SHERIFF-CORONER DEPARTMENT
COUNTY OF ORANGE
CALIFORNIA

MICHAEL S. CARONA
SHERIFF-CORONER

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August 2, 2006

The Honorable Judge Nancy Wieben Stock
Presiding Judge
700 Civic Center Drive West
Santa Ana, CA 92702

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

Dear Judge Wieben Stock:

Pursuant to California Penal Code §933 and § 933.05, I am submitting to you my response to the Grand Jury Findings and Recommendations contained in their subject report.

The Sheriff's Department appreciates the effort and the detail of review performed by the Grand Jury. Their continued efforts to improve the lives and conditions in the County of Orange are an outstanding example of volunteerism to the county and its residents.

Attached are specific responses to the findings and recommendations as well as letters of support from the California State Coroner's Association and from Susan Melanson, Chair for the Southern California Regional Child Death Review Team. If you have any questions regarding this report, please contact Assistant Sheriff Steve Bishop at (714) 647-1804.

Respectfully Submitted,

Michael S. Carona
Sheriff – Coroner

CALIFORNIA STATE CORONER'S ASSOCIATION

PRESIDENT

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July 31, 2006

Jacque Berndt
Chief Deputy Coroner
1071 W. Santa Ana Blvd.
Santa Ana, CA 92703

Dear Chief Deputy Berndt:

As you know, the California State Coroners' Association (CSCA) represents all of the 58 County Coroner, Sheriff-Coroner and Medical Examiner Agencies in California, and as such we are keenly interested in any issues that impact our members. Having read the 2005-2006 Orange County Grand Jury's report titled "When Will We Be Free of Preventable Childhood Deaths" we are greatly concerned with the specific Grand Jury recommendation that there should be Grand Jury representation on the OCCDRT. We believe implementation of this recommendation could have a far-reaching negative impact on all Child Death Review Teams throughout the state.

The CSCA was involved in the development of the original 1986 legislation authorizing counties to establish Child Death Review Teams. This legislation made it possible for agencies involved in the detection and investigation of child abuse to communicate openly with agencies responsible for child health, welfare and protection. The CSCA continues to be involved and has a representative on the State Child Death Review Council. Additionally, there is Coroner or Medical Examiner representation on all CDR teams within California. Whether in the capacity of the chair person, co-chair or simply a team member, the Coroner/Medical Examiner's participation is critical for the accurate review of circumstances surrounding a child's death. A great deal of the information provided by the Coroner/Medical Examiner is highly confidential in nature and public disclosure is prohibited by statue. Many Coroner/Medical Examiner Agencies have policies in place further prohibiting the release of this highly confidential information as well. It is the Teams' unique ability to share this otherwise confidential information between multidisciplinary personnel that allows all CDR teams to achieve success in their goals to advance the detection of child abuse and neglect, improve the multi-agency response and prevent future child fatalities. Because the Grand Jury's function is to investigate County government and file a report that becomes a public document, the presence of the Grand Jury at OCCDRT meetings would interfere with the candid exchange of this confidential information.

CALIFORNIA STATE CORONER'S ASSOCIATION

PRESIDENT

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The CSCA does not believe Grand Jury participation in any CDRT is beneficial; rather their attendance has the potential to halt the wonderful progress toward child abuse detection, investigation and prevention accomplished by these teams since 1986.

The CSCA is in full support of Sheriff-Coroner Michael Carona and the OCCDRT's position that the Grand Jury's representation on the OCCDRT would negatively impact the team's effectiveness. The candid sharing of confidential information must take place in order for any CDRT to perform its function. We are committed to the success of all California Child Death Review Teams and the Coroner/Medical Examiner personnel who work so hard to help these teams achieve their goals.

Sincerely,

Cathy Valceschini

Cathy Valceschini, President
California State Coroner's Association

CHILDREN'S NETWORK

COUNTY OF SAN BERNARDINO

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(909) 387-8966 • Fax (909) 387-4656

KENT PAXTON
Network Officer

July 19, 2006

Jacque Berndt
Chief Deputy Coroner
1071 W. Santa Ana Blvd.
Santa Ana, CA 92703

Dear Ms. Berndt:

Children's Network is the Interagency Council of San Bernardino County, and was the model for the state legislation in 1986, which mandates Interagency Councils, be created in all 58 counties.

