POLICY IX-C: CHILD NEAR FATALITIES AND FATALITIES

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Although an infrequent occurrence, near fatalities and fatalities of children who are receiving services or who have recently received services from the Division do occur. Fatalities may occur due to an illness or other medical condition, as a result of child neglect or abuse, or because of a non-child maltreatment related accident. Regardless of the cause of a near fatality or fatality, these events are extremely traumatic for the family of the child, the foster family (if applicable), Division staff, and service providers. Division staff will be supportive and helpful to those who have had a meaningful and/or legal relationship with the child including relatives and foster parents. Division leadership and management will recognize the importance of appropriately supporting staff who worked directly with the child and encourage those staff members to seek appropriate, individualized services as needed.

Pursuant to A.C.A. §12-18-103 a near fatality (also referred to in DHS Policy 1090 as a serious injury) means an act that, as certified by a physician, places a child in serious or critical condition. As such, the Division will rely on the involved medical facility's designation of the child's condition in determining if a particular incident meets the criteria of near fatality as defined by law.

The Division of Children and Family Services County Office will immediately (within one hour) notify the appropriate Area Director or designee and the Assistant Director of Community Services or designee and initiate action to ensure the safety of other children in the home when DCFS becomes aware of a child near fatality or fatality that may be the result of maltreatment and:

A. **The child or sibling of the child ~~i~~was a subject of a pending child maltreatment investigation or a child maltreatment investigation within the preceding 24~~12~~ months.**
B. **The child or sibling of the child is a client in any open supportive or protective services or out-of-home case.**
C. **The child or sibling of the child was a client in a supportive, protective services, or out-of-home case during the previous 24~~12~~ months.**

The Assistant Director of Community Services or designee will immediately (within one hour) notify the Division Director who will notify the DHS Deputy Director, DHS Chief Counsel (per DHS Policy 1090) and the DHS Director of Communications. As such, the Division will not automatically issue press releases on cases of child near fatality or fatality related to maltreatment but will respond to requests for information as they are received in consultation with the DHS Director of Communications.

The Division will ensure that DHS Policy 1090 adhered to regarding all near fatalities and fatalities.

When a fatality occurs in an open out-of-home case, ~~T~~he Division will respectfully assist and support the parents in making funeral arrangements or take other actions deemed necessary by the Area Director.

Because quality improvement and accountability guides the work of DCFS, an internal team of DCFS staff will meet following a child fatality that meets at least one of the criterion established in items A-C above ~~related to child maltreatment~~ to review the case and identify systemic issues, public health concerns, and where practice could have been improved in that particular case in an effort to prevent future child fatalities and near fatalities.

Following a DCFS internal near fatality or fatality review, the Division will also be responsible for holding a~~n external review~~ meeting with the External Child Near Fatality and Fatality Review Team to review~~of~~ any certified near fatality or fatality for which there is a current child death investigation (i.e., related to child maltreatment) ,with which. ~~the Division has had involvement with the family during the previous twelve months. The DCFS Director will appoint members to the DCFS External Child Near Fatality and Fatality Review Team.~~

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~~Information regarding child fatalities will also be entered into the National Child Death Review Case Reporting System (NCDRCRS). Any child fatality meeting the criteria for an external review based on the information entered into the NCDRCRS will be reviewed by the Arkansas Child Death Review Panel.~~

~~T~~Finally, ~~t~~he External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ will ~~also~~ conduct a comprehensive review of the circumstances leading to the near fatalities and fatalities of children who have been reported through the Arkansas Child Abuse Hotline. Based on the findings of the reviews, the External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ will develop recommendations and actions, as appropriate, to be implemented to prevent other~~future~~ child near fatalities and fatalities.

