TEXAS
Department of Family
and Protective Services

Child Fatality Protocol Handbook

January 2024

Contents

INTRODUCTION

If the child death case you are currently working is a Case Related Special Request see CRSR Child Fatality Protocol. See CRSR Child Fatality Protocol
This protocol handbook serves as a companion to the policy handbook. It is designed to provide staff with a state-wide, consistent model for best practices and task-specific details to help staff meet policies.

Staff should be familiar with all sections of the protocol handbook and can utilize it throughout the course of a child fatality investigation.

It is important to note that this protocol handbook serves as the state-wide protocol. If you or your region comes across a specific issue that could benefit from a standardized protocol, please notify your Regional Director. The Regional Director will notify the Director of the Office of Child Risk and Safety (OCRS) so that it may be reviewed and potentially included in this Child Fatality Protocol Handbook.

INVESTIGATION POLICY & PROTOCOLS

It is critical that all staff that investigate child fatalities, including those that occur in an educational setting, understand all the applicable policies and procedures. In the section below, the various tasks and responsibilities are laid out following the ordering in the CPS Policy Handbook and in the timeline of an investigation. It is the responsibility of staff to refer to the Policy Handbook for all tasks associated with any investigation, including those that involve child fatalities.

NOTIFICATIONS WHEN A CHILD DIES

Notifying DFPS Staff When a Child Dies

Notification of a child fatality occurs when an intake report regarding the fatality is stage progressed to an investigation or the fatality involves a child in an open case, regardless of the stage of service or cause of death.

Within 24 hours (excluding weekends or holidays), the caseworker or Special Investigator assigned to the case:

- completes Notification of Child Fatality – Form 2701 - Part A; and
- forwards it by e-mail to the appropriate Child Safety Specialist.

See: Form 2701A

The Child Safety Specialist reviews the form and then sends an e-mail with the 2701A attached to the appropriate staff as indicated below. The email should be sent no later than 48 hours (excluding weekends or holidays) after initial notification of the fatality.

Regional Notification List:

- CPI Regional Director
- Special Investigator Regional Director
- CPI Program Administrator
- CPI Program Director
- Special Investigator Program Director
- Information Specialist
- Regional Nurse
- Current CPI caseworkers, CPI Supervisors, and Special Investigators assigned to the fatality investigation
- Previous CPI caseworkers, CPI Supervisors, and Special Investigators as appropriate

If the fatality involves CPS, notifications are also sent to:

- CPS Regional Director

- CPS Program Administrator

State Office Notification List

- DFPS General Counsel
- Associate Commissioner for Investigations
- Associate Commissioner for CPS
- Deputy Associate Commissioner for Investigations
- Deputy Associate Commissioner for CPS
- Chief Officer of Consumer Affairs, Child Risk and Safety and Appeals
- CPI Director of Field
- CPS Director of Field
- Director of Special Investigations
- Director of the Office of Child Risk and Safety (OCRS)
- OCRS Lead Child Fatality Specialist
- Director of the Office of Consumer Affairs
- Lead Associates for the Office of Consumer Affairs
- DFPS Office of Child Safety
- OCRS Lead Child Safety Specialist for the Region
- DFPS Media Relations Manager
- DFPS designated attorney (if requested)

(Note: Administration may request that other individuals be added to these lists. The Office of Child Risk and Safety keeps a D-list of individuals who will receive notice. If someone needs to be added to the list, they may contact the Director of the Office of Child Risk and Safety .)

Notifications in Specialized Cases Scenarios

Parental Child Safety Placement

If a child dies during an open stage of service and a parental child safety placement is in effect (that is, the child's parents had placed the child outside the home), the caseworker notifies the parents about the child's death, unless the parents cannot be found.

Motion to Investigate or Motion to Participate Court Orders

If the child dies during an open stage of service that required a court order, such as a Motion to Investigate or a Motion to Participate, the caseworker notifies all the parties involved within 24 hours (or as soon as possible, when a particular party cannot be reached within 24 hours).

See CPSH 2331 When a Child Dies

See CPSH 12920 When a Child Dies During an Open FBSS Case

See CPSH 6490 If a Child Dies While in Substitute Care

See CPSH 2332 Sending Notifications When a Child Dies

INVESTIGATING A CHILD'S DEATH

Steps for Investigating a Child's Death

When CPI receives a report that a child is alleged to have died from abuse or neglect, the supervisor follows standard DFPS policies and procedures for accepting the report and assigning it for investigation. The procedures in CPS Handbook Section 2330 Child Fatality are also followed.

