M. ANDREW WOODMANSEE (BAR NO. 201780)
mawoodmansee@mofo.com
STEVE KEANE (BAR NO. 247588)
skeane@mofo.com
MORRISON & FOERSTER LLP
12531 High Bluff Drive
San Diego, California 92130-2040
Telephone: 858.720.5100
Facsimile: 858.720.5125

ROBERT C. FELLMETH (BAR NO. 49897)
cpil@sandiego.edu
CHRISTINA RIEHL (BAR NO. 216565)
criehl@sandiego.edu
CHILDREN'S ADVOCACY INSTITUTE
University of San Diego School of Law
5998 Alcala Park
San Diego, California 92110
Telephone: 619.260.4806
Facsimile: 619.260.4753

EDWARD P. HOWARD (BAR NO. 151936)
eh4@sbcglobal.net
CHILDREN'S ADVOCACY INSTITUTE
717 K Street, Suite 509
Sacramento, California 95814
Telephone: 916.444.3875
Facsimile: 916.444.6611

Attorneys for Petitioner/Plaintiff Robert K. Butterfield

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO

ROBERT K. BUTTERFIELD,

Petitioner/Plaintiff,

v.

WILL LIGHTBOURNE, Director of California Department of Social Services, in his official capacity; CALIFORNIA DEPARTMENT OF SOCIAL SERVICES,

Respondents/Defendants.

Case No. **37-2011-00097858-CU-MC-CTL**

PETITION FOR WRIT OF MANDAMUS AND VERIFIED COMPLAINT FOR DECLARATORY RELIEF

[C.C.P. §1085; Govt. Code §11350(a); C.C.P §1060]

Petitioner and plaintiff Robert K. Butterfield ("Petitioner") petitions this Court for a writ of mandate under Code of Civil Procedure § 1085 or, in the alternative, a declaratory judgment under Government Code § 11350(a) and Code of Civil Procedure § 1060, as follows:

INTRODUCTION

This action challenges the regulations of the California Department of Social Services ("DSS") that purport to implement Senate Bill 39, Chapter 468, Statutes of 2007 ("SB 39"). The DSS regulations relevant to this action are set forth in the DSS Manual of Policies and Procedures ("MPP").

1. SB 39 was enacted to address a troubling and unacceptable problem in California: the death of children due to abuse or neglect. According to the Legislature, in 2002, approximately 140 children in California were officially reported as having died as a result of abuse or neglect. (Ex. A (SB 39) § 1(a).) The latest data reveal that the number of such deaths continues to hover well over 100 per year. *See* California Department of Social Services, California Fatality and Near Fatality Annual Report, Calendar Year 2009 (May 2011) at 5. In order to help stakeholders formulate recommendations for systemic reform that would minimize these deaths, SB 39 requires public disclosure of non-confidential information about the deceased child's case. By requiring and facilitating such disclosure, the Legislature intended to "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." (Ex. A (SB 39) § 1(c).)

2. SB 39 became law on January 1, 2008 and is codified in California Welfare and Institutions Code sections 827, 826.7 and 10850.4.

3. In order to implement the requirements of SB 39, DSS amended its MPP regulations and issued All County Letter No. 08-13 instructing county child welfare agencies to follow certain new procedures in light of the new law.

4. As described below, Respondents abused their discretion in adopting certain of the MPP regulations, which are inconsistent with SB 39, and with Welf. & Inst. Code section 10850.4 in particular and therefore fail to comply with the requirements of the Administrative

Procedure Act ("APA"). In an attempt to correct those inconsistencies and to ensure the faithful implementation of Legislative intent, counsel for Petitioner negotiated with DSS over the course of several months. (Exs. B-E.) Those negotiations ended with the DSS denial of counsel's formal petition to amend the regulations under the APA. (Ex. E.) DSS denied the petition with respect to four out of five requested amendments. (*Id.*) Four of the requested amendments, including the one that DSS purportedly granted but never implemented, comprise the substance of this petition for writ of mandamus and complaint for declaratory relief. The fifth requested amendment, which involves disclosure of near-fatalities under the federal Child Abuse Prevention and Treatment Act ("CAPTA"), is not at issue here.

PARTIES

5. Petitioner, Robert K. Butterfield, is a resident of San Diego County and is a Founder Emeritus Board Member of Promises2Kids, formerly known as the Child Abuse Prevention Foundation of San Diego. He is a co-founder of that organization and formerly served as its Secretary and Chief Financial Officer. Mr. Butterfield has a beneficial interest in the performance by Respondents of their duties to properly administer the law set forth in SB 39 regarding public disclosure of information related to child fatalities due to abuse and/or neglect.

6. Respondent/Defendant Will Lightbourne is the Director of California Department of Social Services and, as such, he is charged under Welf. & Inst. Code section 10553 with administering the laws pertaining to the administration of public social services and with formulating, adopting, amending or repealing regulations and general policies affecting the purposes, responsibilities, and jurisdiction of DSS and which are consistent with law and necessary for the administration of public social services. Lightbourne is sued in his official capacity.

7. Respondent/Defendant California Department of Social Services is responsible for the delivery and administration of public programs and services relating to children and families in California. DSS is responsible for establishing and administering regulations that are consistent with the public disclosure requirements of SB 39 and for ensuring each county's

compliance those requirements. The counties act as agents of DSS in administering their child welfare programs. Lightbourne and DSS are collectively referred to as "Respondents."

SPECIFIC ALLEGATIONS

8. In at least four important areas, Respondents have abused their discretion by promulgating regulations that violate SB 39 and frustrate the intent of the Legislature in enacting this important legislation. As a result, the regulations improperly and unlawfully reduce the number of cases in which disclosure is made and fail to require all of the mandated information to be released, to the enduring harm of the public's ability to identify and insist upon reforms that could save the lives of California children currently being abused and neglected. The Legislature has rightly identified a connection between disclosing the circumstances surrounding a child's death and the implementation of reforms that will prevent future deaths:

> 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.

(Ex. A (SB 39) § 1(b) (emphasis added).)

MPP § 31-502.42 – Improper consultation with law enforcement

9. Respondents have abused their discretion by promulgating regulation MPP § 31-502.42. This regulation fails to comply with SB 39, because it specifies that "[a]fter consultation with *law enforcement* or the District Attorney, if the release of specific information would jeopardize a criminal investigation or proceeding, that information shall be redacted prior to release." MPP § 31-502.42 (emphasis added). Requiring counties to consult with law enforcement prior to releasing documents is an unjustified impediment not found in the statute. This regulation has amended the statute, not interpreted it. The statute authorizes consultation only with the District Attorney, not "law enforcement." Cal. Wel. & Inst. Code § 10850.4(e)(1)(B). The distinction is not academic. Consultation with law enforcement has had the proven effect of stopping the flow of information to the public, as evidenced by recent experiences in Los Angeles County. *See* Ex. F (Los Angeles County OIR, "Status of Implementation of SB 39: Current Challenges" (Aug. 30, 2010)) at 6-10.

10. Despite assurances from DSS since at least March 2011 that this regulation would be amended to remove the requirement that law enforcement be consulted, DSS has failed to act. *See* Ex. C at 2 ("[T]he statute refers to district attorney and we agree with you that so should the regulation. As we indicated before, we are willing to amend this regulation accordingly."). Indeed, DSS actually granted the formal petition to amend this regulation under the APA. *See* Ex. E at 3 ("[T]he language in SB 39 is clear, and for this reason the regulation, however well meaning, must yield to the statute's terminology....Accordingly, this request in your petition is granted.").

MPP §§ 31-502.33 and 31-502.34 – Disclosures conditioned on identity of perpetrator

11. Respondents have also abused their discretion by promulgating regulations MPP §§ 31-502.33 and 31-502.34. These regulations fail to comply with SB 39 by conditioning the release of child death-related documents on an agency determination that the abuse or neglect was inflicted by the parent/guardian/foster parent in whose home the child was residing at the time of death. There is no such limiting condition in the enabling statute. These regulations exclude deaths caused by, for example, live-in boyfriends of foster parents or live-in grandparents. A recent example underscores the dire need for disclosure in this circumstance. In February 2008, three-year-old Valeeya Brazile was beaten to death by her mother's live-in boyfriend. (Ex. G.) In August 2011, Sacramento Superior Court Judge Michael A. Savage sentenced the boyfriend to prison for the maximum 29 years to life. (*Id.*) In doing so, Judge Savage recounted the repeated failures of CPS to save the little girl from months of beatings that eventually killed her: "There is not the slightest evidence in this case that the protection or safety of Valeeya or her brother was ever a priority, or even a significant concern, for the agency or the caseworker charged with their protection." (*Id.*) Judge Savage further stated that "[t]he evidence in this case of repeated, systematic, purposeful and brutally inflicted trauma by Mr. Martin on Valeeya is mountainous and undeniable. There is no doubt that this defendant routinely and unmercifully battered this absolutely defenseless 3-year-old, eventually beating her with enough force to end her life." (*Id.*) Respondents' regulations forbid the public from accessing information in cases such as Valeeya's, where the perpetrator is a non-parent. Indeed,

the director of the Department of Health and Human Services that oversees the CPS involved in Valeeya's case, stated the Department "cannot comment on the specifics of this case due to confidentiality laws." (*Id.*) Had Respondents' regulations been in compliance with SB 39, the identity of the perpetrator would have been no bar to the public disclosure of Valeeya's routine beatings. Public scrutiny of that information might have then played a role in removing Valeeya from her dangerous environment, thus sparing her life.

12. Valeeya's death is a powerful example of why Respondents' regulations must be rewritten to comply with SB 39. The statute draws a distinction between living with a parent/guardian and living in foster care solely to differentiate between the kinds of documents to be released. Welf. & Inst. Code §§ 10850.4(c)(2)-(3). There is no legal basis for permitting disclosure only when the perpetrator is the parent, guardian or foster parent. For this reason, the Respondents are abusing their discretion by promulgating in regulation a limitation on disclosure not enacted by the Legislature; a limitation that is improperly and unlawfully reducing the number of cases in which public disclosure is being made, in violation of both the plain text and intent of SB 39. Respondents admit that releasing documents based on the identity of the perpetrator "may not be the best method" of complying with SB 39. (Ex. E at 4.) Moreover, Respondents' own data reveal that such disclosure is grossly underinclusive, because the perpetrator in child fatality cases is often not the parent or guardian. For child fatalities due to abuse or neglect in 2009, for example, the parent/guardian was identified as the perpetrator in only 66 percent of cases. *See* California Department of Social Services, California Fatality and Near Fatality Annual Report, Calendar Year 2009 (May 2011) at 23.

MPP § 31-502.35 – Disclosures related to non-residential licensed care providers

13. Respondents' regulation MPP § 31-502.35 also fails to comply with SB 39. This regulation states that "[w]hen a child fatality has occurred as a result of abuse and/or neglect by a non-residential licensed child care provider, the county shall direct any public request to the appropriate licensing department or agency that has jurisdiction over the facility." MPP § 31-502.35. SB 39 does not require the fatal abuse or neglect to have occurred in the child's home in order to trigger public disclosure; the location of the abuse and the identity of the abuser are,

under the statute, irrelevant to whether disclosure must be made. The statute draws a distinction between "cases in which the child's death occurred while living with a parent or guardian" and "cases in which the child's death occurred while the child was in foster care" solely to differentiate between the kinds of documents to be released. Welf. & Inst. Code §§ 10850.4(c)(2)-(3). Yet, according to MPP § 31-502.35, even if the deceased child was living with a parent, if the death occurred at the hands of a day care provider, the public is not entitled to SB 39 disclosure. Respondents concede that this regulation is not intended to affect the public's right to SB 39 disclosures, (Ex. E at 5), but the plain language of the regulation conditions disclosure by the county that was caring for the child — a condition that does not appear in the statute — and then delegates the task of complying with SB 39 to a licensing agency never mentioned in the legislation.

MPP §§ 31-502.2 *et seq.* – Improper causal link between abuse/neglect and child fatality

14. Respondents' regulations MPP §§ 31-502.2 *et seq.* improperly condition SB 39 disclosures on a causation requirement between a child's abuse/neglect and the child's death that is not found in the relevant statute, Welf. & Inst. Code § 10850.4(b). MPP section 31-502.33, for example, states that SB 39 disclosures are to be made only "[w]hen the agency, pursuant to Section 31-502.25, makes the determination that the child fatality was *a result of* abuse and/or neglect." MPP § 31-502.33 (emphasis added). This regulation improperly limits a county's obligation to disclose documents to those cases where county officials determine that the *immediate* cause of the child's death was abuse or neglect. If a child with a lengthy history of substantiated neglect and malnourishment collapses and dies on the playground, for example, there would be no disclosure under Respondents' regulations if the autopsy concludes that the ultimate cause of death was heat exhaustion. The regulations ignore the importance of the fact that ongoing neglect may have contributed to the child's death and thereby deprive the public of any ability to evaluate the need for systemic reform following such cases. Respondents' but-for causation is not supported by the enabling statute, which mandates disclosure in "[a]ll cases in which abuse or neglect *leads to* a child's death." Welf. & Inst. Code § 10850.4(b) (emphasis added). The statute defines what "leads to a child's death" means:

> Abuse or neglect is determined to have led to a child's death if one or more of the following conditions are met:
>
> (1) A county child protective services agency determines that the abuse or neglect was substantiated.
>
> (2) A law enforcement investigation concludes that abuse or neglect occurred.
>
> (3) A coroner or medical examiner concludes that the child who died had suffered abuse or neglect.

Welf. & Inst. Code § 10850.4(b). This statutory definition of "leads to" does not require the specific cause of death to be the direct "result of" the substantiated abuse or neglect. The difference is not academic, because as explained in the recent report of the Los Angeles County Office of Independent Review, "[t]he 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." (Ex. F (OIR Report) at 4.) The statutory language makes clear that (i) substantiated abuse or neglect and (ii) a dead child are, alone, the triggers for release of documents, not a finding of but-for, immediate causation between the abuse/neglect and the child's death. Welf. & Inst. Code § 10850.4(b). The MPP sections that use the "result of" language, MPP §§ 31-502.2 *et seq.*, are leading to an illegal underreporting of child fatalities to the public, because counties will not disclose cases in which no direct causation is found. (*See* Ex. F (OIR Report) at 4-6.) Each of these MPP sections is inconsistent with Welf. & Inst. Code § 10850.4(b) and Respondents have abused their discretion accordingly.

FIRST CAUSE OF ACTION

(Mandamus Pursuant to Code of Civil Procedure Section 1085 — Against Both Respondents)

15. Petitioner realleges and incorporates by reference each allegation in paragraphs 1 through 14 above as fully set forth herein.

16. Respondents have a clear, present, and ministerial duty to administer state law regarding the public disclosure of information on child fatalities following abuse and/or neglect.

17. Petitioner has a beneficial interest in the performance by Respondents of their duties to establish and administer regulations concerning public disclosure of information on child fatalities in accordance with state law.

18. At all times relevant here, Respondents have, and continue to have, the ability to perform their legal duties in accordance with state law but have failed to do so or have abused their discretion in doing so. Respondents have abused their discretion in enacting regulations and policies that fail to comply with state law, as specifically explained and pled in paragraphs 8 through 14 above.

