Development of Interagency Child Death Investigation Protocols

for the

Department of Justice
Special Services - Child Abuse Unit
Sacramento, California

August 7, 1989

FINAL REPORT

Institute for Law and Policy Planning

August 22, 1989

Stan Wilkins
Program Manager
Special Services - Child Abuse Unit
DEPARTMENT OF JUSTICE
P.O. Box 903417
Sacramento CA 94203-4170

Re: Development of Interagency Child Death Investigation Protocols [Amended]Final Report

Dear Mr. Wilkins:

Enclosed please find an updated version of the referenced Final Report submitted August 7, 2989.

As I mentioned to John Turner, this version contains a number of minor corrections and revisions. In substance and content, it is identical to that report submitted earlier.

Thank you very much for allowing us to submit this edited Final Report; as always, we welcome your questions or comments.

Sincerely,

Merry Irwin

Merry Irwin
Project Coordinator

Enclosure

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Credits and Acknowledgements

The following people contributed substantially to the information in this report through response to the Questionnaire and follow-up interviews:

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Table of Contents

		Page
i.	Credits and Acknowledgements	ii
I.	Executive Summary	1
II.	Introduction	6
III.	Findings and Recommendations	10
IV.	Advisory Board Nominees	17
V.	Study Design	19
VI.	Statistical Analyses	22
VII.	Questionnaire Responses and In-Depth Interviews	25
VIII.	Conclusion	39
IX.	Bibliography	41
	Appendices	43

I. Executive Summary

I. Executive Summary

Introduction

The Institute for Law and Policy Planning (ILPP) was awarded Phase I of a three year, three phase California Department of Justice project concerning the impact of child death teams on identification, prosecution and prevention of child homicides. The first phase was a study geared to assessing the institutional response to child death investigation and developing an understanding of the investigative procedures now in use throughout the State, both in counties with interagency child death review teams and in those without such teams. The study was accomplished through telephone contact, personal interviews and extensive information collection via questionnaires submitted to each of the 58 California counties.

This final Phase I report is based on information gathered from these contacts, as well as information collected through extensive contact with various child abuse councils and child advocacy groups throughout the State and nationally.

Interagency Child Death Review Teams

Review teams typically are made up of representatives from some or all of the following agencies: coroner, law enforcement, public health, mental health, child protective services, district attorney, probation and local hospitals. Teams meet at regular intervals to discuss cases selected for review (typically those deaths reported to the coroner). Prior to meeting, agency representatives check their files for prior contact with either the child or members of the child's family. In reviewing agency files together, the team discusses the death using whatever reports are available from the coroner and law enforcement, and hears reports from agency representatives and occasionally from other individuals with information relating to the death. The team then makes a determination to take no further action, to refer the case to one or more agencies for further inquiry, investigation or prosecution, or to take some other action designed to prevent similar injuries or deaths (for instance, installing "speed bumps" around a playground where a number of fatal motor vehicle injuries have occurred).

Assessing the Impact of Interagency Child Death Review

Based on study of systems now in place for the investigation and review of child deaths, Consultants found that the interagency review process can be effective in increasing the rate of identification of suspicious child deaths as homicide.

In purely statistical terms, however, it is difficult to quantify the impact of interagency review in terms of increases in the number of child fatalities identified as homicide due to team operation. This is primarily due to the absence of a uniform database; most counties do not collect data regarding child deaths, whether accidental, homicide or due to natural causes. Even in counties with interagency review teams, data is not collected in a systematic fashion.

The issue of team impact on prosecution of child homicides is similarly difficult to quantify. Undoubtedly, the identification of questionable child deaths as possible homicide increases the likelihood of prosecution of the responsible parties. However, prosecution in these cases remains problematic for a number of reasons.

One reason is the frequent lack of evidence; child murders typically take place without witnesses; without confession or overwhelming physical evidence, conviction is often uncertain. There are other grey areas in the law as well; in the case of prenatal drug use, prosecution of mothers whose heavy drug ingestion undoubtedly contributed to fetal demise or SIDS death, prosecution may hinge on whether or not the mother knew her drug use might kill her unborn baby--and prior knowledge may be difficult to assess or prove in court. In the final analysis, however, the continued refinement of the review process and the education that is necessarily part of that process cannot help but improve the criminal justice system's response to child homicide.

The interagency process can be particularly effective in terms of preventing child homicide by identification of surviving siblings at risk and by heightening participating agency awareness of the larger, social context of preventable childhood death and injury--the dangers of unregulated traffic around parks and playgrounds, unsafe toys, uncovered swimming pools, prenatal drug use, the importance of using seat restraints and car seats, etc.

Study Methodology

Study began with telephone contact with the coroner of each county, to identify the Department of Justice project and elicit cooperation in completing an in-depth questionnaire regarding that county's child death investigation procedures. In many instances, particularly in those counties without child death review teams, the coroner or sheriff/coroner completed the questionnaire; in other instances, the best respondents were found in other agencies, including Child Protective Services, local law enforcement or district attorney's office.

The questionnaire was divided into three sections; the first section identified the respondent and requested an overview of county statistics and procedures; the second section was designed for counties without interagency teams and collected information regarding that county's investigative procedures; the third section was designed for counties with interagency teams in place, and collected information on team membership, operation, problems and impact. The counties without teams were sent the first and second sections, those with teams were sent the first and third sections, and those in the process of forming teams were sent all three sections. Despite persistent follow-up, consultants received only 46 responses to the questionnaires so the discussion is limited to these.

Consultants also made in-depth study of certain target counties, through extensive personal and telephone interviews and attendance at meetings of the Northern California Child Death Review Team coalition and the San Francisco, San Mateo and Santa Clara child death review teams. Particular attention was given to the different needs and experiences of small, rural or remote counties, as opposed to large, urban counties.

Seventeen California counties have instituted some form of interagency child death review, and seven are in the process of implementing a review process. The remaining 34 counties do not have interagency teams in place. However, Consultants discovered that in those counties without a formal review process, informal networks of communication and coordination are often in place between the various law enforcement and human service agencies, for the same purpose as the more formal connections in place in other counties--the identification of child homicides brought about by abuse or neglect.

Consultants found that child death investigation teams are presently in use in most of the large urban counties and in a few of the small rural counties. To quantify this observation, Consultants divided the counties into three groups on the basis of their degree of urbanization. Each county, and the state as a whole, was ranked by its total population, population per square mile, and percent of its population listed as "urban" by the U. S. Bureau of the Census. These groupings are shown in Section VI, Statistical Analyses. The three rankings were averaged to give the composite index. Approximate ranges were shown, but since the index is a combination of the three characteristics a few of the counties in each group lay outside of the ranges in some of these measures.

One of the original goals of this study was to determine whether the establishment of child death review committees resulted in the identification of more deaths as due to abuse rather than apparently natural or unexplained causes. This could be examined in two ways: By asking the respondents whether this had indeed happened, or performing a statistical analysis on the numerical responses to the questionnaire. The latter would involve either looking at individual counties before and after the formation of the team, or comparing the statistics provided by similar counties with and without the teams; these statistics are shown in Section VI, Statistical Analyses, Table 6.

When the data was received, however, it was apparent that neither of these statistical approaches would be fruitful. Comparisons among counties are hampered by the fact that counties have different criteria for undertaking the investigations. One particularly important criterion is the age range of victims, and it is well known that the incidence of fatal child abuse varies strongly with age. Beyond this, most counties simply do not have accurate statistics on the number of deaths or investigations performed. Nonetheless, some comparisons can be made of those counties with teams that kept statistics before and after

formation of teams; shown below are the individual and summary statistics for these counties.[1]

Investigation of Child Deaths
Before and After Team Establishment

County	Reported Deaths Before	Reported Deaths After	Percent Investigated Before	Percent Investigated After
Yolo	28	4	27%	33%
San Luis Obispo	21	6	24%	50%
Solano	151	80	13%	18%
Monterey	89	25	30%	38%
Kern	279	253	26%	34%
TOTAL	568	367	23%	31%

In each county and overall a higher percentage of deaths were investigated after formation of the team. The difference is not large, but it is statistically significant (98% confidence level) and suggests that the establishment of the teams facilitated the investigatory process.

Findings and Recommendations

Consultants found that, in counties that have implemented interagency child death review, the process has worked. As might be expected, the greatest benefit of the team approach was heightened cooperation, coordination and communication between agencies and individuals responsible for investigation of child fatalities. Participants agreed that the interagency approach was an improvement; for the reasons noted above, teams were more likely to gauge their success in terms of improving communication and cooperation between agencies rather than purely statistical terms. While Consultants noted some resistance to the idea of mandated interagency teams in counties without teams, the resistance is not directed toward the basic concept of communication and coordination between agencies, but rather toward mandated systems and procedures for such coordination. Consultants found strong support for increased training in issues relating to child homicide.

Consultants also found widespread support for the development of written protocols for interagency child death investigation and review. Even in counties that did not think a formal review process would be an improvement over their present system, the majority agreed that written protocols for interagency child death investigation were a good idea.

However, the manner in which the protocols are cast will have a great impact on the willingness of counties to implement the procedures. Of particular significance will be promoting the perception that protocols will "make life easier" for those counties that do not have interagency teams, as they will provide a "blueprint" for investigating the relatively rare occurrence of child deaths in such counties. Another vital message that should be

contained in the protocols is that institution and adherence to set child death investigation procedures will protect counties, agencies and responsible individuals from civil liability (i.e., claims of mishandled, incomplete or otherwise defective investigations).

Taken together, the study's findings show strong statewide support for the writing of interagency child death review protocols and for subsequent training in their implementation and use.

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[1]For the three which have had teams for a fraction of a year, the data were allocated and the numbers rounded off.

II. Introduction

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The Problem

California has 600 cases of suspicious child deaths annually, most involving children under age four, and half under the age of one. Reported cases of nonaccidental child deaths nationally have risen dramatically since 1980. As media coverage has treated individual cases, public awareness of the tragedy of these deaths has deepened, and demand for prosecution and prevention has grown.[2]

Despite concern and increased focus, the growth of understanding has not matched the problem. Efforts at identifying suspicious deaths as abuse or neglect and efforts at prevention are constrained by poor coordination between agencies. The Department of Justice Development of Interagency Child Death Protocols project, the first phase of which is the subject of this report, was designed to alleviate this complex problem in three phases:

1. Collection of data relating to child death investigation procedures in counties with and without formal child death investigation systems; organization of an advisory committee; preparation of a report describing existing child death investigation practices and the roles of various agencies involved in child death investigations; and preparation of a directory of those individuals and agencies responsible for child death investigation in each county;

2. Development of written protocols for interagency child death investigation; and

3. Training of individuals and agencies throughout the State in the use of these protocols.

The objective of the program is to develop protocols for urban and rural county interagency child death investigation teams which, when implemented, will increase identification of child deaths as homicide due to abuse or neglect, increase prosecution and conviction of child killers, increase social service intervention on behalf of surviving siblings and family members, improve institutional response to families at risk of serious child abuse or neglect before a death occurs, and improve overall institutional ability to protect children at risk by improving the linkages between the different agencies (police, social services, coroner, health, etc.).

The Importance of Interagency Child Death Review Teams

The importance of establishing interagency teams for investigating child deaths must be emphasized. Abusive behavior leading to child death is frequently concealed or disguised by the abusers or overlooked by investigative agencies, particularly if the family does not fit agency or law enforcement profiles of "typical abusers." The literature on child abuse

often finds that agencies acting in isolation fail to perceive or follow up on deaths which may have resulted from child abuse or neglect. For example:

- Law enforcement personnel may not have prompt access to social service or public health agencies' previous reports of abuse;
- Emergency paramedical squads may destroy evidence of abuse in attempting to save the child's life, or in many instances, attempting to resuscitate an already expired child for the benefit of family or witnesses;
- Medical examiners may miss signs of abuse or not be aware of prior abuse;
- If a child dies in a medical facility as the result of abuse, the private physician signing the death certificate may likewise miss signs of abuse and fail to report it;
- Even with the advent of the 1981 mandated reporting law, confidentiality considerations continue to interfere with information exchange. Resistance to sharing information as approved by AB 4585 may occur because agencies are not thoroughly familiar with the law, have their own conflicting procedures, or are uncertain about when to get involved;
- There is a bias in favor of parents over children which permits parents to discipline their children as they see fit. There may also be a cultural value system which values adults over children, and thus killing children may be seen subconsciously as no worse than the killing of adults, or even less serious than killing adults;
- In this same vein, law enforcement agencies may fail to see the need for differentiating between the investigation of child deaths and those of adults.

AB 4585

Interagency teams can sensitize each of their member disciplines to the perspectives and observations of other participants, and thereby strengthen the approach of the entire team. Governor Deukmejian, while California Attorney General, recognized this in his "Child Abuse Prevention Handbook" (1982), in which he stated:

> The most thorough, consistent, and effective strategies to report, treat and prevent child abuse employ the cooperative application of expertise from all involved disciplines.

Attorney General Van de Kamp's Commission on the Enforcement of Child Abuse Laws (1985) made a number of specific recommendations on relaxing interagency confidentiality requirements in cases of child abuse, and recommended the establishment of specially trained investigative units and interagency coordination councils to examine such cases. AB 4585, the inspiration for this program, authorizes the California counties to establish such interagency teams and requires the development of a protocol to facilitate the operation

of such teams. The bill represents the Legislature's response to the Attorney General's recommendations.

To summarize, the indicators of child abuse are often hidden, and what is known about a particular case may exist only as fragmented bits of information among several agencies unconnected by any uniform reporting system. Characterization of those factors which may lead to fatal abuse, and retrospective identification of abuse as a primary cause of death are important topics for research which have been proposed, but which lie outside the scope of the present study. What does seem clear is that a uniform statewide system of multidisciplinary review teams will be better able to provide the answers to those questions than individual county law enforcement or social service agencies acting alone and in their own unique ways.

A number of states have developed improved systems for identifying and prosecuting child murders. Oregon has a statewide network in place; Illinois has developed a sophisticated protocol for medical examiners; New York has studied cases with previous child protective service records; South Carolina, Louisiana, Florida, Colorado and Texas each have instituted programs and procedures which have resulted in on-going system change. Many other states have protocols for case management within the social service system. The National Center for the Prevention of Child Abuse in Alexandria, Virginia provides a central clearinghouse for projects nationally; multiple national associations and some federal agencies participate in that network.[3]

Within California, most of the large counties have some form of child death review committee in place.[4] Well over 20 million people in California live in counties with such an interagency child death review process in place. A northern and southern California coalition of review teams meets regularly, bringing counties together to share information, problems and ideas. Statewide agencies and associations help connect services throughout California.

Conspicuously absent from the list of counties with teams are most of the small rural counties. The counties which do have review teams have established them independently so that they do not all work in the same way, nor collect information in the same way--which renders the sharing of information across county lines extremely problematic. Some smaller counties do not have the elaborately constructed teams found in urban areas, yet manage to pair law enforcement and child protective workers to provide some measure of interdisciplinary communication and coordination. In fact, several small county sheriffs claim that information flows more freely, with fewer bureaucratic impediments, than in larger jurisdictions with formal communication systems.

If all the counties had review committees and gathered and evaluated information in the same way, it would provide a solid basis from which to develop research results and would allow for more effective identification, prosecution and prevention of child homicides. This, however, may not be feasible. Small counties are often fiscally limited, and do not have access to the breadth and sophistication of expert advice available in Los Angeles or the San Francisco Bay Area. Compromise solutions may be necessary. However, importation of experts may not be necessary, particularly as the teams tend to create their

own breadth and sophistication by exposing the participating agencies and individuals to each other's professional perspectives and expertise.

Although such compromises are more properly part of Phase II--the development of the written protocols--they should be mentioned here as guidelines to the present work. Possible variants of the large-county models might be multi-county review boards, expert staff on loan from large counties, or review committees reduced in scope from those of the larger counties. Outside financial sources may be needed if experts not on local government payrolls are to be employed. Again, this too may not be necessary; as interagency teams draw upon the local talent of their own communities, many may find the financial and personnel resources required.

The Department of Justice Study: Development of Interagency Child Death Protocols

The primary goal of this phase of the Department of Justice study was to identify the methods now used throughout California to investigate child deaths. This was accomplished initially by contacting the primary agencies involved in such work, typically the coroner or sheriff/coroner's office in each county. Through that contact, the study sought to characterize that county's system: whether a law enforcement/coroner investigation only, law enforcement plus occasional outside advice, or a full-fledged interagency, multidisciplinary team approach.

The key questions to be addressed were: "What impact, if any, has interagency review had on the rate of identification, prosecution and prevention of child homicides in those counties with teams? How does that rate compare with the same rate in counties without teams? Which counties have interagency teams in place, and which do not? What are the differences, if any, between child death investigative procedures in large urban counties without teams and those in smaller, rural counties? What are the differences, if any, between child death investigative procedures in large urban counties with teams, and those in smaller, rural counties? How do interagency child death review teams work? These questions are addressed in Section VII, Questionnaire Responses and In-Depth Interviews.

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[2]Durfee, Dr. Michael. Statewide Child Death Case Review System. Program Statement submitted to Los Angeles County Department of Health Services, March 24, 1988.

[3]Interagency Council on Child Abuse and Neglect (ICAN); Child Death Case Review Committee, Los Angeles County, pages 5-6.

[4]17 counties have interagency teams as of June, 1989, and seven more in the process of starting teams; see Section VI, Statistical Analyses, Tables 7 and 8.

III. Findings and Recommendations

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Based on extensive collection and analysis of information from the agencies and individuals working with child fatalities in California, Consultants offer the following findings and recommendations.

The Department of Justice should go forward with Phase II, development of written protocols for interagency child death investigation and review, and Phase III, training of appropriate agencies and individuals in the application of the protocols. Consultants found wide support for development of written interagency child death investigation protocols. This support was strong in counties with interagency teams, but perhaps even more significantly, this support was also strong in counties without interagency teams in place.[5]

To assist in its formulation of written protocols, the Department of Justice should follow through with selection of an Advisory Board.[6] The Advisory Board should be made up of individuals with expertise in the fields of law enforcement, pathology, social services, pediatric medicine and psychiatry. With its diversity of professional perspectives and representation from small rural counties, large urban counties, as well as those with teams and without teams, the Advisory Board should assist the Department in developing protocols that may be effectively applied in any environment.

In addition to the direction provided by the Advisory Board, the Department should actively solicit county input in the development of protocols. This can be done in a variety of ways, including selected contacts with questionnaire respondents from Phase I of the project, and with Northern California and Southern California child death review coalition groups. Another option would be publication and distribution of a Department newsletter, addressing the issues relevant to child death investigation, publicizing the "victories" of death review teams, and soliciting input regarding problems encountered by teams in the practical aspects of child death review, as well as the problems encountered in counties without formal systems for child death investigation.

With input from the counties--both those with and without interagency teams--as well as the Advisory Board, the Department of Justice should develop written protocols that are flexible. The protocols should avoid mandating procedures that will be burdensome and expensive for those counties without the personnel, equipment or resources that may be found, for instance, in Los Angeles, San Francisco or Kern Counties. Counties responding to the questionnaire repeatedly voiced their preference for protocols that were available as flexible guidelines rather than legal mandates. Proportionally speaking, this stated preference was actually stronger in counties <u>with</u> teams than it was in counties <u>without</u> teams.

Development of mandated interagency protocols will undoubtedly provoke resistance in many of the smaller, rural counties. Ironically, these same counties expressed significant approval both for written protocols and for the basic concept of interagency coordination and communication. Moreover, many counties without formal interagency teams in place reported well-established informal networks between agencies and individuals, which

provide the same benefits of communication and cooperation as found in counties with more formalized systems. The Department might even undermine the willingness of agencies and individuals to voluntarily follow essentially identical procedures by issuing the protocols as mandates rather than guidelines, to the possible detriment of the children it seeks to protect.

The Department of Justice should utilize the findings and observations found in this Final Report in crafting its written protocols. Particular attention should be paid to the problems encountered in the course of study, as well as those mentioned by respondents to the questionnaire. For instance, one of the major problems encountered in assessing the statistical impact of interagency teams was the absence of uniform data.[7] A crucial step in advancing the practice of interagency review will be showing an increase in the rate of identification and prosecution of child homicide. Developing this proof will rely heavily on the collection of standardized and uniform child fatality statistics. Consultants recommend that the Department of Justice assist counties in devising standard procedures for collection of child fatality data.

Another problem frequently mentioned in questionnaire responses was the reluctance of agencies to loosen confidentiality requirements in the interests of sharing information with other agencies. To address this problem, the protocols should clearly explain the legislative authority given counties for sharing information between agencies within the context of interagency review. Taken from another perspective, the issue of confidentiality is an issue within interagency teams. In one county, a failure to stress the importance of maintaining confidentiality led to the publication of a highly critical newspaper account which chronicled the failures of several agencies to protect a child who ultimately died of abuse. The release of this story created a crisis of faith within the team and within participating agencies and ultimately jeopardized the entire interagency death review process in that county. Consultants recommend that the protocols suggest each interagency review meeting begin and end with a reminder that matters discussed remain confidential.

The resistance Consultants encountered in the course of this study demonstrates another problem the Department may face in instituting interagency child death investigation protocols. There is a perception among counties without teams--particularly small, rural counties--that the teams will be a burden rather than a benefit (because their county has so few child fatalities, limited financial and/or personnel resources and various other reasons noted in questionnaire responses). To counter this perspective, the Department should emphasize the beneficial, protective aspects of following protocols and practicing interagency coordination.

For instance, the Department can allude to the practices of Plumas County, which has a population of less than 20,000 and no more than three or four child deaths per year, but nonetheless has an interagency review team which meets monthly. It does so because communication and coordination are at a premium in Plumas County, because the monthly meetings give participants an opportunity to expand on their experiences and renew connections and commitment, and because having systems in place aids in investigation and review when child fatalities do occur.

Moreover, when child fatalities are infrequent, familiarity with procedures may be "rusty;" the availability of standard, written guidelines will provide a "roadmap" for investigation and review. It should be pointed out that child homicides may well be missed in communities with few child deaths and fewer procedures for investigating suspicious deaths. One respondent wrote that he had been sheriff in his county for 25 years, and had never had one child homicide; while it is possible that no children had been murdered in that county in 25 years, it is also possible that, without training or systems for identifying suspicious deaths, such deaths occurred but went undetected.

The Department may also wish to point to the growing number of civil lawsuits brought by surviving families against agencies and individuals responsible for investigating, protecting or serving the public. These lawsuits have successfully won claims based on arguments of failure to follow standard agency procedures and policies.[8] Counties may afford themselves some measure of legal protection against such costly and damaging lawsuits by adhering to widely accepted and practiced standards of investigation and review. By virtue of having investigation protocols and systems in place for coordination and communication between responsible agencies, even counties with small populations and infrequent child deaths can lessen their exposure to such lawsuits. Consultants recommend that the protocols stress the advantages and protections afforded by following standard procedures and interagency review.

In these and other areas, the protocols should benefit greatly from the ideas available in this Report and the extensive research and county input on which it was based.

The Department should also be prepared to support formation of interagency teams by advocating additional funding for the appropriate agencies. Many of the responsible agencies in small, rural counties and even moderate-sized counties simply do not have the personnel, equipment or financial resources that expanded child death investigation and review is likely to require. Implementation of standard procedures throughout California may well require appropriations to a number of agencies in various counties, for instance, to pay for importation of forensic pathologists or pediatric specialists in counties that do not have such specialists, or for transportation of victims to neighboring medical facilities for long-bone X-rays, etc.

In its formulation of protocols, the Department should emphasize the benefits of interagency child death review. Consultants found that counties with interagency child death review teams investigated a higher percentage of deaths after formation of the team. The difference is not large, but it is statistically significant, suggesting that the establishment of the teams facilitated the investigative process. Participants agreed that the interagency approach was an improvement, though they were more likely to gauge their success in terms of improved communication and cooperation rather than purely statistical terms.[9] In other words, from an "outside" perspective, there may be a desire to judge the success of the interagency approach in statistical terms (i.e., a higher rate of identification of child homicides). However, from the "inside," the agencies and individuals actually applying the concept of interagency review tend to define "success" in overall terms of improving the institutional response to child death.

The Department of Justice should go forward with its directory of agencies and individuals in each of the California counties responsible for investigation of child fatalities. A partial listing can be found in Appendix 1; this listing includes only those responding counties with interagency child death review teams in place. The complete directory, to be published by October 1, 1989, should be indexed alphabetically by county and identify assigned individuals by name, title, agency, address and telephone number. Such a directory would be of enormous benefit to the Department in responding to inquiries, as well as for individuals and agencies working in the area of child death investigation and review in locating their counterparts in other counties, obtaining advice on problems encountered in particular cases, sharing information regarding suspected abusers who have relocated to another county or jurisdiction, etc.

The Department of Justice should release one copy of this Final Report to each county.[10] There would be several benefits to dissemination of the Report. First, distribution would give the counties the opportunity to share their reaction to the Report with the Department and perhaps expand on Consultants' analysis. Also, completion of the questionnaire required the voluntary investment of many hours by individuals and agencies throughout the state;[11] in return, many specifically requested a copy of the Final Report when it was completed. In addition to rewarding the efforts of those who participated, distribution of the Report would provide counties with additional insights into the logistics of interagency child death review, revealing both the benefits and problems of the interagency approach, as well as fully articulating, perhaps for the first time, the true goals and objectives of interagency review--improving the delivery of service, enhancing communication and cooperation between individuals and agencies and, most importantly, protecting children.

The Department should go forward with Phase III of the subject project, supplying training of appropriate individuals and agencies in application of the protocols developed in Phase II. Consultants found that the majority of responding counties regarded training of the various disciplines in identification of child homicides due to abuse and neglect as important and useful. This overwhelming support for additional training was just as strong in counties without teams as it was in those with teams. Consultants also found substantial agreement among responding counties as to who most needs training, particularly "first responders" and emergency room personnel. Throughout their responses to the questionnaire and in a variety of different contexts, the counties repeatedly expressed their belief in the importance of training. Many county respondents pointed out that improving the institutional response to child fatality would have little chance of success without training and on-going education in identification of child abuse and neglect.

In many respects, Consultants believe that the training component of the Department of Justice project is the most crucial. While Phase III necessarily builds on each previous phase, protocols and improved institutional systems can be no better than the individuals enacting them. To have an impact on identification, prosecution and prevention of child fatalities due to abuse and neglect, each of the responsible agencies needs "cross-training" in the disciplines and perspectives of the others: Paramedics and "first-responders" need the input of law enforcement and prosecutors to understand the mechanics of evidence preservation and the legal requirements of the courts in bringing child murderers to justice. Doctors and emergency room personnel need to work with child protective agencies and

pediatric specialists to learn to recognize the signs of child abuse and neglect. Social service caseworkers and supervisors may need the broadest training of all, as their work with abuse-prone families so often brings them into the "front lines" of the war against child homicide.

As one respondent so succinctly put it, however carefully they are drafted or framed, interagency child death investigation protocols will be "only as good as the professional involved." As the key to professionalism in any discipline is proper education and training, the key to saving children at risk and bringing perpetrators to justice will rely on the support given the professionals charged with that responsibility.

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[5]See Section VII, Questionnaire Responses and In-Depth Interviews.

[6]See Section IV, Advisory Board Nominees.

[7]See Section VII, Statistical Analyses.

[8]See Tolleson vs. City of West Covina. In March of 1980, plaintiff's 10 year old son was kidnapped and held for ransom. Plaintiff immediately called the police to report the kidnapping. Eight days later the child was found dead in a house only two doors away. Plaintiff claimed that the police had no experience or training in handling such cases, that their investigation was negligent and the legal cause of the boy's death. Using a phrase found often in such cases, plaintiff claimed there was a "special relationship" between the police and the plaintiff, and that the plaintiff had reasonably relied on the defendants to act responsibly. The jury found for the plaintiff and awarded over $5,000,000--five times the amount demanded by plaintiff in his complaint.

See also Estate of Bailey v. County of New York, 1985. Relatives of a five year old girl living with her mother and the mother's boyfriend found evidence of child abuse and reported it to a telephone hotline and the police. The next day, a county youth services agency took temporary custody of the girl, but the following day returned the child to her mother without adequately investigating the possibility of further abuse by the mother and boyfriend. A month later the child was dead. The father filed suit on behalf of the child's estate, and the county was held liable for the child's subsequent death from abuse by the boyfriend and mother.

Particularly significant in this vein is Sorichetti v. City of New York. A woman sought a protective order against her ex-husband from Family Court; the court issued the protective order but also granted the father weekend visitation rights. Prior to the incident, the mother sought assistance from officers at the local police department, who knew of the father's violent history, reporting that he had made deaths threats against her and the child when he picked her up for the weekend. The police refused to take action. When the child was not returned at the appointed time, the distraught mother went to the police, and was told to "just to wait." An officer familiar with the father's history urged that a patrol car be sent; his superior rejected the suggestion and at 7:00 PM, the mother was sent home. At 6:55 PM, the six year old child was stabbed repeatedly by her father with a fork, knife and

screwdriver; he then attempted to saw off her leg, which attack resulted in permanent brain damage and severe disabilities. The father was convicted and sentenced for attempted murder. The mother sued the City of New York for negligent failure of the police to provide reasonable protection; the jury awarded the child $3,000,000 in damages and $40,000 to the mother; the appellate court reduced to award to $2,000,000.

Tom on Torts referred to the modern trend that can be seen in cases like Sorichetti: Baker v. City of New York, 1966 (court order authorizing police protection of plaintiff created duty of protection); Nearing v. Weaver, 1983 (in which an enforcement provision of Oregon's Family Abuse Prevention Act mandates that police "shall arrest" any person violating a TRO against domestic violence, the court held that a wife and minor children had a cause of action against police officers who failed to protect them from the violence-prone husband by enforcing the TRO against him); DeLong v. County of Erie, 1983 (death of a housewife from stabbing by a criminal intruder was caused by the negligent processing of her 911 call); Schear v. Board of County Commissioners, 1984 (in which police received a call that a crime was in progress but failed to respond, with the result that plaintiff was raped and tortured) and Chambers-Castanes v. King County, 1983 (showing the importance of the victim's reliance on police assurances that "help is on the way; the cruisers have been dispatched"). According to Tom, these cases disclose "a relaxation of the judicially constructed impediments to recovery for harm caused by negligent failure of the police to prevent crime. The mechanism of enlarged recovery is a modest but steady expansion in the special relationship exception to the no-duty rule." (See also Thurman v. City of Torrington, 1984, where a victim of domestic violence was awarded $2,600,000 in compensatory damages against her town's police force for failing to act on numerous complaints of violence committed against her by her estranged husband, before she was so severely assaulted as to cause permanent paralysis; and Griffin v. Johnson, 1988, where a family reported four times in two and a half hours that the daughter's former boyfriend, a mental patient, was in their garage with a gun; the police did not respond, and six hours later, the man broke into the house and killed the daughter. The jury found the police dispatchers and their supervisors liable, awarding $2.5 million to the daughter's estate and $61,000 to the family.)

