

## When Will We Be Free of Preventable Childhood Deaths?

*"A simple child,  
That lightly draws its breath,  
And feels its life in every limb,  
What should it know of death?"*  
William Wordsworth (1798)

### 1. Summary

Children die everyday in Orange County; many are infants – less than a year old. The tragic fact is that many of these deaths could have been prevented. Through a process called child death review, efforts to understand the causes can help prevent further childhood deaths.

Last year, 290 child deaths were reviewed by the Orange County Child Death Review Team (OCCDRT). Cases reviewed are those deaths of children under 18 years old that are unexplained or unexpected. An average of only 2½ minutes was spent per case.

The Probation Department conducts separate child death reviews (CDRs) of its own in-custody deaths. The Social Services Agency (SSA) conducts separate child death reviews of its own dependency deaths. The vast majority of child deaths, however, are handled by the OCCDRT.

The 2005-2006 Orange County Grand Jury conducted a study of the procedures that County agencies have in place to ensure that child deaths are adequately investigated and all necessary attempts are made to prevent more. The Grand Jury found that:

- 1.1** County CDRs are held on all unexpected deaths. The Probation Department holds a Post Incident Medical and Operational Review within 10 days of a death. The SSA holds semi-annual CDRs. The OCCDRT holds quarterly CDRs.
- 1.2** With one exception, the County does not provide for public oversight of CDRs. By court order, the Juvenile Justice Commission (JJC) participates in SSA CDRs to fulfill its duty to "... inquire into the administration of the juvenile court law ..."; however, the Probation Department procedure does not permit public oversight. The OCCDRT does not provide oversight of any county CDRs and does not permit grand jury oversight of its activities.

#### Some Acronyms in this Report

<b>CDR</b>	Child Death Review
<b>CDRT</b>	Child Death Review Team
<b>JJC</b>	Juvenile Justice Commission
<b>NCCDR</b>	National Center for Child Death Review
<b>OCCDRT</b>	Orange County CDRT
<b>OCH</b>	Orangewood Children's Home
<b>OCSD</b>	Orange County Sheriff's Department

- 1.3** CDRs do not uniformly include a broad spectrum of child welfare organizations. Although the Probation Department CDR may include "...other administrative and supervisory staff relevant to the incident ...," there is no specified representation from the District Attorney (DA) or child welfare organizations. The SSA includes only the JJC, and that is by court order. The OCCDRT includes no representation from the Orangewood Children's Home (OCH) and only limited representation from community child welfare organizations.
- 1.4** The OCCDRT:
- Reviews an average of 72 deaths per quarterly 3-hour meeting
  - Fails to comply with some of its own guidelines, including (1) publishing annual reports and (2) identifying and publicizing preventive measures to save lives
  - Recently eliminated requirement for meeting minutes
  - Provides no internal training to incoming team members and underutilizes the state's CDR training capabilities
  - Does not have adequate resources to effectively function

## **2. Introduction and Purpose of Study**

The purpose of this study was to determine if the procedures that the Coroner Division of the OCSD, SSA, and Probation Department have in place are adequate to effectively review and prevent child deaths in Orange County.

## **3. Method of Study**

To determine if Orange County child deaths are effectively investigated and steps are taken to reduce child deaths, the Grand Jury:

- Reviewed:
  - Juvenile Justice Commission Annual Reports, 2000-2004
  - "Orange County Child Death Review Team Member Manual"
  - Orange County Probation Department procedure 3-1-106
  - Orange County Social Services Agency procedure A-0316
  - "A Program Manual for Child Death Review," National Center for Child Death Review
  - "Child Death Review in California, At a Glance," Inter-Agency Council on Child Abuse and Neglect and National Center on Child Fatality Review
  - Sections of the California Penal Code
  - Senate Bill (SB) 525, Child Abuse: State and Local Coordination Act
  - "Miscellaneous Order 528.6," Orange County Juvenile Court
  - Orange County Sheriff-Coroner response to 2004-2005 Grand Jury report, "Coroner Case Reviews"

- Interviewed members of the:
  - Juvenile Justice Commission
  - Orange County Child Death Review Team
  - National Center on Child Fatality
  - Social Services Agency
  - Probation Department
  - Juvenile Court
  - Los Angeles County Interagency Child Death Review Team

