I. SUBJECT

Child Death and Serious Injury Internal Case Review

II. PRACTICE MODEL

Our organization is focused on providing high quality, timely, efficient, and effective services.

III. LEGAL BASE :

22 M.R.S. § 4004 Authorizations
22 M.R.S. § 4010-A Child Abuse Policies

IV. DEFINITIONS

Domestic Violence Homicide: Fatality resulting from intimate partner violence. A child is involved in a domestic violence homicide when he/she is a victim of either domestic violence homicide or serious injury resulting from domestic violence homicide, or is a child residing in the home of either the victim or identified perpetrator of a domestic violence homicide.

Executive Management Team (EMT): Office of Child and Family Services (OCFS) Director, Deputy Director, Behavioral Health Director, General Counsel, all Associate Directors, and other designees at the discretion of the OCFS Director.

Internal Case Review: The process within the OCFS of reviewing cases involving child death or serious injury.

Serious Injury: Serious physical injury or impairment as defined in 22 M.R.S.A. § 4002(11). Examples of serious injuries to be considered for this internal review procedure include: an injury resulting from Shaken Baby Syndrome, any injury to a child under six (6) months of age, abusive head trauma, skull fracture, inflicted head injury, subdural hematoma, multiple fractures, severe beating resulting in extensive contusions or welts, any injury resulting from Munchausen Syndrome by Proxy, drowning, non-organic failure to thrive, and other significant injuries which may have been inflicted by a person responsible for the child and /or are not consistent with the explanation offered.

Staff Debriefing: The process within the OCFS that supports staff affected by the death or serious injury of a child.

V. PROCEDURE STATEMENT

1. Report: Reports of child death or serious injury must be handled by OCFS Intake. If a district office receives a report that report must immediately be called in to OCFS Intake, and Intake will coordinate the notification. Any child death or serious injury report must be a new linked report for open cases. If there is an existing open assessment with regard to the child, the information will be added to that assessment within twenty-four (24) hours, to include any new allegations and a timeframe for response.

2. Notification: Whenever a child death or serious injury occurs, either as a result of known or suspected maltreatment or a domestic violence homicide occurs with children involved, a Child Death/Serious Injury Email Notification (see Appendix I) must be prepared. This notification will come from OCFS Intake. Those notified include:
    - OCFS Director;
    - OCFS Deputy Director;
    - Associate Director of Child Welfare;
    - Regional Associate Director of Child Welfare;
    - General Counsel;
    - CAPTA Panel Coordinator;
    - Child Protective Division Chief, AAG's Office;
    - Program Administrator (and Assistant Program Administrator, if applicable) for the applicable district;
    - District Assessment Supervisor;
    - Intake Supervisors;
    - Out of Home Unit Manager, if there is a companion Out of Home (OOH) report, or if the report is solely an OOH report;
    - Commissioner of DHHS or Designee; and
    - The Department's Director of Communications (if the child death or serious injury may receive media attention.)

3. Internal Case Review: The Regional Associate Director reviews known information with the Program Administrator in the applicable District and determines the need for internal case review based upon the following criteria: death or serious injury or condition resulting from:
    - Shaken Baby Syndrome, abusive head trauma;
    - Any injury to a child under six months of age;
    - Skull fracture(s);
    - Subdural hematoma(s);
    - Multiple fractures;
    - Severe beating resulting in extensive welts, contusions;
    - Any injury resulting from Munchausen Syndrome by proxy;
    - Non-organic failure to thrive;

- Drowning;
- Other significant injuries or questionable cause of death; and
- Other cases at the discretion of the EMT.

a. The Regional Associate Director contacts the Program Administrator of the applicable District to discuss next steps to complete the Child Death and Serious Injury Review Tool (CDSI Review Tool) (Appendix II), as well as identify and obtain records needed for the review. The CDSI Review Tool should be completed within thirty (30) days.

b. The internal case review consists of a record review completed by the Program Administrator within the applicable District and a follow-up meeting with the Regional Associate Director who then also completes a portion of the CDSI Review Tool (Appendix II). The Regional Associate Director can request others to review the record and/or participate in a meeting to discuss the internal case review when deemed necessary.

c. The Program Administrator or Regional Associate Director may interview staff for clarification and must specifically ask, "Is there anything we as a Department or the system as a whole could have done either before, during or after the incident to support you in your work with this family?"

d. Within thirty (30) days of receiving the CDSI Review Tool, the Regional Associate Director will contact the Program Administrator of the applicable district and discuss the analysis and conclusions of the CDSI Review Tool, and how OCFS can best support staff in their work. The Regional Associate Director will also send the CDSI Review Tool to the OCFS Director, OCFS Deputy Director, Associate Director, and General Counsel to notify the outcome of the case review.

e. Implementation of practice or policy changes if applicable, as a result of the Internal Case Review will be determined through discussions occurring within the Executive Management Team.

f. The Associate Director or designee compiles data obtained from the CDSI Review Tool (Appendix II) and every six (6) months completes the Child Death and Serious Injury Trends Analysis and Recommendations Report (Appendix III) and examines trends, patterns, repeated occurrences, and effectiveness of any implemented changes.

g. The Child Death and Serious Injury Trends Analysis and Recommendation Report (Appendix III) is shared with the OCFS Director, EMT, and others determined by EMT to identify additional practice or policy changes that would be beneficial.

