SENATE BILL No. 1668

Introduced by Senator Bowen

February 24, 2006

An act to amend Section 11174.32 of the Penal Code, relating to child death investigations.

LEGISLATIVE COUNSEL'S DIGEST

SB 1668, as introduced, Bowen. Child death: review teams.

Existing law permits counties to establish interagency child death review teams to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication between persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases.

Existing law also allows interagency child death teams to develop protocol for performing autopsies on children to assist coroners, as specified and identifies the persons who may be consulted in developing the protocol.

This bill would provide that an oral or written communication or a document shared within or produced by a child death review team related to a child death review, provided by a third party to the child death review team, or between a third party and a child review death team is confidential and not subject to disclosure or discoverable by a third party. This bill also would provide an exception to these rules of nondisclosure for recommendations of a child review death team at the discretion of a majority of the members of the team.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 11174.32 of the Penal Code is amended to read:

11174.32. (a) Each county may establish an interagency child death team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases. Interagency child death teams have been used successfully to ensure that incidents of child abuse or neglect are recognized and other siblings and nonoffending family members receive the appropriate services in cases where a child has expired.

(b) Each county may develop a protocol that may be used as a guideline by persons performing autopsies on children to assist coroners and other persons who perform autopsies in the identification of child abuse or neglect, in the determination of whether child abuse or neglect contributed to death or whether child abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for child abuse or neglect, including the designation of the cause and mode of death.

(c) In developing an interagency child death team and an autopsy protocol, each county, working in consultation with local members of the California State Coroner's Association and county child abuse prevention coordinating councils, may solicit suggestions and final comments from persons, including, but not limited to, the following:

(1) Experts in the field of forensic pathology.

(2) Pediatricians with expertise in child abuse.

(3) Coroners and medical examiners.

(4) Criminologists.

(5) District attorneys.

(6) Child protective services staff.

(7) Law enforcement personnel.

(8) Representatives of local agencies which are involved with child abuse or neglect reporting.

(9) County health department staff who deals with children's health issues.

(10) Local professional associations of persons described in paragraphs (1) to (9), inclusive.

(d) An oral or written communication or a document shared within or produced by a child death review team related to a child death review is confidential and not subject to disclosure or discoverable by a third party. An oral or written communication or a document provided by a third party to a child death review team, or between a third party and a child death review team, is confidential and not subject to disclosure or discoverable by a third party. Notwithstanding the foregoing, recommendations of a child death review team upon the completion of a review may be disclosed at the discretion of a majority of the members of the child death review team.

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