A new county-wide Crisis Response system (A3)
- New A3 resources: Peer Respite Center, Mental Health Urgent Care, 17 new Peer Community Support positions
- New Wellness in Schools Program (WISP)
- New Children and Adolescent Crisis Stabilization Unit
- Behavioral Health Care Infrastructure Project (BHCIP) grant proposal efforts

Celebrating Jay Mahler

"I've spent 56 years in the public mental health system, 10 years trying to survive it and 46 years trying to change it."

~ Jay Mahler, 1946-2021

Celebrating Jay Mahler

Next Steps and Future Action

~ From the presentation "The History of The Mental Health Consumer/Peer Movement in Contra Costa County and Looking Ahead" at the CCC MHSA Peer Forum, September 23, 2020

- Peer-run Organization with the focus on the Systems Change & Advocacy
- The Recovery Vision revival
- Creating compassionate crisis response services, without the police officers being first responders to the mental health crisis – AB 988/ Miles Hall Life Line Act
- The SB 803/ The Peer-Provider Certification CA Senate Bill Campaign and implementation

Mental Health Awareness Resolution

- Synetta Freeman, Behavioral Health Office for Consumer Empowerment
- Jonathan San Juan, Behavioral Health Office for Consumer Empowerment

Mental Health Awareness Resolution

In the matter of: Acknowledgment of the Month of May 2022 as Mental Health Awareness Month

- WHEREAS, the County of Contra Costa declares the Month of May 2022 as Mental Health Awareness Month; and
- WHEREAS, nationally, 1 in 5 Americans experiences a mental health challenge in their lifetime, and faces obstacles to effective treatment, such as stigma and language barriers; and

Mental Health Awareness Resolution

- WHEREAS, during May and throughout the year, our society will promote the understanding that those with mental health challenges have treatable conditions and can lead productive lives. We are committed to increasing awareness at all levels and educating the public to promote understanding that those who live with these conditions deserve to be helped and not stigmatized or discriminated against; and

Mental Health Awareness Resolution

- WHEREAS, in an effort to better reflect and celebrate the diverse populations that we serve, and in alignment with our diversity and inclusion efforts, we commit to advancing our goal of creating an environment where all residents of Contra Costa County feel a sense of belonging and may access safe spaces where mental health concerns can be addressed and where mental health services can be accessed in a fair and equitable manner; and

Mental Health Awareness Resolution

- WHEREAS, lack of awareness of the resources and services that are available, as well as the stigma surrounding mental health issues, are the biggest deterrents in seeking professional help; and

Mental Health Awareness Resolution

- WHEREAS, we honor the pioneering work of Jay Mahler, who pioneered the peer movement “Nothing About us Without Us” and advocated “I am not a case, and I don’t need to be managed.” His work will be remembered, spoken about, and carried forward into the future as it continues to thread recovery throughout Contra Costa County; and

Mental Health Awareness Resolution

- THEREFORE, the County of Contra Costa proclaims May 2022 as Mental Health Awareness Month.

Celebrating the Gift of Mental Health

When we have our mental health, we have everything.

THANK YOU

CONTRA COSTA
HEALTH SERVICES

The Board of Supervisors of
Contra Costa County, California

In the matter of:

Resolution No. 2022/

Acknowledgment of the Month of May 2022 as Mental Health Awareness Month

WHEREAS, the County of Contra Costa declares the Month of May 2022 as Mental Health Awareness Month; and

WHEREAS, nationally, 1 in 5 Americans experiences a mental health challenge in their lifetime, and faces obstacles to effective treatment, such as stigma and language barriers; and

WHEREAS, during May and throughout the year, our society will promote the understanding that those with mental health challenges have treatable conditions and can lead productive lives. We are committed to increasing awareness at all levels and educating the public to promote understanding that those who live with these conditions deserve to be helped and not stigmatized or discriminated against; and

WHEREAS, in an effort to better reflect and celebrate the diverse populations that we serve, and in alignment with our diversity and inclusion efforts, we commit to advancing our goal of creating an environment where all residents of Contra Costa County feel a sense of belonging and may access safe spaces where mental health concerns can be addressed and where mental health services can be accessed in a fair and equitable manner; and

WHEREAS, lack of awareness of the resources and services that are available, as well as the stigma surrounding mental health issues, are the biggest deterrents in seeking professional help; and

WHEREAS, we honor the pioneering work of Jay Mahler, who pioneered the peer movement "Nothing About us Without Us" and advocated "I am not a case, and I don't need to be managed." His work will be remembered, spoken about, and carried forward into the future as it continues to thread recovery throughout Contra Costa County; and

THEREFORE, the County of Contra Costa proclaims May 2022 as Mental Health Awareness Month.

_____ _____

JOHN GIOIA
District I Supervisor

CANDACE ANDERSEN
District II Supervisor

_____ _____

KAREN MITCHOFF
District IV Supervisor

FEDERAL D. GLOVER
District V Supervisor

I hereby certify that this is a true and correct copy of an action taken and entered on the minutes of the Board of Supervisors on the date shown.

ATTESTED: May 18, 2021

Monica Nino, County Administrator

By:_____, Deputy

Contra Costa Behavioral Health Services

Behavioral Health Community Infrastructure Program Needs Assessment Findings

Roberta Chambers, PsyD
roberta@indigoproject.net

Kira Gunther, MSW
kira@indigoproject.net

Jamie Dorsey, MSPH
jdorseyconsulting@gmail.com

Agenda

- Welcome and Introductions
- BHCIP Overview
- Needs Assessment Methods
- Needs Assessment Findings
  - Priority Populations
  - Types of Programs/Level of Care
  - Capacity Estimates
- Next Steps
- Questions and Discussion

BHCIP and CCE Overview

Indigo Project

BHCIP and CCE Overview

Behavioral Health Community Infrastructure Program

- Competitive grant program from DHCS
- Purpose to build new or expand capacity in behavioral health facilities for Medi-Cal services for Medi-Cal beneficiaries
- Must be available for 30 years
- Requires a letter of commitment from CCBHS for Medi-Cal service provision

Community Care Expansion

- Competitive grant program from CDSS
- Purpose to build and/or preserve residential care facilities for SSI recipients
- Must be available for 20 years
- Requires evidence of local support but no commitment

- All projects require 10-25% real cash or property match
- Projects can include acquisition, rehabilitation/renovation, or new construction
- All BHCIP and CCE projects are exempt from conditional use permitting and CEQA

BHCIP Timeline

BHCIP	Status
Round 1 Mobile Crisis	CCBHS received infrastructure grant
Round 2 Planning Grant	CCBHS received planning grant
Round 3 Launch Ready	Open through May 31, 2022
Round 4 Children and Youth	Expected: August 2022
Round 5 Addressing Gaps #1	Expected: October 2022
Round 6 Addressing Gaps #2	Expected: December 2022

- CCE projects are being accepted on a rolling basis until funds are exhausted.

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Needs Assessment: Methods

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Purpose of Needs Assessment and Action Plan

Needs Assessment

- Describe the populations who would benefit from BHCIP funded facilities, and
- Describe current capacity and estimate needed capacity based on agreed-upon definitions.

Action Plan

- Guide future pre-development activities,
- Pave the way for subsequent funding requests, and
- Set forth a plan for developing new behavioral health facilities.

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Stakeholder Discussions

Information Gathering

- Contra Costa Behavioral Health
  - AODS, Adult/Older Adult, Children/Youth, Office of Client Empowerment and Community Support Workers, Public Guardian's Office, Justice-Involved Mental Health Program, A3 Program.
- Contra Costa Regional Medical Center
  - PES and Inpatient Psychiatry
- Contracted Providers
  - Children/Youth, AODS, Adult/Older Adult
- Clients living at Crestwood
- NAMI Executive Director
- Community Forum

Education and Outreach

- CCHS and Public Works Real Estate and Capital Projects
- Current Board and Care Operators
- Nonprofit Housing Developers
- Current Contracted Providers
- Out-of-County Providers

Methods: Quantitative Data

- Quantitative data was used to:
  - Describe current systems capacity
  - Identify individuals served out-of-county
  - Estimate capacity needs
- Quantitative data obtained:
  - Aggregated service utilization data for FYs18-19, 19-20, and 20-21
  - Service cost information
  - Existing summary reports

Key Data Sources
PES Utilization & Discharge Data
Inpatient Psychiatric Hospital Utilization Data
MHRC / IMD Utilization Data
Board & Care Utilization Data
Youth Congregate Care Facility Utilization Data
Referrals to Detention-based Mental Health Services
CCBHS Housing Inventory Documents
MH and AODS EQRO Reports & Summary Data
CCBHS Medi-Cal Beneficiary Region Data
Referrals to the Public Guardian
Justice-Involved Mental Health Summary Data

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Guiding Questions

Who are the populations who are most in need of BHCIP and CCE funded facilities?

What types of programs/levels of care are most needed based on target populations?

What is the current facility capacity of the system?

What is the additional estimated capacity to meet identified needs that could be funded by BHCIP and/or CCE?

Needs Assessment: Findings

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Identified System-wide Priorities

- Serve people locally
- Have coverage across the County
- Build back capacity lost from facility closures
- Build capacity across the continuum
- Provide equitable services

Populations Most in Need of BHCIP or CCE Funded Facilities

People who are placed in out-of-county facilities

Adults with behavioral health issues who are involved with the criminal justice system

People living in West and East County

High need children who experience crisis, who may cross systems

Transition age youth who are struggling to launch into adulthood and/or cannot live with family

Older adults with serious mental health issues

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Crisis Services and Psychiatric Hospitalization Utilization

Level of Care	Adults (18+)			Youth (<18)		
	Client Volume	Total Bed Days	Avg. Length of Stay	Client Volume	Total Bed Days	Avg. Length of Stay
Psychiatric Emergency Services	**7,037**	**6,416**	**21.9 Hours**	**1,143**	**1,074**	**22.6 Hours**
Psychiatric Hospitalization	**1,251**	**13,401**	**11 Days**	**303**	**1,925**	**6 Days**
In-County	984	10,958	11 Days	179	1,074	6 Days
Out-of-County	267	2,443	9 Days	124	851	7 Days
Adult Crisis Residential Treatment	**426**	**6,675**	**16 Days**	-	-	-
Hope House	220	3,144	14 Days	-	-	-
Nierika House (Closed)	206	3,531	17 Days	-	-	-

Data represent CCBHS Clients in FY20-21

In-County psychiatric hospitals include CCRMC 4C/4D and John Muir Behavioral Health Hospital. CCRMC 4C/4D does not serve minors. Out-of-County psychiatric hospitalizations represent 42 hospitals across the state.

Hope House and Nierika House are In-County facilities serving adults; however, Nierika House closed in FY21-22.

The majority of crisis and hospital services are located in Central County

- Crisis services organized around CCRMC
  - Planned developments also in Central County (i.e., Children's CSU and Oak Grove)
- Desire for crisis satellite clinics in West and East County
  - Crisis respite services for children
  - CSU/CRT availability

COUNTY REGION OF CCBHS CLIENTS		
Region	**Adults (18+)**	**Youth (<18)**
Central	32%	22%
East	38%	45%
West	24%	29%
Unknown / Out-of-County	6%	4%

Data represent CCBHS Medi-Cal beneficiaries in FY20-21

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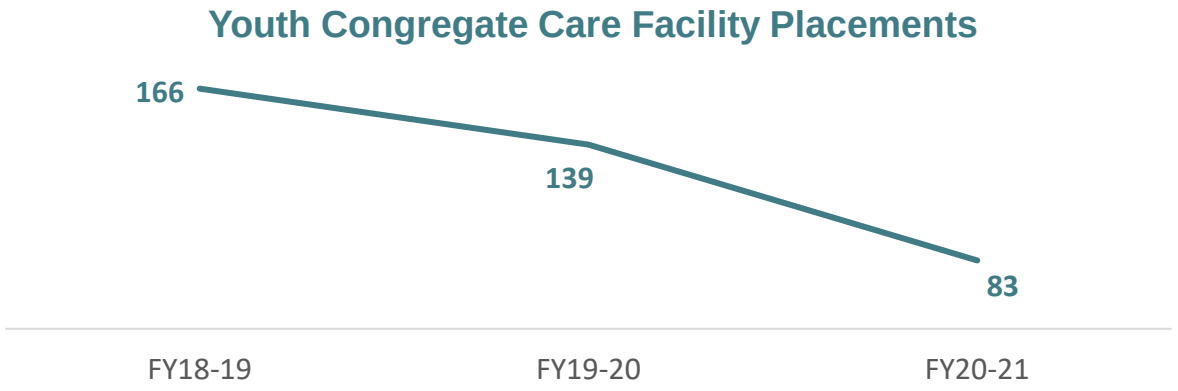
Many contracted residential beds are Out-of-County

Children/Youth

- Limited availability, varying quality, and providers unwilling to take youth with higher needs
- Need for additional and enhanced STRTP and treatment beds for children/youth



Level of Care	FY20-21 Youth Clients		
	Clients Volume	Total Bed Days	Avg. Length of Stay
STRTPs & Group Homes	**82**	**14,015**	**171 Days**
In-County	44	7,677	174 Days
Out-of-County	38	6,338	167 Days
Community Treatment Facilities	**1**	**658**	**658 Days**

Data in represent Contra Costa County youth dependents placed in STRTPs or Group Homes. Bed Day and Length of Stay data reflect the length of placements beginning in FY20-21 through April 28, 2022. All Community Treatment Facilities are Out-of-County.

Many contracted residential beds are Out-of-County

Adults/Older Adults

- Many adults placed in beds that are out of county
- There is a need for long-term, In-County programs:
  - Adult Residential Treatment (ART)
  - Mental Health Rehabilitation Center (MHRC)

Level of Care	FY20-21 Adult Clients		
	Client Volume	Total Bed Days	Avg. Length of Stay
Adult Residential Treatment	**74**	**7,101**	**96 Days**
Nevin House (Closed)	44	2,880	65 Days
The Pathway	30	4,221	141 Days
Mental Health Rehabilitation Centers	**74**	**14,031**	**190 Days**

Data represent CCBHS adult clients in FY20-21.

Nevin House and The Pathway are In-County facilities serving adults; however, Nevin House closed in FY21-22.

Mental Health Rehabilitation Centers represent 9 facilities across Alameda, Solano, Napa, Sacramento, Santa Clara, Marin, Merced, and Humboldt Counties.

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Adult Residential Treatment & MHRCs (FY20-21)

Level of Care	County	Contra Costa Region
Adult Residential Treatment		
Nevin House (Closed in FY21-22)	Contra Costa	West
The Pathway	Contra Costa	Central
Mental Health Rehabilitation Centers		
California Psychiatric Transitions	Merced	-
Canyon Manor	Marin	-
Crestwood - Angwin	Napa	-
Crestwood - Eureka	Humboldt	-
Crestwood - Sacramento	Sacramento	-
Crestwood - Vallejo	Solano	-
Crestwood – San Jose	Santa Clara	-
Gladman	Alameda	-
Villa Fairmont	Alameda	-

Data represent CCBHS contracted-facilities in FY20-21.

Justice Involved Mental Health (JIMH) Capacity

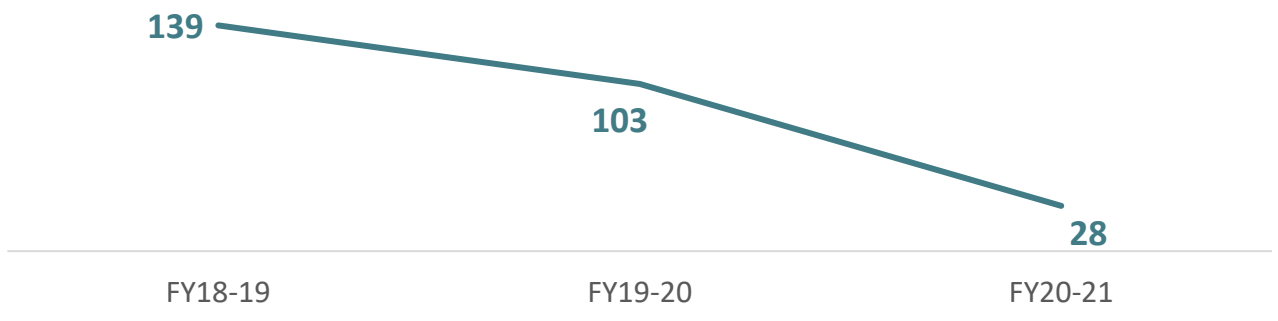
- Adult Detention Mental Health
  - There are approximately 216 referrals per month to detention mental health
  - There are approximately 378 people receiving detention mental health services at any given time.
- ~22 clients at MDF and/or WDF are referred per year to the Public Guardian by the Courts to determine if they meet criteria for LPS conservatorship.
- ~11 clients who are on probation and are open to CCBHS forensic mental health outpatient services need additional housing supports
- There are no in-county residential programs targeting justice-involved mental health
  - Some portion of this group would need secure treatment (PHF/MHRC)
  - Some portion of this group could likely be served in an unlocked setting (ART/B&C)

**JIMH clients who experience detention and are served by PES and/or CCBHS are reflected in the CCBHS and PES data. The only clients not reflected in the capacity estimates are those who only experienced detention and were never served by CCBHS or PES.*

Level of Care	FY20-21 Adult Clients		
	Client Volume	Total Bed Days	Avg. Length of Stay
State Hospitals (Napa, Metro, Patton, Atascadero)	20	5,802	290 Days

Adult Clients	CY 2021
Adults Referred to Detention-based Mental Health	2,586
Average Monthly Census of Adults Open to Detention-based Mental Health	378

Number of Youth in Juvenile Hall Referred to Mental Health Services



The Older Adult population does not have adequate services to meet their needs

- Older adults cannot go to existing programs because of age limitations or mobility needs
- When a Skilled Nursing Facility Special Treatment Facility (SNF/STP) is not appropriate or available, there are few alternatives
- A lack of adequate services causes this population to over-rely on hospital beds

Level of Care	FY20-21 Adult Clients		
	Client Volume	Total Bed Days	Avg. Length of Stay
Skilled Nursing Facility / Special Treatment Programs	**106**	**26,772**	**253 Days**
Board & Cares: Residential Care Facilities for Elderly (RCFEs)	**114**	**34,494**	**303 Days**
In-County	111	33,984	306 Days
Out-of-County	3	510	170 Days

Data represent CCBHS adult clients in FY20-21.

All SNF / STPs facilities are Out-of-County, representing 7 programs (5 facilities) across Alameda, San Joaquin, and Santa Clara counties.

RCFE Board and Cares represent 13 facilities, including 12 In-County and 1 Out-of-County in Solano.

SNF / STP Facilities & RCFEs (FY20-21)

Level of Care	County	Contra Costa Region
Skilled Nursing Facilities / Special Treatment Programs		
Crestwood Treatment Center & Manor - Fremont	Alameda	-
Crestwood Manor - Stockton	San Joaquin	-
Garfield Neurobehavioral Center	Alameda	-
Idylwood Care Center	Santa Clara	-
Morton Bakar Center SNF/STP	Alameda	-

Data represent CCBHS contracted-facilities in FY20-21.

Level of Care	County	Contra Costa Region
Residential Care Facilities for Elderly		
Baltic Sea Manor	Contra Costa	East
Concord Royale Board & Care	Contra Costa	Central
Crestwood Hope Center	Solano	-
Delly's Care Homes	Contra Costa	Central
Divine's Home	Contra Costa	West
Ducre's Residential Care	Contra Costa	West
Family Courtyard	Contra Costa	West
Friendship Care Home	Contra Costa	East
Gines Residential	Contra Costa	Central
Harmony House	Contra Costa	Central
Pleasant Hill Manor	Contra Costa	Central
Ramona Care Home	Contra Costa	Central
Walnut Creek Willows	Contra Costa	Central

Across population groups, there is a need for more supportive housing options

- Transition Age Youth (TAY) populations are in need of more supportive housing
- In addition to supportive housing, adults need far more Board and Care options
- Older adults need additional supportive housing and Residential Care Facilities for the Elderly (RCFE)

Level of Care	FY20-21 Adult Clients		
	Client Volume	Total Bed Days	Avg. Length of Stay
Board & Care: ARFs	**274**	**76,570**	**279 Days**
In-County	169	49,577	293 Days
Out-of-County	105	26,993	257 Days

Other Housing Options	Contracted Units
Permanent Supportive Housing	**180 Units**
MHSA Master Lease Housing: Scattered Site	97 Units
MHSA FSP Housing Flex Funds	Variable Use
MHSA Housing Program / Special Needs Housing Program	52 Units
No Place Like Home	31 Units
Shelter Beds	**95 Beds**

ARF Board & Care data represent CCBHS adult clients in FY20-21. ARF Board and Cares represent 23 facilities, 15 In-County and 8 Out-of-County.

Data were unavailable for Permanent Supportive Housing and Shelter bed utilization. The information reflects contracted beds/units in FY21-22.

Indigo Project

Adult Board and Care Facilities (FY20-21)

Level of Care	County	Contra Costa Region
Board and Care Facilities		
Afu's One Voice Care	Contra Costa	East
Blessed Care Home	Contra Costa	East
CC's Care Home	Contra Costa	Central
Crestwood – Our House	Solano	-
Crestwood – The Bridge	Contra Costa	Central
Ever Well – Enclave at the Delta	San Joaquin	-
Psynergy – Morgan Hill / Nueva Vista	Santa Clara	-
God's Grace – Hampton Road	Alameda	-
God's Grace II – Beckham Way	Alameda	-
Johnson Care Home	Contra Costa	East
Margarita's Villa of Care II	Contra Costa	Central
Menona Drive Care Home	Contra Costa	East
Menona Drive Care Home II	Contra Costa	East
Modesto Residential Living Center	Stanislaus	-
Oak Hills Residential Facility	Contra Costa	East
Paraiso Home	Contra Costa	East
Springhill Home	Contra Costa	East
Williams Board & Care Home - Richmond	Contra Costa	West
Williams Board & Care Home - Vallejo	Solano	-
Woodhaven Home	Contra Costa	Central
Yvonne's Home Care – Shane Drive	Contra Costa	West
Yvonne's Home Care – 6th Street	Contra Costa	West

Data represent CCBHS contracted-facilities in FY20-21.

Since Drug Medi-Cal Reform, the AODS system, with minimal exception, has adequate capacity

Current System

- Excess capacity for women's residential
- At capacity for men's residential
- No medical detox available
- County unable to meet network adequacy standards for Youth Medically Assisted Treatment (MAT) and youth residential

Future Planning

- Changes to women's facilities in progress:
  - One program currently leasing may purchase a building and move
  - A women's residential program may be converted to housing (CCE)
  - County will need to augment Detox beds in a different facility to maintain capacity
- There is a desire to do a multi-level facility that has medically managed detox with social model detox and men's residential beds

Indigo Project

AODS Program Utilization (FY20-21)

Level of Care	FY20-21 Adult AODS Clients		
	Client Volume	Total Bed Days	Avg. Length of Stay
Adult Narcotic Treatment Programs	**1,237**	**1,142,165**	**923 Days**
Adult AODS Residential Treatment	**790**	**32,956**	**42 Days**
Female Facilities	272	10,776	40 Days
Male Facilities	518	22,180	43 Days
Adult Detoxification Treatment	**385**	**1,565**	**4.1 Days**
Female Facilities	123	456	3.7 Days
Male Facilities	262	1,109	4.2 Days

Data reflect adult AODS clients in FY20-21.

All Residential and Detoxification facilities are In-County. Currently, there are no youth-specific NTP, Residential, or Detoxification programs.

Length of Stay reflects the length of stay for any clients enrolled during FY20-21, including clients who began treatment before FY20-21, but continued treatment into FY20-21.

