6

CHILD DEATHS

TABLE OF CONTENTS

6.1 Introduction 3

6.2 Report a child death 3

6.2.1 Report child death to District Office of the Chief Medical Examiner 3

6.2.2 Report child death to local Commonwealth's Attorney and law enforcement 4

6.2.3 Report child death to *CPS Practice Consultant* 4

6.2.4 Submit preliminary information concerning the child death 5

6.2.4.1 Logistical information 5

6.2.4.2 Demographic information 5

6.2.4.3 Reporting requirements 6

6.2.4.4 Circumstances surrounding the child's death 6

6.2.4.5 LDSS's plan of action 6

6.3 Investigation of child death 6

6.3.1 *CPS Practice Consultant* to provide technical assistance 7

6.3.2 Assessing safety in a child fatality 7

6.3.3 Assessing risk in a child fatality 8

6.3.4 Investigative protocol 8

6.3.5 Death of a child in foster care 11

6.3.6 Child death case reporting tool 12

6.3.7 Suspensions of child death investigations 12

6.3.8 Notify *CPS Practice Consultant* of disposition 13

6.4 Local, regional, and state child fatality reviews 13

6.4.1 Local and regional child death review teams 14

6.4.2 Regional Child Fatality Review Teams 15
6.4.2.1 Purpose of child fatality review 15
6.4.2.2 Role and responsibilities of CPS 16
6.4.2.3 Presenting a case for the regional child fatality review meeting 16
6.4.2.4 Regional child fatality review prevention initiatives 18
6.4.3 State Child Fatality Review Team 18
6.5 Release of child fatality or near fatality information 19
6.5.1 Guidelines for release of information in a child fatality or near fatality 19
6.5.2 Investigation of child death by Children's Ombudsman 20
6.5.3 Exceptions for release of information in a child death 20
6.6 Retention of CPS report involving a child death 21
6.7 Appendix A: Preliminary Child Fatality/Near-Fatality Information Form 22
***6.8 Appendix B: Near Child Fatalities* 25**
6.8.1 Definition of "near fatality" 25
6.8.2 Documentation and notification of near fatalities 25
***6.9 Appendix C: Additional Resources for Child Fatalities* 27**
6.9.1 American Academy of Pediatrics 27
6.9.2 The National Center for the Review and Prevention of Child Death 27
6.9.3 Center for Disease Control and Prevention 27
6.9.4 Investigating child fatalities 27
***6.10* Appendix D: *Sample Letter* 28**
6.10.1 Notification to Medical Examiner 28

6

CHILD DEATHS

6.1 Introduction

The investigation of child deaths is one of the most challenging and complex responsibilities of the child welfare system. The investigation of child deaths should be done through a multi-agency and multi-disciplinary process and conducted according to guidance and policy set forth in the VDSS Child and Family Services Manual Chapter C, Section 3: Complaints and Reports and Section 4: Assessments and Investigations. Additionally, 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.

All child fatality cases *investigated by* CPS are reviewed at the regional level by the Child Fatality Review Team (CFRT). T*here is a CFRT for each region*.

6.2 Report a child death

The Virginia Administrative Code (VAC) 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.

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

> (22 VAC 40-705-50 F1). When abuse 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 and local law-enforcement agency 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 *Family Services Specialist* shall document this notification in the *child welfare information system*.

*The Family Services Specialist must request a written copy of the autopsy report **within 5 working days** of notification to the District Office of the Chief Medical Examiner and document the request in the child welfare information system. See Appendix D: Sample Letter for a sample letter LDSS should utilize when providing the Medical Examiner's Office with notification of the child fatality and requesting a written copy of the autopsy report.*

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

> (22 VAC 40-705-50 F2). When abuse 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 suspected 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 *Family Services Specialist* shall document this notification in the child welfare information system.