Consultants also found references to civil suits brought against social service agencies (Babcock v. Washington, 1984, where a complaint was filed against employees of the Department of Social and Health Services of the State of Washington on behalf of four children who were sexually abused and psychologically damaged as a result of federal and state violations relating to the placement and monitoring of the children; and Mamo v. State of Arizona, 1981, a $1 million jury verdict against the state for the wrongful death of a 2-1/2 year old girl due to negligent failure of the state agency to prevent child abuse), and physicians (Landeros v. Flood, 1976, finding civil liability for negligent failure to report conspicuous evidence of child abuse, resulting in the child being returned to the offending parents who inflicted additional abuse).

These cases stand for the theory that individuals can sue governmental authorities for failing to do their jobs, in particular, for failing to protect children from physical and sexual abuse. Several deal with dead children (Tolleson, Bailey, Mamo), whose families sued the

agencies responsible for protection or investigation. Clearly these cases speak to a trend toward survivors suing on behalf of deceased children for the failures of various individuals and agencies charged with their protection. This trend will extend further and further into child death investigations, as a result of studies such as this one and the development of protocols like those contemplated here.

[9]In addition to the requested statistical information, Consultants offered three criteria for assessing the impact of interagency child death review: Whether the team was able to handle more cases or dispose of them more quickly than the previous system; whether the county now identified a higher percentage of deaths as being related to child abuse or neglect than previously; and whether the formation of the team had improved communication and coordination between the various responsible agencies.

[10]In counties with interagency teams in place, the Report might be directed to the team coordinator; in counties that responded to the questionnaire, the Report might be directed to that respondent; in those counties that did not respond to the questionnaire, the Report might be submitted to the County Coroner, as the coroner is an essential component in any child death review structure.

[11]See Credits and Acknowledgements for a complete listing.

IV. Advisory Board Nominees

IV. Advisory Board Nominees

In addition to studying practices and procedures for child death investigation, Consultants were asked to organize an Advisory Board to assist the Department of Justice in developing written child death investigation protocols, Phase II of the subject project. The Advisory Board should reflect in its makeup the professional diversity of the interagency child death review teams and include members from law enforcement, social services, coroner, pathology, district attorney, public nursing, pediatric medicine and psychiatry, experts in the field of investigation, child abuse and interagency child death review, as well as individuals representing agencies in counties that do not have formal interagency child death review teams in place.

The individuals named below have agreed to be considered as nominees to the Department of Justice Development of Interagency Child Death Protocols Advisory Board.

Law Enforcement

Sgt. Rod Decrona
Plumas Co. Sheriff's Dept.
P.O. Box 1106
Quincy CA 95971
(916) 283-0400

Det. Audrey Stacey
Siskiyou Co. Sheriff/Coroner
311 Lane Street
Yreka CA 96097
(916) 842-8300

District Attorney

Harry M. Elias, Esq.
Deputy District Attorney
Chief, Child Abuse Division
San Diego County District Attorney
220 W. Broadway
(619) 531-4300

Coroner, Sheriff/Coroner

Helen Frankel, R.N., P.H.N.
Kern County Coroner's Office
1832 Flower Street
Bakersfield CA 93305
(805) 861-2606

Dr. Boyd Stephens
San Francisco Coroner's Office
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San Francisco CA 94103
(415) 553-1694

Children's Advocacy

Pat Osborne
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460 California Avenue, Suite 13
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Department of Social Services

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Special Consultant

Dr. Michael Durfee
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Dept. of Health Services
Los Angeles County
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Los Angeles CA 90012
(213) 974-8146

V. Study Design

V. Study Design

For those counties with interagency teams in place, Consultants sought to determine the logistics of team operation. Among other questions, Consultants asked which agencies participated in the review process; of those agencies participating, did the same representative attend each meeting, or did agency representation rotate? Consultants sought information relating to frequency of meeting, whether or not the team had clerical support, and how the team was financed. Consultants also attempted to determine how case review itself was conducted; what criteria determined case review; what materials were reviewed prior to meetings; were materials distributed prior to meetings; were those materials returned to the contributing agency or destroyed; were records kept of cases reviewed and of team discussions; what was the extent of follow-up regarding cases reviewed, and how were determinations of suspected abuse or no suspected abuse reached? Consultants also questioned the policies of team operation; how did the team handle questions of agency confidentiality or the confidentiality of team proceedings; what policies did the team have in relation to the media, and what were the teams policies in regard to on-going law enforcement investigation or criminal proceedings?

Consultants next sought to evaluate the effectiveness of the various interagency models by measuring any change in the rate of identification or prosecution of abuse-related deaths before and after establishment of interagency review. Of particular interest for the purposes of this project was the rate of identification of child deaths reported as "child abuse" before and after the establishment of interagency teams, considering the effects of the new child abuse reporting law of 1981, compared with the reporting of such deaths in counties without interagency teams or specific investigative protocols. Did the institution of an improved investigative process lead to an increase in the number of child deaths attributed to abuse or neglect, rather than to "natural," "accidental" or "unknown" causes?[12] A greater rate of deaths reported as abuse or neglect would tend to demonstrate that the interagency teams are more successful at identifying such deaths that might otherwise have been reported as due to natural, accidental or unknown causes than those agencies or counties operating without the benefit of a multidisciplinary approach.

The primary tool used for collection of this information was a lengthy questionnaire (see Appendix 2), which was divided into three sections Section I identified the respondent and provided an overview of each county's investigative system; Section II was geared to counties without interagency teams, and Section III to counties with interagency teams. Initial telephone contact with each county was made to determine (a) the best candidate for receipt of the questionnaire, based on access to the required information as well as willingness to respond, and (b) into which category that county's procedures fit. Based on that telephone contact, each county was sent a letter which further explained the Department of Justice sponsored study, and one copy of the questionnaire containing either Sections I and II, Sections I and III, or all three sections.

Among other things, the questionnaire asked:

- What deaths are investigated? Are there specific criteria for determining which deaths will or will not be investigated? Are fetal deaths, SIDS deaths and adolescent suicides investigated?
- Who decides which deaths are to be investigated?
- What agencies participate in responding to and investigating child deaths? Do the same individuals respond in all cases, or do assignments rotate by shift or some other mechanism? How are these individuals chosen or assigned? Are any private institutions involved in these investigative procedures?
- How is information collected, stored, exchanged and coordinated among individuals and agencies?
- What are the logistics of team operation (time, frequency, duration, staffing, compensation, findings, follow-up, confidentiality, information-sharing, etc.)?
- What are the problems of the current system? How could it be improved?
- What barriers exist to establishment of interagency review? How could those barriers be removed?
- What is the greatest impediment to the identification of child deaths as homicide? Prosecution? Prevention?
- What are the benefits of interagency review? What are the drawbacks?

From responses to the questionnaires, in-depth follow-up studies were conducted in a total of nine counties, six with interagency teams (Los Angeles, Alameda, San Francisco, Santa Clara, San Mateo and Plumas) and three counties without interagency teams (Marin, Tehama and Siskiyou). Topics investigated included the number of cases reviewed/investigated, complaints, prosecutions and convictions which resulted, the use of outside specialists or experts in investigations, categorization of abuse cases, problems encountered, how the present procedure evolved, how it is perceived within the administrative context and by the general public, how responsible agencies and individuals deal with sensitive issues, such as fetal rights, jailed mothers, suicides, how abuses are identified without harassing innocent bereaved families, and keys to both prosecution and preventative intervention. Of special concern were the differing needs and resources of California counties. The key question considered was: Can one interagency child death review protocol be tailored to fit the needs of large, urban counties as well as small, rural counties?

During the course of study, Consultants also attended child death review meetings in three counties: San Francisco, Santa Clara and San Mateo. In addition, Consultants attended workshops sponsored by University of California at Davis Continuing Medical Education, the California State Coroners' Association and the National Center for the Prosecution of

Child Abuse, as well as two working meetings of the Northern California Child Death Review Coalition.

Analysis of questionnaire responses and subsequent follow-up can be found in Section VII, Questionnaire Responses and In-Depth Interviews. In the following section, Consultants provide tables that rank counties with and without teams in terms of total population as well as percentages of urban and rural population. These figures were used as the basis for analyzing the impact of interagency child death review on identification of abuse deaths, as well as assessing the relationship between population and resistance to implementation of interagency child death review protocols.

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[12]Which increase must be distinguished from an actual increase in the occurrence of such deaths.

VI. Statistical Analyses

VI. STATISTICAL ANALYSES

The eight tables that follow show the foundation on which analysis of "large/urban" and "small/rural" counties were formed.

Table 1 gives 1980 Census figures for all counties in California which responded to Consultants' questionnaire. Table 2 ranks in descending order all responding California counties by percentage of urban population (or "most urban"). Conversely, Table 3 ranks in descending order all responding California counties by percentage of rural population (or "most rural"). Table 4 lists all responding California counties with interagency teams in place in descending order of urban population. Conversely, Table 5 lists all responding California counties without interagency teams in descending order of rural population. Table 6 gives county death statistics for the three years considered. Tables 7 and 8, respectively, list counties with and counties without interagency teams in place.

Several general observations can be made from study of the following tables. First, comparison of Tables 1 and 4 shows that the six counties with the largest populations in California--Los Angeles, Orange, San Diego, Santa Clara, Alameda, San Bernardino--have all established interagency child death review teams. Not coincidentally, these same counties also appear as "most urban" in Table 2 (with the exception of San Bernardino, which for the purposes of this study was considered "rural"); on this basis, it can be said that those counties with the highest total population and highest population density have already formed interagency review teams, with the notable exception of Plumas County.[13]

Conversely, comparison of Tables 1 and 5 shows that those counties with the lowest total populations--for instance, Alpine, Sierra, Mono, Modoc, Trinity, Colusa--do not have interagency teams in place. These counties also appear as "most rural" in population density. These figures tend to support the generalization that the smaller, rural California counties do not have interagency child death review teams in place (again, with the exception of Plumas County).

It is immediately clear that child death investigation teams are presently in use in most of the large urban counties and in very few of the small rural counties. To quantify this observation, Consultants divided the counties into three groups on the basis of their degree of urbanization using an arbitrary but perhaps reasonable scale. Each county, and the state as a whole, was ranked by its total population, population per square mile, and percent of its population listed as "urban" by the U. S. Bureau of the Census. The groupings are shown below.

All data are from the 1980 Census; there has been population growth since then but the relative rankings of the counties should not be changed appreciably. The three rankings are averaged to give the composite index. The order shown is that of the rankings so that the lowest counties in one group may not be too different from the highest counties in the next. Approximate ranges are shown, but since the index is a combination of the three characteristics a few of the counties in each group lie outside of the ranges in some of these measures. Despite persistent follow-up, Consultants received only 46 questionnaire

responses, so the discussion is limited to these. The parenthesized counties did not respond.

1. **More urban than the state as a whole; population over 500,000, density over 500/sq. mi. and over 95% urban (except San Diego):**

   Orange, Los Angeles, San Francisco, Alameda, Santa Clara, San Mateo, Sacramento, Contra Costa, San Diego.

2. **Intermediate: Most have populations 100,000 to 500,000, over 75 inhabitants/sq. mi., and over 75% urban:**

   (Ventura), Marin, Solano, San Joaquin, (Riverside), Santa Barbara, (Santa Cruz), Stanislaus, San Bernardino, (Fresno), Sonoma, Monterey, Kern, Yolo, Napa, (Butte), San Luis Obispo, Tulare, (Merced), Placer. San Bernardino County falls into this group despite its larger population because of its enormous geographical area which gives it some of the physical characteristics of rural counties.

3. **Rural: Below the above in most categories:**

   Sutter, Yuba, Kings, Shasta, Imperial, Humboldt, El Dorado, (Madera), Nevada, (Mendocino), San Benito, Tehama, Lake, (Glenn), Del Norte, Amador, Siskiyou, (Tuolomne), Calaveras, Lassen, Colusa, Plumas, Mono, Modoc, Trinity, (Mariposa), (Inyo), Sierra, Alpine.

For the nine large urban counties the establishment of child death review teams is not an issue: All have them, or are in the process of forming them. Twenty-three small rural counties, with the exception of Plumas, do not have the teams. However six others have expressed some interest, and five of these--Amador, Del Norte, Shasta, Siskiyou, and Sutter--are at least in the preliminary discussion stage. In still five others the respondent indicated that a team might be an improvement but that the present demand was not great or county funds and manpower were too tight.

In between these are fourteen counties of moderate size and population density--mostly between 100,000 and 500,000 inhabitants, three-quarters of which are defined as "urban" by the U.S. Census. Six of these have formed teams, all within the last year and a half. These are San Bernardino, Kern, Monterey, Solano, San Luis Obispo, and Yolo. In addition, Placer County is in the process of forming a team, and Marin, Santa Barbara, and Stanislaus have at least had the idea under consideration at one point.

The child death investigation team seems to be an idea whose time has come. More than half of the respondents either have teams or are discussing them, including a number of the

small rural counties. It is now particularly appropriate to evaluate the effectiveness of this approach in order to guide the development of the teams now being organized.

One of the original goals of this study was to determine whether the establishment of interagency child death review committees resulted in the identification of more deaths as being due to abuse rather than apparently natural or unexplained causes. This could be examined in two ways: By asking the respondents whether this had indeed happened, or performing a statistical analysis on the numerical responses to the questionnaire. The latter would involve either looking at individual counties before and after the formation of the team, or comparing the statistics provided by similar counties with and without the teams; these statistics are shown in Table 6.

When the data was received, however, it became immediately apparent that neither of these statistical approaches would be as fruitful as Consultants had initially hoped. Comparisons among counties are hampered by the fact that counties have different criteria for undertaking investigation. One particularly important criterion is the age range of victims: some investigate only very young children's cases while others go up through teenagers, and it is well known that the incidence of fatal child abuse varies strongly with age. Beyond this, quite a number of counties simply do not have accurate statistics on the number of deaths or investigations performed.

Seven counties initiated their teams during the time period under consideration (1986-88). However two of these (Contra Costa and San Bernardino) reported no child death statistics at all. The five counties which have established child death review teams in the past three years and have kept statistics on them are are Kern, Monterey, Solano, San Luis Obispo, and Yolo, all in the medium-sized and semiurban group. They report the total number of child deaths and the number investigated both before and after establishment of the team.

Shown below are the individual and summary statistics for these counties. (For the three which have had teams for a fraction of a year the data were allocated and the numbers rounded off.)

Investigation of Child Deaths
Before and After Team Establishment

County	Reported Deaths Before	Reported Deaths After	Percent Investigated Before	Percent Investigated After
Yolo	28	4	27%	33%
San Luis Obispo	21	6	24%	50%
Solano	151	80	13%	18%
Monterey	89	25	30%	38%
Kern	279	253	26%	34%
TOTAL	568	367	23%	31%

In each county and overall a higher percentage of deaths were investigated after formation of the team. The difference is not large, but it is statistically significant (98% confidence level) and suggests that the establishment of the teams facilitated the investigative process.

[13]With a total population of 17,340 by the 1980 census, there are 34 counties in California with greater total populations than Plumas County that do not have interagency child death review teams in place. Plumas County's unique situation is discussed in Section III, Findings and Recommendations.

VI. Statistical Analyses

TABLE 1; COUNTY POPULATIONS

COUNTY	CO POP	URBAN	RURAL	%URBAN	% RURAL
Los Angeles	7,477,503	7,392,175	85,328	98.86%	1.14%
Orange	1,932,709	1,926,743	5,966	99.69%	.31%
San Diego	1,861,846	1,735,948	125,898	93.24%	6.76%
Santa Clara	1,295,071	1,265,593	29,478	97.72%	2.28%
Alameda	1,105,379	1,093,543	11,836	98.93%	1.07%
San Bernardino	895,016	806,186	88,830	90.08%	9.92%
Sacramento	783,381	752,273	31,108	96.03%	3.97%
San Francisco	678,974	678,974	0	100%	%
Riverside	663,166	546,758	116,408	82.45%	17.55%
Contra Costa	656,380	636,942	19,438	97.04%	2.96%
San Mateo	587,329	576,692	10,637	98.19%	1.81%
Ventura	529,174	500,572	28,602	94.59%	5.41%
Fresno	514,621	403,101	111,520	78.33%	21.67%
Kern	403,089	330,498	72,591	81.99%	18.01%
San Joaquin	347,342	285,979	61,363	82.33%	17.67%
Sonoma	299,681	197,885	101,796	66.03%	33.97%
Santa Barbara	298,694	271,339	27,355	90.84%	9.16%
Monterey	290,444	224,922	65,522	77.44%	22.56%
Stanislaus	265,900	215,205	50,695	80.93%	19.07%
Tulare	245,738	153,219	92,519	62.35%	37.65%
Solano	235,203	221,630	13,573	94.23%	5.77%
Marin	222,568	207,665	14,903	93.3%	6.7%
Santa Cruz	188,141	153,185	34,956	81.42%	18.58%
San Luis Obispo	155,435	117,911	37,524	75.86%	24.14%
Butte	143,851	101,929	41,922	70.86%	29.14%
Merced	134,560	83,788	50,772	62.27%	37.73%
Placer	117,247	59,090	58,157	50.4%	49.6%
Shasta	115,715	63,435	52,280	54.82%	45.18%
Yolo	113,374	92,877	20,497	81.92%	18.08%
Humboldt	108,514	61,188	47,326	56.39%	43.61%
Napa	99,199	80,185	19,014	80.83%	19.17%
Imperial	92,110	64,250	27,860	69.75%	30.25%
El Dorado	85,812	36,480	49,332	42.51%	57.49%
Kings	73,738	48,913	24,825	66.33%	33.67%
Mendocino	66,738	21,062	45,676	31.56%	68.44%
Madera	63,116	30,126	32,990	47.73%	52.27%
Sutter	52,246	35,017	17,229	67.02%	32.98%
Nevada	51,645	6,697	44,948	12.97%	87.03%
Yuba	49,733	35,522	14,211	71.43%	28.57%
Siskiyou	39,732	11,632	28,100	29.28%	70.72%
Tehama	38,888	14,235	24,653	36.61%	63.39%
Lake	36,366	8,658	27,708	23.81%	76.19%
Tuolumne	33,928	3,247	30,681	9.57%	90.43%
San Benito	25,005	11,488	13,517	45.94%	54.06%
Lassen	21,661	6,520	15,141	30.1%	69.9%
Glenn	21,350	8,808	12,542	41.26%	58.74%
Calaveras	20,710	0	20,710	%	100%
Amador	19,314	0	19,314	%	100%
Del Norte	18,217	5,921	12,296	32.5%	67.5%
Inyo	17,895	3,333	14,562	18.63%	81.37%
Plumas	17,340	4,451	12,889	25.67%	74.33%
Colusa	12,791	4,075	8,716	31.86%	68.14%
Trinity	11,858	2,787	9,071	23.5%	76.5%
Mariposa	11,108	0	11,108	%	100%
Modoc	8,610	3,025	5,585	35.13%	64.87%
Mono	8,577	3,929	4,648	45.81%	54.19%
Sierra	3,073	0	3,073	%	100%
Alpine	1,097	0	1,097	%	100%

TABLE 2, "MOST URBAN"

COUNTY	CO POP.	URBAN	RURAL	%URBAN	% RURAL
San Francisco	678,974	678,974	0	100%	%
Orange	1,932,709	1,926,743	5,966	99.69%	31%
Alameda	1,105,379	1,093,543	11,836	98.93%	1.07%
Los Angeles	7,477,503	7,392,175	85,328	98.86%	1.14%
San Mateo	587,329	576,692	10,637	98.19%	1.81%
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Imperial	92,110	64,250	27,860	69.75%	30.25%
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Kings	73,738	48,913	24,825	66.33%	33.67%
Sonoma	299,681	197,885	101,796	66.03%	33.97%
Tulare	245,738	153,219	92,519	62.35%	37.65%
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Placer	117,247	59,090	58,157	50.4%	49.6%
Madera	63,116	30,126	32,990	47.73%	52.27%
San Benito	25,005	11,488	13,517	45.94%	54.06%
Mono	8,577	3,929	4,648	45.81%	54.19%
El Dorado	85,812	36,480	49,332	42.51%	57.49%
Glenn	21,350	8,808	12,542	41.26%	58.74%
Tehama	38,888	14,235	24,653	36.61%	63.39%
Modoc	8,610	3,025	5,585	35.13%	64.87%
Del Norte	18,217	5,921	12,296	32.5%	67.5%
Colusa	12,791	4,075	8,716	31.86%	68.14%
Mendocino	66,738	21,062	45,676	31.56%	68.44%
Lassen	21,661	6,520	15,141	30.1%	69.9%
Siskiyou	39,732	11,632	28,100	29.28%	70.72%
Plumas	17,340	4,451	12,889	25.67%	74.33%
Lake	36,366	8,658	27,708	23.81%	76.19%
Trinity	11,858	2,787	9,071	23.5%	76.5%
Inyo	17,895	3,333	14,562	18.63%	81.37%
Nevada	51,645	6,697	44,948	12.97%	87.03%
Tuolumne	33,928	3,247	30,681	9.57%	90.43%
Calaveras	20,710	0	20,710	%	100%
Amador	19,314	0	19,314	%	100%
Mariposa	11,108	0	11,108	%	100%
Sierra	3,073	0	3,073	%	100%
Alpine	1,097	0	1,097	%	100%

TABLE 3; "MOST RURAL"

COUNTY	CO POP.	URBAN	RURAL	%URBAN	% RURAL
Calaveras	20,710	0	20,710	%	100 %
Amador	19,314	0	19,314	%	100 %
Mariposa	11,108	0	11,108	%	100 %
Sierra	3,073	0	3,073	%	100 %
Alpine	1,097	0	1,097	%	100 %
Tuolumne	33,928	3,247	30,681	9.57%	90.43%
Nevada	51,645	6,697	44,948	12.97%	87.03%
Inyo	17,895	3,333	14,562	18.63%	81.37%
Trinity	11,858	2,787	9,071	23.5%	76.5%
Lake	36,366	8,658	27,708	23.81%	76.19%
Plumas	17,340	4,451	12,889	25.67%	74.33%
Siskiyou	39,732	11,632	28,100	29.28%	70.72%
Lassen	21,661	6,520	15,141	30.1%	69.9%
Mendocino	66,738	21,062	45,676	31.56%	68.44%
Colusa	12,791	4,075	8,716	31.86%	68.14%
Del Norte	18,217	5,921	12,296	32.5%	67.5%
Modoc	8,610	3,025	5,585	35.13%	64.87%
Tehama	38,888	14,235	24,653	36.61%	63.39%
Glenn	21,350	8,808	12,542	41.26%	58.74%
El Dorado	85,812	36,480	49,332	42.51%	57.49%
Mono	8,577	3,929	4 648	45.81%	54.19%
San Benito	25,005	11,488	13,517	45.94%	54.06%
Madera	63,116	30,126	32,990	47.73%	52.27%
Placer	117,247	59,090	58,157	50.4%	49.6%
Shasta	115,715	63,435	52,280	54.82%	45.18%
Humboldt	108,514	61,188	47,326	56.39%	43.61%
Merced	134,560	83,788	50,772	62.27%	37.73%
Tulare	245,738	153,219	92,519	62.35%	37.65%
Sonoma	299,681	197,885	101,796	66.03%	33.97%
Kings	73,738	48,913	24,825	66.33%	33.67%
Sutter	52,246	35,017	17,229	67.02%	32.98%
Imperial	92,110	64,250	27,860	69.75%	30.25%
Butte	143,851	101,929	41,922	70.86%	29.14%
Yuba	49,733	35,522	14,211	71.43%	28.57%
San Luis Obisp	155,435	117,911	37,524	75.86%	24.14%
Monterey	290,444	224,922	65,522	77.44%	22.56%
Fresno	514,621	403,101	111,520	78.33%	21.67%
Napa	99,199	80,185	19,014	80.83%	19.17%
Stanislaus	265,900	215,205	50,695	80.93%	19.07%
Santa Cruz	188,141	153,185	34,956	81.42%	18.58%
Yolo	113,374	92,877	20,497	81.92%	18.08%
Kern	403,089	330,498	72,591	81.99%	18.01%
San Joaquin	347,342	285,979	61,363	82.33%	17.67%
Riverside	663,166	546,758	116,408	82.45%	17.55%
San Bernardin	895,016	806,186	88,830	90.08%	9.92%
Santa Barbara	298,694	271,339	27,355	90.84%	9.16%
San Diego	1,861,846	1,735,948	125,898	93.24%	6.76%
Marin	222,568	207,665	14,903	93.3%	6.7%
Solano	235,203	221,630	13,573	94.23%	5.77%
Ventura	529,174	500,572	28,602	94.59%	5.41%
Sacramento	783,381	752,273	31,108	96.03%	3.97%
Contra Costa	656,380	636,942	19,438	97.04%	2.96%
Santa Clara	1,295,071	1,265,593	29,478	97.72%	2.28%
San Mateo	587,329	576,692	10,637	98.19%	1.81%
Los Angeles	7,477,503	7,392,175	85,328	98.86%	1.14%
Alameda	1,105,379	1,093,543	11,836	98.93%	1.07%
Orange	1,932,709	1,926,743	5,966	99.69%	31%
San Francisco	678,974	678,974	0	100%	%

TABLE 4; COUNTIES WITH TEAMS

COUNTY	CO.POP.	URBAN	RURAL	% URBAN	% RURAL
SanFrancisco	678,974	678,974	0	100.%	.%
Orange	1,932,709	1,926,743	5,966	99.69%	.31%
Alameda	1,105,379	1,093,543	11,836	98.93%	1.07%
LosAngeles	7,477,503	7,392,175	85,328	98.86%	1.14%
SanMateo	587,329	576,692	10,637	98.19%	1.81%
SantaClara	1,295,071	1,265,593	29,478	97.72%	2.28%
ContraCosta	656,380	636,942	19,438	97.04%	2.96%
Ventura	529,174	500,572	28,602	94.59%	5.41%
Solano	235,203	221,630	13,573	94.23%	5.77%
SanDiego	1,861,846	1,735,948	125,898	93.24%	6.76%
SanBernardino	895,016	806,186	88,830	90.08%	9.92%
Riverside	663,166	546,758	116,408	82.45%	17.55%
Kern	403,089	330,498	72,591	81.99%	18.01%
Yolo	113,374	92,877	20,497	81.92%	18.08%
Monterey	290,444	224,922	65,522	77.44%	22.56%
SanLuisObispo	155,435	117,911	37,524	75.86%	24.14%
Plumas	17,340	4,451	12,889	25.67%	74.33%

TABLE 5; COUNTIES WITHOUT TEAMS

COUNTY	CO.POP.	URBAN	RURAL	%URBAN	% RURAL
Alpine	1,097	0	1,097	.%	100.%
Sierra	3,073	0	3,073	.%	100.%
Mariposa	11,108	0	11,108	.%	100.%
Amador	19,314	0	19,314	.%	100.%
Calaveras	20,710	0	20,710	.%	100.%
Tuolumne	33,928	3,247	30,681	9.57%	90.43%
Nevada	51,645	6,697	44,948	12.97%	87.03%
Inyo	17,895	3,333	14,562	18.63%	81.37%
Trinity	11,858	2,787	9,071	23.5%	76.5%
Lake	36,366	8,658	27,708	23.81%	76.19%
Siskiyou	39,732	11,632	28,100	29.28%	70.72%
Lassen	21,661	6,520	15,141	30.1%	69.9%
Mendocino	66,738	21,062	45,676	31.56%	68.44%
Colusa	12,791	4,075	8,716	31.86%	68.14%
DelNorte	18,217	5,921	12,296	32.5%	67.5%
Modoc	8,610	3,025	5,585	35.13%	64.87%
Tehama	38,888	14,235	24,653	36.61%	63.39%
Glenn	21,350	8,808	12,542	41.26%	58.74%
ElDorado	85,812	36,480	49,332	42.51%	57.49%
Mono	8,577	3,929	4,648	45.81%	54.19%
SanBenito	25,005	11,488	13,517	45.94%	54.06%
Madera	63,116	30,126	32,990	47.73%	52.27%
Placer	117,247	59,090	58,157	50.4%	49.6%
Shasta	115,715	63,435	52,280	54.82%	45.18%
Humboldt	108,514	61,188	47,326	56.39%	43.61%
Merced	134,560	83,788	50,772	62.27%	37.73%
Tulare	245,738	153,219	92,519	62.35%	37.65%
Sonoma	299,681	197,885	101,796	66.03%	33.97%
Kings	73,738	48,913	24,825	66.33%	33.67%
Sutter	52,246	35,017	17,229	67.02%	32.98%
Imperial	92,110	64,250	27,860	69.75%	30.25%
Butte	143,851	101,929	41,922	70.86%	29.14%
Yuba	49,733	35,522	14,211	71.43%	28.57%
Fresno	514,621	403,101	111,520	78.33%	21.67%
Napa	99,199	80,185	19,014	80.83%	19.17%
Stanislaus	265,900	215,205	50,695	80.93%	19.07%
SantaCruz	188,141	153,185	34,956	81.42%	18.58%
SanJoaquin	347,342	285,979	61,363	82.33%	17.67%
SantaBarbara	298,694	271,339	27,355	90.84%	9.16%
Marin	222,568	207,665	14,903	93.3%	6.7%
Sacramento	783,381	752,273	31,108	96.03%	3.97%

TABLE 6

TOTAL DEATHS AND
DEATHS INVESTIGATED,
MEDIUM AND SMALL COUNTIES

County	Team?	Total Population	Total Deaths	Deaths Investigated	% Investigated
Marin	N	222,568	17	17	100.0%
Solano	Y	235,203	231	34	14.7%
San Joaquin	N	347,342	83	NA	NA
Santa Barbara	N	298,694	33	NA	NA
Stanislaus	N	265,900	312	81	26.0%
San Bernardino	Y	895,016	807	NA	NA
Monterey	Y	290,444	114	36	31.6%
Kern	Y	403,089	531	157	29.6%
Yolo	Y	113,374	32	9	28.1%
Napa	N	99,199	25	25	100.0%
San Luis Obispo	Y	155,435	27	8	29.6%
Tulare	N	245,738	168	36	21.4%
Placer	N	117,247	47	17	36.2%
Yuba	N	49,733	NA	0	NA
Kings	N	73,738	47	23	48.9%
Shasta	N	115,715	101	32	31.7%
Imperial	N	92,110	36	26	72.2%
Humboldt	N	108,514	7	1	14.3%
El Dorado	N	85,812	47	47	100.0%
Nevada	N	51,645	31	16	51.6%
San Benito	N	25,005	18	13	72.2%
Tehama	N	38,888	15	11	73.3%
Lake	N	36,366	8	8	100.0%
Amador	N	19,314	1	1	100.0%
Siskiyou	N	39,732	28	19	67.9%
Calaveras	N	20,710	10	1	10.0%
Lassen	N	21,661	1	0	0.0%
Colusa	N	12,791	11	9	81.8%
Mono	N	8,577	4	1	25.0%
Plumas	Y	17,340	7	5	71.4%
Modoc	N	8,610	8	3	37.5%
Trinity	N	11,858	13	0	0.0%
Sierra	N	3,073	0	0	NA
Alpine	N	1,097	1	1	100.0%

Notes: For a number of counties, "total deaths" is actually total coroner's cases, and, as such, all were investigated. Several counties reported neither of these figures and were omitted from the table.

