

11

CHILD DEATHS

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CHILD DEATHS

11.1 Introduction

The review of child deaths reported to CPS can best be achieved through a multi-agency, multi-disciplinary process that routinely and systematically examines circumstances surrounding reported deaths of children. The purpose of the review is to enable the Virginia Department of Social Services (VDSS), the local departments of social services (LDSS), and local community agencies to identify important issues related to child protection and to take appropriate action to improve our collective efforts to prevent child fatalities. The review process at all levels emphasizes that DSS is not alone in its responsibility to protect children, and reports should address issues of interagency collaboration, communication, and decision-making.

The investigation of a child death is usually conducted jointly with law enforcement. The LDSS must complete the investigation according to guidance and policy set forth in the CPS Policy/ Guidance Manual Section 3: Complaints and Reports and Section 4: Family Assessments and Investigations.

If the fatality occurs in an Out of Family setting, the LDSS must complete the investigation in accordance with Section 5: Out of Family Investigations.

There are some additional notifications and reporting requirements for all child deaths included in this section. All child fatality cases reported to CPS are reviewed at the regional level by the Child Fatality Review Team. (CFRT)

A child fatality checklist has been included in [Appendix D](#) and can be found on the [public website](#) under forms. This checklist is optional and may be helpful to use to ensure compliance with the additional notifications and reporting requirements for child fatalities.

11.2 Report a child death

The Virginia Administrative Code requires the LDSS to contact the District Office of the Chief Medical Examiner, Commonwealth's Attorney, and local law enforcement when a report or complaint alleging abuse or neglect involves the death of a child.

11.2.1 Report child death to District Office of the Chief Medical Examiner

([22 VAC 40-705-50 F1](#)). When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the regional medical examiner pursuant to § [63.2-1503 E](#) of the Code of Virginia.

The LDSS shall **immediately** notify the [District Office of the Chief Medical Examiner](#) when the LDSS receives a complaint or report of abuse or neglect involving the death of a child. The LDSS should advise the Medical Examiner if the LDSS will be proceeding with an investigation and provide any preliminary information about the child and the caretakers to include any prior child welfare history. The CPS worker shall document this notification in the automated data system.

11.2.2 Report child death to local Commonwealth's Attorney and law enforcement

([22 VAC 40-705-50 F2](#)). When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the attorney for the Commonwealth and the local law-enforcement agency pursuant to § [63.2-1503 D](#) of the Code of Virginia.

The LDSS shall **immediately** notify the local Commonwealth's Attorney and local law enforcement when the LDSS receives a complaint or report of abuse or neglect involving the death of a child. The LDSS should advise the Commonwealth's Attorney and local law enforcement if the LDSS will be proceeding with an investigation and provide any preliminary information about the child and the caretakers. The CPS worker shall document this notification in the automated data system.

11.2.3 Report child death to CPS regional consultant

([22 VAC 40-705-50 F3](#)). The local department shall contact the Department immediately upon receiving a complaint involving the death of a child and at the conclusion of the investigation.

The LDSS's CPS supervisor or supervisor's designee shall contact the CPS Regional Consultant **immediately** upon receiving a complaint involving the death of a child. The CPS worker shall document this notification in the automated data system.

The CPS Regional Consultant shall complete the Preliminary Child Fatality Information Form and forward it to the CPS Program Manager **within 24 hours** of receipt of the information pertaining to the death of the child.

The CPS Program Manager shall inform the Commissioner's Office of the child death **within 24 hours**. This information is also shared with the State Board of Social Services.

11.2.4 Submit preliminary information concerning the child death

The LDSS shall provide the following preliminary information concerning the child death to the CPS Regional Consultant who will submit the information on the Child Fatality Information Form to the CPS Program Manager. The form can be found on *the [public website](#)* and in [Appendix A](#).

The Preliminary Child Fatality Information Form provides initial or preliminary information about the child death and shall be completed with as much of the following information as possible.

11.2.4.1 Logistical information

- Name of LDSS.
- Name of investigating worker.
- Name of CPS supervisor.
- Date of complaint.
- Referral number.
- Person making the complaint.
- Regional Specialist.

11.2.4.2 Demographic information

- Name of deceased child.
- Deceased child's date of birth.
- Date of child's death.
- Sex of child.
- Race of child.
- Type of alleged abuse/neglect.
- Name of alleged abuser/neglector.

- Relationship of alleged abuser/neglector to child.

11.2.4.3 Reporting requirements

- Date reported to CPS Regional Consultant.
- Date reported to Commonwealth's Attorney.
- Date reported to law enforcement.
- Date reported to District Office of the Chief Medical Examiner.
- Date reported to CPS Program Manager.

11.2.4.4 Circumstances surrounding the child's death

- Detailed description of the child's death (when, where, why, how, who, and any related problems, including type of abuse/neglect).
- Information concerning the family's prior involvement with the LDSS (include a summary of prior reports and referral numbers).
- Information concerning the alleged perpetrator of the child's death (relationship to victim or other family members).
- Identification (including names and ages) of any siblings of the deceased child – (requires conducting a safety assessment of any siblings of the deceased child and development of a Safety Plan, if safety decision is Conditionally Safe or Unsafe).

11.2.4.5 LDSS's plan of action

- Description of the LDSS's investigation plan.
- Description of the Regional Consultant's planned involvement and assistance.
- Date disposition is due.
- Any additional concerns or comments.

