

COUNTY OF LOS ANGELES

Family and Social Services

FESIA A. DAVENPORT
Chief Executive Officer



DATE: Wednesday, June 23, 2021
TIME: 1:30 PM

DUE TO THE CLOSURE OF ALL COUNTY BUILDINGS, MEETING PARTICIPANTS AND MEMBERS OF THE PUBLIC WILL NEED TO CALL IN TO PARTICIPATE:

Teleconference Call-In Number: (323) 776-6996/ Conference ID: 599 009 090#

[Join Meeting via Microsoft Teams](#)

AGENDA

Members of the Public may address agenda item. Two (2) minutes are allowed for each item.

- I. Call to Order
- II. **Presentation/Discussion Items:**
 - a. **Department of Children and Family Services:** Request to Accept Fiscal Year 2021-2022 California Alternative Payment Program (CAPP) Grant Funding from the California Department of Education for the Provision of Child Care Services.
 - b. **Los Angeles County Inter-Agency on Child Abuse and Neglect (ICAN)/ Sheriff's Department:** ICAN Child Death Review Team Special 30 Year Report.
- III. Items continued from a previous meeting of the Board of Supervisors or from a previous FSS Agenda Review meeting.
- IV. Public Comment
- V. Adjournment



County of Los Angeles
DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020
(213) 351-5602

BOBBY D. CAGLE
Director

GINGER PRYOR
Chief Deputy Director

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First District
HOLLY J. MITCHELL
Second District
SHEILA KUEHL
Third District
JANICE HAHN
Fourth District
KATHRYN BARGER
Fifth District

July XX 2021

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**REQUEST TO ACCEPT FISCAL YEAR 2021-2022 CALIFORNIA ALTERNATIVE
PAYMENT PROGRAM (CAPP) GRANT FUNDING FROM THE CALIFORNIA
DEPARTMENT OF EDUCATION (CDE) FOR THE PROVISION OF CHILD CARE
SERVICES
(ALL SUPERVISORIAL DISTRICTS) (3 VOTES)**

SUBJECT

Request the Chair to approve, adopt, and execute a Resolution certifying approval of the Board, authorizing the Director, as designee, of Children and Family Services (DCFS) to accept, sign, and execute the California Alternative Payment Program (CAPP) Agreement with the California Department of Education (CDE) for funding to subsidize the DCFS' Child Care Program for children under the supervision of DCFS; and authorize the Director, as designee, of DCFS, to complete, accept, sign, and forward to CDE the amendments and continued funding applications for CAPP funding for Fiscal Year (FY) 2021-2022.

IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve, adopt, and instruct the Chair to execute the Resolution (Attachment A). The Resolution certifies your Board's approval for the Director of DCFS, as designee, to: (a) submit applications to CDE for FY 2021-2022 CAPP funding; (b) accept, sign, and execute Agreements with CDE to accept CAPP funding for FY 2021-2022 (CDE CAPP Agreement – Attachment B); (c) sign the Certification Clause, form CCC-04/2017 (Attachment C), the California Civil Rights Laws

"To Enrich Lives Through Effective and Caring Service"

Certifications (CO-005 – Attachment D) and Federal Certification Form, C0.8 (Attachment E); and (d) sign and execute amendments to the CDE CAPP Agreement for FY 2021-2022 funding, and to increase or decrease the amount of such funding. The Contractor Certification Clause certifies that DCFS is in compliance with all contract requirements.

2. Authorize the Director of DCFS, as designee, to complete, sign, and forward to CDE the CAPP funding application, and accept funding for FY 2021-2022 and subsequent CDE funding agreement documents for 2021-2022.
3. Delegate authority to the Director of DCFS as designee, to sign and execute the CDE CAPP Agreement (Attachment B) to receive FY 2021-2022 CAPP funding, and to sign subsequent amendments for FY 2021-2022 and CDE Agreement documents for FY 2021-2022 CAPP funding and to increase or decrease the amount of such funding, provided that: (a) CAPP funding is available through CDE; (b) Chief Executive Office (CEO) notification is obtained prior to executing amendments to the CDE CAPP Agreement to receive FY 2021-2022 funding; and (c) the Director of DCFS as designee, notifies your Board and the CEO in writing within ten working days of executing the CDE CAPP Agreement and subsequent annual and mid-year amendments.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

The recommended actions will allow DCFS to accept FY 2021-2022 CAPP funding and apply for FY 2021-2022 funding amendments to continue DCFS' Child Care Program for children under its supervision who are at risk of abuse or neglect.

Child Care is made available to children who have been assessed to be at potential risk of abuse or neglect. This care is provided to children who are with their birth parents or are in first-time placements with relatives. The goal of DCFS' Child Care Program is to ensure the child's safety and to assist in avoiding out-of-home placements. This program provides a safety net for the children who are at risk of abuse or neglect and placed with birth parents or relatives.

Without approval of the recommended actions, DCFS would not be able to provide child care services to eligible children and families, and would result in the loss of \$23,078,199 in State and Federal funding for FY 2021-2022 and subsequent funding for FY 2021-2022.

IMPLEMENTATION OF STRATEGIC PLAN GOALS

The recommended actions are consistent with the principles of the Countywide Strategic Plan Goal Five: Children and Families' Well Being. The recommended

actions will allow continued access to subsidized child care for children at risk of abuse or neglect and allow for full utilization of available funding.

FISCAL IMPACT/FINANCING

The amount of State and Federal CAPP funding available for FY 2021-2022 is \$23,078,199, and is subject to change for the current and subsequent fiscal years. Under the CDE CAPP Agreement, the County provides \$170,019 annually for Maintenance of Effort (MOE), which will be net County cost and is also subject to change for the current and subsequent fiscal years. The total amount available, including MOE for DCFS' Child Care Program funding for FY 2021-2022, is \$23,078,199. The CDE CAPP Agreement also provides for 100% reimbursement of administrative cost, provided that total CAPP expenditures do not exceed \$23,078,199. Funding for FY 2021-2022 will be included in the Department's annual budget request.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On June 30, 2020, your Board approved a Resolution and delegated authority to the DCFS Director to sign an agreement, and subsequent amendments, with CDE to receive CAPP funding to subsidize child care services for fiscal years 2020-2021. A new Resolution is required to delegate the Director as designee, of DCFS to accept funding for FY 2021-2022. The CDE CAPP Agreement allows DCFS to receive CAPP funding to provide child care for FY 2021-2022 by amendment. DCFS' Child Care Program provides a safety net for the children who are at risk of abuse or neglect and placed with relatives for the first time.

The terms and conditions of the CDE CAPP Agreement are located online at <http://www.cde.ca.gov/fg/aa/cd>, as referenced in the document. The State normally issues to California counties the CDE CAPP Agreement, or amendments thereto, along with related material, by June of each year for a July 1st implementation date. The State is aware that the clearance and approval timelines for both the State and the County will result in executing the CDE CAPP Agreement, or its amendments, after the implementation date. The Catalog of Federal Domestic Assistance (CFDA) number for CAPP is 93.596.

The CDE CAPP Agreement is not a services contract.

IMPACT ON CURRENT SERVICES

Acceptance of the CAPP funding will enable DCFS to continue to meet the child care needs of parents and relative caregivers served by DCFS. The CDE CAPP Agreement will allow DCFS to continue to provide child care services in FY 2021-2022.

CONCLUSION

Upon approval and execution of this contract by the Board, it is requested that the Executive Officer/Clerk of the Board send one original and one copy of the Resolution, Certification Clause, CCC-04/2017, Civil Rights Laws Certification, CO-005, and the Federal Certification Form, CO.8, to:

1. Contracts, Purchasing, and Conference Services
California Department of Education
1430 N Street, Suite 1802
Sacramento, CA 95814-5901

And, one adopted stamped copy of this Board letter and attachments to:

- | | |
|--|---|
| <ol style="list-style-type: none">2. Children and Family Services
Attn: Cynthia McCoy-Miller
Senior Deputy Director
425 Shatto Place, Room 600
Los Angeles, CA 900204. Auditor-Controller
Accounting Division
Kenneth Hahn Hall of Administration
Room 603
500 West Temple Street
Los Angeles, CA 90012 | <ol style="list-style-type: none">3. Children and Family Services
Attn: Jennifer Hottenroth
Acting Division Chief
425 Shatto Place – 5th Floor
Los Angeles, CA 90020 |
|--|---|

Respectfully submitted,

BOBBY D. CAGLE
Director

BDC:SB
JH:lw

Enclosures

c: Chief Executive Officer
Executive Officer, Board of Supervisors



ICAN CHILD DEATH REVIEW TEAM SPECIAL REPORT CHILD HOMICIDE BY CARETAKER



30 YEAR RETROSPECTIVE

LOS ANGELES COUNTY
**INTER-AGENCY COUNCIL ON
CHILD ABUSE AND NEGLECT**
DEANNE TILTON DURFEE, EXECUTIVE DIRECTOR

ICAN MULTI-AGENCY CHILD DEATH REVIEW TEAM

626•455•4585 | 4024 N. Durfee Ave. El Monte CA 91732
ican@lacounty.gov | www.ican4kids.org

Acknowledgments

This report is unique, covering 30+ years of review by the Los Angeles County Child Death Review Team.

Child Homicides by Caretaker are presented in data and graphs, but each number represents a child's life lost. This motivates team members to continue the heartbreaking task of probing into the nature and extent of child abuse fatalities, - to save other children from such tragic outcomes. The data tell us we have made a difference.

ICAN gratefully acknowledges the following for their contributions to this Special Report:

Susana Montanez, LCSW, ICAN CDRT Administrator
John Solano, ICAN Associates, IT Coordinator
Kenneth Rios, ICAN, Intermediate Typist Clerk
Edie Shulman, MSW, JD, ICAN Assistant Director

LA County Chief Medical Examiner/ Coroner
Jonathan Lucas, M.D.
Pediatric Consultant and CDRT Co-Chair
Carol Berkowitz, M.D.

CDRT Founder & Chief Consultant
Michael Durfee, M.D.

With appreciation to all presenters and participants in the ICAN Child Death Review Team,



Deanne Tilton Durfee, Doc.hc
Executive Director, Inter-Agency Council on Child Abuse and Neglect (ICAN)





Executive Summary

ICAN Child Death Review Team- Special 30 Year Report
73% Decline in Child Homicides by Caretaker

The Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) established the nation's first Child Death Review Team (CDR) in 1978. ICAN subsequently supported the development of teams in other California counties, states and nations, and was recognized by the International Society for the Prevention of Child Abuse and Neglect as the best multi-agency team worldwide.

The ICAN Child Death Review Team has reviewed data on child homicides by caretaker since 1985. The review expanded to include separate teams reviewing Accidental and Undetermined deaths and Suicides. This report includes data and demographics on Child Homicides by Caretaker from ICAN's published reports, 1989 – 2018.

Our analysis of the data has provided important information about victims and perpetrators. Of special significance is the finding that, during the course of this 30-year study, the number of child homicides by caretaker decreased by 73%.¹

The team has benefited from the balanced leadership of co-chairs representing Human Services and Criminal Justice. Child Death Review Team members represent medical, mental health, coroner, law enforcement, child welfare, schools, public social services and the community.

Cases are presented for review by case managers with participation from all agencies that may have had contact with the child victim or family. This multi-agency approach has resulted in valuable lessons and important inter-agency and multi-jurisdictional collaboration for case management and prevention of future child deaths. ICAN will be reaching out to other counties and states to compare findings and trends.

This report presents some of the possible contributors to the decline in child abuse homicides, and analyzes the child and perpetrator demographics, ages, relationships and causes of child homicides.

The data reinforces the importance of recognizing the high risk to very young victims, - over 1/2 were under age one year, 2/3 under age 3 years. The data also show that male caretakers have been the primary perpetrators in the majority of child abuse homicides and that they murder young boys at a higher rate than girls.

The data also revealed that male caretakers committed homicides from age eighteen into their forties, while women, on average, were between the ages of twenty-two and thirty when they committed child homicide.

1. Comparing first five years to last five years.

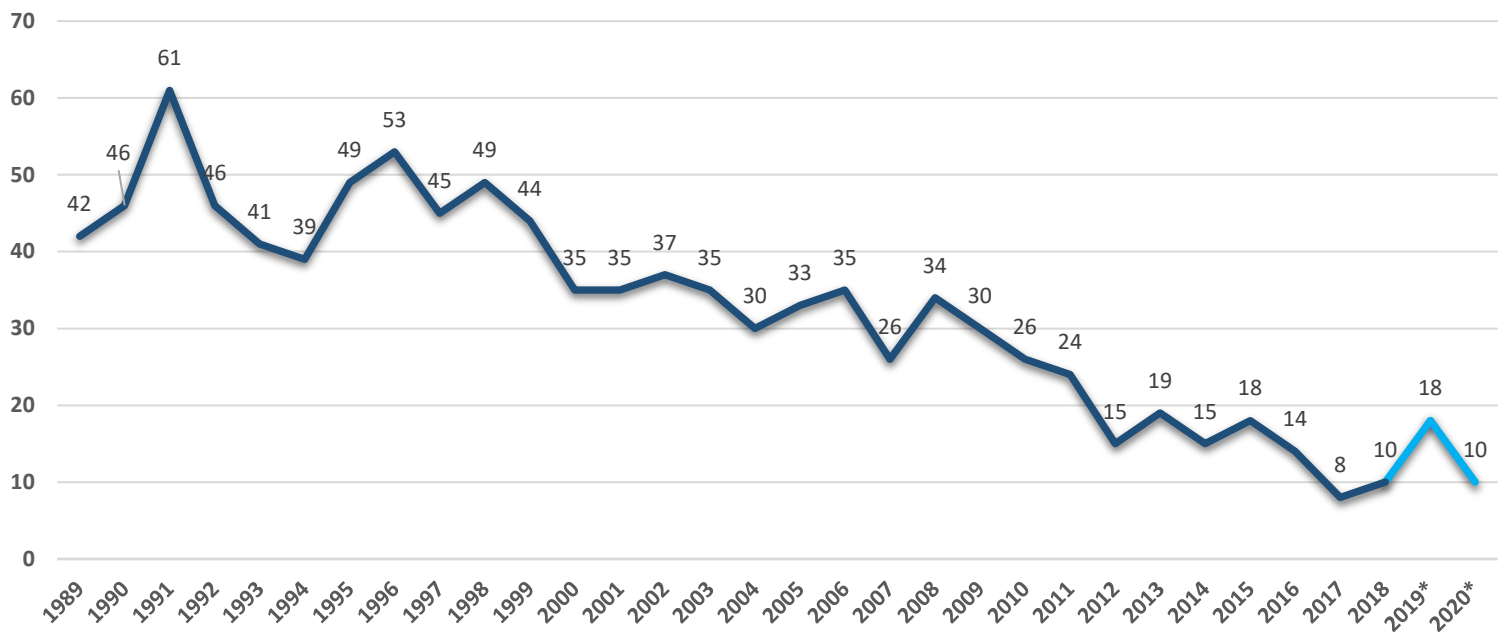
Other findings include:

- African American children and caretakers were over-represented as victims and perpetrators.
- Child victims were more likely to be killed by a parent than extended family or non-related caretaker.
- A history of child welfare, domestic violence and substance abuse were the leading co-related factors, followed by mental illness and history of abuse to the parent/caretaker as a child.

