AMENDED IN SENATE MAY 1, 2006

AMENDED IN SENATE APRIL 18, 2006

AMENDED IN SENATE APRIL 17, 2006

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 amended, 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 review 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 interagency child death review team records that are exempt from disclosure to third parties pursuant to state or federal law remain exempt from disclosure when they are in the possession of a child death review team. *The bill would also contain confidentiality provisions for child death review teams, as specified.* The bill would further provide that no less than once each year, each child death review team shall make available to the public

findings, conclusions and recommendations of the team, including aggregate statistical data on the incidences and causes of child.

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 *review* 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 *review* 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. *No record made available by a child death review team under this section may include names or other personal information regarding any child who was the subject of a review or regarding that child's siblings and nonoffending family members.*

(c) In developing an interagency child death *review* 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) Records exempt from disclosure to third parties pursuant to state or federal law shall remain exempt from disclosure when they are in the possession of a child death review team.
(e) No less than once each year, each child death review team shall make available to the public findings, conclusions and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths.

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