



**TEXAS**  
**Department of Family  
and Protective Services**

**Child Fatality Protocol Handbook**

**Investigations**

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## INTRODUCTION

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.

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

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 notify your Regional Director. The Regional Director will notify the Director of Child Safety 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 investigate child fatalities 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.

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

#### **Notifying Law Enforcement**

When CPI 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 CPI/CPS 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 assigned to the case:

- 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.

**Regional Notification List:**

- Regional Director;
- Program Administrator;
- Special Investigator Program Administrator;
- Program Director;
- Special Investigator Program Director
- Lead Child Safety Specialist for the Region;
- Information Specialist

**State Office Notification List**

- Associate Commissioner for Investigations
- Director of Investigations and Alternative Response;
- Director of Special Investigations
- Director of Child Safety;
- DFPS Deputy Commissioner
- DFPS Office of Child Safety;
- DFPS Media Relations Manager

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

- CPS Regional Director
- CPS Program Administrator
- CPS Director of Field
- CPS Associate Commissioner

**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 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

[6490](#) If a Child Dies While in Substitute Care

***INVESTIGATING A CHILD'S DEATH*****Requesting a Special Investigator be Assigned**

As soon as the Investigation supervisor is notified about a child fatality, either as a new report of abuse or neglect or a death that occurs in an open investigation, the supervisor requests an SI be assigned to the investigation. The SI is made secondary on the investigation and coordinates the investigation activities with primary investigator.

**Coordinating with Law Enforcement to Investigate a Child's Death**

When investigating a child's death, the assigned workers and supervisors coordinate the CPI 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 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 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, including following the procedures in CPS Handbook Section [2231](#) 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 Procedure and Reference Manual. See: [Safety and Risk Assessment Procedure and Reference Manual](#)

**Assessing Safety and Risk**

Surviving Children	No Surviving Children
<p><b>Assessing Safety</b></p> <p>The investigation worker:</p> <ul style="list-style-type: none"> <li>• thoroughly assesses the immediate safety of the surviving children; and</li> </ul> <p>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.</p>	<p><b>Assessing Safety</b></p> <p>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</p>
<p><b>Assessing Risk</b></p> <p>The investigation worker:</p> <ul style="list-style-type: none"> <li>• thoroughly assesses the risk of abuse and neglect of the surviving children;</li> <li>• completes The Risk Assessment tool; and</li> </ul> <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><b>Assessing Risk</b></p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Non-fatality investigation</li> <li>• Close—Kinship investigation</li> <li>• Close—Abbreviated investigation</li> </ul> <p><b>In order to ensure that our case information is as accurate as possible, staff must request a data correction after case closure to change the recommended action to “only child died.”</b></p>

- 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.

## **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 CPI 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.

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**

### **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* 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*.

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
  - 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
  - the household has had CPI/CPS involvement within the last 12 months; or
  - upon request by the RD in collaboration with the CSS team.

Exception: If prior to the QRT being held, the region 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 Quick Response Team (QRT) should be made by Child Safety Specialist (CSS) staff as soon as determination is made that there is a child fatality investigation that meets the requirements for a QRT. 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.

**QRT participants and their roles:**

**Regional Staff**

Participant	Role/Tasks
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 team involved with the family through any open stages of service (INV/SI or ongoing services caseworker, supervisor, program director), if available.	Resource: Provide background information

At least one member of the program team responsible for the case(s) closed in the previous 12 months (INV/SI or ongoing services caseworker, supervisor, program director) if available.	Resource: Provide background information
CPI/CPS Program Administrator and/or CPI/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**

Participant	Role/Tasks
Director of Child Safety and DFPS Office of Child Safety.	Member: Respond to policy information requests
Child Safety Specialist, Lead Child Safety Specialist	Chair: <ul style="list-style-type: none"> <li>• Convenes and chairs QRT</li> <li>• Reviews case history</li> <li>• Develops a chronology</li> <li>• E-mails information to other team members</li> </ul>

- 4) The 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. 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 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 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, 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 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 the management process outside of the QRT. The QRT should focus on what information is known due to the DFPS history and current investigation, what tasks need to be completed, and what additional needs are identified during the QRT.

- 7) 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

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 [2281.2](#) 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.

CPS Reason for Death Code	Circumstances Surrounding the Fatality	Involvement with CPS
<p>NAB</p> <p>Not Abuse/Neglect Related</p> <p>Applicable dispositions: 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</p> <p>Abuse/Neglect In Open Case</p> <p>Applicable dispositions: RTB - Fatal</p>	<p>The child died due to abuse/neglect</p>	<p>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.</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><b>Example</b> 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><b>Example</b> of case where code should NOT be used:</p> <p>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.</p>

<p>ABO Abuse/Neglect In Closed Case Applicable dispositions: RTB - Fatal</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 confirmed perpetrator in a 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.</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 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.</p> <p><b>Example:</b> 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.</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>NIN Not Investigated Applicable dispositions: ADM There cannot be a disposition of RTB or a severity code of Fatal</p>	<p>Death was not investigated.</p>	<p>NA</p>

**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 (ABN)</i></li> <li>• <i>Abuse or neglect in a closed case (ABO)</i></li> <li>• <i>Abuse or neglect, no prior (ABP)</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 must answer Yes to the question: <i>Is this a child fatality allegation?</i></li> </ul>	The investigation worker chooses <i>Not abuse or neglect related</i> 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: <ul style="list-style-type: none"> <li>• may <b>not</b> 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 Yes to the question: <i>Is this a child fatality allegation?</i></li> </ul>	The investigation worker chooses <i>Not able to determine</i> 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: <ul style="list-style-type: none"> <li>• may <b>not</b> 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 Yes to the question: <i>Is this a child fatality allegation?</i></li> </ul>	The investigation worker chooses <i>Not able to complete</i> in IMPACT (UTC)
The child's death was not investigated as possibly due to abuse or neglect	The investigation worker answers No to the question <i>Is this a child fatality allegation?</i>	The investigation worker chooses <i>Not related to abuse or neglect</i> in IMPACT (NIN)

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

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.