~~Per A.C.A. § 9-25-105(b)(1-15), the~~The External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ will be comprised of the following members:

A. DCFS Director or designee;
~~A.~~B. DCFS Assistant Director of Community Services or designee;
~~B.~~C. DCFS Family Service Worker (FSW) Supervisor designated by the DCFS Director;
~~C.~~D. DCFS FSW Investigative Supervisor designated by the DCFS Director;
~~D.~~E. Crimes Against Children Division Commander or designee;
~~E.~~F. Arkansas Commission on Child Abuse, Rape, and Domestic Violence Executive Director or designee;
~~F.~~G. Children's Advocacy Centers of Arkansas Director or designee;
~~G.~~H. Arkansas CASA Association Director or designee;
~~H.~~I. Arkansas Children's Hospital's Team for Children at Risk and Arkansas Children's House Director or designee;
~~I.~~J. Dependency-Neglect Attorney Ad Litem Director or designee;
K. Office of ~~Policy and Legal Services~~Chief Counsel Director or designee;
L. The Governor's Senior Advisor for Child Welfare;
M. A member of the Arkansas Child Death Review Panel;
~~J.~~N. A member of the Arkansas Department of Health;
~~K. Office of the Prosecutor Coordinator Director or designee;~~
~~L.~~O. A member appointed by the chair of the House Subcommitee on Children and Youth of the House Committee on Aging, Children and Youth, and Legislative and Military Affairs;
~~M.~~P. A member appointed by the Chief Justice of the Arkansas Supreme Court.~~;~~
~~A member appointed by the Governor;~~
~~N. A member to be designated by the Arkansas Child Abuse, Rape, and Domestic Violence Commission.~~

~~Per A.C.A. § 9-25-105(n) a committee member will not be reimbursed for expenses to travel to or participate on the committee.~~

~~The Child Death and Near Fatality Multidisciplinary Review Committee will review all child deaths of children under the age of eighteen who had contact with the Division within twenty-four months before the fatality as determined by comparing records of death from the Arkansas Department of Health, Division of Vital Records with information in CHRIS. The sharing of information between the Division of Vital Records and Division of Children and Family Services will be governed by a Memorandum of Understanding between the two agencies.~~

~~The Child Death and Near Fatality Multidisciplinary Review Committee will also review all deaths and near fatalities of children reported through the Arkansas Child Abuse Hotline.~~

This External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ will meet at least quarterly each calendar year. The committee meetings will be closed and information discussed at the meeting will be confidential. Individuals who are not members of the External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ will not be allowed to attend or otherwise participate in a committee meeting unless a majority of the members vote to request the attendance or participation of a non-committee member.

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~~The Child Death and Near Fatality Multidisciplinary Review Committee will produce an annual report that will contain a summary of findings, actions taken by the Department of Human Services or other entities, and recommendations to each branch of the state government to improve practices and prevent future child near fatalities and fatalities. This annual report will be presented to the House Committee on Aging, Children and Youth, Legislative and Military Affairs and will be made available on the Department of Human Services' public disclosure of child deaths and near fatalities website.~~

These external reviews will provide the Division and other stakeholders involved with child serving systems with an additional opportunity to collaboratively review the facts surrounding the fatality and accurately assess child deaths, work to improve systemic issues, address public health concerns, and determine recommendations to improve practice and work together as a system to prevent future child fatalities and near fatalities.

PROCEDURE IX-C1: Near Fatality of Child

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In the case of a child near-fatality the county office will:

A. Report maltreatment or any suspected maltreatment to the Child Abuse Hotline immediately if it has not already been called into the Child Abuse Hotline.

~~A.~~B. Notify the Area Director of the near fatality of the child immediately.

