



Working With

CHILD PROTECTIVE SERVICES AND LAW ENFORCEMENT IN INFANT DEATH INVESTIGATIONS

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Learning Outcomes

- Understand the unique roles and mandates of CPS and Law Enforcement in infant death investigations.
- Identify the shared goals and commonalities between CPS, LE, and ME/C in these cases.
- Recognize legal and policy frameworks guiding information sharing



Learning Outcomes

- Develop strategies for effective initial response and ongoing communication.
- Identify best practices for joint scene processing and interviewing.
- Address common challenges in interagency collaboration and mitigation strategies.



The Multidisciplinary Team (MDT) Approach



- No Single Agency Has All Answers: Requires combined expertise.
- Core Agencies: CPS (DCS), LE, Coroners
- Extended MDT: EMS, Hospitals, Public Health, Child Advocacy Centers (CACs).
- Benefits:
 - Comprehensive investigation.
 - Reduced re-traumatization for families.
 - Consistent messaging.
 - Holistic assessment of risk and needs.
 - Enhanced prevention efforts.

Understanding DCS:

Role & Mandate



■ Primary Mandate	Child protection and safety
■ Focus	Investigation of alleged child abuse/neglect, assessment of safety for surviving children
■ Response to Infant Death	Investigate if death is due to abuse/neglect or if surviving children are at risk
■ Legal Standard	Usually "Reason to Believe" or "Preponderance of Evidence" for findings
■ Outcomes	Substantiation of findings, safety plans, court intervention, provision of services

Understanding Law Enforcement :

Role & Mandate



■ Primary Mandate	Investigation of potential criminal activity, public safety
■ Focus	Determine if a crime occurred, identify perpetrator, gather evidence for prosecution
■ Response to Infant Death	Infant death scenes treated as crime scene until proven otherwise
■ Legal Standard	"Probable Cause" for arrest, "Beyond a Reasonable Doubt" for conviction
■ Outcomes	Arrests, charges, prosecution, case closure

Coroners

The Bridge Agency



Role in Collaboration

- Provide medical/death investigation expertise to LE and DCS
- Integrate scene findings with autopsy results
- Provide objective medicolegal opinion
- Often the central hub for infant death investigations