6.2.3 Report child death to *CPS Practice 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 *Family Services Supervisor* or supervisor's designee shall contact the *CPS Practice Consultant* **immediately** upon receiving a complaint involving the death of a child. *This includes the death or near-fatality of a child in foster care, even if the death or near-fatality occurs out-of-state or in another jurisdiction.* The *Family Services Specialist* shall document this notification in the child welfare information system.

The *CPS Practice Consultant* shall ensure the completion of the Preliminary Child Fatality/Near-Fatality Information Form and forward it to the CPS Program Manager **within *two working days*** 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 *two working days***. This information *may* also be shared with the State Board of Social Services.

6.2.4 Submit preliminary information concerning the child death

The LDSS shall provide the following preliminary information concerning the child death to the *CPS Practice Consultant* who will submit the information on the Child Fatality/Near-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/Near-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.

6.2.4.1 Logistical information

- Name of LDSS.
- Name of investigating worker.
- Name of *Family Services Supervisor*.
- Date of complaint.
- Referral number.
- Person making the complaint.
- *CPS Practice Consultant*.

6.2.4.2 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.

6.2.4.3 Reporting requirements

- Date reported to *CPS Practice 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.

6.2.4.4 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).

6.2.4.5 LDSS's plan of action

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

6.3 Investigation of child death

CPS has an integral role in the investigation regarding the victim child and family. Child death investigations have the best outcomes when there is timely notification and CPS and law enforcement conduct a joint investigation. The It is recommended that the LDSS use a MOU to ensure this notification and collaboration with law enforcement.

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.

6.3.1 *CPS Practice Consultant* to provide technical assistance

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

6.3.2 Assessing safety in a child fatality

CPS is responsible for determining the safety of any other children in the home. The safety assessment must be completed in all investigations involving the death of a child. Special safety considerations for the investigation of a child death includes:

- *Was a drug screen completed with the caretaker at the time of death?*
- *Was the caretaker impaired at the time of death?*
- *Was the child in a designated safe sleep space?*
- *Was the sleep space firm and free from blankets, pillows and objects?*
- *Was there any prior child welfare involvement with the family?*
- *Were there unsecured medication or weapons in the home?*
- *Was the victim child born substance-exposed?*

The safety assessment should include both the inside and outside home environment.

If there are other children in the home, the safety assessment will be either conditionally safe (requires a safety plan) or unsafe (requires a court order) as death of child will be *recorded* in safety factor #1 on the safety assessment tool. “Caretaker caused serious physical harm to the child and/or made a plausible threat to cause physical harm in the current Investigation/Family Assessment.”

If there are other children in the home under the age of two, the Family Services Specialist should provide the caretaker with written information and verbal education on safe sleep practices. The Family Services Specialist should document that safe

sleep information was provided to the caretaker in the child welfare information system.

6.3.3 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 VDSS 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.

6.3.4 Investigative protocol

Prior involvement with the child welfare system should be considered when determining the validity of the report as prior system involvement has been found to correlate with child deaths that are the result of abuse or neglect from a caretaker.

The validity determination of the CPS complaint regarding the fatality must be made prior to the response of the LDSS. The LDSS may not respond to the complaint/report of child abuse or neglect in order to determine the validity of the referral. Once the LDSS responds to a complaint or report of child abuse or neglect, the LDSS is responsible for ensuring the completion of an investigation.

Child death investigations have the best outcomes when there is timely notification and CPS and law enforcement conduct a joint investigation. The Investigating Infant and Child Death Cases protocol developed by the Department of Criminal Justice Services and the Child Death Case Reporting Tool can assist in the completion of a thorough investigation.

