



# **Child Fatality Protocol Handbook**

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## INTRODUCTION

Child Protective Services utilizes a policy handbook to set a consistent and transparent foundation and framework for all practice across the state. It is through the policy and protocol that staff meet federal, state, and rule-based regulations that support successful outcomes for children and families served by Child Protective Services. This protocol guidebook 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.

The protocol guidebook is designed to mirror sections of the policy handbook. Inside you will be able to see current policies and then protocols that support the policy. It is laid out in a format to walk you through a child fatality investigation and the review process. Staff should be familiar with all sections of the protocol guidebook and can utilize it throughout the course of a child fatality investigation, desk duty process, Quick Response Teams, and regional reviews.

It is important to note that this protocol guidebook serves as the state-wide protocol. If you or your region comes across a specific issue that could benefit from a standardized protocol, please email either the Division Administrator for Child Safety or the State Office Child Fatality Program Specialist so that it may be reviewed and potentially encompassed in this Child Fatality Protocol Handbook.

## INVESTIGATION POLICY & PROTOCOLS

It is critical that all staff that may investigate a child fatality understand all of 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.

### WHEN A CHILD DIES - NOTIFICATIONS WHEN A CHILD DIES

#### **Notifying Law Enforcement**

When CPS receives a report that a child is alleged to have died from abuse or neglect, the investigation worker contacts law enforcement and requests a joint investigation.

#### **Notifying Medical Examiner or Justice of the Peace**

The investigation worker reports the death of a child younger than six years old to the medical examiner of the county in which the death occurred.

The death must be reported to the medical examiner whether or not the death was alleged to be the result of abuse or neglect.

#### **Exceptions:**

- The worker is not required to report the death if the death was a result of a motor vehicle accident unless abuse or neglect is suspected, such as if the parent or legal caregiver was under the influence of alcohol or drugs.
- If the county does not have a medical examiner or the death is outside the medical examiner's district, the worker reports the death to a justice of the peace in the county in which the death occurred.
- The death is already being investigated by the medical examiner when the worker initiates the investigation.

*Texas Family Code [§264.513](#)*

**Notifying DFPS Staff When a Child Dies**

The following procedures and policies apply when a child's death is either assigned for investigation or 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 worker:

- completes [Form 2701](#) (Part 1) Notification of Child Fatality; and
- forwards it by e-mail to the appropriate child safety specialist.

See: [Notification of Child Fatality - Form 2701 Part 1 and 2](#)

The child safety specialist then forwards the e-mail to the appropriate management teams and subject matter experts:

Notification List:

- Regional Director;
- Regional Program Administrator;
- Assistant Commissioner of Child Protective Services;
- DFPS Deputy Commissioner
- DFPS Internal Audit;
- Director of Field;
- CPS Director of Investigations;
- CPS Special Projects Program Specialist,
- CPS Project HIP Program Manager;
- CPS Communications Program Specialist;
- DFPS Office of Child Safety;
- Division Administrator for Child Safety;
- Regional Program Administrator;
- Regional Program Director;
- Lead Child Safety Specialist for the Region;
- Local Public Information Officer;
- Media Relations Manager
- State Office Child Fatality Lead Program Specialist
- State Office Child Fatality Program Specialist

**Notifying the Parents and Others When a Child Dies****Parental Child Safety Placements**

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.

**Investigations Where a Court Order is involved**

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

**For More Information**

See: CPS Handbook Sections: [2331 When a Child Dies](#), [6510 When a Child Dies While in Substitute Care](#)

## INVESTIGATING A CHILD'S DEATH

### Coordinating With Law Enforcement to Investigate a Child's Death

When investigating a child's death, the investigation worker and supervisor coordinate the CPS investigation with:

- The law enforcement agency that will investigate the child's death;
- The district attorney, if an arrest occurs during the investigation or charges are taken to a grand jury; and
- The medical examiner or justice of the peace, as applicable.

### Steps for Investigating a Child's Death

When CPS 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 investigation worker 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.
3. The worker completes the following safety and risk related tasks in the IMPACT case management system. The worker also follows the SDM Safety and Risk Assessment Procedure and Reference Manual. See: [SDM Safety Assessment Manual](#)

### Assessing Safety and Risk

Surviving Children	No Surviving Children
<b>Assessing Safety</b>	<b>Assessing Safety</b>
<p>The investigation worker:</p> <p>Thoroughly assesses the immediate safety of the surviving children; and</p> <p>Completes the SDM Safety Assessment tool and documents it in IMPACT within 24 hours to show whether there were safety issues at the start of the investigation</p>	<p>The Investigation worker:</p> <p>Completes the SDM Safety Assessment tool in IMPACT to show whether there were safety issues at the initiation of the investigation.</p> <p>See: <a href="#">SDM Safety Assessment Manual</a></p>
<b>Assessing Risk</b>	<b>Assessing Risk</b>
<p>The investigation worker:</p> <p>Thoroughly assesses the risk of abuse and neglect of the surviving children; and</p> <p>Completes the SDM® FAMILY RISK ASSESSMENT Tool See: <a href="#">SDM Safety Assessment Manual</a></p> <p>Completes the risk assessment by the conclusion of the investigation after the safety assessment has been completed. Complete the risk assessment prior to any decision to open a case for post-investigation services or closure of the referral with no additional services.</p>	<p>The investigation worker:</p> <p>Does not conduct a risk assessment or complete the SDM Risk Assessment tool in IMPACT when there are no surviving children.</p>