4. Staff Debriefing

a. The Regional Associate Director contacts the Program Administrator of the applicable district within twenty-four (24) hours to discuss the need for a staff debriefing. Staff debriefings will occur in the applicable district whenever a child death or serious injury occurs and the child is known to the OCFS staff within the district. The purpose of a staff debriefing is to provide support to staff affected by a child death or serious injury.

b. The Program Administrator arranges for the debriefing with trained individuals within one (1) week of a child death or serious injury.

c. The Regional Associate Director and Program Administrator will identify staff to participate in the debriefing. Participation is voluntary and staff may choose to attend but not actively participate. The Program Administrator will offer to have a clinician available for staff as well as further employee assistance through the Living Resources Program.

VI. ATTACHMENTS/LINKS (Links are under construction)

Appendix I

CHILD DEATH AND SERIOUS INJURY EMAIL NOTIFICATION

(TO BE COMPLETED BY INTAKE)

E-mail Header:

Report #_____ -Type of Notification* (District Office_____)
*(*select which type of notification is being made: Serious Injury/Child Death/Ingestion/DV-Homicide)*

Brief summary of reported concern, including time of call to Intake, referent/title, and a few words about what happened.

Family/Household Composition:
*(*use full names, do not de-identify)*

Summary of Initial Report:
*(*copy and paste presenting problem, no need to de-identify)*

Prior CPS History:

CPS Response/Next Steps:

Appendix II

CHILD DEATH AND SERIOUS INJURY REVIEW TOOL (CDSI REVIEW TOOL)

(THIS FORM IS TO BE COMPLETED BY THE PROGRAM ADMINISTRATOR)

Date of Initial Report: **MACWIS ID #:**

Report Completed By:

District #:

Names of Parents/Caregivers:

Children:

Open Assessment/Case? Yes No

Summary of the Report (*nature of injury, alleged perpetrator, current status of victim)*:

Prior DHHS History in Timeline Format:

Strengths and Challenges of Coordination with Law Enforcement and/or OOH Unit:

Current Plan for Safety:

Media Involvement:

Summary of Findings:

Observations About What Might Have Altered This Outcome:

- Issues internal to OCFS (for example skill sets, priorities, policies. This may also include training needs, caseload issues, and supervision challenges.)

- Issues external to OCFS (for example availability of necessary services, appropriate housing, and lack of informal supports.)

Recommendations to support district staff either before, during or after the incident in their continued work with families:

Recommendations of policy or practice changes to prevent similar outcomes:

Program Administrator_____Date_____

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE REGIONAL ASSOCIATE DIRECTOR:

Observations about what might have altered this outcome:

- Issues internal to OCFS (for example skill sets, priorities, policies. This may also include training needs, caseload issues, and supervision challenges.)

- Issues external to OCFS (for example availability of necessary services, appropriate housing, and lack of informal supports.)

Recommendations to support district staff either before, during or after the incident in their continued work with families:

Recommendations of policy or practice changes to prevent similar outcomes:

Regional Associate Director
_____Date_____

APPENDIX III
CHILD DEATH AND SERIOUS INJURY TRENDS ANALYSIS AND RECOMMENDATIONS REPORT

THIS FORM IS TO BE COMPLETED TWICE YEARLY BY THE ASSOCIATE DIRECTOR.

Number of Child Death and Serious Injury Review Tools completed during the previous six (6) months:

Consider the internal case reviews completed during the prior six (6) months. Are there findings or themes noted about what might have altered outcomes that provide useful insights?

- **Issues internal to OCFS (for example skill sets, priorities, policies. This may also include training needs, caseload issues, and supervision challenges.)**

- **Issues external to OCFS (for example availability of necessary services, appropriate housing, and lack of informal supports.)**

Relevant findings by district:

Recommendations to support district staff either before, during or after the incident in their continued work with families:

Recommendations of policy or practice changes to prevent similar outcomes:

Any further recommendations to prevent similar outcomes based upon reviewing these incidents as a group?