~~B. Immediately (within 24 hours or as required by the Director) prepare CFS-305: Near Fatality Disclosure Case Briefing Summary on the situation that caused the near fatality and fax or email it to the CPS Manager who will forward it to the following entities:~~

~~1) Appropriate Area Director~~
~~2) Office of Community Services~~
~~3) Quality Assurance Unit~~

~~A. Ensure the completion of CFS-306: Documentation of Child's Medical Episode Related to Near Fatality by the child's attending physician or other attending medical personnel who treated the child during the child's medical episode.~~

~~B. Fax or email the completed CFS-306: Documentation of Child's Medical Episode Related to Near Fatality to the CPS Manager within 72 hours of the near fatality.~~

~~C. Place a copy of the CFS-306 in the child's record.~~

The Area Director will:

A. Schedule and hold the internal review of the near fatality within 14 calendar days (or earlier upon the DCFS Director's request) with DCFS staff to ascertain information involving facts surrounding the near fatality. The meeting will include:

1) FSW
2) County Supervisor/Investigative Supervisor
3) Area Director
4) Child Protective Services (CPS) Manager
5) Assistant Director of Community Services or designee
6) Other appropriate staff as needed

The individuals above may participate in the meeting by phone as appropriate.

B. Immediately (within 24 hours or as required by the Director) prepare CFS-307: Near Fatality/Fatality Disclosure Case Briefing Summary and the CFS-309: Children and Family Services Internal Review of Child Near Fatality/Death and fax or email it to the CPS Manager.

C. Ensure the completion of CFS-306: Documentation of Child's Medical Episode Related to Near Fatality by the child's attending physician or other attending medical personnel who treated the child during the child's medical episode.

The CPS Manager will:

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A. Review the completed CFS-307: Near Fatality/Fatality Disclosure Case Briefing Summary and forward it to:
   1) Assistant Director of Community Services or designee
   2) Assistant Director of Prevention and Reunification or designee
   3) Quality Assurance Unit Manager or designee

~~A.~~B. Request updated information from the counties as needed.

~~B. Schedule a meeting with DCFS staff to ascertain information involving facts surrounding the near fatality if needed. The meeting will include the following:~~
   ~~1) FSW~~
   ~~2) County Supervisor/Investigative Supervisor~~
   ~~3) Area Director~~
   ~~4) Assistant Director of Community Services or designee~~
   ~~5) DCFS Director~~
   ~~6) Appropriate staff as needed~~

C. Review the CFS-306: Documentation of Child's Medical Episode Related to Near Fatality.

~~D. Complete and transmit the DHS Incident Reporting Screen data fields in IRIS within 72 hours of the occurrence of the incident (completion of DHS-1910 is only required in the absence of computer transmission capability).~~

~~E.~~D. Work with the chair of the External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ as appropriate in coordinating logistics and necessary reports for the quarterly External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~.

~~F.~~E. Prepare the list of all ~~child deaths and~~certified near fatalities as well as all records related to the child and send the information to the members of the External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ at least fourteen calendar days prior to a scheduled committee meeting.
   1) This information may be sent as hard copies or electronically.

~~G. Prepare a summary of any near fatality to include any DHS actions and recommendations for the Child Death and Near Fatality Multidisciplinary Review Committee prior to each quarterly meeting.~~

The Quality Assurance Unit will:

A. Enter information regarding near fatalities related to maltreatment on the Child Fatality /Near Fatality Disclosure Log.

PROCEDURE IX-C3: Child Fatality Notification

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The Crimes Against Children Division will:

A. Investigate child maltreatment allegations according to established procedures.
B. If safety concerns are identified, immediately contact DCFS to conduct the remaining components of the Health and Safety Assessment (Safety Planning and Investigation Risk Assessment) as appropriate.
   1) DCFS will then be assigned as the secondary investigator on that particular investigation.
C. Coordinate with law enforcement and relinquish their case to them if the possibility of criminal charges is involved and law enforcement prefers to assume responsibility.
D. Initiate needed affidavits for legal action.
E. Keep the county office advised of the status of the investigation, including initial notification when appropriate.
F. Share all information with the parents, offender, and victim.

The Family Service Worker assigned as secondary to the investigation will:

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A. If CACD contacted DCFS to conduct the remaining components of the Health and Safety Assessment (Safety Planning and Investigation Risk Assessment), immediately ascertain the safety of other children remaining under the care of the alleged offender and develop a protection plan or pursue protective custody, as appropriate.
B. Provide any services to the family as needed.
C. Enter all contacts with the family into the CHRIS.
D. Share all information about prior contacts with the family with agency staff and law enforcement who are investigating the case.