Level of Care	Contra Costa Region	Population
Adult Narcotic Treatment Programs		
BAART: Antioch	East	Adults
BAART: Richmond	West	Adults
Adult AODS Residential Treatment		
Bi-Bett: Wollam	East	Female
Bi-Bett: Frederic Ozanam Center	Central	Female
Ujima: La Casa	East	Female
Ujima: The Rectory	West	Female
Discovery House	Central	Male
Bi-Bett: Diablo Valley Ranch	Central	Male
J Cole Recovery Homes	East	Male
Pueblo del Sol	Central	Male
Richmond Health & Wellness	West	Male
Adult Detoxification Treatment		
Bi-Bett: Wollam	East	Female
Bi-Bett: Frederic Ozanam Center	Central	Female
Pueblo del Sol	Central	Male
Richmond Health & Wellness	West	Male

BHCIP Capacity Estimates

Indigo Project

Out-of-County Placements & Costs (FY20-21)

Out-of-County Facilities	Estimated Out-of-County Average Daily Census in FY20-21	Estimated Out-of-County Costs in FY20-21	Estimated Facility Beds Needed to Serve Clients In-County
Psychiatric Hospitals		~$4.1 million*	
Adults	7 Clients	-	8 Beds
Youth	2 Clients	-	2 Beds
Mental Health Rehabilitation Centers	38 Clients	~$5.9 million	45 Beds
Skilled Nursing Facilities / Special Treatment Programs	73 Clients	~$2.8 million	85 Beds
Short-Term Residential Treatment Programs	17 Clients	~$3.4 million	20 Beds
Community Treatment Facilities	1 Clients	~$170,000	1 Bed
Board & Care: Residential Care Facilities for Elderly	1 Clients	~$70,000	1 Bed
Board & Care: Adult Residential Facilities	74 Clients	~$2.9 million	87 Beds

Average Daily Census is calculated as: Number of Admissions Annually x Length of Stay ÷ 365

Estimated Bed Need assumes 85% capacity and is calculated as: Average Out-of-County Daily Census / 0.85

Estimated costs are based on average daily rates from 2021 and/or 2022, depending on data availability. Costs were calculated as Total Placement Days x Average Daily Rate

*Psychiatric hospitalization cost claims data were unavailable for ~50% of out-of-county placements and days for a variety of reasons. To estimate total out-of-county psychiatric placement costs in FY20-21, the average hospital rate was used for out-of-county placement days where cost information was unavailable. Due to these cost limitations, costs were estimated for total out-of-county psychiatric hospitalizations and were not estimated separately for youth and adults. STRTP costs reflect the STRTP reimbursement rate for placement (not including state and federal match) and the average County costs for MH Treatment for each youth per year. As the average length of stay for CTF extended beyond one year, estimated costs for FY20-21 were standardized to 365 days.

Adult Residential & Crisis Residential Costs

Bed Capacity

- All programs are 16-bed facilities and allow for Medi-Cal reimbursement
- ARTs
  - Nevin was a co-occurring residential program with the capacity to serve JIMH clients in West County
  - The Pathway is in Central County
- CRTs
  - All CRT capacity was/is in Central County

Level of Care	Estimated Total Costs in FY20-21	Estimated County Costs in FY20-21
Adult Residential Treatment	**$1,134,157**	**$517,133**
Nevin House (Closed)	$509,031	$210,775
The Pathway	$625,126	$306,358
Adult Crisis Residential Treatment	**$2,813,168**	**$884,547**
Hope House	$1,350,147	$388,003
Nierika House (Closed)	$1,463,021	$496,544

Data represent costs for CCBHS adult consumers in FY20-21.

Nevin House and Nierika House closed in FY21-22.

Total costs reflect total Medi-Cal claimed amount in FY20-21. Total costs to the county reflect the amount not reimbursed by Medi-Cal and paid by the County.

In-County Adult/Older Adult Capacity

Crisis Spokes Capacity

Region	FY20-21 Adult M/C PES Clients Discharged to Home / Self		
	M/C PES Clients Discharged to Home / Self	Estimated Average PES Daily Census by Region	Estimated CSU Beds Needed by Region
TOTAL	**4,590**	**12 Clients**	**14 Beds**
Central	1,453	4 Clients	5 Beds
East	1,744	4 Clients	5 Beds
West	1,124	3 Clients	4 Beds
Unknown / Out-of-County	270	1 Client	1 Bed

In FY20-21, 76% of adult client were discharged to home / self from PES. Of these clients 86% were Medi-Cal beneficiaries, Medicare beneficiaries, or had an unknown insurance status.

To determine estimates, the % of CCBHS Adult Medi-Cal beneficiaries living in each region were applied to the volume of clients discharged to home, and the adult average PES stay of 0.91 days was used.

Children and Youth Capacity

Children's Crisis: CSU or Crisis Respite

Region	FY20-21 Youth M/C PES Clients Discharged to Home / Self		
	M/C PES Clients Discharged to Home / Self	Estimated Average PES Daily Census by Region	Estimated CSU Beds Needed by Region
TOTAL	**479**	**2 Clients**	**2 Beds**
Central	105	<1 Client	<1 Bed
East	215	1 Client	1 Bed
West	140	<1 Client	<1 Bed
Unknown / Out-of-County	20	<1 Client	<1 Bed

In FY20-21, 64% of youth clients were discharged to home / self from PES. Of these clients, 65% were Medi-Cal beneficiaries or had an unknown insurance status.

To determine estimates, the % of CCBHS Youth Medi-Cal beneficiaries living in each region were applied to the volume of clients discharged to home, and the youth average PES stay of 0.94 days was used.

STRTP

- 20 Beds

AODS

- Youth Residential Treatment
  - 6 Beds
- Youth MAT/NTP
  - 6 youth per year

BHCIP Program Needs

BHCIP "Community Wish List"

- Adult/Older Adult System of Care:
  - Build back and expand capacity for Nevin (ART) and Nierika-type programs(CRT)
  - Plan crisis spokes in West and East County (CSU, CRT, Peer Respite)
  - Develop in-county MHRC
- Children and TAY
  - Children's crisis services
  - STRTP+
  - Multi-level, multi-agency outpatient clinics
- AODS
  - Medically supervised withdrawal management
  - Youth residential treatment
  - Youth medication assisted treatment
  - Sobering station

Coming Soon!

- Oak Grove
  - Urgent Care and Crisis Intervention
  - Peer Respite
  - Sobering Station
- CCRMC Campus
  - Children's Crisis Stabilization

**These projects are already funded through other means and do not need to be replicated through the BHCIP process.*

In Discussion

- Crisis Spokes: Do we need buildings for 4-6 bed programs, or can we expand within existing program locations?
- STRTP+: Can we enhance existing contracts, or do we need an additional building with the BHCIP commitment?
- Youth AODS: Is there the possibility of a regional approach?
- Older Adults: The health plans are responsible for SNF and Med Respite levels of care. Is there utility in engaging them in this discussion?

Indigo Project

Residential Living Options

CCE

- Older adult med respite
- Small and large board and care facilities (ARF and RCFE)
- Transitional housing for justice involved mental health consumers
- Supportive housing, project based and scattered site
- Supportive housing for TAY
- Supportive housing for LGBT+ youth

CCE Outreach

- Educational sessions were held for housing developers, current and out-of-county providers, and B&C operators to engage them in this process.
- Many are exploring within their agencies, and some have reached out with additional questions.

Indigo Project

BHCIP and CCE “Short List”

BHCIP

- Mental Health Rehabilitation Center
  - 1- 45 bed facility
  - 1- 16 bed facility
- 1- 16 bed CRT, preferably in West or East County, co-occurring capable
- 2- 16 bed ARTs, preferably in West and East County, co-occurring and JIMH capable
- Concord Outpatient Clinic (1420 Willow Pass) has outgrown its space
- AODS facility that includes medical and non-medical withdrawal management and co-occurring capable residential treatment
- AODS identified project for existing provider residential purchase

CCE

- Residential Living Options for JIMH
  - ~40 B&C and/or transitional housing beds
  - Housing + co-located outpatient services
- B&C Capacity
  - ~85-90 B&C beds
  - Could be a combination of small and large facilities
- AODS identified project for CCE conversion
- Range of supportive housing options for TAY, LGBT+, adults, and older adult CCBHS clients

Indigo Project

Next Steps

Indigo Project

Action Planning

BHCIP and County-initiated CCE

- Confirm projects and draft DHCS Action Plan
- Communicate specifications to real estate and capital projects
- Identify properties
- Engage in pre-development tasks
- Develop applications
- Submit for funding

Community and Provider-initiated CCE

Continue outreach and education efforts with potential CCE partners to encourage CCE project development

Provide TA to potential CCE partners to support their CCE project development

Indigo Project

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

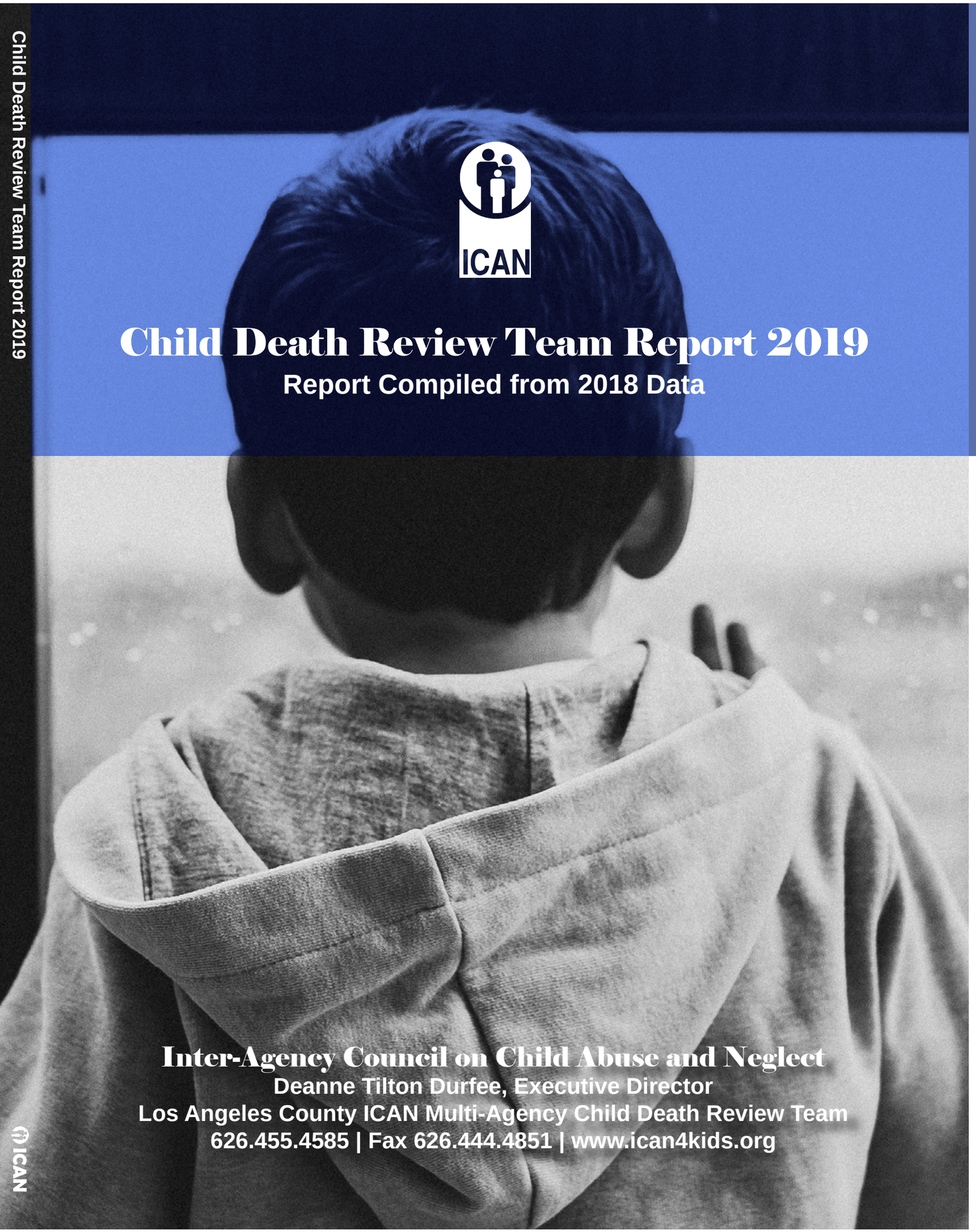
In 1977, the Los Angeles County Board of Supervisors designated the Inter-Agency Council on Child Abuse and Neglect (ICAN) as the official LA County agent to coordinate services for the prevention and treatment of child abuse and neglect.

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

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

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

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



Child Death Review Team Report 2019

Report Compiled from 2018 Data

Inter-Agency Council on Child Abuse and Neglect
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Los Angeles County ICAN Multi-Agency Child Death Review Team
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Table of Contents

Los Angeles County Team Representatives

Child Death Review Team

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

Child and Adolescent Suicide Review Team

Michael Pines, PhD, *Chicago School of Psychology*

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

Rosemary Rubin, *Retired, LAUSD*

Stephanie Murray, *Whittier Union High School District*

Teams Include Representatives From The Following

Los Angeles County Departments

- Children and Family Services
- Public Health
- 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
- Los Angeles Fire Department
- Office of City Attorney
- Los Angeles Unified School District

State and Other Community Partners

- Edelman Children's Court
- Community Care Licensing
- Independent Police Agencies
- Children's Hospital of Los Angeles
- Community Child Abuse Councils
- Chicago School of Professional Psychology
- Almansor Center
- USC School of Medicine
- Pacific Clinics
- Burbank United School District
- Whittier-Union School District
- United American Indian Movement

This report is available on line at: ican4kids.org

Introduction

The Los Angeles County ICAN Child Death Review team (CDRT) has met to analyze the circumstances that lead to child death in Los Angeles County for the past thirty-nine years. CDRT and the Los Angeles County ICAN Child and Adolescent Suicide Review (CASRT) teams meet monthly and are comprised of representatives of the Department of Medical Examiner-Coroner, Los Angeles Police and Sheriff's Departments, District Attorney's Office, Los Angeles City Attorney's Office, Office of County Counsel, Dependency Court, Department of Children and Family Services, Department of Health Services, Department of Public Health, Department of Public Social Services, County Office of Education, Department of Mental Health, California Department of Social Services, Los Angeles Child Abuse Councils and representatives from the medical community.

The Team reviews each referred case with input from the agencies that may have known of the child and family before, during or after the death. This process often illuminates problems in communication between agencies, in policies or procedures within and between agencies, or in dissemination of critical child safety information. Team participants provide feedback to, or seek clarification from their own agencies when a potential problem related to a child's death is identified. This active feedback process has resulted in improved inter- and intra-agency communication, more effective child safety practices, and more successful child death and injury prevention programs.

This report provides information on all child deaths that meet Team protocol and occurred in Los Angeles County during the calendar year 2018. Lessons learned from the reviews are included in the report. Appendix C at the end of the report provides on-line resources for prevention of child deaths.

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

Child Death Review Team: Risk Factors and Lessons Learned

Team case review yields valuable lessons, including identification of systematic issues in need of attention by one or various agencies impacting the welfare of children and families. Additionally, patterns of risk factors present in families surface in the cases. The lessons and risk factors noted from the 2018 child death review cases are as follows:

Child Risk Factors

Young Age

60% of the 2018 child abuse homicide victims killed by a parent/relative/caregiver were three years of age or under. Infants and young children are especially vulnerable to abuse and neglect which can lead to death due to their small size, inability to defend themselves and dependence upon caregivers to meet their needs.

Further, 64% of the children who died as a result of an accident were age five years or younger. Young children are more at risk of death due to drowning, pedestrian or auto back up because of their size and/or lapses of adult supervision to prevent such deaths.

Adolescence

Youth ages 15 – 17 years are most vulnerable for suicide (22 of the 29 suicides) or be a victim of a third party homicide (20 of the 27 victims).

Gender

In 2018, the gender gap of victims of child abuse homicides remains consistent with previous years with males outnumbering the female victims by two or more. There were six males and four females victims of homicide.

Race

Child Abuse Victims of a parent/relative/caregiver included African-American, Caucasian, Hispanic and Chinese. The breakdown is as follows; thirty percent of the child homicide victims were of African American descent (n=3) with an equal number of Caucasian children (n=3) and children of Hispanic descent (n=3). One child homicide was of Chinese descent.

Parental/Caregiver Risk Factors

Domestic Violence

In 2018, the nexus between domestic violence and child abuse/neglect continues to be evident. Seven or 77% of the families or the perpetrator had a documented history of domestic violence or child welfare history with DCFS.

Involvement with the Child Welfare System

A key factor in the majority of the child abuse homicide cases was that the child's mother, father or the perpetrator had at least one contact with the Department of Children and Family Services (DCFS). In 2018, DCFS contact with a parent and/or perpetrator occurred in 80% (n=8) of the families who experienced a child abuse homicide.

Cycle of Abuse

Cycle of abuse was not documented for all parents or caregiver who committed a child homicide. In three cases 30% (n=3) of the 2018 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 documented high risk factor for child abuse or neglect. Substance abuse often is also identified when there is a child fatality. Forty percent of the 2018 families of homicide victims had a history of substance abuse.

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 two causes of accidental death. In 2018, deaths associated with prenatal substance abuse were the largest number of child accident deaths accounting for 26% (n=27) of the accidental child deaths. 74% of the families in which there was an associated prenatal substance abuse accidental death had at least one contact with the child welfare system. Additionally, there were 2 undetermined infant deaths associated with prenatal substance use as evidenced by the mother testing positive at the birth for alcohol or drugs. Two of these mothers had at least one contact with the child welfare system prior to the birth.

Mental Illness

Untreated mental illness is a risk factor seen in many of the child abuse homicide cases. 40% (n=4) of the 2018 child abuse homicides involved a parent(s) and/or perpetrator with a history of mental illness.

Presence of multiple Parental/Caregiver Risk Factors

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

Perpetrator Relationship

Relationship

In 2018, there were 11 suspects in the ten child abuse homicides. Seventy percent of the child homicides involved a male perpetrator and 30% percent a female. Six of the primary suspects were the father, two mothers, two boyfriends, and a babysitter.

Lack of Parenting Skills, Bonding or Poor Attachment

The poor quality of the relationship of the adult to the child continues to be a recurring factor in child homicide deaths. This is particularly important with the person who assumes a primary caretaking role for the child.

Additional Risk Factors

Unsafe Infant Sleeping

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

Undetermined child deaths associated with bed-sharing and/or unsafe sleep environments declined

considerably from the high of 70 in 2009. Infants who die are often placed on their stomach or side on adult beds, couches and/or surrounded by soft bedding, pillows and/or are bundled in blankets in an effort to keep the infant warm. While there was a decline in these deaths in 2017 to 39, in 2018 there was rise to 44, these bed-sharing and/or unsafe sleep environments child deaths accounted for 66% of all the 2018 undetermined child deaths.

Findings

Overall Child Deaths*

- In 2018, a total of 236 child deaths were reported to the Team by the Medical Examiner-Coroner. The reported child deaths were the result of homicide by a parent, relative or caregiver, accident, suicide or undetermined cause in Los Angeles County for 2018. This is an increase from the 187 deaths in 2017.
- Ten children were victims of child abuse homicide by a parent, caregiver or other family member. There were also 29 suicides, 103 accidental child deaths and 67 undetermined child deaths.
- Forty-one children died with an associated bed-sharing or unsafe sleeping environment. All of these deaths were ruled undetermined and 1 as an accident.
- The percentage of children who died in 2018 by race consisted of 47.6% Hispanic, 23.5% Caucasian, 22.5% African American, 4.3% Asian/Pacific Islander, and 2.1% the race was Unknown.
- Fifty-eight percent of the children who died in 2018 were male and 39% female. There were 4 unknown gender child deaths.

Homicides by Parent, Family Member or Caregiver

- There were ten child abuse homicides by parents, caregivers or family members in 2018. This represents an increase of two homicides from 2017 when there were 8 child homicides.
- The number of child abuse homicides in 2018 for Los Angeles County was significantly lower than the 15-year average of 23. The number of child homicides in 2018 was also lower than the 5-year average of 14 percent.
- 44.9% of the children killed by their parents, caregivers or family members were under one year of age or younger and 60% age three years or younger.
- Six males and four females were homicide victims in 2018.
- Seventy percent of the child abuse homicide victims were battered children who died from inflicted trauma. Two of the children who experienced head trauma were also injured by being shaken violently and three died from multiple trauma. In addition, two children were shot by their father and one victim was drowned.
- Thirty percent of the child homicide victims were of African American descent (n=3) with an equal number of Caucasian children (n=3) and Hispanic children. (n=3). One child homicide was of Chinese descent.
- The Department of Children and Family Services (DCFS) or another county's Child Protective Services (CPS) agency had prior contact with 80% (n=8) of the families in which there was a child abuse homicide and the child died in Los Angeles County.
- Child abuse homicides occurred throughout Los Angeles County in 2018. The Fifth Supervisorial District experienced the greatest number of child homicides with 5 homicides occurring in this district. The Second District experienced two homicides. District One and Four both had one homicide each. The Third District did not experience any homicide by parent or caregiver in 2018. One homicide occurred outside of Los Angeles County but the LA County Medical-Examiner-Coroner conducted the autopsy.

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

Suicides

- Twenty-nine children and adolescents died by suicide in 2018 in Los Angeles County. The number of children and youth who died by suicide in 2017 almost doubled from the 14 such deaths in 2016 and the numbers continue to increase in 2018.
- The gender gap of 2017 with 20 (74%) males and 7 (26%) females taking their lives has decreased to 18 males (62%) and 11 female (38%) in 2018.
- The leading method in LA County continues to be death due to hanging, which represents 62% (n=18) of the suicides in 2018. There has been a decrease in the number of youth using firearms to take their life with four in 2018, compared to the five in 2017. In addition, four youths overdosed and three youth jumped from a height.
- The act of suicide historically occurs in the youth's home. Three of the 2018 suicides occurred outside of the youth's place of residence.
- 55% of the child/adolescent suicides in 2018 were by youth of Hispanic descent (n=15). Caucasian youth represented 35% (n=10) and African American youth comprised 10% (n=3).
- Seventy-five percent of the children who died by suicide in 2018 were ages 15 – 17 years. The youngest was 11 years of age.
- Fifty-one percent (n=15) of the youth had a mental health history, four had been hospitalized at some time, nine were prescribed psychotropic medication, and eight youths were in counseling at the time of their death. Ten youths had a history of prior self-injury or cutting and six youths had previously attempted suicide. Ten youths exhibited warning signs prior to their suicide.
- Seven of the youth who died by suicide in 2018 left a suicide note.
- Eleven of the youths' families were noted to exhibit signs of family dysfunction (pending divorce or recent divorce, parental mental illness or domestic violence). Thirty-seven percent (n=11) of the child/adolescent suicides were precipitated by interpersonal conflicts or a recent loss.
- 13 of the youths' families had a prior referral or case with the Department of Children and Family Services.
- Seven youths had a history of drug or alcohol use.
- Two youths had school discipline or truancy problems and four experienced academic problems.
- Child and youth suicides were experienced in all areas of Los Angeles County. The greatest number of incidents occurred in the Third and Fifth Supervisorial District with six suicides occurring in each district. Five suicides occurred in the Second and Fourth District; one suicide in the First District.

Accidental Child Deaths

- The number of children who died from an accident increased by four in 2018 from the previous year. There were 98 accidental child deaths in 2017 and 102 in 2018.
- Prenatal substance abuse and automobile death were the leading causes of accidental child death. Children dying in an automobile accident, either as a driver or a passenger, accounted for 28 of the

accidental deaths in 2018. Prenatal substance abuse also accounted for 28 of child deaths. The third leading cause of accidental child death involved a combination of pedestrian deaths: auto vs. pedestrian (n=12) and auto and bicycle/skateboard/scooter vs. vehicle (n=3) totaling 15 such deaths.

- Child deaths related to vehicles including bicycle/skateboard/scooter and auto-pedestrian accounted for 41% of all accidental child deaths (n=42).
- 23 of the 27 accidental child deaths associated with prenatal substance abuse as determined by the Coroner, hospital toxicology results were fetal deaths. Methamphetamine and/ or amphetamine use by the mother is the most associated drug with these deaths (n=17) accounting for 65%. The mother tested positive for methamphetamine/amphetamine and another substance in seven other deaths. All of the accidental deaths associated with prenatal substance use accounted for 26% of the total accidental child deaths in 2018.
- Accidental drowning claimed the lives of nine children which is a decrease from the 13 drowning deaths in the previous year. Eight of these drowning deaths were children who drowned in residential pools and one drowned in a bathtub.
- Of the 103 accidental child deaths, 84 deaths involved children ages 0 – 14 years. There were 18 accidental deaths of youth ages 15 to 17 years. 65% of the accidental child deaths (n=66) were children younger than five years of age.
- Of the children who died an accidental death in 2018, 55% had a DCFS history. Of the families whose child died as a result of prenatal substance abuse, 20 of 27 had a history with DCFS.
- Hispanic children represented 39% (n=40) of the accidental child deaths in 2018. Caucasian children represented 24% (n=24), African-American children 22% (n=22) and Asian/Pacific Islander represented 6% (n=6) of accidental deaths in 2018.
- As in previous years, males (n=56) outnumbered females (n=41) in accidental deaths. There was one unknown gender death.