Primary Mandate

Determine Cause and Manner of Death

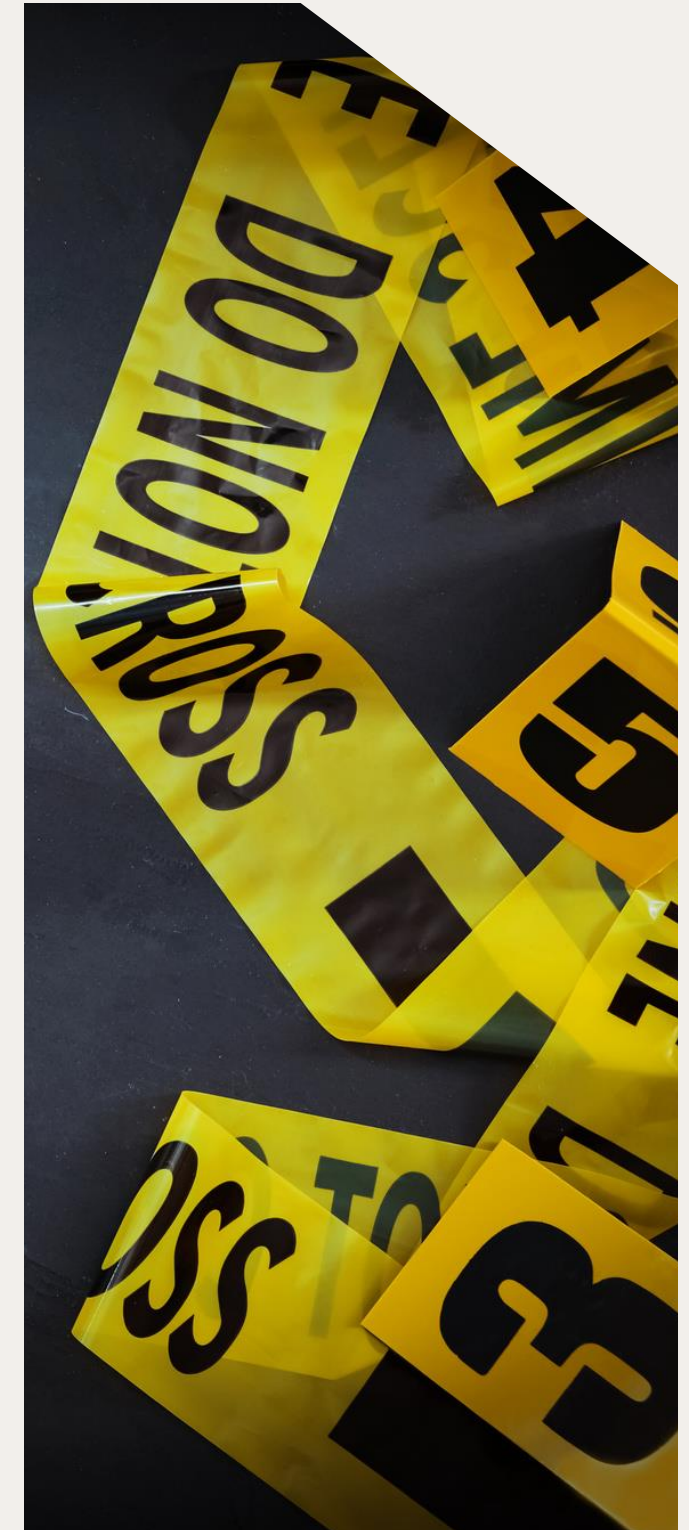


Lead Death Investigation

Coroners have legal authority over the death scene and investigation of the fatality

Shared Goals & Common Ground

- Determine Cause & Manner of Death
- Protect Surviving Children
- Gather Comprehensive Information
- Prevent Future Deaths
- Justice for the Departed
- Support for Families