In the case of a fatality of a child the county office will:

A. Immediately notify the Area Director by phone.
B. Report maltreatment or any suspected maltreatment to the Child Abuse Hotline immediately if it has not already been called into the Child Abuse Hotline.
C. Immediately (within 24 hours or as required by the DCFS Director) complete CFS-307: Child Near Fatality/Fatality Disclosure Case Briefing Summary and CFS-308: Child Fatality Review Packet Checklist and forward the CFS-307 and CFS-308 and all required documents listed on CFS-308 to the CPS Manager.
D. Place copies of CFS-307 and CFS-308 in the child's record.
E. If the child fatality is a result of a prior near fatality event and the fatality occurred more than 24 hours after the near fatality, ensure the completion of CFS-3056-A: Documentation of Near Fatality Subsequently Resulting in Fatality by the child's attending physician or other attending medical personnel who treated the child during the child's medical episode.
F. Fax or email the completed CFS-3056-A: Documentation of Original Near Fatality Subsequently Resulting in Fatality to the CPS Manager within 72 hours of the fatality, if applicable.
G. Place a copy of the CFS-3056-A in the child's record, if applicable.

The Area Director or designee will:

A. Notify the Assistant Director of Community Services or designee immediately by phone.
B. Ensure employee immediately (within 24 hours or as required by DCFS Director) completes and forwards completed CFS-3077: Child Near Fatality/Fatality Disclosure Case Briefing Summary and forward the CFS-3077 to the CPS Manager.
C. Complete the CFS-308: Child Fatality Review Packet Checklist ~~and CFS-309: Child Fatality Internal Review Staffing~~ within seven calendar days ~~72 hours (or the next business day if on a weekend or holiday)~~ of the fatality and fax or email both forms along with all required documents listed on the CFS-308 to the CPS Manager.
    1) Schedule and hold an Internal Fatality Review meeting with DCFS staff within 14 calendar days of the fatality in order to ascertain the facts surrounding the child's death. The meeting will include:
        a) FSW
        b) CACD Investigator
        c) County Supervisor/Investigative Supervisor
        d) CACD Supervisor
        e) Area Director
        f) CPS Manager
        g) Assistant Director of Community Services or designee
        h) Assistant Director of Prevention and Reunification or designee
        ~~C.~~ i) Any other needed staff as appropriate
D. Expeditiously provide all other information requested by CPS Manager.
~~D.~~

The Assistant Director of Community Services or designee will:

A. Notify the DHS Director of Communications by phone within one hour of occurrence if the incident is expected to receive media attention.

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B. Discuss relevant details of the case with the DHS Director of Communications to determine the type of information that will be released to the media. Pertinent information that can be released will include disclosable information as provided by the DHS Disclosure Policy (DHS Policy Group 4009).
   1) Any information concerning siblings or attorney-client communications will not be released.
C. Remain in direct contact with appropriate field personnel in order to develop a clear understanding of the circumstances surrounding the incident.

The CPS Manager will:

~~A.~~ Review CFS-30~~77~~: Child Near Fatality/Fatality Disclosure Case Briefing Summary.

A.

B. Forward the CFS-30~~77~~: Child Near Fatality/Fatality Disclosure Case Briefing Summary to:
   ~~1)~~ Assistant Director of Community Services or designee
   1)
   2) Assistant Director of Prevention and Reunification or designee
   ~~2)~~ DCFS Director
   3)
   ~~3)~~ DHS Director of Communications
   4)
   ~~4)~~5) DHS Deputy Director over DCFS

~~C. Schedule an Internal Fatality Review meeting with DCFS staff within 72 hours of the fatality in order to ascertain to the facts surrounding the child's death. The meeting will include:~~
   ~~1) FSW~~
   ~~2) CACD Investigator~~
   ~~3) County Supervisor/Investigative Supervisor~~
   ~~4) CACD Supervisor~~
   ~~5) Area Director~~
   ~~6) Any other needed staff as appropriate~~

~~D.~~ Review the CFS-308: Child Fatality Review Packet Checklist and all required documents listed on CFS-308 ~~and the CFS-309: Child Fatality Internal Review Staffing in preparation for the Internal Fatality Review~~.