11.3 Investigation of child death

When a CPS report involves a child death, the LDSS must meet ALL investigation requirements according to the CPS Guidance Manual. Refer to Section 3, Complaints and Reports and Section 4, Family Assessment and Investigation.

Additional resources regarding child fatality investigations can be found in [Appendix C](#).

11.3.1 Death of foster child

If the child fatality involves a child in the custody of the LDSS who is in a locally approved foster home, the LDSS should request a neighboring locality to assume jurisdiction and conduct the investigation.

11.3.2 Child Death Case Reporting Tool

The CPS Regional Consultant will provide the LDSS with the [National Maternal Child Health \(MCH\) Center for Child Death Review](#) Case Report tool upon initial notification of a child death. The case reporting tool is also located on *the [public website](#)*. When completing the tool, the CPS worker should refer to the definitions and instructions provided in the data dictionary, which is located *with the tool*.

The purpose of the case report tool is to collect comprehensive information from multiple agencies that participate in the child fatality review. The form will document the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and /or taken by the regional child fatality review team.

The CPS worker should complete the information on the tool to the best of their ability throughout the investigation. **If an attempt was made to find the answer but a sufficient answer could not be found, mark “U/K.” If no attempt was made to find the answer, leave blank.** The CPS worker should obtain detailed information and complete the following sections to the best of their ability:

- **Section A.** Child information (i.e. demographics, medical conditions, mental health concerns, substance abuse issues, prenatal history, prior maltreatment, etc.)
- **Section B.** Primary Caregiver information (i.e. demographics, relationship to child, history of substance abuse, mental health, maltreatment, criminal activity, education, employment, domestic violence, etc.)
- **Section C.** Supervisor information (i.e. was child supervised, how long before incident did supervisor last see child, etc.) Follow directions to complete only questions not answered in prior section if supervisor(s) was not the primary caregiver.
- **Section D.** Incident information (i.e. date and time, exact location, details of what was happening right before child death, Emergency Medical Services (EMS) involvement, etc.)

- **Section E.** Investigation information (i.e. evidence of prior abuse, founded/unfounded, etc.) Questions 1-14 are completed by the medical examiner. CPS is only responsible for questions 15-18 as they relate to CPS
- **Section G.** Details of cause of death (details vary depending on cause of death, only complete the one part that applies)
- **Section H.** Sleep related death details (i.e. place, position, circumstances, etc.) Follow instructions on tool for completion.
- **Section J.** Services to the family (i.e. bereavement, mental health, foster care, etc., do not complete the last column)

The remaining sections of the case report tool will be completed at the regional fatality review team meeting.

11.3.3 Assessing safety in a child fatality

If there are no other children in the home, the safety assessment will be safe.

11.3.4 Assessing risk in a child fatality

When assessing risk using the CPS Risk Assessment Tool, there is a policy override when the parent/ caretaker action or inaction resulted in the death of a child due to abuse or neglect (previous or current). Policy overrides reflect seriousness and/or child vulnerability concerns, and have been determined by the department to warrant a risk level of very high regardless of the risk level indicated by the assessment tool. It is recommended to open a case if the risk is high or very high; however, if there are no other children in the home it is not necessary to provide CPS services.

11.3.5 CPS Regional Consultant to provide technical assistance

The CPS Regional Consultant shall provide technical assistance to the LDSS throughout the investigation. The LDSS must consult with the CPS Regional Consultant prior to making the disposition and developing the service plan.

11.3.6 Suspensions of child death investigations

Effective July 1, 2013, The Code of Virginia [§63.2-1505 B5](#) grants exceptions to completing certain investigations under specific conditions. In any child death investigation which requires reports or records generated outside the local department in order to complete the investigation, such as an autopsy, the time need to obtain these reports or records shall not be counted towards the 45 day timeframe to complete the investigation. These records must be necessary to complete the investigation and not available due to circumstances beyond the control of the local

department. When the LDSS receives the reports or records, the 45 day timeframe resumes where it had left off, it does not start over.

The decision to suspend making a disposition within 45 days in these cases should be approved by a supervisor and documented in the automated data system. If the LDSS has the evidence necessary to make the disposition they should not suspend the investigation.

The LDSS should notify the alleged abuser/neglector or involved caretakers and the alleged victim's parents or guardians when suspending an investigation. The notification to the alleged abuser/neglector or involved caretakers should include a brief explanation of the reason for the suspension. If written notification is made, a copy of the notification must be included in the LDSS's record and documented in the automated data system. If notification is made verbally, then the LDSS must document the notification in the automated data system. The LDSS must document the justification in the automated data system for the additional time needed to complete the investigation.

11.3.7 Notify CPS Regional Consultant of disposition

Within ten (10) working days of making the disposition or as soon as possible thereafter, the LDSS must notify the CPS Regional Consultant with the final disposition, assessed risk and any pending criminal charges or investigations concerning the child death.

The CPS Regional Consultant must notify the CPS Program Manager of the final disposition, assessed risk and criminal charges (if any).

Each child death will be reviewed by a regional child fatality review team. The CPS Regional Consultant is responsible for scheduling the review of the child death with the regional child fatality review team.

Pursuant to [§ 32.1-283.2C](#) of the Code of Virginia, ...The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

11.4 Local, regional, and state child fatality reviews

The Code of Virginia authorizes reviews of child deaths at the local, regional, and/or state level.

