# PART I – INITIAL NOTICE OF CHILD FATALITY/NEAR FATALITY

[ ] Fatality Date of Death:  County:

[ ] Near Fatality Date of Injury:  Service Region:

Date of Referral:  Date of Central Office Notification:

**Reason for Notification:**

 [ ] Suspected Abuse or Neglect

 [ ] Active Ongoing Case

 [ ] Active Investigation

 [ ] Death of a child in OOHC

 [ ] Ongoing Services in the past 12 months

 [ ] Other:

**Child Victim Information:**

 Name:

[ ]  **CHILD IN DCBS CUSTODY AT TIME OF INCIDENT**

**Placement name and type:**

**County of Case Management:**

 DOB:

 SSN:

 Sex:

 Race:

**Parental Information:**

 Mother’s Name:       DOB:       SSN:

 Father’s Name:       DOB:       SSN:

**Other Children in the Home:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **DOB:** | **Age:** | **Current Safety Arrangement** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Other Pertinent Individuals (paramours, other household members, etc.):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Relationship:** | **DOB:** | **SSN:** |
|  |  |  |  |
|  |  |  |  |

**Describe allegations/incident regarding the death or injury(ies):**

|  |
| --- |
|  |

**For Near Fatalities Only:**

Physician certifies the child in serious or critical condition: [ ] Yes [ ] No

**Alleged Perpetrator** and **Relationship to Victim:**

**Media Inquiry Expected?** [ ]  Yes [ ]  No

Describe:

**Worker name/phone number:**

**Supervisor name/phone number:**

**DCBS History?** [ ]  **Yes** [ ]  **No**

# PART II – CHRONOLOGICAL CASE HISTORY

(REPLICATE FOR EACH INTAKE ID)

[ ] **NO HISTORY**

**Intake and Investigation History:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual(s)/Case Name:** |  | **Intake ID:** |  | **Case No:** |  |
| **Date:** |  | **Accepted As:** |  |
| **Allegations:** |  |
| **Finding:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual(s)/Case Name:** |  | **Intake ID:** |  | **Case No:** |  |
| **Date:** |  | **Accepted As:** |  |
| **Allegations:** |  |
| **Finding:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual(s)/Case Name:** |  | **Intake ID:** |  | **Case No:** |  |
| **Date:** |  | **Accepted As:** |  |
| **Allegations:** |  |
| **Finding:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual(s)/Case Name:** |  | **Intake ID:** |  | **Case No:** |  |
| **Date:** |  | **Accepted As:** |  |
| **Allegations:** |  |
| **Finding:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Individual(s)/Case Name:** |  | **Intake ID:** |  | **Case No:** |  |
| **Date:** |  | **Accepted As:** |  |
| **Allegations:** |  |
| **Finding:** |  |

**ONGOING SERVICES HISTORY (replicate for each ongoing case occurrence):**

|  |  |
| --- | --- |
| **DATE CASE OPENED:** |  |
| **DATE CASE CLOSED:** |  |
| **JUSTIFICATION FOR CASE CLOSURE:** |  |

# PART III – SUMMARY OF FATALITY/NEAR FATALITY INVESTIGATION

Victim(s):

Perpetrator(s):

FInding(s):

Describe the circumstances around the fatality/near fatality investigation and the justification for the finding:

|  |
| --- |
|  |

Is an internal review required? [ ] Yes [ ]  No

*(IF YES, PLEASE COMPLETE SECTION IV)*

Date ADT Approved:

# PART IV – INTERNAL REVIEW SUMMARY

**Date of Internal Review:**

**Practice areas identified as strengths:**

**Practice areas identified for improvement:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Issue Identified*\*\**** | **Plan of Action*\*\**** | **Person Responsible & Due Date** | **Measurement of Outcomes** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**\*\* When discussing areas for improvement and action plans, please consider how to incorporate the areas identified as strengths into the planning process**

# PART V – REGIONAL REVIEW

\*required if the F/NF investigation is unsubstantiated and DCBS has received a call on the family in the previous 24 months)

**Practice areas identified as strengths:**

**Practice areas identified for improvement:**

|  |  |  |
| --- | --- | --- |
| **Issue Identified*\*\**** | **Plan of Action*\*\**** | **Person Responsible & Due Date** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**\*\* When discussing areas for improvement and action plans, please consider how to incorporate the areas identified as strengths into the planning process**