On a positive note, this 30-year analysis indicates an overall positive trend as the number of child abuse homicides has declined exponentially, with the largest decrease in the last decade.²

Preliminary data for 2019 and 2020 show 18 and 10 child homicides respectively, reflecting a 9-year downward rate of less than 20 per year.

**ICAN CHILD DEATH REVIEW TEAM
SPECIAL REPORT CHILD HOMICIDE BY
CARETAKER IN LOS ANGELES COUNTY
1989-2020**



2. From 1985–88, ICAN collected data on 145 child homicides using a different methodology. Data from cases reviewed by ICAN 1978-85 are not accessible.



ICAN

**CHILD DEATH REVIEW TEAM
SPECIAL REPORT**

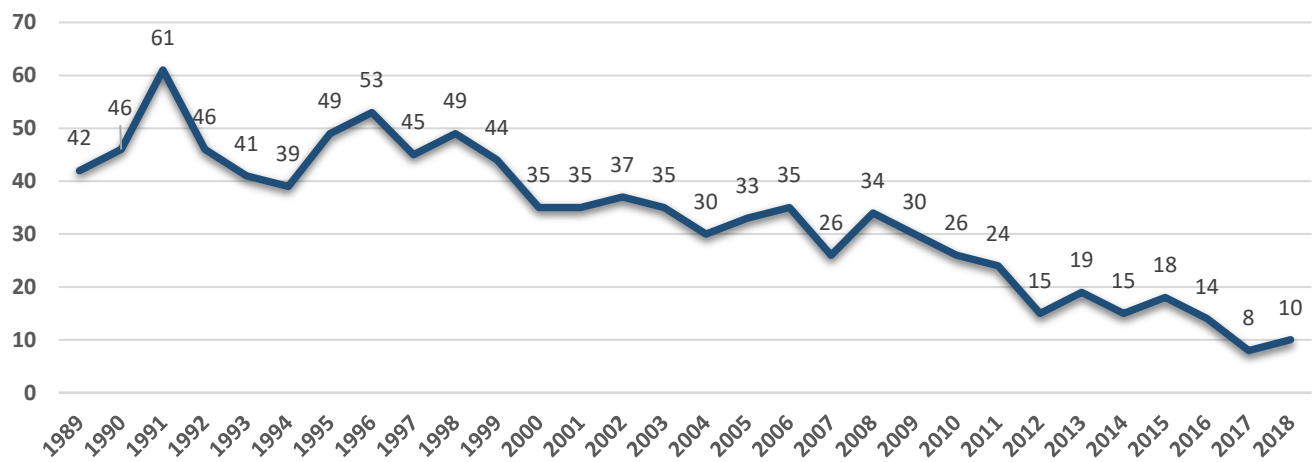
**30 YEAR
RETROSPECTIVE**



CHILD HOMICIDES BY CARETAKER

ICAN Child Death Review Team- Special 30 Year Report

**ICAN CHILD DEATH REVIEW TEAM
SPECIAL REPORT CHILD HOMICIDE BY
CARETAKER IN LOS ANGELES COUNTY
1989-2018**



The Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) began the first multiagency child death review in the world in 1978, starting with a focus on infant homicides and expanding to all Coroner's death cases of children under eighteen years of age. This was a novel concept. However, by 2001, Child Death Review teams had spread to all states and multiple countries.

ICAN's Child Death Review Team includes representatives from City and County offices, agencies and professions involved in the safety and well-being of children. Los Angeles County is unique in size, with a population estimate of 10 million residents and growing.

Over the years, ICAN's Child Death Review Team has reviewed and tracked child deaths from homicide, suicide, accident, and undetermined modes. ICAN now has separate teams reviewing Homicides, Child and Adolescent Suicides and Undetermined Child Deaths. A Domestic Violence Fatality Review Team is managed by the Office of the District Attorney.

This special report focuses on 30 years of data included in ICAN's annual reports on child homicides by caretaker, defined as parent, parent's adult partner, baby-sitter or other family member providing childcare. ICAN's data for these 30 years includes nearly 1,000 homicides by caretaker. As will be demonstrated later in this section, the overall homicide rate of children by caretaker has fallen exponentially over the last 30 years, with the largest decrease in the last decade.

This decrease in child homicides by caretaker is a welcome and positive sign but does raise the question of why the rate has decreased so significantly. ICAN's definition of fatal child abuse is cases that have the Coroner's designation of homicide with law enforcement involvement and a caretaker suspect. Of special significance is the finding that, during the course of this 30-year study, the number of child homicides by caretaker decreased by 73%. Possible factors contributing to the decrease in child homicides include:

I. BIRTH RATE: The birth rate for Los Angeles County dropped significantly. (See Page 6)

II. COMMUNITY AWARENESS: The media has increasingly reported on tragic child abuse deaths of children. Reports on the numbers, risk factors, and high-profile cases reach the public, as do campaigns such as Safe Surrender and Safe Sleep. The 12 Community Child Abuse Prevention Councils bring together service providers by geography, race, ethnicity, and special issues including deaf and developmentally delayed children.

III. AGENCIES ARE MORE CONNECTED WITH EACH OTHER: ICAN's multi-disciplinary Child Death Review process has promoted critical information sharing and collaboration. DCFS incorporated policy and practice to create a more proactive approach to protecting children, collaborating with medical, mental health, educational and community-based agencies. Law enforcement and Prosecutors established specialized units that work with human services agencies in response to high-risk children and families.

IV. HOME VISITOR PROGRAMS: These services are growing in Los Angeles County and involve multiple agencies and professions. The programs are built on perinatal issues and include study and validation of effectiveness in preventing child abuse, unhealthy and high-risk behavior.

V. FAMILY AND CHILDREN INDEX: FCI facilitates the sharing of information among service providing agencies regarding previous significant contacts. This Index was inspired by ICAN's review of child fatalities with multiple agency contacts prior to a child's death. Hospitals will be included in the future.³

VI. SAFE SURRENDER PROGRAM: This program provides a safe, secure, and anonymous way for mothers, who find themselves in a desperate situation, to place their baby into safe hands, at any fire station or hospital. Since 2001, over 200 babies have been given a second chance at life, while the number of abandoned deceased babies has declined from eleven to one.⁴

VII. DOMESTIC VIOLENCE FATALITY REVIEW: The DVDR Team reviews of domestic violence fatalities have been important to understanding inter-related risk factors present in intimate partner and child homicides.

VIII. First5 LA CHILDREN AND FAMILIES COMMISSION: First5 LA was created 22 years ago to invest Los Angeles County's allocation of Proposition 10 tax revenues. The funds are specifically targeted for improving the health, safety, and well-being of children prenatal to 5 years of age. The Commission has funded policies and practices that have impacted young children. Home Visitation, Welcome Baby, Partnerships for Families, and Infant Safe Sleep are examples of important First5LA investments, promoting the health and safety of vulnerable infants and toddlers.

3. For more information on Family and Children Index see page 17 of this report.

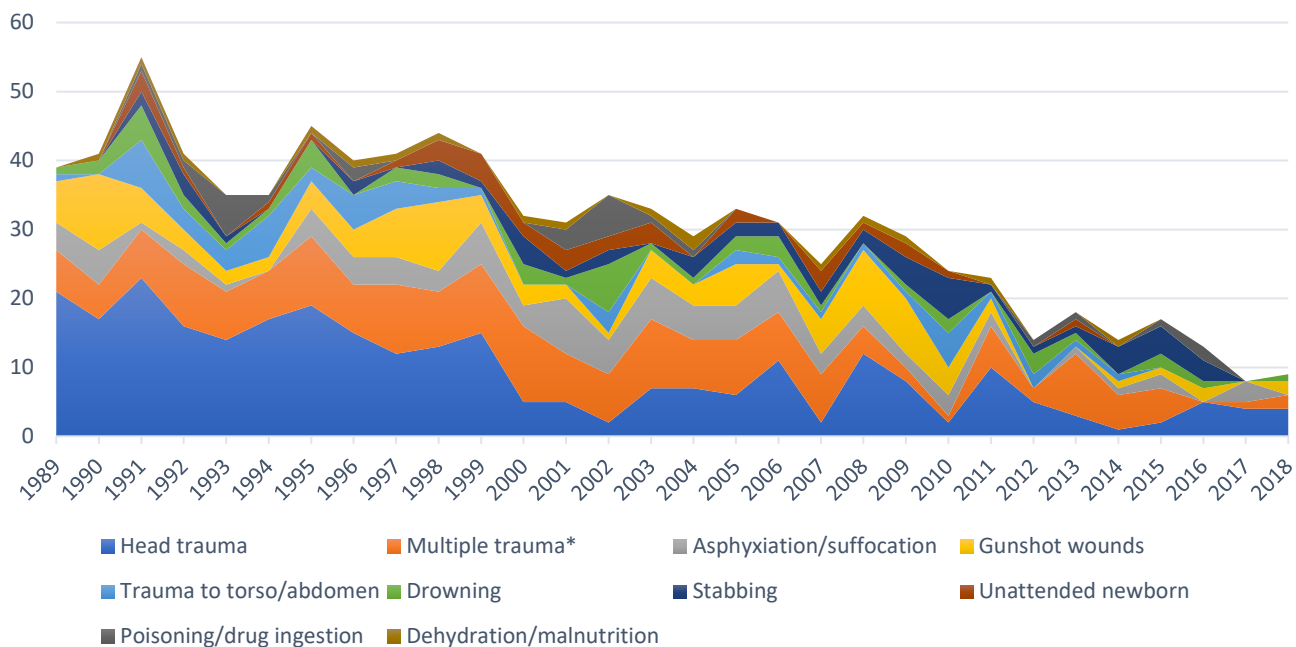
4 For more information on Safe Surrender Program see page 17 of this report.

IX. MEDICAL EXPERTISE IN IDENTIFICATION, DIAGNOSIS AND TREATMENT

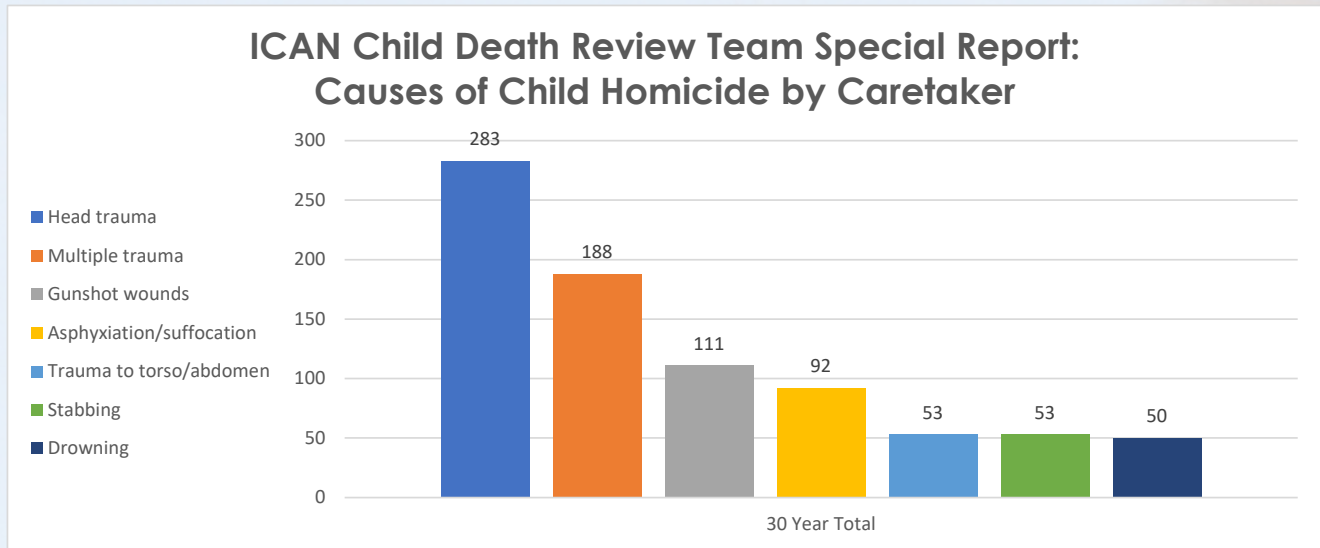
There has been an expansion of medical knowledge regarding child abuse indicators that has increased the ability of medical professionals to identify and report potential child abuse and neglect.

- **THE ICAN HOSPITAL NETWORK:** This ICAN project has shown the potential to tie separate hospitals where children are born, screened, and treated into a working network to connect with the child protection system more effectively.
- **NEONATAL REPORTING LAW:** This law directs each county to build its own criteria for reporting high risk newborns. High risk infants in Los Angeles County are reported to DCFS for follow up and provision of support and protection.
- **OUT-STATIONED PUBLIC HEALTH NURSES:** DCFS has out-stationed Public Health Nurses in District Offices to provide critical support to CSW's in responding to reports of high risk children.
- **MEDICAL HUBS** in Los Angeles County include child abuse pediatric specialists, mental health providers, and access to resources for children and families brought to the attention of the child protection system. This high level of identification and treatment of young victims has prevented escalating harm and provided critical expert testimony to protect children from tragic outcomes.

**CDRT Report 1989 - 2018:
Causes of Child Homicide by Caretaker**

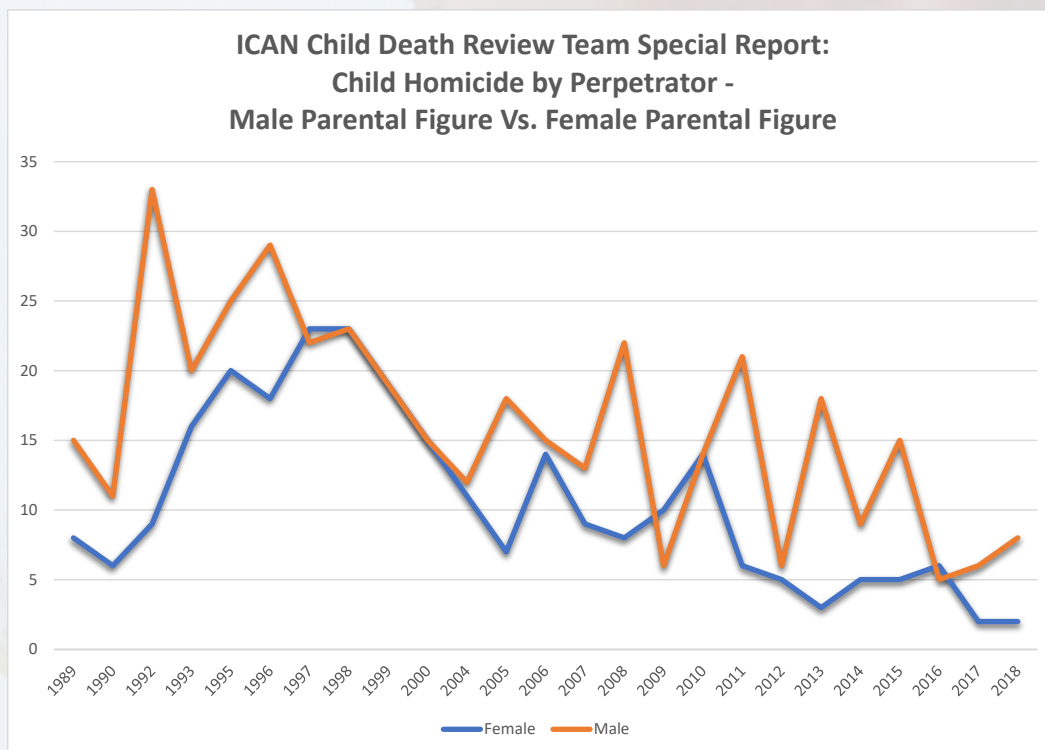


Since 1989, head trauma and multiple trauma have been the most common causes of death inflicted on children by their parent/primary caretaker.