As part of a child death investigation, it is important to ask questions and obtain information to understand the circumstances surrounding the child's death. Some information can be obtained through the use of closed-ended questions but other information is best obtained through the use of open-ended inquiries that solicit narrative responses. The following is a list of suggested questions and inquiries that can be used to guide the investigation:

- *General Information*
  - *Demographics of the victim child and caretaker.*
  - *Who called 911?*
  - *Describe any first aid or emergency care given and who provided it.*

- *Who found the victim?*
- *When was the victim child last seen alive?*
- *When was the last feeding or meal for the victim child?*
- *What was the victim child's physical appearance at the time of death?*
- *What was the alleged abuser/neglector's and caretaker's demeanor at the time of death?*
- *Describe any prior child welfare involvement.*
- *What was the victim child's developmental level?*
- *What was the educational level of the victim child?*
- *What is the educational level of the alleged abuser/neglector and caretaker(s)?*
- *What is the criminal history of the alleged abuser/neglector and caretaker(s)?*

- *Physical Health*
  - *Describe any disabilities of victim child, alleged abuser/neglector, and caretaker(s).*
  - *Describe the victim child's health within the past 48 hours.*
  - *Describe the pregnancy and any complications.*
  - *Who provided prenatal care during the pregnancy?*
  - *What was the victim child's medical history?*
  - *Who was providing the victim child with medical care?*
  - *When was the last time the victim child received medical care?*
  - *Describe any medications being taken and/or prescribed and the name of the prescriber for the victim child, alleged abuser/neglector, or caretaker(s).*
  - *Describe any medical diagnoses for the victim child, alleged abuser/neglector, and caretaker(s).*

- *Mental Health*
    - *Describe any mental health diagnoses of the victim child, alleged abuser/neglector, and caretaker(s).*
    - *Describe any mental health treatment received by the victim child, alleged abuser/neglector, and caretaker(s).*
    - *Who is/was providing the mental health treatment services?*
    - *When did the victim child, alleged abuser/neglector, or caretaker last receive mental health treatment services?*
    - *Describe any psychotropic medications being prescribed and the name of the prescriber for the victim child, alleged abuser/neglector, or caretaker(s).*
- *Substance Use*
    - *Describe any substance use (illegal and legal) by the victim child, alleged abuser/neglector, and caretaker(s).*
    - *When was the substance (illegal and legal) last used and by whom?*
    - *Are there any substances (illegal and legal) in the home?*
- *Home Observations*
    - *Describe the temperature in the home.*
    - *Describe the functionality of the utilities in the home.*
    - *Describe the presence of food or formula in the home.*
    - *Describe any hazards noted inside or outside of the home.*
    - *Describe any notable odors inside or outside of the home.*
    - *Are there pets in the home?*
    - *Describe any pets in the home and their access to the victim child or siblings.*
    - *Describe the sleep space for all children and adults in the home.*
    - *What bedding is used for the sleep spaces in the home?*

- *Are there unsecured weapons in the home?*
- *Where are the weapons and ammunition stored in the home?*
- *Where are medications stored in the home?*

- *Siblings*
  - *Describe the educational and child care arrangements for the siblings in the home.*
  - *Where were the siblings when the victim child died?*
  - *When did the siblings last see the victim child alive?*
  - *When did the sibling last see the victim child eat or be fed?*
  - *Describe where the victim child slept in the home.*
  - *What do the siblings know about the victim child's death?*
  - *Describe the reaction of the siblings to the victim child's death.*
  - *Describe the victim child's relationship with the alleged abuser/neglector or caretaker(s).*
  - *How did the alleged abuser/neglector or caretaker(s) discipline the victim child?*

6.3.5 Death of a child in foster care

If the child fatality involves a child in the custody of a LDSS, the LDSS Family Services Supervisor or Supervisor's designee must ***immediately*** *notify the LDSS with legal custody of the child.*

The LDSS Family Services Supervisor or Supervisor's designee must also ***immediately*** *notify the CPS Practice Consultant and the Foster Care Practice Consultant. The Family Services Specialist must document these notifications in the child welfare information system. The LDSS should discuss potential conflicts of interest with their CPS Practice Consultant if the local department of jurisdiction is the custodian of the child in foster care or if the child is placed in a locally approved foster home approved by the local department of jurisdiction.*

6.3.6 Child death case reporting tool

The purpose of the case reporting 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. It collects critical information that is entered into the national database.