11.4.1 Local and regional child death review teams

(§ [32.1-283.2](#) of the Code of Virginia). Local and regional child fatality review teams established; membership; authority; confidentiality; immunity.

A. Upon the initiative of any local or regional law-enforcement agency, fire department, department of social services, emergency medical services agency, Commonwealth's attorney's office, or community services board, local or regional child fatality teams may be established for the purpose of conducting contemporaneous reviews of local child deaths in order to develop interventions and strategies for prevention specific to the locality or region. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. Violations shall be punishable as a Class 3 misdemeanor. The State Child Fatality Review Team shall provide technical assistance and direction as provided for in subsection A of § [32.1-283.1](#).

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a local or regional medical examiner, a local social services official in charge of child protective services, a director of the relevant local or district health department, a chief law-enforcement officer, a local fire marshal, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, and such additional persons, not to exceed five, as may be appointed to serve by the chairperson of the local or regional team. The chairperson shall be elected from among the designated membership. The additional members appointed by the chairperson may include, but are not restricted to, representatives of local human services agencies; local public education agencies; local pediatricians, psychiatrists and psychologists; and local child advocacy organizations.

C. Each team shall establish local rules and procedures to govern the review process prior to conducting the first child fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ [2.2-3700](#) et seq.) pursuant to subdivision 9 of § [2.2-3705.5](#). All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum, or discovery or be admissible in any criminal or civil proceeding.

If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the reviews nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § [2.2-3711](#). All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

E. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a child fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

11.4.2 Regional Child Fatality Review Teams

All child fatalities will be reviewed by the regional child fatality review team. The regional child fatality review team will examine the circumstances of the child's death.

11.4.2.1 Purpose of child fatality review

The purpose of a fatality review is:

- Take a public health/safety approach to prevention of child injury and death.
- Identify risk and protective factors.
- Evaluate efficacy of systems for child protection and safety.
- Identify points of intervention/systems failures.

- Make recommendations for prevention, policy change, product safety, legislation, training, and death investigations.
- Not to reinvestigate the fatality.

11.4.2.2 Role and responsibilities of CPS worker

CPS is responsible for investigating the allegations of abuse or neglect and recommending services to children and families. CPS also serves as a liaison to other community resources. The CPS worker is responsible for providing vital information to the child review team to include:

- The case status.
- A summary of the investigation.
- Family and child history and socioeconomic factors such as employment, marital status, previous deaths, history of DV, and history of substance abuse or mental illness.
- Prior CPS involvement.

The CPS worker will be notified by phone or in writing by the CPS Regional Consultant as to the date, time and location of the Regional Fatality Review meeting. The notification must include the child's initials, locality, date of birth, and date of death and referral number. In order to preserve confidentiality, e-mails should not include identifying information such as names. Prior to the meeting, the CPS worker should complete all documentation in the automated data system and all supervisory approvals should be done.

11.4.2.3 Presenting a case for the child fatality review meeting

The CPS worker, or the person who will present the case at the review meeting, should be prepared to verbally present the investigative details of the case. The following is a list of suggested questions that can be used as a guide for the verbal presentation:

- How was the agency notified of the fatality?
- What were the circumstances of the death? How was the injury described and explained? What was the supervision of the child? Were other persons present and what did they report?
- What was the agency initial response? Who responded and when? What was happening upon arrival? What were the responses of those

present? Who was interviewed? What did they say? What was observed?

- Was the child or family known to DSS? If so, how?
- Were there any prior family assessments or investigations? What did they involve and what were the outcomes of those interventions?
- What safety factors and protective capacities were identified? What risk factors were identified?
- What services have been provided to the family before and after the fatality?

The presenter should bring the [National MCH Center for Child Death Review Case Report](#) tool, with pertinent information completed, to the review meeting and give to the team recorder, who will complete the remainder of the tool. The final completed tool will be sent to the CPS Program Manager for input into the National MCH Center for Child Death Review database.

The presenter should also bring a copy of the case record, including any photographs.

Maintaining confidentiality is extremely important. The CPS worker or presenter will be asked to sign a confidentiality form at the review meeting. Section [§ 32.1-283.2](#) of the Code of Virginia pertains to confidentiality:

([§ 32.1-283.2](#) of the Code of Virginia). D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act ([§ 2.2-3700](#) et seq.) pursuant to subdivision 9 of [§ 2.2-3705.5](#). All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed.... The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of [§ 2.2-3711](#). All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

For additional information on what to expect at a child fatality review team and a tip sheet for presenters please see [Appendix B](#). For additional information regarding the roles of all key professionals on child fatality review teams please see [Appendix E](#).

11.4.2.4 Regional child fatality review prevention initiatives

The Regional Child Fatality Review Teams will be asked to report to the CPS Program Manager on an annual basis, describing significant findings and themes from the reviews as well as any recommendations or initiatives as a result of the team's discussion of that year's child death cases. These may include actions in the recommended, planning or implementation stage. These actions may be short or long term. These actions may be at the local, state, or national level. Some examples of actions may include conducting media campaigns, having public forums, revising policy, providing training, implementing new programs, or enacting new laws.

11.4.3 State Child Fatality Review Team

The Code of Virginia established a statewide team to analyze child deaths in a systematic way. This includes child deaths due to abuse or neglect as well as child deaths due to other causes.