C.

~~E.~~ Enter information regarding the fatality on the Child Death Log and Child Death Public Disclosure Log.

D.

~~F. Enter information into the online National Child Death Review Case Reporting System.~~

~~G. Complete and transmit the DHS Incident Reporting Screen data fields in IRIS within 72 hours of the occurrence of the incident (completion of DHS 1910 is only required in the absence of computer transmission capability).~~

~~I.~~ Serve as the point of contact for follow-up and subsequent briefings of the Assistant Directors, Division Director, and DHS Deputy Director.

E.

~~J.~~ Work with the chair of the External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ as appropriate in coordinating logistics and necessary reports for the ~~quarterly~~quarterly ~~-~~External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~.

F.

~~K.~~G. Prepare the list of all child deaths ~~and near fatalities~~ as well as all records related to the child and send the information to the members of the External Child Near Fatality and Fatality Review Team ~~Child Death and Near Fatality Multidisciplinary Review Committee~~ at least fourteen calendar days prior to a scheduled committee meeting.
   ~~1)~~ This information may be sent as hard copies or electronically.
   ~~L.~~1) ~~Prepare a summary of any near fatality to include any DHS actions and recommendations for the Child Death and Near Fatality Multidisciplinary Review Committee prior to each quarterly meeting.~~

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The Quality Assurance Unit will:

A. Enter information regarding fatalities related to maltreatment on the Child Fatality /Near Fatality Disclosure Log.

~~The Crimes Against Children Division will:~~

~~A. Investigate child maltreatment allegations according to established procedures.~~

~~B. If safety factors are identified, immediately contact DCFS to conduct the remaining components of the Health and Safety Assessment (Safety Planning and Investigation Risk Assessment) as appropriate.~~

~~1) DCFS will then be assigned as the secondary investigator on that particular investigation.~~

~~C. Coordinate with law enforcement and relinquish their case to them if the possibility of criminal charges is involved and law enforcement prefers to assume responsibility.~~

~~D. Initiate needed affidavits for legal action.~~

~~E. Keep the county office advised of the status of the investigation, including initial notification when appropriate.~~

~~F. Share all information with the parents, offender and victim.~~

~~The Family Service Worker will:~~

~~A. If CACD contacted DCFS to conduct the remaining components of the Health and Safety Assessment (Safety Planning and Investigation Risk Assessment), immediately ascertain the safety of other children remaining under the care of the alleged offender and develop a protection plan or pursue protective custody as appropriate.~~

~~B. Provide any services to the family as needed.~~

~~C. Enter all contacts with the family into the CHRIS.~~

~~D. Share all information about prior contacts with the family with agency staff and law enforcement who are investigating the case.~~

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POLICY IX-C: CHILD NEAR FATALITIES AND FATALITIES

07/2018

Although an infrequent occurrence, near fatalities and fatalities of children who are receiving services or who have recently received services from the Division do occur. Fatalities may occur due to an illness or other medical condition, as a result of child neglect or abuse, or because of a non-child maltreatment related accident. Regardless of the cause of a near fatality or fatality, these events are extremely traumatic for the family of the child, the foster family (if applicable), Division staff, and service providers. Division staff will be supportive and helpful to those who have had a meaningful and/or legal relationship with the child including relatives and foster parents. Division leadership and management will recognize the importance of appropriately supporting staff who worked directly with the child and encourage those staff members to seek appropriate, individualized services as needed.

