

CF OPERATING PROCEDURE
NO. 175-17

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, March 3, 2011

Family Safety

CHILD FATALITY REVIEW PROCEDURES

This operating procedure establishes the roles and responsibilities of all Department staff, contracted community based care providers and child protective investigators in the notification, management and review of child deaths alleged to have occurred as a result of abuse or neglect; and for the deaths of those children who are the subject of an open abuse or neglect investigation or who are currently receiving departmentally operated or contracted child protection services, regardless of whether there are allegations of death due to abuse or neglect.

CONTENTS

	Paragraph
Purpose	1
Objectives of the Child Fatality Review Process.....	2
Scope.....	3
Authority.....	4
Definitions	5
Child Fatality Reviews.....	6
Region Child Fatality Prevention Specialist Responsibilities.	7
State Child Fatality Prevention Specialist Responsibilities	8
Determination of Region Responsible for Oversight of the Internal Death Review Process.	9
General Roles and Responsibilities.....	10
Responsibilities of the Florida Abuse Hotline Staff	11
Responsibilities of the Regional Director	12
Responsibilities of Child Protective Investigators and Child Protective Investigator Supervisors.....	13
Responsibilities of Children's Legal Services (CLS).....	14
Responsibilities of Lead Agencies and Contracted Service Provider Staff Providing Child Protection Services	15
Cooperation with Other Agencies	16
Confidentiality of the Child Abuse Death Review Process.....	17
Appendix A. Limited Review Report Template	
Appendix B. Comprehensive Review Report Template	
Appendix C. Comprehensive Review Guidelines	
Appendix D. Directions for Electronic Maintenance and Transfer of Child Fatality Review Documents	

CHILD FATALITY REVIEW PROCEDURES

1. Purpose. This operating procedure:

a. Establishes the roles and responsibilities of Department staff, contracted community based care providers and child protective investigators in the notification, management and review of child fatalities alleged to have occurred as a result of abuse or neglect; and for the deaths of those children who are the subject of an open abuse or neglect investigation or who are currently receiving departmentally operated or contracted child protection services, regardless of whether there are allegations of death due to abuse or neglect; and,

b. Establishes the roles and responsibilities of the Region Child Fatality Prevention Specialist and the State Child Fatality Prevention Specialist in the child abuse death review processes mandated in Section 383.402, F.S. The statute requires that the Department of Health establish a statewide, multidisciplinary, multi-agency child abuse death assessment and prevention system for the purpose of conducting detailed reviews of the facts and circumstances surrounding verified child abuse and neglect deaths.

2. Objectives of the Child Fatality Review Process. The most important reason for reviewing deaths due to child abuse and neglect is to learn from these deaths in order to prevent similar deaths in the future. Major objectives of the death review process are to:

a. Identify programmatic or operational issues that point to the need for training or technical assistance;

b. Develop recommendations for modification of procedures, policies or programs internal to the Family Safety program and externally with other community agencies in an effort to reduce or eliminate future child fatalities through improved services to children and families; and,

c. Identify community resources for children and families that are needed, but are currently unavailable or inaccessible.

3. Scope.

a. This operating procedure applies to all Family Safety staff, Sheriff's staff responsible for child protective investigations and Community-Based Care staff involved in providing or reviewing the provision of child protection services.

b. Child Fatalities Covered by this Operating Procedure. A child fatality review must be conducted in the following situations:

(1) Child Fatalities Involving Allegations of Abuse or Neglect. This includes circumstances in which a report is accepted for investigation by the Hotline alleging that abuse or neglect was a factor in the child's death.

(2) Deaths of Children Receiving Child Protection Services. This includes the deaths of all children who are the subject of an open abuse or neglect investigation or who are currently receiving departmentally operated or contracted child protection services, regardless of whether there are allegations of death due to abuse or neglect.

4. Authority.

a. Section 383.402, Florida Statutes (F.S.), Child Abuse Death Review; State Child Abuse Death Review Committee; local child abuse death review committees.

- b. Section 39.202, F.S., Confidentiality of reports and records in cases of child abuse or neglect.
- c. Section 119.07, F.S., Inspection, examination, and duplication of records; exemptions.
- d. Rules 65C-30.020 and 65C-30.021, Florida Administrative Code.