## 4. Background

In 1995, the U. S. Advisory Board on Child Abuse and Neglect reported, “In the 33 years since Dr. C. Henry Kempe first described the Battered Child Syndrome, more children have died from child abuse and neglect than from urban gang wars, AIDS, polio, or measles; yet the contrast in public attention and commitment of resources is vast.” The Advisory Board further stated, “It has been estimated that 85 percent of childhood deaths from abuse and neglect are systematically misidentified as accidental, disease related, or due to other causes .... This arises from poor medical diagnoses, incomplete investigations, and widespread flaws in the way deaths are recorded on death certificates, in crime reports, and by the child protection system.”

The concept of CDR originated in 1978 in Los Angeles County. While studying coroner findings, Michael Durfee, M.D., became convinced that many probable child maltreatment deaths were being missed. He found that frequently what was known to one agency, such as the hospital or social services, was not known to others. There might be suspicions raised by a doctor or nurse or children’s services worker about a death, but there was no avenue for sharing the information in order to ensure a complete investigation.

As a result of Dr. Durfee’s initial efforts, some form of CDR takes place in almost every state in the United States, at the state and/or local level. Despite variations in the scope and process, all of these review teams have the common purpose of developing a better understanding of how and why children are dying and more effectively preventing further deaths.

### 4.1 State and National Models for CDR

The National Center for Child Death Review’s (NCCDR) model operating principles of CDRs are:

- “The death of a child is a community responsibility.
- “A child’s death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- “A death review requires multidisciplinary participation from the community.
- “A review of case information should be comprehensive and broad.
- “A review should lead to an understanding of risk factors.

- “A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and keep children healthy, safe and protected.”

The state Inter-Agency Council on Abuse and Neglect (ICAN) recommends CDRTs develop prevention efforts to address non-intentional injury deaths, including drowning, gun-related accidents, and poisoning. Prevention efforts may also address multi-agency team case management issues and particular local issues, including unsafe housing, fire safety, and the need for specialized infant evaluation and home visitations.

From a policy statement by the American Academy of Pediatrics:

“Continually functioning multiagency [sic] review teams with consistent membership have the potential to accelerate progress ... [to] reduce the number of fatal cases of child abuse and neglect that are missed, increase the awareness of familial genetic diseases, focus attention on public health threats, and detect and remediate inadequate medical care. Lack of adequate investigations of infant and child deaths allows flawed systems to continue and is an impediment to preventing illness, injury, and the death of other children at risk.”

#### **4.2 State Legislation on CDR**

In 1988, California Penal Code § 11166.7, authorized counties to establish inter-agency CDRTs and described the parameters of their responsibilities. It also established the State Child Death Review Council (SCDRC) under the Department of Justice. The purpose of the State Council is “... to coordinate and integrate state and local efforts to address fatal child abuse and neglect and to create a body of information to prevent child deaths.” The section further states that the SCDRC, state agencies, and local CDRTs “...shall share data and other information necessary ... to establish accurate information on the nature and extent of child abuse and neglect fatalities in California ....”

In 1999, SB 525 recast several of the provisions of § 11166.7, including the requirement that local CDRTs participate in the statewide child abuse and neglect monitoring system by meeting minimum standard protocols and submitting information on child abuse and neglect fatalities. It also provided for training and technical assistance to CDRTs and professionals involved in case reviews. In 2004, § 11166.7 was amended and renumbered as § 11174.32.

#### **4.3 Los Angeles County CDRT**

The Los Angeles County CDRT maintains confidential meeting minutes and prepares periodic press releases. The press releases include child death trends and recommendations for prevention of further child deaths. Public oversight is provided through the publication of annual reports, presented at press conferences attended by the Los Angeles County Sheriff and District Attorney.

#### **4.4 CDR in Orange County**

Child death review in Orange County includes separate agency reviews by Probation for in-custody deaths and by SSA for dependency child deaths. Established in 1987 and led by the Coroner Division, Orange County Sheriff Department (OCSD), the OCCDRT reviews all unexplained or unexpected deaths of children under the age of 18 in Orange County.