Undetermined Child Deaths

- There were 67 undetermined child deaths in 2018. This is a 24% increase from the 54 such deaths in 2017.
- The majority, 97% of undetermined child deaths are children age one year or younger (n=65). Seventy-six percent of the undetermined child deaths were age six months and under.
- Children of Hispanic descent included 27 deaths. Caucasian children followed with 17. African American children represented 15 of the undetermined child deaths. Six of the children were Asian/Pacific Islander.
- 27% of the families with a child who died from an undetermined death had at least one contact with DCFS or another county CPS agency.
- After a period of decline in bed-sharing and unsafe sleeping environment infant deaths, 2016 represented a significant increase in these undetermined child deaths. Although there was a decrease in 2017 from 2016, there has been another increase in 2018. In 2018, there were 44 infant deaths related to bed-sharing and unsafe sleeping conditions.

Findings

- Associated bed-sharing and unsafe sleep environments accounted for 66% percent of all undetermined child deaths. 77% of these child deaths were associated with bed-sharing (n=34) and 23% with an non-co-sleeping unsafe sleep environment (n= 10).

- African American children are over-represented in bed-sharing and unsafe sleeping environment child deaths representing 30% of these deaths in 2018.

- 84% of the infants whose deaths occurred while bed-sharing or in an unsafe sleeping environment were six months of age or younger (n=37).

- In 18% of the bed-sharing and non-bed-sharing unsafe sleep child deaths, the infant was placed in a prone or side position for sleep. Five infants died while being held by their caretaker during sleep. One infant died while in front carrier.

- Undetermined child deaths involving bed-sharing and unsafe sleep environments occurred throughout Los Angeles County. However, the First and Second Supervisorial District accounted for 60% (n=8) and (n=8) of these deaths. This was followed by the Fourth District with 19% (n=5). District Five 15% (n=4) and the Third District had three, 7% of the death.

- Among the bed-sharing deaths, 7% involved only one unsafe risk factor, 32% involved two, and 61% 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.

- Of the undetermined child deaths involving bed-sharing, the infant was sleeping with one adult in 52% of the incidents and two adults in another 25% of the incidents.

- Twenty-three percent (n=10) of undetermined child deaths were associated with a non-bed-sharing unsafe sleeping environments which include adult bed, couch, foam mat, infant or car seat, pillows, soft or excessive bedding, excessive swaddling, stuffed toy.

- Four of the non-bed-sharing deaths were infants between 0 to 3 months of age (40%) and three were infants between 3 to 6 months of age (30%).

- While a majority of fetal and infant deaths associated with prenatal substance exposure are moded as an accident by the Medical Examiner-Coroner, there were 2 undetermined infant deaths in which the mother either tested positive for a substance at birth or self-reported substance use during pregnancy.

- One of the mothers of these infants had prior contact with a CPS agency in Los Angeles.

Senate Bill 39 (SB 39): Data Variances

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

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

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

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

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

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

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

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 to fatal attacks with clear intent.

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

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

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

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

Table 1	
Over the past 5 years, a parent, caregiver or other family member has murdered an average of 13 children each year	
Year	**Number**
2014	15
2015	6
2016	17
2017	8
2018	10

The average number of children and adolescents who committed suicide over the past five years is 20.6. The leading method from 2014 through 2018 is hanging.	
Year	**Number**
2014	10
2015	23
2016	14
2017	27
2018	29

An average of 100.6 children have died from preventable accidents over the past 5 automobile accidents, drowning and deaths due to auto vs. pedestrian.	
Year	**Number**
2014	103
2015	104
2016	95
2017	98
2018	103

The number of undetermined deaths has averaged 67.2 per year over the past five years	
Year	**Number**
2014	68
2015	44
2016	103
2017	54
2018	67

Child Deaths in Los Angeles County 2014 - 2018

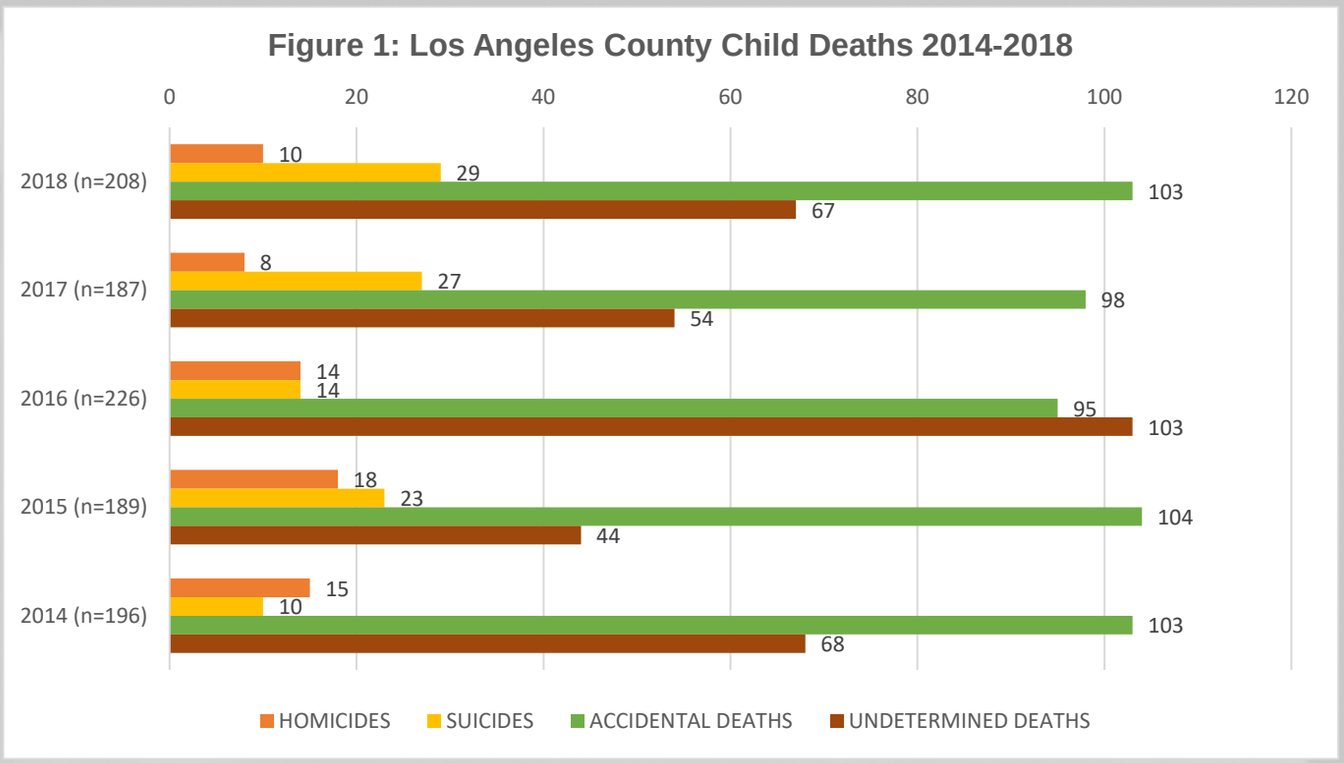
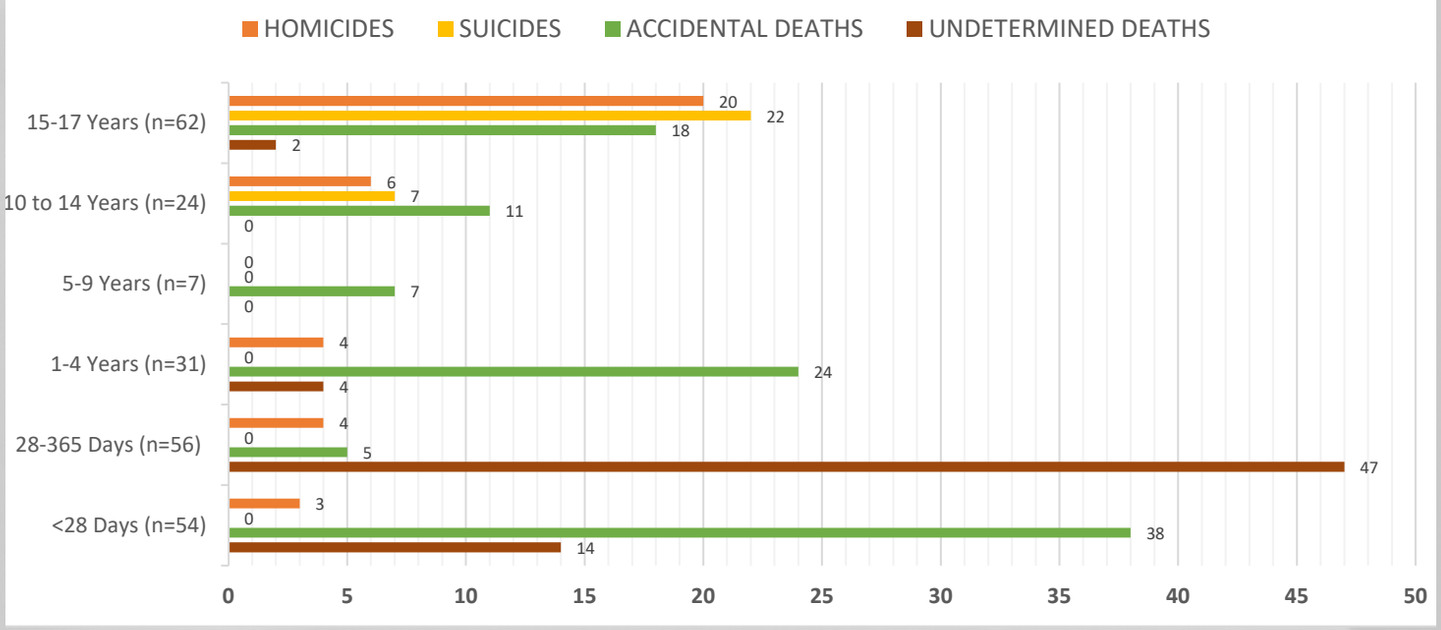


Table 2		
2018 Child Deaths Demographics - Coroner Cases		
	Number	**Percentage**
Total	236	100.0%
Gender		
Female	92	39%
Male	138	58.5%
Unknown	6	2.5%
Age		
Under 1 Year	111	47%
1 – 4 years	32	13.6%
5 – 9 years	8	3.4%
10 – 14 years	23	9.7%
15 – 17 years	62	26.3%
Race		
African American	53	22.5%
Asian/Pacific Islander	14	5.9%
American Indian	0	0.0%
Caucasian	55	23.3%
Hispanic	100	42.4%
Other	2	0.8%
Unknown	12	5.1%

Figure 2: Child Deaths by Age Group and Manner, Los Angeles County 2018 (n=236)



Sample Case Summaries

Cindy

Four-year-old, Cindy's father called 911 and indicated that he found Cindy face down in the bath tub unresponsive. When EMS arrived to the home, Cindy was lying on the bedroom room floor unresponsive and appeared to be in cardiac arrest. Cindy was observed to have burn marks to her vaginal area, upper and inner thigh area as well as face and ear area. Medical staff later reported that the burn marks were in different stages of healing. When father was asked about the burn marks, he had unusual statements. Father stated that Cindy had been sitting too close to a heater and that possibly it could also be due to the child being out too long in the sun. The child was pronounced deceased at the hospital.

Cindy lived primarily with her mother, she had seen her father sporadically throughout four years until three weeks before her death when her mother dropped her off at her father's house. Mother had been homeless and asked father to care for Cindy until she got back on her feet.

As a result of her death, Cindy's father was arrested and charged with murder. The case is currently pending.

Sean

Seven month old Sean reportedly began choking on food while his father fed him. Sean became unresponsive and the parents who did not have a phone ran over to the neighbor who called 911. Paramedics found him pulseless, apneic and cyanotic with vomit present and he was transported to the hospital

At the hospital an ophthalmology exam was able to be completed and revealed retinal hemorrhages in all three layers of the right eye. A skeletal exam was unable to be performed prior to Royal's death. The caller states that based on the findings of ophthalmology exam, Royal's injuries (and subsequent death) are suspicious for non-accidental trauma. The retinal hemorrhaging is not consistent with a choking episode and is suspicious for abuse. After an autopsy was performed the coroner found the cause of Sean's death is blunt for neck trauma and the manner of death is homicide. Father was arrested for the murder of his son.

Tommy

One early afternoon, ten-year-old, Tommy's mother called 911 and indicated that Tommy had collapsed and became unresponsive. Paramedics responded to the home and transported him to the Hospital in cardiac arrest. He was able to be resuscitated and during evaluation by medical staff, he was found to have bruises and abrasions to numerous areas of his body, possible burns, and was also diagnosed with a brain bleed. Tommy also showed signs of being malnourished. His mother provided information suggesting that he had injured himself; however, the story provided was not consistent with how Tommy likely sustained his injuries. His injuries are believed to be the result of severe physical abuse by his mother's current boyfriend, who is also the father to three of Tommy's half-siblings. Tommy was transferred to another hospital to receive a higher level of care, however, he did not survive.

The mother and mother's boyfriend were arrested for the murder of Tommy and their trial is pending.

Note: All names have been changed.

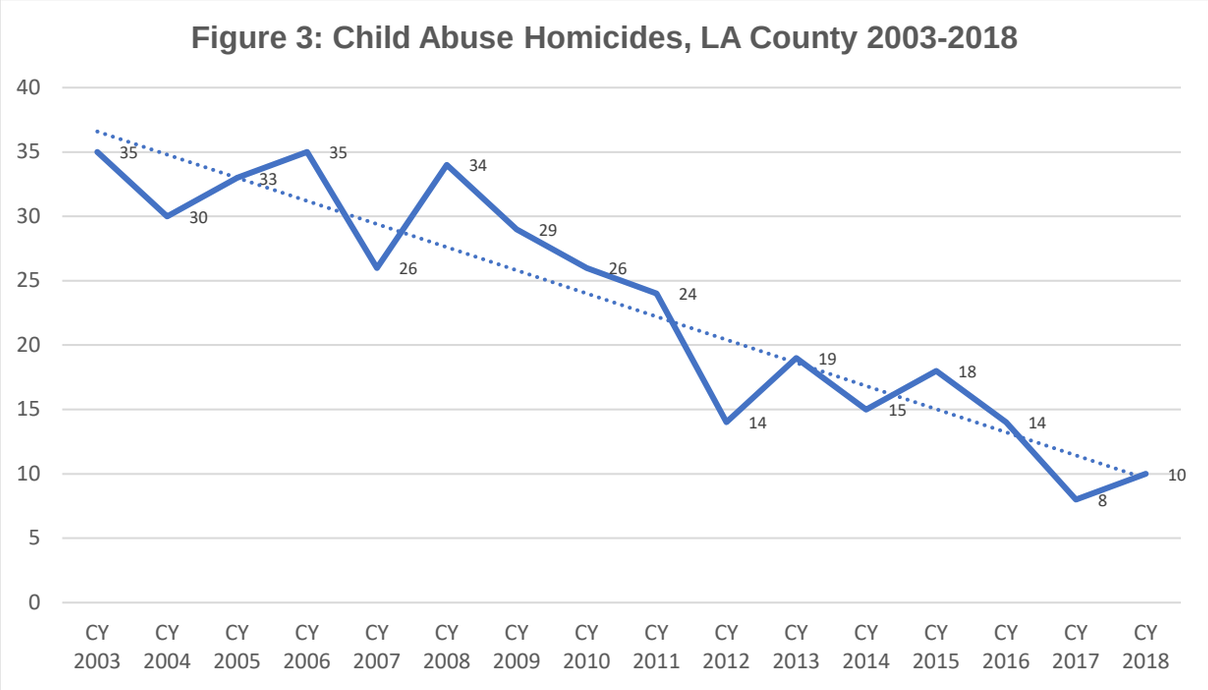


Figure 3: Child Abuse Homicides, LA County 2003-2018
40
35
30
25
20
15
10
5
0
35
30
33
35
26
34
29
26
24
14
19
15
18
14
8
10
CY 2003
CY 2004
CY 2005
CY 2006
CY 2007
CY 2008
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
CY 2014
CY 2015
CY 2016
CY 2017
CY 2018

Table 3

Causes of Child Homicide by Parent/Caregiver/Family Member, Los Angeles County 2003 – 2018

Cause	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	Total
Head trauma	7	7	6	11	11	12	8	2	10	5	3	1	2	5	4	4	**98**
Multiple trauma*	10	7	8	7	7	4	2	1	6	2	9	5	5	0	1	3	**77**
Asphyxiation/suffocation	6	5	5	6	6	3	2	3	2	0	1	1	2	0	3	0	**45**
Gunshot wounds	4	3	6	1	1	8	7	4	2	0	0	1	1	2	0	2	**42**
Trauma to torso/abdomen	0	0	2	1	1	1	1	5	1	2	1	1	0	0	0	0	**16**
Drowning	1	1	2	3	3	0	1	2	0	3	1	0	2	1	0	1	**21**
Stabbing	0	3	2	2	2	2	4	6	1	1	1	4	4	3	0	0	**35**
Unattended newborn	3	0	2	0	0	1	2	1	0	0	1	0	0	0	0	0	**10**
Poisoning/drug ingestion	1	1	2	0	0	0	0	0	0	1	1	0	1	2	0	0	**9**
Dehydration/malnutrition	1	2	0	0	0	1	1	0	1	0	0	1	0	0	0	0	**7**
Strangulation	0	0	0	1	1	0	0	1	0	1	0	0	0	0	0	0	**4**
Fire	0	0	0	3	3	1	0	0	0	0	0	0	0	1	0	0	**8**
Medical neglect	0	0	0	0	0	0	1	1	0	0	0	1	1	0	0	0	**4**
Burns	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Hyperthermia	2	0	0	0	0	1	0	0	0	0	1	1	0	0	0	0	**5**
Post-Term gestation	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**1**
TOTAL *includes auto injuries	**35**	**29**	**35**	**35**	**35**	**34**	**29**	**26**	**24**	**15**	**19**	**16**	**18**	**14**	**8**	**10**	**382**

Table 4						
Child Homicide by Parent/Caregiver/Family Member, Los Angeles County 2018 (N=9)						
Age	**Under 1 year**	**1 to 4 Years**	**5 to 9 Years**	**10 Years to 14 Years**	**15 to 17 Years**	**TOTAL**
Female	3	1	0	0	0	4
Male	1	2	0	3	0	6

40% of the child homicide victims by parents/caregivers/family member were under one year of age. 70% of the homicide victims were 3 years of age and under.

70% of the child homicide victims by parents/caregivers/family member were five years of age and under.

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

Table 5						
Child Abuse Homicides by Age and Cause, 2018						
Cause	**< 6 Months**	**6 - 11 Months**	**1 - 3 Years**	**3+ - 5 Years**	**6 - 12 Years**	**≥ 13 Years**
Head and Neck trauma	3	0	1	0	0	0
Multiple trauma	0	1	1	0	1	0
Gunshot Wound	0	0	0	0	1	1
Drowning	**0**	**0**	**0**	**1**	**0**	**0**
TOTAL	**3**	**1**	**2**	**1**	**2**	**1**

Figure 4: 2018 Child Abuse Homicides - Race

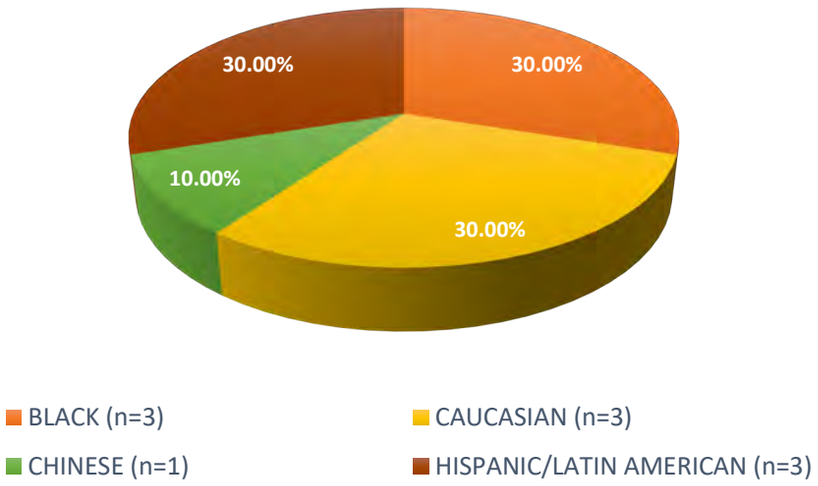


Figure 5: Homicides of Children by Race Compared to the General Population of Children

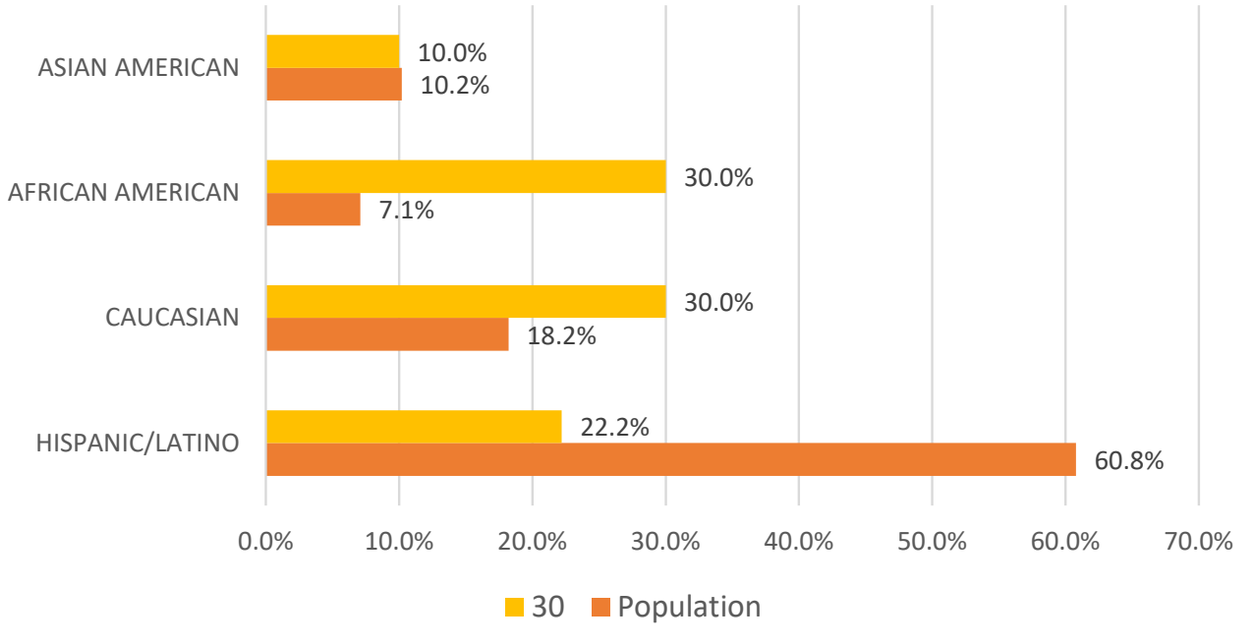
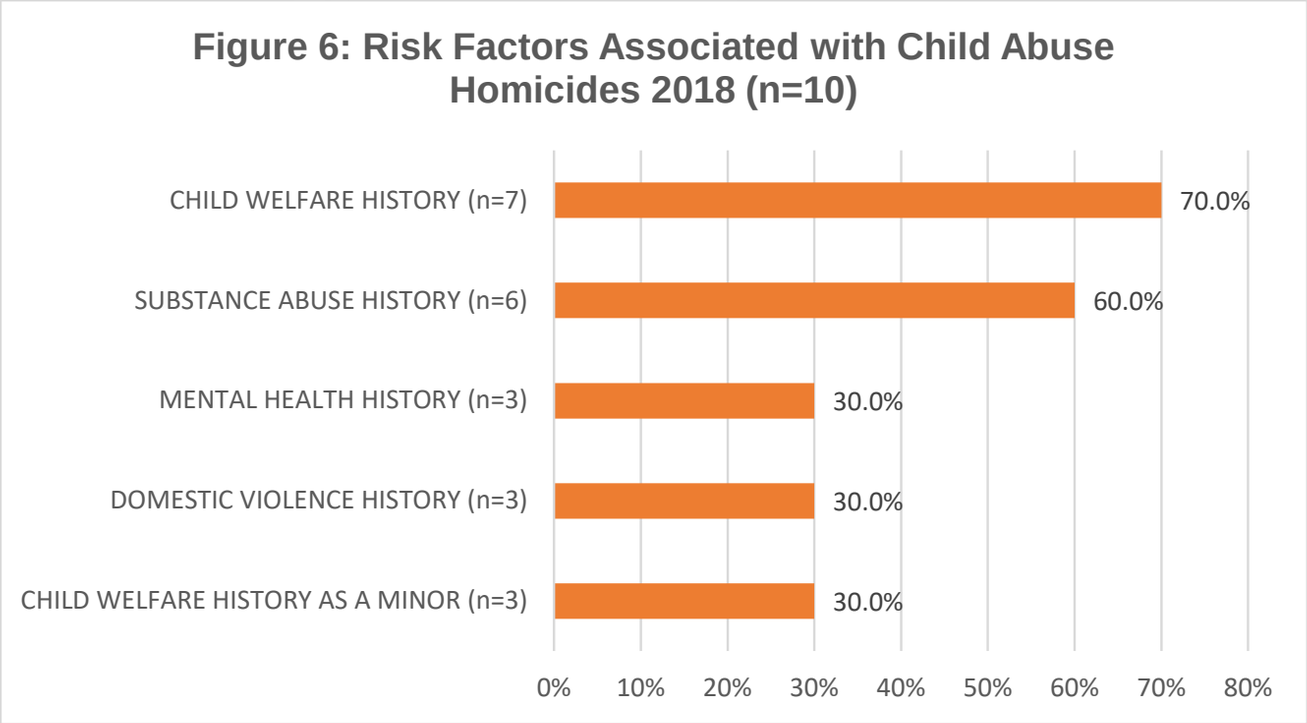


Table 6			
Relationship and Age of Suspect to Child, 2018			
Relationship	**19-30 years**	**31-40 years**	**40+ years**
Biological Mother	1	1	0
Biological Father	3	1	2
Boyfriend	1	1	0
Baby-Sitter	**0**	**0**	**1**
Total	**5**	**3**	**3**



**includes emotional/verbal abuse*

The two top common characteristics present in families in which a child abuse homicide occurred was a parent(s) and/or perpetrator had a child welfare history and a substance abuse history. This was followed by a parent(s) and/or perpetrator having a history of mental health, domestic violence, and child welfare history as a minor.