The CPS Practice Consultant will provide the LDSS with the case reporting tool from the National Center link and color-coded guide upon initial notification of a child death. The case reporting tool is also located on the public website. The data dictionary, which is located with the tool, provides definitions and question-by-question instructions that the Family Services Specialist should always refer to when completing the tool. This tool can assist the LDSS in completing a thorough investigation.

The Family Services Specialist should obtain detailed information and complete the sections as referenced in the color-coded guide, which can also be accessed and printed from FUSION. The Family Services Specialist 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 completed case reporting tool must be submitted to the CPS Practice Consultant ***no later than five business days*** *after the completion of the investigation. The remaining sections of the case reporting tool will be completed at the regional child fatality review team meeting.*

6.3.7 Suspensions of child death investigations

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 needed 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. *The LDSS must submit a written request to the medical examiner to obtain a written copy of the autopsy report and document the request in the child welfare information system.* 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 child welfare information system.

If the LDSS has the evidence necessary to make the disposition they should not suspend the investigation.

As long as the investigation remains open, the LDSS retains all authorities and responsibilities of an investigation. The LDSS must document monthly updates in the child welfare information system until such time that the necessary reports or records to complete the investigation have been received.

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 child welfare information system. If notification is made verbally, then the LDSS must document the notification in the child welfare information system. The LDSS must document the justification in the child welfare information system for the additional time needed to complete the investigation *and the monthly updates*.

6.3.8 Notify *CPS Practice Consultant* of disposition

The LDSS should consult with the CPS Practice Consultant prior to making the final disposition. The LDSS must notify the *CPS Practice Consultant* with the final disposition, assessed risk and any pending criminal charges or investigations concerning the child death. *The results of the autopsy must be documented in the child welfare information system.*

Each child death will be reviewed by a regional child fatality review team. The *CPS Practice 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.

6.4 Local, regional, and state child fatality reviews

The review of child deaths reported to Child Protective Services can best be achieved through a multi-agency, multi-disciplinary process that routinely and systematically examines circumstances surrounding the reported deaths of children.

6.4.1 Local and regional child death review teams

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

(§ 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, *a local emergency medical services agency chief*, 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 *four*, 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.

6.4.2 Regional Child Fatality Review Teams

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

6.4.2.1 Purpose of child fatality review

The purpose of a fatality review is:

- Conduct comprehensive multidisciplinary reviews.
- Better understand how and why children die.
- Improve child death investigations.

- Improve the systematic response to children in need.
- Use the findings to take action to prevent other deaths.
- Improve the health and safety of children.

6.4.2.2 Role and responsibilities of CPS

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 *Family Services Specialist or current Family Services Supervisor* 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 intimate partner violence, and history of substance abuse or mental illness.
- Prior CPS involvement.

The *Family Services Specialist* will be notified by phone or in writing by the *CPS Practice 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 *Family Services Specialist* should complete all documentation in the child welfare information system and all supervisory approvals should be done.

6.4.2.3 Presenting a case for the regional child fatality review meeting

The *Family Services Specialist*, *Family Services Supervisor,* or the person who will present the case at the review meeting, *should* be prepared to verbally present *a summary which includes* 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's 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? W*hat was the outcome and risk level?* 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?
- *Did CPS and law enforcement conduct a joint investigation of the child death?*

The presenter *must* bring a copy of the case record, including any photographs.

Maintaining confidentiality is extremely important. The *Family Services Specialist*, *Family Services Supervisor*, 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.

The completed case reporting tool must be submitted to the CPS Practice Consultant ***no later than five business days*** *after the completion of the investigation.* The remaining sections of the case reporting tool will be completed

at the regional child fatality review team meeting. The final completed tool will be entered into the National MCH Center for Child Death Review database.

For additional information on what to expect at a child fatality review team and a tip sheet for presenters please see Appendix C. For additional information regarding the roles of all key professionals on child fatality review teams *please review the job aid on FUSION*.

6.4.2.4 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.

6.4.3 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.

