SENATE COMMITTEE ON PUBLIC SAFETY

Senator Steven Bradford, Chair
2021 - 2022 Regular

Bill No:	AB 2660	**Hearing Date:**	June 21, 2022
Author:	Maienschein		
Version:	April 18, 2022		
Urgency:	No	**Fiscal:**	Yes
Consultant:	MK		

Subject: ***Child death investigations: review teams***

HISTORY

Source: Children's Advocacy Institute at the University of San Diego School of Law

Prior Legislation: AB 2083 (Chu), Chapter 297, Statutes of 2016
AB 1668 (Bowen), Chapter 813, Statutes of 2006
SB 525 (Polanco), Chapter 1012, Statutes of 1999
AB 4585 (Polanco), Chapter 1580, Statutes of 1988

Support: Children Now

Opposition: None known

Assembly Floor Vote: 74 - 0

PURPOSE

The purpose of this bill is to mandate the establishment of child death review teams in every county.

Existing law allows each county to establish an interagency child death review team 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. (Penal Code § 11174.32 (a).)

Existing law allows each county to develop an autopsy protocol that may be used as a guideline 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 reporting procedures for child abuse or neglect, including the designation of the cause and mode of death. (Penal Code § 11174.32 (b).)

Existing law permits the following information to be disclosed to a child death review team:

a) Medical information, unless disclosure is prohibited by federal law;
b) Mental health information;
c) Information from child abuse reports and investigations, except the identity of the person making the report, which shall not be disclosed;

d) State summary criminal history information, criminal offender record information, and local summary criminal history information, as specified;
e) Information pertaining to reports by health practitioners of persons suffering from physical injuries inflicted by means of a firearm or of persons suffering physical injury where the injury is a result of assaultive or abusive conduct; and,
f) Records of in-home supportive services, unless disclosure is prohibited by federal law. (Penal Code § 11174.32 (e)(2).)

Existing law clarifies that an individual or agency that has information governed by these provisions is not required to disclose information; the intent is to allow the voluntary disclosure of information by the individual or agency that has the information. (Penal Code § 11174.32 (e)(1).)

Existing law maintains the confidentiality of written or oral information disclosed to a child death review team and states that it shall not be subject to disclosure or discovery by a third party, unless otherwise required by law. (Penal Code § 11174.32 (e)(3).)

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

Existing law requires each child death review team to make publicly available, at least once a year, findings, conclusions, and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths, as specified. (Penal Code § 11174.32 (f).)

Existing law requires, subject to available funding, the Attorney General to develop a protocol for the development and implementation of interagency child death teams for use by counties. The protocol shall be designed to facilitate communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases so 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 died. (Penal Code § 11174.33.)

Existing law creates the California State Child Death Review Council to oversee the statewide coordination and integration of state and local efforts to address fatal child abuse or neglect and to create a body of information to prevent child deaths, but makes its implementation contingent on funds being appropriated for its purposes in the Budget Act. (Penal Code § 11174.34 (b)(1) & (d)(6).)

Existing law requires the Department of Social Services (DSS) to work with state and local child death review teams and child protective services agencies in order to identify child death cases that were, or should have been, reported to or by county child protective services agencies. (Penal Code § 11174.35.)

This bill requires every county to establish an interagency child death review team no later than January 1, 2025, to assist local agencies in identifying and reviewing suspicious child deaths.

This bill requires every county to develop or adopt an autopsy protocol no later than January 1, 2025, that can be used as a guideline by persons performing autopsies on children.

This bill sets a due date of July 1 for an annual report by the county child death review team, and requires the report to be posted on the child death review team's website.

This bill requires the Attorney General to post its "Child Death Review Protocol" on the Department of Justice website and requires that this protocol be updated every four years no later than January 1.

This bill requires the Attorney General to submit to the Governor and the Legislature an annual budget that is sufficient to fund the State Child Death Review Council and the county child death review teams.

This bill makes legislative findings and declarations.