##### **4.4.1 Probation CDR**

Although not mandated by law, Probation conducts a CDR (referred to as a Post Incident Medical and Operational Review) as stated in agency procedure 3-1-106, intended to "... assess the conditions surrounding the death. The assessment may provide substance for training and revision to policies and procedures." Deaths reviewed are those of in-custody children who are in Juvenile Hall, Theo Lacy Juvenile Annex, Los Piños Conservation Camp, Joplin Youth Center, Youth Guidance Center, and those on probation.

The CDR will occur within 10 days following an in-custody death of a minor. The review team includes "...the Chief Probation Officer, Chief Deputy of Institutional Services [Probation], Institutional Director [Probation], and other administrative and supervisory staff relevant to the incident, *e.g.*, responsible physician, nursing supervisor, legal counsel, Coroner, etc."

No CDR has taken place since 1969, the last year of a recorded in-custody death. Despite this record, the Grand Jury believes there is a clear need for a CDR process because Probation has oversight of up to 6,000 children at any one time.

##### **4.4.2 SSA CDR**

Although not mandated by law, the SSA conducts internal CDRs, as stated in agency procedure A-0316 (January 30, 2006), intended to:

- "Identify the circumstances of child deaths
- "Confirm compliance with policy, legal requirements, regulations, and best child welfare practices
- "Identify needed policy and/or procedural modifications
- "Identify education and training needs for child welfare staff and the community"

According to this procedure, CDRs take place each year in March and September and include participation by SSA staff and members of the JJC.

The SSA has oversight of approximately 3,500 children at any one time. SSA oversight includes children residing at the OCH, other group homes, in foster care, and, when court ordered, in relative care.

#### **4.4.3 OCCDRT**

According to the OCCDRT member manual from April 2005, "The Orange County Child Death Review Team (OCCDRT) was originally established in 1987 to provide a forum for multi-disciplinary review of child deaths reported to the Coroner. Initially focusing on fetal deaths and deaths of children through 12 years of age, the team set out to improve the multi-agency response on child homicides and unexplained child deaths." The manual further states that, "In 1993, the review process expanded to include children through 17 years of age." It goes on to indicate the primary objectives of the OCCDRT "... have broadened to include prevention efforts. As the team focuses on ensuring the quality of child death investigations, system studies, service planning, and data collection ... to help prosecutors in pursuing child abuse cases, protect surviving siblings, and provide better data about the causes of child death that can be applied to prevention and education programs on behalf of children."

The OCCDRT member manual includes guidelines to member agencies. These guidelines are as follows:

- **Operating Principles**

- "A review of case information should be comprehensive and broad.
- "A death review requires multidisciplinary participation.
- "A review should lead to an understanding of risk factors.
- "A review should focus on prevention of other deaths and the health and safety of children.
- "The death of a child is a community responsibility."

- **Vision Statement**

"Orange County will be free of preventable childhood deaths."

- **Mission Statement**

"Through a comprehensive, multidisciplinary review of child deaths, we will better understand how and why children die, and use our findings to take action that can prevent other deaths and improve the health and safety of our children."

- **Objectives**

The following are two of the six stated objectives in the OCCDRT member manual:

- "Increase public awareness of issues that impinge on the health and safety of children.

- Publish an annual report on child mortality in Orange County.
- Identify significant risk factors and trends in child deaths that the community can address.”
- “Ensure accurate identification and documentation of the cause of every fetal and child death that is reviewed by the Child Death Review Team.”

#### **4.5 Fatal Child Abuse and Neglect Surveillance (FCANS) Program**

The California FCANS reporting program is mandated under SB 525. Based on this statute, the California Department of Health Services is responsible for implementing a statewide system, tracking fatalities resulting from child abuse and neglect, which incorporates information collected by local CDRTs. The goal of FCANS is for all child deaths related to child abuse and neglect to be reviewed by a local CDRT and for them to gather relevant data to assist in reducing the likelihood of future child deaths from all preventable causes. The state pays \$200 for each FCANS report submitted by counties through local CDRTs.

#### **4.6 Coroner Reviews**

At the direction of the Board of Supervisors in 1985, the DA and OCSD entered into a Memorandum of Understanding (MOU). Currently, the DA oversees Coroner investigations of all in-custody and officer-involved deaths. Although not part of the MOU, the OCSD invited members of the Grand Jury to attend a formalized presentation of the case details that became known as Coroner Reviews. The purpose of the Grand Jury presence at Coroner Reviews is to witness the fact that the OCSD and DA are complying with the MOU. According to the Coroner Division, “As these reviews are not open to the public, the presence of the Grand Jury has proved to be a valuable component of the process. It provides for an outside independent body to attest to the fact that the MOU is being followed, while maintaining the integrity of such confidential information as the criminal, psychiatric, or medical history of the decedent.”