5. Definitions.

- a. "Certified" refers to the designation earned by an individual who has met the criteria for Florida certification as a Child Protective Investigator or Child Protective Investigations Supervisor as described in 65C-33.001(4)(a) and 65C-33.001(4)(b) by demonstrating the knowledge, skills, abilities and priorities necessary to competently discharge the duties of his or her position classification, as evidenced by the successful completion of all applicable classroom instruction, field training, testing, and job performance requirements necessary for certification.
- b. "Comprehensive Review" means a detailed child fatality review and written report of the facts and circumstances surrounding the death of a child alleged to have died as a result of abuse, neglect or abandonment. This includes a thorough review and analysis of prior child protection services with the Department, as well as other agencies and services, and is primarily used in circumstances where the child or family had a relevant history involving child abuse, neglect or abandonment with the Department. The guidelines for the Comprehensive Review are in Appendix C of this operating procedure.
- c. "Child Fatality Database" means the Department's system used to capture critical information related to child deaths due to alleged abuse or neglect. Data from this system is used to identify and understand trends and provide information to stakeholders.
- d. "Child Fatality Prevention Specialist" means Department staff responsible for coordinating and documenting the Department's local and state child fatality review activities.
- e. "Child Protection Services" means core child protection programs, such as protective investigations, protective supervision, post placement supervision, foster care and other out-of-home care or adoption services.
- f. "Contracted Service Provider" means a private agency that has entered into a contract with the Department or with a community-based care lead agency to provide supervision of and services to dependent children and children who are at risk of abuse, neglect, or abandonment.
- g. "Florida Safe Families Network (FSFN)" means the Department's statewide automated child welfare information system which is primary record for each protective investigation and case.
- h. "Department" means the Department of Children and Family Services, unless otherwise specified.
- i. "Limited Review" means a basic fatality review and written report of the facts and circumstances surrounding the death of a child alleged to have died as a result of abuse, neglect or abandonment. This review does not involve a detailed analysis of family history and is completed primarily in circumstances where the child and family do not have a relevant history involving child abuse, neglect or abandonment with the Department, or it is clear that the child's death was unrelated to any history of abuse, neglect or abandonment.
- j. "Internal Death Review" means a review of a child abuse or neglect death by Department of Children and Families region/circuit staff, with a focus on the evaluation of departmental, community

based care or other contracted services provided to the child or family prior to the child's death. The review also includes monitoring of the current protective investigation regarding the child death. The purpose of the internal review is to facilitate the identification of case-specific issues and systemic factors that were present at the time of the child's death, and includes a written report of findings with recommendations to address all critical issues identified as part of the review.

k. "Local Child Abuse Death Review" refers to the review of a child abuse or neglect death completed by a local child abuse death review committee. The composition of local child abuse death review committees is described in section 383.402, F.S.

l. "State Child Abuse Death Review Committee" refers to the state level child abuse death review team established and described in section 383.402, Florida Statutes.

m. "Verified" refers to the finding used when a preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, abandonment or neglect.

6. Child Fatality Reviews. The review of child deaths can be very simple or very complex, depending on the circumstances of an individual case. However, all child deaths covered by this operating procedure are subject to a Comprehensive or Limited Review by the Region Child Fatality Prevention Specialist or member of the Quality Assurance Unit, unless the responsibility for a review has been assigned by the Secretary or Regional Director to another office, agency or committee.

a. A Comprehensive Review is required in the following situations:

(1) It is determined, after thorough review, that any prior child protection services involvement of the alleged victim or alleged perpetrator is relevant to the circumstances surrounding the child's death. Considerations for relevancy include, but are not limited to:

(a) Recent child protection services;

(b) Prior involvement of child protection services is a factor in the situation involving the child's death;

(c) Policy or practice issue that has been previously addressed and not corrected;

(d) History of similar maltreatments surrounding those involved in the child's death;

(e) Prior removals based on maltreatment findings; and,

(f) Outcome of prior child protection service interventions.

(2) Local leadership or the Statewide Family Safety Program Director determines an in-depth review of the case is necessary.

b. The format for the Comprehensive Review is included in Appendix B of this operating procedure. At a minimum, all relevant sections of the report must be completed. Region staff may choose to include additional information, as identified, during the review process. Sections A-D of the report shall be completed within 30 calendar days of the receipt of the report or the addition of the death maltreatment to the report, whichever is later. The final report, to include all sections, shall be completed no later than 30 calendar days after the investigation is closed.

c. A copy of the Comprehensive Review report shall be sent to the Director for Family Safety and the State Child Fatality Prevention Specialist within 5 working days of completion.

d. A Limited Review is required in the following situations:

(1) The fatality does not meet the criteria for a Comprehensive Review; or,

(2) The death of a child who is currently receiving child protection services, but there is no suspicion that abuse or neglect was a factor in the child's death.

e. The Limited Review must include an explanation as to why a Comprehensive Review is not required; including specific reasons why any prior child protection services involvement is not relevant.

f. The format for the Limited Review is included in Appendix A of this operating procedure. At a minimum, all relevant sections of the report must be completed, including documentation of the specific reasons why a Comprehensive Review is not required. Region staff may choose to include additional information, as identified, during the review process. The report shall be completed no later than 30 calendar days after the investigation is closed.

g. If all required information is captured in the Child Death Review database or the Incident Reporting and Analysis System, these may be used as the source for the Limited Review.

h. A copy of the Limited Review report shall be sent to the Director for Family Safety and the State Child Fatality Prevention Specialist within 5 working days of completion.