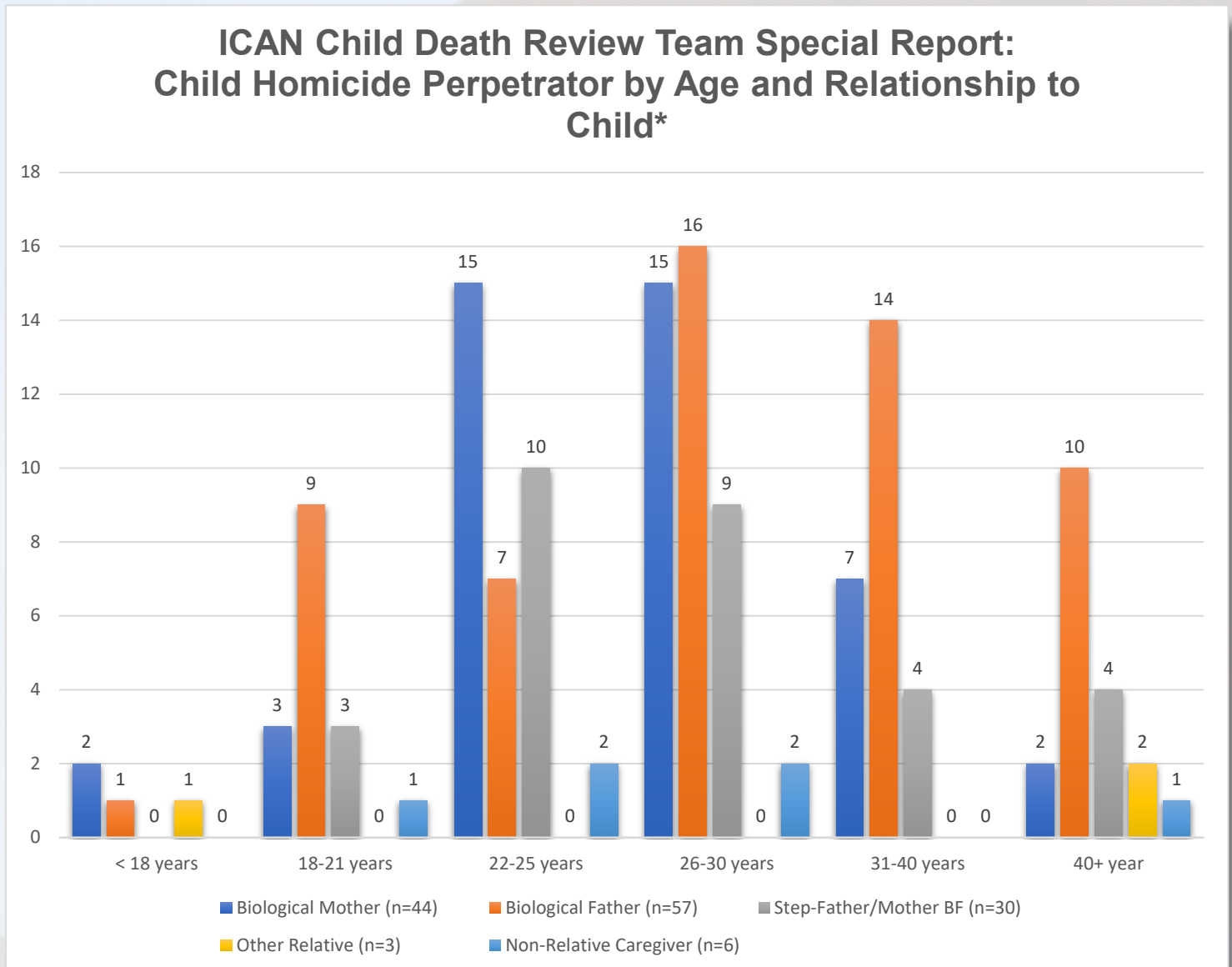
From 1989 to 2018, 524 children out of 994 died because of head trauma, multiple trauma and trauma to torso or abdomen inflicted by their parent/primary caretaker. A multitude of child fatalities revealed that excessive discipline of very young children related to crying, toilet training, bed wetting, feeding, and typical childhood challenging behavior are risk factors for child abuse homicides.

Among the leading causes of child homicides is gunshot wounds. Gunshot wound related deaths often occur during a domestic violence incidence where the father shoots and kills the mother and child. The data indicate that fathers, stepfathers, and mother's boyfriends are the more likely caretaker to kill a child under their care.



Since 1989, fathers, stepfathers, and mother's boyfriends (male parental figure) have represented the primary figure to cause the death of a child they are caring for. In fifty-three percent of the cases, fathers, stepfathers, and mother's boyfriends account for the majority of perpetrators of child homicides in the past 30 years. In comparison female parental figures, including mothers, stepmothers and girlfriends account for only 35% of the cases. These data demonstrate the need to consider examining men's preparation for parenting, life stressors, male social expectations and lack of services or support for male caretakers.

The following graph breaks down age of perpetrator.

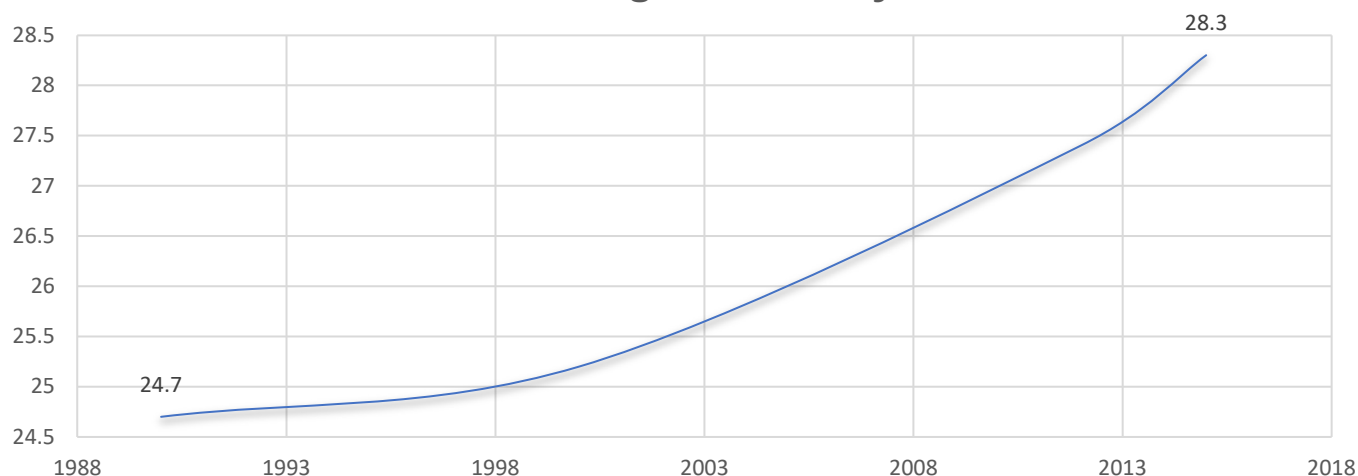


*This data is from 2011 to 2018. ICAN began documenting ages of homicide perpetrators starting in 2011 through the present

ICAN began documenting ages of homicide perpetrators starting in 2011 through the present. As indicated above, we know from our 30-year data analysis that fathers, stepfathers, and boyfriends represent the most likely figures to cause the death of a child when they are the primary caretaker. The above graph charts the ages of fathers, stepfathers, and mother's boyfriends from 18 to 40 years plus, and demonstrates a wider age range when they committed a child homicide as compared to female caretakers.

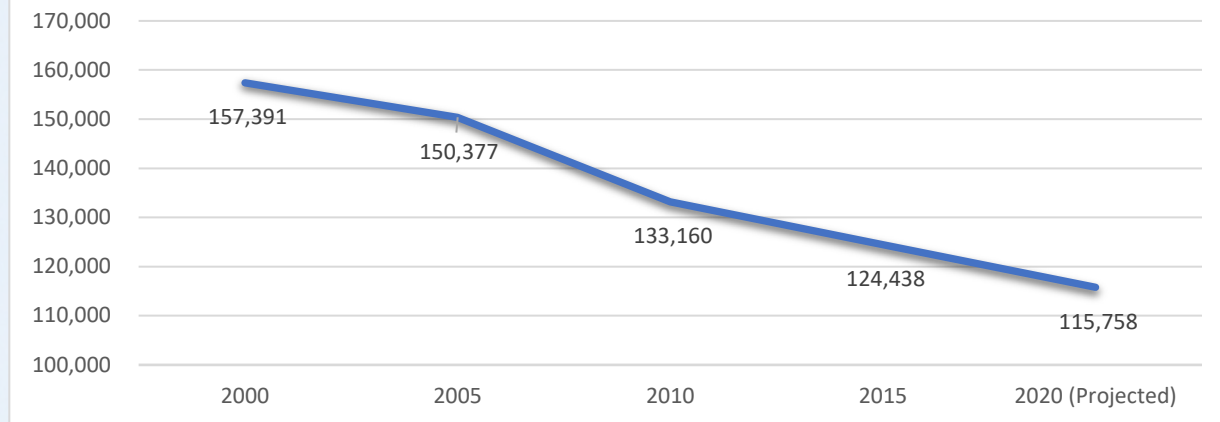
For mothers and other female caretakers, there is a more concentrated number of homicides, with a range between the ages of 22 and 30 for the past 7 years. Fathers, stepfathers, and boyfriends commit between 12 to 24 homicides per each age group with a total of 86 homicides committed between the ages of 18 to 40 plus years.

**Average Age of Mother at First Birth -
Los Angeles County**



In Los Angeles County from 1989 through 2016, the average age when mothers had their first child increased from 24 to 28. Our data from 2011 to the present indicate that mothers between the ages of 26-30 committed a total of 34 homicides compared to 10 homicides by women over the age of 30. Since the data show that the age when mothers had their first child increased to 28.3 and the overall homicides by mothers decreased, there may be a correlation between mothers having a child at a later age and the decrease in homicides. It is possible that older mothers may be better prepared for motherhood, as they have become aware of more resources.

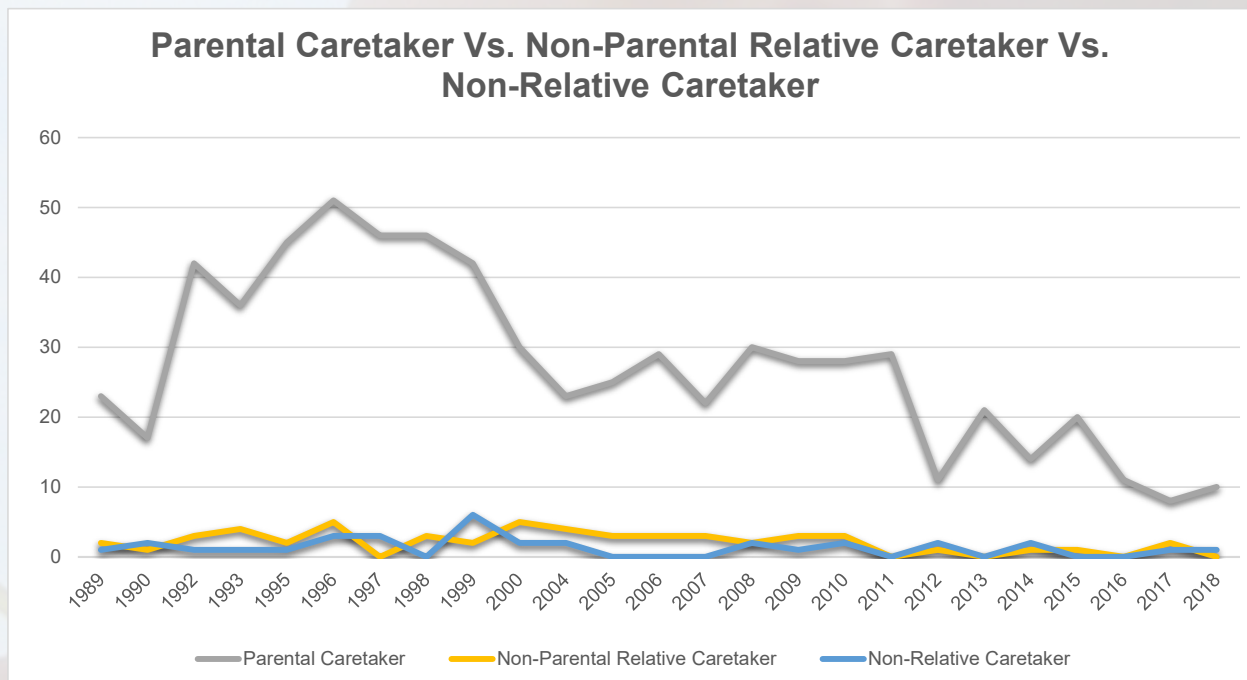
ICAN Child Death Review Team Special Report: Births in Los Angeles County, 1990 - 2020*



*California Department of Public Health, <https://www.kidsdata.org/>

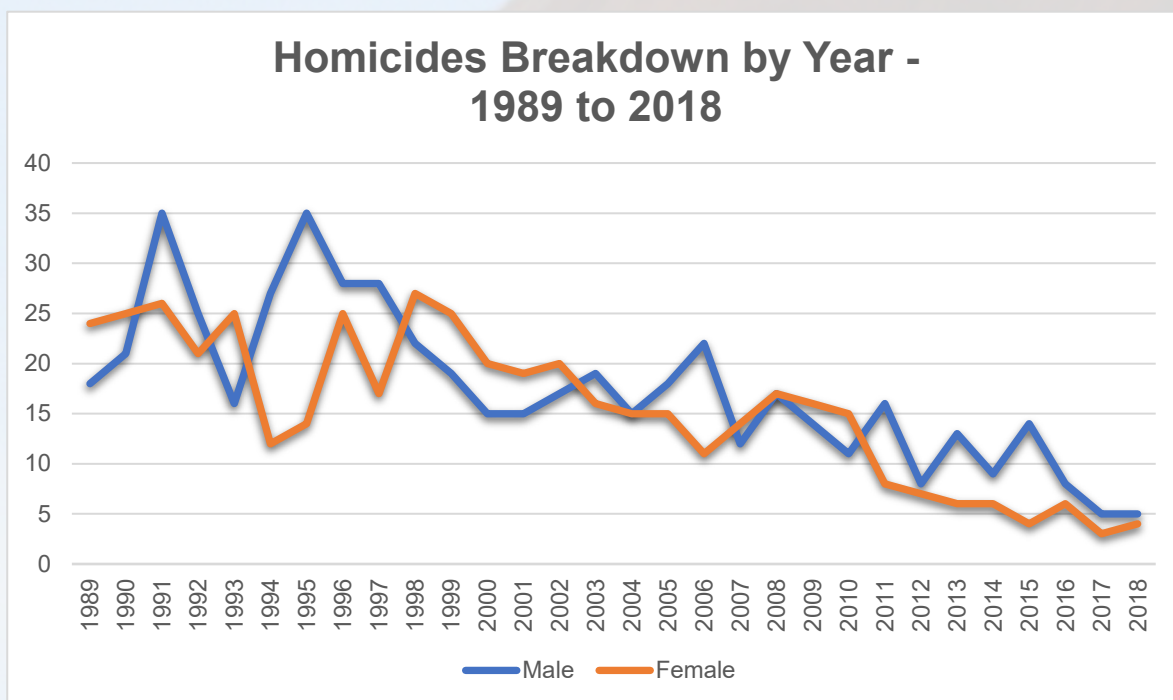
The decline in Los Angeles County births is evident with 204,124 births occurring in 1990 and declining steadily throughout the past 30 years. The projected birth rate for 2020 is 115,758 births. That is 88,366 fewer infants being born; almost a 43% decrease in child births since 2000. Mothers are not only having less children, the average age of first time mothers has increased from age 24 to 28 in the past 30 years.

