SENATE COMMITTEE ON PUBLIC SAFETY

Senator Nancy Skinner, Chair
2017 - 2018 Regular

Bill No:	AB 1098	**Hearing Date:**	July 11, 2017
Author:	McCarty		
Version:	May 26, 2017		
Urgency:	No	**Fiscal:**	Yes
Consultant:	SJ		

Subject: ***Child Death Investigations: Review Teams***

HISTORY

Source: Author

Prior Legislation: AB 2083 (Chu) Ch. 297, Stats. of 2016
AB 1737 (McCarty) 2016 failed Assembly Appropriations
SB 39 (Migden) Ch. 468, Stats. of 2007
SB 1668 (Bowen) Ch. 813, Stats. of 2006
SB 525 (Polanco) Ch. 1012, Stats. of 1999
AB 4585 (Polanco) Ch. 1580, Stats of 1988

Support: Children Now

Opposition: None known

Assembly Floor Vote: 77 - 0

PURPOSE

The purpose of this bill is to require the State Department of Public Health (DPH) to develop a protocol to be used as a guideline by persons investigating child abuse and neglect, and to require a child death review team to collect specified information.

Existing law allows, but does not require, counties to establish interagency child death review teams to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. (Pen. Code, § 11174.32, subd. (a).)

Existing law states that interagency child death teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and non-offending family members receive the appropriate services in cases where a child has expired. (Pen. Code, § 11174.32, subd. (a).)

Existing law provides that each county may develop a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect, in the determination of whether child abuse or neglect contributed to death or whether child abuse or neglect had occurred prior to but

was not the actual cause of death, and in the proper written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death. (Pen. Code, § 11174.32, subd. (b).)

Existing law provides that in developing an interagency child death review team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including, but not limited to, the following:

a) Experts in the field of forensic pathology;
b) Pediatricians with expertise in child abuse;
c) Coroners and medical examiners;
d) Criminologists;
e) District attorneys;
f) Child protective services staff;
g) Law enforcement personnel;
h) Representatives of local agencies which are involved with child abuse or neglect reporting;
i) County health department staff who deals with children's health issues; and
j) Local professional associations of persons described above. (Pen. Code, § 11174.32, subd. (c).)

Existing law provides that records exempt from disclosure to third parties pursuant to state or federal law shall remain exempt from disclosure when they are in the possession of a child death review team. (Pen. Code, § 11174.32, subd. (d).)

Existing law requires that no less than once each year, each child death review team make available to the public findings, conclusions and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths. In its report, the team is required to withhold the last name of the child that is the subject to a review or the name of the deceased child's siblings, except as specified. (Pen. Code, § 11174.32, subd. (f)(1)&(2).)

This bill requires the DPH to develop a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect, in the determination of whether child abuse or neglect contributed to death or whether child abuse or neglect had occurred prior to but was not the actual cause of death.

This bill provides that DPH may consult with the Counties of Los Angeles and Sacramento in developing the protocol.

This bill requires the DPH provide access to the protocol, free of charge, to any county that requests a copy.

This bill requires the protocol to include data collection, confidentiality, and reporting provisions.

This bill requires a child death review team to implement a data collection process that includes, but is not limited to, all of the following information about a deceased child:

a) Race;
b) Gender;
c) Cause of death; and,
d) Age.

This bill requires no less than once every three years, each child death review team make available to the public findings, conclusions and recommendations of the team, including, but not limited to, aggregate statistical data on the incidences and causes of child deaths and recommendations to prevent future deaths.

COMMENTS

1. Need for This Bill

According to the author:

> The child death review teams in California began as informal gatherings of concerned parents and professionals that wanted to take proper steps in order to review child deaths and learn from them in order to save other children's lives.
>
> In 1988, California legislation was enacted to establish child death review teams in order to investigate suspicious child deaths and facilitate communication among the various entities that could provide useful information for the annual report.
>
> The Centers for Disease Control and Prevention, recorded over 23,000 infant deaths in the United States for 2014. In California, the Department of Social Services (CDSS) reported that 88 child fatalities resulted from abuse and/or neglect for 2014, but a complete summary of child death reports had not been finalized at the time the data was collected. Despite efforts to produce an annual child death report, there are only an estimated 22 active child death review teams throughout the state, leaving many counties without a reporting mechanism. We believe that one reason for the lack of participation of some counties is that many do not have the proper tools or guidance to establish their own child death review team. It is the intent of this legislation to create uniformity among counties by requiring the Department of Public Health to develop a protocol for counties to follow. With adequate guidelines for counties to establish and collect data, the information collected from all counties will be comparable throughout the state.

2. Background

Child death review teams bring together agencies in a formal process to systematically share information on child death events and to identify risk factors in those deaths. At the county level, these teams produce educational materials so that the more common causes of child death can be prevented. In Sacramento County for example, the Sacramento County Child Death Review Team reviews the deaths of every child that dies and subsequently uses the report's findings in order to create various public awareness campaigns. The recommendations have translated to the Shaken Baby Syndrome Prevention Campaign, the Infant Safe Sleep Campaign, and the Drowning Prevention Campaign to reduce preventable deaths.

The statewide child death review council is responsible for collecting data and information from the counties and turning it into reports to the public and Legislature. Part of the statutory scheme that created child death review teams included creation of the Child Death Review Council "to coordinate and integrate state and local efforts to address fatal child abuse or neglect, and to create a body of information to prevent child deaths." (Pen. Code, § 11174.34, subd. (a)(1).) The Child Death Review Council is required to "[a]nalyze and interpret state and local data on child death in an annual report to be submitted to local child death review teams with copies to the Governor and the Legislature, no later than July 1 each year." (Pen. Code, § 11174.34, subd. (d)(1).) Copies of the report are required to be distributed to California public officials who deal with child abuse issues and to those agencies responsible for child death investigation in each county. The report must contain, but is not limited to, information provided by state agencies and the county child death review teams for the preceding year. These reports are public documents. Requiring each local child death review team to also make public its own data is consistent with the overall objectives of the teams (i.e., creating a body of information on the causes of child deaths to help prevent such tragedies). Increased transparency may also enhance the public's trust in local child death review.

This bill requires the DPH to develop a protocol to be used as a guideline by persons investigating child abuse and neglect that the counties have access to and to provide free access to the protocol to any county that requests a copy. This bill also requires a child death review team to collect data, including specified demographic information and the cause of death. Both the development of a protocol at the state level that would be used as a guideline by the counties in child abuse and neglect cases and the requirement that child death review teams gather specified information will create greater uniformity in the type of information that is collected across the state.

3. Prior Legislation

AB 1737 (McCarty), of the 2015-2016 Legislative Session, would have required counties to establish interagency child death review teams to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. It failed in the Assembly Appropriations Committee.

4. Argument in Support

Children Now writes:

> Children Now is pleased to support AB 1098 which would require each county to establish an interagency child death review team.
>
> Child death review teams can help counties determine whether child abuse or neglect contributed to a child's death and work collaboratively to develop family services and supports to keep children safe and strengthen systems working with children and families. Improved data collection will help prevent future child deaths by developing best practices and recommendations for keeping children safe.

-- END --