

	<b>INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE MANUAL</b>	
	<b>Chapter 2:</b> Administration of Child Welfare	<b>Effective Date:</b> October 1, 2012
	<b>Section 19:</b> Local Child Fatality Review Teams	<b>Version:</b> 1

**POLICY [NEW]**

The Indiana Department of Child Services (DCS) will form Local Child Fatality Review Teams<sup>1</sup> in each region. These teams will conduct child fatality reviews and examine factors contributing to fatalities. They will also make recommendations for strategies to prevent future deaths.

The Local Child Fatality Review Team will review the death of a child that occurred in the region and is:

1. Sudden;
2. Unexpected;
3. Unexplained;
4. Assessed by DCS for alleged abuse or neglect that resulted in the fatality; or
5. Determined by a coroner in the region served by the Local Child Fatality Review Team to be the result of a homicide, suicide, or accident.

At a minimum, each Local Child Fatality Review Team will meet in executive session<sup>2</sup> quarterly. Any review that involves confidential records or identifying information regarding the death of a child will take place in executive session. Executive sessions will include Local Child Fatality Review Team members and anyone invited to attend by the team Chairperson. Anyone that attends an executive session at the invitation of the team Chairperson and is not a member of the Local Child Fatality Review Team will be required to sign a confidentiality agreement in accordance with IC 31-33-24-12.

Local Child Fatality Review Teams will document data from each review on the National Center for Child Death Review Case Report Form available online through [The National Center for the Review and Prevention of Child Deaths](#). Teams will submit an annual report to the DCS Director and the Statewide Child Fatality Review Committee. The report will include non-identifying information regarding cases reviewed and aggregate data collected, information regarding the circumstances surrounding deaths, factors contributing to the deaths, and suggested prevention strategies.

Each Local Child Fatality Review Team will hold at least one (1) public meeting per year. During this meeting, non-identifying aggregate data, trends, and prevention activities will be discussed.

A Local Child Fatality Review Team will consist of the following members from the area served by that team:

<sup>1</sup> For purposes of this policy Local Child Fatality Review Team refers to the Child Fatality Review Team conducted in each region.

<sup>2</sup> Executive Session refers to a meeting from which the public is excluded. However, the governing body may admit non members necessary or desired to conduct business.

1. A coroner or deputy coroner;
2. A representative from:
  - a. A local health department, or
  - b. A multiple county health department.
3. A pediatrician or family practice physician;
4. A representative of a law enforcement agency;
5. A representative from an emergency medical services provider;
6. A DCS Regional Manager (RM);
7. A representative of the prosecuting attorney;
8. A pathologist with forensic experience who is licensed to practice medicine in Indiana, and who, if feasible, is certified by the American Board of Pathology in forensic pathology;
9. A representative from a fire department or volunteer fire department;
10. A DCS attorney;
11. A mental health provider;
12. A representative from a school district; and
13. The prosecuting attorney or designee from the county where the child fatality occurred, as a non-voting member.

Optional team members from the area served by the Local Child Fatality Review Team may include professionals with experience relevant to a specific death or pattern of deaths, including:

1. A representative from a hospital;
2. A representative from a juvenile or probate court;
3. A representative from the Department of Natural Resources;
4. A representative from Prevent Child Abuse Indiana;
5. A Court Appointed Special Advocate (CASA) or Guardian Ad Litem (GAL); or
6. Other representatives requested to serve by the members of the Local Child Fatality Review Team may include, but are not limited to Toxicologist, Crash Reconstruction Specialist, and Injury Prevention Specialist.

Code References:

1. [IC 31-33-24 Child Fatality Review Teams](#)
2. [IC 5-14-1.5 Public Meetings \(Open Door Law\)](#)
3. [IC 5-14-1.5-3.6 Electronic Meetings of State Agencies](#)
4. [IC 5-14-3 Access to Public Records](#)

<b>PROCEDURE</b>
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**For Recruiting and Appointing members to the Local Child Fatality Review Team**

Central Office Fatality Unit staff will:

1. Recruit individuals to serve as appointees to the team;
2. Reach out to groups that represent the necessary membership; and
3. Determine deadlines for applications and final appointments.

RMs will:

1. Assist Central Office with recruitment activities;
2. Serve as the designee for the Director of DCS to make the final decision on who to appoint for their Local Child Fatality Review Team; and
3. Notify appointees by letter and copy Central Office.

Local Office Directors (LODs) will submit one (1) name of an individual for each position on the Local Child Fatality Review Team to their RM for consideration.

### **Training Local Child Fatality Team Members**

Training for team members will be provided through DCS.

### **Referring a Case to the Local Child Fatality Review Team**

Central Office Fatality Unit staff will:

1. Obtain monthly information on the deaths of children from the Indiana State Department of Health; and
2. Provide information on child deaths to team Chairpersons. The Local Child Fatality Review Teams will determine which cases meet the criteria for review.