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 7.

Table 7

Law Enforcement Agency Involvement in 2018 ICAN Child Homicide by Parent/ Caregiver/Family Member

Agency	N	%
LAPD	3	30%
LASD	4	40%
Pasadena	1	10%
Redondo Beach	1	10%
Fresno	1	10%

The Los Angeles Sheriff's Homicide Bureau had investigative responsibility for a majority of the child homicides by parent/ caretaker/family member with 40% (n=4). Los Angeles Police Department investigated 30% (n=3) of the homicides. Pasadena PD, Redondo Beach PD and Fresno P.D. each investigated one homicide case

There were a total of eleven suspects in the ten homicide cases. Seven of the 2018 cases involving child homicide by parents/caregivers/family member were presented to the District Attorney. Three of the homicide cases that were not presented to the District Attorney were due to the case being dismissed due the suspects committing suicide. In two cases the father shot the mother child and himself and in the third case the father committed suicide after admitting investigating detectives that he had committed the murder.

In 2018, three of the homicide cases were not submitted to the District Attorney because the suspect committed suicide and the case was closed.

Table 8

Law Enforcement Reasons for Not Presenting 2018 ICAN Child Homicide by Parent/ Caregiver/Family Member to the District Attorney

	N	%
The Suspect Was Deceased	3	33%
TOTAL Child Abuse Homicides	**10**	**100%**

Table 9		
Relationship of Perpetrators – 2018 ICAN Child Homicide by Parent/Caregiver/Family Member		
Relationship	**Charged By District Attorney**	**%**
Biological Mother	2	20%
Biological Father	3	60%
Boyfriend	2	10%
Baby-Sitter	1	10%

In 2018, six of the case investigations resulted in presentations to the District Attorney's Office by law enforcement agencies involving seven perpetrators. The District Attorney filed charges in all six cases.

The charge filed by the District Attorney in the past seven years is illustrated by Table 10.

Table 10

Criminal Charges Filed on 2015-2018 ICAN Child Homicide by Parent/Caregiver/ Family Member

	2015	2016	2017	2018
Murder (187 (a) P.C.)	11	9	4	8
Assault on a child under 8 years resulting in death (273ab P.C.)	3	6	4	
Child abuse leading to death of a child (273a(a) P.C.)	1	2	1	
Child endangering (273a(1) P.C.)				
Assault with deadly weapon (245 (A) (1) P.C.)		1		
Voluntary manslaughter (192a P.C.)		1		
Involuntary manslaughter (192b P.C.)				
Attempted murder (664/187 (a) P.C.)		2		
Arson (451(b)		1		
Lewd and lascivious acts by force (288(b)(1) P.C.)				
Battery (242-243(e) 1 P.C.)				
Torture (206 P.C.)	1	1		
Burglary (459)			1	
Violation of protective order (273.6)			1	

Table 11

Criminal Case Disposition of 2014 – 2018 Child Homicides[2]

	2014	2015	2016	2017	2018
Life without possibility of parole		1			
80 years to life prison					
56 years to life prison					
50 years to life prison		1	2		
40 years to life prison		1			
33 years to life prison			1		
31 years to life prison	1				
30 years to life prison				1	
25 years to life prison	3	4	3	3	
19 years to life prison					
18 years to life prison		1			
17 years to life prison					
16 years to life prison					
15 years to life prison	3	1	1	1	
11 years to life prison					
26 years prison	1				
25 years prison	1				1
23 years prison		1			
22 years prison	1		1		
20 years prison					
19 years prison					
18 years prison					
16 years prison	1	1			
15 years prison					
13 years prison					
12 years prison			2		
11 years prison		1		1	
10 years prison			1		
9 years prison					
8 years prison					
7 years prison					
6 years prison	1		1		
5 years prison			1		
4 years prison	1		1		
3 years prison					
3 years jail					
1 years jail					
Less than 3 months jail					
Found not guilty	1				
Dismissed	3	1			
180 days County Jail					
Mental competency hearing					
Pending Trial	1	7	7	5	
DA Requesting Further Investigation	0	0	0	0	

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

Criminal disposition data for 2014 through 2018 is presented in Table 13. 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 2018 child homicides, only one of those charged had a disposition in 2018 receiving a sentence of 25 years to life in state prison. The rest of the 2018 cases filed by the District Attorney are pending trial.

Table 12

Child Homicides by Parents, Caregivers or Family Member
Child Welfare Involvement 2004 – 2018*

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
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[132]	7	5	0 – relative caregivers 0 – foster parent
2015	18	13	11	2[13]	0 – relative caregivers 0 – foster parent
2016	14	6	4	2	0 – relative caregivers 0 – foster parent
2017	8	7	5	2[14]	0 – relative caregivers 0 – foster parent
2018	10	8	8	1	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[1]

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.

One was open to another county.

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.

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.

Includes two deaths with a CPS history in another state and one death with history in another county.

One child died in LA County was under the jurisdiction of Riverside CPS.

One child died in LA County had history in another county but not in LA County.

One child was killed by a caregiver who had an open case with DCFS.

One case was open due to the child's injuries before death. The family had no prior DCFS history.

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.

One case was open due to the incident leading to the fatality. The family had no prior DCFS history.

One referral involved false allegations by the suspect on the older half-sibling.

Table 13

Dates[15] of Child Homicides – 2018

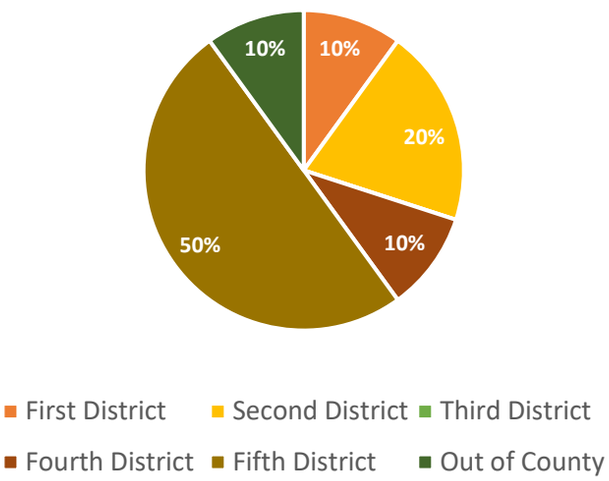
1 homicides occurred in January (1/5)
1 homicide occurred in February (2/4)
0 homicides occurred in March
1 homicides occurred in April (4/28)
2 homicides occurred in May (5/5 & 5/8)
1 homicide occurred in June (6/21)
2 homicides occurred in July (7/3 & 7/11)
1 homicides occurred in July (7/11)
0 homicide occurred in August
0 homicide occurred in September
0 homicides occurred in October
1 homicides occurred in November 11/7)
1 homicide occurred in December (12/2)

Table 14

Locations[16] of Child Homicides – Geographic Area – 2018

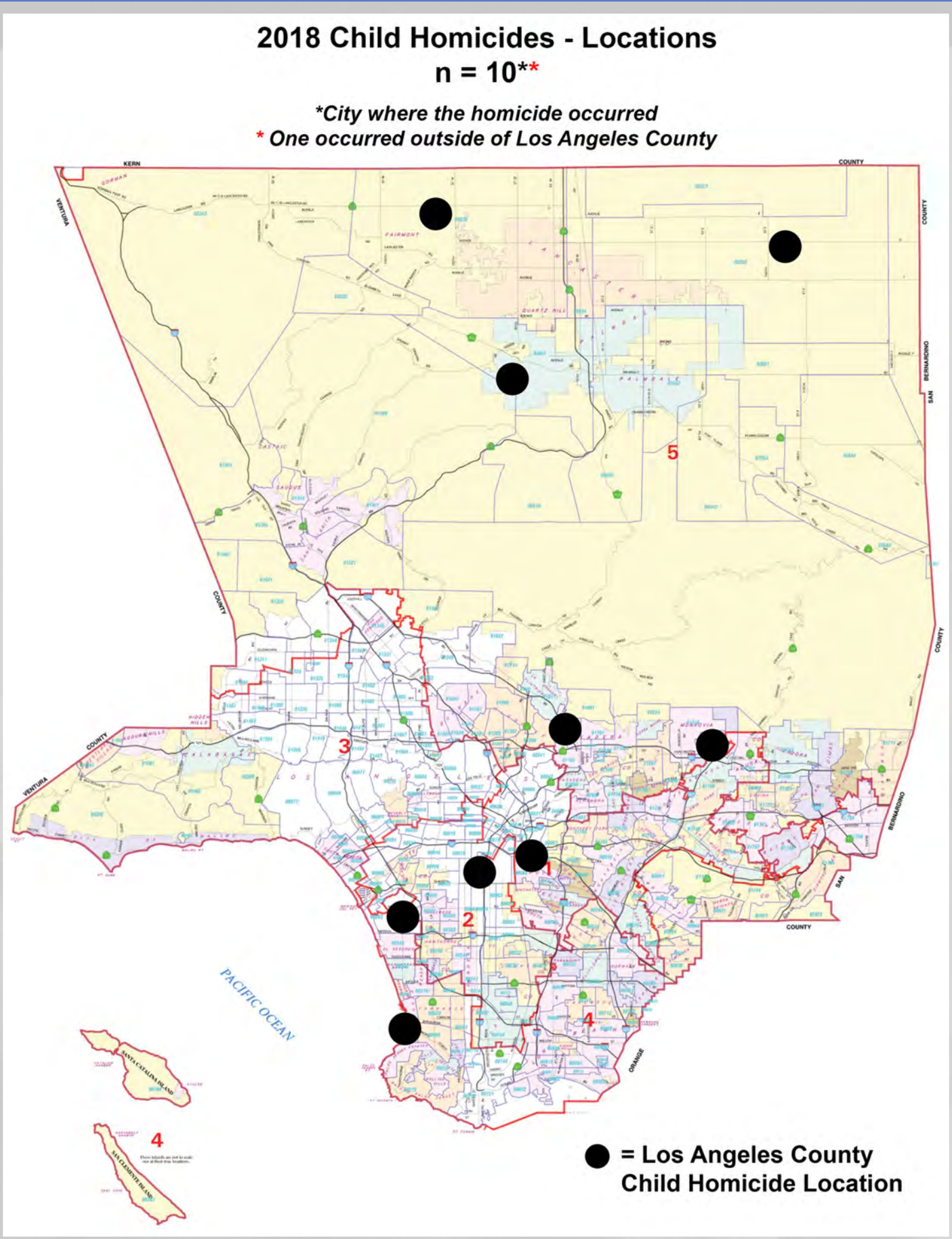
4 homicides occurred in Los Angeles (zip code 2 in 90027 and 90033, 90015)
1 homicide occurred in Pasadena (zip code 91103)
1 homicide occurred in Redondo Beach (zip code 90027)
1 homicide occurred in Santa Clarita (zip code 91390)
1 homicide occurred in Westchester (zip code 90045)
1 homicide occurred in Lancaster (zip code 93536)
1 homicide occurred out of the County (zip code 93702)

Figure 7: Child Abuse Homicides by Board of Supervisor District



[15] 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.

[16] City where the fatal injury or fatality occurred


2018 Child Homicides - Locations
n = 10**
*City where the homicide occurred
* One occurred outside of Los Angeles County
KERN
VENTURA
COUNTY
SAN BERNARDINO
ORANGE
FAIRMONT
QUARTZ HILL
PALMDALE
SAUGUS
CASTAIC
HIDDEN HILLS
MONROVIA
PACIFIC OCEAN
SANTA CATALINA ISLAND
SAN CLEMENTE ISLAND
1
2
3
4
5
= Los Angeles County
Child Homicide Location

Sample Case Summaries

Marvin

Marvin, a 16 year old male with a history of Oppositional Defiant Disorder was found unresponsive by his caregiver. A suicide note was recovered from scene. The note stated, "I don't want to be a burden anymore… my life sucks, I miss my brother and John…" Marvin's close friend, John committed suicide about 3 years ago and Marvin's adult sibling committed suicide about 7 months before Marvin's suicide in the same manner as Marvin. It was reported that Marvin had previously expressed suicidal ideation, one occasion 3 years ago, and was placed on a psychiatric hold as a result. After Marvin was picked up from the hospital, he admitted to expressing suicidal ideation because he didn't want to go to school. Within the last week, Marvin had broken up with his girlfriend and was also involved in an altercation wherein one of his friends was stabbed during the altercation.

Christine

Christine, age 12, female, was at home with friends and family. Christine was last seen alive around 7:30pm when she was playing games on her iPad in her bedroom; she appeared to be cheerful at that time. About an hour later, Christine was discovered unresponsive while sitting on her bedroom floor. Christine had a tie wrapped around her neck and the other end of the tie was tied around her bedframe. The tie was cut from around Christine's neck, CPR was initiated, and 911 was called. Christine was transported by paramedics to the hospital and admitted to the PICU, however, her condition did not improve and her death was pronounced at the hospital. The family indicated that Christine was a happy child and there had been no signs of depression or suicidal ideation. The caregivers pointed out that Christine had searched "The Blue Whale Challenge" on her Ipad before her death. This Blue Whale Challenge was known to have started in the UK and was a game requesting teens to conduct a series of challenges and one of the challenges was committing suicide.

Joshua

Joshua, a 15 year old male had arrived home from school and was at home with his mother. He was last seen eating a burrito in his bedroom. Shortly thereafter, mother went into Joshua's room and discovered him hanging with a rope around his neck from a pull-up bar in his door frame. The pull up bar was usually in the garage. Mother contacted 911 and he was airlifted the hospital he was placed on a ventilator for a few days. He underwent multiple medical exams and was eventually confirmed brain dead. The parents indicated that Joshua had not demonstrated any suicidal ideation or any warning signs before his death. Joshua was a member of ASB, church groups, and was a hip-hop performer. Joshua's family had no history of discord or family problems. All the family and friends interviewed regarding his death were in complete shock at Joshua committing suicide.

Note: All names have been changed.

Figure 8: 2003-2018 Child and Adolescent Suicides

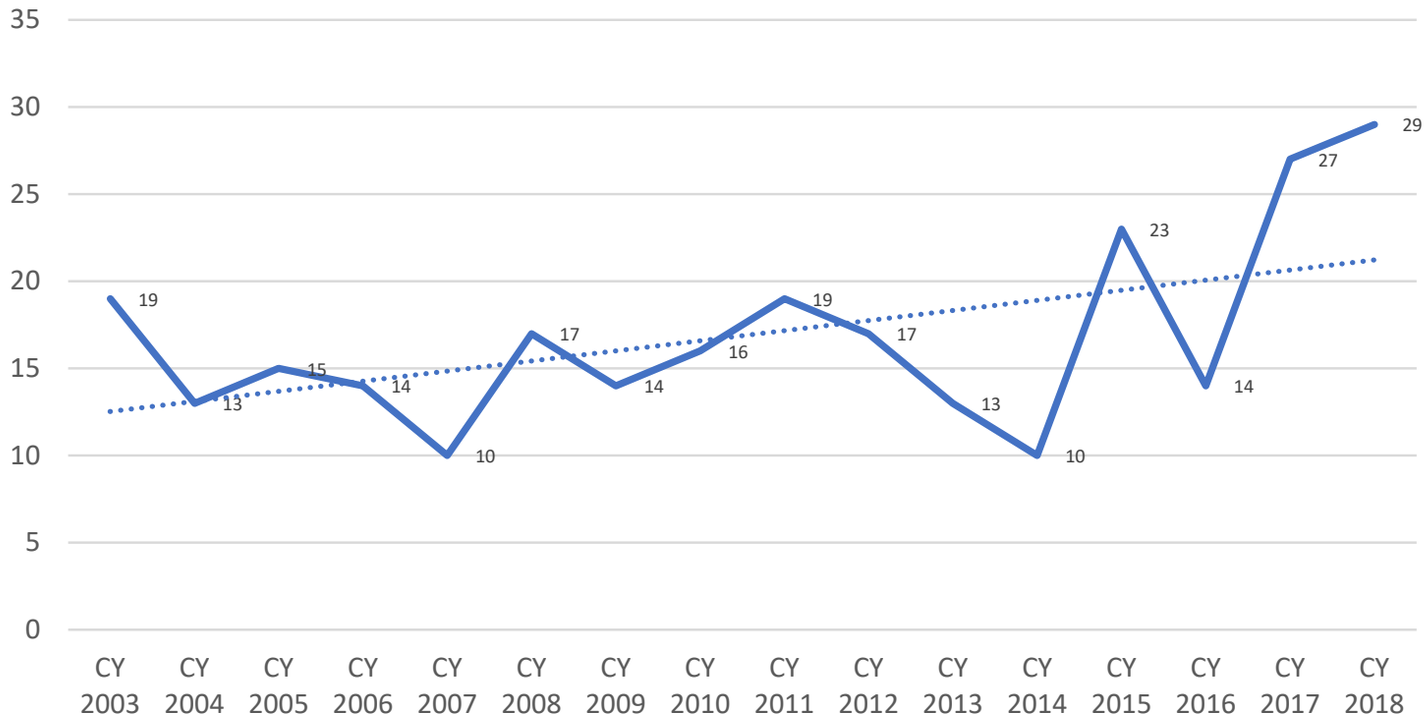


Table 15		
Child and Adolescent Suicides by Method and Gender, Los Angeles County - 2018 (N = 29)		
Method	**Male**	**Female**
Hanging	13	5
Firearms/Gunshot	3	1
Jump from height	2	1
Overdose	0	4
TOTAL	**18**	**11**

Hanging was the most frequent method of suicide among adolescents and represents 62% of the suicides in 2018. Use of a firearm and overdose were both the second most frequent method of suicide in 2018 with 8 youths committing suicide by firearm (n-4) and overdoes (n-4). Three youth jumped to their death.

In 2018, the gender gap between males and females ending their own lives decreased slightly with 74% (n=20 of the adolescent suicide victims being male and 38% (n=11) female.

Table 16								
Five Year Suicide Trend-Gender								
Gender	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**Total 2013-2018**	**5 Year Average**
Male	5	6	14	10	20	18	73	12.2
Female	8	4	9	4	7	11	43	7.2
Total	13	10	23	14	27	29	87	19.3

Figure 9: 2018 Child Suicides - Race

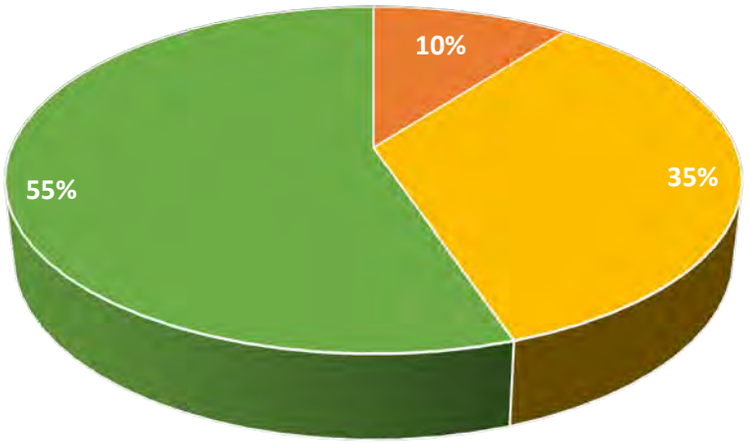


Figure 10: Suicides of Children by Race Compared to General Population

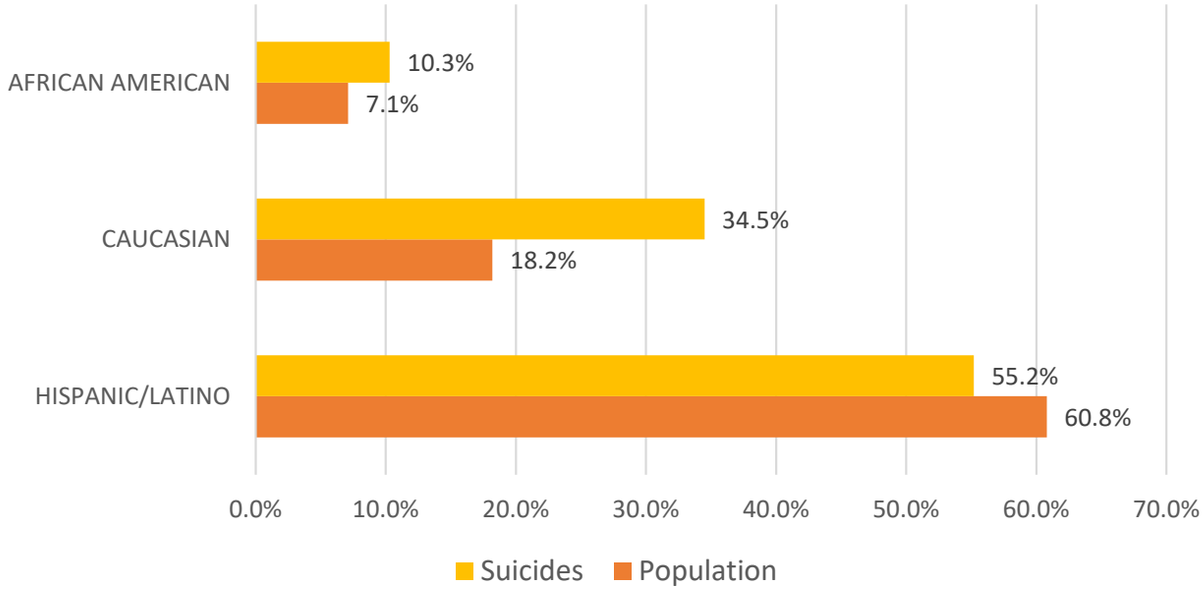


Table 17							
Five Year Trend by Age							
Age	**2014**	**2015**	**2016**	**2017**	**2018**	**Total**	**%**
17 years	1	9	5	9	9	33	32.0%
16 years	2	6	1	3	4	16	15.5%
15 years	0	1	3	4	9	17	16.5%
14 years	3	4	3	4	2	16	15.5%
13 years	2	3	2	4	2	13	12.6%
12 years	1	0	0	2	2	5	4.9%
11 years	1	0	0	0	1	2	1.9%
10 years	0	0	0	1	0	1	1.0%
Total	10	23	14	27	29	103	

