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CHILD DEATHS

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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). There 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

Pursuant to [22 VAC 40-705-50 F1](#), 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.

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

Pursuant to [22 VAC 40-705-50 F2](#), 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

Pursuant to [22 VAC 40-705-50 F3](#), 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 [FUSION](#).

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 *child who is a victim* and family. Child death investigations have the best outcomes when there is timely notification and CPS and law enforcement conduct a joint investigation. 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, Assessments and Investigations.

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 *child who is a victim* 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 *in-home* services.

When there are surviving siblings in the home, the LDSS must use risk level to inform the decision whether or not to open a case as follows:

<i>Low Risk:</i>	<i>Close</i>
<i>Moderate Risk:</i>	<i>Open to In-Home Services or close</i>
<i>High Risk:</i>	<i>Open to In-Home Services</i>
<i>Very High Risk:</i>	<i>Open to In-Home Services</i>

The Family Services Specialist and Family Services Supervisor should assess the decision to open a case for services and document in the child welfare information system the decision not to open a case. For more guidance on service planning in a case refer to [Section 2, Chapter B. Prevention, VDSS Child and Family Services Manual](#).

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 *child who is a victim* and caretaker.

- Who called 911?
- Describe any first aid or emergency care given and who provided it.
- Who found the victim?
- When was the *child who is a victim* last seen alive?
- When was the last feeding or meal for the *child who is a victim*?
- What was the *child who is a victim*'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 *child who is a victim*'s developmental level?
- What was the educational level of the *child who is a victim*?
- 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 *child who is a victim*, alleged abuser/neglector, and caretaker(s).
 - Describe the *child who is a victim*'s health within the past 48 hours.
 - Describe the pregnancy and any complications.
 - Who provided prenatal care during the pregnancy?
 - What was the *child who is a victim*'s medical history?
 - Who was providing the *child who is a victim* with medical care?
 - When was the last time the *child who is a victim* received medical care?
 - Describe any medications being taken and/or prescribed and the name of the prescriber for the *child who is a victim*, alleged abuser/neglector, or caretaker(s).
 - Describe any medical diagnoses for the *child who is a victim*, alleged abuser/neglector, and caretaker(s).

- Mental Health
 - Describe any mental health diagnoses of the *child who is a victim*, alleged abuser/neglector, and caretaker(s).
 - Describe any mental health treatment received by the *child who is a victim*, alleged abuser/neglector, and caretaker(s).
 - Who is/was providing the mental health treatment services?
 - When did the *child who is a victim*, 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 *child who is a victim*, alleged abuser/neglector, or caretaker(s).
- Substance Use
 - Describe any substance use (illegal and legal) by the *child who is a victim*, 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 *child who is a victim* 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 *child who is a victim* died?
 - When did the siblings last see the *child who is a victim* alive?
 - When did the sibling last see the *child who is a victim* eat or be fed?
 - Describe where the *child who is a victim* slept in the home.
 - What do the siblings know about the *child who is a victim's* death?
 - Describe the reaction of the siblings to the *child who is a victim's* death.
 - Describe the *child who is a victim's* relationship with the alleged abuser/neglector or caretaker(s).
 - How did the alleged abuser/neglector or caretaker(s) discipline the *child who is a victim*?

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 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.

6.3.7 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.

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

Section [32.1-283.2](#) of the Code of Virginia authorizes reviews of child deaths at the local, regional, and/or state level.

6.4.2 Regional Child Fatality Review Teams

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 death that meets the following criteria:

- *Current open DSS referral/case at the time of the fatality;*
- *Valid or invalid CPS report within the last 12 months;*
- *Child died while in foster care (not from natural death and no complaint in foster home);*
- *Child died in foster care on a trial home placement; and*
- *Foster care case involving decedent or decedent's siblings was closed within the last 24 months*

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 *Protection Program* 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? What 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.

6.4.2.1 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

Section [32.1-283.1](#) of 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.

6.5 Release of child fatality or near fatality information

Pursuant to [22 VAC 40-705-160 A6](#), 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.

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

[22 VAC 40-910-100 B](#) establishes the information that can be released in child abuse or neglect cases with a child death.

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 Section 9, Confidentiality.

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.