The chart below compares parental caretakers to non-parental relative caretakers and non-relative caretakers.



In the last 30 years, parental caretakers (biological parents or parent's significant other) have been responsible for 89% of child homicides. Non-parental relative caretakers (siblings, grandparents' uncles, aunts, etc.) committed about 7% of child homicides, and non-relative caretakers (babysitters, foster parents, childcare providers, etc.) committed the remaining 4%. As illustrated in the graph above, the overall homicide rate is reflective of the decline in the number of parental caretakers who murder their children, while the number of non-parental caretakers remains stable overall throughout the decades and does not have a significant impact on the overall trend line. Although babysitters or childcare providers should be carefully screened, children are more likely to be killed by parental caretakers, those who are most likely to live with the child or spend significant amounts of time with the child.

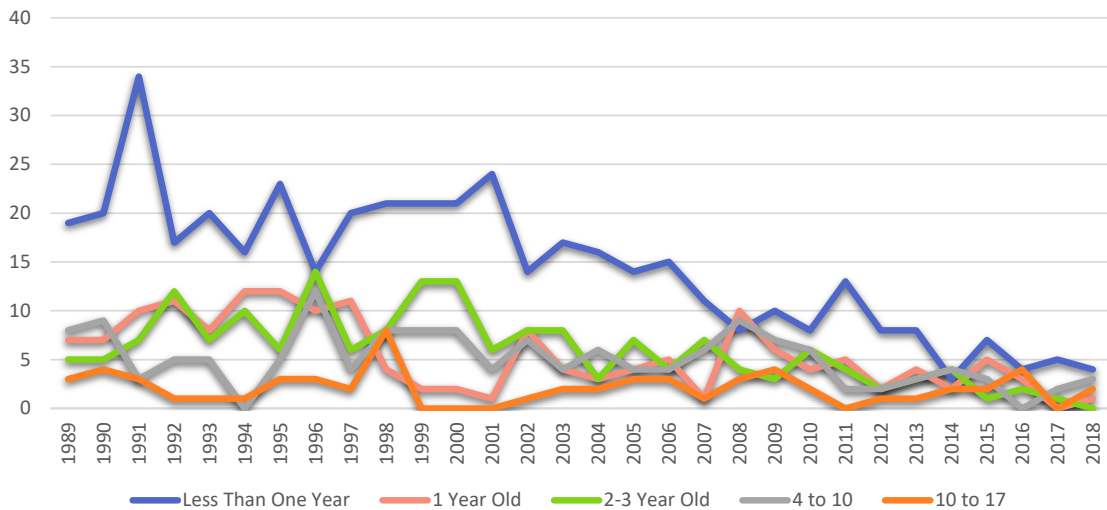
The following graph demonstrates the homicide gender breakdown per year.



Boys are more likely to be killed by a parent or caretaker as indicated by the data showing 529 boys dying at the hands of a parent or caretaker in comparison to 463 girls⁵. The following graph provides an age breakdown of homicides by caretaker.

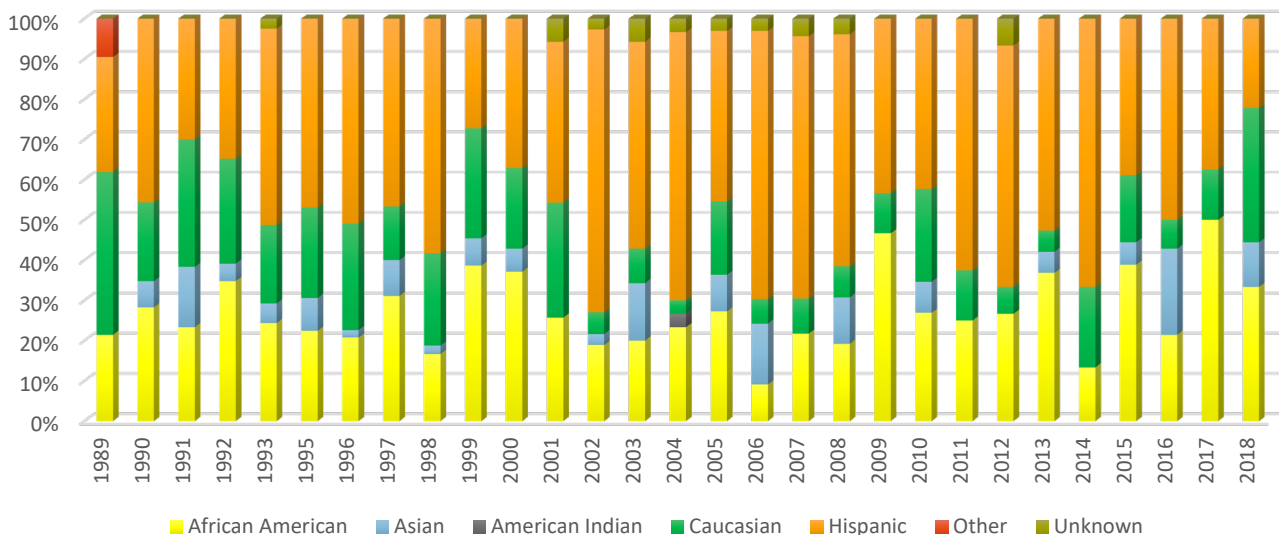
5. There are three cases where the gender of the child is unknown.

ICAN Child Death Review Team Special Report: Child Homicides by Caretakers – Victim Age Trendlines



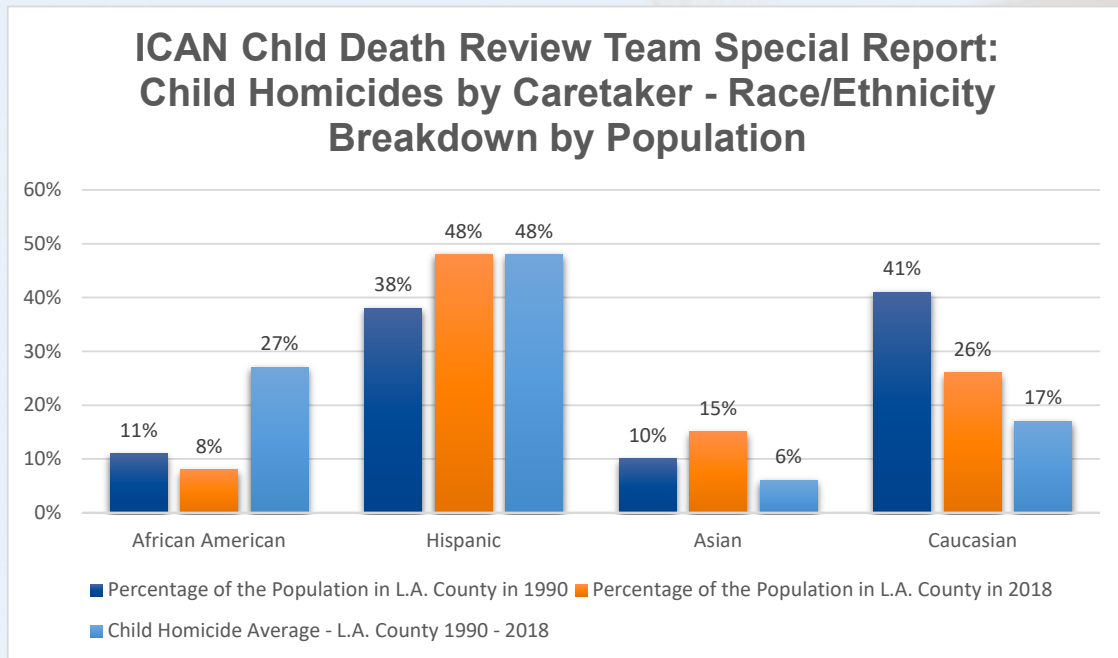
Out of 991⁶ child victims of homicide by caretaker, there have been 676 under the age of 3, which accounts for 68% of the deaths over a 30-year period. Of those 676 children, 416 are children under the age of one. When comparing the deaths of children under the age of one to the total number, children under age one make up 46%, almost half of all child abuse deaths in the past 30 years. Overall, the children most frequently fatally injured at the hands of a primary caretaker have been under one year of age.

ICAN Child Death Review Special Team: Child Homicides by Caregiver - Race/Ethnicity Breakdown by Year



6. There are three cases where the age of the child is not known.

The ICAN Child Death Review Team data charts the number of child abuse homicides for the past 30 years with the highest number of deaths in 1991 (61) and the lowest in 2017⁷.



The above graphs show the percentages and rates of child abuse homicides by race/ethnicity in Los Angeles County. The County has undergone a shift in the ethnic makeup of its population over the course of the last three decades, as the population has become increasingly diverse. According to the 1990 to 2018 Census Estimates, the total percentage of the Hispanic population has grown from 38% to 48% and the Asian population has increased from 10% to 15%. However, the percentages for Caucasian and African Americans have decreased: 41% to 26% for Caucasians and 11% to 8% for African Americans.

When the race/ethnicity makeup of child homicides for the period between 1989 and 2018 is averaged as a percentage, these are the results: 48% Hispanic, 27% African American, 17% Caucasian, 6% Asian, and 2% other. These findings show that African American children have disproportionately been the victims of child homicide over the last 30 years compared to the size of their population in the County. Hispanic children killed by their caretakers have historically been overrepresented, but this rate has narrowed as the population of Hispanic Americans has increased significantly over the last 30 years.

7. *Note: tentative reports from the Coroner/Medical Examiner indicate 15 child homicides by caretaker in 2019.

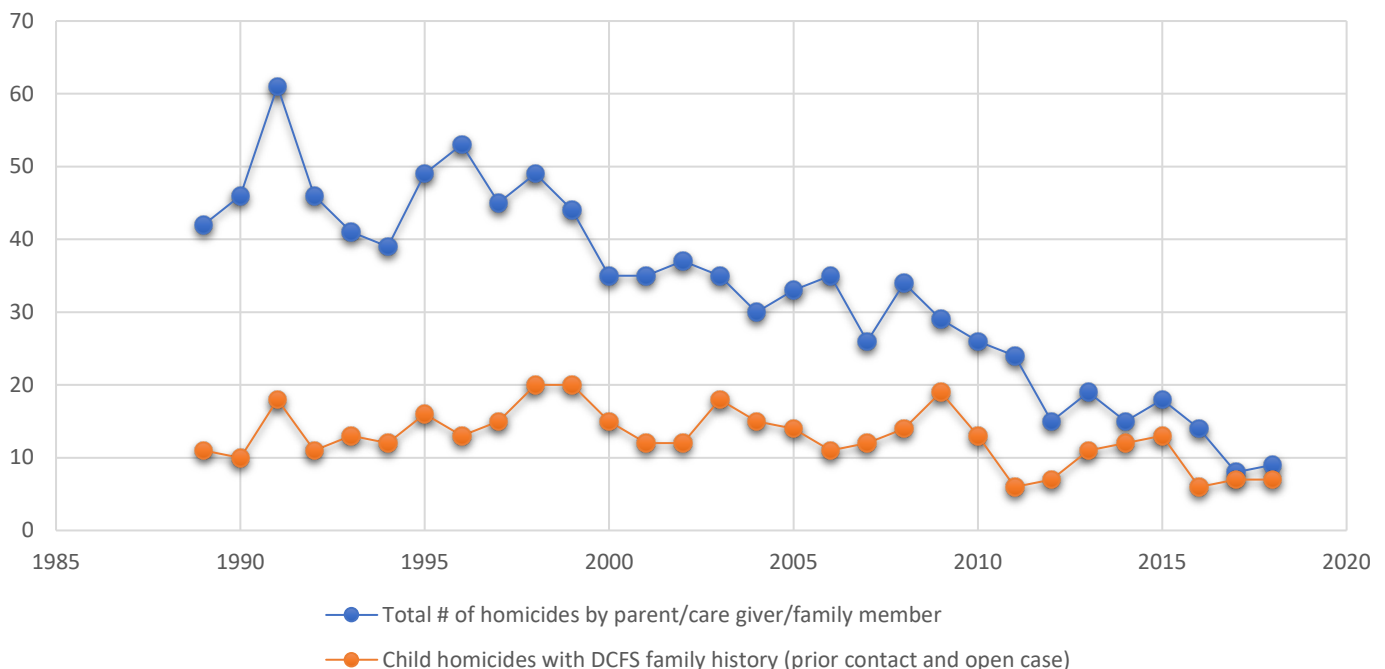
DCFS INVOLVEMENT IN CHILD HOMICIDE CASES

ICAN Child Death Review Team- Special 30 Year Report

ICAN's data show that in the years where more child homicides occurred, there was a lower percentage of case contacts with DCFS. The trend line indicates that as the number of child homicides decreased dramatically between 1989 and 2018, the percentage of families with DCFS history increased. For example, in 1991, with 61 child abuse homicides, 30% (18 families) had prior DCFS contact. In 2018, with 10 caretaker homicides, 80% (8 families) had prior DCFS contact. Although the percentage of families with prior DCFS contact increased, the number of child homicides with prior DCFS contact actually decreased 60%.

It may be that when DCFS is involved, intervention and services provided decrease the likelihood that a death will occur in that family. There were more referrals called into DCFS in 2018 (162,263) than in 1991 (111,799). More recently, it appears that when DCFS receives a referral, there is better trauma-informed involvement by the department, resulting in improved interventions. In addition, DCFS is working more closely with other agencies to provide services and resources, including home visitation, mental health counseling and placement of substance abuse counselors in DCFS offices.