TABLE 7

COUNTIES WITH INTERAGENCY TEAMS;
LENGTH OF OPERATION

COUNTY	YEARS
Alameda	3
Contra Costa	1
Kern	1.5
Los Angeles	11
Monterey	8 mos
Orange	3
Plumas	4
Riverside	1
San Bernardino	4 mos
San Diego	7
San Francisco	5
San Luis Obispo	1
San Mateo	4
Santa Clara	3 .5
Solano	1
Ventura	1
Yolo	5 mos

TABLE 8

COUNTIES WITHOUT INTERAGENCY
CHILD DEATH INVESTIGATION TEAMS
IN PLACE

Alpine	Mono
Amador	Napa*
Butte	Nevada
Calaveras	Placer*
Colusa	Sacramento*
Del Norte*	San Benito
El Dorado	San Joaquin
Fresno	Santa Barbara
Glenn	Santa Cruz
Humboldt	Shasta*
Imperial	Sierra
Inyo	Siskiyou*
Kings	Sonoma
Lake	Stanislaus
Lassen	Sutter*
Madera	Tehama
Marin	Trinity
Mariposa	Tulare
Mendocino	Tuolumne
Merced	Yuba
Modoc	

*Now in the process of forming teams.

VII. Questionnaire Responses and In-Depth Interviews

VII. Questionnaire Responses and In-Depth Interviews

This section summarizes Consultants' findings based on analysis of questionnaires and information obtained through telephone and on-site interviews.

The findings below reveal strong support for the interagency approach in counties that have teams, as well as widespread acceptance of the importance of communication and cooperation between agencies responsible for investigation of child fatalities. Where Consultants noted resistance to interagency teams, this resistance is directed toward mandated procedures. Consultants also found overwhelming support for the development of interagency child death investigation and review protocols, as well as strong support for increased training in issues relating to child homicide.

All 58 California counties were sent questionnaires. Of these, 46 counties completed and returned questionnaires. Those counties that returned completed questionnaires are listed below:

Alameda
Alpine
Amador
Calaveras
Colusa
Contra Costa
Del Norte
El Dorado
Humboldt
Imperial
Kern
Kings
Lake
Lassen
Los Angeles
Marin
Modoc
Mono
Monterey
Napa
Nevada
Orange
Placer
Plumas
Sacramento
San Benito
San Bernardino
San Diego
San Francisco
San Joaquin
San Luis Obispo
San Mateo
Santa Barbara
Santa Clara
Shasta
Sierra
Siskiyou
Solano
Sonoma
Stanislaus
Sutter
Tehama
Trinity
Tulare
Yolo
Yuba

Thirteen counties did not return completed questionnaires:

Butte
Fresno
Glenn
Inyo
Madera
Mariposa
Mendocino
Merced
Riverside
Santa Cruz
Tuolumne
Ventura

In addition to study of completed questionnaires, Consultants also attended child death review meetings in three counties: San Francisco, Santa Clara and San Mateo. Consultants conducted telephone and personal interviews with individuals representing nine California counties: Tehama, Marin, Siskiyou, San Mateo, Santa Clara, San Francisco, Los Angeles, Plumas and Alameda. In addition, Consultants attended workshops sponsored by University of California at Davis Continuing Medical Education, the California State Coroners' Association and the National Center for the Prosecution of Child Abuse, as well as two working meetings of the Northern California Child Death Review Coalition.

General Observations and Findings

Analysis of questionnaire responses yielded four findings with special significance for Phases II and III of the subject State Department of Justice project.

1. 15/15 of the responding counties with teams in place agreed that the team approach is an improvement over previous arrangements for investigation of child deaths. 14/31 responding counties without teams thought the team approach would be an improvement over their present system and 1/31 did not (five were unsure or did not answer).

2. 33/46 respondents agreed that networking between the responsible agencies was an important means of overcoming impediments to identification, prosecution and prevention of child homicides; of these 33, 26 insisted such networking is essential.

3. 38/46 respondents thought written child death investigation protocols would be useful. 22/46 agreed that written protocols must be flexible, and available as guidelines rather than mandated as legally required procedures. 40/46 respondents thought written autopsy protocols would be useful, though 14/46 thought such protocols should be flexible.

4. 41/46 regarded training of the various disciplines in identification of child homicides due to abuse and neglect as important and useful. 37/46 thought training in investigation, legal and medical aspects of identifying child homicides would be useful to some degree; 37/46 thought training in investigation techniques would be helpful (of these

37, 29 thought such training was essential); 37/46 thought training in legal issues would be helpful (of these 37, 21 thought it was essential); and 36/46 thought training in medical issues would be helpful (of these 36, 21 thought such training was essential).

Finding 1 reveals unanimous agreement that the interagency approach works in counties that have review teams in place; however, opinion is mixed among counties that do not have such teams in place.

Finding 2 suggests that the concept of communication and cooperation between agencies is well-accepted. While Consultants noted some resistance to the idea of mandated interagency teams in counties without teams, the resistance is not directed toward the basic concept of interagency coordination, but rather toward mandated systems and procedures for such coordination.

Finding 3 reveals widespread support for the development of written interagency child death investigation and review protocols. It is interesting to note that, of the 12/31 responding counties without teams that did not think such an approach would be an improvement over their present system, 8/12 still thought written protocols would be useful. Note that, of the five counties which were either unsure the team approach would be an improvement or did not answer, all five agreed written child death investigation protocols would be useful.

Finding 4 suggests strong support for increased training in issues relating to child homicide. Questionnaire review also showed substantial agreement among responding counties as to who needs training; 24/46 agreed that "first responders" needed training, and 18/46 wanted education and training for emergency room personnel.

Taken together, these findings show strong statewide support for the writing of interagency child death review protocols (Phase II) and for subsequent training in their implementation and use (Phase III).

How Do Interagency Child Death Review Teams Work?

Seventeen California counties have interagency child death review teams in place; of these, fifteen returned completed questionnaires. These counties are listed in Table 7. Based on these responses, the following observations can be made regarding the typical operating format of such teams.

Interagency child death review teams generally are made up of representatives from the coroner's office, various social service agencies, law enforcement and local hospitals. Team membership varies from county to county; consistent members include representatives of the coroner or sheriff/coroner's office and child protective services, public health and social services departments (15/15). Most teams have regular members from the district attorney's office (13/15), local law enforcement agencies (12/15), child abuse prevention organizations (12/15), local hospitals (10/15), sheriff's department (7/15), the field of pediatrics (7/15), mental health department (5/15), the field of pathology (4/15), probation (4/15), Youth Guidance Center (1/15), the juvenile division of local law enforcement (1/15) and representatives of the local school districts (1/15).

The teams generally meet at regular intervals; 10/15 meet monthly (2/15 meet monthly but skip three months in summer); 4/15 meet quarterly, and one meets every six weeks. Team membership and representation often fluctuates; 9/15 reported that membership stayed the same from meeting to meeting, while 6/15 reported that membership changed, often due to rotating assignments within the various branches of law enforcement. In all cases, representative time in attending and preparing for review meetings is "donated" by their participating agencies, as representatives meet during their agencies' regular business hours. No team has its own support staff, and several (3/15) mentioned that this was a problem; clerical support for team activities (copying, mailing, typing agenda, worksheets, etc.) is provided by representatives or support staff at the participating agencies. 14/15 circulate review materials prior to the meeting, which materials may include agendas of cases to be discussed, death certificates, coroner investigator reports, police and medical reports, agency records or standard team worksheets (3/15 have standard forms that are filled out and circulated prior to meeting; these are attached as Appendix 3).

Typically, only cases referred to the county coroner are reviewed. Certain classes of deaths require coroner review under Government Code 27491.[14] As not all deaths are reported to the coroner, this means only a fraction of the total number of child fatalities are subject to coroner examination. If the attending physician is willing to sign a death certificate, such cases are not reported to the coroner. Respondents in counties with and without teams noted a concern that some child homicides might thus go unreported: "If the death is handled as a doctor's case it may not even be reported to the coroner."

In accordance with Government Code Section 27491, all SIDS and child suicides are investigated; this is standard practice in counties with and without interagency teams.

Of the total number of coroner cases, some or all child fatalities may be referred to the interagency review team, depending on the criteria established by the team. In San Diego County, for instance, the team reviews all child deaths under the age of seven years; in Santa Clara County, the Public Health Nurse selects coroner cases for specific criteria (based on the Los Angeles model) for review by the team.

The majority of teams (12/15) keep records of cases reviewed; 10/15 have policies regarding confidentiality of review materials and team deliberations. 9/15 do not have a policy regarding the media or media coverage of team activities.

At the meeting, each case is identified, and representatives report on their search of agency records for previous dealings with the child or the child's family. Medical evidence is discussed by the coroner or hospital representative. Law enforcement representatives report on his or her investigation of the scene and/or prior involvement with the child or family; if other agencies had prior contact with the child or family, a summary of those dealings may be shared.

After discussion, the team will mutually determine whether or not any action or recommendation is indicated. The team may decide that further information or inquiry is necessary, and one or more representatives will undertake to obtain that information and

report at the next session. The majority of teams (11/15) reported that they will discuss or review a case until a consensus of opinion is reached. The team may decide to take no further action pending completion of an active police investigation, or pending resolution of pending criminal charges. 8/15 have no policy regarding team review of matters under law enforcement investigation or criminal proceedings; 2/15 will not review cases under investigation or adjudication; 4/15 exclude only cases in which criminal charges have been filed and are actually in the process of adjudication. The team may identify some administrative or agency oversight and recommend procedural improvements; the team may decide to take some other sort of preventative action--for instance, in one case, the San Francisco team wrote a letter to a certain toy manufacturer, requesting that it redesign a rocking horse on which too-vigorous play resulted in tipping over backwards, causing several fatal injuries. 12/15 continue to monitor cases after review by the team; 7/15 have an informational "loop" in place, to notify other involved agencies of team review of a given case, or of the outcome of team review.

The majority of counties with interagency teams in place have written protocols (10/15), as compared with counties without interagency teams in place, in which only a minority (4/31) had written protocols for child death investigation. These are attached as Appendix 4. Note that the protocols varied in complexity and inclusiveness, from a brief statement of criteria of deaths to be reviewed by the team, to the 76 page protocols published by the Los Angeles death review team and used as a guide by a number of teams.

Each county system is different, yet most share certain common features. Below is a listing of the more common activities:

- Total body X-rays in some cases, to find previous fractures;
- Review of fetal deaths for cause issues, such as prenatal drug use;
- Toxic screening to detect prenatal and postnatal exposure to drugs and chemicals;
- HIV testing in fetal and infant deaths cases possibly involving drugs;
- Accurate measurements of height and weight to measure possible failure to thrive;
- Review of field deaths paired with maternal trauma or homicide to follow criminal action and involve previous caretakers in looking for risk factors;
- Review of child suicide for previous record of abuse.

Other common features of interagency review are policy-oriented. Some common policy-oriented features are:

- Involvement of support groups, grief counseling and treatment for surviving siblings and other family members in SIDS and other unexpected child and infant deaths;
- Focus on preventable aspects of child deaths, regardless of nature or cause;

- Focus on improvement of delivery of service to children and their families, rather than assessment of blame or responsibility on agencies or agency personnel;

- Systematic multi-agency data collection and manipulation to monitor and direct intra- and interagency case management and to give direction to future prevention programs;

- In-house review for separate agencies to find and correct intra-agency deficiencies;

- Interagency peer review of apparent deficiencies to build and maintain a more efficient and effective system.

There was substantial agreement (14/15) among counties with teams that written protocols would be helpful. The objection of the one dissenting county was not to a written protocol per se, but rather was based on the opinion that "a single, written protocol would not be effective throughout the state." Seven other counties with teams agreed with this sentiment, suggesting that such protocols not be "set in stone," but serve as flexible, discretionary guidelines allowing for the differences in staffing, manpower and financial resources available in small and large counties (8/15).

It is worth noting that concern for the flexibility of any written guidelines was proportionally stronger in counties with teams than in those without. One county was concerned that mandated protocols would lead to "time-consuming forms" and burdensome paperwork. Two counties saw no problems at all with written protocols. One suggested protocols would provide "direction, efficiency and accountability;" on the other hand, the specter of accountability prompted one respondent to worry that protocols might induce "paranoia." Two counties observed that effective use of protocols would depend on adequate training; one observed that the protocols would be "only as good as the professional involved."

There was also agreement (14/15) that written autopsy protocols would be beneficial; the sole dissent was again based on concerns regarding the applicability of a single protocol across the State:

> The protocols will be only as effective as adequately trained forensic pathologists are available. Most communities do not have that capability. Setting forth a protocol requiring x-rays, cultures, or certain types of examination is unlikely to succeed without trained individuals to perform the work. The funding and public recognition of this work will have to be established first.

Many respondents agreed with this perspective, recommending that any written autopsy protocols be available as flexible guidelines rather than legal mandates (10/15), with 3/15 pointing to budgetary restrictions, 3/15 to coroner resistance, and one each citing lack of adequate personnel and training.

Counties with teams were unanimous regarding the utility of training in identifying, verifying, prosecuting and preventing child homicides. 15/15 thought some kind of training would be useful to some degree; all thought training in investigative techniques was useful (of these 15, 12 thought it was essential), 14 thought training in legal issues would be helpful (of these 14, 8 thought it was essential), and 14 thought training in medical issues would be helpful (of these 14, 11 thought it was essential).

There was also substantial agreement as to who most needed training; 7/15 thought "first responders" needed training in identifying suspicious deaths or injuries as well as preservation of evidence; 4/15 thought that emergency room medical staff and law enforcement personnel needed training; 2/15 thought all "mandated reporters" needed ongoing education and training; two thought doctors needed training, two pointed to the education needs of coroners and their investigators, and two mentioned training for judges and attorneys. Los Angeles' list was longest and included:

> All professionals working with high risk pregnancies, infants and young toddlers[,] includ[ing] coroner/ME, L[aw] E[nforcement], City Attorney, Public Defender, C[hild]P[rotective] S[ervices], Health, Mental and Public; probation, parole, Regional Centers, Substance Abuse, Women's shelters.

In ranking the usefulness of networking, child abuse "hot lines" and community education/outreach programs in identifying, verifying, prosecuting and preventing child homicides, each respondent thought such programs were useful to some degree; all thought "hot lines" were helpful (6/15 found them essential), and all thought community outreach and education were useful (6/15 thought they were essential). Somewhat surprisingly, there was less than unanimous agreement among counties with interagency teams on the importance of networking among disciplines. Only 14/15 thought it was essential, while one found networking among agencies was not useful at all.

Assessing The Impact of Interagency Child Death Review[15]

Counties with teams agreed unanimously (15/15) that the interagency review team approach was an improvement over their county or agency's previous child death investigation procedures. However, assessing the criteria for "improvement" was somewhat problematic.

Consultants offered three criteria for assessing the impact of interagency child death review: Whether the team was able to handle more cases or dispose of them more quickly than the previous system; whether the county now identified a higher percentage of deaths as being related to child abuse or neglect than previously; and whether the formation of the team had improved communication and coordination between the various responsible agencies.

When asked if the interagency approach allowed the county to handle more cases or dispose of them more quickly than the previous system, only four answered "yes," while two said "no" (seven either did not answer the question or did not know). When asked if their county was able to identify a higher percentage of deaths as related to abuse, five

answered "yes," and six answered "no" (three either did not answer the question or did not know). However, there was unanimous agreement (15/15) that the team had improved coordination and communication among the agencies responsible for child death investigation.

In other words, from an outside perspective, there may be a desire to judge the success of the interagency approach in statistical terms (i.e., a higher rate of identification of child homicides). However, from the "inside," the agencies and individuals actually implementing the interagency process tend to define "success" in overall terms of improving the institutional response to child death.

Further, there was strong agreement among counties with teams and substantial agreement among counties without teams that the most essential ingredients in any successful system for child death investigation were cooperation, communication and commitment. Counties without teams pointed out that their lines of communication perhaps worked just as well if not better than the formal systems of larger communities; Mono County wrote:

> Informed communication is the most important ingredient. Our county agencies are so small, and so close together, with so little activity that this communication and cooperation takes place with no problem whatsoever. We have no protocols or formal review process, but as can be seen a formal review process is not required in a county of our stature.

Counties with interagency teams were asked to identify problems they may have encountered; 5/15 responded that, to date, they had not encountered any problems; 3/15 noted the need for clerical and other support for team activities; 2/15 mentioned problems of confidentiality and agency resistance to sharing information; 4/15 the failure of all agencies to fully participate; 4/15 mentioned the failure of agencies to follow their own procedures, adequately check their records or follow through with assigned tasks. Turnover of agency personnel was also noted as a problem (1/15), as well as the fact that the work itself was difficult and depressing (1/15). However, 6/15 reported that their problems were soluble, and they were attempting to institute new procedures to overcome them.

How Does Child Death Investigation Work in Counties Without Teams?

41 California counties do not have formal interagency child death review teams in place. These counties are listed in Table 8. In all of the 31 counties that returned completed questionnaires, the coroner or sheriff/coroner's office was the primary agency responsible for child death investigation. All reported working with law enforcement agencies having jurisdiction in each case. Though these counties do not have a formal team which meets on a regular basis, all reported informal ties with other agencies, including sheriff's department, county health officer, child protective services and local hospitals. Almost all (26/31) reported use of outside specialists, particularly forensic pathologists; this is especially true in counties in which the sheriff/coroner is an administrative position held by individuals with law enforcement rather than medical training.

With the exception of certain obvious deaths (such as those occurring in hospices or as the result of automobile accidents) all counties reported conducting full investigations of all reported coroner cases. A full coroner's investigation might include contact with family, pertinent witnesses, police and medical persons who may have knowledge of the case, as well as autopsy, X-rays, drug toxicology and histological slides. Several counties (4/31) reported that all deaths are treated as homicides until proven otherwise. In accordance with Government Code Section 27491, all SIDS and child suicides are investigated by the coroner.

Counties without teams were divided on the question of whether the team approach would be an improvement over their present system. 14 thought it would, while 12 thought it would not (two were unsure and three gave no answer). Of those that did not think the team approach would be an improvement and explained their reasons, four thought their present system was adequate as it was, two thought it would be a "waste of time"--one because the county had so few child fatalities, the other because it would create needless paperwork and another presumably useless committee--and one objected to the likely "intrusion" of individuals without appropriate law enforcement and medical training.

Nearly all (25/31) responding counties thought written protocols for the investigation and review of child fatalities would be helpful. It is interesting to note that of the 12 counties who thought the interagency team approach would not be an improvement over their present system, eight still thought written protocols would be useful; both counties who were unsure whether the team approach would be an improvement nonetheless agreed that written protocols would be useful.

Regarding limitations or obstacles to the use of protocols, some respondents (4/31) noted the difficulty of getting the different agencies involved to go along: "In our county, no agency wants another agency to tell them what to do." Others noted concern that smaller counties would find themselves "tied to a large district's rules," without the necessary personnel (2/31), ongoing caseload (1/31) or the financial resources (4/31) of larger counties; other counties saw no problems with written protocols (6/31), though "guidelines" were preferred to mandated protocols (2/31).

Nearly all (26/31) responding counties without interagency review teams thought written autopsy or post-mortem examination protocols would be helpful. Some saw no problems with instituting autopsy protocols (5/31), while others (4/31) repeated concern that protocols be flexible guidelines rather than mandatory procedures; lack of training was cited as an obstacle to autopsy protocol implementation (2/31); other respondents agreed that getting cooperation would be a problem (4/31). One county expressed the opinion that protocols were not a good idea because their use would "make all investigations uniform," implying a possible inhibition of the coroner's investigation.

Of the 12 counties reporting the opinion that the interagency approach would not be an improvement over their present system, none reported that the team approach was being considered or in the formation stage in their county. Neither did these 12 counties report any difficulty in sharing information with other agencies.

Of the 14 responding counties who thought the approach would be an improvement, four reported that their county was neither considering nor in the process of forming an interagency team; two reported that their county had considered implementing a team but had gone no further with the idea. Seven counties reported they are now in the process of forming interagency review teams; three are in the preliminary discussion stage, three have reached the selection of team member stage, and one has gone so far as to draft protocols for review by agency heads. As stated above, none of the 12 counties that believed the interagency approach would be an improvement over their present system reported any difficulty in sharing information with other agencies; it is interesting to note that of the five counties that did report difficulty in sharing information with other agencies, all five are in the process of forming interagency review teams.

Of the 24 counties that ranked the usefulness of networking, child abuse "hot lines" and community education/outreach programs in identifying, verifying, prosecuting and preventing child homicides, 23/24 thought such programs were useful to some degree; 22/24 thought networking with other disciplines was helpful (of these 22, 14 found it essential), 20/24 thought "hot lines" were helpful (of these 20, 4 found them essential), and 22/24 thought community outreach and education programs were useful (of these 22, 5 thought they were essential).

Counties without teams were nearly unanimous in their opinion of training in identification and review of suspicious child deaths. 27/31 thought such training would be useful, while only three thought it would not (one county gave no response). Of the 24 counties that ranked the usefulness of investigative, legal and medical training, almost all (23/24) thought some kind of training would be useful to some degree; 22/24 thought training in investigative techniques was useful (of these 22, 17 thought it was essential), 23/24 thought training in legal issues would be helpful (of these 23, 13 thought it was essential), and 22/24 thought training in medical issues would be helpful (of these 22, 10 thought it was essential).

There was also strong agreement as to who most needed training; 17/31 wanted training of "first responders" (those dispatched through "911" calls--ambulance drivers, fire-fighters, patrol officers) in identifying suspicious deaths or injuries as well as preservation of evidence; 14/31 thought emergency room medical staff needed training in detecting child abuse; 7/31 wanted training for law enforcement personnel; 5/31 thought coroners and their investigators would benefit from training; 3/31 listed training of teachers and school administrators; 2/31 thought doctors needed training, and one each thought day care workers, Child Protective Services personnel, probation, district attorneys and judges needed training. One respondent thought "everyone involved" needed training.

Consultants also asked the counties to respond to a number of open-ended questions designed to elicit respondent opinions and ideas. Among other questions, Consultants asked what, in respondent's opinion, was the purpose of child death review; what was the greatest impediment in their county to the formation of an interagency child death review team; what limitations they saw to the use of child death investigation protocols; and what they saw as the most essential ingredient in a successful child death review process.

In response to the question regarding the purpose of child death review, many respondents echoed the answer given by San Francisco: "To learn about the cause of the deaths; to protect remaining siblings; to provide social services to the family; to prevent future deaths when possible." The goals of improving services, protecting surviving siblings and preventing deaths were often repeated. Other counties approaching this observation from a different angle, stressing what successful teams could not be: Monterey County wrote:

> ...[I]n 1985 an attempt was made by a physician at Natividad Medical Center to establish a child death review team. Unfortunately, it became a finger pointing session and failed...

In other words, counties agreed that, in order to work effectively, agencies must focus on improvement of service delivery, improvement of overall institutional systems, and avoid the tendency to lay blame when agencies or individuals fail.

In response to the question regarding the greatest impediments to identifying child fatalities due to abuse or neglect, a large number of respondents pointed to the well-intentioned but damaging interference of paramedics and "first responders." Kern and Marin Counties, among others, noted that paramedics frequently remove clearly deceased infants and children, disturbing the death scene and often destroying potential evidence.

Clearly, this is done for the benefit of family members, who may be understandably frantic, and to give whatever comfort may come from the appearance of "doing everything that could be done" to save the child. Counties making this observation agreed that this is a difficult problem to address; several respondents pointed out that training paramedics and "first responders" in the issues of preserving evidence may go a long way towards alleviating this problem.

Several counties also mentioned that coroners' investigators fail to conduct any death scene investigations at all. A study recently published in the New England Journal of Medicine showed that when thorough death-scene investigations were conducted in a sample group of 26 infant deaths that had been attributed to SIDS or classified as unexplained, six cases revealed strong circumstantial evidence of accidental death, and 18 others showed possible causes of death other than SIDS, including accidental asphyxiation by an object in the crib or bassinet, smothering by overlying while sharing a bed, hyperthermia and shaken baby syndrome.[16] These findings suggest that at least some child fatalities classified as SIDS or of undetermined cause might be misclassified and more thorough death scene investigation might be necessary in such cases.

Another frequently cited impediment to identification, prosecution and prevention of child homicides was drug use. Many counties noted drug use, particularly crack cocaine, was clearly on the rise among pregnant women, leading to increased rates of infant morbidity and serious health problems, with a proportional strain on hospital resources. Even when it is clear that prenatal drug use led to fetal death, such cases are difficult to prosecute or even charge. Counties noted that drug use also appears to play a frequent role in cases of child neglect and abuse in the home. As law enforcement and social service authorities

admit they have little or no impact on drug use, it will continue to be difficult to prevent child fatalities resulting from drug-induced abuse or neglect in the home.

As mentioned in Section III, Findings and Recommendations, one of the most serious problems that will be encountered in instituting interagency child death protocols is the resistance of many counties to the formal procedures or mandated protocols. One respondent reported that agency heads in their county had been approached several times regarding formation of an interagency team but had refused to consider it. When a child died under suspicious circumstances but charges were never filed, public outrage was so great that the County Grand Jury conducted an investigation of the District Attorney's Office. This investigation understandably caused some hard feelings and gave agency heads further proof that the purpose of child death review was "headhunting."

Another county reported that it could not get a team started in their county because of opposition from the District Attorney's office. In discussion with a representative of the District Attorney's office in that county, however, Consultants learned that there was probably a sound basis for opposition; a protocol had been drafted and submitted to them which permitted individuals from Child Protective Services to conduct their own investigations in suspected child homicide cases, and which required the DA file charges based on a vote of the review committee, rather than DA determination that charges were warranted or sustainable. The protocol also required that the DA's office open its active files to other agencies. On that basis, both law enforcement and the District Attorney's Office in that county would not consent to participate in an interagency process. However, revision of the draft protocols to modify or delete the objectionable provisions might very well result in their cooperation.

In this vein, Consultants found that the majority of counties with teams in place either withhold review of any case in which there is ongoing police investigation or in which criminal charges have been filed, or allow law enforcement and district attorney members to limit the information they share with other agencies, in order to preserve the viability of active investigations and prosecutions.

In response to the question regarding limitations to the use of protocols, several counties noted that successful use of the protocols would depend heavily on adequate training and funding. San Francisco pointed out that "the protocols will only be effective as adequately trained forensic pathologists are available. Most communities do not have that capability." The smaller counties saw other, perhaps equally severe limitations, and tended to be more terse in explaining their objections:

> If this study is going to lead to state mandates or procedures please feel free to exempt the smaller counties from those time consuming mandates because we probably won't comply anyway. We don't have the time.

Another county alluded to the perception that development of interagency protocols would likely mean having unnecessary procedures and mandates "shoved down its throat:"

> It is my impression that some one has decided child fatality review teams are good, and this questionnaire has been designed to get data to support that view.

As stated frequently throughout this report, the greatest limitation in implementing interagency child death review protocols will be overcoming the resistance of counties without such teams. The task here will be convincing such counties that the availability and use of interagency child death investigation protocols will solve problems, not cause them.

When asked what was the most essential ingredient in a successful review process, many counties repeated their belief in the importance of training and communication between agencies. This emphasis on training and cooperation was as strong in counties without teams--even counties that specifically did not want teams--as it was in counties with teams; the comments of two small rural counties illustrate this: Tulare wrote that the most essential ingredient was "a well trained investigative team with the ability to interact with various agencies;" San Benito agreed that essential to a successful process were "properly trained investigators who are aware of the needs to successfully complete an investigation. The investigators need to be aware of and use all the resources available to them."

In summary, Consultants found that, in counties that have implemented interagency child death review, the process has worked. As might be expected, the greatest benefits of the team approach include heightened cooperation, coordination and communication between agencies and individuals responsible for investigation of child fatalities.

While Consultants noted some resistance to the idea of mandated interagency teams in counties without teams, the resistance is not directed toward the basic concept of communication and coordination between agencies, but rather toward mandated systems and procedures for such coordination. Consultants also found widespread support for the development of written protocols for interagency child death investigation and review protocols. Even in counties that did not think such an approach would be an improvement over their present system, the majority nonetheless agreed that written protocols for child death investigation are a good idea. Consultants also found strong support for increased training in issues relating to child homicide. Taken together, these findings show strong statewide support for the writing of interagency child death review protocols and for widespread training in their implementation and use.

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[14]The Government Code, State of California, Section 27491, directs the coroner to inquire into and determine the circumstances, manner and cause of the following deaths which are immediately reportable:

1. No physician in attendance.
2. Medical attendance less than 24 hours in hospital.

3. Wherein the deceased has not been attended by a physician in the 20 days prior to death.
4. Physicians unable to state cause of death (unwillingness does not apply).
5. Known or suspected homicide.
6. Known or suspected suicide.
7. Involving any criminal action or suspicion of a criminal act.
8. Related to or following known or suspected self-induced or criminal abortion.
9. Associated with a known or alleged rape or crime against nature.
10. Following an accident or injury (primary or contributory, occurring immediately or at some remote time).
11. Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, alcoholism, drug addition, strangulation, or aspiration.
12. Accidental poisoning (food, chemical, drug, therapeutic agents).
13. Occupational diseases or occupational hazards.
14. Known or suspected contagious disease and constituting a public hazard.
15. All deaths in operating rooms.
16. All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room or elsewhere.
17. All deaths in which the patient is comatose throughout the period of physician's attendance, whether in home or hospital.
18. In prison or while under sentence.
19. All solitary deaths (unattended by physician or other person in period preceding death).
20. All deaths of unidentified persons.
21. Sids (sudden Infant Death Syndrome).
22. All deaths at State Mental Hospital.

[15]For a complete discussion of the death statistics provided Consultants in response to the questionnaire, see Section VI, Statistical Analyses.

[16]Bass, Millard, Rivhard Kravath, and Leonard Glass, "Death Scene Investigation in Sudden Infant Death," The New England Journal of Medicine (July 10, 1989), 315(2):100-104, p. 100.