7. Region Child Fatality Prevention Specialist Responsibilities. The Region Child Fatality Prevention Specialist's (CFPS) responsibilities include:

a. Implementation and oversight the Department's local child fatality review process and activities related to the Department's internal review of child abuse deaths, including coordinating fatality review activities with Department staff, community based care providers and sheriff's offices involved in the provision of child protection services;

b. Coordinating death review activities, as needed, with individuals in the community, and the Department of Health;

c. Participating, when possible, with other death review teams, including: domestic violence fatality review teams, local Fetal Infant Mortality Review (FIMR) Teams, local child fatality review teams and the State Child Abuse Death Review Committee;

d. Establishing professional working relationships with medical examiners, state attorneys and law enforcement agencies serving the counties included in the CFPS's geographic service area;

e. Utilize the Department's statewide Child Fatality Database for documenting critical information regarding child deaths during the child abuse fatality review process;

f. Working with the Family Safety Quality Assurance office to keep the statewide Child Fatality Database complete, accurate and current;

g. Determining whether a child fatality requires a Limited Review or a Comprehensive Review, based on the requirements in paragraph 6, Child Fatality Reviews, of this operating procedure;

h. Documenting the type of review to be completed in the Child Fatality Database within 2 working days of making the determination;

- i. Completing either a Limited or Comprehensive Review, pursuant to all of the requirements in paragraph 6, Child Fatality Reviews, of this operating procedure;
- j. Providing electronic copies of all documentation to the State Child Fatality Prevention Specialist through the Child Fatality Network Share Drive, in cases where the investigation meets the criteria for review by the State Child Abuse Death Review Committee as outlined in 383.402, F.S. (see Appendix D of this operating procedure for documentation requirements, format, and directions);
- k. Participating in child abuse death review staffings as the department's representative to the local Child Abuse Death Review Committee, where these committees exist;
- l. Ensuring that critical issues and recommendations resulting from child death reviews are brought to the attention of the Regional Director, Region Family Safety Program Administrator, Region Quality Assurance Director, and the State Child Fatality Prevention Specialist;
- m. Reviewing the protective investigation and informing the child protection investigation supervisor whether or not the protective investigation has been approved for closure within 5 working days of being notified that the protective investigation is ready to be closed;
- n. Ensuring that the report is not closed (locked) until the death has been reviewed by the Region Child Fatality Prevention Specialist and the Specialist has advised the supervisor that the death report has been approved for closure;
- o. Providing technical assistance during the investigation of any report alleging that a child died as a result of abuse or neglect, and during the review of cases involving the death of a child while receiving child protection services;
- p. Working with involved child protection providers to ensure the protective investigation, if applicable, and the review are thorough;
- q. Reviewing the investigative activities in all reports alleging death due to abuse or neglect for completeness and accuracy prior to closure;
- r. Ensuring all documentation, including casework activities, maltreatment findings, client demographics, date of death and cause of death are documented in FSFN prior to approving the investigation for closure; and,
- s. Providing information regarding the results of the review to any involved child protection providers, including supervisors, to reinforce good casework practices and to identify any systemic issues such as training needs, increased supervisory or administrative support, or networking within the community.

8. State Child Fatality Prevention Specialist Responsibilities. The State Child Fatality Prevention Specialists responsibilities include:

- a. Coordinating with Region Child Fatality Prevention Specialist's to ensure the appropriate implementation of the child fatality review process;
- b. Coordinating with quality assurance or other Family Safety staff to ensure headquarters office participation in the fatality review process, particularly for complex or high profile child deaths;
- c. Ensuring that critical issues and recommendations resulting from child fatality reviews are brought to the attention of the Secretary for the Department of Children and Families, Assistant Secretary of Operations, Assistant Secretary of Programs, Director for the Office of Family Safety, and the Director of the Florida Abuse Hotline;

- d. Maintaining the Child Fatality Review Operating Procedure (CFOP 175-17) and providing technical assistance to region Child Fatality Prevention Specialists and other child protection providers, regarding the department's child fatality review process;
- e. Providing Children's Legal Service's (CLS) single point of contact with a weekly report listing all child deaths that have been identified as requiring a Comprehensive Review in the calendar year;
- f. Conducting programmatic reviews of child deaths, as needed, or at the request of the Secretary for the Department of Children and Families or the Director for the Office of Family Safety;
- g. Serving as a liaison between the Office of Family Safety and the State Child Abuse Death Review Committee, including participating in State Child Abuse Death Review Committee meetings;
- h. Providing oversight of the Family Safety Child Fatality Database to ensure data is complete, accurate and current for child deaths covered by this operating procedure;
- i. Analyzing child fatality data to understand patterns and trends, policy and practice strengths and weaknesses, and training needs;
- j. Completing the Department of Children and Families, Family Safety Annual Child Death Report;
- k. Notifying the State Child Abuse Death Review Committee state committee coordinator, or designee, of all verified cases of child death due to abuse, neglect or abandonment; and,
- l. Providing electronic files to the State Child Abuse Death Review Committee coordinator, or designee, for distribution to a local child abuse death review team in cases where the investigation meets the criteria for review by the State Child Abuse Death Review Committee as outlined in 383.402, F.S.

9. Determination of Region Responsible for Oversight of the Internal Death Review Process. The Child Fatality Prevention Specialist for the county where the alleged abuse or neglect that contributed to the child's death occurred shall maintain the lead responsibility for oversight of the internal death review process.