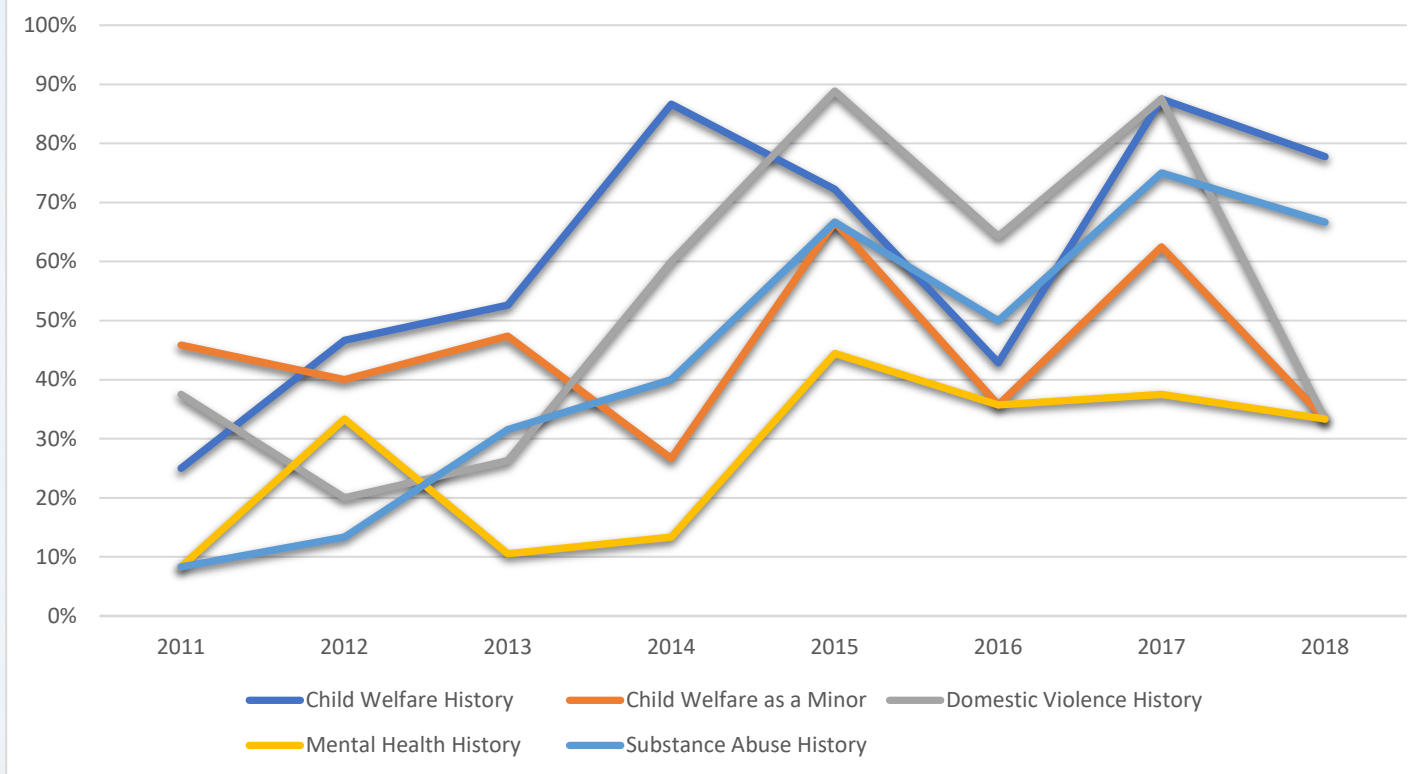
CDRT 1989-2018: Trendlines of Overall Caretaker Child Homicide Cases Vs. Caretaker Child Homicides with DCFS History



In 2011, ICAN began tracking Risk Factors for families where a child homicide occurred. The following graph presents several trend lines (mental health history, substance abuse history, domestic violence history, child welfare history and the parent's child welfare history as a minor) illustrating the percentage of each of these Risk Factors for the child abuse homicides of each year. Please note that Risk Factors are based on documented history. For example, in 2018 there appears to be a decrease in domestic violence as a risk factor in those cases, however, in three of the cases the father killed the child and then killed himself. These three cases had no documented history of domestic violence, but clearly indicate some propensity for violence by the perpetrator.

Contributing to the decrease in child deaths has been multi-agency discussions about Risk Factors. Identifying Risk Factors is an important component of ICAN's multi-agency approach. Child Death Reviews have brought together multi-agency experts in Los Angeles County to work together and identify circumstances that may lead to child homicides. This has resulted in recommendations regarding how the child protection system can be improved. One such system improvement occurred in the 1980's with the Family and Children's Index.

**CDRT REPORT 2011-2018:
Risk Factors Percentage Trendlines Per Year**



FAMILY & CHILDREN'S INDEX (FCI)

ICAN Child Death Review Team- Special 30 Year Report

In the 1980's, the CDRT reviewed a child homicide that illuminated a tragic history in which the year prior to the child's death, there had been multiple contacts with the family by different agencies, including 4 DCFS referrals, yet none of these agencies knew of each other's involvement with the family. At that time, there were prohibitions against the sharing of information and a lack of technology to facilitate this information-sharing.

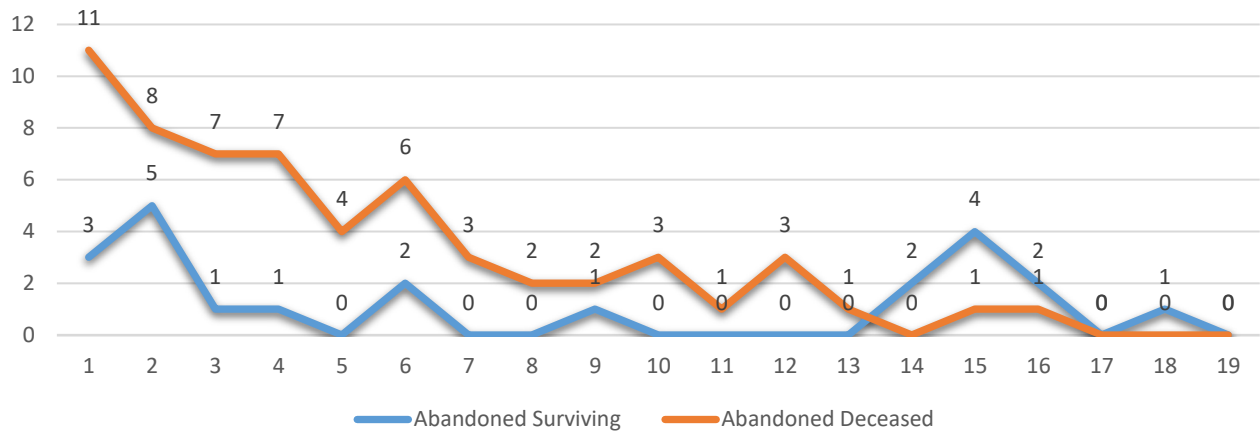
ICAN, with the support of the county, engaged in legislative advocacy in Sacramento, and ultimately, California's first Multi-Disciplinary Team Law (MDT) was enacted in 1991 (WIC 18961.5). The first application designed to make use of this new law, the Family and Children's Index (FCI), was subsequently developed and deployed in LA County by 1995. FCI allows authorized professionals from specified provider agencies to share certain identifying information about children and families with whom they have had contact through the formation of a multi-disciplinary team.

As of 2019, FCI contains historical records of family contact with DCFS, District Attorney, Mental Health, Health Services, Public Health, Public Social Services, Probation, Sheriff, LAPD, and Coroner. Los Angeles County Fire/EMT records were added to FCI beginning in mid-2019.

Another program managed by ICAN and ICAN partners is the Infant **Safe Surrender Program**. The below graph shows comparisons of Safely Surrendered infants with homicides per year.

The data show a correlation between the number of surrendered infants and the number of child homicides. For example, in 2007, 15 babies were safely surrendered, and the number of child abuse homicides decreased from 35 in 2006 to 26 in 2007. In 2015, with 18 babies safely surrendered there were 15 homicides showing another decrease from the year before. In 2017 and 2018, with the lowest numbers of homicide in the 30-year analysis, there were 15 infants safely surrendered both years. Los Angeles County's Infant Safe Surrender Campaign has clearly been effective in saving newborn infants' lives by providing parents the option to surrender their newborns without name, shame, or blame.

Safely Surrendered and Abandoned Infants and Homicides: Los Angeles County 2001–2019 Trend Chart



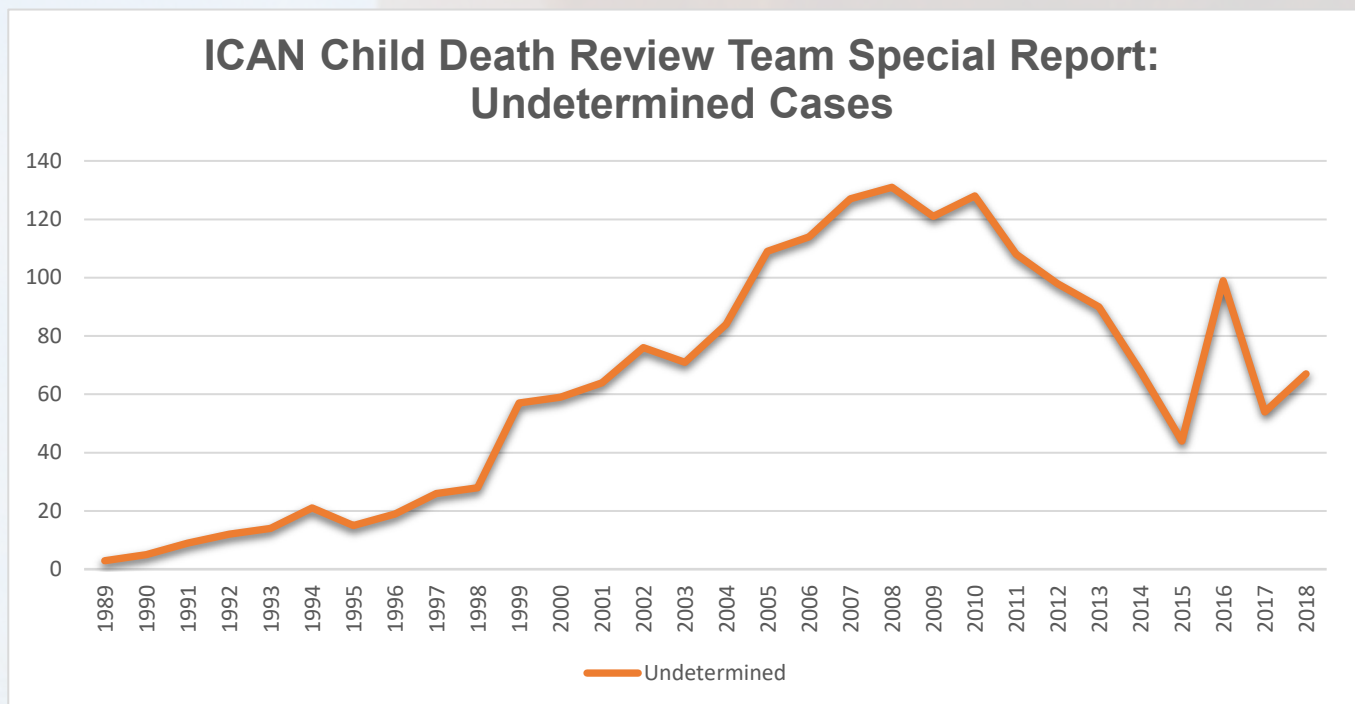
UNDETERMINED CHILD DEATHS AND CHILD & ADOLESCENT SUICIDE CASES

ICAN Child Death Review Team- Special 30 Year Report

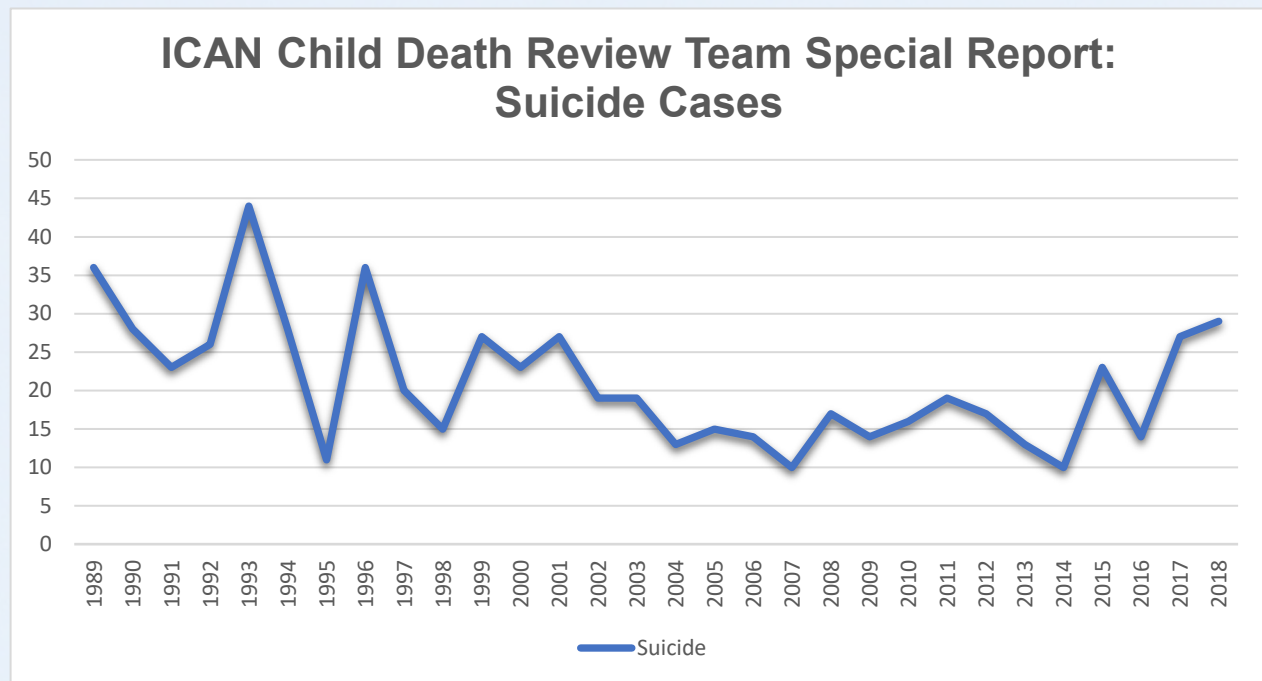
A special review team looks closely at suspicious cases with undetermined modes of death. In an effort to identify common themes, the team also reviews cases where there are high numbers of deaths due to a specific cause, such as maternal substance abuse and unsafe sleep.

Between 2000-2010 the number of undetermined cases increased as the Coroner-Medical Examiner began moding Sudden Unexpected Infant Deaths (SIDS) as Undetermined rather than Natural. From 2010 onward, there is a decline in undetermined cases, including Unsafe Sleep fatalities, that parallels the decline in homicide cases.

In 2015, undetermined cases declined to 44 following the countywide ICAN Unsafe Sleep Campaign, with a one-year spike to 99 cases in 2016.



Another special review team is the Child and Adolescent Suicide Review Team which is a multi-disciplinary sub-group of the ICAN Child Death Review Team. The Team reviews child and adolescent suicides, analyzes trends and makes recommendations aimed at the recognition and prevention of suicide and suicidal behaviors.



The highest number of suicides were in 1993 with 44 suicides and the lowest was 10 in 2007. From 2002 to 2016 the numbers of suicides ranged from 10 to 23. There was a sudden increase to 29 in 2018. The children ranged from ages 9 to 17 years.

Hispanic and Caucasian children were highly represented in the 30-year data. Children of Hispanic descent comprised 40% of the children who died by suicide, followed by Caucasian children (35%). African American children comprised 15% of the population of youth suicides in the past 30 years.

The most significant finding in this 30-year data is the gender gap between children who died by suicide. 446 males died of suicide compared to 171 females. Out of the 617 suicides, 71% were males.