As the Chairman of the Southern Regional Child Death Review Team, member of the State Child Death Review Council and the lead staff for the San Bernardino County for the Child Abuse Prevention Council, as well as the co-chair of the San Bernardino County Child Death Review Team, I strongly support your position regarding the Orange County Grand Jury Report.

County Counsel for San Bernardino County has consistently advised against allow any outside participation in these extremely confidential and highly sensitive meetings. Discussions during these meetings are intended to identify issues, which could negatively impact other children within the family, or in the community, and to provide protective factors to ensure all children's safety.

Further, because the Grand Jury, by mandate, is an investigational body, and they are compelled to base questions from that perspective, their attendance in these meetings would change the entire focus and members of the team may be unable to attend based on County Risk Management policies.

Additionally, the Superior Court issued the Standing Order by which San Bernardino County bases its sharing of confidential information, and all Grand Juries are appointed by the Superior Court; we wonder why the Grand Jury has issues with this process when the court does not.

This issue is one that the State CDR Council has discussed at some length, and I recommend that you ask the Council to weigh in on this report and your response.

I hope this letter is helpful to you as you respond to the GJ report. Thank you for the opportunity to share my perspective based on my experience and interaction with other teams.

Sincerely,

Susan G. Melanson

Susan Melanson

Response to Grand Jury Report 2005-2006
"When Will We Be Free of Preventable Childhood Deaths?"
August 2006

Michael S. Carona
Sheriff – Coroner

ORANGE COUNTY SHERIFF'S DEPARTMENT

When Will We be Free of Preventable Childhood Deaths

FINDINGS
In accordance with California Penal Code §933 and §933.05, responses are required to all findings. The 2005-2006 Orange County Grand Jury arrived at the following seven findings. Beneath each is the Sheriff's Department response to those findings.

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 a death. The Social Services Agency (SSA) procedure is to hold semi-annual CDRs. The Orange County Child Death Review Team (OCCDRT) procedure is to hold quarterly CDRs.*

The Sheriff-Coroner will not respond to the findings addressing the Probation Department and the Social Services Agency.
The Sheriff-Coroner agrees with this finding as it relates to the Orange County Child Death Review Team (OCCDRT) procedure to hold quarterly CDRs.

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.*

The Sheriff-Coroner will not respond to the findings addressing the Probation Department and the Social Services Agency.
The Sheriff-Coroner agrees with the finding that the OCCDRT does not provide oversight of any county child death review other than that conducted by the OCCDRT. The Sheriff-Coroner also agrees with the finding that the OCCDRT does not permit Grand Jury oversight of the OCCDRT.

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 OCH and very limited community child welfare organization representation. The OCCDRT maintains no approved agency list.*

The Sheriff-Coroner will not respond to the findings addressing the Probation Department and the Social Services Agency.
The Sheriff-Coroner agrees with the finding that the OCCDRT has no representatives from the OCH. The OCCDRT has limited community child welfare organization representation and maintains no approved agency list.

6.4 ***OCCDRT practices:*** *During 2005, the OCCDRT only spent an average of 2½ minutes per child death.*

The Sheriff-Coroner disagrees with this finding. Many cases are reviewed by the OCCDRT for months, sometimes for longer than a year. There is no set period of time for review of a case. Rather the length of the review period is as long as is needed to thoroughly address the issues raised by the facts of each individual case.

6.5 *OCCDRT process:* *The OCCDRT is not in compliance with its own member manual, which indicates responsibilities for publication of annual reports and development of preventive efforts. The OCCDRT does not create meeting minutes.*

The Sheriff-Coroner disagrees with this finding to the extent it states that the OCCDRT is not in compliance with its own member manual. The member manual was not implemented until April 2005. Since then, OCCDRT has worked actively to accomplish the member manual's stated goal of publishing an annual report. The first annual report is scheduled for release in the fourth quarter of 2006 and will cover the data collected during the 2005 year.