VIII. Conclusion

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In all, Consultants found that the interagency child death review process works. Because of the problem of inconsistent data collection, it is difficult to assess success in purely statistical terms, but nonetheless in counties with teams as well as those without, there is widespread acceptance of the underlying concept of interagency communication and cooperation. Counties with and without teams agreed that the most essential ingredient in any successful child death investigation process was cooperation, coordination and communication between agencies. In fact, almost all of the counties without teams reported they relied on informal networks between agencies in conducting their investigations.

Consultants also found widespread support for the development of written protocols for interagency child death investigation and review protocols. Even in counties that did not think such an approach would be an improvement over their present system, the majority nonetheless agreed written protocols for child death investigation were a good idea.

However, the manner in which the protocols are cast will have a great impact on the willingness of counties to implement the proposed procedures. Of particular significance will be promoting the perception that protocols will "make life easier" for those counties that do not have interagency teams, as they will provide a "blueprint" for investigating the relatively rare occurrence of child deaths in such counties. Another vital message that should be contained in the protocols is that institution and adherence to set child death investigation procedures will protect counties, agencies and responsible individuals from civil liability and claims of mishandled, incomplete or otherwise defective investigations.

Consultants found strong support for increased training in issues relating to child homicide, with many counties concluding that, in addition to cooperation and communication, the most essential ingredient for successful implementation of interagency protocols would be on-going education and training.

In summary, Phase I of the Department of Justice Development of Interagency Child Death Protocols shows strong statewide support for the writing of interagency child death review protocols and for subsequent training in their implementation and use.

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Appendix 2

Department of Justice Development of Interagency Child Death Investigation Protocols Questionnaire

DEPARTMENT OF JUSTICE
DEVELOPMENT OF INTERAGENCY CHILD DEATH INVESTIGATION PROTOCOLS

QUESTIONNAIRE

Some questions can be answered with a simple "yes" or "no," while others require a short explanation. While we appreciate your generosity in giving as full and detailed responses as are possible, you may "guestimate" in instances where precise answers would require extensive research. If more space is needed, you may use the back of the page. Please do not hesitate to add any comments or attach any written materials which have been helpful to you, or which you believe may be helpful to us.

The Questionnaire has been divided into three sections; the first identifies the respondent and gives an overview of each county's child death investigation procedures; the second is directed toward those counties that do not have interagency child death review teams in place; the third focuses on counties that do have interagency teams.

For your ease in completing the Questionnaire, we have provided you with only the sections that pertain to your county, either Sections I and II, or Sections I and III. If your county is now in the process of forming an interagency team, we appreciate your answering all three sections.

SECTION I

*1. Your Name _____

2. Title _____

3. Agency _____

_____

4. Agency Address _____

_____

5. Telephone _____

6. County _____

7. If you are appointed/elected, term of office (month/year--month/year) _____

*If you prefer, you may attach your business card to this Questionnaire and skip questions 1 through 5.

If you need more space please continue on the back of the page (refer to question by number).

8. What best describes your professional role in the handling of child fatalities (e.g., medical examiner, coroner, sheriff/coroner, private therapist, physician, pediatrician, Child Protective Services (CPS) administrator, chief of police, etc.)?

9. What best describes your actual role in the handling of child fatality cases (e.g., death review team coordinator, investigator, police department liaison to CPS, etc.)?

*10. (a) Does your county have a child death review process? _____ Yes _____ No.

(b) Does your agency have a child death review process? _____ Yes _____ No.

We recognize that many respondents act in more than one capacity--representing a professional discipline, an agency, as well as a county. Therefore, some questions in this Questionnaire will ask you to distinguish between the procedures of your county and those of the agency for which you may work.

11. Is there a written protocol for handling child fatalities? _____ Yes _____ No. If yes, please attach a copy of your protocols to this Questionnaire.

12. (a) Does your agency's child death review process involve more than one agency (CPS, sheriff's department, coroner's office) or discipline (i.e., pediatric or child abuse specialist)? _____ Yes _____ No.

(b) Does your county's child death review process involve more than one agency or discipline? _____ Yes _____ No.

13. Are specialists from other fields occasionally called in on investigation of child fatalities? _____ Yes _____ No.

14. (a) How many months/years has your county's current child death review process been in place?

(b) How many months/years has your agency's current child death review process been in place?

15. What is the area or target population(s) your agency serves?

If you need more space please continue on the back of the page (refer to question by number).

16. Approximately what percentage of your time is spent handling child fatalities (e.g., reviewing files, networking with other agencies or individuals, attending review meetings, etc.)?

17. Approximately what percentage of your agency's case- or work-load is devoted to reviewing child fatalities?

18. How many child deaths were recorded in your county during?

1988_____?
1987_____?
1986_____?

19. Of these recorded deaths, how many were recorded as due to other than natural causes (i.e., homicide, accidental, suicide, undetermined) during:

1988_____?
1987_____?
1986_____?

20. Of the child deaths recorded as due to other than natural causes, how many of these deaths were investigated in your county during:

1988_____?
1987_____?
1986_____?

21. In your opinion, are there any trends in any of the above figures?

If you need more space please continue on the back of the page (refer to question by number).

22. How many (or roughly what percentage) of cases identified in Question 20 were previously known to:

Law enforcement?

Hospital emergency room?

Mental Health Services?

Public Health Services?

Child Protective Services?

23. For those identified through Child Protective Services, how many (or roughly what percentage) came to CPS through:

Law enforcement?

Child abuse "hotline?"

Schools?

Private physician, pediatrician, therapist?

Drug rehabilitation/battered women's shelter?

Other (please specify)?

24. (a) Does your county investigate all child deaths? _____ Yes _____ No.

(b) Please describe this investigative procedure:

(c) Are all deaths subjected to this procedure (i.e., suspected SIDs deaths, suicides, those deemed "cause of death undetermined?") _____ Yes _____ No.

If you need more space please continue on the back of the page (refer to question by number).

(d) If no, what criteria determine whether or not a child death is investigated (i.e., coroner's discretion, child's age, etc.)? Please attach written criteria if available.

25. (a) Does your agency investigate all child deaths? _____ Yes _____ No.

(b) Please describe this investigative procedure:

(c) Are all deaths subjected to this procedure (i.e., suspected SIDs deaths, suicides, those deemed "cause of death undetermined?" _____ Yes _____ No.

(d) If no, what criteria determine whether or not a child death is investigated (i.e., coroner's discretion, child's age, etc.)? Please attach written criteria if available.

26. (a) Does your agency have specific policies regarding investigation and/or autopsy in suspected SIDS deaths? _____ Yes _____ No. Child or teenage suicide? _____ Yes _____ No. Please describe, or attach written policies if available.

If you need more space please continue on the back of the page (refer to question by number).

(b) Does your county have specific policies regarding investigation and/or autopsy in suspected SIDS deaths? _____ Yes _____ No. Child or teenage suicide? _____ Yes _____ No. Please describe, or attach written policies if available.

27. In your opinion, what is the greatest impediment to:

(a) The discovery of child fatalities due to abuse or neglect?

(b) The verification of child fatalities due to abuse or neglect?

(c) The prosecution of child fatalities due to abuse or neglect?

(d) The prevention of child fatalities due to abuse or neglect?

If you need more space please continue on the back of the page (refer to question by number).

28. Please rate the usefulness of the following in overcoming these impediments using a scale of (1) essential (5) not at all useful Please explain any ranking of (3) or below, giving reasons why it is not useful:

RANK EXPLANATION

_____ Networking with other disciplines

_____ Child abuse "hot lines"

_____ Community outreach/education programs

_____ Other (specify):

_____ Seminars/training in:

_____ Investigative techniques

_____ Legal issues

_____ Medical Issues

_____ Other (specify):

29. (a) Would written protocols for investigation or review of child deaths be helpful? _____ Yes _____ No.

(b) What limitations or obstacles do you see to the use of such protocols?

30. (a) Would autopsy or post-mortem examination protocols for suspected child abuse/neglect related deaths be helpful? _____ Yes _____ No.

(b) What limitations or obstacles do you see to the use of such protocols?

31. Would training in identification and review of suspicious child deaths be helpful? _____ Yes _____ No. If yes, who and what kind (e.g., train hospital emergency room staff in signs of child abuse, train "first responders"--paramedics, fire department personnel, etc.--in evidence preservation or information gathering, etc.)?

32. (a) What are your criteria for evaluating a successful child death review process?

(b) Please evaluate your county's system in terms of those criteria:

(c) Please evaluate your agency's system in terms of those criteria:

33. In your opinion, what is the purpose of child death review?

If you need more space please continue on the back of the page (refer to question by number).

SECTION II

These questions are directed to counties that presently do not have interagency child death review teams in place. These teams typically consist of representatives from a number of agencies including but not limited to the coroner, police or sheriff's department, child protective services, child abuse networks, district attorney, county counsel, probation, public health, and publicly- or privately-employed pathologists, psychologists, therapists and pediatric specialists.

34. (a) Who in your county is primarily responsible for handling child fatalities? (Please identify by name, title, specialty, agency, address and telephone number.)

(b) Is this a particular individual, or a function subject to periodic reassignment (i.e., rotation)? _____ Same _____ Changes

(c) How often does this assignment change?

35. (a) Who in your agency is primarily responsible for handling child fatalities? (Please identify by name, title, specialty, agency, address and telephone number.)

(b) Is this a particular individual, or a function subject to periodic reassignment (i.e., rotation)? _____ Same _____ Changes

(c) How often does this assignment change?

36. (a) In your opinion, are there any special problems with changing assignments in child death investigation? _____ Yes _____ No. Please explain:

(b) How might one minimize the problem of changing assignments in child death investigation:

If you need more space please continue on the back of the page (refer to question by number).

37. Who determines which child death cases will be referred for further investigation or action?

38. (a) Does your agency's child death review process involve more than one agency or discipline? _____ Yes _____ No. If yes, which others are involved? Please list by specialty, name, title, agency and telephone number:

(b) Does your county's child death review process involve more than one agency or discipline? _____ Yes _____ No. If yes, which others are involved? Please list by specialty, name, title, agency and telephone number:

39. Are specialists from other fields occasionally called in on investigation of child fatalities? _____ Yes _____ No. If yes, please list by name, title and specialty:

40. Are the specialists paid for their services? _____ Yes _____ No. If yes, by what agency/funding source?

41. (a) If there are no written protocols, please describe your county's process for handling child fatalities:

If you need more space please continue on the back of the page (refer to question by number).

(b) If different from the answer given above, please describe your agency's process for handling child fatalities:

42. (a) Generally how long is the interval between death and the beginning of investigation/review?

(b) Is this interval consistent, or does it vary widely? _____ Consistent
_____ Varies. How and why does the interval vary?

43. On the average, how long does investigation/review take?

(a) Actual work time _____ (hours)
(b) Elapsed time from beginning to end _____ (circle one: days, weeks, months)

44. (a) Has your county ever considered establishing an interagency child death review team? _____ Yes _____ No.

(b) Is your county in the process of forming a team? _____ Yes _____ No.

(c) If yes, at what stage of formation are you (i.e., preliminary discussion, team members selected, protocols developed, first case reviewed, etc.)

(d) If no, please explain any impediments to your county forming a child death review team:

45. (a) Has your agency ever considered establishing an interagency child death review team? _____ Yes _____ No.

(b) Is your agency in the process of forming a team? _____ Yes _____ No.

If you need more space please continue on the back of the page (refer to question by number).

(c) If yes, at what stage of formation are you (i.e., preliminary discussion, team members selected, protocols developed, first case reviewed, etc.)

(d) If no, please explain any impediments to your county forming a child death review team:

46. In your opinion, would the team approach be an improvement over your county or agency's present arrangement for investigating child deaths ? _____ Yes _____ No. Why?

47. (a) Do you see any drawbacks to interagency child death review? Please explain:

(b) What obstacles need to be overcome?

48. In your opinion, would the formation of a child death review team improve communication/coordination among police/coroner/child protective services/schools, etc.?
_____ Yes _____ No.

49. (a) Does your agency encounter difficulties in sharing information with other agencies?
_____ Yes ____ No.

(b) Within agencies? _____ Yes _____ No.

If you need more space please continue on the back of the page (refer to question by number).

(c) If yes, what difficulties (i.e., confidentiality, "turf" issues, etc.)?

50. What linkages do you have with other counties to cover, for example, Child Protective Services placement out-of-county, parents/guardians who relocate, or children who live in your county but die in another?

51. In your opinion, what informational linkages need to be developed or improved?

52. (a) What does your county need to make its present process work better?

(b) What does your agency need to make its present process work better?

53. Please list 2 or 3 of the most important advantages of your present child death review procedure:

54. Please list 2 or 3 of its most significant shortcomings:

55. What do you perceive as the most essential ingredient in a successful child death investigation process (i.e., interdisciplinary networking, regular meetings, written protocols, etc.):

This completes the Questionnaire for counties without interagency child death review teams. Thank you very much for your help.

Please feel free to add here any further comments or information which you think might be helpful to us in our study:

If you need more space please continue on the back of the page (refer to question by number).

SECTION III

The following questions are directed to counties with interagency child death review teams in place. These teams typically consist of representatives from a number of agencies including but not limited to the coroner, police or sheriff's department, child protective services, child abuse networks, district attorney, county counsel, probation, public health, and publicly- or privately-employed pathologists, psychologists, therapists and pediatric specialists.

56. Please list, by name, title, agency, specialty, address and telephone number, all members of your interagency child death review team (or attach a list if one is already available):

57. (a) How many months/years has your team been in place?

(b) Roughly how many cases has your team reviewed?

If you need more space please continue on the back of the page (refer to question by number).

58. Please describe the history of your team, the system it replaced, the individual(s) or event(s) which instigated its formation (if possible, please specify dates):

59. Is there a "team leader?" Please provide his or her name, role, and agency, as well as his/her function(s):

60. Do the same individuals meet each time, or do participating agencies periodically reassign their representatives? _____ Same _____ Changes

61. How often do assignments rotate?

62. In your opinion, are there problems with periodic reassignments to child death review?

63. How might one minimize the problem of changing assignments to child death review?

If you need more space please continue on the back of the page (refer to question by number).

64. (a) Are specialists from other fields occasionally called in on investigation of child fatalities? _____ Yes _____ No.

(b) If yes, please identify, by name, title and specialty:

65. Are the specialists paid for their services? _____ Yes _____ No. If yes, by what agency/funding source?

66. Are meetings open to "outsiders" (i.e., non-team members)? _____ Yes _____ No.

67. How is the team financed (e.g., participating agencies "donate" salaried personnel time in attending meetings, reviewing and copying files, underwrite costs of copying, etc.)?

68. (a) Does the team have its own, separately-funded support staff (i.e., secretary, coordinator, etc.)? _____ Yes _____ No. If yes, how many?

(b) By what agency/funding source are support staff paid?

(c) Please describe their function(s):

69. (a) Do child death investigations begin as soon as the death is reported/discovered? _____ Yes _____ No.

(b) If no, describe the intervals at which reviews occur (i.e., monthly, quarterly, etc.)

70. Generally how long is the interval between the death and the beginning of review?

71. Is this interval consistent, or does it vary widely? _____ Consistent _____ Varies. Why?

72. (a) Does the team have a regular location for its meetings? _____ Yes _____ No.

(b) Where?

(c) When? (___ a.m. - ___ p.m., etc.)

(d) Who calls the meetings?

(e) What is the average length of meeting (in hours)?

(f) What is the average attendance?

73. (a) Is information shared prior to meetings (i.e., copies of death certificates, agency records, etc.)? ____ Yes _____ No.

(b) If yes, what information?

(c) Who collects, copies, distributes the information?

(d) Are there procedures for protection of confidentiality of shared information (i.e., destruction or return of materials to the appropriate agency or team leader)? _____ Yes _____ No.

(e) If yes, what are the procedures?

74. How often are decisions delayed pending receipt of additional information, files, answers to team questions, etc.?

75. How many cases are usually discussed at a team meeting?

If you need more space please continue on the back of the page (refer to question by number).

76. Is there currently a backlog of cases to be reviewed ? _____ Yes _____ No. If yes, how many? _____ Why is there a backlog?

77. Do you (personally) work on cases outside of team meetings? _____ Yes _____ No. If yes, please describe:

78. Do team members work on cases outside of team meetings? _____ Yes _____ No. If yes, please describe:

79. On the average, how long does review of a given case take?

(a) Elapsed time (from time of death to conclusion of review process)_____(days, weeks, months)

(b) Actual work time (in review meetings)_____ (minutes, hours)

80. Are records made of meeting activities (i.e., cases reviewed, discussion, questions, decisions)? _____ Yes _____ No. If yes, how are these records maintained?

81. Is there a policy regarding review of cases under law enforcement investigation or legal action? _____ Yes _____ No. Please describe:

If you need more space please continue on the back of the page (refer to question by number).

82. Is there a policy regarding the role of the media regarding the child death review team, its operations or cases? _____ Yes _____ No. Please describe:

83. How are team determinations (abuse/neglect suspected, not suspected) ultimately reached (i.e., vote, discretion of team leader, etc.)?

84. What is the procedure in cases where the team determines that further investigation or action is warranted?

85. Are cases which are returned to law enforcement or other agency for further investigation/prosecution monitored by the team? _____ Yes _____ No. If yes, how?

86. Is any kind of "informational loop" in place to notify other counties, agencies or individuals of the outcome of cases reviewed by the team (i.e., child's county of birth if other than county where death occurred, notification of CPS worker, district attorney, law enforcement personnel or public health nurse with prior family or child contact, physician or emergency room personnel who initially reported suspected abuse/neglect, etc.)? _____ Yes _____ No. If yes, please describe:

87. If such an informational loop is not in place, would such a system be useful?
_____ Yes _____ No. Why?

If you need more space please continue on the back of the page (refer to question by number).

88. Is the team an improvement over the previous arrangement for investigating child deaths? _____ Yes _____ No. Please explain:

89. Can the team handle more cases, or dispose of them more quickly than your county's/agency's previous system? _____ Yes _____ No.

90. Does your county now identify a higher percentage of deaths as being related to child abuse/neglect than previously? _____ Yes _____ No.

91. Does your agency now identify a higher percentage of deaths as being related to child abuse/neglect than previously? _____ Yes _____ No.

92. Has formation of the team improved communication/coordination between law enforcement, district attorney, coroner, child protective services, public health/mental health schools, etc.? _____ Yes _____ No.

93. What informational linkages (i.e., between law enforcement, district attorney, coroner, child protective services, public health/mental health schools) need to be developed or improved?

94. What difficulties does your team/agency encounter in sharing information with other agencies (i.e., confidentiality, "turf" issues, etc.)?

95. What linkages do you have with other counties to cover, for example, Child Protective Services placement out-of-county, parents/guardians who relocate, or children who live in your county but die in another?

If you need more space please continue on the back of the page (refer to question by number).

96. What kinds of problems has the team encountered in its operation (i.e., agencies fail to follow their own procedures, a given agency consistently fails to prepare for or attend review meetings, local law enforcement agencies send subordinates rather than appropriate ranking officers, etc.)?

97. Has the team been able to institute procedures/systems to overcome these problems? _____ Yes _____ No. Please describe:

98. How could the functioning of your team be improved?

99. Please list 2 or 3 of the most important advantages of the team approach:

If you need more space please continue on the back of the page (refer to question by number).

100. Please list 2 or 3 of its most significant shortcomings:

101. What is the most essential ingredient of a successful child death review process?

This is the end of the Questionnaire for counties with interagency child death review teams. Thank you very much for your help.

Please feel free to add here any further comments or information which you think might be helpful:

If you need more space please continue on the back of the page (refer to question by number).

RATING THE QUESTIONNAIRE

On this page is a very brief section which asks you to rate the Questionnaire. For our own professional purposes, we would very much appreciate your taking a few minutes to note how long it took you to complete it, and your general or specific impressions of this Questionnaire as an information-gathering tool.

How long did it take you to complete the Questionnaire?

Using whatever criteria you consider relevant, please comment on the overall quality of this Questionnaire (was it clear, did it ask the right questions, etc.):

If the Questionnaire failed to ask the right questions, what were the questions, and how would you answer them?

If you need more space please continue on the back of the page (refer to question by number).

Appendix 3
Child Death Review Worksheets

CONFIDENTIAL

Case Name and #: _____

CONTRA COSTA COUNTY CHILD ABUSE
MULTI-DISCIPLINARY TEAM DEATH REVIEW FORM

(M) ( ) (F) ( ) Age ____ yrs. ____ mos.
Date Reviewed: _____

TEAM MEMBERS PRESENT:

( ) Mercedes Anderson, R.N., Public Health Nurse Supervisor
( ) Carol Bryant, Ph.D., Coordinator, Child Abuse Prevention Council CCC
( ) Jim Carpenter, M.D., MPH, Chairman Department of Pediatrics
( ) Louis Daugherty, M.D., Medical Examiner, Coroner's Office
( ) Bonnie Granlund, LCSW, Children's Program Specialist, Mental Health Assoc.
( ) Kathleen Malloy, M.D., MPH, Director of Maternal, Child & Adlosecent Health
( ) Lt. Al Moore, Sheriff/Coroner's Office
( ) Marie Schoolmaster, Detective, Juvenile Bureau, Concord Police Department
( ) Pat Sepulveda, Deputy District Attorney
( ) Linda Waddington, Division Supervisor, Child Protective Services
( ) Demi Winniford, R.N., Public Health Nursing Supervisor

ALTERNATE TEAM MEMBER PRESENT: _____

CONSULTANT(S) PRESNET: _____

	YES	NO	NOT CHECKED
JPD Records	( )	( )	( )
DSS Records	( )	( )	( )
PHN Records	( )	( )	( )
Medical Records	( )	( )	( )
Police Records	( )	( )	( )

SIBLINGS
NO ( )
YES ( )
NAMES and DOB
_____
_____
_____

( ) DEFERRED & REASONS: _____

Follow-up - YES ( ) NO ( )

( ) FOLLOW-UP COMPLETE: _____
(Date)

RECOMMENDATIONS/DISCUSSION: _____

Death Review Committee Classification of Death:

	YES			YES	NO
Abuse related.....	( )		Mother used drugs during pregnancy..	( )	( )
Neglect.....	( )		Smoked/nicodine	( )	( )
Suspicious/homicide.....	( )	( )	Alcohol.....	( )	( )
Non-Maltreatment.....	( )		Cocaine/crack.....	( )	( )
Baby had positive tox...	( )		IV drugs.....	( )	( )
Congenital defect.....	( )		Perscription drugs.....	( )	( )
SIDS (questionable).....	( )		Marijuana.....	( )	( )
SIDS (natural).....	( )		Unknown drugs.....	( )	( )
Other.....	( )		Father used drugs.....	( )	( )
Accidential.....	( )		Drugs in Mom's toxicology screening	( )	( )

This form is mailed out to each member approx 3 wks. prior to the Review. They access their records for info. & bring the info to the Review.

CHILD DEATH INVESTIGATION REVIEW
MONTEREY COUNTY

DECEDENT: _____
(full name)

Age: _____ DOB: _____ Place of Birth: _____

Lived with: _____

_____
(address)

Date/Time of Death _____

Location of Death _____

Manner of Death _____

_____

Toxicology Results: _____

Decedent's Pediatrician: _____ (Phone) _____

Address: _____

Decedent's Clinical History: _____

_____

_____

FAMILY HISTORY

Decedent's Father: _____
(full name)

DOB: _____ Place of Birth: _____ Phone: _____

Address: _____

Previous marriage? _____ Married How long? _____
Children from Previous Marriage? _____ (Identify children by name & age. Also provide their guardian's name and current address.)

_____

_____

_____

Father's employment history (and for how long): _____

_____

_____

Father's Clinical History: _____

_____

Decedent's Mother: _____
(full name)

DOB: _____ Place of Birth: _____ Phone: _____

Address: _____

Previous marriage? _____ How long? _____

Previous Married Name? _____

Are there children from previous marriage? _____
(identify children by name & age. Also provide their guardian's name and current address.)

_____

_____

_____

Are there children by current marriage? _____
(identify children by name & age.)

_____

_____

_____

Mother's employment history (and for how long): _____

_____

_____

Mother's clinical history: _____

_____

_____

Was pregnancy planned? _____ How long in labor? _____

Prenatal physician: _____ Address: _____

Any pregnancy problems? _____

Type of delivery: _____

If "C" Section, why? _____

Physician performing delivery: _____

Birth measurement & weight: _____

Breast fed? _____ Formula? _____ What type formula? _____

Pediatrician: _____

Immunization shots received: _____
(when & where)

Circumstances of Death: _____

MARIN COUNTY (CORONER'S PROTOCOL)

SUSPECTED CHILD ABUSE OR PHYSICAL NEGLECT CASE NUMBER _____

CALL TO THIS OFFICE:

Time: __:__ Date: __/__/__

By: _____

Agency: _____

SUBJECT: _____

Address: _____

Age: _____ Sex: _____ Race: _____

Last seen alive: Time: __:__ Date: __/__/__ By: _____

Did the child appear to be normal at that time? Yes _____ No _____ Explain _____

_____

_____

Who reported the death to the police? _____

_____

Relationship to the child? _____

Was there an apparent time delay between the time the child was believed to be dead and when the death was reported? No _____ Yes _____ How long? _____

Explain _____

_____

_____

What are the circumstances of death as related by the reporting person? _____

_____

_____

_____

INITIAL SCENE INVESTIGATION

Were there any attempts at reviving the child? Yes _____ No _____ Explain _____

_____

_____

Place of death: _____

_____

_____

Position of body when found: Back _____ Stomach _____ Side _____

Rigor mortis: Absent _____ Mild _____ Firmly established _____

Rectal temperature: _____ °F at (time) __:__

Livor mortis: None _____ Anterior _____ Posterior _____ Consistent with body position? Yes _____ No _____

Whitens to finger pressure _____ No change to pressure_____

Secretions: Mouth _____ Nose _____ Mucus_____ Milk_____

"Food" _____ Foam _____ Blood _____

If toys, furniture, playground equipment, etc. is involved does it appear that they would be consistent with the injuries as relayed in the circumstances?

Yes _____ No _____ Explain _____

_____

_____

What offending furniture, toys, etc. has been/will be submitted for laboratory examination? _____

_____

Was there any grossly visible blood or tissue on these? _____

_____

_____

Does anyone at the scene relate different circumstances? Yes _____ No _____

Who? _____ Relationship to the child? _____

Explain _____

_____

Do grandparents, relatives or other such persons have knowledge of the care of the child? Yes _____ No _____ Explain _____

_____

List the name(s) and relationships of those who were with the child at the time of death: _____

If one parent was absent: How long? _____ Where to? _____

Is this a routine or frequent event? Yes _____ No _____ Explain _____

_____

Describe the clothing the victim is wearing. _____

_____

Are they clean and in good repair? Yes _____ No _____ Explain _____

_____

_____

Does it appear that the victim's clothing may have been changed after death occurred? Yes _____ No _____ Explain _____

_____

Are there other children in the household? Yes _____ No _____

If yes, complete the following. Age___ Sex___, Age___Sex___, Age___ Sex___

Are all of the live born children of these parents still living? Yes_____
No _____ Explain _____

_____

Do the other children appear to have been abused or physically neglected?
Yes_____ No _____ Explain _____

_____

_____

Is the clothing of the siblings and parents comparable to the victim's?
Yes _____ No_____ Explain_____

_____

_____

Do the other children appear fearful of parents or adults? Yes _____
No _____ Explain _____

_____

_____

Describe the apparent degree of care provided for the child or children

_____

_____

_____

What is the geographic location of the residence in the community? _____

_____

How does this residence compare with the others in the area with respect to general state of repair, yard care, etc. _____

_____

Describe the condition of the inside of the house including degree of cleanliness, repair of sanitary facilities, lighting, etc. _____

_____

Is there food in the house appropriate for a child of this age? Yes ____
No _____ Explain _____

_____

Is there any evidence of drug or heavy alcohol use at the residence?
Yes _____ No _____ Explain _____

_____

Are there any foul odors (feces, urine, etc.)?Yes _____ No_____ Explain____

_____

_____

Are there any signs of rodent or insect infestation? Yes _____ No _____

Explain _____

_____

_____

Are there any safety hazards such as exposed electrical cords, etc?

Yes_____ No _____ Explain _____

_____

Does it appear as though the house was recently cleaned? Yes _____ No ____

Explain _____

_____

Remarks about the scene: _____

_____

_____

_____

_____

_____

_____

_____

_____

INTERVIEWS

Are the guardians of the child the natural parents? Mother: Yes ___ No ___

Father: Yes ___ No ___ Are they foster parents? Yes ___ No ___ Are they

legally adoptive parents? Yes ___ No ___ If other, explain _____

_____

Mother/paramour: List full name _____

Any other names previously used including maiden _____

_____

Date of Birth: ___/___/___ Social Security Number_____

Father/paramour: List full name _____

Any other names previously used _____

_____

Date of Birth: ___/___/___ Social Security Number _____

If one of the guardians is other than the natural parent complete the following:

Full name of natural parent: _____ Date of Birth: ___/___/___

Complete address _____

Telephone number _____ How long have they been separated_____

Describe the family structure _____

_____

_____

_____

Has the family structure changed since the birth of the child? Yes _____

No _____ Explain _____

_____

Describe the degree of maturity of the parents _____

_____

_____

_____

Was this child the result of a planned pregnancy? Yes _____ No _____

Explain _____

_____

Did the mother of the child have routine prenatal care during her pregnancy?

Yes _____ No _____ Explain _____

_____

_____

Were there any problems or unusual events during the pregnancy? Yes _____

No _____ Explain _____

_____

Has the child's growth and development been normal since birth? Yes ____

No _____ Explain _____

_____

Family physician's name: _____ Telephone _____

Obstetrician's name: _____ Telephone _____

Pediatrician's name: _____ Telephone _____

If neighbors are interviewed: Do they seem surprised at the death of the child?

Yes _____ No _____ Explain _____

How do they describe the parent/child relationships in the family? _____

How do they describe the siblings' relationships with one another? _____

Describe the siblings' reaction to the death. _____

Describe the parents' reaction to the death. _____

Have any of the out-of-home relatives of the family been contacted? Yes _____

No _____ What is their reaction to the death? _____

FOLLOW UP INVESTIGATION

What is the apparent economic level of the household? Low___Middle___High_____

Source of information. _____

Are they receiving assistance or foodstamps? Yes _____ No _____ Explain _____

Was the case worker interviewed? Yes _____ No _____ Remarks: _____

Do any of the agencies in the area have previous reports of child abuse in this family? Yes _____ No _____ Explain _____

Do any of the hospitals have records of treatment for trauma of any of the children? Yes_____ No _____ Explain _____

_____

Does the family physician have a record of previous treatment for trauma? Yes _____ No _____ Explain _____

_____

Do the police have any previous reports of family disturbances at the residence? Yes _____ No _____ Explain _____

_____

_____

Have the police checked for previous criminal record of the mother? Yes ___ No _____ Explain _____

_____

Have the police checked for previous criminal record of the father? Yes ___ No _____ Explain _____

_____

_____

Did these checks include the previous areas of residence of these individuals? Yes _____ No _____ Remarks _____

_____

Is there anything unusual about this case not described above? Yes _____ No _____ Explain _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

INVESTIGATOR _____

This form is mailed out to each member approx 3 wks. prior to the Review. They access their records for info. & bring the info to the Review.