SUMMARY

ICAN Child Death Review Team- Special 30 Year Report

ICAN has tracked nearly seven thousand child deaths in Los Angeles County since 1989. Approximately one thousand of those cases have been the tragic homicides of children by their trusted caretakers. Between 1989 and 2018, the average number of children killed by their caretaker has been 33 per year, but the average has been decreasing each decade. The highest number of child homicides by caretaker was 61 in 1991, and the lowest number was 8, in 2017.

With such a significant decline in the overall number of children killed each year by their caretakers, there is tremendous value in reviewing the information that is known about their short lives.

The data revealed child homicide by caretaker victims died most often because of head trauma, multiple trauma, and gunshot wounds, with these three causes comprising 57% of these deaths. The perpetrators of these fatal injuries are most often fathers, stepfathers, and mother's boyfriends. In the last three decades, male parental figures have been the perpetrators in well over half of all the child abuse homicides in Los Angeles County. This is followed by female parental figures (mothers, stepmothers, and girlfriends) who committed over 35% of the child homicides. Sadly, approximately 90% of all known perpetrators of child abuse homicides are parental figures. The persons most responsible for the well-being of their children most commonly commit this ultimate act of betrayal. The majority of the remaining 10% of child homicides by caretakers are committed by non-parental relatives, followed by non-relative caretakers such as babysitters and daycare workers.

The children most vulnerable to be murdered by their caretakers are children under three years of age, male, and Hispanic or African American. In the last 30 years, 71% of all child homicide victims have been under the age of three with 44% of children not even given a chance to celebrate their first birthday. About 53% of these homicide victims have been male children and 47% have been female. Hispanic and African American children collectively have been the majority (75%) of child homicide victims, on average 48% and 27% respectively. While the overall homicide number has declined significantly, the rates have been relatively consistent throughout the last three decades with only minor fluctuations.

Understanding the dynamics of child homicide has brought to light issues and information necessary to protect the most vulnerable victims. It has allowed professionals of multiple agencies to learn and approach these cases with a more informed and trained mind set. When agencies are working together, they not only learn from each other, but have access to crucial information that can ultimately lead to the safety and well-being of other children.

It is important to remember that homicide victims leave behind siblings and loved ones who survive the trauma of losing their family member. Some children may experience this trauma as a witness to a death that was violent. The Child Death Review Team has focused on the need for each surviving child

8 ICAN has sponsored the annual Children's Traumatic Grief and Loss Conference for 20 years to bring service providers and the community together to increase expertise, and to expand the availability of qualified children's grief and loss counselors.

to receive immediate and skillful grief and trauma counseling.⁸

The 30 year findings of the ICAN Child Death Review Team have opened our minds to the realities of child fatalities, and inspired measures for prevention, intervention and treatment. The recommendations of the Team have included identification of risk factors, the need for expert medical and mental health services, pool drowning safety codes, Co2 safety codes, unsafe sleep prevention, child suicide prevention, cyber-crime prevention, and the pervasive linkage to domestic violence.

This report is intended to expand our historical understanding of the realities of fatal child abuse and inspire further measures to better identify and prevent severe and fatal harm to children.

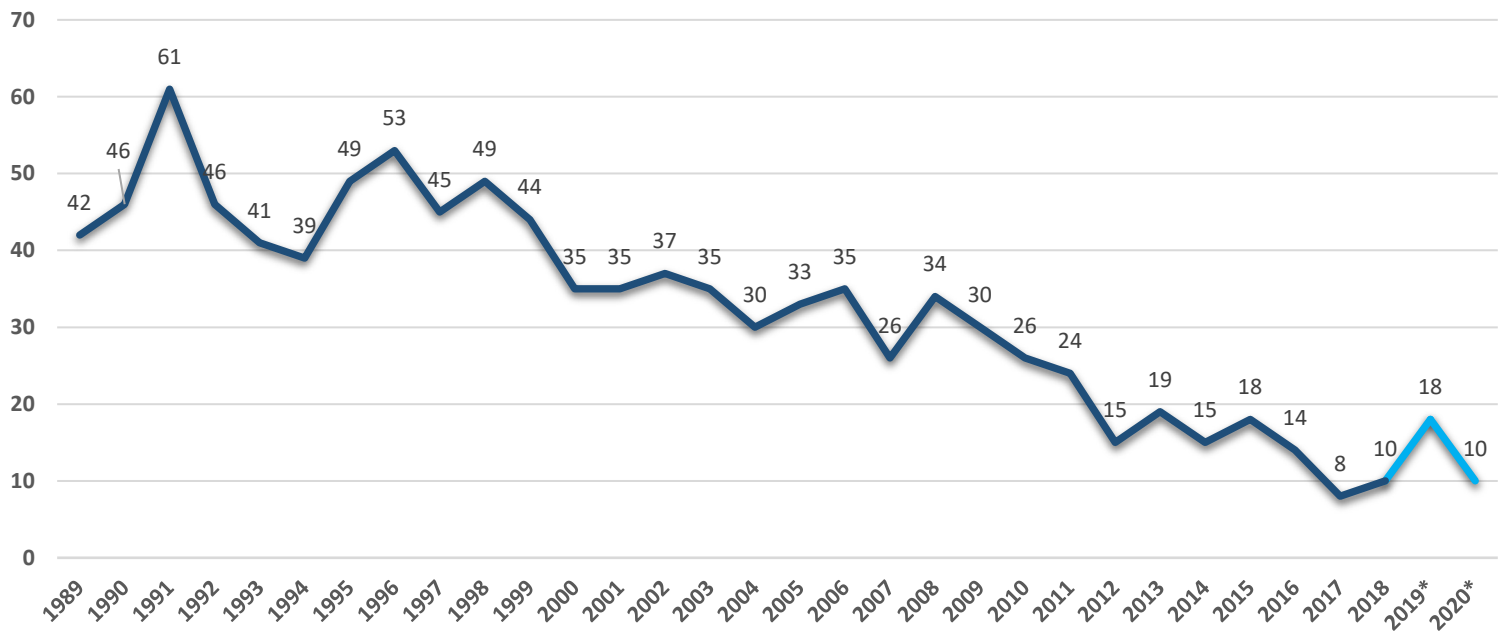
ADDENDUM: CHILD ABUSE HOMICIDES 2019-2020

ICAN Child Death Review Team- Special 30 Year Report

The below graph includes the number of child homicides for 2019 and 2020. This does not include demographics.

Preliminary data for 2019 and 2020 show 18 and 10 child homicides respectively, reflecting a 9-year downward rate of less than 20 per year.

**ICAN CHILD DEATH REVIEW TEAM
SPECIAL REPORT CHILD HOMICIDE BY
CARETAKER IN LOS ANGELES COUNTY
1989-2020**





ICAN

**CHILD DEATH REVIEW TEAM
SPECIAL REPORT**

30 STORIES

The names have been changed but the stories are real.

*"This is for the kids who know that the worst
kind of fear isn't the thing that makes you scream,
but the one that steals your voice and keeps you silent"*
Abby Norman

***...these are the stories of 30 of the 994 children lost to fatal abuse by their parent or caretaker.
In honor of these children, we tell their stories to end the silence.***

Daniel

While out at dinner, two-year old Daniel's mother told Daniel's father that she no longer wanted to be in a romantic relationship with him. The father told the mother that she would be sorry. After dinner, the father returned to the family residence. At approximately 2 A.M., the father left the home with the child. At 8:45 A.M that same morning, a highway patrol officer spotted the father's car on the shoulder of the southbound 710-Freeway. Looking into the car, the officer saw the father slumped over the steering wheel, with a handgun in his lap and a bullet hole through his head. The child was in a car seat in the back of the car, also with a bullet hole through his head. Paramedics responded to the officer's radio call and determined that the father and child were dead.

Baby Boy Garcia

Baby Boy Garcia, a newborn infant, was found in a trash can, tied up in a plastic bag. After giving birth, the mother went to her sister's home and began hemorrhaging while delivering the placenta. 911 was called and she was transported to a hospital. She initially denied giving birth, but after extensive questioning, admitted to placing the infant in the trash can. The baby was found by a Sheriff's investigator prior to the mother's admission. A string ligature was found wrapped around the baby's neck. The mother is a native of El Salvador and was a live-in housekeeper. She quit her job two weeks prior to the baby's birth. She then went to live with her sister, who suspected she was pregnant, but did not think she was so close to term. The mother concealed her pregnancy by wrapping and binding her mid-section. The mother has two other children who reportedly lived with their maternal grandmother in El Salvador and she was saving money to bring them to the United States. It also was reported that the mother was hopeful that the baby's father would help out, but when it was clear that he wouldn't, she panicked and killed the infant. There was no involvement by the DCFS either prior to, or after the death and no record of the mother seeking prenatal care. The District Attorney filed murder charges against the mother. This case highlights some of the difficulties facing women who are alone and pregnant, particularly recent immigrants. They often struggle economically and have no support system.

Sylvia

4-month old Sylvia was brought to Saint Vincent's Hospital by her parents, with an alleged history of falling off a swing. She was transported to Children's Hospital due to the severity of her injuries. Sylvia's injuries included massive head trauma, and other injuries which varied from 7-10 days old to 4 weeks old. Upon notification, DCFS responded to the hospital and detained Sylvia. However, she later died due to complications from her injuries. Sylvia's mother was 16-years old and her father was 20-years old at the time of Sylvia's death. The parents had a history of domestic conflict. The father was known to be possessive, to have a bad temper, and to have restricted the mother's contact with family members and friends. One month prior to her death, Sylvia had been taken to a private hospital by her parents due to concerns about a possible hernia, diarrhea and problems related to an asymmetrical chest. During this visit, both the parents and a nurse observed "a bone sticking out," and the father had inquired about a possible rib fracture. No X-rays were ever ordered.

Upon her death, the Coroner found rib fractures of varying ages, retinal hemorrhages in the left eye, as well as bilateral meningeal hemorrhages. Law enforcement determined that the injuries did not match the parents story that Sylvia fell off a swing. The father eventually admitted to shaking the baby, but other injuries were noted which occurred when the mother was the sole caregiver. Both parents were arrested and charged with P.C. 187, murder, P.C. 273ab, assault on a child under eight resulting in death, and felony child endangerment; the teenage mother was charged as an adult. The prosecution was complicated as it was difficult to assess the relative culpability of each parent in Sylvia's death, given she had several injuries of varying ages, and it was unclear who was with her at the time each of the injuries occurred. Both parents were found to be culpable, based in part on the fact that the parents' apartment was very small, making the actions of one parent known or visible to the other. This case highlights a common risk-factor in child fatality cases, the risk to children in the care of young parents with a history of domestic violence.

Baby Girl Kiley

Baby Girl Kiley, a newborn infant, was found at Los Angeles International Airport in one of the parking structures. A maintenance worker found the infant in a taped-up plastic bag with tape across the baby's mouth and nose. It was determined that the baby was full-term and was hours old. The umbilical cord was still attached and there was no knot or clamp. Law enforcement suspected that the infant was abandoned over a Saturday night/Sunday morning. No fingerprints were found on the tape, and there was no evidence of ritual abuse. The baby's footprints were taken but there was no automated index for matching. The investigator contacted local hospitals about women presenting for bleeding or delivering a placenta, but there were no leads from these contacts. There are 40,000 employees at LAX Airport, and 1500 cars were parked in the garage during that time period. Given the amount of airport traffic, it is possible that the infant could have been brought from anywhere. No suspects were ever arrested.

John

John, age 3, was suffocated to death by his father. The father had a history of drug use and on the day of the child's murder, he reported that he was seeing the devil in a mirror. The father stated the devil told him if he killed John he would be allowed to live forever. After the murder the father fled to northern California and was arrested shortly thereafter. At trial, he pled insanity, stating that he was suffering from a chaotic mental state at the time of the murder. He claimed that he had killed John due to his drug use and underlying mental health issues. Ultimately, he was convicted of first degree murder and sentenced to 25 years to life in prison. The District Attorney was able to show that the father understood his actions were wrong based upon a taped confession and the fact that he fled to Northern California. A review of the family history, showed that the father and mother had divorced 9 years prior to John's death. Mother had been granted custody and the father was granted visits. It was reported that father had been protective and caring towards John, and that he was an overall responsible parent. It also was learned that the father had a history of drug abuse and had been in treatment during the 12 months prior to John's death. The family had no prior history with Child Protective Services.

Sally

11-month old Sally died as result of burns, after a pot of boiling water was spilled on her. The Coroner determined that Sally could have survived had she been given timely medical attention. Sally's parents failed to seek medical attention as they were afraid of DCFS. A year prior to Sally's death, the family had contact with Child Protective Services (CPS) after Sally's 2-year-old sibling was found to have severe burn marks. At that time, CPS did not remove the children, although the social worker informed them that if another such incident occurred, the children would be removed from their care. At the time of Sally's death, her 2-year-old sibling was removed from the parents and placed in foster care. However, a few days later, the Court released the sibling back to the parents when they learned that the parents did not seek medical help for Sally due to fear. Law enforcement determined that the parents did everything to help Sally, short of taking her to the hospital. Based on this information, Sally's mode of death was changed from homicide to an accident.

Bobby

Bobby, age 1-year, lived with his mother and her boyfriend. Reportedly, shortly after the boyfriend came home, he observed Bobby vomiting and milk coming from his nose. He said that he placed Bobby down on the sofa and left him for about 10 minutes while he went to clean up. When he returned from cleaning himself up, he called the mother to let her know about Bobby. She immediately started home and, in the meantime, the boyfriend picked up Bobby and began walking to the hospital. The mother met her boyfriend while in transit to the hospital, and as they were walking, paramedics came and provided assistance. Bobby was transported to the hospital where he was observed to have bruises all over his body and retinal hemorrhages. A CT Scan showed multiple old and new injuries, including fractures. The Scan also showed multiple acute bleeds and subdural hematomas. His injuries were suspected to have been caused by non-accidental trauma. Bobby was in critical condition and was placed on life support. His condition did not improve and he was declared brain dead. An autopsy was performed and the cause of death was multiple injuries and the mode of death was homicide.

Danny and Sean

Mother called 911 and stated that she discovered the bodies of her children, 3-year-old Danny and 7-year-old Sean, after she returned home from a trip to the supermarket. She further stated that the father was found slashed and stabbed to death at the top of the stairs in the family home, near where the children were deceased in their beds. To investigators, the children appeared to be tucked into bed with no apparent trauma. The mother later admitted to suffocating her children with a pillow and stabbing and slashing their father with a sword. She was convicted of three counts of first degree murder and is currently on death row.

James

One-year-old James was found unresponsive by his father and 911 was called. When the Fire Department arrived, they found that James appeared lifeless. He was resuscitated and taken to the hospital. James had swelling of his brain and bruising on his torso and appeared to have been shaken to death. A few years before this incident, his mother and father were under investigation by DCFS for fractures to his older sibling, who was 2-years old at the time. The mother stated the child was injured while roller skating. DCFS referred the case to the hospital SCAN team and they determined that the injuries could not be due to roller skating. The father was arrested and is serving a life sentence. The mother was not charged, however, DCFS pursued permanent placement for James's sister and she was adopted.

