



State of South Carolina

Department of Social Services

Policies and Procedures: Child Welfare Services

Subject:	1630 Child Fatality Response
Authority:	S.C. Code Ann. Sections 63-7-10, 63-7-20, 63-7-920, 63-7-940, 63-7-1990 and 63-11-1900, et. seq, Proviso 38.24 and Child Abuse Prevention and Treatment Act (P.L. 115-271).
Standards:	Guiding Principles and Standards (GPS) Practice Model
Application:	All DSS Staff
Purpose:	To provide an effective, timely, and consistent response to the deaths of children impacted by abuse and neglect by providing support and services to surviving family.
Policy Statement:	All DSS staff must adhere to the Child Fatality Response Protocol to promote the safety of surviving siblings of a deceased child and to ensure effective investigations of all child fatalities and near fatalities reported to DSS with a suspected cause or contributing factor of child abuse or neglect.
Procedures:	
A. Initial Notifications	1. All DSS staff must immediately notify CPS Intake of any Suspicious Child Death. 2. The first DSS staff person to become aware of any child death must immediately assess the need for and, if needed, enact the Critical Incident protocol. Refer to Critical Incident Reporting Policy.
B. Intake Responsibilities	1. Upon receiving a referral, the CPS Intake Case Manager must: a. Immediately notify CPS Intake Team Leader of the Suspicious Child Death; and b. Immediately request a CAPSS administrative lock via the Intake team leader, (Note: Only staff with direct involvement in the case including Intake Hub staff, Regional Directors, and Safety Management staff are authorized to have access to either the physical or electronic records.) c. gather and document information per Child Welfare Intake policy d. refer the Suspicious Child Death to the law enforcement jurisdiction in which the incident occurred. 2. The CPS Intake Team Leader will make a screening decision, within 24 hours of receipt of the referral. 3. The CPS Intake Team Leader will also notify the Systems Transformation Unit within 24 hours of the fatality and the screening decision via email at systemstransformation@dss.sc.gov.

	4. If the referral is accepted for CPS investigation, notify the appropriate County or OHAN Director via phone of the fatality and that a report has been accepted for CPS investigation.
C. County or OHAN Director Responsibilities	The county where the household or facility in which the child fatality occurred is located must complete the following administrative tasks. 1. The County Director or OHAN Director must: a. secure the physical record by keeping all case records in a locked filing cabinet if a physical record exists. Note: Only staff with direct involvement in the case including, Intake Hub staff, Regional Directors, and Safety Management staff are authorized to have access to either the physical or electronic records. 2. When applicable, the following administrative tasks must also be completed by the county where the household or facility in which the child or youth fatality occurred. a. If the deceased child was placed outside the home via current DSS action and parental rights have not been terminated, notify the parent/guardian within two hours. When possible, notification should be in person, b. If the deceased child has a Guardian ad Litem, notify the appointed Guardian ad Litem via phone within 24 hours. If appropriate, the Guardian ad Litem may be invited to participate in parental notification, c. If a Suspicious Child Death occurred during an open CPS investigation, family preservation, foster care case, or OHAN case, conduct an All Staff meeting within 48 hours to report the facts in the case, allow staff the opportunity to share feelings, and share resource information regarding secondary trauma. Staff attendance is optional. d. If the referral is accepted for CPS investigation, any household member has an open DSS CPS case at the time of the child fatality, or any household member had an DSS CPS case within a year of the child's death, contact the county coroner within two business days, to determine if the coroner will lead the Child Death Review. i. If the coroner will lead the Child Death Review, DSS staff will confirm attendance and participate following the steps outlined in Work Aid: 16.4 Child Death Review. Note: To reduce secondary trauma, the County Director may designate either herself, the program coordinator, or the team leader to attend the child death review in place of the case manager. ii. If the coroner will not host the Child Death Review, the County Director will schedule and lead the Child Death Review, following the steps outlined in Work Aid: 16.4 Child Death Review

D. Investigative Steps	The receiving county initiates the CPS investigation and completes all investigative steps per DSS Policy Chapter 3: Investigations, in addition to the following steps or modifications: 1. The case manager works alongside and consults with investigative partners throughout the investigation, soliciting their expertise to inform critical decision making. 2. The County Director must notify the Systems Transformation Unit via systemstransformation@dss.sc.gov of the case determination within two business days.
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Forms:	DSS Critical Incident Reporting Form (3010) National Center for Fatality Review and Prevention CDR Guide National Center for Fatality Review and Prevention Case Reporting Form
Related Management Reports:	N/A

Glossary:
Systems Transformation Unit: Unit responsible for guiding best practice through the analysis of state child fatality data, review of DSS's Child Protective Services' response to and actions preceding child fatalities, and systems-level analyses Child Death Review: A multidisciplinary meeting, which may include the county coroner, a local law enforcement officer, the assigned agent from the State Law Enforcement Division's (SLED) Department of Child Fatalities, a board-certified child abuse pediatrician, a representative from the county DSS office, and a forensic pathologist, to facilitate pertinent case information to further the investigatory process and to discuss prevention efforts. CPS Intake: Intake Hub during Intake Hub operating hours or an after-hours intake Immediately: As soon as possible, not to exceed one hour Investigative Partners: Local law enforcement agencies, State Law Enforcement Division (SLED) Department of Child Fatalities special agents, child abuse pediatricians, and coroners/medical examiners Suspicious Child Death: Any death of a child where the suspected cause is abandonment, abuse, neglect, or harm by a person responsible for the child's welfare Siblings: Any child related to the child victim by birth, adoption, or marriage residing in- or outside the home