### **5. Observations and Discussion**

#### **5.1 Probation CDR**

The Probation Department CDR procedure provides for participation of Probation and Coroner Division personnel within 10 days following an in-custody death of a minor. The department procedure does not provide for public oversight.

#### **5.2 SSA CDR**

Until recently, the SSA held quarterly CDRs of dependency deaths. Based on the 2000-2004 annual reports of the JJC, there was an average of eight deaths in each of those five

years. In 2005, the SSA held just one review in March and notified the JJC that it changed the review frequency to annual; the JJC notified the SSA of its concern with this frequency reduction. With the approval of its first CDR procedure in January 2006, the SSA made yet another change in its review frequency, going to semi-annual; again the JJC notified the SSA of its concern with this frequency. The new SSA procedure does not indicate when a child's death will be reviewed.

The procedure provides for CDR participation by only SSA personnel and members of the JJC; the JJC participates based on Juvenile Court Miscellaneous Order 528.6. There are several County agencies and other organizations that could provide expertise in these reviews, including the Coroner Division, DA, County Counsel, Health Care Agency (HCA), relevant law enforcement agencies, and community child welfare organizations; none is included in the SSA death review process.

The Grand Jury concludes that CDR frequency and representation could be improved.

### **5.3 OCCDRT**

#### **5.3.1 OCCDRT Resources**

Other than approximately \$10,000 received annually from the state for FCANS reports, there is no county funding to support the OCCDRT. There are no full-time CDR personnel assigned to OCCDRT, Probation, or SSA.

According to the OCSD, funds were made available in 2005 to support the hiring of a research analyst for the Coroner Division. This position is for part-time support of the OCCDRT toward improving the maintenance of child death data. A search began in late 2005 for the analyst and the new employee started on March 1, 2006.

#### **5.3.2 OCCDRT Principles and Objectives**

The OCCDRT member manual presents numerous and wide-ranging operating principles, vision and mission statements, and objectives. There are notable differences, however, between the OCCDRT operating principles and those recommended by the NCCDR:

- The first difference is that the OCCDRT manual eliminates the last three words from the NCCDR operating principle, "A death requires multi-disciplinary participation from the community." (Emphasis added.) The Grand Jury interprets this as an attempt to eliminate public oversight.
- The second difference is that the OCCDRT manual does not include the NCCDR operating principle, "Reviews should lead to action." The Grand Jury interprets this as an intention to sidestep the OCCDRT Mission Statement, which promises to take action to prevent other deaths.

Along with differences between NCCDR operating principles and those of the OCCDRT, separate interviews of the OCCDRT and some of its members indicate

that the OCCDRT is not in compliance with many of its member manual guidelines. According to these interviews, the OCCDRT fails to (1) publish annual reports and (2) “Increase public awareness of issues that impinge on the health and safety of children.” The April 2005 OCCDRT member manual stated that meeting minutes were to be maintained, but interviews indicated that was not being done. The OCCDRT member manual was revised in January 2006 to exclude the maintenance of meeting minutes.

The SCDRC recommends several ways of “Improving [CDR] Team Effectiveness”, including “...writing an annual report.” There is discussion within the OCCDRT, however, of preparing an annual report for 2005.

The ICAN publication, “Child Death Review in California, At a Glance”, indicates “The main purpose of ... (CDRTs) is to reduce preventable child deaths and severe injuries.” The primary purpose “... of the State Child Death Review Council is to reduce child deaths associated with abuse and neglect.” The secondary purpose “... is to reduce other preventable child deaths.”

The Grand Jury believes the OCCDRT is woefully lacking in its efforts to prevent child deaths.

### **5.3.3 CDR Process**

According to the California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims, CDRT selection criteria for cases to be reviewed are generally deaths reported to the Coroner or from death certificates. Small and mid-sized counties review all child deaths, whereas larger counties may have more selective review criteria, *e.g.*, coroner cases. Age criteria usually range from selecting only children under seven to selecting all children under 20.

