ICAN CHILD DEATH REVIEW TEAM (CDRT) IMPLEMENTED RECOMMENDATIONS

- The ICAN Child Death Review Team (CDRT) began meeting in 1978. In its inception, the CDRT developed criteria for the identification of suspicious child deaths. ICAN began applying these criteria in 1981 and was able to develop a picture of suspicious child deaths in Los Angeles County from 1981 – 1984. These data were published in 1986 and show that the vast majority of these suspicious child deaths were in the infant-toddler age range, with a dramatic decrease in incidence with age, especially in school-aged children. As a result of these findings, ICAN recognized the vulnerability of infants and toddlers and these findings were a major influence in the establishment of child safety for young children as a number one priority in child protective services at the state and local level.

- The ICAN CDRT developed and advocated for a comprehensive drowning prevention program for Los Angeles County. The program provided for a county ordinance for barrier pool fencing and other safety features and a public awareness campaign on the dangers of swimming pools to young children. ICAN then worked with the State Assembly in their efforts to adopt a statewide swimming pool drowning prevention bill. Assembly Bill 3305 was signed into law on September 26, 1996 and required pool fencing on all newly constructed swimming pools as of January 1, 1997. Accidental deaths due to drowning went from a high of 40 in 1993 to 7 such deaths in 2008.

- ICAN's CDRT recommended that requests for additional medical opinions be sought be Children's Social Workers, law enforcement and others when there were questions regarding a medical practitioner who may have been inexperienced or untrained in the area of child abuse and neglect. ICAN advocated that the medical assessments could be improved if it were assured that children with suspicious injuries be evaluated at a center with professional expertise in the area of child abuse and neglect. ICAN formed a medical evaluation committee under the leadership of Dr. Astrid Heger, which resulted in the development of the Centers of Excellence to ensure that children who were suspected of being victims of child abuse/neglect were evaluated by medical practitioners with this expertise. In addition, ICAN also advocated for the passage of SB 645 Polanco, 1998 which provided that, whenever possible, a child should receive a qualified medical evaluation when taken into protective custody.

- The ICAN CDRT recommended that law enforcement and DCFS assure that child abuse homicides be reported to the California Child Abuse Central Index. In addition, it was recommended that the Coroner and law enforcement report all cases of child fatality which would have resulted in a referral to DCFS had the child lived to the Child Abuse Hotline for entry into the Child Welfare Services/Case Management System (CWS/CMS), even if there were no surviving

siblings, so that this information would be accessible should the family have more children and a referral to child protective services was made. This recommendation became state law as a result of advocacy on the part of ICAN (SB 525 Polanco, 1999).

- As a result of reviewing countless cases where no cross-report was made to either law enforcement or the Department of Children and Family Services (DCFS), ICAN's CDRT formed a subcommittee to examine cross-reporting issues. As a result, ICAN was instrumental in assisting the Los Angeles County District Attorney's Office (LADA) and DCFS in obtaining a grant from the Quality and Productivity Commission for the development of the now active Electronic Suspected Child Abuse Reporting System (E-SCARS) which now has DCFS, LADA and all law enforcement agencies in the county actively cross-reporting cases electronically.

- ICAN's CDRT worked with the Los Angeles County Community Child Abuse Councils to create a child fatality prevention kit for countywide distribution to include materials on safe sleeping, drowning prevention, safety tips in and around cars and shaken baby syndrome.

- The Family and Children's Index was developed by ICAN as a result of case reviews that showed that children and families would have contacts with multiple agencies and none of the agencies knew that any other agency had been interacting with that family. It was clear that a system needed to be developed that would allow for improved information sharing among agencies. ICAN was successful in obtaining legislation to allow for such information sharing and subsequently developed the Family and Children's Index in conjunction with the Internal Services Department.

- ICAN's CDRT recommended that children and other family survivors of severe or fatal family violence should be referred for grief counseling. This recommendation stated that crisis grief intervention should begin immediately following the death, and referrals, when possible, should be made to a provider who meets the guidelines outlined by the ICAN Grief and Mourning Professional Support Group. As a result of this recommendations and similar recommendations, the Los Angeles County Juvenile Dependency Court now ensures that all survivors of severe or fatal family violence receive referrals for appropriate grief counseling and other supportive services. ICAN also developed an annual conference on childhood grief and traumatic loss; the Seventh Annual Conference will be held on March 23, 2011.

- The ICAN CDRT recommended that the Coroner's office develop a procedure to report cases of child homicide to DCFS at the time that they make a report to law enforcement. As a result, the Coroner's office now has a system whereby they report all suspicious child deaths to DCFS.

- As a result of recommendations by the ICAN CDRT regarding the development of protocols for the disrobing/rearranging of clothing of children who have been physically harmed or whose siblings have been physically harmed, DCFS has enhanced its policies on the proper disrobing of children to ensure that there are no hidden injuries. ICAN has also recommended that law enforcement shore up their policies on the disrobing of a child who has been physically abused and several law enforcement agencies have strengthened their policies on disrobing as well.

