Children's Advocacy Institute

University of San Diego
SCHOOL OF LAW

University of San Diego School of Law
5998 Alcalá Park / San Diego, CA 92110
(619) 260-4806 / (619) 260-4753 (Fax)

Sacramento: (916) 844-5646

Washington, DC: (917) 371-5191

Executive Director
Robert C. Fellmeth *Price Professor of Public Interest Law, USD School of Law*

Reply to: □ San Diego □ Sacramento □ Washington
info@caichildlaw.org / www.caichildlaw.org

August 20, 2022

The Honorable Gavin Newsom
Governor, State of California
1303 10th Street, Suite 1173
Sacramento, CA 95814
Submitted via email to Leg.Unit@gov.ca.gov

RE: REQUEST FOR SIGNATURE FOR AB 2660 (MAIENSCHEIN)

Dear Governor Newsom:

As the Department of Public Health ("DPH") correctly observes about California's statewide child death review tracking and evaluation system, "[p]revention is the overriding priority[.]"[1] We track and review the tragic deaths of children in the past to prevent future children from dying.

Governor, respectfully, it is hard to imagine a program that should be of a higher priority for your Administration than accounting for California children who die. Yet, no part of the system by which we account for California children dying, is working. That is a shocking statement but it is true. As documented below, all parts are neglected, impoverished, unaccountable, scattered, or outdated. For example:

- The overseeing statewide Child Death Review Team ceased functioning more than a decade ago when its then-inadequate budget of $150,000 was eliminated.[2]

- There is no accurate count of how many counties have operating child death review teams, even though current law emphasizes their importance in saving child lives.[3] This is not supposed to happen. The Department of Justice ("DOJ") is by law required to

[1] https://ncfrp.org/cdr-map/spotlight-california/#:~:text=Currently%20in%20California%20there%20is,death%20review%20(CDR)%20team.&text=The%20State%20Child%20Death%20Review,Angeles%20County%20starting%20in%201978. This website links to a dead DPH site: :http://www.cdph.ca.gov/programs/Pages/ChildMaltreatmentPrevention.aspx The last report issued by DSS linked rom the site for those children who dies of abuse and neglect (a subset of all children deaths) is for the year 2013 for 2010 data. https://ncfrp.org/wp-content/uploads/State-Docs/CA_2010AnnualCFRReport.pdf

[2] https://ncfrp.org/cdr-map/spotlight-california/ : "Currently in California there is no state child death review (CDR) team. The mandate to the Attorney General's Office for a state team is contingent upon funds being available. The State Child Death Review (CDR) Council was disbanded in 2008 when state funds [$150,000] were cut. … The California Department of Public Health (CDPH) created the Fatal Child Abuse and Neglect Surveillance (FCANS) Program in 2000 to carry out its mandate to track data on fatal child abuse and neglect (Penal Code section 11174.34). General funds for this program were cut in 2008. However, funding is provided for local assistance under the federal Maternal Child Adolescent Health Title V Block Grant. Approximately $150,000 local assistance money is used to provide support for local teams."

[3] Penal Code section 11174.32(a): "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[.]")

ensure we are "updated" about how many local death review teams there are.[4] That law is not being obeyed.

- One state department's child death review webpage has links that lead to dead web pages or provides reports that are years old.

- The applicable codes are a tangle with nobody clearly in charge of this literally-life-and-death-for-children program.

Every year, as the number of California dead children cumulates, we for no policy reason are losing the chance to prevent children from dying.

The Children's Advocacy Institute at the University of San Diego School of Law, which for over 30 years through legal education, legislative and regulatory advocacy, and litigation has sought to advance the well-being of California's children, is sponsoring AB 2660. AB 2660 (Maienschein), addresses the rolling tragedy of failing each year to prevent children dying by accounting for children who have died only via the most surgical and measured amendments to current law imaginable. We respectfully request that you sign this bill to align our proclamations about the importance of children in with our efforts to prevent them from needlessly perishing.

I. EVERY PART IS BROKEN: A DETAILED BACKGROUND OF OUR ONGOING CHILD DEATH REVIEW TRAGEDY.

A. Counting Child Deaths Statewide Means Relying On Counties To Track Deaths. Yet, Counties Are Free Not To Track Children Who Die Within Their Borders And Nobody Knows How Many Counties Are Tracking Child Deaths Voluntarily.