Regarding the development of preventative efforts, the OCCDRT has been very active in providing training related to child deaths and mandated reporting to law enforcement and the medical community. Promoting increased awareness of reporting responsibilities, recognition of child abuse indicators, and understanding of the various services available all result in an improved system response, which leads to prevention. Additionally, as a result of interagency sharing of information through the OCCDRT, several agencies have modified or implemented new procedures to strengthen intra-agency response and to better apply their internal resources where needed.

The Sheriff-Coroner agrees that the OCCDRT does not create meeting minutes.

6.6 *OCCDRT training:* *No internal training is provided to incoming members of the OCCDRT. There is only limited utilization of state training per Penal Code § 11174.32 based on the availability of state stipends.*

The Sheriff-Coroner disagrees with this finding. Team members are multi-disciplinary personnel as defined in Section 18951(d) of the Welfare and Institutions Code. In accordance with that Code section, all OCCDRT members already "are trained in the prevention, identification and treatment of child abuse and neglect cases and ... are qualified to provide a broad range of services related to child abuse." In addition to the fact that all team members already possess the essential expertise and knowledge needed to be on the team, they are also provided a member manual which defines the team's purpose and objectives, explains the processes used for case review and describes their role and responsibility as team members. Accordingly, the limited public resources available for the prevention of child deaths are much better expended on actual prevention efforts than on duplicative training of OCCDRT members who already are experts in the field. Formal instruction about how to be a team member is unnecessary and would be a misuse of limited resources.

Penal Code § 11174.32 does not address training or stipends; however PC §11174.34 mentions training. Members of the OCCDRT attend the State-sponsored training based on the members' availability. In May 2006, the Orange County Sheriff-Coroner hosted the State- sponsored training, which was heavily attended by the OCCDRT members.

6.7 *OCCDRT resources:* *Other than possibly using state income from FCANS reports, the OCSD does not provide funding for OCCDRT activities.*

The Orange County Sheriff-Coroner disagrees with this finding. The OCCDRT is a multi-agency group comprised of at least eleven different county agencies/groups working collaboratively to support the objectives and purpose of the team. The Orange County Sheriff-Coroner Department is the single largest contributor of resources to the OCCDRT, although each other participating agency and/or group contributes some of its personnel and resources. The Chief Deputy Coroner acts as Chairperson of the OCCDRT. At least three other Coroner Division staff members spend many hours preparing for and participating in the quarterly meetings. The computerized data

storage is handled by OCSD Systems Division personnel. In March of 2005, the Sheriff-Coroner hired a new Research Analyst in the Coroner Division for the purpose of collecting and analyzing more specific data and developing the annual report for the OCCDRT. OCSD provides the facility for the quarterly CDRT meetings, all subcommittee meetings and hosted the recent May training attended by over 50 professionals. Finally, all miscellaneous resources used by OCCDRT, such as paper, notebooks, vehicles to deliver confidential pre-meeting packets, computers and other equipment, come from the Sheriff-Coroner budget.

RECOMMENDATIONS

In accordance with California Penal Code §933 and §933.05, responses are required to all recommendations. The 2005-2006 Orange County Grand Jury arrived at the following seven recommendations. Beneath each is the Sheriff's Department response to those recommendations.

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. (See Finding 6.1)*

The recommendation that the OCCDRT hold a child death review in a reasonable timeframe after each death rather than on a periodic basis has been implemented since the inception of the OCCDRT. Quarterly reviews are within a "reasonable" timeframe, given the function of the OCCDRT. Much consideration has been given to this matter throughout the years by the OCCDRT. The OCCDRT members believe the current timeframe for the meetings provides a "reasonable" timeframe for review, and strongly support maintaining the quarterly meetings as the most productive and effective method for this team for the following reasons:

1. The OCCDRT is careful to ensure that it does not conduct a review before enough information is available to enable the OCCDRT to reach valid conclusions supported by fact rather than supposition. At the time the OCCDRT meets to discuss the case, each agency has had the chance to perform most or all of its respective responsibilities, including interacting with the family, delivering services and gathering pertinent information. Thus, the information reviewed by the OCCDRT is accurate rather than speculative, making the OCCDRT's recommendations more credible and sound.