(§ [32.1-283.1](#) of the Code of Virginia). State Child Fatality Review Team established; membership; access to and maintenance of records; confidentiality; etc.

A. There is hereby created the State Child Fatality Review Team, hereinafter referred to as the "Team," which shall develop and implement procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. The Team shall review (i) violent and unnatural child deaths, (ii) sudden child deaths occurring within the first 18 months of life, and (iii) those fatalities for which the cause or manner of death was not determined with reasonable medical certainty. No child death review shall be initiated by the Team until conclusion of any law-enforcement investigation or criminal prosecution. The Team shall (i) develop and revise as necessary operating procedures for the review of child deaths, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) improve the identification, data collection, and record keeping of the causes of child death, (iii) recommend components for prevention and education programs, (iv) recommend training to improve the investigation of child deaths, and (v) provide technical assistance, upon request, to any local child fatality teams that may be established. The operating procedures for the review of child deaths shall be exempt from the Administrative Process Act (§ [2.2-4000](#) et seq.) pursuant to subdivision 17 of subsection B of § [2.2-4002](#).

11.5 Release of child fatality or near fatality information

There are specific requirements related to the release of information in child deaths. The general discussion of laws and regulations regarding confidentiality and disclosure of information are discussed in Section 9: Confidentiality of this manual. The Virginia

Administrative Code requires the VDSS to develop guidelines allowing for public disclosure in instances of a child death.

([22 VAC 40-705-160 A8](#)). Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), the department shall develop guidelines to allow for public disclosure in instances of child fatality or near fatality.

11.5.1 Guidelines for release of information in a child fatality or near fatality

The Virginia Administrative Code establishes the information that can be released in child abuse or neglect cases with a child death.

([22 VAC 40-910-100 B](#)). Releasing confidential social services information.

3. b. Child Protective Services Client Records and Information Disclosure:

(1) Child protective services client records can be released to persons having a legitimate interest pursuant to [§ 63.2-105 A](#) of the Code of Virginia.

(2) The public has a legitimate interest to limited information about child abuse or neglect cases that resulted in a child fatality or near fatality. Pursuant to the Child Abuse and Prevention Treatment Act (CAPTA), as amended (P.L. 108-36(42 USC §5106a)) states must have provisions that allow for public disclosure of the findings or information about the case of child abuse or neglect that has resulted in a child fatality or near fatality. Accordingly, agencies must release the following information to the public, providing that nothing disclosed would be likely to endanger the life, safety, or physical or emotional well-being of a child or the life or safety of any other person; or that may compromise the integrity of a Child Protective Services investigation, or a civil or criminal investigation, or judicial proceeding:

(a) The fact that a report has been made concerning the alleged victim child or other children living in the same household;

(b) Whether an investigation has been initiated;

(c) The result of the completed investigation;

(d) Whether previous reports have been made concerning the alleged victim child or other children living in the same household and the dates thereof, a summary of those previous reports, and the dates and outcome of any investigations or actions taken by the agency in response to those previous reports of child abuse or neglect;

(e) The agency's activities in handling the case.

11.5.2 Exceptions for release of information in a child death

Pursuant to [§ 32.1-283.1D](#) of the Code of Virginia, information gathered at a local, regional or state child fatality reviews is exempt from being released. These teams can publish information in statistical or other forms that do not identify the individual decedent.

11.6 Retention of CPS report involving a child death

The Code of Virginia [§ 32.1-283.1 D](#) requires the records of all reports involving a child death to be retained until the State Child Fatality Review Team has had an opportunity to review them. The reports to be retained include screened out reports and founded and unfounded investigations. The LDSS may contact the CPS Regional Consultant if there is any question about retention of a specific record. The automated data system must indicate a child death occurred so the record will not be purged prematurely.

11.7 Appendix A: Preliminary Child Fatality Information Form

The Preliminary Child Fatality Information Form provides initial or preliminary information and shall be completed with as much of the following information as possible:

Referral #:

Date of Complaint:

LDSS:	
Investigating Worker:	Phone:
CPS Supervisor:	Phone:
Person Making Complaint:	

Section A: Referral Information

Name of Deceased Child:			
Deceased Child's Date of Birth:		Date of Child's Death:	
Sex of Child: <input type="checkbox"/> Male <input type="checkbox"/> Female		Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Unknown	
Type of Alleged Abuse or Neglect: <input type="checkbox"/> Physical Neglect <input type="checkbox"/> Medical Neglect <input type="checkbox"/> Physical Abuse <input type="checkbox"/> Sexual Abuse <input type="checkbox"/> Mental Abuse/Neglect			
Name of Alleged Abuser/Neglector:			
Relationship of Alleged Abuser / Neglector to Child:	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Parents <input type="checkbox"/> Grandmother <input type="checkbox"/> Other	<input type="checkbox"/> Grandfather <input type="checkbox"/> Foster Parent <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt <input type="checkbox"/> Child Care Worker (reg)	<input type="checkbox"/> Siblings <input type="checkbox"/> Stepparent <input type="checkbox"/> Father's Paramour <input type="checkbox"/> Mother's Paramour <input type="checkbox"/> Child Care Worker (unreg)
Name of Second Abuser (if applicable):			
Relationship of 2 nd Abuser to Child (if applicable):			

Section B: Reporting Requirements

CPS Regional Specialist:	Date Reported:
CPS Program Manager:	Date Reported:
Law Enforcement:	Date Reported:
Commonwealth's Attorney:	Date Reported:
District Office of the Chief Medical Examiner:	Date Reported:

Section C: Circumstances Surrounding the Child's Death

Detailed Description of the Child's Death (When, where, why, how, who, and any related problems. (Please attach another page if necessary.)

