

	INDIANA DEPARTMENT OF CHILD SERVICES CHILD WELFARE MANUAL	
	Chapter 4: Assessment	Effective Date: June 1, 2011
	Section 31: Child Fatality and Near Fatality Assessments	Version: 6

POLICY

The Indiana Department of Child Services (DCS) will assess all reported child fatalities and near fatalities for which there is reason to believe that Child Abuse and/or Neglect (CA/N) may be a factor in the fatality or near fatality. If the circumstances surrounding the child's death or near fatality appear to be sudden, unexpected, and unexplained, DCS shall consider these occurrences to determine whether or not the death or near fatality was related to child abuse and/or neglect.

DCS will coordinate child fatality or near fatality assessments with a Law Enforcement Agency (LEA) and the Coroner.

The Coroner shall immediately notify DCS by using the statewide hotline and either the local child fatality review team or if the county does not have a local child fatality team, the statewide child fatality review committee of each death of a person who is less than 18 years of age, or appears to be less than 18 years of age and who has died of an apparently suspicious, unexpected, or unexplained manner.

In the event of a child fatality, if DCS has reason to believe a parent, guardian, or custodian was impaired, intoxicated, or under the influence of drugs or alcohol immediately before or at the time of death, DCS or LEA can request that the parent, guardian, or custodian submit to an alcohol/drug screen. DCS or LEA must make the request within three (3) hours of the death of the child.

Note: If the parent, guardian, or custodian does not submit to the screen within three (3) hours of the request, the refusal may be used in the DCS determination to substantiate or unsubstantiate abuse and/or neglect. However, the refusal to submit to a screen cannot be used in any criminal action.

Code References

1. [IC 31-33-8 Investigation of reports of suspected child abuse or neglect](#)
2. [IC 31-33-18-1.5\(h\) Data and information included in disclosed record of child fatality or near fatality assessment](#)
3. [IC 31-34-12-7 Failure to submit to drug or alcohol test](#)
4. [IC 36-2-14.6.3 Coroner notification of child deaths; coroner consultation with child death pathologist; suspicious, unexpected, or unexplained child deaths; autopsy](#)

PROCEDURE

For fatality and near fatalities, the Family Case Manager (FCM) will:

1. Place any surviving siblings in a safe environment if all legal caregivers have been arrested;
2. Assess risk to any surviving siblings and document in the [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#) narrative;
3. Request the parent, guardian, or custodian submit to an alcohol/drug screen, if DCS has reason to believe impairment is suspected in the fatality of a child, within three (3) hours of the death of the child. The FCM must receive approval from the Supervisor prior to sending the parent, guardian, or custodian for the alcohol/drug screen;

Note: If an alcohol/drug screen is requested, this must be documented in the [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#). If a drug or alcohol screen cannot be completed at the scene, collaboration shall occur between LEA and the DCS Supervisor to determine a safe plan for transport.

4. Assist LEA with conducting interviews of family members as requested;
5. Collect LEA, Hospital, Coroner reports and the final Autopsy Report so that a DCS [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#) can be prepared;

Note: The final Autopsy Report can take some time to obtain depending on various circumstances. Once available, a copy of the final Autopsy Report will be collected.

6. Conduct an appropriately thorough CA/N assessment in coordination with any LEA assessment. See separate policy, [4.3 Conducting the Assessment](#);
7. Refer the family members to support services and document, if applicable;
8. **[REVISED]** Provide each parent, guardian, custodian and alleged perpetrator with a copy of the form, [Notice of Availability of Completed Report and Information \(SF48201/CW0024\)](#) and document in the [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#). If the alleged perpetrator is a child, provide the notice to his or her parent, guardian or custodian.
9. Make an assessment finding (See separate policy, [4.22 Making an Assessment Finding](#)) but do not approve the assessment;

Note: For all fatalities and near fatalities that are substantiated, per [IC 31-33-18-1.5\(h\)](#) the [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#) must include a summary of the following:

1. A summary of the report of CA/N and a factual description of the contents of the report;
2. The date of birth and gender of the child;
3. The cause of the fatality or near fatality, if the cause has been determined; and
4. Whether DCS had any contact with the child or a member of the child's family or household before the fatality or near fatality, and, if DCS had contact include the following:
 - a. The frequency of the contact or communication with the child or a member of the child's family or household before the fatality or near fatality and the date on which the last contact or communication occurred before the fatality or near fatality, and
 - b. A summary of the status of the child's case at the time of the fatality or near fatality including:
 - i. Whether the child's case was closed by DCS before the fatality or near fatality; and

- ii. If the child's case was closed as described under item (i), the reasons that the case was closed.