CHILD DEATH INVESTIGATION REVIEW

DECEDENT: _____
(full name)

Age: _____ DOB: _____ Place of Birth: _____

Lived with: _____

_____
(address)

Date/Time of Death _____

Location of Death _____

Manner of Death _____

_____

Toxicology Results: _____

Decedent's Pediatrician: _____ (Phone) _____

Address: _____

Decedent's Clinical History: _____

_____

_____

FAMILY HISTORY

Decedent's Father: _____
(full name)

DOB: _____ Place of Birth: _____ Phone: _____

Address: _____

Previous marriage? _____ Married How long? _____
Children from Previous Marriage? _____ (Identify children by name & age. Also provide their guardian's name and current address.)

_____

_____

_____

Father's employment history (and for how long): _____

_____

_____

Father's Clinical History: _____

_____

Decedent's Mother: _____
(full name)

DOB: _____ Place of Birth: _____ Phone: _____

Address: _____

Previous marriage? _____ How long? _____

Previous Married Name? _____

Are there children from previous marriage? _____
(identify children by name & age. Also provide their guardian's name and current address.)

_____

_____

_____

Are there children by current marriage? _____
(identify children by name & age.)

_____

_____

_____

Mother's employment history (and for how long): _____

_____

_____

Mother's clinical history: _____

_____

_____

Was pregnancy planned? _____ How long in labor? _____

Prenatal physician: _____ Address: _____

Any pregnancy problems? _____

Type of delivery: _____

If "C" Section, why? _____

Physician performing delivery: _____

Birth measurement & weight: _____

Breast fed? _____ Formula? _____ What type formula? _____

Pediatrician: _____

Immunization shots received: _____
(when & where)

Circumstances of Death: _____

Appendix 4
Written Protocols

HUMBOLDT COUNTY

DATE: APRIL 25, 1988

TO: AL RADDI, PROGRAM MANAGER II
SOCIAL SERVICES

FROM: JOHN FRANK, WELFARE DIRECTOR

SUBJ: POLICY STATEMENT: ADMINISTRATIVE REVIEW
(UPDATING THE DEPARTMENT'S 10/21/87 MEMO ON THE SUBJECT)

(1) When a child currently served by CWS, under Emergency Response, a voluntary service agreement or a court-order plan, dies of suspected physical abuse or under suspicious circumstances, the Welfare Director shall be notified and briefed immediately by the Program Manager II and/or the Social Worker Supervisor II whose unit is responsible for the child's case.

(2) Within one (1) working day or as soon after the verbal briefing as circumstances warrant, the Director shall set a meeting (or series of meetings) with the following to discuss CWS activity in the case: the Deputy Director, the Program Manager II, the Social Worker Supervisor and Social Worker responsible for the case, any other employees who have relevant information on the case. The Social Worker Supervisor II shall bring the case record(s) to the meeting(s) in as complete and up-to-date state as time allows.

(3) If there are siblings of the dead child or other children in the home where the death occurred, the primary purpose of the meeting(s) shall be to determine if and what action may be needed to protect those other children. Another purpose of the meeting(s) is to review the services provided prior to the child's death to determine if there is another course of action which might decrease the likelihood of fatal mistreatment in similar cases. It shall not be a purpose of the meeting(s) to determine whether there is or is not cause for disciplinary action against any employee who has provided services in the case.

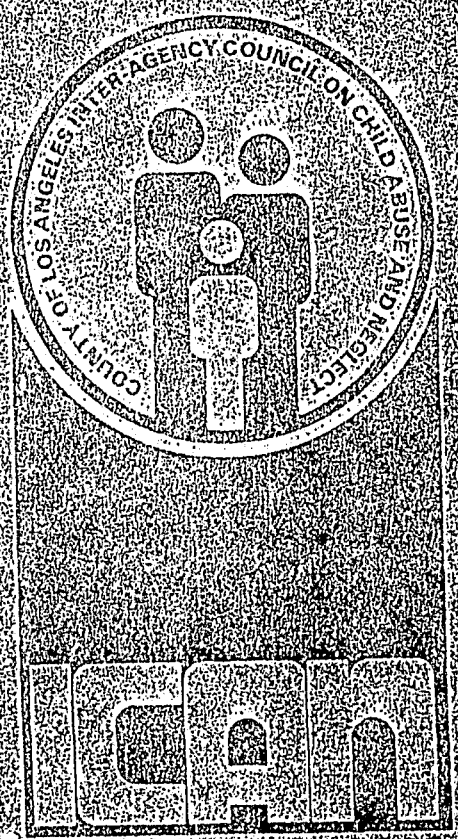
(4) Within five (5) working days of the final Administrative Review meeting, the Program Manager II shall provide the Director with a written summary of the administrative findings, understandings and decisions of the meeting(s) with copies to the Deputy Director, the Social Worker Supervisor and the child's case record.

John Frank
Welfare Director

JF:sd

cc: M. McMorries
cc: N. Simcoe
cc: S. Deininger
cc: J. Tucker
cc: Programs Unit

PROTOCOLS DEVELOPED BY THE ICAN CHILD DEATH REVIEW COMMITTEE



JANUARY 1985

LOS ANGELES COUNTY
INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT
4024 NORTH DURFEE AVENUE
EL MONTE, CALIFORNIA 91732

TABLE OF CONTENTS

PREFACE		i
ACKNOWLEDGEMENTS		1
INTRODUCTION		3
POLICE INVESTIGATION OF CHILD DEATHS		5
I.	Patrol Officer's Protocol	6
II.	Detective's Protocol	16
DISTRICT ATTORNEY'S PROTOCOL		26
DEPARTMENT OF HEALTH SERVICES PROTOCOL		34
I.	Child Death Record Review - Protocol for Medical Records	35
II.	Protocol for Child Death Review	36
III.	Protocol for Acute Medical Facility Case Management in Child Deaths	37
CHIEF MEDICAL EXAMINER-CORONER PROTOCOL		49
I.	Pre-Autopsy	50
II.	Autopsy	53
III.	Post Autopsy Analysis	57
DEPARTMENT OF CHILDREN'S SERVICES PROTOCOL		61
I.	Child Death: Social Servies Assessment	62
II.	DCS Response to Notice from Coroner of Child Deaths Meeting ICAN Criteria	75

PREFACE

The Inter-Agency Council on Child Abuse and Neglect (ICAN) was established in 1977 by the Los Angeles County Board of Supervisors to serve as the County body to coordinate development of services for the prevention, identification and treatment of child abuse and neglect. ICAN includes nineteen County, City and State agencies, all of which are directly involved in the local system of child abuse and neglect services. Members are:

Sherman Block, Sheriff
Los Angeles County
ICAN Policy Committee Chairperson

Los Angeles County Counsel

Department of Health Services
Los Angeles County

Office of Education
Los Angeles County

Los Angeles Police Department
City of Los Angeles

Los Angeles Unified
School District
City of Los Angeles

Department of Children's Services
Los Angeles County

Chief Administrative Office
Los Angeles County

Chief Medical Examiner-Coroner
Los Angeles County

Executive Office
Los Angeles Superior Court

Attorney General
State of California

Presiding Judge
Los Angeles County Juvenile Court

Probation Department
Los Angeles County

Department of Mental Health
Los Angeles County

District Attorney
Los Angeles County

Department of Community & Senior
Citizens Services
Los Angeles County

City Attorney
City of Los Angeles

Dept. of Public Social Services
County of Los Angeles

Morris J. Paulson, Ph.D.
Professor of Psychiatry
UCLA School of Medicine

Community Child Abuse Councils
of Los Angeles County

The development of the protocols contained in the publication was made possible through the combined efforts of the participating ICAN agencies. This coordinated effort exemplifies the type of inter-agency cooperation for which ICAN was established and continues to pursue.

We especially wish to recognize Eddy S. Tanaka, Director of the Department of Public Social Services and past ICAN Chairperson, for his support in making the publication of these protocols possible.

For information about ICAN or additional copies of this publication, contact:

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ACKNOWLEDGEMENTS

ICAN IS GRATEFUL TO THE MEMBERS OF THE OPERATIONS COMMITTEE AND THE FOLLOWING INDIVIDUALS WHO CONTRIBUTED TO THE COMPLETION OF THIS DOCUMENT.

DISTRICT ATTORNEY'S
CHILD ABUSE AND DOMESTIC VIOLENCE SECTION

DEPARTMENT OF PUBLIC SOCIAL SERVICES

DEPARTMENT OF HEALTH SERVICES

CHIEF MEDICAL EXAMINER - CORONER

CITY OF LOS ANGELES
LOS ANGELES POLICE DEPARTMENT
ABUSED CHILD UNIT

COUNTY OF LOS ANGELES
LOS ANGELES SHERIFF'S DEPARTMENT
CHILD ABUSE UNIT

CHILD DEATH REVIEW COMMITTEE

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Barbara Flaherty

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Barbara Davidson

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LOS ANGELES COUNTY

INTER-AGENCY COUNCIL ON CHILD ABUSE AND NEGLECT

P R O T O C O L S

DEVELOPED BY

THE

ICAN CHILD DEATH REVIEW COMMITTEE

January, 1985

BOARD OF SUPERVISORS

COUNTY OF LOS ANGELES

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INTRODUCTION

INTRODUCTION

An increasing number of children die as a result of homicide or neglect by their parents or caregivers. Many of these deaths are medically misdiagnosed, inadequately investigated or prosecuted. The results are lack of appropriate intervention and protection of siblings and other children; and the unsuccesful prosecution of the perpetrator.

Professionals and non-professionals alike have a difficult time believing that parental figures would actually harm their own children, consequently, cases are not carefully and objectively assessed. Foul play is generally not considered unless the nature of the injuries and/or statements regarding the surrounding circumstances makes it extremely obvious.

Inquiries into child deaths have two basic functions: to discover facts surrounding the tragedy and the involvement of various agencies and service departments, and to draw conclusions from these facts to assist the responsible bodies to take necessary action. Well trained and experienced investigators and pathologists who examine all possibilities as to the cause of death and surrounding circumstances are keys to successful prosecutions and protection of surviving children.

The Los Angeles County Inter-Agency Council on Child Abuse and Neglect (ICAN) formed the Child Death Case Review Committee in 1978 to review deaths of children in which a family member or caregiver was suspected of causing the death. This Committee is comprised of representatives from health services, law enforcement, child protective services, medical examiner/coroner's office, and district attorney.

The Committee grew out of the recognition that no one profession has an exclusive interest in the well being of our youth. In order to prevent abuse, protect children and provide appropriate services, a multidisciplinary approach is essential.

The purposes of the Child Death Case Review Committee are to:

- improve identification of deaths caused by child abuse/neglect;
- develop procedures for responding to child deaths;
- increase the thoroughness and effectiveness of the child protection intervention, investigative and legal processes;
- promote early intervention;
- facilitate appropriate protective services for siblings of victims.

All suspicious or violent deaths are required to be reported by statute to the Chief Medical Examiner-Coroner. That office is responsible

for the investigation of the circumstances, and determination of the cause of death, of all persons who die suddenly and unexpectedly when in apparent good health and without medical attention.

The Medical Examiner-Coroner notifies participating departments of the deaths of children age 10 and under where one or more of the following factors are present:

1. Drug ingestion
2. Cause of death undetermined after investigation by coroner
3. Head trauma (subdurals, subarachnoid, subgaleal)
4. Malnutrition/neglect/failure to thrive
5. Bathtub/other type of drowning. (Such as in water bucket, toilet, etc)
6. Suffocation/asphyxia
7. Fractures
8. Sudden Infant Death Syndrome (SIDS). Where history and condition of body raise suspicions or the child is over the age of seven months
9. Blunt force trauma
10. Homicide/child abuse/neglect
11. Burns except where cause is clearly not abuse/neglect such as auto accident, accidental house fires, etc
12. Sexual abuse
13. Gunshot wounds

The committee selects those cases for review which pose particular problems as to the cause of death; identity of the perpetrator; prior involvement of various agencies with this victim or siblings; concern expressed by the child's teacher, neighbor, or medical personnel; investigating officer's observations of parents/caregiver(s) reactions to the death; foul play considered by investigating officer even though apparent injuries are ruled accidental or natural; visiting home nurse's observations regarding lack of parental care and concern for child.

This publication was developed with the participation of each agency on the ICAN Child Death Case Review Committee to increase public awareness and support for effective integrated child abuse/neglect response systems locally and nationally.

POLICE INVESTIGATION

OF CHILD DEATHS

PART I PATROL OFFICER'S PROTOCOL

PART II DETECTIVE'S PROTOCOL

POLICE INVESTIGATION OF CHILD DEATHS,

CHILD ABUSE AND NEGLECT. . .

PATROL OFFICERS' PROTOCOL

The death of a child elicits natural, emotional responses which may hinder a thorough investigation. The patrol officer must detach himself from the emotional aspects of the case and conduct a comprehensive, in-depth investigation of each questionable child death. The uncovering of a child abuse murder which originally appeared to be the result of an accident or Sudden Infant Death Syndrome (SIDS) will not only bring the murderer to justice, it may save the life of another child, perhaps one in the same family.

When a patrol officer is assigned to take a report in a child abuse situation, the decisions the officer makes and the information collected may save the life of this child, another child or a sibling.

The danger facing minor victims of abuse cannot be over-emphasized. This is why police officers and prosecutors cannot tolerate a case which is lost due to improper reporting, lack of appropriate police action or ineffective prosecution.

There are, in general, four kinds of abuse: physical, sexual, emotional and neglect. The goal of the reporting officer, and the basic approach would be the same in this type of case as in any other -- to inform those reading the police reports of the facts which have been uncovered.

Abuse investigations can lead to two types of court action. First, a dependency petition may be filed in Juvenile Court to remove endangered siblings or other children from the custody of the parents or other caregivers; second, a criminal complaint may be filed against the responsible parties. In any given case, either or both of these actions may occur. It is important for the patrol officer to recognize this, because the rules of evidence and the burdens of proof differ in each proceeding, and evidence which is not admissible in a criminal trial may well be admissible in the Juvenile Court case.

This distinction results from the intent of the juvenile proceedings to protect the minor. Courts have been liberal in their interpretation of the admissibility of evidence in dependency proceedings, since it is considered more important to protect a child than to deter alleged unlawful criminal conduct.

The difference in burden of proof refers to the fact that the criminal case must, of course, be proven beyond a reasonable doubt, while the dependency petition in Juvenile Court needs to be proven by clear and convincing evidence, a burden which is decidedly easier for the people to meet.

What steps, then, should a reporting officer take when investigating an abuse case? As in any police investigation, statements of the suspects are very important. If the suspect admits causing the injury, but claims it was an accident, the officer should get as many facts as possible concerning the time, place and conditions of that accident. If there is a denial of knowledge as to the cause of the injury, the officer must question the suspect as to who has had access to, or custody of the victim.

If there are obvious signs of physical abuse, such as bruises, welts, cuts or abrasions, color photographs should be taken as soon as possible. A careful description of the shape, size, color and location of the bruises or injury is extremely important in virtually all contested cases. Some of the medical experts in child abuse can often -- based on this information — positively refute the story told by the suspect.

In addition, certain unique information obtained from parents who are suspects may be useful in later proceedings. For instance, the officer should ascertain the general feeling the parent has for the victim. Many battering parents will admit they don't like, or feel close to their child. It is also helpful to determine whether the parent was subjected to physical abuse in his or her youth, since many battering parents were themselves abused as children. Also, some record of prior serious injuries or accidents which may have involved the victim should be obtained. The doctors or hospitals involved in these earlier incidents should be identified. Often, a pattern will emerge which will enable an expert pediatrician or psychiatrist to give an opinion as to the probable cause of injury or potential risk to the victim.

Cases of sexual abuse or molestation require special treatment, and special consideration by the reporting officer. The officer in a molest case must, again, take careful and accurate statements from all parties.

Finally, every officer should be aware of the fact that he or she will often find abuse in situations where it might not have been expected. When taking a burglary report, stopping a car, or arresting a shoplifter, facts may exist which indicate child abuse or neglect. The officer might be interviewing a witness who mentions her baby. Further questioning may

disclose that the mother wants to get home to her baby, because the child has been alone for over four hours, and the child is three months old. Or a child in the back seat of a car which has been stopped might be observed to have heavy bruises on his leg. An officer should attempt to find out what happpened. It could be very important to the child.

Basically, all the police officer has to do in these cases is use common sense and remember some of the special questions and techniques. If the prosecutor gets the appropriate information in a timely manner, the proper decision can be made to insure the protection of the abused and neglected children. Suggested areas of inquire follow.

HOMICIDE AND CHILD ABUSE/JUVENILE INVESTIGATION

I. OFFICER FIRST ON SCENE

A. Secure Scene -- Immediately Notify Homicide, Child Abuse Investigator or Individual Responsible for the Investigation

B. Photograph Victim at Scene or as Soon as Possible

1. Immediate photographs of the victim are essential

2. Photograph complete scene and surrounding area, including items of evidence where they are found.

II. WITNESSES

A. Identify Witnesses

1. Potential witnesses include, but not limited to:

a. Victim (when death is anticipated)

b. Caregivers, who are defined as: parents, guardian, adult custodian (i.e., mother's boyfriend, babysitter and other household members)

c. Siblings; other children in home regardless of age

d. Neighbors

e. Teachers, school nurses, school principal, etc.

f. Other adults in the home

g. Relatives, regardless of age

h. Doctors, nurses, radiologist, etc.

i. Welfare worker, child protective worker, probation officer, etc.

j. Paramedics

2. Obtain name, address, telephone number, birthdate, place of employment, etc.

B. Interview Witnesses

1. Objectives of interview

a. Criminal proceedings in Adult Court

(i) Exclusionary rule applies, therefore, evidence is admissible only if rules regarding search and seizure, etc., have been followed.

b. Dependency action in Juvenile Court

(i) Exclusionary rule does not apply.

2. Areas to cover in interview: Obtain details regarding the injury/molest/neglect

INTERVIEW ALL PARTIES SEPARATELY

a. Caregiver

(i) How did it occur?

(ii) Who caused it?

(iii) When did it occur?

(iv) What action was taken by which caregiver when the incident was discovered?

(a) What agencies were contacted and by whom?

(b) What other person was informed of the incident?

(c) How soon after the incident was discovered did the caregiver take action?

(d) What was the reaction of the other parent?

(v) Who was present when the incident occurred?

(vi) Did suspect and non-participating parent have knowledge of the current incident or past acts?

Determine whether there is evidence of past abuse/neglect/molest. What medical facilities were used?

(i) What doctors have treated old injuries?

(ii) How did the old injuries occur?

(iii) Who caused the old injuries or molest?

(iv) Approximately when did these acts take place?

Determine whether the victim has been left with other adults in the past

(i) Under what circumstances was the victim left with others?

(ii) What dates and time intervals were involved?

(iii) Who cared for the victim?

b. Victim and Siblings (NOTE: Even a young child can relate important information):

a. Obtain child's explanation of the incident

(i) How did it occur?

(ii) Who caused it?

(iii) What instrument/weapon was used by the abuser/molester?

(iv) Who else was present?

(v) Was the non-participating parent informed?

b. Determine whether there is any past history of abuse/molest

c. Determine whether the child uses any special terms to identify biological parts

c. Neighbors, teachers, relatives, welfare workers, etc.

a. How did they come in contact with the child?

b. What have they observed?

(i) Injuries?

(ii) Evidence of neglect?

(iii) Reports of molest?

c. When did they make these observations?

d. Were other agencies informed?

e. Any documentation of the incident?

f. From whom did they obtain information?

d. Doctors, nurses, etc.

a. What medical records, reports, including birth records, etc., exist?

b. What x-rays exist?

c. How do medical personnel believe the injuries occurred?

d. Is the caregiver's explanation of how the injury occurred consistent with medical evidence?

e. What statements, if any, were made by mother, father, stepparent, boyfriend of mother, girlfriend of father, etc., to medical personnel?

f. Is there evidence of old injuries?

g. Is there evidence of sexual abuse?

h. Is child's physical condition consistent with explanation of sexual abuse?

e. Paramedics

a. Obtain complete name, address and phone number

b. What time did the call come? Who made the call and what was said? What time did they arrive at the scene? What was victim's condition? What did they observe? What was done for victim?

c. Who did they see at the residence?

d. What statements, if any, were made and by whom?

e. What did the caregiver say to the paramedics when they arrived?

f. What was the caregiver's explanation about the victim's condition?

g. Did they question anyone at the scene?

h. What was the emotional condition of the caregiver?

f. Special Problems When Mother's Boyfriend or Father's Girlfriend is Suspected of Being Responsible for Abuse/Molest/Neglect/Death

1. What information can witnesses relate regarding current incident?

2. What information is available regarding past incidents of abuse/molest/neglect?

3. Is there evidence that the natural parent had knowledge of the present or prior abuse/molest?

a. Have neighbors, teachers, babysitters, etc., observed evidence of abuse and reported this to the parent?

b. Did the victim exhibit unusual behavior while in the presence of the suspect - i.e., fear?

4. What actions were taken by parent when confronted with information regarding the present or prior abuse/molest?

5. Is there evidence that the parent has been subjected to abuse by the suspect?

6. Is the suspect still living with, associated with, or communicating with the parent?

7. When did the suspect enter the household?

III. PHYSICAL EVIDENCE

A. Photographs

1. Child's injuries and physical condition of the child are especially important in failure to thrive and neglect cases

a. Obtain immediate photographs on the scene

b. Obtain set of photographs two to three days later to record any changes which might have occurred

2. House

a. Conditions of kitchen, refrigerator, bathroom, toilets, bedrooms, garage, etc.; if house is a "filthy" house or very clean.

b. Completely photograph scene and surrounding area; include items of evidence (i.e., forced entry, etc.)

3. Weapons used

B. Weapons

1. Locate and impound weapon used to inflict abuse

2. Follow search and seizure rules when impounding evidence

C. Physical Evidence in Molest Cases

1. Locate and impound the following:

a. Clothing worn by victim and suspect

b. Bedsheets

c. Towels

d. Any other item used during or after a molest which corroborates the victim's statement or condition

e. Diapers

f. Medication taken by victim

2. Follow search and seizure rules when impounding evidence

3. Use Rape Evidence Kit, if appropriate

D. Obtain Consent to Get Medical Records of Victim and Siblings

E. Obtain Consent to Search Apartment, Van, Car, Vehicle, etc.

F. Gather All Information to Aid Coroner During Autopsy

IV. SIBLINGS

A. Protection — if homicide is suspected, and/or siblings appear to be in danger, take into protective custody

B. Identify Completely

1. Full names with dates of birth

2. Present residence address

3. Full name of guardian

4. School presently attending and prior school

5. Physically examine totally for any inflicted abuse and possible abuse signs

6. Photograph all siblings

INVESTIGATION OF CHILD DEATHS,

CHILD ABUSE AND NEGLECT. . .

DETECTIVES' PROTOCOL

The death of a child elicits natural. emotional responses which may hinder a thorough investigation. The detective must detach himself from the emotional aspects of the case and conduct a comprehensive, in-depth investigation of each questionable child death. The uncovering of a child abuse murder which originally appeared to be the result of an accident or Sudden Infant Death Syndrome (SIDS) will not only bring the murderer to justice, it may save the life of another child, perhaps one in the same family.

Generally, the investigative techniques and processes previously discussed should be used in the investigation of child abuse murders. There are, however, several areas which must be more closely examined due to the specialized nature of these cases.

When a detective is assigned to investigate the death of a child, the decisions he makes and the information collected may save the life of another child.

The danger facing minor victims of abuse cannot be overemphasized. Police officers and prosecutors cannot tolerate a case which is lost due to improper investigation, lack of appropriate police action or ineffective prosecution.

If there are any suspicious signs of child abuse, such as bruises, welts, cuts or abrasions, no matter how insignificant they may appear, color photographs should be taken. A careful description of the shape, size, color and location of the bruises or injury is extremely important in all cases. Based on this information, medical experts in child abuse can often positively refute the story told by the suspect.

Cases of death where the victim has been sexually abused require special treatment by the investigating officer. He must take careful and accurate statements from all parties including minor children who may have witnessed some event or been sexually abused by the same suspect.

At the time of the autopsy it is extremely important that every victim be examined for sexual abuse.

Basically, all the detective has to do in these cases is use common sense and understand that there are some parents who dislike their children enough to kill them.

As in any police investigation, statements of the suspects are very important. If the suspect admits causing the death, but claims it was an accident, the detective should get as many facts as possible concerning the time, place and condition of the crime. If there is a denial of knowledge as to the cause of death, the detective must question the suspect as to who had access to, or custody of the victim.

In addition, certain unique information obtained from parents who are suspects may be useful in later proceedings. For instance, the officer should ascertain the general feeling the parent or suspect had for the victim. Many battering parents will admit they don't like or feel close to their child. It is also helpful to determine whether the parent was subjected to physical abuse in his or her youth, since many battering parents were themselves abused as children. Also, some record of prior serious injuries or accidents which may have involved the victim should be obtained. The doctors or hospitals involved in these earlier incidents should be identified. Often, a pattern will emerge which will enable an expert pediatrician or psychiatrist to give an opinion as to the probable cause of death and the potential risk to the siblings.

I. WITNESSES

A. Identify Witnesses

1. Potential witnesses include, but are not limited to:

a. Victim (when death is anticipated)

b. Caregivers, who are defined as: parents, guardian, adult custodian (i.e., mother's boyfriend, babysitter and other household members)

c. Siblings, regardless of age

d. Neighbors

e. Teachers, school nurses, school principal, etc.

f. Other adults in the home

g. Relatives, regardless of age

h. Doctors, nurses, radiologist, etc.

i. Welfare worker, child protective worker, probation officer, etc.

j. Paramedics

2. Obtain name, address, telephone number, birthdate, school attending and place of employment

B. Interview Witnesses

1. Objectives of interview

a. Criminal proceedings in Adult Court

(i) Exclusionary rule applies, therefore, evidence is admissible only if rules regarding search and seizure, voluntariness of a confession, etc., have been followed.

b. Dependency action in Juvenile Court on siblings

(i) Exclusionary rule does not apply.

2. Areas to cover in interview: Obtain details regarding the death

ALL PARTIES TO BE INTERVIEWED SEPARATELY

a. Caregivers

(i) How did it occur?

(ii) Who caused it?

(iii) When did it occur?

(iv) What action was taken by which caregiver when the incident was discovered?

(a) What agencies were contacted and by whom?

(b) What other person was informed of the incident?

(c) How soon after the incident was discovered did the caregiver take action?

(d) What was reaction of the other parent?

(v) Who was present when the incident occurred?

(vi) Did suspect and non-participating parent have knowledge of the current incident or past acts?

(vii) What was the emotional condition of the caregiver?

b. Determine whether there is evidence of past abuse/neglect/molest. What medical facilities were used?

(i) What doctors have treated old injuries?

(ii) How did the old injuries occur?

(iii) Who caused the old injuries?

(iv) Approximately when did these acts take place?

Determine whether the victim has been left with other adults in the past

(i) Under what circumstances was the victim left with others?

(ii) What dates and time intervals were involved?

(iii) Who cared for the victim?

c. Victim and Siblings (NOTE: Even a young child can relate important information):

(i) Obtain child's explanation of the incident

(a) How did it occur?

(b) Who caused it?

(c) What instrument/weapon was used by the suspect?

(d) Who else was present?

(e) Was the non-participating parent informed?

(ii) Determine whether there is any past history of abuse/molest

(iii) Determine whether the child witness uses any special terms to identify biological parts

d. Neighbors, teachers, relatives, welfare workers, etc.

(i) How did they come in contact with the child/siblings?

(ii) What have they observed?

(a) Injuries?

(b) Evidence of neglect?

(c) Reports of molest?

(iii) When did they make these observations?

(iv) Were other agencies informed?

(v) Any documentation of the incident?

(vi) From whom did they obtain information?

d. Doctors, nurses, etc.

(i) What medical records, reports, including birth records exist?

(ii) What x-rays exist?

(iii) How do medical personnel believe the injuries occurred?

(iv) Is the caregiver's explanation of how the injury occurred consistent with medical evidence?

(v) What statements, if any, were made by mother, father, stepparent, boyfriend of mother, girlfriend of father, etc., to medical personnel?

(vi) Is there evidence of old injuries?

(vii) Is there evidence of sexual abuse?

(viii) Is child's physical condition consistent with explanation of sexual abuse?

e. Paramedics

(i) Obtain complete name, address and phone number

(ii) What time did the call come? Who made the call and what was said? What time did they arrive at the scene? What was victim's condition? What did they observe? What was done for victim?

(iii) Who did they see at the residence?

(iv) What statements, if any, were made and by whom?

(v) What did the caregiver say to the paramedics when they arrived?

(vi) What was the caregiver's explanation about the victim's condition?

(vii) Did they question anyone at the scene? Who did they question? What was said?

(viii) What was the emotional condition of the caregivers?

f. Special Problems When Mother's Boyfriend or Father's Girlfriend is the Suspect

(i) What information can witnesses relate regarding current incident?

(ii) What information is available regarding past incidents of abuse/molest/neglect?

(iii) Is there evidence that the natural parent had knowledge of the present or prior crime?

(a) Have neighbors, teachers, babysitters, etc., observed evidence of abuse and reported this to the parent?

(b) Did the victim exhibit unusual behavior while in the presence of the suspect?

(iv) What actions were taken by parents when confronted with information regarding the abuse/molest?

(v) Is there evidence that the parent has been subjected to abuse by the suspect?

(vi) Is the suspect still living with, associated with, or communicating with the parent?

(vii) When did the suspect enter the household?

II. PHYSICAL EVIDENCE

A. Photographs

1. Child's injuries (i.e., bite and fingernail marks)

a. Obtain immediate photographs on the scene

b. Obtain set of photographs two to three days later to record any changes which might have occurred

2. House

a. Interior and exterior

b. Obtain drawing of floor plan

3. Weapons used

B. Weapons

1. Locate and impound weapon used to inflict injuries

2. Follow search and seizure rules when impounding evidence

3. Bite marks

a. Get teeth impressions with scale from all possible suspects

4. Fingernail marks

a. Obtain scraping from suspect's fingernails

C. Physical Evidence

1. Locate and impound the following:

a. Clothing worn by victim and suspect

b. Bedsheets

c. Towels

d. Any other item(s) used during the crime

e. Drugs and medication

2. Follow search and seizure rules when impounding evidence

3. Sexual abuse examination should be conducted on all cases. Use Rape Evidence Kit, if appropriate

D. Death Caused by Burns: Evidence to Obtain

1. Obtain details regarding death

a. Have thermometer available to take temperature of water

(i) Hot running and standing (in tub/sink immersion)

(ii) Cold running and standing (in tub/sink immersion)

(iii) Hot and cold running together

b. Take measurements of faucets, sink, tub, etc., (i.e., height, length, etc.)

c. Take pictures of sink/tub and room

d. Check water heater

(i) Location

(ii) Name brand

(iii) Location of controls (i.e., high, low, medium)

(iv) Time of day, day of week, etc.. What activities were performed by household member that day?