Family's Prior Involvement with the LDSS:

Program
<p>CPS Case/Referral: Summary of Involvement:</p>
<p>Benefits Case/Referral: Summary of Involvement:</p>
<p>FC/Adoption Case/Referral: Summary of Involvement:</p>
<p>Other:</p>

Siblings of the Deceased Child – (Requires conducting a safety assessment of any siblings of the deceased child and development of a safety plan, if safety decision is conditionally safe or unsafe):

Sibling Name	DOB	Race	Sex	Initial Safety Decision, please choose from: “safe”, “conditionally safe”, or “unsafe”

Safety Plan Summary:

LDSS Action Plan (describe Investigation Plan; Regional Specialist’s planned involvement and assistance; and any additional comments and concerns. (Please attach another page if necessary.)

Disposition Due Date:

11.8 Appendix B: The LDSS and the Child Fatality Review Team

The following information is borrowed from [The National Center on Child Fatality Review](#) and has been edited for Virginia teams.

Attending a Child Fatality Review Team (CFRT) meeting for the first time may seem somewhat overwhelming. LDSS may ask their staff to attend to present a case or staff may wish to attend a meeting for training purposes as an introduction to the concept of child death reviews. Attending a CFRT meeting can also enhance the worker's investigative skills. CPS staff that have had a child death on their caseload can benefit from attending a meeting so that they can share first hand case experience and be a viable part of the response to that death. First hand observations have substance and texture that are lost in the text of written reports.

11.8.1 Who can attend a CFRT

Some LDSS staff may want to take a co-worker or supervisor to their first meeting. Time with a co-worker or supervisor after the meeting may provide a resource and opportunity to debrief.

11.8.2 What to bring to a meeting

For those who are presenting information at the CFRT, preparation is imperative, which means bringing all information about the case that might be helpful to the team. If presenting, staff should also make sure they are familiar with their agency's official protocols for sharing case material. Be sure to bring the [National Maternal Child Health \(MCH\) Center for Child Death Review](#) Case Report tool, having completed as much as possible during the investigation. Please bring the entire record including any photographs.

11.8.3 What to expect at the meeting

As a first-time presenter to the CFRT meeting, you may know some of the team members. Introductions should help you meet others you don't know. You may want to talk to some of them before or after the meeting, as they may bring you resources for other cases. You may have a chance to ask a question of an expert who would otherwise be lost in a chain of command between agencies. Take advantage of the opportunity. Most people on child fatality review teams want to be helpful.

Distractions may exist in the room. Your agency might be defensive, resistant to sharing, and even concerned about blame. You may feel awkward about speaking in a group. Focus on why you are there. Teams are generally protective of each other, even if you are a new member or a visitor. Don't be afraid to ask questions about what you don't understand.

Some people attending a CFRT meeting may feel quite anxious as they approach and enter the room. Others may consider it just another meeting. You will be asked to sign a Confidentiality Agreement before each case presentation. Prior to the presentation of cases, you will be asked to introduce yourself. Your team coordinator or chair may inform you of the process that cases are presented. Cases are reviewed one by one. Each agency will have a turn to share what they know about the death. The process is simple. During the meeting, if you are attending for a specific case, you may be asked to present if you have knowledge of the case or have recommendations. Just relax; be honest and responsible. During most of the meeting, you will have the opportunity to listen to others. If you have something to add, share it. Be factual.

It is not necessary to use names while presenting a case. For example you can use terms such as victim child, siblings, parents, maternal grandparents, neighbors, etc.

11.8.4 Case Presentation

Be thorough yet succinct in presenting your case to the team. Avoid reading from your records. Provide a summary of the agency's involvement with the family and response to this child's fatality. Imagine presenting the information as if telling a story of the incident. It may be helpful to start with the injury and/or death notification to your agency and then move (1) forward to describe your investigation and conclusions on the death and (2) backward from the death to other knowledge and/or contact with the child and his/her family and caregivers. Some suggested questions to answer:

- How was your agency notified of the death? When? Why? By whom?
- What were the circumstances of the death? How was the child's injury described and explained? What did the primary caregiver report about behavior and supervision of the child around the time of the injury? Were other persons present in the household? What did they report about the incident?
- What was your agency's response? Who responded? When? What was going on when you arrived and what did you do while you were there? What was the response from the family/parents/witnesses upon your arrival? What did you do while you were there? With whom did you speak? Were they cooperative? What was the affect of the individuals during your interaction or observation?
- Was the family known to your agency prior to this fatality? Why?
- If your agency did assessments of the child or caregivers, what were the outcomes of those assessments?

- What risk and protective factors were present in the child's life?
- Were you already providing services to this family at the time of the fatality? Had you previously provided services? Did you provide services after this fatality? Describe all services provided.

11.8.5 Confidentiality

Honor confidentiality. The basic rule is that everything stays in the room. The exception is that members may continue contact after the meeting to gather information useful for a case. Material taken to court should be collected separately from the team process. Sometimes, the possibility of a subpoena or court order may be the deciding factor in how information is shared. The rules for sharing records are complicated by different laws and different legal opinions on the meaning of the same law.