Figure 11: 2018 Child and Adolescent Suicides - Age

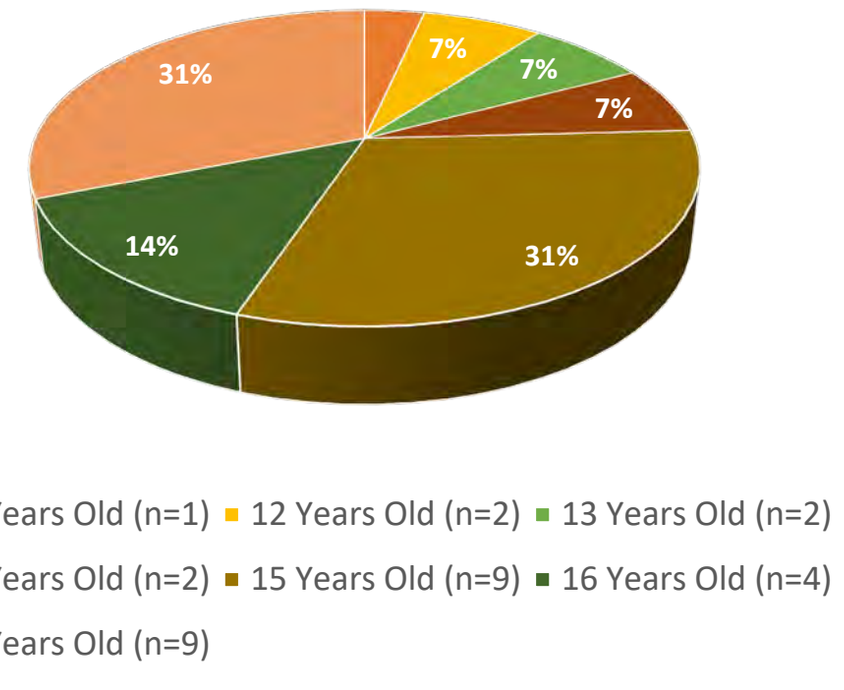


Figure 12: Percentage of Child and Adolescent Suicide Victim Factors

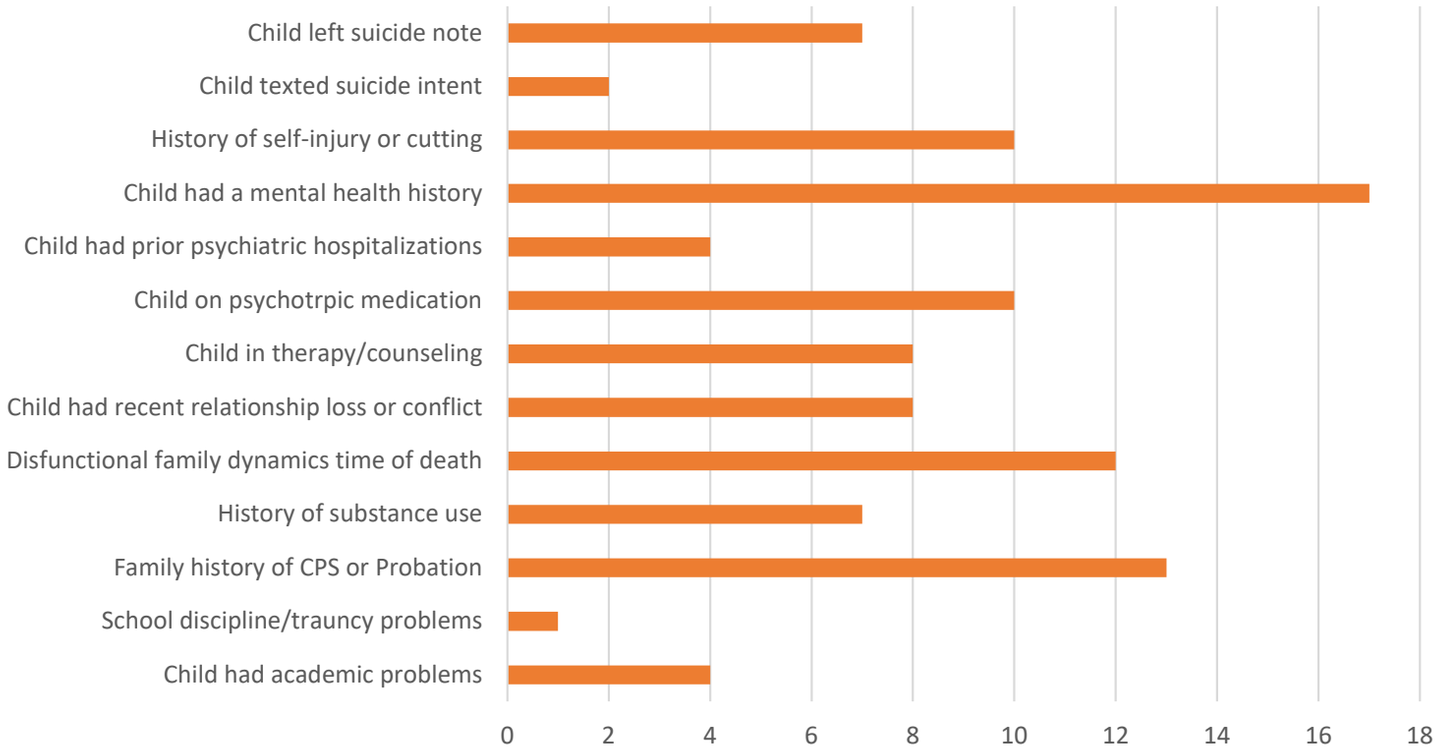
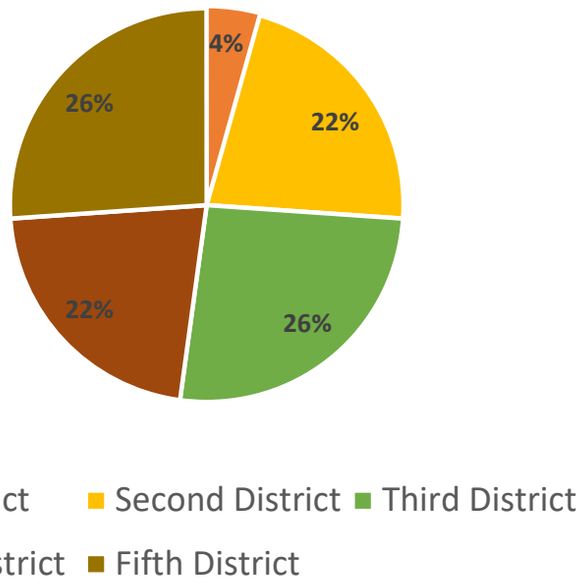


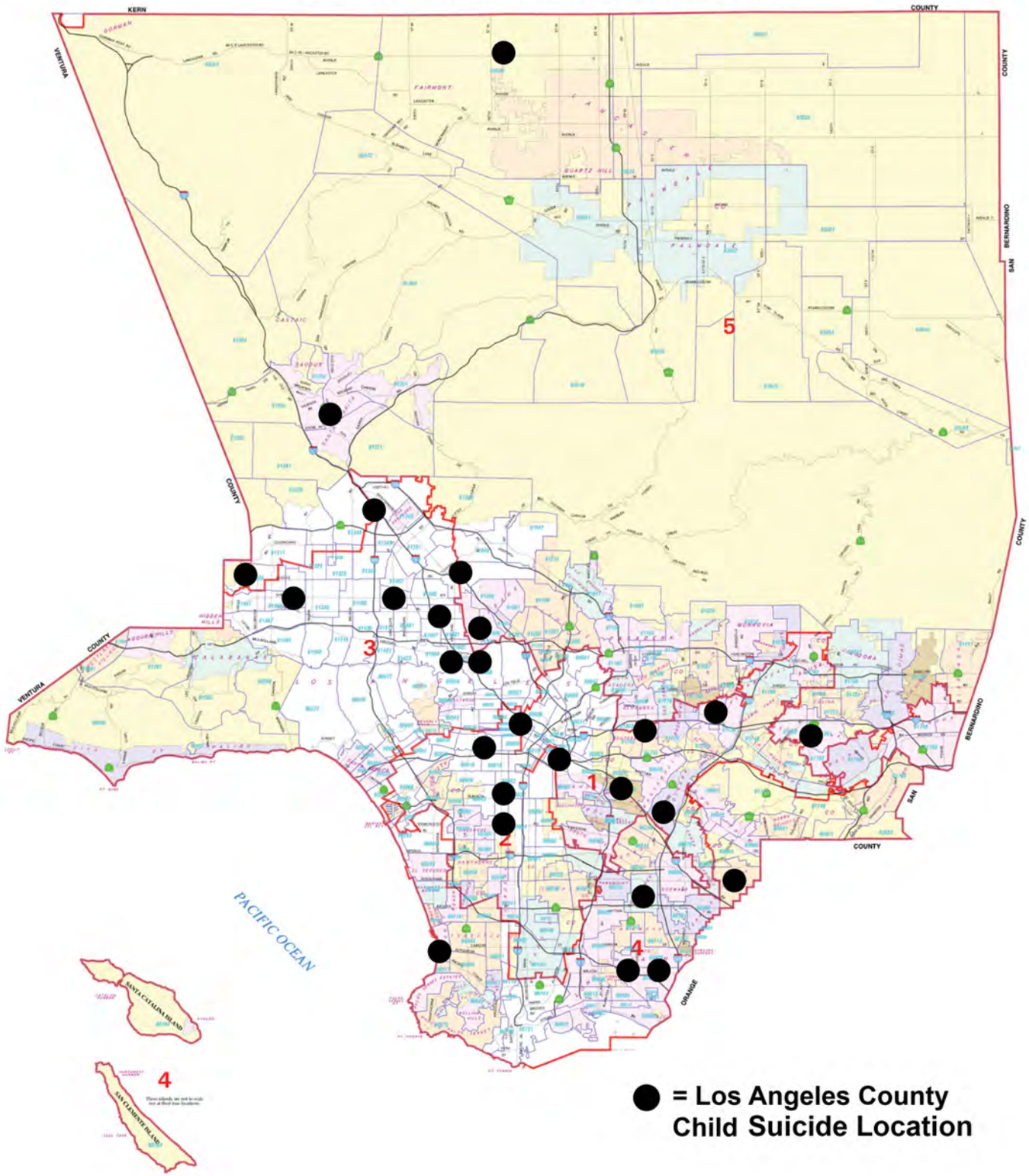
Table 18
Dates of Child and Adolescent Suicides – 2018
5 suicides occurred in January (01/3, 01/15, 01/16, 01/20 & 01/28)
4 suicides occurred in February (02/1, 02/9, 02/18 & 02/19)
3 suicides occurred in March (03/5, 03/21 & 03/25)
0 suicide occurred in April
3 suicides occurred in May (05/14, 05/23, & 05/27)
0 suicides occurred in June
3 suicide occurred in July (07/1, 07/10 & 7/24)
0 suicide occurred in August
1 suicides occurred in September (09/10)
4 suicides occurred in October (10/4, 10/10, 10/12 & 10/17)
5 suicides occurred in November (11/05, 11/14, 11/15, 11/27 & 11/28)
1 suicide occurred in December (12/28)

Figure 13: Location of Suicide by Board of Supervisor District



2018 Child Suicides - Locations
n = 29**

**City where the suicide occurred*
** Three occurred outside of Los Angeles County*



Sample Case Summaries

Brian

Brian, age 1, had moved to California with his parents and sibling to help the paternal grandmother after the paternal grandfather had recently passed away. Mother and the father decided to visit the maternal grandmother and give paternal grandmother some alone time. The child was placed in the room to nap in a child's bed while the parents slept in another adult bed in the same room. Mother woke up by family members screaming when the child was found in the pool unresponsive. Father attempted to do CPR. The child had no pulse. When EMS arrived the child had no pulse. The child regained pulse on his way to the hospital, however, later died at the hospital. The parents stated that they had locked the child inside the room while they slept. It's unknown how long he was in the pool or how he managed to get out of the room unnoticed. It was possible that his 3-year-old sibling may have unlocked the door while the parents slept.

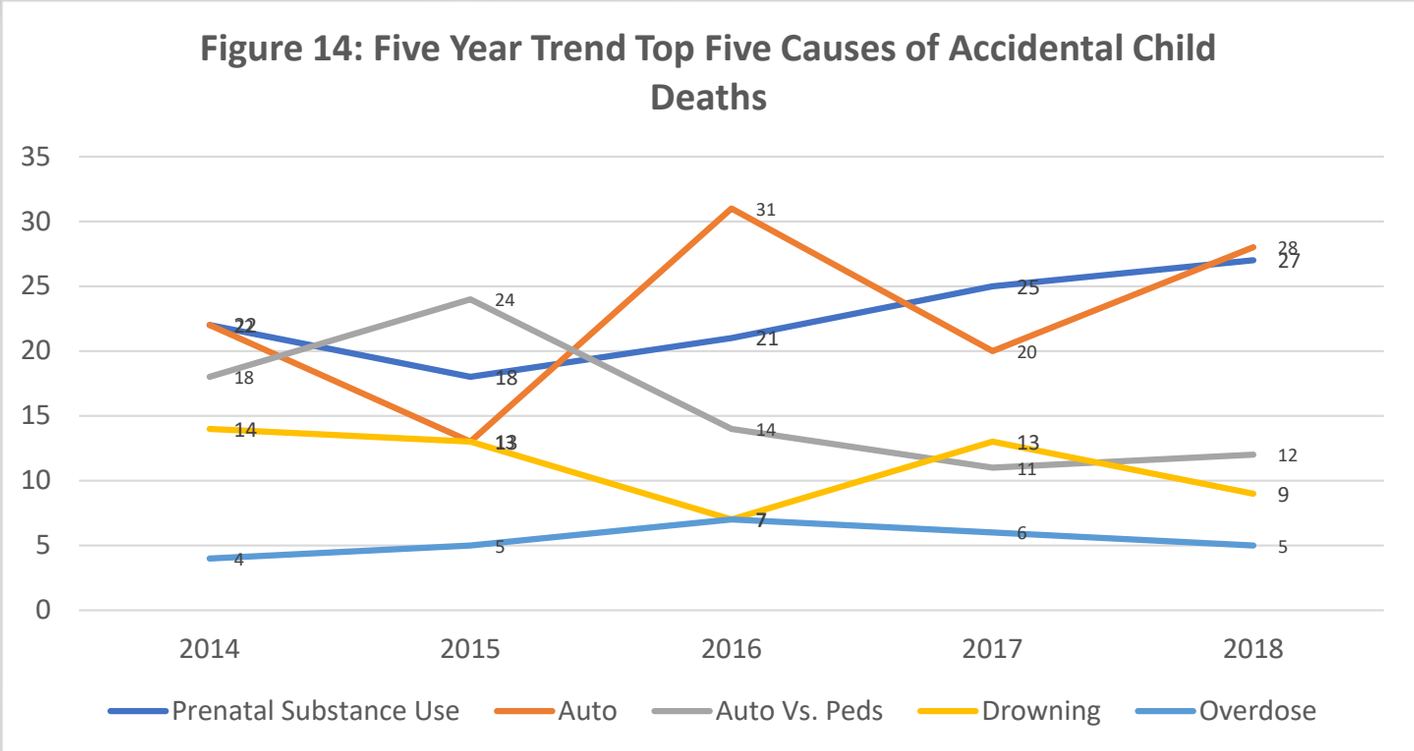
Janis

Four-year-old, Janis's sister (a teenager) had a steak knife after cleaning food stuck on the kitchen floor. It was reported that after cleaning the kitchen and using the knife to scrape the floor and subsequently mopping, the teenage sister accidentally left the knife on the living room couch. Janis had been playing in the living room, got on the couch, and began jumping on the couch. The caller states that it was reported that the knife remained on the couch and there were also stuffed animals among the items on the couch; therefore, the knife was not visible in its position. As Janis was jumping on the couch, she jumped on the stuffed animals and impaled herself with the steak knife. She was transported by EMS to the hospital where she was pronounced dead.

Ziggy

Ziggy, four months old, was being cared for by her grandmother. Ziggy had been placed to sleep in a room and as she awoke, her grandmother left the room to retrieve a bottle for her. A bi-folding door had been left ajar and after grandmother exited the room, the family's dogs (a Rottweiler, Labrador, and terrier) entered the room through the ajar door. Grandmother subsequently returned to the room and discovered Ziggy's head was covered with blood and multiple bite wounds; grandmother reported that she had not heard any noise or crying while she was out of the room. The grandmother immediately transported the child to the hospital. Upon examination, Ziggy was found to have an open skull with cerebrospinal fluid leaking and irregular respirations. A CT scan was performed and revealed multiple fractures with bilateral right greater than left pneumocephalus, bilateral subarachnoid hemorrhage, and probable right frontal and parietal hemorrhagic contusions. Ziggy was unable to be resuscitated and her death was pronounced at the hospital.

Note: All names have been changed.



he chart above depicts the top five causes of accidental child death over a five-year period from 2014 to 2018. Prenatal substance use accidental deaths continue on an upward trend. Drowning deaths had remained fairly steady but increased in 2017 with 13 and appear to be going back down in 2018. There was a large decline in automobile related deaths in 2017 (n=20) from 2016 (n=31), however, that trend appears to be going back up in 2018 with 28 deaths. Auto pedestrian and overdose child deaths in 2018 remained similar to 2017 with a difference of one more death with auto pedestrian and one less death for overdose.

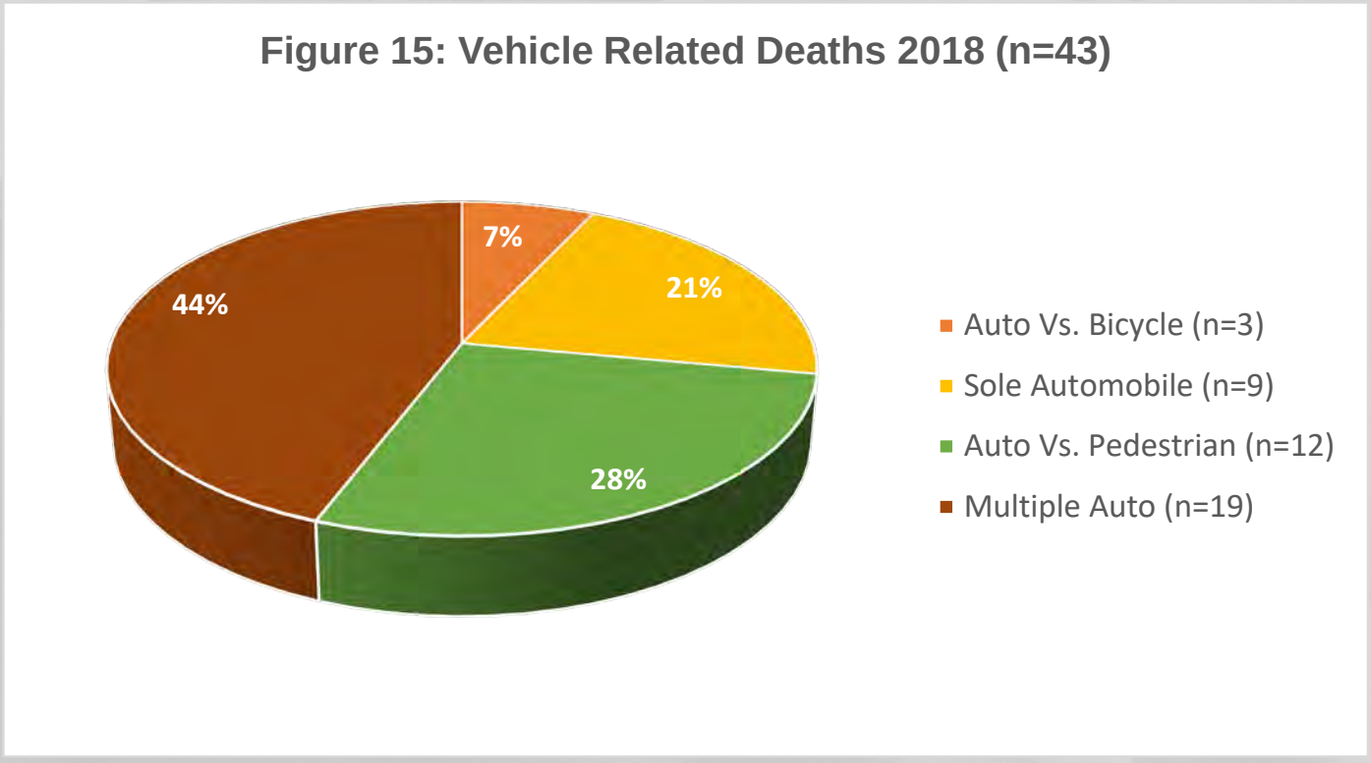


Figure 16: Motor Vehicle Related Deaths by Position of the Decedent, 2018

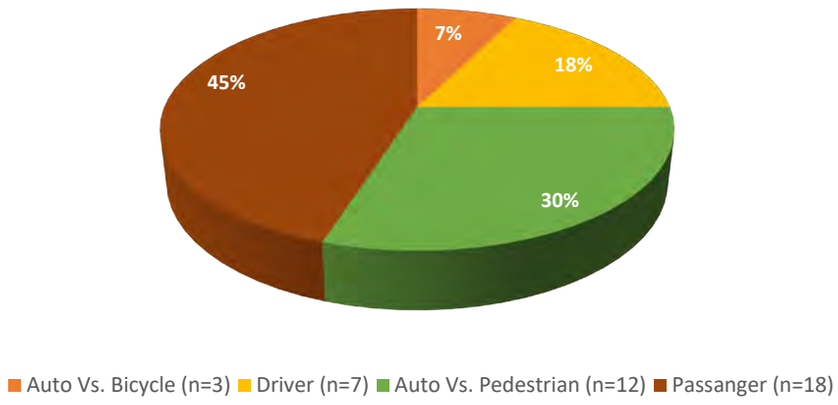


Table 19

Causes of Accidental Child Deaths, Ages 0 – 17, 2018 – Los Angeles County (N = 103)

	N	%
Automobile – multi-vehicle	19	18.4%
Automobile – solo vehicle	9	8.7%
Auto pedestrian	12	11.7%
Auto rollover	0	0.0%
Train vs. pedestrian	0	0.0%
Bicycle vs. auto/bus	3	2.9%
Prenatal Substance Abuse	27	26.2%
Drowning	9	8.7%
Fall	3	2.9%
Fire	3	2.9%
Overdose	5	4.9%
Asphyxia	2	1.9%
Crushed	2	1.9%
Gunshot	1	1.0%
Mauled by Dog	1	1.0%
Plane Crash	1	1.0%
Choking	3	2.9%
Hyperthermia	1	1.0%
Puncture	1	1.0%
Medical Accident	1	1.0%

Table 20			
Causes of Accidental Child Deaths by Age, 2018 – Los Angeles County (N = 103)			
	Age 0 - 5 Years	**Age 6 -14 Years**	**Age 15 - 17 Years**
Automobile – multi-vehicle	12	4	3
Automobile – solo vehicle	3	2	4
Auto pedestrian*	6	3	3
Auto rollover	0	0	0
Train vs. pedestrian	0	0	0
Bicycle vs. auto/bus	0	3	3
Prenatal Substance Abuse	27	0	0
Drowning	9	0	0
Fall	1	1	1
Fire	0	1	2
Overdose	1	3	1
Asphyxia	2	0	0
Crushed	1	0	1
Gunshot	0	1	0
Mauled by Dog	1	0	0
Plane Crash	0	0	1
Choking	3	0	0
Hyperthermia	0	0	1
Puncture	0	0	0
Medical Accident	0	0	0
Total:	65	18	20