19. Respondents, by failing to comply with state law, have denied Petitioner and others similarly situated their rights secured by law.

20. Petitioner has no plain, speedy, or adequate remedy at law except by way of peremptory writ of mandate pursuant to Code of Civ. Proc. § 1085. Petitioner, through his counsel, has exhausted administrative remedies before bringing this action. In particular, Petitioner's counsel attempted to resolve each of the issues identified herein during a months-long process of negotiating with DSS that culminated in a formal petition pursuant to Govt. Code section 11340.6 to amend the relevant DSS regulations, which counsel filed on June 9, 2011. (Ex. D.) On July 11, 2011, DSS denied that petition in all respects that are relevant to this action or has failed to act in a timely manner. (Ex. E.)

SECOND CAUSE OF ACTION

(Declaratory Relief Pursuant to Government Code Section 11350(a) — Against Both Respondents)

21. Petitioner realleges and incorporates by reference each allegation in paragraphs 1 through 14 above as fully set forth herein.

22. An actual controversy exists between Petitioner and Respondents in that Petitioner contends that certain DSS regulations and policies are invalid for substantial failure to comply with the APA, as they are inconsistent with the requirements of SB 39 and Welf. & Inst. Code section 10850.4 concerning the public disclosure of information on child fatalities.

23. Petitioner is an interested person for purposes of Govt. Code section 11350(a) and desires a judicial declaration that certain DSS regulations and policies concerning the public disclosure of information on child fatalities following abuse and/or neglect are invalid for substantial failure to comply with the APA and in particular, for inconsistency with state law, as explained and pled in paragraphs 8 through 14 above. A judicial declaration is necessary and appropriate at this time in order that the parties may ascertain their rights and duties with respect to the public disclosure of information on child fatalities.

PRAYER FOR RELIEF

WHEREFORE, Petitioner respectfully prays that this Court:

1. Issue a peremptory writ of mandate under Code of Civil Procedure section 1085 commanding Respondents to immediately repeal the DSS regulations and policies challenged herein and immediately adopt regulations and policies that fully comply with Welf. & Inst. Code section 10850.4 and SB 39 as described herein;

2. In the alternative, issue a declaratory judgment that the DSS regulations and policies challenged herein are inconsistent with Welf. & Inst. Code section 10850.4 and SB 39 and are therefore invalid;

3. Issue an order awarding Petitioner the costs of this action and awarding reasonable attorneys' fees pursuant to Code of Civil Procedure section 1021.5 and other applicable statutes; and

4. Order other relief as the Court may deem just and proper.

Dated: September 14, 2011

MORRISON & FOERSTER LLP

By: _____
M. ANDREW WOODMANSEE

CHILDREN'S ADVOCACY INSTITUTE

By: _____
EDWARD P. HOWARD

Attorneys for Petitioner/Plaintiff
Robert K. Butterfield

Dated: September 14, 2011

MORRISON & FOERSTER LLP

By: _____
M. ANDREW WOODMANSEE

CHILDREN'S ADVOCACY INSTITUTE
By:

EDWARD P. HOWARD

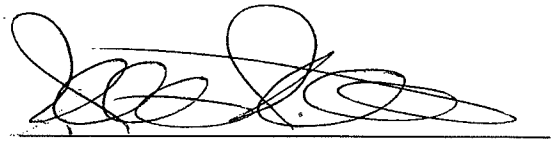
Attorneys for Petitioner/Plaintiff
Robert K. Butterfield

VERIFICATION

I am the petitioner in this proceeding. The facts alleged in the above petition are true of my own knowledge.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: September 7, 2011



Robert K. Butterfield

Exhibit A

Senate Bill No. 39

CHAPTER 468

An act to amend Section 827 of, and to add Sections 826.7 and 10850.4 to, the Welfare and Institutions Code, relating to child abuse and neglect.

[Approved by Governor October 11, 2007. Filed with Secretary of State October 11, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

SB 39, Migden. County welfare agencies and departments: child abuse and neglect: files.

(1) Existing law requires the case file of a dependent child or ward of the juvenile court to be kept confidential, except as specified. Existing law permits the juvenile case files that pertain to a deceased child who was within the jurisdiction of the juvenile court, as provided, to be released to the public after a petition has been filed and interested parties have been afforded an opportunity to file an objection, subject to certain limitations.

This bill would revise those provisions and instead require that juvenile case files that pertain to any child who died as the result of child abuse or neglect shall be released to the public, subject to certain limitations set forth in the bill. The bill would also add specified attorneys to the persons allowed access to a juvenile case file.

(2) Existing law provides for a system of child welfare services administered by each county, with oversight by the State Department of Social Services.

This bill would require the custodian of records within a county welfare agency or department to disclose, within 5 days from a request, or upon substantiation, specified records, subject to the redaction of certain identifying personal information, of child abuse or neglect that results in the death of a child.

This bill would also require all county welfare agencies and departments to notify the State Department of Social Services, as provided, of all child fatalities that occurred within its jurisdiction that were the result of child abuse or neglect, and would require the State Department of Social Services to establish a procedure for, and annually report on, that notification, as specified. The bill would also require the State Department of Social Services to adopt emergency regulations to implement the above-described changes, as specified, which regulations would be excepted from the rulemaking provisions of the Administrative Procedures Act.

By increasing the duties of local agencies, this bill would impose a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

SECTION 1. The Legislature finds and declares the following:

(a) During 2002, approximately 140 children in California were officially reported as having died as a result of abuse or neglect. The State Death Review Council has concluded that official reports of child abuse deaths represent a significant undercount of the actual number of child abuse and neglect fatalities.

(b) 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.

(c) 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.

(d) The current procedures for accessing information about a child's death from abuse or neglect are costly, at times resulting in lengthy delays in the release of that information, fail to provide adequate guidance for what information should and should not be disclosed, and permit significant variation from one jurisdiction to another in the nature and extent of the information released.

(e) Thus, it is the intent of the Legislature to maximize public access to juvenile case files in cases where a child fatality occurs as a result of child abuse or neglect by both providing for an administrative release of certain documents without the filing of a legal petition pursuant to paragraph (2) of subdivision (a) of Section 827 of the Welfare and Institutions Code, while also ensuring that basic privacy protections are consistently afforded, and by enacting reforms to the current process of filing a petition pursuant to paragraph (2) of subdivision (a) of Section 827 of the Welfare and Institutions Code that will offer clarifying guidance to juvenile courts of the legal standards that apply to those petitions and an expedited process for their disposition.

(f) In petitions governed by paragraph (2) of subdivision (a) of Section 827 of the Welfare and Institutions Code, the Legislature has concluded that when a dependent child dies within the jurisdiction of the juvenile court,

the presumption of confidentiality for juvenile case files evaporates and the requirement of an expedited decision becomes manifest, because community reaction to the child's death may abate with the passage of time and, without a prompt investigation and assessment, the opportunity to effect positive change may be lost.

SEC. 2. Section 826.7 is added to the Welfare and Institutions Code, to read:

826.7. Juvenile case files that pertain to a child who died as the result of abuse or neglect shall be released by the custodian of records of the county welfare department or agency to the public pursuant to Section 10850.4 or an order issued pursuant to paragraph (2) of subdivision (a) of Section 827.

SEC. 3. Section 827 of the Welfare and Institutions Code is amended to read:

827. (a) (1) Except as provided in Section 828, a case file may be inspected only by the following:

(A) Court personnel.

(B) The district attorney, a city attorney, or city prosecutor authorized to prosecute criminal or juvenile cases under state law.

(C) The minor who is the subject of the proceeding.

(D) The minor's parents or guardian.

(E) The attorneys for the parties, judges, referees, other hearing officers, probation officers, and law enforcement officers who are actively participating in criminal or juvenile proceedings involving the minor.

(F) The county counsel, city attorney, or any other attorney representing the petitioning agency in a dependency action.

(G) The superintendent or designee of the school district where the minor is enrolled or attending school.

(H) Members of the child protective agencies as defined in Section 11165.9 of the Penal Code.

(I) The State Department of Social Services, to carry out its duties pursuant to Division 9 (commencing with Section 10000), and Part 5 (commencing with Section 7900) of Division 12, of the Family Code to oversee and monitor county child welfare agencies, children in foster care or receiving foster care assistance, and out-of-state placements, Section 10850.4, and paragraph (2).

(J) Authorized legal staff or special investigators who are peace officers who are employed by, or who are authorized representatives of, the State Department of Social Services, as necessary to the performance of their duties to inspect, license, and investigate community care facilities, and to ensure that the standards of care and services provided in those facilities are adequate and appropriate and to ascertain compliance with the rules and regulations to which the facilities are subject. The confidential information shall remain confidential except for purposes of inspection, licensing, or investigation pursuant to Chapter 3 (commencing with Section 1500) and Chapter 3.4 (commencing with Section 1596.70) of Division 2 of the Health and Safety Code, or a criminal, civil, or administrative proceeding in relation thereto. The confidential information may be used by the State Department

of Social Services in a criminal, civil, or administrative proceeding. The confidential information shall be available only to the judge or hearing officer and to the parties to the case. Names that are confidential shall be listed in attachments separate to the general pleadings. The confidential information shall be sealed after the conclusion of the criminal, civil, or administrative hearings, and may not subsequently be released except in accordance with this subdivision. If the confidential information does not result in a criminal, civil, or administrative proceeding, it shall be sealed after the State Department of Social Services decides that no further action will be taken in the matter of suspected licensing violations. Except as otherwise provided in this subdivision, confidential information in the possession of the State Department of Social Services may not contain the name of the minor.

(K) Members of children's multidisciplinary teams, persons, or agencies providing treatment or supervision of the minor.

(L) A judge, commissioner, or other hearing officer assigned to a family law case with issues concerning custody or visitation, or both, involving the minor, and the following persons, if actively participating in the family law case: a family court mediator assigned to a case involving the minor pursuant to Article 1 (commencing with Section 3160) of Chapter 11 of Part 2 of Division 8 of the Family Code, a court-appointed evaluator or a person conducting a court-connected child custody evaluation, investigation, or assessment pursuant to Section 3111 or 3118 of the Family Code, and counsel appointed for the minor in the family law case pursuant to Section 3150 of the Family Code. Prior to allowing counsel appointed for the minor in the family law case to inspect the file, the court clerk may require counsel to provide a certified copy of the court order appointing him or her as the minor's counsel.

(M) A court-appointed investigator who is actively participating in a guardianship case involving a minor pursuant to Part 2 (commencing with Section 1500) of Division 4 of the Probate Code and acting within the scope of his or her duties in that case.

(N) A local child support agency for the purpose of establishing paternity and establishing and enforcing child support orders.

(O) Juvenile justice commissions as established under Section 225. The confidentiality provisions of Section 10850 shall apply to a juvenile justice commission and its members.

(P) Any other person who may be designated by court order of the judge of the juvenile court upon filing a petition.

(2) (A) Notwithstanding any other law and subject to subparagraph (A) of paragraph (3), juvenile case files, except those relating to matters within the jurisdiction of the court pursuant to Section 601 or 602, that pertain to a deceased child who was within the jurisdiction of the juvenile court pursuant to Section 300, shall be released to the public pursuant to an order by the juvenile court after a petition has been filed and interested parties have been afforded an opportunity to file an objection. Any information relating to another child or which could identify another child, except for

information about the deceased, shall be redacted from the juvenile case file prior to release, unless a specific order is made by the juvenile court to the contrary. Except as provided in this paragraph, the presiding judge of the juvenile court may issue an order prohibiting or limiting access to the juvenile case file, or any portion thereof, of a deceased child only upon a showing by a preponderance of evidence that release of the juvenile case file or any portion thereof is detrimental to the safety, protection, or physical or emotional well-being of another child who is directly or indirectly connected to the juvenile case that is the subject of the petition.

(B) This paragraph represents a presumption in favor of the release of documents when a child is deceased unless the statutory reasons for confidentiality are shown to exist.

(C) If a child whose records are sought has died, and documents are sought pursuant to this paragraph, no weighing or balancing of the interests of those other than a child is permitted.

(D) A petition filed under this paragraph shall be served on interested parties by the petitioner, if the petitioner is in possession of their identity and address, and on the custodian of records. Upon receiving a petition, the custodian of records shall serve a copy of the request upon all interested parties that have not been served by the petitioner or on the interested parties served by the petitioner if the custodian of records possesses information, such as a more recent address, indicating that the service by the petitioner may have been ineffective.

(E) The custodian of records shall serve the petition within 10 calendar days of receipt. If any interested party, including the custodian of records, objects to the petition, the party shall file and serve the objection on the petitioning party no later than 15 calendar days of service of the petition.

(F) The petitioning party shall have 10 calendar days to file any reply. The juvenile court shall set the matter for hearing no more than 60 calendar days from the date the petition is served on the custodian of records. The court shall render its decision within 30 days of the hearing. The matter shall be decided solely upon the basis of the petition and supporting exhibits and declarations, if any, the objection and any supporting exhibits or declarations, if any, and the reply and any supporting declarations or exhibits thereto, and argument at hearing. The court may solely upon its own motion order the appearance of witnesses. If no objection is filed to the petition, the court shall review the petition and issue its decision within 10 calendar days of the final day for filing the objection. Any order of the court shall be immediately reviewable by petition to the appellate court for the issuance of an extraordinary writ.

(3) Access to juvenile case files pertaining to matters within the jurisdiction of the juvenile court pursuant to Section 300 shall be limited as follows:

(A) If a juvenile case file, or any portion thereof, is privileged or confidential pursuant to any other state law or federal law or regulation, the requirements of that state law or federal law or regulation prohibiting or limiting release of the juvenile case file or any portions thereof shall prevail.

Unless a person is listed in subparagraphs (A) to (O), inclusive, of paragraph (1) and is entitled to access under the other state law or federal law or regulation without a court order, all those seeking access, pursuant to other authorization, to portions of, or information relating to the contents of, juvenile case files protected under another state law or federal law or regulation, shall petition the juvenile court. The juvenile court may only release the portion of, or information relating to the contents of, juvenile case files protected by another state law or federal law or regulation if disclosure is not detrimental to the safety, protection, or physical or emotional well-being of a child who is directly or indirectly connected to the juvenile case that is the subject of the petition. This paragraph shall not be construed to limit the ability of the juvenile court to carry out its duties in conducting juvenile court proceedings.

(B) Prior to the release of the juvenile case file or any portion thereof, the court shall afford due process, including a notice of and an opportunity to file an objection to the release of the record or report to all interested parties.

(4) A juvenile case file, any portion thereof, and information relating to the content of the juvenile case file, may not be disseminated by the receiving agencies to any persons or agencies, other than those persons or agencies authorized to receive documents pursuant to this section. Further, a juvenile case file, any portion thereof, and information relating to the content of the juvenile case file, may not be made as an attachment to any other documents without the prior approval of the presiding judge of the juvenile court, unless it is used in connection with and in the course of a criminal investigation or a proceeding brought to declare a person a dependent child or ward of the juvenile court.