10. General Roles and Responsibilities.

- a. When a child dies during the course of an active investigation, and it is due to a new incident of alleged abuse or neglect, the Child Protective Investigator assigned to the investigation shall be placed on a mandatory 2 days of Administrative Leave with Pay. Additional Administrative Leave with Pay may be imposed by the Secretary or an authorized representative of the Secretary. The maximum Administrative Leave with Pay shall not exceed 20 work days, unless additional Administrative Leave with Pay is imposed at the request of the Secretary or authorized representative of the Secretary. In addition, the Child Protective Investigator shall be referred to the Employee Assistance Program. The servicing Human Resources office should be contacted to assist with placing the employee on administrative leave in accordance with rules and policies.
- b. Any Department, Lead Agency, contracted service provider or Sheriff's Office employee who provides child protection services who has reasonable cause to suspect that a child died as a result of abuse, neglect or abandonment shall immediately report the death to the Florida Abuse Hotline. A report is required even when there are no surviving children living in the home. If the suspicious death occurs during an active investigation, child protection staff are required to call the Florida Abuse Hotline immediately, rather than adding the death maltreatment code to the existing report.

c. Department and Sheriff's Offices conducting child protective investigations shall develop local procedures for ensuring child protective investigators are certified and have the unique knowledge, skills and abilities to deal with the complex and sensitive nature of investigations involving a child's death.

d. Each Region and Sheriff's Office conducting child protective investigations shall develop procedures with local law enforcement for carrying out joint investigations involving the death of a child due to alleged abuse, abandonment or neglect. These procedures shall:

(1) Be included in the working agreements between the Department and local law enforcement required in section 39.306, F.S.; and,

(2) Ensure criminal investigations and child protective investigations be commenced concurrently, whenever possible.

e. Child Protective Investigators must be certified by the Department to be assigned as the primary investigator of a report involving a child death due to alleged abuse, neglect or abandonment.

11. Responsibilities of the Florida Abuse Hotline Staff.

a. The Florida Abuse Hotline shall accept a report of a child death for protective investigation pursuant to section 39.201, F.S.

b. When a report is received involving an alleged victim in an open protective investigation that has died as a result of the abuse, neglect or abandonment which resulted in the open protective investigation, the report shall be categorized as a "supplemental" report and the maltreatment of "death" shall be added to the existing protective investigation by the Florida Abuse Hotline.

c. When a report is received involving an alleged victim in an open protective investigation that has died as a result of a new incident of abuse, neglect or abandonment, a new "initial" report shall be created.

d. A death report must not be merged with any other reports alleging abuse or neglect that did not cause the death.

12. Responsibilities of the Regional Director.

a. Each Region shall establish local processes and timelines for informing the Regional Director of child deaths covered by this operating procedure using the procedures outlined in CFOP 215-6, Incident Reporting and Client Risk Prevention.

b. The Regional Director or designee must notify the Secretary for the Department of Children and Families immediately (by telephone or through e-mail) upon learning that a child died and there were allegations that the child's death may have been the result of abuse or neglect, and the circumstances of the child's death warrant immediate notification due to special circumstances, such as current or anticipated media coverage.

c. The Regional Director or designee shall use the Department's Incident Reporting System to notify and update the following individuals of all child deaths alleged to have occurred as a result of abuse or neglect, or of the deaths of children who are the currently receiving child protection services within 24 hours of receipt of the intake from the Florida Abuse Hotline or of learning of the child's death:

(1) Secretary for the Department of Children and Families;

(2) Assistant Secretary for Programs;

- (3) Assistant Secretary for Operations;
- (4) Children's Legal Services;
- (5) General Counsel;
- (6) Director for the Office of Communications;
- (7) Inspector General;
- (8) Director of the Office of Family Safety; and,
- (9) State Child Fatality Prevention Specialist.

d. The Regional Director is responsible for establishing an environment that will provide emotional support for child protection staff and supervisors who have been directly involved in a case in which a child has died. The additional pressures associated with a child's death may further inhibit their ability to cope with the tragedy, and perform their duties. In some instances, actions or support services such as the following may be necessary to help staff through times of stress:

- (1) Peer support from other staff, including those who have experienced a child death on their caseload or those who are known to be especially supportive in such situations;
- (2) Temporary assistance with duties from staff within the unit, including leave or a reduced caseload;
- (3) Referral to or information regarding the Employee Assistance Program (EAP) (under the umbrella of the EAP, an employee may be allowed time off from work without using personal leave for grief and loss resolution counseling); and,
- (4) Assigning another counselor to complete the investigation or provide services to the survivors, if appropriate. This action should be taken if requested by the counselor, or if determined necessary by the Regional Director or designee.

e. The Regional Director must ensure that all staff involved in a child death understand the purpose and procedures of the child fatality review process. Staff should be advised of the review, have access to the Child Fatality Prevention Specialist or other appropriate individuals for any questions they may have about the process, and be given an opportunity to respond to questions or concerns raised as part of the review.

f. The Regional Director shall appoint a Child Fatality Prevention Specialist for the Region in accordance with 383.402(18) F.S.

13. Responsibilities of Child Protective Investigators and Child Protective Investigator Supervisors.

a. The Child Protective Investigator shall:

(1) Call in a report to the Florida Abuse Hotline when a child dies during an open protective investigation if:

- (a) The death is due to alleged abuse, neglect or abandonment which resulted in the current open protective investigation; or,
- (b) A new incident of abuse, neglect, abandonment or harm is alleged.

