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CLICK HERE FOR OFFICE OF INDEPENDENT REVIEW REPORT DATED AUGUST 30, 2011

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August 30, 2010

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Re: Status of Implementation of SB39: Current Challenges

On August 24, 2010, this Board directed that the Office of Independent Review ("OIR") examine the requirements and time lines for the disclosure of child fatality information pursuant to SB 39 and Welfare and Institutions Code 827; recommend a protocol to be used by the Department of Children and Family Services ("DCFS") for responding to and tracking SB39 requests; and provide a status report on any pending requests, including objections by law enforcement or other entities.

This correspondence is intended to be responsive to this Board's request. As detailed below, in Los Angeles County, the intent of the bill to provide ready disclosure of non-prejudicial information has recently been frustrated by blanket law enforcement objections to the release of information. Second, DCFS' past interpretations as to what child fatalities qualify as SB 39 cases may have been inconsistent with DCFS' representations about those same child fatality cases in other contexts. While this Board's attention to the topic has drawn increased interest and attention to the issues by County offices, in this correspondence, the OIR supplements those ongoing efforts by offering broad-based recommendations intended to break the logjam that currently exists regarding disclosure of non prejudicial information and ensure that there is a consistent and principled determination of what constitutes SB 39 cases subject to disclosure.[1]

[1] During its review, OIR could not help but notice how very hard County entities were working to address and attempting to develop a fix to the issues discussed in this letter.

Methodology

The OIR became aware of the passage of this Board's motion on August 24, 2010. In the intervening three days, the OIR studied SB 39 and Welfare and Institutions Code 827. More importantly, the OIR met and talked with DCFS officials, County Counsel, the Los Angeles Sheriff's Department and other stakeholders in order to gain insight into the challenges and current status of SB 39 requests for information. It would be remiss not to comment to this Board regarding the responsiveness of DCFS, County Counsel, and LASD to my inquiries. Without such cooperation, any insights that may be offered here would not have been possible.[2]

Challenge 1: Interpretation of Qualifying Cases Pursuant to SB 39

Welfare and Institutions Code section 10850.4 ("SB 39") became effective on January 1, 2008. The California Department of Social Services subsequently issued regulations designed to interpret the statute's provisions. As indicated in the preamble of the statute, SB 39 was enacted to provide a facile and streamlined way for public access to child abuse deaths. As noted in the statute's opening section:

> A child's death from abuse or neglect often leads to calls for reform of the public child protection system. Without accurate and complete information about the circumstances leading to the child's death, public debate is stymied and the reforms, if adopted at all, may do little to prevent further tragedies.
>
> Providing public access to juvenile case files in cases where a child fatality occurs as a result of abuse or neglect will promote public scrutiny and an informed debate of the circumstances that led to the fatality thereby promoting the development of child protection, policies, procedures, practices, and strategies that will reduce or avoid future child deaths and injuries.

This language unmistakably signals the legislature's attempt to create a process whereby information about child abuse deaths is promptly made available in response to public requests.

That being said, the legislation does not anticipate release of information under the statute for all child fatalities, but rather targets the release of child abuse deaths. As a result, the statute instructs DCFS that when a request for release of child abuse fatalities is received, the Department is to determine which child fatalities constitute child abuse deaths. To accomplish this objective, the first determination made by DCFS is whether

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[2] State law and related protocols promulgated by this Board provides a mechanism for prompt and robust access to materials relating to child fatalities. OIR's review found no reason to believe that the reporting requirements to this Board are not being adhered to by DCFS.

there is a "reasonable suspicion that the fatality was caused by abuse or neglect". Once this determination is made, a very limited set of information is to be released within five days of request: Age and gender of the child, date of death, whether the child was in foster care or in the home of his or her parent and guardian at the time of death, and whether an investigation is being conducted by a law enforcement agency or the county child welfare agency."[3]

The statute further provides for a much broader release of materials in which "abuse or neglect leads to a child's death" and either "a child protective services agency determines that the abuse or neglect was substantiated, a law enforcement investigation concludes that abuse or neglect occurred, or a coroner or medical examiner concludes that the child who died had suffered abuse or neglect." In these cases, additional information subject to release include emergency response referral information, cross reports completed by the county child welfare agency to law enforcement, risk and safety assessments, health care records, and police reports. In cases in which the child's death occurred while in foster care, additional information is subject to disclosure: foster parents' licensing and renewals, reported licensing violations, records of foster parent training. SB 39 requires release of this information within ten business days of the request for information.