Initial Response & Scene Management

● Notification Protocol

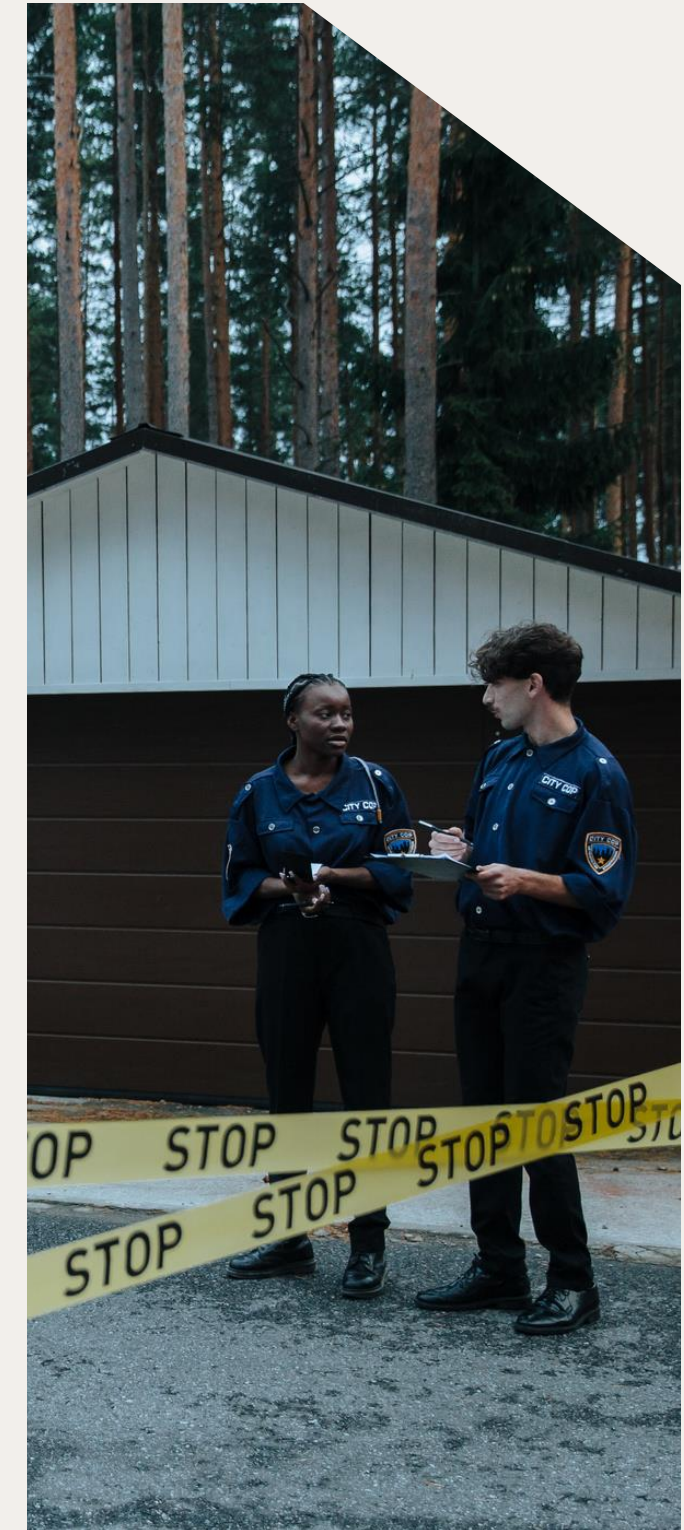
● Scene Security

● Controlled Access

● Initial Walkthrough

● Preliminary Info. Sharing

● Role Clarification

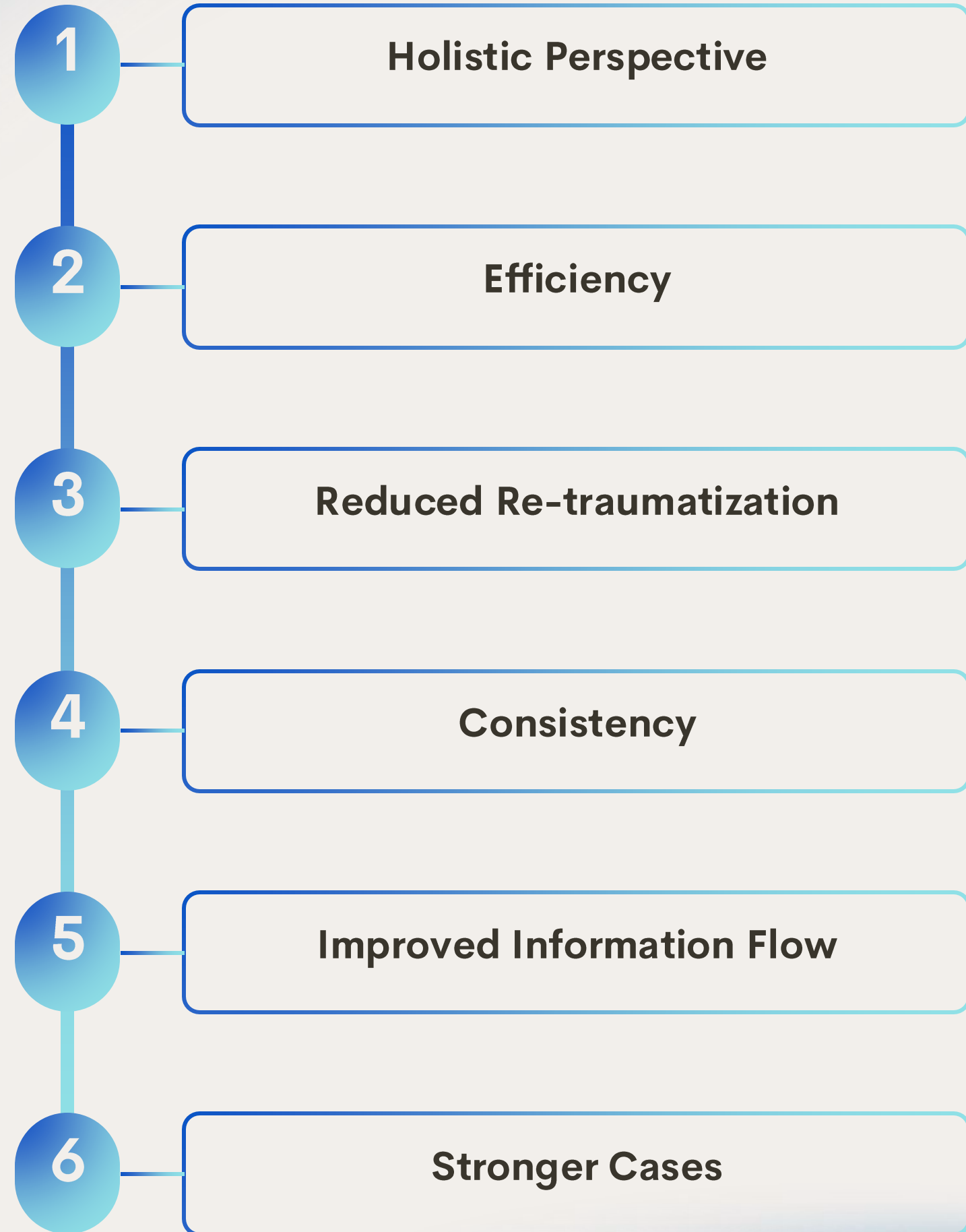


Information Sharing: Legal & Practicalities

- **Confidentiality vs. Need-to-Know:** Balancing legal mandates
- **State/Federal Laws:** FOIA, HIPAA, child abuse reporting laws
- **Memoranda of Understanding (MOUs)/Protocols:** Formalize sharing agreements.
- **Secure Channels:** For transmitting sensitive information
- **Documenting Sharing:** What was shared, when, with whom
- **Over-Sharing vs. Under-Sharing:** Risk of both; find the balance



