CD04-89

DEPARTMENT OF SOCIAL SERVICES

CHILDREN'S DIVISION

P.O. BOX 88

JEFFERSON CITY, MISSOURI

October 25, 2004

MEMORANDUM

What's Inside:

- Why notify Administration of Child Death/Serious Injury
- Importance of Trend Analysis
- Critical Events Protocol
- STAT Involvement

TO: REGIONAL EXECUTIVE STAFF, CIRCUIT MANAGERS AND CHILDREN'S DIVISION STAFF

FROM: FREDERIC M. SIMMENS, DIRECTOR

SUBJECT: CHILD FATALITY, SERIOUS INJURY OR CRITICAL EVENT NOTIFICATION AND STATE TECHNICAL ASSISTANCE TEAM (STAT) FATALITY REVIEW

REFERENCE: CHILDREN'S DIVISION

DISCUSSION:

Our policy regarding notification to Children's Division Regional and Central Office when a child fatality or serious injury results has been revised. The information gathered will allow us to better analyze and identify those trends that surround child fatalities and will also enable us to identify indicators of behaviors that may result in child fatalities and serious injury. Finally with the knowledge of these trends and indicators we can enhance policy, training, and practice with the purpose of preventing child fatalities and serious injury. This information along with information from the Child Fatality Review Panel will serve as a valuable tool in the communities where vulnerable children live.

NOTIFICATION OF CHILD DEATH, SERIOUS INJURY OR CRITICAL EVENT

A new email address (CD_CriticalEventReport) has been set up to notify key staff about child deaths or serious injuries. Key staff includes, but are not limited to: circuit Managers, Regional Directors, Field Support Staff, and Central Office. An electronic copy of the CS-23 (Preliminary Report of Death or Serious Injury) should be completed and attached to the email within 24 hours. The CS-23 is now available as a One-form document and can be downloaded to an individual's computer. Additionally, a review and case summary will be completed by the local CD office; this case summary will consist of prior CD involvement with the child and family and will also include information gathered from external agencies

who have worked with the family prior to the fatality. These external agencies may include but not limited to the Health Department, Social Service Agencies, schools, juvenile court, etc… This review/case summary should be completed and submitted to Central Office within 72 hours of fatality or Critical Event. See Attachment B

CRITICAL EVENTS PROTOCOL

The Critical Events Protocol is a process that has been developed with the assistance of field staff, to review certain child fatalities, serious injuries or critical events. The protocol consists of a review of information about the child, family, prior involvement with CD/other agencies, and the specifics surrounding the fatality/critical event. Key information includes the electronic CS-23 form as described above, copies of case records, if applicable, and a review of data found in the CA/N automated system. Because the case records may be requested, it is critical that field staff secure the case record and have ready to forward to central Office if requested.

- 24 Hours - Staff in the County/Circuit Office will complete a preliminary fatality/critical event summary; please follow attached summary format, that includes demographic information on the child, family prior involvement with the Division (i.e., CA/N reports). When necessary, Central Office staff may request all available case records involving the family and child;

- 24/72 Hours – To analyze trends holistically, county staff will gather and review information such as type and length of involvement from those external agencies which were involved with the family prior to the child fatality/critical event. This additional information will allow for a better frame of the family dynamics and needs prior to the fatality, this frame is important in understanding what the events were that lead up to the fatality/critical event and will be crucial in identifying trends and indicators. Additional information may also be gathered from the Local Child Fatality Review Panel. The external agencies referred to above include, but are not limited to (include length of service):
    - Juvenile Court: related matters may involve delinquency; status offenses; truancy; child protection; and/or domestic relations.
    - Health Department: Services may include WIC; First Steps; Healthy Start; Visiting Nurses; and/or other in home services.
    - Social Service Agencies: Services may include Parent Aide; Special Needs; MC+; and/or Therapy/Counseling.
    - Schools: Services may include Special Education; Suspension.

- 48/72 Hours – Central Office staff will review the summary received from the Circuit/Regional office and may request to review the case record when necessary;
- The information submitted via the CS-23 and Case Review summary will be reviewed by central Office staff within 72 hours of receipt, the information will then be input into the database

TREND ANALYSIS

The goal of the Children's Division is to create a practice environment that will allow early identification and intervention to prevent child fatalities and serious injuries. To identify needed practice enhancements and training needs to accomplish this goal the Division will look to identify those trends and indicators surrounding child fatalities/critical events by analyzing the information gathered through the above described process and reporting out the results. A database is currently under development that will allow us to collect and analyze the data. These reports will be produced and distributed annually.

STATE TECHNICAL ASSISTANCE TEAM (STAT) REVIEW

Effective immediately, staff from STAT will begin reviewing child abuse and neglect fatalities involving children who died while in the custody of the Children's Division (CD). STAT may also review other incidents of abuse/neglect that involve unusual situations, such as a child killing another person or an unusually severe report of abuse/neglect.

During the review, STAT staff will contact the Child Abuse and Neglect (CA/N) investigator for additional information about the child fatality. Upon request, CD staff should share all available information on the investigation to STAT. This includes contacts, notes, narratives and any other information pertaining to the investigation. The CD and STAT staff will continue to communicate until the conclusion of the STAT investigation and determination. This determination should be notated in the case record.

NECESSARY ACTION:

1. Review this Memorandum and Attachments with all Children's Division staff;
2. Staff should review the revised policy on reporting fatalities and serious injuries found in Child Welfare Manual, Section 2.4.3.10, Fatality, Near-Fatality, Serious Injury or Other Critical Event;
3. Effective immediately, staff should complete and send an email to with an attached electronic version of the CS-23 to Central Office within 24 hours of the fatality or serious injury;
4. Effective immediately, begin sharing information from investigations involving child fatalities with STAT;
5. All questions as related to these policy changes should be cleared through normal supervisory channels.

FS:BH:SC/cb

Attachment A: DSS Critical Event Protocol
Attachment B: Case Summary Template