(5) Individuals listed in subparagraphs (A), (B), (C), (D), (E), (F), (H), and (I) of paragraph (1) may also receive copies of the case file. In these circumstances, the requirements of paragraph (4) shall continue to apply to the information received.

(b) (1) While the Legislature reaffirms its belief that juvenile court records, in general, should be confidential, it is the intent of the Legislature in enacting this subdivision to provide for a limited exception to juvenile court record confidentiality to promote more effective communication among juvenile courts, family courts, law enforcement agencies, and schools to ensure the rehabilitation of juvenile criminal offenders as well as to lessen the potential for drug use, violence, other forms of delinquency, and child abuse.

(2) Notwithstanding subdivision (a), written notice that a minor enrolled in a public school, kindergarten to grade 12, inclusive, has been found by a court of competent jurisdiction to have committed any felony or any misdemeanor involving curfew, gambling, alcohol, drugs, tobacco products, carrying of weapons, a sex offense listed in Section 290 of the Penal Code, assault or battery, larceny, vandalism, or graffiti shall be provided by the court, within seven days, to the superintendent of the school district of attendance. Written notice shall include only the offense found to have been

committed by the minor and the disposition of the minor's case. This notice shall be expeditiously transmitted by the district superintendent to the principal at the school of attendance. The principal shall expeditiously disseminate the information to those counselors directly supervising or reporting on the behavior or progress of the minor. In addition, the principal shall disseminate the information to any teacher or administrator directly supervising or reporting on the behavior or progress of the minor whom the principal believes needs the information to work with the pupil in an appropriate fashion, to avoid being needlessly vulnerable or to protect other persons from needless vulnerability.

Any information received by a teacher, counselor, or administrator under this subdivision shall be received in confidence for the limited purpose of rehabilitating the minor and protecting students and staff, and shall not be further disseminated by the teacher, counselor, or administrator, except insofar as communication with the juvenile, his or her parents or guardians, law enforcement personnel, and the juvenile's probation officer is necessary to effectuate the juvenile's rehabilitation or to protect students and staff.

An intentional violation of the confidentiality provisions of this paragraph is a misdemeanor punishable by a fine not to exceed five hundred dollars ($500).

(3) If a minor is removed from public school as a result of the court's finding described in subdivision (b), the superintendent shall maintain the information in a confidential file and shall defer transmittal of the information received from the court until the minor is returned to public school. If the minor is returned to a school district other than the one from which the minor came, the parole or probation officer having jurisdiction over the minor shall so notify the superintendent of the last district of attendance, who shall transmit the notice received from the court to the superintendent of the new district of attendance.

(c) Each probation report filed with the court concerning a minor whose record is subject to dissemination pursuant to subdivision (b) shall include on the face sheet the school at which the minor is currently enrolled. The county superintendent shall provide the court with a listing of all of the schools within each school district, within the county, along with the name and mailing address of each district superintendent.

(d) Each notice sent by the court pursuant to subdivision (b) shall be stamped with the instruction: "Unlawful Dissemination Of This Information Is A Misdemeanor." Any information received from the court shall be kept in a separate confidential file at the school of attendance and shall be transferred to the minor's subsequent schools of attendance and maintained until the minor graduates from high school, is released from juvenile court jurisdiction, or reaches the age of 18 years, whichever occurs first. After that time the confidential record shall be destroyed. At any time after the date by which a record required to be destroyed by this section should have been destroyed, the minor or his or her parent or guardian shall have the right to make a written request to the principal of the school that the minor's school records be reviewed to ensure that the record has been destroyed.

Upon completion of any requested review and no later than 30 days after the request for the review was received, the principal or his or her designee shall respond in writing to the written request and either shall confirm that the record has been destroyed or, if the record has not been destroyed, shall explain why destruction has not yet occurred.

Except as provided in paragraph (2) of subdivision (b), no liability shall attach to any person who transmits or fails to transmit any notice or information required under subdivision (b).

(e) For purposes of this section, a "juvenile case file" means a petition filed in any juvenile court proceeding, reports of the probation officer, and all other documents filed in that case or made available to the probation officer in making his or her report, or to the judge, referee, or other hearing officer, and thereafter retained by the probation officer, judge, referee, or other hearing officer.

SEC. 4. Section 10850.4 is added to the Welfare and Institutions Code, to read:

10850.4. (a) Within five business days of learning that a child fatality has occurred in the county and that there is a reasonable suspicion that the fatality was caused by abuse or neglect, the custodian of records for the county child welfare agency, upon request, shall release the following information:

(1) The age and gender of the child.

(2) The date of death.

(3) Whether the child was in foster care or in the home of his or her parent or guardian at the time of death.

(4) Whether an investigation is being conducted by a law enforcement agency or the county child welfare agency.

(b) All cases in which abuse or neglect leads to a child's death shall be subject to the disclosures required in subdivision (c). Abuse or neglect is determined to have led to a child's death if one or more of the following conditions are met:

(1) A county child protective services agency determines that the abuse or neglect was substantiated.

(2) A law enforcement investigation concludes that abuse or neglect occurred.

(3) A coroner or medical examiner concludes that the child who died had suffered abuse or neglect.

(c) Upon completion of the child abuse or neglect investigation into the child's death, as described in subdivision (b), the following documents from the juvenile case file shall be released by the custodian of records upon request, subject to the redactions set forth in subdivision (e):

(1) All of the information in subdivision (a).

(2) For cases in which the child's death occurred while living with a parent or guardian, all previous referrals of abuse or neglect of the deceased child while living with that parent or guardian shall be disclosed along with the following documents:

(A) The emergency response referral information form and the emergency response notice of referral disposition form completed by the county child welfare agency relating to the abuse or neglect that caused the death of the child.

(B) Any cross reports completed by the county child welfare agency to law enforcement relating to the deceased child.

(C) All risk and safety assessments completed by the county child welfare services agency relating to the deceased child.

(D) All health care records of the deceased child, excluding mental health records, related to the child's death and previous injuries reflective of a pattern of abuse or neglect.

(E) Copies of police reports about the person against whom the child abuse or neglect was substantiated.

(3) For cases in which the child's death occurred while the child was in foster care, the following documents in addition to those specified in paragraphs (1) and (2) generated while the child was living in the foster care placement that was the placement at the time of the child's death:

(A) Records pertaining to the foster parents' initial licensing and renewals and type of license or licenses held, if in the case file.

(B) All reported licensing violations, including notices of action, if in the case file.

(C) Records of the training completed by the foster parents, if in the case file.

(d) The documents listed in subdivision (c) 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.

(e) (1) Prior to releasing any document pursuant to subdivision (c), the custodian of records shall redact the following information:

(A) The names, addresses, telephone numbers, ethnicity, religion, or any other identifying information of any person or institution, other than the county or the State Department of Social Services, that is mentioned in the documents listed in paragraphs (2) and (3) of subdivision (c).

(B) Any information that would, after consultation with the district attorney, jeopardize a criminal investigation or proceeding.

(C) Any information that is privileged, confidential, or not subject to disclosure pursuant to any other state or federal law.

(2) (A) The State Department of Social Services shall promulgate a regulation listing the laws described in subparagraph (C) of paragraph (1) and setting forth standards governing redactions.

(B) Notwithstanding the rulemaking provisions of the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), until emergency regulations are filed with the Secretary of State, the State Department of Social Services may implement the changes made to Section 827 and this section at the 2007–08 Regular Session of the Legislature through all county letters or similar instructions from the director. The department shall adopt

as emergency regulations, as necessary to implement those changes, no later than January 1, 2009.

(C) The adoption of regulations pursuant to this paragraph shall be deemed to be an emergency necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted for filing with the Secretary of State and shall remain in effect for no more than 180 days, by which time the final regulations shall be adopted.

(f) Upon receiving a request for the documents listed in subdivision (c), the custodian of records shall notify and provide a copy of the request upon counsel for any child who is directly or indirectly connected to the juvenile case file. If counsel for a child, including the deceased child or any sibling of the deceased child, objects to the release of any part of the documents listed in paragraphs (2) and (3) of subdivision (c), they may petition the juvenile court for relief to prevent the release of any document or part of a document requested pursuant to paragraph (2) of subdivision (a) of Section 827.

(g) Documents from the juvenile case file, other than those listed in paragraphs (2) and (3) of subdivision (c), shall only be disclosed upon an order by the juvenile court pursuant to Section 827.

(h) Once documents pursuant to this section have been released by the custodian of records, the State Department of Social Services or the county welfare department or agency may comment on the case within the scope of the release.

(i) Information released by a custodian of records consistent with the requirements of this section does not require prior notice to any other individual.

(j) Each county welfare department or agency shall notify the State Department of Social Services of every child fatality that occurred within its jurisdiction that was the result of child abuse or neglect. Based on these notices and any other relevant information in the State Department of Social Services' possession, the department shall annually issue a report identifying the child fatalities and any systemic issues or patterns revealed by the notices and other relevant information. The State Department of Social Services, after consultation with interested stakeholders, shall provide instructions by an all county letter regarding the procedure for notification.

(k) For purposes of this section, the following definitions apply:

(1) "Child abuse or neglect" has the same meaning as defined in Section 11165.6 of the Penal Code.

(2) "Custodian of records," for the purposes of this section and paragraph (2) of subdivision (a) of Section 827, means the county welfare department or agency.

(3) "Juvenile case files" or "case files" include any juvenile court files, as defined in Rule 5.552 of the California Rules of Court, and any county child welfare department or agency or State Department of Social Services

records regardless of whether they are maintained electronically or in paper form.

(4) "Substantiated" has the same meaning as defined in Section 11165.12 of the Penal Code.

(*l*) A person disclosing juvenile case file information as required by this section shall not be subject to suit in civil or criminal proceedings for complying with the requirements of this section.

(m) This section shall apply only to deaths that occur on or after January 1, 2008.

(n) Nothing in this section shall require a custodian of records to retain documents beyond any date otherwise required by law.

(o) Nothing in this section shall be construed as requiring a custodian of records to obtain documents not in the case file.

SEC. 5. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

O

Exhibit B

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)

717 K Street, Suite 509
Sacramento, CA 95814
(916) 444-3875 / (916) 444-6611 (Fax)

Reply to: □ San Diego □ Sacramento

www.caichildlaw.org

January 13, 2011

VIA EMAIL AND CERTIFIED MAIL

Frank S. Furtek
Deputy Director/Chief Counsel
California Department of Social Services
744 P Street, M.S. 17-27
Sacramento, CA 95814

Re: Request to Amend Regulations Related to SB 39 and CAPTA Public Disclosure Requirements

Dear Frank:

We write to follow-up on the December 6, 2010 meeting between DSS and CAI regarding California's mandate to release to the public relevant information and files following a child fatality or near fatality in cases where the child suffered abuse or neglect. As you know, such disclosure is required under both the federal Child Abuse Prevention and Treatment Act ("CAPTA") and under California's SB 39. We have reviewed the relevant DSS regulations and All County Letters ("ACLs") that purport to implement the CAPTA and SB 39 public disclosure requirements and have identified several areas of non-compliance.

In Los Angeles and Sacramento Counties, disclosure about the circumstances surrounding the deaths of abused and neglected children have and are leading to potentially life-saving administrative reforms, just as the statute intended. But, as we discussed, and as documented in the Los Angeles County Office of Independent Review's thoughtful analysis, unwise and illegal facets of the current regulations are frustrating the intent of the statute and impeding the identification and hence implementation of administrative reforms that could save the lives of more children.

By this letter, we follow-up on our promise at the meeting to provide you a write-up of the issues we discussed (and the issues time prevented us from discussing) and we hereby respectfully request that DSS take emergency steps to revise its regulations immediately both to comply with all state and federal disclosure requirements and to err in favor of disclosure as the statute intends

and as the interests of saving the lives of abused and neglected children commands.

Non-Compliance with SB 39 Regarding Disclosure of Child Fatalities

In several critical aspects, DSS regulations violate SB 39 and frustrate the intent of the Legislature in enacting the statute. *See Miller v. Woods*, 148 Cal. App. 3d 862, 876 (1983) ("[There] is no agency discretion to promulgate a regulation which is inconsistent with the governing statute.") (quoting *Woods v. Superior Court of Butte County*, 28 Cal. 3d 668, 679 (1981)). As a result, the regulations improperly and unlawfully reduce the number of cases in which disclosure is made and fail to require all of the mandated information to be released, to the enduring harm of the public's and decision-makers' ability to identify and insist upon potentially life-saving reforms that could save the lives of already abused and neglected children.

The Legislature has rightly identified a connection between disclosing the circumstances surrounding a child's death and the implementation of reforms that will prevent future deaths:

> (b) 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.***
>
> (c) 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.***

(SB 39, as amended, May 1, 2007, §§ 1(b), (c) (emphasis added).) DSS is not free to re-visit or take issue with these legislatively-determined facts. DSS is in fact duty-bound to give this intent robust implementation but has failed to do so. *See Purdue Frederick Co. v. State Bd. of Equalization*, 218 Cal. App. 3d 1021, 1028 (1990). Moreover, the experience in Los Angeles and Sacramento Counties has demonstrated in practice that public disclosure and debate about the systemic circumstances surrounding the death of children is essential to motivating the kind of public accountability, self-reflection, and reform required for potentially life-saving administrative reforms to be implemented and implemented quickly.

Specifically, the following provisions of the DSS Manual of Policies and Procedures (MPP) are non-compliant and need to be revised immediately:

MPP §§ 31-502.33. This provision states that "[w]hen the agency, pursuant to Section 31-502.25, makes the determination that the child fatality was *a result of* abuse and/or neglect," (emphasis added), the county shall release the full range of documents specified in SB 39. This regulation limits a county's ability to disclose documents to those instances where an authority

concludes a child died because of abuse and neglect. The statute says something quite different, however. The statute conditions release upon a finding that the child (i) died and (ii) suffered abuse and neglect, where such abuse or neglect has been substantiated by a third party. Cal. Wel. & Inst. Code § 10850.4(b). The statute does not condition the release of documents on a finding that the child died because of injuries sustained from abuse or neglect. While the statute does limit the release of documents to "[a]ll cases in which abuse or neglect *leads to* a child's death," *id.* (emphasis added), the "leads to" language is immediately defined to make clear that it does not require but-for causation that a child with a substantiated history of abuse and neglect died of those precise injuries rather than some other cause.

Here is the relevant statute in full:

> (b) All cases in which abuse or neglect leads to a child's death shall be subject to the disclosures required in subdivision (c). Abuse or neglect is determined to have led to a child's death if one or more of the following conditions are met:
> (1) A county child protective services agency determines that the abuse or neglect was substantiated.
> (2) A law enforcement investigation concludes that abuse or neglect occurred.
> (3) A coroner or medical examiner concludes that the child who died had suffered abuse or neglect.

Cal. Wel. & Inst. Code § 10850.4(b).

The DSS regulation focuses on the "leads to" language in isolation, by requiring disclosure only for cases where the death was "a result of" abuse or neglect. MPP §§ 31-502.33. The regulation ignores the fact that the statute provides a carefully crafted definition of "leads to" that does not require the specific cause of death to be the direct "result of" the substantiated abuse or neglect.