Most guidelines define what you should not do. Review of child death brings up the counter question regarding the legal hazards of not sharing. Agencies can be held liable for what they don't do, as well as what they do.

You should not share specific case information or team comments outside of the team. The exception is for necessary case management. Ask for assistance or have your team manage this process. You may share general information on the process with a colleague in your agency. You may want to share general comments with no possible case identifiers with your family or friends to debrief yourself and manage your personal reaction to the death of a child. However, families and friends might not want to hear such material.

Ask questions if you want to know how much and with whom you can share information. If the material bothers you, look for a safe outlet. Protect and respect the process.

11.9 Appendix C: Additional Resources for Child Fatalities

The internet is abundant with information relating to child fatalities, child fatality review and investigations of child deaths. The following resources may assist the local CPS worker in the investigation of a child fatality.

11.9.1 American Academy of Pediatrics

The American Academy of Pediatrics Professional Journal, [Pediatrics](#), provides expert research and information on a variety of topics. The following articles may be useful to the LDSS staff:

[Distinguishing Between Sudden Infant Death Syndrome and Child Abuse Fatalities](#)

[SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment.](#)

11.9.2 The National Center for the Review and Prevention of Child Death

The [National Center for the Review and Prevention of Child Death](#) is a resource center for state and local CDR programs, funded by the Maternal and Child Health Bureau. It promotes supports and enhances child death review methodology and activities at the state, community and national levels.

11.9.3 Sudden Unexpected Infant Death (SUID) vs. Sudden Infant Death Syndrome (SIDS)

There is a difference between Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. Sudden unexpected infant deaths (SUID) are defined as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation. Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than 1 year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history. One resource for more information is the [Center for Disease Control and Prevention](#).

11.9.4 Investigating child fatalities

The Office of Juvenile Justice and Delinquency Prevention publishes a portable guide which presents practical information on the circumstances that point to the willful, rather than accidental, injury or death of an infant or child and the evidence required to prove it, as well as the techniques for obtaining such evidence. It is entitled [Battered Child Syndrome: Investigating Physical Abuse and Homicide](#).

11.10 Appendix D Child Fatality Checklist

The following checklist can be located and printed from the [public website](#).

	OASIS / NOTIFICATIONS	DATE
1.	Received report entered into OASIS.	
2.	Fatality box checked in OASIS	
3.	Determine validity; assign response priority. Must be placed in investigation track. <ul style="list-style-type: none"> • If victim is foster child in agency's custody, request a neighboring locality to investigate. • If foster child is in another agency's custody, notify that locality immediately. 	
4.	Contact Regional CPS Program Consultant immediately using Preliminary Fatality Information form .	
5.	Notify regional Office of the Chief Medical Examiner, provide all information available.	
6.	Request copy of autopsy report in writing.	
7.	Notify Commonwealth's Attorney	
8.	Notify local law enforcement, provide all information available.	
	INVESTIGATION	
9.	Conduct investigation according to section 4 of policy/ guidance manual.	
10.	Complete as much as possible on National Center's Data Collection tool	
11.	Assess Immediate Safety of siblings and Immediate Needs of the family. <ul style="list-style-type: none"> • If fatality is only child in home, assess as safe. (do not check #1 safety factor) 	
12.	Assess risk (policy override to very high if a caretaker caused the child's death)	
13.	Contact CPS Program Consultant to review case prior to notifications being sent. <ul style="list-style-type: none"> • The CPS Program Consultant must be notified within 10 days of making a disposition. 	
14.	ALL contacts and notifications must be documented in OASIS.	
15.	Regional Child Fatality Review to be scheduled by Regional CPS Program Consultant. <ul style="list-style-type: none"> • Review is postponed until all criminal investigations are complete unless consent is given by Commonwealth's Attorney. • Present case at child fatality review team meeting (this is likely to be well after a disposition is made and the investigation is closed). 	
16.	All fatality cases must be retained by LDSS until reviewed by State Child Fatality Review Team	

11.11 Appendix E The National Center for the Review and Prevention of Child Death Guidance on the Role of Key Professionals on Child Death Review Teams

The following information has been taken from: The National Center for the Review and Prevention of Child Death. "Roles of Team Members."

<http://www.childdeathreview.org/members.htm>. Accessed September 28, 2012.

Material from this website is provided in an abbreviated and edited form here.

11.11.1 Law Enforcement

Law enforcement is often the first to respond to a scene and has responsibility for ensuring public safety, investigating the deaths of children, determining if crimes have occurred, and making arrests.

The law enforcement member can:

- Provide the team with information on:
 - The case status and investigation of the death scene.
 - The criminal histories of family members and suspects.
- Provide the team with expertise on law enforcement practices such as:
 - Death scene investigation, interviews and interrogations of witnesses and others.
 - Evidence collection.
- Support the team with assistance, particularly by acting as a liaison to other law enforcement agencies by:
 - Persuading officers from other agencies and/or jurisdictions to participate on the Child Death Review (CDR) team when there is a death in that jurisdiction.
 - Providing assistance to member agencies in working with area law enforcement.