Penal Code section 11174.32(a) emphasizes that "child death review teams have been used successfully to ensure that incidents of child abuse or neglect are recognized" yet the same subdivision says that counties are free not to empanel such teams.[5] Some do anyway. Apparently, many do not. Some, apparently, have empaneled such teams in the past but might not be now.

We say "apparently" because, amazingly, nobody actually knows how many counties have currently operating child death review program. Here is one "estimate":

> *"Despite efforts to produce an annual child death report, there are only an estimated 22 active child death review teams throughout the state, leaving many counties without a reporting mechanism."*[6]

DPH differently estimates that "[b]ased on the limited information available to us, there could be up to 37 active local CDR teams[.]"[7] ***DPH itself*** is here saying it has "limited information"

[4] Penal Code section 11174.34 (h): "The Department of Justice shall direct the creation, maintenance, updating, and distribution electronically and by paper, of a statewide child death review team directory, which shall contain the names of the members of the agencies and private organizations participating under this section, and the members of local child death review teams and local liaisons to those teams."

[5] With emphases supplied, Penal Code section 11174.32 in relevant part reads: " (a) Each county ***may*** establish an interagencychild 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."

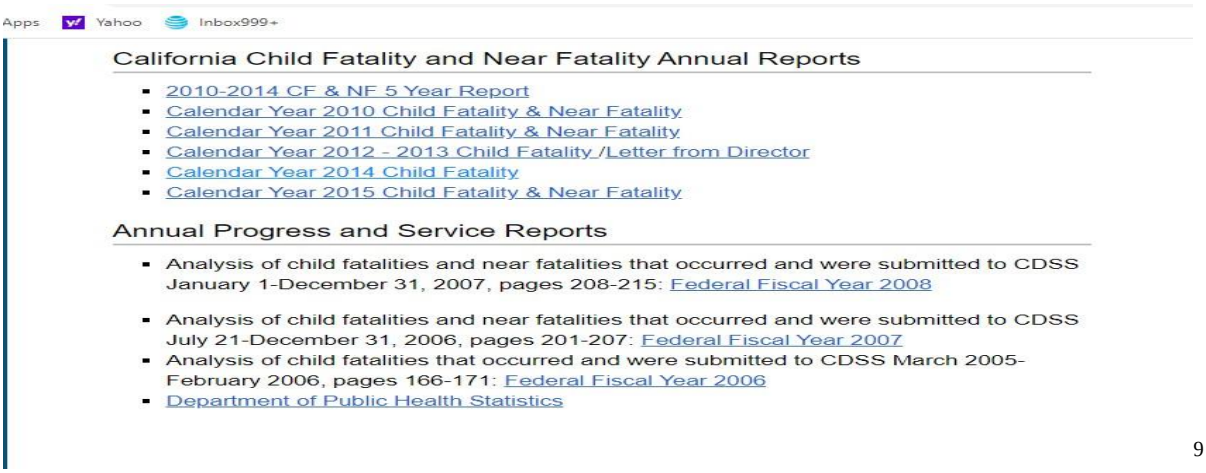
[6] https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180AB1098 (Senate Public Safety Analysis of AB 1098 (McCarty and Arambula) -- this bill died in the Senate Appropriations Committee.

[7] https://ncfrp.org/cdr-map/spotlight-california/

about how many death review teams there are. A local television news team recently reported there may be over 50 such teams.[8]

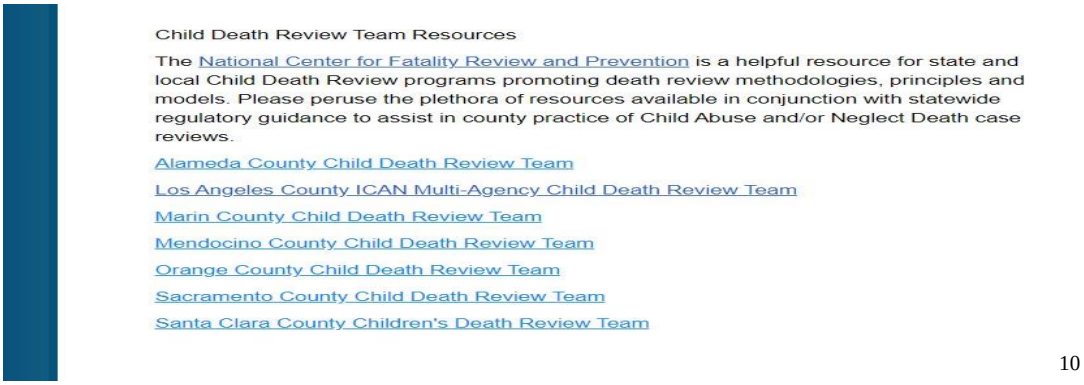
B. Two Current State Government Websites Spotlight How Child Death Prevention Reporting Is Neglected.