Accordingly under the statute, as a first step, DCFS must determine whether with regard to each child fatality, there was a reasonable suspicion that the fatality was caused by abuse or neglect. Secondarily, for purposes of the broader disclosure, those responsible at DCFS for handling SB 39 requests are required to learn whether either DCFS has determined that the abuse or neglect was substantiated, a law enforcement investigation has concluded that abuse or neglect occurred, or a coroner has concluded that the decedent child had suffered abuse or neglect. For purposes of the DCFS findings, abuse or neglect is substantiated if it is determined by the investigator who conducted the child abuse investigation that based upon evidence, it makes it more likely than not that child abuse or neglect occurred.

However, regulations promulgated by the State Department of Social Services subsequent to the enactment of SB 39 and intended to assist in the interpretation of the statute have arguably altered the definition of how DCFS is to conclude that the abuse or neglect was substantiated. In those regulations, DCFS is instructed to consider SDSS Regulation Section 31-502.25 in determining whether the child fatality was a result of abuse or neglect.[4] That statute describes a child welfare agency's determination that a

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[3]If the child died while in foster care, in addition to this information, the Public Records Act requires that the child's name and date of birth also be provided.

[4]The regulations offer additional potential confusion and might be interpreted to exclude from SB 39 inclusion, cases in which the child did not reside with his/her parent or guardian or where the abuse was not inflicted by the parent or guardian. This potential limitation does not exist in SB 39 itself.

child fatality was the result of abuse or neglect as the substantiation of abuse and/or neglect which resulted in the fatality. The question about whether the abuse or neglect "resulted in the fatality" suggests the need to find some sort of connection or causation between the abuse or neglect and the fatality, a finding that is not apparent from the wording of the statute itself.[5]

The possible additional need to find some level of causation or connection as a result of the regulation has potential real world consequences. For example, there may be cases in which it is clear that the deceased child had been victimized by abuse or neglect, but there may be differing views regarding whether that abuse or neglect "caused" or "led to" the death or whether the death "resulted" from the abuse or neglect. This is particularly the case in which there is some attenuation between the actual abuse or neglect and the instrumentality of death suffered by the child.

OIR has been informed that in determining whether child fatality information should be subject to the broader disclosure requirements of the statute, the deciders at DCFS do consideration as to whether or not there is sufficient connectivity between the neglect or abuse and the child's death.

There has been some voiced concern about whether DCFS has interpreted child fatalities too narrowly in determining which qualify for purposes of SB 39. Because the statute is not shy in saying that the disclosure provisions are intended to "promote public scrutiny" and an "informed debate of the circumstances that led to the fatality", it stands to reason that the information provided by the disclosure provisions of SB 39 might ultimately cause criticism of the child protective services agency to occur. Accordingly, there may be either conscious or unconscious incentives for child protective service officials to adopt a narrow rather than broad view of whether, in a particular case, the SB 39 connectivity requirements for disclosure exist. In addition, there may be pragmatic incentives to keep the SB 39 list small; as noted below the identification of an SB 39 case requires work in gathering and redacting materials, contacting law enforcement officials and district attorneys as well as counsel; cases that are not found to qualify will not need

[5]SB 39 itself adds to potential confusion about how much, if any, connectivity between the abuse and/or neglect and the fatality must be established for purposes of disclosure. As noted above, the triggering of the first level of information requires reasonable suspicion that the fatality was "caused by abuse or neglect". Second, while the statute indicates that "all cases in which abuse or neglect leads to a child's death" shall be subject to the broader disclosure responsibilities, it does not seem to require any finding that the abuse or neglect has "led" to the death. OIR recommends that the potential disconnect between SB 39 and the Regulations be brought to the attention of the state agency responsible for their promulgation. Rather than provide more clarity, the regulations as currently written seem to provide more confusion.

to be processed. [6]

In other contexts where the interests and incentives are different, child protective services officials may be influenced to take a broader view of whether the child abuse or neglect led to the child fatality. For example, in cases in which a child fatality has occurred and siblings of the child are at risk, there is certainly an overarching interest in protecting the safety of the remaining children. Accordingly, in papers submitted by child protective service officials designed to ensure their safety, those officials may be more inclined to aver that the fatality was caused through abuse or neglect.

These theoretically inconsistent findings have apparently been borne out in reality. Very recently, it was learned and OIR was informed that in at least one case in which DCFS had found the fatality not to be subject to SB 39 disclosure, DCFS officials had made inconsistent statements in another forum indicating belief that the fatality had been caused by child abuse and/or neglect. As a result of this discovery, OIR has been informed that DCFS is currently reviewing additional historical child fatality cases to learn whether in those cases, inconsistent averments about whether or not the child fatality was a result of abuse or neglect have been made.

