

**Department of Human Services
CHILD WELFARE
PROTOCOL**

Notification and Review of Child Fatalities

Interpretation: Child Protective Services
Program Manager, Office of
Safety and Permanency of
Children, Children and
Families

Approval: Administrator, Office of Safety
and Permanency of Children,
Children and Families

REFERENCES: CF 150, "Sensitive Child Welfare Issue Report"
http://dhsresources.hr.state.or.us/WORD_DOCS/DE0150.doc
CF 326, "Fatality Summary"
http://dhsresources.hr.state.or.us/WORD_DOCS/CE0326.doc

PURPOSE

- (1) The purpose of this protocol is to outline the Department of Human Services, Child Welfare (Department) responsibilities that will be used when a child fatality that may be the result of child abuse or neglect occurs or when a child fatality occurs involving a child or family known to the Department.
- (2) The Department gathers information and compiles statistics on child fatalities that may be the result of child abuse or neglect. This information is used by the Department during its review of child fatalities to:
 - (a) Identify present danger safety threats or impending danger safety threats to surviving siblings and other children in the home;
 - (b) Assure the protection of surviving siblings and other children in the home;
 - (c) Identify social trends that may contribute to child fatalities;
 - (d) Evaluate how the Department operated internally, as a member of a local multi-disciplinary team, and as part of the broader child protection system;
 - (e) Recommend necessary changes to statutes, administrative rules, policies, procedures and practices to respond to Department system issues.

- (f) Provide support to Department staff who often experience traumatic loss and grief when a child dies, particularly when the deceased child was the subject of an open or recently closed case.
- (3) Reviews conducted as provided in this protocol are in addition to and separate from reviews conducted by a local Multidisciplinary Team pursuant to ORS 418.747, a State Fatality Review team pursuant to ORS 418.748, a Critical Incident Response Team or a Sensitive Issue Review.

DEFINITIONS

- (1) **“Child or Family Known to the Department”** is a deceased child or member of the deceased child’s immediate family who was on an open Department case at the time of death or who, within the year prior to the death, was the subject of a child protective services (CPS) assessment or received Department services.
- (2) **“Contact Attorney”** is an Assistant Attorney General in the Human Services Section of the General Counsel Division of the Oregon Department of Justice assigned to provide legal services and advice to the Department.
- (3) **“Critical Incident Review”** is a review of Department case related activities and systems, including Oregon Administrative Rule (OAR), policy, procedure, practice, training and personnel related issues when a critical incident occurs. Refer to Notification and Review of Critical Incidents Protocol.
- (4) **“Immediate Family”** means parents or legal guardians and siblings.
- (5) **“Immediately”** means without undue delay.
- (6) **“Internal Child Fatality Review”** is a review of Department case related activities, systems, policy and practice when a child fatality occurs involving a child or family known to the Department.
- (7) **“Internal Review Committee”** is a group of individuals with expertise in general child welfare practice, legal requirements related to child abuse and neglect investigations and proceedings and Department rules, policies, procedures and practices related to CPS assessments.

ASSISTANCE TO STAFF IN THE EVENT OF A CHILD FATALITY

Management staff may request assistance from the Employee Assistance Program (EAP) when a child fatality occurs involving a child or family known to the Department. The EAP may provide an immediate trauma debriefing if appropriate, or individual Department staff, including management staff, may seek personal assistance. Providing immediate assistance to Department staff may prevent the later development of delayed stress and vicarious trauma reactions. A supervisor may offer the support of another staff person to assist and support the assigned worker when the death occurred on an open Department case.

NOTIFICATION PROCESS

IMMEDIATE NOTIFICATION REQUIRED UPON RECEIPT OF A REPORT OF ANY FATALITY THAT MAY BE THE RESULT OF CHILD ABUSE OR NEGLECT OR WHEN A CHILD FATALITY OCCURS INVOLVING A CHILD OR FAMILY KNOWN TO THE DEPARTMENT.