(v) Does water heater service other residences?

(vi) Between incidents: If time has elapsed were utilities turned off?

e. Recreate the incident consistent with the history given by the caregiver

E. Polygraph is a Good Investigative Tool and Should be Considered Where Appropriate

F. Obtain All Prior Medical, Social Service, Police Records, etc., of Siblings/Victims

G. Obtain All Prior Medical, Social Service, Police and Criminal Records on Caregiver(s)

H. Confer with Medical Expert: Are the Injuries Compatible with the History Given?

I. Consent Forms

1. Medical records at all medical facilities, including physician(s) office(s)

2. Search of residence and all vehicles

J. Information to Aid Coroner

1. Provide all information acquired during the investigation

2. Medication taken by victim

3. Diet of victim; particularly, last meal

4. Date and time of last meal

MANDATORY ATTENDANCE AT AUTOPSY

OFFICE OF THE DISTRICT ATTORNEY

CHILD ABUSE AND DOMESTIC VIOLENCE SECTION

PROTOCOL

COUNTY OF LOS ANGELES

OFFICE OF THE DISTRICT ATTORNEY

CHILD ABUSE AND DOMESTIC VIOLENCE SECTION

PROTOCOL

Role of the District Attorney

The district attorney is the public prosecutor who conducts on behalf of the people all prosecutions for public offenses.

Child Abuse and Domestic Violence Section

The Los Angeles County, District Attorney's Office created the Child Abuse and Domestic Violence Section in 1979. The Section investigates, files criminal complaints and vertically prosecutes child abuse cases where the perpetrator occupies a position of special trust to the victim. Vertical prosecution means that one prosecutor handles a case from the time of the filing of the criminal complaint to final disposition of the case.

"Position of special trust" means that a person in a position of authority who by reason of that position is able to exercise undue influence over the victim. Position of authority includes the position occupied by a natural parent, adoptive parent, stepparent, foster parent, relative, household member, adult youth leader, recreational director who is an adult, adult athletic manager, adult coach, teacher, counselor, religious leader, doctor, or employer.

Child Abuse Reporting Statutes

The Section prosecutes professionals who are mandated by law, under the Child Abuse Reporting Law, to report incidents of child abuse to the appropriate authorities and fail to do so.

Suspected Child Deaths

The Section reviews all deaths of children in which a family member or caregiver is suspected of causing the death. Child abuse encompasses various acts of commission or omission that endanger or damage a child's physical and emotional health. When a child dies as a result of abuse, more than likely, the death is the end of a long continuum of abusive acts. Abuse may begin with a simple bruise and escalate to severe injury or death.

If there is no immediate and effective intervention to remove the child from the abusive environment or provide intensive supervision while the child remains in the home, the abuse will continue and in all probability increase in severity. Crimes against children are prosecuted under the general penal statutes of the State.

Homicide, as well as other abuse cases, are difficult to prosecute. The cases are almost entirely circumstantial in nature. Oftentimes, there are no available or cooperative witnesses to prior abusive episodes or the one(s) causing death.

The only evidence that may be available to prove the case are medical testimony and documentation diagnosing the injuries as inflicted and non-accidental; and testimony establishing the defendant's care and custody of the victim at the time of the abusive incident(s).

The following factors often exist in a majority of suspicious child death cases:

1. A spouse or other caregiver will generally protect the abusive partner because of

   a. love

   b. dependency

   c. fear

   d. disregard for the child

   e. being the instigator of the abuse

2. There are no independent witnesses to the abuse.

3. Maternal and/or paternal grandparents are protective of the abuser.

4. Sibling of dead child may claim that he/she is responsible for the victim's injuries/death.

5. Children may be programmed by the abuser or passive-condoning caregiver to assume responsibility for injuries to themselves or their injured sibling.

   The age, condition, and developmental age of the victim and/or sibling should be taken into consideration when determining the

feasibility of the child's explanations. A child development specialist can aid in this regard. A word of caution: many psychologists, psychiatrists and physicians do not have adequate experience and knowledge of the developmental stages of children for this purpose.

6. Several people had care and custody of the child during the period of time in which the injuries were inflicted, such as multiple baby sitters and family members caring for the child.

Reports of Child Deaths

Initial reports of suspicious child deaths are made by the Coroner's office to the District Attorney's Child Abuse and Domestic Violence Section.

A. The criteria used to review cases include all deaths of children age 18 and under in which one or more of the following factors are present. The age group has been expanded to reflect the prosecutorial scope of the Section.

1. Drug ingestion

2. Cause of death undetermined after investigation by coroner

3. Head trauma (subdurals, subarachnoid, subgaleal)

4. Malnutrition/neglect/failure to thrive

5. Bathtub/other type of drowning. (Such as in water bucket, toilet, etc.)

6. Suffocation/asphyxia

7. Fractures

8. Sudden Infant Death Syndrome (SIDS). Where history and condition of body raise suspicions or the victim is over the age of seven months

9. Blunt force trauma

10. Homicide/child abuse/neglect

11. Burns, except where cause is clearly not abuse/neglect such as auto accident, accidental house fires, etc

12. Sexual abuse

13. Gunshot wounds

B. How cases are obtained:

1. Calls are received from the Coroner's Office within a day or two of the date of death on all cases which fit the criteria. A form is used to record basic information (i.e., name, home address, address where incident occurred, date of birth, date of death, type of abuse, mother's name, father' name, suspect's name and relationship to victim, coroner's case number, and allegation as to the cause of death -- usually a statement given by the custodial caregiver). (See attached form).

2. Cases are also brought to the attention of the District Attorney's office by the investigating officer or agent of a law enforcement agency.

3. Cases are also referred by health care and other professionals.

C. Follow-up procedure:

1. A request is made to the Coroner's Office/Record Section for copies of autopsy reports and photographs.

2. A Prosecutors Management Information System (PROMIS) Computer check is made on cases where the suspect's name is known. If felony child abuse/homicide charges have already been filed against the suspect by an Area/Branch of the District Attorney's Office, a computer printout is obtained. Periodic checks are made on the computer for Court Action/Disposition of the case.

3. The law enforcement agency investigating the case is contacted regarding the status of the case. Request for copies of police reports is made. The investigating officer is advised that the District Attorney's Office is available for case conferences, consultation and assistance with the investigation.

   If a suspect(s) has been criminally charged by an Area/Branch of the District Attorney's Office, the Child Abuse and Domestic Violence Section is no longer involved with the case, except for monitoring and statistical purposes.

4. All past and current medical records of victim and sibling(s) are obained. Information as to the location of these records can be acquired from the Coroner's Investigation Division, police or health department records.

Evidence of prior non-accidental injuries is clearly relevant as tending to show guilty intent and to rebut any claim that the child's current injuries were inflicted by accident in the course of legitimate punishment.

Repeated incidents show malice, intent, motive, identity, common plan, absence of mistake or accident, knowledge, state of mind, particular behavior pattern.

Evidence of injuries sustained by siblings show at the very least a peculiar behavior pattern by the suspect and tends to identify him/her, the perpetrator of earlier crimes, as the person who perpetrated the crime charged. Records documenting the death of a sibling should be obtained and reviewed. The cause of death may have been misdiagnosed, such as sudden infant death syndrome, when in fact, abuse was the cause.

5. All public social services records regarding the victim and/or sibling(s) are obtained to determine if there has been a pattern of abuse.

D. Procedures after all reports and records are received:

1. A case file is opened.

2. All reports are reviewed in detail.

3. Cases which pose serious questions as to the cause of death and/or identity of the perpetrator are case conferenced with the medical examiner, police investigator, appropriate child abuse medical expert (burns, SID Syndrome, sexual abuse, etc.), representative from the health department and the paramedic.

Problems arise when the pathologist is not certain of the cause of death and consequently ascribes death due to sudden infant death syndrome. This is a very specific cause of death and the diagnosis should not be accepted at face value particularly where the body exhibits injuries/neglect; or there is some history of inadequately explained injuries/neglect, or the victim is over the age of six months.

4. Where the cause of death is undetermined after the autopsy, the District Attorney's Office may request the Coroner to conduct an inquest. The Coroner's Office will amend the death certificate to reflect the verdict of the inquest jury.

5. File appropriate criminal charges against the alleged perpetrator(s).

COUNTY OF LOS ANGELES
OFFICE OF THE DISTRICT ATTORNEY

CHILD ABUSE AND DOMESTIC VIOLENCE SECTION

REPORT OF SUSPICIOUS CHILD DEATHS

Date _____

Reporter _____

Coroner Case No. _____ Coroner: _____

Victim's Name _____

Birthdate _____ Date of Death _____ Age _____

Alleged cause of death: _____

_____

_____

Address _____

Mother _____

Father _____

Guardian _____

Siblings:

1. _____

2. _____

3. _____

Autopsy Report Requested (date) _____ Received _____

Autopsy Photographs Requested (date) _____ Received _____

Police Agency Report Requested (date) _____ Received _____

Prior DPSS Involvement _____ Records Received _____

Prior Health Services Involvement _____ Records Received _____

Medical Facilities Involved: _____

_____

_____

Disposition: _____

_____

CHILD DEATHS - CASE REVIEW

Victim's Name/ *Suspect's Name	Coroner Case No.	DOD	DOB/ Age of Victim	Possible Cause of Death	Prior Contacts of Victim				Prior Contacts of Siblings				Subsequent Contacts With Family/Siblings				In Receipt							DA Petition Request			ICAN Petition Request		
					Med.	Soc. Serv.	Law Enf.	Other	Med.	Soc. Serv.	Law Enf.	Other	Med.	Soc. Serv.	Law Enf.	Other	Med. Reods	Autopsy Report	Coroner Photos	Police Report	Follow-up Reports	Law Enf. Photos		Date Filed	Date Approved	Date Reods Available	Date Filed	Date Approved	Date Reods Available

*Suspect's relationship to Victim: Natural father(NF); Stepfather (SF); Mother's boyfriend (MB); Mother's Common-law/live in (MCL); Natural mother(MM); Stepmother (SM); Father's Common-law/live in (FCL); Father's girlfriend (FG); Babysitter (BS)

DEPARTMENT OF

HEALTH SERVICES

PART I	PROTOCOL FOR CHILD DEATH REVIEW
PART II	PROTOCOL FOR ACUTE MEDICAL FACILITY CASE MANAGEMENT IN CHILD DEATHS
PART III	PROTOCOL FOR CORONER'S CASE REVIEW

LOS ANGELES COUNTY

DEPARTMENT OF HEALTH SERVICES

CHILD DEATH RECORD REVIEW

PROTOCOL FOR MEDICAL RECORDS

The review of medical records of a child who has died as a result of unusual circumstances and those of his/her siblings is valuable in the accumulation of information relevant to the investigation of child abuse cases. It also results in recognizing conditions which commonly exist prior to the death of a child which may assist health care, law enforcement, and prosecutorial professionals in the prevention and early detection of child abuse and neglect.

Many children who are victims of homicide were previously seen in multiple health facilities for a variety of injuries and/or illneses. As a single incident, the problem appears inconsequential. However, when the records are reviewed in total, a picture of ongoing abuse, non accidental trauma, or neglect can be readily identified.

Case review has shown that emergency room facilities are frequently over utilized by parents who later murder their children. Health professionals being aware of this possibility, should insist on a complete review of the total patient record including information regarding past emergency room visits when assessing the child's current medical condition.

This record review often reveals a demonstrated history of probable child abuse that was not reported to the appropriate authorities pursuant to the Child Abuse Reporting Laws.

All medical records for the dead child and his/her family should be reviewed and evaluated on every child death to determine whether there is evidence to indicate that death was the result of child abuse and neglect and to access areas in which early prevention should have occurred. This information can be used to set up indepth criteria for medical management of families who are identified as high-risk for abuse/neglect; and can demonstrate the need to follow cases that are reported.

DEPARTMENT OF HEALTH SERVICES (DHS)

CENTRAL CHILD ABUSE PREVENTION PROGRAM

PROTOCOL FOR CHILD DEATH REVIEW

1. Case is identified by Coroner's office and cleared for medical record numbers.

2. Medical record number is recorded on Coroner's Report (log) of cases identified.

3. Information regarding medical records that is obtained by law enforcement investigator is entered in Coroner's Report (log).

4. Coroner's office notifies DHS regarding case.

5. Information provided is entered on Coroner's Project sheet by DHS (Attachment A).

6. Coroner's office calls for all medical records from public and private facilities.

7. DHS is notified when these records are available.

8. DHS conducts review of all medical records using Record Review Guidelines (Attachment B).

9. Information regarding medical record review is shared with death review committee, laws enforcement investigators, and the District Attorney's office.

10. Health facility child abuse teams are notified by DHS if they are identified as having medical records on a child who has been identified by the child death case review process as a possible victim of child abuse and neglect.

PROTOCOL FOR ACUTE MEDICAL

FACILITY CASE MANAGEMENT IN CHILD DEATHS

1. Ask family or responsible person history and locations of previous medical care for child, siblings, and family.

2. Request and review all records from the medical facilities. This review can be accomplished telephonically when time is of the essence.

3. Request and review in-house medical records.

4. Notify the Coroner's office of the existence and location of medical records and previous medical care.

5. Notify the Coroner's office of information suggesting child abuse or neglect.

6. Report suspected child abuse/neglect child deaths to the Department of Public Social Services and Law Enforcement. Complete the required Suspected Child Abuse/Neglect forms and distribute as required by law. Indicate on the report form the existence and location of previous medical records.

INTERAGENCY CHILD ABUSE AND NEGLECT SUBCOMMITTEE

CORONER'S PROJECT

Department of Health Services
County of Los Angeles

DATE:_____

TIME:_____

NAME_____ CC#:_____

DOB:_____

MOTHER'S NAME_____ DOD:_____

FATHER'S NAME_____ LOCATION OF DEATH_____

ADDRESS_____ _____

_____

SEX____M ____F RACE_____

SUSPECTED CAUSE OF DEATH (Please Check)

Drug Ingestion	_____	Suffocation/Asphyxia	_____
Cause undetermined after Coroner's investigation	_____	Fractures	_____
		SIDS age 7 mo. & over	_____
Head Trauma (subdurals, subarachnoid, subgaleal)	_____	Blunt force trauma	_____
		Homicide/Child Abuse/ Neglect	_____
Malnutrition/Neglect, failure to thrive	_____	Burns except where cause is clearly not child abuse/neglect, e.g., accident, house fire, etc.	_____
Bathtub drowning	_____		

OTHER (Specify)

_____

_____

Hospital or Clinic:_____ Record #:_____

Notification:

SCAN Team _____ Call made to Records & Identifcation
(Member)

CART Team _____ _____
(Member) (Date) (Time) (Int)

DATE_____

TIME_____ AM PM

Re-call to Coroner's Office

_____
(Date) (Time) (Int)

Attachment B

CORONER'S CASE #

CHILD ABUSE/NEGLECT

RECORD REVIEW

GUIDELINES

COMPLETED BY:_____

FACILITY:_____

DATE OF REVIEW:_____

NAME:_____ RECORD #:_____

BIRTHDATE:_____ DATE OF DEATH:_____

MEDICAL FACILITY:_____

	AGE/BIRTHDATE
ADDRESS_____	
MOTHER_____	_____
FATHER_____	_____
GUARDIAN_____	_____
SIBLINGS	
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

FOSTER PARENTS:_____

I. Social History

1. Parent:

Previous history of abuse/neglect of children.

History of parents being neglected/abused.

2. Other persons in household and relationships to patient.

_____	_____
_____	_____
_____	_____
_____	_____

3. Case known to DPSS or law enforcement.

II. MEDICAL HISTORY

1. Past history of:

Trauma	Date(s)	Comment

Hospitalizations - (Name, location & record number)

Ingestions:

Usual source of medical care & record number: # _____

	Dates(s)	Comment
Hyperactivity:		
Behavior Problems:		

2. Present medical information

Cause of death:_____

Type of injuries:_____

Evidence of previous injury(s):

Evidence of neglect:

X-Ray findings:

Laboratory findings:

Photographs:

History surrounding present illness/injury:

Delay in seeking medical care Yes_____ No_____

Who brought child to hospital or called for assistance?

Information surrounding death - i.e., time of day, rescue efforts, location.

Other:

3. Developmental history - (Be specific and include dates, if pertinent)

Feeding problems:

Delay in language:

Parent/child conflicts:

Failure to thrive:

Underweight:

Overweight:

Tall or short for age:

Delay in Motor Development-

Other:

4. Prenatal and Neonatal history

Unwanted/Wanted Pregnancy -

Planned/Unplanned Pregnancy -

Difficulty During Pregnancy -

Premature -

Postmature -

Deformities -

Other-

5. Family Medical History

Drug Abuse -

Alcohol Abuse -

Mental Illness -

Disabilities -

Abuse/Neglect in Siblings
(Be specific and give dates, if available)

Death of Siblings(s) -

Other -

III. Home Environment

1. Unsafe or unhealthy condition at home.

2. Children left unsupervised.

IV. Comments - (Any additional information that you feel may be useful in determining the instance of possible child abuse/neglect in this case).

V VISITS TO FACILITY

DATE	PURPOSE	PHYSICAL FINDINGS	COMMENTS*

*Include parental attitude toward child and condition.

(10)

CHIEF MEDICAL EXAMINER-CORONER

PART I	PRE-AUTOPSY
PART II	AUTOPSY
PART III	POST AUTOPSY ANALYSIS

OFFICE OF

CHIEF MEDICAL EXAMINER—CORONER

AUTOPSY PROTOCOL
CHILD ABUSE

The following guidelines are designed to help the pathologist in his examination of newborns, infants and young children who are the victims or who are suspected to be the victims of child abuse or neglect. This includes all cases falling within criteria in the list. The approach to a case can be conveniently divided into three phases:

1. Pre-Autopsy (gathering of information and collection data)
2. Autopsy itself
3. Post-Autopsy (analysis of the findings and interpretation of the data)

PRE-AUTOPSY:

A. Investigation - The case should be assigned to an experienced investigator

1. Coroner's Investigation

a. Check list for Coroner's Investigator added as appendix.

b. General Information:

- Identification of Victim (Identified by Whom?) - Name, Age, Sex.
- Home Address, Place of Death, etc.
- Pronounced Dead - By Whom, Where, When?
- Found Dead - By Whom, Where, When?
- Last Seen Alive - By Whom, Where, When?

c. Family Background:

- Parents' marital status (married, single, divorced, etc.)
- Mother
- Father
- Babysitter
- Guardian
- Foster Parent
- Mother's Boyfriends
- Father's Girlfriends
- Siblings - Number, Age, Sex, Medical Condition

d. Medical Background:

- Growth and Development (height and weight - at birth and currently)
- Medical Illnesses
- Previous Injuries
- Previous Hospitalizations
- Maternity History (Prematurity, Unattended Birth, etc.)

2. Police Investigation

3. Social Services Records

4. Hospital Records:

   a. Recent Injuries
   b. Old Injuries
   c. Disease

5. Attending Physician Statement

6. Witness Statements

7. Chronology of events leading to death (Narrative Description)

B. Processing Body at Scene

1. Photographs

2. Diagram of Scene Showing Original Position of Body

3. Description of Scene

   a. Type of Residence
   b. Cleanliness
   c. Sanitation
   d. Lighting
   e. Heating
   f. State of Kitchen
   g. State of Bathroom
   h. Safety Hazards
   i. Evidence of Rodents
   j. Evidence of Insents
   k. Evidence of Alcoholism
   l. Evidence of Drug Abuse
   m. Food - How much, appropriateness

4. Description of Position of Body (Original position as well as position at time of investigation.)

5. Description of Clothing

   a. Appropriateness
   b. Cleanliness
   c. Changed After Death

6. Investigator's Description of Body - Presence of Wounds, Blood, Vomitus, Urine, Feces, Other Body Fluids.

7. Collection of Evidence at Scene Where Applicable

8. Transportation of Body to Medical Examiner's Office

   - Body shall be properly identified and labeled.

   - Evidence property packaged and labeled. The body is evidence and shall be treated as such. The chain of custody shall be maintained.

4. Note care of skin, cleanliness, rashes, etc.

5. Examine hair, eyes, ears and all orifices

6. Note state of rigor mortis, livor mortis, temperature and estimate time of death when applicable

7. Note fractures usable for identification

8. Note congenital anomalies, deformities, etc.

9. Note scars, marks, tattoos, etc.

B. Evidence of Medical Treatment:

1. Needle marks and I.V.'s
2. Dressings
3. Nasogastric and Tracheostomy Tubes
4. Catheters
5. Cavity Tubes
6. Surgical Wounds and Scars

C. Evidence of Injury:

1. All injuries shall be diagrammed and photographed.

2. Each wound shall be identified, numbered and described in a separate photograph.

3. Each wound shall be located by measuring its distance from the top of the head and to the right or left of the midline.

4. Size, shape and depth of the wound shall be recorded.

5. Wound shall be described and identified as an abrasion, contusion, laceration, incised wound, stab wound, penetrating wound, gunshot wound, etc.

6. Descriptive features relative to the age of the wound shall be noted when applicable.

7. Where in doubt as to the nature of a mark, it shall be carefully incised and examined again as well as photographed.

8. Make microscopic section of wound for further differentiation.

D. Wound patterns commonly seen in Child Abuse:

1. Hair - bald patches often mean that hair has been pulled out at the roots

2. Eyes - contusions of the eyelids, conjunctivae, sclerae, globe, retina, etc.

3. Ears - cauliflower-like lesions from pinching

4. Mouth - torn frenulum of lips and tongue

5. Face - a. Abrasions from repeated slappings
   b. Gag marks

6. Shoulders - hand marks from shaking child

7. Neck - asphyxial wounds

8. Ankles and wrists - Look for ties and restraints

9. Patterned abrasions and bruises, particularly of the buttocks, thighs and back, from belts, straps, etc.

10. Burns

11. Extremities - Examine for deformities, old and recent fractures

12. Genital and perianal injury

E. Internal Examination: Torso

1. All internal wounds shall be photographed and diagrammed

2. Body cavities checked for blood, fluid, purulent material, bowel content

3. Organs - shall be examined in situ for evidence of injury, deformities, congenital anomalies, etc.

4. Specimen Collection:

a.	Blood for Toxicology	g.	Brain
b.	Blood for Serology	h.	Fat
c.	Urine	i.	Viteous
d.	Bile	j.	Liver
e.	Gastric	k.	Kidney
f.	Intestinal Content		

5. Chest Cavity and Ribs - Check for recent and old fractures

6. Heart - Weight, measurements, injuries, congenital anomalies, etc.

7. Lungs - Weight, pneumonia, etc.

8. Mediastinal Contents. Weigh thymus. Obtain Histologic section

9. Liver and Gallbladder - Weight of liver, lacerations

10. Spleen - Weight of Spleen, lacerations

11. Pancreas

12. Gastrointestinal Tract - Note gastric and bowel content particularly in neglect cases.

13. Adrenal

14. Kidneys and Urinary Tract - Weight of Kidneys

15. Internal genitalia

16. Remove any remaining tissue and examine pelvis and spinal column

F. Internal Examination: Head

1. Galea - for hemorrhage
2. Skull - for fractures
3. Dura - for hemorrhage

4. Arachnoid - for hemorrhage
5. Brain - for injuries, stage of development, congenital anomalies

Brain preserved in formaldehyde for further neuropathological studies where appropriate.

G. Internal Examination: Neck

1. The neck shall be carefully dissected by the pathologist in all cases of suspected asphyxia

2. Soft tissues, muscle and thyroid gland dissected layerwise

3. Larynx and trachea dissected free and examined

4. Cervical spine examined

H. Spinal Cord removed and examined where applicable

I. Newborns:

1. Umbilical cord and placenta should be examined if available

2. Gestational age should be determined

3. Determine if death occurred intrauterine, at birth or neonatally

J. Microscopic:

1. Routine tissues
2. Wounds
3. Subdural hematomas

K. Other studies where applicable:

1. Bacteriology
2. Serology
3. Hemoglobin Electrophoresis
4. Toxicology

POST AUTOPSY ANALYSIS:

A. Meeting between Deputy Medical Examiner, Investigator, District Attorney, etc. Ideally they should all be present at the autopsy.

B. Determine Cause of death

C. Determine Manner of death

D. Prepare autopsy report

E. Further proceedings when applicable

PROCEDURE OF NOTIFICATION OF POSSIBLE CHILD ABUSE CASES

BY THE MEDICAL EXAMINER-CORONER'S OFFICE

1. How cases are identified and recorded:

   a. Each working day (morning) the daily report case list for children 0-10 years is checked. If the investigated cause of death is within the criteria developed by the ICAN Child Death Case Review Committee, the Coroner's case number is recorded in the child abuse notification folder.

   b. Cases are also brought to attention by a doctor performing the autopsy who feels the child may have encountered foul play.

2. Procedure after a case has been identified as a possible ICAN notification case:

   a. The investigation report is located.

   b. The report is photocopied.

   c. Preventive Public Health Office is notified and given the basic case information required by them for a computer check for prior health records. The clerical person at Prevention Public Health Office reports back with a prior record number or information that there is no listing.

   d. Department of Public Social Services Child Abuse Services is notified.

   e. The Child Abuse and Domestic Violence Section of the District Attorneys Office is notified of the basic investigated information.

   f. Any prior hospital record is noted in the case folder.

   g. Case numbers reported are checked periodically for final death certificate information. When finalized, the basic information is recorded in the notification folder.

   h. At the end of the year case lists are typed and shared with the committee members.

CHILDREN - AGES 0-10 YEARS OLD

ICAN REFERRALS

CORONER CASE NO. NAME OF CHILD MODE OF DEATH	RACE	SEX	AGE	BIRTH DATE	CAUSE OF DEATH	DEATH DATE	MOTHER'S NAME	FATHER'S NAME	ADDRESS OF CHILD POLICE AGENCY	Prior Record DPSS / Health

DEPARTMENT

OF

CHILDREN'S SERVICES

CHILD DEATH INVESTIGATION PROCEDURES

PART I CHILD DEATH: SOCIAL SERVICES ASSESSMENT

PART II DCS RESPONSE TO NOTICE FROM CORONER OF CHILD DEATHS MEETING ICAN CRITERIA

PART I

CHILD DEATHS: SOCIAL SERVICES ASSESSMENT

There are several types of situations where child protective services agency staff may be involved in investigating a child death;

— A referral may be received for protective services for the siblings of the dead child or for other children in the home where the death occurred.

— A child already receiving services from the agency may die and it must be determined if the death resulted from natural, accidental, or nonaccidental causes.

Whenever a child dies under circumstances of known or suspected child abuse or neglect and there are other children involved who may be endangered, an investigation is necessary to determine what protective services these children may need. These other children who may be endangered include siblings, other children (related or nonrelated) in the home and, in the case of foster care, other children placed in the home or facility. Removal from the home and/or Juvenile Court (WIC 300) intervention may be necessary. In foster care situations, replacement of the other children in the home or facility may be needed. In foster care situations, a determination must also be made as to whether violations of licensing law or regulation exist.

The attached material summarizes the procedures utilized by the Department of Children's Services (formerly the Department of Public Social Services) in investigating child deaths.

I. Assessment: All Deaths

A. Whenever a child under DCS Children's Services supervision dies, an investigation takes place to determine the circumstances of the death. Information is obtained from the following sources:

1. Parents or other caretakers of the child.

2. Others who may be able to provide relevant information — siblings, other relatives, others in home, school personnel, etc.

3. Doctors and other medical personnel.

4. Investigating law enforcement agency.

5. Coroner.

6. Licensing records, if appropriate.

7. Children's Services case records and other Children's Services Workers who have knowledge of the family or facility.

B. Written reports are prepared from the information obtained. (See Attachment I, "DPSS Worker's Report of Death, Injury, Alleged Mistreatment, or Illness of a Child Under DPSS Supervision," PA 1688.)

C. The written reports are reviewed administratively and appropriate action taken. Licensing, the Child Care Institution Evaluation Unit and the Supervising Judge of the Dependency Court receive copies as appropriate. A written report is made to the Department Director.

II. Deaths Suspected to be Child Abuse or Neglect Related: Reports to Law Enforcement and Department of Justice (DOJ)

A. Reports to Law Enforcement

Whenever the death is suspected to be child abuse or neglect related and law enforcement is not already investigating, the Children's Services Worker makes the reports required by the Child Abuse Reporting Law. The law requires that a telephone report be made immediately or as soon as possible to law enforcement and that a written report ("Suspected Child Abuse Report," SS 8575, Attachment II) be sent within 36 hours.

B. Reports to Department of Justice (DOJ)

Whenever DCS investigates a death which is suspected to be child abuse related, a written preliminary report (SS 8575) is sent to DOJ within 15 calendar days of the notification of the death.

If the investigation determines the suspicion of child abuse to be unfounded, DOJ is sent a written notice of this finding (SS 8575) at the conclusion of the investigation.

These written reports to DOJ are required by the Child Abuse Reporting Law.

III. Deaths Suspected to be Child Abuse and Neglect Related: Assessment of Need for Protective Services for Other Children

A. When DCS is advised of a suspected child abuse or neglect-related death and there are other children who may be endangered (siblings or other children in the home/facility), a protective services investigation is undertaken. Other agencies who are supervising children in the home are notified of the suspected abuse or neglect.

B. If law enforcement has not taken the children into protective custody, a home contact must be made immediately (no later than two hours) after notification of the incident.

C. Whenever the suspected child abuse or neglect-related death occurs in a foster home or group home, the agency responsible for licensing the home or facility is notified.

D. The Children's Services Worker evaluates the risk to the child(ren) and determines what action is needed. In making this evaluation, the Worker utilizes the information obtained from the sources listed in section I.A. of this material, the Children's Services Handbook guidelines for assessing a protective services referral (Attachment III) and the Dependency Handbook guidelines for assessing conditions which warrant taking a child into temporary custody (Attachment IV). Possible actions which may be taken include:

1. Request to law enforcement to take child(ren) into protective custody.

2. Request for new or supplemental dependency petition on behalf of child(ren).

3. Replacement of children placed in foster home or group home.

4. Monitoring of child(ren) in home.

If the Children's Services Worker decides that Juvenile Court action should not be initiated on behalf of the child(ren), administrative review and approval of that decision are required. In cases involving a foster home or group home, administrative review and approval are required to allow other DCS-placed children to remain in that facility or home.