Clearly, it is important that the revisiting of these cases be done. It cannot be that DCFS is making determinations that a particular case does not qualify as an SB 39 case and in other contexts preparing reports that the fatality was caused by abuse or neglect. OIR recommends in cases in which there have been written representations by DCFS that the child fatality was caused by abuse or neglect, those cases should be reclassified as SB 39 cases.[7]

It should be known that during OIR's review, it received no information to believe that this alleged inconsistent approach in assessing child fatalities between different components of DCFS was either intentional or designed. It seems more likely that disparate units at DCFS with differing incentives came to opposite conclusions about the same case on arguable issues such as connectivity or causation. That being said, on a going forward basis, DCFS must develop mechanisms to ensure that if a DCFS official has averred causation between the child fatality and the abuse or neglect, a similar finding is made for purposes of SB 39.

Because SB 39 is intended to provide a vehicle for disclosure of child fatality deaths connected to a history of abuse and/or neglect, DCFS would be well-advised in conducting its SB 39 review of the "arguable" cases to adopt on a going forward a broad approach to the possible connectivity between the death and the preceding abuse and/or

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[6] OIR has no information to believe that these are conscious factors employed by the DCFS officials entrusted with making SB 39 determinations. To the contrary, OIR was struck by those individuals' apparent dedication and devotion to their tasks.

[7] Without the broader review it cannot be known whether this case was unique or symptomatic of a larger systemic issue.

neglect. OIR recommends that this broad view be memorialized in internal DCFS guidelines, protocols, and practices.

OIR has been informed that the decision whether to classify a child fatality as an SB 39 case is made internally and passes through several layers of review. However, there is no apparent written product analyzing the SB 39 factors, applying those factors to the particular case, and explaining why a particular fatality either was or was not categorized as an SB 39 case. OIR believes that such a written internal document would be helpful to provide clarity regarding each decision, particularly ones which might have debatable outcomes.

There is no apparent independent oversight of the SB 39 classification decisions. OIR recommends that this Board consider whether, in light of the concern about the classification of these decisions, those decisions should be subject to periodic independent auditing by an outside entity. It should be noted that this assignment may be no small task; potentially each reported child fatality would need to be reviewed to determine whether a principled and consistent SB 39 determination is being made by DCFS.

Challenge 2: Law Enforcement Holds and the Wholesale Stoppage of SB 39 Disclosures

Once a determination has been made that a child fatality qualifies as subject to the larger SB 39 disclosure, the records to be disclosed as described above are subject to certain redactions. SB 39 calls for the agency to redact identifying information of any person or institution other than the county and also requires redaction of privileged and confidential information pursuant to other state and federal laws.[8] SB 39 also requires redaction of any information that would, after consultation with the district attorney, jeopardize a criminal investigation or proceeding.[9]

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[8] During its review, OIR received some expressed concern about the degree of redactions of information on the cases that have disclosed materials. However, considering the wholesale blockage of information as a result of the blanket law enforcement holds placed in 2009 and 2010, the issue of whether the redaction by DCFS is too broad is of relatively less importance at this stage. Certainly, once the pipeline of information is restored, the issue of how DCFS performs its redactions should be periodically reviewed.

[9] The regulations have expanded the consultation to include the law enforcement agency investigating the child's death. Some have opined that the statute did not intend such and the district attorney was chosen as the point of contact so that there would be a more exact and consistent redaction process. Others have suggested that law enforcement must necessarily be included in the consultation, particularly in cases that have not yet moved far in the investigative process and in which the district attorney has played no role.

OIR reviewed case logs provided for all SB 39 cases.[10] That review showed that in 2008, requesters were provided information on fourteen of fifteen cases. In one case, only the minimal "first phase" information was provided. In the remaining thirteen cases, the more extensive package of documents was provided to the requester. In six of those cases, the police report was redacted as a result of objections lodged by law enforcement or the district attorney. In the case in which there was no release of information to the requester, it was because the case was not determined to be an SB 39 case until the middle of 2009.[11]

This pattern of regular release of documents pursuant to SB 39 dramatically changed in calendar year 2009. During that period, disclosure was made in only four of eighteen cases. Of the fourteen cases, blanket objections were lodged in thirteen cases by either law enforcement or the district attorney.

This more recent pattern of non-disclosure has extended into 2010. Of the five cases subject to a disclosure request, there was disclosure in only one case. In the remaining four cases, law enforcement objected to release of any information. It is apparent that the stream of information about SB 39 child deaths that was flowing in 2008, has been largely shut down two years later as a result of law enforcement's blanket holds.[12]

It is unclear why the disclosure of SB 39 child deaths, which appeared to be

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[10] At this point, OIR cannot attest to the accuracy of these charts. On one 2009 case, this Board was informed that disclosure had occurred. However, DCFS internal charts indicate that disclosure had not occurred with regard to that case.

[11] Once the case was learned to be an SB 39 case, the statute suggests that the information subject to disclosure should have then been disclosed to the requester. "The documents ... shall be released to the public by the custodian of records within 10 business days of the request or the disposition of the investigation, whichever is later." There is no evidence that this case was eventually disclosed to the initial requester.