### **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 each region 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](#))

For additional information on the process for complying with this requirement

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

### **FBSS POLICY AND PROTOCOLS**

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

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

##### **Notifications When a Child Dies During an Open FBSS Case**

The FBSS caseworker must make a report to Statewide Intake as soon as possible, but no later than 8 hours after learning of a child’s death (if it has not been reported) and document the Call ID in the case record.

Within 24 hours of receiving notification of a child’s death, the FBSS caseworker notifies:

- the supervisor;
- the Medical Examiner or Justice of the Peace if the child is under age 6 (if not already completed by law enforcement);
- the parents if the child dies while in a parental child safety placement, unless they cannot be found; and
- all parties listed below if the FBSS case is under a court order:
  - 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.

See CPSH 12920 for policy about child fatalities in FBSS.

### **Submitting Form 2701 (Part 1)**

Within 24 hours, excluding weekends and holidays, of receiving notification of the child's death, the regionally designated person in the FBSS program completes Form 2701 Part 1 and forwards it by e-mail to the appropriate Child Safety Specialist (CSS). The CSS forwards it to the appropriate management teams and subject matter experts. See in this Handbook "Notifying DFPS Staff When a Child Dies."

### **Documentation in IMPACT**

If there is no investigation, the FBSS caseworker enters the date of death and the code for the CPS reason for the child's death. The FBSS caseworker consults with the appropriate Child Safety Specialist about documenting the child fatality information and correct *Reason for Death* code.

The FBSS caseworker or supervisor must make a contact entry in IMPACT immediately or within 24 hours of learning of the child's death.

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 XX, 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. See "Completing Documentation After a Child Fatality" in this manual.

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

## **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, if not already notified the conservatorship caseworker notifies:

- Statewide Intake;
- CVS supervisor and PD;
- medical examiner or justice of the peace;
- law enforcement when necessary;
- the court;
- the child's attorney ad litem;
- child's parent (may be notified even if rights terminated) or relatives who have been involved with the child if parents cannot be found;
- parent's attorney(s);
- the child's guardian ad litem;
- attorney representing CPS in child's case;

- CPS regional attorney; and
- Licensed Child Placing Agency Administrator (LCPAA).
- 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 CCI When a Child Dies in a Residential Placement**

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

CCI staff then assigns an CCI 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.

## **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.

### ***Regional Child Death Review Committees (RCDRC)***

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 Services and Child Protective Investigations.

*Texas Family Code:* [§§264.502; 264.503](#)

### ***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 DFPS State Office Legal, CPI/CPS Program, Center for Learning and Organizational Excellence (CLOE), Child Care Investigations (CCI), and Statewide Intake; it also includes the division administrator for child safety, 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 committees. Identified issues are discussed and recommended actions are determined. The recommended actions are provided to CPS/CPI leadership for review and follow-up.

## THE REGIONAL CHILD DEATH REVIEW COMMITTEE

*Regional Child Death Review Committees evaluate department casework and decision-making related to abuse/neglect investigations. Regional Child Death Review Committees 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 (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/CPI history within the last 5 years; or
  - The family had an open CPS/CPI case at the time of the child's death.

The Regional Child Death Review Team meeting is conducted to:

- evaluate the adequacy of the child welfare system's response to the child or family, focusing both on CPS/CPI and on other components of the system;
- identify barriers to the ultimate protection of the child, both within and outside CPS/CPI;
- assess areas where program policy can be strengthened to prevent serious injury or child fatalities; 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 [TFC Sec.261.312](#) and the following guidelines:

- The review committee must have a minimum of five members who serve staggered two-year terms.
- Review 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.
- A member of a review team is a department volunteer for the purposes of Section [411.114](#), Government Code.
- 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/CPI in one region dies from suspected abuse or neglect in a region in which the family does not have a prior CPS/CPI history, both regions must participate in the review. In addition:
  - Staff in the region in which the child died must notify the region in which the family had prior CPS/CPI history; and
  - The region in which the family had a prior CPS/CPI history must conduct the review;
  - Exceptions to this procedure may be made by agreement of the regions' CPS/CPI program administrators.

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

The regional review committee must meet at least quarterly and review child fatality investigations closed during the previous quarter.

- The committee conducts the review by examining the facts of the case as outlined by the department caseworker and law enforcement personnel. A review committee member acting in the member's official capacity may receive information made confidential under Section [40.005](#), Human Resources Code, or Section [261.201](#) Texas Family Code. At a minimum, CPI provides documentation of the fatality investigation, the autopsy report if available, and a summary of the

agency's prior involvement with the family.

- 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/CPI regional director, program administrator, program director, regional lead child safety specialist, director of child safety, and the office of child safety.

The report must:

- specify the date that the committee met;
- identify those in attendance;
- identify each child whose death was reviewed;
- summarize CPS/CPI prior 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 opportunities for strengthening policy and practice;
- identify opportunities to improve 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 any practice changes or supports that the regional or state office staff are completing to address the concerns noted.

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.

### ***MODIFIED DUTY/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 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 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. When reviewing the previous history, regional management may determine a need for a more thorough review of casework either by the individual worker or in the management chain. Regional management will determine whether or not any staff need to be placed on modified duty pending completion of the review.