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

## DOCUMENTING A CHILD'S DEATH

### When documenting a Child's Death the Initial Actions are:

- 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, and CPS intends to investigate the death as the possible result of abuse or neglect, 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 *Allegation Detail* page in the *Investigation* stage.

See:

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

## COMPLETING THE MAINTAIN ALLEGATION TASK IN IMPACT WHEN A CHILD DIES

### Initial Action - Answering the Child Fatality Allegation 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 Yes or No in answer to the question: *is this a child fatality allegation?*

### Required Timeframe

The allegation question must be answered in IMPACT:

- 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 or

- Immediately upon progressing the case to the *Investigation* stage, if the date of death is entered during the intake for the death

### **COMPLETING THE MAINTAIN PERSON TASK IN IMPACT WHEN A CHILD DIES**

When a child has died, the investigation worker documents the following information about the child on the *Person Detail* page in the IMPACT case management system, the date of the child's death; and the Fatality Information.

In order to complete in IMPACT the Fatality Information the investigation worker selects Fatality Information 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

At the time the preliminary autopsy findings are available, the investigator should enter the findings into the Fatality Information window. When the final autopsy information is received the investigation worker will update the Fatality Information window to reflect the final findings.

### **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 related information. The Quick Response Team (QRT) review occurs when the following criteria are met:

- The child's death is alleged/suspected to be from abuse or neglect, and
- there is a previous Reason to Believe (RTB) finding for abuse or neglect of a current household member; or
- in the 36 months prior to the child's death, the family has three or more investigations in which the dispositions were not Reason to Believe, or
- a case is open in any stage of service and a new incident of alleged/suspected abuse or neglect that results in a child's death has occurred, or
- There is a high level of media attention.

Exemption: If the only child in the home died and there is no media attention, a QRT is not required. Regions may still have a regional staffing.

The QRT is convened no later than the 48 hours (or the next business day if the 48 hours would fall on a weekend or holiday) after the agency is notified of the child's death.

#### **QRT Protocol**

- 1) Notification to the Quick Response Team (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. Notification can occur via e-mail or telephone contact. A copy of the Form 2701 - Part 1 completed should be sent to *Regional QRT members and appropriate management teams and subject matter experts, according to the instructions on page 2 of this Handbook "Notifying DFPS Staff When a Child Dies."*

- 2) Once Form 2701 - Part 2 is completed by the current Worker/Supervisor and reviewed by the CSS, the updated form should be sent, by the CSS, to the *Regional QRT members and appropriate management teams and subject matter experts.*
- 3) The QRT must convene via conference call no later than the 48 hours (or the next business day if the 48 hours would fall on a weekend or holiday) after the agency is notified of the child's death. Participants are invited; however, it is recognized that not everyone may be available to participate. At a minimum, participant representation should include Field staff, Public Information Officer, and CPS state office.

QRT participants and their roles:

	<b>Participant</b>	<b>Role/Tasks</b>
Regional Staff	At least one member of the worker/supervisor/ program director team assigned the current child fatality Investigation	Member: Provide information to QRT on the status of the current child death investigation
	At least one member of the current program area (caseworker, special investigator, supervisor, program director) involved with the family through any open stages of service, if available	Resource: Provide background information
	Former involved staff, if available	Resource: Provide background information
	Regional Media Specialist	Member: Update on media involvement
	CPS Program Administrator and/or CPS Regional director	Member: Makes recommendations and case decisions
	Current staff involved with the family through any open stages of service in other DFPS Divisions (APS, CCL, RCCL)	Member: Provide information to QRT on the status of the current child death investigation and to ensure consistency in the investigation
State Office Staff	Media Relations Manager	Member: Update on media involvement at the State Office level
	CPS Assistant Commissioner and Director of Investigations	Member: <ul style="list-style-type: none"> <li>• Respond to legislative or HHSC requests</li> <li>• Alerts Executive staff when appropriate</li> </ul>
	Division Administrator for Child Safety, Lead Child Fatality	Member: Respond to policy



	Program Specialist, and Child Fatality Program Specialist	information requests
	Child Safety Specialist, Lead Child Safety Specialist	Chair: <ul style="list-style-type: none"> <li>• Convenes and chairs QRT</li> <li>• Review case history</li> <li>• Develop a chronology</li> <li>• E-mail information to other team members</li> </ul>

- 4) Child Safety Specialist will be responsible for convening and chairing the committee, sharing documentation such as the chronology of the case (documented on Form 2701 Part 2), and documenting the QRT meeting on Part 3 of the Form 2701. Some regions may elect to also utilize Risk Managers to convene specific QRTs. Given the short time frames for the QRT to be held, the chronology will be at least a high-level review that outlines the dates of past investigations, case dispositions and case ID numbers.