- The ICAN CDRT was involved in the effort to obtain legislation regarding the safe surrender of newborns less than 72 hours of age. ICAN participated in countywide efforts to implement this law under the leadership of Supervisor Don Knabe. ICAN now has primary responsibility for tracking all safely surrendered infants and abandoned deceased or abandoned surviving infants. ICAN also has a speaker's bureau to provide public awareness of the requirements of the Safely Surrendered Baby Law and produces an annual report on this topic, the only one of its kind in the country.

- ICAN's CDRT has made several recommendations regarding the release of newborns from state prison. ICAN has recommended that the California Department of Corrections should develop a standard protocol for the release of infants born to inmates. The protocol should ensure that any relative or home to which the infant is released has been thoroughly investigated for appropriateness by child protective services in the county in which the child and the caregiver will reside. ICAN is currently working with the Los Angeles County Sheriff's Department and the State Department of Corrections on development of a plan to implement this recommendation.

- The ICAN CDRT has made numerous recommendations regarding the need for public awareness efforts to highlight the dangers of co-sleeping and unsafe sleep surfaces. Among these recommendations were the following: LACOE should include information on safe sleeping practices in the curriculum currently in development on the Safely Surrendered Baby Law; The Department of Health Services (DHS) and the Department of Public Health (DPH) should provide information on safe sleeping practices to birthing hospitals for dissemination to new parents; the Perinatal Advisory Council/Los Angeles County (PAC/LAC) and other perinatal councils should be encouraged to continue to survey birthing hospitals in an effort to better determine what these hospitals can do to provide accurate information about the possible dangers in co-sleeping and to encourage safe sleeping practices; the Consumer Produce Safety Commission (Commission) should include information on safe sleeping in products used for infants. In addition, the Commission should encourage the development of new products that facilitate safe sleeping, e.g. infant beds that can be used in or next to the parents' bed to allow a parent to place the infant in a safe place after feeding; law enforcement agencies should be cognizant of the role that substance abuse can

play in co-sleeping fatalities. Responding officers should take steps to determine if a parent might have been under the influence of drugs or alcohol.

- As a result of these recommendations the following actions have occurred: LACOE has included information on safe sleeping practices in their Decisions About a Baby Safely Surrendered Baby Law brochure for use in school curricula, ICAN, DPH and First 5 Los Angeles have developed a brochure on Safe Sleep Tips for Your Baby that has been widely distributed and ICAN is currently engaged in a major Infant Safe Sleeping Campaign under the leadership of Supervisor Mark Ridley-Thomas. We are working with numerous stakeholders including DCFS, DPH, the Department of Public Social Services, the Los Angeles County Coroner's Department and First 5 Los Angeles to develop a broad-based public awareness campaign and other prevention activities aimed at reducing the number of deaths associated with co-sleeping or an unsafe sleep surface.

- In February of 2008, the ICAN Policy Committee approved an exploratory committee to look into the most effective ways that Los Angeles County might develop better identification and investigation of non-fatal severe child injuries. This was in response to the Grand Jury 2006-2007 recommendations about the insufficient communication between hospital professionals and first responders. ICAN formed a committee headed by Dr. Frank Pratt of the Los Angeles County Fire Department, Dr. Carol Berkowitz of Harbor/UCLA and Dr. Michael Durfee of ICAN Associates. Unlike Child Death Review, the main agencies for the non-fatal review process are the hospitals, not the Coroner's Department. The current hospitals involved in this process are: LAC/USC, Harbor/UCLA, Mattel Children's Hospital, Children's Hospital LA, Kaiser Permanente Hospital Sunset, and Sherman Oaks Burn Center. The data from these hospitals represents the majority of all severe injury cases in Los Angeles County. From this process, the main Los Angeles County Pediatric Trauma Centers and Kaiser have begun to measure how their respective hospitals might improve how they identify inflicted trauma and work more closely with each other, DCFS and law enforcement. Cross-training opportunities have also been set up with DCFS, District Attorney's Office, Sheriff's Department, Los Angeles City Attorney's Office, County Counsel, LACOE, and LAPD.

- The Child and Adolescent Suicide Review Team (CASRT) participated on the California State Suicide Strategic Prevention Planning Committee to ensure that the establishment or participation of Suicide Death Review Teams be included as an important component of every county's surveillance activities in programs funded by the Prevention and Early Intervention section of the California Mental Health Services Act.

- The CASRT coordinated activities of the Educator's Suicide Prevention Network (ESPN), a unique partnership of secondary school and university counselors and psychologists formed for the purpose of collecting data and developing joint data-driven suicide outreach and prevention activities.

- The CASRT recommended that the Department of Coroner promptly notify the Los Angeles County Office of Education (LACOE) Division of Student Support Services of all deaths of children age five and above. Following notification of a child's death by the Department of Coroner, the LACOE Division of Student Support Services should then notify the appropriate LACOE district representative so that the child's local school administrator is notified of the child's death. This recommendation has now been implemented and has enabled the schools to be fully prepared to assess the impact the student's death may have on other students and staff so as to organize an effective response.