Table C
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed and evaluated state laws and regulations that are applicable to fetal death registrations.
2	Evaluate the statewide oversight of the fetal death and stillbirth certificate processes, including any relevant policies and procedures.	• Reviewed relevant CDPH documents and interviewed CDPH's Vital Records staff to determine the extent of oversight and support CDPH has provided to local registrars, funeral homes, hospitals, physicians, and coroners to ensure their adherence to applicable fetal death registration timelines outlined in state law. • Reviewed relevant CDPH documents and interviewed CDPH's Vital Records staff to assess the adequacy of CDPH monitoring of fetal death registration timeliness, determined the extent of its follow-up with relevant parties causing registration delays, and evaluated whether these efforts were likely to positively affect the registration process. Determined what additional actions, if any, CDPH could take to help ensure timely registration. • Interviewed key staff at the Medical Board and the Funeral Bureau. Reviewed complaints related to fetal death registrations that the Medical Board provided for the years 2018 through 2023, and complaints resulting in citations that the Funeral Bureau provided for the years 2017 through 2022, to assess the extent of their enforcement efforts related to ensuring that physicians and funeral homes complied with the applicable fetal death registration timeliness requirements. • Reviewed policies and procedures that the Medical Board and the Funeral Bureau use related to their review of physician and funeral home compliance with fetal death registration timeline requirements. • Assessed whether each entity's reviews of relevant complaints against physicians and funeral homes were in compliance with applicable policies and state law.
3	To the extent possible, assess the timeliness of the fetal death and stillbirth certificate processes and determine for the most recent five years the CDPH average, statewide county average, and individual county averages of processing times for issuing such certificates. If statewide county averages are not available, determine for the most recent five years the average processing times for fetal death and stillbirth certificates for the four selected counties.	• Using statewide data for 2017 through 2022, determined the statewide average and median time to complete a fetal death registration and to issue a burial permit. Determined the average processing time for CDPH to complete the State's additional step of certifying a fetal death. • Using detailed FDRS data obtained from CDPH, for 2017 through 2022, segmented the registration process into six key steps and determined the average processing time for each step of the registration process for each local registration district statewide. • Selected Placer and Sacramento as two local registration districts to review per audit request. After reviewing statewide data on the volume of cases and the average time taken to register a fetal death for each local registration district statewide, selected Los Angeles and Contra Costa as the other two local registration districts for review.

	AUDIT OBJECTIVE	METHOD
4	At the four selected counties, compare and contrast the following: a. The roles and responsibilities of each agency, office, and individuals working on behalf of each agency or office involved in the fetal death and stillbirth certificate process. b. The policies and procedures used and training received by the various agencies, offices, and individuals involved in the process. c. The impact that differences in county processes or other external factors, like COVID-19, have on the amount of time it takes to process fetal death and stillborn certificates. d. The differences, if any, in the process for issuing fetal death and stillbirth certificates that exist depending on whether the fetal deaths and stillbirths happen in a hospital or at home and those that are attended by a medical provider versus those that are unattended.	• Interviewed relevant staff from the four local registrars and reviewed duty statements or job descriptions to understand and compare key roles and responsibilities related to fetal death registration, including the circumstances under which coroners become involved. • Interviewed staff at each of the four local registrars and reviewed relevant documentation to identify any training they have received and policies and procedures they follow related to the fetal death registration process. Determined that, in general, all four districts use CDPH guidance as their primary criteria for the registration process. • Evaluated any other procedures and practices the local registrars use to identify any key differences or best practices. • Interviewed staff from CDPH, the four local registrars under review, and funeral homes, hospitals, and coroners to obtain perspective on the causes for registration delays, including whether COVID-19 or legal requirements for unattended fetal deaths impacted the time it took to complete fetal death registrations. Using CDPH data for calendar years 2017 through 2022, determined whether there were significant differences or trends in fetal death registration processing times, before and after COVID-19, and related to unattended fetal deaths, and whether they impacted the processing time of fetal death registrations. • Using FDRS data for calendar years 2017 through 2021, judgmentally selected 80 fetal death registration cases—20 from each of the four local registrars reviewed—considering factors such as time taken overall and at specific phases, entities involved, and other factors. Evaluated the data for each case to determine the extent to which actions by the local registrar, funeral home, hospital, physician, or coroner significantly impacted the processing time of fetal death registrations. Interviewed staff from the four local registrars under review, along with staff from associated funeral homes, hospitals, and coroners to obtain additional perspective about the results of our data analysis.
5	Review and assess any other issues that are significant to the audit, including identifying any improvements that would result in a more efficient timeframe for processing fetal death and stillbirth certificates.	Using our analyses under audit objectives 2, 3, and 4, identified strategies and developed related recommendations to help mitigate delays and improve the oversight of the fetal death registration process.

Source: Audit workpapers.