Once assigned, the worker (CPI caseworker and/or SI) takes the following steps:

1) The worker gathers as much information as possible about the circumstances of the death, including information gathered from examinations, interviews, photographs, and the autopsy of the deceased child.
2) The worker assesses the immediate safety of any surviving children in the home, including following the procedures in CPS Handbook Section 2232 When to Notify Children Advocacy Centers About Reports of Abuse or Neglect.
3) The worker completes the following safety and risk related tasks in the IMPACT case management system. The worker also follows the Safety and Risk Assessment Resource Guide.

See: Safety and Risk Assessment Resource Guide

Completing the Safety and Risk Assessment Tools

Surviving Children	No Surviving Children
Assessing Safety The investigation worker: thoroughly assesses the immediate safety of the surviving children; and completes the Safety Assessment tool and documents it in IMPACT within 24 hours to show whether there were safety issues at the start of the investigation. See policy 2271	**Assessing Safety** When the only child is deceased at the time of the report, the Investigation worker does not complete the Safety Assessment. However, if the only child is alive at time of the initial investigation contact, a safety assessment is completed per current policy
Assessing Risk The investigation worker: thoroughly assesses the risk of abuse and neglect of the surviving children; and completes the risk assessment by the conclusion of the investigation; or completes the risk assessment prior to any decision to open a case for post-investigation services or closure of the referral with no additional services. See policy 2272	**Assessing Risk** The investigation worker does not conduct a risk assessment or complete the Risk Assessment tool in IMPACT when the child was already deceased at the time of intake and there are no surviving children. If the only child was alive at the time of intake and a safety assessment was completed, a risk assessment is not required; however, staff will need to choose one of the following recommended actions as these are the only ones currently available in IMPACT: • Non-fatality investigation • Close - Kinship investigation • Close - Abbreviated investigation **Once case is closed, staff must request a data correction to change the recommended action to "only**

Surviving Children	No Surviving Children
	child died."

4) The worker determines by a preponderance of evidence whether the child's death was the result of abuse or neglect. See: CPI Disposition Guidelines for more details.

INITIAL DOCUMENTATION OF A CHILD'S DEATH

When documenting a child's death, the Initial Actions includes all of the following:

- Entering the Date of Death
- Completing the Maintain Allegation Task in IMPACT When a Child Dies
- Completing the maintain Person Task in IMPACT When a Child Dies

ENTERING THE DATE OF DEATH

Initial Action

To allow the IMPACT system to properly distinguish a death that was investigated as being the possible result of abuse or neglect, the investigation worker:

- reviews the *Person Detail* page in IMPACT immediately after the case is progressed to the *Investigation* stage; and
- determines whether the date of death was entered at intake.

If no date of death was entered at intake, the investigation worker enters the date on the *Person Detail* page as soon as it is known.

If a child dies after an investigation of abuse or neglect is initiated, the investigation worker immediately enters the date of death on the *Person Detail* page.

Once the date of death is entered, whether at intake or during an investigation, the investigation worker immediately updates the Child Fatality Indicator question in the *Allegation Detail* page in the *Investigation* stage.

Texas Family Code §261.203 Child Fatality
Subchapter D, Chapter 702, Title 40 Texas Administrative Code (§§702.301-702.317)

If information is obtained during CPI investigation that a previous child in the household is deceased, do not add this child to person list in order to enter a date of death and/or fatality information unless the death is going to be investigated as a possible abuse/neglect fatality

If it becomes known during the course of an investigation that a child on the person list was deceased prior to the current involvement and the case is not a fatality investigation, enter the date of death and select the Reason for Death (CPS) as Not Investigated (NIN).

COMPLETING THE MAINTAIN ALLEGATION TASK IN IMPACT

Initial Action - Answering the Child Fatality Allegation Indicator Question

When a date of death is entered for a child in an investigation (regardless of whether the date was entered in the *Intake* or *Investigation* stages of IMPACT), the investigation worker:

- reviews in the *Investigation* stage on the *Allegation Detail* page each allegation that involves the deceased child as an alleged victim; and
- for each allegation selects either Y*es* or *No* in answer to the question: Is *this a child fatality allegation?*
    - If one question or more is asked to determine if the death is related to abuse or neglect, then the caseworker must answer Yes

Answering *Yes* to the Child Fatality Indicator question allows the department to gather and report data required by state and federal laws and regulations.

Answering *Yes* to the Child Fatality Indicator question does not imply that any abuse or neglect was found and does not affect the *CPS Reason for Death* entered or the allegation disposition.

If the deceased child is not an alleged victim however one question or more is asked to determine if the death is related to abuse or neglect, then allegations regarding the deceased child should be added and the Child Fatality Indicator question answered *Yes*.