(2) Notify the Region Child Fatality Prevention Specialist of the death of a child who is an active participant in an open investigation when the child's death is not due to abuse, neglect or abandonment. Notification shall be in writing and within 24 hours of learning of the child's death.

(3) In addition to the requirements mandated in Rule 65C-29.003, F.A.C., complete the following activities when investigating a report that alleges a child died as a result of abuse, neglect or abandonment, or when a child dies for reasons unrelated to abuse, neglect or abandonment during an open protective investigation:

(a) Assess the safety of any surviving children, including:

1. Completion of a current Safety Assessment; and,
2. Referral to the local child protection team pursuant to section 39.303(2)(g), F.S..

(b) Obtain a copy of information necessary to determine whether the death was due to abuse, neglect or abandonment, including:

1. Current and prior Child Protection Team reports;
2. Medical records;
3. Emergency Medical Services reports;
4. Court documents;
5. The medical examiner's final report if an autopsy was conducted, and required pursuant to section 39.301(17)(b), F.S.;
6. Any preliminary, supplemental and final law enforcement investigation reports pertaining to the child's death;
7. Criminal history records;
8. Prior abuse, neglect or abandonment reports pertaining to the alleged perpetrator(s), caregivers, and household members; and,
9. Prior prevention or family preservation services records pertaining to the child and the alleged perpetrator(s).

(4) Document in the statewide automated child welfare information system, as the initial contact for the victim, the date and time of the first professional collateral contact with medical staff or law enforcement personnel regarding the child's death.

(5) Document the date, time and cause of death in the statewide automated child welfare information system.

(6) Document that the information entered into the statewide automated child welfare information system clearly reflects the cause and circumstances surrounding the child's death. The findings from the medical examiner and law enforcement (including the status of criminal prosecution, if applicable) shall be included to the extent that information is available and necessary prior to closing the protective investigation.

(7) Provide the Region Child Fatality Prevention Specialist with access to all documentation obtained as required in Rule 65C-30.020(5), F.A.C.

(8) Participate in all child fatality review staffings required by the Region Child Fatality Prevention Specialist.

(9) Notify the Region Child Fatality Prevention Specialist of all child fatality review staffings held on the case.

(10) Document the names of participants and outcomes of all staffings in the statewide automated child welfare information system.

(11) Review information entered into the statewide automated child welfare information system for accuracy and completeness prior to closure of the protective investigation.

(12) Not close the child protective investigation until it has been reviewed and approved for closure by the Region Child Fatality Prevention Specialist. Disagreement on the maltreatment finding, or other items of the investigation, shall be resolved in accordance with the dispute resolution process in Rule 65C-30.020(5)(f), Florida Administrative Code.

(13) Complete the child protective investigation within 60 days after receipt of the report from the Florida Abuse Hotline. The only exceptions to this requirement are defined in subsections 39.301 (17)(a) and 39.301(17)(b), F.S.

b. If a child protective investigation is kept open in accordance with subsection 39.301(17)(a), F.S., the Program Administrator shall review and document in the statewide child welfare information system the reason(s) why closure of the protective investigation may compromise law enforcement's successful criminal prosecution of the child abuse or neglect case.

c. If a child protective investigation is kept open in accordance with subsection 39.301(17)(b), F.S., the Program Administrator shall review and document in the statewide child welfare information system the reason(s) that the final report from the medical examiner is necessary in order to determine if the child's death was due to abuse, neglect or abandonment.

d. The Child Protective Investigator Supervisor shall complete a supervisory review every 30 days until the protective investigation is closed, and document in the statewide automated child welfare information system:

- (1) Activities that have occurred since the last review;
- (2) Any new tasks assigned; and,
- (3) The reasons the protective investigation remains open.

14. Responsibilities of Children's Legal Services (CLS). The Director of Children's Legal Services or designee shall:

a. Identify a single point of contact for coordinating legal reviews of child death cases requiring a Comprehensive Review; and,

b. Ensure CLS staff completes a review of any legal actions in child death cases requiring a Comprehensive Review and schedules a staffing with the Region Child Fatality Prevention Specialist within 14 calendar days of being notified that such review is necessary.

15. Responsibilities of Lead Agencies and Contracted Service Provider Staff Providing Child Protection Services. If a death involves a child receiving in-home supervision, in out-of-home care, under post-placement supervision services or pre-adoptive home supervision services from a Lead Agency or Contracted Service Provider, the provider is responsible for:

- a. Providing support, assisting with access to community resources, assessing the emotional needs of any siblings and other members of the family and providing or arranging for any needed services;
- b. Keeping the Region Child Fatality Prevention Specialist informed of significant developments regarding the child's death and providing copies of pertinent documentation; and,
- c. Ensuring that all information in the child's case file related to the death is accurate and complete. The case file must include the cause and circumstances surrounding the child's death and clearly reflect whether the death was due to abuse, neglect or to other reasons. The date of death and findings from the medical examiner and law enforcement (if applicable) must also be included

16. Cooperation with Other Agencies.

a. Law Enforcement. Upon learning of a child death due to suspected abuse or neglect, the Child Protective Investigator shall report the death to law enforcement immediately. Close cooperation is especially important in death cases to facilitate information sharing and avoid duplication of efforts.

b. Medical Examiner. The role of the medical examiner in the death review process is critical. Specific statutory requirements address the relationship between the Department of Children and Families and the medical examiner.

