County of Orange
California

Thomas G. Mauk
County Executive Officer

August 8, 2006

Jon Michael Penn
FY 05/06 Grand Jury
Superior Court of California
700 Civic Center Drive West
Santa Ana, CA 92702

Subject: Response to Orange County Grand Jury Report, "When Will Be Free of Preventable Childhood Deaths?"

Dear Mr. Penn:

Per your request, and in accordance with Penal Code 993, enclosed please find the County of Orange response to the subject report as approved by the Board of Supervisors. If you have any questions, please contact Theresa Stanberry at (714) 834-3727 in the County Executive Office who will either assist you or direct you to the appropriate individual.

Very truly yours,

Thomas G. Mauk
County Executive Officer

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2005-2006 Grand Jury Report
When Will We Be Free Of Preventable Childhood Deaths?
Response to Findings and Recommendations

Response to Findings 6.1 – 6.6

6.1 **Child death review (CDR) timeliness:** The county practice is to hold CDRs on all in-custody and related deaths. The Probation Department procedure is to hold a Post Incident Medical and Operational Review within 10 days of the death. The Social Service Agency (SSA) procedure is to hold semi-annual CDRs. The Orange County Child Death Review Team (OCCDRT) procedure is to hold quarterly CDRs.

Probation Response: Agrees with finding.

SSA Response: Disagrees wholly with the finding

SSA's current procedure is to conduct quarterly Child Fatality Reviews (CFR) in the months of March, June, September, and December with designated representatives from the Juvenile Justice Commission. SSA initially proposed conducting semi-annual CFRs due to the low number of dependent child deaths; however, this was never implemented.

6.2 **CDR oversight:** The county practice generally does not provide for public oversight of CDRs. As required by a court order, however, the Juvenile Justice Commission (JJC) participates in SSA CDRs. The Probation Department procedure does not permit public oversight. The OCCDRT does not provide oversight of any county CDR and does not permit Grand Jury oversight of its activities.

Response: Agrees with finding.

6.3 **CDR membership**: The Probation Department includes no representation from the District Attorney (DA), HCA, or child welfare organizations. Other than the JJC, SSA includes no other representation. The OCCDRT includes no representatives from the Orangewood Children's Home and very limited community child welfare organization representation. The OCCDRT maintains no approved agency list.

Probation Response: Disagrees wholly with finding.

As referenced in the Grand Jury Report, Probation Procedure 3-1-106 – *Deaths, Suicide Attempts and Other Serious Incidents Related to Minors in Custody* (re-certified October 22, 2004) clearly notes in Section III – *Notification Process*, Subsection D – In the case of the death of a minor in custody, the Chief Probation Officer or her designee will notify the following agencies:

1. The Sheriff-Coroner will be notified immediately by telephone and with a written report to follow within eight hours.

a. Law mandates that the Coroner will be immediately notified. (Note: The Coroner Division of the Sheriff-Coroner Department should be contacted directly. Contacting the Sheriff's Watch Commander is not proper notification to the Coroner.)

b. The Coroner will respond immediately to the scene of the death of a minor in custody.

2. The local Chief of Police (if the institution is within the city limits of an incorporated city) within a reasonable time but not to exceed two hours.

3. The District Attorney as soon as a member of the District's Attorney's Office is on duty and in writing within 24 hours.

4. The Presiding Judge of the Juvenile Court by telephone, with follow-up in writing within 24 hours.

5. The Chairman of the Juvenile Justice Commission by telephone, with follow-up in writing within 24 hours.

6. The Departmental Safety Officer by telephone, with follow-up in writing within 24 hours.

7. The County Risk Management Manager by telephone, with follow-up in writing within 24 hours.

8. Clerk of the Board of Supervisors in writing within 24 hours (or Chairman of the Board of Supervisors immediately, if "exceptional circumstances" exist).

9. The County Executive Officer in writing within 24 hours.

Further, Section IV of Procedure 3-1-106 – *Post Incident Medical and Operational Review*, Subsection C notes: "A medical and operational review will occur within 10 days following an in-custody death of a minor. The review team shall include the Chief Probation Officer, Chief Deputy of Institutional Services, the Institutional Director of the involved institution, and other administrative and supervisory staff relevant to the incident including but not limited to the responsible physician (HCA), the nursing supervisor (HCA), legal counsel, the coroner staff involved, etc."