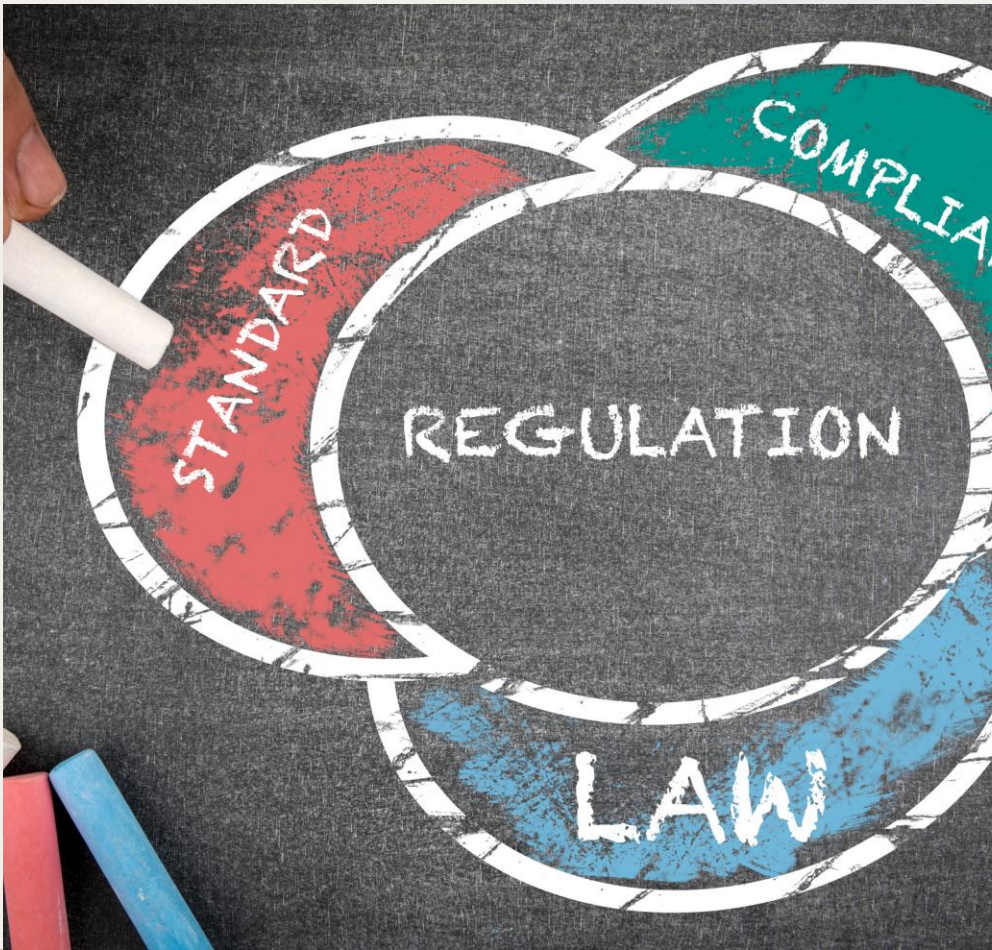
Joint Investigations: Benefits



Joint Investigations

Challenges & Mitigation

Differing Mandates/Priorities
Mitigation: Clear communication, pre-defined roles



Trust & Communication Barriers
Mitigation: Regular joint training, team-building exercises, designated liaisons



Varying Legal Standards
Mitigation: Mutual understanding, careful documentation of standards applied



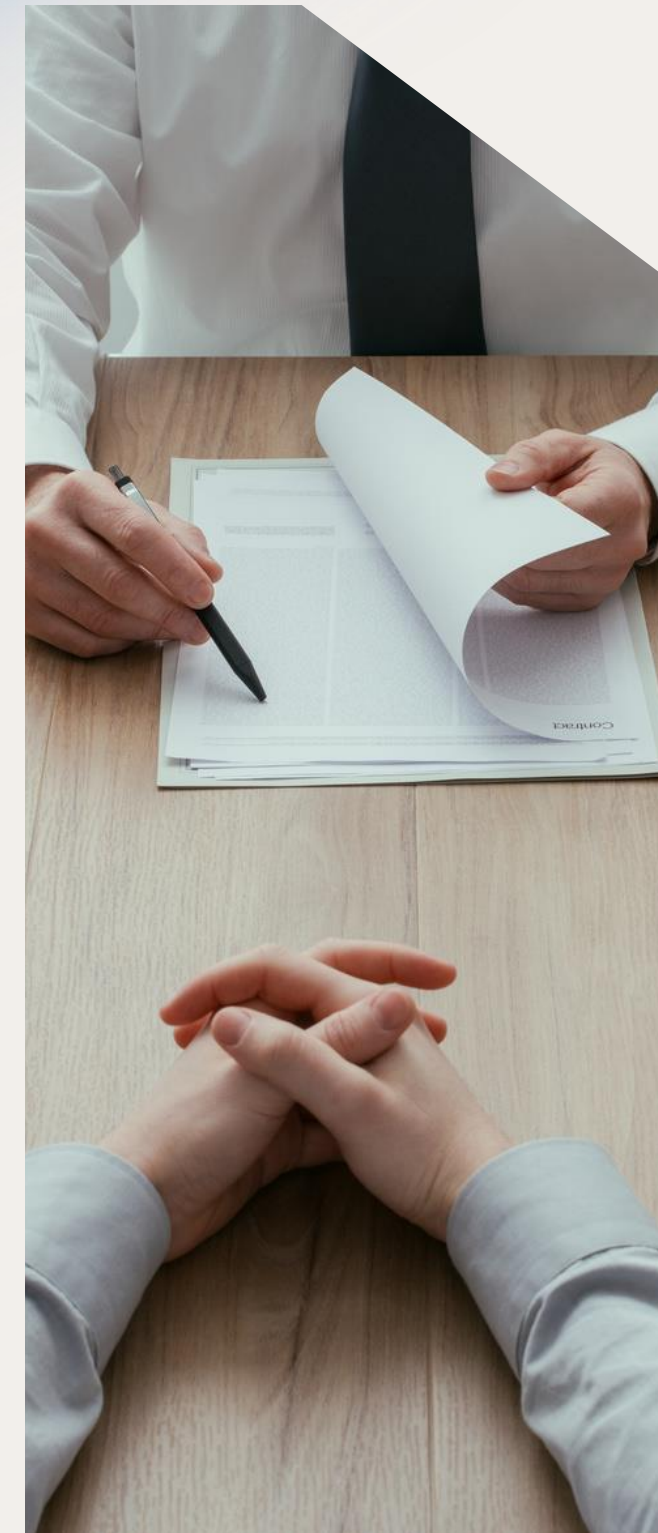
Resource Limits & Personality Conflicts
Mitigation: Shared resources, grant applications; professionalism, clear protocols, leadership intervention