2. The OCCDRT is not intended to be an investigative body or oversight committee that directs an investigation or directs a specific agency's response. Rather, the OCCDRT's purpose is to 1) learn from each case about how the provision of services and the investigation was accomplished, what worked well, and what could have been improved, and 2) to recommend improvements in the provision of services and/or investigations that will help members of the team to become more effective or efficient in future cases. If system gaps or inefficiencies are identified during OCCDRT's retrospective review, then recommendations for improvements will be made and follow up action will be taken for future cases.

3. Accurate and timely interagency communication is a long-standing practice among Orange County agencies. When a child death occurs, no meeting is required in order for critical information exchange to take place. The OCCDRT has been meeting since 1987. Improved communication and coordination between agencies was targeted by the early team. This early work of the OCCDRT has borne fruit so that today, agencies systematically contact each other to gain and share information throughout the normal course of their investigations and delivery of services.

7.2 *CDR oversight:* *Probation should broaden representation in its reviews 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. (See Finding 6.2)*

The Sheriff-Coroner will not respond to the recommendation addressed to the Probation Department.

The recommendation to include representation of the Grand Jury on the OCCDRT will not be implemented. State law makes the information reviewed by child death review teams confidential (e.g., Welfare and Institution Code section 830 and 10850.1; Penal Code section 11167 and 11167.5.) Indeed, specific legislation, Penal Code section 11170 (b)(5) and Welfare and Institution Code section 10850.1, was necessary to enable child death review teams to have access to the confidential information and to share it among themselves. This same legislation only authorizes child death review teams to re-disclose the information to "other child death review teams." (Penal Code section 11170(b)(5), and provides that "[a]ll discussions relative to the disclosure or exchange of any [confidential] information or writing during team meetings are confidential ..." (Welfare and Institution Code section 10850.1). Maintaining this strict confidentiality enables agencies having responsibility for the investigation of child deaths and those having responsibility for protecting the health and welfare of children to share freely and candidly otherwise confidential information that may be critical to protection of siblings of dead children and other children who might fall victim to the same perpetrators or other causes of child death.

The inability of key agencies to lawfully share confidential information prior to 1988 had negative effects on the detection, investigation and prosecution of child abuse and neglect cases. California recognized this as a deficit and enacted legislation (Penal Code section 11174.32 and 11174.33) to facilitate this much-needed communication by authorizing each county to establish an interagency child death review team made up of multidisciplinary personnel. Welfare and Institution Code section 18951 (d) defines multidisciplinary personnel as those who are trained in prevention, identification and treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse.

The Attorney General's office has opined that the decision to allow or not allow the Grand Jury to attend a CDRT meeting is a local issue to be resolved by either the district attorney or the county counsel. Because of the strict confidentiality State statutes require for much of the information reviewed by OCCDRT, and the need for candid exchange of information among the agencies participating in OCCDRT, the County Counsel for the County of Orange has advised against Grand Jury representation. It is also noted that no CDRTs in California permit Grand Jury representation on their team.

Finally, the Grand Jury's participation in CDRT meetings, many of which involve homicides, could compromise the Grand Jury's potential role as the body from which indictments might be sought relative to the same homicides.

7.3 *CDR membership:* *The Probation Department should broaden representation in its reviews 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 additional community child welfare organizations. (See Finding 6.3)*

The Sheriff-Coroner will not respond to the part of the recommendation addressed to the Probation Department and SSA.

The recommendation that the OCCDRT should memorialize approved agencies in its member manual will not be implemented by the OCCDRT. A list of approved agencies attending the OCCDRT meetings is equivalent to the member roster, which is already included in the member manual and updated regularly.

The recommendation that the OCCDRT should consider additional community child welfare organizations is a continuing consideration for the team and has long been implemented on a limited basis. The Sheriff-Coroner does not believe any change from the current method of implementation is warranted. The membership of the core OCCDRT must meet the legal definition of multidisciplinary personnel described in the Welfare and Institutions Code Section 18951(d). The OCCDRT believes that an effective number and type of community child welfare organizations currently are represented within the core team membership. In the rare instance when a death involves a specialty group that is not represented, the team forms subcommittees that pull members from different agencies and groups to address specific issues.