[12] Some have looked to Welfare and Institutions Code section 827 as another way for requesters to obtain child fatality information. The petition for release under section 827 has one distinct advantage; namely a neutral judge determines whether and which documents may be subject to release. However, as noted by the drafters of SB 39, such petitions may be costly, and at times have resulted in lengthy delays in the release of information. These concerns appear to have some resonance in Los Angeles County. OIR has been informed that in at least one case in which a request was made pursuant to section 827, it has thus far taken four months for DCFS to provide the file to the court so that a preliminary review of the materials by the Court could even commence. Moreover, if section 827 were the only way to access SB 39 type cases, such requests could add additional strain on the resources of an already strained Court that is regularly entertaining over 5,000 section 827 disclosure petitions annually.

producing disclosure of information in 2008, have largely been forestalled by the 2009 and 2010 blanket objections lodged by law enforcement. Regardless of purpose, it is important to consider ways to develop a more tailored and precise approach to SB 39 regarding law enforcement holds so as to remedy what is happening in Los Angeles County; a virtual paralysis of the statute's intent.[13]

Currently, when a request for SB 39 information is received by DCFS it sends a letter to the law enforcement agency investigating the matter informing it of the extant request. The letter indicates that under the law it will be required to release "specified records" contained in DCFS files "including, but not limited to, law enforcement reports, emergency response referral documents and certain medical records."[14] In the large majority of 2009/2010 cases, law enforcement has objected to disclosure of all records. This trend toward "blanket" objections stands in sharp contrast to the 2008 requests, in which virtually all objections lodged by law enforcement or the district attorney were to simply request that DCFS excise the police report from the disclosed materials.

One potential explanation for the tendency of law enforcement to make "blanket" objections is that the current process does not provide the law enforcement agency a copy of the materials subject to disclosure. If law enforcement did have such materials to peruse, some of which are already redacted by DCFS pursuant to the statute, it could then make a more educated and precise determination about which materials would jeopardize its ongoing criminal investigation. OIR's review of one case in which materials were disclosed found that the materials subject to potential disclosure contained a significant subset of documents within the stack of documents in which anyone would be hard pressed to argue that the documents could jeopardize an ongoing criminal investigation. However, to law enforcement's defense, without having an opportunity to review all of the actual documents subject to disclosure, it is nearly impossible for it to know which of them might be disclosed without potential harm to the criminal investigation and which of them should be redacted as causing potential jeopardy.

Accordingly, OIR recommends that DCFS consider revising its protocols to provide law enforcement with a copy of the materials that are subject to disclosure. Law enforcement then should go through a page by page determination regarding what materials could be disclosed without jeopardy to its case. Blanket objections should be

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[13] OIR has been informed that there are various initiatives in progress to improve the functioning of SB 39, some spearheaded by County Counsel and the Office of the District Attorney. The hope is that more refined and consistent guidelines for law enforcement can be developed regarding how it considers whether and what to object to regarding materials subject to disclosure.

[14] The regulations promulgated after SB 39 also instruct DCFS to send a similar letter to counsel for any child directly or indirectly related to the deceased child's case record. While at times, this has caused children's counsel to petition the Juvenile Court to prevent release of certain records, unlike the blanket law enforcement objections, those petitions have not to date caused significant disruption in the disclosure process.

looked on skeptically as indicia that this exacting review has not occurred.

In addition to the problem with blanket objections, another problem with the law enforcement objection process is the failure to periodically reevaluate pending requests for information. As criminal investigations move forward, the need to protect certain materials dissipates. For example, after the filing of charges, the discovery provisions will likely provide to the defendant many of the records subject to disclosure. Cases that are presented for filing and are rejected by the District Attorney also do not have the same concern for prejudice from disclosure since the investigation is by all practicable accounts concluded. Accordingly, as a case moves forward in time, law enforcement should be called upon to continually evaluate the need for any objection it has lodged to SB 39 disclosure.

DCFS recognizes this concept and, in its correspondence with law enforcement, requests the law enforcement agency to notify it when a law enforcement objection for release can be removed. However, it appears that of the seventeen blanket holds reflected in data provided to OIR, there has yet to be a case in which an original blanket objection by law enforcement has been subsequently removed. It appears that despite the request of DCFS to do so, law enforcement has not kept the Department apprised of when it might be able to release law enforcement holds.

It is recommended that DCFS play a more active role in reminding law enforcement of the need to continually reevaluate the need for any holds placed on disclosure requests. DCFS should periodically initiate renewed dialogue with any law enforcement agency which has placed an objection on disclosure, document this dialogue, learn the status of the criminal investigation and/or prosecution, and remind law enforcement of the standard necessary to effectuate a hold.[15]

OIR has also learned that DCFS has found it especially challenging in the ten day window it has to learn whether law enforcement does object to the release of documents to locate the investigator and learn whether the agency has objections to release. Some law enforcement agencies have strictures on providing email addresses and contact information and busy detectives apparently do not consider dialogue with DCFS regarding SB 39 matters to be particularly high on their priority list.