Pursuant to A.C.A. §12-18-103 a near fatality (also referred to in DHS Policy 1090 as a serious injury) means an act that, as certified by a physician, places a child in serious or critical condition. As such, the Division will rely on the involved medical facility's designation of the child's condition in determining if a particular incident meets the criteria of near fatality as defined by law.

The Division of Children and Family Services County Office will immediately (within one hour) notify the appropriate Area Director or designee and the Assistant Director of Community Services or designee and initiate action to ensure the safety of other children in the home when DCFS becomes aware of a child near fatality or fatality that may be the result of maltreatment and:

- **A. The child or sibling of the child is a subject of a pending child maltreatment investigation or a child maltreatment investigation within the preceding 24 months.**
- **B. The child or sibling of the child is a client in any open supportive or protective services or out-of-home case.**
- **C. The child or sibling of the child was a client in a supportive, protective services, or out-of-home case during the previous 24 months.**

The Assistant Director of Community Services or designee will immediately (within one hour) notify the Division Director who will notify the DHS Deputy Director, DHS Chief Counsel (per DHS Policy 1090) and the DHS Director of Communications. As such, the Division will not automatically issue press releases on cases of child near fatality or fatality related to maltreatment but will respond to requests for information as they are received in consultation with the DHS Director of Communications.

The Division will ensure that DHS Policy 1090 adhered to regarding all near fatalities and fatalities.

When a fatality occurs in an open out-of-home case, the Division will respectfully assist and support the parents in making funeral arrangements or take other actions deemed necessary by the Area Director.

Because quality improvement and accountability guides the work of DCFS, an internal team of DCFS staff will meet following a child fatality that meets at least one of the criterion established in items A-C above to review the case and identify systemic issues, public health concerns, and where practice could have been improved in that particular case in an effort to prevent future child fatalities and near fatalities.

Following a DCFS internal near fatality or fatality review, the Division will also be responsible for holding a meeting with the External Child Near Fatality and Fatality Review Team to review any certified near fatality or fatality for which there is a current child death investigation (i.e., related to child maltreatment).. The External Child Near Fatality and Fatality Review Team will conduct a comprehensive review of the circumstances leading to the near fatalities and fatalities of children who have been reported through the Arkansas Child Abuse Hotline. Based on the findings of the reviews, the External Child Near Fatality and Fatality Review Team will

develop recommendations and actions, as appropriate, to be implemented to prevent other child near fatalities and fatalities.

The External Child Near Fatality and Fatality Review Team will be comprised of the following members:

- **A. DCFS Director or designee;**
- **B. DCFS Assistant Director of Community Services or designee;**
- **C. DCFS Family Service Worker (FSW) Supervisor designated by the DCFS Director;**
- **D. DCFS FSW Investigative Supervisor designated by the DCFS Director;**
- **E. Crimes Against Children Division Commander or designee;**
- **F. Arkansas Commission on Child Abuse, Rape, and Domestic Violence Executive Director or designee;**
- **G. Children's Advocacy Centers of Arkansas Director or designee;**
- **H. Arkansas CASA Association Director or designee;**
- **I. Arkansas Children's Hospital's Team for Children at Risk and Arkansas Children's House Director or designee;**
- **J. Dependency-Neglect Attorney Ad Litem Director or designee;**
- **K. Office of Chief Counsel Director or designee;**
- **L. The Governor's Senior Advisor for Child Welfare;**
- **M. A member of the Arkansas Child Death Review Panel;**
- **N. A member of the Arkansas Department of Health;**
- **O. A member appointed by the chair of the House Subcommittee on Children and Youth of the House Committee on Aging, Children and Youth, and Legislative and Military Affairs;**
- **P. A member appointed by the Chief Justice of the Arkansas Supreme Court.**

This External Child Near Fatality and Fatality Review Team will meet at least quarterly each calendar year. The committee meetings will be closed and information discussed at the meeting will be confidential. Individuals who are not members of the External Child Near Fatality and Fatality Review Team will not be allowed to attend or otherwise participate in a committee meeting unless a majority of the members vote to request the attendance or participation of a non-committee member.