The difference is critical, because as explained in the recent report of the Los Angeles County Office of Independent Review, "[t]he 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." Aug. 30, 2010 Letter from L.A. County OIR, "Status of Implementation of SB 39: Current Challenges" (OIR Report) at 4. The statutory language makes clear that (i) substantiated abuse or neglect and (ii) a dead child are, alone, the triggers for release of documents, not a finding of direct causation between the abuse/neglect and the child's death. Cal. Wel. & Inst. Code § 10850.4(b).

Section 31-502.33 as written, however, is leading to an illegal underreporting of child fatalities to the public, because counties will not disclose cases in which no direct causation is found. *See* OIR Report at 4-6. Section 31-502.25 and its subsections are similarly flawed, because they contain the same "result of" causation language. Each of these provisions must be revised to comply with SB 39 and its mandate of broad disclosure.

As an illustration of the problem, if a child died from drowning at the home of his or her parents but had repeated contacts with CPS and there was evidence during the autopsy of numerous fractures that the coroner concludes were caused by abuse, the question of whether CPS could have picked up on some signal that might have saved the child and might prevent future deaths is squarely presented, notwithstanding the fact the child ended up perishing from a different kind of abuse or neglect. This is the very aim of SB 39 as expressly set out in its findings – to try to convert tragedy into life-saving lessons for CPS. Yet, as currently enacted, the regulations would forbid disclosure in such circumstances, no matter how many CPS visits, no matter how horrific the evidence of abuse was to CPS personnel, no matter how dramatically the child's death may have revealed failings in the system.

Aside from being directly contrary to the definitional part of the relevant statute, there is simply no policy reason to constrain disclosure and keep decision-makers and the public in the dark, especially if regulatory implementation is mindful of the underlying reasons for the enactment of the legislation.

MPP §§ 31-502.33 and 31-502.34. These provisions condition the release of documents on an agency determination that the abuse or neglect was inflicted by the parent/guardian/foster parent in whose home the child was residing. There is no such limiting condition in SB 39. The statute draws a distinction between living with a parent/guardian and living in foster care solely to differentiate between the kinds of documents to be released. Cal. Wel. & Inst. Code §§ 10850.4(c)(2)-(3). By requiring a nexus between the place that the abuse occurred and the identity of the abuser, the DSS regulations are improperly and unlawfully reducing the number of cases in which public disclosure will be made, once more contrary to both the letter and intent of controlling statute.

MPP § 31-502.35. This provision states that "[w]hen a child fatality has occurred as a result of abuse and/or neglect by a non-residential licensed child care provider, the county shall direct any public request to the appropriate licensing department or agency that has jurisdiction over the facility." By requiring the public to seek disclosure in these cases from "the appropriate licensing department or agency" rather than from the county, DSS misinterprets the controlling statute. SB 39 does not require the fatal abuse or neglect to have occurred in the child's home in order to trigger public disclosure by the county; the location of the abuse and the identity of the abuser are completely irrelevant to whether disclosure must be made. As noted above, the statute draws a distinction between "cases in which the child's death occurred while living with a parent or guardian" and "cases in which the child's death occurred while the child was in foster care" solely to differentiate between the kinds of documents to be released. Cal. Wel. & Inst. Code §§ 10850.4(c)(2)-(3). Yet according to MPP § 31-502.35, even if the deceased child was living with a parent, if the death occurred at the hands of a day care provider, the public is not entitled to SB 39 disclosure, and any disclosure is at the discretion of the "licensing department or agency." Because the regulations do not require the licensing agency to make any disclosures at all, those agencies are free to ignore or deny a request from the public. That is contrary to the statute, because these "child care provider" cases are squarely within the scope of SB 39, and the disclosures remain the county's responsibility. MPP § 31-502.35 should therefore be repealed. SB 39 was enacted to "maximize public access to juvenile case files in cases where a child

fatality occurs" and should be construed accordingly. (SB 39, as amended, June 28, 2007 § 1(e).)

MPP § 31-502.42. This provision states that "[a]fter consultation with *law enforcement* or the District Attorney, if the release of specific information would jeopardize a criminal investigation or proceeding, that information shall be redacted prior to release." (Emphasis added). Requiring counties to consult with law enforcement prior to releasing documents is an unjustified impediment not found in the statute. As with the prior examples, the regulations here have amended code, not interpreted it. The statute authorizes consultation only with the District Attorney, not "law enforcement." Cal. Wel. & Inst. Code § 10850.4(e)(1)(B). The distinction is not academic. Consultation with law enforcement has had the proven effect of stopping the flow of information to the public, as evidenced by recent experiences in Los Angeles County. *See* OIR Report at 6-10.

MPP § 31-502.45. This regulation states that "[t]he county shall adhere to all laws that govern confidentiality of the release of information." This provision does not comply with Cal. Wel. & Inst. Code § 10850.4(e)(2)(A), which says that DSS "shall promulgate a regulation listing the laws" that prohibit disclosure of confidential information and "setting forth standards governing redactions." Although MPP § 31-502.451 lists examples of such laws, that provision acknowledges that the examples are "not intended to be an exhaustive list." Moreover, those examples are found in the "Handbook" section of the MPP, which is not part of the enforceable regulations. Thus, DSS regulations fail to comply with the statutory requirement of listing the relevant confidentiality laws and providing standards governing redactions.

These deficiencies are serious and have the real world effect of reducing the release of information to which the public is entitled by statute. Contrary to an assertion made at the meeting with CAI, no provision of federal law found is pre-emptive of SB 39's provisions such that effectively amending the statute by regulation to impose causation requirements not countenanced in controlling state law is legally warranted. Under the current DSS regulations and guidance, counties are following DSS' unlawful regulations and will continue to do so until the regulations are changed. *See, e.g.*, OIR Report at 4-10.

As set forth above, the Legislature has found a connection between the public accountability resulting from disclosure and the implementation of life-saving reforms. Based on this legislatively determined connection, the regulations' unlawful restraints on disclosure are placing the lives of California children at risk. That these regulations are having, at best, a confusing and frustrating impact on disclosure is documented by the Los Angeles County Office of Independent Review Report. Legally, practically, and morally, these regulations must be repealed on an emergency basis immediately.

Inadequate Tracking and Disclosure of Near Fatalities Under CAPTA

CAPTA requires all states, as a condition to receiving federal grant money, to have provisions in place that "allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality." 42 U.S.C. §

5106a(b)(2)(A)(x). California receives CAPTA funds and is therefore required to follow this public disclosure mandate. It is not doing so. Although SB 39 and DSS regulations address the disclosure of information following a child fatality, California has no adequate regulations in place for public disclosure following a near fatality.

DSS has acknowledged that "[i]n order to comply with [CAPTA], California must provide relevant case specific information not only on child fatalities where there is reasonable suspicion of abuse or neglect but also on near fatalities." (ACL 06-24 at 1.) To date, California has failed to do so. DSS's adopted policy regarding near fatalities requires counties only to complete the Child Fatality/Near Fatality Questionnaire (Form SOC 826) and transmit the form to DSS, which then relies on the limited data contained therein to disclose information to the public, upon request. (ACL 08-13 at 3; ACL 10-06 at 3.) This system does not implement federal law; it frustrates it.

The SOC 826 data is limited to the child's age and gender, the date of the near fatality, where the child resided at the time of the incident, the county where the incident occurred, who conducted the investigation, who determined that the near fatality was the result of abuse/neglect, and five checkboxes for the cause of the incident. (ACL 10-06, SOC 826.) DSS does not require counties to report any information about the case history, including previous referrals, health care records, risk and safety assessments, etc. Indeed, DSS expressly forbids counties from providing any narrative description when reporting near fatalities. (ACL 10-06, SOC 826 ("DO NOT INCLUDE A NARRATIVE").) This is a misguided interpretation of federal law, because under CAPTA, "[t]he State does not have discretion in whether to allow the public access to the child fatality or near fatality information; rather, the public has the discretion as to whether to access the information. In other words, the State is not required to provide the information to the public unless requested, but *may not withhold the facts about a case* unless doing so would jeopardize a criminal investigation." DHHS Child Welfare Policy Manual § 2.1A.4 (emphasis added).[1] DSS is in essence ordering counties to withhold that information both directly, by forbidding a narrative even if a county would elect to provide one, and indirectly, given the absence of guidance about how to provide more than just the terse, unrevealing, and unhelpful data listed on the form.

Moreover, other than the SOC 826 questionnaire, DSS does not appear to have any mechanism of tracking near fatalities that resulted from abuse or neglect. And even for the limited information that DSS collects on near fatalities from the SOC 826 questionnaire, there is no timetable for disclosure when a request is made, and no transparency regarding which data DSS decides to release and on what basis that decision is made. This is not what was intended by CAPTA's directive to "allow for public disclosure of the findings or information" about near fatalities. 42 U.S.C. § 5106a(b)(2)(A)(x).

In short, DSS's policy on disclosing near fatalities obstructs rather than facilitates the implementation of CAPTA and the Congressional intent behind making near-fatality information

[1] While the Child Welfare Policy Manual permits the State the option to determine its own procedures for disclosing "available facts" regarding the case of child abuse that results in a child's fatality or near fatality, the facts disclosed must pertain to the *incident* that led to the fatality or near fatality. (DHHS Policy Manual § 2.1A.4.)

subject to public disclosure. The policy provides nothing more than a low-resolution snapshot of a single incident, bereft of all detail and divorced from any context. Such a policy gives the public absolutely no basis for attempting to address why the incident happened and how future incidents can be prevented for that child and for other children who are similarly situated.

The adoption of this policy is particularly frustrating in light of the prior disclosure policy that DSS abandoned in March 2008. That proactive policy had embraced CAPTA's mandate and promoted public disclosure. Indeed, it was developed "to bring California into compliance" with CAPTA, "[a]fter a careful review of the CAPTA requirements, policies and practices employed by other states." (ACL 06-24 at 1.) Under the former policy, DSS would conduct "a thorough review of the electronic case file…and obtain additional information, if necessary, from CWS/Probation." (*Id.* at 2.) DSS would then "prepare and finalize a summary report in collaboration with CWS/Probation that includes information and findings about the case of child abuse or neglect which has resulted in a child fatality or near fatality. This summary may reflect the perspectives of both CDSS and CWS/Probation if the perspectives differ." (*Id.*) Although the specific content of the summary report would vary depending on whether the child was living in the home or in out-of-home care at the time of the fatality/near fatality, the DSS report was to include the following:

- Whether there was an open case/referral at the time of the fatality/near fatality;
- A description of the current placement, including the basis for the placement decision;
- A summary of the child's placement history;
- A summary of the actions of CWS/Probation relating to the supervision of the current placement;
- Other persons in the home;
- Licensing history, including examples such as type of license, how long licensed, number of reported incidents;
- A summary of any parental involvement with CWS in the preceding five years;
- A summary of actions taken by CWS, including referrals for services;
- Information about the child, including the child's age, gender, family description, and any relevant special needs;
- Cross reports to/from other agencies;
- Cause of the fatality or near fatality as provided by the county;
- Description and findings of the material circumstances leading to the fatality or near fatality; and
- The services that have been provided to the family since the fatality/near fatality.

(*Id.* at 2-3.) The difference between these disclosures and what is disclosed under current DSS policy is striking and confirms that the current policy for disclosing near fatalities is legally, operationally and morally unacceptable, especially given that both Congress and the California Legislature have determined that there are life-saving benefits to disclosing what happened when a child dies or nearly dies.

The difference between the original SOC 826 form, introduced in ACL 06-24, and the current form is also remarkable. The original SOC 826 form required the child's age, gender, date of death, race/ethnicity, suspected cause of fatality/near fatality, residence at the time of fatality/near fatality, and any cross-reporting with other entities. (*Id.* at Attachment A.) More importantly, however, the form called for a *narrative description* of the CWS history of the child and his or her family, which was to include the number of referrals (with associated dates), the number of open cases, the reason(s) for referral(s) (with associated disposition(s)), and the date and description of the last county contact. (*Id.*) The form also had a section for additional open-ended comments about the case. (*Id.*) The extensive and illuminating information provided on the original SOC 826 form stands in stark contrast to the skeletal outline dictated by the current form.

Given the serious deficiencies in current policy regarding the disclosure of near fatalities and the obvious DSS precedent for a more disclosure-friendly policy that better fulfills CAPTA's mandate, it is simply untenable to continue with current policy.

CAI hopes that DSS will take these deficiencies to heart and immediately modify its regulations and its directions to front-line county agencies. CAPTA and SB 39 were enacted to provide the public better insight into the causes of child abuse so that the worst outcomes of such abuse — fatalities and near fatalities — can be prevented. By writing this letter and engaging the Department informally it is our earnest hope that these problems can be resolved quickly and informally.

But, setting aside for the moment that the regulations as detailed above are unlawful, we earnestly hope that DSS will repeal them not because they are vulnerable to litigation but simply because they are poor public policy. Given the Legislature's self-evident intent behind enacting SB 39, "ties" in interpreting the statute should properly go toward regulatory interpretations that will save lives by promoting disclosure and thus promoting reforms that have been demonstrated to flow from such disclosure. Instead, in each of the instances above, the regulations without a justification consistent with a full-throated reading of SB 39 or an appreciation of its settled policy, move to restrain disclosure, frustrating the intent of the legislation and skewing the public debate about the efficacy of the system in arbitrary ways (e.g., a child who dies at the hands of a boyfriend who lives in the home, no disclosure; at the hands of a stepfather, disclosure even if there were numerous CPS reports in the former case).

Given that this matter is literally one of life and death for California's most vulnerable children, we respectfully request a response to this letter outlining your intentions within 10 days of receipt. Further delay in promulgating compliant regulations means further delay in the potentially life-saving reforms that will flow from the public disclosure consistent with the letter and spirit of SB 39.

Sincerely,

Bob Fellmeth

Ed Howard

cc: John Wagner, DSS
Larry Bolton, DSS
Greg Rose, DSS
Christina Riehl, CAI
Steve Keane, Morrison & Foerster LLP

Exhibit C

CDSS
JOHN A. WAGNER
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

March 8, 2011

Mr. Robert C. Fellmeth
Executive Director, Children's Advocacy Institute
University of San Diego School of Law
5998 Alcalá Park
San Diego, CA 92110

Mr. Ed Howard
Children's Advocacy Institute
717 K Street, Suite 509
Sacramento, CA 95814

Dear Mr. Fellmeth and Mr. Howard:

SUBJECT: RESPONSE TO REQUEST TO AMEND REGULATIONS REGARDING SB 39 AND CAPTA DISCLOSURE REQUIREMENTS

Thank you for your letter of January 13, 2011, which summarizes your concerns and requested changes to the California Department of Social Services (CDSS) Senate Bill (SB) 39 regulations. Please know that we are committed to working with advocates and stakeholders in the future, as we have in the past, to produce the very best regulations possible in this important area. While there has been some room left for interpretation, we have looked closely at the law and legislative intent through a public process in which Children's Advocacy Institute (CAI) was involved, to craft regulations that provide the level of disclosure required by SB 39.