See: [Notification of Child Fatality - 2701 Form Part 1 and 2](#)

See: [Notification of Child Fatality - 2701 Form Part 3 and 4](#)

- 5) The Child Safety Specialist (or Risk Manager) must document the QRT on Form 2701, Part 3 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 be able to complete the investigation.
  - Provide a brief synopsis of the discussion during the QRT including any trends, patterns, strengths or concerns.
  - 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, or about 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) The QRT must focus on the current investigation and what is needed to address ongoing child safety, completion of the investigation, and assist other entities involved in the investigation such as law enforcement, medical examiners, legal, and media/legislative inquiries. Information about CPS 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--should be addressed through management process outside of the QRT. The QRT should focus on what information is known due to the CPS history and current investigation, what tasks need to be completed, and what additional needs are identified during the QRT.

QRT meeting notes will be documented on form 2701 - Part 3 by the CSS on the approved form and distributed to members. Any completed Part 3 and Part 4 sections (as applicable) must be kept by the Child Safety Specialist and is not included in the case file.

**DOCUMENTING A CHILD'S DEATH**

**Documenting the Allegation(s), Disposition, and Severity**

To ensure consistent findings and 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

After consulting with the appropriate Child Safety Specialist, the investigation worker documents the decisions in IMPACT:

If a child dies from ...	then the investigation worker ...
abuse or neglect ...	Selects: <ul style="list-style-type: none"> <li>• a disposition of <i>Reason to Believe</i>; and</li> <li>• a severity of <i>Fatal</i>.</li> </ul>
causes other than abuse or neglect ...	does not assign the severity of <i>Fatal</i> 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* (the worker may **not** assign the severity as *Fatal*; a severity code of *Near Fatal* can only be entered in a child fatality investigation when the criteria for Near Fatal has been met. See: [Handbook Section 2281 Reaching Dispositions for the Allegations and Alleged Perpetrators: Reason to Believe](#))

**Concluding Actions — When the Reason for Death Is Abuse or Neglect**

The investigation worker selects an option in the CPS *Reason for Death* field in IMPACT to indicate that a child died from abuse or neglect, **only** if the abuse or neglect that resulted in the child's death:

- met the statutory definition of abuse or neglect;
- was proven by a preponderance of the evidence; and
- is documented in at least one allegation in the following manner:
  - With the disposition of *Reason to Believe*
  - With the severity of *Fatal*
  - With the IMPACT question: *Is this a child fatality allegation?* Answered *Yes*

**Process**

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* field on the *Person Detail* page in IMPACT.

<b>CPS Reason for Death Code</b>	<b>Circumstances Surrounding the Fatality</b>	<b>Involvement with CPS</b>
<p>NAB Not Abuse/Neglect Related</p> <p><b>Applicable dispositions:</b> Any disposition as long as there is not a severity code of "Fatal"</p>	<p>The child died due to something other than abuse/neglect or there is not enough evidence to determine if abuse/neglect caused the fatality</p>	<p>NA</p>
<p>ABN Abuse/Neglect In Open Case</p> <p>Applicable dispositions: RTB - Fatal</p>	<p>The child died due to abuse/neglect</p>	<p>A 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.</p> <p>We would not use this code if the same abuse/neglect incident that opened the current stage ultimately results in the child's death.</p> <p>Example of case where code SHOULD be used:</p> <p>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."</p> <p>Example of case where code should NOT be used:</p> <p>CPS 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.</p>
<p>ABO Abuse/Neglect In Closed Case</p>	<p>The child died due to abuse/neglect</p>	<p>Either the deceased child had a role of VC in a prior case or the person responsible for the fatality (the designated perpetrator of the death) was either an alleged or</p>