Tyler

Tyler, age 6, was taken to the hospital by his father after he reportedly found him unresponsive. The father then left the hospital without providing any of his contact information. He told the hospital that the child's mother would be picking the child up. Tyler was medically examined and found to be suffering from numerous injuries including: a skull fracture; intracranial hypertension; subdural hematoma; retinal hemorrhaging to the right eye; a laceration and bruising to the child's lip; redness and abrasions to the child's chin; multiple open abrasions and healing injuries to the child's back, shoulders, hips, abdomen, and face; wounds and scab marks to the child's face, neck, shoulders, back, legs, and foot; marks and bruising in different stages of healing to the child's abdomen, back, legs, hips, and toes; swollen toes; and pulmonary and cardiac organ systems at risk of failure. The child's father gave inconsistent explanations as to the manner in which the child sustained the injuries. The injuries were determined to be consistent with trauma indicative of ongoing, long-term abuse. The father was arrested for child cruelty: possible injury/death and was awaiting trial as of this writing.

This family had a long history with Child Protective Services (CPS) due to domestic violence, mental health, and substance abuse issues. Tyler had a younger sister, age 4, and they both had been removed from their mother as she had unresolved substance abuse issues, domestic violence incidents with her former boyfriend, and she and the children had been living in deplorable conditions. The children were removed from her care and their father obtained full custody. Tyler's sister told investigators that she had witnessed their father abuse Tyler on multiple occasions, and that she also had suffered abuse by their father. During this time, the children's mother had been in treatment and after Tyler was killed by his father, she was given custody of Tyler's sister. The CPS case was closed after 9-months of Family Maintenance Services with mother.

Baby Girl H and Baby Boy H

Baby Girl-H. and Baby Boy H. were stillborn twins. Their mother reported that she had been assaulted and thrown to the ground. She said that she had immediate discomfort and went to bed. Her water broke 4 hours later and she was subsequently transported by paramedics to the hospital. LAPD reported that they questioned the mother about the delay in her reporting the assault. LAPD indicated that they also had contacted the mother's doctors for medical information and were informed that, up until the assault, the pregnancy had been normal with no problems noted. There was no DCFS involvement with this family. Complications identified for this case included the twins being at a greater risk of spontaneous abortion, the mother failing to notify authorities of her assault for over 24 hours, and a 4 to 5-hour delay in membrane rupture following the assault. The mother did not identify the perpetrator. The ICAN Child Death Review Team considered possible cultural issues concerning the reluctance of the African American community reporting assaults to law enforcement.

Samuel

Samuel, a 13-month old infant, had been born prematurely to a 25-year-old mother and a 38-year-old father. Paramedics responded to a call that Samuel was unconscious. CPR was done and Samuel was transported to the hospital. Medical staff found numerous bruises and reported possible child abuse and foul play to the Sheriff's Department. Samuel died at the hospital. According to Samuel's mother, she was with Samuel's 3-year-old brother when Samuel fell off the couch. Records from the hospital emergency room indicated that Samuel suffered bruises, chipped teeth, an enlarged arm, and facial bruises. The Coroner conducted an autopsy and found that there was blood in the child's abdomen, the liver was split, there were internal bruises at the base of the skull and the brain was swollen. Samuel's teeth were loosened or missing and human bite marks were found on his left arm with possible other bite marks. The death was ruled a homicide. The District Attorney filed charges against the mother, including charges for murder (187 PC) and assault on a child under eight resulting in death (273ab PC).

Mitchell

Mitchell, an 18-month old infant, was taken to the hospital due to breathing problems. The doctor diagnosed the child with pneumonia, and the mother took the child home. That evening, the paramedics were called to the house as the child was unresponsive. The child was pronounced dead and an autopsy was done. The Coroner found the child to have multiple abrasions to his chest and stomach, a lacerated liver, hemorrhage to his thymus and possibly a torn heart. The death was ruled a homicide. After a police investigation, no suspect could be identified. The mother admitted that she had originally taken the child to the hospital because she thought the child may have ingested cocaine at his father's house during a visit. She did not admit that information to the doctor for fear of being killed by the father, as he was a violent drug user. The mother eventually informed law enforcement that she felt her boyfriend caused the injuries when the child was left alone with him. The District Attorney did not file any charges as there was no clear evidence as to who caused the injuries.

Santos

Santos, was a 10-week old infant, whose family was known to Child Protective Services (CPS) for several years due to severe neglect, transiency and the parent's inability to provide regular care for their children. Santos had nine siblings, all of whom had been removed from the parent's custody. The CPS worker involved with the family was unaware of Santos' birth as, although the hospital, AFDC worker, and the church that had been helping the parents were all aware, no one reported it to DCFS. The infant was at high-risk due to his parent's history of mental disability, and homelessness. Despite the parents' disabilities, homelessness, and the mothers' history with the regional center for developmental disabilities, no psychological evaluation or treatment was ever undertaken as part of the CPS or court-involved plan. Santos died from intracranial trauma as a result of shaking. Criminal action was not taken against the parents as investigators were unable to prove which parent caused the fatal injuries to the child.

Gisele

This family was known to Child Protective Services (CPS) due to allegations that the father was molesting 14-year old, Gisele. The case was closed within one month, as Gisele's mother took appropriate steps to protect her children. The mother expelled the father from the home, secured a temporary restraining order, and started divorce proceedings. The mother also attended counseling with Gisele. CPS handles many sexual abuse cases in a similar manner each year. However, in this case, not only was there a history of sexual abuse, the father was a distraught, violent man who subsequently broke into the family's home, shot and killed Gisele and his wife, seriously injured Gisele's 13-year-old sister, and concluded by turning the gun on himself, committing suicide.

Newborn Baby

Law enforcement was called to a local hospital as a woman who had previously given birth was at the hospital, but denied that she had given birth and had no baby with her. The woman, a 19-year-old immigrant from Korea, eventually admitted that she had given birth and had put the baby in a box covered with towels in her room. She further claimed that she had a miscarriage and that she panicked. Law enforcement went to her residence and found the newborn in a trash can beneath some bloody towels. The umbilical cord and placenta were still attached to the infant, who was unresponsive and not breathing. A piece of tissue paper was lodged in the infant's mouth. No signs of external trauma were observed by law enforcement, Fire EMTs or coroner personnel at the scene. Despite efforts to revive the baby, he never regained consciousness and died at the scene. Following autopsy, the Coroner's office ruled the death a homicide. The baby was a healthy, full-term newborn who weighed approximately 6 lbs. The placenta was still attached, and his well-aerated lungs indicated that he had taken at least several breaths after birth, and had likely cried. Reticular hemorrhages were noted, as was a compression bruise on the left side of his neck. The mother, who had been in the United States for seven years, lived at home with her parents. She claimed that she learned of her pregnancy in the seventh month, when it was too late for termination of the pregnancy. She was able to hide the pregnancy from her family. On the day of the birth, she was home with her sister who heard the shower running for a very long time and came into the bathroom where she found the mother sitting on the floor and bleeding, which the mother attributed to a recent car accident. The sister drove the mother to the hospital and she was examined by a doctor, who quickly surmised that she had recently given birth. An observant nurse, not the treating doctor, eventually notified law enforcement of the baby's

birth. The District Attorney's office filed one count of P.C. 187, murder, against the mother. The jury was given the option to find involuntary manslaughter in this case. The defense argued that the baby died of choking on amniotic fluid moments after birth, while the Coroner's report listed the cause of death as perinatal demise due to asphyxia, either by manual compression or manual strangulation. The mother was subsequently convicted of manslaughter and was sentenced to four years in state prison.

Rhonda

27-month-old Rhonda was unresponsive and in a comatose state when she was brought to King/Drew Medical Center by her foster parent. The foster mother reported that Rhonda had fallen in the bathtub the previous day, and had fallen again earlier in the day before being brought to the hospital. When questioned by hospital staff about her delay in seeking treatment for Rhonda, the foster mother admitted that she had hit her with a bath brush on her back, and she feared that when the bruises on her back were observed, Rhonda and the other foster children in her care would be removed. Doctors diagnosed a severe head injury and operated on Rhonda to relieve pressure on her brain, but she died five days later. Rhonda's older sibling was originally placed in protective custody in 1995 due to the mother's long history of alcoholism and associated neglect of the sibling. Rhonda's sibling was subsequently placed in the care of her maternal grandmother. When Rhonda was born less than two years later, she, too, was placed in the care of the grandmother.

The grandmother subsequently obtained legal guardianship of both girls in 1997. Not long after guardianship was ordered, DCFS filed a petition on behalf of the girls, alleging that the grandmother had provided sub-standard care for them, and that her home was found to be filthy, rodent-infested, strewn with animal feces and generally unfit for the children. The girls were placed with another relative, but removed soon thereafter due to the relative's inability to care for the girls. Rhonda's autopsy revealed numerous injuries: she had a 5" by 3" contusion to her scalp; a 1" tear to the galea; a 3" by 1" skull fracture; residual blood in the skull; optic nerve damage; brain stem herniation into the cerebellum; bruises and scars to her forehead, chin, neck, hands and back; and scars on her foot and abdomen. When interviewed by homicide detectives, the foster mother admitted that she had hit Rhonda with a shower brush when she tried to get out of the bathtub. She claimed that Rhonda had fallen twice after making such attempts to get out of the tub, and that she may have hit her head as a result of these falls. The Coroner ruled, however, that the injuries noted must have been inflicted and were not accidental. The foster mother was arrested shortly after Rhonda's death. She was subsequently charged with PC 187, murder, and was later found guilty of the charge of PC 273ab, assault on a child under eight resulting in death. She was sentenced to 25 years to life in state prison for the killing of Rhonda.

Gilda

One afternoon shortly before Christmas, Gilda, age 13, her sisters, ages 14 and 16, and their mother went out shopping. When they returned home, they found their father waiting outside. The mother and father were recently separated. The father notified the mother that his car had broken down and asked her if she would give him a ride back to the car. She agreed, and the family got into their minivan and drove towards the father's car. The mother, who had been driving, was killed instantly. Gilda, who had been seated behind her mother, also was shot. She died at the scene of multiple gunshot wounds to the right ear, left neck and left chest. Both her 14 and 16-year-old sisters were injured and taken to the hospital by paramedics in critical condition. The 14-year-old had been shot in the mouth and the 16-year-old was pistol-whipped. Following the assault, their father fled on foot and jumped or fell off a nearby freeway overpass where he died of massive trauma. Investigation into the case indicated that the family had a history of domestic violence. Both law enforcement and DCFS found no record of prior contact with the family. The mother's friends and co-workers indicated that there had been physical violence between the parents.

Kurt

Kurt, age 10-months, was brought to the hospital by ambulance after his teenage mother called 911 indicating that her child "wasn't doing well." At the hospital, Kurt was found to have various injuries including a severe brain injury and was placed on life support. He died the following day.

At autopsy, Kurt was found to have numerous injuries, including three bruises near his right temple as well as a bruise to the left side of his face and left eyelid. He had numerous retinal hemorrhages, a hemorrhage to the muscle near the neck bone, and a fracture of the left radius, approximately three to five weeks old. Kurt's injuries were consistent with shaken impact and the cause of his death was multiple traumatic injuries. The mother eventually confessed that she had been trying to get Kurt to go to sleep at approximately 9:00 pm but that he wouldn't sleep. She became very frustrated and struck Kurt in the forehead with all her strength. She said that Kurt was fine after she hit him and that it wasn't until the next day that he started "acting mental." She denied ever shaking Kurt or previously hurting him in any way.

Approximately two-weeks before his death, the mother had taken Kurt to the same hospital emergency room for a fractured arm. At that time, she reported to hospital staff that she was encouraging Kurt to walk and that he had fallen with his arm extended. The attending physician indicated that while he could not specify that the injury did not occur the way the mother described, he also could not rule out abuse. A skeletal survey of the child was done to check for additional injuries and was negative. Nonetheless, the physician called the Child Protection Hotline and reported his suspicions. Unfortunately, a hospital hold was not placed on the child and Kurt and his mother left the hospital after his arm was cast and before a social worker arrived at the hospital. DCFS made various attempts to reach mother, however, mother evaded the department until Kurt's death. The District Attorney indicated that while it was a difficult decision to try the mother as an adult, she was living an emancipated lifestyle at the time of Kurt's death. Prosecutors also took into consideration the extent of Kurt's injuries and the fact that they were not the result of a one-time assault but rather multiple incidents of abuse. Mother pled guilty to willful harm or injury to a child with special allegations that the injury resulted in death. She was sentenced to 6 years in state prison.

Jonathan

Four-year old Jonathan was admitted to the hospital with a subdural hematoma, cerebral bleeding and multiple bruising over his body. Jonathan's mother told hospital staff that Jonathan had run into the house while riding his new bicycle. Doctor's believed that Jonathan's injuries were more consistent with child abuse than with the mother's story and they notified police. Jonathan remained in the hospital until his death two days later. The mother, who is Asian, immigrated to the United States with Jonathan's father, an American in the military who she met while he was performing service in her country. Eventually, Jonathan and his grandmother joined his mother and father in America. Upon his arrival, Jonathan began to be brutalized by the father. It was reported that upon the day that Jonathan died, the father had taken him to a baseball game where an usher observed Jonathan's bruises and asked Jonathan if he was okay. However, Jonathan spoke no English and the father intervened and made excuses for Jonathan's injuries.

When law enforcement interviewed family members, several different accounts of the injuries were related. During the interview with the father, he eventually admitted to physically abusing Jonathan over the last week. In one incident, he admitted to punching Jonathan in the mouth with his fist and knocking out several teeth. On the day that Jonathan was admitted to the hospital, the father told the mother that he had been taking a shower with Jonathan when the child slipped and fell striking his head. During his interview with the police, the father admitted to becoming irritated with Jonathan because he was crying. He struck Jonathan in the chest with his fist, started choking him with both hands, and picked him up off the floor by the neck. He then grasped Jonathan's arms, shook him violently, and threw him against the wall, then picked him up again and threw him to the floor. Jonathan's head made a loud thud when it hit the floor and Jonathan began to posture and shake as if he were about to have a seizure. At this point, paramedics were called. The autopsy revealed that Jonathan had multiple injuries, including external bruises on the face, chest, abdomen, back, buttocks, arms and legs, rib fractures, internal abdominal injuries, subdural hemorrhages and retinal hemorrhages. The injuries were in various stages of healing and were not consistent with having all occurred at the same time. DCFS had three prior referrals for this family. The father was charged with the murder of Jonathan.

Anthony

14-month-old Anthony was not breathing when brought to the hospital by his mother. Upon examination, doctors noted that Anthony had numerous bruises to his face, toenails, legs, penis and an injury to his anus. Mother reported that Anthony had been sleeping in her room and when she went to change his diaper she found that he was not breathing. Upon further investigation, it was learned that Anthony's father had been residing in the home, despite Dependency Court orders that he not be allowed in the home. It was learned that the father was with Anthony when Anthony was found not breathing and he stated that he had rolled over onto Anthony. However, it was determined that the father had beaten Anthony to death. Anthony's autopsy revealed multiple external bruises. There were purple lesions of varying ages that were consistent with bite marks. Anthony's upper frenulum was torn and he had a subgaleal hemorrhage. Anthony had numerous rib fractures, including evidence of prior healing rib fractures. As a result of the numerous rib fractures, Anthony showed signs of an evolving bronchopneumonia, which caused his death. In addition to the rib fractures, there was acute trauma to the penis and possible anal and buttock trauma. When Anthony's six-year-old brother was interviewed after Anthony's death, he stated that the father was upset because Anthony had peed in his bed. Anthony was forced to wear underwear because the father believed Anthony was too old to be in diapers. The crime scene indicated that Anthony had been severely beaten in the bathroom.