Figure 17: 2018 Accidental Child Deaths - Race

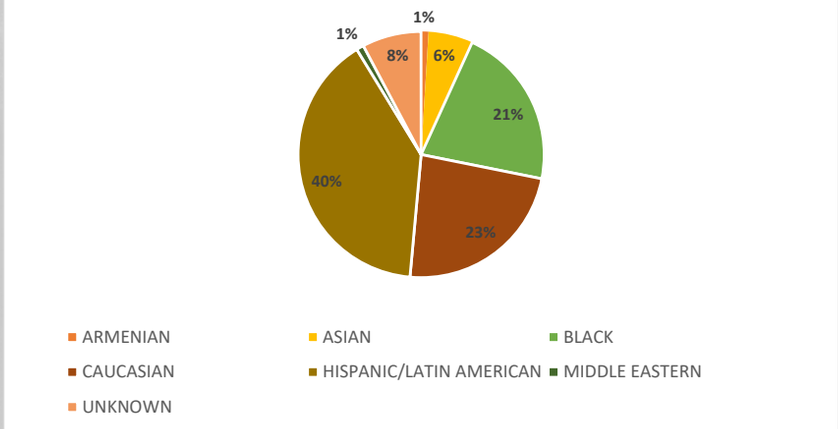


Table 21			
Causes of Accidental Child Deaths by Gender 2018 - Los Angeles County (N = 103)			
	Female	**Male**	**Unknown**
Automobile – multi-vehicle	11	8	0
Automobile – solo vehicle	6	3	0
Auto pedestrian*	5	7	0
Auto rollover	0	0	0
Train vs. pedestrian	0	0	0
Bicycle vs. auto/bus	2	1	0
Prenatal Substance Abuse	17	8	2
Drowning	8	1	0
Fall	1	2	0
Fire	1	2	0
Overdose	3	2	0
Asphyxia	1	1	0
Crushed	1	1	0
Gunshot	1	0	0
Mauled by Dog	0	1	0
Plane Crash	0	1	0
Choking	**2**	**1**	**0**
Hyperthermia	**1**	**0**	**0**
Puncture	**0**	**1**	**0**
Medical Accident	**1**	**0**	**0**
Total:	**61**	**40**	**2**

Figure 18: Accidental Child Deaths Associated with Prenatal Substance Abuse and Child Welfare History

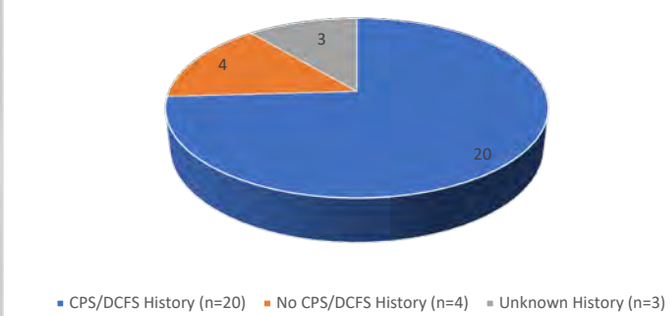


Figure 19: Accidental Child Deaths 2018 - Child Welfare History

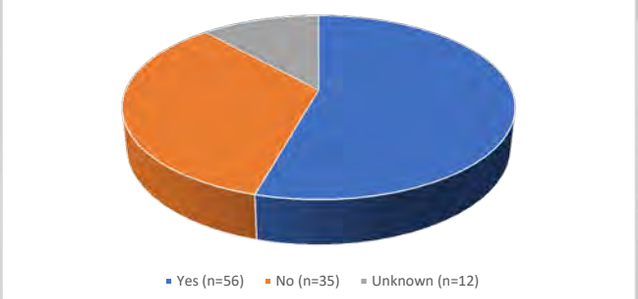


Table 22		
Accidental Child Deaths Associated with Prenatal Substance Abuse (PSA) 2018 - Los Angeles County (N=27)		
Race	**Number of PSA Deaths**	**Percentage**
African American	6	22.2%
Asian/Pacific Islander	0	0.0%
Caucasian	8	29.6%
Hispanic	5	18.5%
Unknown	8	29.6%
Gender		
Female	8	29.6%
Male	17	63.0%
Unknown	2	7.4%
Age		
Stillborn or less than 1 day	25	92.6%
1 day to 30 days	2	7.4%
Substance		
Methamphetamines	16	59.3%
Opiates	1	3.7%
Cocaine	1	3.7%
Methamphetamine and opiates	2	7.4%
Methamphetamine and cocaine	1	3.7%
Methamphetamine and marijuana	5	18.5%
Methamphetamine and medications	1	3.7%

Table 23		
Causes of Accidental Deaths with Child Welfare History, 2018 (N=61)		
	Number	**Percentage**
Automobile	20	19.4%
Auto pedestrian*	4	3.9%
Bicycle vs. auto/bus	2	1.9%
Prenatal Substance Abuse	20	19.4%
Drowning	4	3.9%
Fall	2	1.9%
Fire	3	2.9%
Overdose	1	1.0%
Asphyxia	0	0.0%
Crushed	1	1.0%
Gunshot	1	1.0%
Mauled by Dog	0	0.0%
Plane Crash	0	0.0%
Choking	3	2.9%

*includes moped and bicycle **includes sequelae of drowning

Sample Case Summaries - Undetermined Child Deaths

Franky- Age 2 months

During an evening at home, Franky was in the care of his father and paternal grandmother at their residence. Frankie had been eating normally and laughing during his time with his grandmother and father. At midnight, father fed Franky in his arms and they subsequently fell asleep together. Around 7:00am the next morning, father awoke and discovered Franky unresponsive. Father yelled for paternal grandmother, who then called 911. Deputies responded to the home and transported Franky to the hospital. Continued resuscitation efforts were unsuccessful and Franky's death was pronounced at the hospital.

Mary – 14 days old

Mary had been taken to her well child care visit with her pediatrician with the examination showing no abnormal findings. The next day mother fed Mary at 3am and placed her back in her bassinet and went to use the restroom. When mother returned to bed she checked on Mary in her bassinet one more time before laying down to go back to sleep and noticed the infant was unresponsive. Mother attempted to perform cardiopulmonary resuscitation, however, could not get a pulse mother called 911. Paramedics transported Mary to the hospital, however, despite medical intervention at the hospital she was pronounced dead. Autopsy performed by coroner indicated a normally developed child with no congenital abnormalities.

Sean – 2 Month

Sean was in his mother's care at home. Sean was breastfed and then placed to sleep on his parents' queen-sized bed to sleep (he routinely slept in a bassinet). Sean would become fussy if placed on his back to sleep, therefore he was swaddled and placed on his stomach with his face facing to the side. He would also have a blanket placed on him. After placing Sean to sleep, mother went for a jog, made dinner, and read a book to one of Sean's siblings. After reading the sibling, mother went to check on Sean and after turning on the light in the room, discovered Sean unresponsive. Mother began to panic and had difficulties finding her phone; therefore, she took Sean to a neighbor, who is also a registered nurse. 911 was subsequently called and CPR was initiated, however, Sean was pronounced dead.

Note: All names have been changed.

Figure 20: 2003-2018 Undetermined Deaths

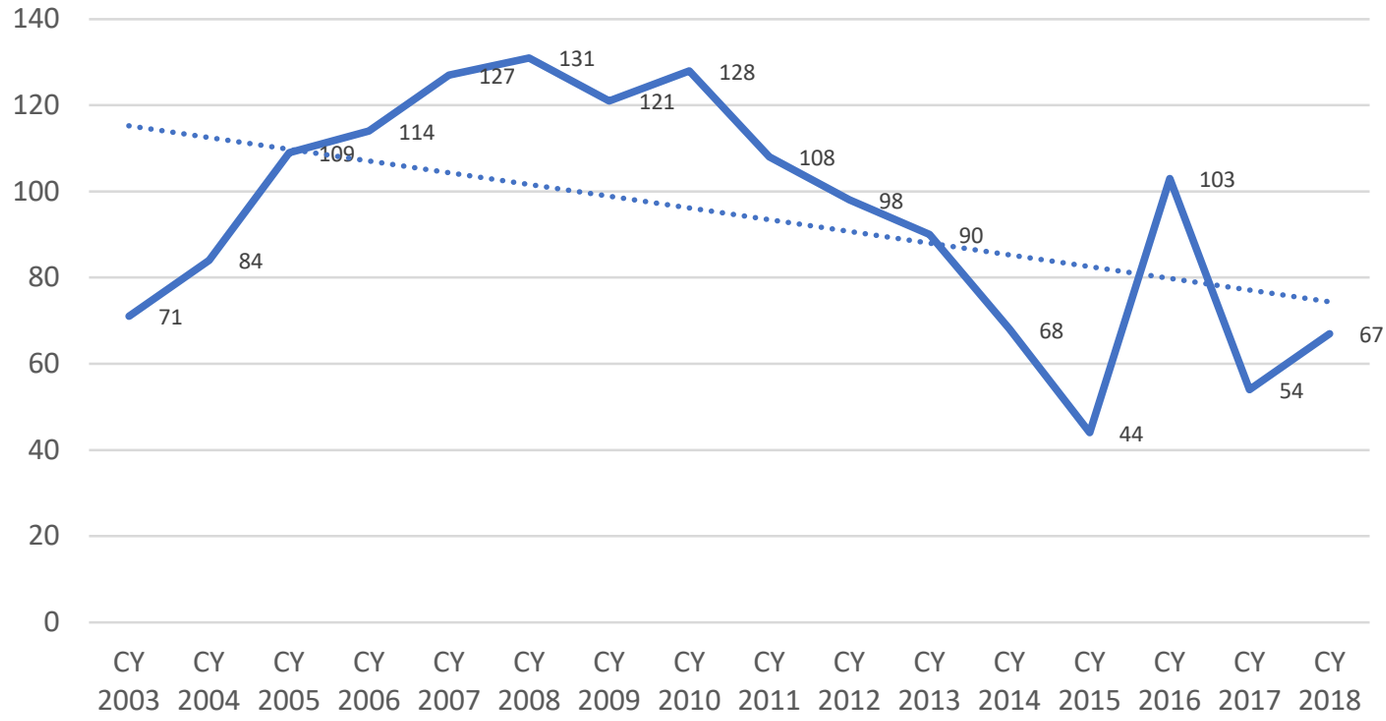


Table 24		
Undetermined Child Deaths – 2018 (N=64)		
Race	**Number**	**Percentage**
African American	15	22.4%
Asian/Pacific Islander	6	8.96%
Caucasian	17	25.37%
Hispanic	27	40.30%
Unknown	2	2.99%

Gender	Number	Percentage
Female	28	41.8%
Male	36	53.7%
Unknown	3	4.5%

Age	Number
Stillborn	6
Less than 1 day	0
1 day to 30 days	8
1 month to 5 months	30
6 months to 1 year	17
1 year to 2 years	4
3 years	1
16 years	1
17 years	1

Child Welfare History	Number	Percentage
At least one contact with CPS	18	28%
Contact as a child with CPS	24	38%

Undetermined Child Deaths:
Bed-Sharing and Unsafe Sleeping Environment (n=44)

Figure 21: Five Year Trend Bed-Sharing/Unsafe Sleep Child Deaths

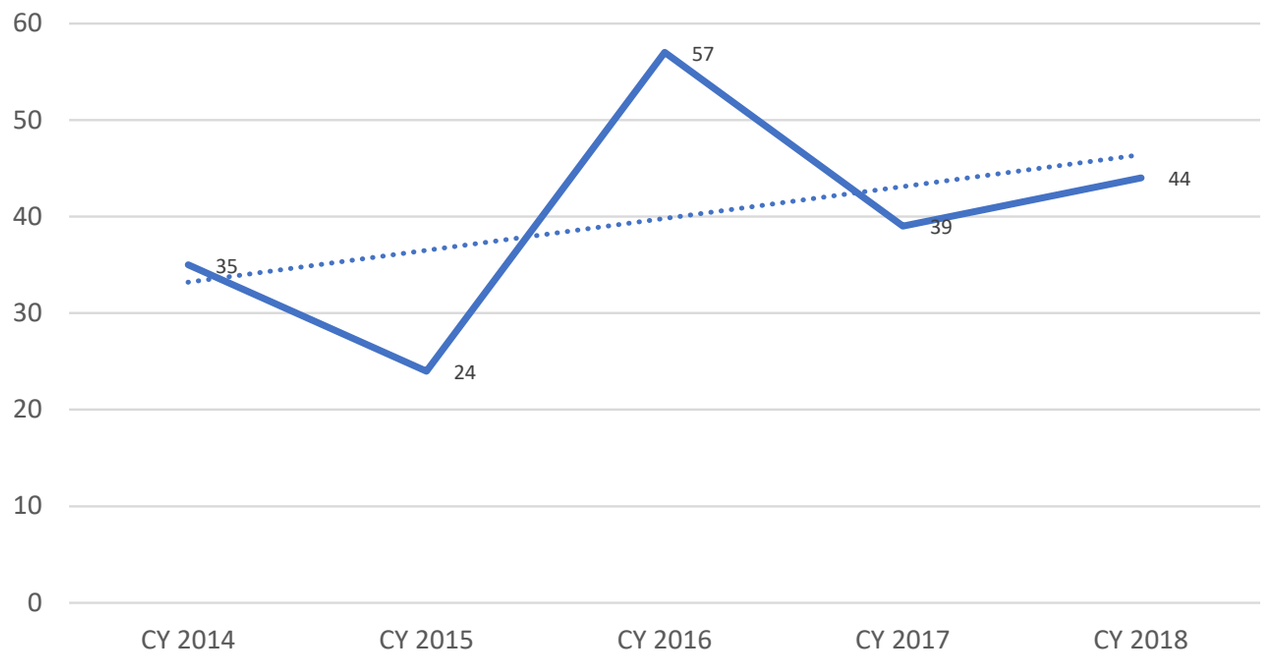
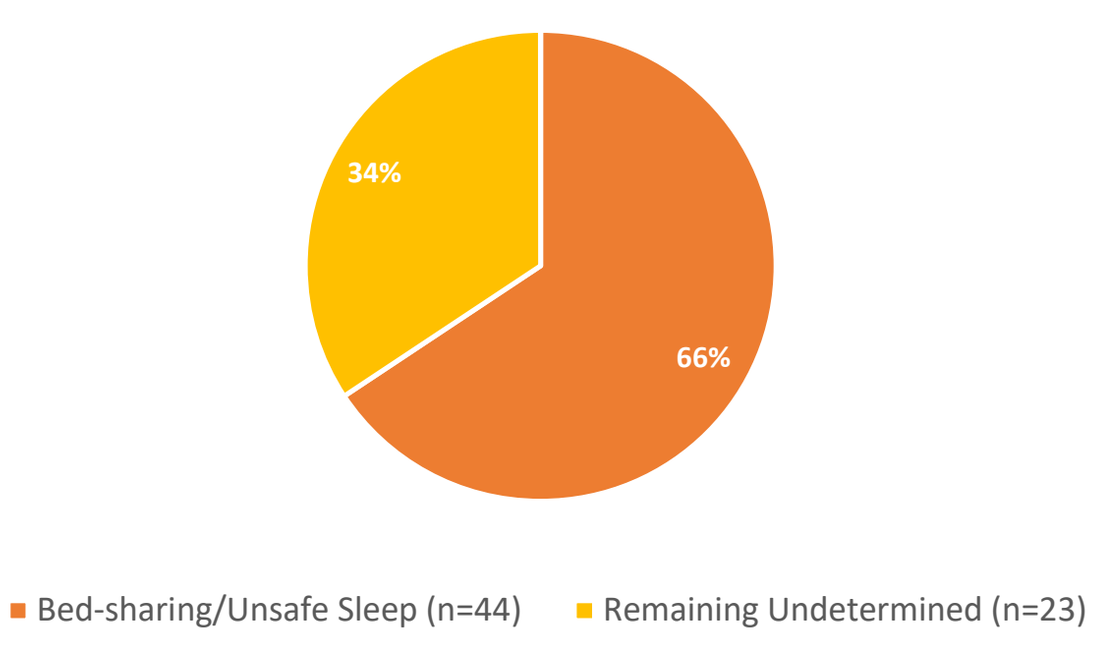


Figure 22: Bed-sharing and Unsafe Sleeping Undetermined Child Deaths 2018



Undetermined Child Deaths: Bed-Sharing and Unsafe Sleeping Environment (N=44)

Figure 23: Unsafe Sleep and Bed-sharing Child Deaths Compared to Remaining Undetermined Child Deaths 2018

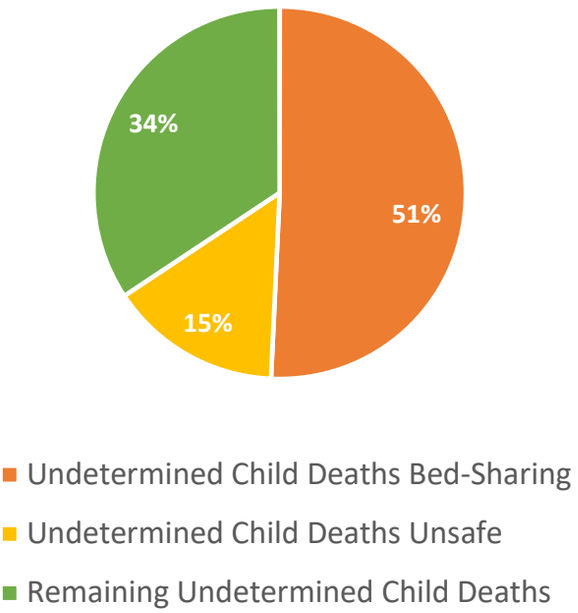
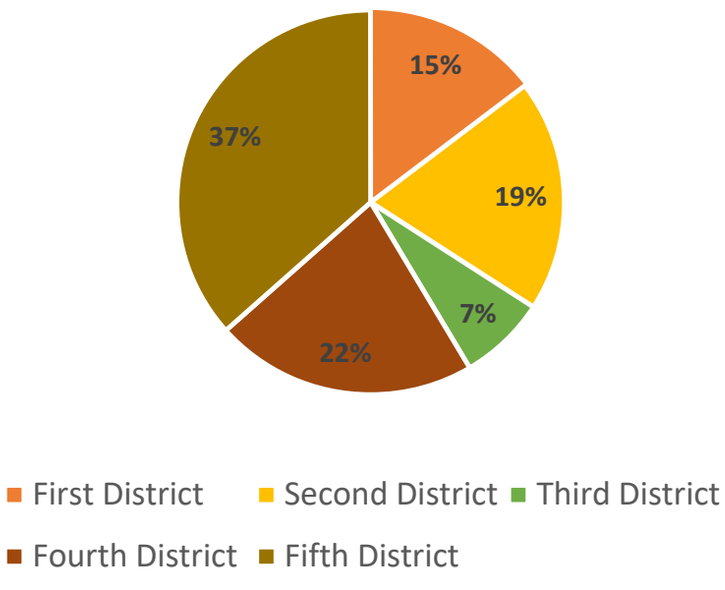


Figure 24: Bed-sharing and Unsafe Sleep Child Deaths by Board of Supervisor District - 2018



Undetermined Child Deaths:
Bed-Sharing and Unsafe Sleeping Environment (N=44)

Table 25		
Bed-sharing and Unsafe Sleeping Environments- Number of Risk Factors Present (N=44)		
Bed-Sharing* (n=34)	**Number**	**Percentage**
One Unsafe Risk Factor	1	3%
Two Unsafe Risk Factors	7	21%
Three or more Unsafe Risk Factors	26	76%

Unsafe Sleeping Environment** (N=10)	Number	Percentage
One Unsafe Risk Factor	2	20.0%
Two Unsafe Risk Factors	7	70.0%
Three or more Unsafe Risk Factors	1	10.0%

*Includes bed-sharing, adult bed, couch, car, 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.

Figure 25: Sleep Surface - Unsafe and Bed-Sharing Deaths 2018

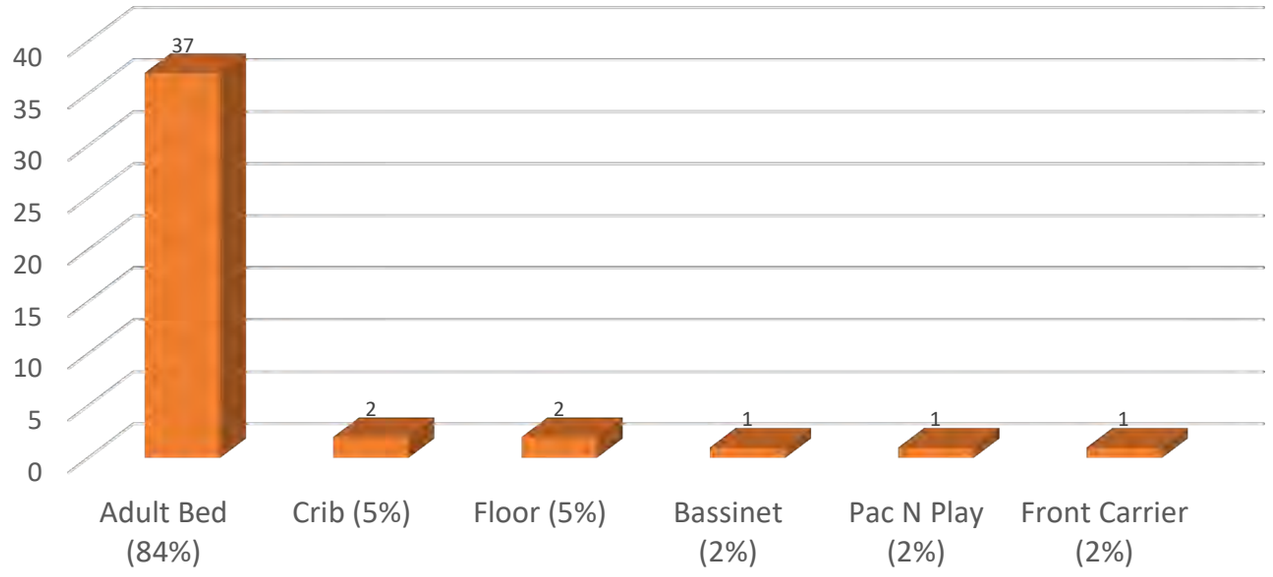


Figure 26: Sleep Position All Unsafe Sleep Practice Deaths (n=44)

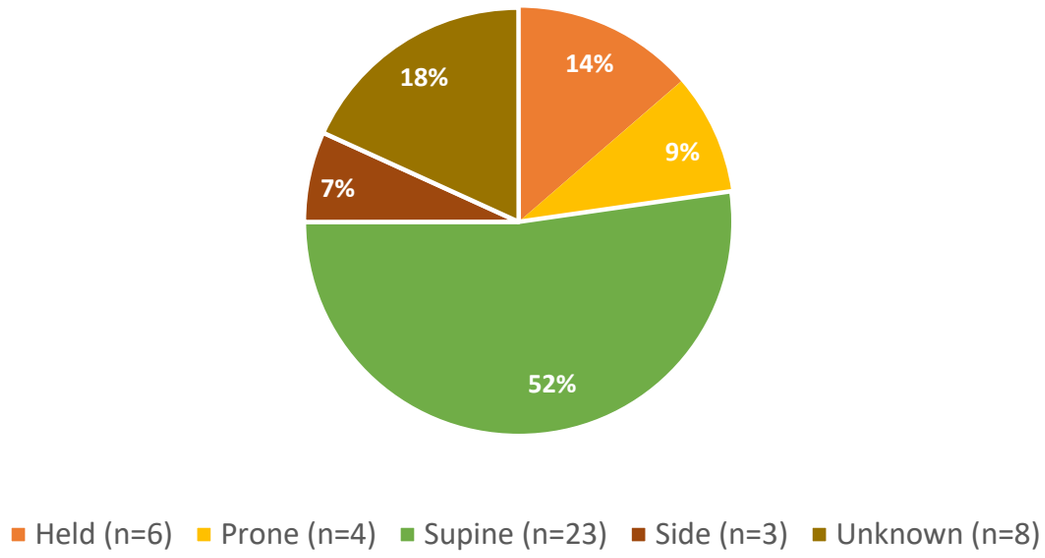


Table 26

Bed-sharing and Unsafe Sleeping Environment Risk Factors Involved* (N = 44)

	Number
Unsafe and/or excessive bedding	25
Swaddling	8
Held Sleep Position	6
Parental drug/alcohol use	1

Table 27

Bed-sharing and Unsafe Sleeping Environment Child Welfare History

	Number	Percentage
Unsafe Sleep/Bed-sharing with Caregiver Child Welfare History	9	38%
Unsafe Sleep/Bed-sharing with Caregiver Child Welfare History as a Minor	15	62%
Total Unsafe Sleep/Bed-sharing	44	100%