(1) Duty to Report Certain Deaths to Medical Examiner. Section 406.12, F.S., provides:

"It is the duty of any person in the district where a death occurs, including all municipalities and unincorporated and federal areas, who becomes aware of the death of any person occurring under the circumstances described in Section 406.11 to report such death and circumstances forthwith to the district medical examiner. Any person who knowingly fails or refuses to report such death and circumstances, who refuses to make available prior medical or other information pertinent to the death investigation, or who, without an order from the office of the district medical examiner, willfully touches, removes, or disturbs the body, clothing, or any article upon or near the body, with the intent to alter the evidence or circumstances surrounding the death, shall be guilty of a misdemeanor of the first degree, punishable as provided in Section 775.082 or Section 775.083."

(2) Deaths Due to Child Abuse or Neglect. Section 39.201(3), F.S., provides:

"Any person required to report or investigate cases of suspected child abuse or neglect who has reasonable cause to suspect that a child died as a result of child abuse or neglect shall report his suspicion to the appropriate medical examiner. The medical examiner will report his findings, in writing, to the local law enforcement agency, the appropriate state attorney, and the department. Autopsy reports maintained by the medical examiner shall not be subject to the confidentiality requirements provided for in Section 39.202."

17. Confidentiality of the Child Abuse Death Review Process.

a. Confidential Records vs. Public Records. In order to comply with all the public records and confidentiality provisions of Chapters 119 and 39, F.S., Department of Children and Families staff must

be very careful to protect the privacy rights of persons named in reports while respecting the right of the press and public to review records. In order to accomplish both goals, all records generated as a result of a child's death must be treated as confidential, unless there is a court order for disclosure or the department legal counsel directs disclosure.

b. Confidentiality requirements in Florida Statute relevant to information obtained from other agencies involved in the internal death review process, such as Child Protection Team, domestic violence, substance abuse or Children's Medical Services case records, may be more restrictive than those requirements that govern the release of Department of Children and Families records and, as such, may not be released to the public under any circumstances. Care must be taken to ensure that the confidentiality of information provided by these agencies and individuals is preserved when releasing the department's records to the general public. The following statutory requirements govern disclosure of Department of Children and Families records:

(1) Generally, reports alleging the death of a child due to abuse or neglect are confidential. However, 39.202(2)(o), F.S., provides access "To any person in the event of the death of a child determined to be a result of abuse, abandonment, or neglect. Information identifying the person reporting the abuse, abandonment, or neglect shall not be released. Any information otherwise made confidential or exempt by law shall not be released pursuant to this paragraph."

(2) Section 119.07(7), F.S., provides that any person or organization may petition the court for an order making public Department of Children and Families records that pertain to investigations of abuse and neglect. Specific operating procedures governing the release of information are included in CFOP 15-12.

(3) Section 39.202(5), F.S., states that "all records and reports of the child protection team of the Department of Health are confidential and exempt from the provisions of ss. 119.07(1) and 456.057, and shall not be disclosed, except, upon request, to the state attorney, law enforcement, the department, and necessary professionals, in furtherance of the treatment or additional evaluative needs of the child, by order of the court, or to health plan payers, limited to that information used for insurance reimbursement purposes."

c. Each Region is responsible for preparing records for release (redaction) under the direction and guidance of the Region's Legal Counsel. In the case of reports subject to release, both the investigative file and death review documentation should be prepared for release upon request, as provided in section 39.202(2)(o), F.S. Region staff must be careful to make a copy of all documents in the file and black out all information on the copies that would identify the reporter or provide any information from an individual or agency who provided services to the child or family or participated in the death review process and is exempt from the provisions of ss. 119.07(1), F.S. Staff must be careful to block out not only names, but also any information, however subtle, that would identify the reporter or provide confidential information from another agency.

(Signed original copy on file)

DAVID E. WILKINS
Secretary

SUMMARY OF REVISED, DELETED OR ADDED MATERIAL

This revised operating procedure delineates requirements for reviews of child death cases, such as reporting, notifying, tracking and reviewing child abuse and neglect deaths and the deaths of children receiving child protection services. Language explaining the requirement for community-based care providers and the sheriff's offices providing child protection services in lieu of departmentally operated child protection services to support the death review process was added to the operating procedure. This revised operating procedure also includes: the role of the Department of Children and Families to support the child abuse death review process established in section 383.402, F.S., which was mandated by the Florida Legislature in 1999; adding requirements for child protective investigators to be placed on Administrative Leave with Pay when a child dies due to new abuse during the course of an investigation; changes the requirements for completing Comprehensive or Limited Reviews; and documents procedures for electronic transfer of records within the Department and to the Department of Health.

LIMITED REVIEW REPORT TEMPLATE

Child's Name: _____ Region: _____

Date of Birth: _____ Circuit: _____

Date of Death: _____ County: _____

Report Number: _____

Specific Reason(s) for Not Completing a Comprehensive Review:

Medical Examiner/Physician Cause of Death:

Law Enforcement Involvement: Include charges filed, if any.