COUNTY OF LOS ANGELES

DEPARTMENT OF PUBLIC SOCIAL SERVICES

DPSS WORKER'S REPORT OF DEATH, INJURY, ALLEGED MISTREATMENT, OR ILLNESS OF A CHILD UNDER DPSS SUPERVISION

A. IDENTIFYING INFORMATION

	1. STATE NUMBER	2. TYPE OF REPORT ☐INITIAL ☐SUPPLEMENTAL
3. CASE NAME	4. COURT NUMBER	5. DATE DPSS NOTIFIED OF INCIDENT
6. CHILD'S NAME	7. TYPE OF CASE ☐SP ☐HOP ☐VP ☐PS	8. DATE OF INCIDENT / TIME
9. BIRTHDATE / AGE / ☐MALE ☐FEMALE	10. TYPE OF INCIDENT ☐DEATH ☐INJURY ☐ILLNESS ☐ALLEGATION OF MISTREATMENT	11. WORKER'S NAME
12. DATE LICENSING/CCIEU NOTIFIED		13. DISTRICT / FILE
14. MINOR'S CARETAKER	15. ADDRESS	16. PHONE / 17. RELATIONSHIP

B. INVESTIGATION

18. What happened? Where did it happen? Is mistreatment of the minor suspected? ☐YES ☐NO

19. What injuries did the child receive? What illness does the child have? What is the child's current condition?

20. In your opinion, was reasonable care, protection and supervision given this child? ☐YES ☐NO
If No, indicate how care was inadequate.

21. Could this incident have been prevented? ☐YES ☐NO If yes, how?

22. Was medical attention obtained in a timely manner? ☐YES ☐NO If no, what caused this delay?

23. What action, if any, is planned or has been taken?

C. CHILDREN'S SERVICES WORKER'S RECOMMENDATION TO THE LICENSING WORKER

- ☐ Not applicable. Child not in placement.
- ☐ Continue license in normal use. The foster care providers were not responsible for the child's injury, illness, or death.
- ☐ Licensing investigation requested. There appears to be some negligence in relationship to this incident.
- ☐ Foster home to be placed on "Hold - Do not Use" status pending further action. There appears to be considerable negligence.

Date "HOLD" Initiated	Person Requesting Hold	Person Placing Hold

Was your recommendation discussed with the foster care provider?

☐ No ☐ Yes, Date _____. If Yes, did the person ☐ accept or ☐ disagree with your recommendation?

D. NOTIFICATION OF PARENTS

Natural parents were notified: _____ (Date) ☐ In Person ☐ By Telephone ☐ By the undersigned CSW

☐ By another person, specify _____

☐ Registered mail, return receipt requested

Date Sent _____

E. POLICE REPORT

Was the local law enforcement agency involved at the time of the incident? ☐ Yes ☐ No

If so, was a report prepared by the police? ☐ Yes ☐ No

F. SUSPICION OF CHILD ABUSE

Is child abuse suspected? ☐ Yes ☐ No If so, the mandatory report to law enforcement was made on the telephone by

_____ (Name) _____ (Date) and in writing by _____ (Name) _____ (Date)

(Under California Penal Code Section 11166(f) a County Welfare Department shall report by telephone and in writing every instance of suspected child abuse. Reference CSH 2768.)

G. ATTACHMENTS

Check Attachments	Check if requested but not received — Date Requested
☐ PA 1689	☐ _____
☐ Licensing Worker's Review	☐ _____
☐ Police Report	☐ _____
☐ Medical Report	☐ _____
☐ Coroner's Report	☐ _____

SIGNATURE/TITLE	DATE	DRSA'S SIGNATURE	DATE
SUPERVISOR'S SIGNATURE	**DATE**	**RSA'S SIGNATURE**	**DATE**

FORM PREPARATION GUIDE. The CSW completes 2 copies. Items not discussed are self-explanatory.

Section A. 2. Initial Report - Check when completing a report on the incident for the first time (within three days of the incident

Supplemental Report - Check when the form is used to record additional information or when supplemental report are received after initial report has been sent. Complete Sections A. 1, 2, 3, 4, 6, and other sections as appropriate Attach Supplemental Reports.

Section A. 7. SP = Suitable Placement Order, HOP = Home of Parent Order
VP = Voluntary Placement, CI = Crisis Intervention

ROUTING

CSW — Original and 1 to SCSW
1 Retains
SCSW — Original and 1 to DRSA
DRSA — Original to RSA
1 Retains

RSA — Original to CSW
1 Retains
1 Director, BSSO
1 Director, MAE
1 Division Chief

1 Director, Child Abuse Services
1 Licensing Director or APD, CCIEU
1 Supervising Judge of Dependency Court (Court Cases Only)

INSTRUCTIONS

TRANSACTION TYPE:

Preliminary Report – Check this box if the preliminary investigation has been completed.

Unsubstantiated Report – Check this box if the preliminary investigation has been completed and although not *proven* unfounded, the incident cannot be substantiated.

NOTE: Unsubstantiated reports are still maintained in the Department of Justice Child Abuse Central Registry as suspected child abuse incidents.

Unfounded Report – Check this box if the incident proves to be unfounded.

A. INVESTIGATING CHILD PROTECTIVE AGENCY:

1. Agency Name – Enter name of the child protective agency investigating the suspected incident.
2. Date of Report – Enter the date the investigating party completes the "Suspected Child Abuse Report."
3. Report No./Case Name – Enter the investigating child protective agency report number or case name for the suspected incident.
4. Name of Investigating Party – Enter the investigating party's name.
5. Telephone – Enter the telephone number where the investigating party can be reached.

B. INVOLVED PARTIES:

Enter the name (last, first, middle), birthdate, sex and race of all victims, parents of victims, siblings living in the same household as the victim(s), and suspects. Check the appropriate box(es) opposite each name. For example, if the parent of the victim is also a suspect in the incident, enter his/her name only one time and check both the "Parent" and "Suspect" boxes.

If there are more than 8 parties involved, attach an additional sheet(s) and check the box at the bottom of Section B.

C. INCIDENT INFORMATION:

1. Date Incident Reported to Child Protective Agency – Enter the date the incident was reported to the child protective agency.
2. Type of Abuse – Check the box(es) which best describes the abuse.
3. Did the Abuse Result in Death of the Victim(s)? – Check "Yes" or "No".
4. Did the Abuse Occur in a Group Home or Institution? – Check "Yes" or "No". If "Yes" is checked, enter the name of the home or institution.

MAILING:

Upon completion, send the Department of Justice copy to:

Department of Justice
Bureau of Criminal Statistics and Special Services
P. O. Box 13417
Sacramento, California 95813

Attention: Child Abuse Program

TRANSACTION TYPE:

☐ PRELIMINARY REPORT ☐ UNSUBSTANTIATED REPORT ☐ UNFOUNDED REPORT

SUSPECTED CHILD ABUSE REPORT
(11169 PC)

TO BE COMPLETED BY THE INVESTIGATING CHILD PROTECTIVE AGENCY

A. INVESTIGATING CHILD PROTECTIVE AGENCY:

1. AGENCY NAME _____

2. DATE OF REPORT _____ 3. REPORT NO./CASE NAME _____

4. NAME OF INVESTIGATING PARTY _____ 5. TELEPHONE (____)_____-_____

B. INVOLVED PARTIES:

ENTER INFORMATION FOR ALL VICTIMS, PARENTS AND SIBLINGS OF VICTIMS, AND SUSPECTS INVOLVED IN THE SUSPECTED INCIDENT.

	NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	SEX	RACE	(CHECK ONE OR MORE) VICTIM	PARENT OF VICTIM	SIBLING	SUSPECT
1.					☐	☐	☐	☐
2.					☐	☐	☐	☐
3.					☐	☐	☐	☐
4.					☐	☐	☐	☐
5.					☐	☐	☐	☐
6.					☐	☐	☐	☐
7.					☐	☐	☐	☐
8.					☐	☐	☐	☐

ATTACH ADDITIONAL SHEET(S) IF NECESSARY AND CHECK HERE ☐

C. INCIDENT INFORMATION:

1. DATE INCIDENT REPORTED TO CHILD PROTECTIVE AGENCY _____

2. TYPE OF ABUSE *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ASSAULT ☐ NEGLECT

☐ OTHER-SPECIFY _____

3. DID THE ABUSE RESULT IN DEATH OF THE VICTIM(S)? ☐ YES ☐ NO

4. DID THE ABUSE OCCUR IN A GROUP HOME OR INSTITUTION? ☐ YES ☐ NO

IF "YES", ENTER NAME OF THE HOME OR INSTITUTION _____

INSTRUCTIONS ON REVERSE

DISTRIBUTION: Police or Sheriff — WHITE Copy; County Welfare or Probation — BLUE Copy; DOJ — PINK Copy

SS8575 1/82

64950-252 1/82 100 M TRIP - OSP

2221 Factors to be Assessed In Investigating a Referral

.1 Factors to be considered in assessing the family's condition and level of danger to the child include, but are not limited to:

.11 The Condition of the Child

.111 Physical indicators which lead to or cause death, disability, irreparable damage, or great physical pain.

a. Does the child appear to need immediate medical treatment? Is the child currently receiving needed medical care?

b. Does the child show evidence of current or repeated bruises or other injuries?

c. If the child has injuries, have they been appropriately treated?

d. Does the child appear to be undernourished, or show symptoms of failure-to-thrive syndrome?

e. Are there indications that the child has been sexually abused?

NOTE: Because the indications of sexual abuse are so diverse, CSWs are encouraged to contact the Child Sexual Abuse Project (CSAP) at 724-0100 ext. 1814 for consultation on specific casework situations.

f. Does the child appear unduly fearful of his/her parents or fearful in general?

g. Are there indications that the child is or has been confined or isolated for long periods of time?

h. Does the child's physical, cognitive, emotional and social development appear to be within the normal range for his/her age? (See CSH Section 2800, Growth and Development Charts and Guidelines.)

i. Does the child cry frequently, continuously or inappropriately?

.112 Social Indicators

a. Is the child described as "different" or "bad" by the parents? Do they refer to child by name or call him/her "it"?

b. Is the child notably passive or withdrawn, hostile, aggressive?

.12 Factors Affecting Parenting

.121 Does either parent have an emotional, mental or physical incapacity which leads directly to or contributes to the endangerment of the children?

.122 Does either parent misuse drugs or alcohol?

.123 Does either parent have a major disease or disability which interferes with proper parenting?

.13 Parental Conditions

.131 Are parents socially isolated? Do they have friends or relatives nearby? Do they belong to a church or any organizations?

.132 Are the parents employed? Are there financial problems?

.133 Do the parent's relate well to each other? Make eye contact with each other and the children? Exhibit a reluctance to discuss family matters in the presence of the other?

2221 (Continued)

.134 Are there cultural factors which might influence parenting or social behavior and relationships?

.135 Are the parents divorced or separated? Is the absent parent involved with the family?

.14 Parental Attitudes

.141 What are the parent's reactions to the allegation(s)?

.142 Are the parents unable or unwilling to explain the child's injuries? Does the explanation fit the injury? Do they offer contradictory explanations?

.143 Do the parents show lack of self-control or fear of losing control?

.144 Do the parents unrealistically blame a sibling or third party for endangerment to the child?

.145 Do the parents believe that they were unloved or unlovable as children or that they were neglected or abused as children? Were the parents abused as children and now believe that it is proper to impose these same conditions on their own children?

.146 Do the parents meet the child's medical needs?

.147 Do the parents appear more involved with themselves and their own needs than those of the child?

.148 Do the parents have unrealistic expectations of their children and become impatient when they cannot meet the parents' standards? Do they see their children as self-sufficient? For example, a five year old being able to supervise him/herself.

2221 (Continued)

.15 Situational Factors

.151 Is there a current crisis (such as loss of job, death in the family, serious illness, family breakup), which has affected the family?

.152 Are there conditions inherent in the family's situation that are endangering to the child, e.g., parents' working hours, type of employment, money mismanagement, inadequate or unsafe housing, lack of transportation, or a lack of child care resources?

24320 Conditions Warranting Temporary Custody

While Section 300 WIC describes all children coming under the jurisdiction of the court, there are specific factors which apply when the action initiating the court process must be taken without delay, and the child must be taken into protective custody.

.1 The determination as to whether protective custody is warranted must be based on an assessment of the facts of the case.

.11 The facts of the case must clearly show:

.111 That the endangering is severe, and

.112 That the parent or caretaker has either committed the endangering act or has taken no action to prevent it, and

24320 .113 That the minor is unsafe in his own home.

.2 Some situations, by their very nature, may in and of themselves justify protective custody. Some of the more obvious conditions include:

.21 Non-accidentally inflicted injuries, including:

.211 Broken bones,

.212 Severe and extensive bruising,

.213 Severe and extensive burns,

.214 Injuries to internal organs,

.22 Sexual molestation including:

.221 Fondling of breasts or genitals,

.222 Sexual intercourse,

.223 Oral copulation,

.224 Sodomy,

.225 Use of a child for pornographic purposes,

.226 Venereal disease in a child under 12 years of age.

.23 Gross lack of supervision or an unfit home, including:

.231 An unsupervised child under 13 years of age when no responsible caretaker is in the home and no one has knowledge of the parent's whereabouts or when (s)he will return;

.232 A filthy home which may include but is not limited to unsanitary conditions, e.g., rotten food, broken and filthy toilet, broken windows which have not been secured, drugs within easy reach of a child;

.233 A child locked in a room or closet and incapable of freeing him/herself;

24320

.234 A child bound or chained;

.235 A child given unprescribed drugs or alcohol;

.236 An infant born addicted to drugs or alcohol (excluding therapeutically prescribed medications, e.g., methadone maintenance).

.24 Severe failure to thrive which has been diagnosed by a physician and is not caused by a medical problem which is known or can be diagnosed. This usually includes malnutrition and dehydration as well as other serious developmental lags.

.3 In contrast to the above, some injuries or conditions may not be easily identifiable as inflicted or as resulting from the negligence of the parent or caretaker. Examples might be an incident of Valium ingestion by a two year old or a burn to the hand of a three year old. When these situations occur, assessing the risk to the child is a key issue, and it must be based on judgement and casework decisions. CSW's should consult with their unit SCSW and, when necessary, DRSA, in making the decision to request or take a child into protective custody. Factors to be considered are:

.31 A history of other similar incidents which can be documented and which have occurred regardless of services offered, and

.32 A strong probability that the endangering will continue.

.4 In many cases there may be siblings or half-siblings in the home who, although not themselves the victims of the endangering act, may need protection from possible similar abuse and from mental injury resulting from witnessing the abuse or its effects. When this situation exists, these children must also be considered to be in need of protective custody and juvenile court action.

For specific instructions on the requirements and procedures in these cases, see Handbook Section 25000, "Petitions"; 73000, "Investigations"; and 75000, "Supervision".

PART II

DCS Response to Notice from Coroner

of Child Deaths Meeting ICAN Criteria

I. Record Clearance

Upon notification by the Coroner's Office of a child death that meets the ICAN criteria, DCS will clear its computer information system (WCMIS) to determine if there is an open or closed case on the family.

II. Eligibility Worker Notification

If there is an open case for Medi-Cal, food stamps or financial assistance, the Eligibility Worker will be notified of the death by DCS Child Abuse Services staff.

III. Initial Assessment of Need for Protective Services on Behalf of Siblings

When siblings are identified from the information supplied by the Coroner's Office, the Eligibility Worker or WCMIS and there is no open services case, an assessment of the need for children's protective services will be made by Child Abuse Services staff. This assessment is made on the information obtained from the Coroner's Office, investigating law enforcement officer and Eligibility Worker. Child Abuse Services staff will make a referral to Children's Protective Services when appropriate. In most cases where Children's Protective Services is needed, law enforcement has already made a referral to DCS.

IV. Administrative Review of Open or Closed Services Cases

Child Abuse Services staff notifies the appropriate DCS Regional Services Administrator (RSA) of the death whenever it is determined that there is an open or closed services case. The RSA insures that an administrative review of the case is completed. The purposes of the review are (1) to assure that any necessary protective action on behalf of siblings or other children in the home is taken and (2) to identify any procedural, policy, or training problems in need of correction.

V. Cases Selected for ICAN Case Review Subcommittee Review

Information on those cases selected by the Subcommittee for review is shared by DCS with the Subcommittee as authorized by the Presiding Judge of the Juvenile Court and federal and state laws and regulations.

Revised August 1984

MONTEREY COUNTY

SUDDEN INFANT DEATH SYNDROME

I. PURPOSE

To provide the investigator with general guidelines for the investigation of Sudden Infant Death Syndrome cases.

II. GENERAL

Definition: Sudden Infant Death Syndrome (SIDS, crib death, sudden, unexpected death in infancy) is an unpredictable, unpreventable sudden death of an otherwise healthy infant, usually between one and six months of age, in whom the complete postmortem examination fails to reveal a cause of death. It is, therefore, a cause of death based on the exclusion of other significant diseases and unnatural events. A history of a recent mild upper respiratory tract infection (cold, sniffles, congestion, etc.) is frequently elicited. Death usually occurs silently during sleep. The expected incidence in the general population is two per one thousand live births.

The Coroner's investigator plays a key role in the management of SIDS cases. He often has the initial contact with families shortly after a sudden infant death has occurred and in some cases it would be the investigator who, having knowledge of these cases, can prevent mishandling by the police or law enforcement agency that may be involved. It is also most important for the investigator to keep in mind that in addition to obtaining necessary information about the victim, he also has a responsibility to extend a warm, helping hand to the family.

If an investigator suspects that a baby had died of SIDS, he might find it helpful to have a pamphlet available so that he can share information with the family.

III. INFORMATION REQUIRED

Because accidental or intentional smothering, strangulation, and positional asphyxia of an infant will usually demonstrate no significant pathologic changes at autopsy, it is of critical importance to thoroughly investigate the circumstances under which the death occurred. This includes examination of the scene. The availability of poisons, drugs, or other agents which could cause respiratory depression, cardiac arrest, or seizures should also be ruled out.

A. The following information about the infant's medical history and other pertinent information should be obtained:

1. Where was the child found?
2. Was it in a prone or supine position?
3. Was it in bed, or in a car?
4. What where the terminal circumstances?
5. Where was the child born?
6. What was the date of birth?
7. How much did the child weigh at birth and on any subsequent visits to the doctor?
8. Was the birth normal or "C" section?
9. Were there any problems during prenatal period or during hospitalization?
10. Did the child have a cold recently?
11. If so, what medication, if any, was it given and was it taken to the doctor?
12. How was the child fed? (Breast, formula, etc.) Try to get sample of the formula food, if indicated.
13. Always include a review of pertinent prenatal, birth, and neo-natal medical records.

B. EXAMINATION OF BODY

Having obtained this brief history, the body can next be examined for size of the child, state of nutrition, does the infant look sick or dehydrated, cleanliness, and old scars and any recent bruise, laceration, or abrasion.

C. EXAMINATION OF SLEEPING PLACE

In most sudden infant deaths the child is found unresponsive or obviously dead in his crib or sleeping place. If the infant has been taken from the home and the investigator has examined the body in the hospital, he should, if possible, go to the home to examine where the infant was sleeping. All infants do not have cribs. Some share a bed with an adult. Some cribs are broken or poorly repaired, or have a mattress which does not fill the bottom of the crib. All these things are hazards and may be related to the infant's death, but might not be volunteered by the family and, thus, might go undetected if the investigator did not go to the home. While there he can also determine the state of cleanliness of the home and the care being given to the other children.

D. Try to obtain the facts while alleviating some of the family's anxieties. This is a difficult task, but then this is a very tragic death. After the baby has been examined and no trauma or injuries found which might suggest child abuse, do not be surprised that the parents, especially the mother, may want to hold the baby. In the interests of the bereavement process, they should be allowed to do this.

IV. POSTMORTEM EXAMINATION OF THE BODY

In all cases of suspected Sudden Infant Death Syndrome, a complete autopsy must be performed. This means that examination of the neck organs, pharynx, middle ears, and optic nerves are required in all cases where the thoracic and abdominal organs and brain reveal no obvious cause of death. Blood, urine, and vitreous humor, as well as tissue samples for toxicology and histology should also be obtained.

I. PURPOSE

To provide the investigator with information and guidelines for the investigation of possible child abuse deaths.

II. Suggested questions and observations for possible child abuse:

A. Always bear in mind, postmortem cooling and rigor mortis occur more rapidly with children than adults. While it is necessary to ask questions if there is any doubt regarding the condition of the body, the police and/or the investigator can always go back after the autopsy if child abuse or maltreatment is found.

B. How injury occurred:

1. Was the fall witnessed?
2. How far did the child fall?
3. Onto what surface?
4. Where did impact occur?
5. Did child fall more than once?
6. Did the child sustain multiple impacts?

C. If a child has obvious injuries, was the child taken to the doctor or to a hospital? Obtain date taken and to which physician or which facility.

D. Should there be other children in the household, often a glance can tell if they also have sustained any mistreatment.

E. Once the child has been transported to the morgue, if child abuse is strongly suspected, call the Pathologist on duty to examine the child, if possible the same day.

III. HELPFUL CLUES TO MALTREATMENT: (Deputy Coroner MUST examine the body and know what he is seeing)

1. Bilaterally of injuries
2. Multiplicity of injuries
3. Varying ages of the injuries (very important)
4. Disparity of injuries with explanation
5. Delay in treatment of injuries
6. Indifference to the severity of the injuries
7. Talk to neighbors

IV. GENERAL OPERATING PROCEDURES:

A. All deaths of children investigated by this agency where child abuse is known or suspected the Deputy Coroner Investigating the death will contact the child abuse command center at the California Department of Justice, Sacramento, California.

B. The deputy coroner will ask the child abuse center to check not only the name of the deceased but also the deceaseds parents and the person(s) that had control of the deceased when the injury occurred. This information will be given to the pathologist, prior to autopsy if possible, as well as police investigators.

C. This policy is to assure that we have all the possible information involving the manner, means of circumstances surrounding a coroner case (California Government Code, Section 27491).

D. CONTACT POINT: State of California
Department of Justice
Child Abuse Center (916) 739-5109

COUNTY OF ORANGE
CHILD DEATH REVIEW TEAM

BACKGROUND

In early 1986, Michael Durfee, M.D., Los Angeles, L. Rex Ehling, M.D., Health Officer, HCA/Public Health, Gary Raley, past administrator of the Juvenile Justice Commission, and Esther V. Murray, Deputy Director, HCA/Public Health, began discussions leading to the formation of an Interagency Child Death Review Team.

The first meeting was held November 3, 1986 with County Agencies and other concerned organizations to determine interest and need for an interagency team. The concept was met with enthusiasm and support from all areas and agreement was reached that a multidiscipline approach was essential.

Subsequent meetings were held to review existing models in Southern California. On December 8, 1986, Michael Durfee, M.D., presented the Los Angeles model and on January 12, 1987, Beth Lennon, M.S.W., and Harry Elias, Deputy District Attorney, presented the San Diego model.

ORANGE COUNTY MODEL

I. Structure

On February 9, 1987 the group, after considering the two models agreed to function in an informal/formal manner with minimal structure. The minimal structure consists of:

(a) The Child Death Review Core Team, who actually does the death reviews, and

(b) A general Child Death Review Committee that supports the CDRT Core Team by addressing protocols, education, data and coordination issues such as increasing cooperation between the Team and local hospitals. This larger committee consists of a wider representation from concerned entities.

II. Purpose

The purpose of the Child Death Review Team (CDRT) is to review deaths of children in which a family member or caregiver is suspected of causing the death.

III. Objectives

A. Improve identification of deaths caused by child abuse/neglect.

B. Develop communication for responding to child deaths.

III. Objectives (continued)

C. Increase the thoroughness and effectiveness of the child protection intervention, investigative and legal process.

D. Facilitate appropriate protective service for siblings of victims.

IV. Child Death Review Core Team (CDRT) Participants

The CDRT will be expanded as needed for individual case discussion. The Core representatives are:

Esther Valles Murray	CDRT Convener - HCA/Public Health
Sgt. Mel Lewellen	Santa Ana Police
Barbara J. Mitchell	Sheriff/Coroner; Chair
Jim Sidebotham	Sheriff
Elaine Hall	SSA/CPS
Richard King	D.A./Homicide
Richard Fukumoto, M.D.	Pathologist
Gerald Wagner, M.D.	HCA/Public Health

V. Case Identification

Cases are referred by hospitals and police to the Sheriff/Coroner. The Sheriff/Coroner, with assistance from the Juvenile Justice Commission, will notify participating agencies of deaths of children age 12 and under, where one or more of the following factors are present:

1. Drug ingestion
2. Cause of death undetermined after investigation by coroner
3. Head trauma (subdurals, subarachnoid, subgaleal)
4. Malnutrition/neglect/failure to thrive
5. Bathtub/other type of drowning (such as in water bucket, toilet, etc.)
6. Suffocation/asphyxia
7. Fractures
8. Sudden Infant Death Syndrome (SIDS), where history and condition of body raise suspicions or the child is over the age of seven months.
9. Blunt force trauma
10. Homicide/child abuse/neglect
11. Burns, except where cause is clearly not abuse/neglect, such as accident, accidental house fires, etc.
12. Sexual abuse
13. Gunshot wounds

Any participating agency can request discussion of a case by the CDRT by notifying the Sheriff/Coroner representative.

VI. Case Peview

The age level for team review may decrease as the team develops and gains experience. Homicides with siblings will be reviewed for the protection of the siblings.

Review of January 1, 1987 child deaths will start in April. The Core team will meet on a monthly basis. The death review has two functions:

- to discuss facts surrounding the tragedy and the involvement of various agencies, and
- to draw conclusions from these facts to assist responsible bodies to take necessary action.

VII. Core Team Agency Roles

A. Sheriff/Coroner

The Sheriff/Coroner role is perceived as the lead agency with implementation assistance from the Health Care Agency/Public Health. Barbara Mitchell will chair the CDRT Core Team meetings.

As cases are identified the Sheriff/Coroner will routinely contact agencies for documentation that will possibly aid in the review. A monthly list of child deaths will be prepared for distribution to persons on the Core Team. The Coroner's office will invite participants who may assist in Core Team discussions.

Each agency will clear their sources for the cases to be discussed. The verbal exchange of information is informal and confidential. No minutes will be kept.

B. Social Services Agency

SSA clears CAR on cases reported to SSA by the Coroner, and advises Coroner of any history of prior CAR reports. The CAR Supervisor pulls and reviews any closed files. If there is an indication that other children are at risk, the case is assigned to a social worker for follow-up.

A list of deceased persons under the age of 18 years old is received from the Health Care Agency. No cause of death is listed on the list. A CAR clearance is made on each child. If there is a history of abuse, neglect or exploitation, the Coroner's office is contacted to determine the child's cause of death. If the minor died of a non-accidental cause and there are siblings in the home, law enforcement and/or ER is contacted for an assessment. Each situation is handled on a case-by-case basis.

C. District Attorney

- Will be a member of the Core Team.

D. Police

- Will investigate case, seek tests from the Coroner, information from CAP and hospitals.
- Will make the initial observation and run record checks on the parents.

E. Public Health

- Will provide medical technical assistance and medical documen tation from Juvenile Health units.
- Will clear records for cases selected for review by CDRT with Field Public Health Nursing, Communicable Disease Treatment Services and other programs as appropriate.
- Will coordinate the general Child Death Review Team committee meetings and assist the Coroner with COPE CDRT meetings.
- Will study its role as the repository for general child abuse data.

F. HCA/Mental Health/Children and Youth Services

- Will be a member of the CDRT general meeting in order to provide a Mental Health point of view.
- Will provide outpatient evaluation, crisis intervention and treatment to minor siblings either in the custody of Social Services or their family to help them deal with the trauma of the death of their brother or sister. One to two sessions could be provided as a community service without charge. If further services or treatment seems necessary, the child's legal guardian would need to request such services and have a fee established according to the State's Uniform Method for Determining Ability to Pay (UMDAP).
- Will provide the CDRT information regarding possible Mental Health treatment of the child or family members when appropriate release of information forms are signed in order to protect confidentiality. Because of confidentiality, this information will be limited to whether or not any memaber of the family is or has received CYS services.

G. Juvenile Justice Commission

- Will be a member of the general meeting and assist as appropriate.

H. The Child Abuse Council

- Will be a member of the general meeting and assist as appropriate.

VII. The formation group included:

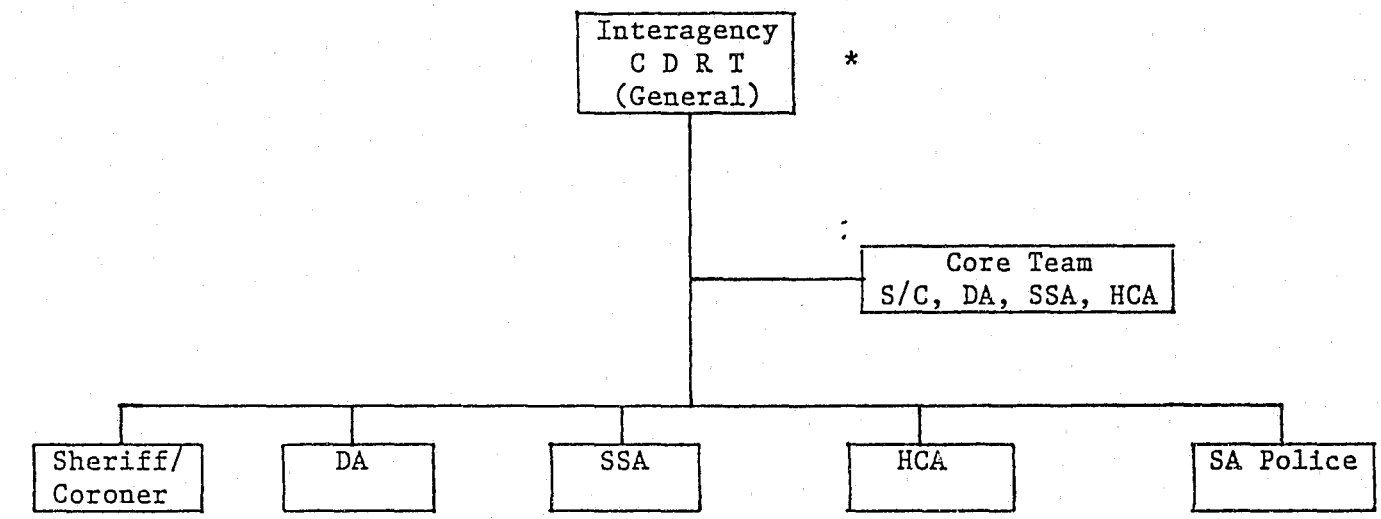
Garry Raley, Juvenile Justice Commission
Jerry Montgomery, District Attorney's Office
Sharon Burkhardt, Social Services Agency
Harry Graves, District Attorney's Office
Sgt. Mel Lewellen, Santa Ana Police Department
Bernard Rappaport, M.D., Deputy Director, HCA/Mental Health/CYS
Louise Kaderlan, HCA/Mental Health/Children Youth Services
Eileen, Walsh, County Administrative Office
Norm Hanson, Police Chief Association
Barbara Mitchell, Coroner's Office
Sheila Dobbs, Child Abuse Council
Gerald Wagner, M.D., HCA/Public Health
Lt. Hugh Mooney, Santa Ana Police Department
Richard King, District Attorney's Office
Sandra Ward, County Administrative Office
Jim Sidebotham, Sheriff's Office
L. Rex Ehling, M.D. HCA/Health Officer
Esther Valles Murray, Deputy Director, HCA/Public Health/Health Promotion/Disease Prevention

VIII. Establishment of the Core Review Team

The first CDRT Core meeting was held April 17, 1987 in the Coroner's Building. Review of child death cases occuring from January 1, 1987 started the review process.