Figure 27: Percentage of Undetermined Child Deaths - Bed-sharing

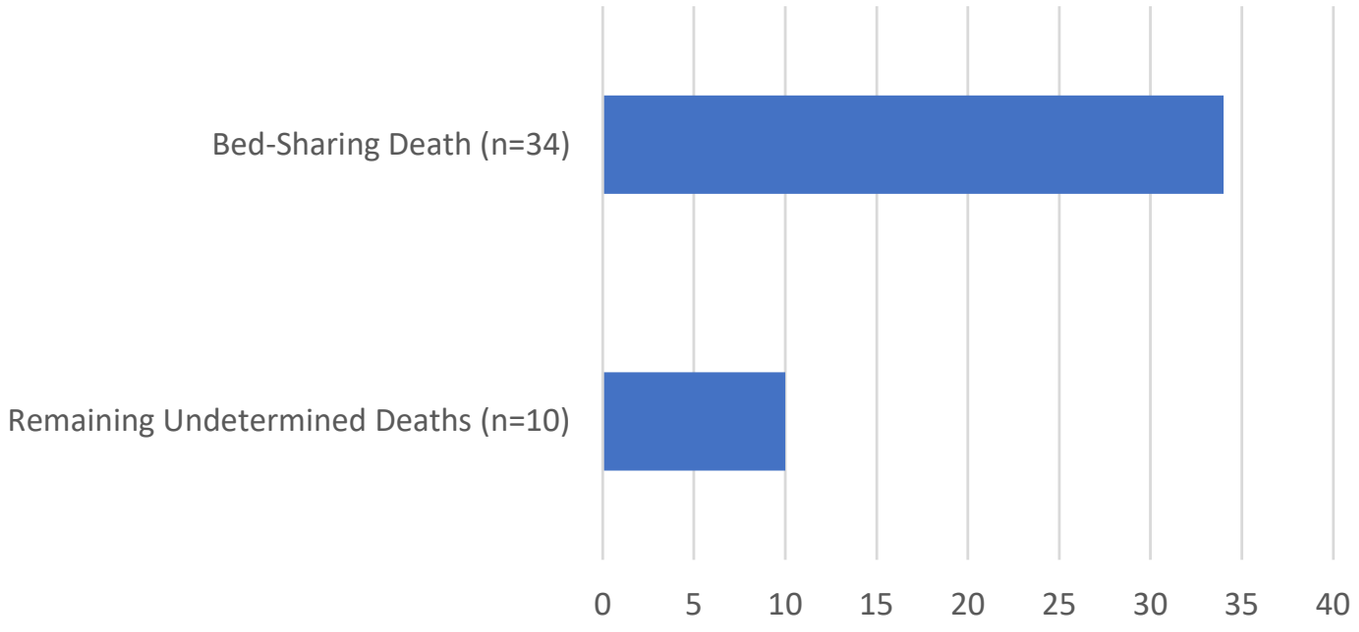


Figure 28: 2018 Bed-sharing Deaths - Number of Persons Sleeping with Child

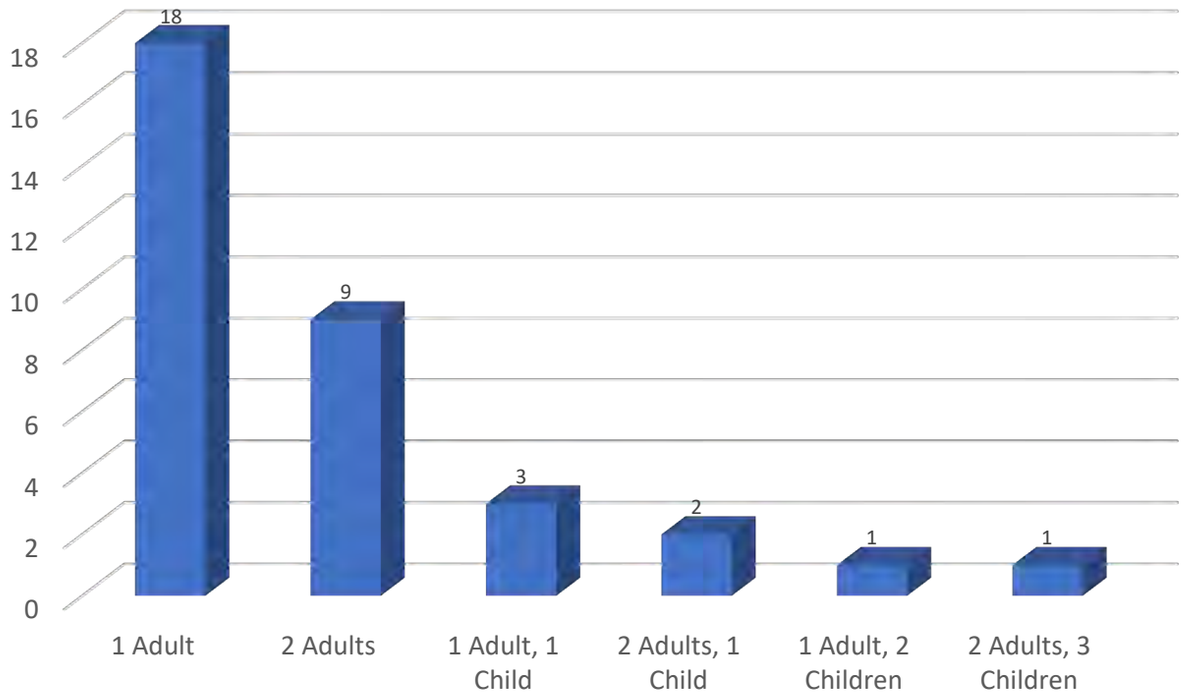


Figure 29: Undeterminded Bed-Sharing Child Deaths - Age

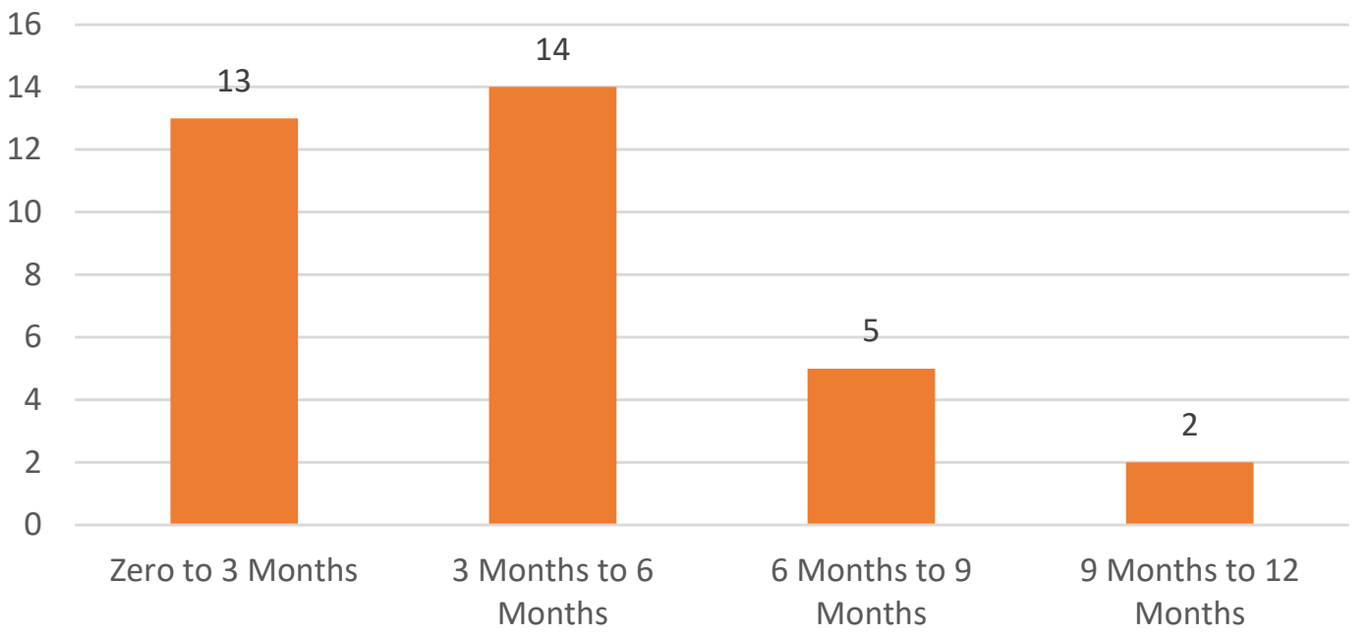


Figure 30: 2018 Bed Sharing Child Deaths - Race

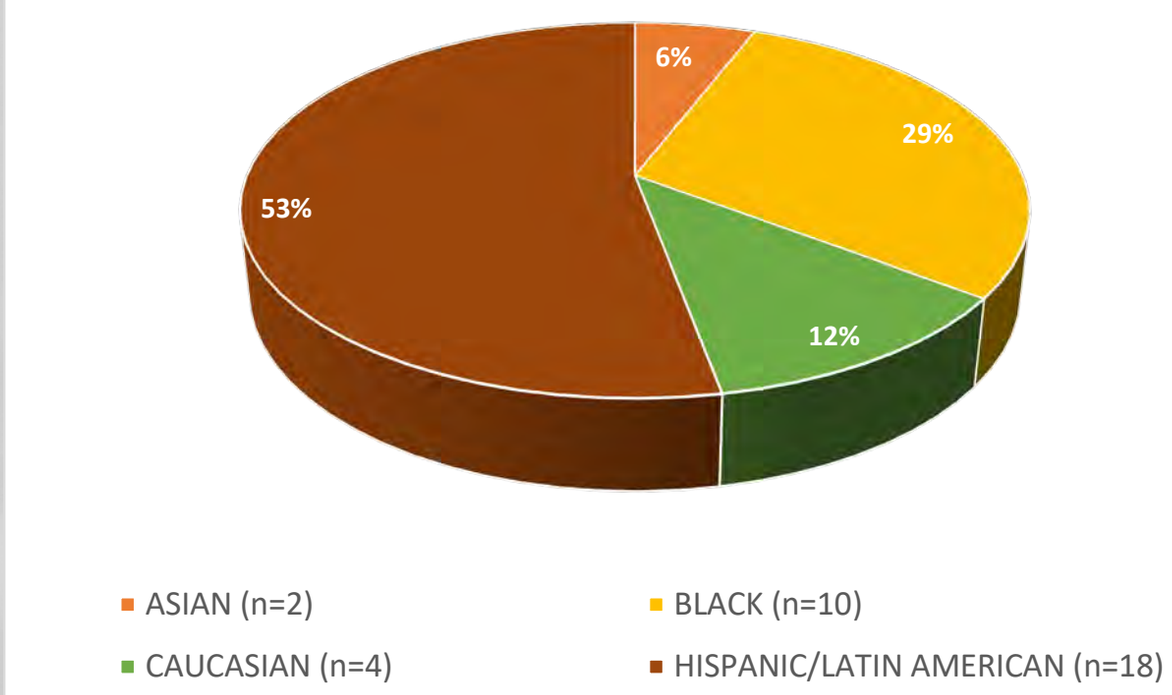


Figure 31: Non-bed-sharing Unsafe Sleep Deaths - Age

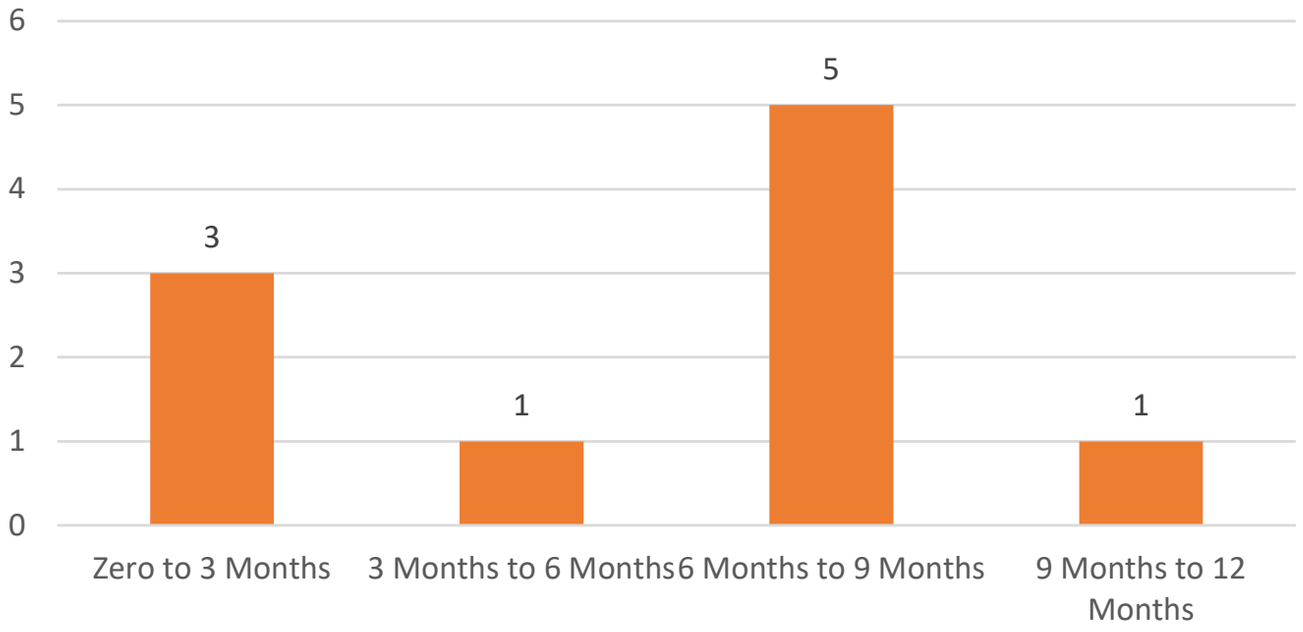


Figure 32: Non-bed-sharing Unsafe Sleep - Race

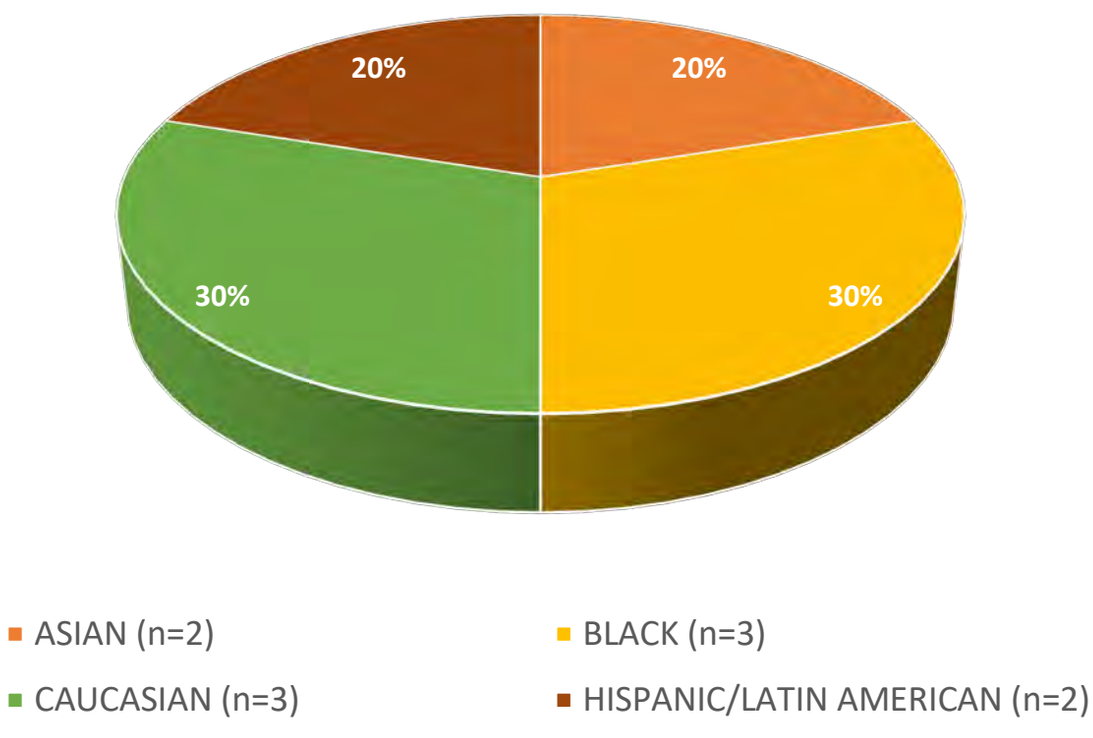


Table 28	
Unsafe Non-bed Sharing Child Deaths Sleeping Environment - 2018	
	Number
Unsafe and/or excessive bedding	8
Adult bed	5
Prone position	1
Held (or Carrier)	1
Swaddling	1
Excessive swaddling	2
Sleep sack	1

Table 29

2018 Undetermined Fetal and Newborn Deaths - Mother Self-reported or Tested Positive for a Substance at Birth

Infant Death- Mother Tested Positive for a Substance at Birth (N = 2)

Substance	Number	Percentage
Methamphetamine	2	100%
Cocaine	1	50%

Undetermined Fetal and Newborn Deaths- Mother Tested Positive for a Substance at Birth - Child Welfare Involvement*

Year	Total # of 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 DCFScase 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%)
2015	5	2 (40%)	2 (100%)	0 (0%)	1 (50%)
2016	8	4 (50%)	3 (75%)	1 (25%)	0 (0%)
2017	3	0 (0%)	1 (33%)	1 (33%)	2 (67%)
2018	2	1 (50%)	1 (50%)	0 (0%)	1 (50%)

*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.

Sample Case Summaries

Ariel

Four month old Ariel and her twin sister were at home when family came to the home to celebrate a birthday. During that time the parents were drinking beer. Later in the evening, Ariel was placed in the main bedroom where she slept with her father in an adult bed (father would sometimes sleep in a separate room from mother when the twins would be fussy). Around 12:00am, Ariel awoke and was fed by her father. She and father then went back to sleep. Around 3:40am, mother got up to use the bathroom and then went into the bedroom to check on father and Ariel. The mother discovered Ariel lying on her stomach underneath a neck pillow that father had initially been sleeping on. 911 was called and Los Angeles County Fire Department responded to the home. Ariel was unable to be resuscitated and her death was pronounced by Paramedics.

Joel

Nineteen-day old, Joel was visiting family for Christmas with her parents. The Christmas Party lasted long into the night. The parents had been drinking,so decided to stay at the family house and sleep on the living room floor. The parents laid out a blanket to sleep on, covered themselves with blankets and slept on pillows. Mother held baby Joel in the crook of her arm. She woke up a few hours into the night to the baby feeling cold to the touch. Mother woke up father who was sleeping beside her and he called 911. The parents were instructed to place baby on the floor and begin chest compressions. However, the child did not survive. The paramedics arrived at the home and pronounced the death of the baby. The parents indicated that Joel normally slept on a crib at their home.

Stevie

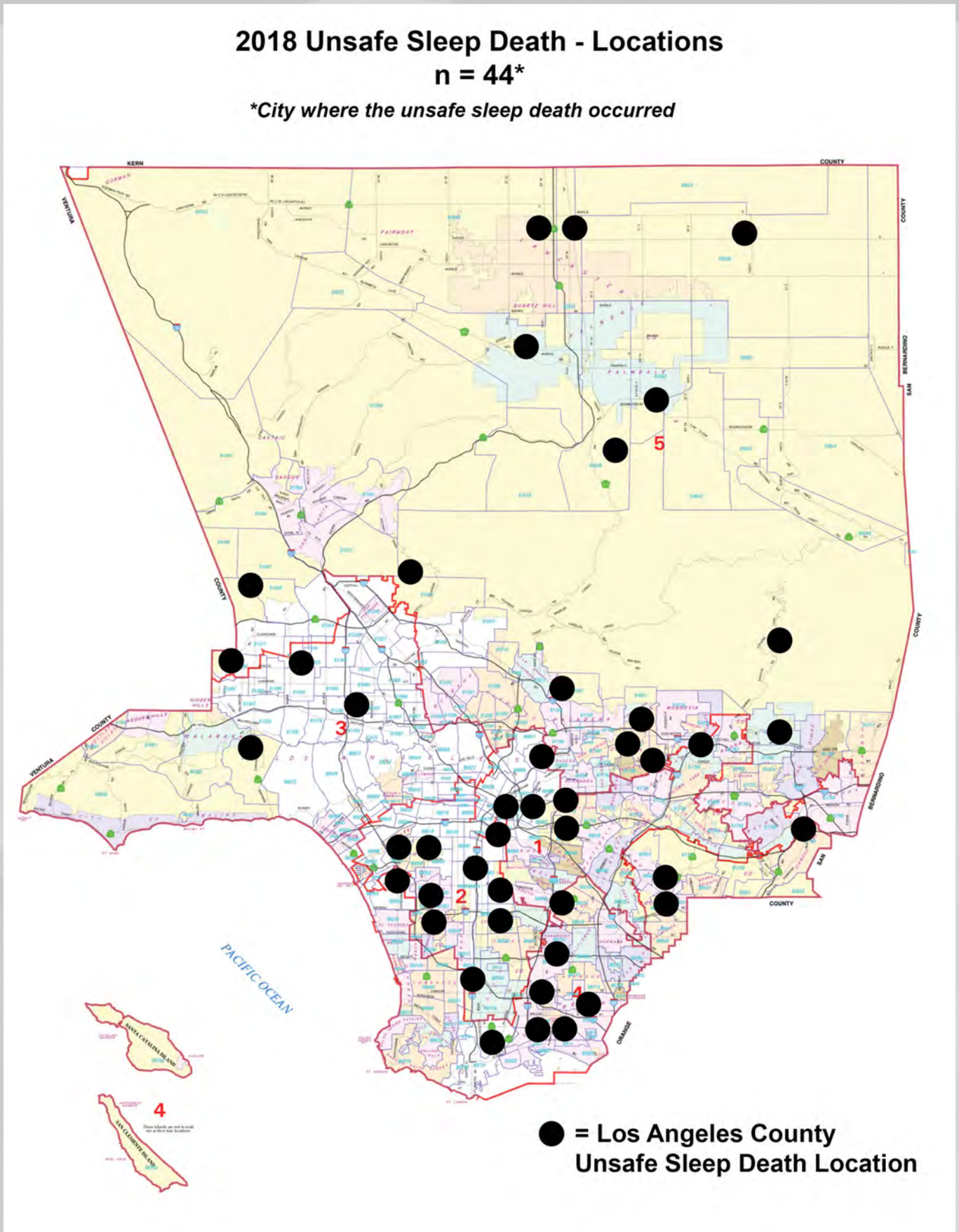
Eighteen-day old, Stevie was fed and placed facing mother on mother's bed. The left side of his face was resting on her arm. Around 8:00am, mother awoke and discovered Stevie unresponsive. He was warm, but limp and not breathing. Mother patted Stevie on his back in an attempt to arouse him, but there was no response. Mother then started CPR and called 911. LE responded to the home and continued resuscitation efforts. Paramedics subsequently arrived and transported Stevie to the emergency room. Continued resuscitation efforts were unsuccessful and Stevie's death was pronounced by the ER doctor.

Cesar

Four month old Cesar was living a home with his mother, father, and 6-year-old sibling. The infant had no known medical history, special needs, or disabilities. Cesar was in the care of his father as mother was at work. Father fed Cesar around 12:00pm and during the early afternoon hours the infant was placed on an adult bed with his father for a nap. When father awoke, he discovered Cesar unresponsive near his leg. Father indicated had no idea how Cesar ended up there. 911 was called and paramedics responded to the home and transported Cesar to the emergency room. Continued resuscitation efforts were unsuccessful and Cesar's death was pronounced by the treating doctor.

Note: All names have been changed.

Unsafe Sleep Death Locations



Third Party Homicides

Introduction

The ICAN Child Death Review Team report has historically 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 when 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 an overall downward pattern in these third party homicides over the past eleven years. However, between the years 2014 – 2018, the homicide rate has gone up from 19 in 2014 to 27 in 2018. Regardless, the decline from 100 such deaths in 2007 to 27 in 2018 is a positive indication that law enforcement and prosecutorial agencies efforts to decrease and prevent gang activity among the youth of Los Angeles continues to be successful.

Sample Case Summaries

Debbie

Seventeen year old Debbie lived in a home with her mother. Debbie was last seen alive on a Sunday night of when her father dropped her off at her mother's home. On Monday, Debbie was absent from school; she was subsequently absent on Tuesday, and Wednesday. The brother of mother's significant other contacted law enforcement to request a welfare check after he received a text from mother's significant other saying that mother and Debbie "were dead and that he messed up." Law Enforcement responded to the family's home to conduct a welfare check and upon the arrival of officers no one answered the front door. An officer subsequently gained entrance into the home through a side window. After entering the home, Debbie and her mother were discovered unresponsive in their beds with blankets and pillows covering them. Paramedics were called and Fire Department responded to the scene. Debbie and her mother's death were pronounced by Paramedic. The mother's significant other was charged with the murder of Debbie and her mother, however, he was bailed out of jail and is on the run.