<p>Applicable dispositions: RTB - Fatal</p>		<p>confirmed perpetrator in a CPS 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.</p> <p><b>Example:</b> Deceased child is in closed INV, FPR, FSU, FRE or SUB stage due to neglectful supervision/substance abuse. All prior stages of service have been closed. A new INV stage is launched to investigate the new fatal event.</p> <p><b>Example:</b> the designated perpetrator of the fatality had an INV stage two years ago that is now closed.</p>
<p>ABP Abuse/Neglect and No Prior Case Applicable dispositions: RTB - Fatal</p>	<p>The child died due to abuse/neglect</p>	<p>The child and designated perpetrator(s) of the fatality have not been involved in any 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.</p> <p>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 CPS case prior to this incident.</p>
<p>NTC Not able to Complete the Investigation Applicable dispositions: UTC There cannot be a severity code of Fatal</p>	<p>Investigation could not be completed</p>	<p>NA</p>
<p>NTD Not able to Determine Applicable dispositions: UTD There cannot be a severity code of Fatal</p>	<p>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.</p> <p>An Unable to Determine</p>	<p>NA</p>

	cause of death by the Medical Examiner does not mean the CPS Reason for Death is UTD	
NIN Not Investigated Applicable dispositions: ADM There cannot be a disposition of RTB or a severity code of Fatal	Death was not investigated.	NA

**ENSURING CONSISTENCY IN IMPACT WHEN A CHILD DIES**

During an investigation of a child’s death allegedly caused by abuse or neglect, 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	CPS Reason for Death
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: <ul style="list-style-type: none"> <li>• names the deceased child as a victim;</li> <li>• selects Yes in answer to the question: <i>Is this a child fatality allegation?</i></li> <li>• assigns the disposition of <i>Reason to Believe</i>; and</li> <li>• assigns the severity of <i>Fatal</i>.</li> </ul>	The investigation worker chooses one of the following in IMPACT: <ul style="list-style-type: none"> <li>• <i>Abuse or neglect in an open case</i></li> <li>• <i>Abuse or neglect in a closed case</i></li> <li>• <i>Abuse or neglect, no prior</i></li> </ul>
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: <ul style="list-style-type: none"> <li>• may <b>not</b> assign the severity of <i>Fatal</i> to any allegation naming the deceased child as a victim; and</li> <li>• on at least one allegation</li> </ul>	The investigation worker chooses <i>Not abuse or neglect related</i> in IMPACT

	must answer <i>Yes</i> to the question: <i>Is this a child fatality allegation?</i>	
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: <ul style="list-style-type: none"> <li>• May not assign the severity code of <i>Fatal</i> to any allegation naming the deceased child as a victim; and</li> <li>• On at least one allegation must answer <i>Yes</i> to the question: <i>is this a child fatality allegation</i></li> </ul>	The investigation worker chooses <i>Not able to determine in IMPACT</i>
The child's death was investigated as possibly due to abuse or neglect, but the investigation could not be completed	The investigation worker: <ul style="list-style-type: none"> <li>• May not assign the severity code of <i>Fatal</i> to any allegation naming the deceased child as a victim; and</li> <li>• On at least one allegation must answer <i>Yes</i> to the question: <i>is this a child fatality allegation</i></li> </ul>	The investigation worker chooses <i>Not able to complete in IMPACT</i>
The child's death was not investigated as possibly due to abuse or neglect	The investigation worker answers <i>No</i> to the question <i>Is this a child fatality allegation?</i>	The investigation worker chooses <i>Not related to abuse or neglect in IMPACT</i>

**COMPLETING DOCUMENTATION OF PRIOR CONTACTS AFTER A CHILD FATALITY OCCURS**

On occasion, when a child fatality occurs, there may be documentation from earlier in an 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 \_\_\_\_\_, 20\_\_\_\_, DFPS was notified of a child fatality (or critical injury) that occurred in this case on \_\_\_\_\_, 20\_\_\_\_. The narrative that follows was entered on \_\_\_\_\_, 20\_\_\_\_ 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.

## RELEASE OF INFORMATION ON A CHILD FATALITY INVESTIGATION

When CPS 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 each region will be required to respond to the request according to the requirements of statute and rule.

*Texas Family Code [§261.203](#)  
40 TAC Chapter 702, [Subchapter D](#)*

For additional information on the process for complying with this requirement

See: [Child Fatality Release of Information Procedures Manual](#).

## PROCEDURES FOR COMPLYING WITH THE REQUEST

No later than the fifth day following the death of the child or the receipt of the request for information regarding the death of the child, whichever occurs later, the designated CPS staff will provide the following information documented on Form 2059a:

- Case identification number
- The age and sex of the deceased child
- The date of the child's death
- Whether the deceased child was in the conservatorship of the department at the time of the child's death
- Whether, at the time of death, the child was living:
  - With the child's parent, managing conservator, a legal guardian, or other person entitled to possession of the child;
  - With an agency foster home, agency foster group home, independent foster home, independent foster group home, or general residential operation; or
  - In another living arrangement.