These external reviews will provide the Division and other stakeholders involved with child serving systems with an additional opportunity to collaboratively review the facts surrounding the fatality and accurately assess child deaths, work to improve systemic issues, address public health concerns, and determine recommendations to improve practice and work together as a system to prevent future child fatalities and near fatalities.

PROCEDURE IX-C1: Near Fatality of Child

07/2018

In the case of a child near-fatality the county office will:

A. Report maltreatment or any suspected maltreatment to the Child Abuse Hotline immediately if it has not already been called into the Child Abuse Hotline.
B. Notify the Area Director of the near fatality of the child immediately.

The Area Director will:

A. Schedule and hold the internal review of the near fatality within 14 calendar days (or earlier upon the DCFS Director's request) with DCFS staff to ascertain information involving facts surrounding the near fatality. The meeting will include:
    1) FSW
    2) County Supervisor/Investigative Supervisor
    3) Area Director
    4) Child Protective Services (CPS) Manager
    5) Assistant Director of Community Services or designee

6) Other appropriate staff as needed

The individuals above may participate in the meeting by phone as appropriate.

B. Immediately (within 24 hours or as required by the Director) prepare CFS-307: Near Fatality/Fatality Disclosure Case Briefing Summary and the CFS-309: Children and Family Services Internal Review of Child Near Fatality/Death and fax or email it to the CPS Manager.
C. Ensure the completion of CFS-306: Documentation of Child's Medical Episode Related to Near Fatality by the child's attending physician or other attending medical personnel who treated the child during the child's medical episode.

The CPS Manager will:

A. Review the completed CFS-307: Near Fatality/Fatality Disclosure Case Briefing Summary and forward it to:
    1) Assistant Director of Community Services or designee
    2) Assistant Director of Prevention and Reunification or designee
    3) Quality Assurance Unit Manager or designee
B. Request updated information from the counties as needed.
C. Review the CFS-306: Documentation of Child's Medical Episode Related to Near Fatality.
D. Work with the chair of the External Child Near Fatality and Fatality Review Team as appropriate in coordinating logistics and necessary reports for the quarterly External Child Near Fatality and Fatality Review Team .
E. Prepare the list of all certified near fatalities as well as all records related to the child and send the information to the members of the External Child Near Fatality and Fatality Review Team at least fourteen calendar days prior to a scheduled committee meeting.
    1) This information may be sent as hard copies or electronically.

The Quality Assurance Unit will:

A. Enter information regarding near fatalities related to maltreatment on the Child Fatality /Near Fatality Disclosure Log.

PROCEDURE IX-C3: Child Fatality Notification

07/2018

The Crimes Against Children Division will:

A. Investigate child maltreatment allegations according to established procedures.
B. If safety concerns are identified, immediately contact DCFS to conduct the remaining components of the Health and Safety Assessment (Safety Planning and Investigation Risk Assessment) as appropriate.
    1) DCFS will then be assigned as the secondary investigator on that particular investigation.
C. Coordinate with law enforcement and relinquish their case to them if the possibility of criminal charges is involved and law enforcement prefers to assume responsibility.
D. Initiate needed affidavits for legal action.
E. Keep the county office advised of the status of the investigation, including initial notification when appropriate.
F. Share all information with the parents, offender, and victim.

The Family Service Worker assigned as secondary to the investigation will:

A. If CACD contacted DCFS to conduct the remaining components of the Health and Safety Assessment (Safety Planning and Investigation Risk Assessment), immediately ascertain the safety of other children remaining under the care of the alleged offender and develop a protection plan or pursue protective custody, as appropriate.
B. Provide any services to the family as needed.
C. Enter all contacts with the family into the CHRIS.

D. Share all information about prior contacts with the family with agency staff and law enforcement who are investigating the case.