Prior Child Protection/Other Related Services: Briefly summarize all prior departmental or contracted child protection services or other relevant services, such as day care, maternal/newborn health or social services, etc.

Child Protective Investigation Findings: List all maltreatments and respective findings.

Summary of Findings: Provide a brief description of the findings, major issues related to the death – use extra pages if necessary.

Name: _____

Title/Position: _____ Work Phone: _____

Signature _____

COMPREHENSIVE REVIEW REPORT TEMPLATE

Child's Name: _____ Region: _____
 Date of Birth: _____ Circuit: _____
 Date of Death: _____ County: _____
 Report Number: _____

A. Family Composition.

Name	DOB and Age	Relationship with Deceased Child	Initial Role	Final Role (to be completed upon closure of the investigation)

B. Circumstances Surrounding Death

C. Summary of Previous History.

D. Analysis of Prior Investigation/Service History (Summary)

1) Quality of Assessments (Summary)

Background Checks

Critical Junctures

Thorough Assessment for Legal Sufficiency

Key Risk Factors Addressed

2) Appropriate Safety Actions (Summary)

3) Supervision (Summary)

Guidance and Direction

Follow-up

4) Services/Service Engagement (Summary)

Identification of Appropriate Services

Follow-Up

5) Communication (Summary)

Multi-disciplinary

Case Transfer

6) Learning Opportunities (Enumerate These)

E. Law Enforcement Involvement/Criminal Investigation. (Summary)

F. Autopsy Results. (Summary)

G. Investigative Findings. (Summary)

Child Fatality Prevention Specialist

Date

Region QA Manager/FSPO Program Manager

Date

Comprehensive Review Guidelines

The Child Fatality Prevention Specialist (CFPS) shall review the entire child welfare history involving the alleged victim or perpetrator and make a determination if the history is relevant to the circumstances surrounding the child's death. If it is determined that any child welfare history is relevant, the CFPS shall complete a Comprehensive Review. Steps A - D shall be completed within 30 calendar days of the receipt of the report or the death of the child, whichever is later. Step E -G shall be completed within 30 days after the investigation is closed. Considerations for relevancy include:

- Recent child protections services,
- Prior involvement of child protection services is a factor in the situation involving the child's death,
- Policy or practice issue that has previously been addressed and not corrected,
- History of similar maltreatments surrounding those identified in the child's death,
- Prior removals based on maltreatment findings, and
- Outcome of prior service interventions.

A. Family Composition. Provide a description of the deceased child's family members at the time of death.

Name	DOB and Age	Relationship with Deceased Child	Initial Role	Final Role (to be completed upon closure of the investigation)

B. Circumstances Surrounding Death. Describe the events which led to the child's death (consistent with information included in the investigative report) and how the child died. Provides not only the immediate cause of death (such as head trauma perpetrated by the mother's boyfriend), but also any other actions or failures to act which contributed to the death (mother's efforts to protect the child and obtain medical care, etc.)

C. Summary of Previous History. Complete a thorough review of prior DCF involvement and summarize the family history. Do not copy what is in each Investigative Summary or break out each previous intervention as a separate incident and summarize. Instead, synthesize the history into the key trends and patterns that emerged based on your review. Tell the story of the family history.

D. Analysis of Prior Investigation/Service History. Provide an analysis of prior child protection (including the Department, CBC's, Sheriff's CPI's, and other contracted service providers) activities in the areas listed below: Note- Focus on strengths, as well as areas of concern that are relevant to the child's death. Also, use the bulleted items as guidelines or areas of consideration, not as sub-headers under which each of these areas is analyzed.

1) Quality of Assessments

- **Background Checks** – Thorough background and record checks provide information on individual or family issues and may identify behavioral patterns that could create a safety risk to the child or affect family functioning. The investigator should use background information in their decision making to determine immediate and escalating risk in the seriousness and/or frequency of background history over time.
- **Critical Junctures** – Appropriate decisions and safety actions is crucial during those times during an investigation or services case when fundamental decisions are being made for the child or when critical events are occurring in the investigation or services case. Careful consideration should be given for the actions taken during the initial contact with the family, when new reports are received during active cases, at case transfer, before a child is returned home, and when the investigation or case is closed (among many others).
- **Thorough Assessment for Legal Sufficiency** – If CLS determined there was not legal sufficiency, were there steps that could have led to legal sufficiency? If yes, did CLS offer guidance about what was needed to reach legal sufficiency? Did investigations and/or case management follow guidance provided? If brought to Legal, CLS should review from a legal perspective.

