**Office of the Chief Medical Examiner**

**Richmond, Virginia**

Meeting of the State Child Fatality Review Team

**May 12, 2017**

**Draft Minutes**

**Members Present:**

**Beitz, Lisa**, Hanover County Community Services Board

**Board, Heather**, Virginia Department of Health

**Bowers, Jennifer**, Assistant Chief Medical Examiner

**Dempsey, Steve,** King George County Sheriff

**Foster, Robin,** Virginia College of Emergency Physicians

**Gormley, William, Chair,** Chief Medical Examiner

**Hunter, Katharine,** Virginia Department of Behavioral Health and Developmental Services

**Milteer, Regina,** American Academy of Pediatricians

**Morales, Stephanie,** Portsmouth City Commonwealth’s Attorney

**\*Rose, Rutherfoord**, Virginia Poison Center

**Sobey, Kimberly**, Bland County Department of Social Services

**Sonenklar, Neil**, Virginia Treatment Center for Children

**Spain, Christopher,** Virginia Department of Social Services

**Wilson, Mary,** Virginia Department of Criminal Justice Services

**Members Absent:**

**Blumberg, Michael**, Medical Society of Virginia

**Coyle, Betty Wade**, Prevent Child Abuse Virginia

**Miller-Hobbs, Corri**, VCU Health Systems – Safe Kids Virginia

**Phipps, Deron¸** Virginia Department of Juvenile Justice

**Rainey, Janet**, Division of Vital Records

**Rodzinka, Elizabeth-Ryan,** 911 Supervisor, Waynesboro First Aid Crew

**Saimre, Maribel**, Virginia Department of Education

**Wilkes, Scott,** Swope Volunteer Fire Company

**Staff:**

**Clevenger, Allison**, Office of the Chief Medical Examiner

**Powell, Virginia,** Office of the Chief Medical Examiner

\*Person attended by conference call.

Allison Clevenger called the meeting to order at 10:15 a.m. and went over the agenda for the day.

**Announcements and Business**

Minutes from the March 10, 2017 meeting were approved as written.

**Mary Wilson** announced that the Department of Criminal Justice Services, in collaboration with the Office of the Chief Medical Examiner and the Department of Social Services, is sponsoring four one day multidisciplinary child fatality investigation training in different regions of the state. This training is targeted to law enforcement, medical examiners, and Child Protective Services (CPS) investigators who respond to and investigate unexpected child deaths and the prosecutors who handle these cases. Participants will learn the roles and responsibilities of law enforcement, CPS, prosecutors, the medical examiner and medicolegal death investigator during a child investigation, as well as what each needs from the others in order to conduct a thorough investigation.

Participants will learn:

* How to be compassionate, yet thorough in the investigation;
* Why contacting CPS immediately is critical and what they can offer to the investigation;
* The diagnostic shift from SIDS to SUIDS (Sudden Unexpected Infant Death Syndrome);
* The importance of using the SUID investigation form;
* When investigators should conduct a doll reenactment;
* How to coordinate information sharing; and much more.

The first training will be held on July, 7, 2017 in Roanoke, Virginia. Registration is now open.

**Heather Board** announced that the Virginia Department of Health (VDH) is hosting a meeting with the Consumer Product Safety Commission (CPSC) related to the Children’s Safety Act. The meeting will highlight products identified as causing injuries and fatalities to children in areas including unsafe sleep, poisoning, and furniture. VDH and CPSC will discuss precautions related to various products to encourage childhood safety and wellbeing. The meeting will be held in June in Richmond, Virginia.

**Child Protective Services Update** was given by Christopher Spain, CPS) Program Manager. Mr. Spain provided an overview of Child Protective Services’ role in a child death investigation. Once a local Department of Social Services receives notice of a child fatality that is suspicious for abuse or neglect, the local department is required to contact the CPS Regional Consultant. The consultant completes a preliminary child fatality information form and forwards it to the CPS Program Manager within 24 hours. Then, the Program Manager must inform the Commissioner of the Department of Social Services within 24 hours, who ultimately shares the information with the State Board of Social Services.

Once CPS is notified of the death, the local department opens an investigation and begins to collect information on the decedent by interviewing his or her caregivers and the caregiver at the time of the fatal incident. CPS also gathers information on the circumstances surrounding the death and whether or not the child or caregivers have had prior CPS involvement. When siblings are identified in the home, CPS performs a safety assessment and creates a safety plan to ensure the other children in the home are in a safe environment. CPS concludes the investigation by making a determination of whether or not the case is Founded or Unfounded for child abuse or neglect. Caregivers are given the determination in-person and through a formal letter. Following the determination, caregivers may appeal the local department’s decision.

Mr. Spain informed that CPS is able to share information with other agencies such as law enforcement, school personnel, potential caregivers, and the medical examiner. The Child Abuse Prevention and Treatment Act (CAPTA) allows certain information to be available to the public including if a report was made to CPS, if an investigation took place, the result of the investigation, if the child or caregiver had previous CPS reports, summaries, dates, and outcomes, and the agencies’ activities in handling the case.

**Discussion of the Review of Child Drowning Deaths.**

The Team entered a confidential session to continue their review of child drowning deaths in Virginia.

The next Team meeting is scheduled for **Tuesday, July 11, 2017.**

The meeting adjourned at 3:02 p.m.

*Minutes recorded by Allison Clevenger, MPH*