The intent behind the regulations has always been to allow for the greatest possible disclosure in a manner consistent with state and federal law. Nevertheless, we believe there are areas in which the existing regulations can be improved and we would like to work with you and other interested stakeholders in this effort. To begin that process, we have set out below our position on each of the points raised in your letter. After you have reviewed them, we would like to meet in person to discuss any differences and possible regulatory or administrative changes that would move us closer to our mutual goals.

MPP § 31-502.42 (Consultation with law enforcement)
This regulation requires a county child welfare agency to consult with the district attorney (DA) or law enforcement when determining whether the release of child fatality information would jeopardize a criminal investigation. Your letter asserts that because

SB 39 specifies only that the district attorney need be consulted, the regulation goes beyond what the statute requires and thereby impedes the flow of information.

As we indicated in our December 6, 2010 meeting, the intent of this regulation was not to chill, but to facilitate public disclosure of information. Local law enforcement is typically the investigating agency with the most knowledge of pending cases that may be sent to the DA for prosecution. Consequently, the SB 39 workgroup believed that notice to law enforcement would actually help expedite review as to whether the release of information would interfere with a criminal investigation or proceeding.

This rationale notwithstanding, the statute refers to district attorney and we agree with you that so should the regulation. As we indicated before, we are willing to amend this regulation accordingly.

MPP §§ 31-502.2 et seq. (Causal Link between Abuse/Neglect and the Fatality)
These regulations condition the release of child fatality information on the determination that the fatality was the result of abuse and/or neglect. While we have conscientiously attempted to capture the essence of the statute, reasonable people can differ and we are certainly willing to sit down and discuss this further. Your letter appears to eliminate causation altogether by suggesting that abuse at some distant time in the past unrelated to the current circumstances is sufficient. We disagree with this interpretation.

We read W&IC § 10850.4 (b) as part of a process through which child fatality information is to be released. W&IC §10850.4(a) begins this process by directing child welfare agencies to release limited information when there is a reasonable suspicion that the fatality was *caused by* abuse or neglect. We believe that this subdivision essentially serves as a gatekeeper thereby identifying cases which are potentially subject to expanded disclosure.

W&IC §10850.4(b) sets forth the type of findings that specified agencies must make before additional SB 39 information may be released. As we understand your argument, these findings need not be necessarily related in any way to the circumstances that led to the death. While we understand and appreciate your concern, we do not believe we have the authority to promulgate regulations that eliminate any connection between the abuse or neglect and the death.

The causation requirement exists throughout SB 39. W&IC § 826.7 provides that case files pertaining to a child who died "as the result of abuse or neglect" shall be released. W&IC § 10850.4(c)(2)(A) requires the release of the emergency response forms relating to the abuse or neglect that "caused" the death of the child. The legislative findings and declarations also indicate that the Legislature meant there to be a causal connection between the abuse or neglect and the child's death: "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 informed debate (SB 39, Chapter 468, Statutes of 2007 Section 1 (c))."

It is the intent of the Legislature to maximize public access to juvenile case files in cases where a child fatality occurs as a "result of abuse or neglect (SB 39, Chapter 468, Statutes of 2007 Section 1 (e))." Consequently, we believe that taken as a whole SB 39 requires a causal link between the abuse or neglect and a child death. We see nothing in the overall scheme of SB 39 to support your position that disclosure is compelled once there is a child fatality coupled with (unrelated) substantiated abuse or neglect.

Finally, our interpretation of SB 39 is consistent with federal law that has the same requirement. The federal Child Abuse and Prevention Treatment Act (CAPTA) allows for the release of "findings or information about a case of child abuse or neglect which has resulted in a child fatality..." at (42 USC 5106a(b)(2)(A)(x)). Otherwise, information pertaining to children served by child welfare agencies remains confidential (42 USC 5106a(b)(2)(A)(viii)). Absent a causal connection between a child fatality and abuse or neglect, there would be no basis to disclose otherwise confidential information.

As we acknowledged previously, reasonable minds can differ and we are willing to discuss this issue further. Additionally, the Department is looking to reestablish an SB 39 regulations workgroup to examine this and other issues regarding the release of child fatality and near fatality information. We would welcome your participation in that effort.

MPP §§ 31-502.33 and 31-502.34 (Causal Link between Abuse/Neglect and the Fatality Specific to the Parent/Guardian or Foster Care Provider)
These regulations provide that once the determination has been made that the child fatality was the result of abuse or neglect, additional information shall be disclosed if the abuse was inflicted by the parent, guardian, or foster parent depending on the child's placement. Your letter asserts that by requiring a nexus between the place where the abuse or neglect occurred and the identity of the perpetrator, CDSS regulations limit the number of cases in which disclosure will be made. We disagree. The intent of the regulations was to ensure that records, unrelated to the abuse/neglect that resulted in the death of the child, would not be disclosed. As indicated in our discussion of the causation issue above, federal law only allows the release of information about a case of child abuse and neglect that resulted in death. Otherwise, information pertaining to children and their parents or guardians remains confidential. This requirement also exists in SB 39 which prohibits the disclosure of information deemed confidential by other laws. (W&IC § 10850.4(e)(1)(C))

MPP §§ 31-502.33 and 31-502.34 ensures that confidential information unrelated to a child's death is not improperly disclosed. For example, if a child was on a field trip and died as a result of abuse or negligence at the hands of a chaperone, CAI's reading

of SB 39 would require release of the parents' history with the child welfare agency even though it would be unrelated to the child's death. We believe such a result would violate federal and state law.

While the Department believes the regulations comport with state and federal law, we are aware that there have been implementation issues associated with this policy. We believe it would be useful to discuss other approaches that ensure maximum disclosure of information while still protecting individuals' privacy and confidentiality when appropriate.

MPP § 31-502.35 (Non-residential Licensed Care Provider)
This regulation provides that if a child dies as a result of abuse or neglect by a non-residential provider (e.g. day care), the county shall direct the public to the appropriate licensing authority. Your letter interprets this regulation as prohibiting SB 39 disclosure in cases where a child dies at the hands of a licensed caregiver. Indeed, your interpretation does not comport with the intent of the regulation or the way it has been implemented.

As you know, W&IC §10850.4(o) specifically provides that a child welfare agency is not required to obtain records that do not exist in its files. A licensing file is distinct from a child's case file and they exist in different places. The intent of this regulation was simply to require child welfare agencies to direct the public to the appropriate licensing entity where individuals could request information that would not otherwise exist in a child's case file.

This regulation has no impact on the obligation of the child welfare agency to comply with SB 39. Any information that the child welfare agency has that is disclosable under SB 39 must still be provided. Finally, we note that this regulation was promulgated at the request of the SB 39 workgroup who wanted to facilitate public access to licensing information in the event a child died of abuse or neglect at the hands of a provider.

Perhaps we can find language that makes clear the information that the child welfare agency has that is disclosable under SB 39 must still be provided in this situation so as to alleviate your concern with the current wording. In the event that it does not, the Department would be willing to repeal this regulation as unnecessary. However, we believe that doing so could reduce public access to information.

MPP § 31-502.45 (Listing of Confidentiality Laws)
SB 39 requires the Department to promulgate a regulation "listing confidentiality laws that prohibit disclosure of confidential information" and "setting forth standards governing redactions." (W&IC §10850.4(e)(2)(A)) The implementing regulation states that counties must comply with confidentiality laws when releasing information. Examples of these laws are set forth in the Handbook section of the MPP. We understand your concern to be that the regulation does not comply with SB 39 because

it fails to provide an exhaustive list of relevant confidentiality laws. You take issue with the fact that those laws listed are in the Handbook section which you believe somehow diminishes their enforceability.

Again, the intention here was to facilitate the release of child fatality information. We specifically sought to provide a list of confidentiality laws that was not so lengthy as to be unwieldy. Indeed, we narrowed the list we initially proposed in response to public comment that it was "overly inclusive."

Our records indicate that CAI was one of the stakeholders that shared this concern (See attached letter dated March 13, 2009, submitted by the National Center for Youth Law (NCYL), the CAI, and the California Newspapers Publishers Association).

We believe your concern about the use of handbook is also misplaced. MPP §31-502.45 requires counties to "adhere to all laws that govern confidentiality of the release of information." The list of laws that follow are all independently enforceable and their location in handbook does not change that fact. Additionally, the Department can easily modify handbook as laws change. Amending a regulation typically takes 18 to 24 months.

We are satisfied that this regulation meets the intent of SB 39 and gives counties the guidance that they need. Nevertheless, your specific suggestions as to how best to implement W&IC §10850.4(e)(2)(A) are welcome.

Disclosure of Near Fatality Information Under CAPTA

In your letter, you note that federal law requires California to have a process that allows for the public disclosure of information regarding child near fatalities. You indicate that California is not in compliance with this law.

CAPTA does require all states, as a condition to receiving federal grant money, to have provisions in place that "allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality." (42 U.S.C. § 5106a(b)(2)(A)(x)). Federal law, however, does not specify the form that disclosure must take. It also contains no requirement that disclosure processes for fatalities and near fatalities be the same. The federal Child Welfare Policy Manual permits considerable leeway in terms of how states release findings and information. A statement of findings, summary, or a more extensive release are all acceptable forms of disclosure.

In California, the manner in which child fatality information is released was determined by the Legislature in the form of SB 39. The manner in which we release near fatality information is set forth in All County Letter (ACL) 08-13 and the SOC 826 form. Both of these documents were deemed by the United States Department of Health and Human Services (DHHS), Administration for Children and Families (ACF) as compliant with

CAPTA. We also note that DHHS approved California's policy for the release of fatality and near fatality information despite the fact that the processes are different.

While the process described above satisfies the CAPTA requirement, CDSS currently also prepares an annual report that includes a great deal of information about child fatalities and near fatalities that result from abuse or neglect. (*see* California Child Fatality and Near Fatality Annual Report) This report is prepared to satisfy W&IC § 10850.4(j) which requires that CDSS produce an annual report on child fatalities reported by counties and as well as any systemic issues revealed by the counties' notices. While not required, the CDSS has also incorporated near fatality information into this report to facilitate an understanding of those cases as well. We have also integrated information from this report as part of the federal Title IV-E and IV-B Annual Progress and Services Report. This is an additional source of information that is available to the public regarding child fatalities and near fatalities that occur in California.

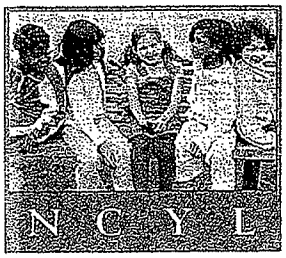
We hope this information is helpful. We look forward to meeting with you to discuss possible amendments to our regulations in those areas where we find we are in agreement on ways they can be improved.

Sincerely,

SUSAN DIEDRICH
Senior Assistant Chief Counsel

Enclosure

c: John A. Wagner, CDSS
Larry Bolton, CDSS
Greg Rose, CDSS
Christina Riehl, CAI
Steve Keane, Morrison & Foerster LLP



National Center for Youth Law

March 13, 2009

Via E-Mail and Mail

Office of Regulations Development
California Department of Social Services
744 P Street, MS 8-4-192
Sacramento, California 95814

Re: Proposed Regulations – SB 39, Child Fatality Reporting and Disclosure Requirements (ORD No. 1008-07)

Dear Sirs:

The National Center for Youth Law, the Children's Advocacy Institute, and the California Newspaper Publishers Association, welcome this opportunity to comment on the California Department of Social Services (CDSS) January 2009 draft regulations, "SB 39, Child Fatality Reporting and Disclosure Requirements" (ORD No. 1008-07).

We propose a number of modifications, the most important of which revise sections 31-502.441 and .442. As currently drafted, those sections would be inconsistent with the underlying statute and therefore prohibited by the Administrative Procedures Act. (Govt. Code section 11349.1(a)(4).)

Proposed Regulations, Sections 31-502.441 and 31-502.442

These subsections require substantial revision because, as currently worded, they fail to provide the guidance required by the statute and they include unnecessary and inappropriate citations to external laws and regulations. Unfortunately, both of these subsections were omitted from the version circulated to interested parties for comment in 2008, so it has not been possible to address their problems until now.

In cases of child abuse or neglect leading to a child's death, SB 39 requires the release of 12 types of documents and/or information maintained by the local child protective services agency. The records and information to be released are specified in the law. The 12 items are:

- Age of child
- Gender of child
- Whether the child was residing with parent(s)/guardian or in foster care

- Whether an investigation is being conducted or has been conducted by law enforcement, child welfare agency, both or neither
- Previous referrals while living with parent(s)/guardian, if any
- Emergency response referral information form
- Emergency response notice of referral disposition form
- Cross reports from child welfare agency to law enforcement
- Risk and safety assessments by child welfare agency
- Health care records, excluding mental health records, if reflective of a pattern of abuse/neglect
- Police reports concerning the perpetrator of abuse/neglect
- If death occurred in foster care, initial and renewal licensing records for the foster parents at the time of the child's death, reports of licensing violations, notices of action concerning licensing violations, and records of the foster parents' training.

For details, see Welfare & Institutions Code, sec. 10850.4(a)-(c).

Prior to release of the records, however, the statute requires the redaction of personally identifying information: "names, addresses, telephone numbers, ethnicity, religion, or any other identifying information of any person or institution, other than the county or the State Department of Social Services . . . ." (Section 10850.4(e)(1)(A).) In addition, requests by the district attorney to redact information because its release would jeopardize a criminal investigation or proceeding are to be honored (section 10850.4(e)(1)(B)). Finally, SB 39 also requires redaction of "[a]ny information that is privileged , confidential, or not subject to disclosure pursuant to any other state or federal law" (section 10850.4(e)(1)(C)).

Recognizing that the above items of information might include information protected by other federal or state statutes, the legislature directed CDSS to promulgate regulations listing such external laws and regulations as are relevant and setting standards governing any further redactions. [1]

The legislature's intent in requiring the CDSS regulations to list external statutes and regulations designating information that is "privileged, confidential, or not subject to disclosure pursuant to any other state or federal law" is, of course, to help county administrators/custodians of records to ensure that within the 12 items or documents to be released there is no information subject to redaction because it is protected by other statutes not overridden by SB 39. Administrators/custodians of records will cross-check the 12 items or documents against the restrictions in the listed external statutes to facilitate appropriate redactions, if any, beyond the scope of the redactions specifically prescribed in SB 39, i.e., information other than "the names addresses,

---

[1] "Prior to releasing any document pursuant to subdivision (c), the custodian of records shall redact the following information: . . .
(e)(1)(C). Any information that is privileged, confidential, or not subject to disclosure pursuant to any other state or federal law.
(e)(2)(A) The State Department of Social Services shall promulgate a regulation ***listing*** the laws described in subparagraph (C)[reproduced immediately above] of paragraph [10850.4(e)](1) and ***setting forth standards*** governing redaction." (Welfare & Institutions Code Sec. 10850.4 (emphasis supplied).)

telephone numbers, ethnicity, religion, or any other identifying information of any person or institution . . . ." (Welf. & Inst. Code, Sec. 10850.4(e)(1)(A).)