- **Key Risk Factors Addressed** – The case file should document that the workers assessments (initial and updated safety assessment, family assessments, etc.) took into consideration all information gathered to make the most appropriate safety decisions.
- 2) Appropriate Safety Actions - Appropriate safety actions should be taken when information is obtained by the worker that has a potential impact on child safety.
- 3) Supervision
- **Guidance and Direction** – Appropriate, clear and timely guidance and direction should be given based upon what is known and needed to ensure child safety and family stability.
 - **Follow-up** – Supervisory reviews should be thorough, with supervisors taking the lead in ensuring critical casework activities are completed timely. In addition, the supervisor is ultimately responsible for ensuring follow-up was completed by the worker.
- 4) Services/Service Engagement
- **Identification of Appropriate Services** – The worker appropriately identified and made arrangements for the immediate service and/or ongoing supervision needs of the children and families served (if applicable).
 - **Follow-Up** – It is critical that families engage in services that have been identified to ensure the immediate and long term safety of the children. If the family is not actively participating with the services being offered, or has a history of not participating in prior cases, the caseworker must take appropriate steps to ensure safety without services being provided.
- 5) Communication - Open and timely communication with both internal and external partners is key to ensure positive outcomes for the children and families we serve. Communication with children's legal services, our community based care partners, the child protection team, and others who may have critical information or can be of support during the child protection process is critical.
- **Multi-disciplinary Staffings** – Multi-disciplinary staffings should be taking place when involvement of more than one agency, service provider or program is involved with the family. These staffings should include representatives from all service providers and key stakeholders serving the child and family.
 - **Case Transfer** – When case activity and responsibility is being shared between a CPI and CBC case worker, it is critical that ownership of case responsibilities are clearly delineated and understood by all. In addition, investigative and case management staff should communicate with each other and the service providers about case events and/or the effectiveness of the services being provided.
- 6) Learning Opportunities – It is critical that these reviews be treated as a learning opportunity, and not a monitoring activity. The most important aspect of the review is to determine if there are internal or external areas needing attention in order to prevent future child deaths. These range from local training needs to statutory revision, and everything in between.
- E. Law Enforcement Involvement/Criminal Investigation.** Identify the agency conducting the criminal investigation and the status of the investigation. Provide a brief summary of any action taken regarding the alleged perpetrator or other persons involved (e.g., whether an arrest was made, the charges that were filed and the status of prosecution).
- F. Autopsy Results.** If an autopsy was performed, summarize the most significant diagnoses and findings, especially cause and manner of death. Provides a brief explanation if the Medical Examiner's Office declined to conduct an autopsy or an autopsy was not conducted due to the death circumstances (e.g., an expected natural death of a medically complex child).
- G. Investigative Findings.** Summarize the results of the child protective investigation, including findings for all alleged maltreatments in the child death report.

Directions for Electronic Maintenance and Transfer of Child Fatality Review Documents

Scanning Child Fatality Review Documents

All Regions have a multi-function device (MFD) that has been set up to allow for scanning and storing of child fatality review documents in a common location. Since each MFD may be different, contact your Region Data Support for training on scanning documents to the Child Fatality group.

Creating Folders and Storing Child Fatality Review Documents on the Share Drive

The share drive, located at `\\scfmzfpb08\users$\Scan\Family Safety\Child Fatality Prevention` is set up with a folder for each calendar year. Documents should be stored based on the calendar year in which the report was received. Within each of these folders are two subfolders, "Active" and "Complete". All in progress work should be saved in the "Active" folder.

1. Upon receiving a new child fatality report, open the "Active" folder for the appropriate calendar year (year in which the report was received) and create a new folder using the child's name (Last Name, First Name). Note: documents stored in this folder will not be shared or reviewed; this is simply a location to store your "in progress" work.
2. Scan or save acquired documents (this can be done as documents are received, throughout the course of the investigation). Documents scanned to the "Child Fatality" template, using the commercial copier-scanner, will automatically be stored at the base scan location (`\\scfmzfpb08\users$\Scan\Family Safety\Child Fatality Prevention`). If you use a desktop scanner, the documents will be stored on your hard drive.
3. Move scanned documents from the base scan location or hard drive to the folder with the child's name.
4. When all of your work is complete, move (don't copy) the entire child's folder to the "Complete" folder, either to the "Verified" folder or the "Not Sub_No Indicator" folder, depending on the finding of the death maltreatment in the investigation.
5. Send an email to the Child Fatality email address (`child_fatality@dcf.state.fl.us`) notifying the State Child Fatality Prevention Specialist that the file is complete and ready to be sent to the state Child Abuse Death Review Committee coordinator.

Naming Convention for Documents Stored on the Share Drive

In order to avoid confusion, amongst ourselves and our DOH partners, we need to use common naming conventions for the different types of scanned records. The naming conventions are as follows:

1. CFPS Death Review – This will be the Comprehensive or Limited Review.
2. FSFN Death Investigation – This includes all documentation from FSFN regarding the investigation of the child's death (e.g., Investigative Summary, Updated/Final Safety Assessment, Case Notes, etc).
3. FSFN Prior Investigation History – This includes documentation from FSFN regarding prior intakes/investigations.
4. FSFN Services Information – This includes documentation from FSFN regarding current or prior services provided (e.g., Family Assessment, Placement Screening, Placement History, Case Notes, etc.).
5. Medical Examiner – This includes autopsy results, death certificate, etc.
6. Medical Records – This includes documents from EMS, hospital, doctors, etc.
7. CPT Records
8. Law Enforcement – This includes information regarding any law enforcement activity.
9. Photos – This includes CPI and Crime Scene Photos.
10. Court Records
11. QA Review – This includes any QA, including relevant investigations and services.