- (1)** Notification must be made immediately. A Sensitive Child Welfare Issue Report, CF150 per Children, Adults and Families (CAF) Policy III-A.1.2 must be completed with the information available and forwarded to all persons listed on the form and the CPS Consultant for that district. As additional information is available the CF150 must be updated as soon as possible, but no later than 4:30pm the same working day.
- (2)** The CF 150 must include a brief summary of the following information, if known, in the "Details of Issue" section of that form:
 - (a)** Child's Date of Death;
 - (b)** Circumstances of death,
 - (c)** Alleged perpetrator and relationship to victim;
 - (d)** Information about any protective action for surviving siblings;
 - (e)** Name of investigating police agency and officer;
 - (f)** Status of the Department case, if any, at the time of the fatality report; and
 - (g)** Pending juvenile, criminal or civil court action.
- (3)** If the fatality occurs involving a child or family known to the Department, a Department Supervisor must secure and sensitize all Department case records related to the fatality. Sensitizing a case record requires restricting access to the information. Assure the information is restricted in the following ways:

- (a) Request the electronic case record be identified as a sensitive case and limit the staff allowed access. Staff allowed access to the case record must be staff assigned to complete work on the case; and
- (b) Gather original hard copies of all Department records relating to the case. Assure the hard copy case record is kept in a location that prevents unauthorized staff from having access.
- (c) Assure that a clear distinction is made in the case record prior to the CIRT designation, if applicable, and after. Prior case notes and narratives must not be altered and new information must be dated.

RESPONSE TO EXTERNAL INQUIRIES

All external inquiries (for example, the media, the community and the deceased child's extended family) must be directed to the Department's Communication Officer. The Department's Communication Officer will develop and approve any plan to address external inquiries.

SCREENING REPORTS OF CHILD FATALITIES

The reported fatality must be screened as any other report to determine if a CPS response is required. A 307 must be created when there is an allegation that the fatality was due to abuse or neglect of the child and/ or *the child or family is known to the Department*. In addition, the 307 must be identified as a fatality. Additional allegations may be identified surrounding the circumstances of the death or reported allegations of abuse or neglect to surviving siblings. The Department's response at screening is as follows:

- (1) If the child fatality is alleged to be the result of abuse or neglect the report must be assigned.
- (2) If the child or family is known to the Department, the fatality is not alleged to be abuse or neglect and there are no additional allegations of abuse or neglect reported, select fatality on the 307, close the referral at screening and notify all appropriate parties.
- (3) If the child or family is not known to the Department, the fatality is not alleged to be abuse or neglect and there are no additional allegations of abuse or neglect reported, the information must not be documented in the Department's information system.
- (4) If a child fatality occurs during an open CPS assessment, and there are new allegations of abuse or neglect, the report must be assigned for CPS assessment.
- (5) If a child fatality occurs during an open CPS assessment and there are no concerns of abuse or neglect, close the 307 at screening and notify all

appropriate parties.

ASSIGNMENT OF THE CPS ASSESSMENT

- (1)** The CPS assessment and fatality review must be assigned to the Department's local office in the county where the deceased child resided.
- (2)** When a child fatality occurs in a county other than where the child resided, a CPS worker may be assigned in the county where the death occurred to assist with the CPS assessment and participate in the fatality staffing. This CPS worker will act as a liaison between the CPS worker in the county where the child resided and local agencies (Law Enforcement Agency (LEA), Medical examiner's Office etc.) in the county where the child died.
- (3)** If the child fatality occurs in an out of home placement, and the report is assigned for a CPS assessment, the 307 must be assigned in the county where the child was placed.

INITIAL CONTACT

When conducting a CPS assessment in a child fatality case the CPS worker has additional challenges. The situation requires a CPS worker to contact and interview family members who are grieving and, as a result, necessitates a high level of sensitivity to the trauma that occurs with death. LEA and medical examiner investigations provide crucial information about the death and circumstances surrounding the death, however, this information will not provide sufficient information for a comprehensive CPS assessment. Even if uncomfortable, it is imperative that the worker complete all required interviews, see the home environment and assess the need for supportive safety services for surviving siblings and other children in the home.

- (1)** Prior to making initial contact:
 - (a)** Review the exception to face to face contact outlined in (3) below, to determine if the exception to face to face contact applies.
 - (b)** Consider bringing grief related resource information or taking a crisis response worker when making the initial contact.
 - (c)** Research funeral planning information, OAR 413-090-0400 through 413-090-0430, when the deceased child was in the custody of the Department.
- (2)** When conducting initial interviews remember the CPS worker is not only gathering enough information to determine whether the death was due to child abuse or neglect, but is also determining whether a protective action plan is necessary to assure the immediate safety of any surviving children in the home.