DPH's current website devoted to disclosing child death reports shows the extent to which statewide tracking of child deaths has tragically been allowed to languish. Consider the most recent date is seven years ago:



9

An even more visible example of how child death reporting has languished is this Department of Social Services ("DSS") website. Notwithstanding estimates of between 22 and 37 of California's counties having child death review teams, DSS lists just seven:



10

Let's please examine each of the 7 links (leaving aside the 51 missing counties):

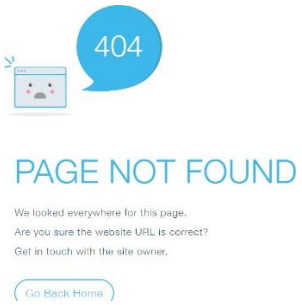
[8] NBC7 in San Diego in its report "*State Health Department Trying to Account for Local Child Death Review Teams,"* **documented in 2017 this problem in the context of the failure to account for SIDS deaths: "** The state health department is trying to determine how many California counties have active Child Death Review Teams after the state program was disbanded in 2008 due to budget cuts … NBC 7 Investigates found the state CDR team was disbanded in 2008 because of budget cuts and was never fully restored. Currently, there is an informal network among the county CDRTs. According to the informal network's website, 50 to 55 of the 58 counties have CDRTs, but a March 2016 state legislative bill analysis said there are only 22 local teams and most of them do not file annual reports." https://www.nbcsandiego.com/news/local/state-health-department-trying-to-account-for-local-child-death-review-teams/33228/ See also: https://youthlaw.org/publication/child-deaths-from-abuse-and-neglect/

[9] https://www.cdss.ca.gov/inforesources/child-fatality-and-near-fatality/data-and-reports accessed 2/6/22

[10] https://www.cdss.ca.gov/inforesources/child-fatality-and-near-fatality/resources-and-faqs accessed 2/6/22

- 1. The Alameda link doesn't link to child deaths. A search for "child death" in the linked site didn't turn up anything.[11]

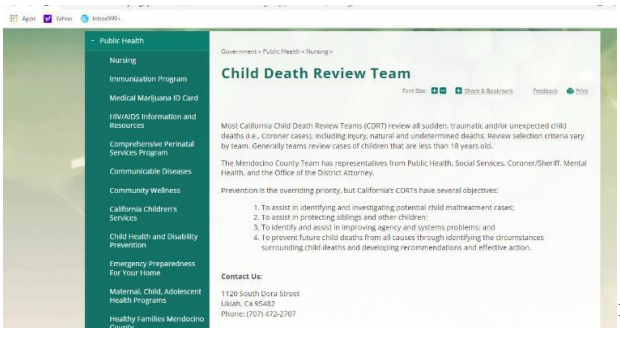
- 2. The Los Angeles County link[12] is dead:



- 3. The Marin County link is a dead link offering the domain for sale:

[13]

- 4. The Mendocino County link takes you to a child death review page with no apparent data. Look up top and it is filed under "nursing":



[14]

- 5. The Orange County link sends you to the Coroner's Office where two child death review team reports are listed … from 2014 and 2007-2011:

[11] https://www.alamedacountycapc.com/ accessed 2/6/22
[12] https://www.ican4kids.org/cdrt.html accessed 2/6/22
[13] http://marinadvocates.org/programs/marin-child-abuse-prevention-council/child-death-review-team.html accessed 2/6/22
[14] https://www.mendocinocounty.org/government/health-human-services-agency/public-health/nursing/child-death-review-team accessed 2/6/22

- At the bottom are two links to death reports. The five year one ends in **2011**:

[15]

- The other one is for **2014**:

[16]

- 6. The Sacramento County link is good but latest posted data is from **2016.**[17]

- 7. Finally, the Santa Clara link is good. At the upper right leads to most recent report and it is from **2018.**[18]

And, that is it for California's 58 counties and child death tracking, according to this DSS website.