If it is determined at the completion of the investigation that the child's death or near fatality was the result of abuse or neglect, CPS will release the following information documented on Form 2059b within 10 days of either the date the investigation is completed or the date the records are requested, whichever occurs later:

- A summary report for each investigation in which the deceased child or the near fatal child was an alleged victim or a child living in the same home as another alleged victim including:
  - The deceased child's name;
  - The near fatal child's PID number (not the child's name);
  - The date the investigation began;
  - A brief description of the nature of the alleged abuse or neglect allegations, the disposition of those allegations, and a description of the role of the subjects for each allegation using descriptors such as deceased child, sibling, parent, alleged perpetrator, step-parent, paramour, and so on;
  - Information on whether a child's death or near fatality resulted in a criminal investigation or the filing of criminal charges if known at the time the investigation is completed;

- Any risk or safety factors noted in the risk or safety assessment and actions taken by the department to mitigate those risks including any actions CPS has taken to mitigate the risk of harm to any other children in the home following the child fatality or near fatal incident;
- A brief description of any services, including family-based safety services (if any), that were provided or offered by the department to the child and the child's family; and whether the services were accepted or declined; and
- If one or more children were previously removed from the home, summarize how long the child was in DFPS conservatorship and when the child was returned to the home.

Once all this information is compiled and reviewed by designated staff, the completed form will be sent to The Open Records Attorney to review and redact for public release upon request.

Once the Open Records Attorney approves the information for release, a copy of the completed form will be sent to the attorney *ad litem*, if one is appointed.

Deaths that are not investigated by DFPS for possible abuse or neglect are not subject to public reporting.

## FBSS POLICY AND PROTOCOLS

It is critical that all staff who work with families through Family Based Safety Services understand their responsibilities outlined in policy and protocol if a child dies while being served in FBSS. 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.

### WHEN A CHILD DIES DURING AN OPEN FBSS CASE

#### **Notifying DFPS Staff When a Child Dies During an Open FBSS Case.**

Within 24 hours (or as soon as possible when a particular party cannot be reached within 24 hours) of receiving notification of a child's death, the FBSS caseworker:

- notifies the DFPS Statewide Intake (SWI) division;
- notifies the supervisor and program director;
- notifies Medical Examiner or Justice of the Peace;
- notifies law enforcement when necessary;
- If the child dies while in a parental child safety placement, the caseworker notifies the parents, unless they cannot be found.
- completes Form 2701 (Part 1) Notification of Child Fatality; and
- forwards the form by e-mail to the appropriate child safety specialist for the DFPS region in which the child lived.

See: [Notification of Child Fatality - Form 2701 Part 1 and 2](#)

The Child Safety Specialist then forwards the form to required DFPS staff.

If the open FBSS case is under a court order, the caseworker notifies all parties involved including the:

- Attorney *ad litem* for the child and parents, if appointed;
- CASA representative and child's guardian *ad litem*, if appointed;
- Any legal counsel appointed to represent or legal counsel retained by the parents;
- Attorney representing DFPS in the child's case; and
- Regional attorney.



If a parental child safety placement is in effect, the caseworker notifies the parents about the child's death, unless the parents cannot be found.

### **Submitting Form 2701 (Part1)**

Within 24 hours (excluding weekends and holidays) of receiving notification of the child's death, the Family-Based Safety Services caseworker completes Form 2701 Part 1 and forwards it by e-mail to the appropriate Child Safety Specialist who forwards it to the appropriate management teams and subject matter experts: See page 2 of this Handbook "Notifying DFPS Staff When a Child Dies."

Documentation in IMPACT

If a CPS investigation is being conducted, the investigator enters the date of death and the code for the CPS reason for the child's death. If there is no investigation, the FBSS caseworker enters this information. The investigation worker consults with the appropriate Child Safety Specialist about documenting the Child Fatality Information and correct Reason for Death code:

## **WHEN A CHILD DIES WHILE IN DFPS CONSERVATORSHIP**

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. 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**

Within 24 hours (or as soon as possible when a particular party cannot be reached within 24 hours) of receiving notification of a child's death, the conservatorship caseworker:

- notifies the DFPS Statewide Intake (SWI) division;
- notifies the supervisor and program director;
- notifies Medical Examiner or Justice of the Peace;
- notifies law enforcement when necessary;
- completes Form 2701 (Part 1) Notification of Child Fatality; and
- forwards the form by e-mail to the appropriate child safety specialist for the DFPS region in which the child lived.

See: [Notification of Child Fatality - Form 2701 Part 1 and 2](#)

The Child Safety Specialist then forwards the form to required DFPS staff.

### **The Roles of SWI and RCCL When a Child Dies in a Residential Placement**

After the conservatorship caseworker notifies SWI about the child's death, SWI staff notifies the DFPS Residential Child Care Licensing (RCCL) division.

RCCL staff then assigns an RCCL investigator to:

- conduct a desk review to see whether there are any allegations of abuse or neglect; or
- conduct a complete investigation when allegations of abuse or neglect are present.