COMMENTS

1. Need for This Bill

According to the author:

> California is failing to track, and therefore prevent, child deaths. By law, every California county is required to report all child abuse and neglect deaths, or near-deaths, to the Department of Social Services. However there are serious concerns about the validity and reliability of that data.
>
> Lack of clear accountability between three state agencies; state funding that ended in 2008; and a lack of state and local priority in tracking child deaths leads to outdated and scattershot child death information. There is no consistency in how counties report information, if they even report at all. Websites claiming to host child death reporting data are extremely outdated or route to broken links. Some counties do not have dedicated child death review teams.
>
> Counties
> Penal Code sections 11174.32-11174.35 establish the current statewide child death review system. Penal Code section 11174.32 authorizes but does not mandate counties to establish child death review teams. We currently do not have an accurate count of how many counties have established such teams. The last count was less than half.
>
> The State
> Penal Code section 11174.33 provides: "Subject to available funding, the Attorney General, working with the California Consortium of Child Abuse Councils, shall develop a protocol for the development and implementation of interagency child death teams for use by counties, which shall include relevant procedures for both urban and rural counties[.]"
>
> Penal Code section 11174.34 establishes the statewide Child Death Review Council but it is nearly impossible to determine from the convoluted statute which agency is responsible for which tasks.

What is apparent is that no one agency is clearly responsible for obtaining and publishing an accurate statewide count of child deaths.

- Penal Code section 11174.34(b)(2) authorizes only the Department of Justice to carry out the purposes of section 11174.34 by "coordinating" all of the Council members.
- The same statute also requires the Department of Public Health (DPH) to "design, test and implement a statewide child abuse or neglect fatality tracking system incorporating information collected by local child death review teams".
- Another portion of the penal code states "The State Department of Social Services shall work with state and local child death review teams and child protective services agencies in order to identify child death cases that were, or should have been, reported" because they were caused by abuse or neglect..

The Child Death Review Council was disbanded in 2008 when funds were cut.

In addition to confusing statutory authority, there are also funding considerations that lead to incomplete and inaccurate data. As authorized by Penal Code 11174.34 DPH, in its Center for Healthy Communities, the Injury and Violence Prevention Branch (IVPB) developed and continues to use standardized Fatal Child Abuse and Neglect Surveillance (FCANS) first authorized in July, 2000, to obtain death reports from the counties. However, even if county death review teams exist they do not have any continual state funding for this purpose and are reimbursed for their FCANS reports on a fee-for-case basis ($150/case) by DPH, without any apparent specific budget authorization.

California has not produced an annual state report for several years due to budget cuts and a lack of a State Council. DPH's current website devoted to disclosing child death reports shows the most recent public report is from 2015. Notwithstanding estimates of about 22 California's counties having child death review teams, DSS's website lists reports from just seven.

Please see Children's Advocacy Institute support letter for additional information and examples of website links that are broken or incomplete

2. Child Death Review Team

Child Death Review (CDR) is a process that works to understand child deaths in order to prevent harm to other children. It is a collaborative process that brings people together at a state or local level, from multiple disciplines, to share and discuss comprehensive information on the circumstances leading to the death of a child and the response to that death. These reviews can lead to action to prevent other deaths locally, at a state level and nationally." (*Child Abuse and Neglect Fatalities*, National Conference of State Legislatures (NCSL) <https://www.ncsl.org/research/human-services/child-fatality-legislation.aspx>.)

Local Child Death Review Teams have been functioning since the early 1980s, with Los Angeles County starting in 1978. Some California counties maintain child death review teams, however while they are formally authorized in statute, they are not mandated. (Penal Code §11174.32.)

This bill would require each county to establish a child death review team.

This bill would also require the Attorney General to submit an annual budget request to the Governor and the Legislature that is sufficient to fund the both the county child death review teams and the State Child Death Review Council. While authorized in statute, currently in California there is not an operative state entity on child death reviews. The mandate to the Attorney General's Office for a state team is contingent upon funds being available. (Pen. Code, § 11174.34 (e)(6).) The State Child Death Review Council was disbanded in 2008 when state funds were cut. AB 2654 (Lackey), which was held in Assembly Appropriations would have reconvened the council regardless of funding.

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