In summation, any death of a minor in custody in an Orange County Probation Department Institution will be immediately investigated by Probation Department Peace Officers with the assistance of a variety of county experts, with findings sent to ten different county and state agencies. Any or all of the contributing investigative agencies noted in Procedure 3-1-106, Section III, Subsection D, may be invited to the post incident medical and operational review.

SSA Response: Agrees with finding.

Response Recommendations 7.1 – 7.3

7.1 **CDR timeliness:** Orange County agencies that conduct CDRs should consider holding them within a defined, reasonable time after each death, rather than on a periodic basis.

Probation Response: The recommendation has been implemented.

See Procedure Item 3-1-106, Section IV, Subsection C.

The California Government Code Section 12525 and Probation Department Procedure Item 3-1-106 require: "A report in writing be submitted to the California Attorney General within ten days after a death in custody, all facts in the possession of the law enforcement agency in charge of the correctional facility concerning the death will be forwarded to the Attorney General's office".

In summation, the Orange County Probation Department reviews any death in custody immediately and findings regarding their investigation are submitted to a variety of county agencies and the California Attorney General's office within ten days.

SSA Response: The recommendation will not be implemented because it is not reasonable.

SSA currently conducts quarterly Child Fatality Reviews. Conducting the reviews on a quarterly basis allows SSA to gather pertinent records and conduct a thorough review.

7.2 **CDR oversight**: Probation should broaden representation in its review by including the JJC. The OCCDRT should include representation of the Grand Jury. Written results of Probation and SSA reviews should be submitted to the OCCDRT for final disposition, for follow-up action if appropriate, and to support any preventative measures.

Response: The recommendation has been implemented.

Orange County Probation Department Procedure 3-1-106, Section III – *Notification Process*, Subsection D, number 5: "The Chairman of the Juvenile Justice Commission will be notified by telephone immediately with follow-up in writing within 24 hours of any death in custody".

In summation, members of the Juvenile Justice Commission will be invited to participate in the post incident medical and operational review required by Department procedure.

SSA Response: The recommendation will not be implemented because it is not reasonable.

SSA is not authorized to disclose child fatality information beyond the JJC. SSA does not have the authority to share information beyond Juvenile Court Miscellaneous Order 528.6, which is driven by law. Where necessary, SSA has the ability to work with the Raise Foundation, which is Orange County's official Child Abuse Prevention Council, or other community and county agencies on educating the community such as public service announcements.

7.2 **CDR membership:** The Probation Department should broaden representation in its review by adding the HCA, DA, and one or more community child welfare organizations. The SSA should broaden representation in its reviews by adding the Coroner Division, HCA, and DA. The OCCDRT should memorialize in its member manual approved agencies and consider additionally community child welfare organizations.

Probation Response: The recommendation has been implemented.

See Procedure Item 3-1-106, Section IV, Subsection C.

Also note, Government Code Section 12525 (Written Notice of Death to Attorney General) declares this report and information therein contained will be considered public record within the meaning of Subdivision (d) of Section 6252 of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1), and are open to public inspection pursuant to Sections 6253, 6256, and 6257. Further, this code section notes that Section 6258 of the Public Records Act reports that "Nothing in this section shall permit the disclosure of confidential medical information that may be submitted to the Attorney General's office, nor would it allow case file information from the deceased minor, ward of a County Juvenile Court to be disclosed".

In summation, a variety of officials from several public agencies within Orange County will be invited to attend the post incident medical and operational review. However, members of the public shall not be invited to this review as prescribed by exceptions in the California Public Records Act noted above.

SSA Response: The recommendation will not be implemented because it is not reasonable.

Juvenile Court Miscellaneous Order 528.6 authorizes the JJC to participate on CFRs and collaboratively review any dependent child fatality. Juvenile Court Miscellaneous Order 528.6 does not authorize SSA to disclose CFR information beyond the JJC. In addition, SSA is limited in regards to disclosure by Welfare and Institutions Code (WIC) 10850. All child deaths, including those reviewed by the CFR, are reviewed by OCCDRT.