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[15] Last week, as a result of this Board's interest in law enforcement holds, DCFS officials did endeavor to contact law enforcement relative to the existing blanket holds to learn if there was still an objection to release of the materials. OIR has been informed that this checking in with law enforcement has caused DCFS to learn that, in at least one case, the law enforcement entity no longer has an objection to release. However, in that case, the district attorney still has an objection to release. This type of regular checking in with law enforcement and the district attorney, not fueled by a crisis, is what is envisioned by OIR's recommendation. Beyond the new information on the one case, as of last week the status of law enforcement holds remains unchanged to that previously provided to this Board. OIR was also informed that last week the Los Angeles Times made an additional request for SB 39 cases occurring since June 24.

To make this information gathering process more facile, it is recommended that each law enforcement agency and the District Attorney designate a point of contact for DCFS officials responsible for the effectuation of SB 39. That point of contact would be responsible for learning whether and to what degree the investigator or deputy district attorney objects to release of information. The point of contact could also potentially assist the detective and deputy district attorney regarding the dictates of the statute as well as the assessment and redaction of the documents potentially subject to release.[16]

Additional Practical Challenges to SB 39 Compliance

As noted above, when DCFS finds that a child fatality qualifies under SB 39, it has ten business days from the date of the request to gather and redact the necessary information, dialogue with law enforcement and the district attorney, and notify counsel for minors related to the case of the request. That ten day window provides daunting challenges to the few personnel assigned at DCFS to handle the requests.[17]

For that reason, it is recommended that in the ordinary course of business, when DCFS determines that a child fatality qualifies as potentially subject to full SB 39 disclosure, it should collect and redact that information even prior to receiving the request. It can be anticipated that DCFS will continue to receive requests for SB 39 disclosure in the foreseeable future. For that reason, rather than have the clock be dictated by the date of the request, DCFS should begin to obtain and redact the documents as soon as it learns a case is subject to full SB 39 disclosure and then, during the ten day window in which the request is received, be able to devote the remainder of its resources to contacting law enforcement, the district attorney, and relevant minors' attorneys.[18]

The recommendations put forward may well result in DCFS being required to devote more resources to processing of SB 39 cases. However, such devotion of resources will be well-served to ensure that the County honors the dictates and legislative intent of SB 39.

Recommendations

1. Cases in which there have been written representations by DCFS that the child fatality was caused by abuse of neglect should be classified as SB 39 cases subject

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[16] OIR has been informed that some preliminary work on this concept has already begun by the District Attorney and County Counsel.

[17] The challenge is compounded by the fact that requests generally come in requesting numerous cases over a relatively long time frame.

[18] OIR has been informed that this concept has been attempted in the past, but that finite resources prevented it to continue.

to disclosure.

2. DCFS should develop mechanisms to ensure that if a DCFS official has averred causation between the child fatality and the abuse and/or neglect, a similar finding is made for purposes of SB 39.

3. On a going forward basis, DCFS should adopt a broad approach to any necessary finding of connectivity between the death and the preceding abuse and/or neglect.

4. In each child fatality in which causation is in issue, DCFS officials should prepare an internal document applying the SB 39 factors to the particular set of facts and explaining why the fatality either was or was not determined to be an SB 39 case.

5. This Board should consider whether the classification of SB 39 decisions should be subject to some sort of audit or independent oversight.

6. DCFS should adopt protocols that regularly provide law enforcement and the District Attorney a copy of SB 39 materials subject to disclosure so that a meaningful review may occur.

7. DCFS should periodically initiate renewed dialogue with law enforcement and the District Attorney regarding any pending objections to learn if the objections can be removed. Any such dialogue should be documented including the status of any law enforcement investigation.

8. Each law enforcement agency and the District Attorney should designate a point of contact for DCFS officials responsible for the effectuation of SB 39.

9. When DCFS determines that a child fatality qualifies as subject to SB 39 disclosure, it should in regular course collect and redact information subject to disclosure.

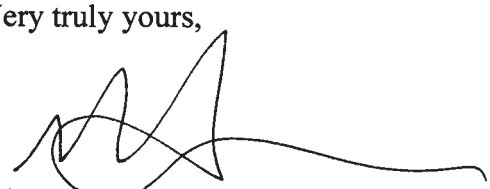
10. DCFS should ensure that sufficient resources are devoted to SB 39 analysis and compliance with SB 39 requests.

11. The potential disconnect between SB 39 and the Regulations as detailed in this correspondence should be brought to the attention of the State Department of Social Services.

Conclusion

It is hoped that the thoughts and recommendations provided here will further fuel efforts to ensure that the intent of SB 39 is not frustrated and prompt disclosure in appropriate cases will occur. Please contact me if you have any questions about the matters discussed herein.