FCM/FCM Supervisors will notify the LOD upon receipt of a fatality assessment.

LODs will notify the RM upon receipt and completion of a fatality assessment.

RMs will ensure each fatality assessment from their region is reviewed by the Local Child Fatality Review Team.

### **Conducting a Local Child Fatality Review Team Meeting and Reviewing a Fatality**

The RMs will:

1. Chair the Local Child Fatality Review Team, and attend all meetings, but may delegate facilitation to another team member;
2. Ensure team members are notified of meeting dates, locations and times;
3. Ensure a staff member familiar with the case being reviewed (FCM, FCM Supervisor, or LOD) attends the Local Child Fatality Review Team meeting;
4. Ensure DCS information on the cases being reviewed is disseminated to team members electronically or by mail at least one week prior to the Local Child Fatality Review Team Meeting;
5. Ensure team members receive identifying information (name, address, date of birth, date of death, location of incident leading to death, if applicable, and city/county of death) on cases that have no DCS history so they can check their agency records for history;
6. Determine the agenda for the meeting and ensure the agenda and notices for both public and executive session meetings are posted on the door of each local office in the region and at the meeting location 48 hours prior to a meeting;
7. Ensure minutes are kept for each meeting;
8. Ensure confidentiality agreements are signed and kept;
9. Ensure the National Center for Child Death Review Case Report Form available online through [The National Center for the Review and Prevention of Child Deaths](#) is completed correctly for each case and is entered into the National Center for Child Death Review Case Reporting System; and
10. Ensure an annual report is completed and submitted timely to the DCS Director and Central Office Fatality Unit.

The Local Child Fatality Review Team members will:

1. Review all records concerning the deceased child that are held by DCS regarding a death that the team is reviewing. The team may also review records obtained from a:

- a. Hospital,
  - b. Physician,
  - c. Coroner,
  - d. Law enforcement officer, or
  - e. Mental health professional.
2. Discuss information obtained from the perspective of each team member; and
  3. Participate in the completion of an annual report.

## PRACTICE GUIDANCE

### **Confidentiality**

All identifying information in a fatality review is confidential. Local Child Fatality Review Team members must sign a confidentiality agreement that will last during their two-year term. Anyone who is invited by the Chairperson to attend an executive session, but is not a member of the Local Child Fatality Review Team will be required to sign a confidentiality agreement.

### **Local Child Fatality Team Membership**

In some regions, a representative from each required discipline may not be available to serve on the Local Child Fatality Review Team. In these cases, a substitution may be made that will substantially fill that position. For example, a forensic pathologist may not be available in some areas. A pathologist could fill this position on the team. If a team member is unable to attend a meeting of the Local Child Fatality Review Team, the team Chairperson should be notified. Team members may not send a proxy to meetings they are unable to attend.

### **Statewide Child Fatality Review Committee Assistance**

The Statewide Child Fatality Review Committee may review a fatality upon request of a Local Child Fatality Review Team. This request is made by completing the Statewide Child Fatality Committee Review Request (available on the Field Ops Report SharePoint under Fatalities).

## FORMS AND TOOLS

Child Fatality Review Team Public Documents are set out below:

1. [Local Child Fatality Review Team Applicant Cover Sheet](#);
2. [Local Child Fatality Review Team Confidentiality Agreement for Team Member](#);
3. [Local Child Fatality Review Team Confidentiality Agreement for Invitee](#);
4. [Local Child Fatality Review Team Vision, Mission, and Goals](#);
5. Mandatory Team Member Roles:
  - a. [Role of the Coroner](#),
  - b. [Role of the DCS Representative](#),
  - c. [Role of the School District Representative](#),
  - d. [Role of the Emergency Medical Services \(EMS\) Representative](#),
  - e. [Role of the Fire Department Representative](#),
  - f. [Role of the Health Department Representative](#) ,
  - g. [Role of the Law Enforcement Representative](#),
  - h. [Role of the Mental Health Provider](#),
  - i. [Role of the Pathologist](#),
  - j. [Role of the Pediatrician-Family Practice Physician](#), and
  - k. [Role of the Prosecuting Attorney Representative](#).

6. Optional Team Member Roles:
  - a. Role of the Court Appointed Special Advocate (CASA)/Guardian Ad Litem (GAL) Representative,
  - b. [Role of the Natural Resources \(DNR\) Representative](#),
  - c. [Role of the Hospital Representative](#),
  - d. [Role of the Juvenile-Probate Court Representative](#), and
  - e. [Role of the Prevent Child Abuse Indiana Representative](#).

Additional forms for internal use or use by the Local Fatality Review Teams are available on the Field Ops Report SharePoint under Fatalities

<b>RELATED INFORMATION</b>
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N/A