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

(22 VAC 40-705-160 A6). 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.

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

The VAC 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.

6.5.2 Investigation of child death by Children's Ombudsman

Pursuant to § 2.2-443 B of the Code of Virginia, the Children's Ombudsman may investigate all child fatality cases that occurred or are alleged to have occurred due to child abuse or child neglect in the following situations:

- *A child died during an active child protective services investigation or open services case, or there was a valid or invalid child protective services complaint within 12 months immediately preceding the child's death.*
- *A child died while in foster care, unless the death is determined to have resulted from natural causes and there were no prior child protective services or licensing complaints concerning the foster home.*
- *A child was returned home from foster care and there is an active foster care case.*
- *A foster care case involving the deceased child or sibling was closed within 24 months immediately preceding the child's death.*

In order to assist the Children's Ombudsman with their investigation of a child fatality, the LDSS must follow the guidance in 9.2.10, Release information to Office of Children's Ombudsman.

6.5.3 Exceptions for release of information in a child death

Pursuant to *§ 32.1-283.1 C* of the Code of Virginia, information gathered at local, regional or state child fatality review is exempt from being released. These teams can publish information in statistical or other forms that do not identify the individual decedent.

6.6 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 Practice Consultant* if there is any question about retention of a specific record. *The LDSS must document that a child death occurred in the child welfare information system so the record is not purged prematurely.*

6.7 Appendix A: Preliminary Child Fatality/Near-Fatality Information Form

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

CAPTA (Child Abuse Prevention and Treatment Act) defines a "near fatality" as an act that, as certified by a physician, places the child in serious or critical condition

(22VAC40-705-10) "Life-threatening condition" means a condition that if left untreated, more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

A near-fatality requires that a physician certify that a child is in serious or critical condition at the time of the report. Such certification can be either in writing or verbal. Hospital records which indicate the child's condition is serious or critical and life threatening are sufficient. The physician certification must be documented in the child welfare information system.

Referral #: Date of Complaint:

LDSS:	
Investigating Worker:	Phone:
Family Services Supervisor:	Phone:
Person Making Complaint:	

Section A: Referral Information

Name of Child:			
Child's Date of Birth:	Date of Child's Death/Significant Event:		
Sex of Child: ☐ Male ☐ Female ☐ Unknown	Race: ☐ White ☐ Black ☐ Asian ☐ Multi-Racial ☐ Unknown		
Type of Alleged Abuse or Neglect: ☐ Physical Neglect ☐ Medical Neglect ☐ Physical Abuse ☐ Sexual Abuse ☐ Mental Abuse/Neglect			
Name of Alleged Abuser/Neglector:			
Relationship of Alleged Abuser / Neglector to Child:	☐ Mother ☐ Father ☐ Parents ☐ Grandmother ☐ Other	☐ Grandfather ☐ Foster Parent ☐ Uncle ☐ Aunt ☐ Child Care Worker	☐ Siblings ☐ Stepparent ☐ Father's Paramour ☐ Mother's Paramour ☐ Child Care Worker

		(reg)	(unreg)
Name of second abuser:			
Relationship of 2nd Abuser to Child (if applicable):			

Section B: Reporting Requirements

CPS Regional Specialist:	Date Reported:
VDSS CPS Program Manager:	Date Reported:
Law Enforcement:	Date Reported:
Commonwealth's Attorney:	Date Reported:
Regional Medical Examiner:	Date Reported:

Section C: Circumstances Surrounding the Child's Death/Significant Event

Detailed Description of the Child's Death/Significant Event (When, where, why, how, who, and any related problems.)

Family's Prior Involvement with the LDSS:

Program
CPS Case/Referral: Summary of Involvement:
Benefits Case/Referral: Summary of Involvement:
FC/Adoption Case/Referral: Summary of Involvement:

Other:

Siblings of the (Victim) Child – (Requires conducting a safety assessment of any siblings of the victim 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.

