Protecting Sonoma County's Most Vulnerable from Abuse and Neglect: For the Children

"Hope in Her Hands" illustration by Veronica Napoles © 2026

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SUMMARY

In response to a complainant's request for investigation, the Grand Jury researched the operation of the Department of Human Services Child Protection Hotline. The Grand Jury found that responses by Hotline social workers to reports of abuse were handled in a professional and consistent manner.

Hotline staff decisions to further investigate were supported by a sophisticated screening tool and professional judgement. When no further investigation is made, the report is said to be "Evaluated Out (EO)". If a given case is evaluated out four times in 12 months, it is reexamined by the Hotline staff and department supervisors. However, it is unclear whether this 4 EO protocol is the optimal threshold for intervention to prevent child abuse or neglect.

The complainant's allegation that a child had died after being evaluated out led the Grand Jury to examine the work of the Sonoma County Child Death Review Team (CDRT), an interagency group charged by statute with identifying unanticipated or accidental child deaths and developing a statistical description of deaths as an overall

indicator of the status of children in the County. The Grand Jury learned that the CDRT has not published a mandatory annual report since 2014. The Grand Jury also found that the Sonoma County CDRT did not employ many of the best practices used by other CDRT teams in California and nationwide. The confidentiality of data concerning children prevented the Grand Jury from either confirming or refuting the complainant's allegation that a child had died after being evaluated out by Hotline staff.

BACKGROUND

The Grand Jury received a request for investigation alleging that the Sonoma County Department of Human Services failed to protect vulnerable and abused children whose cases are handled by the Department's Family, Youth and Children Division (FY&C). One focus of the complaint was FY&C's telephone hotline for receiving calls reporting child abuse or endangerment. The complainant alleged that at least one child had died after FY&C failed to respond to a hotline call reporting abuse. Accordingly, the Grand Jury investigated the operation of the hotline in depth to determine if any children had, in fact, died or suffered severe harm after being reported to the hotline. This investigation led to an examination of the work of Sonoma County's CDRT which, among other things, creates a statistical survey of child mortality and its causes.

METHODOLOGY

The Grand Jury interviewed social workers and supervisors who work on the FY&C hotline, individuals who participate in the CDRT, current and former legal professionals, and child advocates.

The Grand Jury also researched the law and literature pertaining to CDRTs in California and nationwide.

DISCUSSION

The Child Protection Hotline

The Hotline maintained by FY&C operates 24 hours a day, seven days a week. It is staffed by professional social workers. It is an entry point into the County's child protective services system. When a call concerning child endangerment is received,

social workers evaluate what, if any, further investigation is warranted, and the appropriate timeframe for response.

Since 2010, this process has relied on the Structured Decision Making (SDM) system, a suite of online applications in wide use nationwide and mandatory in California. The SDM consists of evidence-based decision trees that provide a standardized framework in which social workers apply professional judgement to arrive at an objective appraisal of each case. The SDM Manual is available for review here.

Social workers respond to incoming calls based on their determination of the degree of risk or endangerment to the child. An emergency determination requires further in-person assessment within 24 hours. For non-emergency cases, an in-person assessment is completed within 10 days. If the social worker finds no need for intervention, the case is “evaluated out”and no additional action is taken, although callers may be referred to other community resources and support services.

Hotline social workers frequently consult with supervisors while assessing cases, and supervisors regularly review decisions to investigate or EO a given case. All decisions to respond or EO are made by Hotline supervisors. When a case has been evaluated out four times within the previous 12 months, it is subjected to review by supervisors and staff. However, FY&C was unable to articulate the rationale for choosing the number four as the trigger for such review. The Grand Jury questioned whether four incidents is the optimal threshold for a more thorough review.

The Grand Jury sought statistics on the number of children, if any, who had died or suffered abuse after their cases had been evaluated out. FY&C was unable to provide that information, due to confidentiality rules. Without this information, the Grand Jury could not determine the effectiveness of the process. It is unclear whether the agency uses these data to evaluate the impact of its decisions.