The list of laws and regulations in the draft of subsections .441 & .442 is overly inclusive and misleading. The mere mention of privacy, confidentiality or privilege in a statute or regulation does not make it relevant to the redaction of the records called for by SB 39. As they stand now, the draft regulations take a scattergun approach that conflicts with both the text and the intent of the statute. For example, Revenue and Taxation Code section 19542, cited at .441(h), refers to the disclosure of information from state tax filings. Such state tax filing information is not part of the records to be released under SB 39. Indeed, they are unlikely to be found in any child welfare records. The list of statutes in the regulations should be much more precise. In Attachment A to this letter we propose an alternative, pared down list of the statutes that may need to be considered. Attachment A also includes language to provide the guidance to county administrators that SB 39 requires.

Listing statutes that do not require redaction of any information would be contrary to SB 39's text and destructive of its intent. To list statutes that would require redaction of the same information that is explicitly required to be redacted by SB 39 also would be contrary to the legislative intent: it would send county administrators on time-wasting, budget-consuming, wild goose chases, wading through irrelevant statutory materials to find only that the same names, addresses, etc., that the administrators have already redacted pursuant to Section 10850.4(e)(1)(A) also would be appropriate for redaction by application of other laws. The time-wasting and budget-depleting consequences of listing laws that should not be listed are particularly troublesome when they occur in the absence of the guidance that SB 39 requires.

The revised list in Attachment A is shorter than the list in the CDSS draft because we have deleted citations to statutes and regulations that meet one or more of the following criteria:

a. The statute or regulation deals with judicial (i.e., court) records or proceedings, not the administrative records that are found in child welfare agency files. For example, Penal Code section 1054.2, cited at proposed regulation .441(g), deals with disclosures by attorneys in criminal trials. It is irrelevant to SB 39.
b. The statute or regulation requires redaction of the same information—names, addresses and/or other personally identifying information—that will be redacted pursuant to Welfare & Institutions Code subdivision 10850.4(e)(1)(A), i.e., ". . . names, addresses, telephone numbers, ethnicity, religion, or any other identifying information . . . ." For example, Penal Code section 293.4, cited at proposed regulation .441(g), allows a sexual crime victim to request deletion of her or his name from trial records. Names must be deleted from responses to SB 39 requests, so a citation to Penal Code section 293.4 would be redundant.
c. The statute or regulation does not exist. For example, we have been unable to find a section 255.7 in the California Health & Safety Code, so it should not be cited at proposed regulation .441(f).
d. The statute or regulation does not prohibit county officials from releasing information. For example, Evidence Code section 1560, cited at proposed regulation .441(c), defines the term "business" and specifies procedures related to subpoenas duces tecum; it has nothing to do with redactions or the limits on disclosure of information. As another example, Family Code section 17505 mandates limits on acquisition of criminal information coming *into* the California Child Support Automation System, but it does not regulate dissemination of

information *from* that system, nor does Family Code section 17505 have any relationship to the files of county agencies.

e. The statute or regulation deals with documents or types of information that are not among the documents or types of information that SB 39 specifies as subject to release. The documents and types of information that are subject to release are only those listed earlier in this letter. (See Welfare & Institutions Code sec. 10850.4(a)-(c).) For example, income tax data is not among the types of information that SB 39 permits to be released, so the citation to the federal Internal Revenue Code, 26 USC, at proposed regulation .442(d), is unnecessary.

SB 39 also requires CDSS to develop standards for application of the state and federal statutes that may apply to the records whose release it requires. The legislature's intent is that CDSS not only provide a list of statutes, but also guidance, i.e., standards, for application of external statutes. The proposed regulations provide no guidance or standards for dealing with the numerous statutes and regulations listed in proposed sections .441(a)-(j) and .442(a)-(g). For that reason, the current draft would produce just the opposite of the statute's mandate. Without the guidance that SB 39 mandates, county administrators would have to do their own parsing of numerous statutes and regulations, leading to precisely the lack of uniformity in disclosure that the legislature, in SB 39, has determined to remedy. The absence of the legislatively mandated standards, along with the excessive and unwarranted number of citations to irrelevant statutes, would impose an unnecessary burden and cost on administrators charged with the release of records.

It is important to provide the sort of guidance that we propose in Attachment A. The legislature has been explicit concerning the need to provide guidance. It explained the problem in the text of the statute:

> "The current procedures for accessing information about a child's death from abuse or neglect are **costly**, at times resulting in **lengthy delays** in the release of that information, fail to provide adequate **guidance** for what information should and should not be disclosed, and permit **significant variation** from one jurisdiction to another in the nature and extent of the information released." (SB 39 (2007), Sec. 1(d) (emphasis supplied).)

Additional Recommendations for the Proposed Regulations

1. Proposed section 31-502 includes potentially troublesome variations of terminology concerning causation:

   "the direct cause" (proposed regulation .221)
   "a direct cause" (proposed regulation .222)
   "a direct result" (proposed regulation .223)
   "a result of" (proposed regulation .23)

   The last of these, "a result of," or "a cause of," is preferable, as it avoids perennial problems in defining causation. If A is "*the* direct cause" of X, can B also be *a* cause of X? If A is *a direct* cause of X, can B also be *a direct* cause of X? The CDSS can avoid seeming to enter into such debates by consistent use of the most straightforward term: "a result of" or "a cause of." This unembellished approach is also required for consistency with the legislature's

choice of terms in SB 39: "the fatality was caused by abuse or neglect," "abuse or neglect leads to a child's death," and "child fatality . . . that was the result of child abuse or neglect." (Welfare & Institutions Code subdivisions 10850.4(a), 10850.4(b), 10850.4(j).)

2. Section .341(e) (p. 8) should read "person(s)" rather than "person."

3. At section .431 (p. 9) and sections .432 and .433 (p. 10) the word "that" should be inserted after "except" for clarity.

The National Center for Youth Law, the Children's Advocacy Institute and the California Newspaper Publishers Association appreciate your consideration of these recommendations and hope that you will find them helpful.

Yours very truly,

Edward M. Opton
Of Counsel
National Center for Youth Law

Bill Grimm
Senior Attorney
National Center for Youth Law

/s/
Ed Howard
Senior Counsel
Children's Advocacy Institute

/s/
Jim Ewert
Legal Counsel
California Newspaper Publishers Association

Enc.

CC: L. Bolton, w/enc.
S. Diedrich, w/enc.
J. O'Toole, w/enc.

Attachment A to letter to CDSS Office of Regulations Development

Proposed revision of SB 39 regulations, sections .441-.442, with guidance

The following listing of laws and regulations and the guidance concerning them applies only to requests pursuant to Welfare & Institutions Code section 10850.4.

.441

(d)[12] Family Code sections 3041.5, 3111, and 7643

Family Code section 3041.5 provides for alcohol and drug testing in judicial proceedings concerning custody, visitation, and guardianship. The results of such tests are confidential and should be redacted.

Family Code section 3111 provides for confidential child custody evaluation reports in cases of contested child custody and contested visitation rights. For example, one family member may object to visits from another family member. Documents from such cases are in the files of the Superior Court, not the Juvenile Court. If such evaluation reports are found in the county's files, they should be redacted.

Family Code section 7643 provides for confidentiality of court proceedings to establish the identity of a child's father. Records of such proceedings, including paternity test results, should be redacted.

(g) Penal Code section 13300

Penal Code section 13300 allows several government agencies, including child welfare agencies, to obtain "local summary criminal history information," more commonly known as "rap sheets." Rap sheet information concerning the perpetrator(s) of neglect or abuse that has come from a local criminal justice agency should be redacted. Rap sheet information concerning the criminal history of persons other than the perpetrator(s) of neglect or abuse should be redacted. Information about the criminal history of the perpetrator(s) of neglect or abuse that has come from sources other than a "rap sheet," such as police reports, the individual concerned, family members, child welfare department personnel, etc., should not be redacted.

(i) Welfare & Institutions Code section 11478.1

Welfare & Institutions Code section 11478.1 requires public agencies to maintain the confidentiality of information gathered for purposes of child and spousal support enforcement. (See 42 U.S.C., ch. 7, Part D, section 651.) Documents generated or acquired for purposes of child or spousal support enforcement, as well as information derived from such documents, should be redacted. Information that could have been acquired for purposes of child or spousal support enforcement, but which actually was acquired through

[12] For convenience in cross-referencing these recommended revisions to CDSS's proposed regulations, we have retained CDSS's numbering system, e.g., .441(a), .441(b), etc. In the final regulations, the sections should be renumbered.

other channels (for example: mother tells Child Protective Services caseworker how much father earns) should not be redacted.

Exhibit D

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)

717 K Street, Suite 509
Sacramento, CA 95814
(916) 444-3875 / (916) 444-6611 (Fax)

Reply to: □ San Diego □ Sacramento

www.caichildlaw.org

June 9, 2011

VIA CERTIFIED MAIL & EMAIL

Susan Diedrich
Senior Assistant Chief Counsel
California Department of Social Services
744 P Street
Sacramento, CA 95814

Re: Petition to Amend Regulations Related to SB 39 and CAPTA Public Disclosure Requirements

Dear Susan:

We write in response to your letters dated March 8 and May 31, 2011 and to petition, pursuant to California Government Code section 11340.6, that DSS take immediate steps to revise its regulations regarding California's mandate to release to the public relevant information and files following a child fatality or near fatality in cases where the child suffered abuse or neglect. As you know, such disclosure is required under both the federal Child Abuse Prevention and Treatment Act ("CAPTA") and under California's SB 39. We have reviewed the relevant DSS regulations and All County Letters ("ACLs") that purport to implement the CAPTA and SB 39 public disclosure requirements and have identified several areas of non-compliance, as identified below and in our letter dated January 13, 2011, which is incorporated by reference herein.

While we appreciate the apparent willingness of DSS to amend its flawed regulations, the path forward that you propose, namely, participation in a regulations workgroup of unspecified duration and unknown outcome, fails to remedy the serious flaws in a timely manner. Urgency is dictated by one compelling and overriding fact: children are dying. The DSS regulations must focus on solving that problem by promoting public disclosure to the maximum extent permitted by the enabling statutes. Any discussions about the content of these regulations should take place within the structure of the Administrative Procedure Act, where all parties can participate. CAI submits this petition to formally start that process and, accordingly, requests suspension of

the ad hoc workgroup in favor of the APA process which embraces all those who may be interested.

In accordance with section 11340.6, this petition provides the substance and nature of the amendments requested and the reasons therefor. The authority of DSS to take the action requested is found in the following provisions: Cal. Wel. & Inst. Code §§ 10553(e), 10554, and 10850.4(e)(2).

Unlawful Regulations on Disclosure of Child Fatalities Under SB 39

For the reasons set forth below and in CAI's letter dated January 13, 2011, the following sections of the DSS Manual of Policies and Procedures (MPP) are out of compliance with SB 39 and need to be revised immediately. A redline of these sections, with CAI's proposed revisions, is provided in Exhibit A.

MPP §§ 31-502.2 *et seq.* – Improper causal link between abuse/neglect and child fatality

As explained in detail in the January 13 letter, the MPP provisions on public disclosure are plagued by causation language not found in the relevant statute. In response, you state that "the causation requirement exists throughout SB 39." Yet you fail to explain where the "result of" causation language is found in W&IC § 10850.4(b), the statutory provision that these MPP sections ostensibly track. Whatever language other statutory provisions may use does not undermine the fact that the legislature chose the "leads to" language for W&IC § 10850.4(b). DSS is not free to cast that language aside in an effort to "capture the essence of the statute" by using words that are more restrictive than those you cite. Accordingly, the affected MPP sections should be amended to track W&IC § 10850.4(b) as faithfully as possible. CAI's proposed revisions, shown in Exhibit A, do precisely that.

It is simply not true that CAI's proposed revisions "eliminate any connection between the abuse or neglect and the death." The connection is spelled out and defined explicitly in W&IC § 10850.4(b), the operative provision, which does not require the abuse or neglect to have "resulted" in the child's death. The statute takes pains to establish three exclusive mechanisms by which to determine whether the abuse or neglect indeed led to the death. W&IC § 10850.4(b)(1)-(3). Thus, you are incorrect to assert that "[a]bsent a causal connection between a child fatality and abuse or neglect, there would be no basis to disclose otherwise confidential information." The basis – bases – are laid out in plain text in section 10850.4(b): there is a dead child and substantiated abuse or neglect in his or her past. That is enough to trigger disclosure under any reasonable interpretation of the statute and certainly under any assessment of the statutory intent. Moreover, even if the "essence of the statute" were the touchstone of regulatory drafting, it cannot be disputed that the essence of this statute is to facilitate public disclosure when abuse or neglect leads to a child's death.

You do not dispute that the MPP language imposes restrictions on disclosure greater than those established by the substantive and operative section 10850.4(b). You do not contest our cited references to or the reasoning from the Los Angeles County study documenting from the front

lines how the causation requirement DSS imposes is not in the statute; frustrates the intent of the law; and sows confusion and arbitrariness in county implementation, where, contrary to the methodology laid out in section 10850.4(b), disclosure under the MPP now turns on the limits of medical science to determine whether it was, for example, a blow to the head or asphyxiation that ultimately killed a child. Indeed, you have not responded at all to the issues raised by the Los Angeles County study.

There is no ambiguity in section 10850.4(b)(1)-(3) that permits the insertion of words and concepts that are not there, particularly when doing so unquestionably results in fewer and fewer reasoned and predictable disclosures.

For these reasons, the "result of" language, which indisputably and unlawfully chills public disclosure, should therefore be removed from the DSS regulations that purport to implement W&IC § 10850.4(b), as shown in Exhibit A.

MPP §§ 31-502.33 and 31-502.34 - No disclosures if perpetrator is not the parent, guardian or foster parent

These regulations improperly condition the release of documents on an agency determination that the abuse or neglect was inflicted by the parent/guardian/foster parent in whose home the child was residing. There is simply no such limiting condition in SB 39. The statute draws a distinction between living with a parent/guardian and living in foster care solely to differentiate between the kinds of documents to be released. Wel. & Inst. Code §§ 10850.4(c)(2)-(3). By limiting disclosure only to cases where the parent/guardian/foster parent is the perpetrator, the DSS regulations are improperly and unlawfully reducing the number of cases in which public disclosure will be made. The following are examples of child fatalities for which the SB 39 disclosure requirements would not be triggered under current DSS regulations:

- A child is repeatedly abused in her home over a period of months by a boyfriend who visits the child's mother on a daily basis, and the child eventually dies of the injuries sustained.

- A child is subject to weekly beatings while visiting an uncle and eventually dies of the injuries sustained.

- A child is taken on an annual camping trip with an aunt and her friends, who ignore the child for the duration of the trip. The child wanders off and ultimately dies of exposure.

- A child living with foster parents is regularly abused by her foster parents and their adult son. One morning, when the foster parents are not home, the adult son beats the child to death.

SB 39 requires disclosure in each of these scenarios, yet current DSS regulations would prohibit it in each case. There is no principled basis for permitting disclosure only when the perpetrator is the parent, guardian or foster parent, and such regulations cannot stand. The only significance of whether the child was living with a parent/guardian or was in foster care is that such residence

determines the categories of documents to be disclosed. *See* Wel. & Inst. Code §§ 10850.4(c)(2)-(3). CAI's proposed revisions, shown in Exhibit A, properly account for the scenarios described above and bring the regulations back to their statutory mooring.