The OCCDRT reviews all coroner cases. The cases, however, are reviewed in quarterly 3-hour meetings each year. In 2005, an average of 72 child deaths were reviewed at each meeting. This is an excessive number of cases, providing only an average of 2½ minutes per death at each meeting. In contrast, the Los Angeles County CDRT meets monthly for about three hours, focusing on just 3-4 child deaths. The NCCDR recommends “Areas with larger populations will likely need to meet on a monthly basis ....”

The Grand Jury concludes that a complete and effective review of a child’s death should take more than 2½ minutes.

### **5.3.4 OCCDRT Member Training**

The SCDRC recommends several ways of “Improving [CDR] Team Effectiveness”, including “Attending workshops/conferences on fatal child abuse and neglect.” The OCCDRT Member Manual indicates among other subcommittees, the “Education & Training” subcommittee. “Members are responsible to... Participate in training or education needs of the team.” The OCCDRT does not, however,

provide any training to its members. Two to three members attend training each year offered through the SCDRC, currently provided by ICAN under a contract with the California Department of Social Services. The limited member training is based solely on the availability of stipends from the state to pay the cost. With an OCCDRT membership of more than two dozen and frequent member turnover, it is currently impossible to train most members. The Grand Jury believes the training and the work of the OCCDRT are valuable enough that county funds should be requested for more member participation.

### **5.3.5 FCANS Reporting**

From January through November 2005, there were 47 FCANS reports prepared. Based on a \$200 state payment for each report and the number of reports issued by the OCCDRT, there is potential income of approximately \$10,000 per year.

### **5.3.6 OCCDRT Membership**

The OCCDRT includes representatives from the DA, SSA, the County Department of Education, one or more law enforcement agencies, County Counsel, HCA, Orange County Fire Authority, and Visiting Nurses Association. The OCCDRT does not include County child welfare organizations such as OCH and community child welfare organizations.

It was difficult for the Grand Jury to discern approved member agencies; no listing exists in the member manual. The roster lists current individual members with no indication of agency vacancies.

While state law does not require public participation on county CDRTs beyond county and community child welfare organizations, neither does it restrict public oversight. According to the SCDRC program office, it is up to the core team members to determine the team's make up. Public oversight ensures Orange County residents that the OCCDRT lives up to its vision for the county to "... be free of preventable childhood deaths."

Representation on the OCCDRT by the Grand Jury would provide such public oversight. As an example, the Grand Jury attends Coroner Reviews, specifically to promote such public oversight and ensure that the OCSD and DA effectively investigate officer-involved and in-custody deaths. State law does provide for the widest possible range of child welfare organization participants in CDRs. State law requires grand juries to investigate civil matters; Orange County Grand Jury practices require it to review the health and welfare of juveniles.

### **5.3.7 OCCDRT and the Grand Jury**

While conducting this study, the Grand Jury requested to attend an OCCDRT meeting. That request was rejected based on (a) restrictive disclosure laws,

- (b) Grand Jury attendance being an impediment to open team discussion, and
- (c) the possibility of conflict of interest. The Grand Jury believes that:
  - a) Members of the Grand Jury would be subject to at least the same confidentiality requirement as full-time members of the OCCDRT. As indicated in a response to the 2004-2005 Grand Jury report, "Coroner Case Reviews", the Sheriff-Coroner stated, as "... witnesses to the [Coroner Review] proceedings, the grand jury is exposed to privileged and confidential information as defined in California statutes." In addition, all members of the Grand Jury are subject to California Penal Code § 911, which includes an oath of secrecy that is "binding for life."
  - b) Public oversight of CDRs would be comparable to that provided in Coroner Reviews and in the SSA CDRs. The OCSD states "...the presence of the Grand Jury [in Coroner Reviews] has proved to be a valuable component of the process." But with the OCCDRT, the OCSD states that oversight would "...interfere with the free exchange of ... information." The Grand Jury believes this is a contradiction which potentially impacts the health and welfare of children.
  - c) A minimum of two members of the Grand Jury attend Coroner Reviews. This would likewise apply if the only official public watchdog organization in Orange County is permitted to witness OCCDRT proceedings. In the unlikely event that the DA would bring a criminal hearing to the Grand Jury that involved a death case reviewed by the OCCDRT, any members who attended the OCCDRT meeting would simply recuse themselves from the criminal hearing without any effect on the hearing.