Required Timeframe

The allegation Child Fatality Indicator question must be answered in IMPACT:

- immediately upon progressing the case to the Investigation stage, if the date of death is entered during the intake for the death. or
- as soon as possible, but no later than 24 hours after the date of death becomes known to the investigation worker, if the date is being entered during an open investigation

QUICK RESPONSE TEAM

Certain child death situations require coordination between the region and state office in order to effectively address ongoing child safety, provide guidance to staff assigned to the child fatality investigation, answer media/legislative inquiries, provide staff support, and efficiently communicate with all staff and internal stakeholders who need to have relevant information. The Quick Response Team (QRT) meeting occurs when the following criteria are met:

- the child's death is alleged/suspected to be from abuse or neglect,

And

- there is an open CPI or CPS case; or
- there is a closed CPI or CPS case within the last 12 months or
- upon request by the RD in collaboration with the Child Safety Specialist team.

Exception: If prior to the QRT being held, the regional director confirms that the death is not related to abuse or neglect, the QRT may be cancelled. Regions may still have a regional staffing.

QRT Protocol

1) Notification to the QRT should be made by Child Safety Specialist staff as soon as determination is made that there is a child fatality investigation that meets the requirements for a QRT. A completed copy of the Form 2701 - Part A should be sent to Regional QRT members, State Office staff, and subject matter experts, according to the instructions on page 4 of this Handbook "Notifying DFPS Staff When a Child Dies."

2) If Form 2701 - Part A is unable to be completed within 24 hours due to the family having excessive history, the current Worker/Supervisor should reach out to the Child Safety Specialist so they can work with CPI staff on getting the form completed timely. Once completed and reviewed by the Child Safety Specialist, the updated form should be sent, by the Child Safety Specialist, to the Regional QRT

members, appropriate State Office staff, and subject matter experts.

3) The QRT should convene via conference call or virtually with TEAMS no later than the 48 hours after the agency is notified of the child's death (or the next business day if the 48 hours would fall on a weekend or holiday). A delay may occur on rare occasion as agreed upon by the Child Safety Specialist and Regional staff. It is also recognized that not everyone invited to the QRT may be available to participate.

4) The Child Safety Specialist will be responsible for facilitating the QRT.

5) The Child Safety Specialist must document the QRT discussion on Form 2701-Part B and include:
   - Circumstances Surrounding Death/Current Investigation
   - Law Enforcement Involvement/Criminal Investigation
   - Preliminary Autopsy Results, if known
   - Concerns discussed: During the QRT it is important to discuss what is known about the family, the safety of surviving children, and tasks needed to complete the investigation. The discussion should include determining if forensic interviews for surviving children, per CPS Handbook 2231, have occurred or been scheduled.
   - Information obtained during the staffing: At times there will be new information presented during the QRT that was not previously available or known. Document any critical information regarding the child fatality, previous interventions, and information relating to ensuring child safety for the surviving siblings.
   - Action Items: During the QRT specific tasks may be discussed and assigned to various staff members for completion. Those specific tasks must be listed and include who is responsible as well as when the task must be completed. The supervisor and program director that are responsible for the current open child fatality investigation are responsible for follow-up.

6) QRT meeting notes will be documented on form 2701 - Part B by the CSS on the approved form and distributed to members. Any completed Part B must be kept by the Child Safety Specialist and is not included in the case file.

7) The QRT must focus on the current investigation and what is needed to address ongoing child safety and completion of the investigation; and to determine information needed when there are media and/or legislative inquiries. Information about history should be framed in the context of how it informs decisions on the current child fatality investigation. Concerns about previous investigations or ongoing stages of service--such as personnel actions, decisions made, missed policy, poor documentation, etc.-- should be addressed through the management process outside of the QRT.

REGIONAL FATALITY STAFFINGS

If a child fatality investigation is being completed, and does not meet the criteria for a QRT, a Regional Fatality Staffing will occur within two weeks of the date of intake in order to effectively address ongoing child safety, provide guidance to staff assigned to the child fatality investigation, provide staff support, and efficiently communicate relevant information.

Follow up Fatality Staffings may occur after a QRT or Regional Fatality Staffing is held. These staffings may occur at any time while the investigation is open upon agreement between CPI staff and the Child Safety Specialist, and may include both investigation and CPS staff (if there is an open ongoing stage of service). The participants discuss the ongoing tasks assigned, further necessary tasks, the disposition of the investigation, and safety of surviving sibling(s).

A Child Safety Specialist will facilitate the staffing, and include the investigator, supervisor, and program director. Program administrators, regional directors, and other DFPS staff may attend as requested.

DOCUMENTING A CHILD'S DEATH PRIOR TO CASE CLOSURE

Documenting the Allegation(s), Disposition, and Severity

To ensure consistent findings, accurate decision-making, and accurate reporting about a child's death; the investigation worker consults with the appropriate Child Safety Specialist about documenting the following:

- The allegations regarding the victim who has died
- The disposition
- The severity, and
- The reason for the death of the child

If a child dies from abuse or neglect, then the investigation worker selects:

- a disposition of Reason to Believe; and
- a severity of Fatal.