Your concern about disclosure of parent-specific information in cases where the parent was not the perpetrator is largely self-inflicted. It was DSS that added a condition in § 31-502.33 that the only documents to be released are those "pertinent to that parent or guardian" and a similar condition in § 31-502.34 for foster parents. These conditions are not found in the statute and improperly limit the SB 39 disclosures. The statutory categories of documents to be released are clear and should be reflected in the regulations accordingly. *See* Wel. & Inst. Code § 10850.4(c).

CAI agrees that in cases where a child living in foster care was killed by someone other than the foster parent, the legislature may not have intended that the foster parent's licensing and training be disclosed to the public, although the statutory language arguably supports such disclosure. *See* Wel. & Inst. Code § 10850.4(c)(3)(A)-(C). Your repeated suggestion that foster parent-specific information would be "unrelated" to the child's death when the perpetrator is someone other than the foster parent is therefore overly simplistic, and proves too much. Circumstances in the home leading up to abuse or neglect by a non-parent cannot be so readily discounted and may indeed be "related" to the abuse or neglect. Nonetheless, CAI believes that the foster parent-specific disclosures listed in W&IC § 10850.4(c)(3)(A)-(C) are best limited to cases where the foster parent was the perpetrator. The revisions shown in Exhibit A properly reflect this interpretation.

MPP § 31-502.35 - Disclosures related to non-residential licensed care providers

This regulation passes the buck from the county child welfare agency to the "appropriate licensing department or agency" when the perpetrator is a non-residential licensed care provider. Your letter concedes that this regulation is not intended to affect the public's right to SB 39 disclosures, but in order to make that clear, the regulation must be amended. Specifically, it must make clear that the public is entitled to SB 39 disclosures in this circumstance and that *in addition*, the public can request further information from the appropriate licensing department or agency that has jurisdiction over the facility. *See* Exhibit A.

MPP § 31-502.42 - Improper requirement to consult with law enforcement

CAI appreciates your willingness to amend this regulation to properly track the underlying statute. As you acknowledge, permitting or requiring counties to consult with law enforcement prior to releasing documents is an unjustified impediment not found in SB 39. CAI's proposed amended language is shown in Exhibit A.

Unlawful Tracking and Disclosure of Near Fatalities Under CAPTA

As explained in CAI's January 13, 2011 letter, DSS's policy on disclosing near fatalities obstructs rather than facilitates the implementation of CAPTA and gives the public absolutely no basis for assessing why a given near-fatality occurred or how future incidents can be prevented for that child and other children who are similarly situated. In your response letter, you contend that DSS's policy is in compliance with CAPTA, citing approval of the policy by DHHS. But DHHS approval alone does not establish compliance with federal law. *See Cal. Alliance of Child & Family Servs. v. Allenby*, 589 F.3d 1017, 1022 (9th Cir. 2009). Indeed, DSS has previously conceded that it was not in compliance with CAPTA and promulgated ACL 06-24 in response. (*See* ACL 06-24 at 1.) The robust disclosure policy under ACL 06-24, however, was abandoned in March 2008, casting serious doubt on whether DSS is currently in compliance with CAPTA regarding near-fatalities.

As you are aware, CAPTA requires disclosure of case-specific information on near-fatalities. (*See* 42 U.S.C. § 5106a(b)(2)(A)(x) (State must have in effect a law or program to "allow for public disclosure of the findings or information about *the case* of child abuse or neglect which has resulted in a child fatality or near fatality.") (emphasis added); *see also* DHHS Child Welfare Policy Manual § 2.1A.4 (Under CAPTA, "[t]he State does not have discretion in whether to allow the public access to the child fatality or near fatality information....[T]he State...may not withhold the facts about a case unless doing so would jeopardize a criminal investigation.").) DSS's goal should not be to skirt by on what it perceives to be literal compliance with these directives. Rather, it should have in place a meaningful policy by which the public can readily and thoughtfully assess the causes and potential solutions for each near-fatality that occurs in California.

Fortunately, DSS has already done the legwork to make such a policy a reality, namely, the requirements set forth in ACL 06-24, including the version of SOC 826 form attached thereto. The case-specific requirements listed in ACL 06-24, including the narrative description that accompanies the SOC 826 form, are indispensable in promoting public participation and in ultimately reducing near-fatal incidents that stem from child abuse or neglect. Accordingly, CAI requests that DSS immediately re-establish the ACL 06-24 framework regarding near-fatalities in order fully comply with the letter and spirit of CAPTA.

We look forward to your response to this petition within 30 days.

Sincerely,

Bob Fellmeth
Children's Advocacy Institute

Ed Howard
Children's Advocacy Institute

Steve Keane
Morrison & Foerster LLP

cc: William Lightbourne, DSS (via email only)
Larry Bolton, DSS (via email only)
Frank Furtek, DSS (via email only)
Greg Rose, DSS (via email only)
Christina Riehl, CAI (via email only)

EXHIBIT A – PROPOSED AMENDMENTS TO MPP §§ 31-502.1 *et seq.*

31-502 CHILD FATALITY REPORTING AND DISCLOSURE REQUIREMENTS

.1 When the county learns that a child fatality has occurred and has reasonable suspicion that the fatality was a result of abuse and/or neglect, the county shall generate a referral within the Child Welfare Services/Case Management system, and the county shall respond to the referral as described in Section 31-101.

.11 If the county finds an allegation to be inconclusive or substantiated, they shall complete the reporting requirements as described in Section 31-501.

[. . .]

.2 The county shall submit a report to the Department for each child fatality when, upon completion of the child abuse and/or neglect investigation, it has been determined, pursuant to Welfare and Institutions Code § 10850.4(b)(1)-(3), ~~-~~that ~~the~~ abuse and/or neglect led to the child fatality ~~was the result of abuse and/or neglect~~. The county shall report this information to the Department using the SOC 826 form. The report shall include the following information:

.21 The age and gender of the child.

.22 The date of death.

.23 Residence of child at the time of death.

.231 Foster care placement as defined by Section 31-002(f)(8).

.232 Parent or Guardian as defined by Sections 31-002(p)(1) and (g)(3).

.24 Whether an investigation is being conducted by a law enforcement agency and/or the county child welfare agency.

.25 The agency that made the determination ~~whether the child fatality was or was not the result of~~ that abuse and/or neglect led to the child fatality. Pursuant to Welfare and Institutions Code § 10850.4(b)(1)-(3), abuse and/or neglect is determined to have led to the child fatality if one or more of the following conditions are satisfied:

.251 CWS or Probation

~~A "determination" of abuse and/or neglect by~~ CWS or Probation determines that the abuse or neglect was substantiated. ~~is the substantiation of abuse and/or neglect allegations which resulted in the fatality.~~

.252 Law Enforcement

A law enforcement investigation concludes that ~~the child's death was a result of~~ abuse and/or neglect occurred.

.253 Coroner/Medical Examiner

A coroner/medical examiner concludes that the child who died had suffered abuse or neglect. ~~the child's death was a result of abuse and/or neglect.~~

[. . .]

.3 Upon public request, whether written, verbal, or via email or facsimile, the county shall release information related to a child fatality to the requesting party in the following circumstances:

.31 When there is reasonable suspicion that the fatality was a result of abuse, and/or neglect, the county shall provide the information as listed in Section 31-502.21 through .24 to the requesting party within five (5) business days of receiving the request.

.32 Upon receiving the public request for information pursuant to Sections 31-502.33 and/or .34, the county shall notify counsel for any child directly or indirectly related to the deceased child's case record.

.33 When the agency, pursuant to Section 31-502.25, makes the determination that ~~the child fatality was a result of~~ abuse and/or neglect led to the child fatality~~,~~ and the child resided with his/her parent or guardian, as defined by Sections 31-002(g)(3) and (p)(1), ~~and the abuse and/or neglect was inflicted by the parent or guardian,~~ the county shall release additional documents ~~pertinent to that parent or guardian~~.

.331 The following information, subject to redactions specified in Section 31-502.4, shall be released by the county upon public request within ten (10) business days of receiving the request or the determination of the investigation, whichever is later:

(a) All information listed in Section 31-502.2.

(b) Any emergency response referral information, completed by the county, which pertains to the abuse and/or neglect that resulted in the death of the child.

(c) Any previous referrals of abuse or neglect specific to the deceased child that were determined to be inconclusive or substantiated while living with that parent or guardian.

(d) Any cross reports relating to the deceased child that were completed by the county and sent to a law enforcement agency.

(e) Any copies of police reports about the person against whom the child abuse and/or neglect was substantiated.

(f) Any health care records, excluding mental health records, related to the child's death and previous injuries reflective of a pattern of abuse and/or neglect.

(g) Any risk and safety assessments, as defined by Sections 31-002(r)(7) and 31-002(s)(1), relating to the deceased child that were completed by the county.

.34 When the agency, pursuant to Section 31-502.25, makes the determination that ~~the child fatality was a result of~~ abuse and/or neglect led to the child fatality~~,~~ and the child resided

in foster care, ~~and the abuse and/or neglect was inflicted by the foster parent(s),~~ the county shall release additional documents ~~pertinent to the foster parent(s)~~.

.341 The following documents, subject to redactions specified in Section 31-502.4, shall also be released by the county to the requesting party within ten (10) business days of the request or the final determination of the investigation, whichever is later:

(a) All of the information listed in Section 31-502.21 through .25.

(b) The emergency response referral information, completed by the county, which pertains to the abuse and/or neglect that resulted in the death of the child.

(c) Any previous referrals of abuse or neglect specific to the deceased child that were determined to be inconclusive or substantiated while living with the foster parent(s).

(d) Any cross reports relating to the deceased child that were completed by the county and sent to a law enforcement agency ~~pertinent to the foster parent(s)~~.

(e) Any copies of police reports about the person(s) against whom the child abuse and/or neglect was substantiated.

(f) Any health care records, excluding mental health records, related to the child's death and previous injuries reflective of a pattern of abuse and/or neglect ~~inflicted by the foster parent(s)~~.

(g) Any risk and safety assessments, as defined by Sections 31-002(r)(7) and (s)(1), relating to the deceased child that were completed by the county ~~pertinent to the foster parent(s)~~.

(h) If the abuse and/or neglect was inflicted by the foster parent(s), ~~R~~records pertaining to the foster parent's license and type of license or licenses held, if in the case record.

(i) If the abuse and/or neglect was inflicted by the foster parent(s), ~~R~~records pertaining to the approval of the foster family home of the relative or non-related extended family member, including a caregiver assessment, and health and safety inspection of the home, if in the case record.

(j) If the abuse and/or neglect was inflicted by the foster parent(s), ~~A~~all documented licensing violations, including plans of correction, if in the case record.

(k) If the abuse and/or neglect was inflicted by the foster parent(s), ~~R~~records of any training completed by the foster parent(s), if in the case record.

(l) If the abuse and/or neglect was inflicted by the foster parent(s), and ~~If~~ the licensing records pertaining to the foster parent(s) are not contained in the child's case record, the county shall release the documents and information specified in Sections 31-502.341(a) through (k) that are available within the case record and direct the requesting party to the appropriate licensing

agency for any additional information or documents. For licensing/approval files maintained by the county, the county shall forward that part of the request to the appropriate county custodian of records.

.35 When ~~a child fatality has occurred as a result of~~ abuse and/or neglect by a non-residential licensed child care provider has led to a child fatality, pursuant to Welfare and Institutions Code § 10850.4(b)(1)-(3), disclosures shall be made in accordance with Sections 31-502.33 or .34. In addition, the county shall direct any public request to the appropriate licensing department or agency that has jurisdiction over the facility so that the public can request information that may not exist in the child's case file.

.36 When a child fatality has occurred, disclosures shall be made pursuant to Sections 31-502.33 through .35 unless one of the following conditions is met:

(a) The agency, pursuant to Section 31-502.25, makes the determination that the child fatality was the result of a terminal illness not associated with abuse and/or neglect;

(b) The agency, pursuant to Section 31-502.25, makes the determination that the child fatality was the result of an accident not associated with abuse and/or neglect;

(c) The agency, pursuant to Section 31-502.25, makes the determination that the child fatality was caused solely by a person or persons not mentioned in the CWS file for the child and not mentioned in any CWS file related to the child (e.g., a sibling's file).

.4 The county shall redact information that is privileged, confidential, or not subject to disclosure prior to public release.

[. . .]

.42 After consultation with ~~law enforcement or~~ the District Attorney, if the release of specific information would jeopardize a criminal investigation or proceeding, that information shall be redacted prior to release.

[. . .]

Exhibit E

CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

July 11, 2011

Mr. Bob Fellmeth
Mr. Ed Howard
Children's Advocacy Institute
717 K Street, Suite 509
Sacramento, CA 95814

VIA CERTIFIED MAIL

Steve Keane
Morrison & Foerster LLP
425 Market Street
San Francisco, CA 94105-2482

Dear Messrs. Fellmeth, Howard and Keane:

SUBJECT: Petition to Amend Regulations Related to SB 39 and CAPTA Public Disclosure Requirements

Pursuant to Government Code § 11340.7, the Department accepts in part and denies in part the petition filed by the Children's Advocacy Institute (CAI) on June 9, 2011, requesting amendments to the Manual of Policies and Procedures (regulations) related to the child death and near death disclosure requirements embodied in California Senate Bill 39 (SB 39) and the federal Child Abuse Prevention and Treatment Act known as CAPTA. Interested persons may obtain a copy of your petition from the Department pursuant to Government Code section 11340.7 by contacting the Office of Regulations Development at (916) 657-2586. Additionally, this decision shall be transmitted to the Office of Administrative Law, pursuant to Government Code section 11346, for publication in the California Regulatory Register at the earliest practicable date.

The current SB 39 regulations were adopted to implement the State statutory provisions enacted by SB 39 as informed by the paramount federal law on the same subject. Federal law, best sets forth the purpose of both, which is to provide meaningful public disclosure of information related to child deaths (and in the case of CAPTA, near child deaths) that result from abuse and/or neglect while at the same time protecting the confidentiality of other family and child welfare information unrelated to the fatality. The right to confidentiality is set forth in the federal CAPTA as follows:

> 42 USC § 5106a(b)(2)(A)(x) requires "public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality ...".
>
> While 42 USC § 5106a(b)(2)(A)(viii) requires states to ensure "methods to preserve the confidentiality of all records in order to protect the rights of the child and of the child's parents or guardians, including requirements ensuring that reports and records made and maintained pursuant to the purposes of this subchapter and subchapter III of this chapter shall only be made available to..." a limited list of parties by exception.

Consistent with this federal foundation, the California Legislature adopted SB 39 which similarly attempts to balance the general obligation to maintain family and child confidentiality while making an exception in order to publicize child deaths that are the result of abuse or neglect. In furtherance of both the federal and state law, the California Department of Social Services (CDSS) adopted the SB 39 regulations pursuant to authority provided under Welfare and Institutions Code (W&IC) §§ 10553, 10554 and 10850.4(e)(2) for the purposes of its administration of public social services and specifically for the implementation of CAPTA public disclosure requirements.