Joint Scene Processing



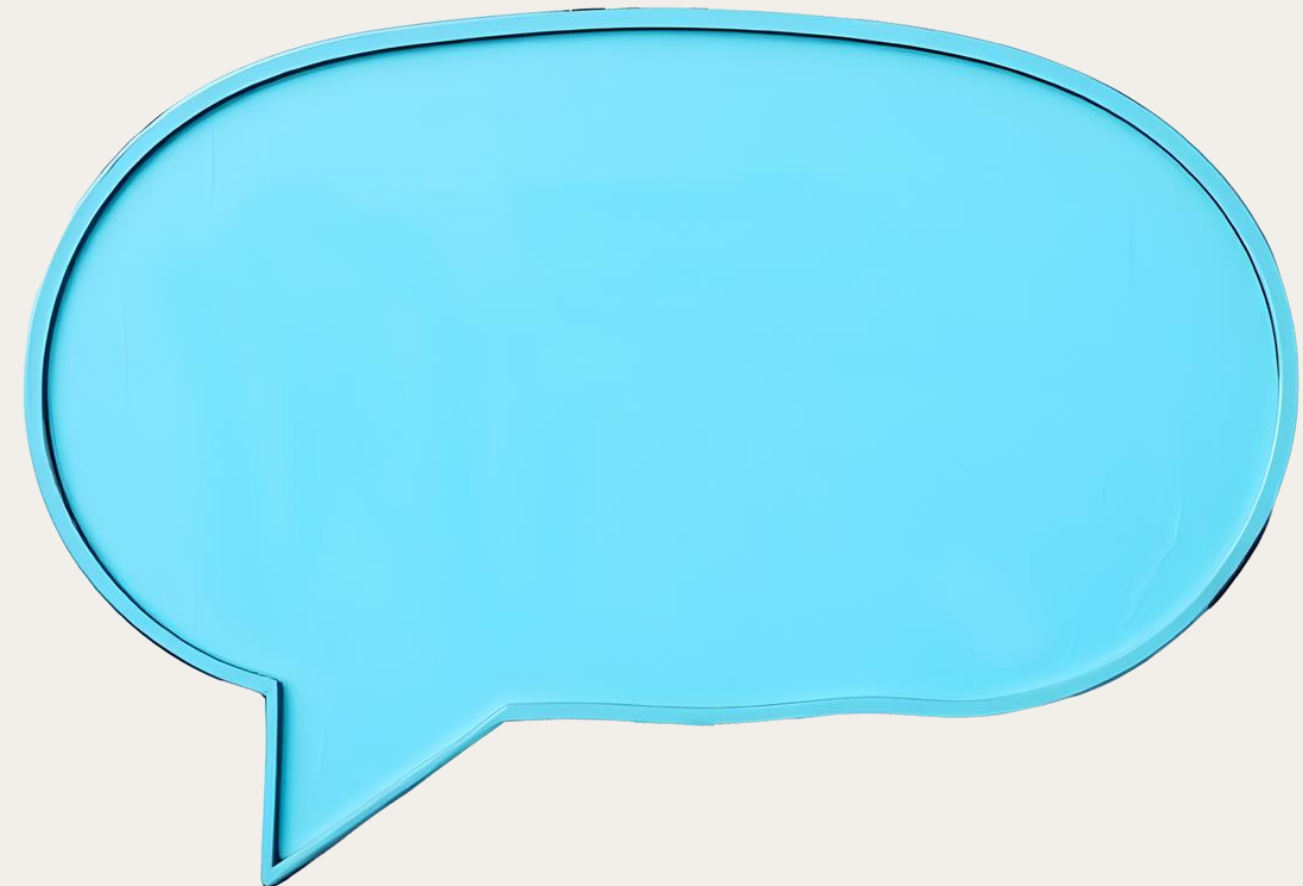
Joint Interviews: Best Practices

- Strategic Decision
- Pre-Interview Briefing
- Tandem Interview
- Trauma-Informed Approach
- Allow for Breaks
- Post-Interview Debriefing