Very truly yours,



MICHAEL J. GENNACO
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WILLIAM T FUJIOKA
Chief Executive Officer

December 14, 2011

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

RESPONSE TO BOARD MOTION RECOMMENDATIONS OF THE OFFICE OF INDEPENDENT REVIEW TO FACILITATE TIMELINES FOR REPORTING THE DISCLOSURE OF CHILD FATALITY INFORMATION UNDER SB 39

On August 31, 2010, on motion of Supervisors Mark Ridley-Thomas and Don Knabe, your Board directed the Chief Executive Office (CEO), to work with the Department of Children and Family Services (DCFS), the Executive Office of the Board of Supervisors, County Counsel, Children's Special Investigations Unit (CSIU), and the Office of Independent Review (OIR) to: 1) evaluate and recommend a single County office that should be charged with overseeing SB 39 compliance, including assembling, assessing, and evaluating information necessary to make an SB 39 determination; 2) develop a process for coordinating the assembly, assessment, and production of information necessary for an independent entity to evaluate and make an informed SB 39 determination; 3) develop a process to coordinate and collect the views of the District Attorney and law enforcement on the materials to be disclosed or not disclosed pursuant to an SB 39 determination; 4) develop a timetable and process for implementing OIR recommendations contained in the OIR's August 30, 2010 Report; and 5) provide a written report within 30 days with quarterly reports to the Board on implementation progress. The 30-day report status update was delivered to your Board on September 30, 2010.

This is to provide you a status report on your Board's directive on implementation of the recommendations made by the OIR to facilitate the timelines for reporting the disclosure of child fatality information under SB 39 and the development of a process for reporting and overseeing SB 39 compliance.

The CEO convened a workgroup consisting of DCFS, County Counsel, CSIU, and OIR to review your Board's requests and the OIR's recommendations and to develop and implement processes to effectuate them. The OIR made 11 recommendations, and this report provides your Board the process by which all the requests were implemented as indicated below and summarized in the Attachment.

I. County Office for Overseeing SB 39 Compliance

Under SB 39, a County's child welfare agency is charged with the responsibility for making the reasonable suspicion determination that the fatality was caused by abuse or neglect, and is one of three entities responsible for making the determination that the abuse or neglect led to the child's death. Law enforcement and the Coroner are the other two agencies. In Los Angeles, DCFS is the County's child welfare agency and has the expertise to make these determinations.

The legal standard for the initial release of information, understood in light of other statutes and the California Department of Social Services' (CDSS) regulations which implement SB 39, require that DCFS make the initial determination of reasonable suspicion. Findings made by any of the three entities may trigger the second broader release by determining that alleged abuse or neglect has resulted in a child's death. However, applicable law indicates that DCFS is the County department responsible for SB 39 processing.

Currently, SB 39 determinations and compliance are being performed within DCFS' Risk Management Division (RMD) as part of its regular duties. To adopt a broader approach to determination of connectivity, to strengthen existing operations, and to facilitate timely determination and reporting, the workgroup recommends that a separate section within the RMD be established to perform all SB 39 functions.

Due to the various legal elements associated with SB 39 compliance and the potential disconnect between the applicable law and CDSS regulations, we also recommend that County Counsel continue to provide assistance to DCFS in the documentation and implementation of protocols and processes to ensure that the County is in full compliance with SB 39.

The CEO and DCFS have assessed the operational requirements for the proposed section to support this function and during the FY 2011-12 Budget process added positions to the DCFS Budget for which existing vacancies could not absorb the new workload. The existing vacancies which were identified and new positions added will be combined to create the SB 39 section within the Risk Management Division. The dedicated functions of this section will include: 1) research and review of all child fatalities and near fatalities; 2) track determinations through the Critical Incident Fatality

Tracking (CIFT) database; 3) interface with CDSS on reporting and reconciliation of all child fatalities and near fatalities; 4) communicate with minor's counsel, appropriate law enforcement and the DA; 5) compile and redact documents; 6) follow-up on a monthly basis on any cases for which objections were received, and; 7) report and release information on reasonable suspicion and causal determinations.

The enactment of SB 39 resulted in an increase in reporting duties of local counties. Since, the Bill imposed a State-mandated local program, the California Constitution requires the State to reimburse local counties for certain costs mandated by the State. As a result, DCFS will submit to the Auditor-Controller any increased costs for which it has not received State funding in order to receive SB 90 reimbursement consideration.

II. SB 39 Evaluation and Determination

In October 2010, a determination form was developed in consultation with County Counsel and was immediately implemented. The form allows the analyst to clearly detail the analysis made in concluding the SB 39 determination in every child fatality reported to the Department.