The Department adopted the original regulations after substantial input from your organization and others. We continue to value and appreciate CAI's concerns and comments related to the regulations. Your input is important and has prompted many discussions. Additionally, the CDSS has reconvened a workgroup composed of department and county staff, other interested parties and advocates such as CAI to specifically address reviewing and modifying the SB 39 regulations. Many of these same participants, including your organization, participated in the initial workgroup and development of the current SB 39 regulations that went through the public process of regulatory promulgation. CDSS hopes that your organization will re-evaluate its decision to discontinue participating in the SB 39 regulations workgroup. CDSS believes that the workgroup and the Administrative Procedure Act (APA) process will provide regulations that will allow for as much disclosure as possible and be clearer and easier to implement than the amendments you have proposed in this Petition.

With this background, let me turn now to the specific responses to each of the issues raised in the petition.

First, the Department accepts the petition insofar as it requests a change in the overbroad reference to law enforcement rather than the District Attorney as is specified in SB 39. The Department denies the rest of the petition for the reasons hereinafter set forth with respect to each specific item.

MPP § 31-502.42 - Improper requirement to consult with law enforcement—Granted

CDSS appreciates your acknowledgement that this issue is one on which we have reached agreement. CDSS does not believe that consultation with local law enforcement rather than only the District Attorney would necessarily impede the release of SB 39 information. However, the language in SB 39 is clear, and for this reason the regulation, however well meaning, must yield to the statute's terminology. While the District Attorney may properly include local law enforcement in its determination of whether or not the release of specific information would impede a law enforcement investigation; its decision cannot be supplanted by a decision of local law enforcement. Accordingly, this request in your petition is granted.

MPP §§ 31-502.2 *et seq.* – Improper causal link between abuse/neglect and child fatality– Denied.

The CDSS reviewed your comments in prior correspondence and in your petition regarding the causation issue in the context of federal and state law. It appears that we all agree that a causal link is required. However, far from clear is whether the Legislature intended that the causal link be (1) incidental, (2) contributing, (3) more likely than not, or (4) the conclusive cause of death. Your proposed amendment does not address the issue by simply adopting the unclear verbiage of the statute itself. This would provide little illumination, clarification, or guidance, which is the purpose of the regulations, that are intended to implement the statute.

Federal law provides that child welfare information is confidential except with respect to child fatalities that are the result of abuse or neglect (42 U.S.C. §5106a(b)(2)(A)(x)). Consistent with federal law, SB 39 is replete with references to the fact that child fatality information is to be released when it "results from" or is "caused by" abuse or neglect. While we agree with CAI's apparent view that the statute may not require causation be proved beyond a reasonable doubt, we disagree that the presence of incidental abuse or neglect without any evidence that it led to the child's death automatically triggers disclosure and public condemnation of the parents along with public release of confidential information about siblings.

Consistent with federal law, W&IC section 10850.4(b) provides that information is to be released in "cases in which abuse or neglect leads to" a child's death. This language, in addition to the rest of SB 39, demonstrates that a causal connection must exist between the instance of abuse or neglect and the child's fatality. "Instance of abuse or neglect" does not mean abuse or neglect that occurred in the past that has no connection to the fatality. W&IC section 10850.4(b) then sets forth the entities that may make a finding of abuse or neglect that led to the fatality thereby requiring disclosure of SB 39 information. Consequently, it is clear to CDSS that causation is necessary under both federal and state law.

Again, the degree of causation is unclear and we believe this issue needs to be further analyzed and, with input from the SB 39 regulations workgroup, and the regulations modified, in accordance with the APA, as indicated by that analysis. Simply inserting the unclear statute verbatim into the regulations as CAI's petition suggests does little to help resolve this question and is therefore denied.

MPP §§ 31-502.33 and 31-502.34 - No disclosures if perpetrator is not the parent, guardian or foster parent -- Denied

We understand your position that the identity of the perpetrator should not be tied to what information is released. However, the law is clear that only information that pertains to a child fatality that was the result of abuse or neglect is subject to public disclosure (See W&IC § 826.7). While the release of documents based on the identity of the perpetrator may not be the best method to obtain this goal, the regulation was an attempt to ensure that only pertinent information is released. This is consistent with federal and state laws that safeguard the confidentiality of child welfare information that is unrelated to a child fatality resulting from abuse or neglect (See 42 U.S.C. § 5106a(b)(2)(A)(viii)). Again, it is within this context of privacy that the exception for public disclosure of child fatality information is exercised (See 42 U.S.C. § 5106a(b)(2)(A)(x)). This balancing of confidentiality with necessary public disclosure of child fatality information is required by federal law and embodied in SB 39 legislation. The implementing regulations must do the same.

The specific examples for which "disclosure requirements would not be triggered under DSS regulations" are not accurate.

- The first example of a child repeatedly abused by mother's boyfriend and dies would, at a minimum, be investigated for allegations that the death was the result of the negligence of the mother. If substantiated, the information about the fatality would be subject to public disclosure.
- The second example would lead to similar actions taken.
- The third example of the aunt taking a child on a camping trip does not provide enough information to establish whether or not an allegation of neglect would result so will not be addressed here.
- The last example of the foster home where the foster parents and adult son systematically abuse the child who dies would certainly be investigated by both the child welfare agency and Community Care Licensing. If substantiated by the child welfare agency, the information about the fatality would be subject to public disclosure.

This may be an example of the lack of clarity in the current regulations or perhaps CAI's lack of clear understanding of the child welfare services processes and regulations. CDSS acknowledges that the regulations do not clearly set forth this intent, nor do CAI's suggested amendments address the issue.

To the extent that amending regulations would help clarify this intent, CDSS is willing to do so. CDSS, the SB 39 workgroup, and the APA process will address this need for clarity. For these reasons, this portion of your petition is denied.

MPP § 31-502.35 - Disclosures related to non-residential licensed childcare providers – Denied.

The CDSS believes that the concern here is unwarranted. The intent of this regulation was to facilitate public disclosure of child fatality information in instances where the child dies in the care of a licensed childcare provider. Non-residential licensed childcare provider information may be helpful in understanding the circumstances surrounding a child fatality, but this information is not housed in the child's case file. Neither the SB 39 statute nor implementing regulations require that the county release any information that is not in the child's case file. (See W&IC § 10850.4(o)). As a result, that information would not be released and the public may not know how to go about finding it. For that reason, CDSS added this regulation to provide an avenue for obtaining this licensing information. CDSS does not see how this regulation could impede the otherwise authorized release of SB 39 information. Nor has CDSS been made aware of any problems in this area. Therefore, this request is denied.

Unlawful tracking and disclosure of near fatalities under Child Abuse Prevention and Treatment Act (CAPTA) – Denied.

Your final issue is related to the tracking and disclosure of near fatalities pursuant to CAPTA. CDSS plans to address this area with the workgroup at the conclusion of our endeavor currently underway related to the SB 39 regulations. Your organization's petition does not appear to ask for regulatory action and no regulation currently exists with respect to near fatalities therefore this request is denied.

Reconvening of the SB39 regulations workgroup

Thank you for memorializing your concerns and bringing issues regarding the SB 39 regulations to our attention. Your input supports CDSS and the workgroup's efforts to closely review and modify the regulations for clarity as indicated by that review, although not necessarily in the manner you suggest for each issue. We note that the recent reconvening of the SB 39 regulations workgroup has revealed additional issues from other interested parties. The workgroup will continue to explore those issues and CAI's concerns, as well as possible solutions. We welcome your continued participation in the workgroup and the APA process that will address the issues discussed herein as well as others that arise in this effort.

Thank you once again for your informed contributions, which we anticipate will continue in the on-going SB 39 regulations workgroup and the attendant APA process.

Sincerely,

Susan E. Diedrich

SUSAN E. DIEDRICH
Acting Chief Counsel

Cc: Will Lightbourne
Greg Rose
Larry Bolton
Christine Riehl
Zaid Dominguez, ORD

Exhibit F

LOS ANGELES COUNTY
Office of Independent Review
4900 SOUTH EASTERN AVENUE, SUITE 204
COMMERCE, CALIFORNIA 90040
TELEPHONE (323) 890-5425
www.laoir.com

MICHAEL J. GENNACO

BENJAMIN JONES
ROBERT MILLER
JULIE RUHLIN
CYNTHIA L. HERNANDEZ
ANGELICA A. ARIAS

August 30, 2010

Chair Gloria Molina
Supervisor Michael D. Antonovich
Supervisor Don Knabe
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

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

---

[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

---

[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

---

[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]

---

[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

---

[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

---

[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.

---

[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

---

[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
Chief Attorney
Office of Independent Review

cc: Andrea Sheridan Ordin, County Counsel, Office of the County Counsel

William T Fujioka, Chief Executive Officer, Chief Executive Office
Kathy House, Acting Deputy Chief Executive Officer, Chief Executive Office

Patricia Ploehn, Director, Department of Children and Family Services

Nick Ippolito, Justice Deputy, Supervisor Don Knabe
Helen Berberian, Justice Deputy, Supervisor Michael D. Antonovich
Martha Molina-Aviles, Justice Deputy, Supervisor Gloria Molina
Lisa Mandel, Justice Deputy, Supervisor Zev Yaroslavsky
Sylvia Drew Ivie, Chief of Staff, Supervisor Mark Ridley-Thomas

Exhibit G

THE SACRAMENTO BEE sacbee.com

Sacramento judge eviscerates defendant, CPS over girl's death

sstanton@sacbee.com

Published Saturday, Aug. 20, 2011

The court hearing Friday was to sentence 23-year-old Thomas Jerome Martin to prison for beating 3-year-old Valeeya Brazile to death.

But it turned into a public trial of Sacramento County's Child Protective Services, and Superior Court Judge Michael A. Savage found the agency guilty.

In a searing condemnation of CPS, the judge recounted repeated failures to save the little girl from months of beatings that eventually killed her and sent her mother and Martin, the mother's live-in boyfriend, off to prison.

"There is not the slightest evidence in this case that the protection or safety of Valeeya or her brother was ever a priority, or even a significant concern, for the agency or the caseworker charged with their protection," Savage said before he sentenced Martin to prison for the maximum 29 years to life.

Valeeya, a smiling little girl who loved pancakes and was proud of the fact that she could recognize the letter "V," was killed Feb. 5, 2008, in a Fair Oaks apartment. The child had been living with Martin, her 6-year-old brother and her mother, Mia Holmes, who is now serving 12 years.

Martin denies killing Valeeya, and as the judge and three of Valeeya's relatives spoke, he sat quietly at the defense table, yawning, shaking his head and cracking his knuckles.

Savage said the jury that convicted Martin of second-degree murder was the only official body that did anything on Valeeya's behalf.

"The evidence in this case of repeated, systematic, purposeful and brutally inflicted trauma by Mr. Martin on Valeeya is mountainous and undeniable," Savage said. "There is no doubt that this defendant routinely and unmercifully battered this absolutely defenseless 3-year-old, eventually beating her with enough force to end her life.

"And, unlike many others involved in this case, the jury was not fooled, did not shrug and did not shirk their responsibility."

Ann Edwards, director of the Department of Health and Human Services that oversees CPS, said in a statement issued Friday that Valeeya's murder "is tragic and we all mourn her loss.

"Although we cannot comment on the specifics of this case due to confidentiality laws, CPS has made significant practice improvements since 2008."

Valeeya's murder was among a series of high-profile deaths involving children whose families had been known to CPS. The mounting death toll, reported in a series of Bee stories, triggered numerous outside reviews.

Lynn Frank, Edwards' predecessor in the top job, resigned in 2009 as a scathing grand jury report was about to be released.

This month, the county announced that CPS Director Laura Coulthard was resigning under unexplained circumstances.

While CPS advocates say the agency has improved, despite budget cuts, Savage said the agency was more concerned with helping the mother than protecting Valeeya and her brother.

Savage said the social worker's "personal policy" to announce all visits contributed to CPS never discovering that Martin was living in the apartment – or using it as a haven for his marijuana-dealing business.

"With that ludicrous practice in place, the worker showed the ultimate disrespect to the one person she should have been duty bound to protect: Valeeya Brazile," Savage said.

The judge noted that in 2006, when Valeeya was 2 and sitting unrestrained in her mother's car, Holmes tried to run over a boyfriend.

"That behavior was so outrageous that CPS was given the responsibility of providing 'protection' for Valeeya and her sibling," Savage said. "At least, that's what the agency title implied.

"Based on that car assault alone, rational adults might have appropriately concluded that Mia had forever forfeited her right to act as a caretaker for Valeeya or any other child, for that manner."

Instead, CPS returned the children to Holmes after only four months. The social worker assigned to the case, Alexis Hince, protected Holmes' interests over that of the children, Savage said.

"How in the world could such a thing happen while CPS watched ... ?" he asked.

"The case worker in this case testified, 'My job was to help her to get her children back, not to take her children away from her, so my job was to work with her in that goal so she didn't have to be worried she was going to lose her kids.'

"Heaven forbid that Mia Holmes would have had to have a moment's worry about losing her kids."

A 2009 Bee investigation found Hince was one of at least 68 individuals out of 969 CPS workers at the time with a criminal record. Savage said Hince made it clear that CPS knew of her convictions for welfare fraud – one while she worked at the agency. However, the judge said, Hince testified her convictions did not become a problem for her until they were reported in The Bee.

A CPS spokeswoman said Hince has not worked for the county since May 2009.

"It should go without saying that having criminals monitor criminals, especially when children are involved, begs for calamity," Savage said.

Martin sat impassively as the judge, a no-nonsense former prosecutor becoming known for his withering comments at sentencings, described how Martin had wasted his life serving as a baby sitter for Holmes, who was 20 years his senior.

"The defendant, 19 years old and unemployed, spent every day of his life devoted to playing video games, selling marijuana and becoming intoxicated," he said. "He completely escaped the notice of CPS, even though he lived in Mia's apartment every day for months on end."

Courtroom seats filled quickly Friday as five sheriff's detectives filed in and were seated among relatives for both Martin and Valeeya. Before the judge's calm, systematic deconstruction of CPS, Deputy District Attorney Rick Miller brought forward three of Valeeya's relatives to express their anger at Martin.

On one side of the courtroom, where Martin's grandmother and other family members were seated, rumblings of discontent began, and two of the five bailiffs present to keep the peace escorted two men out into the hallway, one of them shouting.

Olga Smith, the little girl's aunt, told Martin he was a "monster."

"I don't know what that little baby could have done to you to make you want to torture her on a daily basis," she said, "to make you want to throw her, to make you want to throw her in the air, to feel her heartbeat, punch her in the stomach, man, and on top of her little head.

"I don't know what would make you want do that. What could she have done to you?"

Eventually, Smith's emotions boiled over and she shouted profanities at Martin, something that often will result in expulsion from court.

The judge did not move to stop her, and Martin feigned boredom.

"It makes you angry," prosecutor Miller told The Bee. "Anybody who looks at this just gets angry."

The entire hearing took just over 30 minutes, and bailiffs escorted the emotional relatives out in groups.

Smith stopped one bailiff and told him, "Go hug that judge for me."

As she left the courtroom, with Martin still seated at the defense table, Smith called out one last message:

"Bye, monster."

Call The Bee's Marjie Lundstrom, (916) 321-1055.