If the child fatality is not the result of abuse or neglect, then the investigation worker does not assign the severity of Fatal to any allegation of abuse or neglect.

If the investigation worker concludes that abuse or neglect has occurred, but did not cause the child's death, the worker:

- assigns the disposition as *Reason to Believe*; and
- assigns the severity of *Moderate, Serious or Severe*

Concluding Actions — CPS Reason for Death (CPS)

At the conclusion of an investigation into a child's death, the investigation worker selects one of the following IMPACT codes in the CPS *Reason for Death(CPS)* field on the *Person Detail* page in IMPACT.

NOTE: DO NOT SELECT ANYTHING FROM THE Non-CPS DROP DOWN BOX. This is only used by CCI or RCCI.

Reason for Death (CPS) Code	**Circumstances Surrounding the Fatality**	**Involvement with CPS**
NIN Not Investigated **Applicable dispositions**: ADM	Death was not investigated.	NA
NAB Not Abuse/Neglect Related **Applicable dispositions**: Any disposition as long as there is not a severity code of 'Fatal'	The child died due to something other than abuse/neglect.	NA
ABN Abuse/Neglect In Open Case **Applicable dispositions**: RTB - Fatal	The child died due to abuse/neglect.	A CPI/CPS case involving the child or family was open in any stage of service when a new incident of abuse/neglect that resulted in the child's death occurred. We would not use this code if the same abuse/neglect incident that opened the current stage ultimately results in the child's death. **Example** of case where code SHOULD be used: Child or family is involved in an open stage due to physical neglect. While the stage is open, the child drowns due to neglectful supervision. Because the incident that led to the fatality was different from the specific incident that led to the investigation being opened, the reason for death code should be "Abuse/Neglect In Open Case." **Example** of case where code should NOT be used: CPI opens an investigation on a near-drowning. In the hospital, the child decompensates and ultimately dies. Because the incident that led to the fatality is the same incident that triggered the current investigation, the "Abuse/Neglect In Open Case" should NOT be used as the reason for death code.

Reason for Death (CPS) Code	Circumstances Surrounding the Fatality	Involvement with CPS
ABO Abuse/Neglect In Closed Case **Applicable dispositions**: RTB - Fatal	The child died due to abuse/neglect	Either the deceased child was an alleged or confirmed victim in a prior CPI case or the designated perpetrator of the fatality was an alleged or designated perpetrator in a prior CPI investigation. In either scenario, the prior case must have started and closed before the child's death. There must be no open stages involving the designated victim or the designated perpetrator(s) of the fatality at the time of the fatality in order to use this code. **Example**: Deceased child is in closed INV, FPR, FSU, FRE or SUB stage. All prior stages of service have been closed. A new INV stage is launched to investigate the new fatal event. **Example**: the designated perpetrator of the fatality was an alleged perpetrator in an INV two years ago that is now closed. **Example** of case where code should NOT be used: The deceased child has not been involved in any prior cases however the mother has history involving her and the surviving siblings. The mother is not the designated perpetrator of the fatality and was not responsible for the death. The RTB – Fatal is against the mother's paramour who has no prior history.
ABP Abuse/Neglect and No Prior Case **Applicable dispositions**: RTB - Fatal	The child died due to abuse/neglect	The deceased child and designated perpetrator(s) of the fatality have not been involved in any CPI/CPS stage of service and are unknown to the department prior to INV stage opened to investigate the abuse/neglect that led to the child fatality. **Example**: A child is reported to be in the hospital due to severe physical abuse. The child dies three days later from the reported abuse. The child and family have not been involved in any CPI/CPS case prior to this incident.

Reason for Death (CPS) Code	Circumstances Surrounding the Fatality	Involvement with CPS
NTC Not able to Complete the Investigation **Applicable dispositions**: UTC There cannot be a severity code of Fatal	Investigation could not be completed	NA
NTD Not able to Determine **Applicable dispositions:** RTB or UTD There cannot be a severity code of Fatal	There is not enough evidence to determine if the child died due to something other than abuse/neglect or there is not enough evidence to determine if abuse/neglect caused the fatality. An Unable to Determine cause of death by the Medical Examiner does not mean the CPS Reason for Death is UTD	

COMPLETING THE FATALITY INFORMATION IN IMPACT

In order to complete the Fatality Information in IMPACT, the investigation worker selects *Fatality Information* as an option in the Person Detail window in IMPACT. The investigation worker completes the appropriate fields indicating:

- The *Manner of Death*;
- The *Cause of Death*;
- The *Autopsy Findings* and whether they are preliminary or final;
- The *Status of the Death Certificate/Autopsy (*pending or received); and
- The *Medical Examiner's Findings*.