[15] https://www.ocsheriff.gov/sites/ocsd/files/import/data/files/25782.pdf Accessed 2/6/22
[16] https://www.ocsheriff.gov/sites/ocsd/files/import/data/files/43626.pdf accessed 2/6/22
[17] https://www.thecapcenter.org/why/research-and-publications/child-death-review-team accessed 2/6/22
[18] https://capc.sccgov.org/sites/g/files/exjcpb1061/files/document/CDRT%20Annual%20Report%20-%202018.pdf

C. <u>The Data We Do Have Doesn't Add Up</u>.

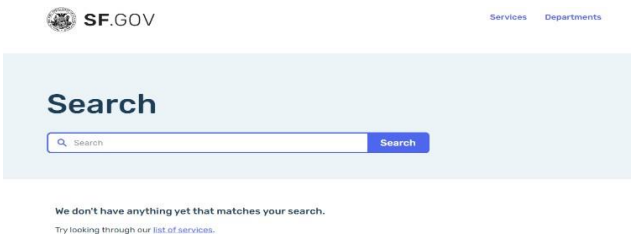
Here is just two examples from the years 2014 and 2016.

1. <u>2014 data.</u>

Kidsadata.org[19] for 2014 reports around 1,390 statewide child deaths.[20]

Page 24 of Santa Clara's 2014 death review report[21] shows 107 total child deaths for just Santa Clara County in 2014. But Los Angeles County shows about 300 total child deaths in LAC for 2015 (earliest year available online.)[22] Orange County reports 89 deaths for 2014.[23]

So, assuming 2015 numbers in Los Angeles County will be in the ballpark for 2014 deaths (a fair assumption if you look at the other years), then ***between just these three counties there are a reported 496 child deaths – about 35% of the 1,390 Kidsdata.org total – from just three counties with 55 more to go.*** Of course, if we had access to child death reports from all counties, we could continue to cross check. But when, for example, one goes to the City and County of San Francisco website and searches for "child death" it returns this:



As for another county (San Diego) research revealed only the following: "The San Diego Child Fatality Review Committee was established in 1982 and was only the second child fatality committee established in the country. During its first 15 years, it reviewed the deaths of children newborn through age 6, but that was expanded to children through age 12 in 1998 and through age 17 in July 2005. In 2011 and 2012 the committee reviewed a total of 164 child deaths. 91 deaths were reviewed in 2013.[24]

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19 "Kidsdata.org, a program of Population Reference Bureau (PRB), promotes the health and well being of children in California by providing an easy-to-use resource that offers high quality, wide ranging, local data to those who work on behalf of children." https://www.kidsdata.org/about#:~:text=Kidsdata.org%2C%20a%20program%20of,work%20on%20behalf%20of%20children. It is funded by "the Lucille Packard Foundation and the DPH. Who Funds Kidsdata.org?
Kisdata.org is funded by a grant from the Lucile Packard Foundation for Children's Health
with additional funding provided by: California Department of Public Health, Injury and Violence Prevention Branch, Rape Prevention and Education Program (through Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Cooperative Agreement 6NUF2CE002501). Ibid."

20 (Total added up from those deaths under 20 years of age, all ages and causes).https://www.kidsdata.org/topic/660/childdeaths- age-cause/table#fmt=939&loc=2,127,347,1763,331,348,336,171,321,345,357,332,324,369,358,362,360,337,327,364,356,217,353,328,354,323,352,320,339,334,365,343,330,367,344,355,366,368,265,349,361,4,273,59,370,326,333,322,341,338,350,342,329,325,359,351,363,340,335&tf=79&ch=1307,1309,446,1308,530,531,533,532,975,534,529&sortColumnId=0&sortType=asc

21 https://capc.sccgov.org/sites/g/files/exjcpb1061/files/document/DRT%20Annual%20Cumulative%20Report- 2013_2015web%20%281%29.pdf

22 https://capc.sccgov.org/sites/g/files/exjcpb1061/files/document/DRT%20Annual%20Cumulative%20Report- 2013_2015web%20%281%29.pdf

23 https://www.ocsheriff.gov/sites/ocsd/files/import/data/files/43626.pdf

24 https://www.sandiegocounty.gov/content/sdc/me/reveiwteamcomm.html

2. 2016 data.

The data from 2016 shows even more starkly how the numbers we do have don't add up.

