LCCS POLICY 157
Internal Review Involving Children Who Have Died When there is an Open or Recently Closed Case

Original Issue Date:	6/28/1990
Revision Dates:	9/21/1992, 2/11/1999, 9/19/2005, 1/4/2011, 8/6/2013, 5/1/20
Revision Number:	6
Current Effective Date:	5/1/2020
Obsolete/Combined Date:	
Reason for Obsoleting/Combining:	
See new Policy #:	

Scope:	LCCS Staff having involvement with or knowledge of a child who dies during or after involvement with LCCS. The Worker of Record, Supervisor, Manager, Manager of the Legal Department, Assigned Attorney, Chief Counsel, Director of Communications, Manager of Quality Assurance, Directors, and Executive Director.
Responsibility:	Manager of Quality Assurance, Supervisor of Quality Assurance and Chief Counsel.
Purpose:	To review the agency's role in providing services to the child/family and to assess the outcome regarding safety, permanency and well being of the child.
Legal Cite:	O.A.C. 5101:2-36-01

POLICY STATEMENT

LCCS conducts internal reviews of every case where a child has died when there is an open case/ referral or there has been an open case/ referral within the 24 months.

PROCEDURE - including required timeframes and documentation

MEETING REQUIREMENTS

The Director of Services, upon learning of a death of a child, may decide that a meeting is necessary. If so determined, the meeting will include the staff and managers who are involved with the case or who are likely to be involved following the death, the Quality Assurance Supervisor and the Director of Communications. The purpose of the meeting is the following:

- Discussion of case history and current involvement.

- The appropriateness of contacting the parents, guardian, custodian or other relatives for a child in the agency's permanent custody.
- Which agency staff will communicate with family members? (temporary and permanent custody)
- Which agency staff will communicate with the media and what will be communicated, if necessary?
- Who are the external persons who need to be made aware of the situation? (i.e. Guardian ad Litem or any relatives or friends who are significantly active in the child's life)
- Which agency staff will make/assist with funeral arrangements, and what will be the role of the birth and substitute caregiver families in the process?
- How much information regarding the death can we share with agency staff, and who will be responsible for sharing the information?
- How can we support staff, substitute caregivers, birth families, or others in grief? Who will take the lead in contacting a mental health provider to meet with involved staff? (A unique supportive plan will be developed based on the needs of the families and staff.)
- Who will be responsible for gathering medical records relating to the child?
- When to schedule a follow up meeting, if needed, in order to ensure that plans are updated and that those who need support are receiving it.
- The Director of Services will take responsibility for ensuring that minutes of the meeting are recorded.

The Quality Assurance Department

The Quality Assurance Supervisor will:

- Conduct a preliminary review of the family file to determine if a full review is necessary and to determine the scope of the review.

- Maintain a log of all child fatalities.

- Outline the history of LCCS involvement with the family.

- Develop a list of concerns/recommendations from the review (if any).

- Provide the Draft Fatality Report to Chief Counsel. Chief Counsel will review the case and the Draft Fatality Report. Chief Counsel will provide feedback to Quality Assurance Supervisor.

- Distribute the Draft Fatality Review Report to the manager of the most critically involved departments for review. The manager will have two weeks to provide feedback regarding the Draft Fatality Review Report. If the manager is not in agreement with any portion of the report, the manager will send an email to the Quality Assurance Supervisor to schedule a meeting to discuss feedback with the Quality Assurance Supervisor and Chief Counsel. The meeting will occur within one week. If consensus cannot be reached, Chief Counsel will make the final decision.

- Submit the Draft Fatality Review Report to the Executive Director, Director of Social Services and the Director of Support Services and will make any requested corrections.
- Submit the consensus Fatality Review Report to the Quality Assurance Manager and the manager of the appropriate department for signature.
- Complete the Child Fatality Review within **60 days** from the time of notification.
- File the final Fatality Review Report in the Quality Assurance Child Fatality Folder.

Should the Toledo District Office complete a Fatality Report, the Quality Assurance Supervisor shall determine if any new information is provided that should be added to the list of concerns/recommendations, and add the appropriate information accordingly to the next semi-annual report.

The Quality Assurance Supervisor shall produce a semiannual Child Fatality Report and annual Child Fatality Report including a summary of the characteristics of the fatalities, and a comprehensive list of all recommendations. This report will be submitted to all Managers, Directors, Chief Counsel, and the Executive Director. The Quality Assurance Supervisor will attend the Director's meeting biannually to discuss progress of recommendations from Child Fatality Reviews.

RELATED POLICIES and FORMS

LCCS Policy 152: Notification Procedures for Serious Injury, Illness or Death of a Child Involved in an Open Case or Recently Closed Case