In the case of a fatality of a child the county office will:

A. Immediately notify the Area Director by phone.
B. Report maltreatment or any suspected maltreatment to the Child Abuse Hotline immediately if it has not already been called into the Child Abuse Hotline.
C. Immediately (within 24 hours or as required by the DCFS Director) complete CFS-307: Child Near Fatality/Fatality Disclosure Case Briefing Summary and CFS-308: Child Fatality Review Packet Checklist and forward the CFS-307 and CFS-308 and all required documents listed on CFS-308 to the CPS Manager.
D. Place copies of CFS-307 and CFS-308 in the child's record.
E. If the child fatality is a result of a prior near fatality event and the fatality occurred more than 24 hours after the near fatality, ensure the completion of CFS-306-A: Documentation of Near Fatality Subsequently Resulting in Fatality by the child's attending physician or other attending medical personnel who treated the child during the child's medical episode.
F. Fax or email the completed CFS-306-A: Documentation of Original Near Fatality Subsequently Resulting in Fatality to the CPS Manager within 72 hours of the fatality, if applicable.
G. Place a copy of the CFS-306-A in the child's record, if applicable.

The Area Director or designee will:

A. Notify the Assistant Director of Community Services or designee immediately by phone.
B. Ensure employee immediately (within 24 hours or as required by DCFS Director) completes and forwards completed CFS-307: Child Near Fatality/Fatality Disclosure Case Briefing Summary and forward the CFS-307 to the CPS Manager.
C. Complete the CFS-308: Child Fatality Review Packet Checklist within seven calendar days of the fatality and fax or email both forms along with all required documents listed on the CFS-308 to the CPS Manager.
    1) Schedule and hold an Internal Fatality Review meeting with DCFS staff within 14 calendar days of the fatality in order to ascertain the facts surrounding the child's death. The meeting will include:
        a) FSW
        b) CACD Investigator
        c) County Supervisor/Investigative Supervisor
        d) CACD Supervisor
        e) Area Director
        f) CPS Manager
        g) Assistant Director of Community Services or designee
        h) Assistant Director of Prevention and Reunification or designee
        i) Any other needed staff as appropriate
D. Expeditiously provide all other information requested by CPS Manager.

The Assistant Director of Community Services or designee will:

A. Notify the DHS Director of Communications by phone within one hour of occurrence if the incident is expected to receive media attention.
B. Discuss relevant details of the case with the DHS Director of Communications to determine the type of information that will be released to the media. Pertinent information that can be released will include disclosable information as provided by the DHS Disclosure Policy (DHS Policy Group 4009).
    1) Any information concerning siblings or attorney-client communications will not be released.
C. Remain in direct contact with appropriate field personnel in order to develop a clear understanding of the circumstances surrounding the incident.

The CPS Manager will:

A. Review CFS-307: Child Near Fatality/Fatality Disclosure Case Briefing Summary.
B. Forward the CFS-307: Child Near Fatality/Fatality Disclosure Case Briefing Summary to:

1) Assistant Director of Community Services or designee
2) Assistant Director of Prevention and Reunification or designee
3) DCFS Director
4) DHS Director of Communications
5) DHS Deputy Director over DCFS

C. Review the CFS-308: Child Fatality Review Packet Checklist and all required documents listed on CFS-308.
D. Enter information regarding the fatality on the Child Death Log and Child Death Public Disclosure Log.
E. Serve as the point of contact for follow-up and subsequent briefings of the Assistant Directors, Division Director, and DHS Deputy Director.
F. Work with the chair of the External Child Near Fatality and Fatality Review Team as appropriate in coordinating logistics and necessary reports for the quarterly External Child Near Fatality and Fatality Review Team .
G. Prepare the list of all child deaths as well as all records related to the child and send the information to the members of the External Child Near Fatality and Fatality Review Team at least fourteen calendar days prior to a scheduled committee meeting.
    1) This information may be sent as hard copies or electronically.

The Quality Assurance Unit will:

A. Enter information regarding fatalities related to maltreatment on the Child Fatality /Near Fatality Disclosure Log.