Kidsdata.org reports about 1,121 statewide child deaths for 2016. [25]

But, "[i]n 2016, 137 children, birth through 17 years of age, died in Sacramento County".[26]

The link to Los Angeles County's report shows that 339 kids died there in 2016. [27]

That means that *just two* of California's 58 counties report -- publicly – reported over 40% of the Kidsdata.org reported number of deaths. This, needless to say, is unlikely.

D. Child Death Review Laws: Nobody Clearly In Charge.

Current state law confusingly vests responsibility for statewide tracking in three different state agencies (DOJ, DPH, DSS) and 58 counties that are not required to have child death review teams.

When it comes to the counties, one state agency delicately describes the county-level situation as follows: "Additionally, incomplete data-sharing between coroners, law enforcement, and child welfare agencies poses a challenge." [28]

When it comes to the three state agencies, division of authority between them is a baffling tangle. Penal Code sections 11174.32-11174.35 in part establishes the state child death review system. Penal Code section 11174.33 with emphasis added provides: "***Subject to available funding***, ***the Attorney General,*** working with the California Consortium of Child Abuse Councils, shall develop a protocol for the development and implementation of interagency child death teams for use by counties, which shall include relevant procedures for both urban and rural counties. …The protocol shall be completed on or before January 1, 1991."

As documented above, in 2008, state budget cuts led DOJ to the disbandment of the state Child Death Review Council. [29] Since that time more than a decade ago, no state department or agency has assumed its statewide child death oversight responsibilities.

Penal Code section 11174.34 (with emphases added) perfectly illustrates how nobody is in charge of this system, explaining in part why it has fallen apart. The statute in part provides:

> (b) (1) It shall be the duty of the California State Child Death Review Council to oversee the statewide coordination and integration of state and local efforts to

[25] https://www.kidsdata.org/topic/660/childdeaths-age-cause/table#fmt=939&loc=2,127,347,1763,331,348,336,171,321,345,357,332,324,369,358,362,360,337,327,364,356,217,353,328,354,323,352,320,339,334,365,343,330,367,344,355,366,368,265,349,361,4,273,59,370,326,333,322,341,338,350,342,329,325,359,351,363,340,335&tf=88&ch=1307,1309,446,1308,530,531,533,532,975,534,529&sortColumnId=0&sortType=asc

[26] https://www.thecapcenter.org/admin/upload/2016%20cdrt%20final%20report%20released%2001.29.19.pdf page ii

[27] https://dcfs.lacounty.gov/category/total-fatalities/?yr=all

[28] https://www.cdss.ca.gov/Portals/9/OAB/2014ChildFatalityAnnualReport.pdf?ver=2017-09-11-111129-790

[29] Adding to the confusion is federal law. Under Section 106 (c)(1)(A)-(B) of the Child Abuse Prevention and Treatment Act (CAPTA, section 42 U.S.C. 5101 *et seq*. and 42 USC section 5116 *et seq*). California must have 3 federally funded Citizen Review Panelsr: "[E]ach panel must evaluate the extent to which the State is fulfilling its child protection responsibilities in accordance with its CAPTA State plan by: (1) examining the policies, procedures and practices of State and local child protection agencies, and (2) reviewing specific cases, where appropriate. In addition, …a panel may examine other criteria that it considers important to ensure the protection of children,…This provision also authorizes the panels to review the child fatalities and near fatalities in the State."

address fatal child abuse or neglect and to create a body of information to prevent child deaths. ***The Department of Justice, the State Department of Social Services, the State Department of Health Care Services, the California Coroner's Association, the County Welfare Directors Association, Prevent Child Abuse California, the California Homicide Investigators Association, the Office of Emergency Services, the Inter-Agency Council on Child Abuse and Neglect/National Center on Child Fatality Review, the California Conference of Local Health Officers, the California Conference of Local Directors of Maternal, Child, and Adolescent Health, the California Conference of Local Health Department Nursing Directors, the California District Attorneys Association, and at least three regional representatives, chosen by the other members of the council, working collaboratively*** for the purposes of this section, shall be known as the California State Child Death Review Council.