Eddie

Eddie, 14 years of age and two other males walked up the driveway where a baptism party was being held. Eddie and the two males were armed with an AK47 and two handguns and open fired on the party. Partygoers returned fire at Eddie and the two males and Eddie was struck multiple times. 911 was called and paramedics responded to the scene and transported Eddie to the hospital. Upon evaluation, He was found to have seven gunshot wounds to the foot, torso, chest, and shoulder. Eddie was intubated and underwent surgery, however, Eddie was unable to be resuscitated and his death was pronounced by his treating physician. It was later found out that Eddie had recently joined a gang.

Maria

Maria, age 17 years, was driving to a community carnival to watch her friend perform. Suspects drove up to Maria and began shooting at Maria and she was struck in the chest by gunfire. 911 was called and law enforcement and Fire Department paramedics responded to the location. Maria was transported by paramedics to the hospital, however, resuscitation efforts were unsuccessful and Maria's death was pronounced at the hospital. Maria had finished high school early and was attending nursing college classes. Maria aspired to be a doctor someday. Her life was cut short by suspects that were never identified.

Jack

Mother was attending a party at a residence. Two unknown individuals approached the residence and began shooting; mother was struck in the back by gunfire. 911 was called and firefighter/paramedics responded to the scene. Mother was found to have multiple apparent gunshot wounds and her death was pronounced at the scene. The baby boy was 20 weeks gestation as was found during mother's autopsy. No suspects are in custody and her case remains under investigation.

Note: All names have been changed.

Third Party Homicides

Findings

- There were 27 third party homicides in 2018. This is an increase from 2017 in which the number of third party homicides were 21.
- Eighty-one percent (n=22) of the youth were victims of gunshot wounds.
- As in the previous five years, male victims outnumbered female victims. Seventeen males and nine females were homicide victims in 2018. One child's gender was unlisted.
- Seventy-four percent (n=20) of the children who were victims of a third-party homicide in 2018 were ages 15 – 17. There was one three-year-old and three stillborn that were result of assault on the mother.
- There were 13 Hispanic youths that were victims of third-party homicides. Ten of the youths were African-American; one Caucasian and one Asian/Pacific Islander victim were among the victims. Two of the victims were of unknown race.
- The greatest number of third-party homicides occurred during the month of January (n=5). The second greatest number occurred in the months of May, June, and November (n=4).
- The least number of homicides occurred during the months of July and December, with one each. No third-party homicide occurred in the month of March.
- While third party homicides occurred throughout Los Angeles County in 2018, the First and Second Supervisorial District accounted for 60% (n=8) and (n=8) of these deaths. This was followed by the Fourth District with 19% (n=5). District Five 15% (n=4) and the Third District had two, 3% of the death.
- The Los Angeles Police Department (LAPD) had investigative authority for 93% of the third-party homicide cases in 2018. Downey PD and West Covina PD each handled one homicide.
- One of the third-party homicides was a law enforcement officer involved shooting.
- Nineteen percent (n=5) of the case investigations resulted in the filing of criminal charges by the District Attorney's Office. When this information was collected these cases were pending trial.
- Sixty-seven percent of the victims had a history with DCFS, another county child welfare agency or Probation.
- Seventeen of the victims had a history with DCFS or another Child Welfare agency and four of the victims had a history with the Probation Department. Two had an open case with DCFS and four had an open case with the Probation Department at the time of the victim's death.

Figure 33: 2007-2018 Third Party Homicides

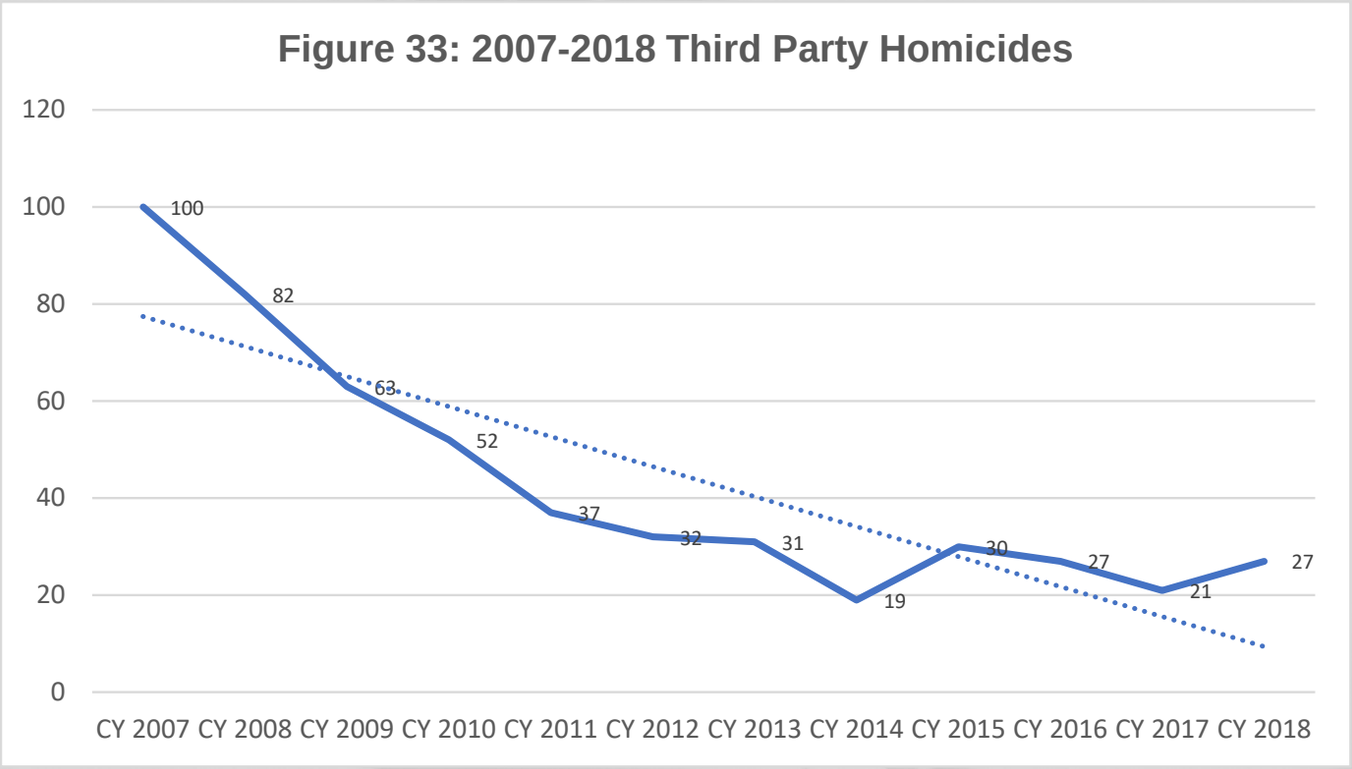


Figure 34: 2018 Third Party Homicides - Cause

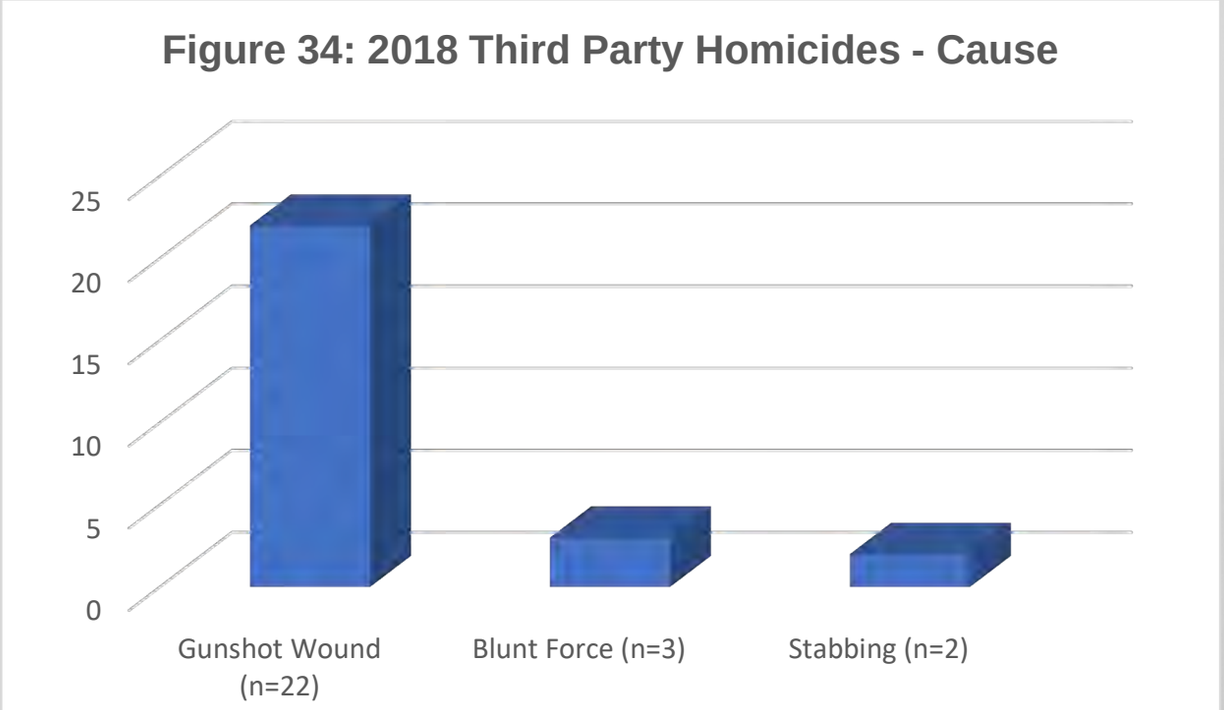


Table 30			
Third Party Homicides by Age and Sex Los Angeles County			
Age	**Female**	**Male**	**Unknown**
Stillborn	0	2	1
3 Years	0	1	0
13 Years	1	0	0
14 Years	0	2	0
15 years	3	3	0
16 years	**1**	**3**	**0**
17 years	**4**	**6**	**0**
Total	**9**	**17**	**1**

95.2% of the third party homicide victims were male.

81% of the third party homicide victims were 16 to 17 years of age.

Figure 35: 2018 Third Party Homicides - Race

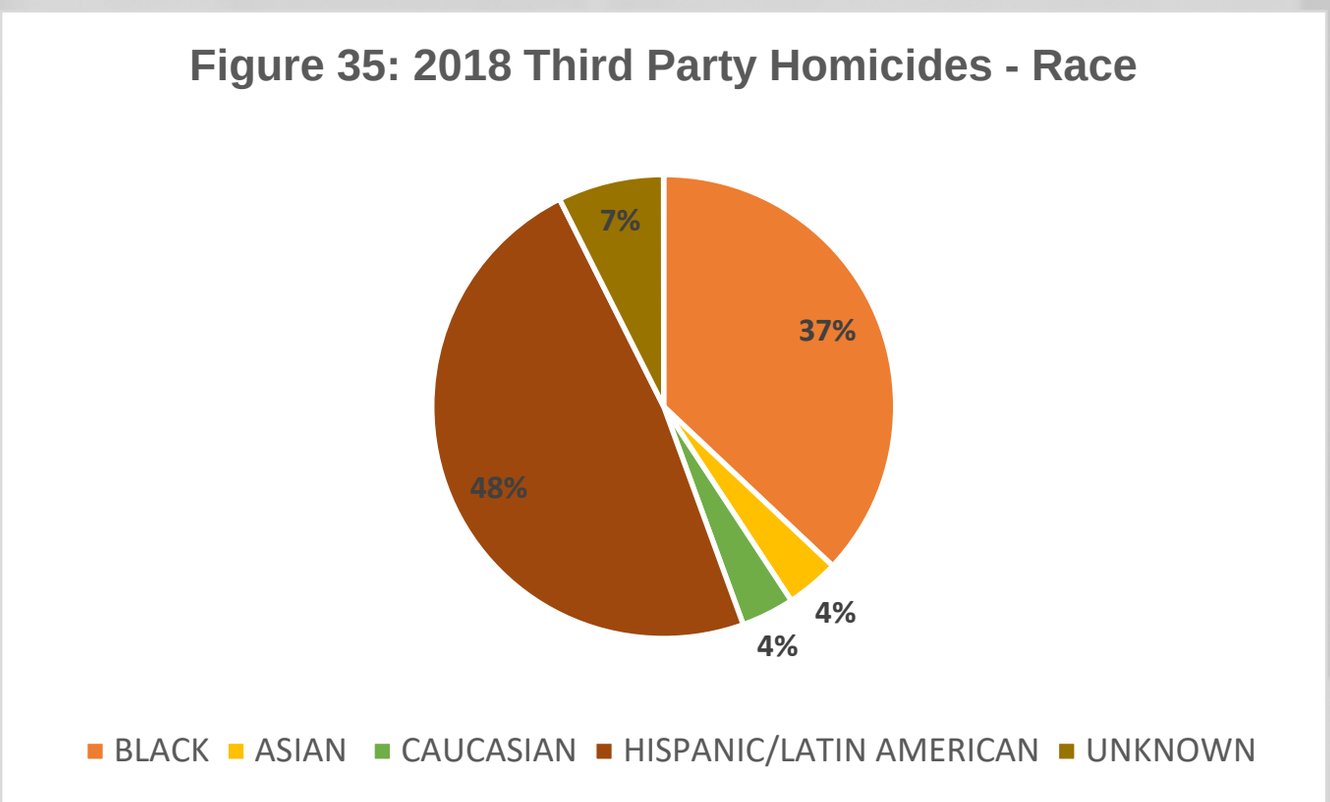


Table 31

Dates[1] of Third Party Homicides - 2018

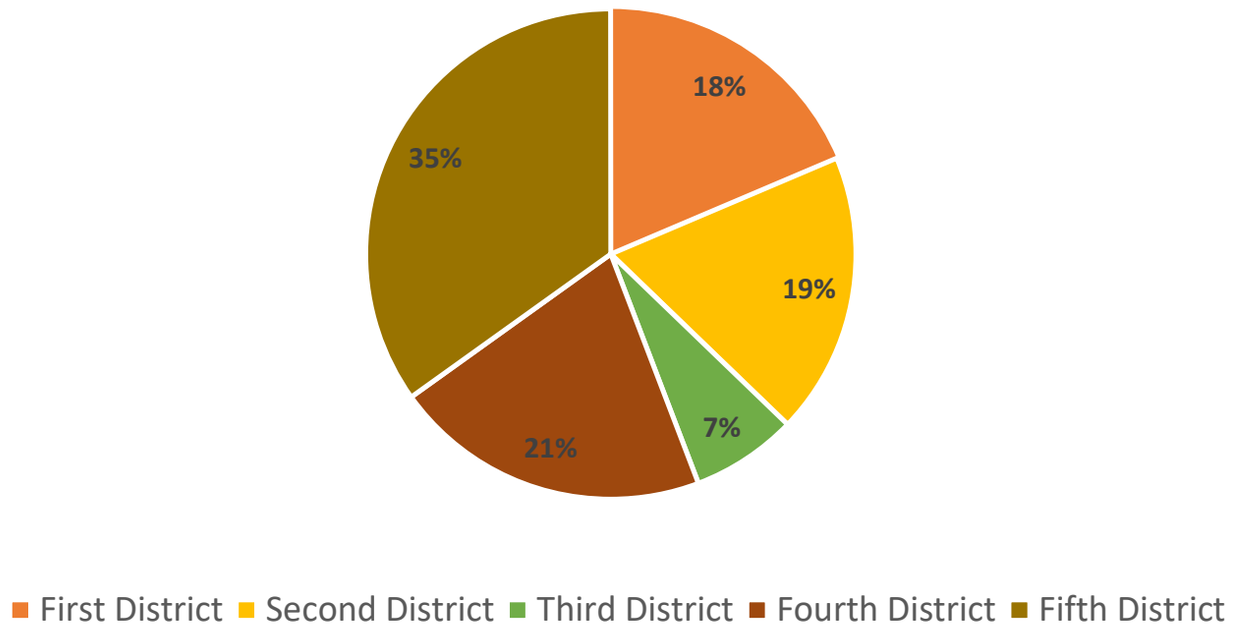
5 homicides occurred in January (01/01, 01/07 & 01/11, 01/20 & 01/30)
2 homicides occurred in February (02/01 & 02/04)
0 homicide occurred in March
1 homicide occurred in April (02/01 & 02/04)
3 homicides occurred in May (05/01, 05/10, 05/13 & 05/15)
5 homicides occurred in June (06/06, 06/16, 06/18, & 06/30)
0 homicides occurred in July
0 homicides occurred in August
3 homicides occurred in September (09/28 & 2 on 09/30)
0 homicide occurred in October
4 homicide occurred in November (11/10, 11/17, 11/24, & 11/26)
1 homicides occurred in December (12/5)

Table 32

Locations[2] of Third Party Homicides – Geographic Area - 2018

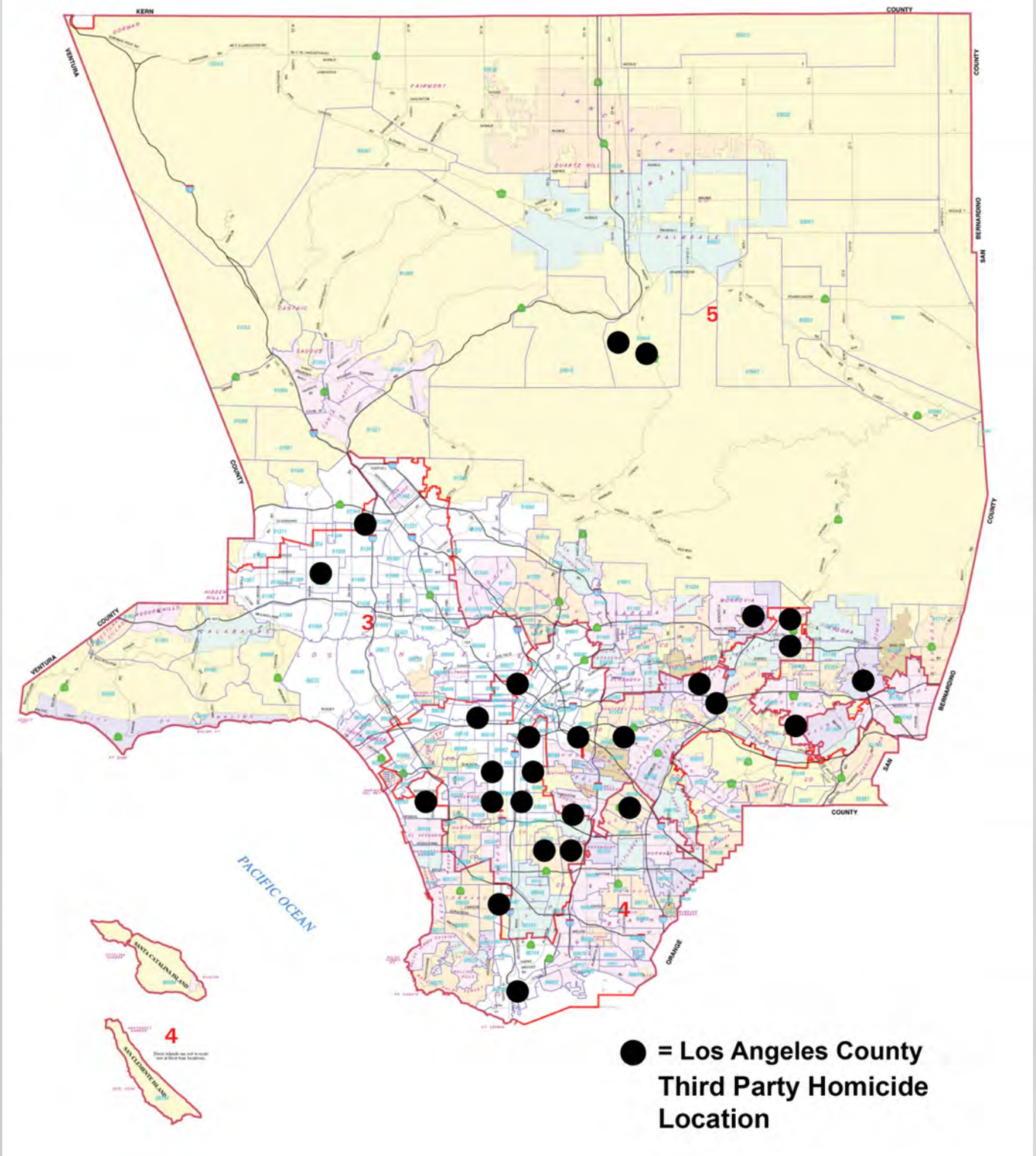
4 homicides each occurred in Los Angeles zip codes 90033)
6 homicide each occurred in Los Angeles (zip codes 90002, 90003, 90015, 90045, 90054)
1 homicides occurred in Azusa (zip code 91702
1 homicide occurred in Compton (zip code 90220)
1 homicide occurred in Downey (zip code 90220)
1 homicide occurred in El Monte (zip code 91733)
1 homicide occurred in Monrovia (zip code 91016)
2 homicide occurred in Lynwood (zip code 90262)
1 homicide occurred in Palmdale (zip code 93550)
2 homicide occurred in Pomona (zip code 93550)
1 homicide occurred in West Covina (zip code 91792)
1 homicide occurred in Sylmar (zip code 91342)
1 homicide occurred in San Pedro (zip code 90731)
1 homicide occurred in Torrance (zip code 90501)

Figure 36: Third Party Homicides by Board of Supervisor District



2018 Third Party Homicides - Locations
n = 27*

**City where the homicide occurred*



Third Party Homicides

Information on the criminal justice system involvement in third party homicide cases was gathered from three sources: Los Angeles County District Attorney's office, Los Angeles Police Department (LAPD), and the Los Angeles Sheriff's Department (LASD). In 2018, there were 27 third party homicide cases. The law enforcement agencies and number of cases for which they were responsible for investigation are shown in Table 36 below.

Table 33		
Agency	**Number of cases**	**%**
LAPD	11	40.7%
LASD	14	51.9%
Downey PD	1	3.7%
West Covina PD	1	3.7%

Table 35 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 not all of the law enforcement agencies were able to provide much detail about the suspect's circumstances, which is why cases fall under the "no information provided" or ":suspected" categories. The majority of these cases remain under investigation and the suspect(s) is unknown. Most of these cases also involve either walk-up or drive-by shootings.

Table 34	
Perpetrator's Relationship to Victim	**Number of cases**
Not a Gang Member	8
Gang Member	2
Officer Involved	1
Suspected to be Gang Related	16

Table 36, below, provides information about the victim's circumstances or activities prior to being killed and whether the victim was known to be gang-involved.

Table 35	
Victim Information	**Number of cases**
No Information provided	
Shot in a walk-up shooting	
Shot during a drive-by shooting	
Officer Involved	1
Gang member or tagger	
Not a Gang Member	
Child Welfare History	17
Open DCFS Case	2
Active Probation Case	4

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), 6 of the 27 cases of third party homicides were referred to the District Attorney's office in 2018. Six cases had criminal charges of murder filed by the District Attorney's office in 2018. One of the twenty-seven cases were officer involved and no charges were filed. The remaining cases continue to be under investigation.

ICAN Youth Suicide Coroner/Medical Examiner Investigation Procedural Guide

Language Interviewed in: ☐ English ☐ Other _____
Translated by: _____

Case Number: _____
Decedent: _____
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

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

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

APPENDIX B - How to Keep Your Baby Safe

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

IS YOUR BABY SLEEPING SAFELY?

Get Safe Sleep Tips

Watch the PSA

Take the E-Learning Course

Like us on Facebook for the latest updates. Like 1.3K

Contact

ICAN Associates
4024 N. Durfee Avenue
El Monte, CA 91732
626-455-4585
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
ican4kids.org

first 5 la
Giving kids the best start

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.org

Domestic Violence
- dvcouncil.lacounty.gov
- lapdonline.org/StopDV
- thehotline.org

Suicide-Youth
- preventsuicide.lacoe.edu
- suicideinfo.ca/youthatrisk
- suicidehotlines.com/california.html
- thetrevorproject.org

Water Safety
- poolsafety.gov
- abcpoolsafety.org

Fire Safety
- fire.lacounty.gov/safety-measures/fire-safety-tips
- firefacts.org

Biking Safety
- Sheriffsyouthfoundation.org
- Nhtsa.gov/bicycles

In and Around Cars
- chp.ca.gov/program&services
- nhtsa.gov
- kidsandcars.org

Pedestrian
- kidsandcars.org
- safekids.org
- ntsa.gov/pedestrian

Teen Drivers
- ntsa.gov

APPENDIX D - Map of Los Angeles County Board of Supervisor District