The investigator should enter the autopsy findings into the *Fatality Information* window. These could be the preliminary findings if the final autopsy has not been received prior to case closure. In IMPACT, there is no 'pending investigation' drop down option for cause of death. If the manner of death is still pending, but you have a preliminary cause of death from the medical examiner or the case circumstances strongly indicate a cause of death (i.e. asphyxiation, drowning, vehicle, etc.); enter 'pending investigation' for manner of death, select the cause of death, and discuss the ME information in the comment box. If the medical examiner is unable to provide a preliminary finding, leave the manner and cause of death BLANK and document in the comment box why this information cannot be provided until final autopsy.

If the final autopsy is received after case closure, CPI staff will need to update the fatality information on the deceased child's person detail page and provide a copy to the Child Safety Specialist.

If the final autopsy is received after case closure and includes information that was not previously known or suspected, consult with CPI management and the Child Safety Specialist to determine next steps. For example, the fatality investigation was closed with a disposition of Ruled Out as preliminary autopsy findings indicated SUIDS; however, the final autopsy has been received and

concludes the child died of methamphetamine toxicity.

ENSURING CONSISTENCY IN IMPACT WHEN A CHILD DIES

The investigation worker ensures that the following data is entered consistently into the IMPACT case management system:

- The CPS reason for the child's death
- The disposition assigned to each allegation
- The severity of the allegations that have a disposition of *Reason to Believe*
- The answer to the question: *Is this a child fatality allegation?*

The following chart summarizes the data that must be entered consistently during the investigation.

Conclusion	**Allegation**	**Reason for Death (CPS)**
The child died from abuse or neglect	IMPACT has at least one allegation relating to the abuse or neglect that resulted in the child's death. For at least one allegation entered, the worker: • names the deceased child as a victim; • selects Yes in answer to the question: *Is this a child fatality allegation?* • assigns the disposition of *Reason to Believe*; and • assigns the severity of *Fatal*.	The investigation worker chooses one of the following in IMPACT: • *Abuse or neglect in an open case (ABN)* • *Abuse or neglect in a closed case (ABO)* • *Abuse or neglect, no prior (ABP)*
The child's death was investigated as possibly due to abuse or neglect, but was found not to be from abuse or neglect	The investigation worker: • does **not** assign the severity of *Fatal* to any allegation naming the deceased child as a victim; and • on at least one allegation must answer Yes to the question: *Is this a child fatality allegation?*	The investigation worker chooses *Not abuse or neglect related* in IMPACT (NAB)
The child's death was investigated as possibly due to abuse or neglect, but it could not be determined if the child died due to abuse/neglect	The investigation worker: • does **not** assign the severity code of *Fatal* to any allegation naming the deceased child as a victim; and • on at least one allegation must answer Yes to the question: *Is this a child fatality allegation?*	The investigation worker chooses *Not able to determine* in IMPACT (UTD)
The child's death was investigated as possibly due to abuse or neglect, but the investigation could not be completed	The investigation worker: • does **not** assign the severity code of *Fatal* to any allegation naming the deceased child as a victim; and • on at least one allegation must answer Yes to the question: *Is this a child fatality allegation?*	The investigation worker chooses *Not able to complete* in IMPACT (UTC)
The child's death was not investigated.	The investigation worker answers No to the question *Is this a child fatality allegation?*	The investigation worker chooses *Not related to abuse or neglect* in

		IMPACT (NIN)

CASE CLOSURE

All CPI child fatality investigations, including school investigations, not being Administratively Closed, must be submitted to the CSS for secondary approval prior to closure. During the secondary approval process, the CSS will work collaboratively with the first line approver to identify any additional tasks, information, or documentation required to resolve the fatality investigation.

WHEN A CHILD DIES AS A RESULT OF PRIOR INJURIES SUSTAINED

When CPI/CPS becomes aware of a child fatality that is a result of injuries previously sustained and already investigated by CPI, a new CPI investigation may not be necessary. However, there are tasks to be completed by CPI staff and the Child Safety Specialist.
For example:

- The deceased child died while in DFPS conservatorship.
- The child had significant medical needs as result of serious physical abuse sustained in the investigation that led to the child's removal.
- This prior investigation was closed with a disposition and severity code of Reason to Believe - Near Fatal.
- The preliminary and/or final autopsy determined the death was a result of the injuries sustained in that case.

Tasks to be completed:

- CPI/CPS staff complete the 2701A (See in this Handbook "Notifying DFPS Staff When a Child Dies." Page 4)
- CPI staff request data correction in order to change the severity code in the prior case – Fatal for the designated perpetrator of the fatality.
- CPI staff enter a closed stage addendum regarding the information obtained and rationale for the disposition and severity code change.
- CPI staff send new notification of findings letters to all those required per policy.
- The Child Safety Specialist completes the Child Fatality Release of Information (2059b) once data correction has been completed.
- The Child Safety Specialist notifies the Lead Child Fatality Specialist of the data correction.
- The Lead Child Fatality Specialist moves the previously completed Near Fatal form (if applicable) to the non-releasable folder on the Child Fatality SharePoint site.