Nobody in current law is actually placed in charge of this vast Council. Penal Code section 11174.34(b)(2) authorizes the DOJ to carry out the purposes of section 11174.34 by "coordinating" all of the Council Members.[30] But, "coordinating" is not the same as being ultimately responsible for statewide child death reviews. In any event, the same statute at subdivision (e) requires another state agency – the DPH -- to "design, test and implement a statewide child abuse or neglect fatality tracking system incorporating information collected by local child death review teams."[31]

But, wait. Penal Code section 11174.35 also confusingly provides: "The State Department of ***Social Services*** shall work with state and local child death review teams and child protective services agencies in order to identify child death cases that were, or should have been, reported to or by county child protective services agencies …. The State Department of Social Services, the State Department of Health Services, and the Department of Justice shall develop a plan to track and maintain data on child deaths from abuse or neglect."[32]

The "statewide child abuse or neglect fatality tracking system"[33] is, recall from above, operated out of DPH. But, as quoted above, under Penal Code 11174.35 ***it is the DSS's Critical Incident Oversight & Support Unit that is by statute actually responsible for the review of critical incidents reported by child welfare agencies*** to the DSS which involve child fatalities and near fatalities resulting from abuse and/or neglect.[34]

Which department is lead on what again?[35]

[30] (2) The Department of Justice is hereby authorized to carry out the purposes of this section by coordinating council activities and working collaboratively with the agencies and organizations in paragraph (1), and may consult with other representatives of other agencies and private organizations, to help accomplish the purpose of this section.

[31] Continuing: "The department shall: (1) Establish a minimum case selection criteria and review protocols of local child death review teams. (2) Develop a standard child death review form with a minimum core set of data elements to be used by local child death review teams, and collect and analyze that data. (3) Establish procedural safeguards in order to maintain appropriate confidentiality and integrity of the data. (4) Conduct annual reviews to reconcile data reported to the State Department of Health Services Vital Statistics, Department of Justice Homicide Files and Child Abuse Central Index, and the State Department of Social Services Child Welfare Services/Case Management System data systems, with data provided from local child death review teams. (5) Provide technical assistance to local child death review teams in implementing and maintaining the tracking system." Of course, counties are not required to establish "local childe death review teams" under current law.

[32] It is unclear whether this has been done.

[33] This is the FCANs system referred to in fn. 2.

[34] The unit is also responsible for the annual reporting of information gathered from these reviews pursuant to the federal CAPTA and Senate Bill 39 (Chapter 468, Statutes of 2007), Assembly Bill 1625 (Chapter 320, Statutes of 2016) which established Welfare and Institutions Code (WIC) section 10850.4 and Manual of Policies and Procedures (MPP), Division 31, section 31-502.12 and 31-502.122). The unit also is authorized to oversee and provide technical assistance to counties to ensure consistent application of child fatality and near fatality reporting and disclosure policies and statutory and regulatory requirements.

[35] It is actually even more confusing. As authorized by Penal Code 11174.34 the DPH, in its Center for Healthy Communities, the Injury and Violence Prevention Branch (IVPB) developed and continues to use standardized Fatal Child Abuse and Neglect Surveillance (FCANS) first

II. Preventing Children From Dying Deserves Better. Enter AB 2660 (Maienschein).

The National Center for Child Death Review's *Program Manual for Child Death Review Strategies to Better Understand Why Children Die & Taking Action to Prevent Child Deaths* identifies "The Operating Principles of Child Death Review" as the following:

- "The death of a child is a community responsibility.
- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- A death review requires multidisciplinary participation from the community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe and protected." [36]

Compared to any of these objectives and the first-tier priority of preventing children from dying, the California *status quo* described above is, respectfully but said plainly, provably inadequate to the morally compelled task of preventing children from dying. Respectfully, the *status quo* cannot endure. Reform is urgently needed.

III. The Cost Of AB 2660 Is Exceedingly Modest And Worth It Given That Preventing Children From Dying Should Be The Highest Priority Of State Government.

There are two sources of possible costs if AB 2660 is enacted.

Counties. Because existing and longstanding code provides counties "*may* establish an interagency child death review team" some number of counties (the vast majority, apparently, from the estimates above) have such teams that either are operating now or were, based on the reports found online and cited above, operating just a few years ago where wheels were invented but just stopped rolling. In the former situation, the cost will be zero; in the second, minimal.

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authorized in July, 2000, to obtain death reports from the counties. But, this whole process is feckless; it lacks needed formality. DPH staff and the FCANS system were instrumental in creating the national child fatality reporting system. But, county death review teams if they exist do not have any state funding at all and were and continue to be reimbursed for their FCANS reports on a fee for case basis ($150/case), *without any specific budget authorization.* FCANS was defunded in 2008 but the DPH has annually redirected without any written agreement or MOU, $150,000 from federal Maternal Child Adolescent Health (MCAH) Title V Block Grant to IVPB as a local assistance fund to pay the county death review teams to carry out FCANS activities. One or more California Epidemiology Intelligence Service Fellows have been funded under the local assistance provision. The IVPB also receives reports of child death cases from the DSS's Critical Incident Oversight & Support Unit (CIOSU) and tries to reconcile the two streams of reporting.

