Effective Date: May 25, 2006 **Number: B-0117**
Revised: April 6, 2018

Child Fatality Reviews

Purpose

To provide guidelines for Child Fatality Reviews conducted by Children and Family Services (CFS) and the Quality Support Team (QST).

Approved

This policy was approved by Anne Bloxom, Director of CFS, on April 6, 2018. *Signature on file*.

Most Recent Revision

This revision of the Policy and Procedure (P&P) includes:

- Removal of timeline to complete a Child Fatality Review Report
- Removal of timeline to present report at an In-House Child Fatality Review meeting
- Revised criteria for conducting CFS Child Fatality Reviews

Background

Although not mandated to do so by law, the Social Services Agency (SSA) CFS Division conducts in-house Child Fatality Reviews in pursuit of best child welfare practice. In addition, CFS collaboratively reviews child fatality reports involving any child for whom a petition has been filed, or any Orange County Juvenile Court dependent whose death is determined to have been caused by abuse or neglect, with the Orange County Juvenile Justice Commission (JJC), per Miscellaneous Court Order 528.7.

CFS child fatality reviews are conducted independently from the interagency child death reviews mandated pursuant to Penal Code § 11174 and conducted by the Orange County Child Death Review Team (OCCDRT).

The guidelines detailed in this P&P pertain to minors. Fatality reviews of non-minor dependents (NMDs) are conducted by QST as determined necessary and on a case-by-case basis.

Definitions

None.

POLICY

CFS Child Fatality Reviews

In-house Child Fatality Reviews will be completed under the following circumstances:

A. All fatalities of children **currently receiving child welfare services from Orange County**, whose death:

- Is determined to have been caused by abuse or neglect

–And/Or–

- Necessitates review of a CFS practice and/or Policy and Procedure (P&P)

B. The death of a child is suspected of resulting from child abuse or neglect, and there was **prior Orange County CFS involvement**. This includes:

- Emergency Response referrals
- Voluntary or court-ordered Family Maintenance, Family Reunification, and Permanency Planning Services
- Voluntary Placement
- Children for whom a petition has been filed with Juvenile Court

Referral to QST

The Social Services Agency (SSA) QST Program is notified of child fatalities by *Special Incident Report (SIR) (F063-03-48)*, pursuant to SSA Administrative P&Ps Client Death/Serious Incident Notification Dependent Children and Voluntary Supervision Cases (D 9) and Special Incident Report (F 13).

Goals of the Review

In-house Child Fatality Reviews are intended to:

- Identify the circumstances of child deaths
- Assess CFS compliance with policy, legal requirements, regulations, and best child welfare practices
- Identify needed policy and/or procedural modifications

- Identify education and training needs for CFS staff and the community

Review Process

QST staff are responsible for conducting Child Fatality Reviews. The review process includes, but is not limited to, the following activities:

A. Preliminary review of any child death reported to the Child Abuse Registry (CAR). This review will determine if a Child Fatality Review is necessary, per the guidelines above.

B. Review of the child's medical records, autopsy report, and all other available records relevant to the child's death.

C. Review of the child's CFS electronic and written case file, current or previous services provided by CFS, previous referrals to CFS, and related information (e.g., medical records, police reports, Coroner's report, etc.) deemed relevant by QST.

D. Interviews of staff assigned to the child's referral/case and/or death, as appropriate.

E. Identification of case management and procedural issues, including an assessment of compliance with state regulations and CFS P&Ps.

Child Fatality Review Report—CFS Review

QST staff will prepare a report summarizing the results of the Child Fatality Review. The written report will include:

- The deceased child's identifying information
- A brief summary of CFS involvement
- A brief summary of the circumstances of the child's death
- Recommendations, if any, for P&P compliance or revision

In-House Child Fatality Review Meeting

An In-House Child Fatality Review meeting will be held monthly to review the results and recommendations of the Child Fatality Review. Designated QST personnel will present the report to the In-House Child Fatality Review participants, including CFS Deputy Directors, PMs, County Counsel, and other attendees as invited, for discussion.

Action items may be identified at the end of each In-House Child Fatality Review meeting. Action items will be assigned to appropriate staff for completion, with subsequent follow-up and review at the next scheduled In-House Child Fatality Review meeting.

PMs will provide staff with feedback on pertinent issues discussed at the In-House Child Fatality Review meeting to support implementation and compliance with established agency policy.