- (3)** If the LEA investigation and a medical examiner are consistent in their determination that the child fatality clearly was the result of abuse or neglect, and it is confirmed there are no siblings to the deceased child and no other children in the home where the fatality occurred, the CPS worker:
 - (a)** May, after consulting with a CPS supervisor, complete the CPS assessment without face to face contact with the parents or caregivers.
 - (b)** Must complete the CPS assessment and document a founded disposition based on the LEA investigation, Medical Examiner's report and any additional information gathered during the CPS assessment. The CPS worker must choose the type of abuse that resulted in the fatality. Enter the LEA contact dates for the face to face contact dates in the Department's information system.
 - (c)** Must provide notice to the reporter, the child's parents, including non-custodial legal parent, caregivers and perpetrators, as outlined in OAR 413-015-0470 (1).

DISPOSITION

- (1)** The CPS worker may decide the disposition cannot be determined until the LEA report or medical examiner's report is released. This is most likely when critical information, such as an alleged perpetrator's interview, is being withheld or when the information may change an unable to determine disposition to unfounded or founded disposition. When delaying the determination of the disposition will assure the soundness and integrity of the determination, the CPS worker must request a CPS assessment extension as outlined in 413-015-0480.
- (2)** When determining the CPS assessment disposition the CPS worker must:
 - (a)** Document whether the fatality was the result of abuse or neglect.
 - (b)** When the determination is unable to determine, assure there are no additional assessment activities that if completed would likely result in an unfounded or founded disposition.
 - (c)** When the fatality was the result of abuse or neglect, document the type of abuse that resulted in the fatality.
 - (d)** When the fatality was the result of abuse or neglect, document who perpetrated the abuse or neglect that led to the fatality.
 - (e)** Address any other allegations of abuse or neglect, separate from the alleged cause of the child fatality and document their dispositions. This includes allegations reported at screening or identified during the CPS assessment process. These allegations may relate to the deceased child, siblings of the deceased child or other children in the home.

COMPLETING THE CPS ASSESSMENT

- (1) When completing the CPS assessment, the CPS worker may determine the disposition or child safety decision cannot be determined until the LEA report or medical examiner's report is released. This is most likely when the cause of death is abuse or neglect, but the perpetrator is unknown or when the cause of death remains unknown. When the absence of information that will be available, or is likely to be available in an LEA report or the medical examiner's report, makes it difficult to determine the disposition or if a child is safe, request a CPS assessment extension as outlined in 413-015-0480.
- (2) When there is adequate information to complete the CPS assessment, including the CPS assessment disposition and the child safety decision, and the LEA or medical examiner's report has not yet been released, the CPS assessment may be closed. The CPS worker remains responsible for obtaining, reviewing and filing the LEA and medical examiner's report.
- (3) When no autopsy was conducted, the CPS worker must obtain and document the cause of death as determined by a medical professional.
- (4) When an LEA investigation and autopsy were conducted on a child fatality, the CPS worker must obtain the reports regardless of the disposition. Once obtained, the CPS worker must review the reports and address any new safety related information.
- (5) When the LEA and medical examiner's reports are received, the CPS supervisor must forward the reports to the CPS consultant for the district.

FATALITY STAFFING

- (1) A fatality staffing must be completed within *three working days* of the receipt of a report that a fatality may be the result of child abuse or neglect or involves a child or family known to the Department. A fatality staffing is a local office review of the information gathered as part of the CPS assessment and LEA investigation, including pertinent case and family history, for the purpose of planning for surviving siblings and continued CPS assessment.
- (2) The staffing must include:
 - (a) A District Manager or designee;
 - (b) A Program Manager or designee;
 - (c) Supervisors of the Department caseworkers assigned to the current assessment and open case or designees;