Anthony's family had numerous referrals and an open case with DCFS prior to Anthony's birth. In 2000, the father had sexually and physically abused Anthony's 4-year old sister. Reportedly, the father had beaten Anthony's sister because she had pooped in her pants and he then assaulted the mother when she tried to intervene. As a result of this incident, father pled guilty to willful infliction of corporal injury and was sentenced to one-year in County jail. He was released after serving six months of his one-year sentence. Prior to this incident, three referrals were made to DCFS for physical abuse, sexual abuse, general neglect and emotional abuse due to domestic violence. These allegations were either unfounded or inconclusive and the referrals closed.

Criminal charges were filed against both mother and father for Anthony's death as mother had failed to protect Anthony by allowing father back into the home. Father was charged with murder, assault on a child under eight resulting in death, and willful harm or injury to a child.

Cecilia

Law enforcement responded to a call from the fire department requesting assistance with “a child not responding.” When the fire department arrived, three-year old Cecilia was in the arms of her mother’s boyfriend. The boyfriend told the responding officers that Cecilia had fallen over. She was observed to have bruises in various stages of healing over most of her body and a hardened stomach. Cecilia’s mother also was on the scene. She smelled of alcohol and appeared intoxicated. The mother indicated that three-year old Cecilia had fallen off a swing set and showed the officers the swing set and the trailer where she, Cecilia, and her boyfriend lived. The officers found it strange that Cecilia’s mother was showing them all the niceties of the trailer, while her daughter was gravely injured and being transported to the hospital by paramedics. At the hospital, the mother’s relatives arrived and began reporting that the mother was a “terrible mother” and that they were not surprised that Cecilia was injured in her care. They reported that the mother’s five other children all resided in the care of others. Shortly after Cecilia was brought to the hospital; she was pronounced dead.

The hospital physician documented multiple bruises to Cecilia’s face, torso and extremities that were in various stages of healing. The autopsy revealed that Cecilia had multiple bruises all over her body. There was over a liter of blood in her abdomen and her stomach was ruptured. There also was a transaction of the pancreas, multiple liver hemorrhages, mesenteric scarring, and a torn frenulum. She suffered multiple rib fractures, one acute and others of older ages. Almost all of her ribs had been repetitively broken. Both the mother and her boyfriend were arrested on suspicion of murder and the District Attorney filed charges against both of them. The mother pled no contest to voluntary manslaughter and was sentenced to eleven years in prison. The mother’s boyfriend pled guilty to a charge for assault on a child under eight resulting in death, and was sentenced to 25 years to life.

Simon

Twenty-two-month old Simon had been residing with his mother under the supervision of DCFS when his mother notified law enforcement that Simon had been abducted. Simon’s mother told authorities that his father had picked him up to go shopping for clothes and never returned. An Amber Alert was issued and law enforcement was instructed to be on the lookout for a Plymouth van with an out-of-state license plate. Sheriff deputies spotted a parked van meeting the Amber Alert description. After questioning the driver, the deputies found a black duffel bag stuffed in the rear storage area of the van. A large object contained in several plastic bags was observed in the duffel bag. Deputies cut through the bags and found extremities of a small person believed to be the missing child, Simon. The duffel bag and body were removed from the van and transported to a criminalist for examination. The decedent was unclothed and his hands and ankles were bound by packaging tape. The decedent was later confirmed to be 22-month old Simon.

The family had a long history of referrals to DCFS and there was an open case since 1993. There also was a Dependency Court order that the father not be allowed in the home without a third-party monitor. It was learned that prior to Simon’s abduction, Simon was reportedly acting up and the father beat him, tied him to his car seat and made him eat disinfectant and/or Clorox. The father then wrapped Simon in a tight ski coat, placed a large stuffed monkey on top of him and tied him tightly to his car seat. As a result, Simon suffocated to death. The father discovered that Simon was not breathing and tried to dispose of his body by placing it in boiling water in a large tamale pot on the stove. The father then took

the body and wrapped it up in trash bags and placed it in a duffel bag. Law enforcement's investigation revealed that neighbors had heard screams in the middle of the night and that one woman told her boyfriend that they should call law enforcement but the boyfriend said that they should not get involved.

Simon's mother allowed Simon's father to stay in the home with the children despite Juvenile Court orders to the contrary. Simon's mother continued to lie to protect the father and tried to aid him in destroying Simon's body. The duffel bag was found approximately five days after Simon's death. Simon's autopsy revealed evidence of obstruction of Simon's airway, the upper frenulum was lacerated, there were numerous contusions and abrasions of the forehead, chest, thigh, upper back and buttocks and a chipped tooth. In addition, there were petechiae in the lungs and evidence of postmortem charred thermal effects on the skin. Death was due to asphyxia and coded a homicide. Criminal charges were filed against both Simon's mother and father. After working with the medical examiner and law enforcement, the District Attorney's Office added the crimes of torture and special circumstances to the charges against the parents.

Carmen

Five-month old Carmen resided with her mother, father, and 17-month old brother. Her mother worked two jobs while her father stayed at home with the two children. On the day Carmen died, her mother arrived home from work, changed the brother's diaper, fixed some food and got into bed with Carmen. She realized Carmen was cold and stiff, and screamed for the children's father. She called 911 and started CPR, and the father fled the apartment. Paramedics arrived and transported Carmen to the hospital where she was pronounced dead. Carmen's mother reported that she had planned to take Carmen to the doctor as she'd heard a rattling in her chest. When told of Carmen's injuries, her mother stated that 2 - 3 weeks ago she had noticed that the baby's head was sunken in, she was no longer sucking on her bottle and was acting "like a newborn." She stated that she did not know how to obtain medical care for Carmen, although she had given birth to Carmen at a nearby hospital. She initially described the children's father as non-violent with the baby, but admitted that he was violent against her and had backhanded Carmen's brother on occasion. After the autopsy, the Coroner notified law enforcement that Carmen was found to have three skull fractures and five healing rib fractures. When law enforcement returned to the home to conduct their investigation, it was learned that the father had fled with Carmen's baby brother. With mother's assistance, law enforcement located the father and interviewed him at which time he confessed to shaking Carmen, squeezing her abdomen, and he demonstrated these actions on videotape, but not with the force required to inflict the fatal injuries. When the father was asked how he was dealing with Carmen's death, he responded that he was fine, but that he would not be if it had been his son who had died. Carmen's mother eventually disclosed a long history of domestic violence perpetrated against her by the children's father. She stated that although he beat her, she didn't think he'd "beat up on his own blood" and that the abuse against Carmen must have happened while she was at work. She stated that she lied to co-workers about her injuries to hide the domestic violence and that when she once attempted to leave the father, he nearly choked her to death.

Jesse

Jesse, age 22-months, died from injuries that were inflicted three days earlier. The mother's boyfriend cared for the child while she worked. He called the mother at work to report the child was having difficulty breathing. The boyfriend refused multiple requests by the mother to call 911. The mother returned home and the boyfriend, a reputed gang member, left because he claimed he wanted nothing to do with the police. The child was ultimately transported to the hospital where it was discovered that he suffered a subdural hematoma, laceration of the liver, bruising throughout the lower half of the body, retinal hemorrhages indicative of shaken baby, and hemorrhage of the pancreas consistent with a forceful punch to the area. The child died after three days on a ventilator. The boyfriend had no prior DCFS history. He initially claimed Jesse was perfectly fine until he developed breathing problems. After deputies confronted him, he changed his story and stated the child had been sick a couple of days. The boyfriend was charged with murder and assault on a child under eight resulting in death.

Sylvia

Two-year-old Sylvia had a developmental delay and she allegedly suffered two falls over two days. Reportedly, she had a history of falling. On the first day that Sylvia allegedly fell, she struck her head and vomited. On the second day, the father claimed she fell and struck her head in the bathtub and became unresponsive, prompting him to call 911. The child was taken to a local hospital and then transferred to another hospital with a pediatric intensive care unit. Her condition failed to improve and she died. Her injuries included a lacerated liver, three acute rib fractures, healing rib fractures, and an advanced stage of pneumonia that may have been due to the broken ribs. The cause of death was blunt force trauma to the torso. The coroner believed that Sylvia must have been struck hard two to three times in order for the lacerated liver to occur. Criminal charges were filed against both the mother and the father on the theory that at least one of them inflicted the injuries and that the other was culpable for failing to protect the child from such crippling injuries. The charges filed included murder and assault on a child under eight resulting in death. DCFS records revealed twelve previous referrals. The mother had given birth to ten other children in addition to Sylvia. One older brother and a newborn still resided with the mother at the time of Sylvia's death, but the other siblings were in permanent placement.

Jessica

Jessica, age 1 ½ years, resided with her mother and father. Jessica's godmother was at the home for a visit. Jessica's father had been living in the home for only the past month. Both parents were twenty-one years of age. On the day of her death, the father was babysitting Jessica while the mother was at work. He suddenly left the home without warning and when Jessica's godmother went to check on her, she was unresponsive. The Medical Examiner ruled the death to be a homicide caused by asphyxia. It was determined that the injury was due to suffocation with body compression while underwater in a bathtub. There was no DCFS history with this family, however, the father had a history with DCFS as a minor. The father was arrested and charged with murder and assault on a child under eight resulting in death. He denies any wrong doing and has refused to cooperate with law enforcement. At the time this story was written, he remained incarcerated and was awaiting trial.

Jeff

Seven-month old Jeff resided with his 22-year-old mother, 25-year-old father, and two-year-old sister. On the day of his death, the father was babysitting Jeff and his sister while the mother was at work. 911 was called when Jeff stopped breathing. Paramedics transported him to the hospital where a CT scan revealed two bilateral skull fractures, subdural hemorrhages and retinal hemorrhages. Jeff died a day later. The father gave conflicting stories for the injuries. He said he was holding the baby and his sister when he dropped Jeff from a standing position. He also said the baby was in a car seat, fell out of it, and hit his head.

When confronted, the father later disclosed he became frustrated with Jeff's crying and he shook Jeff, threw him on the floor and hit his head on the floor multiple times. He also admitted to having shaken Jeff on three prior occasions. The Coroner ruled the death a homicide as a result of blunt head trauma.

There was no DCFS history with this family. The father was arrested on charges of murder and assault on a child under eight resulting in death. At the time of this writing, he remained incarcerated and was awaiting trial.

David

Three and a half-year old David reportedly fell off a bunk bed five days before his death. On the night before and morning of his death, he complained of stomach pain and was vomiting. His mother and her boyfriend brought him to the hospital, as his condition did not improve. In route, David went into cardiac arrest and could not be revived. He passed shortly after his arrival to the ER.

There were eight prior child abuse referrals for this family in Los Angeles and in another county for emotional abuse, neglect and substance abuse. David's mother had a history of alcohol and crystal meth abuse. The children were removed from the mother in the past due to her substance abuse. At the time of his removal, David was found to be suffering from failure to thrive, anemia, and had previously been diagnosed with fetal alcohol syndrome. David and mother's other children were ultimately returned to her care two years later. The case was open at the time of death.

At autopsy, David was found to have two healing rib fractures that were several weeks of age. It was determined that he died as a result of a single blow to the abdomen, which perforated the small intestine. He developed an infection which caused his death. The injury would likely have occurred one to three days prior to his death. The explanation that he hit his head five days earlier from a fall off a bunk bed did not match the injury.

Law enforcement was not aware of the mother's extensive history with DCFS and her history of substance abuse. David's siblings reported that the stepfather had hit David in the stomach on several occasions. Both the mother and step-father are suspects as David was in their care. The investigation remained open at the time of this writing.

Anthony

Anthony, age 2-months, went into cardiac arrest and was transported to the hospital where he died. He had suffered multiple subdural hemorrhages and bilateral retinal hemorrhages. Bruising was noted on his back and face. Anthony's injuries were consistent with inflicted trauma and shaken baby syndrome. At first his mother stated she found him blue while he was napping. After questioning from the coroner investigator and detective, the mother admitted to hitting and shaking Anthony on several occasions, including on the day of his death. Anthony had a history of poor feeding and was hospitalized two-weeks prior to his death for "gastric reflux."

Anthony's 18-year-old mother and one-year-old sister went back and forth between the father's and great-maternal grandmother's homes to live. The mother reported being frustrated with Anthony's crying and fussiness, and his not responding to her interventions. The mother had a history with DCFS as a minor and had an open case for herself at the time of Anthony's death. At the time this story was written, she was being prosecuted on charges of murder and assault on a child under eight resulting in death.

Matthew

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

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

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

Thomas

Case investigation revealed that 2-year old Thomas was beaten to death, though paramedics at the scene and ER personnel did not see any bruising when Thomas was first examined. Reportedly, his mother was not home at the time and the children were in the care of her boyfriend. The boyfriend has denied any abuse toward Thomas. In interviews, Thomas's 4-year-old sister stated that the boyfriend bumped her brother in the bathroom and bedroom. In one interview she said that something happened with Thomas and her mother told her to go to her room. Although the boyfriend is the prime suspect, the timeline does not exclude the possibility that the mother could have been the abuser and/or present at the time of the fatal injury.

Thomas had been hospitalized a week earlier due to food poisoning, which the family blamed on a relative who also lived in the home. Additionally, Thomas was seen two-weeks prior at another hospital for vomiting. At that time, he was diagnosed with pancreatitis; team child abuse pediatricians indicated that his ongoing vomiting was a red flag for abuse.

At autopsy, bruising was observed that had not been evident at his admission to the ER. The autopsy showed that Thomas was brutalized and had internal injuries to his head, neck, spine, abdomen, and that he bled out from a lacerated artery. The final mode of death was ruled a homicide. At the time this case was reviewed by the team, it was still under investigation by law enforcement.

Carlos

Carlos, age one-year, was transported to the hospital after reportedly vomiting and becoming lethargic. He was found to have internal injuries to the spleen, liver, pancreas, bowel and healing and acute rib fractures. His abdomen was full of blood and he died three weeks later after four surgeries.

Three weeks prior to his fatal injuries, he was taken to an ER for vomiting and trouble breathing. Bruising was present on his chest. An x-ray was taken among other tests and while in the ER, his condition improved; he stopped vomiting, and was breathing better. He was diagnosed with a virus. No rib fractures were reported by the radiologist and the mother stated the child fell asleep on his toys as an explanation for the bruising on the chest. A couple of days later, the boyfriend brought the child into the kitchen where the mother was and said the child's eyes rolled back and he became stiff. She noticed his upper teeth to be bloody. She did not take him to an ER as he improved and she thought the incident was due to a seizure. She took him to her pediatrician the next day who advised that the child should have been taken to the ER. He too, did not make a report for the bruises on the chest.

Eventually, the mother's boyfriend admitted to punching the child with a closed fist 4-5 times. He was arrested and charged with murder. He was found guilty and sentenced to 50 years in prison.

This case demonstrates the difficulty of ferreting out abuse vs. illness. ER staff may be more inclined to see illness rather than non-accidental trauma. In this case, the radiologist did not make a report about the rib fractures as he may have been more focused on looking for other findings to explain Carlos' difficulty breathing.

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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.