The Supervisor will:

1. Engage with the FCM and approve the request to send the parent, guardian, or custodian for an alcohol/drug screen within three (3) hours of the death of the child, if the Supervisor is satisfied that DCS has reason to believe impairment is suspected in the fatality of a child ;
2. Send one (1) copy of the assessment file to the Deputy Director of Field Operations for review by the DCS Fatality Unit within 30 days of the receipt of the child fatality or near fatality report, unless the assessment cannot be completed within that time frame due to unavailability of a necessary report or document, such as an Autopsy Report. The assessment file should include these and other items:
 - a. Completed and approved [Preliminary Report of Alleged Child Abuse or Neglect \(SF 114/CW0310\)](#),
 - b. Copies of any history the family may have had with DCS,
 - c. Completed but unapproved [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#),
 - d. Completed and thoroughly documented assessment notes (add printed contacts from ICWIS),
 - e. Hospital report,

Note: This refers to any relevant medical information relating to the fatality or near fatality.

- f. LEA report, any information about charges filed, and/or arrests made,
- g. Emergency Medical Services (EMS) or local Fire Department records, if applicable,
- h. Coroner and autopsy report if applicable,

Note: If there was no autopsy, this needs to be documented in the narrative of the [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#).

- i. State issued Death Certificate, and
 - j. Copies of available newspaper clippings showing the progress of the assessment and, if applicable, the outcomes of the arrest and trial.
3. Following review by the DCS Fatality Team, approve the assessment as directed by the Fatality Unit; and
 4. Send a copy of the completed DCS [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#) to the following persons, if substantiated, and follow-up via phone to confirm receipt:
 - a. County Prosecutor,
 - b. Investigating LEA, and
 - c. County Coroner.
 5. Assess to determine if a referral to the DCS Critical Response Unit is needed to assist local staff.

[NEW] The DCS Local Office Director or designee will:

1. Complete the [Child Death Review](#) using the National Center for Child Death Review's Case Reporting System.

PRACTICE GUIDANCE

Documenting a Fatality or Near Fatality

If a child death occurs due to substantiated abuse and/or neglect, the assessment worker must check the allegation of “death due to abuse” and/or “death due to neglect” under findings on the allegation screen in the assessment module. The type of maltreatment which led to the death of the child must also be checked. A bathtub drowning, for example, might be marked “death due to neglect” (from the list of neglect maltreatment types) **and** “lack of supervision” or “environment life/health endangering,” depending upon the circumstances.

Documenting Impairment of the Parent, Guardian, or Custodian

DCS must document any noted or suspected impairment of the parent, guardian, or custodian during the course of the assessment. If DCS is not on the scene, interview those professionals that were there, for example, LEA, EMS, etc., and obtain any documentation regarding impairment or lack thereof, if applicable. Typically impairment is not mentioned in LEA and EMS reports unless it is obvious. If it is not mentioned, DCS will attempt to contact the other professional responders and ask if any impairment was noted. If no impairment is suspected, DCS will document that there was no suspicion of impairment.

Coordinating with LEA

A DCS assessment shall not interfere with or duplicate the LEA assessment. The DCS local office shall complete a DCS assessment report based on the findings of the LEA or joint DCS/LEA assessment.

DCS Assessment Report

If DCS was not involved in the active assessment, the Law Enforcement Officer and the LEA report are resources for completion of the [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#). For example, interview dates and birth dates can be found in LEA reports.