To determine if a new CPI investigation is necessary, staff with your Supervisor and/or Program Director.

RELEASE OF INFORMATION ON A CHILD FATALITY INVESTIGATION

When CPI is investigating a fatality alleged to be the result of abuse or neglect, the public has the ability to request information concerning the child death. Designated staff in the Office of Child Risk and Safety will be required to respond to the request according to the requirements of statute and rule.

Texas Family Code §261.203
Subchapter D, Chapter 702, Title 40 Texas Administrative Code (§§702.301-702.317)

See: Child Fatality Release of Information Procedures Manual

CPS POLICY AND PROTOCOLS

WHEN A CHILD DIES DURING AN OPEN FAMILY BASED SAFETY SERVICES CASE

It is critical that all staff who work with families in Family Based Safety Services (FBSS) understand their responsibilities outlined in policy and protocol if a child dies in an open FBSS case. It is the role of the FBSS worker to defer to the investigation team regarding the child death investigation and to support and assist where needed.

In the section below, the various tasks and responsibilities are laid out following the order in the CPS policy handbook and in the timeline of an investigation. It is the responsibility of staff to refer to the policy handbook for all tasks associated with any investigation, including those that involve child fatalities.

Notifications When a Child Dies During an Open FBSS Case

When a child dies during an open FBSS case, the caseworker must notify the following people as soon as possible, but at least within 24 hours:

- The FBSS caseworker notifies the FBSS supervisor after learning of a child's death in an open FBSS case.
- If the child dies while in a parental child safety placement, the caseworker notifies the parents, unless they cannot be found.
- If the open FBSS case is under a court order, the caseworker notifies all parties involved including the following people:
  - Attorney ad litem for the child and parents, if appointed.
  - CASA representative and child's guardian ad litem, if appointed.
  - Any legal counsel retained by the parents.
  - Attorney representing DFPS in the child's case.
  - Regional attorney.
- The FBSS caseworker must also make a report to Statewide Intake as soon as possible, but no later than 8 hours after learning of the child's death and document the Call ID in the case record. If the caseworker verifies that the child's death has already been reported to Statewide Intake, the caseworker does not need to make a report.

See 2331 When a Child Dies

See 12920 When a Child Dies During an Open FBSS Case

Submitting Form 2701 (Part A)

Within 24 hours of receiving notification of the child's death (excluding weekends and holidays), the regionally designated person in the FBSS program completes Form 2701 Part A and forwards it by e-mail to the appropriate Child Safety Specialist. The Child Safety Specialist reviews the form and then sends an e-mail with the 2701A attached to the appropriate staff as indicated on page 5.

If the only child dies, then the FBSS caseworker closes the case after completing the above tasks.

WHEN A CHILD DIES DURING AN OPEN CVS CASE

It is critical that all staff who work with children and families while a child is in DFPS conservatorship understand their responsibilities outlined in policy and protocol if a child dies while in DFPS conservatorship. It is the role of the conservatorship (CVS) caseworker to defer to the investigation team regarding the child death investigation and to support and assist where needed.

In the section below, the various tasks and responsibilities are laid out in the CPS policy handbook and in the timeline of an investigation. It is the responsibility of staff to refer to the policy handbook for all tasks associated with any investigation, including those that involve child fatalities.

Notifying DFPS Staff When a Child Dies While in DFPS Conservatorship

Immediately, but no later than 24 hours the CVS caseworker notifies:

- Child's parents (may be notified even if rights terminated) or relatives who have been involved with the child if parents cannot be found.
- State Wide Intake (SWI).
- CVS supervisor and PD.
- Medical examiner or justice of the peace.
- Law enforcement when necessary.
- The court.
- The child's attorney ad litem.
- Parents' attorneys.
- The child's guardian ad litem.
- Attorney representing DFPS in child's case.
- DFPS regional attorney.
- Licensed Child Placing Agency Administrator (LCPAA).

See 6490 If a Child Dies While in Substitute Care

Submitting Form 2701 (Part A)

Within 24 hours of receiving notification of the child's death (excluding weekends and holidays), the regionally designated person in the CVS program completes Form 2701 Part A and forwards it by e-mail to the appropriate CSS. The CSS reviews the form and then sends an e-mail with the 2701A attached to the appropriate staff as indicated on page 5.

The Roles of SWI, SI, CPS, and CCI When a Child Dies in a Residential Placement

After the CVS caseworker notifies SWI about the child's death, SWI staff notifies the DFPS Child Care Investigations (CCI) division. It is important that CPS staff share the needed information about the deceased child to CCI and or the SI assigned, coordinate information to be updated in IMPACT, and be available for any staffings that are scheduled.