Disposition Due Date:

Update/Addendum:

6.8 Appendix B: Near Child Fatalities

The Child Abuse and Prevention Treatment Act requires tracking and public disclosure of cases of child abuse or neglect that result in a near-fatalities. The examination of the circumstances surrounding near fatalities assist in the identification of child protection issues and improve efforts to prevent future child fatalities and near fatalities. See Section 3.7 Report Child Fatalities and Near Fatalities for additional information.

6.8.1 Definition of "near fatality"

The Child Abuse and Prevention Treatment Act (CAPTA) defines a "near fatality" as an act that, as certified by a physician, places the child in serious or critical condition. The VAC provides the following definitions:

> (22VAC40-705-10) "Near fatality" means an act that, as certified by a physician, places the child in serious or critical condition. Serious or critical condition is a life-threatening condition or injury.
>
> (22VAC40-705-10) "Life-threatening condition" means a condition that if left untreated more likely than not will result in death and for which the recommended medical treatments carry a probable chance of impairing the health of the individual or a risk of terminating the life of the individual.

Inherent within the definition of a near fatality is the requirement that a physician certify that the child is in serious or critical condition at the time of the report. Certification by a physician can be either in writing or verbal. Hospital records which indicate the child's condition is serious or critical and life threatening are sufficient. The physician certification must be documented in the child welfare information system. However, "near fatality" is a phrase used in child protective services. It is not a medical term.

6.8.2 Documentation and notification of near fatalities

The LDSS must document situations which constitute a near fatality of a child in the child welfare information system. The type of abuse or neglect believed to have caused the near fatality must be documented in the child welfare information system. The LDSS must inform the *CPS Practice Consultant* as soon as possible of all situations which constitute a near fatality and document the notification in the child welfare information system. The *CPS Practice Consultant* must ensure the completion of the Preliminary Child Fatality/Near-Fatality Information Form. The form can be found on the public website and in Appendix A. The *CPS Practice Consultant* must forward the Preliminary Child Fatality/Near-Fatality Information Form to the CPS Program Manager and Child Fatality Specialist as soon as possible.

Child maltreatment deaths may involve a delay between the time the child is determined to be in critical or serious condition and the subsequent death of the child. If during the course of the investigation the child dies, the child welfare information system must be changed to reflect the fatality. A child cannot be considered a near fatality and a fatality in the child welfare information system.

6.9 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 *Family Services Specialist* in the investigation of a child fatality.

6.9.1 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:

Improvements in Infant Sleep Position: We Can Do Better!

The National Center for Fatality Review and Prevention SIDS/SUID Fact Sheet

6.9.2 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.

6.9.3 Center for Disease Control and Prevention

The *Center for Disease Control and Prevention is a resource for information on* Sudden Unexpected Infant Death (SUID).

6.9.4 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.

6.10 Appendix D: *Sample Letter*

6.10.1 Notification to Medical Examiner

The following letter can be used to provide notification of a child death and to request a written copy of the autopsy report.

Month, Date, Year

Department of Health

Office of Chief Medical Examiner

Street Address

City, VA Zip

In Re: Victim Child

DOB: 2 digits/2 digits/4 digits

Parent: First/Last Name and First/Last Name

Resident at time of death:

Street Address

City, VA Zip

Dear Office of Chief Medical Examiner:

I am writing to provide notification of the death of above referenced child pursuant to §63.2-1503 E of the Code of Virginia. The date of death is 2 digits/2 digits/4 digits.

I am a Family Services Specialist at insert agency name and I have been assigned the death investigation of the victim child reference above. As part of the death investigation, the insert agency name Department of Social Services requests a written copy of the completed autopsy report. Please forward the information to:

- *insert agency name Department of Social Services,*
- *Attention: Assigned Worker Name, Family Services Specialist*
- *Street Address*
- *City, VA Zip.*

If you have any questions, I may be reached at xxx-xxx-xxxx. Thank you for your immediate attention in this matter.

Sincerely,

Worker Name

Family Services Specialist