- (d) Department caseworkers assigned to the current assessment and open case;
 - (e) A CPS Consultant, CPS Program Coordinator or CPS Program Manager;
 - (f) A Certifier, if applicable; and
 - (g) A Self Sufficiency worker, LEA representative or other internal or external partner, as appropriate.
- (3) The staffing participants must:
- (a) Summarize the family history and current circumstances.
 - (b) Obtain and review all available information from other agencies including preliminary findings of the LEA investigation and results of any autopsy;
 - (c) Assist in development of a supportive plan for family members and review the protective action or ongoing safety plan for surviving siblings. This may include discussing funeral arrangements and the Department's role in this (i.e. financial support and attendance by staff);
 - (d) Develop a plan of support for Department staff to deal with the grief and loss and consider use of the EAP; and
 - (e) Consider scheduling an additional staffing, at the conclusion of the CPS assessment, to review the determinations, review plans for adequacy and to assist with the development of the Fatality Summary ([CF0326](#)).
- (4) Documentation of the fatality staffing. The CPS Consultant for the district must document the date of the staffing and the names of the participants in case notes.
- (5) Exception to completing the fatality staffing. An exception to completing the fatality staffing may be granted at the discretion of the CPS Program Manager if information from a medical professional identifies a cause of death that is not the result of abuse or neglect.

FATALITY SUMMARY

- (1) The Child Welfare Program Manager or designee must complete a Fatality Summary ([CF0326](#)) within ten business days of the supervisory review of a CPS assessment of a child fatality when the disposition related to the cause of the fatality is unable to determine or founded. The Fatality Summary ([CF0326](#)):
- (a) Must be a written report;

- (b)** Must include the following:
 - (A)** The case name and number;
 - (B)** The date the fatality summary is created;
 - (C)** A historical case chronology or synopsis prior to the fatality. The chronology or synopsis must:
 - (i)** List the number and dates of all closed at screening reports, family support services referrals and CPS referrals;
 - (ii)** State the disposition of all CPS assessments;
 - (iii)** Identify when a case was opened as a result of a CPS assessment;
 - (iv)** List the dates the deceased child was removed from a parent or caregiver (for example, removal by voluntary custody, voluntary placement or protective custody);
 - (v)** List dates the deceased child was returned home;
 - (vi)** List case closure dates;
 - (vii)** Be as brief or as detailed as necessary to address the objective.
 - (D)** A case chronology or synopsis from the time of the fatality until the date the summary is created. The chronology or synopsis must include:
 - (i)** A summary of the circumstances surrounding the fatality;
 - (ii)** The composition of the household where the deceased child resided at the time of the fatality;
 - (iii)** The perpetrator, or alleged perpetrator's, relationship to the deceased child;
 - (iv)** Whether the deceased child was in foster care at the time of the fatality;
 - (v)** Whether there was an open CPS assessment at the time of the fatality;
 - (vi)** Whether there was an open case at the time of the fatality;
 - (vii)** Whether the deceased child was in the custody of the DHS at the time of the fatality;
 - (viii)** The contributing factors to the fatality (for example, mental health, substance abuse or domestic violence);
 - (ix)** The status of the criminal investigation or prosecution;
 - (x)** Significant medical history and diagnoses of the deceased child, if any;
 - (xi)** Developmental delays or special needs of the deceased child, if any; and
 - (xii)** The current status of the Child Welfare case.
- (c)** When available, the following documents must be included as attachments to the summary.
 - (A)** LEA reports;
 - (B)** Medical Examiner's report; and

- (b)** Identify areas of needed improvement in Department systems;
 - (c)** Review any ongoing safety plans and case plans;
 - (d)** Identify and review any legal issues;
 - (e)** Review additional information obtained since completion of the Fatality Summary ([CF0326](#)); and
 - (f)** Consult with legal counsel and obtain legal services and advice from counsel regarding all matters considered by the committee.
- (5)** A written summary of the results and recommendations of the internal child fatality review shall be written jointly by the District Manager, the CPS Program Manager, and the Contact Attorney.
 - (a)** The summary must include:
 - (A)** A comprehensive review of case history;
 - (B)** Documentation of the Department response;
 - (C)** Analysis of findings; and
 - (D)** Recommendations for future responses including possible statutory, rule, policy, procedure, or practice changes.
 - (b)** The summary must be submitted within 30 calendar days after the internal child fatality review is completed to the Director of DHS, Chief Operations Officer of Child Welfare and Self Sufficiency, Director of the Office of Child Welfare Programs, District Manager, Child Welfare Program Manager, CPS Program Manager and Contact Attorney. The summary may be provided to other Department staff, as appropriate.
- (6)** The Director of DHS may request that the District Manager or other Department staff develop within 60 calendar days an action plan to address issues of concern identified in the internal child fatality review summary.