11.11.2 Child Protective Services

CPS is responsible for investigating allegations of child abuse or neglect and for recommending or providing services to children and families when abuse or neglect is alleged or confirmed. In addition, CPS is the liaison to the broader child welfare agency and many community resources.

The CPS member can:

- Provide the team with information on:
 - The case status and investigation summary for deaths the CDR team is reviewing.
 - The family's and child's history and socioeconomic factors that might influence family dynamics, including unemployment, divorce, previous deaths, history of domestic violence, history of substance abuse, and previous abuse of children.
 - Other children in the home and previous reports of neglect or abuse in the care of an alleged perpetrator and the disposition of those reports.
- Provide the team with expertise by:
 - Using specialized knowledge to design better intervention and prevention strategies and identify ways to integrate these strategies into the system.
 - Identifying local and state issues related to preventable deaths.
 - Educating the team regarding child protection issues and how the CPS system works.
 - Explaining to the CDR team how to improve coordination with social service agencies.

11.11.3 Commonwealth's Attorney

This office is responsible for prosecuting the deaths of children when a criminal act was involved. This office often defines, by the cases they take to trial, what the standards of acceptable practices regarding child safety are in a community.

The Commonwealth's Attorney can:

- Provide the team with information on:
 - The case status for deaths the team is reviewing.
 - Previous criminal prosecution of family members or suspects in a child death.
 - Explanations when a case can or cannot be prosecuted.
 - Legal terminology, concepts and practices.

- Support the team by:
 - Assisting in the development and implementation of strategies in the legal and criminal justice systems to prevent child deaths and serious child injuries.
 - Assisting in the development and implementation of strategies to improve the prosecution of child deaths and serious child injuries.
 - Acting as a liaison between the team and prosecutor/district attorney's offices in other jurisdictions.

11.11.4 Medical Examiner

This office is responsible for determining the cause and manner of death for children who die under suspicious, unexplained or unexpected circumstances.

The medical examiner can:

- Provide the team with information on:
 - The status and results of the office's investigation into a child death and explanation of the manner and cause determination.
 - The autopsy report and other investigation records, such as toxicology reports, scene investigations and medical history records.
- Provide the team with expertise by:
 - Educating the team on the elements and procedures followed by the Medical Examiner's office in investigating a child's death.
 - Giving specific information as to the nature of the child's injuries to aid investigators.
 - Educating the team on causes of child death.
 - Educating the team on medical issues including child injuries and child deaths, medical terminology, concepts and practices.
- Support the team by:
 - Providing access to and information from other medical examiners offices.

11.11.5 Public Health

This agency is responsible for birth and death records, other health statistics and for developing and implementing public health strategies to prevent injuries and deaths. The agency also is the lead agency for maternal and child health (MCH) and is responsible for programs that improve the health and safety of pregnant women, infants and children. The agency may have established Fetal-Infant Mortality Review Teams (FIMR). Public Health can often provide information on neighborhoods and families. Public Health nursing staff may have information from home visits. Some public health agencies may provide direct health care services. Most will have immunization records.

The public health member can:

- Provide the team with information on:
 - Contacts made between the family and the public health agency.
 - Birth and immunization records and death certificates.
 - Statistical data.
 - Access to epidemiological/health surveillance data.
 - Programs for high-risk families.
- Provide the team with expertise by:
 - Providing information on the development and implementation of public health prevention activities and programs.
 - Providing information and assistance on data collection and analysis.

11.11.6 Pediatrician or Other Family Health Provider:

These professionals have expertise in health and medical matters concerning children.

The pediatrician or other family health provider can:

- Provide the team with information on:
 - Services provided to the child or family if seen by the health professional.

- General health issues, including child development, injuries and deaths, medical terminology, concepts and practices.
- Provide the team with expertise by:
 - Offering expert opinion on medical evidence in a child death.
 - Giving a medical explanation and interpretation of events from the point of view of examining thousands of living children.
 - Sharing general knowledge of injuries, SIDS/SUID, child abuse/neglect and childhood disease.

11.11.7 Emergency Medical Services (EMS)

EMS personnel are often the first on the scene when a child dies or is seriously injured. EMS usually prepares run records of their response that they can share at reviews.

The EMS member can:

- Provide the team with information on:
 - EMS run reports.
 - Details on the scene, including the persons at the scene.
 - Medical information related to the emergency procedures performed.
- Provide the team with expertise by:
 - Giving detailed explanations of EMS procedures and protocols.
 - Sharing general knowledge based on EMS training and experience.
 - Helping the team understand and/or participate in critical stress debriefings.

11.12 Appendix F: Child Death / Injury Interview and Documentation Guide

The following guidelines were originally produced in 1997 by the Oklahoma Child Death Review Board, modified by Florida Department of Law Enforcement, and modified for Virginia.

These guidelines were developed for use in cases involving a child death or injury. In child death cases, there are many risk factors to be considered. A child death inquiry will include clues such as the age of the child, criminal history of the parent/ caretaker, history of domestic violence in the household, prior abuse history, hazardous housing conditions, substance abuse in the parent/ caretakers, and other factors. Some child fatalities are due to neglect which may mean the child died either because of the caretaker's actions or because the caretaker failed to act. Neglect covers a broad spectrum of child deaths that may include drowning, suffocation, heat stroke, and medical neglect. Neglect cases may result in outward signs on the child's body. Other child deaths such as those from abuse may not always show outward signs. These deaths may occur from internal injuries to the body. All observations should be documented however any "red flag" items should ensure a complete and comprehensive investigation. In child death cases, always contact the district office of the medical examiner, the Commonwealth's Attorney, and local law enforcement.

