CD05-50

DEPARTMENT OF SOCIAL SERVICES

CHILDREN'S DIVISION

P.O. BOX 88

JEFFERSON CITY, MISSOURI

August 25, 2005

MEMORANDUM

- TO: REGIONAL EXECUTIVE STAFF, CIRCUIT MANAGERS AND CHILDREN'S DIVISION STAFF
- FROM: FREDERIC M. SIMMENS, DIRECTOR
- SUBJECT: POLICY AND PROCEDURE FOR RESPONDING TO FATALITIES AND/OR OTHER CRITICAL EVENTS, INCLUDING NOTIFICATION TO REGIONAL MANAGERS AND CENTRAL OFFICE

FORM REVISIONS: <u>CS-23</u> and <u>Instructions</u>; <u>FATALITY/CRITICAL</u> <u>EVENTS SUMMARY and Instructions</u>

CHILD WELFARE MANUAL REVISIONS: Section 1, Chapter 4.7; Section 2, Chapter 1.1.1.1 and Chapter 1.2.4 Section 2, Chapter 4.3.9 and Chapter 4.3.9.1; Section 2, Chapter 7.5.5; Section 3, Chapter 4, Attachment F (New Attachment); Section 4, Chapter 24.11

DISCUSSION:

The purpose of this memorandum is to introduce revised policy and forms pertaining to staff response to a report involving the death or critical event of a child. Critical Events Protocol that was originally introduced with Memorandum CD04-89

(<u>http://dssweb/cs/memos/2004/89/cd0489.pdf</u>) has been revised. These changes in policy will help to clarify when and how a CS-23 and Fatality/Critical Event Summary are to be completed and forwarded to Regional and Central Office Administration. An attached flowchart will illustrate the communication flow within the Division based on the revised protocol.

Changes to Critical Event Protocol and Related Policy and Forms:

The CS-23 has been revised with some technical changes, and to allow space to include the CA/N incident number on the form. Additionally, the format of the Fatality/Critical Event Summary has been changed, so that the form is now addressed from the CSW, Reviewed by the Circuit Manager and addressed to the Director, with space added for manner of death, and

WHAT'S INSIDE:

- Revised Child Welfare Manual Policy for responding to fatalities & fatality/critical events protocol
- Revised CS-23 & Fatality/Critical Events Summary

expanded case history. The <u>CS-23</u> and <u>Fatality/Critical Event Summary</u> are both on MS word format, and can be located, along with related form instructions, on the CD Intranet under E-Forms. (The CS-23 one form version is now obsolete and any CS-23 sent as a one form will no longer be accepted. Staff should immediately delete the one form version of the CS-23 from their hard drive).

A CS-23 and Fatality/Critical Event Summary are now required for:

- All fatality reports in which child abuse or neglect has been alleged
- All near-fatal, critical events, or other cases with (or potential for) media attention
- Any Non-CA/N fatality referrals on families having current or past CD involvement (past referrals included); except for reports of death due to premature birth only, for which, professional discretion may be used.

Using the above guidelines, a CS-23 must be completed by the CSW/ Supervisor who received notice from CANHU of the fatality and forwarded to Central Office (via e-mail sent to: <u>DSS.CD.CriticalEventReport</u> cc: Circuit Mgr and Regional Director) within:

- 3 hours (or by 9:00 a.m. the following business day for reports alerted after hours) for any open case or case with current media involvement (An open case includes any unconcluded CA/N report, open FCS, or open FCOOH case); or
- 24 hours for CA/N fatalities, or cases with prior history or potential for media involvement as specified above.

Adherence to this policy will require an immediate system check by local staff of fatality reports received to determine if there is any CD involvement with any person listed on the report. If the residence county or State differs from the county receiving the notification of the fatality, the county that received the alert is responsible for completing the CS-23 and summary, however, it is expected that the reporting county may need to explain on the form that the other county (or State) may have additional information.

The Circuit Manager, or designee, is responsible for reviewing and forwarding a completed Fatality/Critical Event Summary to Central Office and Regional Administration within 3 working days as indicated above. The Circuit Manager may designate the person responsible for completing the Summary; however, when there is a current open case, the Investigator/Assessor or FCS/FCOOH Case Manager shall be responsible for completing the Summary. The completed Summary is to be submitted to the Circuit Manager, through supervisory channels, to allow sufficient time for review, and so that the summary is received in Central office (via e-mail) within three (3) working days.

E-mail (sent to: <u>DSS.CD.CriticalEventReport</u>) should be used for submitting these reports, in lieu of faxing them, whenever possible.

The Regional Administrator shall assure that the Guidelines have been followed as indicated above, and that the Director has been informed timely of the fatality.

The Out of Home Investigations Unit Manager will utilize <u>DSS.CD.CriticalEventReport</u> e-mail address to update central office administration of a fatality incident when notifying the Deputy Director. The OHI Investigator is responsible for notifying the child's case manager immediately of the death of a child in CD custody.

An updated CS-23 should be forwarded to Central Office as new pertinent information becomes available, including the identification of, or addition of, involved parties.

Improved public relations, which helps in gaining support from the public and recognition for our efforts, can be facilitated with timely reporting to Division Administration of any fatalities or critical events that have potential for media involvement.

An additional function of the CS-23 and summary is to provide an opportunity for Field Management and Central Office Administration to utilize the information to review and improve our policies, practices and to identify training needs. The Circuit Manager, or Regional Administrator may determine that a local case review is warranted based on information provided on the CS-23 and/or Summary, and is encouraged to arrange a review as indicated. Central Office Administration will maintain a database of fatalities and submitted reports. Designated Central Office Staff may contact Regional Administration, or designee, to request reports not submitted per policy. Additionally, Designated Central Office Staff will conduct, at a minimum, bi-monthly reviews of all fatality cases having CD involvement. The Designated Principal Assistant, or designee, may request that Regional Administration arrange for a local case review as indicated. Regional Administration will provide a summary of any such review to the Designated Principal Assistant, or designee, in a timely manner. Regional Administration will access resources that are available to address practice or training needs discovered through the review process, such as Social Work Specialists, FCS consultants as available, or the Quality Improvement and Field Support Unit.

Change to Burial Arrangements policy:

The Children's Division will pay for burial expenses, <u>not to exceed \$1,500.00</u>, for a child who died in CD custody. However, the CSW should be diligent in assuring that other resources are utilized first, when available.

NECESSARY ACTIONS:

- 1. Review this memorandum with all Children's Division Staff.
- 2. Review Revised Child Welfare Manual Sections.
- 3. Review revised CS-23, Fatality/Critical Event Summary, and related instructions.
- 4. All questions should be cleared through normal supervisory channels and directed to:

PDS CONTACT:	PROGRAM MANAGER:
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CHILD WELFARE MANUAL REVISIONS:	
Section 1, Chapter 4.7; Section 2, Chapter 1.1.1.1 and Chapter 1.2.4	

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Related Statutes:

Chapter 210 RSMo Chapter 58 RSMo

Administrative Rules:

13 CSR 40-60.030

Council on Accreditation (COA) Standards: N/A

PROGRAM IMPROVEMENT PLAN (PIP): N/A

SACWIS REQUIREMENTS:

http://dssweb/cs/priority_tracking/sacwis/status/20050316.xls

1. Intake Management

2. Case Management #2 and #3

Attachment

Flowchart

FMS/MS/cb