#### **5.4 Orange County CDR**

While only partially implemented in Orange County, the NCCDR guidelines are the national model for the effective review of child deaths. The CDRs conducted by the SSA and Probation would be strengthened if OCCDRT provided oversight, using a fully implemented NCCDR model.

## **6. Findings**

In accordance with California Penal Code § 933 and § 933.05, each finding will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. The 2005-2006 Orange County Grand Jury has arrived at the following 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.

- 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.
- 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.
- 6.4** *OCCDRT practices:* During 2005, the OCCDRT only spent an average of 2½ minutes per child death.
- 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.
- 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.
- 6.7** *OCCDRT resources:* Other than possibly using state income from FCANS reports, the OCSD does not provide funding for OCCDRT activities.

**Responses to Findings 6.1 through 6.3 are requested of the Probation Department and Social Services Agency.**

**Responses to Findings 6.1 through 6.7 are required of the Orange County Sheriff-Coroner.**

## 7. Recommendations

In accordance with California Penal Code § 933 and § 933.05, each recommendation will be responded to by the government entity to which it is addressed. The responses are to be submitted to the Presiding Judge of the Superior Court. Based on the findings, the 2005-2006 Orange County Grand Jury makes the following 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)
- 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)

- 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)
- 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)
- 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)
- 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)
- 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)

**Responses to Recommendations 7.1 through 7.3 are requested of the Probation Department and Social Services Agency.**

**Responses to Recommendations 7.1 through 7.7 are required of the Orange County Sheriff-Coroner.**

## 8. Appendix

### 8.1 Acronyms

CDR	Child Death Review
CDRT	Child Death Review Team
DA	District Attorney
FCANS	Fatal Child Abuse and Neglect Surveillance
HCA	Health Care Agency
ICAN	Inter-Agency Council on Abuse and Neglect
ICDR	Interagency Child Death Review

JJC	Juvenile Justice Commission
MOU	Memorandum of Understanding
NCCDR	National Center for Child Death Review
OCCDRT	Orange County CDRT
OCSD	Orange County Sheriff Department
SCDRC	State Child Death Review Council
SSA	Social Services Agency

## 8.2 References

1. "Child Death Review," CFS Operations Manual, Orange County Social Services Agency, Procedure No. A-0316, January 30, 2006
2. "Deaths, Serious Suicide Attempts, and other Serious Incidents Related to Minors in Custody," Orange County Probation Department, Procedure No. 3-1-106, October 22, 2004
3. "Resolution by the Board of Supervisors of Orange County, California," August 9, 1977
4. "Orange County Child Death Review Team Member Manual," April 2005
5. "Child Deaths in California," State Child Death Review Council, June 2005
6. "Miscellaneous Order 528.6," Orange County Juvenile Court, July 1, 2002
7. "Annual Report," Juvenile Justice Commission, 2000-2004
8. "A Program Manual for Child Death Review," The National Center for Child Death Review, September 2005
9. California Penal Code §§ 911, 11174.32, 11165.7, 11166.3, 11166.7, and 11166.95
10. Senate Bill 525, Child Abuse: State and Local Coordination Act, 1999
11. CA Department of Justice letter, April 1, 2003
12. "Investigation and Review of Unexpected Infant and Child Deaths," American Society of Pediatrics, November 1999
13. "California Medical Protocol for Examination of Child Physical Abuse and Neglect Victims," Governor's Office of Emergency Services
14. Child Death Review in California, "A Curriculum & Training Manual," February 14, 2006
15. California's Title IV-B Child and Family Services Plan, "Annual Progress and Services Report," June 30, 2005
16. "Child Death Review in California, At a Glance," Inter-Agency Council on Child Abuse and Neglect and National Center on Child Fatality Review, March 2006
17. "A Child at Risk: Missed Opportunities to Save a Life," 2003-2004 Grand Jury report, May 19, 2004
18. Orange County Sheriff-Coroner response to 2004-2005 Grand Jury report, "Coroner Case Reviews," July 2005
19. "A Nation's Shame: Fatal Child Abuse and Neglect in the United States," U.S. Advisory Board on Child Abuse and Neglect, April 1995