



Administrative Policies and Procedures: 20.28

Subject:	Child Death/Near Death Review
Authority:	TCA 37-1-401 et seq; 37-1-601 et seq; 37-1-607; 37-5-105 (3); 37-5-106; 37-5-107; 37-5-124; 68-142-101(c); Child Abuse Prevention and Treatment Act (CAPTA)
Standards:	COA: AM 6, 7; DCS Practice Standards: 7-200A, 7-205A
Application:	All Department of Children's Services Staff
Policy Statement:	
The Department of Children's Services (DCS) shall review the circumstances of child death/near death of children/youth in Tennessee who were in DCS custody at the time of the death/near death incident, when the child or family has had history with DCS or the child death/near death case was substantiated for abuse.	
Purpose:	
To provide guidelines and requirements for the review of child death/near deaths by DCS which will outline criteria for a child death review, how reviews are conducted, how improvement efforts are carried out and the methods in which data is communicated.	
Procedures:	
A. Child Death/Near Death case review	<ol style="list-style-type: none"> 1. The Department has established criteria for review of child deaths. As such, not all child deaths receive a review. The CDRT will review a death when: <ol style="list-style-type: none"> a) A child was in DCS custody at the time of death; b) DCS had contact with the child or family within three (3) years preceding the child's date of death; c) The child's death has been substantiated for abuse, <u>OR</u> d) The Commissioner, Medical Director or the Deputy Commissioner of the Office of Child Safety requests a review. 2. The Tennessee Department of Health's Child Fatality Review Team should continue to review all child deaths in accordance with <i>TCA 68-142-101(c)</i>. 3. Near deaths are considered preliminary until confirmed by DCS. All confirmed near deaths receive a review. A near death is confirmed when: <ol style="list-style-type: none"> a) A child has a serious or critical medical condition resulting from child abuse or child sexual abuse as reported by a physician who has examined the child subsequent to the abuse, as defined in TCA 37-5-107, OR

	<p>b) Upon substantiation, the case is submitted for physician review, and the physician determines the child was in a serious or critical medical condition.</p>
<p>B. Central Office Child Death Review Team procedures and goals</p>	<ol style="list-style-type: none"> 1. The Office of Child Safety tracks all child death and near death investigations and submits referrals for review to the Safety Analysis division. All referred cases are reviewed by the Central Office Child Death Review Team (CO CDRT) within thirty (30) days of referral. 2. The CO CDRT includes the following positions or assigned designees: <ol style="list-style-type: none"> a) Deputy Commissioner of Child Health b) Medical Director c) Director of Nursing d) Director of Safety Analysis e) Child Safety Representative with CPS Investigations oversight f) CQI Representative g) Child Program Representative with CPS Assessment oversight h) Independent Physician with training specific to children and adolescents i) Safety Nurse j) Safety Analyst 3. It is mandatory that a Safety Nurse and Safety Analyst be present for a CO CDRT meeting to be held, in conjunction with a minimum of at least four (4) remaining representatives/designees from 3(a-h) above. All CO CDRT members present will sign form, CS-0993, Child Death/Systems Analysis Review: Attendance and Confidentiality Agreement. 4. The Case Summary Report (CSR) will be developed by the Safety Analyst and will be presented to CO CDRT. The CSR will include: <ol style="list-style-type: none"> a) A case summary of current and past DCS history. This information will be based, at minimum, on TFACTS data/information, but may include communication with involved staff, as needed. b) A clinical summary (presented by Safety Nurse) which will include (as available and applicable): <ul style="list-style-type: none"> ◆ Current and past relevant medical records (including emergency medical records) ◆ Current and past relevant mental health records ◆ Hospital discharge summaries ◆ Medication history

	<ul style="list-style-type: none">◆ Death certificate◆ Autopsy reportc) Safety Analyst's recommendation for further Systems Analysisd) Recommendation justification <p>5. CO CDRT determines if Systems Analysis is needed by the Grand Regional Systems Analysis Team (GRSAT).</p> <p>Note: Autopsy reports are not always available within this timeframe. Once received, the autopsy report will be reviewed within 60 days at the CO CDRT meeting to determine if a change in action is needed.</p>
<p>C. Recommendations</p>	<ol style="list-style-type: none">1. CO CDRT may develop considerations for improvements to the DCS system based on the cases reviewed, which may include:<ul style="list-style-type: none">a) Enhancements to existing workflows,b) Processes,c) Policies,d) Teamwork, and/ore) Communication.2. A statewide Systems Analysis team meets quarterly and includes the following representatives:<ul style="list-style-type: none">a) Director of Safety Analysisb) Director of Policy and Continuous Quality Improvementc) Safety Analystsd) Safety Nurses3. During this meeting, the team reviews and aggregates considerations received from the CO CDR process and the Systems Analysis process in the previous calendar year quarter. The team identifies and agrees to support received considerations of high importance or to develop new considerations, as needed. The team proposes considerations for the Central Office Safety Action Group (COSAG).4. Each quarter, all members of the COSAG, or their designee, meet to review considerations and make recommendations for improvement. The COSAG includes:<ul style="list-style-type: none">a) Deputy Commissioner of Child Healthb) Deputy Commissioner of Child Safety

	<ul style="list-style-type: none"> c) Deputy Commissioner of Child Programs d) Director of Policy and Continuous Quality Improvement e) Director of Safety Analysis <p>5. Considerations are either approved or left in surveillance. Approved considerations are considered formal recommendations.</p> <ul style="list-style-type: none"> a) If considerations are approved as recommendations, tracking and implementation is completed by the Director of Policy and Continuous Quality Improvement as outlined in the CQI Program Manual. b) If considerations are left in surveillance, they are directed back to the quarterly statewide Systems Analysis meeting for additional support or dissolution.
<p>D. Reporting</p>	<ul style="list-style-type: none"> 1. A Quarterly Death Review Report is prepared by the Director of Safety Analysis and is distributed to the Commissioner within thirty (30) days of the end of the quarter. Specific to reviews within the previous calendar year quarter, this report includes: <ul style="list-style-type: none"> a) Demographic information; b) Findings; c) Recommendations; and d) Department actions. 2. An Annual Child Death Review Report is compiled by the Director of Safety Analysis and submitted to the Commissioner at the end of the first quarter of each calendar year and then made public via the TN DCS website thirty (30) days following the Commissioner’s review. The report includes, but is not limited to, the following information for each death or near death reviewed by the team: <ul style="list-style-type: none"> a) Demographic information; b) Cause and manner of death; c) Cause of near death; d) Findings; e) Recommendations; and f) Department actions.

Forms:	<u>CS-0993. Child Death/Systems Analysis Review: Attendance and Confidentiality Agreement</u> <u>CS-1034. Child Death/Near Death Summary</u> <u>CS-1035. System Analysis Report</u>
Collateral documents:	<u>CQI Program Manual</u> DCS Policy <u>20.27 Child Death/Near Death Rapid Response</u> DCS Policy <u>20.29 Systems Analysis Review</u>