TN Department of Children's Services

POLICY

20.28 Child Death/Near Death Review	
Application: All Department of Children's Services Staff	
Authority: TCA 37-1-401 et seq; 37-1-601et 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
Commissioner:	**Date:**
Original Effective Date: 05/01/01 Current Effective Date: 04/19/17	Supersedes: 05/20/15 Last Review Date: 04/19/17
Glossary: None	

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 had history with DCS within the past three (3) years, 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

1. The Department has established criteria for review of child deaths. As such, not all child deaths receive a review. The Central Office Child Death Review Team (CO CDRT) will review a death when:
   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, OR

d) The Commissioner, Deputy Commissioner of Child Health, the Deputy Commissioner of the Office of Child Safety requests a review.

2. DCS Child Death Reviews are not substitutes for and do not replace the reviews of all child deaths done by the Tennessee Department of Health Child Fatality Review Team under TCA 68-142-101(c.)

3. Near deaths are considered preliminary until confirmed by DCS. All confirmed near deaths receive a review. A near death is confirmed when:

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

b) Upon substantiation, the case is submitted for physician review, and the physician determines the child was in a serious or critical medical condition.

B. Central Office Child Death Review Team procedures and goals

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 CO CDRT within thirty (30) days of referral.

2. The CO CDRT includes the following positions or assigned designees:

a) Executive Director of Child Health

b) Director of Nursing

c) Director of Safety Analysis

d) Child Safety Representative with CPS Investigations oversight

e) CQI Representative

f) Child Program Representative with CPS Assessment oversight

g) Independent Physician with training specific to children and adolescents

h) Safety Nurse

i) 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) is developed by the Safety Nurse and Safety Analyst and is presented to CO CDRT. The CSR includes:

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 which includes (as available and applicable):

- Current and past relevant medical records (including emergency medical records)
- Current and past relevant mental health records
- Hospital discharge summaries
- Medication history
- Death certificate
- Autopsy report

c) Safety Analyst's and Safety Nurse's recommendation, including justification, for further Systems Analysis

5. CO CDRT determines if further Systems Analysis is needed by the Grand Regional Systems Analysis Team (GRSAT).

Note: Autopsy reports are not always available within this reviewing 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.

C. Recommendations

1. CO CDRT may develop considerations for improvements to the DCS system based on the cases reviewed, which may include:
a) Enhancements to existing workflows,
b) Processes,
c) Policies,
d) Teamwork, and/or
e) Communication.

2. The Division of Safety Analysis meets quarterly and includes the following representatives:
a) Director of Safety Analysis
b) Safety Analysts c
c) Safety Nurses

3. During this meeting, the team reviews and aggregates considerations received from the CO CDR process and the Systems Analysis process from the previous quarter. The Division of Safety Analysis identifies quarterly considerations and submits them to the Central Office Safety Action Group (COSAG).

4. Members of the COSAG, or their designee, meet a minimum of quarterly, to review considerations and make recommendations for improvement. The COSAG includes:
a) Executive Director of Child Health
b) Deputy Commissioner of Child Safety
c) Deputy Commissioner of Child Programs
d) Deputy Commissioner of Juvenile Justice

e) Assistant Commissioner of Continuous Quality Improvement
f) Director of Performance and Quality Improvement
g) Director of Safety Analysis

5. Considerations are either approved or left in surveillance. Approved considerations are considered formal recommendations.
a) If considerations are approved as recommendations, tracking and implementation is completed by the Director of Performance and Quality Improvement as outlined in the ***Performance and Quality Improvement Manual.***
b) If considerations are left in surveillance, they are directed back to the Division of Safety Analysis for additional support or dissolution.

D. Reporting

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:

a) Demographic information;
b) Cause and manner of death;
c) Cause of near death;
d) Findings;
e) Recommendations; and
f) Department actions.

Forms:

CS-0993, Child Death/Systems Analysis Review: Attendance and Confidentiality Agreement

Collateral Documents:

Performance and Quality Improvement Manual

20.27 Child Death/Near Death Rapid Response

20.29 Systems Analysis Review