Further, on October 22, 2010, Procedural Guide 0500-501.40, Release of Case Record Information Regarding a Child Fatality, dated March 24, 2010, was revised at the request of County Counsel to clarify CDSS Manual of Policies and Procedures Division Section 31-502-31-502.48.

Finally, the DCFS SB 39 Section will be responsible for coordinating the assembly, assessment and production of information. The SB 39 Section will also collaborate with County Counsel to document the process and protocol required to comply with the reporting and legal requirements.

III. Process to Coordinate District Attorney and Law Enforcement Clearances

Since October 2010, a SB 39 point person has been designated with the District Attorney's Office, Michele L. Daniels, Head Deputy DA of Family Violence Division and Michael Gargiulo, Assistant Head Deputy of Family Violence Division, Los Angeles Sheriff's Department, Lt. Wes Sutton of Sheriff Homicide Bureau, and Los Angeles Police Department, Tina Certeza, Det. of Abused Child Section. The Risk Management Division has maintained regular communication with these entities in the implementation of SB 39 with very favorable, time-sensitive results.

Additionally, a process for communicating with minor's counsels and their supervisors has been implemented in relation to SB39 objections and releases. This has enhanced Risk Management's ability to receive responses in a timely manner.

IV. Status on the Implementation of the OIR Recommendations

In response to your Board's August 24, 2010 motion, the OIR issued his report citing 11 specific recommendations regarding compliance with SB 39 determinations and reporting. The attached matrix is a summary of each recommendation and the status on the implementation.

Please let me know if you have any questions, or your staff may contact David Seidenfeld, Manager CEO at (213) 974-1457, or via email at dseidenfeld@ceo.lacounty.gov.

WTF:BC
DS:RT:ljp

Attachment

c: Executive Office, Board of Supervisors
Auditor-Controller
Children and Family Services
Children's Special Investigation Unit
County Counsel
Office of Independent Review

OIR.bm

OFFICE OF INDEPENDENT REVIEW ("OIR") RECOMMENDATIONS			
No.	Recommendation	Proposed Action	Timetable
1	Cases in which there have been written representations by DCFS that the child fatality was caused by abuse or neglect should be classified as SB 39 cases subject to disclosure.	Under SB 39, DCFS' initial obligation to release information on child fatalities is triggered when there is a reasonable suspicion that the fatality was caused by abuse or neglect, and the secondary obligation to make a broader release is triggered when the abuse or neglect leads to a child's death and DCFS substantiates the abuse or neglect. The first determination can be triggered if DCFS finds that a report of suspected child abuse or neglect was received concerning the deceased child, DCFS determined that an in-person investigation into the allegation was required and, based upon all the available information, the suspicion is reasonable. The second determination can be triggered when DCFS has substantiated the report of alleged child abuse or neglect which was received regarding the deceased child and concludes that the abuse or neglect resulted in the fatality. This can be evaluated by doing the following: (1) Determining whether the alleged abuse or neglect was substantiated (e.g., check CWS/CMS and CACI-related documents). (2) Carefully drafting and reviewing the DCFS reports concerning the deceased child. If DCFS asserts that abuse or neglect resulted in the fatality, it appears that the SB 39 reporting criteria is met. (3) Obtaining a copy of any original or amended WIC § 300 and § 342 petitions which have been filed to seek jurisdiction over surviving siblings. DCFS should also obtain copies of any WIC § 387 and § 385 petitions which involve the death of another child. In the event that any petition is amended by the juvenile court to add additional counts according to proof, DCFS will need to obtain a copy of the amended petition. In addition to the petitions, DCFS should also get a copy of any accompanying Detention Reports.	Completed

OFFICE OF INDEPENDENT REVIEW ("OIR") RECOMMENDATIONS			
No.	Recommendation	Proposed Action	Timetable
		(4) Obtaining a copy of any reports seeking termination of juvenile court jurisdiction due to the death of a child or any last minute court reports which describe the death of a child. (5) Reading the petitions to determine whether § 300 subdivision (f) has been plead and whether any other subdivision has been plead alleging that the parents caused the death of the deceased child. Similarly, DCFS will need to read the Detention Reports to see if such a link has been reported. (6) Likewise, DCFS must read the reports seeking termination of jurisdiction and any last minute information for court officers to see whether the reports contain a statement that the child death was due to abuse or neglect. As the facts associated with SB 39 determinations may develop over the course of time, DCFS will continue to follow the progress of events and make a holistic assessment of each SB 39 determination. DCFS will also continue to consult with County Counsel when questions arise.	
2	DCFS should develop mechanisms to ensure that if a DCFS official has averred causation between the child fatality and the abuse and/or neglect, a similar finding is made for purposes of SB 39.	In August, 2010, Juvenile Court Services developed and implemented a notification process to inform the Risk Management Division of every petition that is filed for a case in which a child has died for the purpose of conducting a SB 39 determination. Immediately upon receipt of a petition being submitted to Dependency Court, Juvenile Court Services electronically sends Risk Management a copy of their internal notification, the petition that was filed, the investigating social worker's Detention Report, and any other supporting documents.	Completed
3	On a going forward basis, DCFS should adopt a broad approach to any necessary finding of connectivity between the death and the preceding	As recommended, DCFS has adopted a broad approach to SB 39 determinations which include any necessary findings of connectivity between child deaths and the preceding abuse and/or neglect.	Completed