## **REGIONAL RESPONSIBILITY TO REVIEW CASES OF CHILD DEATHS**

### **Establishing a Protocol in Each Region for Reviewing Cases That Involve a Child's Death**

CPS has established a single protocol guide for all child fatality investigations. In addition, each region must establish specific protocol for reviewing child deaths assigned for investigation. These regional protocols must:

- designate a single point of contact for investigations of child deaths. This contact is responsible for communication with CPS in the DFPS state office about the status of investigations and any data changes that are needed;
- designate a point of contact and chair for each review by the Regional Child Death Review Committee of cases and;
- A system in which the regional Child Safety Specialist reviews the investigation and is a secondary approver. The Child Safety Specialist reviews for:
  - Consistency of data elements,
  - Compliance with policy, procedure, and good casework practice,
  - Identification of training needs, and

## THE REGIONAL CHILD DEATH REVIEW COMMITTEE

### **The purpose and criteria for conducting a Regional Child Death Review Committee when a Child dies**

When a child dies and the following conditions exist, then a Regional Child Death Review Committee meeting is conducted:

- the child died while in CPS conservatorship, regardless of whether the death was related to abuse or neglect and regardless of the child's placement type; or
- the child's death has been determined by CPS to be the result of abuse or neglect; for example, there is a disposition of Reason to Believe (RTB) for an allegation with a severity of fatal, regardless of whether the medical examiner or other external parties reach the same conclusion; and the family has prior CPS history; or
- The family has an open CPS case at the time of the child's death (*Reason for Death code ABN*).

The Regional Child Death Review Committee meeting is conducted to:

- evaluate the adequacy of the child welfare system's response to the child or family, focusing both on CPS and on other components of the system;
- identify barriers to the ultimate protection of the child, both within and outside CPS;
- assess compliance with program policy; and
- identify staff needs in the areas of training, supervision, resources, supports and program policy and management.

### **The Structure of a Regional Child Death Review Committee**

The review committee must be structured according to the following guidelines:

- The review committee must have a minimum of three members.
- The review committee must include at least two persons from outside DFPS, at least one of whom is not a DFPS contractor or the member of a child welfare board. Committee members must sign a statement agreeing not to disclose any confidential information that DFPS shares with them.
- The review committee must also include a program director or program administrator with responsibility for the case.
- Regional staff 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.

- When a child who is known to CPS in one region dies from suspected abuse or neglect in a region in which the family does not have a prior CPS history, both regions must participate in the review. However:
  - Staff in the region in which the child died must notify the region in which the family had prior CPS history; and
  - The region in which the family had a prior CPS history must conduct the review;
  - Exceptions to this procedure may be made by agreement of the regions' CPS program administrators. Both regions must participate in the review.

### **Procedures for Conducting a Regional Review of a Child's Death**

Each DFPS region must establish procedures for the Regional Child Death Review Committee to child deaths, including the following:

- The review committee must review each child's death within 30 days of receiving the autopsy report or within 30 days of the investigation closing, whichever is later.
- CPS staff must forward all pertinent written materials/case files to the review committee to ensure a thorough review. The review committee may schedule interviews with staff or other parties as needed.
- The review committee summarizes each of its meetings on [Notification of Child Fatality - Form 2701 Part 4](#). The committee must send copies of the report within 15 days of the meeting to the CPS regional director, program administrator, program director, regional child safety specialist, director of investigations, division administrator for child safety, office of child safety and the investigation program specialist for CPS at DFPS state office.

The report must:

- specify the date that the committee met;
- identify those in attendance;
- identify each child whose death was reviewed;
- summarize CPS's involvement with the child's family;
- summarize the involvement of other agencies with the child's family, if known;
- describe the circumstances surrounding the death or near fatality;
- identify all policy or practice issues that the committee has noted;
- identify all issues related to coordination with other entities such as law enforcement agencies, courts, physicians, and medical examiners;
- identify any training issues that need to be addressed;
- identify any strengths and best practice identified;
- note recommendations made by committee members; and
- indicate how and by whom the recommendations will be implemented or the reasons that implementation is not feasible.

See: [Notification of Child Fatality - Form 2701 Part 3 and 4](#)

Any completed Part 3 and Part 4 sections (as applicable) must be kept by the Child Safety Specialist and is not included in the case file.

## **DEFINITIONS OF COMMITTEES AND TEAMS RESPONSIBLE FOR CHILD DEATH REVIEWS**

There are several groups that help provide internal and external review of CPS cases, including those where a child fatality has occurred. Below are the various review teams that exist that may review your case.

## Definitions and Roles of Child Death Committees/Teams

Note: Although the first three committees/teams have different functions, they may have the same members in certain areas of the state.

### Regional Child Death Review Committee

The purpose of the Regional Child Death Review Committee is to promote continuous improvement of the quality of direct delivery of services to families provided by Child Protective Services via ongoing objective, non-judgmental, consistent, and fair evaluation. The role of the Regional Child Death Review Committee in peer review is to provide evaluation of performance to ensure the effective and efficient assessments of the work of CPS staff and their role in ensuring child safety.