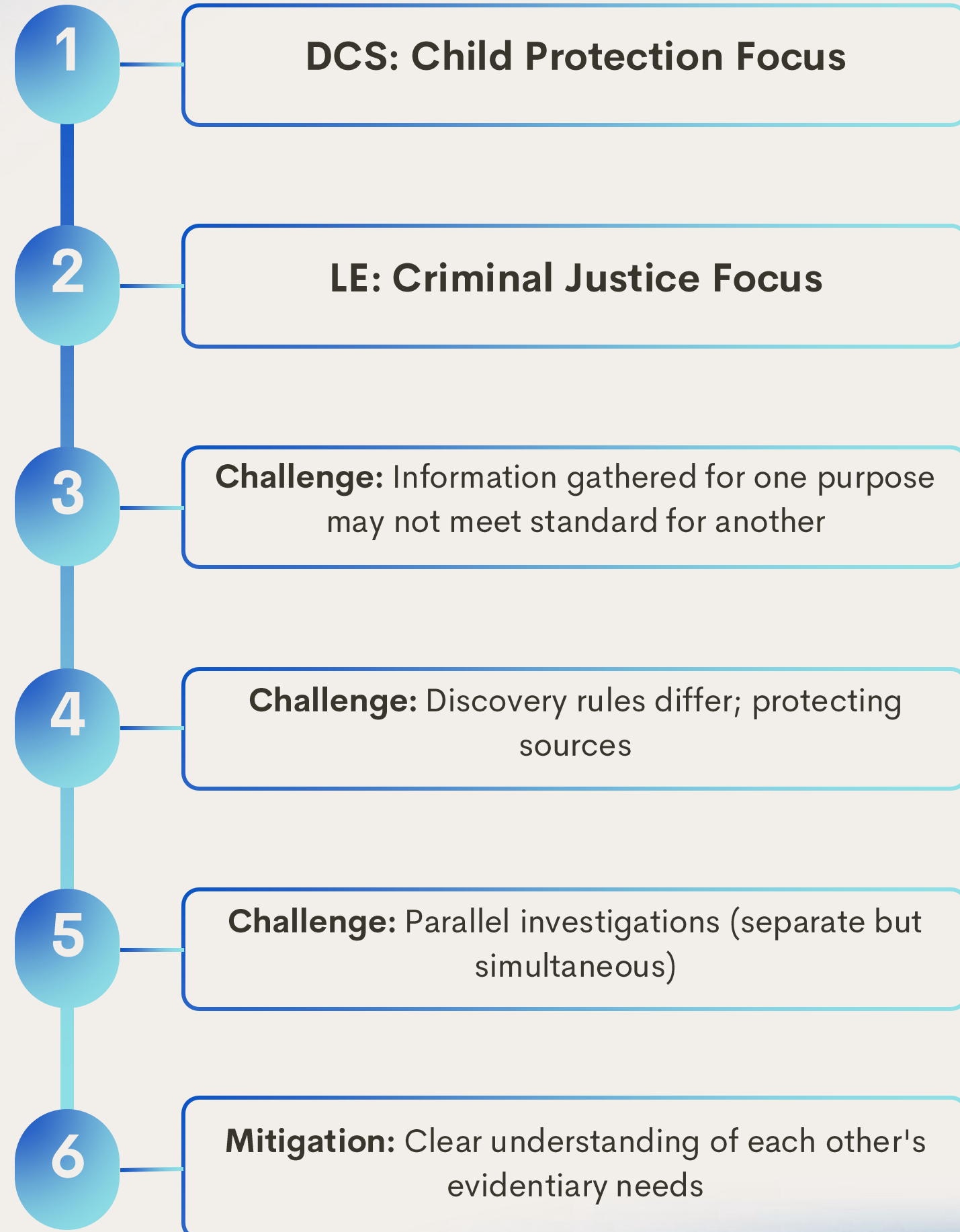


Communication Strategies

- **Designated Liaisons:** Point persons for information exchange
- **Regular Case Conferences:** Scheduled meetings for updates, discussion
- **Shared Communication Platforms:** Secure email, case management systems
- **Formal vs. Informal:** Both have a role; balance is key
- **Documentation of Communication:** Every significant interaction
- **Respectful Dialogue:** Professionalism, active listening



Legal Standards & Challenges: A Deeper Dive



Protecting Surviving Children

- Immediate Safety Assessment
- Collaborative Safety Planning
- Home Removal
- Monitoring & Support
- Preventing Further Harm
- Information from Investigation is Critical



Case Example:

Unsafe Sleep & Surviving Siblings

Scenario: 6-week-old found deceased in adult bed with parents (history of substance use). Two older siblings (ages 2 and 4) also in home.

LE Perspective

Investigate potential criminal neglect/homicide, collect drug paraphernalia



Coroner Perspective

Autopsy to determine cause of death (e.g., positional asphyxia, overdose)



DCS Perspective

Assess immediate safety of 2- and 4-year-old, history of substance use, safe sleep education



Collaboration Points

Joint scene, concurrent interviews, info sharing on toxicology, safety plan for siblings

Training & Education: Bridging Gaps

- **Joint Training:** On safe sleep, SUID/SUID-related deaths, non-accidental trauma (NAT)
- **Understanding Each Other's Roles:** Mandates, legal limitations, resources.
- **Competency Training:** Addressing family backgrounds
- **Trauma-Informed Training:** For all responding personnel
- **Tabletop Exercises:** Practice complex scenarios in a safe environment
- **Guest Speakers:** From other agencies, sharing their perspectives



Child Fatality Review (CFR) Teams

- **Purpose:** Review child deaths to identify preventability and systemic issues
