

## BUTLER COUNTY CHILDREN SERVICES

CQI POLICY NO.: 16.1	SUBJECT: <b>CHILD FATALITY REVIEW</b>
	EFFECTIVE DATE: 11/1/07
	REVISION DATE: 8/09
	REVIEW DATE: 8/09

**PURPOSE:** To assess casework practice and services provision and compliance with Ohio Administrative Code and assist in the continual improvement of services to families to enhance safety for children.

### POLICY:

1. A child fatality review will be conducted for the following:
  - (a) All deaths of children in the custody of BCCS at the time of death.  
(See policy 4.27 for custodian notification and funeral arrangements).
  - (b) All child deaths involving suspected child abuse and neglect as determined by law enforcement, medical or BCCS personnel where any member of the household had prior involvement, including open in-home voluntary cases, open Court Ordered Protective Supervision, or open intake assessments with BCCSB within twelve months of the fatality.

### PROCEDURE:

1. When the agency becomes aware of a child fatality, the agency screeners shall check SACWIS to determine if there is a current or previous history with the family. The screener shall notify the Screening Coordinator, Department Directors and Executive Director.
2. If the screener determines the case was closed within the last twelve months, that information will be forwarded to the Director of the Department that had the last contact in the case.
4. If the case is open, that information will be forwarded to the assigned caseworker, supervisor and Director of the Department.
5. The assigned Department Director will notify the ODJFS field office via e-mail or fax within ten working days of learning about the child's death. The information will be reported on the JFS 01987 "Child Fatality Report Face Sheet."
6. The Department Director assigned to the case will request an internal child fatality case review from the CQI Department within three days of learning about the child's death.
7. The case review shall include:

- (a) Case Summary: A summary of all agency contacts with members of the household. This should include CA/N reports received, additional information that was not accepted as a report, case openings, service provision and subsequent case closures.
  - (b) OAC Compliance: A review of applicable OAC rules and BCCS policies for the time period being reviewed including licensing compliance when the child was in placement.
8. A draft written report will be completed using the CQI Case Review Format by the reviewer within two weeks of the notification of the child fatality.
  9. When the draft report is completed, the reviewer will facilitate a meeting that shall include the child's caseworker if an active case, the caseworker's supervisor and Department Director, or the previous caseworker, supervisor or Department Director if the case has been closed in the last twelve months. The purpose of the meeting is to review the draft report, address any questions, clarify issues, and make corrections to the written case review as needed.
  10. The final report will be provided to the above staff members and the Executive Director. A staffing will be held with the above to discuss recommendations for improvement in policy, practice, and compliance issues. An action plan will be developed if necessary. The action plan will be maintained in the CQI Department for review and follow-up.
  11. The Department Director will be responsible for providing the County's Child Fatality Review Board with required information.

9-25-09  
Approval Date:



Jeff Centers, Executive Director