### Citizen Review Teams (CRT)

According to Texas Family Code [§261.312](#):

"A review team consists of *at least* five members who serve staggered two-year terms. Review team members are appointed by the director 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.* A member of a review team is a department volunteer for the purposes of [Section 411.114, Government Code](#)"

CRTs may review any case in any stage, including near fatal cases. The team review includes a review of the agency's policies and procedures.

### 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.

*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](#)*

### Child Safety Review Committee (CSRC)

The CSRC consists of representatives of CPS State Office Legal, CPS Program, Center for Learning and Organizational Excellence (CLOE), Child Care Licensing (CCL), and Statewide Intake; it also includes the division administrator for child safety, a CPS program administrator, representatives from the State Child Fatality Review Teams, and a representative of the Texas Council on Family Violence. 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 teams and the Citizen Review Teams. Identified issues are discussed and appropriate action is determined. Many recommendations, primarily regarding training and policy, are assigned to the entities represented. In this way major components of State Office operations that affect the field can be coordinated. The recommendations and actions are provided to CPS leadership for review and follow-up.

## DESK DUTY

### PURPOSE

A child death subsequent to an investigation or on an open case is routinely one of the caseworker's most difficult experiences. Secondary trauma is very common in our field of work, particularly when a child fatality occurs with a family who was known to the caseworker. Secondary trauma must be addressed to help support staff. All staff who meet the criteria for desk duty must be placed on desk duty. Based on the circumstances of the individual case and the specific needs of staff who worked with the family, regional management may choose to place other staff on desk duty.

Desk duty is a standard procedure on all child fatalities suspected to be the result of abuse or neglect when CPS has had recent, prior involvement with the family. If a child in a CPS case dies and abuse or neglect is not alleged or suspected, desk duty is not required but an Individualized Plan may be completed. Desk duty is designed to establish a work process that addresses the need to provide support for Child Protective Services staff that have been directly involved in a case in which a child has died due to abuse or neglect while also reviewing casework practice to ensure accountability and transparency. Desk duty allows staff the opportunity to process the traumatic event and address their own individual response about the child fatality without the pressure of normal casework activities

### OVERVIEW

Desk duty has four major components:

- Supportive Supervision when Notified of the Child Fatality
- Assigning Desk Duty
- Case Review by Child Safety Specialist
- Individualized Plan

### SUPPORTIVE SUPERVISION WHEN NOTIFIED OF THE CHILD FATALITY

When investigations staff are notified of a child fatality, they must follow policies regarding notification process (See Form 2701). It is important that if there is an open case with the family that the worker and supervisor assigned to the open case are also notified. The Child Safety Specialist for the region will work with the Supervisor, Program Director, Program Administrator, and Regional Director to identify each staff member required to be on desk duty. It is regional management's responsibility to ensure that desk duty is assigned and the process is followed. Desk duty process is standardized and equitable for all staff so that they may be fully informed of the process and can have specific expectations during desk duty.

The program directors over the open investigation, open stage of service or previous stage must provide their respective staff with a referral to or information regarding the Employee Assistance Program (EAP). Additionally, if needed, the Program Director should work with EAP to have a debriefing session for staff who has 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. Debriefings for units and program areas may be held, but should be mindful of the staff who were involved with the family.

## **ASSIGNING DESK DUTY**

### **Investigations -- Investigators, Special Investigators and Supervisors**

- When there has been an investigation on the family that closed within the last 12 months, regardless of the disposition, the worker on the most recent previous investigation and supervisor of that investigation are placed on desk duty. If a special investigator was assigned to the previous investigation, the special investigator must also be placed on desk duty.
- When there is an open investigation and a new incident occurs resulting in the child's death, the investigator, special investigator (if assigned) and supervisor assigned to the current investigation are placed on desk duty.
  - EXAMPLE: CPS is investigating a family due to neglectful supervision. Before the investigation is concluded, the child dies due to a new incident of abuse/neglect. The worker and supervisor assigned to the initial investigation are placed on desk duty.
- When there is an open investigation due to an abuse/neglect incident and the child subsequently dies from the injuries sustained during that incident, the current worker and supervisor are not placed on desk duty.
  - EXAMPLE: A child is hospitalized due to a traumatic head injury caused by his father. A report is called in to CPS and an investigation initiated. Three weeks later, the child dies from the injuries. The worker assigned to the current investigation is not placed on desk duty. (However, if there has been a prior investigation(s) of the family within the last 12 months the worker and supervisor on the most recent previous investigation are placed on desk duty because these facts would meet the criteria.)
- When CPS is investigating a family and a child dies, but the child's death is not alleged to be abuse/neglect related, desk duty is not required.