EVM:lrf
September 11, 1987
CD

CHILD DEATH REVIEW TEAM STRUCTURE



• TRAINING.

* Includes non-County related organizations: Juvenile Justice Commission, Child Abuse Council, City Police Departments

EVM:dc

SAN BENITO COUNTY

CHILD ABUSE

Suggested questions and observations for possible child abuse:

Always bear in mind, the post-mortem changes in death are faster with children than for adults. While it is necessary to ask questions if there is any doubt regarding the condition of the body, the police and/or the investigator can always go back after the autopsy, if child abuse or maltreatment is found.

How Injury Occurred:

1. Was the fall witnessed?
2. How far did the child fall?
3. Onto what surface?
4. Where did impact occur?
5. Did child fall more than once?
6. Did the child sustain multiple impacts?

If a child has obvious injuries--Was the child taken to the doctor or to a hospital? Obtain date taken and to which physician or which facility.

Should there be other children in the household, often a glance can tell if they also have sustained any mistreatment.

Once the child has been transported to the morgue, if child abuse is strongly suspected, call the Medical Examiner on duty to examine the child if possible, the same day.

HELPFUL CLUES TO MALTREATMENT

1. Bilaterality of injuries
2. Multiplicity of injuries

3. Varying ages of the injuries

4. Disparity of injuries with explanation

5. Delay in treatment of injuries

6. Indifference to the severity of the injuries

SUDDEN INFANT DEATH SYNDROME

(CRIB DEATH)

The Coroner's Investigator plays a key role in the management of SIDS cases. He often has the initial contact with families shortly after a sudden infant death has occurred and in some cases, it would be the investigator who, having knowledge of these cases, can prevent mishandling by the police or law enforcement agency that may be involved. It is also most important for the investigator to keep in mind that in addition to obtaining necessary information about the victim, he also has a responsibility to extend a warm, helping hand to the family.

If an investigator suspects that a baby has died of SIDS, he might find it helpful to have a pamphlet available so that he can share information with the family.

The following information about the infant's medical history and other pertinent information should be obtained:

1. Where was the child found?
2. Was it in a prone or supine position?
3. Was it in bed, or in a car?
4. What were the terminal circumstances?
5. Where was the child born?
6. What was the date of birth?
7. How much did the child weigh at birth and on any subsequent visits to the doctor?
8. Was the birth normal, or "C" section?
9. Were there any problems during prenatal period or during hospitalization?

10. Did the child have a cold recently?

11. If so, what medication, if any, was it given, and was it taken to the doctor?

Try to obtain the facts while alleviating some of the family's anxieties. This is a difficult task, but then, this is a very tragic death.

After the baby has been examined and no trauma or injuries found which might suggest "child abuse", do not be surprised that the parents, especially the mother, may want to hold the baby, and they should be allowed to do this.

Tell the parents that either the doctor or the Coroner's Office will call after autopsy. Also, that they should feel free to telephone regarding any questions.

SAN DIEGO COUNTY

CHILD FATALITY COMMITTEE

presented at:

SIXTH INTERNATIONAL CONGRESS

ON

CHILD ABUSE AND NEGLECT

Sydney, Australia
August 13, 1986

by:

Elizabeth Lennon, A.C.S.W.
Social Services Bureau
San Diego, California
U.S.A.

CHILD FATALITY COMMITTEE

San Diego County (much like Perth) is located in the Southwestern corner of the United States. Mexico is on the southern border and the Pacific Ocean to the West. The population of our two million people is spread over 4,225 square miles. Its ethnic composition includes 4.8% Asian, 5.6% Black, 14.8% Hispanic and 74% Caucasian.

Protective services for children are established by legal statute and delegate the responsibility to governmental social services and law enforcement. The County provides the social services whose workers combine with thirteen law enforcement agencies to work together.

In 1972, a group of twelve professionals from various disciplines established a Community Child Abuse Council to facilitate communication, enhance cooperation and better insure coordination of our efforts. Today, that group, with a current membership of over two hundred (200), plays a major role in areas of child abuse awareness, prevention, training, investigation and treatment.

It was the Coordinating Council that suggested the formation a few years ago of an Ad Hoc Committee to study child fatalities in our county. No data was available. Several traumatic child deaths had been either ignored, unexplained or given only a token response by law enforcement.

According to California law, all unexplained, violent, sudden or unusual deaths are under the jurisdiction of the Coroner's office. The Council explained to our local Coroner our interest in examining records involving child deaths and invited him to participate in the Committee. Social Services, Probation, the District Attorney's office, the Sheriff's Department, a major police department, and Public Health, as well as the Pediatric Departments at the Navy Hospital and the University of California Medical Center, were asked to designate a representative.

Monthly meetings are scheduled to review the deaths of children under seven that have been referred to the Coroner, i.e., unexplained, non-accidental, accidental, inflicted. The group members exchange information gleaned from various sources to insure that the best possible attention or investigation has been given to the incident. Prior to the establishment of this Committee there was no central clearinghouse for child deaths. All too often law enforcement did not respond--or their response was restricted to a transfer for medical attention. Social Services and Public Health often had background information on victims and their families that was never requested. Medical history information was usually not provided nor requested. It seemed as though the official systems did not feel a responsibility to investigate the cause nor seek explanations for the death of a child.

Each year case reviews have increased. Fifty seven (57) cases in 1982 grew to one hundred thirty eight (138) last year. The fatalities cited as "suspicious" escalated from nine (9) in 1983 to fifteen (15) in 1985.

Data from our 1985 cases indicated the following:

VICTIMS

Male	8
Female	7

AGE

Under 1	11
2	1
3	1
4	1
5	---
6	1

INJURIES

beaten	3
head trauma	3
suffocation	2
asphyxiation	1
mother stabbed	1
undetermined	5

PERPETRATORS

male	7
female	4
unknown	4

CRIMINAL CHARGES

felony (convictions)	5
pending trial	3
rejected	3
pending	2

PRIOR CPS CONTACTS

SIDS	7	(57)
Natural	5	(26)
Drownings	1	(9)
Accidents	2	(28)

NON-ACCIDENTAL

Suspicious	0	(5)
Homicides	3	(10)

The Committee has encountered a variety of problems and obstacles during the last few years. There continues to be a reluctance to admit that children are killed by parents and caretakers. Role responsibilities appear vague and unclear at this time. In the case of a child's death, the person responding first immediately seeks medical attention. However, if the victim is an adult, there seems to be no reluctance to consider inflicted trauma or homicide. Proper scene protection and investigations are initiated immediately. On the other hand, training for investigation of child homicides has been sadly lacking. Communication between medical and legal systems is often nonexistent or misunderstood. The needs of law enforcement may be overlooked or ignored by medical personnel, e.g., photographic evidence collection, reporting delays, inappropriate response to family/perpetrator.

Other factors make our work difficult. Political issues continue to impact the case review meetings because individual agencies dislike criticism (implied or direct) and often have liability concerns.

Prosecution problems focus on the difficulty to determine the mode/manner of death by the medical community as well as inability to designate the offender. So often, lack of witnesses and family loyalties as well as the difficulty to establish the probable perpetrator (beyond a reasonable doubt) preclude a complaint.

Quite often obstacles and investigative problems can be resolved or overcome when the prosecutor can devote ample time to the development of the case. However, time often requires money and additional investigative personnel, both items rarely provided in child death cases.

Through the work of the Child Fatality Committee, means have been developed to impact the local scene and focus attention on specific cases.

Now there is immediate communication when a child dies and circumstances are questionable. The Coroner's staff contacts social services and law enforcement as well as any licensing agency that might be involved. Prior medical records are obtained.

Forsenic pathologists perform prescribed autopsies. Training has been provided for medical personnel at the major trauma facility.

A specialized prosecution unit has been organized in the office of the District Attorney that responds promptly giving advice and consultation.

More important, there is now better accountability when a child dies suddenly. We actually have data concerning such deaths--data that was not available a few years ago. Often this information helps provide protection to siblings.

b. Follow the procedure outlined above (#6) if it is determined that the child is not appropriate for a medically fragile placement.

XXXIV. CHILD FATALITY PROTOCOL

A. When the Hotline receives reports of any child death, the following will be done:

1. Clear case.

2. If active:

   a. Notify active worker and supervisor.

   b. Cross report to law enforcement giving active worker's name/phone so information regarding priors can be exchanged.

   c. Advise coroner of name/phone for active worker.

   d. Give photocopy of referral to Hotline supervisor for appropriate follow up.

   e. Notify appropriate licensing agency when applicable.

   f. Notify Deputy Director.

3. If closed case:

   a. Screener should pull case, review record and cross report to law enforcement and coroner.

   b. If closed record not available immediately cross report without information on priors.

   c. Photocopy referral and give to Hotline supervisor.

      (1) Hotline supervisor will do:

         (a) Critical incident report.

         (b) Assess for assignment.

   d. Notify appropriate licensing agency when applicable.

   e. Notify Deputy Director.

4. Active to other will:

a. Notify Hotline.

b. Complete Critical Incident Report.

B. Child Fatality cases will be reviewed by the Case Consultation Review Committee (CCRC) when Childrens Services Bureau has had prior contacts with the family or whenever deemed appropriate. See XXXIX.

XXXV. GUIDELINES FOR ASSESSING PHYSICAL INJURY TO A CHILD

In all children's programs when there has been an allegation of physical abuse or when a previously abused child is returned to the family home, the social worker's responsibility is to assess the child's physical condition.

A. Prohibitions

1. Never disrobe the child totally.

a. Examine limbs, head and neck while the child is clothed.
b. To examine trunk, back and buttocks clothing may be pulled back, rearranged, or one item of clothing may be removed at a time.
c. When examining an older child the social worker may suggest a change to some item of clothing that covers the least possible amount of the child's body.

(A possible exception to this rule is infants. Infants can be observed totally naked. Many times, failure to thrive can be detected more readily when an infant is not clothed.)

2. Never disrobe the child in front of others except an adult witness.

3. Never examine the breasts, genitals or anus. The social worker is not to make physical assessments in a case involving allegations of sexual molest.

4. Never force a child who is unwilling to be disrobed.

a. Consult with your supervisor.
b. Consider requesting assistance from law enforcement.
c. Consider taking the child to a medical practitioner.

SAN DIEGO COMMUNITY CHILD ABUSE COORDINATING COUNCIL

CHILD FATALITY COMMITTEE

In January 1982, a Child Fatality Committee was established by the San Diego Community Child Abuse Coordinating Council with the support and cooperation of David Stark, Coroner for the County.

Representatives from the Office of the District Attorney, Sheriff, San Diego Police Department, Public Health, Probation, Social Services and U.S. Naval Hospital as well as the Coroner are members of the Committee. The group meets monthly and reviews all cases of child fatalities under age seven called to the attention of the Coroner's Office. Other cases may be reviewed upon request. The Coroner's Office provides a list of all cases for review each month and representatives provide information and input from their respective agencies.

On a daily basis, there is an informational exchange and coordination of response and investigations as deaths occur because of the Committee's efforts for the past few years.

The work of the Committee has also enhanced:

- Law enforcement response, investigation and coordination in suspicious cases to insure protection of siblings;
- Ability of District Attorney's Office to access all pertinent information and have pediatric expertise available for consultation;
- Training for hospital staff at major trauma centers;
- Review of cases active or known to major protective systems to improve risk assessments.

SANTA CLARA COUNTY MULTI DISCIPLINARY
CHILD ABUSE TEAM
DEATH REVIEW COMMITTEE

CRITERIA FOR REVIEW:

All deaths of children under the age of fourteen in which one or more of the factors listed below are believed to be present will be reviewed.

1. Drug ingestion
2. Cause of death undetermined after coroner's investigation
3. Head trauma (subdurals, subarachnoid, subglial)
4. Malnutrition/neglect, including failure to thrive
5. Bathtub drowning
6. Suffocation/asphyxia
7. Fractures
8. SIDS age under one month or over seven months
9. Blunt force trauma
10. Homicide/child abuse/neglect
11. Burns except where cause is clearly not abuse such as house fire
12. Sexual Abuse
13. Gunshot wound
14. Suicide*

In addition to the above criteria, we will review any child death as appropriate, if it is brought to our attention by a concerned professional.

* Adolescent suicides through the age of 17 are reviewed.

FB/jg
8/87

The members of the Child Fatality Committee realize that we have only skimmed the surface in seeking information about the children who die from sudden, unexplained, accidental or non-accidental deaths in our community. However, the composition of our group reflects professional expertise and integrity as well as political authority. We seem to have been able to impact response and practice without the need to devise the more formal protocols.

We look forward to a future of continued communication, cooperation, and coordination to help us further understand the cause of children's deaths and how to prevent them.

Elizabeth Lennon, A.C.S.W.
Law Enforcement Liaison
Chairperson of Committee
6950 Levant Street
San Diego, CA 92111
U.S.A.

Appendix B

All deaths of chialdren under the age of thirteen in which one or more of the factors listed below were believed to have been present were reviewed.

1. Drug ingestion
2. Cause of death undetermined after coroner's investigation
3. Head trauma (subdurals, subarachnoid, subglial)
4. Malnutrition/neglect, including failure to thrive
5. Bathtub drowning
6. Suffocation/asphyxia
7. Fractures
8. SIDS age seven months and over
9. Blunt force trauma
10. Homicide/child abuse/neglect
11. Burns except where cause is clearly not abuse such as house fire
12. Sexual abuse
13. Gunshot wound
14. Suicide 14 and younger[10]

This list taken from the LA Co ICAN Case Review Subcom

_____
Date

TO: _____

_____

_____

_____

County: _____

Attached is the Coroner's report regarding _____.

This child died within Santa Clara County, but was a resident of your county. I'm sending this report to you for your information and possible review by your Death Review Committee.

Sincerely,

Fran Bergman, PHN
Santa Clara County Death Review Committee
c/o Santa Clara County Health Dept.
Public Health Nursing Administration
2220 Moorpark Avenue
San Jose, CA 95128
(408) 299-5971

FB/mmr
fb.forms
10/88

SAN LUIS OBISPO COUNTY

CHILD DEATH REVIEW BOARD

The Child Death Review Board is hereby formed by the Coroner of San Luis Obispo County. The function of the board will be to provide professional expertise to the Coroner to assist in investigations into deaths, within the county, of persons eighteen years of age and younger, under particular circumstances.

Upon the death of a child, eighteen years of age or under, under circumstances requiring the exchange of information among those professionals named to the board, the Coroner will provide information surrounding the death to each member and set a meeting date. Members of the board will attend the meeting prepared to discuss the case. The participation of board members is within the investigative process, and as such, information exchanged shall remain confidential.

The board will meet quarterly to discuss matters of policy and on specific occasions as called upon by the Coroner.

This board is made up of the following personnel:

Chairman, Edward C. Williams, Sheriff-Coroner
San Luis Obispo County Sheriff-Coroner's Office

Vice Chairman, Don A. Hines, Chief Deputy Coroner
San Luis Obispo County Sheriff-Coroner's Office

Dr. Stephen Jobst, M.D., Pathologist
Central Coast Pathology, San Luis Obispo, California

Mr. Richard Mansfield, Chief Investigator
San Luis Obispo County District Attorney's Office

Jane A. Kulick, R.N., Director, Child Abuse/S.A.R.T. Program
San Luis Obispo County

Dr. Laura Slaughter, M.D., Consulting Physician
San Luis Obispo County S.A.R.T. Team

Dr. Rene Bravo, Doctor of Pediatrics
1941 Johnson Avenue, San Luis Obispo, California

Dr. Joseph Nargie, M.D.
1050 Las Tablas Road, Templeton, California

Connie Langer, Social Worker III, Child Protective Services
San Luis Obispo, California

Representative from the police agency having jurisdiction where death occurs.

The following death cases shall be included in the review process:

1. Drug ingestion.
2. Cause of death undetermined after investigation by the Coroner.
3. Head trauma (subdurals, subarachnoid, subgaleal hemorrhage cases).
4. Malnutrition/neglect/failure to thrive.
5. All drowning accidents.
6. Suffocation/asphxia.
7. Fractures.
8. S.I.D.S.
9. Blunt force trauma.
10. Homicide/child abuse/neglect.
11. Burns, except where cause is clearly not abuse/neglect such as auto accidents, accidental house fires, etc.
12. Sexual abuse.
13. Gunshot wounds, including suicide.
14. Therapeutic misadventure.
15. Aspiration deaths.
16. Stillborn viable fetuses, if trauma is suspected as are inducement factor.

EDWARD C. WILLIAMS
Sheriff-Coroner
San Luis Obispo County

Coroner and Public Administrator

JAMES E. O'BRIEN
CORONER AND PUBLIC ADMINISTRATOR
SOLANO COUNTY
HALL OF JUSTICE

600 UNION AVENUE
FAIRFIELD, CALIFORNIA 94533
(707) 429-6404 - OFFICE
643-6695 - EVENING

INTERAGENCY CHILD DEATH TEAM
(Protocol Draft)

DRAFT

INTRODUCTION

It is the mission of the Interagency Child Death Team to prevent child deaths by collecting and analyzing data and utilizing this information to formulate appropriate action. The purpose of this team is:

1. To provide a prompt, planned, coordinated interagency, multidisciplinary response to child fatality reports.

2. To provide a multiagency forum for systematic case management and review of previous interventions.

3. To increase the number of interventions on behalf of surviving siblings.

4. To increase the identification of acts that necessitate prosecution.

The interagency Child Death Team shall consist of representative from:

1) Coroner
2) District Attorney
3) Child Welfare
4) Public Health
5) Law Enforcement
6) Various Medical Facilities
7) Child Abuse Prevention Council
8) Child Advocate Specialists (By Invitation)

Because of the sensitivity of the material to be discussed Confidentiality Shall Be Maintained (Penal Code 11167.5).

The Interagency Child Death Team selects those cases for review of any child death under age 18 years or which pose particular problems as to the cause of death.

A suspicious child death for purposes of the protocol is one in which one or more of the following factors are present:

1. Homicide
2. Accident
3. Suicide

4. Undetermined
5. Drowning/Bathtubs, etc.
6. Ingestion/Drug Use/Poisoning
7. Suffocation/Asphyxia
8. Trauma (Head Trauma, Blunt Force, Fractures
9. Burns (Fires, Scalding, Electrical, Chemical)
10. Gunshot Wound
11. Sexual Abuse
12. Malnutrition/Neglect/Failure To Thrive/Child Abuse
13. Sudden Infant Death Syndrome

Other Reasons for suspicion:

14. Prior involvement of various agencies
15. Officer's observations/suspicions
16. Caregiver's and health care provider's concerns
17. Family responses and concerns
18. Concerned public

The protocol is as follows:

1. When a suspicious death (as defined above) comes to the attention of the Coroner's office, the Coroner or Coroner's Investigator notifies the Program Manager of Child Welfare Services and/or the Supervisor of Children's Protective Services along with the appropriate law enforcement agency.

2. The Program Manager of Child Welfare refers the case to the CPS Supervisor for follow up. He/She arranges to get information on prior CPS referrals and information regarding other agencies that are involved with the case. He arranges to have the records available for the appropriate representatives of Law Enforcement.

3. The Law Enforcement Investigator and CPS should discuss the most appropriate way to carry out the investigation. The major consideration is that the investigation not be impeded in any way.

4. Law Enforcement provides the Coroner and CPS with the results of its investigation, verbally and in the form of a written report, upon completion of the investigation. If the investigation is lengthy, he/she will keep the Coroner and CPS apprised of progress during the process.

5. The Coroner's Office obtains verbal and written reports from all appropriate persons and agencies having contact with the child and family, especially the child's doctor, public health, and CPS. (These reports usually refer to contacts made prior to the child death. They ordinarily do not refer to contacts made during the investigation unless pertinent information is revealed.)

6. Any agency having concern about a case may bring it to the ICDT for review.

7. The committee reviews the autopsy, and the various medical, law enforcement, and CPS reports. During or following this meeting any of the agencies may decide to proceed unilaterally or in concert with another agency to do further follow-up on the case within the agency's appropriate role and function, taking care not to interfere with any other agency's investigation or assessment.

This follow up may consists of: (a) further investigation by Law Enforcement, (b) further investigation by CPS for the purpose of considering dependency action on siblings, (c) further consultation with specialist, and (d) referral to the District Attorney's Office.

8. Appropriate action will be taken by the above agencies, with good coordination of all efforts to prosecute the offender(s) and to provide protection for siblings.

9. The team, after review of all reports, may determine that there does not appear to be reason for further action at this time.

10. All agencies involved with the case will forward their final reports to CPS for retention in case of future incidents. (CPS shall serve as the "databank" for all cases reviewed by the ICDT as they maintain files on children in Solano County.)

11. The Interagency Child Death Team should review its performance at the close of a case to evaluate its ability to more thoughtfully serve the next case.

The mission of the Interagency Child Death Team is to prevent Child Deaths by collecting and analyzing data and utilizing this information to formulate appropriate action, including legislation, to prevent future child death and the repetition of death in a family. It is our hope that by combining efforts, the agencies of Solano County that serve and protect children and the public, can better address the needs of our children.

OFFICE OF

SHERIFF/CORONER YOLO COUNTY

AUTOPSY PROTOCOL
CHILD ABUSE

The following guidelines are designed to help the pathologist in his examination of newborns, infants, young children and adolescents who are the victims or who are suspected to be the victims of child abuse or neglect. This includes all cases falling within criteria in the list. The approach to a case can be conveniently divided into three phases:

1. Pre-Autopsy (gathering of information and collection data)
2. Autopsy itself
3. Post-Autopsy (analysis of the findings and interpretation of the data)

PRE-AUTOPSY:

A. Investigation - The case should be assigned to an experienced investigator

1. Coroner's Investigation

a. Check list for Coroner's Investigator added as appendix.

b. General Information:

- Identification of Victim (Identified by Whom?) - Name, Age, Sex.
- Home Address, Place of Death, etc.
- Pronounced Dead - By Whom, Where, When?
- Found Dead - By Whom, Where, When?
- Last Seen Alive - By Whom, Where, When?

c. Family Background:

- Parents' marital status (married, single, divorced, etc.)
- Mother
- Father
- Babysitter
- Guardian
- Foster Parent
- Mother's Boyfriends
- Father's Girlfriends
- Siblings - Number, Age, Sex, Medical Condition

d. Medical Background:

- Physicians Names - Where
- Growth and Development (height and weight - at birth and currently)
- Medical Illnesses
- Previous Injuries
- Previous Hospitalizations
- Maternity History (Prematurity, Unattended Birth, etc.)

2. Police Investigation

3. Social Services Records

4. Hospital Records:

   a. Recent Injuries
   b. Old Injuries
   c. Disease

5. Attending Physician Statement

6. Witness Statements

7. Chronology of events leading to death (Narrative Description)

B. Processing Body at Scene

1. Photographs

2. Diagram of Scene Showing Original Position of Body

3. Description of Scene

   a. Type of Residence
   b. Cleanliness
   c. Sanitation
   d. Lighting
   e. Heating
   f. State of Kitchen
   g. State of Bathroom
   h. Safety Hazards
   i. Evidence of Rodents
   j. Evidence of Insects
   k. Evidence of Alcoholism
   l. Evidence of Drug Abuse
   m. Food - How much, appropriateness

4. Description of Position of Body (Original position as well as position at time of investigation.)

5. Description of Clothing

   a. Appropriateness
   b. Cleanliness
   c. Changed after Death

6. Investigator's Description of Body - Presence of Wounds, Blood, Vomitus, Urine, Feces, Other Body Fluids.

7. Collection of Evidence at Scene Where Applicable

8. Transportation of Body to Coroner's Facility

   - Body shall be property identified and labeled.

   - Evidence property packaged and labeled. The body is evidence and shall be treated as such. The chain of custody shall be maintained.

C. Processing Hospital Deaths:

1. All medical devices and appliances should remain in the body and not be removed or disassembled prior to the arrival of the Coroner.

2. Hospital chart shall, wherever possible, be obtained at this time.

3. Transportation of body as above.

D. Examination of Body at Coroner's Facility:

1. Photograph body both front and back, as is, without disturbing anything.

2. Collection of Evidence:

   - Hair
   - Fingernails
   - Trace Evidence

3. Undress - Properly dry and package clothing

4. Bite Mark Evidence - To be collected by Dentist

5. Sexual Assault Evidence - When applicable.

6. Clean body

7. Re-photograph, both front and back with close-up photographs of each wound

8. Total body x-ray - Film to be read by Radiologist when applicable.

AUTOPSY:

The case should be assigned to an experienced pathologist

A. External Description:

1. Record height, weight, head circumference and chest circumference

2. Note stage of development; is it consistent with child's age?

3. Note state of nutrition

4. Note care of skin, cleanliness, rashes, etc.

5. Examine hair, eyes, ears and all orifices

6. Note state of rigor mortis, livor mortis, temperature and estimate time of death when applicable

7. Note fractures usable for identification

8. Note congenital anomalies, deformities, etc.

9. Note scars, marks, tattoos, etc.

B. Evidence of Medical Tratment:

1. Needle marks and I.V.'s
2. Dressings
3. Nasogastric and Endotracheo Tubes
4. Catheters
5. Cavity Tubes
6. Surgical Wounds and Scars

C. Evidence of Injury:

1. All injuries shall be diagrammed and photographed.

2. Each wound shall be identified, numbered and described in a separate photograph.

3. Each would shall be located by measuring its distance from the top of the head and to the right or left of the midline.

4. Size, shape and depth of the wound shall be recorded.

5. Wound shall be described and identified as an abrasion, contusion, laceration, incised wound, stab wound, penetrating wound, gunshot wound, etc.

6. Descriptive features relative to the age of the wound shall be noted when applicable.

7. Where in doubt as to the nature of a mark, it shall be carefully incised and examined again as well as photographed.

8. Make microscopic section of wound for further differentiation.

D. Wound patterns commonly seen in Child Abuse:

1. Hair - bald patches often mean that hair has been pulled out at the roots
2. Eyes - contusions of the eyelids, conjunctivae, sclerae, globe, retina, etc.
3. Ears - cauliflower-like lesions from pinching
4. Mouth - torn frenulum of lips and tongue
5. Face - a. Abrasions from repeated slappings
   b. Gag marks
6. Shoulders - hand marks from shaking child
7. Neck - asphyxial wounds
8. Ankles and Wrists - look for ties and restraints
9. Patterned abrasions and bruises, particularly of the buttocks, thighs and back, from belts, straps, etc.
10. Burns
11. Extremities - Examine for deformities, old and recent fractures
12. Genital and perianal injury

E. Internal Examination: Torso

1. All internal wounds shall be photographed and diagrammed
2. Body cavaties checked for blood, fluid, purulent material, bowel content
3. Organs - shall be examined in situ for evidence of injury, deformities, congenital anomalies, etc.

4. Specimen Collection:

   a. Blood for Toxicology
   b. Blood for Serology
   c. Urine
   d. Bile
   e. Gastric
   f. Intestinal Content
   g. Brain
   h. Fat
   i. Viteous
   j. Liver
   k. Kidney

5. Chest Cavity and Ribs - Check for recent and old fractures

6. Heart - Weight, measurements, injuries, congenital anomalies, etc.

7. Lungs - Weight, pneumonia, etc.

8. Mediastinal Contents, Weigh thymus. Obtain Histologic section

9. Liver and Gallbladder - Weight of liver, lacerations

10. Spleen - Weight of Spleen, lacerations

11. Pancreas

12. Gastrointestinal Tract - Note gastric and bowel content particularly in neglect cases.

13. Adrenal

14. Kidneys and Urinary Tract - Weight of Kidneys

15. Internal genitalia

16. Remove any remaining tissue and examine pelvis and spinal column

F. Internal Examination: Head

1. Galea - for hemorrhage
2. Skull - for fractures
3. Dura - for hemorrhage

4. Arachnoid - for hemorrhage
5. Brain - for injuries, state of development, congenital anomalies

Brain preserved in formaldehyde for further neuropathological studies where appropriate.

G. Internal Examination: Neck

1. The neck shall be carefully dissected by the pathologist in all cases of suspected asphyxia

2. Soft tissues, muscle and thyroid gland dissected layerwise

3. Larynx and trachea dissected free and examined

4. Cervical spine examined

H. Spinal Cord removed and examined where applicable

I. Newborns:

1. Umbilical cord and placenta should be examined if available

2. Gestational age should be determined

3. Determine if death occurred intrauterine, at birth or neonatally

J. Microscopic:

1. Routine tissues
2. Wounds
3. Subdural hematomas

K. Other studies where applicable:

1. Bacteriology
2. Serology
3. Hemoglobin Electrophoresis
4. Toxicology

POST AUTOPSY ANALYSIS:

A. Meeting between Pathologist, Investigator, District Attorney, etc. Ideally they should all be present at the autopsy.

B. Determine Cause of Death

C. Determine Manner of Death

D. Prepare autopsy report

E. Further proceedings when applicable

C. Processing Hospital Deaths:

1. All medical devices and appliances should remain in the body and not be removed or disassembled prior to the arrival of the Coroner.

2. Hospital chart shall, wherever possible, be obtained at this time.

3. Transportation of body as above.

D. Examination of Body at Medical Examiner's Office:

1. Photograph body both front and back, as is, without disturbing anything

2. Collection of Evidence:

- Hair
- Fingernails
- Trace Evidence

3. Undress - Properly dry and package clothing

4. Bite Mark Evidence - To be collected by Dentist

5. Sexual Assault Evidence - When applicable.

6. Clean body

7. Re-photograph, both front and back with close-up photographs of each wound

8. Total body x-ray - Film to be read by Radiologist when applicable.

AUTOPSY:

The case should be assigned to an experienced pathologist

A. External Description:

1. Record height, weight, head circumference and chest circumference

2. Note stage of development; is it consistent with child's age?

3. Note state of nutrition