Child Death Review Team

A Child Death Review Team (CDRT) is an interagency group that assists officials in identifying and reviewing suspicious child deaths. It also facilitates communication

among the various entities involved in child abuse and neglect cases. California Penal Code §11174.32 is the statutory basis for CDRTs. In developing such a team, a county may solicit suggestions and comments from, among others, experts in forensic pathology, pediatricians, coroners, medical examiners, child protective services, county health department staff, and law enforcement personnel. The statute anticipates that a county will develop protocols to help determine whether abuse or neglect contributed to a child's death. It also anticipates the creation of statistical data. Notably, CDRTs are not mandatory. Counties *may* but are not required to establish a CDRT. However, once a CDRT is established, it must publish its findings, conclusions, data and recommendations annually. View California Penal Code § 11174.32 here.

One consequence of the non-mandatory nature of PC § 11174.32 has been a wide variation in responses to the statute among California's 58 counties. A 2023 survey conducted by the California Citizen Review Panel on Critical Incidents (CICRP) found that 10 counties do not have a fully functioning CDRT. There is a lack of understanding on the part of CDRTs as to whether their role is investigative, deliberative, or administrative. CDRTs have expressed a need for statewide guidance and training.

The Sonoma County CDRT was established in 1993 to further the purposes of PC § 11174.32. Members of the team include experts in forensic pathology, social and health services staff, physicians, law enforcement personnel, and district attorneys. That is, professionals whose work can involve child death cases. The team makeup reflects the areas of expertise cited in PC § 11174.32.

When the Grand Jury turned its attention to the CDRT, it learned that the required annual report had not been issued since 2014. This led to an examination of the work of the CDRT, and to an inquiry into standards applicable to such work.

The 2014 CDRT 5-Year Report presented data on the deaths of children for the years 2008-2012. Though it covered five years, it demonstrates the kind of information an annual report should provide. It reviewed the numbers of deaths from medical causes, accidents, sleep-related causes, homicide, and abuse or neglect. The report examined statistical trends, and contextualized the data by age, gender, and ethnicity. A

significant finding was that in 22% of child deaths, abuse and neglect was a direct or contributing cause. The absence of an annual CDRT report since 2014 means that data of this kind is not available to service providers, policymakers, or the public, and therefore cannot be used to strengthen protection of vulnerable children. View the 2008-2012 Child Death Review Team 5 Year Report here.

CICRP Toolkit

In 1996, the California Department of Social Services established Citizen Review Panels, in accordance with federal guidelines. These panels consist of volunteers who are child welfare professionals, educators, community leaders, former recipients of social services, and others with relevant experience. One such panel is the CICRP, which focuses on reducing child fatalities and near-fatalities caused by abuse or neglect.

Considering the inconsistent implementation of CDRTs throughout California, CICRP developed a Toolkit for use by counties wishing to create or improve CDRTs. CDRT Toolkit - Child and Family Policy Institute of California is available for review here.

The Toolkit emphasizes the need for detailed operating protocols, bylaws, and strong leadership. It provides links to state and national resources and offers numerous other aids for effective management of CDRTs. The stated purpose of the Toolkit is to enable California's counties to apply best practices for each CDRT. It effectively establishes standards by which the performance of Sonoma County's CDRT may be assessed.

Among the best practices identified by the Toolkit are those pertaining to the following:

Leadership

CDRTs benefit from the sustained commitment of a chairperson who not only understands the importance of the work of the team, but who builds relationships with other county agencies and the public. The Toolkit proposes that the CDRT designate a representative to present the team's work to the community, a "champion," whom both policymakers and the public recognize and respect.

The current “co-chairs” of the Sonoma County CDRT are from the Department of Health Services and the District Attorney’s Office. No single individual has been identified, and there is no one who acts as the team’s “champion.”

Protocols, Policies, and Procedures

The Toolkit emphasizes that specific detailed operating protocols, policies, and procedures are essential to the performance of CDRT’s role. The Grand Jury was unable to find any such documents, and CDRT team members who were interviewed were unaware of them. Although the CDRT meets quarterly to review cases, minutes of meetings are not kept. When team members see opportunities to improve child welfare, their recommendations are not recorded and tracked to ensure implementation.

Training

The Toolkit notes that training of team members is essential and provides links to public and private resources. The Sonoma County CDRT offers no training of any kind for its members or those members’ staffs.