[36] *A Program Manual for Child Death Review*. Ed. Theresa Covington, Valodi Foster, Sara Rich. The National Center for Child Death Review, 2005.

The point is that many – likely most -- counties either do have such Teams operating now or will already have created the infrastructure for them.

Moreover, under current law, counties have never stopped reporting what is likely to be the greatest number of child deaths. Since 2008 counties have been required to identify, record, evaluate, and report child deaths from abuse and neglect and report to DSS. (See, for e.g., "For ALL cases of child fatalities wherein there is reasonable suspicion that it is as a result of abuse or neglect, the county shall submit the SOC 826 (3/08) to the CDSS. The SOC 826 (3/08) with Part A completed shall be submitted within five (5) business days of learning of the incident."[37] The same obligation has been imposed regarding near child deaths since 2017.[38]

Thus, as revealed by the DSS's website devoted to "Child Fatality and Near Fatality," there is in existence a robust and existing set of County ACINs, ACLs, and related regulations that already exist when it comes to what is likely to be the largest number of child deaths covered by this bill. Costs, then, attributable this bill are restrained to reviving or establishing systems that address only deaths ***not caused by abuse and neglect***.

On this score, the bill's addition that counties are expressly permitted and so encouraged to pool their resources with other counties and state agencies is a cost-saving reform not expressly permitted under current law.

The requirement of posting of county death review reports should have no discernable costs as all that is required is a PDF upload. No additional requirements such as creating new websites are a part of the bill.

Finally, counties under the bill are given until 2025 to comply so no urgent ramp-up or costs will be needed. Moreover, in both 2023 and 2024 the Attorney General will have under the bill submitted to you a budget for the counties "that is sufficient to fund the council, and the requirements of Section 11174.33 and this section." Thus, this date combined with the Attorney General's duty to submit a budget in time for your 2023 and 2024 budgets (i) offers not one but two years of work among state departments and counties to calculate costs while at the same time collaborating on divisions of labor and program implementation and (ii) and two years of child advocates and counties working to secure the money identified in these budgets.

In any event, what is self-evident is that the current regime of hoping all counties create and maintain child death review teams does not work. Absent the mandate, and mindful of child political powerlessness, the next downturn will see voluntary programs being cut just as the statewide child death review team itself has not been restored since the last downturn.

State Agencies. Only the Attorney General has new mandated duties under the bill and the cost of each is *de minimus*. The cost of annually updating and uploading to the website protocols that already exist should be modest. And the requirement that the Attorney General include an amount in its annual budget request is by definition likely cost neutral (if whatever small amount of cost is needed to craft the request will be built into the request and is thereafter granted) or in and of itself modest even if the request is entirely rejected.

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[37] https://cdss.ca.gov/lettersnotices/entres/getinfo/acl08/08-13.pdf.)

[38] https://cdss.ca.gov/Portals/9/ACIN/2017/I-08_17.pdf

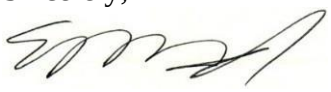
In sum, AB 2660 is surgical. It hews closely to what history has shown must, at the barest minimum, be reformed and does no more. With your signature, AB 2660 will (i) require every county to take account of when children die because history at the state and local level has proven that, when there is a downturn, this life-or-death program benefitting politically powerless children gets slashed and is not revived when the economy improves; (ii) require the DOJ to submit annual budget asks to the Governor to fund a state system that can adequately oversee and ensure the integration of statewide child death reporting; and (iii) require public posting of child death reports in one place by dates certain.

It is in each of its modest provisions AB 2660 is literally the least that can be done to ensure reviewing child deaths to prevent future children from dying is never again allowed to fall apart within the collaborative inter-agency system that currently exists that promotes cooperation in this life-or death effort for our children.

IV. Conclusion.

Thank again your patience in reviewing this lengthy letter. Please sign AB 2660 (Maienschein).

Sincerely,



Ed Howard
Senior Counsel, Children's Advocacy Institute