Child Fatality Review Report—JJC Review

A CFS Deputy Director, the QST PM, and QST staff will meet quarterly with representatives of the JJC to collaboratively review child fatalities of dependent children and children for whom a petition has been filed when:

- The death is determined to have been caused by abuse or neglect

–And/Or–

- Necessitates review of a CFS practice and/or P&P

QST will schedule the meetings and notify the JJC 10 calendar days before the date, of the cases to be reviewed, identifying:

- Deceased child's name
- Date of birth
- Date and cause of death
- DP or J number
- Review date

The outcome of action items identified during the In-House Child Fatality Review meeting will be documented in the final written report to the JJC.

As requested, arrangements may be made for JJC representatives to review the final report at the QST office prior to the meeting date. The final written reports will also be made available to the JJC to review during the quarterly meetings.

REFERENCES

Attachments and CWS/CMS Data Entry Standards

Hyperlinks are provided below to access attachments to this P&P and any CWS/CMS Data Entry Standards that are referenced.

None.

Hyperlinks

Users accessing this document by computer may create a direct connection to the following references by clicking on the links provided.

- CFS P&P Child Fatalities and Near Fatalities (A-0204)
- SSA Administrative P&P Client Death/Serious Incident Notification Dependent Children and Voluntary Supervision Cases (D 9)
- SSA Administrative P&P Special Incident Report (F 13)

Other Sources

Other printed references include the following:

None.

FORMS

Online Forms

Forms listed below may be printed out and completed, or completed online, and may be accessed by clicking on the links provided.

Form Name	Form Number
Special Incident Report	F063-03-48

Hard Copy Forms

Forms that may be completed in hard copy (including multi-copy NCR forms) are listed below. ***For reference purposes only,*** links are provided to view these hard copy forms, where available.

Form Name	Form Number
None.	

CWS/CMS Forms

Forms that may **only** be obtained in CWS/CMS are listed below. ***For reference purposes only,*** links are provided to view these CWS/CMS forms, where available.

Form Name	Form Number
None.	

Brochures

Brochures to distribute in conjunction with this policy may include:

Brochure Name	Brochure Number
None.	

LEGAL MANDATES

The following legal and regulatory references were utilized in the development of this P&P:

Welfare and Institution Code Section (§) 830 authorizes disclosure and exchange of information and writings between members of a multidisciplinary personnel team engaged in the prevention, identification, management, or treatment of child abuse or neglect including any incidents of child abuse that may also be part of a juvenile court record or otherwise designated as confidential under state law. The team member in possession of the information or writing must reasonably believe it is generally relevant to the prevention, identification, management, or treatment of child abuse, or the provision of child welfare services.

Welfare and Institution Code (§) 5328 authorizes disclosure of information and records between persons who are trained and qualified to serve on multidisciplinary personnel teams. The information and records sought to be disclosed must be relevant to the provision of child welfare services or the investigation, prevention, identification, management, or treatment of child abuse and neglect.

Welfare and Institution Code (§) 18951 defines “multidisciplinary personnel” as any team of three or more persons who are trained in the prevention, identification, management, or treatment of child abuse or neglect cases and who are qualified to provide a broad range of services related to child abuse or neglect.

Welfare and Institution Code (§) 18964 authorizes a person who is trained and qualified to serve on a multidisciplinary team to be a member of the team for a particular case whether or not the person is serving on the team. The designated team must specify its reasons, in writing, for deeming that person to be a member of the team. The person deemed a member may receive and disclose information relevant to a particular case as though he or she were a member of the team.

Penal Code (§) 11167.5 allows the disclosure of confidential reports of suspected child abuse or neglect and information contained therein to specified persons or agencies including multidisciplinary personnel teams as defined in WIC 18951.

Penal Code (§) 11174.32 mandates child welfare counties establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child death.

Orange County Juvenile Court Miscellaneous Order 528.7 (Authorization for Inspection of Records, Access to Minors, and Meeting Participation by the Orange County Juvenile Justice Commission) authorizes the Orange County Juvenile Justice Commission to inspect and receive copies of relevant records of minors under the jurisdiction of the Juvenile Court; allows the Juvenile Justice Commission to apply to

the Presiding Judge of the Juvenile Court for an order seeking copies of any available medical or psychological reports of minors under the jurisdiction of the Juvenile Court; orders the notification of the Orange County Juvenile Justice Commission of any incident in which serious injury, or death, of a child under the jurisdiction of the Juvenile Court occurs; authorizes the Juvenile Justice Commission to participate on the Child Death Review Committee, including the sharing of case information related to the review whenever a child is under the jurisdiction of the Juvenile Court and is the subject of the review.

REVISION HISTORY

Since the Effective Date of this P&P, and prior to the Current Revision Date, the following revisions of this P&P were published:

February 20, 2010
April 5, 2012