COUNTY OF ORANGE

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PROBATION DEPARTMENT

July 5, 2006

The Honorable Nancy Wiben Stock
Presiding Judge
Superior Court of California
County of Orange

Dear Judge Wiben Stock:

Enclosed is a copy of Probation's response to the findings and recommendations of the Grand Jury Report "When Will We Be Free of Preventable Childhood Deaths?" dated June 19, 2006 which has been submitted to the County Executive Office.

This response is being sent to you in compliance with Penal Code Section 933 and 933.05.

Should you have any questions, please do not hesitate to contact me.

Respectfully,

COLLEENE PRECIADO
Chief Probation Officer

CP:mmc

Enclosure

cc: Tom Mauk, Chief Executive Officer
Bill Mahoney, Deputy Chief Executive Officer
Tom Wright, Chief Deputy Probation Officer

ORANGE COUNTY PROBATION DEPARTMENT

Chief Deputy Probation Officer
Institutional Services

TO: Theresa Stanberry, CEO Budget Office

FROM: Tom Wright TW

DATE: June 19, 2006

SUBJECT: 2005-2006 ORANGE COUNTY GRAND JURY REPORT "WHEN WILL WE BE FREE OF PREVENTABLE CHILDHOOD DEATHS?"

The Orange County Probation Department has examined the aforementioned report. Per California Penal Code Section 933.05(a) and (b), the following represents the Probation Department's response to findings 6.1, 6.2, and 6.3, and Recommendations 7.1, 7.2, and 7.3.

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 the death".**

Probation agrees with this finding.

6.2 **CDR oversight: "The county practice generally does not provide for public oversight of CDRs. The Probation Department procedure does not permit public oversight".**

Probation agrees with this finding.

6.3 **CDR membership: "The Probation Department includes no representation from the District Attorney, HCA, or child welfare organizations".**

Probation disagrees wholly with this 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, the nursing supervisor, 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.

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".

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.

7.2 CDR oversight: "Probation should broaden representation in its review by including the JJC".

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.

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".

This 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.

TW:nef