Funding

There is no state funding for county CDRTs, though other funding sources exist. In Sonoma County, the Board of Supervisors (BOS) indirectly funds the CDRT through its support of the Department of Health Services, which is a member and co-chair. However, the extent of such support is unclear, as there is evidence that one reason for the CDRT’s failure to produce a report since 2014 is a lack of funds to support data collection. The Toolkit notes that direct funding of the CDRT will greatly enhance its work and identifies the BOS and the Human Services and Health Departments as appropriate sources for such funds.

FINDINGS

F1. The Family, Youth and Children Division was unable to explain the rationale for reexamining cases that had been evaluated out four times within the previous 12 months. Therefore, it is unclear whether the practice is an effective response to reports of child neglect and abuse.

F2. Because the Sonoma County CDRT lacks funding for acquisition of data and retention of records, production of its mandated reports may be impaired.

F3. By failing to report its findings for the past 12 years, the Sonoma County CDRT has not fulfilled its mandate to educate service providers, policymakers, and the public about the risk factors for child neglect, abuse and death. Annual reporting could have led to systemic improvements to alleviate or prevent risks to vulnerable children.

F4. The Sonoma County CDRT lacks leadership. Without formal leadership the CDRT has failed to meet statutory requirements.

F5. The Sonoma County CDRT is without an effective spokesperson for child advocacy in the community. This results in lost opportunities to inform and influence the many service providers and the public regarding children's health and safety in the County.

F6. The Sonoma County CDRT's failure to identify a single leader, develop written bylaws and protocols, provide training for its members, and generate minutes of its meetings has impaired the development of institutional memory.

RECOMMENDATIONS

R1. By October 1, 2026, the BOS shall direct the FY&C to determine the origin and efficacy of reviewing decisions to evaluate out a case which has been reported to the Hotline four times in the previous 12 months.

R2. By October 1, 2026, the BOS shall direct the Sonoma County CDRT to establish procedures, effective by April 1, 2027, that include the following:

- Identify a single individual as chairperson
- Designate a spokesperson to the community
- Create written bylaws and protocols governing its work
- Develop training for members and members' staffs
- Publish a report of its findings annually

R3. By October 1, 2026, the BOS should allocate appropriate resources to assist the Sonoma County CDRT in its activities.

REQUIRED RESPONSES

Pursuant to Penal Code § 933.05, the following responses are *required*:

Sonoma County Board of Supervisors: respond to F1-F6 and R1-R3 within 90 days of receipt of this report.

COMMENDATIONS

1. The FY&C Hotline for reporting child abuse and neglect is staffed by professional social workers who rely on the SDM tool and professional judgment in responding to reports. This results in the consistent application of services to the community.

2. Because supervisors' review of decisions by hotline intake workers are collaborative, there is a unity of effort in reaching the best outcomes for children.

BIBLIOGRAPHY

California Penal Code §11174.32

California Penal Code section 11174.32 (2025)

Child Death Review Team 5-Year Report; A Review of Sonoma County Infant and Child Deaths 2008-2012

Child Death Review Team 5 Year Report

California Child Death Review Team Toolkit – September 2023

CDRT Toolkit - Child and Family Policy Institute of California

SDM Policy and Procedures Manual

CA SDM PP Manual

CA SDM/California SDM Policy and Procedures

CA SDM Policy and Procedures Manual

ABBREVIATIONS

BOS - Board of Supervisors

CDRT - Child Death Review Team

CICRP - California Citizen Review Panel on Critical Incidents

EO – Evaluated Out

FY&C - Family Youth & Children

SDM - Structured Decision Making

GLOSSARY

Evident Change - Formerly the National Council on Crime & Delinquency and Children's Research Center is a nonprofit that uses data and research to improve our social systems.

NCCD - In 1973 the Children's Research Center was created as part of the NCCD to encompass reform of the child welfare system, NCCD changed its name to Evident Change in December.

Structured Decision-Making Tool - SDM is a suite of instruments used to help guide the thinking of case workers when they are making determinations about the overall safety and well-being of children. The Children's Research Center of NCCD (Evident Change) provides the SDM Policy and Procedures Manual and social workers are trained by the DCFS University.

Reports issued by the Grand Jury do not identify individuals interviewed. Penal Code § 929 requires that reports of the Grand Jury not contain the name of any person or facts leading to the identity of any person who provides information to the Grand Jury.