This is just a guide. These guidelines are NOT a substitute for your agency's policies and procedures. Follow your agency's procedures and medical direction.

11.12.1 Things to OBSERVE

11.12.1.1 CHILD/VICTIM OBSERVATIONS

- Appearance in general?
- Bed sharing?
- Body position/ place where found?
- Cleanliness and type of clothing?
- Diaper?
- Face position?
- Head injuries?
- Objects in bed?
- Rigor/ stiffness of body?

- Sweaty body?
- Temperature of body: cold, cool, warm?

11.12.1.2 HOME OBSERVATIONS

- Adequate food available?
- Bedding?
- Crib conditions?
- Heating/ cooling?
- Insect infestation?
- Medications in the home?
- Odors/ toxins?
- Outside temperature?
- Pets/ where do they sleep?
- Room temperature?
- Siblings/ status?
- Smoking by caretaker?
- Ventilation?
- Waste can evidence check?
- Water supply?
- Weapons?

11.12.1.3 PARENT/ CARETAKER OBSERVATIONS(or anyone in the home)

- Frequent calls to the home by police, fire department or emergency room visits?
- Indications of domestic violence?

- Past medical history?
- Physical appearance?
- Resuscitative efforts?

Red Flags for observations: Bedding over/ under child? Body moved? Discoloration? Injuries/ marks? Lack of bed for infant? Alcohol/ drugs present? Unsanitary conditions?

11.12.2 The INTERVIEW

Conduct a mini interview at the scene with the caretaker. Be non-judgmental, non-confrontational, compassionate, observant and composed.

Explain the purpose of the interview by saying:

- "These questions will help evaluate what led to your loss."
- "The history you provide helps evaluate the cause of your loss."

Sample interview questions:

- What is the address of the parents/caretakers?
- How long has the child been at this address?
- Are the parents married?
- What time was the child found?
- When was the last time the child was seen alive?
- Does the child have a disability?
- Who found the child?
- Who was the caretaker at the time of death?
- When was the child last fed?
- How much breast or bottled milk?
- Was there a history of breathing difficulties?
- Had the child been crying or fussy?

- Who is the child's doctor?
- Had the child been ill recently?
- Has there been an ER or doctor visit in the last few weeks?
- Does the child take any medications/ had vaccines?
- What is the child's medical history?
- What type of prenatal care was provided?
- Were there any labor problems?
- Was the child premature or part of a multiple birth?
- Did the mother smoke/ use drugs during the prenatal period?
- What was the child's birth weight?
- Are the child's growth charts available?

Red Flags during the interview: Demeanor of caretaker? Delay in seeking medical treatment? History of other infant deaths? History inconsistent with death or injury?

11.12.3 Fatality investigations

- Investigation should be based on physical and/ or circumstantial evidence, establishing a timeline, and the possible confession.
- Must prove that the suspect had care, custody and control over the child victim.
- Must establish that the suspect was the person with the child at the time the injuries occurred.
- Must establish that the injuries were non-accidental.
- In cases of "accidental deaths" law enforcement and CPS must conduct a complete and thorough investigation.
- Consider tools such as re-enactment dolls: have the suspect demonstrate how the injuries occurred.
- Involve the medical community in establishing accidental vs. intentional, as well as the timeline.

- Many abuse injuries are not visible without the aid of x-rays, CT scans, MRI's or by a forensic autopsy.

How do child fatalities differ from other homicides?

- These cases generally involve brain trauma, internal injuries to the chest or abdomen or severe burns.
- The child often develops infection, or other complications arising from injuries and dies from the complications.
- Most abuse and homicides of children occur in a private location such as the family's home and eyewitnesses are rare.
- Homicides of children rarely involve weapons; most child murders are accomplished by the offender using his/ her hands.
- Often very small children are violently shaken, resulting in death.
- Older children are often struck by a fist or other blunt force object.
- These cases often involve the presence of identifiable and patterned injuries such as bite marks, circumferential tie marks or belt buckle marks.

11.12.4 Characteristics of Sudden Infant Death Syndrome (SIDS)

	Consistent with SIDS	Red Flags
History of death	Healthy infant; fed; put to bed; silent death	Unclear history; prolonged interval between bedtime and discovery
Age at death	2-4 months old most common; 90% of cases the child is 1-12 months old	Child older than 12 months
Physical exam at death	Pink watery frothy fluid from nose/ mouth; post mortem dependent discoloration; no skin trauma; well cared for	Injuries; trauma; bruises; indications of malnutrition; neglect; fractures
History of pregnancy	Cigarette use by parents; premature or low birth weight; multiple births; illness requiring hospitalization	Unwanted pregnancy; no health checks; drugs/ alcohol use during pregnancy
Death scene	Crib in good condition; firm sleep surface; no dangers or toxins; good ventilation	Appearances of chaotic, unsanitary, crowded living conditions; drugs/ alcohol; struggle in crib; blood-stained bedclothes; hostility by caretakers; discord; accusations
Previous deaths	First unexplained or unexpected death	More than one unexplained or unexpected infant death
Previous CPS or law enforcement involvement	None	Prior CPS involvement; family members arrested for violent behavior Previous SUID