OFFICE OF INDEPENDENT REVIEW ("OIR") RECOMMENDATIONS			
No.	Recommendation	Proposed Action	Timetable
	abuse and/or neglect.		
4	In each child fatality in which causation is in issue, DCFS officials should prepare an internal document applying the SB 39 factors to the particular set of facts and explaining why the fatality either was or was not determined to be an SB 39 case	In October, 2010, a determination form was developed in consultation with County Counsel and was immediately implemented. The form allows the analyst to clearly detail the analysis made in concluding the SB39 determination in every child fatality reported to the Department. Subsequent revisions to the form have been made in consultation with County Counsel.	Completed
5	This Board should consider whether the classification of SB 39 decisions should be subject to some sort of audit or independent oversight.	The workgroup recommended that County Counsel conduct quarterly, or as needed, sample evaluations of the SB 39 decisions for a defined period to ensure that they are properly classified. In addition, DCFS staff continue to engage County Counsel staff on an ongoing basis to ensure proper classification. The first quarterly evaluation was completed in April 2011. No set date has been established for the second evaluation. Effective October 2011, a second evaluation by County Counsel commenced and is in process.	Quarterly/Ongoing
6	DCFS should adopt protocols that regularly provide law enforcement and the District Attorney a copy of SB 39 materials subject to disclosure so that a meaningful review may occur.	Risk Management staff has been diligent in preparing SB 39 redacted documents, which are reviewed by County Counsel as soon as a SB 39 Subdivision C determination is made. This allows for approved, scanned redacted documents to be sent electronically to minor's counsel, law enforcement agencies, and the District Attorney's office. This practice allows the three agencies to make a more thorough and educated assessment as to whether any additional redactions are required prior to the release of documents.	Completed
7	DCFS should periodically initiate renewed dialogue with law enforcement and the District Attorney regarding any pending objections to learn if the objections can be removed.	In addition to requesting that the District Attorney and law enforcement contact the Department when they are willing to lift their objections to release, DCFS staff contact the District Attorney and law enforcement on a monthly basis, by telephone and/ or by email, to ask if any of the previously withheld	Ongoing

OFFICE OF INDEPENDENT REVIEW ("OIR") RECOMMENDATIONS			
No.	Recommendation	Proposed Action	Timetable
	Any such dialogue should be documented including the status of any law enforcement investigation.	documents can be released. We communicate directly with the law enforcement agency or District Attorney who is investigating/handling each specific case. Effective October 31, 2011, law enforcement is no longer able to request additional redactions of documents and/or object to release.	
8	Each law enforcement agency and the District Attorney should designate a point of contact for DCFS officials responsible for the effectuation of SB 39.	Points of contact have been established with the District Attorney's Family Violence Division, Sheriff's Department Homicide Bureau, and Los Angeles Police Department's Juvenile Division to comply with this recommendation.	Completed
9	When DCFS determines that a child fatality qualifies as subject to SB 39 disclosure, it should in regular course collect and redact information subject to disclosure.	DCFS's Risk Management Division has established procedures that allow for the collecting and redacting of information subject to disclosure. Also, DCFS staff with County Counsel approval forward the approved redacted information to law enforcement agencies and the District Attorney's office to ensure that a meaningful review occurs prior to disclosure.	Completed
10	DCFS should ensure that sufficient resources are devoted to SB 39 analysis and compliance with SB 39 requests.	The CEO and DCFS have assessed the operational requirements for the proposed section to support this function and during the FY 2011-12 Budget process added the positions to the DCFS Budget for which existing vacancies could not absorb the new workload.	Completed
11	The potential disconnect between SB 39 and the Regulations as detailed in this correspondence should be brought to the attention of the State Department of Social Services ("CDSS").	The State is aware of disparities between the language of the SB 39 statute and SB 39 regulations issued by CDSS. Specific disparities were discussed at the CDSS SB 39 Regulations Workgroup on June 7, 2011. The State continues to study ways to address the discrepancies. California Welfare Directors Association (CWDA) is also considering whether to sponsor legislation to refine SB39, which may resolve some or all of the discrepancies. DCFS will continue to bring to CDSS' attention any future disparities.	Completed Note – Effective 10/31/11, regulations were changed and include that law enforcement is no longer able to request additional redactions of documents and/or object to release.