See 5300 Investigating Fatal or Near Fatal Injuries

COMPLETING DOCUMENTATION OF PRIOR CONTACTS AFTER A CHILD FATALITY OCCURS in CPI or CPS stages

On occasion, when a child fatality occurs and there is an open case, there may be documentation from earlier in the open case that has yet to be entered into IMPACT. When this occurs, it is critical that all documentation is fully updated as soon as possible.

If there is outstanding documentation that needs to be entered into IMPACT regarding contacts the caseworker had prior to the child fatality, the caseworker will need to enter in the statement below with the contact. This will allow others to be able to review the date of the actual contact compared to the date the information was entered.

> "Please note: On__, 20XX, DFPS was notified of a child fatality (or critical injury) that occurred in this case on_____, 20XX. The narrative that follows was entered on_____, 20XX in order to fully document casework activity that occurred before DFPS was notified of the fatality."

This statement does not need to be entered if the contact or attempted contact being documented was made after the fatality or critical injury.

REVIEWING CASES OF CHILD DEATHS

There are several groups that help provide internal and external review of DFPS cases, including those where a child fatality has occurred. Below are the various Review Teams that exist that may review your case. If your case is selected for a review, you will be contacted by the CSS and provided information regarding your role and responsibilities in the review.

Regional Child Death Review Committees (RCDRC) and Citizen Review Teams (CRT)

The purpose of the Regional Child Death Review Committee is to both to evaluate department casework and decision-making and to promote continuous improvement of the quality of direct delivery of services to families provided by Child Protective Investigations and Child Protective Services.

Texas Family Code: §§264.502; 264.503

The Texas Family Code (TFC §261.312) requires that each region have at least one Citizen Review Team. Five of these teams are designated as meeting the requirements of Child Abuse Prevention and Treatment Act (CAPTA), Appendix I. The CAPTA teams are in Region 1, Region 3 (3E and 3W), Region 6 (6A and 6B), Region 7 and Region 11. These sites represent a mixture of urban and rural communities and reflect a broad range of issues encountered by DFPS statewide. The teams evaluate DFPS casework and decision-making related to child abuse or neglect investigations completed by the department.

Texas Family Code: §§261.312

In April 2020, the Department joined the Regional Child Death Review Committee and the Citizen Review Team together as both of these groups had similar roles regarding the evaluation of the Department's response to child abuse or neglect. These committees/teams focus is both on CPI/CPS and other components of the system. In addition, the goal is to identify barriers to the ultimate protection of the child both within and outside CPI/CPS; assess compliance with program policy; and identify staff needs in the areas of training, supervision, and program policy and management. The members of these two committees/teams are volunteers and have experience in the treatment and prevention of child abuse/neglect. The Citizen Review Team however must have at least two members who are also parents and have not been convicted of or indicted for any offense involving child abuse/neglect or is not under investigation by the Department for child abuse or neglect.

Regional Child Death Review Committees/Citizen Review Teams are established in each region of the state and review cases in which:

- The child's death has been determined by CPI to be the result of abuse or neglect; for example, there is a disposition of Reason to Believe for an allegation with a severity of fatal (RTB – Fatal), regardless of whether the medical examiner or other external parties reach the same conclusion; and
    - The deceased child or the designated perpetrator of the RTB – fatal had an open CPI or CPS case at the time of the child's death or
    - the Designated Perpetrator of the RTB - Fatal has been an alleged or designated perpetrator in a prior CPI case within the last 3 years; or
    - the deceased child has been an alleged or designated victim in a CPI case within the last 3 years; or
    - the deceased child was a principal in an FPR/FSU/SUB stage within the last 3 years.

The Structure of a Regional Child Death Review Committee/Citizen Review Team

The committee/team must be structured according to TFC Sec.261.312 and the following guidelines:

- The review committee must have a minimum of five members.
- The committee/team members are appointed by the Commissioner of the Department and consist of volunteers who live in and are broadly representative of the region in which the review team is established and have expertise in the prevention and treatment of child abuse and neglect. At least two members of a review team must be parents who have not been convicted of or indicted for an offense involving child abuse or neglect, have not been determined by the department to have engaged in child abuse or neglect, and are not under investigation by the department for child abuse or neglect.
- The committee/team member is a department volunteer for the purposes of Section 411.114, Government Code.
- The committee/team must also include a program director or program administrator with responsibility for the case.
- The agency must try to recruit a physician or an attorney, or both, to serve on the committee in order to obtain the perspectives of the medical and legal professions. Regional staff may also recruit committee members from the Department of State Health Services (DSHS), law enforcement agencies, the coroner's office, private agencies dealing with abused or neglected children, and children's advocacy groups.
- If the case being reviewed was in one region but has prior CPI/CPS history in a different region, the other region/s must participate in the review. In addition:
    - If the case being reviewed is a child fatality meeting criteria for a Regional Child Death Review Committee, the region with the prior history must conduct the review; Exceptions to this procedure may be made by agreement of the Lead Child Safety Specialist assigned to the regions involved.