7.4 *OCCDRT practices:* *The OCCDRT should revisit and reconsider the case selection process and time spent to review each selected case. (See Finding 6.4)*

This recommendation will not be implemented by the OCCDRT. The OCCDRT case selection criterion is based on deaths reported to the Coroner of children less than 18 years of age. The Sheriff-Coroner believes the current OCCDRT selection process is appropriate.

The OCCDRT appreciates the opportunity to respond regarding the time spent by the OCCDRT to review each case. As stated in the response to finding 6.4, many cases are reviewed for months, sometimes for longer than a year. The cases may undergo extensive internal reviews by the respective agencies in addition to the many months spent in review by the OCCDRT. The Sheriff-Coroner believes the amount of time spent reviewing each case is sufficient and appropriate.

The OCCDRT review process is as follows:

- Members receive demographic information and detailed circumstances of the death from the coroner's records approximately 30 days prior to the meeting.
- Members review their agencies' files to determine if any interaction took place with the child or the child's family either before or after the death occurred.
- Members bring all information from their agencies' files to share with the other team members.
- The team members review:
  - if the investigation conducted by all investigative agencies was thorough and complete
  - if appropriate services were rendered to the families
  - if interactions between agencies were effective
  - if proper protocols are in place to ensure timely and effective response
  - what worked well and/or what could have been done better
  - what can be done to prevent similar future deaths
- If follow up action is required at the time of the review, the case will be brought back for further review/discussion at the next meeting. The continuation of the review process is on-going until all required follow up is completed. This may take many meetings and extend over a year. Occasionally, subcommittees will be formed to study the case at greater depth. This can involve side meetings with individuals who are non-team members, but were involved in the investigation or delivery of services.

7.5 *OCCDRT process:* *The OCCDRT should create and maintain confidential meeting minutes and should publish annual reports. The team should analyze child death data, determine trends, and notify appropriate public agencies and the public. (See Finding 6.5)*

The recommendation to create and maintain confidential meeting minutes will not be implemented. The State protocol for establishing county Child Death Review Teams does not require minutes and calls for the decision to be made at the local level. The vast majority of California CDRTs do not keep minutes.

The recommendation to publish an annual report has been implemented. The OCCDRT collected data throughout the 2005 year for the purpose of creating an annual report. The report will be published in the fourth quarter of 2006.

7.6 *OCCDRT training:* *The OCCDRT should provide formal internal training to incoming members of the team. Training through the SCDRC should be opened to more than 2-3 members each year and funds designated to cover the expense. (See Finding 6.6)*

The recommendation to provide formal internal training to incoming members will not be implemented. As indicated in finding 6.6, team members are selected based on the skill and expertise they already possess in the area of child protection and welfare. Further, the State-sponsored training through SCDRC is open to all members who are interested, as evidenced by the most recent local training held at the OC Sheriff-Coroner Training Center where at least seven members from the OCCDRT attended. Additional formal training would be duplicative; is not necessary to assist in the sharing of information among members; and would not contribute to the team's accomplishment of its mission. The member manual adequately explains the team's purpose and objective as well as the role and responsibility of the team member.

7.7 *OCCDRT resources:* *The OCSD should consider combining FCANS income with other OCSD funds to support OCCDRT activities by the Coroner Division of the OCSD, including the equivalent of one full-time investigator designated only for CDR. (See Finding 6.7)*

The recommendation to hire a full time investigator designated only for CDR will not be implemented by the Sheriff-Coroner. The OCCDRT is a multi-agency group comprised of at least eleven different county agencies/groups working collaboratively to support the objectives and purpose of the team. Although each agency and/or group contributes personnel and resources; the Orange County Sheriff-Coroner Department is the single largest contributor of resources. The OCSD currently contributes a deputy coroner, a chief deputy coroner, an administrative secretary, a clerical supervisor, an IT specialist, a research analyst, a Lieutenant, and a Captain. No additional Sheriff-Coroner personnel are needed.

The Sheriff-Coroner will support OCCDRT and the Southern California Regional Child Death Review Team activities by combining FCANS income with OCSD funds to create a means for secure information sharing. This project will aid in prevention efforts of all CDRTs throughout the state.