Delayed Coroner’s Reports and Autopsies

DCS has 30 days to complete a CA/N assessment, although it may take longer than 30 days to receive the final Coroner’s report and autopsy report.

Note: Delayed Coroner’s reports and autopsies are not justification for delaying sending the assessment file, including the completed Assessment Report, to the Deputy Director of Field Operations, unless the FCM is unable to get a verbal Coroner’s report and autopsy report, and has documented this in ICWIS. If the FCM is unable to obtain a report necessary to complete the assessment within 30 days after receiving the fatality report, the Supervisor will notify the DCS Fatality Unit of the reason for delay and will complete and transmit the Assessment Report as soon as reasonably possible after receipt of the delayed report.

Accidental Death

A Coroner’s finding of “accidental death” does not preclude a DCS assessment finding of substantiated CA/N. For example, a Coroner may rule a child’s drowning an “accidental death,” but DCS may substantiate neglect due to the parent’s lack of supervision of the child.

Sudden Unexplained Infant Death (SUID)

According to the Centers for Disease Control (CDC), sudden unexpected infant deaths are defined as infant deaths that occur suddenly and unexpectedly, and whose manner and cause of death are not immediately obvious prior to investigation.

FORMS AND TOOLS

1. [Preliminary Report of Alleged Child Abuse or Neglect \(SF 114/CW0310\)](#)
2. [Assessment of Alleged Child Abuse or Neglect Report \(SF 113/0311\)](#) – Available in ICWIS
3. **[NEW]** [Child Death Review](#) –Available online at <http://www.childdeathreview.org/reports/CDRCaseReportForm2-1-11009.pdf>
4. **[NEW]** [4.B Tool - Assessment Narrative](#)
5. [Notice of Availability of Completed Report and Information \(SF48201/CW0024\)](#)— Available in Hardcopy

RELATED INFORMATION

“Near Fatality”

A "near fatality" is defined by the Child Abuse Prevention and Treatment Act (CAPTA) as “an act that, as certified by a physician, places the child in serious or critical condition.”

DCS defines near fatality as a situation where a child has been admitted to the intensive care unit (ICU) or a neonatal intensive care unit (NICU) **and** has been placed on a ventilator due to injuries sustained from alleged abuse and/or neglect (this definition was developed in conjunction with forensic pediatric experts). Once the child meets this criteria then the allegation of “near fatality” should be marked along with any other type(s) of maltreatment.

A child cannot be determined to be a near fatality and a fatality for the same originating injury. If a child dies as a result of the near fatality injury, the assessment is to be considered as a fatality only. The worker must unapprove the near fatality assessment, unsubstantiate the near fatality allegation, and add the allegation of death to the assessment. The FCM is required to e-mail the Assistant Deputy Director of Field Operations of the death as soon as possible but no later than 24 hours upon learning of the fatality. The worker must document in ICWIS that the fatality resulted from the near fatality injury.

Autopsy Report

A clinical report issued by a medical doctor/pathologist.

According to [IC 36-2-14-18\(e\)](#), a coroner shall make available, upon written request, a full copy of an autopsy report, including photograph, a video recording, or an audio recording of the autopsy to:

1. DCS established by [IC 31-25-1-1](#), including the DCS local office where the death occurred;
2. Statewide child fatality review committee established by [IC 31-33-25-6](#); or
3. A county child fatality review team or regional child fatality review team established by [IC 31-33-24-6](#) by the county or for the county where the death occurred

One (1) and three (3) above are for purposes of conducting a review or an investigation of the circumstances surrounding the death of a child (as defined in [IC 31-9-2-13\(d\)\(1\)](#)) and making a determination as to whether the death of the child was a result of abuse, abandonment, or neglect. An autopsy report made available under this subsection is confidential and shall not be disclosed to another individual or agency, unless otherwise authorized or required by law.

Coroner's Report

A document issued by an elected official usually based on the findings in an autopsy report.

Coroner's Inquest

A fact finding process initiated by the Coroner involving the presentation of evidence and witness testimony in front of a jury to determine circumstances surrounding the death.

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