March 17, 2010

Major Connie Shingledecker, Chairperson
State Child Abuse Death Review Committee
c/o Manatee County Sheriffs Office
515 11th Street West
Bradenton, Florida 34205

Dear Major Shingledecker:

During this past year, there has been great collaboration between the Department and the State Child Death Review Committee on child safety issues. Because of this, we began to implement many of the recommendations contained in the 2009 Annual Report prior to its formal release in January. We commend the state team for the recommendations contained in the report as they serve to protect all of Florida’s children. The Department of Children and Families supports these recommendations and will continue to work toward implementation of activities under our span of control.

In an effort to assess child safety concerns, Secretary Sheldon appointed the Safe Families Subcommittee of the Task Force on Fostering Success in October 2009. The goal of the subcommittee was to look at all child safety issues, including Florida Abuse Hotline operations. The subcommittee was chaired by Judge Gooding from Jacksonville. Dr. Michael Haney, Florida Department of Health, was a member of the subcommittee and provided a wealth of information on child deaths with specific recommendations for improving child safety practices. In February, the subcommittee submitted a series of recommendations regarding child safety to the Task Force on Fostering Success. These recommendations were subsequently adopted by the Task Force and submitted to the Secretary. The five recommendations specific to child deaths are listed below.

1. Further analysis must be done on the role of investigators in child deaths allegedly due to abuse or neglect. There should be a consideration of policy change to require the Florida Abuse Hotline to accept certain child death calls as a Special Condition Report. A case could be reclassified to a full investigation as the circumstances surrounding the death of a child are warranted based on additional medical and law enforcement information.

2. The change of policy at the Florida Abuse Hotline in 2007 to refer for investigation child deaths due to drowning and unsafe sleeping needs further clarification.

3. The Department should develop a uniform practice for the internal review of child deaths that ensures the engagement of investigators and case managers to learn from these tragedies and create a learning environment that advances improved ability to assess for risk and protective capacities.
4. Alternative approaches for the handling of child death cases should be explored, such as the West Palm Beach rapid response conducted jointly by the Department and law enforcement, to balance the need to insure child safety while minimizing intrusion in a family at a time of such tragedy.

5. This subcommittee should seek a meeting with the Statewide Child Abuse Death Review Team to discuss goals and expectations for stakeholders involved in the investigation and review of child deaths due to abuse or neglect.

In early 2010, we began to focus our work on ensuring consistency in the way we screen calls at the Florida Abuse Hotline and the way our child protective investigators conduct investigations of child abuse and neglect. On January 22, 2010, the Florida Abuse Hotline began to accept reports that do not meet statutory criteria but indicate a "Parent Needs Assistance". This process allows us to reach out to families who have not been accused of abuse of neglect, but by the nature of the Florida Abuse Hotline call, may need services.

- Each report is entered into FSFN and routed through the Florida Abuse Hotline’s Crime Intelligence Unit (CIU) where criminal background checks are completed on subjects of the intake.

- The CIU then assigns the "Parent Needs Assistance" intake to the local county investigations office and it is assigned to a Child Protective Investigator (CPI).

- A CPI responds and makes contact with the family and looks into the concerns expressed in the Florida Abuse Hotline intake. Prior to closing a case, the CPI Supervisor must review these intakes and approve the CPI’s actions/recommendations.

We have also increased Florida Abuse Hotline oversight. Florida Abuse Hotline supervisors now review a specified number of intake reports, screened calls, and prevention referrals per counselor, per day. Each week a total of about 2,800 documents are reviewed and, to date, approximately 99% of those were assessed as correct decisions. In addition:

- Florida Abuse Hotline Call Center Managers conduct a random Quality Assurance review of the counselors in their units each week.

- Each quarter, the Florida Abuse Hotline’s Quality Assurance Unit conducts a Quality Assurance review for each counselor at the Florida Abuse Hotline.

- Results of reviews are provided to the unit supervisor, who reviews and provides feedback, coaching, and training to Florida Abuse Hotline Counselors. Any report that was erroneously either screened out, or screened in as a Parent Needs Assistance, will be called back to the Florida Abuse Hotline by Florida Abuse Hotline staff reviewing the report.
Overall, we believe that our ability to identify child deaths associated with abuse or neglect, especially in the area of unsafe sleep and drowning, has substantially improved over the past few years. The state and local child death review committees have worked diligently to train our child protective investigators and local law enforcement in the identification of factors that would impact the maltreatment findings. Unsafe sleep and drowning cases that may have been considered accidents in the past, are now identified as verified neglect when factors such as substance misuse are involved.

In February, I provided testimony on child abuse and neglect deaths in Florida to the Florida Senate Children, Families, and Elder Affairs Committee. During this testimony, I had the opportunity to recognize the local child death review committees. In particular, I highlighted Dr. Barbara Wolf, Medical Examiner for the Fifth Judicial Circuit and her outstanding work with the Department, law enforcement, and state attorneys on unsafe sleep. Due to the good work of Dr. Wolf, child protective investigators and law enforcement are better prepared for these difficult cases. I also formally recognized the Broward County Child Death Review Committee as one of the longest standing, stable local committees in Florida, and the Broward County Sheriffs’ Office for their drowning task force.

The good work of the state and local child death review committees continues to guide the development of prevention programs and impact public policy in Florida’s child welfare system. This year, we will continue to work closely with the Department of Health and the State Child Abuse Death Review Committees. Your continued commitment to child protection in Florida is greatly appreciated.

Please call me at (850) 566-5670 if you have any questions.

Sincerely,

Alan Abramowitz
State Director
Office of Family Safety

cc: David Fairbanks, Assistant Secretary for Programs
    Peter Digre, Assistant Secretary for Operations
    Dr. Michael L. Haney, Division Director for Prevention and Intervention, Department of Health