- **MDT at the Review Level:** Brings together all key agencies
- **Confidentiality:** Strict rules to encourage open discussion
- **Aggregate Data:** Identify trends, common risk factors.
- **Recommendations:** For policy, public health, and practice changes
- **Beyond Individual Case:** Focus on prevention, not re-investigation



Addressing Burnout & Compassion Fatigue in Collaboration

High-Stress Work

Infant death investigations are profoundly impactful



Impact on Collaboration

Can lead to irritability, disengagement, poor communication



Risk Factors

Repetitive exposure, empathy fatigue, lack of closure, past trauma



Mitigation Strategies

- Peer support programs.
- Critical incident stress debriefings (CISD).
- Promoting self-care among team members.
- Acknowledging the emotional toll of the work.

Ethical Considerations in Interagency Work



Key Takeaways

- **MDT Essential:** No single agency has all the answers for infant death cases
- **DCS Mandate:** Child protection, safety assessment, services
- **LE Mandate:** Criminal investigation, public safety
- **Coroner:** The bridge, cause & manner of death, medical context
- **Shared Goals:** Determine cause, protect children, prevent future deaths
- **Collaboration Principles:** Early communication, joint action, information sharing, training



Resources for Further Learning

- **National Center for Fatality Review & Prevention (NCFRP):** <https://ncfrp.org/about-us/building-fatality-review-teams/>
- **National Children's Advocacy Center:** <https://www.nationalcac.org/about-us/>
- **National Institutes of Health:** <https://pmc.ncbi.nlm.nih.gov/articles/PMC7100151/>



Thank You!

Further Inquiries

For training, technical assistance on casework, and more, please visit or reach out as noted below:

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