### **Family Based Safety Services -- Caseworkers and Supervisor**

- When the FBSS stage is open and the child dies as a result of a new incident of suspected abuse or neglect, the FBSS worker and supervisor are placed on desk duty.
- When the family was last served through FBSS and the FBSS case closed within 12 months prior to a child's death from suspected abuse/neglect, the FBSS worker and supervisor assigned to the prior case are placed on desk duty.

### **Conservatorship -- Caseworkers and Supervisor**

- When CVS is working with a family and a child dies as a result of a new incident of suspected abuse or neglect, the CVS worker and supervisor who are responsible for the monthly face-to-face contact with the child are placed on desk duty. This is done regardless of where the child is placed.
- When a CVS case closed within 12 months prior to a child's death from suspected abuse/neglect, the CVS worker and supervisor assigned to the prior case are placed on desk duty.
- When CVS is working with a family and a child dies but the death is not suspected to be from abuse or neglect, the CVS worker and supervisor who are responsible for the monthly face-to-face contact with the child, or those staff that have had a significant relationship with the child are placed on desk duty. This is done regardless of where the child is placed.

## **DESK DUTY - REVIEW PROCESS**

Desk duty is required until the Child Safety Specialist (CSS) (or Risk Manager when there is no prior RTB history on the family) has an opportunity to review the case and its history. Within two business days after

receiving notification of the child fatality, the CSS or Risk Manager will review the case and provide feedback to the Regional Director, Program Administrator, Program Director, and Supervisor.

- In respect to desk duty, the CSS will review the case and provide feedback to the Regional Director, Program Administrator, Program Director, and Supervisor about the strengths and weaknesses of the casework in the prior cases. Regional management then determines if there is a need for a further review due to possible administrative actions/HR actions.
- If administrative actions warrant HR desk duty or administrative leave, then desk duty due to the child fatality is ended and the HHSC HR desk duty or administrative leave process is followed. An individualized plan can still be utilized to support the staff member during this process.

### **DESK DUTY - WHAT DOES DESK DUTY LOOK LIKE?**

Staff assigned to desk duty often have critical knowledge regarding the family, their history, and supports for surviving children. Staff assigned to desk duty should utilize the time between being assigned desk duty and the CSS/Risk Manager review to focus on:

- addressing their own feelings about the fatality. In order to help serve families, staff need to address their own needs and must be referred to EAP services.
- Updating any documentation or collateral contact information into IMPACT that has not been entered.

See: page 12 of this Guidebook: Completing Documentation of Prior Contacts After a Child Fatality Occurs

Based on the worker's own assessment and that of the supervisor and program director, the worker may participate in any staffing or assist in any casework processes related to the child fatality investigation if the investigator and investigator's supervisor approve to help ensure a continuity of information and support for the family and/or surviving children. If needed, the caseworker and supervisor may attend any related court hearings or staffings.

Staff on desk duty should not have primary case responsibility until their individualized plan is developed (which should be started within two workdays after the notification of the child fatality). While on desk duty, other workers, supervisors, or program directors may have to assume temporary responsibility for cases and supervisor responsibilities such as home visits, phone calls, attendance at Family Group Decision Making meetings or approval of casework decisions.

### **DESK DUTY - INDIVIDUALIZED PLAN AND SUPPORTIVE LEAVE**

Once the CSS/Risk Manager has reviewed the case and provided feedback to regional management, (within two business days after receiving notification of the child fatality), the Program Director is responsible for the development of the individualized plan for each staff member on desk duty. The individualized plan is designed to support the staff member through times of stress, provide tailored supports to the staff member and help address any training needs after a child fatality. The Program Director may ask the CSS and/or Risk Manager to assist in the development of the plan by providing feedback on practice issues noted and possible training supports that can be provided. The Regional Director must review the individualized plan and approve of the ending of desk duty for each staff member. Examples of what individualized plans can include:

- peer support from other staff, including those who have experienced a child death on their caseload or those who are known to be especially supportive in such situations;
- One-on-one case review between the staff member and the Child Safety Specialist;
- assigning a mentor/peer to help complete joint visits, help review assessment skills, and be supportive through the casework process;

- Temporary assistance with duties from staff within the unit or program area, including leave or a reduced caseload;
- Requirements to attend specific trainings or one-on-one opportunities for learning and skill development;
- Referral to or information regarding the Employee Assistance Program (EAP); and/or
- Utilization of supportive leave/emergency leave to ensure that staff address his/her own needs.

When creating an individualized plan, it is critical to recognize that some staff on desk duty may be ready to assume a full workload while others may need additional supports. It is the responsibility of regional management to provide an environment that supports and provides assistance to staff when a child fatality occurs. Staff should be given time to address their needs and obtain adequate emotional support so that they can successfully return to full duty.

Individualized plans should be reevaluated as needed. Ideally, a plan would be designed to cover needs during the first two weeks after the child fatality. Additional needs may be identified during the internal review process and may include additional tasks, trainings, or administrative process needs.