Procedures for Conducting a Regional Child Death Review Committee or a Citizen Review Team

The Regional Child Fatality Review Committee/Citizen Review Team must meet at least quarterly and review child fatality investigations closed during the previous quarter. If there is no child fatality investigation meeting criteria for a regional review, a meeting must still be held. The facilitator will choose another case to review such as a near fatality or serious injury case (on open case or with prior history within the last 3 years).

- The meeting is facilitated by the Office of Child Risk and Safety Child Safety Specialist.
- The committee/team conducts the review by examining the facts of the case as outlined by the department staff. A committee/team member acting in the member's official capacity may receive information made confidential under Section 40.005, Human Resources Code, or Section 261.201Texas Family Code. At a minimum, the department provides documentation of the fatality investigation, the autopsy report if available, and a summary of the agency's prior involvement with the family.

- The Child Safety Specialist summarizes each of its meetings on Form 2701C. Copies of the report must be sent within 15 days of the meeting to the CPI/CPS Regional Director, Program Administrator, Program Director, Office of Child Risk and Safety Lead Child Safety Specialist, Director of Office of Child Risk and Safety, Lead Child Fatality Specialist in the Office of Child Risk and Safety, and the Office of Child Safety.
  The report must:
  - specify the date that the committee met;
  - identify those in attendance;
  - describe the circumstances surrounding the death, near fatality, or case chosen for review;
  - identify opportunities for strengthening policy and practice;
  - identify opportunities to improve coordination with external entities such as law enforcement agencies, courts, physicians, and medical examiners;
  - identify any staff training issues that need to be addressed;
  - identify any strengths and best practice identified;
  - note recommendations made by committee members; and
  - indicate any practice changes or supports that the regional or state office staff are completing to address the concerns noted.

See: Form 2701C

Any completed Part C must be kept by the Child Safety Specialist and the Lead Child Fatality Specialist and is not included in the case file.

Child Safety Review Committee (CSRC)

The Child Safety Review Committee (CSRC) consists of the Director of the Office of Child Risk and Safety , the Lead Child Fatality Specialist, representatives of DFPS State Office Legal, CPI and CPS Program, Center for Learning and Organizational Excellence (CLOE), Child Care Investigations (CCI), Statewide Intake, and Prevention and Early Intervention – Office of Child Safety. The CSRC also includes representatives from the State Child Fatality Review Teams, a representative of the Texas Council on Family Violence, and other subject matter experts from the community. The CSRC meets quarterly.

The CSRC considers issues that have statewide implications for policy, training, resource development, casework practice, coordination with external entities, and so on. The issues are identified through a review of recommendations from the Regional Child Death Review Committees/Citizen Review Teams. Identified issues are discussed and recommended actions are determined. The recommended actions are provided to CPI/CPS leadership for review and follow-up.

Child Fatality Review Teams (CFRT)

Child fatality review teams are multi-disciplinary, multi-agency panels that review child deaths regardless of the cause. Local teams identify gaps in service and coordination among all agencies represented on the team and focus on developing community programs and activities to reduce the incidence of preventable child deaths. These teams are not facilitated or scheduled by DFPS staff as they are community based and led by Texas Department of State Health Services.

Texas Family Code §§264.505; 264.506(a)

Statewide coordination of the local CFRTs is conducted by the Department of State Health Services through the State Child Fatality Review Team Committee.

Texas Family Code §§264.502; 264.503; 264.504

SUPPORTIVE SUPERVISION WHEN NOTIFIED OF THE CHILD FATALITY

Secondary trauma is very common in child protection work, particularly when a critical incident such as a child fatality occurs with a family who was known to the caseworker. Secondary trauma must be addressed to help support staff. Managers are expected to help staff process the traumatic event and address their own individual response about the child fatality. The management response needed can range from a check-in by the manager to see how the staff is doing, modified duty, to allowing the worker to take time off.

All staff who were assigned to an open case in which a new incident of abuse or neglect resulted in the child's death must be provided with information about the Employee Assistance Program (EAP). Regional management may also provide EAP information to other staff affected by the fatality as needed.

Additionally, if needed, the Program Director should work with EAP to have a debriefing session for staff that worked with the family prior to the child fatality as well as the child fatality investigation. This debriefing session should be specifically for the staff that worked with the family and not open for all staff.

The primary investigator's chain of command will determine whether or not an employee will be placed on modified duty.