Date of Hearing: April 6, 2016

ASSEMBLY COMMITTEE ON LOCAL GOVERNMENT
Susan Talamantes Eggman, Chair
AB 1737 (McCarty) – As Introduced February 1, 2016

SUBJECT: Child death investigations: review teams.

SUMMARY: Requires 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.

EXISTING LAW:

1) 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.

2) States that interagency child death review teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired.

3) Allows each county 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, and in the proper written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death.

4) Allows, 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, to 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 in a) through i), above.

5) 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.

6) Requires, no less than once each year, each child death review team to make available to the public findings, conclusions, and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths, and requires, in its report, that the team withhold the last name of the child that is subject to a review or the name of the deceased child's siblings, unless the name has been publicly disclosed or is required to be disclosed by state law, federal law, or court order.

7) States that it is the duty of 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.

FISCAL EFFECT: This bill is keyed fiscal.

COMMENTS:

1) **Bill Summary.** Current law allows, but does not require, each county to establish an interagency child death review team, and requires that child review death team to compile a report containing findings, conclusions, and recommendations, including aggregate statistical data on the incidences and causes of child deaths.

   This bill would *require* each county to establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths, and require that county to develop an autopsy protocol. Because the bill mandates that each county create a team, the corresponding report by the child death review team would also be mandatory.

   This bill is author-sponsored.

2) **Author's Statement.** According to the author, "Child review death teams in California began as informal gatherings of concerned parents and professionals [who] 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.

   "AB 1737 aims to increase accountability and transparency and as a community improve protection services for children. The purpose of producing an annual child death report is to provide vital information should children be dying of similar reasons in one county compared to another. With no data of common occurrences, county officials do not have accurate information to link these occurrences and therefore prevent future deaths. This bill requires

all counties to produce an annual child death review report in order to identify how and why children die, to further facilitate the creation and implementation of strategies to prevent future deaths."

3) **Background.** The primary purpose of child death review teams is to prevent future child deaths. At the county level, these teams produce educational materials so that the more common causes of child death can be prevented. For example, according to the author, in Sacramento "The Sacramento County Child Death Review Team, which reviews the deaths of every child that dies in Sacramento County, has used the report's findings in order to create public awareness campaigns. The recommendations have translated to the S*haken Baby Syndrome Prevention Campaign*, the *Infant Safe Sleep Campaign*, and the *Drowning Prevention Campaign* to reduce preventable deaths." However, each county's experience is different. This is where statewide child death review can help prevent counties from duplicating efforts.

   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." (Penal Code Section 11174.34(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. Copies of the report shall also 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 shall contain, but not be limited to, information provided by state agencies and the county child death review teams for the preceding year." (Penal Code Section 11174.34(d)(1).) Therefore, a report analyzing the data collected by each local child death review team is currently a public document. Requiring each local child death review team to also make public its own data appears to be 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.

4) **State Mandate.** This bill contains language that says that if the Commission on State Mandates determines that the bill contains costs mandated by the state, then reimbursement to local agencies for those costs shall be made, as specified.

5) **Arguments in Support.** Sierra Health Foundation, in support, argues that "requiring each county to have an active child death review team will create uniformity across the state; with accurate data this information could be used to create public awareness campaigns and reduce the number of child deaths much like our efforts here in Sacramento County."

6) **Arguments in Opposition.** None on file.

7) **Double-Referral.** This bill was heard by the Public Safety Committee on March 15, 2016, and passed on consent.

REGISTERED SUPPORT / OPPOSITION:

Support

American Academy of Pediatrics, California
Legal Advocates for Children & Youth
National Association of Social Workers, California Chapter
Sierra Health Foundation: Center for Health Program Management
The Child Abuse Prevention Center

Opposition

None on file

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